

# Free-functioning gracilis transfer to restore upper limb function in brachial plexus injury

Interventional procedures guidance  
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[www.nice.org.uk/guidance/ipg687](https://www.nice.org.uk/guidance/ipg687)

## 1 Recommendations

- 1.1 Evidence on the safety of free-functioning gracilis transfer to restore upper limb function in brachial plexus injury shows well-recognised complications. Evidence on its efficacy is adequate to support the use of this procedure provided that standard arrangements are in place for clinical governance, consent and audit. Find out [what standard arrangements mean on the NICE website](#).
- 1.2 This procedure should only be done in a specialist brachial plexus unit by a multidisciplinary team including specialised physiotherapists, with input from microvascular surgeons.

## 2 The condition, current treatments and procedure

### The condition

- 2.1 The brachial plexus is a network of nerves that carries signals from the spinal cord to the shoulder, arm and hand. These nerves can be damaged by being stretched, compressed or torn from the spinal cord. The most severe brachial plexus injuries are often a result of road traffic accidents. Severe nerve damage can lead to paralysis of an upper limb, with a loss of function and sensation, and severe pain.

### Current treatments

- 2.2 Treatment depends on the type and severity of the injury, and the length of time since the injury. Injuries of the upper brachial plexus roots affect the muscles around the shoulder. Injuries of the lower roots affect the hand. Many injuries affect both upper and lower roots. Current treatments include medicines to treat pain and conservative care (such as physiotherapy). For some people, surgical procedures are needed to restore function. These include direct suture, nerve grafts, nerve transfer, tendon transfer and free-functioning muscle transfer.

### The procedure

- 2.3 This procedure aims to restore the function of the upper limb after brachial plexus injury, improving the patient's ability to carry out daily activities.
- 2.4 The procedure is done under general anaesthesia, with the patient in a supine position. A functioning gracilis muscle, with its own nerve and blood supply, is dissected from the inner thigh. The gracilis muscle is then transferred and joined to the prepared recipient site of the upper limb. The gracilis muscle's nerve is connected to a functioning nerve in the arm. The transfer is usually to 1 muscle group but transfer to different

sites, such as the biceps or the finger flexors, may be needed depending on the nerve injury. The aim is usually to reconstruct a single function, such as elbow flexion.

- 2.5 After the procedure, the patient needs to wear a cast or splint for about 6 weeks to immobilise the elbow and protect the transferred gracilis muscle. Long-term physiotherapy is needed after the procedure so that the patient can learn to control the transferred muscle.

## 3 Committee considerations

### The evidence

- 3.1 NICE did a rapid review of the published literature on the efficacy and safety of this procedure. This comprised a comprehensive literature search and detailed review of the evidence from 10 sources, which was discussed by the committee. The evidence included 2 systematic reviews, 4 non-randomised comparative studies and 4 case series. It is presented in [table 2 of the interventional procedures overview](#). Other relevant literature is in the appendix of the overview.
- 3.2 The professional experts and the committee considered the key efficacy outcomes to be: restoring upper limb function and improving quality of life.
- 3.3 The professional experts and the committee considered the key safety outcomes to be: pain, bleeding, infection and graft failure.
- 3.4 Patient commentary was sought but none was received.

### Committee comments

- 3.5 The committee noted that this procedure can be done as a single or double free-functioning gracilis transfer. The evidence suggests a double transfer may be more effective than a single transfer.

- 3.6 The committee noted that postoperative physiotherapy is essential for functional recovery and relearning neurological muscle control. Long-term supervision from physiotherapists is needed and the patient must be completely engaged with their therapy.
- 3.7 The committee was informed that after the procedure it takes about 4 months for nerve reconnection and up to 1 year for muscle movement.
- 3.8 The committee noted that severe brachial plexus injury can have considerable adverse effects on a person's ability to carry out daily activities and their quality of life.
- 3.9 The committee noted that the procedure can be done as a part of primary treatment for total brachial plexus paralysis, or as a salvage treatment when reinnervation of existing muscles has failed to restore function in the upper limb.

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## Endorsing organisation

This guidance has been endorsed by [Healthcare Improvement Scotland](#).

## Accreditation

