Monocyte Chemotactic Protein-1 Promotes Inflammatory Vascular Repair of Murine Carotid Aneurysms via a Macrophage Inflammatory Protein-1α and Macrophage Inflammatory Protein-2–Dependent Pathway

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Background—Up to 5% of the population may have a brain aneurysm. If the brain aneurysm ruptures, there is >50% mortality, and more than one third of survivors are dependent. Brain aneurysms detected before rupture can be treated to prevent rupture, or ruptured aneurysms can be treated to prevent rerupture. Endovascular coiling of brain aneurysms is the treatment of choice for some aneurysms; however, up to one quarter of aneurysms may recur. The coiled aneurysms that do not recur are characterized by inflammatory intra-aneurysmal tissue healing; therefore, we studied the biology of this process, specifically the role of monocyte chemotactic protein-1 (MCP-1), a cytokine known for tissue healing.

Methods and Results—We created coils with a 50:50 poly-DL-lactic glycolic acid (PLGA) coating that released MCP-1 at 3 different doses (100 μg/mL, 1 mg/mL, and 10 mg/mL) and performed a dose-response study for effect on intra-aneurysmal tissue healing in a murine carotid aneurysm model. We then demonstrated that MCP-1 (100 μg/mL)–releasing coils promote significantly greater aneurysm tissue in-growth than bare platinum or PLGA-only coils. We show that MCP-1 recruits the migration of fibroblasts, macrophages, smooth muscle cells, and endothelial cells in vitro in cell migration assays and in vivo in murine carotid aneurysms. Using gfp+ bone marrow–transplant chimeric mice, we demonstrate that the MCP-1–recruited fibroblasts and macrophages are derived from the bone marrow. We demonstrate that this MCP-1–mediated vascular inflammatory repair occurs via a macrophage inflammatory protein (MIP)-1α– and MIP-2–dependent pathway. MCP-1 released from coiled murine aneurysms causes significant upregulation of MIP-1α and MIP-2 expression by cytokine array assay. Blocking MIP-1α and MIP-2 with antagonist antibody causes a significant decrease in MCP-1–mediated intra-aneurysmal tissue healing.

Conclusion—Our findings suggest that MCP-1 has a critical role in promoting inflammatory intra-aneurysmal tissue healing in an MIP-1α– and MIP-2–dependent pathway. (Circulation. 2011;124:2243-2252.)

Key Words: aneurysm ■ cerebrovascular disorders ■ inflammation ■ mice ■ MIP-1alpha ■ MCP-1 protein, mouse ■ MIP-2 chemokine

Up to 5% of the population may have a brain aneurysm.1 If a brain aneurysm ruptures, there is an associated >50% mortality rate, and more than one third of survivors end up dependent.2 Brain aneurysms that are detected before they rupture can be treated to prevent rupture, and ruptured brain aneurysms can be treated to prevent rerupture. Endovascular coiling is the treatment of choice for some ruptured and unruptured brain aneurysms.3,4 A significant drawback of endovascular coiling is aneurysm recurrence and the need for retreatment, which may occur in up to one quarter of aneurysms.5

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Surgically harvested and autopsy-derived specimens of human brain aneurysms demonstrate that durable aneurysm cure is achieved by intra-aneurysmal wound healing. Successful healing is characterized by the presence of connective tissue proliferation, fibroblasts, collagen, smooth muscle cells, capillary in-growth, and macrophages.6 The aim of brain aneurysm therapies should therefore be achievement of this type of intra-aneurysmal wound healing.

We studied the biology of intra-aneurysmal tissue healing, in particular the role of monocyte chemotactic protein-1 (MCP-1), a cytokine known to be important in tissue healing,7,8 for inflammatory vascular tissue repair in a murine carotid aneurysm model.

Methods

Animals

All animal experimentation was performed in accordance with a protocol approved by our institution’s Institutional Animal Care and Use Committee.
Murine Carotid Aneurysm Model
Murine carotid aneurysms were created in C57BL/6 female mice (Charles River, Wilmington, MA) with a method previously described. Briefly, the right common carotid artery is microsurgically exposed; porcine pancreatic elastase solution (Worthington Biochemical Corp, Lakewood, NJ) 10 U diluted in 1 mL of saline (Invitrogen, Carlsbad, CA) is applied extravascularly for 20 minutes; and then the vessel is occluded distally to create a stump. Three weeks later, a saccular aneurysm has formed at the right common carotid artery stump.

