Heart failure (HF) is a common, lethal, disabling, and expensive disorder. Its prevalence in industrialized nations has reached epidemic proportions and continues to rise. Despite significant therapeutic advances, the prognosis for patients who are admitted to the hospital with HF remains poor, with a 5-year mortality of ≈50%, which is worse than heart failure (HF) is a common, lethal, disabling, and expensive disorder. Its prevalence in industrialized nations has reached epidemic proportions and continues to rise. Despite significant therapeutic advances, the prognosis for patients who are admitted to the hospital with HF remains poor, with a 5-year mortality of ≈50%, which is worse than
that for patients with breast or colon cancer. In the United States, HF affects ≈6 million persons, kills >300,000 people per year, and is directly responsible for >$40 billion in healthcare expenditures. 2

Although current therapeutic approaches to HF improve symptoms and prolong life, they are palliative in the sense that they do not address the fundamental problem of the loss of cardiac tissue. It is for this reason that stem cells have sparked intense interest. Stem cell–based therapies have the potential to dramatically transform the treatment and prognosis of HF by achieving what would have been unthinkable only a few years ago—myocardial regeneration. For the first time since cardiac transplantation, the goal is not damage control but damage elimination, that is, removal of the underlying cause of HF. It is the curative potential of this new therapy that explains why translational efforts have proceeded at lightning speed (Figure 1). The first study of bone marrow cells in experimental myocardial infarction (MI) was published in 2001; within a year, this therapy had been applied in patients. 4 In the setting of HF, it took only 3 years from the first use of stem cells (skeletal myoblasts) in an animal model to the first use of these cells in humans. 6 Few ideas in medicine have been translated from the experimental laboratory to the clinical arena faster than the use of stem cells in heart disease.

During the past 15 years, numerous preclinical and clinical studies have been performed that support the ability of various stem cell populations to improve cardiac function and attenuate adverse left ventricular (LV) remodeling in both ischemic and nonischemic cardiomyopathy. Despite this rapid progress, however, many fundamental issues remain to be resolved and, to date, no cell therapy has been conclusively shown to be effective in patients with HF. The purpose of this article is to critically review the large body of work performed with respect to the use of stem/progenitor cells in HF, both at the experimental and clinical levels, and to discuss current controversies, unresolved issues, challenges, and future directions. This review focuses specifically on chronic HF; studies of stem cells in acute MI, refractory angina, and other conditions not relevant to chronic HF are not discussed.

**Stem Cell Types Investigated Heretofore in HF**

Stem cells are undifferentiated, self-renewing cells that possess a multilineage differentiation potential. As illustrated in Figure 2, various types of stem cells have been considered for the treatment of HF. The preclinical and clinical studies that have assessed the use of stem cells in chronic HF are summarized in Tables 1 and 2, respectively.

**Embryonic Stem Cells**

Embryonic stem cells (ESCs) are pluripotent cells harvested from the inner cell mass of preimplantation-stage blastocysts. 60 When cultured as 3-dimensional cystic aggregates (embryoid bodies), both mouse and human ESCs have the capacity to differentiate into cells of all 3 germ layers, namely, ectoderm, endoderm, and mesoderm (including cardiomyocytes). 70,71 Human ESC–derived cardiomyocytes, which can be isolated from embryoid bodies by either mechanical dissection or enzymatic methods, 72 exhibit adult cardiomyocyte morphology with properly organized sarcomeric proteins and express cardiac-specific transcription factors such as NK2 homeobox 5 (Nkx2.5), GATA binding protein 4 (GATA-4), myocyte-specific enhancer factor 2C (MEF2C). 73 Also, they display spontaneous beating activity with characteristic atrial, ventricular, and nodal action potentials. 74,75 The strong cardiogenic potential of ESCs and the availability of human ESC–derived cardiomyocytes have motivated research into their effects in HF. In the only study of these cells performed in a large animal model to date, Ménard et al 76 reported that cardiac-committed mouse ESCs, transplanted into infarcted sheep myocardium, differentiated into cardiomyocytes and improved LV function. Similarly, using human ESC–derived cardiomyocytes, Caspi et al 77 and Cai et al 78 reported formation of stable cardiomyocyte grafts, attenuation of LV remodeling, and improvement in LV systolic function in rat models of old MI (although in the latter study, 78 they caused formation of teratomas).

Despite the well-documented capacity of ESCs for cardiac differentiation, both ethical and biological concerns have prevented their use as a treatment modality in patients.

<table>
<thead>
<tr>
<th>Nonstandard Abbreviations and Acronyms</th>
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<tbody>
<tr>
<td>BM-MNC</td>
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<td>CABG</td>
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<td>CDC</td>
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<td>CSC</td>
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<td>ECM</td>
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<td>ESC</td>
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<td>iPSC</td>
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<td>LVEF</td>
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<td>MI</td>
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<td>MMP</td>
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<td>MSC</td>
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<td>NYHA</td>
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</table>

Figure 1. Use of various types of stem cell therapies in patients with cardiovascular disease. Illustrated is the number of patients treated with 6 major types of cells from 2000 (when the first cell therapy for heart disease was performed) to 2012.
Specifically, because of their pluripotency and allogeneic nature, adoptive transfer of ESCs is plagued by teratoma formation\textsuperscript{69,79} and graft rejection,\textsuperscript{79,2} formidable problems that essentially preclude the clinical use of these cells. In contemporary clinical research, the margin of tolerance for such catastrophic effects as tumor formation is zero and, no matter how much the probability of tumors is reduced by various ESC manipulations,\textsuperscript{80–82} it is unlikely that it will be completely eliminated. One teratoma would be sufficient to halt clinical investigation of ESCs for years. However, the recent emergence of induced pluripotent stem cells (iPSCs), which have pluripotency comparable with ESCs, has provided an alternative that obviates one of the 2 major problems inherent in ESC-based therapies, graft rejection.

For ESCs, the chasm between promises made and results delivered has been striking. Since the late 1990s,\textsuperscript{69} these cells have been enthusiastically heralded as a major breakthrough in medicine that will usher in unprecedented opportunities for the treatment of human disease.\textsuperscript{83–87} Despite these claims, however, no clinical trial of ESCs in cardiovascular disease has been performed or even initiated nor, to the best of our knowledge, is any such trial even being planned. During the same time frame, adult stem cells have been used safely in thousands of patients, with results that were sufficiently encouraging to warrant phase II and phase III trials. Clearly, the expectations raised by the advocates of ESCs have not been met. This sobering realization, coupled with the problems of tumorigenesis and rejection, makes it unlikely that enthusiasm for the therapeutic use of ESCs will continue unabated.

The most reasonable interpretation of current knowledge is that ESC-based therapies have no future in terms of clinical application, at least in the next few years, and will probably become obsolete, a thing of the past, which will be remembered as an unfulfilled promise.

Induced Pluripotent Stem Cells

In 2006, Takahashi and Yamanaka\textsuperscript{88} produced a population of iPSCs by transducing mouse adult fibroblasts with defined transcription factors (octamer-binding transcription factor 3/4 [OCT3/4], sex determining region Y-box 2 [Sox-2], c-Myc, Kruppel-like factor 4 [Klf4]; the Yamanaka factors). These iPSCs express ESC surface markers and exhibit morphology and growth properties similar to those of ESCs.\textsuperscript{88} It was subsequently demonstrated that the cardiogenic potential of iPSCs is very similar to that of ESCs, and that iPSC-derived cardiomyocytes possess functional properties typical of cardiac cells, such as spontaneous beating, contractility, and ion channel expression.\textsuperscript{89} However, to date, no study has specifically assessed the therapeutic potential of iPSCs in animal models of HF.

Although iPSCs hold great promise for cardiac regeneration, the transcription factors used to generate these cells (c-Myc, Oct4, and Kruppel-like factor 4) are known oncogenes that can produce teratomas. Newer methods that involve transient expression of the reprogramming factors may obviate this problem,\textsuperscript{90,91} but the pluripotent nature of these cells may still promote tumorigenesis.\textsuperscript{92} Other problems include the low efficiency of iPSC generation and the variability from one cell line to another.\textsuperscript{93} Given the rapidly evolving technology in this field, it is possible that these technical hurdles will soon be overcome, and that iPSC-based approaches will prove to be helpful for the therapy of HF; at present, however, iPSCs are not ready for clinical application.

Skeletal Myoblasts

Skeletal myoblasts are derived from satellite cells, a skeletal muscle progenitor cell population present under the basal membrane of myofibers. With muscle injury, these satellite cells undergo proliferation and promote regeneration by differentiating into myotubes and new muscle fibers.\textsuperscript{94,95} Because of their ease of procurement from muscle biopsies, rapidity
Table 1. Animal Studies of Stem Cell Therapy in Heart Failure

