Acknowledgments

Our thanks to Benjamin L. Viglianti, Andrew N. Fontanella, and Kelly Kennedy for their thoughtful discussions regarding this commentary. We also thank Chamali Wickamasekara for technical help and the creativity of Isabel Cardenas-Navia. This work was supported by NIH/NCI grants CA40355 and CA42745.

Address correspondence to: Mark W. Dewhirst, Duke University Medical Center, Box 3455, Room 201 MSRB Research Drive, Durham, North Carolina, USA. Phone: (919) 684-4180; Fax: (919) 684-8718; E-mail: dewh@duke.edu


Linking adiponectin to proteinuria

Nonstandard abbreviations used: AdipoR, adiponectin receptor; AICAR, 5-aminoimidazole-4-carboxamide-1-β-D-ribose-nucleotide; HMW, high molecular weight; Nox, NADPH oxidase; ZO-1, zona occludens-1.

Conflict of interest: R.S. Ahima has received research support from Biomeasure/Ipsen Inc. and served on scientific advisory boards of Biomeasure/Ipsen Inc. and Ethicon Endo-Surgery (Johnson & Johnson).


Obesity predisposes toward renal disease independently of diabetes and hypertension. In this issue of the JCI, Sharma and colleagues assessed the role of adiponectin, an adipose-derived hormone, in the pathogenesis of albuminuria (see the related article beginning on page 1645). Obese African Americans had reduced adiponectin levels associated with albuminuria. Adiponectin deficiency in mice induced oxidative stress, fusion of podocyte foot processes in the kidney glomerulus, and urinary albumin excretion. Adiponectin treatment reversed these abnormalities, likely through activation of AMPK. The benefits of adiponectin were observed in diabetic and nondiabetic mice. These findings suggest that adiponectin is a biomarker for kidney disease and may be targeted for prevention and treatment.

Obesity and kidney disease

The obesity epidemic has been linked to rising incidences of type 2 diabetes, cardio-vascular disease, nonalcoholic fatty liver disease, sleep apnea, and cancer (1). Studies also indicate that obesity increases the risk of kidney disease independently of diabetes and hypertension (2, 3). Renal blood flow and glomerular filtration rate are elevated in obesity and are related to increased levels of the protein albumin in the urine (albuminuria) (4). Epidemiological studies suggest that microalbuminuria, defined as a urine albumin/creatinine ratio of 30–300 μg/mg, increases cardiovascular morbidity (5). Furthermore, an albumin/creatinine ratio considered to be within the normal range (10–30 μg/mg) is associated with higher cardiovascular risk (6). Insulin resistance, oxidative stress, and inflammation have all been implicated in albuminuria and declining kidney function, but the underlying mechanisms are unclear (4).

Hypoadiponectinemia is related to albuminuria

In the current issue of the JCI, Sharma et al. describe a role of adiponectin in the pathogenesis of albuminuria (7). Adiponectin is...
secreted exclusively by adipocytes (8). The monomer is a 30-kDa protein with 3 distinct domains: N-terminal hypervariable region, collagenous stalk, and C-terminal globular domain (8, 9). Adiponectin circulates in plasma as various complexes: high-molecular weight (HMW; 12- to 36-mer), low–molecular weight (hexamer), and trimeric forms. Total and HMW adiponectin levels are more abundant in females and decline in obesity (8, 9). Low adiponectin levels are related to higher prevalence of type 2 diabetes, inflammation, and atherosclerosis, and these abnormalities are reversed by adiponectin treatment (8, 10). The insulin-sensitizing effect of chiazolidinediones is related to increased HMW adiponectin levels (9, 10).

Previously, adiponectin receptors AdipoR1 and AdipoR2 — containing 7-transmembrane domains that are structurally and functionally distinct from G protein-coupled receptors — have been described (8). AdipoR1 is more widely expressed and enriched in muscle, while AdipoR2 is abundant in liver. Binding of adiponectin to AdipoR1 and AdipoR2 increases AMPK activation and PPARα signaling, resulting in suppression of gluconeogenesis, stimulation of fatty acid oxidation, and amelioration of diabetes (8, 11). AdipoR1- and AdipoR2-mediated signal transduction has been implicated in steatosis, inflammation, and oxidative stress, all key abnormalities associated with obesity and the metabolic syndrome (8).

