Australian Government
Repatriation Medical Authority

Statement of Principles
concerning
TRAUMATIC BRACHIAL PLEXOPATHY
(Balance of Probabilities)
(No. 2 of 2025)

The Repatriation Medical Authority determines the following Statement of Principles under subsection 196B(3) of the *Veterans' Entitlements Act 1986*.

Dated 17 December 2024.

Professor Terence Campbell AM
Chairperson
by and on behalf of
The Repatriation Medical Authority

Contents

1 Name

This is the Statement of Principles concerning *traumatic brachial plexopathy (Balance of Probabilities)* (No. 2 of 2025).

2 Commencement

This instrument commences on 28 January 2025.

3 Authority

This instrument is made under subsection 196B(3) of the *Veterans' Entitlements Act 1986*.

4 Application

This instrument applies to a claim to which section 120B of the VEA or section 339 of the *Military Rehabilitation and Compensation Act 2004* applies.

5 Definitions

The terms defined in the Schedule 1 - Dictionary have the meaning given when used in this instrument.

6 Kind of injury, disease or death to which this Statement of Principles relates

(1) This Statement of Principles is about traumatic brachial plexopathy and death from traumatic brachial plexopathy.

*Meaning of **traumatic brachial plexopathy***

(2) For the purposes of this Statement of Principles, traumatic brachial plexopathy:

(a) means a physical injury to the brachial plexus; and
(b) excludes:

(i) Parsonage-Turner syndrome (neuralgic amyotrophy);
(ii) radiation induced plexus injury;
(iii) thoracic outlet syndrome;
(iv) cervical radiculopathy or myelopathy; and
(v) upper limb mononeuritis multiplex.

Note: There are a separate set of SoPs for thoracic outlet syndrome that may also be applicable.

*Death from **traumatic brachial plexopathy***

(3) For the purposes of this Statement of Principles, traumatic brachial plexopathy, in relation to a person, includes death from a terminal

event or condition that was contributed to by the person's traumatic brachial plexopathy.

Note: ***terminal event*** is defined in the Schedule 1 – Dictionary.

7 Basis for determining the factors

On the sound medical-scientific evidence available, the Repatriation Medical Authority is of the view that it is more probable than not that traumatic brachial plexopathy and death from traumatic brachial plexopathy can be related to relevant service rendered by veterans or members of the Forces under the VEA, or members under the MRCA.

Note: ***MRCA***, ***relevant service*** and ***VEA*** are defined in the Schedule 1 – Dictionary.

8 Factors that must exist

At least one of the following factors must exist before it can be said that, on the balance of probabilities, traumatic brachial plexopathy or death from traumatic brachial plexopathy is connected with the circumstances of a person's relevant service:

(1) having trauma to the upper chest, shoulder or neck of the affected side within the 1 year before clinical onset or clinical worsening;

Note 1: ***trauma to the upper chest, shoulder or neck*** is defined in the Schedule 1 – Dictionary.

Note 2: Examples of trauma involving traction and or compression to the brachial plexus include blows to the upper chest and shoulder causing injury, injuries from motor vehicle accidents, a fall from height resulting in injury, or sports injuries,

Note 3: Examples of types of penetrating injury to the upper chest, shoulder or neck include gunshot wounds or laceration injuries from knives or glass.

Note 4: Examples of surgery that may cause trauma to the upper chest, shoulder or neck include surgery for clavicle fracture, brachial plexus nerve block, catheterisation of the subclavian or internal jugular veins, and axillary arteriography.

Note 5: Delayed onset of traumatic brachial plexopathy may occur as a result of the response to injury, including the formation of callus around fractures and the development of scar tissue.

(2) having malposition of the head, neck, or shoulders in any of the following circumstances within the 24 hours before clinical onset or clinical worsening:

(a) surgery under general anaesthesia;
(b) prone positioning in an intensive care unit;
(c) reduced conscious state;

Note 1: Examples of types of surgery that can cause malposition of the head, neck, or shoulders include surgery in the prone position such as oesophagectomy or spinal surgery or surgery involving the Trendelenburg position such as abdominal or pelvic laparoscopy.

Note 2: Examples of malposition of the head, neck, or shoulders with reduced conscious state include sleep associated with alcohol or drug induced intoxication (“Friday or Saturday night palsy”) or head injury.

(3) having a median sternotomy within the 7 days before clinical onset or clinical worsening;

Note: Examples where median sternotomy is performed include coronary artery bypass graft, cardiac valve surgery, surgery to the thoracic aorta, thoracic operations (retrosternal goitre, oesophagectomy), neurosurgical procedures where access to thoracic vertebral bodies or discs is required, and in emergency thoracotomy for penetrating trauma.

(4) having an electrical injury to the brachial plexus within the 24 hours before clinical onset or clinical worsening;

(5) carrying a load of at least 20 kilograms where the bulk of the load is supported by the shoulders, for at least 2 hours within the 24 hours before clinical onset or clinical worsening;

Note: Examples of a load include a loaded backpack, body armour, rifle, ammunition, communication systems or sandbags. Where more than one type of load is combined the combined weight must exceed 20kgs.

(6) carrying a load of at least 10 kilograms where the bulk of the load is supported by one shoulder, for at least 2 hours within the 24 hours before clinical onset or clinical worsening;

Note: Examples of a load include a loaded backpack, body armour, rifle, ammunition, communication systems or sandbags. Where more than one type of load is combined the combined weight must exceed 10kgs.

(7) inability to obtain appropriate clinical management for traumatic brachial plexopathy before clinical worsening.

9 Relationship to service

(1) The existence in a person of any factor referred to in section 8, must be related to the relevant service rendered by the person.

(2) The clinical worsening aspects of factors set out in section 8 apply only to material contribution to, or aggravation of, traumatic brachial plexopathy where the person's traumatic brachial plexopathy was suffered or contracted before or during (but did not arise out of) the person's relevant service.

10 Factors referring to an injury or disease covered by another Statement of Principles

In this Statement of Principles:

(1) if a factor referred to in section 8 applies in relation to a person; and

(2) that factor refers to an injury or disease in respect of which a Statement of Principles has been determined under subsection 196B(3) of the VEA;

then the factors in that Statement of Principles apply in accordance with the terms of that Statement of Principles as in force from time to time.

Schedule 1 - Dictionary

Note: See Section 5

1 Definitions

In this instrument:

MRCA means the *Military Rehabilitation and Compensation Act 2004*.

relevant service means:

(a) eligible war service (other than operational service) under the VEA;
(b) defence service (other than hazardous service and British nuclear test defence service) under the VEA; or
(c) peacetime service under the MRCA.

Note: ***MRCA*** and ***VEA*** are defined in the Schedule 1 - Dictionary.

terminal event means the proximate or ultimate cause of death and includes the following:

(a) pneumonia;
(b) respiratory failure;
(c) cardiac arrest;
(d) circulatory failure; or
(e) cessation of brain function.

trauma to the upper chest, shoulder or neck means traction, compression, penetrating injury or surgery to the affected upper chest, shoulder or neck region.

traumatic brachial plexopathy—see subsection 6(2).

VEA means the *Veterans' Entitlements Act 1986*.