Deletion of Transient Receptor Potential Vanilloid Type 1 Receptors Exaggerates Renal Damage in Deoxycorticosterone Acetate-Salt Hypertension

Youping Wang, Dagmar Babánková, Jie Huang, Greg M. Swain, Donna H. Wang

Abstract—To determine whether the transient receptor potential vanilloid type 1 (TRPV1) channel provides protection against hypertension-induced renal damage, hypertension was induced by uninephrectomy and by giving deoxycorticosterone acetate (DOCA)-salt in wild-type (WT) and TRPV1-null mutant (TRPV1⁻/) mice. Mean arterial pressure, as determined by radiotelemetry, increased significantly and reached the peak 7 days after DOCA-salt treatment in both WT and TRPV1⁻/⁻ mice. There was no difference in mean arterial pressure between the 2 strains at the baseline or at the peak that lasted for 4 treatment weeks. DOCA-salt treatment in both WT and TRPV1⁻/⁻ mice led to increased urinary excretion of albumin and 8-isoprostane, glomerulosclerosis, renal cortical tubulointerstitial injury, tubulointerstitial fibrosis, increased number of tubular proliferating cell nuclear antigen–positive cells, and renal monocyte/macrophage infiltration, all of which were much more severe in DOCA-salt–treated TRPV1⁻/⁻ compared with DOCA-salt-treated WT mice. Renal TRPV1 protein expression, but not the renal anandamide content, was elevated in DOCA-salt–treated WT compared with vehicle-treated WT mice. Renal anandamide levels were markedly elevated in DOCA-salt–treated TRPV1⁻/⁻ but not in vehicle-treated TRPV1⁻/⁻ mice. Thus, our data show that ablation of the TRPV1 gene exacerbates renal damage induced by DOCA-salt hypertension, indicating that TRPV1 may constitute a protective mechanism against end-organ damage induced by hypertension. (Hypertension. 2008;52:1-7.)

Key Words: transient receptor potential vanilloid type 1 channel ▪ hypertension ▪ renal injury ▪ deoxycorticosterone ▪ mice

It is well accepted that hypertension is a major cardiovascular risk factor and a major factor contributing to end-stage renal disease.¹ ² Clinical investigation shows that patients with salt-sensitive hypertension have a greater incidence of end-stage renal disease compared with salt-resistant hypertensive individuals, suggesting that salt may be a key determinant of the development of hypertension-induced renal damage.³ Multiple factors, including endothelin-1, angiotensin II, and oxidative stress, have been suggested to contribute to end-stage renal disease associated with salt-sensitive hypertension.⁴ ⁵ However, the mechanisms underlying the progression of hypertension and end-stage renal disease in salt-sensitive hypertension are not fully elucidated.

The transient receptor potential vanilloid type 1 (TRPV1) channel is a ligand-gated cation channel.⁷ It functions as a molecular transducer to integrate multiple stimuli, including noxious heat, low pH, and the “hot” pepper–derived vanilloid compound, capsaicin.⁷ ⁸ In addition, TRPV1 can be activated by endogenous arachidonic acid derivatives, such as anandamide.⁹ ¹⁰ TRPV1 predominantly resides in unmyelinated C-fibers and thinly myelinated Aδ-afferent nerve fibers innervating the cardiovascular system, and activation of TRPV1 expressed in these nerves causes release of a number of sensory neuropeptides, including calcitonin gene-related peptide and substance P, which are potent vasodilators in various vascular beds.¹¹ TRPV1-positive sensory nerves are also widely distributed in the kidney, suggesting that TRPV1-mediated action may participate in the regulation of renal function under pathophysiological conditions.¹¹ Indeed, sodium excretion in response to sodium loading is impaired in salt-sensitive hypertension induced by surgical sensory denervation or by sensory nerve degeneration after neonatal capsaicin treatment.¹² ¹³ We also found that blockade of TRPV1 increased blood pressure in Wistar or Dahl salt-resistant rats fed a high-salt but not a normal salt diet,¹⁰ ¹⁴ suggesting that high-salt intake may activate TRPV1, conferring a protective effect.

The present study was designed to study the effects of TRPV1 on hypertension-induced renal damage using a genetargeting approach. The renal function and morphological changes occurring especially in various microstructures in the
renal cortex, including the glomeruli, tubules, and tubular interstitium, were examined during the development of deoxycorticosterone acetate (DOCA)-salt hypertension in the wild-type (WT) and TRPV1-null mutant (TRPV1−/−) mice.

