Letter to the Editor Regarding the article: "Obstetric Paralysis: Who is to blame? A systematic literature review" – Galbiatti JA, Cardoso FL, Galbiatti MGP. Rev Bras Ortop 2020;55(2):139-146

Andreas Rehm[1] Azeem Thahir[2]

[1] Department of Paediatric Orthopaedics, Paediatric Division, Cambridge University Hospitals NHS Trust, Cambridge, United Kingdom
[2] Department of Trauma & Orthopaedics, Cambridge University Hospitals NHS Trust, Cambridge, United Kingdom

Address for correspondence Andreas Rehm, MD, Consultant Paediatric Orthopaedic Surgeon, Addenbrooke's Hospital, Cambridge University Hospitals NHS Trust, Hills Road, Cambridge, CB2 0QQ, United Kingdom (e-mail: leoreporting@yahoo.co.uk).

Rev Bras Ortop 2021;56(3):403–404.

Dear Editor,

We read with interest the recent publication by Galbiatti and colleagues: "Obstetric Paralysis: Who is to blame? A systematic literature review." The title is incorrect, since the review described in the publication is a narrative literature review, which is limited to review articles, and not a systematic review (SR). A SR should only include original research and not review articles. The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) statement (27-item checklist), with a flow diagram, should be used, and it is advisable to register a SR with a protocol registry (Campbell or Cochrane Collaboration, International Prospective Register of Systematic Reviews [PROSPERO]). Randomized controlled trials provide the highest validity and the least bias, followed by prospective cohort studies, case-control/retrospective cohort studies, and case series with increasing bias. There are multiple tools available to assess the quality of the evidence used for SRs, such as the Grading of Recommendations Assessment, Development and Evaluation (GRADE) approach, which rates the certainty of evidence, and the Quality in Prognosis Studies (QUIPS) tool, which assesses the risk of bias.

Galbiatti et al.[1] stated that the literature is changing its direction and that, with their study, they helped to break the paradigm that obstetric palsy (OP) is compulsorily associated with shoulder dystocia and that its occurrence necessarily implies negligence, malpractice, or recklessness of the team involved. We are not aware that such a paradigm exists or has existed in the medical literature for over 20 years, with the direction having been changed already a long time ago. Jennett et al.[2] reported, in 1992, that only 43% of their OP cases were associated with shoulder dystocia and that the data were strongly suggestive that intrauterine maladaption may play a role in OP and should not be taken as prima facie evidence of a birth-process injury.

Gilbert et al.[3] reported, in 1999, on 1,611 OP cases born in California in 1994 and 1995, identifying large birth weight (> 4.5 kg), malpresentation, maternal diabetes, and operative vaginal deliveries, in addition to shoulder dystocia, as risk factors without indicating an association to training, experience, or malpractice of the team.

Galbiatti et al.[1] indicated that the incidence of OB does not differ if the baby is delivered by young obstetricians or surgeons with extensive experience. This is contradicted by Murphy et al.,[4] who reported on 393 operative deliveries of term singletons with 59 cases of head trauma and brachial plexus palsy. Ninety-eight percent of deliveries were performed by a trainee, and 2% by a consultant obstetrician. The six most severe cases of neonatal morbidity were initiated by a trainee. The authors concluded: "Operator experience clearly played a role in the frequency of excessive pulls and the use of multiple instruments."

Inglis et al.[5] reported, in 2011, that training of maternity staff resulted in a decrease of the OP rate in vaginal deliveries from 0.4 to 0.14%, and after shoulder dystocia from 30 to 10.67%. Ameh et al.[6] reported, in 2019, that staff training, adherence to protocols, communication, team working, and

received
June 18, 2020
accepted
September 16, 2020
published online
September 25, 2020

DOI https://doi.org/10.1055/s-0040-1722581.
ISSN 0102-3616.

© 2021. Sociedade Brasileira de Ortopedia e Traumatologia. All rights reserved.
This is an open access article published by Thieme under the terms of the Creative Commons Attribution-NonDerivative-NonCommercial-License, permitting copying and reproduction so long as the original work is given appropriate credit. Contents may not be used for commercial purposes, or adapted, remixed, transformed or built upon. (https://creativecommons.org/licenses/by-nc-nd/4.0/)

Thieme Revinter Publicações Ltda., Rua do Matoso 170, Rio de Janeiro, RJ, CEP 20270-135, Brazil

resuscitation technique reduce trauma after shoulder dystocia and neonatal hypothermia and hypoxia.

The change that has taken place is the acknowledgement that communication and training on how to manage complex deliveries with shoulder dystocia can reduce the risk of OP.

Conflict of Interests

The authors have no conflict of interests to declare.

References

1 Galbiatti JA, Cardoso FL, Galbiatti MGP. Obstetric Paralysis: Who is to blame? A systematic literature review. Rev Bras Ortop (Sao Paulo) 2020;55(02):139–146

2 Jennett RJ, Tarby TJ, Kreinick CJ. Brachial plexus palsy: an old problem revisited. Am J Obstet Gynecol 1992;166(6 Pt 1):1673-–1676, discussion 1676–1677

3 Gilbert WM, Nesbitt TS, Danielsen B. Associated factors in 1611 cases of brachial plexus injury. Obstet Gynecol 1999;93(04): 536–540

4 Murphy DJ, Liebling RE, Patel R, Verity L, Swingler R. Cohort study of operative delivery in the second stage of labour and standard of obstetric care. BJOG 2003;110(06):610–615

5 Inglis SR, Feier N, Chetiyaar JB, et al. Effects of shoulder dystocia training on the incidence of brachial plexus injury. Am J Obstet Gynecol 2011;204(04):322.e1–322.e6

6 Ameh CA, Mdegela M, White S, van den Broek N. The effectiveness of training in emergency obstetric care: a systematic literature review. Health Policy Plan 2019;34(04):257–270