Creation of MCP-1–Releasing Coils
MCP-1–releasing coils were created by dipping standard platinum aneurysm coils into an aqueous protein suspension consisting of MCP-1 at 3 different doses of 100 μg/mL, 1 mg/mL, and 10 mg/mL (Sigma-Aldrich, St. Louis, MO) in 50:50 poly-t-lactic glycolic acid (PLGA; Sigma-Aldrich) and dichloromethane anhydrous (Sigma-Aldrich) neutralized to a pH of 7.0 with Mg(OH)₂ and drying for 24 hours at 4°C. Control PLGA-only coils were created by dipping standard platinum aneurysm coils into an aqueous suspension of PBS in 50:50 PLGA and dichloromethane anhydrous without protein. Control bare platinum coils were not dipped.

The pharmacokinetic release of MCP-1 from the coils was measured by Quickstart Bradford Protein Assay (Bio-Rad Laboratories Inc, Hercules, CA) with the Infinite 200 PRO Nanoquant microplate reader (Tecan Group Ltd, Mannedorf, Switzerland).

Dose-Response Study of MCP-1–Releasing Coils in Murine Carotid Aneurysm Model
The 3 different doses of MCP-1–releasing coils (100 μg/mL, 1 mg/mL, and 10 mg/mL) were microsurgically implanted into 3-week fully developed murine carotid aneurysms (n=10 for each). Control PLGA-only coils (n=10) were microscopically implanted into control murine carotid aneurysms. Coil implantation was performed by microsurgically inserting coils via a distal portion of the aneurysm and advancing into a proximal sacular part of the aneurysm. Implanted aneurysms were harvested 3 weeks later and sectioned by cryostat into 5-μm sections, and hematoxylin and eosin staining was performed. Quantitative measurements for tissue in-growth were performed by blinded observers who measured intraluminal tissue in-growth under microscopy using Image-Pro Plus software (Media Cybernetics, Silver Spring, MD).

Effect of MCP-1–Releasing Coil on Intra-Aneurysmal Tissue In-Growth in Murine Carotid Aneurysm Model
MCP-1-releasing coils (100 μg/mL), control PLGA-only coils, and control bare platinum coils were microsurgically implanted into 3-week fully developed murine carotid aneurysms (n=20 for each). Implanted aneurysms were harvested 3 weeks later, sectioned, stained, and measured in the same manner described above for the MCP-1 dose-response study. Immunohistochemical staining for fibroblasts (anti-FSP-1, Abcam), smooth muscle cells (anti-α SMA, Sigma), endothelial cells (anti-MECA-32, BD Pharmingen), and macrophages (anti-CD11b, BD Pharmingen) was performed.

Cell Migration Assay
The recruitment effect of MCP-1 on fibroblasts, smooth muscle cells, endothelial cells, and macrophages was studied in vitro by cell migration assay. Briefly, 3T3 fibroblasts (ATCC), mouse MOVAS smooth muscle cells (ATCC), human umbilical vein endothelial cells (HUVEC, C-003-5C, Invitrogen) and mouse J774 macrophages (ATCC) were grown to 80% confluence, followed by serum starvation for 12 hours for fibroblasts, smooth muscle cells, and endothelial cells and for 24 hours for macrophages. They were then seeded onto the upper chamber of Transwell Permeable Supports (6.5 mm diameter wells, 8 μm pore size) (Corning Life Sciences, Lowell, MA) at a concentration of 20,000 cells per well for fibroblasts and smooth muscle cells, 30,000 cells per well for endothelial cells, and 200,000 cells per well for macrophages. The bottom chambers were filled with 0.6 mL serum-free medium with MCP-1 (10 ng/mL). Controls contained serum-free medium without MCP-1 in bottom chambers. Fibroblasts and smooth muscle cells were allowed to migrate for 6 hours and macrophages and endothelial cells were allowed to migrate for 24 hours at 37°C 5% CO₂.

