Impaired sodium-dependent adaptation of arterial stiffness in formerly preeclamptic women: the RETAP-vascular study

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van der Graaf AM, Paauw ND, Toering TJ, Feelisch M, Faas MM, Sutton TR, Minnion M, Lefrandt JD, Scherjon SA, Franx A, Navis G, Lely AT. Impaired sodium-dependent adaptation of arterial stiffness in formerly preeclamptic women: the RETAP-vascular study. *Am J Physiol Heart Circ Physiol* 310: H1827–H1833, 2016. First published April 8, 2016; doi:10.1152/ajpheart.00010.2016.—Women with a history of preeclampsia have an increased risk for cardiovascular diseases later in life. Persistent vascular alterations in the postpartum period might contribute to this increased risk. The current study assessed arterial stiffness under low sodium (LS) and high sodium (HS) conditions in a well-characterized group of formerly early-onset preeclamptic (fPE) women and formerly pregnant (fHP) women. Eighteen fHP and 18 fPE women were studied at an average of 5 yr after pregnancy on 1 wk of LS (50 mmol Na$^+$/day) and 1 wk of HS (200 mmol Na$^+$/day) intake. Arterial stiffness was measured by pulse-wave analysis (aortic augmentation index, AIx) and carotid-femoral pulse-wave velocity (PWV). Circulating markers of the renin-angiotensin aldosterone system (RAAS), extracellular volume (ECV), nitric oxide (NO), and hydrogen sulfide (H$_2$S) were measured in an effort to identify potential mechanistic elements underlying adaptation of arterial stiffness. AIx was significantly lower in fHP women on LS compared with HS while no difference in AIx was apparent in fPE women. PWV remained unchanged upon different sodium loads in either group. Comparable sodium-dependent changes in RAAS, ECV, and NO/H$_2$S were observed in fHP and fPE women. fPE women have an impaired ability to adapt their arterial stiffness in response to changes in sodium intake, independently of blood pressure, RAAS, ECV, and NO/H$_2$S status. The pathways involved in impaired adaptation of arterial stiffness, and its possible contribution to the increased long-term risk for cardiovascular diseases in fPE women, remain to be investigated.

preeclampsia; formerly preeclamptic women; cardiovascular risk; arterial stiffness; augmentation index; sodium intake

NEWS & NOTEWORTHY

This study assessed arterial stiffness in healthy formerly preeclamptic (fPE) women under standardized sodium intake and shows that fPE women have a blunted response to adapt their arterial stiffness in response to low sodium intake. This phenomenon might be a first indication of an unfavorable vascular profile in fPE women.

PREECLAMPSIA complicates approximately 1–5% of all pregnancies (19) and is characterized by new-onset hypertension and proteinuria or other findings such as new-onset thrombocytopenia, renal insufficiency, neurological complications, liver involvement, and fetal growth restriction during the second half of pregnancy (1). Delivery of the placenta is the only therapeutic solution and results in rapid normalization of the maternal manifestations (46). Despite normalization of hypertension and proteinuria after termination of pregnancy, a history of preeclampsia entails long-term vascular consequences. Over the years, observational cohort studies have shown that women with a history of preeclampsia experience an increased risk to develop premature cardiovascular and renal diseases in later life (3, 51, 55).

Unraveling the underlying mechanisms accounting for the increased cardiovascular and renal risk after preeclampsia has been the subject of recent studies. The enhanced risk could be the result of preexisting cardiovascular risk factors or long-term effects caused by preeclampsia itself (38, 42, 52). Since preeclampsia affects the maternal vascular bed, persistent vascular alterations in the postpartum period might potentially contribute to the increased cardiovascular risk of formerly preeclamptic women.

Recent studies in fPE women have reported subtle vascular alterations such as arterial stiffness, as measured by pulse-wave analysis (PWA) and pulse-wave velocity (PWV) (10, 11, 25, 27, 33, 37, 39, 47, 57). However, these studies show some inconsistencies; differences in study design, heterogeneity of the preeclamptic phenotype, and the presence or absence of comorbidities (i.e., hypertension and increased BMI) may explain the contradictory findings. Moreover, none of these studies was performed under standardized sodium intake. Sodium restriction has been reported to be an important extrinsic factor in the reduction of blood pressure and arterial stiffness by reduction in extracellular volume and oxidative stress (15, 26, 44). High sodium intake affects arterial stiffness by the induction of endothelial dysfunction, enhancement of vascular smooth muscle tone, and hypertrophy of the vascular wall (9,

17). To our knowledge, adaptation or nonadaptation of arterial stiffness by short-term changes in dietary sodium load has not been studied in healthy subjects at risk for development of premature vascular disease.

