Stromal vascular fraction cells for the treatment of critical limb ischemia: a pilot study

Adas Darinskas1*, Mindaugas Paskevicius2, Gintaras Apanavicius2, Gintaris Vilkevicius3, Liutauras Labanauskas5, Thomas E. Ichim6 and Rytis Rimdeika5

Abstract

Background: Cell-based therapy is being explored as an alternative treatment option for critical limb ischemia (CLI), a disease associated with high amputation and mortality rates and poor quality of life. However, therapeutic potential of uncultured adipose-derived stromal vascular fraction (SVF) cells has not been evaluated as a possible treatment. In this pilot study, we investigated the efficacy of multiple injections of autologous uncultured adipose-derived SVF cells to treat patients with CLI.

Methods: This study included 15 patients, from 35 to 77 years old, with rest pain and ulceration. SVF cells were injected once or twice in the ischemic limb along the arteries. Digital subtraction angiography was performed before and after cell therapy. The clinical follow up was carried out for the subsequent 12 months after the beginning of the treatment.

Results: Multiple intramuscular SVF cell injections caused no complications during the follow-up period. Clinical improvement occurred in 86.7% of patients. Two patients required major amputation, and the amputation sites healed completely. The rest of patients achieved complete ulcer healing, pain relief, improved ankle–brachial pressure index and claudication walking distance, and had ameliorated their quality of life. Digital subtraction angiography performed before and after SVF cell therapy showed formation of numerous vascular collateral networks across affected arteries.

Conclusion: Results of this pilot study demonstrate that the multiple intramuscular SVF cell injections stimulate regeneration of injured tissue and are effective alternative to achieve therapeutic angiogenesis in CLI patients who are not eligible for conventional treatment.

Trial registration number at ISRCTN registry, ISRCTN13001382. Retrospectively registered at 26/04/2017.

Keywords: Angiogenesis, Arteriosclerosis obliterans, Stromal vascular fraction cells, Critical limb ischemia

Background

Peripheral arterial disease (PAD) is a major health care problem in our aging society. It results in obstruction of the blood supply to the lower or upper extremities. Intermittent claudication and rest pain are the main symptoms of limb ischemia. Critical limb ischemia (CLI) is the most advanced stage of PAD. It often coincides with ischemic ulceration and/or gangrene [1], and significantly decreases a patient’s quality of life. It is difficult to manage using current treatment modalities. Although several therapies, including medical and surgical procedures, may reduce patients’ symptoms and improve the condition of their limbs, a lot of patients are not candidates for surgery or percutaneous transluminal angioplasty (PTA). 25% of CLI patients requires a major amputation of a limb within 1 year after diagnosis [2]. It has been recently shown that cell-based therapies using bone marrow mononuclear cells (BM-MNCs), peripheral blood mononuclear cells (PB-MNCs) and bone marrow-derived mesenchymal stem cells (BM-MSCs) have effective outcomes in patients with CLI [1–5]. Nevertheless, the availability of an easily accessible
cell source may greatly facilitate the development of new cell-based therapies. Cells residing in stroma of adipose tissue are now recognized as an accessible, abundant, and reliable source of various adult stem cells suitable for tissue engineering and regenerative medicine applications [6]. Adipose tissue is one of the most accessible tissues by mild operation and the only tissue in the human body that can be removed without leaving a functional defect.

A vast amount of the stromal vascular fraction (SVF) in adipose and connective tissues can be easily obtained from patients using conventional liposuction and isolation methods [7]. The SVF consists of a heterogeneous mesenchymal population of cells that includes not only adipose stromal, hematopoietic stem and progenitor cells but also endothelial cells, erythrocytes, fibroblasts, lymphocytes, monocyte/macrophages and pericytes [8, 9]. During the past decade, the number of scientific publications related to preclinical and clinical use of adipose-derived stromal/stem cells (ASCs) has increased dramatically. A group of scientists in a clinical survey with SVF cells and more than 1000 patients treated, have shown that adipose tissue without substantial manipulation is beneficial even in orthopedic field [10]. A pilot study conducted by Lee et al. showed that ASC implantation could be a safe alternative to achieve therapeutic angiogenesis in CLI patients [11]. However, the therapeutic potential of uncultured SVF cells for CLI patients has not been investigated.

