



SOGP GUIDELINE OF EXTERNAL CEPHALIC VERSION AND REDUCING THE INCIDENCE OF BREECH PRESENTATION

Adapted for Pakistan from the Green top RCOG guideline No: 20a, 2006
By the Guideline Committee of SOGP through consensus & literature review
Reviewed by: The executive Body of SOGP
Endorsed by: The CPSP

1. Purpose and scope

The aim of this guideline is to provide up to date information on mode of delivery for women with breech presentation in Pakistan. The scope is confined to decision making regarding the route of delivery and choice of various techniques used during delivery. It does not include antenatal or postnatal care.

2. Background

External cephalic version (ECV) is the manipulation of the fetus, through the maternal abdomen, to a cephalic presentation. This guideline summarises the evidence regarding the routine use of ECV for breech presentation. The rationale behind ECV is to reduce the incidence of breech presentation at term and therefore the associated risks, particularly of avoidable caesarean section.

Breech presentation complicates 3–4% of all term deliveries and a higher proportion of preterm deliveries. It is more common where there has been a previous breech presentation. The incidence of caesarean section for breech presentation has increased markedly in the last 20 years and further with the publication of the term breech trial in Lancet in 2000. This trial concluded that, at least for mortality and markers of intermediate term morbidity, elective caesarean section was safer for the fetus and of similar safety to the mother when compared with intention to deliver vaginally. This means that measures to reduce the incidence of breech presentation have become more important and that the effect of any such measure on the incidence of caesarean section will be more marked. Recommendations for developing country like Pakistan with high prenatal mortality as considered by the guideline group of SOGP are incorporated

External cephalic version

1: What is the impact of ECV on the incidence of breech presentation at delivery?

Women should be counselled that ECV reduces the chance of breech presentation at delivery.

2: What is the effect of ECV on the caesarean section rate?

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

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

3: What is the success rate of ECV and what influences it?

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

4: Does the use of tocolysis improve the success rate of ECV?

- The use of tocolysis with beta-sympathomimetics may be offered to women undergoing ECV as it has been shown to increase the success rate.
- The use of tocolysis should be considered where an initial attempt at ECV without tocolysis has failed.

5: What other methods can be used to increase the success rate of ECV?

Where ECV fails, the possibility of a further attempt should be discussed.

6: When should ECV is offered?

ECV should be offered at term from 37 weeks onwards in nulliparous and multiparous women. In Pakistan, ECV at earlier gestations is discouraged because of possibility of need of urgent delivery in view of limited nursery and NICU care in majority of facilities

7: Is ECV safe?

- Women should be counselled that ECV has a very low complication rate.
- Women should be alerted to potential complications of ECV.
- ECV should be performed where facilities for monitoring and immediate delivery are available.
- The minimum requirement of the procedure is real time USG along with intermittent FH auscultation post ECV.

- USG should be performed in all women before and after ECV. Women should be retained in hospital for at least 1 hr after ECV with intermittent fetal heart rate monitoring to ascertain FHR abnormalities post ECV.
- Where facilities are available, electronic fetal monitoring with CTG trace before and after attempting ECV is recommended
- At discharge the woman should be advised to maintain fetal kick count chart.
- The standard preoperative preparations for caesarean section are not necessary for women undergoing ECV.

8: Is ECV painful?

Women should be advised that ECV can be painful and the procedure will be stopped if they wish.

9: What are contraindications to ECV?

There are few absolute contraindications to ECV.

Absolute contraindications for ECV that is likely to be associated with increased mortality or morbidity:

- Where caesarean delivery is required
- Ante partum haemorrhage
- Abnormal Cardiotocography
- Major uterine anomaly
- Ruptured membranes
- Multiple pregnancy (except delivery of second twin).

Relative contraindications:

- Small-for-gestational-age fetus with abnormal Doppler parameters
- Gestational Hypertension especially proteinuric preeclampsia
- Oligo hydramnios
- Major fetal anomalies
- Scarred uterus
- Un stable lie.

10: Increasing the uptake of ECV

Local policies should be implemented to actively increase the number of women offered and undergoing ECV. Obstetricians and midwives should be able to discuss the benefits and risks of ECV accurately.

11: Alternatives to ECV

There is insufficient evidence to support the use of postural management as a method of promoting spontaneous version over ECV. Moxibustion should not be recommended as a method of promoting spontaneous version over ECV.

12: Developing an ECV service

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

All women undergoing ECV should be offered detailed information (preferably written) concerning the risks and benefits of the procedure. Consent may also be appropriate.