STOX2 but not STOX1 is differentially expressed in decidua from pre-eclamptic women: data from the Second Nord-Trøndelag Health Study

M.H. Fenstad1,*, M.P. Johnson2, M. Løset1, S.B. Mundal1, L.T. Roten1, I.P. Eide3, L. Bjørge4, R.K. Sande4, Å.K. Johansson1, T.D. Dyer2, S. Forsmo5, J. Blangero2, E.K. Moses2, and R. Austgulen1

1Department of Cancer Research and Molecular Medicine, Faculty of Medicine, Norwegian University of Science and Technology (NTNU), Trondheim 7006, Norway 2Department of Genetics, Southwest Foundation for Biomedical Research, San Antonio, TX 78227, USA 3Department of Obstetrics and Gynecology, St Olavs Hospital, Trondheim 7006, Norway 4Department of Obstetrics and Gynecology, Haukeland University Hospital, Bergen 5021, Norway 5Department of Public Health and General Practice, Faculty of Medicine, NTNU, Trondheim 7006, Norway

*Correspondence address. E-mail: mona.n.fenstad@ntnu.no

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ABSTRACT: Variation in the Storkhead box-1 (STOX1) gene has previously been associated with pre-eclampsia. In this study, we assess candidate single nucleotide polymorphisms (SNPs) in STOX1 in an independent population cohort of pre-eclamptic (n = 1,139) and non-pre-eclamptic (n = 2,269) women (the HUNT2 study). We also compare gene expression levels of STOX1 and its parologue, Storkhead box-2 (STOX2) in decidual tissue from pregnancies complicated by pre-eclampsia and/or fetal growth restriction (FGR) (n = 40) to expression levels in decidual tissue from uncomplicated pregnancies (n = 59). We cannot confirm association of the candidate SNPs to pre-eclampsia (P > 0.05). For STOX1, no differential gene expression was observed in any of the case groups, whereas STOX2 showed significantly lower expression in deciduas from pregnancies complicated by both pre-eclampsia and FGR as compared with controls (P = 0.01). We further report a strong correlation between transcriptional alterations reported previously in choriocarcinoma cells over expressing STOX1A and alterations observed in decidual tissue of pre-eclamptic women with FGR.

Key words: intrauterine growth restriction (IUGR) / decidua basalis / pre-eclampsia / HUNT2 / STOX genes

Introduction

Pre-eclampsia is a serious complication of pregnancy and a major cause of preterm intervention by Caesarean section, as delivery relieves symptoms. The condition presents with de novo elevated blood pressure and proteinuria after 20 weeks of pregnancy. Severe pre-eclampsia is not well defined, but assessment for severity includes both the mother (severe hypertension, end organ manifestations and preterm disease), and the fetus (intrauterine growth restriction, fetal movement assessment and oligohydramnios) (Gifford et al., 2000). As defined in clinical practice, ~20% of pre-eclamptic cases are severe. Early identification, as well as more refined treatment options, is particularly important for these women, and this remains a major challenge in obstetric medicine. Thus, there is a rationale for concentrating research efforts on severe cases (Gifford et al., 2000).

Pre-eclampsia is a complex disorder, including both placental and maternal components. Disease heritability is as high as 54% (Salonen et al., 2000), but a distinct pattern of inheritance is not known. Whole genome linkage studies of families with an increased prevalence of pre-eclampsia have identified several genetic susceptibility loci for pre-eclampsia (Harrison et al., 1997; Arngren et al., 1999; Moses et al., 2000, 2006; Lachmeijer et al., 2001; Laivuori et al., 2003; Johnson et al., 2007). Several studies have suggested the involvement of epigenetic mechanisms for the disease (Graves, 1998), and evidence for a maternal effect in one of the pre-
eclampsia susceptibility loci has been observed for a region of genes on chromosome 10q22 (Oudejans et al., 2004). The exons of 17 positional candidate genes in this region were sequenced in a Dutch cohort of families with two or more sibling pairs affected by pre-eclampsia (van Dijk et al., 2005). All families with increased prevalence of pre-eclampsia showed nonsense mutations within the Storkhead box-1 (STOX1, AK057891) gene on chromosome 10q22, identical between affected sisters (van Dijk et al., 2005).

