Long-term survival of children born with congenital anomalies: a systematic review and meta-analysis of population-based studies

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**Short title**: Long-term survival of children with congenital anomalies

# Abstract

**Background:** Following a reduction in global child mortality due to communicable diseases, the relative contribution of congenital anomalies to child mortality is increasing. While infant survival of children born with congenital anomalies has improved for many anomaly types in recent decades, there is less evidence on survival beyond infancy. We aimed to systematically review, summarise and quantify the existing population-based data on long-term survival of individuals born with specific major congenital anomalies and examine the factors associated with survival.

**Methods and findings:** Seven electronic databases (Medline, Embase, Scopus, PsycINFO, CINAHL, ProQuest Natural and Biological Science Collections), reference lists and citations of the included articles for studies published, 1st January 1995 to 30th April 2020, were searched. Screening for eligibility, data extraction and quality appraisal were performed in duplicate. We included original population-based studies that reported long-term survival (beyond one year of life) of children born with a major congenital anomaly with the follow up starting from birth that were published in the English language as peer-reviewed papers. Studies on congenital heart defects (CHD) were excluded due to a recent systematic review of population-based studies of CHD survival. Meta-analysis was performed to pool survival estimates, accounting for trends over time. Of 10,888 identified articles, 55 (n=367,801 live births) met the inclusion criteria and were summarised narratively, 41 studies (n=54,676) investigating eight congenital anomaly types (spina bifida (n=7,422), encephalocele (n=1,562), oesophageal atresia (n=6,303), biliary atresia (n=3,877), diaphragmatic hernia (n=6,176), gastroschisis (n=4,845), Down syndrome by presence of CHD (n=22,317) and trisomy 18 (n=2,174)) were included in the meta-analysis. These studies covered birth years from 1970 to 2015. Survival for children with spina bifida, oesophageal atresia, biliary atresia, diaphragmatic hernia, gastroschisis and Down syndrome with an associated CHD has significantly improved over time; with the pooled odds of surviving per 10-year increase in birth year being OR=1.34 (95% CI 1.24-1.46), OR=1.50 (95% CI 1.38-1.62), OR=1.62 (95% CI 1.28-2.05), OR=1.57 (95% CI 1.37-1.81), OR=1.24 (95% CI 1.02-1.5) and OR=1.99 (95% CI 1.67-2.37) respectively, *p*<0.001 for all, except for gastroschisis (*p*=0.029). There was no observed improvement for children with encephalocele (OR=0.98 (95% CI 0.95-1.01), *p*=0.19) and children with biliary atresia surviving with native liver (OR=0.96 (95% CI 0.88-1.03), *p*=0.26). The presence of additional structural anomalies, low birth weight and earlier year of birth were the most commonly reported predictors of reduced survival for any congenital anomaly type. The main limitation of the meta-analysis was the small number of studies and the small size of the cohorts which limited the predictive capabilities of the models resulting in wide confidence intervals.

**Conclusions:** This systematic review and meta-analysis summarises estimates of long-term survival associated with major congenital anomalies. We report a significant improvement in survival of children with specific congenital anomalies over the last few decades and predict survival estimates up to 20 years of age for those born in 2020. This information is important for the planning and delivery of specialised medical, social and education services and for counselling affected families.

Registered on the PROSPERO database (CRD42017074675).

# Author summary

**Why was this study done?**

* Following a reduction in global child mortality due to communicable diseases, the relative contribution of congenital anomalies to child mortality under age five years is increasing globally.
* Identifying and addressing the emerging priority of congenital anomalies, including for children aged five to nine years, is one of the strategic directions for the post-2015 child health agenda.
* This research aimed to summarise and quantify the existing population-based evidence on long-term survival of children born with specific major congenital anomalies that manifest in childhood.

**What did the researchers do and find?**

* This systematic review included 55 international studies that estimated survival beyond one year of age of children born with major congenital anomalies.
* Our meta-analysis results of 41 studies over the birth years 1970-2015 showed a statistically significant improvement in survival over time in children with spina bifida, oesophageal atresia, biliary atresia, congenital diaphragmatic hernia, gastroschisis and Down syndrome associated with a congenital heart defect, but there was no evidence of improvement in those with encephalocele or biliary atresia with a native liver.
* The commonest significant independent predictors of reduced survival for any congenital anomaly type were presence of additional structural anomalies, low birth weight and earlier birth year period.

**What do these findings mean?**

* A significant improvement in survival of children with specific congenital anomalies over the last few decades reported by individual studies and identified by the meta-analysis has important public health, medical, social and family implications.
* Information on predicted survival of children with congenital anomalies up to 20 years of age is important for planning specialised medical, social and education services for these children and for estimating costs associated with special care needs in childhood and adulthood.

# Introduction

Globally, mortality in children aged under five years has halved since 1990 mainly due to a sharp reduction in deaths from communicable diseases as a result of targeted child health strategies and interventions of the United Nations (UN) Millennium Development Goals [[1](#_ENREF_1)]. Following this worldwide reduction, the relative contribution of congenital anomalies to child mortality is increasing globally and is therefore outlined as an emerging priority to be addressed by the UN Sustainable Development Goals in the post-2015 child health agenda [[2](#_ENREF_2)]. While the contribution of congenital anomalies to infant mortality is well described, in particular for developed countries [[3-5](#_ENREF_3)], there is less research focussed on survival beyond the first year of life. However, this is of considerable public health importance, as according to evidence from North America and Europe, the mortality rate of individuals born with congenital anomalies significantly exceeds that of the general population after infancy as well [[6-9](#_ENREF_6)]. In addition, a large variation in child death rates still exists between countries, even within Europe [[10](#_ENREF_10)]. In 2012, the child death rates (age 0-14 years) were about 60% higher in the UK and Belgium compared to Sweden, with an additional ten Western European countries being 30% higher than Sweden [[10](#_ENREF_10)]. Currently, a quantitative summary of population-based studies of survival beyond infancy for specific congenital anomalies is lacking. Accurate estimates of long-term survival are important for clinicians counselling parents when a congenital anomaly is diagnosed pre- or postnatally and for public health commissioners to ensure adequate resources are in place to provide high quality medical and social care for these individuals. Importantly, it is essential that estimates are provided according to type of congenital anomaly, given the diversity in aetiology, treatment and prognosis.

We performed a systematic review and meta-analysis to summarise and quantify the existing population-based data on long-term survival (beyond infancy) of individuals born with specific major congenital anomalies that manifest in childhood, and explore the risk factors associated with survival.

# Methods

## Search strategy

This study is reported as per the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guideline (S1 PRISMA Checklist).A protocol for this systematic review was registered on the International Prospective Register of Systematic Reviews (PROSPERO) database (CRD42017074675) (S1 Text). We conducted comprehensive literature searches using a combination of the following sources of information:

(1) Electronic bibliographical databases: MEDLINE, EMBASE, Scopus, PsycINFO, CINAHL, ProQuest Natural and Biological Science Collections and also the databases of the systematic reviews, i.e. PROSPERO, the JBI Database of Systematic Reviews and Implementation Reports. We used key words and subject headings (dependent on the database) combining the keywords for the population (birth, pregnancy, delivery), exposure (congenital anomaly, including specific anomaly groups), outcome (long-term survival, mortality) and study design (population-based studies), incorporating elements of the PICOS (Population/Patient; Intervention/Exposure; Comparator group; Outcome; Study design) framework into our systematic search strategy [[11](#_ENREF_11)] (S1 Table). The final search results were limited to English papers and to humans, while the initial searches had no language limitations to examine if there were any relevant studies we could have missed. We have identified 66 papers published in non-English language (79% from Europe) based on Medline search, but no papers met our inclusion criteria.

(2) Manual searching of the reference lists of the included full papers and of the relevant previous literature reviews, including systematic, was performed. (3) Citation searching for studies that had referenced the included studies was performed via the Google Scholar citation function. (4) Key word searches in key journals, including Birth Defects Research, Archives of Disease in Childhood, Pediatrics, The Journal of Pediatrics, Journal of Pediatric Surgery, were also undertaken. (5) Authors were contacted if there was insufficient information to decide whether the study met the inclusion criteria, or if additional information for the inclusion in the meta-analysis was needed. (6) Reference lists and citations of any new articles identified were further searched for any additional studies in the iterative process until no new studies were identified. Database searches were completed in March 2019 and updated in May 2020.

SVG conducted all searches and screened the titles and abstracts of all the identified records according to the inclusion criteria, and three other authors (MS, AC, JR) independently screened a random 10% sample of the records using the Rayyan software for systematic reviews [[12](#_ENREF_12)]. Any discrepancies (n=4) in the included studies were discussed amongst all authors and agreement reached.

## Definitions and classification of congenital anomalies

Major congenital anomalies in the included studies were classified according to the International Classification of Disease (ICD) revision 8 (ICD-8) [[8](#_ENREF_8)], ICD-9 (majority of papers), ICD-10 [[13-15](#_ENREF_13)], British Paediatric Association (BPA-ICD-9) diagnosis coding [[16-20](#_ENREF_16)] or surgical codes [[21](#_ENREF_21)]. Some papers that included a long birth year period used more than one ICD version for the corresponding time periods [[9](#_ENREF_9),[22-25](#_ENREF_22)]. The included studies reported the survival estimates for all congenital anomalies combined (e.g. ICD-9 codes 740.0-759.9), and/or by congenital anomaly group (the system affected, e.g. urinary system, ICD-9 753.0–753.9) and/or subtype (the individual disorder, e.g. spina bifida, ICD-9 741). Some European studies [[14](#_ENREF_14),[15](#_ENREF_15),[17](#_ENREF_17)] classified major congenital anomalies according to European Surveillance of Congenital Anomalies (EUROCAT) guidelines [[26](#_ENREF_26),[27](#_ENREF_27)]. We have presented the congenital anomaly subtypes within the major congenital anomaly groups according to the EUROCAT classification [[26](#_ENREF_26)].

## Eligibility criteria

Studies meeting the following criteria were included: 1) original population-based peer-reviewed studies that reported long-term (beyond one year of life) survival of children born with a major congenital anomaly that manifests in childhood; 2) survival probability (or the number of patients born and the number or proportion alive at age > 1 years) was reported for these children that were followed up from birth; 3) published from 1st January 1995 to 30th April 2020 to increase comparability of included birth cohorts in relation to medical care and treatment availability/policies; 4) involving humans only and published in the English language.

Studies were excluded if: 1) they reported survival during the first year of life only; 2) patients were not followed up from birth, because this may have under-ascertained deaths occurring prior to follow-up (e.g. if follow up began after surgical correction); 3) they were not population-based as other study designs are more likely to incur ascertainment bias (e.g. hospital-based studies may capture more severe phenotypes); 4) they focused on individuals born with congenital heart defect (CHD), because there was a recently published systematic review covering these population-based studies [[28](#_ENREF_28)]: 5) they followed up a restricted sub-group of patients (e.g. preterm births only, or extracorporeal membrane oxygenation (ECMO) patients only). No exclusions were made based on the birth year of studied cohorts.

## Data extraction

Information on the following study characteristics was extracted: study location, birth year period, duration of follow up/years of survival, congenital anomaly type and if isolated/non-isolated, sources of case ascertainment (e.g. congenital anomaly register) and sources of death identification (e.g. linkage with a mortality database), number of cases and deaths, Kaplan-Meier survival estimates reported or the survival estimates calculated by the reviewers. Authors were contacted if survival estimates were reported for sub-groups of patients only (e.g. by sex or age at operation), if it was not possible to calculate 95% confidence intervals (95% CI), extract survival estimates from the Kaplan-Meier curves, or if further information was required or clarification needed (n=18). If the authors did not respond after two reminders or if the study was closed and access to the data was not possible, we calculated the lower and upper limits of the 95% CI according to the efficient-score method (corrected for continuity) described by Newcombe, 1998 [[29](#_ENREF_29)], based on the procedure outlined by Wilson, 1927 [[30](#_ENREF_30)] (<http://www.vassarstats.net/survival.html>). If survival estimates were not reported in the text or tables of the included paper, they were extracted from Kaplan-Meier survival curves, where available, using PlotDigitizer software [[31](#_ENREF_31)]. If none of the above was possible, the study was excluded.

Data extraction and quality appraisal of the included studies were performed in duplicate, i.e. all by SVG and a subset of studies by each co-author. Data were entered into piloted data extraction forms (S2 Table).

## Statistical analysis

Where three or more articles reported survival with the number of births (or where the numbers of births could be estimated from the 95% CIs provided) for a specific congenital anomaly, a meta-analysis was performed to estimate pooled survival at ages 1, 5, 10, 20 (and 25 where available) years. The STATA program “gllamm” was used to fit univariate multilevel meta-analysis of longitudinal data in order to allow for the correlations in survival over several time periods within studies [[32](#_ENREF_32),[33](#_ENREF_33)]. Survival according to age (0-25 years) was modelled using the logistic regression options within the gllamm program: family(binomial) and link(logit). The outcome of interest was the number of deaths occurring out of the total number of live births. The number of deaths at each time point, if not provided, was estimated from the published proportions surviving and the number of live births by assuming there was no loss to follow-up. Calculating the number of deaths in this way will be unbiased (as the proportion surviving is unbiased) but will result in slightly too narrow confidence intervals. To confirm that this is valid, an alternative method using the arcsine square root transformation [[34](#_ENREF_34)] of the published survival estimate was applied and the estimated standard error was calculated, and a model was fitted in gllamm using the weighted regression options instead of the logistic regression above. Both methods reported consistent results and hence the results of the logistic regression models are reported here as they enable the interpretation of the odds of increasing survival over time. Studies were treated as a random effect and cohort of birth and age at survival as fixed effects nested within the studies. Age was modelled as a continuous variable using a linear term or where significant (according to a Likelihood Ratio test) a quadratic term. Cohort of birth was modelled as a continuous variable. Most included studies reported survival across distinct periods (e.g. between 2000-2009), so the mean year of birth was used (e.g. 2005). For studies that reported survival estimates for multiple cohorts (e.g. 2000-2004, 2005-2009), survival for both cohorts were entered into the model, again with average year of birth for each cohort (e.g. 2002 and 2007). Using the models, survival at ages 1, 5, 10, 20 and 25 years was estimated for cases born in 2000 and 2020. Models were fitted separately for each type of congenital anomaly. ORs representing the increase/ decrease in survival per 10-year increase in time, were extracted from the models. Where less than three studies reported survival for a specific congenital anomaly, the survival estimates were discussed narratively. The ages for which more than three studies reported a survival rate were plotted separately; often the reports were at five or ten years of age. This allows the reader to evaluate the changes that have occurred over time in the survival of the children up to five years of age and separately up to 10 years of age. All modelled survival curves, although plotted on two separate figures, are derived from the one model fitted on all the data.

Analysis was performed in Stata 15 (StataCorp), and *p*<0.05 was considered statistically significant.

## Quality appraisal

The Newcastle-Ottawa Quality Assessment Scale (NOS) for cohort studies [[35](#_ENREF_35)] was used to assess the quality of the included studies. The scale assesses information bias, selection bias and confounding (S2 Table). Although a traditional cohort study can be awarded a maximum of nine stars, for survival population-based studies a comparison group is not a mandatory component of the study design, therefore a maximum of six stars can be allocated to the majority of the included studies (S3 Table)**.**

# Results

## Search results

A total of 10,888 records identified from the electronic database searches and other sources were available for screening titles and abstracts (Fig 1). After excluding 10,660 records, 228 were eligible for full text review. After further exclusion of 173 articles, 55 met the inclusion criteria, covering a total population of 367,801 live births with various types of major congenital anomalies. Earlier follow up studies based on the same population were replaced by more recent ones if they also reported survival at a younger age (n=2 [[36](#_ENREF_36),[37](#_ENREF_37)]). However, if survival at a more advanced age only was reported in the later article [[38](#_ENREF_38)], the earlier article was also included (n=1 [[39](#_ENREF_39)]).

## Characteristics of included studies

Table 1 provides the description of 55 studies included in this review. Further detail on the sources of case ascertainment and death identification, and the description of the comparison group, if any, is given in S4 Table. Nine studies analysed long-term survivalof all congenital anomalies combined; seven with [[6](#_ENREF_6),[8](#_ENREF_8),[15](#_ENREF_15),[17](#_ENREF_17),[40-42](#_ENREF_40)] and two without [[7](#_ENREF_7),[43](#_ENREF_43)] stratification by congenital anomaly group/subtype (Table 1). Other studies (n=46) focused on specific groups or subtypes of congenital anomalies: the central nervous system (n=5 [[44-49](#_ENREF_44)]), including spina bifida [[44-46](#_ENREF_44),[48](#_ENREF_48),[49](#_ENREF_49)] and encephaloсele [[44](#_ENREF_44),[47](#_ENREF_47)], orofacial clefts (n=1 [[16](#_ENREF_16)]), anomalies of the digestive system (n=22), including oesophageal atresia [[9](#_ENREF_9),[50](#_ENREF_50),[51](#_ENREF_51)], anorectal malformations [[52](#_ENREF_52)], congenital diaphragmatic hernia [[18](#_ENREF_18),[23](#_ENREF_23),[51](#_ENREF_51),[53](#_ENREF_53),[54](#_ENREF_54)], biliary atresia [[36-39](#_ENREF_36),[55-64](#_ENREF_55)] and Hirschsprung disease [[24](#_ENREF_24)], abdominal wall defects (n=1 [[21](#_ENREF_21)]), chromosomal anomalies (n=12), including trisomy 21 [[14](#_ENREF_14),[19](#_ENREF_19),[22](#_ENREF_22),[65-69](#_ENREF_65),[70l](#_ENREF_70),[71](#_ENREF_71)], trisomy 13 [[25](#_ENREF_25),[72](#_ENREF_72)] and trisomy 18 [[25](#_ENREF_25),[72](#_ENREF_72)], skeletal dysplasias (n=2 [[13](#_ENREF_13),[20](#_ENREF_20)]) and Prader-Willi syndrome (n=1 [[73](#_ENREF_73)]). The included studies were conducted in Europe (n=29 [[8](#_ENREF_8),[9](#_ENREF_9),[13-15](#_ENREF_13),[17](#_ENREF_17),[21-24](#_ENREF_21),[36-39](#_ENREF_36),[44](#_ENREF_44),[45](#_ENREF_45),[50-54](#_ENREF_50),[56-58](#_ENREF_56),[60](#_ENREF_60),[61](#_ENREF_61),[64](#_ENREF_64),[65](#_ENREF_65),[68](#_ENREF_68)]), USA (n=12 [[7](#_ENREF_7),[18-20](#_ENREF_18),[40](#_ENREF_40),[41](#_ENREF_41),[43](#_ENREF_43),[46-48](#_ENREF_46),[70](#_ENREF_70),[72](#_ENREF_72)]), Australia (n=7 [[16](#_ENREF_16),[42](#_ENREF_42),[59](#_ENREF_59),[66](#_ENREF_66),[67](#_ENREF_67),[69](#_ENREF_69),[73](#_ENREF_73)]), Canada (n=3 [[6](#_ENREF_6),[25](#_ENREF_25),[63](#_ENREF_63)]), Japan (n=1 [[62](#_ENREF_62)]), Brazil (n=1 [[55](#_ENREF_55)]) and Hong Kong (n=1 [[71](#_ENREF_71)]). One international study reported survival of children with spina bifida from a number of registries form Europe and USA [[49](#_ENREF_49)]. As all included studies were population-based, sources of case ascertainment for most studies (n=39) were congenital anomaly registers or surveillance programmes which either included all types of major congenital anomalies or were anomaly-specific. The majority of these studies linked their congenital anomaly data with death registration data to ascertain data on age at death (S4 Table).

As our literature search was restricted to years between Jan 1995 - April 2020, the publication years ranged between 1997 [[68](#_ENREF_68)] and 2020 [[71](#_ENREF_71)], whilst cases were mostly born between 1970 and 2010, with the earliest birth year in 1950 [[73](#_ENREF_73)] and the latest ending in June 2016 [[58](#_ENREF_58)]. Table 1 also describes the duration of follow up, the survival age analysed and whether survival was reported in the papers (with or without 95% CI) or estimated by our reviewers. Table 1 also gives the NOS study quality assessment scores that range between 5 and 8 respective of the use of the comparison group that it not mandatory for the survival studies (see S3 Table for detailed scoring). According to NOS, all studies were of low risk of bias.

## Survival of children with different congenital anomalies

Table 2 shows survival estimates overall and by birth cohort, where reported, for individuals up to 25 years of age for studies estimating survival for all congenital anomalies combined and by different group/type. S5 Table presents more detail for studies reporting survival estimates by other risk factors (e.g. ethnicity or presence of additional anomalies). Most studies reported 1- and 5-year survival estimates only. Survival varied considerably according to anomaly, therefore, survival estimates are presented by different groups and subtypes (Table 2). The five year survival for all anomalies combined varied from 85% to 95%, due to different inclusion and exclusion criteria. It was not considered appropriate to pool survival estimates for all congenital anomalies combined due to the diversity of the contributing congenital anomaly groups.

## Congenital anomalies of the nervous system

Survival in live births with anencephaly analysed by four studies was extremely low and varied from 0% [[15](#_ENREF_15),[42](#_ENREF_42)] to 7.3% [[40](#_ENREF_40)] by year one (Table 2).

