High-Salt Diet and Hypertension: Focus on the Renin-Angiotensin System


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Introduction

Hypertension is defined by a systolic blood pressure that is ≥140 mm Hg and a diastolic blood pressure that is ≥90 mm Hg [1]. The World Health Organization ranks coronary heart disease and cerebrovascular diseases as the world’s leading causes of death [2]. Globally, according to the World Health Report 2002, about 62% of cerebrovascular disease and 49% of ischemic heart disease are attributable to suboptimal blood pressure (systolic >115 mm Hg), and hypertension is estimated to cause 7.1 million deaths, about 13% of the total [3]. For the last several decades, hypertension has been ranked as one of the top 10 leading causes of worldwide disability-adjusted life years [4]. According to the results of Kearney et al. [5], more than 25% of the world adult population (approx. 1 billion) has hypertension, and it was estimated that in 2025, 29% (1.56 billion) of the adult population will be hypertensive (an increase of the total number of hypertensive individuals by 60%). The Prospective Studies Collaboration observed a linear relationship between blood pressure levels and cardiovascular and cerebrovascular mortality [6]. The continuum between blood pressure and cardiovascular morbidity and mortality is present.
even below the present cutoff for hypertension, as confirmed in the Framingham study [7].

At present, the worldwide prevalence of hypertension is higher than it was several decades ago [8–10]. Wolf-Maier et al. [8] observed differences in age-adjusted prevalence of hypertension between Northern America and developed countries in Europe (28 vs. 44%). They have also confirmed that hypertension is more strongly correlated to cerebrovascular mortality (r = 0.79) than to total cardiovascular mortality (r = 0.44), which is in line with the fact that cerebrovascular mortality in the United States and Canada is the lowest in the world (27.6/100,000 vs. 41.2/100,000 in Europe). Based on results of the Epidemiology of Arterial Hypertension in Croatia study (EHUH), overall prevalence of hypertension in Croatia is 37.5% [11], so it should not be surprising that cardiovascular morbidity in Croatia is also very high (>54% in 2004). EHUH results are in line with reports from other European countries like Italy 37.7%, Spain 45.1%, England men 33.1%, England women 30.1%, Germany 55.3%, France men 37.7%, France women 32.2%, Sweden 38.4%, Finland men 52.1%, Finland women 33.6% and Poland 29% [12–20]. Concordance was found with countries that belong to former socialistic economies [5]: Romania 36.6% [23], Czech Republic 39.1% [21] and Slovakia [22]. The data is summarized in table 1.

Dietary salt intake is a known risk factor for hypertension. Although a large number of studies have been conducted to elucidate this association, the mechanisms by which the increase in salt intake leads to development of salt-dependent hypertension are not completely understood. However, it is known that a high-salt diet alters the functioning of the renin-angiotensin system (RAS; discussed below).

Table 1. Prevalence of hypertension in adult populations of several European countries and globally

<table>
<thead>
<tr>
<th>Country</th>
<th>Prevalence of hypertension (year)</th>
<th>Reference number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Croatia</td>
<td>37.5% (2007)</td>
<td>11</td>
</tr>
<tr>
<td>Czech Republic</td>
<td>39.1% (2001)</td>
<td>21</td>
</tr>
<tr>
<td>England</td>
<td>men: 33.1%, women: 30.1% (2003)</td>
<td>13</td>
</tr>
<tr>
<td>Finland</td>
<td>men: 52.1%, women: 33.6% (2007)</td>
<td>18</td>
</tr>
<tr>
<td>France</td>
<td>men: 37.7%, women: 32.2% (1996)</td>
<td>20</td>
</tr>
<tr>
<td>Germany</td>
<td>55.3% (1998)</td>
<td>16</td>
</tr>
<tr>
<td>Italy</td>
<td>37.7% (1998)</td>
<td>14</td>
</tr>
<tr>
<td>Poland</td>
<td>29.0% (2002)</td>
<td>12</td>
</tr>
<tr>
<td>Romania</td>
<td>36.6% (2005)</td>
<td>23</td>
</tr>
<tr>
<td>Spain</td>
<td>45.1% (1998)</td>
<td>15</td>
</tr>
<tr>
<td>Sweden</td>
<td>38.4% (1996)</td>
<td>17</td>
</tr>
<tr>
<td>Global burden</td>
<td>26.4% (2000), estimate for the year 2025: 29.2%</td>
<td>5</td>
</tr>
</tbody>
</table>

