

# Triplet Pregnancies: Clinical Management, Fetal Reduction, and Perinatal Outcomes in a Tertiary Referral Center

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## Research Article

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# Abstract

**Background:** Triplet pregnancies are associated with high rates of prematurity, low birth weight, and neonatal morbidity. However, the influence of fetal reduction and chorionicity on perinatal and follow-up outcomes remains uncertain. This study aimed to describe maternal, obstetric, neonatal, and follow-up outcomes of triplet pregnancies and to evaluate outcomes according to fetal reduction status and chorionicity.

**Methods:** This retrospective cohort study included 60 triplet pregnancies between January 2020 and November 2025. Maternal, obstetric, neonatal, and follow-up data were analyzed according to fetal reduction status and chorionicity.

**Results:** Fetal reduction was performed in 22 pregnancies (36.7%). Pregnancies managed with fetal reduction had a higher gestational age at delivery ( $34.1 \pm 3.5$  vs.  $31.1 \pm 3.6$  weeks,  $p=0.008$ ). Infants in the reduction group had greater birth weights ( $1994.5 \pm 610.0$  g vs.  $1469.2 \pm 548.3$  g,  $p<0.001$ ) and lower rates of low birth weight (71.4% vs. 97.6%,  $p<0.001$ ), neonatal intensive care unit admission (67.9% vs. 91.7%,  $p=0.004$ ), and retinopathy of prematurity (0.0% vs. 20.8%,  $p=0.009$ ). Survival at last available follow-up was numerically higher following fetal reduction (96.4% vs. 80.5%,  $p=0.069$ ). Survival rates according to chorionicity were 63.6%, 84.3%, and 88.7% in monochorionic, dichorionic, and trichorionic pregnancies, respectively ( $p=0.115$ ).

**Conclusions:** Fetal reduction was associated with later delivery and improved short-term neonatal outcomes. These findings highlight the importance of considering both fetal reduction status and chorionicity when counseling and managing triplet pregnancies.

## Introduction

Multiple pregnancies are high-risk pregnancies associated with increased maternal, fetal, and neonatal morbidity compared with singleton pregnancies [1]. The risk increases with fetal number, and triplet pregnancies represent one of the most challenging forms of high-order multiple gestation [2, 3]. Despite advances in obstetric and neonatal care, triplet pregnancies remain strongly associated with adverse outcomes, including preterm birth, low birth weight, fetal growth restriction, neonatal intensive care unit admission, and perinatal mortality [1, 4].

The incidence of triplet pregnancies has increased with delayed childbearing and the widespread use of assisted reproductive technologies [5]. As a result, understanding the clinical characteristics and outcomes of triplet gestations remains important for optimizing antenatal surveillance and perinatal management. Chorionicity is a major determinant of pregnancy risk and influences both counseling and clinical follow-up in triplet pregnancies [6, 7].

Management strategies include expectant follow-up and fetal reduction in selected cases. Fetal reduction remains a complex clinical decision requiring individualized counseling regarding potential

benefits and procedure-related risks. Previous studies have suggested that reduction of triplet pregnancies may improve certain perinatal outcomes, although results may vary according to chorionicity and clinical circumstances [4, 7].

The aim of the present study was to describe maternal, obstetric, neonatal, and follow-up outcomes in a cohort of triplet pregnancies managed at a tertiary referral center and to evaluate outcomes according to fetal reduction status and chorionicity.

## **Materials And Methods**

### **Study Design and Population**

This retrospective cohort study included all triplet pregnancies managed at a tertiary referral perinatal center between January 2020 and November 2025. Maternal, obstetric, fetal, neonatal, and follow-up data were retrieved from electronic medical records. All triplet pregnancies managed during the study period were eligible for inclusion. Analyses were performed using available data for each variable and outcome.

### **Data Collection**

Maternal demographic characteristics, obstetric history, conception method, chorionicity, amnionicity, pregnancy complications, delivery characteristics, neonatal outcomes, and postnatal follow-up data were collected.

Maternal variables included age, gravidity, parity, previous cesarean section history, blood group, Rh status, use of assisted reproductive technologies, cervical cerclage, chorionicity, and amnionicity. Pregnancy-related variables included preterm premature rupture of membranes, pregnancy loss before viability, maternal postpartum length of hospital stay, gestational age at delivery, mode of delivery, and indications for delivery.

