Cellular Cardiomyoplasty Improves Survival After Myocardial Injury

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Background—Cellular cardiomyoplasty is discussed as an alternative therapeutic approach to heart failure. To date, however, the functional characteristics of the transplanted cells, their contribution to heart function, and most importantly, the potential therapeutic benefit of this treatment remain unclear.

Methods and Results—Murine ventricular cardiomyocytes (E12.5–E15.5) labeled with enhanced green fluorescent protein (EGFP) were transplanted into the cryoinjured left ventricular walls of 2-month-old male mice. Ultrastructural analysis of the cryoinfarction showed a complete loss of cardiomyocytes within 2 days and fibrotic healing within 7 days after injury. Two weeks after operation, EGFP-positive cardiomyocytes were engrafted throughout the wall of the lesioned myocardium. Morphological studies showed differentiation and formation of intercellular contacts. Furthermore, electrophysiological experiments on isolated EGFP-positive cardiomyocytes showed time-dependent differentiation with postnatal ventricular action potentials and intact /H9252-adrenergic modulation. These findings were corroborated by Western blotting, in which accelerated differentiation of the transplanted cells was detected on the basis of a switch in troponin I isoforms. When contractility was tested in muscle strips and heart function was assessed by use of echocardiography, a significant improvement of force generation and heart function was seen. These findings were supported by a clear improvement of survival of mice in the cardiomyoplasty group when a large group of animals was analyzed (n=153).

Conclusions—Transplanted embryonic cardiomyocytes engraft and display accelerated differentiation and intact cellular excitability. The present study demonstrates, as a proof of principle, that cellular cardiomyoplasty improves heart function and increases survival on myocardial injury. (Circulation. 2002;105:2435-2441.)

Key Words: transplantation • cells • electrophysiology • contractility • survival

Cardiovascular diseases are the most frequent cause of death in the western hemisphere. The critical loss of functional cardiomyocytes causes a severe deterioration of pump function, resulting in heart failure. Because differentiated cardiomyocytes lack prominent regenerative capacity, heart transplantation remains the only effective causal therapy. Because of the increasing number of patients requiring this treatment and the decline in available donor organs, alternative methods, such as cellular cardiomyoplasty,1–3 are urgently needed. Thus far, however, convincing evidence showing a clear therapeutic benefit of this approach is lacking.

To compare survival in a large group of mice after heart injury alone or combined with cellular cardiomyoplasty, we used an operative procedure with very low mortality.4 A combination of morphological, functional, and molecular methods enabled us to gain detailed insight into differentiation, physiological function, and contractility of transplanted cells and their role for heart function.

Methods

The Animal Care Committee of the University of Cologne approved all the procedures performed on animals.

Mouse Breeding and Harvesting of Embryonic Cardiomyocytes

Transgenic mice5 of the strain HIM:OF1 or C57/Bl6 were bred and enhanced green fluorescent protein (EGFP)-positive embry-
onic ventricular cardiomyocytes (E12.5-E15.5) harvested as reported. After dissociation, the cells were resuspended in DMEM (20,000 cells/μL). Flow cytometry was performed as described.

Operation and Cell Injection

Male wild-type mice of the respective strains were used as recipients. The surgical procedure and the injection of cells (100,000 cells diluted in 5 μL of solution) were performed as reported. For control, EGFP-positive cardiomyocytes or solution without cells was injected into the intact myocardium or the cryolesioned myocardium, respectively.

Histology, Immunohistochemistry, and Western Blot Analysis

Morphological preparation and staining of tissue samples were performed as described. Nuclei were stained with DAPI (Vector Laboratories). To evaluate cross-striation, anti–α-sarcromeric actin (1:800, Sigma) primary and Cy3 goat anti-mouse (1:1000, Dunn Labortechnik), which recognizes both Tal isoforms. Comparable protein loading was assessed with Coomassie staining.

