Acid-Base Homeostasis

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Abstract

Acid-base homeostasis and pH regulation are critical for both normal physiology and cell metabolism and function. The importance of this regulation is evidenced by a variety of physiologic derangements that occur when plasma pH is either high or low. The kidneys have the predominant role in regulating the systemic bicarbonate concentration and hence, the metabolic component of acid-base balance. This function of the kidneys has two components: reabsorption of virtually all of the filtered HCO$_3^-$ and production of new bicarbonate to replace that consumed by normal or pathologic acids. This production or generation of new HCO$_3^-$ is done by net acid excretion. Under normal conditions, approximately one-third to one-half of net acid excretion by the kidneys is in the form of titratable acid. The other one-half to two-thirds is the excretion of ammonium. The capacity to excrete ammonium under conditions of acid loads is quantitatively much greater than the capacity to increase titratable acid. Multiple, often redundant pathways and processes exist to regulate these renal functions. Derangements in acid-base homeostasis, however, are common in clinical medicine and can often be related to the systems involved in acid-base transport in the kidneys.


Acid-base homeostasis and pH regulation are critical for both normal physiology and cell metabolism and function. Normally, systemic acid-base balance is well regulated with arterial pH between 7.36 and 7.44; intracellular pH is usually approximately 7.2. For instance, chronic metabolic acidosis can be associated with decreased bone density, nephrolithiasis, muscle wasting, and progression of CKD (1–3). On a cellular level, many essential cellular processes, metabolic enzymes, and transmembrane transport processes are highly pH sensitive. Although this review will address systemic pH regulation and the role of the kidneys, individual cells also have a variety of mechanisms to regulate their intracellular pH (4). Overall concepts will be emphasized rather than specific pathways or processes, which are well covered elsewhere; references are selective.

Basic Concepts

Intracellular and extracellular buffers are the most immediate mechanism of defense against changes in systemic pH. Bone and proteins constitute a substantial proportion of these buffers. However, the most important buffer system is the HCO$_3^-$ /CO$_2$ buffer system. The Henderson–Hasselbach equation (Equation 1) describes the relationship of pH, bicarbonate (HCO$_3^-$), and P$_{CO2}$:

$$\text{pH} = 6.1 + \log \frac{\text{HCO}_3^-}{0.03 \times \text{P}_{CO2}}$$

where HCO$_3^-$ is in milliequivalents per liter and P$_{CO2}$ is in millimeters of mercury. Equation 2 represents the reaction (water [H$_2$O]):

$$\text{CO}_2 + \text{H}_2\text{O} \leftrightarrow \text{H}_2\text{CO}_3 \leftrightarrow \text{H}^+ + \text{HCO}_3^-$$

This buffer system is physiologically most important because of its quantitative capacity to buffer acid or alkali loads and because of the capacity for independent regulation of HCO$_3^-$ and P$_{CO2}$ by the kidneys and lungs, respectively. In fact, this latter aspect of independent regulation is the most powerful aspect of this system. Although the lungs and kidneys can compensate for disorders of the other, normal homeostasis requires that both CO$_2$ and HCO$_3^-$ be normal. Disorders of CO$_2$ are usually referred to as respiratory disorders, and disorders of HCO$_3^-$ or fixed acids are referred to as metabolic disorders.

Arterial CO$_2$ is predominantly regulated by alveolar ventilation after production in peripheral tissues; CO$_2$ is often referred to as a gaseous acid, because its addition to aqueous solutions produces carbonic acid, which then releases H$^+$ and HCO$_3^-$ (Equation 2 driven to the right). Plasma HCO$_3^-$ is predominantly regulated by renal acid-base handling, and it will be discussed extensively below. The kidneys reabsorb, produce, and in some circumstances, excrete HCO$_3^-$. Plasma HCO$_3^-$ is normally consumed daily by dietary acids and metabolic acids. As expressed by Equation 1, raising HCO$_3^-$ or lowering P$_{CO2}$ will raise systemic pH, and lowering HCO$_3^-$ or raising P$_{CO2}$ will lower pH.

In physiologic systems, the addition of an acid and the loss of alkali are essentially equivalent; for instance, as obvious in Equation 2, loss of HCO$_3^-$ will pull the equation to the right, producing more H$^+$. A frequent example of this is the loss of HCO$_3^-$ with diarrhea or proximal renal tubular acidosis. Conversely, the physiologic addition of alkali and the loss of acid are
essentially equivalent. Therefore, the excretion of acid by the kidneys is equivalent to the production of base or HCO$_3^-$; this point becomes important in considering below how the kidneys produce more HCO$_3^-$.

Typical high-animal protein Western diets and endogenous metabolism produce acid, typically on the order of 1 mEq/kg body wt per day or approximately 70 mEq/d for a 70-kg person. Phosphoric acid and sulfuric acid are significant products of this normal metabolism of dietary nutrients, such as proteins and phospholipids. To maintain acid-base homeostasis, these nonvolatile acids must be excreted by the kidney. Other nonvolatile acids, such as ketoacids and lactic acids, are produced in pathologic conditions. Nonvolatile acid loads (or loss of HCO$_3^-$, which is an equivalent process) in excess of the excretory capacity of the kidneys cause metabolic acidosis. Of note, vegetarian diets with high fruit and vegetable content are not acid producing and may produce a net alkali load (5); this may be an important consideration in the progression or treatment of CKD (6). Although the kidneys normally control plasma HCO$_3^-$, a few other factors have been considered. Endogenous acid production may be regulated, at least under certain circumstances (7); for instance, lactic acid and ketoacid production are decreased by a low pH. Also, hepatic production of HCO$_3^-$ in the metabolism of proteins and amino acids is altered by systemic acid-base balance. Therefore, a role for hepatic contribution to the control of plasma HCO$_3^-$ has been hypothesized (8).

