Pharmacologic Atrial Natriuretic Peptide Reduces Human Leg Capillary Filtration

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Summary: Atrial natriuretic peptide (ANP) is produced and secreted by atrial cells. We measured calf capillary filtration rate with prolonged venous-occlusion plethysmography of supine healthy male subjects during pharmacologic infusion of ANP (48 pmol/kg/min for 15 min; n = 6) and during placebo infusion (n = 7). Results during infusions were compared to prior control measurements. ANP infusion increased plasma [ANP] from 30 ± 4 to 2,568 ± 595 pmol/L. Systemic hemoconcentration occurred during ANP infusion: mean hematocrit and plasma colloid osmotic pressure increased 4.6 and 11.3%, respectively, relative to preinfusion baseline values (p < 0.05). Mean calf filtration, however, was significantly reduced from 0.15 to 0.08 ml/100 ml/min with ANP. Heart rate increased 20% with ANP infusion, whereas blood pressure was unchanged. Calf conductance (blood flow/arterial pressure) and venous compliance were unaffected by ANP infusion. Placebo infusion had no effect relative to prior baseline control measurements. Although ANP induced systemic capillary filtration, in the calf, filtration was reduced with ANP. Therefore, pharmacologic ANP infusion enhances capillary filtration from the systemic circulation, perhaps at upper body or splanchnic sites or both, while having the opposite effect in the leg. Key Words: Extracellular fluid—Hemoconcentration—Capillary permeability—Capillary pressure.

Atrial natriuretic peptide (ANP) is a hormone produced and secreted by atrial myocytes on distention of the atria (1,2). ANP is an established vasodilator, yet may also decrease blood pressure and cardiac output by reducing intravascular volume and cardiac filling pressure, because increases in hematocrit and plasma protein concentration are commonly associated with ANP administration (3). Furthermore, ANP-induced hematocrit elevation has been observed in nephrectomized animals (4,5), and it occurs too quickly to be attributed solely to urinary loss. It seems that ANP somehow augments systemic filtration, or at least discourages reabsorption of extracellular fluid into the circulation.

Three studies have investigated effects of ANP on capillary filtration in the human forearm using prolonged venous-occlusion plethysmography. Two found that ANP increased forearm capillary filtration up to 63% (6,7), whereas the third showed only an insignificant trend toward elevation of forearm filtration (8). Using similar methods, we sought to determine whether ANP affects capillary filtration rate as measured in legs of human subjects; we hypothesized that ANP produces systemic hemoconcentration in part by increasing calf capillary filtration. We also attempted to relate effects on calf filtration rate to peripheral arteriolar or venous dilation or both, and to two systemic indices of hemoconcentration, hematocrit and plasma colloid osmotic pressure. The legs are important sites for study of capillary filtration because gravitational pressures in the circulation encourage leg filtration while upright, and because disease states such as congestive heart failure may be associated with supraphysiologic plasma [ANP] (1) and leg edema. Prolonged venous occlusion holds venous and capillary pressures relatively constant, which emphasizes effects of other Starling forces and permeability changes on capillary fluid movement. Conversely, effects of factors that alter filtration by
changing capillary pressure cannot be assessed by this technique.

METHODS

Subjects
Ten healthy male subjects gave written, informed consent to participate. All were normotensive (arterial blood pressures ≤140/90), unmedicated, did not use tobacco, and were not obese (life insurance tables). They were 24 to 47 years old (mean, 33 years), 180 ± 3 cm tall (mean ± SEM), and they weighed 75.6 ± 2.9 kg. Female subjects were not recruited because of potential reproductive risks of radiation imposed by this research.

ANP and placebo infusions
We used synthetic 26 amino acid met-ANP provided by Merck, Sharp, and Dohme Research Laboratories. Lyophilized ANP was reconstituted in isotonic saline such that infusion of the resulting solution at 1.17 ml/min would deliver 48 pmol ANP/kg/min (150 ng/kg/min) for 15 min to the subject. Placebo infusion consisted of an equal amount of isotonic saline (17.6 ml total). This research was approved by the UT Southwestern Human Research and Radiation Safety Committees, and by the U.S. Food and Drug Administration (Investigational New Drug number 30,392).