Presumed Pathophysiology of Salt-Induced Hypertension

An explanation of the link between sodium intake and hypertension was established roughly 40 years ago by Guyton et al. [24]. They proposed that sodium balance after salt intake is regulated by the pressure-natriuresis mechanism. Sodium loading is associated with a transient increase in blood pressure which returns to primary values after pressure-natriuresis and regulation of extracellular volume (ECV). Some individuals have impairments of sodium elimination mechanisms and for the same sodium natriuresis effect they need to have higher blood pressure. Thus, sodium retention causes expansion of ECV, causing higher cardiac output with tissue perfusion that exceeds metabolic needs. Peripheral tissue vasculature responds by activating autoregulatory vasoconstriction, causing further increases in peripheral resistance [24, 25]. All these facts, as well as studies performed on transplanted kidney patients, places the kidney in a central position in the regulation of blood pressure [26].

A later model proposed by Julius [27] aligned contradictory results in previously seen studies related to role of ECV expansion and described different phases of hypertension, with a transition from a high cardiac output (ECV expansion) and normal systemic vascular resistance early in the course of the disease to a normal cardiac output (normal ECV) and increased systemic vascular resistance at a later phase [26]. However, a number of newer studies have shown that the mechanisms involved in hypertension associated with high salt intake are much more complex and that multiple interconnected factors participate in the pathophysiology of hypertension.

High sodium concentrations may also, in addition to effects mediated by ECV expansion, have direct hypertensive actions, such as induction of cardiac myoblast and smooth muscle cell hypertrophy [28], activation of NF-κB in proximal tubular cells (leading to renal inflammation) [29], changes in the RAS, induction of oxidative stress, and others. A dysregulation of sodium metabolism can also be related to changes in genes and receptors associated with mineralocorticoid synthesis and function [26].
Studies Confirming the Relation of Sodium Intake to High Blood Pressure

Experimental observations by Gu et al. [30, 31] examined whether a long-term high-salt diet causes hypertension and renal injury in normal Sprague-Dawley rats. It was demonstrated that hypertension can be induced by a prolonged high-salt diet and that it is associated with increased renal injury and significant changes in renal cytokine gene expression profiles that are closely related to the proinflammatory response, promatrix formation and endothelial dysfunction, and attenuated cell survival and differentiation [30]. They found that a high-salt diet decreases renal expression of vascular endothelial growth factor [31], whereas a subsequent study revealed that inhibition of the vascular endothelial growth factor receptor enhances dietary salt-induced hypertension [32].

A large number of epidemiologic, evolutionary and clinical studies have confirmed that salt intake is a significant factor in determining the blood pressure level, and thereby the prevalence of hypertension. Epidemiological studies indicate that blood pressure increases with age only if accompanied by increased salt intake. For example, Yanomamo Indians are still eating food which contains very low salt, i.e. less than 50 mmol NaCl (2.9 g NaCl), and is very similar to the food humans have consumed over thousands of years of evolution [33, 34]. In this Neolithic tribe, as well as in many similar populations worldwide, there is no age-related rise in blood pressure, and the prevalence of hypertension is less than 5%. However, an increase in blood pressure was observed when members of those populations migrated to the Westernized societies where sodium intake is several-fold higher. The impact of this change is most obvious in Aborigines and African-Americans, who have the highest prevalence of salt-sensitive hypertension (73% compared to 51% and 26% in other hypertensive groups and normotensives, respectively) [35].

