Pre-Eclampsia Is Associated With Increased Risk of Stroke in the Adult Offspring
The Helsinki Birth Cohort Study

Eero Kajantie, MD; Johan G. Eriksson, MD; Clive Osmond, PhD; Kent Thornburg, PhD; David J.P. Barker, FRS

Background and Purpose—Women who develop pre-eclampsia in pregnancy are at increased risk of cardiovascular disease. The offspring from pregnancies complicated by pre-eclampsia have higher blood pressures during childhood, but little is known about their long-term health. We hypothesized that pre-eclampsia would lead to an increased risk of cardiovascular disease in the offspring.

Methods—We traced 6410 babies born in Helsinki, Finland, from 1934 to 1944. We used the mothers’ blood pressure levels and the presence of proteinuria during pregnancy to define pre-eclampsia and gestational hypertension without proteinuria according to modern criteria.

Results—Two hundred eighty-four of the pregnancies were complicated by pre-eclampsia (120 with nonsevere and 164 with severe disease) and 1592 by gestational hypertension. The crude hazard ratio for all forms of stroke among people whose mothers had pre-eclampsia was 1.9 (1.2 to 3.0; P=0.01); among people whose mothers had gestational hypertension, it was 1.4 (1.0 to 1.8; P=0.03). There was no evidence that these pregnancy disorders were associated with coronary heart disease in the offspring. Pre-eclampsia, in particular severe disease, was associated with a reduced mean head circumference at birth, whereas gestational hypertension was associated with an increased head circumference in relation to body length.

Conclusions—People born after pregnancies complicated by pre-eclampsia or gestational hypertension are at increased risk of stroke. The underlying processes may include a local disorder of the blood vessels of the brain as a consequence of either reduced brain growth or impaired brain growth leading to “brain-sparing” responses in utero. (Stroke. 2009;40:1176-1180.)

Key Words: coronary artery disease ■ pre-eclampsia ■ pregnancy ■ pregnancy complications ■ stroke

Women who develop pre-eclampsia in pregnancy have higher levels of cardiovascular risk factors, including raised blood pressures, serum cholesterol concentrations, and hyperinsulinemia, and are at increased risk of cardiovascular disease in later life.1-9 The offspring from pregnancies complicated by pre-eclampsia have higher blood pressures during childhood,10-12 but little is known about their long-term health. We have examined hospital discharges and deaths from cardiovascular disease among men and women whose gestation was complicated by pre-eclampsia or by gestational hypertension and compared them with people born to normotensive mothers. We hypothesized that pre-eclampsia would lead to an increased risk of cardiovascular disease in the offspring.

Methods
The Helsinki Birth Cohort Study includes 13 345 men and women who were born as singletons from 1934 through 1944 in one of 2 maternity hospitals in Helsinki, the University Central Hospital and the City Maternity Hospital, who attended child welfare clinics in the city and who were still living in Finland in 1971, by which time a unique personal identification number had been assigned to each resident of the country. Details of the birth records have been described.13 They include the mother’s height, weight on admission to the birth hospital, age, and parity. Duration of gestation was estimated from the date of the last menstrual period. After birth, the babies visited child welfare clinics where their heights and weights were recorded.13 The birth, child welfare clinic, and school health-care records included in addition data on the fathers’ occupations, which were grouped into upper and lower middle class and manual workers based on a classification from Statistics Finland. We used father’s occupation as a marker of the family’s socioeconomic status.

In 6410 of the pregnancies, the mothers’ blood pressures and the results of urinary protein tests were recorded after 20 weeks of pregnancy at antenatal clinics or at the birth hospital. There were on average 2.0 blood pressure and 2.5 urinary protein measurements recorded in each pregnancy. All pregnant women were encouraged to attend the antenatal clinics, which were introduced in Helsinki in
We used the blood pressure levels and urinary protein results to define pre-eclampsia and defined 4 groups of mothers: (1) those who had severe pre-eclampsia, with proteinuria + and a systolic blood pressure of \(160\) mm Hg or more or a diastolic pressure of \(110\) mm Hg or more; (2) those who had nonsevere pre-eclampsia, with proteinuria+ and a systolic pressure of \(140\) mm Hg or a diastolic pressure of \(90\) mm Hg but no proteinuria; and (4) those who were normotensive, with neither systolic pressure attaining \(140\) mm Hg nor diastolic pressure attaining \(90\) mm Hg. The National Public Health Institute’s Register of people on medication for hypertension in Finland approved the study.
The associations were little changed by adjustment for birth weight or length of gestation. A total of 1275 of the offspring had received treatment for hypertension. Of these, 356 were born after pregnancies complicated by hypertension. People whose mothers had had severe pre-eclampsia or gestational hypertension were at increased risk of hypertension (Table 2).

