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# **Timing of birth and adverse pregnancy outcomes in cases of prenatally diagnosed Vasa Previa: A systematic review and meta-analysis**

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# 1 **Condensation page**

## 2 **Condensation**

3 This systematic review examines the risks of prematurity and of pregnancy prolongation in  
4 prenatally diagnosed vasa previa across deliveries at various gestational ages.

5

## 6 **Short title**

7 Timing of birth in cases of antenatally diagnosed vasa previa

8

## 9 **AJOG at a glance**

### 10 A. Why was this study conducted?

- 11 • The optimum time of delivery in pregnancies diagnosed with vasa previa is unclear
- 12 • Recommendations from individual studies differ, and guidelines suggest delivery
- 13 within broad periods of 2-3 weeks

14

### 15 B. What are the key findings?

- 16 • The overall rate of complications in cases of prenatally diagnosed vasa previa decreased
- 17 until 36 weeks and remained generally low thereafter.

18

### 19 C. What does this study add to what is already known?

- 20 • This is the only study that has analyzed the complications of vasa previa by each
- 21 discrete gestational week at birth
- 22 • The findings of this study could add greater specificity to existing guidelines

## 23 **Abstract**

24 **Objective:** The ideal time of birth in pregnancies diagnosed with vasa previa remains unclear.  
25 We conducted a systematic review aiming to identify the gestational age of delivery that best  
26 balances the risks of prematurity and of pregnancy prolongation in cases of prenatally  
27 diagnosed vasa previa.

28

29 **Data sources:** Ovid MEDLINE, PubMed, CINAHL, EMBASE, SCOPUS and Web of Science  
30 were searched from inception to January 2022.

31

32 **Study eligibility criteria (study design, populations, and interventions):** The intervention  
33 analyzed was delivery at various gestational ages in pregnancies prenatally diagnosed with vasa  
34 previa. Cohort studies, case series and case reports were included in the qualitative synthesis.  
35 Where summary figures could not be obtained directly from the studies for the quantitative  
36 synthesis, authors were contacted and asked to provide a breakdown of perinatal outcomes by  
37 gestational age at birth.

38

39 **Study appraisal and synthesis methods:** Study appraisal was completed using the NIH  
40 quality assessment tool for respective studies. Statistical analysis was performed using random-  
41 effects meta-analysis of proportions.

42

43 **Results:** The search identified 3,435 studies, of which 1,264 were duplicates. After screening  
44 2,171 titles and abstracts, 140 studies proceeded to the full text screen. 37 studies were included  
45 for analysis, 14 of which were included in a quantitative synthesis. Among 490 neonates, there  
46 were two perinatal deaths (0.4%), both of which were neonatal deaths below 32 weeks. In  
47 general, the rate of neonatal complications decreased steadily from <32 weeks (4.6% rate of

48 perinatal death, 91.2% respiratory distress, 11.4% 5-minute Apgar score <7, 23.3% neonatal  
49 blood transfusion, 100% neonatal intensive care unit (NICU) admission, 100% low  
50 birthweight) until 36 weeks (0% perinatal death, 5.3% respiratory distress, 0% 5-minute Apgar  
51 score <7, 2.9% neonatal blood transfusion, 29.2% NICU admission, 30.9% low birthweight).  
52 Complications then increased slightly at 37 weeks before decreasing again at 38 weeks.

53

54 **Conclusions:** Prolonging pregnancies until 36 weeks appears to be safe and beneficial in  
55 otherwise uncomplicated pregnancies with antenatally diagnosed vasa previa.

56

57 **Key words:** Vasa previa, fetal hemorrhage, cesarean, stillbirth, perinatal death, blood  
58 transfusion, prematurity, neonatal outcomes

59

## 60 Introduction

61 Vasa previa is an uncommon condition of pregnancy, affecting between 1 in 2,000 and 1 in  
62 5,000 pregnancies,<sup>1-9</sup> although the true incidence is difficult to estimate as there are scarce  
63 reports in the literature. The most common risk factors for vasa previa include low-lying  
64 placenta (seen in 61.5% of diagnosed cases of vasa previa), pregnancies conceived via assisted  
65 reproduction techniques (28.2% of diagnosed cases) and multiple gestation (8.9% of diagnosed  
66 cases).<sup>3,9</sup> Vasa previa can be caused by velamentous cord insertions, coursing of vessels  
67 between a bilobed placenta or succenturiate lobe,<sup>1</sup> or when fetal vessels follow a ‘boomerang’  
68 orbit.<sup>10</sup>

69

70 Pregnancies affected by vasa previa present a significant threat to the fetus. As the fetal blood  
71 vessels are embedded within the fetal membranes, rupture of the amniotic sac during (or prior  
72 to) labor can lead to fetal hemorrhage, exsanguination, and death.<sup>1,4</sup> Additionally, as the fetus  
73 descends into the pelvis, the pressure on the unsupported vessels can cause fetal asphyxia.<sup>11</sup> To  
74 reduce these complications, it is vital to make a diagnosis in the antenatal period. Oyelese *et*  
75 *al.* showed that the survival rate in cases of diagnosed vasa previa is approximately 97%,  
76 whereas in undiagnosed cases the survival rate is approximately 40%.<sup>12</sup> As such, some studies  
77 have recommended routine sonographic screening for vasa previa, especially in pregnancies  
78 with risk factors, such as low-lying placenta,<sup>13-15</sup> allowing for close monitoring and scheduling  
79 of an elective cesarean birth prior to membrane rupture.<sup>16</sup>

80

81 Whilst delivering the fetus before membrane rupture is key to the management of vasa previa,  
82 it is also important to consider that neonates delivered at earlier gestations are more likely to  
83 be affected by complications of prematurity. The safest time to deliver should hence be  
84 considered the gestation that most appropriately balances the risks of prematurity with the risks

85 associated with the onset of labor. The ideal window of delivery remains unclear, and  
86 recommendations differ. Some observational studies have suggested delivery as early as 33  
87 weeks,<sup>17</sup> whilst others have proposed that birth can potentially wait until 37 weeks.<sup>18–20</sup>  
88 Additionally, a purely theoretical decision-tree analysis advocated that scheduled delivery at  
89 34-35 weeks would result in the highest quality-adjusted life-years.<sup>21</sup> Guidelines from leading  
90 institutions are largely based upon experts' opinion and similarly do not have consistent  
91 recommendations; they also generally suggest delivery within a broad window of 2-3  
92 weeks.<sup>11,16,22</sup> This breadth allows ample room for interpretation, and could result in delivery at  
93 either late-preterm or early-term gestations, each of which carries a unique set of risks. This  
94 highlights the need for a more specific, evidence-based recommendation for timing of delivery  
95 in pregnancies diagnosed with vasa previa.

