Comparative Efficacy of Intracoronary Allogeneic Mesenchymal Stem Cells and Cardiosphere-Derived Cells in Swine with Hibernating Myocardium

Brian R. Weil, Gen Suzuki, Merced M. Leiker, James A. Fallavollita, John M. Canty Jr

Rationale: Allogeneic bone marrow–derived mesenchymal stem cells (MSCs) and cardiosphere-derived cells (CDCs) have each entered clinical trials, but a direct comparison of these cell types has not been performed in a large animal model of hibernating myocardium.

Objective: Using completely blinded methodology, we compared the efficacy of global intracoronary allogeneic MSCs (icMSCs, ≈35×10^6) and CDCs (icCDCs, ≈35×10^6) versus vehicle in cyclosporine-immunosuppressed swine with a chronic left anterior descending coronary artery stenosis (n=26).

Methods and Results: Studies began 3 months after instrumentation when wall thickening was reduced (left anterior descending coronary artery % wall thickening [mean±SD], 38±11% versus 83±26% in remote; P<0.01) and similar among groups. Four weeks after treatment, left anterior descending coronary artery % wall thickening increased similarly after icCDCs and icMSCs, whereas it remained depressed in vehicle-treated controls (icMSCs, 51±13%; icCDCs, 51±17%; vehicle, 34±3%, treatments P<0.05 versus vehicle). There was no change in myocardial perfusion. Both icMSCs and icCDCs increased left anterior descending coronary artery myocyte nuclear density (icMSCs, 1601±279 nuclei/mm^2; icCDCs, 1569±294 nuclei/mm^2; vehicle, 973±181 nuclei/mm^2; treatments P<0.05 versus vehicle) and reduced myocyte diameter (icMSCs, 16.4±1.5 μm; icCDCs, 16.8±1.2 μm; vehicle, 20.2±3.7 μm; treatments P<0.05 versus vehicle) to the same extent. Similar changes in myocyte nuclear density and diameter were observed in the remote region of cell-treated animals. Cell fate analysis using Y-chromosome fluorescent in situ hybridization demonstrated rare cells from sex-mismatched donors.

Conclusions: Allogeneic icMSCs and icCDCs exhibit comparable therapeutic efficacy in a large animal model of hibernating myocardium. Both cell types produced equivalent increases in regional function and stimulated myocyte regeneration in ischemic and remote myocardium. The activation of endogenous myocyte proliferation and regression of myocyte cellular hypertrophy support a common mechanism of cardiac repair.

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Key Words: bone marrow ■ cell- and tissue-based therapy ■ coronary stenosis ■ in situ hybridization, fluorescence ■ mesenchymal stromal cells ■ myocardial ischemia

The development of cell-based therapeutic approaches to treat ischemic heart disease has proceeded at a rapid pace since initial clinical trials commenced over a decade ago. Studies have been fueled by optimism that exogenous stem cells could replenish the pool of functional cardiac myocytes that is depleted by acute and chronic injury. There has been an abundance of positive results in preclinical rodent models of myocardial infarction using a variety of cell types with surprisingly few negative studies. Nevertheless, as research has translated to large animal studies and phase I and 2 clinical trials, the functional effects of cell therapy have been variable. Thus, although clinical trials have confirmed the safety of most preclinical cardiac cell therapies, limited functional improvement has been observed in comparison with animal studies.1-3 This has been highlighted by a recent meta-analysis of clinical cell therapy studies using individual patient data, which concluded that intracoronary cell therapy neither reduces clinical events nor improves left ventricular (LV) function in patients with recent myocardial infarction.4 There are several potential explanations for the difficulty in translating preclinical findings to clinical trials. Some are unique to cardiovascular research, whereas others are...
common to translating preclinical research in other fields of medicine. First, rodents tolerate myocardial infarctions that are much larger than what a human can survive. This amplifies the deleterious effects of LV remodeling in rodent models. At the same time, remodeling in humans is now markedly attenuated by pharmacological therapy and early reperfusion when compared with untreated animal models. In addition, most models use young animals that do not have the underlying cardiovascular risk factors present in humans with diseases such as hypertension, diabetes mellitus, and hypercholesterolemia or the impact of aging. There is also likely publication bias toward positive results with under-reporting of negative preclinical studies.

