Phenotypic and pharmacogenetic evaluation of patients with thiazide-induced hyponatremia

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Introduction

Cardiovascular disease is the leading cause of mortality worldwide (1, 2) and hypertension one of its most important modifiable causes. Thiazide diuretics inhibit the thiazide-sensitive sodium chloride cotransporter NCC in the distal convoluted tubule (DCT) of the kidney (3) and are among the most widely used class of medicines in the management of hypertension (4).

However, some patients given thiazides develop thiazide-induced hyponatremia (TIH) (5). Severe TIH (serum sodium <125 mM) causes debilitating symptoms (5) and is the most common form of drug-induced hyponatremia requiring hospital admission (6). The mechanism of TIH is poorly understood. Serum sodium concentration in the thiazide-treated general population is virtually unchanged by thiazide therapy (7), implying that TIH occurs in a susceptible subgroup, but that this subgroup cannot be prospectively identified, and so TIH is largely unpredictable at the point of thiazide initiation. Pharmacogenetic predisposition to a range of adverse drug effects (8–14) raises the possibility that TIH might also have genetic causation. This hypothesis is supported by the highly reproducible nature of TIH even on single-dose rechallenge in individuals for whom environmental factors are controlled (15–17). We therefore set out to study the phenotypic and genetic characteristics of 2 cohorts of patients admitted to the hospital with severe symptomatic TIH in the United Kingdom.

Results

Characteristics of cohort 1 and cohort 2 TIH cases and controls

Two cohorts of patients of mixed European descent who were hospitalized with symptomatic TIH were recruited (Figure 1, Methods, and Supplemental Methods; supplemental material available online with this article; https://doi.org/10.1172/JCI89812DS1). The characteristics of the TIH cases and controls from cohorts 1 and 2 are presented in Table 1. In both cohorts, hyponatremic TIH cases on thiazides were typically aged over 70 years, with a predominance of females (Table 1).

Phenotypic differences between hyponatremic TIH cases on thiazides and nonthiazide THI cases

Cohort 1 hyponatremic TIH cases on thiazides had lower serum potassium compared with cohort 1 normonatremic thiazide controls (Supplemental Table 2). In cohort 2, hyponatremic TIH cases...
Thiazide-Induced Hyponatraemia study recruitment

**Cohort 1 (2002-2003)**
- 48 Hyponatremic TIH cases on thiazides
  - Na"^+" < 130 mM clinically due to thiazide
- 80 Normonatremic thiazide controls
  - Na"^+" 135-145 mM, taking a thiazide
  - Blood for DNA only
  - Clinical blood and urine results recorded

**Cohort 2 (2012-2015)**
- 109 Hyponatremic TIH cases on thiazides
  - Na"^+" ≤ 130 mM clinically due to thiazide
- 106 Normonatremic thiazide controls
  - Na"^+" 135-145 mM, taking a thiazide
  - Blood for DNA and extended phenotyping
  - 24 h urine collection

**TIH cases display an exaggerated increase in free water reabsorption**
Cohort 2 TIH cases reabsorbed 48% more free water when on thiazides compared with when off thiazides, which is in marked contrast with cohort 2 controls, who showed only a 9% increase in free water reabsorption while on thiazide (Supplemental Table 3). This suggests that TIH cases display an exaggerated increase in free water reabsorption in response to thiazide exposure. All groups in cohort 2 were in a state of net free water reabsorption (Supplemental Table 3). Although solute-free water reabsorption was lower in cohort 2 hyponatremic TIH cases on thiazides than in cohort 2 normonatremic thiazide controls, continued water reabsorption and production of a concentrated urine by hyponatremic TIH cases on thiazides is clearly inappropriate in the context of profound hyponatremia and intravascular volume expansion (as assessed by increased fractional urate clearance).

**Increased fractional uric acid clearance in TIH suggests volume expansion**
Increased fractional renal excretion of uric acid is observed in the syndrome of inappropriate antidiuretic hormone secretion (SIADH) and is caused by arterial blood volume expansion (18, 19). Mean serum and urinary uric acid concentration in cohort 2 were in a state of net free water reabsorption (Supplemental Table 3). Although solute-free water reabsorption was lower in cohort 2 hyponatremic TIH cases on thiazide than in cohort 2 normonatremic thiazide controls, continued water reabsorption and production of a concentrated urine by hyponatremic TIH cases on thiazides is clearly inappropriate in the context of profound hyponatremia and intravascular volume expansion (as assessed by increased fractional urate clearance).

