Catheter-Based Renal Nerve Ablation and Centrally Generated Sympathetic Activity in Difficult-to-Control Hypertensive Patients: Prospective Case Series

Abstract
Endovascular renal nerve ablation has been developed to treat resistant hypertension. In addition to lowering efferent renal sympathetic activation, the intervention may attenuate central sympathetic outflow through decreased renal afferent nerve traffic, as evidenced by a recent case report. We tested the hypothesis in 12 nonpreselected patients with difficult-to-control hypertension (aged 45–74 years) admitted for renal nerve ablation. All patients received ≥3 antihypertensive medications at full doses, including a diuretic. ECG, respiration, brachial and finger arterial blood pressure, and muscle sympathetic nerve activity were recorded before and 3 to 6 months after renal nerve ablation. Heart rate and blood pressure variability were analyzed in the time and frequency domain. Pharmacological baroreflex slopes were determined using the modified Oxford bolus technique. Resting heart rate was 61±3 bpm before and 58±2 bpm after ablation (P=0.4). Supine blood pressure was 157±7/85±4 mm Hg before and 157±6/85±4 mm Hg after ablation (P=1.0). Renal nerve ablation did not change resting muscle sympathetic nerve activity (before, 34±2 bursts per minute; after, 32±3 bursts per minute; P=0.6), heart rate variability, or blood pressure variability. Pharmacological baroreflex control of heart rate and muscle sympathetic nerve activity did not change. We conclude that reduced central sympathetic inhibition may be the exception rather than the rule after renal nerve ablation in unselected patients with difficult-to-control arterial hypertension.

Health-Related Quality of Life After Renal Denervation in Patients With Treatment-Resistant Hypertension

Abstract
Recent studies have demonstrated the effectiveness of radiofrequency ablation of the renal sympathetic nerves in reducing blood pressure (BP) in patients with resistant hypertension. The effect of renal denervation on health-related quality of life (QoL) has not been evaluated. Using the Medical Outcomes Study 36-Item Short-Form Health Survey and Beck Depression Inventory-II, we examined QoL before and 3 months after renal denervation in patients with uncontrolled BP. For baseline comparisons, matched data were extracted from the Australian Diabetes, Obesity, and Lifestyle database. Before renal denervation, patients with resistant hypertension (n=62) scored significantly worse in 5 of the eight 36-Item Short-Form Health Survey domains and the Mental Component Summary score. Three months after denervation (n=40), clinic BP was reduced (change in systolic and diastolic BP, −16±4 and −6±2 mm Hg, respectively; P<0.01). The Mental Component Summary score improved (47.6±1.1 versus 52±1; P=0.001) as a result of increases in the vitality, social function, role emotion, and mental health domains. Beck Depression Inventory scores were also improved, particularly with regard to symptoms of sadness (P=0.01), tiredness (P<0.001), and libido (P<0.01). The magnitude of BP reduction or BP level achieved at 3 months bore no association with the change in QoL. Renal denervation was without a detrimental effect on any elements of the 36-Item Short-Form Health Survey. These results indicate that patients with severe hypertension resistant to therapy present with a marked reduction in subjective QoL. In this pre- and post-hypothesis generating study, several aspects of QoL were improved after renal denervation; however, this was not directly associated with the magnitude of BP reduction.

Hypertension Editors’ Picks
Renal Denervation

The Editors
The following articles are being highlighted as part of Hypertension’s Editors’ Picks series. As most of our readers would be well aware, there has been a significant increase in publications on resistant hypertension and specifically on the therapeutic renal denervation. The number of publications in PubMed has increased from 23 in 2009 to 147 in the first 7 months of 2013 (Figure). We therefore collated for our readers all full-length articles on renal denervation published in our Journal in 2012 and the first half of 2013.
Renal Sympathetic Denervation Suppresses Postapneic Blood Pressure Rises and Atrial Fibrillation in a Model for Sleep Apnea

