Conditional Deletion of \textit{Hsd11b2} in the Brain Causes Salt Appetite and Hypertension

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\textbf{Background}—The hypertensive syndrome of Apparent Mineralocorticoid Excess is caused by loss-of-function mutations in the gene encoding 11β-hydroxysteroid dehydrogenase type 2 (11βHSD2), allowing inappropriate activation of the mineralocorticoid receptor by endogenous glucocorticoid. Hypertension is attributed to sodium retention in the distal nephron, but 11βHSD2 is also expressed in the brain. However, the central contribution to Apparent Mineralocorticoid Excess and other hypertensive states is often overlooked and is unresolved. We therefore used a Cre-Lox strategy to generate 11βHSD2 brain-specific knockout (\textit{Hsd11b2.\textbf{BKO}}) mice, measuring blood pressure and salt appetite in adults.

\textbf{Methods and Results}—Basal blood pressure, electrolytes, and circulating corticosteroids were unaffected in \textit{Hsd11b2.\textbf{BKO}} mice. When offered saline to drink, \textit{Hsd11b2.\textbf{BKO}} mice consumed 3 times more sodium than controls and became hypertensive. Salt appetite was inhibited by spironolactone. Control mice fed the same daily sodium intake remained normotensive, showing the intrinsic salt resistance of the background strain. Dexamethasone suppressed endogenous glucocorticoid and abolished the salt-induced blood pressure differential between genotypes. Salt sensitivity in \textit{Hsd11b2.\textbf{BKO}} mice was not caused by impaired renal sodium excretion or volume expansion; pressor responses to phenylephrine were enhanced and baroreflexes impaired in these animals.

\textbf{Conclusions}—Reduced 11βHSD2 activity in the brain does not intrinsically cause hypertension, but it promotes a hunger for salt and a transition from salt resistance to salt sensitivity. Our data suggest that 11βHSD2-positive neurons integrate salt appetite and the blood pressure response to dietary sodium through a mineralocorticoid receptor–dependent pathway. Therefore, central mineralocorticoid receptor antagonism could increase compliance to low-sodium regimens and help blood pressure management in cardiovascular disease. \textit{(Circulation. 2016;133:1360-1370. DOI: 10.1161/CIRCULATIONAHA.115.019341.)}

\textbf{Key Words:} aldosterone \hspace{1em} mineralocorticoids \hspace{1em} pressoreceptors \hspace{1em} salt \hspace{1em} solitary nucleus

Congenital, acquired (licorice ingestion), or age-related deficiency in the glucocorticoid-metabolizing enzyme 11β-hydroxysteroid dehydrogenase type 2 (11βHSD2) promotes low-renin hypertension, hypokalemia, and sodium retention attributable to unregulated activation of the mineralocorticoid receptor (MR) by endogenous cortisol (corticosterone in rodents).\cite{1} Reduced 11βHSD2 activity causes a spectrum of disease: genetic ablation of the enzyme causes the life-threatening syndrome of Apparent Mineralocorticoid Excess (AME; OMIM +218030), diagnosed in early childhood;\cite{2} reduced activity causes hypertension in adults,\cite{3} and loss-of-function variants in \textit{HSD11B2} are associated with increased blood pressure per se or with salt sensitivity of blood pressure.\cite{4,5}

\textbf{Editorial, see p 1335}
\textbf{Clinical Perspective on p 1370}

AME presents with sodium retention\cite{6} and, in common with monogenic Liddle syndrome,\cite{7} can be resolved by renal transplantation.\cite{8} This suggests that high blood pressure follows the kidney,\cite{9} at least in these spectral disorders. This renal-centric view of hypertension is supported by our studies in \textit{Hsd11b2 null mice, which are hypertensive on a basal salt intake;\cite{10}} renal sodium excretion is reduced, and sodium...
transport pathways in the aldosterone-sensitive distal nephron are inappropriately activated.\textsuperscript{11,12} Similarly, \textit{Hsd11b2} heterozygote null mice, which have normal basal blood pressure, cannot efficiently excrete a sodium load and are salt sensitive.\textsuperscript{13,14}

11βHSD2 is also normally expressed in the brain, but the contribution of central pathways to hypertension in AME and other hypertensive states is poorly understood and often overlooked. Studies in humans suggest that 11βHSD2 in the brain may contribute to abnormal sodium homeostasis: increased salt appetite has been reported in AME\textsuperscript{15} and loss-of-function variants positively associate with sodium intake in the general population.\textsuperscript{16} Moreover, the sympathetic nervous system is activated in \textit{Hsd11b2} null mice, contributing importantly to the maintenance of hypertension in these animals.\textsuperscript{11}

