HEALTH HOLDING
HAFER ALBATIN HEALTH CLUSTER
MATERNITY AND CHILDREN HOSPITAL

Department:	Obstetrics and Gynecology (Ward)		
Document:	Departmental Policy and Procedure		
Title:	External Cephalic Version and Breech Presentation		
Applies To:	All Obstetrics and Gynecology Staff		
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1. PURPOSE:

1.1 To standardize the health care provided to patients with breech presentation at term.

2. DEFINITIONS:

1.1 **Breech Presentation**- is the presentation in which the fetus is in longitudinal lie and its buttock is the lower most part.

1.2 **External Cephalic Version (ECV)**- is the manipulation of the fetus, through the maternal abdomen, to a cephalic position.

3. POLICY:

3.1 The reason behind ECV is to reduce the incidence of breech presentation at term and therefore the associated risks, particularly of avoidable caesarean section.

3.2 An ECV service, provided by appropriately trained physician, should be available to all women with a breech presentation at term.

3.3 Women with a breech fetal should be informed that attempting ECV lowers their chances of having a caesarean section.

3.4 Labour with a cephalic presentation following ECV is associated with a higher rate of obstetric intervention than when ECV has not been required.

3.5 Women should be counselled that, with a trained operator, about 35-50% of ECV attempts will be successful but this rate can be individualised for them.

3.6 The use of tocolysis with beta-sympathomimetic may be offered to women undergoing ECV as it has been shown to increase the success rate.

3.7 ECV should be offered from 36 weeks in nulliparous women and from 37 weeks in multiparous women.

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

3.8.1 Complications include placental abruption, uterine rupture and feto-maternal hemorrhage.

3.8.2 ECV does not appear to promote labor but is associated with alterations in fetal parameters. These include a fetal bradycardia and a nonreactive cardiotocograph.

3.9 ECV should be performed where facilities for monitoring and immediate delivery are available.

3.10 Contraindication to ECV:

3.10.1 Absolute contraindications for ECV that are likely to be associated with increased mortality and morbidity:

3.10.1.1 Where caesarean delivery is required.

3.10.1.2 Antepartum hemorrhage within the last 7 days.

3.10.1.3 Abnormal cardiotocography.

3.10.1.4 Major uterine anomaly.

3.10.1.5 Ruptured membranes.

3.10.1.6 Multiple pregnancies (except delivery of second twin).

3.10.2 Relative contraindications where ECV might be more complicated:
- 3.10.2.1 Small-for-gestational-age fetus with abnormal Doppler parameters.
- 3.10.2.2 Proteinuric preeclampsia.
- 3.10.2.3 Oligohydramnios.
- 3.10.2.4 Major fetal anomalies.
- 3.10.2.5 Scarred uterus.

4. PROCEDURE:

4.1 Obstetrician and midwives should be able to discuss the benefits and risks of ECV accurately.
4.2 All women undergoing ECV should be offered detailed information (preferably written) concerning the risks and benefits of the procedure. Consent may also be appropriate.
4.3 ECV is best performed at a weekly session with access to ultrasound, cardiotocography and theatre facilities.
- 4.3.1 Contact the physician and inform the Anesthetist.
- 4.3.2 Cardiotocography should be performed after the procedure.
- 4.3.3 Anti-D immunoglobulin is normally offered to the rhesus-negative women.
- 4.3.4 Starvation, anaesthetic premedication and intravenous accesses are all unnecessary.

4.4 Women should be advised that ECV can be painful and the procedure will be stopped if they wish.
4.5 Where ECV fails the possibility of a further attempt should be discussed.
4.6 The use of tocolysis should be considered where an initial attempt at ECV without tocolysis has failed.
4.7 All details of care should be clearly documented, including details of counselling and the identity of all those involved in the procedures.

5. MATERIAL AND EQUIPMENT:

5.1 CTG

6. RESPONSIBILITIES:

6.1 Physician
6.2 Nurses

7. APPENDICES:

7.1 History and Examination form

8. REFERENCES:

8.1 Guidelines for Obstetrics and Gynecology/ Ministry of Health, General Directorate of Health Centers-Riyadh, 2013

9. APPROVALS:

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