Adipose-derived stem cells in articular cartilage regeneration: current concepts and optimization strategies

Authors: Xingjian Gu, Caixin Li, Feng Yin and Guanghua Yang

DOI: 10.14670/HH-11-955
Article type: REVIEW
Accepted: 2017-12-15
Epub ahead of print: 2017-12-15

This article has been peer reviewed and published immediately upon acceptance.
Articles in "Histology and Histopathology" are listed in Pubmed
MANUSCRIPT

Title: Adipose-derived stem cells in articular cartilage regeneration: current concepts and optimization strategies

Running title: ASCs for cartilage regeneration

Authors: Xingjian Gu$^{1,2,3,5}$, Caixin Li$^4$$^5$, Feng Yin$^4$, Guanghua Yang$^{1,2,3,5}$*

Affiliations:

1. International Research Center for Marine Biosciences at Shanghai Ocean University, Ministry of Science and Technology, Shanghai 201306, P.R. China

2. National Pathogen Collection Center for Aquatic Animals, Shanghai 201306, P.R. China

3. Shanghai Collaborative Innovation for Aquatic Animal Genetics and Breeding, Shanghai 201306, P.R. China

4. Research Center for Translational Medicine, East Hospital, School of Medicine, Tongji University, Shanghai 200120, P.R. China

5. Shanghai Telebio Biomedical Co., Ltd., Shanghai 201321, P.R. China

*Corresponding author: Tel: +86-15921731086; E-mail: ghyang119@163.com

Postal address: No.908 Ziping Road, Building 25, Pudong New Area, Shanghai 201321, China
Abstract

Knee osteoarthritis (KOA) is the most common progressive joint disorder associated with disability in the world. As a chronic disease, KOA has multifactorial etiology. However, the poor self-healing ability of the articular cartilage due to its intrinsic tissue hypovascularity and hypocellularity seems to be directly incriminated in the physio-pathological mechanism of KOA. While conventional therapies result in unfavorable clinical outcomes, regenerative cell therapies have shown great promise in articular cartilage regeneration. Adipose-derived stem cells (ASCs) appear to be an ideal alternative to bone-marrow derived stem cells (BMSCs) and autologous chondrocytes, due to their lower immunogenicity, richer source and easier acquisition. Since the first case report in 2011, ASCs have demonstrated safety and efficacy for articular cartilage regeneration in several phase I/II clinical trials. However, different levels of abnormality were found in the regenerated cartilage for most of the patients. A large portion of recent publications investigated different optimization strategies to improve the therapeutic function of ASCs, including cell source selection, preconditioning and co-delivery. Herein, we give an update on the latest research progress on ASCs, with a focus on the most promising optimization strategies for ASC-based therapy.

**Keywords:** Adipose-derived stem cells; SVF; Cartilage; Regeneration; Osteoarthritis
1 Introduction

Osteoarthritis (OA) is a degenerative disease involving the whole joint, including the articular cartilage, subchondral bone, and periarticular tissue. The knee is one of the joints most commonly affected by osteoarthritis. More than one-third of people over 65 years old suffer from pain and disability caused by knee OA (Bhatia et al., 2013). Damaged articular cartilage in OA knees has poor intrinsic healing potential due to its hypovascularity and hypocellularity, which is a major problem in clinical OA treatment. Various surgical procedures have been performed to regenerate articular cartilage but have achieved limited success, including abrasion arthroplasty, subchondral drilling and microfracture (Bert, 1993; Bae et al., 2006; Sakata et al., 2013).

Recently, the cell-based regenerative therapy emerged as a promising approach to facilitate cartilage regeneration. Autologous chondrocyte transplantation (ACT) has been investigated since 1987 showing encouraging results in early studies, but its therapeutic efficacy showed no significant difference compared to microfracture in a recent randomized, controlled trial (Knutsen et al., 2004; Cole, 2008). Besides, ACT usually comes with other problems such as the dedifferentiation of chondrocytes, donor site morbidity and the two-step surgery procedure (Dehne et al., 2010; Harris et al., 2010; Minas et al., 2014). To address these problems, mesenchymal stem cells (MSCs) have been extensively studied as an alternative cell source to chondrocytes for cartilage repair. MSCs isolated from bone marrow possess several advantages, such as immunomodulatory activity and multipotency, demonstrating outstanding safety and efficacy for cartilage repair in multiple pre-clinical and clinical studies (Johnstone and Yoo, 1999; Pittenger et al., 1999; Centeno et al., 2008; Centeno et al., 2011). However, clinical application of bone marrow-derived mesenchymal stem cells (BMSCs) is limited by the painful and invasive surgical
procedure, an extremely low cell yield and the physiological conditions of donors (Fennema et al., 2009; Alt et al., 2012; Hernigou et al., 2014).

Zuk et al. first isolated adipose tissue-derived stem cells ASCs from adipose tissue in 2001. (Zuk et al., 2001). During the last decade, ASCs have attracted great attention because of their abundant source and ease of accessibility as well as the comparable regenerative capability compared to BMSCs (Erickson et al., 2002; Awad et al., 2004b; Estes et al., 2008). Since the autologous SVF transplantation was approved for clinical trials in 2009 by Korea, significant progress has been made in its clinical application for cartilage regeneration. Most of the completed clinical trials delivered ASCs in the form of SVF, and reported safety and efficacy for cartilage repair (Black et al., 2007; Pak, 2011; Toghraie et al., 2012). However, current clinical data also indicated that simple SVF injection is not sufficient to fully restore the damaged cartilage back toward normal function (Koh et al., 2014; Koh et al., 2016; Nguyen et al., 2017), thus an optimized ASC therapy is needed to achieve better therapeutic efficacy. The work presented here gives an update on the latest information on ASCs, with a focus on the most attractive optimization strategies (A schematic representation is provided in Figure 1).

