

TITLE

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1 **Genetic predisposition to salt-sensitive normotension and its effects on salt taste perception**
2 **and intake (Genetics of salt sensitivity and salt intake)**

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9

10 **ABSTRACT**

11 Salt sensitivity is an independent CVD and mortality risk factor, present in both hypertensive and
12 normotensive populations. It is genetically determined and it may affect the relationship between
13 salt taste perception and salt intake. The aim of this study was to explore the genetic predisposition
14 to salt sensitivity in young and a middle-aged adult population and its effects on salt taste
15 perception and salt intake. The effects of sodium loading on blood pressure (BP) were investigated
16 in 20 normotensive subjects and salt sensitivity defined as the change in BP after seven days of low
17 sodium (51.3 mmol sodium/day) and seven days of high sodium diet (307.8 mmol sodium/day).
18 Salt taste perception was identified using the British Standards Institution sensory analysis method
19 (BS ISO 3972:2011). Salt intake was assessed with a validated FFQ. DNA was genotyped for SNPs
20 in the *SLC4A5*, *SCNN1B* and *TRPV1* genes. The subjects with AA genotype of the *SLC4A5*
21 rs7571842 exhibited the highest increase in BP (Δ SBP=7.75 mmHg, $p=0.002$, $d=2.4$; Δ DBP=6.25
22 mmHg, $p=0.044$, $d=1.3$; Δ MAP=6.5 mmHg, $p=0.014$, $d=1.7$). The *SLC4A5* rs10177833 was
23 associated with salt intake ($p=0.037$) and there was an association between salt taste perception and
24 salt sensitivity ($r_s=0.551$, $p=0.041$). The association between salt taste perception and discretionary
25 salt use may depend on the *SLC4A5* and *TRPV1* genotype. In conclusion, there is a genetic
26 predisposition to salt sensitivity and it is associated with salt taste perception. The association
27 between salt taste perception and discretionary salt use suggests that preference for salty taste may
28 be a driver of salt intake in healthy population and warrants further investigation.

29 **Keywords: blood pressure, genetics, salt sensitivity, salt intake, taste**

30 1. Introduction

31 Hypertension is a major cause of CVD and overall mortality ⁽¹⁾. High dietary sodium intake
32 is a major risk factor for hypertension ^(2,3) estimated to be responsible for one in 10 deaths from
33 CVD events ⁽⁴⁾. In 2010, the estimated mean global sodium consumption was 3.95 g per day, with
34 regional mean levels ranging from 2.18 g to 5.51 g/day, exceeding the reference intake of 2.0 g of
35 sodium/day ^(4,5).

36 One of the main determinants of food intake, and potentially salt, is taste ⁽⁶⁾. The ability to
37 perceive a certain taste may be genetically determined ⁽⁷⁾. More specifically, genetic variation in
38 taste receptors may alter an individual's taste function ⁽⁸⁾. However, to our knowledge, only one
39 study reports the genetic predisposition to salt taste in humans. SNPs in genes coding for ion
40 channels, the epithelial sodium channel (*SCNN1B*) rs239345 and the transient receptor potential
41 cation subfamily V member 1 channel (*TRPV1*) rs8065080, modified the salt taste perception in 95
42 white young adults ⁽⁸⁾. The effect of these genetic variants on actual sodium intake has not been
43 investigated and the results warrant further investigation. In addition, a link between salt taste
44 perception and blood pressure (BP) is suggested. A number of studies reported that individuals with
45 lower ability to taste salt (i.e. reduced salt taste sensitivity) exhibited higher BP compared to
46 individuals with enhanced ability to perceive salty taste. This was observed both in adults and
47 children and across different populations ⁽⁹⁻¹²⁾. Moreover, research suggests an association between
48 salt taste sensitivity and salt intake, albeit inconclusive ^(13,14). Considering the above and with the
49 notion that high salt intake is a major risk factor for raised BP ^(2,3), it can be hypothesised that
50 reduced salt taste sensitivity would result in higher dietary salt intake and consequently in higher
51 BP.

52 Furthermore, the mechanisms behind the possible link between salt taste perception and salt
53 intake are unclear and confounded by other metabolic and physiological aspects of salt metabolism.
54 The main confounder is salt sensitivity which is defined as an increase in BP in response to a high
55 dietary salt intake ⁽¹⁵⁾. Considering that some individuals do not exhibit such increase, the
56 distinction is made between salt-sensitive and salt-resistant populations ⁽¹⁶⁾. Salt sensitivity displays
57 a strong heritable component and the genes involved in sodium transport across the cell membrane
58 have shown a strong effect on salt-sensitive changes in BP ^(17,18). Specifically, rs7571842 and
59 rs10177833 in the *SLC4A5* gene, coding for electrogenic sodium bicarbonate cotransporter 2, have
60 been associated with salt sensitivity in Caucasian hypertensive and normotensive populations ⁽¹⁹⁾. In
61 addition to salt taste perception, the *TRPV1* gene has been associated with salt sensitivity in

62 animals^(20,21). Wang and Wang⁽²⁰⁾ have reported that in Dahl salt-sensitive rats on a high-salt diet,
63 TRPV1 expression and function is impaired rendering these rats sensitive to salt load in terms of BP
64 regulation. Furthermore, the *TRPV1* rs8065080 is a missense SNP resulting in amino acid change at
65 position 585, from isoleucine to valine, potentially affecting protein function⁽²²⁾. Cantero-Recasens
66 et al.⁽²³⁾ have tested its functional effect by expressing it in HeLa cells and showed a decreased
67 channel activity in response to two typical TRPV1 stimuli, heat and capsaicin, in TRPV1-Val-585
68 cells compared to TRPV1-Ile-585. The loss of function effect of the rs8065080, together with
69 reduced expression and activity of the TRPV1 reported in salt-sensitive animals suggests this
70 variant may also be involved in salt sensitivity in humans. Finally, several common variants of the
71 epithelial sodium channel *SCNN1B* gene, including the rs239345, have been associated with BP or
72 hypertension in different populations^(24,25).

