

ROYAL HOSPITAL FOR WOMEN

LOCAL OPERATING PROCEDURE

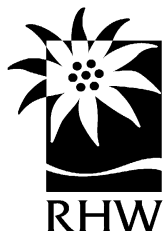
CLINICAL POLICIES, PROCEDURES & GUIDELINES

Approved by Quality & Patient Safety Committee
December 2012

EXTERNAL CEPHALIC VERSION

This LOP is developed to guide clinical practice at the Royal Hospital for Women. Individual patient circumstances may mean that practice diverges from this LOP.

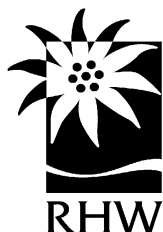
- **AIM**
 - To rotate a fetus from a breech presentation to a cephalic presentation
- **PATIENT**
 - Woman with a breech presentation from 36 weeks gestation
- **STAFF**
 - Medical Officer
 - Registered Midwife
 - Sonographer
- **EQUIPMENT**
 - Terbutaline 250 micrograms subcutaneously
 - Cardiotocographic (CTG) monitoring equipment
 - Ultrasound machine
- **CLINICAL PRACTICE**
 - Perform portable ultrasound if breech presentation suspected from 36 weeks gestation
 - Arrange formal ultrasound scan (prior to the ECV procedure) if breech presentation is suspected from 36 weeks gestation, to assess presentation, liquor volume, growth parameters, placental site, attitude of the fetal head, type of breech eg. frank, complete, footling
 - Counsel woman regarding options and benefits and risks
 - Give patient the patient information leaflet: P:\Patient Information Leaflets\Antenatal\Breech Birth.pdf (Appendix 1)
 - Book the ECV procedure to be performed in Delivery Suite
 - Perform abdominal palpation followed by CTG monitoring prior to the procedure to assess fetal wellbeing and further confirm presentation
 - **Do not proceed with the ECV procedure if CTG is not reassuring**
 - Check fetal presentation with portable ultrasound
 - Ensure that the woman has been counselled by the medical officer performing the procedure regarding the benefits and risks, including possible caesarean section prior to the ECV procedure
 - Obtain written consent from the woman for ECV
 - Give bolus dose of subcutaneous terbutaline (Option 1) OR intravenous Salbutamol via butterfly (Option 2) prior to ECV procedure
 - Commence the procedure, when Tocolysis is achieved, by elevating the breech from the pelvis and gently guiding the head toward the pelvis
 - Monitor post ECV procedure with CTG to assess fetal wellbeing (whether or not successful)
 - Offer Rhesus negative woman Anti D
 - Arrange follow up with the treating medical or midwifery team within one week
 - Advise woman to call Delivery Suite, if experiencing decreased fetal movements, bleeding, ruptured membranes or abdominal pain

**EXTERNAL CEPHALIC VERSION cont'd****• DOCUMENTATION**

- Antenatal card
- Integrated clinical notes
- Medication chart
- CTG stickers

• EDUCATIONAL NOTES

- 3-4 % of pregnancies present as breech at term
- The Cochrane review of randomised controlled trials showed:
 - A significant reduction in the risk of caesarean without any increased risk to the fetus
 - Routine Tocolysis with Beta agonists stimulants appears to be effective with some trials showing increased ECV success rate at term and fewer caesarean sections. Sublingual nitro-glycerine was not found to be effective
- Contraindications:
 - Antepartum haemorrhage within one week
 - Major uterine abnormalities
 - Multiple pregnancies
 - Ruptured membranes
 - When a CS is already indicated such as placenta praevia
 - Non reassuring CTG
- Relative contra-indications:
 - Small-for-gestational-age fetus (<5th centile) with abnormal Doppler parameters
 - Pre-eclampsia
 - Oligohydramnios defined as Amniotic Fluid Index (AFI) less than the 5th centile
 - Major fetal anomalies
 - Scarred uterus
 - Unstable lie
- The success rates for ECV are approximately 40% in nulliparous women and 60% in multiparous women
- Spontaneous reversion to breech presentation after successful ECV occurs in less than 5% of women
- ECV is 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 (RR 0.44, 95% CI 0.07–2.92) but are underpowered for these rare outcomes. Systematic reviews report a very low complication rate but are subject to the limitations of reporting bias. These, and large consecutive series, however, suggest a 0.5% immediate emergency caesarean section rate and no excess perinatal morbidity and perinatal mortality.
- Salbutamol 100 micrograms intravenously may be considered an alternative to Terbutaline for Tocolysis