<table>
<thead>
<tr>
<th>Study</th>
<th>Host</th>
<th>Type of Heart Failure</th>
<th>Time of Cell Therapy</th>
<th>Dose and Route of Administration</th>
<th>Follow-Up Period After Cell Therapy</th>
<th>Outcomes</th>
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<tr>
<td><strong>Skeletal myoblasts</strong></td>
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<tr>
<td>Suzuki et al&lt;sup&gt;7&lt;/sup&gt;</td>
<td>Lewis rat</td>
<td>Doxorubicin-induced cardiomyopathy</td>
<td>4 wk after last doxorubicin dose</td>
<td>1×10&lt;sup&gt;6&lt;/sup&gt; cells, intracoronary</td>
<td>4 wk</td>
<td>↓ Mortality Improved hemodynamic parameters</td>
</tr>
<tr>
<td>Ghodiste et al&lt;sup&gt;8&lt;/sup&gt;</td>
<td>Sheep</td>
<td>Embolization using absorbable hemostatic gauze</td>
<td>14 d after MI</td>
<td>50,000 cells, intramyocardial</td>
<td>12 mo</td>
<td>↑ LVEF ↓ LVEDV Improved global wall motion score</td>
</tr>
<tr>
<td>Pouly et al&lt;sup&gt;9&lt;/sup&gt;</td>
<td>CHF147 Syrian hamster</td>
<td>β-sarcoglycan deficiency-induced dilated cardiomyopathy</td>
<td>...</td>
<td>5×10&lt;sup&gt;6&lt;/sup&gt; cells, intramyocardial</td>
<td>4 wk</td>
<td>↑ FAC ↓ Fibrosis</td>
</tr>
<tr>
<td>Chachques et al&lt;sup&gt;10&lt;/sup&gt;</td>
<td>Sheep</td>
<td>Permanent coronary occlusion</td>
<td>3 wk after MI</td>
<td>70×10&lt;sup&gt;6&lt;/sup&gt; cells, intramyocardial</td>
<td>3 mo</td>
<td>↑ LVEF</td>
</tr>
<tr>
<td>He et al&lt;sup&gt;11&lt;/sup&gt;</td>
<td>Dog</td>
<td>Coronary microembolization</td>
<td>After hemodynamic confirmation of establishment of heart failure</td>
<td>270 to 830×10&lt;sup&gt;6&lt;/sup&gt; cells, intramyocardial</td>
<td>10 wk</td>
<td>↑ LVEF ↓ LV remodeling Improved hemodynamic parameters</td>
</tr>
<tr>
<td>Gavira et al&lt;sup&gt;12&lt;/sup&gt;</td>
<td>Gottingen mini-pig</td>
<td>Vascular embolization in the intermediate branch of first or second marginal artery</td>
<td>8 wk after MI</td>
<td>407.55±115×10&lt;sup&gt;6&lt;/sup&gt;, intramyocardial or intracoronary</td>
<td>3 mo</td>
<td>↑ LVEF ↓ Fibrosis ↑ Vasculogenesis</td>
</tr>
<tr>
<td>Farahmand et al&lt;sup&gt;13&lt;/sup&gt;</td>
<td>Lewis rat</td>
<td>Permanent coronary occlusion</td>
<td>Either 5 d after MI or 30 d after MI</td>
<td>5×10&lt;sup&gt;6&lt;/sup&gt; cells, intramyocardial</td>
<td>30 d</td>
<td>↑ LVFS ↓ LV remodeling Improved hemodynamic parameters Attenuated matrix remodeling</td>
</tr>
<tr>
<td>Fukushima et al&lt;sup&gt;14&lt;/sup&gt;</td>
<td>Sprague-Dawley rat</td>
<td>Permanent coronary occlusion</td>
<td>3 wk after MI</td>
<td>5×10&lt;sup&gt;6&lt;/sup&gt; cells, intramyocardial or intracoronary</td>
<td>84 d</td>
<td>↑ LVEF Improved physical activity ↔ Mortality</td>
</tr>
<tr>
<td><strong>Bone marrow mononuclear cells</strong></td>
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<tr>
<td>Tomita et al&lt;sup&gt;15&lt;/sup&gt;</td>
<td>Sprague-Dawley rat</td>
<td>Cryosurgery</td>
<td>3 wk after surgery</td>
<td>1×10&lt;sup&gt;6&lt;/sup&gt; cells, intramyocardial</td>
<td>3 wk</td>
<td>Improved hemodynamic parameters ↓ LV remodeling ↑ Angiogenesis Cardiac differentiation +</td>
</tr>
<tr>
<td>Bel et al&lt;sup&gt;16&lt;/sup&gt;</td>
<td>Sheep</td>
<td>Ligation of circumflex artery</td>
<td>3 wk after MI</td>
<td>422×10&lt;sup&gt;6&lt;/sup&gt; cells, intramyocardial</td>
<td>2 mo</td>
<td>↔ LVEF ↔ LV remodeling No differentiation into endothelial cells or cardiomyocytes</td>
</tr>
<tr>
<td>Waksman et al&lt;sup&gt;17&lt;/sup&gt;</td>
<td>Pig</td>
<td>Permanent coronary occlusion</td>
<td>4 wk after MI</td>
<td>24×10&lt;sup&gt;6&lt;/sup&gt; cells, intramyocardial</td>
<td>4 wk</td>
<td>↔ Global wall motion score ↓ Infarct size ↑ Angiogenesis</td>
</tr>
<tr>
<td><strong>Bone marrow– and adipose-derived mesenchymal cells</strong></td>
<td></td>
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<tr>
<td>Nagaya et al&lt;sup&gt;18&lt;/sup&gt; (bone marrow MSCs)</td>
<td>Lewis rat</td>
<td>Myosin-induced autoimmune myocarditis</td>
<td>5 wk after immunization</td>
<td>5×10&lt;sup&gt;6&lt;/sup&gt; cells, intramyocardial</td>
<td>4 wk</td>
<td>Improved hemodynamic parameters ↑ Angiogenesis Cardiac differentiation + ↓ Fibrosis</td>
</tr>
<tr>
<td>Silva et al&lt;sup&gt;19&lt;/sup&gt; (bone marrow MSCs)</td>
<td>Dog</td>
<td>Ameroid-induced chronic coronary occlusion</td>
<td>30 d after MI</td>
<td>100×10&lt;sup&gt;6&lt;/sup&gt; cells, intramyocardial</td>
<td>30 d</td>
<td>↑ LVEF Neovascularization +</td>
</tr>
<tr>
<td>Miyahe et al&lt;sup&gt;20&lt;/sup&gt; (adipose-derived MSCs)</td>
<td>Sprague-Dawley rat</td>
<td>Permanent coronary occlusion</td>
<td>4 wk after MI</td>
<td>5–8×10&lt;sup&gt;6&lt;/sup&gt; cells as monolayered grafts into myocardium</td>
<td>4 wk</td>
<td>↓ Mortality Improved hemodynamic parameters Cardiac regeneration +</td>
</tr>
</tbody>
</table>

(Continued)
of expansion in vitro, and resistance to hypoxic and ischemic conditions. Skeletal myoblasts were the first cells to be tested both in preclinical and clinical studies of HF. However, myoblasts transplanted in injured hearts have been found to form skeletal (striated) muscle fibers rather than cardiac muscle fibers.

### Table 1. Continued

<table>
<thead>
<tr>
<th>Study</th>
<th>Host</th>
<th>Type of Heart Failure</th>
<th>Time of Cell Therapy</th>
<th>Dose and Route of Administration</th>
<th>Follow-Up Period After Cell Therapy</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Liu et al21 (bone marrow MSCs)</td>
<td>Sprague-Dawley rat</td>
<td>Permanent coronary occlusion</td>
<td>4 wk after MI</td>
<td>1×10⁶ cells, intramyocardial</td>
<td>4 wk</td>
<td>↓ Infarct size; ↓ LV remodeling; ↑ LVEF; ↓ Fibrosis; Cardiac differentiation; ↑ Angiogenesis</td>
</tr>
<tr>
<td>Mazo et al22 (adipose-derived MSCs)</td>
<td>Sprague-Dawley rat</td>
<td>Permanent coronary occlusion</td>
<td>5 wk after MI</td>
<td>1×10⁶ cells, intramyocardial</td>
<td>3 mo</td>
<td>↑ LVEF; Improved tissue metabolism; ↓ Infarct size; ↓ Fibrosis; Neovascularization +</td>
</tr>
<tr>
<td>Li et al23 (bone marrow MSCs)</td>
<td>Wistar rat</td>
<td>Isoproterenol-induced heart failure</td>
<td>4 wk after injection</td>
<td>3×10⁶ cells, intramyocardial</td>
<td>4 wk</td>
<td>↑ LVEF; Fibrosis</td>
</tr>
<tr>
<td>Schuleri et al24 (bone marrow MSCs)</td>
<td>Gottingen pig</td>
<td>Ischemia/reperfusion injury</td>
<td>12 wk after MI</td>
<td>20×10⁶ to 200×10⁶ cells, intramyocardial</td>
<td>24 wk</td>
<td>High dose: ↑ LVEF; Infarct size; Both high and low dose: ↑ Regional contractility and myocardial blood flow</td>
</tr>
<tr>
<td>Mazo et al25 (bone marrow MSCs)</td>
<td>Sprague-Dawley rat</td>
<td>Permanent coronary occlusion</td>
<td>4 wk after MI</td>
<td>1×10⁶ cells, intramyocardial</td>
<td>4 wk</td>
<td>↑ LVEF; Fibrosis; ↑ Angiogenesis</td>
</tr>
<tr>
<td>Rota et al26 (c-kit+ cells)</td>
<td>Fischer 344 rat</td>
<td>Permanent coronary occlusion</td>
<td>20 d after MI</td>
<td>40,000 cells, intramyocardial</td>
<td>2 wk</td>
<td>↑ LVEF; Attenuated matrix remodeling</td>
</tr>
<tr>
<td>Johnston et al27 (CDCs)</td>
<td>Mini-pig</td>
<td>Permanent coronary occlusion</td>
<td>4 wk after MI</td>
<td>10×10⁶ cells, intracoronary</td>
<td>8 wk</td>
<td>↓ Infarct size; Improved hemodynamic parameters; ↔ LVEDV; ↓ LV remodeling; Cardiac regeneration +</td>
</tr>
<tr>
<td>Tang et al28 (c-kit+ cells)</td>
<td>Fischer 344 rat</td>
<td>Ischemia/reperfusion injury</td>
<td>30 d after MI</td>
<td>40,000 cells, intracoronary</td>
<td>35 d</td>
<td>↑ LVEF; Improved hemodynamic parameters; Attenuated matrix remodeling; ↓ Fibrosis; ↓ LV remodeling; Cardiac regeneration +</td>
</tr>
<tr>
<td>Lee et al29 (cardiospheres)</td>
<td>Mini-pig</td>
<td>Permanent coronary occlusion</td>
<td>4 wk after MI</td>
<td>1×10⁶ cells, intracoronary</td>
<td>8 wk</td>
<td>↑ LVEF; ↓ LV remodeling</td>
</tr>
<tr>
<td>Bolli et al30 (c-kit+ cells)</td>
<td>Pig</td>
<td>Ischemia/reperfusion injury</td>
<td>90 d after MI</td>
<td>500,000 cells, intracoronary</td>
<td>31 d</td>
<td>↑ LVEF; Improved hemodynamic parameters; ↓ Fibrosis; ↓ LV remodeling; Cardiac regeneration; ↑ Angiogenesis</td>
</tr>
</tbody>
</table>

↑ indicates increased; ↓, decreased; ↔, no change; CDC, cardiosphere-derived cell; FAC, fractional area change; LV, left ventricular; LVEDV, LV end-diastolic volume; LVEF, LV ejection fraction; LVFS, LV fractional shortening; MI, myocardial infarction; and MSC, mesenchymal stem cell.
Table 2. Clinical Trials of Stem Cell Therapy in Heart Failure

