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Yellow= needs work/edits/figure it out

Red = definitely needs work, not done yet at all

Tiffany blue= DONE ☺

# Specific Aim 1

**Determining the effects of chronic stress on placental** **transport of nutrients and endocrine function.**

The placenta is the direct and only site of communication between mother and fetus during *in utero* development (Brett *et al.*, 2014). The placenta is the rate-limiting step for fetal nutrient and gas acquisition (Brett *et al.*, 2014). Additionally, the placenta plays an important endocrine role to promote fetal growth and nutrient supply (Malassine *et al.*, 2003). The placenta is highly regulated to ensure adequate growth of the fetus in normal pregnancies (Napso *et al.*, 2018). In cases of maternal glucocorticoid-induced stress, placental nutrient transport and endocrine function are compromised leading to potentially suboptimal fetal growth (Kipmen-Korgun *et al.*, 2012; Waffarn & Davis, 2012). In Denmark, 20% of women reported use of corticosteroids from 4 weeks prior to delivery until delivery between 1996-2008 (Hviid & Mølgaard-Nielsen, 2011). The mechanisms by which maternal corticosteroids influence fetal health and placental function are understudied (Kemp *et al.*, 2015). Some side effects like reduced birthweight, offspring hypertension and altered HPA axis remain controversial (Reynolds, 2013; Moisiadis & Matthews, 2014). My hypothesis is that corticosteroid treatments prior to conception and/or during conception cause altered placental transport and hormonal function in a time-dependent manner by which an early and prolonged exposure during pregnancy has more prominent side effects on the placenta and fetus. To test this hypothesis, we will examine a) how maternal dexamethasone effects on placental development and function, b) how maternal dexamethasone affects fetal and offspring development and health, and c) the role of placental glucocorticoid receptor in mitigating the effects of maternal dexamethasone exposure.

# Rationale and Background

## Murine Placental Development and Physiology

The definitive structure of the mouse placenta is determined at midgestation (Malassine *et al.*, 2003). The placenta encompasses two sides, an arc-shaped surface facing the maternal side and another flat surface facing the fetal side (Georgiades *et al.*, 2002). The mouse placenta has three distinct compartments, a decidual maternal zone which is the outermost compartment, a fetal-derived junctional zone that mediates placental endocrine function, and a fetal-derived labyrinthine zone that comprises the majority of the placenta and is the main site for nutrient and gas exchange (Woods *et al.*, 2018). Three exchange barriers exist moving inwards from the decidua to the fetal compartment including two syncytiotrophoblast layers (in the labyrinthine layer) and one fetal endothelial cell layer (Georgiades *et al.*, 2002). The two syncytiotrophoblast barriers comprise the microvillous membrane facing the maternal circulation and the basal membrane facing fetal circulation (Brett *et al.*, 2014).

At midgestation, placental invasion of the maternal uterine cavity occurs to allow maternal blood flow into the placental cavity (Malassine *et al.*, 2003; Woods *et al.*, 2018). This invasion permits direct nutrient uptake from the maternal circulation to the fetus through the placenta. Prior to this invasion, the embryo acquires nutrients from the yolk sac, the initial placental structure that absorbs nutrients from maternal circulation (Malassine *et al.*, 2003; Woods *et al.*, 2018).

## Cortisol/Corticosterone Levels in Pregnancy

During human pregnancy, mean cortisol rises gradually as pregnancy progresses (Carr *et al.*, 1981). Mean cortisol levels increase during the first, second and third trimester by 1.6, 2.4 and 2.9 folds, respectively (Jung *et al.*, 2011). The increased cortisol levels may be explained by placental secretions of estrogen stimulating maternal cortisol production and mitigating maternal negative feedback (Lindsay & Nieman, 2005) and/or by placental production of free cortisol into the maternal circulation (Jung *et al.*, 2011). However, in mouse pregnancy, corticosterone levels do not increase as much as humans. In pregnant control mice, corticosterone levels were not significantly different at E11 and E17 despite slightly higher levels at E17 (Jafari *et al.*, 2017). Other studies showed an increase in corticosterone levels at E19 compared to E16 in control unstressed mice (Vaughan *et al.*, 2012). Unstressed pregnant mice had higher corticosterone levels compared to non-pregnant mice and progressively increased from E10 till E16 then dropped by E19 to levels similar to E10 (Barlow *et al.*, 1973). Despite the natural increase in maternal circulating cortisol levels, the placenta is efficient at inactivating cortisol by hydroxysteroid 11-beta dehydrogenase 2 (Hsd11B2) activity allowing only 10-20% of maternal cortisol to cross to the fetus (Gitau *et al.*, 1998; Ellman *et al.*, 2008). In mice, HSD11B2 gene activity is highly expressed in the labyrinthine zone at E14.5 then decreases by E16.5 thus allowing a higher corticosterone flux to the fetus later in gestation and near term (Brown *et al.*, 1996; Malassine *et al.*, 2003)