In this study, we therefore aimed to explore arterial stiffness in healthy formerly early-onset preeclamptic (fPE) women and formerly healthy pregnant (fHP) women in the absence of comorbidity. For this purpose, we measured arterial stiffness in the population of the REsponse To Angiotensin II in formerly Preeclamptic women (RETAP) study of which we previously reported on renal function (RETAP-renal) (48). All women were studied after 1 wk of low sodium (LS) and after 1 wk of high sodium (HS) intake to assess the influences of short-term changes in sodium load on measures of arterial stiffness. To identify potential pathways involved in the adaptation of arterial stiffness in response to differences in sodium intake we measured circulating components of the renin-angiotensin aldosterone system (RAAS), extracellular volume (ECV), and nitric oxide (NO)/hydrogen sulfide (H_2S)-related markers of endothelial function.

MATERIALS AND METHODS

Study population. Our study population consisted of 18 fPE women and 18 fHP controls who participated in the RETAP study (The Netherlands National Trial Register http://www.trialregister.nl; trial registration number: 2635). Baseline characteristics of this study group and data on renal function and renal response to angiotensin II infusion within this group were published before (RETAP-renal) (48). In short, this study showed no differences in glomerular filtration rate (GFR; measured by ^{125}-I-iothalamate) and no differences in renal hemodynamic response to angiotensin II infusion between groups, but the study did reveal a higher filtration fraction (FF) in the fPE group on both LS and HS diet (48). The study population was selected from the electronic delivery database of the Department of Obstetrics and Gynecology at the University Medical Center Groningen. Preeclampsia was defined according to the definition of the International Society for the Study of Hypertension in Pregnancy (2), and early-onset preeclampsia was defined as developing preeclampsia before 34 wk of gestation. Participants without comorbidity were selected by the exclusion of women with renal disease, diabetes, or a history of gestational diabetes, obesity (BMI > 30 kg/m^2 at screening), and women using antihypertensive medication. Additional exclusion criteria were pregnancy, current lactation, and postmenopausal status. None of the women included were using oral contraceptives. A control for each preeclamptic women was selected using the following selection criteria: same parity, age (within 1 yr), and year of index pregnancy (within 1 yr). All subjects were nonsmokers and normotensive, having a sitting systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg measured by Dinamap (an average of 3 measurements was taken). All patients underwent physical examination and electrocardiography at enrollment into the study, which did not reveal any abnormalities. The study was approved by the local ethics committee (Medical Ethical Committee UMCG Groningen, the Netherlands; number 2010/294), and all subjects gave written informed consent. For this cross-over study a multivariate power calculation with three factors and two confounders was performed for three renohemodynamic end points (48). The regular power calculation demanded 25 women/group. After inclusion of 18 women/group the interim analysis showed significant difference between both groups and the inclusions for the study were stopped.

Study protocol. The selected participants underwent a cross-over protocol consisting of two 1-wk periods with at least 4 wk wash-out in between, a 7-day period on LS diet (target: 50 mmol Na$^+$/day) and a 7-day period on a HS diet (target: 200 mmol Na$^+$/day). For

assessment of dietary compliance and the achievement of a stable sodium balance, 24-h urine was collected at *day 3* and *day 6* of each period. All women were studied at *day 7* of each treatment after an overnight fasting period at *day 7* ($\pm$ 2) of their menstrual cycle.

