Characterization of an animal model to study risk factors and new therapies for the Cardiorenal Syndrome, a major health issue in our aging population

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Running head – An animal model for the cardiorenal syndrome

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Abstract

Background The cardiorenal syndrome (CRS) is a major health problem in our aging population. The term was introduced to cover disorders of the kidneys and the heart whereby dysfunction of the one organ may induce dysfunction of the other. As the natural history of the CRS is mostly slow, hence difficult to explore in clinical trials, adequate animal models combining cardiovascular and renal disease are required. Therefore, we developed and characterized a usable model for CRS type 4 i.e. chronic kidney disease (CKD) causing cardiac dysfunction.

Methods CKD was induced in rats by adenine supplementation of the diet. During 8 weeks several aspects of CRS were studied: CKD, mineral-bone disorder (MBD), cardiovascular disease and (iron deficient) anemia. Hereto the following parameters were monitored: serum creatinine, -calcium, -phosphate, -FGF23, dynamic bone parameters, aortic Ca deposits, heart weight, serum NT-proANP, Hct, Hb, retyculocytes, spleen iron and serum hepcidin.

Results Animals developed a severe CKD together with a disturbed mineral balance as reflected by the increased serum creatinine and phosphorus levels and decreased serum calcium levels; and in association herewith aberrations in hormonal levels of FGF-23. In turn, the well-known and highly undesirable complications of CKD, i.e. high turnover bone disease and pathological vessel calcification were induced. Furthermore (iron-deficient) anemia developed quickly.

Conclusion The animal model described in this manuscript in many aspects mimics the human situation of the CRS type 4 and will be useful to concomitantly evaluate effects of new treatment strategies on the various aspects of CRS.

Introduction

Maintenance of blood volume, vascular tone, and hemodynamic stability is controlled by a set of elegant interactions between the heart and kidney. For some time, physicians have recognized that severe dysfunction in either of these organs rarely occurs as an isolated event. However, only recently the widespread concept of the cardiorenal syndrome (CRS) was introduced and defined as a group of disorders of the heart and the kidneys whereby dysfunction of one organ induces or aggravates dysfunction of the other. Knowledge of the precise pathophysiological connections between the failing heart and kidneys is key in understanding the mechanisms underlying the CRS and would allow us to develop therapies that interrupt this dangerous feedback loop.

As the natural history of the CRS is mostly slow, hence difficult to explore in clinical trials, adequate animal models combining cardiovascular and renal disease are required to explore the physiopathological mechanisms, and even more importantly the development of new therapeutic targets. Therefore, we further developed and characterized our previously described model of CKD-MBD (Chronic Kidney Disease - Mineral and Bone Disorders) [1] and investigated whether it would be usable as a model for CRS type 4, as defined by the Ronco classification [2]; i.e. chronic kidney disease (CKD) causing cardiac dysfunction.

CRS type 4 is a major health problem in our aging population. The prevalence of CKD steadily increases year by year [3] and CKD is associated with an increased risk for cardiovascular events and mortality in comparison with the general population [4]. Cardiovascular disease s even the most common cause of death in the setting of CKD and individuals suffering from CKD stage 3 are more likely to die from cardiovascular disease than to develop end stage renal disease [5].

In order to characterize the CKD-MBD rat model as a CRS type 4 model we firstly evaluated the development of heart failure (hypertrophy). Furthermore, since a recent review article of Charytan et al. [5], next to abnormalities in the bone and mineral axis, also put forward abnormalities in iron metabolism and development of anemia as important factors in the pathogenesis and prevention or treatment of CRS, we also characterized these CKD-related complications in our animal model.

Materials and methods

Study set-up and mortality

Animals had free access to food and water and were housed two per cage. All animals were weighed weekly and monitored daily for morbidity.

60 male Wistar rats were used (225-250 g) and randomly assigned to different groups. Sample size of the different groups was determined by power analysis with respect to the 3R principle of animal ethics and expected mortality. An equilibration period of 3 weeks was included to ensure a body weight of approximately 320 g at the start of the study. CKD was induced by maintaining the rats (n=56) on an adenine diet with low vitamin K (0.35% adenine, 0.2 mg/kg VitK, 1% Ca, 1% P, 1 IU/g VitD and 6% protein) (SSNIFF Spezialdiäten, Soest, Germany) for 4 consequent weeks, followed by a diet with the same composition except for a relatively lower adenine concentration (0.25%) during the 4 following weeks. A control group (n=4) with normal renal function was included and maintained on a control diet with low vitamin K (0.2 mg/kg VitK, 1% Ca, 1% P, 1 IU/g VitD and 6% protein). The CKD groups were sacrificed weekly starting from week 3 until week 8 (n=8 for week 3 and 4, n=10 for week 5, 6, 7 and 8), i.e. the end of the experiment. Animals that were fed a control diet were sacrificed at the end of the study (week 8, controls). Only 1 animal (from the 7 weeks group) died prior to planned sacrifice, consequently n=9 for all the results reported for this group.

Blood/urine sampling and analyses

Every two weeks starting from week 0 until sacrifice, animals of the control group and the CKD group scheduled to be euthanized at week 8 were placed in individual metabolic cages for a 24 hours urine collection, followed by blood sampling via the tail vein. The rats

of the remaining groups were only put in metabolic cages for 24 hours urine collection the day before sacrifice.

