Sodium Intake and Essential Hypertension

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SUMMARY This review briefly considers the hypothesis that a generous dietary sodium intake contributes to the development or maintenance of essential hypertension. Three lines of evidence are presented that are not mutually exclusive. Epidemiological studies examining sodium intake, prevalence of hypertension, and increases of blood pressure with age provide circumstantial support for the concept that hypertension is related to sodium intake. Analyses of cellular electrolyte transport suggest that hypertensives and their relatives are at a disadvantage with respect to extruding sodium from cells. A conceptual framework indicates that blood pressure is determined by a balance between the natriuretic effect of increased blood pressure and the pressor effect of sodium retention.

Clinical studies in humans support the sodium hypothesis. The kidney’s ability to excrete sodium and its sodium regulatory system are genetically determined. In hypertensive humans, blood pressure is directly correlated with total body and exchangeable sodium, a relationship that increases with age. Groups at risk for hypertension excrete sodium less well than those at less risk. Yet both hypertensives and normotensives exhibit heterogeneous blood pressure responses when sodium-loaded or -depleted. It has not been shown that sodium restriction will prevent the development of hypertension in normal individuals; however, it is clear that sodium restriction is an important aspect of management. In three prospective randomized controlled trials, practical sodium restriction lowered blood pressure by 8 mm Hg. Such a decrease would lower cardiovascular morbidity by 10% to 15%. Were means available to detect “salt-sensitive” hypertensives, sodium restriction could be conducted in a more appropriate fashion. (Hypertension 4 (supp III): 111-14—III-19, 1982)

KEY WORDS sodium salt restriction nutrition

A relationship between dietary sodium intake and the development of hypertension has been proposed since antiquity; however, the very notion and its implications continue to engender controversy. Recently the matter has been brought to national public attention by various communications media. Lobbying groups have been formed dedicated to the task of influencing the legislative branch of the federal government to enact laws affecting the sodium content of foods and the labeling of food products. The implications of these activities are considerable. In addition to presenting a major public health issue, the socioeconomic impact of such legislation is great. Thus, it is particularly important that available evidence regarding dietary sodium intake and the development of hypertension be critically examined. Areas in which adequate information is wanting must be identified. Additional research to address specific issues should receive the necessary support. The feasibility of modifying human dietary behavior, and monitoring that behavior, must be addressed. Additional dietary intervention studies examining the sodium-hypertension hypothesis are necessary. Fortunately, the National Institutes of Health recognizes these problems. A task force has identified deficits in the currently available body of knowledge, and support has been earmarked for specific projects; however, current levels of funding will not be enough. Additional support from other sources will be necessary.

Mechanisms Relating Sodium and Hypertension

Evidence relating dietary sodium intake to the development of hypertension is compelling, but largely circumstantial. Comparisons of populations suggest that in unacculturated persons, who ingest a diet very low in sodium and relatively high in potassium, hypertension is much less likely to occur, and blood pressure does not increase with age, as it does in acculturated societies where sodium is ingested in large amounts. Considerable evidence suggests that humans ingest much more sodium than the minimal requirement, although the amount providing maximum well-being is not defined. The homeostatic mechanisms in healthy persons probably require an intake of less than 10 mEq/day. However, attempts to relate blood pressure to sodium intake within given populations have met with little success. Failure to show such a relationship may stem from the fact that the range of sodium intake

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within the population is relatively narrow, or that only a minority of individuals within that population are sensitive to the blood-pressure-raising effects of sodium.6

The available epidemiological studies have been properly criticized.7 The blood pressure measurements were not always standardized.7 The societies often differed vastly in ways other than dietary sodium intake.8 The documentation of dietary sodium intake was often obtained in only a subset of the population examined, or depended on poorly established methodology such as dietary recall, or "spot" urine collections.9

