REVIEW

Renoprotective Effects of \( \text{ET}_A \) Receptor Antagonists Therapy in Experimental Non-Diabetic Chronic Kidney Disease: Is There Still Hope for the Future?

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Summary

Chronic kidney disease (CKD) is a life-threatening disease arising as a frequent complication of diabetes, obesity and hypertension. Since it is typically undetected for long periods, it often progresses to end-stage renal disease. CKD is characterized by the development of progressive glomerulosclerosis, interstitial fibrosis and tubular atrophy along with a decreased glomerular filtration rate. This is associated with podocyte injury and a progressive rise in proteinuria. As endothelin-1 (ET-1) through the activation of endothelin receptor type A (\( \text{ET}_A \)) promotes renal cell injury, inflammation, and fibrosis which finally lead to proteinuria, it is not surprising that \( \text{ET}_A \) receptors antagonists have been proven to have beneficial renoprotective effects in both experimental and clinical studies in diabetic and non-diabetic CKD. Unfortunately, fluid retention encountered in large clinical trials in diabetic CKD led to the termination of these studies. Therefore, several advances, including the synthesis of new antagonists with enhanced pharmacological activity, the use of lower doses of ET antagonists, the addition of diuretics, plus simply searching for distinct pathological states to be treated, are promising targets for future experimental studies. In support of these approaches, our group demonstrated in adult subtotally nephrectomized Ren-2 transgenic rats that the addition of a diuretic on top of renin-angiotensin and \( \text{ET}_A \) blockade led to a further decrease of proteinuria. This effect was independent of blood pressure which was normalized in all treated groups. Recent data in non-diabetic CKD, therefore, indicate a new potential for \( \text{ET}_A \) antagonists, at least under certain pathological conditions.

Key words

Endothelin A receptor blockade • End-organ damage • Chronic kidney disease • Proteinuria • Diuretics • RAS blockade

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Introduction

Chronic kidney disease (CKD) is a life-threatening disease arising as a frequent complication of diabetes, obesity and hypertension. Since it is typically undetected for a long time, it often progresses to end-stage renal disease. Prevalence of CKD is sharply increasing in recent decades due to the ageing of the world population: affecting more than 10 % of the adult population. CKD is characterized by the development of progressive glomerulosclerosis, interstitial fibrosis and tubular atrophy along with a decreased glomerular filtration rate. This is associated with podocyte injury and a progressive rise in proteinuria.

Angiotensin converting enzyme inhibitors (ACEi) and angiotensin type 1 receptor blockers (ARB) are used as the “gold standard” in the treatment of CKD due to their antihypertensive and renoprotective effects. However, the renin-angiotensin system (RAS) blockade only partially slows down the progression of CKD to
end-stage renal disease. Although other additional strategies on top of RAS blockade are used for the management of this disease, the tremendous interest in new therapeutics is apparent. As endothelin-1 (ET-1) leads through the activation of ET\textsubscript{A} receptors to renal cell injury, inflammation, fibrosis and finally to proteinuria, it is not surprising that ET\textsubscript{A} receptor blockers were proven to have beneficial renoprotective effects in both experimental and clinical studies (Barton 2008, Barton and Yanagisawa 2008, Kohan and Pollock 2013, Kohan and Barton 2014, Komers and Plotkin 2016, Czopek et al. 2016). However, due to the presence of edema encountered in clinical trials with ET\textsubscript{A} receptor blockade, ASCEND and RADAR clinical trials have been prematurely terminated. Although the SONAR trial attempted to overcome these complications by using a lower dose of atrasentan, the trial was also terminated before its planned conclusion. Thus, only the DUET trial evaluating sparsentan – the dual antagonist of AT\textsubscript{1} and ET\textsubscript{A} receptors (comprising moieties of irbesartan and atrasentan in one molecule) – in patients with primary focal segmental glomerulosclerosis (Komers et al. 2017) (DUET trial NCT01613118), ambrisentan in patients with sickle cell nephropathy (NCT02712346 trial), and the ZEBRA trial (NCT02047708) evaluating highly selective ET\textsubscript{A} antagonist zibotentan in scleroderma patients provide optimistic indications to this area of research at present.