**Respiratory Control of P$_{CO_2}$**

Alveolar ventilation normally eliminates approximately 15 mol CO$_2$ per day produced from normal cellular oxidative metabolism and maintains arterial P$_{CO_2}$ around 40 mmHg. Normally, with increases (or decreases) in CO$_2$ production, alveolar ventilation increases (or decreases) to maintain P$_{CO_2}$ and keep pH constant. Alveolar ventilation is controlled by chemoreceptor cells located in the medulla oblongata (and to a lesser extent, those in the carotid bodies), which are sensitive to pH and P$_{CO_2}$ (4). Chemoreceptors respond to a decrease in cerebral interstitial pH by increasing ventilation and hence, lowering P$_{CO_2}$. Therefore, small increases in plasma CO$_2$, which decrease pH, will result in stimulation of ventilation, which will normally rapidly return P$_{CO_2}$ toward normal. Metabolic acidosis and the resulting acidemia will also result in an increase in ventilation (and lowering of P$_{CO_2}$) in response to decreases in cerebral interstitial pH. However, in contrast to the rapid response to changes in CO$_2$, the response to nonvolatile acids or a change in plasma HCO$_3^-$ is slower, because the central chemoreceptors are relatively insulated by the blood-brain barrier. Hence, acute changes in plasma HCO$_3^-$ have a slower effect on cerebral interstitial pH and hence, stimulation of central chemoreceptors. This likely accounts for the 12- to 24-hour delay in the maximal ventilatory response to metabolic acid-base disturbances. The maximal ventilatory response cannot usually reduce P$_{CO_2}$ <10–12 mmHg (9–12). Decreases in ventilation may be limited because of a variety of clinical circumstances, such as lung disease, fluid overload, and central nervous system derangements. Also, decreases in P$_{O_2}$ may limit the extent to which decreased ventilation can raise P$_{CO_2}$.

**Renal Control of Plasma HCO$_3^-$**

The kidneys have the predominant role of regulating the systemic HCO$_3^-$ concentration and hence, the metabolic component of acid-base balance. This function of the kidneys has two components: reabsorption of virtually all of the filtered HCO$_3^-$ and production of new HCO$_3^-$ to replace that consumed by normal or pathologic acids. This production or generation of new HCO$_3^-$ is done by net acid excretion. In other words, the kidneys make new HCO$_3^-$ by excreting acid. Because HCO$_3^-$ is freely filtered at the glomerulus, approximately 4.5 mol HCO$_3^-$ is normally filtered per day (HCO$_3^-$ concentration of 25 mM/L × GFR of 0.120 L/min × 1440 min/d). Virtually all of this filtered HCO$_3^-$ is reabsorbed, with the urine normally essentially free of HCO$_3^-$ Seventy to eighty percent of this filtered HCO$_3^-$ is reabsorbed in the proximal tubule; the rest is reabsorbed along more distal segments of the nephron (Figure 1).

In additional to reabsorption of filtered HCO$_3^-$, the kidneys also produce additional HCO$_3^-$ beyond that which has been filtered at the glomerulus. This process occurs by the excretion of acid into urine. (As indicated above, the excretion of acid is equivalent to the production of alkali.) The net acid excretion of the kidneys is quantitatively equivalent to the amount of HCO$_3^-$ generation by the kidneys. Generation of new HCO$_3^-$ by the kidneys is usually approximately 1 mEq/kg body wt per day (or about 70 mEq/d) and replaces that HCO$_3^-$ that has been consumed by usual endogenous acid production (also about 70 mEq/d) as discussed above. During additional acid loads and in certain pathologic conditions, the kidneys increase the amount of acid excretion and the resulting new HCO$_3^-$ generation. Net acid excretion by the kidneys occurs by two processes: the excretion of titratable acid and the excretion of ammonium (NH$_4^+$). Titratable acid refers to the excretion of protons with urinary buffers. The capacity of the nephron to excrete acid as free protons is limited as illustrated by the fact that the concentration of protons (H$^+$), even at a urine pH 4.5, is <0.1 mEq. However, the availability of urine

![Figure 1. Relative HCO$_3^-$ transport along the nephron. Most of the filtered HCO$_3^-$ is reabsorbed in the proximal tubule. Virtually no HCO$_3^-$ remains in the final urine. CCD, cortical collecting duct; DT, distal convoluted tubule; IMCD, inner medullary collecting duct; TAL, thick ascending limb.](image-url)
buffers (chiefly phosphate) results in the excretion of acid coupled to these urine buffers (13). Under normal conditions, approximately one-third to one-half of net acid excretion by the kidneys is in the form of titratable acid. The other one-half to two-thirds is the excretion of NH₄⁺. The mechanism whereby the excretion of NH₄⁺ results in net acid excretion will be discussed below. The capacity to excrete NH₄⁺ under conditions of acid loads is quantitatively much greater than the capacity to increase titratable acid (Figure 2) (14,15). Net acid excretion in the urine is, therefore, calculated as

\[
\text{net acid excretion} = \text{titratable acid} + \text{ammonium} - \text{urinary HCO}_3^- \quad (3)
\]

Loss of alkali in the urine in the form of HCO₃⁻ decreases the amount of net acid excretion or new HCO₃⁻ generation. Loss of organic anions, such as citrate, in the urine represents the loss of potential alkali or HCO₃⁻. However, in humans, the loss of these organic anions is not usually quantitatively significant in whole-body acid-base balance (15).

