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Feasibility of nephrinuria as a screening tool for the risk of pre-eclampsia: prospective observational study

Tianyue Zhai, Itsuko Furuta, Rina Akaishi, Kosuke Kawabata, Kentaro Chiba, Takeshi Umazume, Satoshi Ishikawa, Takahiro Yamada, Mamoru Morikawa, Hisanori Minakami

ABSTRACT

Objectives: To investigate the possibility of nephrinuria as a screening tool for the risk of pre-eclampsia (PE).

Design: Prospective observational study.

Setting: A single university hospital. Changes in urinary nephrin:creatinine ratio (NCR, ng/mg) and protein:creatinine ratio (PCR, mg/mg) in pregnancy were determined. Significant proteinuria in pregnancy (SPIP) was defined as PCR>0.27. PE was diagnosed in women with both SPIP and hypertension.

Participants: 89 pregnant women in whom neither hypertension nor SPIP was present at enrolment, providing 31, 125 and 93 random urine samples during first, second and third trimesters, respectively.

Results: PE developed in 14 of the 89 women. NCR increased with increasing PCR in 14 women with PE (correlation coefficient, 0.862; p<0.0001). In contrast, NCR did not change significantly despite significant increases in PCR in 75 women with normotensive pregnancies defined as neither SPIP nor hypertension, indicating that there was little increase in nephrinuria over the physiological range of proteinuria in pregnancy. Relative risk of later development of PE among asymptomatic second and third trimester women with NCR (ng/mg) ≥122 (95th centile value for 75 women with normotensive pregnancies) was 5.93 (95% CI 2.59 to 13.6; 60% (6/10) vs 10% (8/79)) and 13.5 (95% CI 3.31 to 55.0; 75% (6/8) vs 5.5% (2/36)), respectively, compared with women with NCR<122 at that time.

Conclusions: Nephrinuria was unlikely to increase in normal pregnancy. A certain NCR cut-off may efficiently differentiate women at higher risk of PE.

INTRODUCTION

Nephrin is a podocyte-specific transmembrane protein that is predominantly localised at the glomerular slit diaphragm of podocytes. The podocytes, glomerular epithelial cells located at the outermost layer of the glomerular basement membrane (GBM) and their foot processes form tight interdigitating networks and regulate the filtration of circulating plasma proteins from the capillary lumen into Bowman’s space. Thus, podocytes together with the GBM determine the permselectivity of plasma proteins, and podocytopathies result in proteinuria and increased numbers of podocytes in the urine (podocyturia). Increased podocyturia has been confirmed in pregnant women with pre-eclampsia (PE).

Nephrin expression was shown to be reduced in kidney biopsy specimens from women with PE and in autopsy specimens from women who died from PE. Soluble
nephrin (nephrinuria) is detected in the urine of pregnant women, and an increase in nephrinuria is seen in women with PE, indicating that reduced nephrin excretion is associated with increased nephrin shedding from podocytes.

To the best of our knowledge, there have been four studies regarding urinary nephrin concentration in pregnant women. All of these studies acknowledged the possibility of urinary nephrin as a biomarker predicting onset of PE. However, since longitudinal data on urinary nephrin in pregnancy have not been reported, the behaviour of urinary nephrin in pregnancy is not well understood. The present study was performed to determine changes in nephrinuria and the associations with proteinuria in women with normotensive and PE pregnancies.

**METHODS**
This study was conducted in accordance with the principles of the Declaration of Helsinki and with the approval of the Institutional Review Board of Hokkaido University Hospital (013-3999, 30 April 2014), a tertiary teaching hospital managing mainly high-risk pregnant women.

**Participants**
A total of 89 women participated in this study. All participants gave written informed consent prior to enrolment and fulfilled the following three conditions: (1) gestational week (GW) <22 at enrolment; (2) with neither significant proteinuria in pregnancy (SPIP) nor hypertension at enrolment and (3) gave birth at Hokkaido University Hospital during the study period from May 2014 to October 2015.

