Dent’s disease: chloride–proton exchange controls proximal tubule endocytosis

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Review of the field

Receptor-mediated endocytosis in the proximal tubule

Several grams of albumin and low-molecular-weight (LMW) plasma proteins are filtered daily through the glomerular basement membrane, to be reabsorbed by proximal tubule (PT) cells [9]. These LMW proteins, which are characterized by a molecular mass lower than that of albumin (~69 kDa), include hormones, vitamin-binding proteins, enzymes, immunoglobulin light chains, drugs and toxins. Most of the filtered LMW proteins are reabsorbed and metabolized by PT cells, and the human urine is virtually devoid of plasma proteins under physiological conditions. Such a massive uptake of proteins accounts for as much as 80% of the total metabolic clearance of small proteins and peptides, and plays a key role in hormone and vitamin homeostasis [10].

The uptake of LMW proteins by PT cells essentially involves receptor-mediated endocytosis, while fluid-phase capture can be considered as quantitatively negligible. During receptor-mediated endocytosis, filtered proteins are concentrated at the apical cell surface, and further reabsorbed by clathrin-mediated endocytosis. The process requires two multiligand receptors, megalin and cubilin, that are abundantly expressed at the brush border of PT cells [10]. Ligand binding and interactions between both receptors induce their internalization into coated vesicles and their subsequent delivery to endosomes and lysosomes for ligand processing and receptor degradation or recycling. The progression along the endocytic apparatus requires a sustained vesicular acidification, which triggers receptor–ligand dissociation and modulates vesicle trafficking, endosomal fusion events, and coat formation [11]. In PT cells, the endosomal acidification is driven by the electrogenic vacuolar H⁺-ATPase (V-ATPase) requiring a countercurrent system to dissipate the positive potential and to maintain electroneutrality (Figure 1). It has long been assumed that chloride channels would provide such an electrical shunt to neutralize the H⁺ gradient [12].
The paradigm of Dent's disease

Investigations on the pathophysiology of Dent's disease and the role of CIC-5 have provided critical information on the role of chloride transporters in proximal tubule endosomes. Dent's disease (OMIM #300009) is a rare X-linked renal tubulopathy characterized by LMW proteinuria associated with hypercalciuria, which may provoke nephrolithiasis, nephrocalcinosis and renal failure [2,3]. The disease is caused by mutations in the \textit{CLCN5} gene that encodes ClC-5, an electrogenic Cl$^-$/$H^+$ exchanger [1,6,7]. ClC-5 belongs to the CLC family of Cl$^-$ channels/transporters that have been discovered and characterized by Jentsch and colleagues [13]. ClC-5 consists of 746 amino acids and forms diamond-shaped homodimers, each having a pore responsible for the selective coupling of Cl$^-$ flux to H$^+$ countertransport [14]. In vitro studies have demonstrated that natural mutations in CIC-5 lead to a loss of function [1]. Furthermore, genetic inactivation of the \textit{Clcn5} gene in the mouse mimics the severe PT dysfunction observed in Dent's disease [15,16].

Pathophysiology of Dent's disease

Based on its initial characterization and its co-distribution with the V-ATPase in renal endosomes [1,15–17], CIC-5 was thought to mediate the Cl$^-$ countercurrent necessary for endosomal acidification. Studies in endosomes isolated from CIC-5 KO mice confirmed a decreased ATP-dependent vesicular acidification [4], and indeed, mice lacking CIC-5 showed a severe defect in PT endocytosis [15,16]. In addition, CIC-5 inactivation induces a generalized trafficking defect in PT cells, with loss of megalin and cubilin at the brush border and impaired lysosome biogenesis, which also contributes to defective endocytosis and urinary loss of LMW ligands and lysosomal enzymes [18].

