Routine ultrasound examination at 12 or 18 gestational weeks for prenatal detection of major congenital heart malformations? A randomized controlled trial comprising 36 299 fetuses.

Maria Westin, MD*, Sissel Saltvedt, MD**, Gunnar Bergman, MD†, Marius Kublickas, MD, PhD, Harald Almström, MD, PhD‡, Charlotta Grunewald, MD, PhD**, Lil Valentin, MD, PhD*

* Department of Obstetrics and Gynecology, Malmö University Hospital, Malmö, Sweden
** Department of Obstetrics and Gynecology, South Stockholm General Hospital, Stockholm
¶ Department of Obstetrics and Gynecology, Huddinge University Hospital
† Department of Pediatric Cardiology, Hospital of Astrid Lindgren, Stockholm
‡ Department of Obstetrics and Gynecology, Danderyd Hospital, Stockholm

Obstetric, gynecological and prenatal ultrasound research unit
Department of Clinical Sciences, Malmö
University of Lund, Sweden

Short title: Prenatal diagnosis of heart defects at 12 or 18 weeks

Key words: Nuchal translucency measurement, Congenital cardiac defect, Ultrasonography, Screening, Prenatal diagnosis

Corresponding author:
Maria Westin
Department of Obstetrics and Gynecology
Malmö University Hospital
Malmö, Sweden

Telephone +46 40 33 21 10, fax +46 40 962600

e-mail: Maria.Westin@med.lu.se
ABSTRACT

Objective. To compare the rate of prenatal diagnosis of heart malformations between two policies of screening for heart malformations.

Design. Randomized controlled trial.

Setting. Six university hospitals, two district general hospitals.

Sample. 39,572 unselected pregnancies randomized to either policy.

Methods. The 12-week policy implied one routine scan at 12 weeks including measurement of nuchal translucency (NT), the 18-week policy implied one routine scan at 18 weeks. Fetal anatomy was scrutinized using the same checklist in both groups, and in both groups indications for fetal echocardiography were ultrasound findings of any fetal anomaly, including abnormal four-chamber view, or other risk factors for heart malformation. In the 12-week scan group, NT ≥3.5 mm was also an indication for fetal echocardiography.

Main outcome measure. Prenatal diagnosis of major congenital heart malformation.

Results. In the 12-week group, seven (11%) of 61 major heart malformations were prenatally diagnosed vs. 9 (15%) of 60 in the 18-week group; p = 0.60. In four (6.6%) cases in the 12-week group the routine scan was the starting point for investigations resulting in a prenatal diagnosis vs. in 9 (15%) cases in the 18-week group (p = 0.15). The diagnosis was made ≤22 weeks in 5% (3/61) of the cases in the 12-week group vs. in 15% (9/60) in the 18-week group (p = 0.08).

Conclusion. The prenatal detection rate of major heart malformations was low with both policies. The 18-week scan policy seemed to be superior to the 12-week scan policy, even though the differences in prenatal detection rates were not statistically significant.
INTRODUCTION

Cardiac malformations are among the most common congenital abnormalities. The prevalence of heart malformations is estimated to be 8 per 1000 live births, half of those (4 per 1000 live births) being regarded as major, i.e., either lethal or requiring intervention within the first year of life. The spectrum of heart defects diagnosed prenatally differs from what is usually seen in postnatal practice. Cardiac malformations diagnosed prenatally are more often complex, i.e., they consist of several separate anatomical defects, and they are often associated with extra-cardiac malformations and/or abnormal karyotype.

Prenatal diagnosis allows optimization of perinatal management, i.e., preparation of the parents for the likely outcome, and planning of time, mode and site of delivery. The possibility to plan optimal management may improve neonatal outcome, e.g., in case of hypoplastic left heart syndrome, complete transposition of the great arteries, or coarctation of the aorta. Alternatively, prenatal diagnosis may constitute a rationale for termination of pregnancy.

