Investigation of Association with First-Trimester Free Human Chorionic Gonadotropin - β, Pregnancy - Associated Plasma Protein-A, and Adverse Pregnancy Outcomes

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ABSTRACT

OBJECTIVES: This study aimed to investigate the association between first-trimester screening maternal serum markers (free human chorionic gonadotropin-beta (β-hCG), pregnancy-associated plasma protein-A, and adverse pregnancy outcomes (gestational hypertension, preeclampsia, preterm delivery, intrauterine growth restriction, oligohydramnios, intrauterine ex-fetus, abruptio placentae, and gestational diabetes mellitus).

STUDY DESIGN: This was a retrospective cohort study including 1516 women who delivered a singleton pregnancy at GATA Haydarpaşa Education Hospital from 2006 to 2009. Patients with multiple pregnancies, chromosome aberrations, or fetal anomalies were excluded. Extreme values of corrected-pregnancy-associated plasma protein-A and free β-hCG, and their association with adverse pregnancy outcomes were analyzed.

RESULTS: Adverse pregnancy outcomes at the cutoff level of ≤0.25 c-pregnancy-associated plasma protein-A MOM values positive likelihood ratio (+LR) was 7.5 (95%CI 2.426-19.836) and had a significant correlation (r=0.108, p<0.01). It was also a significant correlation with adverse pregnancy outcomes (r=0.189, p<0.01) at the cut-off level of ≤0.50 corrected-pregnancy-associated plasma protein-A MOM values and the +LR was 2.388 (95%CI 1.889-2.991). Association between low corrected-pregnancy-associated plasma protein-A MOM values and adverse pregnancy outcomes were statistically significant and had a poor association (AUC, 0.630 95%CI 0.596-0.663, p<0.01). Preeclampsia was statistically significant, however had a fair association (AUC, 0.74 95% CI 0.690-0.802, p<0.01). Preterm birth was statistically significant but had a poor association (AUC, 0.568 95% CI 0.512-0.624, p<0.05).

CONCLUSION: First-trimester maternal serum low pregnancy-associated plasma protein-A values are significantly associated with adverse pregnancy outcomes. It may be a useful tool to predict not only chromosome anomalies but also adverse pregnancy outcomes.

Keywords: Fetal growth restriction, Gestational hypertension, Human chorionic gonadotrophin beta subunit, Nuchal translucency, Preeclampsia, Pregnancy-associated plasma protein A

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Introduction

First-trimester screening tests were found to be effective for trisomy 21 screening (1-5). This screening technique is used to evaluate fetal nuchal translucency (NT) ultrasound and maternal serum markers pregnancy-associated plasma protein-A (PAPP-A) and free human chorionic gonadotropin beta subunit (β-hCG) (6-8). The insulin-like growth factor (IGF) system plays an important role in regulating ovarian follicular development (ovarian follicle growth, selection, atresia, cellular differentiation, oocyte maturation, cumulus expansion, and follicle dynamics), and steroidogenesis. PAPP-A is a secreted metalloprotease responsible for the cleavage of IGF binding protein-4 in the ovary (8,9). These data demonstrate an im-
portant role of PAPPA in modulating ovarian function, placenta
tion, placental function, and female fertility by control of
the bioavailability of ovarian IGF (8,10). If the level of
PAPPA is insufficient to successfully cleave IGF, IGF remains
in its bound, inactive form, possibly leading to diminished
fetal and placental growth (11).

While several other publications have shown statistically
significant associations between low PAPPA levels and
preeclampsia, fetal loss, preterm birth, and (IUGR), they have
failed to demonstrate high sensitivity and high positive pre-
dictive values to deem a patient high or low risk for the ad-
verse outcomes (12-20). Free β-hCG is a syncytiotrophoblast-
derived promoter of cell growth and differentiation in the em-
byro (21). Evidence is lacking to support an association be-
tween free β-hCG and non-chromosomal adverse pregnancy
outcomes (19,22,23).

In this retrospective cohort study, we aimed to investigate
the relationship between the first-trimester screening maternal
serum markers especially corrected PAPPA levels, and ad-
verse pregnancy outcomes such as gestational hypertension,
preeclampsia, IUGR, oligohydramnios, preterm birth, in-
trauterine ex fetus (IUEF), gestational diabetes mellitus
(GDM), placental abruption.

Material and Method

This was a retrospective cohort study including the final
number of 1516 women delivered of a singleton pregnancy at
GATA Haydarpaşa Education Hospital from 2006 to 2009 for
whom first-trimester serum markers analysis, as well as preg-
nancy outcome data, were available. Multiple pregnancies
confirmed fetal chromosomal abnormalities and fetal demise
before 20 weeks of gestation were excluded. Records with in-
complete pregnancy outcome data were excluded. Clinical
records and hospital computer automation systems were used
as data sources. The three first-trimester markers including
PAPPA level, free β-hCG, and NT were evaluated.