Blood pressure and arterial stiffness measurements. Blood pressure was assessed at the end of each dietary period. After a 2-h rest in semi-supine position in a quiet room, blood pressure and heart rate were measured by the use of an automated sphygmomanometer (Dinamap; GE Medical Systems, Milwaukee, WI) at 15-min intervals for 2 h (10 am until 12 am). Arterial stiffness was measured using the Sphygmocor System (AtCor Medical; Sydney, Australia) by experienced researchers. To obtain the augmentation index (AIx), the radial pulse wave contour was recorded by means of applanation tonometry and converted to the central arterial waveform using a generalized transfer function. In short, the radial artery of the right arm was pressed gently at the site of maximal pulsation with the tip of the tonometer containing a micromanometer (Millar Instruments, Houston, TX) that accurately records the pressure pulsations within the artery. First, the mean of the last 3 successive recordings of the systolic and diastolic blood pressure measured at the right brachial artery was calculated and entered in the program (SphygmoCor; version 8.2) and subsequently three successive tonometry recordings were obtained from the right radial artery. Only recordings with an operator index > 80 were used for averaging. Central AIx is defined as the ratio of late systolic pressure (P2) to early systolic pressure (P1) and varies as a function of heart rate. Central aortic AIx and AIx adjusted for heart rate (AIx@75; AIx at 75 beats/min), pulse pressure (PP), augmentation pressure (AP), time to first peak (t1), time to second peak (t2), time to reflection (tr), subendocardial variability ratio (SEVR), and ejection duration (ED) were automatically calculated by the software. The average of three successive readings was used for analysis. The SphygmoCor system was subsequently used to assess carotid-femoral pulse wave velocity (PWV). The PWV was determined by sequential acquisition of pressure waveforms from the carotid and the femoral arteries. The timing of these waveforms was synchronized with that of the R-wave on the simultaneously recorded ECG. To minimize the influence of body contour, the proximal distance was measured from the sternal notch to the sampling site on the carotid artery and the distal distance was measured from the acromial angle to the sampling site on the femoral artery. The average of more than 8 successive measurements was used in the analysis to cover a complete respiratory cycle.

Extracellular volume measurements. ECV was estimated from the distribution volume of ^{125}-I-iothalamate (IOT). Assessment of ECV by the constant-infusion method with IOT was validated previously and the method was demonstrated to be reproducible (53). A priming solution containing 20 ml infusion solution (0.04 MBq) plus an extra amount of 0.6 MBq IOT was given at a constant infusion of 12 ml/h. Plasma concentrations of IOT were stabilized during a 1.5-h equilibration, followed by a 2-h period of clearance. ECV was calculated as follows: $[(I \times V + B \times V) - (U \times V)]/P$, where $I \times V$ is the infusion rate of the tracer, $B \times V$ the bolus infusion of the tracer, $U \times V$ the urinary excretion of the tracer and P the plasma levels of IOT (53). This formula equals the amount of infused IOT minus the amount of excreted IOT. ECV was indexed for body surface area (BSA); crude values of ECV were divided by BSA, calculated according to the DuBois-DuBois formula (8), and multiplied by 1.73 m^2. Data of uncorrected ECV in this population have been reported earlier (48).

Blood and urine analysis. Fasting blood samples were drawn for analysis of RAAS activity and endothelial/metabolic function markers. Aldosterone was measured with a commercially available radioimmunoassay kit (Coat-A-count RIA, Siemens). Plasma renin activity (PRA) was measured with a radioimmunoassay that detects the amount of angiotensin I produced in the presence of excess endogenous angiotensinogen (ng of angiotensin I produced per liter of plasma per h; CisBio International). Plasma levels of cyclic 3′,5′-guanosine monophosphate (cGMP) were assessed using a competitive

enzyme immunoassay (ELISA) according to the manufacturer's instructions (KGE003; R&D Systems, Minneapolis, MN). The plasma concentrations of total nitrosated species (RxNO) were measured following group-specific reductive denitrosation by iodine-iodide in glacial acetic acid, with subsequent detection of liberated NO by its chemiluminescent reaction with ozone (12). Plasma nitrate (NO_3^-) was quantified by ion chromatography with online reduction of nitrate to nitrite and post-column Griess reaction (ENO20 Analyser; Eicom, Kyoto, Japan) (36). Plasma total sulfide (HS^-) levels were measured using a novel UPLC-MS/MS technique based on the derivatization of sulfide by N-ethylmaleimide (NEM) (31). Briefly, the disubstituted sulfide adduct (NEM-S-NEM) was separated from other alkylated thiols by C18 reversed-phase chromatography and the $NEM-SH_2^+$ fragment produced in the electrospray source operating in positive ionization mode was detected by a Xievo triple quadrupole (Waters, Waltham; m/z $285 > 160$) (Minnion M, Sutton TR, Feelisch M, unpublished observations). Plasma sulfide levels were semiquantified using a standard curve produced from a dilution series of NEM derivatized Na_2S. The standard was used to verify the elution time and fragmentation pattern of the sulfide adduct. Urine samples were drawn from the 24-h urine and the levels of sodium, potassium, and urea were assessed by the use of an automated clinical chemistry analyzer (Roche Modular Basel).

