

# Perinatal Diagnosis, Management, and Follow-up of Cystic Renal Diseases

## A Clinical Practice Recommendation With Systematic Literature Reviews

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### Supplemental content

**IMPORTANCE** Prenatal and neonatal cystic kidney diseases are a group of rare disorders manifesting as single, multiple unilateral, or bilateral cysts or with increased echogenicity of the renal cortex without macroscopic cysts. They may be accompanied by grossly enlarged kidneys, renal oligohydramnios, pulmonary hypoplasia, extrarenal abnormalities, and neonatal kidney failure. The prognosis is extremely variable from trivial to very severe or even uniformly fatal, which poses significant challenges to prenatal counseling and management.

**OBJECTIVE** To provide a clinical practice recommendation for fetal medicine specialists, obstetricians, neonatologists, pediatric nephrologists, pediatricians, and human geneticists by aggregating current evidence and consensus expert opinion on current management of cystic nephropathies before and after birth.

**METHODS** After 8 systematic literature reviews on clinically relevant questions were prepared (including 90 studies up to mid-2016), recommendations were formulated and formally graded at a consensus meeting that included experts from all relevant specialties. After further discussion, the final version was voted on by all members using the Delphi method. The recommendations were reviewed and endorsed by the working groups on inherited renal disorders of the European Renal Association–European Dialysis and Transplant Association (ERA-EDTA) and European Society for Paediatric Nephrology (ESPN); the German Society of Obstetrics and Gynecology (DGGG), German Society of Perinatal Medicine (DGPM), and German Society of Ultrasound in Medicine (DEGUM); and the alliance of patient organizations, PKD International.

**RECOMMENDATIONS** The group makes a number of recommendations on prenatal and postnatal imaging by ultrasound and magnetic resonance imaging, genetic testing, prenatal counseling, in utero therapeutic interventions, and postnatal management of prenatal and neonatal cystic kidney diseases, including provision of renal replacement therapy in neonates. In addition to detailed knowledge about possible etiologies and their prognosis, physicians need to be aware of recent improvements and remaining challenges of childhood chronic kidney disease, neonatal renal replacement therapy, and intensive pulmonary care to manage these cases and to empower parents for informed decision making.

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Cystic kidney diseases can manifest anytime from early pregnancy to adulthood and include multicystic dysplastic kidneys (MCDK), cystic dysplasia, polycystic kidney disease, and numerous syndromic conditions. The incidence of these conditions varies widely from 0.44 cases per 10 000 births for neonatal-onset polycystic kidney disease<sup>1</sup> to 4.1 cases per 10 000 births for MCDK.<sup>1,2</sup>

Some cystic renal disorders are life limiting (eg, Meckel-Gruber syndrome or bilateral MCDK), and some have a grave prognosis, especially if associated with early-onset oligohydramnios. Chronic kidney disease is a common feature but varies greatly in severity and time of onset. Initial presentation frequently occurs with enlarged or hyperechogenic kidneys, with cysts only developing later. There is some overlap of these intrinsic kidney diseases with congenital anomalies of the kidney and urinary tract (eg, cystic dysplasia). However, it is important to differentiate urinary tract obstruction as urological interventions are usually not required in cystic diseases.

Because the prognosis may be grave, prenatal detection of cystic renal diseases currently often leads to termination of pregnancy.<sup>1</sup> However, owing to the low incidence and heterogeneity of presentations, there are few controlled studies to guide counseling and management. In addition, major advances in the treatment of neonatal renal failure in the last decades have significantly improved survival. Therefore, the aim of this clinical practice recommendation is to aggregate current evidence and expertise as guidance for clinicians managing prenatal and neonatal cystic kidney disease.

After completion of systematic literature reviews on 8 clinically relevant questions based on 90 studies up to mid-2016, recommendations were formulated and formally graded at a consensus meeting that included experts from all relevant specialties. After further discussion, the final version was voted on by all members using the Delphi method. The recommendations were reviewed and endorsed by the working groups on inherited renal disorders of the European Renal Association–European Dialysis and Transplant Association (ERA-EDTA) and European Society for Paediatric Nephrology (ESPN); the German Society of Obstetrics and Gynecology (DGGG), German Society of Perinatal Medicine (DGPM), and German Society of Ultrasound in Medicine (DEGUM); and the patient organization PKD International.

Details of the systematic literature reviews and structured consensus procedure are given in the eMethods (eTable 1 and eTable 2) and eAppendix in the [Supplement](#). **Table 1** lists the definitions of different levels of evidence and strength of recommendations. The following sections summarize our recommendations, which are given in *italics*.

## Imaging

Ultrasound is the first-line diagnostic procedure for detecting, classifying, and following up on prenatal renal cystic disease and for defining renal pathology, assessing amniotic fluid volume, and detecting associated anomalies. Because many cystic kidney diseases manifest initially as hyperechogenic kidneys without visible cysts, their differential diagnosis should be considered together. The most likely etiology and differential diagnosis of different ultrasound findings and consensus recommendations for prenatal follow-up intervals (*Recommendation 1.1*), indication for magnetic resonance imaging (MRI) (*Recommendation 1.2*), and timing of postnatal imaging (*Recommendation 1.3*) are given in **Table 2**.

## Key Points

**Question** How should prenatal and neonatal cystic kidney disease be treated according to the best available evidence?

**Findings** Eight systematic literature reviews (90 studies) revealed an extremely variable etiology and prognosis of perinatal cystic kidney disease, with ultrasound being the most useful diagnostic tool but some evidence for focused genetic diagnostics and/or complementary magnetic resonance imaging. While most prenatal therapeutic interventions lack adequate evidence, postnatal prognosis has improved with neonatal intensive care and renal replacement therapy for neonates, which is now an established therapeutic option.

**Meaning** These clinical practice guidelines delineate current evidence in managing perinatal cystic nephropathies and stress the need for multiprofessional counseling by adequately specialized obstetricians and pediatricians, as well as shared decision making in moderate to severe cases.

**Table 1. Grading of Evidence and Recommendations<sup>a</sup>**

Grade	Level	Recommendation
<b>Quality of Evidence</b>		
High	A	Further research is very unlikely to change our confidence in the estimate of effect.
Moderate	B	Further research is likely to have an important influence on our confidence in the estimate of effect and may change the estimate.
Low	C	Further research is very likely to have an important influence on our confidence in the estimate of effect and is likely to change the estimate.
Very low	D	Any estimate of effect is very uncertain.
<b>Strength of Recommendation</b>		
Strong	1	Based on the available evidence, the intervention is very likely to have greater benefit than harm.
Weak/discretionary	2	Based on the available evidence, the intervention will probably have greater benefit than harm, but patients may take a different view.
Consensus	NA	Recommendations based on clinical expertise of the guideline group owing to the lack of directly relevant studies.

Abbreviation: NA, not applicable.

<sup>a</sup> Adapted from the study by Guyatt et al.<sup>3</sup>

In selected cases, MRI may add valuable information, especially if there is oligohydramnios, unusual location, or appearance of cysts or malformations of other organs (Table 2). However, regional availability and expertise in fetal MRI is still variable. eTable 3 in the [Supplement](#) lists a systematic literature review of fetal MRI for genitourinary tract imaging. In suspected very early-onset autosomal dominant polycystic kidney disease (ADPKD) or when dominant gene defects (eg, *HNF1B* [OMIM 189907]) mutations are found, imaging of asymptomatic first-degree relatives can be helpful.