The STOX1 gene encodes a winged-helix domain-containing transcription factor, and is believed to play a role in the differentiation of trophoblast cells (van Dijk et al., 2005). The longest isoform of the STOX1 protein, STOX1A (NM_152709) exerts regulatory effects in several tissues (van Dijk et al., 2010a). Over expression of STOX1A in choriocarcinoma cells (JEG-3 cell line) was shown to be associated with transcriptional alterations similar to those observed in third-trimester pre-eclamptic placentas (Rigourd et al., 2008). The predominant variation co-segregating with pre-eclampsia disease status in the Dutch families (van Dijk et al., 2005), STOX1A-Y153H (rs1341667) is located in the DNA binding domain. Recently published data suggest that this variant may negatively regulate trophoblast invasion by up-regulation of the cell–cell adhesion protein a-T-catenin (CTNNA3) (van Dijk et al., 2010b).

Storkhead box 2 (STOX2, AB037813) has been identified as the only known human parologue to STOX1 (van Dijk et al., 2005; Kivinen et al., 2007), but to our knowledge little is known of its function. In humans, there is evidence that STOX2 is a component of a molecular profile unique and globally characteristic of uncommitted stem cells (Thomas et al., 2008). The STOX2 transcript is also included in a transcriptional profile observed with increased inflammatory response to air pollutants, differing between pregnant and non-pregnant mice (Fedulov et al., 2008). The gene is situated at chromosome 4q35, near a replicated region of known, suggestive linkage to pre-eclampsia on chromosome 4q31-q32 (Harrison et al., 1997; Moses et al., 2000; Lavuori et al., 2003).

The involvement of STOX1 in pre-eclampsia observed in the Dutch families (Oudejans et al., 2004; van Dijk et al., 2005) has not been confirmed in independent studies (Berends et al., 2007; Kivinen et al., 2007; Iglesias-Platas et al., 2007). It has therefore been hypothesized that STOX1 is relevant to a clinically severe subgroup of women with early onset of the disease, and fetal growth restriction (FGR) (Oudejans et al., 2007; Oudejans and van Dijk, 2008; van Dijk et al., 2007).

In the present study, we investigated candidate functional single nucleotide polymorphisms (SNPs) within STOX1 in an independent large population-based pre-eclampsia cohort. The proposed disease-causing STOX1A-Y153H (rs1341667) variant was tested for association with defined clinical subgroups of pre-eclamptic women. We also compared decidual gene expression of STOX1 and STOX2 in uncomplicated pregnancies and pregnancies complicated by pre-eclampsia, FGR or both. Furthermore, we compared transcriptional alterations in Rigourd’s cultured trophoblast cells with increased expression of STOX1A (Rigourd et al., 2008), with transcriptional alterations seen in our clinically defined subgroups.

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**Materials and Methods**

**Candidate gene expression study**

**Human subjects**

Women with pregnancies complicated by pre-eclampsia, FGR, pre-eclampsia with FGR and women with uncomplicated pregnancies were recruited at St Olavs Hospital, Trondheim, Norway and Haukeland University Hospital, Bergen, Norway from 2002 to 2006. Pre-eclampsia was defined as hypertension (blood pressure ≥140/90 mmHg) plus proteinuria (≥0.3 g/24 h or ≥1 + according to a dipstick test) on at least two occasions, developing after 20 weeks of pregnancy (Gifford et al., 2000). FGR was defined by a stringent small for gestational age (SGA) definition (birthweight ≤2 SD below the expected weight for gestational age and sex, corresponding to the 2.5 percentile) (Marsal et al., 1996), confirmed by at least one of the following: reduced fundal height in serial measurements, serial ultrasound biometry identifying failure to grow along a consistent centile or abnormal umbilical artery wave form. Multiple pregnancies and pregnancies with chromosomal aberrations, fetal and placental structural abnormalities or suspected perinatal infections were excluded.

**Decidual tissue collection**

Decidua basalis tissue samples were collected by vacuum aspiration of the placental bed during Caesarean section as previously described (Staff et al., 1999; Harsen et al., 2004). Caesarean section in the control group was done for reasons considered irrelevant to the study hypotheses (breech presentation, cephalopelvic disproportion or maternal request). Samples were flushed with 500 ml sterile saline solution at room temperature to remove excess blood. The decidual tissue was immediately submerged in RNA-later (Ambion, Valencia, CA, USA). Spectrophotometric determination of purified total RNA yield (µg) was performed using the NanoDrop ND-1000 (Wilmington, DE, USA). Total RNA quality was measured using the total RNA Nano Series II kit on the Agilent BioAnalyzer 2100 using the 2100 Expert software (Agilent Technologies, Germany).