**Proximal Tubule HCO₃⁻ Reabsorption**

The proximal tubule reabsorbs at least 70%–80% of the approximately 4500 mEq/d filtered HCO₃⁻. The proximal tubule, therefore, has a high capacity for HCO₃⁻ reabsorption. The mechanisms of this reabsorption are illustrated in Figure 3. Most (probably >70%) of this HCO₃⁻ reabsorption occurs by proton secretion at the apical membrane by sodium-hydrogen exchanger NHE3 (16) (Figure 3). This protein exchanges one Na⁺ ion for one H⁺ ion, driven by the lumen to cell Na⁺ gradient (approximately 140 mEq/L in the lumen and 15–20 mEq/L in the cell). The low intracellular Na⁺ is maintained by the basolateral Na⁺/K⁺-ATPase. An apical H⁺-ATPase and possibly, NHE8 under some circumstances account for the remaining portion of proximal tubule H⁺ secretion and HCO₃⁻ reabsorption (17–19). This H⁺-ATPase shares most subunits with the distal tubule H⁺-ATPase described below.

In the lumen of the proximal tubule, the secreted H⁺ reacts with luminal HCO₃⁻ to generate CO₂ and H₂O, which for the purposes here, can be considered to be freely permeable across the proximal tubule and reabsorbed. This reaction in the lumen (Equation 2 going from right to left) is relatively slow unless catalyzed, which occurs normally, by carbonic anhydrase (CA; in this case, membrane-bound CAIV tethered in the lumen). There are multiple isoforms of CA, but membrane-bound CAIV and cytosolic CAII are most important in renal acid-base transport (20,21). Mutations in CAII are known to cause a form of mixed proximal and distal renal tubular acidosis with osteopetrosis (22).

The source of the H⁺ in the cells is the generation of H⁺ and HCO₃⁻ from CO₂ and H₂O (Equation 2) catalyzed in the cell by intracellular CA, predominantly cytosolic CAI. The HCO₃⁻ generated within the proximal tubule cell by apical H⁺ secretion exits across the basolateral membrane. Most of this HCO₃⁻ exit occurs by sodium HCO₃⁻ co-transport, NBCe1-A, or SLC4A4 (23). The stoichiometry and transported ionic species have been active areas of investigation, but studies suggest that 3 HCO₃⁻ Eq or 1 HCO₃⁻ Eq and 1 CO₂⁻ Eq are transported with each Na⁺; this electrogenic stoichiometry results in Na⁺ and HCO₃⁻ being driven out of the cell by the cell-negative membrane voltage. Mutations in this (NBC-e1) protein cause proximal renal tubular acidosis (24). Chloride-bicarbonate exchange may also be present on the basolateral membrane of the proximal tubule but is not the main mechanism of HCO₃⁻ reabsorption.

The proximal tubule is a leaky epithelium on the basis of its particular tight junction proteins and therefore, unable to generate large transepithelial solute or electrical gradients; the minimal luminal pH and HCO₃⁻ obtained at the end of the proximal tubule are approximately pH 6.5–6.8 and 5 mM, respectively. The inability of the proximal tubule to lower pH further may also result from the
dependence on the Na⁺ gradient (140:15–20) driving the H⁺ (pH) gradient. In the late proximal tubule, ongoing reabsorption of the low concentrations of luminal HCO₃⁻ may be countered and balanced by passive backleak of plasma or peritubular HCO₃⁻ into the lumen; however, continued Na⁺/H⁺ exchange activity will result in continued Na⁺ reabsorption.

**Regulation of HCO₃⁻ Reabsorption in the Proximal Tubule**

A number of processes regulate proximal tubule HCO₃⁻ reabsorption both acutely and chronically. Many of these regulatory processes function to maintain acid-base homeostasis and are seemingly quite redundant; this is true in both the proximal and distal nephron segments. However, other processes overlap with volume or sodium regulatory processes, and the acid-base effects seem secondary and at times, dysfunctional for pH per se; for instance, during metabolic alkalosis induced by vomiting and volume depletion, various hormones are activated (catecholamines, angiotensin II, and aldosterone) that restore volume status but secondarily maintain high plasma HCO₃⁻ and alkalemia.

To maintain or restore acid-base balance, the proximal tubule increases HCO₃⁻ reabsorption during acidemia or acid loads and decreases HCO₃⁻ reabsorption during alkalemia or alkali loads (such that HCO₃⁻ might be excreted into the urine). Because this has been recently reviewed in this series (18), only a few comments will be made. The signals for these changes are often thought to be pH per se, either intracellular or extracellular. A variety of pH sensors have also been proposed (25), most notably including nonreceptor tyrosine kinase Pyk2, endothelin B receptor (activated by endogenous renal endothelin) (26,27), and CO₂ activation of ErbB1/2, ERK, and the apical angiotensin I receptor (28). More directly, decreased intracellular pH will increase the availability of protons for H⁺ secretion and also, allosterically enhance the Na⁺/H⁺ exchanger (29). In addition to allosteric modulation of acid-base transporters, acute acidosis will cause insertion of additional transport proteins into the apical membrane, probably through the mechanisms immediately above; this has been best studied for NHE3. Chronic acidosis induces the production of additional transport proteins by increased transcription and production of mRNA; this is achieved through a variety of signal transduction processes that are still being actively investigated. Both apical transport proteins (e.g., NHE3) and basolateral transporters (e.g., NBCe1-A) are often activated and increased in abundance in parallel, although the specificity may vary (30). Chronic potassium depletion also increases H⁺ secretion, probably in response to changes in intracellular pH (31). In fact, hypokalemia has many effects on the kidney that parallel chronic acidosis, including effects on NH₄⁺ excretion discussed below.

