Serum Inhibin-A and PAPP-A2 in the prediction of pre-eclampsia during the first and second trimesters in high-risk women

Elina Keikkala a,b,*, Janina Forstén c, Olli Ritvos d, Ulf-Håkan Stenman e, Eero Kajantie a,b,f,g, Esa Hämäläinen e, Katri Räikkönen h, Pia M. Villa i,j, Hannele Laivuori k,l,m

a Oulu University Hospital and University of Oulu, Medical Research Center Oulu, PEDEGO Research Unit, Oulu, Finland
b Finnish Institute for Health and Welfare, Population Health Unit, Helsinki and Oulu, Finland
c University of Helsinki and Helsinki University Hospital, Children's Hospital, Child Psychiatry, Helsinki, Finland
d Bacteriology and Immunology and Physiology, University of Helsinki and Helsinki University Hospital, Helsinki, Finland
e Departments of Clinical Chemistry, University of Helsinki, Helsinki and University of Eastern Finland, Kuopio, Finland
f Departments of Clinical and Molecular Medicine, University of Helsinki and Helsinki University Hospital, Helsinki, Finland
g Department of Clinical and Molecular Medicine, Norwegian University of Science and Technology, Trondheim, Norway
h Department of Psychology and Logopedics, University of Helsinki, Helsinki, Finland
i Obstetrics and Gynaecology, University of Helsinki and Helsinki University Hospital, Helsinki, Finland
j Department of Obstetrics and Gynaecology, Hyvinkää Hospital, Hyvinkää, Finland
k Medical and Clinical Genetics, University of Helsinki and Helsinki University Hospital, Helsinki, Finland
l Institute for Molecular Medicine Finland, Helsinki Institute of Life Science, University of Helsinki, Helsinki, Finland
m Department of Obstetrics and Gynaecology, Tampere University Hospital and Tampere University, Faculty of Medicine and Health Technology, Tampere, Finland

ARTICLE INFO

Keywords: Pre-eclampsia Prediction Pregnancy inhibin-A pregnancy associated plasma protein-A2 Placental growth factor

ABSTRACT

Objectives: Maternal serum inhibin-A, pregnancy associated plasma protein-A (PAPP-A) and PAPP-A2 together with placental growth factor (PlGF), maternal risk factors and uterine artery pulsatility index (UtA PI) were analysed to study their ability to predict pre-eclampsia (PE).

Study design: Serial serum samples for the nested case-control study were collected prospectively at 12–14, 18–20 and 26–28 weeks of gestation from 11 women who later developed early-onset PE (EO PE, diagnosis < 34 weeks of gestation), 34 women who developed late-onset PE (LO PE, diagnosis > 34 weeks of gestation) and 89 controls.

Main outcome measures: Gestational age-adjusted multiples of the median (MoM) values were calculated for biomarker concentrations. Multivariate regression analyses were performed to combine first trimester biomarkers, previously reported results on PlGF, maternal risk factors and UtA PI. Area under curve (AUC) values and 95% confidence intervals (CIs) for the prediction of PE and its subtypes were calculated.

Results: A high first trimester inhibin-A predicted PE (AUC 0.618, 95%CI, 0.513–0.724), whereas PAPP-A and PAPP-A2 predicted only EO PE (0.701, 0.562–0.840 and 0.724, respectively). At 26–28 weeks PAPP-A2 and inhibin-A predicted all PE subtypes. In the multivariate setting inhibin-A combined with maternal pre-pregnancy body mass index, prior PE and mean UtA PI predicted PE (0.811, 0.726–0.896) and LO PE (0.824, 0.733–0.914).

Conclusions: At first trimester inhibin-A show potential ability to predict not only EO PE but also LO PE whereas PlGF and PAPP-A predict only EO PE. At late second trimester inhibin-A and PAPP-A2 might be useful for short-term prediction of PE.

Abbreviations: AUC, area under curve; ASA, acetylsalisylic acid; BMI, body mass index; EO PE, early-onset pre-eclampsia (diagnosis < 34 weeks of gestation); IGF, insulin-like growth factor; IGFBP, insulin growth factor binding protein; IUGR, intrauterine growth restriction; LO PE, late-onset pre-eclampsia (diagnosis ≥ 34 weeks of gestation); MoM, multiples of the median; PAPP-A, plasma protein-A; PAPP-A2, plasma protein-A2; PE, pre-eclampsia; PlGF, placental growth factor; UtA PI, uterine artery pulsatility index; ROC, receiver-operating characteristic; SGA, small for gestational age.

