Mesenchymal stem cells: A potential source for skeletal repair

W E Fibbe

The bone marrow serves as a reservoir for different classes of stem cells. In addition to haematopoietic stem cells the bone marrow comprises a population of marrow stromal cells or mesenchymal stem cells (MSCs). Stromal cells exhibit multilineage differentiation capacity, and are able to generate progenitors with restricted developmental potential, including fibroblasts, osteoblasts, adipocytes, and chondrocyte progenitors.

Recently, techniques have become available to isolate and grow mesenchymal progenitors and to manipulate their growth under defined in vitro culture conditions. As a result MSCs can be rapidly expanded to numbers that are required for clinical application. Here the role of MSCs for repair of bone and cartilage is discussed.

Marrow Stromal Cells

Marrow stromal cells comprise a heterogeneous population of cells, including reticular endothelial cells, fibroblasts, adipocytes, and osteogenic precursor cells that provide growth factors, cell to cell interactions, and matrix proteins that play a part in the regulation of haematopoiesis. The notion that a stromal microenvironment could support haematopoiesis followed by the development of the long term bone marrow culture by Dexter. In this system an adherent bone marrow derived stromal culture could support the production of haematopoietic colonies. For instance, CFU-F from fetal bone marrow, termed the CFU-F precursor cell was in the CD34neg/low fraction and expressed the markers Thy-1 (CD90), CD106 (VCAM), the SH-4 antibodies recognise epitopes on human MSCs, the antigen also involved in the activation of B lymphocytes.

A number of markers are expressed on MSCs and some of these have been used to enrich MSCs from populations of adherent bone marrow stromal cells. For instance, CFU-F enrichment has been accomplished using the STRO-1 antibody. The CFU-F precursor cell was in the CD34neg/low, CD45neg, glycophosphin-A (CD105), the TGFβ receptor III present on endothelial cells, syncytiotrophoblasts, macrophages, and connective tissue stromal cells. The SH-3 and SH-4 antibodies recognise epitopes on human MSCs, the antigens now being identified as distinct epitopes of CD73, an antigen also involved in the activation of B lymphocytes. However, none of these markers are specific for MSCs, thus hampering the isolation of pure populations of MSCs. In addition, expanded MSCs express HLA class-I but not HLA class-II antigens and lack expression of costimulatory molecules.

Sources and Phenotype of Mesenchymal Stem Cells

Although the bone marrow serves as the primary reservoir for MSCs, there presence has been reported in a variety of other tissues. These include periostem and muscle connective tissue, fetal bone marrow, liver, blood. It is still an ongoing debate as to their presence in steady state peripheral blood, their frequency probably being extremely low. MSCs have been identified in cytokine (G-CSF) mobilised peripheral blood by some investigators, although other studies were negative. MSCs have been identified in fetal blood and by some laboratories also in umbilical cord blood. However, other laboratories have been unable to grow MSCs from umbilical cord blood. The frequency of MSCs in these sources is very low. In fetal blood the frequency has been reported to decline with gestational age, from about 1/100 mononuclear cells in first trimester fetal blood to 0.3/100 MNC in term cord blood.

At present no unique phenotype has been identified that permits the reproducible isolation of MSC precursors with predictable developmental potential. The isolation and characterisation of stromal cell function therefore still relies primarily on their ability to adhere to plastic and their expansion potential. Standard conditions for expansion of MSCs include the presence of serum, in most instances fetal bovine serum. Cell density is a critical factor affecting the growth of cells.

The immune-phenotypical characterisation is usually applied on culture expanded cells and not on primary cells. Characteristic markers for expanded MSCs have been reported and designated SH-2, SH-3, and SH-4. The SH-2 antibody raised against human bone marrow derived MSCs recognises an epitope of endoglin (CD105), the TGFβ receptor III present on endothelial cells, syncytiotrophoblasts, macrophages, and connective tissue stromal cells. The SH-3 and SH-4 antibodies recognise epitopes on human MSCs, the antigens now being identified as distinct epitopes of CD73, an antigen also involved in the activation of B lymphocytes.