Seven studies of survival in children born with spina bifida [[6](#_ENREF_6),[15](#_ENREF_15),[40-42](#_ENREF_40),[45](#_ENREF_45),[48](#_ENREF_48)] including 7,422 live births were summarised in a meta-analysis, with pooled survival estimates of 92%, 91%, 89% and 88% at ages 5, 10, 20 and 25 years predicted for cases born in 2020 (Table 3). Survival has improved significantly over time, with an increased OR per 10-year increase in birth year 1.34 (95% CI 1.24-1.46, *p*<0.001) (Table 3 and Fig 2).

Four studies [[15](#_ENREF_15),[40](#_ENREF_40),[41](#_ENREF_41),[47](#_ENREF_47)] reported survival of 1,562 encephalocele live births, with pooled survival estimates of 72%, 72%, 71% and 71% at ages 5, 10, 20 and 25 years predicted for cases born in 2020 (Table 3). A small decrease in survival was observed over time, which was not statistically significant (*p*=0.19), but was included in the model predictions to be consistent with the models for other congenital anomalies and acknowledging that the power from analysing only 4 studies is very low (Table 3 and S1 Fig).

Survival in individuals with hydrocephalus was reported in four studies, with the three more recent studies reporting very similar survival rates at age 5 years [[15](#_ENREF_15),[40](#_ENREF_40),[42](#_ENREF_42)] and at 15 years in two studies with longer follow up. The earlier study (1967-79) reported lower survival of 50.8% for male individuals by age 18 years [[8](#_ENREF_8)] (Table 2). Comparison of survival between these studies is difficult due to differences in the inclusion criteria.

## Orofacial clefts

Seven studies providing survival estimates for children born with orofacial clefts [[6](#_ENREF_6),[15-17](#_ENREF_15),[40-42](#_ENREF_40)] included 32,492 live births. There was insufficient number of studies reporting data by specific cleft type that met criteria for a meta-analysis, therefore the survival data are presented in Table 2. Generally, 1-year and long-term survival of children with isolated cleft lip is over 99% [[15](#_ENREF_15),[16](#_ENREF_16)], about 96%-97% for isolated cleft palate [[15](#_ENREF_15),[16](#_ENREF_16)] and much lower for non-isolated orofacial cleft types [[40](#_ENREF_40),[41](#_ENREF_41)].

## Anomalies of the digestive system

Seven studies reporting survival in children with oesophageal atresia (n=6,303) were summarised in a meta-analysis [[9](#_ENREF_9),[15](#_ENREF_15),[40-42](#_ENREF_40),[50](#_ENREF_50),[51](#_ENREF_51)]. There was a statistically significant improvement in survival over time, with an increased OR of 1.50 (95% CI 1.38-1.62, *p*<0.001) per 10-year increase in birth year. The pooled survival estimates predicted for cases born in 2020 were 93%, 93%, 92% and 92% at ages 5, 10, 20 and 25 years, respectively (Table 3 and Fig 3).

The survival estimates for children with anorectal malformations and for those with Hirschsprung disease were reported in four [[15](#_ENREF_15),[40](#_ENREF_40),[41](#_ENREF_41),[52](#_ENREF_52)] and three studies [[15](#_ENREF_15),[24](#_ENREF_24),[42](#_ENREF_42)] with survival ranging between 86%-97% and 93%-98% respectively (Table 2).

Fourteen studies (n=3,877 live births) reporting overall (after Kasai hepatoportoenterostomy (KP)) and/or liver transplantation) and/or survival with native liver (NLS, without liver transplantation) in children born with biliary atresia [[15](#_ENREF_15),[36-38](#_ENREF_36),[55-64](#_ENREF_55)] were included in the meta-analysis. Pooled overall survival for biliary atresia at ages 5, 10 and 20 years were estimated to be 94%, 92% and 88% for cases born in 2020 (Table 3). Fig 4 and Table 3 show a significant linear increasing trend in the overall survival and ORs for improvement in survival over time with OR=1.62 (95% CI 1.28-2.05, *p*<0.001). A small decrease in survival was observed over time in NLS, which was not statistically significant (*p*=0.26), but was included in the model predictions to be consistent with the models for other congenital anomalies (Table 3). The predicted five year survival estimates was 41% (95% CI 33-49) for cases born in 2020 (the survival curve is shown in S2 Fig).

Nine studies of children born with congenital diaphragmatic hernia (CDH) (n=6,176) were summarised in a meta-analysis [[15](#_ENREF_15),[18](#_ENREF_18),[23](#_ENREF_23),[40-42](#_ENREF_40),[51](#_ENREF_51),[53](#_ENREF_53),[54](#_ENREF_54)]; pooled survival estimates of 83% at ages 5, 10, 20 and 25 years respectively predicted for cases born in 2020 were reported in Table 3. The studies demonstrated that the majority of deaths occurred within the first year of life, with survival plateauing after that. Survival has improved significantly over time, with an increased OR per 10-year increase in birth year 1.57 (95% CI 1.37-1.81, *p*<0.001) (Table 3 and Fig 5).

## Abdominal wall defects

Five studies (n=4,845) reporting survival of children born with gastroschisis were summarised in a meta-analysis [[15](#_ENREF_15),[21](#_ENREF_21),[40-42](#_ENREF_40)]. There was a statistically significant improvement in survival over time, with an increased OR of 1.24 (95% CI 1.02-1.50, *p*=0.029) per 10-year increase in birth year. Similar to studies on CDH, the majority of deaths occurred within the first year of life, with survival plateauing after that. The pooled survival estimates predicted for cases born in 2020 were 94%. 93% and 92% at ages 5, 10 and 20 years, respectively (Table 3 and Fig 6). Survival was consistently higher for gastroschisis than omphalocele in the three register-based studies reporting survival for both conditions [[15](#_ENREF_15),[40](#_ENREF_40),[41](#_ENREF_41)] (Table 2).

## Chromosomal anomalies: trisomies 21, 13 and 18

Survival of children born with Down syndrome (trisomy 21) reported by the presence of CHD in ten studies (22,317 live births) [[14](#_ENREF_14),[19](#_ENREF_19),[22](#_ENREF_22),[42](#_ENREF_42),[65-70](#_ENREF_65)] was summarised in the meta-analysis. We found significantly increasing survival trends over time for children with Down syndrome associated with CHD (OR=1.99 (95% CI 1.67-2.37, *p*<0.001) per 10-year increase in birth year; Table 3 and Fig 7). Children with Down syndrome without CHD had relatively high survival for live births in 2000 with no statistically significant improvement over time predicted for those born in 2020 (OR=1.17 (95% CI 0.91-1.5, *p*=0.23) (Table 3 and Fig 8). As there was a significant improvement in children with Down syndrome with CHD, the estimated improvement in children without CHD (although not statistically significant) was also modelled. For cases born in 2020, pooled survival for Down syndrome at ages 5, 10 and 20 years were estimated to be 97%, 97% and 96% for those both with and without CHD.

Studies analysing long-term survival in children with trisomy 13 (n=4) and 18 (n=5) reported consistently low 1-year survival ranging from 12% [[72](#_ENREF_72)] to 21% [[40](#_ENREF_40)] for trisomy 13 and from 2% [[15](#_ENREF_15)] to 20.6% [[42](#_ENREF_42)] for trisomy 18 (Table 2). However, large studies from USA and Canada have shown that the majority of those individuals who survived to one year were alive at five [[72](#_ENREF_72)], ten [[25](#_ENREF_25)] and 15 [[40](#_ENREF_40)] years. A Canadian study reported that 76% and 65% of one-year survivors with trisomy 13 were alive at 5 and 10 years respectively; the corresponding figures for trisomy 18 were 90% and 77% [[25](#_ENREF_25)]. In a US study, conditional 5-year survival (for those who survived the first year of life) was over 80% for both trisomy 13 and 18 [[72](#_ENREF_72)]. Four studies (n=2,174) reporting survival of children born with trisomy 18 were summarised in a meta-analysis [[25](#_ENREF_25),[40](#_ENREF_40),[42](#_ENREF_42),[72](#_ENREF_72)]. The pooled survival estimates predicted for cases born in 2020 were 14% and 13% at ages 5 and 10 years, respectively (Table 3 and S3 Fig). The time trends were not tested due to a very small size of the most recent study reporting higher survival.

## Other congenital anomalies

Fewer studies analysing survival in children born with limb anomalies, renal anomalies, skeletal dysplasias and syndromes met our inclusion criteria, with four being register-based studies that analysed a range of main anomaly groups/subtypes [[15](#_ENREF_15),[40-42](#_ENREF_40)] (Table 2).

Survival of children born with upper or lower limb defects was similar at about 87%-89% at 5 and 8 years of age in both US register-based studies that included isolated anomalies and those with additional anomalies [[40](#_ENREF_40),[41](#_ENREF_41)], while survival for upper limb defects was higher at 99% than that for lower limb defects at 93%% after 1 year of age in an English register-based study that included only isolated anomalies [[15](#_ENREF_15)]. However, the latter, study was much smaller, with ≤3 deaths for these anomalies.

Survival of children with urinary system anomalies is not comparable between the studies because of the differences in inclusion criteria (isolated vs non-isolated) and different birth year periods (Table 2).

Four studies reporting survival/mortality for children with skeletal dysplasia beyond 1 year of age were quite heterogeneous in terms of subtypes included which may have caused differences in survival between a recent Australian study [[42](#_ENREF_42)] and three other studies [[13](#_ENREF_13),[15](#_ENREF_15),[20](#_ENREF_20)].

Two studies reported survival in patients with Prader-Willi syndrome (PWS), but the sample size was very low (n=10, with one death) in one [[15](#_ENREF_15)]. According to an Australian study using data from the PWS register, 10-year survival (97%) was similar to one-year survival (98.6%), however, by age 25 it reduced to 89% [[73](#_ENREF_73)].

## Factors associated with survival of children with congenital anomalies

Table 4 shows that overall, long-term survival in children born with congenital anomalies was much lower than in the reference populations, with the risks of death varying from 6.7 to 12.9 times greater than the general population in the three studies reporting this [[6-8](#_ENREF_6)]. In the US study, the hazard ratio (HR) of death at age 7 years was only slightly reduced (from 7.2 to 6.9) when adjusted for child’s sex and mother’s race, age and education [[7](#_ENREF_7)] (Table 4). Table 4 also shows risks of death associated with some specific congenital anomalies compared to the reference population.

Studies analysing survival predictors reported the presence of additional major anomalies as a universal risk factor of reduced survival [[9](#_ENREF_9),[14](#_ENREF_14),[19](#_ENREF_19),[22](#_ENREF_22),[36](#_ENREF_36),[37](#_ENREF_37),[40](#_ENREF_40),[44](#_ENREF_44),[46](#_ENREF_46),[47](#_ENREF_47),[50](#_ENREF_50),[52](#_ENREF_52),[65](#_ENREF_65),[66](#_ENREF_66),[68](#_ENREF_68),[69](#_ENREF_69),[71](#_ENREF_71),[72](#_ENREF_72)] (Table 5), even after adjustment for such factors as birth cohort, birth weight and/or gestational age at delivery [[9](#_ENREF_9),[14](#_ENREF_14),[19](#_ENREF_19),[40](#_ENREF_40),[44](#_ENREF_44),[50](#_ENREF_50),[69](#_ENREF_69),[72](#_ENREF_72)] (Table 5). Other common risk factors associated with survival in children with congenital anomalies were low birth weight (LBW) [[9](#_ENREF_9),[14](#_ENREF_14),[19](#_ENREF_19),[40](#_ENREF_40),[47](#_ENREF_47),[48](#_ENREF_48),[50](#_ENREF_50),[52](#_ENREF_52),[66](#_ENREF_66),[69](#_ENREF_69),[71](#_ENREF_71)] or preterm birth [[14](#_ENREF_14),[40](#_ENREF_40),[42](#_ENREF_42),[72](#_ENREF_72)] and earlier birth year period, after adjustment for covariates [[9](#_ENREF_9),[14](#_ENREF_14),[19](#_ENREF_19),[40](#_ENREF_40),[50](#_ENREF_50),[66](#_ENREF_66),[69](#_ENREF_69),[71](#_ENREF_71)] (Table 5). Ethnicity was inconsistently associated with survival of children with some anomalies in US studies. Hispanic ethnicity was associated with reduced survival by age 8 years in children with spina bifida weighing at birth between 1500-2499g, but not in those with lower (<1500g) or higher (≥2500g) birth weight [[46](#_ENREF_46)]. In another multi-state US study [[41](#_ENREF_41)] there was no significant association of spina bifida survival at ≤8 years with any ethnic group when adjusted for covariates (Table 5, S6 Table). However, the latter study reported a significantly increased adjusted HR for reduced survival in Black and Hispanic children for both orofacial clefts and those with oesophageal atresia after adjustment for essential covariates, and significantly increased adjusted HR for Down syndrome and CDH in Black children only [[41](#_ENREF_41)] (S6 Table). Black ethnicity, however, was associated with a lower risk of death at 5 years for trisomy 18 [[72](#_ENREF_72)]. In New York State, maternal nativity (‘Others’ vs ‘US born’) was significantly associated with a higher risk of death up to 25 years for all congenital anomalies and for anomalies of the central nervous system, when adjusted for other factors including ethnicity [[40](#_ENREF_40)]. Being Aboriginal had a significant independent effect on reduced 10-year survival of children with Down syndrome in an earlier Australian study after adjustment for presence of CHD, birth weight and birth cohort [[69](#_ENREF_69)], but not in a more recent study [[66](#_ENREF_66)] (Table 5).

Due to rarity of biliary atresia and dependence of outcome on successful and timely KP, the survival factors most commonly explored in these children were annual centre caseload as [[36](#_ENREF_36),[38](#_ENREF_38),[39](#_ENREF_39),[58](#_ENREF_58),[61](#_ENREF_61)] and age at KP [[36](#_ENREF_36),[37](#_ENREF_37),[55](#_ENREF_55),[56](#_ENREF_56),[58](#_ENREF_58),[63](#_ENREF_63),[64](#_ENREF_64)]. The higher centre caseload, or care centralisation, associated with centralisation of surgical and medical resources and better surgical staff experience, together with the earlier age at KP, were considered as positive factors for survival. Earlier KP was associated with better NLS at age 4 years [[55](#_ENREF_55),[63](#_ENREF_63),[64](#_ENREF_64)] and 5 years [[58](#_ENREF_58)]. The 20-year NLS was also higher for children operated at a younger age compared to >90 days in a French study [[36](#_ENREF_36)] and to >75 days in a Dutch study [[56](#_ENREF_56)]. However, 10-year NLS was not associated with age at KP in a UK study [[37](#_ENREF_37)]. Centre caseload (<5 vs >5) was the only significant factor for both 5-year overall survival and NLS in an earlier UK study after adjustment for confounders [[39](#_ENREF_39)] but at 13 years it remained a significant factor for NLS only [[38](#_ENREF_38)]. Centre caseload (<3 vs >3) was also a significant predictor of 5-year NLS in a collaborative Scandinavian study [[58](#_ENREF_58)], and in Finland centralisation of care for patients with biliary atresia significantly increased both overall and NLS to age four years [[60](#_ENREF_60)] (Table 5). In a French study, lower centre caseload was significantly associated with both the reduced overall survival and NLS in the earlier period (1986-96) but not in the later (1992-2002 and 2003-2009) periods [[36](#_ENREF_36)] (Table 5).

# Discussion

This systematic review and meta-analysis summarise long-term survival for individuals born with a range of congenital anomalies from population-based studies, covering a total population of 367,801 live births with congenital anomalies. This work is part of the “EUROlinkCAT: Establishing a linked European Cohort of Children with Congenital Anomalies”, a collaborative project investigating survival, morbidity and educational outcomes in children born with congenital anomalies using population-based data from multiple EUROCAT registries linked to a number of health and education datasets (<https://www.eurolinkcat.eu/>). A total of 55 studies were included in the narrative synthesis, with 41 studies included in meta-analyses. Our meta-analyses showed predicted 20-year survival for cases born in 2020 as 89% for spina bifida (n=7 studies), 71% for encephalocele (n=4), 92% for oesophageal atresia (n=7), 88% for biliary atresia (n=14), 83% for CDH (n=9), 92% for gastroschisis (n=5) and 96% and 96% for Down syndrome with and without CHD (n=10). As expected, the first-year of life was critical for survival of children with a congenital anomaly, but there remained a gradual decline in survival beyond infancy that exceeded that of the general population. Our meta-analyses showed statistically significant improvement in survival over time in those with spina bifida, oesophageal atresia, biliary atresia, CDH, gastroschisis and Down syndrome in those with CHD, but not in those with encephalocele, biliary atresia with a native liver or Down syndrome without CHD. The evidence from individual studies showed that improvement in survival was not equal for all patient groups, being more pronounced, for example, for a group with non-isolated anomalies [[50](#_ENREF_50)] or differing by ethnic group [[18](#_ENREF_18)]. The commonest significant independent predictors of reduced survival for any congenital anomaly type were presence of additional structural anomalies, low birth weight and earlier birth year period.

Advances in prenatal diagnosis, neonatal care, including intensive care, standard use of antenatal steroids and surfactant therapy for prevention of neonatal mortality and morbidity in preterm births, early surgical interventions, ECMO, care centralisation and liver transplantation (for biliary atresia patients) were likely to improve survival in these children. One of the factors that may have contributed to the improvement in survival of live births with spina bifida over the last 30 years reported by individual studies [[45](#_ENREF_45),[46](#_ENREF_46)] and revealed by our meta-analysis, is the increasing use and accuracy of prenatal diagnosis and the consequent increase in terminations of pregnancy for fetal anomaly (TOPFA) for most severe anomaly types. One of the included studies found an independent association of annual TOPFA rate with increase in survival [[15](#_ENREF_15)]. Indeed, there is evidence of an association between the increased TOPFA rates and reduced live birth prevalence of congenital anomalies and consequent reduction in infant mortality [[74](#_ENREF_74),[75](#_ENREF_75)]. Periconceptional folic acid intake or fortification is likely to be another factor of improving survival by reducing the number of severe types of spina bifida [[76](#_ENREF_76)]. Advances in neonatal and surgical care including early neonatal or elective fetal surgery for spina bifida repair [[77](#_ENREF_77),[78](#_ENREF_78)] may have also contributed to increased long-term survival of these patients.

In addition to the above listed general advances in prenatal diagnosis and neonatal care contributing to improvement in survival of children with various types of congenital anomalies, there are specific principles in care of CDH patients that affect survival of these patients. These are; early intubation with avoidance of bag mask ventilation, prevention and treatment of pulmonary hypertension and lung hypoplasia, the primary causes of neonatal mortality in CDH patients, by minimising lung damage using gentle lung ventilation, e.g. high-frequency oscillatory ventilation; gastric decompression, ensuring adequate blood pressure, ECMO if indicated, delayed surgical repair after stabilisation of pulmonary and haemodynamic status [[79](#_ENREF_79)].

Studies of survival of children with biliary atresia, a rare life-limiting progressive disorder of bile ducts, which is fatal without early surgery (KP) and eventually requiring liver transplantation, were mostly limited to 4-5 years of follow up, with two European studies reporting survival at age 20 years [[36](#_ENREF_36),[56](#_ENREF_56)]. Despite a number of existing reviews on biliary atresia, including a systematic review published in 2013 [[80](#_ENREF_80)], this condition was included in our review as we aimed to update the existing evidence on a population base and pool data in a meta-analysis. The 4-year NLS was as low as 23.5% before centralisation of care (1987-2005) in Finland, increasing to 76% after centralisation [[60](#_ENREF_60)]. In addition to centralised care, earlier age at KP was a predictor of better NLS in these patients in some studies [[36](#_ENREF_36),[55](#_ENREF_55),[56](#_ENREF_56),[58](#_ENREF_58),[63](#_ENREF_63),[64](#_ENREF_64)] which was in agreement with an earlier systematic review [[80](#_ENREF_80)]. However, in the UK centre, caseload was the only significant factor associated with better NLS at age 5, 10 or 14 [[37-39](#_ENREF_37)]. Care centralisation and liver transplantation are crucial factors in the care of these patients, increasing the overall 10-year patient survival to 79.7% in France [[36](#_ENREF_36)] and 87%, 89% and 91.5% in the Scandinavian countries [[58](#_ENREF_58)], UK [[37](#_ENREF_37)] and Switzerland [[64](#_ENREF_64)] respectively.

A significant association between birth year and increase in survival of individuals with Down syndrome was reported in some reviewed studies [[14](#_ENREF_14),[19](#_ENREF_19),[66](#_ENREF_66),[69](#_ENREF_69)]. Recent advances in intensive care of preterm and very LBW babies are likely to account for prevention of infant death in many children with Down syndrome who are at a twofold higher risk of infant death compared to very LBW babies without a congenital anomaly due to higher risk of infection and lung disease such as bronchopulmonary dysplasia [[81](#_ENREF_81)]. Improved access to early cardiac surgery in infants with septal defects may have also contributed to their increased long-term survival by prevention of development of pulmonary arterial hypertension and Eisenmenger syndrome, the conditions of high risk mortality [[66](#_ENREF_66),[82](#_ENREF_82),[83](#_ENREF_83)]. Our meta-analysis has shown that survival estimates significantly increased over time for children with CHD but the improvement for those without CHD was not statistically significant.

