Fetal hydrops and the Incremental yield of Next-generation sequencing over standard prenatal Diagnostic testing (FIND) study: prospective cohort study and meta-analysis

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KEYWORDS: exome sequencing; fetus; hydrops; next-generation sequencing; non-immune hydrops fetalis; prenatal diagnosis

CONTRIBUTION
What are the novel findings of this work?
This is the first systematic review assessing the incremental diagnostic yield of prenatal exome sequencing over chromosomal microarray analysis or karyotyping in prenatally diagnosed non-immune hydrops fetalis. An apparent incremental yield of exome sequencing was demonstrated.

What are the clinical implications of this work?
Prenatal exome sequencing should be considered in prenatally diagnosed non-immune hydrops fetalis that is unexplained by standard genetic testing, in both isolated cases and those associated with an additional fetal structural anomaly.

ABSTRACT
Objective To determine the incremental yield of exome sequencing (ES) over chromosomal microarray analysis (CMA) or karyotyping in prenatally diagnosed non-immune hydrops fetalis (NIHF).

Methods A prospective cohort study (comprising an extended group of the Prenatal Assessment of Genomes and Exomes (PAGE) study) was performed which included 28 cases of prenatally diagnosed NIHF undergoing trio ES following negative CMA or karyotyping. These cases were combined with data from a systematic review of the literature. MEDLINE, EMBASE, CINAHL and ClinicalTrials.gov databases were searched electronically (January 2000 to October 2020) for studies reporting on the incremental yield of ES over CMA or karyotyping in fetuses with prenatally detected NIHF. Inclusion criteria for the systematic review were: (i) at least two cases of NIHF undergoing sequencing; (ii) testing initiated based on prenatal ultrasound-based phenotype; and (iii) negative CMA or karyotyping result. The incremental diagnostic yield of ES was assessed in: (i) all cases of NIHF; (ii) isolated NIHF; (iii) NIHF associated with an additional fetal structural anomaly; and (iv) NIHF according to severity (i.e. two vs three or more cavities affected).

Results In the extended PAGE study cohort, the additional diagnostic yield of ES over CMA or karyotyping was 25.0% (7/28) in all NIHF cases, 21.4% (3/14) in those with isolated NIHF and 28.6% (4/14) in those with
non-isolated NIHF. In the meta-analysis, the pooled incremental yield based on 21 studies (306 cases) was 29% (95% CI, 24–34%; P < 0.00001; I² = 0%) in all NIHF, 21% (95% CI, 13–30%; P < 0.00001; I² = 0%) in isolated NIHF and 39% (95% CI, 30–49%; P < 0.00001; I² = 1%) in NIHF associated with an additional fetal structural anomaly. In the latter group, congenital limb contractures were the most prevalent additional structural anomaly associated with a causal pathogenic variant, occurring in 17.3% (19/110) of cases. The incremental yield did not differ significantly according to hydrops severity. The most common genetic disorders identified were RASopathies, occurring in 30.3% (27/89) of cases with a causative pathogenic variant, most frequently due to a PTPN11 variant (44.4%; 12/27). The predominant inheritance pattern in causative pathogenic variants was autosomal dominant in monallelic disease genes (57.3%; 51/89), with most being de novo (86.3%; 44/51).

Conclusions Use of prenatal next-generation sequencing in both isolated and non-isolated NIHF should be considered in the development of clinical pathways. Given the wide range of potential syndromic diagnoses and heterogeneity in the prenatal phenotype of NIHF, exome or whole-genome sequencing may prove to be a more appropriate testing approach than a targeted gene panel testing strategy. © 2021 The Authors. Ultrasound in Obstetrics & Gynecology published by John Wiley & Sons Ltd on behalf of International Society of Ultrasound in Obstetrics and Gynecology.

