Does Plasma Immunoreactive Ouabain Originate From the Adrenal Gland?

Kiyoko Naruse, Mitsuhide Naruse, Akiyo Tanabe, Takanobu Yoshimoto, Yasuko Watanabe, Fumihiko Kurimoto, Nobuo Horiba, Masaaki Tamura, Tadashi Inagami, Hiroshi Demura

Abstract

It was reported recently that the endogenous digitalis-like factor ouabain may mainly originate from the adrenal gland. To ascertain the pathophysiological significance of endogenous ouabain and to examine if it originates in the adrenal gland, we determined plasma immunoreactive ouabain levels in patients with various cardiovascular and endocrine diseases. Plasma immunoreactive ouabain levels were also determined in the adrenal venous blood by adrenal venous sampling. Plasma immunoreactive ouabain levels were significantly increased in patients with essential hypertension, primary aldosteronism, Cushing’s syndrome, pheochromocytoma, acromegaly, and chronic renal failure. Plasma immunoreactive ouabain levels were decreased in patients with primary aldosteronism after unilateral adrenalectomy, acromegaly after pituitary adenomectomy, and chronic renal failure after hemodialysis. Plasma immunoreactive ouabain levels in patients after bilateral adrenalectomy were similar to those in healthy subjects. There was no significant step-up of immunoreactive ouabain levels in the adrenal vein from the peripheral vein in three patients, whereas one patient with hypertension and right adrenal tumor but without any known adrenal hormone excess showed higher plasma immunoreactive ouabain levels in the right adrenal vein than those in the peripheral vein. These results suggest an important pathophysiological significance of endogenous ouabain in various cardiovascular and endocrine diseases. It is unlikely that the adrenal gland is a major source of plasma ouabain, although a possible excess production of ouabain by the adrenal tumor remains to be elucidated. (Hypertension. 1994;23[suppl I]:I-102-I-105.)

Key Words: • hypertension, essential • adrenal glands • ouabain • hyperaldosteronism • acromegaly

The presence of an endogenous digitalis-like factor with natriuretic and vasoconstrictive actions has been postulated for some time.1 Recently, Hamlyn et al2 purified the substance from human plasma and identified it to be indistinguishable from ouabain. The endogenous substance was shown to inhibit Na+,K+-ATPase and to have cardiovascular actions.3-4 With the use of an enzyme-linked immunosorbent assay,5 elevated levels of plasma ouabain were shown in patients with congestive heart failure,6 suggesting its important role as a homeostatic factor. In addition, it was also suggested that the adrenal gland is a major source of ouabain.7

To investigate the pathophysiological significance of endogenous ouabain, we determined plasma immunoreactive ouabain in various diseases with abnormalities in blood pressure and/or fluid volume. We further attempted to test the hypothesis that endogenous ouabain originates from the adrenal gland.

Methods

Subjects

Plasma immunoreactive ouabain levels were determined in 17 healthy subjects and patients with various diseases as follows: essential hypertension without (n=42) and with (n=15) antihypertensive agents, primary aldosteronism (n=20), Cushing’s syndrome (n=2), Cushing’s disease after bilateral adrenalectomy (n=2), pheochromocytoma (n=7), acromegaly (n=16), chronic renal failure (without hemodialysis, n=4; with hemodialysis, n=10), and hypertension with adrenal tumor without any known adrenal hormone excess (n=7, patients 1 to 7, Table). Plasma immunoreactive ouabain was determined after unilateral adrenalectomy in patients with primary aldosteronism and pituitary adenomectomy by transsphenoidal surgery in patients with acromegaly, respectively. Blood samples were collected from a peripheral vein between 8:30 and 10 AM after an overnight fast and after 30 minutes of recumbency. In patients under chronic hemodialysis, plasma levels were determined before and after 5 hours of hemodialysis.

Plasma immunoreactive ouabain levels also were determined in the adrenal vein. The adrenal venous sampling was performed for the purpose of diagnosis in patients exhibiting clinical features not typical of primary aldosteronism: small nodules in the right adrenal by computed tomographic (CT) scan (patient 8, 67 years old), no definite adrenal tumor by CT scan (patient 9, 65 years old), and right adrenal tumor (10 mm) by CT scan with a slightly increased ratio of aldosterone to renin in patient 7 (64 years old). All subjects consented to the study after being informed of its nature and purpose. The protocol of the study was approved by the ethics committees of the institutions.