**Evaluating the baseline physiology of TIH cases after thiazide withdrawal**
Serum abnormalities resolved following thiazide cessation with the exception of levels of chloride and zinc (Supplemental Table 2). Although hyperchloremia and hypozincemia improved following thiazide cessation, cohort 2 normonatremic case remained hyperchloremic and hypozincemic 2 months after stopping thiazide therapy (Supplemental Table 2).
In our GWAS data set, rs4854769, the intronic sentinel SNP within SLCO2A1 showed association with TIH at $P = 3.92 \times 10^{-6}$ (odds ratio [OR] = 2.58). Targeted resequencing of SLCO2A1 in cohort 1 TIH cases and cohort 1 controls confirmed the presence of the nonsynonymous variant encoding p.A396T (rs34550074) in complete linkage disequilibrium ($r^2 = 1$) with the sentinel GWAS SNP rs4854769. Association with rs34550074 between cohort 1 cases and the carefully phenotyped normonatremic cohort 1 controls on thiazide was observed at $P = 0.0005$ (OR = 3.3; Bonferroni’s corrected threshold with $\alpha = 0.05 = 0.0017$; Supplemental Table 7).

The minor allele frequency (MAF) of rs34550074 in cohort 1 TIH cases was 0.35 (54% of TIH cases in cohort 1 carry at least 1 copy of the variant allele) compared with 0.14 in cohort 1 controls (25% carry at least 1 copy of the variant allele) and 0.18 in HAPMAP_CEU. The total burden of rare protein-altering variants in other genes prioritized by the GWAS did not differ significantly between cohort 1 cases and controls after correcting for multiple testing (Supplemental Table 8). SLCO2A1 was nominally associated by the c$\alpha$ test ($P = 0.0019$), driven by the association with p.A396T. Sanger sequencing also confirmed the presence of rs34550074 in cohort 1 hyponatremic TIH cases on thiazides (Supplemental Figure 5).

TIH cases off thiazides (Figure 2B). Although plasma ADH concentration increased in TIH cases after thiazide cessation and resolution of hyponatremia, ADH remained lower in normonatremic TIH cases off thiazide than in normonatremic nonthiazide controls.

### Results of genetic studies

GWAS. We undertook a GWAS using the cohort 1 cases and controls from the 1958 British birth cohort. Given the limited number of cases available in cohort 1, we used a predefined cutoff for signals of interest showing suggestive association of $P < 10^{-5}$. After quality control filters were applied (see Methods), 502,663 SNPs from 48 cohort 1 hyponatremic cases on thiazides and 2,905 controls remained for association testing. The genomic inflation factor ($\lambda = 1.007$) and the resultant quantile-quantile (QQ) plot (Supplemental Figure 2) were not indicative of inflation of test statistics due to population substructure. In total, 17 SNPs within 14 regions were identified as showing suggestive association with TIH ($P < 10^{-5}$) (Supplemental Figures 3 and 4 and Supplemental Table 6). Of these, we chose SLCO2A1 for performing additional studies, given its potential role in altered prostaglandin transport and regulation of water reabsorption in the kidney.

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The total burden of rare protein-altering variants in other genes prioritized by the GWAS did not differ significantly between cohort 1 cases and controls after correcting for multiple testing (Supplemental Table 8). SLCO2A1 was nominally associated by the c-$\alpha$ test ($P = 0.0019$), driven by the association with p.A396T. Sanger sequencing also confirmed the presence of rs34550074 in cohort 1 hyponatremic TIH cases on thiazides (Supplemental Figure 5).