Sharma et al. found that plasma adiponectin concentration was inversely related to urinary albumin excretion in obese African Americans, a group prone to obesity and chronic kidney disease (7). Conversely, BMI, blood pressure, lipid levels, and plasma levels of IL-6 and plasminogen activator inhibitor–1 (PAI-1) were not associated with albuminuria in this group. To establish a role of adiponectin in the pathogenesis of albuminuria, Sharma et al. compared wild-type mice with adiponectin-deficient mice. Blood pressure, glucose levels, and lipid levels were not affected in Ad+/− mice fed a regular rodent diet; however, albuminuria was significantly higher, worsened with age, and was exacerbated by diabetes. Hydrogen peroxide levels increased in the urine of Ad+/− mice, consistent with oxidative stress. Electron microscopic examination revealed segmental fusion of the feet processes of podocytes (interdigitated cells that closely invest the glomerular capillary network in the kidney, as shown in Figures 1 and 2, and act in part as a filter for large macromolecules) in Ad+/− mice, although the thickness of the glomerular basement membrane and the structures of endothelial and mesangial cells were not altered by adiponectin deficiency. Albumin permeability was increased in a monolayer culture of podocytes from Ad+/− mice, consistent with albuminuria in this model.

The authors showed that AdipoR1 was highly expressed in podocytes (7). AMPK phosphorylation was increased in podocytes by adiponectin or the AMPK activator 5-aminimidazole-4-carboxamide-1-β-d-ribofuranoside (AICAR; Figure 2A). The distribution of the tight junction protein zonula occludens–1 (ZO-1) was disrupted in podocytes from Ad+/− mice and restored by adiponectin or AICAR treatment. Although the involvement of AdipoR1 in albuminuria and how this is coupled to AMPK signaling requires further study, these results demonstrate major effects of adiponectin on the kidney.

### Adiponectin decreases oxidative stress and albuminuria

To determine whether adiponectin is causally related to kidney disease, the authors assessed effects of adiponectin treatment on urine albumin and hydrogen peroxide excretion (7). These parameters were related to podocyte structure, activity of AMPK, and expression of oxidative enzymes. Ad+/− mice were treated with the full-length or globular forms of adiponectin. Restoration of plasma adiponectin to levels measured in wild-type mice blunted albuminuria in nondiabetic as well as diabetic Ad+/− mice. Remarkably, adiponectin reversed the fusion of podocyte foot processes in Ad+/− mice. AMPK activity was attenuated in podocytes and glomeruli, and the expression of the NADPH oxidase Nox4, but not Nox1 or Nox2, was enhanced in the absence of adiponectin in Ad+/− mice. As predicted, adiponectin treatment restored AMPK activity and decreased Nox4 expression in parallel with improvements in urinary albuminuria and hydrogen peroxide levels.

### Adiponectin as a biomarker of kidney disease: ready for prime time?

These carefully conducted studies demonstrate an important link between adiponectin and albuminuria (Figure 2) (7). The experiments in rodents and cell culture suggest that adiponectin signaling via AMPK regulates oxidative stress, segmental fusion of podocyte foot processes, and albuminuria. The capacity of adiponectin to reverse these abnormalities in Ad+/− mice is independent of glucose. These results are in agreement with exacerbation of albuminuria following surgical resection of kidneys in Ad+/− mice (12), which resulted in glomerular hypertrophy, podocyte injury, oxidative stress, inflammation, and fibrosis. Adiponectin decreased albuminuria, glomerular hypertrophy, and tubulointerstitial fibrosis, and these changes were associated with restoration of VCAM-1, monocyte chemotactant protein–1, TNF-α, TGF-β1, collagen type I/III, and Nox to the levels found in wild-type mice. An antiinflammatory role for adiponectin in the kidney is in agreement with its similar actions in the vasculature, liver, and colon (13–15).
Low plasma adiponectin concentration could potentially serve as a biomarker for early detection of kidney disease. However, the inverse relationship between adiponectin and proteinuria among obese African Americans found in the current study (7) has not been consistently observed in others (16, 17). The plasma adiponectin concentration may reflect the extent of kidney damage, metabolic state, and ethnic background of the population under study (7, 15, 16). As mentioned earlier, adiponectin exists as HMW, hexamer, and trimer complexes, yet these forms of the protein were not measured in patients or mice in the current study (7).