Methods

Animals
TRPV1−/− mice were kindly provided by Dr David Julius (University of California, San Francisco, Calif) and were generated by deleting an exon encoding part of the fifth and all of the sixth putative transmembrane domains (including the interconnecting p-loop) of the channel, as described by Caterina et al.7 TRPV1−/− mice were backcrossed to WT mice (C57BL/6) for ≥6 generations and had been shown to have impaired nociception and pain sensation.7 Ten-week-old male TRPV1−/− mice or C57BL/6 mice as the WT control (weighing 26 to 28 g) were used in this study. All of the experiments were approved by the institutional animal care and use committee.

Telemetry Blood Pressure Assay
Mean arterial pressure (MAP) and heart rate (HR) were determined using a telemetry system (Data Sciences International) according to the manufacturer’s instruction. In brief, the mice were anesthetized with ketamine and xylazine (80 and 4 mg/kg SC, respectively), the transmitter catheter was implanted into the left carotid artery, and the transmitter body was placed subcutaneously in the lower right side of the abdomen. The mice were returned to their individual cages and allowed to recover for 3 days before radiotelemetric recording was started.

Experimental Protocol
One week after the radiotelemetric recording, the mice, including WT and TRPV1−/− mice, were reanesthetized as described above, and the left kidney was removed. The DOCA pellet (24 mg/10 g of body weight, Innovative Research of America) was implanted subcutaneously in the neck area under anesthesia. Mice receiving DOCA were given 1% NaCl and 0.2% KCl to drink, and treatment with DOCA-salt continued for 4 weeks. The control groups, consisting of WT and TRPV1−/− mice, underwent uninephrectomy without receiving DOCA and saline. Each group consisted of ≥5 mice.

Radiotelemetric recording continued for an additional 4 weeks. At the end of 4-week treatment, mice were placed in metabolic cages designed for mice for 24-hour urine collection. After that, plasma, kidney, and heart were harvested, weighted, and stored at −80°C for biochemical analysis or fixed in a 10% formaldehyde solution in phosphate buffer for histological analysis.

Plasma and Urine Analysis
Plasma and urine creatinine concentrations were assayed by the use of an improved Jaffe creatinine assay kit (BioAssay System). Plasma concentrations of K+ and Na+ were measured using flame photometry (Model IL 943, Instrumentation Laboratory). Urinary albumin was measured with an ELISA kit (Exocell Inc). Urinary 8-isoprostane levels were determined using the kit from Cayman Chemical.

Histological Analysis
The degree of sclerosis and mesangial matrix expansion within the glomerular tuft and tubulointerstitial injury was determined in paraffin-embedded tissue sections stained with periodic acid-Schiff and Masson’s trichrome stain, respectively, by 2 examiners without knowledge of previous treatment of sections.

The degree of glomerulosclerosis was determined using a semi-quantitative scoring method, as described previously.13 Fifty glomeruli per section were selected randomly and scored as follows: grade 0, normal glomeruli; grade 1, sclerotic area ≤25% of total glomerular area or distinct adhesion present between capillary tuft and Bowman’s capsule; grade 2, sclerotic area between 25% and 50%; grade 3, sclerotic area 50% to 75%; and grade 4, sclerotic area 75% to 100% of the total glomerular area. The ultimate score was obtained by multiplying the degree of changes by the percentage of glomeruli with the same degree of injury and adding up these scores.

The degree of mesangial matrix expansion was assessed using in-house image analysis software, which, based on the total area of a glomerulus occupied by mesangial matrix, stained periodic acid-Schiff positively. The degree of the matrix expansion is expressed as the percentage of the total glomerular area.

Tubulointerstitial injury was graded according to Shih et al16 on a scale of 0 to 4: grade 0, normal; grade 0.5, small focal areas of damage; grade 1, involvement of <10% of the cortex; grade 2, involvement of 10% to 25% of the cortex; grade 3, involvement of 25% to 75% of the cortex; and grade 4, extensive damage involving >75% of the cortex.

