Periconception folic acid supplementation, fetal growth and the risks of low birth weight and preterm birth: the Generation R Study

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(Countries worldwide, including the Netherlands, recommend that women planning pregnancy use a folic acid supplement during the periconception period. Some countries even fortify staple foods with folic acid. These recommendations mainly focus on the prevention of neural tube defects, despite increasing evidence that folic acid may also influence birth weight. We examined whether periconception folic acid supplementation affects fetal growth and the risks of low birth weight, small for gestational age (SGA) and preterm birth, in the Generation R Study in Rotterdam, the Netherlands. Main outcome measures were fetal growth measured in mid- and late pregnancy by ultrasound, birth weight, SGA and preterm birth in relation to periconception folic acid supplementation (0.4–0.5 mg). Data on 6353 pregnancies were available. Periconception folic acid supplementation was positively associated with fetal growth. Preconception folic acid supplementation was associated with 68 g higher birth weight (95 % CI 37.2, 99.0) and 13 g higher placental weight (95 % CI 1.1, 25.5), compared to no folic acid supplementation. In these analyses parity significantly modified the effect estimates. Start of folic acid supplementation after pregnancy confirmation was associated with a reduced risk of low birth weight (OR 0.61, 95 % CI 0.40, 0.94). Similarly, reduced risks for low birth weight and SGA were observed for women who started supplementation preconceptionally, compared to those who did not use folic acid (OR 0.43, 95 % CI 0.28, 0.69 and OR 0.40, 95 % CI 0.22, 0.72). In conclusion, periconception folic acid supplementation is associated with increased fetal growth resulting in higher placental and birth weight, and decreased risks of low birth weight and SGA.

Folate: Birth weight: Epigenetics: Effect modification

Low birth weight, as a proxy for fetal growth, is associated with various chronic diseases later in life1,2. Fetal growth depends on multiple genetic factors and environmental exposures, derived from the mother. In this respect, maternal nutrition during pregnancy has been shown to play a critical role3,4,5,6.

Because developing organ systems directly respond with permanent adaptations to the availability of nutrients during critical periods of rapid development, timing of adequate maternal nutrition is important to determine the effects both in the fetus and child7,8. Moreover, first evidence has suggested that fetal growth is vulnerable to maternal nutrition, especially during the preconception period and first weeks of gestation, since it has the potential to affect epigenetic mechanisms in the placenta and fetus9. Folate is for this reason of great interest. Together with vitamin B12, it plays a critical role in homocysteine metabolism. The folate-dependent homocysteine pathway is important for protein, lipid and DNA synthesis. In addition, folate provides methyl groups for the synthesis of methionine and its derivate S-adenosyl-methionine. The latter is the most important methyl donor in the human body for DNA methylation, and represents one of the best known epigenetic mechanisms10,11.

During pregnancy folate demand increases because of placental and fetal growth and development10. For this reason pregnant women with a folate deficiency are at an increased risk for various reproductive failures, including neural tube defects and congenital malformations12–16. As a consequence, most European countries, including the Netherlands, recommend that women planning pregnancy use a folic acid supplement during the periconception period in addition to a healthy diet17,18. Several studies have shown positive associations between maternal folate intake and fetal growth19–27. However, the majority of these studies were focused on the effects of folate acid on fetal growth in mid- and late pregnancy. Only few studies assessed the associations

Abbreviation: SGA, small for gestational age.
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in early pregnancy and failed to be consistent\(^{(23,28)}\). Thus, despite the fact that early pregnancy is the most important period for placental development, embryogenesis and fetal programming, relatively little is known about the implications of folic acid supplementation during this particular pregnancy period on fetal growth\(^{(7,8,29,30)}\).

The aim of the present study was to investigate the effects of low-dose periconception folic acid supplementation on fetal and placental growth in low-risk singleton pregnancies. Also, we studied the associations between periconception folic acid intake and low birth weight, small for gestational age (SGA) and preterm birth.