11βHSD2 has a widespread central expression during fetal development and modulates glucocorticoid programming of adult behavior and cognitive function.\textsuperscript{17} Fetal 11βHSD2 expression is progressively silenced from midgestation, and, in adulthood, 11βHSD2 is restricted to subpopulations of neurons in brain areas influencing blood pressure and, less certainly, salt appetite.\textsuperscript{17–19} In the adult mouse, \textit{Hsd11b2} is only expressed in the nucleus of the solitary tract (NTS).\textsuperscript{20} However, defining the role of 11βHSD2 in these NTS neurons of the adult brain has been challenging. Overstimulation of these neurons by intracerebrovascular infusion of aldosterone\textsuperscript{21} or 11βHSD2 inhibitors\textsuperscript{22} increases blood pressure. Such studies are informative but lack precision; conventional gene targeting

expression in the aldosterone-sensitive distal nephron was confirmed by immunohistochemistry, and 11βHSD2 enzyme activity was measured as the conversion of [\textsuperscript{3}H]corticosterone to [\textsuperscript{3}H]dehydrocorticosterone, quantified by thin-layer chromatography.

\textbf{Blood Pressure Measurement}

Radiotelemetry devices (model TA-11PAC-10, Data Systems International, St Paul, MN) were inserted into \textit{Hsd11b2} BKO (n=6) and control mice (n=6) under ketamine-medetomidine anesthesia. After a week of postoperative recovery, data were collected over a 5-minute period every 20 minutes at an acquisition rate of 2 kHz. Mice were housed under controlled temperature (21±1°C) and humidity (50±10%) with a fixed 12-hour light:dark cycle (lights on 7 AM local time). Each animal underwent the following protocols.

\textbf{Ad Libitum Salt Intake}

Blood pressure was recorded over a 7-day baseline period during which mice were able to drink from 2 bottles containing deionized water. This experiment was repeated in an independent cohort of nontelemetered mice, and the data sets were merged to give \textit{Hsd11b2}.BKO (n=12) and control (n=9). Water intake was \(\approx 4\) mL/24 h and was not different between groups. After 7 days, 1 water bottle was replaced with a 1.5% NaCl bottle for a 21-day period. Bottle position was alternated every 24 hours to negate side preference. Throughout this experiment, both groups of mice had a similar food intake.

\textbf{Fixed Salt Intake}

Mice were fed a diet in which sodium was incorporated as a powdered chow mixed with gelatin. During baseline, the diet contained \(\approx 0.1\) sodium by weight, which was then increased to \(\approx 1\) sodium for a 7-day period. The amount of the gel consumed per day was predetermined to ensure that mice ate the entire block, clamping sodium intake across genotypes during the experimental phase. Mice had access to deionized drinking water throughout this experiment, and blood pressure was recorded by radiotelemetry.

\textbf{Dexamethasone}

Once blood pressure had reached steady state under matched sodium feeding, dexamethasone (DEX) was administered via the drinking water (1 \(\mu\)g/mL in 0.1% ethanol) and plasma corticosterone measured at 7 pm was reduced in both genotypes (\textit{Hsd11b2}.BKO=186±38 versus 31±5 nmol/L after DEX; Control=205±18 basal versus 43±8 nmol/L after DEX).

\textbf{Salt-Taste Threshold}

In a cohort of control (n=4) and \textit{Hsd11b2}.BKO (n=4) mice, taste threshold was assessed by offering a first drinking bottle containing deionized water and a second containing either a saline solution (0.25%–3%) or quinine (1%). Each measurement was made over 48 hours.

\textbf{Mineralocorticoid Receptor Antagonism}

Intake of 1.5% saline was determined in a separate group of \textit{Hsd11b2}. BKO mice (n=8), before (baseline) and after MR antagonism with spironolactone; measurements were also made in a group (n=3) of control mice. Spironolactone was distributed 1:4 w:w in an elastomer matrix (Silastic MDX4-4210, Dow Corning) and pellets cured overnight at 37°C. After ad libitum salt preference had been measured, pellets were implanted subcutaneously under isoflurane anesthesia. Each pellet contained \(\approx 30\) mg of the drug, designed to achieve a plasma concentration of canrenone (the active metabolite of spironolactone) of \(\approx 75\) nmol/L.\textsuperscript{25}

\textbf{Sodium Balance in Conscious Mice}

Mice (n=6 of each genotype) were housed in individual metabolism cages for measurement of sodium and potassium excretion, first on basal sodium diet (0.1% sodium), then 1% sodium diet. Urinary
sodium and potassium concentration was measured by flame photometry; plasma sodium and potassium were measured by ion-selective electrode (AVI 9180 Electrolyte analyzer, Roche UK). Aldosterone and corticosterone concentration in urine was measured by enzyme-linked immunosorbent assay.