## Fetal HPA Axis Development

The fetal hypothalamic-pituitary axis activity is detected as early as 8-12 weeks of gestation (Ng, 2000) and is fully developed in the second trimester of pregnancy (Moisiadis & Matthews, 2014). In early pregnancy, fetal cortisol is thought to primarily be attained from maternal cortisol, as the fetus is believed to sufficiently produce cortisol at 22 weeks of gestation (Buss *et al.*, 2012). Given the critical developmental window by which fetal organs and HPA axis are developing, it is possible that increased maternal cortisol levels in early pregnancy compared to late pregnancy may have more deleterious effects on fetal development (Barker, 2007; Braun *et al.*, 2013). In mice, the HPA develops postnatal in two phases. On postnatal day (PND) 1 through 12, the mouse HPA is considered hypo-responsive, and after PND 12 the HPA system matures (Schmidt *et al.*, 2003).

## Glucocorticoid Treatments in Pregnancy

In addition to the naturally increasing cortisol levels in pregnancy, glucocorticoid treatments are further prescribed during pregnancy for multiple reasons. A single course of synthetic corticosteroid treatment is prescribed to women who are at risk of delivering premature babies. The treatment is proven to increase offspring chances of survival post-delivery (Doyle *et al.*, 2000; Baisden *et al.*, 2007). Glucocorticoid treatments are prescribed as they enhance fetal growth, specifically fetal lung maturation to prevent respiratory distress syndrome (RDS), and aid in overall embryogenesis to prevent perinatal death due to hemorrhages, heart failure and other underlying causes associated with preterm birth (Lunghi *et al.*, 2010; Singh *et al.*, 2012). Specifically, betamethasone, dexamethasone, prednisolone, corticosteroids, or cortisol are prescribed to women who have acute asthma or asthma, hyperemesis gravidarum, depression, stress, or are at risk of delivering preterm babies (Singh *et al.*, 2012). The use of corticosteroids is widespread. In a Danish cohort study encompassing all births in Denmark from 1996-2008, about 20% of women reported use of corticosteroids from 4 weeks prior to delivery until delivery (Hviid & Mølgaard-Nielsen, 2011). In an American cohort study including 152,531 pregnancies between 1996-2000, 3.5% of pregnant women who had a documented diagnosis associated with preterm birth used corticosteroids, while 1.7% of pregnant women who did not have a documented diagnosis used corticosteroid (Andrade *et al.*, 2004). Despite the placenta’s function to protect the fetus from excess maternal corticosteroid, synthetic corticosteroids used in preterm treatments can readily cross the placenta bypassing inactivation by Hsd11B2 (Cuffe *et al.*, 2011; Singh *et al.*, 2012).

## Effect of In Utero Glucocorticoid Exposure on Placental Function

Multiple doses of dexamethasone treatment reduced placental and fetal weights (Hahn *et al.*, 1999; Baisden *et al.*, 2007) and increased trophoblast apoptosis thus impairing placental growth (Baisden *et al.*, 2007; Chan *et al.*, 2007).

Triamcinolone (TA) glucocorticoid treatments showed an increase in GLUT3 and GLUT1 mRNA expression in human placental endothelial cells (HPEC) suggesting that glucose flux to the fetus may be increased (Kipmen-Korgun *et al.*, 2012).

Furthermore, despite the placenta’s role in inactivating maternal free cortisol into cortisone, administering high doses of glucocorticoids overwhelms the placental HSD11B2 system in addition to the fact that synthetic cortisol readily passes to the fetus bypassing this enzymatic activity (Cuffe *et al.*, 2011; Singh *et al.*, 2012). Nutrient transport across the placenta and placental hormone secretions are understudied with glucocorticoid treatments.