96

97 In this systematic review, we aimed to identify the gestational age at which the rate of perinatal  
98 complications was the lowest, which is likely to represent the safest time to deliver in  
99 pregnancies affected by vasa previa.

100

## 101 **Methods**

102 We conducted a systematic review of studies with prenatally diagnosed vasa previa. The  
103 protocol of this review was registered with the International Prospective Register of Systematic  
104 Reviews (PROSPERO CRD42020186416) and the results were reported according to the  
105 Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA) guidelines.<sup>23</sup>

106

### 107 **Eligibility criteria, information sources and search strategy**

108 Given the rarity of vasa previa, study included in this review were cohort studies, case series  
109 and case reports. Due to the limited literature on neonatal outcomes from pregnancies affected



110 by vasa previa, conference abstracts were not strictly excluded from eligibility criteria;  
111 however, they were excluded if they were too brief to draw relevant conclusions from or did  
112 not contain enough data on outcomes of interest. Studies were only included if they were  
113 available in English and if they were human studies. Studies only proceeded to the quantitative  
114 synthesis if they had more than five cases and a detailed breakdown of complications by  
115 gestational age was available.

116

117 A systematic search of Ovid MEDLINE, PubMed, CINAHL, EMBASE, SCOPUS and Web of  
118 Science databases from inception to January 2022 was performed to identify studies that  
119 analyzed prenatally diagnosed cases of vasa previa and neonatal outcomes. Reference lists of  
120 relevant studies were also searched to identify any additional studies that may not have been  
121 captured in the initial searches.

122

123 A combination of medical subject headings (MeSH) terms and key terms and variants of  
124 prenatally diagnosed, vasa previa, delivery, cesarean and outcomes were searched in the  
125 aforementioned databases. Variations of search terms were combined with the Boolean  
126 operator 'OR', and the different elements of the PICO (Population, Intervention, Comparator  
127 and Outcome) framework were combined with the Boolean operator 'AND'. The complete  
128 search strategy is included in Appendix A.

129

### 130 **Study Selection**

131 The study selection process was performed using Covidence systematic review software  
132 (Covidence systematic review software, Veritas Health Innovation, Melbourne, Australia).  
133 After duplicates were removed, two independent reviewers (GN and SM) screened the title and  
134 abstract of each study for eligibility; studies that were mutually considered relevant, as well as

135 any conflicts, proceeded to the next stage of screening. Full texts of these papers were then  
136 assessed for eligibility by the same two independent reviewers, with strict adherence to the pre-  
137 defined inclusion and exclusion criteria. Disagreements were discussed, and any persistent  
138 conflicts were resolved through discussion with a third reviewer (DLR).

139

140 Papers from the qualitative synthesis were excluded from the quantitative synthesis if they had  
141 a sample size less than five, as the presence of outcomes in studies with smaller sample sizes  
142 were likely to cause overly significant shifts in proportions.<sup>24</sup> Where data breakdown by  
143 gestational age was not reported, authors were contacted, and further data was requested. As  
144 per the eligibility criteria, if sufficient data could not be obtained, the paper was excluded from  
145 the quantitative analysis.

146

## 147 **Data Extraction**

148 Two authors (GN and SM) independently extracted author names, year of publication, study  
149 design, sample sizes and outcomes directly from papers. Additionally, for the quantitative  
150 synthesis, the counts of relevant outcomes at each gestational age were also extracted, either  
151 directly from the paper or from a raw data set requested from authors. Gestational ages were  
152 grouped as: <32 weeks, 32 weeks (i.e., 32+0 to 32+6), 33 weeks, 34 weeks, 35 weeks, 36  
153 weeks, 37 weeks, and 38 weeks or later. Once the extraction was complete, the spreadsheets  
154 were then directly cross-checked between the two authors to identify any discrepancies; these  
155 were resolved through consensus among the authors.

156

## 157 **Assessment of Risk of Bias**

158 The quality assessment was completed using the NIH Study Quality Assessment Tools, as  
159 recommended by Ma *et al.* for non-randomized studies.<sup>25</sup> The tool for observational cohort and

160 cross-sectional studies was used for cohort studies, and the tool for case series was used for  
161 both case series and case reports. These checklists were completed by two independent  
162 reviewers (GN and SM) and compared. Discrepancies were again resolved through discussion.  
163 Study quality was globally rated as poor, fair, or good.

164

## 165 **Outcomes of Interest and Data Synthesis**

166 Data extracted from each study for the quantitative analysis included the total number of  
167 neonates delivered at each gestational age and the number of neonates with the outcomes of  
168 interest. These included perinatal mortality, respiratory distress syndrome (RDS) requiring  
169 intubation, Apgar scores <7 at five minutes, neonatal intensive care unit (NICU) admission,  
170 low birthweight (<2500 grams), and neonatal blood transfusions. We then analyzed the  
171 aggregate rates of each outcome of interest overall and per gestational age. Pooled proportions  
172 of different adverse pregnancy outcomes, overall and stratified by gestational age, were  
173 calculated with random-effects models using inverse-variance weights and the arcsine  
174 transformation to achieve stabilization of the variances. Publication bias was investigated by  
175 inspection of funnel plots and the Egger's test for outcomes reported by ten studies or more.  
176 Finally, we performed sensitivity analysis of the aggregate rates of adverse pregnancy  
177 outcomes including only studies considered of good quality, to investigate the impact of studies  
178 at high risk of bias on the results. Analyses were conducted with the package metafor in the  
179 statistical software R.<sup>26</sup>

180

## 181 **Results**

### 182 **Study Selection**

183 A total of 3,435 studies were identified through the search, of which 1,264 were duplicates.  
184 After screening 2,171 titles and abstracts, 140 studies were deemed potentially relevant and

185 were included in the full text screen, although nine reports could not be retrieved. A further 94  
186 were then excluded due to inconsistency with the pre-defined eligibility criteria or irrelevance.  
187 This left 37 studies to be included in the systematic review. The study selection process is  
188 presented in Figure 1, and the characteristics of included studies are included in Supplementary  
189 Table 1.

