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Qualitative assessment of women's experiences with ECV

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ABSTRACT

For women with unsuccessful ECV, discussions about their mode of delivery should include the benefits and risks of a planned caesarean or vaginal breech birth. However, most obstetric units continue to offer only planned caesarean births when ECVs are unsuccessful despite the proven safety of vaginal breech births in selected patients. Such unit policies can be at variance with a woman's desire and preference for vaginal birth. Thus, a conflict situation arises that could have varying medical, emotional and cultural implications.

Aim: To provide a consumer perspective on ECV from women who had an unsuccessful procedure.

Methodology: A qualitative study involving focus group discussions with women who had unsuccessful ECV at secondary obstetric facility in Melbourne, Australia.

Results: Emergent themes from the focus group discussions were related to emotions associated with the inevitability of a caesarean section for breech, consequences of an unsuccessful ECV and the various activities undertaken by women to induce spontaneous version.

Conclusion: A medicalized approach to ECV fell short of women's expectations of care. There is a need to develop strategies that will help women deal with any conflicts occasioned by an unsuccessful ECV.

1. Introduction

External cephalic version (ECV) is an obstetric procedure for manipulating the breech presenting fetus to a cephalic presentation. It improves the chances of vaginal births by increasing the proportion of vertex presentations among babies formerly in breech position.

The procedure has received renewed interest in the last 2 decades coincident with publication of results of the term breech trial as well as the global concerns about rising rates of caesarean section.[1] ECV has been subjected to rigorous scientific appraisal and has demonstrated a reduction in caesarean births without any significant effect on perinatal mortality and morbidity.[1] Hence the Royal College of Obstetricians and Gynaecology recommends that all women with an uncomplicated breech pregnancy at term should be offered ECV.[2]

The procedure has a success rate of 30–80%.[2] This rate is influenced by race, parity, type of breech and the location of the placenta.[3] In Sydney, a success rate of 39% has been reported.[4] Thus, a significant proportion of ECVs are unsuccessful. For those women with unsuccessful ECV, discussions about their mode of delivery should include the benefits and risks of a planned caesarean or vaginal breech birth.[10] However, most obstetric units continue to offer only planned caesarean births[5] when ECVs are unsuccessful despite the proven safety of vaginal breech births in selected patients.[10] Such policies can be at variance with a woman's desire and preference for vaginal birth.[6,7] Thus, a conflict situation arises that could have varying medical, emotional and cultural implications.

In the past, the debate on ECV has primarily focused on its cost effectiveness, safety, appropriate gestational age for the procedure as well as its impact on caesarean section rates.[2,8] Recently, this debate has expanded to identify and include strategies for increasing patient's understanding of the procedure to enable them make informed decisions.[4,6] Unfortunately despite the sizable number of unsuccessful ECV among women who consent for the procedure, no studies to date have attempted an evaluation of women's experiences with ECV.

This paper therefore seeks to provide a perspective on ECV from women whose ECV were unsuccessful. It is our view that their contribution to the ECV debate can only improve the quality of ECV service. The paper was developed from an original research project that undertook a qualitative assessment of women's experiences with ECV at a secondary level obstetric facility in the south eastern suburbs of Melbourne, Australia. Its maternity services records more than 2500 deliveries a year.

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2. Materials and methods

The antenatal and birth records of patients attending the antenatal clinics at the Women's Children and Adolescent health department (WCAH) were reviewed over a 3 year period. The review was undertaken following the hospital ethics committee approval to undertake a qualitative assessment of women's experiences with ECV at the hospital. Specific details about patients' antenatal and birth records were elicited from the hospital database. All the women who had an ECV during the period under review were identified and invited to participate in a focus group discussion (FGD). One FGD was held for women with unsuccessful ECV and another for women who were successful with ECV. There were 5 participants in the FGD for women with unsuccessful ECV. A FGD facilitator and an assistant were recruited as part of the project. A FGD questionnaire was developed, piloted and then modified prior to use in the FGD. The FGD was voice recorded while an assistant took notes that highlighted the nonverbal cues that were associated with the expression of a participant's point of view. Transcripts of the interview were analysed for content and specific themes identified from the participants' description of their experiences with ECV.

2.1. The ECV protocol

We offer ECV to women with a breech presenting fetus at term that are eligible for the procedure. The exclusion criteria for an ECV in our unit include placenta praevia, reduced liquor volume, ruptured membranes, multiple pregnancy, maternal or fetal anatomical abnormality and previous uterine surgery. Others include severe gestational hypertension, fetal macrosomia and poorly controlled gestational diabetes mellitus.