## Genetic Testing

Genetic defects have an important role in most pediatric cystic nephropathies. Currently, monogenic diseases can be identified in

Table 2. Different Patterns of Prenatal Renal Cystic Disease, With Likely Etiology and Recommendations for Perinatal Imaging

	Solitary Renal Cyst	Multiple Unilateral Cysts	Bilateral Cysts and/or Hyperechogenicity Without Oligohydramnios	Bilateral Cysts and/or Hyperechogenicity With Oligohydramnios
Most likely diagnosis	Single cortical cyst	MCDK	Bilateral cystic dysplasia (with or without obstruction)	ARPKD, syndromes, or bilateral (cystic) dysplasia
Differential diagnosis	<ul style="list-style-type: none"> <li>Dilated dysplastic upper pole of a duplex kidney</li> <li>Segmental multicystic dysplastic kidney</li> <li>Extrarenal cyst (eg, adrenal gland)</li> <li>Cystic tumor</li> <li>Beginning of a polycystic kidney disease</li> </ul>	<ul style="list-style-type: none"> <li>Cystic dysplasia (with or without obstruction)</li> <li>Unilateral start of polycystic kidney disease</li> <li>Unilateral start of other cystic disease (see the 2 columns on the right)</li> </ul>	<ul style="list-style-type: none"> <li><i>HNF1B</i> mutation</li> <li>ARPKD</li> <li>ADPKD</li> <li>Bardet-Biedl syndrome</li> <li>Meckel-Gruber syndrome</li> <li>Other genetic abnormalities and syndromes<sup>a</sup></li> <li>Infantile nephronophthisis</li> <li>Tubular dysgenesis</li> <li>Metabolic diseases<sup>b</sup></li> <li>Drug toxicity<sup>c</sup></li> <li>Lower urinary tract obstruction</li> </ul>	<ul style="list-style-type: none"> <li>Bilateral MCDK</li> <li>Lower urinary tract obstruction (urethral valves)</li> <li>ADPKD (especially with 2 hypomorphic mutations)</li> <li>Bardet-Biedl syndrome</li> <li>Meckel-Gruber syndrome</li> <li>Metabolic diseases<sup>b</sup></li> <li>Other syndromes and genetic abnormalities<sup>a</sup></li> </ul>
Further pathologies to exclude	See the Multiple Unilateral Cysts column. By definition, there should be no other related pathology	<ul style="list-style-type: none"> <li>Malformations of the contralateral kidney</li> <li>Inadequate compensatory hypertrophy of the contralateral kidney</li> <li>Malformations of the genital tract<sup>d</sup></li> <li>Organ screening<sup>e,f</sup></li> </ul>	Complete organ screening, especially CNS and cardiac malformations	Complete organ screening, especially CNS and cardiac malformations
Recommendation 1.1 (consensus strength, evidence level D): Intervals for prenatal follow-up	Follow-up ultrasound after 4-6 wk during pregnancy to exclude newly developed cysts. Consequently, a confirmed single cyst does not require regular follow-up	Follow-up ultrasound after 4 wk. Subsequent follow-up intervals dependent on contralateral hypertrophy and amniotic fluid volume	Repeated ultrasound scans every 4 wk until end of pregnancy unless higher frequency indicated for obstetric reasons <sup>g</sup>	Repeated ultrasound scans every 4 wk until end of pregnancy unless higher frequency indicated for obstetric reasons <sup>g</sup>
Recommendation 1.2 (consensus strength, evidence level C): Need for fetal MRI	Not needed unless cyst appears unusual regarding echopattern or size. Consider MRI if suspicion of tumor	Not needed for typical MCDK. Whenever MCDK appears unusual in size or echogenicity, MRI can add information. Also, the following features are usually easier to detect on MRI: <ul style="list-style-type: none"> <li>Small cystic lesions in the contralateral kidney</li> <li>Accompanying malformations of the gastrointestinal tract, the ureters, or genital tract</li> <li>In ectopic MCDK, MRI helps to differentiate from coccygeal teratoma</li> </ul>	MRI adds valuable information regarding CNS malformations	Recommended MRI, especially in cases of oligohydramnios there is a significant advantage for imaging fetal kidneys and CNS by MRI because ultrasound quality can be severely compromised by the lack of amniotic fluid
Optimal timing of prenatal MRI	The later MRI is done, the better quality will be	If needed, MRI should be performed in the third trimester	MRI has better accuracy after 28-30 wk of pregnancy but may be helpful earlier if termination of pregnancy is being considered	Fetal MRI should be performed as early as possible; however, accuracy is low before 24 wk and increases with later gestational age
Recommendation 1.3 (consensus strength, evidence level C): Postnatal imaging	Renal ultrasound should be performed within 4 wk after birth unless there is clinical concern	Renal ultrasound should be performed ideally between days 3 and 7 of life to confirm diagnosis and focus on the contralateral kidney, as well as additional genital malformations	Renal ultrasound should be performed within the first week of life to confirm diagnosis. Additional imaging may be required for the CNS (eg, molar tooth sign in Joubert syndrome, periventricular cystic lesions in Zellweger syndrome), liver, pancreas, and genital tract	Renal ultrasound should be performed within the first few days of life to confirm diagnosis. Additional imaging may be required for the CNS, liver, pancreas, and genital tract

Abbreviations: ADPKD, autosomal dominant polycystic kidney disease; ARPKD, autosomal recessive polycystic kidney disease; CNS, central nervous system; MCDK, multicystic dysplasia of the kidney; MRI, magnetic resonance imaging.

<sup>a</sup> For example, chromosomal rearrangements or trisomies.

<sup>b</sup> For example, carnitine palmitoyltransferase deficiency type II or glutaric acidemia type II.

<sup>c</sup> For example, angiotensin-converting enzyme inhibitors or angiotensin II receptor blockers.

<sup>d</sup> Although these may be difficult to detect prenatally.

<sup>e</sup> Multicystic dysplasia of the kidney can be part of a more complex malformation syndrome (eg, vertebral, anal, cardiac, tracheal, esophageal, renal, and limb anomalies [VACTERL]).

<sup>f</sup> Multicystic dysplasia of the kidney is rarely caused by an underlying *HNF1B* mutation.

<sup>g</sup> For example, growth retardation or (suspected) placental insufficiency.

50% to 70% of children with 2 or more renal cysts and/or increased cortical echogenicity.<sup>4</sup> In fetuses with extrarenal anomalies, chromosomal rearrangements or aberrations are not uncommon<sup>1</sup>; however, genetic pathology is rare for solitary cysts with normal renal parenchyma, unilateral MCDK, or cystic dysplasia, especially without other malformations.

The broad phenotypic and genetic heterogeneity of cystic nephropathies and cystic dysplasia makes gene panel next-generation sequencing a powerful alternative to time-consuming and expensive single-gene sequencing, which may remain preferable for cases with a specific presumptive diagnosis.<sup>5</sup> Whole-exome analysis with subsequent filtering for cystic kidney disease genes is

becoming less costly, but interpretation may still pose challenges. Additional testing may be necessary to detect copy number variations, such as heterozygous deletions (eg, *HNF1B*) or defects in complex genomic regions not fully covered by whole-exome analysis or most gene panels (eg, *PKD1* [OMIM 601313]).

Establishing a genetic diagnosis in a fetus or infant can have far-reaching consequences. For example, genetic testing (1) can lead to earlier diagnosis and avoid unnecessary diagnostic procedures (eg, renal biopsy); (2) may establish a definite diagnosis, which can be psychologically helpful (however, sometimes it may also increase anxieties); (3) can point to renal and extrarenal comorbidities or highlight possible future complications (eg, maturity-onset diabetes of the young [MODY5, OMIM 137920] and autism spectrum disorders in patients with *HNF1B* deletions, or risk of progressive blindness in patients with *NPHP5* [OMIM 609254] mutations), which allows focused screening and sometimes prevention but may cause unnecessary anxiety; (4) can enable informed genetic counseling about recurrence risk for future children; (5) may influence the parents' decision on continuation of pregnancy in case of a grave prognosis; and (6) may in the future provide guidance for personalized medical management.

In our view, genetic testing should always be offered to families facing early-onset bilateral cystic kidney disease, and the medical and ethical implications should be discussed openly. Especially for prenatal testing, the physician must respect the principles of beneficence and respect for autonomy (ie, the parents' values and beliefs and their perspective on their interests) and should implement only those clinical strategies authorized after informed consent.<sup>6</sup> All of the following remarks presume that this kind of detailed and respectful genetic counseling has taken place and that local legislation is respected.

In practical terms, prenatal and preimplantation genetic diagnosis is feasible if the underlying genotype has been previously identified in an affected family member.<sup>7</sup> For pregnancies without a previously diagnosed index case, prenatal genetic testing can be effective, but sequence variations of unknown pathogenicity can cause uncertainty. Moreover, many cystic kidney diseases lack a clear-cut genotype-phenotype association, with large heterogeneity even within a family. Despite these limitations, DNA storage should be readily offered, especially if results could influence family planning.

### Recommendations for Prenatal Genetic Testing

**Recommendation 2.1 (consensus strength, evidence level D):** It is important to offer nondirective counseling whenever genetic testing is considered for cases of prenatal cystic kidney disease.

This will often also require multiprofessional support for the family (see the Prenatal Assessment section).

### Unilateral Cystic Kidney Disease

**Recommendation 2.2 (consensus strength, evidence level C):** For fetuses with solitary cysts or multiple unilateral cysts, only consider prenatal or postnatal genetic testing when there are extrarenal manifestations.

Renal cystic disease may be part of a multisystem syndromic disorder where extrarenal pathology may have major influence on prognosis and outcome (eg, chromosomal aberrations or Bardet-Biedl syndrome). However, without extrarenal manifestations, the identification of a genetic defect is very unlikely.

