Normalization of Pressure–Natriuresis by Nisoldipine in Spontaneously Hypertensive Rats

Francisco J. Fenoy, Michael L. Kauker, Ivan Milicic, and Richard J. Roman

This study examined whether the calcium antagonist nisoldipine can shift the relations between sodium excretion, papillary blood flow, renal interstitial pressure, and renal perfusion pressure toward lower pressures in spontaneously hypertensive rats. Mean arterial pressure decreased similarly by 9% and 12% in Wistar-Kyoto and spontaneously hypertensive rats after nisoldipine (0.5 μg/kg bolus+0.017 μg/kg/min). Urine flow and sodium excretion increased by 35% and 24% in Wistar-Kyoto rats after nisoldipine. In contrast, urine flow and sodium excretion rose by 121% and 132% in spontaneously hypertensive rats, and fractional sodium excretion rose from 1.9±0.3 to 4.2±0.4%. Control sodium excretion, papillary blood flow, and renal interstitial pressure were significantly lower in spontaneously hypertensive rats than in Wistar-Kyoto rats when compared at similar renal perfusion pressures. Sodium excretion, papillary blood flow, and renal interstitial pressure all increased in spontaneously hypertensive rats after nisoldipine, whereas it had no effect on papillary blood flow or renal interstitial pressure in Wistar-Kyoto rats. The relations among sodium excretion, papillary blood flow, renal interstitial pressure, and renal perfusion pressure were shifted toward lower pressures in spontaneously hypertensive rats given nisoldipine and became similar to those seen in Wistar-Kyoto rats. These results indicate that nisoldipine normalizes the relations among sodium excretion, renal interstitial pressure, papillary blood flow, and renal perfusion pressure in spontaneously hypertensive rats perhaps by correcting the defect in renal medullary perfusion associated with resetting of pressure natriuresis in this model of hypertension. (Hypertension 1992;19:49–55)

Previous studies have indicated that the pressure–natriuretic response is blunted in spontaneously hypertensive rats (SHR) and that this abnormality is associated with shifts in the relations among papillary blood flow, renal interstitial pressure, and renal perfusion pressure toward higher pressures. Papillary blood flow and the pressure–natriuretic response are also reduced in very young SHR, supporting the view that changes in renal function may play a role in the development of hypertension in this model. Recently, we reported that vascular tone is elevated in the preglomerular vasculature of juxtamedullary nephrons in SHR. This change appears to be functional rather than structural since it was abolished by removal of calcium from the bath and perfusate. We suggested that elevations in preglomerular vascular tone in deep nephrons may contribute to the alterations in renal medullary hemodynamics previously reported in SHR.

Calcium antagonists are widely used in the treatment of hypertension. Unlike many vasodilators, they lower arterial pressure without causing sodium retention, indicating that these agents reset the pressure–natriuretic relation. In addition, calcium channel blockers increase sodium excretion when administered acutely to hypertensive patients or SHR, but they have little effect in normotensive animals. The mechanism by which calcium entry blockers alter renal function in hypertension remains obscure. The purpose of this study was to evaluate whether the natriuretic and diuretic effects of nisoldipine in SHR are associated with changes in papillary blood flow and renal interstitial pressure.

Methods

Experiments were performed on 38 SHR and 32 Wistar-Kyoto (WKY) rats purchased from Harlan.
Laboratories, Madison, Wis. The rats were 12–16 weeks of age at the time of the study and body weight was between 250 and 320 g. The rats were anesthetized with an intramuscular injection of ketamine (30 mg/kg) and an intraperitoneal injection of Inactin (50 mg/kg) and were placed on a heated table to maintain body temperature at 36.5°C. Cannulas were placed in the jugular vein for infusions, in the femoral artery for measurements of arterial pressure, and in the ureter for the collection of urine. An aortic clamp was placed above the left renal artery, and ties were loosely placed around the mesenteric and celiac arteries so that renal perfusion pressure could be manipulated by adjusting peripheral resistance as described previously.1,2,14 The rats received an intravenous infusion of a 0.9% sodium chloride solution containing 1% bovine serum albumin at a rate of 15 μl/min/100 g throughout the experiment.