Recently it has been proposed that the blood cells of individuals with essential hypertension, or their normotensive relatives, transport sodium abnormally.10-14 This abnormal transport may promote an intracellular excess of sodium because of net pump underactivity.15 However, current studies reporting both erythrocyte sodium concentration and content have yielded conflicting results. Some investigators have found normal sodium and potassium concentrations,13,16-18 while others have reported elevated sodium concentrations.10,19-21 Certain pumps have been identified that are overactive, perhaps in an attempt to compensate for the underactivity of other pumps.16 These abnormalities, which presumably occur in other cells as well, may result in constriction of vascular smooth muscle and hypertension. Such a notion would explain the increased amounts of sodium found within some smooth muscle cells.12-20 It has been suggested that an inhibitor of sodium transport circulates to facilitate renal sodium excretion at high sodium intake.13,25 Such an inhibitor may be elaborated in response to an as yet unclear renal defect in sodium excretion in patients with essential hypertension.25 In other subjects, a genetically determined deficiency of such a factor may predispose them to increased sodium sensitivity and a greater risk for the development of hypertension.26,27 Thus, an elevated blood pressure would occur in individuals who are genetically susceptible and who indulge in a high sodium intake.

A conceptual framework, which has received considerable attention, maintains that a reduction in the ability of the kidneys to excrete sodium at a given arterial pressure leads to sodium retention. This retention raises blood pressure to the point where sodium balance is restored.28 Increased arterial pressure results in increased urinary sodium excretion.29 In the intact organism, the relationship between arterial pressure and urinary sodium excretion is modulated by numerous homeostatic mechanisms, including the autonomic nervous system, the renin-angiotensin-aldosterone system, the kallikrein-kinin system, and the renal prostanoids.28 The pressure-natriuresis relationship may be modified, or displaced, by changes in these control mechanisms, as well as by changes in renal function.30 An example of the pressure-natriuresis relationship generated in a study of normotensive men is shown in figure 1.31 Alterations in the normal pressure-natriuresis relationship would serve to modify blood pressure in response to changes in sodium intake. Modification of the curve, such as increasing the slope, would indicate an increased dependency of blood pressure on changes in sodium intake. Displacing the entire curve upward, without altering its configuration, would depict a greater arterial pressure for a given sodium intake; however, only modest decreases in blood pressure would occur in response to sodium restriction unless sodium restriction were severe. In this way the entire relationship would be "reset."
These three mechanisms relating sodium and hypertension — namely, dietary sodium, cellular sodium transport, and renal sodium homeostasis — are by no means mutually exclusive, but rather are likely to be interrelated in a complex fashion. Initial mechanisms elevating blood pressure are probably numerous and heterogeneous. However, initiating mechanisms may result in secondary lesions, such as renal disease, which then serve to further elevate blood pressure and augment sensitivity to dietary sodium intake or hamper the ability of the kidney to respond to a sodium load by increasing its excretion.

**Sodium Intake and Sodium Sensitivity**

It is unlikely that a high sodium intake raises the blood pressure of most people. If that were to be the case, blood pressure of persons within a given population should be correlated with their sodium intake, and hypertensive subjects should eat and excrete more sodium than normal subjects. Neither appears to be the case. Alternatively, it is possible that only a susceptible minority within a population will experience an increased blood pressure when exposed to a high sodium intake. Thus, if the range of sodium intake within that population is relatively small, even though the sodium intake itself is large, no correlation between arterial pressure and sodium intake would be found.

Considerable evidence from studies in both hypertensive and normotensive humans supports heterogeneity in sensitivity to sodium intake. In hypertensive patients sodium restriction does not invariably lower blood pressure. The dietary approach advocated by Kempen decreased sodium intake to less than 10 mEq/day. Although Kempen reported dramatic reductions in blood pressure, there were patients whose blood pressures did not decrease. When Kawasaki et al. gave patients with essential hypertension sodium at either 9 or 249 mEq/day, they were able to divide their patients into two distinct groups, a “salt-sensitive” and a “salt-resistant” group. The former group retained more sodium on the high sodium diet than the latter. Similar responses have been observed in hypertensive patients following more modest dietary sodium restriction. While some patients exhibit a decrease in blood pressure others may actually be adversely affected. Adverse effects may be related to stimulation of the renin-angiotensin and sympathetic nervous systems. Potential explanations for these diverse responses are outlined elsewhere.

If dietary sodium intake is responsible for blood pressure elevations in at least some hypertensives, certain changes in body electrolyte composition would be expected. The dietary, cellular, and renal-sodium hypotheses would all predict a correlation between total body sodium and arterial blood pressure, at least in subjects with hypertension. Total body sodium in hypertensives may not necessarily be increased, since the increased arterial pressure may establish a new equilibrium in the presence of a normal total body sodium.