**Total RNA processing**

Decidua basalis tissue was disrupted in a 2:1 (w/v) trizol:sample mixture using a Polytron® PT 1300 D digital, handheld homogenizer with a PT-DA 1300/2EC generator (Kinematica Inc., Lucerne, Switzerland). Total RNA was isolated using a trizol extraction protocol with chloroform interphase separation; isopropanol precipitation and ethanol wash steps. Isolated total RNA was purified with an RNAeasy Mini Kit using spin technology (Qiagen, Valencia, CA, USA). Spectrophotometric determination of purified total RNA yield (µg) was performed using the NanoDrop ND-1000 (Wilmington, DE, USA). Total RNA quality was measured using the total RNA Nano Series II kit on the Agilent BioAnalyzer 2100 using the 2100 Expert software (Agilent Technologies, Germany). Synthesis, amplification, purification and biotin labelled complementary RNA (cRNA) was produced from a total RNA template using the Illumina TotalPrep RNA Amplification Kit (Ambion, TX, USA), according to manufacturer’s instructions. Purified cRNA yield was determined spectrophotometrically using the NanoDrop ND-1000.

A total of 1.5 µg purified cRNA per sample was hybridized onto Illumina’s HumanWG-6 v2 Expression BeadChip® following Illumina’s 6 × 2 BeadChip protocol (Illumina, San Diego, CA, USA). After hybridization, the 6 × 2 expression arrays were washed, blocked, stained with streptavidin-Cy3 (GE Healthcare, Buckinghamshire, UK) and dried prior to them being scanned on the Illumina BeadArrayer 500GX reader using Illumina BeadScan image data acquisition software (version 2.3.0.13). Illumina’s BeadStudio Gene Expression software module
(version 3.2.7) was used to subtract background noise signals for each individual sample and generate an output file for statistical analysis. The control summary report generated by the Gene Expression software module was used to evaluate the performance of the built-in controls for each BeadChip. The control summary report summarizes signal intensity, hybridization signal, background signal and the background to noise level for all samples scanned in a particular batch.

**Candidate gene association study**

**HUNT2 case/control subjects**

The samples used for our candidate gene association study were retrospectively identified from the second Nord-Trøndelag Health Study in Norway (HUNT2). The HUNT2 study was conducted from 1995 to 1997. All residents above 19 years were invited and 75.5% of the invited women (n = 35,280) participated. This population is considered well suited for genetic studies as it is homogeneous (<3% non-Caucasians) and stable (net out migration of 0.3% each year). The HUNT2 survey included a questionnaire, a clinical examination and collection of biological samples as previously described (Holmen et al., 2003). Obstetrical data from these women were obtained by linking the HUNT2 data with the The Medical Birth Registry of Norway (MBRN). Physicians and midwives have been registering obstetrical data from all deliveries in Norway after 16 weeks of gestation in standard questionnaires since 1967. More than 1.8 million births are included. Each resident in Norway is registered with an 11-digit personal identification number, also used for all national registries such as the MBRN and HUNT. The women having experienced pre-eclampsia in one or more pregnancies, defined as new onset of hypertension (blood pressure $\geq 140/90 \text{mmHg}$) and proteinuria ($\geq 0.3 \text{ g/d} \text{ or } \geq 1 \text{ + according to a dipstick test}$), developing after 20 weeks of pregnancy (Gifford et al., 2000), were identified using diagnosis codes ICD-8 (before 1998) and ICD-10 (after 1998). Pre-eclamptic women with multiple pregnancies were excluded. Two controls per case were identified at random among parous women in the HUNT2 cohort with no registered pre-eclamptic pregnancy in the MBRN. All personal identification numbers in the total data set were randomly replaced by a serial number in order to ensure patient anonymity.

**Clinical characterization of the HUNT2 pre-eclampsia-cohort**

Premature delivery was defined as delivery before 37.0 weeks (Gifford et al., 2000), and FGR as delivery of a SGA infant (birthweight $\leq 2 \text{ SD below the expected weight for gestational age and sex, corresponding to the 2.5 percentile}$) (Marsal et al., 1996). As fasting blood glucose was not available for all the individuals in the study cohort, an International Diabetes Federation (IDF)-proxy definition (Hildrum et al., 2007) was used for assessment of metabolic syndrome. This method has been evaluated in a cross-sectional analysis of 10.206 participants in HUNT2 and no differences in the prevalence of metabolic syndrome. This conservative procedure results in normalized expression phenotypes that are comparable between individuals and across all genes (Goring et al., 2007). To evaluate the magnitude of differential gene expression between case (pre-eclampsia and/or FGR) and control women, we measured the displacement of each detected gene’s mean expression value between the two groups. We performed a standard regression analysis on the case group to test whether the mean gene expression level is significantly different (up- or down-regulated) in the case group compared with the control group.

