Trends in Survival Among Children With Down Syndrome in 10 Regions of the United States

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**KEY WORDS**

Down syndrome, survival, mortality, congenital heart defects, epidemiology, low birth weight, population-based, racial disparities

**ABBREVIATIONS**

aHR—adjusted hazard ratios
BPA—British Paediatrics Association
CHD—congenital heart defect
CI—confidence interval
DS—Down syndrome

Mr Kucik conceptualized and designed the study, carried out the analyses, drafted the initial manuscript, and approved the final manuscript as submitted; Dr Shin conceptualized and designed the study, carried out the initial analyses, contributed to the initial draft of the initial manuscript, and approved the final manuscript as submitted; Dr Siffel conceptualized and designed the study, carried out the initial analyses, contributed to the initial draft of the initial manuscript, and approved the final manuscript as submitted; Ms Marengo coordinated data submission from 1 of the study sites, contributed to the initial draft of the initial manuscript, reviewed and revised the manuscript, and approved the final manuscript as submitted; and Dr Correa conceptualized and designed the study, reviewed and revised the manuscript, and approved the final manuscript as submitted.

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The findings and conclusions in this report are those of the author(s) and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

(Continued on last page)

**WHAT’S KNOWN ON THIS SUBJECT:** Although survival of children born with Down syndrome has improved, unexplained racial and ethnic disparities in survival persist in the United States.

**WHAT THIS STUDY ADDS:** This study used population-based data from 10 birth defects monitoring programs in the United States to examine survival trends among children born with Down syndrome and to evaluate the changing influence of survival predictors over the life course.

**OBJECTIVE:** This study examined changes in survival among children with Down syndrome (DS) by race/ethnicity in 10 regions of the United States. A retrospective cohort study was conducted on 16,506 infants with DS delivered during 1983–2003 and identified by 10 US birth defects monitoring programs. Kaplan-Meier survival probabilities were estimated by select demographic and clinical characteristics. Adjusted hazard ratios (aHR) were estimated for maternal and infant characteristics by using Cox proportional hazard models.

**RESULTS:** The overall 1-month and 1-, 5-, and 20-year survival probabilities were 98%, 93%, 91%, and 88%, respectively. Over the study period, neonatal survival did not improve appreciably, but survival at all other ages improved modestly. Infants of very low birth weight had 24 times the risk of dying in the neonatal period compared with infants of normal birth weight (aHR 23.8; 95% confidence interval [CI] 18.4–30.7). Presence of a heart defect increased the risk of death in the postneonatal period nearly fivefold (aHR 4.6; 95% CI 3.9–5.4) and continued to be one of the most significant predictors of mortality through to age 20. The postneonatal aHR among non-Hispanic blacks was 1.4 (95% CI 1.2–1.8) compared with non-Hispanic whites and remained elevated by age 10 (2.0; 95% CI 1.0–4.0).

**CONCLUSIONS:** The survival of children born with DS has improved and racial disparities in infant survival have narrowed. However, compared with non-Hispanic white children, non-Hispanic black children have lower survival beyond infancy. Congenital heart defects are a significant risk factor for mortality through age twenty. *Pediatrics* 2013;131:e27–e36
Down syndrome (DS) is the most common chromosomal disorder among live births and occurs in 1 in every 700 live births in the United States. DS is associated with premature mortality and an increased risk for a number of comorbid conditions including cardiac, gastrointestinal, musculoskeletal or orthopedic, ear and hearing, ophthalmic, endocrine, leukemia, and autism. Even though trends in the total birth prevalence of DS have been difficult to determine because of the lack of reliable data on trends in the number of DS-related fetal deaths, the birth prevalence of DS has increased in recent decades in the United States and many other countries. These trends are due in part to an increasing proportion of births to women over age 35.

