EXTERNAL CEPHALIC VERSION GUIDELINE

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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

CONTENTS

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.

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.

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.

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.

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