Regulation of Sodium Transport in the Proximal Tubule by Endothelin

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Abstract

Human essential hypertension and rodent genetic hypertension are associated with increased sodium transport in the renal proximal tubule and medullary thick ascending limb of Henle. The proximal tubule, which secretes endothelin (ET), expresses the ET\textsubscript{B} receptor. Low (nM) concentrations of ET, via the ET\textsubscript{B} receptor, inhibit sodium and water transport and ATP-driven drug secretion in the proximal tubule. In contrast, very low (pM) and high nM concentrations of ET increase renal proximal sodium transport, but the receptor involved remains to be determined. The natriuretic effect of ET\textsubscript{B} receptor stimulation is impaired in spontaneously hypertensive rats, due in part to a defective interaction with D\textsubscript{3} dopamine and angiotensin II type 1 receptors. Impaired ET\textsubscript{B} receptor function in the renal proximal tubule may be important in the pathogenesis of genetic hypertension.
two receptors subtypes (ET\textsubscript{A} and ET\textsubscript{B}). Renal tissue expresses both ET receptor subtypes [6], and ET is secreted by renal tubules, including the renal proximal tubule [7, 8], where it can regulate sodium transport in an autocrine/paracrine manner [9]. In the renal proximal tubules, ET-1 (the major ET expressed in the renal proximal tubule) inhibits ion transport principally through the ET\textsubscript{B} receptor [10], an effect opposite that of the ET\textsubscript{A} receptor. This review focuses on the regulation of ET on sodium transport in the renal proximal tubule and its role in the pathogenesis of essential hypertension.

**Endothelin and Its Metabolism**

In 1985, Hickey et al. [11] described the existence of a trypsin-sensitive endothelium-derived constricting factor in cultured bovine endothelial cells, which they named as ET. Subsequently, more ET family members were found. These members include ET-1, ET-2, ET-3, and ET-4 (analogue of human ET-2 in rat and mouse, also named as a vasoactive intestinal contractor), as well as three isoforms of 31-amino-acid ETs (ET\textsubscript{1–31}, ET\textsubscript{2–31}, and ET\textsubscript{3–31}) [12]. Owing to the similarity of actions between ET\textsubscript{1–31} and ET-1 in vivo, it is possible that some of the effects of ET\textsubscript{1–31} result from their partial bioconversion into ETs [13]. Among these isoforms, ET-1 is the principal isoform and is the most potent and long-lasting constrictor of human vessels known to date [5].

ET-1 is produced in many cell types in the renal and cardiovascular systems, such as endothelial cells, smooth muscle cells, cardiomyocytes, leucocytes, macrophages, and renal tubular and mesangial cells [14, 15]. Bioactive ETs are the product of post-translational processing of the parent preproET peptide. The transcription and translation of preproET result in the formation of a 203-amino-acid peptide which is subsequently cleaved by a furin convertase to the 38-amino-acid peptide big ET\textsubscript{1–38}. Big ET is processed further into ET\textsubscript{1–31} by different isoforms of ET-converting enzymes (ECEs), a group of proteases that belong to the metalloprotease family [16], including ECE-1a, ECE-1b, ECE-1c, and ECE-1d, derived from a single gene by the action of alternative promotors.

ET synthesis is regulated by many factors. It is enhanced in response to low-shear stress, turbulent blood flow, hypoxia, cytokines, angiotensin II, epinephrine, and low-density lipoproteins [17]. In contrast, high-shear stress, nitric oxide, vasodilating prostaglandins, and natriuretic peptides suppress ET production [18]. ET synthesis is regulated by sodium diet; a high-sodium diet, independent of blood pressure status, increases renal synthesis of ET [19]. Distal nephron segments synthesize ET-1 to a greater extent than the proximal tubule [8].

Synthesized ET-1 is released in two ways. One way is via a constitutive pathway, producing intense constriction of the underlying smooth muscle, which contributes to the maintenance of endogenous vascular tone. The other way is via release from endothelial cell-specific storage granules (Weibel-Palade
bodies) in response to external physiological stimuli, producing further vaso-
constriction [20]. Although plasma ET-1 is present in the highest concentra-
tion in blood/plasma, compared with ET-2 and ET-3, ET-1 concentrations are
still lower in plasma than in endothelial and other cells. It is accepted that ET-1
functions as a locally released, rather than a circulating, hormone.

**Endothelin Receptors**

*Endothelin Receptor Classification*

ET receptors are classified as ETA and ETB by the International Union of
Pharmacology Committee on Receptor Nomenclature and Drug Classification
[21]. Both ETA and ETB receptors belong to the 7-transmembrane domain or G
protein-coupled rhodopsin-type receptor superfamily. Pharmacologically het-
erogeneous responses seem to be related to the existence of alternatively spliced
variants of ETA and ETB receptors. A third receptor, named ET C, which is spe-
cific for ET-3 binding, was cloned from dermal melanophores from the amphibi-
an *Xenopus laevis*, but a mammalian homologue has yet to be identified [21]
(see below).