Creation of Chimeras
Bone marrow–derived cells in the intra-aneurysmal tissue in-growth were identified by experiments with bone marrow–transplant chimeras that were created with a method previously described. Briefly, C57BL/6 mice harboring fully developed 3-week carotid aneurysms were depleted of bone marrow by irradiation with 950 rads and then injected via retro-orbital sinus with total gfp+ bone marrow cell populations (5×10⁶) harvested from the femurs of UBC-gfp mice (The Jackson Laboratory, Bar Harbor, ME) to create chimeras designated C57BL/6anar.gfp/bm. C57BL/6anar.gfp/bm chimeras are intended to have aneurysms exhibiting wild-type characteristics but circulating bone marrow–derived cells which are gfp+.

Whole-bone marrow engraftment was confirmed 3 months later by flow cytometry analysis of peripheral blood mononuclear cells for the cell surface markers CD3, B220, and CD11b.

Cytokine Array
At 2 different time points, 1 day and 1 week after implantation of MCP-1–releasing coils (100 μg/mL), control PLGA-only coils, and control bare platinum coils, aneurysms were harvested and proteins extracted with radioimmunoprecipitation assay buffer (Sigma-Aldrich), and cytokine array was performed with a RayBio Mouse Cytokine Antibody Array Kit (RayBiotech, Norcross, GA), which screens for the following cytokines: Axl, CD30 L, CD30 T, CD40, CRG-2, CTACK, CXCL16, etoxin, etoxin-2, Fas L, fractalkine, growth colony stimulating factor, granulocyte macrophage colony stimulating factor, interferon-γ, insulin-like growth factor binding protein (IGFBP)-3, IGFBP-5, and IGFBP-6, interleukin (IL)-1α, IL-1β, IL-2, IL-3, IL-3Rβ, IL-4, IL-5, IL-6, IL-9, IL-10, IL-12 p40/p70, IL-12 p70, IL-13, IL-17, KC, leptin R, leptin, CXCL5, L-selectin, lymphotoxin, MCP-1, MCP-5, macrophage colony stimulating factor, monokine induced by interferon-g, macrophage inflammatory protein-1α (MIP-1α), MIP-1g, MIP-2, MIP-3β, MIP-3α, CXCL4, P-selectin, RANTES, stem cell factor, stromal-derived factor-1g, thymus- and activation-regulated chemokine, TCA-3, TECK, tissue inhibitor of metalloproteinase-1, tumor necrosis factor (TNF)-α, sTNF-R1, sTNF-R2, thyroid peroxidase, vascular cell adhesion molecule-1, and vascular endothelial growth factor.

MIP-1α and MIP-2 Blockade
C57BL/6 mice harboring fully developed 3-week carotid aneurysms were given an antibody antagonist of MIP-1α (15 μg in 100 μL PBS; R&D Systems) subcutaneously (n=10), an antibody antagonist of MIP-2 (8 μg in 100 μL PBS; R&D Systems) intravenously, (n=10) or vehicle (100 μL PBS) subcutaneously and intravenously (n=10) every 48 hours starting 48 hours before implantation of MCP-1–releasing coils (100 μg/mL) and until aneurysms were harvested 3 weeks later.

Statistical Analysis
For the MCP-1–releasing coil dose-response study, the comparison of MCP-1–releasing coil with PLGA-alone and bare platinum coils, and the MIP-1α and MIP-2 blockade study, we fit mixed linear models to the data using SAS PROC MIXED (version 9.1). For all experiments, our response variable was the individual reading taken by 1 of 2 observers on 1 of 5 slides for each mouse (we did no averaging of measurements). Fixed factors were group membership, observer, and group-by-observer interaction. We modeled mouse and mouse-by-observer interaction as random effects, and we assumed a variance component covariance-matrix structure. We verified this covariance choice by using SAS PROC GENMOD to fit general estimating equation models to the data, which produced almost identical results. We decided a priori that in post hoc tests for all
experiments, we would make pairwise comparisons against only 1 group (PLGA in the dose-response study, MCP-1 in the study with both PLGA-alone and bare platinum control groups, and control in the MIP-1α and MIP-2 blockade study). Hence, we used the Dunnett method (2 sided) for multiple comparisons against a single group to control the type I error rate at 0.05 when performing these tests.