Fetal and neonatal variables included congenital anomalies, fetal reduction procedures, intrauterine fetal demise/exitus, spontaneous abortion, birth weight, Apgar scores, umbilical artery pH, base excess, neonatal intensive care unit admission, respiratory distress syndrome, sepsis, retinopathy of prematurity, necrotizing enterocolitis (NEC), postnatal mortality, and neurodevelopmental outcomes during follow-up.

### **Definitions**

Chorionicity and amnionicity were determined according to first-trimester ultrasonographic findings and confirmed by delivery records when available. Fetal reduction was defined as intentional reduction of one or more fetuses because of fetal anomaly, multifetal pregnancy reduction, or pregnancy-related complications.

Survival at last available follow-up was defined as survival among live-born infants with available postnatal follow-up data. Spontaneous abortion was defined as fetal loss before 20 weeks of gestation, whereas intrauterine fetal demise (IUFD) was defined as fetal demise at or after 20 weeks of gestation, including demise of a single fetus in an ongoing multiple pregnancy. Survival status at last available follow-up was compared using live-born infants with available outcome data as the denominator.

### **Ethics approval and consent to participate**

The study protocol was approved by the Institutional Review Board (IRB) of Ankara Bilkent City Hospital (approval date and number: 25/11/2025 and TABED 2-25-1645). The requirement for informed consent was waived by the IRB due to the retrospective nature of the study. All procedures were conducted in accordance with the Declaration of Helsinki. The study was conducted and reported in accordance with the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) guidelines.

### **Statistical Analysis**

Statistical analyses were performed using IBM SPSS Statistics version 23.0 (IBM Corp., Armonk, NY, USA). The study consisted of three analytical components. First, descriptive analyses were performed for the entire triplet pregnancy cohort. Second, maternal, obstetric, neonatal, and follow-up outcomes were compared between pregnancies managed with and without fetal reduction. Third, survival at last available follow-up was evaluated according to chorionicity and fetal reduction status. Continuous variables were presented as mean  $\pm$  standard deviation or median (minimum–maximum), according to data distribution. Categorical variables were expressed as number and percentage. Comparisons between reduction and non-reduction groups were performed using Student's t-test or the Mann–Whitney U test for continuous variables and Pearson's chi-square test or Fisher's exact test for categorical variables, as appropriate. Survival at last available follow-up according to chorionicity and fetal reduction status was compared using Pearson's chi-square test or Fisher's exact test, as appropriate. A two-sided p value  $<0.05$  was considered statistically significant.

## **Results**

A total of 60 triplet pregnancies were included in the study, comprising 180 fetuses. Maternal, pregnancy, obstetric, neonatal, and follow-up data were retrospectively evaluated. Fetal reduction was performed in 22 pregnancies (36.7%), involving 31 fetuses. The distribution of maternal and pregnancy characteristics is presented in Table 1.

The mean maternal age was  $31.6 \pm 6.6$  years. Mean gravidity and parity were  $1.9 \pm 1.2$  and  $0.47 \pm 0.68$ , respectively. Most women were Rh positive (85.0%), and blood group A was the most common blood type (46.7%). Assisted reproductive techniques were used in the majority of pregnancies, with in vitro fertilization accounting for 56.7% of conceptions. Fetal reduction was performed in 22 pregnancies; reduction of one fetus was carried out in 13 pregnancies, whereas reduction of two fetuses was performed in 9 pregnancies. Cervical cerclage was applied in 3 pregnancies (5.0%). Regarding

chorionicity, 6 pregnancies (10.0%) were monochorionic, 30 (50.0%) were dichorionic, and 24 (40.0%) were trichorionic (Table 1).

### **Obstetric and Perinatal Outcomes**

The mean gestational age at delivery was  $32.2 \pm 3.8$  weeks. Preterm premature rupture of membranes occurred in 9 pregnancies (16.7%) at a mean gestational age of  $25.4 \pm 6.3$  weeks. Pregnancy loss before viability occurred in 8 pregnancies (13.3%). Delivery data were available for 51 pregnancies. Cesarean section was the predominant mode of delivery, accounting for 92.2% of births, whereas vaginal delivery occurred in 7.8% of cases. The most common indication for delivery was spontaneous preterm labor (64.7%), followed by spontaneous term labor (13.7%), fetal distress (9.8%), and severe preeclampsia (7.8%) (Table 2).