2 Adipose-Derived Stem Cells

2.1 Origin of ASCs

Since MSCs were first isolated from bone marrow cultures, BMSCs have been the most well-characterized MSC type. However, later it was found that MSCs can be isolated from other sites of the body, including umbilical cord blood, placenta, adipose tissue and elsewhere (Erices et al., 2000; Zuk et al., 2001; In 't Anker et al., 2004). In fact, current concept supports that MSCs exist within the connective tissue of virtually all organs (Meirelles et al., 2006). Since Zuk et al. first
isolated a new group of multipotent cells from adipose tissue in 2001, now termed adipose-derived stem cells (ASCs), extensive studies have been performed to determine if ASCs can be an ideal substitute for BMSCs, due to the much higher stem cell yield and ease of accessibility from liposuction (Zuk et al., 2001). Adipose tissue from liposuction is first digested by collagenase, followed by centrifugation to remove the floating adipocytes, leaving the remaining cell pellets on the bottom, named stromal vascular fraction (SVF) (Lindroos et al., 2011; Pires de Carvalho et al., 2014). SVF is a heterogeneous cell population composed of ASCs (about 3%), endothelial progenitor cells, vascular mural cells, T regulatory cells, macrophages, preadipocytes and other stromal components (Riordan et al., 2009; Baer and Geiger, 2012; Rodriguez et al., 2012). Finally, ASCs are enriched by plastic adherence and subsequent expansion (Zuk et al., 2002; Mitchell et al., 2006). SVF and ASCs have both been investigated for cartilage regeneration in recent phase I/II clinical trials (Jo et al., 2014; Koh et al., 2014; Freitag et al., 2015).

### 2.2 Characterization of ASCs

ASCs are able to differentiate along multiple lineages into adipocytes, osteoblasts, chondrocytes, myocytes, tendon fibroblasts, neuronal-like and endothelial cells (Gimble et al., 2007; Shen et al., 2013). The surface markers of ASCs are similar to those of BMSCs with an overlapping of more than 90% (Zuk et al., 2002). There has been a consensus that ASCs are positive for the typical markers of MSCs while being negative for CD31 and CD45 (Zuk, 2013). Recently in 2013, the International Federation for Adipose Therapeutics and Science (IFATS) and the International Society for Cellular Therapy (ISCT) proposed a set of minimal definitions for ASCs, including self-renewal ability, tri-lineage differentiation, being positive for CD90, CD73, CD105 and CD44 (>80%) while being negative for CD45 and CD31 (<2%) (Bourin et al., 2013). It was also suggested that ASCs can be distinguished from BMSCs by their positivity for CD36 and negativity
for CD106 (Bourin et al., 2013). To note, multiple studies confirmed that CD34 appeared on the freshly isolated ASCs, which is typically not expressed on MSCs, but gradually disappeared during successive passages (Traktuev et al., 2008; Maumus et al., 2013).

Resembling BMSCs, ASCs secrete a variety of proteins into conditioned media, known as the trophic effect. Lately, more and more evidence suggests that paracrine effect of ASCs plays an important part during the regeneration process, exhibiting anti-apoptotic, anti-aging and anti-inflammatory abilities. For example, Platas et al. found an anti-aging effect of the conditioned medium of ASCs on OA chondrocytes, featured by down-regulation of senescence markers induced by inflammatory stress (Platas et al., 2016). A list of 68 commonly expressed proteins regardless of the specific protocols used, were thoroughly reviewed by Kapur et al. (Kapur and Katz, 2013), which may serve as potential candidates of conserved secretome proteins for further research.

2.3 ASCs compared to BMSCs

The most attractive point of ASCs might be the much higher cell yield compared to BMSCs. As is known, BMSCs only constitute a very small fraction of the whole marrow nucleated cells. A recent study showed that even though the bone marrow contained 6-fold more nucleated cells than SVF, the adherent cells in SVF were 4-fold greater than bone marrow (Jang et al., 2015). Specifically, the MSC population (CD45-CD31-CD90+CD105+) was 4.28% in SVF and 0.42% in bone marrow concentration (Jang et al., 2015). It was calculated that there was a 500-fold increase in MSC yield from adipose tissue, with approximately $1 \times 10^5$-6 ASCs in 1 ml of lipoaspirate while only 50-675 BMSCs in 1 ml of bone marrow aspirate (Zuk et al., 2001; Hass et al., 2011; Li et al., 2011). Hence, the therapeutic dose of ASCs could be achieved without in vitro
expansion, making it possible to finalize the stem cell transplantation during a one-step surgical procedure.

The proliferation potential of ASCs and BMSCs varies among species. BMSCs were reported to show higher proliferation potential than ASCs in some species, such as monkey (Izadpanah et al., 2006) and pig (Bayraktar et al., 2017). Conflicting results were reported for ASCs from mice (Ikegame et al., 2011), sheep (Ude et al., 2014), dog (Spencer et al., 2012) and human (Chen et al., 2012). Despite the species variation, the results for human cells were highly consistent (Izadpanah et al., 2006; Kern et al., 2006; Chen et al., 2012; Dmitrieva et al., 2012). Human ASCs (hASCs) demonstrated higher proliferation capacity than human MSCs (hMSCs) (Kern et al., 2006). In addition, hASCs can undergo more passages before senescence while maintaining the differentiation potential and a stable phenotype after a longer time of culture (Izadpanah et al., 2006; Dmitrieva et al., 2012). Furthermore, donor’s age has less effect on the proliferation of hASCs, and this still holds true in elderly patients with osteoporosis (Chen et al., 2012), which makes it an attractive alternative to hBMSCs in clinical use.

