Altered Release of Cytochrome P450 Metabolites of Arachidonic Acid in Renovascular Disease

Pietro Minuz, Houli Jiang, Cristiano Fava, Lucia Turolo, Stefania Tacconelli, Marco Ricci, Paola Patrignani, Alberto Morganti, Alessandro Lechi, John C. McGiff

Abstract—The aim of the present cross-sectional study was to investigate whether activation of the renin-angiotensin system in renovascular disease affects the cytochrome P450 \( \omega \omega \)-1 hydroxylation (20-hydroxyeicosatetraenoic acid [20-HETE]) and epoxidegenase (epoxyeicosatrienoic acids [EETs]) pathways of arachidonic acid metabolism in vivo, each of which interacts with angiotensin II. Plasma concentration and urinary excretion of 20-HETE and EETs and their metabolites, dihydroxyeicosatrienoic acids, were measured in urine and plasma by mass spectrometry in 10 subjects with renovascular disease, 10 with essential hypertension, and 10 healthy normotensive subjects (control subjects), pair-matched for gender and age. Vascular and renal function were evaluated in all of the subjects. Plasma 20-HETE was highest in subjects with renovascular disease (median: 1.20 ng/mL; range: 0.42 to 1.92 ng/mL) compared with subjects with essential hypertension (median: 0.90 ng/mL; range: 0.40 to 2.17 ng/mL) and control subjects (median: 0.45 ng/mL; range: 0.14 to 1.70 ng/mL; \( P < 0.05 \)). Plasma 20-HETE significantly correlated with plasma renin activity in renovascular disease (\( r = 0.67; n = 10; P < 0.05 \)). The urinary excretion of 20-HETE was significantly lower in subjects with renovascular disease (median: 12.9 \( \mu \)g/g of creatinine; range: 4.4 to 24.9 \( \mu \)g/g of creatinine) than in control subjects (median: 31.0 \( \mu \)g/g of creatinine; range: 11.9 to 102.8 \( \mu \)g/g of creatinine; \( P < 0.01 \)) and essential hypertensive subjects (median: 35.9 \( \mu \)g/g of creatinine; range: 14.0 to 72.5 \( \mu \)g/g of creatinine; \( P < 0.05 \)). Total plasma EETs were lowest, as was the ratio of plasma EETs to plasma dihydroxyeicosatrienoic acids, an index of epoxide hydrolyase activity, in renovascular disease (range: 2.4; range: 1.2 to 6.1) compared with essential hypertension (range: 3.4; range: 1.5 to 5.6) and control subjects (range: 6.8; range: 1.4 to 18.8; \( P < 0.01 \)). In conclusion, circulating levels of 20-HETE are increased and those of EETs are decreased in renovascular disease, whereas the urinary excretion of 20-HETE is reduced. Altered cytochrome P450 arachidonic acid metabolism may contribute to the vascular and tubular abnormalities of renovascular disease. (Hypertension. 2008;51:1-7.)

Key Words: eicosanoids  ▪  20-HETE  ▪  EETs  ▪  DHETs  ▪  renal artery stenosis  ▪  hypertension  ▪  angiotensin II

In the past 2 decades, the view that the cytochrome P450 (CYP) monooxygenase pathway of arachidonic acid (AA) metabolism affects blood pressure and contributes to the development of hypertension is supported by studies in several experimental models.\(^1\)\(^2\) However, little information is available on possible contributions of CYP products to essential hypertension (EH) and human renal vascular hypertension.\(^3\) The role of angiotensin II (Ang II) in the development of hypertension and ischemic nephropathy in the experimental model of the 2-kidney 1-clip hypertension is evident, because a fall in renal perfusion pressure triggers renin release. Vasoconstriction, vascular remodeling, glomerulosclerosis, and interstitial matrix deposition implicate an array of mediators that operate downstream from Ang II.\(^4\) CYP monooxygenases are expressed in the renal vasculature and nephron,\(^5\) generating primarily 20-hydroxyeicosatetraenoic acid (20-HETE) by \( \omega \omega \)- and \( \omega \)-1 hydroxylation and 5,6-, 8,9-, 11,12-, and 14,15-epoxyeicosatrienoic acids (EETs) by epoxidegenases. The several individual isozymes that produce 20-HETE and EETs are independently regulated. For example, the rat 2C23 epoxidegenase isozyme responds to a salt load by increasing expression and activity to augment synthesis of antipressor EETs.\(^6\) 20-HETE exhibits both pressor and antipressor activities.\(^7\)\(^8\) 20-HETE mediates renal circulatory autoregulation\(^9\) and contributes to pressure natriuresis.\(^10\) One or more EETs may serve as endothelial-derived hyperpolarizing factors.\(^11\)\(^12\) EETs are metabolized rapidly by epoxide hydrolases to dihydroxyeicosatrienoic acid in renovascular disease.
acids (DHETs), which are generally viewed as biologically inactive with a few exceptions.\textsuperscript{13} Inhibition of soluble epoxide hydrolase (sEH) produces increased EETs with decreased blood pressure in experimental and genetic hypertension in rats.\textsuperscript{14–16}