The Intersalt Study, which attempted to relate sodium intake to blood pressure from an epidemiological perspective [36], was a cross-sectional assessment of more than 10,000 subjects in 52 locations around the world. Within centers, sodium excretion was significantly related to blood pressure in individual subjects. In an initial analysis of 48 of the 52 centers in which sodium intake averaged >100 mmol/24 h, no significant association between sodium intake and median blood pressure was found. However, after inclusion of the remaining 4 centers, in which the average sodium consumption was 0.2–50 mmol/24 h, a significant association of sodium to blood pressure was revealed [36].

The lowering of dietary sodium has been demonstrated to cause a decrease in blood pressure, as evident from multiple trials [37]. Kempner’s rice diet from 1948 was efficient in lowering blood pressure in malignant hypertension [38]. Dose-related effects of salt reduction on blood pressure values were shown in the DASH study [39], and results from NHANES I revealed that a difference of 100 mmol of NaCl is related to a 32% decrease of cerebrovascular risk [40, 41]. The valuable effect of salt reduction in elderly subjects, where isolated systolic hypertension is the most prevalent, was observed in the Trial of Nonpharmacological Intervention in the Elderly (TONE) [42]. A decrease of 40 mmol of salt was related to a decrease of systolic/diastolic blood pressure by 4.3/2.0 mm Hg. Evaluations of a ‘no added salt diet’ on a hypertensive population with high dietary sodium intake (and not on any drug therapy for hypertension) revealed beneficial effects. 24-hour Holter monitoring of blood pressure and 24-hour urinary sodium excretion were measured before and after 6 weeks of the ‘no added salt diet’. Despite a modest effect on dietary sodium restriction, the ‘no added salt diet’ significantly decreased systolic and diastolic blood pressure [43]. Randomized controlled trials in patients with hypertension [44] suggest that reducing sodium intake by 80–100 mmol per day (equating a reduction of 4.7–5.8 g salt/day) from an initial intake of around 180 mmol per day reduces blood pressure by an average of 4–6 mm Hg [1, 37, 45–48], although with large variability among patients. Jürgens and Graudal [49] reviewed 57 trials, mainly in Caucasians, to study the influence of sodium intake levels on blood pressure and concluded that reduced sodium intake in Caucasians with elevated blood pressure has a useful effect to reduce blood pressure in the short term. The results suggest that the effect of low versus high sodium intake on blood pressure was greater in Black and Asian patients than in Caucasians [49]. Finally, subjects enrolled in TOHP-I and TOHP-II who had reduced salt intake (net decrease in sodium excretion was 44 and 33 mmol/24 h, respectively) had 25% less cardiovascular death and 20% less total death after 15 years of follow-up [50].

Alterations in Functioning of the RAS

The RAS is a major homeostatic system that controls body fluid volume, electrolyte balance, blood pressure, and neuronal and endocrine functions related to cardio-
vascular control. The RAS is a key factor in many cases of essential hypertension, as indicated by the successful treatment of high blood pressure with angiotensin-converting enzyme (ACE) inhibitors and angiotensin II receptor blockers. The RAS exhibits its effects through the effector molecule angiotensin II, which binds to specific membrane-bound angiotensin receptors located in multiple tissues, including the vasculature [51, 52]. Renin is the rate-limiting enzyme in angiotensin II formation [53]. Renin is an aspartyl protease that is synthesized and released by juxtaglomerular cells located in the afferent and efferent arterioles of the renal glomerulus in response to a variety of stimuli, including decreased renal perfusion pressure [54], increased activity of renal sympathetic nerves and decreased NaCl delivery to the macula densa of the juxtaglomerular apparatus [24]. Renin cleaves angiotensinogen, a glycoprotein consisting of 429 amino acids (MW = 53–57 kDa) which is synthesized by hepatocytes [55], to the decapeptide angiotensin I [56], which is further processed by ACE to angiotensin II, a potent vasoactive octapeptide. Angiotensin II can also be formed via non-ACE pathways, such as chymase, which can lead to a phenomenon called ‘angiotensin escape’ in some patients treated with ACE inhibitors. In these cases, circulating concentrations of angiotensin II can return to normal despite continuing therapy with ACE inhibitors (hence ‘escape’), illustrating the importance of alternative non-ACE angiotensin II-forming pathways [57]. Angiotensin II exerts its effects through activation of angiotensin II type 1 (AT₁) and angiotensin II type 2 (AT₂) receptors, with the latter generally assumed to counteract the vasoconstrictor and growth-stimulatory actions of AT₁ receptors [58]. There are several biologically active angiotensin metabolites, including angiotensin III, angiotensin IV and angiotensin-(1–7), which stimulate the 2 receptors mentioned above (but with low affinity), and/or newly discovered putative receptors [58, 59]. Angiotensin III is formed from angiotensin II by aminopeptidase A and angiotensin IV is formed from angiotensin II by aminopeptidase N, whereas angiotensin-(1–7) is formed from angiotensin I by neutral endopeptidase or prolyl endopeptidase and from angiotensin II by prolyl endopeptidase, prolyl carboxypeptidase or ACE 2 [58, 60]. The biological relevance of the different metabolites in various tissues is still under investigation.

Salt-sensitive hypertension is generally associated with some form of impaired renal function, which results in an impaired ability of the individual to properly excrete sodium and water. A high-salt diet normally suppresses angiotensin II level through physiological blood pressure level control mechanisms. In 40–50% of the essential hypertensive population, adrenal and renal vascular responses to angiotensin II do not exhibit the expected changes predicted by changes in sodium intake. These individuals have been called nonmodulators [61]. ‘Salt sensitivity’ is manifested as a large blood pressure change in response to an acute or chronic salt intake change, and is defined as the tendency for blood pressure to fall during salt reduction and rise during salt repletion [62]. If the difference in blood pressure between a salt-loaded state (after administration of 2 liters of saline) and a salt-depleted state (low-sodium diet, about 10 mmol/day of Na plus oral furosemide) is ≥10 mm Hg, it can be defined as salt sensitivity, whereas a difference of ≤5 mm Hg can be defined as salt resistance [26]. Using this definition, salt sensitivity has been reported in certain segments of the population where 26% of normotensive subjects and 51% of hypertensive subjects could be classified as salt-sensitive [63]. It is determined by many factors, such as genetic constitution, race/ethnicity, age, body mass, overall diet quality and associated disease states [62]. Salt sensitivity has been reported among people with renal disease, diabetes, obesity, hypertension and old age [35, 64].

Recent studies have demonstrated several structural alterations of genes encoding the components of the RAS that are related to the development of essential hypertension in humans and in animal models of hypertension. Haplotype analysis in humans by Hasimu et al. [65] revealed a significantly different haplotype distribution between normotensive individuals and subjects with essential hypertension in regard to the renin gene. Elevated plasma renin activity levels with a missense mutation in exon 9 of the renin gene were associated with a specific G/G genotype and hypertension, suggesting that the mutation in exon 9 may affect the enzymatic function of renin by increasing its activity, and consequently may be involved in the etiology of hypertension [65]. A genetic association study in the human population by Giner et al. [66] and Poch et al. [67] evaluated the association between salt-sensitive hypertension and genetic polymorphisms of the RAS in humans. Their study demonstrated a significant association between the insertion/deletion (I/D) polymorphism of the ACE gene and salt-sensitive hypertension. Additionally, salt-sensitive patients exhibited higher blood pressure and less plasma renin activity suppression in response to elevated sodium intake. This was associated with a particular 11b-hydroxysteroid dehydrogenase type 2 (11b-HSD2) genotype, compared to hypertensive salt-resistant patients [67]. A synergistic effect between these 2 polymorphisms in relation to salt...
sensitivity was not present. The authors concluded that a polymorphism in these 2 genes (ACE I/D and 11b-HSD2) is significantly associated with salt-sensitive hypertension [67]. In a cross-sectional study of 284 Japanese working men (age range: 20–64 years) the interaction between the ACE I/D polymorphism and daily salt intake was examined [68]. ACE I/D per se was not associated with blood pressure levels or hypertension. ACE I/D interacted with daily salt intake and correlated with hypertension, suggesting a gene-environment interaction [68]. It is interesting to note that the genes which are overexpressed in the cerebral arteries following salt-induced hypertension are regulated by angiotensin II [69].

Some ethnic populations have been shown to have a greater incidence of hypertension compared with others. African-Americans are more prone to hypertension than Caucasians [70, 71]. The African-American RAS is more salt-sensitive and they tend to develop hypertension even with less sodium intake [72–74]. Changes in the local RAS have also been observed by a number of researchers in different tissues of various rat strains. Strehlow et al. [75] detected downregulation of aortic AT1 receptor density and aortic and renal (AT1) receptor mRNA in Dahl salt-sensitive rats on a high-salt diet, whereas (AT1) receptor mRNA was upregulated in the brain. Wang and Du [76] found increased (AT1) mRNA levels both in the aorta and in mesenteric resistance arteries of Wistar rats fed a high-salt diet. Steven et al. [77] showed that (AT1) receptor density was increased in the renal cortex of spontaneously hypertensive rats after chronic high salt intake. Bayorh et al. [78] evaluated changes in plasma and tissue levels of aldosterone and angiotensin II in Dahl salt-sensitive rats on a high-salt diet, as well as the reduced-to-oxidized glutathione ratio. The high-salt diet caused a reduction in both plasma angiotensin II and aldosterone levels, while their levels in the heart and kidney were increased and the reduced-to-oxidized glutathione ratio in plasma, heart and kidney was lowered by exposure to high salt [78]. The authors concluded that high dietary salt induces inappropriate activation of the local renin-angiotensin-aldosterone systems, that tissue levels of angiotensin II and aldosterone may be more reflective of the severity of vascular maladaptations than plasma levels are, and that they may play a greater role in the maintenance of hypertension [78].

There are important regulatory interactions between RAS, nitric oxide (NO) and O2 in the kidney, where O2 acts as vasoconstrictor and enhances tubular sodium reabsorption and NO exhibits opposite effects. O2 rapidly interacts with NO and thus, when O2 production increas-

Endothelial Dysfunction May Play an Important Role in the Development of Hypertension

Despite efforts devoted to elucidate the role of dietary salt intake in the development (and maintenance) of hypertension, the underlying mechanisms of salt loading that lead to impairment of endothelial function in salt-sensitive hypertension have not been identified. However, there is an increasing body of evidence that normal regulation of the RAS plays an important role in the vascular relaxation mechanisms that are impaired in hypertension, and could contribute to maintenance of the high blood pressure by an elevated total peripheral resistance. Salt-sensitive patients display baseline RAS suppression and a blunted RAS response to high salt intake, which is inversely correlated with the BP response [67, 82]. Panza et al. [83–85] reported a defect in the endothelium-derived NO system in patients with essential hypertension, which may account for increased vascular resistance under basal conditions and an impaired response to endothelium-dependent vasodilators. In a similar fashion, a later study by Bragulat et al. [86] demonstrated the involvement of the NO system in the pathogenesis of salt-sensitive hypertension. That study showed a greater impairment of ACh-induced vasodilation and a significantly reduced effect of L-NMMA on vasodilation in salt-sensitive essential hypertensive patients compared to
salt-resistant hypertensive patients. Maximal ACh-induced dilation was inversely correlated with the 24-hour mean blood pressure elevation during the high-salt diet, and 24-hour urinary secretion of nitrates was significantly decreased only in salt-sensitive patients [86]. Raij and coworkers showed, through multiple studies [87–89], that in salt-sensitive hypertensive rats there is a link between tissue angiotensin II, increased reactive oxygen species production, decreased NO bioactivity, and impaired endothelium-dependent relaxation to ACh.

On the other hand, other authors have failed to demonstrate the influence of increased dietary salt intake on NO-dependent vascular endothelial function. For example, forearm blood flow in response to ACh did not differ significantly between salt-sensitive and salt-resistant patients [90]. A study by Dishy et al. [91] on normotensive human subjects has shown that a high-salt diet leads to a significant decrease in the level of NO degradation products (nitrite and nitrate). Although blood pressure significantly increased with salt loading, changes in blood pressure from a low- to high-salt diet did not correlate with changes in plasma nitrite and nitrate. Additionally, forearm blood flow in response to mental stress (a mathematical task, which has been shown to be an NO-mediated vascular response) significantly increased from control levels in subjects on a high-salt diet, but was not significantly different compared to subjects on a low-salt diet [91]. The authors concluded that the increased blood pressure response to salt loading may occur through mechanisms other than changes in NO, or that salt-sensitive individuals are more sensitive to the reduced NO production that occurs after salt loading in both salt-sensitive and salt-resistant subjects [91]. More research needs to be done to resolve this question.

dos Santos et al. [92] found evidence of endothelial modulation in their experiments on isolated rat caudal and renal vascular beds. Salt treatment of healthy Wistar rats over 4 weeks increased systolic, diastolic and mean arterial pressures and sodium excretion in the absence of changes in plasma sodium levels. Salt increased the reactivity to phenylephrine (PHE) without changing the sensitivity to PHE in the tail vascular bed, but these parameters did not change in the renal bed [92]. In subsequent studies on the isolated caudal vascular bed, the authors found that endothelial damage, but not L-NAME or indomethacin, abolished the increment in PHE reactivity induced by high salt intake, whereas losartan reduced the reactivity in the high-salt diet group to control values [92]. Additionally, local ACE activity in segments from the tail artery increased by 95%. Those studies indicate that 4 weeks of a high-salt diet induces specific territorial vascular changes in response to PHE. The authors also suggested that the increment in the vascular reactivity of the tail vascular bed was endothelium-dependent and was mediated by the activation of the local RAS [92].

Animal Models of Hypertension

Studies on animal models of hypertension have been more successful in demonstrating a genetic basis for salt-sensitive hypertension. Genetic linkage analysis has revealed cosegregation of the SHR (‘spontaneously hypertensive rats’) renin allele with higher blood pressure and lower plasma renin concentrations in an F2 generation from an intercross of SHR and WKY (Wistar-Kyoto) rats [93] and salt-sensitive and Dahl R rats [94], but further genetic analysis of the polymorphism in the salt-sensitive/R strains has not been pursued. A difference in nucleotide sequence was observed in the renin gene promoter region of SHR and WKY rats, and the target region showed protein binding [95]. Furthermore, unique nucleotide variations in intron I of the renin gene, the putative transcriptional factor binding site, were found in the SHR strain. It is possible that an alteration in the DNA binding characteristics that results in renin gene overexpression might form the basis for a tissue renin-angiotensin-dependent form of hypertension in this strain of rats [96].

Different strains of rats may exhibit substantial differences in vascular control mechanisms and other physiological phenotypes, emphasizing the importance of understanding the role of genetic factors in determining physiological control mechanisms [97]. For example, the Dahl salt-sensitive rat strain represents an excellent model in which to study the importance of the RAS in the regulation of the mechanisms that mediate vascular reactivity. Salt-sensitive rats show impaired regulation of the RAS resulting in chronic, low levels of angiotensin II, which could be expected to lead to impaired relaxation to vasodilator stimuli. This rat strain exhibits many of the abnormalities, including salt sensitivity of blood pressure, that occur with hypertension in African-Americans, who exhibit a low-renin salt-sensitive form of hypertension, insulin-resistance and hyperlipidemia [98]. While salt-sensitive rats have low renin levels and high sodium intake suppresses plasma angiotensin II, kidney angiotensin II levels are not decreased by high salt. In fact, a high-salt diet increases renal angiotensinogen levels in salt-sensitive rats – a paradoxical enhancement...
which may represent an important contribution to salt sensitivity in this model [79].

