Introduction
Primary aldosteronism (PA) displays a prevalence of around 5–10% in patients with hypertension increasing up to 20% in patients with treatment-resistant hypertension [1–3]. Patients with PA have an elevated risk of cerebrovascular and cardiovascular events relative to patients with hypertension with matched cardiovascular risk profiles [4–6]. Different subtypes of PA have been defined which affect one or both adrenal glands. The main subtypes are a unilateral aldosterone-producing adenoma (APA) or bilateral adrenal hyperplasia (BAH, also called idiopathic hyperaldosteronism). Other sporadic forms include unilateral adrenal hyperplasia and the very rare occurrences of aldosterone-producing carcinoma. Hereditary forms of familial hyperaldosteronism are rare and the genetic basis of the 4 described forms of familial hyperaldosteronism (FH types I–IV) has been identified [7, 8]. A number of somatic mutations, mainly in ion channels and ATPases, have been reported which are likely to drive the aldosterone excess in the majority of APAs. Increasing interest in autoantibodies led to studies reporting a potential role for autoantibodies against the angiotensin II type 1 receptor (AT1R-Abs) in either of the two main subtypes of PA (aldosterone-producing adenoma or bilateral adrenal hyperplasia) requires clarification. In this review, we discuss the studies performed to date on AT1R-Abs in PA.

G-Protein-Coupled Receptors
The largest superfamily of receptors in the human genome are GPCRs that are located in the plasma membrane of nearly all cell types [9]. The research of Koblika and Lefkowitz about the molecular structure and function of GPCRs, especially β2-adrenergic G-protein-coupled receptors, was rewarded in 2012 by the Nobel prize in chemistry [10]. GPCRs are responsible for signal transduction to regulate numerous essential functions by mediating extracellular signals from hormones, neurotransmitters or environmental stimuli to the intracellular metabolic pathways [9]. Their structure consists of seven transmembrane-spanning helices
bound by intra- and extracellular loops [11]. On the extracellular side, GPCRs are targeted by their ligands but also by autoantibodies, which may induce agonistic receptor stimulation or inhibition dependent on the autoantibody binding site to the first and second or third extracellular loops, respectively [9].

Binding of extracellular agonists activate the receptor by initiating a conformational change that induce further signal transduction pathways [12]. Conformational changes result in the hetero-trimeric G-protein to exchange GDP for GTP at its Ga subunit [13]. The Ga subunit with GTP and the Gβγ subunit both dissociate from the receptor, resulting in the activation of specific signaling pathways such as, adenylyl cyclase (via cAMP generation) and phospholipase C (via diacylglycerol (DAG) and inositol trisphosphate (IP3) production) [13]. The Ga subunit bound to GTP hydrolyses GTP back to GDP to reassociate with the Gβγ subunit [13]. Receptor signaling determination is mediated by G-protein-coupled receptor kinases (GRK) which phosphorylate the activated receptor to bind to a distinct scaffold protein for subsequent internalization into the cells [13]. These scaffold proteins are arrestins and are known to desensitize GPCRs and induce G-protein independent signaling [14]. Following internalization the receptor is either degraded or recycled back to the plasma membrane [13]. Besides its involvement in GPCR internalization, arrestins are able to interact directly with activated GPCRs resulting in a clear conformational change that could initiate further downstream signaling pathways [13]. There is some evidence for biased agonism of GPCRs towards β-arrestin-mediated signaling [15, 16].

The angiotensin II type 1 and 2 receptors (AT1R and AT2R) are GPCRs with opposing functions in blood pressure regulation and sodium excretion [17–19]. The two subtypes share 34% sequence homology and stimulate different signaling pathways to elicit distinct and counter-regulatory biological functions [17]. AT1R is highly expressed in the fetal state although lower levels are present in the adult brain, heart, kidney and the adrenal [17]. In some diseases, AT2R is upregulated acting as an anti-inflammatory and repair factor for wound healing or after cardiac or vascular events [20, 21]. In contrast, the AT1R is widely distributed, for example, in the adrenal gland, liver, kidney, fat, brain, placenta, spleen, or thyroid, and its physiological role as a component of the renin-angiotensin-aldosterone system (RAAS) is well characterized via binding of its cognate ligand angiotensin II for blood pressure regulation, vasoconstriction, inflammatory response and vascular and cardiac hypertrophy [21].

