



Increased nuchal translucency after low-risk noninvasive prenatal testing: What should we tell prospective parents?

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Abstract

Three decades ago, the observation that first trimester fetuses with excess fluid accumulation at the back of the neck were more likely to be aneuploid, gave rise to a new era of prenatal screening. The nuchal translucency (NT) measurement in combination with serum biomarkers and maternal age, resulted in the first trimester combined screening (FTCS) program. The introduction of noninvasive prenatal testing (NIPT) over the past decade has introduced the option for parents to receive highly sensitive and specific screening information for common trisomy from as early as 10 weeks gestation, altering the traditional pathway FTCS pathway. The retention of the 11–13-week NT ultrasound remains important in the detection of structural anomalies; however, the optimal management of pregnancies with a low-risk NIPT result and an isolated increased NT measurement in an era of advanced genomic testing options is a new dilemma for clinicians. For parents, the prolonged period between the initial diagnosis in first trimester, and prognostic information at each successive stage of investigations up to 22–24 weeks, can be emotionally challenging. This article addresses the common questions from parents and clinicians as they navigate the uncertainty of having a fetus diagnosed with an increased NT after a low-risk NIPT result and presents suggested approaches to management.

Key points

What is already known about this topic?

- Noninvasive prenatal testing (NIPT) is a superior screen for the common autosomal trisomies 13, 18, and 21
- Increased nuchal translucency (NT) is associated with chromosomal, genetic, and structural anomalies
- Options for advanced genomic testing are increasing

What does this paper add?

- Review of the definition “increased NT” in the context of changing practice and guidelines
- Synthesized data from available literature to provide updated clinical guidance on management of pregnancies with increased NT and low-risk NIPT, incorporating psychosocial needs of parents

1 | INTRODUCTION

Three decades ago, the critical observation that first trimester fetuses with excess fluid accumulation at the back of the neck were more likely to be aneuploid gave rise to a new era of prenatal screening.¹ The nuchal translucency (NT), as it became known, subsequently formed a key element of the first trimester combined screen (FTCS) in combination with serum biomarkers and maternal age. The FTCS quickly became the benchmark for prenatal screening for trisomy 21, 13, and 18, providing detection rates of 85% or more for pregnancies at 11–13 weeks gestation.² However, with the implementation of noninvasive prenatal testing (NIPT) over the past decade, FTCS has yielded some of its dominance, with 20% or more of women in some countries now choosing NIPT as their first-line screening test.^{3–5}

Although NIPT has the highest sensitivity and specificity of any screening test for the common autosomal aneuploidies,⁶ professional societies continue to recommend and endorse the retention of the 11–13-week NT ultrasound as it provides the opportunity for accurate pregnancy dating, identification of multiples/chorionicity, and early detection of fetal anomalies.^{7,8} In the current molecular era of NIPT, chromosomal microarray, and fetal exome sequencing, the debate has shifted from the value of retaining the 11–13-week ultrasound for early structural anomaly detection, to questions about the optimal management of pregnancies with a low-risk NIPT result and an increased NT measurement.^{9,10} This article addresses the common questions from parents as they navigate the uncertainty of having a fetus diagnosed with an increased NT after a low-risk NIPT result, and presents the rationale for our approach to management.

2 | NUCHAL TRANSLUCENCY MEASUREMENT

2.1 | What is the NT and why is it measured?

The NT is described as the subcutaneous fluid visualized behind the fetal neck on ultrasound in first trimester.¹ It is a powerful marker of aneuploidy when measured in fetuses with crown rump length (CRL) of 45–84 mm correlating with gestations of 11 + 0 to 13 + 6 weeks.¹ Distinctions between increased NT, enlarged jugular sacs, cystic hygroma (a septated increased NT), or hydrops in the first trimester can be unclear; however, clinical management follows a similar approach regardless of the variations in appearance (Figure 1).¹¹ A heterogeneous range of conditions are associated with increased NT, reflecting varied underlying mechanisms including cardiac dysfunction, altered composition of the extracellular matrix, venous congestion in the head and neck, and failure of lymphatic drainage.¹²

Measuring the NT remains an important component of the 11–13-week scan in the context of a low-risk NIPT result, as a marker for genetic conditions and fetal anomalies that would not be detected by NIPT (Table 1).^{13,14} Prognostically, the overall risk of an adverse pregnancy outcome after normal conventional karyotype is proportional to the NT measurement (Table 2).¹⁵

Key counseling points: *The measurement of NT remains an important component of the 11–13-week ultrasound due to the association with structural and genetic anomalies not detected by NIPT. There is an 80% risk of adverse pregnancy outcome when the NT measures ≥ 6.5 mm (Table 2).*

2.2 | What is an abnormal NT measurement?

