Dual Angiogenic and Neurotrophic Effects of Bone Marrow–Derived Endothelial Progenitor Cells on Diabetic Neuropathy

Jin-Ok Jeong, MD, PhD*; Mee-Ohk Kim, MD, PhD*; Hyongbum Kim, MD, PhD; Min-Young Lee, MS; Sung-Whan Kim, PhD; Masaaki Ii, MD, PhD; Jung-uek Lee, MS; Jiyoon Lee, MS; Yong Jin Choi, MS; Hyun-Jai Cho, MD, PhD; Namho Lee, MD, PhD; Marcy Silver, BS; Andrea Wecker, MS; Dong-Wook Kim, PhD; Young-sup Yoon, MD, PhD

**Background**—Endothelial progenitor cells (EPCs) are known to promote neovascularization in ischemic diseases. Recent evidence suggested that diabetic neuropathy is causally related to impaired angiogenesis and deficient growth factors. Accordingly, we investigated whether diabetic neuropathy could be reversed by local transplantation of EPCs.

**Methods and Results**—We found that motor and sensory nerve conduction velocities, blood flow, and capillary density were reduced in sciatic nerves of streptozotocin-induced diabetic mice but recovered to normal levels after hind-limb injection of bone marrow–derived EPCs. Injected EPCs were preferentially and durably engrafted in the sciatic nerves. A portion of engrafted EPCs were uniquely localized in close proximity to vasa nervorum, and a smaller portion of these EPCs were colocalized with endothelial cells. Multiple angiogenic and neurotrophic factors were significantly increased in the EPC-injected nerves. These dual angiogenic and neurotrophic effects of EPCs were confirmed by higher proliferation of Schwann cells and endothelial cells cultured in EPC-conditioned media.

**Conclusions**—We demonstrate for the first time that bone marrow-derived EPCs could reverse various manifestations of diabetic neuropathy. These therapeutic effects were mediated by direct augmentation of neovascularization in peripheral nerves through long-term and preferential engraftment of EPCs in nerves and particularly vasa nervorum and their paracrine effects. These findings suggest that EPC transplantation could represent an innovative therapeutic option for treating diabetic neuropathy. (Circulation. 2009;119:699-708.)

**Key Words:** angiogenesis ■ diabetes mellitus ■ progenitor cells ■ diabetic neuropathy

Peripheral neuropathy is the most common complication of diabetes mellitus, affecting up to 60% of diabetic patients.\(^1\) Loss of sensation in the feet, the most frequent manifestation of diabetic neuropathy (DN), frequently leads to foot ulcers and may progress into amputation of the limb.\(^2,3\) Despite a continuous increase in the incidence of diabetes mellitus and DN, current treatments have yet to effectively treat DN. Our group reported that experimental DN is characterized by reduced microcirculation in peripheral nerves caused by the destruction of the vasa nervorum and thus administration of angiogenic factors such as vascular endothelial growth factors (VEGFs), sonic hedgehog (SHh), and statin could restore neural function by augmenting angiogenesis.\(^4\)\(^-\)\(^6\) In addition, deficiency of neurotrophic factors is regarded as one of the most plausible mechanisms underlying DN.\(^7\) Alterations of nerve growth factor, ciliary neurotrophic factor, glial-derived neurotrophic factor, and brain-derived neurotrophic factor have been reported.\(^8\)\(^-\)\(^12\) However, in clinical trials, single neurotrophic cytokines turned out to be ineffective for treating DN.\(^13\) Recently, many classic angiogenic factors were shown to possess neurotrophic activities and vice versa. VEGF,\(^14\)\(^-\)\(^16\) SHh,\(^17\)\(^,18\)

*Dr Jeong and Kim contributed equally to this work.

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Correspondence to Young-sup Yoon, MD, PhD, Division of Cardiology, Department of Medicine, Emory University School of Medicine, 1639 Pierce Dr, WMB 319, Atlanta, GA 30322. E-mail yyoon5@emory.edu
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insulin-like growth factor-1,19 and neurotrophins20,21 are some of the representative factors with these dual effects. Because DN lacks both angiogenic and neurotrophic factors, using a therapeutic agent that has dual angioneutrophic activities may prove more beneficial for treating DN. In this regard, endothelial progenitor cells (EPCs) can be an optimal candidate for treating DN because they possess paracrine properties that encompass both angiogenic and neurotrophic effects. Furthermore, unlike protein or gene therapy, cell therapy may be able to provide long-term effects. EPCs are putative progenitor cells of endothelial cells, exist in peripheral blood and bone marrow (BM), and contribute to postnatal neovascularization. Growing evidence suggests that EPCs are effective in treating various cardiovascular diseases.22–25 Mechanistically, EPCs work through transdifferentiation into vascular22,26 and paracrine effects.24,27 The paracrine effects are made possible because EPCs produce multiple biological factors such as VEGF, insulin-like growth factor-1, and fibroblast growth factor-2 (FGF-2). Accordingly, we sought to investigate whether transplantation of EPCs could attenuate or reverse DN by augmenting neovascularization and providing angiogenic and neurotrophic factors.

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In the present study, we report that BM-derived EPCs, by directly augmenting neural neovascularization, could effectively treat DN. We found for the first time that intramuscularly injected EPCs are preferentially engrafted into peripheral nerves, are specifically localized around vasa nervorum, and increase the expression of various angiogenic and neurotrophic factors.

