Effect of oral calcium supplementation on intracellular calcium and plasma renin in men

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Abstract

A double-blind, placebo-controlled parallel study was conducted on the effect of a high daily oral calcium supplementation of 1 g elemental calcium, given twice daily for 16 weeks in normal male subjects, on plasma renin, aldosterone, kallikrein, cGMP, cAMP and calcitropic hormones, intracellular calcium concentrations and plasma total and ionized calcium. After a 1-month run-in period on a limited use of dairy products, the subjects (n=32) were allocated to a placebo or a calcium group. Placebo or 1 g elemental calcium was administered twice daily in the morning and evening for 16 weeks. All subjects were investigated at baseline and after 1, 2, 4, 8 and 16 weeks of placebo or calcium administration. A decreased intraerythrocyte and intraplatelet Ca^{2+} concentration was observed in the calcium-treated subjects. Compared with the placebo group, an increase in the plasma renin activity (PRA) in the calcium group was observed after 4, 8 and 16 weeks of oral calcium administration. However, plasma aldosterone and urinary excretion of aldosterone, kallikrein, cGMP and cAMP were not changed during calcium administration. Oral calcium supplementation in these men was also accompanied by a reduction in the plasma concentration of intact parathyroid hormone and 1,25-dihydroxyvitamin D_{3}, an increase in 24-h urinary calcium excretion but no change in the plasma total Ca^{2+} concentration, serum ionized Ca^{2+} level and plasma phosphate or 25-hydroxyvitamin D_{3}. Lacidipine tended to increase PRA in the placebo-treated subjects and to decrease it in the calcium-treated subjects: this difference in lacidipine effect between the placebo and calcium group was significant (P<0.05). Our data show that the increase in PRA observed in men during oral calcium supplementation is accompanied by a reduction in the intracellular free and total Ca^{2+} concentration in platelets and erythrocytes and by a decrease in the plasma concentration of intact parathyromone and 1,25-dihydroxyvitamin D_{3}.


Introduction

An inverse association between calcium concentration in the incubation medium and renin release was first recognized by Vandongen & Peart (1974) in the isolated perfused kidney of the rat. Such an inverse relationship can be observed under a variety of in vitro conditions in which the intracellular free calcium concentration is changed, or can be assumed to be changed, by pharmacological or physical manipulations.

An increase in renin release was indeed observed when extracellular calcium was drastically lowered in renal cortical cell suspensions, renal cortical slice incubations, isolated glomeruli and isolated perfused rat kidneys (Hackenthal et al. 1990). The agent 8-N,N-diethylaminodioctyl-3,4,5-trimethoxybenzoate (TMB-8), which acts as an intracellular calcium antagonist by preventing the stimulus-induced release of calcium from the endoplasmic reticum, has been found to increase renin release from kidney slices (Antonpillai & Horton 1985, Baxter et al. 1985, Heinrich & Campbell 1986) and in isolated perfused rat kidneys (Hackenthal & Taugner 1986).

An inhibition of renin release from kidney slices and from isolated rat kidneys was found with the calcium-channel agonist BAY K8644 and CGP 28392 which induce a rise in intracellular calcium (Hackenthal & Taugner 1986, Churchill & Churchill 1987, Matsumura et al. 1987). Inhibition of renin release is also observed in vitro with ouabain which by inhibiting sodium transport out of the cells facilitates calcium entry in the epitheloid cells (Lyons & Churchill 1974, Cruz-Soto et al. 1984, Churchill & Churchill 1980). There is thus a close association between calcium influx and renin secretion in vitro; renin secretion is inhibited by increased transport of calcium into juxtaglomerular cells and inhibition of calcium transport stimulates renin secretion (Blaine et al. 1970, Fray 1980, Baumbach & Scott 1981, Park et al. 1981, Matsumura et al. 1987).
Discordant findings are, however, reported on the in vivo effect of calcium on plasma renin activity (PRA). Zemel et al. (1986) found an increased PRA after a high salt/high calcium diet in normotensive and hypertensive black adults, while Rich et al. (1991) found similar PRA values after a high salt/high calcium or high salt/low calcium diet in hypertensive white patients. In spontaneously hypertensive rats, Wuorela et al. (1992) found a suppression of the plasma renin-angiotensin system after oral calcium supplementation. According to Kotchen & Guthrie (1988) a high calcium chloride intake in normotensive rats on a normal salt intake did not affect PRA, while a high calcium chloride intake in rats on a low salt diet decreased PRA. During acute calcium infusions into the renal artery of mongrel dogs, peripheral calcium concentrations increased and renal venous PRA decreased (Kotchen & Guthrie 1988). A decrease in PRA was seen after calcium infusion in normal sodium-deplete men (Kisch et al. 1976), while calcium infusion had no effect on PRA in subjects on an unspecified dietary sodium intake (Maxwell & Kleeman 1972). In these in vivo studies, however, no measurements of intracellular calcium were performed.

