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External cephalic version

The purpose of this leaflet is to provide the patient with information on the nature, indications, process and possible risks of external cephalic version.

External cephalic version (ECV) is a procedure in obstetrics used to turn a foetus from a breech position to a head-first position.

In the first and second trimesters of pregnancy, a large proportion of foetuses are in a breech position; however, the majority of them turn spontaneously to a head-first position by 34 to 36 weeks of pregnancy. Before birth, most babies are positioned head down in the uterus, which means that the baby is born head first. Around 5% of babies are in a breech position and present bottom or feet first. In uncomplicated cases, a breech baby can be delivered vaginally; however, the head down position makes it easier and safer for the baby to pass through the birth canal. It is therefore recommended that the baby be externally rotated before delivery. ECV is typically performed after 36 weeks of pregnancy, preferably at 36 to 37 weeks, when the chances of success are highest and the risks are lower.

How is ECV performed?

Prior to performing ECV, a cardiotocography (CTG) and an ultrasound examination are performed to check the wellbeing and position of the foetus in the womb. ECV is performed under ultrasound guidance. It is recommended that the bladder be emptied before the procedure. Before the version attempt, the pregnant woman is given a medication to relax the uterus. The doctor performing the procedure then places her/his hands on the maternal abdomen to gently guide the baby's head toward the pelvis. The version is performed without excessive use of force; however the woman may feel some pain or discomfort during the procedure. Following the procedure, a repeat cardiotocography is performed to ensure foetal wellbeing.

Rh-negative women who do not have antibodies are given anti-D immunoglobulin after the version.

Risks of ECV

ECV is safe for both the mother and the baby; however, in very rare cases, it can cause:

- premature rupture of the membranes;
- preterm delivery (in 3% of cases);
- vaginal bleeding (in 1.1% of cases);
- foetal arrhythmias, especially bradycardia (in 1-16% of cases);
- placental abruption (in 0.4-1% of cases).

Complications of ECV

The woman’s risk of requiring an emergency caesarean section due to complications during the procedure is very low (0.4-4%). In the event of placental abruption, which is a very rare complication, an emergency caesarean section is required. To avoid the aforementioned risks to the foetus, ECV is performed after 36 gestational weeks, when the foetus is sufficiently mature and delivery at this stage of pregnancy is safe.

Success rates of ECV

The probability of a successful ECV is 35-57% (an average success rate of 40%) for first-time mothers and 52-84% (an average success rate of 60%) for women who have had previous children. Should the first attempt fail, a second attempt in a few days to a week can be considered.

Regardless of whether the ECV was successful or not, the woman must seek emergency care at the Women’s Clinic of East Tallinn Central Hospital at Ravi 18, Tallinn, if:

- foetal movements have decreased;
- bleeding occurs;
- contractions begin;
- waters break.

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