Breech Presentation – Antenatal management and ECV - Full Clinical Guideline

Reference no.: UHDB/AN/09:21/B6-1

Contents

1. 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.

2. Purpose and Outcomes

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 noncephalic presentation at delivery and therefore, caesarean section and its sequelae.

3. Key Responsibilities and Duties

- Breech presentation at 32 weeks is more likely to persist at term, so arrangements should be made for appropriately timed follow up to identify and offer timely ECV from 36+0 weeks onwards. If a woman has had a previous breech presentation she should be offered a 36 week scan for presentation as the risk of recurrence is 10%
- Offer ECV to primips as close to 36+0 weeks as possible, ideal timing for multips is from 37+0 weeks but can be offered anytime after 36+0 weeks. There is no type of breech that is a contraindication to ECV.
- ECV is more likely to be successful the earlier it is offered. Labour following a successful ECV is more likely to be successful if there is a longer ECV to delivery interval
- Women with a *persistent transverse lie* can also be offered ECV but should be advised that the success rate is much lower.
- *ECV is rarely indicated in the management of an unstable lie*. It should only be considered in the context of a stabilising induction where a valid indication for IOL already exists, as the rate of version following remains high with increased risks of transverse lie in labour, cord prolapse and CTG abnormalities

4. Abbreviations

CTG - Cardio Tocograph
ECV - External Cephalic Version
IOL - Induction of Labour

5. Main guideline

The guidance for women with a Breech presentation during the antenatal period is covered within the Care Pathway (Appendix A). This Pathway is to be used for documentation of care for all women who have a confirmed breech presentation at scan from 36 weeks gestational age and later.
Patient information is integrated into the pathway.

6. Monitoring Compliance and Effectiveness

Audit of Care Pathways to monitor compliance. This document will be implemented as a trial document and finalised based on feedback during this period set a maximum of 6 months.

7. References

RCOG External Cephalic Version and reducing the incidence of Term Breech presentation. Green top guideline No.20a

University Hospitals of Derby and Burton NHS Foundation Trust

Breech Presentation at Term / External Cephalic Version (ECV) Integrated Care Pathway

Please affix patient's sticker here
(to include name, address, DOB and hospital number)

EXCEPTIONAL CareTogether

GUIDANCE SUMMARY

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Direct access pathway for ECV (RDH site only for women under MLC)

CMW suspects breech presentation at 34-36 wks:

- Offer appointment in Midwife Sonographer Led Presentation clinic on Wednesday a.m. at 36 weeks.
- If breech confirmed and suitable for ECV will be counselled about this option by Midwife sonographer and offered direct access to ECV clinic on same afternoon if slots available.
- If declined Consultant appointment and transfer of care to be arranged.

Suitability criteria for ECV before referral (tick boxes to confirm)

☐	Normal fetal growth scan and confirmation of breech presentation within 2 weeks of procedure (discuss with Consultant if fetal growth restriction)
☐	AFI 10cm or above (discuss with Consultant if reduced as less likely to be successful)
☐	One previous C/S is not a contraindication to ECV provided the Consultant responsible for woman's care feels that VBAC is appropriate and woman wants a VBAC

Contraindications to ECV (tick any boxes if applicable)

☐	C/S indicated for reasons other than breech presentation (eg placenta praevia)
☐	APH current or within preceding week

☐	Multiple pregnancy
☐	Rhesus isoimmunisation
☐	Ruptured membranes
☐	Abnormal CTG
☐	Fetal growth restriction with Abnormal fetal doppler
☐	Nuchal cord
☐	Severe PET
☐	Unable to consent to procedure
☐	Current thromboprophylaxis (no LMWH within 12 hours of procedure)

Relative contraindications to ECV (tick any boxes if applicable and discuss with consultant undertaking ECV)

☐	AFI less than 10cm
☐	Hypertensive disease
☐	Fetal growth restriction with normal umbilical doppler

PATIENT INFORMATION LEAFLET (tear out)

What is external cephalic version (ECV)?

ECV is a procedure that is used to turn a baby in the womb, from presenting bottom first (BREECH), to head first (CEPHALIC).

What is a breech presentation?

Before birth most babies are head down in the womb, therefore most babies are born head first. When babies are bottom first this is known as a Breech presentation. This occurs in about 3 - 4% (3 - 4 in 100) of pregnancies after 37 weeks. There are many reasons why babies present by the breech but in most pregnancies where an ECV is offered there is no obvious cause.

