Preeclampsia and cardiovascular disease: interconnected paths that enable detection of the subclinical stages of obstetric and cardiovascular diseases

Gloria Valdés
Department of Nephrology, Facultad de Medicina, Pontificia Universidad Católica, Santiago, Chile

Abstract: The potent and now longstanding evidence of the association between placentation-related disorders and cardiovascular disease should be translated into clinical practice in order to introduce a preventive approach to future obstetric and cardiovascular diseases. The purpose of this review is to integrate cardiovascular risk/disease and obstetric complications, which are linked by endothelial dysfunction, as windows of opportunity for improving women’s health. Questionnaires adaptable to local practices are proposed to incorporate cardiovascular and obstetrical indexes in two stages of a woman’s lifetime.

Keywords: pregnancy, preeclampsia, placentation-related disorders, cardiovascular disease, cardiovascular stress test, prevention, endothelial dysfunction, women’s health

Plain language summary
This review concentrates the evidence accumulated since the mid-1990s showing that women who suffer hypertensive pregnancies or have premature and/or low-weight babies are at an increased risk of presenting later in life with hypertension and cardiovascular events, such as coronary artery disease, stroke, obstruction of the carotid and lower limb arteries, cardiac failure, and thromboembolism. I intend to reinforce the need for obstetricians to recognize this association to ensure that cardiovascular risks (CVRs) are identified after a complicated pregnancy, to introduce early prevention of cardiovascular disease. It should also stimulate cardiologists to incorporate the outcomes of previous pregnancies when gauging the risk of women consulting for symptoms of myocardial ischemia or infarction. This summary focuses on making women aware that a hypertensive pregnancy is not a one-in-a-lifetime event, but a marker of future gestational complications and cardiovascular events after they lose the protection of estrogen. Though much more research is needed, the triad of women, their obstetricians/gynecologists, and cardiologists can do much to improve health in women and their offspring, who tend to have increased CVR when exposed to an unfavorable intrauterine environment.

Introduction
Since the first associations of preeclampsia with cardiovascular disease (CVD) in the mid-1990s and the start of the 21st century, numerous publications have corroborated this finding and added associations with other placentation-related disorders, including recurrent abortions, intrauterine growth retardation, preterm labor, abruptio placentae, and stillbirths.1–16 The risk of CVD increases according to the clinical severity of the maternal and fetal manifestations, as demonstrated by a prospective registry follow-up of 506,350 women in Norway in whom the presentation of major coronary
events increased 2.1-fold with previous preeclampsia, while adding intrauterine growth retardation or preterm birth augmented this risk to 3.3- and 5.4-fold risk, respectively.16 Coronary calcification, a precedent of coronary artery disease, is increased three decades after a preeclamptic pregnancy.17 Women submitted to angiography for suspected coronary lesions who had previous hypertensive pregnancies presented earlier with clinical manifestations and an increased number of stenotic arteries compared to women with normotensive pregnancies.18

Systematic reviews and meta-analyses represent potent tools for integrating information and contribute to its rational application and are especially relevant to this issue. In the last decade, four such papers have addressed and proven the association of preeclampsia with CVD with remarkable consistency (Table 1).19–22 However, CVR screening has not been incorporated into the preconception or early pregnancy clinical and laboratory evaluations to permit the correction of modifiable factors in order to reduce the risk of gestational hypertension. The short-term and medium-term follow-up of women with hypertension in pregnancy is only performed by a few post-preeclampsia clinics.23,24

Moreover, no retrospective evaluation of the obstetric history is routinely obtained in women presenting with symptoms of CVD several decades after the reproductive period, though the American Heart and Stroke Associations have stressed the remote risk of a complication of pregnancy.25,26 This is especially important for improving the screening for ischemic heart disease, the leading cause of death in women, which remains underdiagnosed and undermanaged for a number of reasons. The main confounding factors are the surreptitious clinical presentation of coronary artery disease in females, the maintenance of the current biochemical and electrocardiographic criteria applied to men, the lesser frequency of coronary arterial lesions, and the presence of microvascular dysfunction, which in the absence of obstructive lesions presents major adverse outcomes in 30% of patients during follow-up.27–29

This review represents a call to action to translate epidemiological, clinical, and molecular biology research into patient care, stressing the recent appeal of Arabín and Baschat.14 The future diffusion of preventive programs will benefit mothers who failed an early stress test, as well as the offspring exposed to an unfavorable intrauterine environment, thus perpetuating the cycle generated by an unfavorable pregnancy and CVD.10,31