The Discovery of Autoantibodies Against Angiotensin II Type 1 Receptor

The prevalence of autoimmune diseases in the population is around 2.5% although autoantibodies are also often present in healthy individuals [22, 23]. Impaired B cell tolerance can allow autoantibody-producing B cells with medium or low binding affinity to self-antigens to escape from elimination or further energy during B cell maturation thus becoming autoantibody-secreting plasma cells [22]. However, the pathogenic role of autoantibodies is mostly unknown.

The role of autoantibodies against the AT1R (AT1R-Abs) in hypertension has been investigated over the last decades. In 1999, Wallukat et al. described the presence of AT1R-Abs in patients with preeclampsia, which is discussed further below [24]. This discovery was extended one year later by Fu and coworkers who observed elevated AT1R-Abs levels in 33% of patients with malignant secondary hypertension, but also found increased levels of AT1R-Abs in 14% of the control group [25]. Soon afterwards, an association of AT1R-Abs and renal graft failure was observed by many research groups, especially in patients without donor-specific human leukocyte antigen (HLA)-antibodies [26–29]. Dragun et al. reported a comparable prevalence of kidney rejections associated with either AT1R-Abs (3.6%) or donor-specific HLA-antibodies (3.2%) in a cohort of 278 kidney transplantations including 119 rejections [29]. High levels of AT1R-Abs (>17 units) without additional presence of donor-specific antibodies have been ascribed to an increased risk for antibody-mediated kidney rejection [27]. Other studies reported on AT1R-Abs levels of >9 U/ml or >10 U/ml that have been shown to elevate the risk of graft loss [28, 30]. Notably, in some patients (17–47%) AT1R-Abs were already present before transplantation [26–28, 30]. A case report of Jobert et al. described a 28-year old male recipient of a well-matched renal allograft lacking anti-HLA-antibodies but with a high AT1R-Abs level of 14.1 U/ml prior transplantation who developed acute vascular rejection four days post-transplantation [31]. The authors hypothesized that the AT1R-Abs are the only factor that could have led to the allograft rejection due to the otherwise well-matched HLA-type and virus status [31]. Treatment with anti-thymocyte globulin, methylprednisolone, candesartan and plasma exchange was successful suggesting probably plasma exchange as a considerable option in patients with AT1R-Abs [31]. However, AT1R-Abs also appeared after kidney transplantation in prior AT1R-Ab-negative patients without an associated worse clinical outcome [32]. Of note is that Taniguchi et al. stressed that such studies report an association of AT1R-Abs levels and allograft failure and do not explain any causal relationship [26]. The occurrence of autoantibodies is widely distributed in transplantation medicine but also in autoimmune diseases such as Huntington, multiple sclerosis or systemic sclerosis [33, 34]. A summary of diseased states widely reported as associated with increased AT1R-Abs levels is shown in the ▶ Fig. 1.

Comparison of Different Assays for AT1R-Ab Characterization

AT1R-Abs in patient serum have been widely measured by enzyme-linked immunosorbent assays (ELISA). For such ELISAs, the target antigens are immobilized on a solid phase, mainly on a microplate to detect binding autoantibodies from serum samples [22]. As antigens serve the human full-length AT1R or peptides comprising known epitopes (AFHYEQS or ENTNIT) for AT1R-Abs in the AT1R second extracellular loop [29]. The bound autoantibodies are then either directly labelled with reporter enzymes (direct ELISA) or by a secondary labelled antibody coupled to a reporter enzyme (indirect ELISA) for quantification. Internal laboratory assays have been developed as well as commercially available kits (▶ Table 1). Piazza et al. compared in a study with patients diagnosed with APA two of the commercially available Sandwich-ELISA kits used for AT1R-Abs determination [35, 36] by CellTrend and Cusabio [37]. The results of both assays were consistent and both demonstrated higher AT1R-Abs levels in patients diagnosed with an APA compared with healthy controls [37]. In contrast, the same
CellTrend kit and a second kit from ELISA-Creative Diagnostics revealed the detection of contrasting AT1R-Ab levels depending on the assay used for patients with pre-eclampsia relative to controls [38]. This highlights the inherent drawbacks of assays based on the detection of AT1R-Ab concentrations and not AT1R bioactivity. To investigate if AT1R-Abs activate the AT1R, assays have been developed, which measure cultured spontaneously beating neonatal rat cardiomyocytes in response to immunoglobulins G (IgGs) and the perfused rat cremaster arteriole assay to measure losartan-sensitive antibody-mediated vasoconstriction [24, 39]. In vitro experiments using genetically engineered cells (for example, Chinese hamster ovary cells (CHO), or human bone osteosarcoma cells (U2OS)) stably transfected with human AT1R) to measure the functional activation of the AT1R in response to whole serum or purified IgGs have also been used [37–40]. Upon receptor activation, the transfected U2OS or CHO cells mediate chemiluminescent or fluorescent signals that can be quantitatively measured. Of note is that many cell-based assays used to quantify AT1R-Ab agonistic activity measure responses mediated by the β-arrestin signaling pathway. In addition, the production of aldosterone or increased expression of the aldosterone synthase gene (CYP11B2) in response to treatment with IgG fractions or whole serum has been measured using human adrenocortical carcinoma cell line (HAC15) [37].