190

191 Three studies were excluded from the quantitative synthesis as they had a study sample less  
192 than five.<sup>27-29</sup> Of the remaining 34 studies, four presented a data breakdown by gestational  
193 age.<sup>1,18,19,30</sup> The remaining 30 studies only reported the total incidence of complications across  
194 all deliveries, and did not specify the gestational age that they occurred at.<sup>2,4,7,12-14,17,20,31-52</sup>  
195 Authors of these papers were contacted to request the breakdown of complications by  
196 gestational age. Nineteen authors either could not be contacted, did not respond, or did not have  
197 the data that we requested available.<sup>2,4,7,12,13,14,32-35,42,44-46,48-52</sup> 11/03/2022 22:35:00 The  
198 corresponding author of one study<sup>39</sup> reported that their data was included in another, larger  
199 study,<sup>31</sup> so this was treated as a duplicate and was removed from the quantitative synthesis. Ten  
200 sets of raw, stratified data were obtained from corresponding authors.<sup>17,20,31,36-38,40,41,43,47</sup>  
201 Hence, 14 studies were included in the quantitative synthesis.<sup>1,17-20,30,31,36-38,40,41,43,47</sup>

202

### 203 **Risk of bias**

204 In total, there were three case reports, 21 case series and 13 cohort studies. The scoring and  
205 overall rating of the studies is shown in Supplementary Tables 2A and 2B.

206

207 In terms of case series and case reports, the criterion that was consistently poor was the use of  
208 statistical analysis; however, reviewers believed that this was not necessary in most cases,  
209 given the small sample sizes and the descriptive nature of the series. Fifteen of the 21 case

210 series were rated as ‘good,’ and six were rated as ‘fair.’ All three case reports were rated as  
211 ‘fair’.

212

213 There were some criteria that were consistently not applicable to cohort studies. These included  
214 variation in amount or level as an exposure (as one can only have vasa previa or not), whether  
215 outcome assessors were blinded (as most studies were retrospective) and whether there was a  
216 sample size justification (this was considered unnecessary as most studies included all  
217 consecutive cases within a reasonable period). Overall, six cohort studies were rated as ‘good’,  
218 and seven were rated as ‘fair’.

219

220 There was difficulty in assessing the overall quality of conference abstracts, due to the lack of  
221 essential information for this. For this reason, it was difficult for the global assessments of  
222 conference abstracts to exceed ‘fair.’

223

## 224 **Qualitative synthesis**

225 The most commonly reported outcomes included perinatal mortality,<sup>4,7,12–14,18,19,27–43,45–52</sup>  
226 respiratory distress syndrome (RDS) requiring intubation,<sup>12,14,27,30,33,34,36–38,40,41,46</sup> 5-minute  
227 Apgar scores <7,<sup>1,2,12,14,18,19,27–29,31–43,45–48,50</sup> requirement of blood transfusion to the  
228 neonate,<sup>4,7,12,14,19,31–34,36–38,40,41,43–45,48,50</sup> NICU admission,<sup>4,7,14,19,28,29,31,32,36–41,43,45–49</sup> and low  
229 birthweight.<sup>1,2,14,18–20,27–29,32,33,37,38,40,41,43,45–49,51</sup>

230

231 The number of cases of vasa previa in the included studies ranged from two to 586 with a mean  
232 of 63.7 and a median of 23. Three of the 37 studies were prospective, of which two were case  
233 series and one was a cohort study.<sup>1,13,32</sup> Broadly, cohort studies that compared outcomes of  
234 prenatally diagnosed vasa previa with vasa previa undiagnosed prenatally reported a reduced

235 risk of neonatal mortality among diagnosed cases.<sup>12,20,35,46</sup> Studies comparing women without  
236 vasa previa to women with vasa previa demonstrated an increased risk of neonatal mortality,  
237 RDS requiring intubation and need for neonatal blood transfusions. Perinatal mortality ranged  
238 from 0% to 16.6% in the studies analyzing prenatally diagnosed vasa previa. NICU admission  
239 was a common event for neonates delivered from pregnancies affected by vasa previa, with the  
240 rates ranging from 53.5% to 100%.

241

242 Other complications of prematurity were also included in a small number of studies. Six studies  
243 reported on IVH (0 – 16.7%),<sup>1,17,34,38,41,46</sup> two studies reported on cases of bronchopulmonary  
244 dysplasia (0.02 – 8.7%),<sup>38,48</sup> and five studies reported cases of necrotizing enterocolitis (0 –  
245 8.7%).<sup>1,17,38,41,48</sup> However, there was not enough data available to perform a quantitative  
246 analysis on these neonatal outcomes.

247

248 Of the 37 included studies, 14 provided recommendations on the timing of delivery, which  
249 ranged from 33 to 37 weeks. The most common recommendations were 34 to 35 weeks<sup>30,33,42</sup>  
250 and 35 weeks.<sup>7,12,29</sup> Only one study suggested delivery earlier than this at 33 to 34 weeks.<sup>17</sup>  
251 Broader recommendations included 34 to 36 weeks,<sup>46</sup> 34 to 37 weeks,<sup>20</sup> and 35 to 37 weeks.<sup>18,19</sup>  
252 35 to 36 weeks<sup>14,40</sup> and 36 weeks<sup>32</sup> were also proposed by some other studies.

253

254 To note, while all studies largely defined vasa previa as fetal vessels running unprotected over  
255 or close to the internal cervical os, four studies defined the distance of the fetal vessels to the  
256 internal cervical os explicitly.<sup>13,14,33,36,45–47</sup> Six studies defined vasa previa as fetal vessels  
257 within 2 cm of the cervical os, and the last defined close proximity as within a distance of 4  
258 cm.