Immunohistochemistry
Immunohistochemical staining was performed using 3-µm-thick paraffin-embedded kidney sections obtained 4 weeks after the treatment, as described previously.17 Kidney sections were incubated with a primary antibody that recognizes proliferating cell nuclear antigen (PCNA; mouse antihuman PCNA, BioGenex) or F4/80 (rat antimouse macrophage monoclonal antibody. Serotech) overnight at 4°C. Sections were then incubated with appropriate secondary antibody conjugated with horseradish peroxidase and visualized by incubating the sections with the substrate 3,3′-diaminobenzidine or vector fast red, both of which were purchased from Vector Laboratories. Negative control experiments were performed by omitting incubation with the primary antibody.

The quantitation of PCNA and F4/80-positive cells in the cortex was carried out in a blind fashion under ×400 magnification. For each section, 15 randomly selected cortical fields were examined. The number of positive cells was expressed as cells per square millimeter.

Hydroxyproline Assay
The collagen content of renal tissue was determined by hydroxyproline assay. Kidney samples were processed as described by Peng et al.18 Hydroxyproline content was determined with a colorimetric assay and a standard curve of 0 to 5 µg of hydroxyproline (Sigma-Aldrich).16 Data were expressed as micrograms of collagen per milligram of dry weight, assuming that collagen contains an average of 13.5% hydroxyproline.3

Endocannabinoid Analysis
A renal anandamide extraction procedure was performed before separation and detection by reversed-phase high-performance liquid chromatography with UV detector, as described by Folch et al.19 Briefly, separations were carried out on a Discovery BIO Wide pore ODS column (Supelco, 5 µm, 45×4.6 mm i.d.) connected with a Discovery BIO Wide pore ODS guard column (5 µm, 20×4 mm i.d.). Detection was accomplished with an enhanced chemiluminescence detector (ECL, Amersham Biosciences). Band intensity was densitometrically measured. β-Actin was used to normalize protein levels loaded on blots.

Western Blot Analysis
Western blot analysis was performed as described previously,14 with the use of goat anti-Rat TRPV1 polyclonal IgG (1:800, Santa Cruz Biotechnology, Santa Cruz, Calif) and horseradish peroxidase-conjugated bovine anti-goat IgG (1:500, Santa Cruz Biotechnology). Detection was accomplished with an enhanced chemiluminescence Western blot test (ECL, Amersham Biosciences). Band intensity was densitometrically measured. β-Actin was used to normalize protein levels loaded on blots.
Statistical Analysis

All of the values are expressed as means±SEs. The significances of differences between groups for the blood pressure data were evaluated with an ANOVA for repeated measures followed by a Bonferroni’s test. The differences among groups were analyzed using 1-way ANOVA, followed by a Bonferroni’s adjustment for multiple comparisons. An unpaired t test was applied to compare the differences between the 2 groups. Differences were considered statistically significant at P<0.05.

Results

As shown in the Table, there was no significant difference in body weight and plasma levels of electrolytes between groups at the end of the experimental period. Heart:body weight and kidney:body weight ratios increased significantly in DOCA-salt hypertensive WT and TRPV1−/− mice compared with their respective control groups (P<0.05), but no difference was seen between DOCA-salt–treated WT and TRPV1−/− groups (P>0.05). Urinary output increased markedly in DOCA-salt hypertensive WT and TRPV1−/− mice compared with their respective controls (P<0.01), but there was no difference (P>0.05) between DOCA-salt–treated WT and TRPV1−/− groups, although there was a tendency toward lower output in the latter group. Urinary albumin and 8-isoprostane excretion were increased significantly in DOCA-salt–treated WT and TRPV1−/− mice, and the magnitude of the increase was greater in the latter group (P<0.05). Urinary creatinine clearance was significantly decreased in DOCA-salt–treated WT and TRPV1−/− mice, and the degree of the decease was greater in the latter group (P<0.05).