Extracellular fluid volume status is also an important determinant of proximal HCO₃⁻ reabsorption. Decreasing extracellular causes increased reabsorption of not only sodium but also, HCO₃⁻, both in large part through increased Na-H exchange. Increases in volume status inhibit reabsorption of sodium and HCO₃⁻, other factors being unchanged. As mentioned above and discussed more below, clinically, this relates to the association of metabolic alkalosis with both volume contraction and edematous states (because these have decreased effective arterial volume). Volume expansion can be associated with decreased plasma HCO₃⁻ and metabolic acidosis, usually mild. An important additional component of the change in net HCO₃⁻ reabsorption with volume overload is an increased backleak of HCO₃⁻ into the tubule lumen. In contrast to the effects of volume, increasing delivery of HCO₃⁻ to the proximal tubule with constant extracellular volume results in a proportional increase in HCO₃⁻ reabsorption; this can be conceptualized as an increase in delivery to a reabsorptive system that is not saturated (i.e., below the transport Kₘ, the Michaelis–Menten constant [the substrate concentration that gives half-maximal velocity of an enzymatic reaction and also, is used to model transport kinetics]).

A variety of hormones, some as above, affect proximal HCO₃⁻ reabsorption (32,33). Some of these hormones act on a short-term basis (response in minutes to hours), and others act over longer periods (days). On an acute basis, for instance, adrenergic agonists and angiotensin II stimulate HCO₃⁻ reabsorption (32). Parathyroid hormone acting through cAMP inhibits but hypercalcemia stimulates proximal HCO₃⁻ reabsorption. With these hormones and others, many studies have addressed the specific processes and signal transduction events (32). With chronic acid loads or acidosis, intrarenal endothelin-1 acting through the endothelin B receptor has been identified as a crucial element in the upregulation of Na⁺/H⁺ exchange (26,27). Glucocorticoids are also important in the development of proximal HCO₃⁻ transport and may be important in the chronic response to acidosis (34). In clinical circumstances, various regulatory factors may interact and be simultaneously operative. The net effect of these combined influences would vary depending on the exact circumstance. For instance, in metabolic alkalosis, volume contraction (and the associated hormonal changes and frequent fall in GFR) and high filtered loads of HCO₃⁻ increase proximal tubule HCO₃⁻ reabsorption, whereas increases in peritubular HCO₃⁻ and increased intracellular pH may be inhibiting HCO₃⁻ reabsorption—the net effect is maintenance of metabolic alkalosis until the volume status is corrected.

Despite the regulation mentioned above, changes in proximal HCO₃⁻ reabsorption may not be directly reflected in changes in whole–kidney net acid excretion or urinary HCO₃⁻ excretion, because additional HCO₃⁻ reabsorption and acid secretion occur in the distal nephron. Also, because virtually all of filtered HCO₃⁻ is normally reabsorbed by the kidneys, increases in HCO₃⁻ reabsorption per se cannot compensate for increased systemic acid loads. This compensation can only occur with increased acid excretion as titratable acids or NH₄⁺.

**Distal Tubule Acidification**

Several segments after the proximal tubule contribute substantially to acid-base homeostasis. First, the thick ascending limb (TAL) reabsorbs a significant amount of HCO₃⁻, approximately 15% of the filtered load, predominantly through an apical Na⁺/H⁺ exchanger (35). TAL acid-base transport is regulated by a variety of factors
(e.g., Toll-like receptors, dietary salt, aldosterone, angiotensin II, etc. [36–38]), but the integrated role of the thick limb acid-base transport in various acid-base disorders has not been well clarified.

Beyond the TAL, the distal tubule compared with the proximal tubule has a limited capacity to secrete H⁺ and thereby, reabsorb HCO₃⁻. During inhibition of proximal tubule HCO₃⁻ reabsorption, increased distal delivery of HCO₃⁻ can overwhelm this limited reabsorptive capacity. However, the collecting tubule is able to generate a large transepithelial pH gradient (urine pH < 5 with blood pH approximately 7.4). This large pH gradient is achievable because of the primary active pumps responsible for distal nephron H⁺ secretion (discussed below) and because of the relative impermeability of the distal tubule to ions (i.e., a tight epithelial membrane). The large pH gradient ensures the generation of titratable acid and the entrapment of NH₄⁺. The limitation in HCO₃⁻ reabsorption is likely, in part, caused by the absence of luminal CA discussed below, but there may be other factors as well, such as a limited number of H⁺ pumps.

The distal tubule beyond the TAL consists of several distinct morphologic and functional segments, including the distal convoluted tubule, the connecting segment, and several distinct collecting duct segments, each with several cell types. Although several of these cell types can secrete H⁺, the CA-containing (and mitochondrial–rich) intercalated cells (ICs) are chiefly responsible for acid-base transport. There are at least three types of ICs: type A or α ICs, which secrete H⁺; type B or β ICs, which secrete HCO₃⁻; and non–A, non–B ICs, with a range of function that remains under investigation. These have been recently reviewed in this series (39) (Figure 4).

