Preeclampsia

Urinary Excretion of C5b-9 in Severe Preeclampsia
Tipping the Balance of Complement Activation in Pregnancy

Richard M. Burwick, Raina N. Fichorova, Hassan Y. Dawood, Hidemi S. Yamamoto,
Bruce B. Feinberg

Abstract—The complement cascade is activated in normal pregnancy, and excessive complement activation propagates the systemic inflammatory response in severe preeclampsia. Consequently, biomarkers of complement dysregulation may be useful for prediction or treatment of disease. Because renal damage with proteinuria is a characteristic pathological feature of preeclampsia, we hypothesized that complement markers in urine, rather than plasma, could better reflect complement dysregulation in disease. To investigate this, we performed a case–control study of pregnant women, enrolling 25 cases with severe preeclampsia, 25 controls with chronic hypertension, and 25 healthy controls without hypertension matched by gestational age and parity. Subjects were recruited from the Brigham and Women’s Hospital from March 2012 to March 2013. Urine and blood samples were collected on the day of enrollment, with complement activation (C3a, C5a, and C5b-9) measured by ELISA. Severe preeclampsia was associated with marked elevations in urinary C5b-9 (median [interquartile range], 4.3 [1.2–15.1] ng/mL) relative to subjects with chronic hypertension (0 [0–0]) and healthy controls (0 [0–0]; P<0.0001). Urinary excretion of C5b-9 was detected in 96% of cases with severe preeclampsia, 12% of controls with chronic hypertension, and 8% of healthy controls. Cases were also notable for significantly greater urinary excretion of C3a and C5a. Plasma levels of C5a and C5b-9, but not C3a, were increased in the cases with severe preeclampsia compared with healthy controls; however, they did not distinguish preeclampsia from chronic hypertension, supporting our hypothesis that complement markers in urine, rather than plasma, better reflect complement dysregulation. Complement inhibition is an intriguing treatment option for patients with severe preeclampsia. (Hypertension. 2013;62:1040-1045.)

Key Words: complement system proteins ■ eculizumab ■ HELLP syndrome ■ preeclampsia ■ pregnancy

Central to innate immunity, complement activation is heightened in pregnancy,1 in part, to facilitate normal clearance of fetoplacental debris,2 circulating fetal DNA,3 and immune complexes.4 Under normal pregnancy conditions, the fetus is protected from maternal immune responses through an array of mechanisms, including trophoblast expression of complement regulatory proteins that inhibit complement at different steps of the activation cascade.5 However, in women who develop preeclampsia, early placental aberrations affect blood flow and oxygenation to the placenta, thereby predisposing to necrotic shedding of syncytiotrophoblast.6 The burden of fetoplacental debris becomes exaggerated in severe preeclampsia,7–10 propagating a systemic inflammatory response and placing strain on both classical and alternative complement signaling pathways (Figure 1) as early as the first trimester.11,12 In plasma, upstream complement activation fragments Bb and C3a are associated with future risk of preeclampsia,11,12 whereas excess generation of downstream factors C5a and C5b-9 is associated with severe clinical disease.13–16

The kidney is at particular risk of complement-mediated injury. For example, in response to renal ischemia, C3a and C5a induce inflammatory responses that contribute to renal tissue destruction, and C5b-9 mediates direct renal tubular injury.17,18 Because kidney injury is fundamental to the diagnosis and pathophysiology of preeclampsia and because both activated complement proteins and complement regulatory proteins have been found in the urine of patients with renal disease,19–21 we hypothesized that complement markers in urine, rather than plasma, would better reflect the degree of complement dysregulation in preeclampsia. To investigate this, we measured urine and plasma levels of C3a, C5a, and C5b-9 in subjects with severe preeclampsia compared with controls.