The normal range of NT changes with gestational age in euploid fetuses.¹² When considered independently from the FTCS screening algorithm, an “increased NT” triggering diagnostic evaluation has been variously defined as a fixed measurement of ≥ 3.5 mm,¹⁶ or a gestation-specific threshold of ≥ 99 th centile.¹⁷ Other authors suggest lower thresholds for offering genetic counseling and prenatal diagnosis such as 3.0 mm^{18,19} or the 95th centile.¹⁰ The International Society for Ultrasound in Obstetrics and Gynecology (ISUOG) does not specify a definition of “increased NT,” but the American College of Obstetricians and Gynecologists (ACOG) and the Society for Maternal Fetal Medicine (SMFM) now recommend thresholds of 3.0 mm or the 99th centile, although these two definitions are not equivalent.^{7,8}

Bardi et al. recently calculated the Area Under the Curve (AUC) of NT measurement and found that the best NT threshold was 3.55 mm for the prediction of congenital anomalies.¹⁰ Similarly, the best cutoff for the prediction of adverse pregnancy outcome was NT of 3.6 mm (AUC 0.779, for sensitivity of 70%, and specificity of 75%). If a threshold below 3.5 mm is to be used, we recommend a gestational-age-controlled cutoff of 99th centile, or 1.9 multiples of the median (MoM) as this has similar detection rate for atypical chromosome abnormalities as a 3.0 mm threshold, but with 31% fewer false positives.²⁰ This adjustment for gestational age is particularly relevant as women with low-risk NIPT at 10–11 weeks may be advised to schedule their first trimester anatomy scan in the latter half of the 11–13 + 6-week window (i.e., 12 + 4 to 13 + 6 weeks) in order to improve detection of structural defects.²¹ This shift could have the effect of increasing the number of euploid fetuses that have an NT > 3.0 mm but below the 99th centile (Figure 2).

Key counseling points: *There is no clear international consensus on a definition of an increased NT after low-risk NIPT, beyond the traditional fixed cutoff of 3.5 mm. If a lower threshold is to be chosen, a gestational-age-controlled threshold such as the 99th centile or 1.9 MoM may minimize false-positive rates for atypical chromosome abnormalities.*

2.3 | What about nuchal edema before 11 weeks gestation?

The increasing local practice of performing a “pre-NIPT” ultrasound at 10 weeks to exclude missed miscarriage, multiple pregnancy or incorrect dating prior to NIPT may lead to the detection of nuchal edema in fetuses with CRL <45 mm. This creates clinical uncertainty as there are no established protocols for management of an

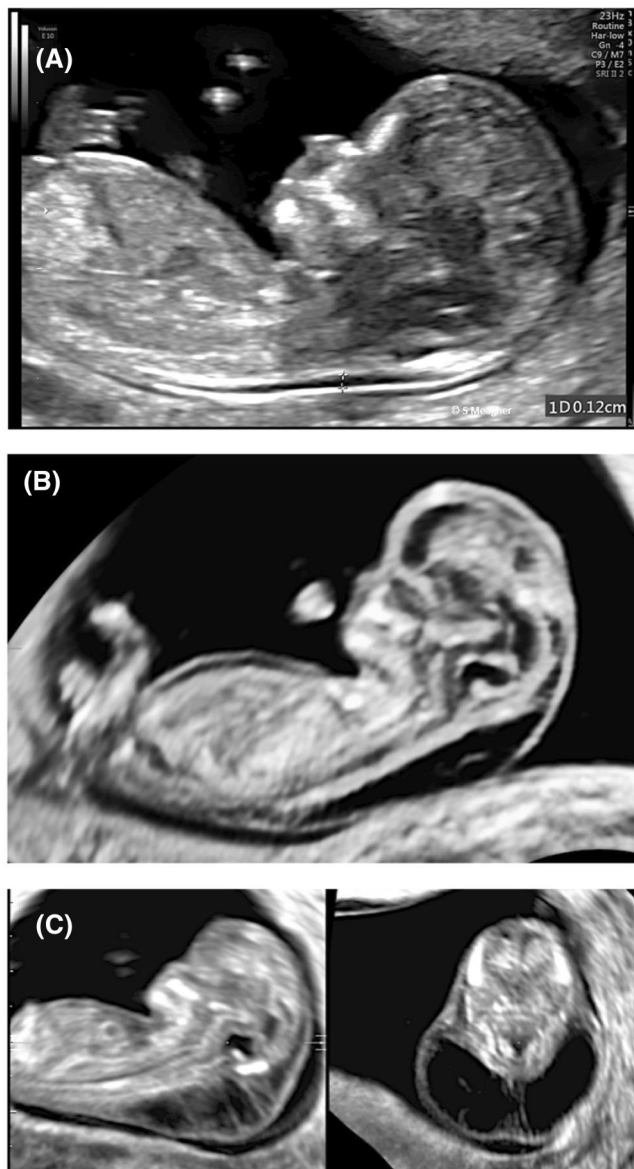


FIGURE 1 (A) A normal nuchal translucency (NT) measurement in a fetus at 13 weeks 0 days gestation. (B) An increased NT in an 11-week fetus. (C) Cystic hygroma (nuchal edema with septations) at 11 weeks. Source: Images courtesy of A/Prof Simon Meagher, University of Melbourne

TABLE 1 Conditions associated with increased NT after low-risk targeted NIPT^a

Associations	Most common example
Structural anomalies	Cardiac
Microdeletions (pathogenic submicroscopic copy number variants)	22q11.2 deletion syndrome ^b
Single gene disorders	Noonan syndrome
Other chromosomal	Triploidy ^b

Abbreviations: NIPT, noninvasive prenatal testing; NT, nuchal translucency.