Information on maternal medical and obstetrical history, ges-
tational age, maternal weight, fetal crown-rump length (CRL),
and NT measures at the examination, type of delivery, time of
weeks at delivery, and pregnancy outcomes were collected.

The adverse pregnancy outcomes examined including gesta-
tional hypertension (GHT), preeclampsia, preterm birth, IUGR,
oligohydramnios, low birth weight, IUEF, abruptio
placentaes, and GDM.

Pregnancy-associated plasma protein-A values and free β-
hCG values measured in maternal serum were obtained by the
chemiluminescence method using immulite kits in Immulite
1000 analyzer of the Hospital Biochemistry Laboratory.
Multiples of median values (MOM) of the corrected median
were calculated by using the first-trimester screening test form
which was filled in perinatology outpatient clinic with
PRISCA package software program. Demographic distribu-
tions of patients, ultrasonographic findings in first-trimester
between 10 weeks 0 days and 13 weeks 6 days of gestation
(CRL between 38 and 83 mm), and biochemical test data were
collected in the Office 2007 Excel program.

Preterm birth was defined as a delivery occurring before
37 weeks of pregnancy. IUGR was defined as a fetus whose
estimated weight was below the 10th percentile for gestational
age. GHT was defined as a new onset of hypertension (systolic
blood pressure 140 mmHg and/or diastolic blood pressure 90
mmHg) were documented on at least two occasions at least 6
hours apart at 20 weeks of gestation, in the absence of pro-
etinuria. Preeclampsia was defined as the presence of systolic
blood pressure ≥140 mmHg and/or diastolic blood pressure
≥90 mmHg after 20 weeks of pregnancy detected on two or
more occasions separated by 6 h with the presence of protein-
uria randomly detection of ≥2+ on dipstick or 0.3 g in a 24 h
urine specimen. Intrauterine fetal demise, ex fetus, or stillbirth
was defined as intrauterine fetal deaths after 20 weeks of preg-
nancy. Oligohydramnios was defined as an amniotic fluid
index <5 cm. GDM was diagnosed if fasting glucose level 92
and 126 mg/dL at first-trimester or at least one value of plasma
glucose concentration 92, 180, and 153 mg/dL (for fasting, 1-
and 2-h post-glucose load glucose values, respectively), after
performing a 75 g oral glucose tolerance test or at least two
values of plasma glucose concentration 95, 180, 155, and 140
mg/dL (for fasting, 1., 2., and 3. hour post-glucose load glu-
cose values, respectively), after performing a 100 g oral glu-
cose tolerance test if 50 g oral glucose tolerance test first hour
glucose level was >140 mg/dL at 24-28 weeks of gestation.
Small for gestational age (SGA) was defined as a birth weight
of less than the 10th percentile for gestational age.

In the primary analysis, relations between ≤0.25 MOM
and ≤0.50 MOM levels of PAPPA and adverse pregnancy out-
comes were evaluated. Descriptive analysis of adverse preg-
nancy outcomes under <1.0 MOM level with 0.25 MOM in-
tervals of PAPPA was performed (Figure 1).

Statistical analyses were performed with the SPSS package
(SPSS Inc., Windows, version 17.0). Categorical variables
were compared by the χ² test. Continuous variables were de-
scribed using median and interquartile ranges and categorical
variables using frequencies. Spearman correlation and
Receiver operating characteristic (ROC) curve analysis were
performed to evaluate the relationship between independent
variables. The traditional academic point system was used to
classify the area under the curve (AUC). AUC from 0.90 to
1.0, 0.80 to 0.90, 0.70 to 0.80, 0.60 to 0.70, and 0.50 to 0.60 in-
dicates excellent, good, fair, poor, and fail association ability.
Likelihood ratio, sensitivity, specificity, predictive values, and
95% CI were calculated by using the diagnostic test calculator
program of evidence-based medicine toolbox in (https://ebm-
tools.knowledgetranslation.net/calculator/diagnostic/) web-
page. Statistical significance was defined as p-value 0.05.
Results

The final number of the study population was 1516 after excluding multiple pregnancies, fetal chromosomal abnormalities, and fetal demise before 20 weeks of gestation, records with incomplete pregnancy outcome data during the study period, from the beginning of January 2006 to the end of December 2008. Descriptive characteristics of the study group of 1516 pregnant women were shown in Table I.

Adverse pregnancy outcomes among 1516 pregnant women were as follows: 33 (2.2%) gestational hypertension (GHT), 68 (4.5%) preeclampsia, 107 (7.1%) preterm birth, 29 (1.9%) intrauterine growth restriction (IUGR), 14 (0.9%) intrauterine growth restriction (IUEF), 33 (2.2%) oligohydramnios, 69 (4.6%) gestational diabetes mellitus (GDM), 12 (0.8%) abruptio placentae. Adverse pregnancy outcomes distribution showed among 0.25 MOM intervals of under <1.0 corrected PAPPA MOM values (Table II). It has been used maternal weight correction of maternal serum PAPPA values to reduce the population variability of the markers and the impact on detection rate and false-positive rate is very small (3-5).