Methods

We enrolled 25 cases with severe preeclampsia, 25 controls with chronic hypertension, and 25 healthy controls without hypertension from a cohort of women receiving care at Brigham and Women’s Hospital from March 2012 to March 2013. The approval of institutional review board was obtained through the Partners Human Research Committee, and subjects gave informed consent. All procedures followed were in accordance with institutional guidelines. Pregnancies with multiple gestation or major fetal anomalies were excluded. Cases with preeclampsia were recruited from the labor and delivery ward or antepartum units and defined as severe if ≥1 of the following criteria were present: (1) persistent blood pressure ≥160 mmHg systolic or ≥110 mmHg diastolic, (2) proteinuria ≥5 g in a 24-hour urine specimen...
or ≥3+ in a random urine specimen, (3) oliguria <500 mL in 24 hours, (4) cerebral or visual disturbances, (5) pulmonary edema or cyanosis, (6) severe epigastric or right upper quadrant pain, (7) impaired liver function, defined by aspartate transaminase ≥100 K/µL (normal range, 150–450 K/µL), or (9) fetal growth restriction <10th percentile for gestational age. Blood pressure measurements were performed by licensed nurses or medical assistants, using automated digital manometers with the subject in sitting position and the arm at the level of the right atrium. Small, medium, or large blood pressure cuffs were used depending on body mass index (BMI). Control subjects had blood pressure measurements on the day of enrollment and additional measurements at subsequent antenatal visits to confirm proper group assignment. Eight subjects with chronic hypertension and 1 healthy control who developed preeclampsia after enrollment were excluded, being replaced by newly selected matched controls. Subjects with preeclampsia had serial blood pressures to confirm persistent blood pressure elevation by newly selected matched controls. Subjects with preeclampsia had blood pressures ≥160 mm Hg systolic or ≥110 mm Hg diastolic despite bed rest. All preeclampsia subjects had ≥300 mg protein on a 24-hour urine specimen or a spot urine protein/creatinine ratio ≥0.30 by clinical measurement. Controls with pre-existing chronic hypertension and healthy controls without pre-existing chronic hypertension or renal disease were recruited from prenatal clinics and matched 1:1 to cases with severe preeclampsia by parity (nulliparous or multiparous) and gestational age (±2 weeks). To minimize selection bias, every eligible case with severe preeclampsia identified during recruitment periods was approached for enrollment. Controls were identified from outpatient clinics as the first available subject meeting the matching criteria. Matching was confirmed by the treating provider who was blinded to demographic characteristics of the corresponding case.

Blood and urine samples were collected on the day of enrollment. Blood was collected in EDTA tubes and urine with a random clean-catch specimen or a Foley catheter. Samples were immediately centrifuged at −4°C, with the supernatant aliquoted and stored at −80°C. Complement activation was determined by human ELISA to measure C3a/C3a desArg (C3a), C5a/C5a desArg (C5a), and C5b-9 concentrations (BD Biosciences, San Jose, CA). Urinary placental growth factor (PlGF) levels were determined by human ELISA (R&D Systems, Minneapolis, MN). Samples were run in duplicate, and quality control samples (pooled plasma or urine) were used for determination of assay variability. Plasma samples were analyzed after 1:10,000 dilution (C3a) or 1:100 dilution (C5a, C5b-9); urine samples were analyzed after 1:2 dilution (C5a, C5a, C5b-9, and PlGF) followed by 1:20 to 1:200 dilution if protein levels exceeded the top standard. Intra-assay coefficient of variation was 5.6% (C3a), 3.4% (C5a), 4.5% (C5b-9), and 6.2% (PlGF); interassay coefficient of variation was 11.1% (C3a), 13.8% (C5a), 7.4% (C5b-9), and 13.2% (PlGF). Assay values within 2 SDs of the blank were considered below the lower limit of detection, which were 0.013 ng/mL (C3a), 0.012 ng/mL (C5a and C5b-9), and 3.2 pg/mL (PlGF).

Using colorimetric methods, urine total protein was determined with the Pierce-BCA Protein Assay Kit (Thermo Scientific, Rockford, AL) after separating interfering substances from the supernatant with the use of the Pierce Compat-Able Preparation Set (Thermo Scientific, Rockford, AL). Urine creatinine (U-Cr) was determined with the Pierce Creatinine Assay Kit (R&D Systems, Minneapolis, MN). Additional clinical variables (eg, BMI and blood pressure) and clinical laboratory parameters (eg, serum uric acid and 24-hour urine protein) were abstracted from medical records. The syndrome of hemolysis, elevated liver enzymes, and low platelets was diagnosed by established criteria.

Statistics

Before study initiation and based on previous studies,13–15,21 we estimated that 25 subjects per arm were required to demonstrate a 50% difference in plasma C3a, C5a, or C5b-9 levels between groups and a 2-fold difference in urine complement levels between groups, with α=0.05 and power=0.80. Plasma protein concentrations were presented as means±SD, and urine protein concentrations were presented as medians (interquartile range). Significant differences in the levels of protein concentrations between groups were determined with the paired t test (plasma) or the Wilcoxon sign-rank test (urine). Correlations between complement levels and clinical parameters were determined using Pearson correlation coefficient or Spearman correlation coefficient (nonparametric tests). Data analysis was performed with Stata 10.0 (StataCorp, College Station, TX), and statistical significance was determined by α=0.05.