When evaluating the correlation between transcriptional alterations in Rigourd’s data set (Rigourd et al., 2008) and our data set (E-TABM-682), we performed a Spearman rank test, as the beta-values and the fold change values generated from these two studies are not directly comparable. The microarray data have been reported to ArrayExpress according to MIAME standards with accession number E-TABM-682.

**SNP association analysis**

SNP association analyses of all selected SNPs were performed for the total case/control cohort using Pearson’s $\chi^2$ statistic in the software package SPSS 16.0 for Windows. The Y153H variation was analyzed separately for subgroups of pre-eclamptic women and control women (FGR, recurrence) for both a dominant (CC $+$ CT genotype frequency versus TT genotype frequency) and additive (C allele frequency versus T allele frequency) genetic model. Multivariate logistic regression was used to model pre-eclampsia as the (dichotomous) dependent variable against maternal age. Odds ratios (OR) with 95% confidence intervals were calculated. Concordance with Hardy–Weinberg proportions was tested using a $\chi^2$ goodness-of-fit statistic. A threshold of $\alpha = 0.05$ was set for statistical significance of all computed analyses.

**Clinical characterization**

Descriptive statistics means and standard deviations were computed in the software package SPSS 16.0 for Windows. P-values were computed based on t-test statistics. Recurrent and non-recurrent pre-eclamptic cases were
analyzed separately. Each pre-eclamptic group (recurrent and non-recurrent) was compared with the non-pre-eclamptic group. Multivariate logistic regression was used to model pre-eclampsia as the (dichotomous) dependent variable against maternal age. A threshold of \( \alpha = 0.05 \) was set for statistical significance of all computed analyses.

**Ethical approval**

Informed written consent was obtained from all participants in this study. The study was approved by the Regional Committees for Medical Research Ethics, the National Data Inspectorate and The Directorate of Health and Social Welfare, Norway. Ethical approval for genotyping the Norwegian case/control cohort (HUNT2), decidual RNA processing and statistical analysis of decidual RNA was obtained from The University of Texas Health Science Center at San Antonio, Institutional Review Board.

## Results

### Decidual tissue candidate gene expression analysis

Decidua basalis tissue was vacuum aspirated from the placental bed of 14 women with pre-eclampsia, 9 non-pre-eclamptic women with FGR neonates, 29 women with both pre-eclampsia and FGR (pre-eclampsia + FGR) and 59 normal pregnancies. Seven samples of low RNA quality were excluded (assessed by the RIN value and visual evaluation of digital electrophoretic gel pictures). We therefore processed a total of 104 samples. Clinical characteristics of the study groups are presented in Table I.

| Sample group comparison | Gene  | \( \beta^* \) | P-value | Gene  | \( \beta^* \) | P-value |
|-------------------------|-------|--------------|---------|-------|--------------|---------|
| Pre-eclampsia versus control | STOX1 | 0.39 | 0.19 | STOX2 | 0.07 | 0.81 |
| FGR versus control | 0.49 | 0.18 | -0.17 | 0.61 |
| Pre-eclampsia with FGR versus control | 0.04 | 0.86 | -0.59 | 0.01 |

*The \( \beta \) (beta) value is the measure of displacement between the case and control group mean expression signals and is expressed in standard deviation units. A positive \( \beta \) implies a higher mean transcript expression signal in the case group compared with the control group and is analogous to a gene/transcript being up-regulated. A negative \( \beta \) implies a lower mean transcript expression signal in the case group compared with the control group and is analogous to a gene/transcript being down-regulated. Values significant at the 1% level are outlined in bold.

| Sample group comparison | Correlation coefficient \(^2\) \( \text{(Spearman } \rho \text{)} \) | P-value |
|-------------------------|---------------------------------|---------|
| Pre-eclampsia | 0.16 | 0.004* |
| Pre-eclampsia with FGR | 0.23 | 0.00008* |
| FGR | 0.09 | 0.17 |

*\( \rho \) is 2 SD of expected weight, confirmed by at least one of the following: reduced fundal height in serial measurements, serial ultrasound biometry identifying failure to grow along a consistent centile or abnormal umbilical artery wave form.

**Table I** Clinical characteristics of the cohort used in the gene expression analysis.

|                          | Pre-eclampsia (n = 13) | FGR* (n = 9) | Pre-eclampsia with FGR (n = 24) | Controls (n = 58) |
|--------------------------|------------------------|-------------|---------------------------------|-------------------|
| Maternal age (years)     | 30 ± 5*                | 34 ± 4      | 31 ± 5                          | 31 ± 5            |
| Gestational age (weeks)  | 35 ± 3**               | 32 ± 5**    | 30 ± 4**                        | 39 ± 1            |
| Systolic blood pressure (mmHg) | 153 ± 18**    | 128 ± 15    | 151 ± 16**                      | 116 ± 11          |
| Diastolic blood pressure (mmHg) | 95 ± 9**     | 74 ± 8      | 97 ± 12*                        | 70 ± 9            |
| Birthweight (g)          | 2364 ± 510**           | 1225 ± 21** | 1118 ± 470**                    | 3619 ± 469        |

Data are presented as mean ± SD. All case groups were compared with controls and \( P \)-values were computed based on t-test statistics.