259

## 260 **Quantitative synthesis**

261 A total of 490 neonates were included across the 14 studies for analysis. This included 44  
262 (9.0%) neonates born at less than 32 weeks, 20 (4.1%) at 32 weeks, 34 (6.9%) at 33 weeks, 122  
263 (24.9%) at 34 weeks, 145 (29.6%) at 35 weeks, 80 (16.3%) at 36 weeks, 33 (6.7%) at 37 weeks  
264 and 12 (2.4%) at 38 weeks or later. Figure 2 demonstrates the unweighted pooled rates of  
265 perinatal complications, whilst Supplementary Table 3 summarizes the rates (numerically) of  
266 different perinatal complications. Supplementary Figure 1(A–E) presents the forest plots of the  
267 inverse-variance weighted proportions of morbidity outcomes overall, and Supplementary  
268 Figure 2(A–E) by gestational age at birth. Meta-analyses were not possible for the outcome of  
269 perinatal mortality given the low number of events.

270

271 There was no evidence of publication bias for the outcomes of respiratory distress requiring  
272 intubation, Apgar < 7 at five minutes, low birthweight, and blood transfusion (Egger's test p-  
273 values 0.196, 0.833, 0.132 and 0.817, and Supplementary Figures 3A, 3B, 3D and 3E,  
274 respectively). There was some evidence of small study effects for the outcome of NICU  
275 admission, with a tendency towards smaller studies reporting lower rates of NICU admission  
276 (Egger's test p-value 0.033, Supplementary Figure 3C). A sensitivity analysis restricted to good  
277 quality studies showed similar trends to those of the main analysis (Supplementary Table 4 and  
278 Supplementary Figure 4).

279

### 280 Perinatal mortality

281 There were two cases of perinatal mortality, both of which occurred below 32 weeks of  
282 gestation due to complications of prematurity (4.6% of births in this age bracket). The  
283 cumulative incidence of perinatal death after the diagnosis of vasa previa was 4.1 in 1,000 (95%  
284 confidence interval [CI] 0.5 to 14.7 in 1,000).

285

286 Respiratory Distress Syndrome requiring intubation

287 The highest rate of RDS was unsurprisingly amongst neonates born <32 weeks of gestation,  
288 with an incidence of 91.2%. RDS affected 47.1% of neonates born at 32 weeks, 44.0% at 33  
289 weeks, 27.5% at 34 weeks and 21.1% at 35 weeks. This further decreased to 5.3% at 36 weeks  
290 (5.7%), rose to 16.7% at 37 weeks and then decreased again to 0.0% at 38 weeks or later.

291

292 Apgar <7 at five minutes

293 The highest rate of Apgar scores <7 at five minutes occurred at 33 weeks of gestation (14.7%).  
294 In contrast, the lowest rate was at 36 weeks and 38 weeks or later (both 0%). The incidence of  
295 five-minute Apgar scores <7 at other gestations was 11.4% at less than 32 weeks, 10.0% at 32  
296 weeks, 4.2% at 34 weeks, 4.2% at 35 weeks, and 9.1% at 37 weeks.

297

298 NICU Admission

299 All neonates born before or at 32 weeks required an admission to NICU. The lowest rate of  
300 NICU admission was 0.0% at 38 weeks or later, followed by 29.2% at 36 weeks. Other rates  
301 of NICU admission included 94.1% at 33 weeks, 86.9% at 34 weeks, 64.7% at 35 weeks and  
302 31.8% at 37 weeks.

303

304 Low birthweight

305 All neonates delivered at <32 weeks and at 32 weeks were of low birthweight. This steadily  
306 declined at each subsequent gestational week to 90.5% at 33 weeks, 84.1% at 34 weeks, 48.3%  
307 at 35 weeks, 30.9% at 36 weeks, 16.7% at 37 weeks and 0.0% at 38 weeks.

308

309 Neonatal blood transfusion



310 The highest incidence of transfusions occurred at <32 weeks (23.3%). Neonatal blood  
311 transfusion at other gestations was relatively uncommon, with incidence of 0.0% at 32 weeks,  
312 5.9% at 33 weeks, 0.9% at 34 weeks, 2.2% at 35 weeks, 2.9% at 36 weeks, 3.6 % at 37 weeks  
313 and a slight rise to 8.3% at 38 weeks or later.

314

## 315 **Comment**

### 316 **Principal findings**

317 In this systematic review, we analyzed 37 studies. The qualitative synthesis identified relevant  
318 neonatal outcomes relating to vasa previa, including perinatal mortality, RDS, five-minute  
319 Apgar scores <7, NICU admissions, low birthweight, and requirement of neonatal blood  
320 transfusion; other complications of prematurity (including IVH, BPD and NEC) were less  
321 commonly reported neonatal outcomes. Moreover, the qualitative synthesis reiterated the  
322 importance of a prenatal diagnosis of vasa previa.

323

324 Fourteen studies were included in the quantitative synthesis to investigate the gestational age  
325 with the lowest rate of complications. This analysis found a downward trend in the rate of  
326 complications until 36 weeks; this gestational age saw no perinatal deaths or 5-minute Apgar  
327 scores <7, low rates of RDS (5.3%) and blood transfusion (2.9%), and relatively low rates of  
328 NICU admission (29.2%) and low birthweight (30.9%). At 37 weeks, the rates of most  
329 complications slightly increased again (RDS, 5-minute Apgar <7, blood transfusions, and  
330 NICU admission), but remained generally low. The lowest absolute risk of complications  
331 appeared to be at 38 weeks or later, where the rate of all complications was 0.0%, except for  
332 neonatal blood transfusion (8.3%). However, it must be considered that there was only a small  
333 number of neonates born after 38 weeks (n = 12), which was likely due to guidelines suggesting  
334 delivery prior to this time. The small sample size at 38 weeks and later significantly limits the

335 reliability of conclusions about the rates of adverse outcomes at these gestational ages; hence,  
336 it cannot be confidently stated that delivery at this time is safe. Given the decrease in  
337 complications until 36 weeks and small increase in complications at 37 weeks, this may suggest  
338 that waiting until late preterm may be the best time to deliver in otherwise uncomplicated  
339 pregnancies with prenatally diagnosed vasa previa.