Who can have an ECV?

ECV is recommended for all women with straightforward pregnancies whose babies are presenting bottom first. If your baby is found to be a breech presentation this will be confirmed by ultrasound scan and the baby's growth will also be checked to make sure your baby is healthy.

A senior midwife or obstetrician will see you and discuss ECV with you if suitable.

ECV is usually performed around 36 - 37 weeks as there is more chance that the baby will turn back if it is done earlier, however it may be performed at any time from 36 weeks onwards before labour.

How successful is ECV?

The success rate is over 50%. Of these only 2 - 3% turn back to breech.

What does the procedure involve?

ECV is carried out on labour ward. You can have a light meal before coming to the hospital.

Before the procedure we will perform an antenatal check, monitor your baby's heartbeat for approximately 20 minutes and an ultrasound scan will be performed to ensure there are no reasons why we should not carry out the procedure.

During this scan we check on the way your baby is lying, make sure your babys' cord is not in the way and that your baby is well.

You will be given the chance to discuss ECV in more detail and will be asked to give your consent for the procedure. We will recommend the use of a drug to relax your womb as this increases the chances of turning your baby. This drug is safe for you and your baby and has no long lasting effects.

If you are happy for us to turn your baby we will ask you to lie down on the bed and when you are comfortable the specialist carrying out the ECV will place both hands on your tummy to locate the baby's bottom. The baby's bottom is then lifted up and the baby is encouraged to kick itself into a different position.

A small number of women find the procedure uncomfortable, please be reassured that we will stop the procedure if you feel you do not want us to carry on. It is important for you to know that any slight discomfort you may feel will not be affecting your baby as it is well protected by your abdominal wall, the wall of the womb and the fluid surrounding the baby inside the womb.

You may notice some redness and a slight stinging sensation on the skin afterwards.

Following the procedure if successful or not, we will ask you to stay so we can monitor your baby for a further hour.

Are there any risks involved with having an ECV?

Once we decide it is safe to carry out an ECV the risks to your baby are extremely small. In 1 - 2 in a 100 cases, there may be a small transfer of blood across the placenta, between you and your baby. This can also happen in normal pregnancy for other reasons without you being aware of it. The chances of this causing your baby any harm is extremely low, but this is one of the reasons why we monitor your baby carefully during the procedure. If however your blood group is **Rhesus Negative**, it will mean you will need an Anti-D injection following the procedure. If there were any concerns about your baby it would be possible to deliver your baby by caesarean birth. However please be reassured that the chance of this being necessary is extremely low.

There is a 5/1000 risk of emergency delivery within 24 hours of the procedure.

What happens if my baby is turned?

The chance of having a normal birth following a successful ECV is almost as good as if the baby had always been head down. There is no need to interfere with the pregnancy just because you have had an ECV and your pregnancy can be allowed to carry on as normal. However, we will recommend birth in a Consultant led unit with continuous fetal monitoring during labour. Your doctor or midwife will be asked to examine you to check the baby is still head down.

If your baby turns back and your pregnancy remains straightforward you may be offered a further ECV as later in the pregnancy the baby is more likely to stay head down.

What if the baby doesn't turn?

If we are unable to turn your baby we will discuss with you the options for your birth and the best

way to have your baby. The obstetrician will be happy to discuss any questions you may have.

What to expect afterwards

Following your ECV your pregnancy should continue as normal. Your babys movements should not change or become reduced in any way, and you should not experience any pain or bleeding. There is no evidence to suggest that your labour will start any earlier due to your baby being turned

If you have any concerns after leaving the hospital you should contact your community midwife or the Assessment Unit at the hospital for advice. For RDH call PAU on 01332 785796 and for QHB call MAU on 01283 593038

More information

Please contact Labour Ward at the Royal Derby Hospital on 01332 785141 or 01332 785140 or QHB MAU on 01283 593038