### Table 1. Demographic and medical details of TIH patients and controls in cohorts 1 and 2

| Clinical characteristic | Cohort 1 | Cohort 2 |
|-------------------------|----------|----------|
|                         | Hyponatremic TIH cases on thiazides | Normonatremic thiazide controls | Hyponatremic TIH cases on thiazides | Normonatremic TIH cases off thiazides | Normonatremic thiazide controls | Normonatremic nonthiazide controls |
| Number                  | 48       | 80       | 109      | 109      | 106      | 60       |
| Age, yr (±SD)           | 76 ± 9   | 75 ± 10  | 80 ± 9   | 80 ± 9   | 72 ± 8   | 70 ± 14  |
| Female (%)              | 54       | 68       | 70       | 70       | 69       | 52       |
| ACEi (%)                | 21       | 29       | 51       | 39       | 30*      | 33       |
| ARB (%)                 | 6        | 5        | 16       | 12       | 25       | 22       |
| Beta blocker (%)        | 35       | 19       | 32       | 28       | 23       | 30       |
| CCB (%)                 | 19       | 29       | 41       | 38       | 39       | 37       |
| Loop diuretic (%)       | –        | –        | 6        | 16       | 2        | 13       |
| K$^+$-sparing diuretic (%) | 6     | 2.5      | 4        | 3        | 4        | 7        |
| SSRI (%)                | 6        | 4        | 10       | 6        | 0*       | 7        |
| Low-dose aspirin (%)    | 27       | 34       | 30       | 34       | 19       | 17       |
| NSAID (%)               | 6        | 5        | 3        | 3        | 12       | 7        |

**Comorbidities**

| Treated hypothyroidism (%) | 4 | 4 | 6 | 6 | 6 | 8 |
| Diabetes mellitus, glucose < 13.9 mM (%) | 15 | 16 | 17 | 17 | 16 | 14 |
| Mild LV impairment (%)     | 2 | 3 | 0 | 0 | 0 | 2 |
| eGFR 30–60 ml/min (%)      | 15 | 16 | 19 | 19 | 20 | 18 |

**Thiazide type**

| BFZ (%) | 73 | 94* |
| Chlortalidone (%) | 15 | 1 |
| Indapamide (%)    | 4 | – |
| HCTZ (%)          | 6 | 4 |
| Clopenthiazide(%)  | 2 | 1 |

All patients were of mixed European descent. ACEi, angiotensin-converting enzyme inhibitor; ARB, angiotensin II receptor blocker; CCB, calcium channel blocker; SSRI, selective serotonin reuptake inhibitor; BFZ, bendroflumethiazide; HCTZ, hydrochlorothiazide. Comparisons are by 1-way ANOVA/χ$^2$ with Bonferroni’s correction. *Cohort 2 hyponatremic TIH cases on thiazides versus cohort 2 normonatremic thiazide controls, $P < 0.05$. **Cohort 1 hyponatremic TIH cases on thiazides versus cohort 1 normonatremic thiazide controls, $P < 0.05$. Treated hypothyroidism (no clinical features of hypothyroidism and TSH within normal range), diabetes mellitus (plasma glucose < 13.9 mM), mild left ventricular (LV) impairment (no clinical features of heart failure and ECHO mild left ventricular impairment). eGFR, estimated glomerular filtration rate.
positive in the medulla, colocalizing with AQP1 and AQP2. Strong staining was detected in the proximal straight tubule, with comparatively weaker labeling of outer medullary collecting ducts and no PGT expression in the thick ascending limb loop of Henle (Figure 3 and Supplemental Figure 6, E–I). Expression of PGT increased as it transitioned into the inner medullary collecting ducts, with faint staining of the thin limb loop of Henle detectable only at higher laser/detector settings (Figure 3 and Supplemental Figure 6, J–M).

Species conservation of rs34550074 is shown in Supplemental Table 10. The tissue expression of genes near GWAS loci is shown in Supplemental Table 11.

Urinary prostaglandin E2 and PGE2 metabolite concentrations are increased in TIH
Mean prostaglandin E2 (PGE2) and PGE2 metabolite (PGE2M) concentrations from 24-hour urine samples were significantly higher in cohort 2 hyponatremic TIH cases on thiazide compared with Replication of association between SLCO2A1 p.A396T and TIH
The MAF for rs34550074 in cohort 2 TIH cases on thiazide was 0.26 (45% carried at least 1 copy of the variant allele) and 0.18 in normonatremic thiazide controls (test of association: \( P = 0.0304, \) OR = 1.70) (Supplemental Table 9). When data were combined across both cohorts, the pooled effect estimate for the association between rs34550074 and severe TIH was OR = 2.13 (\( P = 1.70 \times 10^{-4} \), Supplemental Table 9).