Eligible women are recruited through the antenatal clinic following standard counselling. Women who consent for the procedure are booked for an ECV. All ECVs are carried out on the labour ward. Prior to ECV, arrangements are made with the operating theatre for immediate access if required. The procedure may be performed by a registrar or a specialist.

On admission to labour ward a written consent is obtained. A bedside ultrasound is used to confirm the breech presentation and an intravenous canula is inserted. A cardiotocograph is recorded prior to the commencement of the procedure. The ECV is attempted with the woman lying recumbent with a wedge under the right hip to give 30 degrees left lateral tilt to avoid vena caval compression. Tocolysis (salbutamol or tertbutaline) may be used to reduce uterine tone if earlier attempts are unsuccessful.

Using ultrasonic gel as lubricant, an attempt is made to lift the breech out of the pelvis by manipulating the pregnant abdomen. This is followed by simultaneously encouraging forward movement of the head and backward movement of the buttocks to induce forward rotation. If this is ineffective, an attempt to move the fetus in the reverse direction may be undertaken provided the woman consents to continuing the procedure. A CTG is performed at intervals during the procedure to monitor the fetal heart rhythm. The procedure is abandoned if a number of attempts are unsuccessful or if the woman complained of excessive discomfort. The procedure may last up to 30 min.

Following the ECV, the fetal presentation and heart rate are immediately assessed by ultrasound. A 1 h cardiotocogram is performed after the procedure and anti D immunoglobulin is administered to rhesus negative women. Women were discharged following a normal fetal heart rate tracing. Prior to discharge, women with unsuccessful ECV are consented and booked for a caesarean section at 39 weeks.

3. Results and discussion

A total of 21 ECVs were performed in the period under review. 13 (62%) were unsuccessful. Of these, 7 (58%) women accepted our invitation to participate in the focus group discussion but 5 (71.4%) attended. The reasons for declining to participate include "*phobia for public speaking*, *ill health*, *economic engagement* and *the experience of ECV being too painful to talk about*".

The demographic characteristics of participants in the FGD were similar. Their mean age was 29 years. All the participants had a college education and resided in the catchment area served by the hospital. 43% of the ECV occurred with nulliparous women and 76% of the ECVs were performed after 37weeks gestation (see Table 1).

3.1. Emotions associated with caesarean section for breech presentation at term

The experience of childbirth is an important life event for women. Indeed, memories of childbirth persist throughout life. A key component of a satisfactory childbirth experience is the actualization of a desired mode of delivery. Although, the majority of women prefer the option of vaginal birth[6,7] the persistence of the breech at term is an indication for caesarean birth.[5] Despite the criticisms of the term breech trial,[11] many obstetric units continue to implement a policy of caesarean section for a persisting breech presentation at term. Such policies may be at variance with a woman's desired mode of delivery and can result in various conflict situations. These situations were explored during the FGD. Our participants stated:

> "...It wasn't the Caesar I was scared about, I was absolutely devastated because I wanted to puff and pant and I thought, it has taken that away. I wanted to have the birth... I can't tell you why now... But I really wanted to... And I thought if I was to have a Caesar, I wanted to be awake. I don't want someone to take my baby first... straight to midwife and they will get that first cuddle... that was my fear..."

> "...But he (Dr.) said to me if the baby does not turn, you will have to have a caesarean. And I think I was more worried about the caesarean than I was about the baby being breech...I knew how hard it was for my friends that had Caesar...my other daughter had just turned 18months... she is a handful... looking after Jamie (newborn) and her wasn't easy with my tummy wound..."

3.2. Activities to turn breech to cephalic

Participants in our FGD engaged in a number of activities to encourage spontaneous version and achieve vaginal birth despite

Table 1
Demographic characteristics of patients undergoing ECV.

Characteristics		Number (%)
Age	≤30 years	15 (71.4%)
	>30 years	6 (28.6%)
BMI	≤30	11 (52.4%)
	>30	10 (47.6%)
Parity	Nullipara	9 (42.9%)
	Multipara	12 (57.1%)
Race	Caucasian	18 (85.7%)
	Asian	2 (9.5%)
	Others	1 (4.8%)
Timing of ECV	≤36weeks	0
	36–37weeks	5 (23.8%)
	>37weeks	16 (76.2%)