^aAssuming targeted NIPT has excluded trisomy 21, 13, 18, and sex chromosome aneuploidy.

^bSome NIPT assays screen for these conditions.

increased NT before 11 weeks. A recent retrospective study reporting outcomes in more than 100 fetuses with CRL of 28–45 mm CRL and nuchal edema >2.2 mm (95th percentile for NT at 10 weeks) or hydrops showed that the risks of structural (4%) or chromosome abnormalities (19%) increased with NT size.²² Of the 77/104 pregnancies that continued to a 11–13⁺⁶ weeks ultrasound, 82% had resolution of nuchal edema and these cases had fewer adverse outcomes (miscarriage, structural or chromosomal anomaly) than those who developed an NT ≥ 3.5 mm (10.9% vs. 76.5%, respectively, $p < 0.001$). Of the 76 women who received a low-risk NIPT result, two received an atypical chromosome result from diagnostic testing. Both these fetuses had generalized edema, rather than isolated nuchal edema.

When there are concerning appearances before the timeframe for a formal NT assessment, our advice is to consider deferring NIPT and re-assess with ultrasound at 12–13 weeks. If an enlarged NT is still present or a structural abnormality is evident (including generalized edema) at 12–13 weeks, diagnostic testing should be offered. If the nuchal edema has resolved and no structural abnormalities are detected, then a choice of diagnostic testing or NIPT would be appropriate. More data from larger prospective studies are needed before we can confidently offer management recommendations based on the independent predictive value of nuchal edema at <11 weeks.

Key counseling points: While nuchal edema before 11 weeks may indicate an increased risk of miscarriage or fetal abnormality, many will resolve spontaneously. Further assessment at 12–13 weeks will assist in determining if a screening or a diagnostic approach is warranted.

2.4 | Did I do something to cause this?

Parents are often concerned that the finding of increased NT is due to a behavior in pregnancy, or sometimes other cultural or spiritual beliefs. Ideally this question is answered by clinicians in a way that addresses both the psychosocial need for reassurance and practical elements of the question.

Key counseling points: With few exceptions, identified causes of increased NT are unrelated to maternal behavior or environmental exposures, and reassurance can usually be provided.

NT (mm)	n	Chance of live-born without congenital anomaly	Risk of abnormal outcome
3.5-4.4	157	141 (90%)	1 in 10
4.5-5.4	38	30 (79%)	2 in 10
5.5-6.4	11	5 (45%)	5 in 10
≥6.5	17	3 (18%)	8 in 10
Total	223	149 (67%)	1 in 3

TABLE 2 Risk of abnormal pregnancy outcome after NT ≥3.5 mm and normal karyotype (adapted from Ayräs et al.¹⁵)

Note: Bold entries are to highlight the summary or pooled data.

Abbreviation: NT, nuchal translucency.

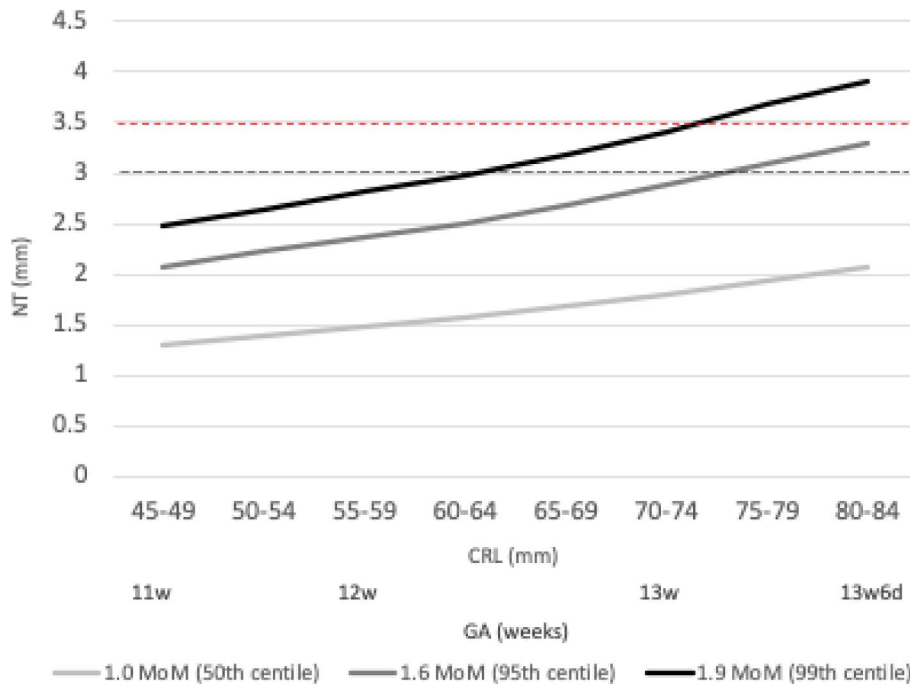


FIGURE 2 Distribution of nuchal translucency measurements among 81,244 singleton pregnancies in Victoria, 2015–2016. CRL, crown rump length; NT, nuchal translucency, MoM, multiples of the median. Source: Data courtesy of Leonard Bonacquisti, Victorian Clinical Genetics Services. Software: Alpha Version 8.0.16281.67, Logical Medical Systems Ltd, London, United Kingdom

3 | NONINVASIVE PRENATAL TESTING

3.1 | So what problems have been excluded by my low-risk NIPT result?