Lever et al. have recently reviewed their elegant and extensive studies of electrolyte composition in normal and hypertensive subjects of different ages. In their hands, total body and exchangeable sodium and potassium were highly correlated ($r = 0.91$ and $r = 0.96$ respectively). They found that total body and exchangeable sodium were positively correlated with blood pressure in hypertensives but not in normal subjects. These correlations were greater for older than for younger patients. Younger patients had exchangeable sodium values less than those of normal subjects. Plasma, exchangeable, and total body potassium were inversely correlated with blood pressure in hypertensives. These correlations were greater in the young patients. Their findings led Lever and associates to conclude that young hypertensives differ from older hypertensives in several important respects. In young hypertensives, blood pressure seems more closely related to potassium than to sodium. A secondary abnormality, such as a renal lesion, develops later, possibly as a consequence of hypertension. This secondary abnormality displaces the pressure-natriuresis relationship, so that the susceptibility to a high dietary sodium intake is increased.

The data of Lever et al support the notion of a variable sensitivity to high sodium intake. The correlation of exchangeable sodium and blood pressure in hypertensives, coupled with the correlation of exchangeable sodium and age in hypertensives, suggests a progressively steeper pressure-natriuresis relationship with age. Moreover, it is possible that more sodium is retained by hypertensives during sodium-loading and is accompanied by arterial pressure changes greater than those that would occur in normotensive individuals. In the sodium-loading experiments illustrated in figure 1, we noted a considerable heterogeneity in response. While some individuals developed an obvious increase in blood pressure at 800 mEq/day sodium intake, others demonstrated no increase in blood pressure, even at 1500 mEq/day sodium intake (fig. 2). When demographic factors such as race were considered, black subjects were noted to exhibit a greater increase in blood pressure than whites. Sodium loading also augmented urinary potassium excretion causing potassium loss by exceeding the dietary intake. When negative potassium balance was avoided (fig. 3), the increases in blood pressure were significantly attenuated. Thus an interaction between potassium and sodium in influencing the blood pressure response to high dietary sodium intake was apparent.

In other experiments we examined the excretory capacity for sodium in three groups of normotensive individuals who exhibit a greater propensity for the development of arterial hypertension than the general population. Blacks, subjects greater than 40 years of age, and first-degree relatives of essential hypertensives were each given a standardized 150 mEq/day sodium diet, and then also received 2 liters of normal saline intravenously over 4 hours. Short-term sodium excretion, during the 4 hours of saline infusion, was not different among the groups. Thus, we did not iden-
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**FIGURE 2.** The heterogeneity of blood pressure responses in 14 normal men exposed to extremes of sodium intake (see ref. 37).

We identified an exaggerated natriuresis, which occurs in certain hypertensives during sodium-loading. As shown in figure 4, the subjects from each of these groups excreted less sodium per 24 hours than did matched control subjects. Moreover, blacks and older subjects excreted proportionately more of their sodium loads at night. Blacks and the older subjects also had lower renin values, as well as an alteration in the normal diurnal variation of creatinine clearance. The first-degree relatives of essential hypertensives, who were relatively young individuals, had higher renin values than controls. We concluded that in blacks and older individuals a renal lesion may develop capable of resetting or modifying the pressure-natriuresis relationship. Such a change would increase the susceptibility to a high dietary sodium intake. In the relatives of hypertensives a different mechanism, perhaps related to the renin-angiotensin system, appeared to be initially operative. However, the data suggest that each of these groups at risk for the development of hypertension excretes sodium in a fashion that may contribute to increased susceptibility to hypertension following a generous dietary intake. Finally, the sodium excretory capacity and its regulatory mechanisms have been shown to be under genetic influences. Since essential hypertension is heritable, it is highly likely that sensitivity to dietary sodium intake is heritable as well.

**Sodium Restriction in Prevention and Treatment**

Dietary intervention in the prevention and treatment of hypertension has considerable appeal. The risks and side effects of drug therapy may be reduced. Sodium restriction may provide a cost advantage, particularly when considering that the size of the population in...
obstacle is developing a dietary program that not only
opposing the disease for susceptible individuals.