Although the survival probability for children with DS has improved in recent years, the overall fatality among infants with DS remains more than 5 times higher than that of general population. Furthermore, there is evidence that survival is lower for black children with DS than for white children with DS, however, the reason for the higher fatality rates among blacks is unknown. Factors associated with premature mortality among infants and children with DS include the presence of congenital heart defects (CHD), other structural malformations, leukemia, and low birth weight. Whether variations in the prevalence of these risk factors among race/ethnicity groups explain the observed differences in survival is unclear.

In this study, we examined the long-term trends in survival for children with DS and the variation in survival probabilities by maternal and infant characteristics based on data from 10 population-based surveillance programs in the United States. Adjusted hazard ratios (aHRs) were estimated to assess the association between possible prognostic factors and mortality.

**METHODS**

**Data Sources and Case Criteria**

Infants born with DS were identified by 10 population-based birth defects monitoring programs located in Arkansas, Georgia (5 central counties of metropolitan Atlanta*), California (11 counties†), Colorado, Iowa, New York (New York City excluded), North Carolina, Oklahoma, Texas, and Utah. The birth cohorts available for each program were Arkansas, 1993–2002; Georgia, 1983–2003; California, 1983–2002; Colorado, 1989–2003; Iowa, 1983–2003; New York, 1983–2003; North Carolina, 1989–1993, 1995–2003; Oklahoma, 1994–2003; Texas, 1996–2003; and Utah, 1995–2003. Vital status was ascertained for all births with DS through December 31, 2004, for all of the regions except for Arkansas and California, the follow-up periods of which ended on December 31, 2003, and December 31, 2002, respectively. Infants with karyotype diagnosis of trisomy 21 were classified as DS by using a modified British Paediatrics Association (BPA) coding system in most regions except for New York, where infants with DS were classified by both BPA and _International Classification of Diseases, Ninth Revision, Clinical Modification_ (ICD-9-CM) codes, and in the regions of North Carolina and Colorado, where they were classified by ICD-9-CM codes only. Deaths among children with DS were ascertained by linkage with medical records, state vital records, and the National Death Index.

Children with DS and no death records were considered alive at the end of the study follow-up period and treated as censored observations in the survival analysis. Demographic and clinical characteristics of infants with DS from birth were also collected by the surveillance programs. Infants of <500 g, <20 weeks of gestational age, or with unconfirmed diagnosis of DS were excluded from our study. Both demographic and clinical characteristics were included as potential risk factors for survival of infants with DS including maternal race/ethnicity (non-Hispanic white, non-Hispanic black, Hispanic, and other), maternal age (<35 years vs ≥35 years), maternal education (<12 years, ≥12 years), sex, birth weight (<1500 g, 1500–2499 g, ≥2500 g), and region. Infants with DS were classified as having a major CHD if their records indicated the presence of ICD-9-CM or BPA codes for CHD (745.000–747.430 and 747.640). Codes for normal physiologic findings in newborns or premature infants (eg, patent foramen ovale, patent ductus arteriosus), minor conditions such as tricuspid insufficiency, or unconfirmed cardiac defects were not considered structural heart defects.

**Data Analysis**

The survival probabilities at 1 month, 1 year, 5 years, 10 years, and 20 years were estimated by the Kaplan-Meier product-limit method. Greenwood’s method was used to calculate the variance of the estimated survival probability and their 95% confidence intervals (CIs). For those study regions with at least 20 years of follow-up (GA, CA, IA, and NY), the infant survival probabilities and 95% CIs were estimated for 4 birth cohorts (1983–1987, 1988–1992, 1993–1997, 1998–2003), and a trend analysis for the increasing survival over birth cohorts across race/ethnicity was conducted. A log-rank test was used to determine whether the survival probabilities were significantly different among various levels of potential demographic and clinical risk factors.
hazard models were used to estimate unadjusted and adjusted hazard ratios (aHR) for possible prognostic factors. The assumption of proportionality for the hazards was checked by plotting estimated log-cumulative hazard versus log of survival time for different categories of the risk factors. Possible time-dependent trends were also tested to confirm the assumption of proportionality. Final multivariate proportional hazard models were obtained, and the aHRs were estimated for the significant covariates. For the multivariate proportional hazard models, aHRs were estimated assuming survival through the preceding age period. Computations were performed by using SAS-PC (version 9.13; SAS Institute Inc, Cary, NC), and figures were generated by using S-PLUS (version 6.0; Insightful Corp, Seattle, WA). This study was approved by the Institutional Review Board of the Centers for Disease Control and Prevention.