Perhaps a more substantial barrier common to translating preclinical studies in all fields is the way that most are conducted. In comparison with clinical trial methodology, few preclinical studies use a blinded randomized controlled approach. The team of preclinical investigators and research scientists is rarely blinded to treatment allocation. Although interpretation of some aspects is sometimes blinded (eg, cardiac imaging results), blinding of investigators involved in pathological analysis and other physiological endpoints is rarely used. A recent meta-analysis of preclinical cardiovascular cell therapy studies found that only 42% of included studies reported blinded assessment of some data, and only 11% reported allocation concealment. Thus, many studies may have selection bias related to inclusion/exclusion of experiments and variable observer bias in most of the end point analyses. These problems have recently been highlighted in the field of cardioprotection research by the National Institutes of Health–sponsored Consortium for Preclinical Assessment of Cardioprotective Therapies. Using rigorous blinded treatment and data analysis comparable with randomized clinical trials, the Consortium for Preclinical Assessment of Cardioprotective Therapies consortium has been unable to show the beneficial effects of 2 agents that had been widely shown to reduce infarct size in previous small, poorly controlled preclinical studies in multiple species. Thus, the absence of a completely blinded randomized study design may be a significant methodological hurdle to overcome in translation of preclinical research into clinical application.

With this in mind, we determined whether a randomized blinded experimental approach could be used in a single-center preclinical trial comparing 2 types of cell therapy versus vehicle-treated controls. Bone marrow–derived mesenchymal stem cells (MSCs) and cardiosphere-derived cells (CDCs) cultured from explanted heart tissue are promising cell types that have recently entered clinical trials. A particularly attractive feature of both cell types is the feasibility of using allogeneic cells, which would permit off-the-shelf availability of cells for treatment and circumvent the need for personalized cell expansion. Both MSCs and CDCs have been shown to improve ventricular function in preclinical studies by our laboratory and others, but they have not been compared in a head-to-head fashion in a large animal model of myocardial ischemia. Previous studies including our own have been limited by the fact that investigators were not completely blinded to treatment allocation and all functional and pathological analyses. Therefore, the present study addresses these issues by using a rigorous, clinical trial-based 3-way design to directly compare the therapeutic efficacy of bone marrow–derived intracoronary allogeneic MSCs (iMSCs) and intracoronary allogeneic CDCs (icCDCs) infused to the entire heart in a swine model of chronic myocardial ischemia. Any potential effects of allogeneic cell rejection were minimized by treating all animals with chronic cyclosporine. The results demonstrate preclinical therapeutic equipoise of allogeneic icMSCs and icCDCs.

Methods

All procedures and protocols conformed to institutional guidelines for the care and use of animals in research and were approved by the University at Buffalo Institutional Animal Care and Use Committee.

Study Design and Treatment of Data

All personnel involved in data collection and analysis (including echocardiographic imaging and histological assessment of myocyte morphometry and proliferation) were blinded to the treatment status of each animal. Serial data collection and analysis were conducted by an independent biostatistician not involved in the protocols or assays (J.A.F.). Animals were randomized to receive vehicle, icMSCs, or icCDCs in a 1:1:1 ratio. Regional wall thickening of the area supplied by the left anterior descending coronary artery (LAD %WT) 1 month after treatment was selected as the primary endpoint.

Isolation and Characterization of MSCs and CDCs

Bone marrow (n=2) and LV tissue (n=3) samples were collected from healthy donor pigs (age, 8±3 weeks) for the isolation and cultivation of MSCs and CDCs, as previously described and summarized in the Online Data Supplement. Cells were cultured for 4 to 7 passages, at which time they were collected for characterization by flow cytometry and immunohistochemistry or intracoronary infusion to recipient pigs with hibernating myocardium. Flow cytometric and immunohistochemical characterization included assessment of hematopoietic (CD45, cKit), mesenchymal (CD90, CD105), and cardiac (GATA4, Nkx2.5) markers. Before administration, both cell types were filtered through a 30-μm pore filter to circumvent administering cell aggregates (magnetic-activated cell sorting [MACS] preseparation filters; Miltenyi Biotec) and suspended in heparinized HBSS solution (3000 U heparin in 30 mL in total) for intracoronary infusion.

Effects of icMSCs and icCDCs on Flow and Function in Hibernating Myocardium

Experimental groups and the study timeline are summarized in Online Figure I. Pigs (n=34) were chronically instrumented with a 1.5-mm Delrin occluder on the proximal LAD to produce hibernating
myocardium as previously described. Briefly, juvenile pigs were sedated (Telazol 100 mg/mL/xylazine 100 mg/mL, 0.022 mg/kg IM), intubated, and ventilated with a 0.5% to 2% isoflurane–oxygen mixture. Through a small pericardiotomy, the Delrin occluder was placed on the proximal LAD. Antibiotics (cefazolin, 25 mg/kg and gentamicin, 3 mg/kg IM) were given 1 hour before surgery and repeated after closing the chest. Analgesia included an intercostal nerve block (0.5% Marcaine) and intramuscular doses of butorphanol (2.2 mg/kg Q6H) and flunixin (1–2 mg/kg QD).

