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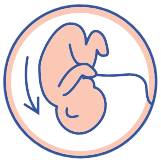

Evidence on: Breech Version

By Rebecca Dekker, PhD, RN

Question: What is an external cephalic version?

Answer: By the end of pregnancy, most babies are in a cephalic (head-down) position in the uterus. However, in 3% to 4% of term pregnancies the babies are in breech (bottom-first) position.

External cephalic version refers to a procedure in which a care provider puts their hands on the pregnant person's belly and turns the breech positioned baby, using either a forward or backward roll, into a head-down position. This is also called an ECV, version, or "hands to belly" procedure.

Question: Why do some people choose to attempt ECV?

Answer: ECV is typically done at or near term, and sometimes in early labor, to improve someone's chances of having a cephalic vaginal birth. Attempting one or more ECVs will result in a baby who is head-down at the time of birth in around 33% of first-time birthing people and 61% of people who have given birth before. Medications that prevent labor contractions have been shown to improve the success of ECV.

Since breech vaginal birth is not commonly supported in the U.S., the vast majority of people who give birth with breech babies do so by Cesarean (94% Cesarean rate). But when ECV is successful at turning breech babies into a head-down position, the risk of Cesarean is greatly reduced (24% Cesarean rate after successful ECV).

Question: What are the risks of ECV?

Answer: The most common risk is a temporary change in the infant's heart rate (highest rates reported in the research are 4.7%); serious complications requiring urgent Cesarean are rare (0.2%).

An ECV can be painful, but it's less painful if the procedure is successful, and there are medications that can be used to manage pain.

Question: Are there any reasons why someone cannot attempt an ECV?

Answer: Whenever there is a medical reason not to do something, that reason is called a "contraindication." People should not have an ECV if they have a history of placenta abruption or if placenta abruption is suspected, if there is a diagnosis of severe pre-eclampsia, or if there are signs of fetal distress. Also, if vaginal birth is contraindicated, then an ECV would also be contraindicated. Having a history of prior Cesarean does not mean you should not be offered an ECV.

Many factors haven't been well studied, and some care providers may use their expert opinion to recommend against an ECV in certain circumstances. It's important that care be individualized.

Question: What's the bottom line?

Answer: ECV is an underused procedure! In the U.S., as many as 20-30% of people who are eligible for ECV are not offered it, even though attempting ECV lowers their chance of Cesarean. The evidence supports offering everyone with breech presentation an ECV attempt after 37 weeks of pregnancy if there are no contraindications. If ECV is not successful, the decision to plan a Cesarean versus a breech vaginal birth should be based on the pregnant person's wishes and the provider's expertise.

> **"Successful ECVs can have personal benefits by helping people avoid major abdominal surgery, and population-level benefits by lowering the overall Cesarean rate."**

1. ACOG (2020). Practice Bulletin No. 221 External Cephalic Version. Obstet Gynecol, 135(5):e203-e212.
2. Rosman, A. N., Guijt, A., Vlemmix, F., et al. (2012). Contraindications for external cephalic version in breech position at term: a systematic review. Acta obstetricia et gynecologica Scandinavica.
3. Hutton, E. K., Simioni, J. C., Thabane, L. (2017). Predictors of success of external cephalic version and cephalic presentation at birth among 1253 women with non-cephalic presentation using logistic regression and classification tree analyses. Acta Obstet Gynecol Scand, 96(8), 1012-1020.

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