International Symposium 3
Recent Advances in Maternal–Fetal Medicine

3. The Hannah Term Breech Trial: A Re-appraisal after 7 Years

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Occasionally, there appears a journal article on a topic that an obstetrician copes with in his daily practice that may produce such an impact that he may alter his manner of practice. An example is this article from Canada which aims to answer the question as to which is the best method for delivering a term breech infant—


The most important results of this study were:

1. Perinatal mortality, neonatal mortality, or serious neonatal morbidity were significantly lower for the planned cesarean section group (17 of 1039 [1.6%]) than for the planned vaginal birth group (52 of 1039 [5.0%]) giving a RR 0.33 [95% CI 0.19–0.56] ; p<0.0001).

2. There were no differences between groups in terms of maternal mortality or serious maternal morbidity (41 of 1041 [3.9%] vs. 33 of 1042 [3.2%] ; RR 1.24 [0.79–1.95] ; p = 0.35).

3. Statistics did not change significance when specific factors were considered (experience of obstetrician defined 4 ways, PNMR of countries) but the benefits are greater in countries with lower perinatal mortality rates.

The same authors reported that >90% of hospitals switched to planned C/S based on their data. BUT more than 7 years have passed since its publication and serious doubts now start to be cast regarding the correctness of the article. Specifically, questions are being raised regarding the clinical execution of the original study protocol along the following aspects—

1. Violations in the inclusion criteria of recruited patients.
2. Disparity in levels of standard of care.
3. Skilled attendant at time of vaginal breech delivery
4. Faulty assessment of short and long-term morbidity results.

Where should we stand on this topic? Have we reached our “comfort zones” and the point of no return as far as planned vaginal breech delivery is concerned, despite the fact that clinical evidence may be faulty?