

Transvaginal Ultrasound Scans undertaken in the Maternity Setting

Policy information

Guideline number: 1557

Classification: Clinical

Supersedes: New guideline

Local Safety Standard for Invasive Procedures (LOCSSIP) reference: NA

National Safety Standards for Invasive Procedures (NatSSIPs) standards: NA

Version number: Version 1.

Date of Equality Impact Assessment: 25.08.2026

Approval information

Approved by: Maternity Written Document Group

Date of approval: 27/08/2026

Date made active: 14.09.2026

Review date: 27.08.2029

Summary of document:

The use of transvaginal cervical length measurements is an important clinical tool to identify women who are at risk. These include:

- Women at high risk for preterm birth in order for interventions to prevent, delay or prepare for PTB to be put in place. Preterm birth remains a major cause of neonatal death and short and long-term disability across the world. The majority of preterm births are spontaneous, and cervical length screening is one tool that can be utilized to identify women at increased risk who may be candidates for preventive interventions
- Women who have low lying placenta or placenta praevia for whom the accurate and repeatable visualisation of the internal os allows accurate diagnosis and allows the safest route of birth to be reliably predicted.

Scope:

This guideline is to support Hywel Dda University Health Board Midwife Sonographers and appropriately trained obstetricians who undertake Transvaginal Ultrasound Scans in the Maternity setting. This policy uses the term “women” to reflect that maternity and reproductive care are sex-based health needs. It applies equally to all people who are pregnant or have recently given birth, including trans men and non-binary people. Care must be delivered in an inclusive, respectful and responsive way.

To be read in conjunction with:

[1247 Ultrasound Scans undertaken in the Maternity Ward Setting](#) (opens in a new tab)

[1241 - All Wales Preterm Birth Guidance](#) (opens in a new tab)

[618- Placenta Praevia and Placenta Accreta guideline](#) (opens in a new tab)

[657 - Management of Multiple Pregnancy Guideline](#)(opens in a new tab)

[312.Chaperone Policy](#) (opens in a new tab)

[467 - Medical Devices Policy](#) (opens in a new tab)

[390 - Cleaning and Decontamination of Equipment Prior to Inspection, Servicing, Repair or Disposal Policy](#) (opens in a new tab)

[010 Health and Safety Policy](#) (opens in a new tab)

[149 Hand Hygiene Policy](#) (opens in a new tab)

[151 Personal Protective Equipment PPE Policy](#) (opens in a new tab)

[230 Management of Blood and Body Fluid Spillages Policy](#)(opens in a new tab)

[008 Consent to examination or treatment policy](#) (opens in a new tab)

Patient information:

Owning group:

Maternity Guideline, Audit and Research Group 27/08/2026

Executive Director job title: Chief Operating Officer

Reviews and updates:

Version 1 - New Guideline 27.08.2026

Keywords: Transvaginal scan, Cervix, Preterm birth

Glossary of terms

TVS Transvaginal scan

PTB preterm birth

Contents

Policy information.....	1
Approval information	1
1247 Ultrasound Scans undertaken in the Maternity Ward Setting	Error! Bookmark not defined.
1241 - All Wales Preterm Birth Guidance	Error! Bookmark not defined.
657 - Management of Multiple Pregnancy Guideline	Error! Bookmark not defined.
312.Chaperone Policy.....	Error! Bookmark not defined.
Scope.....	4
Aim.....	4
Objectives	4
Introduction	4
Consent.....	4
Absolute contraindications for performing TVS	4
Chaperones	5
Placental localisation	5
Technique for Assessment of Cervical length (ISUOG)	5
Curvature of Cervix	6
Changes in cervical length during pregnancy	6
Measurements of Cervical length.....	6
Cervical length Antenatal screening.....	6
Cervical length scanning in diagnosis of preterm labour (PTL) in women who are 30+ weeks gestation with intact membranes	6
Cleaning and Disinfection of Transvaginal Probes (transducers).....	7
Cleaning of Probe	7
Disinfection of probes.	7
Recording of Actions.....	7
Documentation.....	7
References.....	8
Appendix 1	9
Appendix 2	10

Scope

This guideline is to support Hywel Dda University Health Board Midwife Sonographers and appropriately trained obstetricians who undertake Transvaginal Ultrasound Scans in the Maternity setting

Aim

This guideline is to support Hywel Dda University Health Board Midwife Sonographers and appropriately trained obstetricians who undertake Transvaginal Ultrasound Scans in the Maternity setting.

Objectives

- Define criteria and process for performing Transvaginal ultrasound scans in maternity setting.

Introduction

Transvaginal scan provides superior resolution compared to abdominal scans particularly in the second and third trimester Transvaginal ultrasound is the gold standard for assessment of cervical length and for precise assessment of placental position, especially when lying close to internal os.