Socioeconomic Status
Mothers with pre-eclampsia tended to be of higher socioeconomic status. Among upper middle class mothers, 3.0% had nonsevere pre-eclampsia and 3.1% had severe pre-eclampsia compared with 2.0% and 2.9% among mothers in lower middle class and 1.7% and 2.4% in manual workers’ families (P for trend = 0.03 and 0.02, respectively). Adjustment for socioeconomic status had little effect on the association between severe pre-eclampsia and stroke in the offspring, the hazard ratio being 2.3 (1.2 to 4.2; P = 0.01). The corresponding figure for gestational hypertension was 1.4 (1.0 to 1.8; P = 0.03). The associations of nonsevere or severe pre-eclampsia or gestational hypertension with coronary heart disease remained nonsignificant after adjustment for socioeconomic status (all P > 0.2).

Discussion
We have found that people born after pregnancies complicated by pre-eclampsia are at increased risk of stroke in adult life. Pre-eclampsia was also associated with increased risk of hypertension. However, we found no evidence of an increased risk of coronary heart disease in the offspring, although it is not possible to exclude a small increase in risk in a sample of this size.

Table 1. Mean Value (SD) of Measurements of Mothers and Babies in Pregnancies With Normal Blood Pressure, Gestational Hypertension, or Nonsevere or Severe Pre-Eclampsia

<table>
<thead>
<tr>
<th>Measurement</th>
<th>Normotension</th>
<th>Gestational Hypertension</th>
<th>Nonsevere Pre-Eclampsia</th>
<th>Severe Pre-Eclampsia</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(n=4271)</td>
<td>(n=1592)</td>
<td>(n=120)</td>
<td>(n=164)</td>
</tr>
<tr>
<td>Mother</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Height, cm</td>
<td>6089</td>
<td>159.5 ± 5.7</td>
<td>159.6 ± 5.7</td>
<td>160.4 ± 5.8</td>
</tr>
<tr>
<td>Body mass index in late pregnancy, kg/m²</td>
<td>5995</td>
<td>26.0 ± 2.8</td>
<td>26.8 ± 3.2              &lt;0.001</td>
<td>26.9 ± 3.4          0.002</td>
</tr>
<tr>
<td>Age, years</td>
<td>6404</td>
<td>27.8 ± 5.2</td>
<td>28.9 ± 5.8              &lt;0.001</td>
<td>27.7 ± 5.0          0.8</td>
</tr>
<tr>
<td>Parity</td>
<td>6408</td>
<td>1.9 ± 1.3</td>
<td>1.9 ± 1.3               0.06</td>
<td>1.6 ± 1.0           0.005</td>
</tr>
<tr>
<td>Primiparous, %</td>
<td>6408</td>
<td>48.6% ± 4.6%</td>
<td>54.4% ± &lt;0.001</td>
<td>65.8% ± 6.6%         0.002</td>
</tr>
<tr>
<td>Body size at birth</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight, g</td>
<td>6410</td>
<td>3435 ± 468</td>
<td>3382 ± 500              0.001</td>
<td>3216 ± 545          &lt;0.001</td>
</tr>
<tr>
<td>Length, cm</td>
<td>6365</td>
<td>50.3 ± 1.9</td>
<td>50.3 ± 2.0              0.05</td>
<td>49.7 ± 2.2          0.001</td>
</tr>
<tr>
<td>Head circumference, cm</td>
<td>6366</td>
<td>35.0 ± 1.5</td>
<td>35.1 ± 1.6              0.007</td>
<td>34.7 ± 1.5          0.05</td>
</tr>
<tr>
<td>Ponderal index, kg/m³</td>
<td>6365</td>
<td>26.9 ± 2.2</td>
<td>26.5 ± 2.3              &lt;0.001</td>
<td>25.9 ± 2.2          &lt;0.001</td>
</tr>
<tr>
<td>Length of gestation, days</td>
<td>6204</td>
<td>280.2 ± 12.9</td>
<td>279.7 ± 13.2            0.2</td>
<td>277.5 ± 14.8        0.02</td>
</tr>
<tr>
<td>Preterm, %</td>
<td>6204</td>
<td>4.7% ± 5.1%</td>
<td>5.1% ± &lt;0.001</td>
<td>6.7% ± 6.7%         0.03</td>
</tr>
<tr>
<td>Body size at age 2 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight, kg</td>
<td>6409</td>
<td>12.1 ± 1.2</td>
<td>12.1 ± 1.2              0.9</td>
<td>12.0 ± 1.2          0.5</td>
</tr>
<tr>
<td>Height, cm</td>
<td>6403</td>
<td>86.0 ± 3.2</td>
<td>86.1 ± 3.3              0.2</td>
<td>86.3 ± 3.4          0.4</td>
</tr>
<tr>
<td>Body mass index, kg/m²</td>
<td>6405</td>
<td>16.5 ± 1.2</td>
<td>16.5 ± 1.3              0.08</td>
<td>16.3 ± 1.2          0.03</td>
</tr>
</tbody>
</table>

