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Research article

Peripheral blood mono-nuclear cells implantation in patients with Peripheral Arterial Disease: a pilot study for clinical and biochemical outcome of neoangiogenesis

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Abstract

A.2 Background

A.2.1 Substantial progresses in the management of peripheral arterial disease (PAD) have been made in the past two decades. Progress in the understanding of the endothelial-platelet interaction during health and disease state has resulted in better antiplatelet drugs that can prevent platelet aggregation, activation and thrombosis during angioplasty and stenting. A role in physiological and pathological angiogenesis in adults has been recently shown in bone marrow-derived circulating endothelial

progenitors (BM-DCEPs) identified in the peripheral blood. These findings have paved the way for the development of therapeutic neovascularization techniques using endothelial progenitors.

A. 3 Methods

A. 3. 1 This pilot study includes five patients, aged 60 to 75, with a history of claudication and recruited from September 2010 to February 2011 at the A.O.U. Federico II of Naples.

A. 3. 2 PBMNCs have been implanted three times in the limb with the worst ABI value in all the patients included in the study.

A. 3. 3 The clinical follow up was performed during the subsequent 12 months from the beginning of the treatment.

A. 4 Results

A. 4. 1 In four patients there was a regression of ulcerative lesions.

A. 4. 2 One patient's condition improved after the first implantation but later did not respond to the further treatments.

A. 4. 3 All patients achieved a pain relief as judged by the numeric pain scale. Pain relief remained satisfactory in three patients for one year. Pain gradually returned to the pre-treatment level in two patients.

A. 4. 4 All patients referred an ameliorating in their quality of life expressed even by an improvement in claudication free walking distance.

A. 4. 5 These improvements are reflected also by intra-arterial digital subtraction angiography (IADSA) that shows an improvement of arterial vascularization.

A. 5 Conclusions

A. 5. 1 The data from this study suggest an efficacy of BM-DCEPs implantation in terms of improvement of the vascularization and quality of life in patients affected by Peripheral Arterial Disease. Nevertheless a double-blind placebo-controlled study is needed to confirm our findings.

Background

B. 1. 1 Peripheral arterial disease (PAD) is a pathologic condition associated with arteriosclerosis. The symptoms of PAD mainly affect the lower limbs resulting in intermittent claudication and rest pain.

B. 1. 2 Strategies to treat the limb ischemia and its resulting symptoms include both pharmacologic therapy and invasive procedures. Despite the available therapies, 25% of patients still progress each year to limb amputations.

B. 1. 3 Recently, bone marrow derived circulating endothelial progenitors (BM-DCEPs) have been identified in peripheral blood showing a role in physiological and pathological angiogenesis in the elderly. Preclinical studies showed BM-DCEPs to be useful when implanted in the ischemic limb for treatment of PAD. Based on the above mentioned observation, peripheral blood mononuclear cells implantation (PB-MNCs) has been used as therapeutic strategy for critical limb ischemia (CLI).

B.1.4 Although encouraging results have been obtained by using those therapies, the underlying mechanism is still not completely known. This is based on stimulation of angiogenesis by extracellular and cellular components.

B.1.5 This pilot study has been conducted to evaluate the efficacy of implanted PBMNCs on clinical outcomes in patients at a symptomatic stage of PAD. We also focused on molecular markers of neo-angiogenesis to elucidate the real mechanism underlying the creation and stabilization of neo-vessels and in which measure the circulating endothelial progenitors (CEPs) and muscle cells are involved.

Methods

B.2.1 Five patients (three males) aged 60 to 75 (mean 65) with a history of claudication were recruited from September 2010 to February 2011 at the A.O.U. Federico II of Naples to participate in this pilot study, according to the Ethical Committee of Federico II University of Naples. Written informed consent was obtained before study participation. Patients who met the following inclusion/exclusion criteria were eligible for inclusion: those with symptomatic bilateral PAD (Fontaine scale \geq IIB - CFW distance \leq 100 mt), aged 60 -75, where PAD has been diagnosed according to the clinical criteria and ABI $<$ 0.6 (calculated as the worst value recorded at tibial anterior or posterior artery), with one or more stenosis of at least 50% in an artery of the lower limbs shown by duplex, angio-RM or intra-arterial digital subtraction angiography (IADSA) not eligible for endovascular revascularization treatments and with at least 2 comorbidities (e.g., hypertension, hyperlipaemia, obesity and/or carotid, coronary obstructions).

B.2.2 Exclusion criteria were: a) estimated survival less than 6 months; b) acute stage of severe limb ischemia with severe inflammatory process affecting the patient's life that required limb amputation to avert grave outcome; c) lymphopenia and/or thrombocytopenia and/or hemophilia; d) diabetes; e) chronic inflammatory diseases; f) connective tissues diseases; g) acute infectious processes; h) fever, physical trauma or surgery in the previous 45 days; i) acute illness, such as acute coronary or limb ischemia within 16 weeks; j) cancer. A detailed medical history was compiled for all patients with special attention given to cardio-vascular risk factors. The presence of arterial hypertension was defined with a blood pressure \geq 140/90 mmHg in at least two measurements or current treatment with anti-hypertensive drugs. The presence of dyslipidemia was defined as total cholesterol $>$ 200 mg/dl, LDL-cholesterol $>$ 100 mg/dl, triglycerides $>$ 150 mg/dl, or current treatment with lipid-lowering drugs. The presence of diabetes was defined by concentrations of fasting plasma glucose \geq 126 mg/dl or current treatment with oral antidiabetics and/or insulin.