**Methods**

**Design**

The study was embedded in the Generation R Study, Rotterdam, the Netherlands, a population-based prospective cohort study from early pregnancy onwards. The Generation R Study was designed to identify early environmental and genetic determinants of growth, development and health from fetal life until young adulthood. The Generation R Study is conducted in Rotterdam, the second largest city in the Netherlands, and eligible women were those who were resident in the study area and delivered between April 2002 and January 2006. The study aimed to enrol women in early pregnancy (gestational age <18 weeks), but enrolment was possible until the birth of the child. All midwifery practices and three hospitals located in the study area participated during the prenatal phase. The overall response rate was about 61 %, and is based on the number of children born to eligible mothers during the inclusion period. The Medical Ethics Committee of the Erasmus Medical Centre has approved the study, and all participants gave their written informed consent\(^{(31,32)}\).

**Folic acid use**

Pregnant women were asked by questionnaire at enrolment (median 15.4 weeks of gestation, 95 % range 10.2–24.8) whether they had used a folic acid supplement periconceptionally (folic acid dosage of 0.4–0.5 mg/d, according to the advice of the Health Council of the Netherlands), and when supplementation was started\(^{(33,34)}\). Self-reported folic acid use was categorized into three groups: (1) preconception start: defined as preconception start of folic acid supplement intake at any moment prior to conception; (2) start before 8 weeks: defined as start of folic acid supplementation from the moment that pregnancy was recognized but before the eighth week of gestation; and (3) no use: defined as no use of folic acid supplementation at all. Because our interest was mainly focused on start, and use, of folic acid supplementation during the period just before and after conception, i.e., the periconception period, we did not include women who only started folic acid supplementation after the eighth week of gestation in our main analysis (n = 46). However, because this group may present an interesting comparison group, we did include them in a sensitivity analysis. About 15 % of the women reported to have used folic acid as part of a multivitamin supplement regimen. The doses of folic acid in these multivitamins were approximately 0.4–0.5 mg/d.

**Fetal ultrasonography**

Fetal ultrasound examinations were carried out in early pregnancy (median 13.5 week of gestation, 95 % range 10.6–17.5), mid-pregnancy (median 20.6 weeks of gestation, 95 % range 18.6–23.4) and late pregnancy (median 30.4 weeks of gestation, 95 % range 28.4–33.0). The ultrasound examinations were used for establishing both gestational age and fetal growth characteristics\(^{(35)}\). Fetal biometry, including head circumference, biparietal diameter, abdominal circumference and femur length, was measured transabdominally during each ultrasound examination. Crown–rump length was measured in early pregnancy. Dating of pregnancy was performed using the first ultrasound measurement of either crown–rump length (gestational age until 12 weeks and 5 d of gestation, and crown–rump length measurement smaller than 65 mm), or biparietal diameter (gestational age from 12 weeks and 5 d of gestation onwards, and biparietal diameter larger than 23 mm)\(^{(35)}\). Estimated fetal weight was calculated for mid- and late pregnancy using the formula of Hadlock \textit{et al.} \(^{(36)}\). Longitudinal growth curves and gestational age-adjusted standard deviation scores were constructed for all fetal growth measurements. These gestational age-adjusted standard deviation scores were based on reference growth curves from the whole study population, and represent the equivalent of z-scores\(^{(35)}\).

**Birth outcomes**

Medical records completed by community midwives and obstetricians were used to obtain information about gestational age at birth (weeks), birth weight (g), gender and placental weight (g), and to calculate placental index (placental weight/birth weight)\(^{(37,38)}\). Prematurity was defined as the birth of an infant before 37.0 weeks of gestation, and low birth weight was defined as a birth weight <2500 g. Being SGA was defined as a standard deviation score ≤−2.3 (<5th percentile) and based on standard deviation curves derived from this cohort\(^{(35)}\).