Information about ECV to discuss with woman before referral	
☐	ECV is a safe procedure with a very low risk of complications (risk of emergency delivery within 24 hours of procedure is 0.5%). It does not cause labour to start
☐	There is no need to starve before the procedure
☐	The procedure is carried out on Labour Ward and they will need to make arrangements to be with us for at least 3-4 hours
☐	Success rate is over 50%
☐	There is no evidence that adopting different postures will help baby to turn and insufficient evidence to recommend Moxibustion as an alternative
☐	ECV may be an uncomfortable procedure but only 5% of women find it too painful to continue
☐	If successful very few babies will turn back (2-3%)
☐	If ECV is unsuccessful after 36+0 weeks it is very unlikely that baby will spontaneously turn to cephalic
☐	Successful ECV reduces the risk of breech presentation at delivery and need for Caesarean Section
☐	After successful ECV birth is recommended in a Consultant Led unit with CEFM due to a increased risk of intervention in labour for both delayed progress and fetal compromise
☐	ECV is less likely to be successful if maternal BMI is raised but can still be attempted
☐	Rhesus negative blood group will require Anti-D after procedure unless fetus is known to be Rhesus D negative
☐	Routine use of tocolysis is recommended as this has been shown to increase success rate
☐	Give copy of ECV patient information leaflet
Woman's choice	
☐	ECV accepted

☐	Not applicable, not suitable for ECV
☐	ECV declined If declined see section on discussion about mode of delivery

Signature

Name of health professional (print)	
Job title	
Signature	
Date	

ECV procedure Admission

Date	Time	Location	Grav/Par	Gestation	Blood group	Rh factor	Allergies

Blood pressure	Pulse	Temperature	Urinalysis	Fetal movements	CTG
…… / ……	…….. BPM	……..°C			Time commenced: …… ☐ Normal ☐ Abnormal

Vaginal loss:		Pain	

Admission history and discussion

Confirmed has received and read copy of ECV Patient Information Leaflet: ☐ Yes ☐ No

Risk factors	Pre-existing	Identified in this pregnancy
Obstetric		
Medical		
Lifestyle		

Signature

Name of health professional		Job title	
Signature		Date	

Ultrasound pre-procedure

Lie	☐ Longitudinal	☐ Oblique	☐ Transverse			
Presentation	☐ Breech	☐ Cephalic	☐ Other			
Type breech	☐ Extended	☐ Flexed	☐ Footling	☐ Other:		
Position	☐ RSA	☐ Direct SA	☐ LSA	☐ Direct SP	☐ RSP	☐ LSP
Liquor volume	☐ Normal	☐ Low	☐ Oligohydramnios	☐ Increased		
Placental site	☐ Cornual	☐ Anterior	☐ Posterior			
Nuchal cord	☐ Yes	☐ No				
Comments						

Risks and benefits of the procedure discussed

Name of health professional		Job title	
Signature		Date	

Patient agreement to ECV (top copy to be given to patient)

Name of proposed procedure: External Cephalic Version (ECV)

Statement of health professional (to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy)

I have explained the procedure to the patient. In particular, I have explained that:

The intended benefits: Reduces risk of Caesarean Section if successful and increases chances of vaginal birth

Significant, unavoidable or frequently occurring risks: Unsuccessful procedure (40-50%); too painful to continue (5%); baby turns back to breech (3%); Fetomaternal Haemorrhage (2-3%); need for emergency delivery (0.5%).

I have also discussed what the procedure is likely to involve, the absence of any available alternative treatments but leaving the option to not have the procedure, and any particular concerns of this patient.

The following leaflet has been provided:

☐ External Cephalic Version

Health professional

Signed: _____ **Date:** _____

Name: (PRINT) _____ **Job Title:** _____

Statement of interpreter (where appropriate)

I have interpreted the information above to the patient to the best of my ability and in a way in which I believe s/he can understand.

Signed: _____ **Date:** _____

Name: (PRINT) _____

Statement of patient or person with parental responsibility for patient

I agree to the procedure described above

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience

Guidance to health professionals

(to be read in conjunction with consent policy)

What a Consent Form is for

This form documents the patient's agreement to go ahead with the investigation or treatment you have proposed. It is not a legal waiver - if patients, for example, do not receive enough information on which to base their decision, then the consent may not be valid, even though the form has been signed. Patients are also entitled to change their mind after signing the form, if they retain capacity to do so. The form should act as an aide-mémoire to health professionals and patients, by providing a check-list of the kind of information patients should be offered, and by enabling the patient to have a written record of the main points discussed. In no way, however, should the written information provided for the patient be regarded as a substitute for face-to-face discussions with the patient.

The Law on Consent

See the Department of Health's Reference guide to consent for examination or treatment for a comprehensive summary of the law on consent (also available at www.doh.gov.uk/consent).