The present double-blind, placebo-controlled parallel study was therefore conducted on the effect of a high daily oral calcium supplementation of 1 g elemental calcium, given twice daily for 16 weeks in normal men, on the intracellular calcium concentrations in platelets and erythrocytes, plasma total, ionized calcium and calciotropic hormones such as intact parathyroid hormone (PTH), 25-hydroxyvitamin \( \text{D}_3 \), and 1,25-dihydroxyvitamin \( \text{D}_3 \) and on plasma renin, aldosterone, kallikrein, cAMP and cGMP. The aim of the present study was to investigate whether in vivo alterations in intracellular calcium concentrations or in plasma ionized calcium and calciotropic hormones participate in the stimulation of the renin secretion during oral calcium supplementation.

**Materials and Methods**

**Subjects**

Thirty-two normal male volunteers gave written consent for participation in the study after the procedure and purpose of the study had been explained. This study has been approved by the Ethics Committee of the Faculty of Medicine, University of Leuven. The age of the subjects averaged \( 24 \pm 1 \) (s.e.m.) years (height \( 179.5 \pm 1.1 \) cm and weight \( 75.9 \pm 1.3 \) kg).

**Design**

All subjects \( (n=32) \) received dietary advice for a limited use of dairy products throughout the whole study period. After a 1-month run-in period on a limited use of dairy products, baseline measurements were performed. Then the subjects were allocated randomly either to a placebo \( (n=16) \) or a calcium \( (n=16) \) group. Placebo or 1 g elemental calcium as a powder was administered twice daily, in the morning and evening, for 16 weeks. All subjects were reinvestigated after 1, 2, 4, 8 and 16 weeks of oral placebo or calcium administration. They collected their 24-h urine samples the day immediately preceding the investigation. After 16 weeks of placebo or calcium administration, the 16 subjects in each group were treated at random with the calcium-channel blocker lacidipine (2 mg twice daily; \( n=8 \)) or placebo \( (n=8) \) for an additional period of 8 weeks. The subjects were reinvestigated after 4 and 8 weeks of additional lacidipine or placebo administration.

The formulation of calcium used in this study was calcium gluconate, citric acid, aspartam and an orange aroma; that of placebo consisted of \( \beta \)-lactose, citric acid, aspartam and an orange aroma.

**Blood sampling**

After 10 min rest, blood was collected from an antecubital vein in each subject after an overnight fast preceded by a light evening meal. Blood was collected into heparinized or acid citrate–dextrose tubes, the plasma was separated, theuffy coat discarded and the fresh cells handled as described previously (Lijnen et al. 1986).

PRA (Fyhrquist & Puutula 1978), aldosterone concentrations (Lijnen et al. 1978) and 24-h excretion of aldosterone (Malvano et al. 1976), cAMP and cGMP (Tovey et al. 1974) were measured by radioimmunoassay. The urinary excretion of kallikrein was measured spectrophotometrically (Overlack et al. 1980).

The intraerythrocyte total Ca\(^{2+} \) concentration was determined by atomic absorption spectrophotometry (Zemel et al. 1988b). The platelet cytosolic free Ca\(^{2+} \) concentration was assayed by measuring the fluorescence of quin-2 entrapped by platelets (Tsien et al. 1982).

Plasma Na\(^+ \), K\(^+ \), urea, uric acid, phosphate, creatinine, chloride, bicarbonate, alkaline phosphatase and protein were measured by a multichannel autoanalyzer. Plasma Ca\(^{2+} \) and Mg\(^{2+} \) were determined by atomic absorption spectrophotometry. Serum ionized calcium and pH were measured by an ICA2 ionized calcium analyser (Radiometer, Copenhagen, Denmark).