**Table II** Decidua basalis differential STOX1 and STOX2 expression analysis.

|                          | Pre-eclampsia | FGR* | Pre-eclampsia with FGR | Controls |
|--------------------------|---------------|------|------------------------|----------|
| Clinical characteristics of the cohort used in the gene expression analysis. |

*In the study by Rigourd et al. (2008), 259 of the 500 most up/down-regulated genes in pre-eclamptic placentas had detectable transcript levels in the microarray experiment comparing JEG-3 cells over...
expressing STOX1A with mock-transfected JEG-3 cells. Of these 259 genes, 242 were found to have transcripts expressed above the background in the transcriptomic data from our material (E-TABM-682). We observed a strong correlation (Spearman \( r = 0.23, P = 0.00008 \)) between the beta-values (ratio of up/down-regulation compared with controls) for these genes in our subgroup of women experiencing pre-eclampsia with FGR and the ratio of up/down-regulation in the study by Rigourd et al. (2008). The beta-values for the women with pre-eclampsia only, showed a weaker correlation (Spearman \( r = 0.16, P = 0.004 \)), and there was no correlation to the beta-values for the non-pre-eclamptic women delivering FGR neonates (Spearman \( r = 0.09, P = 0.17 \)) (Table III).

The HUNT2 case/control cohort

DNA samples were available for 1139 women registered with pre-eclamptic pregnancies (cases) and 2269 non-pre-eclamptic women (controls) (Moses et al., 2007). Of the available cases, 1003 women were registered with one and 136 women with more than one pre-eclamptic pregnancy. Mean follow-up time from diagnosis in the MBRN to inclusion in the present study was 25 ± 10 years. As expected, gestational age and birthweight differed between the neonates in pre-eclamptic and non-pre-eclamptic pregnancies; the pre-eclamptic women had a higher risk of delivering preterm, and of delivering a FGR neonate (Table IV, \( P < 0.001 \)). The metabolic syndrome, evaluated by data from the HUNT2 study, was also higher in the case groups as compared with controls (Table IV, \( P < 0.001 \)). After adjusting for maternal age, the differences in clinical phenotype between case and control groups remained significant at \( \alpha < 0.001 \) level (Table IV).

We also observed clinical differences between the recurrent and non-recurrent pre-eclamptic groups (Table IV). The women in the recurrent group delivered earlier (\( P = 0.018 \)) and the neonates had a lower birthweight (adjusted for gestational age, \( P = 0.055 \)). The prevalence of preterm birth was higher in the recurrent group (22%) compared with the non-recurrent group (14%) (\( P < 0.01 \)), but the seemingly different prevalence of FGR (20 versus 15%) was not statistically significant (\( P = 0.2 \)). The P-values are adjusted for maternal age. Metabolic syndrome at inclusion in the HUNT2 study was more prevalent in the recurrent group compared with the non-recurrent when adjusting for age at inclusion (\( P = 0.019 \)).

**Statistical power analysis for the HUNT2 case/control cohort**

A priori power calculations ad modum Lalouel and Rohrwasser (2002) for the STOX1A Y153H (rs1341667) variant demonstrated 90% power to detect an effect size (OR) difference of 1.3 for the total case/control (HUNT2) cohort and 1.9 for the recurrent pre-eclampsia subgroup (\( n = 136 \)).

STOX1 genotyping and association analysis

The R18P STOX1 SNP failed the SNPlex assay design due to high homology and another two STOX1 SNPs were non-polymorphic. There were no significant differences in allele frequencies between the case and control groups for the genotyped SNPs (Table V). There was a high average sample genotype success rate of 87% (range 84–88%) and all SNPs conformed to Hardy–Weinberg proportions (\( P > 0.05 \)).

Assuming a dominant genetic model for the Y153H variant, it is proposed that this variant becomes mutagenic through mechanisms of imprinting either of STOX1 itself, or of downstream proteins (van Dijk et al., 2005). Under this analysis model, the pre-eclampsia + FGR subgroup did not show any association with the STOX1A-Y153H variant when compared with the control group (Table VI). However, the recurrent pre-eclampsia subgroup showed a tendency towards higher incidence of the C-genotype (\( P = 0.09 \)) (Table VI).