Ang II stimulates 20-HETE synthesis in renal microvessels\textsuperscript{2,17} and decreases EET levels by downregulating epoxygenases and increasing their degradation by increasing expression and activity of sEH.\textsuperscript{18,19} These studies provide the rationale to the hypothesis that occasioned the present study; namely, metabolism of AA via CYP monooxygenases is altered in renovascular disease (RVD). To assess whether altered generation of eicosanoids derived from CYP AA metabolism occurs with activation of the renin-angiotensin system, we set up a cross-sectional study to measure 20-HETE, EET, and DHET levels in plasma and urine by paired analyses in hypertensive subjects with RVD that were compared with these levels in normotensive control subjects and those with EH.

Materials and Methods

Subjects

Three groups of subjects, pair-matched for gender and age, were studied: patients with RVD (n = 10), patients with EH (n = 10), and normotensive subjects (n = 10). Hypertensive patients were recruited among those admitted to the hypertension unit of the Department of Internal Medicine, University Hospital of Verona. Diagnosis of RVD was based on angiographic evidence of severe stenosis (exceeding 70% of the lumen diameter) of a renal artery in hypertensive patients.\textsuperscript{20} All of the subjects with RVD and EH were on antihypertensive treatment to normalize blood pressure. Those drugs, having a direct effect on the activity of the renin-angiotensin system, angiotensin-converting enzyme inhibitors, and Ang II type 1 receptor antagonists, were withdrawn \(\geq 2\) months before the study.

For a detailed description of selection and exclusion criteria, as well as clinical characteristics of patients and control subjects, please see the data supplement available at http://hyper.ahajournals.org.

Study Protocol

The protocol consisted of clinical evaluation, blood pressure measurement, analysis of endothelial function and vascular profile, and blood and urine sampling. Both patients with RVD and EH were hospitalized during the study and received a diet containing \(\geq 150\) mmol of sodium per day.

The urinary excretion of eicosanoids was evaluated from overnight urine collections (from 8 PM to 8 AM). The timing and total volume were recorded, and the samples (2 mL) of urine were stored at \(\sim 80^\circ\mathrm{C}\) for the assay of derivates of AA by CYP metabolism after the addition of deuterated 20-HETE (Cayman Chemical Co), DHET, 8,9-EET, 11,12-EET, and 14,15-EET (Biomol) as internal standards. Free eicosanoids were directly extracted with 2 mL of ethyl acetate.

Measurements of Eicosanoids

Free eicosanoids were directly extracted with 2 mL of ethyl acetate twice from plasma samples (0.4 mL) after adding internal standards (DHET-d8 4.8 ng, 20-HETE-d6 4 ng, and EET-d8 12 ng) and acidified to \(\mathrm{pH}\) 4 with acetic acid. For analysis of total eicosanoids, plasma was extracted with 2 mL of CHCl\(_3\)/CH\(_3\)OH (2:1) containing 0.1 mmol/L of triphenylphosphine as an antioxidant according to the method of Karara et al.\textsuperscript{21} After frequent vortexing for 30 minutes, the mixtures were centrifuged at 2000g for 10 minutes, and the chloroform layer was transferred to another tube, dried under gentle nitrogen blow, and subjected to hydrolysis using 1 mL of 1 mol/L sodium hydroxide at room temperature for 90 minutes. The reaction mixtures were adjusted to \(\mathrm{pH}\) 4 with 1 mol/L HCl and extracted with 2 mL of ethyl acetate twice.

The urine samples (2 mL each) with internal standards added were first incubated with 0.2 mg of \(\beta\)-glucuronidase from Escherichia coli (in 0.075 mol/L of potassium phosphate buffer [\(\mathrm{pH}\) 6.8]) containing 1 g/L of BSA for 2 hours at 37°C, and the samples were then acidified to \(\mathrm{pH}\) 6 with 10% acetic acid.\textsuperscript{22} The treated urine samples were applied to preconditioned Bond Elut-Certify II columns (Varian), washed with 2 mL of methanol/water (1:1), and then collected with 2 mL of hexane/ethyl acetate/acetic acid (75:25:1) for eicosanoid analysis.