73 Recent research in animals suggests an association between salt taste perception and salt-
74 sensitive hypertension mediated by the renin-angiotensin aldosterone system (RAAS) dysfunction
75⁽²⁶⁾. To the best of our knowledge, there are no studies in humans confirming this association. In
76 addition, there are no studies comprehensively exploring the link between salt sensitivity of BP, salt
77 taste perception and intake. Furthermore, salt sensitivity is present in 51% of hypertensive and 26%
78 of normotensive populations and it is an independent cardiovascular and mortality risk factor^(27,28).
79 Since reduction in salt intake may lead to significant reductions in BP in susceptible individuals^(1,2),
80 detecting salt sensitivity in young and healthy individuals may result in more successful prevention
81 of hypertension and consequently CVD⁽²⁹⁾.

82 Considering the potential link between salt sensitivity, salt taste perception and dietary salt
83 intake together with the underlying genetic basis, the aim of this study was to explore the genetic
84 predisposition to salt sensitivity, expressed as the BP response to sodium loading, in a healthy adult
85 population and its effects on salt taste perception and dietary salt intake.

86

87 **2. Methods**

88 **2.1. Subjects**

89 The subjects were predominantly young Caucasians, eight males and 12 females. Subjects
90 were recruited through advertisements, internet postings and the institutional Centre for Workplace
91 and Community Health. Eligibility criteria were clearly stated. More specifically, subjects were
92 excluded with current stage-2 hypertension (systolic blood pressure (SBP) ≥ 160 mm Hg and/or

93 diastolic blood pressure (DBP) ≥ 100 mm Hg), current or recent (less than one month prior to
94 screening visit) use of anti-hypertensive medications or medications that affect BP. Further, those
95 with secondary hypertension, history of CVD, chronic kidney failure, current diabetes were
96 excluded. Also excluded were individuals with peptic ulcer disease or liver disease requiring
97 treatment during the previous two years. In addition, pregnant women, underweight (BMI < 18.5
98 kg/m²) and obese (BMI > 30 kg/m²) individuals, individuals exceeding maximal recommended
99 alcohol intake for the UK, those currently adhering to a low sodium diet, or with an illness that
100 permanently alters taste were also excluded from the study.

101 All 20 subjects completed the taste threshold determination test to assess salt taste
102 perception, FFQ and provided a saliva sample. Out of 20 subjects, 19 completed the low- and high
103 sodium dietary protocols, however, five subjects were excluded due to incomplete 24-hour BP or
104 urinary excretion data (Figure 1).

105 This study was conducted according to the guidelines laid down in the Declaration of
106 Helsinki and all procedures involving human subjects were approved by the Institutional Ethics
107 Committee. Written informed consent was obtained from each subject before the baseline data
108 collection informing they can withdraw from the study at any point. The study is registered under
109 Research Registry unique identification number: researchregistry1652.

110

111 **2.2. Baseline measurements**

112 Height and baseline BP and weight were measured during the first examination. Subjects
113 were instructed to avoid alcohol, cigarette smoking, coffee/tea, and exercise for at least 30 minutes
114 prior to their BP measurement. Seated BP was measured with an automated BP monitor (OMRON
115 M24/7, Milton Keynes) using an appropriate size cuff after five minutes of rest. Two measurements
116 were performed within five minute intervals and used for the analysis and calculation of the mean
117 baseline SBP and DBP. In addition, demographic data (age, sex and race) was collected and
118 assessed together with smoking habits and health status information. Physical activity was assessed
119 with the General Practice Physical Activity Questionnaire. Participants were considered as: active,
120 moderately active, moderately inactive or inactive ⁽³⁰⁾.

121

122

2.3. Taste thresholds for salt

Identification of taste thresholds for salt (salt taste perception) was determined using the British Standard BS ISO3972:2011 methodology. Salt taste detection and recognition thresholds were determined using eight graded sodium chloride solutions (4 mmol/l, 6 mmol/l, 8 mmol/l, 12 mmol/l, 17 mmol/l, 24 mmol/l, 34 mmol/l and 49 mmol/l). Solutions were prepared by dissolving food grade sodium chloride in spring water. All solutions were prepared on the day of the testing. Subjects were presented with a sample of each solution by order of increasing concentration starting with the lowest concentration of 4 mmol/l. The procedure was repeated three times. Three additional vessels containing dilutions of the same concentration as the preceding vessel were presented randomly within the sample series. The salt taste detection threshold (STDT) was identified as the lowest concentration of the sample where the subject can consistently perceive an impression but not identify the taste. The salt taste recognition threshold (STRT) was identified as the sample concentration where the subject consistently perceives the taste as salt ⁽³¹⁾.