Corrected PAPPA MOM was equal to PAPPA MOM/((79.858×1/weight) -0.230).

\[ \text{Corrected PAPPA MOM values, percentile distribution of adverse pregnancy outcomes at 0.25 MOM intervals below 1.0 MOM, n=1516, Istanbul 2006-2009. Corrected PAPPA MOM values mean: pregnancy-associated plasma protein-A multiples of the median values of the corrected median that was calculated by using the first-trimester screening perinatology outpatient clinic test form with PRISCA package software program. Gray color in each bar shows the number and percentage of adverse pregnancy outcomes (gestational hypertension, preeclampsia, preterm delivery, fetal growth restriction, oligohydramnios, intrauterine ex fetus, abruptio placentae, and gestational diabetes mellitus). White areas in each bar show the number and percentage of normal pregnancy outcomes.} \]

**Table I: Patients characteristics of the study group, Istanbul 2006-2009 All (n=1516)**

<table>
<thead>
<tr>
<th>Maternal age</th>
<th>29.01</th>
<th>4.467</th>
<th>19</th>
<th>43 year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal weight</td>
<td>61.00</td>
<td>8.683</td>
<td>41</td>
<td>105 kg</td>
</tr>
<tr>
<td>Gestational age at the sampling day</td>
<td>87.76</td>
<td>4.10</td>
<td>73</td>
<td>97 days</td>
</tr>
<tr>
<td>CRL</td>
<td>63.00</td>
<td>7.982</td>
<td>38</td>
<td>83 mm</td>
</tr>
<tr>
<td>corrected PAPPA MOM</td>
<td>0.87</td>
<td>0.57</td>
<td>0.10</td>
<td>5.08</td>
</tr>
<tr>
<td>Free β-hCG MOM</td>
<td>0.88</td>
<td>0.86</td>
<td>0.17</td>
<td>6.51</td>
</tr>
<tr>
<td>NT MOM</td>
<td>0.96</td>
<td>0.22</td>
<td>0.11</td>
<td>3.16</td>
</tr>
<tr>
<td>Birth weight</td>
<td>3350.00</td>
<td>545.72</td>
<td>500.00</td>
<td>5150.00 gram</td>
</tr>
<tr>
<td>Gestational age of weeks at delivery</td>
<td>38.38</td>
<td>2.14</td>
<td>22</td>
<td>42 week</td>
</tr>
</tbody>
</table>

*Data are given as median, standard deviation, minimum, and maximum values*

**Table II: Corrected PAPPA MOM values and frequency distribution of adverse pregnancy outcomes at 0.25 MOM intervals below 1.0 MOM, Istanbul 2006-2009.**

<table>
<thead>
<tr>
<th>Adverse pregnancy outcomes</th>
<th>≤0.25</th>
<th>0.25-0.50</th>
<th>0.51-0.75</th>
<th>0.75-1.0</th>
<th>&gt;1.0</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gestational hypertension</td>
<td>2 (6.1%)</td>
<td>8 (24.2%)</td>
<td>7 (21.1%)</td>
<td>7 (21.2%)</td>
<td>9 (27.3%)</td>
<td>33</td>
</tr>
<tr>
<td>Preeclampsia</td>
<td>2 (2.9%)</td>
<td>25 (36.8%)</td>
<td>25 (36.8%)</td>
<td>7 (10.3%)</td>
<td>9 (13.2%)</td>
<td>68</td>
</tr>
<tr>
<td>Preterm birth</td>
<td>4 (3.8%)</td>
<td>20 (19.2%)</td>
<td>25 (23.4%)</td>
<td>22 (21.2%)</td>
<td>36 (33.6%)</td>
<td>107</td>
</tr>
<tr>
<td>Intrauterine growth restriction</td>
<td>2 (6.9%)</td>
<td>9 (31.0%)</td>
<td>9 (31.0%)</td>
<td>5 (17.2%)</td>
<td>4 (13.8%)</td>
<td>29</td>
</tr>
<tr>
<td>Oligohydramnios</td>
<td>0 (0.0%)</td>
<td>5 (15.2%)</td>
<td>11 (33.3%)</td>
<td>6 (18.2%)</td>
<td>11 (33.3%)</td>
<td>33</td>
</tr>
<tr>
<td>Abruptio placentae</td>
<td>0 (0.0%)</td>
<td>1 (38.3%)</td>
<td>4 (33.3%)</td>
<td>2 (16.7%)</td>
<td>5 (41.7%)</td>
<td>12</td>
</tr>
<tr>
<td>Fetal demise</td>
<td>0 (0.0%)</td>
<td>5 (35.7%)</td>
<td>4 (28.6%)</td>
<td>2 (14.3%)</td>
<td>3 (21.4%)</td>
<td>14</td>
</tr>
<tr>
<td>Gestational diabetes mellitus</td>
<td>1 (1.4%)</td>
<td>17 (14.6%)</td>
<td>18 (26.1%)</td>
<td>10 (14.5%)</td>
<td>23 (33.3%)</td>
<td>69</td>
</tr>
<tr>
<td>Total adverse pregnancy outcome</td>
<td>11 (3.0%)</td>
<td>90 (24.7%)</td>
<td>103 (28.2%)</td>
<td>61 (16.7%)</td>
<td>100 (27.4%)</td>
<td>365</td>
</tr>
<tr>
<td>Study Population</td>
<td>16 (1.1%)</td>
<td>219 (14.4%)</td>
<td>366 (24.1%)</td>
<td>298 (19.7%)</td>
<td>617 (40.7%)</td>
<td>1516</td>
</tr>
</tbody>
</table>
There was no relationship between high c-PAPPA or free corrected β-hCG MOM levels and adverse pregnancy outcomes except it was a statistically significant association with the cut-off level of corrected free β-hCG ≥2.9 MOM values and fetal macrosomia (>4500g) (r=0.068, p<0.01). Also, we analyzed that below the 5th percentile of corrected free β-hCG (≤0.33 MOM) cutoff level, it was evidence of statistically significant association with small for gestational age (10th percentile birth weight) (r=0.088, p=0.01). Corrected PAPPA MOM values frequency distribution and percentiles of adverse pregnancy outcomes were shown in figure 1 and Table II.

