ANTENATAL GUIDELINES

No.34 E.C.V – Referral and Procedure

Contents	Page
Referral	1
Patient information and discussion	1
Criteria for ECV	1
Contraindications for ECV	1
Pre-requisites for booking into ECV clinic	1-2
Procedure	2
Rh negative women	2
Follow-up	2
Unsuccessful version	2
Record keeping and documentation	2
Appendix 1. Referral flow chart for ECV	3
Appendix 2. ECV – Checklist for midwives	4

1. Referrals

Referrals can be made from clinics or wards, but not directly from GPs or Community Midwives. Appointments for external cephalic version (ECV) can be booked via the labour ward. See flowchart - appendix 1.

2. Patient information and discussion

Women must be afforded a documented discussion re: risks and benefits of ECV and receive a patient information booklet. It is important to ensure that the woman has read and understood all the relevant information to assist them in making the decision that is best for them.

3. Criteria for ECV

Breech presentation or transverse/oblique lie.
Singleton pregnancy.
36 weeks gestation (nulliparous) or 37 weeks or more (multiparous) (there is no recommended upper limit).

4.0 Contraindications for ECV

4.1 Absolute contraindications

- Where caesarean delivery is indicated even if cephalic.
- Antepartum haemorrhage within the last 7 days.
- Abnormal electronic fetal monitoring.
- Major uterine anomaly.
- Ruptured membranes.
- Multiple pregnancy (except delivery of second twin).

4.2 Relative contraindications

- Previous significant third trimester haemorrhage.
- Evidence of 'placental dysfunction' (e.g. significant small for gestational age, oligohydramnios, severe PET).
- Rhesus iso-immunisation.
- Serious fetal anomaly.
- Oligohydramnios.
- Unstable lie (unless as part of a stabilising induction).
- Previous uterine surgery (data on safety after one caesarean section is reassuring but limited).
- Women on treatment doses of clexane should have their ECV performed in discussion with the operator at a time interval closest to the trough level of anticoagulation.

5. Pre-requisites for booking into ECV clinic

- Each woman should have had an ultrasound examination prior to ECV to:
  - Confirm the presentation (including type of breech).
  - For fetal weight estimation.
  - To exclude congenital abnormality e.g. hydrocephalus)

If booking from a peripheral clinic and USS not already performed, a scan (for growth/liquor volume and presentation) appointment should be arranged prior to the clinic appointment.

6. Procedure

- Electronic fetal monitoring (EFM) must be performed prior to the attempted ECV in order to demonstrate 'normality'; if this meets Dawes Redman criteria then 10 minutes should be sufficient.

- A Scan to confirm presentation and position of fetal spine should be performed by the Doctor performing the ECV.
- Terbutaline 250 mcg s/c 15 min prior to procedure may be used at the discretion of the operator (e.g. for primigravida with tight musculature).
- Electronic fetal monitoring should be performed for 60 minutes following the procedure - whether it was successful or not.

6.1 Rh negative women:

Women who are rhesus negative should be treated in accordance with the antenatal guideline and given prophylactic anti-D for a sensitising event. Kleihauer testing is not necessary (RCOG, 2017).

6. Follow-up

- **Successful version** - woman should be seen in the ECV clinic the following week to check the presentation. If the fetus has reverted to breech, a repeat ECV may be offered.