Data analysis. Statistical analysis was performed using SPSS for Windows (Version 21.0). Parametric data are presented as means ± SD or estimated marginal means (EMM) ± SE, and nonparametric data as medians with interquartile ranges such as stated in text, table, and figures. Differences in baseline characteristics were tested with a Student's *t*-test for parametric data and Mann-Whitney *U*-test for nonparametric data. Generalized Estimated Equations (GEE) analysis was performed for AIx, AIx@75, PWV, MAP and ECV to separately test the effects of history of preeclampsia (factor group) and sodium intake (factor diet). In addition, this analysis enabled us to separately study the changes in parameters in response to change in diet within the fHP and fPE group. The same GEE analysis was performed to analyze plasma nitrate, RxNO, cGMP, and total sulfide. To determine whether age is a determinant of arterial stiffness we used linear regression, which was performed for both LS and HS diet. Differences were considered significant if $P < 0.05$.

RESULTS

Baseline characteristics and blood pressure response to changes in sodium intake. Baseline characteristics of our study population are presented in Table 1. No differences were found for age, gravidity, parity, and time since last pregnancy (index pregnancy) between the two groups. fPE women had a significantly higher BMI compared with fHP-women while on either diet. Hip-to-waist ratio did not significantly differ between groups. Urinary sodium concentrations showed that the dietary compliance during LS and HS diet was excellent in both groups. No statistically significant differences in potassium and urea excretion were found between the groups reflecting an equal intake of potassium and proteins. Serum sodium did not differ between fHP and fPE women on either LS or HS diet. No differences in PRA and aldosterone were found between groups, and the changes in PRA and aldosterone in response to low sodium intake was similar in both groups. All women were normotensive at the time of the screening visit, and there were no significant differences in mean baseline 2-h blood pressure, aortic mean pressure, pulse pressure and ECV/BSA measured after LS diet and HS diet week (47). Both fHP and fPE women demonstrated a significant higher blood pressure and ECV/BSA on HS compared with LS and the GEE-analyses showed

Table 1. *Baseline characteristics*

	History of Normotensive Pregnancy (n = 18)	History of Preeclamptic Pregnancy (n = 18)	*P* Value
Age, yr	36 ± 5	36 ± 5	0.95
Gravidity	2.5 ± 1.3	2.6 ± 1.1	0.95
Parity	2.0 ± 0.7	2.2 ± 1.0	0.59
Elapsed time since index pregnancy, yr	4.2 ± 2.6	5.3 ± 3.0	0.24
Waist/hip ratio	0.83 ± 0.04	0.84 ± 0.06	0.44
MAP, mmHg			
LS	81 ± 7	83 ± 8	0.38
HS	85 ± 8	86 ± 9	0.71
HR, beats/min			
LS	67 ± 8	67 ± 9	0.95
HS	67 ± 8	66 ± 10	0.64
BMI, kg/m²			
LS	22.6 ± 2.6	25.3 ± 3.3	0.01*
HS	23.2 ± 2.7	25.9 ± 3.5	0.02*
ECV/BSA			
LS	13.4 ± 1.9	13.5 ± 2.5	0.85
HS	14.9 ± 2.0	14.9 ± 2.0	0.92
Urinary sodium, mmol/24 h			
LS	39 ± 14	45 ± 23	0.33
HS	221 ± 64	258 ± 86	0.15
Urinary potassium, mmol/24 h			
LS	66 ± 21	76 ± 25	0.20
HS	80 ± 34	73 ± 15	0.46
Urinary urea, mmol/24 h			
LS	264 ± 91	306 ± 63	0.12
HS	339 ± 89	340 ± 65	0.97
Serum sodium, mmol/l			
LS	140 ± 1.6	140 ± 1.9	0.36
HS	142 ± 1.8	141 ± 2.4	0.31
PRA, $nmol·l^{-1}·h^{-1}$			
LS	0.80 (0.50–1.20)	0.85 (0.70–1.50)	0.50
HS	0.20 (0.10–0.50)	0.20 (0.09–0.30)	0.58
Aldosterone, pmol/l			
LS	255 (204–395)	341 (214–477)	0.16
HS	71 (29–93)	59 (35–96)	0.84
Aldosterone:PRA ratio			
LS	331 (201–450)	456 (250–494)	0.38
HS	224 (151–499)	316 (181–517)	0.23
Change in PRA, HS to LS, %	225 (100–350)	325 (160–700)	0.18
Change in Aldosterone, HS to LS, %	320 (187–462)	436 (90–700)	0.48