The muscle tissue where the therapeutic cells are injected is, in fact, connective tissue, like the SVF cells themselves. That classifies this therapy as homologous, which, in the light of regulatory concerns about application of SVF cells in the European Union, is an important fact to point out.

In this study we aimed to evaluate the therapeutic potential of autologous, uncultured, readily available and easily isolated adipose-derived SVF cells injected directly into ischemic limb of patients with CLI who are not eligible for conventional treatment modalities.

**Methods**

**Patients**

Fifteen patients (from 35 to 77 years old) with CLI were enrolled in this study, which was conducted between April 2014 and May 2015. All patients were suffering from arteriosclerosis obliterans (ASO). Surgical bypass and/or PTA were not possible for all patients. Surgical amputation was the only treatment option for these patients who were suffering from rest pain (all cases) and ulcers (cases 1, 8, 11, 12, 15), and pregangrene of two fingers (case 6). One patient (case 11) had already undergone minor amputation in the limb. Characteristics of the patients are shown in Table 1. All patients provided written informed consent and, after approval by the medical ethics committee of Vilnius City Clinical Hospital and the rule of compassionate use, underwent the SVF cell therapy. All patients had undergone angiography before and after SVF cell therapy. The clinical efficacy was evaluated by assessing arterial revascularization, pain relief, ulcer healing, walking distance and changes in ankle-brachial pressure index (ABI).

**Adipose tissue collection**

Adipose tissue was collected using 3 mm inner diameter cannula with three pyramidal order holes in the end. Cannula was used with 50 ml luer lock syringe (BD) and vacuum was made with the help of surgeon’s finger.

### Table 1 Patients’ characteristics

| Case | Age/gender | Diagnosis | Ulcer | Claudication (m) | Risk factors |
|------|------------|-----------|-------|------------------|--------------|
| 1 (L) | 57/M | ASO | +, non-healing | 100–150 | – |
| 2 (R) | 70/M | ASO | – | 100–150 | Smoking |
| 3 (L) | 68/M | ASO | – | 100–150 | Smoking |
| 4 (L) | 52/M | ASO | – | 150–200 | DM |
| 5 (R) | 59/M | ASO | – | 50–100 | DM, smoking |
| 6 (Lu) | 77/F | ASO | Pregangrene of two fingers | – | – |
| 7 (L) | 77/F | ASO | +, non-healing | 100–150 | DM |
| 8 (L) | 67/M | ASO | + | 50–100 | DM, smoking |
| 9 (L) | 60/F | ASO | – | 100–150 | DM, obesity |
| 10 (R) | 68/F | ASO | – | 150–200 | DM, obesity |
| 11 (L) | 60/M | ASO | +, non-healing | 50–100 | DM, obesity |
| 12 (R) | 56/M | ASO | + | 150–200 | DM, smoking |
| 13 (L) | 67/M | ASO | – | 200–250 | – |
| 14 (R) | 72/F | ASO | – | 150–200 | – |
| 15 (R) | 64/M | ASO | + | 50–100 | DM, smoking |

Lu left upper limb, L left lower limb, R right lower limb, ASO arteriosclerosis obliterans, DM diabetes mellitus
aspiration force. All adipose tissue was collected from abdomen area, under local anesthesia with lidocaine and adrenaline. Minimum amount of collected tissue was 40 ml.

