Blunted Erythropoietin Production and Decreased Erythropoiesis in Early Pregnancy

By Yves Beguin, Gyorgyi Lipsel, Henri Thoumsin, and Georges Fillet

After decreasing in the first trimester of pregnancy, the total red blood cell mass increases in the second and third trimesters to peak at term at about 120% to 125% of nonpregnant values, but how this is brought about by changes in the rate of erythropoiesis is not known. We evaluated erythropoiesis by measuring serum transferrin receptor (TfR) levels in 406 women during normal pregnancy (N = 317), at delivery (N = 63), or in the early postpartum (N = 27). Despite the presence of the placenta and the frequent occurrence of iron deficiency, TfR levels remained low in the first two trimesters and increased in the third trimester and at delivery. To explain why erythropoiesis activity was relatively low in early pregnancy, we also measured serum immunoreactive erythropoietin (Epo) in relation to the degree of anemia. There was a very strong correlation between serum TfR and Epo levels in the entire group (r = 0.59, P < .0001) as well as in each period of pregnancy. Epo levels remained low for the degree of anemia and did not correlate with hematocrit in the first two trimesters, but recovered afterwards. In the early postpartum, Epo production and erythropoiesis were normal. We conclude that: (1) erythropoiesis is decreased in the first part of pregnancy but increases afterwards; and (2) blunted Epo production in early pregnancy could be responsible for that observation.

Pregnancy causes an increase in plasma volume and red blood cell (RBC) mass, which reach, respectively, 150% and 120% to 125% of nonpregnant values near term. However, the total RBC mass first decreases in early pregnancy, before gradually returning to nonpregnant values by week 30 and further increasing in late pregnancy. Because the RBC lifespan remains unchanged during pregnancy, modifications in the RBC mass must be preceded by changes in the rate of erythropoiesis. Because until recently only ferrokinetics could provide a quantitative assessment of erythropoiesis, no measurement of erythropoiesis has been performed during pregnancy, except by reticulocyte counts, which are only of semiquantitative value. The measurement of serum transferrin receptor (TfR) levels has recently been proposed as a convenient method to monitor erythropoiesis in animal and in humans. In the present study, we measured TfR levels in pregnant women and found them to be significantly decreased in the first part of pregnancy as compared with controls. Production of erythroid cells depends on stimulation by erythropoietin (Epo) produced by the kidney in response to hypoxia. Previous studies in small groups of women, including one by us, have shown increased Epo levels in pregnant as compared with nonpregnant women, but the relationship of Epo to the hematocrit (Hct) often was not assessed. We therefore evaluated serum Epo levels in relation to the degree of anemia and found relatively low levels as compared with control women. This finding suggests that blunted Epo production could be responsible for the low erythropoietic activity observed in early pregnancy.

Subjects and Methods

Subjects. We studied 406 women who gave their consent to having blood drawn for hematologic tests while undergoing routine antenatal and obstetrical care. Mean age was 27 years (range 15 to 45 years). Gestational age, as established by one or more ultrasound scans, ranged from 5 to 42 weeks. Erythropoiesis was evaluated during pregnancy (N = 317), during labor leading to vaginal delivery (N = 63), as well as on day 7 postpartum (N = 27).

Control Epo samples were obtained from 74 women with Hct levels in the 25% to 44% range. This control group included 33 normal adult subjects who had not donated blood in the last 3 months, and 41 women with hypoplastic/aplastic (N = 9), hemolytic (N = 7), dyserythropoietic (N = 9), or iron-deficient anemia (N = 16), who had not received RBC transfusions in the preceding week. Control TfR samples were also obtained from 43 healthy women with normal Hct and serum ferritin (12 to 120 ng/mL).

TfR assay. Human placental receptor-transferrin complex was purified as described elsewhere and injected repeatedly into rabbits. Serum IgG was isolated from rabbit serum and transferrin antibodies were removed by passing through a column of human diferric transferrin coupled to Affigel 15 (Bio-Rad, Richmond, CA). Characterization of the plasma TfR and receptor antibody has been described elsewhere.