Results

The baseline characteristics of the 3 study groups are provided in Table 1. Healthy nonhypertensive controls and hypertensive controls were matched to cases with severe preeclampsia by parity and gestational age at enrollment. Subjects with...
chronic hypertension or preeclampsia had higher BMI, subjects with chronic hypertension were older, and race was not significantly different between groups. Cases with severe preeclampsia were most commonly characterized by severe range blood pressures (72%), fetal growth restriction (56%), and transaminits (40%); 5 cases (20%) had hemolysis, elevated liver enzymes and low platelets syndrome superimposed on severe preeclampsia and 15 (60%) required delivery before 34 weeks of gestation. The peak systolic/diastolic blood pressure (mean±SD) among cases on the day of enrollment was 176±20.7/104±11.0 mm Hg, with 24-hour urine protein (median [range]) measuring 1020 (376–7329) mg.

Table 1. Characteristics of Study Subjects by Group

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Healthy Controls (n=25)</th>
<th>Chronic Hypertension (n=25)</th>
<th>Severe Preeclampsia (n=25)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gestational age at enrollment,* wk</td>
<td>30.9±4.8</td>
<td>31.3±4.7</td>
<td>32.3±4.2</td>
</tr>
<tr>
<td>Gestational age at delivery, wk</td>
<td>39.5±1.2</td>
<td>38.2±1.6</td>
<td>32.7±4.0†</td>
</tr>
<tr>
<td>Peak SBP at enrollment, mm Hg</td>
<td>111±9.5</td>
<td>133±12.1‡</td>
<td>176±20.7†</td>
</tr>
<tr>
<td>Peak DBP at enrollment, mm Hg</td>
<td>67.0±7.9</td>
<td>82.3±10.6‡</td>
<td>104±11.0†</td>
</tr>
<tr>
<td>Urine total protein/creatinine,§ mg/mg</td>
<td>0.64 (0–1.3)</td>
<td>0.64 (0.3–1.2)</td>
<td>1.9 (1.0–4.0)</td>
</tr>
<tr>
<td>Nulliparous,* %</td>
<td>68.0</td>
<td>68.0</td>
<td>68.0</td>
</tr>
<tr>
<td>Maternal age, y</td>
<td>29.0±5.5</td>
<td>33.6±5.9¶</td>
<td>30.6±5.2</td>
</tr>
<tr>
<td>Body mass index, kg/m²</td>
<td>28.6±4.1</td>
<td>34.4±9.2#</td>
<td>31.8±6.0**</td>
</tr>
<tr>
<td>Race, %</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>44.0</td>
<td>52.0</td>
<td>60.0</td>
</tr>
<tr>
<td>Black</td>
<td>24.0</td>
<td>32.0</td>
<td>20.0</td>
</tr>
<tr>
<td>Hispanic</td>
<td>28.0</td>
<td>16.0</td>
<td>12.0</td>
</tr>
<tr>
<td>Other</td>
<td>4.0</td>
<td>0.0</td>
<td>8.0</td>
</tr>
</tbody>
</table>

Data are mean±SD; comparisons between groups assessed by paired t tests and differences are nonsignificant (P>0.05) unless otherwise specified. CHTN indicates chronic hypertension.

*Controls matched 1:1 to cases by gestational age and parity.
†P<0.0001, preeclampsia vs healthy controls or CHTN.
¶P<0.0001, CHN vs healthy controls.
§Data are medians (interquartile range).
||Wilcoxon signed-rank test P<0.01, preeclampsia vs healthy controls or CHTN.
#P<0.003, CHTN vs healthy controls.
**P=0.04, preeclampsia vs healthy controls.

Table 2. Plasma C3a, C5a, and C5b-9 in Cases and Controls

<table>
<thead>
<tr>
<th>Study Measure</th>
<th>Healthy Controls (n=25)</th>
<th>Chronic Hypertension (n=25)</th>
<th>Severe Preeclampsia (n=25)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plasma C3a</td>
<td>3219±548</td>
<td>3038±656</td>
<td>3373±916</td>
</tr>
<tr>
<td>Plasma C5a</td>
<td>31.6±13.5</td>
<td>51.8±9.9*</td>
<td>40.8±15.5†</td>
</tr>
<tr>
<td>Plasma C5b-9</td>
<td>348±172</td>
<td>485±233‡</td>
<td>444±171‡</td>
</tr>
</tbody>
</table>

Data are mean±SD (ng/mL); comparisons between groups assessed by paired t tests and differences are nonsignificant (P>0.05), unless otherwise specified. CHTN indicates chronic hypertension.

*P<0.0001, CHTN vs healthy controls; †P=0.01, CHTN vs preeclampsia.
¶P=0.04, preeclampsia vs healthy controls.