Urinary volume was recorded at the end of each collection. Two 5 ml aliquots of the urine collection were frozen at -20°C pending further analysis (Ca, P, creatinine, total protein). Blood samples were collected in Multivette 600 tubes by tail vein puncture in restrained, conscious animals or during exsanguination at sacrifice (+/- 5ml). After clotting on ice and centrifugation at high speed, two 250 µl aliquots of serum were stored at -20 and -80°C until further processing (Ca, P, creatinine, FGF-23, hepcidin and N-terminal pro atrial nartriuretic peptide (NT-proANP)).

Labeling of the bone

All animals received an i.p. injection of 30 mg/kg tetracycline and 25 mg/kg demeclocycline at day 7 and day 3 before sacrifice respectively for later histomorphometric analysis of a series of dynamic bone parameters (see further).

Sacrifice, whole blood analysis and tissue prelevation

Animals were euthanized by exsanguination via the retro-orbital plexus after pentobarbital anesthesia (60 mg/kg i.p.). Whole blood analysis was performed immediately upon sampling using either i-STAT Point of Care technology (Abott point of care, Princeton, New Jersey, USA) for measuring hematocrit (Hct) and hemoglobin (Hb) concentrations or Sysmex technoglogy (Sysmex corporation, Kobe, Japan) for quantification of the reticulocyte number and the mean corpuscular Hb content (average Hb content/red blood cell).

Aorta, aa. carotis and femoralis, spleen, heart and both tibiae were taken at sacrifice. The presence of vascular calcification was evaluated histomorphometrically on paraffin embedded Von Kossa stained sections of the thoracic aorta. Spleen and heart were weighted and samples of the spleen were taken and preserved at -20°C pending measurement of iron. The left tibia was removed, cleared of soft tissue and subsequently fixed in 70% ethanol and stored at 4°C until further processing for quantitative histomorphometric bone analysis.

Serum analysis

Serum samples were analysed for the following parameters: creatinine, calcium, phosphorus, FGF-23, hepcidin and NT-proANP. Creatinine, phosphorus, hepcidin, FGF-23 and NT-proANP were measured using commercially available kits: Creatinine Merckotest (Diagnostica Merck, Darmstadt, Germany), Ecoline®S Phosphate (DiaSys, Holzheim, Germany), rat hepcidin Elisa (BioSource, San Diego, California, USA), rat FGF-23 Elisa (Kainos, Tokyo, Japan), rat NT-proANP (MesoScaleDiscovery, Rockville, Maryland, USA) respectively. Serum calcium was measured by by flame atomic absorption spectrometry (FAAS, Perkin Elmer, Waltham, Massachusetts).

Quantitative histomorphometric bone analysis

The left tibia was cleared of soft tissue, and fixated overnight in 70% ethanol. After dehydration in increasing concentrations of alcohol, the samples were embedded in methylmetacrylate polymer. After polymerization, sections were cut using a heavy-duty microtome and mounted onto glass microscopy slides. Goldner stained sections were used to quantify static bone parameters, while unstained sections were analysed for the tetracycline labeling using fluorescence microscopy. All analyses are performed using an

AxioVision v. 4.5 image analysis system (Zeiss, Jena, Germany), running in-house developed programs. Out of the primary measured parameters, the following results were calculated and reported: osteoblast, osteoclast and eroded perimeter (all three as percentage of total perimeter), mineral apposition rate (rate by which osteoid is mineralized, µm/day), bone formation rate (surface of bone formed per unit of time expressed per tissue area, $\mu m^2/mm^2$/day), mineralization lag time (mean time interval between deposition and mineralization of osteoid days, days).

Iron measurement in spleen

After weighing, a piece of spleen tissue was homogenized with a tissue ruptor (Quiagen, Hilden, Germany) in 2ml demineralized water after which 2 ml HCl/TCA was added (HCl/TCA was prepared by adjusting 4ml HCL (37%) to 50 ml with 10% TCA). Subsequently, the tissue homogenate was incubated for 1.5h at 95°C and centrifuged for 10 min at 8200 rcf. Finally, iron was measured by Zeeman corrected electrothermal atomic absorption spectrometry (Perkin Elmer, Waltham, Massachusetts) in the supernatant [6].

Statistics

Results are expressed as mean ± SEM. Nonparametric statistical analyses were performed with SPSS 20.0 software (IBM Corp., Armonk, NY, USA). Statistical differences between groups were investigated with Kruskal Wallis test followed by Mann-Whitney U test (two-tailed). Bonferroni correction was applied when appropriate. $p<0.05$ is considered statistically significant.

Results

Mortality and body weight

Throughout the study, only one animal died prior to the scheduled sacrifice. Animals of the control group steadily gained weight while body weight of CKD animals remained stable from the time-point adenine was administrated.