ASCs might be better for allogenic transplantation than BMSCs. Multiple studies have demonstrated that ASCs expressed less HLA-ABC than BMSCs, indicating a lower immunogenicity (Rider et al., 2008). Furthermore, ASCs appear to have a better immunosuppressive capacity. Ivanova-Todorova et al. showed that ASCs inhibited the maturation and differentiation of human blood monocytes into DCs while enhancing the IL-10 level secreted by DCs, to a greater extent than BMSCs (Ivanova-Todorova et al., 2009). The feasibility of allogenic transplantation is particularly meaningful when the patients cannot provide enough stem cells themselves. Besides, it allows the future development of the off-the-shelf stem cell product, which is time-efficient and cost-effective.
Although several groups reported that chondrogenic potential in vitro of ASCs was lower than that of BMSCs (Rider et al., 2008; Diekman et al., 2010), it was also suggested that the combined use of growth factors such as transforming growth factor-β2 (TGF-β2), insulin-like growth factor-1 (IGF-1) and bone morphogenetic protein 6 (BMP-6) could promote the chondrogenic capacity of ASCs to a comparable level to BMSCs (Hennig et al., 2007; Kim and Im, 2009). Collectively, current data indicates that ASCs could be an ideal alternative to BMSCs in cartilage regeneration.

3 Optimization strategies

Although ASCs have demonstrated encouraging results for cartilage regeneration in multiple animal studies and human trials, the regenerated cartilage is still inferior to the native tissue in many aspects, such as the compressive strength and the biochemical composition (Vilar et al., 2014). To achieve better clinical outcomes, ASC-based therapy needs further optimization.

3.1 SVF vs ASCs

SVF is the heterogeneous cell mix obtained after enzyme digestion of the lipoaspirates. Apart from ASCs, SVF mainly contains endothelia progenitor cells, immune cells, smooth muscle cells, pericytes and other stromal components. After isolation of the SVF, ASCs can be enriched by plastic adherence and subsequent expansion (Mitchell et al., 2006).

Currently, few studies have compared the cartilage regeneration capacity between SVF and expanded ASCs. Jurgens et al. investigated the chondrogenic differentiation potential between SVF and culture-expanded ASCs seeded in PLA-CPL scaffold, where both of them showed similar characteristics with a slightly higher glycosaminoglycans (GAGs) deposition for SVF (Jurgens et al., 2009). Similarly, in a co-culture study with primary human chondrocytes in alginate gel, co-culture pellets of SVF-chondrocytes showed more GAGs and cartilage matrix deposition than that
of ASCs-chondrocytes (Wu et al., 2016). The authors suggested that the synergic interaction between different types of cells might enhance the trophic effects of SVF (Wu et al., 2016). However, it cannot be concluded that SVF is superior to ASCs based on the weak evidence above without the evaluation of collagen type I and II content. Although no clear evidence indicates a better regenerative capacity of SVF, recent studies showed greater interest in applying SVF for clinical knee OA treatment. The main reason is that SVF transplantation is regarded as a one-step medical procedure with minimal manipulations in some countries such as Korea, whereas the expanded ASCs are generally considered as pharmaceutical products requiring rigorous clinical trials and regulatory approval (Pak et al., 2016a). In addition to the advantage in regulatory issues, SVF delivery can be done as a single surgical setting right in the operating theatre and on the same day, avoiding the time-consuming cell culture process as well as the contamination risk.

The most concern for SVF is the therapeutic efficacy. As mentioned above, current clinical data indicated that simple SVF injection is not sufficient to fully repair the damaged cartilage, especially when dealing with large cartilage lesions (Koh et al., 2014). The endothelial cells contained in SVF might induce angiogenesis, which could impede hyaline cartilage formation (Marsano et al., 2016; Staubli et al., 2017). Besides, most of the human trials using SVF required the co-delivery of platelet rich plasma (PRP) to achieve the reported therapeutic efficacy (Pak et al., 2016a), making the therapy more expensive and complicated.

Compared to SVF, culture-expanded ASCs have several advantages. First, a large dose of ASCs can be obtained after expansion. In a randomized, double-blinded and dose-escalation clinical trial conducted by Jo et al., the high dose group (1×10^8 ASCs) showed the best hyaline-like cartilage regeneration and functional recovery outcomes, while the low dose group (1×10^7 ASCs) almost did not show any improvement, indicating the importance of a larger stem cell dose (Jo et al.,
When the volume of SVF is not sufficient to reach the minimal therapeutic dose, an *in vitro* expansion procedure might be necessary (Jo *et al*., 2014; Pers *et al*., 2016). Apart from the dosage issue, another important point is the potential to enhance therapeutic efficacy through combination with various promising tissue engineering techniques, such as preconditioning and co-delivery, during or after the culture expansion process (Clevenger *et al*., 2016). Last but not least, purified and expanded ASCs may have a lower immunogenicity and higher immunosuppression property compared to the freshly isolated SVF, making it more suitable for allogenic stem cell transplantation. It is even possible to develop the off-the-shelf stem cell product, which is highly cost-effective and convenient for patients (McIntosh *et al*., 2006).

The main concern about expanded ASCs is the potential for malignant transformation. *In vitro* cultured human BMSCs were reported to acquire chromosomal aberrations eventually leading to genomic instability and tumorigenicity, so it is possible that ASCs would also undergo malignant transformation during culture expansion (Buyanovskaya *et al*., 2009; Tarte *et al*., 2010; Ben-David *et al*., 2011). However, so far there is no direct evidence of malignant transformation related to cultured hASCs. In a recent study investigating genomic stability of ASCs, *in vitro* expanded ASCs did not show genetic alterations and replicative senescence nor anchorage-independent growth during early passages (Neri *et al*., 2013). The safety of expanded ASCs has also been demonstrated on humans, without tumor development or any serious adverse events (Ra *et al*., 2011; Pers *et al*., 2016). Taken together, it is extremely important to push forward the evaluation of culture-expanded ASCs for cartilage regeneration.

