Flow-Mediated Vasodilation and Plasma Fibronectin Levels in Preeclampsia

Atsushi Yoshida, Shinji Nakao, Mitsunao Kobayashi, Hisaaki Kobayashi

Abstract—To clarify the vascular endothelial function in pregnant women with hypertensive disorders, we assessed the flow-mediated vasodilation in the radial artery and compared it with plasma fibronectin levels. We determined flow-mediated vasodilation by measuring the change in radial artery diameter during hyperemia in 58 normal pregnant women, 22 preeclamptic pregnant women, and 15 pregnant women with chronic hypertension. In 41 of the 95 pregnant women, we measured the plasma fibronectin levels. Flow-mediated vasodilation in preeclamptic women was significantly less than that in normal pregnant women \( (P<0.001) \). In chronic hypertensive women, flow-mediated vasodilation was significantly less than that in normal pregnant women \( (P<0.001) \) but more than that in preeclamptic women \( (P<0.001) \). Flow-mediated vasodilation showed significant negative correlation with plasma fibronectin levels \( (P<0.001, r=0.73) \). Our results indicate that the endothelial function can be noninvasively assessed in pregnant women with hypertensive disorders by measuring the flow-mediated vasodilation of the radial artery with high-resolution ultrasound. (Hypertension. 2000;36:400-404.)

Key Words: endothelium ■ vasodilation ■ preeclampsia ■ hypertension, pregnancy ■ fibronectins

Recent evidence suggests that vascular endothelial dysfunction might play an important role in the pathogenesis of preeclampsia. There are several suggested methods for assessment of the endothelial damage, including the evaluation of endothelial cell–derived biochemical markers. Endothelium-related serum factors such as cellular fibronectin and the von Willebrand factor have been shown to be abnormal in preeclampsia.

Another method is the assessment of endothelium-dependent vascular relaxing function. An important functional consequence of endothelial dysfunction is the inability to release endothelium-derived relaxing factor (EDRF). EDRF is released in response to various pharmacological and physiological stimuli and results in increased blood flow. Under physiological conditions, increased blood flow subsequent to the release from temporal occlusion of the peripheral artery causes vasodilation, which is called reactive hyperemia. With high-resolution ultrasound, it is possible to objectively observe the vascular changes associated with reactive hyperemia.

To clarify the endothelial function in pregnancy complicated with hypertensive disorders, we noninvasively assessed the flow-mediated vasodilation in the radial artery with a recently developed 30-MHz mechanical linear probe. Previously, we reported flow-mediated vasodilation in smaller number of pregnant subjects. In our current report, we measured plasma fibronectin level, one of the endothelial cell–injury markers, and determined the relationship between vasodilation and fibronectin level.

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at end diastole. Flow-mediated vasodilation was determined by calculating the change in the radial artery diameter \( \frac{\text{[maximum radial artery diameter]}}{\text{[baseline radial artery diameter]}} \times 100\% \).

We measured the plasma fibronectin levels in 41 of the 95 subjects with antigen-antibody reaction of the turbidimetric immunoassay method. Blood samples were taken within 24 hours after measurement of the radial artery diameter.

ANOVA was used to compare the mean values. Populations were compared with use of the \( \chi^2 \) test. Correlation coefficients were compared with use of the \( \chi^2 \) correlation test. The significance of the difference among the correlation coefficients was assessed with \( t \) correlation test; \( P < 0.01 \) was considered statistically significant.

## Results

The baseline radial artery diameter under the conditions of normal pregnancy, preeclampsia, and chronic hypertension was 2.3 ± 0.3, 2.4 ± 0.5, and 2.5 ± 0.4 mm, respectively. No significant differences were seen among these 3 groups.

Figure 2 shows the changes in mean percent dilation of radial artery before and after the cuff deflation. Maximum dilation was obtained 1 minute after cuff deflation. No significant difference was shown between baseline diameter and radial artery diameter after 4, 5, and 6 minutes: that is, radial artery diameter returned to the baseline diameter 4 minutes after the cuff deflation.

Figure 3 shows the relationship between gestational age and radial artery vasodilation. In the normal pregnant subjects, vasodilation was gradually increased according to the progression of gestational age. However, preeclamptic women persistently had little vasodilation. Pregnant women with preeclampsia showed significantly less vasodilation (7.9 ± 3.0\%) than did normal pregnant women (17.4 ± 4.2\%, \( P < 0.001 \)) or chronic hypertensive pregnant women (13.9 ± 2.2\%, \( P < 0.001 \)). The chronic hypertensive pregnant women showed significantly less vasodilation than did the normal pregnant women (\( P < 0.001 \)).