Results from prospective studies show that the detection rate of major heart defects at routine ultrasound examination at 18 – 23 gestational weeks in unselected or low-risk populations varies from 0 to 81%. In a recent national survey from the United Kingdom including 4000 cases of major cardiac defects the antenatal detection rate was 23%. This survey is retrospective and does not distinguish between detection at routine and indicated scans. In a study comprising 29 154 euploid fetuses of which 50 had a major congenital heart malformation, Hyett and colleagues investigated first trimester nuchal translucency (NT) measurement as a screening tool for major congenital heart malformation. The use of NT thickness ≥ 95th percentile to indicate major congenital heart malformation was associated with a sensitivity of 56% (95% confidence interval, CI, 41 – 70%) and a false positive rate of 6%, and the use of NT thickness ≥ 99th percentile (approximately 3.5 mm) with a detection
rate of 40% (95% CI, 26 – 54%) and a false positive rate of 1%. Hyett and colleagues concluded that “measurement of fetal NT thickness at 10 – 14 weeks of gestation is a sensitive method of screening for major defects of the heart and great arteries”, and that ”this method of screening compares favorably with using the four chamber view of the heart at 16 — 22 weeks of gestation.”

The aim of this study, which was performed in pregnancies derived from the Swedish NUPP-trial, was to compare the rate of prenatal diagnosis of congenital heart malformations between two policies of offering prenatal diagnosis: one routine ultrasound examination at 12 – 14 weeks including NT measurement vs. one routine ultrasound examination at 18 weeks.

METHODS

Study design

The Swedish NUPP-trial (NackUPPklarning means nuchal translucency) is a randomized controlled national multicenter trial involving eight Swedish hospitals. It includes 39 572 pregnancies and has been described elsewhere according to the Consolidated Standards of Reporting Trials (CONSORT). It was approved by the Ethics Committees at the Karolinska Institute in Stockholm, and those of the Medical Faculties of Lund University and Uppsala University. Women were recruited to the trial between March 1999 and December 2002 from an unselected population of pregnant women cared for at maternity care units affiliated to the hospitals involved. Those who consented to take part were randomized to one of two policies of offering prenatal diagnosis. The main outcome measure of the NUPP-trial was the number of babies born with Down syndrome. Power calculation is described below. The 12-week policy implied one routine scan at 12 weeks including measurement of NT, the 18-week policy implied one routine scan at 18 weeks. In this paper we compare the rate of prenatal diagnosis of heart malformation between the two policies. Fetal anatomy was
scrutinized using the same checklist in both scan groups, and in both groups indications for fetal echocardiography were ultrasound findings of any fetal anomaly – including abnormal four-chamber view of the heart – or other risk factors for heart malformation, e.g., family history. The 12-week policy also included NT \( \geq 3.5 \) mm as an indication for fetal echocardiography. Fetal echocardiography was carried out by an obstetrician or pediatric cardiologist specially trained in fetal echocardiography. Details of each policy are given below.

Details about the ultrasound operators and equipment are described elsewhere\textsuperscript{23}.

**Details of the 12 – 14 week scan policy**

The 12-week scan included fetal biometry, scrutiny of the fetal anatomy, measurement of NT and calculation of risk of trisomy 21 using the software developed by the FMF \textsuperscript{24}. Anatomy screening was performed following the same checklist as in the 18-week group. However, in the 12-week group, inadequate visualization of the four-chamber view of the heart was accepted provided that NT was within the normal range. Women at increased risk of fetal aneuploidy according to NT screening who declined fetal karyotyping or whose fetuses proved to have normal chromosomes were offered a rescan of the fetal anatomy at 18 weeks by one of the obstetricians involved in the trial. Fetal echocardiography was offered to women whose fetus had NT \( \geq 3.5 \) mm if fetal chromosomes were normal or if the woman declined fetal karyotyping, and at one center (contributing 1257 of the 18 148 pregnancies in the 12-week group) fetal echocardiography was also offered to women with risk of trisomy 21 \( \geq 1:250 \) if fetal chromosomes were normal or the woman declined fetal karyotyping.

**Details of the 18-week scan policy**

Fetal anatomy was scrutinized following the same checklist as in the 12-week scan group. Visualization of the four-chamber view of the heart was obligatory. Examination of the outflow tracts of the heart did not form part of the standard 18-week examination. If the four-
chamber view was abnormal or difficult to interpret the woman was referred to a scan by an obstetrician, who then, if indicated referred her for fetal echocardiography.