Plasma ANP radioimmunoassay
Atrial natriuretic peptide-like immunoreactivity in unextracted human plasma was measured with radioimmunoassay (RIA) kits purchased from Research and Diagnostic Antibodies, Inc., as previously described (9). Extraction is not called for by this RIA, and ANP measurement in unextracted plasma is a simpler technique with which we (9) and others (10) have had consistent and reliable results previously. Briefly, 7-ml blood samples were drawn into EDTA tubes after withdrawal of a 2-ml sample to avoid dilution of blood with the saline in the catheter. Blood was drawn from the arm before and at the end of control and infusion periods. The total volume of blood drawn during a study equaled ~40 ml and was replaced with an equal volume of isotonic saline. Chilled blood samples were centrifuged (20 min at 1,800 g), and plasma aliquots were frozen at −20°C. Duplicate 100-μl thawed plasma samples were assayed according to the RIA kit instructions. The mean correlation coefficient for standard curves was 0.994. Intra- and interassay coefficients of variation were 10.3 and 17.4%, respectively. Percentage recovery by this RIA of ANP added to plasma samples averaged 83.1 ± 7.2% (SEM) over a range from 1 to 7 fmol ANP/tube.

Resting calf blood flow and conductance
Subdiastolic venous-occlusion plethysmography was employed with a Mercury-in-liquid strain gauge to measure calf blood flow. This method is well established and described in the literature (11). The strain gauge is placed around the point of maximum calf girth, and a pressure cuff is placed proximal to the knee. Inflation of the cuff to a subdiastolic pressure (50 mm Hg) impedes venous drainage from the calf without affecting arterial inflow. Conductance is calculated by dividing flow by mean arterial pressure and provides an index of local vasodilation.

Calf capillary filtration rate, blood volume, and vascular compliance
Calf capillary filtration rate, blood volume, and vascular compliance were measured by combining venous-occlusion plethysmography (to measure relative calf volume changes) with blood imaging (99mTc technetium-labeled red blood cells) to measure relative calf blood volume (13,14). Two ml of centrifuge-packed erythrocytes (5 min at 1,300 g) were labeled in vitro with 20 mCi 99mTc according to instructions provided with the kit from Cadema Medical Products, Inc. (Middletown, NY, U.S.A.). Labeling of centrifuge-packed erythrocytes avoids undesirable and incidental labeling of plasma proteins. Before injection of the labeled erythrocytes, percentage binding of Tc to erythrocytes was quantified by recentrifuging an aliquot of the labeled sample in a microhematocrit centrifuge and then dividing gamma counts in the packed cells by counts in cells plus supernatant. Percentage of Tc bound to erythrocytes was always >96% and usually >98%, thereby confirming minimal free and protein-bound Tc. Tc percentage binding remained at or above these levels in vivo. A Picker Digital Dyna Gamma Camera acquired images of both legs. Gamma counts were corrected for background and decay. One leg, determined at random, was instrumented for venous-occlusion plethysmography, and the other served as an unoccluded control.

Plethysmographic calf volume increase during the rapid arterial inflow phase of venous occlusion (the first minute, when filtration is assumed to be negligible) calibrates the radionuclide blood volume technique (13,14). Baseline calf blood volume percentage is calculated by applying the relationship between plethysmographic calf-volume elevation and gamma counts during the first minute of occlusion to the preocclusion gamma level (14). Prolonged venous occlusion consisted of 9 min at 50 mm Hg. Calf vascular compliance was quantified as the increase in calf blood volume at 2 min of venous occlusion. Calf capillary filtration rate during venous occlusion equals elevation of plethysmographic calf volume minus the elevation of scintigraphic calf blood volume per unit time (i.e., rate of extravascular volume elevation). Calf filtration was quantified between 1 and 9 min of occlusion.