When the number of adverse pregnancy outcomes analyzed by One-Sample Kolmogorov-Smirnov test whether it is appropriate to a normal distribution, groups have been found to follow a normal distribution (p<0.05). Nonparametric tests χ² and Spearman correlation were used for correlation analysis.

The likelihood ratio was preferred to sensitivity, specificity, and predictive values. Because they have advantages over sensitivity, specificity, and positive/negative predictive values because they are less likely to change with the prevalence of the disorder, they can be calculated for several levels of the symptom/sign or test, they can be used to combine the results of multiple diagnostic tests and they can be used to calculate the post-test probability for a target disorder.

The association with corrected PAPPA MOM values under or equal to 0.25 MOM and adverse pregnancy outcomes were shown in Table III. Two gestational hypertension cases (6.1%) were detected at the cut off level of ≤0.25 c-PAPPA MOM values. The positive likelihood ratio (+LR) was 6.778 (95% CI 5.27-27.12) and had a statistically significant correlation at this cut off value (r=0.073, p<0.01). Two preeclampsia cases (2.9%) were detected at the cutoff level of ≤0.25 c-PAPPA MOM values. The positive likelihood ratio was 2.9 (95% CI 0.705-1.118) but had no statistically significant correlation at this cutoff value (r=0.040, p>0.05). Four Preterm birth cases (3.8%) were detected at the cutoff level of ≤0.25 c-PAPPA MOM values. The positive likelihood ratio (+LR) was 4.111 (95% CI 1.44-3.378) and had a statistically significant correlation at this cutoff value (r=0.072, p<0.01). Two IUGR cases (6.9%) were detected at the cutoff level of ≤0.25 c-PAPPA MOM values. Positive likelihood ratio (+LR) was 7.667 (95% CI 1.744-30.772) and had statistically significant correlation (r=0.80, p<0.01). One GDM case (1.4%) was detected at the cutoff level of ≤0.25 c-PAPPA MOM values. The positive likelihood ratio was 1.4 (95% CI 0.187-10.432) and had no statistically significant correlation (r=0.008, p>0.05). Oligohydramnios, abruptio placentae, IUEF had not any cases at the cutoff level of ≤0.25 c-PAPPA MOM values. The positive likelihood ratio was 7.5 (95% CI 2.426-19.836) and had a statistically significant correlation (r=0.108, p<0.01) (Table III).