What appears to be a straightforward question is becoming increasingly complicated given the emergence of numerous categories of NIPT with varying coverage of the genome. There are also variable detection rates within a particular assay depending on the chromosome, fetal fraction, platform, and size of the genomic region of interest. Clinicians need to understand the specific NIPT product, its limitations (biological and statistical), and the concept of residual risk to answer this question for parents. In some settings, such as the Netherlands, where there is a single publicly funded provider with published data, this may be relatively straightforward.²³ However, in other settings such as Australia, there are a variety of providers, each with their own options. Most NIPT platforms in current clinical use in

Australia utilize massively parallel sequencing, with single nucleotide polymorphism (SNP)-based approaches less common. Options include:

- Targeted NIPT for the common autosomal trisomies: trisomy 21, 13, and 18, +/- sex chromosome aneuploidy (SCA) and fetal sex
- Genome-wide NIPT: autosomal trisomies of chromosomes 1–22, segmental chromosomal aneuploidy >10 Mb size for chromosomes 1–22, +/-SCA
- Targeted NIPT for the common autosomal trisomies with 22q11.2 microdeletion syndrome +/- other selected microdeletion syndromes
- Targeted NIPT plus triploidy +/- microdeletion(s) screening (SNP-based option)

The confidence that a condition has been excluded by a low-risk NIPT result depends on the negative predictive value (NPV). This is a

function of the background prevalence of the condition and the sensitivity of NIPT for detecting that particular condition. The presence of a common autosomal aneuploidy in a pregnancy would be very unlikely after a low-risk NIPT result (unless in mosaic form), particularly if the fetus appears structurally normal. However, confidence in the NPV for other conditions varies and is hampered by biological variation and limited published follow-up on cohorts with low-risk NIPT results. In summary, we advise parents that a low-risk NIPT cannot provide reassurance for conditions other than the common autosomal trisomies.

Key counseling points: *While the presence of a common autosomal aneuploidy is very unlikely after a low-risk NIPT result, NIPT cannot exclude any condition with complete certainty. Most NIPT does not exclude microdeletions/duplications and mosaic forms of whole chromosome aneuploidy.*

4 | INITIAL ASSESSMENT

4.1 | What should we do now?

4.1.1 | Family and medical history

The value of taking a detailed pedigree or family history is twofold; as an important tool for insight into family history of miscarriage, congenital anomaly, stillbirth, consanguinity, physical and intellectual disability, and as a means by establishing rapport with parents.²⁴ This exploration of both the genetic and psychosocial landscape may provide information regarding the potential for rare underlying monogenic causes and inheritance patterns of increased NT, and assist clinicians in establishing a working alliance with parents. A medical history may reveal potential risk factors for structural anomalies, such as pre-pregnancy diabetes mellitus, or teratogen exposure including congenital infection.

While fetal infections have been associated with nuchal edema, it is most strongly associated with fetal hydrops in second and third trimesters.²⁵ In a study of 426 euploid pregnancies with increased NT at 10–14 weeks, 6 had maternal serology suggestive of recent maternal infection, but none were confirmed to have fetal infection.²⁶ Based on this study, we reserve serological testing for women with a specific clinical history that suggests an increased risk of cytomegalovirus, parvovirus, or toxoplasmosis infection.

4.1.2 | Specialist fetal ultrasound at 12–13 and 16 weeks

Structural anomalies are present in approximately one in three (30.7%) of euploid fetuses with NT ≥ 3.5 mm.²⁷ A detailed specialist obstetric ultrasound is recommended for all fetuses with an increased NT given the increased risk of a structural abnormality. The detection rate of structural abnormalities with an expert

12–13-week ultrasound has improved considerably over the past decade, particularly with the use of transvaginal imaging, and it is now expected to detect at least 50% of anomalies seen in the general fetal population.^{28,29}

The value of a 16-week ultrasound as both an assessment of further NT evolution and other structural anomalies not seen at 13 weeks can provide parents with information that may prompt further investigation or provide reassurance.^{13,30} In a recent study published by Le Lous et al., the 16-week scan detected the greatest proportion of associated structural abnormalities: the first trimester scan detected 31.3%, the 16-week scan 41.2%, and the 22-week scan detected the remaining 27.4%.²⁷ These authors showed that a normal 16-week scan was associated with favorable outcomes in 85% of pregnancies, and that those with a normal 20-week scan had almost 100% chance of a favorable outcome. Thus, an additional scan at 16 weeks is helpful for facilitating earlier diagnosis of major structural anomalies, or conversely, providing interim reassurance before the 20–22-week ultrasound.

If a lower NT threshold of ≥ 95 th centile is employed, the overall rate of associated structural abnormalities is lower, at about 1 in 10 (9.3%).¹⁰ The majority of these structural anomalies are also detectable before 18 weeks, either at the time of the 11–13-week scan or at the time of tertiary referral (before 18 weeks).

