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| <b>MANAGEMENT OF EXTERNAL CEPHALIC VERSION (ECV)</b> | <b>CLINICAL GUIDELINES</b><br>Register no: <b>08096</b><br>Status: <b>Public</b> |
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| Consulted With   | Individual/Body  | Date        |
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| <b>Policy to be followed by (target staff)</b>          | <b>Midwives, Obstetricians, Paediatricians</b>   |
| Distribution Method                                     | Intranet and Website   |
| Related Trust Policies (to be read in conjunction with) | 04071 Standard Infection Prevention<br>04072 Hand Hygiene<br>04269 Management of Breech Birth<br>06036 Maternity Record Keeping including Documentation in the Handheld Records<br>06065 Administration of Antenatal Prophylactic Aniti-D for Rhesus Negative Women<br>06034 Reduced fetal movements |

**Document History Review:**

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| 1.0        | Dr Padmagirison                    | 11 Dec 2008     |
| 2.0        | Sarah Moon                         | 24 Nov 2011     |
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## **1.0 Purpose**

- 1.1 External cephalic version (ECV) is the manipulation of the fetus, through the maternal abdomen, to a cephalic presentation. The rationale behind ECV is to reduce the incidence of breech presentation at term and therefore the associated risks, particularly of avoidable caesarean section.

## **2.0 Equality and Diversity**

- 2.1 Mid Essex Hospital Services NHS Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.

## **3.0 Background**

- 3.1 The incidence of breech presentation at term is about 3-4%. It is more common if there has been a previous breech presentation. The incidence of caesarean section for breech presentation has increased markedly in the last 20 years and further with the publication of the term breech trial.
- 3.2 This trial concluded that, at least for mortality and markers of intermediate term morbidity, elective caesarean section was safer for the fetus and of similar safety to the mother when compared with intention to deliver vaginally.
- 3.3 This means that measures to reduce the incidence of breech presentation have become more important and that the effect of any such measure on the incidence of caesarean section will be more marked.

## **4.0 Guidelines for Offering and Booking ECV**

- 4.1 All women diagnosed as having a breech presentation at or after 36 weeks should be offered an Antenatal Clinic appointment with the Obstetric Consultant. ECV should be offered from 36 weeks in nulliparous patients and from 37 weeks in multiparous women.
- 4.2 Women should be offered ECV with appropriate counselling and written information about the procedure. They should be counselled that ECV reduces the chance of breech presentation at delivery and lowers their chances of having a caesarean section.
- 4.3 Women should be counselled that with a trained operator, about 50% of ECV attempts will be successful but this rate can be individualized for them.
- 4.4 Women should be counselled that ECV has a very low complication rate. Women should be alerted to potential complications of ECV such as placental abruption, uterine rupture and feto-maternal haemorrhage. Large consecutive series suggest a 0.5% immediate emergency caesarean section rate and no excess perinatal morbidity and perinatal mortality.

## **5.0 Contraindications**

- 5.1 Absolute
  - Where caesarean delivery is required
  - Antepartum haemorrhage within the last 7 days
  - Abnormal cardiotocography

- Major uterine anomaly
- Ruptured membranes
- Multiple pregnancy (except delivery of second twin)

## 5.2 Relative

- Small-for-gestational-age fetus with abnormal Doppler parameters
- Proteinuric pre-eclampsia
- Oligohydramnios
- Major fetal anomalies
- Lower segment scar

## 5.3 Women in labour or those with 1 or more of the following obstetric complications should not be offered external cephalic version:

- Uterine scar or abnormality
- Fetal compromise
- Ruptured membranes
- Vaginal bleeding
- Medical conditions

## 5.4 When obtaining informed consent for this procedure the woman should be provided with balanced information about the benefits and risks of external cephalic version.

## 6.0 Guideline for the Procedure

6.1 The woman should be asked to have an early (7.00am), light breakfast that morning and then nil-by-mouth until the procedure. Given the low complication rate, particularly when compared with labour, starvation, anaesthetic premedication and intravenous access are all unnecessary.

6.2 The woman should be admitted to the Labour Ward.

6.3 A cardiotocograph (CTG) should be carried out until the criteria are met.

6.4 A consent form should be signed.

6.5 The success rate of ECV is increased by the use of tocolysis. Terbutaline 250 mcg (micrograms) or 500mcg should be administered subcutaneously.

6.6 An ultrasound is performed to check the following points:

- Presentation
- Position of fetal back and flexion of the fetal head
- Adequate liquor

6.7 The woman is positioned in a supine posture with a wedge to tilt her to the side away from fetal back.

6.8 Talcum powder or oil lubricant may be used and an attempt is made to turn the fetus by disengaging the breech with one hand and flexing the fetal head with the other. This may be uncomfortable but should not be painful for the mother.