**Definitions of terms used in this study**
SPIP was defined as a protein:creatinine ratio (PCR, mg/mg) >0.27 (corresponding to 30 mg/mmol) in spot urine specimens. Hypertension was diagnosed in women with systolic blood pressure ≥140 mm Hg and/or diastolic blood pressure ≥90 mm Hg on at least two occasions recorded more than 12 hours apart. The GW at new onset of hypertension and SPIP were specified in each participant. PE was diagnosed in women who showed hypertension and SPIP on and after GW 20. Normotensive pregnancy was defined as neither hypertension nor SPIP throughout pregnancy.

**Urine collection and assay methods for nephrin, protein and creatinine**
All spot urine samples were coded and processed within 2 hours of collection. Urine samples were transferred to tubes and centrifuged at 700×g for 5 min. Urinary supernatant was stored at −20°C until measurement of protein, creatinine and nephrin levels. Protein and creatinine concentrations were measured using a Protein Assay Rapid Kit Wako and Laboassay Creatinine (Wako Pure Chemical Industries, Osaka, Japan), respectively. Nephrin concentration was measured using an ELISA kit (Exocell, Philadelphia, Pennsylvania, USA). Urine samples were diluted in the range of 1:10–1:50 depending on proteinuria in the sample. The intra-array and interassay coefficients of variation for nephrin were <10%. Since the detection limits were 0.26 ng/mL for nephrin and 5 μg/mL for protein, we assumed that samples with undetectable levels contained 0.13 ng/mL nephrin and 2.5 μg/mL protein. Protein and nephrin concentrations in the urine were corrected by urine creatinine concentration and expressed as PCR (mg/mg) and nephrin:creatinine ratio (NCR, ng/mg).

**Statistical analyses**
Data are presented as the median (range). Statistical analyses were performed using the JMP10 statistical software package (SAS, Cary, North Carolina, USA). The Wilcoxon/Kruskal-Wallis method was used for comparison of medians. The Mann-Whitney U test with Bonferroni’s correction was used to compare median values between groups. Spearman’s rank-order correlation was used to test associations between two variables. In all analyses, p<0.05 was taken to indicate statistical significance.

**RESULTS**
Of the 89 women included in the study, 14 later developed both SPIP and hypertension during pregnancy and were diagnosed as having PE, while the remaining 75 developed neither SPIP nor hypertension and were judged as having normal pregnancies (table 1). The 14 and 75 women with PE and normotensive pregnancies provided 134 and 115 urine samples, respectively (table 1). Of the 75 normotensive control women, 18 provided three urine samples including one each collected during the first, second and third trimesters, five provided two urine samples including one each during the first and second trimesters, 18 provided two urine samples including one each during the second and third trimesters and the remaining 34 women provided only one urine sample collected during the second trimester. Thus, 134 urine samples from control women consisted of 23, 75 and 36 urine specimens collected during the first, second and third trimesters, respectively (table 1). Fourteen women who later developed PE provided a total of 115 urine samples (4–13 samples/woman; median, 7 samples) (table 1). Of the 115 urine samples, 73 were collected at a latent phase with neither SPIP nor hypertension. Six of the 14 women with PE developed SPIP first at GW 33.5 (26.0–29.1) and hypertension later at GW 37.1 (35.4–40.4). Six women developed SPIP and hypertension simultaneously at GW 30.8 (27.0–36.0). The remaining two women developed hypertension first at GW 32.9 and 34.2 and SPIP later at GW 35.3 and 36.1, respectively.

**Changes in NCR and PCR in normotensive pregnancies**
The urinary nephrin concentration ranged from 0.13 to 389.9 ng/mL, protein concentration ranged from 2.5 to 389.9 ng/mL, and creatinine concentration ranged from 0.13 to 30 mg/mmol.
165.0 μg/mL and the creatinine concentration ranged from 0.138 to 3.26 mg/mL in urine samples from 75 normotensive control women. NCR did not change significantly during pregnancy in normotensive control women. In the PCR range >0.27 in women with complications showed a PCR level of 0.047 (0.002–0.065) at enrolment.