Until recently, trisomy 13 and 18 were regarded as lethal conditions, with the majority of prenatally diagnosed cases being electively terminated and those resulting in live births (about 19% and 14% for trisomy 13 and 18 respectively [[84](#_ENREF_84)]) commonly receiving palliative care only. Two recent studies that analysed survival of children with trisomy 13 or 18 beyond one year [[25](#_ENREF_25),[72](#_ENREF_72)] demonstrated that although cumulative survival was low, children who were alive at their first birthday had an around 80% chance of survival to their fifth birthday, and 86% of those who survived to age five were likely to live to age 10 years [[25](#_ENREF_25)]. Despite the emerging evidence that intensive care and surgical interventions improve the survival in these children [[85](#_ENREF_85)], the debate in the medical community in relation to the interventions to be offered to infants with these trisomies is ongoing [[85-87](#_ENREF_85)] because of severe cognitive impairment in the survivors and considerations in relation to family and societal burden [[87](#_ENREF_87)]. Current medical experts’ view is that medical care of children with trisomy 13 and 18 should be evidence-based [[85](#_ENREF_85)] and more consideration should be given to personalised care of these children, providing more information to parents and taking into account their hopes and wishes [[86](#_ENREF_86)].

The commonest significant independent predictors of reduced survival at and beyond one year of life for any congenital anomaly type were presence of additional structural anomalies, low birth weight and earlier birth year period. The association with ethnicity was inconsistent in the US studies across different anomaly types and Aboriginality was significantly associated with reduced survival in children with Down syndrome in an earlier study [[69](#_ENREF_69)] but not in a more recent one [[66](#_ENREF_66)]. Ethnicity may be a proxy indicator of deprivation which is associated with increased neonatal and infant mortality across all major causes of death including congenital anomalies [[88-91](#_ENREF_88)], however, the associations with other deprivation measures were not analysed in the included studies.

This systematic review and meta-analysis is strengthened by a rigorous search strategy and comprehensive literature searches using a combination of multiple sources of information to identify relevant papers. Our systematic search strategy was informed by the research protocol registered in the PROSPERO database and developed according to clear inclusion criteria based on elements of the PICOS framework. To ensure that the search strategy was appropriately inclusive it was piloted using Medline, refined and retested. Additionally, we manually searched the reference lists of all included papers, citations of the included papers repeating that process for newly identified papers, and also key journals in the field. This approach is recognised to increase the identification of relevant papers [[92](#_ENREF_92)]. A 10% sample of titles and abstracts of records was screened by co-authors to enable consistency in study inclusion following pre-defined eligibility criteria. All data were extracted in duplicate by two independent reviewers to ensure accuracy in the reported results and to minimise subjectivity. Authors were contacted where more information was required during data extraction. We also used an established quality assessment tool as part of the critical appraisal process.

We restricted the start year for our literature searches to 1995 to make the birth cohorts used in the studies more comparable in relation to antenatal and neonatal care and treatment availability/policies and to avoid subsequent differences. In addition, restricting our review to population-based studies with follow up from birth reduces bias in death ascertainment.

We used multilevel meta-analytic models to allow for studies reporting the survival of different cohorts of births over several time periods. Importantly, we estimated survival for cases born in 2020, which will be useful for counselling parents when a congenital anomaly is diagnosed and for health and social care planning. The gllamm model allows the correlation of survival over time within a study to be modelled, whilst allowing for the random effects from different studies. As the included studies used differing birth cohorts with their effect on survival that increased over time, we felt that it would be inappropriate to present I2 heterogeneity results that is a standard measure of variation between studies, usually clinical trials. We also did not test for publication bias as survival studies profoundly differ by their nature from clinical trials where publication bias can be expected due to a higher likelihood of publication of positive results, which is not the case for survival studies. Moreover, as a number of register-based studies included in the meta-analysis estimated survival of many different anomaly groups and types, publication bias for a specific anomaly is unlikely. Due to the lack of data in terms of the small number of studies, formal tests for publication bias lack power and funnel plots were not informative. The paucity of data limits the predictive capabilities of the models, as shown by the wide confidence intervals on some estimates. A further limitation is the assumption that improvements in survival in the past will continue to be maintained in the future. This is a particular issue with Down syndrome children with CHD. There have been recent dramatic improvements in their survival, but such improvements are unlikely to continue and it is likely that their survival will always be slightly lower than that of children with Down syndrome without CHD. Yet the two models predicted very similar survival for such children born in 2020.

Meta-analysis was not possible for all studies included in this systematic review as there were either an insufficient number of studies reporting survival for the same anomaly subtype, the studies did not report 95% CI or the number of cases. Moreover, not all studies included in the meta-analysis of some structural anomalies (e.g. spina bifida, CDH) were consistent in their exclusion of non-isolated anomalies, which may have accounted for the variability in the survival estimates. All but one of the included studies were conducted in high-income countries, which limited generalisability of the results to low-income countries. Lack of relevant studies from 66 papers identified from our Medline search not restricted to English language, most of which were from Europe, suggests that population-based studies with long-term follow up of children with congenital anomalies or linkage studies to identify deaths beyond infancy are rare in low income countries.

The papers analysing survival predictors were not systematically searched for, only studies eligible for this review that also explored predictors were included. We acknowledge that summarised data on survival predictors reported in the reviewed studies are supplementary and enrich the interpretation of the results but are not a comprehensive review of predictors of congenital anomaly related survival. Therefore, the association of survival with some important risk factors such as maternal deprivation shown to be linked to lower infant and child survival [[89](#_ENREF_89),[93](#_ENREF_93)], including children born with congenital anomalies [[94](#_ENREF_94)], could have been under-investigated in this review.

This systematic review and meta-analysis summarised the existing international evidence from population-based studies to provide information on long-term survival of children with selected congenital anomalies and temporal changes in survival. Our findings reveal a wide variation in survival by congenital anomaly subtype and suggest reduced survival associated with many anomaly subtypes compared with the reference population. The meta-analysis has demonstrated that survival has significantly improved over time for a number of specific congenital anomalies. We have also provided predicted survival estimates for children born in 2020. This information has important implications for the planning and delivery of public health services, specialised medical care and educational services, and is valuable for clinicians, public health professionals, health care providers and parents. We identified a lack of good quality reasonably sized studies for many congenital anomaly subtypes that prevented estimation of their pooled survival and analysis of trends over time. Future survival studies should endeavour to use multicentre case data from different parts of the world linked to reliable mortality data with follow up from birth to avoid selection bias and under-ascertainment of deaths.

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# Figure legends and footnotes

**Fig 1. PRISMA flowchart of searches, screening and study selection**

**Fig 2. Survival estimates (with 95% CI) of children with spina bifida at 1 (a), 5 (b|) and 10 (c) years of age over time (10 birth cohorts from 7 studies)**

**Note:** The numbers at survival points indicate the included study which may appear more than once if survival was reported for more than one birth cohort: 1 – Agha, 2006, Canada; 2 – Borgstedt-Bakke, 2017, Western Denmark; 3 – Wong, 2001, Atlanta, USA; 4 – Tennant, 2010, Northern England; 5 – Wang, 2011; USA, 6 – Wang, 2015, USA; 7 – Schneuer, 2019, New South Wales, Australia.

**Fig 3. Survival estimates (with 95% CI) of children with oesophageal atresia at 1 (a) and 5 (b) years of age over time (7 studies)**

**Note:** 1 – Cassina, 2016, North East Italy; 2 – Garne, 2002, Funen, Denmark; 3 – Oddsberg, 2012, Sweden; 4 – Tennant, 2010, Northern England; 5 – Wang, 2011; USA, 6 – Wang, 2015, USA; 7 – Schneuer, 2019, New South Wales, Australia.

**Fig 4. Survival estimates (with 95% CI) of children with biliary atresia at 5 (a) and 10 (b) years of age over time (11 birth cohorts from 9 studies)**

**Note:** The numbers at survival points indicate the included study which may appear more than once if survival was reported for more than one birth cohort: 1 – McKiernan, 2000, UK and Ireland; 3 – Nio, 2003, Japan; 6 – Tennant, 2010, Northern England; 8 – Wildhaber, 2008, Switzerland; 9 –Davenport, 2011, England & Wales, 10 – Chardot, 2013, France; 11 –Pakarinen, 2018, Nordic countries; 13 – Grizelj, 2010, Croatia; 15 –Tu, 2015, South Australia.

**Fig 5. Survival estimates (with 95% CI) of children with congenital diaphragmatic hernia at 1 (a) and 5 (b|) years of age over time (5 studies)**

**Note:** 2 – Garne, 2002, Denmark; 6 – Tennant, 2010, Northern England; 7 – Wang, 2011; USA, 8 – Wang, 2015, USA; 9 – Schneuer, 2019, New South Wales, Australia.

**Fig 6. Survival estimates (with 95% CI) of children with gastroschisis at 1 (a) and 5 (b) years of age over time (5 studies).**

**Note:** 1 – Risby,2017, Southern Denmark; 2 – Schneuer, 2019, New South Wales, Australia; 3 – Tennant, 2010, Northern England; 4 – Wang, 2011; USA, 5 – Wang, 2015, USA.

**Fig 7. Survival estimates (with 95% CI) of children with Down syndrome associated with congenital heart defect at 1 (a), 5 (b) and 10 (c) years of age over time (11 birth cohorts from 10 studies)**

**Note:** The numbers at survival points indicate the included study which may appear more than once if survival was reported for more than one birth cohort: 1 – Glasson, 2016, Western Australia; 2 – Hayes, 1997, Ireland; 3 – Kucik, 2013, USA; 4 – Leonard, 2000, Western Australia; 5 – Rankin, 2012, Northern England; 6 – Rasmussen, 2006, Atlanta, USA; 10 – Brodwall, 2018, Norway; 11 – Frid, 1999, Northern Sweden; 12 – Halliday, 2009, Victoria, Australia, 13 –Schneuer, 2019, New South Wales, Australia.

**Fig 8. Survival estimates (with 95% CI) of children with Down syndrome without congenital heart defect at 1 (a), 5 (b) and 10 (c) years of age over time (11 birth cohorts from 10 studies).**

**Note:** The numbers at survival points indicate the included study which may appear more than once if survival was reported for more than one birth cohort: 1 – Glasson, 2016, Western Australia; 2 – Hayes, 1997, Ireland; 3 – Kucik, 2013, USA; 4 – Leonard, 2000, Western Australia; 5 – Rankin, 2012, Northern England; 6 – Rasmussen, 2006, Atlanta, USA; 10 – Brodwall, 2018, Norway; 11 – Frid, 1999, Northern Sweden; 12 – Halliday, 2009, Victoria, Australia, 13 –Schneuer, 2019, New South Wales, Australia.

# Supporting information captions

**S1 Fig. Survival estimates (with 95% CI) of children with encephalocele at 1 year of age over time (4 studies).**

**Note:** 1 –Siffel, 2003, Atlanta, USA; 2 – Tennant, 2010, Northern England; 3 – Wang, 2011, USA; 4 – Wang, 2015, USA.

Survival at 5 years was not plotted as survival data were available for three studies only.

**S2 Fig. Survival with native liver (with 95% CI) of children with biliary atresia at 5 (a) and 10 (b) years of age over time (11 birth cohorts from 9 studies).**

**Note:** The numbers at survival points indicate the included study which may appear more than once if survival was reported for more than one birth cohort:

**Footnote:** The numbers at survival points indicate the included study which may appear more than once if survival was reported by birth cohort: 1 – McKiernan, 2000, UK and Ireland; 3 – Nio, 2003, Japan; 7 – Schreiber, 2007, Canada; 8 – Wildhaber, 2008, Switzerland; 9 –Davenport, 2011, England & Wales, 10 – Chardot, 2013, France; 11 –Pakarinen, 2018, Nordic countries; Brazil; 13 – Grizelj, 2010, Croatia; 15 –Tu, 2015, South Australia.

**S3 Fig. Survival estimates (with 95% CI) of children with trisomy 18 (4 studies).**

1 – Meyer, 2016, USA; 2 – Nelson, 2016, Ontario, Canada; 3 – Schneuer, 2019, New South Wales, Australia; 4 – Wang, 2011, USA;

**S1 Table. Search terms and search results in electronic databases Medline, Embase and PsycInfo.**

**S2 Table. Data extraction form and Newcastle-Ottawa Quality Assessment Scale for cohort studies.**

**S3 Table. Quality assessment scores of the included studies using the Newcastle-Ottawa scale for cohort studies.**

**S4 Table. Details of sources of case ascertainment and death identification of included studies and description of a comparison group.**

**S5 Table. Survival estimates by congenital anomaly type at age one to 25 years, overall and by risk factor.**

**S6 Table. Predictors of survival/mortality in the included studies that explored risk factors associated with survival at different age points, including infancy (n=35), by congenital anomaly group/subtype.**