<table>
<thead>
<tr>
<th>N 1516</th>
<th>Sensitivity 95% CI</th>
<th>Specificity 95% CI</th>
<th>PPV 95% CI</th>
<th>NPV 95% CI</th>
<th>+LR 95% CI</th>
<th>-LR 95% CI</th>
<th>r</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gestational hypertension</td>
<td>2 (6.1%)</td>
<td>0.061 (0.017-0.196)</td>
<td>0.991 (0.984-0.994)</td>
<td>0.125 (0.035-0.36)</td>
<td>0.979 (0.971-0.985)</td>
<td>6.778 (1.52-27.12)</td>
<td>0.948 (0.869-1.034)</td>
<td>0.073</td>
</tr>
<tr>
<td>Preeclampsia</td>
<td>2 (2.9%)</td>
<td>0.029 (0.008-0.101)</td>
<td>0.99 (0.984-0.994)</td>
<td>0.125 (0.035-0.36)</td>
<td>0.956 (0.944-0.965)</td>
<td>2.9 (0.705-13.118)</td>
<td>0.981 (0.94-1.022)</td>
<td>0.040</td>
</tr>
<tr>
<td>Preterm birth</td>
<td>4 (3.8%)</td>
<td>0.037 (0.015-0.092)</td>
<td>0.99 (0.985-0.995)</td>
<td>0.25 (0.102-0.495)</td>
<td>0.931 (0.917-0.943)</td>
<td>4.111 (1.44-13.378)</td>
<td>0.972 (0.935-1.008)</td>
<td>0.072</td>
</tr>
<tr>
<td>Intrauterine growth restriction</td>
<td>2 (6.9%)</td>
<td>0.069 (0.019-0.22)</td>
<td>0.991 (0.984-0.994)</td>
<td>0.125 (0.035-0.36)</td>
<td>0.982 (0.974-0.988)</td>
<td>7.667 (1.744-30.772)</td>
<td>0.939 (0.851-1.038)</td>
<td>0.80</td>
</tr>
<tr>
<td>Oligohydramnios</td>
<td>0</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Abruptio placenta</td>
<td>0</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Fetal demise</td>
<td>0</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Gestational diabetes mellitus</td>
<td>1 (1.4%)</td>
<td>0.014 (0.003-0.078)</td>
<td>0.99 (0.983-0.994)</td>
<td>0.063 (0.011-0.283)</td>
<td>0.955 (0.943-0.964)</td>
<td>1.4 (0.187-10.432)</td>
<td>0.996 (0.967-1.025)</td>
<td>0.008</td>
</tr>
<tr>
<td>Total adverse pregnancy outcome</td>
<td>11 (3.0%)</td>
<td>0.03 (0.017-0.053)</td>
<td>0.996 (0.99-0.998)</td>
<td>0.688 (0.444-0.858)</td>
<td>0.764 (0.742-0.785)</td>
<td>7.5 (2.426-19.836)</td>
<td>0.974 (0.956-0.992)</td>
<td>0.108</td>
</tr>
</tbody>
</table>

PPV: positive predictive value, negative predictive value, + likelihood ratio, - likelihood ratio, CI: 95% confidence interval, r: correlation coefficient (spearman correlation)
(r=0.61, p<0.05), preeclampsia (r=0.145, p<0.01), preterm birth (r=0.053, p<0.05), IUGR (r=0.087, p<0.01), GDM (r=0.054, p<0.05), total adverse pregnancy outcomes (r=0.189, p<0.01) at the cutoff level of ≤0.50 c-PAPPA MOM values. It was not statistically significant correlation with oligohydramnios (r=-0.001, p>0.05) and abruptio placentae (r=0.018, p>0.05).

The positive likelihood ratio (+LR) of the adverse pregnancy outcomes at the cutoff level of ≤0.50 c-PAPPA MOM values were GHT 1.993 (95%CI 1.174-3.398), preeclampsia 2.757 (95%CI 2.01-3.802), preterm birth 1.493 (95%CI 1.031-2.176), IUGR 2.51 (95%CI 1.557-4.073), GDM 1.74 (95%CI 1.148-2.636), total adverse pregnancy outcomes 2.388 (95%CI 1.889-2.991) (Table IV).

ROC curve analysis of c-PAPPA MOM values and adverse pregnancy outcomes were showed in table V. Association between low c-PAPPA MOM values and adverse pregnancy outcomes were showed that preeclampsia was statistically significant and had a fair association (AUC, 0.74 95% CI 0.690-0.802, p<0.01). Preterm birth was statistically significant but had a fail association (AUC, 0.568 95%CI 0.825-0.862).

