Prospects for Descemet Stripping Automated Endothelial Keratoplasty Using Cultured Human Corneal Endothelial Cells

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Abstract

Study background: Descemet stripping automated endothelial keratoplasty (DSAEK) allows selective replacement of the diseased corneal endothelium. However, DSAEK requires a donor cornea and the worldwide shortage of corneas limits its application. In this review, we introduce our recent work on tissue engineering for DSAEK using cultured human corneal endothelial cells (HCEC) and recently published experimental data on HCEC precursors.

Methods and Results: We seeded Dil-labeled cultured HCECs onto collagen sheets, yielding HCEC sheets. The pump function parameters of these sheets were 76% to 95% of those for human donor corneas. Then HCEC sheets were transplanted onto the posterior stroma of New Zealand white rabbits after Descemetorhexis (DSAEK group). Rabbit corneas with only Descemetorhexis were the control group. The mean corneal thickness was significantly smaller in the DSAEK group than in the untransplanted control group throughout the observation period. Dil-labeled cells covered the posterior corneal surface in the DSAEK group. Severe stromal edema was detected in the control group by microscopy with hematoxylin-eosin staining, but not in the DSAEK group. Next, we isolated HCEC precursors from human donor corneas. Cultured precursor cells formed sphere colonies that expressed neural and mesenchymal proteins. The progeny of these colonies were HCEC-like hexagonal cells. Cell sheets constructed using HCEC precursors showed stronger staining for BrdU and nestin than cell sheets constructed with differentiated cultured HCECs.

Conclusions: These findings indicate that cultured HCECs transplanted from adult human donor corneas retain their corneal dehydration function and suggest the feasibility of using DSAEK with HCECs to treat endothelial dysfunction. Adult human corneal endothelium contains precursors that can differentiate into corneal endothelial cells. HCEC precursors may become a powerful tool for the construction of HCEC-coated collagen sheets.

Keywords: Review; Corneal endothelium; Descemet stripping automated endothelial keratoplasty (DSAEK); Precursors; Transplantation

Abbreviations: CEC: Corneal Endothelial Cell; HCEC: Human CEC; DSAEK: Descemet’s stripping with automated endothelial keratoplasty; Dil:1,1-Dioctadecyl-3,3,3,3-Tetramethylindocarbocyanine Perchlorate

Introduction

The cornea is composed of a multilayered epithelium, Bowman’s membrane, stroma, Descemet’s membrane, and endothelium. The corneal endothelium is a single layer of hexagonal cells that separates the corneal stroma from the aqueous humor of the anterior chamber. Transparency of the cornea is maintained by regulation of stromal hydration through the barrier and pump functions of the corneal endothelium. Corneal transplantation has long been used to treat defects of corneal endothelial cells (CECs). In fact, more than half of the patients who receive full-thickness corneal transplantation have decreased visual acuity due to corneal endothelial problems alone and have normal corneal epithelium [1-3]. Corneal transplantation requires a fresh human cornea, but there is a worldwide shortage of donors [4-7].

As a step toward to clinical application of human CEC sheet transplantation as a substitute for full thickness corneal transplantation, the feasibility of using cultured human CECs (HCECs) has been reported [8-15]. Cultured HCECs derived from adult human donor corneas have been transplanted onto denuded Descemet’s membrane [8-13], collagen matrix [14], amniotic membrane [15], and human corneal stromal discs [16] ex vivo. Culture of differentiated HCECs yields cells with an HCEC-like morphology and function, but the cells become increasingly heterogeneous with older donor age and more passaging [17-19]. The number of HCECs, a pivotal factor in maintaining corneal transparency over the long term, decreases after transplantation [14]. Thus, a high cell density and normal hexagonal cells with adequate endothelial function are crucial requirements for producing cultured HCEC sheets that are comparable with or better than donor CECs.

Over the last few years, Descemet stripping with automated endothelial keratoplasty (DSAEK) has become a standard procedure for corneal transplantation in patients with endothelial dysfunction [20-23]. This procedure improves postoperative visual function and reduces the risks associated with penetrating keratoplasty, such as severe astigmatism and expulsive hemorrhage. However, DSAEK requires a donor cornea, so the worldwide shortage of donor corneas limits the application of this procedure [4-7]. If cultured HCECs could be used in corneal transplantation, many patients with corneal endothelial dysfunction could be treated by using cells from a single donor cornea. Therefore, we have been investigating the feasibility of DSAEK using cultured HCECs [14,16]. In this review, we introduce our recent work on tissue engineering of corneal endothelium with cultured HCECs and progenitor cells.