### **Fetal Anomalies and Fetal Reduction Characteristics**

At least one fetal anomaly was identified in 14 of 60 pregnancies (23.3%). Among pregnancies with fetal anomalies, a single anomalous fetus was present in 10 pregnancies, whereas multiple anomalous fetuses were present in the remaining pregnancies. Overall, 19 fetuses were diagnosed with congenital anomalies. Hydrops fetalis was the most common anomaly, accounting for 31.6% of anomalous fetuses, followed by cystic hygroma or increased nuchal translucency (21.1%). Cardiac anomalies and abdominal wall defects each accounted for 15.8% of all anomalies.

Fetal reduction was performed in 22 pregnancies involving 31 fetuses. The most frequent indication was elective selective reduction (58.1%), followed by cystic hygroma or hydrops fetalis (16.1%), stage III–IV twin-to-twin transfusion syndrome (12.9%), abdominal wall defects (9.7%), and urinary tract anomalies (3.2%) (Table 3).

### **Comparison According to Fetal Reduction Status**

Maternal demographic characteristics did not significantly differ between pregnancies managed with and without fetal reduction. Maternal age, gravidity, parity, and abortion history were comparable between groups. Similarly, the frequencies of fetal anomalies, preterm premature rupture of membranes, pregnancy loss, twin-to-twin transfusion syndrome, and IUFD did not significantly differ.

Pregnancies managed with fetal reduction had a significantly shorter maternal postpartum length of hospital stay than non-reduced pregnancies ( $2.3 \pm 1.1$  vs.  $3.9 \pm 3.0$  days,  $p=0.017$ ). Fetal reduction status was also associated with a significantly higher gestational age at delivery ( $34.1 \pm 3.5$  vs.  $31.1 \pm 3.6$  weeks,  $p=0.008$ ).

Delivery characteristics differed significantly between groups ( $p=0.007$ ). Spontaneous preterm labor was more frequent in non-reduced pregnancies (78.1% vs. 42.1%), whereas term delivery occurred more commonly in pregnancies managed with fetal reduction (31.6% vs. 3.1%) (Table 4).

## Neonatal and Follow-Up Outcomes According to Fetal Reduction Status

Neonatal outcomes are summarized in Table 5. Infants in the reduction group had significantly greater birth weights than those in the non-reduction group ( $1994.5 \pm 610.0$  g vs.  $1469.2 \pm 548.3$  g,  $p < 0.001$ ). Gestational age at delivery was also significantly higher in the reduction group ( $34.1 \pm 3.5$  vs.  $31.1 \pm 3.6$  weeks,  $p = 0.008$ ).

The incidence of low birth weight was significantly lower in the reduction group (71.4% vs. 97.6%,  $p < 0.001$ ). Likewise, neonatal intensive care unit admission was less frequent in the reduction group (67.9% vs. 91.7%,  $p = 0.004$ ). Retinopathy of prematurity occurred exclusively in the non-reduction group (20.8% vs. 0%,  $p = 0.009$ ). No statistically significant differences were observed regarding respiratory distress syndrome, sepsis, necrotizing enterocolitis (NEC), congenital anomalies, or postnatal mortality.

Follow-up outcomes were evaluated among infants with available follow-up data. Follow-up duration ranged from 3 to 62 months. Three infants had a follow-up duration of 3 months, 26 had 12 months, 31 had 13–24 months, 37 had 25–48 months, and 18 had more than 48 months of follow-up. Overall, 55 of 115 children (47.8%) were followed for more than 24 months. Median follow-up duration did not differ significantly between the reduction and non-reduction groups (20 [3–56] vs. 26 [3–62] months,  $p = 0.846$ ). Neurodevelopmental delay, cerebral palsy, and epilepsy were uncommon and showed no statistically significant differences between groups.

Among infants who died postnatally, the median survival time was 12 days (range, 1–497 days). One infant survived for 497 days and subsequently died following complications related to intestinal surgery.