**Serial Physiological Studies**

Studies began 3 months after instrumentation when stable reductions in LAD WT and perfusion indicative of hibernating myocardium were present. Under propofol sedation (5–10 mg/kg per hour IV), a catheter (Millar) was inserted to measure LV pressure and inject microspheres. Regional WT was assessed with transthoracic echocardiography from a right parasternal approach. All pigs showed anterior dysfunction without dyskinesis. Systolic WT \(=\Delta \text{WT-end-diastolic WT}\); %WT = systolic WT−end-diastolic WT×100 was quantified in dysfunctional LAD regions and remote, normally perfused regions of the same heart.

**Microsphere Perfusion**

Microsphere flow was measured at rest and after adenosine vaso-dilation to characterize hibernating myocardium 3 months after instrumentation and repeated 4 weeks after therapy as previously described. Briefly, we injected 15-μm microspheres \(\left(>3\times10^{10}\right)\) labeled with fluorescent dyes into the LV, whereas a reference arterial sample was withdrawn at 6 mL/min for 90 seconds. At the end of the study, samples were taken from mid-ventricular circumferential rings divided into 12 wedges with each cut into 3 transmural layers. Fluorescent dyes were extracted using standard techniques and quantified at selected excitation wavelengths.

**Cell Administration and Follow-Up**

After baseline physiological measurements, pigs were randomly assigned to receive coded treatments of vehicle \((n=8)\), \(3.5\times10^6\) icMSCs \((n=9)\), or \(3.5\times10^6\) icCDCs \((n=9)\) with all investigators and research personnel blinded to treatment allocation. Each treatment was divided into 3 aliquots and infused into each of the 3 major arteries of the heart. Y-chromosome fluorescent in situ hybridization (ID Labs, London, Ontario, Canada) was used to determine the fate of male donor icMSCs \((n=4)\) and icCDCs \((n=5)\). Tissue samples were hybridized with fluorescein isothiocyanate–conjugated porcine Y-chromosome probe according to the manufacturer’s instructions (ID Labs). Y-chromosome fluorescent in situ hybridization staining in male control cardiac tissue was used to correct for the fact that myocyte nuclear diameter was greater than histological slice thickness. The efficiency of Y-chromosome identification was \(37\pm3\%\) and similar to previously published data. Sections were also incubated with antibodies to cardiac troponin I to detect colocalization of Y-chromosome fluorescent in situ hybridization in myocytes derived from donor cells.

**Statistical Analysis**

Data are expressed as mean±SD. Differences among treatment groups were assessed by 2-way ANOVA with repeated measures and the post hoc Holm–Sidak test. For all comparisons, \(P<0.05\) was considered significant.

**Results**

A total of 34 animals were instrumented with a chronic LAD stenosis. Consistent with previous data demonstrating an elevated risk of sudden cardiac death in this model, 7 animals died before completion of the study. Of these, 5 died before the 3-month study and 2 died between the 3- and 4-month studies (1 CDC-treated animal and 1 vehicle-treated animal, >10 days after the intracoronary infusion). One animal was removed from further study at the 3-month time point when angiography demonstrated that there was no stenosis of the LAD and the Delrin occluder had been displaced from the vessel. All remaining animals \((n=26)\) were included in the final data analysis with no exclusions after randomization to treatment.

**Allogeneic MSC and CDC Cell Characterization**

Cell culture resulted in comparable total cell injections from each treatment \((32.4\pm7.3\times10^6\) icMSCs and \(35.3\pm5.9\times10^6\) icCDCs; \(P=0.40)\). Flow cytometry confirmed that cell surface marker expression profiles were consistent with previous reports. At the time of infusion, MSCs and CDCs expressed similar frequencies of CD90+ and CD105+. Both were also CD45− with a small number expressing cKit+ (Figure 1).
Despite these similarities, they had markedly different expression of cardiac transcription factors. Both GATA4 and Nkx2.5 were absent in MSCs but ubiquitous in CDCs with nearly all demonstrating that they were cardiac lineage committed at the time of administration.

**Comparative Physiological Effects of icMSCs and icCDCs in Swine With Hibernating Myocardium**

There were no differences in hemodynamic variables at rest or during adenosine between treatment groups (Online Table I). Baseline studies 3 months after instrumentation confirmed the presence of viable dysfunctional hibernating myocardium. Regional LAD %WT was reduced when compared with normal remote regions (38±11% vs 83±26%; \(P<0.01\)) along with reductions in resting perfusion (LAD, 0.63±0.21 vs 0.80±0.34 mL/min per gram in remote; \(P<0.05\)). Adenosine-dilated flow was also attenuated (LAD, 1.62±0.90 vs 4.00±2.90 mL/min per gram in remote; \(P<0.001\)). Indices of LV function and flow were comparable among all treatment groups at baseline.