2.4. Habitual dietary salt intake

Baseline energy and dietary salt intake were assessed using a semi-structured validated FFQ. The questionnaires were analysed using the open source, cross-platform tool FETA ⁽³²⁾ and information on 46 nutrients, including sodium, was obtained. Habitual dietary sodium intake was energy adjusted and expressed as mg of sodium per 1000 kcal. Information on the frequency of discretionary salt use was also obtained. Subjects recorded the frequency of adding salt while cooking and at the table by choosing one of the following: 1) never, 2) rarely, 3) sometimes, 4) usually and 5) always.

2.5. Dietary sodium intervention

Study subjects received a low-sodium diet (3 grams of salt or 51.3 mmol of sodium/day) for seven days, followed by a high-sodium diet (18 grams of salt or 307.8 mmol of sodium/day) for an additional seven days. Minimal wash-out period between the diets was seven days. The low sodium diet was designed by investigators using the nutritional analysis software (Nutritics, Nutritics LTD, Dublin, Ireland). Three meals and two snacks were designed to provide a total of 3 grams of salt per day and recommended macronutrient intake ⁽³³⁾. Total energy intake was determined based on individual requirements of each subject. Subjects were provided with detailed written instructions

154 about the diets and they were also instructed to maintain their coffee, smoking and physical activity
155 levels. The high sodium diet was formulated by supplementing the low-sodium diet with additional
156 256.5 mmol of sodium/day (15g of salt per day) dispensed by research staff in small paper sachets
157 each containing 1g salt (NaCl). To monitor subject compliance with the diets, on the last day of
158 each period, 24-hour urine was collected for sodium, potassium and creatinine excretion
159 measurements. During the same period, 24-hour BP measurements were performed with the 24-
160 hour ambulatory BP monitoring device (ABPM).

161

162 **2.6. Twenty-four-hour automated BP monitoring**

163 Twenty-four-hour ABPM was attached to the upper, non-dominant arm and BP was
164 registered at 30-minute intervals during daytime and 60-minute intervals at night time. Data from
165 the ABPM was downloaded using BP Tracker Software and mean SBP and DBP were calculated.
166 Subject data with less than 30 successful measurements on each occasion was excluded from the
167 analysis for salt sensitivity⁽³⁴⁾. Pulse pressure (PP) was calculated according to the formula: $PP =$
168 $SBP - DBP$ and mean arterial pressure (MAP) as: $MAP = DBP + 1/3 PP$. Salt sensitivity was
169 defined as an increase of ≥ 3 mmHg in MAP when transitioning from the low to high sodium diet,
170 as suggested by Kurtz et al.⁽³⁵⁾. The change in BP between the high sodium and low sodium diet
171 (ΔBP) was calculated as: $\Delta BP = \text{high sodium diet BP} - \text{low sodium diet BP}$.

172

173 **2.7. Biochemical measurements**

174 The 24-hour urinary sodium and potassium were analysed using an automated clinical
175 chemistry analyser (Randox: Rx Daytona), with intra-assay CV < 6%. Estimated salt intake was
176 calculated using the equation 17.1 mmol of sodium = 1g of salt. Assessment of the completeness of
177 the collection was assessed by measuring creatinine levels from the same urine samples. The
178 following criteria were used: 1) incomplete urine = < 0.7 of $[\text{mmol urinary creatinine} \times 113] / [21 \times$
179 $\text{kilograms of body weight}]$ ⁽³⁶⁾, 2) urinary creatinine < 4 mmol/day for women, or < 6 mmol/day for
180 men, or a 24 h urine collection of < 500 mL for either sex and extreme outliers for urinary creatinine
181 (ie, > 3 SD from the mean) considered as unacceptable⁽³⁷⁾. Subjects with incomplete urine
182 collection from any of the dietary intervention periods, based on any of the two criteria, were
183 excluded from the analysis.

184

185 **2.8. Single nucleotide polymorphism (SNP) determination**

186 Following the extensive literature review, four SNPs were selected for genotyping:
187 rs7571842 (A/G) and rs10177833 (A/C) in the *SLC4A5* gene, rs239345 (T/A) in the *SCNN1B* and
188 rs8065080 (T/C) in the *TRPV1* gene. These SNPs were chosen based on their previously reported
189 associations with BP phenotypes, such as hypertension or salt sensitivity, and salt taste perception.
190 This was combined with prevalence data (minor allele frequencies) for the SNP ^(8,19,38)
191 (Supplementary Table 1).

192 At baseline examination a 2 ml saliva sample was collected into a collection vial
193 (SalivaGene collection module II, STRATEC Molecular, Berlin). A stabiliser provided by the
194 manufacturer was added to the saliva sample and it was stored at -20 °C until DNA was extracted.
195 Genomic DNA was extracted using a commercial kit PSP[®] SalivaGene 17 DNA Kit 1011
196 (STRATEC Molecular, Berlin) in accordance with the manufacturer protocol. Quality and quantity
197 were assessed using Nanodrop (ThermoFisher, Waltham, MA, USA). Genotyping was performed
198 using a pre-designed TaqMan[®] SNP genotyping assays for the SNPs: rs7571842, rs10177833,
199 rs239345, rs8065080 and the StepOnePlus thermocycler (Applied Biosystems, CA, USA) with two
200 technical replicates for each sample. The primers and the probes were pre-designed by Applied
201 Biosystems with the following codes (C___197439_10, C___1137534_10, C___2387896_30,
202 C___11679656_10). The PCR amplification was performed under the conditions specified by the
203 manufacturer. SNPs were accepted when the quality threshold was above 98%. All SNPs had minor
204 allele frequencies higher than or equal to 30% and these reflected the ones reported in European
205 populations ⁽³⁸⁾ (Supplementary Table 2).