In addition, delivery before 32 weeks occurred significantly less frequently in the reduction group than in the non-reduction group (24.1% vs. 49.5%,  $p = 0.017$ ). Birth weight below 1000 g was observed exclusively in the non-reduction group (25.3% vs. 0.0%,  $p = 0.003$ ). Infants weighing less than 1500 g were also less frequent in the reduction group (27.6% vs. 45.1%), although this difference did not reach statistical significance ( $p = 0.096$ ). Fetal sex distribution was similar between groups (female: 55.2% vs. 53.8%,  $p = 0.901$ ).

In the dichorionic subgroup, survival at last available follow-up was numerically higher in the reduction group than in the non-reduction group (100% vs. 78.9%); however, this difference was not statistically significant (Fisher's exact test,  $p = 0.096$ ).

## Survival at Last Available Follow-Up According to Chorionicity and Fetal Reduction

Figures 1 and 2 summarize the distribution of triplet pregnancies according to chorionicity and fetal reduction status, together with fetal losses, live births, and survival at last available follow-up. A total of 180 fetuses were evaluated. Of these, 31 underwent fetal reduction, 5 experienced IUFD, 14 resulted in spontaneous abortion, and outcome data were unavailable for 15 fetuses. Overall, 115 infants were live-born, of whom 97 were alive at the last available follow-up.

Fetal reduction was performed in 1 of 6 monochorionic pregnancies (16.7%), 13 of 30 dichorionic pregnancies (43.3%), and 8 of 24 trichorionic pregnancies (33.3%).

Among monochorionic pregnancies (n=6), fetal reduction was performed in one pregnancy because of a structural abnormality. The two remaining fetuses from this pregnancy were live-born and were alive. No cases of IUFD or spontaneous abortion were observed in this group. Among the five non-reduced pregnancies, outcome data were unavailable for six fetuses, whereas nine fetuses resulted in live birth, of whom five were alive at the last available follow-up. Overall, 11 live births and 7 survivors at last available follow-up were recorded in the monochorionic group. One pregnancy involving all three fetuses was affected by structural anomalies; however, outcome data for this pregnancy were incomplete. In addition, one surviving infant with a structural cardiac anomaly remains alive and under follow-up.

Among dichorionic pregnancies (n=30), 17 pregnancies were not reduced and 13 underwent fetal reduction. In the reduction group, 21 fetuses were reduced. Among non-reduced dichorionic pregnancies, 38 infants were live-born, of whom 30 were alive at the last available follow-up, whereas 8 died postnatally, including 2 infants with structural anomalies. In this subgroup, spontaneous abortion occurred in 6 fetuses, IUFD occurred in 4 fetuses, and outcome data were unavailable for 3 fetuses who had reached 28 weeks of gestation. In the reduced dichorionic subgroup, 13 infants were live-born and all were alive at the last available follow-up. In addition, 1 fetus had no available data after the first trimester, 1 fetus experienced IUFD, and 3 fetuses resulted in spontaneous abortion.

Among trichorionic pregnancies (n=24), fetal reduction was performed in 8 pregnancies, involving 9 fetuses. Structural anomalies were identified in 5 fetuses that underwent fetal reduction. In one additional pregnancy, two fetuses were reduced for maternal indications due to chronic hypertension and a pulmonary embolism occurring during the first trimester. Among non-reduced trichorionic pregnancies (n=16), no cases of IUFD were observed, whereas 5 fetuses experienced spontaneous abortion. Outcome data were unavailable for 3 fetuses who had reached 27 weeks of gestation. A total of 40 infants were live-born, of whom 35 were alive at the last available follow-up. In the reduced trichorionic subgroup, no cases of IUFD or spontaneous abortion occurred. Outcome data were unavailable for 2 fetuses after the first trimester. Overall, 13 infants were live-born, of whom 12 were alive at the last available follow-up.

Survival at last available follow-up differed numerically among chorionicity groups but did not reach statistical significance (63.6% in monochorionic, 84.3% in dichorionic, and 88.7% in trichorionic pregnancies;  $p=0.115$ ) (Table 6).

