Impact of the Antiphospholipid Syndrome on Complications during Pregnancy

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Summary
The antiphospholipid syndrome (APS) is an autoimmune disease characterized by the appearance of antiphospholipid antibodies (APA) and at least one clinical manifestation like venous and arterial thrombosis or recurrent miscarriages and fetal loss in the second and third trimester. This most common acquired thrombophilia can also cause placental insufficiency, preclampsia, intrauterine growth retardation, and placental abruption. Several potential pathogenic pathways leading to a procoagulant state by activation of endothelial cells, monocytes or platelets and inhibition of the protein C activation pathway have been identified. These are supposed to be responsible for thrombosis and obstetric complications. Failed trophoblast differentiation and invasiveness, with subsequently hampered uteroplacental development, as well as thrombosis in the placental vessels are further pathogenic pathways for observed complications specific for pregnancy. Tests for anticardiolipin antibodies and lupus anticoagulant are most commonly used in clinical practice although antiphospholipid antibodies are a heterogeneous group. Current criteria for the classification of APS recommend the use of standardized ELISAs that measure β2-glycoprotein I-dependent IgG and IgM antiphospholipid antibodies and/or lupus anticoagulant. Current recommendations regarding prophylactic and therapeutic strategies in pregnancy are based on a systematic Cochrane review. Although APS is an autoimmune disease, anticoagulant therapy is the favored strategy to prevent thromboembolic events, miscarriages, or other pregnancy complications. The recommended therapy is the combination of heparin and low-dose aspirin reducing pregnancy loss by 54%. Aspirin alone, prednisone, or intravenous immunoglobulin infusion had no significant beneficial effect on pregnancy outcome, but rather a higher rate of side effects. Oral anticoagulants are contraindicated during pregnancy because of substantial embryotoxic side effects. Currently low-molecular-weight heparin replaces unfractonated heparin as drug of choice because of safe use for mother and fetus as well as fewer side effects as several studies have shown. Our experience has taught us that prophylaxis should be initiated as soon as pregnancy has been recognized in order to prevent the described pathologies in placental development.

Key Words
Antiphospholipid syndrome · Pregnancy outcome · Thrombosis · Fetal loss · Low-molecular-weight heparin · Low-dose aspirin

Schlüsselwörter
Antiphospholipid-Antikörpersyndrom · Schwangerschaft · Fehlegeburt · Thrombose · Niedermolekulares Heparin · Niedrig dosiertes Aspirin

Zusammenfassung
Introduction

The antiphospholipid syndrome (APS) is an autoimmune disease characterized by antiphospholipid antibodies (APA) along with at least one clinical manifestation [1]. The most specific clinical features are thrombosis (both venous and arterial), recurrent miscarriages and fetal loss in the second and third trimester, and autoimmune thrombocytopenia. It is the most common acquired thrombophilia and was originally described as part of systemic lupus erythematosus (SLE). Therefore, APS is considered to be primary when its occurrence is isolated, but secondary when associated with a connective tissue disease, particularly SLE [2]. Recent findings demonstrate the growing importance of APS for obstetricians pertaining the role of this autoimmune disease in recurrent pregnancy loss, placental insufficiency, preeclampsia, placental abruption, and thrombosis.

Classification and Diagnosis

Criteria for the classification of patients with definite APS were developed during a consensus meeting in Sapporo in 1998 [3] (table 1). Sapporo criteria have been evaluated and reported to have a sensitivity of 71% and a specificity of 98%, suggesting that the threshold for inclusion is high and that most cases have ‘definite’ APS [4].

Thus, in clinical practice APA should be monitored in all patients with venous or arterial thrombosis and fetal loss for which there is no alternative explanation, particularly in the presence of recurrent manifestations. Likewise, unexplained thrombocytopenia, hemolytic anemia and prolongation of any phospholipid coagulation tests should lead to determination of APA status because they could also represent clinical features of the APS (table 2).