Development of CKD-MBD

Animals receiving the adenine supplemented diet quickly developed impairment of renal function and disturbances of mineral balance (figure 1). The former was reflected by the serum creatinine levels, which became already significantly different from control values at two weeks of adenine administration. After six weeks a plateau was reached at concentrations almost 8 times higher than the control values (5.6 ± 0.03 vs 0.7 ± 0.05 mg/dl). Concomitantly, the mineral balance of the animals was disturbed as reflected by a significant hyperphosphatemia from week 4 on, reaching a triplication of control values at week 6 (15.4 ± 0.6 vs 5.6 ± 0.3 mg/dl). Hyperphosphatemia was preceded by a significant rise in serum FGF-23 levels at week 2, achieving values that were 150 times higher than control values at week 6 (88777 ± 33945 vs 583 ± 10 pg/ml). In line herewith, serum Ca concentrations significantly decreased from week 6 onwards (6.9 ± 0.3 vs 10.7 ± 0.1 mg/dl at week 8).

As a result of the disrupted mineral balance rats developed a disturbed bone and mineral metabolism. This well-known complication of CKD is mainly expressed as high turnover bone disease (figure 2) and concomitant arterial calcification (figure 3). High turnover bone disease was clearly observed from week 5 on as reflected by static (figure 2 A, B and C) and dynamic bone parameters (figure 2 D, E and F). A significantly increased osteoblast

(11±4 to 22±2 %, figure 2A) and eroded (10±0.5 to 16±1.6 %, figure 2c) perimeter was seen at week 5, osteoclast perimeter doubled (however not significant) from 10±0.5 to 20±2.5 % at week 8 (figure 2B). Furthermore, at week 5 a significantly increased mineral apposition rate and bone formation rate and a significantly decreased mineralization lag time (figure 2D, E and F) were observed. These latter bone parameters worsened during the further course of the observation period resulting in a mineral apposition rate of 5.7±0.4 µm/day (vs controls 2.6 ± 0.2 µm/day), a bone formation rate of 7722 ± 808 $\mu m^2/mm^2$/day (vs controls 1449±213 $\mu m^2/mm^2$/day) and a mineralization lag time of 1.8±0.4 days (vs controls 10.6 ± 6 days) at week 8. Concomitantly with the high turnover bone disease at week 5, calcification in the aorta was detected (figure 3) as shown by Von Kossa positive staining of the aortic sections. After 8 weeks of CKD, the % calcified surface in the aorta was significantly increased vs controls (12.7 ± 5.1 vs 0.002 ± 0.0008 % calcified surface).

CKD induced iron deficient anemia

Hct en Hb values rapidly decreased in CKD (figure 4 A and B): point of care analysis detected significant reductions in Hct and Hb after 3 weeks of CKD induction. Values further decreased steadily during the course of the study ending up with values as low as 22.9 ± 1.7 % (vs 47.3 ± 1.6 % in controls) for Hct and 8.2 ± 0.3 g/dl (vs 16.1 ± 0.5 g/dl in controls) for Hb. Whole blood analysis using Sysmex technology allowed us to count the amount of reticulocytes which at week 3 had almost halved to 0.16 ± 0.01 $x10^6$/µl (vs 0.3 ± 0.01 $x10^6$/µl at baseline, $p<0.0005$), remaining constant at that low rate during the further course of the study. The amount of Hb in each erythrocyte or the mean

corpuscular Hb (MCH) was decreased at week 3 (from 17.8 ± 0.15 pg to 16.8 ± 0.17 pg, p=0.005) and remained constant during the further course of the study, except at week 8 where baseline values were reached again (17.2 ± 0.4 pg, p=0.17 vs baseline). Decreased MCH values indicate iron deficiency, further evidenced by two other critical parameters; i.e. serum hepcidin concentration and spleen iron concentration (figure 4 C and D). Serum hepcidin became significantly increased already in week 2, attaining its highest level at week 4 reaching values almost as high as 20 times the average control level (7.8 ± 1.7 vs 0.4 ± 0.1 ng/ml). Spleen iron levels, although measured at different time points, followed the same pattern: a significant increase at week 3, highest value at week 5 (2085 ± 574 vs 841 ± 218 µg/g wet weight) and partial normalization thereafter.

Heart failure

The development of heart failure or hypertrophy was reflected by the steadily increasing heart weight (normalized to body weight) which was significantly increased after 7 weeks of CKD and ended up with an almost 50% increase versus control values at the end of the study (figure 5A). Furthermore, the significantly increased serum NT-proANP concentration in CKD animals as compared to controls at week 8 (3.4 ± 0.8 vs 1.6 ± 0.4 ng/ml) is in line with the development of heart hypertrophy (figure 5B).

Discussion

The animal model described in this manuscript in many aspects mimics the human situation of the CRS type 4. A severe CKD develops with the direct consequence of a disturbed mineral balance as reflected by the altered calcium and phosphorus levels and in association herewith the aberrations in hormonal levels of FGF-23 (PTH was not measured in this study but was reported earlier by our group to be increased in rats with adenine-induced CKD [1]) which in turn induced the well-known and highly undesirable complication of CKD, i.e. mineral and bone disorder (MBD) which is characterized by high turnover bone disease and pathological vessel calcification.

Furthermore (iron-deficient) anemia, another important CRS associated co-morbidity in humans [7], developed quickly. The increased serum hepcidin levels together with proven iron retention in spleen, indicate that the anemia, at least partially, developed as a consequence of iron deficiency.