The effects of icMSCs and icCDCs on regional function are summarized in Figure 2 and Online Table II. One month after treatment, LAD %WT increased in both icMSC-treated (50.7±13.4%) and icCDC-treated (50.9±16.6%) animals versus vehicle-treated controls (33.7±9.2%; \(P<0.05\) versus each cell therapy). Functional effects of cell therapy were not limited to the ischemic LAD area because both cell types prevented the deterioration of remote zone WT that was observed in vehicle-treated animals. As a result, remote zone %WT was significantly higher in animals treated with icMSCs (88.4±26.0%) and icCDCs (94.3±39.3%) than that in vehicle-treated controls (59.5±18.2%; \(P<0.05\) versus each cell therapy) 1 month after treatment. Global LV ejection fraction was minimally reduced at baseline and was not significantly affected by any treatment (Online Table II). Importantly, there were no significant differences in functional improvement comparing icMSCs with icCDCs.

Consistent with our previous results, there were no significant effects of either cell therapy on serial measurements of coronary flow at rest or during adenosine vasodilation (Figure 3). Although icMSC- and icCDC-treated animals exhibited a significant increase in capillary density in both LAD and remote regions of the LV (Figure 4), neither treatment promoted arteriogenesis because there was no change in arteriolar density. Thus, the functional improvement afforded by icMSCs and icCDCs was accompanied by capillary angiogenesis without arteriogenesis or increased collateral blood flow.

**Comparative Effects of icMSCs and icCDCs on Cardiomyocyte Number and Size**

Blinded analysis of myocyte nuclear density and diameter is summarized in Figure 5. Nuclear density in
vehicle-treated animals was reduced throughout the LV (LAD, 973±181 nuclei/mm²; remote, 1005±88 nuclei/mm²) compared with previous measurements from normal sham pigs of similar size (=1200–1400 nuclei/mm²).17,26 icMSC treatment (LAD, 1601±279 nuclei/mm²; remote, 1387±348 nuclei/mm²; both P<0.05 versus vehicle) and icCDC treatment (LAD, 1569±294 nuclei/mm²; remote, 1545±276 nuclei/mm²; both P<0.05 versus vehicle) each significantly increased myocyte nuclear density throughout the LV. Increases in nuclear density were not the result of karyokinesis without cytokinesis because the number of nuclei per myocyte was not different among all treatment groups (vehicle, 4.4±0.3; icMSCs, 4.5±0.6; icCDCs, 4.2±0.3; P=ns). Increases in myocyte nuclear density were also accompanied by reductions in myocyte diameter. Vehicle-treated controls (LAD, 20.2±3.7 μm; remote, 19.8±1.7 μm) were larger than icMSC-treated (LAD, 16.4±1.5 μm; remote, 16.9±2.4 μm; both P<0.05 versus vehicle) and icCDC-treated animals (LAD, 16.8±1.2 μm; remote, 16.9±1.0 μm; both P<0.05 versus vehicle). Interestingly, these changes were not associated with anatomic LV hypertrophy because postmortem LV mass/body mass ratio was not different among groups (vehicle, 2.5±0.3; icMSCs, 2.3±0.3; icCDCs, 2.3±0.3 g/kg).

Effects of icMSCs and icCDCs on Myocyte Proliferative Markers

Ki67 expression (vehicle-treated LAD, 573±158 nuclei/10⁶ myocyte nuclei; remote, 540±209 nuclei/10⁶ myocyte nuclei) tended to increase throughout the LV after icMSCs (LAD, 1068±585 nuclei/10⁶ myocyte nuclei; P=0.11 versus vehicle; remote, 994±471 nuclei/10⁶ myocyte nuclei; P=0.06 vs vehicle). After icCDCs, Ki67 expression was greater (LAD, 1866±858 nuclei/10⁶ myocyte nuclei; remote, 1530±588 nuclei/10⁶ myocyte nuclei; both P<0.05 versus vehicle and icMSCs; Figure 6A). There were similar differences in phosphorylated histone-H3 (pHH3) expression (Figure 6B) with icMSC-treated animals being borderline significant (LAD, 156±96 nuclei/10⁶ myocyte nuclei; P=0.10 versus vehicle; remote, 167±99 nuclei/10⁶ myocyte nuclei; P=0.11 versus vehicle) versus vehicle-treated animals (LAD, 73±31 nuclei/10⁶ myocyte nuclei; remote, 57±37 nuclei/10⁶ myocyte nuclei). In contrast, the magnitude of pHH3 expression increased significantly after icCDCs (LAD, 302±141 nuclei/10⁶ myocyte nuclei; remote, 362±210 nuclei/10⁶ myocyte nuclei; both P<0.05 vs vehicle and icMSCs).