The three ET receptors have different affinities to the three isoforms of ET
(ET-1, ET-2, and ET-3). ET receptors can bind all ET isoforms, but the ETA
receptor has a much higher affinity for ET-1, the most abundant ET in human
plasma, than for ET-3, while the ET C receptor has a higher affinity for ET-3 than
ET-1. In contrast, the ETB receptor binds to all three ET isoforms with equal
affinity.

*Localization of Endothelin Receptors*

In all species studied, including humans, ET-binding is greater in the renal inner
medulla than in the inner cortex [8, 22, 23].

In the rat, there is faint immunostaining of the ETA receptor in the proximal
convoluted and straight tubules, restricted to the basal side, and intense staining
in the distal tubule collecting duct [24, 25]. The ETA receptor is also expressed in
mesangial cells, pericytes of descending vasa recta, and vascular smooth muscle
cells of veins and arteries, specifically the interlobar, arcuate, and interlobular
arteries, as well as efferent and afferent arterioles [25]. The ETB receptor is the
major ET receptor in the kidney; 70–80% of ET receptors in the kidney are ETB
receptors [6, 8], which in the rat are expressed in the proximal tubule, inner
medullary collecting duct, glomerular capillaries, vasa recta endothelial cells,
and vascular smooth muscle cells of interlobular, efferent, and afferent arteries
[25–28].

In the mouse, the ETA receptor has been shown to be expressed in some prox-
imal tubules and vessels, but not in glomeruli. In agreement with the rat studies,
the ETB receptor is expressed in the proximal tubule and collecting duct [29].
Faint staining of $\text{ET}_A$ and $\text{ET}_B$ receptors has also been reported in human glomeruli, and proximal and distal tubules. In agreement with the rat studies, the distal nephron expresses more ET receptors than the proximal nephron [30, 31].

**Signal Transduction of Endothelin Receptors in the Renal Proximal Tubules**

Both $\text{ET}_A$ and $\text{ET}_B$ receptors are linked to $\text{Gq/11}$, $\text{Ga}_S$, and $\text{Ga}_{i/O}$ [32, 33]. In some cells (e.g. Chinese hamster ovary cells), the $\text{ET}_A$ receptor is linked to $\text{Ga}_S$ while the $\text{ET}_B$ receptor is linked to $\text{Ga}_i$ [34]. However, in hepatocytes, the $\text{ET}_B$ receptor is also linked to $\text{Ga}_S$ [35]. The $\text{ET}_B$, but the $\text{ET}_A$, receptor also activates $\text{Ga}_{i13}$ [36].

In rat renal brush border membranes, the ET-mediated increase in phospholipase C activity and protein kinase C translocation to the brush border membrane are mediated by the $\text{ET}_B$ but not the $\text{ET}_A$, receptor. In contrast, the $\text{ET}_C$ receptor is involved in ET-mediated signaling in basolateral membranes [37]. Both the $\text{ET}_A$ and $\text{ET}_B$ receptors belong to the class A receptors of the G protein-coupled receptor family because they bind to $\beta$-arrestin 1 with a higher affinity than $\beta$-arrestin 2, and do not bind to visual arrestin [38, 39].

**Effect of Endothelin on Renal Proximal Tubule Transport**

*In vivo Studies*

Low-dose infusion of ET in anesthetized rats has been reported to decrease sodium transport in proximal and distal nephron segments, assessed by lithium clearance, which is associated with an increase in renal blood flow, but not glomerular filtration rate [40]. At a dose that does not alter renal plasma flow, ET also decreases proximal but not distal tubule sodium reabsorption, also assessed by lithium clearance [8, 41, 42]. This shows that ET infusion causes natriuresis without altering glomerular filtration rate or renal blood flow, and suggests a direct inhibitory effect of ET-1 on Na\(^+\) transport along the nephron. However, ET-mediated natriuresis has not been consistently observed [43, 44]. One group reported that the natriuretic effect of exogenous ET-1 is due solely to an increase in blood pressure since renal decapsulation or maintaining renal perfusion pressure at baseline values (ET agonists often increase arterial pressure) with an aortic clamp prevents ET-1-induced natriuresis [43]. The possible explanation for the inconsistent findings on ET agonist-induced natriuresis may be due, at least partly, to differential activation of $\text{ET}_A$ and $\text{ET}_B$ receptors. For example, when the $\text{ET}_A$ receptor, but not the $\text{ET}_B$ receptor, is blocked, a natriuretic effect of ET-1 is detected [45]. One study showed that low doses of ET causes a natriuresis by decreasing renal proximal tubular reabsorption that is not due to $\text{ET}_B$ receptors [46].
In contrast to the studies on sodium excretion, there is unanimous agreement that systemically administered ET increases urinary water excretion. Even when given at doses that markedly decreased renal blood flow, the renal arterial infusion of ET-1 increased urine volume and free water clearance [47]. This effect may be mediated by the ETB receptor because the infusion of ETB-specific agonists (IRL1620 or sarafotoxin 6c) increases urine flow [10, 46].