**Baroreceptor Reflex**

The integrated baroreceptor reflex was assessed pharmacologically in anesthetized mice (thiobutabarbital; 120 mg/kg IP) maintained on either 0.1% sodium diet or 1% sodium diet for 7 days before the experiment. A cannula was inserted into the jugular vein and a tracheostomy was performed. A cannula filled with heparin-saline was placed in the carotid artery. The cannula was made from a ≈5-mm length of p10 Portex tubing inserted into a ≈50-mm length of p50 tubing. The undampened pulse wave was recorded continuously at 1 kHz using a Capto pressure transducer connected to a Powerlab (AD Instruments, Oxford, UK). After postsurgical equilibration, sodium nitroprusside (30, 60, and 120 μg/kg) and phenylephrine (10, 20, and 40 μg/kg) were injected intravenously in random order, to induce acute decreases and acute increases in blood pressure, respectively. For each injection, the change in heart rate at the peak change in systolic blood pressure (SBP) was recorded and Δheart rate/ΔSBP was used as an index of baroreceptor gain.

**Statistics**

Data are presented as mean±standard error, as medians with interquartile range, or as linear regression with 95% confidence interval, as appropriate. Statistical comparisons (Graphpad Prism 6, La Jolla, CA) were made by using 2-way analysis of variance (ANOVA) with repeated measures, Mann-Whitney U or t tests, as stated in the figure legends. For 2-way ANOVA, we assessed the main effects of the genotype and treatment and the interaction between the 2. When used, planned or post hoc comparisons were made by using Holm-Sidak test to correct for multiple comparisons. The family P value was fixed at 0.05, and the number of comparisons is indicated in the figure legends. The diurnal variation in SBP and heart rate was characterized by cosinor analysis, calculating by sine function least-squares regression, mesor, amplitude, and acrophase for each mouse; these values were then used to calculate the group mean comparison between genotypes by the Welch t test. The goodness-of-fit model was confirmed in all cases by the significance of the F statistic using the zero-amplitude test (P<0.01 or less).

**Results**

**Baseline Parameters**

The expression of Hsd11b2 mRNA in the NTS of adult Hsd11b2.BKO mice was reduced by >90% in comparison with controls (Figure I in the online-only Data Supplement). Expression and localization of renal 11ßHSD2 in adult Hsd11b2.BKO mice was not different from control animals (Figure II in the online-only Data Supplement).

Under baseline conditions SBP, diastolic blood pressure (DBP), and heart rate were similar in Hsd11b2.BKO mice and controls (Figure III in the online-only Data Supplement; Table I in the online-only Data Supplement); the acrophase of the diurnal variation for SBP and heart rate corresponded to 3 AM local time in both groups of animals. Food/water intake, plasma electrolytes, hematocrit, and corticosteroids were not different between genotypes (Table II in the online-only Data Supplement). These data contrast with observations in animals with global Hsd11b2 deletion, which are hypertensive and hyperkalemic and have a suppressed renin-angiotensin-alderosterone system under conditions of basal sodium intake.

**Salt-Sensitive Hypertension in Hsd11b2.BKO Mice**

When offered 1.5% NaCl solution to drink, Hsd11b2.BKO mice became hypertensive, average 24-hour SBP increasing by 20 to 30 mmHg over a 2-week period (Figure 1A); blood pressure was not changed in control mice during ad libitum access to saline. In Hsd11b2.BKO mice, blood pressure returned to baseline when the saline-drinking option was withdrawn (Figure 1A).

Cosinor analysis was performed on data acquired over 4 consecutive days (periods indicated in Figure 1A) during both basal and saline periods. High salt intake caused a significant increase in mesor SBP in Hsd11b2.BKO mice but not in controls (Figure IVB in the online-only Data Supplement; Table I in the online-only Data Supplement). The amplitude of the diurnal SBP variation was also significantly higher in Hsd11b2.BKO mice than in controls (Figure IVB in the online-only Data Supplement; Table I in the online-only Data Supplement), whereas acrophase was not affected by sodium intake. Both SBP (Figure 1B) and DBP (Figure 1C) were significantly elevated during the dark phase of the day/night cycle in Hsd11b2.BKO mice, but this salt sensitivity was not associated with a genotypic difference in the heart rate over the 24-hour cycle (Figure V in the online-only Data Supplement; Table I in the online-only Data Supplement).

**Salt Appetite and Hypertension**

Both Hsd11b2.BKO and control mice had a daily deionized water intake of ≈4 mL. When presented with the option, Hsd11b2.BKO mice spontaneously drank 8 mL/24 h of 1.5% NaCl while maintaining their deionized water intake (Figure 2A). Hsd11b2.BKO mice had salt preference, saline accounting for >60% of total fluid intake. Control mice also drank from the saline bottle but displayed a modest salt aversion, with saline accounting for <40% of total intake. Thus, daily sodium intake increased significantly in both genotypes, but the average intake over the experiment was 3 times higher in the Hsd11b2.BKO mice than in controls (Hsd11b2.BKO=3154±352 μmol/24 h; Control=982±129 μmol/24 h; P<0.001).

