considering hyponatraemia as a cause of reversible cerebellar dysfunction.

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Spontaneous flail chest in multiple myeloma

Sir,
Spontaneous flail chest is rare in multiple myeloma but poses a difficult therapeutic problem.^{1–3} We report prolonged survival of a patient after hemibody irradiation.

He presented at age 59 with a 2 month history of chest pain. On examination there was a large anterior flail segment, with paradoxical movement of the sternum and 4th to 9th ribs bilaterally; a chest X-ray revealed multiple bilateral rib fractures. Full blood count and renal function were normal. Abnormal findings confirming

myelomatosis were a serum calcium of 2.7 mmol/l (albumin 36 g/l), a faint M-band in serum, 0.1 g/l of kappa light-chains in urine, widespread lytic bone lesions, and 41% atypical plasma cells in bone marrow. There was no respiratory failure. Ten milligrams of melphalan and 40 mg prednisolone were given daily for 3 days but his pain worsened. He was therefore treated with a modified upper (600 cGy in single fraction), followed by lower, hemibody irradiation⁴ and then 9 further courses of melphalan and prednisolone. Four months after starting treatment there was reduced mobility of the flail, radiological bone healing, improved spirometry and under 2% plasma cells in bone marrow. His chest is deformed but stable 4 years after diagnosis.

Although skeletal involvement is common in multiple myeloma, reports of spontaneous flail chest are rare. Our experience accords with previous descriptions:^{1–3} despite its alarming presentation, this complication does not necessarily predict a poor prognosis and justifies an aggressive approach to therapy.

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