Changes in NCR and PCR in PE pregnancies
The urinary nephrin concentration ranged from 0.13 to 26.691 ng/mL, protein concentration ranged from 2.5 to 19,903 μg/mL, and creatinine concentration ranged from 0.079 to 3.58 mg/mL in urine samples from 14 women with PE. Both NCR and PCR increased gradually with advancing GW (figure 1A,B, lower panels). The urinary nephrin concentration ranged from 0.13 to 3.26 mg/mL in urine samples from 75 normotensive control women. In the PCR range >0.27 in women with complications showed a PCR level of 0.047 (0.002–0.065) at enrolment.

Correlation of PCR with NCR and nephrin:protein ratio (NPR) in control women and women with PE
NCR was positively correlated with PCR in women with PE with a correlation coefficient of 0.862 (figure 3, upper right). Since the correlation between PCR and NCR was strong in women with PE, the NPR (ng/ng) did not change significantly according to PCR in women with PE (figure 3, lower right). However, NPR decreased significantly with increasing PCR (figure 3, lower left), confirming that nephrinuria hardly increased even in the presence of a significant increase in PCR in normotensive control women. In the PCR range >0.27 in women with PE, the correlation coefficient between PCR and NCR became stronger, reaching a value of

### Table 1 Demographic characteristics of 89 women

<table>
<thead>
<tr>
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<th>Control</th>
<th>Pre-eclampsia</th>
<th>p Value</th>
</tr>
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<tbody>
<tr>
<td>Number of women</td>
<td>75</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Maternal age (years)</td>
<td>34 (20–43)</td>
<td>38 (19–43)</td>
<td>0.6216</td>
</tr>
<tr>
<td>≥35</td>
<td>36 (48%)</td>
<td>8 (57%)</td>
<td>0.5299</td>
</tr>
<tr>
<td>≥40</td>
<td>8 (11%)</td>
<td>6 (43%)</td>
<td>0.0024</td>
</tr>
<tr>
<td>Nulliparous</td>
<td>39 (52%)</td>
<td>13 (93%)</td>
<td>0.0018</td>
</tr>
<tr>
<td>Twin pregnancy</td>
<td>0 (0.0%)</td>
<td>4 (29%)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Body height (m)</td>
<td>1.58 (1.45–1.68)</td>
<td>1.58 (1.48–1.66)</td>
<td>0.7290</td>
</tr>
<tr>
<td>Prepregnancy weight (kg)</td>
<td>51 (40–100)</td>
<td>54 (34–67)</td>
<td>0.7670</td>
</tr>
<tr>
<td>Body mass index (kg/m²)</td>
<td>20.2 (16.8–38.1)</td>
<td>21.8 (14.9–27.9)</td>
<td>0.6332</td>
</tr>
<tr>
<td>≥25</td>
<td>9 (12%)</td>
<td>2 (14%)</td>
<td>0.8115</td>
</tr>
<tr>
<td>Complications</td>
<td>56 (75%)*</td>
<td>8 (57%)†</td>
<td>0.1805</td>
</tr>
</tbody>
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GW at onset
- Hypertension
  - Control: NA
  - Pre-eclampsia: 34 (27–40)
- SPiP
  - Control: NA
  - Pre-eclampsia: 32.5 (26–39)

GW at delivery
- Control: 38 (36–41)
- Pre-eclampsia: 36 (30–40)

Infant birth weight (kg)
- Control: 2.91 (2.22–3.86)
- Pre-eclampsia: 2.29 (1.08–2.86)

Total number of urine samples
- Control: 134
- Pre-eclampsia: 115

Number of samples/person
- Control: 2 (1–3)
- Pre-eclampsia: 7 (4–13)