Effects of Dex on mouse <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3723833/>

<https://academic.oup.com/edrv/article/18/3/378/2530781> review with **figure** on placental hormone activity on fetus and mother

Glucose and AA transport with dex exposure in mice <https://academic.oup.com/edrv/article/34/6/885/2354710>

Link with mTORC! <https://academic.oup.com/edrv/article/34/6/885/2354710> Obesity increases mTORC activity but GC decrease it. “A connection between the mTOR pathway and glucocorticoid signaling has been established in cell lines (355), but the effect of glucocorticoids on placental mTOR signaling is not known. Elevated endogenous levels of glucocorticoid in the rat have been shown to suppress mTOR signaling in skeletal muscle (356). A recent study on human term placentas in women with self-reported high levels of environment-related stressful conditions during pregnancy showed a significant downregulation of Dishevelled, Egl-10, and Pleckstrin domain-domain-containing and mTOR-interacting protein (DEPTOR) as a modulator of mTOR signaling (357). There are currently no data regarding antenatal glucocorticoid exposure and placental mTOR signaling. Given the importance of antenatal administration of synthetic glucocorticoids in the management of preterm delivery, it is essential that future studies interrogate these pathways.”

Mouse studies:

Using a minipump on embryonic day 12.5,pregnant dams were given dexamethasone (dex) at a rate of 1ul/hr for 48 or 60 hours prior to sacrifice at E14.5 or E17.5, respectively. At E14.5, fetal weights were smaller for male and female dex-exposed pups. Placental weight was smaller at E14.5 for dex-exposed females only. At E17.5, no differences were noted in fetal or placental weight. HSD11b2 gene expression was higher in female placentas exposed to dex at E14.5, and protein expression was increased in female placentas at E17.5. Placental vasculogenesis was measured by genes of the vascular endothelial growth factor family (VEGFA) receptors: VEGFR1 (Flt1) and VEGFR2 (Kdr). Female placentas showed increased gene expression of Vegfa at E14.5 while protein expression as unchanged, and reduced placental growth factor (Pgf) expression at E17.5 after dex exposure. Kdr expression was significantly lower in male placentas at E14.5.

In females, Igf2 gene expression as higher in female placentas regardless of treatment at E14.5.MAPK1 protein expression was reduced in female placentas at E14.5 but gene expression was not changed. Selected glucose (GLUT1 and GLUT3) and amino acid (SNAT1,2 and 4) transporters were unaltered as an effect of treatment or sex.

Corticosteroidsin pregnant murine models have not been thoroughly examined in context of placental function.

## Effect of In Utero Glucocorticoid Exposure on Offspring

Limited studies have investigated the effect of antenatal glucocorticoid treatment on fetal hypothalamic-pituitary-adrenal axis showing potential blunted offspring HPA activity (Waffarn & Davis, 2012). Despite popular use of corticosteroids, offspring side effects have been understudied and largely unknown. Some studies have shown increased blood pressure in children, increased risk of preeclampsia, impaired mental development in infants, increased infant cortisol, reduced fetal weight, and other symptoms associated with timing, dosage and type of corticosteroid treatment during pregnancy (Singh *et al.*, 2012). The effects of corticosteroid use further manifest in childhood where maternal third trimester cortisol levels were shown to influence childhood adiposity (Entringer *et al.*, 2016). In mice, studies have shown reduced placental weights after a short period preterm exposure to dexamethasone and potential fetal growth restriction (Cuffe *et al.*, 2011). The mechanisms by which maternal corticosteroids influence fetal health and placental function remain understudied with conflicting results (Kemp *et al.*, 2015). The effects of prenatal glucocorticoid exposure remain controversial, and the exact mechanisms by which they are manifested remain poorly understood (Bandoli *et al.*, 2017).