Figure 4 shows the mean fibronectin levels in each group. The preeclamptic subjects showed significantly higher levels of plasma fibronectin than did the normal pregnant or chronic hypertensive pregnant women. The relationship between vasodilation and plasma fibronectin is shown in Figure 5. A significant negative correlation was seen between vasodilation and plasma fibronectin (\( P < 0.001 \)); the correlation coef-

### Characteristics of the 3 Groups

<table>
<thead>
<tr>
<th></th>
<th>Normal Pregnancy</th>
<th>Preeclampsia</th>
<th>Chronic Hypertension</th>
<th>Total</th>
<th>( P )</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of patients</td>
<td>58</td>
<td>22</td>
<td>15</td>
<td>95</td>
<td></td>
</tr>
<tr>
<td>Maternal age, y</td>
<td>29.3 ± 5.0</td>
<td>30.1 ± 3.70</td>
<td>29.9 ± 4.5</td>
<td>29.6 ± 4.5</td>
<td>NS</td>
</tr>
<tr>
<td>Gestational age at measurement, wk</td>
<td>26.1 ± 8.0*</td>
<td>35.5 ± 3.7*</td>
<td>27.1 ± 7.6*</td>
<td>28.3 ± 8.2</td>
<td>( * P &lt; 0.001, * P &lt; 0.001 )</td>
</tr>
<tr>
<td>Parity</td>
<td>0.6 ± 0.7</td>
<td>0.3 ± 0.5</td>
<td>0.5 ± 0.7</td>
<td>0.5 ± 0.7</td>
<td>NS</td>
</tr>
<tr>
<td>Arterial blood pressure, mm Hg</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Systolic</td>
<td>113.0 ± 9.7*†</td>
<td>145.1 ± 6.3*</td>
<td>151.1 ± 11.2*†</td>
<td>126.9 ± 20.0</td>
<td>( * P &lt; 0.001, * P &lt; 0.001 )</td>
</tr>
<tr>
<td>Diastolic</td>
<td>65.3 ± 11.2*†</td>
<td>91.0 ± 3.9*</td>
<td>94.5 ± 11.0*†</td>
<td>76.1 ± 17.1</td>
<td>( * P &lt; 0.001, * P &lt; 0.001 )</td>
</tr>
<tr>
<td>Mean</td>
<td>81.2 ± 9.7*†</td>
<td>109.0 ± 3.8*</td>
<td>113.4 ± 9.7*†</td>
<td>93.0 ± 17.5</td>
<td>( * P &lt; 0.001, * P &lt; 0.001 )</td>
</tr>
<tr>
<td>Baseline radial artery diameter, mm</td>
<td>2.3 ± 0.4</td>
<td>2.4 ± 0.5</td>
<td>2.5 ± 0.4</td>
<td>2.4 ± 0.4</td>
<td>NS</td>
</tr>
<tr>
<td>Gestational age at delivery, wk</td>
<td>38.2 ± 1.1</td>
<td>38.8 ± 0.8</td>
<td>37.5 ± 1.5</td>
<td>38.0 ± 1.2</td>
<td>NS</td>
</tr>
<tr>
<td>Birth weight, g</td>
<td>2879 ± 413</td>
<td>3175 ± 450</td>
<td>2856 ± 715</td>
<td>2893 ± 514</td>
<td>NS</td>
</tr>
<tr>
<td>Cesarean delivery, %</td>
<td>20.7</td>
<td>33.3</td>
<td>31.8</td>
<td>25.3</td>
<td>NS</td>
</tr>
</tbody>
</table>

Values are mean ± SD or percent. NS, \( P > 0.01 \).
sufficient (Pearson’s correlation coefficient, $r$) was 0.73. In each group, a significant negative correlation was seen between vasodilation and plasma fibronectin (normal $P<0.01$, $r=0.45$; chronic hypertension $P<0.001$, $r=0.74$; preeclampsia $P<0.001$, $r=0.77$). A significant negative correlation was seen ($P<0.001$) between vasodilation and mean arterial pressure; the correlation coefficient between vasodilation and mean arterial pressure was 0.56, which was lower than that between vasodilation and plasma fibronectin, but the difference was not significant ($P=0.14$). In the preeclamptic group, a significant negative correlation was seen between vasodilation and mean arterial pressure ($P<0.01$, $r=0.52$). However, in the normal and chronic hypertensive groups, no significant correlation was seen (normal $P=0.1$, $r=0.21$; chronic hypertension $P=0.06$, $r=0.51$).

**Discussion**

Vascular endothelial damage has recently been thought to be a central pathogenic feature of preeclampsia.$^{1,2}$ To assess the endothelial damage, several methods have been used. One of the methods is the assessment of the endothelium-dependent vascular relaxing function. Another method is the assessment of the endothelial injury by measuring biochemical markers such as fibronectin and the von Willebrand factor.