**Discussion**

In this study, we demonstrate reduced decidual gene expression of STOX2 in pre-eclamptic women delivering FGR neonates. To our

**Table IV** Clinical characteristics of the HUNT2 case/control cohort.

|                      | Pre-eclampsia (recurrent\(^1\), \( n = 136 \)) | Pre-eclampsia (non-recurrent, \( n = 1.003 \)) | Control (\( n = 2.269 \)) |
|----------------------|-----------------------------------------------|-----------------------------------------------|---------------------------|
| Maternal age at index pregnancy (years) | 25 ± 5                                        | 27 ± 6\(^*\)                                   | 25 ± 5                    |
| Gestational age (days)       | 271 ± 20\(^*\)                                 | 275 ± 22\(^*\)                                 | 282 ± 18                  |
| Birthweight (g)             | 3.040 ± 846\(^*\)                              | 3.238 ± 837\(^*\)                              | 3.483 ± 592               |
| FGR\(^2\)                  | 26 (20)\(^*\)                                  | 147 (15)\(^*\)                                 | 87 (4)                    |
| Preterm birth\(^3\)         | 29 (22)\(^*\)                                  | 132 (14)\(^*\)                                 | 114 (5)                   |
| Maternal age at inclusion in HUNT2 | 37 ± 9\(^*\)                                  | 40 ± 11                                       | 40 ± 11                   |
| Metabolic syndrome\(^4\)    | 30 (22)\(^*\)                                  | 163 (16)\(^*\)                                 | 212 (9)                   |

Data presented as mean ± SD or number (percentage). \( P \)-values are computed based on \( t \)-test statistics, each pre-eclampsia group is compared with the non-pre-eclampsia group. IDF, the International Diabetes Federation; HDL, high-density lipoprotein; CI, confidence interval.

\(^1\)More than one pre-eclamptic pregnancy.

\(^2\)≥ 2 SD of expected weight.

\(^3\)Delivery before week 37.

\(^4\)IDF-proxy definition; waist circumference ≥ 80 cm plus any two of the following: (HDL cholesterol < 1.29 mmol/l, treatment for hypertension or blood pressure ≥ 130/85 mmHg, diabetes diagnosed after age of 30 or fasting plasma glucose ≥ 5.6 mmol/l) [43].

\(^*\)\( P < 0.001 \).
knowledge, this is a novel finding. We also elaborate the results of Rigourd et al. showing correlation between transcriptional alterations of pre-eclamptic placentas (relative to controls) and JEG-3 cells overexpressing STOX1A (relative to mock-transfected JEG-3 cells) (Rigourd et al., 2008). Transcriptional alterations in our decidua basalis tissue (E-TABM-682) show the strongest correlation to Rigourd’s data set in pre-eclamptic pregnancies complicated by FGR, but not in non-pre-eclamptic pregnancies with FGR. Furthermore, in a population- and registry-based cohort, we find that women experiencing pre-eclampsia more than once are at a higher risk of complications and co-morbidity (preterm birth, lower birthweight and development of metabolic syndrome) compared with those experiencing pre-eclampsia once. There is also a tendency towards higher frequency of the C genotypes for the previously reported STOX1A-Y153H variation (van Dijk et al., 2005) in this group of women.

Reduced placental perfusion due to impairment of trophoblast invasion and failed spiral artery remodelling are proposed to be pathogenic features of both fetal growth restriction and pre-eclampsia (Brosens et al., 1972, 1977). We believe the present study of decidua basalis tissue, where these disease processes are taking place, to be an important supplement to previous reports of STOX1 gene expression in placental tissues (van Dijk et al., 2005; Iglesias-Platas et al., 2007; Kivinen et al., 2007) and cultured trophoblast cells (van Dijk et al., 2005, 2010; Rigourd et al., 2009). We show novel evidence that the STOX2 gene is down-regulated in term decidua basalis from pre-eclamptic women delivering FGR neonates. STOX2 resides on chromosome 4q35, near a replicated region of suggestive linkage to pre-eclampsia on chromosome 4q31-q32 (Harrison et al., 1997; Moses et al., 2000; Laivuori et al., 2003). To our knowledge, the role of STOX2 in the maternal–fetal interface is not known. Gene duplication is an important evolutionary mechanism, and is a continuous matter of research in evolutionary systems biology (Hughes, 2005; Hittinger and Carroll, 2007). Studies of paralogous genes show that duplication does not create genes with novel functions, but rather daughter genes performing specialized sub functions of the ancestral gene (Jensen, 1976; Conant and Wolfe, 2008). STOX2 has a high sequence similarity to STOX1 (van Dijk et al., 2005; Kivinen et al., 2007), and it is reasonable to hypothesize that it is involved in some of the same biological processes. Therefore, the role of STOX2 in