<table>
<thead>
<tr>
<th>Study Name of the Trial</th>
<th>Study Design</th>
<th>No. of Patients</th>
<th>Delivery Method</th>
<th>Cell Dose</th>
<th>End Point Evaluation Method</th>
<th>Follow-Up Period</th>
<th>Outcomes</th>
<th>Side Effects in Cell-Treated Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Skeletal myoblasts</strong></td>
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<tr>
<td>Menasche et al31</td>
<td>Nonrandomized, uncontrolled study</td>
<td>Cell treatment=10; no controls</td>
<td>Intramyocardial injection during CABG</td>
<td>871×10⁶ cells</td>
<td>Echocardiography</td>
<td>10.9 mo</td>
<td>↑ LVEF, ↑ Regional wall motion, ↓ NYHA class</td>
<td>Ventricular arrhythmias in 4/10 patients, 2 deaths</td>
</tr>
<tr>
<td>Smits et al32</td>
<td>Nonrandomized, uncontrolled pilot study</td>
<td>Cell treatment=5; no controls</td>
<td>Intramyocardial (transendocardial)</td>
<td>196±105×10⁶ cells</td>
<td>MRI, LV angiography, nuclear radiography, echocardiography</td>
<td>3 to 6 mo</td>
<td>↑ Wall thickening, ↑ LVEF, ↑ Regional wall motion at 3 mo but not at 6 mo</td>
<td>Ventricular arrhythmias in 1/5 patients</td>
</tr>
<tr>
<td>Herreros et al33</td>
<td>Nonrandomized, uncontrolled study</td>
<td>Cell treatment=12; no controls</td>
<td>Intramyocardial injection during CABG</td>
<td>221×10⁶</td>
<td>Echocardiography, PET scan</td>
<td>3 mo</td>
<td>↑ LVEF, ↑ Myocardial contractility and tissue viability, ↑ Regional wall motion</td>
<td>No major complications reported</td>
</tr>
<tr>
<td>Siminiak et al34</td>
<td>Nonrandomized, uncontrolled study</td>
<td>Cell treatment=10; no controls</td>
<td>Intramyocardial injection during CABG</td>
<td>4×10⁹ cells</td>
<td>Echocardiography</td>
<td>12 mo</td>
<td>↑ Contractility, ↑ LVEF, ↑ Regional wall motion</td>
<td>Ventricular arrhythmias in 4/10 patients, 1 death</td>
</tr>
<tr>
<td>Ince et al35</td>
<td>Nonrandomized, case-controlled study</td>
<td>Cell treatment=6; controls=6</td>
<td>Intramyocardial (transendocardial)</td>
<td>210±150×10⁶ cells</td>
<td>Echocardiography</td>
<td>12 mo</td>
<td>↑ LVEF, ↑ Walking distance, ↓ NYHA class</td>
<td>Two patients developed early ventricular arrhythmias, which was not sustained</td>
</tr>
<tr>
<td>Siminiak et al36 (POZNAN)</td>
<td>Nonrandomized, uncontrolled study</td>
<td>Cell treatment=10; no controls</td>
<td>Percutaneous transcoronary-venous</td>
<td>100×10⁶ cells</td>
<td>Echocardiography</td>
<td>6 mo</td>
<td>↓ NYHA class, ↑ LVEF</td>
<td>No major complications reported</td>
</tr>
<tr>
<td>Dib et al37</td>
<td>Nonrandomized, uncontrolled study</td>
<td>Cell treatment=30; no controls</td>
<td>Intramyocardial injection during CABG (24 patients) and LVAD (6 patients)</td>
<td>CABG group: 10, 30, 100, 300×10⁶ cells; LVAD group: 300×10⁶ cells</td>
<td>Echocardiography, PET scan</td>
<td>24 mo</td>
<td>↑ LVEF, ↑ Regional wall motion, ↑ Viability, ↓ LVEF, ↓ LVESV and LVEDV, ↓ NYHA class</td>
<td>CABG group: Ventricular arrhythmias in 4/24 patients, 1 death and 1 MI; LVAD group: Ventricular arrhythmias in 2/6 patients, 3 deaths</td>
</tr>
<tr>
<td>Biagini et al38</td>
<td>Nonrandomized, uncontrolled study</td>
<td>Cell treatment=10; no controls</td>
<td>Intramyocardial (transendocardial)</td>
<td>15×10⁶ cells</td>
<td>Echocardiography</td>
<td>12 mo</td>
<td>↑ LVEF, ↓ LVESV, ↓ NYHA class</td>
<td>No major complications reported</td>
</tr>
<tr>
<td>Hagège et al39</td>
<td>Cohort study</td>
<td>Cell treatment=9; no controls</td>
<td>Intramyocardial injection during CABG</td>
<td>62 to 1100×10⁶ (871×10⁶) cells</td>
<td>Echocardiography</td>
<td>18–58 (49.4) months</td>
<td>↑ LVEF, ↓ NYHA class</td>
<td>Ventricular arrhythmias in 5/9 patients</td>
</tr>
<tr>
<td>Gavira et al40</td>
<td>Nonrandomized, controlled study</td>
<td>Cell treatment=12; controls=14</td>
<td>Intramyocardial injection during CABG</td>
<td>50×10⁶ cells</td>
<td>Echocardiography, PET scan</td>
<td>12 mo</td>
<td>↑ LVF, ↑ Perfusion and viability, ↑ Regional contractility</td>
<td>No major complications reported</td>
</tr>
<tr>
<td>Veitman et al41</td>
<td>Nonrandomized, controlled study</td>
<td>Cell treatment=14; controls=28</td>
<td>Intramyocardial (transendocardial)</td>
<td>3 to 50×10⁶ cells</td>
<td>Echocardiography</td>
<td>4 y</td>
<td>↔ LVEF, ↔ Myocardial performance index</td>
<td>Ventricular arrhythmias in 7 cell-treated patients, 3 and 11 deaths in cell-treated and control groups, respectively. (Continued)</td>
</tr>
<tr>
<td>Study/Name of the Trial</td>
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<td>Side Effects in Cell-Treated Patients</td>
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<tr>
<td>Menasché et al50 (MAGIC)</td>
<td>Randomized, placebo-controlled, double-blind study</td>
<td>Cell treatment=97 (low dose: 33 patients, high dose: 34 patients); controls=30</td>
<td>Intramyocardial injection during CABG</td>
<td>Low dose: 400×10⁶ High dose: 800×10⁶ cells</td>
<td>Echocardiography</td>
<td>6 mo</td>
<td>↔ LVEF, ↓ Regional wall motion</td>
<td>Low dose: 4 patients with ventricular arrhythmias and 5 deaths</td>
</tr>
<tr>
<td>Dib et al43 (CAUSMIC)</td>
<td>Randomized, placebo-controlled, double-blind study</td>
<td>Cell treatment=12; controls=11</td>
<td>Intramyocardial (transendocardial)</td>
<td>Three patients' dose group, receiving 30, 100, 300, or 600×10⁶ cells</td>
<td>Echocardiography</td>
<td>12 mo</td>
<td>↔ NYHA class, ↓ LV dimension, ↑ LVEF, ↑ Regional wall motion, ↑ Viability</td>
<td>Ventricular arrhythmias in 6/12 patients</td>
</tr>
<tr>
<td>Duckers et al44 (SEISMIC)</td>
<td>Prospective, randomized, open-label study</td>
<td>Cell treatment=26; controls=14</td>
<td>Intramyocardial (transendocardial)</td>
<td>150 to 800×10⁶ cells</td>
<td>MUGA scan</td>
<td>6 mo</td>
<td>↔ LVEF, ↓ 6MWD, ↓ NYHA class</td>
<td>Ventricular arrhythmias in 12/26 patients, 1 death</td>
</tr>
<tr>
<td>Povsic et al45</td>
<td>Randomized, double-blind, controlled study</td>
<td>Cell treatment=15; controls=8</td>
<td>Intramyocardial (transendocardial)</td>
<td>Low dose: 400×10⁶ High dose: 800×10⁶ cells</td>
<td>Doubutamine stress echocardiography, MUGA scan</td>
<td>6 mo</td>
<td>↑ 6MWD</td>
<td>Ventricular arrhythmias in 7/15 cell-treated patients</td>
</tr>
<tr>
<td>Bone marrow mononuclear cells</td>
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<tr>
<td>Perin et al46</td>
<td>Prospective, nonrandomized, open-label study</td>
<td>Cell treatment=14; controls=7</td>
<td>Intramyocardial (transendocardial)</td>
<td>25.6±6.3×10⁶ cells</td>
<td>Echocardiography, SPECT</td>
<td>2 and 4 mo</td>
<td>2 mo: ↓ NYHA class, ↓ CCSAS, ↑ LVEF, ↓ LVESV and LVEDV, 4 mo: ↑ LVEF, ↓ LVESV and LVEDV</td>
<td>One sudden cardiac death in cell-treated group</td>
</tr>
<tr>
<td>Perin et al47</td>
<td>Prospective, nonrandomized, open-label study</td>
<td>Cell treatment=11; controls=9</td>
<td>Intramyocardial (transendocardial)</td>
<td>25.6±6.3×10⁶ cells</td>
<td>Echocardiography, SPECT</td>
<td>6 and 12 mo</td>
<td>↑ Exercise capacity, ↑ Perfusion, ↔ LVEF</td>
<td>No major complications reported</td>
</tr>
<tr>
<td>Galiñanes et al48</td>
<td>Nonrandomized, uncontrolled study</td>
<td>Cell treatment=14; no controls</td>
<td>Intramyocardial injection during CABG</td>
<td>CD34+ (31.5±3.5×10⁶) and CD117+ (0.61±0.1×10⁶) cells</td>
<td>Doubutamine stress echocardiography</td>
<td>6 wk and 10 mo</td>
<td>↑ LVEF, improved wall motion score</td>
<td>No major complications reported</td>
</tr>
<tr>
<td>Blatt et al49</td>
<td>Nonrandomized, uncontrolled study</td>
<td>Cell treatment=6; no controls</td>
<td>Intracoronary</td>
<td>16.7×10⁶ cells</td>
<td>Doubutamine stress echocardiography</td>
<td>4 mo</td>
<td>↓ NYHA class, improved wall motion score</td>
<td>No major complications reported</td>
</tr>
<tr>
<td>Assmus et al50 (TOPCARE-CHD)</td>
<td>Randomized, controlled study</td>
<td>Cell treatment=52 (28 patients BMCs, 24 patients circulating progenitor cells); controls=23</td>
<td>Intracoronary</td>
<td>BMCs: 205±110×10⁶ Circulating progenitor cells: 22±11×10⁶ cells</td>
<td>Echocardiography, SPECT, MRI</td>
<td>3 mo</td>
<td>↑ LVEF (BMCs only), ↓ NYHA class (BMCs only)</td>
<td>One episode of ventricular arrhythmia and 5 deaths in circulating progenitor cell group</td>
</tr>
<tr>
<td>Hendrikkx et al51</td>
<td>Randomized, controlled trial</td>
<td>Cell treatment=10; controls=10</td>
<td>Intramyocardial injection during CABG</td>
<td>60±31×10⁶ cells</td>
<td>MRI</td>
<td>4 mo</td>
<td>↔ LVEF, ↑ Systolic thickening, ↓ NYHA class and LVESV</td>
<td>No major complications reported</td>
</tr>
</tbody>
</table>

(Continued)
Table 2.  Continued

<table>
<thead>
<tr>
<th>Study/Name of the Trial</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Gao et al52</td>
<td>Nonrandomized, controlled study</td>
<td>Cell treatment=14; controls=14</td>
<td>Intracoronary</td>
<td>28 to 32 ×10^6 cells</td>
<td>Echocardiography</td>
<td>3 mo</td>
<td>↑ LVEF ↓ LVESV</td>
<td>No major complications reported</td>
</tr>
<tr>
<td>Seth et al53</td>
<td>Pilot study</td>
<td>Cell treatment=24; controls=120</td>
<td>Intracoronary</td>
<td>120×10^6 cells</td>
<td>Echocardiography</td>
<td>3 mo</td>
<td>↑ LVEF ↓ LVESV ↓ NYHA class</td>
<td>No major complications reported</td>
</tr>
<tr>
<td>Beeres et al54</td>
<td>Nonrandomized, uncontrolled study</td>
<td>Cell treatment=15; no controls</td>
<td>Intramyocardial (transendocardial)</td>
<td>94±14×10^6 cells</td>
<td>SPECT</td>
<td>3 mo</td>
<td>↑ LVEF ↑ Perfusion ↑ Regional wall motion</td>
<td>One death due to heart failure</td>
</tr>
<tr>
<td>Yao et al55</td>
<td>Randomized, placebo-controlled trial</td>
<td>Cell treatment=24; controls=23</td>
<td>Intracoronary</td>
<td>12×10^6 cells</td>
<td>Echocardiography, MRI, SPECT</td>
<td>6 mo</td>
<td>↔ LVEF ↔ LVEDV and LVESV ↔ Perfusion ↔ Infarct size</td>
<td>No major complications reported</td>
</tr>
<tr>
<td>Ang et al56</td>
<td>Randomized, controlled, single-blinded trial</td>
<td>Cell treatment=42 (21 intramyocardial, 21 intracoronary); controls=23</td>
<td>Intramyocardial injection during CABG or intracoronary</td>
<td>Intramyocardial: 84±56×10^6 BMCs and 142±166×10^6 CD34+/CD177+ cells Intracoronary: 115±73×10^6 BMCs and 245±254×10^3 CD34+/CD177+ cells</td>
<td>Echocardiography, MRI</td>
<td>6 mo</td>
<td>↔ LVEF ↔ LVEDV and LVESV ↔ Infarct wall motion ↔ Infarct size</td>
<td>No major complications reported</td>
</tr>
<tr>
<td>Diederichsen et al57</td>
<td>Nonrandomized, uncontrolled study</td>
<td>Cell treatment=32; no controls</td>
<td>Repeated intracoronary</td>
<td>First infusion: 647±382×10^6 cells Second infusion: 889±361×10^6 cells</td>
<td>Echocardiography</td>
<td>12 mo</td>
<td>↑ LVEF improved LV filling</td>
<td>No major complications reported</td>
</tr>
<tr>
<td>Perin et al58 (FOCUS-HF)</td>
<td>Randomized, double-blind, controlled study</td>
<td>Cell treatment=20; controls=10</td>
<td>Intramyocardial (transendocardial)</td>
<td>30×10^6 cells</td>
<td>Echocardiography, SPECT</td>
<td>6 mo</td>
<td>↔ LVEF ↓ CCSAS ↑ Perfusion</td>
<td>No major complications reported</td>
</tr>
<tr>
<td>Hare et al59 (POSEIDON)</td>
<td>Randomized pilot Study</td>
<td>Cell treatment=31; no controls</td>
<td>Intramyocardial (transendocardial)</td>
<td>Three different doses: 20, 100, 200×10^6</td>
<td>Computed tomography</td>
<td>12 mo</td>
<td>↔ LVEF Improved physical performance ↓ LVEDV</td>
<td>One patient in each group was hospitalized for HF</td>
</tr>
<tr>
<td>Patel et al60</td>
<td>Randomized, controlled study</td>
<td>Cell treatment=10; controls=10</td>
<td>Intramyocardial injection during CABG</td>
<td>22×10^6 cells</td>
<td>Echocardiography, SPECT</td>
<td>6 mo</td>
<td>↑ LVEF</td>
<td>No major complications reported</td>
</tr>
<tr>
<td>Manginas et al61</td>
<td>Pilot, controlled study</td>
<td>Cell treatment=12; controls=12</td>
<td>Intracoronary</td>
<td>CD133+; 16.9±4.9×10^6 cells CD133-/CD34+; 8.4×10^5 cells</td>
<td>Echocardiography</td>
<td>28±8.7 mo</td>
<td>↑ LVEF LV remodeling ↓ LVESV and LVEDV ↑ Perfusion</td>
<td>One patient developed restenosis at the cell delivery site</td>
</tr>
<tr>
<td>Stamm et al62</td>
<td>Nonrandomized, controlled study</td>
<td>Cell treatment=20; controls=20</td>
<td>Intramyocardial injection during CABG</td>
<td>5.8×10^5 cells</td>
<td>Echocardiography, SPECT</td>
<td>6 mo</td>
<td>↑ LVEF ↑ Perfusion</td>
<td>No major complications reported</td>
</tr>
<tr>
<td>Fischer-Rasokat et al63</td>
<td>Pilot study</td>
<td>Cell treatment=33; no controls</td>
<td>Intracoronary</td>
<td>259±135×10^6 cells</td>
<td>MRI, LV angiography</td>
<td>3 mo, 12 mo</td>
<td>↑ LVEF improved regional wall motion</td>
<td>No major complications reported</td>
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(Continued)
The ability of skeletal myoblasts to promote cardiac repair has been evaluated in small \(^{13,34}\) and large \(^{8,10-12,98}\) animal models of HF. Both after intramyocardial and intracoronary administration, these cells have been shown to differentiate into myotubes and form viable skeletal muscle-like grafts in the scarred myocardium, which was associated with attenuation of adverse ventricular remodeling, decreased interstitial fibrosis, and improvement of cardiac performance. \(^{13,99,100}\) The reduction in fibrosis has been ascribed to correction of the imbalance between matrix metalloproteinases (MMPs) and tissue inhibitors of MMPs. \(^{101}\) The ability of skeletal myoblasts to improve cardiac function has also been shown in nonischemic cardiomyopathy (induced by doxorubicin and \(\delta\)-sarcoglycan gene mutation in rats) \(^7\) and CHF \(^{147}\); in both studies, intramyocardial injection of myoblasts improved LV function and decreased inotropic requirements, warranting the use of implantable cardioverter-defibrillators. This electric instability has been ascribed to the lack of electromechanical coupling because of the failure of differentiated myotubes to express key gap junction proteins such as N-cadherin and connexin-43. \(^{102}\)

