Fig. 1. Antero posterior view of the injured foot and undisplaced fractures of the base of the fifth metatarsal and a fracture of the accessory navicular are evident.

foot when he landed badly whilst practising long jump.

He presented to the accident and emergency department unable to weight bear and on examination a swollen forefoot on the medial side was evident together with excruciating tenderness over the base of the fifth metatarsal. Radiographs revealed an undisplaced fracture of the base of the fifth metatarsal and a fracture of a type II accessory navicular (Fig. 1).

A factor to consider in the management of fractures of these bones is the urgency with which the patient wants to return to physical activity and surgery is warranted if a trial of conservative immobilization management has been unsuccessful.

The patient, who was treated with a non-weight bearing Plaster of Paris cast for 6 weeks and made a full recovery, illustrates how a previously symptomless accessory bone of the foot can cause significant morbidity following sports trauma and that injuries to these bones, albeit rare, must be considered when managing foot injuries.

REFERENCE

1. Lepore L., Francobandiera L. & Maffulli N. (1990) Fracture

of the os tibiale externum in a decathlete. *Journal of Foot Surgery* 29, 366–368.

M. GAVALAS,¹ S. HARRIS¹ & N. MAFFULLI²

Departments of ¹ Accident and Emergency and ² Orthopaedics, Newham General Hospital, Glen Road, Plaistow London

Toxic shock syndrome after burns in children

Non-menstrual toxic shock syndrome (TSS) has received little publicity compared with the form associated with tampon use. The care of children with burns may be improved if all those dealing with them (parents as well as professionals) were aware of the clinical manifestations of TSS, to allow early diagnosis and treatment.

TSS has a high mortality rate (15%)¹ rising to over 50% amongst patients with shock at presentation.² Although uncommon, accident and emergency (A&E) staff must be aware of the problem^{3,4} and the possibility that TSS can occur even after an apparently trivial burn.⁵

To establish current practice we wrote to 39 A&E departments (seeing more than 20 000 patients a year), a teaching hospital and general hospital in each region, and also to children's hospitals with A&E facilities asking the consultant in charge two questions. Namely, (1) are your junior staff taught to give advice about the early signs of TSS to parents of children with a burn? and (2) do you have printed advice about TSS to give to parents?

Twenty replies were received. Only one indicated that their junior staff gave advice; this was supplemented by an advice sheet which contained both general advice and advice related to TSS.

We feel that A&E staff and parents should be advised about the early signs of TSS and that the most effective way to do this would be with an advice sheet. This sheet should ask the parents to bring back their child in the event of any of the following:

- (1) sudden fever (>39.5 C),
- (2) gastrointestinal upset,
- (3) breathlessness,
- (4) sore throat/pharyngitis,
- (5) skin problems,
- (6) drowsiness or confusion,
- (7) headache.

A&E staff should enquire specifically about the manifestations listed above and also seek further evidence of TSS⁶ for example:

- (1) cardiovascular disturbance — tachycardia or

postural drop in diagnostic BP > 15 mmHg, systolic BP < 5th centile;

(2) haematological disturbance — low haemoglobin, leucopenia and thrombocytopenia may occur (not necessarily together);

(3) biochemical disturbance — elevation to greater than twice the upper limit of the reference range of the following may occur: creatinine kinase, urea, creatinine, AST or ALT;

(4) sterile pyuria;

(5) mucous membrane hyperaemia; and

(6) myalgia.

We hope to add this advice to the information currently given to parents in this department and wonder if this should become more widespread.

REFERENCES

1. Glazowski M.J., Osergaard G.Z., Arpi M. & Thomsen

M. (1992) Toxic shock syndrome. A case of a child with burns. *Ugeskrift for Laeger* **154**, 868–869.

2. McAllister R.M., Mercer N.S., Morgan B.D. & Sanders R. (1993) Early diagnosis of staphylococcal toxaemia in burned children. *Burns* **19**, 22–25.

3. Frame J.D., Even M.D., Hackett M.F., Dowsett E.G., Brain A.N., Gault D.T. & Wilmshurst A.D. (1985) Toxic shock syndrome in burned children. *Burns* **11**, 234–241.

4. Cole R.P. & Shakespeare P.G. (1990) Toxic shock syndrome in scalded children. *Burns* **16**, 221–224.

5. Heywood A.J. & al-Essa S. (1990) Toxic shock syndrome in a child with only 2% burn. *Lancet* **335**, 867.

6. Shands K.N., Schmid G.P., Dan B.B., *et al.* (1986) Toxic shock syndrome in menstruating women. *New England Journal of Medicine* **303**, 1436–1442.

R. HARDERN & S. CAVANAGH

*Accident and Emergency Department, Leeds
General Infirmary, Leeds*