The combined ethyl acetate extracts for each sample were dried and dissolved in methanol for high-performance liquid chromatography separation and gas chromatography/mass spectrometry analyses as described.\textsuperscript{23} The ions \(m/z\) of 319 and 327 were monitored for endogenous and deuterium (d8)-labeled EETs; the ions \(m/z\) of 391 and 397 were monitored for 20-HETE, and the ions \(m/z\) of 481 and 489 were monitored for DHETs. The amounts of eicosanoids were calculated from their peak area ratios according to standard curves, respectively. Three plasma samples of each group were analyzed by liquid chromatography/mass spectrometry to estimate the EET composition as described.\textsuperscript{25}

Statistical Analysis

The Kruskall-Wallis test was used to compare variables in the 3 groups of subjects. The Dunn test was applied to posthoc pairwise comparisons. The Fisher’s exact test was also applied when appropriate. Spearman coefficient (\(r_s\)) was calculated to quantify correlation between variables. \(P<0.05\) was considered statistically significant. Data are expressed as the median and range in the text and as individual values in the figure, unless differently indicated.

Results

The baseline characteristics of the 3 groups of subjects are detailed in Table S1. No statistically significant differences were observed in lipid profile, plasma glucose, and inflammatory markers displayed in Table S1. Systolic and diastolic blood pressures were not different in the 3 groups of subjects; neither were the hemodynamic and vascular profiles shown in
Table S2, except for plaques of the internal carotid arteries, more frequently observed in RVD.

Hypertensive subjects with RVD differed significantly from EH and control subjects in having a higher plasma creatinine (RVD: 109.17 µmol/L; range: 71.6 to 163.5 µmol/L; EH: 80.8 µmol/L; range: 52.1 to 95.4 µmol/L; control subjects: 67.6 µmol/L; range: 60.0 to 102.5 µmol/L; P<0.05, RVD versus control subjects) and a lower creatinine clearance (RVD: 50.1 mL/min; range: 29.3 to 168.7 mL/min; EH: 79.9 mL/min; range: 51.5 to 134.5 mL/min; control subjects: 84.8 mL/min; range: 42.0 to 170.3 mL/min; P<0.05, RVD versus control subjects; Table S1). PRA was not significantly different in the 3 groups and was not significantly lower in RVD and EH patients receiving β-blockers than in patients receiving other antihypertensive drugs. However, PRA exceeded 0.5 ng/mL per hour in 6 subjects with RVD but only in 2 with EH and 1 normotensive subject.

Plasma and urinary levels of 20-HETE were significantly different among the 3 groups; subjects with RVD demonstrated the highest plasma and the lowest urinary values of 20-HETE (Figure 1A and 1B). Plasma 20-HETE in control subjects was 2- to 3-fold higher. The urinary excretion of 20-HETE was reduced in patients with RVD but only in 2 with EH and 1 normotensive subject.

Plasma EET concentrations were significantly correlated with hypertensive status (r=0.41; P=0.026; Figure 2A): the lowest value occurred in subjects with RVD (7.39 ng/mL) and the highest in control subjects (60.60 ng/mL). An estimation of the relative total epoxygenase activity of the 3 groups tested is available by obtaining the sum of plasma EETs+DHETs for each group, which was also significantly correlated with hypertensive status; viz, control 32.5; EH 30.4; and RVD 18 ng/mL plasma (r=0.39; P=0.035; Figure 2C). The measurements of plasma EETs in control and RVD subjects reflect total EETs, ie, free and esterified. Plasma-free EETs were low, accounting for ≤3% of the total according to Karara et al,23 which is in agreement with our findings, because these low levels of EETs were usually below the level of detection (0.5 ng/mL plasma) by gas chromatography/mass spectrometry in control and RVD subjects. The exception was the EH group, which exhibited plasma levels of free EETs between 0.9 and 10 ng/mL of plasma (4.7±1.1 ng/mL of plasma, mean±SD), perhaps reflecting the reported increase in activity of plasma phospholipase A₂ in hypertensive rats.27

Three plasma samples from each group were analyzed by liquid chromatography/mass spectrometry to detect regioisomeric composition of EETs. This analysis failed to discern differences among the 3 groups in their regioisomeric composition; the 14,15-EET predominated and the 11,12-EET was least. The average levels of 14,15-, 11,12-, and 8,9-EETs in the control subjects were 3.9±0.9, 2.0±0.9, and 4.7±1.3 ng/mL, respectively. In EH subjects, the average values were 3.7±0.6, 1.6±0.4, and 4.1±0.2 ng/mL, and in RVD subjects, 3.3±0.4, 0.6±0.1, and 2.4±0.7 ng/mL. The levels of 5,6-EET cannot be accurately estimated because of its lability.

