External Cephalic Version (ECV) protocol (CG549)

Approval

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<tr>
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Change History

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1.0 Purpose of the protocol
To formalise the procedure when carrying out External Cephalic Version (ECV).

2.0 Introduction
ECV is the manipulation of the fetus, through the abdomen, to a cephalic presentation.

3.0 Background
Breech presentation complicates 3-4% of all term fetuses, and a higher proportion of pre-term fetuses. It is more common when there has been a previous breech presentation. With the publication of the term breech trial (Hannah, 2000) the incidence of Caesarean section for breech presentation has increased markedly.

4.0 When should ECV be offered?
Royal College of Obstetrics & Gynaecology (RCOG) recommends offering ECV to primips from 36+0 and multips from 37+0.
Recently evidence shows that ECV done from 34+0 to 35+6 has a higher success rate and a lower Caesarean section rate (absolute reduction of 4%). However, this does come with a slightly increased rate of pre-term deliveries (but not statistically significant) with no difference in serious neonatal or maternal morbidity or mortality.

5.0 Pre-requisites
From Community
- If a breech presentation is suspected at 36 weeks and the mother is under GP/MW care, the midwife should telephone the antenatal clinic on 0118 322 7290 to request an ultrasound scan by a trained antenatal clinic midwife for suspected breech presentation
- If the mother is booked under a consultant, the community midwife should check when the mother is scheduled to attend the hospital and if necessary adjust the appointment to 36-7 weeks. A scan will be organised when the mother attends.

From ANC
- Arrange an appointment for ECV on maternity day assessment unit on Friday morning or consult with obstetric consultant skilled in carrying out ECV’s to arrange a appropriate time.
- The clinic midwife will book on the electronic booking system and commence the ECV care pathway document
• The doctor will order anti-D if Rh(D) neg.
• A formal ultrasound scan (USS) should be done prior to undertaking the procedure; this should have taken place no more than one week prior to the ECV.
• Women should be counselled regarding the risks and benefits of the procedure.
• She should be given the Maternity information sheet ‘External cephalic version for breech presentation at term’, which is available on the Trust website.

6.0 On Day of the ECV
• Consent should be obtained for the procedure.
• ECV should be performed where ultrasound and cardiotocography (CTG) is available to enable the fetal heart rate visualisation. Access to theatres should also be available nearby.
• An appropriately trained obstetrician or midwife should perform the procedure.
• The fetal heart should be monitored on a CTG for at least 15 minutes prior to the ECV and 30 minutes after the procedure and both CTG’s should be classified as normal.
• Tocolysis may be offered to women undergoing ECV as it has been shown to increase the success rate and should be considered where an initial attempt at ECV without tocolysis has failed. A simple protocol is to offer subcutaneous terbutaline 250 micrograms 10-15 minutes routinely prior to commencing the procedure, after all checks are complete and consent is gained to proceed with ECV. Women should be advised of the adverse effects of tocolysis with beta-2-agonists. Staff should be made aware that terbutaline may cause transient maternal tachycardia.

7.0 Procedure
• Ensure the woman has emptied her bladder.
• Position the woman in a recumbent position (a wedge placed under her buttocks), or the woman may be position with her buttocks elevated (up side down on the coach with the back rest raised and the legs over the top of the coach).
• Lubrication of the maternal abdomen using mineral oil, ultrasonic gel, or talcum powder may be used. This decreases friction which may reduce maternal discomfort. Entonox may also be offered to help reduce maternal discomfort.
• Place your hands between the fetal breech and the maternal symphysis pubis.
• Dislodge the breech from the maternal pelvis.
• After the breech is dislodged, guide the fetal head in a forward or backward roll toward the maternal pelvis while simultaneously guiding the breech towards the fundus.
• If the forward roll is unsuccessful an alternative approach, the backward flip can be attempted but must be carried out under USS guidance.

• Abandon the procedure if:
  1. attempts at a forward roll or a backward flip are unsuccessful
  2. more than 5 minutes of uterine pressure is required
  3. there is maternal intolerance to the procedure

A maximum of 2 attempts can be allowed (by Midwives before involving consultant)

8.0 Complications of ECV

• Women should be counselled that ECV has a very low complication rate.

• Women should be alerted to potential complications of ECV.

• Although rarely associated with complications, nevertheless, a few case reports exist of complications such as placental abruption, uterine rupture and fetomaternal haemorrhage. Randomised controlled trials have reported no evidence of an increase in neonatal morbidity and mortality.

• ECV does not appear to promote labour, although can be associated with fetal bradycardia and a non-reactive CTG, they are almost invariably transient, alterations in umbilical artery and middle cerebral artery waveforms.

9.0 Contraindications

a. Absolute Contraindications:

• Where Caesarean delivery is required. e.g. Placenta praevia;

• Antepartum haemorrhage within the last 7 days;

• Abnormal cardiotocography;

• Major uterine anomaly;

• Amniotic fluid abnormalities; Ruptured membranes; Oligohydramnios;

b. Relative Contraindications:

• Multiple pregnancy (except delivery of second twin to be carried out by obstetrician).