Engraftment and Fate of Allogeneic icMSCs and icCDCs

To estimate the number of new myocytes derived from icMSCs and icCDCs, Y⁺ cells were assessed in the LAD and remote regions of the hearts of female recipients who had received male donor-derived cells (icMSCs, n=4; icCDCs, n=5; Figure 7A). A similar number of Y⁺ cells were observed in icMSC-treated (LAD, 3.1±2.6 Y⁺ cells/cm²; remote, 0.7±0.5 Y⁺ cells/cm²) versus icCDC-treated animals (LAD, 1.8±1.4 Y⁺ cells/cm²; P=0.36 versus icMSC treated; remote, 0.3±0.4 Y⁺ cells/cm²; P=0.20 versus icMSC treated; Figure 7B). This amounted to only ~1 in 10000/cm² of the new myocytes formed from allogeneic CDCs or MSCs based on our estimates of ~40000 to 60000/cm² new myocytes after intracoronary cell therapy (after accounting for myocyte multinucleation; Figure 7C). The paucity of Y⁺ myocytes despite large increases in total myocyte number provides evidence that both icCDCs and icMSCs stimulated endogenous myocyte proliferation with rare cardiac myocytes derived from injected MSCs or CDCs.

Discussion

There are several important findings from the present study. First, using a blinded, randomized vehicle-controlled study design, we have shown that global infusion of allogeneic icMSCs and icCDCs produces comparable increases in myocardial function and myocyte proliferation. Improvements in function were associated with myocyte proliferation in both ischemic and remote myocardium. Second, although there was no functional arteriogenesis, cell therapy globally increased capillary density and myocyte nuclear density with a reduction in myocyte diameter. This, along with the observation that the number of nuclei per myocyte is unchanged, is consistent with significant myocyte proliferation throughout the LV that is quantitatively similar between the 2 cell therapies. Finally, the increase in myocyte nuclear number despite minimal engraftment of allogeneic cells in sex-mismatched donor-recipients indicates that new myocytes are formed via endogenous mechanisms rather than direct differentiation of injected cells and is supported by the elevated expression of myocyte proliferative markers. Collectively, our results demonstrate that global intracoronary infusion of allogeneic MSCs and CDCs promotes a similar degree of myocardial repair via the stimulation of endogenous myocyte proliferation.

This is the first study to directly compare allogeneic intracoronary infusion of CDCs and MSCs in a large animal model of chronic myocardial ischemia. A few studies have...
compared these cell types after direct intramyocardial injection into infarcted tissue. For example, after xenogeneic transplantation of human cells to immunocompromised mice with myocardial infarction, CDCs were shown to be therapeutically superior to bone marrow–derived MSCs, adipose tissue–derived MSCs, and bone marrow–derived mononuclear cells.27 Xenogeneic cell transfer of human cKit+ cardiac stem cells also promoted greater myocardial repair than human bone marrow–derived MSCs after injection in mice with permanent coronary artery ligation.28 In a subsequent study using a porcine reperfused myocardial infarct model, myocardial injection of human cardiac stem cells and bone marrow–derived MSCs produced equivalent functional improvement.29 Interestingly, the combination of human MSCs and cardiac stem cells produced greater functional improvement than either cell type alone. Although not examined in our study, it is plausible that combining MSCs and CDCs could yield greater functional repair than either cell alone and should be considered in future studies.

Although intracoronary infusion of both allogeneic MSCs and CDCs was efficacious, our preclinical results suggest that it may be difficult to demonstrate that either cell type would be superior to the other in a head-to-head clinical trial. The similarity of functional repair afforded by each cell type is perhaps not surprising given several similarities between MSCs and CDCs revealed by in vitro analyses. For example, using a microarray-based approach, Dey et al30 demonstrated significant overlap in the transcriptional profiles of bone marrow–derived MSCs and CDCs. Consistent with this, we observed nearly identical cell surface antigenic profiles in MSCs and CDCs with high levels of CD105+ and CD90+, a small population of cKit+ cells, and the absence of CD45 expression at the time of infusion. Nevertheless, because Ki67 and pHH3 expressions in icCDC-treated animals remained elevated in animals receiving icMSCs at 4 weeks, it is possible that icCDCs could lead to more prolonged stimulation of myocyte proliferation and superior functional improvement if the comparison was performed beyond 1 month.