Plasma concentrations of DHET, a major metabolite of EETs, were not significantly different in the 3 groups of subjects (Figure 2B). The ratio of plasma EETs/plasma DHETs provides an index of the activity of sEH. When the ratio is decreased (Figure 2D), metabolism of EETs is increased, a factor contributing to elevation of blood pressure.15,28 The lowest ratio occurred in subjects with RVD, whereas that of control subjects was 3-fold greater. EETs...
were undetectable in the urine of almost all of the samples (only 3 samples contained 0.05 to 0.25 ng/mL of EETs), whereas excretion of DHETs was similar in the 3 groups (RVD: 0.07 µg/h; range: 0.02 to 0.22; EH: 0.07 µg/h; range: 0.02 to 0.15 µg/h; control: 0.06 µg/h; range: 0.03 to 0.16 µg/h; please see Figure S1E).

A statistically significant positive correlation between plasma 20-HETE and PRA was observed within the group of patients with RVD, as well as the whole study population (Figure 3). Plasma 20-HETE and plasma DHETs were positively correlated only when all of the subjects were included ($r_s=0.538; P=0.002$; please see Figure S2). Similarly, a positive correlation was observed between plasma 20-HETE and plasma concentration of homocysteine ($r_s=0.503; P=0.005$) and creatinine ($r_s=0.460; P<0.02$).

**Discussion**

The present study identified differences between subjects with RVD and those with either EH or normal blood pressure (control subjects) in terms of disparities between the 2 groups in their plasma levels and urinary excretion of EETs and 20-HETE and metabolism of EETs to DHETs. Subjects with RVD exhibited increased plasma 20-HETEs, reduced excretion of 20-HETE, decreased plasma EETs, and increased plasma DHETs. The present study does not offer proof of a causal role of these CYP-derived eicosanoid abnormalities in the development of RVD and hypertension. However, because EETs and 20-HETE are essential components of renal vascular and transport mechanisms that regulate blood pressure, their alterations in RVD can be conditionally linked to elevation of blood pressure, as the following analysis will attempt to disclose.

Although PRA decreases soon after the development of renal artery stenosis, Ang II still represents a primary stimulus via activation of Ang II type 1 receptor for the release of a number of bioactive compounds, including aldosterone, endothelin, and eicosanoids, that inden-
ently contribute to vasoconstriction, salt and water retention, vascular remodeling, renal fibrosis, and the decline in glomerular filtration rate that ultimately determines the progression of the disease. Furthermore, studies on 2-kidney, 1-clip renovascular hypertension in rats have shown that blocking the renin-angiotensin system prevented hypertension indefinitely. In the present study, PRA correlated positively with plasma levels of 20-HETE in subjects with RVD (Figure 3). Ang II can activate the release of renal 20-HETE by stimulating the synthesis of 20-HETE at critical sites in the kidney: the glomerular microvessels that determine renovascular resistance\(^7\),\(^8\),\(^17\),\(^32\) and a nephron segment, the medullary thick ascending limb, that contributes decisively to salt and water balance.\(^29\) The pressor response to increases in circulating Ang II can be attenuated by inhibition of 20-HETE synthesis.\(^7\) Furthermore, overexpression of an \(\omega\)-hydroxylase isozyme, which increased the production of 20-HETE in blood vessels, caused endothelial dysfunction.\(^13\)

Either deficient or excessive renal production of 20-HETE was reported to elevate blood pressure. In the spontaneously hypertensive rat, increased renal 20-HETE contributes to elevation of blood pressure,\(^34\) whereas in the salt-sensitive Dahl rat, reduced 20-HETE synthesis also elevates blood pressure.\(^35\) The prohypertensive effects of either increased or decreased renal 20-HETE production depend on the principal site, either a nephron segment such as the TAL (decreased 20-HETE) or renal microvessels (increased 20-HETE) as the afferent arteriole,\(^29\) that exhibits altered synthesis of 20-HETE. Increased synthesis of 20-HETE by glomerular microvessels elevates renovascular resistance, reducing intravascular pressures in the medullary circulation, promoting movement of fluid into the vasa rectae with expansion of extracellular fluid volume and elevation of blood pressure.\(^36\)