340

341 In total, there were two neonatal deaths (0.4% of all neonates in this study), both of which were  
342 due to complications of prematurity. Since we only included cases of vasa previa with prenatal  
343 diagnosis, the low rate of perinatal mortality is in line with previous studies demonstrating  
344 much lower death rates in cases diagnosed prenatally as compared to those without prenatal  
345 diagnosis.<sup>12</sup>

346

347 When examining the ‘safest’ time to deliver in cases of prenatally diagnosed vasa previa, it is  
348 also important to consider the individual patient. For example, some women may be at higher  
349 risk of preterm premature rupture of membranes (PPROM) than others; a relevant predictor of  
350 PPRM is short cervical length, which can be assessed using transvaginal ultrasound.<sup>53</sup> Hence,  
351 this relatively simple assessment could provide valuable patient-specific information on the  
352 risk of fetal vessel rupture at earlier gestational ages, and subsequently guide timing of  
353 delivery.<sup>54</sup> Recent literature has also suggested elective hospitalization of women in the weeks  
354 prior to planned delivery, which would allow for closer monitoring for signs of preterm labor  
355 and timely access to emergency cesarean if indicated.<sup>55</sup> However, data to endorse this as  
356 standard practice is lacking, and the cost-effectiveness of this strategy has not been adequately  
357 explored.<sup>11</sup>

358

359 **Comparison with existing literature**

360 There have been some recent systematic reviews on vasa previa which have explored risk  
361 factors and neonatal outcomes in cases of vasa previa.<sup>3,56,57</sup> This review differs from these as  
362 we examined a broader range of outcomes and included both a qualitative and quantitative  
363 synthesis.

364

365 We found 14 studies that provided recommendations on timing of delivery in cases of vasa  
366 previa. Suggestions ranged from as early as 33 to 34 weeks,<sup>17</sup> up until 37 weeks.<sup>18–20</sup> Half of  
367 the 14 studies recommended delivery at 35 weeks or earlier.<sup>7,12,17,29,30,33,42</sup> One study  
368 recommended 36 weeks.<sup>32</sup> The remaining studies proposed a window of time that extended to  
369 at least 36 weeks, but also included gestations at 35 weeks or prior.<sup>14,18–20,40,46</sup> Our data suggests  
370 that it is generally safe and beneficial to prolong otherwise uncomplicated pregnancies with a  
371 diagnosis of vasa previa to at least 36 weeks, slightly more than most recommendations made  
372 by previous studies.

373

374 Another important resource to compare these findings to are current guidelines. The American  
375 College of Obstetricians and Gynecologists (ACOG) and the Society for Maternal-Fetal  
376 Medicine (SMFM) both recommend birth at 34 to 37 weeks, and the Royal College of  
377 Obstetricians and Gynaecologists (UK) and the Royal Australian and New Zealand College of  
378 Obstetricians and Gynaecologists (RANZCOG) recommend delivery at 34 to 36 weeks.<sup>11,16,22</sup>  
379 Given the lack of large studies to base these recommendations upon, most guidelines rely on  
380 experts' consensus of a gestational age period at which the rates of adverse neonatal outcomes  
381 are usually low in high-resource settings. Our finding of relatively low complication rates at  
382 36 weeks supports these guidelines and could also add greater specificity.

383

384 **Strengths and limitations**

385 Existing literature on this topic commonly analyzed the cohort as a whole and reported mean  
386 event rates. This study was unique as it analyzed the rate of complications at each discrete  
387 gestational age, as well as the trends in these adverse outcomes. To the best of our knowledge,  
388 no study has stratified neonatal outcomes in cases of vasa previa by gestational age in order to  
389 find the age with the lowest rate of complications.

390

391 There were also weaknesses to this study. As the incidence of vasa previa is low, there is only  
392 limited literature available. Although this study combined results of many previous studies, the  
393 stratified data from some of the largest studies could not be obtained. This left us with a  
394 relatively small sample (490 cases) to obtain reliable estimates, and potentially introduced  
395 some bias into our results. Future studies should hence focus on prospective data collection  
396 through multicenter collaborations to increase confidence, with clear and uniform criteria for  
397 vasa previa diagnosis.

398

399 When interpreting these results, it is important to consider that not all outcomes are equal in  
400 severity, and that individual patients would likely have differing opinions on which risks  
401 (prematurity or vasa previa) they are most accepting of. However, the rates of all complications  
402 seem to be well balanced at 36–36+6 weeks, minimizing the need for subjective data  
403 interpretation. Moreover, long-term outcomes were not reported, and hence could not be  
404 accounted for in this study. For example, neonates born with RDS are at risk of developing  
405 bronchopulmonary dysplasia.<sup>16</sup> Prolonged fetal anemia, which could be secondary to preterm  
406 delivery or fetal hemorrhage, can lead to ischemic brain lesions and, consequently,  
407 neurodevelopmental delay or other forms of disability.<sup>58</sup> These could form further important  
408 considerations women and clinicians may have in the decision-making for timing of birth.

409

410 As the data that we received from authors was aggregate patient data, we were unable to obtain  
411 the indications for delivery, including whether the delivery was planned or emergent. This is a  
412 limitation to our study, as emergent or medical indications for earlier delivery may bias the  
413 data towards more complications. Subgroup analysis examining emergent delivery, and the  
414 specific indications, prior to planned deliveries would have been valuable but was not possible  
415 in this review. Formal meta-analysis techniques were used to consider clustering, as well as  
416 intra- and between-study variability in the calculation of weights and in the assessment of  
417 statistical heterogeneity. Further adjustments for clustering are only possible in individual  
418 participant data meta-analyses, which was outside the scope of this study. It was also unclear  
419 which particular management protocols were being followed in most studies. We acknowledge  
420 that the comparison of management protocols could also have been of great interest, but we  
421 lacked the data to do so.

