Distinct First Trimester Cytokine Profiles for Gestational Hypertension and Preeclampsia

Line H. Tangerås, Marie Austdal, Ragnhild B. Skråstad, Kjell Å. Salvesen, Rigmor Austgulen, Tone F. Bathen, Ann-Charlotte Iversen

Objective—Gestational hypertension and preeclampsia involve dysregulated maternal inflammatory responses to pregnancy, but whether such responses differ between the disorders has not been determined. We aimed to investigate disease-specific early pregnancy serum cytokine profiles of women subsequently developing gestational hypertension or preeclampsia for new insight into the underlying pathogeneses and differences between the disorders.

Approach and Results—The study cohort consisted of 548 pregnant Norwegian women who were either multiparous with previous gestational hypertension or preeclampsia or were nulliparous. Maternal sera at gestational weeks 110–136 were assayed for 27 cytokines, C-reactive protein, total cholesterol, high-density lipoprotein, triglyceride, creatinine, calcium, uric acid, and placental growth factor. Compared with normotensive women, women with both hypertensive conditions presented an atherogenic lipid profile at early gestation, but only those later developing gestational hypertension had significantly higher serum levels of interleukin (IL)-5 and IL-12. Comparing the 2 hypertensive pregnancy disorders, women subsequently developing gestational hypertension had higher serum levels of IL-1α, IL-5, IL-7, IL-8, IL-13, basic fibroblast growth factor, and vascular endothelial growth factor than the women subsequently developing preeclampsia.

Conclusions—This study identifies early pregnancy differences in serum cytokine profiles for gestational hypertension and preeclampsia.

Key Words: cytokines ■ first trimester ■ gestational hypertension ■ inflammation ■ preeclampsia

Hypertensive disorders of pregnancy are major causes of maternal and fetal morbidity and mortality.1-3 Most common is gestational hypertension, defined as new onset hypertension after 20 weeks gestation, affecting 2% to 17% of pregnant women.1-2 Preeclampsia is characterized by de novo hypertension with proteinuria after gestational week 20 and complicates 2% to 7% of pregnancies.1 The distinction between the 2 diagnoses is not clear-cut, with several recent international clinical guidelines defining preeclampsia as hypertension combined with any from a list of signs and symptoms of end-organ damage, including proteinuria.4,5 Whether gestational hypertension and preeclampsia are separate disorders with the common clinical sign of hypertension, or part of a spectrum, is an ongoing debate.4,6 Several risk factors, including obesity and diabetes mellitus, are shared between the 2 conditions.5 Primiparity is strongly associated with risk of developing preeclampsia only, and the risk of recurrence is higher for gestational hypertension, whereas both disorders are considered warning signs for future cardiovascular disease.5,8-11 Most studies group these 2 conditions together or focus solely on preeclampsia.6 A recent systematic review of the global incidence of hypertensive pregnancy disorders excluded gestational hypertension from the analysis because of the lack of specific studies.12 Further research is warranted to specifically address the underlying pathogenesis of gestational hypertension and how it interrelates with preeclampsia.

Serum biomarkers reflecting underlying disease processes of hypertensive disorders of pregnancy include heightened C-reactive protein, implicating inflammation; a dyslipidemic lipid profile, suggesting ongoing atherosclerotic processes; altered creatinine and uric acid levels, indicating renal dysfunction; decreased calcium levels, reflecting metabolic changes; and reduced placental growth factor (PIGF), pointing to placental dysfunction.13-18 A shared pathophysiology...
is indicated by dyslipidemia in early gestation and elevated C-reactive protein at clinical manifestation in both gestational hypertension and preeclampsia, whereas reduced PlGF levels are predominantly associated with preeclampsia.15,19–22 More refined biomarkers identifying distinct components and differences between gestational hypertension and preeclampsia in early pregnancy are missing.

Gestational hypertension and preeclampsia are characterized as excessive maternal inflammatory responses to pregnancy.23 Inflammation involves a complex network of cytokines released from stressed cells and damaged tissue.23 Essential hypertension has been associated with increased serum levels of interleukin (IL)-1β, IL-6, IL-8, and tumor necrosis factor (TNF)-α, and an inflammatory cytokine profile is detected before disease manifestation.24–26 Regarding hypertensive disorders of pregnancy, preeclampsia has been linked to increased serum levels of proinflammatory cytokines, such as IL-6, IL-8, and TNF-α, accompanied by an angiogenic factor imbalance, and for gestational hypertension, increased serum IL-1β, IL-10, and TNF-α has been reported.27–32 Information is limited for early pregnancy; serum IL-1β and TNF-α has been shown elevated before onset of disease in women developing preeclampsia, whereas gestational hypertension has not been separately investigated at early gestation.33,34 This study aimed to compare disease-specific early gestation serum cytokine profiles of women subsequently developing gestational hypertension or preeclampsia.