### 3.2 Cell source selection

Different cell sources can have a great impact on the therapeutic efficacy of ASCs. Two main factors are donor’s physiological condition and harvest site.
3.2.1 Donor

The influence of donor’s age is controversial. It was shown in some studies that the proliferation of ASCs from elders was lower than that of younger subjects (Van Harmelen et al., 2004; Efimenko et al., 2011; Alt et al., 2012). The chondrogenic differentiation of ASCs was also decreased by aging in one study (Alt et al., 2012). On the contrary, some other studies found no significant correlation between these properties and aging (Chen et al., 2012; Ding et al., 2013; Abbo et al., 2017). It was suggested that the wide inconsistency could be due to the differences in donor’s gender, the sources of the adipose tissue and the culture conditions (Clavijo-Alvarez et al., 2006; Ding et al., 2013). Interestingly, the results were consistent in two studies both using the low-calcium keratinocyte serum free medium (KFSM) during the cell culture, supporting the irrelevance between aging and proliferation rate of ASCs (Chen et al., 2012; Ding et al., 2013). Another concern is that ASCs might be influenced by donor’s chronic diseases, since ASCs used for autologous transplantation come from these patients themselves. While in some studies obesity and diabetes showed a negative effect on the proliferation potential and clonogenic capacity of ASCs (Gu et al., 2012), the OA condition of the knee did not show any influence on ASCs or the cellular composition in adipose tissue (Pires de Carvalho et al., 2014).

3.2.2 Harvest site

For ASCs from different body sites, the results showed more consistency. Pires de Carvalho et al. compared the infrapatellar fat pad (IPFP) to the periarticular subcutaneous adipose tissue (SQ) of 7 subjects and found that ASCs derived from both sites exhibited similar characteristics (Pires de Carvalho et al., 2014). Grasys et al. investigated the lipoaspirates from abdomen, thigh and knee, demonstrating no significant differences in the content of soluble factors nor the yield, proliferation and percentage of ASCs (Grasys et al., 2016). Nonetheless, the evaluation of
chondrogenic differentiation and cartilage regeneration efficacy of ASCs from different body sites is rare.

With the conflicting results, hardly any suggestions can be made towards the donor selection. However, multiple studies have confirmed that harvest site does not affect the property of ASCs. Hence the ideal harvest site of ASCs seems to be the subcutaneous abdominal adipose tissue. In addition to the promising outcomes in multiple clinical trials, patients can also rest in a comfortable supine position during the surgery (Riis et al., 2015). Furthermore, most of the surgeons prefer the abdomen as the primary harvest site as well, according to a survey conducted in 2007, probably because in this case they will have no need to consider the asymmetry issue (Kaufman et al., 2007; Riis et al., 2015).

### 3.3 Cell processing

Differentiation of stem cells along the chondrogenic lineage is important for cartilage repair (Estes et al., 2010). It was shown that ASCs expanded in conventional growth medium without appropriate pretreatment could have a negative effect on the chondrocytes and inhibit cartilage regeneration (Lee et al., 2012). Cell proliferation and *in vivo* therapeutic function of ASCs can be greatly improved through *in vitro* cell processing. There can be a variety of cell processing techniques, herein we discuss some of the most attractive ones described in recent publications.

#### 3.3.1 Chondrogenic medium (CM)

The chondrogenic medium (CM) can induce ASCs to a chondrocyte-like phenotype. The active ingredients of CM mainly include dexamethasone (Dex), ascorbic acid 2-phosphate (AA2P), transforming growth factor beta family (TGFβ) and bone morphogenetic protein family (BMP) (Estes et al., 2010). ASCs cultured in CM showed elevated levels of chondrogenic-specific genes.
such as Sox-9 together with increased production of collagen type II and GAG (Awad et al., 2004a; Im et al., 2006; Kolambkar et al., 2007). The positive function of growth factors, such as TGF-β1, TGF-β3 and BMP-6, was also demonstrated when incorporated in ASC-seeded scaffolds to repair cartilage defects, resulting in a significant increase of cell proliferation and chondrogenic marker expression (Sukarto et al., 2012; He and Pei, 2013; Yin et al., 2015).

However, recent studies found that different components of CM might have distinct effects on ASCs, and their functions could be largely influenced by the concentration, the patient’s disease state, and the interaction between different growth factors. For example, TGF-β1 is considered to have a biphasic effect under different concentrations. It was reported that TGF-β1 inhibited endothelial cell invasion and induced ASC chondrogenesis in relatively high concentrations (5 to 10 ng/ml) while exhibiting opposite effects in low concentrations (0.1 to 1 ng/ml) (Iruela-Arispe and Sage, 1993; Pepper et al., 1993; Estes et al., 2006). Moreover, TGF-β1 showed different effects on ASCs from different donors, probably because of the differential expression of TGFβ receptors such as ALK5 in osteoarthritic cartilage (Blaney Davidson et al., 2006; Blaney Davidson et al., 2009). Lee et al. compared different components of CM, and demonstrated their distinct effects on growth factor secretion of ASCs (Lee et al., 2013). In this study, AA2P appeared to be the most beneficial CM component. AA2P enhanced the secretion of chondrogenic factors (IGF-1, TGF-β2) and reduced the secretion of angiogenic factor (VEGF-A) and the mRNA level of chondrocyte hypertrophy factor (FGF-18), while VEGF-A was previously found to inhibit cartilage regeneration in rats (Lee et al., 2012; Lee et al., 2013). Their study also provided some evidence of the interaction between growth factors, which remains to be further elucidated (Lee et al., 2013). Future studies need to work out the optimal concentration and combination of growth factors in the chondrogenic medium, with the disease state of patients taken into consideration.
3.3.2 Platelet rich plasma (PRP)

