Letters to the Editor

Symphysiotomy for Shoulder Dystocia

Original Article: Shoulder Dystocia: Managing an Obstetric Emergency

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To the Editor: I read Dr. Hill and colleagues' excellent review on shoulder dystocia with particular interest, remembering a terrifying experience early in my career attending the delivery of a patient who was short, morbidly obese, primiparous, and who had type 2 diabetes mellitus. At the time, I worked in a 40-bed rural hospital in the Smoky Mountains, and the blizzard of 1982 was occurring. I attempted to manage shoulder dystocia using the HELPERR mnemonic from an American Academy of Family Physicians Advanced Life Support in Obstetrics course.[1] None of the maneuvers worked, and the baby's heart rate dropped to 20.

Our general surgeon arrived despite deep snowdrifts; however, the surgery suites were without electricity, and our anesthetist could not get in. "Section here with local and conscious sedation?" I asked. The surgeon shook his head. "No time! Ever done a symphysiotomy?" I had not. "No better time than now to learn." He guided me through my first and only symphysiotomy, which I have described elsewhere.[2] The procedure was easy to perform and instantly successful (as was the neonatal resuscitation).

Symphysiotomy does not require an operating room or advanced surgical skills. Infiltrating the skin and the subcutaneous and fibrocartilaginous tissues of the symphysis pubis with local anesthetic allows an incision through the symphysis. This allows instant modest separation of the pubic bones, which increases the size of the pelvic outlet to allow vaginal delivery.[3-5] One review of the procedure states, "Although effective, we recommend avoiding symphysiotomy unless all other maneuvers have failed, and cesarean delivery is not possible."[3]

According to a Cochrane review of symphysiotomy for fetopelvic disproportion, "Criticism of the operation because of complications, particularly pelvic instability, and as being a 'second-best' option has resulted in its decline or disappearance from use in many countries." However, "several large observational studies have reported high rates of success, low rates of complications, and very low mortality rates."[4] A meta-analysis of seven studies (n = 1,266) from low- to middle-income countries compared symphysiotomy with cesarean and found no differences in maternal or perinatal mortality.[6]

Complications are rare, and "long-term complications after symphysiotomy do not differ notably from those after cesarean section for similar indications."[4-6] A potential advantage is that "the modest permanent enlargement of the pelvis post symphysiotomy, together with the absence of a scarred uterus, may facilitate subsequent vaginal delivery."[5] More importantly, "If there is no other available option, symphysiotomy may be lifesaving for the baby, the mother, or both."[4] Health care professionals attending deliveries should be aware of this option for shoulder dystocia. I'm glad my consultant was.

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Editor's Note: This letter was sent to the authors of "Shoulder Dystocia: Managing an Obstetric Emergency," who declined to reply.

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