206

207 **2.9. Statistical analysis**

208 Sample size calculation was based on the 4 mmHg difference in MAP when transitioning
209 from low to high sodium diet. This difference in BP was observed in other studies investigating salt
210 sensitivity in normotensive populations and with a 24-hour ABPM ^(39,40). A sample size of 15 was
211 calculated using an alpha of 0.05, power of 80%, expected large effect size (d=0.8) and a standard
212 deviation of 5 mmHg. This standard deviation was chosen due to lower variability of BP reported in
213 younger and healthy individuals ^(40,41).

214 All continuous variables are presented as mean and SEM or median (interquartile range).
215 Categorical variables are presented as absolute (relative) frequencies. Before further statistical

216 analysis, continuous variables were tested for normality with the Shapiro-Wilk test. Differences in
217 baseline characteristics by salt sensitivity status were assessed using an independent samples t-test
218 (with Levene's test for equality of variance) or Fischer's exact test. The difference between clinical
219 characteristics of subjects between the low and high sodium diets was assessed using paired
220 samples t-test. An independent samples t-test (with Levene's test for equality of variance) or Mann-
221 Whitney U test, as appropriate, was used to test for the difference in salt-sensitive changes in BP
222 and dietary sodium intake by genotypes of interest. The model used for the analysis was: major
223 allele homozygote versus heterozygote plus minor allele homozygote. A Cochran Armitage test of
224 trend was run to determine whether a linear trend exists between the genotypes of interest and the
225 proportion of subjects with low and high STDT and STRT as well as the proportion of subjects in
226 different tertiles of energy adjusted sodium intake. Considering there is no universal cut-off point
227 provided to distinguish between the subjects with low and high salt taste thresholds, a median was
228 used as a cut-off. Subjects with STDT \leq 8 mmol/l and STRT \leq 12 mmol/l were considered to have
229 low thresholds.

230 To assess the relationship between salt taste thresholds and salt-sensitive changes in BP and
231 salt taste thresholds and sodium intake, Spearman's correlation analysis was performed. Analyses
232 were performed using the SPSS software package (version 22.0, Chicago, IL, USA). All tests were
233 two-tailed, with $p < 0.05$ considered statistically significant.

234

235 **3. Results**

236 **3.1. Subject characteristics and compliance with the dietary sodium intervention**

237 Twenty subjects completed the baseline examination, taste threshold determination test and
238 FFQ. Of these, 14 subjects provided complete 24-hour ABPM and 24-hour urine excretion data and
239 were included in the analysis on salt sensitivity of BP. Five subjects were considered salt-sensitive
240 using the criteria of ≥ 3 mmHg increase in MAP when transitioning from low to high sodium diet.
241 The study population was normotensive, predominantly white, physically active and non-smoking
242 with a median age of 28 years (Table 1). There was no significant difference in any of the baseline
243 parameters between salt-sensitive and salt-resistant subjects.

244 In addition, there was no difference in BP between the low sodium and high sodium diet
245 periods (Table 2). Urinary sodium excretion results demonstrated good compliance with the diet
246 ($p < 0.0005$) whereas potassium intake remained similar on both diets ($p = 0.243$).

3.2. Genetic predisposition to salt sensitivity of BP, altered salt taste perception and salt intake

Regarding the genetic predisposition to salt sensitivity, the mean change in BP between the low and high sodium diet differed according to *SLC4A5* rs7571842 genotype (Figure 2). The subjects with AA genotype had the highest increase in BP (Δ SBP=7.75 \pm 1.44 mmHg, p=0.002, d=2.4; Δ DBP=6.25 \pm 2.81 mmHg, p=0.044, d=1.3; Δ MAP=6.5 \pm 2.10 mmHg, p=0.014, d=1.7). SNPs rs10177833 (*SLC4A5*) (Figure 2), rs239345 (*SCNN1B*) and rs8065080 (*TRPV1*) had no statistically significant effects on the BP response to dietary sodium manipulation (data not shown). Moreover, the analysis was conducted to test for the possible difference in the prevalence of males and females, BMI and age, between the rs7571842 genotype groups. There was no difference in any of the variables between the AA and AG + GG group (p=1.000, p=0.846 and p=0.584 for sex, BMI and age respectively).

In contrast with the above described, the proportion of study subjects with low and high salt taste recognition thresholds was similar according to genotypes of interest (Figure 3). The results of a Cochran Armitage test of trend between the different genotype groups (homozygous major allele, heterozygous and homozygous minor allele) and the proportion of subjects with low and high STRT were: rs7571842 (p=0.905), rs10177833 (p=0.714), rs239345 (p=0.456), rs8065080 (p=0.078). Similar were observed for STDT (data not shown). However, a linear trend was observed regarding the distribution of subjects in the first or second + third tertile of energy adjusted sodium intake according to the *SLC4A5* rs10177833. With the increasing number of A alleles, sodium intake increased (p=0.037, Figure 4). The mean age and BMI as well as the distribution of sex did not differ between the rs10177833 genotype groups (p=0.129, p=0.551, p=1.000 for age, BMI and sex respectively).

