Editorial Comments

Endothelin receptor antagonists: a place in the management of essential hypertension?

Michel Burnier and Valentina Forni

Service de Néphrologie et Hypertension, Centre Hospitalier Universitaire Vaudois, Lausanne, Switzerland

Correspondence and offprint requests to: Michel Burnier; E-mail: michel.burnier@chuv.ch

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Introduction

The endothelin system is a potent endothelial system that controls vascular tone and regulates regional blood flow [1]. Today, three isoforms of the endothelin peptide have been described (endothelin-1, -2 and -3) but most biological effects of endothelin are mediated by the 21 amino acid endothelin-1. In addition to its vascular properties, endothelin influences cell proliferation and extracellular matrix synthesis and contributes to the homeostasis of water and electrolytes by direct effects on the kidney [1]. Endothelin acts through the activation of two specific G-protein-coupled receptors, i.e. endothelin Type A (ETA) and endothelin Type B (ETB) receptors. Stimulation of vascular ETA receptors induces vasoconstriction, whereas activation of vascular ETB receptors promotes vasodilatation. Therefore, the impact of endothelin on vascular tone will depend on the balance between the ETA and ETB receptor activation. Since its discovery, the endothelin system has been implicated in the pathophysiology of several diseases including essential arterial hypertension, pulmonary hypertension, congestive heart failure, acute kidney injury and more recently the progression of chronic kidney diseases (CKDs) [2–5].

Since 1992, several peptidic and non-peptidic endothelin receptor antagonists have been synthesized (Table 1) [6]. Animal studies using these antagonists have provided promising results in different indications but today, except for the management of pulmonary hypertension, the clinical development of endothelin receptor antagonists has been relatively slow and their use for the management of essential arterial hypertension is still under investigation. The purpose of this review is to discuss the potential role of endothelin receptor antagonists in the management of arterial essential hypertension and perhaps in the prevention of the progression of CKDs.

Endothelin receptor blockade in hypertension

Because of its important vascular properties, the endothelin system has naturally been considered as a potential mechanism in the development and maintenance of arterial hypertension. The infusion of exogenous endothelin has indeed been shown to raise blood pressure significantly in animals as well as in humans [7]. The possibility that endothelin generates arterial hypertension was further considered with the observation that two patients suffering from a malignant form of hemangioendothelioma, a vascular tumour-secreting endothelin, presented with marked hypertension [8]. High plasma endothelin concentrations have been measured in malignant hypertension and pregnancy-induced hypertension and also in Afro-Americans [7–10]. At last, a greater vasoconstrictor effect of exogenous endothelin has been found in hypertensive patients when compared to healthy subjects [9].

In animal models, endothelin receptor antagonists are effective in lowering blood pressure in salt-sensitive hypertensive models and in stroke prone and malignant hypertension models [11]. In contrast, endothelin receptor blockade appears to be ineffective in renin-dependent models of hypertension. In addition to lowering blood pressure, endothelin antagonists have been shown to have favourable effects on cardiovascular remodelling, on the incidence of stroke and on the progression of renal lesions in animals [11, 12].

In healthy normotensive subjects, the administration of a non-selective endothelin antagonist decreases peripheral arterial resistances leading to a decrease in blood pressure [13]. However, the infusion of a selective ETB antagonist increases vascular resistances suggesting that the hypertensive effect of non-selective antagonists is due essentially to the blockade of ETA receptors [14].

The first large study in essential arterial hypertension compared the anti-hypertensive efficacy of increasing doses of the non-selective endothelin antagonist bosentan with that of enalapril 20 mg and a placebo [15]. The study was conducted in patients with Stage 1–2 hypertension. In this study, bosentan effectively lowered blood pressure and endothelin receptor blockade was significantly superior to placebo but comparable to enalapril. Interestingly, there was no clear dose–response for the anti-hypertensive effect of bosentan between 500 and 2000 mg. The incidence of side effects essentially headaches, flushes and leg oedema
Endothelin receptor antagonists: a potential role in renal protection?