Transvaginal Ultrasound scans are undertaken within the Maternity settings for the following criteria

1. To confirm Placental localisation to exclude low lying placenta or placenta praevia.
2. Screening of women with high-risk criteria for Preterm Labour.
3. For the Assessment of women who attend in suspected Preterm Labour and are 30+0 weeks pregnant or more with intact membranes.

Prior to the scan the woman may be given access given via BadgerNet to the patient information leaflet "Cervical Length Scan".

Consent

Consent for the examination should be obtained by the appropriate health professional in line with the Health Boards [Consent to Examination and Treatment Policy 008](#) (opens in a new tab).

When a woman attends for her scan appointment the Sonographer should confirm the woman's consent for the examination/procedure by providing a clear explanation, appropriate to the needs of the woman, explaining the reason that the examination/procedure is needed, what technique is being used and any other necessary information.

If the woman asks that a practitioner of a specific gender performs their examination, this request should be accommodated. If their request is unable to be accommodated immediately then the woman needs to understand that the scan may be delayed.

The woman can choose to withdraw her consent at any time. If after an explanation of the clinical reason for a transvaginal scan (i.e. improved views) the woman still chooses not to have a TVS then this must be respected and recorded on the patient's ultrasound report.

Absolute contraindications for performing TVS

Absolute contraindications for performing TVS are few but include:

- Patient decline
- Premature rupture of the membranes during pregnancy
- Bleeding associated with known placenta praevia

Chaperones

All women should be offered a chaperone to be present during the examination. If the patient is offered and declines a chaperone (and there is no concern about the mental capacity to make this informed decision/provide this consent e.g. is often the case during pregnancy and childbirth care processes), it is important to record in the patient's clinical record that the offer was made and declined. Refer to [312.Chaperone Policy](#) (opens in a new tab).

Women may request a chaperone and/or express a preference for the healthcare professional performing the procedure. Wherever practical, these requests should be considered and supported.

If their request is unable to be accommodated immediately then the woman needs to understand that the scan may be delayed. Where clinically possible they should have the opportunity to discuss the procedure prior to attendance so that any concerns may be highlighted in advance and resolved where possible.

Placental localisation

Following a routine 20-week fetal anomaly ultrasound scan where the placenta is $\leq 20\text{mm}$ from, reaches or overlaps the cervical os a further ultrasound, usually at 32 weeks, will be required. Transvaginal ultrasound is safe in the presence of placenta praevia and is recommended to diagnose a persistent low-lying placenta and to confirm placenta praevia. Using TAS alone is associated with false positives.

If following transabdominal ultrasound visualisation of the placental edge is unclear (i.e. Due to maternal habitus or obscured by bowel gas) or the placenta appears to be low-lying or placenta praevia the sonographer should proceed to TVS with consent. Refer to [618 - Placenta Praevia and Placenta Accreta Guideline](#) (opens in a new tab).

Technique for Assessment of Cervical length (ISUOG)

Stage of exam	Recommendation
Pre-exam	Maternal bladder empty
Maternal position	Semi-recumbent position with abducted legs
Transducer selection	High-frequency transvaginal transducer with disposable sheath and gel (caution: remove air bubbles)
Introduction of probe	Place probe at anterior fornix with longitudinal axis orientation for sagittal imaging. Gentle pressure may be necessary for better identification of structures
Required structures	Inferior bladder border (peritoneal reflection), external os, endocervical canal and mucosa, internal os (limited by edge of mucosa).
Minimize pressure	Certify that both cervical lips have same width, keeping all required structures in image
Magnification	Cervix should occupy 50–75% of screen

Measurement	Place callipers between functional internal os and external os, obtaining a straight line between them
Repetition	Obtain three distinct measurements and choose the shortest technically correct one
Duration	Obtain three technically correct measurements to allow for observation of dynamic changes over time
Pitfalls	Full bladder or excessive transducer pressure may elongate artificially cervical length Thickened lower segment or uterine contractions may mimic funnelling: identify cervical mucosa properly. Avoid confounding cervical mucus with funnel by delineating course of membranes at level of internal os Distinguishing the isthmus from the cervix can be challenging when identifying the internal os, especially between 16–20 weeks' gestation. This may contribute to variability in cervical length assessment if adjacent uterine tissue is inadvertently included in the measurement. (see appendix 1)

Measurement of Cervix

A straight line measurement is used to measure the cervical length

It is recognised that curvature of the cervix is present in 51% of cases when CL is >25mm, in 25% of cases when CL is between 16 and 25mm and in no cases when CL is <16mm, so a straight-line measurement can be used without affecting management of the pregnancy as a short cervix always appears to be straight (USOG).