Plasma intact PTH was measured by an immunoradiometric assay (Bouillon et al. 1990), plasma 25-hydroxyvitamin \( \text{D}_3 \) by a competitive protein binding assay (Edelstein et al. 1974) and plasma 1,25-dihydroxyvitamin \( \text{D}_3 \) by a radioreceptor assay (Holllis 1986).

**Statistical methods**

Values are expressed as arithmetic means ± s.e.m. Serial measurements in the two treatment groups were compared using the method of Matthews et al. (1990). This
TABLE 1. General characteristics of the subjects at randomization. Blood pressure and heart rate were measured with the subjects recumbent. Values are expressed as means ± S.E.M. (n = 16). No significant differences were observed between the placebo and calcium groups using paired t-test.

<table>
<thead>
<tr>
<th></th>
<th>Placebo group</th>
<th>Calcium group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>24.4 ± 1.4</td>
<td>24.2 ± 1.1</td>
</tr>
<tr>
<td>Weight (kg)</td>
<td>74.8 ± 1.7</td>
<td>77.4 ± 2.0</td>
</tr>
<tr>
<td>Height (cm)</td>
<td>178.4 ± 1.6</td>
<td>180.5 ± 1.7</td>
</tr>
<tr>
<td>Blood pressure (mmHg)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Systolic</td>
<td>114 ± 2</td>
<td>114 ± 2</td>
</tr>
<tr>
<td>Diastolic</td>
<td>72 ± 2</td>
<td>74 ± 2</td>
</tr>
<tr>
<td>Heart rate (beats/min)</td>
<td>72 ± 2</td>
<td>72 ± 1</td>
</tr>
<tr>
<td>24-h urinary excretion of:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sodium (mmol)</td>
<td>139 ± 13</td>
<td>147 ± 16</td>
</tr>
<tr>
<td>Potassium (mmol)</td>
<td>68 ± 5</td>
<td>64 ± 6</td>
</tr>
<tr>
<td>Calcium (mmol)</td>
<td>4.79 ± 0.50</td>
<td>4.69 ± 0.62</td>
</tr>
<tr>
<td>Magnesium (mmol)</td>
<td>4.20 ± 0.37</td>
<td>4.52 ± 0.45</td>
</tr>
<tr>
<td>Phosphate (mmol)</td>
<td>2.61 ± 1.9</td>
<td>2.97 ± 2.6</td>
</tr>
<tr>
<td>Creatinine (mmol)</td>
<td>14.3 ± 0.9</td>
<td>14.9 ± 1.1</td>
</tr>
<tr>
<td>Plasma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sodium (mmol/l)</td>
<td>140.4 ± 0.6</td>
<td>140.4 ± 0.7</td>
</tr>
<tr>
<td>Potassium (mmol/l)</td>
<td>3.82 ± 0.04</td>
<td>3.93 ± 0.05</td>
</tr>
<tr>
<td>Magnesium (mmol/l)</td>
<td>0.81 ± 0.02</td>
<td>0.81 ± 0.02</td>
</tr>
<tr>
<td>Phosphate (mmol/l)</td>
<td>1.04 ± 0.05</td>
<td>1.11 ± 0.03</td>
</tr>
</tbody>
</table>

method considers the individual as the basic unit and uses the average response over time for each subject as a summary statistic of that subject’s response curve. The summary measures in the two treatment groups were then compared using Student’s t-test. The single t-value obtained corresponds to the average difference in the treatment effect between the placebo- and calcium-treated groups. Repeated measures of analysis of variance also shows no interaction effect of group and time for the various variables.

Results

At randomization there were no significant differences in demographic, anthropometric and clinical characteristics between the groups allocated to placebo and calcium (Table 1). No significant differences between the two groups were observed at randomization in the erythrocyte or platelet intracellular calcium concentrations or in the plasma and urinary variables.

Blood pressure and body weight

Compared with the placebo group, standing systolic blood pressure was decreased in the calcium group, while the standing diastolic blood pressure tended to decrease (Fig. 1). Compared with the baseline value, the average decrease in the standing systolic blood pressure in the calcium group (−7.8 mmHg, range from −16 to +4 mmHg) was different (P=0.013) from the changes observed in the placebo group (−2.1 mmHg, range from −15 to +7 mmHg). A tendency (P=0.059) for a reduction in standing diastolic blood pressure in the calcium group (−2.6 mmHg, range from −14 to +6 mmHg) compared with the placebo group (−0.9 mmHg, range from −4 to +16 mmHg) was also observed. No significant difference was found in body weight between the calcium and placebo group.