### Table IV: Association with cut off level of ≤0.50 corrected PAPPA MOM values and adverse pregnancy outcomes

<table>
<thead>
<tr>
<th>Pregnancy Outcome</th>
<th>Sensitivity 95% CI</th>
<th>Specificity 95% CI</th>
<th>PPV 95% CI</th>
<th>NPV 95% CI</th>
<th>+LR 95% CI</th>
<th>-LR 95% CI</th>
<th>r</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gestational hypertension</td>
<td>0.303 (0.174-0.473)</td>
<td>0.848 (0.829-0.866)</td>
<td>0.043 (0.023-0.077)</td>
<td>0.982 (0.973-0.988)</td>
<td>1.993 (1.174-3.398)</td>
<td>0.822 (0.655-1.03)</td>
<td>0.61</td>
<td>p&lt;0.05</td>
</tr>
<tr>
<td>Preeclampsia</td>
<td>0.397 (0.289-0.516)</td>
<td>0.856 (0.837-0.873)</td>
<td>0.115 (0.08-0.162)</td>
<td>0.968 (0.957-0.976)</td>
<td>2.757 (2.01-3.802)</td>
<td>0.704 (0.58-0.855)</td>
<td>0.145</td>
<td>p&lt;0.01</td>
</tr>
<tr>
<td>Preterm birth</td>
<td>0.224 (0.156-0.312)</td>
<td>0.85 (0.831-0.868)</td>
<td>0.102 (0.07-0.147)</td>
<td>0.935 (0.92-0.947)</td>
<td>1.493 (1.031-2.176)</td>
<td>0.913 (0.822-1.013)</td>
<td>0.053</td>
<td>p&lt;0.05</td>
</tr>
<tr>
<td>Intrauterine growth restriction</td>
<td>0.379 (0.227-0.56)</td>
<td>0.849 (0.83-0.867)</td>
<td>0.047 (0.026-0.082)</td>
<td>0.986 (0.978-0.991)</td>
<td>2.51 (1.557-4.073)</td>
<td>0.731 (0.549-0.972)</td>
<td>0.087</td>
<td>p&lt;0.05</td>
</tr>
<tr>
<td>Oligohydramnios</td>
<td>0.152 (0.067-0.309)</td>
<td>0.845 (0.826-0.862)</td>
<td>0.021 (0.009-0.049)</td>
<td>0.978 (0.969-0.985)</td>
<td>0.981 (0.432-2.209)</td>
<td>1.004 (0.868-1.162)</td>
<td>-0.001</td>
<td>p&lt;0.05</td>
</tr>
<tr>
<td>Abruptio placentae</td>
<td>0.083 (0.015-0.354)</td>
<td>0.844 (0.825-0.862)</td>
<td>0.004 (0.001-0.024)</td>
<td>0.991 (0.985-0.995)</td>
<td>0.532 (0.082-3.511)</td>
<td>1.086 (0.914-1.289)</td>
<td>-0.018</td>
<td>p&lt;0.05</td>
</tr>
<tr>
<td>Fetal demise</td>
<td>0.357 (0.163-0.612)</td>
<td>0.847 (0.828-0.884)</td>
<td>0.021 (0.009-0.049)</td>
<td>0.993 (0.987-0.996)</td>
<td>2.333 (1.143-4.757)</td>
<td>0.759 (0.513-1.122)</td>
<td>0.054</td>
<td>p&lt;0.01</td>
</tr>
<tr>
<td>Gestational diabetes mellitus</td>
<td>0.261 (0.172-0.375)</td>
<td>0.85 (0.831-0.868)</td>
<td>0.077 (0.049-0.118)</td>
<td>0.96 (0.948-0.97)</td>
<td>1.74 (1.148-2.636)</td>
<td>0.869 (0.755-1.002)</td>
<td>0.064</td>
<td>p&lt;0.05</td>
</tr>
<tr>
<td>Total adverse pregnancy outcome</td>
<td>0.277 (0.233-0.325)</td>
<td>0.884 (0.864-0.901)</td>
<td>0.43 (0.368-0.494)</td>
<td>0.794 (0.771-0.815)</td>
<td>2.388 (1.889-2.991)</td>
<td>0.818 (0.766-0.875)</td>
<td>0.189</td>
<td>p&lt;0.01</td>
</tr>
</tbody>
</table>

**PPV:** positive predictive value, **NPV:** negative predictive value, +LR: + likelihood ratio, -LR: - likelihood ratio, CI: 95% confidence interval, r: correlation coefficient (spearman correlation)

### Table V. Association between low corrected PAPPA MOM values and adverse pregnancy outcomes

<table>
<thead>
<tr>
<th>Pregnancy Outcome</th>
<th>n=1516</th>
<th>AUC</th>
<th>95% CI</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gestational hypertension</td>
<td>33 (2.2%)</td>
<td>0.58</td>
<td>0.472-0.688</td>
<td>0.116</td>
</tr>
<tr>
<td>Preeclampsia</td>
<td>68 (4.5%)</td>
<td>0.746</td>
<td>0.690-0.802</td>
<td>0.000</td>
</tr>
<tr>
<td>Preterm birth</td>
<td>107 (7.1%)</td>
<td>0.568</td>
<td>0.512-0.624</td>
<td>0.019</td>
</tr>
<tr>
<td>Intrauterine growth restriction</td>
<td>29 (1.9%)</td>
<td>0.697</td>
<td>0.606-0.787</td>
<td>0.000</td>
</tr>
<tr>
<td>Oligohydramnios</td>
<td>33 (2.2%)</td>
<td>0.549</td>
<td>0.460-0.637</td>
<td>0.338</td>
</tr>
<tr>
<td>Abruptio placentae</td>
<td>12 (0.8%)</td>
<td>0.470</td>
<td>0.323-0.616</td>
<td>0.717</td>
</tr>
<tr>
<td>Fetal demise</td>
<td>14 (0.9%)</td>
<td>0.657</td>
<td>0.528-0.787</td>
<td>0.042</td>
</tr>
<tr>
<td>Gestational diabetes mellitus</td>
<td>69 (4.6%)</td>
<td>0.571</td>
<td>0.499-0.643</td>
<td>0.047</td>
</tr>
<tr>
<td>Total adverse pregnancy outcome</td>
<td>365 (24.1%)</td>
<td>0.630</td>
<td>0.596-0.663</td>
<td>0.000</td>
</tr>
</tbody>
</table>