**Covariates**

Information about maternal age, educational level, ethnicity, smoking and parity was obtained from the questionnaire at enrolment in the study. Educational level was assessed by the highest completed educational level of the mother and classified into two categories: (1) primary school; and (2) secondary school, university or college\(^{(32,39)}\). Ethnic background was defined from information from the country of birth of the woman herself and her parents and categorized as follows: (1) western, including Dutch, European, North American, and Oceanian; (2) Moroccan; (3) Turkish; (4) Antillean and Surinamese; and (5) other non-Western, including African, Asian, South American and Central American\(^{(32,40)}\). At the first ultrasound examination, maternal height (m) and weight (kg) were measured and BMI (in kg/m\(^2\)) was calculated. Information on fertility treatment and pregnancy complications, including pre-eclampsia and gestational diabetes, was obtained from midwives and obstetricians. Women who became pregnant after fertility treatment, including in vitro fertilization and intracytoplasmatic sperm-injection, were excluded from analyses.
Statistical analyses

First, independent Student’s t test and Mann–Whitney U test were used to test differences in characteristics between women who used periconception folic acid and women who did not use a folic acid supplement. Next, associations of folic acid supplementation with fetal growth characteristics (head circumference, abdominal circumference, femur length, estimated fetal weight) and birth characteristics (birth weight, placental weight) in low-risk singleton pregnancies were assessed using univariate linear regression models (model A). The linear regression analyses that were based on fetal growth characteristics (head circumference, abdominal circumference, femur length and estimated fetal weight) were restricted to those mothers who enrolled and had their pregnancies dated in early pregnancy (78%). The consideration of confounding variables in our analyses was primarily determined a priori and based on earlier literature. These included time of enrolment in study, gestational age, maternal age, height, weight, parity, ethnicity, fetal gender, educational level, smoking, alcohol use, primary or secondary antenatal care, gestational diabetes and pre-eclampsia\(^{41,42}\). Potential confounders were selected as a result of exploratory analyses and were included in the analyses if the effect estimates of the fetal growth parameters changed more than 10%. By using this approach, type of antenatal care, alcohol consumption, pre-eclampsia and gestational diabetes were not included in the final multivariate regression model (model B). To analyse the associations of folic acid supplementation with the risks of low birth weight, SGA and preterm birth, we used univariate and multivariate logistic regression models, with a similar approach to select confounders. Effect modification was tested by multiplying folic acid supplement use with the covariates educational level, ethnicity, smoking habits, parity and BMI. Subsequently, and under the condition of a \( P \) value <0·1, multivariate linear regression analyses were performed in strata of that specific determinant. Last, to test any possible associations of folic acid supplementation started after the eighth week of gestation with fetal growth, we also performed similar analyses with the cohort categorized into four groups, namely (1) preconception start; (2) start before 8 weeks; (3) start from 8 weeks onwards; and (4) no folic acid use. The size of the effect estimates (regression coefficients and OR) were presented with their 95% CI. Statistical analyses were performed using the Statistical Package of Social Sciences version 15.0 for Windows (SPSS Inc., Chicago, IL, USA).

Results

Between 2002 and 2006, 8880 women enrolled during pregnancy in the Generation R Study\(^{32}\). Forty-six women (0·5%) started using a folic acid supplement after the eighth week of gestation and information on folic acid supplementation was missing in 25% of the women (n 2274). Of the remaining 6560 women, forty-seven in vitro fertilization or intracytoplasmatic sperm-injection pregnancies, sixty-three twin pregnancies and seventy-seven fetal deaths were identified, and twenty women were lost to follow up. Data on 6353 low-risk singleton pregnancies (71·6%) were available.

Characteristics of the women per folic acid category are presented in Table 1. Of all women 39·2% (n 2493) started folic acid supplementation preconceptionally. Approximately 31% of all women (n 1983) started folic acid supplementation after pregnancy recognition, and 29·5% of the women (n 1877) did not use folic acid supplementation at all. The age of the cohort ranged from 15·3 to 46·3 years with a median of 29·8 years, and the lowest median age was found in women who did not use folic acid (27·8 years). The percentage of women with a higher educational level was also lowest in this group (26·9%). In the whole cohort the largest ethnic groups were the Dutch and other western (63%). The percentage of women who did not use folic acid was highest among non-western women, including Moroccan, Turkish, Surinam and Antillean women (total of 71·6%).