We were not able to detect a lower threshold for salt preference, Hsd11b2.BKO mice maintained a higher saline-to-water intake at all but the highest concentration (3% NaCl) tested (Figure 2B). This abnormality was not a generalized taste phenomenon, because Hsd11b2.BKO mice retained an aversion for quinine (Figure 2B). Systemic administration of the MR antagonist, spironolactone, did not affect saline intake in the 3 control mice (Figure 2C) but reduced saline drinking in all 8 Hsd11b2.BKO mice tested (Figure 2D). On average, spironolactone reduced saline intake to 69±5% of predrug values (P=0.0006, 1-sample t test). Nevertheless, saline intake remained higher in Hsd11b2.BKO mice than in controls during spironolactone treatment. Spironolactone did not affect water consumption in either group of mice.

To resolve whether increased salt intake in Hsd11b2.BKO mice was causal or permissive for the hypertensive phenotype, the 2 groups of mice were fed an equivalent amount of sodium-rich gel-diet. The average sodium intake was 4619±121 μmol/24 h in Hsd11b2.BKO mice and 4790±215 μmol/24 h in controls (n=6 per group. P=0.452). High sodium
feeding significantly increased SBP (Figure 3A and 3B) and DBP (Figure 3C) in Hsd11b2.BKO mice. The amplitude of the 24-hour SBP rhythm was also significantly increased ($P=0.006$; Table I in the online-only Data Supplement). Heart rate was not different between genotypes, but high salt intake reduced the amplitude of the 24-hour rhythm significantly in Hsd11b2.BKO mice ($P=0.044$; Table I in the online-only Data Supplement).

Blood pressure in control mice was not affected by high salt intake, indicating that the C57BL6/J background strain was not intrinsically salt sensitive. This salt resistance in the control animals means that the salt-sensitive hypertension of Hsd11b2.BKO mice cannot just reflect increased salt appetite. The data suggest that central homeostatic response to salt intake becomes abnormal following deletion of 11βHSD2 in the brain. This does not reflect abnormalities in systemic corticosteroid production: aldosterone and corticosterone excretion were similar in both genotypes under high-salt conditions (Table II in the online-only Data Supplement).

### Effect of Oral Dexamethasone
Deficiency of 11βHSD2 allows MR to be activated by endogenous glucocorticoid. DEX suppression of the hypothalamic-pituitary-adrenal axis, which markedly reduces cortisol levels, can be used to treat patients with AME. DEX suppressed corticosterone (the endogenous glucocorticoid in rodents) in both Hsd11b2.BKO mice and controls, and, after 5 days of treatment, the genotypic difference in mean blood pressure was no longer apparent (Figure 4A). However, unequivocal interpretation of these data is challenging, because, as expected, DEX increased SBP (Figure 4B) and DBP (Figure 4C) in control mice.
Hypertension Is Not Caused by Sodium Retention

The effect of increased salt intake on renal sodium excretion was assessed in a separate cohort of mice (n=6 for each genotype), fed first the basal salt diet (0.1% sodium) diet, followed by the high-salt (1% sodium) diet. Basal sodium intake averaged 420±15 μmol/24 h in Hsd11b2.BKO mice and 397±20 μmol/24 h in controls: urinary sodium excretion was not different between genotypes (Figure VIA in the online-only Data Supplement). During the high-salt phase, average sodium intake again increased 10-fold in both control (4810±177 μmol/24 h) and Hsd11b2.BKO (4335±240 μmol/24 h) mice and was not significantly different between the 2 groups (P=0.143; unpaired t test). Urinary sodium excretion was significantly higher in Hsd11b2.BKO mice than in controls during this period (Figure VIA in the online-only Data Supplement), suggesting that hypertension was not attributable to renal sodium retention.

Basal urine flow rate was slightly higher in Hsd11b2.BKO mice than in controls, and the diuresis prompted by high-sodium feeding was significantly greater in Hsd11b2.BKO mice (Figure VIB in the online-only Data Supplement). Dietary sodium feeding was not associated with marked changes in hematocrit in either genotype (Table II in the online-only Data Supplement). Overall, these data indicate that hypertension was not caused by absolute plasma volume expansion following sodium retention.