### Materials and Methods

Materials and Methods are available in the online-only Data Supplement.

### Results

#### Characteristics of the Study Population

A flow chart describing the 640 pregnant women invited to the study and the final study population is shown in Figure 1. Of the 548 pregnant women included in the final analyses, 504 (92%) remained normotensive throughout pregnancy, 19 (3.5%) developed gestational hypertension, and 25 (4.6%) developed preeclampsia. Of the 513 nulliparous women, 3.1% developed gestational hypertension and 3.9% preeclampsia, whereas of the 35 multiparous women, 8.6% developed gestational hypertension and 14.3% preeclampsia. All preeclampsia cases and 18 (95%) of the women developing gestational hypertension were classified as late onset (delivery after gestational week 34). Characteristics of the final study population are shown in Table 1 and are further described in Skråstad et al.35 In the study population, 98.5% of the women were classified as white. Compared with normotensive women at gestational weeks 11–13, women who later developed gestational hypertension had significantly higher body mass index, whereas women who later developed preeclampsia had higher uterine artery pulsatile index (UtAPI; Table 1). Systolic and diastolic blood pressure was significantly higher in both case groups, but below the threshold for hypertension (Table 1). Only women who subsequently developed preeclampsia delivered significantly smaller babies and at an earlier gestation compared with normotensive women (Table 1).

#### Early Pregnancy Serum Profiles of Hypertensive Pregnancy Disorders Compared With Normotensive Pregnancies

Serum levels of cytokines and serum markers are shown in Tables 2 and 3, respectively. Women who later developed

---

**Table 1. Flowchart of the study population of pregnant women.** GA indicates gestational age. *Corresponding to fetal crown-rump length of 45 to 84 mm. †Conditions apparent at study visit resulting in exclusion included self-reported chronic hypertension, twin pregnancy, missed abortion, crown-rump length >84 mm, abnormal fetal anatomy, use of acetyl salicylic acid or low molecular weight heparin during pregnancy, and multiparity without a history of gestational hypertension or preeclampsia in a previous pregnancy. ‡Conditions appearing after study visit resulting in exclusion included termination of pregnancy, spontaneous abortion, and women who could not be venepunctured.35
Gestational hypertension showed significantly higher serum levels of IL-5 and IL-12 compared with normotensive women at gestational weeks 110–136 (Table 2). In contrast, the serum cytokine profile of women who subsequently developed preeclampsia did not differ from normotensive women at this gestational age (Table 2). Women who later developed either of the hypertensive pregnancy disorders showed an atherogenic serum lipid profile compared with women with normotensive pregnancies; significantly higher levels of serum triglyceride was associated with gestational hypertension, whereas lower levels of high-density lipoprotein and higher levels of low-density lipoprotein was associated with pre eclampsia (Table 3). As expected, women who later developed preeclampsia had significantly lower serum PlGF than normotensive women at gestational weeks 110–136 (Table 3). Adjusting for body mass index and mean arterial pressure did not eliminate cytokine or serum marker differences between the 3 outcome groups, except for the significant difference in triglyceride levels between later gestational hypertension and normotensive pregnancies (data not shown). The significant cytokine or serum marker differences between the 3 outcome groups were not affected by including outlier values (data not shown). Comparisons of the 2 case groups with the rest of the cohort (including women with other pregnancy complications) yielded the same significant differences as when comparing with the normotensive control group (data not shown).

### Early Pregnancy Serum Profiles Comparing Gestational Hypertension and Preeclampsia

The early pregnancy serum cytokine profile clearly differed between women who later developed gestational hypertension and those who developed preeclampsia, whereas the serum markers did not distinguish between the 2 disorders at 110–136 weeks gestational age (Tables 2 and 3). Women later developing gestational hypertension showed higher serum levels of IL-1β, IL-5, IL-7, IL-8, IL-13, and basic fibroblast growth factor compared with women later developing preeclampsia (Table 2 and Figure I in the online-only Data Supplement). When only nulliparous women were included in the analyses, IL-1β, IL-5, IL-7, and IL-8 remained significantly different, and additionally, serum levels of granulocyte colony–stimulating factor were significantly higher in women who later developed gestational hypertension compared with women who later developed preeclampsia. These cytokine values are presented in scatterplots labeled for parity for women who subsequently developed gestational hypertension or preeclampsia (Figure II in the online-only Data Supplement).