Electrophysiology

Single cardiomyocytes were isolated with Langendorff perfusion at 5 or 6 (early) and 11 to 14 (late) days after operation. Transplanted cardiomyocytes were identified on the basis of their EGFP expression. Action potentials (APs) and ionic currents were recorded in the whole-cell configuration (for details, see Reference 9). APs in cells of a 2-ms current injection. Only cells with stable APs were included in the analysis. The inward rectifier current (I\text{IR}) was normalized, offset-corrected, and fitted with a double-exponential equation.

Isometric Tension Measurements

Defined tissue strips (2.0 mm long and 0.5 mm wide) were obtained under a fluorescence microscope with a self-manufactured stage. The strips were skinned with 1% Triton X-100 as described in Reference 10, with the modification of added protease inhibitors [0.2 mmol/L 4-(2-aminoethyl)benzenesulfonylfluoride hydrochloride, 10 μmol/L leupeptin, 10 μmol/L aprotinin, and 5 μg/mL antipain]. The strips were placed into relaxing solution (pCa 7.5) and mounted in a myograph (Scientific Instruments). Strips were preshunted by 10% of their slack length, and maximum Ca\textsuperscript{2+}-activated force was initiated by exposure to activating solution (pCa 4.5). Experiments were performed at 10°C.

Echocardiography

Mice were anesthetized, and heart function was monitored on days 1, 4, 7, and 14 after operation. Echocardiography was performed with an ultrasound machine (HDI-5000, ATL-Ultrasound) equipped with a linear-array transducer (CL15-7) operating at 15 MHz and providing frame rates up to 284 Hz. Centrifuged gel was used for acoustic coupling to minimize imaging artifacts. Parasomal short- and long-axis views in B and M imaging modes were performed. In addition to wall thickness, the dimension of the cavity and the ejection fraction were calculated. Regional wall motion was visually assessed and analyzed offline. Wall motion scores were applied as suggested by the American Society of Echocardiography. Myocardial segments were subdivided by use of the 15-segment model. The reader was blinded to the study group, and analysis of the data was performed 1 month after data acquisition to minimize bias.

Statistics

For statistical analysis of the time course of survival, both log-rank and Breslow tests were used. The latter weights, in particular statistical, differences that occurred early during the time course. The statistical significance of other parameters was examined with Student’s t test; a value of P<0.05 after Bonferroni correction was considered significant. Wall motion scores were tested by repeated-measurements ANOVA. Data are indicated as mean±SEM (electrophysiology, echocardiography) or mean±SD (tension measurements).

Results

Identification of Transplanted Cells, Engraftment, and Differentiation

Large, reproducible lesions were induced in mouse hearts by cryoinjury. To allow direct identification of the transplanted cells, we used transgenic embryos (E12.5–E15.5) in which the cardiac α-actin promoter drives the EGFP expression in the cardiac myocytes. Echocardiography was performed at 10, with the modification of added protease inhibitors [0.2 mmol/L antipain, and 5 μg/mL aprotinin]. The strips were skinned with 1% Triton X-100 as described in Reference 9. APs in cells of a 2-ms current injection. Only cells with stable APs were included in the analysis. The inward rectifier current (I\text{IR}) was normalized, offset-corrected, and fitted with a double-exponential equation.

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Within a few days after transplantation, intercalated disks were detected, suggesting the establishment of electromechanical coupling (Figure 2e, bottom right). The reduced size of the transplanted cardiomyocytes and the relatively thickened cross-striation suggest that the cells late after operation are not yet terminally differentiated. Taken together, our morphological studies demonstrate that the cryolesion is replaced by fibrotic scar tissue within a week.

**Figure 1.** Transgenic mouse and cryoinjury model. a, Transgenic embryonic (E13.5) heart displaying prominent enhanced green fluorescent protein (EGFP) expression under fluorescent light. The ventricles (V) and atria (A) can be recognized. b, Flow cytometry of freshly isolated transgenic ventricle-derived cells (E13.5). A large fraction of intact (propidium iodide-negative) cardiomyocytes (EGFP positive cells) is detectable. Van Gieson staining (c) and (d) electron microscopy of changes occurring after cryoinjury. Upper, middle, and lower panels depict heart tissue 2, 4, and 6 days after lesion. In van Gieson stainings muscle tissue is yellow and fibrotic tissue is red (c). Two days after injury, myocytolysis with myofibrillar degeneration and mitochondrial damage is seen. From day 4 invasion of fibroblasts and de novo synthesis of extracellular matrix takes place (d). Bar 100 μm in c and 6 μm in d.