Although not yet fully understood, CKD patients often develop left ventricle hypertrophy ensuing in cardiac failure. The obvious hypertrophy of the heart together with the significant rise in NT-proANP, are indicative for a failing heart function in our animal model. Atrial natriuretic peptide (ANP) is synthesized by cardiomyocytes in response to increased wall stress [8] and therefore is considered a valid marker for the assessment of heart failure and particularly of left ventricle hypertrophy/systolic dysfunction in humans [9, 10] and in rats as well [11]. Because the active peptide is rapidly degraded upon secretion, however, concentrations of the NT-proANP better reflect the total amount of secreted ANP, both in humans and rats [12, 13].

To the best of our knowledge, this is the first report describing various characteristics/parameters used to diagnose CRS type 4 in humans in an animal model. The reciprocal interactions between all these parameters were extensively considered and discussed in the recent past, however are only partially understood until now. In order to define the clinical manifestations of cardiovascular disease in patients with CKD, Silverberg et al [14] proposed the term cardiorenal anemia syndrome (CRAS) to conceptualize the association between anemia and cardiorenal failure, and later on the term was even further refined to CRAIDS (cardiorenal anemia iron deficiency syndrome) by Klip et al. [15]. The term CKD-MBD was introduced also and is now frequently used to describe the relationship between CKD, abnormal mineral metabolism and vascular calcification; which has repeatedly been reported to importantly contribute to cardiovascular disease [16].

Less obvious interactions are the presumed direct promoting effect of FGF-23 on cardiomyocyte hypertrophy [17] and the anemia-independent worsening effect of iron-deficiency on heart function [18]. Our results argue for an association between the bone mineral axis and iron metabolism. Indeed, for reasons that are not yet clear, at the end of the study serum hepcidin, spleen iron and serum FGF-23 concentrations together partially normalize. Hepcidin is a protein regulating the iron homeostasis by blocking iron absorption from the gut and iron release from spleen macrophages [19]. Increased hepcidin levels are seen in states of iron overload or inflammation [20], in the latter case to deplete invading organisms from iron. Hepcidin levels are also elevated in CKD and thus, are thought to contribute to the dysregulation of iron homeostasis in patients with impaired renal function [21]. However, the primary factors associated with increased hepcidin levels in CKD patients are not fully understood. A study in CKD patients reported

abnormalities in serum phosphate and FGF-23 levels to be associated with increased hepcidin levels independently of eGFR [22], suggesting a direct interaction between, on the one hand the phosphate metabolism, and on the other hand hepcidin and the iron metabolism. In a more recent publication, the same authors provided experimental evidence for this interaction since iron deficiency stimulated FGF-23 production [23]. This interaction however does not explain why in the first place at the end of our study serum hepcidin, spleen iron and serum FGF-23 partially normalize.

Testing new CRS treatment strategies in the animal model described in this manuscript opens perspectives for more efficient treatment of CRS but can also importantly contribute to the elucidation of the reciprocal interactions between all CRS related parameters, which in turn may initiate the development of more efficient and safer treatment strategies.

Treatments targeting iron deficiency have proven to be able to achieve satisfactory hemoglobin levels without the administration of erythropoietin stimulating agents (ESAs) as in clinical studies intravenous iron administration resulted in a substantial increase of the Hb level [24]. Administration of a molecule antagonizing hepcidin function in a CKD rat model was able to reverse anemia [25]. Furthermore, those treatments possibly should also affect cardiac function: intravenous administration of ferric carboxymaltose in a clinical study improved symptoms of heart failure [26]. The current animal model will allow us to investigate in a straight forward manner whether treatments targeting iron deficiency, in addition to anemia, are also capable to improve other CKD-induced co-morbidities such as MBD, which in view of the above mentioned link between phosphate metabolism and iron deficiency is worth being considered.

Treatment of the most fatal complication of CKD, i.e. vascular calcification, until now has not been proven highly efficacious and in general is limited to optimizing the mineral metabolism and related bone disease; e.g. by using phosphate binders, to which it is inextricably linked. An alternative approach could be to directly interfere with the calcification process by for example treatment with the endogenic calcification inhibitor pyrophosphate either or not in combination with its most important degrading enzyme tissue-non-specific alkaline phosphatase (TNAP). Another therapeutic strategy could consist in the therapeutic use of ferric pyrophosphate (Fe-PPi or Triferic) [27] which allows us to directly evaluate the combined effect of this treatment on vascular calcification and iron deficient-related anemia in one and the same animal. As such, our current model again would enable to test the effects of these particular treatments on all aspects of the CRS.

Another new treatment strategy in the setting of CKD-MBD/CRS consists in the use of the activin receptor IIA ligand trap which, based on its characteristics, might exert a beneficial effect on the most important CKD complications: anemia, bone disease and vascular calcification. Activin receptor IIA ligand trap has proven to have beneficial effects in different models of anemia (including hepcidin transgenic mice) and bone loss [28-31], however, so far has never been tested in the frame of CKD induced anemia and bone mineral disorder. In a recent manuscript, however, it has been elegantly shown to prevent aortic intima calcification and even decrease renal fibrosis in an LDL-receptor knockout model [32].

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Statement of ethics

Experimental procedures were conducted according to the National Institutes of Health Guide for the Care and Use of Laboratory Animals (1996) and were approved by the University of Antwerp Ethical Committee.