Follow-up

To facilitate follow-up, all women were given a questionnaire at their routine scan where they were asked to report pregnancy outcome. Information on pregnancy outcome was retrieved from delivery records, from departments of neonatology, pediatric cardiology, genetics and pathology providing services to the hospitals involved, and from the National Registry of Congenital Anomalies. Newborns were followed-up with regard to heart malformation until 12 months of age. All information about the pregnancies in the trial, the results of the ultrasound examinations and outcome of pregnancy was collected in an internet based anonymous data base.

Outcome variables, classification of cardiac defects

Congenital cardiac defects were subdivided into major and minor malformations by the pediatric cardiologist of our team (GB). A major heart malformation was defined as one requiring surgery or catheter intervention – except interventions for persisting arterial duct or atrial septal defect (ASD) secundum – within the first 12 months of life. In addition, a ventricular septal defect (VSD) was regarded as a major cardiac malformation if the child was symptomatic despite pharmacological treatment. For consistency and to facilitate comparison of our results with those of others, cardiac defects were grouped into eight categories modified after Makrydimas et al. 25

1) Left heart lesions (including hypoplastic left heart syndrome, aortic atresia with or without mitral atresia, aortic valve stenosis, and coarctatio of the aorta with or without VSD).

2) Right heart lesions (including tricuspid atresia, tricuspid valve dysplasia, Ebstein’s anomaly, pulmonary atresia with or without VSD, and pulmonary stenosis)
3) Septal defects (including ASD and VSD, and atrio-ventricular septal defects with normal situs)

4) Outflow tract anomalies (including transposition of the great arteries with or without VSD, common arterial trunk, tetralogy of Fallot with or without atresia of the pulmonary valve, and absent pulmonary valve syndrome).

5) Laterality anomalies (including left and right atrial isomerism)

6) Complex abnormalities (including atrio-ventricular to ventriculo-atrial disconcordance, double outlet right ventricle, and double inlet ventricle).

7) Other lesions (e.g., cardiomyopathy, abnormal pulmonary venous drainage)

8) Non-classifiable cases

Statistical analysis

The prevalence of congenital heart malformations and the rate of prenatal diagnosis of congenital heart malformations were compared between the 12-week scan group and the 18-week scan group. All statistical analyses were carried out using the Statistical package for the Social Sciences (SPSS Inc, Chicago, IL, USA, 2003). The statistical significance of differences in proportions was determined using Fisher’s exact test or the Chi-2 test. A two-sided p-value < 0.05 was considered statistically significant.

The sample size in the NUPP-trial (18,000 women in each group) was calculated to give the trial power to show a change in the number of babies born with Down’s syndrome. Details on our power calculation have been published 23. The power of the trial to detect possible differences in detection rates of heart malformations is low. Assuming a detection rate of 23% (mean detection rate in a national survey from the United Kingdom 20) and a prevalence of major heart malformations of 0.4%1−4, and using an alpha-error (two-sided) of 0.05 and a power of 0.80, a sample size of 62 750 fetuses in each arm of a trial would be needed to detect a 10% (absolute value) difference in prenatal detection rate as statistically significant. Our
actual sample size of approximately 18 150 fetuses in each arm would allow detection of a change in detection rate from 23% to 33% with a power of 0.17 or from 23% to 13% with a power of 0.22; and a change from 15% to 5% with a power of 0.33 or from 15% to 25% with a power of 0.20.

RESULTS

Of 39 572 women randomized, 36 240 turned up for their routine scan. All fetuses alive at the routine scan are included in our analysis irrespective of whether they were later found to have a chromosomal abnormality.

