Focus on Obesity

Obesity, pregnancy, inflammation, and vascular function

F C Denison, K A Roberts, S M Barr and J E Norman

Queen’s Medical Research Institute, Centre for Reproductive Biology, 47 Little France Crescent, Edinburgh, EH16 4TJ, UK

Correspondence should be addressed to F C Denison; Email: fiona.denison@ed.ac.uk

Abstract

Maternal obesity is associated with increased morbidity and mortality for both mother and offspring. The mechanisms underlying the increased risk associated with maternal obesity are not well understood. In non-pregnant populations, many of the complications of obesity are thought to be mediated in part by inflammation and its sequelae. Recent studies suggest that a heightened inflammatory response may also be involved in mediating adverse clinical outcomes during pregnancy. This review summarizes our current knowledge about adipose tissue biology, and its role as an endocrine and inflammatory organ. The evidence for inflammation as a key mediator of adverse pregnancy outcome is also presented, focusing on the role of inflammation in adipose tissue, systemic inflammation, the placenta, and vascular endothelium.


Clinical impact of maternal obesity on pregnancy

Human obesity is an increasingly common condition among both sexes, with an estimated prevalence of 4–28% among European men and 6–37% among European women (Berghofer et al. 2008). The prevalence of obesity is also increasing in women of reproductive age, and currently it is estimated that more than one in five pregnant women are obese (Heslehurst et al. 2007, 2009). Maternal obesity is associated with increased morbidity and mortality for both mother and offspring. Antenatal risks include gestational diabetes and hypertensive disorders including pre-eclampsia and thromboembolic complications (Sebire et al. 2001, Bhattacharya et al. 2007, Denison et al. 2008). Peripartum, women are more likely to face induction of labor, operative delivery, and postpartum hemorrhage (Sebire et al. 2001, Denison et al. 2008). High pregravid body mass index (BMI) and excessive gestational weight gain are also important predictors of short-term postpartum morbidity and higher postpartum weight retention (Gunderson et al. 2001), with the latter being associated with increased risks during future pregnancies and of lifelong obesity for women (Oken et al. 2008). Offspring of obese mothers tend to be large for gestational age at birth and are at a higher risk of late fetal death, congenital anomaly, and admission to the neonatal unit. Maternal obesity also increases the lifetime risk of obesity in offspring and a tendency to develop metabolic syndrome in childhood and adolescence (Boney et al. 2005), thus perpetuating the cycle of obesity and its adverse consequences into the next generation. The mechanisms underlying the increased risk associated with maternal obesity are not well understood. However, many of the complications of obesity in non-pregnant populations are thought to be mediated in part by inflammation and its sequelae. Recent studies suggest that a heightened inflammatory response, both locally (adipose tissue, placenta, and vascular endothelium) and systemically (circulating plasma concentrations), may also be involved in mediating adverse clinical outcomes during pregnancy. This article reviews the evidence which links maternal obesity, local and systemic inflammation, and adverse pregnancy outcomes.

Adipose tissue biology

Obesity involves a massive expansion of adipose tissue, with a disproportionately smaller expansion of other tissue types within the body. Over the last decade, there has been a paradigm shift in the understanding of the nature of adipose tissue. It is now known that fat is not just a storage organ, but it is a highly active tissue metabolically, comprising one of the largest endocrine organs in the body. In obesity, expansion of adipose tissue mass is associated with increasing inflammation of
adipose tissue, and there is emerging evidence that this inflammation is causally linked both to insulin resistance and to other obesity-related morbidities such as cardiovascular disease. To date, much of the evidence in this area comes from the studies on non-pregnant individuals, with much less information on adipose tissue biology in pregnant women. In this section, we will attempt to review current understanding of adipose tissue ontogeny and function, how it becomes disordered in obesity, and the possible impact both of pregnancy on adipose tissue biology and of adipose tissue expansion and inflammation on pregnancy disorders.