The associations between folic acid use and fetal growth characteristics in mid- and late pregnancy are presented in Table 2. Periconception folic acid supplementation was associated with trends towards significantly larger head circumference and abdominal circumference, in mid- and late pregnancy, compared to women who did not use folic acid. In addition, similar trends towards larger femur length in mid- and late pregnancy were observed for women who periconceptionally used a folic acid supplement, compared to women who did not use folic acid. However, these effect estimates were not significant.

Figure 1 shows the differences in standard deviation scores (z-scores) of fetal weight from mid-pregnancy until birth between the three folic acid categories. No significant differences in standard deviation scores between the folic acid supplementation groups were observed for estimated fetal weight in mid-pregnancy. This effect changed over time with significantly higher estimated fetal weight in late pregnancy for women who periconceptionally started folic acid supplementation (SD 0·10, 95% CI 0·02, 0·19), and significant higher birth weight for both women who periconceptionally started folic acid supplementation and women who started after pregnancy recognition, compared to no folic acid supplementation at all (SD 0·16, 95% CI 0·09, 0·23 and SD 0·13, 95% CI 0·06, 0·20, respectively). After adjustment for potential confounders birth weight was 68 g higher in women who periconceptionally started folic acid supplementation (95% CI 37·2, 99·0) and 53 g higher in women who started supplementation after pregnancy recognition (95% CI 23·60, 83·18), compared to birth weight of newborns of women who did not use folic acid supplementation.

Table 3 shows the associations between folic acid use and placental weight. Placental weight was approximately 10 g more in women who periconceptionally started using a folic acid supplement (95% CI 0·32, 20·49) compared to placental weight of women who did not use folic acid supplementation. After adjusting for potential confounders this effect estimate did not change. For placental index, a trend was observed towards a smaller index in both women who used preconception folic acid (β = −0·004, 95% CI = −0·007, −0·002), as well as in women who started after pregnancy recognition but before the eighth week of gestation (β = −0·003, 95% CI = −0·006, −0·001), compared to women who did not use folic acid. This trend, however, was not significant anymore after adjusting for potential confounders.

Table 4 shows the associations between folic acid use and birth outcomes. Preconception start of folic acid was associated with a decreased risk of low birth weight (OR 0·47,
95% CI 0·33, 0·68) as well as a decreased risk of SGA (OR 0·38, 95% CI 0·23, 0·63), compared to women who did not use folic acid supplementation. After adjustment for potential confounders these effect estimates did not further change. In addition, after adjustment for potential confounders, start of folic acid supplementation after pregnancy recognition was also associated with a decrease of having a child with low birth weight (OR 0·61, 95% CI 0·40, 0·94), compared to women who did not use a folic acid supplement. Folic acid supplementation (either preconception start, or start after pregnancy confirmation) was not significantly associated with the risk of preterm birth after controlling for confounders.

Parity significantly modified the effect of periconceptional folic acid use on birth weight ($P < 0·001$) (Fig. 2). After adjustment for potential confounders, preconception start of folic acid among multiparous women was associated with about 240 g higher birth weight (95% CI 195-13, 282-92), compared to nulliparous women who did not use a folic acid supplement. We did not observe further significant effect modification on the multiplicative scale by educational level, ethnicity, smoking or BMI.

Last, the analysis performed to test possible associations of folic acid supplementation started after the eighth week of gestation with fetal growth, did not reveal any differences between (1) non-users, preconception users and women who started before eight weeks, and (2) folic acid supplementation from 8 weeks onwards, and similarly, no association of this latter group with fetal growth (likely due to small numbers in this group; $n\ 46$).