For the test of control for MIP-1α and MIP-2 in the cytokine array study, we used ANOVA with the proportion of positive control as the response and treatment group as the independent variable. We used the Bonferroni method to make 2-sided post hoc pairwise comparisons. Finally, for the cell migration assay, we used negative-binomial regression models to determine whether counts in the control and MCP-1 groups differed significantly for each cell type. For each cell type, we used the number of cells observed as the response variable and group membership as the independent variable. We also included test specimen (1, 2, or 3) as a covariate in the analyses.

Results

MCP-1 Promotes Tissue In-Growth and Healing in Murine Carotid Aneurysms

To study the role of MCP-1 in the inflammatory vascular repair of aneurysms, we created coated coils that slowly release MCP-1 over 21 days and implanted them in our murine carotid aneurysm model.9 We chose to use a 50:50 poly-DL-lactic glycolic acid (PLGA) by MCP-1–releasing coils. MCP-1–releasing coils at 3 doses (100 μg/mL, 1 mg/mL, and 10 mg/mL), PLGA-only coils, and bare platinum coils (5 mm of each) were placed in 100 mL PBS and shaken in a 37°C incubator; PBS was then collected at each time point, and Bradford assay was performed.

We performed a dose-response study in which murine carotid aneurysms were implanted with MCP-1–releasing coils at 3 different doses of 100 μg/mL, 1 mg/mL, and 10 mg/mL (n=10 each), and 3 weeks later, aneurysms were harvested, sectioned, stained, and measured for intra-aneurysmal tissue in-growth (Figure 2A). We then studied the effect of MCP-1 on intra-aneurysmal tissue in-growth by comparing MCP-1–releasing coils (100 μg/mL) with control PLGA-only and control bare platinum coils (n=20 each) implanted into murine carotid aneurysms, and 3 weeks later, MCP-1–releasing coils were associated with significantly more intra-aneurysmal tissue in-growth and healing than the aneurysms implanted with control PLGA-only coils (P<0.05) or control bare platinum coils (P<0.01; Figure 2B).

MCP-1 Causes Migration of Fibroblasts, Endothelial Cells, Smooth Muscle Cells, and Macrophages

In harvested human cerebral aneurysms, durable tissue healing is characterized by fibroblasts, smooth muscle cells, capillary in-growth, and macrophages.6 In our murine carotid aneurysm model, we demonstrate that MCP-1 promotes
greater intra-aneurysmal tissue in-growth than control PLGA-only and control bare platinum coils. MCP-1 is a potent chemokine of macrophages, fibroblasts, smooth muscle cells, and endothelial cells and has been shown to be critical in inflammatory healing in extravascular tissues such as cutaneous wounds and myocardial infarction. In intravascular environments, however, MCP-1–induced inflammatory healing produces undesired effects such as neointimal hyperplasia and atherosclerosis. In the specific instance of aneurysms, however, intravascular tissue proliferation is a desired result; therefore, MCP-1 may have a specific role in this specific disease.

We tested in vitro MCP-1 chemotaxis of the desired cell types: macrophages for positive paracrine production to initiate inflammatory healing, fibroblasts for connective tissue proliferation, endothelial cells for capillary in-growth, and smooth muscle cells for vascular integrity. Cell migration assays with MCP-1 and control serum-free medium were performed and demonstrated that MCP-1 has a pronounced recruitment effect on the migration of fibroblasts, endothelial cells, smooth muscle cells, and macrophages (Figure 3). Thus, MCP-1 can recruit the appropriate players to carry out inflammatory tissue healing of aneurysms.

In vivo, in our murine carotid aneurysm model, the tissue in-growth and healing promoted by MCP-1 are characterized by significant infiltration of smooth muscle cells, macrophages, fibroblasts, and endothelial cells (Figure 4), replicating what was seen in the cell migration assay. C57BL/6anr.gfp bm aneurysms 3 weeks after implantation with MCP-1–releasing coils (n = 8) are infiltrated with gfp cells that are FSP-1 and CD11b+, demonstrating that fibroblasts and macrophages recruited to intra-aneurysmal tissue in-growth are derived from the bone marrow (Figure 5). From this, we can conclude that MCP-1–releasing coils induce significantly better intra-aneurysmal tissue healing than PLGA-only coils or bare platinum coils, and that the MCP-1–induced tissue healing is an inflammatory process carried out by fibroblasts, macrophages, smooth muscle cells, and endothelial cells that are derived from the bone marrow and migrate to the site of aneurysm healing via the circulation.