### Bilateral Cystic Kidney Disease

**Recommendation 2.3 (consensus strength, evidence level C):** For fetuses with bilateral cystic kidney disease and/or bilateral hyper-echoic or enlarged kidneys, consider prenatal genetic testing irrespective of the presence of oligohydramnios and/or extrarenal malformations.

However, the relevance of results of genetic testing for informed decision making needs to be established beforehand; otherwise, postnatal testing should be preferred because of the lower risk of complications.

### Postmortem Analysis

**Recommendation 2.4 (consensus strength, evidence level C):** After intrauterine fetal death or termination of pregnancy, offer post-mortem genetic analysis or DNA storage because test results may influence family planning and diagnostic procedures in subsequent pregnancies.

Sensitivity and specificity of subsequent genetic diagnostic tests benefit greatly from available DNA of the family's index patient. If the family declines genetic analysis, recommend DNA storage.

### Recommendations for Postnatal Genetic Testing

#### Solitary Renal Cyst

**Recommendation 2.5 (consensus strength, evidence level C):** In children with a solitary cyst in one kidney with normal renal parenchyma and without extrarenal manifestations, we do not recommend genetic testing on a routine basis because of the very low risk of genetic disease.

#### Unilateral Cystic Kidney Disease

**Recommendation 2.6 (consensus strength, evidence level C):** For children with unilateral multicystic kidney disease and adequate hypertrophy and normal parenchyma of the contralateral kidney, we do not recommend genetic testing in the absence of extrarenal manifestations because of the low risk of specific genetic disease and the good prognosis.

However, if extrarenal symptoms are present, this may point to a genetically determined syndromic disorder, and genetic testing should be considered.

#### Bilateral Cystic Kidney Disease

**Recommendation 2.7 (consensus strength, evidence level C):** For patients with 2 or more renal cysts and/or bilaterally increased echogenicity of the renal cortex of any age, genetic testing should be offered, especially if the result could influence further family planning and/or when an individual benefit from knowledge is expected.

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## Prenatal Assessment

### General Prognosis of Prenatally Detected Cystic Renal Disease

A systematic literature review of prognostic studies is summarized in Table 3 (evidence level C). In summary, prenatally detected solitary cysts (with normal surrounding renal parenchyma) are rare and overwhelmingly have a good prognosis. However, they may occasionally be the first manifestation of more severe cystic renal disease or occur together with multiple extrarenal malformations,

Table 3. Summary of Evidence on Prognosis of Prenatally Detected Cystic Kidney Disease

	Quality Assessment						Effect				
No. of Studies	Study Design	Risk of Bias	Inconsistency	Indirectness	Imprecision	Other Considerations	No. of Events/Deaths	No. of Patients	Rate, %	Quality	Importance <sup>a</sup>
Solitary Cysts											
Death											
2 Studies <sup>1,8</sup>	Registry/population study	Not serious	Serious <sup>b</sup>	Not serious	Not serious	None	4	37	11	Medium	6
Spontaneous resolution											
1 Study <sup>8</sup>	Cohort	Not serious	NA	Not serious	Serious	None	25	28	89	Low	6
Revised diagnosis											
1 Study <sup>8</sup>	Cohort	Not serious	NA	Not serious	Serious	None	1	28	4	Low	5
Multiple Unilateral Cysts and/or Unilateral Increased Echogenicity											
Death											
4 Studies <sup>9-12</sup>	Case series	Not serious	Not serious	Not serious	Serious <sup>c</sup>	None	13	177	7	Low	7
MCDK only											
6 Studies <sup>2,13-17</sup>	Registry/case series	Not serious	Not serious	Not serious	Serious <sup>c</sup>	None	73	572	13	Medium	8
Impaired renal outcome in survivors											
1 Study <sup>9</sup>	Case series	Not serious	NA	Not serious	Serious	Serious <sup>d</sup>	1	52	2	Very low	5
Bilateral Cysts and/or Bilateral Hyperechoic Kidneys (Oligohydramnios Not Specified)											
Death											
5 Studies <sup>9,12,18-20</sup>	Cohort/case series	Not serious	Not serious	Not serious	Serious	None	95	118	81	Low	7
Only hyperechogenicity and cysts											
1 Study <sup>21</sup>	Case series	Not serious	NA	Not serious	Serious <sup>e</sup>	None	22	30	73	Low	6
Only polycystic disease											
1 Study <sup>1</sup>	Registry	Not serious	NA	Not serious	Not serious	None	17	27	63	Medium	6
Only bilateral MCDK											
3 Studies <sup>2,16,22</sup>	Registry/case series	Not serious	Serious	Not serious	Not serious	None	160	290	55	Medium	6
Impaired renal outcome in survivors											
2 Studies <sup>9,18</sup>	Case series	Not serious	Not serious	Not serious	Serious	Serious <sup>d</sup>	9	13	69	Very low	5
Bilateral Cysts and/or Bilateral Hyperechoic Kidneys With Oligohydramnios											
Death											
6 Studies <sup>10,11,23-26</sup>	Cohort/case series	Not serious	Not serious	Not serious	Serious	None	54	71	76	Low	5
Only isolated hyperechogenic kidneys											
1 Study <sup>27</sup>	Case series	Not serious	NA	Not serious	Serious <sup>e</sup>	None	20	22	90	Very low	4
Only bilateral MCDK											
2 Studies <sup>13,14</sup>	Case series	Not serious	Not serious	Not serious	Serious <sup>e</sup>	None	27	27	100	Low	5
Only hyperechogenicity and cysts											
1 Study <sup>28</sup>	Case series	Not serious	NA	Not serious	Serious <sup>e</sup>	None	20	21	95	Low	5
Impaired renal outcome in survivors											
2 Studies <sup>23,24</sup>	Case series	Not serious	Not serious	Not serious	Serious	Large effect	7	7	100	Low	4
Bilateral Cysts and/or Bilateral Hyperechoic Kidneys Without Oligohydramnios											
Death											
7 Studies <sup>11,14,26-30</sup>	Case series	Not serious	Not serious	Not serious	Serious <sup>e</sup>	None	8	89	9	Low	7
Impaired renal outcome in survivors											
2 Studies <sup>27,30</sup>	Cohort/case series	Not serious	Not serious	Not serious	Serious <sup>f</sup>	None	6	25	34	Low	5
Spontaneous resolution											
3 Studies <sup>11,27,30</sup>	Cohort/case series	Not serious	Not serious	Not serious	Serious <sup>g</sup>	Serious <sup>h</sup>	11	35	31	Low	5

(continued)



Table 3. Summary of Evidence on Prognosis of Prenatally Detected Cystic Kidney Disease (continued)

No. of Studies	Quality Assessment						Effect				
	Study Design	Risk of Bias	Inconsistency	Indirectness	Imprecision	Other Considerations	No. of Events/Deaths	No. of Patients	Rate, %	Quality	Importance <sup>a</sup>
<b>Bilateral Cysts/Bilateral Hyperechoic Kidneys With Extrarenal Anomalies</b>											
<b>Death</b>											
4 Studies <sup>1,9,18,19</sup>	Registry/cohort	Not serious	Not serious	Not serious	Serious <sup>e</sup>	None	288	383	75	Low	7
Only Meckel-Gruber syndrome											
1 Study <sup>31</sup>	Registry	Not serious	NA	Not serious	Serious <sup>e</sup>	None	158	191	83	Low	7
Only bilateral MCDK											
3 Studies <sup>14,16,17</sup>	Case series	Not serious	Not serious	Not serious	Serious <sup>g</sup>	None	24	28	86	Low	5
Only hyperechogenicity and cysts											
1 Study <sup>21</sup>	Case series	Not serious	NA	Not serious	Serious <sup>e</sup>	None	15	18	83	Low	5
<b>Impaired renal outcome in survivors</b>											
1 Study <sup>18</sup>	Cohort	Not serious	NA	Not serious	Serious	None	19	22	86	Low	4

Abbreviations: MCDK, multicystic dysplastic kidneys; NA, not applicable.

<sup>a</sup> Range of 1 to 9, where 9 is the highest level of importance.

<sup>b</sup> Four deaths were all in the same study. Also, they were all due to termination of pregnancy (2 with additional multiple malformations, 1 with chromosomal syndrome, and 1 with non-chromosomal syndrome).

<sup>c</sup> Most deaths unrelated to disease in that kidney.

<sup>d</sup> No details on renal function.

<sup>e</sup> Majority of deaths are by termination of pregnancy.