Methods

Induction of Diabetes Mellitus

All protocols were approved by St Elizabeth’s Institutional Animal Care and Use Committee. We induced diabetes mellitus in 6-week-old male C57BL/6J mice by intraperitoneal injection of streptozotocin (150 mg/kg).

Isolation of EPCs and Cell Culture

For EPC culture, the bones of 8-week-old C57BL/6J mice were excised and crushed with PBS. Mononuclear cells were fractionated by density gradient centrifugation. Isolated mononuclear cells were cultured on rat plasma vitronectin–precoated 10-cm dishes.23,24

Intramuscular Injection of Cultured EPCs

We labeled EPCs with a red fluorescent dye, CM-DiI (Invitrogen, Carlsbad, Calif), as previously described23 and injected EPCs (1×106) or the same volume of saline into the muscles percutaneously along the course of the sciatic nerve.

Laser Doppler Imaging of Vasa Nervorum Blood Flow

Perfusion of sciatic vasa nervorum was measured in each hind limb of mice with a laser Doppler perfusion imager (Moor Instruments, Axminster, Devon, UK).4,5 After anesthesia, nerves were exposed, and flow measurements were repeated twice over the same region of interest.

Fluorescent Imaging of Blood Vessels in Sciatic Nerves and Femoral Muscles

Vascularity of sciatic nerves and femoral muscles was assessed by in situ fluorescent staining with an endothelial cell–specific marker, BS-1 lectin.4,5 After anesthesia, the hind limbs were perfused with BS-1 lectin conjugated to FITC (Vector Laboratories, Burlingame, Calif) by cardiac injection. Fifteen minutes later, the animals were killed, and the sciatic nerves and femoral muscles were harvested. After fixation, samples were either whole mounted or embedded in optical coherence tomography compound for frozen section.

Statistical Analysis

All results are presented as mean±SEM. Statistical analysis was performed by an unpaired Student t test for comparisons between 2 groups and ANOVA for ≥2 groups. For statistical analysis of nerve conduction velocity (NCV) measurements in Figure 1, we used a repeated-measures ANOVA. Values of P<0.05 are considered statistically significant.

Details on the materials and methods, including the following items, can be found in the online-only Data Supplement: measurements of NCV,5,15 tail-flick testing,6,8 double-fluorescence immunohistochemistry for BrdU28 and terminal deoxynucleotidyl transferase-mediated dUTP nick-end labeling (TUNEL),29 in vitro cell proliferation assay,6 quantitative reverse-transcription polymer-
EPC Transplantation Improves Neural Function in Diabetic Mice

To determine the impact of local transplantation of EPCs on the function of peripheral nerves in diabetes mellitus, we measured NCVs every 2 weeks for 8 weeks after treatment. At baseline, 12 weeks after induction of diabetes mellitus, both motor and sensory NCVs were slowed by ≈35% and 40%, respectively, in diabetic mice (injected with saline) compared with the nondiabetic mice (NDM-saline), indicating development of significant peripheral neuropathy (Figure 1A and 1B). Diabetic mice were randomly assigned to EPC (DM-EPC) or saline injection (DM-saline) groups and were injected intramuscularly around the sciatic nerves. After EPC treatment, both motor and sensory NCVs gradually recovered to normal levels over 8 weeks (Figure 1A and 1B). Statistically, a repeated-measures ANOVA demonstrated a significant difference in NCVs between the DM-EPC and DM-saline groups at baseline (P<0.05) and at 4 and 8 weeks (P<0.01). Tail-flick testing 4 weeks after treatment showed that in DM-saline mice, tail-flick temperatures were significantly increased compared with nondiabetic control mice. In contrast, in the DM-EPC mice, tail-flick temperatures were significantly decreased to the level of nondiabetic mice, indicating recovery of sensory nerve function (Figure 1C).

EPC Transplantation Improves Neural Vascularity in Diabetic Mice

We measured sciatic nerve blood flow in each limb using laser Doppler flow imaging at 4 weeks after treatment. Nerve blood flow was markedly decreased in DM-saline compared with NDM-saline mice (P<0.05; Figure 2A and 2B). The blood flow and the blood flow ratio between treated and nontreated limbs were significantly increased in the DM-EPC mice compared with the DM-saline mice (P<0.001; Figure 2C).

Next, to investigate changes in functional vessels, we harvested sciatic nerves at 4 weeks after treatment after injection of BS-1 lectin into the heart. Whole-mount images of sciatic nerves showed that DM-saline mice had fewer functional vasa nervorum, which are responsible for perfusion of peripheral nerves, compared with NDM-saline mice (P<0.01) (Figure 3A and 3B, left and middle). In contrast, the vasa nervorum was visibly increased after EPC treatment (Figure 3A and 3B, middle and right). Quantitative analysis of the vessels in cross sections of sciatic nerves showed a higher number of vasa nervorum in the EPC-injected mice compared with the saline-injected mice (Figure 3C).