E-mail address: elina.keikkala@oulu.fi (E. Keikkala).

https://doi.org/10.1016/j.preghy.2021.05.024
Received 16 September 2020; Received in revised form 28 May 2021; Accepted 30 May 2021
Available online 2 June 2021
2210-7789/© 2021 The Author(s). Published by Elsevier B.V. on behalf of International Society for the Study of Hypertension in Pregnancy. This is an open access article under the CC BY license (http://creativecommons.org/licenses/by/4.0/).
1. Introduction

Early identification of women destined to develop pre-eclampsia (PE) in pregnancy would enable preventive interventions such as low-dose acetylsalicylic acid (ASA) and more intensive follow-up of these women [1–3]. The most promising predictive model includes a combination of first trimester serum placental growth factor (PIGF) and the maternal clinical risk factors such as pre-pregnancy body mass index (BMI), maternal age and a history of PE. The accuracy could be slightly improved by adding pregnancy-associated plasma protein-A (PAPP-A) and uterine artery pulsatility index (UtA PI) measured by doppler ultrasound [4]. The ability of this model to predict early-onset PE (EO PE) (diagnosis < 34 weeks of gestation) is fairly good. However, its clinical use is limited because its modest value in predicting late-onset PE (LO PE), which is the most common subtype of PE [4].

Inhibin-A is a glycoprotein hormone produced by placental trophoblasts [5,6]. It is used in the second trimester combined screening of chromosomal abnormalities [7]. Several studies have shown that women who developed PE have higher levels of inhibin-A already in the first trimester [6,8,9]. However, its sensitivity has been found to be too low for use as a single marker to predict PE [10].

PAPP-A is mainly produced by placental syncytiotrophoblasts [11,12] and low levels are associated with pregnancy complications such as PE, small-for-gestational age (SGA), preterm delivery and spontaneous abortion [13–15]. Pregnancy-associated plasma protein-A2 (PAPP-A2) is a homologue of PAPP-A sharing 46% amino acid similarity [16]. PAPP-A2 is also expressed by the syncytiotrophoblasts [17–19] and it cleaves specifically insulin-like growth factor-binding protein 5 (IGFBP-5) while PAPP-A cleaves insulin-like IGFBP-4 [16]. In contrast to PAPP-A, the cleavage of IGFBP-5 by PAPP-A2 does not require the presence of IGF [16], which is essential for normal placentaion [20]. Maternal serum concentration of PAPP-A2 has been shown to be significantly higher in manifest PE than in uncomplicated pregnancy [19,21,22]. PAPP-A2 plays a role in normal placentaion and alterations in its concentration may be implicated in pregnancy complications [23].

We studied whether inhibin-A, PAPP-A, and PAPP-A2 analysed at three timepoints during first and second trimesters serve as potential biomarkers to predict PE and its subtypes. The results were compared with the previously reported PIGF results [24]. All first trimester biomarkers were also analysed together with the maternal clinical risk factors and UtA PI.

2. Methods

2.1. Subjects

Women in the present nested case-control study participated in the PREDO (Prediction and Prevention of Pre-eclampsia and Intrauterine Growth Restriction) project [25]. Women with clinical risk factors for PE were prospectively recruited between September 2005 and December 2009 at ten participating maternity clinics in Finland. The ethics Committee at Helsinki and Uusimaa Hospital District approved the study and written informed consent was obtained from all participants.

A subcohort of 134 women was included in this study: 45 women diagnosed with PE and 89 controls who did not develop PE (49 with and 40 without known clinical risk factors for PE). In the pre-eclampsia group, 11 had early-onset PE (EO PE, diagnosis < 34 + 0 weeks of gestation) and 34 had late-onset PE (LO PE, diagnosis ≥ 34 + 0 weeks).