Critical studies examining the value of sodium restriction are very difficult to perform. The first major
obstacle is developing a dietary program that not only
achieves the desired sodium restriction, but also gains
long-term patient acceptance. The second is develop-
ing the means of documenting patient compliance. The
latter obstacle requires solution in order to examine the
progress of the former. The problems inherent in estab-
lishing sodium intake are detailed elsewhere. Currently, no investigation has convincingly and simulta-
neously solved both problems.

Proponents of lowering sodium intake in the entire
population are hopeful that the development of hyper-
tension would thereby be prevented. In short-term
studies, it has not been shown that lowering sodium
intake of normal individuals to low levels lowers their
blood pressure. However, even potent antihyperten-
sive drugs may have little or no effect on the blood
pressure of normal subjects. Whitten and Stewart fed
two groups of black infants either 1.93 or 9.25 mEq
Na/100 Kcal for 5 months starting at 3 months of age.
They found no difference in blood pressure at 8 months
of age. Long-term follow-up showed no difference in
blood pressure at 8 years of age. The authors noted a
6% increase in extracellular fluid volume in salt-fed
infants, but no correlation with blood pressure. They
concluded that a sodium intake representing the 99th
percentile of U.S. infants had no hypertensive effect in
infancy, or at 8 years. Nor was there an indication of
salt preference imprinting.

Gillum et al. modified the dietary sodium intake of
80 school children with blood pressures above the 95th
percentile. Sodium intake was lowered from 130 to 87
mEq/day according to periodic dietary records and
urine values. No change in blood pressure was found.
These results do not necessarily mitigate against the
value of sodium restriction, since mechanisms inde-
pendent of sodium may serve to initiate hypertension.

The study of sodium restriction in the treatment of
essential hypertension presents the same problems out-
lined above. Table 1 summarizes the results of three
clinical trials. These trials were specifically select-
ed because each was prospective and the subjects were
randomly assigned to sodium restriction or control
regimens. Two of the studies were of cross-over de-
sic. Two included drug treatment periods or drug-
treated groups, the results of which are not included in
the table. One of the studies was long-term. In each
study the sodium restriction attained was modest. The
degree to which compliance was documented was vari-
able and not altogether convincing in any of the stud-
ies. In the study by Morgan et al., U NaV after inter-
vention exceeded that observed in free-living citizens
of Indiana. Nevertheless, each study demonstrated
that relatively modest sodium restriction in mild hyper-
tensives reduced blood pressure significantly by about
8 mm Hg. This degree of decrease was not different
from that evoked by thiazides alone in the trial of
Morgan et al. Parjis et al. noted a greater blood
pressure decrease with combined diuretic therapy.
Utilizing both strategies decreased blood pressure still
further. In these three controlled trials, no attempt was
made to select individuals who might be particularly
sensitive to sodium restriction. Accordingly the re-
sponses within individuals were variable.

Although the decreases in arterial pressure produced
in these trials appear modest, the results are not to be
belittled. According to the Framingham Study data, a
difference of 8 mm Hg diastolic blood pressure would
produce a change in death rate in the order of 10% to
15%. To attain such a decrease without any defined
risk is a worthy achievement indeed.

Conclusions

Dietary sodium intake is an important issue with
socioeconomic as well as medical ramifications. The
evidence that a high sodium diet increases blood pres-
sure, or aggravates increases in blood pressure of other
causes, is substantial. Current thinking emphasizes the
importance of cellular transmembrane sodium trans-
port, the influence of circulating mediators of sodium
transport, and the role of the kidney and its control
mechanisms. Human studies indicate that not all peo-
ple are at risk from a high sodium intake, and that not
all hypertensives will respond to sodium restriction.
Although sodium-sensitive hypertensives have not
been clearly identified, older individuals and hyperten-
sive black Americans may be in his category. Three
prospective, randomized, and controlled trials indicate
that sodium restriction of a practical degree will de-
crease blood pressure by 8 mm Hg. Such a decrease
could influence cardiovascular morbidity substantial-
lly. Additional controlled trials are needed to identify
sodium-sensitive hypertensive individuals.
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