Transplanted EPCs Home to Sciatic Nerves and Are Durably Engrafted

Next, we studied the engraftment and transdifferentiation characteristics of EPCs in sciatic nerves harvested at 2, 4, 8, and 12 weeks after EPC transplantation. The endothelial characteristics of cultured EPCs were confirmed by conventional EPC assay and fluorescence-activated cell sorter analyses. We found that 31% of the EPCs were positive for Tie2 expression and 91% for CD11b expression, suggesting that a majority of cultured EPCs originated from a monocyte population and that cultured EPCs possess proangiogenic/vasculogenic potential (Figure I of the online-only Data Supplement). To identify vasa nervorum, we injected BS-1 lectin before the mice were killed. In whole-mount preparations of sciatic nerves, we observed that intramuscularly injected EPCs, prelabeled with the red fluorescent dye Dil, homed to sciatic nerves and robustly engrafted over the study period of 12 weeks (Figure 4A and 4B). In contrast, engrafted EPCs were observed less frequently in the femoral muscles at 2 weeks, and most of the EPCs disappeared within 8 weeks (Figure 4C). These findings suggest that EPCs preferentially home to the sciatic nerve and that a large number of the engrafted EPCs migrated along the course of and abutting the vasa nervorum (Figure 5A through 5C). Immunohistochemistry and fluorescence-activated cell sorter analysis of the digested nerves at 8 weeks after treatment revealed that ≈90% of the engrafted EPCs exhibit CD11b and Tie2, suggestive of the phenotype of proangiogenic Tie2-expressing monocytes/macrophages (online-only Data Supplement Figure IIA and IIB).
cross sections, a small portion of the EPCs expressed an endothelial cell phenotype, suggesting transdifferentiation into endothelial cells (Figure 5D and 5E). These data show that locally injected EPCs have specific tissue tropism to diabetic nerves and affinity for endothelial cells within the nerves. We found that the expression of SDF-1α and MCP-1 was detected only in the nerves, not in the muscles, which suggests that these factors may play a role in recruiting EPCs to diabetic nerves (online-only Data Supplement Figure III).

### EPC Transplantation Increases Proliferation of Endothelial Cells and Schwann Cells
We also investigated the paracrine effects of EPCs. We implanted a mini-osmotic pump loaded with BrdU in the back...
skin immediately after treatment that released BrdU for 4 weeks. These sciatic nerves were harvested at 4 weeks, and double immunohistochemistry with antibodies against BrdU and a Schwann cell marker, S-100, was performed. We found 4 times as many BrdU-positive Schwann cells in the DM-EPC group as in the DM-saline group (Figure 6A and 6B). To determine whether this proliferative effect could be mediated through the paracrine action of EPCs, we used hypoxic conditions to mimic the in vivo status of diabetic nerves that are under ischemia as a result of the loss of vasa nervorum. Schwann cells or endothelial cells (human umbilical vein endothelial cells [HUVECs]) were cultured in EPC-conditioned media, collected after EPCs had been cultivated either in normoxia or 5% hypoxia or in plain EBM-2 (Figure 6C and 6D). We found that proliferation of both Schwann cells and HUVECs grown in hypoxic EPC-conditioned media was significantly higher than controls (Schwann cells, 13.4% increase over 3% FBS, P<0.01; HUVECs, 24.4% increase over 3% FBS, P<0.01; Figure 6C and 6D). Taken together, these findings suggest that transplanted EPCs effectively induced proliferation of Schwann cells and endothelial cells through their paracrine activity.

EPC Transplantation Decreases Apoptosis in Endothelial Cells and Schwann Cells in Diabetic Nerves

We further asked whether EPC transplantation can affect ongoing apoptosis in diabetic nerves. We performed TUNEL assay on sciatic nerves obtained 1 week after cell transplantation. The number of TUNEL-positive cells was 4-fold higher in the nerves of DM-saline mice than in NDM-saline mice (P<0.05; Figure 7A and 7B), but this number was reduced by 50% in the DM-EPC mice (P<0.001 versus DM-saline; Figure 7B). Qualitatively, concomitant staining...
with TUNEL and either ILB4 or S100 revealed that apoptosis occurred in both endothelial cells and Schwann cells (Figure 7C and 7D).

**EPC Transplantation Increases Multiple Angiogenic, Antiapoptotic, and Neurotrophic Factors**

Next, to determine whether paracrine factors secreted by EPCs could mediate the proproliferative and antiapoptotic effects of EPCs, we examined the levels of angiogenic and neurotrophic factors in sciatic nerves at 4 weeks after EPC transplantation. Quantitative reverse-transcription polymerase chain reaction revealed that mRNA expression levels of angiogenic and neurotrophic factors were higher in the EPC-injected group than in the saline-injected group (VEGF-A, 3.4-fold; FGF-2, 1.5-fold; and Gli 1, 2.6-fold; all \( P<0.05 \); brain-derived neurotrophic factor, 5.9-fold; SHh, 2.4-fold; and SDF-1, 1.9-fold).

**Figure 7.** EPC transplantation decreased apoptosis. A, A representation illustrating TUNEL-positive cells (green fluorescence) in a diabetic nerve. Inset shows the magnified view of TUNEL- and DAPI-positive nuclei in a diabetic nerve. Blue is DAPI. Bar=50 μm. B, The number of TUNEL-positive cells was 4-fold higher in diabetic nerves than in nondiabetic nerves \( (P<0.05, \text{DM-saline vs NDM-saline}). \) EPC-transplanted diabetic nerves have reduced TUNEL-positive cells \( (P<0.001, \text{DM-saline vs DM-EPC}). \) n=5 each group. C and D, To further investigate the identity of TUNEL-positive cells, double immunohistochemistry was performed. Both ILB4-positive endothelial cells (C) and S100-positive Schwann cells (D) showed positive reaction in TUNEL assay. Bars=20 μm. HPF indicates high-power field.
fold, all $P<0.001$; Figure 8A through 8G). The levels of nerve growth factor, angiopoietin 1, epidermal growth factor, and hepatocyte growth factor were too low to be detected (data not shown). Western blot analysis further demonstrated that the protein levels of VEGF, FGF-2, and Gli 1 were significantly increased in the EPC group compared with the saline group (VEGF A, 2.2$\pm$0.5-fold; FGF-2, 1.6$\pm$0.2-fold; and Gli 1, 1.9$\pm$0.3-fold, all $P<0.05$). These findings suggest that intramuscular injection of EPCs upregulated multiple angiogenic and neurotrophic factors at the mRNA and protein levels (Figure 8H and 8I).