Protocol 1: Laser-Doppler Blood Flow Measurements

One week before the experiments, the rats were anesthetized with ketamine (100 mg/kg) and acepromazine (2 mg/kg), and the left kidney was exposed through a flank incision. A small amount of renal cortical tissue overlying the papilla on the dorsal surface of the kidney was Surgically removed as previously described.2,14 The creation of this papillary window allowed for the later exposure of the renal papilla after removal of the ureter.2 On the day of the experiment, the animals were reanesthetized with ketamine and Inactin and were surgically prepared as described above. The left kidney was placed dorsal side up in a holder positioned above the abdominal aorta. The papilla was exposed by making a longitudinal incision in the ureter from the tip to the base of the papilla. Papillary red blood cell (RBC) flow was measured using a dual channel, PEd laser-Doppler flowmeter (Perimed, Stockholm, Sweden) by placing a fiberoptic probe (Pf 316) 1 mm from the tip of the papilla. Cortical blood flow was measured by placing the probe at five random locations on the dorsal surface of the kidney, and the mean flow signal from these areas is reported.

After surgery and a 1-hour equilibration period, the relations between cortical and papillary RBC flow and renal perfusion pressure were determined during a control period. The laser-Doppler flow signals obtained from the renal cortex and the papilla were recorded as renal perfusion pressure was varied from 150 to 80 mm Hg in SHR and from 120 to 70 mm Hg in WKY rats by tightening the clamp on the aorta. Nisoldipine was then administered intravenously (0.5 μg/kg bolus plus 0.017 μg/kg/min sustaining infusion, n = 6 SHR and 6 WKY rats), and mean arterial pressure and papillary RBC flow were continuously recorded for 30 minutes. After this equilibration period, the relations between cortical and papillary RBC flow and renal perfusion pressure were determined.
Fenoy et al Nisoldipine and Pressure-Natriuresis

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FIGURE 1. Plots show comparison of relation between cortical blood flow and renal perfusion pressure in Wistar-Kyoto (WKY) rats and spontaneously hypertensive rats (SHR), before (top panel) and after (bottom panel) the administration of nisoldipine (0.5 μg/kg i.v. bolus plus 0.017 μg/kg/min maintenance infusion).

Analytical Methods

Urine volume was measured gravimetrically and factored by gram kidney weight. [3H]Inulin concentrations in urine and plasma samples were determined with the use of a liquid scintillation spectrophotometer (model 3320, Packard Instruments, Downers Grove, Ill.). GFR was calculated as the urine-to-plasma inulin concentration ratio times urine flow rate. The sodium concentration of urine and plasma samples was determined by flame photometry.

Statistical Methods

Data are presented as mean values±SEM. The significance of differences in the measured values within a group was evaluated using an analysis of variance for repeated measures followed by a Duncan multiple range test. Differences in measured values between groups were analyzed using a two-way analysis of variance followed by a Duncan multiple range test. Linear regression analysis was performed to determine the relations between cortical and papillary RBC flow, RIHP, and renal perfusion pressure. The slopes and y intercepts of these relations were compared using an unpaired t test. A value of p<0.05 (two-tailed test) was considered statistically significant.

Results

Protocol 1: Laser-Doppler Blood Flow Measurements

The relation between cortical blood flow and renal perfusion pressure was similar in WKY rats and SHR during the control period (Figure 1, top). Treatment with nisoldipine had no effect on this relation in either group (Figure 1, bottom).