The high-sodium diet induced hypokalemia in Hsd11b2.BKO mice (Figure VIB in the online-only Data Supplement). This did not reflect a change in dietary potassium intake, which was consistent throughout the study and not different between genotype. Given the exaggerated salt-induced diuresis in Hsd11b2.BKO mice, we anticipated that urinary potassium losses would account for potassium depletion. Although urinary potassium excretion was indeed higher in Hsd11b2.BKO mice, it was not significantly different from controls (Figure VIA in the online-only Data Supplement).
Figure 3. Radiotelemetry data from conscious unrestrained mice on fixed sodium intake. A, Systolic blood pressure measured every 20 minutes over a 24-hour period in Hsd11b2.BKO mice (n=6; filled squares) and controls (n=6; open circles). Data are group mean±SEM, generated by averaging each mouse over 5 consecutive days of recording. Mesor, amplitude, and acrophase were calculated by cosinor analysis (Figure I and Table II in the online-only Data Supplement) of nonaveraged data obtained over consecutive days indicated by the box. The black line indicates subjective night (7 PM to 7 AM local time). Twenty-four–hour averaged systolic (B) and 24-hour averaged diastolic (C) blood pressure in Hsd11b2.BKO mice (filled squares) and controls (open circles) before and during a period of equivalent high-sodium feeding. Data are mean±SEM. For SBP ANOVA reported a significant effect of diet (P<0.0001) but not genotype (P=0.079); for DBP, there were significant differences for diet (P<0.0001), genotype (P=0.013), and the interaction between these main effects (P<0.0001). ANOVA indicates analysis of variance; DBP, diastolic blood pressure; SBP, systolic blood pressure; and SEM, standard error of the mean.
BKO than in controls, this difference was observed under both dietary regimens and not increased during the high-sodium feeding (Figure VIC in the online-only Data Supplement).

**Enhanced Pressor Effect of Phenylephrine and Impaired Baroreflex Gain in Hsd11b2.BKO Mice**

The salt-sensitive hypertension in *Hsd11b2* mice was not associated with a compensatory fall in heart rate, but the amplitude of the 24-hour cycle of heart rate was significantly reduced, suggesting impaired autonomic cardiac control. The NTS is an important site of baroreflex integration, and we therefore assessed directly the bradycardic response to an acutely applied pressor stimulus. In *Hsd11b2* mice maintained on a 0.1% salt diet, the pressor response to phenylephrine was significantly enhanced (Figure 5A), and the bradycardic baroreflex gain was significantly attenuated (Figure 5B). Reflex tachycardia response to sodium nitroprusside was similar in both genotypes (Figure 5C), as was the net fall in SBP. Overall, *Hsd11b2* mice displayed an asymmetrical attenuation of the baroreceptor reflex curve (Figure 5D; *P*<0.0001). Similar results were obtained in a separate cohort of *Hsd11b2* mice and controls maintained on a 1% sodium diet for 7 days (Figure VII in the online-only Data Supplement). There was no significant effect of increased dietary salt intake on baroreflex function in control mice. *Hsd11b2* mice displayed impaired bradycardic baroreflex gain. This defect was not exaggerated by dietary salt loading.

**Discussion**

Reduced 11βHSD2 activity causes a spectrum of hypertension-associated disease. Its most severe form, AME, can be rescued by renal transplantation, suggesting that high blood pressure follows the kidney. However, 11βHSD2 is also expressed in the brain, restricted to a subset of neurons in the NTS in the adult mouse. We used a Cre-Lox strategy to conditionally delete *Hsd11b2* in the brain, reducing expression...
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We found that 11βHSD2 in the brain normally exerts significant influence over sodium homeostasis and blood pressure control, independent of renal function. We identified 3 important phenotypes in Hsd11b2.BKO mice: (1) an innate salt appetite, blocked by MR antagonism; (2) salt sensitivity of blood pressure, independent of salt appetite and sodium retention; and (3) an exaggerated pressor response to α-adrenoreceptor activation and an impaired reflex bradycardia.

Central Deletion of 11βHSD2 and Salt Appetite
Negative salt balance evokes an instinctive salt-seeking behavior. The central pathways for this physiological response are not fully elucidated, but 11βHSD2-expressing neurons in the NTS are selectively activated by sodium depletion and rapidly inactivated when salt appetite is satiated. Hsd11b2.BKO mice had a strong salt appetite in the absence of sodium/volume depletion or systemic aldosterone excess. This underscores the concept that local corticosteroid levels in the brain influence the physiological control of sodium homeostasis. Genetic defects in central MR signaling would act synergistically with those in the distal nephron to amplify hypertension.

Systemic administration of an MR antagonist was an effective treatment but did not completely abolish salt appetite in Hsd11b2.BKO mice. Spironolactone is a competitive antagonist of MR and, although our method of delivery achieves high plasma concentrations of the active metabolite, canrenone, the levels reaching the NTS may be lower. Nevertheless, similar dosing regimens provide neuroprotection after cerebral ischemia in mice, and oral administration of low-dose spironolactone decreases sympathetic drive and improves baroreflex function in rats with heart failure. This suggests that central MR can be effectively blocked by systemic spironolactone, and the incomplete rescue of salt appetite in the current study may suggest that additional pathways contribute in the Hsd11b2.BKO mice. Central angiotensin II promotes thirst and, to a lesser extent, sodium appetite, particularly in response to sodium depletion or hypovolemia.