<sup>f</sup> Short follow-up.

<sup>g</sup> Low patient numbers.

<sup>h</sup> Publication bias suspected.

leading to termination of pregnancy, which were the only deaths in this group. Isolated multiple unilateral cysts with contralateral compensatory hypertrophy and without associated anomalies have an excellent prognosis. In cases with associated anomalies, outcome is mainly determined by other organ involvement, contralateral renal disease, and/or the particular syndrome complex. Fetuses with bilateral kidney cysts or hyperechogenic kidneys without oligohydramnios have good survival but significant risk of long-term renal disease. Fetuses with bilateral kidney cysts or hyperechogenic kidneys with oligohydramnios have poorer survival, especially with early onset of oligohydramnios, due to neonatal respiratory disease and longer-term renal dysfunction. Fetuses with bilateral cysts or hyperechogenic kidneys with concomitant extrarenal malformations have a mixed prognosis depending mainly on other organ involvement and the underlying syndrome, varying from extremely poor (eg, Meckel-Gruber syndrome) to an often mild renal phenotype (eg, Bardet-Biedl syndrome).

### Predicting Individual Prognosis

Classification into unilateral/bilateral disease and presumed diagnosis helps to stratify patients' prognosis, along with the identification of comorbidities and complications. The presence of oligohydramnios is an important prognostic feature even after adjustment for disease type and multiple anomalies.<sup>18</sup> While earlier onset of oligohydramnios is associated with worse outcome,<sup>23-25</sup> the distinction between oligohydramnios and anhydramnios is less helpful.<sup>24</sup> Further imaging and laboratory parameters that might help define individual prognosis are examined below.

*There is insufficient evidence to make recommendations on prenatal lung assessment as a means to predict postnatal mortality and morbidity in children with renal oligohydramnios (no grading).*

Data for predicting postnatal outcome by prenatal lung assessment come mainly from patients with premature rupture of mem-

branes, diaphragmatic hernias, and/or congenital heart defects. However, renal oligohydramnios should be considered separately (eg, because enlarged kidneys further constrain lung growth, amniotic fluid movement, and postnatal inflation). They can also distort the thoracic to abdominal circumference ratio.<sup>32</sup> Unfortunately, few studies analyzed renal patients separately, and some did not include neonatal survivors (eTable 4 in the [Supplement](#)). Three-dimensional lung volume was the best predictor of pulmonary hypoplasia in renal oligohydramnios in one study,<sup>32</sup> followed by 2-dimensional thoracic area to heart area ratio. Magnetic resonance imaging lung volume measurements may be helpful, especially if oligohydramnios hampers ultrasound, but MRI was not superior to oligohydramnios in predicting outcome in the only published study.<sup>33</sup> Studies of pulmonary perfusion either by conventional Doppler ultrasound<sup>34,35</sup> or after maternal hyperoxygenation have also not included renal survivors. Meta-analysis could not confirm that the amniotic lecithin to sphingomyelin ratio predicts lung maturity.<sup>36</sup>

*There is insufficient evidence to make recommendations on prenatal renal function tests as a means to predict postnatal renal outcome for fetuses with cystic kidney disease (no grading).*

Fetal urinary electrolytes have been used to estimate renal function in lower urinary tract obstruction. However, their predictive power is poor, the bladder is not usually enlarged and easy to puncture in cystic diseases, and postrenal obstruction produces different electrolyte patterns than cysts of the collecting ducts, tubules, or glomeruli. Therefore, fetal blood sampling by cordocentesis, which has a slightly higher complication rate than amniocentesis or chorionic villus sampling,<sup>37</sup> is more suitable. eTable 5 in the [Supplement](#) summarizes studies on prenatal renal function tests for the prediction of postnatal renal function that include nonobstructive nephropathies. While higher serum  $\beta_2$ -microglobulin reflects glomerular damage and correlates with postnatal serum creatinine levels

to some degree, sensitivity and specificity for distinguishing mild from moderate or severe renal disease are suboptimal. Especially in diseases where renal function may decline over the course of pregnancy (eg, ARPKD), normal fetal  $\beta_2$ -microglobulin does not preclude later severe renal failure.<sup>38</sup>

### Counseling

**Recommendation 3.1 (consensus strength, evidence level D):** *In case of oligohydramnios, parents should be offered counseling by a fetal medicine specialist and a neonatologist; irrespective of the presence of oligohydramnios, parents of fetuses with bilateral cystic renal disease should be offered counseling by a pediatric nephrologist.*

Because of the broad spectrum of prognoses and diverse possible therapeutic interventions (eg, ventilation, different dialysis modalities, and transplantation), interdisciplinary counseling is extremely important. In severe cases, this will require repeated consultations with several specialists and psychosocial support.<sup>39</sup> High parental anxiety is often encountered even in less severely affected fetuses because of difficulties in pinpointing the prognosis after first examination and common preconceptions about dialysis; therefore, even families facing unilateral disease often find pediatric nephrological counseling helpful. Contact with patient organizations, which exist for several cystic nephropathies and genetic renal diseases in general on a national and international level, should be offered.

Where termination of pregnancy is locally available, nondirective counseling should be provided, aiming to give a realistic prospect of outcome. The visual analog scale shown in the eFigure in the Supplement may be helpful for this. When termination of pregnancy is offered, postnatal palliative care should always also be offered as an equal option.

### Therapeutic Interventions

#### Corticosteroids

**Recommendation 3.2 (consensus strength, evidence level C):** *Despite the lack of evidence on the use of corticosteroids in late preterm pulmonary hypoplasia to improve pulmonary outcome, a single course of 2 doses is reasonable for this indication owing to the potential benefit.*

There is overwhelming evidence that corticosteroids can enhance lung maturation in threatened preterm delivery before 34 weeks' gestation, and it is recommended in multiple national guidelines.<sup>40-45</sup> A recent meta-analysis<sup>46</sup> also demonstrated benefits on respiratory morbidity for infants born late preterm (34-36 weeks' gestation) and before planned cesarean delivery at 37 weeks or later. Postnatal glucose levels should be monitored owing to the significantly higher rate of neonatal hypoglycemia.<sup>47</sup> While there is some concern about the adverse effects of repeated courses of corticosteroids, a single course is considered safe.<sup>41</sup> Corticosteroids have been used routinely before delivery of fetuses with congenital diaphragmatic hernia, with supporting evidence from animal models of diaphragmatic hernia.<sup>48</sup> For oligohydramnios-induced pulmonary hypoplasia, findings in a rabbit model suggested that corticosteroids in late gestation may improve outcome.<sup>49</sup> While animal data raised concern about their effect on the number of glomeruli,<sup>50</sup> nephrogenesis is largely complete in the late preterm period; therefore, we believe that a first course for pulmonary hypoplasia is reasonable even after 34 weeks' gestation.

#### Serial Amnioinfusions

*There is insufficient evidence to make a recommendation on serial amnioinfusions for renal oligohydramnios (no grading).*

Serial percutaneous amnioinfusions have been studied mainly for spontaneous premature rupture of membranes, for which they may reduce mortality and pulmonary hypoplasia.<sup>51,52</sup> However, there is already an increased risk of infection in this setting, which is probably not elevated further. Amnioinfusions into previously intact membranes are commonly complicated by iatrogenic premature rupture of membranes, premature labor, and miscarriage.<sup>53</sup> In addition, infection and injury to fetus or mother are potential risks. The procedure should be considered only for pulmonary palliation because it does not improve renal function.

For renal oligohydramnios, there is a recent study using an amniopore device for serial amnioinfusions<sup>54</sup> and only case reports for serial percutaneous amnioinfusions (eTable 6 [evidence level D] in the Supplement). Because of the unknown balance of risks and benefits, results of a planned prospective study should be awaited.<sup>54</sup>

#### Induction of Early Delivery

**Recommendation 3.3 (consensus strength, evidence level D):** *Do not offer early delivery for kidney reasons.*

There is no logical benefit on renal function from early delivery. On the contrary, prematurity should be avoided because it poses additional perinatal risks, and lower body weight can complicate treatment of renal dysfunction. Oligohydramnios may cause cord compression and fetal distress during labor, requiring obstetric management.