Data are presented as means ± SD, or as medians (25th–75th percentiles). LS, low-sodium diet (<50 mmol Na^+/24 h); HS, high-sodium diet (>200 mmol Na^+/24 h); MAP, mean arterial pressure; HR, heart rate; BMI, body mass index; ECV/BSA, extracellular volume corrected for body surface area; PRA, plasma renin activity. *$P < 0.05$ by Student's *t*-test.

that differences in blood pressure and ECV/BSA between HS and LS were similar between groups.

Changes in arterial stiffness as a function of sodium load. Arterial stiffness in fHP and fPE on LS and HS intake expressed as AIx and PWV is shown in Fig. 1, *A–C*. No differences for AIx between fHP and fPE were found in both LS and HS conditions. However, the GEE-analysis showed that LS intake was associated with a significant lower AIx compared with HS intake in fHP women ($P_{diet×fHP} = 0.016$) while no difference in AIx between LS and HS intake was observed in fPE women. As for AIx, there were no differences between the groups on LS and HS, but the fHP women showed a significant lower AIx@75 on LS diet compared with HS diet ($P_{diet×fHP} = 0.024$), while there was no difference in AIx@75 between LS and HS diet in fPE women. The other parameters obtained during the PWA did not differ between groups
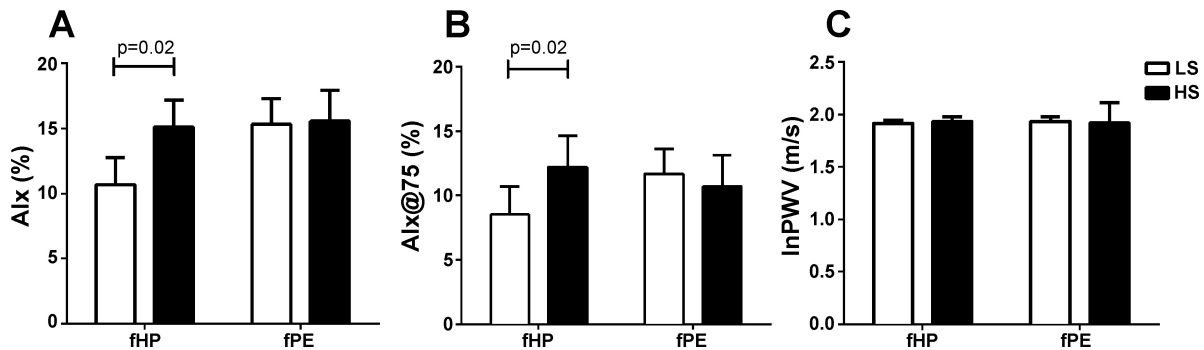
VASCULAR HEALTH AFTER PREECLAMPSIA

Fig. 1. Augmentation index (AIx, *A*), AIx corrected for heart rate (AIx@75, *B*) and pulse wave velocity (PWV, *C*) during low sodium (LS, white bars) and high sodium (HS, black bars) intake in women with a history of healthy pregnancy (fHP) and in formerly preeclamptic (fPE) women. Data are expressed as estimated marginal means ± SE.

(Table 2). No effect of group (fHP or fPE) and diet (LS or HS) within groups was observed for PWV. Linear regression showed a positive relation between age and arterial stiffness under both LS and HS conditions ($P < 0.05$ for age $\times$ AIx, age $\times$ AIx@75, and age $\times$ PWV). GEE-analysis corrected for age showed that differences in age did not affect the adaptation of arterial stiffness in response to LS.