The time course effects of nisoldipine on papillary blood flow and arterial pressure are presented in Figure 2. Nisoldipine lowered mean arterial pressure in WKY rats (from 119±4 to 105±6 mm Hg) and had no effect on papillary blood flow over a 30-minute period. Arterial pressure also fell in SHR given nisoldipine (from 144±4 to 131±6 mm Hg), but papillary blood flow increased from a control value of 2.36±0.1 to a maximum of 3.14±0.2 V 30 minutes after infusion of nisoldipine was initiated.

The effects of nisoldipine on the relation between papillary RBC flow and renal perfusion pressure in WKY rats and SHR is depicted in Figure 3. The relation between renal perfusion pressure and papillary blood flow was shifted toward higher pressures in SHR during the control period (Figure 3, top), and the slope of the regression line relating papillary RBC flow and renal perfusion pressure was significantly greater in WKY rats than in SHR (2.46±1.93 versus 0.89±0.45 mV/mm Hg). The relation between papillary RBC flow and renal perfusion pressure in SHR was reset toward lower pressures in SHR after

4.0

3.5

3.0

2.5

2.0

1.5

1.0

0.5

0.0

0 5 10 15 20 25 30

MEAN ARTERIAL PRESSURE (mmHg)

FIGURE 2. Plots show effects of nisoldipine (0.5 μg/kg i.v. bolus plus 0.017 μg/kg/min maintenance infusion) on mean arterial pressure and papillary blood flow in Wistar-Kyoto (WKY) rats and spontaneously hypertensive rats (SHR). *Significant difference from control.
FIGURE 3. Plots show comparison of relation between papillary blood flow and renal perfusion pressure in Wistar-Kyoto (WKY) rats and spontaneously hypertensive rats (SHR), before (top panel) and after (bottom panel) the administration of nisoldipine (0.5 μg/kg i.v. bolus plus 0.017 μg/kg/min maintenance infusion).

nisoldipine so that there was no significant difference in this relation in SHR and WKY rats during the experimental period (Figure 3, bottom).

Protocol 2: Renal Interstitial Pressure Measurements

The time course of the effects of nisoldipine on RIHP and arterial pressure in WKY rats and SHR are presented in Figure 4. Nisoldipine lowered mean arterial pressure (from 113±3 to 93±2 mm Hg 30 minutes after the drug) and had no effect on RIHP in WKY rats. Blood pressure also fell after nisoldipine in SHR (from 161±5 to 137±2 mm Hg). However, RIHP increased in SHR from a control value of 3.5±0.6 to a maximum of 5.3±0.6 mm Hg, 30 minutes after the administration of the nisoldipine.

The effects of nisoldipine on the relation between RIHP and renal perfusion pressure in SHR and WKY rats are presented in Figure 5. During the control period, the relation between RIHP and renal perfusion pressure was shifted toward higher pressures in SHR when compared with that seen in WKY rats (Figure 5, top). The slope of the regression line relating RIHP and renal perfusion pressure was significantly greater in WKY rats than in SHR (0.052±0.006 versus 0.019±0.008 mm Hg/mm Hg). After treatment with nisoldipine the relation between RIHP and renal perfusion pressure was reset toward lower pressures in SHR and was not significantly different from this relation in WKY rats given nisoldipine (Figure 5, bottom).

Protocol 3: Clearance Experiments

The results of these experiments are presented in Table 1. Mean arterial pressure fell by 9% and 12% in WKY rats and SHR, respectively, after nisoldipine. GFR and RBF were not significantly altered in either group. In WKY rats, nisoldipine increased sodium and water excretion by 35% and 24%, respectively. However, fractional excretion of sodium and urinary osmolality were not significantly altered. In SHR, urine flow increased 121%, and absolute and fractional excretion of sodium rose by 132% and 110%, respectively, after nisoldipine. The diuretic and natriuretic response observed in SHR was accompanied by a fall in urine osmolality.