When pregnancies were categorized according to fetal reduction status, survival at last available follow-up was observed in 70 of 87 live-born infants (80.5%) in the non-reduction group and in 27 of 28 live-born infants (96.4%) in the reduction group ( $p=0.069$ ) (Table 7).

## Discussion

In this retrospective cohort of 60 triplet pregnancies comprising 180 fetuses, we evaluated maternal, obstetric, neonatal, and follow-up outcomes according to fetal reduction status and chorionicity. The main findings were that pregnancies managed with fetal reduction had a higher gestational age at delivery, greater birth weight, lower rates of low birth weight, lower neonatal intensive care unit admission, and lower retinopathy of prematurity. Survival at last available follow-up was numerically higher in the reduction group, although this difference did not reach statistical significance. Similarly, survival differed numerically according to chorionicity, with the lowest rate in monochorionic pregnancies and the highest rate in trichorionic pregnancies, but this comparison was also not statistically significant.

Triplet pregnancies remain one of the highest-risk forms of multiple gestation. Recent studies have suggested that fetal reduction may improve perinatal outcomes in triplet pregnancies by reducing the risk of severe prematurity and very low birth weight, two major determinants of neonatal morbidity and mortality [8-11]. In our cohort, pregnancies managed with fetal reduction were delivered at later gestational ages and had higher birth weights, findings that may partly explain the lower rates of adverse neonatal outcomes observed in this group. However, because reduction was performed for heterogeneous indications, including both elective and medically indicated procedures, these findings should be interpreted cautiously. Chorionicity, fetal anomalies, parental preference, and indication for reduction may all have influenced both management decisions and subsequent outcomes.

Chorionicity is another central determinant of risk in triplet pregnancies, influencing surveillance, counseling, and perinatal outcomes. Systematic review and meta-analysis data have shown that non-trichorionic triplet pregnancies, particularly those with a monochorionic component, may have higher risks of perinatal mortality, neonatal morbidity, and neonatal intensive care admission compared with trichorionic triamniotic pregnancies [3, 8]. In our study, survival at last available follow-up was lowest in monochorionic pregnancies and highest in trichorionic pregnancies. Although this difference did not reach statistical significance, the direction of the finding is consistent with the published literature.

The lack of statistical significance in chorionicity-based survival analysis should be interpreted cautiously. Triplet pregnancies are rare, and subgroup analyses according to chorionicity are often limited by small numbers, a limitation that was particularly relevant for the monochorionic group in our cohort, which included only six pregnancies. Nevertheless, previous studies have reported poorer perinatal outcomes in triplet pregnancies with a monochorionic component compared with trichorionic pregnancies [12, 13]. Management of triplet pregnancies with a monochorionic component also remains clinically challenging, and studies of monochorionic triamniotic triplets have compared expectant management with fetal reduction because of the specific risks related to shared placentation [14]. Therefore, the numerically lower survival observed in our monochorionic group compared with dichorionic and trichorionic pregnancies may still be clinically relevant despite the absence of statistical significance.

In the dichorionic subgroup, survival at last available follow-up was numerically higher among pregnancies that underwent fetal reduction than among those managed expectantly, although the difference did not reach statistical significance. Because of the small number of cases, this finding should be interpreted cautiously and should not be considered evidence of a definitive benefit. Nevertheless, the numerical difference suggests that outcomes after fetal reduction in dichorionic triplet pregnancies may warrant further evaluation. This interpretation is consistent with previous evidence suggesting that, in dichorionic triplets, reduction of the monochorionic pair to achieve a singleton pregnancy may be considered because of the additional risks associated with a monochorionic component [4, 12, 15]. However, management of triplet pregnancies remains controversial. In a large cohort of trichorionic triplet pregnancies, Lee et al. reported that expectant management was associated with higher fetal survival, despite a higher risk of preterm birth, compared with multifetal pregnancy reduction [7]. Larger studies are needed to clarify whether the effect of fetal reduction differs according to chorionicity and to compare outcomes after reduction to singleton versus reduction to twin gestations.