Urinary levels of complement activation are displayed in Table 2. Subjects with severe preeclampsia or chronic hypertension had higher levels of plasma C5a and C5b-9, but not C3a, compared with healthy controls. Plasma levels of C5a, C3a, and C5b-9 did not correlate with peak systolic/diastolic blood pressure or BMI.

Urinary levels of complement activation are displayed in Figure 2. Urinary C3a levels were detectable in nearly all subjects but were significantly increased in severe preeclampsia group versus both control groups (P<0.01). These findings were unchanged after adjustment for U-Cr (median urine C5a/U-Cr [interquartile range], preeclampsia: 9.2 [2.0–20] ng/mg, compared with healthy controls. Plasma levels of C5a, C3a, and C5b-9 were significantly different between groups. Cases with severe preeclampsia were older, and race was not significantly different between chronic hypertension and preeclampsia, but were greater in both these groups compared with healthy controls (Figure 2). These findings were unchanged after adjustment for U-Cr (median urine C5a/U-Cr [interquartile range], preeclampsia: 0.59 [0.17–2.5] ng/mg or chronic hypertension: 0.46 [0.27–0.81] ng/mg versus healthy controls: 0.11 [0–0.38] ng/mg; P<0.01). Urine C5a levels correlated with total urine protein (r=0.43; P=0.0001) and peak systolic blood pressure (r=0.36; P=0.002) but not BMI.

Urinary C5b-9 was detectable in 96% of subjects with severe preeclampsia compared with only 12% of controls with chronic hypertension and 8% of healthy controls (P<0.0001). C5a levels were not significantly different between preeclampsia and chronic hypertension groups but were greater in both these groups compared with healthy controls. These findings were unchanged after adjustment for U-Cr (median urine C5a/U-Cr [interquartile range], preeclampsia: 0.59 [0.17–2.5] ng/mg or chronic hypertension: 0.46 [0.27–0.81] ng/mg versus healthy controls: 0.11 [0–0.38] ng/mg; P<0.01). Urine C5a levels correlated with total urine protein (r=0.43; P=0.0001) and peak systolic blood pressure (r=0.36; P=0.002) but not BMI.
In severe preeclampsia, heightened activation of downstream complement protein C5 leads to excess generation of C5a, C5b-9, and platelet activation, procoagulant effects, and lytic cell death. In addition, C5a stimulates monocytes to release soluble fibronectin-like tyrosine kinase 1, which sequesters vascular endothelial growth factor and PlGF, contributing to hypertension and glomerular endotheliosis.

Our results introduce the novel finding that complement activation products C3a, C5a, and C5b-9 are excreted in urine in association with severe preeclampsia. Although urinary excretion of C3a, C5a, and C5b-9 was exaggerated in cases with severe preeclampsia compared with healthy controls, excretion of C5b-9 distinguished most clearly between severe preeclampsia and chronic hypertension. As a biomarker of disease, urinary C5b-9 was superior to plasma C5b-9, which could not distinguish between cases and hypertensive controls, supporting our hypothesis that complement markers in urine, rather than plasma, better reflect complement dysregulation.

Considering that plasma levels of C5a and C5b-9 were increased in subjects with preeclampsia, it is possible that urinary excretion of C5a and C5b-9 occurred because normal plasma clearance mechanisms were overwhelmed. However, we found that urinary complement levels (C3a, C5a, or C5b-9) did not correlate with plasma complement levels among women with severe preeclampsia, arguing against simple renal clearance of circulating complement proteins. Although urinary excretion of complement proteins correlates with blood pressure and proteinuria, among cases with preeclampsia, urinary complement markers correlated more strongly with each other than with markers of renal impairment. We hypothesize that exaggerated and coordinated urinary excretion of C3a, C5a, and C5b-9 in severe preeclampsia occurred because of complement-mediated inflammation and injury in the kidney, possibly at the level of the proximal tubule as seen in renal ischemia reperfusion injury.

Although urinary levels of C3a, C5a, and C5b-9 were all increased in cases with severe preeclampsia, downstream markers of C5 activation, particularly C5b-9, were more exaggerated in disease. Similarly, plasma levels of C5a and C5b-9, but not C3a, were increased in cases with severe preeclampsia and controls with chronic hypertension. Increased plasma C5 activation in controls with chronic hypertension may reflect heightened endothelial dysfunction or systemic inflammation and is consistent with the general finding that chronic hypertension in pregnancy predisposes to severe preeclampsia.