This review focuses on the experimental data obtained in non-diabetic chronic kidney disease with a focus on selective versus non-selective ET receptor antagonists in hypertension and associated end-organ damage resulting in CKD. We shall also examine the use of diuretics in CKD.

**Endothelin-1 and its receptors**

ET-1 is the best known and predominant isoform among the family of endothelins (ET-1, ET-2, and ET-3) (Yanagisawa et al. 1988). It is a more potent and longer lasting vasoconstrictor in humans than angiotensin II (Ang II). ET-1 exerts its action through two types of G-protein coupled receptors, ET\textsubscript{A} and ET\textsubscript{B}. While ET\textsubscript{A} receptors located on vascular smooth muscle cells mediate vasoconstriction and cell proliferation, the effects of ET\textsubscript{B} receptors located mainly on endothelial cells include vasodilation through the release of nitric oxide and prostacyclin (Hirata et al. 1993), ET-1 clearance and inhibition of sodium reabsorption in the renal collecting duct, thus contributing to the regulation of sodium and water homeostasis (for review see Kohan 2013, Maguire and Davenport 2014, Boesen 2015, Davenport et al. 2016). Moreover, it must be pointed out that there is also a diurnal regulation of kidney function contributing to the proper water and electrolyte homeostasis (Zhang and Pollock 2018). ET-1 stimulation of ET\textsubscript{A} receptors leads to proliferation and fibrosis, while the ET\textsubscript{B} receptors mediate opposite effects. The interrelation of vasoconstrictr pathways, i.e. the activation of ET-1 by Ang II and vice versa, has been known for more than 20 years (Kohno et al. 1992, Kawaguchi et al. 1990, Barton et al. 1997). Recently, the interrelationship between the vasodilator pathways of renin-angiotensin and endothelin systems, namely the crosstalk between Ang-(1-7) and ET-1 through the Mas receptor and ET\textsubscript{B} receptor, respectively, has been described (Hood et al. 2016).

**Non-selective versus selective ET receptor antagonists in experimental hypertension**

There has been considerable debate among researchers and clinicians on the benefits of the non-selective versus selective endothelin receptor blockade which arose from the controversial results obtained in experimental studies. While some authors reported antihypertensive or nephroprotective effects of selective ET\textsubscript{A} receptor blockade in various hypertensive models – Sabra salt-sensitive rats (Rothermund et al. 2003), DOCA-salt hypertensive rats (Allcock et al. 1998, Matsumura et al. 1999), salt-loaded stroke-prone SHR (Okada et al. 1995), or adult Dahl salt-sensitive rats (Barton et al. 1998, Okada et al. 2000, Zicha et al. 2012), no protective effects of ET\textsubscript{A} blockade were found in young and adult Ren-2 transgenic rats harboring additional mouse renin gene (TGR) (Rossi et al. 2000, Rothermund et al. 2003), inducible TGR (CYP1A1) rats (Vaňourková et al. 2009), and young Dahl salt-sensitive rats (Zicha et al. 2012). On the other hand, our group has demonstrated a mild hypotensive effect of ET\textsubscript{A} blockade with atrasentan in both young and adult TGR which was associated with cardio- and renoprotection (Vaněčková et al. 2005, Opočenský et al. 2006, Vaněčková et al. 2006, Vernerová et al. 2008). In young homozygous TGR rats, the antiproteimuric effect of atrasentan was found despite the persistence of severe hypertension (Vaněčková et al. 2006).