No significant difference in the effect of lacidipine versus placebo on standing systolic or diastolic blood pressure or on body weight was found between the calcium- and placebo-treated subjects.

FIGURE 1. Standing systolic (SBP) and diastolic blood pressure (DBP) before and during oral administration of calcium (●) or placebo (○) in 16 men. The t-value corresponds to the average difference in treatment effect between the placebo and calcium groups (Matthews et al. 1990).

FIGURE 2. PRA before and during oral administration of calcium (●) or placebo (○) in 16 men. The t-value corresponds to the average difference in the treatment effect between the placebo and calcium groups (Matthews et al. 1990). Geometric means ± S.E.M. are given.
TABLE 2. Plasma aldosterone concentration and urinary excretion of aldosterone, kallikrein, cGMP and cAMP before (0) and during (1, 2, 4, 8, 16 weeks) oral administration of placebo or calcium in 16 men. Values are means ± S.E.M.

<table>
<thead>
<tr>
<th>Group</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>4</th>
<th>8</th>
<th>16</th>
<th>t-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plasma aldosterone (ng%)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Placebo</td>
<td>22.7 ± 3.0</td>
<td>23.1 ± 2.3</td>
<td>27.5 ± 4.6</td>
<td>24.8 ± 4.1</td>
<td>21.4 ± 3.5</td>
<td>26.3 ± 3.5</td>
<td>0.28NS</td>
</tr>
<tr>
<td>Calcium</td>
<td>24.8 ± 3.3</td>
<td>25.2 ± 3.4</td>
<td>23.5 ± 2.7</td>
<td>29.0 ± 4.0</td>
<td>23.8 ± 2.8</td>
<td>37.8 ± 6.0</td>
<td></td>
</tr>
<tr>
<td>Urinary aldosterone (µg/24 h)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Placebo</td>
<td>10.4 ± 1.5</td>
<td>10.0 ± 2.0</td>
<td>8.2 ± 1.6</td>
<td>8.6 ± 1.4</td>
<td>8.4 ± 1.4</td>
<td>9.5 ± 1.4</td>
<td>0.53NS</td>
</tr>
<tr>
<td>Calcium</td>
<td>8.9 ± 1.2</td>
<td>8.7 ± 1.2</td>
<td>7.0 ± 1.1</td>
<td>6.2 ± 0.9</td>
<td>6.3 ± 1.1</td>
<td>9.3 ± 1.4</td>
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<tr>
<td>Urinary kallikrein (U/24 h)</td>
<td></td>
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<td></td>
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<tr>
<td>Placebo</td>
<td>0.788 ± 0.165</td>
<td>0.884 ± 0.223</td>
<td>0.763 ± 0.142</td>
<td>0.839 ± 0.178</td>
<td>0.771 ± 0.145</td>
<td>0.980 ± 0.188</td>
<td>0.85NS</td>
</tr>
<tr>
<td>Calcium</td>
<td>0.624 ± 0.074</td>
<td>0.623 ± 0.088</td>
<td>0.601 ± 0.069</td>
<td>0.661 ± 0.076</td>
<td>0.545 ± 0.046</td>
<td>0.621 ± 0.086</td>
<td></td>
</tr>
<tr>
<td>Urinary cGMP (µmol/24 h)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Placebo</td>
<td>0.492 ± 0.067</td>
<td>0.470 ± 0.058</td>
<td>0.448 ± 0.060</td>
<td>0.526 ± 0.049</td>
<td>0.510 ± 0.048</td>
<td>0.499 ± 0.049</td>
<td>1.00NS</td>
</tr>
<tr>
<td>Calcium</td>
<td>0.436 ± 0.041</td>
<td>0.482 ± 0.044</td>
<td>0.448 ± 0.050</td>
<td>0.495 ± 0.042</td>
<td>0.469 ± 0.040</td>
<td>0.433 ± 0.047</td>
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<tr>
<td>Urinary cAMP (µmol/24 h)</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Placebo</td>
<td>4.92 ± 0.33</td>
<td>4.65 ± 0.36</td>
<td>4.79 ± 0.41</td>
<td>4.77 ± 0.30</td>
<td>4.46 ± 0.26</td>
<td>4.53 ± 0.31</td>
<td>0.90NS</td>
</tr>
<tr>
<td>Calcium</td>
<td>4.51 ± 0.38</td>
<td>4.66 ± 0.29</td>
<td>4.57 ± 0.28</td>
<td>3.72 ± 0.31</td>
<td>4.22 ± 0.38</td>
<td>4.00 ± 0.31</td>
<td></td>
</tr>
</tbody>
</table>

NS, not significant. The t-value corresponds to the average difference in treatment effect between the placebo and calcium groups.