Prostaglandin transporter is expressed in the collecting duct of human cadaveric kidneys and colocalizes with AQP2
SLCO2A1 is principally expressed in the kidneys, adrenal glands, and lungs. Similarly to the renal cortex of the rat, human glomeruli and renal capillaries stained positive for prostaglandin transporter (PGT) (the protein product of \( \text{SLCO2A1} \)) (Figure 3 and Supplemental Figure 6, A and B) (20). Cortical tubules were primarily negative for PGT (Figure 3 and Supplemental Figure 6, C–E). PGT stained positive in the medulla, colocalizing with AQP1 and AQP2. Strong staining was detected in the proximal straight tubule, with comparatively weaker labeling of outer medullary collecting ducts and no PGT expression in the thick ascending limb loop of Henle (Figure 3 and Supplemental Figure 6, E–I). Expression of PGT increased as it transitioned into the inner medullary collecting ducts, with faint staining of the thin limb loop of Henle detectable only at higher laser/detector settings (Figure 3 and Supplemental Figure 6, J–M).

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Urinary prostaglandin E\(_2\) and PGE\(_2\) metabolite concentrations are increased in TIH
Mean prostaglandin E\(_2\) (PGE\(_2\)) and PGE\(_2\) metabolite (PGE\(_2\)M) concentrations from 24-hour urine samples were significantly higher in cohort 2 hyponatremic TIH cases on thiazide compared with

Figure 2. Phenotypic characteristics of TIH cases and controls and in vitro activity of SLCO2A1 (PGT) site mutants. (A) Fractional renal uric acid clearance in patients in cohort 2 TIH cases and controls. Fractional uric acid clearance is increased in hyponatremic TIH cases on thiazides compared with controls, suggesting volume expansion. \( n = 20 \) in each group. (B) Plasma ADH concentration in cohort 2 TIH cases and controls. ADH is lower in hyponatremic TIH cases on thiazides compared with controls. \( n = 20 \) in each group. (C) and (D) Urinary PGE\(_2\) and PGE\(_2\)M concentration in cohort 2 TIH cases by SLCO2A1 p.396 allele. p.396T, \( n = 22, \) p.396A, \( n = 25 \), (E) Rate of \( ^{3}H\)-PGE\(_2\) uptake (fmol PGE\(_2\)/mg protein/10 min) by human SLCO2A1 expressed transiently in HEK293 cells. Data are presented as ratio of \( ^{3}H\)-PGE\(_2\) uptake (396T/396A, left, \( n = 5 \) paired experiments, 396T = 37.8 ± 8.1, 396A = 33.5 ± 4.0, \( P = 0.44 \); r396E/396A, right, \( n = 3 \) paired experiments, 396A = 35.7 ± 6.2, 396E = 23.1 ± 4.6, \( P = 0.02 \). Data are represented as mean ± SEM. \(* P < 0.05; ** P < 0.01; *** P < 0.001. \) Comparisons in A–D were determined by 1-way ANOVA with Bonferroni’s correction. Comparison in E was determined by 2-tailed Student’s \( t \) test. Ucr, urinary creatinine; Ctrl, control.
cohort 2 normonatremic thiazide controls (Supplemental Figure 7) and normalized after thiazide cessation. Analysis of urinary prostaglandin concentration by SLCO2A1 p.A396T status in cohort 2 demonstrated that TIH cases who carry at least 1 variant allele have significantly elevated urinary PGE₂ and PGE₂M concentrations relative to those homozygous for A396 (Figure 2, C and D). No such effect was observed in cohort 2 normonatremic thiazide controls.

**In vitro assessment of SLCO2A1 396 Ala/Thr/Glu variants**

Figure 2E shows functional assays of PGE₂ transport rate by 396Thr compared with that of 396Ala. The ratio of transport was not significantly different from 1. Because urinary PGE₂ levels were higher in 396Thr compared with 396Ala subjects (Figure 2, C and D), we hypothesized that 396Thr may be subject to regulation by phosphorylation. Accordingly, we substituted Glu for Thr, since the charge and size will mimic phospho-Thr and recapitulate physiological effects of phosphorylation at a regulatory site. Figure 2E shows that the 396Glu moiety had a transport rate of 65% compared with 396Ala, suggesting that the 396Thr variant may result in reduced PGT function relative to 396Ala.