3.3. Associations between salt sensitivity of BP, salt taste perception and salt intake

When exploring the associations between the main outcome variables, there was no correlation between the mean change in SBP, DBP and MAP, when transitioning from a low to high sodium diet, and salt taste thresholds (Table 3). However, a positive moderate correlation was observed between the mean change in PP and STDT ($r_s=0.551$, p=0.041). Sub-group analysis revealed a strong positive correlation between the change in PP and STDT in the *SLC4A5* rs7571842 AG + GG group ($r_s=0.845$, p=0.002). Similar was observed for the rs10177833. There

278 was a strong positive correlation between the change in PP and STDT in the AC + CC group
279 ($r_s=0.781$, $p=0.022$, Supplementary Table 3).

280 Furthermore, in the total study population, the correlation between the STDT and energy-
281 adjusted sodium intake was not significant ($r_s=0.069$, $p=0.774$). Similar was observed for STRT
282 ($r_s=0.025$, $p=0.918$). In addition, the correlation between adding salt while cooking and at the table
283 and salt taste thresholds was also investigated. No significant correlation was observed (STDT:
284 $r_s=0.134$, $p=0.573$ for adding salt at the table and $r_s=0.342$, $p=0.140$ for adding salt while cooking;
285 STRT: $r_s=0.083$, $p=0.727$ for adding salt at the table and $r_s=-0.071$, $p=0.767$ for adding salt while
286 cooking, Supplementary Table 4). However, as shown in Figure 5, when stratifying according to
287 genotype, in the AA group of the *SLC4A5* rs7571842, a strong and positive correlation was
288 observed between adding salt while cooking and both STDT ($r_s=0.868$, $p=0.011$) and STRT
289 ($r_s=0.868$, $p=0.011$). In addition, in the TT group of the *TRPV1* rs8065080, a moderate and negative
290 correlation was observed between adding salt at the table and salt taste recognition threshold ($r_s=-$
291 0.636 , $p=0.048$).

292

293 4. Discussion

294 4.1. Genetics of the BP response to sodium loading, salt taste perception and salt intake

295 Findings from the present study suggest a genetic predisposition to salt sensitivity in the
296 study population. Despite the small sample size, salt-sensitive increase in BP was detected.
297 Moreover, other studies with similar sample sizes, 14-16 subjects respectively, have successfully
298 investigated and detected this phenomenon in normotensive populations⁽⁴²⁻⁴⁴⁾. Finally, urinary
299 markers of compliance with the diets, sodium and potassium, were satisfactory showing an overall
300 good compliance with the diets.

301 *SLC4A5* gene, coding for a sodium hydrogen bicarbonate transporter involved in sodium
302 transport across the cellular membrane⁽⁴⁵⁾, affected salt-sensitive changes in BP. Carey et al.⁽¹⁹⁾
303 noted that SNPs rs7571842 and rs10177833 had the most pronounced effects on salt sensitivity.
304 One of these SNPs, rs7571842, had the greatest effect in this study population, increasing BP in
305 individuals with AA genotype and confirming the protective effect of the G allele⁽¹⁹⁾. A *post hoc*
306 power calculation revealed that, with the two-tailed 0.05 significance level, this test had a power of
307 92% to detect a difference in SBP between the two *SLC4A5* rs7571842 genotype groups (mean

308 values for Δ SBP 7.75 mmHg vs. 0.00 mmHg and standard deviations 2.87 mmHg vs. 1.06 mmHg).
309 Regarding the rs10177833, the lack of confirmation of its effect may be due to its lower effect size
310 that could potentially be detected in a larger sample size study. These results, however, align with
311 Carey et al. ⁽¹⁹⁾ where the effect of rs10177833 on salt sensitivity observed in the University of
312 Virginia (UVA) discovery cohort was not replicated in a HyperPATH study population. Other
313 SNPs investigated in the present study were not associated with salt sensitivity in previous studies
314 conducted in humans. The *SCNN1B* SNPs were associated with hypertension^(24,25) but not salt
315 sensitivity *per se* suggesting rs239345 may not have an effect on this specific phenotype in healthy
316 population. Finally, the *TRPV1* rs8065080 appears to be functional and is associated with lower
317 channel activity, a trait observed in salt-sensitive rats ^(20,23). In this population, it did not have an
318 effect on salt-sensitive changes in BP, suggesting that other variants in this gene may have more
319 pronounced effects on BP.