Table. Effect of DOCA-Salt Treatment on Body Weight, Heart Weight, Kidney Weight, Plasma, and UrineChemistries in WT and TRPV1−/− Mice

<table>
<thead>
<tr>
<th>Parameters</th>
<th>WT</th>
<th>TRPV1−/−</th>
<th>DOCA-WT</th>
<th>DOCA-TRPV1−/−</th>
</tr>
</thead>
<tbody>
<tr>
<td>BW, g</td>
<td>28.1±0.4</td>
<td>28.7±0.3</td>
<td>28.5±0.4</td>
<td>29.4±0.4</td>
</tr>
<tr>
<td>Heart weight, mg/10 g of BW</td>
<td>43.9±1.4</td>
<td>44.6±1.7</td>
<td>58.2±2.1*</td>
<td>59.9±2.4*</td>
</tr>
<tr>
<td>Kidney weight, mg/10 g of BW</td>
<td>78.9±1.3</td>
<td>75.8±1.2</td>
<td>111.5±3.4*</td>
<td>115.2±3.1*</td>
</tr>
<tr>
<td>Plasma [K⁺], mmol/L</td>
<td>6.3±0.4</td>
<td>6.0±0.5</td>
<td>5.9±0.3</td>
<td>5.7±0.5</td>
</tr>
<tr>
<td>Plasma [Na⁺], mmol/L</td>
<td>148±4</td>
<td>152±3</td>
<td>149±2</td>
<td>150±5</td>
</tr>
<tr>
<td>Urinary output, mL/24 h</td>
<td>1.6±0.2</td>
<td>1.4±0.3</td>
<td>18.1±2.3*</td>
<td>12.5±1.4*</td>
</tr>
<tr>
<td>Urinary albumin, μg/24 h</td>
<td>5.8±0.7</td>
<td>6.5±0.9</td>
<td>26.6±2.8*</td>
<td>74.8±4.5†</td>
</tr>
<tr>
<td>Urinary 8-isoprostane, ng/24 h</td>
<td>0.52±0.11</td>
<td>0.60±0.10</td>
<td>1.27±0.19*</td>
<td>2.64±0.38†</td>
</tr>
<tr>
<td>Creatinine clearance, mL/24 h</td>
<td>344±23</td>
<td>334±25</td>
<td>206±17*</td>
<td>114±19†</td>
</tr>
</tbody>
</table>

Values are means±SEs; n=7 to 8 mice. DOCA-WT indicates WT mice treated with DOCA-salt; DOCA-TRPV1−/− mice treated with DOCA-salt; BW, body weight.

*P<0.05 vs control WT or TRPV1−/− mice.
†P<0.05 vs DOCA-WT mice.
WT and TRPV1−/− mice had similar baseline MAP determined by radiotelemetry, as presented in Figure 1. One week after treatment with DOCA and salt, MAP increased remarkably compared with the baseline and remained at this level for 4 weeks in both WT and TRPV1−/− mice, with no difference between the 2 strains (P>0.05). In addition, there was no difference in HR between WT and TRPV1−/− mice during the baseline and DOCA-salt treatment period.

As illustrated in Figure 2, DOCA-salt treatment led to a more severe glomerulosclerosis in the kidneys of TRPV1−/− mice than WT mice (Figure 2A). There was no difference in the glomerulosclerosis index between control WT and TRPV1−/− mice (P>0.05; Figure 3A). As shown in Figure 3A, the glomerulosclerosis index increased significantly in DOCA-salt–treated WT and TRPV1−/− mice, and the magnitude of the increase was greater in the latter group (P<0.05).

More severe tubular injury and interstitial fibrosis were observed in DOCA-salt–treated TRPV1−/− mice than in DOCA-salt–treated WT mice, as demonstrated by Masson’s trichrome staining, whereas no observable damage was observed in control WT and TRPV1−/− kidneys (Figure 2B). Quantitative analysis showed that cortical tubular injury was significantly greater in DOCA-salt–treated TRPV1−/− mice than in DOCA-salt–treated WT mice (P<0.05; Figure 3C). Renal collagen content determined using hydroxyproline assay was significantly increased in DOCA-salt–treated TRPV1−/− mice compared with DOCA-salt–treated WT mice, control TRPV1−/− mice, or WT mice (P<0.05), whereas there was no significant difference among the latter 3 groups (P>0.05; Figure 3D).

As shown in Figure 2, PCNA-positive cells were largely restricted to the renal tubular epithelium in control WT and TRPV1−/− kidneys (Figure 2C). PCNA-positive cells, particularly observed in dilated tubules, increased significantly in DOCA-salt–treated WT and TRPV1−/− mice with a greater magnitude in the latter group (P<0.05; Figure 4A). PCNA-positive cells in interstitials were also observed in DOCA-salt–treated TRPV1−/− mice but to a lesser extent compared with those in tubules. Monocyte/macrophage infiltration, an indicator of inflammation in the kidney, was also determined immunohistochemically (Figure 2D). Cortical F4/80-positive cells increased significantly in DOCA-salt–treated WT and TRPV1−/− mice compared with controls (P<0.05; Figure 4B), and the magnitude of the increase was greater in the latter group (P<0.05).