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Figure legends

Figure 1: Development of chronic kidney disease-CKD (A) and disturbed mineral balance in serum (B-D) in animals receiving adenine supplemented diet, compared to control (CTR) animals. A. Serum creatinine, B. Serum phosphate (P), C. Serum FGF-23 and D. Serum calcium (Ca). Each data-point represents mean ± sem of 10 animals for the CKD and 4 animals for the CTR group. *p<0.05 vs CTR)

Figure 2: Development of chronic kidney disease (CKD) induced bone pathology (high turnover bone disease) as became clear from measuring static (A-C) and dynamic (D-F) bone parameters in animals receiving an adenine supplemented diet (CKD), compared to control (CTR) animals. A. Osteoblast-, B. osteoclast- and C. eroded perimeter (all as percentage of total perimeter). D. Mineral apposition- and E. bone formation rate, F. mineral lag time. Each data-point represents mean ± sem of 10 animals for the CKD 5 and 8 week groups and of 4 animals for the CTR group. *p<0.05 vs CTR.

Figure 3: Development of CKD induced aortic calcifications in animals receiving adenine supplemented diet, compared to control (CTR) animals. A. Quantification of Von Kossa positive area percentage in tissue sections of CKD and CTR animals. Each data-point represents mean ± sem of 10 animals for the CKD 5 and 8 week groups and of 4 animals for the CTR group.*p<0.05 vs CTR B. Microscopic image of a Von Kossa stained aortic section of an animal receiving adeniene supplemented diet (week 5, calcifications stain black).

Figure 4: Development of iron-deficient anemia in animals receiving adenine supplemented diet, compared to control (CTR) animals. A. Whole blood Hct and B. Hb levels. C. Serum hepcidin and D. spleen iron concentrations. For A,B and D each data-point represents mean ± sem of 8 animals CKD week 0, 3 and 4 groups, of 9 animals for CKD week 7 group and 10 animals for the CKD week 5, 6 and 8 groups and of 4 animals for the CTR group. For C each data-point represents mean ± sem of 10 animals for the CKD and 4 animals for the CTR group.*p<0.05 vs CTR

Figure 5: Development of heart hypertrophy in animals receiving adenine supplemented diet, compared to control (CTR) animals. A. Heart weight (relatively to body weight), each data-point represents mean ± sem of 8 animals CKD week 3 and 4 groups, of 9 animals for CKD week 7 group and 10 animals for the CKD week 5, 6 and 8 groups and of 4 animals for the CTR group. B. Serum N-terminal pro-ANP (NT-pro ANP) concentrations, each data-point represents mean ± sem of 10 animals for the CKD and 4 animals for the CTR group.*p<0.05 vs CTR

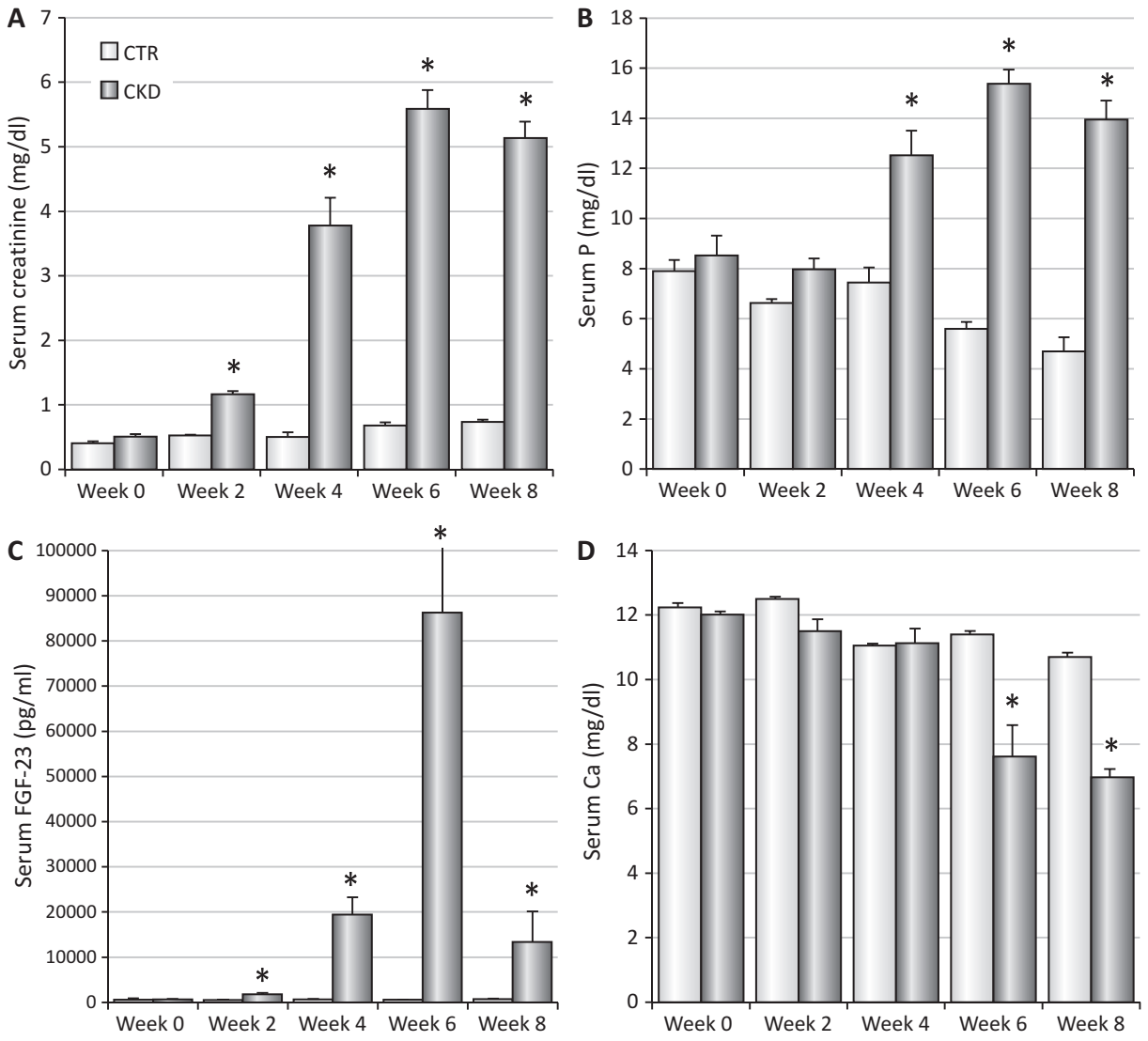
A
CTR
CKD
Serum creatinine (mg/dl)
0
1
2
3
4
5
6
7
Week 0
Week 2
Week 4
Week 6
Week 8
B
Serum P (mg/dl)
0
2
4
6
8
10
12
14
16
18
C
Serum FGF-23 (pg/ml)
0
10000
20000
30000
40000
50000
60000
70000
80000
90000
100000
D
Serum Ca (mg/dl)
0
2
4
6
8
10
12
14