Endothelin-1 also exerts opposing effects on the kidney associated with the activation of vascular and tubular endothelin receptors [21, 22]. Through renal vascular ETA receptors, endothelin-1 induces a vasoconstriction of renal afferent and efferent arterioles. Thus, infusion of endothelin-1 decreases renal blood flow and glomerular filtration rate and eventually reduces urine flow rate and urinary sodium excretion. A contrario activation of tubular ETB receptors increases urine output and sodium excretion. Thus, blockade of ETA, in contrast to ETB receptor blockade, has been recognized as a potential mean to lower filtration fraction and hence proteinuria. This property of selective ETA receptor blockers was nicely demonstrated in animals and in a small set of patients with CKDs [12, 23–25]. Interestingly, the impact of ETA receptor blockade was more prominent in CKD patients than in healthy subjects suggesting that the contribution of the endothelin system to the regulation of renal haemodynamics is important mainly in patients with renal diseases [22].

In CKD patients, several small studies using different agents have demonstrated that endothelin receptor blockers, essentially ETA receptor blockers, lower blood pressure and/or proteinuria [23, 24, 26–29]. Of note, the anti-proteinuric effect of ETA blockade was observed even in patients already treated with a blocker of the renin–angiotensin system, suggesting an additive effect [30, 31]. In one study, the effect of the endothelin antagonist sitaxsentan on proteinuria was superior to that of a placebo or nifedipine, despite comparable decreases in blood pressure when compared with nifedipine 10 mg [32]. The ability of ETA receptor blockade to lower proteinuria urged investigators to perform a large Phase III study in patients with diabetic nephropathy and proteinuria already on a blocker of the renin–angiotensin system [33]. In this randomized controlled trial, two doses of avosentan (25 and 50 mg) were compared to placebo and the main objectives of the study were the changes in proteinuria and the progression of the diabetic nephropathy. At 6 months, a significant decrease in albumin/creatinine ratio was obtained with both doses of avosentan but not with the placebo. Unfortunately, the impact on the progression of diabetic nephropathy could not be investigated because the study was interrupted prematurely. Indeed, the safety committee reported an increased incidence of fluid overload leading to heart failure in patients receiving the two doses of avosentan [33]. This finding therefore corroborated the observations made previously with other endothelin antagonists as discussed above.

In order to clarify the mechanisms leading to the development of fluid overload with endothelin receptor antagonist, a mechanistic study was designed to investigate the dose-dependent renal effects of avosentan in healthy subjects [34]. The results of this placebo-controlled study demonstrated that avosentan indeed induces fluid and sodium retention at high doses (>10 mg/day) in healthy subjects. The fluid retention leads to a significant weight gain and decrease in haematocrit after 1 week of administration. At lower doses

Table 1. Non-peptide endothelin receptor antagonists and their relative selectivity for endothelin receptors

<table>
<thead>
<tr>
<th>Drug name</th>
<th>Chemical class</th>
<th>ETA/ETB</th>
<th>Relative selectivity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bosentan</td>
<td>Pyrimidine sulfonamide</td>
<td></td>
<td>20</td>
</tr>
<tr>
<td>Tezosentan</td>
<td>Pyrimidine sulfonamide</td>
<td></td>
<td>30</td>
</tr>
<tr>
<td>Avosentan</td>
<td>Pyrimidine sulfonamide</td>
<td></td>
<td>50–600</td>
</tr>
<tr>
<td>Enrasentan</td>
<td>Carboxylic acid</td>
<td></td>
<td>110</td>
</tr>
<tr>
<td>Darusentan</td>
<td>Propanoic acid</td>
<td></td>
<td>130–170</td>
</tr>
<tr>
<td>Ambrisentan</td>
<td>Propanoic acid</td>
<td></td>
<td>200</td>
</tr>
<tr>
<td>Clazosentan</td>
<td>Pyrimidine sulfonamide</td>
<td></td>
<td>1000–3200</td>
</tr>
<tr>
<td>Atrasentan</td>
<td>Carboxylic acid</td>
<td></td>
<td>1860</td>
</tr>
<tr>
<td>Sitaxsentan</td>
<td>Heteroarylsulfonamide</td>
<td></td>
<td>7000</td>
</tr>
<tr>
<td>Edonentan</td>
<td>Biphenylsulfonamide</td>
<td></td>
<td>80 000</td>
</tr>
</tbody>
</table>

*Adapted from reference [6].
(1.5 and 5 mg), this effect was not observed suggesting that it might be linked to the loss of receptor selectivity when high doses of the ETA antagonist are administered. Of note, a decrease in haematocrit upon administration of high doses of avosentan has also been found in anephric rats indicating that other mechanisms than sodium and water retention by the kidney may play a role [35]. We have hypothesized that a drug-induced extravasation of fluid as observed with potent peripheral vasodilators may also contribute to the development of oedema in subjects receiving endothelin antagonists.