Taken in the context of previous findings, our results add support to the emerging notion that both allogeneic MSCs and CDCs are safe and promote functional improvement. Previous studies have shown that MSCs and CDCs stimulate endogenous myocyte proliferation and subsequent myocardial regeneration despite limited long-term engraftment of injected cells. In the present study, histological analyses indicated that only ≈1 of every 10000 new myocytes was derived from donor-derived MSCs or CDCs, yet cell-treated animals exhibited elevated markers of myocyte proliferation. Taken together, these data are consistent with the idea that exogenous MSCs and CDCs stimulate endogenous myocyte proliferation, resulting in a significant increase in myocyte number. The cellular mechanism by which endogenous myocyte proliferation is stimulated remains unclear and could not be evaluated in our large animal model. Recent data in rats indicate that a potential candidate for the reparative actions of CDCs is the secretion of micro–RNA-rich exosomes that, in vitro, enhance angiogenesis, promote
myocyte proliferation, and decrease apoptosis. There is also evidence supporting an important role of cell-to-cell contact-dependent CDC stimulation of myocyte proliferation that is mediated by β1 integrin signaling. The requirement of cell-to-cell contact to promote myocardial repair extends to MSCs as well. Hatzistergos et al demonstrated that intramyocardial injection of MSC-conditioned media (containing secreted growth factors) was not sufficient to replicate the beneficial effects of MSC injection in a porcine infarct model. On the basis of limited in vivo data at hand, we found that both cell types likely facilitate endogenous myocyte repair either via cell-to-cell communication or the prolonged release of paracrine factors or exosomes from cells that are retained in the heart.

Our results also demonstrate that icMSCs and icCDCs can promote functional improvement in the absence of changes in myocardial perfusion in the setting of a chronic coronary stenosis. Indeed, the significant improvement in LAD regional WT in icMSC- and icCDC-treated animals was not accompanied by changes in resting or adenosine-vasodilated perfusion. These findings are consistent with previous results in this model and provide further evidence that interventions that stimulate myocyte proliferation can dissociate the myocardial flow–function relationship by improving function independently of perfusion. The failure of either cell type to produce measurable improvements in myocardial blood flow may relate to their inability to significantly increase arteriolar density. At the same time, both cell types stimulated capillary angiogenesis, which has been used by some as an indirect index of improved tissue perfusion. Increases in capillary number did not lead to measurable changes in resting or vasodilated perfusion in the LAD region supplied by the chronic stenosis since capillaries have a negligible contribution to total coronary vascular resistance. Interestingly, however, increases in capillary density matched increases in myocyte nuclear density with the capillary/myocyte ratio maintained after icMSCs and icCDCs. This matching has been described by others and may facilitate tissue oxygen exchange. The concomitant regression of cellular hypertrophy would also improve oxygen transport across the sarcolemma via reversion of the so-called ischemic core phenomenon. This postulates that increases in myocyte cross-sectional area limit oxygen delivery to the center of the myocyte. Thus, the decrease in myocyte size and increases in capillary density could improve oxygen transport at the cellular level.

The majority of cardiac cell therapy studies have attempted to regenerate myocytes in areas of infarction by administering cells down an infarct-related artery using stop-flow intracoronary infusion or to infarct border areas.
via transendocardial injection. However, our laboratory has demonstrated therapeutic success with global intracoronary infusion under continuous flow. This allows cells to be administered throughout the dysfunctional LV, thus promoting beneficial effects in nonischemic remote areas of the heart. From a practical standpoint, cell infusion without transient coronary occlusion or the use of transendocardial injection devices could be performed easily in any standard catheterization laboratory, thereby facilitating rapid, widespread clinical implementation. This approach is also safe with a variety of cell types, as demonstrated in the present study, as long as cells are infused before extended passage, filtering is performed, and an appropriate dose and rate of infusion are selected. Finally, from a clinical perspective, the amount of cyclosporine used (≈3 mg/kg per day) is well below that used in organ transplantation. Although previous studies have demonstrated safety and efficacy of allogeneic MSCs and CDCs without immunosuppression, it is possible that short-term, low-dose cyclosporine could delay the immune response to allogeneic cells and enhance functional improvement.

Because the swine model of hibernating myocardium used in the present study is characterized by regional dysfunction of viable myocardium in the absence of scar, our results indicate that global icCDCs and icMSCs promote functional repair independent of any potential effects on infarct size. This finding may be particularly relevant in the clinical translation of intracoronary cell therapy because many patients exhibit large areas of viable, dysfunctional myocardium with residual perfusion because of contemporary reperfusion strategies that successfully limit infarct size and preserved LV ejection fraction. Despite improvements in regional WT, neither cell type produced significant increases in global LV function. This likely reflects the mild impairment in ejection fraction present at baseline and the limitations of M-mode echocardiographic assessment. Importantly, recent data from our laboratory demonstrate that global icCDC delivery can also improve global function when myocardial scar is present and global ejection fraction is reduced.