Plasma renin—aldosterone

Compared with the placebo group, on average an increase in the PRA was observed in the calcium group (Fig. 2), whereas plasma aldosterone concentration did not change during calcium administration (Table 2). Unpaired t-tests revealed no significant change in PRA after 1 and 2 weeks of oral calcium supplementation. A significant rise in PRA was seen after 4 weeks of calcium supplementation (P<0.05) and remained elevated after 8 (P<0.02) and 16 (P<0.005) weeks of calcium administration.

Intracellular calcium concentrations

Compared with the placebo group, intraerythrocyte total Ca$^{2+}$ concentration and intraplatelet free cytosolic Ca$^{2+}$ concentration were reduced in the subjects given calcium (Fig. 3). The decrease in intracellular Ca$^{2+}$ concentration in the erythrocytes and platelets was already present after 1 week of oral calcium administration and persisted throughout the 16 weeks of calcium supplementation, while the rise in PRA occurred only after 4 weeks of oral calcium administration, and then remained elevated up to 16 weeks of calcium administration (Fig. 2).

Urinary and plasma variables

Compared with the placebo group, the 24-h urinary excretion of calcium increased (P<0.05) in the calcium group (Fig. 4), while no differences were found in the 24-h urinary excretion of sodium, potassium, magnesium and phosphate. No significant differences were found in serum ionized calcium and total plasma calcium (Fig. 5) or in plasma phosphate, magnesium, sodium and potassium between the calcium and placebo group. The 24-h urinary

FIGURE 3. Erythrocyte total intracellular Ca$^{2+}$ concentration (Ca$^{2+}_{i, e}$) and platelet intracellular free cytosolic Ca$^{2+}$ concentration (Ca$^{2+}_{i, p}$) before and during oral administration of calcium (●) or placebo (○) in 16 men. The t-value corresponds to the average difference in treatment effect between the placebo and calcium groups (Matthews et al. 1990).
excretion of aldosterone, kallikrein, cAMP and cGMP did not change during oral calcium supplementation (Table 2).

The plasma concentration of intact PTH and 1,25-
dihydroxyvitamin D₃ decreased in the calcium group (Fig. 6). However, no significant difference was found in the plasma concentration of 25-hydroxyvitamin D₃ between the placebo- and calcium-treated groups (Fig. 6).

Figure 4. 24-h urinary excretion of calcium (U-Ca²⁺) before and during oral administration of calcium (●) or placebo (○) in 16 men. The t-value corresponds to the average difference in treatment effect between the placebo and calcium groups (Matthews et al. 1990).

Figure 5. Serum ionized Ca²⁺ and plasma total Ca²⁺ concentrations before and during oral administration of calcium (●) or placebo (○) in 16 men. The t-value corresponds to the average difference in treatment effect between the placebo and calcium groups (Matthews et al. 1990).

Discussion

The present study shows that, in men, oral supplementation with 2 g elemental calcium per day in a divided dose (1 g twice daily) is associated with a reduction in intraerythrocyte total Ca²⁺ concentration and intraplatelet free cytosolic Ca²⁺ concentration and an enhancement of
PRA. However, plasma and urinary aldosterone as well as the urinary excretion of kallikrein, cAMP and cGMP did not change during calcium supplementation. A modest but significantly lower systolic blood pressure in standing position during oral calcium supplementation was also observed (Fig. 1), while the standing diastolic blood pressure tended to be lower (Lijnen & Petrov 1995).