Taken together, our data suggest that complement dysregulation in ongoing disease occurs primarily at the level of C5. Animal models also support a dominant role for C5, relative to C3, in both complement-mediated kidney injury and adverse pregnancy outcomes. Levels of C5a and C5b-9 may rise out of proportion to C3a because of direct C5 activation (ie, enzymatic cleavage) by extrinsic serine proteases, bypassing proximal complement pathways. These extrinsic activators of C5 may be derived from leukocytes or the coagulation cascade (eg, thrombin). Alternatively, complement gene mutations (eg, CD46 gene mutations) may predispose to increased production of C5 convertases that generate C5a and C5b.

Presumably, C5a and C5b-9 should be generated in similar amounts from C5 activation. However, C5a has high affinity for its receptors and is rapidly cleared from circulation.

(Discussion)
Furthermore, distinct C5a receptors in the kidney may be expressed in the proximal tubule or thick ascending limb of Henle loop (C5aR) or the distal convoluting tubule (C5L2), which may limit the usefulness of urinary C5a as a biomarker of disease activity. C5b-9 seems to be a more reliable urinary marker for various renal diseases. C5b-9 may be formed at the glomerular membrane and shed into the urine, or complement proteins may pass through the glomerular membrane into the tubular lumen to stimulate complement activation and formation of C5b-9 in the proximal tubule. Furthermore, our data also show that increased levels of urinary C5b-9, but not C3a or C5a, correlate well (ie, inversely) with urinary PIGF, a validated marker of the altered angiogenic state in preeclampsia.

Our findings support the concept that severe preeclampsia is propagated by excess complement activation and eventual complement dysregulation, particularly at the level of C5. We propose that during gestation increasing amounts of apoptotic fetoplacental debris secondary to early placental aberrations, underlying comorbid conditions (eg, chronic hypertension), or genetic factors may trigger excess complement activation, which propagates systemic inflammation, angiogenic imbalance, endothelial dysfunction, coagulation activation, and oxidative stress, with eventual kidney injury and hypertension. We suspect that complement-mediated inflammation and injury in the kidney are particularly detrimental in severe preeclampsia as suggested by marked urinary excretion of C5b-9 during active disease. Although heightened C5 activation occurred in pregnant gravidas with chronic hypertension, urinary excretion of C5b-9 was specific to preeclampsia. Our findings support urinary C5b-9 as a promising biomarker for severe preeclampsia, which may distinguish pathologic complement dysregulation from simply heightened complement activation. Furthermore, our finding that complement dysregulation is common in severe preeclampsia suggests that complement inhibition may be a viable treatment option.

Perspectives

Our conclusions are limited by sample size and heterogeneity of disease in severe preeclampsia. At this point, neither can we apply our findings to mild preeclampsia or atypical disease nor may we generalize them to gravidas with multiple gestation or baseline renal disease. We also cannot comment on the ability of urinary complement markers to predict disease onset. However, our findings support the hypothesis that active disease in severe preeclampsia is commonly associated with complement dysregulation, which is particularly manifest through exaggerated urinary excretion of C5b-9. In an ongoing pregnancy, if the nidus for complement activation is fetoplacental debris, the downward spiral of complement dysregulation will only abate with delivery and removal of the placenta. Delivery is a safe and preferred option at term or near-term, but delivery of an extremely premature neonate in the setting of early-onset severe preeclampsia is associated with high neonatal morbidity and mortality. Considering our data, we think that there is a compelling argument to attempt C5 blockade, in the setting of a clinical trial, as a putative treatment for early-onset severe preeclampsia. This rationale is supported by our recent report in which Eculizumab, a C5 inhibitor, was used to prolong pregnancy in the setting of severe preeclampsia/hemolysis, elevated liver enzymes, and low platelets syndrome. Treatment with complement blockade offers the intriguing potential to stem ongoing disease in preeclampsia while safely prolonging pregnancy for both the mother and the child.

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Disclosures

None.

References

Urinary Complement Proteins in Severe Preeclampsia

What Is New?

- In association with severe preeclampsia, complement proteins are excreted in the urine.
- Urinary excretion of C5b-9 in pregnancy differentiates cases with severe preeclampsia from healthy controls and controls with chronic hypertension.

What Is Relevant?

- Complement dysregulation may propagate systemic inflammation, kidney injury, and hypertension in severe preeclampsia.
- Complement blockade, at the level of C5, is an intriguing therapeutic target for severe preeclampsia.

Novelty and Significance

Severe preeclampsia is commonly associated with urinary excretion of downstream complement proteins. In particular, exaggerated urinary excretion of C5b-9 in pregnancy seems to distinguish cases with severe preeclampsia from healthy controls and controls with chronic hypertension. C5-mediated inflammation and injury in the kidney may be a central feature of disease, suggesting a therapeutic rationale for complement blockade.
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