PRP is isolated from the autologous blood by centrifugation, containing highly concentrated platelets and a hematocrit typically below 5% (Centeno et al., 2008). A rich source of growth factors is contained in the concentrated platelets via an intricate vesicular storage system, which can be immediately released by platelet activation. The growth factors in PRP mainly include basic fibroblast growth factor (FGF-2), insulin-like growth factor-1 (IGF-1), transforming growth factors (TGFs), platelet-derived growth factors (PDGFs), epidermal growth factor (EGF), vascular endothelial growth factor (VEGF) and various kinds of Interleukins (IL) (Fréchette et al., 2005; Scioli et al., 2017). The potential immunogenicity and the risk of disease transmission make it unsuitable to culture ASCs with fetal bovine serum (FBS) when intended for clinical use (Bieback, 2013). While the cell functions are compromised in various serum-free solutions and the human serum is short of source, PRP seems an ideal substitute to FBS for stem cell culture (Bieback, 2013). Hildner et al. reported that ASCs cultured in 5% platelet lysate showed better proliferation and in vitro chondrogenic (re)differentiation than in 10% FBS (Hildner et al., 2015). The growth rate of ASCs in 10% tPR was even much faster than in 10% FBS when using a novel rapid thrombin activation method to prepare the platelet lysate (tPR), with an at least 3-fold increase while maintaining the multipotency of ASCs (McLaughlin et al., 2016). It was suggested that the increased cell proliferation was due to the avoidance of heparin during tPR preparation, as heparin could inhibit the proliferation of ASCs (Kocaoemer et al., 2007; McLaughlin et al., 2016). Despite these encouraging results, the appropriate concentration of PRP in culture medium needs further investigation before it can eventually replace FBS.

3.3.3 Hypoxia
The chondrocytes in cartilage tissue reside in a hypoxia environment with only 1-6% O\textsubscript{2} in the deepest zone (Treuhaft and McCarty, 1971). In vitro tests showed that the hypoxia with 1-5% oxygen tension significantly improved the proliferation and chondrogenesis of ASCs, while the morphology and surface markers did not change (Merceron et al., 2010; Portron et al., 2013; Choi et al., 2014). The analysis on growth factor expression of co-cultured ASCs and chondrocytes under hypoxia showed a significant increase of hypoxia-inducible factor-1α (HIF-1α) (Shi et al., 2016), supporting the previous finding that HIF-1α played an important role in mediating the effects of low oxygen tension (Schipani et al., 2001; Malladi et al., 2007). HIF-1α upregulates the transcriptional activity of SOX9 by binding on specific hypoxia-responsive element sequences, stimulating the extracellular matrix (ECM) synthesis of ASCs (Robins et al., 2005; Amarilio et al., 2007). Consistently, the most regulated proteins of ASC after hypoxia preconditioning were involved in the ECM synthesis and cell metabolism, confirming the ECM remodeling through HIF-1α pathway as a main mechanism of hypoxia (Riis et al., 2016). Despite the convincing in vitro studies, the direct evidence supporting a similar function of hypoxia in vivo is quite limited. It was even shown in one study that hypoxia could not exert the expected beneficial functions on in vivo cartilage regeneration in rabbits and humans (Portron et al., 2013). However, this could be due to various reasons, for example, the Si-HPMC hydrogel as the cell scaffold in this study might already create a hypoxia environment (Portron et al., 2013). More data from in vivo studies is required to confirm the function of hypoxia on cartilage regeneration, and a standard protocol of hypoxia pretreatment should be established.

3.3.4 Pro-inflammatory factors

Preconditioning with pro-inflammatory factors seems to be highly promising. The anti-inflammation effect of ASCs is crucial for its therapeutic function. Recent studies showed that the
anti-inflammatory function of ASCs can be stimulated by various pro-inflammatory cytokines such as IL-1β, IL-6, tumor necrosis factor (TNF), and especially the interferon-gamma (IFNγ) (Crop et al., 2010). Maumus et al. investigated IFNγ-primed ASCs on murine OA model, and found significantly enhanced anti-inflammatory and chondroprotective effects both in vitro and in vivo (Maumus et al., 2016). The authors suggested that the positive effect of IFNγ preconditioning was associated with the modulation of ASC secretome, and the effect of IFNγ-priming on the inflammatory gene profile of ASCs is shown in Figure 2 (Maumus et al., 2016).

Besides, the therapeutic function of ASCs was largely influenced by the inflammation status of the diseased joints, exhibiting no significant effect without severe inflammation or when they were delivered at the late stage of OA (Ter Huurne et al., 2012; Schelbergen et al., 2014). The pro-inflammatory cytokines released by the synovial macrophages during the early phase of OA might be responsible for activating the injected ASCs, which was reflected by the level of alarmins S100A8/A9 before and after the cell delivery (Schelbergen et al., 2014). And in turn the delivered ASCs could decrease these secreted pro-inflammatory factors by switching the activated-M1-like inflammatory macrophages to a M2-like phenotype (Manferdini et al., 2017). These studies indicated that in some cases pro-inflammatory factor pretreatment on ASCs might even be necessary.

3.4 Co-delivery

The delivery of ASCs alone is not sufficient to regenerate the damaged cartilage. A high rate of abnormality was found in mechanical property, chemical composition and biological function of the neo-formed cartilage, regardless of the cell dose (Jo et al., 2014; Koh et al., 2014; Pers et al., 2016). Among various co-delivery strategies, the cell-seeded scaffolds are being most widely
discussed in recent publications, showing great potential in future clinical translation (summarized in Table 1).