An enzyme-linked immunosorbent assay (ELISA) was used with minor modifications to measure serum levels of TfR. Immunoplates I with certificate (Nunc Intermed, Roskilde, Denmark) were used. The aliquots of blanks, standards, and unknown samples were added using a Digiflex automatic pipetor (Micromedic Instruments, Philadelphia, PA). Standards were diluted to between 5 and 100 ng/mL and unknown sera were diluted 1:50 to 1:2,000 with 0.15 mol/L phosphate-buffered saline (PBS) (pH 7.4) containing 0.5% bovine serum albumin and 0.05% Tween 20. After color development, differential absorbance was read in dual wavelength mode at 492 and 690 in a Titertek Multiskan MCC/340 plate reader (Flow Laboratories, Herts, England). Each sample was run in triplicate. The between-assay variability (coefficient of variation) was 7.2% when the same control sample was measured in each plate. Because the standard consisted of a complex of receptor and transferrin molecules, all TfR values given are actually receptor-complex values.

Epo assay. Circulating Epo levels were measured by a commercially available radioimmunoassay (Incstar Corp, Stillwater, MN).

From the Department of Hematology and the Department of Gynecology and Obstetrics, University of Liege, Liege, Belgium.

Submitted November 28, 1990; accepted March 1, 1991.

Supported in part by Grant No. 3.4513.88 from the Fund for Medical Scientific Research (FRSM, Belgium) and by a grant from the University of Liege School of Medicine.

Address reprint requests to Yves Beguin, MD, University of Liege, Department of Hematology, SI-3, CHU Saint-Tilman, 4000 Liege, Belgium.

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that uses recombinant human Epo (rHuEpo) for tracer and standards. Samples are incubated with rabbit anti-Epo serum for 2 hours at room temperature before Epo tracer is added. After overnight incubation, goat antirabbit serum is added. After centrifugation, the unbound tracer is removed by decantation and the pellet is counted. Several samples had to be diluted 1:10. Twelve control samples were run in each assay, with a between-assay coefficient of variation ranging from 10.3% to 14.1%.

**Miscellaneous.** Serum iron and total iron-binding capacity (TIBC) were measured by standard procedures. Serum ferritin was measured by a radioimmunoassay.

**Statistical methods.** Log transformed Epo and TFr values were used in statistical analyses. Student’s t-tests, with pooled or Welch’s test as appropriate, was used to compare more than two groups. Analysis of variance (ANOVA), with Snedecor’s F-test or Welch’s test as appropriate, was used to compare more than two groups. Two-way analysis of variance was used to assess the effect derived for each sample and the O/P ratio of observed/predicted log(Epo) ranged from 0.80 to 1.20. Consequently, O/P ratios in study subjects were considered abnormal if lower than 0.80.

Study subjects. Table 1 displays Hct, iron status, serum erythropoiesis, and serum Epo values in controls and pregnant women.

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### Table 1. Hct, Iron Status, Erythropoiesis, and Serum Epo Values in Controls and Pregnant Women