**MCP-1-Mediated Tissue In-Growth Occurs via an MIP-1α– and MIP-2–Regulated Pathway**

We suspected that other cytokines are activated by MCP-1 in carrying out tissue healing of aneurysms, and to better study the pathway by which MCP-1 initiates this inflammatory

![Figure 2](http://circ.ahajournals.org/)

Figure 2. Monocyte chemotactic protein-1 (MCP-1) induces in vivo intra-aneurysmal tissue healing. **A**, A dose-response study was performed by implanting murine carotid aneurysms with MCP-1–releasing coils at 3 different doses (100 μg/mL, 1 mg/mL, and 10 mg/mL; n = 10 each) and 3 weeks later examining them for intra-aneurysmal tissue in-growth. Percentage of lumen area occupied by tissue in-growth as measured by blinded observers using imaging measurement software. **B**, The effect of MCP-1 on intra-aneurysmal tissue healing was studied by implanting MCP-1–releasing coils (100 μg/mL), control 50:50 poly-DL-lactic glycolic acid (PLGA)–only coils, and control bare platinum coils into murine carotid aneurysms (n = 20 for each). Aneurysms implanted with MCP-1–releasing coils demonstrated significantly more intra-aneurysmal tissue in-growth and healing than aneurysms implanted with control PLGA-only coils or control bare platinum coils. Percentage of lumen area occupied by tissue in-growth as measured by blinded observers using imaging measurement software (mean ± SEM). *P < 0.05, **P < 0.01. **C**, Hematoxylin and eosin staining of representative sections of aneurysms implanted with bare platinum coil, PLGA-only coil, or MCP-1–releasing coil. Scale bar is 200 μm.
repair process, we performed a cytokine array to screen for cytokines upregulated by MCP-1 in our murine carotid aneurysm model. Cytokine array of 59 different cytokines (see Methods for a list) performed on aneurysms 1 day and 1 week after implantation with MCP-1–releasing coils demonstrated significantly elevated expression of MIP-1α and MIP-2 compared with similar aneurysms after implantation with control PLGA-only coils and control bare platinum coils (Figure 6). To further elucidate the roles of MIP-1α and MIP-2 in MCP-1–mediated intra-aneurysmal tissue ingrowth, mice harboring aneurysms implanted with MCP-1–

![Figure 3](image1.png)

Figure 3. Monocyte chemotactic protein-1 (MCP-1) induces in vitro migration of fibroblasts, endothelial cells, smooth muscle cells (SMCs), and macrophages. MCP-1 chemotaxis for each specific cell type was studied with Transwell Permeable Supports with 10 ng/mL MCP-1 protein (experimental group) or without protein (control group) in the bottom chamber. All cells were seeded on the upper chamber. After the assay was performed, the migratory cells on the bottom side of the membrane were stained and counted. Error bars are mean±SEM. HUVEC indicates human umbilical vein endothelial cell. *P<0.05, **P<0.01, ***P<0.001.

releasing coils were administered an antibody antagonist of MIP-1α (n=10), antibody antagonist of MIP-2 (n=10), or vehicle (n=10). MIP-1α– and MIP-2–blocked aneurysms had significantly reduced tissue ingrowth compared with controls (Figure 7A and 7B). We concluded from these results that MCP-1 upregulates MIP-1α and MIP-2 in carrying out inflammatory tissue healing of aneurysms and that MCP-1–induced aneurysm healing is dependent on MIP-1α and MIP-2.

![Figure 4](image2.png)

Figure 4. Monocyte chemotactic protein-1 (MCP-1)–induced intra-aneurysmal tissue healing is infiltrated by macrophages, fibroblasts, smooth muscle cells, and endothelial cells. Murine carotid aneurysms implanted with MCP-1–releasing coils demonstrated robust intra-aneurysmal tissue in-growth, and immunohistochemical staining demonstrates infiltration with fibroblasts (anti-FSP-1), smooth muscle cells (anti-αSMA), endothelial cells (anti-MECA-32), and macrophages (anti-CD11b). Scale bar is 50 μm.