422

423 This study only analyzed pregnancies that had been diagnosed prenatally. One of the most  
424 significant prognostic markers for poor neonatal outcomes in pregnancies affected by vasa  
425 previa is the lack of a prenatal diagnosis; these pregnancies are likely to be prolonged until the  
426 labor occurs spontaneously, or birth is indicated for other reasons, which places the fetus at  
427 high risk of exsanguination. Unfortunately, the benefits of screening the general population  
428 remain unclear and routine antenatal screening is currently not performed in many settings.<sup>16</sup>  
429 However, with advances in ultrasound technology and guidelines for more thorough evaluation  
430 of high-risk pregnancies, many cases are still able to be identified.<sup>16,58</sup>

431

## 432 **Conclusions**

433 In otherwise uncomplicated cases of prenatally diagnosed vasa previa, perinatal mortality is  
434 low, and it seems safe and beneficial to prolong pregnancy until 36 weeks. Given the possible

- 435 small increase in complications at term, 36–36+6 weeks may represent the gestational age that
- 436 best balances the risks of complications from vasa previa and prematurity.

## References

1. Catanzarite V, Maida C, Thomas W, Mendoza A, Stanco L, Piacquadio KM. Prenatal sonographic diagnosis of vasa previa: ultrasound findings and obstetric outcome in ten cases. *Ultrasound in Obstetrics & Gynecology*. 2001;18(2):109-115. doi:10.1046/j.1469-0705.2001.00448.x
2. Yeaton-Massey A, Girsen AI, Mayo JA, et al. Vasa previa and extreme prematurity: a population-based study. *J Perinatol*. 2019;39(3):475-480. doi:10.1038/s41372-019-0319-8
3. Pavalagantharajah S, Villani LA, D'Souza R. Vasa previa and associated risk factors: a systematic review and meta-analysis. *American Journal of Obstetrics & Gynecology MFM*. 2020;2(3). doi:10.1016/j.ajogmf.2020.100117
4. Zhang W, Geris S, Beta J, Ramadan G, Nicolaides KH, Akolekar R. Prevention of stillbirth: impact of two-stage screening for vasa previa. *Ultrasound in Obstetrics & Gynecology*. 2020;55(5):605-612. doi:10.1002/uog.21953
5. Carp HJA, Mashlach S, Serr DM. Vasa Previa: A major complication and its management. *Obstetrics & Gynecology*. 1979;53(2):273-275.
6. Fung TY, Lau TK. Poor perinatal outcome associated with vasa previa: is it preventable? A report of three cases and review of the literature. *Ultrasound in Obstetrics & Gynecology*. 1998;12(6):430-433. doi:10.1046/j.1469-0705.1998.12060430.x
7. Bronsteen R, Whitten A, Balasubramanian M, et al. Vasa Previa: Clinical Presentations, Outcomes, and Implications for Management. *Obstetrics & Gynecology*. 2013;122(2 PART 1):352-357. doi:10.1097/AOG.0b013e31829cac58
8. Quek SP, Tan KL. Vasa Praevia. *Australian and New Zealand Journal of Obstetrics and Gynaecology*. 1972;12(3):206-209. doi:10.1111/j.1479-828X.1972.tb00503.x
9. Oyelese KO, Turner M, Lees C, Campbell S. Vasa Previa: An Avoidable Obstetric Tragedy. *Obstetrical & Gynecological Survey*. 1999;54(2):138-145.
10. Suekane T, Tachibana D, Pooh RK, Misugi T, Koyama M. Type-3 vasa previa: normal umbilical cord insertion cannot exclude vasa previa in cases with abnormal placental location. *Ultrasound in Obstetrics & Gynecology*. 2020;55(4):556-557. doi:10.1002/uog.20347
11. Sinkey RG, Odibo AO, Dashe JS. #37: Diagnosis and management of vasa previa. *American Journal of Obstetrics & Gynecology*. 2015;213(5):615-619. doi:10.1016/j.ajog.2015.08.031
12. Oyelese Y, Catanzarite V, Prefumo F, et al. Vasa Previa: The Impact of Prenatal Diagnosis on Outcomes: *Obstetrics & Gynecology*. 2004;103(5, Part 1):937-942. doi:10.1097/01.AOG.0000123245.48645.98
13. Daly-Jones EL, Drought A, Story L, et al. P21.09: Incorporation of vasa previa screening into a routine anomaly scan. *Ultrasound in Obstetrics & Gynecology*. 2017;50(S1):224-224. doi:10.1002/uog.18216
14. Kulkarni A, Powel J, Aziz M, et al. Vasa Previa: Prenatal Diagnosis and Outcomes: Thirty-five Cases From a Single Maternal-Fetal Medicine Practice. *Journal of Ultrasound in Medicine*. 2018;37(4):1017-1024. doi:10.1002/jum.14452

