

Very young and advanced maternal age strongly elevates the occurrence of nonchromosomal congenital anomalies: a systematic review and meta-analysis of population-based studies

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Introduction

Congenital anomalies are structural or functional abnormalities that occur during intrauterine life and can be

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Ethical approval: No ethical approval was required for this systematic review with meta-analysis, as all data were already published in peer-reviewed journals. No patients were involved in the design, conduct or interpretation of our study.

The datasets used in this study can be found in the full-text articles included in the systematic review and meta-analysis.

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BACKGROUND: Nonchromosomal congenital anomalies (NCAs) are the most common cause of infant mortality and morbidity. The role of maternal age is well known, although the specifics are not thoroughly elucidated in the literature.

OBJECTIVE: To evaluate the role of maternal age in the incidence of NCAs and to pinpoint age groups at higher risk to refine screening protocols.

STUDY DESIGN: A systematic review and meta-analysis were conducted following the PRISMA 2020 guidelines and *Cochrane Handbook*. Searches were performed on October 19, 2021, across MEDLINE (via PubMed), Cochrane Library (CENTRAL), and Embase. Population-based studies assessing the impact of maternal age on the incidence of NCAs in pregnant women were included, without restrictions on age range, country, or comorbidities. A random-effects model was used for pooling effect sizes, considering the heterogeneity across studies.

RESULTS: From 15,547 studies, 72 were synthesized. Maternal age >35 showed an increased NCA risk (risk ratio [RR]: 1.31, confidence interval [CI]: 1.07 -1.61), rising notably after >40 (RR: 1.44, CI: 1.25 -1.66). The latter changes to 1.25 (CI: 1.08 -1.46) if the co-occurrence of chromosomal aberrations is excluded. Specific anomalies like cleft lip/palate (>40, RR: 1.57, CI: 1.11 -2.20) and circulatory system defects (>40, RR: 1.94, CI: 1.28 -2.93) were significantly associated with advanced maternal age. Conversely, gastroschisis was linked to mothers <20 (RR: 3.08, CI: 2.74 -3.47).

CONCLUSION: The study confirms that both very young and advanced maternal ages significantly increase the risk of NCAs. There is a pressing need for age-specific prenatal screening protocols to better detect these anomalies, especially considering the current trend of delayed childbearing. Further research is required to fully understand the impact of maternal age on the prevalence of rarer NCAs.

Key words: aging, congenital abnormalities, maternal age, nonchromosomal anomalies, pregnancy, screening

identified intrauterinely, at birth, or, less often, only during infancy.¹ Congenital anomalies are the most common cause of infant mortality and morbidity, accounting for the loss of 25.3 to 38.8 million disability-adjusted life years worldwide.² According to data provided by the World Health Organization, 6% of babies are born with a congenital anomaly.³ Maternal age is included among the many known

risk factors, and the significance of advanced maternal age (AMA) (≥ 35) particularly appears to be supported.

Over the last few decades, there has been an increasing trend in women's average delivery age.⁴ An increasing portion of couples are having their first child over the maternal age of 30 to 35 years.⁵ Many studies have associated the postponement of childbearing with various pregnancy and fetal complications^{6–8} and made

AJOG at a Glance

Why was this study conducted?

This study was conducted to investigate how maternal age affects the risk of nonchromosomal congenital anomalies by analyzing data from numerous population-based studies.

Key findings

Very young and advanced maternal ages are linked to a higher incidence of these anomalies. Specifically, risks increase significantly for those over 40 years old, with elevated risks for conditions affecting the circulatory system and cleft lip/palate, and for those under 20, with a notable rise in gastroschisis cases.

What does this add to what is known?

First in-depth meta-analysis of the age dependence of the risk of nonchromosomal congenital anomalies by anomaly category. This highlights the necessity for age-specific prenatal screening protocols to better detect congenital anomalies.

recommendations on managing these high-risk pregnancies.⁹ Among congenital anomalies, chromosomal abnormalities (CAs) are clearly associated with AMA,^{10–13} a long-established fact that has led to the current professional screening protocols that are widely used worldwide and constantly evolving.^{14,15} However, the etiology of nonchromosomal congenital anomalies (NCAs) is far from being fully understood. While the role of maternal age in the development of NCAs is well known and is the subject of active research, the literature is inconsistent in its assessment of the risk of NCAs in different age groups. This is a major issue not only because of the trend towards delayed childbearing but also because of the emerging risks of adolescent pregnancies.

Objective

Considering the disagreement in the literature, we aimed to investigate the role of maternal age in the occurrence of NCAs in a meta-analysis. There are currently no meta-analyses or other comprehensive studies that specifically and exclusively examine the association of NCAs with maternal age. We hypothesized that both very young and AMAs increase the risk of NCAs. We aimed to identify high-risk age groups to improve screening protocols and reach a better detection rate for NCAs.

Methods

We reported our systematic review and meta-analysis based on the recommendation of the PRISMA 2020 guideline¹⁶ (see [Supplemental Table 1](#)), and we followed the Cochrane Handbook for Systematic Reviews of Interventions.¹⁷ The protocol of the study was prospectively registered on International Prospective Register of Systematic Reviews¹⁸ (registration number CRD42021283593), and we adhered to it, with some deviations: title adjustment for clarity and summary purposes; subgroup analyses were conducted but not prespecified; searches included screening reference lists of eligible articles; only population-based studies with exact NCA counts were included to enable risk assessment; risk ratios (RRs) were used instead of odds ratios for ease of interpretation; publication bias assessed only visually. However, these modifications are fundamentally technical in nature and do not alter the conceptual framework of the study.

Information sources

The systematic search was conducted in 3 comprehensive medical databases: MEDLINE (via PubMed), the Cochrane Library (CENTRAL), and Embase on October 19, 2021.

Search strategy

We used for the systematic search the following search key: (“maternal age” OR “maternal ages” OR “mother age” OR “mother ages”) AND (((congenital OR birth) AND (anomaly OR anomalies OR disorder OR disorders OR malformation OR malformations OR defect OR defects)) OR congenital abnormalities. No language restrictions or filters were applied during the search. We also screened the reference list of eligible articles.

Eligibility criteria

We formulated our research question using the population, exposure, comparator, outcome framework. We included population-based studies reporting on pregnant women (P). We did not have predefined exclusion criteria (eg, age range, country, comorbidities) for our population. Eligible studies compared different maternal age groups (E and C) regarding NCAs. We examined every predefined age group reported by the eligible studies. Our primary outcome (O) was the rate of total NCAs, while we considered as secondary outcomes the various structural defects regarding different organ systems (eg, congenital heart defects [CHDs]) and common birth defects separately. We did not have predefined diagnostic criteria for the NCAs. Studies not reporting on the exact number of NCAs in the different age groups and the total number of patients were not eligible. The following exclusion criteria were predefined: CAs as target outcomes; case-control or cohort studies; case series; and case reports, because our concept was to analyze relative frequency.

Study selection

After removing duplicates, the selection was performed independently by 3 review authors (B.P., F.I., and Z.B.), first by title, then by abstract, and finally based on full text according to the aforementioned criteria. Endnote v20 (Clarivate Analytics, Philadelphia, PA) reference manager software was used for the selection. We calculated Cohen's kappa coefficient (κ) after each selection

process to measure interrater reliability.¹⁹ Disagreements were resolved by consensus; if consensus was not reached, a final decision was made with involvement from a fourth independent review author (S.V.). The study selection process is shown using PRISMA 2020 flowchart (Figure 1).

Data extraction

Three authors (B.P., F.I., and Z.B.) independently collected data from the eligible articles. In the case of disagreement, the decision was based on consensus. If consensus was not reached, a final decision was made by involving a fourth author (S.V.).

The following data were extracted with a standardized collection method to an Excel sheet (Office 365, Microsoft, Redmond, WA): first author, the year of publication, study population, study period, study site (country), study design, demographic data of the patients, total number of patients in the age groups, number of NCAs in the age

groups, and information for assessing the risk of bias in the studies.

We extracted the total number of live births and events involving birth defects from each study. To investigate which maternal age increases the probability of particular birth defects, we used the age categories from the included studies or defined new ones by merging 2 or more age groups. The age group of 20- to 30-year-old mothers was used as a reference group. In defining the age groups, the ideal 10-year period was based on other studies, including our own work.²⁰ We aimed to look at AMA (35 or older), as commonly defined; very young mothers (under 20); and mothers over 40. In addition, between 30 and 40 years of age, we created additional groupings with a 5-year split to investigate at which stage the risk increase occurs for each anomaly. We only included studies for each outcome in the analysis if the reference and at least 1 more age category could be formed. For maximum accuracy, we grouped the endpoints

according to the International Classification of Diseases-10 (ICD-10) categories.

Assessment of risk of bias

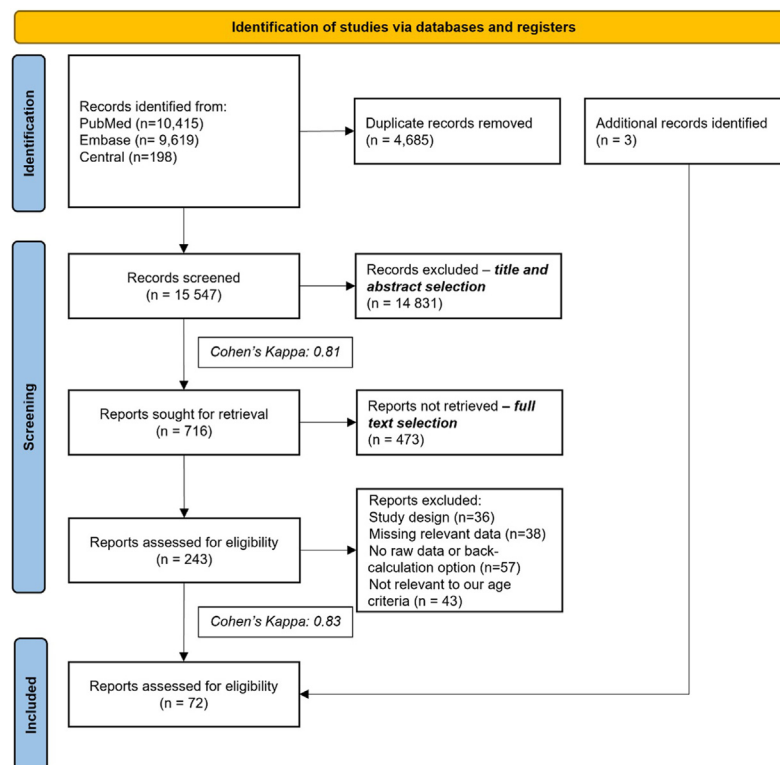
Two authors (B.P., Á.M.) performed the risk of bias assessment independently with the help of the Quality in Prognostic Studies tool.²¹ Disagreements were resolved by a third review author (S.V.) (Supplementary Table 3). The specific methodological details are described in Supplemental Appendix 1. The web-based version of the Risk-of-Bias VISualization tool was used to visualization of the results (Supplementary Table 4).²²

Data synthesis

We carried out a mathematical synthesis if there were at least 3 homogenous articles regarding the age groups and NCAs.

All statistical analyses were made with R²³ using the meta (Schwarzer 2022, v5.5.0; University of Freiburg, Freiburg, Germany) and dmetar (Cuijpers

FIGURE 1
PRISMA 2020 flowchart representing the study selection process



[Amsterdam, Netherlands], Furukawa [Tokyo, Japan], and Ebert [Zurich, Switzerland] 2022, v0.0.9000) packages.²⁴

We anticipated considerable between-study heterogeneity in the study population; therefore, a random-effects model was used to pool effect sizes. RR with 95% confidence interval (CI) was calculated as a random effects estimate with the meta-bin function of the meta (Schwarzer 2022, v5.5.0) R package. The Mantel-Haenszel method^{25–27} was used to pool RRs. Since the exact Mantel-Haenszel method was used, we did not apply continuity correction to handle 0 cell counts.²⁸

For outcomes with at least 5 studies, a Hartung-Knapp adjustment was used.^{29,30}

We applied the Paule-Mandel method³¹ to estimate the between-study variance (τ^2).

Additionally, between-study heterogeneity was investigated by Cochrane's Q test. Significant heterogeneity was considered at $P < .1$. Higgins & Thompson's I² statistics and 95% CI (30) were reported to illustrate the total variation across studies due to between-study heterogeneity.

Following the recommendations of Int'Hout et al,³² where applicable, we also reported the prediction intervals (ie, the expected range of effects of future studies) of the pooled estimates.

A Cochrane Q test was used between subgroups to assess the age group differences. The null hypothesis was rejected at a 5% significance level. We used forest plots to summarize the results graphically. All statistical analyses were made with R (R Core Team 2022, v4.2.0) using the meta (Schwarzer 2022, v5.5.0) and dmetar (Cuijpers, Furukawa, Ebert 2022, v0.0.9000) packages.

Results

Study selection

Altogether 15,547 studies were identified by our search, from which 72 full-text articles were included in our synthesis following the selection process described above (Figure 1).

Study characteristics

The baseline characteristics of the enrolled studies are detailed in Supplemental Table 1.

Our meta-analysis includes population-based studies from around the world. A precise geographic location is indicated in the baseline table. From the American continent, 37 articles were included; from Europe, 17; from Asia, 14; from Australia, 3; and from Africa 1. In terms of the study's examination period, the included articles encompass an overall timeframe between 1940 and 2018. All studies are population-based, with 36 studies carried out at the national level, 34 at the subnational level, and 2 at the multinational level, mostly based on the corresponding registries.

Risk of bias assessment

The results of the risk of bias assessment are presented in Supplemental Table 2.

Publication bias and heterogeneity: Most of our analyses showed high heterogeneity. This is attributable to the diversity of geographical regions, population sizes, date, and duration of the study periods represented by the included studies.

Based on the visual inspection of the funnel plots we did not find significant publication bias. The inspection of funnel plots was used to assess publication bias when a minimum of 10 articles were available for 1 outcome (Supplemental Figures 18–37).

Synthesis of results

The role of maternal age in the occurrence of NCAs

Table summarizes our results, while in the Supplementary Materials, we detail each of our forest plots. By default forest plots and summary statistics were prepared including all eligible studies regardless concomitant CAs.

Regarding our primary outcome, when we analyzed the total NCAs, we found that age >35 (RR 1.31, CI: 1.07–1.61) and especially age >40 (RR 1.44, CI: 1.25–1.66) increase the risk of NCAs (Figure 2). On this topic, we conducted 2 subgroup analyses to investigate this question more deeply. When we examined the age risk of total NCAs without the co-occurrence and influence effects of CAs, we found significant results for the >40 age category (RR 1.25, CI: 1.08–1.46). Furthermore, in the analysis

where the influence of the chromosome abnormality was present, the risk of NCAs was found to increase in relation to maternal age >35 (RR 1.26, CI: 1.12–1.42) and >40 (RR 1.63, CI: 1.26–2.09), with risk increasing each year. *Congenital malformations of the nervous system (Q00–Q07)*

Analyzing 5 to 10 articles from different age groups, we found no effect between maternal age and congenital nervous system malformations.

Congenital malformations of the circulatory system (Q20–Q28)

We found a risk-increasing effect of AMA (>40, RR 1.94, CI: 1.28–2.93). Among the diseases of the circulatory system, we highlighted the group of CHDs, where we also found the risk-increasing effect of AMA (>35, RR 1.50, CI: 1.11–2.04 and >40, RR 1.75, CI: 1.32–2.32), while the preventive effect of young maternal age was observed (<20, RR 0.87, CI: 0.78–0.97; Figure 3).

Cleft lip and cleft palate (Q35–Q37)

AMA (>40, RR 1.57, CI: 1.11–2.20) increased the risk of cleft lip and cleft palate. Regarding cleft palate separately, we found an even higher risk with AMA, which appears as early as the 35th maternal age (age >35, RR 1.78, CI: 1.16–2.73, and age >40, RR 1.77, CI: 1.48–2.11).

Congenital malformations of the digestive system (Q38–Q45)

We found a risk-increasing effect of AMA (age >40, RR 2.16, CI: 1.34–3.49).

Congenital malformations of the urinary system (Q60–Q64)

We could not show an association between maternal age and congenital malformations of the urinary system after analyzing 3 eligible population-based articles with homogeneous age categories.

Congenital malformations and deformations of the musculoskeletal system (Q65–Q79)

We did not find an association with maternal age. However, this can also be explained by the low number of articles, the heterogeneity, and the diverse nature of the group.

Other malformations

On the other hand, we found a clear association between maternal age and

TABLE

Summary of our results based on International Classification of Diseases-10 groups

Congenital anomaly	ICD-10 category	Age<20	N	Age 30–35	N	Age 35–40	N	Age>35	N	Age>40	N
All NCAs (with or without CAs)	Q00–Q89	1.08 (0.89; 1.32)	14	1.23 (0.85; 1.78)	13	1.47 (0.87; 2.49)	9	1.31 (1.06; 1.61)	13	1.44 (1.25; 1.66)	11
All NCAs (without CAs)	Q00–Q89	1.21 (0.59; 2.49)	5	1.54 (0.55; 4.32)	6	1.73 (0.45; 6.70)	5	1.37 (0.76; 2.45)	6	1.25 (1.08; 1.46)	6
All NCAs (with CAs)	Q00–Q89	1.15 (0.87; 1.52)	10	1.02 (0.99; 1.06)	7	1.20 (0.99; 1.44)	4	1.26 (1.12; 1.42)	7	1.63 (1.26; 2.09)	6
Nervous system	Q00–Q07	1.16 (0.74; 1.81)	10	1.64 (0.70; 3.81)	8	2.56 (0.64; 10.32)	5	1.53 (0.80; 2.94)	8	1.56 (0.67; 3.62)	7
Encephalocele	Q01	1.76 (0.44; 7.12)	3	1.51 (0.33; 6.83)	3	No data		1.43 (0.57; 3.60)	3	No data	
Congenital hydrocephalus	Q03	1.19 (1.02; 1.38)	2	No data		No data		No data		No data	
Spina bifida	Q05	1.30 (0.93; 1.82)	9	1.15 (0.65; 2.06)	8	1.79 (0.61; 5.31)	5	1.39 (0.75; 2.59)	8	1.96 (0.72; 5.31)	5
Anencephaly	Q00.0	1.40 (0.98; 1.99)	9	1.15 (0.72; 1.84)	8	1.20 (0.53; 2.72)	6	1.02 (0.60; 1.72)	8	1.30 (0.71; 2.38)	6
Circulatory system	Q20–Q28	0.87 (0.68; 1.11)	3	1.09 (1.00; 1.20)	3	1.18 (0.94; 1.49)	3	1.33 (0.97; 1.82)	3	1.94 (1.28; 2.93)	4
Congenital heart defects	Q20–Q26	0.87 (0.78; 0.97)	10	1.45 (0.83; 2.52)	10	1.91 (0.65; 5.62)	6	1.50 (1.11; 2.04)	10	1.75 (1.32; 2.32)	6
Cleft lip and palate	Q35–Q37	0.93 (0.76; 1.14)	6	1.58 (0.77; 3.22)	6	1.85 (0.59; 5.75)	4	1.47 (0.95; 2.28)	6	1.57 (1.11; 2.20)	4
Cleft palate	Q35	0.99 (0.56; 1.73)	6	1.42 (0.66; 3.06)	8	2.08 (0.54; 7.99)	5	1.78 (1.16; 2.73)	8	1.77 (1.48; 2.11)	5
Digestive system	Q38–Q45	0.98 (0.71; 1.37)	2	No data		No data		No data		2.16 (1.34; 3.49)	2
Urinary system	Q60–Q64	No data		0.97 (0.75; 1.26)	3	No data		0.86 (0.57; 1.29)	3	No data	
Hypospadias	Q54	0.99 (0.91; 1.07)	5	1.06 (0.96; 1.17)	4	No data		1.11 (0.88; 1.39)	4	No data	
Musculoskeletal system	Q65–Q79	0.88 (0.72; 1.08)	2	No data		0.93 (0.71; 1.22)	2	0.94 (0.65; 1.37)	2	0.90 (0.55; 1.46)	3
Congenital diaphragmatic hernia	Q79.0	0.96 (0.88; 1.06)	5	1.74 (0.52; 5.80)	4	No data		1.52 (0.79; 2.91)	5	No data	
Omphalocele	Q79.2	1.44 (1.08; 1.92)	14	1.13 (0.85; 1.50)	14	1.35 (0.98; 1.87)	13	1.47 (1.20; 1.79)	14	2.57 (1.77; 3.73)	13
Gastroschisis	Q79.3	3.08 (2.74; 3.47)	22	0.32 (0.23; 0.44)	17	0.27 (0.16; 0.47)	12	0.22 (0.15; 0.32)	17	0.41 (0.23; 0.74)	11

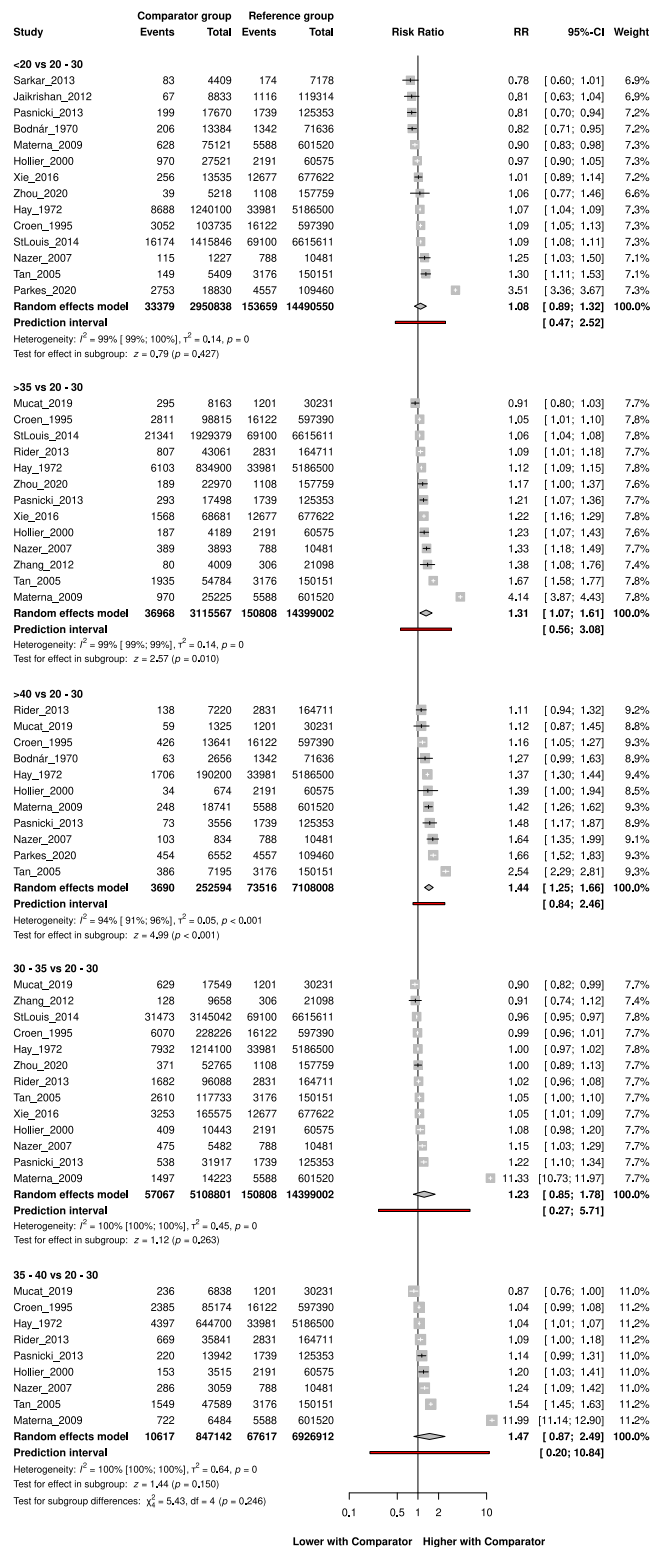
N—numbers represent the number of studies included in the analysis.

The reference group for each comparison was pregnant women between the age of 20–30.

CA, chromosomal abnormality; ICD-10, International Classification of Diseases-10; NCA, nonchromosomal congenital anomaly.

FIGURE 2

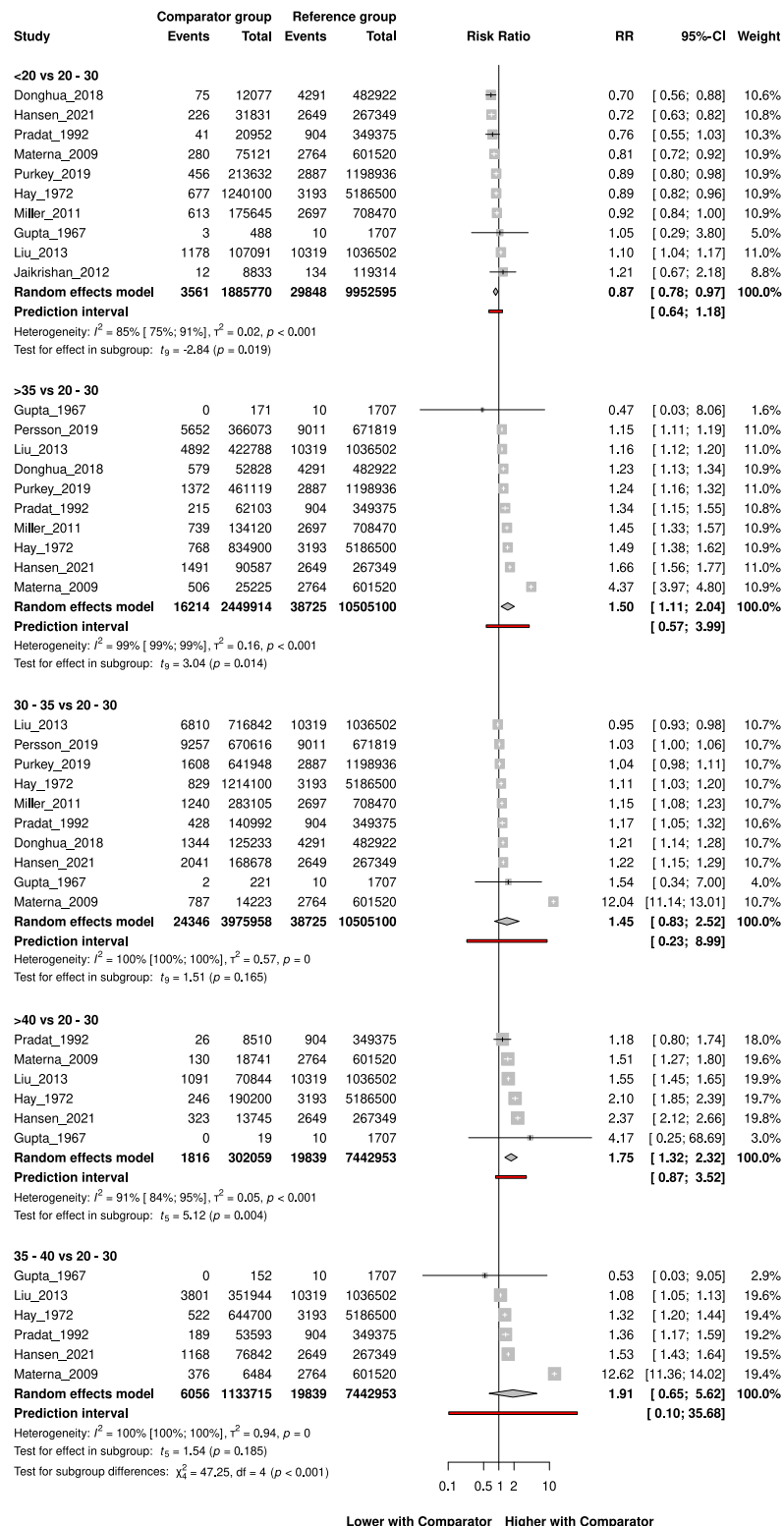
Forest plot representing the RR with 95% CI of all nonchromosomal anomalies (ICD-10: Q00–Q89) in different age groups compared to the 20–30 age group



CI, confidence interval; RR, risk ratio.

FIGURE 3

Forest plot representing the RR with 95% CI of congenital heart defects (ICD-10: Q20–Q26) in different age groups compared to the 20–30 age group



CI, confidence interval; ICD-10, International Classification of Diseases-10; RR, risk ratio.

some individual malformations. The risk of omphalocele was higher in both very young (age <20, RR 1.44, CI: 1.08–1.92) and AMA (age >40, RR 2.57, CI: 1.77–3.73) women. Based on 22 eligible articles (age <20, RR 3.08, CI 2.74–3.47), gastroschisis shows a strong association with very young maternal age. The analyses of the ICD-10 main groups and certain individual anomalies can be found in the supplementary material ([Supplementary Figures 1–17](#)).

Regarding the congenital malformations of the eye, ear, face, and neck (Q10–Q18), congenital malformations of the respiratory system (Q30–Q34), and congenital malformations of genital organs (Q50–Q56), we did not find enough studies with homogenous age groups and NACs to carry out a mathematical synthesis.

Additionally, we also resorted our study-level outcomes by year of publication to showcase any apparent trend in case of outcomes where sufficient number of articles were available to have any chance to reliably assess any effect ([Supplemental Figures 38–47](#)) and we could not see any convincing trend. We also analyzed the subset of studies published from 2005 onward ([Supplemental Figures 48–57](#)): no clear and convincing trend could be identified, only weak trends in a few cases (summarized in [Supplemental Table 6](#)).

Comment

The present study aimed to investigate the influence of maternal age on the risk of NCAs. Overall, our results suggest that maternal age plays a significant role in NCAs, with notable variations observed across different age groups. This finding is particularly important given that the focus of the analysis was specifically on the NCAs, while CAs were excluded from the analysis. The coexistence of CAs occurred in several established studies, but examining maternal age associations of CAs was not the subject of our present study.

Principal findings and comparison with existing literature

One key finding of our study is the association between AMA (≥ 35 years and

≥ 40 years) and an increased risk of NCAs. This finding is consistent with previous research,^{33–35} highlighting the importance of considering AMA as a risk factor in prenatal care and genetic counseling. The meta-analysis written on the subject in 2022 also considered AMA as a risk.³⁶ However, the significance of our present study is given by the fact that we specifically and exclusively examined NCAs and grouped them according to the International Classification of Diseases. We separately analyzed the main groups and some individual deviations. In addition, during our study, we examined the risk of several age groups compared to the reference age group. The increased risk observed in older mothers may be attributed to various factors, including increased rate of in vitro fertilization,^{37–40} increased prevalence of comorbidities especially pregestational diabetes mellitus,^{41–43} and a higher likelihood of exposure to environmental factors^{44,45} over an extended period. Contrary to our findings, some research has questioned the risk-increasing effect of AMA.^{46,47} This may be explained by the fact that the increase in maternal age in Europe is especially associated with women of higher social status, which may have led to a decrease in the risk of NCA in this age group compared to previous trends.^{47,48} Some studies show that AMA is associated with a reduced risk of NCAs, with researchers hypothesizing that the “all-or-nothing” phenomenon plays a stronger role in embryonic development as the egg ages and that anatomically normal fetuses are more likely to survive.⁴⁹

Our findings support and strengthen previous research that has suggested a significant association between maternal age and the risk of different NCAs.^{20,50,51} By pooling data from multiple studies, our meta-analysis demonstrates a consistent pattern of increased risk among older and younger mothers. This finding adds to the body of evidence and underscores the importance of considering maternal age as a critical factor in assessing the risk of these anomalies.

Interestingly, we also observed an elevated risk of NCAs among younger

maternal age groups (<20 years), but this association is not statistically significant. This finding is consistent with previous studies and suggests that a very young maternal age may also be a significant risk factor for these anomalies.⁴⁷ Possible explanations for this increased risk among younger mothers include inadequate prenatal care, a higher prevalence of socioeconomic disadvantages, and increased susceptibility to nutritional deficiencies during pregnancy.⁵²

It is known that in addition to CAs, the incidence of NCAs also increases with age, which is why it is worthwhile to examine the relationship even without their copresence. We found that the increased risk persisted in subgroup analyses excluding coincident chromosomal anomalies (see [Supplemental Table 5](#)) The RR for NCAs between mothers aged 20 to 30 and those aged >40, without coincidence of chromosomal anomalies, was 1.25 (95% CI: 1.08–1.46), indicating a 25% higher risk of nonchromosomal anomalies in older mothers when chromosomal anomalies were not present. This finding aligns with our recent population-based study,²⁰ which demonstrated an increased risk of nonchromosomal anomalies in older mothers even after excluding CAs from the analysis. According to the current guidelines, there is no specific recommendation for screening for NCAs based on maternal age. However, it has been previously demonstrated that maternal age is a significant risk factor for chromosomal anomalies. Consequently, there has been a growing emphasis on age-based screening, which has led to a notable improvement in the detection rate. While CAs are well-established in the etiology of developmental disorders, NCAs can also arise from gene abnormalities. However, no routine screening protocol is currently available for these; thus, their presence could not be excluded in this study. Moreover, their incidence is less associated with maternal age.^{53,54}

A further aim of the present meta-analysis was to investigate the effect of maternal age on the prevalence of NCA using data classified by ICD-10

categories. By analyzing data from 5 different age groups (<20; 30–35; >35; 35–40; >40) and comparing them to a control age group of 20 to 30 years, we sought to provide a comprehensive understanding of the relationship between maternal age and specific types of NCAs. CHDs and neural tube defects (NTDs) should be addressed separately, as fetal echocardiography and neurosonography serve as complementary screening methods for these conditions.