![Figure 5](image3.png)

Figure 5. Fibroblasts and macrophages derived from bone marrow infiltrate monocyte chemotactic protein-1 (MCP-1)–induced intra-aneurysmal tissue healing. C57Bl/6anj.gfp/bbm aneurysms 3 weeks after implantation with MCP-1–releasing coils (n=8) are infiltrated with gfp+ cells that are FSP-1+ and CD11b+, demonstrating that fibroblasts and macrophages recruited to intra-aneurysmal tissue ingrowth are derived from the bone marrow. We did not see gfp+ cells that were SMA+ or MECA-32+. Scale bar is 50 mm. αSMA indicates α-smooth muscle actin.

![Figure 6](image4.png)

Figure 6. Monocyte chemotactic protein-1 (MCP-1) upregulates macrophage inflammatory protein-1α (MIP-1α) and MIP-2 expression in inflammatory aneurysm healing. A cytokine array to screen for cytokines upregulated by MCP-1 in our murine carotid aneurysm model was performed 1 day and 1 week after implantation with MCP-1–releasing coils and demonstrated significantly elevated expression of MIP-1α and MIP-2 compared with similar aneurysms after implantation with control 50:50 poly-d-lactic glycolic acid (PLGA)–only coils and control bare platinum coils. One day results shown here. Error bars are mean±SEM. *P<0.05.
Discussion

Cerebral Aneurysms

Rupture of a cerebral aneurysm can be a devastating event, resulting in death in 50% of patients and permanent disability in more than a third. Sudden death occurs in 12% who never reach medical attention. Although 24,000 people suffer from a cerebral aneurysm rupture each year in the United States, up to 5% of the population have a brain aneurysm that is not yet ruptured. Ruptured cerebral aneurysms are treated with urgent craniotomy and clipping or endovascular coiling to prevent rebleeding from the aneurysm but are associated with 30.9% death and disability for clipping and 23.5% for coiling. Unruptured cerebral aneurysms are treated with urgent craniotomy and clipping or endovascular coiling to prevent rebleeding from the aneurysm but are associated with 30.9% death and disability for clipping and 23.5% for coiling. Unruptured cerebral aneurysms are treated with prophylactic clipping or coiling to prevent them from rupturing but are associated with 10.1% to 12.6% death and disability for clipping and 7.1% to 9.8% for coiling.

National trends demonstrate that endovascular clipping is the treatment of choice for some ruptured and unruptured cerebral aneurysms. Coiling, however, is associated with recurrence, which may be seen in up to one quarter of aneurysms. Clearly, there is a need for a better treatment for ruptured and unruptured cerebral aneurysms.

The aim of cerebral aneurysm treatment should be a safe, effective, durable permanent cure. Histological analysis of surgically harvested and autopsy-derived specimens of coiled human cerebral aneurysms demonstrates that a durable permanent cure is achieved when there is intra-aneurysmal wound healing characterized by connective tissue proliferation, fibroblasts, collagen, smooth muscle cells, capillary in-growth, and macrophages. These are characteristics found in inflammatory-mediated wound healing: macrophage migration and infiltration, fibroblast proliferation, connective tissue proliferation, and capillary arteriogenesis.

MCP-1 in Inflammatory-Mediated Wound Healing

MCP-1 was originally described as a potent chemoattractant for monocytes, T cells, natural killer cells. It has a critical role in wound healing, as well as the healing and remodeling response in myocardial infarction. MCP-1–mediated tissue healing is likely an inflammatory process that has different implications in extravascular tissue compared with intravascular healing at the endoluminal wall. At the intravascular endoluminal wall, inflammatory healing of a vascular injury could result in undesired neointimal hyperplasia, and MCP-1 has been implicated in contributing to neointimal hyperplasia.

Intra-aneurysmal healing of cerebral aneurysms is a specific situation in which intravascular tissue in-growth and tissue proliferation are desired. We studied the role of MCP-1, its mechanism, and the potential to harness its actions in intravascular wound healing as a novel therapy to achieve intra-aneurysmal healing in a murine carotid aneurysm model.