Figure 1

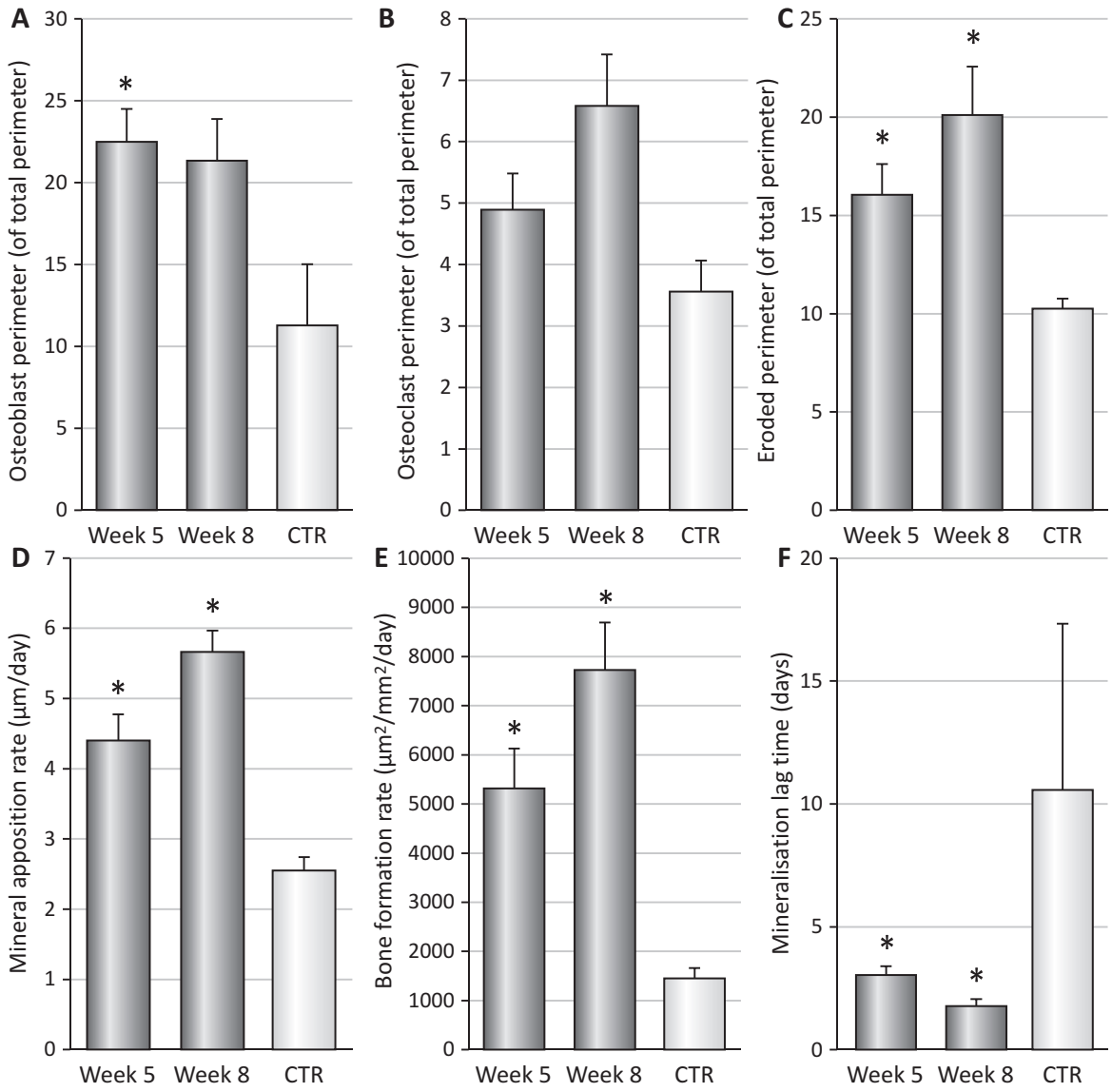
A
Osteoblast perimeter (of total perimeter)
30
25
20
15
10
5
0
*
Week 5
Week 8
CTR
B
Osteoclast perimeter (of total perimeter)
8
7
6
5
4
3
2
1
0
Week 5
Week 8
CTR
C
Eroded perimeter (of total perimeter)
25
20
15
10
5
0
*
*
Week 5
Week 8
CTR
D
Mineral apposition rate (µm/day)
7
6
5
4
3
2
1
0
*
*
Week 5
Week 8
CTR
E
Bone formation rate (µm²/mm²/day)
10000
9000
8000
7000
6000
5000
4000
3000
2000
1000
0
*
*
Week 5
Week 8
CTR
F
Mineralisation lag time (days)
20
15
10
5
0
*
*
Week 5
Week 8
CTR