There is no doubt about the efficacy of bosentan
in pulmonary hypertension (Clozel et al. 2006). Concerning other hypertensive models, non-selective ET receptor blockade was found to be organoprotective in homozygous TGR (Dvořák et al. 2004, Opočenský et al. 2004), double transgenic rats (Muller et al. 2000) and rats with diabetic nephropathy (Ding et al. 2003). Antihypertensive effects of non-selective ET receptor blockade were demonstrated in DOCA-salt hypertensive rats (Schiffrin et al. 1996), double transgenic rats (Muller et al. 2000), young TGR (Rossi et al. 2000) and 2K1C Goldblatt hypertensive rats (Li et al. 1996). However, our group repeatedly demonstrated the absence of hypotensive effect of bosentan in both heterozygous and homozygous TGR on either normal or high-salt diets (Dvořák et al. 2004, Vančeková et al. 2005, Vančeková et al. 2006, Opočenský et al. 2006, Vernerová et al. 2008).

**Chronic kidney disease**

Endothelin 1 is known to be associated with the development and progression of chronic kidney disease and associated cardiovascular complications. Thus, the beneficial antiproteinuric effects of selective endothelin receptor A blockade were not surprising in patients with chronic renal disease (Dhaun et al. 2011, Gagliardini et al. 2011, Kohan and Barton 2014), especially in those with diabetic CKD. However, adverse side effects (edema) led to the termination of three large clinical trials with ET	extsubscript{A} blockade (ASCEND, RADAR, SONAR) in patients with diabetic nephropathy (www.clinicaltrial.gov, Nrs. NCT0120328, NCT01356849, NCT01858532, respectively). On the other hand, positive results of the dual blockade with sparsentan in patients with focal segmental glomerulosclerosis in the DUET trial (Komers et al. 2017, Komers 2017), showing better antiproteinuric effects of sparsentan as compared with AT	extsubscript{1} receptor blocker irbesartan, support further experimental testing. In addition, other approaches including the synthesis of new antagonists with enhanced pharmacological activity, such as macitentan (Bolli et al. 2012), the use of lower doses of ET antagonists (Baltatu et al. 2014), or the addition of diuretics (Jin et al. 2014, Morales et al. 2015, Fiuwa et al. 2016, Vančeková et al. unpublished results, see below) could be promising. Another important consideration comes from the field of genetics – the finding of rs9349379, a common SNP in PHACTR1 gene, as a putative causal variant of five common diseases (coronary artery disease, migraine, cervical artery dissection, fibromuscular dysplasia, and hypertension), and its distal regulatory effect on endothelin-1 expression (Gupta et al. 2017). While the proposed mechanism(s) of action of the first four diseases is mediated through ET	extsubscript{A} receptors and is associated with an increased risk of coronary artery disease and a decreased risk of the other three diseases, decreased risk of hypertension is connected with the hypotensive actions of ET	extsubscript{B} receptors on endothelial cells of large arteries and renal collecting ducts and is connected with lower risk of hypertension. Perhaps, this might be one of the possible explanations for conflicting results in different CKD models.

**Proteinuria and podocytes**

Proteinuria is an indicator of deteriorated kidney function which arises from the defect of the filtration barrier in the kidney, affecting mainly podocytes. The reduction of proteinuria incidence is an important goal in the treatment of kidney disease. Podocyte injury is associated with many disease conditions, such as, focal segmental glomerulosclerosis, minimal change disease, and membranous nephropathy. Although the primary cause may differ, the derangement of the actin cytoskeleton leading to the loss of functional integrity of the glomerular filtration barrier and to podocyte detachment is a common feature of these diseases. Considerable attention has been given to the remodeling of podocytes in both diabetic and non-diabetic nephropathies (Pavenstadt et al. 2003, Hayden et al. 2005, Fligny et al. 2011, Raij et al. 2016). The remodeling of podocytes consists of cellular swelling, effacement of foot processes, vacuole formation, fusion of foot processes, and finally their detachment from the glomerular basement membrane (Mallipattu and He 2016). Different therapeutic strategies, including the use of RAS blockers, glucocorticoids or calcineurin inhibitors, were partly effective in alleviating podocyte damage. An important role in this deleterious process also involves ET-1, through the activation of ET	extsubscript{A} receptors (Barton and Tharaux 2012) and also ET	extsubscript{B} receptors (Lenoir et al. 2014). Thus, the restoration of proper podocyte functioning is the aim of various pharmacological interventions, including ET receptor blockade. Important information on the role of podocytes comes from older studies performed in Dahl hypertensive rats (Nagase et al. 2006), aged Wistar rats (Ortmann et al. 2004), or DOCA-salt hypertensive rats (Kretzler et al.
leads to the disruption of glomerular glycocalyx which consequently resulted in proteinuria and renal damage signaling through the increase in heparanase in podocytes. Moreover, the study by Garsen et al. (2016) demonstrated that ET-1 signaling through the increase in heparanase in podocytes leads to the disruption of glomerular glycocalyx which consequently resulted in proteinuria and renal damage (Garsen et al. 2016). ET<sub>A</sub> receptors are responsible for this process since atrasentan treatment through the decrease in heparanase expression induced the increase in glycocalyx thickness and led to the reduction of albuminuria (Boels et al. 2016).

**Endothelin antagonists in experimental non-diabetic CKD**

The positive effects of ET receptor blockade have been demonstrated shortly after ET-1 discovery in experimental studies of CKD (Benigni et al. 1991, Benigni et al. 1996, Brochu et al. 1999). These beneficial effects were suggested to be associated with the intervention to the activated endothelin system following kidney ablation or renovascular hypertension (Orisio et al. 1993, Diekmann et al. 2000). Previous studies have shown that urinary ET-1 excretion correlates with kidney damage and proteinuria (Orisio et al. 1993). Recent study in TGR rats showed that the rise in renal ET-1 concentration in the early phase after 5/6 nephrectomy was 50-fold (Sedláková et al. 2017). In fact, urinary ET-1 excretion, which reflects renal ET production, is increased not only in renovascular hypertension or nephrectomized animals but in all forms of CKD including diabetes, hypertension, glomerulonephritis, and others (Kohan and Barton 2014). Urinary ET-1 excretion increased with the deterioration of kidney function also in patients with CKD (Kohan and Pollock 2012, Dhaun et al. 2009) and could potentially serve as a marker of renal damage. In contrast, plasma ET-1 levels are considered as an unreliable marker due to the technical problems encountered with its measurement, rapid receptor-mediated uptake, and especially due to its paracrine action. Recently, in patients with chronic kidney disease the plasma concentrations of stable precursors of ET-1 synthesis (C-terminal pro-ET-1 peptide and endothelin-like domain peptide) were demonstrated to be good markers of kidney injury which negatively correlated with glomerular filtration rate (Dhaun et al. 2015). In addition, ET<sub>A</sub> receptor blockade increased their levels reflecting the upregulation of ET-1 gene, which could be responsible for fluid retention encountered with ET<sub>A</sub> receptor blockade. However, more clinical and experimental studies are needed to support this finding.

Since the role of the endothelin system in chronic kidney disease was exhaustively summarized by Kohan and others (Kohan 2013, Kohan and Barton 2014, Kohan and Pollock 2014, Culshaw et al. 2016), the present review will focus only on the recent experimental studies in this field.