Timing of urine sampling
- First trimester (5–13)
  - Control: 23/23‡
  - Pre-eclampsia: 8/7‡
- Second trimester (14–27)
  - Control: 75/75‡
  - Pre-eclampsia: 50/14‡
- Third trimester (28–38)
  - Control: 36/36‡
  - Pre-eclampsia: 57/14‡
- Latent phase
  - Control: NA
  - Pre-eclampsia: 73/14‡
- SPiP alone phase
  - Control: NA
  - Pre-eclampsia: 16/6‡
- Hypertension alone phase
  - Control: NA
  - Pre-eclampsia: 4/2‡
- Pre-eclampsia phase
  - Control: NA
  - Pre-eclampsia: 22/14‡

Data are presented as the median (range).

*Complications included nine thyroid diseases, seven autoimmune diseases (Sjogren’s syndrome, immune thrombocytopenic purpura, antiphospholipid syndrome and rheumatoid arthritis), four depressions, four malignant neoplasms (after treatment), three familial protein S deficiency, three poor obstetrical history (fetal death in utero), 1 each with Wilson’s disease, brain aneurysm, Moyamoya disease, Cushing’s disease, lymphangitis, gene carrier of congenital immunodeficiency, recurrent pyelonephritis, epilepsy, pulmonary sarcoidosis, scoliosis, arrhythmia and asthma. These 56 women with complications showed a PCR level (mg/mg, median (range)) of 0.026 (0.001–0.111) at enrolment.

†Complications included three autoimmune diseases (2 systemic lupus erythematosus and 1 Sjogren’s syndrome), three urogenital malformations (unilateral renal aplasia, duplicate uterus, and bicornuate uterus), 1 diabetes mellitus and 1 chronic thyroiditis. These 56 women with complications showed a PCR level of 0.047 (0.002–0.065) at enrolment.

‡In square brackets, the number of women who provided urine samples is indicated.
In this range of proteinuria, nephrin accounted for $\sim 0.1 \text{–} 1.0\%$ of protein weight (figure 3, lower right).

**Correlation of NCR and PCR with GW in control women and possibility of NCR as a screening tool for prediction of PE onset**

As expected, the NCR level was not correlated significantly with GW (figure 4, upper left), while the PCR level was significantly positively correlated with GW in normotensive control women ($R=0.434$, $p<0.0001$) (figure 4, upper right). This implied that the 95th centile NCR level was constant, but the 95th centile PCR level changed with advancing GW during normotensive pregnancy.

To investigate the possibility that NCR was more efficient for differentiation of women at higher risk of PE than PCR, data on NCR and PCR of 14 women with PE at the latent phase were superimposed onto the upper panels of figure 4 (figure 4, lower panels). This expectation was confirmed. Women with NCR$>$95th centile value (122 ng/mg) compared with those with NCR$<$95th centile value showed relative risks (RR) of later developing PE of 5.93 ($p<0.0001$; 95% CI 2.59 to 13.6) and 13.5 ($p=0.0003$; 95% CI 3.31 to 55.0) for the second and third trimesters, respectively (see legend for figure 4). Women with PCR$>$95th centile value compared with women with PCR$<$95th centile value had RR of later developing PE of 4.06 ($p=0.0024$; 95% CI 1.64 to 10.0) for the second trimester. For the third trimester, however, PCR no longer significantly differentiated women with a higher and lower risk of PE (see legend for figure 4).
DISCUSSION

Since this study included a considerable number of women who were examined longitudinally, differences in changes in urinary NCR and PCR during normal pregnancies could be clearly observed; nephrinuria did not change significantly, while proteinuria increased with increasing GW in normotensive pregnancies. This dissociation between nephrinuria and proteinuria in normal pregnancy was noted for the first time in this study, and suggested that urinary NCR may be a more efficient means of detecting women at higher risk of developing PE compared with urinary PCR. In PE pregnancies, the degree of nephrinuria was closely correlated to that of proteinuria, especially at higher degrees of proteinuria with PCR>0.27. The nephrinuria in the preclinical stage of PE pregnancies (before onset of SPIP) was already greater than that in normal pregnancy.

