

ALSO (UK) – ARE WE MAKING A DIFFERENCE?

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The ALSO course was brought to the UK from America in 1996, funded by a research grant from central 'Changing Childbirth' monies. We have now trained several thousand practitioners in the management of rare emergencies such as shoulder dystocia: 2701 midwives, 247 GPs, 995 obstetricians and 50 others (A&E physicians, paramedics etc) – figures at December 2002..

Previous publications have confirmed that attending the ALSO course leads to significant and sustained improvement in confidence levels in subsequent clinical practice¹. However, as the important adverse outcome measures we wish to avoid are rare (eg maternal and neonatal mortality), there is no definitive evidence to confirm improvement in these outcomes. However, two recent publications in the UK from the NHSLA (National Health Service Litigation Authority) provide surrogate evidence that we may be having a real effect on clinical outcome^{2,3}.

At a time when obstetric litigation is generally increasing, it is interesting to see a downturn in the number of registered claims for brachial plexus injury from 1998/9 onwards² (see fig 1)

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Erb's Palsy - claims and requests for records between 1993 and 2002.

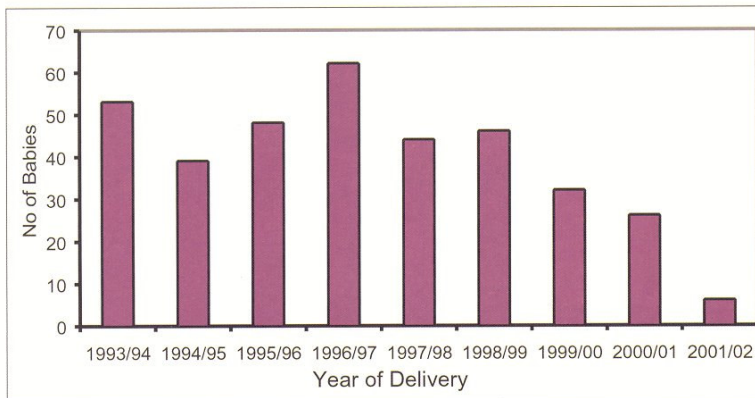


Fig 1

Provider Course – Numbers Trained

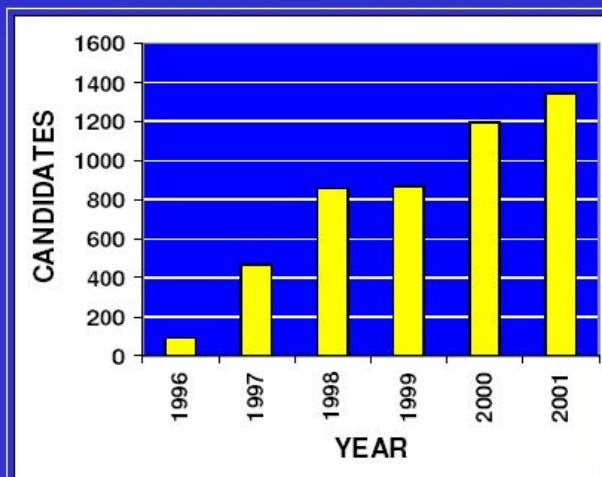


Fig 2

Whilst accepting that not all cases of brachial plexus trauma may have reached litigation as yet, the article points out that notification of claims are mostly submitted within 1 year of delivery. Although we cannot prove 'cause and effect', it is interesting to propose that this change may be due to improved clinical care related to the implementation and dissemination of ALSO and similar courses. Figure 2 shows the number of providers trained in the UK between 1996 and 2001.

The 'Recommendations' section in the second article³, quotes Roger Clements' description of *three* appropriate manoeuvres for managing shoulder dystocia: 1) McRobert's position; 2) Suprapubic pressure (prior to traction) and 3) Attempt to deliver posterior arm. The author has recently reviewed available evidence for the chapter on 'Shoulder Dystocia' in the MOET ('Managing Obstetric Emergencies and Trauma') course manual⁴. It is important to point out that internal rotatory manoeuvres (eg Wood Screw) as described in the ALSO 'H.E.L.P.P.E.R.' mnemonic are effective alternatives to removal of the posterior arm. Richard Johanson's survey of obstetric practice in the UK showed that 36% would primarily use rotatory manoeuvres and 56% would use removal of the posterior arm⁵. Both are effective and there is no published data showing one to be more effective than the other. Indeed, the 5th CESDI report recommended that drills should include a variety of approaches to deal with shoulder dystocia⁶. The order of application is not the important issue: the practitioner should use the manoeuvre that they are most familiar and comfortable with. However, they should be aware of the alternatives should their preferred approach fail.

References

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