Early diagnosis of a fetal anomaly provides parents with further prognostic information and provides a strong indication for diagnostic testing with chromosomal microarray (CMA).^{31,32} The chance of additional clinically relevant finding on CMA after normal conventional karyotype is 7% in fetuses with increased NT and structural anomaly, compared with 4% in fetuses with an isolated increased NT.¹⁶ However, where there is a clear diagnosis of a major structural anomaly, parents may feel they have sufficient information on which to base a decision about termination of pregnancy (TOP) without prenatal diagnostic testing. Parents should be supported appropriately and offered postnatal testing on products of conception.

4.1.3 | Diagnostic testing with CMA

There are numerous studies examining the yield of CMA after normal karyotype for the isolated finding of increased NT.^{16,19,33,34} A meta-analysis from 2015 demonstrated that 5% of fetuses with increased NT (predominantly defined in the included studies as ≥ 3.5 mm) had a clinically significant copy number variant (CNV) detected after a normal karyotype.¹⁶ In contrast, the yield of CMA after normal karyotype for a NT threshold of 3.0 mm is similar to that for diagnostic testing in pregnancies without an ultrasound abnormality, that is, 0.37% (1 in 270).^{19,33–35}

Key counseling points: *A medical history, detailed obstetric ultrasound, and offer of diagnostic testing with CMA rather than karyotype should be part of the assessment of women with increased NT and low risk-NIPT.*

5 | YIELD FROM PRENATAL DIAGNOSIS

5.1 | What is the chance of a chromosome condition being detected on CMA after low-risk NIPT?

Several recent studies have modelled the yield of CMA testing after low-risk NIPT results for targeted NIPT including the SCA, summarized in Table 3. The most common conditions that would be missed by targeted NIPT include triploidy, rare autosomal trisomies (often in mosaic form, including confined placental mosaicism), 22q11.2 deletion syndrome, other pathogenic CNVs, and mosaic monosomy X.^{10,20,35} The risk of a clinically significant chromosome abnormality varies depending on the definition of increased NT, presence of associated structural abnormalities, as well as the coverage of the prior NIPT.

Overall, the frequency of a clinically significant condition being detected after prenatal diagnosis in fetuses with NT ≥ 3.5 mm or ≥ 99 th centile after low-risk NIPT is 3.5%–6.1%.^{10,17,20} For those with NT 3.0–3.4 mm or 95th–99th centile, the risk is lower at 1.5%–1.9%. However, when including all pregnancies with NT 3.0–3.4 mm as the denominator, and not just the subgroup that undergoes prenatal diagnosis, the chance is lower at 0.37% (95% CI 0.05%–1.35%).²⁰ However, this is still within a range where diagnostic testing is conventionally offered after screening and the option of diagnostic testing may be discussed with parents with this finding in pregnancy.

The presence of an associated ultrasound abnormality increases the risk of a chromosome abnormality. In a large population-based study with over 80,000 women, the risks of an atypical abnormality after low-risk targeted NIPT (assessing chromosomes 21, 13, 18, X, and Y) increased from 3.1% to 11.0% in the presence of an additional structural anomaly. The most common pathogenic CNV detected was 22q11.2 deletion syndrome, consistent with this CNV ranking as the most common in other populations.²⁰

5.1.1 | The risk of a submicroscopic deletion/duplication after whole genome NIPT for fetuses with NT 3.0–3.4 mm

In a review synthesizing original data and previously published studies, Petersen et al. calculated the residual risks in fetuses with NT 3.0–3.4 mm and high-risk combined first trimester result.³⁵ They reported that the risk of a CNV was 1 in 500 (0.2%) if a genome-wide 10-Mb resolution NIPT test had returned a low risk result.

Bardi et al. reported the outcomes on 1007 fetuses with NT 95th–99th centile after low-risk whole genome NIPT and calculated a 0.9% risk of a submicroscopic CNV. This risk rose to 3% for those fetuses with NT ≥ 99 th centile.¹⁰

Key counseling points: Increasing NT measurements are associated with higher chance of a pathogenic CNV, with the presence of additional ultrasound abnormalities further increasing this chance. A threshold that segregates those with a higher-than-background chance of an atypical chromosome condition is 3.5 mm and/or

>99 th centile⁸/1.9 MoM.⁸ Prenatal diagnosis and CMA provide important information to parents.

6 | GENOMIC TESTING

6.1 | My microarray result was normal. Are there more genetic tests that I can have?

After a normal CMA in the presence of an increased NT, genetic counseling may turn to the option of testing for single gene conditions. About half of all single gene conditions associated with increased NT belong to the RASopathy family,¹⁰ and associated panels are the most common testing that is offered for increased NT after normal CMA.

6.2 | RASopathy testing

Collectively known as RASopathies, this group of genetic conditions result from dysregulation of the *Ras/mitogen-activated protein kinase* (RAS-MAPK) signaling pathway. There are more than 20 genes in this pathway. The most common RASopathy syndrome, Noonan's syndrome, has a well-documented prenatal ultrasound phenotype including increased NT with or without cystic hygroma, hydrops, pleural effusion, and cardiac abnormalities.^{36,37} Diagnostic testing for RASopathies are commonly performed using next-generation sequencing with a customized gene panel, or exome or genome sequencing with a targeted data analysis.

