

Reaudit of Local External Cephalic Version (ECV) Performance

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Background		Results & Discussion		
External Cephalic Version (ECV) is a manoeuvre performed to reposition a foetus from a breech presentation to a cephalic presentation. It is performed after 37 weeks of gestation, although 36 weeks of gestation is considered for nulliparous women. The reported success rate of ECVs is 50% but this can be improved by using either a tocolytic or a betamimetics. There are risks associated with an ECV procedure: ❖ Spontaneous reversion to breech after a successful ECV ❖ Increased risk of instrumentation in vaginal deliveries ❖ Increased risk of needing an emergency Caesarean Section An audit analysing the departmental compliance to local and RCOG guidelines was conducted in 2020. This reaudit was performed to complete the audit cycle and see whether improvements have been made.		1) Of the 100 patient admitted for an ECV procedure, 37 were deemed eligible for the audit. Patients were excluded for various reasons, namely: there being no ECV performed (38), no ECV being required (17), a booked ECV being undocumented (5) and the patient records not being found (3). The mean age was 33 (range: 20-43), the mean BMI was 29 (range: 18-47) and the mean parity was 1 (range: 0-8). 2) The mean gestational age at which ECVs were performed was week 37 (range: 35-40), and the main reason for an ECV being booked was a breech presentation (35/37). These results suggest ECVs are generally being performed at the correct time and for the correct reasons. 3) The primary obstetrician performing the ECVs was known in 17/37 cases (46%), of which 12/17 (71%) were specialist registrars. This is an improvement from 33% in 2020, demonstrating that junior doctors are being given more opportunities to practice this competency. 4) The success rate of the 37 ECV cases was 38% (14/37). These foetuses were then delivered via spontaneous vertex delivery (64%), instrumental delivery (7%) or Caesarean Section (29%). Unsuccessful ECV cases were almost always delivered via Caesarean Section (87%). A small percentage were delivered by a vaginal breech delivery (13%). 5) Only 13/37 (35%) ECV procedures had an accompanying electronic ECV proforma completed. Although not ideal, this is an improvement from 2020, when the completion rate was 12%. However, of the 13, only 6/13 (46%) fully completed the proforma. This suggest the guidelines, particularly those surrounding the ECV discussions and what the patients should be informed about, were not being fully adhered to. Furthermore, only 9/37 (24%) patients were given an information leaflet prior to the ECV being performed. 6) Terbutaline 250 micrograms was used in 14/37 (38%) cases. The ECV success rate with Terbutaline use was 36% (5/14) whilst the success rate without it was 39% (9/23). This opens the discussion about whether it is worth using tocolytics like Terbutaline during the procedure. 7) Regarding the location of ECV procedures, 34 were performed in the labour ward delivery suite, 2 in the Emergency Obstetrics Unit, 1 in theatre ('Other') and 0 in a dedicated ECV clinic. With the majority of ECVs being performed in the labour ward delivery suite, this led to delays in some procedures due to a busy ward or the occurrence of emergencies. The 0 cases in a dedicated ECV clinic is notable because the implementation of such a clinic was a recommendation made in the 2020 audit. These results suggest the recommendation from that audit was not followed.		
Aims		❖ To complete the audit cycle started in 2020 ❖ To assess the management and outcomes of women who were booked and admitted for ECV between January and October 2021 ❖ To compare local outcomes with national RCOG outcomes		
Methodology		❖ A retrospective review of the electronic notes of all patients admitted for an ECV between January and October 2021 was performed ❖ Data regarding each patient was collected using the trust's EPR records and a labour ward ECV record book ❖ Data collection and analysis was performed using an Excel spreadsheet ❖ The auditable standards were taken from the Green-top Guideline No. 20a of March 2017 ❖ No consent or ethical approval was needed		
Conclusion		Overall, there was a limited following of local and RCOG guidelines: ✓ ECVs were performed at the appropriate times ✓ ECVs were performed for the correct indication ✗ Improvements needed regarding protocol compliance Suggestion: Increase the ECV proforma completion rate and this will improve compliance		
Recommendations & Action Plan		1. Make the completion of ECV proformas mandatory by March 2023 2. Have a regular dedicated ECV clinic with an associated electronic booking system implemented by March 2023 3. Reaudit the departmental ECV performance in December 2023		
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