INTRODUCTION

Non-immune hydrops fetalis (NIHF) is defined traditionally as fluid accumulation in two or more fetal body cavities in cases not secondary to maternal red cell alloimmunization. It affects up to 1 in 1700 pregnancies, with associated high risks of perinatal morbidity and mortality. Excluding cases due to infection, fetal structural anomaly (FSA) or complications of twin pregnancy, aneuploidy may explain one-quarter of cases, with chromosomal microarray analysis (CMA) demonstrating copy-number variants (CNVs) in a further 6–14% of cases. Despite this, the definitive diagnostic yield of CMA over standard G-banding karyotyping is moderate and, following exclusion of the aforementioned causes, up to 50% of cases of NIHF remain unexplained, with a significant proportion thought to be secondary to single-gene variants. Over 170 genes have been identified as being associated with NIHF and, until the recent emergence of next-generation sequencing (NGS), testing for such conditions has relied on targeted gene testing and enzyme assays. Single-gene causes of NIHF are associated with significant risks of perinatal death or neurodevelopmental sequelae. Establishing the diagnostic etiology of NIHF prenatally is a vital step in facilitating informed decision-making for both parents and clinicians when considering options such as termination of pregnancy, planning neonatal care and addressing recurrence risks. The latter risk could theoretically be mitigated by using novel technologies, such as preimplantation genetic testing. While individual cohort studies have assessed the diagnostic yield of exome sequencing (ES) over quantitative fluorescence polymerase chain reaction (QF-PCR) and CMA or karyotyping in NIHF, they are heterogeneous in relation to the populations assessed and the genetic platforms used. Given this heterogeneity, there is a need to integrate existing data on single-gene disorders underlying NIHF. Hence, the aims of this study were to evaluate the incremental diagnostic yield of prenatal ES over CMA or karyotyping in prenatally diagnosed NIHF for: (i) all cases of NIHF; (ii) isolated NIHF; (iii) NIHF associated with an additional FSA; and (iv) NIHF according to severity (i.e. two cavities vs three or more cavities affected).

METHODS

Extended PAGE study cohort

The Fetal hydrops and the Incremental yield of Next-generation sequencing over standard prenatal Diagnostic testing (FIND) study included prospectively identified cases of prenatally confirmed NIHF from an extended cohort of the Prenatal Assessment of Genomes and Exomes (PAGE) study. For the purposes of this study, we defined NIHF as pathological fluid accumulation in at least two fetal cavities confirmed prenatally on ultrasound, excluding cases with aneuploidy, congenital infection, alloimmunization and/or twin–twin transfusion syndrome. The final extended PAGE cohort comprised 850 fetuses (including 596 of the published cohort) with fetal–parental trio ES performed when an ultrasound-confirmed FSA was detected. These cases were recruited between October 2014 and May 2018 across 34 fetal medicine centers in England and Scotland, with ES performed centrally at the Wellcome Trust Sanger Institute, Hinxton, UK. PAGE eligibility criteria included: (i) prenatal detection of a FSA after 11 weeks’ gestation; (ii) availability of proband and parental DNA; and (iii) negative CMA or karyotyping result. The PAGE study methodology has been published previously and utilized a standard ES approach with variant interpretation based on a targeted virtual gene panel for developmental disorders encompassing 1628 genes. Phenotypes of all cases were classified using Human Phenotype Ontology (HPO) terms, and those defined as hydrops fetalis (HP:0001789) were selected and analyzed further to determine if the criteria for NIHF for the purposes of the FIND study were met. Cases were classified further as isolated or associated with an additional FSA using the HPO approach to coding additional anomalies. The fetal phenotype was described by fetal medicine specialists/sonographers and documented principally on ViewPoint® version 5.6.16 (GE Healthcare, Zipf, Austria). Variants were classified in accordance with the American College of Medical Genetics and Genomics (ACMG) guidelines, as agreed by a clinical review panel, and incidental findings (IFs) were not reported. Pathogenic and likely
pathogenic variants explaining the fetal phenotype were confirmed using Sanger sequencing, and the results were returned to the parents after the end of the pregnancy. Ethical approval was obtained from the research ethics committees at West Midlands – South Birmingham (ref: 13/WM/1219) and Harrow (ref: 01/0095). Local research and development offices subsequently approved the study at each participating organization.