15. Reddy UM, Abuhamad AZ, Levine D, Saade GR. Fetal Imaging. *Journal of Ultrasound in Medicine*. 2014;33(5):745-757. doi:10.7863/ultra.33.5.745
16. Jauniaux ERM, Alfirevic Z, Bhide AG, Burton GJ, Collins SL, Silver R. Vasa Praevia: Diagnosis and Management. *BJOG: An International Journal of Obstetrics & Gynaecology*. 2019;126(1):e49-e61. doi:10.1111/1471-0528.15307
17. Swank ML, Garite TJ, Maurel K, et al. Vasa previa: diagnosis and management. *American Journal of Obstetrics & Gynecology*. 2016;215(2):223.e1-223.e6. doi:10.1016/j.ajog.2016.02.044
18. Golic M, Hinkson L, Bamberg C, et al. Vasa Praevia: Risk-Adapted Modification of the Conventional Management – a Retrospective Study. *Ultraschall Med*. 2013;34(4):368-376. doi:10.1055/s-0032-1313167
19. Yerlikaya-Schatten G, Chalubinski KM, Pils S, Springer S, Ott J. Risk-adapted management for vasa praevia: a retrospective study about individualized timing of caesarean section. *Arch Gynecol Obstet*. 2019;299(6):1545-1550. doi:10.1007/s00404-019-05125-9
20. Smorgick N, Tovbin Y, Ushakov F, et al. Is neonatal risk from vasa previa preventable? The 20-year experience from a single medical center. *J Clin Ultrasound*. 2010;38(3):118-122. doi:10.1002/jcu.20665
21. Robinson BK, Grobman WA. Effectiveness of Timing Strategies for Delivery of Individuals With Vasa Praevia. *Obstetrics & Gynecology*. 2011;117(3):542-549. doi:10.1097/AOG.0b013e31820b0ace
22. Medically Indicated Late-Preterm and Early-Term Deliveries: ACOG Committee Opinion, Number 818. *Obstetrics & Gynecology*. 2021;137(2):e29. doi:10.1097/AOG.0000000000004245
23. Page MJ, McKenzie JE, Bossuyt PM, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *BMJ*. 2021;372:n71. doi:10.1136/bmj.n71
24. Patterson PD, Weaver M, Clark S, Yealy DM. Case reports and case series in prehospital emergency care research. *Emergency Medicine Journal*. 2010;27(11):807-809. doi:10.1136/emj.2009.073668
25. Ma LL, Wang YY, Yang ZH, Huang D, Weng H, Zeng XT. Methodological quality (risk of bias) assessment tools for primary and secondary medical studies: what are they and which is better? *Military Medical Research*. 2020;7(1):7. doi:10.1186/s40779-020-00238-8
26. R Core Team. R: A language and environment for statistical computing. Published 2013. Accessed August 29, 2021. <https://www.r-project.org/>
27. Mabuchi Y, Yamoto M, Minami S, et al. Two cases of vasa previa diagnosed prenatally using three-dimensional ultrasonography. *Journal of Clinical Ultrasound*. 2010;38(7):389-392. doi:10.1002/jcu.20722
28. Isotton AL, Salazar CC, Peralta CFA, Abdalla JML, Vettorazzi J. In Vitro Fertilization and Vasa Praevia: A Report of Two Cases. *Rev Bras Ginecol Obstet*. 2019;41(05):348-351. doi:10.1055/s-0039-1683354
29. Wiafe YA, Adu-Bredu TK, Appiah-Denkyira K, Senaya CM. Antenatal diagnosis of vasa previa: report of three cases in an African setting. *Pan Afr Med J*. 2020;37:24. doi:10.11604/pamj.2020.37.24.25663



30. Gandhi MMD, Cleary-Goldman JMD, Ferrara LMD, Ciorica DRDMS, Saltzman DMD, Rebarber AMD. The Association Between Vasa Previa, Multiple Gestations, and Assisted Reproductive Technology. *Journal of Perinatology*. 2008;25(9):587-589.
31. Erfani H, Haeri S, Shainker SA, et al. Vasa previa: a multicenter retrospective cohort study. *American Journal of Obstetrics and Gynecology*. 2019;221(6):644.e1-644.e5. doi:10.1016/j.ajog.2019.06.006
32. Sullivan EAM, Javid NR, Duncombe GM, et al. Vasa Previa Diagnosis, Clinical Practice, and Outcomes in Australia. *Obstetrics & Gynecology*. 2017;130(3):591-598. doi:10.1097/AOG.0000000000002198
33. Catanzarite V, Cousins L, Daneshmand S, et al. Prenatally Diagnosed Vasa Previa: A Single-Institution Series of 96 Cases. *Obstetrics & Gynecology*. 2016;128(5):1153-1161. doi:10.1097/AOG.0000000000001680
34. Lee W, Lee VL, Kirk JS, Sloan CT, Smith RS, Comstock CH. Vasa Previa: Prenatal Diagnosis, Natural Evolution, and Clinical Outcome. *Obstetrics & Gynecology*. 2000;95(4):572-576.
35. Weintraub AY, Gutvirtz G, Sergienko R, Sheiner E. 113: Vasa-previa: a critical analysis of risk factors and perinatal outcomes of 237 cases. *American Journal of Obstetrics & Gynecology*. 2012;206(1):S63. doi:10.1016/j.ajog.2011.10.131
36. Melcer Y, Jauniaux E, Maymon S, et al. Impact of targeted scanning protocols on perinatal outcomes in pregnancies at risk of placenta accreta spectrum or vasa previa. *American Journal of Obstetrics and Gynecology*. 2018;218(4):443.e1-443.e8. doi:10.1016/j.ajog.2018.01.017
37. Nohuz E, Boulay E, Gallot D, Lemery D, Vendittelli F. Can we perform a prenatal diagnosis of vasa previa to improve its obstetrical and neonatal outcomes? *Journal of Gynecology Obstetrics and Human Reproduction*. 2017;46(4):373-377. doi:10.1016/j.jogoh.2017.02.009
38. Westcott JM, Simpson S, Chasen S, et al. Prenatally diagnosed vasa previa: association with adverse obstetrical and neonatal outcomes. *American Journal of Obstetrics & Gynecology MFM*. 2020;2(4):100206. doi:10.1016/j.ajogmf.2020.100206
39. Dunn T, Nassr AA, Moaddab A, Eppes C, Shamshirsaz AA. Vasa Previa: Maternal and Early Neonatal Outcomes in the New Era of Obstetrical Care [13K]. *Obstetrics & Gynecology*. 2017;129(5):115S. doi:10.1097/01.AOG.0000514606.70935.d2
40. Hasegawa J, Arakaki T, Ichizuka K, Sekizawa A. Management of vasa previa during pregnancy. *Journal of Perinatal Medicine*. 2015;43(6):783-784. doi:10.1515/jpm-2014-0047
41. Romero V, Perni U, Joshi D, Mozurkewich E, Treadwell M. Neonatal outcomes after prenatally diagnosed vasa previa. A Case Series. *Reproductive Sciences*. 2011;18(3).
42. Rebarber A, Dolin C, Fox NS, Klauser CK, Saltzman DH, Roman AS. Natural History of Vasa Previa Across Gestation Using a Screening Protocol. *Journal of Ultrasound in Medicine*. 2014;33(1):141-147. doi:10.7863/ultra.33.1.141
43. Gross A, Markota Ajd B, Specht C, Scheier M. Systematic screening for vasa previa at the 20-week anomaly scan. *Acta Obstetrica et Gynecologica Scandinavica*. 2021;100(9):1694-1699. doi:10.1111/aogs.14205
44. Konishi N, Misguri T, Suekane T, et al. Perinatal outcomes of the 29 cases with vasa previa. In: *The Journal of Obstetrics and Gynaecology Research*; 2020. doi:10.1111/jog.14342