320 Nevertheless, the A allele of the *SLC4A5* rs7571842 is present in approximately half of the
321 European descent population with a third of the population having the risky AA genotype ⁽³⁸⁾.
322 Additionally, salt-sensitive rise in BP, following a high sodium diet, was expressed as a continuous
323 variable. The risk of CVD increases continuously and with each 2 mmHg increase in SBP there is a
324 7% increase in risk of mortality from IHD and a 10% increase in the risk of mortality from stroke
325 ⁽⁴⁶⁾. The increase in SBP in healthy subjects with the rs7571842 AA genotype was 7.75 mmHg,
326 which emphasises the clinical relevance of these results. Moreover, it has been estimated that
327 approximately a third of deaths attributed to BP occur in individuals with BP lower than the
328 hypertensive range ⁽⁴⁷⁾. They may represent a salt-sensitive part of the population which reflects salt
329 sensitivity prevalence of 36% in this study. Considering the discrepancies in methods used in
330 previous studies, it is difficult to draw any conclusion whether this prevalence could be expected in
331 other populations with similar characteristics. Salt sensitivity prevalence of 26% in normotensives
332 was established using an intravenous protocol for diagnosis of salt sensitivity ⁽²⁷⁾. However, more
333 recent work suggests that this method can lead to misclassification and incorrect diagnosis ^(39,40).
334 Another potential issue in comparison of different study results is the BP measurement. While most
335 studies still use the conventional measurements, from the studies that employ 24-hour BP
336 measurements only a limited number is investigating salt sensitivity solely in healthy, normotensive
337 populations ⁽⁴⁸⁻⁵⁰⁾.

338 It should be noted, however, that this study primarily investigated the effects of sodium
339 loading on BP and as such, the above-described salt sensitivity prevalence should be regarded with

340 caution. When identifying subjects as salt-sensitive or salt-resistant it is recommended that the low
341 and high sodium diets should be administered in a random order to achieve maximal reproducibility
342 ⁽³⁵⁾. When a low sodium period precedes high sodium period RAAS may not be uniformly
343 suppressed ⁽⁵¹⁾. This may result in an increased BP response on a low sodium diet and would require
344 larger sample size compared to the one in this study to detect the true effect of dietary sodium
345 manipulation on BP and estimate the salt sensitivity prevalence. Therefore, if the order of the diets
346 was randomised and high sodium diet preceded the low sodium diet in a proportion of the study
347 population, the RAAS may have been suppressed to an extent where more uniformity in the BP
348 response to dietary intervention may have been observed. This in turn, may have resulted in a
349 statistically significant difference in BP when transitioning from the low to the high sodium diet in
350 the total study population.

351 Besides observed genetic predisposition to salt sensitivity of BP, the *SLC4A5* rs10177833
352 was associated with salt intake. With increasing number of A alleles there was a trend towards an
353 increased energy adjusted sodium intake. The highest proportion of subjects in the second and third
354 tertile of energy adjusted sodium intake was in the AA genotype group with the majority of these
355 subjects (85%) having absolute sodium intake above the recommendations ^(5,52). Recently, Smith et
356 al. ⁽⁵³⁾ have reported how individuals with enhanced bitter taste perception genotype (GC and GG
357 alleles for the bitter taste receptor gene *TAS2R38*) were significantly more likely than CC
358 homozygotes to have daily sodium intake higher than recommended. Furthermore, Kho et al. ⁽⁵⁴⁾, in
359 their genome wide association study (GWAS) have reported on several variants associated with salt
360 intake. These variants were in genes coding for sodium, potassium and calcium channels,
361 suggesting that genes coding for sodium transport proteins may be associated with increased salt
362 intake, similar to the findings of this study. The mechanism behind this association is to be
363 explored. It is not to exclude the potential expression of this cotransporter in taste receptor cells, as
364 other sodium-dependent transporters primarily expressed in other tissues have been localised in
365 tongue ^(55,56). However, impaired sodium metabolism was reported as a consequence of rs10177833
366 induced increase in the *SLC4A5* transcription under conditions of high sodium intake ⁽⁵⁷⁾.
367 Considering its strong linkage disequilibrium (LD) with rs7571842 ⁽¹⁹⁾, these two SNPs are most
368 likely inherited together making the carriers of this genotype at increased risk of developing
369 hypertension and CVD.

370 Moreover, there was no genetic predisposition to altered salt taste perception. The
371 discrepancy in the results of the present study and the one by Dias et al. ⁽⁸⁾ may be explained by the

372 difference in thresholds measured. The taste quality of salt stimulus can be concentration
373 dependent^(58,59) which may explain the associations observed with suprathresholds in Dias et al. ⁽⁸⁾
374 but not with lower concentrations (STDT, STRT) used in this study. Nevertheless, the borderline
375 non-significant trend observed for the *TRPV1* rs8065080 may be detected in a larger sample size
376 study. For such study to be clinically meaningful, in addition to salt taste perception, dietary salt
377 intake should be measured, as acknowledged by Dias et al.⁽⁸⁾. It has been shown that the reduction
378 in salt intake results in important falls in BP, in both hypertensive and normotensive salt-sensitive
379 individuals ⁽²⁾, and a reduction in overall CVD risk ⁽¹⁾.

380

381 **4.2. Associations between salt sensitivity, salt taste perception and salt intake**

382 Together with the observed effect of genetics, salt sensitivity expressed as a change in BP
383 after sodium loading was associated with taste thresholds for salt. In subjects that had complete
384 dietary intervention data PP was positively associated with STDT. PP is the difference between
385 SBP and DBP and is argued to be a better predictor of cardiovascular risk than SBP ⁽⁶⁰⁾. PP may be
386 genetically determined by the *SLC4A5* rs7571842 ⁽⁶¹⁾. The mechanisms behind this association and
387 the causality remain unknown. However, the hypothesis was that genetics may play a role in this
388 relationship which aligns with the finding that this association was observed only in certain
389 genotype groups of the *SLC4A5* SNPs. This sub-group analysis should, nevertheless, be replicated
390 in a study with a larger sample size in each genotype group, to achieve appropriate statistical power,
391 and as such considered preliminary in this study.