Systematic review and meta-analysis

Information sources

This review was performed in a standardized manner in line with recommended methods for systematic reviews and the preferred reporting items for systematic reviews and meta-analyses (PRISMA)\(^\text{12}\) and meta-analysis of observational studies in epidemiology (MOOSE)\(^\text{13}\) guidance and was registered prospectively (PROSPERO No. CRD42020221427). The following databases were searched electronically for relevant citations, from January 2000 (ES technology was not available prior to this time) until October 2020: MEDLINE, EMBASE, CINAHL and ClinicalTrials.gov. The search strategy consisted of relevant medical subject headings (MeSH) terms, keywords and word variants for 'exome sequencing', 'fetus' and 'abnormality', used with alternative terms encompassing 'genome sequencing', 'exome', 'fetal', 'prenatal', 'antenatal', 'defect' and 'anomaly'. Bibliographies of relevant articles were searched manually and experts in prenatal genomics were contacted to identify further relevant studies. The search strategy is available from the corresponding author on request.

Study selection

The inclusion criteria for study selection were any prospective or retrospective cohort study or case series which: (i) included two or more cases of NIHF undergoing ES; (ii) initiated testing based on prenatal ultrasound-based phenotype; (iii) included cases with a negative CMA or karyotyping result; and (iv) included cases with known genetic testing result. Cases in which ES was initiated postnatally were included if testing was based on the prenatal phenotype. Cases in which sequential Sanger sequencing was utilized were also included. When studies were not specific to NIHF exclusively, data regarding NIHF cases were extracted from the paper or were requested from the corresponding author. All study abstracts were screened by two reviewers (F.M. and M.D.K.) and the full manuscripts were reviewed subsequently when further information was required.

Data extraction and quality assessment

Both reviewers extracted independently data on study characteristics and outcome using a proforma. Data extracted from studies, when obtainable, included: ultrasound phenotype, sequencing approach, reported variants, source of fetal DNA, turnaround time, fetal outcome, maternal age and gestational age at testing. Quality assessment was performed using modified standards for reporting of diagnostic accuracy studies (STARD) criteria\(^\text{14}\). The criteria deemed most important to optimize accuracy were: (i) trio analysis; (ii) use of ACMG criteria for variant interpretation; (iii) Sanger sequencing validation; and (iv) description of the prenatal phenotype.

Statistical analysis

Descriptive tables were produced detailing study characteristics and outcomes. The incremental diagnostic yield for causative Class-IV and Class-V variants, or risk difference, with 95% CI, of ES over CMA or karyotyping was calculated for each study and as a pooled value for: (i) all NIHF; (ii) isolated NIHF; (iii) NIHF associated with an additional FSA; and (iv) NIHF according to severity (i.e. two vs three or more cavities affected). When reported, pooled values for variants of uncertain significance (VOUS) and IFs were also determined. Risk differences from each study were pooled using a random-effects model throughout to estimate incremental yield using a previously published method which facilitates calculation with adjustment for zero values from negative CMA or karyotyping\(^\text{15,16}\). Results were displayed in forest plots with corresponding 95% CI. Heterogeneity was assessed graphically using forest plots and statistically using the Higgins I\(^2\) statistic. Publication bias was assessed graphically using funnel plots. Statistical analysis was performed using RevMan version 5.3.4 (Review Manager; The Cochrane Collaboration, Copenhagen, Denmark) statistical software.