**S1 PRISMA Checklist.**

**S1 Text.Protocol for PROSPERO registration.**

# Table 1. Description of included studies.

| **Author, publication year, ref, country** | **Congenital anomaly (CA) group/subtype** | **Birth year period** | **Duration and completeness of follow up (FU)** | **Inclusion of additional anomalies/ exclusions** | **Reporting of survival estimates** | **Study quality total score\*** |
| --- | --- | --- | --- | --- | --- | --- |
| Agha, 2006 [[6](#_ENREF_6)], Ontario, Canada | All anomalies and by group | 1979-86 | 10 years for all anomalies | Multiple births excluded | 1- and 5-year estimates by CA group reported, 10-year survival for all CAs extracted from K-M curves | 9 |
| Bakker, 2019 [[49](#_ENREF_49)] 5 European and 4 USA registries‡ | Spina bifida  ICD‐10 Q05 and ICD‐9 741 | 2001-2012 (for 7 out of 8 included registers) | Up to 5 and ≥5 years depending on the registry | Only registries with FU beyond 1 year and using linkage to vital records (n=9) are included in this review. Cases excluded when present with anencephaly. Both isolated and syndromic cases are included | Survival estimates calculated using mortality rates reported | 6 |
| Bell, 2016 [[16](#_ENREF_16)], Western Australia | Orofacial clefts (OFC) | 1980-2010 | FU to 20 years for 1980-1992, low loss to FU (~2.8%) | Estimates for isolated and those with additional CA | 1-year estimates by cleft type (for 1980-2010 cohort) and 20-year estimates (for 1980-92) reported | 8 |
| Berger, 2003 [[7](#_ENREF_7)], Michigan, USA | All anomalies (not stratified by group) | 1992-98 | Up to 7 complete years of FU (for those born in 1992-97%) | Multiple births excluded | Reported mortality for each birth year, survival estimated by reviewer | 8 |
| Borgstedt-Bakke, 2017 [[45](#_ENREF_45)], Western Denmark | Spina bifida (myelomeningocele) | 1 Jan 1970-30 Jun 2015 | Up to 20 years, censored on Nov 9, 2015; median age at death – 1 year of age. | Excluded cases with incomplete mortality or clinical data (n=16) | Survival estimates extracted from K-M curves by birth year period: 1970-79, 1980-89 and 1990-2015 | 7 |
| Brodwall, 2018 [[22](#_ENREF_22)], Norway | Down syndrome | 1994-2009 | Complete FU to 5 years for those traced (5.5% lost to FU - censored) | Isolated Down syndrome and with associated (CHD and/or ECM) anomalies included | K-M survival estimates reported in the paper or obtained from authors on request | 8 |
| Burgos, 2017 [[23](#_ENREF_23)], Sweden | Congenital diaphragmatic hernia | 1987-2013 | FU up to 20 years for the whole period, up to 10 years for 2000-2013, complete for 98.7% | Patients who were diagnosed of CDH after the neonatal period were excluded | 1 year and overall (beyond 1 year) mortality reported, 1-, 5- and 10-year survival extracted from K-M curves | 6 |
| Cassina, 2016 [[50](#_ENREF_50)], North East Italy (NEI) | Oesophageal atresia (ICD-9 750.3) | 1981-July 31 2012 | FU up to age 25 years (min 3 months) or censored at Oct 31, 2012, survival traced in 91.7% (330/360) | Chromosomal anomalies (n=42, 10.3%) excluded, other non-isolated cases included | Survival estimates reported for 1 and 25 years, for 5 and 10 years extracted from K-M curves | 6 |
| Cassina, 2019 [[52](#_ENREF_52)], North East Italy | Anorectal malformations | 1981-2014 | Survival status was traced for patients born between 1 Jan 1990 and 31 July 2012 up to 20 years (88.2%) | Those with non-isolated anomalies were included (n=216, 50.5%), isolated (n=212) included 7 patients with trisomy 21. | Overall K-M survival estimates (with 95% CI) reported for 1 and 20 years, for 10 years separately for isolated and non-isolated | 5 |
| Chardot, 2013 [[36](#_ENREF_36)], France | Biliary atresia (BA) | 1986-2009 | Median FU in survivors 9.5 y (range 3 m–24.6 y). | Only cases with corrected diagnosis of BA, including those with BASM | K-M survival estimates reported for 5, 10, 15 and 20 years, 95% CI calculated using reported SE | 6 |
| Chua, 2020 [[71](#_ENREF_71)], Hong Kong | Down syndrome (ICD-9 code 758.0) | 1995-2014 | FU from birth until the age of 5 years, up to June 30, 2017, or the date of death (FU range 0.01-22.0 yrs) | All with Down syndrome, with or without associated anomalies | K-M survival estimates reported for 6 months, 1 and 5 years | 6 |
| Dastgiri, 2003 [[17](#_ENREF_17)], Glasgow, Scotland | All anomalies and by group | 1980-1997 | 5 years FU for all (97% complete) | Isolated anomalies only included | K-M survival estimates reported for 1 and 5 years and 95% CI provided by authors on request | 6 |
| Davenport, 2011 [[37](#_ENREF_37)], England & Wales | Biliary atresia | 1999-2009 | Vital status assessed in Jan 2010 – up to 10 years of age, none lost to FU. | BA cases with BASM and other associated anomalies (n=84) included | Actuarial survival estimates reported for 5 and 10 years, extracted from survival curve for 4 years | 6 |
| De Carvalho, 2010 [[55](#_ENREF_55)], Brazil | Biliary atresia | Jul 1982 to Dec 2008 | FU between Jul 1982 and Dec 2008, loss to FU not reported | BA cases with BASM or other associated anomalies (n=61) included | K-M survival estimates (without 95% CI) reported for 4 years | 5 |
| De Vries, 2011 [[56](#_ENREF_56)], The Netherlands | Biliary atresia | 1977-88 | 20-year FU - median 23.8 (range 20.2-31.4), 2 lost to FU | All BA cases (including BASM, n=7) included, no other anomalies reported | 20-year survival reported | 6 |
| Eide, 2006 [[8](#_ENREF_8)], Norway | All anomalies and by selected subgroup | 1967-79; FU 1967-98 | FU 18 years for all birth years, 6.2% (n=24,355) untraceable from the whole cohort of 393,570. | Male cases and live singleton births only included. CAs ascertained during the first week after birth only, selection bias possible | No survival analysis performed, mortality by age 18 yrs (military draft) reported, survival estimated by reviewers assuming no censoring | 8 |
| Folkestad, 2016 [[13](#_ENREF_13)], Denmark | Osteogenesis Imperfecta (OI): | 1977-2012 | FU to Dec 31, 2013, up to 20 years (for this review) | All patients with OI diagnosis on NPR included, survival up to 20 yrs for patients born from 1977 included in this review | Survival estimated by reviewers using data on deaths and number at risk provided by authors on request | 9 |
| Frid, 1999 [[65](#_ENREF_65)], northern Sweden | Down syndrome | 1973-1980, FU 1973-1997 | Complete FU to age 14.5 years (n=213, 95.1%) | All with Down syndrome, with or without associated anomalies | Mortality reported, survival estimated by reviewers | 6 |
| Garne, 2002 [[51](#_ENREF_51)], Funen county, Denmark | Gastrointestinal anomalies (atresias, abdominal wall defects and CHD) | 1980-1993, FU 1980-98 | FU of all patients to 5 years of age | All patients with and without associated anomalies | Number of deaths and survivors reported, survival estimated by reviewers | 6 |
| Glasson, 2016 [[66](#_ENREF_66)], Western Australia (WA) | Down syndrome | 1980-2010, censored to end 2013 | FU to 31 Dec 2013, up to 25 years for birth years 1980-2010 | From the survival analysis, deaths within the first 24 hours excluded (n=11) | 1-, 5-, 10-, 20- and 25-year K-M survival estimates with 95% CI reported | 7 |
| Grizelj, 2010 [[57](#_ENREF_57)], Croatia | Biliary atresia | 1992-2006 | FU to Dec 31, 2006, (median 2.65 y (range 0.2–14.3), (6.9% (2/29) lost to FU) | 1 inoperable patient excluded from survival analysis | K-M 5- and 10-year NLS estimates with 95% CI reported; all deaths included by reviewers for the overall survival | 6 |
| Gudbjartsson, 2008 [[53](#_ENREF_53)], only Iceland centre included | CDH | 1983-2002 | FU 1983-Apr 2005, 3-year FU of all patients (mean FU 5 years) | Only early presenters (diagnosed within first 24 hrs –n=19) included | 3-year survival reported for early presenters, overall survival estimated by reviewers (n=23) | 6 |
| Halliday, 2009 [[67](#_ENREF_67)], Victoria, Australia | Down syndrome | two birth cohorts: 1988-1990 and 1998-2000 | FU to 2005, 5-year FU for all births (unless the child died interstate - % of migration <2%) | Patients with associated anomalies (n=121 in 1988-90 and n=89 in 1998-2000) included | K-M 5-year survival reported, 1-year survival estimated by reviewers | 6 |
| Hayes, 1997 [[68](#_ENREF_68)], Dublin, Ireland | Down syndrome | 1980-89 | FU data collected in 1992 (range 3-12 yrs) (vital status unavailable in 1.3% (n=5) | Patients with associated anomalies (n=212) included (data on additional CAs available in 365/389 (93.6%) | K-M survival reported for 1980-89, and for 1980-94 and 1985-89 | 6 |
| Hinton, 2017 [[18](#_ENREF_18)], Atlanta, USA | CDH | 1979-2003 | FU to death or censored at Dec 31, 2006; 3-yr survival complete for all cases | Excluded children with known chromosomal anomalies or syndromes. | K-M overall survival reported by various factors, K-M survival curves plotted for White and Black ethnicity by birth period, poverty and CHD | 6 |
| Jaillard, 2003 [[54](#_ENREF_54)], France | CDH | 1991-98 | FU to 2 years of all the surviving infants with CDH | Patients with associated lethal CAs (n=9) excluded. | Early (<2 months) and late deaths (between 2 m and 3 yrs) reported, 2-yr survival with 95% CI estimated by reviewers | 6 |
| Kucik, 2013 [[19](#_ENREF_19)], 10 regions, USA | Down syndrome | 1983-2003 | FU ranged from 9 to 22 years between the regions (8 regions with up to 11+ yrs, 4 – 20-22 yrs) | Cases with additional anomalies (e,g, CHD) included | K-M survival estimates with 95% CI reported for 1, 5, 10 and 20 years | 6 |
| Lampela, 2012 [[60](#_ENREF_60)], Finland | Biliary atresia | 1987-2010 | FU to 4 full years for all live births with BA | All BA cases included: with BASM (n=9, 14%), with other anomalies (n=6, 9%) | Actuarial 4-year survival estimates reported and final figures provided by author on request, 95% CI calculated by reviewers | 6 |
| Leonard, 2000 [[69](#_ENREF_69)], Western Australia | Down syndrome | 1980-96 | FU to 10 yrs for all born in 1980-85, to 10 yrs for 1986-90 and to 5 yrs for 1991-96 | Cases with additional anomalies (e,g, CHD) included | K-M 1-, 5- and 10-year survival estimates reported, overall and by 3 birth periods | 6 |
| Leonhardt, 2011 [[61](#_ENREF_61)], Germany | Biliary atresia | 2001-2005 | Follow up to 2 full years (16/183 lost to FU – 8.7%) | All with BA diagnosis included | 2-year K-M survival estimates after KP or LT reported, overall survival (including 3 initial deaths) calculated by reviewers | 5 |
| Lionti, 2012 [[73](#_ENREF_73)], Victoria, Australia | Prader-Willi syndrome | 1950-May 31, 2010 | FU to 35 years of age, loss to FU not reported | Only patients with diagnosed PWS included, infant deaths may have been missed by the register. | K-M survival estimates with 95% CI reported for 10, 20, 30 and 35 years, estimates for 1, 5, 15 and 25 yrs extracted from K-M-curves | 5 |
| Löf Granström, 2017 [[24](#_ENREF_24)], Sweden | Hirschsprung disease (HSCR) | 1964-2013 | FU to Dec 31, 2013 (up to 50 yrs of age), median - 19 years (range 2-49), loss to FU not reported† | Only those with confirmed diagnosis of HSCR included (n=739), those with HSCR and Down syndrome also included | K-M survival curves with 95% CI presented up to 50 yrs, survival estimates up to 25 yrs extracted by reviewers | 8 |
| McKiernan, 2000 [[39](#_ENREF_39)], UK and Ireland | Biliary atresia | March 1993 to end Feb 1995 | FU up to 5 years (median 3.5 years, range 0.3-5.4), lost to FU 2.2% | Those with additional CAs included (n=20, n=9 BASM | Actuarial survival estimated by K-M method and 5-yr overall survival and NLS reported | 6 |
| McKiernan, 2009 [[38](#_ENREF_38)], UK and Ireland | Biliary atresia | March 1993 to end Feb 1995 | FU: median age at last FU 12 years (range 0.25-14), only 2 lost to FU (2.2%) | Those with additional CAs included (n=20, n=9 BASM | Actuarial survival estimated by K-M method and 13-yr overall survival and NLS reported | 6 |
| Meyer, 2016 [[72](#_ENREF_72)], 9 States USA | Trisomy 13 and trisomy18 | 1999-2007 | FU 1999-2008, birth years 1999-2005 included for survival estimation to 5 yrs, loss to FU not reported† | All cytogenetic variants included; different birth years included in different States | K-M survival estimates with 95% CI (<28 d, < 1y and <5 y) reported | 6 |
| Nelson, 2016 [[25](#_ENREF_25)], Ontario, Canada | Trisomy 13 and trisomy18 | 1991-2012 | FU 1991-2013 – up to 7000 days (1.6%, n=7 lost to FU). | All cytogenetic variants included (90.2% unspecified, 3.5% mosaic, 6.3% translocation) | K-M survival estimates with 95% CI for 1, 5 and 10 years reported | 6 |
| Nembhard, 2010 [[43](#_ENREF_43)], Texas, USA | All CAs, not stratified by group | 1996-2003 | FU to 2005, 5-year survival analysed; loss to FU not reported† | 3.7% (unduplicated n=1877) excluded: trisomy 13 or 18 (n=511), not born to a NHW, NHB, or Hispanic mother (n=1340), deaths with no date of death (n= 50) | 5-year K-M survival estimates with 95% CI for NHW, NHB and Hispanic ethnicity for term and preterm births reported and by size at birth | 6 |
| Nio, 2003 [[62](#_ENREF_62)], Japan | Biliary atresia | 1989-1999 | 1989 only – compete FU for 10-yr survival, 1989-94 – complete FU for 5-yr survival, 2.6% lost to FU (n=19) | BA cases with additional anomalies included (19.6% including n=33 with BASM) | 5- and 10-year survival estimates reported only for those birth years with complete FU | 6 |
| Oddsberg, 2012 [[9](#_ENREF_9)],  Sweden | Oesophageal atresia | 1964-2007 | Complete FU of the nationwide cohort by birth year - up to 25 yrs for 1964-69 (% missing negligible) | Patients older than 1 year at diagnosis excluded to avoid misclassification; cases with associated CAs included | K-M survival estimates up to 20 years by time period extracted from K-M curves by reviewers | 9 |
| Pakarinen,2018 [[58](#_ENREF_58)], Nordic countries | Biliary atresia | 1.1.2005–30.6.2016 | FU for at least 4 months, median 4.9 (IQR 1.8-7.9 years) | Non-curable CHD or CNS CA (n=4) withdrawn from treatment and excluded from the survival analysis, other associated CAs (n=41, BASM n=19) included | K-M 5 and 10-year survival estimates reported for 154 included cases, survival estimated by reviewers based on all 158 BA patients for consistency | 6 |
| Rankin, 2012 [[14](#_ENREF_14)], Northern England | Down syndrome | 1985-2003 | FU to 29th Jan 2008 – 95.3% traced (669/702) | All live born cases with DS - full trisomy 21, mosaicism and translocation – were included | K-M survival estimates with 95% CI reported for 1, 5, 10 and 20 years | 6 |
| Rasmussen, 2006 [[70](#_ENREF_70)], Metropolitan Atlanta, USA | Down syndrome | 1979-1998 | 1979-1999, FU complete for 1979-88 for 10-year survival, censored by 20 years (loss to FU not reported†) | 47(of 692) excluded: cytogenetic results unavailable (22), complex rearrangements involving chromosome 21 (7), mosaicism (16), and not DS (2). | K-M survival estimates with 95% CI reported for 1 and 10 years, 5- and 20-year estimates with 95% CI extracted from K-M curves by reviewers | 6 |
| Risby, 2017 [[21](#_ENREF_21)], Southern Denmark | Gastroschisis | 1997-2009 | FU to 5 years for the whole cohort (between Jun 2013 and Apr 2014) | All cases with gastroschisis included | 1- and 5-year survival estimated by reviewers using mortality data | 6 |
| Schneuer, 2019[[42](#_ENREF_42)], New South Wales (NSW), Australia | All anomalies, by group and subtype by EUROCAT classification | 2004-2009 | FU to death, five years of age or until the 31 March 2014, whichever came first. | Excluded cases without linked birth records (n=701), mothers residents outside NSW (n=110), born at 19 weeks of gestation (n=3) | K-M 1- and 5-year survival estimates with 95% CI reported | 6 |
| Schreiber, 2007 [[63](#_ENREF_63)], Canada | Biliary atresia | 1985-2002 | FU up to 10 years, 7% missing survival data for 1985-95, no missing for 1996-2002 | All with confirmed DS of BA included, including 27 (14%) with BASM phenotype | K-M survival estimates with 95% CI reported for 4 and 10 years | 6 |
| Shin, 2012 [[46](#_ENREF_46)], 10 regions, USA | Spina bifida: | 1979-2003 | FU to 2004 (up to 20 years for 1983-2003) for 8 registries, loss to FU not reported† | Cases with associated anomalies (e.g. major CHD) included | K-M 1-, 5-and 20-year survival reported for 1983-2003; other - extracted from K-M curves by reviewers | 6 |
| Siffel, 2003 [[47](#_ENREF_47)], Atlanta, USA | Encephalocele | 1979-98 | FU 1979-99 (for survivors censored at 31 Dec 1999); loss to FU not reported† | Excluded 8 cases: trisomy 13 (1), trisomy 18 (1), amniotic bands (3), coded with ‘possible’ diagnosis (3). With other major CAs included (n=17) | K-M survival estimates reported for 1, 5 and 20 years – overall and by risk factor | 6 |
| Simmons, 2014 [[20](#_ENREF_20)], Texas, USA | Achondroplasia | 1996-2005 | FU to 31 Dec 2007 up to age 10 years (minimal 2-year FU for all patients), none lost to FU | All with confirmed diagnosis of achondroplasia included. | Mortality reported, 2-year survival with 95% CI estimated by reviewers (no censoring as all FU to age 2 years) | 6 |
| Sutton, 2008 [[44](#_ENREF_44)], Dublin, Ireland | Spina bifida, encephalocele | 1976-1987 | Retrospective data collection between Aug 1989 and Apr 1990 for 5-year survival (1.1% (n=6) lost to FU) | Excluded: those with anencephaly and with spina bifida occulta; infants lost to FU immediately after birth (n=6). | K-M 1- and 5-year survival estimates (no 95% CI) reported. | 6 |
| Tennant, 2010 [[15](#_ENREF_15)], Northern England | All anomalies, by group and subtype | 1985-2003 | FU to 29th Jan 2008 – up to 20 years; 99% traced (10,850/10,964) | Excluded individuals with unavailable data on survival status (114 -1%); those with chromosomal anomalies outside the EUROCAT range (ICD codes Q940-59**)** | K-M survival estimates with 95% CI reported for EUROCAT CA groups and subtypes for 1, 5, 10, 15 and 20 years | 6 |
| Tu, 2015 [[59](#_ENREF_59)], South Australia | Biliary atresia | 1989-2000 | The median FU period 13.4 years (IQ, 6.2–18.2; range 0.6–21), no loss to FU. | Excluded 2 patients as the initial KP was performed interstate | K-M 5-year survival estimates with 95% CI reported by authors for both overall survival and NLS | 6 |
| Wang, 2011 [[40](#_ENREF_40)], New York State, USA | All anomalies and by group | 1983-2006 | FU to end 2008 for up to 25 years (assuming alive if no death by Dec 31, 2008), loss to FU not reported | Only CMR cases matched to their birth certificates (97%) included (n=57,002), cases with additional anomalies included. | K-M survival estimates with 95% CI reported for selected CA groups and subtypes for 1, 5, 15 and 25 years | 5 |
| Wang, 2015 [[41](#_ENREF_41)], 12 states, USA | All anomalies and by group | 1999-2007 | FU to end 2008 (ranging from 1 to 9 years), loss to FU not reported | All live births with a major CA included (n=98833); infants with multiple defects were included in each relevant birth defect category | K-M survival estimates with 95% CI reported for selected CA groups and subtypes for <1, <2 and <8 years | 5 |
| Wildhaber, 2008 [[64](#_ENREF_64)], Switzerland | Biliary atresia | 1994-2004 | Median FU 58 months (range, 5–124); no loss to FU. | All patients, including those with associated anomalies were included: BASM (n=4), other associated anomalies or disease (n=6). | K-M 5-year survival estimates (overall and NLS) with SE reported, 95% CI calculated by reviewers | 6 |
| Wong, 2001 [[48](#_ENREF_48)], Atlanta, USA | Spina bifida: | 1979-94 | FU 1979-96), loss to FU not reported† | Excluded cases associated with anencephaly or trisomies 13 or 18 | K-M survival estimates with 95% CI to age 18 years (1, 5, 10, 15, 18) | 6 |

**Note:**

\*Study data quality was measured using Newcastle-Ottawa scale for cohort studies – max 9, max 6 for those with no comparison group/non-exposed cohort. Scores of <5 indicated high risk of bias.[[95](#_ENREF_95)]

†Loss to FU likely to be low as the linkage system for tracing deaths is well established (involving linkage with the National Death Index in the US studies for deaths outside the State).

‡Data from USA-Atlanta are not included as are part of the cohort used by Wang, 2015 [[41](#_ENREF_41)].

BA, biliary atresia, BASM, biliary atresia splenic malformation syndrome; CA, congenital anomaly, CDH, Congenital diaphragmatic hernia; CMR, Congenital Malformations Registry; CNS, central nervous system; EUROCAT, European Surveillance of Congenital Anomalies; FU, follow up; HSCR, Hirschsprung disease; ICD, International Classification of Disease (ICD); KP, Kasai hepatoportoenterostomy; K-M, Kaplan-Meier; LT, liver transplantation; MBR, Medical Birth Registry; NHB, Non-Hispanic Black; NHW, Non-Hispanic White; NLS, native liver survival; NPR, National Patient Register; OI, osteogenesis imperfecta.