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Origin and Development of the Corneal Endothelium

Neural crest cells, from which the corneal endothelium is derived [24,25], migrate and differentiate in two waves during corneal development [26,27]. In the first wave, the corneal epithelium is formed by periocular mesenchymal cells of neural crest origin and it synthesizes the primary stroma, after which neural crest cells migrate to the margin of the optic cup and then migrate between the lens and corneal epithelium to contribute to development of the corneal endothelium and trabecular meshwork. In the second wave, neural crest cells invade the primary stroma and differentiate into corneal keratocytes.

Culture of HCECs

Several groups have established HCEC culture techniques [9,12,19,28]. Various growth factors have been reported to influence the proliferation of cells cultured from human corneal endothelium, including fibroblast growth factor [9,12,28-31] epidermal growth factor [12,28,31,32], nerve growth factor [12], and endothelial cell growth supplement [28,33]. In addition, cell attachment and growth can be supported by seeding onto an artificial matrix, such as chondroitin sulfate and laminin [29], laminin-5 [34], extracellular matrix secreted by bovine corneal endothelial cells [19,33], or fibronectin plus type I collagen coating mix [18].

In our studies, human donor corneas were handled according to the tenets of the Declaration of Helsinki of 1975 and its 1983 revision. All donor corneas were obtained from the Rocky Mountain Lion’s Eye Bank. The age of the donors ranged from 42 to 67 years. HCECs were isolated and cultured according to the published protocols of Joyce and our laboratory with some modifications [12,18,19]. Briefly, Descemet’s membrane with intact endothelium was carefully dissected. After centrifugation, the strips were incubated in 0.02% ethylenediamine tetraacetic acid disodium salt solution at 37°C for 1 hour to loosen intercellular junctions. Isolated cells were plated in 6-well tissue culture plates that had been precoated with uninduced fibronectin plus type I collagen coating mix. The plates were then incubated at 37°C in a humidified atmosphere with 5% carbon dioxide. After primary cultures reached confluence, cells were subcultured at a 1:4 ratio. Subsequent passages were done by the same method, but at a ratio of 1:16 and cells from the fourth, fifth, or sixth passages were used in this study.

Construction of a Cell Sheet from Cultured HCECs

Seeding of cultured HCECs on collagen sheets

As a cell carrier, collagen sheets obtained from Nippi Research Institute of Biomatrix (Tokyo, Japan) were employed. These sheets were composed of a network of loosely arranged cross-linked type I collagen fibers that had been treated with an alkaline solution, dried, and sterilized for 2 hours under ultraviolet light [36]. Before use, the desiccated sheets were immersed in sterile saline for 10 minutes. A 6.0-mm trephine was used as the biopsy punch. Each sheet was composed of a network of loosely arranged cross-linked type I collagen coating mix. The plates were then incubated at 37°C in a humidified atmosphere with 5% carbon dioxide. After primary cultures reached confluence, cells were subcultured at a 1:4 ratio. Subsequent passages were done by the same method, but at a ratio of 1:16 and cells from the fourth, fifth, or sixth passages were used in this study.

Transplantation of DSAEK Grafts in a Rabbit Model

Transplantation technique

All procedures were done in accordance with the ARVO Statement for the Use of Animals in Ophthalmic and Vision Research. Rabbits were obtained from Saitama Experimental Animals, Inc. (Saitama, Japan). Eight New Zealand White rabbits weighing 2.0 to 2.4 kg were anesthetized with intramuscular ketamine hydrochloride (60 mg/kg) and xylazine (10 mg/kg). HCEC sheets were prepared as shown in Figure 3A. An HCEC sheet (with the HCEC side up) was placed on a foldable silicone plate for transplantation (Figure 3A). After disinfection and sterile draping, a 6-mm sclerocorneal incision centered at 12 o’clock was made with a slit knife, and a viscoelastic agent was infused...
into the anterior chamber (Figure 3B). After the corneal surface had been ruled with a marking pen, a circular Descemetorhexis (6.0-mm in diameter) was created in the center of the cornea with a 30-gauge needle (Figure 3C) or a Price hook (Moria), and Descemet’s membrane was removed from the anterior chamber. An HCEC sheet was brought into the anterior chamber with the forceps (Figure 3D) or using a foldable silicone plate (Figure 3E) and then was fixed to the posterior stroma that had been stripped of Descemet’s membrane (Figure 3F).

When the HCEC sheet was brought into anterior chamber using the silicone, the plate was settled on a wound, but was not brought into the anterior chamber. After the rolled HCEC sheet was pushed into anterior chamber through the folded silicone plate using forceps, the plate was removed from the wound. Cultured HCEC sheet was fixed to the posterior stroma that had been stripped of Descemet’s membrane. The rabbit was divided into two groups, which were the DSAEK group (rabbits with peeling of Descemet’s membrane and transplantation of an HCEC sheet) and the control group (rabbits with peeling of Descemet’s membrane only). Each group comprised four rabbits (four eyes). No immunosuppressive agents were administered either topically or systemically.