APA tests may also result positive in a variety of other disorders, including connective tissue diseases, infectious disorders such as syphilis, Q fever, and AIDS. In these conditions, IgM isotype is present predominantly in low titers and not usually associated with clinical features of APS [5]. APA are a heterogeneous group of autoantibodies that are detected by immunoassays and functional coagulation tests. Tests for anticardiolipin antibodies and lupus anticoagulant are most commonly used in clinical practice. However, it is demonstrated that one of the main target antigens of APA actually consists of β2-glycoprotein I (β2-GPI), a phospholipid-binding protein involved in coagulation processes. Also antibodies directed toward other coagulation proteins, e.g. prothrombin, protein S, protein C and annexin V, act as phospholipid cofactors [6]. Even tough not yet fully understood, it is generally believed that not phospholipids but rather phospholipid-binding proteins or phospholipid-protein complexes constitute the real target of APA [7]. It has yet to be evaluated whether or not specific testing of these autoantibodies add significantly in the APS diagnosis [8]. Current criteria for the classification of APS recommend the use of standardized ELISAs that measure (β2-GPI-dependent IgG and IgM anticardiolipin antibodies and/or lupus anticoagulant according to the recommended criteria from the International Society on Thrombosis and Haemostasis Subcommittee on Lupus Anticoagulant/Antiphospholipid Antibody (see table 1) [9].

Epidemiology

A high variability in the prevalence of APA is reported in the normal population. Several studies have reported a frequency of 1–5% in the normal controls of case control studies [10]. The prevalence increases with age up to 12% in elderly people with chronic diseases [11]. A secondary APS will be developed in 30% of SLE patients [10]. In patients with rheumatoid arthritis a mean prevalence of 28% was reported [12]. Venous thrombosis can affect the vessels of any organ and is the most common manifestation of APS, followed by cerebral ischemia in the form of strokes and transient ischemic attacks [5]. Particularly, deep vein thrombosis of the lower limb occurs in up to 55%, half of whom also have pulmonary emboli [13]. The absolute risk of developing new thrombosis is low (<1% per year) in otherwise healthy patients without prior thrombotic events, may be moderately increased (up to 10% per year) in women with recurrent fetal loss without prior thrombosis, and is highest (>10% in the first year) in patients with a history of venous thrombosis who have discontinued anticoagulant drugs within 6 months [14].

Prospective studies in the general population have shown that the occurrence of APA was predictive of both a first deep venous thrombosis [15] and recurrent thromboembolism [16]. The prevalence of APA is about 30% in patients with venous thrombosis [10]. Two thirds of puerperal cerebral sinus venous thromboses seem to be associated with positive APA [17]. Among 128 unselected patients with primary APS, the clinical manifestations were deep vein thrombosis in 62 (48%) patients, arterial thrombosis in 63 (49%) patients, miscarriage in 177/320 (55%) pregnancies, and pulmonary embolism in 37 (30%) patients. Other clinical manifestations were migraine in 51 (40%), thrombocytopenia in 48 (38%), livedo reticularis in 47 (37%), and valvular disease in 27 (21%) patients [18].

The prevalence of anticardiolipin antibodies in general obstetric clinics has been reported to be between 2.7 and 7%. Prospective studies of low-risk pregnancies have found that their presence carried a 3–9 times higher risk of fetal loss [19]. A positive test for APA may be found in up to 45% of women with recurrent pregnancy loss [20]. An APS was present with either recurrent embryonic loss [21] or late abortion after 10 weeks of gestation (fig. 1) [22]. It is found in 10–15% of women with fetal death in later pregnancy [23]. In women with a history of at least three prior miscarriages and no ab-
normality, 90% miscarried and 94% experience fetal losses in further pregnancy [21].

The relation between APS and preeclampsia has been demonstrated in several studies (fig. 1) [24]. In a series of more than 300 patients with severe preeclampsia an overall incidence of 21% was found related to detectable APA, with a 27% incidence in the group with delivery at less than 28 weeks of gestation [25]. It should be noted that most studies found only an association with early-onset severe preeclampsia [26].

Laboratory criteria
1) Anticardiolipin antibody of IgG and/or IgM isotype in blood, present in medium or high titer, on 2 or more occasions, at least 6 weeks apart, measured by a standardized enzyme-linked immunosorbent assay for β2-GPI-dependent anticardiolipin antibodies.