Mature adipose tissue consists of adipocytes and stromal vascular cells, with the latter including vascular endothelial cells, fibroblasts, and cells of the hematopoietic lineage. Immature adipose tissue first appears in the fetus between 14 and 16 weeks of gestation. The stages in adipose development are as follows: i) emergence of undifferentiated loose connective tissue clusters, ii) mesenchymal condensation associated with angiogenesis, iii) differentiation of mesenchymal cells into preadipocytes within a vascular matrix, iv) emergence of primitive fat lobules characterized by the appearance of fat vacuoles appearing in the cytoplasm of the mesenchymal cells, and v) appearance of definitive fat lobules: fat lobules well separated from each other by dense septae of perilobular mesenchymal tissue (Poissonnet et al. 1983). In terms of location, adipose tissue becomes first noticeable in the fetus at the head and neck, followed by the trunk, and finally in the upper and lower limbs (Poissonnet et al. 1984). By 28 weeks of gestation, fat tissue is present in the fetus in the six principal fat deposit areas: the face (buccal and ocular pads, cheek, and chin), the neck, the thorax (anterior and posterior chest wall, and mammary area), the abdomen (abdominal wall and perirenal), the upper limb (shoulder, forearm, arm, and hand), and the lower limb (gluteus, thigh, leg, and foot), and the number of fat lobules in adipose tissue is likely complete, with further adipose tissue expansion being mostly due to an increase in the size of fat lobules (Poissonnet et al. 1984). However, the development of obesity during childhood can further increase the number of adipocytes, with greater adipocyte number in obese individuals compared with lean individuals being obvious as early as 1 year (Knittle et al. 1979). In contrast, once adulthood is reached, adipose cell number likely remains constant, with obesity due to an expansion of adipose cell size, except possibly in extreme obesity (Spalding et al. 2008). Importantly, different types and sites of adipose tissue have different functions. All mammals contain white adipose tissue (WAT) and brown adipose tissue, with specific functions of lipid storage and thermogenesis respectively, with possible transdifferentiation between the two (Cinti 2009). Additionally, in many animals including humans, visceral adipose tissue, which surrounds internal organs, is more important than subcutaneous adipose tissue in the development of the metabolic syndrome (Despres & Lemieux 2006).

Adipose tissue as an endocrine organ

The concept that adipose tissue has actions far beyond the mere storage of triglycerides began in 1993 with the demonstration that the adipocytes in mouse adipose tissue generate tumor necrosis factor α (TNF), and with obese animals having greater adipose-specific TNF expression and greater circulating levels of TNF (Hotamisligil et al. 1993). A strong relationship between adipose tissue TNF production and insulin resistance was also identified, with cause and effect being confirmed by experiments showing that TNF antagonism reduced peripheral insulin resistance in this mouse model (Hotamisligil et al. 1993). The following year, leptin, the product of the ob gene (deletion of which causes profound obesity), was identified as a major secretory product of adipose tissue, and the model of adipose tissue as an endocrine organ became firmly established (Zhang et al. 1994). TNF and leptin are examples of ‘adipokines’, peptides released by adipose tissue, and which can signal to distant tissues (Hotamisligil et al. 1993). In humans, WAT produces over 50 ‘adipokines’, including TNF which contributes to the low-grade inflammation found in obesity, leptin which has effects on food intake, and a host of other agents with a variety of effects (Lago et al. 2007, Maury & Brichard 2010). Table 1 lists some of the major adipokines and their functions. In parallel with these proinflammatory events, WAT also produces anti-inflammatory cytokines such as adiponectin (which, paradoxically, tends to be lower in obese individuals) and interleukin (IL)10 and IL1R1 (IL-1Rα; production of which is proportional to body weight). These inflammatory markers, although originating in fat, circulate and are measurable in serum.

In obesity, there is an upregulation of chemokine and receptor synthesis in both visceral and subcutaneous adipose tissues (Huber et al. 2008), albeit with a greater increase in visceral adipose tissue (Fain et al. 2004), and this is likely a mechanism by which visceral adipose tissue is more strongly associated with the metabolic syndrome than the subcutaneous adipose tissue (Demerath et al. 2008). Cytokines secreted by visceral adipose tissue are ‘sensed’ directly by the liver due to venous drainage from this adipose depot via the portal system. Thus, visceral adipose tissue is plausibly capable of influencing hepatic glucose homeostasis and insulin sensitivity (Tordjman et al. 2009). Figure 1 summarizes the potential interactions between adipose tissue and distant organs.

Inflammatory gene expression in fat is closely positively correlated with both liver fat content and systemic arterial dysfunction (the latter assessed using

ultrasound), and inversely correlated with whole body insulin sensitivity and omental lipogenic factors (Makkonen et al. 2007, Apovian et al. 2008, Poulain-Godefroy et al. 2008). A recent study in a rodent model has demonstrated that i.v. infusion of each of TNF and CCL2 (also known as MCP-1; Tateya et al. 2010) induced features of the metabolic syndrome, and blockade of TNF with drugs such as infliximab has been reported to improve insulin sensitivity in a murine model (Araujo et al. 2007). Together, these studies suggest that adipokines may have a more causal relationship with the metabolic syndrome that has been recognized previously. In addition to cytokines, the enzyme 11β-hydroxysteroid dehydrogenase type 1, which is involved in intra-adipose regulation of local bioavailability of active corticosteroid, is also significantly increased in adipose tissue in obese/overweight individuals compared with non-obese individuals (Paulsen et al. 2007, Wake et al. 2007, Morton & Seckl 2008). This key enzyme is likely to modulate local inflammatory responses within adipose tissue.