<table>
<thead>
<tr>
<th></th>
<th>Controls</th>
<th>1st Trimester</th>
<th>2nd Trimester</th>
<th>3rd Trimester</th>
<th>Delivery</th>
<th>Postpartum</th>
<th>P Value</th>
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</thead>
<tbody>
<tr>
<td>N</td>
<td>43</td>
<td>53</td>
<td>108</td>
<td>156</td>
<td>110</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>Hct (%)</td>
<td>39.5 ± 2.1</td>
<td>36.3 ± 3.4</td>
<td>34.4 ± 2.4</td>
<td>34.2 ± 3.0</td>
<td>36.8 ± 3.2</td>
<td>36.1 ± 4.0</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Tf saturation (%)</td>
<td>29 ± 12</td>
<td>23 ± 12</td>
<td>19 ± 10</td>
<td>17 ± 8</td>
<td>14 ± 8</td>
<td>&lt;.0001</td>
<td></td>
</tr>
<tr>
<td>Ferritin (µg/L)</td>
<td>33 ± 20</td>
<td>44 ± 30</td>
<td>26 ± 24</td>
<td>14 ± 14</td>
<td>20 ± 16</td>
<td>16 ± 13</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>TFr (µg/L)</td>
<td>6,940 ± 1,480</td>
<td>5,350 ± 2,360</td>
<td>5,130 ± 1,480</td>
<td>7,170 ± 2,990</td>
<td>9,200 ± 3,420</td>
<td>8,380 ± 3,220</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Epo (mU/mL)</td>
<td>16.4 ± 4.1</td>
<td>19.1 ± 6.2</td>
<td>28.4 ± 15.5</td>
<td>37.7 ± 24.2</td>
<td>33.9 ± 22.3</td>
<td>36.1 ± 34.7</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>O/P ratio</td>
<td>1.00 ± 0.10</td>
<td>0.91 ± 0.17</td>
<td>0.92 ± 0.14</td>
<td>0.98 ± 0.14</td>
<td>1.04 ± 0.21</td>
<td>1.00 ± 0.16</td>
<td>&lt;.0001</td>
</tr>
</tbody>
</table>

*P values are given for comparison between groups of pregnant women.*
ERYTHROPOIESIS IN PREGNANCY

Fig 1. Evolution of Hct, TIR levels, Epo levels, and Epo O/P ratios (Mean ± SEM) throughout pregnancy, as compared with normal control values.

Fig 2. Relationship between Epo levels and Hct in the first trimester (I), second trimester (II), third trimester (III), and on day 7 postpartum (PP). Control subjects are represented by their 95% confidence limits (shaded area).

Table 2. Effect of Iron Status on Serum TIR Levels According to Time of Pregnancy

<table>
<thead>
<tr>
<th>Time of Pregnancy</th>
<th>1st Trimester</th>
<th>2nd Trimester</th>
<th>3rd Trimester</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Iron status</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deficient</td>
<td>7.590 ± 4.810*</td>
<td>5.680 ± 1.400</td>
<td>8.260 ± 3.260</td>
<td>&lt;.0001</td>
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<tr>
<td>Marginal</td>
<td>5.490 ± 2.000</td>
<td>5.870 ± 1.640</td>
<td>&lt;.0001</td>
<td></td>
</tr>
<tr>
<td>Normal</td>
<td>5.040 ± 1.490</td>
<td>4.570 ± 1.040</td>
<td>5.460 ± 1.710</td>
<td>&lt;.0001</td>
</tr>
</tbody>
</table>

*Deficient and marginal iron status combined (N = 7).

and second (r = −.14) trimesters, and was weak in the third trimester (r = −.26, P < .01). In multivariate stepwise regression analysis (r = .68), serum Epo contributed the most to the prediction of serum TIR (change in r²: .35), transferrin saturation (change in r²: .08), and ferritin (change in r²: .02) somehow enhanced precision, while Hct and week of pregnancy did not add significance.

DISCUSSION

Pregnancy causes considerable alterations in plasma volume and RBC mass. There is little change in plasma volume before week 16, but then a steady increase takes place to 120% of nonpregnant values by week 20, to 140% by week 30, and to 150% at term.²reactor to the prediction of serum TIR (change in r²: .35), transferrin saturation (change in r²: .08), and ferritin (change in r²: .02) somehow enhanced precision, while Hct and week of pregnancy did not add significance.