Other dependent variables
Heart rate was determined from ECG. A Narco Biosystems PE-300 electrophysgomanometer indirectly measured brachial arterial blood pressure. Mean arterial pressure (MAP) was calculated as:

\[
MAP = DBP + \frac{(SBP - DBP)}{3}
\]

We measured hematocrit of unoccluded arm venous blood with microhematocrit centrifugation. Plasma colloid osmotic pressure was measured in 100-μl samples with a membrane-exclusion colloid osmometer modified from Aukland and Johnsen (15). Samples were taken from those collected for ANP analysis. Plasma colloid osmotic pressure was not measured in the placebo group, because hematocrit did not change in that group (see Results).

Protocol
Subjects were instructed to abstain from caffeine, medications, and alcohol for at least 24 h before the study. All experiments were performed during mid-afternoon in the
TABLE 1. Influence of ANP infusion on plasma [ANP], hemodynamics, plasma colloid osmotic pressure, and calf capillary filtration

<table>
<thead>
<tr>
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<th>Control</th>
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<tr>
<td>ANP (pmol/L)</td>
<td>30 ± 4</td>
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<tr>
<td>HR (beats/min)</td>
<td>61 ± 5</td>
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<td>MAP (mm Hg)</td>
<td>78 ± 3</td>
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<td>Calf blood volume (vol%)</td>
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<td>Hematocrit (%)</td>
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<td>Plasma colloid osmotic pressure (mm Hg)</td>
<td>21.7 ± 0.6</td>
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<td>Calf filtration (vol%/min)</td>
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*Vol%, milliliters per 100 ml tissue; ANP, atrial natriuretic peptide; HR, heart rate; MAP, mean arterial pressure. Values reported as mean ± SEM, n = 6.

TABLE 2. Changes in plasma ANP concentrations and hemodynamics.

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Nuclear Medicine Division of Parkland Memorial Hospital, Dallas, Texas. Subjects were catheterized in an arm vein, after which they underwent the erythrocyte radiolabeling procedure. Subjects were then instrumented while supine with their legs elevated ~15° from horizontal (calves 15-20 cm above heart level, to facilitate emptying of leg veins) and knees slightly bent for comfort. Legs were supported with pillows and foam pads such that the calf, however, decreased 47% during ANP infusion. Individually, five of the six subjects who received ANP infusion exhibited a clear depression of calf filtration rate; ANP relative to preinfusion control values (Fig. 1). The single subject whose calf filtration rate was not affected by ANP had the lowest control value and was our oldest subject (47 years). Calf filtration rate was inversely related to plasma ANP concentration during control data collection (R^2 = 0.846, Fig. 2), but this relationship became insignificant during ANP infusion (R^2 = 0.484, p = 0.125).

FIG. 1. Responses of individual subject's calf filtration rates to ANP infusion relative to control. Vol% equals milliliters per 100 ml tissue.

FIG. 2. Relationship between calf filtration rate and plasma colloid osmotic pressure during preinfusion control periods in both ANP and placebo subject groups (r = 0.796, Fig. 3). Calf venous compliance was unaffected by ANP infusion (Table 1). Control data for placebo and ANP...
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prior control measurements (Table 2).

infusion groups were statistically similar. Placebo infusion had no effect on any variable relative to prior control measurements (Table 2).

**DISCUSSION**

Hematocrit and plasma colloid osmotic pressure findings confirm that a pharmacologic ANP stimulus produces hemoconcentration, in accordance with the literature (1,3,17). Weidmann et al. (3) pointed out that ANP-induced hemoconcentration occurs more quickly than if diuresis were responsible. Our findings support their conclusion. A plasma volume reduction of ~200 ml occurred during the 15-min ANP infusion we employed (estimated from hematocrit increase, assuming blood volume of ~5 L; 5,9). To excrete this volume over such a short time would require a urine production rate of 13 ml/min, which is unlikely. We can conclude, therefore, that ANP enhanced fluid movement from plasma to interstitium in this study.