**Discussion**

In this study, we have found that local transplantation of BM-derived EPCs improved various manifestations of experimental DN through direct effects on peripheral nerves. Some of the most salient findings of the present study are as follows. First, local transplantation of BM-derived EPCs restored neurophysiological deficits in DN. Second, EPC treatment increased neural vascularity functionally and histologically. Third, intramuscularly injected EPCs preferentially homed to sciatic nerves, characteristically localized in close proximity to vasa nervorum, and transdifferentiated into endothelial cells, albeit infrequently. Fourth, a large number of engrafted EPCs survived in peripheral nerves for $>12$ weeks and induced prolonged expression of angiogenic and neurotrophic factors. Fifth, EPC transplantation increased proliferation and decreased apoptosis of endothelial and Schwann cells.
It is our hypothesis that microvascular insufficiency in nerves plays a major role in the development and progression of DN and therefore that therapeutic intervention by EPC transplantation can reverse or attenuate DN by inducing neovascularization and supplying angioneutrophic cytokines. The coincidence of restoration of vasa nervorum accompanied by functional nerve recovery has been documented in DN with distinct angiogenic agents. Again, this study provides strong evidence that the development of and recovery from DN are pathophysiologically associated with loss and gain, respectively, of vasa nervorum.

The most notable finding of the present study is the direct effect of EPCs on peripheral nerves. BS-1 lectin perfusion experiments clearly demonstrate for the first time that EPC transplantation increases capillary density and blood flow in nerves, suggesting that EPCs induce genuine neovascularization in nerves. Mechanistically, because transdifferentiation of EPCs into endothelial cells was observed only infrequently, our results suggest a greater contribution by angiogenesis than vasculogenesis to this process. This neural angiogenesis appears to be made possible through upregulation of various angiogenic factors in nerves after EPC transplantation. In fact, this is the first evidence documenting upregulation of multiple paracrine or humoral factors in peripheral nerves after treatment with stem/progenitor cells. In this study, factors such as VEGF-A, FGF-2, brain-derived neurotrophic factor, SHh, and SDF-1α, which are known to function as both angiogenic and neurotrophic factors, were highly expressed in EPC-transplanted nerves. These upregulated factors could have provided additional benefits for the recovery of neural function by promoting proliferation and inhibiting apoptosis of Schwann cells. In addition, these humoral effects might be contributed not only by the injected EPCs but also by the recovering nerves after EPC treatment. This is the first report showing such dual angiogenic and neurotrophic effects of EPCs. This upregulation of various classes of biologically important factors may be one of the greatest benefits of stem cell therapy over any single protein or gene therapy, enabling the concerted efforts of multiple neuroangiogenic cytokines necessary for neurovascular recovery.

One prior study showed that cord blood–derived EPCs were effective for treating DN. Although this study reported a therapeutic potential of cord blood cells, mechanistically, a wide difference exists between that study and the present one. The study by Naruse et al., which used umbilical cord blood–derived EPCs, suggested that the therapeutic effects might be due to increased differentiation of EPCs into endothelial cells in hind-limb muscles, which then led to an increase in sciatic nerve blood flow. However, that study did not investigate the fate or engraftment characteristics of the EPCs in tissues, nor did it address the mechanisms by which transplanted EPCs increase neovascularization in muscles or nerve. In fact, more studies argue against the transdifferentiation of EPCs as a major mechanism underlying therapeutic effects. In contrast, our study clearly provided 2 important mechanistic insights. First, intramuscularly injected EPCs exert therapeutic effects through direct modulation of nerves, not through muscular neovascularization. Second, the domain mechanism is humoral or paracrine effects, not transdifferentiation. Histological examination of our samples revealed that in hind-limb muscles the number of engrafted EPCs was much smaller, and a majority of EPCs disappeared within 8 weeks; in the sciatic nerves, however, EPCs robustly survived for >12 weeks. Interestingly, the study by Naruse et al showed that capillary density, which had decreased in hind-limb muscles of diabetic rats at 12 weeks of diabetes mellitus, was significantly increased after cord blood EPC treatment. In contrast, our data suggested that blood flow and capillary density were decreased mildly but not statistically significantly in hind-limb muscles. This discrepancy might have been due to the difference in animal species or genetic backgrounds of mice used for a diabetic model: Naruse et al used nude rats, whereas we used C57BL6/J mice. Nude rats exhibit more severe impairment in angiogenesis because they lack T cells; this blunted angiogenic response in the nude rat might have caused the significantly reduced vascularity seen in the hind-limb muscle in diabetic nude rat. Thus, we have concerns that using human cord blood EPCs in nude rats might not have properly addressed the mechanisms involving the therapeutic effects of EPCs resulting from xenogenic mismatch and the choice of an angiogenically impaired animal model. In contrast, the present study, by using syngeneic mice for both donors and recipients, avoided such potential confounding factors.