RESULTS

Extended PAGE study cohort

Of the 850 cases with a FSA detected prenatally on ultrasound that underwent ES in the extended PAGE cohort, 28 (3.3%) met the definition for NIHF. Of these, 50.0% (n = 14) were apparently isolated and 50.0% (n = 14) were associated with an additional FSA. In the majority of cases (96.4%; 27/28), the initial genetic test was CMA, while the remainder had karyotyping, and proband DNA most frequently originated from cultured amniocytes (50.0%; n = 14). The additional diagnostic yield of ES was 25.0% (7/28) in all NIHF cases, 21.4% (3/14) in isolated NIHF cases and 28.6% (4/14) in NIHF cases associated with an additional FSA. When an additional anomaly associated with a causative pathogenic variant was present, the most common additional anomaly was congenital limb contractures due to arthrogryposis multiplex congenita (HP0002804) (75%; 3/4). In cases with an associated anomaly in which no causative pathogenic variant was obtained, the most common additional anomalies were cardiac, genitourinary or thoracic in nature (50.0%...
(5/10 for each). One case of Noonan syndrome was not detected initially as pathogenic as it was filtered out of the bioinformatic pipeline due to inheritance from an apparently unaffected parent. Subsequently, the pipeline was adjusted so that such variants were not filtered out even if they were inherited. The incidence of VOUS was 7.1% (2/28). Causative pathogenic variants (Classes IV and V) and VOUS are described in Tables S1 and S2, respectively.

### Systematic review and meta-analysis

For nine studies that were suitable for inclusion but data were incomplete, the corresponding author was contacted to request further data regarding fetal phenotype, of whom two responded and provided full datasets. For the study of Petrovski et al., based in Columbia University Medical Centre, New York, USA, the authors provided an extended dataset. In total, in addition to the extended PAGE study cohort, a further 20 studies met the inclusion criteria. Table 1 shows the characteristics of the included studies and Figure 2 shows the overall quality assessment.

The 21 included studies encompassed a total of 306 NIHF cases. When stated (n = 218), there were 109 (50.0%) cases of apparently isolated NIHF (on detailed prenatal ultrasound) and 109 (50.0%) cases associated with an additional FSA. Mean maternal age and gestational age at testing were 30.9 ± 3.5 years and 21.9 ± 5.4 weeks, respectively. Fetal DNA was obtained via amniocentesis in the majority of cases (50.6%; 121/239). The initial test prior to ES was CMA in 84.0% (257/306) of cases and G-banding karyotyping in the remainder. When documented (eight studies), the median turnaround time for ES was 40 (range, 7–140) days. Pregnancy outcome was available for 83.7% (256/306) of cases (termination of pregnancy (35.2%; 90/256), in-utero demise (34.4%; 88/256), neonatal survival (22.3%; 57/256) and neonatal death (8.2%; 21/256)). When reported (60.8%; 186/306), the pooled incremental yield for VOUS and IFs was 19% (95% CI, 6–22%; P = 0.003; I² = 62%) and 4% (95% CI, −1 to 9%; P = 0.09; I² = 0%), respectively. All documented pathogenic variants and VOUS are outlined in Tables S1 and S2, respectively.

The pooled incremental yield of ES in all NIHF cases, those with isolated NIHF and those with NIHF associated with an additional FSA is demonstrated in forest plots, with respective values of 29% (95% CI, 24–34%; P < 0.00001; I² = 0% (Figure 3)), 21% (95% CI, 13–30%; P < 0.00001; I² = 0% (Figure 4)) and 39% (95% CI, 30–49%; P < 0.00001; I² = 1% (Figure 5)). The corresponding funnel plots are displayed in Figure S1. In cases with an additional FSA, the most common additional anomalies associated with a causative pathogenic variant were those affecting the upper and/or lower limbs due to congenital contractures (HP:0002803) (17.3%;

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**Figure 1** Flowchart summarizing inclusion in the systematic review of studies on the incremental yield of exome sequencing (ES) over chromosomal microarray analysis (CMA) or karyotyping in fetuses with prenatally detected non-immune hydrops fetalis. *Corresponding author was contacted to request additional information but did not respond. PAGE, Prenatal Assessment of Genomes and Exomes study. **