Abstract

The aim of this study was to identify the relative effect of adrenergic and cholinergic activity on atrial fibrillation (AF) inducibility and blood pressure (BP) in a model for obstructive sleep apnea. Obstructive sleep apnea is associated with sympathovagal disbalance, AF, and postapneic BP rises. Renal denervation (RDN) reduces renal efferent and possibly also afferent sympathetic activity and BP in resistant hypertension. The effects of RDN compared with β-blockade by atenolol on atrial electrophysiological changes, AF inducibility, and BP during obstructive events and on shortening of atrial effective refractory period (AERP) induced by high-frequency stimulation of ganglionated plexi were investigated in 20 anesthetized pigs. Tracheal occlusion with applied negative tracheal pressure (NTP; at −80 mbar) induced pronounced AERP shortening and increased AF inducibility in all the pigs. RDN but not atenolol reduced NTP-induced AF inducibility (20% versus 100% at baseline; \(P = 0.0001\)) and attenuated NTP-induced AERP shortening more than atenolol (27±5 versus 43±3 ms after atenolol; \(P = 0.0272\)). Administration of atropine after RDN or atenolol completely inhibited NTP-induced AERP shortening. AERP shortening induced by high-frequency stimulation of ganglionated plexi was not influenced by RDN, suggesting that changes in the sensitivity of ganglionated plexi do not play a role in the antiarrhythmic effect of RDN. Postapneic BP rise was inhibited by RDN and not modified by atenolol. We showed that vagally mediated NTP-induced AERP shortening is modulated by RDN or atenolol, which emphasizes the importance of autonomic disbalance in obstructive sleep apnea–associated AF. RDN displays antiarrhythmic effects by reducing NTP-induced AERP shortening and inhibits postapneic BP rises associated with obstructive events.

Systemic and Renal-Specific Sympathoinhibition in Obesity Hypertension

Abstract

Chronic pressure–mediated baroreflex activation suppresses renal sympathetic nerve activity. Recent observations indicate that chronic electric activation of the carotid baroreflex produces sustained reductions in the global sympathetic activity and arterial pressure. Thus, we investigated the effects of global and renal-specific suppression of sympathetic activity in dogs with sympathetically mediated, obesity-induced hypertension by comparing the cardiovascular, renal, and neurohormonal responses with chronic baroreflex activation and bilateral surgical renal denervation. After control measurements, the diet was supplemented with beef fat, whereas sodium intake was held constant. After 4 weeks on the high-fat diet, when body weight had increased ≥50%, fat intake was reduced to a level that maintained this body weight. This weight increase was associated with an increase in mean arterial pressure from 100±2 to 117±3 mm Hg and heart rate from 86±3 to 130±4 bpm. The hypertension was associated with a marked increase in cumulative sodium balance despite an ≈35% increase in glomerular filtration rate. The importance of increased tubular reabsorption to sodium retention was further reflected by ≈35% decrease in fractional sodium excretion. Subsequently, both chronic baroreflex activation (7 days) and renal denervation decreased plasma renin activity and abolished the hypertension. However, baroreflex activation also suppressed systemic sympathetic activity and tachycardia and reduced glomerular hyperfiltration while increasing fractional sodium excretion. In contrast, the glomerular filtration rate increased further after renal denervation. Thus, by improving the autonomic control of cardiac function and diminishing glomerular hyperfiltration, suppression of global sympathetic activity by baroreflex activation may have beneficial effects on obesity beyond simply attenuating hypertension.

Renal Hemodynamics and Renal Function After Catheter-Based Renal Sympathetic Denervation in Patients With Resistant Hypertension

Abstract

Increased renal resistive index and urinary albumin excretion are markers of hypertensive end-organ damage and renal vasoconstriction involving increased sympathetic activity. Catheter-based sympathetic renal denervation (RD) offers a new approach to reduce renal sympathetic activity and blood pressure in resistant hypertension. The influence of RD on renal hemodynamics, renal function, and urinary albumin excretion has not been studied. One hundred consecutive patients with resistant hypertension were included in the study: 88 underwent interventional RD and 12 served as controls. Systolic, diastolic, and pulse pressure, as well renal resistive index in interlobar arteries, renal function, and urinary albumin excretion, were measured before and at 3 and 6 months of follow-up. RD reduced systolic, diastolic, and pulse pressure at 3 and 6 months by 22.7/26.6, 7.7/9.7, and 15.1/17.5 mm Hg (\(P < 0.001\)), respectively, without significant changes in the control group. Reduction in systolic blood pressure after 6 months correlated with systolic blood pressure baseline values (\(r = -0.46\); \(P < 0.001\)). There were no renal artery stenoses, dissections, or aneurysms during 6 months of follow-up. Renal resistive index decreased from 0.691±0.01 at baseline to 0.674±0.01 and 0.670±0.01 (\(P = 0.037/0.017\)) at 3- and 6-month follow-up. Mean cystatin C glomerular filtration rate and urinary albumin excretion remained unchanged after RD; however, the number of patients with microalbuminuria or macroalbuminuria decreased. RD reduced blood pressure, renal resistive index, and incidence of albuminuria without adversely affecting glomerular filtration rate or renal artery structure within 6 months and seems to be a safe and effective therapeutic approach to lower blood pressure in patients with resistant hypertension.
**Renal Sympathetic Denervation in Patients With Treatment-Resistant Hypertension After Witnessed Intake of Medication Before Qualifying Ambulatory Blood Pressure**

