

HYWEL DDA UNIVERSITY HEALTH BOARD



EXTERNAL CEPHALIC VERSION GUIDELINE

The guidance uses the term “woman” (pronouns she or her) to describe individuals whose sex assigned at birth was female, whether they identify as female, male or non-binary. It is important to acknowledge it is not only people who identify as women for whom it is necessary to access women’s health and reproductive services. Therefore, this should include people who do not identify themselves as women but who are pregnant or have recently given birth. Obstetric and midwifery services and delivery of care must therefore be appropriate, inclusive and sensitive to the needs of those individuals whose gender identify does not align with the sex that they were assigned at birth.

Guideline Number:	634	Supersedes:		Classification	Clinical
LOCSSIP Reference:		NATSSIP Standard:	List standard (NATSSIPS Standards)		
Version No:	Date of EqIA:	Approved by:	Date Approved:	Date made active:	Review Date:
2	N/A	Obstetric Guideline and Audit Group	4.6.2019	4.6.2019	August 2020
		Obstetric Group - Extended whilst review is undertaken	08/02/2022	09/02/2022	08/08/2022
		Obstetric Guideline Group - Extended whilst review is undertaken	23.08.2022	25.08.2022	23.02.2023
		Obstetrics WCD Group – extended whilst review is undertaken	23.02.2023	01.03.2023	23.08.2023
		Obstetrics WCD Group – extended whilst review is undertaken	22.08.2023	24.08.2023	22.02.2024
		Obstetric Written Control Documentation Group – extended whilst review is finalised	29.02.2024	06.03.2024	29.08.2024

HYWEL DDA UNIVERSITY HEALTH BOARD

		Obstetric Written Control Documentation Group – extended whilst review is finalised	16.09.2024	17.09.2024	16.03.2025
		Obstetric Written Control Documentation Group – extended whilst review is finalised	10.04.2025	15.04.2025	09.10.2025
		Obstetric Written Control Documentation Group – extended whilst review is finalised	16.09.2025 16.02.2026	19.09.2025 16.02.2026	16.12.2025 16.08.2026

Brief Summary of Document:	The purpose of this guideline is to outline standards for the performance and monitoring of women and their babies undergoing an external cephalic version.
----------------------------	---

Scope	Maternity Units within the Health Board. 'The term "woman/women" in the context of this document is used as a biologically based term and is not intended to exclude trans and non-binary people who do not identify as women.'
-------	--

To be read in conjunction with:	Management of Breech Presentation
---------------------------------	-----------------------------------

Patient Information:	Include links to Patient Information Library
----------------------	---

Owning committee/ group	Obstetric Guideline and Audit Group.
-------------------------	--------------------------------------

Reviews and updates		
Version no:	Summary of Amendments:	Date Approved:
1	Guideline Update	14/09/2017
2	Flowchart and review	4.6.2019

Glossary of terms

Term	Definition
ECV	External cephalic version

HYWEL DDA UNIVERSITY HEALTH BOARD

CONTENTS

1. PURPOSE	4
2. INTRODUCTION	4
3. EXTERNAL CEPHALIC VERSION (ECV)	4
3.1. HOW EFFECTIVE IS ECV IN PREVENTING NON-CEPHALIC BIRTH?	4
3.2. DOES ECV AFFECT THE OUTCOME OF LABOUR?	4
3.3. WHAT METHODS CAN BE USED TO IMPROVE THE SUCCESS RATE OF ECV?... 4	
3.4. UNSTABLE LIE	4
3.5. WHAT ARE THE CONTRAINDICATIONS TO ECV?	4
3.6. WHAT ARE THE RISKS OF ECV?	5
3.7. MEASURES TO ENSURE FETAL SAFETY	5
3.8. WHO SHOULD PERFORM ECV ?	5
3.9. WHAT IS THE ROLE OF NON-ECV METHODS?	6
4. AUDITABLE STANDARDS	6
5. REFERENCES	6
6. APPENDIX: ECV FLOW CHART	7
7. APPENDIX 2 – EXTERNAL CEPHALIC VERSION AUDIT PROFORMA	8

HYWEL DDA UNIVERSITY HEALTH BOARD

1. PURPOSE

External cephalic version (ECV) is the manipulation of the fetus, through the maternal abdomen, to a cephalic presentation. The purpose of this guideline is to describe and summarise the best evidence concerning methods to prevent non-cephalic presentation at delivery and therefore, caesarean section and its sequelae.