2) Lupus anticoagulant present in plasma, on 2 or more occasions at least 6 weeks apart, detected according to the guidelines of the International Society of Thrombosis and Hemostasis (Scientific Subcommittee on Lupus Anticoagulants/Phospholipid-Dependent Antibodies) in the following steps:
   a) Prolonged phospholipid-dependent coagulation demonstrated on a screening test, e.g., activated partial thromboplastin time, kaolin clotting time, dilute Russell’s viper venom time, dilute prothrombin time, textarin time.
   b) Failure to correct the prolonged coagulation time on the screening test by mixing with normal platelet-poor plasma.
   c) Shortening or correction of the prolonged coagulation time on the screening test by addition of excess phospholipid.
   d) Exclusion of other coagulopathies, e.g., factor VIII inhibitor or heparin, as appropriate.

Pathogenesis

Several potential pathogenic pathways have been identified which are considered responsible for thrombosis and obstetric complications in patients with APS (fig. 2). Various studies have suggested that APA might cause thrombosis by activation of endothelial cells, monocytes or platelets, or by inhibition of the protein C activation pathway [5]. APA interfere with the function of the coagulation cascade, leading to a procoagulant state. Most of the antigenic targets of APA (table 3) are involved in the initiation and control of coagulation, thus influencing the pro- and anticoagulant balance [28]. Examples include inhibition of the activated protein C and antithrombin III pathways, inhibition of fibrinolysis, and upregulation of tissue factor activity. [13].

In this respect it may play a central role that the anticoagulant function of β2-GPI is compromised by APA. APA bind to the endothelial cell surface in a β2-GPI-dependent manner leading to direct endothelial cell activation, which is distinguished by upregulation of cell surface adhesion molecules and in-
Increased secretion of IL-6 and prostaglandins [13]. This endothelial dysfunction has recently been demonstrated clinically by an impaired vasodilatory response to increased blood flow shear stress [29]. Since clinical manifestation of APS does not occur in every case, an additional factor such as vascular bed injuries, cytokine and endothelial activation by infection or other procoagulant factors (immobilization, hormone and pregnancy effects, etc.), may be required.

In pregnancy, thrombosis of placental vessels may result in placental insufficiency which can in turn lead to fetal loss. Placental pathology is variable but can include infarction with utero-placental thrombus, perivillous fibrin deposits, and even chronic inflammatory lesions [30]. Placental tissue demonstrated more infarction, intravascular fibrin deposition, syncytial knot formation, and fibrosis than controls. These non-specific histologic features are not different in tissues from live births and pregnancy losses, or in treated and untreated pregnancies [31]. Annexin-V, an anticoagulant phospholipid-binding protein, is found expressed on the apical membranes of syncytiotrophoblasts as early as 7 weeks of gestation until term. The concentration of this protein appears to be reduced in the presence of APA, which may play an important role in the placental insufficiency and consequent fetal loss [32]. Disruption of this anticoagulant shield may predispose to coagulation in the intervillous space of the placenta and to recurrent spontaneous pregnancy losses.

Interestingly the most frequent histological abnormality in primary, APS-associated, early pregnancy loss is not excessive intervillous thrombosis but a defective decidual endovascular trophoblast invasion [33]. Lupus anticoagulant-positive sera cause increased apoptosis and reduced proliferation of the trophoblast in cultured placental villous tissue [34]. APA has
also been found to inhibit the differentiation of the extravil-
lous throphoblast cells in vitro. This leads to the suggestion
that this failure of trophoblast differentiation and invasiveness
subsequently hampers uteroplacental development and thus
represents a further pathogenic pathway for the observed
complication during pregnancy [35].

Prophylaxis and Therapy during Pregnancy

The management of the APS during pregnancy comprises the
following objectives:
– primary prophylaxis in asymptomatic pregnant women,
– secondary prophylaxis of recurrences in women who have
previously developed a pregnancy complication or throm-
boembolism, and
– treatment of an acute thromboembolic event or complica-
tion of the ongoing pregnancy.

Current recommendations regarding prophylactic and therapeu-
tic strategies in pregnancy are based on a systematic re-
view and meta-analysis of randomized controlled trials in the
Cochrane database [36]. Within a planned treatment, both ef-
cacy and adverse outcomes must be considered. Thirteen
studies, involving 849 participants, were included using treat-
mant with intravenous immunoglobulin infusion, low-dose as-
pirin, either alone, or in combination with prednisone, unfrac-
tionated heparin or low-molecular-weight heparin (LMWH).