RESULTS

From 1983 to 2003, 16,506 liveborn infants with DS were identified in the 10 regions included in our study. The number of infants ascertained in the regions ranged from 362 in Arkansas to 4886 in California with a median number of 982 infants, and the period of follow-up ranged from 9 years in Texas to 22 years in Georgia, Iowa, and New York (Table 1). Among those with comparable follow-up time (11 years), the regional variation was greatest between Arkansas (87.2%) and Utah (90.7%, P = .01).

The overall 1-month and 1-, 5-, and 20-year survival probabilities were 98%, 93%, 91%, and 88%, respectively (Tables 2 and 3), with the highest mortality occurring in the postneonatal period. Over the 20-year study period, neonatal survival did not improve appreciably, but modestly improved survival at older ages was observed for those infants with DS born after 1996 (Table 4). Univariate analysis demonstrated that survival varied by a number of demographic and maternal characteristics (Table 2 and 3). The greatest variation in survival to 1 year of age was by birth weight. Infants with normal birth weight had a 95% survival to 1 year compared with 55% and 90% survival to infants of very low and low birth weight, respectively. Infants born with a CHD had lower infant survival than those without (90% vs 96%). Infants born to non-Hispanic black and non-Hispanic white mothers had nearly identical neonatal survival, but thereafter infants to non-Hispanic black mothers experienced increasingly lower survival through age 20 (Fig 1). When stratified by birth weight, infants of non-Hispanic black mothers had lower overall survival only among normal and low birth weight (1500–2499 g) infants; among very low birth weight infants (<1500 g), infants of non-Hispanic black mothers had higher survival than infants of either non-Hispanic white or Hispanic mothers.

Restricting the cohort period to the years during which all regions contributed case data (1997–2003), the pooled survival probability to 1 year was 94% (Fig 2). The 1-year survival probability ranged from 92% in Arkansas to 96% in Utah (P = .02). For the regions with ≥20 years of follow-up (GA, CA, IA, and NY), an increasing trend of survival across 4 birth cohort periods was detected (P = .002) overall and for each region except for the region of Georgia (data not shown). Trends of improving survival were apparent across the 4 time periods for each major racial/ethnic group: non-Hispanic white (P = .0002), non-Hispanic black (0.0117), and Hispanic (0.0002); however, the greatest improvement in 1-year survival trends was among infants with a major CHD or of birth weight <2500 g (Fig 3).

