Lack of Relationship between Urinary Glycosaminoglycans and Indices of Tubular or Glomerular Renal Damage

Urinary GAG Are an Unreliable Nephrotoxicity Index

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Dear Sir,

Glycosaminoglycans (GAG) are the major constituents of the anion layer of the glomerular basement membrane which provides an electrostatic barrier to the filtration of anionic macromolecules like albumin [1]. It has been recently suggested that the increased urinary excretion of GAG observed in diabetics [2, 3] might reflect a derangement of GAG in the glomerulus, which would represent the first step toward the development of microalbuminuria [4]. In support for this hypothesis, a correlation between urinary GAG and albuminuria has been reported in 25 insulin-dependent diabetics with daily excretion levels of albumin between 25 and 250 mg [5].

To assess the validity of urinary GAG as index of the charge selectivity of the glomerular basement membrane, we have compared the urinary excretion of GAG with that of albumin, retinol-binding protein (RBP; a marker of proximal tubular function), Tamm-Horsfall glycoprotein and β-N-acetylglucosaminidase (NAG) in 69 diabetics (duration of diabetes 1–32 years, mean 13 years), in 34 workers chronically exposed to cadmium and in 15 patients with acute tubular damage due to multiple injuries, rhabdomyolysis or acute poisoning. The control group consisted of 31 age-matched subjects (age 20–65 years).

GAG were assayed by the method of Whiteman [6] as in the studies by Baggio et al. [4, 5]. Albumin, RBP and Tamm-Horsfall glycoprotein were measured by latex immun assay [7] and NAG by fluorimetry [8]. In comparison with the control group, cadmium workers, patients with acute tubular injury and diabetics exhibited an increased prevalence of elevated GAG values in urine (fig. 1: χ² test significant for diabetics and patients with tubular injury). This prevalence parallels the mean urinary excretion of albumin, NAG and RBP, which suggests that urinary GAG might have some link with renal da-

6∞

(o 1,000)

500
Healthy Cadmium Patients with Diabetics
subjects workers acute tubular injury

Fig. 1. Effect of cadmium exposure, acute tubular injury and diabetes on the urinary excretion of GAG. The horizontal dashed line represents the mean +2 SD of control values. The symbols indicate the subjects with different patterns of proteinuria, using as upper limit of normal 20 mg/g creatinine for albumin, 300 µg/g creatinine for RBP and 5 U/g creatinine for NAG. O = Normal; Δ = increased RBP; · = increased albumin; □ = increased NAG; V = increased RBP+NAG; A = increased albumin + RBP; ▼ = increased albumin + NAG; ■ = increased albumin + RBP + NAG.

But, it can be readily seen from figure 1 that quantitatively the urinary excretion of GAG shows no relationship with that of albumin, RBP or NAG. The latter parameters were normal in the two subjects excreting the highest amounts of GAG and in 6 of the 12 subjects with GAG values above 200 mg/g creatinine. No correlation could be demonstrated either, within each group or in the total population between the urinary excretion of GAG and that of albumin, RBP or NAG. The latter parameters were normal in the two subjects excreting the highest amounts of GAG and in 6 of the 12 subjects with GAG values above 200 mg/g creatinine. No correlation could be demonstrated either, within each group or in the total population between the urinary excretion of GAG and that of albumin, RBP or NAG. The latter parameters were normal in the two subjects excreting the highest amounts of GAG and in 6 of the 12 subjects with GAG values above 200 mg/g creatinine. No correlation could be demonstrated either, within each group or in the total population between the urinary excretion of GAG and that of albumin, RBP or NAG. The latter parameters were normal in the two subjects excreting the highest amounts of GAG and in 6 of the 12 subjects with GAG values above 200 mg/g creatinine. No correlation could be demonstrated either, within each group or in the total population between the urinary excretion of GAG and that of albumin, RBP or NAG. The latter parameters were normal in the two subjects excreting the highest amounts of GAG and in 6 of the 12 subjects with GAG values above 200 mg/g creatinine. No correlation could be demonstrated either, within each group or in the total population between the urinary excretion of GAG and that of albumin, RBP or NAG. The latter parameters were normal in the two subjects excreting the highest amounts of GAG and in 6 of the 12 subjects with GAG values above 200 mg/g creatinine. No correlation could be demonstrated either, within each group or in the total population between the urinary excretion of GAG and that of albumin, RBP or NAG. The latter parameters were normal in the two subjects excreting the highest amounts of GAG and in 6 of the 12 subjects with GAG values above 200 mg/g creatinine. No correlation could be demonstrated either, within each group or in the total population between the urinary excretion of GAG and that of albumin, RBP or NAG. The latter parameters were normal in the two subjects excreting the highest amounts of GAG and in 6 of the 12 subjects with GAG values above 200 mg/g creatinine.

In conclusion, the present data lead us to question the validity of urinary GAG as an index of the charge-selectivity of the glomerulus or even as a nonspecific marker of renal damage. The fact that GAG are constituents of the extracellular matrix and basement membranes present all along the nephron, and that an enhanced urinary excretion of these compounds may reflect tissue injury or an increased cellular turnover associated with tissue regeneration or else a derangement of GAG metabolism, probably accounts for the lack of reliability of this parameter as a nephrotoxicity index.
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References