Eight women who developed PE participated in low-dose ASA trial of the PREDO project. They were treated with low-dose ASA 100 mg/day from 12th to 35th week of gestation. Equal numbers of women who received low-dose ASA and did not develop PE were included as controls. Other controls were chosen based on sample availability.

Inclusion criteria for women with clinical risk factors for PE were as follows: PE, intrauterine growth restriction (IUGR), gestational diabetes or foetal demise in a previous pregnancy; pre-pregnancy obesity (BMI ≥ 30 kg/m2); chronic hypertension; type 1 diabetes; maternal age at childbirth < 20 years or > 40 years; systemic lupus erythematosus (SLE) or Sjögren’s syndrome [25].

PE was defined as systolic blood pressure ≥ 140 mmHg and/or diastolic blood pressure ≥ 90 mmHg occurring after 20th weeks of gestation and proteinuria (≥ 300 mg per 24 h) or the dipstick equivalent in two consecutive measurements [26]. Women with pre-eclampsia superimposed on chronic hypertension were included in the PE group. SGA was defined as birthweight lower than −2 SD adjusted for sex and gestational age according to Finnish birth weight charts [27].

Blood samples were obtained at three timepoints during pregnancy (12–14, 18–20 and 26–28 weeks of gestation). Mean UtA PI was measured by doppler ultrasound in all participants at 12–14 weeks of gestation [2].

2.2. Laboratory methods

Serum was separated by centrifugation within 1 h and aliquots were stored at −80 °C until analyses [25]. Serum inhibin-A, PAPP-A and PAPP-A2 concentrations were measured by ELISA Kits according to manufacturer’s instructions (Ansh Labs, Webster, USA) from total of 372 serum samples. Inter-assay coefficients of variation (CV) were 10.9% (at control concentration of 110 pg/ml) and 4.9% (at control concentration of 344 pg/ml) for inhibin-A; 2.3% (at control concentration of 310 ng/ml) and 15.8% (at control concentration of 1150 ng/ml) for PAPP-A, and 8.9% (at control concentration of 0.9 ng/ml) and 19.5% (at control concentration of 3 ng/ml) for PAPP-A2. PIGF concentrations were analysed by a Delfia method Kits as described previously (PerkinElmer, Turku, Finland) [24].

2.3. Statistics

Continuous variables between groups were compared using the Mann-Whitney U test and categorical variables were compared using the Chi-square test. Correlations between continuous variables were analysed using Pearson’s correlation. Change of biomarker concentration during advancing pregnancy between two sampling points were analysed using Wilcoxon signed rank test for paired samples. The results were expressed as mean ± SD, median and 95% confidence intervals (CIs) or interquartile range (IQR) when appropriate. Concentrations were log10 transformed and normality was tested according to the Kolmogorov-Smirnov’s test. To adjust the concentrations for gestational age, multiples of the median (MoM) values were calculated for each biomarker: the linear regression equation calculated at three different time points from the samples collected from 40 controls without risk factors from log10 transformed values. For the prediction of PE, clinical background factors (maternal age, pre-pregnancy BMI, prior PE, prior SGA, prior foetus mortus, type 1 diabetes, primiparity, chronic hypertension), biomarkers at 12–14 weeks of gestation and UtA PI were analysed by logistic regression using forward stepwise method where variables with p < 0.10 were included in model. The diagnostic accuracy for separate biomarkers and for the combinations of clinical risk factors and biomarkers were analysed using receiver-operating characteristic (ROC) curve analysis and expressed as the area under the curve (AUC). Analyses were performed using SPSS Statistics version 25 (IBM). Two-sided P values < 0.05 were considered statistically significant.

The power of the study was calculated using previous results on PIGF for prediction of EO PE [24]. With these mean MoM values and SDs the power was 98.6% to detect differences between the groups (9 women with EO PE and 67 controls) with two-sided p-value < 0.05.

3. Results

3.1. Clinical characteristics

Clinical characteristics of the study groups are presented in Table 1.
Inhibin-A MoM values were higher at 18 studied gestational weeks in women with subsequent PE (Table 2B) and the MoM values were higher than in controls at all (data not shown).