Bardi et al. reported the overall rate of a single gene condition in fetuses with NT >99 th centile (including those with structural abnormalities) to be 3.3%, of which Noonan's syndrome made up almost half (1.4%) (Table 4).¹⁰ When there are multiple ultrasound features associated with RASopathies, an overall yield of 10%–14% has been reported after a normal CMA.^{36–40} Recently Scott et al. found that the overall diagnostic yield for RASopathy testing after a normal CMA and increased NT was 14% (50/352), however the yield was much lower for isolated increased NT (1/90) compared with increased NT with other typical ultrasound abnormalities (16%, 27/167) (Table 4).³⁹ These findings are consistent with the large study on prenatal RASopathy testing by Stuurman et al., which recommended that RASopathy testing only be offered for very large isolated NTs (≥ 5.0 mm), or if at least one other typical ultrasound feature was present.³⁶

6.3 | Exome and whole genome sequencing

The final step in the prenatal diagnostic journey of increased NT could be exome or whole genome sequencing, with analysis of many genes linked to single gene conditions presenting before or after birth. One of the earliest fetal exome studies that included five fetuses with isolated increased NT did not return any positive

TABLE 3 Modelled yield of chromosomal microarray in pregnancies with increased NT after low-risk targeted NIPT for trisomy 21/13/18 and sex chromosome aneuploidy

First author, year	Increased NT criteria	No. of pregnancies with CMA	Yield of CMA N (%)
Bardi, 2020	≥99th centile	1007	45 (4.5) ^a
Hui, 2021 ^c	≥3.5 mm	329	20 (6.1)
	≥1.9 MoM	399	22 (5.5)
Miranda, 2020	>99th centile	226	13 (3.5)
Bardi, 2020	95th–99th centile	894	13 (1.5) ^b
Petersen, 2020	3.0–3.4 mm and high-risk FTC	522 (pooled cohort)	10 (1.9) ^d
Hui, 2021 ^c	3.0–3.4 mm	129	2 (1.6%)

Abbreviations: CMA, chromosomal microarray; FTC, first trimester combined screening; NIPT, noninvasive prenatal testing; NT, nuchal translucency.

^aFifteen autosomal trisomies and triploidy plus 30 CNVs (calculated from Tables 2 and 4).

^bThree autosomal trisomies, two triploidy, and eight CNVs (calculated from Tables 2 and 4).

^cIncludes results of cases with postnatal testing on products of conception.

^dResult calculated by excluding 9 susceptibility CNVs from the 19 total “undetectable” abnormalities in pooled cohort in Table 1 in Petersen et al.³⁵

TABLE 4 Yield of RASopathy testing in fetuses with increased NT and normal chromosomal microarray

First author, year	Criteria for RASopathy testing	No. of tested fetuses	Yield of RASopathy panel (%)
Isolated increased NT			
Bardi, 2020	NT ≥99th centile	1007	14 (1.4)
Scott, 2021	Isolated increased NT	90	1 (1)
Mixed cohorts of isolated and non-isolated increased NT			
Scott, 2021	Increased NT, polyhydramnios, hydrops, effusions, congenital heart disease, and/or renal anomalies	352	50 (14)
Sinajon, 2020	NT ≥3.5 mm	103	3 (3) ^a

Abbreviations: NIPT, noninvasive prenatal testing; NT, nuchal translucency.

^aAll three positive cases had additional ultrasound findings.

diagnoses.⁴¹ Since then, larger cohorts of fetuses with isolated and non-isolated increased NT have been studied with sequencing after normal microarray (Table 5).^{42–48} Yang et al. performed trio exome sequencing on 73 fetuses with isolated first trimester increased NT ≥3.5 mm and normal CMA.⁴⁵ Three of four cases with pathogenic variants developed structural anomalies on ultrasound at mid pregnancy, leading to pregnancy termination. When considering only those fetuses with isolated first trimester increased NT, normal CMA and with no ultrasound abnormalities in second trimester, the diagnostic yield of exome sequencing in that study was only 1.4% (1/70). Sparks et al. performed exome sequencing on 127 second trimester fetuses with nonimmune hydrops, defined as the presence of fetal ascites, pleural or pericardial effusions, skin edema, cystic hygroma, increased NT, or a combination of these conditions.⁴⁴ The median gestation at diagnosis was 20 weeks (range 13.4–24.6). Among the 29 cases with increased NT or cystic hygroma (either isolated or concurrent with other anomalies), 31% (9/29) had a diagnostic variant. However, among the cases with isolated increased NT or

cystic hygroma, the diagnostic yield was 7% (1/15). Not surprisingly, the presence of hydrops, effusions, or other lymphatic system anomalies increased the yield of pathogenic variants up to 24%–34%.^{42,44} When combining all the apparently isolated NT ≥3.5 mm from these studies, the weighted average diagnostic yield was 3.7%, including RASopathy conditions (Table 5).