#### Delivery in Hospital With Specialized Neonatal Care

**Recommendation 3.4 (consensus strength, evidence level D):** *In all cases with anticipated pulmonary problems (ie, oligohydramnios from early pregnancy), delivery should be planned in a hospital with high-level neonatal care (including availability of high-frequency oscillatory ventilation and inhaled nitric oxide therapy).*

*For fetuses with bilateral cystic renal disease without oligohydramnios, consider delivery in a hospital with easy access to a pediatric nephrologist.*

*Patients with unilateral cystic renal disease and healthy contralateral kidney generally do not require specialized neonatal care due to renal disease.*

Because of the wide spectrum of renal function impairment and secondary consequences, such as pulmonary hypoplasia, the place of delivery should be planned after individual risk assessment. Management of severely affected children will require an experienced team of neonatologists, pediatric nephrologists, and pediatric radiologists, as well as pediatric surgeons, urologists, and anesthesiologists. Also, complex decisions about offering palliative or intensive care or choosing dialysis modality may benefit from additional input from ethical experts and psychosocial support of the family (see the Postnatal Management section). In the initial neonatal phase, management of pulmonary complications is usually paramount, but nephrological assessment should not be delayed too long because treatment decisions may take some time to prepare and a number of children require dialysis soon after birth.

### Postnatal Management

Similar to the wide variety of prenatal presentations of cystic renal disease, a broad spectrum of postnatal morbidity is encountered.

While management of mild cases may focus mainly on ultrasound examination, severe cases require a multidisciplinary team, including neonatologists and pediatric nephrologists with expertise in neonatal kidney failure. Involvement of a geneticist may also be helpful (see the Genetic Testing section).

### Assessment in the Neonatal Period

**Recommendation 4.1 (consensus strength, evidence level C):** Neonates with a prenatal diagnosis of a solitary kidney cyst should be seen for ultrasound examination within the first 4 weeks of life.

This will confirm the diagnosis or identify further cysts due to the greater sensitivity of postnatal ultrasound in detecting smaller cysts or abnormalities of the contralateral kidney.

**Recommendation 4.2 (consensus strength, evidence level C):** Neonates with prenatally diagnosed unilateral cystic kidney disease/hyperechogenic kidneys should be examined by ultrasound between the third and seventh days of life.

Despite enormous advances in prenatal ultrasound, there is still a considerable proportion of children in whom the prenatal diagnosis of unilateral cysts has to be revised postnatally, usually to severe ureteropelvic junction obstruction.<sup>22</sup> Confirmation of the diagnosis is advised within the first week of life as severe obstruction may require surgical management. Because urine production only reaches normal quantities slowly after delivery, ultrasound before the third day of life may underestimate ureteric obstruction.

**Recommendation 4.3 (consensus strength, evidence level C):** There is no need to perform blood tests for renal function in children with unilateral cystic disease and a normal contralateral kidney with adequate compensatory hypertrophy.

Adequate compensatory hypertrophy is defined as renal volume above the 95th percentile (corrected for gestational age), which may take until the end of the first year of life to develop. Inadequate compensatory hypertrophy and other urogenital abnormalities should be excluded by postnatal ultrasound because they are the main risk factors for renal damage (albuminuria, hypertension, or renal function impairment) in patients with congenital solitary kidneys.<sup>55</sup> In case of the absence of other urogenital malformations and adequate contralateral hypertrophy, measurement of serum creatinine is unlikely to reveal impaired renal function. Micturating cystogram or scintigraphy is only indicated if there are clues toward further pathology, such as ureteric dilation, suspicion of MCDK in only one pole of a duplex kidney, or additional symptoms (eg, urinary tract infections). Patients require long-term follow-up for repeated ultrasound scans and measurements of proteinuria and blood pressure.

**Recommendation 4.4 (consensus strength, evidence level C):** In patients at risk for neonatal renal failure (oligohydramnios or bilateral renal involvement), urine output should be monitored from birth.

Serum creatinine and electrolyte levels and acid/base status should be monitored regularly but are largely influenced by maternal kidney status until 48 hours after birth. In addition to confirmatory postnatal ultrasound, renal function should be assessed with adequate time lag to allow clearance of maternal creatinine. Children with collecting duct abnormalities, such as ARPKD, are particularly at risk of hyponatremia and metabolic acidosis. Dialysis may need to be initiated after a few days or weeks of life depending on fluid overload and uremia. Peritoneal dialysis is the method of choice for most neonates.

### Current Prognosis of Children With Severely Impaired Kidney Disease From Birth

Individual prognosis of cystic renal disease is related to both underlying disease and comorbidities, with poorest outcomes in neonates after renal oligohydramnios (Table 4 [evidence level D]). In 6 single-center studies, 24 out of 42 neonates died, but life-supporting therapy was not offered or was discontinued in at least 5. Owing to the small cohort sizes, it is difficult to distinguish the effects of age at onset of renal oligohydramnios, presence of associated malformations, and level of postnatal care on survival. Also, respiratory support and dialysis techniques have improved in recent years; therefore, outcome may now be better.

More detailed but very heterogeneous patient and organ outcome data are available for children with ARPKD (Table 4). In 4 current national registries and retrospective cohort studies, neonatal survival after birth with ARPKD was 88%, and 1-year survival was 78% (evidence level C). In 5 epidemiological studies with a mean follow-up time of 5 years, portal hypertension occurred in 15% to 86% (mean, 36%), and liver transplantation was performed in 0% to 50% (mean, 11%) of patients.

### Renal Replacement Therapy From Infancy

Solid epidemiological evidence is available regarding outcomes of renal replacement therapy (RRT) in neonates and infants for all indications (including 10%-15% with cystic kidney disease) (Table 5). Two international registries evaluated patient survival in 362 children started on long-term RRT in the first month of life since 2000; patient survival was 81% at 2 years, 79% at 3 years, and 76% at 5 years.<sup>67,71</sup> This compares with 85% 3-year survival among 182 children started on RRT from the second to the 12th month of life.<sup>71</sup> Neurological comorbidities increased the risk of death 5-fold. While van Stralen et al<sup>67</sup> did not demonstrate differing survival across 4 diagnosis groups, mortality was higher in children with polycystic kidney disease than in those with obstructive nephropathy in an American cohort.<sup>71</sup> Patient and graft survival after renal transplantation has also improved over time, including recipients aged 0 to 2 years,<sup>74</sup> even though transplantation is usually delayed until the child has reached about 10 kg. Results of further studies on neurological development, growth, and hospital admissions are summarized in eTable 7 in the Supplement. In resource-limited countries, pediatric renal replacement mortality is higher, especially when low public health expenditure limits provision of specialized pediatric renal services.<sup>75</sup>

**Recommendation 4.5 (level 2 strength, evidence level B):** Renal replacement therapy should be offered to neonates with life-threatening kidney failure due to cystic renal disease. Depending on individual circumstances, it can be appropriate to opt against RRT and pursue a palliative care plan.

Renal replacement therapy should now be considered an established therapy even in neonates because available data show marked improvement of survival in the last decades, with survival rates similar to those of older children.

However, concomitant conditions limiting life expectancy and/or quality of life independent of kidney function should be considered in the decision-making process. While most pediatric nephrologists recommend RRT as standard of care even for neonates and many families choose this treatment for their children,