Conceptually, H⁺ secretion in the type A ICs will result in HCO₃⁻ reabsorption in the presence of luminal HCO₃⁻ but will acidify the urine and generate new HCO₃⁻ in the absence of luminal HCO₃⁻ (i.e., if virtually all of the filtered HCO₃⁻ has been reabsorbed upstream). The mechanism of this H⁺ secretion involves primarily an apical H⁺-ATPase as illustrated in Figure 4. The apical H⁺-ATPase is an electrogenic active pump (vacular ATPase) able to secrete H⁺ down to a urine pH of approximately 4.5. This is a multisubunit ATPase resembling that in intracellular organelles. The subunits are in two domains: a V₀ transmembrane domain and a V₁ cytosolic domain. Mutations in certain subunits are a known cause of distal renal tubular acidosis (40). Regulation of this pump is primarily by recycling between subapical vesicles and the plasma membrane involving the actin cytoskeleton and microtubules (41). Regulation may also be accomplished, in certain situations by assembly or disassembly of the two domains and phosphorylation of subunits. H⁺ secretion also occurs through another set of pump(s): apical H⁺/K⁺-ATPases. H⁺/K⁺-ATPases in the collecting duct include both the gastric form of H⁺/K⁺-ATPase and the colonic form of H⁺/K⁺-ATPase (42). On the basis of inhibitor studies, there may also be a third type of H⁺/K⁺-ATPase in the collecting duct (43,44). These transporters likely contribute to urine acidification under normal conditions but particularly during states of potassium depletion (42,44).

Conceptually, HCO₃⁻ reabsorption (or new HCO₃⁻ generation) as in the proximal tubule is a two-part process: secretion of H⁺ into the lumen and HCO₃⁻ exit from the cell across the basolateral membrane. Therefore, to complete the process of HCO₃⁻ reabsorption or new HCO₃⁻ generation, HCO₃⁻ produced in the cell from CO₂ and H₂O exits across the basolateral membrane (Equation 2 as in the proximal tubule, with H⁺ being secreted across the apical membrane). In other words, the HCO₃⁻ generated intracellularly by any of these pumps exits the basolateral membrane. This exit into the blood occurs through a chloride-bicarbonate exchanger, a truncated version of the anion exchanger 1 (AE1; band 3 protein), which is the Cl⁻/HCO₃⁻ exchanger in red blood cells that facilitates CO₂ transport (45). This is an electroneutral exchanger driven by the ion concentrations of chloride and HCO₃⁻. Mutations in AE1 may also cause distal renal tubular acidosis (40,46). Two other transporters SLC26a7 (a Cl⁻/HCO₃⁻ exchanger) and KCC4 (a KCl cotransporter) are also in the basolateral membrane of some acid secreting cells in the collecting duct and likely contribute to urine acidification in certain conditions (47–49).

In the cortical collecting duct, in addition to HCO₃⁻ reabsorption by type A ICs, simultaneous HCO₃⁻ secretion occurs in separate cells, the type B ICs (39,50). This process involves an apical chloride-bicarbonate exchanger and a basolateral H⁺-ATPase (51). In animal studies, HCO₃⁻ secretion is stimulated by alkali loading and inhibited by low luminal chloride. The basolateral H⁺-ATPase is the same pump as in the apical membrane of type A IC, but the apical Cl⁻/HCO₃⁻ exchanger has been identified as pendrin, a protein first identified as being abnormal in

![Figure 4. Schematic of H⁺ and HCO₃⁻ transport in the types A and B intercalated cells (ICs) in the collecting tubule (details are in the text). AE, anion exchanger.](image-url)
some patients with hereditary deafness (39,52,53). The importance of HCO₃⁻ secretion in human pathophysiologic circumstances is not well characterized but may be important in the maintenance and/or repair of metabolic alkalosis.

The type B ICs, non-A, non-B ICs, and pendrin have now also been implicated in NaCl transport/balance and hypertension (53). This involves transport of Cl⁻ and HCO₃⁻ on pendrin and also, a sodium–driven chloride/HCO₃⁻ exchanger (NDCBE or SLC4A8). Cl⁻ exits the cell on AE4 (54–57).

Cytoplasmic CA, CAII, is present in all ICs of the collecting tubule, and it facilitates provision of H⁺ to be secreted into the lumen and HCO₃⁻ to be released into the basolateral aspect and blood. However, several segments of the distal nephron do not have luminal CA (i.e., CAIV). The implications of this are that, as H⁺ is secreted into the lumen, luminal pH may be below equilibrium pH, with pH, CO₂, and HCO₃⁻ only coming to equilibrium later downstream in the final urine. Final urine P₇CO₂ may, therefore, rise above blood P₇CO₂ (as H⁺ and HCO₃⁻ react and come to equilibrium with CO₂) and be an index of distal nephron H⁺ secretion.

**Regulation of Acid-Base Transporters in the Distal Nephron**

Regulation of distal nephron acid-base transport is crucial, because this is the final site of control of urine composition. The distal tubule responds to systemic acidosis in a teleologically appropriate direction of increased H⁺ secretion and new HCO₃⁻ generation. As in the proximal tubule, changes in intracellular pH and plasma P₇CO₂ affect proton secretion in the distal nephron. A significant portion of this increased H⁺ secretion is through insertion of additional H⁺-ATPase by fusion of subapical vesicles (containing H⁺-ATPase) with the plasma membrane. These processes are mediated, in part, by a variety of signal transduction systems (cAMP, cGMP, and PLC/protein kinase C) (39,41). A role for soluble adenyl cyclase, G protein–coupled receptor 4, and other mechanisms in sensing pH changes or acid-base loads has also been proposed in type A ICs and previously discussed in this series (39,41).

Although the response to acidosis begins with these fairly rapid changes, chronic acidosis leads to a variety of changes in mRNA and protein levels of various transporters. Potassium depletion also increases H⁺ secretion in the distal tubule, similar to changes in the proximal tubule.