P value based on Mann-Whitney U test for continuous variables or Chi-Square test for categorical variables. PE = pre-eclampsia, EO PE = early-onset pre-eclampsia (diagnosis < 34 weeks of gestation), LO PE = late-onset pre-eclampsia (diagnosis ≥ 34 weeks of gestation), BMI = body mass index, HELLP = haemolysis, elevated liver enzymes, low platelets, SGA = small-for-gestational age.

There were no significant differences in gestational age at sampling between the study groups (data not shown). Eight women who developed both subsequent PE and SGA were analysed as a separate subgroup (data not shown).

3.2. MoMs for biomarker concentrations

Inhibin-A concentration decreased from 12 to 14 to 18–20 weeks of gestation and increased after that (p < 0.001 for controls and p = 0.001 for PE) in all groups (p < 0.001 for both) (Supplementary Fig. 1A). Inhibin-A concentration was higher than in controls at 18–20 and 26–28 weeks (Table 2A) and the MoM values were higher than in controls at all studied gestational weeks in women with subsequent PE (Table 2B). Inhibin-A MoM values were higher at 18–20 and 26–28 weeks in women with subsequent EO PE and at 26–28 weeks in women with LO PE compared to controls (Table 2B).

PAPP-A concentrations increased during advancing pregnancy in all groups (p < 0.001 for all) (Supplementary Fig. 1B). Women developing EO PE had lower PAPP-A concentrations and MoM values than controls at 12–14 weeks of gestation (Table 2A and 2B).

PAPP-A2 concentrations increased during advancing pregnancy in all groups (p < 0.001 for all) (Supplementary Fig. 1C). PAPP-A2 concentrations and MoM values were higher in women with subsequent PE as compared to controls at 26–28 weeks. Higher PAPP-A2 MoM values were observed already at 18–20 weeks in women with subsequent EO PE (Table 2A and 2B).

Inhibin-A concentrations and MoM values were higher in women with subsequent PE with SGA already at 12–14 weeks of gestation. Higher PAPP-A2 MoM values were observed already at 18–20 weeks in women with subsequent PE with SGA (p < 0.001) in addition to 26–28 weeks of gestation (data not shown).

Table 2A
Concentrations of serum Inhibin-A, pregnancy associated plasma protein-A (PAPP-A) and pregnancy associated plasma protein-A2 (PAPP-A2).

<table>
<thead>
<tr>
<th>Weeks</th>
<th>Controls</th>
<th>PE</th>
<th>EO PE</th>
<th>LO PE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N = 89</td>
<td>N = 45</td>
<td>N = 11</td>
<td>N = 34</td>
</tr>
<tr>
<td></td>
<td>Median</td>
<td>Median</td>
<td>Median</td>
<td>Median</td>
</tr>
<tr>
<td></td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
</tr>
<tr>
<td></td>
<td>IQR</td>
<td>IQR</td>
<td>IQR</td>
<td>IQR</td>
</tr>
<tr>
<td>Inhibin-A (pg/mL)</td>
<td>12–14</td>
<td>88</td>
<td>277</td>
<td>41</td>
</tr>
<tr>
<td></td>
<td>200–410</td>
<td>195</td>
<td>43</td>
<td>227</td>
</tr>
<tr>
<td></td>
<td>139–253</td>
<td>346</td>
<td>40</td>
<td>507</td>
</tr>
<tr>
<td></td>
<td>26–28</td>
<td>88</td>
<td>269–466</td>
<td>21.3</td>
</tr>
<tr>
<td></td>
<td>16.3–27.4</td>
<td>22.6</td>
<td>43</td>
<td>25.8</td>
</tr>
<tr>
<td></td>
<td>16.7–31.1</td>
<td>26–28</td>
<td>88</td>
<td>36.1</td>
</tr>
<tr>
<td></td>
<td>25.2–51.6</td>
<td>12–14</td>
<td>129</td>
<td>41</td>
</tr>
<tr>
<td></td>
<td>72.9–185</td>
<td>18–20</td>
<td>89</td>
<td>621</td>
</tr>
<tr>
<td></td>
<td>464–938</td>
<td>26–28</td>
<td>88</td>
<td>1392</td>
</tr>
</tbody>
</table>

P value based on Mann-Whitney U test as compared to controls. PE = pre-eclampsia, EO PE = early-onset pre-eclampsia (diagnosis < 34 weeks of gestation), LO PE = late-onset pre-eclampsia (diagnosis ≥ 34 weeks of gestation), IQR = interquartile range.