- 6.9 The position should be checked with ultrasound at the end of the procedure.
- 6.10 Where ECV fails, the possibility of a further attempt should be discussed. A later, second attempt, particularly with a second operator or where the back has been in the midline, may lead to a small increase in overall success rates but tocolysis markedly increases the success rate at a second attempt if it has not been used first time.
- 6.11 A further CTG should be done lasting for one hour whether the procedure is successful or not.
- 6.12 All rhesus D negative women should be given an anti-D injection  
(Refer to guideline entitled 'Administration of antenatal prophylactic anti-D for rhesus negative women'; register number 06065.)
- 6.13 If the attempt is successful then the patient should be treated as cephalic presentation.
- 6.14 If the attempt is unsuccessful then an individual plan of care should be documented in the woman's healthcare records following further discussion with the patient.
- 6.15 Women should be advised to report if there is reduction in fetal movements or any other concerns.  
(Refer to the guideline for 'Reduced fetal movements'; register number 06034)
- 6.16 Following the ECV procedure the woman should be advised to remain on Labour Ward for a further two hours to ensure that the patient experiences no further side effects.

## **7.0 Staffing and Training**

- 7.1 All midwifery and obstetric staff must attend yearly mandatory training which includes skills and drills training.
- 7.2 All midwifery and obstetric staff are to ensure that their knowledge and skills are up-to-date in order to complete their portfolio for appraisal.

## **8.0 Professional Midwifery Advocates**

- 8.1 Professional Midwifery Advocates provide a mechanism of support and guidance to women and midwives. Professional Midwifery Advocates are experienced practising midwives who have undertaken further education in order to supervise midwifery services and to advise and support midwives and women in their care choices.

## **9.0 Infection Prevention**

- 9.1 All staff should follow Trust guidelines on infection control by ensuring that they effectively 'decontaminate their hands' before and after each procedure.
- 9.2 All staff should ensure that they follow Trust guidelines on infection control, using Aseptic Non-Touch Technique (ANTT) when carrying out procedures i.e. when citing a cannula.

## **10.0 Audit and Monitoring**

- 10.2 Audit of compliance with this guideline will be considered on an annual audit basis in accordance with the Clinical Audit Strategy and Policy (register number 08076), the Corporate Clinical Audit and Quality Improvement Project Plan and the Maternity annual audit work plan; to encompass national and local audit and clinical governance identifying key harm themes. The Women's and Children's Clinical Audit Group will identify a lead for the audit.
- 10.3 The findings of the audit will be reported to and approved by the Multi-disciplinary Risk Management Group (MRMG) and an action plan with named leads and timescales will be developed to address any identified deficiencies. Performance against the action plan will be monitored by this group at subsequent meetings.
- 10.4 The audit report will be reported to the monthly Directorate Governance Meeting (DGM) and significant concerns relating to compliance will be entered on the local Risk Assurance Framework.
- 10.5 Key findings and learning points from the audit will be submitted to the Patient Safety Group within the integrated learning report.
- 10.6 Key findings and learning points will be disseminated to relevant staff.

## **11.0 Guideline Management**

- 11.1 As an integral part of the knowledge, skills framework, staff are appraised annually to ensure competency in computer skills and the ability to access the current approved guidelines via the Trust's intranet site.
- 11.2 Quarterly memos are sent to line managers to disseminate to their staff the most currently approved guidelines available via the intranet and clinical guideline folders, located in each designated clinical area.
- 11.3 Guideline monitors have been nominated to each clinical area to ensure a system whereby obsolete guidelines are archived and newly approved guidelines are now downloaded from the intranet and filed appropriately in the guideline folders. 'Spot checks' are performed on all clinical guidelines quarterly.
- 11.4 Quarterly Clinical Practices group meetings are held to discuss 'guidelines'. During this meeting the practice development midwife can highlight any areas for future training needs will be met using methods such as 'workshops' or to be included in future 'skills and drills' mandatory training sessions.

## **12.0 Communication**

- 12.1 A quarterly 'maternity newsletter' is issued and available to all staff including an update on the latest 'guidelines' information such as a list of newly approved guidelines for staff to acknowledge and familiarise themselves with and practice accordingly.
- 12.2 Approved guidelines are published monthly in the Trust's Staff Focus that is sent via email to all staff.

- 12.3 Approved guidelines will be disseminated to appropriate staff quarterly via email.
- 12.4 Regular memos are posted on the 'Risk Management' notice boards in each clinical area to notify staff of the latest revised guidelines and how to access guidelines via the intranet or clinical guideline folders.

### **13.0 References**

National Institute for Clinical Excellence (2008) Antenatal care for uncomplicated pregnancies. CG62; Updated January 2017. London: NICE.

Royal College of Obstetricians and Gynaecologists (2017) The Management of Breech Presentation. Green Top Guideline, No 20b.

Hutton EK, Hofmeyr GJ, Dowswell T. External cephalic version for breech presentation before term. Cochrane Database of Systematic Reviews 2015, Issue 7. Art. No.: CD000084. DOI: