

Renoprotective effects of Vitamin D and renin-angiotensin system

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Abstract

Vitamin D has many physiological functions. First it is a primary regulator of calcium homeostasis. Beyond that, vitamin D and its receptors (VDR) play important role in the immune system, cardiovascular system, reproductive system and insulin resistance. An important aspect of vitamin D pleiotropic effects is the interaction with components of the renin-angiotensin system (RAS). It was demonstrated that vitamin D-null mice have a sustained elevation of renin expression. The combination of both the AT1 blockers and the vitamin D analogues, leads to a marked amelioration of the molecular and clinical markers of diabetic nephropathy. This combination may protect the kidney through the effects on both the glomerular and the tubulointerstitial compartments. There are different studies that corroborate the renoprotective action of vitamin D in CKD. In fact the renoprotective mechanisms in humans remain to be assessed, but these are realized through reduction of proteinuria, high blood pressure, inflammation as well as hemodynamic effects. An important mechanism is the role of vitamin D as a potent negative endocrine regulator of renin expression. It was shown that low levels of vitamin D represent a novel risk factor for the progression of renal disease but it is not demonstrated yet that vitamin D can prolong the time to end-stage renal disease. This question remains to be answered in other future controlled clinical trials. Hippokratia 2011; 15 (4): 308-311

Key words: vitamin D, renin-angiotensin system, angiotensin II, chronic kidney disease review

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Vitamin D is a primary regulator of calcium homeostasis. Genetic inactivation of either the vitamin D receptor (VDR), a member of the nuclear receptor superfamily that mediates the action of 1,25-dihydroxyvitamin D₃ [1,25(OH)₂D₃], or 25-hydroxyvitamin D₃ 1 α -hydroxylase, the rate-limiting enzyme for the biosynthesis of 1,25(OH)₂D₃, results in impaired calcium homeostasis, leading to hypocalcemia, secondary hyperparathyroidism, and rickets¹⁻⁵. However, the wide tissue distribution of VDR suggests that the vitamin D endocrine system has additional physiological functions beyond calcium homeostasis. There are many experimental and clinical data that corroborate the pleiotropic actions of vitamin D. Indeed, vitamin D and VDR have been shown to play important roles in the immune system, cardiovascular system, reproductive system, and hair growth¹. Many of these actions of vitamin D are realized independently from the effects on PTH and the level of calcium and phosphorus. Although VDR-deficient mice do not have a spontaneous increase in cancer, they are more prone to oncogene- or chemocarcinogen-induced tumors⁶. Also, it was shown that, low levels of vitamin D in the circulation are associated with a high incidence of autoimmune diseases, insulin resistance, and peripheral arterial diseases^{7,8}. Epidemiological evidence suggest that diabetes mellitus type 1 is more prevalent in countries with lower ambient winter ultraviolet light, supporting the theory that vitamin D supplementation in early childhood may offer protection against diabetes mellitus type1⁹. In

different animal models, 1,25(OH)₂D or its analogues reduced proteinuria levels, preserved glomerular podocyte structure, decreased levels of TGF- β 1, an inducer of renal fibrosis and inhibited mesangial cell proliferation, a marker of renal injury⁸. Also, it has been demonstrated an inverse association of circulating vitamin D levels with blood pressure and it has been shown that the treatment with vitamin D analogues reduces blood pressure¹⁰.

An important aspect of vitamin D pleiotropic effects is the interaction between receptors of vitamin D (VDR) and the components of RAS. 1,25(OH)₂D₃ reduces plasma renin activity, angiotensin II (Ang II) and myocardial hypertrophy¹¹. This makes possible, the inhibition of profibrotic and proinflammatory as well as the endothelial damage caused by RAS.

In a previous study¹ it was demonstrated that VDR-null mice have a sustained elevation of renin expression while still maintaining a normal level of blood electrolytes. The augmentation of renin synthesis leads to increased plasma Ang II production from angiotensinogen, which drives VDR-null mice to increase water intake and intestinal salt absorption, since Ang II is a very potent thirst-inducing agent that acts on the CNS, as well as a potent stimulator of intestinal sodium absorption¹². As a result, the mutant mice have to excrete more urine and salt to maintain volume and electrolyte homeostasis. Since Ang II is a potent vasoconstrictor, its augmentation also leads to the development of hypertension and cardiac hypertrophy in VDR null mice, although the lat-

ter effect still needs more experimental verification. This is not unexpected, as hypertension and cardiac hypertrophy have been well documented in patients and animals with high renin and Ang II¹³. Thus, a new steady state of the renin-angiotensin system is established in VDR-null mice, in which the basal renin expression is higher but still responds appropriately to the same tubular salt load and volume stimuli as in the normal state. Based on these assessments, it was suggested that the upregulation of renin expression is a primary defect in VDR-null mice¹.