Dietary calcium supplementation has indeed been reported to decrease the intracellular free Ca$^{2+}$ concentration in lymphocytes and vascular smooth muscle cells in spontaneously hypertensive rats (SHR) and in stroke-prone SHR (SHRSP) (Furspant et al. 1989, Dominiczak & Bohr 1990, Pörsti et al. 1992, Pörsti et al. 1992, Wuorela et al. 1992, Arvola et al. 1993) as well as the intracellular total Ca$^{2+}$ concentration in erythrocytes of diabetic hypertensive patients (Zemel et al. 1988a). In the present study we also observed a reduction in the free cytosolic Ca$^{2+}$ concentration in platelets and in the total intracellular Ca$^{2+}$ content in erythrocytes during oral calcium supplementation in men. An activation of calcium transport mechanisms or a direct effect on cell membrane could have contributed to the reduction in intracellular Ca$^{2+}$ concentration. Indeed, calcium supplements significantly increase the erythrocyte Ca-ATPase activity and reduce intracellular calcium compared with the placebo group (Zemel et al. 1988a).

Increased dietary calcium has been reported to reduce the plasma digitalis-like immunoreactive factor in rats (Doris 1988). Dietary calcium supplementation in men could thus have increased the activity of Na−K-ATPase in erythrocytes and platelets or in vascular smooth muscle cells (Pörsti et al. 1992) by reducing the amount of circulating sodium pump inhibitor. The latter inhibitor was, however, not measured in the present study.

An increased Na−K-pump activity observed during high calcium intake can lead to a decreased intracellular Na$^+$ concentration, thus increasing the driving force for Na$^+$$-$Ca$^{2+}$ and Na$^+$$-$H$^+$ exchange mechanisms, which have a central role in controlling the intracellular free Ca$^{2+}$ level (Ashida & Blaustein 1987, Beck et al. 1988), and consequently leading to a reduced free cytosolic Ca$^{2+}$ concentration.

Furthermore, the effect of high calcium intake on cytosolic Ca$^{2+}$ is not mediated by its possible natriuretic (Pörsti et al. 1991) and sympathoinhibitory (Young et al. 1988) actions.

Because hormone secretion is usually stimulated by calcium, it is of interest that, in the entire endocrine system, probably only three situations exist in which hormone secretion is inhibited by calcium (Pang et al. 1992). They are parathyroid secretion of PTH and plasma hypertensive factor (PHF), juxtaglomerular secretion of renin and renal production of 1,25-dihydroxyvitamin D$_3$.

In the present study oral calcium supplementation in men is indeed accompanied by a reduction in the plasma concentration of intact PTH and 1,25-dihydroxyvitamin D$_3$. The circulating 1,25-dihydroxyvitamin D$_3$, the major determinant of intestinal absorption of calcium, is indeed reduced when calcium intake is high (Adams et al. 1979, Gallagher et al. 1979). According to Basile et al. (1993) increasing dietary calcium intake increases urinary calcium excretion and reduces plasma 1,25-dihydroxyvitamin D$_3$, but total and ionized serum Ca$^{2+}$ and plasma 25-hydroxyvitamin D$_3$ are unchanged, as observed in the present study. The rise in 24-h urinary calcium excretion (+16.8±1.5%) observed in the present study during oral calcium supplementation (50 mmol/day for 16 weeks) is in agreement with the increase reported in various studies (Grobbec & Hofman 1986, Luft et al. 1986, Nowson & Morgan 1986, Strazzullo et al. 1986, Van Beresteyn et al. 1986, Cappuccio et al. 1987, Meese et al. 1987, Siani et al. 1988, Zoccali et al. 1988, Belizan et al. 1991). In these trials with a duration of 8±2 to 3 weeks and an oral supplementation of 26.5±3.6 mmol of elemental calcium

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**Table 3. Effect of additional administration of lacidipine or placebo, for 4 and 8 weeks, in placebo- and calcium-treated normal men.** The average change in PRA during placebo or lacidipine administration (Matthews et al. 1990) is shown. Values are means ± s.e.m. (n=8)

<table>
<thead>
<tr>
<th>PRA (ng/ml per h) after 16 weeks of (A) placebo or (B) calcium administration</th>
<th>PRA (ng/ml per h) after additional administration of lacidipine or placebo for 4 weeks</th>
<th>8 weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Placebo group</strong></td>
<td>Placebo</td>
<td>1.82 ± 0.34</td>
</tr>
<tr>
<td></td>
<td>Lacidipine</td>
<td>2.35 ± 0.29</td>
</tr>
<tr>
<td><strong>B. Calcium group</strong></td>
<td>Placebo</td>
<td>1.63 ± 0.30</td>
</tr>
<tr>
<td></td>
<td>Lacidipine</td>
<td>2.65 ± 0.48</td>
</tr>
</tbody>
</table>

The difference in lacidipine effect between the placebo and calcium groups: t-test = 2.38; P<0.05.
per day the 24-h urinary calcium excretion increased by 17.9 ± 1.6%.