When to offer fetal exome or RASopathy panel can be impacted by the competing elements of awaiting further ultrasound phenotypic information to guide appropriate testing, and parental desire for comprehensive and timely results. Genomic testing is expensive, requires careful pre- and post-test counseling, specific gene selection, and variant interpretation in the context of the fetal phenotype. The cost to the patient, service, and ultimately the public healthcare sector are important considerations that will vary according to the local context.

Key counseling points: Single gene testing with a RASopathy panel is expected to have a yield of ~1% and exome sequencing ~3%–4% for fetuses with isolated increased NT and normal CMA. Comprehensive

TABLE 5 Yield of fetal exome sequencing for isolated increased NT ≥ 3.5 mm after normal microarray

First author, year	Definition of increased NT	No. with isolated increased NT	Diagnostic yield n (%)
Lord, 2019	≥ 4.0 mm	93	3 (3.2)
Petrovski, 2019	≥ 3.5 mm	30	1 (3.3) ^a
Yang, 2020	≥ 3.5 mm	70	1 (1.4)
Sparks, 2020	≥ 3.5 mm	15	1 (7)
Choy, 2019	≥ 3.5 mm	34	3 (8.8)
Total pooled yield		242	9 (3.7%)

Note: Bold entries are to highlight the summary or pooled data.

Abbreviation: NT, nuchal translucency.

^aInferred from Table 1 in Petrovski et al.⁴²

pre- and post-test counseling, that includes setting realistic expectations of further testing are important considerations. Progressive fetal phenotype can better assist test choice, gene selection, and variant interpretation.

7 | MANAGING UNCERTAINTY AND SUPPORTING DECISION-MAKING

7.1 | When will I know if my baby is healthy? I am having trouble coping

Receiving news about a possible or confirmed fetal anomaly is acutely distressing for parents.^{49–51} Parents benefit greatly from timely access to information, support and multidisciplinary care when faced with an uncertain prognosis in their pregnancy.^{49,52} Information provision of itself is not sufficient for parents to feel supported during the often months-long journey of uncertainty during the pregnancy. Information needs to be integrated and contextualized for parents, with attention to parent responses, questions, and concerns.^{53,54} Genetic counselors can assist prospective parents to manage uncertainty by providing specific clinical information and anticipatory guidance around potential outcomes of further testing, as well as identifying areas of control and supporting coping mechanisms for the couple.^{50,51,55} Supportive decision-making should be nondirective in terms of the decision itself, but directive in terms of guiding parents through the diagnostic journey.⁴⁹ Some parents may benefit from referral to specialist perinatal mental health services, particularly in context of previous mental health issues or persistent distress.⁵²

Key counseling points: *Acknowledging the emotional impact of diagnostic uncertainty and providing guidance and support is a key component of care.*

7.2 | What should I tell my family and friends? Can I have a termination of pregnancy?

Parents often have difficulty sharing uncertain prenatal information with family and friends, increasing the potential for social alienation, increased grief reactions, and emotional distress.⁵⁶ These feelings

can be compounded by expectations of negative judgement a couple elects to have a termination of pregnancy.^{57,58} Exploring sources of support with parents, offering simple written and verbal explanation example, and revising knowledge at subsequent information points can assist parents with this process.