We made 3 novel observations on the fate of EPCs in tissues. One of the most striking findings was that EPCs homed to peripheral nerves far more preferentially than to muscles (Figure 5). This scale of close interaction between any BM cells and steady-state tissues was not previously reported either with or without diabetes mellitus. SDF-1α and MCP-1 produced by diabetic nerves seemed to be able to attract injected EPCs. Another notable finding was the durable engraftment of BM-derived EPCs into diabetic nerves. After reports on the short-lasting engraftment of transplanted BM cells in a myocardial infarction model, the notion has been widely accepted that engrafted adult stem/progenitor cells disappear within a couple of weeks. However, the present study disclosed that a large number of BM-derived progenitor cells could survive for a prolonged period of time, 12 weeks, in nerves. These data indicate that the engraftment characteristics of progenitor cells may depend more on the recipient environment than on the transplanted cells themselves. However, a limitation of this study is that although we detected long-term EPC engraftment, the 12-week time frame is much shorter than the clinical course of this disease. The last intriguing finding is that the engrafted EPCs were localized in close proximity to the vasa nervorum. To the best of our knowledge, such a significant magnitude of tropism of BM-derived cells to blood vessels has not been reported in any other tissues, either in normal or in diseased states. These unique characteristics of BM-derived EPCs, ie, peripheral neurotropism, sustained engraftment, and vascular localization of EPCs, could have caused robust and prolonged paracrine or humoral effects and led to the reversal of functional and histological impairment of peripheral nerves in diabetes mellitus.
Because advanced DN, which is a likely candidate for cell therapy, is frequently combined with and presents by diabetic foot ulcers and/or limb ischemia and because EPCs are also known to be effective for treating diabetic wounds or lower-limb ischemia, a therapeutic approach of using EPCs in advanced DN can be clinically relevant and valuable. Practically, because the safety of autologous BM-derived EPCs or similar progenitor cells has been documented by a number of clinical trials,²⁵,³⁹ it would be possible to advance this strategy into a pilot clinical trial. The effectiveness of the patient’s own diabetic EPCs versus healthy EPCs needs to be evaluated because of a potential concern about the negative effects of diabetes mellitus on EPCs. Taken together, these findings suggest that cell therapy with BM-derived EPCs may represent an innovative therapeutic option for treating DN.

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Disclosures
None.

References


**CLINICAL PERSPECTIVE**

In the United States alone, >18 million people suffer from diabetes mellitus. Peripheral neuropathy is the most common complication of diabetes mellitus, affecting up to 60% of long-standing diabetic patients. Diabetic neuropathy (DN) commonly manifests with loss of sensation in the feet, frequently leading to foot problems such as ulcers. Despite a continuous increase in the incidence of diabetes and DN, current treatments have yet to effectively treat DN. Recent evidence suggests that DN is causally related to impaired angiogenesis and deficient neurotrophic factors. Endothelial progenitor cells exist in peripheral blood and bone marrow. Therapeutically, preclinical and clinical pilot studies have demonstrated that endothelial progenitor cells are effective in repairing various cardiovascular diseases via differentiation into new vessels and production of angiogenic and neurotrophic factors. In this study, we demonstrate that local injection of endothelial progenitor cells reversed functional impairments of DN in experimental DN by augmenting neovascularization and providing angiogenic and neurotrophic factors in diabetic nerves. Our study suggests a novel therapeutic strategy, the application of stem/progenitor cell therapy, for DN and provides new insight into the pathophysiological features of DN. Considering that DN is frequently combined with diabetic foot ulcers, limb ischemia, or both, an approach that uses endothelial progenitor cells could have additional clinical benefits for treating complicated DN.
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Supplemental Methods

Induction of diabetes

All protocols were approved by St. Elizabeth’s Institutional Animal Care and Use Committee. We induced diabetes in 6 week-old male C57BL/6J mice by intraperitoneal injection of streptozotocin (150 mg/kg in 0.9% sterile saline). Serum glucose levels were measured 2 weeks later, and all animals with levels less than 250 mg/dl were excluded from these studies. The mice were randomly assigned to EPC or saline injection groups 12 weeks after induction of diabetes (n = 25, each group). Age- and sex- matched mice were used as non-diabetic controls and received the same treatment.

Isolation of endothelial progenitor cells (EPCs) and cell culture

For EPC culture, the femur, tibia, sternum, vertebrae and humerus of 8-week old female C57BL/6J mice were excised, with special attention given to remove all connective tissue attached to the bones. These bones were crushed with EDTA mixed with PBS. Mononuclear cells were fractionated by density gradient centrifugation (HISTOPAQUE®-1083, Sigma-Aldrich, St. Louis, USA). Isolated
mononuclear cells (8.0×10^7 per animal) were cultured at 0.8–1.0×10^6 cells/cm^2 on rat plasma vitronectin (Sigma-Aldrich)-precoated 10 cm dishes. The cells were cultured in EC basal medium (EBM-2) supplemented with 5% fetal bovine serum (FBS), antibiotics and cytokine cocktail (SingleQuots) (Clonetics, San Diego, California) \(^1\). At day 4 in culture, nonadherent cells were removed by washing with PBS and the media was changed. The culture was maintained through day 7. These cells showed typical characteristics of early EPCs (suppl Figure 1)\(^2-5\). Mouse Schwann cells were obtained from ATCC (Manassas, VA) and cultured in DMEM (Cambrex) with 10% FBS. Human umbilical vein endothelial cells (HUVECs) were cultured in EBM-2 supplemented with 5% FBS, antibiotics and SingleQuots.