In the 12-week scan group 18 266 fetuses were alive at the scan, 118 were lost to follow up and 18 148 were included. Of the 18 148 living fetuses included in the 12-week group, 16 567 had an NT measurement. Absent information on NT in 1699 fetuses is explained by the woman being too advanced in her pregnancy for NT measurement to be possible (crown rump length > 84 mm), difficulties with obtaining an accurate measurement, failure to enter the result of the NT measurement into the trial database, and, in a few cases, obvious lethal fetal malformations, e.g., anencephaly. The four chamber view was properly seen in 10 274 fetuses, judged as suspicious in 16 fetuses and not possible to evaluate in 7858 fetuses. In the 18-week scan group 18 288 fetuses were alive at the scan, 137 were lost to follow up, and 18 151 were included. Of 18 151 fetuses in the 18 week scan group, 19 had a suspicious four chamber view, six of which had a major heart malformation.

Among the 36 299 fetuses included we identified 294 fetuses with a congenital heart malformation (8.1/1000), of which 121 fetuses had a major heart malformation (3.3/1000). Both the total prevalence of congenital heart defects and the prevalence of major heart defects was almost identical in the 12-week scan group and the 18-week scan group (139/18 148 vs. 155/18 151, i.e., 7.7/1000 vs. 8.5/1000; 61/18 148 vs. 60/18 151, i.e., 3.4/1000 vs. 3.3/1000).
The cardiac malformations are described in Table 1. The outcome of fetuses affected by a heart malformation is presented in Table 2.

In the 12-week scan group, seven of the 61 cases of major heart malformation were prenatally diagnosed (11%, 95% CI 4.7 – 22.2) vs. nine of the 60 cases (15%, 95% CI 7.1 – 26.6) in the 18-week scan group (p = 0.60). In the 12-week scan group four cases of 61 (6.6%, 95% CI 1.8 – 16.0) were detected at the routine scan, i.e., the routine scan was the starting point for investigations eventually resulting in a prenatal diagnosis of a major cardiac malformation, in the 18-week scan group nine cases of 60 (15.0%, 95% CI 7.1 – 26.6) were detected at the routine scan; p=0.15. In the 12-week scan group three diagnoses were made before 22 weeks (5%, 95% CI 1.0 –14.0) vs. nine in the 18-week scan group (15%, 95% CI 7 – 27); p = 0.08.

Details of the 12-week scan group

Details about the prenatally diagnosed cases of major cardiac malformations in the 12-week scan group are presented in Table 3. Three of the seven cases diagnosed before birth in the 12-week group were detected incidentally at a scan performed because of pregnancy complications ≥28 weeks.

Among the 16 567 fetuses with information on NT thickness, the risk of Down’s syndrome according to NT screening was ≥1:250 in 587 fetuses (3.5%), and NT was ≥3.5mm in 77 fetuses (0.5%). Of the 61 fetuses with a major heart malformation, three (5%) had NT ≥3.5 mm and six (10%) had increased risk of Down’s syndrome but NT <3.5mm. None of the three fetuses with a major cardiac malformation and NT ≥3.5mm had their heart malformation diagnosed before birth: one was not referred for fetal echocardiography by an administrative mistake (preductal coarctatio of the aorta diagnosed after birth), one miscarried before fetal echocardiography was performed (common arterial trunc diagnosed at autopsy), and in one fetus an ASD and a VSD were missed at fetal echocardiography but diagnosed after birth.
Three of the six fetuses with a major heart malformation and increased risk of Down’s syndrome but NT <3.5 mm underwent fetal echocardiography: two of them had their heart malformation diagnosed prenatally, but in the third fetus stenosis of the pulmonary valves was not detected at the fetal echocardiography but diagnosed after birth.

Details of the 18-week scan group

Details about the prenatally diagnosed cases of major heart malformation in the 18-week scan group are presented in Table 4. In all nine cases diagnosed before birth the indication for fetal echocardiography was abnormal fetal anatomy at the routine scan: in eight cases the heart appeared abnormal, and in one case (Fallot’s tetralogy) a finding of gastroschisis was the indication to perform fetal echocardiography.

DISCUSSION

Our purpose was to compare two complete policies of offering prenatal screening for major heart malformations. We wondered whether it would be possible to replace our current policy of offering one routine scan at 18 weeks with one of offering one routine scan at 12 weeks. Because of the high sensitivity of increased NT with regard to heart malformation reported by Hyett et al 21 we believed that with regard to prenatal diagnosis of heart malformations this would be possible. Where for priority reasons it is possible to offer only one routine scan during pregnancy, it is a clinically important question how to best organize a service of offering prenatal diagnosis to all pregnant women.