# Table 2. Survival estimates by congenital anomaly type at age one to 25 years, overall and by birth cohort.

| **Congenital anomaly group/subtype** |  | |  | **Survival estimates % (95% CI)** | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Study and birth year** | | **N deaths/**  **live births** | **1 year** | | **5 years** | | **10 years** | **15 years** | **20 years** | **25 years** |
| **All congenital anomalies** | | |  |  | |  | |  |  |  |  |
| ICD-9 codes 740.0-759.9 | Agha, 2006 [[6](#_ENREF_6)]  1979-86, Canada | | 3620/45,200 | 93.4 | | 92.5 | | ***92.3*** | **―** | **―** | **―** |
| ICD-9 codes 740-759 | Berger, 2003 [[7](#_ENREF_7)]  1992-98, USA | | 2182/43,708 | 95.7 | | *95.0* | | **―** | **―** | **―** | **―** |
| BPA-ICD-9 codes 740-759 | Dastgiri, 2003 [[17](#_ENREF_17)] 1980-1997, Scotland | | 740/6153 | 89.11 | | 87.95 | | **―** | **―** | **―** | **―** |
| ICD-8 codes (740-759) | Eide, 2006 [[8](#_ENREF_8)]  1967-79, Norway | | 1169/9186 | **―** | | **―** | | **―** | **―** | *87.4*a | **―** |
| ICD-9 740.00-758.090 | Nembhard, 2010 [[43](#_ENREF_43)], 1996-2003, USA | | 3518/48,391 | *93.7* | | *92.7* | **―** | | **―** | **―** | **―** |
| ICD-10 (Q00-Q99) | Tennant, 2010 [[15](#_ENREF_15)], 1985-2003, Northern England | | 1465/10,850 | **―** | | **―** | | **―** | **―** | 85.5 (84.8-86.3) | **―** |
| ICD-9 codes 740-759 | Wang, 2011 [[40](#_ENREF_40)]  1983-2006, USA | | 9112/57,002 | 87.1 (86.8–87.4) | | 85.2 (84.9–85.5) | **―** | | 83.9 (83.6–84.2) | **―** | 82.7 (82.4-83.1) |
| **Neural tube defects** | | |  |  | |  | |  |  |  |  |
| Including anencephaly | Dastgiri, 2003 [[17](#_ENREF_17)], 1980-1997, Scotland | | 40/144 | 72.2 (64.9-79.5)b | | 71.5 (63.8-79.3)b | | **―** | **―** | **―** | **―** |
| Including anencephaly | Schneuer, 2019 [[42](#_ENREF_42)]. 2004-2009  NSW, Australia | | 34/110 | 69.1 (60.5–77.7) | | 69.1 (60.5–77.7) | | **―** | **―** | **―** | **―** |
| Including anencephaly | Tennant, 2010 [[15](#_ENREF_15)], 1985-2003, Northern England | | 87/226 | 65.0 (58.4-70.9) | | 62.8 (56.2-68.8) | | 62.4 (55.7-68.3) | 62.4 (55.7-68.3) | 63.4 (53.4-66.7) | **―** |
| Excluding anencephaly | Sutton, 2008 [[44](#_ENREF_44)], 1976-87, Ireland | | 313/543 | 43.7 | | 40.8 | | **―** | **―** | **―** | **―** |
| **Anencephaly** |  | |  |  | |  | |  |  |  |  |
| ICD-9 code  740.0–740.2 | Agha, 2006 [[6](#_ENREF_6)]  1979-86, Canada | | 183/ | 4.8 | | 4.6 | | **―** | **―** | **―** | **―** |
|  | Schneuer, 2019 [[42](#_ENREF_42)], 2004-2009  NSW, Australia | | 19/19 | 0.0 | | **―** | | **―** | **―** | **―** | **―** |
|  | Tennant, 2010 [[15](#_ENREF_15)], 1985-2003, Northern England | | 17/17 | 0.0 | | **―** | | **―** | **―** | **―** | **―** |
| ICD-9 740.0–740.1 | Wang, 2011 [[40](#_ENREF_40)], 1983-2006, USA | | 447/479 | 7.3 (5.2-9.9) | | 6.8 (4.8–9.3) | | **―** | 6.5 (4.5-9.0) | **―** | 6.5 (4.5-9.0) |
| **Spina bifida** |  | |  |  | |  | |  |  |  |  |
| ICD-9 code  741.0–741.9 | Agha, 2006 [[6](#_ENREF_6)]  1979-86, Canada | | 182/ | 78.5 | | 75.3 | | **―** | **―** | **―** | **―** |
| ICD‐10 Q05 and ICD‐9 741 | Bakker, 2019 [[49](#_ENREF_49)]  **2001-2012:**  Czech Republic | | /139 | *91.4* | | *90.0* | | *88.6c* | **―** | **―** | **―** |
|  | Malta MCAR | | /28 | *92.8* | | *92.8* | | **―** | **―** | **―** | **―** |
|  | Sweden | | /263 | *92.5* | | *92.1* | | *91.7c* | **―** | **―** | **―** |
|  | UK-Wales | | /78 | *91.0* | | *89.7* | | *89.7c* | **―** | **―** | **―** |
|  | USA‐Arkansas | | /177 | *87.0* | | *84.2* | | *83.1c* | **―** | **―** | **―** |
|  | USA‐Texas | | /1578 | *91.6* | | *90.5* | | *90.1c* | **―** | **―** | **―** |
|  | USA‐Utah | | /213 | *90.7* | | *90.7* | | *90.2c* | **―** | **―** | **―** |
|  | USA-Atlanta – 2001-2008 | | /112 | *95.5* | | *95.5* | | *95.5c* | **―** | **―** | **―** |
|  | Italy-Lombardy – 2003-2012 | | /25 | 100.0 | | 96.0 | | **―** | **―** | **―** | **―** |
| Myelomeningocele | Borgstedt-Bakke, 2017 [[45](#_ENREF_45)], 1970-79, Denmark | | 16/58 | ***84.5*** | | ***84.5*** | | ***82.8*** | ***79.4*** | ***79.4*** | **―** |
|  | 1980-89 | | 5/39 | ***97.5*** | | ***92.4*** | | ***92.4*** | ***92.4*** | ***89.8*** | **―** |
|  | 1990-2015 | | 6/90 | ***95.6*** | | ***95.6*** | | ***94.5*** | ***92.8*** | ***92.8*** | **―** |
| Spina bifida  (ICD-8 code 741) | Eide, 2006 [[8](#_ENREF_8)]  1967-79, Norway | | 56/113 | **―** | | **―** | **―** | | **―** | *50.4*a | **―** |
| Spina bifida | Schneuer, 2019 [[42](#_ENREF_42)], 2004-2009  NSW, Australia | | 11/56 | 80.4 (70.0–90.8) | | 80.4 (70.0–90.8) | **―** | | **―** | **―** | **―** |
| ICD-9 741.0 and 741.9 | Shin, 2012 [[46](#_ENREF_46)]  1997-2003, USA | | 162/2259 | 92.8 (91.7-93.8) | | **―** | **―** | | **―** | **―** | **―** |
|  | 1983-1987 | |  | ***87.1*** | | ***84.5*** | ***82.7*** | | ***80.7*** | ***80.4*** | **―** |
|  | 1988-1992 | |  | ***90.4*** | | ***87.6*** | ***86.7*** | | ***85.7*** | **―** | **―** |
|  | 1993-1997 | |  | ***89.9*** | | ***88.2*** | ***87.2*** | | **―** | **―** | **―** |
|  | 1998-2003 | |  | ***92.8*** | | ***90.8*** | **―** | | **―** | **―** | **―** |
| Myelomeningocele and spinal meningocele | Sutton, 2008 [[44](#_ENREF_44)], Ireland | | /373 | 50.4 | | 47.3 | **―** | | **―** | **―** | **―** |
| Spina bifida  ICD-10 Q05 | Tennant, 2010 [[15](#_ENREF_15)], 1985-2003, Northern England | | 63/195 | 70.8 (63.8-76.6) | | 69.2 (62.2-75.2) | 68.7 (61.6-74.7) | | 68.7 (61.6-74.7) | 66.4 (58.9-72.9) | **―** |
| ICD-9 741.0, 741.9 | Wang, 2011 [[40](#_ENREF_40)]  1983-2006, USA | | 324/1999 | 88.5 (87.0–89.8) | | 86.4 (84.8-87.8) | **―** | | 83.8 (82.0-85.4) | **―** | 82.2 (80.1-84.0) |
| Spina bifida without anencephaly | Wang, 2015 [[41](#_ENREF_41)]  1999-2007, USA | | 318/3903 | 91.9 (90.9-92.7) | | **―** | 90.2 (89.0-91.2)d | | **―** | **―** | **―** |
|  | Wong, 2001 [[48](#_ENREF_48)], USA  1979-94 | | 45/235 | 87.2 (83.1-91.6) | | 83.8 (79.2-88.6) | 80.9 (75.8-86.3) | | 78.4 (72.4-84.7) | 78.4 (72.4-84.7)a | **―** |
|  | 1979-83 | |  | 83 (75-91) | | 82 (73-90) | 79 (71-88) | | **―** | 76 (68-86**)**a | **―** |
|  | 1984-88 | |  | 89 (92-96) | | 85 (78-93) | 81 (73-90) | | **―** | **―** | **―** |
|  | 1989-94 | |  | 91 (85-98) | | 84 (75-94) | **―** | | **―** | **―** | **―** |
| **Encephalocele** |  | |  |  | |  |  | |  |  |  |
|  | Siffel, 2003 [[47](#_ENREF_47)]  1979-98, USA | | 25/83 | 72.2 (62.6-81.9) | | 70.8 (60.9-80.7) | **―** | | **―** | 67.3 (55.7-78.8) | **―** |
|  | Sutton, 2008 [[44](#_ENREF_44)]  1976-87, Ireland | | /64 | 32.9 | | 27.3 |  | |  |  |  |
|  | Tennant, 2010 [[15](#_ENREF_15)], 1985-2003, Northern England | | 7/14 | 64.3 (34.3-83.3) | | 50.0 (22.9-72.2) | 50 (22.9-72.2) | | 50 (22.9-72.2) | **―** | **―** |
| ICD-9 742.0 | Wang, 2011 [[40](#_ENREF_40)]  1983-2006, USA | | 171/556 | 75.7 (71.9-79.1) | | 72.1 (68.1–75.6) | **―** | | 69.7 (65.6–73.4) | **―** | 67.2 (62.7–71.3) |
|  | Wang, 2015 [[41](#_ENREF_41)]  1999-2007, USA | | 254/909 | 72.1 (69.0-74.9) | | **―** | 69.9 (66.1-73.3)d | | **―** | **―** | **―** |
| **Hydrocephalus** |  | |  |  | |  |  | |  |  |  |
|  | Eide, 2006 [[8](#_ENREF_8)]  1967-79, Norway | | 29/59 | **―** | | **―** | **―** | | **―** | *50.8*a | **―** |
|  | Schneuer, 2019 [[42](#_ENREF_42)], 2004-2009  NSW, Australia | | 15/60 | 75.0 (64.0–86.0) | | 75.0 (64.0–86.0) | **―** | | **―** | **―** | **―** |
|  | Tennant, 2010 [[15](#_ENREF_15)], 1985-2003, Northern England | | 32/108 | 76.9 (67.8-83.7) | | 75.0 (65.7-82.1) | 71.2 (61.3-79.0) | | 69.8 (59.6-77.8) | 66.4 (54.5-75.9) | **―** |
| 742.3 | Wang, 2011 [[40](#_ENREF_40)]  1983-2006, USA | | 1314/5378 | 82.7 (81.6-83.7) | | 78.5 (77.4–79.6) | **―** | | 75.3 (74.1–76.5) | **―** | 73.4 (72.1–74.7) |
| **Orofacial clefts** | | |  |  | |  |  | |  |  |  |
| Cleft palate and cleft lip (749.0–749.9) | Agha, 2006 [[6](#_ENREF_6)]  1979-86, Canada | | 188/ | 90.2 | | 88.2 | **―** | | **―** | **―** | **―** |
| Orofacial clefts (749.0-749.9) | Bell, 2016 [[16](#_ENREF_16)]  1980-2010, W Australia | | 113/1509 | 92.5 *(91.0-93.8)* | | **―** | **―** | | **―** | **―** | **―** |
| Orofacial clefts | 1980-1992 | | 73/585 | **―** | | *87.5* *(84.5-90.0)* | **―** | | **―** | **―** | **―** |
| Cleft lip only (BPA-ICD9 -749.10–749.19) | 1980-2010 for 1 year, 1980-2007 for 5 yrs; 1980-1992 for 20 yrs | |  | 95.8 (all)  99.7 (isolated) | | *95.8* (all)  99.7 (isolated) | **―** | | **―** | 97.7 (all)  100.0 (isolated) | **―** |
| Cleft lip & palate (749.20–749.27, 749.29) | 1980-2010 for 1 year,  1980-2007 for 5 yrs, 1980-1992 for 20 yrs | |  | 91.2 (all)  99.1 (isolated) | | *99.1* (isolated) | **―** | | **―** | 84.5 (all);  98.0 (isolated) | **―** |
| Cleft palate (749.00–749.09) | 1980-2010 for 1 year, 1980-1992 for 20 yrs | |  | 91.7 (all)  99.2 (isolated | | **―** | **―** | | **―** | 83.5 (all);  97.2 (isolated) | **―** |
| Cleft lip with/without palate | Dastgiri, 2003 [[17](#_ENREF_17)], 1980-97, Scotland | | 5/278 | 98.2 (96.8-99.6)b | | 98.2 (96.6-99.8)b | **―** | | **―** | **―** | **―** |
| Cleft lip | Eide, 2006 [[8](#_ENREF_8)]  1967-79, Norway | | 6/250 | **―** | | **―** | **―** | | **―** | *97.6*a | **―** |
| Cleft palate |  | | 9/151 | **―** | | **―** | **―** | | **―** | *94.0*a | **―** |
| Cleft lip & palate |  | | 19/357 | **―** | | **―** | **―** | | **―** | *94.7*a | **―** |
| Orofacial clefts | Schneuer, 2019 [[42](#_ENREF_42)], 2004-2009  NSW, Australia | | 7/575 | 99.0 (98.1–99.8) | | 98.8 (97.9–99.7) | **―** | | **―** | **―** | **―** |
| Cleft lip & palate |  | | 0/188 | 100.0 | | 100.0 | **―** | | **―** | **―** | **―** |
| Orofacial clefts | Tennant, 2010 [[15](#_ENREF_15)], 1985-2003, Northern England | | 14/584 | 97.8 (96.2-98.7) | | 97.8 (96.2-98.7) | 97.6 (95.9-98.6) | | 97.6 (95.9-98.6) | 97.6 (95.9-98.6) | **―** |
| Cleft lip |  | | 1/140 | 99.3 (95.0-99.9) | | 99.3 (95.0-99.9) | 99.3 (95.0-99.9) | | 99.3 (95.0-99.9) | 99.3 (95.0-99.9) | **―** |
| Cleft lip & palate |  | | 5/227 | 98.2 (95.4-99.3) | | 98.2 (95.4-99.3) | 97.7 (94.6-99.1) | | 97.7 (94.6-99.1) | 97.7 (94.6-99.1) | **―** |
| Cleft palate |  | | 8/217 | 96.3 (92.8-98.1) | | 96.3 (92.8-98.1) | 96.3 (92.8-98.1) | | 96.3 (92.8-98.1) | 96.3 (92.8-98.1) | **―** |
| Cleft lip with or without cleft palate |  | | 6/367 | 98.6 (96.8-99.4) | | 98.6 (96.8-99.4) | 98.3 (96.3-99.2) | | 98.3 (96.3-99.2) | 98.3 (96.3-99.2 | **―** |
| Cleft palate without cleft lip (ICD-9 749.0) | Wang, 2011 [[40](#_ENREF_40)]  1983-2006, USA | | 410/3719 | 91.0 (90.0–91.8) | | 89.6 (88.6–90.6) | **―** | | 88.9 (87.8–89.9) | **―** | 88.3 (87.1-89.4) |
| Cleft lip with/without cleft palate (ICD-9 749.1-749.2) |  | | 454/4691 | 91.7 (90.9–92.5) | | 90.8 (89.9–91.6) | **―** | | 90.2 (89.3-91.0) | **―** | 90.0 (89.1-90.8) |
| Cleft palate without cleft lip | Wang, 2015 [[41](#_ENREF_41)]  1999-2007, USA | | 660/7356 | 91.0 (90.4-91.7) | | **―** | 90.3 (89.5-91.1)d | | **―** | **―** | **―** |
| Cleft lip with or without cleft palate |  | | 999/11862 | 91.6 (91.1-92.1) | | **―** | 90.8 (90.1-91.4)d | | **―** | **―** | **―** |
| **Digestive system anomalies** | | |  |  | |  |  | |  |  |  |
| **Oesophageal atresia** | | |  |  | |  |  | |  |  |  |
| ICD-9 code 750.3 | Cassina, 2016 [[50](#_ENREF_50)], 1981-2012 (all), NE Italy | | /330 | 88.4 (84.9-91.9) | | **―** | **―** | | **―** | **―** | 85.1 (80.8–89.4) |
|  | 1981-96 (isolated) | |  | ***96.1*** | | ***94.6*** | ***94.6*** | | ***90.6*** | ***90.6*** | ***90.6*** |
|  | 1997-2012 (isolated) | |  | ***95.3*** | | ***95.3*** | ***95.3*** | | ***95.3*** | **―** | **―** |
|  | 1981-96 (non-isolated) | |  | 63.0 (49.1–76.9)e | | ***58.7 (44.4–73.0)*** | 58.7 (44.4–73.0)e | | ***58.7 (44.4–73.0)*** | ***58.7 (44.4–73.0)*** | 58.7 (44.4–73.0) |
|  | 1997-2012 (non-isolated) | |  | 88.4 (82.7–94.1)e | | ***87.3 (81.2–93.4)*** | 87.3 (81.2–93.4)e | | ***87.3 (81.2–93.4)*** | **―** | **―** |
|  | Garne, 2002 [[51](#_ENREF_51)], Denmark | | 11/27 | ― | | 59.3 (*39.0-77.0*) | ― | | ― | ― | ― |
| ICD-7 756.21, ICD-8 750.20, 750.28, ICD-9 750D, ICD-10 Q39.0- Q39.2. | Oddsberg, 2012 [[9](#_ENREF_9)]  1964-2007, Sweden | | 227/1126 | *82.1* | | *80.7* | *80.6* | | *80.5* | *80.1* |  |
| 1964-69 | |  | *62.1* | | ***62.1*** | ***62.1*** | | ***62.1*** | ***58.5*** | ***58.5*** |
| 1970-79 | |  | ***77.2*** | | ***75.6*** | ***75.6*** | | ***75.2*** | ***75.2*** | ***75.2*** |
| 1980-89 | |  | *82.5* | | ***82.1*** | ***81.9*** | | ***81.9*** | ***80.5*** | ― |
|  | 1990-99 | |  | *86.1* | | ***85.1*** | ***85.1*** | | ***84.9*** | ― | ― |
|  | 2000-2007 | |  | ***87.8*** | | ***87.6*** | ― | | ― | ― | ― |
|  | Schneuer, 2019 [[42](#_ENREF_42)], 2004-2009  NSW, Australia | | 0/51 | 100.0 | | 100.0 | ― | | ― | ― | ― |
|  | Tennant, 2010 [[15](#_ENREF_15)], 1985-2003, Northern England | | 7/105 | 95.2 (88.9-98.0) | | 93.3 (86.5-96.8) | 93.3 (86.5-96.8) | | 93.3 (86.5-96.8) | 93.3 (86.5-96.8) | ― |
| ICD-9 750.3 | Wang, 2011 [[40](#_ENREF_40)]  1983-2006, USA | | 336/1580 | 81.5 (79.5–83.4) | | 79.5 (77.4–81.4) | ― | | 78.6 (76.4–80.5) | ― | 78.3 (76.1–80.3) |
|  | Wang, 2015 [[41](#_ENREF_41)]  1999-2007, USA | | 476/3084 | 84.6 (83.2-85.8) | | ― | 83.8 (82.1-85.2)d | | ― | ― | ― |
| **Anorectal malformations** | | |  |  | |  |  | |  |  |  |
| ICD-9/BPA 752.1-752.4, cloaca - 751.55 | Cassina, 2019 [[52](#_ENREF_52)], NE Italy, 1990-2012 | | /253 | 89.7 (85.2-92.9) | | ― | ― | | ― | 86.7 (81.6–90.4) | ― |
| **Anorectal atresia or stenosis** | | |  |  | |  |  | |  |  |  |
|  | Tennant, 2010 [[15](#_ENREF_15)], 1985-2003, Northern England | | 2/83 | 98.8 (91.8-99.8) | | 98.8 (91.8-99.8) | 98.8 (91.8-99.8) | | 96.6 (86.1-99.2) | 96.6 (86.1-99.2) | ― |
| ICD-9 751.2 | Wang, 2011 [[40](#_ENREF_40)]  1983-2006, USA | | 374/2654 | 87.7 (86.4–88.9) | | 86.5 (85.2–87.8) | ― | | 85.9 (84.5–87.2) | ― | 84.8 (83.1–86.4) |
|  | Wang, 2015 [[41](#_ENREF_41)]  1999-2007, USA | | 702/5400 | 87.0 (86.1-87.9) | | ― | 86.1 (85.0-87.2)d | | ― | ― | ― |
| **Hirschsprung disease** | | |  |  | |  |  | |  |  |  |
| ICD-7: 756.31, ICD-8: 751.39, ICD-9: 751D, ICD-10: Q431 | Löf Granström, 2017 [[24](#_ENREF_24)], 1964-2013, Sweden | | 22/739 | ***99.3 (98.7-99.8)*** | | ***98.3 (97.4-99.2)*** | ***98.3 (97.4-99.2)*** | | ***97.9 (96.9-99.0)*** | ***97.7 (96.5-98.8)*** | ***97.7 (96.5-98.8)*** |
|  | Schneuer, 2019 [[42](#_ENREF_42)], 2004-2009  NSW, Australia | | 5/90 | 96.7 (93.0–100) | | 94.4 (89.7–99.2) | ― | | ― | ― | ― |
|  | Tennant, 2010 [[15](#_ENREF_15)], 1985-2003, Northern England | | 4/61 | 93.4 (83.5-97.5) | | 93.4 (83.5-97.5) | 93.4 (83.5-97.5) | | 93.4 (83.5-97.5) | 93.4 (83.5-97.5) | ― |
| **Biliary atresia** |  | |  |  | |  |  | |  |  |  |
| **Overall survival** | | |  |  | |  |  | |  |  |  |
|  | Chardot, 2013 [[36](#_ENREF_36)], 1986-2009, France | | 228/1107 | **―** | | 80.8 (78.4-83.2) | 79.7 (77.2-82.2) | | 78.6 (75.9-81.3) | 77.6 (74.5-80.7) | **―** |
|  | 1986-96 | |  | **―** | | 72.1 (68.0-76.2) | **―** | | **―** | **―** | **―** |
|  | 1997-2002 | |  | **―** | | 88.0 (84.1-91.9) | **―** | | **―** | **―** | **―** |
|  | 2003-2009 | |  | **―** | | 88.5 (84.8-92.2) | **―** | | **―** | **―** | **―** |
|  | Davenport, 2011 [[37](#_ENREF_37)], 1999-2009, England &Wales | | 41/443 | **―** | | 90 (88-93) | 89 (86-93) | | **―** | **―** | **―** |
|  | De Carvalho, 2010 [[55](#_ENREF_55)], 1982-2008, Brazil | | 166/513 | **―** | | 67.6f | **―** | | **―** | **―** | **―** |
|  | De Vries, 2011 [[56](#_ENREF_56)], Netherlands | |  |  | |  |  | |  |  |  |
|  | 1977-1982 | | 32/49 | **―** | | **―** | **―** | | **―** | 34.7 (*22.1-49.7)* |  |
|  | 1983-1988 | | 27/55 | **―** | | **―** | **―** | | **―** | 50.9 (*37.2-64.5)* |  |
|  | Grizelj, 2010 [[57](#_ENREF_57)], 1992-2006, Croatia | | 7/29 | **―** | | *75.9 (56.1-89.0)* | *75.9 (56.1-89.0)* | | **―** | **―** | **―** |
|  | Lampela, 2012 [[60](#_ENREF_60)], 1987-2010, Finland | | 27/72 | **―** | | 62.5 (*50.3-73.4*)h | **―** | | **―** | **―** | **―** |
|  | Leonhardt, 2011 [[61](#_ENREF_61)], 2001-2005, Germany | | 31/183 | *81.9 (75.4-87.0)*k | | **―** | **―** | | **―** | **―** | **―** |
|  | McKiernan, 2000 [[39](#_ENREF_39)], 1993-95, UK & Ireland | | 14/93 | **―** | | 85.0 (77.7-92.3) | ― | | **―** | **―** | **―** |
|  | McKiernan, 2009 [[38](#_ENREF_38)], UK & Ireland | | 15/93 | ― | | ― | 83.8 (76.2-91.4)l | | **―** | **―** | **―** |
|  | Nio, 2003 [[62](#_ENREF_62)], Japan | |  |  | |  |  | |  |  |  |
|  | 1989 birth year | | 35/108 | **―** | | **―** | 66.7 | | **―** | **―** | **―** |
|  | 1989-94 | | 182/735 | **―** | | 75.3 | **―** | | **―** | **―** | **―** |