3.4.1 Scaffold

Directly injected cells usually have limited cell retention and survival at the target site. The feasibility of intra-articular (IA) injected ASCs for knee joint repair was questioned, because only 15% of IA injected ASCs was detectable in the joint of experimental mice after one month, and this number further decreased to 1.5% in six months (Maumus et al., 2013). In a recent clinical trial, 76% of all patients (37 in total) showed abnormality in cartilage repair following direct ASC injection, especially those with large cartilage lesions ($\geq 5.4 \text{ cm}^2$) (Koh et al., 2014). It was suggested that an appropriate cell scaffold should be developed for treating patients with large cartilage defects, since ASCs seeded in scaffolds may have better viability, retention and aggregation (Koh et al., 2014). The same group evaluated fibrin glue as a scaffold for ASC implantation. The results showed a significant difference in International Cartilage Repair Society (ICRS) grades between the scaffold group and non-scaffold group, where 12 of the 17 lesions (58%) and 9 of the 39 lesions (23%) achieved a grade I or II in each group, respectively (Kim et al., 2015). Their preliminary clinical data provides direct evidence that a well-designed bioactive scaffold can really improve the therapeutic function of ASCs for cartilage regeneration. However, the in vivo evaluation of ASC-seeded scaffolds for cartilage regeneration remains scarce. The beneficial effects of scaffolds on in vitro proliferation, adhesion, migration and chondrogenic differentiation of ASCs were also reported in other studies with convincing data, although in these studies the in vivo characterizations of ASC-seeded scaffolds did not set the control group of ASCs alone (Zhang et al., 2013; Li et al., 2015; Scioli et al., 2017; Gwon et al., 2017). Thus, the
beneficial role of scaffolds on ASCs needs further investigation, particularly in large-scale randomized and double-blinded human trials.

There is a considerable amount of recent papers discussing the influence of scaffolds on ASCs. However, most of them focused their attention on natural scaffolds instead of synthetic scaffolds. One reason is that some novel scaffolds fabricated by natural polymers exhibited impressive bioactivity. For example, multiple studies described the superiority of CDM and collagen scaffolds for cartilage tissue engineering. The natural polymeric molecules contained in these scaffolds, especially collagen type II (Col II), were able to stimulate chondrogenic differentiation of ASCs (Cheng et al., 2013; Portron et al., 2013; Choi et al., 2014; Garrigues et al., 2014; Kang et al., 2014; Almeida et al., 2015; Scioli et al., 2017). ASCs underwent morphological and ultrastructure changes when seeded in 3D collagen scaffold (Scioli et al., 2017). It was suggested that collagen type II promotes chondrogenic differentiation of ASCs by evoking a round cell shape through beta1 integrin-mediated Rho A/Rock signaling pathway (Lu et al., 2010). Consistently, it was found that Col II enhanced condensation and chondrogenesis of ASCs through increased cell–matrix adhesion, and this was mainly mediated by integrin α10β1-Col II interaction (Choi et al., 2014). Notably, the implantation of scaffolds containing allogenic or xenogeneic materials, such as collagen, could induce the host immune response (Hassanbhai et al., 2017). However, very little attention is given to this issue (Badylak and Gilbert, 2008; Keane and Badylak, 2015). The influence of the potential immune response to patients and cartilage regeneration process induced by biological scaffold materials needs careful examination before clinical application.

Tailoring the physical parameters of scaffolds can significantly influence the cellular behavior of ASCs. The effect of Young’s modulus showed a non-linear pattern. The viability and retention of ASCs were enhanced in the chitosan gel when the Young’s modulus was between 225 and 380
kpa (Sukarto et al., 2012). In accordance, ASCs showed decreased cell attachment and ECM formation on the genipin-crosslinked CDM scaffold when the crosslinking degree increased from 50% to 89% (Cheng et al., 2013). Teong et al. demonstrated that modulating the stiffness of methacrylated hyaluronan (MeHA) hydrogel could enhance the chondrogenesis of ASCs, and the hydrogel with 140% degree of methacrylation (8 kPa) exhibited the highest rates of GAG and collagen type II synthesis (Teong et al., 2017). The pore size of porous scaffolds also affects the cartilage repair ability of ASCs. It was shown that the migration, proliferation, and chondrogenic differentiation of ASCs were enhanced in scaffolds with the larger pore size (Im et al., 2012; Almeida et al., 2015). And the enhanced performance of ASCs was confirmed when regenerating cartilage in rabbits (Im et al., 2012). However, there is limited data from in vivo studies that can help to understand its inherent molecular mechanism.

The importance of cell-binding affinity and biodegradability were also highlighted recently. It was demonstrated that stem cell spreading, proliferation, adhesion and migration was much better in heparin-HA hydrogel compared to heparin-PEG and HA-PEG hydrogel, due to the combination of the cell-binding affinity from heparin and the biodegradability from HA (Gwon et al., 2017). In addition, HA was also able to initiate and enhance ASCs chondrogenesis through increased cell-matrix adhesion via HA-CD44 interaction (Wu et al., 2010; Wu et al., 2013). Consistently, grafting RGD-contained peptides onto N-methacrylate glycol chitosan (MGC) gel increased the in vitro viability and retention of encapsulated ASCs (Sukarto et al., 2012). However, of our particular interest, Zhang et al. claimed that the excessive cell adhesion and spreading on scaffolds might actually have negative influence on ASC chondrogenesis, generating fibrous tissue in neo-cartilage, therefore limiting the success of current scaffold technology (Zhang et al., 2015). By designing an anti-adhesive poly(L-glutamic acid)/chitosan (PLGA/CS) scaffold and another cell-adhesive
PLGA/CS scaffold through a combination of air-drying and freeze-drying procedures, they demonstrated that ASCs in anti-adhesive scaffold exhibited high-level GAG and collagen type II but low-level collagen type I deposition both in vitro and in vivo, similar to normal cartilage (shown in Figure 3), as opposed to the cell-adhesive group (Zhang et al., 2015). It was suggested that ASCs formed multicellular spheroids through spontaneous cellular aggregation on the anti-adhesive scaffold, mimicking the “condensation” step during embryonic limb development which promoted chondrogenesis (Zhang et al., 2015). This study provided a unique strategy to design new scaffolds which might better mimic the in vivo biological environment.