**Local transplantation of EPCs**

After completion of baseline nerve conduction studies, we labeled EPCs with a red fluorescent dye, CM-Dil (Invitrogen) as previously described \(^6\) and injected EPCs (1×10^6 /100µl saline per limb) or the same volume of saline into the muscles percutaneously along the course of the sciatic nerve at 4 sites using a 30-gauge needle.

**Neurophysiologic measurements**
**Measurements of nerve conduction velocity**

Sciatic nerve conduction velocity (NCV) was measured bilaterally using standard orthodromic surface recording techniques and a Teca TD-10 (Oxford Instruments, Chicago, Illinois, USA) portable recording system at baseline (before treatment) and at 2, 4 and 8 weeks after treatment as described previously \(^7\,^8\). Briefly, motor nerve conduction velocity (MCV) was calculated by dividing the distance between stimulating electrodes by the average latency difference between the peaks of the compound muscle action potentials (CMAPs) evoked from two sites (sciatic notch and ankle). Sensory nerve conduction velocity (SCV) was calculated by dividing the distance between stimulating and recording electrodes by the latency of the signal from the stimulation artifact to the onset of the peak signal. For each nerve, maximal velocities were independently determined four times at both sides and the average values were used for comparison.

**Tailflick testing**

This behavioral test examines the response of each mouse to a noxious thermal stimulus which is mediated by small fiber dorsal root ganglia sensory neurons \(^8\,^9\). The animals were loosely restrained with their tails immersed in a beaker of water to a depth of about 2 cm. The beaker was uniformly heated at a rate of about 2°C per
minute beginning at 35°C. The temperature at which each animal flicked its tail out of
the water was recorded to the nearest 0.5°C.

**In vivo assessment of perfusion and vascularity**

**Laser Doppler imaging of vasa nervorum blood flow**

Perfusion of sciatic vasa nervorum was measured in each hindlimb of mice, with a
laser Doppler perfusion imager (LDPI) system (Moor Instruments, Wilmington,
Delaware, USA) as described previously \(^9,10\). After anesthesia, nerves were exposed
by scalpel incision and blunt dissection of the overlying muscle. Immediately after
exposure of the nerves, measurements were repeated twice over the same region of
interest. Color-coded images were recorded and analysis was performed by
calculating the average perfusion for each nerve.

**Fluorescent imaging of blood vessels in sciatic nerves and femoral muscles**

Vascularity of sciatic nerves and femoral muscles from both non-diabetic and
diabetic mice was assessed by in situ fluorescent staining using an endothelial cell–
specific marker, BS-1 lectin conjugated to FITC (Vector Laboratories, Burlingame,
California, USA) as described previously \(^9,10\). After anesthesia, the hindlimbs were
perfused with BS-1 lectin (0.25 mg per mice) by direct cardiac injection. Fifteen
minutes later, the animals were sacrificed and the sciatic nerves and femoral muscles were harvested and fixed in 4% paraformaldehyde (PFA). After fixation, samples were either whole-mounted for longitudinal analysis or embedded in OCT compound for frozen section. Samples were analyzed using a computer assisted Nikon fluorescence microscope with a digital camera (Eclipse TE200, Nikon Inc., Melville, New York). The number of vessels was measured in 10 randomly selected cross sections under a fluorescent microscope (× 200).

**Histopathologic analysis of sciatic nerves**

*Double fluorescence immunohistochemistry for BrdU*

To determine the proliferative fraction of cells, we implanted miniosmotic pumps (Alzet, Cupertino, California) in the skin which release BrdU continuously. Mice were sacrificed after 4 weeks and sciatic nerves were isolated and prepared for frozen sections. Frozen tissue sections (6 µm- thickness) were fixed with 4% PFA. Sections were incubated with biotinylated sheep anti-BrdU antibody (1:100, Biodesign, Saco, Maine) for 1 hour followed by Rhodamine conjugated streptavidin (1:500, Jackson ImmunoResearch). After washing with PBS, sections were incubated with either biotinylated isolectin B4 (ILB4) (1:100, Vector laboratories) for detection of endothelial cells or goat polyclonal anti-S100 (1:100, Santa Cruz)
antibody for detection of Schwann cells, followed by fluorescein (FITC)-conjugated streptavidin (1:500) or Cy2 conjugated anti goat IgG (1:500) (Jackson ImmunoResearch), respectively. Sections were counterstained with DAPI (1:5000). Proliferation activity was evaluated by fluorescent microscopy as an average number of BrdU-positive cells in 5 randomly selected high power fields.

**Double fluorescence immunohistochemistry for TUNEL**

Frozen tissue sections were incubated with TUNEL mixture (In Situ Cell Death Detection Kit, Fluorescein, Roche Molecular, Penzberg, German) for 60 min at 37°C. After washing with PBS, sections were stained with biotinylated ILB4 followed by Texas Red-conjugated streptavidin (1:500) or goat polyclonal anti-S100 antibody (1:100, Santa Cruz), followed by Cy3 conjugated anti-goat IgG (1:500) (Jackson ImmunoResearch). Sections were counterstained with DAPI (1:5000) and mounted in aqueous mounting medium. Apoptosis activity was evaluated under fluorescent microscopy as an average percentage of TUNEL-positive cells in 5 randomly selected high power fields.