Changes in endothelial function markers. Both NO and H_2S are produced by endothelial cells to regulate vascular tone and arterial stiffness. We therefore measured plasma nitrate, RxNO, and cGMP (NO related read-outs) and total sulfide (H_2S related metabolite) as markers of endothelial function in fHP and fPE women (Fig. 2, *A–D*). GEE analysis for nitrate

showed no significant differences between groups, but on LS intake nitrate concentrations were significantly higher compared with HS in both groups ($P_{diet \times fHP} = 0.016$, $P_{diet \times fPE} = 0.04$). We did not find differences in RxNO, cGMP, and sulfide concentrations between diet and groups, in part presumably due to the rather large interindividual variation in circulating biomarker levels observed.

DISCUSSION

This is the first study that assessed arterial stiffness in formerly early-onset preeclamptic women without any comorbidity, under standardized low and high sodium conditions. We demonstrated that fPE women have an impaired ability to adapt their arterial stiffness (AIx and AIx@75) upon low sodium diet compared with fHP women. The nonadaptation of arterial stiffness could not be explained by differential responses between fHP and fPE women in blood pressure, circulating RAAS components, extracellular volume expansion, and plasma concentrations of nitrate, RxNO, cGMP, and sulfide. Increased arterial stiffness is known to be associated with the development of hypertension and cardiovascular diseases (4, 21, 28, 32). An impaired ability to decrease AIx in response to sodium status in fPE women might be a first indication of an unfavorable vascular profile.

While both AIx and PWV were similar in fHP and fPE women on LS and HS diet, AIx and AIx@75 were lower on LS diet compared with HS diet in fHP-women but not in fPE-women. We are the first to show this nonadaptation of arterial stiffness in a well-controlled setting, studying subjects at risk for premature vascular disease and healthy controls in the absence of any comorbidity. LS diet normally reduces arterial stiffness, as shown earlier by a meta-analysis exploring the effect of dietary and nutritional interventions on arterial stiffness (34) and by a study in (postmenopausal) female hypertensive subjects (44). Our findings of nonadaptation of arterial stiffness in response to LS in fPE thus suggest that fPE women lost the capability to adjust arterial stiffness upon LS intake.

Previous studies on arterial stiffness in fPE women were not performed under standardized dietary conditions and did not standardize for phase of menstrual cycle. Assuming that sodium intake in the previous studies is in the range of average intake in the Western diet, these studies are comparable with our HS condition under which we observed no differences in AIx and PWV between groups. Under this assumption, our

Table 2. *Pulse wave analysis data*

	History of Normotensive Pregnancy (n = 18)	History of Preeclamptic Pregnancy (n = 18)	*P* Value
PP, mmHg			
LS	43 ± 6	42 ± 5	0.72
HS	44 ± 5	43 ± 5	0.62
AP, mmHg			
LS	3.4 ± 3.2	5.0 ± 3.2	0.13
HS	5.2 ± 3.6	5.0 ± 3.8	0.91
P1, mmHg			
LS	27 ± 5	26 ± 4	0.87
HS	27 ± 5	26 ± 6	0.38
P2, mmHg			
LS	30 ± 6	31 ± 6	0.47
HS	32 ± 7	31 ± 7	0.46
T1, ms			
LS	105 ± 10	107 ± 6	0.35
HS	105 ± 10	108 ± 7	0.28
T2, ms			
LS	217 ± 16	223 ± 15	0.33
HS	225 ± 20	229 ± 15	0.57
Tr, ms			
LS	147 ± 10	146 ± 7	0.67
HS	146 ± 14	148 ± 12	0.54
ED, ms			
LS	311 ± 16	312 ± 17	0.82
HS	325 ± 20	324 ± 17	0.88
SEVR, %			
LS	150 ± 24	162 ± 36	0.22
HS	144 ± 32	161 ± 34	0.15