| Table V Genotyped SNPs within STOX1. |
|---|
| SNP            | Genotype (NN), Allele (N) | Pre-eclampsia (proportion of total) | Control (proportion of total) | P-value |
| R18P           | Failed assay design       |                                      |                              |         |
| rs1341667 (Y153H) | CC 412 (0.418) CT 450 (0.456) TT 124 (0.126) C 1274 (0.646) T 698 (0.354) | 840 (0.416) 931 (0.462) 245 (0.122) 2611 (0.648) 1421 (0.352) | 0.9     |
| rs41278530 (LSB2F) | AA 583 (0.591) AC 346 (0.351) CC 57 (0.058) A 1512 (0.767) C 460 (0.233) | 1206 (0.597) 716 (0.355) 97 (0.048) 3128 (0.775) 910 (0.225) | 0.5     |
| rs41278532 (NB25I) | AA 953 (0.968) AT 28 (0.028) TT 3 (0.004) A 1934 (0.983) T 34 (0.017) | 1827 (0.972) 50 (0.027) 2 (0.001) 3704 (0.986) 54 (0.014) | 0.4     |
| rs7904300 (A865T) | Non-polymorphic           |                                      |                              |         |

P-values were computed using Pearson’s χ² statistic.

| Table VI The STOX1A-Y153H variation in severe subgroups of pre-eclamptic women. |
|---|
| Y153H variation | Pre-eclampsia + FGR* | Recurrentb pre-eclampsia | Control |
| Number of individuals genotyped | 151 | 115 | 2010 |
| Dominant model frequency CC + TC | 0.881 | 0.930 | 0.878 |
| OR* (CI) | 1.0 (0.6–1.7) | 1.9 (0.9–3.9) |
| P-value | 0.92 | 0.09 |

*FGR, fetal growth restriction measured by birthweight below 2 SD for gestational age.

bMore than one pre-eclamptic pregnancy.

*OR for each of the subgroups of pre-eclamptic women compared with controls with 95% confidence intervals (CIS) using χ² statistics.
normal placental development as well as in the pathogenesis of pre-
eclampsia with FGR warrants further investigation. A comprehensive
assessment of genetic regulatory variation as well as a molecular func-
tional evaluation is required to confirm the biological importance of
our observation.

Rigourd et al. recently showed a strong correlation between trans-
scriptional alterations in trophoblast cell-lines over expressing
STOX1A and transcriptional alterations shown in term pre-eclamptic
placentas (Rigourd et al., 2008). This supports the observation made
by others, that the possible disease-causing effects of STOX1 dys-
regulation are mediated through aberrant transcriptional regulation
of trophoblasts (van Dijk et al., 2005, 2010). The dysregulation of
STOX1 can potentially have deleterious effects as it affects the trascript
level of many other genes shown to be important in the development
of pre-eclampsia (such as Endoglinin, human Chorionic Gonadotrophi,n
and Glial Cell Missing Homolog (Rigourd et al., 2009). Furthermore, a direct effect of STOX1 on CTNNA3 expression was recently confirmed, affecting trophoblast differentiation and growth (van Dijk et al., 2010b). When comparing the transcriptional alterations of our defined subgroups of women with the transcriptional alterations in Rigourd’s trophoblast cell line over expressing STOX1A, we confirm their results from placental tissue in decidua basalis. Furthermore, the observed correlation is strongest in the group of women with both pre-eclampsia and FGR. Our findings suggest that the STOX genes are associated with a severe fetal phenot
ype (FGR), interestingly though, only in pre-eclamptic patients, and not in non-pre-eclamptic women delivering FGR neonates. This sup-
ports the opinion that FGR in pre-eclampsia and FGR alone represent different pathogenic conditions, as discussed by others (Ness and Sibai, 2006; Huppertz, 2008; Srinivas et al., 2009).

The analysis of gene expression in whole tissue harvested from
patients with manifest disease benefits from describing the in vivo situ-
ation. However, interesting differences will potentially be masked due
to the heterogeneity of the material. Approximately 40% of cells in decidua basalis are maternal leukocytes, 20% are extravillous tropho-
blast and 30% are decidual stromal cells (Benirschke et al., 2006). This
is a possible confounding factor; however, our results were inter-
preted in relation to, and are consistent with, earlier observations
(Rigourd et al., 2009; van Dijk et al., 2010b). Our findings are limited to describing gene expression in decidua basalis samples col-
lected at birth; we do not report expression throughout the preg-
nancy. The strength of this study, however, is a thorough monitoring
by an obstetrician; multiple blood pressure and proteinuria measure-
ments, prenatal ultrasound measures and birthweight confirmation,
providing a sound diagnostic basis (Eide et al., 2006).