|  | Pakarinen, 2018 [[58](#_ENREF_58)], 2005-2016, Nordic countries | | 21/158 | **―** | | 87.3 (80.9-91.9) | 86.7 (80.2-91.4) | | **―** | **―** | **―** |
|  | Schreiber, 2007 [[63](#_ENREF_63)], Canada | |  |  | |  |  | |  |  |  |
|  | 1985-2002 | | 81/349 |  | | 77 (72-92)h | 75 (70-80) | | **―** | **―** | **―** |
|  | 1985-95 | | 55/199 |  | | 74 (67-79)h | **―** | | **―** | **―** | **―** |
|  | 1996-2002 | | 26/150 |  | | 82 (75-88)h | **―** | | **―** | **―** | **―** |
|  | Tennant, 2010 [[15](#_ENREF_15)], 1985-2003, Northern England | | 3/14 | 85.7 (53.9-96.2) | | 85.7 (53.9-96.2) | **―** | | **―** | **―** | **―** |
|  | Tu, 2015 [[59](#_ENREF_59)],  1989-2000, S Australia | | 13/29 | ― | | 89.7 (71.5-97.3) | ― | | ― | ― | ― |
|  | Wildhaber, 2008 [[64](#_ENREF_64)],1994-2004, Switzerland | | 4/48 | 91.5 (83.5-99.5)k | | 91.5 (83.5-99.5) | 91.5 (83.5-99.5) | | ― | ― | ― |
| **Biliary atresia** |  | |  |  | |  |  | |  |  |  |
| **Survival with native liver (NLS)** | | |  |  | |  |  | |  |  |  |
|  | Chardot, 2013 [[36](#_ENREF_36)], 1986-2009, France | | (99+542)g/  1035 | **―** | | 40.0 (36.9-43.1) | 35.8 (32.7-38.9) | | 32.1 (28.8-35.4) | 29.6 (25.7-33.5) | **―** |
|  | 1986-96 | |  | **―** | | 38.2 (32.9-43.5) | **―** | | **―** | **―** | **―** |
|  | 1997-2002 | |  | **―** | | 43.1 (37.0-49.2) | **―** | | **―** | **―** | **―** |
|  | 2003-2009 | |  | **―** | | 39.0 (32.5-45.5) | **―** | | **―** | **―** | **―** |
|  | Davenport, 2011 [[37](#_ENREF_37)], 1999-2009, England &Wales | | (24+179)g/  424 | **―** | | 46 (41-51) | 40 (34-46) | | **―** | **―** | **―** |
|  | De Carvalho, 2010 [[55](#_ENREF_55)], 1982-2008, Brazil | | (94+165)g/  392 | **―** | | 36.8h | **―** | | **―** | **―** | **―** |
|  | De Vries, 2011 [[56](#_ENREF_56)], Netherlands | | |  | |  |  | |  |  |  |
|  | 1977-1982 | | (31+8)g49 | **―** | | **―** | **―** | | **―** | 20.4 (*10.7-34.8*)g | **―** |
|  | 1983-1988 | | (21+16)g/55 | **―** | | **―** | **―** | | **―** | 32.7 *(21.0-46.8*)g | **―** |
|  | Grizelj, 2010 [[57](#_ENREF_57)], 1992-2006, Croatia | | (6+6)/28 | **―** | | 51.7 (40.6-62.8) | 38.8 (24.9–52.7) | | **―** | **―** | **―** |
|  | Lampela, 2012 [[60](#_ENREF_60)], 1987-2010, Finland | | (19+25)/72 | **―** | | 38.9 (*27.8-51.1*)h | **―** | | **―** | **―** | **―** |
|  | Leonhardt, 2011 [[61](#_ENREF_61)], 2001-2005, Germany | | (28+105)/167 | 20.4 *(14.7-27.4)*k | | **―** | **―** | | **―** | **―** | **―** |
|  | McKiernan, 2000 [[39](#_ENREF_39)], 1993-95, UK & Ireland | | (14+33)/93 | **―** | | *49.5 (39.0-60.0)* | **―** | | **―** | **―** | **―** |
|  | McKiernan, 2009 [[38](#_ENREF_38)], UK & Ireland | | (10+42)/93 | **―** | | **―** | 43.8 (33.3-54.1)l | | **―** | **―** | **―** |
|  | Nio, 2003 [[62](#_ENREF_62)], Japan | |  |  | |  |  | |  |  |  |
|  | 1989 birth year | | 51/108 | **―** | | **―** | 52.8 | | **―** | **―** | **―** |
|  | 1989-94 | | /735 | **―** | | 59.7 | **―** | | **―** | **―** | **―** |
|  | Pakarinen, 2018 [[58](#_ENREF_58)], 2005-2016, Nordic countries | | 72/154 | **―** | | 53 (45-62) | 45 (35-55) | | **―** | **―** | **―** |
|  | Schreiber, 2007 [[63](#_ENREF_63)], Canada | | (81+169/  349 |  | | 33 (28-38)h | 24 (19-29) | | **―** | **―** | **―** |
|  | 1985-95 | | (55+98)/  199 |  | | 31 (31-38)h | **―** | | **―** | **―** | **―** |
|  | 1996-2002 | | (26+71)/  150 |  | | 36 (28-45)h | **―** | | **―** | **―** | **―** |
|  | Tu, 2015 [[59](#_ENREF_59)],  1989-2000,  S Australia | |  | ― | | 55.2 (36.0-73.0) | ― | | ― | ― | ― |
|  | Wildhaber, 2008 [[64](#_ENREF_64)],1994-2004, Switzerland | | (4+27)/48 | 40.5 (26.0-55.0)k | | 32.7 (18.6-46.8) | ― | | ― | ― | ― |
| **Congenital diaphragmatic hernia (CDH)**o | | | |  | |  |  | |  |  |  |
| ICD-9 756.6, ICD-10 Q79.0 and Q79.1 | Burgos, 2017 [[23](#_ENREF_23)]  1987-2013  (all fatalities) | | 314/861 | *65.4 (62.1-68.5)* | | *63.5 (60.2-66.7)*m | **―** | | **―** | **―** | **―** |
|  | 1987-1999  (all fatalities) | | 210/480 |  | | *56.3 (51.7-60.7)*m | **―** | | **―** | **―** | **―** |
|  | 2000-2013  (all fatalities) | | 104/381 |  | | *72.7 (67.9-77.1)*m | **―** | | **―** | **―** | **―** |
|  | Garne, 2002 [[51](#_ENREF_51)]  1980-1993 | | 10/17 | **―** | | 41.2 (*19.4-66.5*) | **―** | | **―** | **―** | **―** |
|  | Gudbjartsson, 2008 [[53](#_ENREF_53)], 1983-2002, Iceland | | 8/23 | | **―** | *65.2 (42.8-82.8)*j | **―** | | **―** | **―** | **―** |
| BPA code 756.610 | Hinton, 2017 [[18](#_ENREF_18)], 1979-2003, USA | |  | |  |  |  | |  |  |  |
|  | Overall survival (up to 20 y, min 3 y for all cases) | | | | |  |  | |  |  |  |
|  | <1988 | | 22/37 | | **―** | **―** | 40.5 (23.4-57.6) | | **―** | ***40.5 (23.4-57.6)*** | **―** |
|  | ≥1988 | | 41/113 | | **―** | **―** | 58.3 (46.0-70.6) | | **―** | **―** | **―** |
|  | Jaillard, 2003 [[54](#_ENREF_54)], 1991-98, France | | 34/85 | | *60.0 (48.9-70.3*)j | **―** | **―** | | **―** | **―** | **―** |
|  | Schneuer, 2019 [[42](#_ENREF_42)], 2004-2009  NSW, Australia | | 24/90 | | 73.3 (64.2–82.5) | 73.3 (64.2–82.5) | **―** | | **―** | **―** | **―** |
|  | Tennant, 2010 [[15](#_ENREF_15)], 1985-2003, Northern England | | 69/161 | | 58.4 (50.4-65.6) | 57.1 (49.1-64.4) | 57.1 (49.1-64.4) | | 57.1 (49.1-64.4) | 57.1 (49.1-64.4) | **―** |
| ICD-9 756.6 | Wang, 2011 [[40](#_ENREF_40)]  1983-2006, USA | | 586/1541 | | 63.5 (61.0–65.8) | 62.6 (60.1–64.9) | **―** | | 62.1 (59.6-64.5) | **―** | 61.4 (58.8-63.8) |
|  | Wang, 2015 [[41](#_ENREF_41)]  1999-2007, USA | | 1017/3248 | | 68.7 (67.1-70.3) | **―** | 68.0 (66.0-69.9)d | | **―** | **―** | **―** |
| **Limb anomalies** | | |  |  | |  |  | |  |  |  |
| **Limb reduction defects** | | |  |  | |  |  | |  |  |  |
|  | | Schneuer, 2019 [[42](#_ENREF_42)], 2004-2009  NSW, Australia | 5/52 | 90.4 (82.4–98.4) | | 90.4 (82.4–98.4) | **―** | | **―** | **―** | **―** |
| **Upper limb reduction** | | |  |  | |  |  | |  |  |  |
|  | Tennant, 2010 [[15](#_ENREF_15)], 1985-2003, Northern England | | 1/111 | 100.0 | | 99.1 (93.8-99.9) | 99.1 (93.8-99.9) | | 99.1 (93.8-99.9) | 99.1 (93.8-99.9) | **―** |
| ICD-9 755.2 | Wang, 2011 [[40](#_ENREF_40)]  1983-2006, USA | | 199/1752 | 90.7 (89.2–92.0) | | 89.4 (87.9–90.8) | **―** | | 89.0 (87.4–90.4) | **―** | 87.7 (85.8–89.4) |
|  | Wang, 2015 [[41](#_ENREF_41)]  1999-2007, USA | | 387/3602 | 89.3 (88.2-90.2) | | **―** | 88.2 (86.9-89.4)d | | **―** | **―** | **―** |
| **Lower limb reduction** | | |  |  | |  |  | |  |  |  |
|  | Tennant, 2010 [[15](#_ENREF_15)], 1985-2003, Northern England | | 3/42 | 92.9 (79.5-97.6) | | 92.9 (79.5-97.6) | 92.9 (79.5-97.6) | | 92.9 (79.5-97.6) | 92.9 (79.5-97.6) | **―** |
| ICD-9 755.3 | Wang, 2011 [[40](#_ENREF_40)]  1983-2006, USA | | 136/1044 | 88.6 (86.5–90.4) | | 87.3 (85.2–89.2) | **―** | | 87.1 (84.9–89.0) | **―** | 86.7 (84.4–88.6) |
|  | Wang, 2015 [[41](#_ENREF_41)]  1999-2007, USA | | 219/1913 | 88.6 (87.0-89.9) | | **―** | 88.2 (86.4-89.8)d | | **―** | **―** | **―** |
| **Abdominal wall defects** | | |  |  | |  |  | |  |  |  |
| Abdominal wall defects | Eide, 2006 [[8](#_ENREF_8)]  1967-79, Norway | | 72/206 | **―** | | **―** | **―** | | **―** | *65.0*a | **―** |
|  | Schneuer, 2019 [[42](#_ENREF_42)], 2004-2009  NSW, Australia | | 14/139 | 90.6 (85.8–95.5) | | 89.9 (84.9–94.9) | **―** | | **―** | **―** | **―** |
| **Gastroschisis** |  | |  |  | |  |  | |  |  |  |
| surgical code DQ79.3, JAG10 | Risby, 2017 [[21](#_ENREF_21)]  1997-2009, S Denmark | | 7/71 | *93.0 (83.7-97.4)* | | *91.5 (81.9-96.5)* | **―** | | **―** | **―** | **―** |
|  | Schneuer, 2019 [[42](#_ENREF_42)], 2004-2009  NSW, Australia | | 9/109 | 91.7 (86.6–96.9) | | 91.7 (86.6–96.9) | **―** | | **―** | **―** | **―** |
|  | Tennant, 2010 [[15](#_ENREF_15)], 1985-2003, Northern England | | 12/190 | 93.7 (89.2-96.4) | | 93.7 (89.2-96.4) | 93.7 (89.2-96.4) | | 93.7 (89.2-96.4) | 93.7 (89.2-96.4) | **―** |
| ICD-9 756.73 | Wang, 2011 [[40](#_ENREF_40)]  1983-2006, USA | | 116/777 | 87.8 (85.3–89.9) | | 85.5 (82.8–87.8) | **―** | | 84.8 (82.0–87.2) | **―** | 81.7 (74.0–87.3) |
|  | Wang, 2015 [[41](#_ENREF_41)]  1999-2007, USA | | 266/3698 | 92.8 (91.9-93.6) | | **―** | 92.1 (91.0-93.2)d | | **―** | **―** | **―** |
| **Omphalocele** |  | |  |  | |  |  | |  |  |  |
|  | Tennant, 2010 [[15](#_ENREF_15)], 1985-2003, Northern England | | 6/47 | 87.2 (73.8-94.1) | | 87.2 (73.8-94.1) | 87.2 (73.8-94.1) | | 87.2 (73.8-94.1) | 87.2 (73.8-94.1) | **―** |
| ICD-9 756.72 | Wang, 2011 [[40](#_ENREF_40)]  1983-2006, USA | | 200/639 | 69.5 (65.8–72.9) | | 68.8 (65.1-72.3) | **―** | | 68.6 (64.9-72.1) | **―** | 68.6 (64.9-72.1) |
|  | Wang, 2015 [[41](#_ENREF_41)]  1999-2007, USA | | 367/1281 | 71.4 (68.8-73.7) | | **―** | 71.2 (68.0-74.1)d | | **―** | **―** | **―** |
| **Urinary system anomalies** | | |  |  | |  |  | |  |  |  |
| ICD-9 753.0–753.9 | Agha, 2006 [[6](#_ENREF_6)]  1979-86, Canada | | 451/ | 68.8 | | 67.2 | **―** | | **―** | **―** | **―** |
|  | Dastgiri, 2003 [[17](#_ENREF_17)], 1980-1997, Scotland | | 69/618 | 89.0 | | 88.8 | **―** | | **―** | **―** | **―** |
| Bilateral renal agenesis | Schneuer, 2019 [[42](#_ENREF_42)], 2004-2009  NSW, Australia | | 5/5 | 0.0 | | **―** | **―** | | **―** | **―** | **―** |
| Cystic kidney disease |  | | 9/83 | 89.2 (82.5–95.8) | | 89.2 (82.5–95.8) | **―** | | **―** | **―** | **―** |
| ICD-10 Q60-Q64 | Tennant, 2010 [[15](#_ENREF_15)], 1985-2003, Northern England | | 84/1258 | 93.9 (92.4-95.1) | | 93.5 (86.6-94.2) | 93.4 (91.9-94.6) | | 93.2 (91.6-94.5) | 93.2 (91.6-94.5) | **―** |
| Bilateral renal agenesis |  | | 21/21 | 0.0 | | **―** | **―** | | **―** | **―** | **―** |
| Cystic kidney disease |  | | 20/225 | 92.0 (87.6-94.9) | | 91.1 (86.6-94.2) | 91.1 (86.6-94.2) | | 91.1 (86.6-94.2) | 91.1 (86.6-94.2) | **―** |
| Renal agenesis or dysgenesis – ICD-9 753.0 | Wang, 2011 [[40](#_ENREF_40)]  1983-2006, USA | | 693/1946 | 66.1 (63.9–68.1) | | 64.8 (62.6–66.9) | **―** | | 64.2 (62.0–66.3) | **―** | 63.8 (61.6–66.0) |
| **Down syndrome** | | |  |  | |  |  | |  |  |  |
| 759.3 (ICD-8), 758.0 (ICD-9) and Q90.0, Q90.1, Q90.2 or Q90.9 (ICD-10). | Brodwall, 2018 [[22](#_ENREF_22)], 1994-2009, Norway | | 78/1251 | 96.3 | | 94.2 | **―** | | **―** | **―** | **―** |
| 1994-1999 | |  | 94.2b | | 91.8e | **―** | | **―** | **―** | **―** |
| 2000-2009 | |  | 97.5b | | 95.8e | **―** | | **―** | **―** | **―** |
| 758.0 (ICD-9) | Chua, 2020 [[71](#_ENREF_71)], 1995-2014, Hong Kong | | 83/1010 | 94.4 *(92.7-95.7)* | | *91.8*b *(89.9-93.4)* | **―** | | **―** | **―** | **―** |
|  | Dastgiri, 2003 [[17](#_ENREF_17)], 1980-1997, Scotland | | 33/210 | 87.1 (82.6-91.7)b | | 84.3 (78.3-90.3)b | **―** | | **―** | **―** | **―** |
|  | Frid, 1999 [[65](#_ENREF_65)]  1973-1980, Sweden | | 54/213 | 85.4 (*79.8-89.8*) | | ***77.4*** | 76.5 (*70.1-81.9*) | | 74.6 (*68.2-80.2*) i |  |  |
|  | Glasson, 2016 [[66](#_ENREF_66)], 1953-2010, W Australia | | 245/1378 | **―** | | 88 (86-90) | 87 (85-89 | | **―** | **―** | 83 (80-85) – at 30 years |
|  | 1980-2010 | | 78/772 |  | |  |  | |  |  |  |
|  | 1980-1990 | |  | 93 (89-96) | | 86 (81-89) | 85 (80-89) | |  | 84 (79-88) | 82 (77-87) |
|  | 1991-2000 | |  | 97 (94-99) | | 96 (92-98) | 95 (91-97) | |  | 94 (90-96) | 94 (90-96) |
|  | 2001-2010 | |  | 96 (92-98) | | 94 (90-96) | 94 (90-96) | | 94 (90-96) | 94 (90-96) | 94 (90-96) |
|  | Halliday, 2009 [[67](#_ENREF_67)], Australia | |  |  | |  |  | |  |  |  |
|  | 1988-90 | | 25/236 | *94.1* | | 89.4 | **―** | | **―** | **―** | **―** |
|  | 1998-2000 | | 10/165 | *94.5* | | 93.9 | **―** | | **―** | **―** | **―** |
|  | Hayes, 1997 [[68](#_ENREF_68)]  1980-89, Ireland | | 63/389 | 88.2 (85-91) | | ***83 (79-87)*** | 83 (79-87) | | **―** | **―** | **―** |
|  | 1980-84 | |  | 87 | | 82 | **―** | | **―** | **―** | **―** |
|  | 1985-89 | |  | 90 | | 86 | **―** | | **―** | **―** | **―** |
| BPA codes, or both BPA and ICD-9-CM, or ICD9-CM only (N Carolina and Colorado) | Kucik, 2013 [[19](#_ENREF_19)]  1983-2003 (20-year survival), USA | | 1584/16506 | 92.9 (92.5-93.2) | | 91.0(90.5-91.4) | 90.7 (90.2-91.1) | | **―** | 88.1 (87.0-89.0) | **―** |
| 1983-89 (20-year survival) | | 334/2454 | 91.3 (90.0–92.4) | | 88.1 (86.8–89.3) | 87.4 (86.0–88.6) | | **―** | 85.7 (84.1–87.1) | **―** |
| 1990-96 (10-year survival) | | 624/5441 | 91.2 (90.5–92.0) | | 89.2 (88.3–90.0) | 88.4 (87.6–89.3) | | **―** | **―** | **―** |
|  | 1997-2003 (5-year survival) | | 608/8611 | 94.3 (93.8–94.8) | | 92.5 (91.9–93.0) | **―** | | **―** | **―** | **―** |
|  | Leonard, 2000 [[69](#_ENREF_69)], 1980-96, W Australia | | /440 | 91.7 (88.7-94.0) | | 87.0 (83.0-89.0) | 85.0 (81.0-89.0) | | **―** | **―** | **―** |
|  | 1980-85 | |  | 89 | | 80 (72-86)e | 79 | | **―** | **―** | **―** |
|  | 1986-90 | |  | 92 | | 86 (79-91)e | 85 | | **―** | **―** | **―** |
|  | 1991-96 | |  | 94 | | 93 (88-96)e | **―** | | **―** | **―** | **―** |
| Q900-Q902 | Rankin, 2012 [[14](#_ENREF_14)],  Northern England  1985–1990 | | 54/235 | 86.0 (80.8–89.8) | | 79.2 (73.4–83.8) | 78.3 (72.5–83.0) | | **―** | 77.5 (71.6–82.3) | **―** |
|  | 1991–1996 | | 36/193 | 83.9 (78.0–88.4) | | 82.4 (76.2–87.1) | 81.9 (75.7–86.6) | | **―** | 80.6 | **―** |
|  | 1997–2003 | | 21/241 | 94.2 (90.4–96.5) | | 91.7 (87.4–94.6) | 91.2 (86.8–94.2) | | **―** | 90.7 | **―** |
| ICD-9-CM (758.000-758.090) | Rasmussen, 2006 [[70](#_ENREF_70)], 1979-98, USA | | 70/645 | 92.9 (90.9-94.9) | | ***89.9 (87.3-92.1)*** | 88.6 (85.0-92.2**)** | | **―** | 87.4 (84.3-90.5) | **―** |
|  | Schneuer, 2019 [[42](#_ENREF_42)], 2004-2009  NSW, Australia | | 30/425 | 94.1 (91.9–96.4) | | 92.9 (90.5–95.4) | **―** | | **―** | **―** | **―** |
| ICD-9 758.0 | Wang, 2011 [[40](#_ENREF_40)]  1983-2006, USA | | 754/6819 | 92.0 (91.3-92.6) | | 89.9 (89.1-90.6) | **―** | | 88.9 (88.1-89.7) | **―** | 87.5 (86.5-88.5) |
|  | Wang, 2015 [[41](#_ENREF_41)]  1999-2007, USA | | 944/15,939 | |  | | --- | | 94.1 (93.7-94.4) | | | **―** | 92.8 (92.3-93.2)d | | **―** | **―** | **―** |
| **Trisomy 13** |  | |  |  | |  |  | |  |  |  |
|  | Meyer, 2016 [[72](#_ENREF_72)]  1999-2007, USA | | 625/693 | 11.5 (9.3-14.1) | | 9.7 (7.2-12.5) | **―** | | **―** | **―** | **―** |
| ICD-9, 758.1 or ICD-10, Q91.4-Q91.7 | Nelson, 2016 [[25](#_ENREF_25)]  1991-2012, Canada | | /174 | 19.8 (14.2-26.1) | | 15 (10-21) | 12.9 (8.4-18.5) | | **―** | **―** | **―** |
|  | Tennant, 2010 [[15](#_ENREF_15)], 1985-2003. Northern England | | 26/29 | 13.8 (4.4-28.6) | | **―** o | **―** | | **―** | **―** | **―** |
| ICD-9 758.1 | Wang, 2011 [[40](#_ENREF_40)]  1983-2006, USA | | 437/525 | 21.3 (17.9-24.9) | | 18.4 (15.3–21.9) | **―** | | 16.2 (13.0–19.7) |  | 15.2 (12.0–18.8) |
| **Trisomy 18** |  | |  |  | |  |  | |  |  |  |
|  | Meyer, 2016 [[72](#_ENREF_72)]  1999-2007, USA | | 984/1,113 | 13.4 (11.5-15.5) | | 12.3 (10.1-14.8) | **―** | | **―** | **―** | **―** |
| ICD-9, 758.2 or ICD-10, Q91.0-Q91.3 | Nelson, 2016 [[25](#_ENREF_25)]  1991-2012, Canada | | /254 | 12.6 (8.9-17.1) | | 11 (8-16) | 9.8 (6.4-14.0) | |  |  |  |
|  | Schneuer, 2019 [[42](#_ENREF_42)], 2004-2009  NSW, Australia | | 28/34 | 20.6 (7.0–34.2) | | 17.6 (4.8–30.5) | **―** | | **―** | **―** | **―** |
|  | Tennant, 2010 [[15](#_ENREF_15)], 1985-2003, Northern England | | 62/63 | 1.6 (0.1-7.5) | | **―** o | **―** | | **―** | **―** | **―** |
| ICD-9 758.2 | Wang, 2011 [[40](#_ENREF_40)]  1983-2006, USA | | 667/773 | 18.8 (16.1-21.6) | | 15.2 (12.8-17.8) | **―** | | 13.2 (10.9–15.8) | **―** | 12.3 (9.8–15.1) |
| **Skeletal dysplasia** | | |  | : | |  |  | |  |  |  |
| Osteogenesis Imperfecta  ICD-10 Q78.0 | Folkestad, 2016 [[13](#_ENREF_13)], 1977-2012, Denmark | | 24/366 (up to 20 years) | *94.8 (91.8-96.8)* | | *94.8 (91.8-96.8)* | **―** | | **―** | *91.6 (88.2-94.2)* | **―** |
| Skeletal dysplasia | Schneuer, 2019 [[42](#_ENREF_42)], 2004-2009  NSW, Australia | | 15/75 | 80.0 (70.9–89.1) | | 80.0 (70.9–89.1) | **―** | | **―** | **―** | **―** |
| Achondroplasia  BPA code 756.430 | Simmons, 2014 [[20](#_ENREF_20)], 1996-2005, USA | | 4/106 | *96.2 (90.1-98.8)* | | *96.2 (90.1-98.8)*k | **―** | | **―** | **―** | **―** |
| Achondroplasia/Hypochondroplasia | Tennant, 2010 [[15](#_ENREF_15)], 1983-2003, Northern England | | 2/22 | 95.5 (71.9-99.4) | | 90.9 (68.3-97.7) | 90.9 (68.3-97.7) | | 90.9 (68.3-97.7) | **―** | **―** |
| **Prader-Willi syndrome** | | |  |  | |  |  | |  |  |  |
|  | Lionti, 2012 [[73](#_ENREF_73)]  1950-2010, Australia | | 15/163 (to 35 years) | ***98.6 (95.2-99.7)*** | | ***98.6 (95.2-99.7)*** | 97 (93-99) | | ***96.3 (91.1-98.4)*** | 94 (88-97) | ***89.4 (80.8-94.5*** |
| ICD-10 Q87.1 | Tennant, 2010 [[15](#_ENREF_15)], 1983-2003, Northern England | | 1/10 | 100.0 | | 90.0 (47.3-98.5) | 90.0 (47.3-98.5) | | **―** | **―** | **―** |