Because water intake was not different between genotypes, we...
Central Deletion of 11βHSD2 and Salt-Sensitive Blood Pressure

An important observation in our study was the salt-resistant blood pressure of the control mice. Thus, with the enzymatic barrier protecting MR intact, blood pressure is not affected by large (3-fold) increases in sodium intake; if the barrier is broken this same sodium load induces a rapid and sustained hypertension. The influence of 11βHSD2-positive neurons in the NTS therefore extends beyond the regulation of salt appetite by normally preventing large fluctuations in dietary salt intake from exerting corresponding changes to blood pressure.

Unlike humans, in mice or rats with global 11βHSD2 deficiency, deletion in the brain alone is not sufficient to change basal blood pressure, and the additional insult of a sustained high sodium intake is required for hypertension. The nature of this interaction is not yet defined. High salt intake was necessary but not sufficient for the hypertensive response, a situation analogous to the pressor effect of intracerebrovascular aldosterone infusion, which is sensitized by, but not directly natriorexigenic, they potentiate the salt appetite induced by mineralocorticoids by increasing MR expression in the brain.36

Central Deletion of 11βHSD2 and Peripheral Blood Pressure Control

Salt sensitivity was not associated with sodium retention; urinary sodium excretion was higher in Hsd11b2.BKO mice than in controls during the dietary salt challenge. The regulation of blood pressure by aldosterone-target neurons in the NTS appears independent of kidney function, suggesting that MR-dependent hypertension may have a substantial neurogenic component.22,43 In other salt-sensitive models, increased central sympathetic drive and increased peripheral resistance sustain hypertension.44–46 The salt-induced increase in DBP and heightened pressor responsiveness to α-adrenoreceptor agonism in Hsd11b2.BKO mice are consistent with this hypothesis. Similarly, salt-induced hypokalemia in the absence of potassium wasting may suggest redistribution of potassium into the intracellular compartment following sympathetic activation.47 An impaired baroreflex would release tonic inhibition of sympathetic nerve activity, increasing sympathetic drive to the peripheral vasculature. In Hsd11b2.BKO mice, the impairment was asymmetrical, and the ability to buffer a pressor response was compromised. Similar observations are found in healthy humans following systemic aldosterone infusion48 and in patients with mild congestive heart failure,49 and contribute to increased cardiovascular risk in these patients.50

Summary and Perspectives

Our study demonstrates a unifying link between activation of MR in the NTS, salt appetite, and blood pressure control. In the absence of a physiological stimulus to consume salt, this arc is maladaptive and causes salt-sensitive hypertension. These same molecular pathways regulate renal salt reabsorption. Thus, global mutations in key genes will give a double hit for hypertension by increasing the behavioral drive to consume sodium and impairing the ability of the kidney to excrete this salt. Given that global sodium intake is habitually high, this integrated framework of sodium homeostasis is highly relevant and suggests that MR antagonists could be used to improve compliance to dietary sodium restriction in the treatment of cardiovascular disease.

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Disclosures

None.

References


**CLINICAL PERSPECTIVE**

For the majority of people in industrialized societies, dietary salt intake habitually exceeds the recommended upper tolerable limit. This sustained high salt intake is associated with hypertension and with increased risk of cardiovascular disease. Reducing sodium intake may be beneficial for a large number of people, particularly those with hypertension or heart failure. However, compliance to restricted salt intake is poor, which may in part reflect enhanced salt appetite. The central pathways controlling salt intake are incompletely defined, but it is known that certain neurons in the brain stem are activated by salt depletion. We genetically modified mice, removing a gene in the brain stem to amplify local aldosterone signaling. Basal blood pressure and systemic electrolyte and hormonal status were not affected by this genetic modification. However, ad libitum salt intake increased 3-fold and this caused hypertension. We were able to partially block salt appetite with the mineralocorticoid antagonist spironolactone. This study demonstrates an important role for brain stem pathways in the control of sodium homeostasis and blood pressure. Mineralocorticoid antagonists could help improve compliance to restricted salt regimens during the management of cardiovascular disease.
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**Supplemental Table 1.** Cosinor analysis of A) systolic blood pressure and B) heart rate in control and Hsd11b2.BKO mice made from recordings over 5 consecutive days in each of the baseline, *ad libitum* and fixed salt phases. Mesor (mmHg); amplitude (mmHg) and acrophase (degrees) are shown as group arithmetic mean±SE. The P values are 2-tailed and comparisons were made using unpaired t-tests.