### Table 1: Key adipokines expressed and secreted by adipose tissue and their functions.

<table>
<thead>
<tr>
<th>Adipokine</th>
<th>Changes in obesity</th>
<th>Functional effects</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>‘Proinflammatory’ cytokines</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tumor necrosis factor α (TNF)</td>
<td>↑ Circulating (Cartier et al. 2008)</td>
<td>Activity is predominantly paracrine</td>
</tr>
<tr>
<td></td>
<td>↔ Circulating levels</td>
<td>Stimulates lipolysis</td>
</tr>
<tr>
<td></td>
<td>↔ mRNA expression, but ↑ release by cultured adipose (Kern et al. 2001)</td>
<td>Increases insulin resistance via interference with IRS1 downstream signalling</td>
</tr>
<tr>
<td>Chemokine (C-C motif) ligand 2 (CCL2; also known as MCP-1)</td>
<td>↑ Expression in WAT (Bruun et al. 2005, Di Gregorio et al. 2005)</td>
<td>Impairs preadipocyte differentiation</td>
</tr>
<tr>
<td>Interleukin (IL)6</td>
<td>↑ Circulating levels correlate with visceral adiposity (Sabio et al. 2008, Maury &amp; Brichard 2010)</td>
<td>Downregulates anti-inflammatory pathways</td>
</tr>
<tr>
<td>IL8</td>
<td>↑ Circulating (Straczkowski et al. 2002)</td>
<td>Promotes monocyte recruitment into WAT</td>
</tr>
<tr>
<td>IL1B</td>
<td>↑ Expression (Juge-Aubry et al. 2003)</td>
<td>Secretion by adipose tissue leads to hepatic insulin resistance in upregulation of SOCS3</td>
</tr>
<tr>
<td><strong>Anti-inflammatory cytokines</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IL10</td>
<td>↑ Circulating (Esposito et al. 2003)</td>
<td>Potent chemoattractant</td>
</tr>
<tr>
<td></td>
<td>↑ Circulating (Juge-Aubry et al. 2005)</td>
<td>Impacts insulin signaling by downregulation of IRS1</td>
</tr>
<tr>
<td>IL1R1 (IL-1Ra)</td>
<td>↑ Circulating (Meier et al. 2002)</td>
<td>Cytotoxic effects on pancreatic islet cells</td>
</tr>
<tr>
<td><strong>Hormones</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adiponectin</td>
<td>↑ Expression in visceral adipose</td>
<td>Stimulates fatty acid oxidation in the liver and skeletal muscle</td>
</tr>
<tr>
<td></td>
<td>↓ In subcutaneous adipose (Rasouli &amp; Kern 2008)</td>
<td>Increases fatty acid oxidation via ADIPOR1</td>
</tr>
<tr>
<td>Visfatin</td>
<td>↑ Expression in visceral adipose</td>
<td>Activates PPARγ via ADIPOR2</td>
</tr>
<tr>
<td></td>
<td>↓ In subcutaneous adipose (Rasouli &amp; Kern 2008)</td>
<td>Reduces hepatic gluconeogenesis</td>
</tr>
<tr>
<td>Resistin</td>
<td>↑ Expression in mice (Steppan &amp; Lazar 2002)</td>
<td>Antagonizes TNF</td>
</tr>
<tr>
<td></td>
<td>↔ In humans (Janke et al. 2002)</td>
<td>Regulates β-cell function in pancreas</td>
</tr>
<tr>
<td>Apelin</td>
<td>↑ Circulating (Heinonen et al. 2005)</td>
<td>Role unclear in humans</td>
</tr>
<tr>
<td><strong>Adipokines involved in vitamin A metabolism</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Role unclear in humans</td>
</tr>
<tr>
<td><strong>Other factors</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plasminogen activator inhibitor (PAI)1</td>
<td>↑ Secretion (Maury &amp; Brichard 2010)</td>
<td>Oversecretion leads to decreased fibrinolysis and excessive thrombosis</td>
</tr>
<tr>
<td>Angiotensinogen</td>
<td>↑ Circulating (Maury &amp; Brichard 2010)</td>
<td>Increases fat mass and hypertension</td>
</tr>
<tr>
<td>Prostaglandins</td>
<td>↑ Release of PGE2 by cultured adipose tissue (Fain et al. 2004, Héutu &amp; Riendeau 2007)</td>
<td>Inhibits adipocyte lipolysis</td>
</tr>
</tbody>
</table>
Inflammation in adipose tissue

Although the association between obesity, low-grade inflammation, and insulin resistance is propagated in part by adipokines generated by adipocytes and cells of the stromal vascular fraction as described above, an influx of inflammatory cells into adipose tissue is also implicated (Xu et al. 2003, Hotamisligil 2006). Originally, it was thought that cells of the innate immune system were the major players in this event, but increasing evidence implicates T cells and possibly other leukocytes (Lumeng et al. 2009). However, the predominant leukocytes in adipose tissue are macrophages, which are present in the stromal vascular fraction and their density is in direct proportion to the levels of obesity (Weisberg et al. 2003). Indeed, there is a significant functional overlap between adipose tissue and macrophage biology, with both (under the correct conditions) being phagocytic; producing transcription factors, cytokines, inflammatory molecules, fatty acid transporters, and scavenger receptors; and with some evidence that preadipocytes can be ‘converted’ to macrophages (Charriere et al. 2003, Wellen & Hotamisligil 2003).