In the circulatory system category, the risk of nonchromosomal anomalies was significantly higher in mothers aged >40. Specifically, CHDs within this category showed a similarly increased risk, with a 75% risk-increasing effect for mothers aged >40 compared to those aged 20 to 30. When comparing mothers aged >35 to those aged 20 to 30 a 50% increased risk was indicated in the older age group. These are significant findings from a clinical point of view, because there is currently no maternal age-related indication for fetal echocardiography.^{55,56}

No association with maternal age was found for NTDs. The literature does not provide consistent findings regarding the effect of age. Most studies also highlight the role of both very young and AMA.^{57,58} While other researchers suggest that a higher risk of NTD is associated with increased maternal age,⁵⁹ the diverse outcomes observed in studies may be attributed to the inconsistent definition of NTDs, as grouping was not uniformly applied across different research studies.

The included studies have span a long time period (1940–2018) during which substantial changes in lifestyle, prevention strategies,⁶⁰ and diagnostics may have happened; hence, the incidence of certain NCAs may have also changed over time. However, this shift does not appear to have impacted the dependence of RRs on maternal age.

Since no specific additional screening options are available for other NCA groups, ultrasound examinations adjusted for age in these particular age groups should prioritize the assessment of these organ systems. Special attention should be dedicated to the more frequent

disparities observed in the low and high maternal age categories. Exploring the underlying causes of the risk-increasing effects within each age group can aid the identification of appropriate preventive options. Our findings indicate that the inclusion of age in screening protocols can enhance the likelihood of early detection of NCAs. While this study alone does not provide conclusive evidence regarding the isolated impact of age, it is important to consider the potential influence of lifestyle factors commonly associated with different age categories. Nevertheless, age alone can still be considered a distinct and significant risk factor.

Strengths and limitation

Regarding the strengths of our analysis, we followed our protocol, which was registered in advance. A rigorous methodology was applied. We included population-based articles, which gave us a comprehensive view of all NCAs. We included articles from around the world with a large number of cases, enabling the generalizability of the result.

However, there are several limitations. All included studies had a retrospective design that limited our ability to establish causality and precluded the assessment of certain confounding variables. The quality and heterogeneity of the included studies may have introduced some biases and limitations in interpreting our results. As with any meta-analysis, publication bias may be a concern, as studies with nonsignificant results are less likely to be published. Additionally, the sample sizes, the long study period with changing screening methods, and data reporting across the included studies may have introduced some degree of heterogeneity.

Conclusions and implication

The importance of immediate implementation of the results has been previously proven.^{61,62} Based on our study, we suggest advanced ultrasound screening and additional screening methods (fetal echocardiography) in high-risk age groups, and considering this knowledge in family planning due to the clear

advantages of the rapid integration of the results into clinical practice. Our results suggest that introducing fetal echocardiography may be a priority for AMA.

Further prospective data collection is needed to assess the problem in question more accurately and to understand the role of maternal age in the case of rare NCAs.

In conclusion, our meta-analysis of population-based articles provides compelling evidence of the influence of maternal age (especially AMA) on the risk of NCAs. These findings have important clinical implications, emphasizing the need for age-specific prenatal care and genetic counseling to mitigate the risk of these anomalies. ■

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Appendix Supplementary Appendix 1. Risk of bias assessment methodology

Overall ratings for each domain were assigned as carrying 'low' (green), 'moderate' (yellow), or 'high' (red) risk of bias, based on the items included in each domain.

Study design: (1) low risk of bias was attributed if the proportion of baseline sample was available, also if the reason for lost to follow-up was detailed; (2) moderate risk of bias was attributed if a part of the above listed criteria were missing; (3) high risk of bias was attributed if data was missing for the above mentioned criteria.

Study participation measurement: (1) low risk of bias was attributed if authors adequately described the source population, including methods to identify patients and eligibility criteria; (2) moderate risk of bias was attributed if a part of the above listed descriptions were missing; (3) high risk of bias was attributed if baseline characteristics, eligibility criteria, time and place of recruitment were not described.

Prognostic factor measurement: (1) low risk of bias was attributed if clear and detailed age categories were used covering all age groups; (2) moderate risk of bias was attributed if clear categories were defined but some age groups were missing; (3) high risk of bias was attributed if only 1 group was examined.

Outcome measurement: (1) low risk of bias was attributed if there was clear definition of outcome, if the study used International Classification of Diseases-10 (ICD-10) category; (2) moderate risk of bias was attributed if a mentioned criteria were missing but can be matched to ICD-10 category; (3) high risk of bias was attributed if the anomaly could not be precisely identified or it was inadequate.

Study confounding measurement: (1) low risk of bias was attributed if important potential confounders were described and accounted for in the analysis; (2) moderate risk of bias was attributed if some of the important confounders were not measured; (3) high risk of bias was attributed if studies did not provide data on confounding factors.

Statistical analysis measurement: (1) low risk of bias was attributed if there is clear, raw data (no or negligible contradiction); (2) moderate risk of bias was attributed if requires some calculation or reading from a graph (minor contradiction); (3) high risk of bias was attributed if only approximate data can be obtained (serious contradiction).

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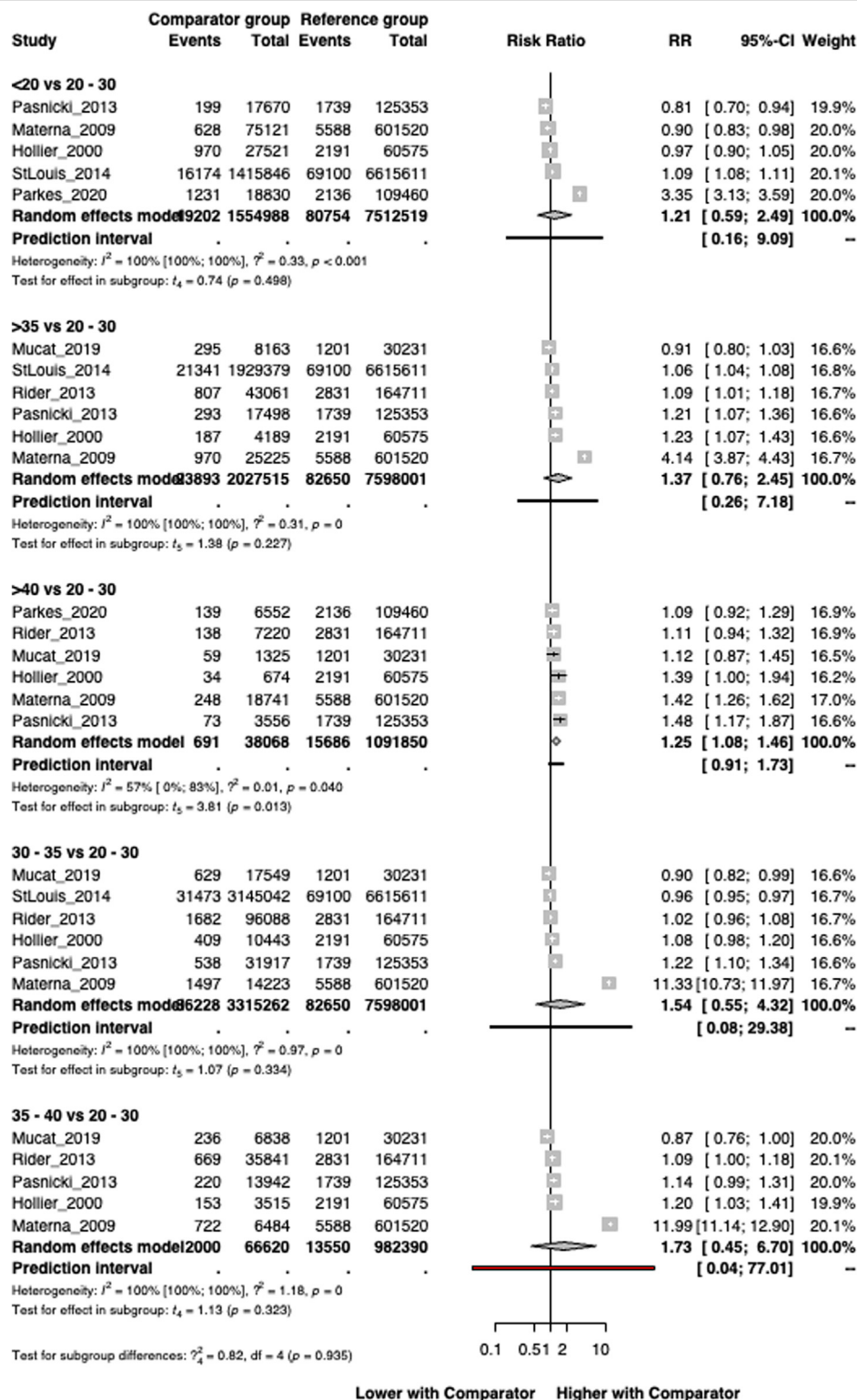
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SUPPLEMENTAL FIGURE 1

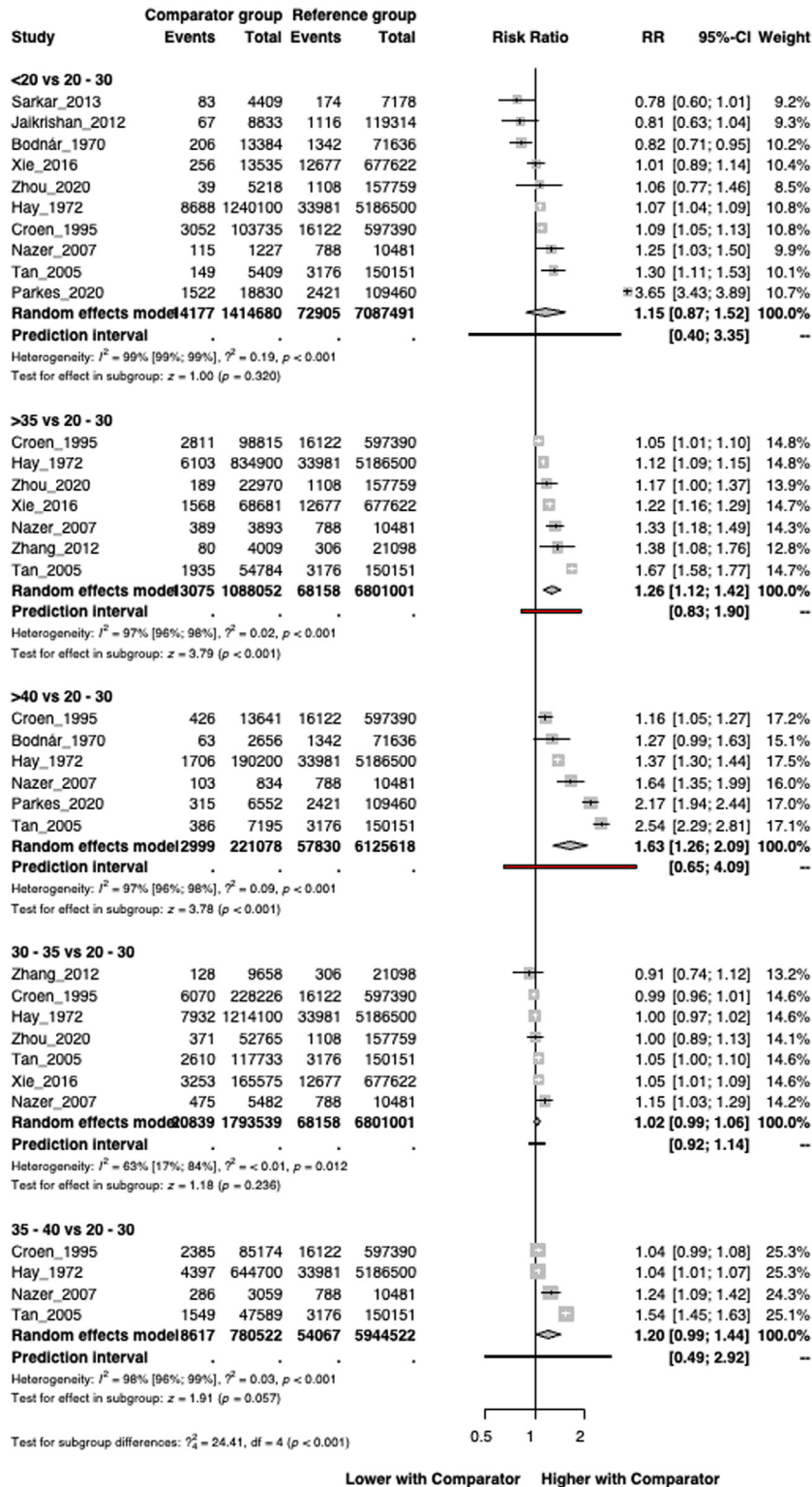
Forest plot representing the RR with 95% CI of *all nonchromosomal anomalies (only studies excluding concomitant chromosomal anomalies)* (ICD-10 Q00–Q89) in different age groups compared to the 20 to 30 age group



CI, confidence interval; ICD-10, International Classification of Diseases-10; RR, risk ratio.

SUPPLEMENTAL FIGURE 2

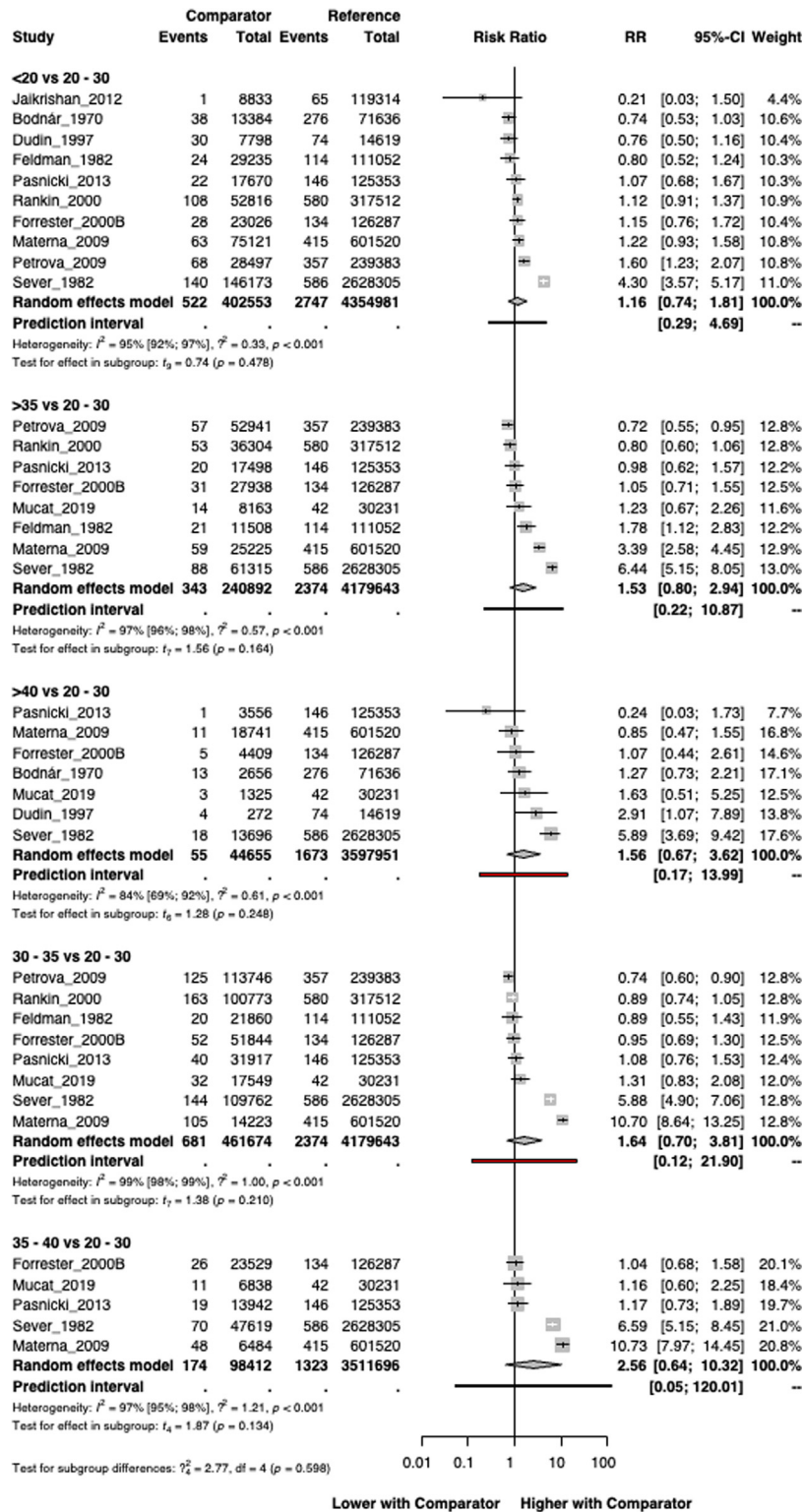
Forest plot representing the RR with 95% CI of all nonchromosomal anomalies (only studies including concomitant chromosomal anomalies) (ICD-10: Q00–Q89 with Q90–Q99) in different age groups compared to the 20 to 30 age group



CI, confidence interval; ICD-10, International Classification of Diseases-10; RR, risk ratio.

SUPPLEMENTAL FIGURE 3

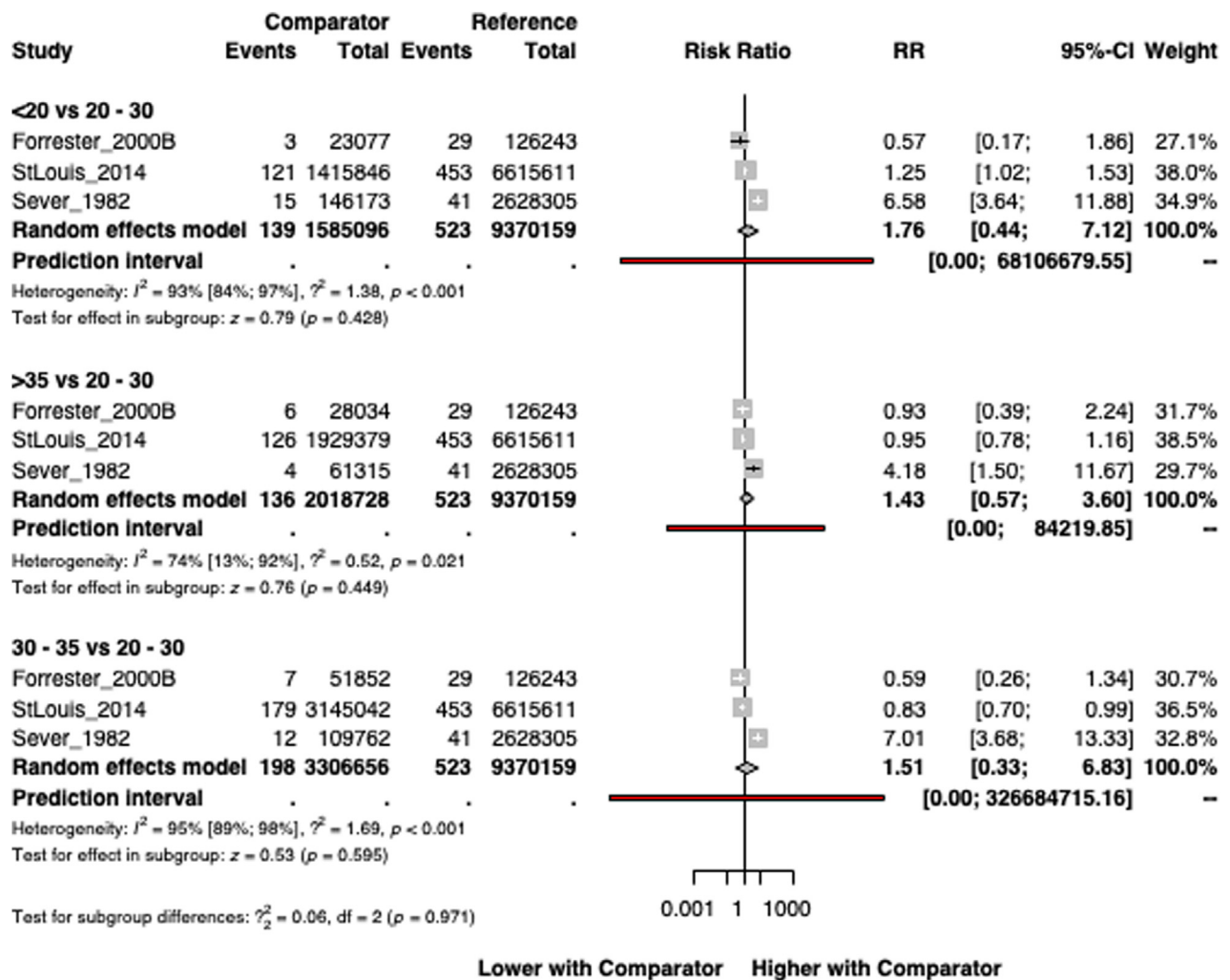
Forest plot representing the RR with 95% CI of *congenital anomalies of the nervous system* (ICD-10: Q00–Q07) in different age groups compared to the 20 to 30 age group



CI, confidence interval; ICD-10, International Classification of Diseases-10; RR, risk ratio.

SUPPLEMENTAL FIGURE 4

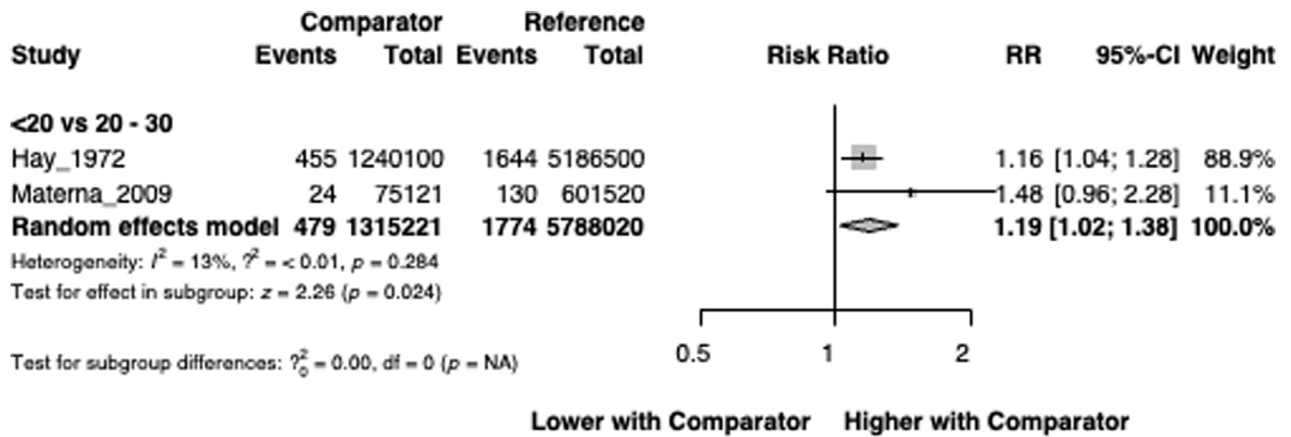
Forest plot representing the RR with 95% CI of *encephalocele* (ICD-10: Q01) in different age groups compared to the 20 to 30 age group



CI, confidence interval; ICD-10, International Classification of Diseases-10; RR, risk ratio.

SUPPLEMENTAL FIGURE 5

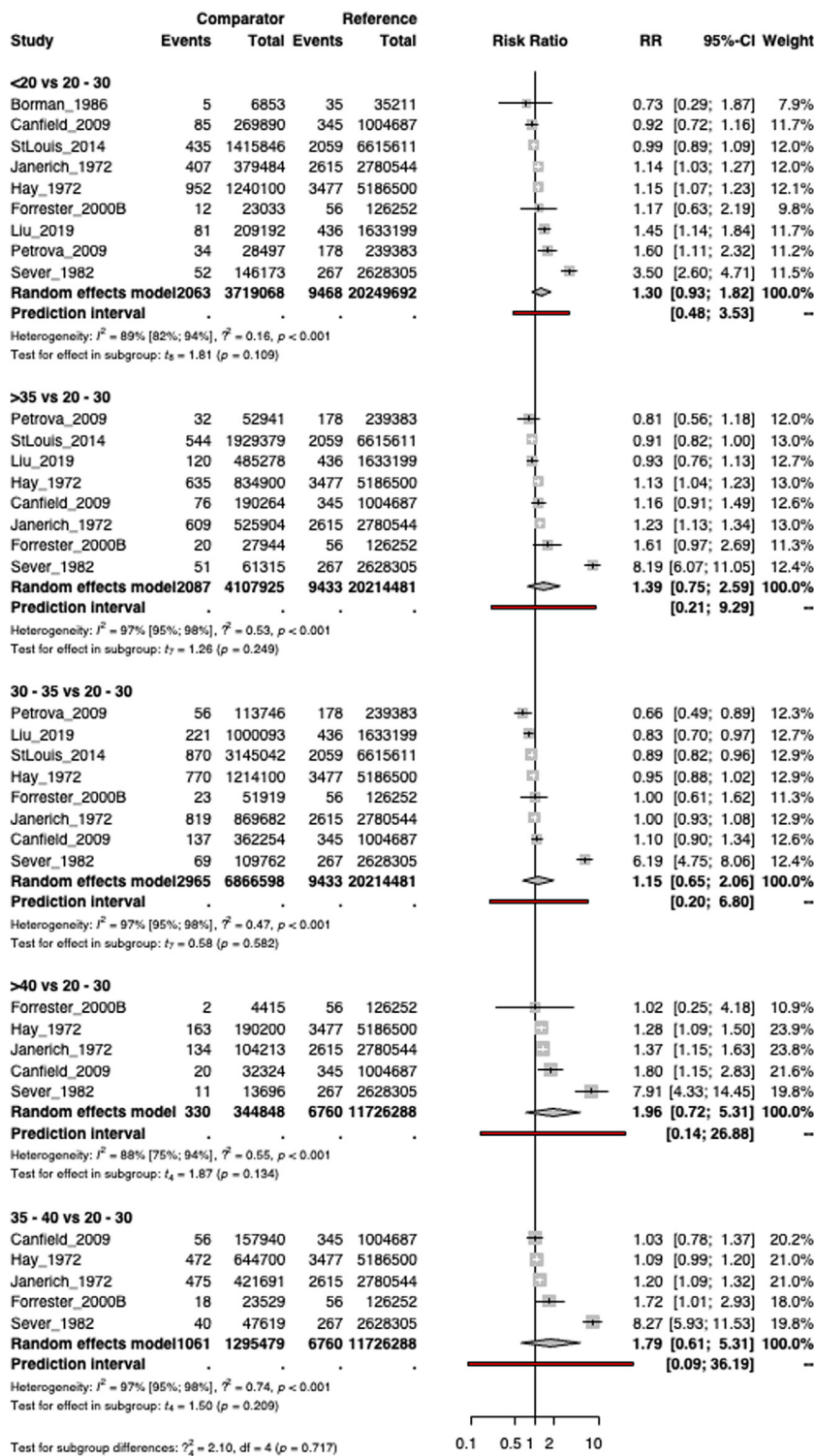
Forest plot representing the RR with 95% CI of *congenital hydrocephalus* (ICD-10: Q03) in different age groups compared to the 20 to 30 age group



CI, confidence interval; ICD-10, International Classification of Diseases-10; RR, risk ratio.

SUPPLEMENTAL FIGURE 6

Forest plot representing the RR with 95% CI of *spina bifida* (ICD-10: Q05) in different age groups compared to the 20 to 30 age group

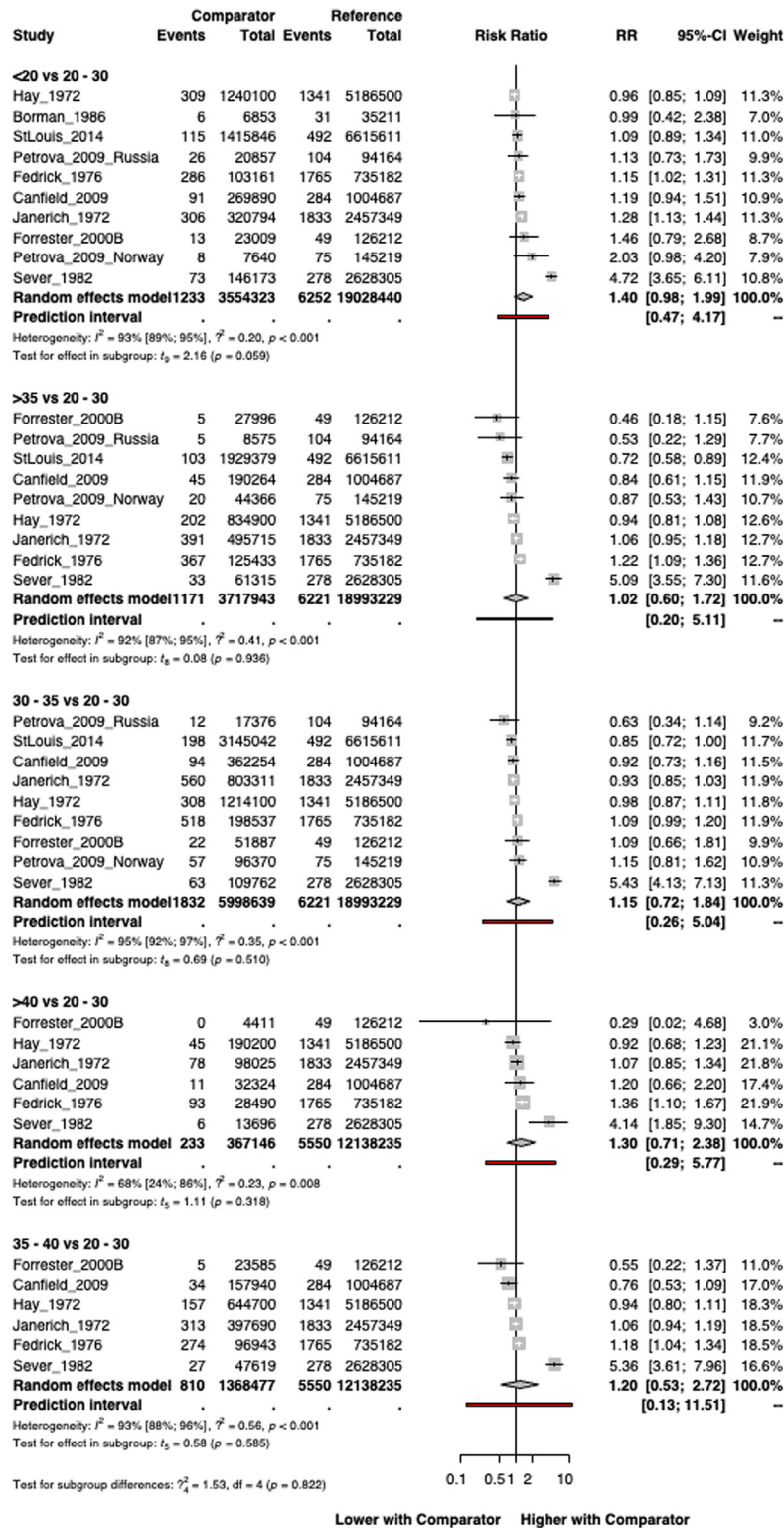


Lower with Comparator Higher with Comparator

CI, confidence interval; ICD-10, International Classification of Diseases-10; RR, risk ratio.