**Discussion**

TIH remains a substantial clinical problem: population-based studies suggest that as many as 9% of subjects taking a thiazide may develop hyponatremia. Here, we report the largest and most detailed phenotypic description of TIH patients to date. In addition, we suggest a possible mechanism that may underlie TIH in some patients.
Systematic review of existing data suggests that TIH affects an older and predominantly female demographic with low serum osmolality, and limited spot urine testing suggests inappropriately concentrated urine and saliuresis (21). Our study supported this and also demonstrated a phenotype resembling SIADH, with low plasma osmolarity, inappropriately concentrated urine, more than minimal urinary sodium excretion, and normal thyroid function, but with low or normal ADH levels. Moreover, the phenotype of TIH also involved severe hypochloridemia, mild hyperglycemia, and intravascular volume expansion. Hypochloridemia and hypozotic abnormalities that far outlast any kinetic or dynamic effect of thiazide medications, raising the possibility that such features might be present at baseline before thiazide commencement. So how does one reconcile suppressed ADH with elevated PGE, and intravascular volume expansion? And how might a reduction in SLCO2A1 activity cause TIH? SLCO2A1 is expressed at the apical membrane of the renal collecting duct, where it scavenges newly synthesized PGE, away from luminal EP receptors (22, 23). Activation of these apical EP receptors increases the water permeability of this nephron segment 10- to 15-fold, even in the absence of ADH (24, 25). Thus, reduced activity of collecting duct apical SLCO2A1 would be predicted to increase hydraulic conductivity of the collecting duct, even in the absence of ADH (Figure 4). Although urinary osmolality in the TIH subjects was 15% higher than in control subjects (Supplemental Table 3) (probably as a result of increased renal medullary PGE, ref. 26), which would mitigate water reabsorption, the proportionally larger increase in collecting duct water permeability observed would more than offset the slight reduction in osmotic driving force.

Although the putative effects of SLCO2A1 inactivation appear to be compensated under normal conditions, they are made manifest when the patients are given a thiazide diuretic. Thiazides reduce the ability of the late diluting segment (DCT) to generate solute-free water directly and also act by reducing effective vascular volume and thus solute delivery from the end-proximal tubule (27). We suggest therefore that, in individuals carrying the SLCO2A1 A396T variant, the combination of thiazide-specific
effects on free water generation and the increase in collecting duct water permeability from reduced SLCO2A1 activity combine to produce TIH (Figure 4).

**Methods**

**Clinical recruitment.** Two cohorts of patients of mixed European descent hospitalized with symptomatic TIH were recruited (Figure 1 and Supplemental Methods). Cohort 1 comprised 48 hyponatremic TIH cases on thiazides (serum sodium < 130 mM) recruited during their acute admission to Nottingham University Hospitals NHS Trust and matched healthy normonatremic thiazide controls from primary care. Cohort 2 comprised a further 109 hyponatremic TIH cases on thiazides recruited during their acute admission to the same hospital together with 2 matched control groups from primary care (cohort 2 normonatremic thiazide controls and cohort 2 normonatremic nonthiazide controls). Cohort 2 TIH cases were also assessed 2 months after thiazide cessation (termed cohort 2 nonthiazide TIH cases off thiazides).

**GWAS.** A GWAS was performed using 48 cohort 1 TIH cases genotyped using the Illumina Omni1Quad array and 2,922 general population controls from the British 1958 birth cohort (28), genotyped using the Illumina 1.2M chip. Controls were all aged 44 to 45 years at the time of DNA collection (2002 to 2004) and 48% were female. Following quality control of the genotype data (Supplemental Methods), 502,663 SNPs that were genotyped in both cases and controls remained for association testing. A case-control association analysis was undertaken using a logistic regression model, with adjustment for 10 principal components and assuming an additive genetic model, using Plink v 1.07.

