

Table Details:

The International Classification Disease codes and definition of the anomaly are printed at the bottom of each table.

Prevalence rates and 95% confidence intervals are per 10,000 births (see prevalence and confidence interval calculations page for more information).

The prevalence of non-genetic subgroups can also be shown excluding cases with additional chromosomal and genetic anomalies by selecting “Excluding cases with known genetic conditions” or “Display both” in the anomalies section of the selection screen.

Technical Notes:

1. In all tables: LB = live births, FD = fetal deaths from 20 weeks gestation, including stillbirths, TOPFA = termination of pregnancy for fetal anomaly following prenatal diagnosis.
2. Data from the most recent year is provisional as there is likely to be under-reporting as late diagnoses may not be included
3. In Cork & Kerry, Dublin, Galway, South East Ireland and Malta, terminations of pregnancy for fetal anomaly are illegal - in these registries numbers of TOPFA are "0" and these registries are included in total prevalence rates across registries. Terminations of pregnancy were legal but information about terminations of pregnancy was not available to Wielkopolska, Poland, South East Sicily, Spain Hospital Network, North East Italy before 1988, and Central East France before 1985. In Emilia Romagna, data on terminations were not available until 1989, recording was very incomplete between 1989 and 1993, and since 1994, ascertainment of TOPFA has improved. In Norway registration of all abortions induced after prenatal diagnosis of a congenital anomaly was introduced on 1st December 1998, prior to this some of these cases may be missing. Numbers of cases of terminations and total prevalence rates for these registries are represented by "-" where the data were missing for the entire period referred to in the Table.
4. Where terminations of pregnancy are missing from the data for a registry (marked "-"), that registry is not included in the total prevalence rates for all registries combined. Where the total number of live births (denominator) is missing for a registry, the live birth prevalence rate for that registry is marked "-", but in calculating the live birth prevalence rate for all registries combined the live birth denominator for that registry is substituted by the total birth (live and still) denominator.
5. Counts of "all anomalies" include all major congenital anomalies included in subgroup "All anomalies" except where registries used a more restrictive registration list. See the registry descriptions of North West Thames and North East Italy for more detail on exclusions in these registries. Where a registry is missing from tables for a specific congenital anomaly subgroup, this does not mean that cases of that subgroup are not included in the total congenital anomaly count. Missing data could mean non-standard ICD coding of these anomalies or for associate member registries, transmission of a restricted list of anomaly subgroups to Central Registry (aggregate data).
6. The definition of stillbirth is registry specific and is based on birth weight, gestational age, or crown foot length. See <http://www.eurocat-network.eu/content/EUROCAT-Population-Table-II.pdf> for the official stillbirth definition per registry. Ascertainment of earlier fetal death (spontaneous abortions) with congenital anomaly from GA 20 weeks and up to the official stillbirth definition may be variable, see the registry descriptions for further information.
7. There are 7 EUROCAT subgroups of congenital anomalies with no ICD9 code (see EUROCAT Guide 1.4, Chapter 3.3 <http://www.eurocat-network.eu/content/EUROCAT-Guide-1.4.pdf>), therefore tables based on a time period spanning pre-2005 and post-2005 years will not include data for years when registries were coding in ICD9.
8. In tables containing data by UK registry, cells containing less than five cases have been suppressed. All proportions and prevalence rates based on such numbers have also been suppressed. Secondary suppression has also been applied as necessary to avoid the possibility of disclosure through differencing/subtracting.
9. The number of cases in each congenital anomaly subgroup is NOT the number of isolated cases. In particular the outcome, such as fetal deaths (FD) or terminations (TOPFA), for seemingly less severe anomalies may have occurred as the case had other more severe major anomalies.