The ETB receptor also works as a clearance receptor. The ETB receptor in endothelial cells removes ET-1 from the circulation [48, 49]. Blockade of the ETB receptor increases circulating immunoreactive ETs (ET-1 and ET-3), and mice with genetic ablation of the ETB receptor in endothelial cells have elevated plasma concentrations of ET-1 [48, 49].

**In vitro Studies**

ET has diverse effects throughout the nephron. In the rat proximal tubule, ET has a biphasic effect on ion and fluid transport [50]. Low concentrations (pm) increase, whereas a high concentration (low nm) of ET-1 decreases fluid transport through protein kinase C-, cyclooxygenase- and lipoxygenase-dependent mechanisms [42, 50]. However, higher concentrations (high nm) of ET also increase renal proximal tubule transport [7]. In agreement with the data on sodium transport, low nm concentrations of ET, via the ETB receptor, have also been shown to inhibit the secretion of fluorescent substrates in renal proximal tubules of the killifish [51].

ET-1 inhibits fluid and bicarbonate absorption in the isolated-perfused rat proximal straight tubule [52] and fluid transport in the midproximal convoluted tubule measured by the split-drop micropuncture method [53]. A preliminary report also indicates that ET decreases sodium-phosphate cotransport in rat renal brush border membranes [53, 54]. Garvin and Sanders [52] showed that the ability of ET to inhibit fluid and bicarbonate transport in the rat proximal straight tubule is mediated by a reduction in Na+-K+ ATPase activity. These effects are probably mediated by the ETB receptor because stimulation of the ETB receptor also inhibits Na+-K+ ATPase activity in immortalized rat S1 renal proximal tubule cells [55], similar to that observed in proximal tubules, with a reduction of about 20–40% [52, 53]. The inhibitory effect of ET, via the ETB receptor, on Na+-K+ ATPase activity in human and rat renal proximal tubule cells is mediated by an increase in intracellular calcium via phosphatidylinositol-3 kinase [55]. However, in suspensions of rabbit proximal tubule cells, ET was not found to reduce oxygen consumption, which is used as an index of Na+-K+ ATPase activity [56]. It remains to be determined whether or not the differential effect of ET on Na+-K+ ATPase activity between rats and rabbits is related to species differences.

The effect of ET on NHE3 activity in renal proximal tubule cells is still controversial. Short-term (<1 h) incubation of rat renal cortical slices with ET increases NHE3 activity that is mediated by protein kinase C and inhibition
of cAMP production [57]. Short-term (<1 h) stimulation with ET of opossum kidney cells which express ET$_B$ but not ET$_A$ receptors, also increases NHE3 that is mediated equally by Ca$^{2+}$-dependent and tyrosine kinase-dependent pathways [58, 59]. However, long-term (≥6 h) stimulation of the ET$_B$ receptor in the same opossum kidney cells leads to inhibition of NHE3 activity and expression [60]. One may conclude from these studies that in the renal proximal tubule, ET, via the ET$_B$ receptor, inhibits sodium transport by decreasing Na$^+$/K$^+$ ATPase activity. In contrast, ET, via the ET$_B$ receptor, acutely stimulates, but chronically inhibits NHE3 activity. However, the end-result of ET$_B$ receptor stimulation should still be a decrease in renal proximal tubule transport because of the inhibition of Na$^+$/K$^+$ ATPase activity.

**Interaction with Other G Protein-Coupled Receptors**

*Interaction between Endothelin A and Endothelin B Receptors*
ET$_A$ and ET$_B$ receptors may exist as constitutive homodimers [61]. They may also exist as constitutive heterodimers [62]; therefore, there may be a ‘cross-talk’ between these two ET receptors. The ET$_B$ receptor may be essential in regulating the development or expression of the ET$_A$ receptor because ET$_A$ receptor expression is decreased in central or peripheral tissues of ET$_B$ receptor-deficient mice [63]. ET$_A$ and ET$_B$ receptor heterodimers may be responsible for a sustained Ca$^{2+}$ signaling by delaying their internalization [64]. Both the ET$_A$ and ET$_B$ receptors are required for the full diuretic and natriuretic actions of ET associated with the intramedullary hyperosmotic saline infusion [65]. An increased ratio of ET$_A$ and ET$_B$ receptor activity is important in the development and progression of DOCA-salt-induced hypertension and organ damage [66]. Indeed, blockade of ET$_B$ receptors in this model of hypertension increases the severity of vascular and renal proximal tubular damage [66].