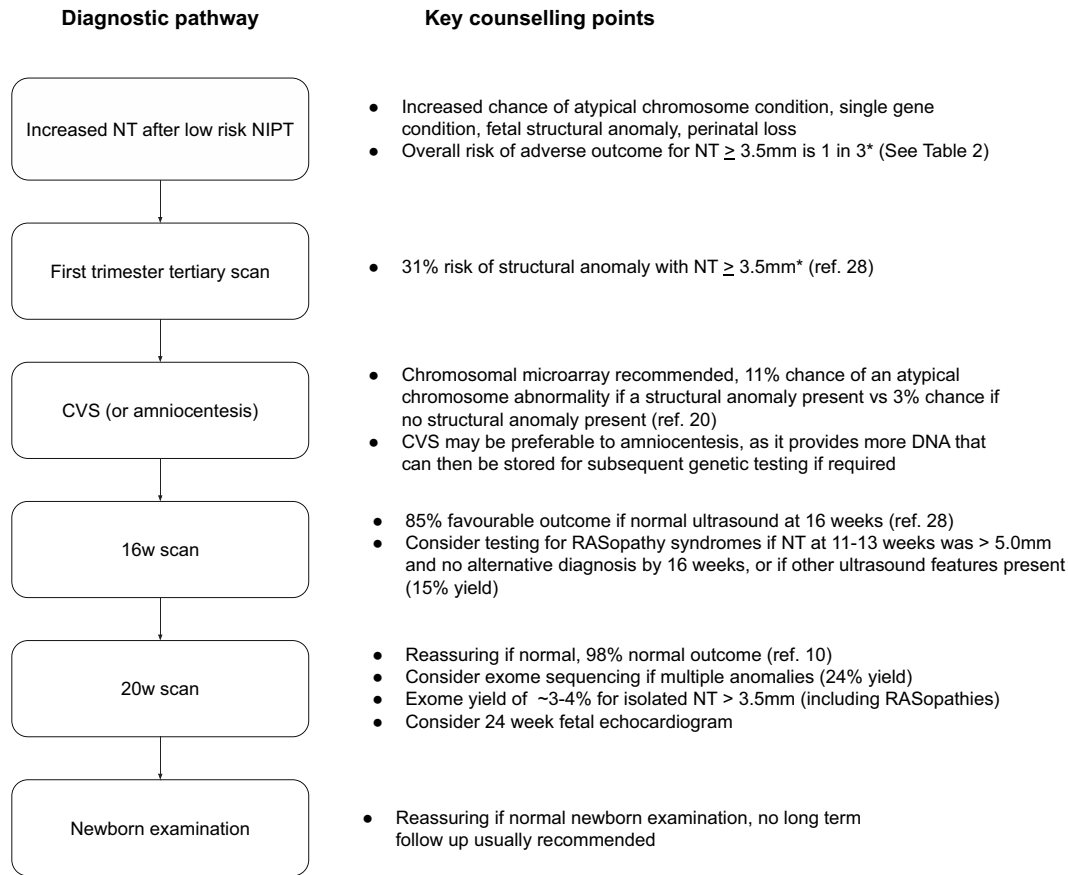
Women and their partners may wish to discuss TOP early in the journey, particularly if the NT is large (Table 2). A woman's decision about TOP is dependent on many factors, including risk perception, tolerance for uncertainty, spiritual beliefs, personal and family experience of grief or disability, and many other components of complex decision-making. Parents may change their views regarding TOP when faced with a poor obstetric outcome or diagnosis of a genetic condition, and exploration of choices, appreciating context and providing non-judgmental support is essential. Access to safe and timely termination of pregnancy varies greatly according to location and healthcare setting. Clinicians caring for parents should have an awareness of the laws, accessibility, and barriers that could impact a woman's decision-making, and raise these potential issues with patients while counseling. Many couples benefit from the multidisciplinary nature of fetal medicine teams, with access to support from pastoral care, social workers, and other mental health care professionals.

Key counseling points: *Parents benefit from simple verbal and written resources to understand and explain the finding of increased NT in pregnancy. Clinicians have an obligation to be aware of services and facilitate referral for TOP as an essential component of patient care.*

8 | FINAL ASSESSMENT

8.1 | My 20-week scan was normal and so was my CMA. What is the chance my baby will be born with a problem?

After a normal 20-week ultrasound showing resolution of nuchal edema and normal CMA, parents should be reassured that the chances of having a child with a significant health issue are probably not greater than the background risk.^{30,59} A recently published prospective study compared the neurodevelopmental outcomes of 203 children who had isolated increased NT ≥ 95 th centile with a



*Data on outcomes after normal karyotype used as proxy for outcomes after low risk NIPT

FIGURE 3 Example of diagnostic pathway for increased nuchal translucency (NT) and low-risk noninvasive prenatal testing (NIPT)

control group with normal NT measurements.⁶⁰ Using objective psychomotor testing at 2 years corrected age, the investigators found that the mean developmental quotient of the increased NT group was within the normal range, although it was lower than the control group. These reassuring findings also applied for those who had an isolated NT ≥ 3.5 mm.⁶⁰

While the majority of major cardiac defects are detectable by 18–22 weeks, a small proportion may not be recognizable until the third trimester or after birth.^{20,29,61} Increased NT or hydrops are common features of serious skeletal dysplasias presenting in early pregnancy; however, evaluation of long bones in the second or third trimester may prompt further investigation for other skeletal dysplasias.⁶² Other structural defects, such as pulmonary or gastrointestinal anomalies, are less likely to be detected on ultrasound, even in the third trimester.^{10,63} A 24-week fetal echocardiogram may be considered, depending on adequacy of prior fetal heart assessment at 20 weeks, parental concern, and family history. The balance between comprehensive investigation and normalizing a pregnancy for parents is an important consideration in the counseling process.

Key counseling points: Parents should be reassured of a likely good pregnancy outcome when second trimester investigations are normal. Clinical examination of the baby prior to discharge from hospital should inform the need for postnatal follow-up.

9 | CONCLUSION

Parents are now faced with a myriad of choices around screening and testing options in pregnancy. The experience of receiving a low-risk result on NIPT and a subsequent 12–13-week ultrasound with an increased NT is a contemporary dilemma, made more complex by the emerging options for single gene testing. The psychological journey for parents is made even more challenging by the prolonged period between initial diagnosis in first trimester, and prognostic information at each successive stage of investigations up to 22–24 weeks (Figure 3). The balance between comprehensive investigation and normalizing a pregnancy for parents is an important consideration throughout management. As ever, the integration of new genomic

testing into prenatal care is associated with ethical, counseling, and healthcare resource utilization challenges. Despite the continuous advances in technology, supporting parents with appropriate information and supporting decision-making remains a constant principle to guide practice in the genomic era.

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CONFLICT OF INTEREST

The authors have no conflicts of interest.

ETHICS STATEMENT

Ethics approval not required as no new data was created in this manuscript.

DATA AVAILABILITY STATEMENT

No new data was created in this manuscript.

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