Changes in cervical length during pregnancy

The CL is generally stable between 14 and 28 weeks of gestation, and tends to shorten gradually afterwards, its median length decreasing from ~43mm at 16 weeks to ~31mm at 36 weeks' gestation.

Measurements of Cervical length

Cervical length Antenatal screening

- Cervical length of 25mm or more is reassuring.
- Cervical length of less than 25mm is significantly short and specialist management should be offered, refer to [1241 All Wales Preterm Birth Guideline](#) (opens in a new tab).

Cervical length scanning in diagnosis of preterm labour (PTL) in women who are 30+ weeks gestation with intact membranes

If a patient is not suitable for Partosure® testing but has symptoms suggestive of preterm labour, TVS may be performed only after discussion with the Consultant Obstetrician on call as to whether she would be suitable for cervical length measurement.

- Cervical length ≤15mm is significantly short and plan of care should be offered, refer to [1241 All Wales Preterm Birth Guideline](#). (opens in a new tab).

Cleaning and Disinfection of Transvaginal Probes (transducers)

Cleaning of Probe

After each use remove the probe cover and dispose of it in the Tiger waste bags, wipe off any gel with compatible cleaning agents as per the manufacture instructions.

Disinfection of probes.

Transvaginal probes within Hywel DD are disinfected using either the Trophon machine or using the Tristel Trio Wipes System. (see appendix 2.)

Recording of Actions

A record of cleaning and disinfection and / or sterilisation must be kept for any transducer. The record should be able to identify that the transducer was cleaned after each examination .and should include as a minimum

- Patient ID number
- transducer serial number;
- cleaning product serial number
- date and time;
- staff member undertaking cleaning.

Documentation

Midwife sonographer and doctors who have access to Soliton and Viewpoint will maintain accurate records electronically on Viewpoint with images uploaded to PACS.

Clinicians who do not have access to Soliton or Viewpoint must document scan findings on the *Obstetric Ultrasound in Maternity Report* (refer to [1247 Ultrasound Scans undertaken in the Maternity Ward Setting](#)) (opens in a new tab), and images printed, labelled with patient ID and stored in a CTG envelope folder and carried by the woman .

The report should include

- Reason for referral /Any pregnancy concerns
- Ultrasound findings:
 - Report the “best” shortest measurement of the functional cervical length
 - Presence/ absence of funnelling

Resources for cervical length assessment

The Fetal Medicine Foundation Cervical Assessment [Courses | The Fetal Medicine Foundation](#) -opens in new tab

NHS England elfh Hub : Saving babies Lives, Cervical Length assessment 21 34 [NHSE elfh Hub](#) - opens in a new tab

References

British Medical Ultrasound Society (BMUS) [Best Practice Summary - probe decontamination - FINAL 13 02 2020.pdf](#)

EGUM Recommendations on Infection Prevention in Ultrasound and Endoscopic Ultrasound Thomas M.üller. *Ultraschall in Med* 2018; 284–303.

Cervical length measurement: Comparison of transabdominal and transvaginal approach Susan Campbell Westerway. *Australasian Journal of Ultrasound in Medicine* 2015;18(1): 19-26.

Iams JD, Goldenberg RL, Meis PJ, Mercer BM, Moawad A, Das A, Thom E, McNellis D, Copper RL, Johnson F, Roberts JM. The Length of the Cervix and the Risk of Spontaneous Premature Delivery. *N Engl J Med* 1996; 334: 567–573

ISUOG Practice Guidelines: role of ultrasound in the prediction of spontaneous preterm birth *Ultrasound Obstet Gynecol* 2022; 60: 435–456, 29 July 2022.

To MS, Skentou C, Chan C, Zagaliki A, Nicolaides KH. Cervical assessment at the routine 23-week scan: standardizing techniques. *Ultrasound Obstet Gynecol* 2001; 17: 217–219.

[Revision 2025 Transvaginal Ultrasound Guidance Document V2 January 2025.pdf](#)