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19/110). When the NIHF phenotype was described ($n = 156$), the incremental yield for causative pathogenic variants did not differ significantly according to the severity of hydrops (two cavities affected (34%; 95% CI, 23–45%; $P = 0.00001$; $I^2 = 0%$) vs three or more cavities affected (30%; 95% CI, 19–40%; $P = 0.00001$; $I^2 = 0%$); $P = 0.26$) (Figure S2). When a causative pathogenic variant was documented ($n = 89$) (Table S1), the most common genetic disorders were: (i) RASopathies (30.3%; 27/89), primarily due to PTEN1 variants (44.4%; 12/27); (ii) musculoskeletal disorders (14.6%; 13/89), primarily due to RYR1 variants (38.5%; 5/13); and (iii) inborn errors of metabolism (12.4%; 11/89), primarily due to GUSB variants (45.5%; 5/11). The predominant inheritance pattern of causative pathogenic variants was autosomal dominant in monoallelic disease genes (57.3%; 51/89), with most being de novo (86.3%; 44/51). When the type of ES performed was stated (20 studies; Table 1), the overall incremental yield did not differ significantly according to whether a panel or whole-exome approach was used (26% (95% CI, 16–36%; $I^2 = 0%$) and 27% (95% CI, 19–36%; $I^2 = 25%$), respectively).

**DISCUSSION**

The findings of this systematic review demonstrate a substantial incremental yield of 29% of ES over CMA or karyotyping in cases with prenatally diagnosed NIHF. This yield was higher among cases with an additional FSA, but severity of NIHF did not demonstrate a significant effect on the incremental yield. The majority of causative pathogenic variants were de novo in autosomal dominant disease genes, predominantly in those causative of RASopathies.

**Table 1** Characteristics of included studies reporting on the incremental yield of exome sequencing over chromosomal microarray analysis or karyotyping in fetuses with prenatally detected non-immune hydrops fetalis (NIHF)

| Study                  | Next-generation sequencing approach                                      | Number of NIHF cases |
|------------------------|---------------------------------------------------------------------------|----------------------|
|                        |                                                                           | All Isolated With additional FSA |
| Becher (2020)36        | WES, trio, 103× coverage, Roche SeqCap EZ MedExome Plus capture + Illumina NextSeq 500 | 4 4 0 |
| Boissel (2018)18       | WES, trio, 110× coverage, Agilent capture + Illumina HiSeq 2000 or 2500   | 2 0 2 |
| Corsten-Janssen (2020)12 | WES, trio, 20× coverage, Agilent capture + Illumina NextSeq500             | 6 2 4 |
| Croonen (2013)31*      | Clinical exome, Noonan panel, Illustra amplification, sequencer not stated | 15 N/S N/S |
| Deden (2020)27         | WES, trio, 200–300× coverage, Agilent capture + Illumina NextSeq500       | 4 1 3 |
| Deng (2020)19          | WES, trio, 120× coverage, Agilent capture + Illumina HiSeq X Ten or Novaseq 6000 | 21 16 5 |
| Greenbaum (2019)28     | WES, trio, 100× coverage, capture kit unknown + Illumina sequencing        | 3 2 1 |
| Jelin (2020)20         | WES, trio, depth of coverage < 10 removed, Agilent capture + Illumina HiSeq 2500 | 5 3 2 |
| Lord (2020)8†         | WES, trio, 1628 genes, Agilent capture + Illumina HiSeq 2500, 98.3% of bait regions covered at minimum depth of 5× | 28 14 14 |
| Mone (2020)34          | WES, trio, 1628 genes, Agilent capture + Illumina HiSeq 2500, 98.3% of bait regions covered at minimum depth of 5× | 6 3 3 |
| Normand (2018)21       | WES, trio, 150× coverage, Roche NimbleGen capture, Illumina Genome Analyzer Ix platform/HiSeq 2000 | 10 N/S N/S |
| Petrovski (2019)16     | WES, trio, NimbleGen SeqCap EZ capture + Illumina HiSeq 2500, average read coverage 89.3 reads, bioinformatic signatures | 23 14 9 |
| Sparks (2019)29*       | WES (n = 1), clinical exome (n = 7), other details not specified          | 8 N/S N/S |
| Sparks (2020)20*       | WES, trio, Illumina HiSeq 2500 or Illumina NovaSeq 6000                   | 78 32 46 |
| Stals (2018)23         | WES, parents only, 80× coverage, Agilent capture + Illumina HiSeq 2500 or NextSeq500, included only heterozygous rare (MAF < 0.001) variants in same gene in both parents | 4 0 4 |
| Vora (2017)22*         | Clinical exome and WES, trio, Illumina HiSeq 2500                        | 2 2 0 |
| Westerfield (2015)30   | WES, trio, 130× coverage, Roche NimbleGen capture + Illumina Genome Analyzer Ix or HiSeq 2000 | 2 0 2 |
| Westphal (2019)24      | WES, trio, 20000 genes, 150× coverage                                   | 2 0 2 |
| Yang (2012)31*         | Clinical exome, lymphedema panel, Oligo 6.1 PCR amplification + ABI, PRISM 3000 DNA sequencer | 27 N/S N/S |
| Yates (2017)25         | WES, trio, 140× coverage, Agilent capture + Illumina HiSeq 2000 or 2500   | 28 N/S N/S |
| Zhou (2020)17*         | WES, trio in recurrent NIHF, Agilent capture + Illumina HiSeq X Ten       | 28 16 12 |