Multivariate analysis combines variables that are not necessarily significant on their own into combinations of variables that may be characteristic for a specific class. Partial least squares discriminant analysis (PLS-DA) compresses multiple variables into simpler and more information-rich latent variables, and the resulting PLS-DA model can be visualized with score and loading plots. Variable importance in projection is a method of assessing which variables are most important to the model; a score ≥1 indicates that the variable is important in discriminating between groups. PLS-DA is prone to overfitting, so to ensure that an equally good model cannot be built from randomly assigned classes, classification results are validated by permutation testing. In permutation testing, classes are shuffled and models built using the same parameters. The classification error is recorded and the process repeated 1000 times, giving a distribution of errors for the null hypothesis that no difference exists between classes. The results obtained from the true classes should be outside the 95% confidence interval of the permutated result for the null hypothesis that no difference exists between classes.
gestational age at enrolment) were further explored by multivariate analysis to uncover group differences and covariance (valid models; $P ≤ 0.05$ by permutation testing). PLS-DA classified serum cytokine profiles as gestational hypertension or preeclampsia with 74% accuracy (sensitivity=0.68 and specificity=0.80, 8 latent variables; Table 4 and Figure 2). This confirmed that serum cytokine profiles clearly separated between the hypertensive pregnancy disorders. The score plot

### Table 2. Maternal Serum Cytokine Levels (pg/mL) at Gestational Weeks 11<sup>e</sup>–13<sup>e</sup>

<table>
<thead>
<tr>
<th>Cytokines</th>
<th>Gestational Hypertension (n=19)</th>
<th>Preeclampsia (n=25)</th>
<th>Normotensive (n=504)</th>
</tr>
</thead>
<tbody>
<tr>
<td>IL-1β</td>
<td>2.81 (2.66–3.27)†</td>
<td>2.41 (2.08–2.89)</td>
<td>2.59 (2.24–3.04)</td>
</tr>
<tr>
<td>IL-1Ra</td>
<td>210 (189–264)</td>
<td>190 (169–237)</td>
<td>198 (166–233)</td>
</tr>
<tr>
<td>IL-2</td>
<td>18.6 (15.9–24.3)</td>
<td>18.7 (15.6–22.9)</td>
<td>18.3 (16.1–21.2)</td>
</tr>
<tr>
<td>IL-4</td>
<td>5.22 (4.68–6.15)</td>
<td>5.03 (4.49–5.62)</td>
<td>5.14 (4.64–5.69)</td>
</tr>
<tr>
<td>IL-5</td>
<td>2.89 (2.67–3.86)*†</td>
<td>2.18 (1.69–2.74)</td>
<td>2.53 (1.98–3.13)</td>
</tr>
<tr>
<td>IL-6</td>
<td>9.88 (7.68–11.09)</td>
<td>9.40 (8.36–12.53)</td>
<td>9.28 (7.98–10.88)</td>
</tr>
<tr>
<td>IL-7</td>
<td>17.4 (15.3–23.1)†</td>
<td>14.9 (11.0–18.7)</td>
<td>15.8 (13.2–18.6)</td>
</tr>
<tr>
<td>IL-8/CXCL8</td>
<td>19.3 (17.5–23.3)†</td>
<td>16.6 (14.3–19.3)</td>
<td>18.0 (15.6–21.5)</td>
</tr>
<tr>
<td>IL-9</td>
<td>30.7 (22.8–36.3)</td>
<td>26.6 (22.7–34.5)</td>
<td>26.9 (22.2–33.2)</td>
</tr>
<tr>
<td>IL-10</td>
<td>4.89 (3.80–5.94)</td>
<td>3.83 (2.60–4.99)</td>
<td>3.83 (2.88–5.21)</td>
</tr>
<tr>
<td>IL-12p70</td>
<td>38.6 (24.7–46.1)*</td>
<td>25.8 (20.7–31.6)</td>
<td>26.5 (20.8–34.8)</td>
</tr>
<tr>
<td>IL-13</td>
<td>6.87 (4.85–8.57)*†</td>
<td>4.88 (3.73–5.76)</td>
<td>5.64 (4.38–7.15)</td>
</tr>
<tr>
<td>IL-15</td>
<td>7.87 (6.84–10.5)</td>
<td>7.59 (6.51–8.85)</td>
<td>7.73 (6.68–9.18)</td>
</tr>
<tr>
<td>IL-17A</td>
<td>111.1 (89.6–162.5)</td>
<td>95.4 (79.0–120.1)</td>
<td>97.9 (80.2–123.0)</td>
</tr>
<tr>
<td>Eotaxin/CCL11</td>
<td>188 (137–207)</td>
<td>153 (128–192)</td>
<td>158 (134–188)</td>
</tr>
<tr>
<td>bFGF</td>
<td>124 (111–143)†</td>
<td>108 (97–122)</td>
<td>113 (100–131)</td>
</tr>
<tr>
<td>G-CSF</td>
<td>89.0 (78.6–114.8)</td>
<td>75.6 (70.3–90.3)</td>
<td>85.9 (74.5–99.9)</td>
</tr>
<tr>
<td>GM-CSF</td>
<td>93.5 (83.5–115.2)</td>
<td>85.3 (73.2–96.2)</td>
<td>88.4 (79.8–99.1)</td>
</tr>
<tr>
<td>IFN-γ</td>
<td>475 (400–532)</td>
<td>415 (334–493)</td>
<td>434 (371–501)</td>
</tr>
<tr>
<td>IP-10/CXCL10</td>
<td>987 (775–1442)</td>
<td>874 (627–1102)</td>
<td>860 (681–1098)</td>
</tr>
<tr>
<td>MCP-1/CCL2</td>
<td>15.9 (12.2–20.9)</td>
<td>15.7 (14.0–18.3)</td>
<td>16.2 (13.5–19.2)</td>
</tr>
<tr>
<td>MIP-1α/CCL3</td>
<td>4.80 (4.24–6.28)</td>
<td>3.97 (3.65–5.00)</td>
<td>4.33 (3.62–5.18)</td>
</tr>
<tr>
<td>MIP-1β/CCL4</td>
<td>98.0 (80.3–114.2)</td>
<td>95.8 (76.2–118.8)</td>
<td>89.3 (71.4–110.2)</td>
</tr>
<tr>
<td>TNF-α</td>
<td>65.3 (58.8–80.51)</td>
<td>60.9 (54.9–69.2)</td>
<td>65.5 (57.1–76.4)</td>
</tr>
<tr>
<td>VEGF-A</td>
<td>38.0 (31.7–51.7)</td>
<td>33.9 (26.5–41.9)</td>
<td>35.5 (29.8–42.5)</td>
</tr>
</tbody>
</table>