392 Sakamoto et al. ⁽²⁶⁾ reported that the ENaC activity may be the link between salt taste
393 sensitivity and salt sensitivity of BP in animals. However, the *SCNN1B* rs239345 was not
394 associated with salt sensitivity or salt taste thresholds in this study. In a larger sample size study
395 potential effect of interactions between the *SLC4A5* and ENaC SNPs may be investigated and may
396 provide insight into the mechanism behind this relationship. Nevertheless, the relevance of these
397 findings lies in the actual relationship between salt taste thresholds and salt intake.

398 If there is a positive association between the thresholds for salt and salt-sensitive changes in
399 BP, it can be theorised that salt-sensitive individuals with higher thresholds are at greater risk of
400 developing hypertension due to their higher salt intake. In the present study, however, neither
401 detection nor the recognition threshold for salt have been associated with total habitual dietary salt
402 intake. Nevertheless, discretionary salt use accounts for approximately 15% of salt intake in

403 Western countries ⁽⁶²⁾ and the results of the present study suggest it may be associated with salt taste
404 thresholds. The association between salt taste perception and discretionary salt use may depend on
405 the *SLC4A5* and *TRPV1* genotype, however these sub-group analyses should be replicated in a
406 larger size study. This would, nonetheless, be in line with the notion that reduced salt taste
407 sensitivity (i.e. higher salt taste threshold) drives individuals to consume more salt until reaching the
408 salt concentration identified as pleasant ⁽¹⁴⁾. Conversely, improved ability to taste salt when the taste
409 of salt is deemed pleasant may result in increased salt intake. Indeed, research suggests that the
410 preference for salty taste may be one of the factors affecting salt intake in younger populations and
411 that discretionary salt use is more frequent in younger compared to older populations ^(63, 64).
412 Moreover, when salt content of processed food is reduced, consumers compensate its apparent lack
413 by increasing the discretionary salt use ⁽⁶⁵⁾. Considering the evolving food supply and dietary habits
414 of the UK population and worldwide, a better understanding of this behaviour could enable more
415 targeted and effective public health interventions to reduce salt intake.

416

417 **4.3. Strengths and limitations**

418 This study has several strengths and limitations. A strength is the salt sensitivity
419 phenotyping procedure with the dietary control of sodium intake. Moreover, a 24-hour ABPM
420 procedure to determine the difference in BP between the diets provides many more measurements
421 than conventional BP measurement reflecting usual BP more accurately. It also allows
422 identification of individuals with a ‘white coat’ response or masked hypertension, and is a stronger
423 predictor of cardiovascular morbidity and mortality than conventional measurement ⁽³⁴⁾. One of the
424 limitations is a use of a FFQ to determine dietary salt intake. Even though FFQ represents dietary
425 intake over a longer time-period, it relies heavily on respondents’ honesty and long-term memory.
426 However, sodium intake was energy adjusted, improving measurement accuracy. Freedman et al.
427 ⁽⁶⁶⁾ suggest that the attenuations and correlations with truth for the FFQs are improved when
428 considering sodium densities, utilised in this study. Regarding the associations between genetics
429 and variables of interest, where possible, a Cochran-Armitage test of trend was used. The advantage
430 of the Cochran-Armitage trend test is that it is not dependent on the Hardy-Weinberg equilibrium
431 assumption and is suggested as the genotype-based test for association ⁽⁶⁷⁻⁶⁹⁾. Finally, the small
432 sample size in sub-group analyses of the correlations between salt taste perception, BP response to
433 sodium loading and salt intake warrants replication of these results in a larger sample size study.

434 In conclusion, this preliminary data suggests there is a genetic predisposition to salt
435 sensitivity in healthy, adult Caucasians. The *SLC4A5* rs7571842 was confirmed as the variant with
436 the effect on salt-sensitive changes in BP. Another *SLC4A5* variant, rs10177833, most likely
437 inherited together with the rs7571842, is associated with salt intake. Moreover, the observed
438 associations between salt taste perception and salt sensitivity, together with the association between
439 salt taste perception and discretionary salt use may depend on the *SLC4A5* and *TRPV1* genotype.
440 Since there was no association between genetics and salt taste perception, the mechanisms behind
441 these associations are to be further explored together with gene-gene interactions. Nevertheless,
442 preference for salty taste may be a driver of salt intake in younger populations and warrants further
443 investigation. Studies investigating these associations should comprehensively explore all potential
444 variables, such as genetic predisposition, salt taste perception and salt intake to contribute towards
445 more successful prevention of hypertension and CVD.

446

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456

457 **Conflict of interest**

458 None.

459

460

461 **Authorship**

462 Y.M and L.P. designed the experiment. L.P. conducted data collection, data analysis and wrote the
463 paper. Y.M supervised the project. Both authors discussed the results and implications and
464 commented on the manuscript at all stages.