Only first author of each study is given. *Coverage not stated. †Including cases identified in the current study. FSA, fetal structural anomaly; MAF, minor allele frequency; N/S, not stated; PCR, polymerase chain reaction; WES, whole-exome sequencing.
Figure 2 Quality assessment of 21 studies included in systematic review, using modified standards for reporting of diagnostic accuracy studies (STARD) criteria. ACMG, American College of Medical Genetics and Genomics; NGS, next-generation sequencing; TAT, turnaround time; VOUS, variants of uncertain significance. ☐, no; ☑, yes.

Study or subgroup | ES Events | CMA/karyotyping Events | Weight | Incremental yield | Incremental yield |
|------------------|------------|------------------------|--------|------------------|------------------|
| | Total | Total | | M–H, random, 95% Cl | M–H, random, 95% Cl |
| Becher (2020) | 1 4 0 | 4 4 | 1.2% | 0.25 (0.23, 0.73) |
| Boissel (2018) | 1 2 0 | 2 2 | 0.5% | 0.50 (0.21, 1.21) |
| Corsten-Janssen (2020) | 1 6 0 | 6 6 | 2.1% | 0.17 (0.19, 0.53) |
| Croonen (2013) | 4 15 0 | 15 15 | 4.8% | 0.27 (0.03, 0.50) |
| Deden (2020) | 2 4 0 | 4 4 | 1.0% | 0.50 (0.01, 1.01) |
| Deng (2020) | 3 21 0 | 21 21 | 9.9% | 0.14 (0.02, 0.31) |
| Greenbaum (2019) | 0 3 0 | 3 3 | 1.3% | 0.00 (0.46, 0.46) |
| Jelin (2020) | 1 5 0 | 5 5 | 1.6% | 0.20 (0.21, 0.61) |
| Lord (2019) | 7 28 0 | 28 28 | 9.7% | 0.25 (0.08, 0.42) |
| Mone (2020) | 2 6 0 | 6 6 | 1.7% | 0.33 (0.07, 0.74) |
| Normand (2018) | 4 10 0 | 10 10 | 2.7% | 0.40 (0.08, 0.72) |
| Petrovski (2019) | 9 23 0 | 23 23 | 6.5% | 0.39 (0.19, 0.60) |
| Sparks (2019) | 1 8 0 | 8 8 | 3.3% | 0.13 (0.16, 0.41) |
| Sparks (2020) | 27 78 0 | 78 78 | 23.7% | 0.35 (0.24, 0.45) |
| Stals (2018) | 3 4 0 | 4 4 | 1.2% | 0.75 (0.27, 1.23) |
| Vora (2017) | 1 2 0 | 2 2 | 0.5% | 0.50 (0.21, 1.21) |
| Westerfield (2015) | 1 2 0 | 2 2 | 0.5% | 0.50 (0.21, 1.21) |
| Westphal (2019) | 1 2 0 | 2 2 | 0.5% | 0.50 (0.21, 1.21) |
| Yang (2012) | 8 27 0 | 27 27 | 8.6% | 0.30 (0.12, 0.47) |
| Yates (2017) | 6 28 0 | 28 28 | 10.6% | 0.21 (0.06, 0.37) |
| Zhou (2020) | 10 28 0 | 28 28 | 8.2% | 0.36 (0.18, 0.54) |
| Total (95% CI) | 306 | 306 | 100.0% | 0.29 (0.24, 0.34) |