**Abstract**

It is unknown whether the decline in blood pressure (BP) after renal denervation (RDN) is caused by denervation itself or concomitantly improved drug adherence. We aimed to investigate the BP-lowering effect of RDN in true treatment-resistant hypertension by excluding patients with poor drug adherence. Patients with resistant hypertension (n=18) were referred for a thorough clinical and laboratory workup. Treatment-resistant hypertension was defined as office systolic BP >140 mm Hg, despite maximally tolerated doses of ≥3 antihypertensive drugs, including a diuretic. In addition, ambulatory daytime systolic BP >135 mm Hg was required after witnessed intake of antihypertensive drugs to qualify. RDN (n=6) was performed with the Symplicity Catheter System. The mean office and ambulatory BPs remained unchanged at 1, 3, and 6 months in the 6 patients, whereas there was no known change in antihypertensive medication. Two patients, however, had a fall in both office and ambulatory BPs. Our findings question whether BP falls in response to RDN in patients with true treatment-resistant hypertension. Additional research must aim to verify potential BP-lowering effect and identify a priori responders to RDN before this invasive method can routinely be applied to patients with drug-resistant hypertension.

**Reversal of Genetic Salt-Sensitive Hypertension by Targeted Sympathetic Ablation**

**Abstract**

The sympathetic nervous system plays an important role in some forms of human hypertension and the Dahl salt-sensitive rat model of hypertension; however, the sympathetic targets involved remain unclear. To address this, we examined the role of the renal and splanchnic sympathetic nerves in Dahl hypertension by performing sham surgery (n=10) or targeted sympathetic ablation of the renal nerves (renal denervation; n=11), the splanchnic nerves (celiac ganglionectomy; n=11), or both renal and splanchnic nerves (n=11) in hypertensive Dahl rats. Mean arterial pressure increased from ≈120 mm Hg, while on a 0.1% sodium chloride diet, to ≈140 mm Hg after being fed a 4.0% sodium chloride diet for 3 weeks. At that point, rats underwent sham or targeted sympathetic ablation. Four weeks after treatment, mean arterial pressure was lower in renal-denervated (150.4±10.4) and celiac ganglionectomized (147.0±6.1) rats compared with sham rats (165.0±3.7) and even lower in rats that underwent both ablations (128.4±6.6). There were no differences in heart rate or fluid balance between sham and renal-denervated rats; however, rats that underwent either celiac ganglionectomy or both ablations exhibited marked tachycardia, as well as sodium and water retention after treatment. These data suggest that targeted sympathetic ablation is an effective treatment for established hypertension in the Dahl rat and that the kidneys and the splanchnic vascular bed are both independently important targets of the sympathetic nervous system in this model.

