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PHS 303: RENAL PHYSIOLOGY BODY FLUID AND TEMPERATURE REGULATION

**ASSIGNMENT**

**Question 1**

**Discuss the role of kidney in glucose homeostasis?**

The maintenance of glucose homeostasis is crucial in preventing pathological consequences that may result from hyperglycemia or hypoglycemia. Chronically uncontrolled hyperglycemia leads to a higher risk of macrovascular and microvascular complications, such as cardiovascular disease, nephropathy, neuropathy, and retinopathy. Hypoglycemia, on the other hand, may lead to a myriad of central nervous system complications (e.g, confusion, behavioral changes, seizures, loss of consciousness, and even death), since the brain is the body’s largest consumer of glucose in the fasting or “postabsorptive” state. Maintenance of glucose homeostasis involves several complementary physiologic processes, including glucose absorption (in the gastrointestinal tract), glycogenolysis (in the liver), glucose reabsorption (in the kidneys), gluconeogenesis (in the liver and kidneys), and glucose excretion (in the kidneys).

The kidneys are capable of synthesizing and secreting many important hormones (e.g renin, prostaglandins, kinins, erythropoietin) and are involved in a wide variety of metabolic processes such as the activation of vitamin D3, gluconeogenesis and metabolism of numerous endogenous compounds (e.g insulin. steroids). With respect to renal involvement in glucose homeostasis, the primary mechanisms include release of glucose into circulation via gluconeogenesis, uptake of glucose from the circulation via gluconeogensesis, uptake of glucose from the circulation to satisfy the kidneys energy needs and reabsorption of glucose at the level of the proximal tubule.

Renal release of glucose into the circulation is the result of glycogenolysis and gluconeogenesis. Glycogenolysis involves the breakdown of glycogen to glucose-6-phosphate from precursors (eg, lactate, glycerol, amino acids) and its subsequent hydrolysis (via glucose-6-phosphatase) to free glucose. Gluconeogenesis involves formation of glucose-6-phosphate from those same precursors and subsequent conversion to free glucose. The liver and skeletal muscles contain most of the body’s glycogen stores, but only the liver contains glucose-6-phosphatase. As such, the breakdown of hepatic glycogen leads to release of glucose, whereas the breakdown of muscle glycogen leads to release of lactate. Lactate (generated via glycolysis of glucose by blood cells, the renal medulla, and other tissues) may be absorbed by organs and reformed into glucose.

With regard to glucose utilization the kidney may be perceived as two separate organs, with glucose utilization occurring predominantly in the renal medulla and glucose release limited to the renal cortex. These activities are separated as a result of differences in the distribution of various enzymes along the nephron. To the point cells in the renal medulla have significant glucose phosphorylating enzyme activity and can therefore phosphorylate and accumulate glucogen. However since these cells lack glucose-6-phosphatase and other gluconeogenic enzymes they cannot release free glucose into the circulation. On the other hand, renal cortex cells do possess gluconeogenic enzymes and therefore can make and release glucose into the circulation. But because these cells have little phosphorylating capacity they cannot synthesize glycogen.

In addition to their important role in gluconeogenesis, the kidneys contribute to glucose homeostasis by filtering and reabsorbing glucose. Under normal conditions, the kidneys retrieve as much glucose as possible, rendering the urine virtually glucose free. The glomeruli filter from plasma approximately 180 grams of D-glucose per day, all of which is reabsorbed through glucose transporter proteins that are present in cell membranes within the proximal tubules. If the capacity of these transporters is exceeded, glucose appears in the urine. This maximum capacity, known as the tubular maximum for glucose (TmG), ranges from 260 to 350 mg/min/1.73 m2 in healthy adults and children, and corresponds to a plasma glucose level of approximately 200 mg/dL.4 Once the threshold is reached and transporters are unable to reabsorb all the glucose, glucosuria ocurrs. Glucosuria may also occur at lower plasma glucose concentrations in certain conditions of hyperfiltration (eg, pregnancy), but as a consequence of hyperfiltration rather than significant hyperglycemia.

**Question 2**

**Discuss the process of micturition?**

Micturition or urination is the process of expelling urine from the bladder. This act is also known as voiding of the bladder. The excretory system in humans includes a pair of kidneys, two ureters, a urinary bladder and a urethra. The kidneys filter the urine and it is transported to the urinary bladder via the ureters where it is stored till its expulsion. The process of micturition is regulated by the nervous system and the muscles of the bladder and urethra. The urinary bladder can store around 350-400ml of urine before it expels it out.