Our 18-week policy was associated with a disappointingly low rate of prenatal diagnosis of major cardiac malformations (15%), even though our prenatal detection rate fell within the range of detection rates reported in prospective studies conducted in settings that seem to have been similar to ours (0 – 75%) 9 – 11, 13, 14, 16 – 19. The extremely wide variation in reported prenatal detection rates of heart malformations at routine mid-gestation scans (0 – 81% 9 – 20, 26, 27) is to be explained not only by differences in operator skills, but also by differences in study
design (retrospective 20, 26, 27 or prospective 9 – 19), study population (unselected 10 – 16, 26, 27, low risk 9, 17 – 19, or not clearly described 20), definition of major heart malformation (complex malformations 16, malformations potentially detectable by abnormal four chamber view 12, 18, or – as in our present study – all cases requiring surgery or catheter intervention within the first 12 months of life but also VSDs where the child was symptomatic despite pharmacological treatment), and the completeness of postnatal follow-up, incomplete follow-up resulting in low prevalence of heart malformations and falsely high detection rate. The high detection rate of 69% reported by Sharland and Allan 12 may be partly explained by them only including major heart malformations potentially detectable by an abnormal four-chamber view. Rusico et al, too, excluded some heart malformations that are difficult to detect in the second trimester, e.g., progressive valvular stenosis, but their detection rate was less than half of that reported by Sharland and Allan (31%) 18. Because only about 50% of all heart malformations are supposed to be detectable by an abnormal four-chamber view 28, the 81% detection rate by Vergangi et al 15, who seem not to have included examination of the outflow tracts in their routine scans, is difficult to explain. Incomplete follow-up may have been a source of bias in some studies, where the prevalence of major heart malformation is neither reported nor possible to calculate 12, 13, 20 or much lower than expected (0.1%) 17, 19, 26. Our own low prenatal detection rate of congenital heart malformations in the 18-week group was associated with a very low rate of abnormal four-chamber view (19 cases i.e., 0.1%). This low rate of abnormal four-chamber view is identical to that reported by Buskens et al 9 (who had a 17% prenatal detection rate of heart malformations) and Luck et al 10 (who had a 36% prenatal detection rate of heart malformations), but much lower than the 4% reported by Tegnander et al 11 (who had 26% second trimester detection rate of major heart malformations). However, abnormal four-chamber view seems to have been defined differently in the studies cited. Buskens et al 9 and Vergangi et al 15 defined abnormal four chamber view as a suspicious view,
Tegnander et al \textsuperscript{11} included in their definition of abnormal four chamber view inability to obtain a four chamber view at the routine scan. It is often not possible to calculate the rate of abnormal four-chamber view on the basis of data presented in articles either because of uncertainty about the total number of women scanned\textsuperscript{12,13,20} or because the number of cases with abnormal or un-interpretable four-chamber view is not given \textsuperscript{14,26,27}.