### Pathophysiology

Apart from epidemiological studies that support the association of placentation-derived disorders (hereafter represented by preeclampsia) with CVD, many pathophysiological conditions are common to both: arterial hypertension, obesity, insulin resistance, diabetes, hyperlipidemia, oxidative stress, inflammation (autoimmune or infectious), snoring, familial prematurity CVD and CVD-related genotypes.11,32–34 Additional common features are the mild to moderate preventive effect of aspirin in pregnancy and coronary artery disease late in life and the atherosclerotic plaques and atherosclerosis.35–38

<table>
<thead>
<tr>
<th>Reference</th>
<th>Studies (n)</th>
<th>PE cases (n)</th>
<th>Control cases (n)</th>
<th>Hypertension, RR (95% CI)</th>
<th>CVD, RR (95% CI)</th>
<th>Ischemic heart disease, RR (95% CI)</th>
<th>Stroke, RR (95% CI)</th>
<th>Other risks, RR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bellamy et al, 200719</td>
<td>25</td>
<td>198,252</td>
<td>&gt;3 million</td>
<td>3.70 (2.7–5.05)</td>
<td>Fatal and nonfatal: 2.16 (1.86–2.52)</td>
<td>1.81 (1.45–2.27)</td>
<td>Thromboembolism: 1.79 (1.37–2.33)</td>
<td></td>
</tr>
<tr>
<td>McDonald et al, 200820</td>
<td>15</td>
<td>116,175</td>
<td>2 million</td>
<td>2.48 (1.22–5.9)</td>
<td>2.03 (1.95–2.67)</td>
<td>Cardiovascular death: 2.29 (1.73–3.04)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brown, 201321</td>
<td>43</td>
<td>Stroke: 62,235</td>
<td>&gt;1 million</td>
<td>3.13 (2.51–3.89)</td>
<td>2.28 (1.87–2.39)</td>
<td>1.77 (1.43–2.21)</td>
<td>Cardiovascular death: 2.29 (1.73–3.04)</td>
<td></td>
</tr>
<tr>
<td>Hypertension: 87,250</td>
<td>CVD: 40,584</td>
<td>779,135</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wu et al, 201722</td>
<td>22</td>
<td>&gt;250,000</td>
<td>&gt;4 million</td>
<td>2.50 (1.43–4.37)</td>
<td>1.81 (1.29–2.55)</td>
<td>Heart failure: 4.19 (2.09–8.38)</td>
<td>Cardiovascular death: 2.21 (1.83–2.66)</td>
<td></td>
</tr>
</tbody>
</table>

**Note:** Empty spaces represent unreported data.

**Abbreviations:** CI, confidence interval; CVD, cardiovascular disease; PE, preeclampsia; RR, relative risk.
In contrast, deficient endometrial preconditioning in adolescence, increased placental mass in multiple pregnancies, and smoking, which benefits from the reduction of sFLT1, differ between preeclampsia and CVD. The value of biochemical markers of endothelial dysfunction was validated by a review and meta-analysis of 65 studies that tested vascular dysfunction by an array of images and/or biochemical markers in 3,356 cases of pregnancy-induced hypertension and 5,346 controls, as women with prior hypertensive pregnancies had vascular functional and structural abnormalities that derive from endothelial dysfunction. Although the endothelial dysfunction is usually considered a remnant of the injury provoked by the factors deported by the placenta to the maternal circulation, the fact that endothelial dysfunction is present after pregnancy in women with recurrent abortions supports its causal role because they were exposed intermittently to minimal placental factors. This postulate is reinforced by the presence of preconceptual CVRs linked to endothelial dysfunction in women presenting with a hypertensive pregnancy or preeclampsia (familial, pre- and gestational diabetes mellitus, familial premature myocardial infarction, overweight, obesity, elevated blood pressure, leukocyte count, and elevated triglycerides). Endothelial dysfunction became central to preeclampsia when Roberts et al and Redman et al presented the novel concept that preeclampsia is a two-stage syndrome that begins with defective spiral artery remodeling leading to placental underperfusion and the clinical syndrome provoked by endothelial injury due to cytotoxic, inflammatory, oxidative, and immunological cytotoxic factors. Later, an intermediate stage was added to include placental ischemia/reperfusion and probable mechanic damage of the blood jet entering the intervillous space. Finally, a recent study has attributed a determinant role of decidualization, stretching the concept of a multistage syndrome to five phases while substantiating the potential effect of deficient endometrial preconditioning in teenage pregnancy.

Therefore, I propose integrating the pathophysiology and preconceptual and postgestational management to emphasize a clinical continuum that provides several stages for screening and preventing complications of subsequent pregnancies, as well as CVR and CVD (Figure 1). Thus, introducing CV prevention during the reproductive phase will translate current evidence into routine obstetric practice.