SUPPLEMENTAL FIGURE 7

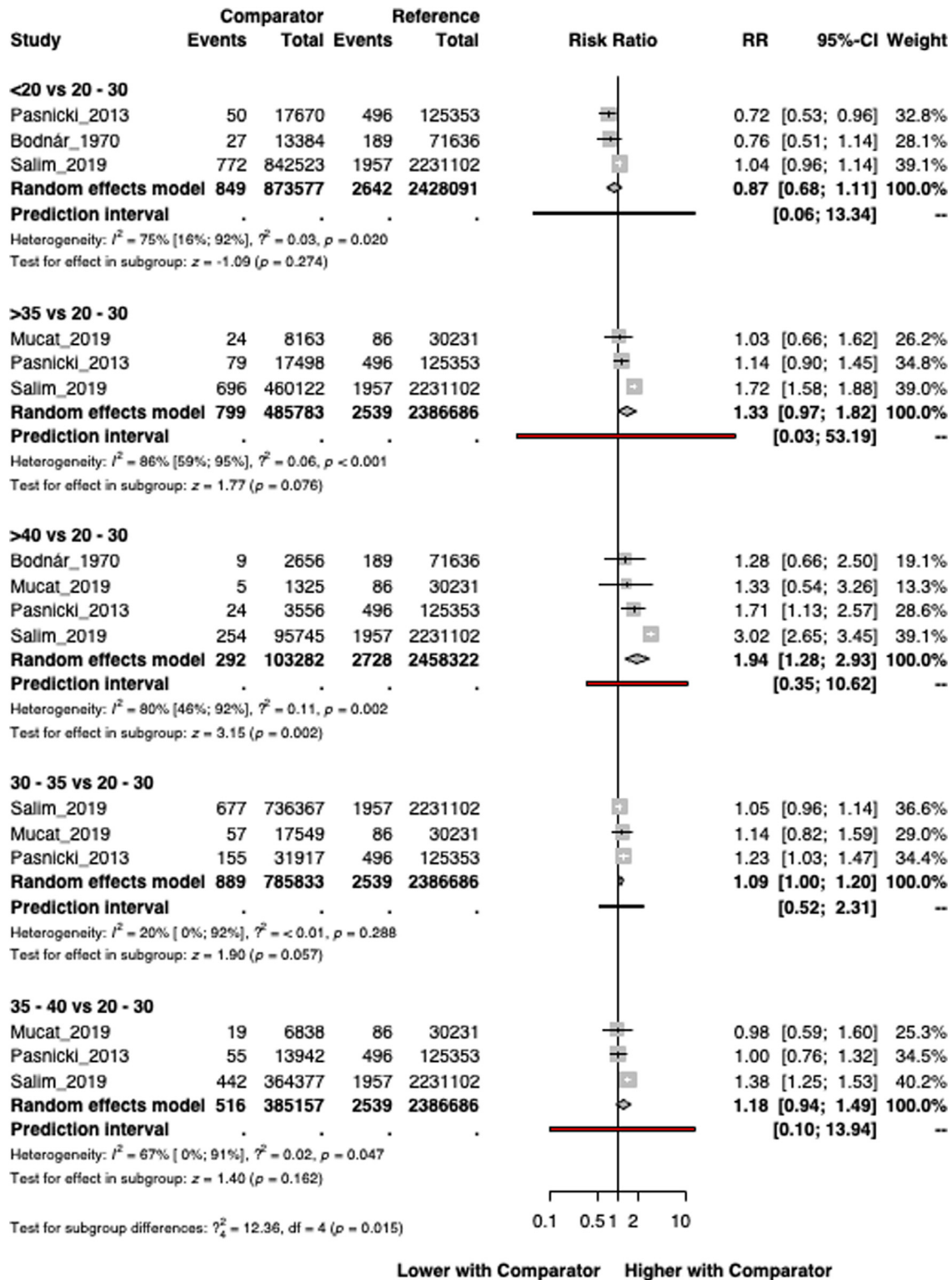
Forest plot representing the RR with 95% CI of *anencephaly* (ICD-10: Q00.0) in different age groups compared to the 20 to 30 age group



CI, confidence interval; ICD-10, International Classification of Diseases-10; RR, risk ratio.

SUPPLEMENTAL FIGURE 8

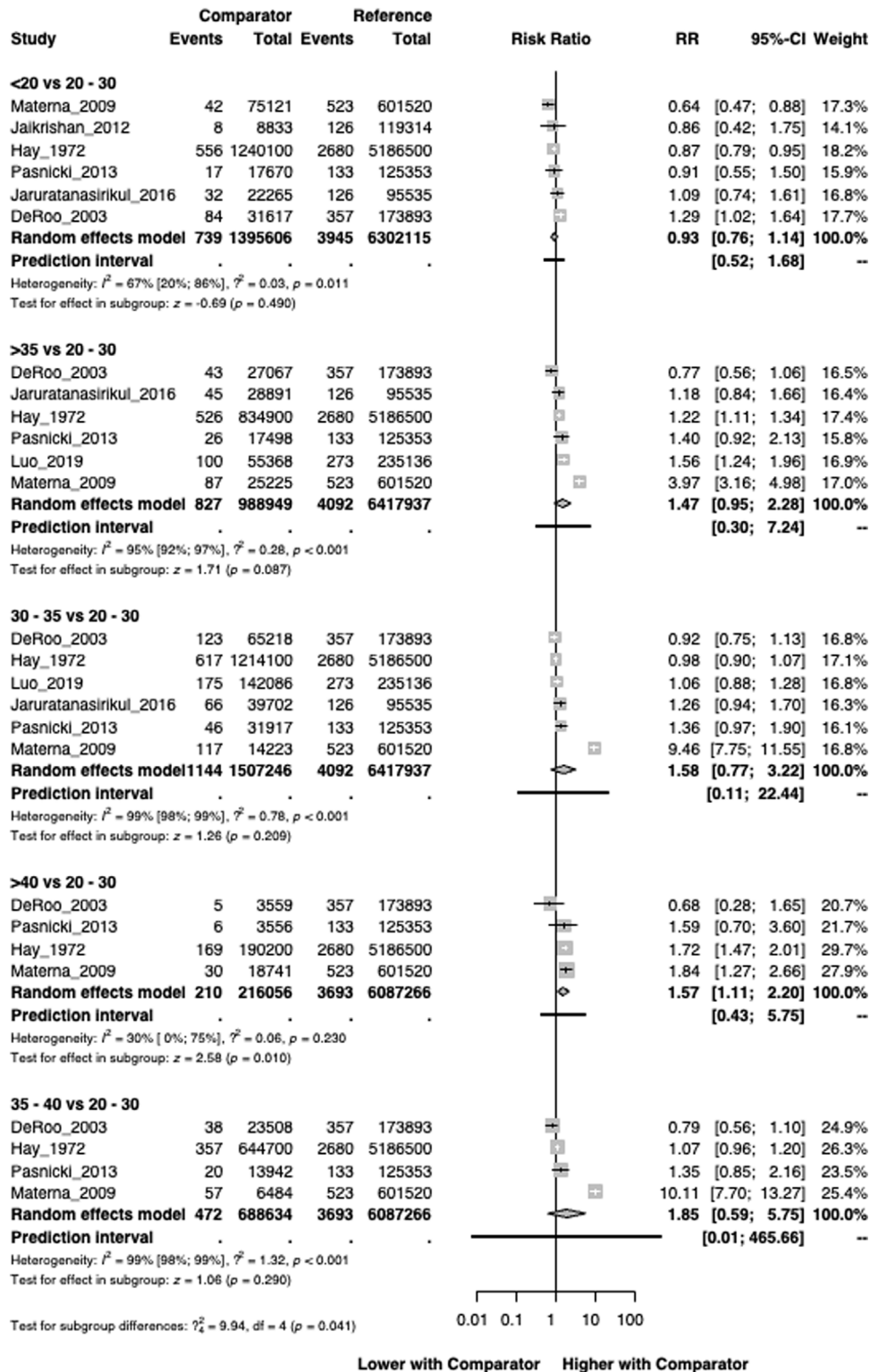
Forest plot representing the RR with 95% CI of congenital anomalies of the circulatory system (ICD-10: Q20–Q28) in different age groups compared to the 20 to 30 age group



CI, confidence interval; ICD-10, International Classification of Diseases-10; RR, risk ratio.

SUPPLEMENTAL FIGURE 9

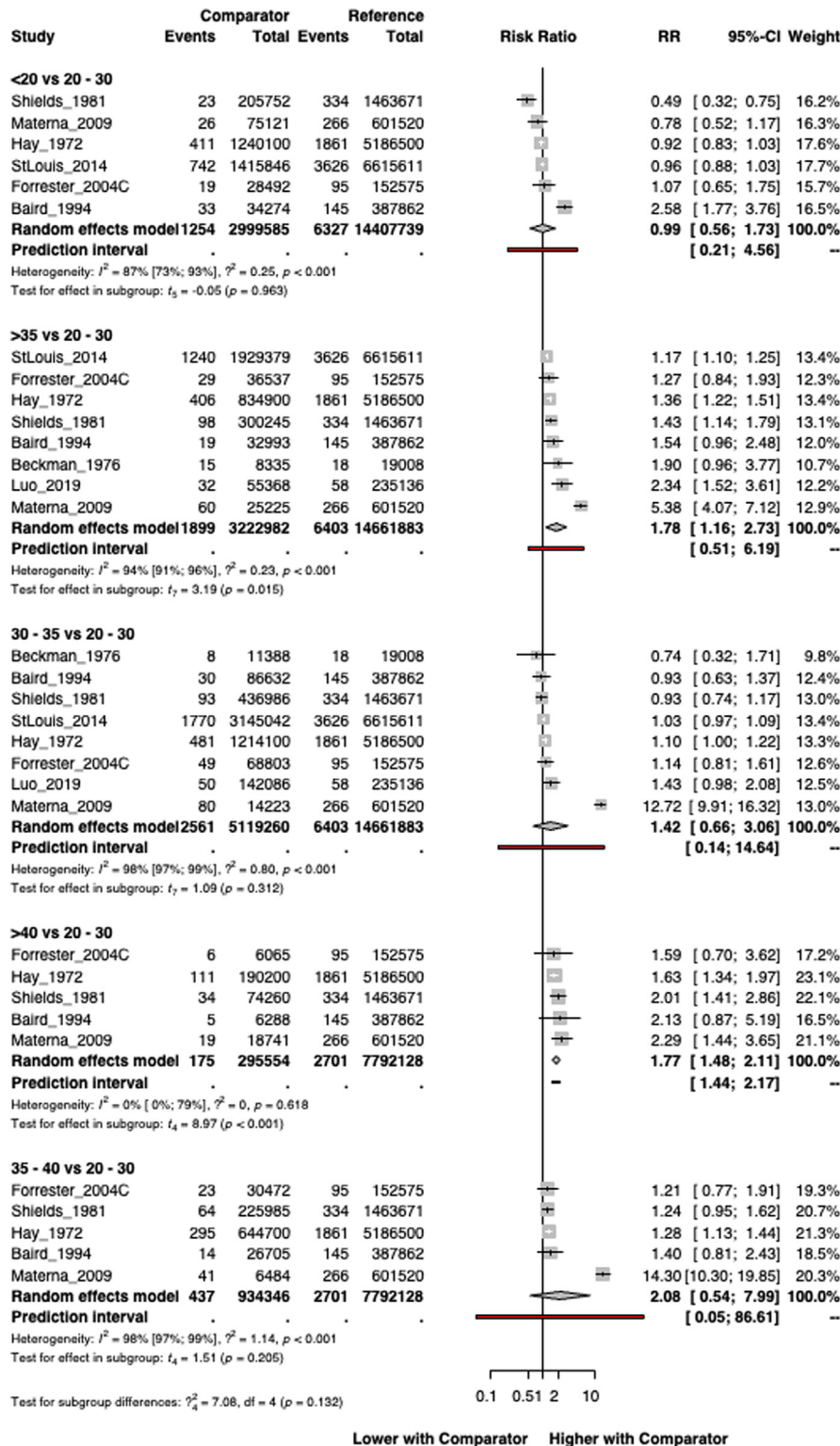
Forest plot representing the RR with 95% CI of *cleft lip and cleft palate* (ICD-10: Q35–Q37) in different age groups compared to the 20 to 30 age group



CI, confidence interval; ICD-10, International Classification of Diseases-10; RR, risk ratio.

SUPPLEMENTAL FIGURE 10

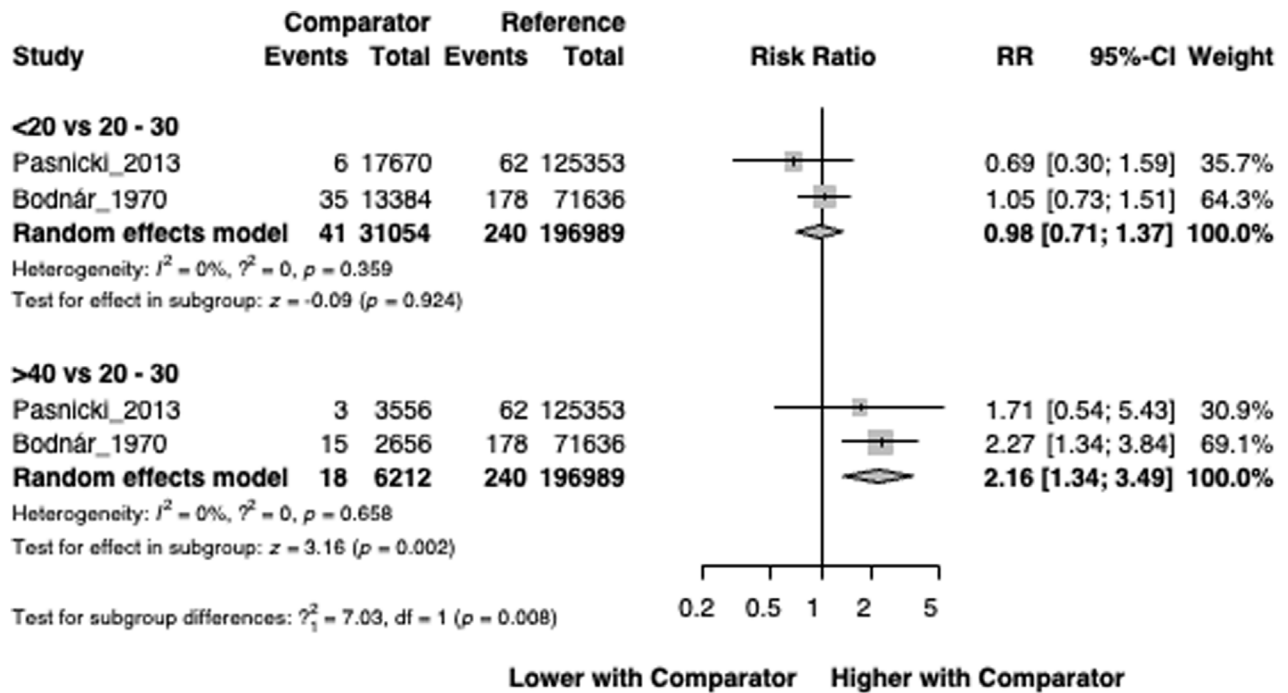
Forest plot representing the RR with 95% CI of *cleft palate* (ICD-10: Q35) in different age groups compared to the 20 to 30 age group



CI, confidence interval; ICD-10, International Classification of Diseases-10; RR, risk ratio.

SUPPLEMENTAL FIGURE 11

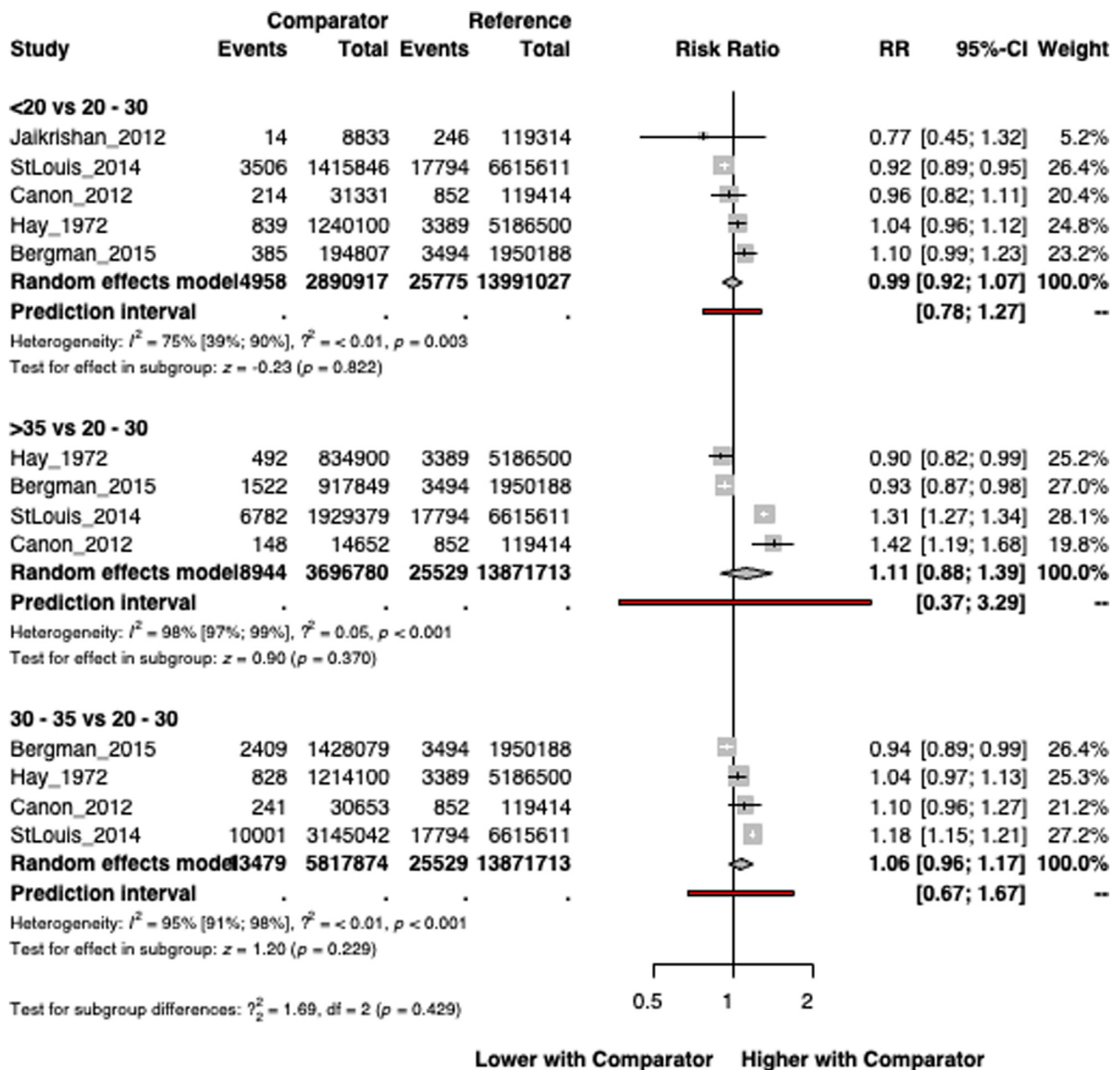
Forest plot representing the RR with 95% CI of *congenital anomalies of the digestive system* (ICD-10: Q38–Q45) in different age groups compared to the 20 to 30 age group



CI, confidence interval; ICD-10, International Classification of Diseases-10; RR, risk ratio.

SUPPLEMENTAL FIGURE 12

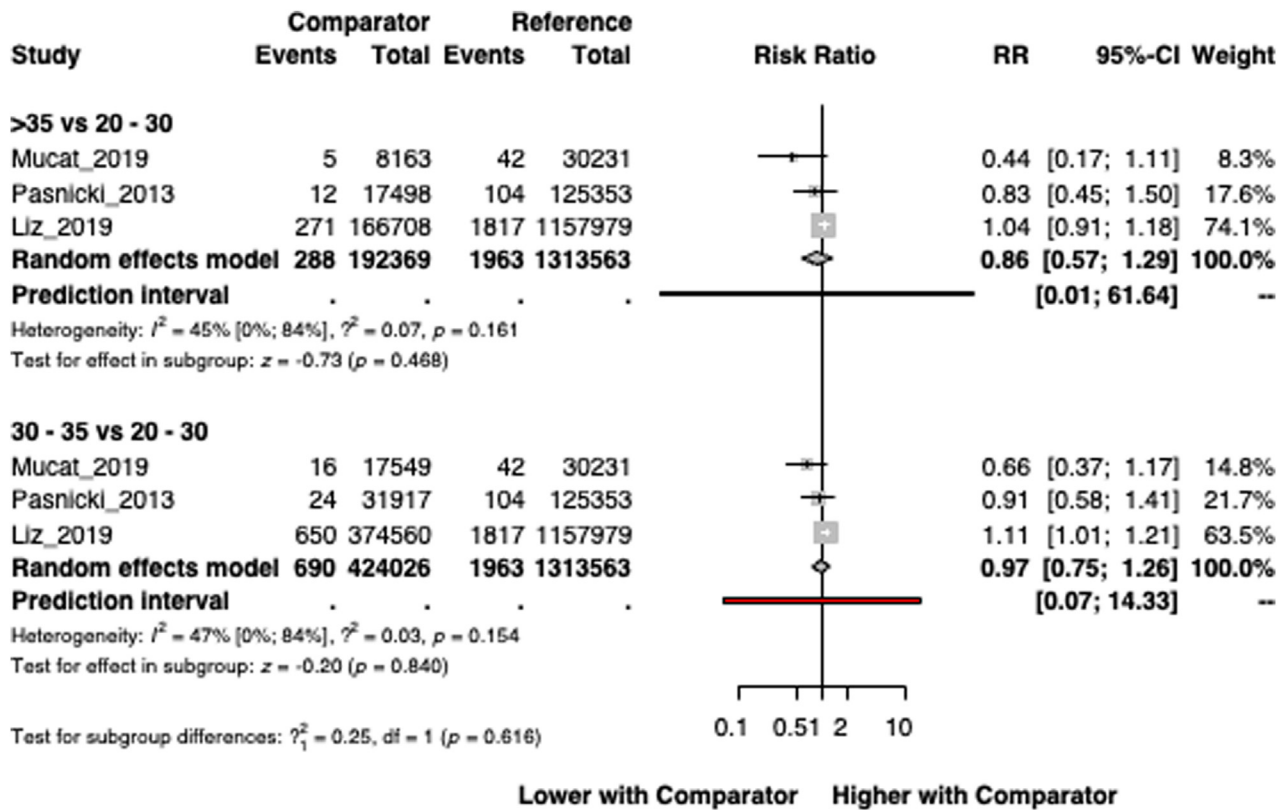
Forest plot representing the RR with 95% CI of *hypospadias* (ICD-10: Q54) in different age groups compared to the 20 to 30 age group



CI, confidence interval; ICD-10, International Classification of Diseases-10; RR, risk ratio.

SUPPLEMENTAL FIGURE 13

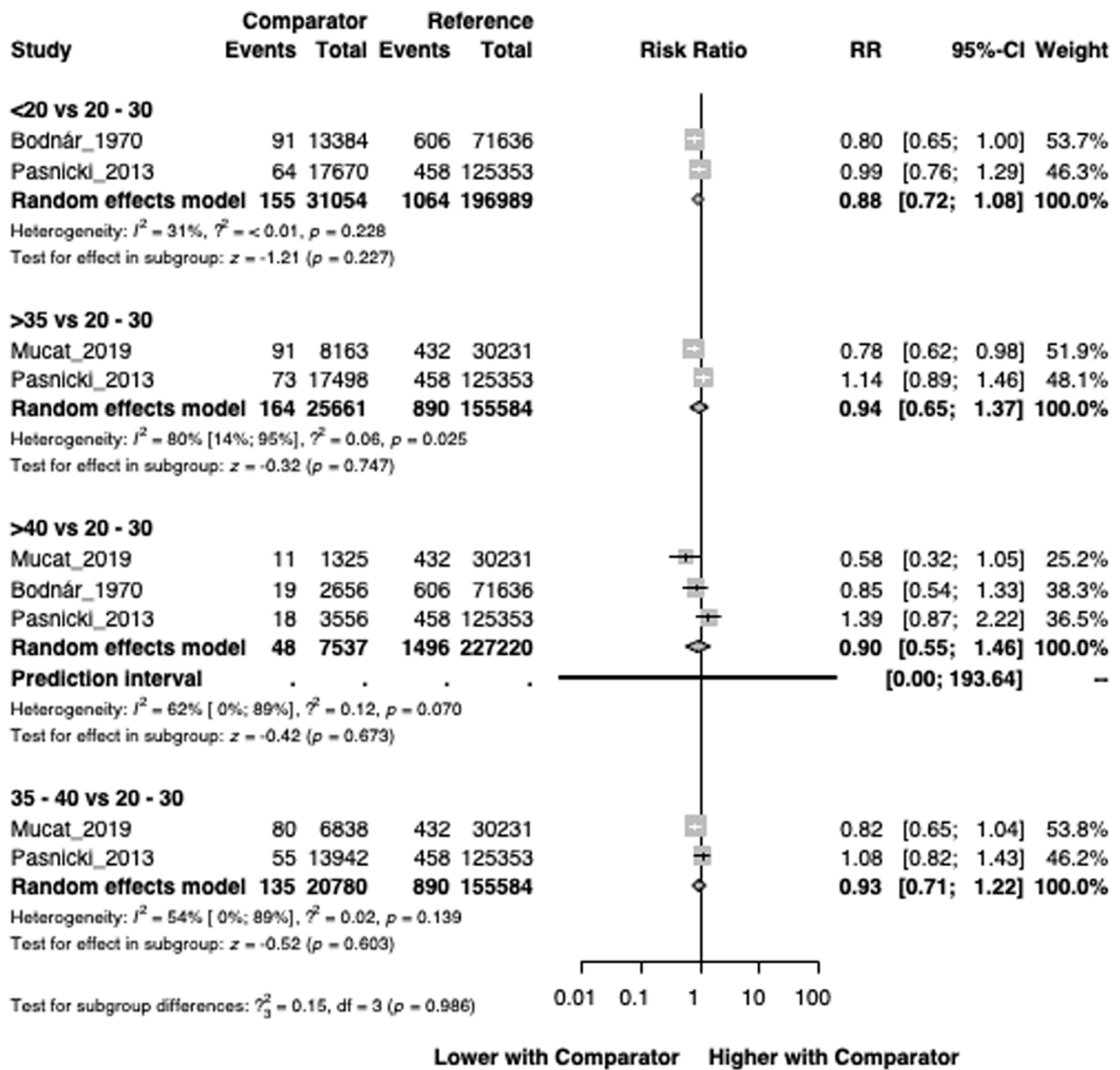
Forest plot representing the RR with 95% CI of *congenital anomalies of the urinary system* (ICD-10: Q60–Q64) in different age groups compared to the 20 to 30 age group



CI, confidence interval; ICD-10, International Classification of Diseases-10; RR, risk ratio.

SUPPLEMENTAL FIGURE 14

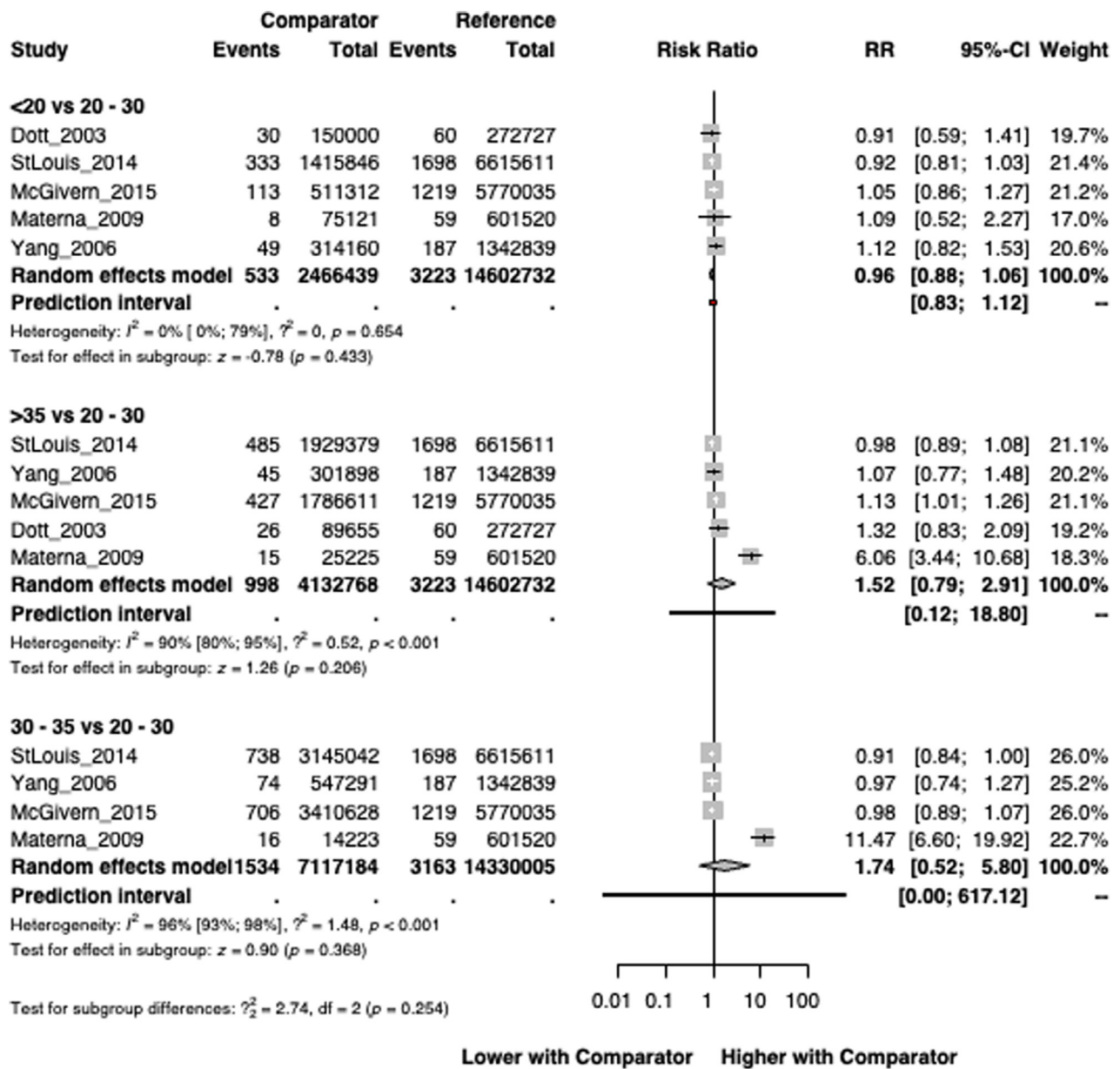
Forest plot representing the RR with 95% CI of *congenital anomalies of the musculoskeletal system* (ICD-10: Q65–Q79) in different age groups compared to the 20 to 30 age group



CI, confidence interval; ICD-10, International Classification of Diseases-10; RR, risk ratio.

SUPPLEMENTAL FIGURE 15

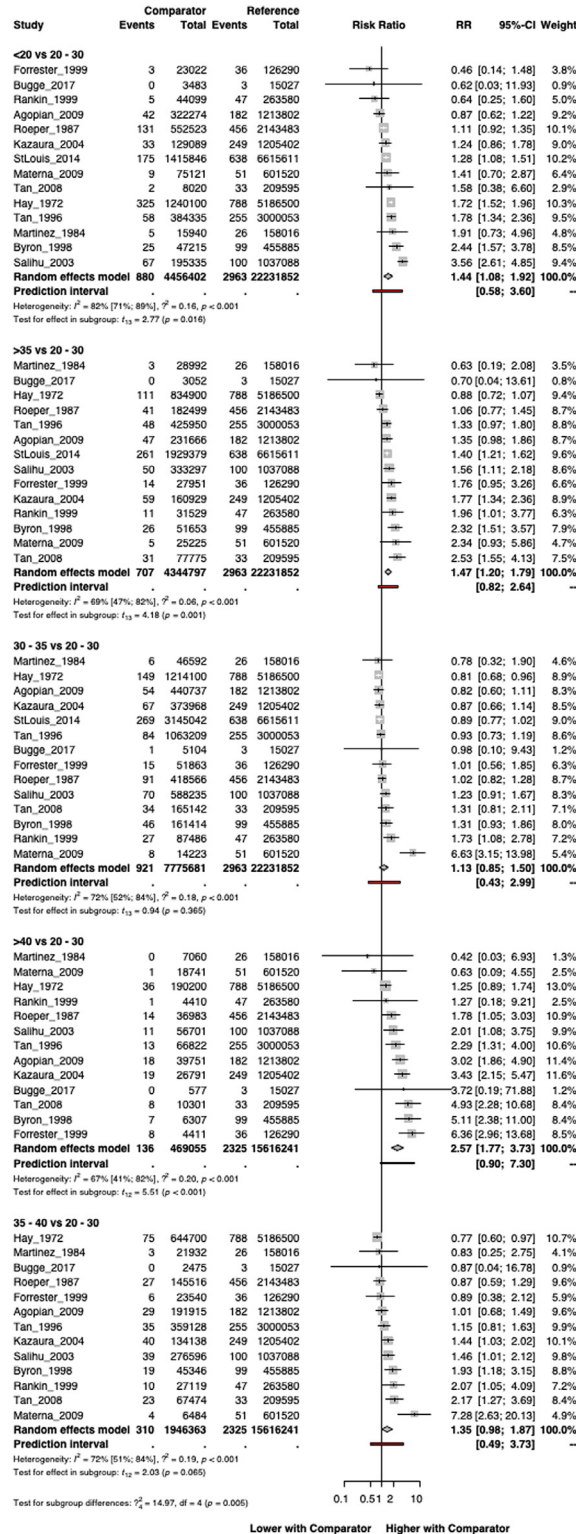
Forest plot representing the RR with 95% CI of *congenital diaphragma hernia* (ICD-10 Q79.0) in different age groups compared to the 20 to 30 age group



CI, confidence interval; ICD-10, International Classification of Diseases-10; RR, risk ratio.