For those infants with no missing values for the covariates included in the Cox proportional hazard models (n = 16,418), factors associated with an increased risk of death for children with DS were race/ethnicity, maternal age, birth weight, multiple births, and presence of CHD (Table 4). The only factor associated with an increased risk of neonatal death was birth weight. Infants of very low birth weight had 24 times the risk of dying compared with infants of normal birth weight (aHR 23.8; 95% CI 18.4–30.7), and infants of low birth weight had nearly 2.5-fold increased risk (aHR 2.4; 95% CI 1.8–3.2). Among those who survived the neonatal period, birth weight continued to be associated with an increased risk for death by age 1 for very low (aHR 1.9; 95% CI 1.7–2.3) and low (aHR 6.9; 95% CI 5.6–8.6) birth weight infants. The presence of a heart defect increased the risk of death in the postneonatal period nearly fivefold (aHR 4.6; 95% CI 3.9–5.4) and continued to be one of the most significant predictors of mortality through age 20.
<table>
<thead>
<tr>
<th>Births</th>
<th>Deaths</th>
<th>Survival % (95% CI)</th>
<th>Deaths</th>
<th>Survival % (95% CI)</th>
<th>Deaths</th>
<th>Survival % (95% CI)</th>
<th>Deaths</th>
<th>Survival % (95% CI)</th>
<th>Deaths</th>
<th>Survival % (95% CI)</th>
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<tr>
<td>Total</td>
<td>1,6506</td>
<td>318</td>
<td>98.1 (97.9–98.3)</td>
<td>1,180</td>
<td>92.9 (92.5–93.2)</td>
<td>1,489</td>
<td>91.0 (90.5–91.4)</td>
<td>1,551</td>
<td>90.7 (90.2–91.1)</td>
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<tr>
<td>Non-Hispanic White</td>
<td>8877</td>
<td>183</td>
<td>97.9 (97.6–98.2)</td>
<td>618</td>
<td>93.3 (92.5–93.6)</td>
<td>784</td>
<td>90.9 (90.2–91.5)</td>
<td>818</td>
<td>90.3 (89.6–90.9)</td>
<td>839</td>
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<td>Non-Hispanic Black</td>
<td>1576</td>
<td>34</td>
<td>97.8 (97.0–98.4)</td>
<td>156</td>
<td>90.2 (88.6–91.0)</td>
<td>209</td>
<td>86.1 (84.2–87.8)</td>
<td>220</td>
<td>84.8 (82.9–86.6)</td>
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<td>Hispanic</td>
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<td>73</td>
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<td>93.8 (93.1–94.4)</td>
<td>383</td>
<td>92.2 (91.4–92.9)</td>
<td>391</td>
<td>91.8 (91.0–92.6)</td>
<td>396</td>
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<td>Other</td>
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<td>24</td>
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<td>91.1 (89.0–92.8)</td>
<td>97</td>
<td>88.4 (86.0–90.4)</td>
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<td>Male</td>
<td>8928</td>
<td>186</td>
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<td>644</td>
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<td>800</td>
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<td>833</td>
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<td>Female</td>
<td>7577</td>
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<td>98.3 (97.9–98.5)</td>
<td>556</td>
<td>92.9 (92.5–93.5)</td>
<td>699</td>
<td>90.6 (89.3–91.3)</td>
<td>718</td>
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<td>Birth wt (g)</td>
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<tr>
<td>&lt;2500</td>
<td>12826</td>
<td>127</td>
<td>99.0 (98.9–99.2)</td>
<td>637</td>
<td>95.1 (94.7–95.4)</td>
<td>856</td>
<td>93.1 (92.3–93.5)</td>
<td>903</td>
<td>92.3 (91.8–92.8)</td>
<td>927</td>
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<tr>
<td>1500–2499</td>
<td>3190</td>
<td>74</td>
<td>97.7 (97.1–98.2)</td>
<td>327</td>
<td>89.8 (88.7–90.8)</td>
<td>405</td>
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<td>&lt;1500</td>
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<td>112</td>
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<td>53.3 (48.7–57.7)</td>
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<td>Maternal age (y)</td>
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<td>&lt;35</td>
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<td>1046</td>
<td>84.5 (83.9–90.1)</td>
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<td>≥35</td>
<td>5933</td>
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<td>97.8 (97.4–98.2)</td>
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<td>93.4 (92.8–94.0)</td>
<td>484</td>
<td>91.6 (90.8–92.2)</td>
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</table>

Note: no estimates were produced because of small numbers.

* P < .0001.
** P < .05.
*** P < .01.

**DISCUSSION**

Survival among individuals with DS has improved in the United States over time, and survival among those born to Hispanic mothers has increased to 2.0 (95% CI 1.0–4.0) compared with non-Hispanic whites and reduced risk for mortality (aHR 0.89, 95% CI 0.7–0.95) compared with non-Hispanic whites.
Linkage of surveillance data with the National Death Index ensured the most accurate determination of the vital status of children even if they died out of state and adds significantly to the credibility of the findings17; however, the assumption that a child was alive if there was no record of death found from the three data sources could be a potential limitation of the study. Additionally, no information on surgeries, clinical management, or barriers to health care as potential contributors to the long-term survival of children with DS was examined.

