

Pach et al. (1978; 1979) reviewed cases of CO poisoning in the Toxicological Clinic, Cracow, Poland, in the years 1975-1976. Excluded from this study were mixed intoxications (e.g., by CO and medicaments). Group A comprised 101 persons (60 men and 41 women, mean age  $48 \pm 15$  years) who had died from CO poisoning before arrival at the clinic. Measurement of COHb and autopsy was done on these subjects. Group B comprised 220 subjects (95 men and 125 women, mean age  $38 \pm 18$  years) who were treated for CO poisoning. COHb was determined upon arrival at the clinic. Patients were excluded from further analysis if more than 120 min elapsed between the end of exposure and the blood drawing at the clinic ( $n = 62$ ). For the patients, the COHb level was recalculated at the end of exposure. Mean COHb values for Groups A and B were  $62\% \pm 10\%$  and  $28\% \pm 14\%$ , respectively. In Group A, the percentages of subjects with COHb levels of 30-40%, 40-50%, 50-60%, 60-70%, 70-80%, and 80-90% were 2%, 6%, 26%, 44%, 21%, and 2%, respectively, and 3%, 25%, 32%, 24%, 12%, 3%, 0.6%, and 0.6% of the patients in the corrected Group B had COHb values of 0-10%, 10-20%, 20-30%, 30-40%, 40-50%, 50-60%, 60-70%, and 70-80%, respectively. Within each group, no correlation between COHb and either sex, blood alcohol above 0.1%, or poisoning circumstances (accidental or suicidal) were found. Group A showed a higher percentage (34%) of subjects who were 60 years or older than Group B (13%); Group B had a higher percentage of subjects younger than 30.

Grace and Platt (1981) reported two cases of myocardial infarction due to CO poisoning. In the first case, a 67-year-old man was exposed to increased CO concentrations for about a few weeks in his home due to a rusted-out flue of a gas furnace. The man presented to the emergency room after 3 days of persistent light-headedness with vertigo, brief stabbing anterior chest pain that worsened with deep inspiration, a dry cough, chills, and a mild headache. His wife experienced similar malaise and dizziness that had been resolving over the past week. At the hospital, his symptoms were explained with a diagnosis of viral syndrome, hypokalemia of unclear origin, and diabetes mellitus with diabetic peripheral and autonomic neuropathy. Ten days after discharge he was seen in the emergency room with true vertigo, palpitations, and nausea but was sent home to be followed up as an outpatient. Four days later he returned to the emergency room after development of rectal urgency and an explosive incontinent diarrheal stool, followed by a severe crushing anterior chest pain. With the pain he collapsed on the floor. The electrocardiogram showed an acute myocardial infarction. His COHb (measured on arterial blood gases) was 15.6%; the level of the patient's wife was 18.1%. The patient survived and recovered completely.

In the second case, a 69-year-old man came to the emergency room after awakening 2 days earlier with confusion, nausea, and vomiting. He then passed out and awoke the next day in the bathroom. He crawled to the living room, where he again passed out for an undetermined amount of time, awoke to open his door for fresh air, and then went to bed. He later experienced auditory and visual hallucinations and phoned his neighbor for help. An acute inferior myocardial infarction with secondary mild congestive heart failure and chronic ob-