The electrogenic nature of the apical H⁺-ATPase makes this process sensitive to transepithelial voltage. Therefore, an increased lumen–negative voltage (e.g., more Na⁺ reabsorption) will increase H⁺ secretion. Increased Na⁺ reabsorption, such as with increased mineralocorticoids, will, therefore, be accompanied by increased H⁺ secretion. Interestingly, the cell voltages of ICs are strikingly different from most cells, including principal cells: first, although there is little data, the cell-negative voltages as shown in Figure 4 are much less (less negative), and second, the cells are energized by the H⁺ pump rather than by Na-K-ATPase as in most cells (54,57,58). H⁺ secretion, including in the medullary collecting tubule, is also directly stimulated by mineralocorticoids, not just by secondary electrical effects (59,60). Distal tubule acidification may be strongly influenced by chloride concentration gradients between tubular lumen and peritubular blood; this may result both from voltage changes and by direct lumen to cell concentration gradients driving pendrin and other transporters.

In addition to aldosterone, other hormones and receptors, including angiotensin II and the calcium-sensing receptor, stimulate distal acidification (61). An important role for intrarenal endothelin has also been found (27,62,63).

Remodeling of IC morphology, number (relative numbers of A, B, and non--A, non-B ICs), and distribution of various transporters has also been characterized (64,65). The matrix protein hensin is a key mediator of this remodeling.

**Ammonia Excretion**

NH₄⁺ excretion represents the other major mechanism whereby the kidneys excrete acid (66). Of the net acid excreted (or new HCO₃⁻ generated) by the kidneys, approximately one-half to two-thirds (approximately 40–50 mmol/d) is because of NH₄⁺ excretion in the urine. Additionally, during acid loading or acidosis, NH₄⁺ excretion can increase several fold, in contrast to a more limited increase in titratable acidity (15) (Figure 2).

Traditionally, NH₄⁺ excretion was viewed as the excretion of protons in conjunction with a buffer (ammonia [NH₃]):

\[ H^+ + NH_3 \leftrightarrow NH_4^+ \]  (4)

However, NH₃/NH₄⁺ is not an effective physiologic buffer, because its pKa is too high (approximately 9.2), and most of total ammonia (>98%) at physiologic pH is NH₄⁺ on the basis of the pKa. Furthermore, NH₄⁺, not NH₃, is produced within the kidneys. However, total ammonia excretion in the urine does represent acid excretion (or the production of new HCO₃⁻) when considered in conjunction with the metabolism of the deaminated carbon skeleton of glutamine. Glutamine is the predominant precursor of NH₃ in the kidney (Figure 5). Conceptually, the metabolism of the carbon skeleton of glutamine can result in the formation of one HCO₃⁻ for every NH₄⁺ excreted. Other amino acids can also be used to some extent. The predominant enzymatic pathway for NH₃ formation is mitochondrial phosphate–dependent glutaminase in the proximal tubule, which produces one NH₄⁺ and glutamate. Glutamate dehydrogenase can then convert glutamate into α-ketoglutarate and a second NH₄⁺. The α-ketoglutarate produced can be converted to glucose or completely metabolized to HCO₃⁻. Other pathways for NH₃ production also exist but are thought to be less important. Other nephron segments other than the proximal tubule can produce NH₃ but not to the same extent, and the other segments do not have the same significant adaptive increase in ammoniagenesis with sustained acidosis as the proximal tubule. A variety of conditions affect the renal production of NH₃, but the most important is that of acid-base status. Chronic metabolic acidosis can increase NH₃ production several fold in the kidneys. Potassium balance also alters NH₃ production, such that hyperkalemia suppresses NH₃ formation (and transport in both the proximal tubule and thick limb), and hypokalemia increases NH₃ production by the kidneys. Each of these changes has clinical correlates in overall acid-base balance. A variety
Figure 5. Schematic of ammonia (NH₃) production in the proximal tubule. A proximal tubule cell is enlarged to show that glutamine (Gln) is metabolized to ammonium (NH₄⁺) by phosphate-dependent glutaminase (PDG); through a series of steps, the carbon skeleton of glutamine can be metabolized to HCO₃⁻. NH₃ can enter the proximal tubule lumen by either NH₃ diffusion or NH₄⁺ movement on the Na⁺-H⁺ exchanger. AA⁰, neutral amino acids; B*AT1, B-type neutral amino acids transporter; GDH, glutamate dehydrogenase; αKG, alfa keto-glutarate; LAT2, L-type amino acids transporter-2; OAA, oxalo-acetate; PEP, phospho enol-pyruvate; PEPCK, phospho enol-pyruvate carboxy kinase; TCA, XXX.

Figure 6. Ammonium (NH₄⁺) transport along the nephron. In the thick ascending limb, NH₄⁺ is reabsorbed by the Na⁺-K⁺-2Cl⁻ transporter. In the collecting duct, Rh proteins mediate ammonia (NH₃)/NH₄⁺ transport. The numbers depict the percentages of urinary total NH₃ at each site. Total NH₃ is concentrated in the medulla (details are in the text). Gln, glutamine; PDG, phosphate-dependent glutaminase.
of hormones (angiotensin II, prostaglandins, etc.) have also been shown to alter \( \text{NH}_3 \) production. The enzymatic and transporter changes that facilitate enhanced ammoniagenesis during acidosis have recently been reviewed in this series (18).

The transport of the produced \( \text{NH}_4^+ \) along the nephron and into the urine is a complex process that is still a topic of intense study (Figure 6). Most of the \( \text{NH}_4^+ \) produced is excreted into the urine rather than added to the venous blood; this is particularly true with acidosis—the proportions into urine and blood are almost even in normal conditions (13,67). Therefore, during acidosis, both total \( \text{NH}_3 \) secretion into urine and blood are almost even in normal circumstances, with \( \text{NH}_3 \) and \( \text{NH}_4^+ \) transport across the apical membrane predominantly on the basolateral membrane of type A ICs and can transport \( \text{NH}_3 \) and \( \text{NH}_4^+ \) into the cell, whereas RhCG, present at the apical membrane of several cell types (and in some circumstances, basolateral membrane), transports \( \text{NH}_3 \) into the lumen. Luminal \( \text{NH}_3 \) is then titrated by secreted \( \text{H}^+ \) to \( \text{NH}_4^+ \) as described above.