Factors most associated with an increased risk of mortality among individuals with DS were race/ethnicity, low birth weight, and the presence of CHD. Although some studies have suggested a survival advantage among male children,6,18 our study confirmed findings from other studies that found no survival differences by sex9,10,19–21.

Although previous reports have found an increased risk of mortality among individuals with DS were race/ethnicity, low birth weight, and the presence of CHD,22 this study found no survival differences by sex.16,18,21

TABLE 3

<table>
<thead>
<tr>
<th>Births</th>
<th>&lt;28 d</th>
<th>1 y</th>
<th>5 y</th>
<th>10 y</th>
<th>20 y</th>
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<tr>
<td>Deaths</td>
<td>Survival, % (95% CI)</td>
<td>Deaths</td>
<td>Survival, % (95% CI)</td>
<td>Deaths</td>
<td>Survival, % (95% CI)</td>
</tr>
<tr>
<td>Maternal education (y)</td>
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<tr>
<td>≥12</td>
<td>11437</td>
<td>220</td>
<td>98.1 (97.8–98.3)</td>
<td>787</td>
<td>93.1 (92.7–93.6)</td>
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<tr>
<td>&lt;12</td>
<td>4132</td>
<td>66</td>
<td>98.4 (98.0–98.7)</td>
<td>309</td>
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<td>32</td>
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<td>84</td>
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<td>Plurality</td>
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<td>Singleton</td>
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<td>308</td>
<td>98.1 (97.9–98.3)</td>
<td>1129</td>
<td>93.0 (92.6–93.4)</td>
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<td>Multiple</td>
<td>440</td>
<td>8</td>
<td>97.7 (95.8–98.8)</td>
<td>58</td>
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<td>CHDs</td>
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<td>No</td>
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<td>334</td>
<td>96.0 (95.5–96.4)</td>
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<td>Yes</td>
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<td>142</td>
<td>98.2 (97.9–98.5)</td>
<td>837</td>
<td>90.6 (88.9–90.2)</td>
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<td>Birth cohort</td>
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<td>1990–1996</td>
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<td>98.0 (97.5–98.3)</td>
<td>477</td>
<td>91.2 (90.5–92.0)</td>
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<td>1997–2003</td>
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<td>98.2 (97.9–98.4)</td>
<td>480</td>
<td>94.3 (93.8–94.8)</td>
</tr>
</tbody>
</table>

—, no estimates were produced because of small numbers.

*P < .001.

**P < .0001.
TABLE 4  aHRs for Select Covariates Among Children With Down Syndrome (n = 16 418) by Age at Follow-up From 10 US Regions, 1983–2003