Who can give Consent

Everyone aged 16 or more is presumed to be competent to give consent for themselves, unless the opposite is demonstrated. If a child under the age of 16 has "sufficient understanding and intelligence to enable him or her to understand fully what is proposed" , then he or she will be competent to give consent for himself or herself. Young people aged 16 and 17, and legally 'competent' younger children, may therefore sign this form for themselves, but may like a parent to countersign as well. If the child is not able to give consent for himself or herself, someone with parental responsibility may do so on their behalf and a separate form is available for this purpose. Even where a child is able to give consent for himself or herself, you should always involve those with parental responsibility in the child's care, unless the child specifically asks you not to do so. If a patient is mentally competent to give consent but is physically unable to sign a form you should complete this form as usual, and ask an independent witness to confirm that the patient has given consent orally or non-verbally.

When NOT to use this form

If the patient is 18 or over and is not legally competent to give consent, you should use the form for adults who are unable to consent to investigation or treatment instead of this form. A patient will not be legally competent to give consent if:

•they are unable to comprehend and retain information material to the decision and/or

•they are unable to weigh and use this information in coming to a decision

You should always take all reasonable steps (for example involving more specialist colleagues) to support a patient in making their own decision, before concluding that they are unable to do so. Relatives cannot be asked to sign this form on behalf of an adult who is not legally competent to consent for himself or herself.

Information

Information about what the treatment will involve, its benefits and risks (including side-effects and complications) and the alternatives to the particular procedure proposed, is crucial for patients when making up their minds. The courts have stated that patients should be told about 'significant risks which would affect the judgement of a reasonable patient'. 'Significant' has not been legally defined, but the GMC requires doctors to tell patients about 'serious or frequently occurring' risks. In addition if patients make clear they have particular concerns about certain kinds of risk, you should make sure they are informed about these risks, even if they are very small or rare. You should always answer questions honestly. Sometimes, patients may make it clear that they do not want to have any information about the options, but want you to decide on their behalf. In such circumstances, you should do your best to ensure that the patient receives at least very basic information about what is proposed. Where information is refused, you should document this on page 2 of the form or in the patient's notes.

ECV Procedure (only to be undertaken by suitably trained operator on labour ward with access to ultrasound, CTG and emergency theatre facilities)

Venous access		
Tocolysis	☐ Salbutamol	500 micrograms in 20ml saline, 50 micrograms in 2ml by slow intravenous injection
	Total dose used:	
	☐ Terbutaline	250 micrograms subcutanously
Technique	☐ Forward flip	☐ Backward flip
	☐ Lateral tilt	☐ Head down
Number of attempts (max 4)		
FHR during procedure		
FHR immediately post procedure		
Outcome	☐ Successful	☐ Unsuccessful
Comments:		

Signature

Name of health professional		Job title	
Signature		Date	

Post procedure monitoring

CTG for 60 minutes	☐ Normal	☐ Abnormal: escalate to Obstetrician
Tocograph	☐ No uterine activity or unchanged from pre-procedure	
	☐ Changed from previous: escalate to Obstetrician	

Maternal symptoms

☐ Pain	☐ Tightenings	☐ Bleeding	☐ SROM

If any present, escalate to Obstetrician

☐ Rhesus negative	☐ Blood group/Kleihauer 30 minutes post procedure and arrange Anti-D
Anti-D given Date:	**Time:**
Dose:	Batch Number
Additional notes	

Signature

Name of health professional		Job title	
Signature		Date	

Successful ECV: ensure appropriate follow up arrangements in place

- ☐ Transfer to Consultant Led Care if previously Midwife Led Care
- ☐ Advise birth in Consultant Led Care unit
- ☐ Community Midwife follow up for presentation
- ☐ Antenatal Clinic follow up Date arranged:
- ☐ Advise woman to self refer if pain, contractions, bleeding or altered fetal movements as these are not expected after discharge

Assessment and discussion about mode of delivery if unsuitable for, declines or unsuccessful ECV

1	**Recommend Caesarean Section**

☐ Due to increased risk perinatal morbidity/mortality in the following circumstances (tick if any of these apply):

- ☐ Hyperextended neck
- ☐ EFW greater than 3.8 kg
- ☐ EFW less than 10th centile
- ☐ Footling breech presentation
- ☐ Evidence of antenatal fetal compromise
- ☐ Other contraindications to vaginal birth:
- ☐ Unable to provide trained and skilled clinician for intrapartum care (can be offered referral to another unit)

☐ Previous caesarean section is a relative contraindication. Decisions about mode of delivery in this situation should always

be individualized and discussed with a Consultant Obstetrician

Nulliparity alone is not a reason to recommend caesarean section

2	**All other women are suitable for either vaginal breech birth or planned Caesarean Section**

If no absolute contraindication to VBB identified (see above) an unbiased discussion should take place with the woman about the relative risks/benefits of planned Vaginal Breech Birth versus planned C/S after 39 weeks and she should be offered the option of either.