Protocol 4: Pressure–Natriuresis Response

The effects of nisoldipine on the pressure–natriuretic relation in SHR are depicted in Figure 6. Control urine flow and sodium excretion measured at their spontaneous level of arterial pressure were not different in SHR and WKY rats and averaged approximately 25 μl/min/g kidney wt and 3.5 μeq/min/g kidney wt, respectively. The relations between urine flow, sodium excretion, and renal perfusion pressure were shifted toward higher pressures in SHR com-
Nisoldipine shifted the relations between urine flow, absolute and fractional excretion of sodium, and renal perfusion pressure toward lower pressures in SHR, so that these relations were similar in SHR given nisoldipine and control WKY rats. At renal perfusion pressures of 150 and 175 mm Hg, fractional sodium excretion averaged 2.18±0.53% and 4.42±1.37% of the filtered load, respectively. At a renal perfusion pressure of 150 mm Hg, fractional sodium excretion was also greater in WKY rats than in SHR, averaging 8.29±1.65% and 2.18±0.53% of the filtered load, respectively.

Discussion
Calcium entry blockers are effective antihypertensive agents that usually lower arterial pressure in the absence of sodium retention. This observation suggests that this class of compounds in some way alters renal function and resets the pressure-natriuretic relation toward lower pressures in hypertension. In this regard, the natriuretic response to calcium antagonists is greater in SHR versus normotensive rats. Since this model of hypertension is characterized by a blunted pressure-natriuretic response, enhanced renal medullary vascular tone, and a shift in the relation between RBF, RIHP, and renal perfusion pressure, it is tempting to speculate that calcium antagonists may selectively reset the pressure-natriuretic response in SHR by reducing the elevated renal medullary vascular resistance and secondarily alter sodium reabsorption by raising renal interstitial pressure. However, very little is known about the effects of calcium channel blockers on the intrarenal distribution of blood flow especially in hypertensive animals.

Figure 5. Plots show comparison of relation between renal interstitial pressure and renal perfusion pressure in spontaneously hypertensive rats (SHR) and Wistar-Kyoto (WKY) rats, before (top panel) and after (bottom panel) the administration of nisoldipine (0.5 µg/kg i.v. bolus plus 0.017 µg/kg/min maintenance infusion).

Figure 6. Plots show comparison of relation between glomerular filtration rate (G.F.R.), urine flow, sodium excretion (UNaV), and renal perfusion pressure in Wistar-Kyoto (WKY) rats and in spontaneously hypertensive rats (SHR) after administration of vehicle or nisoldipine (0.5 µg/kg i.v. bolus plus 0.017 µg/kg/min maintenance infusion). †Significant difference between the treated and the untreated SHR.
However, the calcium antagonist produced a significant change in sodium and water excretion in WKY rats. These observations suggest that this compound selectively blocked the enhanced vasodilator response in the juxtamedullary nephrons of SHR. In addition, nisoldipine shifted the relations between sodium excretion, papillary blood flow, RIHP, and renal perfusion pressure in SHR so that they were not different from those seen in WKY rats. These observations suggest that this compound corrects the defect in vasa recta hemodynamics observed in SHR that we have suggested may be involved in resetting kidney function in this model of genetic hypertension.

Overall, our findings are consistent with those of Abe et al., who reported that calcium entry blockers caused a redistribution of RBF from the outer cortex to the juxtamedullary nephrons in anesthetized dogs. They are also consistent with a recent study showing that chronic administration of enalaprilat, an agent that also increases papillary blood flow, normalizes the pressure-natriuretic response in SHR. Therefore, it is reasonable to propose that changes in renal medullary hemodynamics and resetting of the pressure-natriuretic response may be important in the antihypertensive actions of calcium entry blockers.