The evidence concerning mode and technique of the delivery of breech presentation is summarised in the Royal College of Obstetricians and Gynaecologists (RCOG) Green-top Guideline No. 20b Management of Breech Presentation.

2. INTRODUCTION

Breech presentation complicates 3–4% of term deliveries and is more common in nulliparous women and in preterm deliveries. Following the publication of the Term Breech Trial there was a significant decrease in the number of women undergoing vaginal breech birth. In many countries, including the UK, planned vaginal breech birth remains rare and attempts to prevent breech presentation at delivery remain important.

3. EXTERNAL CEPHALIC VERSION (ECV)

3.1. How effective is ECV in preventing non-cephalic birth?

Women should be informed that the success rate of ECV is approximately 50%.

Women should be informed that after an unsuccessful ECV attempt at 36+0 weeks of gestation or later, only a few babies presenting by the breech will spontaneously turn to cephalic presentation.

Women should be informed that few babies revert to breech after successful ECV.

Women should be informed that a successful ECV reduces the chance of caesarean section.

3.2. Does ECV affect the outcome of labour?

Women should be informed that labour after ECV is associated with a slightly increased rate of caesarean section and instrumental delivery when compared to spontaneous cephalic presentation.

3.3. What methods can be used to improve the success rate of ECV?

Use of tocolysis with betamimetics improves the success rates of ECV. **Dose Administration: 250 micrograms of salbutamol in 25 ml of normal saline (10 micrograms/ml) by slow intravenous injection, or 250 micrograms of terbutaline subcutaneously**

Routine use of regional analgesia or neuraxial blockade *is not recommended*, but **may be** considered for a repeat attempt or for women unable to tolerate ECV without analgesia.

3.4. Unstable Lie

ECV is reasonable in the course of a stabilising induction. There are limited data on this procedure, but potential risks include cord prolapse, transverse lie in labour and fetal heart rate abnormalities. **ECV should only be performed if there is a valid indication for induction in discussion with Consultant Obstetrician on call.**

3.5. What are the contraindications to ECV?

There is no general consensus on the contraindications to ECV.

HYWEL DDA UNIVERSITY HEALTH BOARD

ECV is contraindicated where an absolute reason for caesarean section already exists eg) placenta praevia major.

It is generally considered to be contraindicated in:

- multiple pregnancy (except after delivery of a first twin)
- rhesus isoimmunisation
- current or recent (less than 1 week) vaginal bleeding
- abnormal electronic fetal monitoring (EFM)
- rupture of the membranes
- where the mother declines or is unable to give informed consent.

ECV should be performed with additional caution where there is oligohydramnios or hypertension

Women should be informed that ECV after one caesarean delivery appears to have no greater risk than with an unscarred uterus.

3.6. What are the risks of ECV?

Women should be counselled that with appropriate precautions, ECV has a very low complication rate.

The reported risk of emergency caesarean section within 24 hours is approximately 0.5%, with the indication in over 90% being vaginal bleeding or an abnormal CTG following the procedure.

3.7. Measures to ensure fetal safety

- ECV should be performed where facilities for monitoring and surgical delivery are available
- **No more than four** attempts are advised, for a suggested maximum of 10 minutes overall.
- EFM prior to the attempt is advised
- Ultrasound should be used during and after the ECV to confirm a normal fetal heart rate.
- *A transient (less than 3 minutes) fetal bradycardia after ECV is common but should instigate continuous monitoring in a left lateral position, if persistent and not improving after 6 minutes, should prompt preparation for category I caesarean section.*
- **The standard preoperative preparations for caesarean section are not recommended for women undergoing ECV**
- Following ECV, EFM is recommended
- Women undergoing ECV who are D negative should undergo testing for fetomaternal haemorrhage and be offered anti-D.

Dose administration: minimum of 500 iu is recommended within 72 hours

3.8. Who should perform ECV ?

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

HYWEL DDA UNIVERSITY HEALTH BOARD

3.9. What is the role of non-ECV methods?

Women may wish to consider the use of moxibustion for breech presentation at 33–35 weeks of gestation, under the guidance of a trained practitioner.