### Conclusion

As the evidence derived from retrospective and prospective epidemiological registries, partial pathophysiological insight, clinical studies, systematic reviews, and meta-analyses substantiating the association of preeclampsia and CVD has achieved level 1, the time is ripe for implementing a safe, integral obstetric, and cardiological approach. The fact that...
the subjects of these studies are derived from different ethnic and geographic backgrounds indicates that the association is not limited to confined groups.

From a practical standpoint, questionnaires and basic laboratory screenings have to be developed and consensuated among the leading scientific societies in the field, to be applied in centers of excellence as well as underdeveloped nations.

The Global Pregnancy Collaboration (CoLab) provides a very solid starting point for clinical registries and biobanks that would contribute to elucidate the missing links of the association of gestational diseases and CVDs.67 Based on this and our clinical research experience, I have drafted questionnaires for obstetric and cardiology attentions that may be adapted to local clinical practices (Tables 2 and 3). These questionnaires

Figure 1 Diagram depicting the stages of preeclampsia integrated to subsequent pregnancies and cardiovascular risk and disease in order to install preventive measures and impact women’s health.

Notes: The natural evolution of CVRs to disease is purposefully depicted in gray, as an active preventive strategy should reduce the spontaneous transition. The different gestational stages are framed in blue to highlight the fact that underlying maternal factors enhance impaired vascular remodeling and its alterations. Yellow arrows point to the four windows that permit preventive interventions. In women with a high risk of severe preeclampsia, the addition of L-arginine to the early use of low dose aspirin and calcium supplementation in women with low intake has proven safe and effective, whereas pravastatin is emerging as a potential intervention.62–65 This flowchart complements the one recently proposed by Arabin and Baschat regarding the different levels of clinical care that should be provided at the different stages.14

Abbreviations: CVR, cardiovascular risk; NK, natural killer.

Table 2 Questionnaire to evaluate of cardiovascular risks in pregnant women

<table>
<thead>
<tr>
<th>Personal risks</th>
<th>Weight</th>
<th>Height</th>
<th>BMI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nutritional status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smoking</td>
<td>Yes</td>
<td>No</td>
<td>Age at initiation/suspension</td>
</tr>
<tr>
<td>Snoring</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td>Yes</td>
<td>No</td>
<td>Age at initiation treatment</td>
</tr>
<tr>
<td>Hyperlipidemia</td>
<td>Yes</td>
<td>No</td>
<td>Age at diagnosis/treatment Col/triglycerides/HDL</td>
</tr>
<tr>
<td>Type</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Last value(s)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Family history</td>
<td>Father</td>
<td>Mother</td>
<td>Siblings</td>
</tr>
<tr>
<td>Cause of death (age)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td>Yes/no</td>
<td>Yes/no</td>
<td>Yes/no</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Yes/no</td>
<td>Yes/no</td>
<td>Yes/no</td>
</tr>
<tr>
<td>Coronary artery disease (years)</td>
<td>Yes/no</td>
<td>Yes/no</td>
<td>Yes/no</td>
</tr>
<tr>
<td>Stroke (years)</td>
<td>Yes/no</td>
<td>Yes/no</td>
<td>Yes/no</td>
</tr>
<tr>
<td>Preeclampsia in mother or sisters who underwent pregnancies</td>
<td>Yes/no</td>
<td>Yes/no</td>
<td>Yes/no</td>
</tr>
</tbody>
</table>

Abbreviations: BMI, body mass index; col, cholesterol; HDL, high-density lipoprotein.
should make a proviso for aspects missed in past studies, such as the need to include women with impeccable pregnancies in the control group (no preterm delivery or intrauterine growth restriction in normotensive pregnancies, spontaneous abortions), the characterization of the different types of pregnancy hypertension, the parity of the index pregnancy, and the precise use and timing of hormonal replacement, data that have not been considered in studies including women over 60 years of age.12,13,68 The weight of the evidence is such that waiting for prospective controlled cohort studies, full understanding of the molecular pathways involved in this association, identification of the most cost-effective markers, and an evaluation of the effect of CVR modification on pregnancy constitute an ethical conundrum.

Acknowledgments
I thank Alfredo Germain, MD, for including me in the first studies of endothelial function performed in Chile. Watching in real time the normal or reduced brachial flow-mediated vasodilation and waveforms of the uterine arteries underscored the gatekeeper role of the spiral arteries to accept or oppose the invading trophoblast. The English usage was edited by San Francisco Edit.

Disclosure
The author reports no conflicts of interest in this work.

References


