Carboxyhaemoglobin levels and clinical features in five patients with acute carbon monoxide poisoning.

<table>
<thead>
<tr>
<th>Case No</th>
<th>Age</th>
<th>Sex</th>
<th>Carboxyhaemoglobin (%)</th>
<th>Clinical features</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>47</td>
<td>M</td>
<td>23%</td>
<td>nausea, vomiting, headache, diarrhoea</td>
</tr>
<tr>
<td>2</td>
<td>40</td>
<td>F</td>
<td>30%</td>
<td>nausea, vomiting, headache, diarrhoea</td>
</tr>
<tr>
<td>3</td>
<td>14</td>
<td>F</td>
<td>24%</td>
<td>nausea, vomiting, headache</td>
</tr>
<tr>
<td>4</td>
<td>12</td>
<td>F</td>
<td>40%</td>
<td>nausea, vomiting, headache</td>
</tr>
<tr>
<td>5</td>
<td>10</td>
<td>M</td>
<td>16%</td>
<td>nausea, vomiting, headache</td>
</tr>
</tbody>
</table>

hyperbaric oxygen even when it is given late. Chronic low level exposure is believed to be prevalent in the community and the diagnosis is usually missed because of the protein manifestations.

It is worth noting that the presence of carboxyhaemoglobin makes monitoring by pulse oximetry unreliable because the displayed saturation level equals the sum of oxyhaemoglobin and carboxyhaemoglobin. Significant hypoxia may therefore be masked and the clinician lulled into a false sense of security. Initial treatment should be with a non-rebreathing circuit with a non-return valve, oxygen reservoir, and tight fitting mask. The type of mask used by ourselves only delivers a maximum inspired oxygen concentration of 85% if applied correctly and connected to high flow oxygen. It is important to supply the highest oxygen concentration possible as the elimination half life of carbon monoxide is 240 minutes when breathing air, but only 60 minutes when breathing 100% oxygen.

The initial reluctance to transfer the other three patients suggests that the indications and potential benefits of hyperbaric oxygen are not well enough known; the reluctance appeared to be based on the belief that there is little scientific evidence to support the use of hyperbaric oxygen in carbon monoxide poisoning, as indicated by a recent survey by the BMA's Board of Science and Education. The indications for the use of hyperbaric oxygen following carbon monoxide poisoning are:

- Loss of consciousness at any time
- Neurological or psychiatric symptoms or signs, other than a mild headache, identified on thorough testing
- Cardiac complications such as arrhythmias, ischaemic chest pain, or ischaemic ECG changes
- Carboxyhaemoglobin concentration more than 40%, regardless of symptoms
- Pregnancy

Although all of these indications are well described in published reports, we feel that they require stressing as they may often be overlooked. In addition, we recommend that carbon monoxide poisoning be routinely excluded in all cases of suspected food poisoning or sudden illness affecting several people, especially family members, who are brought from the same location.

The authors would like to thank Dr J Ross, PCANAES, Senior Lecturer, Environmental and Occupational Medicine, University of Aberdeen, for providing information about the five patients in the case report.

3. BBC 1, 7 March 1994: "Watchdog".

Cortical bone cyst following a greenstick radial fracture

A R Wass, J P Sloan

Abstract
There are only a few reports of well defined cystic lesions of the peripheral skeleton following fracture. In children, these lesions are mostly small cortical defects affecting the distal radial metaphysis after a greenstick or torus fracture. A cyst is reported complicating a greenstick fracture, together with a brief review of published reports confirming that these are asymptomatic lesions which can be managed conservatively without further investigation.

(J Accid Emerg Med 1996;13:63-64)
Discussion
Greenstick or torus fractures are common injuries in children. They usually heal after a brief period of immobilisation with complete functional recovery. The development of cysts adjacent to such fractures has occasion-
ally been reported. A review of the English language reports1 identified 17 similar cases, 15 involving the distal radial metaphysis. The incidence of these postfracture cysts is un-known. They are probably more common than the published reports would suggest since most distal radius fractures in children are moni-
tored on clinical signs alone.

In all previously reported cases the post-
fracture cortical cysts were asymptomatic.
These cysts are discovered either during radi-
ological follow up of a fracture or after reinjury of the same limb (as in this case). They usually appear more than one month after the fracture. Characteristically the cysts are less than 10 mm in diameter, do not expand, appear rounded or slightly oval shaped, and may be multiple. Healing of the initial fracture is not affected by these cysts, nor do they predispose to patho-
logical fractures. Pfister-Goedeke and Braune reported spontaneous resolution in three out of nine cases (33%) at 3 years.3

There is debate about the aetiology of these cysts. Pfister-Goedeke and Braune4 suggested that they are resorption cysts within an excessive periostal reaction, related to the subperiosteal haematoma that accompanies greenstick fractures. Phillips and Keats attribute post-traumatic cysts to the resorption of intraosseous haemorrhage.4 Malghem et al reported that computed tomographic scanning of two cases showed a density consistent with a fatty content.3 They postulated that this fat resulted from the inclusion of medullary fat within the subperiosteal haematomata. This theory of transcortical escape of intramedullary fat is supported by Davids et al, who showed fat within a postfracture cortical cyst on magnetic resonance imaging.1 Uncertainty about the aetiology of these lesions is likely to continue as long as their histological nature remains unknown.4 However, to date, biopsy of these lesions has never been clinically justified in view of their asymptomatic nature. These small asymptomatic postfracture cor-
tical cysts are invariably incidental x ray findings and of little clinical importance. Failure to recognise this apparently rare com-
plication of minor fractures in children may cause confusion for the clinician and un-
necessary concern for parents. Expensive diag-
nostic investigation or operative intervention are not indicated in these cysts. We advocate review after 6 to 12 months to ensure that the lesion remains asymptomatic.

2 Malghem J, Maldague B. Transient fatty cortical defects following fractures in children. Skeletal Radiol 1986;15:
368–71.
83–6.
6 Moore TE, King AR, Travis RC, Allen BC. Post-traumatic cysts and cyst-like lesions of bone. Skeletal Radiol 1989;18:
93–7.

Two cases of paraduodenal hernia, a rare internal hernia

Thomas McDonagh, George A Jelinek

Abstract
Paraduodenal hernia is a rare congenital internal hernia which arises from an error of rotation of the midgut with entrapment of the small intestine beneath the develop-
ingsing colon. It is important as it usually presents as intestinal obstruction, and before laparotomy is often misdiagnosed. Mortality increases significantly with delays in surgical treatment. Two cases
Cortical bone cyst following a greenstick radial fracture.

A R Wass and J P Sloan

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