An interesting study investigated the combined effect of ARB: Losartan and non calcemic vitamin D analogue paricalcitol on the development and progression of diabetic nephropathy¹⁴. In this experimental study it was shown that combination of both the AT1 blocker losartan and the vitamin D analogue paricalcitol, leads to a marked amelioration of the molecular and clinical markers of diabetic nephropathy. It was demonstrated absence of glomerulosclerosis in the combined treatment group, whereas thickening of glomerular basement membrane and podocyte effacement was shown in the groups where either paricalcitol or losartan was used alone. Lowest values of blood glucose levels were encountered in the combined treatment group as well as significant lower level of creatinine in comparison with the single treatment groups.

Another more recent study, of Li and colleagues¹⁵ is an extension of a previous work by the authors that demonstrated that the combination of angiotensin receptor blockers plus paricalcitol therapy abrogates progression of streptozotocin induced diabetes¹⁴. In this study the authors demonstrated that combination therapy is better than sum of the parts with respect to progression of kidney disease as measured by kidney structure (kidney histology) and function (albuminuria, serum creatinine) in mice with type 2 diabetic nephropathy. The mechanism of renal protection appears to be the protection of podocytes and blockade of the TGF- β system in the glomerulus¹⁵. TGF- β also activates interstitial fibroblasts and induces tubular epithelial to mesenchymal transition. This way, VDRA by blocking TGF- β may have the potential to abrogate tubulointerstitial fibrosis. Furthermore, VDRA have an anti inflammatory effect. Taken together these studies suggest that VDRA may protect the kidney through their effects on both the glomerular and the tubulointerstitial compartments¹⁶.

Epidemiological and clinical studies in the last two decades have suggested an inverse relationship between vitamin D and blood pressure and/or plasma renin activity¹⁷. Cutaneous production of vitamin D is influenced by sunlight, seasonal changes and skin pigmentation. Data from the INTERSALT study have revealed a linear correlation between the rise in blood pressure or the prevalence of hypertension and the latitudes north or south of the equator¹⁸. Blood pressure tends to be higher in the winter than in the summer, and is affected by variations in skin pigmentation as well. In fact, ultraviolet light has been reported to lower blood pressure in patients with mild essential hypertension¹⁹.

In patients where disturbances of RAS are important

in the progression of disease such as diabetic nephropathy, the positive effects of ARB and ACE-I has been shown since many years but one can expect also that the inhibitory action of vitamin D on RAS, can be useful in slowing the progression of renal damage. Any way although there is strong evidence from the studies described above implicating the RAS in the mechanism of renal protection among animals with diabetic nephropathy, whether the same holds true in humans is unclear.

Actually there are at least four studies on the renoprotection by VDRA among patients with CKD not on dialysis¹⁶. In the first study it was reported a reduction of proteinuria in stage 3 and 4 CKD patients who participated in 3 controlled trials of oral paricalcitol²⁰. Moreover, reduction of proteinuria occurred despite concomitant treatment with RAS blockers. Alborzi et al²¹. studied 24 patients with stage 3 CKD who were allocated randomly to three equal groups to receive either 0, 1, or 2 μ g paricalcitol orally for 1 month. At 1 month the treatment-baseline ratio of high-sensitivity C reactive protein was improved with a 2 μ g dose of paricalcitol. At 1 month even the treatment-baseline ratio of 24-h albumin excretion rate was improved with paricalcitol. This study suggest that paricalcitol may evince reduction in albuminuria and inflammation independent of its effects on hemodynamics (measured in this study by glomerular filtration rate and ambulatory blood pressure monitoring) and parathyroid hormone suppression.

In another uncontrolled trial, ten patients with Ig-A nephropathy and persistent proteinuria despite angiotensin converting enzyme inhibition and angiotensin II receptor blockade were treated with 0.5 μ g Calcitriol twice weekly for 12 weeks²². After this period there was a significant overall decrease in urine protein-creatinine ratio. No significant change in blood pressure or renal function was noted. There was a simultaneous decrease in serum TGF- β level and the percentage of decrease in serum TGF- β level significantly correlated with percentage of change in proteinuria.