Designer rat strains, such as congeneric and consomic strains, provide a powerful strategy for mapping important functional traits and provide clues for genomic regions important in hypertension and in other complex traits. One component of the Programs for Genomic Applications project at the Medical College of Wisconsin utilizes the salt-sensitive rat strain together with the BN strain as parental strains to develop a panel of consomic rat strains that have individual chromosomes from the BN rat introgressed into the salt-sensitive genetic background by backcrossing. Those consomic rat strains provide a unique model to study the genetic basis of different cardiovascular traits, including blood pressure regulation [99, 100].

In their research related to the role of the renin gene in salt-dependent hypertension, Drenjancevic-Peric and colleagues [101–104] used 4 genetically inbred rat strains to explore the role of the RAS in regulating normal vascular relaxation mechanisms. The results of their studies showed that rats fed a high-salt diet have impaired vascular relaxation mechanisms and that introduction of a functioning renin gene by chromosomal transfer contributes to recovery of dilator responses [101]. These changes in vascular reactivity are found in the middle cerebral artery and mesenteric and skeletal muscle resistance arteries of the rat [101–105]. Other studies suggest that a high-salt diet leads to increased oxidative stress in the microcirculation and to altered ratios between pro- and antioxidative enzymes levels [106, 107]. It has been shown that the loss of vascular relaxation, impaired endothelial cell (Ca²⁺) signaling, increased vascular oxidative stress, and reduced expression of Cu/Zn superoxide dismutase in resistance arteries of animals fed a high-salt diet can all be prevented by chronic intravenous infusion of a suppressor dose of angiotensin II that prevents salt-induced angiotensin II suppression [105, 108]. Not only angiotensin II suppression but also reduced interaction of angiotensin II with its AT₁ receptor contributes to impaired vascular relaxation in Sprague-Dawley rats fed a high-salt diet [109–111], which taken together with the other findings suggests that tonic activation of the AT₁ receptor by normal circulating levels of angiotensin II plays an important role in maintaining vascular relaxation mechanisms under normal physiological conditions [105].

Some experiments have linked a high-salt diet to oxidative stress in the rostral ventrolateral medulla of spontaneously hypertensive rats [112], an area that contributes to the neural mechanisms involved in the development of hypertension. In those animals, elevated salt intake enhanced the blood pressure increase and sympathetic nervous system activity. Elevated dietary salt intake also enhances the sympathoexcitatory actions of angiotensin II in the rostral ventrolateral medulla via changes in the intrinsic properties of rostral ventrolateral medulla neurons [113].

The deoxycorticosterone acetate (DOCA)-salt hypertension model is interesting and might prove helpful in understanding the causes of hypertension resulting from hypervolemia, hyperaldosteronism and high salt intake. In the DOCA-salt rat model, the effects of chronic administration of DOCA (a mineralocorticoid) reduce renal mass and a high-salt diet leads to development of hypertension in several stages [114]. In the first 48 h, there is an abrupt increase in arterial pressure, followed by a delayed, slower rise in arterial pressure over the next few weeks, leading to sustained hypertension. 8–12 weeks later, severe hypertension may be observed (malignant phase) [114]. Neural and humoral contributions might, alongside the dietary and renal factors, be important in the development of hypertension in this model, with neural factors (sympathetic nerve activity, possibly enhanced by increased sodium levels) contributing more in the early phases, and humoral factors (vasopressin and endothelin) contributing in the later malignant phase [114].