Stages of micturition

The urinary bladder has two distinct stages or phases:

* Resting or filling stage: It is in this phase of the bladder that the urine is transported from the kidneys via the ureters into the bladder. The ureters are thin muscular tubes that arise from each of the kidneys and extend downwards where they enter the bladder obliquely. The oblique placement of the ureters in the bladder wall serves a very important function. The opening of the ureter into the urinary bladder is not guarded by any sphincter or muscle. Therefore, this oblique nature of opening prevents the urine from re-entering the ureters. At the same time, the main muscle of the urinary bladder, the detrusor muscle, is relaxing allowing the bladder to distend and accommodate more urine.
* Voiding stage: During this stage, both the urinary bladder and the urethra come into play together. The detrusor muscle of the urinary bladder which was relaxing so far starts to contract once the bladder’s storage capacity is reached. The urethra is controlled by two sets of muscles: The internal and external urethral sphincters. The internal sphincter is a smooth muscle whereas the external one is skeletal. Both these sphincters are in a contracted state during the filling stage.

The opening, described as the neck of the bladder, between the bladder and the urethra, is closed by two rings of muscle - the internal and external sphincters. The internal sphincter contains smooth muscle fibers and the normal muscle tone of these fibers keeps it contracted; it is therefore not under voluntary control. The external sphincter is formed of a circular band of skeletal muscle which is supplied by the pudendal nerve and is under voluntary control. These fibers remain contracted, as a result of central nervous system stimulation, except during micturition when they relax.

When the volume of urine in the bladder reaches about 250ml, stretch receptors in the bladder walls are stimulated and excite sensory parasympathetic fibers which relay information to the sacral area of the spine. This information is integrated in the spine and relayed to two different sets of neurons. Parasympathetic motor neurons are excited and act to contract the detrusor muscles in the bladder so that bladder pressure increases and the internal sphincter opens. At the same time, somatic motor neurons supplying the external sphincter via the pudendal nerve are inhibited, allowing the external sphincter to open and urine to flow out, assisted by gravity.

**Question 3**

**Explain juxtaglomerular apparatus?**

The juxtaglomerular apparatus is a structure in the kidney that regulates the function of each nephron, the functional units of the kidney. The juxtaglomerular apparatus is named because it is next to the glomerulus.

The juxtaglomerular apparatus consists of three types of cells:

* The macula densa, a part of the distal convoluted tubule of the same nephron, At the point where the afferent arterioles enter the glomerulus and the efferent arteriole leaves it, the tubule of the nephron touches the arterioles of the glomerulus from which it rose. At this location, in the wall of the distal convoluted tubule, there is a modified region of tubular epithelium called the macula densa. Cells in the macula densa respond to changes in the sodium chloride levels in the distal tubule of the nephron via the tubuloglomerular feedback (TGF) loop. The macula densa's detection of elevated sodium chloride, which leads to an increase in GFR, is based on the concept of purinergic signaling. An increase in the salt concentration causes several cell signals to eventually cause the adjacent afferent arteriole to constrict. This decreases the amount of blood coming from the afferent arterioles to the glomerular capillaries, and therefore decreases the amount of fluid that goes from the glomerular capillaries into the Bowman's space (the glomerular filtration rate (GFR)). When there is a decrease in the sodium concentration, less sodium is reabsorbed in the macular densa cells. The cells increase the production of nitric oxide and Prostaglandins to vasodilate the afferent arterioles and increase renin release.
* Juxtaglomerular cells, also known as granular cells which secrete renin, these cells are similar to epithelium and are located in the tunica media of the afferent arterioles as they enter the glomeruli. The juxtaglomerular cells secrete renin in response to:
  1. Stimulation of the beta-1 adrenergic receptor
  2. Decrease in renal perfusion pressure (detected directly by the granular cells)
  3. Decrease in NaCl concentration at the macula densa, often due to a decrease in glomerular filtration rate
* Extraglomerular mesangial cells are located in the junction between the afferent and efferent arterioles. These cells have a contractile property similar to vascular smooth muscles and thus play a role in regulating glomerular filter rate by altering the vessel diameter. Renin is also found in these cells

**Question 4**

**Discuss the role of kidney in regulation of blood pressure?**

The kidneys play a central role in the regulation of arterial blood pressure. Renal artery perfusion pressure directly regulates sodium excretion; a process known as pressure natriuresis, and influences the activity of various vasoactive systems such as the renin–angiotensin–aldosterone (RAS) system . Along with vessel morphology, blood viscosity is one of the key factors influencing resistance and hence blood pressure. A key modulator of blood viscosity is the renin-angiotensin system (RAS) or the renin-angiotensin-aldosterone system (RAAS), a hormone system that regulates blood pressure and water balance.

The blood pressure in the body depends upon:

* The force by which the heart pumps out blood from the ventricles of the heart - and this is dependent on how much the heart muscle gets stretched by the inflowing blood into the ventricles.
* The degree to which the arteries and arterioles constrict-- increases the resistance to blood flow, thus requiring a higher blood pressure.
* The volume of blood circulating round the body; if the volume is high, the ventricles get more filled, and the heart muscle gets more stretched.