SUPPLEMENTAL FIGURE 16

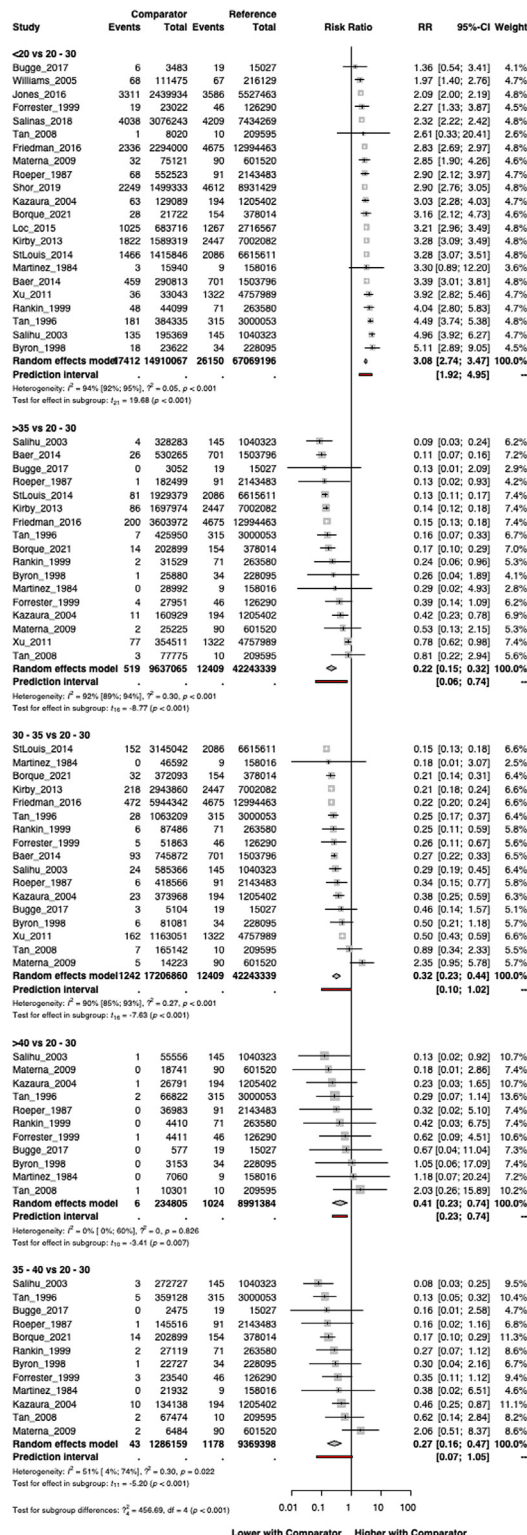
Forest plot representing the RR with 95% CI of *omphalocele* (ICD-10: Q79.2) in different age groups compared to the 20 to 30 age group



CI, confidence interval; ICD-10, International Classification of Diseases-10; RR, risk ratio.

SUPPLEMENTAL FIGURE 17

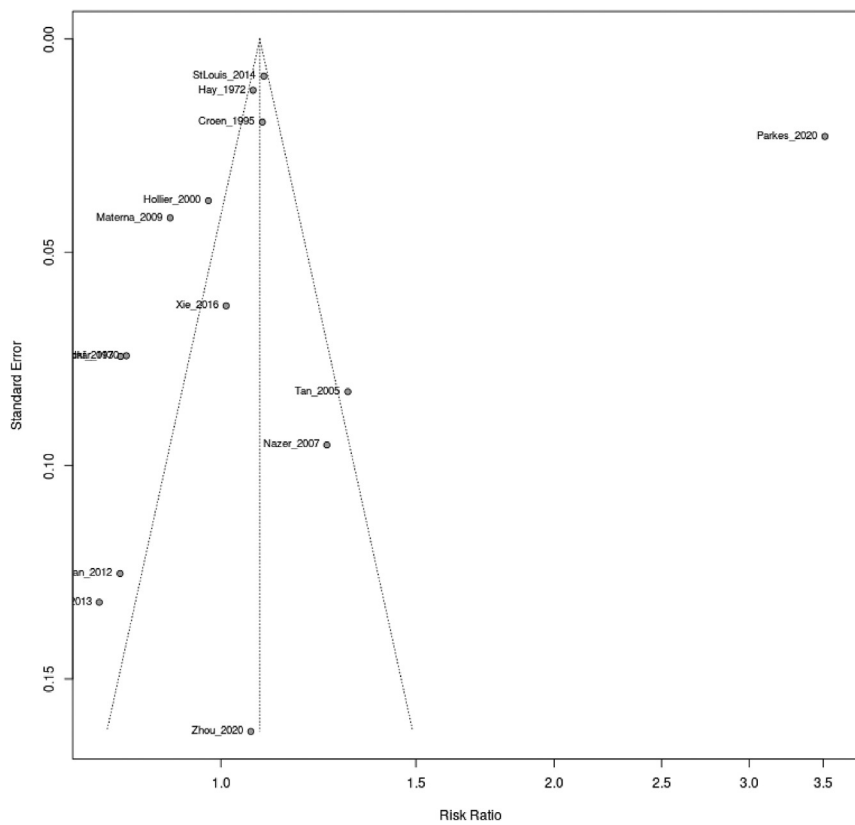
Forest plot representing the RR with 95% CI of *gastroschisis* (ICD-10: Q79.3) in different age groups compared to the 20 to 30 age group



CI, confidence interval; ICD-10, International Classification of Diseases-10; RR, risk ratio.

SUPPLEMENTAL FIGURE 18

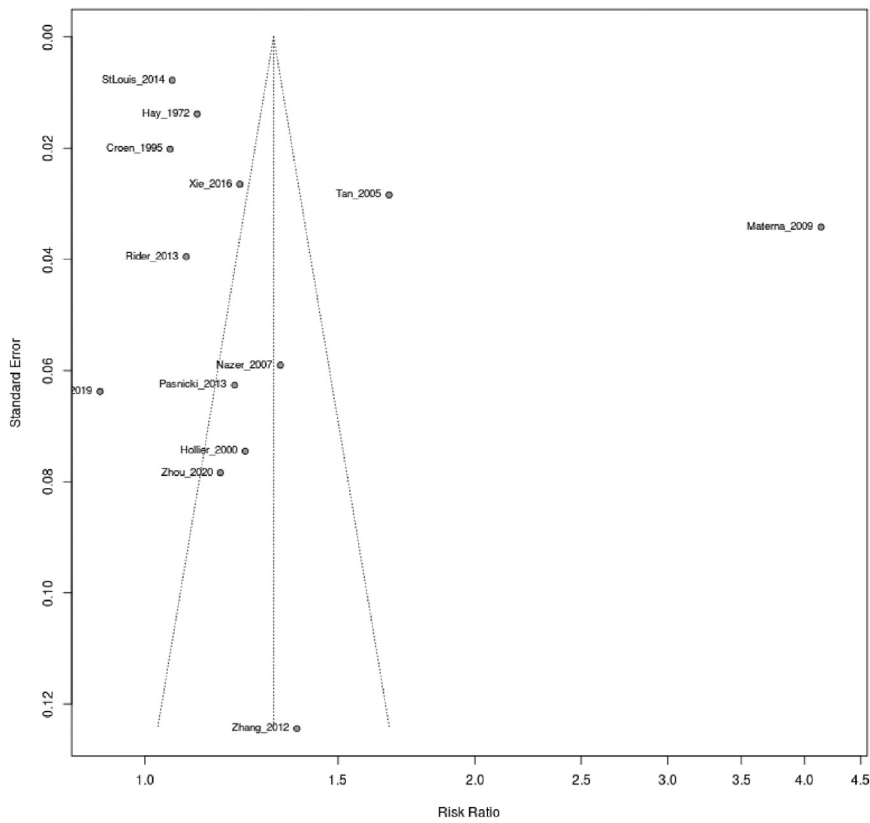
Funnel plot for the association between maternal age and *all nonchromosomal anomalies* (ICD-10: Q00–Q89) (<20 vs 20–30 age groups)



ICD-10, International Classification of Diseases-10.

SUPPLEMENTAL FIGURE 19

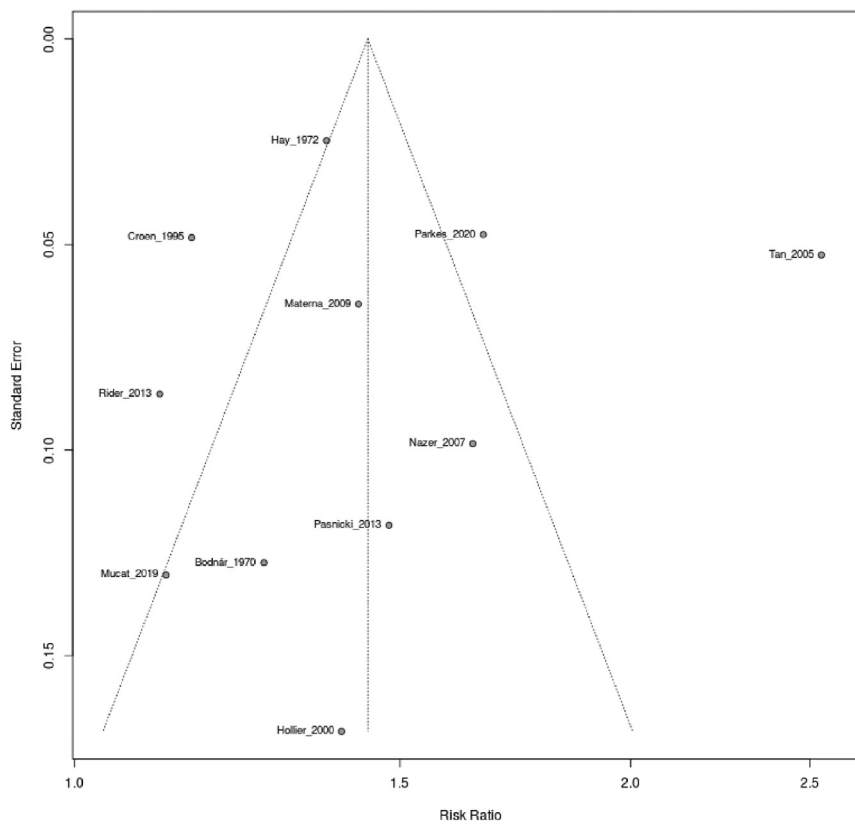
Funnel plot for the association between maternal age and *all nonchromosomal anomalies* (ICD-10: Q00–Q89) (>35 vs 20–30 age groups)



ICD-10, International Classification of Diseases-10.

SUPPLEMENTAL FIGURE 20

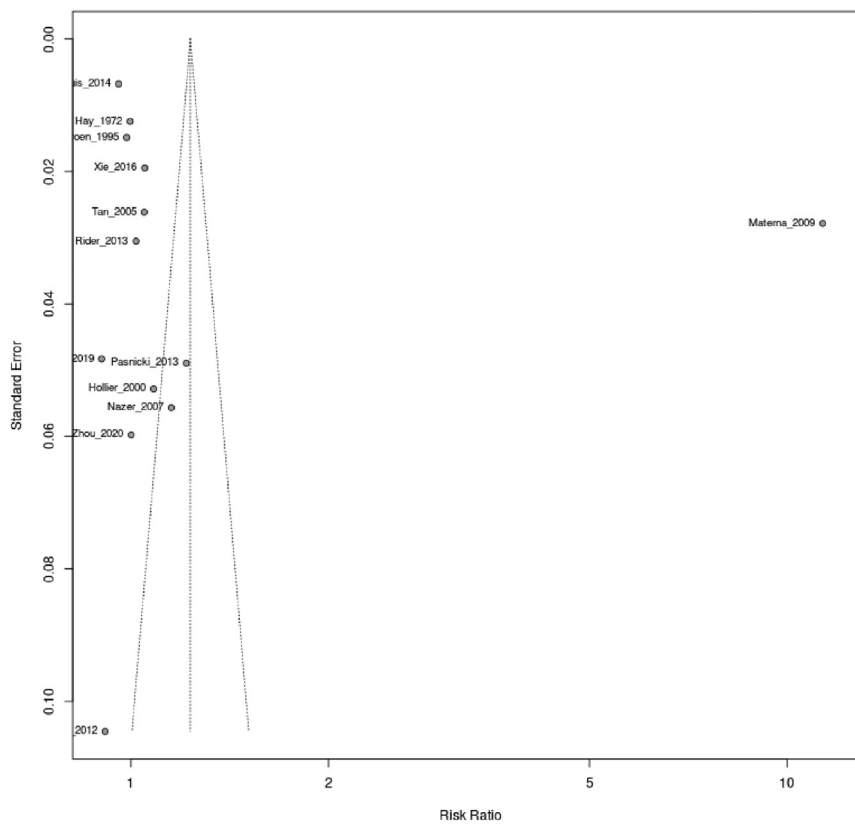
Funnel plot for the association between maternal age and *all nonchromosomal anomalies* (ICD-10: Q00–Q89) (>40 vs 20–30 age groups)



ICD-10, International Classification of Diseases-10.

SUPPLEMENTAL FIGURE 21

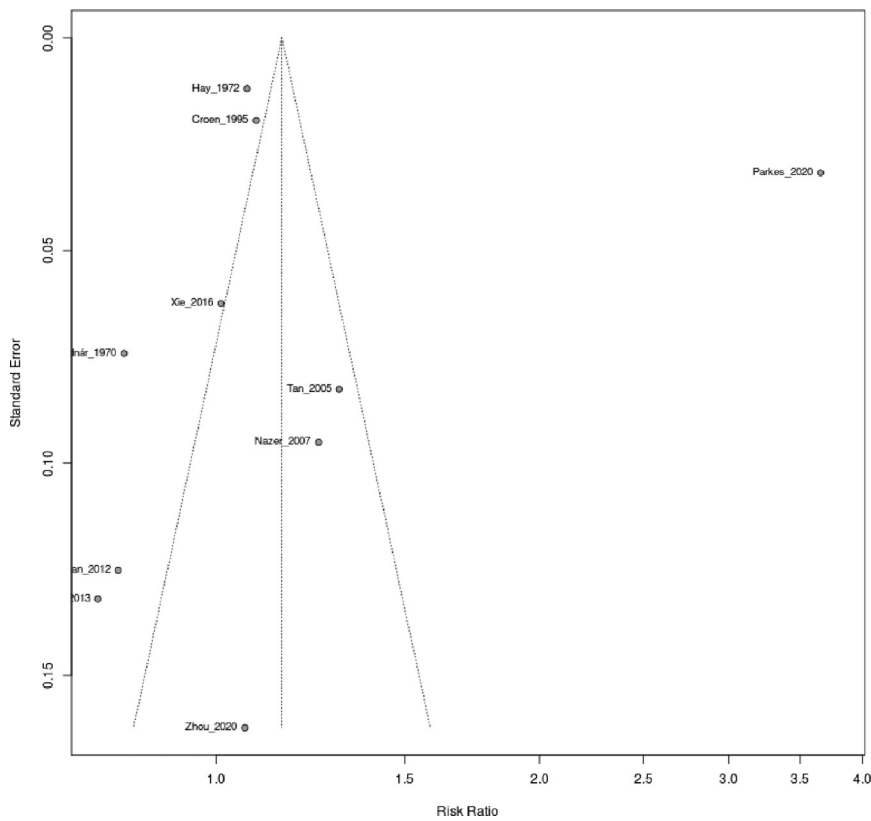
Funnel plot for the association between maternal age and *all nonchromosomal anomalies* (ICD-10: Q00–Q89) (30–35 vs 20–30 age groups)



ICD-10, International Classification of Diseases-10.

SUPPLEMENTAL FIGURE 22

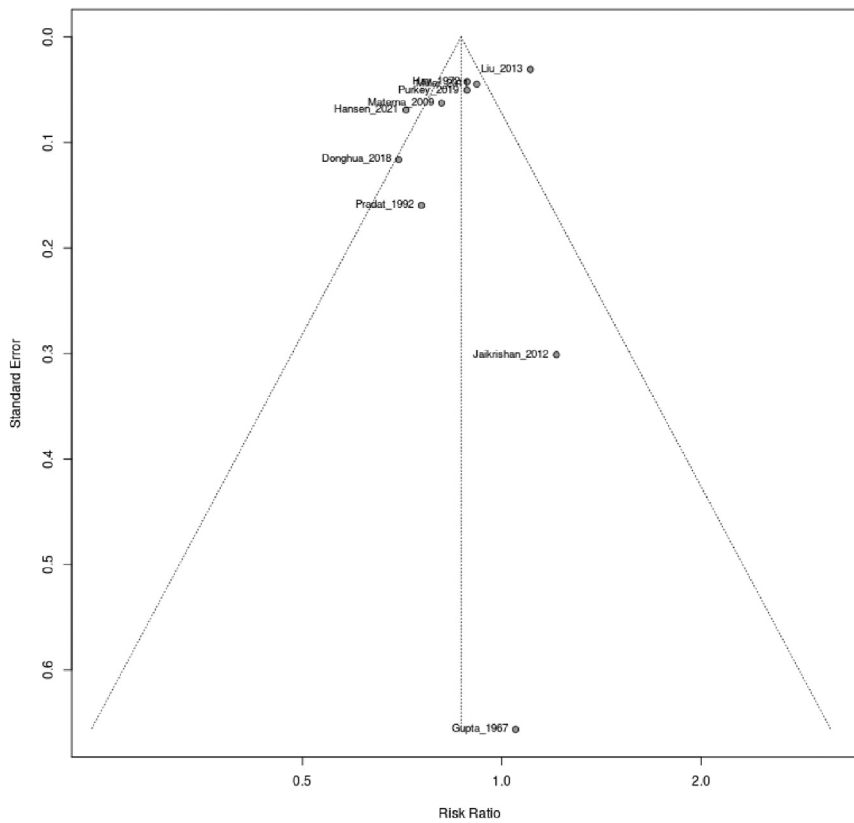
Funnel plot for the association between maternal age and *all nonchromosomal anomalies (only studies including concomitant chromosomal anomalies)* (ICD-10: Q00–Q99 with Q90–Q99) (<20 vs 20–30 age groups)



ICD-10, International Classification of Diseases-10.

SUPPLEMENTAL FIGURE 23

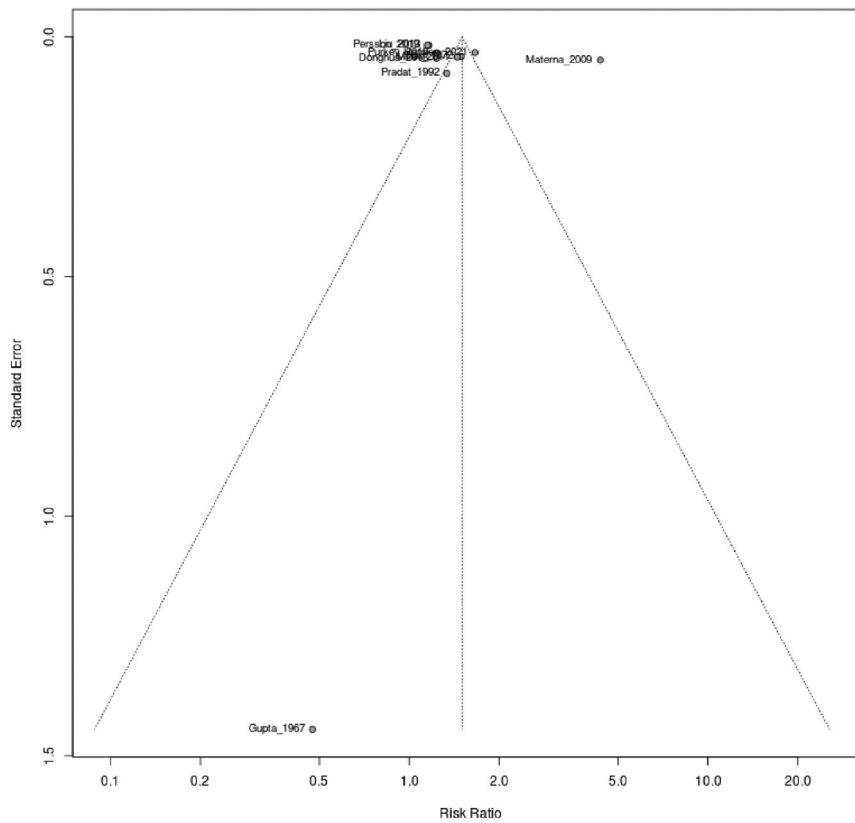
Funnel plot for the association between maternal age and *congenital heart defects* (ICD-10: Q20–Q26) (<20 vs 20–30 age groups)



ICD-10, International Classification of Diseases-10.

SUPPLEMENTAL FIGURE 24

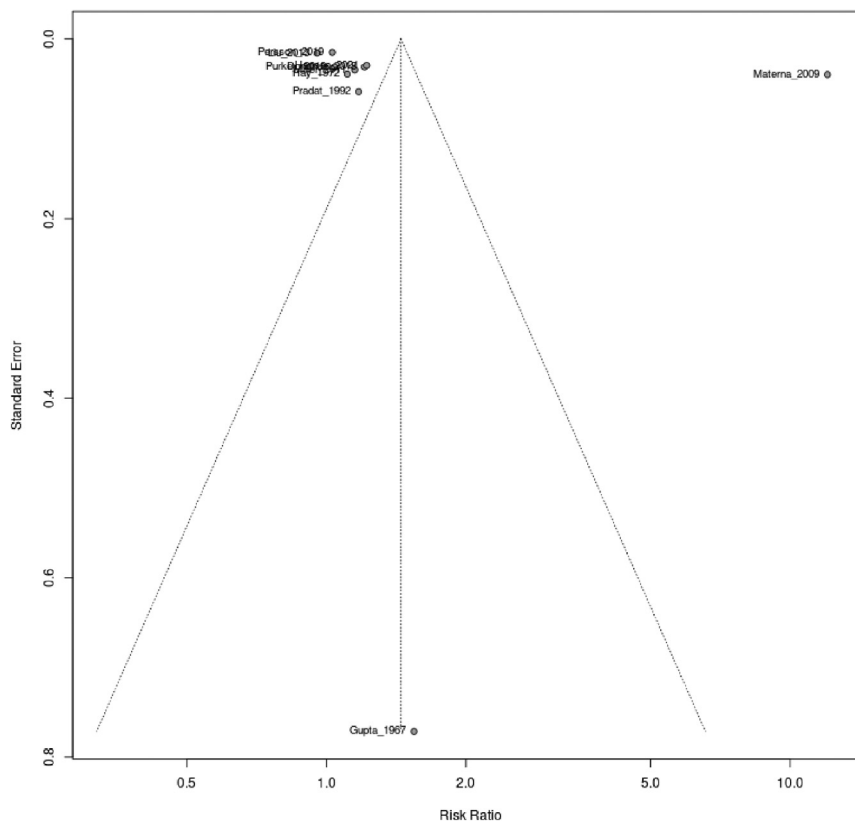
Funnel plot for the association between maternal age and *congenital heart defects* (ICD-10: Q20–Q26) (>35 vs 20–30 age groups)



ICD-10, International Classification of Diseases-10.

SUPPLEMENTAL FIGURE 25

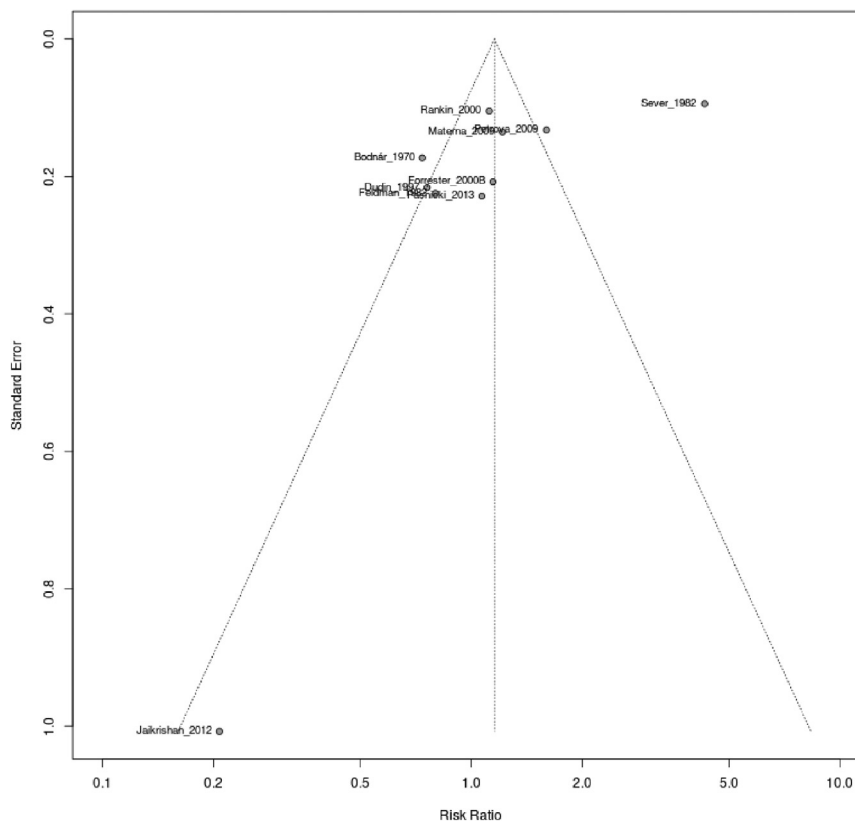
Funnel plot for the association between maternal age and *congenital heart defects* (ICD-10: Q20–Q26) (30–35 vs 20–30 age groups)



ICD-10, International Classification of Diseases-10.

SUPPLEMENTAL FIGURE 26

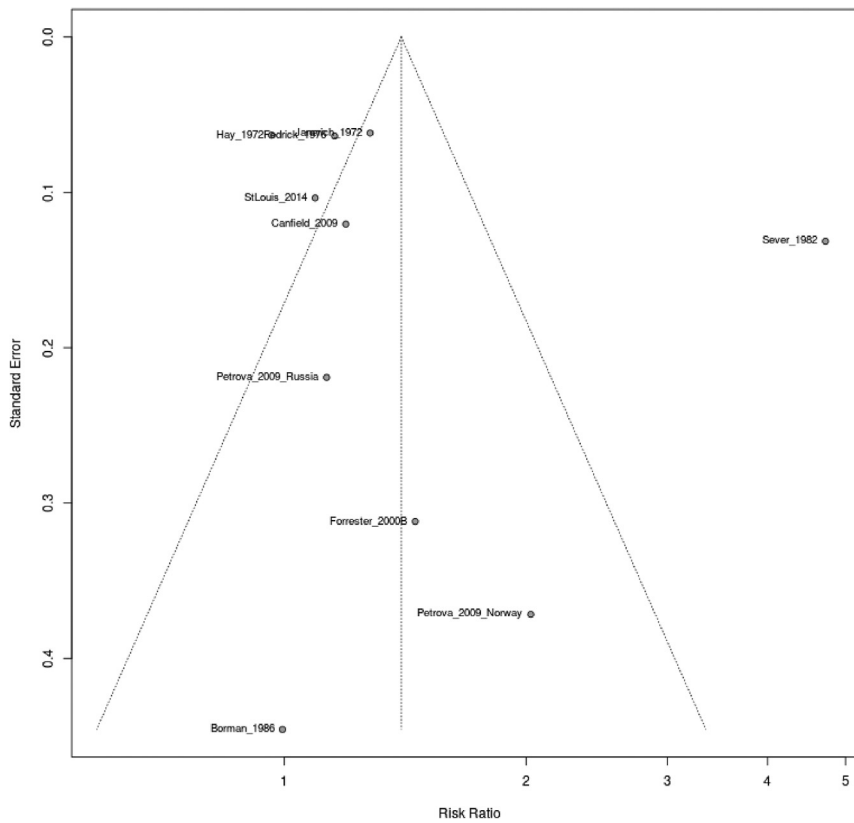
Funnel plot for the association between maternal age and *congenital anomalies of the nervous system* (ICD-10: Q00–Q07) (<20 vs 20–30 age groups)



ICD-10, International Classification of Diseases-10.

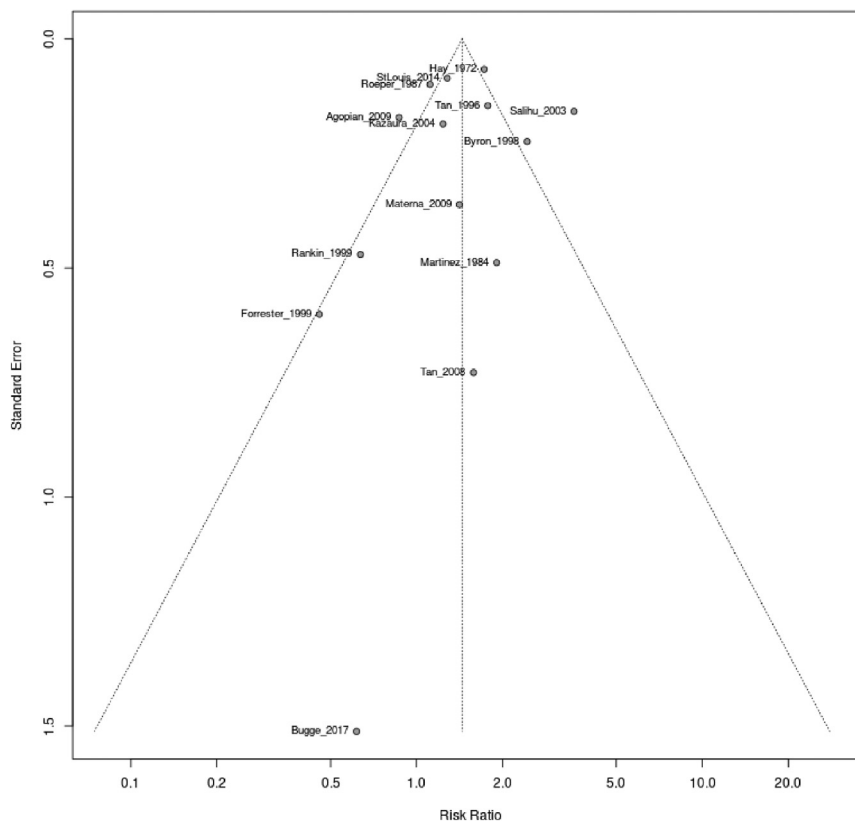
SUPPLEMENTAL FIGURE 27

Funnel plot for the association between maternal age and *anencephaly* (ICD-10: Q00.0) (<20 vs 20–30 age groups)



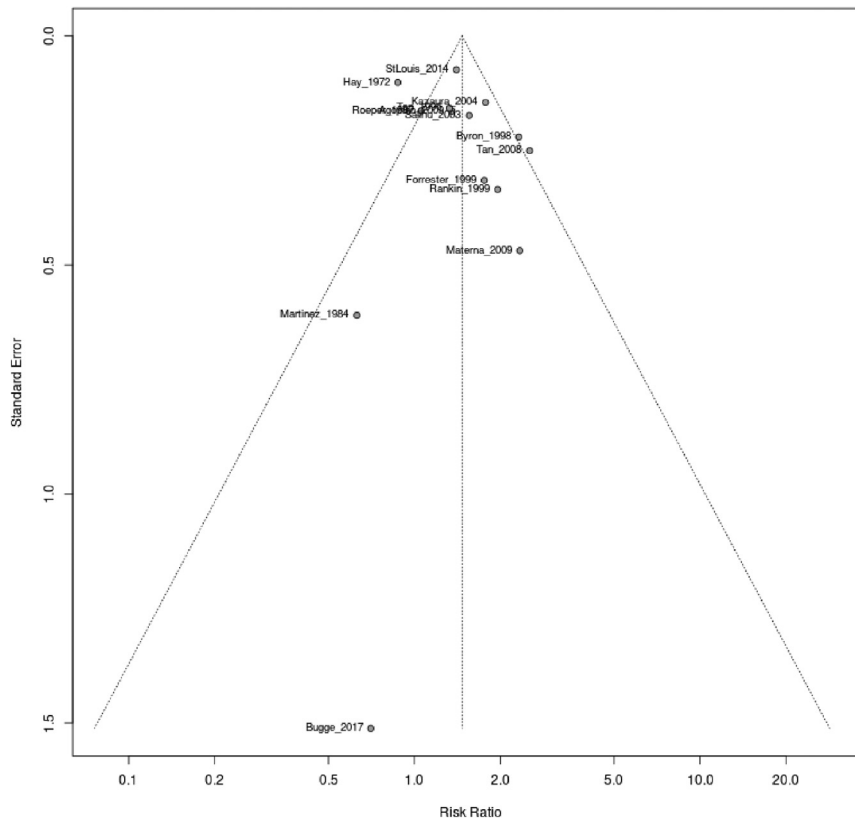
ICD-10, International Classification of Diseases-10.

SUPPLEMENTAL FIGURE 28

Funnel plot for the association between maternal age and *omphalocele* (ICD-10: Q79.2) (<20 vs 20–30 age groups)

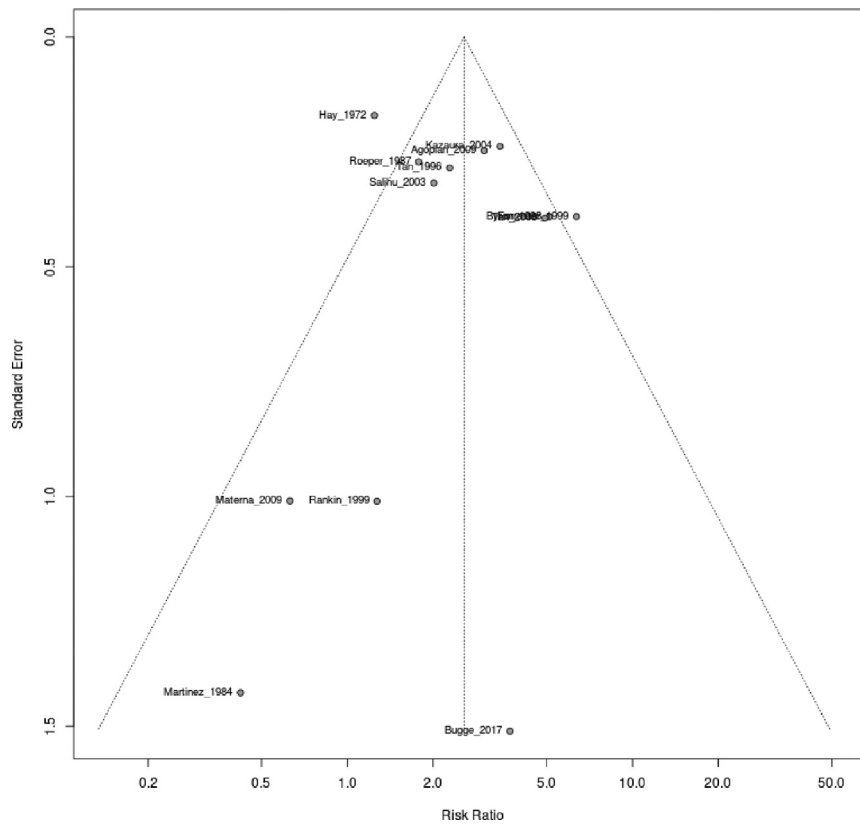
ICD-10, International Classification of Diseases-10.