### A) Systolic Blood Pressure

<table>
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<th>Control</th>
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<th>Hsd11b2.BKO</th>
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<tr>
<td><strong>Baseline</strong></td>
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<tr>
<td>Mesor</td>
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<td>Acrophase</td>
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<td>-1.40±0.06</td>
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<tr>
<td>Acrophase</td>
<td>-1.03±0.06</td>
<td>0.143</td>
<td>-1.22±0.09</td>
</tr>
<tr>
<td><strong>Fixed salt intake</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mesor</td>
<td>134.7±2.3</td>
<td>0.252</td>
<td>144.7±7.6</td>
</tr>
<tr>
<td>Amplitude</td>
<td>10.70±0.78</td>
<td>0.006</td>
<td>15.2±1.02</td>
</tr>
<tr>
<td>Acrophase</td>
<td>-0.97±0.01</td>
<td>0.342</td>
<td>-1.01±0.11</td>
</tr>
</tbody>
</table>

### B) Heart rate

<table>
<thead>
<tr>
<th></th>
<th>Control</th>
<th>P</th>
<th>Hsd11b2.BKO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Baseline</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mesor</td>
<td>571±7</td>
<td>0.937</td>
<td>570±16</td>
</tr>
<tr>
<td>Amplitude</td>
<td>70±5</td>
<td>0.443</td>
<td>62±8</td>
</tr>
<tr>
<td>Acrophase</td>
<td>-1.21±0.07</td>
<td>0.222</td>
<td>-1.03±0.12</td>
</tr>
<tr>
<td><strong>Ad lib. salt intake</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mesor</td>
<td>472±83</td>
<td>0.368</td>
<td>555±17</td>
</tr>
<tr>
<td>Amplitude</td>
<td>52±3</td>
<td>0.814</td>
<td>54±9</td>
</tr>
<tr>
<td>Acrophase</td>
<td>-0.64±0.08</td>
<td>0.963</td>
<td>-0.64±0.06</td>
</tr>
<tr>
<td><strong>Fixed salt intake</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mesor</td>
<td>542±8</td>
<td>0.677</td>
<td>535±15</td>
</tr>
<tr>
<td>Amplitude</td>
<td>56±6</td>
<td>0.044</td>
<td>37±5</td>
</tr>
<tr>
<td>Acrophase</td>
<td>-0.45±0.06</td>
<td>0.089</td>
<td>-3.19±0.08</td>
</tr>
</tbody>
</table>
Supplemental Table 2. Plasma sodium and potassium concentration, haematocrit and urinary excretion of aldosterone and corticosterone for control and Hsd11b2.BKO mice maintained on either a 0.1% or 1% sodium diet. Data are mean±SEM and comparisons were made by 1-way ANOVA with Holm-Sidak post-hoc test used to test 3 planned comparisons with a family alpha of 0.05. *P<0.05; **P<0.01 within genotype; ††P<0.01 between genotype.

<table>
<thead>
<tr>
<th>Diet</th>
<th>Control n=6</th>
<th>Control n=6</th>
<th>Hsd11b2.BKO n=6</th>
<th>Hsd11b2.BKO n=6</th>
<th>ANOVA P</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.1% Na</td>
<td>1% Na</td>
<td>0.1% Na</td>
<td>1% Na</td>
<td></td>
</tr>
<tr>
<td>PNa (mmol/l)</td>
<td>147.0±0.7</td>
<td>151.0±1.2</td>
<td>154.3±2.0††</td>
<td>153.0±1.2</td>
<td>0.008</td>
</tr>
<tr>
<td>PK (mmol/l)</td>
<td>4.84±0.25</td>
<td>4.26±1.21</td>
<td>4.79±0.18</td>
<td>3.09±0.27**</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Hct (%)</td>
<td>44±2</td>
<td>42±1</td>
<td>41±2</td>
<td>44±1</td>
<td>0.293</td>
</tr>
<tr>
<td>UAldo (pmol/24h)</td>
<td>2.15±0.45</td>
<td>3.58±0.78</td>
<td>1.83±0.24</td>
<td>3.35±0.41</td>
<td>0.197</td>
</tr>
<tr>
<td>UCort (pmol/24h)</td>
<td>209±13</td>
<td>329±29*</td>
<td>196±25</td>
<td>294±50</td>
<td>0.047</td>
</tr>
</tbody>
</table>
Supplemental Figure 1. *Hsd11b2* mRNA abundance in the Nucleus of the Solitary Tract (NTS) micro-dissected from adult male control (n=13; open circles) and *Hsd11b2*.BKO mice (n=11; black squares). The brain was removed after cervical dislocation and the hind-brain was cut away from the forebrain and the cerebellum removed. The top half of the medial section of the hind-brain, containing the NTS was collected for extraction of total RNA. A) *Hsd11b2* mRNA abundance expressed in arbitrary units (AU) was normalised to that of hypoxanthine guanine phosphoribosyl transferase (*hprt*) in the same sample. B) The percentage reduction in *Hsd11b2* expression in *Hsd11b2*.BKO mice was calculated by normalizing to the mean expression of the control group. Individual points are shown with the group median and interquartile range. The comparisons were made using the Mann-Whitney test.