Table 4. Summary of Evidence on Prognosis of Postnatal Cystic Renal Disease

No. of Studies	Quality Assessments						Effects				
	Study Design	Risk of Bias	Inconsistency	Indirectness	Imprecision	Other Considerations	No. of Events/Survivors	No. of Patients	Event Rate/Survival Rate, % (Range)	Quality	Importance
<b>Prognosis After Live Birth With Cystic Renal Disease and Renal Oligohydramnios</b>											
Overall survival											
6 Studies <sup>23-27,56</sup>	Mainly single-center case	Very serious	Not serious	Not serious	Serious <sup>a</sup>	None	18	42	43 (25 to 66)	Low	Medium
<b>Prognosis of Neonatal ARPKD</b>											
Neonatal survival											
4 Studies <sup>57-60</sup>	Cohort studies	Not serious	Not serious <sup>b</sup>	Not serious	Not serious	None	353	403	88 (82-96)	Medium	Medium
2 Studies <sup>61,62</sup>	Historical cohort studies	Not serious	Serious <sup>c</sup>	Not serious	Serious <sup>c</sup>	None	63	125	50 (25-87)	Low	Low
1-y Survival of neonatal survivors											
4 Studies <sup>57-60</sup>	Cohort studies	Not serious	Not serious <sup>b</sup>	Not serious	Not serious <sup>b</sup>	None	315	353	89 (85-92)	Medium	Medium
2 Studies <sup>61,62</sup>	Historical cohort studies	Not serious	Not serious	Not serious	Not serious	None	42	63	67 (62-78)	Medium	Low
Survival until end of observation											
4 Studies <sup>57-60</sup>	Cohort studies	Not serious	Not serious <sup>b</sup>	Not serious	Not serious <sup>d</sup>	None	323	416	78 (70-81)	Medium	Medium
3 Studies <sup>61-63</sup>	Historical cohort studies	Not serious	Serious <sup>c</sup>	Not serious	Serious <sup>c</sup>	None	139	235	59 (23-87)	Low	Low
Hypertension											
6 Studies <sup>57,58,62,65</sup>	Cohort studies	Not serious	Not serious	Not serious	Not serious	None	307	470	65 (55-73)	Medium	Medium
Chronic kidney disease											
4 Studies <sup>57,58,63,65</sup>	Cohort studies	Not serious	Not serious	Not serious	Serious <sup>e,f</sup>	None	183	352	52 (42-65)	Low	Medium
End-stage renal disease											
7 Studies <sup>57-60,62,63,65</sup>	Cohort studies	Serious <sup>f</sup>	Serious <sup>f</sup>	Not serious	Not serious	None	128	588	22 (10-74)	Low	Medium
Renal transplantation											
5 Studies <sup>57,60,63-65</sup>	Cohort studies	Serious <sup>f</sup>	Not serious	Not serious	Not serious	None	64	421	15 (5-55)	Low	Low
Portal hypertension											
5 Studies <sup>57,58,60,63,65</sup>	Cohort studies	Serious <sup>g</sup>	Not serious	Not serious	Serious <sup>h</sup>	None	134	375	36 (15-86)	Low	Low
Variceal bleed											
6 Studies <sup>57,58,60,62,65,66</sup>	Cohort studies	Not serious <sup>g</sup>	Not serious	Not serious	Not serious	None	37	368	10 (4-27)	Low	Low
Cholangitis											
4 Studies <sup>58,60,65,66</sup>	Cohort studies	Serious <sup>i</sup>	Not serious	Not serious	Serious <sup>j</sup>	None	22	306	7.2 (4-25)	Low	Medium
Liver transplantation											
5 Studies <sup>57,58,60,65,66</sup>	Cohort studies	Serious <sup>f,g</sup>	Not serious	Not serious	Not serious	None	37	337	11 (2-50)	Low	Low

Abbreviation: ARPKD, autosomal recessive polycystic kidney disease.

<sup>a</sup> All studies have low patient numbers; inclusion of patients with other malformations varies.<sup>b</sup> Despite varying inclusion criteria (eg, clinical/only genetically confirmed cases).<sup>c</sup> Early neonatal deaths missed by tertiary hospital in pre-ultrasound era.<sup>d</sup> Despite varying length of follow-up.<sup>e</sup> Very variable definitions of chronic kidney disease.<sup>f</sup> Dependent on follow-up time.<sup>g</sup> Higher incidence in studies focusing on patients with congenital hepatic fibrosis.<sup>h</sup> Very variable definitions of portal hypertension.<sup>i</sup> Not reported in many studies (unclear if none occurred or simply not reported).<sup>j</sup> Cholangitis and sepsis of other origin often hard to distinguish clinically.

Table 5. Summary of Evidence on Prognosis After Starting Renal Replacement Therapy for Any Renal Disease Before Age 24 Months

No. of Studies	Quality Assessment						Effect				
	Study Design	Risk of Bias	Inconsistency	Indirectness	Imprecision	Other Considerations	No. of Events/Survivors	No. of Patients	Event Rate/Survival Rate, % (Range)	Quality	Importance
<b>1-y Survival</b>											
3 Studies <sup>67-69</sup>	Cohort studies (after 2000)	Not serious	Not serious	Not serious	Not serious <sup>a</sup>	<sup>b</sup>	874	1007	87 (83-88)	Medium	High
2 Studies <sup>69,70</sup>	Cohort studies (before 2000)	Not serious	Not serious	Not serious	Not serious <sup>a</sup>	<sup>b</sup>	120	143	84 (79-86)	Low	Medium
<b>2-y Survival</b>											
3 Studies <sup>67-69</sup>	Cohort studies (after 2000)	Not serious	Not serious	Not serious	Not serious <sup>a</sup>	<sup>b</sup>	813	1007	81 (80-81)	Medium	High
2 Studies <sup>69,70</sup>	Cohort studies (before 2000)	Not serious	Not serious	Not serious	Not serious <sup>a</sup>	<sup>b</sup>	111	143	78 (68-81)	Low	Medium
<b>3-y Survival</b>											
4 Studies <sup>67-69,71</sup>	Cohort studies (after 2000)	Not serious	Not serious	Not serious	Not serious <sup>a</sup>	<sup>b</sup>	1000	1287	78 (73-88)	Medium	High
4 Studies <sup>23,69,70,72</sup>	Cohort studies (before 2000)	Not serious	Not serious	Not serious	Not serious <sup>a</sup>	<sup>b</sup>	509	687	74 (68-80)	Medium	Medium
<b>5-y Survival</b>											
3 Studies <sup>67-69</sup>	Cohort studies (after 2000)	Not serious	Not serious	Not serious	Not serious <sup>a</sup>	<sup>b</sup>	638	1007	63 (58-78)	Medium	High
2 Studies <sup>69,70</sup>	Cohort studies (before 2000)	Not serious	Not serious	Not serious	Not serious <sup>a</sup>	<sup>b</sup>	109	143	76 (68-79)	Low	Medium
<b>Survival Until End of Study</b>											
4 Studies <sup>67-69,71</sup>	Cohort studies (after 2000)	Not serious	Not serious	Not serious	Not serious <sup>a</sup>	<sup>b</sup>	1049	1329	79 (74-83)	Medium	Medium
5 Studies <sup>23,69,70,72,73</sup>	Cohort studies (before 2000)	Not serious	Not serious	Not serious	Not serious <sup>a</sup>	<sup>b</sup>	620	864	72 (66-78)	Medium	Medium
<b>Temporary Return of Native Kidney Function</b>											
5 Studies <sup>23,26,27,58,59</sup>	Cohort studies	Not serious	Not serious	Not serious	Not serious	None	105	1869	6 (2-8)	Medium	Medium
<b>Renal Transplant by End of Study</b>											
5 Studies <sup>67-69,71,72</sup>	Cohort studies (after 2000)	Not serious	Serious <sup>c</sup>	Not serious	Serious <sup>d</sup>	None	668	1219	55 (49-80)	Medium	Medium
2 Studies <sup>68,72</sup>	Cohort studies (before 2000)	Not serious	Not serious	Not serious	Serious <sup>d</sup>	None	217	416	52 (49-60)	Medium	Medium

<sup>a</sup> Despite varying definitions of age at starting renal replacement therapy (<1 month, <1 year, and <2 years) and some studies excluding hemodialysis patients.

<sup>b</sup> Survival not stratified for primary diagnosis in most studies.

<sup>c</sup> Historical cohorts cannot be separated out for the studies by Muller et al<sup>38</sup> and Brownfoot et al.<sup>41</sup>

<sup>d</sup> Rate of transplant highly dependent on survival rate and length of follow-up.

the lifelong burden of disease is considerable for affected children and their caregivers. The decision on initiation, withholding, or discontinuation of RRT should be carefully evaluated in a shared

decision-making process with all involved disciplines and the parents. A formalized ethical decision-making framework can give useful guidance in this process.<sup>76,77</sup>