The cardiac cell therapy field has grown rapidly over the past decade, but attempts to translate promising preclinical findings to patients have been met with disappointment. Unfortunately, concerns over experimental design and investigator blinding, coupled with publication bias toward positive results, may deserve blame for some of this. A recent review by Rosen and Myerburg contrasted the positive results of numerous unblinded or uncontrolled studies with neutral findings in randomized, blinded, and appropriately controlled trials. These same issues extend to preclinical studies conducted in large animal models of heart disease that serve as the pivotal step in the translation of novel cell-based therapeutic approaches. The present study circumvented these limitations by using an approach where animals were randomized to 1 of 3 treatment arms.
Our ability to compare the effects of each cell type on this remote zone WT tended to be higher (between groups in any measured variable before treatment, tic efficacy. Although there were not significant differences multiple cardiovascular risk factors that could impact therapeu-
last the fact that the target population is of advanced age with mul-
study were relatively young, healthy animals. Thus, clini-
clinical translation to patients may still be complicated by the
conclusions between autologous and allogeneic cells or the impact of blinding, randomiza-
we found different relative increases in Ki67 labeling versus磷酸化 labeling 4 weeks after cell infusion versus vehicle-
treatments. This could reflect the time course of these markers before tissue harvesting and variations in the time over which cells are Ki67 or磷酸化 positive with each treatment.
Recent studies have demonstrated that physiological stimuli such as revascularization itself can also stimulate cardiac repair and alter these myocyte proliferation indices. Regardless of the proliferative indices measured at a single time point (which reflect a rate of myocyte division at that point in time), the increase in nuclear density and reduction in myocyte size assessed 4 weeks after treatment reflects the cumulative myocyte increase, which was the same with icMSCs and icCDCs. 

**Conclusions**

The present study demonstrates therapeutic equipoise of 2 contemporary cell therapy platforms in a large animal model of chronic ischemia. Global icMSCs and icCDCs each significantly improved regional contractile function and increased myocyte number throughout the left ventricle without affecting myocardial perfusion. These results occurred despite evidence of limited cell engraftment 1 month after treatment, implicating cell therapy–mediated stimulation of endogenous myocyte regeneration as a primary mechanism of repair for both cell types. Our preclinical study demonstrates the feasibility of implementing a rigorous blinded experimental design that is similar to that used in single-center randomized clinical trials. Although the results suggest that it may be difficult to identify therapeutic superiority of either cell type over the other in clinical studies, they support their ability to produce myocyte cellular remodeling before global LV dysfunction and heart failure develop.

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**Disclosures**

None.

**References**


3. Marban E, Malliaris K. Mixed results for bone marrow–derived cell thera-


progenitor cells and promoting myocytes to reenter the growth phase of vulnerable to sudden death.


What Is Known?
• Despite extensive preclinical evidence, clinical efficacy of cardiac cell-based therapeutic approaches remains unclear.
• Most patients with coronary artery disease and heart failure have relatively preserved left ventricular systolic function as assessed by ejection fraction.
• In ischemic heart disease, significant myocyte loss and compensatory hypertrophy can develop before global LV dysfunction and heart failure.

What New Information Does This Article Contribute?
• Using a blinded, randomized, vehicle-controlled study design, we found that global intracoronary infusion of allogeneic MSCs and CDCs produced comparable improvements in regional function in swine with chronic myocardial ischemia and hibernating myocardium.
• Both intracoronary allogeneic mesenchymal stem cells and intracoronary allogeneic cardiosphere-derived cells increased capillary density and myocyte nuclear density and reduced myocyte cellular hypertrophy.
• Few cells were derived from allogeneic cell transplants, clearly implicating activation of endogenous repair mechanisms in intracoronary allogeneic cardiosphere-derived cell– and intracoronary allogeneic mesenchymal stem cell–treated animals.
• The beneficial effects of both cell therapies occur in ischemic and remote regions of the heart at a time when reductions in ejection fraction and heart failure are absent.

In this study, using a rigorous, clinical trial-based study design, we demonstrate therapeutic equipoise of 2 therapies in a large animal model of chronic ischemia associated with myocyte cellular loss and hypertrophy in the absence of infarction. We found that improvements in regional function were accompanied by substantial reverse myocyte remodeling with increases in myocyte number and reductions in myocyte size. The ability of both of these therapies to replace myocytes lost from the stress of chronic repetitive ischemia raises the possibility that treating the entire heart to prevent the development of left ventricular dysfunction and ischemic cardiomyopathy may be feasible. Strategies to prevent the development of heart failure earlier in the course of the disease may potentially have more impact than reversing dysfunction in the advanced failing heart.
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Comparative Efficacy of Intracoronary Allogeneic Mesenchymal Stem Cells and Cardiosphere-Derived Cells in Swine with Hibernating Myocardium

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Abbreviated Title – MSCs vs. CDCs in Hibernating Myocardium