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Methodology has been recently introduced for the measurement of serum TfR levels as a valuable alternative to ferrokinetics for the quantitative assessment of erythropoiesis. Using this assay in the present study, we found that erythropoiesis was decreased in early pregnancy, normalized in the first part of the third trimester, and was moderately stimulated in late pregnancy, at delivery, and in the early postpartum. These data are consistent with the changes of RBC mass observed throughout pregnancy. Others have measured TfR levels without other parameters of erythropoiesis in a small group of women, and observed increased levels in late pregnancy, but no change in the first part of pregnancy. The nature and standardization of the material measured in that assay is not well established and direct comparison is difficult.

There are theoretical interferences potentially precluding the use of serum TfR levels as a measurement of erythropoiesis during pregnancy. First, the placenta is very rich in receptors quite similar to the erythroid TfR, allowing its use as immunogen and standard in the present assay. If placental TfR contributed significantly to circulating TfR levels, they would have caused an apparent overestimation of erythropoiesis in pregnancy, but this was obviously not the case. Second, functional iron deficiency beyond depletion of iron stores has been shown to produce an increase in serum TfR levels. The effect of iron stores on TfR levels was also observed in pregnancy. Women with deficient iron status had higher levels than women with marginal status and even more so than those with normal iron stores. When only women with normal stores were considered, mean TfR levels in each trimester were even more decreased, while iron deficient women had normal levels. Therefore, iron deficiency does not appear to interfere significantly with the conclusion that the rate of erythropoiesis is low in pregnancy.

Plasma expansion could cause an apparent reduction in the serum concentration of TfR by diluting the total number of soluble receptors in a larger volume. Correcting for plasma volume would give mean receptor levels of about 5,290, 5,710, and 7,930 pg/L in women with normal iron stores, respectively, in the first, second, and third trimester. These levels are still well below expected values, particularly in view of levels of 23,258 ± 5,640 and 32,900 ± 8,352 pg/L in patients with immune hemolytic anemia or hemoglobin H disease, where a similar degree of anemia (Hct 35% ± 5%) induced considerably higher rates of erythropoiesis.

We attempted to identify factors responsible for decreased erythropoiesis in pregnancy. In multivariate stepwise regression analysis, serum Epo contributed the most to the prediction of serum TfR. The correlation between serum TfR and Epo was strong in each period of pregnancy. Epo levels are best expressed in relation to the Hct. We found an excellent correlation between Epo levels and Hct in 74 women with various degrees of anemia. Therefore, Epo levels measured in pregnant subjects could be related to predicted values calculated from the Hct. Absolute Epo levels increased throughout pregnancy and were in agreement with the Hct in the third trimester, at delivery, and in the early postpartum, but in the first two trimesters they were below predicted levels in the vast majority and low relatively to the Hct in 25% of the cases. The inverse linear relationship between log(Epo) and Hct, absent in the first trimester, progressively returned to normal as pregnancy advanced (Fig 2).

Several physiologic adaptations to pregnancy may augment oxygen supply to the kidney sensor, thus depressing Epo release in the first trimester. Erythrocyte 2,3-diphosphoglycerate increases early in pregnancy, producing a shift in the oxygen dissociation curve to the right. In the first trimester, the renal blood flow is considerably increased, but in the second half of pregnancy, a larger part of the expanded cardiac output is directed to the utero-placental and cutaneous circulations. These alterations in oxygen supply to the kidney could in part explain variations in Epo production rate throughout pregnancy and the early postpartum. Modifications in the endocrine status, such as the production of human placental lactogen, have also been suggested to possibly influence changes in Epo production and release during pregnancy.

We conclude that serum Epo levels, though increased over nonpregnant values, remain relatively low for the degree of anemia in the first part of pregnancy but return progressively to predicted levels thereafter. These changes in Epo production could explain the slowdown in erythropoietic activity observed in the first two trimesters and its normalization later in pregnancy. It should be emphasized that these alterations in the rate of erythropoiesis are adaptive changes that would certainly not require therapeutic intervention, such as the administration of rHuEpo.

REFERENCES

Blunted erythropoietin production and decreased erythropoiesis in early pregnancy [see comments]

Y Beguin, G Lipscei, H Thoumsin and G Fillet