

Maine Medical

PARTNERS

Women's Health

A department of Maine Medical Center

External Cephalic Version

Breech presentation occurs in 3-4% of term pregnancies. The goal of external cephalic version (ECV) is to increase the proportion of vertex presentations at term, and thereby increase the chances of a vaginal delivery. Success rates from 16-100% are reported, with an average pooled success rate of 58%.¹

Pregnant patients with breech presentation near term and no contraindication should be offered an external version attempt. However, external cephalic version should be attempted only after 37w0d and in settings where cesarean delivery services are immediately available.¹

Indications:

Non-vertex infants, after 37w0d gestation

Exclusion Criteria:

Any contraindication to a vaginal delivery, including but not limited to:

- Placenta previa or vasa previa
- Major fetal anomaly
- Prior classical c-section
- Uterine anomaly
- Third trimester bleeding
- Non reassuring fetal status

Relative Contraindications

- Labor
- Ruptured membranes
- Fetal macrosomia
- Evidence of uteroplacental insufficiency, *i.e.* IUGR, oligohydramnios, abnormal Doppler studies

Adverse Reactions:²

- Labor
- NRFHT
- Placental abruption (<1%)
- Vaginal Bleeding (1.5%)
- PROM within 48 hours of ECV (2%)
- Cord prolapse (<0.5%)

Method:

Preparation

- Obtain informed consent, full H&P should be documented in chart
- Patient should be NPO 8 hours prior to the procedure due to the potential for urgent delivery via cesarean section

Pre-Procedure

- Ensure stable vital signs
- Perform a bedside ultrasound to confirm presentation, placental location, AFI, and rule out anomalies that are a contraindication to vaginal delivery
- Ensure there is a reactive NST prior to ECV
- Obtain IV access; CBC and type and screen should be drawn
- Order RhoGam if indicated, for post-procedure administration
- Request anesthesia to see and consent patient

Procedure

- Consider tocolysis with 0.25mg SQ terbutaline 10-15 minutes before ECV unless a contraindication exists
- Neuraxial analgesia can be considered a reasonable intervention to increase ECV success rate
- Place patient in the supine or slight reverse Trendelenburg position
- ECV attempt should be discontinued if the patient has intolerable discomfort, or if non-reassuring fetal status develops

Post-Procedure

- Perform EFM for at least 60 minutes. A reactive NST should be obtained before discharge
- Administer RhoGam if indicated

References:

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4. Fernandez CO, Bloom SL, Smulian JC, Ananth CV, Wendel GD. A randomized placebo-controlled evaluation of terbutaline for external cephalic version. Obstet Gynecol 1997; 90:775-79.
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7. Carlan SJ, Dent JM, Huckaby T, Whittington EC, Shaefer D. The effect of epidural anesthesia on safety and success of external cephalic version at term. *Anesth Analg* 1994;79:525-28.
8. Schorr SJ, Speights SE, Ross EL, Bofill JA, Rust OA, Norman PF, et al. A randomized trial of epidural anesthesia to improve external cephalic version success. *Am J Obstet Gynecol* 1997;177:1133
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