By way of contrast, 20-HETE, which inhibits Na\(^+\)-K\(^+\)-2Cl\(^-\) cotransporter activity in the TAL,\(^35\) will promote Na\(^+\) reabsorption and elevate blood pressure when deficient, as in the Dahl salt-sensitive rat.\(^38\) The 4 isozymes of \(\omega\)-hydroxylase that synthesize 20-HETE\(^39\) are differentially localized in the kidney and individually regulated, eg, the 4A8 isozyme is regulated by testosterone.\(^40\) In addition, catalytic activities of the individual \(\omega\)- and \(\omega\)-1-hydroxylase isozymes vary by as much as 40-fold.\(^29\)

Decreased urinary concentration of 20-HETE (Figure 1B), associated with RVD, may reflect diminished 20-HETE production by nephron segments, the TAL and proximal tubules. As 20-HETE functions in these segments to inhibit Na\(^+\) reabsorption and elevate blood pressure when deficient, as in the Dahl salt-sensitive rat.\(^38\) The elevated plasma concentrations of 20-HETE in RVD occurred with decreased urinary excretion of 20-HETE (Figure 1A through 1C) and probably reflects the multiple pathways for disposition of 20-HETE, namely, incorporation of 20-HETE into phospholipids, \(\omega\)- and \(\beta\)-oxidation, and transformation of 20-HETE via cyclooxygenase into prostaglandin analogs.\(^31\),\(^42\) In addition, separate sites of origin, vasculature and renal tubules, can account for differences in plasma and urinary levels of 20-HETE. In humans, 20-HETE is excreted primarily as a glucuronide conjugate,\(^43\) as we have confirmed in the present study. This pathway of 20-HETE excretion was not found in the rat but is greatly increased in human hepatic cirrhosis.\(^44\)

EETs in blood are primarily acylated at the sn2 position of phospholipids and capable of being released by phospholipase A\(_2\).\(^23\) EETs are avidly incorporated into cellular phospholipids and “released at rates exceeding those for arachidonic acid.”\(^45\) Endothelial cells are a major site of EET incorporation, a process greatly enhanced by preventing hydrolysis of EETs by sEH,\(^13\) because DHETs show negligible incorporation into phospholipids.\(^45\) Thus, high levels of unbound EETs in the endothelium\(^13\) presumably will increase circulating EETs that are mainly esterified in the phospholipids of circulating lipoproteins\(^53\) (Figure 2A).

Plasma concentrations of DHETs are lowest in control subjects (Figure 2B), presumably reflecting decreased activity of sEH contributing to the elevated plasma concentrations of EETs in control subjects (Figure 2A). Vascular-free EETs can be increased by release from endothelial phospholipids; eg, bradykinin stimulates phospholipase activity to increase unbound EETs that exert antipressor effects by relaxing vascular smooth muscle.\(^46\) On the other hand, the low levels of tissue/plasma EET concentrations in RVD may result from Ang II upregulating vascular endothelial sEH activity.\(^19\) Diminished EET levels will augment 20-HETE vasoconstrictor activity, because 11,12-EET functions as a physiological antagonist of 20-HETE.\(^47\) Deficiency of 11,12-EET has also been linked to salt-sensitive hypertension, because 11,12-EET inhibits the epithelial sodium channel in the rat collecting duct.\(^48\) Moreover, impairment of 11,12-EET synthesis in mice produced by disruption of the gene controlling EET synthase caused salt-sensitive hypertension.\(^49\)

Perspectives

This study supports the hypothesis that CYP-dependent AA metabolism is altered by RVD. Decline in the urinary excretion of 20-HETE in RVD (Figure 2C) was suggested to reflect decreased 20-HETE production by the TAL and proximal tubules that may contribute to increased Na\(^+\) reabsorption in these tubular segments.\(^37\) Circulating 20-HETE was positively correlated with PRA in RVD (Figure 3) and may contribute to elevation of blood pressure by increasing vasomotion and enhancing vascular reactivity.\(^29\) Circulating EETs incorporated into phospholipids achieved plasma concentrations 2- to 3-fold higher in control subjects than in those with RVD (Figure 2A) and serve as sources of unbound EETs mobilized by vasoactive hormones to dilate blood vessels.\(^13\) Finally, the reduced ratio of plasma EETs: DHETs (Figure 2C) in RVD and EH subjects; vis a vis control subjects, suggests increased sEH activity that will reduce EET levels and, thereby, decrease antipressor activity in RVD and EH (Figure 2A). In conclusion, the present study sets the stage for further studies to address the involvement of the CYP pathway in primary and secondary forms of hypertension.

