

LETTER TO THE EDITOR

MICROSURGERY 28:580 2008

RE: NERVE TRANSFERS IN CHILDREN WITH TRAUMATIC PARTIAL BRACHIAL PLEXUS INJURIES

Dear Editor,

We are honored by your interest in our article.¹ We think that the double nerve transfer is a very efficient technique, even better than nerve grafting, for the treatment of upper partial brachial plexus palsies in adults.² Of course there is no reason for this technique to be excluded for children and this is a point we tried to make by presenting these cases, since traumatic brachial plexus injuries may concern children as well. However, as you mentioned in your letter, only two patients have been presented in the current literature. Actually we think that this surgical option must be promoted, as being equally indicated as nerve grafting procedures, for the restoration of active elbow flexion in upper brachial plexus palsies. Moreover, it has been proven that nerve recovery is generally better in children even if the surgery is delayed,³ and the double nerve transfer seems to be a better choice than the use of nerve grafts 6 months post-traumatically because of the shorter distance between the nerve suture site and the paralyzed muscle.

We agree with you about the possibility of performing this technique in obstetrical palsies to restore active elbow flexion. Currently, nerve grafting is the common method used in obstetrical palsies.^{4–6} However, some short series have shown the good results of the double nerve transfers.^{7,8} Our relevant experience is still limited, because we have recently started using the technique in obstetrical palsy patients, so it is too early to proceed to a publication. Nevertheless, we do not perform nerve grafting procedures for the restoration of active elbow

flexion in our patients with upper-type plexus obstetrical palsy anymore. In cases where shoulder function was either satisfactory or had spontaneously recovered there was no need for surgical treatment. In patients where shoulder function was not satisfactory, nerve grafting from C5 or C6 root was performed in the presence of neuroma-in-continuity with bad intraoperative nerve conduction, whereas in case of C5, C6 roots avulsion spinal to suprascapular nerve transfer was the treatment of choice.

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