The role played by CIC-5, however, became more difficult to understand when it was discovered that, instead of being a simple Cl$^-$ channel, CIC-5 is in fact a Cl$^-$/H$^+$ exchanger exploiting the H$^+$ gradient to move Cl$^-$ ions into the endosomes [6,7] (Figure 1). To better understand the biological role of this exchange activity, and its relevance
for Dent’s disease, Novarino, Jentsch and colleagues [8] generated a novel KI mouse model carrying a point mutation of CIC-5 (E211A) that they had extensively characterized in vitro. This mutation affects a critical intra-membrane glutamate residue that is essential for the gating of the CLC exchangers [14]; by replacing this glutamate by an alanine, CIC-5 is converted into a pure, uncoupled Cl− conductor. At variance with the lack of CIC-5 in KO mouse, this very mutation should not affect the endosomal acidification. Thus, comparative analysis of the renal phenotype in the KO and KI mouse models should provide a strong indication about the role of the Cl−/H+ exchange in the pathophysiology of Dent’s disease. Indeed, Novarino et al. [8] showed that vesicular acidification was similar in WT and KI mice, contrasting with a severe impairment in KO mice. However, despite the normal endosomal acidification, KI mice showed the same renal phenotype as KO mice and patients with Dent’s disease, including LMW proteinuria, glucosuria, hyperphosphaturia and hypercalciuria. Furthermore, both the KI and KO mouse showed a similar impairment in PT endocytosis, with reduced levels of the endocytic receptors megalin and cubilin and internalization of the sodium–phosphate co-transporter NaPi-2a indicating a trafficking defect (Figure 1).

Thus, PT dysfunction in Dent’s disease may occur despite normal acidification of renal endosomes, which excludes the chloride shunt hypothesis. Instead, the disease appears to be caused by defective exchange activity, i.e. uncoupling of Cl− from H+ gradients and defective endosomal Cl− accumulation (Figure 1). CIC-5 may drive endosomal acidification independently of the V-ATPase, for instance by exchanging cytosolic H+ for intravesicular Cl− in early endosomes [7]. Novarino et al. suggest that the 2Cl−/H+ exchange maintains high vesicular Cl− concentration not only during active acidification but also under steady state [8]. This hypothesis is supported by a companion paper by Weinert et al., who demonstrate lower Cl− concentration in lysosomes harboring an uncoupling mutation in CIC-7 despite normal lysosomal pH [19]. At this stage, the role of the vesicular Cl−—regulation of other transport systems, interaction with other proteins involved in the organelle or importance for vesicle recycling—remains speculative.

Relevance for the practising nephrologist

The family of CLC proteins is important for nephrologists, as a pure Cl− channel such CIC-Kb is involved in salt-losing tubulopathies affecting the distal nephron (Bartter and Gitelman syndromes), whereas the Cl−/H+ exchanger CIC-5 is involved in a generalized PT dysfunction (Dent’s disease) [3,13].

Dent’s disease illustrates how investigations of a rare disorder can give insights into fundamental biological processes that are clinically relevant. The disease stresses the importance of PT endocytosis, essential for the metabolism of small proteins and the homeostasis of hormones and vitamins. Defective PT endocytosis can readily be detected by LMW proteinuria. The consequences of such an endocytic defect are not small, since cells lacking CIC-5 show dedifferentiation and oxidative stress [20], and progression to ESRD occurs in 30–80% of affected males [2]. The work of Novarino et al. also illustrates the importance of identifying the structure of a molecule, including critical residues involved in gating, as well as the power of genetic engineering in the mouse [8]. Finally, these data provide new insights into the question of the endosomal acidification, which has puzzled cell biologists for decades. In particular, they point to the physiological requirement of chloride along the endocytic apparatus.

Important questions remain: what is the role of intravesicular Cl− concentration? And, how does this affect membrane traffic in PT cells? What is the relation between defective CIC-5/endocytosis and the hypercalciuria in Dent’s disease? What is the role of other Cl− channels and transporters [21] present in endosomes? Will these new data be helpful to design drugs able to restore normal endocytosis and PT function?

Take-home message

Dent’s disease is a disorder of the proximal tubule caused by inactivating mutations in CIC-5 that impair the endocytic uptake of ultrafiltered proteins. New data show that CIC-5 is a chloride–proton exchanger that controls the accumulation of Cl− ions into renal endosomes. Reduced endosomal Cl− concentration may thus impair proximal tubule endocytosis and cause renal Fanconi syndrome.

Conflict of interest statement. None declared.

References


Received for publication: 2.8.10; Accepted in revised form: 17.8.10