3.3. Prediction of PE, EO PE and LO PE

The AUC values for all studied biomarkers including previous data on PIGF [24] are shown in Table 3. The AUC value for the prediction of all subtypes of PE at 12–14 weeks of gestation was 0.618 for inhibin-A and it improved during advancing pregnancy (0.643 at 18–20 weeks and 0.717 at 26–28 weeks of gestation). PAPP-A2 predicted PE at 26–28 weeks (AUC 0.700 and 0.796). Combination of Inhibin-A MoM with pre-pregnancy BMI, prior SGA, and UtA PI gave an AUC value 0.906 for prediction of EO PE. PlGF MoM and clinical risk factors were superior to combinations of 0.694. AUC value for BMI, prior PE and UtA PI was 0.796. Combination of Inhibin-A MoM with pre-pregnancy BMI, prior PE, and UtA PI gave an AUC value of 0.811 (Table 4, Fig. 1).

Of the studied biomarkers, PAPP-A MoM and PIGF MoM predicted EO PE (AUC 0.701 and 0.798, respectively). AUC value for BMI, prior SGA and UtA PI was 0.825. Combining PIGF MoM with information of prior SGA, pre-pregnancy BMI, and UtA PI gave an AUC value 0.906 for prediction of EO PE. PIGF MoM and clinical risk factors were superior to PAPP-A MoM to predict EO PE in the multivariate setting (Table 4, Supplementary Fig. 2).

None of the studied biomarkers alone predicted LO PE. Combining

3.4. Multivariate analyses at 12–14 weeks of gestation

The combinations of the studied biomarkers, previous data on PIGF, maternal clinical risk factors and UtA PI were studied using stepwise forward logistic regression analysis (Table 4). The MoM for Inhibin-A and PAPP-A showed capacity to predict PE with an AUC value for the combination of 0.694. AUC value for BMI, prior PE and UtA PI was 0.796. Combination of Inhibin-A MoM with pre-pregnancy BMI, prior PE, and UtA PI gave an AUC value of 0.811 (Table 4, Fig. 1).

Of the studied biomarkers, PAPP-A MoM and PIGF MoM predicted EO PE (AUC 0.701 and 0.798, respectively). AUC value for BMI, prior SGA and UtA PI was 0.825. Combining PIGF MoM with information of prior SGA, pre-pregnancy BMI, and UtA PI gave an AUC value 0.906 for prediction of EO PE. PIGF MoM and clinical risk factors were superior to PAPP-A MoM to predict EO PE in the multivariate setting (Table 4, Supplementary Fig. 2).

None of the studied biomarkers alone predicted LO PE. Combining

Table 2B

The area under the curve (AUC) values from receiver operating characteristic (ROC) curve and 95% confidence intervals (CIs) of different biomarkers in the prediction of pre-eclampsia and its subgroups.