B.2.3 All of the patients included in the study were treated three times with PBMNCs (one injection every two months for a 6 month treatment) implantation in the limb with the worst ABI value. Tissue samples from the gastrocnemius of the interested leg were collected before the first cells implantation (T1) and before the third cycle of cells implantation to detect the markers of neoangiogenesis reported in Fig. 1. Blood samples were collected at the following times: T0 – enrollment; T1 before the implantation; 1 and 2 weeks and then 1 month after the first implantation; T2 before the second implantation; 1 and 2 weeks and then 1 month after the second implantation; T3 before the third implantation; 1 and 2 weeks and then 1 month after the third implantation.

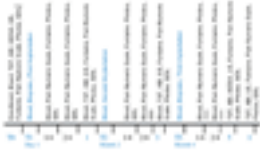


Fig. 1. Follow up scheme to evaluate the patient's response to the treatment.

B. 2. 4 The clinical follow up was performed during the subsequent 12 months from the beginning of the treatment at the followings time points: T0 – enrolment; 1 and 2 weeks and then 1 month after the first implantation; 1 and 2 weeks and then 1 month after the second implantation; 1 and 2 weeks and then 1 month after the third implantation; after 12 months from the time of enrolment. The following parameters were considered: 1) clinical history reporting *a*) onset of complication during the follow up, *b*) require of specific surgical treatment for PAD, *c*) return or progression of symptoms of claudication, *d*) evaluation of trophic lesions [1] documented also by photography, *e*) evaluation of the pain (using the pain numeric scale 0-10); *f*) a multi-parametric questionnaire on the quality of life analysing the previous 4 weeks named SF-36 [2]; 2) improvement in walking (Fontaine scale) measured as claudication-free walking distance (CFWD) and maximal walking distance (MWD), using the Skinner-Gardner protocol and the 6-minute walk distance test; 3) measurement of the ABI (ankle-brachial pressure index or Windsor index); 4) peripheral arterial diameter and blood flow characteristics (peak, volume, pulse systolic rates of blood flow, indices of vessels stiffness) by Duplex Ultrasonography; 5) evolution of the stenosis and neoangiogenesis documented by intra-arterial digital subtraction angiography (IADSA) (Fig.1).

Results

B. 3. 1 During the one year follow-up no complications or need of surgical treatments were registered. In four patients there was a regression of ulcerative lesions after the second treatment with a complete resolution of the lesions one month after the third treatment. A 73 year old male patient condition improved after the first implantation but then did not respond to further treatments. In this patient necrosis was seen in two sites; on the tips of the left big toe and middle fingers and in three sites on the right leg. The necrotic tissue on the top of the left big toe fell off spontaneously and the ulcer undermined deeper in the necrotic area epithelialized and healed eventually after one year. Unfortunately, he died 14 months after the enrolment due to a cardiovascular complication. Relief of pain as judged by the numeric pain scale was achieved in all patients in a week and continued up to one month in four patients. Pain relief remained satisfactory in three patients for one year. However pain gradually returned to the pre-treatment level in two patients.

B. 3. 2 All patients referred an ameliorating in their quality of life expressed even by an improvement in claudication free walking distance more evident in three of five patients.

B. 3. 3 The ABI surprisingly did not reach the expected improvement, remaining in a mean of 0.6 (mean baseline values 0.4), and not showing a direct relation between the clinical features and the instrumental detections. Therefore, We should be careful when using ABI as follow up and as a diagnostic parameter to monitor neo-angiogenesis. However the number of patients is too small to assume that our results are definitive.

B. 3. 4 IADSA in three patients showed an apparent increase of visible arteries after treatment (Figure 2). Such a long-term effect could be obtained to bona fide

angiogenesis induced by repeated implantation of PB-MNCs.

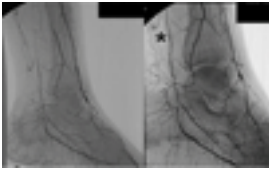


Fig. 2. Left, at enrolment, Right, after treatment.