Neonatal outcomes in our cohort further support the importance of prematurity and birth weight as key mediators of outcome [16]. Infants in the reduction group had higher birth weights, lower rates of low birth weight, lower NICU admission, and lower ROP. Delivery before 32 weeks and birth weight below 1000 g were also less frequent after reduction, whereas birth weight below 1500 g and postnatal mortality were numerically lower but did not reach statistical significance. This pattern is consistent with prior studies showing that neonatal morbidity in triplet pregnancies is largely driven by early gestational age and low birth weight [2, 12, 13]. However, not all neonatal outcomes differed significantly between groups, suggesting that the observed benefit may be concentrated mainly in prematurity-related outcomes.

Follow-up data represent an important aspect of the present study. Because follow-up duration varied among infants, we used the term survival at last available follow-up rather than long-term survival. Follow-up extended up to 62 months, with approximately half of the children followed beyond 24 months, and median follow-up duration did not differ significantly between the reduction and non-reduction groups. Survival at last available follow-up was numerically higher in the reduction group and in trichorionic pregnancies, but neither comparison reached statistical significance. Neurodevelopmental delay, cerebral palsy, and epilepsy were uncommon and did not differ significantly according to fetal reduction status. This finding contrasts with Lee et al., who reported a higher risk of developmental delay in the multifetal pregnancy reduction group in a large cohort of trichorionic triplet pregnancies [7]. Differences in study population, chorionicity distribution, reduction indications, timing and type of reduction, and neurodevelopmental assessment may explain this discrepancy. Given the small number of adverse neurodevelopmental events in our cohort, these findings should be interpreted cautiously.

Higher-order multifetal pregnancies are associated with substantial obstetric complexity and often require increased antenatal surveillance and hospitalization because of the elevated risk of maternal and pregnancy-related complications [2, 17, 18]. In our cohort, rates of PPROM, pregnancy loss, TTTS, and

intrauterine fetal demise were similar between groups. Nevertheless, pregnancies managed with fetal reduction had a shorter maternal postpartum length of hospital stay. Although the reasons for hospitalization were not specifically available in our dataset, the reduction group was characterized by lower rates of spontaneous preterm labor and higher rates of term delivery, which may have contributed to this finding.

## **Strengths and Limitations**

This study has several limitations. First, it was retrospective and conducted at a single tertiary referral center. Second, the sample size was limited, particularly for subgroup analyses according to chorionicity and fetal reduction status. Third, indications for fetal reduction were heterogeneous, including elective reduction and reduction because of fetal anomaly or pregnancy-related complications. Fourth, some outcome data were unavailable, and survival analyses were therefore performed using available outcome data. Finally, because fetal reduction was not randomly assigned, residual confounding by indication, chorionicity, fetal anomaly, and parental preference cannot be excluded. Despite these limitations, the study provides detailed real-world data on triplet pregnancies, including fetal reduction status, chorionicity, neonatal outcomes, and survival at last available follow-up.

## **Conclusion**

Triplet pregnancies remain high-risk pregnancies requiring individualized counseling and close perinatal surveillance. In this cohort, fetal reduction was associated with later delivery, higher birth weight, lower NICU admission, and lower ROP. Survival at last available follow-up was numerically higher in the reduction group and in trichorionic pregnancies, although these differences were not statistically significant. These findings support the importance of evaluating triplet pregnancies according to both fetal reduction status and chorionicity.

## **Abbreviations**

ART: Assisted reproductive technology

IUFD: Intrauterine fetal demise

IUI: Intrauterine insemination

IVF: In vitro fertilization

NEC: Necrotizing enterocolitis

NICU: Neonatal intensive care unit

PPROM: Preterm premature rupture of membranes

ROP: Retinopathy of prematurity

TTTS: Twin-to-twin transfusion syndrome

## Declarations

### Ethics approval and consent to participate

The study protocol was approved by the Institutional Review Board (IRB) of Ankara Bilkent City Hospital (approval date and number: 25/11/2025 and TABED 2-25-1645). Obtaining informed consent was waived by the Ankara Bilkent City Hospital IRB because of the study's retrospective design. All the procedures were conducted in compliance with the Declaration of Helsinki. Analysis and reporting of the results are in compliance with the Strengthening the Reporting of Observational Studies in Epidemiology checklist.

### Consent for publication

Not applicable.

### Availability of data and materials

The datasets used and/or analyzed during the current study are available from the corresponding author on reasonable request.

### Competing interests

The authors declare that they have no competing interests.