Our rate of prenatal diagnosis of heart malformations in the 12-week group was even lower than that in the 18-week group (5%, 7% or 11% depending on how detection rate is defined vs. 15%), even though the differences were not statistically significant. Lack of statistical significance is almost certainly to be explained by low power. Only three (5%) of the 61 fetuses in the 12-week group with a major heart malformation had NT $\geq 3.5$mm, and none of these fetuses had their diagnosis before birth (miscarriage before fetal echocardiography, not referred for fetal echocardiography by an administrative mistake, missed diagnosis of stenosis of the pulmonary valves at fetal echocardiography). Only 0.5% of the fetuses that had an NT measurement documented in our trial vs. the expected 1% had NT $\geq 3.5$mm. This would seem to indicate that our NT measurements were too ‘conservative’ and could explain the low sensitivity of NT $\geq 3.5$mm with regard to heart malformation. On the other hand, our measurements were regularly checked and approved by the FMF, and others, too, have reported low sensitivity of NT $\geq 3.5$mm with regard to heart malformation (0%\textsuperscript{29} and 11%\textsuperscript{30}). The use of a lower NT cut-off than 3.5 mm would probably have been associated with a higher sensitivity but also with a larger number of fetuses that would have needed to undergo fetal echocardiography. We chose the 3.5 mm cut-off believing that 1% of our fetuses would need to be referred for fetal echocardiography on the basis of increased NT (in addition to those referred on other indications included in the 12-week policy). Our resources would not have allowed a higher percentage of fetuses to be examined by fetal echocardiography. The size of a test-positive group needing specialist investigation needs to be taken into account
when planning routine antenatal care. In the 12-week scan group two cases (3%) of major
heart defects were detected at fetal echocardiography performed because of increased risk of
Down’s syndrome according to NT screening, but both fetuses had NT < 3.5mm. If all fetuses
with NT ≥3.5mm and/or a risk of Down’s syndrome ≥ 1:250 according to NT screening
would have undergone fetal echocardiography nine (15%) of the 61 cases of major heart
malformation in the 12-week group would have been potentially detectable for a test positive
rate of 3.5%. This hypothetical 15% detection rate is equal to the actual detection rate of the
18-week scan policy. However, using the calculated risk of Down’s syndrome as a screening
tool for heart malformations is questionable, because risk calculation is based on previous
history of chromosomal aberrations, maternal age, gestational age and NT. Of these
parameters only increased NT is known to be associated with increased risk of congenital
heart malformation.

Because improved prognosis can be expected for babies with some types of heart
malformations if the diagnosis is made before birth6, 7, 8, the low rate of prenatal diagnosis of
major heart malformations not only in our study but also in others 9, 14, 19 is a problem. Pooling
results from prospective studies examining the performance of mid-trimester routine
ultrasound examination in an unselected population undertaken in a setting similar to ours 9–
11, 13, 14, 16–19 yielded a detection rate of 36%. It seems that in the prospective studies reporting
the highest detection rates 12, 15, 16 the skill of those performing the routine scans was higher
than that of our operators, because in the studies cited the operators were continuously and
systematically taught how to obtain, recognize and interpret the four-chamber view12, 16, or the
operators consisted of a limited number of obstetricians with special training in fetal
ultrasonography 15. Moreover, in the study by Carvalho et al, the sonographers were
encouraged to include examination of the outflow tracts of the heart in their routine scans 16.
Easy access to fetal echocardiography is also likely to have contributed to the high rate of prenatal diagnoses the studies cited 12, 15, 16.

Despite the low power of our trial, we believe that our results do not support the idea of replacing the 18-week policy with the 12-week policy as we have defined these policies in our trial. We would rather recommend that resources be spent on teaching and training those performing routine scans in pregnancy to visualize and interpret the four chamber view of the heart at 18 – 23 weeks and to include examination of the great vessels into the routine scan. The efficacy of routine ultrasound screening for major congenital heart malformations can be improved by education and training of operators 11, 31 – 33 and by including examination of the outflow tracts of the heart31. The time spent learning to obtain a four-chamber view and a proper view of the outflow tracts is relatively long32. Systematic training of operators, a low threshold for referring patients for fetal echocardiography, easy access to fetal echocardiography followed by direct feedback to the operator would probably facilitate the building up of the skills of those performing routine scans in pregnancy.

The question of whether adding a 12-week NT scan to an 18-week fetal anatomy scan would increase the prenatal detection rate of major cardiac malformations – while keeping the number of fetuses needing to undergo specialist fetal echocardiography reasonably low – can only be answered in a randomised controlled trial. Assuming a detection rate of 23%20, a prevalence of major heart malformations of 0.4% 1 – 4, using alpha-error (two-sided) 0.05 and power 0.80, and defining a 10% difference in detection rate as clinically relevant, a sample size of 62750 fetuses in each arm of the trial would be needed.