Proteinuria increases physiologically with advancing gestation\(^{16}\) as confirmed in this study. In a study by Smith et al.,\(^{16}\) the mean PCR increased with advancing gestation in otherwise healthy women with singleton pregnancies; 0.065 in GW 16–20, 0.093 in GW 24–28 and 0.154 in GW 34–38. Spot urine PCR (mg/mg) >0.27 has been proposed as an alternative for confirmation of protein loss >300 mg/day in 24-hour urine collection.\(^{17}\) International guidelines support the upper limit of normal proteinuria during pregnancy of 300 mg/24 hours.\(^{18}–^{21}\) Some patients with PE exhibit SPIP first and hypertension later.\(^{22}–^{23}\) This suggested that PCR can be used as a biomarker for prediction of PE. Indeed, 6 of the 14 women with PE developed SPIP first before development of hypertension in this study, and some benefits of the use of PCR for the prediction of PE were demonstrated in this study; a PCR cut-off specific for the second trimester differentiated women with higher from lower risk of PE. However, the observation that PCR increased with advancing gestation even in normal pregnancy decreased the usefulness of PCR in advanced GW; a PCR cut-off specific for the third trimester no longer differentiated women with higher from lower risk of PE among asymptomatic women in the third trimester in this study. This drawback, inherent to PCR, was suggested to be negligible in NCR for prediction of PE in this study.

The results of this study suggested that nephrinuria did not increase in normal pregnancy, but increased in

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**Figure 2** Changes in nephrin:creatinine ratio (NCR) and protein:creatinine ratio (PCR) in 14 women with pre-eclampsia (PE). Fourteen women with PE provided a total of 115 urine samples. Open and closed circles indicate urine samples before and after onset of significant proteinuria in pregnancy (SPIP), respectively (upper panels). Urine samples from individuals were classified into the following four clinical phases: phase 1 (P1), urine collected at the earliest gestational week (GW) of 13.5 (10.6–21.7); phase 2 (P2), urine collected at the latest GW of 29.7 (23.0–37.4), but before onset of SPIP; phase 3 (P3), urine exhibiting SPIP for the first time at GW of 34.0 (26.0–39.1); and phase 4 (P4), urine collected on the day closest to delivery at GW 35.6 (29.1–40.4). The median NCR (ng/mg) was 49.2, 142.1, 851.4 and 3368.7 for P1, P2, P3 and P4, respectively. The median PCR (mg/mg) was 0.041, 0.087, 0.436 and 2.360 for P1, P2, P3 and P4, respectively. The median NCR of 142.1 for P2 was significantly higher than those in normotensive pregnancy (14.3, 32.3 and 26.6 for the first, second and third trimesters, respectively). The median protein concentrations (μg/mL) were 26.3, 56.4, 301.4 and 1237.8 for P1, P2, P3 and P4, respectively.

PE pregnancy. Even before the onset of SPIP, NCR levels in women who subsequently developed PE were already higher than those in normal pregnancy (see legend for figure 2). This enabled efficient differentiation of women with higher from lower risk of PE in our small population; in women in the second and third trimesters asymptomatic with respect to PE (with neither SPIP nor hypertension), but with NCR>122 ng/mg (95th centile value for normal pregnancy), the risks of PE were 5.9-fold and 13.5-fold higher, respectively, than in women with NCR<122 ng/mg.

