Breech presentation at term and ECV
(External Cephalic Version)
Information for patients and their families

Most babies are in the head down position by the last four to five weeks of pregnancy. This is known as cephalic presentation and is the easiest and safest position for birth. If the baby presents bottom first, this is known as a breech presentation and is quite common before 36 weeks.

Why some babies are breech

Three in every 100 babies are breech at the end of pregnancy. Sometimes it is just a matter of chance a baby does not turn and remains in the breech position. At other times certain things make it difficult for a baby to turn during pregnancy. This includes the amount of fluid in the womb (either too much or too little) the position of the placenta or if there are twins. In most cases where a baby remains in breech presentation after 36 weeks an External Cephalic Version (ECV) will be recommended in an attempt by the obstetric doctor to turn the baby to head first.

How is ECV done?

Before the ECV is done, you will need an ultrasound to confirm the position of the baby and the amount of fluid around the baby. This may happen on the day of ECV or a few days before. On the day of ECV, it is best not to eat for two to three hours before coming into hospital. Please come to the Day Assessment Unit in the Maternity Clinic at the time arranged by the obstetrician.

On arrival, your baby’s heart rate will be monitored for about 20 to 30 minutes using a cardiotocograph (CTG). An injection of a drug called Terbutaline is given into the skin on your arm 15 to 20 minutes before the ECV. This injection will relax the muscles of your uterus and make it easier to turn your baby.

The doctor will use moderate to firm pressure with both hands to push your baby into a forward or backwards somersault. Talcum powder is usually sprinkled on your abdomen to prevent discomfort from friction between the doctor’s hands and your skin. The ECV can be uncomfortable but not painful and usually takes about five minutes. After the EVC the position of baby will be checked with the bedside ultrasound. Another CTG tracing will be completed for about an hour. Approximately half of ECVs are successful, but up to 12 per cent of these babies may turn back to breech either immediately or several days later. In this case, the doctor may offer you another ECV.

Risks of ECV

Rarely, there may be changes in babies heart rate or bleeding behind the placenta that could require a caesarean section to be performed at the time. Women with Rhesus (Rh) negative blood will need an anti-D injection after ECV. Side effects from Terbutaline are rare; symptoms usually only last a few minutes and settle by themselves.
What happens after ECV
If the baby has been successfully turned to head first, we will see you in the clinic the following week to check the baby’s position. If the baby stays head first then you wait for the normal start of labour.

After the ECV: discharge advice
Whether the procedure is successful or not it is important that you contact the hospital if you notice any of the below:
• vaginal bleeding
• vaginal fluid loss
• baby is less active than usual
• abdominal (stomach) pain
• contractions.

What if the ECV doesn’t work; isn’t appropriate or I choose not to have one?
The obstetrician will discuss the following options with you:
• vaginal breech birth
• elective caesarean section.

There are benefits and risks associated with both caesarean and vaginal breech births. Caesarean delivery carries a slightly higher risk to you and your baby in future pregnancies. Caesarean birth for breech presentation is generally considered the safest option for your baby. However some of the evidence that supports this belief is under review and many now consider vaginal breech birth a valid option. A vaginal breech birth may not be recommended as safe in all circumstances. When considering a vaginal breech birth it is important that an obstetrician is available who is trained and experienced in delivering a breech baby vaginally, and that an ultrasound has confirmed that there are no particular features about your pregnancy that would make a vaginal breech birth more risky.

You would be advised against having a vaginal breech birth if:
• your baby is footling breech
• your baby is thought to be particularly large or small
• you have had a caesarean delivery in a previous pregnancy
• you require induction of labour
• your breech presentation is a first twin.

Further information
If you have any further questions about ECV, vaginal breech birth or elective caesarean section, please discuss these with your midwife or obstetrician.

Contact details:
Maternity Clinic Reception
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