**A) Hsd11b2 expression in NTS**

![Graph showing Hsd11b2 expression in NTS](image)

- *P*<0.0001

**B) Relative Hsd11b2 expression**

![Graph showing relative Hsd11b2 expression](image)

- *P*<0.0001
Supplemental Figure 2. Expression of 11βHSD2 immunoreactivity in fixed sections from A) control and B) Hsd11b2.BKO mouse kidney. 11βHSD2 expression was restricted to the collecting duct segments. Images (x200 magnification) of cortical collecting ducts are shown and in both genotypes, 11βHSD2 was expressed in principal cells, but not in intercalated cells. C) Hsd11b2 mRNA abundance and D) 11βHSD2 enzyme activity in whole kidney homogenates. There were no differences between genotype analysed by Mann-Whitney test and unpaired t-test, respectively.
Supplemental Figure 3. A) Systolic blood pressure; B) diastolic blood pressure; and C) heart rate in control (open symbol; n=6) and Hsd11b2.BKO (black symbol; n=6) mice. Recordings were made by radiotelemetry over 7 consecutive days during which all mice had ad libitum access to standard rodent diet and dH2O. The diurnal variability was assessed in each mouse over the final 4 days of recording and data combined to give a group average. Bar indicates subjective night. Data are shown as mean ± SEM.
**Supplemental Figure 4.** The effect of salt on mesor and amplitude SBP in control (open circles; n=6) and Hsd11b2.BKO (black squares; n=6) mice. Group mean and SEM are shown in Supplemental Table 2. In this figure, data points (with group means ± SEM) from individual mice are shown for A) mesor and B) amplitude of SBP. Two-way ANOVA with repeated measures was used to assess the main effects of salt diet and genotype and the interaction between these two. For mesor, there was a significant effect of diet (P=0.016) and genotype (P=0.008), but not of interaction (P=0.161). For amplitude there was no significant effect of salt diet (P=0.623), but the effect of genotype was different (P=0.039) as was the interaction (P=0.015). Planned comparisons were made within genotype, as indicated.

**A) Mesor time-series**

![Mesor time-series graph]

**B) Amplitude time-series**

![Amplitude time-series graph]
Supplemental Figure 5. Heart rate in control (open circle; n=6) and hsd11b2.BKO (black square; n=6) mice. Recordings were made by radiotelemetry and mice had ad libitum access to standard rodent diet and two drinking bottles containing dH2O and 1.5% NaCl, respectively. Bottles were rotated every 24 hours. The diurnal variability was assessed in each mouse over the final 4 days of recording and data combined to give a group mean ± SEM. The bar indicates subjective night.
Supplemental Figure 6. A) sodium excretion, B) urine flow rate and C) potassium excretion in control mice (n=6; open circles) and Hsd11b2.BKO mice (n=6, black squares). Mice were fed a gel diet delivering a fixed sodium intake per day. For the first 5 days, mice received 0.1% Na diet before being fed 1% Na diet for the next 8 days. Data, normalized to body weight, are mean ± SEM. Two-way ANOVA with repeated measures was used to assess the main effects of salt diet and genotype and the interaction between these two. For sodium excretion, the effect of diet was significant (P<0.0001), the effect of genotype not significant (P=0.063) and the interaction significant (P=0.048). For urine flow rate the effect of diet (P<0.0001), genotype (P=0.004) and the interaction (P<0.0001) was significant. For potassium excretion the effect of diet (P<0.0001 and genotype (P=0.035) was significant; the interaction was not significant (P=0.837). No planned or post-hoc comparisons were made.
Supplemental Figure 7. Baroreceptor reflex function under high salt conditions. The baroreflex was measured pharmacologically in anaesthetized Hsd11b2.BKO mice (black squares; n=5 mice/59 responses) and controls (white circles; n=6 mice; 71 responses) mice after 7 days of ad libitum access to 2.5% salt diet. A) the baroreflex curve showing individual data points for the change in heart rate (ΔHR) in response to induced changes in systolic blood pressure (ΔSBP). There was a significant difference (P<0.0001) between genotypes by linear regression analysis. B) the baroreflex gain during intravenous injection of sodium nitroprusside (tachycardic gain) and during C) intravenous injection of phenylephrine (bradycardic gain); individual data points are shown, with the median and IQR. Comparisons were by Mann-Whitney test, with P values as indicated.

A) Baroreflex curve on high salt diet

![Baroreflex curve on high salt diet graph]

B) Tachycardic gain

C) Bradycardic gain