Figure 2

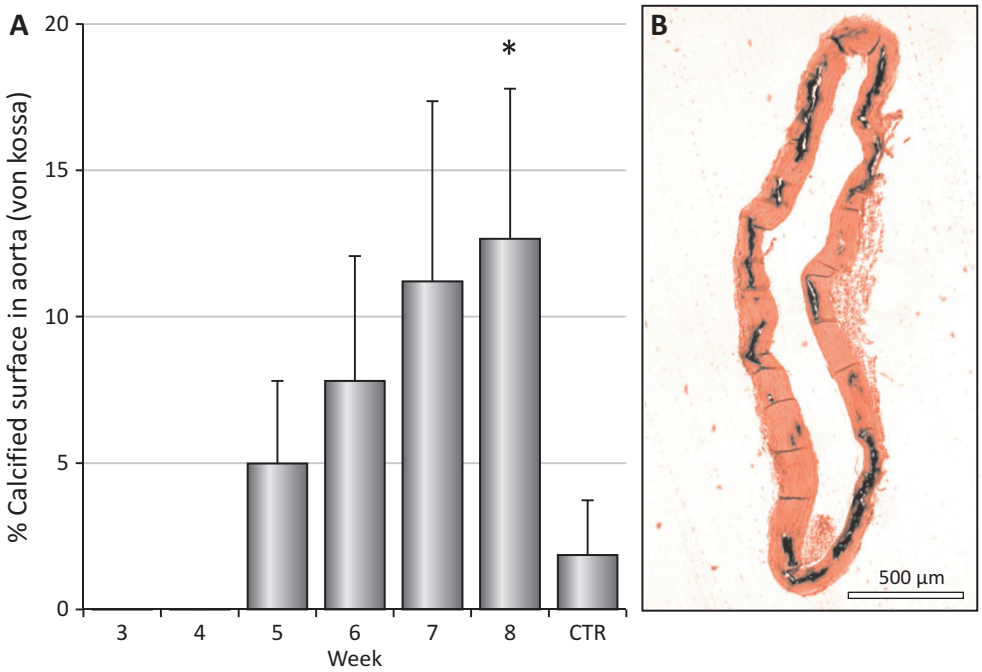
A
B
% Calcified surface in aorta (von kossa)
20
15
10
5
0
*
3
4
5
6
7
8
CTR
Week
500 µm