The authors’ findings in Ad−/− mice raise an intriguing possibility that increasing adiponectin levels or stimulating AMPK activity may blunt albuminuria and prevent the progression of kidney disease. However, there are pitfalls in the translation of these results. Recombinant adiponectin was administered in mice with total adiponectin deficiency. As is often the case in hormone replacement, Ad−/− mice are expected to be hyperresponsive to adiponectin treatment. Because there are no patients with total adiponectin deficiency, the question remains as to whether patients with partial adiponectin deficiency will benefit from treatments that increase adiponectin levels. Previous studies in diabetic patients suggest this may be the case: rosiglitazone increased adiponectin levels, enhanced insulin sensitivity, and suppressed albuminuria in patients with type 2 diabetes (18, 19). AMPK activation also has the potential to ameliorate kidney disease, as evidenced by the effects of metformin and AICAR to increase AMPK phosphorylation and inhibit renal hypertrophy in diabetic rats (20).

Conclusions
The article by Sharma et al. (7) advances our understanding of renal pathophysiology. Until the discovery of leptin, the prevailing view of adipose tissue was that of a passive storage site for triglycerides. It is now well established that adipocytes secrete proteins that actively control energy homeostasis, glucose and lipid metabolism, neuroendocrine and cardiovascular function, and various physiological systems. Adiponectin is a logical candidate for exploring the link between adipose tissue and kidney function. The tools for assessing the relationships among adiposity, adiponectin, metabolism, and renal pathophysiology in rodents and humans are readily available, making the clinical translation of key elements of this paper feasible. The demonstration of the validity of adiponectin as a biomarker of albuminuria in humans is a crucial step in
this process and may ultimately facilitate the prevention and treatment of kidney disease.

Address correspondence to: Rexford S. Ahima, University of Pennsylvania School of Medicine, Division of Endocrinology, Diabetes, and Metabolism, 712A Clinical Research Building, 415 Curie Boulevard, Philadelphia, Pennsylvania 19104, USA.

Phone: (215) 573-1872; Fax: (215) 573-5809; E-mail: ahima@mail.med.upenn.edu.

Soluble Nef induces PPAR expression and STAT5A and STAT5B, two factors necessary for proper function of hematopoiesis by extracellular Nef plays a role in the development of T cell immunodeficiency and the high levels of chronic immune activation associated with AIDS.

HIV-associated hematological abnormalities involve all lineages of blood cells, thus implying that the virus impairs the function of early HSCs. However, the underlying mechanisms of this defect are unknown, particularly since HSCs are largely resistant to HIV-1 infection. In this issue of the JCI, Prost and colleagues show that the viral accessory protein Nef plays a potentially critical role in the pathogenesis of HIV/SIV-associated hematopoietic dysfunction by affecting the clonogenic potential of HSCs (see the related article beginning on page 1765). Soluble Nef induces PPARγ in uninfected HSCs, thereby suppressing the expression of STAT5A and STAT5B, two factors necessary for proper HSC function. The identification of this novel activity of extracellular Nef defines a new mechanism of HIV/SIV pathogenesis and suggests that approaches aimed at increasing STAT5A and STAT5B expression may be considered in HIV-infected individuals with prominent hematological abnormalities. The results also raise the question of whether dysregulation of hematopoiesis by extracellular Nef plays a role in the development of T cell immunodeficiency and the high levels of chronic immune activation associated with AIDS.


Is Nef the elusive cause of HIV-associated hematopoietic dysfunction?

Frank Kirchhoff1 and Guido Silvestri2

1Institute of Virology, University of Ulm, Ulm, Germany.
2Department of Pathology and Laboratory Medicine, University of Pennsylvania, Philadelphia, Pennsylvania, USA.

HIV-1 infection causes immunodeficiency by inducing a progressive decline in number of CD4+ helper T cells. However, the mechanisms of HIV/AIDS pathogenesis are complex, as it is still unclear to what extent this progressive CD4+ T cell depletion is caused by direct killing of infected cells or rather by the indirect effects of chronic, generalized immune activation (1). Importantly, HIV infection is also associated with hematopoietic abnormalities characterized by impaired generation and function of cells of all blood lineages (i.e., red blood cells, platelets, and white blood cells). These hematopoietic dysfunctions may cause various levels of cytopenias and also contribute to the development of T cell immunodeficiency (Figure 1). Since all blood cell lineages may be affected, HIV-1 infection apparently deregulates the function of early hematopoietic progenitor cells. This assumption was confirmed by studies showing that CD34+ progenitor cells from HIV-infected patients show reduced growth and differentiation in vitro (3, 4).

HIV-associated hematological abnormalities seem to be dependent on the level of virus replication, as these abnormalities are severe in late-stage AIDS patients with high viremia but can be corrected by highly active antiretroviral therapy (HAART) (5, 6). The mechanisms underlying these hematological abnormalities are still obscure. While HSCs express low levels of CD4 and CCR5,