Under physiological conditions, the endothelium of peripheral vessels produces vascular relaxing factors (EDRF). EDRF was first described by Furchgott and Zawadzki.$^6$ EDRF is produced by the endothelial cells and acts on vascular smooth muscles; it is released in response to various chemical and physical stimuli. An important functional consequence of endothelial dysfunction is the inability to release EDRF. Endothelial dysfunction has been shown in response to various pharmacological and physiological stimuli through the use of intravascular catheterization.$^7,8$ These invasive studies are not suitable for the assessment of endothelial function during pregnancy.

One stimulus that releases EDRF is increased blood flow.$^{15–17}$ Celermajer et al.$^9,10$ reported on noninvasive assessment through the measurement of postocclusion effects on the brachial artery during hyperemia with the use of high-resolution ultrasound. They showed that flow-mediated vasodilation of brachial artery is abnormal in smokers and in persons with hypercholesterolemia. Lieberman et al.$^{11}$ reported that endothelium-dependent vasodilation is impaired in postmenopausal women and improved with estrogen replacement therapy. Several other investigators reported on the noninvasive assessment of flow-mediated vasodilation.$^{18–21}$ However, all of these studies were conducted with nonpregnant subjects.

In pregnant subjects, previous studies have reported that endothelium relaxing function is reduced in pregnant women with preeclampsia. Ashworth et al.$^{22}$ reported that markedly reduced endothelium-dependent relaxation in response to bradykinin was found in the myometrial arteries of preeclamptic women. Cockell and Poston$^{23}$ reported that the arteries of preeclamptic women showed less flow-mediated vasodilation. However, these studies were in vitro studies with biopsy samples obtained from pregnant women during cesarean section.

In the present study, we indirectly assessed endothelial function in pregnant women who had hypertensive disorders with the use of high-resolution ultrasound. Flow-mediated vasodilation in preeclamptic women was significantly less than that of normal pregnant or chronic hypertensive women, and this finding is consistent with earlier studies. We used a recently developed 30-MHz ultrasound transducer, whereas previous studies with nonpregnant subjects have used 7.0- or 7.5-MHz high-resolution ultrasound transducer. Sorensen et al.$^{24}$ claimed that a 7.0-MHz transducer provided visualization of the brachial artery and flow-mediated vasodilation.$^{24}$ We, however, previously reported the serious limitations of the
7.5-MHz transducer in detection of the peripheral arteries such as the brachial and radial arteries. Instead of B-mode ultrasound, others have used an A-mode ultrasonic echo-tracking device with a 10-MHz transducer for the assessment of endothelial function in their report.

Joannides et al used an A-mode echo-tracking system in the radial artery and reported the relationship between nitric oxide (an EDRF) and flow-mediated vasodilation. We have never used this device, but in general, B-mode ultrasound images provide more directly recognizable visualization. In the current study, we used a recently developed 30-MHz ultrasound transducer, which enabled us to obtain clear visualization of the radial artery in all cases.

A number of researchers have reported increased levels of endothelial cell–derived biochemical markers in preeclamptic women. Fibronectin, an adhesive glycoprotein, is thought to be one of the cell-injury markers. Shaarawy and Didy compared the levels of various biomarkers (thrombomodulin, plasminogen activator inhibitor type 1, and fibronectin) and concluded that fibronectin was the most predictive of the three. Several authors reported increased plasma levels of fibronectin as a predictor of preeclampsia. In our current study, the plasma levels of fibronectin in preeclamptic women were significantly higher than those in women with normal pregnancy or chronic hypertension. This supports the potential predictive value of fibronectin as a marker of preeclampsia.

We compared the 2 methods (endothelium-dependent vascular relaxing function and a marker for preeclampsia) to assess the endothelial damage in preeclamptic women. Plasma total fibronectin is not exactly a marker of endothelial function and accurate measurement of the radial artery was in all cases. Flow-mediated vasodilation in preeclamptic women was significantly less than in normal pregnant women or chronic hypertensive pregnant women. There was a significant negative correlation between vasodilation and the plasma fibronectin level. These findings indicate that the decreased vasodilation response in preeclamptic women is probably related to endothelial dysfunction and that we can assess endothelial damage in preeclamptic women with non-invasive measurement of flow-mediated vasodilation.

**Conclusion**

We evaluated endothelial function during pregnancy with a 30-MHz ultrasound transducer, which provided clear visualization and accurate measurement of the radial artery was in all cases. Flow-mediated vasodilation in preeclamptic women was significantly less than in normal pregnant women or chronic hypertensive pregnant women. There was a significant negative correlation between vasodilation and the plasma fibronectin level. These findings indicate that the decreased vasodilation response in preeclamptic women is probably related to endothelial dysfunction and that we can assess endothelial damage in preeclamptic women with non-invasive measurement of flow-mediated vasodilation.

**References**


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