**Acid and Alkali Loads**

With this background, what are the pathologic challenges to normal acid-base homeostasis? Table 1 provides a basic conceptual classification of pathophysiologic types of acid and alkali loads. This differs from the usual classifications of acid-base disorders per se, which focus only on clinical diagnostic algorithms or dive deeper into mechanisms. Acid loads can be in the form of either \( \text{CO}_2 \) or nonvolatile acids. Both types of acid loads occur normally on a daily basis and must be excreted. Primary ventilatory disorders resulting in increased arterial \( P_{\text{CO}_2} \) are referred to by the term respiratory acidosis. Nonvolatile acids, such as phosphoric acid and sulfuric acid, are also normal by-products of metabolism of dietary nutrients, proteins, and phospholipids. Nonvolatile acid loads in excess of the excretory capacity of the kidneys produce conditions termed metabolic acidosis. In other words, with normal acid loads or some increased acid loads that develop slowly, the kidneys can adapt, increasing acid excretion by both titratable acid and \( \text{NH}_4^+ \) excretion, and maintain normal systemic acid-base homeostasis and \( \text{pH} \). With larger acid loads (or base losses; for example, through severe diarrhea), the kidneys cannot keep up (i.e., cannot excrete sufficient acid into the urine), and metabolic acidosis ensues. Metabolic acidosis is reflected predominantly by lowering of plasma or systemic \( \text{HCO}_3^- \). Also, the loss of alkali from the body is equivalent to the addition of acid, and therefore, it represents metabolic acidosis; such loss of alkali might occur from excess stool \( \text{HCO}_3^- \) losses or loss of \( \text{HCO}_3^- \) in the urine.

Alkali loads, in contrast to acid loads, are not the result of normal physiology in persons on most diets, which provide net dietary acid. Alkali loads can be either respiratory or metabolic. Primary increases in ventilation and lowering of \( P_{\text{CO}_2} \) are referred to as respiratory alkalosis. Metabolic alkali loads can result from excess excretion of urinary acid, loss of other acids (such as gastric acid), or administration of exogenous alkali, and they can result in metabolic alkalosis. Metabolic alkalosis is reflected primarily by an increased plasma or systemic \( \text{HCO}_3^- \).

Usually, however, as briefly discussed below, such metabolic alkali loads can be quickly excreted, so that the focus in understanding metabolic alkalosis is more on the factors that maintain the high plasma \( \text{HCO}_3^- \) and not the original generation by alkali load (79). Clinically, the factors that often maintain high plasma \( \text{HCO}_3^- \) include extracellular volume and chloride depletion, which may decrease GFR, increase proximal tubule \( \text{HCO}_3^- \) reabsorption, and increase angiotensin and mineralocorticoids, potent stimuli for \( \text{H}^+ \) secretion in the proximal and distal tubules, respectively, as discussed above. The intermediaries in volume depletion include increased sympathetic activity and increased catecholamines, angiotensin II, and aldosterone, all of which increase \( \text{H}^+ \) secretion, \( \text{HCO}_3^- \) reabsorption, and/or \( \text{NH}_4^+ \) excretion as discussed above. The classic edematous disorders of congestive heart failure and cirrhosis and some nephrotic syndrome also have effective extracellular volume depletion because of low...
Compensation for Acid-Base Disorders
The mechanisms of physiologic responses to acid or base loads can be expected on the basis of the understanding of the mechanisms of usual physiology described above. The predicted extent of clinical response, however, is on the basis of empirical observations and not just mechanisms. On the basis of the chemistry, acute changes in $P_{CO_2}$ alter plasma $HCO_3^-$ slightly, because nonbicarbonate body buffers are titrated. With chronic changes in $P_{CO_2}$ (respiratory acid-base disorders), the kidneys respond to the change in pH by altering plasma $HCO_3^-$ reabsorption, $H^+$ secretion, and/or $NH_4^+$ excretion caused by the factors discussed above. Therefore, both volume depletion (e.g., vomiting and diuretics) and edematous disorders (primarily heart failure and cirrhosis) can and often are associated with metabolic alkalosis. Chloride depletion alone through a variety of mechanisms may also maintain metabolic alkalosis. Excess mineralocorticoids from any condition can also stimulate $H^+$ secretion and maintain metabolic alkalosis. Potassium depletion contributes to the maintenance of metabolic alkalosis by stimulating continued $H^+$ secretion.