SUPPLEMENTAL FIGURE 29

Funnel plot for the association between maternal age and *omphalocele* (ICD-10: Q79.2) (>35 vs 20–30 age groups)

ICD-10, International Classification of Diseases-10.

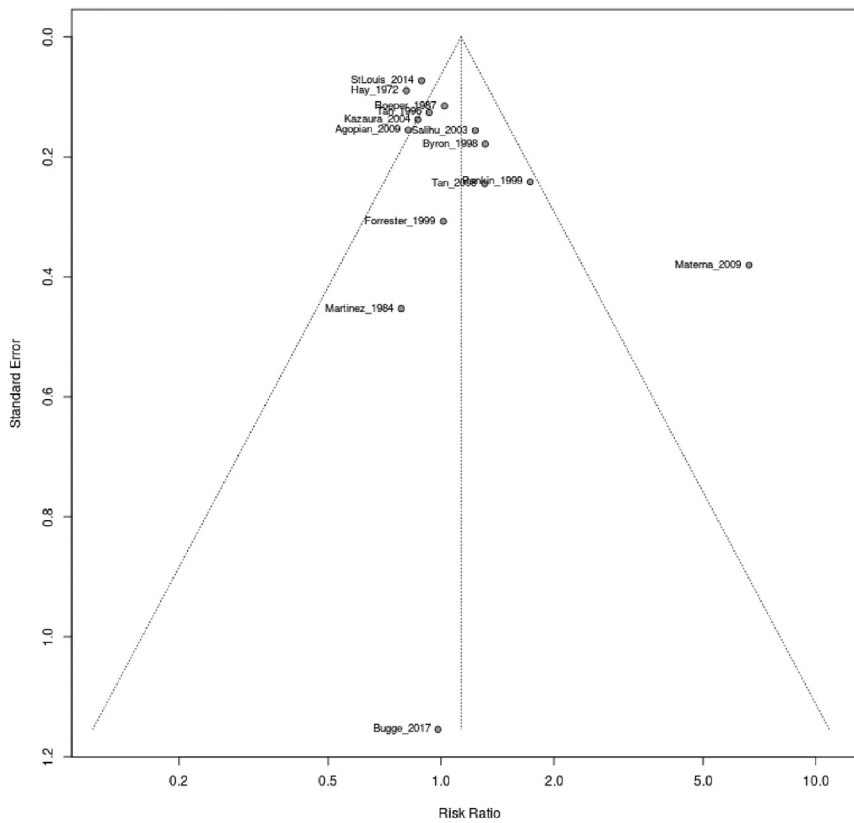
SUPPLEMENTAL FIGURE 30

Funnel plot for the association between maternal age and *omphalocele* (ICD-10: Q79.2) (>40 vs 20–30 age groups)

ICD-10, International Classification of Diseases-10.

SUPPLEMENTAL FIGURE 31

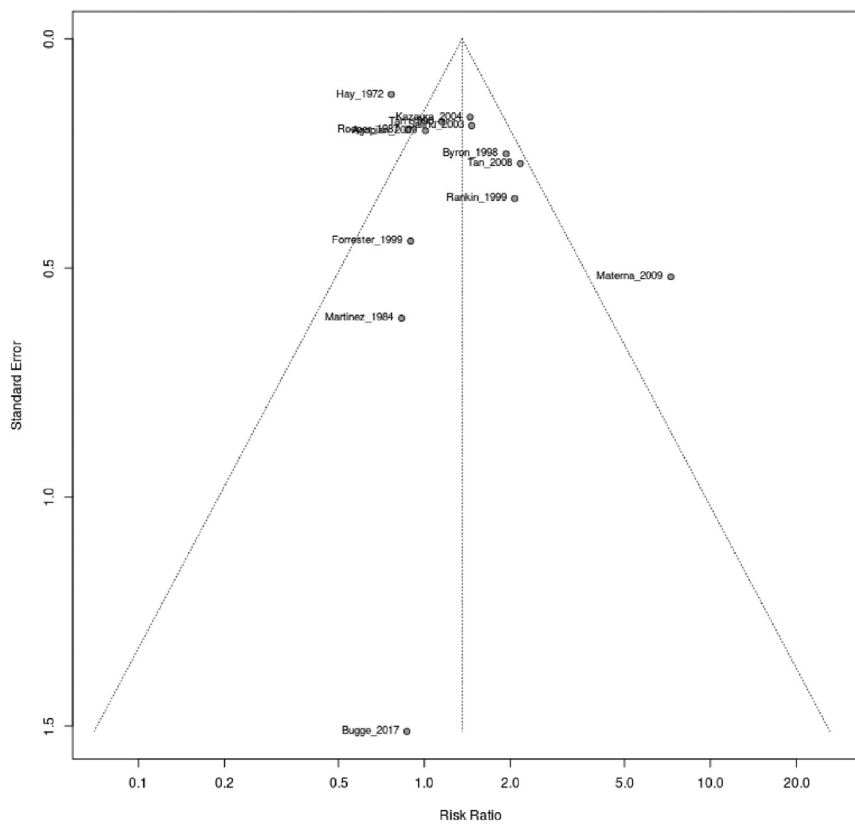
Funnel plot for the association between maternal age and *omphalocele* (ICD-10: Q79.2) (30–35 vs 20–30 age groups)



ICD-10, International Classification of Diseases-10.

SUPPLEMENTAL FIGURE 32

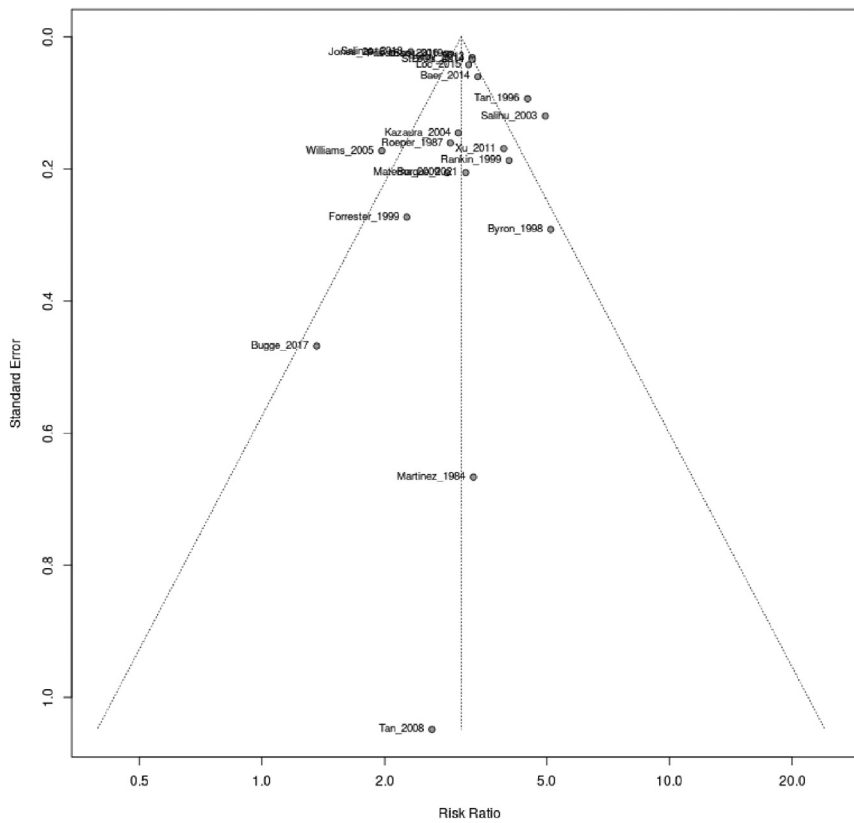
Funnel plot for the association between maternal age and *omphalocele* (ICD-10: Q79.2) (35–40 vs 20–30 age groups)



ICD-10, International Classification of Diseases-10.

SUPPLEMENTAL FIGURE 33

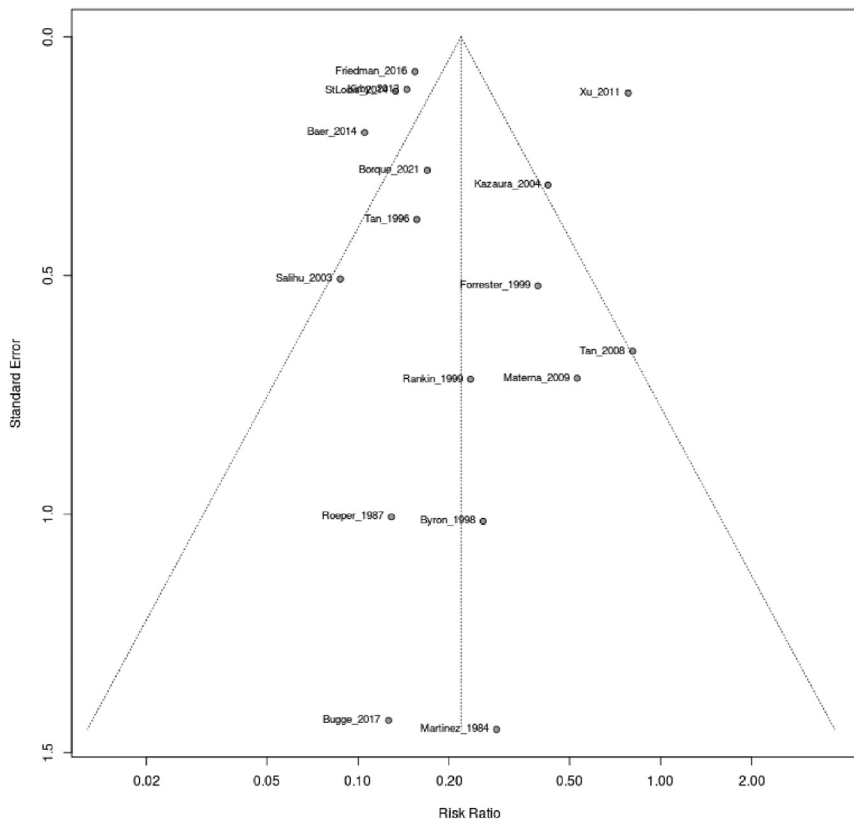
Funnel plot for the association between maternal age and *gastroschisis* (ICD-10: Q79.3) (<20 vs 20–30 age groups)



ICD-10, International Classification of Diseases-10.

SUPPLEMENTAL FIGURE 34

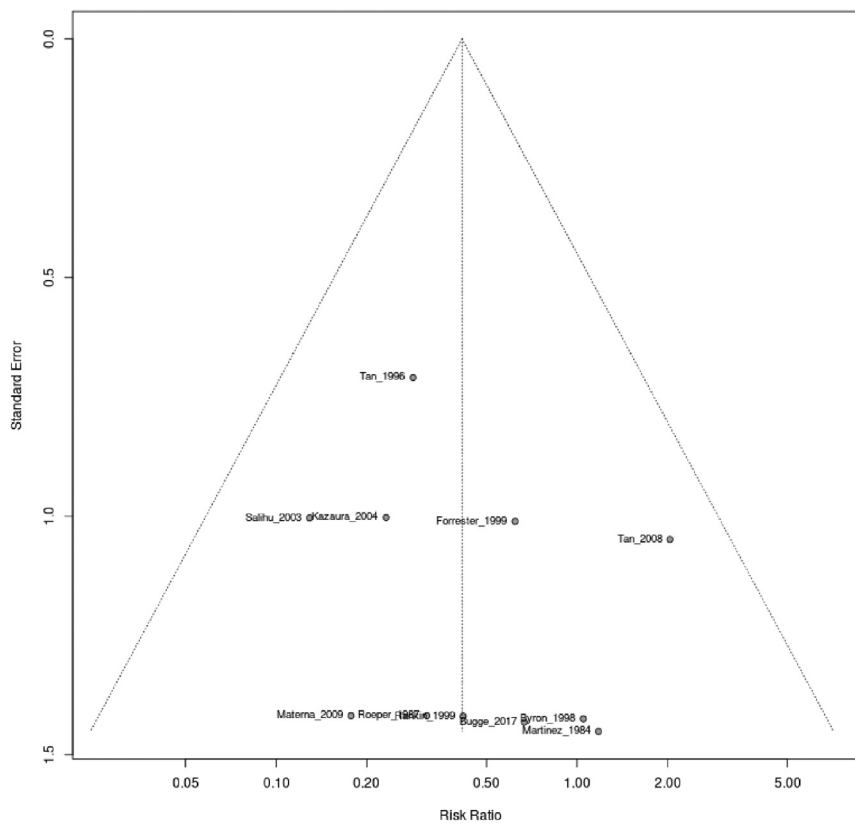
Funnel plot for the association between maternal age and *gastroschisis* (ICD-10: Q79.3) (>35 vs 20–30 age groups)



ICD-10, International Classification of Diseases-10.

SUPPLEMENTAL FIGURE 35

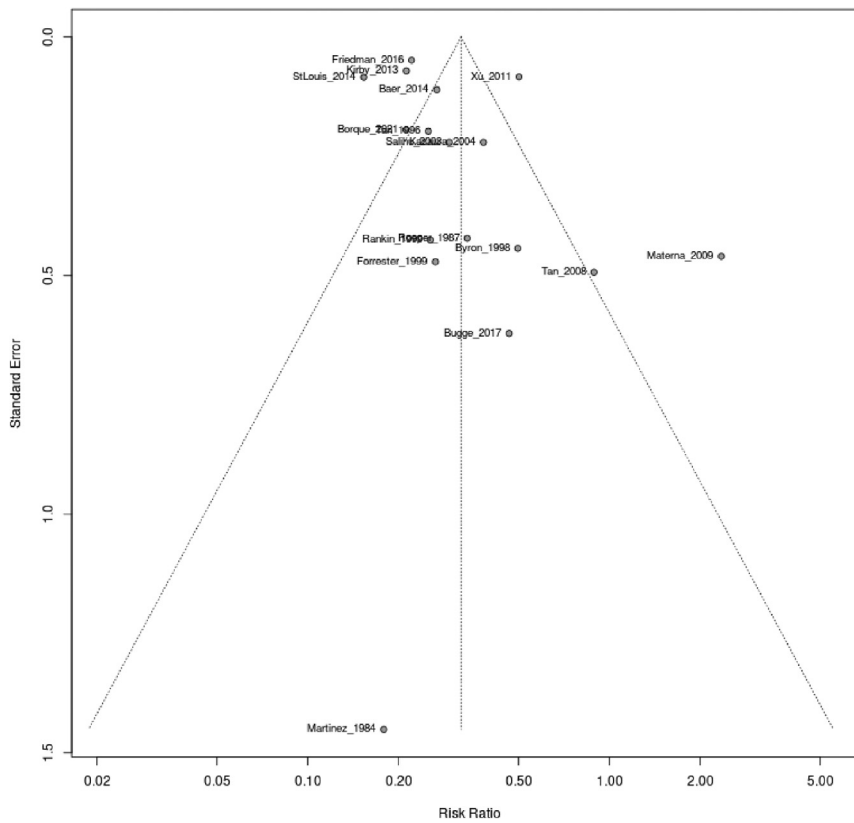
Funnel plot for the association between maternal age and *gastroschisis* (ICD-10: Q79.3) (>40 vs 20–30 age groups)



ICD-10, International Classification of Diseases-10.

SUPPLEMENTAL FIGURE 36

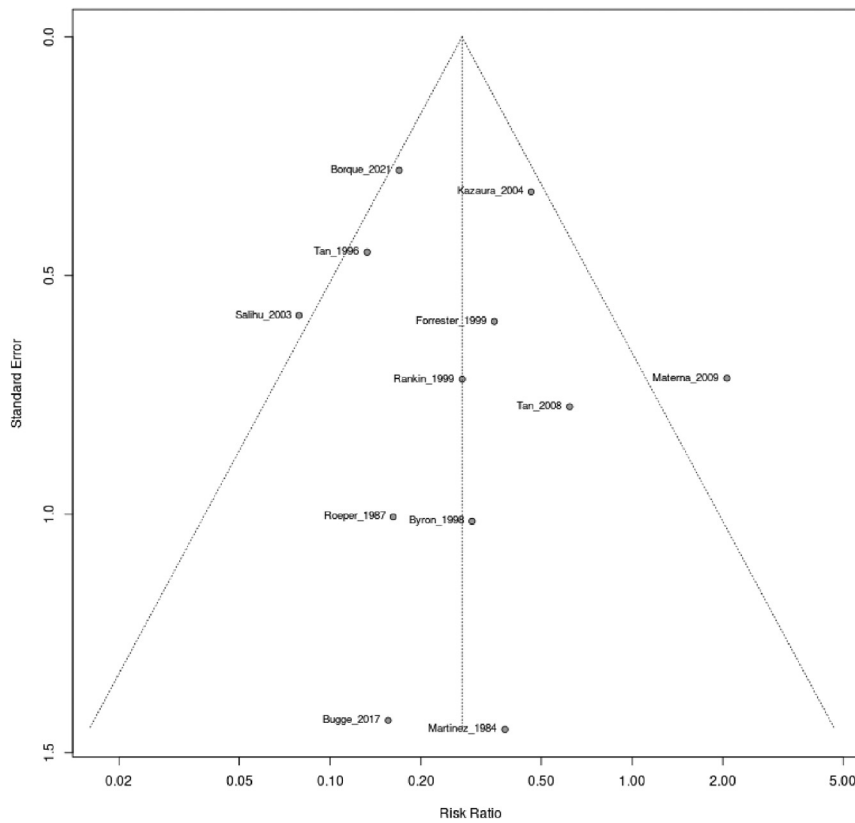
Funnel plot for the association between maternal age and *gastroschisis* (ICD-10: Q79.3) (30–35 vs 20–30 age groups)



ICD-10, International Classification of Diseases-10.

SUPPLEMENTAL FIGURE 37

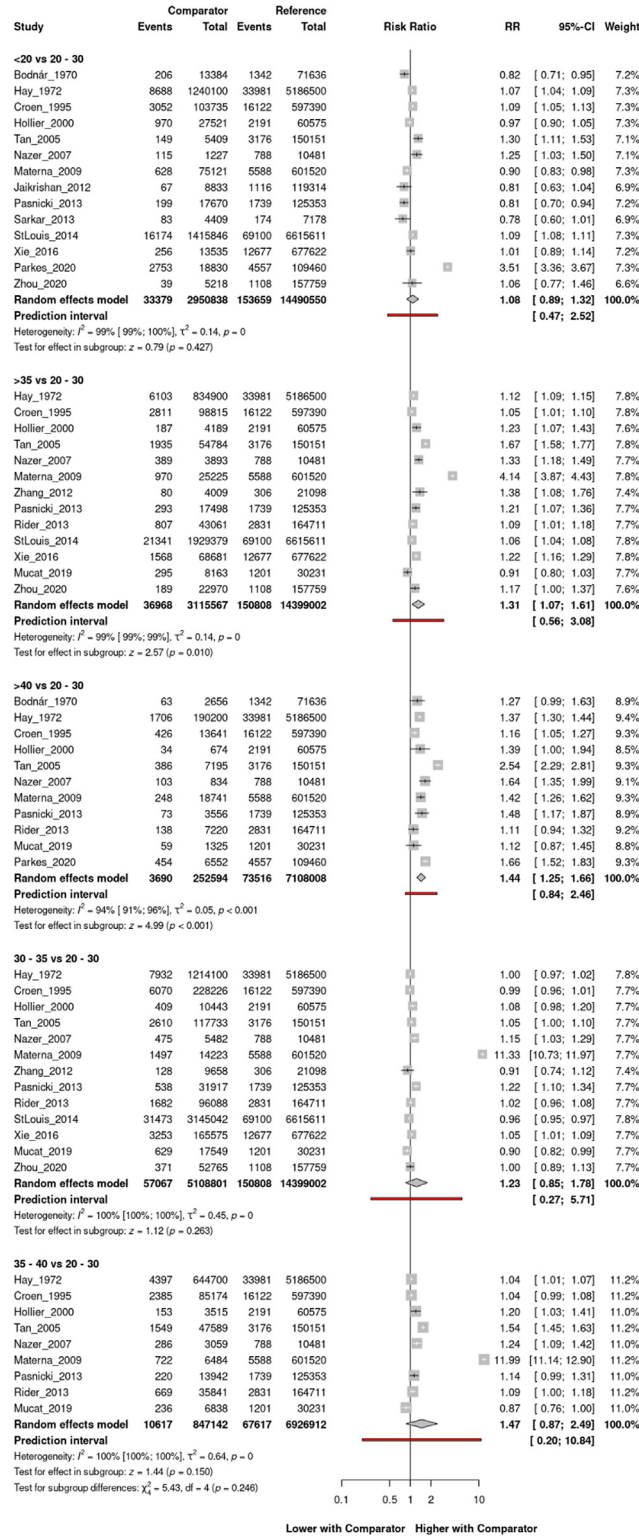
Funnel plot for the association between maternal age and *gastroschisis* (ICD-10: Q79.3) (35–40 vs 20–30 age groups)



ICD-10, International Classification of Diseases-10.

SUPPLEMENTAL FIGURE 38

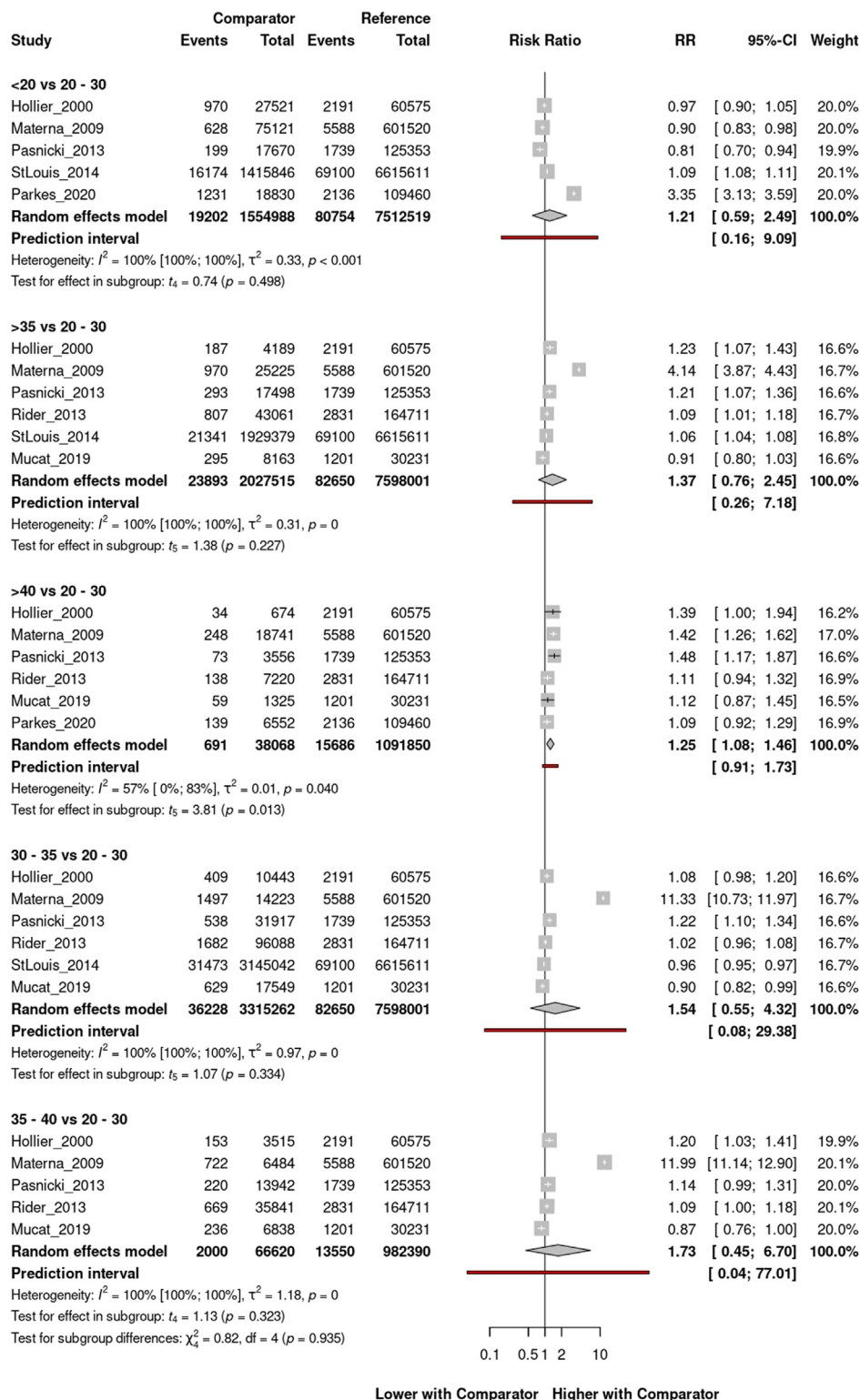
Forest plot representing the RR with 95% CI of all nonchromosomal anomalies (ICD-10: Q00–Q89) in different age groups compared to the 20 to 30 age group and sorted by year of publication



CI, confidence interval; ICD-10, International Classification of Diseases-10; RR, risk ratio.

SUPPLEMENTAL FIGURE 39

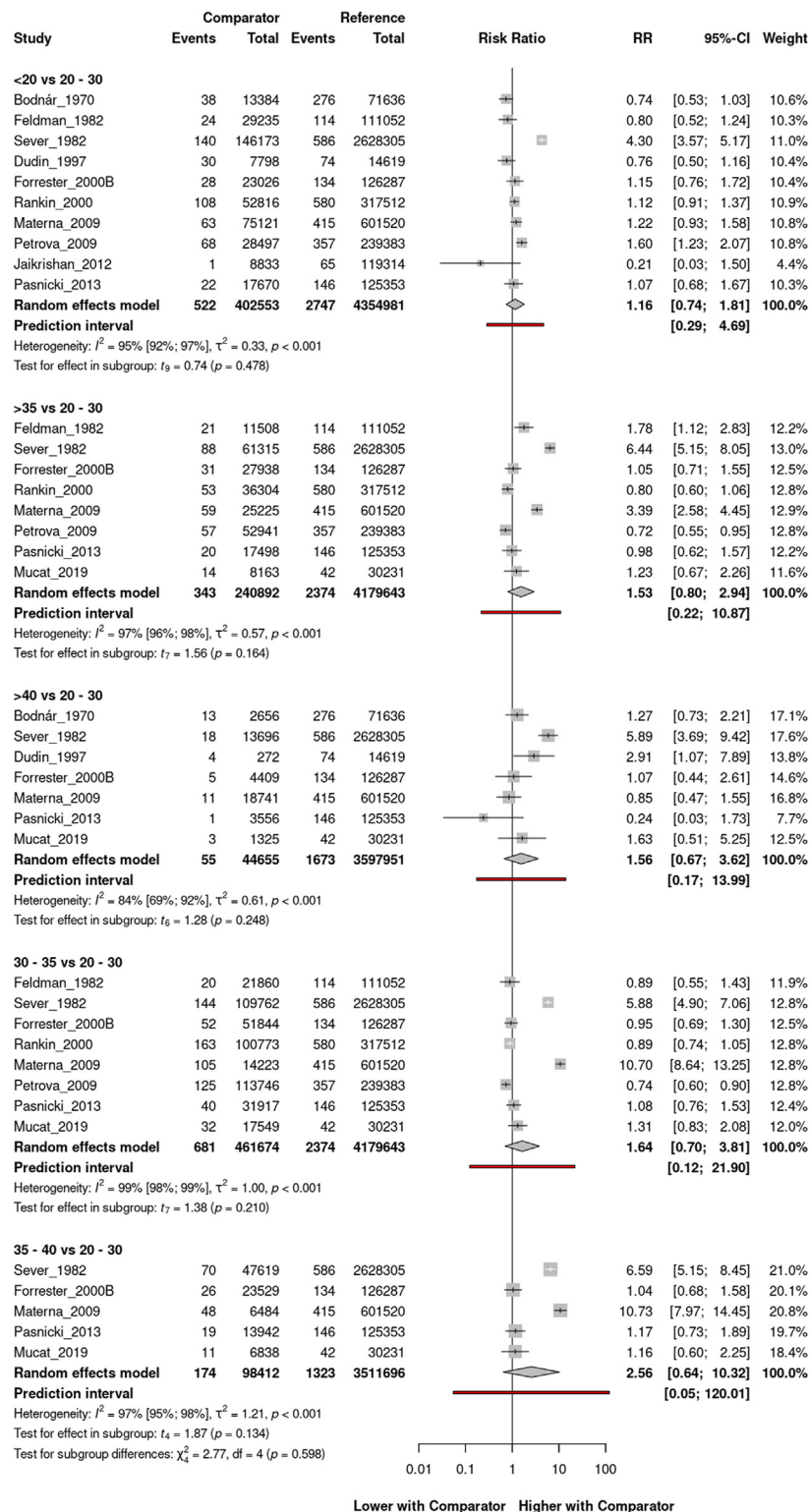
Forest plot representing the RR with 95% CI of *all nonchromosomal anomalies (only studies excluding concomitant chromosomal anomalies)* (ICD-10: Q00–Q89) in different age groups compared to the 20 to 30 age group and sorted by year of publication



CI, confidence interval; ICD-10, International Classification of Diseases-10; RR, risk ratio.

SUPPLEMENTAL FIGURE 40

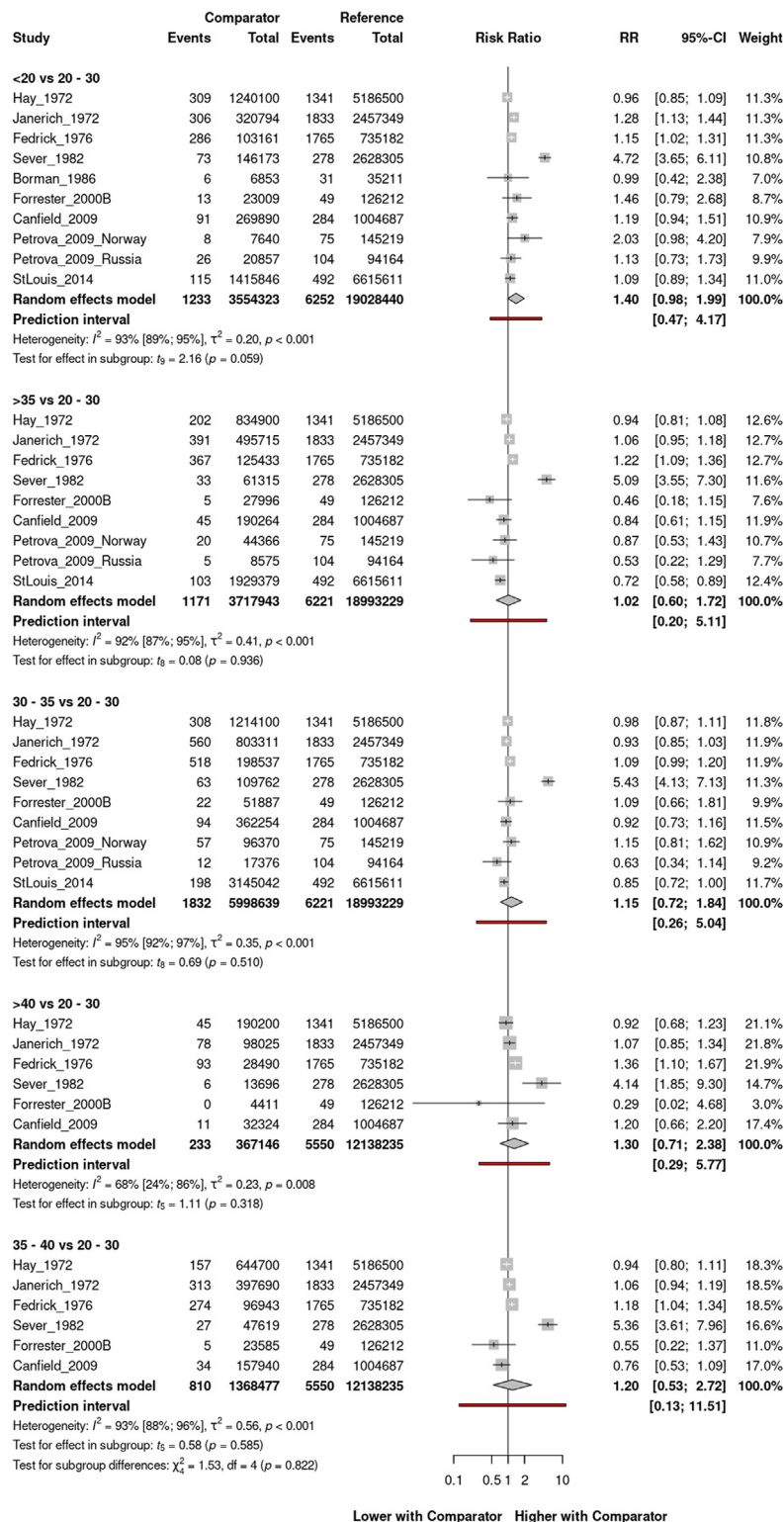
Forest plot representing the RR with 95% CI of congenital anomalies of the nervous system (ICD-10: Q00–Q07) in different age groups compared to the 20 to 30 age group and sorted by year of publication



CI, confidence interval; ICD-10, International Classification of Diseases-10; RR, risk ratio.