In the present study, the relations between sodium excretion, papillary blood flow, RIHP, and renal perfusion pressure were shifted toward higher pressures in SHR, confirming previous reports. The administration of nisoldipine raised papillary blood flow and RIHP in SHR, even though renal perfusion pressure fell. Nisoldipine had little effect on papillary blood flow and RIHP in WKY rats, indicating that this compound selectively blocked the enhanced vascular tone that is present in the juxtamedullary nephrons of SHR. In addition, nisoldipine shifted the relations between sodium excretion, papillary blood flow, RIHP, and renal perfusion pressure in SHR so that they were not different from those seen in WKY rats. These observations suggest that this compound corrects the defect in vasa recta hemodynamics observed in SHR that we have suggested may be involved in resetting kidney function in this model of genetic hypertension.

### Table 1. Effect of Nisoldipine on Renal Function in Spontaneously Hypertensive Rats and Wistar-Kyoto Rats

<table>
<thead>
<tr>
<th>Measurements</th>
<th>WKY</th>
<th>SHR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Period</td>
<td>Control</td>
<td>Nisoldipine</td>
</tr>
<tr>
<td>Mean arterial pressure (mm Hg)</td>
<td>123±2.6</td>
<td>114±1.7*</td>
</tr>
<tr>
<td></td>
<td>123±2.8</td>
<td>111±1.7*</td>
</tr>
<tr>
<td>GFR (ml/min/g kidney wt)</td>
<td>1.0±0.1</td>
<td>1.3±0.1</td>
</tr>
<tr>
<td></td>
<td>1.1±0.9</td>
<td>1.5±0.2</td>
</tr>
<tr>
<td>Renal blood flow (ml/min/g kidney wt)</td>
<td>9.5±2.0</td>
<td>9.5±2.0</td>
</tr>
<tr>
<td></td>
<td>9.2±2.0</td>
<td>9.5±2.0</td>
</tr>
<tr>
<td>Urine flow (µl/min/g kidney wt)</td>
<td>18.3±7.1</td>
<td>24.2±7.8*</td>
</tr>
<tr>
<td></td>
<td>19.3±7.5</td>
<td>22.6±7.1*</td>
</tr>
<tr>
<td>Sodium excretion (µeq/min/g kidney wt)</td>
<td>2.6±1.0</td>
<td>3.7±1.1*</td>
</tr>
<tr>
<td></td>
<td>2.8±1.0</td>
<td>3.6±1.0*</td>
</tr>
<tr>
<td>Fractional sodium excretion (%)</td>
<td>1.6±0.5</td>
<td>1.9±0.5</td>
</tr>
<tr>
<td></td>
<td>1.7±0.6</td>
<td>1.8±0.5</td>
</tr>
<tr>
<td>Urine osmolality (mosm/kg)</td>
<td>1,000±198</td>
<td>868±167</td>
</tr>
<tr>
<td></td>
<td>868±167</td>
<td>887±167</td>
</tr>
</tbody>
</table>

Values are expressed as mean±SEM. WKY, Wistar-Kyoto rats; SHR, spontaneously hypertensive rats; GFR, glomerular filtration rate.

*Significant difference from the control values of the same group.
†Significant difference from the corresponding value in WKY rats.
Previous studies have shown that calcium antagonists can attenuate the autoregulation of RBF and GFR. Impairment of autoregulation of RBF and GFR would be expected to shift the pressure-natriuretic relation to lower pressures and likely contributes to the natriuretic and diuretic actions of these compounds when used therapeutically.

In the present study, the low dose of nisoldipine used did not change the autoregulation of GFR. However, GFR was greater in SHR given nisoldipine than in control SHR (Figure 6), and this contributed to the normalization of the pressure-natriuresis relation in SHR after nisoldipine.

In summary, the present study indicates that nisoldipine normalizes the relations between sodium excretion, renal interstitial pressure, papillary blood flow, and renal perfusion pressure in spontaneously hypertensive rats perhaps by correcting the defect in renal medullary perfusion associated with resetting of pressure-natriuresis in this model of hypertension.

References

Key Words: kidney medulla • kidney concentrating ability • kidney • glomerular function • hemodynamics • flowmeters
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