**Discussion**

In this prospective population-based cohort study we demonstrate that low-dose periconceptional folic acid supplementation is associated with increased fetal growth compared to non-users, and that parity significantly modifies the effect. Low-dose periconceptional folic acid supplementation is also associated with reduced risks of having a child with low birth weight or being SGA at birth. No significant association

### Table 1. Characteristics of participants in the study stratified by category of folic acid use

<table>
<thead>
<tr>
<th>Folic acid supplementation</th>
<th>No use ($n\ 1877$)</th>
<th>Start before 8 weeks ($n\ 1983$)</th>
<th>Preconception start ($n\ 2493$)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mean</strong></td>
<td><strong>SD</strong></td>
<td><strong>Mean</strong></td>
<td><strong>SD</strong></td>
</tr>
<tr>
<td><strong>Median age (years)</strong></td>
<td>27·8</td>
<td>17·0–39·2</td>
<td>29·7</td>
</tr>
<tr>
<td>Height (cm)</td>
<td>164·4</td>
<td>7·0</td>
<td>168·1</td>
</tr>
<tr>
<td>Weight (kg)</td>
<td>69·6</td>
<td>14·8</td>
<td>69·2</td>
</tr>
<tr>
<td>Multigravida (%)</td>
<td>55·8</td>
<td>37·4</td>
<td>39·1</td>
</tr>
<tr>
<td>Education (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary school</td>
<td>26·9</td>
<td>6·9</td>
<td>30·0</td>
</tr>
<tr>
<td>Secondary school, university or college</td>
<td>73·1</td>
<td>93·1</td>
<td>67·0</td>
</tr>
<tr>
<td>Ethnicity (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Western</td>
<td>28·4</td>
<td>69·0</td>
<td>83·9</td>
</tr>
<tr>
<td>Moroccan</td>
<td>15·5</td>
<td>3·8</td>
<td>2·1</td>
</tr>
<tr>
<td>Turkish</td>
<td>17·4</td>
<td>7·2</td>
<td>3·8</td>
</tr>
<tr>
<td>Surinam and Antilles</td>
<td>19·6</td>
<td>12·0</td>
<td>5·9</td>
</tr>
<tr>
<td>Other non-western</td>
<td>19·1</td>
<td>8·0</td>
<td>4·3</td>
</tr>
<tr>
<td>Smoking habits any time in pregnancy (%)</td>
<td>29·4</td>
<td>31·8</td>
<td>16·5</td>
</tr>
<tr>
<td>Alcohol consumption any time in pregnancy (%)</td>
<td>32·0</td>
<td>57·9</td>
<td>58·6</td>
</tr>
<tr>
<td>Enrolment in study in early pregnancy (%)</td>
<td>67·4</td>
<td>80·0</td>
<td>84·7</td>
</tr>
<tr>
<td>Antenatal care during first trimester (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care</td>
<td>90·5</td>
<td>92·5</td>
<td>92·1</td>
</tr>
<tr>
<td>Secondary care</td>
<td>7·9</td>
<td>7·5</td>
<td>9·5</td>
</tr>
<tr>
<td>Median gestational age at birth (weeks)*</td>
<td>39·7</td>
<td>39·7–40·0</td>
<td>39·9</td>
</tr>
<tr>
<td>Birth weight (g)</td>
<td>3340·2</td>
<td>563·6</td>
<td>3424·7</td>
</tr>
<tr>
<td>Placental weight (g)</td>
<td>628·7</td>
<td>149·5</td>
<td>633·5</td>
</tr>
<tr>
<td>Placental index</td>
<td>0·190</td>
<td>0·036</td>
<td>0·187</td>
</tr>
<tr>
<td>Male gender (%)</td>
<td>51·8</td>
<td>50·9</td>
<td>48·6</td>
</tr>
</tbody>
</table>

* Median with 95% range.
Table 2. Associations between periconception folic acid use and fetal growth measured by ultrasound**
(Regression coefficients and 95% confidence intervals)