**Resequencing and replication studies.** 101 samples (48 cohort 1 hyponatremic TIH cases on thiazides and 53 cohort 1 normonatremic thiazide controls) underwent resequencing of the genes nearest to SNPs that were associated with TIH at \( P < 10^{-5} \), followed by association testing (Supplemental Table 7 and Supplemental Methods). Next Generation sequencing data were deposited at the European Nucleotide Archive (ENA accession number PRJEB21924; http://www.ebi.ac.uk/ena). Replication for one SNP of interest identified in the sequencing analysis of cohort 1 (rs34550074, p.A396T) was undertaken using Sanger sequencing in the second cohort of TIH cases and controls (Supplemental Methods). Rare variant association was carried out using Plink/Seq (29). Rare variants were assessed using the burden test, which is a collapsing allelic sum test using adaptive permutation to derive an empirical \( P \) value. Combined rare and common variants were also assessed using the c-u test (30), also implemented in Plink/Seq.

**Kidney immunofluorescence.** Formalin-fixed paraffin-embedded human tissue sections were obtained from the Cambridge Human Research Tissue Bank. After antibody labeling, confocal imaging was performed (Supplemental Methods).

In vitro functional studies of SLCO2A1 p.A396T. Human SLCO2A1 cDNA (encoding PGT) was modified by site-directed mutagenesis using standard methods so as to generate cDNAs encoding amino acids Ala, Thr, or Glu at position 396. DNA sequences were confirmed by direct sequencing. Human embryonic kidney (HEK) cells were transiently transfected with one of the 3 cDNAs, and the timed uptake of \(^3\)H-PGE\(_2\) was assayed as described previously (26).

**Statistics.** Significance between groups was assessed using a 2-tailed Student’s \( t \) test. Where comparisons between more than 2 groups were undertaken, 1-way ANOVA and Bonferroni’s post hoc test were used. The data were analyzed using Graph Pad Prism V6.05. \( P < 0.05 \) was considered significant. Statistical methods used for GWAS and resequencing experiments are contained within the relevant Methods and Supplemental Methods sections.

**Study approval.** This study was conducted in line with the standards of ICH/Good Clinical Practice sections 8.2.8 and was given approval by the Queen’s Medical Centre Ethics Committee (cohort 1; reference GM030208) and the UK National Research Ethics Committee (cohort 2; reference 11/EM/0233). Written informed consent was received from participants prior to inclusion in the study.

**Author contributions**

JSW, SC, LVW, SKC, VEJ, EE, RL, KS, WJ, NS, APH, and MG performed experiments and analyzed data. SK, MJ, JC, and MG recruited patients. KMO, VLS, MDT, IPH, and MG designed the study. All authors contributed to the drafting and revision of the manuscript, which was led by MG and IPH.