• Small-for-gestational-age fetus with abnormal Doppler parameters

• Proteinuric pre-eclampsia; Pregnancy-induced hypertension, Uncontrolled hypertension

• Maternal cardiac disease
• Maternal BMI >40 at booking.
• Major fetal anomalies;
• Scarred uterus;
• Unstable lie.

c. Success rates
Rates vary from 30% up to 80% in different series. Race, parity, uterine tone, liquor volume, engagement of the breech and whether the head is palpable, and the use of tocolysis, all affect the success rate.

An overall success rate of the below can be achieved:
• Primips: around 40%;
• Multips: around 60%.

10.0 Further care - POST PROCEDURE
Regardless of whether the ECV is successful or not:
1. Monitor the FHR by CTG for 30-40 minutes. A reactive non stress test must be achieved prior to discharge.
2. Monitor and record the maternal pulse, BP, and vaginal loss.
3. Obtain a blood group and antibody screen sample for a Kleihauer test and arrange prophylactic Anti-D administration if the maternal blood group is Rhesus negative.
4. Women may be discharged home after 1 hour provided:
   • the maternal observations are normal
   • the CTG is reactive
   • the obstetric team is satisfied with the fetal and maternal condition.
5. 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.
6. Documentation in the ECV care pathway and in the Patients hand held notes and audit forms completed.
• All successful ECV patients should be seen one week later to check presentation this can be arranged through ANC on EXT 7290.

• If ECV fails, elective Caesarean section should be booked for 39 weeks gestation and pre op. arranged.

**If the mother expresses a willingness to attempt vaginal delivery** referral to a obstetrician should take place and the following assessments should be made, and information should be given to her:

• A clinical examination of mother and fetus
  o Maternal habitus
  o Engagement of the presenting part
  o **Arrange an MRI of pelvis**

• Check the ultrasound examination report for;
  o Presentation (particularly the arrangement of the legs)
  o Placental site and other pelvic masses such as ovarian cysts or fibroids
  o Flexion or extension of fetal head (inencephaly)
  o Fetal size (beware macrosomia and IUGR)

• Review the prior obstetric history
  o Length of second stage
  o Mode of delivery
  o Size of baby / ies

The mother must be made aware that many obstetricians, particularly those trained within the last ten years in the UK, have very little experience in delivering breech babies vaginally. When she is admitted in labour, the consultant on duty will be fully informed by the specialist obstetrician on the Delivery Suite. Records of the consultation and the potential risks of a vaginal breech delivery must be documented.

Whilst individual parental preferences are acknowledged, the doctors on duty must be satisfied that the baby is delivered safely and in good condition, so he or she may recommend a Caesarean delivery if progress is slow in labour. Once the second stage of labour is reached, the obstetrician who conducts the delivery should advise what position the mother should adopt for delivery. A consultant might be present at some deliveries, but this depends on them being alerted in a timely fashion by the resident team. A neonatal practitioner will be present to check the baby over immediately after birth.
Mothers need to be aware that we do not offer induction of labour if they are still pregnant after 41+ weeks. A Caesarean section will normally be arranged.

11.0 Roles and Responsibilities

- The Care Group Manager / Head of Midwifery / Obstetric Clinical Lead responsible for maintaining an overview of the effectiveness of care through the review of audit findings.

- Midwifery Leads and Consultants are responsible for:
  - The implementation of this guideline;
  - Monitoring the implementation and compliance with this guideline;
  - Ensuring staff access training commensurate with their role and responsibilities.

- Senior Midwives are responsible for:
  - Implementing this guideline within their clinical area;
  - Ensuring staff understand their accountability and responsibility in relation to complying with this guideline;
  - Ensuring the staff who carry out ECV have the knowledge, skills and commensurate with their role and responsibilities to run the breech clinic.

12.0 Objectives

To ensure there is a clear process in place for those staff that carry out ECV.

13.0 Definitions

**External cephalic version (ECV):** is the manipulation of the fetus, through the abdomen, to a cephalic presentation.

**Breech:** is a baby who is in the bottom first presenting.

14.0 Who is this guideline for?

This guideline applies to all staff that has the responsibility of carrying out ECV.
15.0 Implementation Plan

The latest ratified version of this policy and procedure will be posted on the Trust's Intranet and Internet sites for all members of staff to view. A notice will be placed on the intranet and the newsletter informing Maternity staff of version changes. New members of Maternity staff will be signposted to how to find and access this policy at Trust Induction.

16.0 Monitoring Compliance of Guideline

Data will be collected for each woman who has an ECV. The Maternity Risk and Audit team will be responsible for monitoring that the audit takes place and will act as a resource for the midwifery and obstetric staff carrying out the audit.

The audit report will be made available to Supervisors of Midwives, Midwifery and Obstetric staff through the multi disciplinary OCGG. In the event of the audit standards not being met, the multidisciplinary OCGG will instigate the development of an action plan, which will have clear timescales.

The Obstetric Clinical Director and the Associate Director of Midwifery will monitor progress against the action plan, which will remain an agenda item at the multidisciplinary OCGG until satisfactorily completed.

17.0 Auditable Standards

- Antenatal detection of breech presentation
- Proportion of women with a breech presentation offered ECV
- Success rate of ECV
- Complications of / after ECV
- Maternal perceptions of ECV.

18.0 References


