Paper version of the *Hong Kong Medical Journal* should stay

To the Editor—I enjoyed reading the editorial of the December 1999 issue of the Journal, titled 'Whither the *Hong Kong Medical Journal*?'.[1]

Nothing should and would replace printed publications in my lifetime, because reading words on a piece of paper was (and still is) how I learned and entertained myself. I can do it comfortably while I am taking the train, on a ferry, lying in bed, or even in the bathroom! While I know my way around a computer, which serves many useful purposes, I still prefer to read sheets of paper rather than a glaring computer screen.

The only change that should be made to the Journal, in my opinion, is the use of cheaper and thinner paper. The glossy cover looks good on a coffee table, but that is not what the Journal is for. A thinner and lighter version is easier to carry, cheaper to produce, and 'greener'.

CS Feng, MB, BS, FHKAM (Pathology)
Clinical Laboratory
St Paul's Hospital
2 Eastern Hospital Road
Causeway Bay, Hong Kong

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Constant clinical surveillance is also important when monitoring blood gases

To the Editor—I read with interest the article by Mak et al titled 'Management of carbon monoxide poisoning using oxygen therapy'.[1]

I recently encountered a case of hereditary methaemoglobinaemia in a term infant who presented with central cyanosis on her first day of life. The family and antenatal history was unremarkable, and there was no history of drug treatment except for that of intramuscular vitamin K, which was given at birth. Apart from the central cyanosis, results of the clinical examination were normal. Her oxygen saturation in room air was 93%, as measured by pulse oximetry. Arterial blood gas measurements were as follows: pH 7.45; oxygen tension, 70 mm Hg; carbon dioxide tension, 26 mm Hg; base excess, -4.4; and a calculated oxygen saturation of 99%. The discrepancy between the clinical findings, pulse oximeter reading, and arterial blood gas measurements suggested dyshaemoglobinaemia. The patient was subsequently found to have a methaemoglobin level of 18.5% (normal level, <1%). The activity of NADH-cytochrome b5 reductase, which is the most important enzyme involved in the reduction of methaemoglobin to haemoglobin, was found to be much lower than normal (0.2 versus 2.8 IU/g haemoglobin). The result led to the diagnosis of hereditary methaemoglobinaemia due to deficient NADH-cytochrome b5 reductase activity. The diagnosis of methaemoglobinaemia in this case would have been missed if the attending physician had interpreted the pulse oximeter reading as being normal and if further investigations were not performed. As with any form of monitoring, an understanding of the working principle is vitally essential. But one must not forget the importance of constant clinical surveillance of the patient concerned.

AM Li, MRCP, MRCPCH
Department of Paediatrics
The Chinese University of Hong Kong
Prince of Wales Hospital
Shatin, Hong Kong

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