The fourth study comprised 61 patients with CKD and proteinuria greater than 400 mg/d assigned equally to either 1 μ g paricalcitol/per day or placebo²³. In this study, changes in protein excretion from baseline to last evaluation were +2.9% for controls and -17.6% for the paricalcitol group (P=0.04). Anyway the magnitude of reduction of proteinuria at 6 months was much less compared with that seen at 1 month by Alborzi et al²¹.

Trying to understand the mechanism of the vitamin D and RAS interaction, it was shown that VDR-null mice maintain a high level of renin expression that is, to our knowledge, a novel finding, but the underlying physiological cause can be complicated. The observation that renin expression in VDR-null mice reacts properly to high salt load or dehydration indicates that the mechanism underlying the sustained renin elevation is independent of the pathways activated by tubular salt load or volume depletion. In fact, the involvement of cyclooxygenase-2 (COX-2), which may play an important role

in macula densa–mediating renin release, in renin elevation in VDR-null mice is unlikely, since it was observed the same low COX-2 protein level in the kidneys of both VDR-null and wild-type mice²⁴. Since adult VDR-null mice develop hypocalcemia and secondary hyperparathyroidism, the upregulation of renin expression could be due to VDR inactivation per se, hypocalcemia, and/or high PTH. However, several lines of evidence from our study strongly suggest that vitamin D regulation of renin gene expression is direct and independent of the calcium status. Many facts provide very compelling evidence to establish that vitamin D is a potent negative endocrine regulator of renin expression *in vivo*¹.

If VDRAs effectively block the RAS, one would expect to share the side effects of RAS blockers such as hypokalemia, renal failure and hypotension. These side effects are absent in humans, so the mechanisms that afford renal and cardiovascular protection in humans may not be the same as that seen among rodents²⁵. In fact the renoprotective mechanisms in humans remain to be discovered.

It can't be excluded at this time, the possibility that, *in vivo*, secondary hyperparathyroidism may also contribute to the renin upregulation in VDR-null mice. Previous studies have shown that intravenous infusion of PTH increases plasma renin activity and renin release in humans and animals but the molecular mechanism whereby PTH regulates renin expression *in vivo* remains unknown. PTH may indirectly regulate renin expression *in vivo*¹.

Black patients who start dialysis tend to have lower levels of vitamin D than non-hispanic white patients, and are therefore presumably more likely to receive intravenous activated vitamin D. A recent study indicates that this difference in vitamin D treatment might contribute to the extended survival of black patients on dialysis compared to white patients.

Wolf et al. analysed data from 9303 patients (55% white, 35% black) in the US²⁶. At the initiation of dialysis, black patients had a higher mean parathyroid hormone level and a lower mean 1,25-dihydroxyvitamin D level than white patients ($P < 0.05$ for both). More black patients than white patients received activated vitamin D (88% vs 71%; $P < 0.05$). and baseline parathyroid hormone level was the strongest predictor of vitamin D treatment. Black ethnicity was associated with a 32% (95% CI 23-29%) lower risk of death than white ethnicity, and use of activated vitamin D was associated with a 52% (95% CI 46-57%) decrease in the risk of death. Multivariate analysis revealed that black people who received vitamin D had a 16% lower risk of death than white people who received vitamin D ($P < 0.05$); however the survival advantage of black ethnicity disappeared when the dose of vitamin D was taken into account. By contrast, among vitamin D untreated individuals, black patients had a 35% higher risk of death than white ones ($P < 0.05$).

On the basis of its suppression of the RAS and on animal models showing beneficial effects on albuminuria, mesangial cell proliferation, inflammation, and extracellular matrix formation, low vitamin D levels represent

a novel risk factor for the progression of renal disease⁸. Until now we can say that vitamin D must be given to patients with CKD in order to maintain bone health as well as immunological, cardiovascular and renal health. An adequate dose is considered when the serum level of vitamin D is greater than 30 ng/ml¹⁶. But regarding renal effects, although vitamin D reduce proteinuria and hypertension, it was not demonstrated yet that it can prolong the time to end-stage renal disease. This question remains to be resolved more precisely in other future controlled clinical trials.

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