SUPPLEMENTAL FIGURE 41

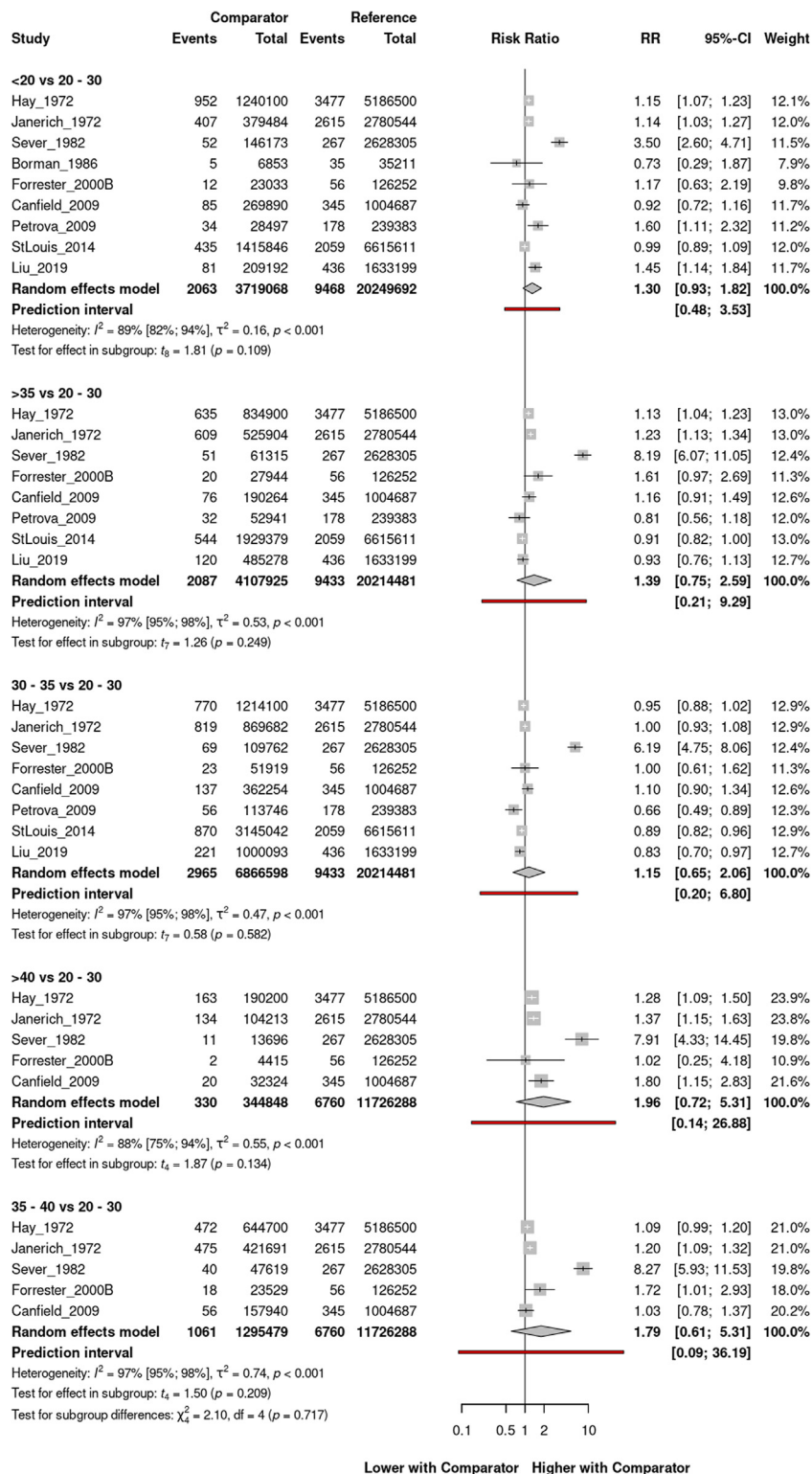
Forest plot representing the RR with 95% CI of *anencephaly* (ICD-10: Q00.0) in different age groups compared to the 20 to 30 age group and sorted by year of publication



CI, confidence interval; ICD-10, International Classification of Diseases-10; RR, risk ratio.

SUPPLEMENTAL FIGURE 42

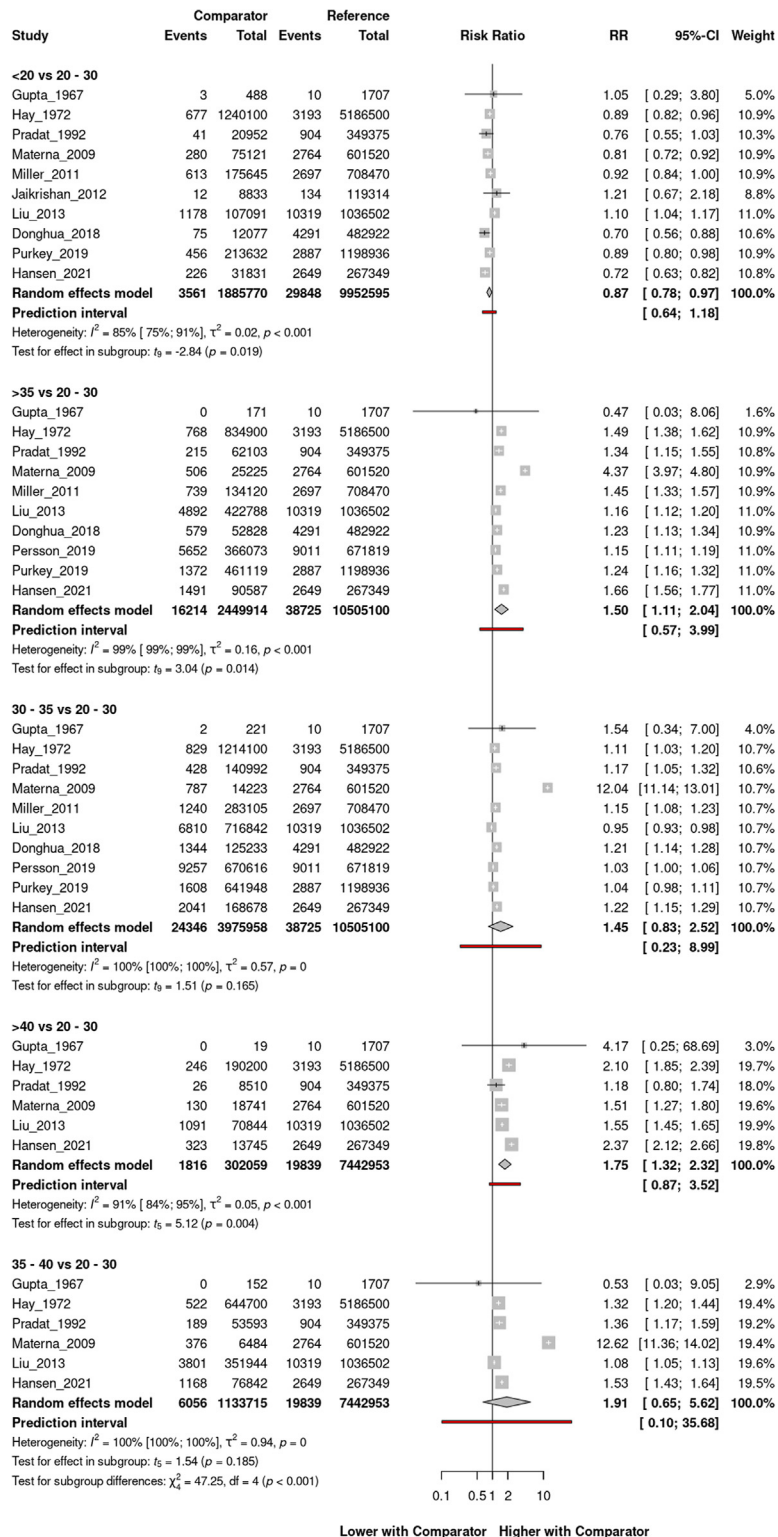
Forest plot representing the RR with 95% CI of *spina bifida* (ICD-10: Q05) in different age groups compared to the 20 to 30 age group and sorted by year of publication



CI, confidence interval; ICD-10, International Classification of Diseases-10; RR, risk ratio.

SUPPLEMENTAL FIGURE 43

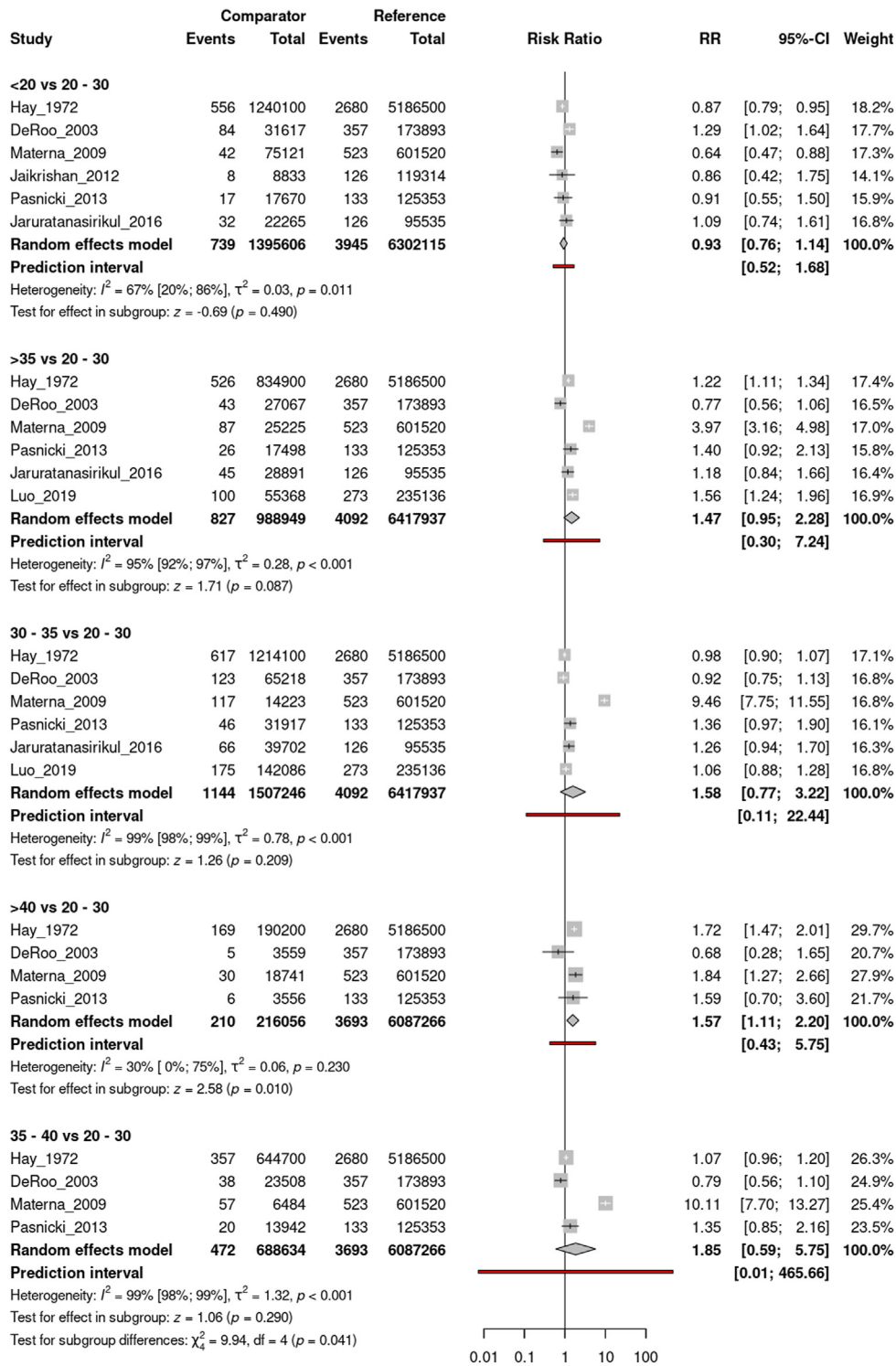
Forest plot representing the RR with 95% CI of congenital heart defects (ICD-10: Q20–Q26) in different age groups compared to the 20 to 30 age group and sorted by year of publication



CI, confidence interval; ICD-10, International Classification of Diseases-10; RR, risk ratio.

SUPPLEMENTAL FIGURE 44

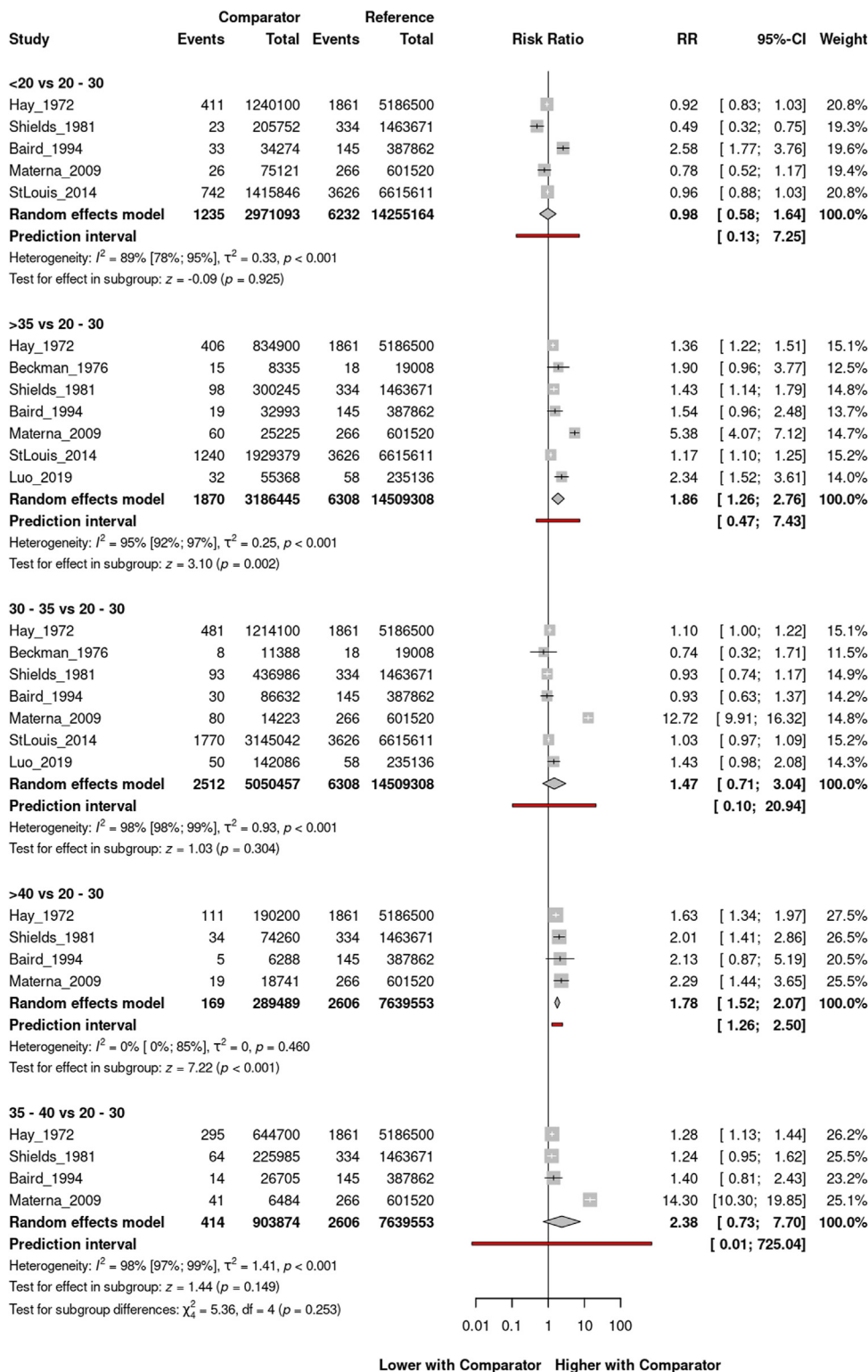
Forest plot representing the RR with 95% CI of *cleft lip and cleft palate* (ICD-10: Q35–Q37) in different age groups compared to the 20 to 30 age group and sorted by year of publication



CI, confidence interval; ICD-10, International Classification of Diseases-10; RR, risk ratio.

SUPPLEMENTAL FIGURE 45

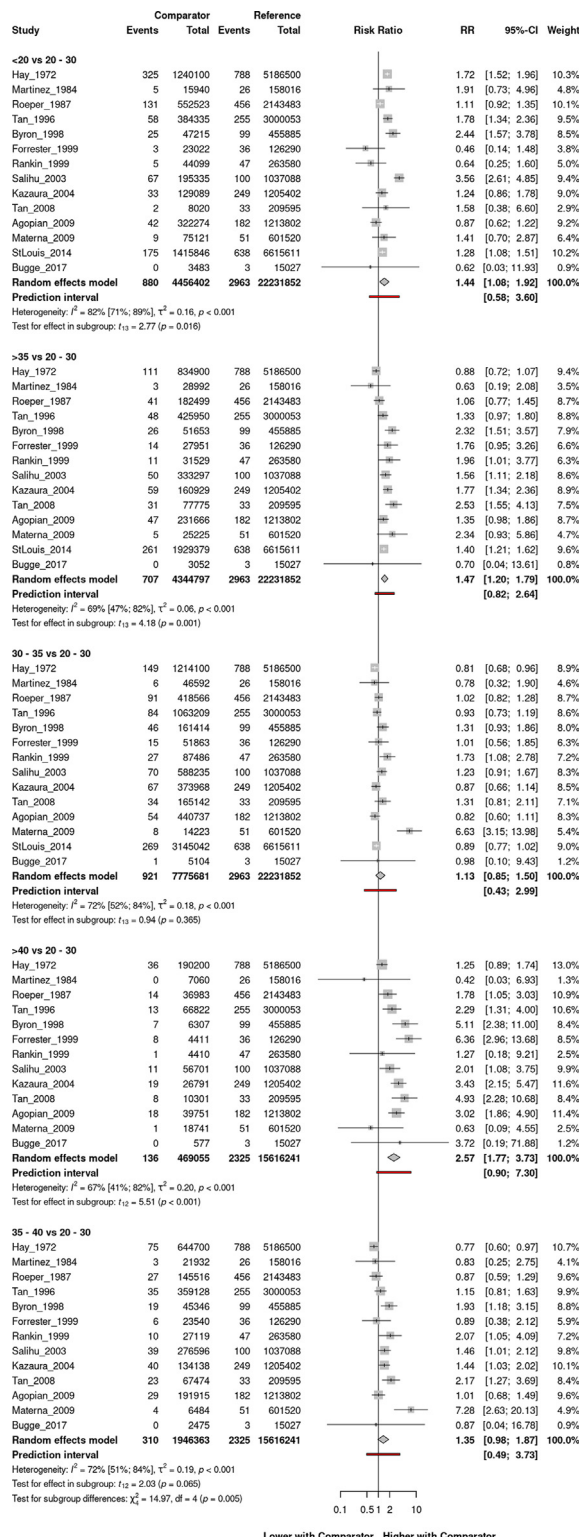
Forest plot representing the RR with 95% CI of *cleft palate* (ICD-10: Q35) in different age groups compared to the 20 to 30 age group and sorted by year of publication



CI, confidence interval; ICD-10, International Classification of Diseases-10; RR, risk ratio.

SUPPLEMENTAL FIGURE 46

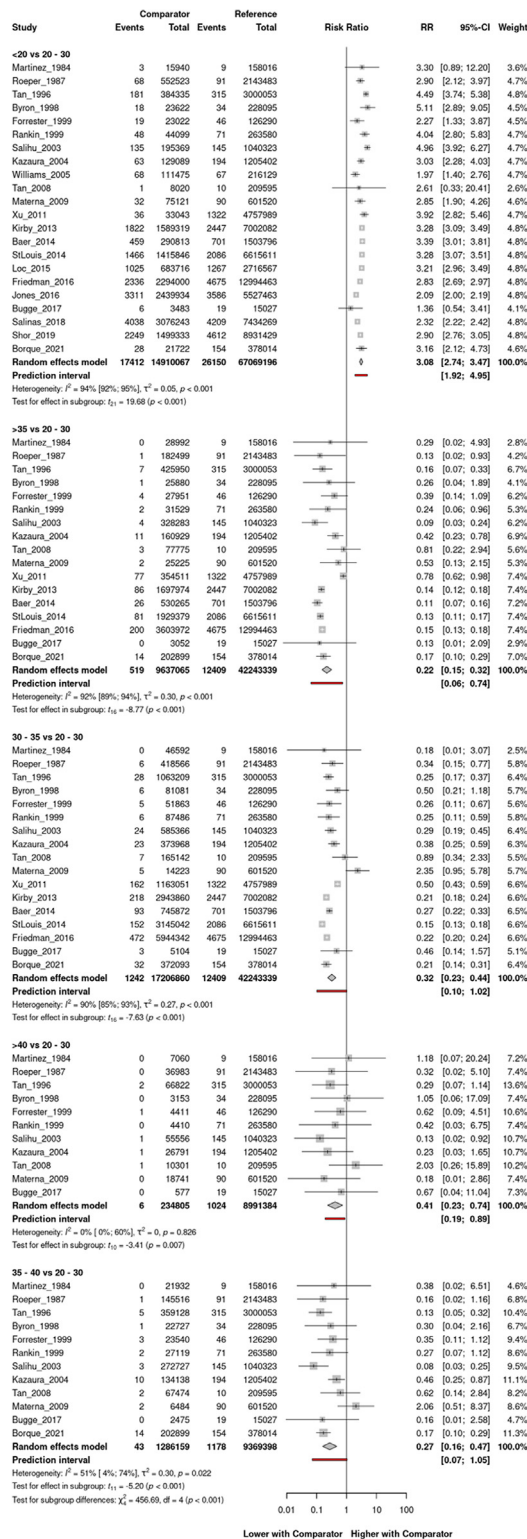
Forest plot representing the RR with 95% CI of *omphalocele* (ICD-10: Q79.2) in different age groups compared to the 20 to 30 age group and sorted by year of publication



CI, confidence interval; ICD-10, International Classification of Diseases-10; RR, risk ratio.

SUPPLEMENTAL FIGURE 47

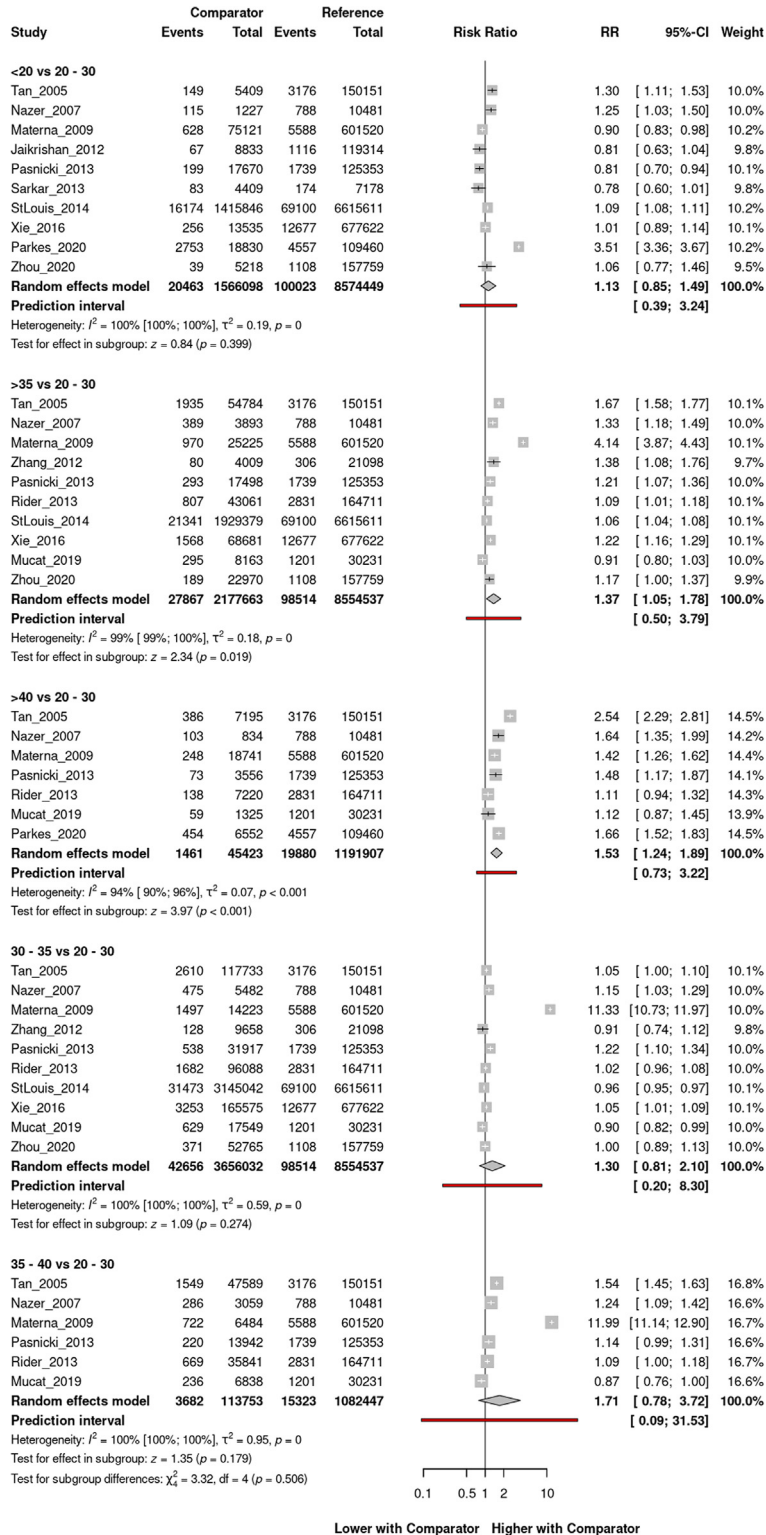
Forest plot representing the RR with 95% CI of *gastroschisis* (ICD-10: Q79.3) in different age groups compared to the 20 to 30 age group and sorted by year of publication



CI, confidence interval; ICD-10, International Classification of Diseases-10; RR, risk ratio.

SUPPLEMENTAL FIGURE 48

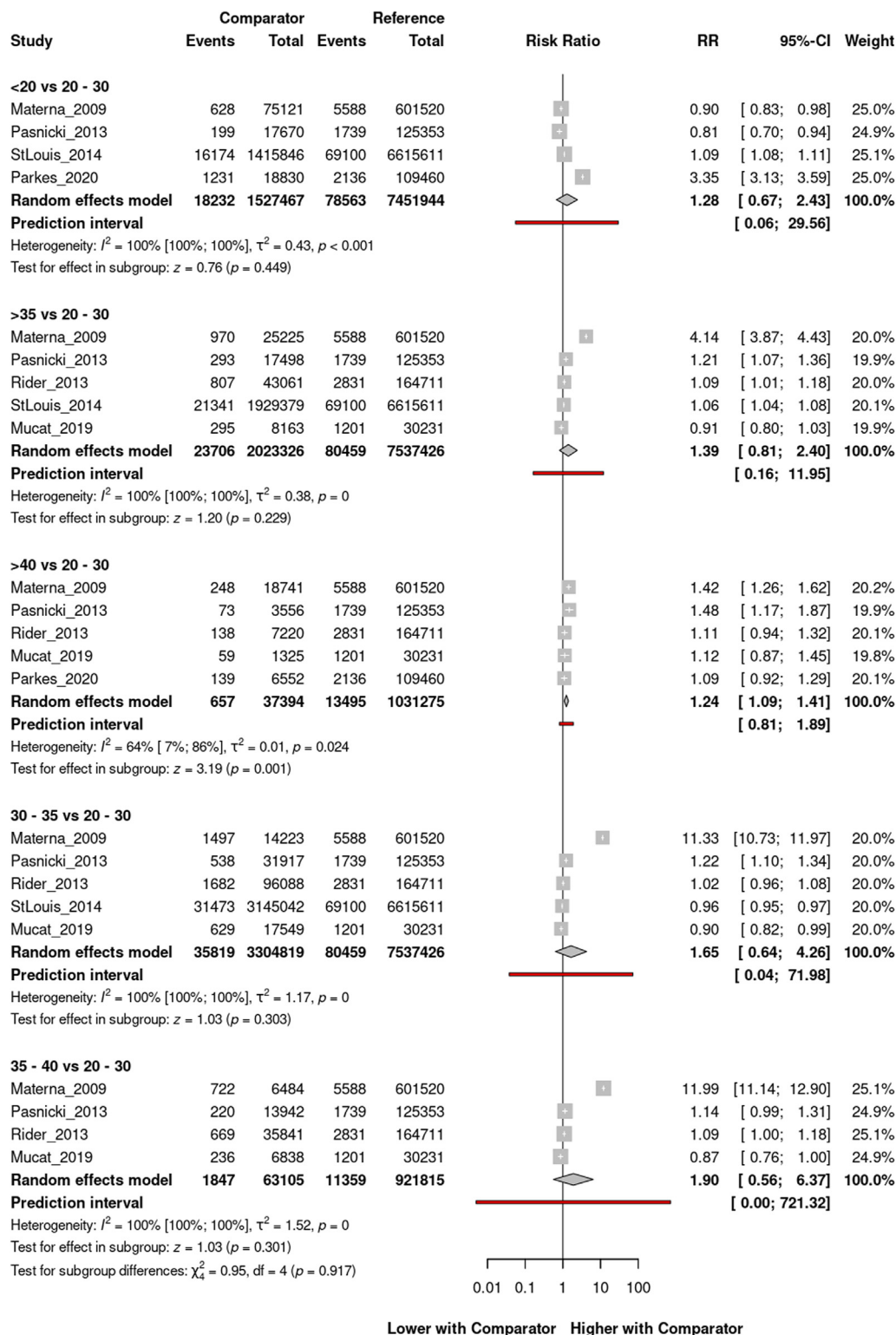
Forest plot representing the RR with 95% CI of all nonchromosomal anomalies (ICD-10: Q00–Q89) in different age groups compared to the 20 to 30 age group and sorted by year of publication but only including studies published since 2005



CI, confidence interval; ICD-10, International Classification of Diseases-10; RR, risk ratio.

SUPPLEMENTAL FIGURE 49

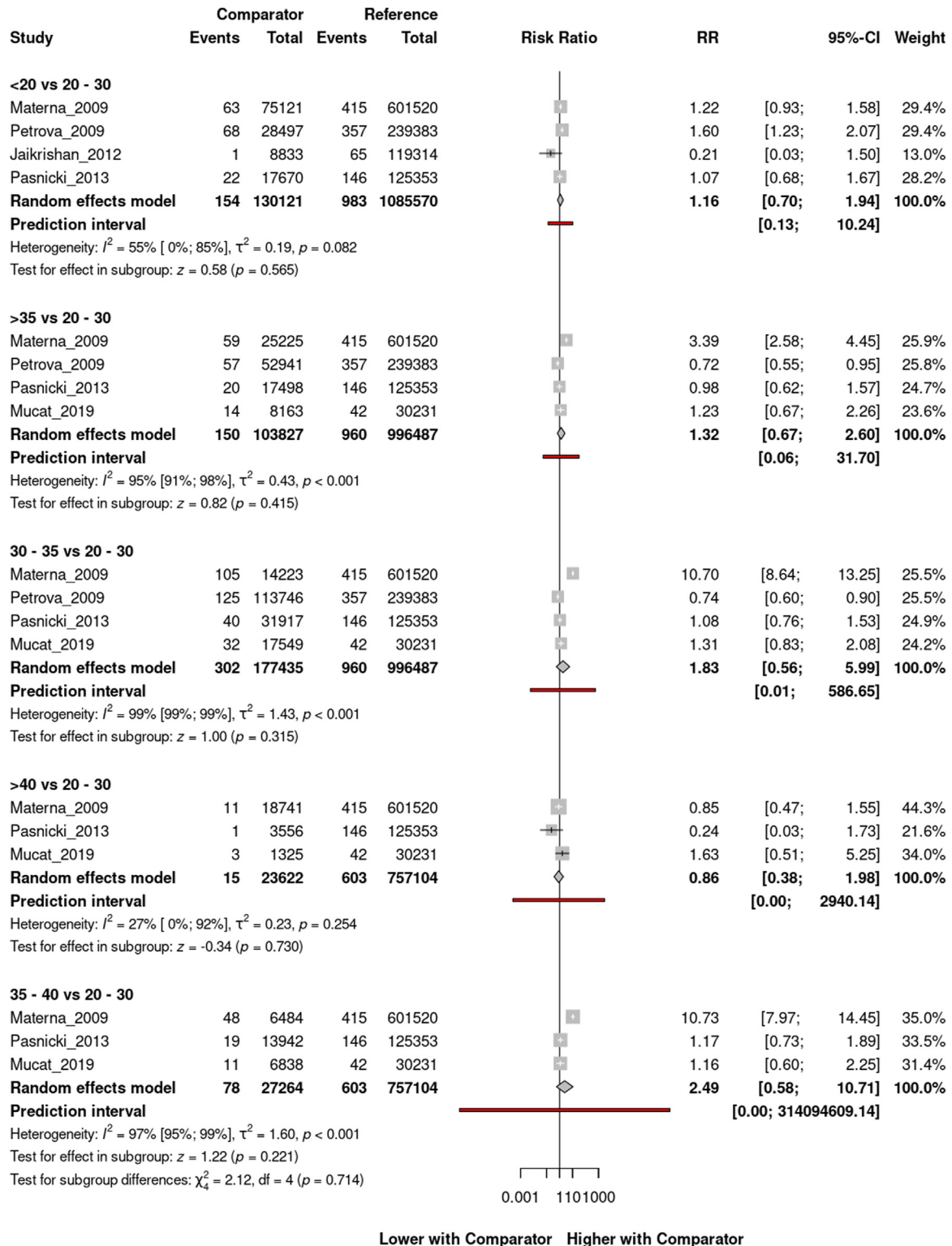
Forest plot representing the RR with 95% CI of *all nonchromosomal anomalies (only studies excluding concomitant chromosomal anomalies)* (ICD-10: Q00–Q89) in different age groups compared to the 20 to 30 age group and sorted by year of publication but only including studies published since 2005



CI, confidence interval; ICD-10, International Classification of Diseases-10; RR, risk ratio.