Although we expected ANP to increase leg capillary filtration in accordance with the systemic hemoconcentration we observed, the opposite actually occurred: ANP infusion reduced leg filtration. This observation disagrees with prior studies (6,7) that reported ANP-induced elevation of forearm filtration despite significant increases in plasma protein concentration. Therefore, ANP-induced colloid osmotic pressure elevation cannot explain the depression of leg filtration we observed.

Alternative mechanisms exist to explain elevated systemic and forearm filtration induced by ANP. First, increased capillary hydrostatic pressure would oppose the reabsorptive force generated by plasma proteins (5,27,28). Second, increased capillary permeability to various extracellular fluid constituents, including protein, would favor capillary filtration (29-32). These mechanisms are not mutually exclusive and could occur separately or together in specific vascular beds. Venous occlusion hypothetically holds capillary pressure constant. If

![FIG. 3. Relationship between calf conductance and plasma [ANP] during preinfusion control data collection. Three subjects were in both placebo and ANP groups; data points for those subjects represent averages of data from their two control periods. n = 10, R² = 0.634, p = 0.006. VoH% equals milliliters per 100 ml tissue.](image)

**TABLE 2. Influence of placebo infusion on plasma [ANP], hemodynamics and calf capillary filtration**

<table>
<thead>
<tr>
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<th>Control</th>
<th>Placebo</th>
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<tbody>
<tr>
<td>ANP (pmol/L)</td>
<td>21 ± 2</td>
<td>22 ± 2</td>
</tr>
<tr>
<td>HR (beats/min)</td>
<td>66 ± 4</td>
<td>68 ± 4</td>
</tr>
<tr>
<td>MAP (mm Hg)</td>
<td>88 ± 4</td>
<td>86 ± 4</td>
</tr>
<tr>
<td>Calf blood volume (vol%)</td>
<td>3.8 ± 0.5</td>
<td>3.8 ± 0.4</td>
</tr>
<tr>
<td>Conductance (vol% - 10³/min/mm Hg)</td>
<td>2.4 ± 0.3</td>
<td>2.5 ± 0.5</td>
</tr>
<tr>
<td>Compliance (vol% - 10⁵/mm Hg)</td>
<td>2.8 ± 0.2</td>
<td>2.6 ± 0.4</td>
</tr>
<tr>
<td>Hematocrit (%)</td>
<td>44 ± 1</td>
<td>44 ± 1</td>
</tr>
<tr>
<td>Calf filtration (vol%/min)</td>
<td>0.11 ± 0.02</td>
<td>0.09 ± 0.01</td>
</tr>
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ANP, atrial natriuretic peptide; vol%, milliliters per 100 ml tissue; HR, heart rate; MAP, mean arterial pressure.

Values reported as mean ± SEM, n = 7, α = 0.05.
ANP increases filtration by elevating capillary pressure, then it should be rendered ineffective during venous occlusion. If, however, the peptide acts by increasing capillary permeability, then ANP should necessarily increase occlusion-induced filtration (6,7). Our results, therefore, suggest that ANP actually reduces capillary permeability in the legs, while increasing it elsewhere.

ANP infusion often increases heart rate (1,7,33). Most investigators view this finding as a reflexive response to ANP-induced systemic hypotension, because no direct chronotropic (or inotropic) effects of ANP have been conclusively identified (1,3,34). The positive relationship we observed between plasma [ANP] and calf conductance during the control period (Fig. 3) suggests that ANP contributes to calf vasomotor control in supine resting conditions. An increase in calf conductance during ANP infusion, such as we saw evidence of, is indicative of arteriolar vasodilation, which should reduce blood pressure. We may not have observed a reduction in blood pressure with ANP as compared to control because the cardiac arm of the carotid baroreflex defended an already low mean arterial pressure. (The control MAP mean was 78 mm Hg.)

In summary, we confirmed that a pharmacologic ANP dose produces hemoconcentration in normal human males, and that because it occurs so quickly, this hemoconcentration cannot be solely attributed to control because the cardiac arm of the carotid baroreflex defended an already low mean arterial pressure. (The control MAP mean was 78 mm Hg.)

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