<table>
<thead>
<tr>
<th>Inhibin-A</th>
<th>Controls</th>
<th>PE</th>
<th>EO PE</th>
<th>LO PE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weeks</td>
<td>N</td>
<td>Median</td>
<td>N</td>
<td>Median</td>
</tr>
<tr>
<td>12-14</td>
<td>87</td>
<td>1.01</td>
<td>41</td>
<td>1.16</td>
</tr>
<tr>
<td>18-20</td>
<td>80</td>
<td>0.96</td>
<td>43</td>
<td>1.12</td>
</tr>
<tr>
<td>26-28</td>
<td>87</td>
<td>0.9</td>
<td>40</td>
<td>1.3</td>
</tr>
<tr>
<td>PAPP-A2</td>
<td>MoM</td>
<td>0.71-1.2</td>
<td>0.93-2.08</td>
<td>1.43-9.56</td>
</tr>
<tr>
<td>12-14</td>
<td>87</td>
<td>1.03</td>
<td>41</td>
<td>1.02</td>
</tr>
<tr>
<td>18-20</td>
<td>80</td>
<td>1.06</td>
<td>43</td>
<td>1.17</td>
</tr>
<tr>
<td>26-28</td>
<td>87</td>
<td>1.08</td>
<td>41</td>
<td>1.67</td>
</tr>
<tr>
<td>PIGF MoM</td>
<td>0.76-1.33</td>
<td>0.63-1.44</td>
<td>0.58-1.71</td>
<td>0.63-1.37</td>
</tr>
<tr>
<td>12-14</td>
<td>87</td>
<td>0.82</td>
<td>41</td>
<td>0.65</td>
</tr>
<tr>
<td>18-20</td>
<td>80</td>
<td>0.83</td>
<td>43</td>
<td>0.88</td>
</tr>
<tr>
<td>26-28</td>
<td>87</td>
<td>0.85</td>
<td>41</td>
<td>0.78</td>
</tr>
<tr>
<td>PlGF MoM</td>
<td>0.79-1.43</td>
<td>0.73-1.84</td>
<td>0.88-4.57</td>
<td>0.68-1.36</td>
</tr>
<tr>
<td>12-14</td>
<td>87</td>
<td>0.63-1.36</td>
<td>0.49-1.15</td>
<td>0.32-2.11</td>
</tr>
<tr>
<td>18-20</td>
<td>80</td>
<td>0.63-1.36</td>
<td>0.49-1.15</td>
<td>0.32-2.11</td>
</tr>
<tr>
<td>26-28</td>
<td>87</td>
<td>0.74-1.2</td>
<td>0.44-1.05</td>
<td>0.19-0.59</td>
</tr>
</tbody>
</table>

The AUC and P values are based on receiver operating characteristics (ROC) curve compared to controls (n = 89). PE = pre-eclampsia, EO PE = early-onset pre-eclampsia (diagnosis < 34 weeks of gestation), LO PE = late-onset pre-eclampsia (diagnosis ≥ 34 weeks of gestation), MoM = multiples of median, PAPP-A = pregnancy associated plasma protein-A, PIGF = placental growth factor.
The area under the curve (AUC) values from receiver operating characteristic (ROC) curve for combinations of maternal clinical risk factors, studied biomarkers and uterine artery pulsatility index (UtA PI) at 12–14 weeks of pregnancy in predicting of pre-eclampsia (PE), early-onset pre-eclampsia (EO PE) and late-onset pre-eclampsia (LO PE).