Data are presented as means ± SD. LS, low-sodium diet (<50 mmol Na$^+$/24 h); HS, high-sodium diet (>200 mmol Na$^+$/24 h); PP, pulse pressure; AP, augmented pressure; P1, peak 1 first systolic inflection; P2, peak 2 systolic peak, T1, time to first peak; T2, time to second peak; Tr, time to reflection; ED, ejection duration; SEVR, subendocardial viability ratio.
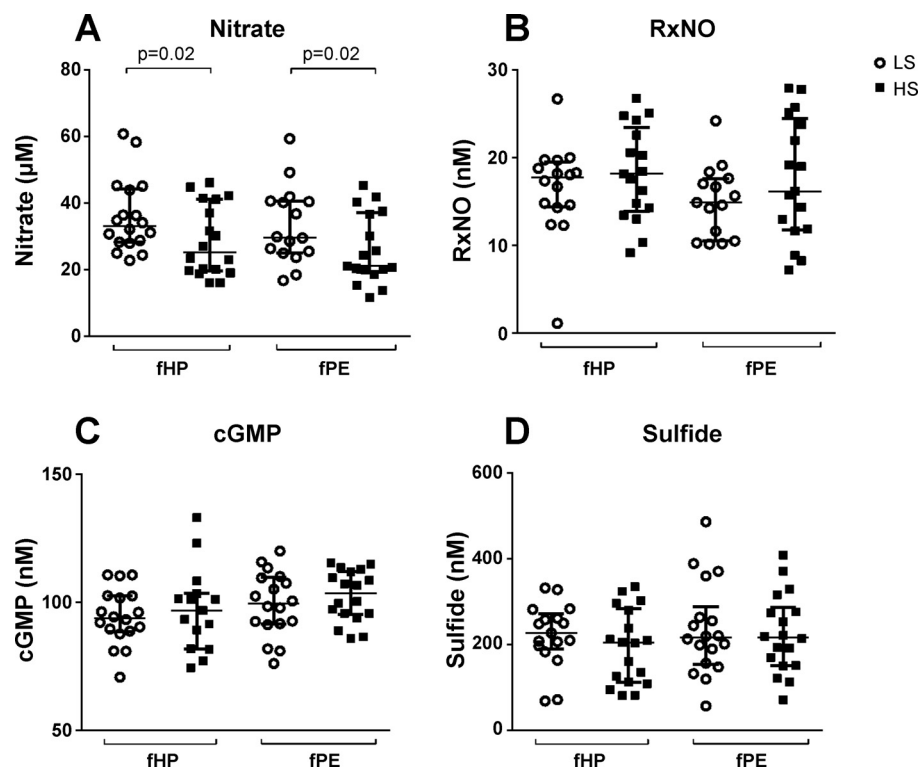
Fig. 2. Plasma concentrations of nitrate (*A*), total nitrosated species (RxNO, *B*), cyclic GMP (cGMP, *C*), and total sulfide (D) during low sodium (LS, white circles) and high sodium (HS, black squares) intake in women with a history of healthy pregnancy (fHP) and in formerly preeclamptic (fPE) women. Data are expressed as medians with interquartile ranges and individual levels.

results are in line with two other studies that showed no differences in AIx in fPE women compared with controls (25, 39). However, other studies have reported increased arterial stiffness as measured by AIx (10, 27, 37, 47, 57) as well as by PWV (33, 37, 47) in fPE women. These conflicting findings are likely a result of differences in study design, heterogeneity of the preeclamptic phenotype, and variable presence of comorbidities (e.g., hypertension and increased BMI). The strength of our study is that we studied a well-characterized group of healthy fPE women under standardized dietary conditions compared with a control group with the same parity, age, and year of index pregnancy. Therefore, we can conclude that fPE women without comorbidity do not differ in arterial stiffness compared with fHP women on a regular Western diet.

Our finding of nonadaptation of arterial stiffness upon LS diet was only reflected in AIx and not in the PWV measurements. This might be explained by the different (age-related) vascular responses that these measures represent (29). In general, PWV is affected by structural vascular changes such as narrowing and sclerosis of the vessels that occur during the later phase of atherosclerosis. The central AIx is a measure of arterial wave reflection which depends both on the PWV and intrinsic properties of the vessel wall. While PWV is the gold standard for measurement of arterial stiffness(49), AIx was found to be correlated with diverse cardiovascular risk factors at a young age, in the absence of structural vascular changes (6, 50). In addition, vasoactive drugs influence AIx independent of PWV which shows that wave reflection is influenced by small-artery tone/structure (22). According to this evidence, AIx might be more suitable compared with PWV in detecting early stage vascular dysfunction based on sensitivity to detect functional vessel abnormalities.

Increased arterial stiffness is a result of aging (changes in extracellular matrix composition) (23) and is associated with

hypertension, diabetes mellitus, atherosclerosis, and renal failure (35, 40). We carefully excluded these factors from our study design by comparing our fPE group with a control group of the same age and by the exclusion of women with comorbidity. To overcome the influences of differences in sodium intake on arterial stiffness we had an excellent standardization of the diets as observed in the urinary sodium values. On both LS and HS serum sodium did not significantly differ between fHP and fPE but there was a slightly different response of serum sodium to the change in diet within groups (fHP LS vs. HS $P < 0.05$, while fPE LS vs. HS ns; P values earlier not shown). This slight difference might have influenced the nonadaptation of arterial stiffness in response to LS in the fPE group.