In summary, with the safety of ASC-seeded scaffolds already demonstrated in multiple pre-clinical animal models and small-scale humans trials (Kim et al., 2015), the next step is to confirm their safety and efficacy in large-scale human trials. And the ASC-seeded scaffolds should be compared with the delivery of ASCs alone. In addition, the material, structure and physicochemical parameters of scaffolds require further optimization based on the latest findings to provide better regenerative capacity for ASCs.

3.4.2 Bioactive factors

Co-delivery of growth factors or PRP is another effective way to enhance the proliferation and chondrogenesis of ASCs (Li et al., 2015; Yin et al., 2015; Scioli et al., 2017). In fact, the co-delivery of PRP as a source of growth factors has already been applied to most of the recent clinical trials using SVF (Pak et al., 2016a; Pak et al., 2016b). Nevertheless, the delivery of growth factors in these studies was still in an uncontrolled manner. Some growth factors might not exert the expected function when delivered in an inappropriate concentration, for example, the TGF-β1. The homogenous and sustained drug release could be achieved by covalent conjugation of growth factors onto the scaffolds. Choi et al. significantly reduced the burst release by covalently linking
TGF-β1 to the chitosan hydrogel via SMCC linker (Choi et al., 2015). Another choice is encapsulating growth factors in drug carrier systems, such as microspheres (Sukarto et al., 2012; Yin et al., 2015; Deepthi and Jayakumar, 2016). Certain natural materials could be used to fabricate the microspheres, such as chondroitin sulphate and ECM, and these natural-derived molecules might enhance the bioactivity of the co-delivered scaffolds, especially the synthetic scaffolds (Gibson et al., 2014; Deepthi and Jayakumar, 2016). However, before moving into human trials, the safety of micro- or nano-phase drug carriers still needs careful investigation for any potential side-effects.

4 Future perspective

Various pre-operative optimization strategies have been investigated recently, including cell source selection, preconditioning and co-delivery. Despite the encouraging results already achieved, few of these methods has really moved into the clinical stage. One reason is that the underlying mechanisms behind these methods are not fully understood. Besides, the healing process of treated cartilage and the biological process ASCs undergo following delivery needs further elucidation. If these basic questions were clearly answered, the optimized therapies could achieve a more consistent result in pre-clinical studies, thereby accelerating their pace into clinical stage.

Except for the pre-operative optimization, some post-operative strategies can also be considered. Some pilot studies demonstrated that special mechanical stimuli can induce ASC chondrogenesis, for example, low-intensity ultrasound (Shafaei et al., 2013). In the future, effective physical therapies could be designed to further improve the therapeutic function of ASCs post-operatively, as a supplement to the surgical treatments.
To conduct large-scale clinical trials and eventually enter the market, more efforts should be made on the stem cell quality control. Recently, some pilot studies have already been conducted. For liposuction, the commercialized Bodyjet® water-jet-assisted liposuction and ultrasound-assisted liposuction (UAL) have shown no influence on the cell yield, viability and differentiation potential of ASCs, demonstrating good compatibility for ASC production (Bony et al., 2015; Duscher et al., 2016). For SVF isolation, fully-automatic systems are attractive due to the minimal manipulation which minimizes the contamination risk and variability between batches. Incellator® (Tissue Genesis™) and Celution® (Cytori) are two kinds of commercialized systems that automatically isolate SVF from adipose tissue, with comparable or even better efficiency compared to the manual procedure (Riis et al., 2015).

Short-term hypothermic preservation, which is necessary for quality control inspection and cell product transportation, remains an unsolved problem because of the cell injury and death upon rewarming. Hajmousa et al. proposed a modified 6-chromanol SUL-109 as a novel single molecule cell preservation additive agent in the culture medium to protect ASCs from hypothermic damage while maintaining the differentiation capacity, showing great potential for future application (Hajmousa et al., 2017).

Conventional static monolayer culture techniques in the laboratory are not suitable in industry due to low efficiency, risk of contamination and difficulties in quality control. Thus, a well-designed novel culture system needs to be developed. Yu et al. fabricated a novel non-chemically crosslinked decellularized adipose tissue (DAT) porous microcarrier for dynamic culture of ASCs (Yu et al., 2017). After over one month of continuous culture, ASCs that expanded on the DAT microcarriers maintained their immunophenotype and multilineage differentiation capacity while
exhibiting stronger chondrogenesis than baseline control, showing great promise in ASC mass culture (Yu et al., 2017).

5 Conclusion

Adipose-derived stem cells are an ideal alternative to BMSCs, due to the similar regenerative capacity but more abundant source and easier accessibility. To date, most of the completed clinical trials delivered ASCs in the form of SVF and reported safety and efficacy for cartilage regeneration, exhibiting great potential for clinical knee osteoarthritis treatment. However, simple SVF injection is not sufficient to fully restore the damaged cartilage back toward normal function, thus an optimized ASC therapy is needed for an enhanced therapeutic function. Based on current technology, culture-expanded ASCs are more promising than crude SVF in future application. Among various optimization strategies investigated recently, preconditioning and co-delivery showed the most encouraging results in preliminary studies, but more convincing data from well-designed pre-clinical and clinical trials are needed before practical use. Due to the bright future of expanded ASCs, techniques involving isolation, expansion and storage of ASC products also need to be explored to ensure the good quality of stem cell products and the smooth industrial translation.