*Interaction with the D$_3$ Dopamine Receptor*
Dopamine, an endogenous catecholamine, is an important regulator of sodium balance and blood pressure via renal and nonrenal mechanisms, including the regulation of appetite centers in the brain, secretion/release of hormones, and humoral agents, as well as interaction with hormones that regulate renal ion transport. Dopamine receptors are divided into D$_1$- and D$_2$-like subtypes based on their interaction with the effector enzyme adenylyl cyclase. Among D$_2$-like receptor subtypes, the D$_3$ receptor, along with the D$_4$ receptor, has the highest affinity for dopamine. Stimulation of the D$_3$ receptor increases sodium and water excretion in normotensive rats [67, 68]. The natriuresis caused by D$_3$ receptor stimulation is due, in part, to inhibition of Na$^+$/K$^+$ ATPase activity via a cooperative interaction with ET$_B$ receptors [28]. The D$_3$ and ET$_B$ receptors colocalize and physically interact in rat renal proximal tubules and increase each other’s expression (fig. 1).
In immortalized renal proximal tubule cells, D₃ receptor stimulation increases ET₆ receptor expression by a calcium-mediated process which is absent in renal proximal tubule cells from spontaneously hypertensive rats [69, 70].

**Interaction with the AT₁ Receptor**

In the basal state of normal sodium intake and especially during sodium deficit, angiotensin II, via the AT₁ receptor, is pre-eminent in renal sodium conservation. The AT₁ and ET₆ receptors physically interact and regulate each other’s expression (fig. 1). Long-term activation of the AT₁ receptor increases ET₆ receptor expression, whereas short-term activation increases cell surface ET₆ receptor expression in rat renal proximal tubule cells, effects that are not observed in renal proximal tubule cells from spontaneously hypertensive rats [71, 72].

**Endothelin and Hypertension**

Increased ET-1 plasma levels, relative to normotensive subjects, regardless of renal function, have been reported in hypertensive patients in some studies.
Most studies, however, have found no differences in circulating ET levels between hypertensive and normotensive subjects [76]. However, the ET$_B$ receptor may be involved in the pathogenesis of hypertension. A high-sodium diet or deoxycorticosterone-salt treatment increases the blood pressure of ET$_B$ receptor-deficient rats. The increased renal sodium transport in these rats probably occurs at a distal tubular level because the increased blood pressure caused by an increased-sodium diet is normalized by blockade of the epithelial sodium channel with amiloride [77]. ET$_B$ receptor blockade produces hypertension that is exaggerated by salt intake or deoxycorticosterone [78, 79]. Systemic ET$_B$ receptor blockade also produces hypertension in mice that is maintained by the ET$_A$ receptor [80]. These findings strongly suggest that the ET$_B$ receptor, by itself or in conjunction with the ET$_A$ receptor, can regulate blood pressure and decreased expression or activity of ET$_B$ receptors increases blood pressure. However, these studies have not determined the involvement of the ET$_B$ receptor expressed in the proximal tubule. As indicated above, the natriuretic effect of ET$_B$ receptor agonists is impaired in spontaneously hypertensive rats. Although ET$_B$ receptor expression is not different in renal proximal tubules between normotensive and spontaneously hypertensive rats, angiotensin II increases total ET$_B$ receptor expression or plasma membrane expression in cells from normotensive, but not hypertensive, rats [71]. The physical interaction between ET$_B$ and AT$_1$ receptors is also impaired in renal proximal tubule cells from spontaneously hypertensive rats [72]. The blunted natriuretic effect of dopamine in spontaneously hypertensive rats may also be due to an impaired physical interaction between D$_3$ and ET$_B$ receptors in the proximal tubule [28], resulting in the impaired inhibition of Na$^+$-K$^+$ ATPase activity [70].

**Conclusion**

The renal proximal tubule in all studied species expresses the ET$_B$ receptor. ET has a U-shaped effect on ion and fluid absorption in the renal proximal tubule. The natriuretic effect of ET$_B$ receptor agonists and low nm concentrations of ET is, in part, due to inhibition of sodium and water transport in the proximal tubule. This is due mainly to inhibition of Na$^+$-K$^+$ ATPase activity and NHE3 activity, the latter occurring only in the long term, as acute stimulation of ET$_B$ receptors increases NHE3 activity. The inhibition of Na$^+$-K$^+$ ATPase activity in renal proximal tubules by stimulation of the ET$_B$ receptor that results in natriuresis is probably abetted by increased positive interaction with the D$_3$ receptor and negative interaction with the AT$_1$ receptor. The impaired natriuretic effect of ET$_B$ receptor stimulation in spontaneously hypertensive rats may be caused by impaired ET$_B$ receptor function that may be related to impaired interaction with D$_3$ and AT$_1$ receptors.
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