See check list on next page to guide discussion with all women falling within this group with regards to their birth options.

After completion and signing provide the top copy to the woman.

Discussion about mode of delivery with a breech presentation

for women suitable for either vaginal breech birth or Caesarean section (give top copy to woman)

Your baby is in the Breech presentation. As you are more than 36 weeks gestation it is unlikely that your baby will spontaneously turn as most babies will remain in this presentation.

At present it is suitable for you to have your baby either by vaginal breech birth or by Caesarean Section as for your baby there is no clear evidence that one way is better than the other.

This document covers the risks and benefits of both options which the doctor will discuss with you so you can decide which you would prefer. Please take your time to ask as many questions as you need to help you decide.

☐	With careful selection and skilled labour and delivery care planned vaginal breech birth is nearly as safe as planned vaginal cephalic birth if conducted in a Consultant Led Unit with adherence to local protocols and facilities for emergency delivery. Vaginal breech birth outside of this setting carries higher risk of early neonatal morbidity (harm).
☐	The overall very small risk of perinatal mortality (death of your baby due to birth) is slightly less with planned Caesarean Section compared to vaginal birth for three reasons. Only one of these is unique to having a breech baby as the others would be the same even if your baby was head down (cephalic). a) There is a stillbirth risk which exists and increases for all pregnancies after 39 weeks and having a Caesarean avoids this risk b) There is a risk of labour complications common to all births which is reduced by planned Caesarean c) Having a Caesarean avoids risks which are specific to vaginal breech birth
☐	Comparative risks of perinatal mortality are a) 0.5 in 1000 with Caesarean section after 39 weeks b) 2.0 in 1000 with spontaneous vaginal breech (bottom first) birth c) 1.0 in 1000 with cephalic (head first) vaginal birth
☐	There is an increased risk with vaginal breech birth of some short term complications: low Apgar scores at birth; early neonatal unit admission (in Term Breech Trial but not shown in PREMODA study); rare complications of clavicle fractures or haematomas (PREMODA study) There is no evidence of any increased risk of longer term harm to your baby
☐	The risk of complications for yourself is lowest with successful vaginal birth, higher with planned Caesarean Section, highest with emergency Caesarean Section particularly if needed in the late first or second stage of labour
☐	Delivery by Caesarean Section in labour is required in approximately 30-45 % of all planned vaginal breech births

☐	Planned Caesarean Section has a higher risk of immediate complications for yourself compared to vaginal birth
☐	Having a Planned Caesarean Section for this baby gives you a higher risk in future pregnancies a) The increased risk of vaginal birth after Caesarean section b) Increased risk of need for repeat Caesarean section c) Increased risk of abnormally invasive placenta (0.3% after 1 previous C/S) d) Increased risk of stillbirth in future pregnancy (reasons for this unclear)
☐	Labour in this pregnancy even if delivery is needed by Caesarean section increases your chance of a successful vaginal birth in future pregnancies
☐	There is a risk of spontaneous labour before planned Caesarean Section and in this situation, after assessment it may be necessary or safer to proceed with vaginal breech birth even though you may have preferred a Caesarean Section
☐	Induction of labour with a breech is not recommended so if complications develop in your pregnancy it may not be advisable to continue with plans for a vaginal breech birth
If there are any other particular longer term risks of Caesarean Section for you or your baby these will be discussed with you	
Document any other relevant discussions:	

Name of health professional	Job title
Signature	Date

Woman's choice and plan on discharge

For all pregnancies where baby was in confirmed breech position at or after 36 weeks gestational age, document on baby notes as a reminder to organise a hip examination referral following birth.

Document discharge plan

Signature

Name of health professional		Job title	
Signature		Date	

Documentation Control

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	Royal Derby prior to merged document:			
Version / Amendment	Version	Date	Author	Reason
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	Burton Trust prior to merged document:			
WC/OG/22	5	April 2015	Mrs K Anwar – Consultant Obstetrician	Review / update
Version control for UHDB merged document:				
UHDB	1	Jan 2021	Miss R Hamilton - Consultant Obstetrician	Merge QHB and RDH. Introduce Care Pathway to reduce variance
Intended Recipients: all clinical staff delivering antenatal care				
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