Acknowledgements

The authors would like to thank for the financial support from Shanghai Telebio Biomedical Co., Ltd.

Disclosures

The authors indicate no potential conflicts of interest.
Reference


**Figures**

**Figure 1.** Overview of the optimization strategies discussed in this work.
Figure 2. Effect of IFNγ-priming on the inflammatory gene profile of eASCs. Gene array analysis of inflammatory cytokines and chemokines mRNA compared naïve and IFNγ-primed eASCs. (A) Hierarchical clustering comparing naïve or IFNγ-primed eASCs, (B) induced gene expression levels in IFNγ-primed eASCs expressed as relative expression (2−ΔCT), (C) significantly modulated gene expression levels in IFNγ-primed eASCs. Results are represented as mean ± SEM for three independent biological replicates. Data were analyzed using the Mann–Whitney test. *p < 0.05. (Adapted from Front. Immunol. 2016; 7: 392, “Utility of a Mouse Model of Osteoarthritis to Demonstrate Cartilage Protection by IFNγ-Primed Equine Mesenchymal Stem Cells” by Maumus et al., used under CC BY)
Figure 3. Morphological evaluation of neo-cartilage in critical-size rabbit cartilage defects. Defect repaired with the ASC spheroids/scaffold A construct was set as group I. Defect repaired with adherent ASCs/scaffold B construct was set as group II. a, Gross appearance of the neo-cartilage at 6 w and 12 w. b, H&E staining of normal cartilage. H&E staining of group I (c), group II (d) at 6 w, and group I (g), group II (h) at 12 w. e, f, i and j were higher-magnification images selected from the regenerated areas outlined by the rectangles in c,d,g and h, respectively. H&E staining showed that cells in the regenerated tissue of group I possessed larger volume and more obvious cartilage lacuna structure than those in group II. And the arrangement features of cells in group I were more obvious. (Bar scales: 1000 µm for c,d,g,h, 250 µm for b,e,f,i,g). (Adapted from Biomaterials 2015, 71: 24-34, with permission from Elsevier).
<table>
<thead>
<tr>
<th>Material</th>
<th>Model</th>
<th>Conclusion</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDM scaffold</td>
<td>Rabbit</td>
<td>ASC-ECM scaffold regenerates hyaline cartilage, comparable to native cartilage</td>
<td>(Kang et al., 2014)</td>
</tr>
<tr>
<td>Chitosan hydrogel + RGD/growth factors</td>
<td>N/A</td>
<td>Young’s modulus affects ASC viability and retention; RGD peptide improves ASC viability; growth factor-loaded MPs enhance ASC chondrogenesis</td>
<td>(Sukarto et al., 2012)</td>
</tr>
<tr>
<td>Genipin-crosslinked CDM scaffold</td>
<td>N/A</td>
<td>Chemical crosslinking by genipin prevents scaffold contraction while preserving the chondrogenic potential of CDM</td>
<td>(Cheng et al., 2013)</td>
</tr>
<tr>
<td>Poly(L-glutamic acid)-chitosan scaffold</td>
<td>Rabbit</td>
<td>PLGA/CHI scaffold repairs full-thickness cartilage defects, comparable to native cartilage</td>
<td>(Zhang et al., 2013)</td>
</tr>
<tr>
<td>CDM-chitosan hydrogel</td>
<td>N/A</td>
<td>Col II enhances ASC condensation and chondrogenesis through increased cell–matrix adhesion, mediated by integrin α10</td>
<td>(Choi et al., 2014)</td>
</tr>
<tr>
<td>CDM-PCL scaffold</td>
<td>N/A</td>
<td>Multi-layer electrospun constructs enhance cell infiltration; inclusion of CDM stimulates chondrogenesis</td>
<td>(Garrigues et al., 2014)</td>
</tr>
<tr>
<td>CDM scaffold</td>
<td>N/A</td>
<td>Scaffolds with larger pore size have greater ASC migration, proliferation, and chondrogenic differentiation</td>
<td>(Almeida et al., 2015)</td>
</tr>
<tr>
<td>TGF-β1-conjugated chitosan hydrogel</td>
<td>Rat</td>
<td>Covalently conjugated TGF-β1 via SMCC linker significantly reduces burst release</td>
<td>(Choi et al., 2015)</td>
</tr>
<tr>
<td>Poly(L-glutamic acid)-chitosan scaffold</td>
<td>Rabbit</td>
<td>Non-fouling scaffold drives ASCs into multicellular spheroids, which facilitates hyaline-like cartilage Regeneration</td>
<td>(Zhang et al., 2015)</td>
</tr>
<tr>
<td>Fibrin glue</td>
<td>Human</td>
<td>Scaffolds improve the cartilage regeneration capacity of ASCs for large cartilage lesions</td>
<td>(Kim et al., 2015)</td>
</tr>
<tr>
<td>Type I collagen scaffold + PRP/insulin</td>
<td>N/A</td>
<td>3D culture and PRP/insulin treatment enhance ASC chondrogenesis</td>
<td>(Scioli <em>et al.</em>, 2017)</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>-----</td>
<td>---------------------------------------------------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>Heparin-HA hydrogel</td>
<td>N/A</td>
<td>Hydrogel degradation is necessary for 3D cellular activities; Hep-HA superior to Hep-PEG and PEG-HA</td>
<td>(Gwon <em>et al.</em>, 2017)</td>
</tr>
</tbody>
</table>

*Table 1.* ASC-seeded scaffolds for cartilage regeneration reviewed in this work.