The kidney influences blood pressure by:

* Causing the arteries and veins to constrict
* Increasing the circulating blood volume

Specialized cells called macula densa are located in a portion of the distal tubule located near and in the wall of the afferent arteriole. These cells sense the sodium in the filtrate, while the arterial cells (juxtaglomerular cells) sense the blood pressure. When the blood pressure drops, the amount of filtered sodium also drops. The arterial cells sense the drop in blood pressure, and the decrease in sodium concentration is relayed to them by the macula densa cells. The juxtaglomerular cells then release an enzyme called renin.

Renin converts angiotensinogen (a peptide, or amino acid derivative) into angiotensin-1. Angiotensin-1 is thereafter converted to angiotensin-2 by an angiotensin-converting enzyme (ACE), found in the lungs. Angiotensin-2 causes blood vessels to contract, the increased blood vessel constrictions elevate the blood pressure. When the volume of blood is low, arterial cells in the kidneys secrete renin directly into circulation. Plasma renin then carries out the conversion of angiotensinogen released by the liver to angiotensin-1. Angiotensin-1 is subsequently converted to angiotensin-2 by the enzyme angiotensin converting enzyme found in the lungs. Angiotensin-2 is a potent vasoactive peptide causes blood vessels to constrict, resulting in increased blood pressure. Angiotensin-2 also stimulates the secretion of the hormone aldosterone from the adrenal cortex.

Aldosterone causes the tubules of the kidneys to increase the reabsorption of sodium and water into the blood. This increases the volume of fluid in the body, which also increases blood pressure. If the renin-angiotensin-aldosterone system is too active, blood pressure will be too high. Many drugs interrupt different steps in this system to lower blood pressure. These drugs are one of the main ways to control high blood pressure (hypertension), heart failure, kidney failure, and harmful effects of diabetes. It is believed that angiotensin-1 may have some minor activity, but angiotensin-2 is the major bioactive product. Angiotensin-2 has a variety of effects on the body: throughout the body, it is a potent vasoconstrictor of arterioles.

**Question 5**

**Discuss the role of Kidney in Calcium homeostasis?**

Calcium is both filtered and reabsorbed in the kidneys but not secreted. Only about 60 percent of the plasma calcium is ionized, with 40 percent being bound to the plasma proteins and 10 percent complexed with anions such as phosphate. Therefore, only about 60 percent of the plasma calcium can be filtered at the glomerulus. Normally, about 99 percent of the filtered calcium is reabsorbed by the tubules, with only about 1 percent of the filtered calcium being excreted. About 65 percent of the filtered calcium is reabsorbed in the proximal tubule, 25 to 30 percent is reabsorbed in the loop of Henle, and 4 to 9 percent is reabsorbed in the distal and collecting tubules. This pattern of reabsorption is similar to that for sodium. As is true with the other ions, calcium excretion is adjusted to meet the body’s needs. With an increase in calcium intake, there is also increased renal calcium excretion, although much of the increase of calcium intake is eliminated in the feces. With calcium depletion, calcium excretion by the kidneys decreases as a result of enhanced tubular reabsorption.

Most of the calcium reabsorption in the proximal tubule occurs through the paracellular pathway; it is dissolved in water and carried with the reabsorbed fluid as it flows between the cells. Only about 20% of proximal tubular calcium reabsorption occurs through the transcellular pathway in two steps:

* Calcium diffuses from the tubular lumen into the cell down an electrochemical gradient due to the much higher concentration of calcium in the tubular lumen, compared with the epithelial cell cytoplasm, and because the cell interior has a negative charge relative to the tubular lumen.
* Calcium exits the cell across the basolateral membrane by a calcium-ATPase pump and by sodium-calcium counter-transporter

In the loop of Henle, calcium reabsorption is restricted to the thick ascending limb. Approximately 50% of calcium reabsorption in the thick ascending limb occurs through the paracellular route by passive diffusion due to the slight positive charge of the tubular lumen relative to the interstitial fluid. The remaining 50% of calcium reabsorption in the thick ascending limb occurs through the transcellular pathway, a process that is stimulated by PTH.

In the distal tubule, calcium reabsorption occurs almost entirely by active transport through the cell membrane. The mechanism for this active transport is similar to that in the proximal tubule and thick ascending limb and involves diffusion across the luminal membrane through calcium channels and exit across the basolateral membrane by a calcium-ATPase pump, as well as a sodium-calcium counter-transport mechanism. In this segment, as well as in the loops of Henle, PTH stimulates calcium reabsorption. Vitamin D (calcitriol) and calcitonin also stimulate calcium reabsorption in the thick ascending limb of Henle’s loop and in the distal tubule, although these hormones are not as important quantitatively as PTH in reducing renal calcium excretion.