After this trial, several small, nonrandomized studies showed augmented LV function, \(^{31,40,43}\) improved LV remodeling, \(^{33,34,103}\) and histological evidence of myoblast survival in the myocardium \(^{104}\) after intramyocardial injection in patients with ischemic cardiomyopathy. Based on the promising results of these studies, Menasche et al performed The Myoblast Autologous Grafting in Ischemic Cardiomyopathy (MAGIC), a phase II randomized, placebo-controlled, double-blind trial that examined the effects of intramyocardial injection of skeletal myoblasts (at 2 doses: 400 or 800 millions) plus CABG versus CABG alone (controls) in 97 patients with severe LV dysfunction (LV ejection fraction [LVEF] between 15% and 35%). There were no significant differences in cardiac function and occurrence of malignant arrhythmias between patients receiving myoblasts and controls at the end of 6 months; however, in a substudy, it was found that patients treated with 800 million cells had attenuation of LV remodeling and a decrease in LV volumes. \(^{42}\)

Other investigators have used catheter-based intramyocardial injection of skeletal myoblasts in ischemic HF \(^{52,55,56,38,43}\) A small (10 patients) phase I study of percutaneous transcoro-nary-venous myoblast transplantation (Percutaneous Transcoro-nary-venous Transplantation of Autologous Skeletal

### Table 2. Continued

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<tbody>
<tr>
<td>Vrtovec et al (^6)</td>
<td>Randomized, controlled study</td>
<td>Cell treatment = 28; controls = 27</td>
<td>Intracoronary</td>
<td>123 ± 23 \times 10^6 cells</td>
<td>Echocardiography</td>
<td>12 mo</td>
<td>↑LVEF, ↑6MWD</td>
<td>Five patients died of cardiac causes and 5 patients underwent heart transplantation</td>
</tr>
<tr>
<td>Vrtovec et al (^6)</td>
<td>Randomized, controlled study</td>
<td>Cell treatment = 55; controls = 55</td>
<td>Intracoronary</td>
<td>123 ± 23 \times 10^6 Cells</td>
<td>Echocardiography</td>
<td>5 y</td>
<td>↑LVEF, ↑6MWD</td>
<td>Twenty-seven patients died of cardiac causes and 9 patients underwent heart transplantation</td>
</tr>
<tr>
<td>Perin et al (^6)</td>
<td>Randomized, controlled study</td>
<td>Cell treatment = 10; controls = 10</td>
<td>Intramyocardial (transendocardial)</td>
<td>2.37 ± 1.31 \times 10^6 cells</td>
<td>Echocardiography, SPECT</td>
<td>6 mo</td>
<td>↓LVEDV improved maximal oxygen consumption</td>
<td>No major complications reported</td>
</tr>
<tr>
<td>Bolli et al (^6) (SCIPIO)</td>
<td>Open-label, randomized, controlled study</td>
<td>Cell treatment = 16; controls = 7</td>
<td>Intracoronary</td>
<td>1 \times 10^6 cells</td>
<td>Echocardiography, MRI</td>
<td>4 and 12 mo</td>
<td>↑LVEF, ↓Infarct size, ↓NYHA class</td>
<td>No major complications reported</td>
</tr>
<tr>
<td>Makkar et al (^6) (CADUCEUS)</td>
<td>Randomized, controlled study</td>
<td>Cell treatment = 17; controls = 8</td>
<td>Intracoronary</td>
<td>12.5–25 \times 10^6 cells</td>
<td>MRI</td>
<td>6 and 12 mo</td>
<td>↔LVEF, ↔LV volumes, ↓Scar mass</td>
<td>Four cell-treated patients had serious adverse events</td>
</tr>
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</table>

\(^{\dagger}\) indicates increased; ↓ indicates decreased; ↔, no change; BMC, bone marrow cell; CABG, coronary artery bypass grafting; CCSAS, Canadian Cardiovascular Society Angina Score; LV, left ventricular; LVAD, LV assist device; LVEDV, LV end-diastolic volume; LVESV, LV end-systolic volume; LVEF, LV ejection fraction; MAGIC, The Myoblast Autologous Grafting in Ischemic Cardiomyopathy; MUGA, Multigated acquisition scan; MWD, minute walk distance, NYHA, New York Heart Association; PET, positron emission tomography; and SPECT, single photon emission computed tomography. |
Myoblasts in the Treatment of Post-infarction Myocardial Contractility Impairment [POZ NAN] trial" reported an improvement in NYHA class and LVEF at 6 months of follow-up. Other studies in small patient cohorts by Biagini et al. and Dib et al. (Study to Assess the Efficacy and Safety of Transplanting Autologous Skeletal Myoblasts, Into Infarcted Heart, Using a Catheter Delivery System [CauSIMIC] trial) reported improved NYHA functional class and increased LVEF at 1 year after therapy; however, in the former study, the improvement in LV function was noted only during dobutamine infusion. A double-blind, randomized, placebo-controlled, multicenter study of transcatheter intramyocardial administration of myoblasts in HF (To Assess Safety and Efficacy of Myoblast Implantation Into Myocardium Post Myocardial Infarction [MARVEL] trial), designed to enroll 330 patients, was terminated prematurely because of financial constraints; the preliminary results in 23 patients showed improvement in 6-minute walk distance at 3 and 6 months, and an increase in the occurrence of sustained ventricular tachycardia in 7 of 15 patients.35

The long-term effects of intramyocardial myoblast injection in patients with ischemic cardiomyopathy have been evaluated in 4 trials37,39–41 (including a follow-up of the first Menasche study).39 Although in 3 of these trials37,39–41 cardiac function improved, myoblasts were transplanted during surgical revascularization (CABG) or LV assist device placement, which, as pointed out above, complicates the interpretation of the outcome. In the fourth study, in which myoblasts were delivered percutaneously by transcatheter injection, there was no beneficial effect on global or regional LV function at 4-year follow-up. These findings are consistent with the results of the Safety and Effects of Implanted (Autologous) Skeletal Myoblasts (MyoCell) Using an Injection Catheter (SEISMIC) trial, a recent phase Ia, randomized, open-label trial of percutaneous intramyocardial administration of myoblasts in patients with HF.44 In this study, myoblast therapy was not associated with any improvement in LVEF at 6-month follow-up, although there was an improvement in 6-minute walk distance.44

In summary, most of the smaller, nonrandomized clinical trials of skeletal myoblasts have yielded encouraging results, but the largest study to date (the MAGIC trial) failed to corroborate these findings. It must also be noted that many of these trials were performed in conjunction with CABG or LV assist device procedures, making it difficult to separate the effects of myoblasts from those of revascularization. Because of the negative results of MAGIC, the risk of arrhythmias, and the availability of other cell types, interest in skeletal myoblasts has waned, and it seems unlikely that these cells will play a role in cell therapy of HF.

**Bone Marrow–Derived Stem Cells**

The bone marrow harbors different types of hematopoietic and nonhematopoietic stem cell (HSC) populations that have the potential to differentiate into diverse phenotypes (Figure 2). Because of the relatively greater concentration of stem cells in the bone marrow and the ease of procurement of these cells, most of the preclinical and clinical studies in HF have used bone marrow–derived stem cells (Figure 1; Tables 1 and 2).

**Unfractionated Bone Marrow Mononuclear Cells**

Bone marrow mononuclear cells (BMMNCs) are a heterogeneous population composed of mesenchymal stem cells (MSCs), HSCs, endothelial progenitor cells (EPCs), and more committed cell lineages. Because BMMNCs can be easily procured using density gradient centrifugation and because these cells do not require extensive culture techniques, they have been used by many investigators in animal models of acute MI. Relatively fewer studies have been performed in the setting of chronic HF, and the results are conflicting. In sheep and pig models of postinfarction HF, BMMNCs (injected directly into the scar tissue) produced no improvement in LV function (although a study reported increased angiogenesis and reduction in infarct size).17 In contrast to these findings, studies in dogs (postinfarction HF) and rats (cryoinjury-induced HF) have reported improvement in myocardial function, reduction in plasma N-terminal proatriuretic peptide levels, and induction of angiogenesis.

Conflicting results have also been obtained in patients with HF. Perin et al. were the first to evaluate the safety and efficacy of autologous BMMNCs, injected transendocardially with an NOGA Myostar catheter, in patients with chronic ischemic HF (Figure 1). At 2 and 4 months after therapy, there was a significant improvement in LVEF and a reduction in end-systolic volume in cell-treated patients.46 During longer follow-up (6 and 12 months), these patients exhibited not only improved cardiac performance but also an increase in myocardial perfusion and exercise capacity compared with controls.7,58 Directionally concordant observations were made by other investigators, who reported that intramyocardial injection of BMMNCs (performed during surgery or percutaneously via a NOGA device) was associated with a decrease in HF symptoms and an improvement in LV function in patients with severe ischemic LV dysfunction. In contrast, trials using in-scar injections of BMMNCs in patients with ischemic HF failed to show improved LV function.31,56 The reasons for these differences are not obvious; one possibility is the site of cell delivery, as in the study by Perin et al., cells were injected into the peri-infarct viable myocardium rather than into the scar itself.