In four previous studies regarding nephrinuria in pregnancy, the degree of nephrinuria was consistently greater in women with established PE.12–15 For example, in a study by Wang et al12 reporting nephrinuria in pregnancy for the first time in 2012, the mean NCR (ng/mg) was 107 vs 1894 and mean nephrin concentration (ng/mL) was 86 vs 1226 for women with normotensive pregnancy vs women with PE pregnancy having a mean proteinuria of 2579 mg/day, respectively. Screening characteristics of urinary nephrin were examined in two previous studies with promising results;13 15 sensitivity and specificity were 73% and 79%, respectively, in one study,13 and 57% and 58%, respectively, in the other study for prediction of PE.15 In this study, the NCR cut-off of 122 ng/mg gave a sensitivity of 43% (6/14) and specificity of 95% (34/36) for the third trimester, respectively. Non-invasive urine tests, such as determination of NCR, may be useful for detecting women at higher risk of PE.

**STUDY LIMITATIONS**

Since our institution is a tertiary centre managing mainly women at higher risk, the PE prevalence rate in our cohort was higher than that in the general population. Indeed, 72% (64/89) of women had at least one

![Figure 3](http://example.com/figure3.png)

**Figure 3** Correlations of nephrin:creatinine ratio (NCR) and nephrin:protein ratio (NPR) with protein:creatinine ratio (PCR) in normotensive and pre-eclampsia (PE) pregnancies. Oblique lines, linear regression lines between two variables. Upper panels: the correlation between PCR and NCR was much weaker in normotensive control women than in women with PE (R=0.221 vs 0.862, respectively). In women who eventually developed PE, the correlation between PCR and NCR became stronger after onset of significant proteinuria in pregnancy (SPIP) compared with the clinical phase before SPIP onset; the R=0.577 for 77 urine samples before SPIP onset, which increased to 0.904 for 38 urine samples after SPIP onset. Lower panels: the NPR (ng/ng) did not change significantly according to PCR (right panel) in women with PE, while in normotensive control women, NPR decreased significantly with increasing PCR (left panel), suggesting that nephrinuria did not increase according to the amount of proteinuria over the physiological range, ie, PCR<0.27.
complication listed in the footnote for Table 1. Although not all of these complications were necessarily risk factors for PE, advanced maternal age, body mass index ≥25 kg/m² among Japanese women, twin pregnancy, diabetes mellitus/gestational diabetes mellitus, and connective tissue diseases such as rheumatoid arthritis, systemic lupus erythematosus, Sjögren’s syndrome, antiphospholipid syndrome, and some thyroid diseases...
associated with autoantibody are risk factors for PE. In our study population, as many as 49% (44/89) of women were aged 35 years or more. In the 14 women who developed PE, 43% (6/14) were aged 40 years or more, 29% (4/14) were twin pregnancies, and all of the remaining 6 women with singleton pregnancies and aged <40 years had risk factors for PE including systemic lupus erythematosus in two women, advanced maternal age (>35 years) in two women, Sjögren’s syndrome in one woman and diabetes mellitus in one woman. Thus, since our study participants were prone to PE, larger controlled studies in general pregnant women are required to determine the precise features of screening characteristics of NCR for prediction of PE.

CONCLUSIONS

Detailed investigations of changes in urinary NCR and PCR in normal and PE pregnancies revealed that urinary NCR and PCR increased gradually with advancing gestation in PE pregnancies, while NCR did not show significant changes despite the gradual increases in PCR in normotensive pregnancy. These observations suggested that urinary NCR may be a more efficient means of detecting women at higher risk of developing PE compared with urinary PCR.

Contributors TZ and IF contributed to the study design, sample collection, determination of urine variables and drafting of the manuscript. RA, KK, KC, TU, SI, TY and MM were responsible for obtaining informed consent from participants, sample collection and discussion on the study design. HM contributed to the study design, drafting of the manuscript and supervision of this study.

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Competing interests None declared.

Patient consent Obtained.

Ethics approval Institutional Review Board of Hokkaido University Hospital (O13-3999, April 30, 2014).

Provenance and peer review Not commissioned; externally peer reviewed.

Data sharing statement No additional data are available.

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