# Experimental Design

To determine how glucocorticoid exposure affects placental function, we will obtain n=X females and males /per group 8 week-old C57BL/6 virgin mice from Jackson laboratory. Mice will be given two weeks to acclimatize with *ad libitum* access to normal chow diet and water. After acclimatization, mice will then be single-housed and randomized into one of the following groups:

Cohort A of groups treated one week prior to conception:

1. Water*E-1-14.5:* control group on water one week prior to conception and until midgestation at embryonic day 14.5
2. Dex*E-1-14.5*: experimental group exposed to Dexamethasone in drinking water a week prior to conception and until midgestation at embryonic day 14.5
3. Water*E-1-17.5*: control group on water one week prior to conception and until late gestation at embryonic day 17.5
4. Dex*E-1-17.5*: experimental group exposed to Dexamethasone in drinking water a week prior to conception and until late gestation at embryonic day 17.5
5. Water*E-1-21.5*: control group on water one week prior to conception and until delivery
6. Dex*E-1-21.5*: experimental group exposed to Dexamethasone in drinking water a week prior to conception and until delivery

Cohort B of groups treated at conception:

1. Water*E0.5-14.5*: control group on water starting at conception and until midgestation at embryonic day 14.5
2. Dex*E0.5-14.5*: experimental group exposed to Dexamethasone in drinking water starting at conception and until midgestation at embryonic day 14.5
3. Water*E0.5-17.5*control group on water starting at conception and until late gestation at embryonic day 17.5
4. Dex*E0.5-17.5*: experimental group exposed to Dexamethasone in drinking water starting at conception and until late gestation at embryonic day 17.5
5. Water*E0.5-21.*5: control group on water starting at conception and until delivery
6. Dex*E0.5-21.5*: experimental group exposed to Dexamethasone in drinking water starting at conception and until delivery

All groups will have *ad libitum* access to normal chow diet and water or Dexamethasone depending on treatment arm. Experimental groups will receive 1mg/kg/day dexamethasone in their drinking water with *ad libitum* access.

For groups of Cohort A (receiving Dex or water a week prior to conception), female mice will be mated with age-matched male mice after one week of treatment. A copulatory plug will be checked daily to identify E0.5 day.

For groups of Cohort B (receiving Dex or Water at conception), mice will be mated with age-matched males immediately after acclimatization while having *ad libitum* access to water. We will check for the presence of copulatory plugs daily to determine treatment initiation. Once a copulatory plug is identified, mice will be placed on Dexamethasone or Water based on their assigned group.

For Water and Dex groups that will complete their pregnancy and deliver their pups, they will have *ad libitum* access to normal chow diet and water during lactation.

Males will be removed from the cage after a copulatory plug is detected to minimize male exposure to treatment and to better detect potential miscarriages.

Dams from all groups will undergo body mass assessment three times weekly using magnetic resonance to assess body composition. Water and food intake will be recorded weekly. For groups that will be sacrificed prior to delivery (E14.5 and E17.5), placental and fetal extractions will occur midgestation at E14.5 or late gestation at E17.5. Briefly, the dams will be anesthetized using a vaporizer during the placental and fetal extraction. Litter size will be determined per dam and will account for potential resorbed placentas. Placental and fetal weights will be collected. Placentas will be snap frozen in liquid nitrogen while some will be embedded in paraffin for histology. Molecular studies on placental samples will be conducted to determine protein expression.

For the groups that will deliver their pups at E21.5, survival and birth rates will be noted. Pups will be sexed and culled to 2 at PND2.5. The offspring will be weighed at PND0.5, PND7.5, 14.5, 16.5, and at 21.5. Pups will be weaned based on sex and treatment group. The weaned pups will have *ad libitum* access to normal chow diet and water. Their water and food intake will be assessed weekly. They will further undergo body composition analysis by echoMRI at weaning and weekly thereafter. To assess offspring HPA axis activity, retro-orbital bleeds will be done to collect blood followed by sacrifice and tissue collection of fat pads 3 days later. Offspring fat pads (gWAT and iWAT) will be collected and weighed to determine adiposity.

To determine if the effects of Dexamethasone exposure on the placenta and the fetus can be rescued using a placenta-specific glucocorticoid receptor (GR) knockout (KO) model. To isolate placental from fetal and maternal glucocorticoid signaling, our knockout model will ablate GR conditionally in the placenta. To generate the GR-KO, we will use the Cre-loxP recombination technology. Female mice with flanked exon 2 of *Nr3c1* will be crossed with a male having placental driver *Cyp19a1-CreTg/+* to avoid ablation of GR in female tissue. This cross will be generated as depicted in Figure 1. Briefly, the parental strains for this experiment will be male *Tsc1* +/+;*Cyp19a1-Cre* Tg/+ *crossed with* female *Tsc1* fl/fl ; *Cyp19a1-Cre* +/+. This cross will yield a combination of knockout *Tsc1* fl/fl;*Cyp19a1-CreTg/+* , conditionally heterozygous *Tsc1* fl/+;*Cyp19a1-CreTg/+* , or wild-type *Tsc1* fl/fl ; *Cyp19a1-Cre* +/+ (no Cre transgene) at an expected ratio of 1:2:5 with the knockout and wild-type animals only being used for further breeding. The offspring generated from the next generation will all have the floxed allele with the Cre (KO) or without (WT). The offspring generated from the last breed will either be WT with intact placentas or knockout with placental KO and a phenotypically WT embryo.