Figure 5 shows that DOCA-salt treatment significantly increased renal levels of anandamide, one of the endogenous TRPV1 agonists, in TRPV1−/− mice compared with control TRPV1−/− mice (P<0.01; Figure 5A). In contrast, DOCA-salt treatment did not change renal anandamide levels in WT mice (P>0.05). In addition, renal TRPV1 protein expression was upregulated in DOCA-salt–treated WT mice compared with control WT mice (P<0.05; Figure 5B). TRPV1 expression was undetectable in TRPV1−/− mice with or without DOCA-salt treatment (data not shown).

Discussion

This is the first study to explore the influence of long-term TRPV1 deletion on renal injury induced by DOCA-salt hypertension. The results of the present study demonstrate that DOCA-salt treatment exacerbated renal damage when TRPV1 was deleted, evident by further decreased creatinine clearance, further increased albuminuria, and more deteriorate renal morphology consisting of exaggerated glomerulosclerosis, tubular dilation, tubulointerstitial proliferation, interstitial fibrosis, and increased interstitial monocyte/macrophage infiltration. These results indicate a key role of TRPV1 in protecting against the advancement of nephropathy in salt-dependent hypertension.

Interestingly, MAP determined by radiotelemetry was equally elevated by DOCA-salt treatment in TRPV1−/− and WT mice. Although systemic pressure was similar in these 2 strains subject to DOCA-salt treatment, we could not rule out the possibilities that the local hemodynamics were different or that the exacerbated renal injury in TRPV1−/− mice was induced by the mechanical force from hypertension because TRPV1−/− mice were more susceptible to the pressure increase.
We found that urinary albumin excretion, an important predictor for end-stage renal disease, was about 4-fold higher in DOCA-salt–treated WT mice than in control WT mice. Regardless, only moderate morphological alterations were observed in renal glomeruli of DOCA-salt–treated WT mice. The results are consistent with previous studies showing that urinary albumin was significantly increased before the development of lesions detectable by light microscopy, a finding plausibly explained by ultrastructural changes preceding the light microscopic changes and leading to albuminuria. Indeed, it has been shown that ultrastructural changes, including thickening of the glomerular basement membrane and degenerative changes of podocytes, preceded light microscopic histological disturbances. Growing evidence suggests that podocyte injury is intimately related to proteinuria. Although the mechanisms underlying exacerbated urine albumin excretion in DOCA-salt–treated TRPV1 mice compared with WT mice remain to be confirmed, several possible pathways discussed below may contribute to markedly enhanced urine albumin excretion in the former and may predict higher risk of end-stage renal disease in knockout hypertensive mice.

Anandamide, one of the endogenous ligands for the cannabinoid receptor, has been shown to excite peripheral terminals of capsaicin-sensitive primary sensory neurons via TRPV1-dependent mechanisms. Although no change in anandamide levels was found in the kidney of DOCA-salt–treated WT mice in the present study, renal TRPV1 expres-
Proliferation of tubular epithelial cells was found in DOCA-salt–treated WT and TRPV1-deficient mice, an indicator of cell proliferation.23 Significant renal damage, and we, therefore, examined PCNA levels (A) and TRPV1 protein expression (B) in WT or TRPV1-deficient mice. Values are means ± SEs (n = 5 to 7). *P < 0.05 vs control WT or TRPV1-deficient mice; †P < 0.05 vs DOCA-salt–treated WT mice.

Figure 5. Effect of DOCA-salt treatment on renal anandamide levels (A) and TRPV1 protein expression (B) in WT or TRPV1-deficient mice. Values are means ± SEs (n = 5 to 7). *P < 0.05 vs control WT or TRPV1-deficient mice; †P < 0.05 vs DOCA-salt–treated WT mice.