Total events 93 0
Heterogeneity: tau² = 0.00; chi² = 16.52, df = 20 (P = 0.68); I² = 0%
Test for overall effect: Z = 10.98 (P < 0.00001)

Favors CMA/karyotyping 0
Favors ES 1

Figure 3 Forest plot showing incremental yield of exome sequencing (ES) over chromosomal microarray analysis (CMA) or karyotyping in all fetuses with prenatally detected non-immune hydrops fetalis. Only first author of each study is given. M–H, Mantel–Haenszel.
Exome sequencing in non-immune hydrops fetalis

Table 5: Forest plot showing incremental yield of exome sequencing (ES) over chromosomal microarray analysis (CMA) or karyotyping in fetuses with prenatally detected isolated non-immune hydrops fetalis. Only first author of each study is given. M–H, Mantel–Haenszel.

![Figure 5 Forest plot showing incremental yield of exome sequencing (ES) over chromosomal microarray analysis (CMA) or karyotyping in fetuses with prenatally detected isolated non-immune hydrops fetalis. Only first author of each study is given. M–H, Mantel–Haenszel.](image)

The findings of the extended PAGE cohort and the systematic review were broadly concordant, but with a lower incremental yield of ES in the cohort study, which may be explained by the smaller number of cases as well as the unselected approach to case selection. The high incidence of RASopathies and of de-novo variants in autosomal dominant disease genes is expected and not mutually exclusive. The incremental yield of ES was higher in NIHF cases in which an additional FSA was present, particularly in cases of congenital arthrogryposis, which is intuitive given that contractures are a common musculoskeletal phenotype known to have a higher diagnostic yield on sequencing. In contrast, isolated NIHF was seen commonly within the RASopathies diagnostic yield on sequencing. In contrast, isolated NIHF was seen commonly within the RASopathies (40.7%; 11/27). This is in keeping with the variable phenotype reported in RASopathies and supports the use of prenatal ES in cases of isolated NIHF. There is phenotypic variability in cases with a pathogenic variant in other types of genetic disease in addition to RASopathies (40.7%; 11/27). This is in keeping with the variable phenotype reported in RASopathies and supports the use of prenatal ES in cases of isolated NIHF.

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This supports the use of ES or whole-genome sequencing (WGS), rather than a targeted or stepwise approach, in the investigation of NIHF\textsuperscript{37}. The role of QF-PCR or conventional karyotyping in NIHF should always be respected, given the high incidence of aneuploidy\textsuperscript{38}. However, given the limited additional yield of CMA over karyotyping, and considering the ability of WGS to detect both structural variants and aneuploidy, it may be reasonable in the future to consider WGS as the second-line test after QF-PCR\textsuperscript{3}. The list of novel causative genes in NIHF is constantly expanding and, over time, the yield of prenatal NGS will likely improve as more genes are discovered and our understanding of the prenatal phenotype develops\textsuperscript{2,37}. This is supported by the high number of Class-III variants (VOUS) identified within candidate genes in this systematic review and highlighted by the largest included series\textsuperscript{2}. Reanalysis and potential reclassification of VOUS is currently underway for the PAGE cohort, which may increase the diagnostic yield.