The dams with GR-KO will be treated with Dexamethasone similar to the previous groups in cohorts A and B to determine placental, embryonic and offspring function and growth.

### Figure 1: Diagram representing the experimental design and respective timeline

Using the above-mentioned model,we will measure placental expression of HSD11B2 mRNA using RT-qPCR. Placental cell lines described above will also be used to quantify HSD11B2 expression using western blotting and RT-qPCR to measure mRNA expression. HSD11B2 activity will be measured by determining the conversion of cortisol to cortisone as mentioned by Zhu et al. (Zhu *et al.*, 2016). We will further determine if there is a correlation between maternal, fetal and placental cortisol levels. In normal pregnancies, fetal cortisol levels are supposed to be less than the maternal serum cortisol, as the placenta efficiently inactivates 80-90% of the maternal cortisol (Duthie & Reynolds, 2013). Increased fetal levels in response to increased maternal cortisol following dexamethasone treatment will highlight the placenta’s failed ability to adequately inactivate the surplus of maternal cortisol and will further corroborate our previous results that may indicate altered placental HSD11B2 function and expression. We will further assess the exact flux of maternal cortisol by using radiolabeled corticosterone as per Li et al. (Li *et al.*, 2015) and further quantify placental and fetal expressions using the HSD11B2 assay kit.

**Aim 2.3: Is placental endocrine function altered with increased maternal cortisol levels?** As previously mentioned, multiple doses of dexamethasone treatment reduced placental and fetal weights (Hahn *et al.*, 1999; Baisden *et al.*, 2007), and small-for-gestational-age babies show reduced PGH levels (Männik *et al.*, 2010). As our preliminary data suggests that the pups of dexamethasone-treated dams are inviable, placental growth hormone and fetal GH secretions can be altered in a dose-dependent manner. We will conduct the previously mentioned studies in Aim 1.2 but using the cortisol exposure.

# Methods

## Dexamethasone Exposure

Water-soluble dexamethasone (Sigma) will be prepared at a concentration of 53 mg/L, which our previous work shown results in a dose of approximately 1 mg/kg/day in non-nursing mice.

If the dam is single housed or with nursing pups:

(the new added total water/dexamethasone- the last measurement’s water/dexamethasone) / # of days between measurements

If more than one adult mouse is in the cage (when the male is breeding in the same cage), food intake will be calculated as follows:

(the new added total water/dexamethasone - the last measurement’s water/dexamethasone) \* #of days between measurements / sum of days spent by each mouse in that cage between measurements

## Food Intake

Food will be weighed when the treatment starts and throughout the experiment. The weight of the dam’s food will be recorded three times weekly every Monday, Wednesday, and Friday. Food will also be weighed at delivery for the dam. Food will be topped off to ~400g weekly every Friday. Food intake will be calculated as:

If the dam is single housed or with nursing pups:

(the new added total food weight - the last measurement’s food weight) / # of days between measurements

If more than one adult mouse is in the cage (when the male is breeding in the same cage, or when weaned offspring are housed together), food intake will be calculated as follows:

(the new added total food weight - the last measurement’s food weight) \* #of days between measurements / sum of days spent by each mouse in that cage between measurements

## Body Composition

Mice will be weighed by using dynamic weighing to capture accurate weight using a digital scale. The weight will be recorded along with the mouse ear tag number. The mouse will be gently placed in the MRI tube with the plunger slightly compressing along the mouse body to ensure it cannot move during the measurement. Fat, lean, free water and total water mass (g) will be recorded for each animal.