In addition to the intramyocardial route, numerous studies have examined the effect of intracoronary infusion of BMMNCs in patients with HF, again with mixed results. A number of trials have reported an improvement in various parameters of LV function and anatomy. In the Transplantation of Progenitor Cells and Recovery of Left Ventricular Function In Patients With Nonischemic Dilatative Cardiomyopathy (TOPCARE CHD) study, Assmus et al. compared the effects of intracoronary infusion of 22±11×10⁶ circulating EPCs or 205±110×10⁶ BMMNCs on global LV function in 75 patients with chronic ischemic cardiomyopathy. At 3 months after therapy, LVEF improved significantly in patients receiving BMMNCs (3.7±4.0 absolute ejection fraction units) but not in those receiving circulating EPCs (0.4±3.0 absolute EF units). This difference in response may be because of the functional impairment of circulating EPCs in patients with chronic HF, which limits their recruitment into the scar tissue, or it may reflect the contribution of cell types other than circulating EPCs. In the Transplantation of Progenitor Cells and Recovery of Left Ventricular Function In Patients With Nonischemic Dilatative Cardiomyopathy registry, Assmus et al. enrolled 121 patients with ischemic HF and reported a significant reduction of both N-terminal natriuretic peptide levels, and induction of angiogenesis.
probran natriuretic peptide and N-terminal atrial natriuretic peptide serum levels and a reduction in mortality at 3 months after intracoronary infusion of BMMNCs. However, other trials have failed to confirm the beneficial effects of intracoronary delivery of BMMNCs in HF.\textsuperscript{55,56} For example, when BMMNCs were given (intramyocardially or intracoronarily) during CABG surgery,\textsuperscript{56} there was no improvement in regional or global LV function and no reduction in scar size.

BMMNCs have also been studied in the setting of nonischemic cardiomyopathy.\textsuperscript{53,63} In Transplantation of Progenitor Cells and Recovery of Left Ventricular Function In Patients With Nonischemic Dilatative Cardiomyopathy (TOPCARE-DCM),\textsuperscript{61} intracoronary infusion of 259±135×10^6 BMMNCs in 33 patients with dilated cardiomyopathy was associated with an improvement in regional contractile and microvascular function and a decrease in N-terminal probran natriuretic peptide serum levels, suggesting a beneficial effect on LV remodeling. Interestingly, the increase of regional contractile function was directly proportional to the functionality of the infused cells as measured by their colony-forming capacity.\textsuperscript{61}

In summary, studies of BMMNC administration in patients with chronic ischemic HF have yielded inconsistent results; all of these trials, however, have been small. Larger, phase II trials are needed to achieve definitive conclusions.

**Mesenchymal Stem Cells**

MSCs, also known as bone marrow stromal cells, are a subset of nonhematopoietic cells that are multipotent and plastic-adherent under culture conditions. MSCs can differentiate into chondrocytes, adipocytes, osteoblasts, and skeletal muscle cells and have also been reported to differentiate into cardiomyocytes\textsuperscript{10,11} and endothelial cells\textsuperscript{12} although this cardiogenic potential remains controversial.\textsuperscript{13} MSCs typically express CD105, CD73, CD90, and STRO-1 but lack hematopoietic markers (CD45, CD34, and CD14/CD11b).\textsuperscript{14}

The results of MSC administration in animal models of chronic HF have been encouraging. Direct epicardial injection of allogeneic MSCs in a dog model of ischemic HF induced by ameroid constriction resulted in differentiation of MSCs into smooth muscle cells and endothelial cells, increased vascularity, and improved myocardial function.\textsuperscript{19} Similarly, autologous MSCs, injected directly into a myocardial infarct scar, have been reported to attenuate LV remodeling and reduce infarct size in a swine model of ischemic cardiomyopathy.\textsuperscript{24} These data provided the groundwork for an ongoing randomized, double-blind, placebo-controlled study of autologous MSCs in patients with chronic ischemic LV dysfunction undergoing CABG (Prospective Randomized Study of Mesenchymal Stem Cell Therapy in Patients Undergoing Cardiac Surgery [PROMETHEUS]; NCT00587990; Table 3). In rat models of both ischemic\textsuperscript{21,22,25} and nonischemic\textsuperscript{23} cardiomyopathy, intramyocardial injection of MSCs has been shown to improve cardiac function,\textsuperscript{18,21,23,25} increase angiogenesis,\textsuperscript{18,21} and reduce myocardial fibrosis.\textsuperscript{18,22} To date, the only clinical study that has examined the effects of MSCs in patients with HF is the Percutaneous Stem Cell Injection Delivery Effects on Neomyogenesis (POSEIDON) trial by Hare et al.,\textsuperscript{59} which compared 3 doses of autologous or allogeneic MSCs (20, 100, and 200×10^6 cells) in patients with ischemic cardiomyopathy and demonstrated that all doses favorably affected patient functional capacity, quality of life, and ventricular remodeling (Table 2).

**HSCs and EPCs**

HSCs reside in the bone marrow and differentiate into cells of both myeloid and lymphoid lineages. EPCs, on the other hand, are mobilized into peripheral blood in response to ischemic injury and promote neovascularization by differentiating into endothelial cells (re-endothelialization).\textsuperscript{15,16} CD34 is a typical surface marker of both HSCs and EPCs.\textsuperscript{17} Thus, CD34+ cells are found in the bone marrow and in the peripheral blood and have the potential to give rise to all blood cell types as well as endothelial cells (<1% of nucleated cells in the blood are CD34+).

Autologous CD34+ cell transplantation has been performed in patients with both ischemic\textsuperscript{60} and nonischemic\textsuperscript{64,65} cardiomyopathy (Figure 1). In the former setting, injection of CD34+ cells into the peri-infarct, viable LV regions during off-pump CABG surgery produced a greater improvement in contractile function than did CABG alone.\textsuperscript{60} Also, a small pilot study evaluating the safety and feasibility of intracoronary CD133+ or CD133−, CD34+ cell therapy in patients with old anterior MI reported a sustained improvement in regional perfusion and LV remodeling with both cell types.\textsuperscript{61} In the setting of nonischemic cardiomyopathy, a study by Vrtovec et al\textsuperscript{64} concluded that intracoronary infusion of CD34+ cells led to an increase in LVEF and 6-minute walk distance and a decrease in N-terminal probran natriuretic peptide levels. Importantly, these beneficial effects were sustained during long-term follow-up.\textsuperscript{65} Another surface marker of HSCs and EPCs is CD133 (AC133).\textsuperscript{18} Stamm et al\textsuperscript{62} examined the effects of CD133+ cells, given by intramyocardial injection during CABG, in patients with ischemic HF. At 6 months after treatment, LVEF and perfusion of the infarcted myocardium increased to a greater extent in patients who received CABG and CD133+ therapy than in those who received CABG alone.

Recently, Perin et al\textsuperscript{66} investigated a novel population of hematopoietic cells, referred to as aldehyde dehydrogenase–bright cells, in 20 patients with ischemic HF (10 control and 10 treated), aldehyde dehydrogenase–bright cells, which have been isolated from human bone marrow and peripheral blood, express CD34, CD117, CD105, CD133, and CD166 and include primitive CD34+/CD38− cells.\textsuperscript{19} Transendocardial delivery of aldehyde dehydrogenase–bright cells produced a significant decrease in LV end-systolic volume at 6 months and a trend toward improved maximal oxygen consumption.\textsuperscript{66}

In summary, the initial experience with CD34+ and CD133+ cells in HF (both of ischemic and nonischemic origin) is encouraging but limited by the small size of the trials. As is the case for other cells, larger studies will be necessary to evaluate the role of these cell types in the treatment of HF.

**Adipose-Derived MSCs**

Adipose tissue contains a pool of multipotent stem cells, designated as adipose-derived MSCs that are able to replicate as undifferentiated cells, to develop as mature adipocytes, and to differentiate into other cell types along the mesenchymal lineage. Reports that adipose-derived MSCs can differentiate into cardiomyocytes\textsuperscript{20} and endothelial cells\textsuperscript{21} have motivated studies in animal models of HF. Using a cell sheet technology, Miyahara et al\textsuperscript{20} reported that
transplantation of monolayered MSCs into scarred myocardium reversed wall thinning in the scar area and improved cardiac function. In another study, the effects of transplanting undifferentiated or cardiac predifferentiated adipose-derived MSCs were compared with those of BMMNCs in a rat model of chronic MI. One month after transplantation, adipose-derived MSCs induced an improvement in LVEF, an increase in angiogenesis, and a decrease in fibrosis that were significantly greater than those effected by adipose-derived cardiomyogenic cells or BMMNCs. Additionally, intramyocardial injection of adipose stem cells at 1 week after coronary occlusion has been reported to mitigate the deterioration in cardiac contractile function and enhance angiogenesis in infarcted rat hearts.

In the clinical arena, no full report of adipose-derived MSCs in HF is available yet. The preliminary results of the A Randomized Clinical Trial of Adipose-derived Stem Cells in Treatment of Non Revascularizable Ischemic Myocardium (PRECISE) trial by Perin et al. in 27 patients indicate that administration of adipose-derived cells resulted in stabilization of infarct size and improvement in maximal oxygen consumption.

**Cardiac Stem Cells**

One of the most dramatic developments in the history of cardiac biology has been the recent recognition that the adult heart...
undergoes a continuous turnover of its cellular components (including myocytes). This process is thought to be underlain by a population of resident stem cells that possess the capacity to differentiate into cardiomyocytes, smooth muscle cells, and endothelial cells (Figure 2). The discovery that the heart is a self-renewing organ has not only refuted the long-held doctrine that the myocardium is a postmitotic tissue (composed of cells that have withdrawn from the cell cycle and are terminally differentiated) but has also opened exciting therapeutic avenues.

**c-Kit+ CSCs**

In 2003, Beltrami et al described a population of cells isolated from the adult rat heart that expressed the tyrosine kinase receptor c-Kit (a marker of stemness) but lacked any markers of hematopoietic lineage. These c-kit+ CSCs were shown to be self-renewing, clonogenic, and multipotent, exhibiting the ability to differentiate into cardiomyocytes, smooth muscle cells, and endothelial cells both in vitro and in vivo. Four years later, a similar population of c-kit+ CSCs were identified in the adult human heart. Injection of human CSCs into infarcted rodent myocardium resulted in improvement of LV function and structure and formation of a chimeric heart that contained human myocardium composed of myocytes and coronary vessels.

In the past decade, the ability of human and rodent CSCs to alleviate LV dysfunction and remodeling and promote regeneration has been repeatedly demonstrated by several laboratories in various preclinical animal models of acute MI. Evidence that ischemic cardiomyopathy is associated with loss of functionally competent CSCs has ignited interest in investigating the effects of CSCs in the setting of chronic HF as well. Intramyocardial injection of c-kit+ CSCs at the borders of an infarct 20 days after a permanent coronary occlusion in rats was reported to result in replacement of ≈42% of the scar with new myocardium, attenuation of LV dilation, and preservation of LV function. However, in contemporary medicine, most infarcts are reperfused. Furthermore, from a practical standpoint, the technique most conducive to widespread use of CSCs in patients with HF would be intracoronary delivery. To address these issues, Tang et al investigated whether administration of CSCs is effective in regenerating cardiac tissue and alleviating postinfarction LV remodeling and dysfunction when these cells are infused intracoronarily in the setting of an old MI produced by a temporary coronary occlusion followed by reperfusion. One month after coronary occlusion/reperfusion, rats received an intracoronary infusion of vehicle or enhanced green fluorescent protein-labeled (EGFP) CSCs. Thirty-five days later, CSC-treated rats exhibited more viable myocardium in the risk region, less fibrosis in the noninfarcted region, and improved LV function. However, the number of enhanced green fluorescent protein+ cells expressing markers of cardiogenic commitment was too small to account for the augmentation of LV function (enhanced green fluorescent protein+ cells accounted for only 2.6±1.1% of the region at risk and 1.1±0.4% in the noninfarcted region). These observations suggest that an important mechanism whereby CSCs produced their salutary effects was the secretion of cytokines/growth factors that exerted paracrine actions on endogenous cells, particularly endogenous CSCs, which in turn proliferated and differentiated into adult cardiac cells. In support of this hypothesis was the finding that the pool of endogenous CSCs expanded to a greater degree in CSC-treated than in control rats.