SUPPLEMENTAL FIGURE 50

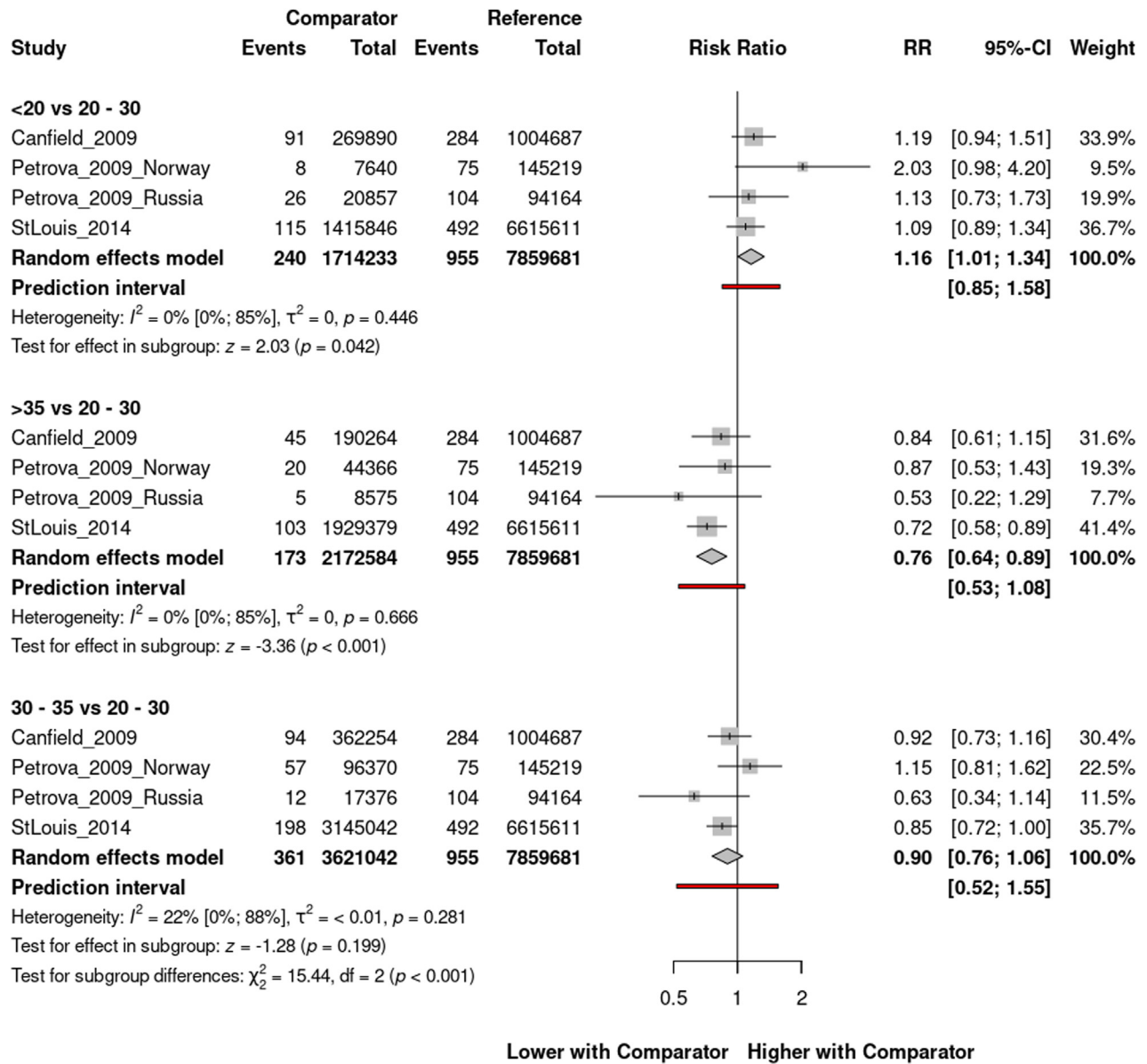
Forest plot representing the RR with 95% CI of congenital anomalies of the nervous system (ICD-10: Q00–Q07) in different age groups compared to the 20 to 30 age group and sorted by year of publication but only including studies published since 2005



CI, confidence interval; ICD-10, International Classification of Diseases-10; RR, risk ratio.

SUPPLEMENTAL FIGURE 51

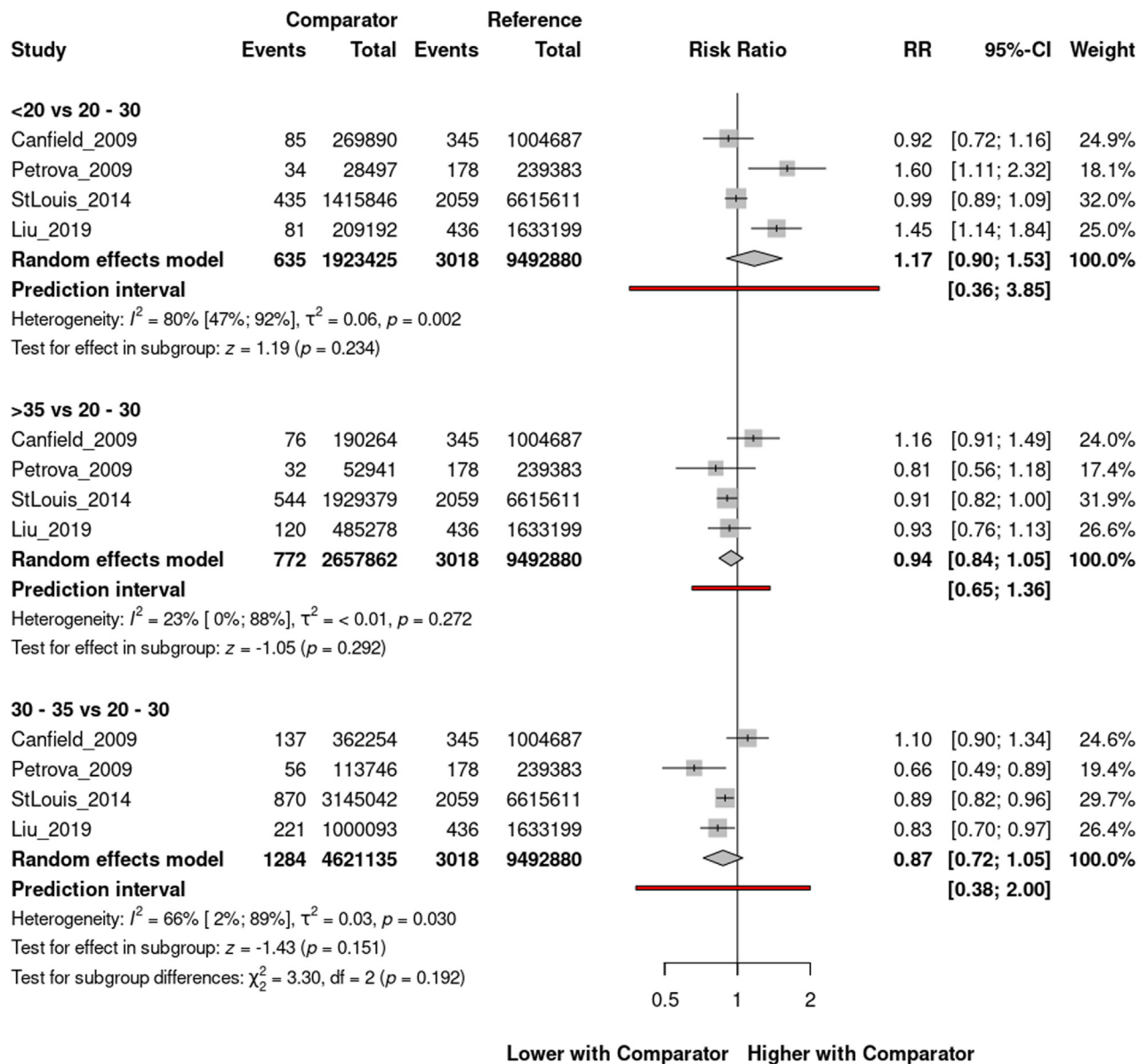
Forest plot representing the RR with 95% CI of *anencephaly* (ICD-10: Q00.0) in different age groups compared to the 20 to 30 age group and sorted by year of publication but only including studies published since 2005



CI, confidence interval; ICD-10, International Classification of Diseases-10; RR, risk ratio.

SUPPLEMENTAL FIGURE 52

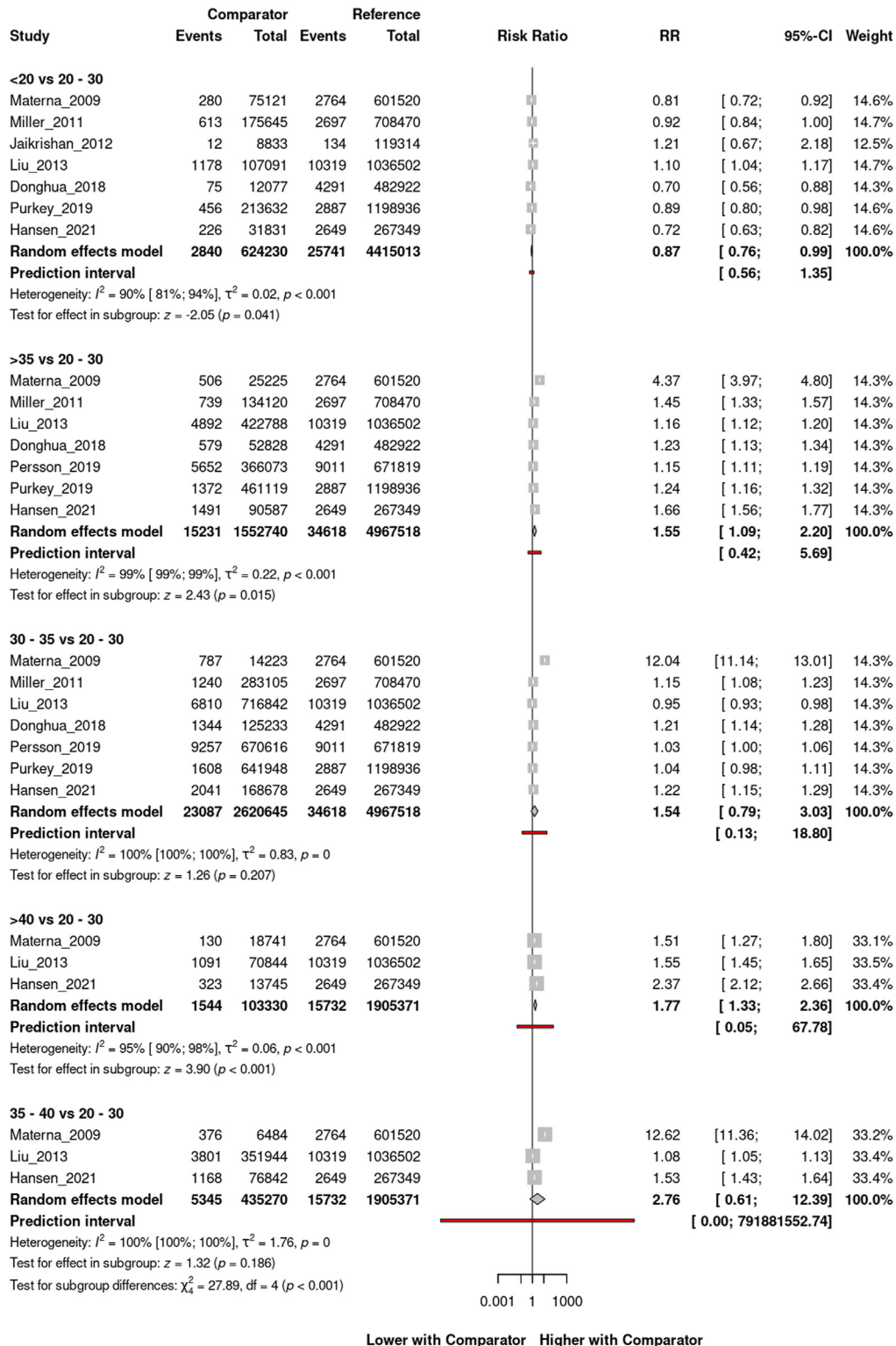
Forest plot representing the RR with 95% CI of *spina bifida* (ICD-10: Q05) in different age groups compared to the 20 to 30 age group and sorted by year of publication but only including studies published since 2005



CI, confidence interval; ICD-10, International Classification of Diseases-10; RR, risk ratio.

SUPPLEMENTAL FIGURE 53

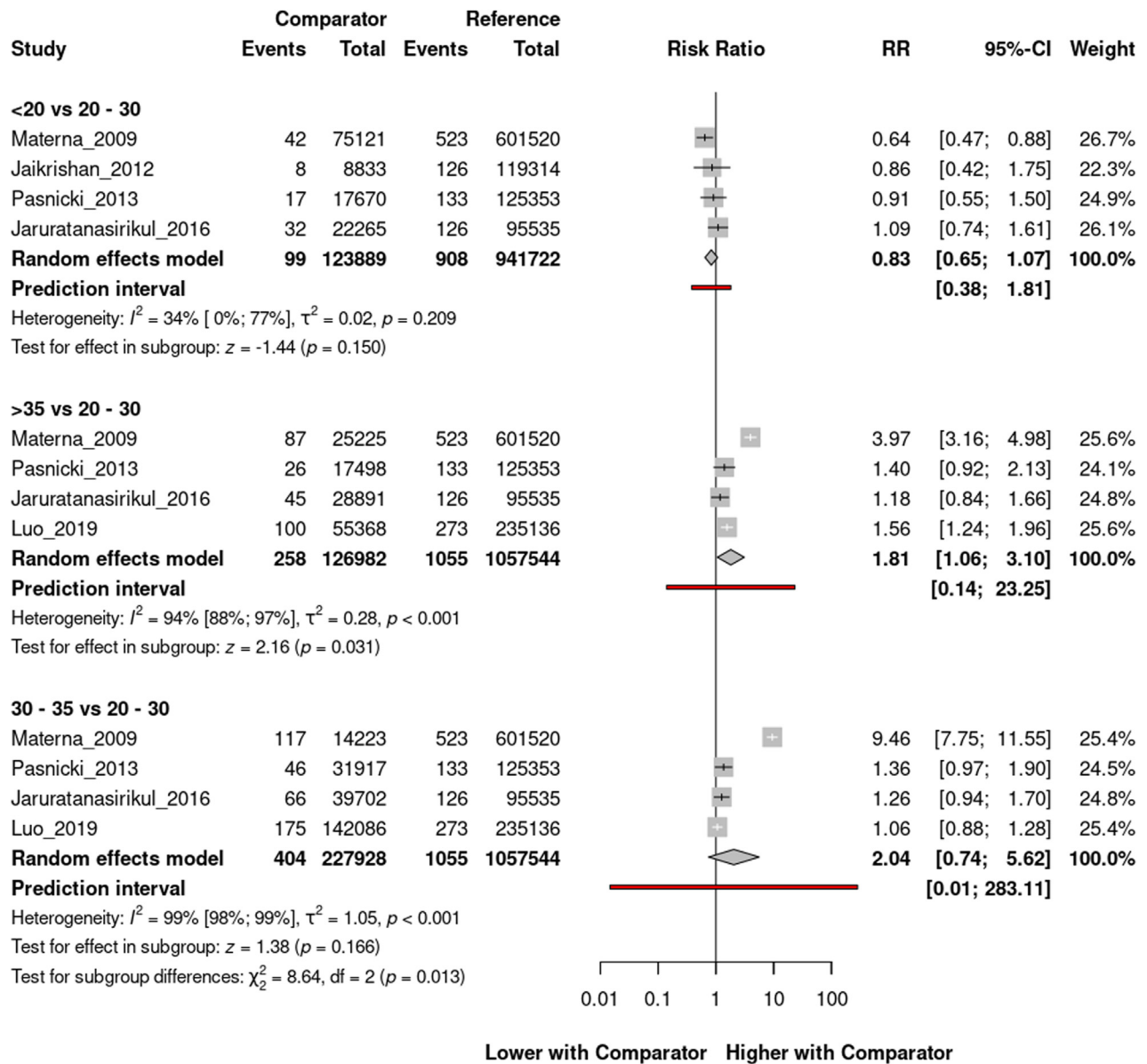
Forest plot representing the RR with 95% CI of *congenital heart defects* (ICD-10: Q20–Q26) in different age groups compared to the 20 to 30 age group and sorted by year of publication but only including studies published since 2005



CI, confidence interval; ICD-10, International Classification of Diseases-10; RR, risk ratio.

SUPPLEMENTAL FIGURE 54

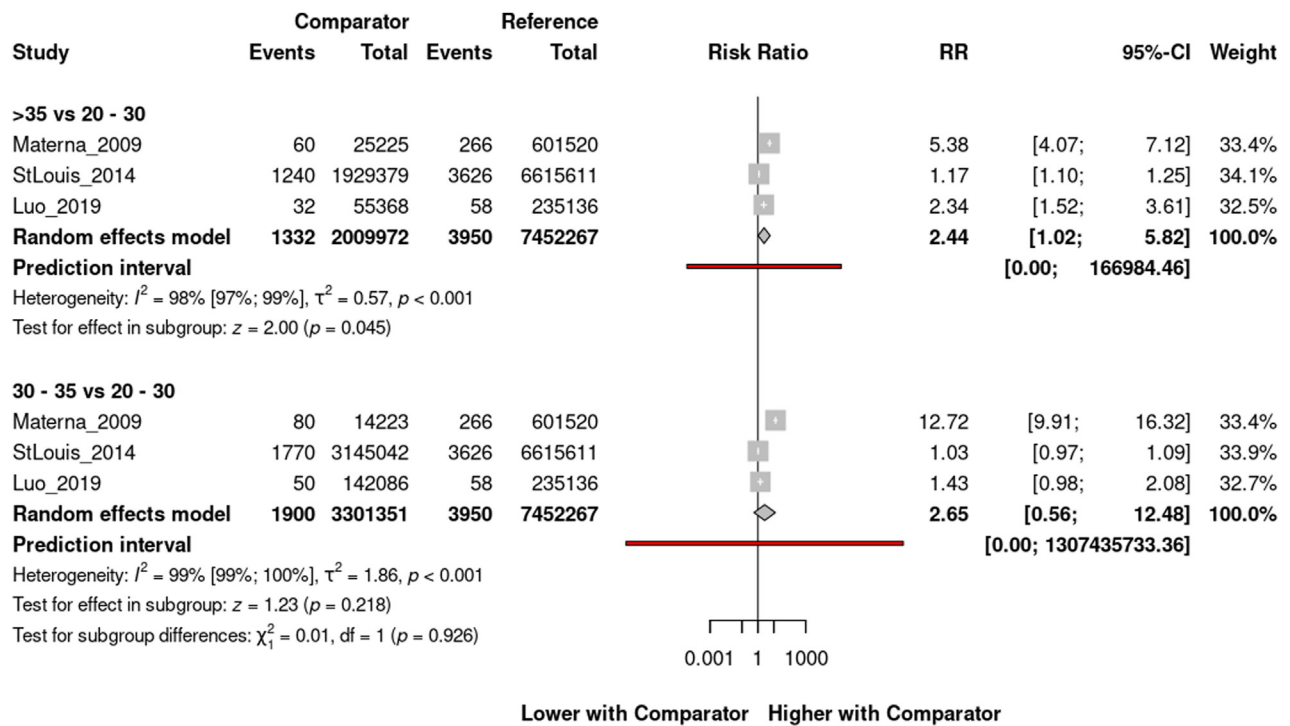
Forest plot representing the RR with 95% CI of *cleft lip and cleft palate* (ICD-10: Q35–Q37) in different age groups compared to the 20 to 30 age group and sorted by year of publication but only including studies published since 2005



CI, confidence interval; ICD-10, International Classification of Diseases-10; RR, risk ratio.

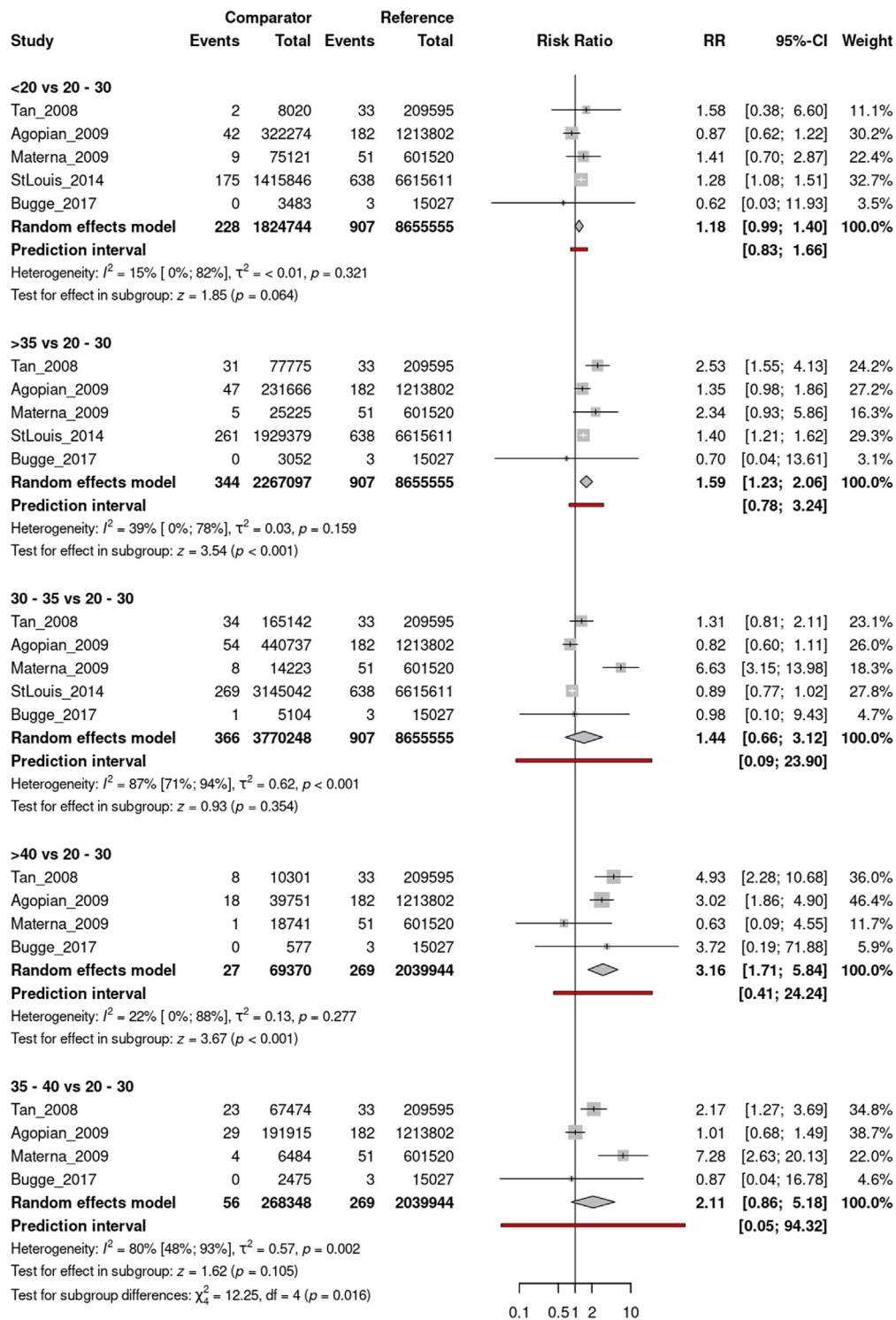
SUPPLEMENTAL FIGURE 55

Forest plot representing the RR with 95% CI of *cleft palate* (ICD-10: Q35) in different age groups compared to the 20 to 30 age group and sorted by year of publication but only including studies published since 2005



SUPPLEMENTAL FIGURE 56

Forest plot representing the RR with 95% CI of *omphalocele* (ICD-10: Q79.2) in different age groups compared to the 20 to 30 age group and sorted by year of publication but only including studies published since 2005

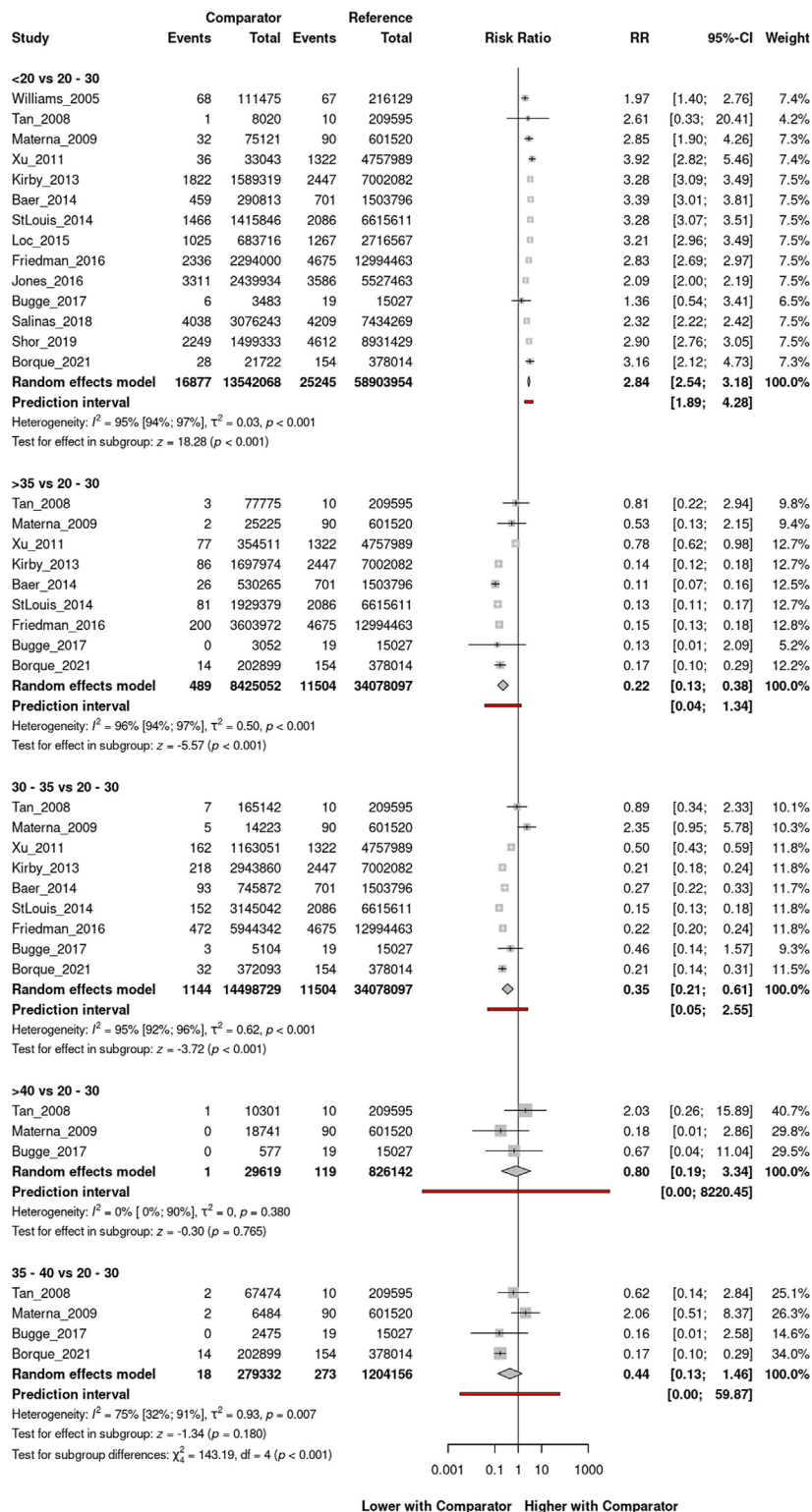


Lower with Comparator Higher with Comparator

CI, confidence interval; ICD-10, International Classification of Diseases-10; RR, risk ratio.

SUPPLEMENTAL FIGURE 57

Forest plot representing the RR with 95% CI of *gastroschisis* (ICD-10: Q79.3) in different age groups compared to the 20 to 30 age group and sorted by year of publication but only including studies published since 2005



CI, confidence interval; ICD-10, International Classification of Diseases-10; RR, risk ratio.

SUPPLEMENTAL TABLE 1**PRISMA checklist**

Section and topic	Item #	Checklist item	Location where item is reported
Title			
Title	1	Identify the report as a systematic review.	
Abstract			
Abstract	2	See the PRISMA 2020 for Abstracts checklist.	
Introduction			
Rationale	3	Describe the rationale for the review in the context of existing knowledge.	
Objectives	4	Provide an explicit statement of the objective(s) or question(s) the review addresses.	
Methods			
Eligibility criteria	5	Specify the inclusion and exclusion criteria for the review and how studies were grouped for the syntheses.	
Information sources	6	Specify all databases, registers, websites, organizations, reference lists and other sources searched or consulted to identify studies. Specify the date when each source was last searched or consulted.	
Search strategy	7	Present the full search strategies for all databases, registers and websites, including any filters and limits used.	
Selection process	8	Specify the methods used to decide whether a study met the inclusion criteria of the review, including how many reviewers screened each record and each report retrieved, whether they worked independently, and if applicable, details of automation tools used in the process.	
Data collection process	9	Specify the methods used to collect data from reports, including how many reviewers collected data from each report, whether they worked independently, any processes for obtaining or confirming data from study investigators, and if applicable, details of automation tools used in the process.	
Data items	10a	List and define all outcomes for which data were sought. Specify whether all results that were compatible with each outcome domain in each study were sought (eg, for all measures, time points, analyses), and if not, the methods used to decide which results to collect.	
	10b	List and define all other variables for which data were sought (eg, participant and intervention characteristics, funding sources). Describe any assumptions made about any missing or unclear information.	
Study risk of bias assessment	11	Specify the methods used to assess risk of bias in the included studies, including details of the tool(s) used, how many reviewers assessed each study and whether they worked independently, and if applicable, details of automation tools used in the process.	

(continued)

SUPPLEMENTAL TABLE 1
PRISMA checklist (continued)

Section and topic	Item #	Checklist item	Location where item is reported
Effect measures	12	Specify for each outcome the effect measure(s) (eg, risk ratio, mean difference) used in the synthesis or presentation of results.	
Synthesis methods	13a	Describe the processes used to decide which studies were eligible for each synthesis (eg, tabulating the study intervention characteristics and comparing against the planned groups for each synthesis [item #5]).	
	13b	Describe any methods required to prepare the data for presentation or synthesis, such as handling of missing summary statistics, or data conversions.	
	13c	Describe any methods used to tabulate or visually display results of individual studies and syntheses.	
	13d	Describe any methods used to synthesize results and provide a rationale for the choice(s). If meta-analysis was performed, describe the model(s), method(s) to identify the presence and extent of statistical heterogeneity, and software package(s) used.	
	13e	Describe any methods used to explore possible causes of heterogeneity among study results (eg, subgroup analysis, meta-regression).	
	13f	Describe any sensitivity analyses conducted to assess robustness of the synthesized results.	
Reporting bias assessment	14	Describe any methods used to assess risk of bias due to missing results in a synthesis (arising from reporting biases).	
Certainty assessment	15	Describe any methods used to assess certainty (or confidence) in the body of evidence for an outcome.	
Results			
Study selection	16a	Describe the results of the search and selection process, from the number of records identified in the search to the number of studies included in the review, ideally using a flow diagram (see Figure 1).	
	16b	Cite studies that might appear to meet the inclusion criteria, but which were excluded, and explain why they were excluded.	
Study characteristics	17	Cite each included study and present its characteristics.	
Risk of bias in studies	18	Present assessments of risk of bias for each included study.	
Results of individual studies	19	For all outcomes, present, for each study: (a) summary statistics for each group (where appropriate) and (b) an effect estimate and its precision (eg, confidence/credible interval), ideally using structured tables or plots.	