Taken together, these data confirm that endothelin receptor blockade can lower proteinuria but the benefits of these drugs may be limited by their tolerability profile. Thus, additional studies with well dosed and highly selective ETA antagonists should be conducted in the future to investigate the real potential of this therapeutic approach for renal protection.

Conclusions

There is increasing evidence that endothelin receptor antagonists have some clinical potential in the management of essential hypertension and probably also to retard the progression of renal diseases. However, at this stage, several issues need to be resolved before this approach can be considered for our patients. Firstly, it is obvious that highly selective ETA receptor antagonists should be developed rather than poorly selective blockers. Indeed, the impact on blood pressure and proteinuria appears to be mediated essentially by ETA receptor blockade. In this respect, it is of major importance to define as precisely as possible the dose–response curve of any new agent in order to avoid a lack of selectivity and thereby increase the side effect profile. Secondly, the development of endothelin receptor antagonists further emphasizes the importance of understanding the mechanisms of the major side effects. Thus, the exact role of ETB receptors in the occurrence of fluid overload needs to be clarified and the precise mechanisms of fluid retention should be investigated further in susceptible patients. Indeed, in the ASCEND trial, it appears that fluid retention was very sensitive to loop diuretics and rapidly reversible. Combining an endothelin antagonist with a diuretic might perhaps be one way to limit the incidence of fluid overload if renal mechanisms are predominant. In any case, it seems too early to abandon the development of endothelin receptor antagonists for the management of cardiovascular and renal diseases as we may miss therapeutic opportunities.

Conflict of interest statement. None declared.

References

4. Kalra PR, Moon JC, Coats AJ. Do results of the ENABLE (Endothelin Antagonist Bosentan for Lowering Cardiac Events in Heart Failure) study spell the end for non-selective endothelin antagonism in heart failure? Int J Cardiol 2002; 85: 195–197

Table 2. Randomized controlled trials assessing the anti-hypertensive efficacy of endothelin receptor antagonists in essential hypertension

<table>
<thead>
<tr>
<th>Publication</th>
<th>Population</th>
<th>Length (months)</th>
<th>Antagonist</th>
<th>Drug and dose</th>
<th>ΔBP (mmHg) Systolic blood pressure</th>
<th>ΔBP (mmHg) Diastolic blood pressure</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Krum et al. [15]</td>
<td>Stage I–II hypertension (n = 267)</td>
<td>1</td>
<td>ETA–ETB</td>
<td>Bosentan 2000</td>
<td>−10.3/−5.7</td>
<td>n.s.</td>
<td></td>
</tr>
<tr>
<td>Nakow [16]</td>
<td>Stage II hypertension (n = 387)</td>
<td>1½</td>
<td>Selective ETA</td>
<td>Darusentan 100</td>
<td>−11.3/−8.3b</td>
<td>n.s.</td>
<td>0.0001</td>
</tr>
<tr>
<td>Raichlin [17]</td>
<td>Hypertension and high CV risk (n = 72)</td>
<td>6</td>
<td>Selective ETA</td>
<td>Atrasentan 10</td>
<td>−14/7</td>
<td>n.s.</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Black et al. [18]</td>
<td>Resistant hypertension (n = 115)</td>
<td>2½</td>
<td>Selective ETA</td>
<td>Darusentan 300</td>
<td>−11.5/−6.3b</td>
<td>n.s.</td>
<td>0.015/0.002</td>
</tr>
<tr>
<td>Weber et al. [19]; DORADO</td>
<td>Resistant hypertension and high CV risk (n = 379)</td>
<td>2</td>
<td>Selective ETA</td>
<td>Darusentan 300</td>
<td>−18/−11</td>
<td>n.s.</td>
<td>0.0001</td>
</tr>
<tr>
<td>Bakris et al. [20]; DORADO-AC</td>
<td>Resistant hypertension (n = 849)</td>
<td>2½</td>
<td>Selective ETA</td>
<td>Darusentan</td>
<td>−15/−10</td>
<td>n.s.</td>
<td></td>
</tr>
</tbody>
</table>

aETA, A receptor of endothelin; ETB, B receptor of endothelin; BP, blood pressure; SBP, systolic blood pressure; DBP, diastolic blood pressure; n.a., not applicable; n.s., not significant.
bPlacebo subtracted.


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