**AT1R-Abs and Pre-Eclampsia**

Pre-eclampsia is the sudden appearance of hypertension in pregnant women after 20 weeks’ gestation week that is associated with increased risks of long-term hypertension, stroke, cardiovascular...
morbidity and proteinuria for the mother and uteroplacental dysfunction, preterm birth, fetal distress and fetal death for the unborn child [24, 41]. In 1999, Wallukat et al. were the first who reported the presence of AT₃R-Abs in pregnant women with preeclampsia compared to controls [24]. The purified IgG fractions from patients with preeclampsia demonstrated losartan-suppressible AT₃R stimulation and identified the amino acid sequence AFHYESQ in the secondary extracellular loop of the AT₃R as the possible binding site for these autoantibodies [24]. Peptides against the AFHYESQ epitope successfully abolished AT₃R-Ab mediated activation of the AT₃R suggesting a potential target for the treatment of patients with preeclampsia [42, 43]. Despite postpartum persisting AT₃R-Ab levels in 17 % of women with previous preeclampsia [44], the drop in AT₃R-Ab levels after giving birth and the correlation of AT₃R-Ab levels with the severity of the disease indicated a role for AT₃R-Abs in preeclampsia [24, 45]. Numerous studies subsequent-

| Table 1 | Angiotensin II type 1 receptor autoantibody measurements in primary aldosteronism. |
|---------|----------------------------------------------------------------------------------|

**ELISA**

**Indirect ELISA using immobilized AT₃R peptides of extracellular loop 2**
- Rossitto et al. 2013 [51] – AT₃R-Ab level in patients with PA (n = 46) higher than in NT (n = 45)
- AT₃R-Ab level in patients with APA (n = 26) 2-fold higher than IHA (n = 20)

**Sandwich-ELISA with full-length AT₃R**
- Sabbadin et al. 2018 [35] Human angiotensin II receptor 1 antibody, ATIIR1 Ab ELISA Kit (Cusabio, Wuhan, China)
- elevated AT₃R-Ab levels in 4 of 13 patients with PA (n = 12) compared to NT (n = 7)

**Functional AT₃R agonist measurements**

**Cell-based functional assays**
- Williams et al. 2019 [38]
  - without losartan: no group differences between APA (n = 40), BAH (n = 40), PH (n = 40), NT (n = 25)
  - with losartan: AT₃R-bioactivity of APA, PE and NT reduced in comparison to BAH

**Perfused rat cremaster arteriole assay**
- Kem et al. 2014 [39]
  - higher cremaster arteriole contractility in patients with PA (n = 3) than NT which could be inhibited by losartan