7. Unsuccessful version

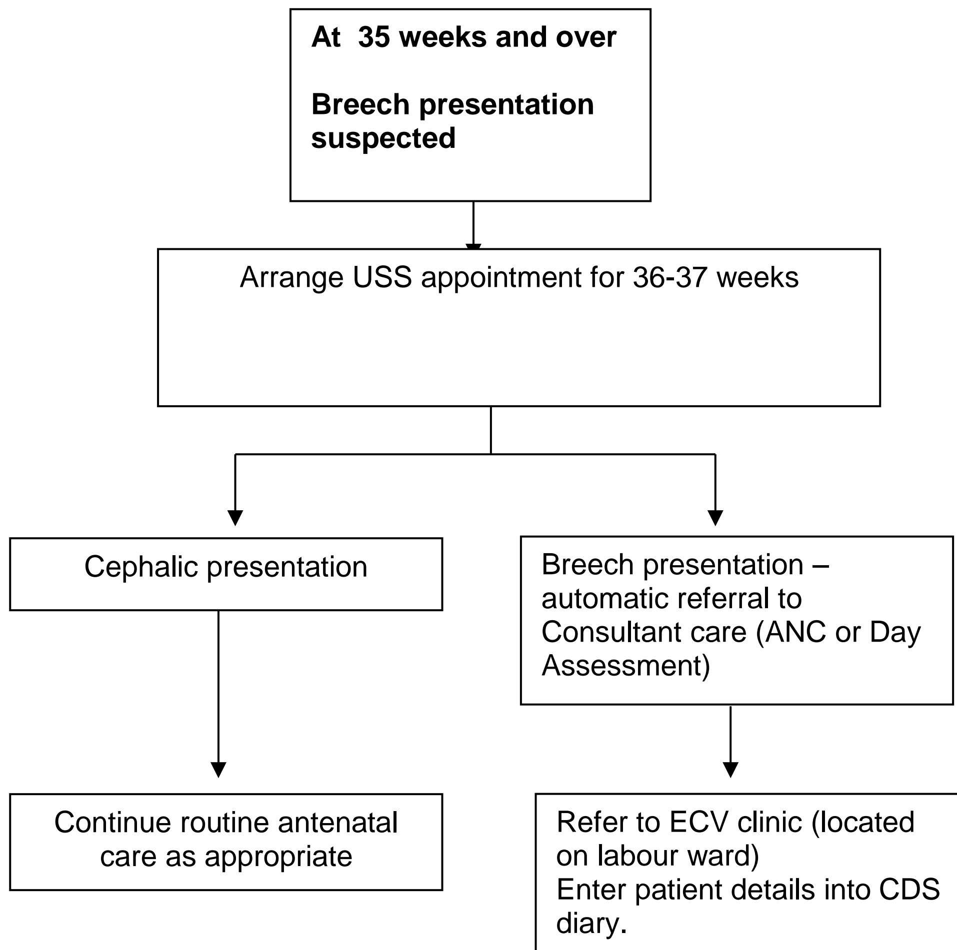
In the event of an unsuccessful version, the woman should have a documented discussion re: evidence of LSCS vs. vaginal breech. Patient choice should be supported, although the evidence encourages an elective LSCS to improve safety for the fetus. If the woman opts for LSCS, the staff on CDS must refer to **antenatal guideline 21: Women attending for elective LSCS preparation**, and complete the relevant pack.

8. Record keeping and documentation

It is expected that every episode of care be recorded clearly, in chronological order and as contemporaneously as possible by all healthcare professionals as per Hospital Trust Policy. This is in keeping with standards set by professional colleges, i.e. NMC and RCOG.
All entries must have the **date and time** together with **signature and printed name.**

APPENDIX 1

FLOWCHART FOR REFERRAL FOR ECV



Appendix 2

Successful E.C.V – Checklist for midwives:

Electronic fetal monitoring (EFM) for one hour post procedure.	
Arrange follow up in following week ECV clinic for presentation scan check.	
Return to routine antenatal care.	
Anti-D to be administered if the patient is Rhesus Negative.	
ECV antenatal coding form to be complete (in box file) and handed to ward clerk.	

N.B Women may continue with their planned home birth following a successful E.C.V as few babies revert to breech, however they should be informed that there is a slightly increased rate of instrumental delivery or caesarean section (RCOG, 20a. 2017).

Failed E.C.V – checklist for midwives

Electronic fetal monitoring (EFM) for one hour post procedure.	
Organise discussion with obstetrician re: mode of delivery.	
Obstetrician to complete an elective c/section booking form for a HCA/MW can take to DAW. Ensure correct patient details are on the form, including telephone numbers.	
Contact DAW to arrange date for EL LSCS prep. Inform the woman of date, time and location of appointment.	
Ensure consent form is completed by obstetrician.	
Inform patient that she will receive a phone call to arrange clerking and for bloods to be performed prior to c/section. A date will not be given until the patient is 39 weeks.	
Take swabs for MRSA screening for patients who match the criteria to require screening. (Health care workers, previous +ve MRSA result).	
Patient information leaflet for *Elective Caesarean Section* should be given.	
Anti-D to be administered if the patient is Rhesus Negative.	
ECV antenatal coding form to be complete (in box file) and handed to ward clerk.	

Monitoring and Audit

Auditable standards:
Documented patient discussion and PIL

Please refer to audit tool, location: 'Maternity on cl2-file11', Guidelines

Reports to:
Clinical Effectiveness Committee – responsible for action plan and implementation of recommendations from audit

Clinical Governance & Risk Management Committee

Frequency of audit:
Annual

Responsible person:
Audit midwife

Cross references

Antenatal Guideline 3- Anti-D Immunoglobulin
Antenatal Guideline 21 - Women attending for elective LSCS preparation
Antenatal Guideline 44 - Guideline development within Maternity Services
Clinical Record Keeping Policy Derriford Hospital

References

National Institute for Health and Clinical Excellence, 2004, **Caesarean section**. RCOG, London.
Royal College of Obstetricians and Gynaecologists Green-top , 2017.Guideline No 20a ,**External Cephalic Version (ECV) and reducing the incidence of breech. RCOG London.**
Royal College of Obstetricians and Gynaecologists Green-top, 2017 . Guideline No. 20b, **The Management of Breech Presentation.** RCOG London

Author	Guideline Committee		
Work Address	Maternity Unit, Derriford Hospital, Plymouth, Devon, PL6 8DH		
Version	4		
Changes	In line national standards		
Date Ratified	**May 2017**	**Valid Until Date**	**May 2022**