**Figure 2.** Morphological characterization of transplanted cardiomyocytes. a, Cross section of left ventricular wall shows engraftment of large numbers of EGFP-positive cardiomyocytes 2 weeks after operation. Note reduced wall thickness of infarcted area. Yellow color is a result of background fluorescence of infarcted heart muscle. b, Higher magnification evidences rod shape and end-to-end and end-to-side contacts (arrowheads) between transplanted cardiomyocytes. c, Costaining with DAPI shows that EGFP-positive cells are mononucleated. d, α-Actinin–stained transplanted cardiomyocytes display cross-striation; EGFP expression (inset) proves their transgenic nature. e, Ultrastructural analysis of transplanted cardiomyocytes in central area of cryoinjury. Two cardiomyocytes form side-to-side contacts (left). High magnification of transplanted cardiomyocyte depicted on left shows intact sarcomeric organization (top right). Intercalated disks can be detected (bottom right). Bar 110 μm in a, 20 μm in b and c, 15 μm in d, 45 μm in d (inset), 4 μm in e (left), and 2 μm in e (right).
Cellular cardiomyoplasty yields successful engraftment, physiological orientation, and differentiation of the implanted cells.

**Functional Characteristics of Transplanted Cells**

Next, we wondered whether the physiological characteristics of transplanted cells were similar to those of native cardiomyocytes. Because of their key role for heart function, we examined the expression of ion channels. Isolated transplanted cardiomyocytes could be easily identified because of their EGFP expression (Figure 3a) and functionally characterized with the patch-clamp technique. Early after operation, many round cells were observed, whereas late after operation, higher numbers of rod-shaped transplanted cells were seen. The time-dependent differentiation of transplanted cardiomyocytes was illustrated by comparison of the 90% AP duration (APD$_{90}$) of embryonic and transplanted cardiomyocytes. Early after operation, the transplanted cells displayed spontaneous electrical activity with depolarized resting membrane potentials (56.3±0.3 mV, n=3) and prolonged APD$_{90}$ (208.3±7 ms, n=3) (Figure 3c and 3e). The significant prolongation of the APD$_{90}$ in early-postoperation cells compared with E12.5/E13.5 embryonic cardiomyocytes (359.2±40 ms, n=5, Figure 3e) suggested differentiation. In fact, these early-postoperation cells resembled ventricular cardiomyocytes of the late embryonic/perinatal stage. At this stage, intact β-adrenoceptor–mediated modulation, a hallmark for physiological heart function, was already seen, because isoprenaline (1 μmol/L) led to prolongation of the APD and a more positive plateau phase (Figure 3c). When late-transplanted cells were measured, stable resting membrane potentials (−68±8 mV, n=8) similar to those of native cells (−71.4±0.5 mV, n=12) isolated from the same hearts were found. In control (Figure 3b) and transplanted (Figure 3d) cells, electrical stimulation evoked the typical spiky APs with short-lasting APD$_{90}$s of 35.8±0.8 (n=12) and 41.9±2.4 (n=8) ms, respectively (Figure 3e). $I_{K1}$ is critical for setting the membrane potential; therefore, current densities were determined. These were similar in wild-type (4.8±0.4 pA/pF, n=10) and late-transplanted (4.5±0.1 pA/pF, n=9) but significantly lower in early-transplanted (1.3±0.2 pA/pF, n=5) cardiomyocytes. In early- and late-postoperation cardiomyocytes, the L-type Ca$^{2+}$ current, a key component of excitation-contraction coupling, displayed normal biophysical characteristics (Figure 3f) and similar current densities (Figure 3g, top). In line with the establishment of intact Ca$^{2+}$-induced Ca$^{2+}$ release during differentiation, the inactivation kinetics of the L-type Ca$^{2+}$ current were found to be accelerated in late-transplanted cells (Figure 3g, bottom). Occasionally, a tight connection between EGFP-positive and native cardiomyocytes was seen after the isolation. When lucifer yellow (3 mg/mL) was included in the patch pipette, the passage of dye from the patched EGFP-positive cell to the tightly connected native cardiomyocyte was observed (n=3), suggesting the expression of functional gap junctions between these cells. To gain more insight into the differentiation of transplanted cells, the expression pattern of Tnl, known to switch at the perinatal stage from the slow skeletal to the cardiac isoform$^{13}$ (Figure 4a), was analyzed by Western