Summary

We have compared two policies of offering prenatal diagnosis to all pregnant women with regard to prenatal detection of major heart malformation, i.e., one scan at 12 – 14 weeks including NT measurement vs. one scan at 18 – 20 weeks, both scans including scrutiny of
fetal anatomy. The rate of prenatal diagnosis of heart malformation was low with both policies. The 18-week scan policy seemed to be superior to the 12-week scan policy, even though the differences in prenatal detection rates were not statistically significant. The question of whether adding a 12-week NT scan to an 18-week fetal anatomy scan would increase the prenatal detection rate of major cardiac malformations can be answered in a randomized controlled trial including 62 750 fetuses in each arm.

ACKNOWLEDGEMENTS

This work was supported by grants from the Stockholm County Council Public Health and Medical Services Committee Research and Development departments, the Karolinska Institute South Hospital, governmental grants from the county of Scania (landstingsfinansierad regional forskning), and Funds administered by Malmo University Hospital, Sweden. Colleagues and midwives at the participating ultrasound units are gratefully acknowledged for their contribution to this study. Dr Sven-Erik Sonesson is acknowledged for kindly providing us with information from the fetal and pediatric cardiac database at Astrid Lindgren Children's Hospital, Stockholm. The Fetal Medicine Foundation and Professor Kypros Nicolaides are acknowledged for generous support in education and quality control.

Steering Committee of NUPP-trial (alphabetical order)

Harald Almström, MD, PhD
Charlotta Grunewald, MD, PhD
Sissel Saltvedt, MD
Lil Valentin, MD, PhD

Data base

Marius Kublickas MD, PhD

Principal investigators of NUPP-trial (alphabetical order)
References


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Table 1. Description of the cardiac malformations

<table>
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<tr>
<th></th>
<th>12-week scan group</th>
<th>18-week scan group</th>
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<tr>
<td></td>
<td>Number</td>
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<td>Major malformations</td>
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<td>60</td>
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<tr>
<td>Left heart</td>
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</tr>
<tr>
<td>Right heart</td>
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<td>10</td>
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<td>Septal defects</td>
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<td>Outflow tract defects</td>
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<tr>
<td>Complex abnormalities</td>
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<tr>
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<td>Minor malformations</td>
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<td>ASD</td>
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<td>VSD</td>
<td>62</td>
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<td>Nonclassifiable</td>
<td>8</td>
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ASD, atrial septum defect; VSD, ventricular septum defect
Table 2. Outcome of fetuses with congenital cardiac malformation

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<tr>
<th></th>
<th>12-week scan group n = 18 148</th>
<th>18-week scan group n = 18 151</th>
<th>P-value</th>
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<td>Any heart malformation, n</td>
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<td>155</td>
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<tr>
<td>Major heart malformation, n</td>
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<td>Prenatally diagnosed, n (%)</td>
<td>7 (11%)</td>
<td>9 (15%)</td>
<td>0.60</td>
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<tr>
<td>Diagnosed ≤ 22 weeks, n (%)</td>
<td>3 (5%)</td>
<td>9 (15%)</td>
<td>0.08</td>
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<tr>
<td>Legal abortion, n</td>
<td>3</td>
<td>7</td>
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<td>Fetal loss, n</td>
<td>1</td>
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<tr>
<td>Liveborn, n</td>
<td>57</td>
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<tr>
<td>Neonatal death, n</td>
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<tr>
<td>Death within 12 months, n</td>
<td>2</td>
<td>2</td>
<td></td>
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<tr>
<td>Minor heart malformation,</td>
<td></td>
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<td>Prenatally diagnosed, n (%)</td>
<td>1 (%)</td>
<td>0 (0%)</td>
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Table 3: Major cardiac malformations diagnosed prenatally in the 12-week group

