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Turning a breech baby in the womb (external cephalic version) - information for you

This information is also available as a pdf: Turning a breech baby in the womb (external cephalic version): Information for you [1].

What is breech?

Breech means that your baby is lying bottom first or feet first in the womb (uterus) instead of in the usual head first position. In early pregnancy breech is very common. As pregnancy continues, a baby usually turns by itself into the head first position. Between 37 and 42 weeks (term), most babies are lying head first, ready to be born.

What is external cephalic version (ECV)?

Vaginal breech birth is more complicated than normal birth. Your obstetrician or midwife may advise trying to turn your baby to a head-first position. This technique is called external cephalic version (ECV). This is when gentle pressure is applied on your abdomen which helps the baby turn a somersault in the womb to lie head first.

What is the main benefit of ECV?

ECV increases the likelihood of having a vaginal birth.

When can it be done?

ECV is usually tried after 36 weeks. Depending on your situation, ECV can be done right up until you give birth.

Does ECV always work?

ECV is successful for about half of all women (50%). Your obstetrician or midwife should give you information about your own individual chance of success. Relaxing the muscles of the womb with medication during an ECV is likely to improve the chance of success. This medication will not affect the baby. You can help by relaxing your abdominal (tummy) muscles.

If the baby does not want to turn, it is possible to have a second attempt on another day. If the baby does not turn after a second attempt, your obstetrician or midwife will discuss your options for birth (see RCOG Patient Information A breech baby at the end of pregnancy).

Is ECV safe for me and my baby?

ECV is generally safe and does not cause labour to begin. The baby?s heart will be monitored before and after the ECV. Like any medical procedure, complications can sometimes occur. About one in 200 (0.5%) babies need to be delivered by emergency caesarean section immediately after an ECV because of bleeding from the placenta and/or changes in the baby?s heartbeat. An ECV should be carried out in a place where the baby can be delivered by emergency caesarean section if necessary.

ECV should not be carried out if:

- you need a caesarean section for other reasons
- you have had vaginal bleeding during the previous seven days
- the baby?s heart rate tracing (also known as a CTG) is abnormal
- your womb is not the normal pear-shape (some women have a womb which resembles a heart-shape, known as a bicornuate uterus)
- your waters have broken before you go into labour (see RCOG Patient Information When your waters break early (preterm prelabour rupture of membranes))
- you are expecting twins or more (except before delivering the last baby).

Is ECV painful?

ECV can be uncomfortable. Tell your obstetrician or midwife if you are experiencing pain so they can move their hands or stop.

At home after ECV

You should telephone the hospital if you have bleeding, abdominal pain, contractions or reduced movements after ECV.

Is there anything else I can do to help my baby turn?

There is no scientific evidence that lying down or sitting in a particular position can help your baby to turn. Always ask if you are unsure or want further information.

A glossary of all medical terms [2] is available. [3]

Sources and acknowledgements

This information is based on the Royal College of Obstetricians and Gynaecologists (RCOG) guideline External Cephalic Version and Reducing the Incidence of Breech Presentation [4] (published by the RCOG in December 2006). This information will also be reviewed, and updated if necessary, whenever the guideline has been reviewed. The guideline contains a full list of the sources of evidence we have used.

Clinical guidelines are intended to improve care for patients. They are drawn up by teams of medical professionals and consumers? representatives, who look at the best research evidence there is about care for a particular condition or treatment. The guidelines make recommendations based on this evidence.

This information has been developed by the Patient Information Subgroup of the RCOG Guidelines and Audit Committee, with input from the Consumers? Forum and the authors of the clinical guideline. It was reviewed by women attending clinics in Guildford, Edinburgh and Glasgow before being published. The final version is the responsibility of the Guidelines and Audit Committee of the RCOG.

A final note

The Royal College of Obstetricians and Gynaecologists produces Patient Information for the public. This is based on guidelines which present recognised methods and techniques of clinical practice, based on published evidence. The ultimate judgement regarding a particular clinical procedure or treatment plan must be made by the obstetrician of other attendant in the light of the clinical data presented and the diagnostic and treatment options available.

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