Salt-dependent increases in blood pressure have been found in other animal species as well. For example, Denton et al. [115] studied the effect of different sodium intake levels on blood pressure in chimpanzees. The effect of high salt intake differed between chimpanzees, with some animals having a large blood pressure rise and others a small rise or none at all. Overall, the authors found that sodium reduction can lower blood pressure and sodium addition can produce a significant elevation in arterial pressure [115].

**Possible Role of Renal Cytokine Gene Expression in the Development of Hypertension**

Cytokines, such as transforming growth factor-beta (TGF-β)-1 (which is a modulator of multiple processes such as cell growth and proliferation, inflammation, endothelial and vascular smooth muscle cell function, and extracellular matrix metabolism), may play a role in human hypertension [116]. TGF-β-1 is involved in renal glomerulosclerosis, tubulointerstitial fibrosis and progressive renal failure, while studies in patients with essential hypertension linked circulating TGF-β-1 levels and mi-
crobalbuminuria [116]. Overexpression of TGF-β by intravenous injection, transient gene transfer or transgene insertion in animals has shown that the kidney is highly susceptible to rapid fibrosis, and complex interactions between TGF-β and the RAS have been discovered [117]. In various experiments on animals, such as in angiotensin II-induced hypertension, inflammatory changes associated with renal injury have been characterized and angiotensin II was proposed as the major factor responsible for monocyte recruitment and vascular inflammatory changes in the kidney [118, 119]. Other studies investigated renal inflammatory response in aldosterone/salt-induced hypertension and found that aldosterone/salt-induced renal vascular injury and fibrosis are associated with leukocyte infiltration and increased expression of the proinflammatory cytokines osteopontin, monocyte chemoattractant protein-1, interleukin-1 beta (IL-1β) and IL-6 [118]. The inhibition of tumor necrosis factor-alpha (TNF-α) reduces renal injury in DOCA-salt hypertensive rats, suggesting a TNF-α contribution to the increase in renal inflammation [120]. Interestingly, the anti-inflammatory cytokine IL-10 has been demonstrated to have a significant antihypertensive effect. Adeno-associated virus-mediated systemic IL-10 expression reduces systolic blood pressure in Dahl salt-sensitive rats, suggesting a proinflammatory role for IL-1α in hypertension [121]. Although our knowledge about the role of changes in renal cytokine gene expression in the development of hypertension is still incomplete, it seems that these changes may be indeed relevant for a better understanding of the interaction of salt and the RAS in hypertension.

**Final Remarks**

The causes of essential hypertension are still unknown despite the investigative efforts of scientists worldwide. Taken together, the results of previous studies suggest that mutations in the renin gene (or other genes that encode components of the RAS) could be crucial in the development of hypertension and salt sensitivity. Besides the mentioned effects of high sodium intake on the RAS, endothelial dysfunction and sympathetic nervous system activity, there are other factors that cannot be disregarded as important contributors to the blood pressure increase linked to salt intake, including volume expansion (and elevated peripheral resistance in the later phase), functional changes of ion exchangers (such as the Na-Li countertransport), a polymorphism in the protein α-aducin (the Gly460Trp allele) [122] and possibly a reduced activity of the kallikrein-kinin system in the kidney as recently proposed by Katori and Majima [122]. Better understanding of the mechanisms involved in the interaction of sodium intake and blood pressure will be essential for successful therapeutic interventions; and new insights into this issue represent a valuable means of controlling the aforementioned public health problems. But whatever the precise mechanisms may be, we can now say with nearly complete certainty that nonpharmacological treatment of the prehypertensive population, such as reduction in the salt intake, is crucial for reducing the number of hypertensive patients in the future. Public health measures should be directed toward increasing public awareness of the pathophysiological effects of excessive usage of dietary salt in the development of hypertension.

**References**


88. Drenjančević-Perić/Jelaković/Lombard/Kunert/Kibel/Gros
High-Salt Diet and Hypertension

Kidney Blood Press Res 2011;34:1–11