cardiac output or arterial underfilling (80); these conditions, thus, have sodium and $H_2O$ retention but also, can have increased $HCO_3^-$ reabsorption, $H^+$ secretion, and/or $NH_4^+$ excretion caused by the factors discussed above. Therefore, both volume depletion (e.g., vomiting and diuretics) and edematous disorders (primarily heart failure and cirrhosis) can and often are associated with metabolic alkalosis. Chloride depletion alone through a variety of mechanisms may also maintain metabolic alkalosis. Excess mineralocorticoids from any condition can also stimulate $H^+$ secretion and maintain metabolic alkalosis. Potassium depletion contributes to the maintenance of metabolic alkalosis by stimulating continued $H^+$ secretion; a variety of proteins seem to serve some of this function, but no single sensor can be proposed (25). Increased metabolic acid production or ingestion will initially result in increased new $HCO_3^-$ generation, such that plasma $HCO_3^-$ does not change. With larger acid loads, the capacity of the kidneys to generate new $HCO_3^-$ is overwhelmed, and plasma $HCO_3^-$ decreases. Metabolic acid loads or metabolic acidosis results in increased fractional proximal tubule $HCO_3^-$ reabsorption, increases in distal $H^+$ secretion (resulting in lower urine pH), and increased $NH_4^+$ excretion. (However, the lower plasma $HCO_3^-$ during metabolic acidosis decreases filtered $HCO_3^-$ and hence, decreases absolute proximal $HCO_3^-$ reabsorption.) Increased $H^+$ excretion may result not only from adaptive changes in response to systemic pH per se but also, secondary to increases in systemic glucocorticoids and mineralocorticoids with chronic acidosis and potassium depletion. The adaptive changes within the kidney include various factors discussed in the sections above, including endogenous endothelin. The increased $H^+$ secretion can result in increased titratable acid excretion up to 2- to 3-fold in certain situations. Urinary $NH_4^+$ excretion (a result of both increased production and increased secretion of produced $NH_4^+$) can increase several fold (Figure 2). The maximum renal compensation for acid loading requires 3-5 days. Metabolic acid loads sufficient to lower plasma pH result in increased ventilation, resulting in a decrease in $P_{CO_2}$ sufficient to raise the systemic pH toward but not to normal. The full respiratory compensation requires 12-24 hours. Paradoxically, the compensatory hypcapnia during metabolic acidosis may actually decrease somewhat the renal response to metabolic acidosis (84).

Metabolic alkali loads can normally be quickly eliminated in the urine, because the filtration rate of $HCO_3^-$ is high, and a small reduction in proximal tubule $HCO_3^-$ reabsorption can result in spillage of $HCO_3^-$ in the urine and prompt correction of the metabolic alkalosis. Frequently, however, in states of metabolic alkalosis, other factors prevent the excretion of $HCO_3^-$ and maintain the metabolic alkalosis as described above. Metabolic alkalosis also results in some hypoventilation and increase in $P_{CO_2}$ to compensate for the alkalemia.

**Table 1. Acid and alkali loads**

<table>
<thead>
<tr>
<th>Acid loads</th>
<th>Excess CO$_2$ exhalation: Respiratory alkalosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nonvolatile acids: Metabolic acidosis</td>
<td>Exogenous acids (e.g., salicylate, methanol, and ethylene glycol)</td>
</tr>
<tr>
<td>Pathologic endogenous acids (e.g., ketoacids and lactic acid)</td>
<td>Decreased renal acid excretion (e.g., renal failure and distal renal tubular acidosis)</td>
</tr>
<tr>
<td>Loss of alkali, equivalent to acid load</td>
<td>Gastrointestinal losses (e.g., diarrhea)</td>
</tr>
<tr>
<td>Urine losses (e.g., proximal renal tubular acidosis)</td>
<td></td>
</tr>
</tbody>
</table>

| Alkali loads | Excess CO$_2$ exhalation: Respiratory base disorders | Nonvolatile alkali: Metabolic alkalosis |
|---|---|
| Exogenous alkali (e.g., NaHCO$_3$ administration) | Loss of acid, equivalent to alkali load |
| Gastrointestinal losses (e.g., gastric fluid) | Excess urine $H^+$ losses and renal production of new $HCO_3^-$ (most classic causes of metabolic alkalosis, including chloride depletion metabolic alkalosis and mineralocorticoid excess) |

Increased metabolic acid production or ingestion will initially result in increased new $HCO_3^-$ generation, such that plasma $HCO_3^-$ does not change. With larger acid loads, the capacity of the kidneys to generate new $HCO_3^-$ is overwhelmed, and plasma $HCO_3^-$ decreases. Metabolic acid loads or metabolic acidosis results in increased fractional proximal tubule $HCO_3^-$ reabsorption, increases in distal $H^+$ secretion (resulting in lower urine pH), and increased $NH_4^+$ excretion. (However, the lower plasma $HCO_3^-$ during metabolic acidosis decreases filtered $HCO_3^-$ and hence, decreases absolute proximal $HCO_3^-$ reabsorption.) Increased $H^+$ excretion may result not only from adaptive changes in response to systemic pH per se but also, secondary to increases in systemic glucocorticoids and mineralocorticoids with chronic acidosis and potassium depletion. The adaptive changes within the kidney include various factors discussed in the sections above, including endogenous endothelin. The increased $H^+$ secretion can result in increased titratable acid excretion up to 2- to 3-fold in certain situations. Urinary $NH_4^+$ excretion (a result of both increased production and increased secretion of produced $NH_4^+$) can increase several fold (Figure 2). The maximum renal compensation for acid loading requires 3-5 days. Metabolic acid loads sufficient to lower plasma pH result in increased ventilation, resulting in a decrease in $P_{CO_2}$ sufficient to raise the systemic pH toward but not to normal. The full respiratory compensation requires 12-24 hours. Paradoxically, the compensatory hypcapnia during metabolic acidosis may actually decrease somewhat the renal response to metabolic acidosis (84).

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Summary
Acid-base homeostasis is critical for normal physiology and health. Hence, multiple, often redundant pathways and processes exist to control systemic pH. Derangements in acid-base homeostasis, however, are common in clinical medicine and can often be related to the systems involved in acid-base transport in the kidneys. These have been studied for decades, but a variety of new pathways, such as pendrin and Rh proteins, have illustrated that our understanding is still far from complete.

Disclosures
None.

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Published online ahead of print. Publication date available at www. cjasn.org.