Extraction Procedure

Blood samples collected in chilled tubes containing Na2EDTA (4 mmol/L) were centrifuged at 4°C, and plasma was stored at −70°C until assayed. One milliliter of each plasma was applied on a Sep-Pak C18 cartridge (Waters Associates, Milford, Mass). The adsorbed material was eluted with 3 mL of 75% ethanol, evaporated, lyophilized, dissolved in 300 μL of the assay buffer, and subjected to radioimmunoassay. Recovery of the ouabain (Sigma Chemical Co, St Louis, Mo) added to 1 mL of plasma was approximately 95%. No
immunoreactive digoxin was detected by the commercially available radioimmunoassay kits for digoxin in the plasma extracts of healthy subjects.

**Radioimmunoassay**

Antiserum to ouabain was prepared by the method described previously. In brief, ouabain pretreated with sodium periodate was conjugated to bovine serum albumin (BSA) using cyanoborohydride. Conjugated ouabain was emulsified with Freund's complete adjuvant (Difco) and used for immunizing New Zealand White rabbits. They were boosted with the same amount of the conjugate emulsified with Freund's incomplete adjuvant and bled at 2-week intervals. Although the cross-reactivity of the antiserum obtained was 9.2% with digoxin, that with BSA, rhamnose, hydrocortisone, and aldosterone was less than 0.007%.

The radioimmunoassay incubation mixture consisted of 100 μL of standard ouabain, 100 μL of antiserum (final dilution of 1:10), and 200 μL of the assay buffer (0.1 mol/L phosphate buffer, pH 7.4, containing 0.1% BSA [fraction V, Sigma] and 0.01% NaN₃). After incubation for 15 minutes at 4°C, 100 μL of [21,22-3H]ouabain (approximately 10 000 cpm, Amersham International plc, Buckinghamshire, England) was added and incubated for 30 minutes at 4°C. The antibody-bound and -free tracer ouabain were separated by adding 100 μL each of goat anti-rabbit IgG antiserum (1:25) and normal rabbit serum. The plasma immunoreactive ouabain was further characterized by reversed-phase high-performance liquid chromatography on a Zorbax ODS column (0.46×25 cm, Du Pont, Wilmington, Del) with a linear gradient of acetonitrile in 0.1% trifluoroacetic acid at a rate of 1 mL/min.

The immunoreactive ouabain in plasma samples was composed of a major peak with a retention time corresponding to that of ouabain.

**Statistical Analysis**

Data were analyzed by the Student's t test, Mann-Whitney U test, or Wilcoxon signed rank test, as appropriate. A value of P<.05 was considered statistically significant.

**Results**

Plasma immunoreactive ouabain levels were significantly higher in patients with essential hypertension than those without treatments. There was no significant correlation between plasma immunoreactive ouabain and blood pressure. After unilateral adrenalectomy in primary aldosteronism (P<.01), pituitary adenomectomy in acromegaly (P<.01), and hemodialysis in chronic renal failure (P<.05), plasma immunoreactive ouabain decreased significantly (Fig 2). Plasma immunoreactive ouabain levels in two patients after bilateral adrenalectomy were 30.3 and 31.0 pmol/L, respectively.

Clinical features of seven patients with hypertension and adrenal tumors but without definitive evidence for any excess of adrenal hormones are summarized in the Table. Plasma immunoreactive ouabain levels in six patients did not differ from those of healthy subjects, whereas patient 7 showed an increased plasma level.

In patient 8, plasma immunoreactive ouabain levels in the right adrenal vein were lower than in the left adrenal vein. There was no significant step-up of immunoreactive ouabain levels in the adrenal vein from the inferior vena cava (Fig 3a). The right adrenal, which was surgically removed, contained four small adrenocortical nodules. Also in patient 9, there was no step-up of plasma immunoreactive ouabain levels in the adrenal vein from the inferior vena cava (Fig 3b). Because plasma aldosterone levels in the right adrenal vein were significantly higher than those in the left adrenal vein and the inferior vena cava, whereas there was no significant change in the plasma aldosterone and cortisol levels in either side of the adrenal vein (Fig 3c).
Discussion

Plasma immunoreactive ouabain levels were significantly elevated in patients with various diseases associated with hypertension and/or fluid overload, suggesting an important role in the pathophysiology of the cardiovascular system. Although the plasma levels were significantly lower than the known ED₉₀ value of ouabain in inhibiting Na⁺,K⁺-ATPase activity, details of the source, regulatory mechanism, mode of action, and clearance from the circulation are not known presently. It may act through a paracrine/autocrine mechanism rather than an endocrine mechanism. Therefore, the pathophysiological significance of the plasma immunoreactive ouabain may not be simply discussed only from the plasma level.