**Translational Examination of Changes in Baroreflex Function After Renal Denervation in Hypertensive Rats and Humans**

**Abstract**

Renal denervation has shown promise in the treatment of resistant hypertension, although the mechanisms underlying the blood pressure (BP) reduction remain unclear. In a translational study of spontaneously hypertensive rats (n=7; surgical denervation) and resistant hypertensive human patients (n=8; 5 men; 33–71 years), we examined the relationship among changes in BP, sympathetic nerve activity, and cardiac and sympathetic baroreflex function after renal denervation. In humans, mean systolic BP (SBP; sphygmomanometry) and muscle sympathetic nerve activity (microneurography) were unchanged at 1 and 6 months after renal denervation (P<0.05). Interestingly, 4 of the 8 patients showed a 10% decrease in SBP at 6 months, but sympathetic activity did not necessarily change in parallel with SBP. In contrast, all rats showed significant and immediate decreases in telemetric SBP and lumbar sympathetic activity (P<0.05) 7 days after denervation. Despite no change in SBP, human cardiac and sympathetic baroreflex function (sequence and threshold techniques) showed improvements at 1 and 6 months after denervation, particularly through increased sympathetic baroreflex sensitivity to falling BP. This was mirrored in spontaneously hypertensive rats; cardiac and sympathetic baroreflex sensitivity (spontaneous sequence and the Oxford technique) improved 7 days after denervation. The more consistent results in rats may be because of a more complete (>90% reduction in renal norepinephrine content) denervation. We conclude that (1) renal denervation improves BP in some patients, but sympathetic activity does not always change in parallel, and (2) baroreflex sensitivity is consistently improved in animals and humans even when SBP has not decreased. Determining procedural success will be crucial in advancing this treatment modality.
Abstract
Renal denervation (RDN) has been shown to reduce blood pressure (BP) and muscle sympathetic nerve activity (MSNA) in patients with resistant hypertension. We examined whether RDN differentially influences the sympathetic discharge pattern of vasoconstrictor neurons in patients with resistant hypertension. Standardized office BP, single-unit MSNA, and multiunit MSNA were obtained at baseline and at 3-month follow-up in 35 patients with resistant hypertension. Twenty-five patients underwent RDN, and 10 patients underwent repeated measurements without RDN (non-RDN). Baseline BP averaged 164±93 mmHg (RDN) and 164±87 mmHg (non-RDN) despite use of an average of 4.8±0.4 and 4.4±0.5 antihypertensive drugs, respectively. Mean office BP decreased significantly by −13±6 mmHg for systolic BP (P<0.001) and diastolic BP (P<0.05) in RDN but not in non-RDN at 3-month follow-up. RDN moderately decreased multiunit MSNA (79±3 versus 73±4 bursts/100 heartbeats; P<0.05), whereas all properties of single-unit MSNA, including firing rates of individual vasoconstrictor fibers (43±5 versus 27±3 spikes/100 heartbeats; P<0.01), firing probability (30±2 versus 22±2% per heartbeat; P<0.02), and multiple firing incidence of single units within a cardiac cycle (8±1 versus 4±1% per heartbeat; P<0.05), were substantially reduced at follow-up. BP, single-unit MSNA, and multiunit MSNA remained unaltered in the non-RDN cohort at follow-up. RDN results in the substantial and rapid reduction in firing properties of single sympathetic vasoconstrictor fibers, this being more pronounced than multiunit MSNA inhibition. Whether the earlier changes in single-unit firing patterns may predict long-term BP response to RDN warrants further exploration.
Renal Denervation: Ultima Ratio or Standard in Treatment-Resistant Hypertension

Abstract

Depending on studied populations and applied definitions, the prevalence of treatment-resistant hypertension varies from 10% to 15% but is higher in conditions associated with increased sympathetic drive, such as obesity, obstructive sleep apnea, diabetes mellitus, or renal dysfunction. The SYMPLICITY studies recently demonstrated that reducing sympathetic tone by intravascular renal denervation (IRD) is feasible in resistant hypertension but did not provide conclusive evidence on the size and durability of the antihypertensive, renal, and sympatholytic effects, long-term safety, quality of life, the possibility to relax antihypertensive drug treatment, cost-effectiveness, and benefit in terms of long-term hard cardiovascular-renal outcomes. At the time of writing of this report, 28 IRD trials in various indications were registered at http://www.clinicaltrials.gov, but only 7 had a randomized controlled design. In the United States, IRD remains an investigational procedure that cannot be used in clinical practice, but in Europe, CE-label certification of electric safety permits to market catheter systems to any interventional facility for regular clinical use. IRD should not be routinely applied as a substitute for regular clinical use. IRD should only be offered within a clinical research context at highly skilled tertiary referral centers that participate in international registries constructed, independent of the manufacturers.

References

Hypertension Editors' Picks: Renal Denervation
The Editors

Hypertension. 2013;62:e26-e30; originally published online October 7, 2013;
doi: 10.1161/HYPERTENSIONAHA.113.02348

Hypertension is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
Copyright © 2013 American Heart Association, Inc. All rights reserved.
Print ISSN: 0194-911X. Online ISSN: 1524-4563

The online version of this article, along with updated information and services, is located on the
World Wide Web at:
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