Women should be advised that there is no evidence that postural management alone promotes spontaneous version to cephalic presentation.

4. AUDITABLE STANDARDS

- Antenatal detection of breech presentation.
- Proportion of women with a breech presentation offered ECV in the absence of contraindications (100%).
- Success rates of ECV (50%).
- Complications of/after ECV.
- Maternal perceptions/experience of ECV.
- Compliance with completion of External Cephalic Version Audit Proforma

5. REFERENCES

Royal College of Obstetricians and Gynaecologists. Management of Breech Presentation. Green-top Guideline No. 20b. London: RCOG; 2017.

HYWEL DDA UNIVERSITY HEALTH BOARD

6. APPENDIX: ECV FLOW CHART

ECV PROCEDURE FLOWCHART 2017

APPOINTMENT TO BE ARRANGED VIA ANC GGH/ BGH
Give RCOG Patient Information Leaflet 'Breech Baby at the end of Pregnancy'

ON DAY OF ECV PROCEDURE

- May have a normal diet on day of admission.
- Consent should be obtained for the procedure.
- ECV should be performed where ultrasound and CTG facilities are available

The fetal heart should be monitored on a CTG prior to the ECV procedure and classified as **normal**

No more than 4 attempts are advise over a maximum duration of 10 minutes

Abandon the procedure if:

- attempts at a forward roll or a backward flip are unsuccessful
- there is maternal intolerance to the procedure

Tocolysis may be offered to increase the success

Dose: Subcutaneous terbutaline 250micrograms can be routinely administered prior to commencing the procedure

*Routine use of regional analgesia or neuraxial blockade is **not** recommended, but **MAY BE** considered for a repeat attempt or for women unable to tolerate ECV without*

POST PROCEDURE

Regardless of whether the ECV is successful or not:

- Complete ECV Audit Proforma
- Monitor the FHR by CTG
- Monitor and record the maternal pulse, BP, and vaginal loss.
- Maternal blood group is Rhesus negative - obtain a blood group and antibody screen sample for a Kleihauer test & administer prophylactic Anti-D administration minimum dose 500iu within 72 hours
- If ECV fails, elective CS should be booked for 39 weeks gestation

Women may be discharged home provided:

- The maternal observations are normal
- The CTG is classified as normal
- The obstetric team is satisfied with the fetal and maternal condition.

Instruct the woman to phone or return to the hospital if any of the following occur:

- Vaginal bleeding/ any signs of APH
- Rupture of membranes
- Commencement of labour
- Change in pattern or decreased fetal movements
- Abnormal abdominal pain.

HYWEL DDA UNIVERSITY HEALTH BOARD

7. APPENDIX 2 – EXTERNAL CEPHALIC VERSION AUDIT PROFORMA

EXTERNAL CEPHALIC VERSION (ECV) AUDIT PROFORMA

To be completed in clinic following discussion with patient

- ✓ Enter patient's details on elective LSCS list and ensure that Consultant Obstetrician is aware and available.
- ✓ Ensure that recent ultrasound has been performed and records fetal growth, liquor and nature of breech
- ✓ Aim for ECV at 36/40 for nullipara, 37/40 for multipara.
- ✓ May have normal diet on day of admission.

Refer to Health Board **External Cephalic Version (ECV) Guideline 2017** for guidance and contraindications

FINDINGS IN ANTENATAL CLINIC	
Patient ID	Gravidity & Gestation:
	Consultant Informed Y/N:
Patient counselled regarding options	
Patient Information Leaflet given	
Does patient wish to proceed with LSCS if ECV unsuccessful	
USS findings: flexed/ extended breech	
Liquor volume	
Growth centile	
Rhesus group	
FINDINGS AT TIME OF ECV	
Obstetric theatre, Anaesthetist and Band 7 Co-ordinator to be informed on admission	
Ultrasound Position	
Tocolytics and route	
ECV attempted & operator name	
If not attempted – reason	
If not successful – reason	
Midpoint monitoring performed	
Outcome	
If Rhesus negative - Anti D administered & dose	

ALL OPERATORS TO COMPLETE PROFORMA & FILE IN ECV FOLDER ON LABOUR WARD

Please check that this is the most up to date version of this written control document