Abbreviations: MSC, mesenchymal stem cell; CFU-F, colony forming unit fibroblast.

MULTILINEAGE POTENTIAL OF MESENCHYMAL STEM CELLS

The differentiation potential of MSCs into multiple mesenchymal lineages—that is, bone, cartilage and adipose tissue—is most commonly used as a functional criterion defining MSC precursor cells. After culture expansion in vitro human MSC exhibit a spindle shape fibroblastic morphology. It has been reported that a proportion of the initial adherent bone marrow derived stromal colonies are multipotent and maintain multilineage potential into osteogenic, condrogenic, and adipogenic lineages. These results suggest that the progeny of MSC after culture expansion retain multipotentiality. Human MSC derived from bone marrow have been reported to maintain their differentiation capacity into the osteogenic lineages for over 40 cell doublings.

To promote adipogenic differentiation expanded MSCs are cultured in the presence of dexamethasone, methylisobutylxanthine, insulin, and indomethacin. After induction cells accumulate lipid rich vacuoles that can be stained with Oil Red O. MSCs can also be promoted to differentiate into the chondrogenic lineage when cultured without serum in the presence of transforming growth factor. Cells can be stained for type 2 collagen, which is characteristic for articular cartilage.

When cultured in the presence of dexamethasone and ascorbic acid, purified MSCs undergo a development characterised by the transient induction of alkaline phosphatase, expression of bone matrix protein mRNAses, and deposition of calcium. In the CFU-F progeny, a proportion seems to exhibit osteogenic potential and become alkaline phosphatase positive. These colonies are able to form foci of mineralised bone and therefore contain osteoprogenitor cells.

(PR)CLINICAL RESULTS OF MESENCHYMAL STEM CELL TREATMENT

Based on the in vitro observations to differentiate into the osteogenic and chondrogenic lineage, attempts have been undertaken to use expanded MSCs for in vivo tissue repair. A number of studies have reported the in vivo osteogenic potential of bone marrow derived stromal cells. Bone marrow derived MSCs have been loaded on extracellular matrices such as hydroxyapatite-tricalcium phosphate. After in vivo implantation into NOD/SCID mice bone formation was observed. In various animal models MSCs have been used for repair of critical size segmental bone defects. For instance, HA/TCP matrices loaded with MSCs have been applied into a femoral critical size segmental bone defects. For instance, HA/TCP various animal models MSCs have been used for repair of autologous bone marrow derived MSCs. In canines, full repair was observed after intra-articular injection of autologous MSCs of large full thickness defects of the weight bearing region of the articular cartilage.

Recently, autologous culture expanded bone marrow derived MSCs have been applied in patients with osteoarthritis. Twelve patients received MSC treatment by injection of the cells into the articular cartilage defect of the medial femoral condyle of the knee joint at the time of high tibial osteotomy. The injected MSCs were covered with autologous periosteum. Twelve other patients undergoing the same procedure served as controls and received no cells. In comparison with the control group, patients treated with MSCs had a betterarthroscopic and histological grading score. Although the clinical improvement was not significantly different between the two groups, these studies illustrate the feasibility and potential of MSC therapy for cartilage repair.

CONCLUSION

MSCs transferred in a bone marrow graft may play a potential therapeutic part in the correction of osteogenesis imperfecta. However, controlled studies are required to further substantiate this effect. Preclinical work clearly shows the potential of local MSC treatment for bone and cartilage repair and clinical studies in a variety of conditions are being started. MSCs may also serve as vehicles for gene therapy. For instance, the in vivo osteogenic activity of an adenovirus expressing bone morphogenetic protein 7 has been shown in mice, suggesting that this may be a viable tool to promote bone regeneration in vivo.

A number of fundamental questions relating to the biology of MSCs are still unanswered. To further advance bone and cartilage tissue engineering, a better understanding of progenitor cells and the role of their microenvironment in osteogenic and chondrogenic differentiation and development is required. What is the relation between MSC immune-phenotype and function? Are MSCs derived from different sources functionally similar and do culture expanded cells retain their self renewal and multilineage differentiation potential? Continued fundamental and clinical studies are required to turn these developments into a therapeutic reality.

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