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This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

### Authors' contributions

GRT contributed to the conceptualization and design of the study, data collection, statistical analysis, interpretation of the data, and drafting of the manuscript. HA contributed to the study design, interpretation of the data, and critical revision of the manuscript. FCE and EI contributed to data acquisition and interpretation of the data. EBB contributed to data collection, interpretation of the data, and critical revision of the manuscript. DS supervised the study and contributed to the interpretation of the data and critical revision of the manuscript. All authors read and approved the final manuscript and agreed to be accountable for all aspects of the work.

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Tables

Tables are available in the Supplementary Files section.

Figures

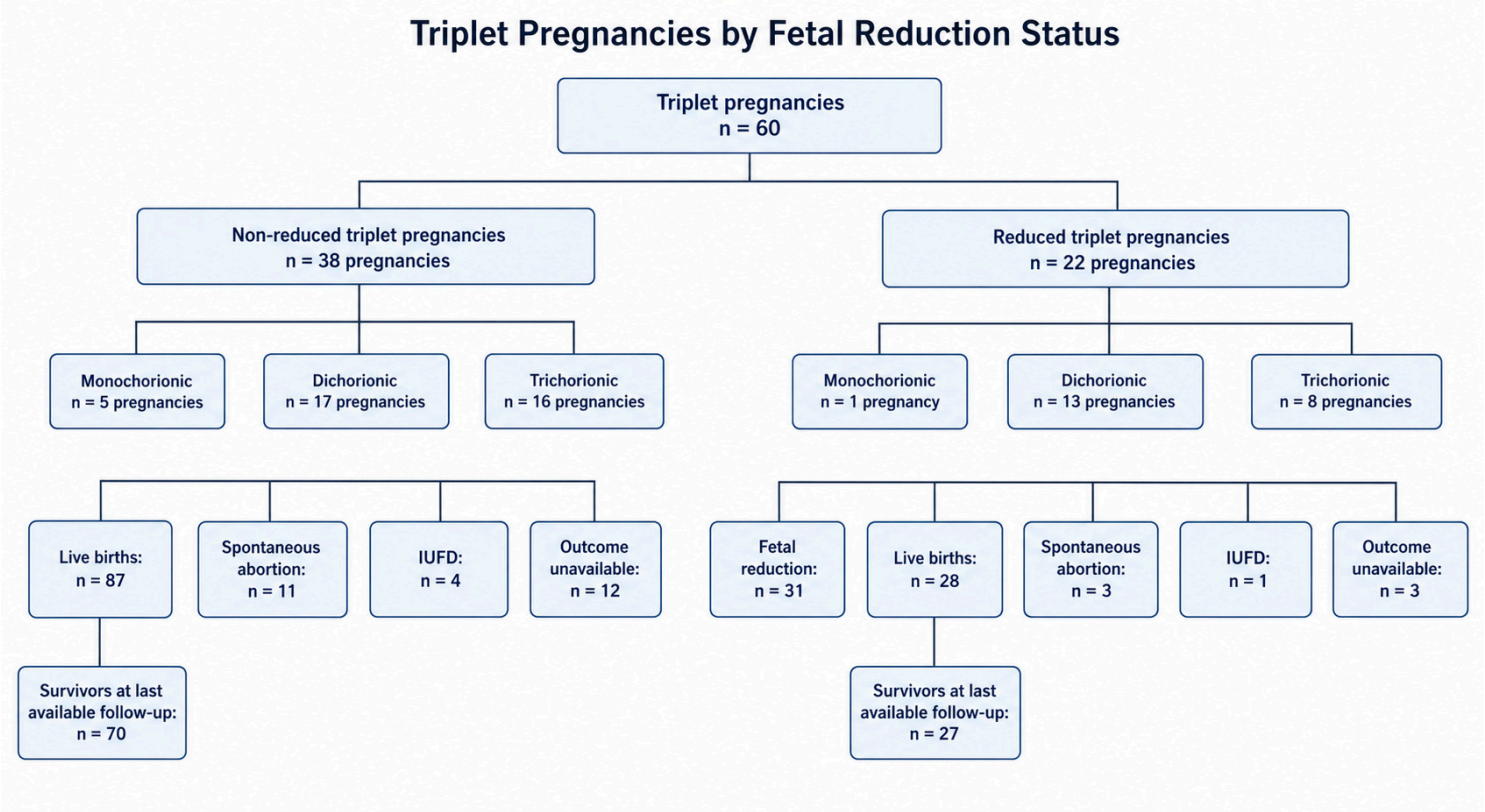


Figure 1

Triplet pregnancies by fetal reduction status.