Data are reported as median (25th–75th percentile). bFGF indicates basic fibroblast growth factor; G-CSF, granulocyte colony-stimulating factor; GM, granulocyte macrophage; IFN, interferon; IL, interleukin; IP, IFN-γ–induced protein; MCP, monocyte chemotactic protein; MIP, macrophage inflammatory protein; TNF, tumor necrosis factor; and VEGF, vascular endothelial growth factor. Comparisons between outcome groups (Kruskal–Wallis and Dunn’s test): *$P<0.05$ vs normotensive controls, †$P<0.05$ vs preeclampsia.

### Table 3. Maternal Serum Marker Levels at Gestational Weeks 11<sup>e</sup>–13<sup>e</sup>

<table>
<thead>
<tr>
<th>Serum Markers</th>
<th>Gestational Hypertension (n=19)</th>
<th>Preeclampsia (n=25)</th>
<th>Normotensive (n=504)</th>
</tr>
</thead>
<tbody>
<tr>
<td>hsCRP, μg/mL</td>
<td>6.23 (3.01–14.6)</td>
<td>3.16 (1.95–6.32)</td>
<td>3.84 (2.05–6.67)</td>
</tr>
<tr>
<td>Total cholesterol, mmol/L</td>
<td>5.1 (4.3–5.5)</td>
<td>4.9 (4.4–5.3)</td>
<td>4.5 (4.1–5.0)</td>
</tr>
<tr>
<td>HDL, mmol/L</td>
<td>1.73 (1.37–1.99)</td>
<td>1.62 (1.35–1.85)*</td>
<td>1.80 (1.56–2.04)</td>
</tr>
<tr>
<td>Triglyceride, mmol/L</td>
<td>1.37 (0.98–1.64)*</td>
<td>1.13 (0.91–1.36)</td>
<td>0.96 (0.75–1.21)</td>
</tr>
<tr>
<td>LDL†, mmol/L</td>
<td>2.61 (1.95–3.22)</td>
<td>2.80 (2.10–3.20)*</td>
<td>2.23 (1.82–2.65)</td>
</tr>
<tr>
<td>Creatinine, μmol/L</td>
<td>48 (42–52)</td>
<td>49 (45–52)</td>
<td>50 (45–53)</td>
</tr>
<tr>
<td>Calcium, mmol/L</td>
<td>2.35 (±0.09)</td>
<td>2.36 (±0.10)</td>
<td>2.36 (±0.10)</td>
</tr>
<tr>
<td>Uric acid, μmol/L</td>
<td>198 (172–220)</td>
<td>186 (172–218)</td>
<td>183 (161–207)</td>
</tr>
<tr>
<td>PlGF MoM‡</td>
<td>0.74 (0.58–0.84)</td>
<td>0.64 (0.53–0.85)*</td>
<td>0.79 (0.64–0.98)</td>
</tr>
</tbody>
</table>