## ARTICLE INFORMATION

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## REFERENCES

- Wiesel A, Queisser-Luft A, Clementi M, Bianca S, Stoll C; EUROSCAN Study Group. Prenatal detection of congenital renal malformations by fetal ultrasonographic examination: an analysis of 709,030 births in 12 European countries. *Eur J Med Genet.* 2005;48(2):131-144.
- Winding L, Loane M, Wellesley D, et al. Prenatal diagnosis and epidemiology of multicystic kidney dysplasia in Europe. *Prenat Diagn.* 2014;34(11):1093-1098.
- Guyatt GH, Oxman AD, Vist GE, et al; GRADE Working Group. GRADE: an emerging consensus on rating quality of evidence and strength of recommendations. *BMJ.* 2008;336(7650):924-926.
- Vivante A, Hildebrandt F. Exploring the genetic basis of early-onset chronic kidney disease. *Nat Rev Nephrol.* 2016;12(3):133-146.
- Bergmann C. ARPKD and early manifestations of ADPKD: the original polycystic kidney disease and phenocopies. *Pediatr Nephrol.* 2015;30(1):15-30.
- Chervenak FA, McCullough LB. Ethical issues in perinatal genetics. *Semin Fetal Neonatal Med.* 2011;16(2):70-73.
- Hartung EA, Guay-Woodford LM. Autosomal recessive polycystic kidney disease: a hepatorenal fibrocystic disorder with pleiotropic effects. *Pediatrics.* 2014;134(3):e833-e845.
- Blazer S, Zimmer EZ, Blumenfeld Z, Zelkovic I, Bronshtein M. Natural history of fetal simple renal cysts detected in early pregnancy. *J Urol.* 1999;162(3, pt 1):812-814.
- Damen-Elias HA, De Jong TP, Stigter RH, Visser GH, Stoutenbeek PH. Congenital renal tract anomalies: outcome and follow-up of 402 cases detected antenatally between 1986 and 2001. *Ultrasound Obstet Gynecol.* 2005;25(2):134-143.
- Sanghvi KP, Merchant RH, Gondhalekar A, Lulla CP, Mehta AA, Mehta KP. Antenatal diagnosis of congenital renal malformations using ultrasound. *J Trop Pediatr.* 1998;44(4):235-240.
- Estroff JA, Mandell J, Benacerraf BR. Increased renal parenchymal echogenicity in the fetus: importance and clinical outcome. *Radiology.* 1991;181(1):135-139.
- Reuss A, Wladimiroff JW, Niermeijer MF. Antenatal diagnosis of renal tract anomalies by ultrasound. *Pediatr Nephrol.* 1987;1(3):546-552.
- Al Naimi A, Baumüller JE, Spahn S, Bahlmann F. Prenatal diagnosis of multicystic dysplastic kidney disease in the second trimester screening. *Prenat Diagn.* 2013;33(8):726-731.
- Chang LW, Chang FM, Chang CH, Yu CH, Cheng YC, Chen HY. Prenatal diagnosis of fetal multicystic dysplastic kidney with two-dimensional and three-dimensional ultrasound. *Ultrasound Med Biol.* 2002;28(7):853-858.
- van Eijk L, Cohen-Overbeek TE, den Hollander NS, Nijman JM, Wladimiroff JW. Unilateral multicystic dysplastic kidney: a combined pre- and postnatal assessment. *Ultrasound Obstet Gynecol.* 2002;19(2):180-183.
- Lazebnik N, Bellinger MF, Ferguson JE II, Hogge JS, Hogge WA. Insights into the pathogenesis and natural history of fetuses with multicystic dysplastic kidney disease. *Prenat Diagn.* 1999;19(5):418-423.
- Rizzo N, Gabrielli S, Pili G, et al. Prenatal diagnosis and obstetrical management of multicystic dysplastic kidney disease. *Prenat Diagn.* 1987;7(2):109-118.
- Kumar M, Thakur S, Puri A, et al. Fetal renal anomaly: factors that predict survival. *J Pediatr Urol.* 2014;10(6):1001-1007.
- Ryckewaert-D'Halluin A, Le Bouar G, Odent S, et al. Diagnosis of fetal urinary tract malformations: prenatal management and postnatal outcome. *Prenat Diagn.* 2011;31(11):1013-1020.
- Wilson RD, Morrison MG, Wittmann BK, Coleman GU. Clinical follow-up of fetal urinary tract anomalies diagnosed prenatally by ultrasound. *Fetal Ther.* 1988;3(3):141-151.
- Chaumoitre K, Brun M, Cassart M, et al. Differential diagnosis of fetal hyperechogenic cystic kidneys unrelated to renal tract anomalies: a multicenter study. *Ultrasound Obstet Gynecol.* 2006;28(7):911-917.
- Eckoldt F, Woderich R, Smith RD, Heling KS. Antenatal diagnostic aspects of unilateral multicystic kidney dysplasia: sensitivity, specificity, predictive values, differential diagnoses, associated malformations and consequences. *Fetal Diagn Ther.* 2004;19(2):163-169.
- Klaassen I, Neuhaus TJ, Mueller-Wiefel DE, Kemper MJ. Antenatal oligohydramnios of renal origin: long-term outcome. *Nephrol Dial Transplant.* 2007;22(2):432-439.
- Grijseels EW, van-Hornstra PT, Govaerts LC, et al. Outcome of pregnancies complicated by oligohydramnios or anhydramnios of renal origin. *Prenat Diagn.* 2011;31(11):1039-1045.
- Spiro JE, Konrad M, Rieger-Fackeldey E, et al. Renal oligo- and anhydramnios: cause, course and outcome: a single-center study. *Arch Gynecol Obstet.* 2015;292(2):327-336.