According to Pang et al. (1992) the secretion of PHF in SHR is inhibited by dietary calcium loading. Whether PHF has a direct effect on the intracellular free Ca$^{2+}$ concentration is not yet elucidated. However, 1,25-
dihydroxyvitamin D$_3$ directly increased radiolabelled calcium uptake in vascular smooth muscle cells (Bukoski et al. 1987) and PTH also enhanced calcium influx in red blood cells (Bogin et al. 1982). The decrease in intraerythrocyte and intraplatelet Ca$^{2+}$ concentration observed after oral calcium supplementation in men (Fig. 2) could probably be attributed to a reduced cellular influx of Ca$^{2+}$, induced by the suppressed circulating levels of intact PTH and 1,25-dihydroxyvitamin D$_3$. If the intracellular free Ca$^{2+}$ concentration is also reduced in the juxtaglomerular cells, this could lead to an elevated secretion of renin. Indeed, exposure of rat renal cortical slices to low-Ca$^{2+}$ EGTA buffer did not alter the β-adrenergic stimulation of renin release by isoprenaline, but blocked the inhibition of the renin release by angiotensin II. The Ca$^{2+}$-channel blocker nifedipine produced a dose-related increase in renin release in these cortical slices, suggesting that reduction of Ca$^{2+}$ entry into juxtaglomerular cells is a potent stimulating signal for renin release. The agent TMB-8, which inhibits intracellular Ca$^{2+}$ release, also produced a significant dose dependent increase in renin release (Nadler & Antonpillai 1986), indicating that intracellular Ca$^{2+}$ levels are key signals for renin release. Calmodulin, a specific calmodulin inhibitor, is a potent stimulator of renin release, indicating that intracellular Ca$^{2+}$ interacts with the Ca$^{2+}$ binding protein calmodulin as an inhibiting signal for renin secretion by blocking an early step in the cellular events that lead to renin secretion such as pH gradient-dependent swelling of renin secretory granules (Park et al. 1992). The increased PRA during oral calcium supplementation can, however, also be related to intravascular volume depletion.

In the present study, PRA started to rise after 4 weeks of oral calcium supplementation in normal men and remained elevated after 8 and 16 weeks of calcium administration. No significant change in plasma renin was observed after 1 or 2 weeks of oral calcium administration in these men. In vivo, there seems thus to be a lag period before the renin secretion in the juxtaglomerular cells is stimulated by the reduced intracellular Ca$^{2+}$ concentration, provoked by the high dietary calcium intake. In vitro, in primary cultures of mouse renal juxtaglomerular cells, an increase in extracellular calcium had a dual effect on renin secretion (Schricker et al. 1993): an inhibitory one that lasted for at least 1 h and a powerful stimulatory one that occurred with a delay of approximately 1–3 h.

When Ca$^{2+}$ entry into juxtaglomerular cells is inhibited by a calcium-channel antagonist such as verapamil, diltiazem or dihydropyridines, renin release is stimulated from isolated juxtaglomerular cells (Kurtz 1986), isolated glomeruli (Baumbach & Scott 1981), kidney slices (Park et al. 1981, Naftilan & Oparil 1982, Heinrich & Campbell 1986), isolated perfused kidneys (Marre et al. 1982, Loutzenhiser et al. 1985) and in vivo (Abe et al. 1983, Roy et al. 1983, Imagawa et al. 1986).

In some studies, however, blockers of calcium entry, such as verapamil or diltiazem, failed to stimulate renin release when infused into the renal artery (Cho et al. 1987) or did not attenuate the inhibition of renin release from rat kidney slices by angiotensin II (Churchill 1987).

These observations do not, however, contradict the basic concept of an inverse relationship between calcium and renin secretion (Hackenthal et al. 1990), as other actions of calcium-channel antagonists probably counteract their stimulatory effects on renin secretion. Also, in the present study, a divergent effect of lacidipine, either an increase or a decrease, on PRA is observed in the placebo- and calcium-treated subjects.

A possible explanation for the occasional lack of or divergent effects of calcium-channel antagonists and of variations in extracellular calcium on renin is that the interplay of mobilization and sequestration of intracellular free calcium may primarily control renin release and that extracellular calcium becomes important only when the intracellular calcium homeostasis is disturbed.

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