**Note:**

Congenital anomaly subtypes were presented within the major congenital anomaly groups according to the EUROCAT classification [[26](#_ENREF_26)].

Estimates (or 95% CI) in italics were not reported in the article but were estimated from the raw data provided and in italics and bold were extracted from Kaplan-Meier or actuarial survival curves. For calculation of 95% CIs, we used the efficient-score method (corrected for continuity) described by Newcombe, 1998,[[29](#_ENREF_29)] based on the procedure outlined by Wilson, 1927 [[30](#_ENREF_30)].

a18-year survival values; bProvided by authors on request or confirmed by authors; csurvival at ≥5 years reported; d8-year survival values; e*p* values <0.05; foverall survival reported, including all deaths (also without operation or liver transplantation), without specifying age at survival; gdeaths and secondary liver transplantation used in calculation of native liver survival; h4-year survival values; i14.5-year survival values; j3-year survival values, k2-year survival values, l13-year survival values; moverall survival (beyond one year of age) for all live births reported;  nthis article (Rankin, 2012 [[14](#_ENREF_14)]) was included despite being a subset of the larger study analysing all types of congenital anomalies (Tennant et al [[15](#_ENREF_15)]) because it reported survival by year period and explored predictors of survival. To avoid duplication in reporting, survival for Down syndrome from Tennant et al [[15](#_ENREF_15)] was included neither in the tables of this review nor in the meta-analysis; o survival not reported as <5 cases at risk at the end of the time period.

CA, major congenital anomaly; KP, Kasai hepatoportoenterostomy; LT, liver transplantation; NLS, native liver survival, NSW, New South Wales.

# Table 3. Predicted survival estimates for children born with selected congenital anomalies in 2000 and 2020 (results of the meta-analysis).

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Congenital anomaly subtype (n of studies)** | **Survival period** | **Survival estimates for cases born in 2000 (%)** | **Survival estimates for cases born in 2020 (%)** | | **Trend in survival over time** | |
| **Relative Odds**  **(95% CI)** | **P value** |
| **Spina Bifida (n=7)** |  |  |  | | 1.34 (1.24-1.46)\* | <0.001 |
|  | 1 year | 88 (87-89) | 93 (91-94) | |  |  |
|  | 5years | 87 (86-88) | 92 (90-94) | |  |  |
|  | 10years | 86 (84-87) | 91 (89-93) | |  |  |
|  | 20 years | 82 (80-85) | 89 (86-92) | |  |  |
|  | 25 years | 81 (77-83) | 88 (84-91) | |  |  |
| **Encephalocele (n=4)** |  |  |  | | 0.98 (0.95-1.01)\* | 0.19 |
|  | 1 year | 73 (73-74) | 73 (71-74) | |  |  |
|  | 5 years | 73 (73-74) | 72 (71-74) | |  |  |
|  | 10 years | 73 (72-74) | 72 (70-74) | |  |  |
|  | 20 years | 72 (71-73) | 71 (69-74) | |  |  |
|  | 25 years | 72 (71-73) | 71 (68-74) | |  |  |
| **Oesophageal atresia (n=7)** |  |  |  | | 1.50 (1.38-1.62)\* | <0.001 |
|  | 1 year | 86 (85-87) | 93 (92-94) | |  |  |
|  | 5 years | 86 (85-87) | 93 (91-94) | |  |  |
|  | 10 years | 85 (84-87) | 93 (91-94) | |  |  |
|  | 20 years | 85 (82-87) | 92 (90-94) | |  |  |
|  | 25 years | 84 (82-87) | 92 (89-94) | |  |  |
| **Biliary atresia (n=14)** |  |  |  | |  |  |
| **Overall survival** |  |  |  | | 1.62 (1.28-2.05)\* | <0.001 |
|  | 1 year | 87 (85-90) | 95 (90-97) | |  |  |
|  | 5 years | 85 (81-89) | 94 (87-97) | |  |  |
|  | 10 years | 82 (74-87) | 92 (83-97) | |  |  |
|  | 20 years | 73 (59-84) | 88 (70-96) | |  |  |
| **Survival with native liver** |  |  |  | | 0.96 (0.88-1.03)\* | 0.26 |
|  | 1 year | 44 (41-47) | 41 (35-48) | |  |  |
|  | 5 years | 43 (38-47) | 41 (33-49) | |  |  |
|  | 10 years | 42 (36-48) | 40 (30-50) | |  |  |
|  | 20 years | 40 (31-50) | 38 (26-52) | |  |  |
| **Congenital diaphragmatic hernia (n=9)** | |  |  | | 1.57 (1.37-1.81)\* | <0.001 |
|  | 1 year | 67 (66-69) | 84 (78-88) | |  |  |
|  | 5 years | 67 (65-69) | 83 (78-88) | |  |  |
|  | 10 years | 67 (64-69) | 83 (77-88) | |  |  |
|  | 20 years | 66 (63-69) | 83 (76-88) | |  |  |
|  | 25 years | 66 (62-69) | 83 (75-88) | |  |  |
| **Gastroschisis (n=5)** |  |  | | |  |  |
|  | 1 year | 90 (90-91) | | 94 (90-96) | 1.24 (1.02-1.50)\* | 0.029 |
|  | 5 years | 90 (89-91) | | 93 (89-96) |  |  |
|  | 10 years | 89 (87-91) | | 93 (88-96) |  |  |
|  | 20 years | 88 (84-90) | | 92 (85-95) |  |  |
| **Down syndrome (n=10)** |  |  |  | |  |  |
| **with CHD** |  |  |  | | 1.99 (1.67-2.37)\* | < 0.001 |
|  | 1 year | 92 (91-93) | 98 (97-99) | |  |  |
|  | 5 years | 90 (88-92) | 97 (95-99) | |  |  |
|  | 10 years | 88 (84-92) | 97 (93-98) | |  |  |
|  | 20 years | 87 (76-93) | 96 (90-99) | |  |  |
| **without CHD** |  |  |  | | 1.17 (0.91-1.5)\* | 0.23 |
|  | 1 year | 97 (96-98) | 98 (95-99) | |  |  |
|  | 5 years | 96 (95-98) | 97 (94-99) | |  |  |
|  | 10 years | 96 (92-98) | 97 (91-99) | |  |  |
|  | 20 years | 95 (85-98) | 96 (82-99) | |  |  |
| **Trisomy 18 (n=4)** | |  |  | | Not Tested |  |
|  | 1 year | 15 (14-17) | | |  |  |
|  | 5 years | 14 (12-16) | | |  |  |
|  | 10 years | 13 (11-16) | | |  |  |

\*per 10-year increase compared to any previous birth cohort

CHD, congenital heart defect.

# Table 4. Risk of death in children born with a congenital anomaly (CA) compared to the reference population.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Study** | **Congenital anomaly group/subtype** | **Length of survival for prediction analysis** | **Presence of congenital anomaly** | **Unadjusted**  **OR/HR/RR/SMR**  **survival (95% CI)** | **Adjusted**  **HR (95% CI)** | **Factors adjusted for** |
| Agha, 2006 [[6](#_ENREF_6)] | All CAs | 10 years for all, up to 17 years for birth year 1979 | Yes | RR  12.9 (12.1-13.7) | **―** | **―** |
| Berger, 2003 [[7](#_ENREF_7)] | All CAs | 7 years | Yes | HR  7.2 (6.9-7.6)c | aHR  6.9 (6.6-7.3)c | Race, sex, mother’s age, mother’s education |
| Eide, 2006 [[8](#_ENREF_8)]\* | All CAs | 18 years | Yes | RR  6.7 (6.3-7.1) | **―** | **―** |
|  | Spina bifida | 18 years | Yes | 26.4 (21.9-31.8) | **―** | **―** |
|  | Cleft lip | 18 years | Yes | 1.3 (0.6-2.8) | **―** | **―** |
|  | Clef palate | 18 years | Yes | 3.2 (1.7-6.0) | **―** | **―** |
|  | Cleft lip & palate | 18 years | Yes | 2.8 (1.8-4.4) | **―** | **―** |
|  | Abdominal wall defect | 18 years | Yes | 18.6 (15.4-22.4) | **―** | **―** |
|  | Multiple | 18 years | Yes | 24.0 (21.7-26.5) | **―** | **―** |
| Bell, 2016 [[16](#_ENREF_16)] | Cleft lip only(isolated) | 1 year | Yes | OR  0.56 (0.08-4.12) | **―** | **―** |
|  | Cleft palate only (isolated) | 1 year | Yes | OR  1.50 (0.45-4.96) | **―** | **―** |
|  | Cleft lip and palate (isolated) | 1 year | Yes | OR  1.37 (0.41-4.52) | **―** | **―** |
| Folkestad, 2016 [[13](#_ENREF_13)] | Osteogenesis imperfecta | 18 years | Yes | HR  66.1 (15.7-278.7) | aHR  68.1 (16.2-287.3) | Co-morbidity |
| Löf Granström, 2017 [[24](#_ENREF_24)] | Hirschsprung disease | 50 years | Yes | HR  4.77 (2.87-7.91) | aHR  3.6 (2.04-6.37) | Down syndrome |
| Oddsberg, 2012 [[9](#_ENREF_9)] | Oesophageal atresia | 40 years | Yes | SMR  11.8 (10.3-13.5) | **―** | Matched with the background population by calendar year, sex and age |

\*Selected anomalies only are presented

aHR, adjusted Hazard Ratio; CA, congenital; anomaly; HR, Hazard Ratio; OR, odds ratio, RR, relative risk; SMR, standardised mortality ratio

# Table 5. Predictors of survival/mortality in the included studies that explored factors associated with long-term survival at different age points beyond 1 year of life