465

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644 **Tables**

645 Table 1. Baseline characteristics of study subjects, total sample (n=20) and according to salt
 646 sensitivity status (n=14). Data presented as mean and SEM or absolute (relative) frequencies. P
 647 value for difference between salt-sensitive and salt-resistant subjects (Independent samples t-test,
 648 Fischer's exact test).

	Total (n=20)		Salt-sensitive (n=5)		Salt-resistant (n=9)		p
	Mean	SEM	Mean	SEM	Mean	SEM	
Age (years)	28.0	(10.5) ^{a)}	35.8	4.6	33.2	2.7	0.612
Sex							
Male	8 (40)		2 (40)		2 (22)		0.580
Female	12 (60)		3 (60)		7 (78)		
Race							
White	16 (80)		4 (80)		6 (67)		0.999
Other	4 (20)		1 (20)		3 (33)		
BMI (kg/m²)	23.9	0.7	24.7	1.9	23.7	0.7	0.633
SBP (mmHg)	121.3	3.0	125.8	9.2	118.2	4.4	0.413
DBP (mmHg)	70.4	2.1	71.9	6.3	71.2	2.9	0.913
Smoking status							
Yes	1 (5)		1 (20)		0		0.357
No	19 (95)		4 (80)		9 (100)		
Physical activity level							
Active	15 (75)		2 (40)		7 (78)		0.413
Moderately active	1 (5)		1 (20)		0		
Moderately inactive	2 (10)		1 (20)		1 (11)		
Inactive	2 (10)		1 (20)		1 (11)		

649 DBP, diastolic blood pressure; SBP, systolic blood pressure

650 a), median (interquartile range)

651

652 Table 2. Clinical characteristics of study subjects (n=14) on low- and high-salt diet (mean and
 653 SEM). P values for difference between low- and high-salt diets (Paired samples t-test).

	Low-salt diet		High-salt diet		p
	Mean	SEM	Mean	SEM	
SBP (mmHg)	113.6	2.7	115.8	3.0	0.107
DBP (mmHg)	66.9	1.4	68.6	2.2	0.261
MAP (mmHg)	82.5	1.6	84.4	2.4	0.170
PP (mmHg)	46.7	2.2	47.2	1.8	0.656
Urine sodium excretion (mmol/24 hour)	66.1	8.9	281.5	24.4	3.3 x 10 ⁻⁷
Urine potassium excretion (mmol/24 hour)	75.8	5.5	81.8	5.8	0.243

654 DBP, diastolic blood pressure; MAP, mean arterial pressure, PP, pulse pressure; SBP, systolic
 655 blood pressure

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668 Table 3. Correlation analysis between salt taste thresholds (mol/l) and mean change in BP (mmHg)
 669 from low- to high-salt diet, and salt taste thresholds (mol/l) and dietary sodium intake (mg sodium
 670 per 1000 kcal) (n=14)

	Δ SBP	Δ DBP	Δ MAP	Δ PP	Sodium intake
STDT	0.098 (0.740)	-0.377 (0.185)	-0.303 (0.293)	0.551 (0.041)	-0.016 (0.956)
STRT	0.403 (0.153)	0.209 (0.473)	0.260 (0.370)	0.039 (0.895)	-0.113 (0.700)

671 DBP, diastolic blood pressure; MAP, mean arterial pressure; PP, pulse pressure; STDT, salt taste
 672 detection threshold; STRT, salt taste recognition threshold; SBP, systolic blood pressure

673 Spearman rho (p value)

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689 **Figure legends**

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691 Figure 1. Overview of the study procedure.

692 Footnotes: ABPM, ambulatory blood pressure monitoring device; BP, blood pressure

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694 Figure 2. Systolic blood pressure (SBP), diastolic blood pressure (DBP), and mean arterial pressure
695 (MAP) change from low- to high-salt diet according to *SLC4A5* rs7571842 (a) and rs10177833 (b)
696 genotype status (n=14). Analysis conducted on the following model: major allele homozygote
697 versus heterozygote plus minor allele homozygote. Error bars represent + SEM. (Independent
698 samples t-test, *Mann-Whitney U test).

699 Footnotes: DBP, diastolic blood pressure; MAP, mean arterial pressure; SBP, systolic blood
700 pressure

701

702 Figure 3. Proportion of subjects (n=20) with low and high salt taste recognition thresholds
703 according to *SLC4A5* rs7571842 (a) and rs10177833 (b), *SCNN1B* rs239345 (c) and *TRPVI*
704 rs8065080 (d) genotype. Open bars represent low threshold and closed bars high threshold (Cochran
705 Armitage test of trend).

706

707 Figure 4. Proportion of subjects (n=20) in the different tertiles of energy adjusted sodium intake
708 according to *SLC4A5* rs7571842 (a) and rs10177833 (b), *SCNN1B* rs239345 (c) and *TRPVI*
709 rs8065080 (d) genotype. Open bars represent first tertile (< 1241 mg/1000 kcal) and closed bars
710 second + third tertile combined (\geq 1241 mg/1000 kcal) (Cochran Armitage test of trend).

711

712 Figure 5. Correlation between salt taste thresholds and discretionary salt use according to *SLC4A5*
713 rs7571842 (n=6) and *TRPVI* rs8065080 (n=10) genotypes. Adding salt while cooking/table; 1-
714 always, 2-usually, 3-sometimes, 4-rarely, 5-never (Spearman's correlation).

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