45. La S, Melov SJ, Nayyar R. Are we over-diagnosing vasa praevia? The experience and lessons learned in a tertiary centre. *Australian and New Zealand Journal of Obstetrics and Gynaecology*. 2021;61(2):217-222. doi:10.1111/ajo.13259
46. Liu N, Hu Q, Liao H, Wang X, Yu H. Vasa previa: Perinatal outcomes in singleton and multiple pregnancies. *Biosci Trends*. 2021;15(2):118-125. doi:10.5582/bst.2021.01052
47. Tachibana D, Misugi T, Pooh RK, et al. Placental Types and Effective Perinatal Management of Vasa Previa: Lessons from 55 Cases in a Single Institution. *Diagnostics (Basel)*. 2021;11(8):1369. doi:10.3390/diagnostics11081369
48. Toscano M, Betancourt M, Satchell M, Malshe A. 635 Neonatal morbidity associated with pregnancies complicated by vasa previa: a comparative study. *American Journal of Obstetrics & Gynecology*. 2021;224(2):S398-S399. doi:10.1016/j.ajog.2020.12.656
49. Trostle ME, Ferrara L, Stone J, et al. 931 Maternal and neonatal outcomes associated with vasa previa resolution during the antepartum period. *American Journal of Obstetrics & Gynecology*. 2021;224(2):S577-S578. doi:10.1016/j.ajog.2020.12.956
50. Fujita T, Kazuhiro T, Murakami T, Taniguchi S, Shimamoto T. Clinical outcome for vasa previa: A retrospective analysis of 9 cases. *The Journal of Obstetrics and Gynaecology Research*. 2020;46:70-91. doi:10.1111/jog.14454
51. Akolekar R, Al-Emara N, Kostiv V, Beta J. Vasa praevia: impact of routine screening on pregnancy outcomes. Published online 2018.
52. Attilakos G, David A, Brocklehurst P, Knight M. Vasa praevia: A national UK study using the UK Obstetric Surveillance System (UKOSS). Published online 2017.
53. Odibo AO, Berghella V, Reddy U, Tolosa JE, Wapner RJ. Does transvaginal ultrasound of the cervix predict preterm premature rupture of membranes in a high-risk population? *Ultrasound in Obstetrics & Gynecology*. 2001;18(3):223-227. doi:10.1046/j.1469-0705.2001.00419.x
54. Vintzileos AM, Ananth CV, Smulian JC. Using ultrasound in the clinical management of placental implantation abnormalities. *American Journal of Obstetrics & Gynecology*. 2015;213(4):S70-S77. doi:10.1016/j.ajog.2015.05.059
55. Fishel Bartal M, Sibai BM, Ilan H, et al. Prenatal Diagnosis of Vasa Previa: Outpatient versus Inpatient Management. *Am J Perinatol*. 2019;36(4):422-427. doi:10.1055/s-0038-1669396
56. Villani LA, Pavalagantharajah S, D'Souza R. Variations in reported outcomes in studies on vasa previa: a systematic review. *Am J Obstet Gynecol MFM*. 2020;2(3):100116. doi:10.1016/j.ajogmf.2020.100116
57. Zhang W, Geris S, Al-Emara N, Ramadan G, Sotiriadis A, Akolekar R. Perinatal outcome of pregnancies with prenatal diagnosis of vasa previa: systematic review and meta-analysis. *Ultrasound in Obstetrics & Gynecology*. 2021;57(5):710-719. doi:10.1002/uog.22166
58. Sinha P, Kaushik S, Kuruba N, Beweley S. Vasa praevia: A missed diagnosis. *Journal of Obstetrics and Gynaecology*. 2008;28(6):600-603. doi:10.1080/01443610802344365

## Figure legends

**Figure 1:** PRISMA flow diagram

**Figure 2:** Pooled rates of respiratory distress syndrome requiring intubation, Apgar score <7 at five minutes, NICU admission, low birthweight, blood transfusion and perinatal death (Numbers and percentages provided in Supplementary Table 3)

**Appendix A:** Search strategy

**Supplementary Table 1.** Table of Included Studies

**Supplementary Table 2.** NIH Study Quality Assessments. A. Cohort studies; B. Case series and case reports

**Supplementary Table 3.** Rates of perinatal morbidity and mortality according to gestational age at birth in cases of prenatally diagnosed vasa previa

**Supplementary Table 4.** Rates of perinatal morbidity and mortality according to gestational age at birth in cases of prenatally diagnosed vasa previa. Sensitivity analysis restricted to studies considered of good quality / low risk of bias.

**Supplementary Figure 1.** Forest plots presenting meta-analyses of the overall proportions with random effects models and including studies with at least five cases of prenatally diagnosed vasa previa. A: Respiratory distress syndrome requiring intubation at birth; B: Apgar scores <7 at five minutes; C: Neonatal intensive care unit (NICU) admission; D: Low birthweight; E: Neonatal blood transfusion.

**Supplementary Figure 2.** Forest plots presenting meta-analyses of proportions with random effects models and including studies with at least five cases of prenatally diagnosed vasa previa. A: Respiratory distress syndrome requiring intubation at birth; B: Apgar scores <7 at five

minutes; C: Neonatal intensive care unit (NICU) admission; D: Low birthweight; E: Neonatal blood transfusion.

**Supplementary Figure 3.** Funnel plots of different adverse perinatal outcomes. A: Respiratory distress syndrome requiring intubation at birth (Egger's test p-value 0.196); B: Apgar scores <7 at five minutes (p-value 0.833); C: Neonatal intensive care unit (NICU) admission (p-value 0.033); D: Low birthweight (p-value 0.132); E: Neonatal blood transfusion (p-value 0.817).

**Supplementary Figure 4.** Pooled rates of respiratory distress syndrome requiring intubation, Apgar score <7 at five minutes, NICU admission, low birthweight, blood transfusion and perinatal death. Sensitivity analysis restricted to studies considered of good quality / low risk of bias.