**Observation after surgery**

Corneal edema decreased much earlier after HCEC sheet transplantation in the DSAEK group than in the control group (Figure 4A). In the control group, mean corneal thickness remained at approximately 1,000 µm throughout the 28-day observation period. In contrast, it decreased rapidly in the DSAEK group, and the cornea was significantly thinner than in the control group at 1 (P<0.05), 3, 7, 14, 21, and 28 days (P<0.001) after surgery (Figure 4A). Figure 4B and 4C show representative anterior segment photographs from each group. The cornea is opaque with severe stromal edema in the control group, while the cornea transplanted with a cultured HCEC sheet is clear and has no stromal edema on day 28 in the DSAEK group (Figure 4). Slit lamp examination showed only mild opacity of the collagen sheet. In the DSAEK group, grafts remained transparent for 1 month after surgery and the corneas with HCEC sheets were significantly thinner than the corneas of the control group. These results suggest the feasibility of performing corneal reconstruction by using HCEC cultured from adult donor corneas.

**Histologic examination**

Fluorescence microscopy of whole mounted corneas showed...
DiI-positive cells localized on the transplanted collagen sheet and a clear margin of the sheet at 28 days after transplantation (Figure 5A). HCECs on the collagen sheets had a fairly regular morphology with well-defined boundaries (Figure 5B). No defects were detected on the collagen sheets. Most cells on the collagen sheets transplanted to the posterior surface of the cornea were DiI-positive in the DSAEK group (Figure 5C). Since endocytosed DiI cannot be transferred to adjacent cells [41], it is probable that the cultured HCECs remained on the sheet. The endothelial cell density of the four grafts in the DSAEK group was around 2,500 cells/mm² at 28 days after surgery, whereas the preoperative endothelial density was around 3,500 cells/mm². In the control group, no CECs were detected on the stroma at the site of Descemetorhexis. HE-stained sections obtained 28 days after transplantation are shown in Figure 6. There is edema and diffuse cellular infiltration of the stroma in the control group (Figure 6A). Fibrous tissue and fibroblast-like cells were observed in the posterior stroma of the control group (Figure 6B). In contrast, there was no edema of the transplanted HCEC collagen sheets in the DSAEK group (Figures 6C, D).

Immune Privilege of the Anterior Chamber

The anterior chamber of the eye is an immune-privileged site and anterior chamber-associated immune deviation allows the long-term acceptance and survival of histoincompatible tissue grafts that would be rejected if transplanted to other sites [42,43]. In our study, no evidence of an inflammatory reaction, such as massive cell infiltration, keratic precipitates, or fibrin deposition, was detected in the anterior chamber by slit lamp microscopy, indicating that there was no notable acute rejection. When HCEC sheets are grafted, the transplanted HCECs face the anterior chamber may induce anterior chamber-associated immune deviation, thereby avoiding rejection, as evidenced by the lack of any immune reaction at one month after human to rabbit HCEC sheet [14] or precursor cell [44] xenotransplantation. Another possible reason is that the collagen sheet does not permit cell infiltration.

Current Limitations and Challenges

Autologous CEC transplantation is undoubtedly an ideal strategy to completely negate the possibility of rejection. Because CECs from the peripheral cornea contain a higher density of precursors than CECs from...
to select corneal endothelial precursor cells with their potential to differentiate into corneal endothelial lineage committed cells from these undifferentiated embryonic stem cells, adult stem cells, or iPSCs in final cell preparations.

Precursor Cells Derived From HCECs

Schimmelpfennig and Amann et al. reported that the density of HCECs is higher in the peripheral cornea than the central cornea [47,48]. It is also well known that the density of HCECs gradually decreases throughout life. Several groups have studied HCEC replication and have measured cell densities at the peripheral and central cornea [49,50]. Tissue culture studies by Bednarz et al. have shown that HCECs from the peripheral cornea are able to replicate, while cells from the central cornea exhibit little to no mitotic activity [49]. We previously reported that the percentage of replication-competent HCECs is higher for cells from the peripheral cornea than the central cornea. Significantly fewer central HCECs from older donors retain the ability to replicate compared with cells from the central cornea of younger donors, and HCECs, particularly those from the central cornea, undergo senescence-like changes with advancing donor age [51].