Baltatu et al. (2014) demonstrated in double transgenic rats (harboring human renin and the angiotensinogen gene) that the treatment with a low doses of avenosentan in combination with low dose of valsartan for five weeks significantly decreased albuminuria and renal damage with no signs of fluid retention. Our results in TGR rats with ablation nephropathy also supported the positive antiproteinuric effects of ET<sub>A</sub> blockade using atrasentan combined with maximal RAS blockade (Čertíková Chábová et al. 2014, Vaněčková et al. unpublished data, see below), although for the manifestation of its positive effects, the treatment must be very long (approximately one year) (Čertíková Chábová et al. 2014). When the duration of treatment was only 20 weeks, the positive effects were not observed (Vaněčková et al. 2012). This is consistent with a study in 5/6 nephrectomized female Sprague Dawley rats in which a three-month treatment with atrasentan in combination with enalapril (ACEi) and paricalcitol (vitamin D activator) had no additional renoprotective effects as compared to the treatment with enalapril alone (Ritter et al. 2014). Unfortunately, beneficial effects were also not demonstrated in TGR rats in which the long-term treatment with ET<sub>A</sub> blockade on top of RAS blockade was delayed to the phase of established hypertension and CKD (Sedláková et al. 2017). On the other hand, in a swine model of renovascular disease, the postponed treatment with ET<sub>A</sub> receptor blockade (but not ET<sub>B</sub> blockade) was successful in attenuation of the
progression of renal inflammation and fibrosis in the stenotic kidney, which was associated with improved hemodynamic parameters and decreased albuminuria (Chade et al. 2014). In addition, the same group demonstrated that non-selective ET antagonist macitentan had anti-inflammatory effects, improved hemodynamics of the stenotic kidney and reduced albuminuria and glomerulosclerosis (Tullos et al. 2015).

Positive cardiorenal effects of ET<sub>A</sub> blockade with atrasentan, which were independent of blood pressure, were demonstrated in salt-sensitive Dahl rats kept on high-salt diet for 12 weeks (Samad et al. 2015). Although no hypotensive effects of enalapril (10 mg/kg/day) or atrasentan (5 mg/kg/day) were observed at the end of the study, both drugs attenuated cardiac hypertrophy. In addition, atrasentan but not enalapril decreased proteinuria and serum creatinine suggesting the attenuation of CKD progression with ET<sub>A</sub> blockade in this model.

A new potential for endothelin antagonists in non-diabetic CKD also derives from their positive effects in acute and chronic kidney damage induced by nephrotoxic agents. While Helmy et al. (2014) reported on the beneficial effects of selective ET<sub>A</sub> receptor blockade (but not of nonselective blockade) in cisplatin-induced nephrotoxicity, Caires et al. (2017) demonstrated positive effects of nonselective blockade with both bosentan and macitentan in reversing cyclosporine-induced changes mainly through their hemodynamic effects. Interestingly, the effects of bosentan were even better than those of macitentan.

The negative side effects of calcineurin inhibitors such as cyclosporine and tacrolimus are associated with the activation of both renin-angiotensin and endothelin systems (Hošková et al. 2017). The mechanism underlying nephrotoxic effects of cyclosporine A (CSA) is connected with the induction of endothelin-converting enzyme by CSA resulting in ET-1 generation which leads to further renal hypoxia and ET-1 synthesis (Heyman et al. 2018). Blockade of ET<sub>A</sub> receptors with atrasentan ameliorated nephrotoxic effects induced by a combination of CSA with indomethacin, including positive effects on renal function and inhibition of oxidative stress (Helmy et al. 2015).

Another possible field for the use of ET<sub>A</sub> antagonists is nephropathy associated with sickle cell disease (SCD). The first demonstration of positive effects of nonselective ET antagonist bosentan on organ injury and mortality in a mouse model of SCD was reported by Sabaa et al. (2008). The mechanisms underlying the involvement of endothelin as a mediator of diverse complications occurring in different organs in sickle cell disease involve the endothelial dysfunction associated with albuminuria (Ataga et al. 2016) and the stimulation of ET<sub>B</sub> receptors present on neutrophils which leads to their increased adhesion to the endothelium (Koehl et al. 2017). Fox and Kasztan in their review (2016) provided a deep insight into this area showing positive results of endothelin receptor antagonists in the treatment of this disease which may lead to the adoption of ET<sub>A</sub> blockade as a novel pharmacological strategy. In fact, recent study of Kasztan et al. (2017) demonstrated in a murine model of SCD that a ten-week treatment with ambrisentan started from weaning dramatically improved glomerular filtration rate and reduced proteinuria, which was accompanied by an improvement of the podocyte structure, decreased podocyte loss and attenuation of glomerulosclerosis. In contrast, combined ET<sub>A</sub>/ET<sub>B</sub> antagonist (A-182086) provided only a partial protection in comparison with selective ET<sub>A</sub> blockade, supporting the rationale of implementing this strategy in the treatment of this type of non-diabetic CKD.