**In vitro cell proliferation assay**

The proliferating cell number of viable Schwann cells and HUVECs was determined
using a validated non-radioactive cell proliferation assay kit (CellTiter 96; Promega, Madison, Wisconsin, USA) as previously described \(^8\). Cells were seeded in 96-well plates at 80% confluence \((1 \times 10^4 \text{ cells/well})\) and were cultured in EBM-2 media containing 0.5% and 3% FBS or EPC conditioned media for 48 h. Then, 15 µl of dye solution from the cell proliferation assay kit was added per well, and cells were incubated for 4 h before measurement of absorbance at 570 nm. To prepare EPC conditioned media, we cultured EPCs for 7 days and changed to new growth factor free EBM-2 media. After 3 hours cultivation under 5% \(O_2\) (hypoxic EPC-conditioned media) or normoxia (normoxic EPC-conditioned media), EPCs were cultured for another 12 hours under normal culture conditions and conditioned media was collected.

**Measurements of paracrine factors in the nerves**

**Quantitative RT-PCR for mRNA expression**

Total RNA was extracted from sciatic nerve with RNA-Stat (Iso-Tex Diagnostics, Friendswood, TX) according to the manufacturer’s instructions. First-strand cDNA was generated using the Taqman Multiscribe Reverse Transcription Kit (Applied Biosystems, Foster City, CA) primed with a mix of oligo-dT and random hexamers. Gene expression was determined by Taqman real-time quantitative PCR (7300
Sequence Detection System) (Applied Biosystems) using Taqman PCR Master Mix (Applied Biosystems). Taqman primer/probe sets (Biosearch Technologies) were designed using Primer Express Software (Applied Biosystems). The PCR conditions were as follows. 2 min at 50°C and 10 min at 95°C, followed by 2 step PCR: 95°C for 15 seconds and 60°C for 60 seconds for 40 cycles with fluorescence monitoring at the end of each elongation step. Relative mRNA expression of target genes was calculated with the comparative C\textsubscript{T} method. All target sequences were normalized to GAPDH in multiplexed reactions performed in duplicate. The primers and probes we used are summarized in Table 1.

**Western blot analysis**

Sciatic nerves were harvested 4 weeks after EPC transplantation. Protein extraction and Western blots were performed as described previously \textsuperscript{11}. We used VEGF, FGF-2 and Gli 1 antibodies (Santa Cruz Biotechnology Inc, Santa Cruz, California) for immunoblotting. Densitometric analyses for the blots were performed using NIH Image\textsuperscript{TM} software.

**Statistical Analysis**

All results are presented as the mean ± SEM. Statistical analysis was performed by
an unpaired Student’s t-test for comparisons between two groups and ANOVA for more than two groups. \( P < 0.05 \) is considered to denote statistical significance.

Supplemental Table 1. Oligonucleotide primers and probes used for mRNA expression analysis by real-time PCR

<table>
<thead>
<tr>
<th>Primer Sequences (5’-3’)</th>
<th>Reverse</th>
<th>Probe</th>
</tr>
</thead>
<tbody>
<tr>
<td>VEGF-A</td>
<td>GCGGCGCGCTGCGAATG</td>
<td>CATAGTGAGCGTGGCTCTCCGAC</td>
</tr>
<tr>
<td>FGF-2</td>
<td>GTACGCGAAATACCTCGAGTTG</td>
<td>CCCGTTGCGAATCGAGTTGACT</td>
</tr>
<tr>
<td>BDNF</td>
<td>CCAAGGCGCGGCGACTCG</td>
<td>GAGCGCTCAAAAGCGACTCTG</td>
</tr>
<tr>
<td>Gli-1</td>
<td>GCGTGGAGTGAAGGACTCTTTCG</td>
<td>GCGTGGACAGCCATAGCT</td>
</tr>
<tr>
<td>Shh</td>
<td>CAGCGCGACGCCCTCAGCT</td>
<td>CCGGCTGCGTGCTCAGT</td>
</tr>
<tr>
<td>SDF-1alpha</td>
<td>CCTCGAAGCAGCATCGCTCA</td>
<td>CCTCGAAGCAGCATCGCTCA</td>
</tr>
<tr>
<td>IGF-1</td>
<td>TGAGTGCGGTGCTGGCTGACT</td>
<td>CGCGCTGCTGGCTGACTG</td>
</tr>
<tr>
<td>eNOS</td>
<td>TCGTGGCGCGGCTGACTATG</td>
<td>CATCGCGCGGCTGGCTGACTATG</td>
</tr>
<tr>
<td>NGF</td>
<td>CCCATGTCACCTCGCTCTGG</td>
<td>GAAGCTCCAGGAGCAAGCTG</td>
</tr>
<tr>
<td>EGF</td>
<td>GTGCGAGGAGCGCGCTGCTCA</td>
<td>GGCGAGGAGCGCGCTGCTCA</td>
</tr>
<tr>
<td>Ang 1</td>
<td>GGGCGCGAGCGCGAGCG</td>
<td>TGGGATGGAGCGCGAGCG</td>
</tr>
<tr>
<td>HGF</td>
<td>CGTGGATGCGGCGCTGCGGCT</td>
<td>CGTGGATGCGGCGCTGCGGCT</td>
</tr>
<tr>
<td>GAPDH</td>
<td>CTGGTGGGCTGCTGCTG</td>
<td>TGGGATGGAGCGCGAGCG</td>
</tr>
</tbody>
</table>