There were no significant differences in allele frequencies between
the case and control groups in the population-based cohort for the
genotyped candidate SNPs within STOX1. This is in agreement with
smaller population samples included in other studies (Berends et al.,
2007; Kivinen et al., 2007).

Severe pre-eclampsia is diagnosed by assessment of both maternal
and fetal phenotypes (Gifford et al., 2000). It has been shown that
mothers developing early onset pre-eclampsia have a higher preva-
lence of fetal growth restriction, as well as increased maternal morbid-
ity and cardiovascular risk later in life (Ness and Roberts, 1996;
Mostello et al., 2002; Brown et al., 2007). The MBRN did not
include information about onset of disease until 1998, and we are
therefore not able to include this parameter in our analyses. It has
been shown, however, that women developing severe pre-eclampsia
in the second trimester are at high risk of recurrent pre-eclampsia
as well as later life chronic hypertension and increased maternal mor-
bidity and mortality (Sibai et al., 1986, 1991; Odegard et al., 2000).
Therefore, research on multiparous pre-eclamptic women is encour-
aged as a tool of better understanding of disposition to, and develop-
ment of strategies for treatment and prevention of pre-eclampsia
(Gifford et al., 2000). Findings in our cohort are consistent with
earlier studies, as the recurrent group shows the highest risk of preterm labour, of low fetal birthweight and the highest later life cardi-
avascular risk, assessed as metabolic syndrome. We do find a ten-
dency towards higher incidence of the C genotypes of the Y153H
mutation in the recurrent group under a dominant genetic model.
This finding is however, not significant at the 5% level. Assessment
of the Y153H mutation in pre-eclamptic women delivering FGR neo-
nates did not show association. Thus, we cannot confirm the hypoth-
thesis that this variant is linked to severe pre-eclampsia, or
pre-eclampsia with FGR in the Norwegian population.

In the population-based part of the study, we are using registry data,
and some misclassification can be expected. This will limit the power
to detect a true association. The prevalence and recurrence rates of
pre-eclampsia in MBRN are, however comparable to those reported
in other Nordic countries (Trosgstad et al., 2001). Being born SGA
does not necessarily imply FGR, but can also reflect e.g. different eth-
nicity, constitutional smallness and chromosomal aberrations.
However, the growth curves used in this study are based on ultrasoni-
cally estimated fetal weights, appropriate for the population (which is
homogeneous) and considers the sex of the fetus (Marsal et al., 1996).
Furthermore, a stringent SGA definition of ±2 SD is used, which is
more likely to identify the true FGR cases within the SGA group
(ACOG, 2002; Sheridan, 2005). This leads us to believe that SGA is
a good approximation to FGR in our study. Also, the possible maternal
imprinting effect on STOX1 is a matter of debate (Berends et al.,
2007; Iglesias-Platas et al., 2007; van Dijk et al., 2007). We are not
able to evaluate this in a case–control cohort, and epigenetic effects
will lessen our power to detect a true association. However, the strength
of this study is a large sample size, and the extensive clinical infor-
mation available.

In conclusion, we present novel observations suggesting involve-
ment of STOX2 in the pathogenesis of pre-eclampsia with FGR. We
confirm Rigourd’s findings in decidual tissue, and link the transcrip-
tional alterations observed with STOX1A over expression to altera-
tions seen in decidua of pre-eclamptic women delivering FGR neo-
nates. Conceivably, these findings might reflect a role for the
STOX genes in the pathophysiology of pre-eclampsia with FGR.

Authors’ roles

M.H.F. wrote the paper, contributed substantially to acquisition of
gene expression and epidemiological data and to data analysis and
interpretation of results. M.P.J., J.B., E.K.M. and R.A. contributed sub-
stantially to conception and design, analysis and interpretation of data,
revising and final approval of manuscript. M.L., S.B.M., A.K.J. and
T.D.D. contributed substantially to acquisition and analysis of
expression data, revising and final approval of manuscript. L.T.R. acqui-
sition and interpretation of genotype data, revising and final approval
of manuscript. I.P.E. contributed substantially to acquisition of data, revising and final approval of manuscript. S.F. contributed substantially to acquisition of epidemiology data, analysis and interpretation, revising and final approval of manuscript. L.B. and R.K.S. recruitment of patients, collection and cryopreservation of decidual tissues, establishment of clinical database, revising and final approval of manuscript.

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