The efficacy of CSCs in chronic ischemic cardiomyopathy was surprising, as a scar would seem to be a very hostile environment to the homing and survival of transplanted cells, and the signals (adhesion molecules and growth factors) that attract and activate CSCs soon after ischemia-reperfusion would be expected to have largely abated once the healing process is complete. To verify these rat findings in a large, clinically relevant species, a similar study was performed in pigs that underwent a 90-minute coronary occlusion followed by reperfusion. At the time of occlusion, the right atrial appendage was harvested for isolation and expansion of c-kit+ CSCs; 3 months after MI, 1 million autologous CSCs were infused into the infarct-related artery using a balloon catheter. Similar to the results obtained in rats, a month later the pigs treated with CSCs exhibited an increase in LVEF and systolic thickening fraction in the infarcted LV wall, as well as a decrease in LV end-diastolic pressure and an increase in LV dP/dt max. The encouraging results of these studies of intracoronary CSC infusion in the setting of an old MI laid the groundwork for Cardiac Stem cell Infusion in Patients with Ischemic Cardiomyopathy (SCIPIO), the first clinical trial of CSCs (Figure 1). SCIPIO was a phase I, randomized, open-label trial of autologous CSCs for the treatment of ischemic HF. The target population consisted of patients with LVEF ≤40% who underwent CABG. Approximately 4 months after CABG, 1 million autologous CSCs (isolated and expanded from myocardial tissue harvested during surgery) were administered by intracoronary infusion; controls were not given any treatment. Although the 2-year follow-up has not been completed, the interim results are very encouraging. In 20 CSC-treated patients, LVEF (measured by 3-dimensional echo) increased from 29.0±1.7% before CSC infusion to 36.0±2.5% at 4 months after infusion. By contrast, in 13 control subjects, LVEF did not change. The salubrious effects of CSCs persisted and, if anything, became even more pronounced at 1 year (LVEF: +8.1% versus baseline; n=17) and 2 years (LVEF: +12.9%; n=8). In 9 CSC-treated patients in which MRI could be performed, there was a profound reduction in infarct size at 4 months (from 34.9±2.3 to 21.6±2.7 g [−38.1%]) and even more at 1 year (from 33.9±3.0 to 18.7±3.6 g [−44.8%]). These salubrious effects were associated with a significant improvement in the NYHA functional class and in the quality of life (measured by the Minnesota Living with Heart Failure Questionnaire).

Aside from the setting of ischemic cardiomyopathy, CSCs have also been found to exert salutary effects in a rat model of anthracycline-induced cardiomyopathy.

In summary, several studies have documented the ability of CSCs to promote regeneration and alleviate LV dysfunction and remodeling in various preclinical models of post-MI cardiomyopathy. The results of the first clinical trial (SCIPIO) are consistent with this preclinical work and suggest that intracoronary infusion of autologous CSCs results in a substantial and sustained improvement in LV systolic function, in a...
reduction in infarct size, and in clinical improvement in patients with ischemic HF. These promising observations warrant larger, phase II studies. It is important to note that although in SCIPIO, CSCs were isolated from the right atrial appendage, it is now possible to isolate and expand these cells from endomyocardial biopsy specimens, which makes the use of autologous CSCs potentially applicable to most patients with HF.

**Cardiospheres and Cardiosphere-Derived Cells**

Cardiospheres were first described by Messina et al in 2004. Using subcultures of atrial or ventricular human biopsy samples and murine hearts, these authors isolated a population of cells that grew as self-adherent clusters and could differentiate into cardiomyocytes, endothelial cells, and smooth muscle cells. Messina et al termed these clusters cardiospheres. Three years later, Smith et al presented a method in which cardiospheres obtained from percutaneous endomyocardial biopsy specimens were plated to yield cardiosphere-derived cells (CDCs). These CDCs were reported to differentiate into electrically stable cardiomyocytes in vitro and, when injected into a murine infarct model, to promote cardiac regeneration and improved cardiac function. In 2009, Johnston et al reported that intracoronary delivery of human CDCs in pigs with old MI resulted in cardiac regeneration, reduction in relative infarct size, attenuation of adverse LV remodeling, and improvement in cardiac function. Phenotypically, cardiospheres and CDCs are a heterogeneous mixture of many different cell types, including cells that express endothelial (kinase insert domain receptor [KDR] [human]/flk-1 [mouse], CD31), stem cell (CD34, c-kit, Sca-1), and mesenchymal (CD105, CD90) antigenic markers (Figure 2). Which of these cells type(s) is responsible for the observed effects on cardiac function and remodeling is unknown. In Cardiosphere-Derived Autologous Stem Cells to Reverse Ventricular Dysfunction (CADUCEUS), 98% of CDCs infused were positive for CD105, suggesting a mesenchymal nature. In a recent study by the same group, the safety and efficacy of direct intramyocardial injection of CDCs and cardiospheres were compared in a porcine model of post-MI HF; although CDCs and cardiospheres had equivalent effects on LVEF, the latter were superior in improving hemodynamics and regional function and in mitigating ventricular remodeling. The enhanced potency of cardiospheres for myocardial repair has been attributed to enhanced stemness and cell–matrix interactions. This preclinical work was translated by Makkar et al into a phase I, randomized trial (CADUCEUS) in patients with a recent MI and an LVEF≤45% but ≥25%. At 1.5 to 3 months after MI, 17 patients received an intracoronary infusion of escalating doses of autologous CDCs (12.5, 17.3, or 25 million cells), which were produced from an endomyocardial biopsy. (However, the amount of tissue used to produce CDCs was reported to be 276 mg [SD, 177; range, 93–891 mg], which is all but impossible to obtain with endomyocardial biopsies). Eight control patients received standard care. In 2 patients, CDCs were found to be aneuploid (trisomy 8) and had to be discarded. At 12 months of follow-up, CDC-treated patients exhibited a 42% reduction in scar size (from 24% to 12% of the LV), concomitant with an increase in viable tissue and regional systolic wall thickening in the infarcted region. However, CDC therapy failed to increase LVEF, reduce LV volumes, and improve NYHA functional class or quality of life as assessed with the Minnesota Living with Heart Failure Questionnaire. Although the increase in nongadolinium enhanced tissue in CDC-treated patients was claimed to be proof of cardiac regeneration, it could also be accounted for by other changes unrelated to regeneration, such as hypertrophy, decreased interstitial space, reduced vascular permeability, and improved perfusion.

In summary, CDCs are a mixture of different cell types (predominantly expressing mesenchymal markers) that have been reported to promote regeneration and alleviate post-MI dysfunction and remodeling in various preclinical models. The clinical effects of CDCs are unclear. The MRI data reported in CADUCEUS are consistent with regeneration (but they do not prove it); however, evidence that CDCs have beneficial effects on global LV function and clinical status is still lacking. Given the heterogeneous nature of this cell preparation, it will be difficult to identify which component(s) accounts for the salutary effects. As is the case of c-kit+ CSCs, larger phase II studies are needed to evaluate the therapeutic potential of CDCs.

**Other Cardiac Progenitor Cells**

**Sca-1+ CSCs.** The existence of Sca-1+ progenitors in the adult mouse heart was reported by Oh et al. These cells expressed CD31 and cardiogenic transcription factors (GATA-4, MEF2C, and MEF-1) but lacked blood lineage markers, c-kit, Flt-1, Flk-1, vascular endothelial cadherin, von Willebrand factor, and HSC markers (CD45 and CD34). In vitro, Sca-1+ cells have the ability to express cardiac structural genes and differentiate into beating cardiomyocytes on treatment with 5-azacytidine and oxytocin. Transplantation of Sca-1+ cells into the peri-infarct and infarct zones in a murine model of MI resulted in endothelial and cardiomyogenic differentiation of these cells with attenuation of LV remodeling. However, the effects of these cells in the setting of chronic HF remain to be determined; furthermore, the lack of a human homolog of Sca-1 makes translation difficult.

**Side Population Cells.** The so-called side population cells are characterized by their ability to exclude the Hoechst 33342 dye via the ATP-binding transporters breast cancer resistance protein/ATP-binding cassette sub-family G member 2 (Bcrp1/Abcg2) and multidrug resistance protein 1 (MDR1). First identified in murine bone marrow as HSCs, side population cells were subsequently isolated by Martin et al from adult as well as embryonic mouse hearts and characterized as CD31+, Sca-1high, c-kitlow, CD34low, and CD45low. Although cardiac side population cells have been reported to differentiate into mature cardiomyocytes, endothelial cells, and smooth muscle cells and to regenerate cryoinjured myocardium, their ability to induce cardiac repair has not been tested.

**Islet-1+ Cells.** During cardiogenesis, Isl-1+ cells give rise to cardiac muscle, the conduction system, and endothelial and smooth muscle cells in the heart compartments. Laugwitz et al proposed that Isl-1+ cells represent endogenous cardiac progenitors that display conversion to a mature cardiac phenotype, with intact calcium dynamics and action potentials; however, the ability of these cells to repair...
injured myocardium in vivo has never been demonstrated. Importantly, these cells do not exist in the postnatal ventricular myocardium, either under normal conditions or after MI, making it unlikely that they serve as cardiac progenitors or will have any clinical application.156

Potential Mechanisms of Actions of Stem Cells in HF

Taken together, the studies reviewed above (Tables 1 and 2) suggest that at least some types of cell therapy are likely to improve cardiac function in chronic HF. What remains largely unknown, however, is the mechanism(s) responsible for these beneficial effects. Here, we discuss briefly the various hypotheses that have been proposed (Figure 3).

(Trans)differentiation of Transplanted Cells Into Cardiac Cells

Although this may seem the most obvious explanation for the salubrious effects of stem cells, the evidence obtained thus far does not support (trans)differentiation of transplanted cells as the only, or even the major, mechanism of action. As mentioned earlier, Reinecke et al157 found that transplanted skeletal myoblasts differentiate into skeletal muscle fibers and do not express cardiac-specific genes. Transdifferentiation of bone marrow cells into cardiac myocytes remains highly controversial, with studies both supporting3,15,158 and refuting105,106 this concept. Others have suggested fusion of bone marrow cells with resident cardiomyocytes as the responsible mechanisms,159,160 but this has also been refuted.161,162 Similarly, transdifferentiation of human peripheral blood CD34+ cells into cardiomyocytes and vascular smooth muscle cells remains controversial.163,164 Although the therapeutic benefits of MSCs have been ascribed to differentiation toward cardiac and vascular lineages,18,110,111,165 most studies have not supported this concept, suggesting instead that the major actions of MSCs are paracrine.166–168

A similar uncertainty applies to cardiac-derived cells. As discussed above, CSCs are multipotent, being able to differentiate into myocytes, endothelial cells, and vascular smooth muscle cells in vitro.125 When transplanted in injured hearts, CSCs give rise to vascular cells and to cells that express myocyte-specific proteins (although these cells are usually small and do not resemble adult myocytes).26,28,30,128,131 In some studies, particularly in models of acute MI, the magnitude of this regenerative process has been found to be substantial.125,126,169,170 However, in a rat28 and pig30 model of chronic post-MI HF, differentiation of transplanted CSCs into myocytes or myocyte-like cells was quantitatively insufficient to account for the improvement in LV function. In the case of CDCs, differentiation into cardiac cells has been reported to be either a minor mechanism of action171 or nonexistent.172,173

In summary, differentiation of transplanted cells along the cardiac lineage may occur. However, the key issue is the magnitude of this phenomenon vis-à-vis the improvement in function. In most of the studies reported to date, the functional benefits seem to be disproportionately small number of new cardiac cells formed by differentiation of transplanted cells; consequently, the former cannot be accounted for solely by the latter. Other mechanisms must be at work.