**AUC:** area under curve, CI: 95% confidence interval, p: statistically significant at <0.05

**ROC:** receiver operating characteristic
0.512-0.624, p<0.05). IUGR was statistically significant and had a fair association (AUC, 0.697, 95%CI 0.606-0.787, p<0.01). IUEF was statistically significant but had a poor association (AUC, 0.657 95%CI 0.528-0.787, p<0.05). GDM was statistically significant but had a fail association (AUC, 0.571 95%CI 0.499-0.643, p<0.05). Total adverse pregnancy outcomes were statistically significant and had a poor association (AUC, 0.630 95%CI 0.596-0.663, p<0.01). GHT was not statistically significant and had a fail association (AUC, 0.58, 95%CI 0.472-0.688, p>0.05). Oligohydramnios was not statistically significant and had a fail association (AUC, 0.549, 95%CI 0.460-0.637, p>0.05). Abruptio placentae had not any statistically significant difference or association (AUC, 0.323-0.616, p>0.05).

Discussion

This study aimed to investigate the relationship between the first-trimester screening maternal serum markers especially corrected PAPPA levels and adverse pregnancy outcomes such as GHT, preeclampsia, IUGR, oligohydramnios, preterm birth, IUEF, GDM, and abruptio placentae (placenta mediated obstetric complications). This study suggests that first-trimester maternal serum low c-PAPPA MOM values were significantly associated with adverse pregnancy outcomes. These markers alone do not have high sensitivity and low false positivity rates for clinical use. However, except for Down syndrome risk assessment in the first-trimester screening test, there was a significantly increased correlation and the risk was identified between adverse pregnancy outcomes and especially low c-PAPPA (<0.5 MOM) values. Our study results agreed with previous studies that have found a low c-PAPPA level to be associated with an increased risk of IUGR, preeclampsia, preterm birth, and IUEF (12-18,22,24,25). Similar to previous studies, it was not evidence of statistically significant association with any cut-off levels of corrected free β-hCG MOM values and other adverse pregnancy outcomes. However, we found that there was a statistically significant association between extreme values of corrected free β-hCG MOM values and fetal birth weight.

Gomes et al.’s study suggest that an unexplained low level of PAPPA (<10th percentile) during the first trimester can be associated with adverse outcomes and placenta-mediated obstetric complications namely preeclampsia, fetal growth restriction, and abruptio placentae (26). Low levels of free β-hCG (<1st, 5th, and 10th percentiles) were not associated with adverse outcomes. Dugoff et al. and Smith et al. studies demonstrated an association between low levels of free β-hCG (<0.4 or 0.5 MOM) and birth weight below the 5th or 10th percentile (OR 1.6–1.7) (17,23). In our study, we analyzed that below the 5th percentile of corrected free β-hCG (<0.33 MOM) cut-off level, it was the evidence of statistically significant association with small for gestational age (10th percentile birth weight) (r=0.088, p<0.01). And also, we found that it was also a statistically significant association with the cutoff level of corrected free β-hCG ≥2.9 MOM values and fetal macrosomia (>4500 gram) (r=0.068, p<0.01).

Smith et al. found that pregnant women who had values below the 5th percentile as a result of their PAPPa measurements between the gestational weeks had an increased risk of IUGR, preterm birth, preeclampsia, and stillbirth (11,23). Based on their findings, they suggested that the control of the IGF system in trophoblasts in the first and early second trimester may play a key role in determining the prognosis of pregnancy (23). In animal experiments, it has been shown that blocking of the PAPPA gene results in a 40% reduction in fetal development (27). It is thought that PAPPA has either autocrine and paracrine effects on local activities of IGF (28). These data demonstrate an important role of PAPPA in modulating ovarian function, placentation, placental function, and female fertility by control of the bioavailability of ovarian IGF (8,29). If the level of PAPPA is insufficient to successfully cleave IGF, IGF remains in its bound, inactive form, possibly leading to diminished fetal and placental growth and also placental inflammation (11). In our study, we had a statistically significant correlation with IUEF, IUGR, preeclampsia, and low level of PAPPA.