<table>
<thead>
<tr>
<th>Race/ethnicity</th>
<th>1 mo</th>
<th>2–12 mo</th>
<th>1–5 y</th>
<th>6–10 y</th>
<th>11–20 y</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>1.0 (0.7–1.5)</td>
<td>1.4 (1.2–1.8)</td>
<td>1.9 (1.4–2.6)</td>
<td>2.0 (1.0–4.0)</td>
<td>1.7 (0.5–5.1)</td>
<td>1.4 (1.0–1.6)</td>
</tr>
<tr>
<td>Blacks</td>
<td>0.8 (0.6–1.0)</td>
<td>1.0 (0.9–1.2)</td>
<td>0.8 (0.6–1.0)</td>
<td>0.6 (0.3–1.2)</td>
<td>1.7 (0.8–4.7)</td>
<td>0.8 (0.7–0.9)</td>
</tr>
<tr>
<td>Hispanics</td>
<td>1.3 (0.8–2.0)</td>
<td>1.3 (1.0–1.7)</td>
<td>1.2 (0.8–2.0)</td>
<td>2.4 (1.1–5.4)</td>
<td>1.9 (0.4–8.0)</td>
<td>1.3 (1.1–1.6)</td>
</tr>
<tr>
<td>Birth wt</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>≥2500</td>
<td>Referent</td>
<td>Referent</td>
<td>Referent</td>
<td>Referent</td>
<td>Referent</td>
<td>Referent</td>
</tr>
<tr>
<td>1500–2499</td>
<td>2.4 (1.8–3.2)</td>
<td>1.9 (1.7–2.3)</td>
<td>1.4 (1.1–1.9)</td>
<td>1.2 (0.7–2.4)</td>
<td>1.3 (0.5–3.1)</td>
<td>1.8 (1.6–2.0)</td>
</tr>
<tr>
<td>&lt;1500</td>
<td>23.8 (18.4–30.7)</td>
<td>6.9 (5.6–8.6)</td>
<td>2.1 (1.2–3.9)</td>
<td>1.1 (0.2–8.2)</td>
<td>8.5 (2.5–28.6)</td>
<td>8.5 (7.3–8.8)</td>
</tr>
<tr>
<td>Maternal age</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;35</td>
<td>Referent</td>
<td>Referent</td>
<td>Referent</td>
<td>Referent</td>
<td>Referent</td>
<td>Referent</td>
</tr>
<tr>
<td>≥35 y</td>
<td>1.0 (1.0–1.0)</td>
<td>1.0 (1.0–1.0)</td>
<td>1.0 (1.0–1.0)</td>
<td>1.0 (1.0–1.0)</td>
<td>1.0 (0.9–1.0)</td>
<td>1.0 (1.0–1.0)</td>
</tr>
<tr>
<td>CHD, yes vs no (referent)</td>
<td>0.8 (0.6–1.2)</td>
<td>4.6 (3.9–5.4)</td>
<td>4.0 (3.1–5.2)</td>
<td>1.9 (1.1–3.2)</td>
<td>2.0 (1.0–4.0)</td>
<td>2.7 (2.4–3.0)</td>
</tr>
<tr>
<td>Birth cohort</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1983–1989</td>
<td>Referent</td>
<td>Referent</td>
<td>Referent</td>
<td>Referent</td>
<td>Referent</td>
<td>Referent</td>
</tr>
<tr>
<td>1990–1996</td>
<td>0.9 (0.6–1.2)</td>
<td>1.0 (0.8–1.2)</td>
<td>0.6 (0.5–0.8)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1997–2003</td>
<td>0.8 (0.5–1.1)</td>
<td>0.5 (0.4–0.6)</td>
<td>0.5 (0.4–0.7)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Birth wt reference group is ≥2500. Survival probability among non-Hispanic blacks, Hispanic, and other was compared with the survival probability among non-Hispanic whites. —, no estimates were produced because of small numbers.

a Adjusted for race/ethnicity, birth wt, maternal age and education, presence of a CHD, birth period, and region of birth.

b Statistical difference in survival probabilities between category stratum and the referent group.

FIGURE 1

to racial and ethnic disparities in survival\textsuperscript{9,10}; however, the discrepancy is likely the result of 2 study attributes. First, each used nonoverlapping time periods of observation, so that the later study (Vendola et al) might reflect the narrowing survival gap as evidenced by the decreasing trend in disparities seen in this study. The second and more compelling reason for the differences in the study findings was that Rasmussen et al presented
overall hazard ratios up to 20 years of age, whereas Vendola et al restricted their analysis to the first year of life. Our study showed that association between race and mortality increased with increasing age.