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1. National Institute for Health and Care Excellence (NICE). Hypertension in adults: diagnosis and management. https://www.nice.org.uk/guidance/gg127. Accessed June 19, 2017.
2. Global Strategy on Diet, Physical Activity and Health. World Health Organization Web site. http://www.who.int/dietphysicalactivity/en/. Accessed June 19, 2017.
3. Glover M, Mercier Zubar A, O’Shaughnessy KM. Hypertension, dietary salt intake, and the role of the thiazide-sensitive sodium chloride transporter NCCT. *Cardiovasc Ther.* 2011;29(1):68–76.
4. Freis ED, Wanko A, Wilson IM, Parrish AE. Treatment of essential hypertension with chlorothiazide (diuril): Its use alone and combined with other antihypertensive agents. *J Am Med Assoc.* 1958;166(2):137–140.
5. Glover M, Clayton J. Thiazide-induced hyponatraemia: epidemiology and clues to pathogenesis. *Cardiovasc Ther.* 2012;30(5):e219–e226.
6. Clayton JA, Le Jeune IR, Hall iP. Severe hyponatraemia in medical in-patients: aetiology, assessment and outcome. *QJM.* 2006;99(8):505–511.
7. Clayton JA, Rodgers S, Blakey J, Averly A, Hall IP. Thiazide diuretic prescription and electrolyte abnormalities in primary care. *Br J Clin Pharmacol.* 2006;61(1):87–95.
8. The SEARCH Collaborative Group. SLCO1B1 variants and statin-induced-myopathy—a genomewide study. *N Engl J Med.* 2008;359(8):789–799.
9. Singer JB, Lewitzky S, Leroy EL, et al. A genome-
wide study identifies HLA alleles associated with lumicarcinorib-related liver injury. Nat Genet. 2010;42(8):711–716.
10. Hautekeete ML, et al. HLA association of amoxicillin-clavulanate--induced hepatitis. Gastroenterology. 1999;117(5):1181–1186.
11. O’Donohue J, et al. Co-amoxiclav jaundice: clinical and histological features and HLA class II association. Gut. 2000;47(5):717–720.
12. Chung WH, et al. Medical genetics: a marker for Stevens-Johnson syndrome. Nature. 2004;428(6982):486.
13. Mallal S, et al. Association between presence of HLA-B*5701, HLA-DR7, and HLA-DQ3 and hypersensitivity to HIV-1 reverse-transcriptase inhibitor abacavir. Lancet. 2002;359(9308):727–732.
14. Kindmark A, Jawaid A, Harbron CG, et al. Genome-wide pharmacogenetic investigation of a hepatic adverse event without clinical signs of immunopathology suggests an underlying immune pathogenesis. Pharmacogenomics J. 2010;8(3):186–195.
15. Fuisz RE, Lauler DP, Cohen P. Diuretic-induced hyponatraemia and sustained antidiuresis. Am J Med. 1962;33:783–791.
16. Friedman E, Shadel M, Halkin H, Farfel Z. Thiazide-induced hyponatraemia. Reproducibility by single dose rechallenge and an analysis of pathogenesis. Ann Intern Med. 1989;110(1):24–30.
17. Frenkel NJ, Vogt L, De Roosij SE, et al. Thiazide-induced hyponatraemia is associated with increased water intake and impaired urea-mediated water excretion at low plasma antiuretic hormone and urine aquaporin-2. J Hypertens. 2015;33(3):627–633.
18. Fenske W, Stork S, Koschker AC, et al. Value of Fractional Uric Acid Excretion in Differential Diagnosis of Hypoatremic Patients on Diuretics. J Clin Endocrinol Metab. 2008;93(8):2991–2997.
19. Sonnenblick M, Rosin AJ. Significance of the measurement of uric acid fractional clearance in diuretic induced hyponatremia. Postgrad Med J. 1986;62(728):449–452.
20. Kanazawa K, Lu R, Satriano JA, Bao Y, Wolkoff AW, Schuster VL. Identification and characterization of a prostaglandin transporter. Science. 1995;268(5212):866–869.
21. Barber J, et al. A systematic review and meta-analysis of thiazide-induced hyponatraemia: time to reconsider electrolyte monitoring regimens after thiazide initiation? Br J Clin Pharmacol. 2015;79(4):566–577.
22. Nomura T, Chang HY, Lu R, Hainkin J, Murphy RC, Schuster VL. Prostaglandin Signaling in the Renal Collecting Duct: release, reuptake, and oxidation in the same cell. J Biol Chem. 2005;280(31):28424–28429.
23. Bao Y, Pucci ML, Chan BS, Lu R, Ito S, Schuster VL. Prostaglandin transporter PGT is expressed in cell types that synthesize and release prostanooids. Am J Physiol Renal Physiol. 2002;282(6 Pt 2):F1103–F1110.
24. Ando Y, Asano Y. Luminal prostaglandin E2 modulates sodium and water transport in rabbit cortical collecting ducts. Am J Physiol. 1995;268(6 Pt 2):F257–F265.
25. Sakairi Y, Jacobson HR, Noland TD, Breyer MD. Luminal prostaglandin E receptors regulate salt and water transport in rabbit cortical collecting duct. Am J Physiol. 1995;269(2 Pt 2):F257–F265.
26. Pucci ML, et al. Coordinate control of prostaglandin E2 synthesis and uptake by hyperosmolality in renal medullary interstitial cells. Am J Physiol Renal Physiol. 2006;290(3):F641–F649.
27. Chi Y, Pucci ML, Schuster VL. Dietary salt induces transcription of the prostaglandin transporter gene in renal collecting ducts. Am J Physiol Renal Physiol. 2008;295(3):F765–F771.
28. Power C, Elliott J. Cohort profile: 1958 British birth cohort (National Child Development Study). Int J Epidemiol. 2006;35(1):34–41.
29. PLINK/SEQ. The Analytic and Translational Genetics Unit. https://atgu.mgh.harvard.edu/plinkseq/. Accessed June 19, 2017.
30. Neale BM, et al. Testing for an unusual distribution of rare variants. PLoS Genet. 2011;7(3):e1001322.