Due to the relatively high yield of ES evident in isolated NIHF in this study (and in individual papers in the literature), it was decided to add NIHF (from March 2021) as an indication for inclusion in the R21 pathway of the National Health Service (NHS) England National Genomic Test Directory for Rare and Inherited Disease\textsuperscript{36,39}. The R21 pathway is a nationally (England presently) commissioned rapid prenatal ES service for fetuses with multiple, multisystemic, major and selected isolated FSAs, performed by two genomic laboratory hubs, in line with a set protocol\textsuperscript{80}. Furthermore, the Fetal Oedema and Lymphatic Disorder (FOLD) study is ongoing in the UK\textsuperscript{41}.

The selection criteria for this study were based on the routine definition of NIHF\textsuperscript{1}. It has been proposed that this definition should be expanded to include pathological fluid accumulation in one or more fetal body cavity, inclusive of increased (> 3.5 mm) nuchal translucency thickness (NT) or cystic hygroma\textsuperscript{2}. This is being explored further, but appears to be a reasonable argument given the large variability in NIHF phenotypes as well as their complex evolution, and sometimes resolution, seen in causative syndromes such as RASopathies. This notion is also supported by our finding that the mere presence of NIHF, as opposed to its severity, influences the diagnostic yield of ES. Hydropic phenotypes can change during pregnancy and findings that may be evident in the first trimester may regress by the third trimester, hence pleural effusion or cystic hygroma in the first trimester may be the only opportunity to detect an anomaly and offer testing. There is a need for studies documenting the evolution of the different phenotypes of NIHF and the respective diagnostic yields of NGS. Despite this, prenatal ES in cases of isolated elevated NT appears to offer a modest increase in diagnostic yield over CMA\textsuperscript{2,42–44}, of around 5–7%. The severity of increased (≥ 5 mm) NT, its persistence and its association with additional anomalies also appear to influence the diagnostic yield of NGS\textsuperscript{2,37,44}.

The strengths of this systematic review lie in its novelty with regard to concept, the robust methodology utilized, as well as collaboration between experts of some of the largest contemporary series in this area\textsuperscript{2,8,16,17}. Despite the relatively small number of cases (\(n = 306\)), the present systematic review represents the largest review of prenatally diagnosed NIHF cases, and heterogeneity did not appear to be affected. None of the included studies used a WGS approach, and therefore the difference in yield between WGS and ES could not be assessed. The lack of studies utilizing WGS is likely to change in the coming years and it will likely prove to be more beneficial than ES due to its all-in-one ability to detect most chromosomal and genetic differences\textsuperscript{7,39}.

In conclusion, the use of prenatal NGS in both isolated NIHF and NIHF associated with an additional FSA should be considered in the development of clinical pathways. Given the vast syndromic categories and heterogeneity in the prenatal phenotype of NIHF, a whole-exome or WGS approach in combination with accurate prenatal phenotyping is likely to be a more appropriate tool than a targeted or stepwise single-gene testing strategy in achieving an optimum diagnostic yield. The existing definition of NIHF appears to be appropriate for assessing the diagnostic yield of ES, although further studies assessing expansion of this definition are required to support this.

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SUPPORTING INFORMATION ON THE INTERNET

The following supporting information may be found in the online version of this article:

Table S1 Documented diagnostic (Class-IV or -V) variants in studies reporting on the incremental yield of exome sequencing over chromosomal microarray analysis or karyotyping in fetuses with prenatally detected non-immune hydrops fetalis

Table S2 Documented variants of uncertain significance (Class III) in studies reporting on the incremental yield of exome sequencing over chromosomal microarray analysis or karyotyping in fetuses with prenatally detected non-immune hydrops fetalis

Figure S1 Funnel plots for studies reporting on the incremental yield of exome sequencing over chromosomal microarray analysis or karyotyping in fetuses with prenatally detected non-immune hydrops fetalis (NIHF), overall (a) and in those with isolated NIHF (b) or NIHF with an additional fetal structural anomaly (c).

Figure S2 Forest plots showing incremental yield of exome sequencing over chromosomal microarray analysis or karyotyping in fetuses with prenatally detected non-immune hydrops fetalis (NIHF), according to whether two (a) or three or more (b) body cavities were affected.