**CYP11B2-mRNA expression in HAC15 cells**
- Piazza et al. 2019 [37]
  - purified IgG from patients with an APA (n = 10) induced a 40 % increase in CYP11B2-mRNA expression
ly supported the findings of Wallukat et al. with reports of AT, R-Abs in pregnant women with pre-eclampsia [43, 46, 47]. Diverse studies have reported a role for AT, R-Abs in pre-eclampsia in mediating intracellular Ca2+ release [43], induction of nicotinamide adenine dinucleotide phosphate (NADPH) oxidase and reactive oxygen species (ROS) production leading to the activation of the transcription factor nuclear factor Kappa B (NFκB) activation [46] and initiation of vasoconstriction [47], all of which were inhibited by losartan. Further in vivo experiments ascribed a causative role for AT, R-Abs in the development of pre-eclampsia. Zhou et al. infused pregnant mice with human total IgG or affinity purified AT, R-Abs which resulted in the characteristic symptoms of pre-eclampsia including proteinuria, hypertension and abnormal appearance of the placenta [42]. In addition, Wenzel et al. injected angiotensin II, purified rabbit AT, R-Abs or both in pregnant rats which induced a phenotype resembling pre-eclampsia when a combination of both, angiotensin II and purified AT, R-Abs were applied [48]. In contrast to the aforementioned findings, in a population of Mexican-Mestizo women diagnosed with pre-eclampsia no AT, R-Abs were found [49]. Despite an apparently clear role for AT, R-Abs in pre-eclampsia, a recent retrospective analysis of 485 women with pre-eclampsia concluded that AT, R-Abs levels alone are not sufficient to predict hypertension in such patients, and additional risk factors for hypertension should be considered [50].

### AT, R-Abs in Primary Aldosteronism

Recently, AT, R-Abs were also detected in patients diagnosed with PA suggesting a possible role of AT, R activation in aldosterone production in some patients. Rossetto et al. described for the first time AT, R-Abs in patients with PA which was subsequently reported by other research groups [39, 40, 51]. In this study, the AT, R-Abs levels of serum from 46 patients with PA (26 APA, 20 BAH) as well as 62 patients with primary hypertension (PH) was measured by an indirect ELISA assay using an immobilized peptide of the second extracellular loop of AT, R. Thirteen pregnant women with preeclampsia and 45 normotensive control patients (NT) were used as positive and negative controls, respectively. Patients with PA and PH showed significantly higher AT, R-Ab levels than NT, with higher levels in patients with PA than in PH [51]. In 92.3 % of patients with APA, AT, R-Abs were detected comprising a concentration 2-fold higher than of patients diagnosed with BAH or PH, despite comparable blood pressure levels (Table 1) [51]. Interestingly, the AT, R-Ab levels of patients with APA and women with pre-eclampsia were similar (3.43 ± 1.20 vs. 3.66 ± 1.79) [51]. Another indirect ELISA using the peptide AFHYESQ located in the extracellular loop 2 was performed in the studies of Kem et al. and Li et al. [39, 40]. Kem et al. described elevated AT, R-Ab levels in 4 of 13 patients with PA (31 %) while the latter study focused on the subtypes of PA and measured elevated AT, R-Ab levels in 42 % of BAH, 23 % of APA and 7 % of NT which contradicts the initial findings of the same group [40].

Using a commercially available ELISA kit with full-length AT, R as antigen, Sabbadin et al. found higher AT, R-Ab levels in patients with PA compared with healthy controls which is in accordance with previous findings [35]. However, the authors could not distinguish patients with APA (n = 15) and BAH (n = 29) [35]. In contrast, a larger study comprising a cohort of 80 patients with PA (40 APA, 40 BAH), 40 with PH, 23 with pre-eclampsia and 25 NT observed equal levels of AT, R-Abs in all groups except for patients with pre-eclampsia using two different commercial available ELISA kits (Table 1) [38]. Using the same CellTrend ELISA kit, Piazza et al. described higher AT, R-Ab levels in patients with APA (n = 27) compared to healthy controls (n = 7) [37]. Overall, it is clear that these studies using ELISA-based assays have yielded highly contrasting results.

AT, R-Abs levels pre- and post-adrenalectomy were investigated in 14 patients with APA [37] who were biochemically cured following surgery according to the PASO criteria [52]. The authors found no significant decrease in AT, R-Ab levels at one month after adrenalectomy indicating that the resected adrenal was not the source of antigens stimulating the immune response [37].