Data are reported as mean (±standard deviation) or median (25th–75th percentile). HDL indicates high-density lipoprotein; hsCRP, high-sensitivity C-reactive protein; LDL, low-density lipoprotein; MoM, multiple of the median; and PlGF, placental growth factor. Comparisons between outcome groups (ANOVA and Tukey’s test or Kruskal–Wallis and Dunn’s test): *$P<0.05$ vs normotensive controls; †LDL was calculated based on the Friedewald equation<sup>36</sup>; ‡MoM calculations were performed by Perkin Elmer, based on median values from a large reference population.<sup>35,37</sup>
(Figure 2A) displays the separation between the hypertensive disorders, with pregnant women in each group represented by symbols, and the loading plot (Figure 2B) shows the magnitude of contribution for each of the 25 cytokines as indicated on the variable importance in projection color scale. Women who later developed gestational hypertension could by multivariate analysis be distinguished from later preeclamptic women by their higher serum levels of, in order of importance, vascular endothelial growth factor A, IL-5, IL-4, IL-8, interferon-γ–induced protein 10, IL-12, and interferon-γ at 110–136 weeks gestational age. The PLS-DA models using serum markers or clinical characteristics as input were not significant, underlining that only serum cytokines contributed useful information to separate between pregnant women who later developed gestational hypertension or preeclampsia (Table 4 and Figure 2).

**Table 4.** PLS-DA Classification of Samples as Preeclampsia or Gestational Hypertension

<table>
<thead>
<tr>
<th>Variables in Model</th>
<th>Variables Contributing Substantially to Separation (VIP &gt; 1)</th>
<th>LVs</th>
<th>Classification Accuracy</th>
<th>Sensitivity</th>
<th>Specificity</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cytokines*</td>
<td>VEGF-A, IL-5, IL-4, IL-8, IP-10, IL-12, IFN-γ</td>
<td>8</td>
<td>74%</td>
<td>0.7</td>
<td>0.8</td>
<td>0.001</td>
</tr>
<tr>
<td>Serum markers†</td>
<td>hsCRP</td>
<td>1</td>
<td>62%</td>
<td>0.5</td>
<td>0.7</td>
<td>0.076</td>
</tr>
<tr>
<td>Clinical characteristics‡</td>
<td>MAP, BMI</td>
<td>1</td>
<td>65%</td>
<td>0.6</td>
<td>0.7</td>
<td>0.056</td>
</tr>
</tbody>
</table>

The sensitivity is for detecting a preeclampsia sample using PLS-DA. Classification accuracy, sensitivity, and specificity are from the leave-one-out cross validation. P-values are from permutation testing the model with 1000 repeats. BMI indicates body mass index; hsCRP, high-sensitivity C-reactive protein; IL, interleukin; IP, interferon (IFN)-γ–induced protein; LVs, latent variables; MAP, mean arterial pressure; PLS-DA, partial least squares discriminant analysis; UtAPI, uterine artery pulsatile index; and VIP, variable importance in projection.

*Includes 25 cytokines (Human Cytokine Group I multiplex panel).
†Includes hsCRP, total cholesterol, high-density and low-density lipoprotein, triglyceride, creatinine, uric acid, calcium, and placental growth factor.
‡Includes maternal age, BMI, MAP, UtAPI, and gestational age at enrolment.