Discussion and conclusions

B. 4. 1 Peripheral vascular disease (PVD) is known to affect 10% to 15% of the adult population in developed countries and is often associated with coronary artery disease. Arteriosclerosis obliterans (ASO) is the most common cause of PVD affecting the lower limbs. The two cardinal symptoms of limb ischemia are intermittent claudication and rest pain. Intermittent claudication (IC), defined as a symptomatic deficiency in blood supply to the exercising muscle that is relieved with rest, is generally a reliable indicator of occlusive arterial disease. This disorder results from an imbalance between supply and demand of blood flow that fails to satisfy ongoing metabolic requirements. Rest pain occurs in patients with critical limb ischemia and often coincides with ischemic ulceration and/or gangrene. Treatment of PVD includes pharmacotherapy, percutaneous transluminal angioplasty, and vascular surgery. The treatment chosen depends on the severity of symptoms and the arteries involved. However, 30% to 50% of patients with critical limb ischemia require limb amputation within one year because of a poor response to treatment [3]. Recent progress in understanding the mechanisms underlying vascular formation in adults as well as during embryogenesis has opened up a therapeutic avenue for patients without any current options [4]. Initial therapeutic approaches were aimed at delivering angiogenic factors, such as vascular endothelial growth factors (VEGF) and fibroblast growth factor-2, to ischemic tissues by using recombinant proteins or vectors encoding these factors [5,6]. A number of preclinical studies reported improvement of perfusion by such methods in animal models with limb ischemia [7,8]. Although the initial nonrandomized clinical trials showed beneficial effects, the results of controlled clinical trials were not consistent. More recently, bone marrow-derived circulating endothelial progenitors (BM-DCEPs) were identified in the peripheral blood [9,10] and have been shown to contribute to both physiological and pathological angiogenesis in adults [11,12]. These findings have led to the development of therapeutic neovascularization techniques using endothelial progenitors. Preclinical studies indicated that implantation of bone marrow mononuclear cells (BM-MNC), which contain endothelial progenitors, into ischemic limbs was very effective [13-15]. The results of the first clinical trial showed that implantation of BM-MNC significantly improved the tissue oxygen concentration and blood flow in ischemic limbs, resulting in a decrease of rest pain and the involution of ischemic ulcers [16]. Although promising results have been obtained, the mechanism by which cell therapy improves limb ischemia is largely unknown. Because direct incorporation of implanted cells into newly formed vessels is reported to be relatively rare, it has been assumed that angiogenic factors secreted by implanted cells are responsible for the efficacy of cell therapy [17,18]. Implantation of mononuclear cells increased the production of the angiogenic cytokines in muscle cells. A deficiency of the angiogenic cytokines in muscle cells blunted the ability of implanted cells to increase vascularization, suggesting that muscle cells and not mononuclear cells were important as a source of the angiogenic cytokines. Subsequently, Tateno et al. discovered that angiogenic cytokines, especially IL-1 β , were associated with the response to treatment. Many previous studies by other groups suggested that angiogenic factors secreted by implanted cells play a critical role in therapeutic neovascularization [17,18]. In

contrast, Tateno's group *in vitro* and *in vivo* studies demonstrated that the implanted mononuclear cells did not secrete sufficient cytokines for neovascularization but, instead, stimulated muscle cells to produce IL-1beta. This is consistent with the observation that most of the implanted cells disappeared from the ischemic tissues as early as 3 days after implantation, which is before the reconstruction of the vascular system started. Thus, it is likely that muscle cells but not implanted cells are a major source of angiogenic cytokines in ischemic limbs [19]. Recently, a Japanese study analyzed the long-term outcome of therapeutic neovascularization with PB-MNCs. Overall, improvement of ischemic symptoms was observed in 60% to 70% of the treated patients. The annual major amputation rate decreased to 10%, and the mortality rate was reduced to 20% at 2 years and 30% at 3 years in their patients. Their results, together with previous reports suggest that the performance of therapeutic neovascularization with PB-MNCs might be safe and effective for patients with critical limb ischemia. Although this study was not placebo-controlled and therefore cannot assess the efficacy and safety of cell therapy only with their results, they conclude that therapeutic angiogenesis with PB-MNCs is a safe and potentially effective treatment for critical limb ischemia [20].

B. 4. 2 Although the results of this pilot study suggest an efficacy of BM-DCEPs implantation in terms of improvement of the vascularization and quality of life in patients affected by peripheral arterial disease, double-blind placebo-controlled studies are needed to confirm our findings.

B. 4. 3 Such a study is currently in progress.

List of abbreviations

B. 5. 1 CEAP: (Clinical-Etiology-Anatomy-Pathophysiology); CHIVA: Cure Conservatrice et Haemodynamique de l'Insuffisance Veineuse en Ambulatoire procedure; LMWH: Low Molecular Weight Heparin

Competing interest

B. 6. 1 The authors declare that they have no competing interests.

Authors' contributions

B. 7. 1 BA: conception and design, interpretation of data, given final approval of the version to be published.

B. 7. 2 RC: acquisition of data, drafting the manuscript, given final approval of the version to be published

B. 7. 3 ADC: acquisition of data, drafting the manuscript, given final approval of the version to be published

B. 7. 4 GM: acquisition of data, drafting the manuscript, given final approval of the version to be published.

B. 7. 5 TB: acquisition of data, drafting the manuscript, given final approval of the version to be published.

B. 7. 6 GC: acquisition of data, drafting the manuscript, given final approval of the version to be published.

B. 7. 7RR: acquisition of data, drafting the manuscript, given final approval of the version to be published.

B. 7. 8AB, CT: acquisition of data, drafting the manuscript, given final approval of the version to be published

B. 7. 9GA, AP: conception and design, given final approval of the version to be published

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