

Decreased brachial plexus palsy after institution of shoulder dystocia protocol

TO THE EDITORS: In the recent study evaluating outcomes after instituting a shoulder dystocia protocol that included 5 components, the authors describe a “reduced frequency of brachial plexus palsy when a shoulder dystocia occurred.”¹ I have several questions for the authors:

1. After institution of the protocol, did the institutional cesarean rate change?
2. Did the protocol include the use of downward traction?
3. Given the stable shoulder dystocia rate for the 3 study periods, to what do the authors ascribe the decreased brachial plexus palsy rates after institution of the protocol?

If the brachial plexus injuries were related to the shoulder dystocia event and not traction by the provider, would the authors have expected the brachial plexus palsy rate to have remained stable? ■

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The author reports no conflict of interest.

REFERENCE

1. Grobman WA, Miller D, Burke C, Hornbogen A, Tam K, Costello R. Outcomes associated with the introduction of a shoulder dystocia protocol. *Am J Obstet Gynecol* 2011;205:513-7.

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REPLY

We would like to thank Dr Jelsema for his interest in our article¹ as well as the questions he has asked. During time periods A, B, and C of the study, the cesarean rates were 27.1%, 28.2%, and 29%, respectively. This change in the point estimate was not statistically significant ($P = .12$). Even if statistical significance had been reached, we do not believe this would explain a decrease in the frequency of brachial plexus palsy documented

given the denominator for the frequency was “per shoulder dystocia,” and that the frequency of shoulder dystocia per delivery did not change over time. The protocol itself was focused upon the team response to the shoulder dystocia and did not convey specific maneuvers, or order of maneuvers, that should be employed in the management of the shoulder dystocia. Thus, providers’ judgment was relied upon to determine what maneuvers and traction were employed.

The last 2 questions are more difficult to answer, as they are speculative as opposed to factual. We do not believe we can know, from the study itself, what exact factor is responsible for the reduction in brachial plexus palsy. However, we do not believe it is due to providers changing their approach to traction, as that change was not part of the protocol. Indeed, we believe this study highlights that it is unlikely that there is one “provider” who is responsible for each and every obstetric outcome, particularly in a setting as emergent as shoulder dystocia and for an outcome with as many potential etiologies as brachial plexus palsy. Instead, the importance of a team approach, which includes contributions from physicians, midwives, nurses, patients, and their families, is emphasized as a potential factor in ameliorating the consequences of this obstetric emergency. ■

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Lymphadenectomy in endometrial cancer: what’s the right question?

TO THE EDITORS: We read, with great interest, the article by Sharma et al,¹ in which, in a large retrospective study on data from the National Cancer Institute’s Surveillance, Epidemiology, and End Results database, the authors analyzed women with stages I-II endometrioid adenocarcinomas of the uterine corpus treated between 1988 and 2006. Findings suggest that,

especially among women with high- to intermediate-risk tumors, patients who undergo lymphadenectomy are less likely to receive external-beam radiation. According to the authors, data support lymphadenectomy for the majority of women with endometrial carcinoma, thus sparing radiation-related morbidity and costs.