**Discussion**

This study revealed that the serum cytokine profile of women who subsequently developed gestational hypertension differed considerably from that of women who subsequently developed preeclampsia, revealing novel distinctive features of these hypertensive pregnancy disorders at early gestation. Subsequent development of gestational hypertension, but not preeclampsia, could at gestational age 110–136 weeks be distinguished from normotensive pregnancies by serum cytokines. Maternal body mass index and mean arterial pressure at study visit did not influence the differences in serum cytokine levels, confirming that the cytokine profiles reflected underlying early disease development. These findings clearly indicate differences in the underlying pathogeneses of gestational hypertension and preeclampsia, highlighting the importance of separately addressing the 2 conditions.
Serum cytokine levels were increased in women later developing gestational hypertension compared with those with normotensive pregnancies, with concomitant rise of proinflammatory IL-12 and anti-inflammatory IL-5 at early gestation. Although proinflammatory cytokines promote inflammation, endothelial activation, and elevated blood pressure, the simultaneous increase of their anti-inflammatory counterparts might represent an early compensatory mechanisms, possibly counteracting endothelial dysfunction. Similar serum cytokine profiles of both pro- and anti-inflammatory nature have been reported at term for gestational hypertension. A first trimester study by Wolf et al concluded that inflammatory activation, assessed by high-sensitivity C-reactive protein measurements, was not associated with gestational hypertension, but our somewhat contradictory findings result from a more comprehensive cytokine profiling approach. For preeclampsia, serum cytokine profiling has previously shown results ranging from elevated first trimester IL-1β levels predicting early onset disease to no cytokine differences before clinical manifestation of early or late onset preeclampsia. We did not find any such differences in our cohort of late onset preeclampsia compared with normotensive pregnancies. The increased serum levels of cytokines IL-1β and IL-8 identified in early detection of late-stage gestational hypertension in comparison to preeclampsia point to systemic stress and inflammation. Higher levels of IL-1β have been detected at term for gestational hypertension compared with preeclampsia. The anti-inflammatory cytokines IL-5 and IL-13 and proangiogenic basic fibroblast growth factor and vascular endothelial growth factor A shown elevated in this early detection of late-stage gestational hypertension in comparison to preeclampsia could reflect a vascular rescue mechanism. The first stage of the preeclampsia pathogenesis is characterized by placental dysfunction, which in this study was evident at gestational weeks 11th–13th by reduced PlGF levels and higher UtAPI compared with normotensive women. The initial placental insufficiency eventually manifests systemically closer to term, but based on our data, the maternal serum cytokine response is not initiated at this early gestation in late-onset preeclamptic pregnancies. For late-onset gestational hypertension, our data indicate that systemic inflammatory activation is initiated in early pregnancy, but is subdued by compensatory mechanisms. This implies that cytokine profiling at gestational age 11th–13th weeks represents a novel tool to characterize early maternal responses in gestational hypertension, whereas preeclampsia is better identified by markers like PlGF, reflecting the local placental disease at this early stage. For both hypertensive pregnancy conditions, dyslipidemia manifested in early gestation, reflecting their previously reported atherogenic nature, but unlike serum cytokines, lipid profiling could not distinguish between the hypertensive pregnancy conditions. Interestingly, the distinct cytokine profile for gestational hypertension at gestational age 11th–13th weeks resembles allergic responses characterized by elevated levels of IL-4, IL-5, and IL-13, but the incidence of self-reported allergic or asthmatic disease or medication did not differ between the groups in this cohort, and such a link could therefore not be substantiated.

The serum cytokine profiles reported here are based on a cross-sectional study design, which prevents comparison of cytokine kinetics throughout pregnancy for the 2 disorders, but the importance of revealing the distinct characteristics of gestational hypertension at this early gestation remains. A limitation of this study is the relatively small number of cases, but we find these numbers to be comparable to previous case-control studies investigating serum cytokines in hypertensive pregnancy disorders and our study includes a larger control group. Because our medium- to high-risk cohort predominantly included women developing late-onset gestational hypertension or preeclampsia, the findings presented here should be followed-up in a general pregnant population with larger groups, including early- and late-onset disease. Because maternal ethnicity is known to affect the levels of first trimester serum biomarkers, such as PlGF and cytokines, these findings should be investigated in study populations of other ethnic origins. The issue of whether gestational hypertension and preeclampsia are separate disorders with the common clinical sign of hypertension, or part of a spectrum, has not been settled. The findings of this study support the former, with marked differences in early pregnancy cytokine profiles for gestational hypertension and preeclampsia, reflecting different underlying pathogenesis. Our findings strongly suggest that these hypertensive pregnancy disorders should be addressed separately in future studies.

Acknowledgments

We acknowledge the involved doctors, midwives, and secretaries at the National Center for Fetal Medicine at St. Olavs Hospital in Trondheim, Kristin Rian, Astrid Solberg Gundersen and Berit Marianne Bjelkåsen at NTNU, and Turid Follestad at the Unit for Applied Clinical Research at NTNU for her statistical guidance. We additionally thank the Regional Research Biobank of Central Norway for systematic collection, storage, and retrieval of samples, in addition to safety storage of the sample and clinical information, all according to Best Biobanking Practice.

Sources of Funding

This work was supported by the Research Council of Norway project number 205400/V50 and through its Centres of Excellence funding scheme, project number 223255/F50, the Liaison Committee between the Norwegian University of Science and Technology and the Central Norway Regional Health Authority, and the Family Blix’ Foundation for the furtherance of medical research.

Disclosures

None.