Acknowledgments

We thank Angela G. Zha, Magdalena Mamczur, and Maurizio Degan for their technical support in eicosanoid analyses and Gail Anderson for preparation of the article.
Sources of Funding
This study was supported by grants from the Italian Ministry of the University and Scientific Research (cofinanziamento 60%; to P.M. and A.L.), Philip Morris USA Inc and Philip Morris International (to H.J.), National Institutes of Health program project grant 34300 (to J.C.M.) and HL-25394 (to J.C.M.), and European Community’s Sixth Framework Program (Eicosanox, LSMH-CT-2004-005033; to P.P.).

Disclosures
None.

References


Altered Release of Cytochrome P450 Metabolites of Arachidonic Acid in Renovascular Disease

Pietro Minuz, Houli Jiang, Cristiano Fava, Lucia Turolo, Stefania Tacconelli, Marco Ricci, Paola Patrignani, Alberto Morganti, Alessandro Lechi and John C. McGiff

Hypertension. published online March 31, 2008;
Hypertension is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
Copyright © 2008 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:
http://hyper.ahajournals.org/content/early/2008/03/31/HYPERTENSIONAHA.107.105395.citation

Data Supplement (unedited) at:
http://hyper.ahajournals.org/content/suppl/2008/03/26/HYPERTENSIONAHA.107.105395.DC1

Permissions: Requests for permissions to reproduce figures, tables, or portions of articles originally published in Hypertension can be obtained via RightsLink, a service of the Copyright Clearance Center, not the Editorial Office. Once the online version of the published article for which permission is being requested is located, click Request Permissions in the middle column of the Web page under Services. Further information about this process is available in the Permissions and Rights Question and Answer document.

Reprints: Information about reprints can be found online at:
http://www.lww.com/reprints

Subscriptions: Information about subscribing to Hypertension is online at:
http://hyper.ahajournals.org//subscriptions/
ALTERED RELEASE OF CYTOCHROME P450 METABOLITES OF ARACHIDONIC ACID IN RENOVASCULAR DISEASE.

Pietro Minuz, MD¹, Houli Jiang, MD, PhD²*, Cristiano Fava, MD¹*, Lucia Turolo, BS³, Stefania Tacconelli, PhD⁴, Marco Ricci, MD¹, Paola Patrignani, PhD⁴, Alberto Morganti, MD³, Alessandro Lechi, MD¹ and John C McGiff, MD².

* These two authors equally contributed to the study

¹Department of Biomedical and Surgical Sciences, University of Verona, Italy; ²Department of Pharmacology, New York Medical College, Valhalla, NY; ³Cattedra di Medicina Interna and Centro Ipertensione Arteriosa, University of Milan, Milan, Italy and ⁴Department of Medicine and Center of Excellence on Aging, CeSI, “G. d’Annunzio” University, School of Medicine, Chieti, Italy.

Short title: CYTOCHROME P450 METABOLITES IN RENOVASCULAR DISEASE

Corresponding Author

Pietro Minuz, MD
Department of Biomedical and Surgical Sciences
Medicina Interna C, Policlinico GB Rossi
University of Verona
37134 Verona, Italy
Tel: +39-045-812-4414
E-mail: pietro.minuz@univr.it
MATERIALS AND METHODS

Clinical characteristics of patients and control subjects. Selection and exclusion criteria.

Three groups of subjects, pair-matched for gender and age, were studied in patients with renovascular disease (RVD) (n=10), patients with essential hypertension (EH) (n=10), and normotensive subjects (C) (n=10). Hypertensive patients were recruited among those admitted to the Hypertension Unit of the Department of Internal Medicine, University Hospital of Verona. Diagnosis of RVD was based on angiographic evidence of severe stenosis (exceeding 70% of the lumen diameter) of a renal artery in hypertensive patients. The diagnosis of RVD with hypertension was supported by positive renal scintigraphy and magnetic resonance angiography of the renal arteries and then confirmed by percutaneous renal artery angiography.