Canini et al. found that PAPPA values were significantly lower in babies with SGA, and PAPPA was significantly higher in babies with LGA (30). They found a significant correlation between birth weight percentiles and c-PAPPA values (r=0.192, p<0.001). In this case, high PAPPA levels may be expected to be associated with high IGF and thus fetal macrosomia (30). In the study of Dugoff et al., there was no significant association with fetal macrosomia (over 4500 g) at levels above the 99.9th percentile of PAPPA level (p<0.05) (17). However, in our study we found that there was a significant correlation between maternal serum free β-hCG corrected MOM ≥2.9 MOM values with fetal macrosomia infants (r=0.068, p<0.01). There was no significant association with the cut-off level of free β-hCG<0.5 MOM value and GDM (p>0.05). However, it was a significant association between GDM and the cutoff level of corrected PAPPA ≤0.5 MOM values (r=0.064, p<0.05).

The traditional approach to screening for preeclampsia, which is based on maternal demographic characteristics and medical history, identifies approximately 30% of cases destined to develop early PE for a false-positive rate of 5% (26). It is necessary to find additional predictive parameters to classify the high-risk pregnancy group. Poon et al used the combination of mean arterial pressure (MAP), placental growth factor (PIGF), and PAPPA MOM values to increase the likelihood ratio or post-test probability. In this way, they were aimed at the care of low-risk pregnancies is decentralized to local, 1-stop settings or at home, whereas high-risk pregnancies are cared for in specialized centers (31).
We were referred to analyze the predictive values of adverse pregnancy outcomes by likelihood ratio because it can be used to calculate the post-test probability and it is less affected by the prevalence of the adverse pregnancy outcome (Table III and IV). This situation provided us that if we detected increased post-test probability, we would have guided the patient to another test and the first test’s post-probability value could be used as the next test pre-test probability. In this way, calculating the final likelihood ratio of certain cutoff levels obtained from a meta-analysis may be a useful tool with additional tests for conditions and diseases that have low prevalence. In our study, we have reported the likelihood ratio results of PAPPA ≤0.25 and ≤0.50 MOM cutoff values to be able to use in future meta-analysis. And we saw that the positive likelihood ratio changes by the cut of level value are certain these changes will reflect the post-test probability. Post-test probability calculating is very important nowadays because we are living in the artificial intelligence century. In artificial intelligence, one of the suitable and calculable data that can be used in artificial intelligence algorithms may be the post-test probability value. According to Bayes theorem, the formula may be as shown (32).

Post-test probability of total adverse pregnancy outcome for first pregnancy = pre-test probability (i.e. prevalence) × positive likelihood ratio (i.e. first-trimester screening test) × positive likelihood ratio (i.e. second-trimester screening test) × positive likelihood ratio (second-trimester ultrasonography)

Taking into account the cutoff level of the test and considering the patient in a high-risk group or not is insufficient to artificial intelligence algorithms. Such a formula as shown may help the calculation of the pre-test probability of the first-trimester screening test of the second pregnancy and may be useful data for artificial intelligence algorithms to identify and follow the high-risk pregnant women in the National health care program.

The most important limitation of our study is the need for more cases in the evaluation of the prediction of adverse obstetric outcomes with low prevalence. It may not be appropriate to exclude miscarriage cases because of the significant association between the low levels of PAPPA and adverse pregnancy outcomes such as IUGR and IUEF. While we were preparing this article for an academic publication, the military coup incident took place. We could not access the data after preparing this article for an academic publication, the military coup incident took place. We could not access the data after

Conclusion

In our study, it was observed that first-trimester maternal serum low PAPPA MOM values were significantly associated with adverse pregnancy outcomes. These markers alone do not have high sensitivity and low false positivity rates for clinical use. However, except for Down syndrome risk assessment in the first-trimester screening test, there was a significantly increased correlation, and the risk was identified between adverse pregnancy outcomes and especially low corrected PAPPA (≤0.5 MOM) values. It is necessary to be careful when planning the follow-up of pregnancies of first-trimester markers by increasing the sensitivity and decreasing the false positivity with additional tests to be performed in the following gestational weeks.

Declarations

**Ethics approval and consent to participate**

All participants signed informed written consent before being enrolled in the study. The study was reviewed and approved by the ethics committee of GATA Haydarpasa Education Hospital. All procedures were performed according to the Declaration of Helsinki.

**Availability of data and materials:** The data supporting this study is available through the corresponding author upon reasonable request.

**Competing interests:** The authors declare that they have no competing interests.

**Funding:** There is no funding or financial support used for this study.

**Authors’ contributions:** GG: Project development, data collection, analysis, interpretation of data, manuscript writing, revising the manuscript. YKA: Manuscript writing and revising the manuscript. MM: Idea, check, and consultancy. All authors contributed to the writing of the paper, and have read and approved the final manuscript.

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**References**

1. Gonen G. Akpak YK. Muhcu M.