<table>
<thead>
<tr>
<th>Postnatal diagnosis</th>
<th>Gws at decision to perform fetal echocardiography</th>
<th>Indication for fetal echocardiography</th>
<th>Gws at diagnosis</th>
<th>Genotype</th>
<th>Outcome</th>
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</thead>
<tbody>
<tr>
<td>Complex situs inversus, AV-discordance</td>
<td>12</td>
<td>Dextrocardia at 12-week scan</td>
<td>18</td>
<td>Normal</td>
<td>TOP</td>
</tr>
<tr>
<td>Common arterial trunk</td>
<td>12</td>
<td>Risk of trisomi 21 1:243 (NT 1.7 mm)</td>
<td>23</td>
<td>Autosomal monosomi</td>
<td>Alive at 12 months</td>
</tr>
<tr>
<td>Single ventricle, TGA</td>
<td>18</td>
<td>Abnormal kidneys at 12-week scan</td>
<td>19</td>
<td>Normal</td>
<td>TOP</td>
</tr>
<tr>
<td>Hypoplasite left heart syndrome</td>
<td>18</td>
<td>Risk of trisomi 21 1:123 (NT 2.3 mm)</td>
<td>19</td>
<td>Normal</td>
<td>TOP</td>
</tr>
<tr>
<td>Tetralogy of Fallot</td>
<td>28</td>
<td>Intrauterine growth retardation</td>
<td>28</td>
<td>Normal</td>
<td>Alive at 12 months</td>
</tr>
<tr>
<td>Double outlet right ventricle. AVSD</td>
<td>33</td>
<td>Polyhydramnion</td>
<td>34</td>
<td>Normal</td>
<td>Death at 4 days</td>
</tr>
<tr>
<td>Malformation of tricuspid valve and pulmonary artery</td>
<td>35</td>
<td>Cardiac arythmia</td>
<td>35</td>
<td>Normal</td>
<td>Alive at 12 months</td>
</tr>
</tbody>
</table>

Gws = gestational weeks; AV-discordance = atrioventricular discordance; NT = nuchal translucency; IUGR = intrauterine growth restriction; AVSD = atrioventricular septal defect; TOP = termination of pregnancy
<table>
<thead>
<tr>
<th>Postnatal diagnosis</th>
<th>Gws at decision to perform fetal echocardiography</th>
<th>Indication for fetal echocardiography</th>
<th>Gws at diagnosis</th>
<th>Genotype</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>TGA</td>
<td>15</td>
<td>Multiple malformations. Enlarged heart</td>
<td>16</td>
<td>Trisomi 18</td>
<td>TOP</td>
</tr>
<tr>
<td>Tetralogy of Fallot</td>
<td>16</td>
<td>Extra cardiac malformations</td>
<td>17</td>
<td>Normal</td>
<td>TOP</td>
</tr>
<tr>
<td>Double outlet right ventricle. Isomerism of the aatrias. Stenosis of the pulmonary valve</td>
<td>17</td>
<td>Abnormal 4-chamber view</td>
<td>18</td>
<td>Normal</td>
<td>Alive at 12 months</td>
</tr>
<tr>
<td>Common arterial trunk. Dextrocardia</td>
<td>17</td>
<td>Abnormal 4-chamber view</td>
<td>17</td>
<td>Normal</td>
<td>TOP</td>
</tr>
<tr>
<td>Tetralogy of Fallot Double outlet right ventricle. Stenosis of the aorta</td>
<td>17</td>
<td>Abnormal 4-chamber view</td>
<td>18</td>
<td>Normal</td>
<td>Alive at 12 months        cont.</td>
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<tr>
<td>Postnatal diagnosis</td>
<td>Gws at decision to perform fetal echocardiography</td>
<td>Finding indicating fetal echocardiography</td>
<td>Gws at diagnosis</td>
<td>Genotype</td>
<td>Outcome</td>
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<td>TGA, AV-discordance</td>
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<td>Abnormal outflow tract</td>
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<td>Functionally one-ventricle heart</td>
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<tr>
<td>Ebstein's anomaly</td>
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<td>Abnormal 4-chamber view</td>
<td>20</td>
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<td>Death at 3 months</td>
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<tr>
<td>Common arterial trunk</td>
<td>20</td>
<td>Enlarged heart, VSD?</td>
<td>22</td>
<td>Normal</td>
<td>Alive at 12 months</td>
</tr>
</tbody>
</table>

Gws = gestational weeks; TGA = transposition of the great arteries; AV discordance = atrioventricular discordance; VSD = ventricle septal defect; TOP = termination of pregnancy