Adipose tissue macrophages (ATMs) are found in both lean and obese individuals, and have been identified in ‘crown-like structures’ (SM Barr, JE Norman, BR Walker & NM Morton, 2009, unpublished observations; Fig. 2) surrounding the necrotic adipocytes. However, their functional activity is proportional to the degree of obesity (Lumeng et al. 2007), and may reflect the need for additional scavenger activity due to additional adipocyte death as a result of disordered hypertrophy (Zeyda & Stulnig 2007). ATMs have a distinct phenotype, being typical of neither M1 nor M2. In lean individuals, ATMs more closely resemble the M2 ‘alternatively activated’ phenotype, secreting anti-inflammatory cytokines such as IL10 and IL1 decoy receptor, and also secreting arginase which blocks inducible nitric oxide synthase (NOS2, also known as iNOS) activity; however they are capable of significant proinflammatory cytokine production (Zeyda et al. 2007) on stimulation with interferon-γ. In contrast, in obese individuals, there is a shift toward the M1 ‘classically activated’ phenotype, secreting proinflammatory cytokines TNF, IL6, and IL12, and generating reactive oxygen species such as nitric oxide via activation of NOS2 (Lumeng et al. 2007). T_{H}2 cytokines are the likely drivers toward the M2 phenotype of ATMs in lean individuals (Lumeng et al. 2007). With the development of obesity, there is both a change in macrophage phenotype toward M1 and an increase in macrophage density (probably as a result of invasion of new macrophages from the bloodstream rather than local proliferation of macrophages (Weisberg et al. 2003)). These invading and activated macrophages then interact with adipocytes to initiate vicious cycle of macrophage recruitment, production of inflammatory cytokines, and impairment of adipocyte function (Wellen & Hotamisligil 2003). As with adipokine production, the increase in macrophage density in adipose tissue is greater in visceral deposits than in subcutaneous deposits (Harman-Boehm et al. 2007). Additionally, increased macrophage invasion into the adipose tissue is associated with insulin resistance, an important component of the metabolic syndrome (Xu et al. 2003). A feedback loop likely exists, since treatment with an insulin-sensitizing agent (rosiglitazone) in a mouse model of obesity reduces markers of macrophage density (Xu et al. 2003). The adverse metabolic effects of ATM invasion are not limited to insulin resistance: endothelial dysfunction in obesity is also related to ATM number and activity (Apovian et al. 2008).
The change in ATM phenotype in obesity is likely to be driven by the action of T\textsubscript{H1} cytokines, with emerging data suggesting that T cells in adipose tissue play a major role in regulating ATM phenotype and function (Lumeng et al. 2009). As with ATM biology, much of the information on T cell function in adipose tissue comes from mouse studies. In lean mice, CD3+ T cells account for just under 15% of the stromal vascular cell fraction in adipose tissue (Nishimura et al. 2009). Obesity in mice is associated with a greater adipose tissue density of CD8+ T cells (largely effector T cells) and a lower density of CD4+ T cells and Treg cells (Feuerer et al. 2009, Nishimura et al. 2009, Winer et al. 2009). Temporally, CD8+ cell invasion precedes that of reduced CD4+ and reduced Treg cell density in adipose tissue following diet-induced obesity, and both changes are followed by an increase in macrophage density (Nishimura et al. 2009). These data, together with data from CD8+ cell activity was blocked, show that CD8+ cells are necessary for both initiation and maintenance of ATM invasion, particularly M1 macrophages. Importantly, CD8+ activity and decreased Treg cell density also appear to be crucial in the pathogenesis of the insulin resistance that accompanies obesity (Feuerer et al. 2009, Nishimura et al. 2009, Winer et al. 2009).

Thus, T cells appear to be major regulators in controlling ATM number and function in mouse and in human obesity (Kintscher et al. 2008). However, the question of what initiates adipose tissue inflammation remains incompletely answered. Although necessary, CD8+ cells alone are not sufficient to initiate macrophage invasion, differentiation, and activation in adipose tissue: interactions between CD8+ T cells and adipose tissue are required (Nishimura et al. 2009). The factor(s) triggering the type of interaction between T cells and adipose tissue that will initiate macrophage recruitment and phenotypic change are unknown, but free fatty acid-induced physical stress or oxidative damage to the endothelium (Wellen & Hotamisligil 2003) (possibly mediated via Toll-like receptors) (Schaeffler et al. 2009), hypoxia, and adipocyte death have all been proposed (Lumeng et al. 2009) as the initiating factors.