Angiography revealed the presence of significant stenosis of a single renal artery related to atherosclerotic plaques in 8 patients (aged 60 to 85 years) and fibromuscular dysplasia in the remaining two male patients (aged 26 and 75 years). None of the patients had bilateral stenosis. EH was diagnosed on the basis of negative results of the investigation for secondary hypertension, which included in most cases a negative renal magnetic resonance angiography.

All patients were on antihypertensive treatment at the time of study to obtain normalization of the arterial pressure. Angiotensin-converting enzyme inhibitors (ACE-I) and antagonists of the angiotensin receptor (AT₁) were replaced with other antihypertensive drugs. All subjects with RVD and essential hypertension were on antihypertensive treatment to normalize blood pressure. Those
drugs, having a direct effect on the activity of the RAS, ACE-I and AT1 receptor antagonists, were withdrawn 2 months or more before the study.

Antihypertensive drugs were calcium antagonists (n=7), α-receptor blockers (n=5), β-receptor blockers (n=4), diuretics (n=5), spironolactone (n=1) and clonidine (n=1) at the time of study (median number of drugs prescribed per patient 2, range 1-5).

Essential hypertensive patients were being treated with calcium antagonists (n=8), α-receptor blockers (n=3), β-receptor blockers (n=3), or diuretics (n=1) at the time of study (median number of drugs prescribed per patient 1.5, range 1-3).

Ten normotensive and healthy subjects were studied and matched with hypertensive patients for gender and age. Two RVD patients had diabetes mellitus, treated with oral anti-diabetic drugs. Two RVD patients, one with EH and one control were receiving a statin. None of the subjects was receiving any other cardiovascular drug.

Exclusion criteria for all subjects were: heart failure, previous cardiovascular events, renal atrophy, end stage renal disease, neoplasia, chronic inflammatory disease. Non steroidal anti-inflammatory drugs, including aspirin, were not permitted or withdrawn at least 2 months before study. All the studied subjects were Caucasian.

**Measurement of flow-mediated vasodilatation**

Endothelial function was investigated according to the model of flow-mediated vasodilatation (FMD)\(^2\). FMD was evaluated using a high resolution ultrasound echo Doppler (AU5; Esaote Ultrasound System) with a 7.5 MHz linear transducer. The axial resolution of this probe was 0.05 mm, and ultrasonic calipers were accurate to 0.05 mm. We measured brachial artery diameters and
flow velocity (at a fixed position: 1 cm above the elbow fold). Hemodynamic measurements related to FMD were obtained 30 s and 1, 2, 4, 6 and 8 min after the beginning of distal hyperemia and related increase in flow velocity at the level of investigated arteries. Diameter variations were expressed as percentage of variation with respect to the basal diameter.

**Analysis of carotid artery structure and stiffness.**

All subjects underwent an echo-Doppler evaluation of the carotid arteries for the measurement of intima-media thickness and identification of atherosclerotic plaques.

Intima media thickness of the common carotid artery (cIMT) was measured in the segment 1 cm long proximal to the bulb (the average of two measurements in the distal wall). Plaques were defined as focal structure encroaching into the arterial lumen at least 0.5 mm or 50% of the surrounding cIMT values or demonstrated thickness >1.5 mm.

Applanation tonometry was performed at carotid level using PulsePen (Dia-Tecne) to calculate augmentation index (AI) and augmentation pressure (AP) 3.

**REFERENCES**


TABLE S1. Anthropometric and biochemical characteristics of Hypertensive Patients and Healthy Subjects