## Sacrifice and Tissue and Blood Collection

Dams of groups E14.5 and E17.5 will be sacrificed on the respective dates based on their treatment group. Dams will be anesthetized using an isoflurane vaporizer. Toe punches will be performed to ensure that the mouse is under anesthesia. A midline incision of the skin from the rectum to the diaphragm will be made while the mouse is still alive and anesthetized using the vaporizer. The uterine horn will be exposed and placental and fetal excision will begin in order along the uterine horn starting from the side (closer to the ovaries). The amniotic sac for each pup will be ruptured using fine scissors. The placenta will be detached from the maternal tissue and the umbilical cord then weighed and immediately snap frozen or cryopreserved and in paraffin for future molecular and histological studies. Fetuses will be weighed after removal from the amniotic sac then they will be immediately sacrificed by decapitation using surgical scissors. After the complete extraction of tissue, dams will be euthanized while under anesthesia by cardiac exsanguination.

Offspring of dams that will be allowed to deliver and nurse (groups of E21.5) will be dissected at 6 weeks of age. Offspring will be first anesthetized using isoflurane drop jar. Retro-orbital bleeds will be performed while the offspring are under anesthesia using capillaries injected into the peritoneal area of the eye. Blood will be collected in 1.5ml tubes then stored in ice. Blood will then be centrifuged for 20 minutes at 5000rpm to collect the plasma. Plasma will be stored at -80C for later corticosteroid analysis. Immediately after the retro-orbital bleed, offspring will be sacrificed using isoflurane drop jar. Cervical dislocation will be performed as a secondary measure to confirm euthanasia. We will dissect the offspring fat pads by a midline incision of the skin from the rectum to the diaphragm, extract inguinal and gonadal white adipose tissue. Inguinal white adipose tissue (iWAT) will be collected from the mouse right side first by pulling the peritoneum away from the skin. Inguinal fat will be carefully extracted, weighed then snap frozen in liquid nitrogen for further molecular studies. Right gonadal white fat tissue (gWAT) will be collected next by scraping the fat along the gonads (ovaries or testis), weighed, and then snap frozen in liquid nitrogen in 2ml tubes. The fat pads will be stored at a temperature of -80C.

## Real time qPCR

Using the placental tissues collected from the dams, we will assess RNA expression of macronutrient transporters and endocrine hormones. RNA samples will be prepared from the mouse tissues using the PureLink RNA Mini Kit. Briefly, tissues will be cut to ~50mg samples that will be homogenized and treated to collect the RNA. The RNA will be quantified using a nanodrop. Later, first strand cDNA will be synthesized from the purified RNA samples using High Capacity cDNA Reverse Transcription Kit. The cDNA samples will be diluted and added to the clear 384 well plate in triplicates. A Primer/SYBR Green mix will be prepared for each primer. Briefly, we will use sequence-specific primers to amplify the genes ACC1, SREBP1c, ACLY and FASN using primer pairs (forward and reverse). This will allow us to assess the overall endocrine and transport function of the placentas of Dex- and Water-treated dams.

## Western Blotting

Using the placentas collected at E14.5 and E17.5, mTORC1 activity will be assessed. Briefly, a portion of the sample will be boiled and loaded into different wells with a ladder control. Proteins will transfer to nitrocellulose overnight. The matrix will be stained for total protein using Revert total protein and scanned by LiCOR to normalize against total protein. Samples will be incubated with the primary then the secondary antibodies. Briefly, antibodies against total and phosphorylated mTORC1 targets (S6K, 4EBP1, S6) and regulators (Akt, IRS and TSC2) will be used.

## Histology

Placentas collected from control and experimental at E14.5 and E17.5 will be embedded in paraffin and stained at the Rogel Cancer Center’s Tissue and Molecular Pathology. Slides will be blindly assessed for decidual, junctional and labyrinthine thickness. CD68+ cells will be assessed to determine

# Expected Results

## **Aim 1.1:**How does maternal GC exposure affect placental, fetal IUGR, and offspring survival?

## **Aim 1.2:** How does maternal GC exposure affect placental endocrine function (specific hormones: lactogen,IGF2 , GDF15…) look at qPCR mRNA expression – will not use ELISA yet since ELISA is expensive and we may not see a difference in qPCR/mRNA expression initially

The experiments conducted above will determine the placental efficiency at inactivating maternal cortisol and will shed light on potential side effects of the treatment dose and timing. We expect that placental expression of HSD11B2 will be upregulated in a time-dependent manner by which an earlier and more prolonged dexamethasone exposure will manifest this placental change in gene expression. Despite the increased placental expression of HSD11B2, we expect the placenta to fail to overcompensate for the excess maternal cortisol thus allowing the increased passage of cortisol to the fetus. We expect the fetal cortisol levels to increase and correlate with maternal levels. We expect that fetal weight will be reduced and thus placental growth hormone secretion will be decreased in a corticosteroid dose-dependent manner.