In various fields of regenerative medicine, precursor cells have been isolated by the neurosphere assay and utilized to regenerate tissues. Precursor cells are immature and have a greater potential to proliferate. Using the neurosphere assay, we tried to obtain precursor cells from CECs to explore the possibility of reversing senescence [44-46,52-57]. The CEC and Descemet’s membrane were peeled away in a sheet from the periphery to the center of the inner surface of the cornea with fine forceps. The separated CEC and Descemet’s membrane were incubated at 37°C for 3 hours in basal medium containing 0.02% collagenase. The tissues next were incubated in 0.2% EDTA at 37°C for 5 minutes, then dissociated into single cells by trituration with a fire-polished Pasteur pipette. Basal medium containing a methylcellulose gel matrix (1.5%) was used to prevent cell reaggregation. Cells were plated at the density of 1.0 viable cell/μL (5000 cells/well; 250 cells/cm²) in uncoated wells of 60-mm culture dishes. The basal medium was Dulbecco’s modified Eagle’s medium (DMEM)/F12 supplemented with B27, epidermal growth factor (EGF, 20 ng/mL), and basic fibroblast growth factor (bFGF, 20 ng/mL). For passaging, primary spheres (day 7) were treated with 0.5% EDTA, dissociated into single cells, and the cells plated in 24-well culture plates at a density of 1 cell/μL.

After spheres formed, gene expression was examined by immunostaining and semiquantitative real-time polymerase chain reaction [52]. To differentiate HCECs, spheres adherent to dishes coated with poly-L-lysine and fibronectin were incubated in medium containing bovine serum. Gene expression of adherent cells that differentiated from the spheres was examined by immunostaining and real-time polymerase chain reaction. 

Primary and secondary spheres were obtained from human corneal endothelium. Bromodeoxyuridine labeled most of the cells within each sphere, indicating that the colonies contained proliferating cells [52,56]. When the primary colonies were trypsinized and incubated in floating culture, some secondary colonies were generated, suggesting that HCECs have the capacity for self-renewal as colony. Cultured cells derived from the spheres had a polygonal shape at confluence. The mean potential difference and short circuit current for cell sheets derived from spheres were around 70% of those for normal corneas, suggesting that the spheres generated cells with considerable transport activity. Immunostaining showed that the sphere colonies expressed nestin (a marker of immature cells), α-smooth muscle actin

the central cornea in rabbits [45] and humans [46], culture of peripheral cells obtained by resecting a small piece of Descemet’s membrane may eventually allow HCEC sheet transplantation for unilateral bullous keratopathy. However autologous CEC transplantation could not be used in patients with bilateral bullous keratopathy. For patients with bilateral CEC deficiency, use of heterologous CECs, embryonic stem cells, and induced pluripotent stem cells (iPSCs) are valuable option. Heterologous CECs can be isolated from the donor cornea or healthy patients’ corneal limbal region. However there is still the requirement.
that transplanted precursors may not proliferate continuously in the anterior chamber, because sphere progenies are exposed to aqueous humor containing TGF-β2 and reach cell confluence on Descemet’s membrane for a short while.

Summary and Future Directions

New techniques that can replace full-thickness corneal transplantation have been tried both clinically and experimentally. HCEC transplantation with posterior stroma has been done clinically by procedures such as microkeratome-assisted deep lamellar keratoplasty [61-63], deep lamellar endothelial keratoplasty [64,65], and Descemet stripping endothelial keratoplasty [20-23]. HCEC transplantation without any stroma has been done clinically by Descemet membrane endothelial keratoplasty [66]. HCEC transplantation on carriers [14,16,67-71] has been investigated experimentally. Cultured HCECs should become a powerful tool for cell or tissue regeneration and transplantation. We have also demonstrated that sphere-forming precursors derived from HCECs largely give rise to HCEC-like cells with a hexagonal shape that possess essential functions such as pump activity. With the improvements in the ability to derive and purify HCEC precursors in vitro, HCECs can be now produced in sufficient quantities for in vitro experimental applications essential to clinical translation. However, several problems remain that will provide future challenges in the treatment of corneal endothelial dysfunction in the near future. As for experimental challenges, future work should address the way in which various type of stem cells are differentiated to HCECs with a focus on developmental physiology and cell culture microenvironments. Both approaches are essential step in improving the technology before clinical deployment. Before clinical trials, a very long-term investigation including histological observation will be necessary to evaluate the long-term viability of cultured HCEC after transplantation and clinically relevant postoperative complications such as graft rejection in animal model. Additionally, ethical and regulatory issues should be resolved for the cultured HCECs transplantation to be a routine clinical treatment. The culture medium contains some animal-derived purified proteins and the use of animal derived materials carries a risk of transmitting animal pathogens. Therefore, animal derived materials should be avoided. Several stem cell types such as embryotic stem cells, iPSCs, and adult stem cells may be a candidate for HCEC-replacement therapy. Isolation of human corneal endothelial precursors from peripheral portion of the cornea raises the possibility of autologous transplantation. This technique will circumvent the logistical, safety and ethical issues that arise with the transplantation of various other human stem cell types. Highly proliferative sphere-forming precursors may be employed for the treatment of corneal endothelial dysfunction at some point in the future.

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