If inflammatory-mediated wound healing is the process in which coiled aneurysms progress to a durable permanent cure, then it would seem that MCP-1 would have a critical role in that process. MCP-1 has been shown to mediate all 4 elements of inflammatory-mediated wound healing: macrophage migration and infiltration, fibroblast proliferation, connective tissue proliferation, and capillary arteriogenesis.

MCP-1 is a potent chemokine for monocytes, macrophages, memory T lymphocytes, and natural killer cells.
MCP-1 expression is significantly expressed in human cutaneous wound healing and coincides with the timing of macrophage migration and infiltration. MCP-1 has been demonstrated to be critical and necessary for wound healing in murine cutaneous wound models.

The role of MCP-1 in inflammatory-mediated wound healing has been studied in models of myocardial infarction. MCP-1 induces macrophage infiltration, neovascularization, and accumulation of cardiac myofibroblasts in a murine model of myocardial infarction. MCP-1 deficiency results in decreased and delayed macrophage infiltration in healing myocardial infarcts, delayed replacement of injured cardiomyocytes with granulation tissue, and attenuated postinfarction left ventricular remodeling. In the case of myocardial infarction, inflammatory healing leading to left ventricular remodeling can result in undesired left ventricular dysfunction, and blocking MCP-1 has been shown to reduce left ventricular dysfunction after myocardial infarction. The receptor for MCP-1 is CCR2, and deficiency of the CCR2 receptor reduces left ventricular dysfunction after myocardial infarction.

MCP-1 mediates fibroblast proliferation and stimulates fibroblasts to produce collagen, both key elements in inflammatory-mediated wound healing. MCP-1 is also critical in capillary arteriogenesis, another key finding in inflammatory wound healing. MCP-1 has been shown to induce arteriogenesis in hind-limb ischemia, and deficiency in CCR2 results in reduced macrophage infiltration and impaired arteriogenesis in hind-limb ischemia. Endothelial cells express CCR2, the receptor for MCP-1, and MCP-1 promotes endothelial cell migration and inflammatory-activated endothelial wound repair and angiogenesis in tumor by recruiting macrophages. Human vascular smooth muscle cells express CCR2, the receptor for MCP-1, and there is evidence that MCP-1 induces smooth muscle cell proliferation. MCP-1 has been shown to recruit vascular smooth muscle cells and mesenchymal cells toward endothelial cells and is critical for transforming growth factor-β-induced angiogenesis in wound healing.

**MCP-1 in Intravascular Inflammatory Healing**

Wound healing of cutaneous wounds, myocardial infarction, and hind-limb ischemia is an example of extravascular tissue healing. Endoluminal intravascular wound healing, however, presents different problems, and the effects of MCP-1–mediated inflammatory healing intravascularly have been found to be deleterious. MCP-1 has been implicated in atherosclerotic disease. MCP-1 has been found in human atherosclerotic lesions and is thought to mediate macrophage infiltration in atherosclerosis. Mice deficient in CCR2 have reduced macrophage accumulation in atheroma and reduced atherosclerotic lesion formation.

A classic model of intravascular inflammatory wound healing is neointimal hyperplasia after arterial injury. MCP-1 has a critical role in neointimal hyperplasia by recruiting inflammatory monocytes to the site of vascular injury. Blocking MCP-1 has been shown multiple times to inhibit neointimal hyperplasia; likewise, deficiency in CCR2 results in reduced neointimal hyperplasia after arterial injury.

**MCP-1 in Intra-Aneurysmal Tissue Healing**

The deleterious effects of neointimal hyperplasia are due to stenosis of the vessel lumen by the tissue proliferation induced by recruiting macrophages.
by the inflammatory healing cascade. However, intra-aneurysmal tissue healing represents a unique example in which intravascular tissue proliferation is a desired outcome. The aim of brain aneurysm therapies should be intra-aneurysmal tissue healing characterized by inflammatory elements consisting of connective tissue proliferation, fibroblasts, collagen, smooth muscle cells, capillary in-growth, and macrophages.