P indicates P value for comparison with normotensives; preterm, 36 weeks to 6 days of gestation or before.

Table 2. Hospital Admissions or Deaths From Coronary Heart Disease and Stroke and the Occurrence of Hypertension Among Offspring Born at ≥37 Weeks of Gestation From Pregnancies Complicated By Gestational Hypertension or Pre-Eclampsia

<table>
<thead>
<tr>
<th>Cardiovascular Outcome</th>
<th>All (n=6410)</th>
<th>Gestational Hypertension (n=1592)</th>
<th>Pre-Eclampsia, Nonsevere (n=120)</th>
<th>Severe Pre-Eclampsia (n=164)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N of Cases</td>
<td>Relative Risk*</td>
<td>95% CI</td>
<td>P</td>
</tr>
<tr>
<td>Coronary heart disease</td>
<td>464</td>
<td>117</td>
<td>0.8–1.3</td>
<td>0.8</td>
</tr>
<tr>
<td>Stroke</td>
<td>272</td>
<td>81</td>
<td>1.0–1.8</td>
<td>0.03</td>
</tr>
<tr>
<td>Hemorrhagic</td>
<td>84</td>
<td>25</td>
<td>1.0–2.2</td>
<td>0.3</td>
</tr>
<tr>
<td>Thrombotic</td>
<td>173</td>
<td>55</td>
<td>1.1–2.2</td>
<td>0.02</td>
</tr>
<tr>
<td>Hypertension</td>
<td>1275</td>
<td>356</td>
<td>1.1–1.5</td>
<td>0.002</td>
</tr>
</tbody>
</table>

*Hazard ratios (adjusted for sex) for coronary heart disease and stroke; ORs (adjusted for sex and age) for hypertension using normotensive pregnancies as the comparison group.
Although there is considerable evidence linking pre-eclampsia with increased risk of coronary heart disease and stroke in the mother, we are unaware of any previous study that has followed up the offspring long enough to attain substantial rates of cardiovascular disease. The detailed maternity clinic and hospital records in the Helsinki Birth Cohort Study allowed us to achieve this. The prevalence of pre-eclampsia in our study was consistent with reported prevalences of 3% to 5% of pregnancies. As expected, it was more common among first pregnancies. Consistent with some, although not all, observations in European populations, pre-eclampsia was also more common in mothers in families of higher socioeconomic status. There was, however, no evidence of confounding by family socioeconomic status.

