Study	Echocardiogram parameters	Type/s of echocardiogram performed	Significant outcomes
S1. Levy et al., 2015 [37]	Four ECHOs performed on preterm infants on DOL 1 and 3, then at 32–36 w of PMA Only two ECHOs on term infants (control group)	RV-FAC	- A faster rate of RV-FAC maturation in preterm infants occurred at 32–36 w of gestation. - The maturation process was unfavourably affected by the presence of significant BPD. The infants with moderate to severe BPD had a lower RV-FAC in the late preterm period.
S2. Choi et al., 2016 [38]	One ECHO performed between 35–37 w of PMA	TR, RV-MPI via PWD, RV-MPI via TDI	- No significant difference was found between TR and RV-MPI via PWD groups. - RV-MPI via TDI was significantly higher in the severe BPD group compared to the no or mild BPD groups ($P < 0.05$). - A linear regression analysis indicated a significant correlation between BPD severity and RV-MPI via TDI ($P = 0.01$).
S3. Sehgal et al., 2016 [39]	One ECHO performed at 36 w of PMA	TR, TAPSE, RV-MPI via TDI, RV-FAC, E/E'	- TR was measurable in 7/18 (40%) of the BPD group, with 3/7 with TR Vmax > 2.7 m/s. No controls had a measurable TR. - MPI ($P < 0.0001$) and E/E' ($P < 0.0001$) were significantly elevated in BPD patients compared to controls. - RV-TDI peak systolic velocities were significantly lower ($P < 0.0001$) in BPD patients compared to controls. - RV-FAC was significantly lower in BPD patients compared to controls.
S4. Yajamanyam et al., 2016 [40]	One ECHO performed at 36–37 w + 2 d of PMA	TR, septal flattening, RV-MPI via TDI, RV-IVRT	- Significantly higher RV-MPI via TDI was observed in patients with severe BPD compared to the groups with no ($P < 0.001$) or mild ($P = 0.006$) BPD. - Significantly longer RV-IVRT was found in patients with severe BPD compared to the groups with no ($P = 0.001$) or mild ($P = 0.031$) BPD. - BPD patients were further divided into subgroups to assess whether they received dexamethasone and whether they were discharged on supplemental O2. - 14/50 BPD patients who received dexamethasone had significantly higher RV-MPI ($P = 0.015$) but had no significant difference in RV-IVRT and no ventricular hypertrophy in comparison to subgroup who did not receive dexamethasone. - RV-MPI was significantly higher in the 30 patients who were discharged with O2 therapy compared to the other 20 with no O2 therapy at discharge ($P = 0.004$). RV-IVRT did not differ in both subgroups.
S5. Bokiniec et al., 2017 [41]	Three ECHOs performed on DOL 1 and at 28 w and 36 w of PMA	TR, TV–E/A ratio, AcT/RVET, RV-MPI via PWD and TDI	- RV-MPI assessment success rates were 73.6% and 77.2% for TDI and PWD, respectively. - RV-MPI via PWD was higher in preterm infants with sBPD compared to preterm infants with no ($P = 0.014$) or mild ($P = 0.031$) BPD when measured on the 28th DOL. However, these results were not replicated by RV-MPI via TDI.
S6. Haque et al., 2017 [42]	One ECHO performed at > 36 w of PMA	TR, RV-FAC, TAPSE, RV-MPI via PWD, RV-TDI, RV-SR-MDI	- The only significant difference detected was the regional peak systolic strain in the free wall middle segment (1/6 segments), which was lower in patients with sBPD ($P < 0.01$).

DOL: day of life; w: weeks, d: day; PMA: postmenstrual age; sBPD: significant bronchopulmonary dysplasia (moderate to severe BPD); TDI-MPI: tissue Doppler imaging–myocardial performance index; RV–FAC: right ventricle–fraction area change; TR: tricuspid regurgitation; TAPSE: tricuspid annular plane systolic excursion; TV–E/A ratio: tricuspid valve–early to late diastolic waves ratio; PWD: pulsed-wave Doppler; RV–SR–MDI: right ventricle–strain rate–myocardial deformation imaging; AcT: pulmonary artery acceleration time; RVET: *right ventricle ejection time; RV–IVRT: right ventricle–isovolumic relaxation time*