Our study demonstrates that MCP-1 has a recruitment effect on the migration of fibroblasts, smooth muscle cells, endothelial cells, and macrophages, all key players in the inflammatory tissue healing response. Endothelial cells play a critical role in the repair of the endoluminal surface of the aneurysm ostium at the aneurysm–parent artery interface. Fully healed coiled human cerebral aneurysms commonly demonstrate a neointimal plate at the aneurysm ostium and are likely important for preventing thromboembolism and for providing structural repair of the blood vessel. We have demonstrated that MCP-1 recruits the migration of endothelial cells both in an in vitro cell migration assay and in vivo in an aneurysm repair model.

By creating a coil that releases MCP-1, we were able to demonstrate that MCP-1 promotes intra-aneurysmal tissue in-growth and healing in murine carotid aneurysms by the recruitment of fibroblasts, smooth muscle cells, endothelial cells, and macrophages that originate from the bone marrow and migrate to the aneurysm site. We also show that that pathway is regulated by MIP-1α and MIP-2.

We demonstrate that intravascular MCP-1–mediated inflammatory tissue healing is dependent on MIP-1α and MIP-2. When MIP-1α or MIP-2 is blocked, the tissue in-growth seen with MCP-1 release in our murine carotid aneurysm model was significantly inhibited. The pathway by which MCP-1 upregulates and is dependent on MIP-1α and MIP-2 has not been elucidated. Figure 8 illustrates the postulated pathway by which MCP-1, MIP-1α, and MIP-2 interact in the inflammatory tissue healing cascade.

Our study and others have demonstrated that MCP-1 activates fibroblasts, smooth muscle cells, and macrophages and recruits the migration of neutrophils, directly recruit the migration of neutrophils, macrophages, and other leukocytes to the site of injury and repair. Additional studies are needed to further define the interaction between MIP-1α and MIP-2 with MCP-1 and the steps in the MIP-1α– and MIP-2–regulated pathway on which MCP-1-mediated inflammatory tissue healing is dependent.

Coils or other endovascular devices designed to release MCP-1 such as the MCP-1–releasing coils in this animal study could be translated to treatment for human cerebral aneurysms or may be the first step in developing better biological therapies as our understanding of the biological processes of aneurysm healing advances. Further studies can examine time of release and amount of MCP-1 or other chemokines to be delivered, other carriers for carrying and releasing chemokines, and possible cocktail combinations of chemokines. There are clear limitations of our murine carotid aneurysm model: It is extracranial and therefore differs in some characteristics of intracranial vessels such as not being surrounded by arachnoid and cerebrospinal fluid; it is created by the application of elastase, which clearly does not happen naturally in human cerebral aneurysms; and rodents differ from humans in many anatomic and physiologic ways. Nevertheless, it is a model that can serve as a rapid preclinical screening tool for the biological study of aneurysm healing, with the hope of eventually translating to therapy for humans.

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Disclosures
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References


CLINICAL PERSPECTIVE

Up to 5% of the population may have a brain aneurysm. If a brain aneurysm ruptures, there is an associated >50% mortality rate, and more than one third of survivors end up dependent. Brain aneurysms that are detected before they rupture can be treated to prevent rupture, and ruptured brain aneurysms can be treated to prevent rerupture. Endovascular coiling is the treatment of choice for some ruptured and unruptured brain aneurysms. A significant drawback of endovascular coiling is aneurysm recurrence and the need for retreatment, which may occur in up to one quarter of aneurysms. Surgically harvested and autopsy-derived specimens of human brain aneurysms demonstrate that durable aneurysm cure is achieved by intra-aneurysmal wound healing. Successful healing is characterized by the presence of connective tissue proliferation, fibroblasts, collagen, smooth muscle cells, capillary in-growth, and macrophages. The aim of brain aneurysm therapies should therefore be achievement of this type of intra-aneurysmal wound healing. We studied the biology of intra-aneurysmal tissue healing, in particular the role of monocyte chemotactic protein-1, which is a cytokine known to be important in tissue healing, for inflammatory vascular tissue repair in a murine carotid aneurysm model. Coils or other endovascular devices designed to release monocyte chemotactic protein-1 such as the monocyte chemotactic protein-1–releasing coils in this animal study could be translated to treatment for human cerebral aneurysms or may be the first step in developing better biological therapies as our understanding of the biological processes of aneurysm healing advances.
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