Endothelin-1 plays an important role also in ischemia/reperfusion (IR) injury following coronary ischemic events as it is released at higher levels into the circulation after myocardial infarction (Tamareille et al. 2013). It has been shown that ET<sub>B</sub> receptors have a critical role in this process. This is caused by the increased sensitivity to ET-1 associated with the augmented ET<sub>B</sub> receptor-mediated contractility of vascular smooth muscle cells (Kristiansen et al. 2018). However, Boesen et al. (2016) did not disclose an effect of ET<sub>A</sub> blockade on renal blood flow in mouse after unilateral renal IR injury in mouse, although it had positive effect on renal mass.

Last but not least, we should mention the positive results of ET<sub>A</sub> blockade in pigs with renal artery stenosis – showing that a four-week treatment with ET<sub>A</sub> receptor antagonist following percutaneous transluminal renal angioplasty led to a further attenuation of hypertension and renal injury. In contrast, non-selective blockade led to a deterioration of the kidney function (Chade et al. 2015).

Positive results from most of the above mentioned experiments together with the DUET study in patients with focal segmental glomerulosclerosis support the use of ET<sub>A</sub> antagonists at least in non-diabetic CKD. However, more studies are necessary to confirm this idea.
Importantly, new insights into the complex pathogenetic mechanisms of CKD include the study of Dhande et al. (2018) involving the genetic susceptibility to hypertension-induced renal injury in stroke-prone, spontaneously hypertensive rats and indicating that hypertensive kidney damage is associated with a genetic variation of the immunoglobulin heavy chain.

**Diuretics in CKD**

Chronic kidney disease is often complicated by hypertension which is a major risk factor in CKD progression. Therefore, the control of hypertension is an associated critical goal which should be managed by pharmacological treatment. Diuretics in combination with other classes of antihypertensives, such as RAS blockers, calcium channel blockers, and β blockers, are the inexpensive and efficient second-line treatment possibility which can be administered even in advanced CKD. Although thiazides were not previously recommended in advanced stages of CKD, their involvement is now reconsidered (Sinha and Agarwal 2015) on the basis of clinical studies showing that the addition of thiazides to RAS blockers in advanced CKD is effective in the lowering of blood pressure (Cirilo et al. 2014, Fuwa et al. 2016) and proteinuria (Morales et al. 2015).

The use of ET\(_A\) receptor blockade in clinical practice is limited by their side-effect on fluid retention, which is probably of renal origin. Originally, ET-1 was demonstrated to act through ET\(_B\) receptors to promote natriuresis and diuresis, especially in response to increased salt load (Ahn et al. 2004). In addition to many experimental studies, diuresis and natriuresis following ET-1 infusion has also been recently demonstrated in humans (Hunter et al. 2017). Previous studies in rats with knockout of ET\(_B\) receptors demonstrated salt-sensitive hypertension in these animals (Gariepy et al. 2000). In addition, specific knockout of ET-1 or ET\(_B\) receptor genes in the collecting duct led to sodium retention and hypertension (Ahn et al. 2004, Ge et al. 2006). Later, the contribution of ET\(_A\) receptors to the natriuretic response to ET-1 was reported in female ET\(_B\)-deficient rats (Nakano and Pollock 2009). Stuart et al. (2013) demonstrated the absence of ET\(_A\)-induced fluid retention during ambrisentan or atrasentan treatment in mice with a deletion of ET\(_A\) receptor in mice (either in the whole nephron or in the collecting duct only) suggesting rather the role of ET\(_A\) instead of ET\(_B\) receptor in this process.