| **Study** | **Congenital anomaly (CA) group/subtype** | **Risk factor category** | **Unadjusted**  **OR/HR/RR/survival rate (95% CI)** | **Adjusted**  **HR/OR/RR (95% CI)** | **Factors adjusted for** |
| --- | --- | --- | --- | --- | --- |
| **Presence of additional anomalies (isolated vs non-isolated)** | | |  |  |  |
| Agha, 2006 [[6](#_ENREF_6)] | All CAs | Number of anomalies  1  2  3  ≥4 | n/a | 10-year aRR  1.0 (ref)  3.3 (3.1-3.7)  6.8 (6.2-7.6)  13.8 (12.7–15.0) | Gestational age, birthweight, maternal age, number of previous stillbirths |
| Wang, 2011 [[40](#_ENREF_40)] | All CAs\* | Isolated  Non-isolated | n/a | 25-year aHR  1.0 (ref)  2.8 (2.7-3.0)c | Infant sex, birth weight, gestational age, plurality, number of CAs, parity, maternal ethnicity, nativity and education, birth year period |
| Shin, 2012 [[46](#_ENREF_46)] | Spina bifida | Presence of major CHD  No | 1-year survival  81.9 (75.4-86.8)  93.8 (92.6-94.7)f | 8-year aHRa  1500-2499g group:  2.6 (1.3-5.0)c  ≥2500g: 3.6 (2.1-6.1)c  1.0 (ref) | Ethnicity, birth cohort |
| Wong, 2001 [[48](#_ENREF_48)] | Spina bifida | Multiple defects  No | 18-year survival  59.0 (42-84)  81.9 (76-88)d | aHR not reported  NS (Yes vs No) | Maternal ethnicity, birth weight, location of the lesion |
| Siffel, 2003 [[47](#_ENREF_47)] | Encephalocele | Isolated  Non-isolated | 20-year HR  1.0 (ref)  3.8 (1.7-8.6)e | 20-year aHR  1.0 (ref)  2.8 (1.2-6.7)c | Birth weight, race, birth cohort, gestational age |
| Cassina, 2016 [[50](#_ENREF_50)] | Oesophageal atresia | Isolated  Non-isolated | 25-year survival  91.8 (86.9-96.7c  79.2 (72.9-85.5) | 25-year aHR  1.0 (ref)  2.8 (1.3-6.0)d | Birth period, birth weight |
| Oddsberg, 2012 [[9](#_ENREF_9)] | Oesophageal atresia | Any CA  Circulatory CA  Non-circulatory CA  None | 40-year HR  4.7 (3.5–6.3)  5.4 (3.9–7.5)  4.2 (3.0–5.8)  1.0 (ref) | 40-year aHR  4.9 (3.7–6.6)  5.6 (4.0–7.8)  4.5 (3.2–6.2)  1.0 (ref) | Sex, birth weight, birth year period |
| Cassina, 2019 [[52](#_ENREF_52)] | Anorectal malformations | ≥2 associated CAs  No | HR  7.9 (2.2-27.8)d  1.0 (ref) | n/a | n/a |
| Chardot, 2013 [[36](#_ENREF_36)] | Biliary atresia | BASM  No | 20-year NLS  15.1% (SE=4.6%)  31.2% (SE=2.3%)f | RR for 20-year NLS  1.0 (ref)  0.59 (0.45-0.78)e | Anatomical type, age at Kasai operation |
| Hinton, 2017 [[18](#_ENREF_18)] | Congenital diaphragmatic hernia (CDH) | Non-isolated Isolated | 20-year HR  2.08 (1.24–3.48)  1.0 (ref) | 20-year aHR  2.06 (1.22–3.49)  1.0 (ref) | Treatment era, neighbourhood poverty |
| Brodwall, 2018 [[22](#_ENREF_22)] | Down syndrome | Down syndrome (no additional CAs)  ECM, CHD or a combination | n/a | 5-year aHR  1.0 (ref)  Ranging from 2.6 (0.6-12) for ECM to 28 (8.9-88) for conotruncal CHD and ECM | Year of birth |
| Chua, 2020 [[71](#_ENREF_71)], Hong Kong | Down syndrome | CHD present  No | n/a | 5-year aHR  1.9 (1.2 -3.0)c  1.0 (ref) | Age and sex |
| Glasson, 2016 [[66](#_ENREF_66)] | Down syndrome | CHD present  No | 25-year HR  2.9 (1.7-4.9)e  1.0 (ref) | 25-year aHR  3.1 (1.8-5.3)e  1.0 (ref) | Sex, aboriginality, birth cohort |
| Hayes, 1997 [[68](#_ENREF_68)] | Down syndrome | No  CAVD present | 10-yr survival  90%  58% | RR  1.0 (ref)  5.6 (3.2-9.7)e | Leukaemia (only significant variables in the bivariate model, i.e CAVD and leukaemia were included in the in the Cox proportional hazards model) |
| Kucik, 2013 [[19](#_ENREF_19)] | Down syndrome | CHD present  No | n/a | 20-year aHR  2.7 (2.4–3.0)c  1.0 (ref) | Race/ethnicity, birth weight, maternal age and education, birth period, and region of birth |
| Leonard, 2000 [[69](#_ENREF_69)] | Down syndrome | CHD present  No | 10-year HR  3.4 (2.0-5.9)  1.0 (ref) | 10-year aHR  3.7 (2.1-6.7)d  1.0 (ref) | Aboriginality, birth weight, maternal age, sex, birth cohort |
| Rankin, 2012 [[14](#_ENREF_14)] | Down syndrome | None  CHD only  Digestive only  CHD and digestive only  Other(s) | 1.0 (ref)  3.8 (2.4-6.0)e  5.1 (2.1-12.4)  8.8 (3.3-18.0)e  3.5 (1.2-10.0)c | 20-year aHR  1.0 (ref)  5.0 (3.1-8.1)e  6.5 (2.6 (16.1)e  7.8 (3.8-16.4)e  5.1 (1.7-15.1)d | Birth year, maternal age, gestational age, IMD, karyotype, plurality, infant sex, birth weight |
| Schneuer, 2019 [[42](#_ENREF_42)] | Down syndrome | None  CHD | 5-year survival  93.7 ( 90.5–96.9)  92.0 ( 88.3–95.8)g | n/a | n/a |
| Meyer, 2016 [[72](#_ENREF_72)] | Trisomy 18 | CHD  No  Omphalocele  No | 1-year survival  5.7 (3.0-9.6)g  15.0 (12.8-17.4)  3.2 (1.4-13.0)c  13.8 (11.8-16.0) | 5-year aHR  1.3 (1.1-1.6)c  1.0 (ref)  1.6 (1.1-2.3)c  1.0 (ref) | Gestational age, maternal ethnicity, plurality, sex, presence of omphalocele, State, geographical area  Same confounders, except for presence of CHD instead of omphalocele |
| **Birth year** |  |  |  |  |  |
| Wang, 2011 [[40](#_ENREF_40)] | All CAs\* | 1982-1988  1989-1994  1995-2000  2001-2006a | n/a | 25-year aHR  1.8 (1.6-1.9)c  1.5 (1.4-1.6)c  1.3 (1.2-1.4)c  1.0 (ref) | Infant sex, birth weight, gestational age, plurality, number of CAs, parity, maternal age, ethnicity, nativity and education. |
| Borgstedt-Bakke, 2017 [[45](#_ENREF_45)] | Myelomeningocele | Time trend 1990-2015 vs 1970-1979 and 1980-1989 | HR (overall risk of death up to 25 years)  0.7 (0.5-1.0), *p*=0.05 | n/a | n/a |
| Shin, 2012 [[46](#_ENREF_46)] | Spina bifida | Birth year  (1979-2003) | n/a | 8-year aHR  NS for any BW groups | Ethnicity, presence of CHD |
| Siffel, 2003 [[47](#_ENREF_47)] | Encephalocele | 1989-98  1979-88  1989-98 | 20-year HR  0.5 (0.2-1.2)g  1.0 (ref) | 20-year aHR  0.4 (0.2-1.0)  1.0 (ref)  0.3 (0.01-0.9)c (for <2500g);  NS for ≥2500) | Birth weight, race, gestational age, presence of associated CAs |
| Cassina, 2016 [[50](#_ENREF_50)] | Oesophageal atresia | 1997+  Before 1997 | 10-year survival (non-isolated only)  87.3 (81.2–93.4)d  58.7 (44.4-73.0) | 25-year aHR  1.0 (ref)  2.4 (1.3-4.8)d | Birth weight, presence of additional anomalies |
| Oddsberg, 2012 [[9](#_ENREF_9)] | Oesophageal atresia | 1964-69  1970-79  1980-89  1990-99  2000-2007 | n/a | aHR (risk of death up to 40 years)  4.6 (2.3–9.2)  3.1 (2.0–4.7)  2.1 (1.4–3.2)  1.2 (0.8–1.8)  1.0 (ref) | Sex, additional anomalies, birth weight |
| Cassina, 2019 [[52](#_ENREF_52)] | Anorectal malformations | 1990-1999  2000-2012 | 4.7 (1.8-11.8)d  1.0 (ref) | ― | ― |
| Löf Granström, 2017 [[24](#_ENREF_24)] | Hirschsprung disease | 1964-80  1981-2000  2001-2013 | 50-year OR  1.0 (ref)  0.6 (0.1-4.2)g  0.4 (0.1-3.3)g | n/a | n/a |
| Hinton, 2017 [[18](#_ENREF_18)] | CDH | <1988  ≥1988 | 20-year HR  1.9 (1.3–3.3)  1.0 (ref) | 20-year aHR  2.1 (1.3–3.6)  1.0 (ref) | Neighbourhood poverty, presence of additional CAs |
| Chua, 2020 [[71](#_ENREF_71)], Hong Kong | Down syndrome | 1995-1999  2000-2004  2005-2009  2010-2014 | n/a | 5-year aHR  1.0 (ref)  0.4 (0.2-0.8)c  0.5 (0.3-1.0)c  0.5 (0.3-1.0)g | Age and sex |
| Glasson, 2016 [[66](#_ENREF_66)] | Down syndrome | 1980-1990  1991-2000  2001-2010 | 25-year HR  2.9 (1.7-5.2)e  0.9 (0.5-1.9)g  1.0 (ref) | 25-year aHR  2.9 (1.6-5.2)e  0.7 (0.4-1.5)g  1.0 (ref) | Sex, aboriginality, presence of a CVD |
| Kucik, 2013 [[19](#_ENREF_19)] | Down syndrome | 1983-1989  1990-1996  1997-2003 | n/a | 20-year aHR  1.0 (ref)  0.6 (0.5–0.8)c  0.5 (0.4–0.7)c | Race/ethnicity, birth weight, maternal age and education, presence of a CHD and region of birth |
| Leonard, 2000 [[69](#_ENREF_69)] | Down syndrome | 1991-96  1983-89 | 10-year HR  0.4 (0.2-0.8)d  1.0 (ref) | 10-year aHR  0.3 (0.2-0.7)d  1.0 (ref) | Aboriginality, birth weight, presence of CHD, maternal age group, sex |
| Rankin, 2012 [[14](#_ENREF_14)] | Down syndrome | Continuous (between 1985-2003) | 20-year HR  0.93 (0.89–0.96)e | 20-year aHR  0.89 (0.85–0.92)e | Presence of additional structural anomalies, gestational age, maternal age, birth weight, karyotype, IMD, plurality, infant sex |
| **Low birth weight (LBW) or small for gestational age (SGA)** | | |  |  |  |
| Agha, 2006 [[6](#_ENREF_6)] | All CAs | ≤2500g  2501-3000g  3001-4000g  >4000g | n/a | 10-year aRR  2.2 (2.0-2.4)c  1.0 (ref)  0.6 (0.5-0.7)  0.5 (0.4-0.6) | Gestational age, number of birth defects, maternal age, number of previous stillbirths |
| Wang, 2011 [[40](#_ENREF_40)] | All CAs\* | ≥37, <1500  ≥37, 1500-2499  ≥37, 2500-3999  ≥37, ≥4000 | n/a | 25-year aHR  4.4 (3.7-5.2)c  2.9 (2.7-3.1)c  1.0 (ref)  0.7 (0.6-0.8)g | Infant sex, plurality, number of CAs, parity, maternal age, ethnicity, nativity and education, birth year period |
| Nembhard, 2010 [[43](#_ENREF_43)] | All CAs | AGA  SGA  LGA | 5-year HR  1.0 (ref)  2.6 (2.4-2.8)f  0.6 (0.5-0.7) f | 5-year aHR  1.0 (ref)  2.1 (1.9-2.2)f  0.6 (0.5-0.7)f | Maternal age, maternal education, infant sex, border county, and number of birth defects |
| Wong, 2001 [[48](#_ENREF_48)] | Spina bifida | <1500  1500-2499  ≥2500  <2500  ≥2500 | Survival at <18 years  33.3 (15-74)  68.2 (53-88)  82.8 (77-90) | 18-year aHR  2.3 (1.1-4.9)c  1.0 (ref) | Maternal ethnicity, location of the lesion, presence of multiple defects |
| Siffel, 2003 [[47](#_ENREF_47)] | Encephalocele | <2500g  ≥2500g | 20-year HR  6.3 (2.7-14.4)f  1.0 (ref) | 20-year aHR  5.2 (2.7-12.6)f  1.0 (ref) | Race, birth cohort, gestational age, presence of associated CAs |
| Cassina, 2016 [[50](#_ENREF_50)] | Oesophageal atresia | <2500  ≥2500 | n/a | 25-year aHR  3.7 (1.7-8.3)d  1.0 (ref) | Birth period, presence of additional anomalies |
| Oddsberg, 2012 [[9](#_ENREF_9)] | Oesophageal atresia | <1500  ≥1500 | n/a | 40-year aHR  7.0 (4.9-10.1)c  1.0 (ref) | Sex, additional anomalies, birth year period |
| Cassina, 2019 [[52](#_ENREF_52)] | Anorectal malformations | <2500g  ≥2500g | 6.4 (2.3-17.9)e  1.0 (ref) | ― | ― |
| Chua, 2020 [[71](#_ENREF_71)], Hong Kong | Down syndrome | <2500g  ≥2500g | n/a | 5-year aHR  2.4 (1.2 -4.8)c  1.0 (ref) | Age and sex |
| Glasson, 2016 [[66](#_ENREF_66)] | Down syndrome | <2500  ≥2500 | 25-year HR  2.3 (1.4-3.7)e  1.0 (ref) | 25-year aHR  1.8 (1.0-3.1)c  1.0 (ref) | Sex, birth cohort, aboriginality, presence of a CHD |
| Kucik, 2013 [[19](#_ENREF_19)] | Down syndrome | <1500  1500-2499  ≥2500 | n/a | 20-year aHR  8.5 (7.3–9.8)c  1.8 (1.6–2.0)c  1.0 (ref) | Race/ethnicity, maternal age and education, presence of a CHD, birth period, and region of birth |
| Leonard, 2000 [[69](#_ENREF_69)] | Down syndrome | <2500  ≥2500 | 10-year HR  2.3 (1.4-4.0)d  1.0 (ref) | 10-year aHR  2.2 (1.2-3.7)d  1.0 (ref) | Aboriginality, presence of CHD, maternal age group, sex, birth cohort |
| Rankin, 2012 [[14](#_ENREF_14)] | Down syndrome | Continuous  BW z-score | 20-year HR  0.88 (0.77–1.0) | 20-year aHR  0.81 (0.71–0.91) | Presence of additional structural anomalies, birth year, maternal age, gestational age, birth year, karyotype, IMD, plurality, infant sex |
| **Gestational age (GA)** | |  |  |  |  |
| Agha, 2006 [[6](#_ENREF_6)] | All CAs | ≤37 weeks  38-40 weeks  >40 weeks | n/a | 10-year aRR  1.1 (0.99-1.2)  1.0 (ref)  1.2 (1.1-1.3) | Number of birth defects, birthweight, maternal age, number of previous stillbirths |
| Nembhard, 2010 [[43](#_ENREF_43)] | All CAs | ≥37 weeks  <37 weeks | 5-year HR  1.0 (ref)  3.0 (2.8-3.2)f | 5-year aHR  1.0 (ref)  2.7 (2.5-2.9)f | Maternal age, maternal education, infant sex, border county, and number of birth defects |
| Schneuer, 2019 [[42](#_ENREF_42)] | All CAs | ≥37 weeks  <37 weeks | 5-year survival  95.6 (95.3-96.3)  79.4 (77.5–81.4)e | n/a | n/a |
| Wang, 2011 [[40](#_ENREF_40)] | All CAs\* | <37 w, <1500  <37 w, 1500-2499  <37w, 2500-3999  ≥37 w, 2500-3999 | n/a | 25-year aHR  4.9 (4.6-5.2)c  2.7 (2.6-2.9)c  1.5 (1.4-1.6)c  1.0 (ref) | Infant sex, plurality, number of CAs, parity, maternal age, ethnicity, nativity and education, birth year period |
| Siffel, 2003 [[47](#_ENREF_47)] | Encephalocele | <37 weeks  ≥37 weeks | 20-year HR  4.7 (2.1-10.5)f  1.0 (ref) | n/a | n/a |
| Glasson, 2016 [[66](#_ENREF_66)] | Down syndrome | <37 weeks  ≥37 weeks | 25-year HR  2.4 (1.5-3.7e  1.0 (ref) | 25-year aHR  1.9 (1.1-3.3)c  1.0 (ref) | Sex, birth cohort, aboriginality, presence of a CHD |
| Rankin, 2012 [[14](#_ENREF_14)] | Down syndrome | Continuous (weeks) | 20-year HR  0.80 (0.76–0.84)e | 20-year aHR  0.76 (0.72–0.80)e | Presence of additional structural anomalies, birth year, maternal age, birth weight, karyotype, IMD, plurality, infant sex |
| Meyer, 2016 [[72](#_ENREF_72)] | Trisomy 18 | <32 weeks  32-36 weeks  ≥37 weeks | 1-yr survival  4.9 (2.5-8.4)e  9.4 (6.3-13.2)  17.2 (14.3-20.3) | 5-year aHR  2.7 (2.2-3.4)c  1.5 (1.2-1.8)c  1.0 (ref) | Sex, maternal ethnicity, plurality, presence of CHD, presence of omphalocele, State, geographical area |
| Meyer, 2016 [[72](#_ENREF_72)] | Trisomy 13 | <32 weeks  32-36 weeks  ≥37 weeks | 1-yr survival  6.6 (3.1-11.9)e  8.1 (5.0-12.1)  15.2 (11.6-19.2) | 5-year aHR  1.9 (1.5-2.5)c  1.3 (1.0-1.6)  1.0 (ref) | Sex, maternal ethnicity, State, geographical area |
| **Ethnicity** |  |  |  |  |  |
| Berger, 2003 [[7](#_ENREF_7)] | All CAs | White  Black | 7-year HR  1.0 (ref)  1.5 (1.4-1.6)c | 7-year aHR  1.0 (ref)  1.0 (0.9-1.1)g | Birth weight, sex, mother’s age, mother’s education, number of organ systems affected |
| Wang, 2011 [[40](#_ENREF_40)] | All CAs | Maternal nativity  US born  Other | n/a | 25- year aHR  1.0 (ref)  1.1 (1.03-1.15)c | Infant sex, birth weight, gestational age, plurality, number of CAs, parity, maternal age, ethnicity and education, birth year period |
| Nembhard, 2010 [[43](#_ENREF_43)] | All CAs | NHW  NHB  Hispanic | 5-year HR  1.0 (ref)  1.3 (1.6-1.9)f  1.4 (1.3-1.5)c | 5-year aHR  1.0 (ref)  1.5(1.4-1.7)f  1.1 (1.01-1.2) | Maternal age, maternal education, infant sex, border county, and number of birth defects |
| Wong, 2001 [[48](#_ENREF_48)] | Spina bifida | White  Black  Other | Survival at <18 years (%)  82.8 (76-90)  67.1 (56-81)c  87.5 (63-100) | aHR not reported  NS (Black vs White) - | Birth weight, presence of multiple defects, location of the lesion o |
| Wang, 2015 [[41](#_ENREF_41)] | Spina bifida, encephalocele, limb deficiencies, gastroschisis, omphalocele | NHB  Hispanic  A/PI  AI/AN  NHW | n/a | 8-year aHR  NS  NS  NS  NS  Ref | Birth weight and gestational age, maternal age, birth period, and state surveillance program |
|  | Cleft palate, cleft lip with/w/o cleft palate, esophageal atresia, rectal atresia/stenosis | NHB  Hispanic  A/PI  AI/AN  NHW | n/a | P<0.05  P<0.05  NS  NS  Ref | Birth weight and gestational age, maternal age, birth period, and state surveillance program |
|  | CDH; Down syndrome | NHB  Hispanic  A/PI  AI/AN  NHW | n/a | 1.4c  NS  NS  NS  Ref | Birth weight and gestational age, maternal age, birth period, and state surveillance program |
| Shin, 2012 [[46](#_ENREF_46)] | Spina bifida | White  Black  Hispanic | 1-year survival  94.1 (92.6-95.4)  87.8 (82.5-91.6)c  92.2 (90.3-93.8) | 8-year aHR   1. (ref)   NS for any BW groupsg  3.7 (1.8-7.8)c for 1500-2499g group, NS for other BW groups | Birth year, presence of CHD |
| Siffel, 2003 [[47](#_ENREF_47)] | Encephalocele | Black  Other | 20-year HR  2.7 (1.1-6.5)c  1.0 (ref) | 20-year aHR  2.4 (0.95-5.9)g  1.0 (ref) | Birth weight, birth cohort, gestational age, presence of associated CAs |
| Glasson, 2016 [[66](#_ENREF_66)] | Down syndrome | Aboriginal  Non-aboriginal | 25-year HR  1.6 (0.7-3.8)g  1.0 (ref) | 25-year aHR  1.1 (0.5-2.7)g  1.0 (ref) | Sex, birth cohort, presence of a CHD |
| Leonard, 2000 [[69](#_ENREF_69)] | Down syndrome | Aboriginal  Non-aboriginal | 10-year HR  3.2 (1.4-7.4)d  1.0 (ref) | 10-year aHR  3.2 (1.3-7.9)d  1.0 (ref) | Presence of CHD, birth weight, maternal age, sex, birth cohort |
| Kucik, 2013 [[19](#_ENREF_19)] | Down syndrome | White  Black  Hispanic  Other | n/a | 1-5-year aHR  1.0 (ref)  1.4 (1.0–1.6)  0.8 (0.7–0.9)c  1.3 (1.1–1.6)c | Birth weight, maternal age and education, presence of a CHD, birth period, and region of birth. |
| Meyer, 2016 [[72](#_ENREF_72)] | Trisomy 18 | NH White  NH Black  Hispanic  NH Asian/PI  Other/unknown | 1-year survival  13.6 (10.7-16.9)  17.3 (12.5-22.7)c  10.1 (7.3-13.5)  13.2 (4.8-25.8)  23.3 (10.3-39.4) | 5-year aHR  1.0 (ref)  0.7 (0.6-0.9)c  0.9 (0.8-1.1)  0.8 (0.5-1.2)  1.0 (0.6-1.7) | Gestational age, plurality, sex, presence of CHD, presence of omphalocele, State, geographical area |
| **Maternal age (years)** | |  |  |  |  |
| Agha, 2006 [[6](#_ENREF_6)] | All CAs | ≤20  21-34  ≥35 | n/a | 10-year aRR  1.2 (1.03-1.3)c  1.0 (ref)  0.9 (0.8-1.1 | Number of birth defects, gestational age, birthweight, number of previous stillbirths |
| Wang, 2011 [[40](#_ENREF_40)] | All CAs | ≤19  20-24  25-29  30-34  ≥35 | n/a | 25-year aHR  1.2 (1.1-1.3)c  1.1 (1.03-1.2)c  1.05 (1.0-1.1)g  1.0 (ref)  1.0 (0.9-1.0)g | Infant sex, birth weight, gestational age, plurality, number of CAs, parity, maternal ethnicity, nativity and education, birth year period |
| Leonard, 2000 [[69](#_ENREF_69)] | Down syndrome | <20  ≥20 | 10-year HR  2.8 (1.1-7.1)c  1.0 (ref) | 10-year aHR  2.4 (0.9-6.1)g  1.0 (ref) | Aboriginality, presence of CHD, ex, birth cohort, birth weight |
| Rankin, 2012 [[14](#_ENREF_14)] | Down syndrome | <20  20-30  >30 | 20-year HR  1.25 (0.63-2.49)  1.0 (ref)  0.91 (0.61-1.36)g | 20-year aHR  0.67 (0.32-1.40)  1.0 (ref)  1.08 (0.71-1.64)g | Presence of additional structural anomalies, birth year, birth weight, gestational age, karyotype, IMD, plurality, infant sex |
| **Centre annual caseload (biliary atresia studies)** | | |  |  |  |
| Chardot, 2013 [[36](#_ENREF_36)] | Biliary atresia | 1986-1996c  ≥20  3 to5  ≤2  1997-2002  2003-2009 | 5-year overall survival  77.6 (72.1-83.1)  61.9 (51.1-72.7)  69.6 (62.5-76.7)  NS  NS | n/a | n/a |
| Leonhardt, 2011 [[61](#_ENREF_61)] | Biliary atresia | <5  ≥5 | 2-yr NLS  7.7%  26.4%d | n/a | n/a |
| McKiernan, 2000 [[39](#_ENREF_39)] | Biliary atresia | <5  >5  >5 | 5-year RR  1.0 (ref)  0.32 (0.11-0.94) (overall survival)  0.48 (0.28-0.86) (NLS) | The only significant factor, RR not reported | Age at surgery, sex, gestational age, presence of BASM |
| McKiernan, 2009 [[38](#_ENREF_38)] | Biliary atresia | <5  >5  <5  >5 | Overall 13-year survival  75% (61.6–89.4)  89.5% (81.3–97.7)g  13-year NLS (%)  27.3 (12.3-42.3)  54.0 (40.8-67.2)d | n/a | n/a |
| Pakarinen, 2018 [[58](#_ENREF_58)] | Biliary atresia | >3  <3 | 5-year NLS  66 (54-77)d  44 (32-56) | aHR for 5-year NLS  3.5 (1.8-6.8)e  1.0 (ref) | Presence of associated CAs, age at surgery, sex, anatomical type of BA, presence of BASM, clearance of jaundice, European ethnicity |
| **Age at KP for NLS (biliary atresia studies)** | |  |  |  |  |
| Chardot, 2013 [[36](#_ENREF_36)] | Biliary atresia | ≤30 days  31-60 days  61-90 days  >90 days | 20-year survival  38.9% ((SE=7.5%)d  31.7% (SE=3.4%)  28.1% (SE=3.1%)  18.7% (SE=4.8%) | RR for 20-year NLS  0.54 (0.37-0.79)f  0.58 (0.45-0.75)  0.74 (0.37-0.79)  1.0 (ref) | Anatomical type, presence of BASM |
| Davenport, 2011 [[37](#_ENREF_37)] | Biliary atresia | <44 days  44-55  56-69  70+ | NS for 10-yr NLS  Overall *- p*=0.34 or between two most different (<44 and 44-55) groups: *p*=0.15 | n/a | n/a |
| De Carvalho, 2010 [[55](#_ENREF_55)] | Biliary atresia | ≤60 days  61-90  >90 | HR for 4-year NLS  1.0 (ref)  1.6 (1.2-2.3)d  1.9 (1.3-2.7)d | n/a | n/a |
| De Vries, 2011 [[56](#_ENREF_56)] | Biliary atresia | <45 days  45-60  60-75  >75 | 20-year NLS survival  14±9%g (vs 45-60 or 60-75 days)  33±8%g (vs 60-75)  42±10%c (vs >75)  11±6% | n/a | n/a |
| Pakarinen, 2018 [[58](#_ENREF_58)] | Biliary atresia | < 65  >65 | 5-year NLS  66 (55-78)d  44 (32-56) | 5-year aHR  1.5 (0.8-2.9)g  1.0 (ref) | Presence of associated CAs; sex; anatomical type of BA, presence of BASM, clearance of jaundice, European ethnicity, centre caseload |
| Schreiber, 2007 [[63](#_ENREF_63)] | Biliary atresia | ≤30  31-90  >90 | 4-year NLS  49 (26-69)f  36 (28-43)  23 (12-37) | n/a | n/a |
| Wildhaber, 2008 [[64](#_ENREF_64)] | Biliary atresia | ≤45  46-75  >75 | 4-year NLS (%, ±SE)  75% ±15.3%  33.3% ± 10.3%  11.3% ± 10.6% | n/a | n/a |

**Note:**

Only factors examined in ≥3 studies are included, n=33 studies).

\*The association with the reported factors was also significant for the following congenital anomaly groups: central nervous system, orofacial clefts, gastrointestinal, genitourinary, musculo-skeletal, and chromosomal anomalies, but was not reported for specific congenital anomaly subtypes.

aOnly predictors with significant results in either unadjusted or adjusted analysis are shown.

bConotruncal defects include Tetralogy of Fallot, double outlet right ventricle, conotruncal ventricular septal defects, aortic hypoplasia, truncus arteriosus and interrupted aortic arch;

cp<0.05 (also for those significant associations where the exact p value not reported), dp<0.01, ep<0.001, fp<0.0001, gnot significant (p≥0.05)

hcentre where the child was primarily treated

iTreatment eras are before 1988 (routine immediate surgical repair), and post-1988 (preoperative stabilization, delayed surgical repair, and addition of lung-sparing strategies).

AGA, appropriate for gestational age; aHR, adjusted Hazard Ratio; A/PI, Asian/Pacific Islander; AI/AN, American Indian/Alaska Native; BASM, biliary atresia splenic malformation syndrome; CAVD, complete atrio-ventricular defect; CHD, Congenital heart defect; ECM, extracardiac malformations; HR, Hazard Ratio; IMD, Index of Multiple Deprivation; KP, Kasai hepatoportoenterostomy; LBW, low birth weight (<2500g); LGA, large for gestational age; NH, Non-Hispanic; NHB, Non-Hispanic Black; NHW, Non-Hispanic White; NLS, native liver survival; NS, not significant (results not reported); OR, odds ratio; RR, relative risk; SGA, small for gestational age.