VEGF-A, fibroblast growth factor (FGF)-2, brain derived neurotrophic factor (BDNF), Gli-1, sonic hedgehog (SHH), stromal cell-derived factor (SDF)-1\(\alpha\), insulin-like growth factor (IGF)-1, eNOS, nerve growth factor (NGF), epidermal growth factor (EGF), angiopoietin (Ang)-1, and hepatocyte growth factor (HGF)
Methods for Supplemental Figures

Dil-acLDL uptake assay and isolectin B4 staining of cultured BM-EPCs

The phenotype of the cultured BM-EPCs was examined by uptake of Dil-labeled acetylated LDL (Dil-acLDL) and staining for isolectin B4 (IB4) as previously described (Kalka C and Asahara T et al. PNAS 2000). Briefly, adherent cells were incubated with 20 µg/mL of Dil-acLDL (Molecular probes) for 1 hour and fixed with 1% paraformaldehyde for 10 min. After washes, cells were stained with 2 µg/ml of Alexa 488-conjugated IB4 (Molecular probes).

FACS analysis of BM-EPCs and diabetic nerves transplanted with BM-EPCs

All antibodies used were from BD biosciences (San Jose, CA) or eBioscience, Inc. (San Diego, CA) unless specified. For analysis of cultured EPCs, cells were collected using a cell scraper in MACS buffer (Miltenyi Biotec GmbH, Germany). For analysis of EPCs transplanted into diabetic nerves, the nerves were minced, digested at 37°C for 60 – 90 min with an enzyme cocktail (250 µg/ml of collagenase, 10 µg/ml of elastase, and 25 µg/ml of DNase I, Roche Applied Science), and filtered through a 70 µm strainer to obtain single cell suspensions. Single cell suspensions were stained for CD45 (APC-Cy7, eBioscience), Tie-2 (PE or with secondary
antibody conjugated to APC, all from eBioscience), c-kit (APC, eBioscience), CD11b (APC or APC-Cy7, BD biosciences), B220 (PE-Cy7, BD bioscience), and CD3e (PE, BD biosciences) (all the antibodies were used at 1:100 dilution) and analyzed using the BD LSRII system (BD biosciences). FACS data were analyzed with FlowJo (Tree Star, Inc., Ashland, OR) using isotype-matched IgG controls.

Immunohistochemistry of diabetic nerves transplanted with BM-EPCs

Nerves were fixed for 4 h in 4% paraformaldehyde and incubated in 15% sucrose solution. The nerves were embedded in OCT compound and snap-frozen in liquid nitrogen, and sectioned at 5 µm thickness. As macrophage markers we used anti-CD11b antibody (1:200; eBioscience) and anti-F4/80 antibody (1:200; eBioscience), with secondary biotinylated anti-rat IgG and Streptavidin-Alexa 488 (1:400; Invitrogen). As T and B cell markers, we used anti-CD3 antibody (1:200; eBioscience) with secondary biotinylated anti-hamster IgG and Streptavidin-Alexa 488, and anti-B220 antibody (1:200; eBioscience) with secondary biotinylated anti-rat IgG and Streptavidin-Alexa 488. Nuclear counterstaining was performed with DAPI (Sigma).
Supplemental Figure Legends

Suppl Figure 1. Cultured bone marrow-derived early endothelial progenitor cells (BM-EPCs) possess characteristics of endothelial cells and monocytes/macrophages

A. BM-EPCs at day 7 in culture were positive for both Alexa 488-conjugated isolectin B4 (IB4) immunoreactivity (green fluorescence) and Dil-labeled acetylated LDL (Dil-acLDL, red fluorescence). Bars, 50 µm (low magnification) and 200 µm (high magnification). B. FACS analyses of BM-EPCs at day 7 in culture demonstrated that 31% of the BM-EPCs were positive for Tie2 expression and 91% for CD11b. n=3, BM-EPC cultures.

Suppl Figure 2. A majority of engrafted EPCs in diabetic nerves express angiogenic monocyte/macrophage markers

A. Immunohistochemistry of a sciatic nerve harvested from a diabetic mouse at 8 weeks after EPC transplantation with antibodies to CD11b, F4/80, B220, and CD3e (all green fluorescence) demonstrated that Dil-EPCs (red fluorescence) were positive for the expression of CD11b and F4/80. DAPI (blue fluorescence), Bars, 100 µm. B. FACS analyses of digested diabetic nerves 8 weeks after EPC transplantation
demonstrated that 87.3% of Dil-EPCs were positive for CD11b and 94.2% for Tie2.
n=3, diabetic nerves.

Suppl Figure 3. Chemokine production by diabetic nerves might contribute to recruitment of injected EPCs to the nerves

Real-time PCR analyses of sciatic nerves and hindlimb muscles from diabetic mice of 12 week duration demonstrated that SDF-1α and monocytes chemoattractant protein (MCP)-1 are highly expressed in diabetic nerves whereas the levels of SDF-1α and MCP-1 are below the detection limit in diabetic muscles. n= 3 animals, each group.
Suppl Figure 1
Suppl Figure 2
Suppl Figure 3
Supplemental References


