

## Another technique for elevating the fetal vertex

I would like to compliment Dr. Andrew Chao on his excellent article, "Safe delivery of the fetal head during cesarean section" [January].

Dr. Chao addresses a seldom-discussed topic—delivering the fetal head from a low pelvic station—that presents a clinical dilemma to every practicing Ob/Gyn.

In my years of practice, I have found the straight-wrist elevation of the fetal vertex to be the most important aspect

of this difficult delivery. As Dr. Chao points out, levering the vertex from the pelvis often causes extensions down to the bladder or cervix. My technique for handling this problem is to have the operating physician always use the hand closest to the patient's head when elevating an engaged fetal vertex. This across-the-body reach automatically results in the straight-line traction needed to elevate the head. This position makes it virtually impossible to lever the lower uterine segment unless the operator turns his body and leans over.

—DAVID J. EVANS, MD, FACOG  
SIDNEY, OHIO

### Dr. Chao responds:

Thanks to Dr. Evans for his novel suggestion. His technique uses the operator's non-

dominant hand and arm, advanced into position by—I presume—rotation of the trunk. If the fingers meet resistance during insertion, clinicians may consider bracing the outside of the elbow with the opposite hand to give the maneuver additional rigidity and strength.

## A clarification for the defendant physician

Dr. Richard Soderstrom's article, "Chicken soup for the defendant physician" [February], has some good tips for the physician who is facing a lawsuit and trial. I write to point out 1 small but significant error.

The article states, "The plaintiff also must demonstrate that the defendant's alleged error was the proximate cause of an injury." The correct term is "a proximate cause." Although the law varies somewhat from state to state, all jurisdictions—to my knowledge—require only that the negligence constitute *a* proximate cause or a substantial factor in causing the injury. Thus, there can be more than 1 cause of injury—for example, the underlying illness of the patient plus negligence or a violation of the standard of care.

The distinction is important because if it were required that the medical error be *the* proximate cause of an injury, it would be almost impossible for a plaintiff to ever prevail in a malpractice suit.

—JACK H. OLENDER, JD, LL.M.  
WASHINGTON, DC

### Dr. Soderstrom responds:

I appreciate Mr. Olender's correction; it is an important distinction for all to understand. This was an error on my part and



I know the editors will publish our correspondence so my error does not become “a proximate cause.”

### **Shoulder dystocia: 2 pearls**

**T**he article on shoulder dystocia by Drs. Gimovsky and Michael [December] was a very useful review of a serious and common problem. I would like to add 2 relevant pearls.

1. A generous episiotomy or episio-proctotomy may facilitate prompt delivery by permitting easier shoulder rotation and more room for delivery of the posterior arm.
2. Delivery of the posterior arm—as mentioned in the article—may result in humeral fracture. To avoid this, the practitioner should slide his or her hand along the posterior arm to the elbow and place thumb pressure in the antecubital fossa. This will cause the arm to flex at the elbow. The operator should grab the forearm and sweep it across the chest as indicated by the authors. Pressure applied to the mid-humerus should be avoided, as this may result in fracture.

—MARK S. BROWN, MD, FACOG  
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#### **Dr. Gimovsky responds:**

Dr. Brown makes a most important observation. Since few deliveries with this complication require delivery via the posterior arm, flexing the arm in this manner is an effective technique for resolving shoulder girdle dystocia.

Avoiding humerus fracture by generating flexion in the manner described by Dr. Brown can reduce the risk of neonatal injuries. ■