Formation of New Blood Vessels From Transplanted Cells

Differentiation of transplanted cells into new blood vessels has been reported with various cells (eg, MSCs,19 adipose-derived cells,174,175 CD34+ cells,176,177 and CSCs).125,178 Experimentally, this phenomenon may be important in models of chronic coronary occlusion, which can be associated with the presence of ischemic but viable myocardium,125,126,169,170 but not in models...
in which the artery that supplies the infarcted/scarred myocar-
dium is patent.28,30 Clinically, formation of new vessels may
contribute to improved cardiac performance in some patients
with ischemic heart disease, but it is difficult to envision how
it could do so in the setting of nonischemic cardiomyopathy or
in patients with ischemic heart disease who do not have flow-
limiting coronary lesions (eg, revascularized patients).

Paracrine Mechanisms
The inability to explain the salutary effects of transplanted
stem cells on the basis of their differentiation has led to the
paracrine hypothesis,167 that is, the concept that transplanted
cells induce myocardial repair by releasing signals (cytokines,
chemokines, growth factors, possibly exosomes or micropar-
ticles) into the surrounding tissue, which in turn promote a
number of restorative processes including activation of endo-
genous CSCs, neovascularization, inhibition of apoptosis, inhibi-
tion of hypertrophy, and favorable alterations of the ECM.
Collectively, these actions result in enhanced LV function, im-
proved perfusion, and myocardial repair.167

1. Activation of endogenous CSCs: In the aforementioned
study by Tang et al26 in a rat model of chronic HF, infu-
sion of exogenous CSCs was found to promote prolif-
eration of endogenous CSCs in both the infarcted and
noninfarcted regions, suggesting that activation of the
endogenous pool of CSCs via paracrine mechanisms
was a major mechanism of benefit. It is known that CSCs
secrete growth factors (such as hepatocyte growth factor
and insulin growth factor-1) that stimulate other CSCs
to migrate through the myocardial interstitium, proliferate,
and differentiate into myocytes and vascular structures.26,168
 Activation of endogenous CSCs has also been
suggested to be an important mechanism underlying the
beneficial effects of other cell types, including MSCs.168

2. Induction of neovascularization: Many stem cells can
induce neovascularization by secreting chemokines
(stromal cell–derived factor-1)107,179,180 and proangio-
genic factors (vascular endothelial growth factor, basic
fibroblast growth factor, hepatocyte growth factor, insu-
lin growth factor-1, tissue growth factor-β, and angiopoietin-1).18,101,181,182 EPCs recruited to the ischemic area
can also secrete the endothelial and inducible isoforms
of nitric oxide synthase and promote proliferation of en-
dothelial cells.183 The resulting neovascularization may
improve blood supply to the viable cells that remain in
the infarcted region and thus improve cardiac function in
settings of chronic coronary occlusion; as mentioned
above, however, this mechanism would not account for
improved function in experimental models of reperfused
infarction, where no residual ischemia is present, or in
patients without persistent ischemia.

3. Inhibition of apoptosis: A number of studies suggest
that paracrine factors (such as insulin growth factor-1)
released by stem cells after transplantation inhibit car-
diomyocyte death by apoptosis.18 In vitro and in vivo
data in models of acute MI suggest that Akt overex-
pressing MSCs decrease cardiomyocyte apoptosis.167,182
 Combined transplantation of skeletal myoblasts and
AC133+ cells was also reported to improve cardiac func-
tion by reducing myocardial apoptosis.180

4. Inhibition of hypertrophy: Administration of stem cells
in models of HF is associated with a reduction in the
hypertrophic response of surviving myocytes.13,15,21,26,28
 It remains uncertain, however, whether this is a primary
action of transplanted cells or it is secondary to improved
cardiac performance.

5. Remodeling of the ECM: Stem cells can modulate vari-
ous constituents of the ECM, thereby limiting infarct
expansion, LV remodeling, and myocardial fibrosis.
Skeletal myoblasts have been reported to preserve ma-
trix collagen architecture,13 to reduce fibrosis in the peri-
infarct and infarct-remote regions,14 and to modulate
MMP-2 and tissue inhibitors of MMP-4 levels,101 sug-
gestig a favorable effect on the ECM metabolism. The
importance of ECM alterations in CSC-dependent repair
is underscored by the findings of Rota et al,26 who report-
ed that CSCs increased MMP-2, MMP-9, and MMP-14
levels and decreased tissue inhibitors of MMP-4 levels in
a rat model of post-MI HF.

Cell Fusion
In 2004, spontaneous cell fusion was proposed as an alter-
native mechanism by which transplanted bone marrow cells
produce apparent regeneration of various adult tissues.105,106,160
This concept was based on work by Alvarez-Dolado et al,159
who used a method based on Cre-Lox recombination for de-
tecting cell fusion events of bone marrow cells with cardi-
omyocytes. Subsequent studies,161,162 however, concluded that
c-kit+ bone marrow cells differentiated into myocytes and coro-
nary vessels independent of cell fusion. The use of Cre-Lox
recombination as an appropriate model to study cell fusion has
been challenged because the unmodified Cre-recombinase in
the progenitor cells can cross the membrane of the recipient
cell,184 thus mimicking cell fusion. The notion that cell fusion
is an important mechanism underlying the salubrious effects
of stem cells has lost support in recent years.

Current Challenges, Unresolved Issues, and
Future Directions
Taken together, the preclinical and clinical work performed
to date suggests that administration of stem cells has consid-
erable potential to improve cardiac function and regenerate
viable myocardium in HF. Despite these encouraging results,
however, no cell type has been conclusively demonstrated to
be effective in alleviating HF in patients. It is clear that to
unleash the full potential of cell-based therapies and proceed
toward clinical translation, a number of major unresolved is-
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tues will have to be resolved; for example, what are the op-
timal cell type(s), the optimal cell dose, the optimal route of
cell administration, and the optimal frequency of treatment?
These questions can be answered only by performing careful
preclinical and clinical studies.

Unfortunately, the current environment does not support
studies that compare cells, doses, routes of administration,
and frequency of treatment. At the preclinical level, this type
of work is likely to receive low-priority scores by peer review
groups because it is, by definition, descriptive and lacks mecha-
nistic insights and conceptual novelty. In the clinical arena,
comparisons of different cell types or doses are expensive
and time-consuming. It is hoped that sponsors and funding
agencies will recognize that this type of research is indispensable to translate cell-based therapies to humans and will identify it as a priority for funding.

**Cell Type**

It is unknown which, among the many different types of stem/progenitor cells that have been studied to date (Tables 1 and 2), is most effective in a given pathophysiological setting. Despite the obvious importance of this question, very few studies have directly compared different cell types with respect to the outcomes of therapy.\(^{24,101,107,185}\) Such studies are difficult because they require that the dose–response relationships for each cell type be defined and compared (as simply comparing one dose of cells would be inadequate). This has not been done heretofore. For example, the claim that CDCs are superior to CSCs is untenable because it is predicated on the use of 1 dose of cells.\(^{185}\) Similarly, the few studies that have compared different cell types\(^{25,101,107}\) have not evaluated the dose–response relationships for each cell type.

A related and unresolved issue is whether combinations of different cell types may be more efficacious than a single-cell type. Theoretical considerations, as well as preclinical studies of BMMNCs, skeletal myoblasts,\(^{100,186,187}\) MSCs, and CSCs,\(^{188}\) suggest that the former approach may confer advantages because the actions of different cells may be complementary or even synergistic.\(^{188}\)

**Cell Dose**

It is evident from Tables 1 and 2 that the doses of cells used to treat chronic HF have varied enormously. Although it seems obvious that the effects of cell-based therapies will depend on the number of cells administered, the nature of this relationship is still unknown for most cell types. In the clinical realm, only 2 studies have addressed the dose dependency of the effects of stem cells in HF. In the MAGIC trial,\(^{42}\) a higher dose (8x10⁶) of skeletal myoblasts was more effective in decreasing LV volumes and reversing LV remodeling than a low dose (4x10⁶), although neither dose improved LV function. In the POSEIDON trial, Hare et al\(^{59}\) compared 3 doses of autologous or allogeneic MSCs (20, 100, and 200x10⁶ cells) in patients with ischemic cardiomyopathy and demonstrated that all doses favorably affected patient functional capacity, quality of life, and ventricular remodeling, although 200x10⁶ cells were (unexpectedly) less effective than 20x10⁶ cells. These results differ from those obtained by these investigators in a swine model of ischemic cardiomyopathy, in which both a high dose (200x10⁶ cells) and a low dose (20x10⁶ cells) of MSCs increased regional function, but only the high dose effect reversed remodeling.\(^{24}\) To address this important issue, an ongoing phase II dose-escalation study (A Phase II Dose-escalation Study to Assess the Feasibility and Safety of Transendocardial Delivery of Three Different Doses of Allogenic Mesenchymal Precursor Cells [MPCs] in Subjects With Heart Failure [REVASCOR]) is assessing the feasibility and safety of transendocardial delivery of 3 doses of allogenic mesenchymal precursor cells (25, 75, 150x10⁶ cells) in patients with HF (NCT00721045; Table 3). Similar studies of the dose–response relationship are needed for other cell types.

**Route of Administration**

As is the case for the optimal cell type and dose, the most effective technique to deliver cells to the heart is still unknown. The major routes used to date are direct injection into the LV wall (transendocardially or transepicardially) and intracoronary infusion. Transepidermal injection is performed during cardiac surgery\(^{24,42}\); this method offers direct visualization of the scarred regions but is limited by the requirement for surgery. With transendocardial injection, cells can be delivered directly into the LV wall by using an injection catheter advanced across the aortic valve and positioned against the endocardial surface. The advantages of this technique over intracoronary infusion are that (1) electromechanical mapping of the endocardial surface with a NOGA system can be used to trace viable, ischemic, and scarred myocardium, thereby enabling targeted injection of cells into the scar or into the border zone, and (2) cells can be delivered to a scarred region and if the coronary artery supplying it is totally occluded. Because of these advantages, transendocardial injection has been used extensively in the clinical arena.\(^{52,35,38,41,43–47,54,58}\) However, intramyocardial injections may disrupt tissue architecture and create cell clumps that lack adequate blood supply, resulting in cell death. Furthermore, the distribution of cells within the infarcted region is usually inhomogeneous.\(^{131,189}\)

Intracoronary delivery involves the infusion of cells into a coronary artery, usually during a brief coronary occlusion produced by inflating a balloon at the tip of the catheter. The rationale for stopping flow is to prevent the rapid washout of the cells and to facilitate their extravasation into the interstitium. Compared with transendocardial injection, intracoronary delivery offers several advantages: (1) it results in a much more uniform distribution of cells within the infarcted region,\(^{131}\) (2) it does not require specialized training or the purchase of specialized equipment, and (3) it is technically easier, and therefore more practical for widespread use in clinical practice. The widespread distribution of cells within the infused vascular bed has also the theoretical advantage of enabling them to decide where to go in response to local cues. However, intracoronary delivery has also certain disadvantages versus transendocardial injection: (1) the immediate retention of cells is lower\(^{190,191}\) (eg, 2.6±0.3% after intracoronary infusion compared with 11±3% after intramyocardial injection),\(^{192}\) presumably because of rapid wash out of cells, (2) microvascular occlusion can occur when large cells such as MSCs (10–20 µm)\(^{193,194}\) skeletal myoblasts (≈20 µm),\(^{195}\) and CDCs (≈21 µm)\(^{27,137,139}\) are infused (this problem is not encountered when smaller cells, such as CSCs and BMMNCs, are used), and (3) delivery of cells to a myocardial region supplied by an occluded artery is not possible.

To date, relatively few studies have compared different routes of cell delivery,\(^{12,14,56,131,191,194,196–198}\) with discrepant results. None of them has used a range of doses, which, as discussed above, is necessary to achieve valid conclusions. Comparisons of the intracoronary and transendocardial delivery routes in large animal models using a range of doses of cells are needed to resolve this issue.

