Role of $K^+$ Channels in the Pathophysiology of Primary Aldosteronism

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Primary aldosteronism (PA) is defined as a group of endocrine disorders in which aldosterone production is inappropriately high, relatively autonomous, and independent of the renin-angiotensin system and extracellular potassium ($K^+$), the major normal aldosterone stimulators, and in which aldosterone secretion is not suppressed by sodium loading. Patients with PA exhibit hypertension, high plasma aldosterone concentration, low plasma renin activity, and varying degrees of hypokalemia and metabolic alkalosis.1 The 2 most common causes of PA are unilateral aldosterone-producing adenoma (APA) and idiopathic hyperaldosteronism (IHA) with bilateral adrenal hyperplasia.

PA is the most common cause of secondary (remediable) hypertension, estimated to occur in \( \approx 8\% \) of the general hypertensive population and in \( \approx 20\% \) of patients with pharmacologically resistant hypertension. Because the cardiovascular morbidity and mortality rates are much higher in PA than in primary (essential) hypertension, intense research efforts have focused on understanding the pathophysiology of these disorders. Although APA, estimated to account for \( \leq 50\% \) of PA, is potentially curable with unilateral laparoscopic adrenalectomy, IHA must be treated with lifelong mineralocorticoid receptor blockers and other antihypertensive agents. For both APA and IHA, an important unresolved question has been, “What drives autonomous adrenal zona glomerulosa (ZG) cell proliferation and the production of aldosterone in these most common forms of PA?”

For IHA, this question is now beginning to be addressed by studies in knockout mice, several of which have been reported as models of PA with bilaterally increased aldosterone production. The first approach has been using TWIK-related acid-sensitive $K$ (TASK) channel knockouts. TASK channels are members of the KCNK family of 2-pore domain/4 transmembrane $K^+$ channels. The channel subunits expressed in the adrenal, TASK-1 and TASK-3, form homodimeric and heterodimeric “leak” channels that provide the background hyperpolarizing conductance important for setting the negative membrane voltage of aldosterone-producing ZG cells.2 Aldosterone production from ZG cells is calcium dependent, and elevation in intracellular free calcium is critical for increased production to occur. Low voltage–activated T-type calcium channels, the major calcium channel of the ZG, are generally closed in the resting state but are available for opening during membrane depolarization. Recent studies have shown that TASK channels are predominant $K$ conductance channels of the ZG cell, serving to clamp the membrane at hyperpolarized voltages, thereby restraining aldosterone production.

In 2008, it was demonstrated that double deletion of the channel subunits (TASK-1 and TASK-3 double knockout mice) produces a \( \approx 20\text{-mV} \) depolarization of ZG plasma membrane potential that permits autonomous overproduction of aldosterone characteristic of the IHA phenotype (Figure).3 TASK-1 and TASK-3 double knockout mice have hypertension, increased urinary aldosterone excretion, decreased plasma renin, increased aldosterone:renin ratio, failure to suppress aldosterone secretion with salt loading, and failure to normalize aldosterone production with angiotensin II type 1 receptor blockade, demonstrating aldosterone autonomy.3 Interestingly, single subunit TASK-1 channel knockout mice have a completely different phenotype resembling human glucocorticoid-remediable PA but not associated with documented membrane depolarization because of presumed concurrent upregulation of TASK-3.4 TASK-3 single subunit knockout mice have yet to be reported.

In addition to TASK channel knockout mice, the deletion in mice of circadian clock genes cryptochrome 1 and 2, which regulate circadian biological activity, also results in PA.5 These animals have increased aldosterone production and salt-sensitive hypertension because of constitutive ZG overexpression of 3-\( \beta \)-hydroxysteroid dehydrogenase isoform 6, which is normally under negative transcriptional control by the circadian clock.6 Whether any of these mouse models of PA with increased bilateral aldosterone production will provide insight into the pathogenesis of human IHA and related disorders awaits further investigation, including association of single nucleotide polymorphisms of the appropriate genes.

For APA, the pathophysiology remained an enigma until 2011, when Choi et al.7 reported that somatic mutations of the gene for KCNJ5, encoding an inwardly rectifying $K^+$ channel expressed in human APAs, induce autonomous adrenal cell proliferation and aldosterone hypersecretion. Inwardly rectifying $K^+$ channels are structurally different from TASK channels. Major pharmacological differences exist between KCNJ5 and TASK channels: KCNJ5 channels are voltage dependent and are activated by G protein-$\beta\gamma$ subunits, whereas TASK channels have open pores, are weakly voltage dependent, and are inhibited by extracellular $H^+$ ions and...
The recent identification of KCNJ5 mutations in the pathophysiology of APA raises a number of intriguing questions. First, why do some patients with these mutations develop bilateral adrenal hyperplasia, whereas the majority develops APAs? Second, why does the common pathway of increased intracellular calcium that results from ZG cell membrane depolarization lead to APA in humans but to IHA with bilateral adrenal hyperplasia in mice? Finally, why do ZG cells become hyperresponsive to angiotensin II in IHA and in some, but not all, patients with APA? Answers to these questions await future research.

During the past 4 years, new discoveries in the molecular biology and genetics of PA have led to greater understanding of the pathogenesis of both IHA and APA. The studies reported here by Azizan et al enrich our knowledge of the role of KCNJ5 in the etiology, phenotypic characteristics, and epidemiology of APA and help refine the modern diagnostic approach to this relatively common and important form of human hypertension.

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Disclosures
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