References


Cytokines in Hypertensive Pregnancy Disorders


**Significance**

This study identified early pregnancy differences in serum cytokine profiles for gestational hypertension and preeclampsia and revealed a state of inflammatory activation for gestational hypertension at gestational age 11^th^-13^th^ weeks. Broad serum cytokine profiling provides a novel tool for early detection of late-stage gestational hypertension and for distinguishing the 2 hypertensive pregnancy disorders. The distinct serum cytokine profiles identified in this study reflect differences in mechanisms underlying development of gestational hypertension and preeclampsia and warrants separating between these 2 pregnancy disorders.
Distinct First Trimester Cytokine Profiles for Gestational Hypertension and Preeclampsia

Line H. Tangerås, Marie Austdal, Ragnhild B. Skråstad, Kjell A. Salvesen, Rigmor Austgulen, Tone F. Bathen and Ann-Charlotte Iversen

*Arterioscler Thromb Vasc Biol.* 2015;35:2478-2485; originally published online September 24, 2015;

doi: 10.1161/ATVBAHA.115.305817

*Arteriosclerosis, Thrombosis, and Vascular Biology* is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231

Copyright © 2015 American Heart Association, Inc. All rights reserved.

Print ISSN: 1079-5642. Online ISSN: 1524-4636

The online version of this article, along with updated information and services, is located on the World Wide Web at:

http://atvb.ahajournals.org/content/35/11/2478

Data Supplement (unedited) at:

http://atvb.ahajournals.org/content/suppl/2015/09/24/ATVBAHA.115.305817.DC1

Permissions: Requests for permissions to reproduce figures, tables, or portions of articles originally published in *Arteriosclerosis, Thrombosis, and Vascular Biology* can be obtained via RightsLink, a service of the Copyright Clearance Center, not the Editorial Office. Once the online version of the published article for which permission is being requested is located, click Request Permissions in the middle column of the Web page under Services. Further information about this process is available in the Permissions and Rights Question and Answer document.

Reprints: Information about reprints can be found online at:

http://www.lww.com/reprints

Subscriptions: Information about subscribing to *Arteriosclerosis, Thrombosis, and Vascular Biology* is online at:

http://atvb.ahajournals.org/subscriptions/
Materials and methods

Study Population

The study was approved by the Regional Committee for Medical Research Ethics in mid-Norway, entries REK 2010/102 and 2013/386. All women gave written informed consent. The study population consisted of pregnant women who were nulliparous or had preeclampsia or gestational hypertension in a previous pregnancy, invited to attend an examination at 11\textsuperscript{0}-13\textsuperscript{6} weeks of gestation, as previously described.\cite{1,2} Women were not eligible if they were parous without previous preeclampsia or gestational hypertension, or if they used acetylsalicylic acid or low-molecular-weight heparin in the current pregnancy. At the study visit participants were interviewed about maternal age, chronic diseases, medication, ethnical origin, smoking status, method of conception, any previous pregnancies affected by preeclampsia or gestational hypertension, family history of preeclampsia and present height. Participants were weighed on a scale and body mass index (BMI) was calculated in kg/m\textsuperscript{2}. Blood pressure was measured with a CAS 740 MAX NIBP automated device (CAS Medical Systems Inc, CT, USA; http://www.casmed.com), calibrated prior to and once during the study period. The procedure was identical to that recommended by the European Society of Hypertension.\cite{3} The woman was positioned in a chair with her upper arms on armrests. The cuff-size was adapted to the overarm circumference, and the cuff was placed at the level of the heart. The woman rested for at least 10 min before blood pressure was measured three times with an approximately one-minute interval for both arms. The first blood pressure taken on each arm was discarded, and the average mean arterial blood pressure (MAP) from the last two recordings on each arm was calculated.\cite{4} The robustness of the MAP measurement resulted in the selection of MAP as the parameter for blood pressure entered into the linear regression and multivariate analysis.\cite{5} The MAP from the arm with the highest MAP was used. The blood pressure measurements were conducted by a physician, medical secretary or staff engineer, who had received specific training. Participants were examined with transabdominal ultrasound using a Siemens ACUSON Antares™ machine (Siemens Medical Solutions USA Inc, CA, USA). Missed abortions, multiple pregnancies and severe congenital anomalies were excluded. Fetal crown-rump length was used to estimate gestational age, and women were included if this measured between 45 and 84 mm. The uterine artery pulsatility index (UTAPI) was measured according to the method described by Khalil and Nicolaides.\cite{6} The average of three PI measurements on each side was calculated, to correct for intra-observer variability. The average of the PI from the right and left uterine artery was calculated and used. All scans were carried out by specialized trained midwives certified by the Fetal Medicine Foundation (http://www.fetalmedicine.com). Participants were asked to fast for one hour before their visit. Maternal venous blood was drawn into non-heparinized tubes and centrifuged at 1800G for 10 minutes. A serum sample (0.8 mL) was separated and stored at -80°C, thawed once and aliquots were stored at -80°C until further analysis. Data on pregnancy outcomes were collected from hospital records.