Renal cell proliferation may result from hypertension-induced renal damage, and we, therefore, examined PCNA expression, an indicator of cell proliferation.23 Significant proliferation of tubular epithelial cells was found in DOCA-salt–treated WT and TRPV1-deficient mice, with a higher number of PCNA-positive cells in the latter. The increased cell proliferation correlated well with the degree of renal morphological damage under microscopic examination. Increased PCNA-positive cells may result from increased endothelin-1 and angiotensin II levels in the local tissues given that endothelin-1 and angiotensin II have been shown to increase renal cell proliferation via enhancing superoxide production.24,25 Alternatively, increased tubular cell proliferation may be secondary to tubular dilation induced by glomerular ischemia.

Although the precise mechanisms responsible for DOCA-salt–induced renal injury remain to be elucidated, several studies showed that enhanced activity of the sympathetic nervous system might actively participate in the pathogenesis of renal damage in hypertension.26,27 Activation of TRPV1 expressed in sensory nerves leads to inhibition of sympathetic nervous activity.28,29 Thus, TRPV1 deficiency may aggragate renal injury induced by DOCA-salt treatment because of attenuated inhibition of the sympathetic nervous system. In contrast to the studies by Veelken et al30 showing that the arterial baroreflex is not altered in DOCA-salt rats, we found that DOCA-salt treatment caused similar increases in blood pressure in WT and TRPV1-deficient mice, without significant baroreflex bradycardia that normally accompanies such increases in blood pressure. These data, although unexpected, are consistent with the previous observations showing that DOCA-salt hypertensive rats are associated with increased sympathetic nerve activity or a predisposition to respond to environmental stress with increased sympathetic nerve activity.31,32 Given the complex interplay of several neurohormonal systems in the central and peripheral sites, further studies are required to clarify the mechanisms underlying the enhanced baroreflex in DOCA-salt hypertension and the role of the sympathetic nervous system in DOCA-salt–induced exaggeration of renal damage in TRPV1-deficient mice that showed an indistinguishable baroreflex from WT mice.

In addition to its well-established role of vasodilatation, activation of TRPV1 may convey protection to tissues via other mechanisms. Although the caveat exists in the current study in which the lifelong loss of the protein produced by the TRPV1 gene deleted may cause compromising changes that may impact the results, data obtained from studies using different experimental approaches show that activation of TRPV1 may increase NO release that suppresses oxidative stress via inhibition of reduced nicotinamide-adenine dinucleotide phosphate oxidase.33,34 In addition, most recent studies have demonstrated that TRPV1 attenuates endotoxin-induced proinflammatory cytokine production, inflammatory cell infiltration, and migration.35–37 Indeed, the progression of hypertension-induced renal damage has been linked to oxidative stress and inflammation.37,38 It is likely that TRPV1 deficiency may lead to disturbed glomerular hemodynamics, enhanced oxidative stress, and/or proinflammatory responses. In the present study, we found that deletion of TRPV1 exaggerated DOCA-salt–induced renal injury, which was associated with enhanced urinary 8-isoprostane excretion and renal macrophage recruitment. These data may be interpreted that an antioxidant and anti-inflammation effect of TRPV1 may be involved in renoprotection in DOCA-salt hypertension, or that renal injury observed in TRPV1-deficient mice may contribute to enhanced oxidative stress and inflammatory responses. To distinguish these possibilities, further studies are necessary to explore the time course of renal inflammation and injury in DOCA-salt hypertension in TRPV1-deficient and WT mice.

In summary, the data show that TRPV1 gene deletion leads to enhanced renal damage characterized by the decreased creatinine clearance, albuminuria, glomerulosclerosis, tubulointerstitial injury, and interstitial monocyte/macrophage infiltration during DOCA-salt treatment, whereas systemic blood pressure in these mice is indistinguishable from that of WT mice. These findings suggest that TRPV1 may play a protec-
tive role in preventing renal injuries possibly via inhibition of an inflammatory response during hypertension.

**Perspectives**

Impairment in sensory nerves and TRPV1 function occurs in Dahl salt-sensitive rats, a model closely mimicking human salt-sensitive hypertension, suggesting that such impairment may contribute to the pathogenesis of hypertension in this model.14 The data from the present study further support the notion that development and exacerbation of salt-sensitive hypertension–associated end-organ damage may be attributed, at least in part, to the lack of adequate counterregulatory action of TRPV1. It follows that improvement of function of sensory nerves or TRPV1 may confer a therapeutic potential in the treatment of end-organ damage associated with salt-sensitive hypertension.

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**Disclosures**

None.

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