26. Emmanuelli V, Lahoche-Manucci A, Holder-Espinasse M, et al. Prenatal diagnosis of hyperechogenic kidneys: a study of 17 cases [in French]. *J Gynecol Obstet Biol Reprod (Paris)*. 2010;39(8):637-646.
27. Tsatsaris V, Gagnadoux MF, Aubry MC, Gubler MC, Dumez Y, Dommergues M. Prenatal diagnosis of bilateral isolated fetal hyperechogenic kidneys: is it possible to predict long term outcome? *BJOG*. 2002;109(12):1388-1393.
28. Decramer S, Parant O, Beaufrils S, et al. Anomalies of the *TCF2* gene are the main cause of fetal bilateral hyperechogenic kidneys. *J Am Soc Nephrol*. 2007;18(3):923-933.
29. Mashiah R, Davidovits M, Eisenstein B, et al. Fetal hyperechogenic kidney with normal amniotic fluid volume: a diagnostic dilemma. *Prenat Diagn*. 2005;25(7):553-558.
30. Carr MC, Benacerraf BR, Estroff JA, Mandell J. Prenatally diagnosed bilateral hyperechoic kidneys with normal amniotic fluid: postnatal outcome. *J Urol*. 1995;153(2):442-444.
31. Barisic I, Boban L, Loane M, et al. Meckel-Gruber syndrome: a population-based study on prevalence, prenatal diagnosis, clinical features, and survival in Europe. *Eur J Hum Genet*. 2015;23(6):746-752.
32. Gerards FA, Twisk JW, Fetter WP, Wijnaendts LC, van Vugt JM. Predicting pulmonary hypoplasia with 2- or 3-dimensional ultrasonography in complicated pregnancies. *Am J Obstet Gynecol*. 2008;198(1):140.e1-140.e6.
33. Zaretsky M, Ramus R, McIntire D, Magee K, Twickler DM. MRI calculation of lung volumes to predict outcome in fetuses with genitourinary abnormalities. *AJR Am J Roentgenol*. 2005;185(5):1328-1334.
34. Roth P, Agnani G, Arbez-Gindre F, et al. Use of energy color Doppler in visualizing fetal pulmonary vascularization to predict the absence of severe pulmonary hypoplasia. *Gynecol Obstet Invest*. 1998;46(3):153-157.
35. Laudy JA, Tibboel D, Robben SG, de Krijger RR, de Ridder MA, Wladimiroff JW. Prenatal prediction of pulmonary hypoplasia: clinical, biometric, and Doppler velocity correlates. *Pediatrics*. 2002;109(2):250-258.
36. Besnard AE, Wirjosekarto SA, Broeze KA, Opmeer BC, Mol BW. Lecithin/sphingomyelin ratio and lamellar body count for fetal lung maturity: a meta-analysis. *Eur J Obstet Gynecol Reprod Biol*. 2013;169(2):177-183.
37. Wilson RD, Gagnon A, Audibert F, Campagnolo C, Carroll J; Genetics Committee. Prenatal diagnosis procedures and techniques to obtain a diagnostic fetal specimen or tissue: maternal and fetal risks and benefits. *J Obstet Gynaecol Can*. 2015;37(7):656-668.
38. Muller F, Dreux S, Audibert F, et al. Fetal serum  $\beta_2$ -microglobulin and cystatin C in the prediction of post-natal renal function in bilateral hypoplasia and hyperechogenic enlarged kidneys. *Prenat Diagn*. 2004;24(5):327-332.
39. Aulbert W, Kemper MJ. Severe antenatally diagnosed renal disorders: background, prognosis and practical approach. *Pediatr Nephrol*. 2016;31(4):563-574.
40. Roberts D, Brown J, Medley N, Dalziel SR. Antenatal corticosteroids for accelerating fetal lung maturation for women at risk of preterm birth. *Cochrane Database Syst Rev*. 2017;3:CD004454.
41. Brownfoot FC, Gagliardi DI, Bain E, Middleton P, Crowther CA. Different corticosteroids and regimens for accelerating fetal lung maturation for women at risk of preterm birth. *Cochrane Database Syst Rev*. 2013;(8):CD006764.
42. Roberts D. Antenatal corticosteroids to reduce neonatal morbidity and mortality (Green-top Guideline No. 7). <https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg7/>. Accessed October 5, 2017.
43. American College of Obstetricians and Gynecologists' Committee on Obstetric Practice; Society for Maternal-Fetal Medicine. Committee Opinion No. 677: antenatal corticosteroid therapy for fetal maturation. *Obstet Gynecol*. 2016;128(4):e187-e194.
44. Crane J, Armson A, Brunner M, et al; Executive Committee of the Society of Obstetricians and Gynaecologists of Canada. Antenatal corticosteroid therapy for fetal maturation. *J Obstet Gynaecol Can*. 2003;25(1):45-52.
45. Dudenhausen JW, Berger R, Gortner L, Hackelöer BJ, Schneider KT, Vetter K. Antenatale Kortikosteroide zur Lungenreifung (ACS)1. *Frauenarzt*. 2009;50(7):621.
46. Saccone G, Berghella V. Antenatal corticosteroids for maturity of term or near term fetuses: systematic review and meta-analysis of randomized controlled trials. *BMJ*. 2016;355:i5044.
47. Gyamfi-Bannerman C, Thom EA, Blackwell SC, et al; NICHD Maternal-Fetal Medicine Units Network. Antenatal betamethasone for women at risk for late preterm delivery. *N Engl J Med*. 2016;374(14):1311-1320.
48. Guarino N, Oue T, Shima H, Puri P. Antenatal dexamethasone enhances surfactant protein synthesis in the hypoplastic lung of nitrogen-induced diaphragmatic hernia in rats. *J Pediatr Surg*. 2000;35(10):1468-1473.
49. Asabe K, Oka Y, Kai H, Shirakusa T. Effect of maternal dexamethasone treatment on the type II pneumocytes in hypoplastic lung by oligohydramnios: an ultrastructural study. *Pediatr Surg Int*. 2007;23(10):967-970.
50. Figueroa JP, Rose JC, Massmann GA, Zhang J, Acuña G. Alterations in fetal kidney development and elevations in arterial blood pressure in young adult sheep after clinical doses of antenatal glucocorticoids. *Pediatr Res*. 2005;58(3):510-515.
51. Porat S, Amsalem H, Shah PS, Murphy KE. Transabdominal amniocentesis for preterm premature rupture of membranes: a systematic review and metaanalysis of randomized and observational studies. *Am J Obstet Gynecol*. 2012;207(5):393.e1-393.e11.
52. Hofmeyr GJ, Eke AC, Lawrie TA. Amniocentesis for third trimester preterm premature rupture of membranes. *Cochrane Database Syst Rev*. 2014;(3):CD000942.
53. Kozinsky Z, Pásztor N, Vanya M, Sikovanyecz J, Pál A. Management of severe idiopathic oligohydramnios: is antepartum transabdominal amniocentesis really a treatment option? *J Matern Fetal Neonatal Med*. 2013;26(4):383-387.
54. Polzin WJ, Lim FY, Habli M, et al. Use of an amniocentesis to maintain amniotic fluid volume in fetuses with oligohydramnios secondary to lower urinary tract obstruction or fetal renal anomalies. *Fetal Diagn Ther*. 2017;41(1):51-57.
55. Westland R, Schreuder MF, Ket JC, van Wijk JA. Unilateral renal agenesis: a systematic review on associated anomalies and renal injury. *Nephrol Dial Transplant*. 2013;28(7):1844-1855.
56. Mehler K, Beck BB, Kaul I, Rahimi G, Hoppe B, Kribs A. Respiratory and general outcome in neonates with renal oligohydramnios: a single-centre experience. *Nephrol Dial Transplant*. 2011;26(11):3514-3522.
57. Guay-Woodford LM, Desmond RA. Autosomal recessive polycystic kidney disease: the clinical experience in North America. *Pediatrics*. 2003;111(5, pt 1):1072-1080.
58. Capisonda R, Phan V, Traubci J, Daneman A, Balfe JW, Guay-Woodford LM. Autosomal recessive polycystic kidney disease: outcomes from a single-center experience. *Pediatr Nephrol*. 2003;18(2):119-126.
59. Bergmann C, Senderek J, Windelen E, et al; APN (Arbeitsgemeinschaft für Pädiatrische Nephrologie). Clinical consequences of *PKHD1* mutations in 164 patients with autosomal-recessive polycystic kidney disease (ARPKD). *Kidney Int*. 2005;67(3):829-848.
60. Luoto TT, Pakarinen MP, Jahnukainen T, Jalanko H. Liver disease in autosomal recessive polycystic kidney disease: clinical characteristics and management in relation to renal failure. *J Pediatr Gastroenterol Nutr*. 2014;59(2):190-196.
61. Kääriäinen H, Koskimies O, Norio R. Dominant and recessive polycystic kidney disease in children: evaluation of clinical features and laboratory data. *Pediatr Nephrol*. 1988;2(3):296-302.
62. Roy S, Dillon MJ, Trompeter RS, Barratt TM. Autosomal recessive polycystic kidney disease: long-term outcome of neonatal survivors. *Pediatr Nephrol*. 1997;11(3):302-306.
63. Zerres K, Rudnik-Schöneborn S, Deget F, et al; Arbeitsgemeinschaft für Pädiatrische Nephrologie. Autosomal recessive polycystic kidney disease in 115 children: clinical presentation, course and influence of gender. *Acta Paediatr*. 1996;85(4):437-445.
64. Gunay-Aygun M, Font-Montgomery E, Lukose L, et al. Correlation of kidney function, volume and imaging findings, and *PKHD1* mutations in 73 patients with autosomal recessive polycystic kidney disease. *Clin J Am Soc Nephrol*. 2010;5(6):972-984.
65. Rawat D, Kelly DA, Milford DV, Sharif K, Lloyd C, McKiernan PJ. Phenotypic variation and long-term outcome in children with congenital hepatic fibrosis. *J Pediatr Gastroenterol Nutr*. 2013;57(2):161-166.
66. Gunay-Aygun M, Font-Montgomery E, Lukose L, et al. Characteristics of congenital hepatic fibrosis in a large cohort of patients with autosomal recessive polycystic kidney disease. *Gastroenterology*. 2013;144(1):112-121.e2.
67. van Stralen KJ, Borzych-Dużalka D, Hataya H, et al; ESPN/ERA-EDTA Registry; IPPN Registry; ANZDATA Registry; Japanese RRT Registry. Survival and clinical outcomes of children starting renal replacement therapy in the neonatal period. *Kidney Int*. 2014;86(1):168-174.
68. Carey WA, Talley LI, Sehring SA, Jaskula JM, Mathias RS. Outcomes of dialysis initiated during the neonatal period for treatment of end-stage

renal disease: a North American Pediatric Renal Trials and Collaborative Studies special analysis. *Pediatrics*. 2007;119(2):e468-e473.

69. Alexander RT, Foster BJ, Tonelli MA, et al; Pediatric Renal Outcomes Group Canada. Survival and transplantation outcomes of children less than 2 years of age with end-stage renal disease. *Pediatr Nephrol*. 2012;27(10):1975-1983.

70. Kari JA, Gonzalez C, Ledermann SE, Shaw V, Rees L. Outcome and growth of infants with severe chronic renal failure. *Kidney Int*. 2000;57(4):1681-1687.

71. Carey WA, Martz KL, Warady BA. Outcome of patients initiating chronic peritoneal dialysis during the first year of life. *Pediatrics*. 2015;136(3):e615-e622.

72. Ehrich JH, Rizzoni G, Brunner FP, et al. Renal replacement therapy for end-stage renal failure before 2 years of age. *Nephrol Dial Transplant*. 1992;7(12):1171-1177.

73. Coulthard MG, Crosier J. Outcome of reaching end stage renal failure in children under 2 years of age. *Arch Dis Child*. 2002;87(6):511-517.

74. Van Arendonk KJ, Boyarsky BJ, Orandi BJ, et al. National trends over 25 years in pediatric kidney transplant outcomes. *Pediatrics*. 2014;133(4):594-601.

75. Chesnaye NC, Schaefer F, Bonthuis M, et al; ESPN/ERA-EDTA Registry Committee. Mortality risk disparities in children receiving chronic renal

replacement therapy for the treatment of end-stage renal disease across Europe: an ESPN-ERA/EDTA registry analysis. *Lancet*. 2017;389(10084):2128-2137.

76. Dionne JM, d'Agincourt-Canning L. Sustaining life or prolonging dying? appropriate choice of conservative care for children in end-stage renal disease: an ethical framework. *Pediatr Nephrol*. 2015;30(10):1761-1769.

77. Lantos JD, Warady BA. The evolving ethics of infant dialysis. *Pediatr Nephrol*. 2013;28(10):1943-1947.