Recently, experiments in rats demonstrated that the mechanisms of edema formation during selective ET\(_A\) blockade result from the activation of ET\(_B\) receptors leading to an increase in vascular permeability and fluid retention (Vercauteren et al. 2017). Whatever are the mechanisms responsible for the unwanted fluid retention, the use of diuretics to overcome this problem seems to be reasonable. In line with this, Weber et al. (2009) demonstrated in patients with resistant hypertension that fluid retention caused by darusentan could be managed with diuretics.

Jin et al. (2014) reported on the beneficial renoprotective effects of combined a four-week treatment with thiazide diuretic chlorthalidone with ET\(_A\) blockers in a model of metabolic syndrome (Dahl salt-sensitive rats on high-salt and high-fat diet), which was associated with the improvement of podocyte function. The beneficial effect of a combined treatment with angiotensin receptor blocker losartan and diuretic hydrochlorothiazide (Arias et al. 2013) (but not with furosemide) was also documented in 5/6 nephrectomized rats (Arias et al. 2016). The superiority of hydrochlorothiazide over other diuretics has been documented also in the clinical studies on CKD (Morales et al. 2015, Fuwa et al. 2016).

Our laboratory demonstrated the positive effects of treatment with diuretic hydrochlorothiazide on top of combined RAS and ET\(_A\) blockades in a long-term study performed in adult hypertensive TGR rats subjected to 5/6 nephrectomy (Fig. 1) (Vaněčková et al. 2017). We have found that all therapies which included RAS blockade substantially improved survival of rats with experimentally induced CKD. Moreover, the addition of an ET\(_A\) receptor blockade had further beneficial effect. The renal damage evaluated by proteinuria gradually increased in rats treated with RAS blockade alone (green line), while it was substantially lowered by additional ET\(_A\) blockade (blue line).

Most importantly, in rats treated with a diuretic added to a combination therapy (hydrochlorothiazide on top of RAS and ET\(_A\) blockade – red line) proteinuria was progressively reduced throughout the duration of the experiment. Finally, since blood pressure was maximally reduced by RAS therapy in all groups, it is evident that this effect is blood pressure-independent and goes beyond that of selective ET\(_A\) blockade. However, it must be proven in further studies whether this “triple” therapy will also be successful in animals with already established CKD.
Since the sites and mechanisms of natriuretic action of thiazide diuretics (Na\textsuperscript{+}Cl\textsuperscript{−} cotransporter in the distal tubule) and ET-1 (mainly epithelial sodium channel in the cortical collecting duct) (Lynch et al. 2013, Kohan 2013) are different, the exact mechanism of positive results of the treatment with thiazide diuretics in a model of CKD in TGR rats needs to be examined in the future.

**Conclusions**

Although the major clinical trials evaluating endothelin receptors in diabetic patients were prematurely terminated, there are experimental data in non-diabetic chronic kidney disease supporting the potential of endothelin receptor blockers at least under these conditions.

However, as with all drugs, caution must be given to their side-effects – in case of ET\textsubscript{A} receptors – fluid retention. However, it appears that this problem could be overcome; based on our experimental study diuretic treatment added to RAS and ET\textsubscript{A} receptor blockade could further attenuate renal damage. Considering the positive results of the DUET trial in patients with focal segmental glomerulosclerosis as well as experimental studies in non-diabetic CKD, there is still hope for future advancement in this field.

**Conflict of Interest**

There is no conflict of interest.

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ASCEND TRIAL https://clinicaltrials.gov/ct2/show/NCT00120328


DUET TRIAL https://clinicaltrials.gov/ct2/show/NCT01613118


RADAR TRIAL https://clinicaltrials.gov/ct2/show/NCT01356849


SONAR TRIAL https://clinicaltrials.gov/ct2/show/NCT01858532


SONAR TRIAL https://clinicaltrials.gov/ct2/show/NCT01858532


ZEBRA TRIAL https://clinicaltrials.gov/ct2/show/NCT02047708