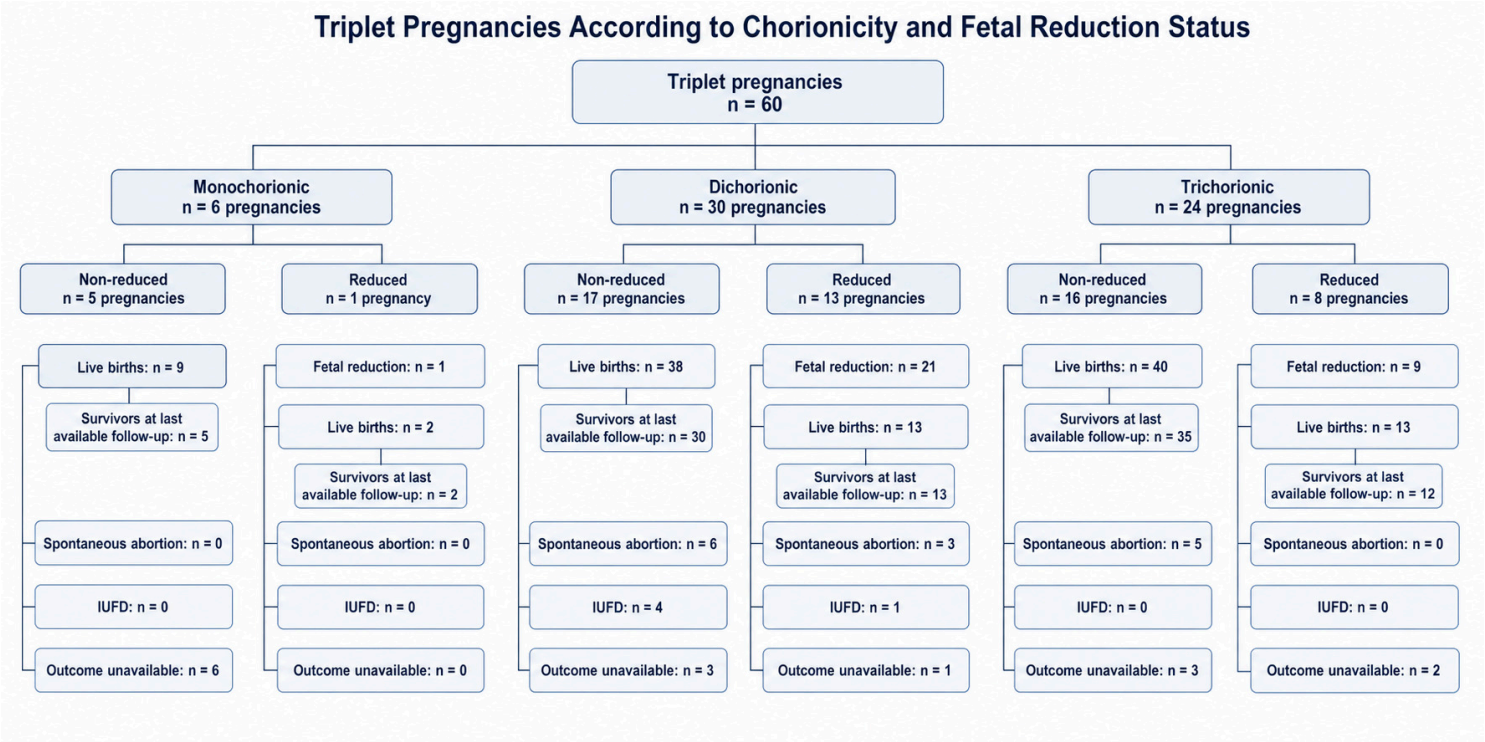


Figure 2

Triplet pregnancies according to chorionicity and fetal reduction status.

## Supplementary Files

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