Whether macrophages and T cells are the only important leukocytes in adipose tissue inflammation is unclear. For example, the activity of mast cells in adipose tissue may also be relevant – obesity is associated with increasing mast cell density in WAT in both humans and rodents (Liu et al. 2009), and reducing mast cell numbers in a mouse model of diet-induced obesity reduces body weight and insulin resistance, probably via decreased adipocyte apoptosis and angiogenesis (Liu et al. 2009). The possible efficacy of mast cell-stabilizing agents as therapies to prevent/treat obesity is demonstrated by the association between BMI and serum tryptase (a mast cell product) levels after adjustment for gender (Liu et al. 2009).

Maternal studies

Fewer studies have looked at the link between obesity and inflammation during pregnancy. In a study of 47 women, serum levels of leptin, CRP, and IL6 were higher in obese women compared with gestation-, smoking-, and parity-matched lean women (Ramsay et al. 2002). These findings were confirmed in a subsequent study by the same group, which also showed higher serum ICAM-1 levels and lower plasminogen activator inhibitor (PAI)1:PAI2 ratios in obese women compared with non-obese pregnant women (Stewart et al. 2007). This increase in circulating proinflammatory cytokines relates in part to production by maternal peripheral blood mononuclear cells, which show greater TNF and IL6 mRNA production and expression of differentiation and activation markers (CD14 and CD68; Challier et al. 2008).

In contrast to the evidence on macrophage invasion and other inflammatory events in adipose tissue in non-pregnant obese individuals, there have (to our knowledge) been no quantitative studies on these events in pregnant women, although we have identified macrophages and crown-like structures in visceral and subcutaneous adipose tissues from obese pregnant women (SM Barr, JE Norman, BR Walker & NM Morton, 2009, unpublished observations; Fig. 2). This finding is supported by a recent study in baboons in which maternal obesity was accompanied by macrophage infiltration into adipose tissue (Farley et al. 2009).

In pregnancy, as in the non-pregnant state, obesity and particularly abdominal obesity are associated with glucose intolerance and insulin resistance (Ramsay et al. 2002, Martin et al. 2009), with the result that gestational diabetes is commoner in obese pregnant women. The biochemistry of these events is less well studied in pregnancy. TNF has been shown to be a predictor of insulin resistance in non-obese pregnant women in late gestation (Kirwan et al. 2002), although secretion of TNF from adipose tissue was not different when pregnant women with normal glucose tolerance were compared to lean women with gestational diabetes (Kirwan et al. 2002). However, defects in the insulin signaling cascade have been described in pregnant obese women of normal glucose tolerance (Kirwan et al. 2002), although secretion of TNF from adipose tissue was not different when pregnant women with normal glucose tolerance were compared to lean women with gestational diabetes (Kirwan et al. 2002). However, defects in the insulin signaling cascade have been described in pregnant obese women of normal glucose tolerance in both adipose tissue and skeletal muscle (Colomiere et al. 2009). Given that both glucose intolerance (Metzger et al. 2008) and insulin resistance (seen in women with polycystic ovarian syndrome; Boomsma et al. 2006) are associated with adverse pregnancy outcome, and given their link with obesity in pregnancy, it seems likely that both glucose intolerance (Metzger et al. 2008) and insulin resistance partially mediate the effects of obesity on adverse pregnancy outcome (described above). The increased inflammation found in pregnant and non-pregnant individuals is also plausibly linked to the increased rates of
pre-eclampsia in obese individuals, given that around 30% of the effect of increased BMI risk on pre-eclampsia is related to inflammation and triglyceride levels (Bodnar et al. 2005).

**Placental biology**

Inflammation and inflammatory cytokines have a pivotal role in placental function throughout pregnancy. Virtually, all known cytokines are capable of being synthesized and released by cytotrophoblast, syncytiotrophoblast, and resident placental macrophages or Hofbauer cells (Bowen et al. 2002) with their release being developmentally regulated (Hauguel-de Mouzon & Guerre-Millo 2006). For example, in early pregnancy, coordinated release of IL10 (Pang et al. 2008) and IL11 (Paiva et al. 2007) regulates trophoblast differentiation and invasion (for review see Guzeloglu-Kayisli et al. (2009)), and is therefore involved in the establishment of pregnancy. The physiological role of cytokines in later pregnancy is less well established; however, IL6 and TNF are thought to be involved in the regulation of fetal growth via modulation of expression and activity of the system A, but not 1-amino acid transporter (Jones et al. 2009).

Over the last decade, significant advances in our understanding of placental biology have established that placental function is dynamic and influenced by maternal health, and has an important regulatory role in maternal well-being during pregnancy. For example, in women with type 1 diabetes, there is upregulation of placental glycosylation and acylation pathways and a trend toward increased placental weight (Nelson et al. 2009, Radaelli et al. 2009). Moreover, the progressive development of insulin resistance during pregnancy is due in part to placentally derived cytokines (Rusterholz et al. 2007) such as TNF (Kirwan et al. 2002) and leptin (Hauguel-de Mouzon & Guerre-Millo 2006). Studies have also demonstrated major changes in the placental gene expression profile of inflammatory genes in women who have developed gestational diabetes mellitus (GDM; Radaelli et al. 2009). Given that maternal obesity is accompanied by significant dysregulation of normal physiology, it is therefore plausible that placental structure and function may be altered as a consequence of maternal obesity, and equally, that the placenta may modulate maternal physiology by release of inflammatory cytokines. Table 2 compares the gene expression changes found in placenta from women with GDM with gene expression changes which have been described in placenta from obese women.