<table>
<thead>
<tr>
<th>Model</th>
<th>Variables</th>
<th>N</th>
<th>AUC</th>
<th>95% CI</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>PE</td>
<td>Clinical risk factors&lt;sup&gt;a&lt;/sup&gt;</td>
<td>BMI + prior PE</td>
<td>44</td>
<td>0.769</td>
<td>0.684–0.853</td>
</tr>
<tr>
<td></td>
<td>BMI</td>
<td>44</td>
<td>0.684</td>
<td>0.587–0.782</td>
<td>0.001</td>
</tr>
<tr>
<td></td>
<td>Prior PE</td>
<td>45</td>
<td>0.666</td>
<td>0.563–0.769</td>
<td>0.002</td>
</tr>
<tr>
<td></td>
<td>Doppler US</td>
<td>UtA PI</td>
<td>39</td>
<td>0.629</td>
<td>0.520–0.739</td>
</tr>
<tr>
<td></td>
<td>Combination</td>
<td>BMI + prior PE + UtA PI</td>
<td>38</td>
<td>0.796</td>
<td>0.715–0.878</td>
</tr>
<tr>
<td></td>
<td>Biomarkers&lt;sup&gt;b&lt;/sup&gt;</td>
<td>Inhibin-A + PAPP-A</td>
<td>41</td>
<td>0.694</td>
<td>0.597–0.792</td>
</tr>
<tr>
<td></td>
<td>All&lt;sup&gt;c&lt;/sup&gt;</td>
<td>BMI + prior PE + Inhibin-A + UtA PI</td>
<td>31</td>
<td>0.811</td>
<td>0.726–0.896</td>
</tr>
<tr>
<td>EO PE</td>
<td>Clinical risk factors&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Prior SGA + BMI</td>
<td>11</td>
<td>0.734</td>
<td>0.599–0.869</td>
</tr>
<tr>
<td></td>
<td>BMI</td>
<td>11</td>
<td>0.667</td>
<td>0.530–0.844</td>
<td>0.044</td>
</tr>
<tr>
<td></td>
<td>Prior SGA</td>
<td>31</td>
<td>0.591</td>
<td>0.397–0.786</td>
<td>0.324</td>
</tr>
<tr>
<td></td>
<td>Doppler US</td>
<td>UtA PI</td>
<td>8</td>
<td>0.780</td>
<td>0.670–0.890</td>
</tr>
<tr>
<td></td>
<td>Combination</td>
<td>Prior SGA + BMI + UtA PI</td>
<td>8</td>
<td>0.825</td>
<td>0.724–0.926</td>
</tr>
<tr>
<td></td>
<td>Biomarkers&lt;sup&gt;b&lt;/sup&gt;</td>
<td>PIGF</td>
<td>9</td>
<td>0.798</td>
<td>0.686–0.909</td>
</tr>
<tr>
<td></td>
<td>All&lt;sup&gt;c&lt;/sup&gt;</td>
<td>Prior SGA + BMI + PIGF + UtA PI</td>
<td>6</td>
<td>0.906</td>
<td>0.824–0.988</td>
</tr>
<tr>
<td>LO PE</td>
<td>Clinical risk factors&lt;sup&gt;a&lt;/sup&gt;</td>
<td>BMI + prior PE</td>
<td>33</td>
<td>0.777</td>
<td>0.685–0.869</td>
</tr>
<tr>
<td></td>
<td>BMI</td>
<td>33</td>
<td>0.684</td>
<td>0.573–0.794</td>
<td>0.002</td>
</tr>
<tr>
<td></td>
<td>Prior PE</td>
<td>34</td>
<td>0.683</td>
<td>0.569–0.796</td>
<td>0.002</td>
</tr>
<tr>
<td></td>
<td>Doppler US</td>
<td>UtA PI</td>
<td>31</td>
<td>0.590</td>
<td>0.467–0.714</td>
</tr>
<tr>
<td></td>
<td>Combination</td>
<td>BMI + prior PE + UtA PI</td>
<td>30</td>
<td>0.807</td>
<td>0.723–0.892</td>
</tr>
<tr>
<td></td>
<td>Biomarkers&lt;sup&gt;b&lt;/sup&gt;</td>
<td>Inhibin-A</td>
<td>31</td>
<td>0.613</td>
<td>0.495–0.732</td>
</tr>
<tr>
<td></td>
<td>All&lt;sup&gt;c&lt;/sup&gt;</td>
<td>BMI + prior PE + Inhibin-A + UtA PI</td>
<td>27</td>
<td>0.824</td>
<td>0.733–0.914</td>
</tr>
<tr>
<td></td>
<td>All (excluding UtA PI)&lt;sup&gt;c&lt;/sup&gt;</td>
<td>BMI + prior PE + Inhibin-A</td>
<td>30</td>
<td>0.815</td>
<td>0.730–0.900</td>
</tr>
</tbody>
</table>

The area under the curve (AUC) and P values are based on receiver operating characteristics (ROC) curve compared to controls (n = 89). Combinations are analysed using logistic regression analysis stepwise forward method where variables with p < 0.10 are included to model. 95% CI = confidence interval, PE = pre-eclampsia, US = ultrasound, EO PE = early-onset pre-eclampsia (diagnosis < 34 weeks of gestation), LO PE = late-onset pre-eclampsia (diagnosis ≥ 34 weeks of gestation).

<sup>a</sup> Clinical background factors include: maternal age, pre-pregnancy body-mass-index (BMI), prior pre-eclampsia, prior small-for-gestational age, prior foetus mortus, type 1 diabetes, primiparity, chronic hypertension.

<sup>b</sup> Inhibin-A, pregnancy associated plasma protein-A2 (PAPP-A2), pregnancy associated plasma protein-A (PAPP-A) and placental growth factor (PIGF)

<sup>c</sup> Clinical risk factors, Inhibin-A, PAPP-A2, PAPP-A and PIGF and uterine artery pulsatility index (UtA PI).