<table>
<thead>
<tr>
<th>Week of growth measurement and folic acid supplementation</th>
<th>Model A†</th>
<th>Model B‡</th>
<th>Model A†</th>
<th>Model B‡</th>
<th>Model A†</th>
<th>Model B‡</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 weeks</td>
<td>RC</td>
<td>95% CI</td>
<td>RC</td>
<td>95% CI</td>
<td>RC</td>
<td>95% CI</td>
</tr>
<tr>
<td>Start before 8 weeks</td>
<td>0·54</td>
<td>0·07, 0·99</td>
<td>0·10</td>
<td>−0·41, 0·60</td>
<td>0·53</td>
<td>−0·67, 1·13</td>
</tr>
<tr>
<td>Preconception start</td>
<td>1·26</td>
<td>0·82, 1·70</td>
<td>0·61</td>
<td>0·09, 1·12</td>
<td>1·31</td>
<td>0·75, 1·88</td>
</tr>
<tr>
<td>30 weeks</td>
<td>RC</td>
<td>95% CI</td>
<td>RC</td>
<td>95% CI</td>
<td>RC</td>
<td>95% CI</td>
</tr>
<tr>
<td>Start before 8 weeks</td>
<td>1·33</td>
<td>0·63, 2·04</td>
<td>0·63</td>
<td>−0·12, 1·38</td>
<td>0·85</td>
<td>−0·13, 1·84</td>
</tr>
<tr>
<td>Preconception start</td>
<td>2·78</td>
<td>2·11, 3·45</td>
<td>1·34</td>
<td>0·57, 2·11</td>
<td>3·32</td>
<td>2·39, 4·25</td>
</tr>
</tbody>
</table>

RC, regression coefficient; Ref., reference.

* For details of subjects and procedures, see Methods and Table 1. Results are from linear regression analysis. Values are regression coefficients (in mm) and reflect the difference in growth for each characteristic measured in mid-pregnancy (median 20·5 weeks, 95% range 18·8–23·1) or late pregnancy (median 30·4 weeks, 95% range 28·5–32·7), compared to no folic acid use.

† Adjusted for gestational age at time of ultrasound measurement.
‡ Adjusted for gestational age at time of ultrasound measurement, maternal age, height, weight, parity, ethnicity, fetal gender, educational level and smoking.
Folate is essential for DNA methylation, an important epigenetic mechanism that plays a regulatory role in genome programming and imprinting during pregnancy\(^{(10,11)}\). Differences in quantitative methylation may affect genes implicated in embryogenesis and fetal growth\(^{(8,46,47)}\). It has been shown that variations in preconception exposure to folic acid can lead to epigenetic modifications of the genome in the offspring associated with adiposity, insulin resistance and high blood pressure in adulthood\(^{(8,29)}\). This might also apply to the present results, suggesting that preconception folic acid supplementation may cause epigenetic modifications in the preimplantation embryo which may result in increased placental and fetal growth patterns\(^{(8,48)}\). However, at this moment these speculations need to be studied in further detail.

An important finding from the present analysis was the modifying effect of parity. The positive effect of parity on birth weight has been well established\(^{(37,38,49,50)}\). However, to our knowledge, the effect modification by parity on the association between periconception folic acid use and fetal growth has not been reported before. In the past, Kloosterman suggested that multiparous women offer, through remodelling of the maternal vascular structure in former pregnancies, a more favourable environment for placental development and function in subsequent pregnancies\(^{(37,38,49)}\). From this respect it can be hypothesized that periconception folic acid supplementation interacts with these vascular remodelling processes in multiparous women, thereby affecting placental and subsequent fetal growth. However, this needs to be studied further by other investigators.

The present study was embedded in a large prospective cohort study with a significant number of measurements performed in the mothers, which increases the accuracy of our effect estimates. However, some limitations should be addressed. First, because the response rate of the Generation R Study was approximately 61\%, selective participation of pregnant women may have influenced the observed associations\(^{(42,51,52)}\). In addition, complete information on folic acid supplementation was missing in approximately 25\% of the women, and this non-response could lead to selection bias if the association of periconception folic acid supplementation with fetal growth would differ between those with and without complete data. Even though this seems unlikely, it cannot be fully excluded.

