Aneurin Bevan University Health Board

External Cephalic Version Guideline

N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out of date printed versions of the document. The Intranet should be referred to for the current version of the document.

Contents:

Owner: Maternity Services Status: Issue 5

Guideline for External Cephalic Version

1 Executive Summary

This document is a clinical guideline designed to support safe and effective practice

1.1 Scope of guideline

This guideline applies to staff and teams providing maternity services.

1.2 Essential Implementation Criteria

Auditable standards are stated where appropriate

2 Aims

To provide support for clinical decision making

3 Responsibilities

The Gynaecology and Maternity Management team

4 Training

Staff are expected to access appropriate training where provided. Training needs will be identified through appraisal and clinical supervision. Trainees can also access STRATOG module about ECV and management of breech.

5 Monitoring and Effectiveness

Local service Improvement Plan will guide monitoring and effectiveness.

6 Appendices

See guideline overleaf

External Cephalic Version

External Cephalic version (ECV) is the manipulation of the fetus through the maternal abdomen to cephalic presentation. All women with an uncomplicated breech presentation at term from 37^{+0} weeks gestation should be offered an External Cephalic Version (ECV).

Information to women:

- Success rate of ECV 50% (multiparous 60% nulliparous women 40%)
- Spontaneous version from breech to cephalic is unusual at term and occurs only in 8% of women after 36 weeks gestation
- Spontaneous reversion to Breech following successful ECV in only 3%
- Women should be informed that labour after ECV is associated with a slightly increased rate of caesarean section and instrumental delivery when compared with spontaneous cephalic presentation
- Women should be told of small possibility of the need for an emergency caesarean section immediately following the procedure (1 in 200).
- All women should be given an ECV information leaflet before leaving clinic.

Exceptions to ECV are listed below.

Contraindications for ECV

- Where caesarean delivery is required(eg:major placenta praevia)
- Current or recent vaginal bleeding <1week
- Abnormal cardiotocography
- Abnormal Doppler
- Severe pre eclampsia
- Ruptured membranes
- Multiple pregnancy (except delivery of second twin)
- Rhesus isoimmunisation
- Pt unable to give informed consent

Additional caution where there is oligohydramnios or hypertension

Please discuss with Consultant Obstetrician if:

- Coexisting medical problems particularly if poorly controlled
- Anticoagulation including aspirin+/heparin or warfarin
- Previous history of abruption

Booking

ECV should be offered at term from 37+0 weeks. In nulliparous women maybe offered from 36^{+0} weeks. There is no upper gestation limit for ECV.

All ECV's will be performed at the Grange University Hospital and must be booked via the ward clerk on 01633 493182.

Process

- All ECVs should be performed on the labour ward during 'office hours'.

- Obstetric theatre should be immediately available. The duty anaesthetist, ODA and midwifery staff must be informed before commencing ECV

- Women may have a light breakfast and be admitted to the maternity department on the day of the ECV.

- A CTG should be performed prior to the procedure

- Prior to the procedure, an ultrasound scan will be performed by the operator to assess fetal lie, position of fetal legs, liquor volume and placental site.

- The final decision to proceed to ECV will be made by the operator and must involve the woman.

- Written consent is desirable and will be obtained and detailed in the obstetric notes.

- Tocolytics such as Salbutamol inhaler or terbutaline 250 microgram SC. ECV under regional analgesia can be discussed if patient not tolerating procedure on a case by case basis after discussion with anaesthetist and the consultant responsible.

- ECV should only be performed by a trained practitioner or by a trainee working under direct supervision.

- The fetal heart should be regularly assessed throughout the procedure

- A CTG should be obtained following an ECV whether successful or not before the woman returns home.

- All rhesus negative women should receive 500IU Anti-D whether version successful or not. Kleihauer should be performed to screen for fetomaternal haemorrhage. More than 30ml fetomaternal haemorrhage should prompt immediate fetal review.

- Transient (<3 minutes) fetal bradycardia after ECV is common, but should instigate continuous monitoring in left lateral position, and if persistent and not improving after 6 minutes, should prompt preparation for category I caesarean section. Urgent delivery should also be advised following the procedure if there is vaginal bleeding or unexplained abdominal pain, or if an abnormal CTG persists.

ECV Successful

Return to appropriate lead professional. There is no indication to induce labour earlier than induction guideline suggests.

ECV Unsuccessful

Second attempt with same or different operator should be offered on another day. If second attempt unsuccessful / patient declines El LSCS at 39 weeks to be booked prior to discharging patient or after meticulous counselling attempt a vaginal breech delivery. Women should be informed that she will be scanned on admission and if there is a cephalic presentation caesarean section will be not performed.

Please file copy of the proforma in ECV folder with ward clerk available on labour ward. This is for audit purposes.

ECV PROFORMA GUH

Pts name and crn number

DATE

OPERATOR & GRADE

TIME

OBSTETRIC HISTORY

PARITY

PREV DELIVERIES

GESTATION

RHESUS STATUS

USS FINDINGS

PLACENTAL SITE;

PRESENTATION

FHHR

LIQUOR VOLUME

PROCEDURE

CONSENT VERBAL/WRITTEN

CTG PRIOR TO ECV

TOCOLYTIC USED

USS TO CHECK FHH THROUGHOUT PROCEDURE YES/NO

CTG POST ECV

RESULT SUCCESSFUL/UNSUCCESSFUL

LEVEL OF PAIN(RATE1-10)

PLAN

KLEIHAUR-ANTI D NEEDED YES/NO

ARM

REPEAT ECV

IOL BOOKED

C/S BOOKED

EXPECTANT MANAGEMENT

SIGNATURE