## **Aim 1.3:** Is placental mTORC1 signaling altered after maternal GC exposure?  Western blot for 4EBP, S6, PS6, AKT

## **Aim 1.4:** How does maternal time-dependent GC exposure affect the expression of placental nutrient transporters? qPCR of transporters, not flux until we see a change in nutrient transporters

The experiments conducted in this aim will examine the effect of timed corticosteroid treatment on placental transport and transporters. We predict that placental glucose transporters (see Table 1) will have increased expression (Kipmen-Korgun *et al.*, 2012) and glucose flux across the placenta to the fetus will be increased . We further expect increased placental lipid transporters and flux but reduced amino acid transporters and flux. We predict maternal corticosteroid treatment will alter placental glucose, lipid, and amino acid transporters and nutrient flux and will influence fetal and placental viability in a time-dependent manner. Earlier exposure at E5.5 and E12.5 will have the most prominent effect on placental transport and may lead to reduced nutrient flux overall, while later exposure at E17.5 will only increase glucose and lipid transporters and flux.

## **Aim 1.5:** Is offspring metabolic health survival, wt, mri, if they survive after Dex exposure during gestation only (no 1 week preconception)

## **Aim 1.6:**Does a placental GR-KO model rescue the placental and fetal effects of GC exposure?

# Potential Pitfalls and alternate Approaches (Aims 1.1-1.6)

It is possible that mice in groups E-1Water or Dex will not conceive immediately at mating thus causing Dex exposure to be more than a week. We will have to eliminate all dams that will be exposed to Dex fro more than a week and the half prior to conception, thus we may need more mice ordered. It is also possible for both groups that the mice may have spontaneous abortions and resorptions due to induced stress. Thus we will need to try this experiment with more mice.

If both treatments prove to reduce

**Potential Pitfalls and Alternate Approaches:** It might be that we are unable todetermine *in vitro* uptake since cortisol and dexamethasone treatments may alter placental cell differentiation and function, in which case we will resort to looking at different cell lines that may be less influenced in regards to differentiation by cortisol and dexamethasone. Another potential problem that may arise is fetal resorption with early dexamethasone exposures. Our pilot study has shown that some dams on dexamethasone who were pregnant did not deliver pups which highlights the possibility of fetal death. In this case, we will have to resort to testing later dexamethasone exposures at 1-6 days prior to conception, instead of starting one full week prior to conception, to determine which treatment leads to the highest birth rate and least fetal resorption rate. We may also need to limit our exposure time to better mimic the human one-course treatment of corticosteroids and to ensure the viability of the pups.

**Potential Pitfalls and Alternate Approaches:**If our hypothesis is correct and fetal cortisol is upregulated, then the change in fetal and placental weights may be due to the cortisol and not the nutrient acquisition. Using results from Aim 2.1, we need to distinguish the effects of fetal nutrient uptake and fetal cortisol uptake to prevent misinterpreting our findings. Although both effects synergistically will yield the final phenotype, we need to be diligent about interpreting our data keeping the full results in mind.Corticosteroid treatment may cause perinatal death and thus placental collection to determine placental function may be difficult. If this is the case, we will collect the placentas at an earlier time point prior to E18.5 when perinatal death may have already occurred. Finally, quantification of radiolabeled corticosterone is uncommon, and so we may need to develop our own protocol using the available references.

Our preliminary data show that dams on dexamethasone (1 mg/kg/day) one week prior to conception and throughout pregnancy are fertile but their offspring are inviable and die either at postnatal day one or prior to delivery suggesting that the placental transport of nutrient, placental endocrine function, or both were impaired or that the fetuses were small for gestational age and thus inviable. Dams on dexamethasone do not gain as much weight during pregnancy compared to the control dams on water, and they mainly lose lean mass consistent with other studies on chronic dexamethasone treatment, while maintaining a constant fat mass. This further directs our future investigation to determine the underlying mechanisms altering placental function and leading to perinatal fetal death during dexamethasone-treated pregnancy compared to a normal pregnancy. This aim will help determine the effect of corticosteroids on placental nutrient transport and placental hormone-secreting capacity in a stress-induced environment.

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