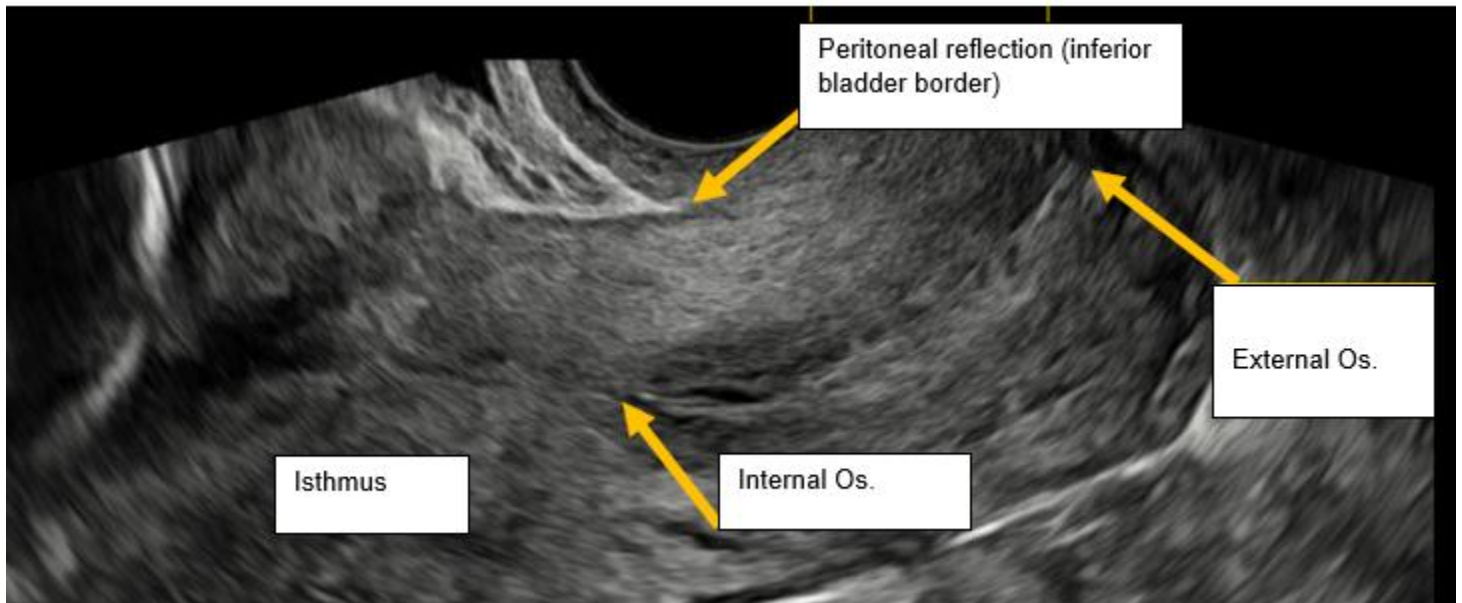
RCOG Ultrasound guidance [ultrasound-guidance-v6-final.pdf](#)

Salomon LJ, Diaz-Garcia C, Bernard JP, Ville Y. Reference range for cervical length throughout pregnancy: non-parametric LMS-based model applied to a large sample. *Ultrasound Obstet Gynecol* 2009; 33: 459–464.

Appendix 1

The uterine isthmus is a region of constriction between the lower uterine segment and the cervix. This region can be made more prominent on transvaginal ultrasound due to physiological changes particularly during earlier gestations.

Between 16-20 weeks' gestation distinguishing the isthmus from the cervix can be challenging when identifying the internal os. This may contribute to variability in cervical length assessment if adjacent uterine tissue is inadvertently included.



The appearance of the isthmus may vary with gestational age, uterine activity, bladder filling, and probe position. (Callen, 2020; Salomon et al., 2013)

Appendix 2

Tristel wipes are used in a three-step process: pre-cleaning, high-level disinfection with activated Sporidical Wipe, and rinsing to ensure medical devices are safe for patient use.

Step-by-Step Instructions

1. Pre-Cleaning

- Wear gloves before handling the device and wipes.
- Take a **Pre-Clean Wipe** from its sachet and lay it out in your palm.
- Wipe the surface of the medical device thoroughly to remove visible soiling and organic matter.
- For heavily soiled devices, use additional wipes as needed.
- Discard the used wipe and gloves according to local guidance. This step ensures that the device is free from debris before high-level disinfection.

2. High-Level Disinfection

- Wear clean gloves
- Take a **Sporidical Wipe** from its sachet and lay it in your palm.
- Remove the lid from the **Activator Foam** bottle and apply two doses of foam onto the wipe. Do **not shake** the bottle.
- Fold the wipe in on itself and scrunch it for 15 seconds to the wipe to generate chlorine dioxide, the active disinfectant
- Wipe the entire surface of the device, from “clean” to “dirty” ensuring full coverage.
- Leave probe for 30 seconds
- Discard the used wipe and gloves after use.

3. Rinsing

- Use a **Sterile Rinse Wipe** to remove any chemical residue from the device.
- This prevents recontamination and ensures the device is patient ready.
- Discard the rinse wipe after use.

Traceability for Tristel wipes

add to patient records

1. **Pre- clean Wipe** Document Lot and expiry date
2. **Sporidical Wipe** Utilise adhesive label on wipe and write Activator Lot Number
3. **Rinse Wipe.** Utilise adhesive label on wipe.