Figure 3

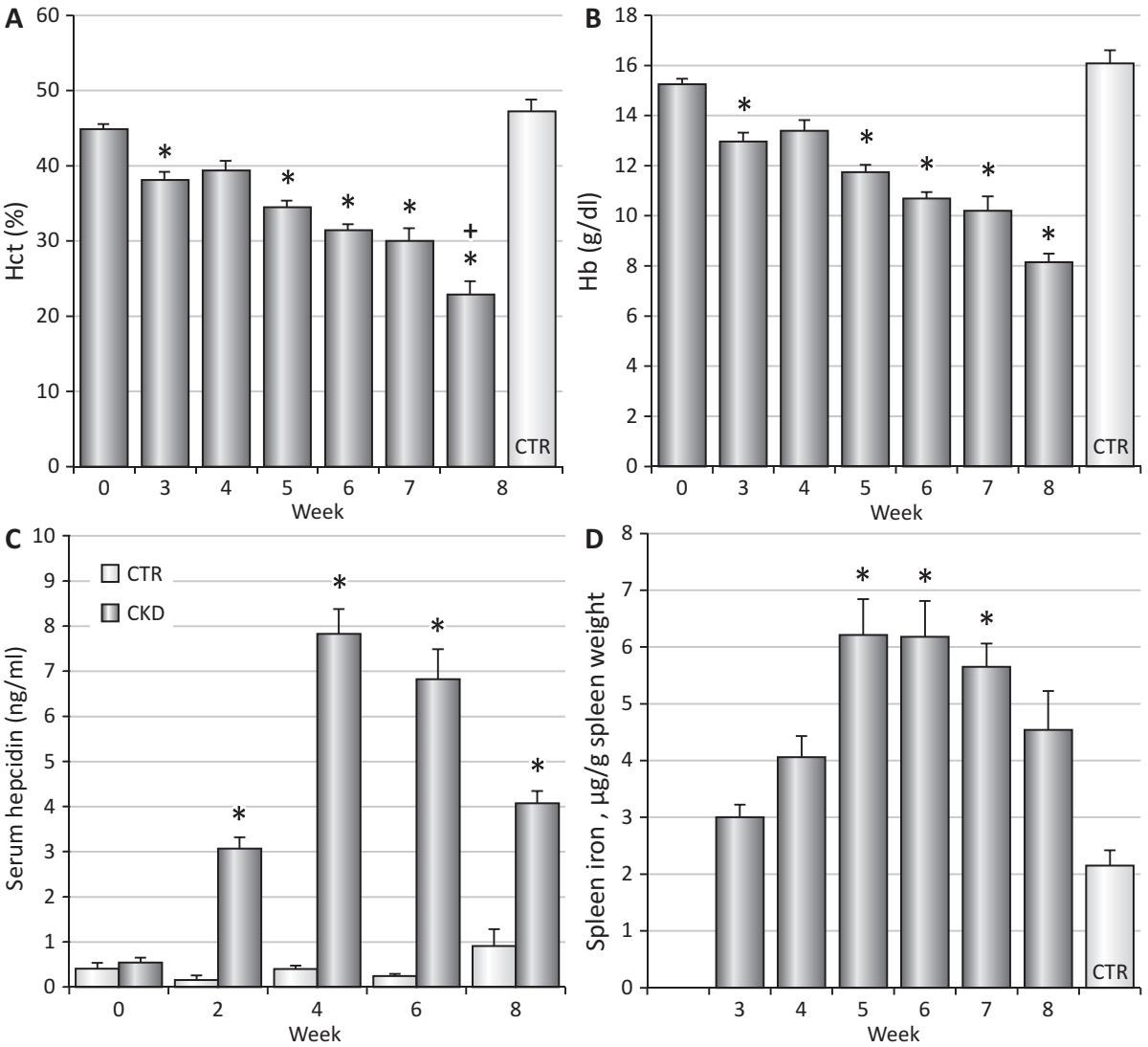
A
Hct (%)
60
50
40
30
20
10
0
CTR
0
3
4
5
6
7
8
Week
B
Hb (g/dl)
18
16
14
12
10
8
6
4
2
0
CTR
0
3
4
5
6
7
8
Week
C
Serum hepcidin (ng/ml)
10
9
8
7
6
5
4
3
2
1
0
CTR
CKD
0
2
4
6
8
Week
D
Spleen iron , µg/g spleen weight
8
7
6
5
4
3
2
1
0
CTR
3
4
5
6
7
8
Week

Figure 4

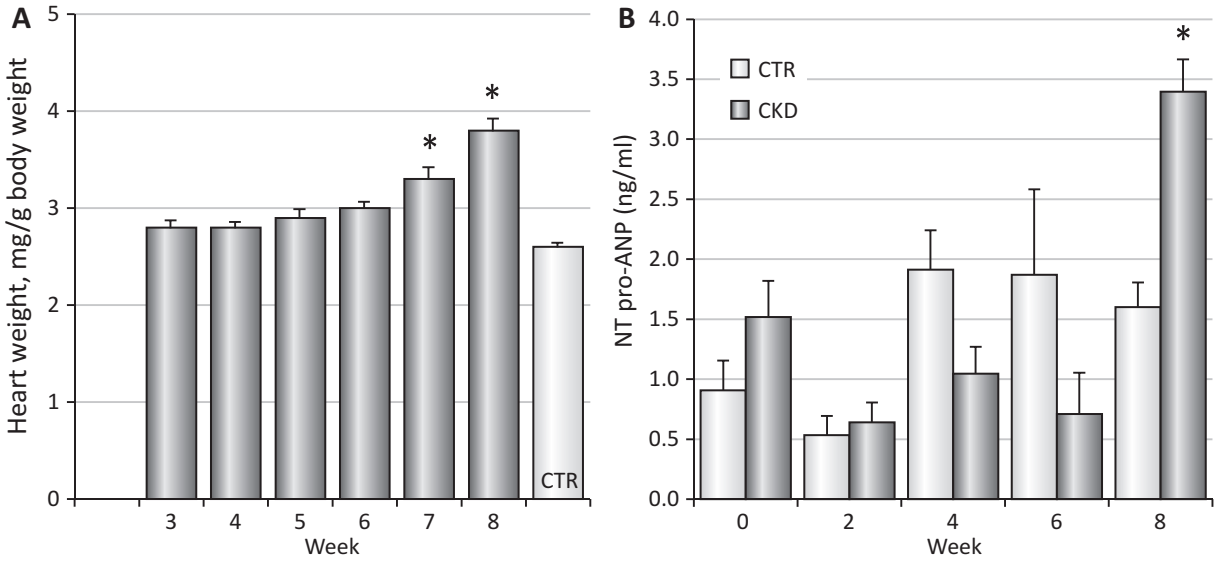
A
Heart weight, mg/g body weight
5
4
3
2
1
0
*
*
CTR
3
4
5
6
7
8
Week
B
NT pro-ANP (ng/ml)
4.0
3.5
3.0
2.5
2.0
1.5
1.0
0.5
0.0
CTR
CKD
*
0
2
4
6
8
Week

Figure 5