(continued)

SUPPLEMENTAL TABLE 1
PRISMA checklist (continued)

Section and topic	Item #	Checklist item	Location where item is reported
Results of syntheses	20a	For each synthesis, briefly summarize the characteristics and risk of bias among contributing studies.	
	20b	Present results of all statistical syntheses conducted. If meta-analysis was done, present for each the summary estimate and its precision (eg, confidence/credible interval) and measures of statistical heterogeneity. If comparing groups, describe the direction of the effect.	
	20c	Present results of all investigations of possible causes of heterogeneity among study results.	
	20d	Present results of all sensitivity analyses conducted to assess the robustness of the synthesized results.	
Reporting biases	21	Present assessments of risk of bias due to missing results (arising from reporting biases) for each synthesis assessed.	
Certainty of evidence	22	Present assessments of certainty (or confidence) in the body of evidence for each outcome assessed.	
Discussion			
Discussion	23a	Provide a general interpretation of the results in the context of other evidence.	
	23b	Discuss any limitations of the evidence included in the review.	
	23c	Discuss any limitations of the review processes used.	
	23d	Discuss implications of the results for practice, policy, and future research.	
Other information			
Registration and protocol	24a	Provide registration information for the review, including register name and registration number, or state that the review was not registered.	
	24b	Indicate where the review protocol can be accessed, or state that a protocol was not prepared.	
	24c	Describe and explain any amendments to information provided at registration or in the protocol.	
Support	25	Describe sources of financial or nonfinancial support for the review, and the role of the funders or sponsors in the review.	
Competing interests	26	Declare any competing interests of review authors.	
Availability of data, code, and other materials	27	Report which of the following are publicly available and where they can be found: template data collection forms; data extracted from included studies; data used for all analyses; analytic code; any other materials used in the review.	

SUPPLEMENTAL TABLE 2

Basic characteristics of the included studies

Author (year)	Ref	Country	Study period	Total	Cases	Age category	Congenital anomalies
Agopian 2009	¹	Texas (USA)	1999–2004	2,208,758	325	<20, 20–24, 25–29, 30–34, 35–39, ≥40	Omhalocele
Baer 2014	²	California (USA)	2005–2010	3,070,957	1279	<19, 20–24, 25–29, 30–34, ≥35	Gastroschisis
Beckman 1976	³	Sweden	1950–1973	61,061	280	<24, 25–29, 30–34, ≥35	Cleft palate, cleft lip with or without cleft palate, polydactyly, syndactyly, clubfoot
Bergman 2015	⁴	Europe	2001–2010	5,871,855	10,929	<20, 20–24, 25–29, 30–34, 35–39, ≥40	Hypospadiasis
Baird 1994	⁵	Canada	1966–1981	576,815	702	<20, 20–24, 25–29, 30–34, 35–39, ≥40	Isolated cleft palate, cleft lip and cleft palate
Bodnár 1970	⁶	Hungary	1958–1967	115,215	2100	<19, 20–24, 25–29, 30–39, ≥40	All NCAs, nervous system, circulatory system, urogenital anomalies, musculoskeletal system, digestive system
Borman 1986	⁷	New Zeland	1978	52,143	104	<20, 20–24, 25–29, ≥30	Anencephlaus, spina bifida
Borque 2021	⁸	Canada	2012–2018	1,001,080	231	<20, 20–24, 25–29, 30–34, 35–39, ≥40	Gastroschisis
Bugge 2017	⁹	Greenland	1989–2015	26,666	33	<20, 20–24, 25–29, 30–34, 35–39, 40–44, ≥45	Gastroschisis, omphalocele
Byron 1998	¹⁰	Australia	1980–1990	358,679	59; 104	<20, 20–24, 25–29, 30–34, 35–39, ≥40	Gastroschisis, omphalocele
Canfield 2009	¹¹	Texas (USA)	1999–2003	1,827,317	514; 643	<20, 20–24, 25–29, 30–34, 35–39, ≥40	Anencephlaus, spina bifida
Canon 2012	¹²	Arkansas (USA)	1998–2007	196,050	1455	<20, 20–24, 25–29, 30–34, ≥35	Hypospadiasis
Croen 1995	¹³	California (USA)	1983–1988	1,028,255	29,848	<20, 20–24, 25–29, 30–34, 35–39, ≥40	All NCAs
DeRoo 2003	¹⁴	Washington (USA)	1987–1990	298,138	608	<20, 20–24, 25–29, 30–34, 35–39, ≥40	Cleft lip and cleft palate
Dott 2003	¹⁵	Metropolitan Atlanta (USA)	1968–1999	1,029,143	249	<20, 20–24, 25–34, ≥35	Diaphragmatic hernia
Dudin 1997	¹⁶	Palestina	1986–1993	26,934	148	15–19, 20–24, 25–29, 30–39, ≥40	Neural tube defects
Fedrick 1976	¹⁷	Scotland	1961–1972	1,162,939	3246	<20, 20–24, 25–29, 30–34, 35–39, 40–44, ≥45	Anencephlaus
Feldman 1982	¹⁸	New York, Brooklyn (USA)	1968–1976	173,670	179	<20, 20–24, 25–29, 30–34, ≥35	Neural tube defects
Forrester 2004	¹⁹	Hawaii (USA)	1986–2000	281,866	544	<19, 20–24, 25–29, 30–34, 35–39, ≥40	Cleft lip and cleft palate
Forrester 1999	²⁰	Hawaii (USA)	1986–1997	229,584	150	19≥, 20–24, 25–29, 30–34, 35–39, ≥40	Omphalocele, gastroschisis
Forrester 2000	²¹	Hawaii (USA)	1986–1997	246,231	245	19≥, 20–24, 25–29, 30–34, 35–39, ≥40	Anencephaly, spina bifida, encephalocele
Friedman 2016	²²	USA	2005–2013	24,836,777	5985	<20, 20–24, 25–29, 30–34, ≥35	Gastroschisis

(continued)

SUPPLEMENTAL TABLE 2

Basic characteristics of the included studies (continued)

Author (year)	Ref	Country	Study period	Total	Cases	Age category	Congenital anomalies
Gupta 1967	²³	Nigeria	1964	4220	15	15–19 20–24, 25–29, 30–34, 35–39, 40–44	CHD
Hansen 2021	²⁴	Australia	1990–2016	765,419	8173	<20, 20–24, 25–29, 30–34, 35–39, ≥40	CHD
Hay 1972	²⁵	USA	1961–1966	8,475,600	1063	<20, 20–24, 25–29, 30–34, 35–39, ≥40	Anencephaly, spina bifida, hydrocephalus, congenital heart defects, cleft lip without cleft palate, cleft lip and palate, cleft palate without cleft lip, tracheoesophageal fistula and other esophageal defects, omhalocele, imperforate anus and other anorectal defects, hypospadias, position foot defects, polydactyly, syndactyly, reduction deformities
Hollier 2000	²⁶	Dallas (Texas, USA)	1988–1994	102,728	3466	<20, 20–24, 25–29, 30–34, 35–39, ≥40	All NCAs
Jaikrishan 2012	²⁷	India	1995–2011	141,540	1370	15–19, 20–29, ≥30	Clubfoot, CHD, cleft palate/lip, NTD, hypospadias
Janerich 1972	²⁸	New York State (USA)	1945–1970	4,555,614	4450	15–19; 20–24; 25–29; 30–34; 35–39; 40–44	Spina bifida
Janerich 1972	²⁹	New York State (USA)	1945–1967	4,074,079	3090	15–19; 20–24; 25–29; 30–34; 35–39; 40–44	Anencephaly
Jaruratanasirikul 2016	³⁰	Southern Thailand	2009–2013	186,393	269	<20; 20–<25; 25–<30; 30–<35; ≥35	Oral clefts
Jones 2016	³¹	USA	1995–2012	21,040,437	8866	<20; 20–24; 25–29; 30–34; 35–39	Gastroschisis
Kazaura 2004	³²	Norway	1967–1998	1,869,388	699	<20; 20–24; 25–29; 30–34; 35–39; ≥40	Gastroschisis, omphalocele
Kirby 2013	³³	USA	1995–2005	13,233,235	4713	<20; 20–24; 25–29; 30–34; 35–39	Gastroschisis
Liu 2013	³⁴	Canada	2002–2010	2,283,223	26,488	<19; 20–24; 25–29; 30–34; 35–39; 40–44	CHD
Liu 2019	³⁵	Canada	2004–2015	3,327,762	1517	<19; 20–24; 25–29; 30–34; 35–39; 40–44	Spina bifida, anencephaly/encephalocele
Li 2019	³⁶	Zhejiang Province (China, People's Republic of)	2010–2016	1,748,023	2790	<20; 20–25; 30–35; ≥35	Kidney and urinary tract defects
Loc-Uyen 2015	³⁷	USA-Texas	1999–2011	4,970,525	2549	<19; 20–24; 25–29; 30–34	Gastroschisis
Luo 2019	³⁸	China-Shenzhen	2003–2017	591,024	777	<25; 25–; 30–; 35–	Cleft lip and palate
Martinez-Frias 1984	³⁹	Spain	1976	264,502	52	<19; 20–24; 25–29; 30–34; 35–39; 40–44	Gastroschisis, omphalocele

(continued)

SUPPLEMENTAL TABLE 2

Basic characteristics of the included studies (continued)

Author (year)	Ref	Country	Study period	Total	Cases	Age category	Congenital anomalies
Materna-Kirylyuk 2009	⁴⁰	Poland	1998–2002	716,089	8683	<19; 20–24; 25–29; 30–34; 35–39; 40<	All NCAs (excluded muskuloskeletal defects), diaphragmatic hernia, gastroschisis, omphalocele, neural tube defects, microcephalus, hydrocephalus, congenital heart defects, hypospadias, renal agenesis or hypoplasia, cystic kidney disease, hydronephrosis, cleft palate, cleft lip with or without cleft palate, oesophageal atresia, small intestinal/large intestinal atresia or stenosis, anal atresia or stenosis
McGivern 2015	⁴¹	Europe	1980–2009	11,478,586	3373	<20; 20–24; 25–29; 30–34; 35<	Diaphragmatic hernia
Miller 2011	⁴²	Atlanta (Georgia, USA)	1968–2005	1,301,340	5289	<35; 35<	CHD
Mucat 2019	⁴³	Malta	2000–2014	55,943		20–24; 25–29; 30–34; 35–39; 40<	All NCAs, nervous system, eye, ear, face, neck, circulatory system, respiratory system, digestive system, genital organs, urinary system, muskuloskeletal system
Nazer 2007	⁴⁴	Chile	1996–2005	21,083	1767	<15; 15–19; 20–24; 25–29; 30–34; 35–39; 40–44; 45<	All NCAs
Nazer 2013	⁴⁵	Chile	2002–2011	15,636	1174	<15; 15–19; 20–24; 25–29; 30–34; 35–39; 40–44; 45<	All NCAs
Parkes 2020	⁴⁶	England, Scotland (UK)	2003–2010	219,486		<19; 20–29; 30–39; 40<	All NCAs
Pasnicky 2013	⁴⁷	Poland	1988–2007	192,438	2769	<18; 20–24; 25–29; 30–34; 35–39; 40<	All NCAs, nervous system, circulatory system, cleft lip and cleft palate, digestive system, genital organs, urinary system, muskuloskeletal system, other
Persson 2019	⁴⁸	Sweden	1992–2012	2,050,491	28,628	>24; 25–29; 30–34; 35<	CHD
Petrova 2009	⁴⁹	Norway and Arkhangelskaja Oblast (Russia)	1995–2004	434,567	615	<19; 20–24; 25–29; 30–34; 35<	Neural tube defects: anencephalus, spina bifida
Pradat 1992	⁵⁰	Sweden	1981–1986	573,422	1605	<20; 20–24; 25–29; 30–34; 35–39; 40–44; >44	CHD
Purkey 2019	⁵¹	California (USA)	2008–2012	2,054,516	6325	<19; 20–24; 25–29; 30–34; 35<	CHD
Rankin 1999	⁵²	North of England	1986–1996	426,694	296	11–19; 20–24; 25–29; 30–34; 35–39; >40	Gastroschisis, omphalocele, omphalocele

(continued)

SUPPLEMENTAL TABLE 2

Basic characteristics of the included studies (continued)

Author (year)	Ref	Country	Study period	Total	Cases	Age category	Congenital anomalies
Rankin 2000	⁵³	North of England	1984–1996	507,405	934	11–19; 20–24; 25–29; 30–34; 35–39; >40	Neural tube defects
Rider 2013	⁵⁴	Utah (USA)	1999–2008	480,125	8510	<24; 25–29; 30–34; 35–39; 40–60	All NCAs
Roeper 1987	⁵⁵	California (USA)	1968–1977	3,297,071	166	<19; 20–24; 25–29; 30–34; 35–39; 40<	Gastroschisis, omphalocele
Salih 2003	⁵⁶	New York State (USA)	1992–1999	2,153,955; 2,149,340	595	<19; 20–24; 25–29; 30–34; 35–39; 40<	Omphalocele, gastroschisis
Salim 2019	⁵⁷	Brazil	1996–2014	4,270,114	5062	<19; 20–29; 30–34; 35–39; 40<	Circulatory system
Sarkar 2013	⁵⁸	India	2011–2012	12,896	286	<20; 20–30; 30<	All NCAs
Sever 1982	⁵⁹	Los Angeles County (California, USA)	1966–1972	2,945,555	962	<14; 15–19; 20–24; 25–29; 30–34; 35–39; 40–44; 45<	Anencephalus, spina bifida, encephalocele, neural tube defects, all NCAs
Shields 1981	⁶⁰	Denmark	1940–1971	2,406,654	548	<19; 20–24; 25–29; 30–34; 35–39; 40–44; 45<	Cleft palate
Short 2019	⁶¹	USA	2006–2015	17,686,317	3489	<19; 20–24; 25–29; 30<	Gastroschisis
StLouis 2017	⁶²	USA	1999–2007	13,105,878	138,999	<19; 20–24; 25–29; 30–34; 35<	All NCAs, anencephalus, spina bifida, encephalocele, anotia/microtia, common truncus CHD, transposition of the great arteries, tetralogy of fallot, atrioventricular septal defect without down syndrome, hypoplastic left heart syndrome, coarctation of the aorta, aortic valve stenosis, cleft palate without cleft lip, cleft lip with and without cleft palate, esophageal atresia/tracheoesophageal fistula, pyloric stenosis, rectal and large intestinal atresia/stenosis, hypospadiasis, upper limb deficiency, lower limb deficiency, any limb deficiency, diaphragmatic hernia, gastroschisis, omphalocele
Tan 1996	⁶³	England, Wales (UK)	1987–1993	4,873,547	1043	<20; 20–24; 25–29; 30–34; 35–39; >40	Gastroschisis, omphalocele
Tan 2005	⁶⁴	Singapore	1994–2000	328,077	7870	<20; 20–24; 25–29; 30–34; 35–39; >40	All NCAs
Tan 2008	⁶⁵	Singapore	1993–2002	460,532	121	<20; 20–24; 25–29; 30–34; 35–39; >40	Gastroschisis, omphalocele
Williams 2005	⁶⁶	Atlanta (USA)	1968–2000	877,604	211	<20; 20–24; 24<	Gastroschisis
Xie 2016	⁶⁷	China-Hunan Province	2005–2014	925,413	17,753	<20; 20–24; 25–29; 30–34; 35<	All NCAs
Xie 2018	⁶⁸	China (People's Republic of)	2012–2016	673,060	6289	<20, 20–24, 25–29, 30–34, ≥35	Congenital heart defects

(continued)

SUPPLEMENTAL TABLE 2**Basic characteristics of the included studies** *(continued)*

Author (year)	Ref	Country	Study period	Total	Cases	Age category	Congenital anomalies
Xu 2011	⁶⁹	China (People's Republic of)	1996–2007	6,308,594	1601	<19; 20–24; 25–29; 30–34; 35<	Gastroschisis
Zhang 2012	⁷⁰	China (People's Republic of)	2012	62,526	976	<25; 25–30; 35<	All NCAs
Yang 2006	⁷¹	California (USA)	1989–1997	2,506,188	550	<20; 20–24; 25–29; 30–34; 35–39; 40–55	Diaphragmatic hernia
Zhou 2020	⁷²	China (People's Republic of), Southern Jiangsu	2014–2018	238,712	1707	<19; 20–24; 25–29; 30–34; 35<	All NCAs

CHD, congenital heart defect; *NCAs*, nonchromosomal congenital anomalies; *NTD*, neural tube defect.

SUPPLEMENTAL TABLE 3
Risk of bias assessment using the QUIPS tool

	D1	D2	D3	D4	D5	D6	
	<p>Low-risk: table or detailed text about population Moderate: moderate information about population High risk: limited information about study population</p>	<p>Low risk: population—based study—whole country/region/hospital Moderate risk: case-control study—high-case numbers High risk: case-control study—low case numbers or just descriptive information about cases</p>	<p>Low risk: clear and detailed age categories covering all age groups Moderate risk: clear categories, but some age groups are missing High risk: only 1 group is examined</p>	<p>Low risk: clear definition of outcome—exact ICD-10 category Moderate risk: can be matched to ICD-10 category High risk: unclear definition</p>	<p>Low risk: clear information about confounders/multivariate models Moderate risk: limited information High risk: no information about relevant confounders</p>	<p>Low risk: clear, raw data; no or negligible contradiction Moderate risk: needs some calculation or reading from graph; minor contradiction High risk: only approximate data can be obtained; serious contradiction</p>	<p>High quality: max. ++ Acceptable: max. ++ +/+ Low quality: ++ or more</p>
Code	Study population	Study design	Prognostic factor measurement	Outcome	Study confounding	Data Quality—statistics	Overall rate
Agopian_2009	Low risk	Low risk	Low risk	Low risk	Low risk	Low risk	High quality
Baer_2014	Low risk	Low risk	Low risk	Low risk	Low risk	Low risk	High quality
Beckman_1976	Moderate risk	Low risk	Low risk	Moderate risk	Low risk	Moderate risk	Acceptable
Bergman_2015	Low risk	Low risk	Low risk	Low risk	Moderate risk	Low risk	High quality
Baird_1994	Moderate risk	Low risk	Low risk	Moderate risk	Moderate risk	Low risk	Acceptable
Bodnár_1970	Moderate risk	Low risk	Low risk	Moderate risk	Moderate risk	Low risk	Acceptable
Borman_1986	Moderate risk	Low risk	Low risk	Low risk	Moderate risk	Low risk	High quality
Borque_2021	Moderate risk	Low risk	Low risk	Low risk	Moderate risk	Moderate risk	Acceptable
Bugge_2017	Moderate risk	Low risk	Low risk	Low risk	Low risk	Low risk	High quality
Byron_1998	Low risk	Low risk	Low risk	Low risk	Low risk	Moderate risk	High quality
Canfield_2009	Moderate risk	Low risk	Low risk	Low risk	Low risk	Low risk	High quality
Canon_2012	Low risk	Low risk	Low risk	Low risk	Low risk	Low risk	High quality
Croen_1995	Low risk	Low risk	Low risk	Moderate risk	Moderate risk	Moderate risk	Acceptable
DeRoo_2003	Moderate risk	Low risk	Low risk	Moderate risk	Low risk	Low risk	High quality
Donghua_2018	Low risk	Low risk	Low risk	Moderate risk	Moderate risk	Low risk	High quality
Dott_2003	Moderate risk	Low risk	Low risk	Low risk	Moderate risk	Moderate risk	Acceptable
Dudin_1997	Moderate risk	Low risk	Low risk	Low risk	Moderate risk	Low risk	High quality
Fedrick_1976	Moderate risk	Low risk	Low risk	Low risk	Low risk	Low risk	High quality

(continued)

SUPPLEMENTAL TABLE 3

Risk of bias assessment using the QUIPS tool *(continued)*

	D1	D2	D3	D4	D5	D6	
	Low-risk: table or detailed text about population Moderate: moderate information about population High risk: limited information about study population	Low risk: population—based study—whole country/region/hospital Moderate risk: case-control study—high-case numbers High risk: case-control study—low case numbers or just descriptive information about cases	Low risk: clear and detailed age categories covering all age groups Moderate risk: clear categories, but some age groups are missing High risk: only 1 group is examined	Low risk: clear definition of outcome—exact ICD-10 category Moderate risk: can be matched to ICD-10 category High risk: unclear definition	Low risk: clear information about confounders/multivariate models Moderate risk: limited information High risk: no information about relevant confounders	Low risk: clear, raw data; no or negligible contradiction Moderate risk: needs some calculation or reading from graph; minor contradiction High risk: only approximate data can be obtained; serious contradiction	High quality: max. ++ Acceptable: max. ++ +/+ Low quality: ++ or more
Code	Study population	Study design	Prognostic factor measurement	Outcome	Study confounding	Data Quality—statistics	Overall rate
Feldman_1982	Moderate risk	Low risk	Low risk	Low risk	Low risk	Low risk	High quality
Forrester_2004C	Low risk	Low risk	Low risk	Moderate risk	Moderate risk	Low risk	High quality
Forrester_1999	Low risk	Low risk	Low risk	Low risk	Moderate risk	Low risk	High quality
Forrester_2000	Moderate risk	Low risk	Low risk	Low risk	Low risk	Low risk	High quality
Friedman_2016	Low risk	Low risk	Low risk	Low risk	Low risk	Low risk	High quality
Gupta_1967	Moderate risk	Low risk	Low risk	Low risk	Moderate risk	Low risk	High quality
Hansen_2021	Low risk	Low risk	Low risk	Low risk	Moderate risk	Moderate risk	High quality
Hay_1972	Low risk	Low risk	Low risk	Moderate risk	Moderate risk	Low risk	High quality
Hollier_2000	Low risk	Low risk	Low risk	Moderate risk	Low risk	Low risk	High quality
Jaikrishan_2012	Low risk	Low risk	Low risk	Moderate risk	Moderate risk	Low risk	High quality
Janerich_1972	Moderate risk	Low risk	Low risk	Low risk	Moderate risk	Low risk	High quality
Janerich_1972	Moderate risk	Low risk	Low risk	Low risk	Moderate risk	Low risk	High quality
Jaruratanasirikul_2016	Moderate risk	Low risk	Low risk	Low risk	Moderate risk	Low risk	High quality
Jones_2016	Moderate risk	Low risk	Low risk	Low risk	Moderate risk	Moderate risk	Acceptable
Kazaura_2004	Moderate risk	Low risk	Low risk	Low risk	Low risk	Low risk	High quality
Kirby_2013	Low risk	Low risk	Low risk	Low risk	Low risk	Low risk	High quality
Liu_2013	Low risk	Low risk	Low risk	Low risk	Moderate risk	Moderate risk	High quality
Liu_2019	Low risk	Low risk	Low risk	Low risk	Low risk	Low risk	High quality

(continued)

SUPPLEMENTAL TABLE 3
Risk of bias assessment using the QUIPS tool (continued)

	D1	D2	D3	D4	D5	D6	
	Low-risk: table or detailed text about population Moderate: moderate information about population High risk: limited information about study population	Low risk: population-based study—whole country/region/hospital Moderate risk: case-control study—high-case numbers High risk: case-control study—low case numbers or just descriptive information about cases	Low risk: clear and detailed age categories covering all age groups Moderate risk: clear categories, but some age groups are missing High risk: only 1 group is examined	Low risk: clear definition of outcome—exact ICD-10 category Moderate risk: can be matched to ICD-10 category High risk: unclear definition	Low risk: clear information about confounders/multivariate models Moderate risk: limited information High risk: no information about relevant confounders	Low risk: clear, raw data; no or negligible contradiction Moderate risk: needs some calculation or reading from graph; minor contradiction High risk: only approximate data can be obtained; serious contradiction	High quality: max. ++ Acceptable: max. ++ +/+ Low quality: + + or more
Code	Study population	Study design	Prognostic factor measurement	Outcome	Study confounding	Data Quality—statistics	Overall rate
Liz_2019	Low risk	Low risk	Low risk	Low risk	Moderate risk	Low risk	High quality
Loc_2015	Low risk	Low risk	Low risk	Low risk	Low risk	Low risk	High quality
Luo_2019	Low risk	Low risk	Low risk	Moderate risk	Low risk	Low risk	High quality
Martinez_1984	Low risk	Low risk	Low risk	Moderate risk	Moderate risk	Low risk	High quality
Materna_2009	Low risk	Low risk	Low risk	Low risk	Low risk	Low risk	High quality
McGivern_2015	Low risk	Low risk	Low risk	Low risk	Moderate risk	Moderate risk	High quality
Miller_2011	Low risk	Low risk	Low risk	Moderate risk	Low risk	Moderate risk	High quality
Mucat_2019	Low risk	Low risk	Low risk	Moderate risk	Moderate risk	Low risk	High quality
Nazer_2007	Moderate risk	Low risk	Low risk	Low risk	Moderate risk	Low risk	High quality
Parkes_2020	Moderate risk	Low risk	Low risk	Low risk	Moderate risk	Low risk	High quality
Pasnicky_2013	Moderate risk	Low risk	Low risk	Low risk	Low risk	Low risk	High quality
Persson_2019	Low risk	Low risk	Low risk	Low risk	Low risk	Low risk	High quality
Petrova_2009	Moderate risk	Low risk	Low risk	Low risk	Low risk	Low risk	High quality
Pradat_1992	Low risk	Low risk	Low risk	Low risk	Low risk	Low risk	High quality
Purkey_2019	Moderate risk	Low risk	Low risk	Low risk	Moderate risk	Low risk	High quality
Rankin_1999	Low risk	Low risk	Low risk	Low risk	Low risk	Low risk	High quality
Rankin_2000	Low risk	Low risk	Low risk	Low risk	Moderate risk	Low risk	High quality
Rider_2013	Low risk	Low risk	Low risk	Moderate risk	Low risk	Low risk	High quality

(continued)

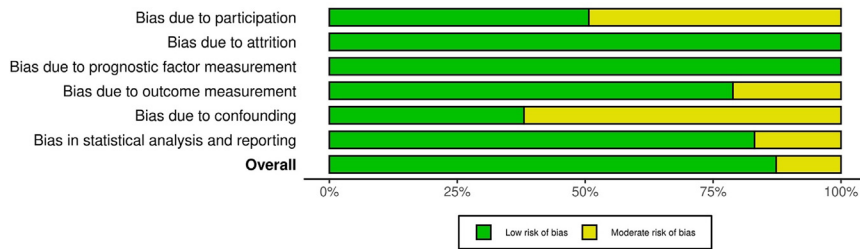
SUPPLEMENTAL TABLE 3
Risk of bias assessment using the QUIPS tool (continued)

	D1	D2	D3	D4	D5	D6	
	<p>Low-risk: table or detailed text about population Moderate: moderate information about population High risk: limited information about study population</p>	<p>Low risk: population—based study—whole country/region/hospital Moderate risk: case-control study—high-case numbers High risk: case-control study—low case numbers or just descriptive information about cases</p>	<p>Low risk: clear and detailed age categories covering all age groups Moderate risk: clear categories, but some age groups are missing High risk: only 1 group is examined</p>	<p>Low risk: clear definition of outcome—exact ICD-10 category Moderate risk: can be matched to ICD-10 category High risk: unclear definition</p>	<p>Low risk: clear information about confounders/multivariate models Moderate risk: limited information High risk: no information about relevant confounders</p>	<p>Low risk: clear, raw data; no or negligible contradiction Moderate risk: needs some calculation or reading from graph; minor contradiction High risk: only approximate data can be obtained; serious contradiction</p>	<p>High quality: max. ++ Acceptable: max. ++ +/+ Low quality: ++ or more</p>
Code	Study population	Study design	Prognostic factor measurement	Outcome	Study confounding	Data Quality—statistics	Overall rate
Roeper_1987	Moderate risk	Low risk	Low risk	Low risk	Low risk	Low risk	High quality
Salihu_2003	Moderate risk	Low risk	Low risk	Low risk	Moderate risk	Moderate risk	Acceptable
Salim_2019	Moderate risk	Low risk	Low risk	Low risk	Moderate risk	Low risk	High quality
Salinas_2018	Low risk	Low risk	Low risk	Low risk	Moderate risk	Low risk	High quality
Sarkar_2013	Moderate risk	Low risk	Low risk	Low risk	Moderate risk	Low risk	High quality
Sever_1982	Low risk	Low risk	Low risk	Low risk	Moderate risk	Low risk	High quality
Shields_1981	Low risk	Low risk	Low risk	Low risk	Moderate risk	Low risk	High quality
Short_2019	Moderate risk	Low risk	Low risk	Low risk	Moderate risk	Moderate risk	Acceptable
StLouis_2014	Moderate risk	Low risk	Low risk	Low risk	Moderate risk	Low risk	High quality
Tan_2008	Moderate risk	Low risk	Low risk	Low risk	Moderate risk	Low risk	High quality
Tan_2005	Moderate risk	Low risk	Low risk	Low risk	Moderate risk	Low risk	High quality
Tan_1996	Low risk	Low risk	Low risk	Low risk	Moderate risk	Low risk	High quality
Williams_2005	Low risk	Low risk	Low risk	Low risk	Moderate risk	Low risk	High quality
Xie_2016	Low risk	Low risk	Low risk	Low risk	Moderate risk	Low risk	High quality
Xu_2011	Moderate risk	Low risk	Low risk	Low risk	Moderate risk	Low risk	High quality
Yang_2006	Moderate risk	Low risk	Low risk	Low risk	Moderate risk	Low risk	High quality
Zhang_2012	Moderate risk	Low risk	Low risk	Low risk	Moderate risk	Low risk	High quality
Zhou_2020	Moderate risk	Low risk	Low risk	Low risk	Moderate risk	Low risk	High quality

Colors represent: Green: low risk of bias, Yellow: moderate risk of bias, Red: high risk of bias.
 ICD-10, International Classification of Diseases-10; QUIPS, Quality in Prognostic Studies.

SUPPLEMENTAL TABLE 4

Overall risk of bias including all studies using the Risk-of-Bias VISualization tool



SUPPLEMENTAL TABLE 5

Comparison of the “all NCAs” (ICD-10: Q00–Q89) risk ratio outcomes: studies with concomitant CAs excluded vs studies with concomitant CAs included

Risk groups	Excluding cases with concomitant CAs	Including cases with concomitant CAs
<20 vs 20–30	1.21 [0.59–2.49; n=5]	1.08 [0.89–1.32; n=14]
>35 vs 20–30	1.37 [0.76–2.45; n=6]	1.31 [1.07–1.61; n=13]
>40 vs 20–30	1.25 [1.08–1.46; n=6]	1.44 [1.25–1.66; n=11]
30–35 vs 20–30	1.54 [0.55–4.32; n=6]	1.23 [0.85–1.78; n=13]
35–40 vs 20–30	1.73 [0.45–6.70; n=5]	1.47 [0.87–2.49; n=9]

CAs, chromosomal abnormalities.

SUPPLEMENTAL TABLE 6

Summary of effect of year of publication on the maternal age dependence of risk of congenital anomalies

ICD-10 NCA categories	<20		>35		30–35		>40		35–40	
	Trend	Subset	Trend	Subset	Trend	Subset	Trend	Subset	Trend	Subset
Q00–Q89 all nonchromosomal anomalies	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Q00–Q89 ^j all nonchromosomal anomalies ^j	✗	✗	✓ ^a	✗	✓ ^a	✗	✓ ^b	✗	✓ ^a	✗
Q00–Q07 malformations of the nervous system	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Q00.0 anencephaly	✗	✓ ^c	✗	✓ ^d	✗	✗	✗	—	✗	—
Q05 spina bifida	✗	✗	✗	✗	✗	✗	✗	—	✗	—
Q20–Q26 malformations of the circulatory system	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Q35–Q37 cleft lip and cleft palate	✗	✗	✗	✓ ^e	✗	✗	✗	—	✗	—
Q35 cleft palate	✗	—	✗	✓ ^f	✗	✗	✓ ^g	—	✗	—
Q79.2 exomphalos	✗	✓ ^h	✗	✗	✗	✗	✗	✗	✗	✗
Q79.3 gastroschisis	✗	✗	✗	✗	✗	✗ ⁱ	✗	✓ ^h	✗	✓ ^h

The “trend” column shows if any trend could be detected visually in the study-level effect sizes of the full set of studies sorted by date of publication. The “subset” column shows if the subset of studies published since 2005 yielded a different pooled effect size compared to that of the full set of studies. ✗: no trend or difference detected. ✓: some trend or difference was detected. —: too few articles to analyze the subset.

^a Slight nonsignificant negative trend; ^b Moderate nonsignificant negative trend; ^c Full set is just nonsignificant, subset is just significant; ^d Full set is nonsignificant risk effect, subset is significant protective effect; ^e Full set is nonsignificant, subset is significant; ^f The risk has increased; ^g Slight nonsignificant positive trend; ^h Full set is significant, subset is nonsignificant; ⁱ subset is less significant as the full set; ^j Only studies where concomitant chromosomal abnormality cases were excluded.