A limitation of the study is that we have no data on eclampsia itself, which at that time was a major obstetric challenge complicating 0.6% of pregnancies at Helsinki University Central Hospital. Moreover, our data did not allow us to require 2 elevated blood pressure measurements to establish diagnosis, resulting in a relatively high percentage of mothers with gestational hypertension. Although the number of subjects allowed relatively accurate hazard ratios for the main outcomes, conclusions based on subgroups analyses such as hemorrhagic and thrombotic stroke include a degree of uncertainty. Furthermore, we did not have data on some potential confounders such as family history of cardiovascular disease. We ascertained the occurrence of stroke and coronary heart disease through the national mortality and hospital discharge registers. These registers have been validated against individual hospital records. For stroke, there is a 90% agreement with the national hospital discharge register and 97% agreement with the death register. Corresponding figures for coronary heart disease are 94% and 95%. In Finland, 97% of stroke diagnoses are verified by CT scan, MRI imaging, or necropsy. We have previously discussed other limitations of the Helsinki Birth Cohort Study, which comprises 13 345 people who were born in one of 2 public hospitals in the city and attended child welfare clinics. Although the majority of children attended these clinics, which were free, attendance was voluntary. The distribution of social class, as indicated by fathers’ occupations, was similar, however, to that of the city as a whole. Only half of the cohort had antenatal records after 20 weeks of pregnancy and were therefore eligible for the present study. The body size at birth of people with these records was similar to that of people without records. Their mothers tended to be shorter and younger, although these differences were small. More of the mothers were primiparous, and more were married to manual workers. These differences would, however, introduce bias only if the association between hypertensive disorders in pregnancy and offspring cardiovascular disease were different in people who have antenatal records as compared with those who do not. This seems unlikely but cannot be excluded. Our data on body mass indices were based on the mother’s weight in late pregnancy and do not allow us to distinguish fat mass from retained fluid.

We followed up the offspring for 60 to 70 years after their birth. A number of previous studies have shown that low birth weight and short duration of gestation are associated with an increased risk of stroke in later life. We found that people whose mothers had pre-eclampsia were at increased risk of hemorrhagic or thrombotic stroke. This association was independent of the babies’ birth weights or gestational age at birth and therefore does not simply reflect the association between pre-eclampsia and fetal growth restriction or preterm birth. Babies from pregnancies complicated by pre-eclampsia had reduced head circumferences. We speculate that stroke may originate through reduced brain growth in utero as a consequence of fetal undernutrition. People whose mothers had gestational hypertension were also at increased risk of stroke. Although they had low birth weight indicating a degree of fetal undernutrition, they had a large head circumference in relation to their length. This suggests that growth of the brain had been protected at the expense of growth of the trunk. We have previously suggested that redistribution of cardiac output in favor of the brain, one of the fetal brain-sparing responses, may permanently change the structure of the cerebral arteries. We now speculate that stroke may originate in 2 ways, either through reduced brain growth or impaired brain growth leading to “brain sparing” responses. Obviously, these suggestions cannot be proved in a birth cohort study but remain to be tested in experimental settings.

In the mother, pre-eclampsia may more clearly be viewed as an early manifestation of an adverse phenotype that leads to cardiovascular disease. This phenotype may in part originate through slow growth in utero because women who had low birth weight are at increased risk of pre-eclampsia, hypertension, coronary heart disease, and stroke. This phenotype is associated with impaired implantation. This initiates pre-eclampsia in the mother and leads to impaired placentation and reduced nutrition in the fetus.

We found that children from pregnancies complicated by severe pre-eclampsia were thin at age 2 years. This is consistent with the reported association between thinness at 2 years of age and later hemorrhagic and thrombotic stroke. This association was not the result of the children’s living conditions after birth as assessed by the father’s occupation. This led to the suggestion that the association was a consequence of fetal undernutrition leading to thinness at birth that persisted through infancy. The association between severe pre-eclampsia and thinness at 2 years of age is in agreement with this.

Although we were unable to find evidence of an association between pre-eclampsia and coronary heart disease in the offspring, the point estimates of the relative risk were increased and the CIs did not overlap the null value by a lot. Hence, a small increase in the risk of coronary heart disease is possible, but to confirm it requires a larger study. The associations with stroke were much stronger. This suggests that pre-eclampsia is linked to a local disorder of the blood vessels of the brain rather than, or in addition to, a general vascular lesion. Both pre-eclampsia and gestational hypertension were also associated with hypertension, the major risk factor for hemorrhagic and thrombotic stroke, in the offspring. This is consistent with the observation that the offspring from pregnancies complicated by pre-eclampsia have raised blood pressures during childhood and adolescence.

In conclusion, we have found that people born after pregnancies complicated by pre-eclampsia or gestational...
hypertension are at increased risk of stroke in adult life. We speculate that the underlying processes may include local disorders of the blood vessels of the brain as a consequence of either reduced brain growth or impaired brain growth leading to “brain-sparing” responses.

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Disclosures
None.

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