![Figure 3](image-url)
No TnI was detected in untreated cryoinfarcted tissue strips (n=5). Showing engraftment and start of differentiation, both the skeletal (26-kDa) and the cardiac (30-kDa) TnI isoforms were detected 5 days after operation in treated ventricular muscle strips. Interestingly, as early as 2 weeks after transplantation, an almost complete switch to the adult cardiac TnI isoform was observed, suggesting accelerated differentiation of the transplanted cardiomyocytes (Figure 4a). These experiments show that the transplanted cells are physiologically intact and differentiate faster.

**Contractility and Heart Function**

To investigate the functional contribution of contractile proteins, maximal force development at 30 μmol/L Ca$^{2+}$ was determined in permeabilized muscle strips. In the tissue strips harvested from the lesioned areas without engrafted cells, almost no contractile force development (36.9±27 μN, n=5, Figure 4b) was measured. In clear contrast, a significant increase of force development (221.4±52 μN, n=5, Figure 4b) was observed when strong EGFP fluorescence confirmed engraftment of a large number of cells. When the active isometric force per cross-sectional area of tissue strips containing transplanted cells was normalized, it amounted to ≈10% of controls (Figure 4b, inset). To assess whether this force could be generated by the engrafted cardiomyocytes, their total number was counted in tissue slices yielding ≈2000 (n=4) cells, ≈22% of control strips. With their smaller volume taken into account, the theoretical force per cross-sectional area of tissue strips containing transplanted cardiomyocytes lies in the range of 11% of control, close to our experimentally determined value. When fibroblasts instead of embryonic cardiomyocytes were transplanted, almost no contraction (48.6±16.6 μN, n=3) was detected. To evaluate whether this recovery of contractility correlated with an improvement in vivo, echocardiographic analysis was performed. M-mode images in the region of the cryoinfarct-
tality between sham-operated mice and mice with cardiomyoplasty occur at a time when the cardiomyocytes are not yet differentiated and echocardiography shows no clear functional improvement. We therefore presume that the better clinical outcome is also related to decreased compliance of scar tissue and possible beneficial effects of the injected cardiomyocytes on scar formation. Nevertheless, because experiments that used fibroblasts instead of embryonic cardiomyocytes did not yield any recovery of contractile function, the use of noncontractile cell types for cellular cardiomyoplasty is questionable, as suggested by other groups.

The formation of intercalated disks and the passage of lucifer yellow from EGFP-positive cells to native cardiomyocytes suggest at least some degree of electrical coupling between the grafted cells and the native myocardium. Future studies should analyze this important topic in detail.

Therapeutic strategies using human embryonic cardiomyocytes for cell replacement will be limited because of ethical and immunological problems. Although grafting of autologous skeletal muscle tissue is devoid of these problems, lack of electrical coupling and different contractile properties pose considerable limitations to their therapeutic use. Therefore, the use of embryonic stem cells, somatic stem cells, and/or their in vivo transdifferentiation represent potential alternatives in the treatment of cardiovascular diseases, even more so because bone marrow mobilization improves repair and survival of infarcted mice. It remains to be proved, however, that embryonic/somatic stem cell–derived “cardiomyocytes” display typical cardiac-like functional characteristics and augment long-term survival.

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References

8. Linz KW, Meyer R. Profile and kinetics of L-type Ca2+ current during the cardiac ventricular action potential compared in guinea-pig, rats and rabbits. Pflugers Arch. 2000;439:588–599.


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