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Supplemental Methods

Isolation of MSCs and CDCs

Mesenchymal Stem Cell Isolation: Bone marrow was sampled for isolation and expansion of MSCs 2-months after instrumentation as previously described. Approximately 30 ml of bone marrow was aspirated from the sternum under propofol sedation. Samples were heparinized using a 1:10 (v:v) ratio of preservative-free heparin to bone marrow aspirate and placed in a Ficoll gradient (BD Vacutainer CPT with Sodium Heparin) for isolation of the buffy coat. Samples were centrifuged at 2250 RPM (1160 RCF) for 20 minutes at 25°C and 2 ml of plasma was cryopreserved until MSC implantation. For each sample, 1.5-2 ml of monocyte/lymphocyte layer was removed from the buffy coat layer, washed twice in Hanks Balanced Salt Solution (HBSS), resuspended in 10 ml ADMEM (Invitrogen/Gibco Inc.) with 10% FBS and plated on separate plastic 100 mm tissue culture dishes (BD Biosciences). Samples were incubated in a humidified atmosphere at 37°C and 5% CO₂ and adherent cells were permitted to attach to the bottom of the plastic dishes. Non-adherent cells were easily detached by successive washings with HBSS at 2 and 4 days after initial plating followed by replacement of fresh media. Upon reaching confluency (5-6 days after initial plating), all cultures were virtually devoid of non-adherent cells and trypsinized (0.25% trypsin in HBSS solution) and expanded in plastic 150 mm tissue culture dishes (BD Biosciences). Culture media was changed every 4-5 days and after trypsinizations. After ~3-weeks of cultivation, cells were collected for intracoronary infusion.

Cardiosphere-Derived Cell Isolation: Left ventricular tissue specimens were obtained by needle biopsies (2-5 biopsies from the LV basal free wall, 20-50 mg total) and cut into 1-2mm pieces. After removal of gross connective tissue, they were washed and partially enzymatically digested in a solution of type IV collagenase for 60 minutes at 37 degrees. Tissue fragments were cultured as ‘explants’ on dishes coated with fibronectin. After ~8 days, a layer of stromal-like cells arose from and surrounded the explants. Over this layer a population of small, round, phase-bright cells migrated. Once confluent, the cells surrounding the explants were harvested by gentle enzymatic digestion. These cardiospheres-forming cells were seeded at 2 to 3x10⁶ cells/mL on poly-D-lysine–coated dishes in cardiosphere medium (20% heat-inactivated fetal calf serum, gentamicin 50µg/ml, 2mmol/L L-glutamine, and 0.1mmol/L 2-mercaptoethanol in Iscove’s modified Dulbecco medium). Cardiospheres formed after 4-10 days in culture, detached from the tissue culture surface, and began to slowly grow in suspension. When sufficient in size and number, free-floating cardiospheres were harvested by aspirating them along with media. Cells that remained adherent to the poly-D-lysine–coated dishes were discarded. Detached cardiospheres were then plated on fibronectin-coated flasks where they attached to the culture surface and formed monolayers of CDCs. Cells were subsequently passaged by trypsinization and splitting at a 1:2 ratio until a sufficient number were available.
Supplemental References


Supplemental Table I. Effects of icMSCs and icCDCs on Hemodynamics at Rest and During Adenosine Vasodilation in Swine with Hibernating Myocardium. Paired analysis of data at 4-months vs. 3-months for each treatment group

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<th>Systolic Pressure (mm Hg)</th>
<th>Mean Aortic Pressure (mm Hg)</th>
<th>Heart Rate (bpm)</th>
<th>LV dP/dt Max (mm Hg/sec)</th>
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Values are mean±SD
Supplemental Table II: Echocardiographic Indices of Left Ventricular Function in Vehicle-, icMSC-, and icCDC-Treated Animals with Hibernating Myocardium.

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Values are mean±SD; * p<0.05 vs. 3-months, # p<0.05 vs. Vehicle; LAD – Left Anterior Descending Artery; WT – Wall Thickening; %WT - % Wall Thickening; %WT = 100 * (End Systolic WT – End Diastolic WT)/ End Diastolic WT; Δ WT – End Systolic WT – End Diastolic WT; LVEF = Left Ventricular Ejection Fraction.
Supplemental Figure I: Experimental Study Protocol. Juvenile swine were instrumented with a Delrin LAD stenosis to produce hibernating myocardium which consistently developed after 3-months. At that time, a baseline closed-chest study was conducted to assess LV function (echocardiography), myocardial perfusion at rest and vasodilation (microspheres), hemodynamics, and coronary angiography. Subsequently, animals were randomized to receive global intracoronary infusion of vehicle, icMSCs, or icCDCs in a blinded fashion. All animals returned to the laboratory 1-month later for follow-up studies, after which they were euthanized and the heart was excised for post-mortem histopathological analysis.