**Table 3.** Associations between periconception folic acid use, placental weight and placental index*

(Regression coefficients and 95\% confidence intervals)

<table>
<thead>
<tr>
<th>Folic acid supplementation</th>
<th>Placental weight</th>
<th>Placental index</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Model A†</td>
<td>Model B‡</td>
</tr>
<tr>
<td>No use</td>
<td>RC</td>
<td>95% CI</td>
</tr>
<tr>
<td>Start before 8 weeks</td>
<td>0·37</td>
<td>−10·20, 10·90</td>
</tr>
<tr>
<td>Preconception start</td>
<td>10·41</td>
<td>0·32, 20·49</td>
</tr>
</tbody>
</table>

RC, regression coefficient; Ref., reference.

* For details of subjects and procedures, see Methods and Table 1. Results are from linear regression analysis. Values are regression coefficients and reflect the difference for each characteristic (placental weight in g) compared to no folic acid use.

† Adjusted for gestational age at birth (placental weight).

‡ Adjusted for gestational age at birth (placental weight), maternal age, height, weight, parity, ethnicity, fetal gender, educational level and smoking.
The use of questionnaires to assess folic acid supplementation encompasses several limitations, including information bias and giving desirable answers. Yet, studies show that self-reported intake of folic acid correlates to folate serum levels (53). Moreover, we aimed to assess folic acid supplementation in early pregnancy to minimize possible recall bias. However, even though we used a clear definition of folic acid supplementation in the questionnaire misclassification, especially between those who started using a folic acid supplement preconceptionally and those who started after pregnancy recognition, should always be considered. Last, folic acid supplement use is related to socioeconomic status, lifestyle factors (dietary habits) and adverse health behaviours (smoking). Even though we were able to control for a large number of potential confounders available from our questionnaires, residual confounding is always of particular concern in vitamin supplement studies, and should for this reason be taken into account (54). For these reasons, the present findings would be much stronger if we had had availability of maternal, placental or neonatal folate biomarkers such as erythrocyte folate levels, or global methylation status.

In conclusion, periconception folic acid supplementation is significantly associated with increased fetal growth resulting in higher placental and birth weight, and decreased risks of having a child with low birth weight or being SGA. The effects are most pronounced in women who preconceptionally start using a folic acid supplement, and are modified by parity.

To investigate the underlying pathways in more detail and possible consequences for postnatal growth and development, future studies are necessary.

**Acknowledgements**

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**Table 4.** Associations between periconception folic acid use and pregnancy complications* (Odds ratios and 95% confidence intervals)

<table>
<thead>
<tr>
<th>Folic acid supplementation</th>
<th>Low birth weight</th>
<th>SGA</th>
<th>Prematurity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Model A†</td>
<td>Model B‡</td>
<td>Model A†</td>
</tr>
<tr>
<td>No use</td>
<td>OR  95% CI</td>
<td>OR  95% CI</td>
<td>OR  95% CI</td>
</tr>
<tr>
<td>Start before 8 weeks</td>
<td>0.75 0.52, 1.07</td>
<td>0.61 0.40, 0.94</td>
<td>0.82 0.53, 1.25</td>
</tr>
<tr>
<td>Preconception start</td>
<td>0.47 0.33, 0.68</td>
<td>0.43 0.28, 0.69</td>
<td>0.38 0.23, 0.63</td>
</tr>
</tbody>
</table>

Ref. reference; SGA, small for gestational age.
*For details of subjects and procedures, see Methods and Table 1. Results are from logistic regression analysis.
† Adjusted for gestational age at birth (not prematurity).
‡ Adjusted for gestational age at birth (not prematurity), maternal age, height, weight, parity, ethnicity, fetal gender, educational level and smoking.

References