**The placenta as an inflammatory organ**

There has been a recent trend toward increasing placental weight (Swanson & Bewtra 2008), paralleling the significant rise in maternal BMI; however, further studies are needed to confirm whether the rise in maternal obesity is responsible for the increase in placental weight. Hypo- or hypercoiling of the umbilical cord, associated with fetal demise and vascular thrombosis (Sebire 2007), is also more common in pregnancies complicated by obesity, gestational

### Table 2 Changes in gene expression levels in placenta from women with gestational diabetes mellitus (GDM) and obese women compared to non-obese healthy pregnant women.

<table>
<thead>
<tr>
<th>Gene</th>
<th>Changes in GDM placenta</th>
<th>Changes in obesity placenta</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Proinflammatory cytokines</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TNF</td>
<td>↑ (Radaelli et al. 2003)</td>
<td>↑ (Varastehpour et al. 2006)</td>
</tr>
<tr>
<td>IL6</td>
<td>↔ (Kleiblova et al. 2010)</td>
<td>↑ (Challier et al. 2008)*</td>
</tr>
<tr>
<td>IL1</td>
<td>↔ (Kleiblova et al. 2010)</td>
<td>↑ (Challier et al. 2008)*</td>
</tr>
<tr>
<td>IL8</td>
<td>↔ (Kleiblova et al. 2010)</td>
<td>↑ (Challier et al. 2008)*</td>
</tr>
<tr>
<td>CCL2</td>
<td>−</td>
<td>−</td>
</tr>
<tr>
<td>IFNG</td>
<td>↓ (Radaelli et al. 2003)</td>
<td>−</td>
</tr>
<tr>
<td><strong>Hormones</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leptin</td>
<td>↑ (Lepercq et al. 1998)</td>
<td>↑ (Varastehpour et al. 2006)</td>
</tr>
<tr>
<td>Leptin receptor</td>
<td>↔ (Kleiblova et al. 2010)</td>
<td>−</td>
</tr>
<tr>
<td>Adiponectin</td>
<td>−</td>
<td>−</td>
</tr>
<tr>
<td>Adiponectin receptor 1</td>
<td>↔ (Kleiblova et al. 2010)</td>
<td>−</td>
</tr>
<tr>
<td>Adiponectin receptor 2</td>
<td>↔ (Kleiblova et al. 2010)</td>
<td>−</td>
</tr>
<tr>
<td>Resistin</td>
<td>↔ (Kleiblova et al. 2010)</td>
<td>−</td>
</tr>
<tr>
<td>Vistatin</td>
<td>↔ (Telejko et al. 2009)</td>
<td>−</td>
</tr>
<tr>
<td><strong>Other factors</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MIF</td>
<td>↓ (Radaelli et al. 2003)</td>
<td>−</td>
</tr>
<tr>
<td>ESR1</td>
<td>↔ (Kleiblova et al. 2010)</td>
<td>−</td>
</tr>
<tr>
<td>ESR2</td>
<td>↔ (Kleiblova et al. 2010)</td>
<td>−</td>
</tr>
<tr>
<td>PLA2G2A</td>
<td>↑ (Varastehpour et al. 2006)</td>
<td>−</td>
</tr>
<tr>
<td>PLA2G5</td>
<td>↑ (Varastehpour et al. 2006)</td>
<td>−</td>
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</tbody>
</table>

* ↔, no relative change in gene expression levels; −, change not determined.

*Changes in gene expression levels in macrophage population isolated from placenta.
diabetes, and pre-eclampsia (de Laat et al. 2005). Although these pregnancy complications are all associated with increased inflammation, a causal link between inflammation and cord coiling abnormalities is yet to be established.

At the microscopic level, there are (to our knowledge) no detailed studies examining the effect of maternal obesity on placental structure. However, given that placentae from gestational diabetics have a characteristic morphology (placental immaturity and edema, chorangiosis, and vascular anomalies; Madazli et al. 2008), it is plausible that obesity may also affect placental structure. Supportive of this is a study by Challier et al. (2008) which demonstrates a two- to three-fold increase in placental macrophages in obese women compared with non-obese women. The macrophage population was characterized by increased expression of the proinflammatory cytokines IL1, TNF, and IL6, and marked phenotypic heterogeneity with complex subsets of CD14+, CD68+, and CD11b+ (mac-1) cells. A similar placental phenotype has recently been reported in a baboon model of obesity (Farley et al. 2009). It is also possible that maternal obesity may affect the number and function of other immune cell populations (Weisberg et al. 2003, Maroof et al. 2005, Macia et al. 2006) at the maternal–fetal interface including natural killer cells and dendritic cells. Alterations in these cell populations could have lifelong implications for the fetal acquired immune system and disease susceptibility in later life (Challier et al. 2008).