**Frequency of Administration**

There is no a priori reason to posit that the effects of a single-cell administration cannot be improved by a repeated
administration. Most stem cells can be frozen, stored, and reused at a later time. Consequently, it seems rather curious that almost every study performed heretofore has used a single injection of cells to determine whether this therapy is efficacious in HF. This would be tantamount to determining the effect of an antibiotic on an infectious disease by giving only 1 dose. The lack of studies evaluating repeated cell injections is all the more perplexing when one considers that there is evidence suggesting a dose-dependent–response relationship between number of cells injected and functional benefit. As discussed above, the effects of stem cells in HF patients should not be labeled as negative, modest, or small on the basis of the results obtained with a single treatment; in our opinion, the effects of repeated administrations of stem cells need to be compared with those of a single administration, lest a cell therapy may be inappropriately dismissed as ineffective.

The few available data do support the concept that repeated injections of cells are more efficacious than a single injection. In animal models of old MI, repeated injections of skeletal myoblasts were more effective than single injections in increasing LV EF and vasculogenesis and in decreasing fibrosis. Clearly, further studies are necessary to determine the relationship between the number/frequency of cells administered and their effects on cardiac function.

Although it is appreciated that the issues discussed above (items 1–5) are not conceptually challenging, it is our opinion that they have enormous practical importance and need to be addressed. It is unlikely that optimal clinical application of cell therapy will be achieved until we have an answer to these questions.

Cell Retention, Survival, Long-Term Engraftment, and Lineage Commitment

Stem cell studies have consistently shown very low rates of long-term cell engraftment: regardless of cell type, dose, and mode of delivery, >90% of injected cells disappear in the first few days and <2% can still be found 4 weeks after transplantation. This massive cell loss is the result of 2 sequentially distinct events. During or immediately after delivery, there is significant loss attributable to failure of cells to extravasate (intracoronary infusion) or leakage through transendocardial/transendocardial puncture holes coupled with removal through the venous system (intramyocardial injection). For example, in the acute phase of MI, only ~10% of CSCs and <10% of MSCs were found in the myocardium 24 hours after intramyocardial injection in mice and only 2% to 5% of BMMNCs a few hours after intracoronary infusion in humans. In a porcine model of cardiopulmonary bypass, only 10% of epidermally injected microspheres approximating the size of MSCs were retained within the sites of injection after 30 minutes. Then, during the first weeks after transplantation, most of the cells that were initially retained die because of ischemia caused by poor vascularization of the injected region, inflammation with attendant oxidative stress and release of cytotoxic cytokines, immune destruction of allogeneic cells, and apoptosis after disengagement of anchorag-depencant cells from their ECM (anoikis).

Clearly, the massive loss of transplanted cells is a major unresolved problem that limits the efficacy of any type of cell therapy. Improving cell homing, survival, and engraftment in the hostile ischemic environment is therefore important for optimizing therapeutic benefits. Several strategies are currently under investigation, including pretreatment of the target tissue, ex vivo pretreatment of cells (genetic modifications, physical or pharmacological preconditioning), and implantation of cells included in scaffolds made of biocompatible matrix. Pretreatment of the host tissue has been accomplished with ultrasound-mediated destruction of microbubbles in the coronary circulation (which improves recruitment of BMMNCs and MSCs, probably by creating capillary pores and extracorporeal shock wave treatment (which has shown benefit in patients with ischemic HF receiving intracoronary BMMNCs in the Combined Extracorporal Shock Wave Therapy and Intracoronary Cell Therapy in Chronic Ischemic Myocardium [CELLWAVE] trial). Concerning ex vivo pretreatment of stem cells, many promising strategies have emerged. One is the overexpression of antiapoptotic genes, such as heme oxygenase-1 (HO-1), B-cell lymphoma 2 (Bcl-2) Akt, or proto-oncogene serine/threonine-protein kinase (Pim-1), which has been shown to increase the survival and function of MSCs and CSCs including their capacity to secrete paracrine mediators. Augmenting either the expression of stromal cell–derived factor-1 in the myocardium or that of its receptor, chemokine receptor type 4 (CXCR4), on stem cells increases cell recruitment. Preconditioning EPCs with antibodies, high mobility group box-1 (HMGB-1), or small molecules increases their neovascularization capacity by activating β2 integrins. Similarly, preconditioning human EPCs and BMMNCs with the endothelial nitric oxide synthase transcription enhancer AVE9488 improves their migratory and neovascularization potential. Many studies have found that preconditioning MSCs and EPCs with simulated ischemia upregulates prosurvival, angiogenic, and migratory proteins, such as hypoxia inducible factor-1α (HIF-1α), Akt-1, Bcl-2, angiopoietin-1 (Ang-1), vascular endothelial growth factor, as well as the receptors CXCR4 and c-Met, and imparts beneficial effects. Preconditioning human CSCs with the HO-1 inducer cobalt protoporphyrin (CoPP) significantly enhances their resistance to apoptosis.

The importance of promoting the lineage commitment of transplanted cells is illustrated by the recently reported Cardiopoietic stem cell therapy in heart failure (C-CURE) trial, in which lineage specification of MSCs was achieved by exposing them to a cardiogenic cocktail regimen that triggered expression and nuclear translocation of cardiac transcription factors; in this study, administration of autologous bone marrow–derived mesenchymal cardiopoietic cells was found to effect favorable LV remodeling and improve cardiac function in patients with ischemic HF.

Embedding cells in natural (eg, matrigel, collagen, fibrin, alginate) or synthetic (eg, peptide nanofibers) biomaterials is another means of enhancing stem cell function. Biomaterials promote cell engraftment, retention, and differentiation because of their low viscosity and their similarity to myocardial ECM, which preserves cell-to-matrix signals. The 2 main approaches in cardiac tissue engineering are in vitro engineering, which consists of seeding cells on preformed porous scaffolds that are cultivated in vitro and then applied on the
epicardial surface, and in vivo engineering, in which a mixture of biomaterials and cells is injected and the formation of a bicomplex occurs in situ.\textsuperscript{21,22} Conceptually, biomaterials could be designed to release growth factors in a controlled manner that promotes survival and engraftment of cells, and also guides cell phenotype decisions.\textsuperscript{21,22}

In summary, improving cell survival and engraftment is crucial to the progress of cell therapy and thus should be a high-priority area for research. The strategies summarized above (pretreatment of target tissue, pretreatment of cells, embedding cells in a matrix) are not mutually exclusive and may have additive or even synergistic effects.

**Ongoing Clinical Trials**

At the time of this writing, ClinicalTrials.gov lists 10 clinical trials that are testing the safety and efficacy of stem cells in patients with HF (Table 3). To evaluate the effects of intramyocardial injection of BMMNCs and MSCs in patients with ischemic cardiomyopathy, 3 phase I/II randomized, double-blind, placebo-controlled trials are being performed at the University of Miami. The primary end point of PROMETHEUS is to test the safety of intramyocardial injection of autologous human MSCs in patients with chronic MI undergoing CABG. The Transendocardial Autologous Cells (human MSCs or human bone marrow cells) in Ischemic Heart Failure Trial (TAC-HFT) is directly comparing human MSCs and human BMMNCs in a prospective manner. The recently published preliminary data from the phase I pilot study of TAC-HFT suggest that transendocardial injection of autologous bone marrow progenitor cells (human MSCs or human BMMNCs) improves regional contractility in a myocardial scar and reverse LV remodeling.\textsuperscript{223,224} Because of the absence of major histocompatibility complex class II, MSCs are immunoprivileged and suppress T-cell proliferation. These cells are being evaluated in the POSEIDON in Dilated Cardiomyopathy (POSEIDON-DCM), which is comparing allogeneic MSCs with autologous MSCs in patients with nonischemic dilated cardiomyopathy. In the early stage study of patients with ischemic cardiomyopathy, POSEIDON demonstrated that transendocardial injection of allogeneic and autologous MSCs favorably affected patient functional capacity, quality of life, and ventricular remodeling.\textsuperscript{99}

Cardio3 BioSciences is currently recruiting patients in its phase III trial (Safety and Efficacy of Autologous Cardiopoietic Cells for Treatment of Ischemic Heart Failure [CHART-1]) to examine autologous bone marrow–derived mesenchymal cardiopoietic cells (C3BS-CQR-1) in patients with chronic HF. In this study, the investigators are using a unique cardiopoietic cocktail of growth factors (transforming growth factor-β1, bone morphogenetic protein-4, activin A, retinoic acid, insulin-like growth factor-1, fibroblast growth factor-2, α-thrombin, and interleukin-6), which has been reported to engage MSCs to differentiate into CSCs.\textsuperscript{225} Using a patient-specific multicellular therapy expanded from a small sample of a patient’s own bone marrow, Aastrom Biosciences is using Ixmyelocel-T (primarily CD34+ MSCs, CD14+ monocytes, and alternatively activated macrophages) to evaluate the efficacy, safety, and tolerability of transendocardial injection in subjects with HF because of ischemic dilated cardiomyopathy. The Safety and Efficacy Study of Intramyocardial Stem Cell Therapy in Patients with Dilated Cardiomyopathy (NOGA-DCM) study is using CD34+ cells in patients with HF. This study is being performed by Dr Vrtovec’s group, who has recently demonstrated that intracoronary stem cell transplantation is associated with improved ventricular function, exercise tolerance, and long-term survival (≤5 years) in patients with dilated cardiomyopathy.\textsuperscript{65} NOGA-DCM is designed to directly compare the effects of intracoronary and intramyocardial stem cell delivery in nonischemic dilated cardiomyopathy at 1-year follow-up. Aside from these studies using bone marrow–derived cells, Allogeneic Heart Stem Cells to Achieve Myocardial Regeneration (ALLSTAR), sponsored by Capricor Inc, is a phase I/II study that tests the safety and efficacy of intracoronary delivery of allogeneic CDCs in patients with an anterior MI and HF.

**Conclusions**

When considering the current status of cell-based therapies for HF, it is important to keep a historical perspective. We are still at the dawn of the era of regenerative medicine. Only 15 years ago suggesting that it was possible to regenerate dead myocardium would have been considered science fiction. Notwithstanding the many mechanistic, pathophysiological, and practical issues that remain unresolved, it is important to remember that tremendous progress has been made in a relatively short time. Many promising candidates for cell therapy have been identified, both in experimental animals and in humans, and several studies are ongoing in patients with chronic HF (Figure 1; Tables 1–3). Never has an idea been translated from preclinical models to humans so quickly. Importantly, cell therapy appears to be safe, to date, no adverse effect of stem/progenitor cells has been reported.

It is true that the precise mechanism of action of stem cells remains unclear, and their efficacy in HF has not been proven. But wouldn’t it be surprising if a conclusive answer to these complex questions had been achieved in just a decade? How long did it take for reperfusion therapy to become a routine part of the management of acute MI? And do we understand the mechanism of action of all therapies that we use daily? We must remember that tremendous progress has been made in a relatively short time. Many promising candidates for cell therapy have been identified, both in experimental animals and in humans, and several studies are ongoing in patients with chronic HF (Figure 1; Tables 1–3). Never has an idea been translated from preclinical models to humans so quickly. Importantly, cell therapy appears to be safe, to date, no adverse effect of stem/progenitor cells has been reported.

Acknowledgments

We gratefully acknowledge Heather L. Jones for expert assistance with graphics design.

**Sources of Funding**

The work discussed in this article was supported in part by the National Institutes of Health grants R01-HL-68088, HL-70897, HL-76794, HL-78825, HL-55757, HL-74351, and HL-91202.
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cardial delivery of adipose-derived stem cells in swine infarction lead to response.


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Circ Res. 2013;113:810-834
doi: 10.1161/CIRCRESAHA.113.300219

Circulation Research is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
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Print ISSN: 0009-7330. Online ISSN: 1524-4571

The online version of this article, along with updated information and services, is located on the World Wide Web at:
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