One of the critical issues concerning the pathophysiological significance of the endogenous digitalis-like factor is whether digitalis glycosides cause hypertension. Recently, it was demonstrated that chronic infusion of ouabain provokes chronic hypertension in rats. Thus, the increased plasma immunoreactive ouabain levels in essential hypertension suggest that endogenous ouabain may be a causative factor. Interestingly, it was found that plasma immunoreactive ouabain levels were almost normal after therapy. It is therefore suggested that ouabain may be a part of a compensatory mechanism through its natriuretic effect, which in turn elevates the blood pressure.

Increased plasma immunoreactive ouabain levels in acromegaly coincide with a previous finding of a digitalis-like factor. Hypertension is one of the representative features of the disease. The mechanism underlying the hypertension, however, is not known. The increased plasma immunoreactive ouabain can be a candidate for the cause of hypertension. Decrease in the plasma levels after pituitary surgery suggests a pituitary origin of the plasma immunoreactive ouabain. However, no evidence has been available to support the presence of ouabain in the anterior pituitary. In contrast, we have recently shown the presence of immunoreactive ouabain in the hypothalamus, suggesting a hypothalamic origin of endogenous ouabain. It is not known, however, whether the hypothalamic ouabain is released into the circulation, and if so, how the pituitary tumor affects the hypothalamic ouabain. Increased plasma levels also could be a result of a compensatory mechanism for the increased plasma volume in acromegaly and may participate in the hypertension.

Plasma immunoreactive ouabain was significantly elevated and showed a slight but significant decrease after hemodialysis in patients with chronic renal failure. The changes in plasma levels may relate to changes in body volume.

**Fig 1.** Scatterplot shows plasma immunoreactive (Ir-) ouabain levels in patients with various diseases. EH− indicates essential hypertension without antihypertensive agents; EH+, essential hypertension with antihypertensive agents; PA, primary aldosteronism; and CRF, chronic renal failure without hemodialysis.

**Fig 2.** Line plots show changes in plasma immunoreactive (Ir-) ouabain levels before and after unilateral adrenalectomy in patients with primary aldosteronism (a), pituitary adenomectomy in patients with acromegaly (b), and hemodialysis (HD) in patients with chronic renal failure (c).
fluid volume, although possible removal from the circulation by hemodialysis remains to be investigated.

Manunta et al reported that plasma ouabain may originate largely from the adrenal gland. Increased plasma immunoreactive ouabain in primary aldosteronism and the decrease after adrenectomy agree with this hypothesis. However, plasma immunoreactive ouabain in two patients after bilateral adrenectomy was in the normal range. In addition, although possible episodic secretion from the adrenal was not ruled out, there was no definite step-up of plasma immunoreactive ouabain levels in the adrenal vein from levels in the inferior vena cava. Therefore, it is unlikely that the adrenal is a major source.

The same group also reported a new syndrome with elevated plasma ouabain and hypertension secondary to an adrenal tumor/primary adrenobainoma. In the present study, there was no significant increase in plasma immunoreactive ouabain in six patients with hypertension and adrenal tumors. However, in one patient, plasma immunoreactive ouabain was elevated both in the right adrenal and peripheral veins, suggesting the right adrenocortical tumor as a source of ouabain. Therefore, the issue of adrenal primary ouabainoma as a cause of hypertension deserves further investigation.


References

Fig 3. Schematic diagrams show plasma immunoreactive (ir) ouabain levels in the adrenal venous blood obtained by adrenal venous sampling in three patients with hypertension (a, patient 8; b, patient 9; c, patient 7). Sites of blood sampling: (1), right adrenal vein; (2), lower portion of inferior vena cava; (3), upper portion of inferior vena cava; (4), left adrenal vein; and (5), left renal vein. Aldo indicates aldosterone (pmol/L); F., cortisol (nmol/L); and Ob., ouabain (pmol/L).
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