When summarizing the results of AT, R-Ab quantification by ELISA it can be stated that there is a high variability in the AT, R-Ab levels of patients with PA with studies reporting contrasting AT, R-Ab levels for the different subtypes of PA [39, 51]. Of note is that elevated AT, R-Ab levels were also described in healthy individuals without initiating subsequent AT, R activation [40]. Furthermore, Kem et al. found for instance more frequently elevated AT, R-bioactivity in patients with PA by a cell-based assay using AT, R-transfected CHO cells than autoantibodies were quantified by ELISA which is in agreement with a second study from the same group [39, 40]. The authors hypothesized that the use of a linear peptide for the secondary extracellular loop instead of full-length AT, R could miss other potential binding sites for the autoantibodies in ELISA [39]. This is supported by the findings of multiple binding sites for IgG on the AT, R [53] and the recommendations to avoid using immobilized peptides in ELISA for GPCR-autoantibody detection [54]. However, using the full-length AT, R does not guarantee the functional activity of the captured autoantibodies which can be demonstrated in cell-based-functional assays using whole serum and/or purified IgG [38–40].

The rat cremaster arteriole assay or AT, R-transfected CHO cells both demonstrated elevated receptor activation when exposed to serum of patients with PA compared to controls, which was largely normalized by the AT, R-blockers losartan or candesartan [39]. Similarly, candesartan was able to reduce AT, R-Ab-stimulated aldosterone production in vitro in HAC15 cells [39]. AT, R-activity is more frequently observed in patients diagnosed with BAH (75 %) compared to APA patients (46 %), while serum of NT induced no AT, R-bioactivity [40]. However, one research group failed to measure AT, R-bioactivity in patients with APA and controls using this assay which might be due to the lack of activating function of the autoantibodies [37]. AT, R-transfected U2OS cells also showed no group differences when incubated with serum of patients with APA, BAH or pre-eclampsia or NT in the absence of losartan [38]. Notably, the administration of losartan only barely reduced AT, R-activation in the BAH group in comparison to APA, pre-eclampsia and NT indicating a losartan-independent activation pathway of the receptor [38]. Purified IgGs also caused an increase in AT, R-bioactivity in the BAH compared to APA group, independent of losartan [38]. This can be explained by different binding sites for IgG and losartan at the AT, R while angiotensin II and losartan share a common binding site on the AT, R [53].

Autoantibody levels were not correlated with age, gender, BMI, blood pressure, baseline aldosterone and aldosterone-to-renin ratio (ARR) [35, 51]. Mineralocorticoid receptor antagonist (MRA) treatment of patients with PA was also not associated with AT, R-
Ab levels [35]. Agonistic AT$_1$R-Abs displayed vasoconstrictive effects and correlate with the mean arterial pressure [39, 40]. The previously mentioned elevated agonistic activity of AT$_1$R-Abs in patients diagnosed with BAH and the higher responsiveness to angiotensin II in those patients [55] suggest an allosteric function of the autoantibodies which promotes the binding angiotensin II to its receptor. This is supported by the reduction of aldosterone levels after captopril-challenge in AT$_1$R-Ab-positive compared with AT$_1$R-Ab-negative patients with hypertension or PA [51]. In addition, treatment of HAC15 cells with angiotensin II and affinity-purified IgGs increased aldosterone production compared with angiotensin II treatment alone [39].

As previously indicated, upon activation, the AT$_1$R can initiate two distinct independent signaling pathways. More prominent is the G-protein signaling pathway in which PIP$_2$ is cleaved to DAG and IP$_3$ resulting in increased intracellular Ca$^{2+}$ and aldosterone production [15]. Secondly, biased signaling mediated by β-arrestin1 is independent of G-proteins and may occur in parallel to the G-protein signaling pathway [15]. Aldosterone production appears to be stimulated via extracellular signal-regulated kinase (ERK)-mediated activation of steroidogenic acute regulatory protein (StAR) to promote transfer of cholesterol to mitochondria [15]. When AT$_1$Rs are activated by angiotensin II, both pathways appear to be initiated [15]. This has been demonstrated in vivo in rats with overexpression of β-arrestin1, which showed suppressed aldosterone production only through the administration of candesartan or valsartan and not by losartan or irbesartan despite belonging to the same pharmacological class [56, 57].

In conclusion, some evidence supports a pathological role for autoantibodies against the AT$_1$R in different diseases. It has not been established if AT$_1$R-Abs play a causative role or are a consequence of the pathology. Further studies are warranted to address the functional relevance of AT$_1$R-Abs in PA and the significance of AT$_1$R biased signaling.

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**Conflict of Interest**

The authors declare that they have no conflict of interest.

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