<table>
<thead>
<tr>
<th>Variables</th>
<th>RVD</th>
<th>EH</th>
<th>Controls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, years</td>
<td>75 (25-85)</td>
<td>73 (33-86)</td>
<td>71 (25-81)</td>
</tr>
<tr>
<td>Gender, male/female</td>
<td>7/3</td>
<td>7/3</td>
<td>7/3</td>
</tr>
<tr>
<td>BMI, kg/m² (table 2)</td>
<td>27.5 (21.2-33.1)</td>
<td>26.0 (17.5-35.7)</td>
<td>24.9 (21.5-31.3)</td>
</tr>
<tr>
<td>p-Cholesterol, mmol/L</td>
<td>4.8 (4.0-6.9)</td>
<td>5.1 (3.8-5.7)</td>
<td>5.48 (4.2-6.0)</td>
</tr>
<tr>
<td>p-HDL-Cholesterol, mmol/L</td>
<td>1.5 (0.9-2.2)</td>
<td>1.61 (1.1-2.1)</td>
<td>1.36 (1.1-1.6)</td>
</tr>
<tr>
<td>p-Triglycerides, mmol/L</td>
<td>1.7 (0.4-3.7)</td>
<td>1.02 (0.5-1.4)</td>
<td>1.26 (0.6-2.3)</td>
</tr>
<tr>
<td>p-Homocysteine, µmol/L</td>
<td>18.1 (8.9-30.3)</td>
<td>15.3 (11.5-74.1)</td>
<td>15.2 (8.7-21.0)</td>
</tr>
<tr>
<td>p-Glucose, mmol/L</td>
<td>5.61 (4.3-11.6)</td>
<td>5.06 (4.5-11.3)</td>
<td>5.27 (4.7-6.4)</td>
</tr>
<tr>
<td>Creatinine, µmol/L</td>
<td>109.17 (71.6-163.5)*</td>
<td>80.8 (52.1-95.4)</td>
<td>67.6 (60.0-102.5)</td>
</tr>
<tr>
<td>Creatinine clearance, mL/min</td>
<td>50.1 (29.3-168.7)*</td>
<td>79.9 (51.5-134.5)</td>
<td>84.8 (42.0-170.3)</td>
</tr>
<tr>
<td>p-TNF-α, pg/mL</td>
<td>10.1 (1.8-113.4)</td>
<td>9.9 (0.7-44.2)</td>
<td>10.6 (2.9-38.3)</td>
</tr>
<tr>
<td>s-C-RP, mg/L</td>
<td>1.6 (0.5-6.5)</td>
<td>1.1 (0.3-13.8)</td>
<td>2.0 (0.2-6.4)</td>
</tr>
<tr>
<td>PRA, ng/mL per hour</td>
<td>0.55 (0.05-5)</td>
<td>0.20 (0.05-1)</td>
<td>0.20 (0.05-2.7)</td>
</tr>
</tbody>
</table>

Data are presented as median (range); * indicates $P <0.05$ vs normotensive controls

RVD, renovascular disease patients; EH, essential hypertensive patients; BMI, body mass index; HDL, high density lipoprotein; GFR, glomerular filtration rate.
<table>
<thead>
<tr>
<th>Variables</th>
<th>RVD</th>
<th>EH</th>
<th>Controls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carotid artery stenosis, n</td>
<td>9/10 *</td>
<td>6/10</td>
<td>2/10</td>
</tr>
<tr>
<td>IMT, mm</td>
<td>0.93 (0.75-1.5)</td>
<td>0.89 (0.44-1.15)</td>
<td>0.88 (0.72-1.03)</td>
</tr>
<tr>
<td>SBP, mmHg</td>
<td>143 (124-170)</td>
<td>154 (128-170)</td>
<td>143 (122-154)</td>
</tr>
<tr>
<td>DBP, mmHg</td>
<td>73 (67-74)</td>
<td>77 (67-89)</td>
<td>83 (74-93)</td>
</tr>
<tr>
<td>FMD, %</td>
<td>-0.34 (-2.38-5.57)</td>
<td>0.24 (-9.35-7.5)</td>
<td>1.37 (-1.0-4.81)</td>
</tr>
<tr>
<td>AI, %</td>
<td>30 (9-50)</td>
<td>25 (9-46)</td>
<td>20 (9-54)</td>
</tr>
<tr>
<td>AP, mmHg</td>
<td>16 (5-64)</td>
<td>11 (3-27)</td>
<td>8 (4-22)</td>
</tr>
</tbody>
</table>

* indicates $P <0.05$ vs normotensive controls

RVD, renovascular disease patients; EH, essential hypertensive patients; IMT, intima media thickness; SBP, systolic blood pressure; DBP, diastolic blood pressure; FMD, flow mediated dilatation; AI, augmentation index; AP augmentation pressure.
Figure S1: Plasma concentration of EETs, DHETs, EETs/DHETs ratio and urinary excretion of DHETs

a) K.W. test p=n.s., \( r_s = -0.41 \) p<0.05

b) K.W. test p=n.s.

c) K.W. test p=n.s., \( r_s = -0.39 \) p<0.05

d) K.W. test p<0.01

Figure S1 includes graphs showing the plasma concentration of EETs, DHETs, EETs/DHETs ratio, and urinary excretion of DHETs. Each graph compares controls, EH, and RVD groups with statistical significance indicated.
Figure S2: Correlation between plasma 20-HETE and plasma DHETs

- All subjects:
  \[ r_s = 0.54 \]
  \[ p < 0.005 \]

- RVD patients:
  \[ r_s = 0.43 \]
  \[ p = \text{n.s.} \]