Several studies observed that the greatest black-white disparity occurred among infants with no major CHD, suggesting that more undiagnosed CHD among non-Hispanic blacks might be contributing to the disparity. Non-Hispanic black infants without a CHD had lower 1-year survival than non-Hispanic whites from 1983 to 1989 (91.3% vs 95.8%), but the disparity nearly disappeared by the 1997–2003 period (97.4% vs 97.7%). To evaluate the potential role of undiagnosed CHD in the black-white disparity, we examined the percent of infants with DS and a CHD by race and over time. During both the earliest and most recent time periods, a greater percent of non-Hispanic blacks with DS was diagnosed with a heart defect compared with non-Hispanic whites: 44% among non-Hispanic blacks versus 41% among non-Hispanic whites during 1983–1989 and 53% among non-Hispanic blacks versus 50% among non-Hispanic whites during 1997–2003. Furthermore, although less severe CHD such as muscular ventricular septal defects are reported less frequently among non-Hispanic blacks compared with non-Hispanic whites, there appear to be little racial/ethnic difference in the birth prevalence of more severe heart defects that would have a greater influence on survival, such as atrioventricular septal defect, the most common heart defect among infants with DS.
Unique to this study was the examination of the changing impact across the life span of factors that contribute to mortality. Goldman et al found age variations in the contribution by specific factors to mortality, but the study was limited to the first year of life.22 Our analysis showed that very low and low birth weight conferred the greatest risk of mortality during the neonatal period, but the associated risk lessened with increasing age. CHDs are the leading cause of death among infants with DS8 and conferred a risk of mortality that was highest during the post-neonatal period and was associated with the greatest risk relative to the other factors from age 1 through 10. The mortality risk associated with non-Hispanic black race increased with increasing age even after adjusting for the presence of a heart defect and low birth weight, possibly reflecting inadequate access or utilization of health care services.

The population-based approach of this study is a substantial strength in that it ensures the most complete live-born population of infants with DS. The limitation of this and most survival studies is the lack of accounting for the prenatal experience. Attitudes toward prenatal testing and the use of it vary by a number of maternal factors, including sociodemographic factors, race, and ethnicity.28 The proportion of elective terminations of a fetus with DS in the United States ranged from 7% to 37% with variations by time period and regional racial/ethnic composition.29–32 A recent review of population-based studies of pregnancies with a positive prenatal diagnosis of DS estimated that 67% of pregnancies were terminated, but a temporal analysis found that the proportion of electively terminated pregnancies has consistently decreased in recent years.33 Although information on frequency of termination is scarce and difficult to interpret,34,35 evidence suggests that elective terminations might have a significant impact on the epidemiology of live born infants with DS.36,37 If the presence of severe comorbid conditions such as major CHD factor into the decision to terminate, the observed decreasing trends in the decision to terminate a pregnancy with a positive diagnosis of DS could be the result of more fetuses with less complicated health profiles being carried to term. This potential scenario would lead to a live birth population with an overall higher likelihood of survival, but the extent to which this might contribute to the recent improvements in survival among children with DS is not clear.

Survival in the United States compares favorably for both short- and long-term survival of individuals with DS. The 93% infant survival in the United States was higher than that reported in the United Kingdom (88%).38 Australia (92%),8 Ireland (88%),20 Italy (80%),21 and Denmark (85%).39 The 10-year survival of 91% in the United States was also higher than estimates elsewhere, which ranged from 82% to 85%,6,20,37 and the 20-year survival rate of 88% was higher than reported elsewhere.37 International comparisons should be made with some caution because differences in ascertainment methods, the time period of observation, and disposition for elective terminations could account for some of the observed differences in infant survival.4,40 However, comparison of the longer-term survival estimates that are likely to be less affected by such factors can become particularly important in planning for health services to address specialized health and social services needs of children, adolescents, and adults with DS. In particular, about half of children with DS have major comorbid conditions such as CHD for which access to timely and quality health care services is critically important not only for survival but also to ensure a reasonable quality of life.

**CONCLUSIONS**

Survival of individuals with DS has improved over the past 20 years, and the racial and ethnic disparities have diminished, particularly during infancy, potentially as the result of improved access to health care services; however, non-Hispanic blacks still appear to be at greater risk of mortality throughout childhood and adolescence. Improved surgical and medical management of CHD and issues related to low birth weight have contributed to the overall improved survival of those with DS, yet significant risks are still associated with these factors. Population-based survival analyses to date have been limited to the evaluation of demographic and clinical factors present at birth. Linkage of population-based birth defects surveillance data with additional data sources such as hospital discharge data would provide a powerful tool to examine the impact of health care access, quality, and utilization on health outcomes of individuals with DS.

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(Continued from first page)
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*Pediatrics* 2013;131;e27; originally published online December 17, 2012; DOI: 10.1542/peds.2012-1616

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