We used the Norwegian Association for Obstetricians and Gynecologists’ definitions of hypertensive pregnancy disorders,\cite{7} which are slightly modified versions of the guidelines of the American Congress of Obstetricians and Gynecologists.\cite{8} Gestational hypertension was defined as systolic blood pressure ≥ 140 mmHg and/or diastolic blood pressure ≥ 90 mmHg occurring after gestational week 20. Preeclampsia was defined by the same hypertension criteria as for gestational
hypertension in combination with proteinuria ≥ 0.3g per 24 hours measured twice within 4-6 hours, occurring after gestational week 20. Women in the study population who remained normotensive throughout pregnancy were eligible as controls, while women with self-reported chronic hypertension, preterm birth before 37 weeks or small-for-gestational age babies (birth weight mean ≤ –22%) were excluded. None of the women in the cohort had chronic diseases known to increase the risk of gestational hypertension or preeclampsia, except for the two women with pre-existing hypertension who were excluded.

**Serum Measurements**

Laboratory analyses were performed blinded to pregnancy outcomes after all women had delivered. Serum levels of 27 cytokines (Human Cytokine Group I multiplex panel) were measured using Luminex xMAP Technology on a Bio-Plex 200 system (Bio-Rad Laboratories, CA, USA). Two of the 27 cytokines analyzed (PDGF-BB and RANTES) were excluded from further analyses, since more than half of the measurements were above the upper detection limit. The serum samples were measured in a single replicate, whereas cytokine standards and blank samples were measured in duplicate on each plate. To minimize technical variation when comparing samples analyzed on different plates, a quality control sample of two pooled sera was run in replicates on each plate, and between-run coefficients of variation used for adjustment of cytokine measurements. The serum markers high sensitivity C-reactive protein (turbidimetric assay, Modular P analyzer, Roche, Burgess Hill, UK), total cholesterol, high-density lipoprotein, triglyceride, creatinine, uric acid and calcium (enzymatic colorimetric assays, Modular P analyzer), were measured at the Department of Clinical Chemistry at St. Olavs Hospital. The serum levels of low-density lipoprotein were calculated using the Friedewald equation. Placental growth factor was measured, as previously described in Skråstad et al., on the 6000 DELFIA Xpress clinical random access screening platform (Perkin Elmer Life and Analytical Sciences, Turku, Finland).

**Statistical Analyses**

Statistical analyses were done in GraphPad Prism v.5.0 (GraphPad Software, CA, USA), Matlab r2013b (The Mathworks Inc, MA, USA) and SPSS v.21.0 (SPSS Inc, IL, USA). Data were tested for normality using the D'Agostino-Pearson test. Non-normal data was reported as median (interquartile range), normally distributed data as mean (± standard deviation), and categorical variables as number (percentages). Outliers were identified by Grubbs' test, for which non-normal data was logarithmically transformed before 24 outliers (4%, total of 602 samples) were identified. Graphical presentations of the data were inspected to verify the statistical identification of outliers. Samples with at least one outlier value were removed from all analyses prior to final significance testing. Non-normal data was analyzed by Kruskal-Wallis test and Dunn's test for pairwise comparisons, normal data by ANOVA and Tukey's test for pairwise comparisons, and categorical variables by Chi-square test. To adjust for the possible confounding effects of maternal BMI and MAP, linear regression models with serum measurements as the dependent variable and group, BMI and MAP as independent variables were generated. The interaction between group and BMI or MAP was included in the model.

Multivariate analysis was used to further compare women who later developed gestational hypertension or preeclampsia, by analyzing the measured cytokines,
maternal serum markers, or clinical characteristics as a set. Prior to partial least squares discriminant analysis, all data were mean centered and cytokine and serum marker data was additionally logarithmically transformed. Multivariate models comparing women later developing preeclampsia with women later developing gestational hypertension were constructed using PLS Toolbox 7.3.1 (Eigenvector Research, WA, USA). The classification models were evaluated by leave-one-out cross validation, and mean sensitivity, specificity and accuracy of cross validated classification was calculated. The classification results were validated using 1000 permutation tests. For all statistical analyses $P \leq 0.05$ was considered statistically significant.
References


Figure I: Significant differences in serum cytokine profiles at gestational age $11^0-13^6$ weeks between women who later developed gestational hypertension (GH; n = 19) or preeclampsia (PE; n = 25). bFGF indicates basic fibroblast growth factor; IL, interleukin. *$P<0.05$, **$P<0.01$ vs PE.
Figure II: Serum cytokine profiles at gestational age $11^0-13^6$ weeks for nulliparous (black squares) and multiparous (red diamonds) women who later developed gestational hypertension (GH; n = 19) or preeclampsia (PE; n = 25). bFGF indicates basic fibroblast growth factor; G-CSF, granulocyte colony-stimulating factor; IL, interleukin; VEGF-A, vascular endothelial growth factor A.