Women with no history of thrombosis or prior fetal loss who
were found to have APA during the first pregnancy do not
need any treatment. Women with APS who have had prior

pregnancy complications or thromboembolic events, whether
or not associated with pregnancy, must receive therapy
throughout pregnancy and the post-partum period. Our ex-
perience has taught us that prophylaxis should be initiated as
soon as pregnancy has been recognized in order to prevent the
described pathologies in placental development.

Although APS is an autoimmune disease, anticoagulant ther-
apy is the favored strategy to prevent thromboembolic events,
miscarriages, or other pregnancy complications. The recom-
mended therapy is a combination of heparin and low-dose as-
pirin reducing pregnancy loss by 54% (relative risk (RR) 0.46;
95% confidence interval (95%-CI) 0.29–0.71) [36]. Aspirin
alone, when compared to placebo or standard care in 3 stud-
ies, had no significant beneficial effect on pregnancy outcome
(RR 1.05; 95%-CI 0.66–1.68) [19] (fig. 3).

Fig. 2. Pathogenic
mechanisms in APS
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Oral anticoagulants are contraindicated during pregnancy be-
because of substantial side effects. Coumarin derivatives cross
the placenta and are associated with embryopathy in up to 5%
of exposed fetuses, especially during the first trimester. Cen-
tral nervous system lesions by intracerebral hemorrhages can
occur in any trimester [37].

A prednisone plus aspirin therapy in moderate to high doses
could also not be recommended due to the lack of a beneficial
effect on the risk of fetal loss as compared to placebo or as-
pirin alone (RR 0.85, 95%-CI 0.53–1.36). On the other hand,
prednisone administration significantly increases the risk for
preterm delivery, preeclampsia, low birth weight, gestational
diabetes, and neonatal intensive care admission [38].

Intravenous immunoglobulin infusion seems to be effective in
some uncontrolled studies, but in randomized studies this very
expensive therapy was inferior to LMWH combined with aspirin or unfractionated heparin and aspirin alone (pregnancy loss or premature delivery RR 2.5, 95%-CI 1.27–4.95) [36]. In contrast, outcomes of intravenous immunoglobulin infusion did not significantly differ from that of prednisone and aspirin administration [39].

Although there is only a limited number of randomized studies as yet [40–42], LMWH currently replaces unfractionated heparin as drug of choice. LMWH exhibits a number of advantages [43]:

- LMWH do not cross the placenta and has no teratogenic or fetotoxic risks,
- the use is safe for mother and fetus as shown in several studies,
- improved bioavailability and easy route of self-administration,
- a longer half-life allows mostly only once daily injection,
- no monitoring necessary in prophylactic dosages,
- fewer side effects like hemorrhage, heparin-induced thrombocytopenia or osteoporosis.

The risk for preterm delivery was lower in LMWH-treated pregnancies compared with unfractionated heparin (27 vs. 48%; p < 0.001), whereas the rate of preeclampsia and intrauterine growth retardation was not different [42].

In own results the combination of LMWH and low-dose aspirin improved the rate of successful pregnancy outcome from 32 to 88% [44]. Generally all different LMWH used in clinical practice are suitable for prophylaxis during pregnancy (table 4). However, experience has mostly gained only for dalteparin [45], enoxaparin [46], and tinzaparin [47].

Low-dose aspirin prophylaxis with 100 mg daily is usually initiated as early as possible in pregnancy, but should be stopped after 35 weeks of gestation to prevent hemorrhages sub partum. LMWH therapy should be continued up to term, stopped during delivery, but started immediately after birth for at least 4–6 weeks because the highest risk for venous and arterial thrombosis is postpartum.

In women with acute venous thromboembolism, adjusted-dose LMWH is recommend throughout pregnancy for at least 5 days, followed by adjusted-dose LMWH for the remainder of the pregnancy and at least 6 weeks postpartum [48].

In nonpregnant patients with APS a moderately intense oral anticoagulation (adjusted to a target international normalized ratio of 2.0–3.0) reduces the risk of recurrent venous thrombosis by 80–90%, irrespective of the presence of APA, and may be effective in preventing recurrent arterial thrombosis [14].

The elucidation of the complexity of pathogenic mechanisms during pregnancy allows us today to substantially improve pregnancy outcome and women’s health.

Yet many questions remain open and await answers that further experimental research as well as prospective randomized clinical trials may deliver.
References