Figure 3 summarizes the potential role of inflammation in the placenta and the interactions between maternal and fetal tissues.

Maternal obesity may also affect placental transport and substrate availability. Varastehpour et al. (2006) demonstrated a significant increase in the expression of the phospholipase A2 (PLA2) genes PLA2G2A and PLA2G5 (the main placenta phospholipases), leptin, and TNF in placentae from obese neonates (body fat >16%) compared with lean neonates (body fat <8%; Varastehpour et al. 2006). By demonstrating that leptin and TNF induced a time-dependent activation of PLA2G2A and PLA2G5, they suggested that this inflammatory loop may be one mechanism by which excess fat accumulates in obese neonates. Alternatively, Elchalal et al. (2005) demonstrated that insulin and fatty acids enhance the expression of adipophilin, which is associated with cellular lipid droplets and implicated in cellular fatty acid uptake and storage of neutral lipids, in term human trophoblasts (Elchalal et al. 2005). In maternal obesity, higher circulating levels of insulin (Challier et al. 2008, Catalanao et al. 2009) might therefore upregulate the expression of fatty acid transporters, thereby increasing the availability of fatty acids to both the placenta and the fetus.

Amino acid transport may also be affected by maternal obesity. As described previously, physiological concentrations of the proinflammatory cytokines IL6 and TNF stimulate the activity of amino acid transporter system A (Jones et al. 2009). In maternal obesity, increased levels of IL6 and TNF in the placenta could systemically stimulate the system A transporter further, thus increasing amino acid transport to the fetus. Other inflammatory markers that have been demonstrated to differ in placentae from obese animals compared with non-obese animals are carboxypeptidase E (Singh et al. 2006) and resistin (Zhou et al. 2006). Adipokines also modulate placental function. For example, leptin has been shown to regulate placental angiogenesis (Islami et al. 2003), protein synthesis (Perez-Perez et al. 2009), and growth, and cause immunomodulation (Fietta 2005). Thus, it is possible that the increase in local and/or circulating levels of leptin in maternal obesity may modulate placental inflammation and function (Islami et al. 2003, Fietta 2005, Perez-Perez et al. 2009).
Thus far, the evidence presented suggests that the placenta is a passive bystander in the hostile inflammatory environment of maternal obesity. However, this explanation may be too simplistic. A recent study by Roberts et al. (2009) has demonstrated that although nitrative stress was increased in placentae from obese women compared with non-obese women, this was accompanied by a decrease in oxidative stress. They proposed that the shift in balance between nitrative and oxidative stress may act as a protective mechanism for the placenta with the formation of peroxynitrite consuming reactive oxygen species and reducing oxidative stress. A similar protective mechanism appears to be present in women with gestational diabetes with antioxidant gene expression being increased in placentae from women with gestational diabetes compared with controls (Lappas et al. 2005). Furthermore, when placent al explants from women with gestational diabetes were subjected to oxidative stress, expression and release of inflammatory cytokines were reduced compared to explants from normal pregnant women (Lappas et al. 2010). Finally, Colomiere et al. (2009) demonstrated post-receptor defects in the insulin signaling pathway in placentae from obese women compared to non-obese women with significant decreases in expression of mRNA for IR-β, PI3K p85α, and SLC2A4 (GLUT-4; Colomiere et al. 2009). Together, these studies raise the intriguing possibility that the placenta may be able to ‘sense’ the maternal environment and adapt to protect not only itself but also potentially the fetus from the hostile inflammatory, oxidative, hyperinsulinemic milieu present in maternal obesity.

Vascular and fibrinolytic function

In the non-pregnant state, obesity has profound and complex effects on vascular and fibrinolytic function (Stapleton et al. 2008). Clinically, this is reflected by an increased risk of hypertension, atherosclerosis, and ischemic heart disease, and having a myocardial infarction or a cerebrovascular accident. Thus far, most studies investigating the link between obesity and vascular and fibrinolytic function have been undertaken in non-pregnant individuals as opposed to pregnant individuals. In this section, we will review the current evidence linking obesity and inflammation to vascular and fibrinolytic dysfunction in non-pregnant individuals, the effect of pregnancy on vascular and fibrinolytic function, and finally, the combined effect of pregnancy and obesity on these variables.