Other important nonstructural determinants of arterial stiffness are activity of the RAAS (14, 45), fluid volume status (20), and endothelial function (41). These determinants are also known to be affected by dietary sodium intake and could therefore be mechanisms underlying the observed nonadaptation of arterial stiffness in response to sodium (9). However, we did not detect any differences in circulating RAAS markers between groups; moreover, we found that the systemic RAAS was adequately modulated by sodium intake in both groups as observed by a similar increase in PRA and aldosterone in response to LS in our study. Our ECV data show that both the fHP and fPE group are reducing their ECV upon LS to a similar extent. As expected, reducing extracellular volume resulted in a reduction in arterial stiffness in fHP women, illustrating the ability of healthy vessels to shift stiffness along their compliance curve in response to volume reduction. Since nonadaptation of arterial stiffness was observed in fPE women, we hypothesize that fPE women have stiffer vessels that already work at the upper end of their compliance having less adaptability upon extrinsic factors.

With respect to endothelial function, the production of the "gasotransmitters" NO and H_2S plays an important role in the control of vascular tone (30, 56). While endothelial NO production is also a key regulator of arterial stiffness (54), little is currently known about the biological significance of H_2S in this context. Nevertheless, there is ample cross-talk between these mediators at the functional and chemical level with sulfide affecting NO bioavailability (7). Plasma nitrate, RxNO, cGMP, and sulfide did not differ between groups, while both fHP and fPE women showed an increase in plasma nitrate on LS. Plasma nitrate is the final end product of NO metabolism, thus suggesting enhanced endogenous NO production upon LS intake. In this study we were limited to plasma analysis and we analyzed the circulating components in a relatively small number of patients with large interindividual variation which might explain the lack of trend observed in cGMP while we do observe a trend in nitrates. While the true levels of H_2S related metabolites in blood are currently a matter of lively debate, total plasma sulfide concentrations are, at least in part, likely of endothelial origin but do not seem to change upon changes in sodium load. Based on our findings we cannot conclude with certainty that endothelial function is not involved in the non-adaptation of arterial stiffness, as circulating levels do not necessarily reflect vascular tissue concentrations. A limitation of our study is that we did not assess flow-mediated dilatation (FMD), the gold standard to assess endothelial function. Previous work suggests that fPE women have an impaired FMD compared with controls (5, 16, 18, 33, 43, 58) and this might be a mechanism associated with nonadaptation of arterial stiffness under LS.

Future studies should investigate the mechanistic pathways behind the nonadaptation of arterial stiffness in fPE women and should include arterial stiffness measurements in combination with FMD. It would be of interest to characterize the structure and character of the vessel wall and endothelial surface layer (glycocalyx). The glycocalyx plays an important role in both sodium homeostasis and regulation of arterial stiffness. Under high sodium conditions, endothelial sodium channels are upregulated resulting in an increased sodium influx in the endothelial cells, which leads to increased stiffness (24). Defects in the glycocalyx might result in increased arterial stiffening under LS condition by increased access of sodium via endothelial sodium channels with subsequently reduced NO release causing reduced arterial stiffness and vasoconstriction (13, 24). In addition, the question whether inability to adapt arterial stiffness in response to LS was preexisting or induced by preeclampsia remains to be answered.

In conclusion, the current study is the first to show an effect of nonadaptation of arterial stiffness in fPE women in response to sodium intake. We could not explain the nonadaptation by differences in blood pressure, plasma RAAS parameters, ECV, circulating markers of NO production and availability or plasma sulfide as a read-out of H_2S activity. The exact underlying pathways involved in the nonadaptation in fPE women therefore remains to be elucidated. However, independent of the underlying mechanisms, impaired adaptation of arterial stiffness in response to sodium intake might be a marker of subclinical vascular damage in fPE women without comorbidity. We propose that nonadaptation in response to sodium intake is a first sign of unfavorable vascular alterations in fPE women, which might put them at risk to develop hypertension and cardiovascular disease.

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