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- Breech vaginal birth
- Rh D Immunoglobulin in Obstetrics
- Intrapartum fetal heart rate monitoring

• REFERENCES

- 1 The Management of Breech Presentation. Dec 2006. Clinical Green Top Guidelines. Royal College of Obstetricians and Gynaecologists
- 2 Hofmeyr GJ, Kulier R. External cephalic version for breech presentations at term (Cochrane review) 2010. Issue 10 2012
- 3 Oral Nifedipine versus subcutaneous Terbutaline Tocolysis for external cephalic version: A double blind randomised trial. BJOG 2009 Jan 116 (1): 74-80

REVISION & APPROVAL HISTORY

Endorsed Neonatal Services Management Committee 16/5/12

PATIENT INFORMATION LEAFLET

P:\Patient Information Leaflets\Antenatal\Breech Birth.pdf

IF YOUR BABY IS IN THE BREECH POSITION WHAT ARE YOUR CHOICES?

What is the breech position?

Usually by 36 weeks your baby will be in a head down or cephalic presentation. However 3-4% of babies (3-4 in a 100) will present bottom down. This is called the breech presentation. Before 36 weeks the baby has plenty of room to move into the head down position. If your midwife or doctor thinks the baby is still in the breech position after 36 weeks you will be offered an ultrasound. Once breech presentation is confirmed you may be offered a procedure to turn the baby. This is called external cephalic version (ECV).

External cephalic version (ECV)

This is where an obstetrician attempts to turn your baby with his/her hands. He/she applies pressure on your abdomen to turn the baby to the headfirst position. This procedure has been found to be safe for your baby. It significantly reduces the rate of vaginal breech births and the need for caesarean section. Vaginal birth in a head down presentation carries less risk than vaginal breech birth or caesarean section. Very few babies will turn back to breech position after ECV.

If the ECV is unsuccessful you can discuss your options with your obstetrician or midwife. This may include vaginal breech birth, caesarean section or repeat ECV.

Where to go on a day of procedure?

The ECV will be performed in the Delivery Suite. You will be asked to ring the Delivery Suite on the day of the ECV to check what time to come to the hospital. Please go to the front desk on the ground floor on arrival.

What will happen on the day?

You will receive an injection of a medication that will relax your uterus (womb). An ultrasound machine will be used before and after the procedure. Most women do not find the procedure uncomfortable. If necessary the obstetrician performing the ECV can pause until you are more comfortable. The procedure can be stopped at any time. Your baby's heart rate will be monitored before, during and after the procedure.

You will be in hospital for about 2 hours. If the ECV is successful your pregnancy will be expected to continue as normal. If the ECV is unsuccessful you have some choices to make regarding the birth of your baby.

Breech vaginal birth versus planned caesarean section

You will need to discuss the known risks and benefits of both a breech vaginal birth and a caesarean section with your midwife and an obstetrician. You may wish to read further information about your options from the Society of Obstetricians and Gynaecologists Canada (SOGC) website.

FREQUENTLY ASKED QUESTIONS

Are there any risks to the baby or me from an ECV?

Research suggests that there is a low rate of complications after ECV. If complications occur you will be monitored and an emergency caesarean section may need to be performed. The chance of this happening is small (less than 0.5% or 1:200). The Royal Australian and New Zealand College of Obstetricians (RANZCOG) and The NSW Ministry of Health recommend offering an ECV when a baby is in a breech position.

Do I have to have an ECV?

While we encourage you to have an ECV, the choice is yours. If you decline an ECV then you will need to have a discussion with an obstetrician regarding the best mode of birth for your baby. If your baby remains breech you can elect to have either a vaginal breech birth or a caesarean section.

Are there alternative methods available?

There is limited evidence of the benefit of exercises, acupuncture and moxibustion, to change a baby's position.