In obese individuals, local and systemic vascular and endothelial function is significantly impaired. Blood vessel structure is altered in obesity with an increase in vessel diameter, basement membrane thickness, vascular permeability, and vessel stiffness (Zebekakis et al. 2005). With disease progression, microvascular vessel walls start to atrophy, vessel diameter narrows, and progressive microvascular rarefaction develops (Frisbee 2005, Stepp & Belin De Chantemele 2007), increasing the risk of local tissue ischemia. Adipose tissue, which surrounds blood vessels (perivascular adipose tissue), also indirectly affects vascular structure and tone via release of vasoactive inflammatory mediators including adipokines, angiotensin, and endothelin-1 (Zhang & Zhang 2009). At a functional level, the vasodilatory response to endothelium-dependent vasodilators such as acetylcholine is attenuated (Steinberg et al. 1996), whereas the response to endothelium-independent vasodilators, such as sodium nitroprusside, remains intact (Van Guelder et al. 2006). Flow-mediated dilation, which induces release of endothelium-dependent relaxing factors increasing blood vessel diameter, is also impaired (Sturm et al. 2009). Vasomotor responses are further blunted by an increase in sensitivity to vasoconstrictive agonists including prostanooids, endothelin-1, and a hyperactivity of the sympathetic nervous system (Esler et al. 2001, Agapitov et al. 2002, Traupe et al. 2002, Frisbee 2006).

Obesity is also associated with a prothrombotic state with plasma concentrations of prothrombotic factors including von Willebrand factor, fibrinogen, and factor VII being higher in obese controls compared with lean controls (Faber et al. 2009). Excess adipose tissue contributes directly to the prothrombotic state by i) impairing platelet function via low-grade inflammation and increase in circulating leptin, ii) impairing fibrinolysis by production of plasminogen activator inhibitor-1 and possibly thrombin-activatable fibrinolysis inhibitor, iii) impairing coagulation by release of tissue factor, and iv) affecting hepatic synthesis of the coagulation factors fibrinogen, factor VII, factor VIII, and tissue factor, by releasing free fatty acids and proinflammatory cytokines (IL1B, TNF, and IL6) into the portal circulation and by inducing hepatic insulin resistance (Faber et al. 2009).

In order to sustain the developing fetus, extensive cardiovascular adaptation occurs during pregnancy (Robb et al. 2009a, 2009b). Increased production of endothelium-derived vasodilators is accompanied by enhancement of endothelial function and reactivity (Anumba et al. 1999) and an increase in flow-mediated dilation of the brachial artery (Dorup et al. 1999). This is accompanied by a progressive increase in pulse wave velocity and augmentation index over the third trimester (Robb et al. 2009b). These changes occur despite the increase in systemic inflammation (Sacks et al. 1998, 2004), insulin resistance, and hyperlipidemia that occur during normal pregnancy (Sattar & Greer 2002). Pregnancy is also accompanied by significant alterations in the fibrinolytic and coagulation system with increased plasma concentrations of t-PA, coagulation factors, and inhibitors of fibrinolysis (Hellgren 2003, Robb et al. 2009a) and impaired endogenous fibrinolysis (Robb et al. 2009a).
Vascular and fibrinolytic function and inflammation

Obese women enter pregnancy with chronic preexisting endothelial activation. Although endothelium-dependent function increases during pregnancy in obese and lean women, it remains lower in obese women compared with lean women at all stages of pregnancy (Ramsay et al. 2002, Stewart et al. 2007). Moreover, by 4 months post partum, endothelial function declines to first trimester levels in obese women, whereas improved endothelium-dependent function persists in lean women (Stewart et al. 2007). Endothelium-dependent vasodilation is also impaired in myometrial arteries from women with an elevated BMI at booking compared with those with a BMI within the normal range (Myers et al. 2006). The mechanisms underlying impaired endothelial function in obese women are not well understood. However, it is likely that both systemic (Ramsay et al. 2002, Stewart et al. 2007) and local inflammation within the vasculature are likely to be involved in mediating impaired endothelial function (Walsh 2007). Maternal obesity is also associated with an increased risk of thromboembolism. However (to our knowledge), there are no studies that have compared endogenous fibrinolysis in obese women compared to lean women during pregnancy, nor established whether there are any differences in clotting factors between these groups.

Summary

Maternal obesity is associated with an increase in maternal and neonatal morbidity and mortality. However, the mechanisms underlying this association remain poorly understood. It is likely that excessive local and systemic inflammation play a key role in the pathophysiology of the adverse outcomes (Fig. 4). Further studies are urgently required to investigate the biology of adipose tissue in obese pregnant women, its links to insulin resistance, circulating inflammatory cytokines, placental, endothelial and fibrinolytic function, and adverse pregnancy outcome. Such studies will inform rational therapies for testing to reduce pregnancy-related mortality and morbidity among both the mother and the neonate.

Declaration of interest

The authors confirm that there is no conflict of interest that could be perceived as prejudicing the impartiality of the research reported.

Funding

Our work on obesity, inflammation, and vascular function in pregnancy was funded by Tommy’s, the baby charity, to whom we are very grateful.
Acknowledgements

We would like to thank Ronnie Grant for graphical design.

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