Inhibin-A MoM with pre-pregnancy BMI, information of prior PE, and UtA PI the AUC value to predict LO PE was 0.824. Combination of clinical risk factors and UtA PI without inhibin-A gave an AUC value of 0.807 and when UtA PI was removed the AUC value for the combination of inhibin-A and clinical risk factors was 0.815 (Table 4, Supplementary Fig. 3). In women who developed PE with SGA Inhibin-A MoM combined with information about chronic hypertension and UtA PI gave an AUC value of 0.857 (95% CI 0.724–0.990; p = 0.001). In a multivariate setting with clinical risk factors Inhibin-A performed better than PIGF in predicting PE with SGA (data not shown).

3.5. Correlations

At 12–14 weeks, PAPP-A and PAPP-A2 correlated negatively with maternal pre-pregnancy BMI and PAPP-A2 correlated positively with chronic hypertension status. Otherwise, the markers studied were independent of maternal age, parity, pre-pregnancy BMI and chronic hypertension. When comparing inhibin-A, PAPP-A2 and PAPP-A concentrations between ASA and placebo users in women with subsequent PE, EO PE or LO PE, among women with subsequent PE, inhibin-A at 18–20 weeks of gestation was slightly lower in women having ASA than in women receiving placebo (MoM values: 0.94, 0.76 – 1.26; median, IQR: vs. 1.58, 1.17–2.86; p = 0.006). Other biomarker concentrations did not differ between ASA and placebo users (data not shown).

4. Discussion

We found that inhibin-A together with clinical risk factors and UtA PI performed well in the prediction of PE, especially LO PE was predicted already at 12–14 weeks of gestation. Previously established biomarkers,
PIGF and PAPP-A, showed advantage only for the prediction of EO PE. In the present study concentrations of PAPP-A and PAPP-A2 was associated with all studied PE subtypes at 18–20 and 26–28 weeks of gestation. Increased concentrations have been shown previously in subsequent [22] and established PE [19,32]. In contrast to PAPP-A, the level of IGF-I and PAPP-A2 does not change in the case of IGF [16]. Hypoxia, which is known to occur in the PE placenta, has been shown to upregulate the expression of PAPP-A2 mRNA in placental ex- plants [21] and placental cells (BeWo cells) in cell culture [39]. These findings suggest that increased PAPP-A2 serum levels are more likely to be a consequence of placental pathology than vice versa. Thus, PAPP-A2 may be more specific for PE than PAPP-A.

In the prediction of all PE and EO PE, Inhibin-A [40] and PAPP-A2 showed similar ability with PIGF at 26 to 28 weeks of gestation. PIGF can be used in short-term prediction of PE with or without soluble fms-like tyrosine kinase-1 (sFlt-1) [41,42]. Our study suggests that inhibin-A and PAPP-A2 may, as well, have potential for short-term prediction of PE among women having suspected symptoms of PE.

The strength of our study is the prospectively recruited, well-characterised cohort with three consecutive serum samples from the same individuals. Its main weakness is the relatively small sample size and the phenomenon that ASA might have had an effect on biomarker concentrations at 18–20 and 26–28 weeks of gestation and development of PE. However, the difference between ASA and placebo users was observed only in concentrations of inhibin-A at 18–20 weeks in women with subsequent PE and with unknown mechanism.

In conclusion, this study showed that inhibin-A with maternal clinical risk factors and UtA PI show potential ability to predict all PE and LO PE at 12–14 weeks of gestation whereas PIGF was superior for predicting EO PE. PAPP-A2 and inhibin-A show potential capacity for short-term prediction of PE at 26–28 weeks of gestation.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Acknowledgements

Laboratory technician Maarit Leinimaa is gratefully thanked for her expertise in the laboratory analyses. Ansh Labs and PerkinElmer are thanked for providing ELISA Kits for the scientific purpose.

Funding

The PREDO project has been supported by EVO research funding (A special Finnish state subsidy for health science research), Academy of Finland, Signe and Ane Gyllenberg Foundation, Sigrid Juselius Foundation, University of Helsinki Research Funds, Research Funds of Oulu University Hospital, Finnish Medical Foundation, Juho Vainio Foundation, Novo Nordisk Foundation, Jane and Aatos Erkko Foundation, and Päiviikki and Sakari Sohlberg Foundation.

Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.preghy.2021.05.024.

References

E. Keikkala et al.
122