**SVF cell isolation**

The lipoaspirate was washed within 12 h of collection with plenty of physiological solution and gentamicin (80 mg/l). Adipose fraction was cut using specially produced blend mesh to avoid usage of collagenase. A mechanical stainless steel two-bladed mill placed in a cylinder 5 cm in diameter and equipped with a metal 3 mm diameter mesh was used to mechanically disrupt the adipose tissue. The mill was rotated at speed not exceeding 260 rpm. Each fraction was minced three times and remaining homogenous lipoaspirate was centrifuged for 7 min at 850 g in 50 ml falcon tubes. The upper fraction containing adipocytes was discarded, and the pellet was washed once with physiological solution and prepared for injections. Cell densities were determined by counting in a Neubauer's hemocytometer, and cell viability was assessed using Trypan blue exclusion assay.

**Injection of SVF cells**

Cells were prepared in 20 ml luer lock syringes (BD). Cells were diluted in physiological solution and autologous serum of the patient. Minimum amount of viable cells per one syringe applied was 20 million. Application consisted of at least 30 injections per one 20 ml syringe. Secondary injections were performed 2 months after first application of cells.

**Results**

Multiple intramuscular SVF cell injections did not cause any complications in any of the patients during 5 days of hospitalization and all follow-up period. Overall, 86.7% of patients showed clinical improvement. Two patients (cases 10, 15) underwent a major amputation, 1 and 2 weeks after SVF cell therapy. The rest of patients reported either diminished or decreased rest pain at 12 weeks after SVF cell treatment. Table 2 shows the outcomes of SVF cell therapy. Necrosis was completely cured or improved in limbs of all patients suffering from ulcers after SVF cell therapy (Figs. 1, 3). No ulcer recurrence was observed in any of the patients during the follow-up period. 86.7% of patients showed improvement in walking distances. The ankle-brachial index (ABI) was improved from 17 to 48% at 12 months after SVF cell therapy, and the ABI was still higher 2 years later for all the patients. Digital subtraction angiography (DSA) performed before and after SVF cell therapy showed formation of numerous vascular collateral networks across affected arteries (Figs. 1, 2). None of the patients died during the follow-up period. The survival rate and freedom from major amputation of the limb at 24 months after SVF cell therapy were 100 and 86.7%, respectively.

**Table 2** SVF cell therapy and outcomes

| Case | Age/gender | Diagnosis | Cells (mln.) administered per procedure (numbers of procedure) | Time after procedure (months) | Clinical symptom, ulcer healing | Claudication (m) | ABI improvement (%) |
|------|------------|-----------|-------------------------------------------------|-----------------------------|------------------------|----------------|---------------------|
| 1 (L) | 35/M | ASO | 40 (2) | 12 | Improved, ulcer healed | 500–600 | 48 |
| 2 (R) | 70/M | ASO | 56 (2) | 12 | Improved | 300–350 | 23 |
| 3 (L) | 67/M | ASO | 45 (2) | 12 | Improved | 250–300 | 18 |
| 4 (L) | 57/M | ASO | 55 (2) | 12 | Improved | 400–450 | 40 |
| 5 (R) | 59/M | ASO | 38 (2) | 12 | Improved | 300–350 | 35 |
| 6 (Lu) | 77/F | ASO | 45 (2) | 12 | Improved | – | – |
| 7 (L) | 77/M | ASO | 42 (1) | 12 | Improved, ulcer healed | 150–200 | 17 |
| 8 (R) | 67/M | ASO | 56 (2) | 12 | Improved, ulcer healed | 200–250 | 29 |
| 9 (L) | 60/M | ASO | 36 (2) | 12 | Improved | 300–350 | 37 |
| 10 (L) | 68/M | ASO | 32 (1) | 1 week | Major amputation, wound healed | – | – |
| 11 (L) | 60/M | ASO | 43 (2) | 12 | Improved, ulcer healed | 300–350 | 25 |
| 12 (R) | 56/M | ASO | 51 (1) | 12 | Improved, ulcer healed | 300–350 | 23 |
| 13 (L) | 67/M | ASO | 39 (2) | 12 | Improved | 300–350 | 28 |
| 14 (R) | 72/F | ASO | 33 (1) | 12 | Improved | 250–300 | 25 |
| 15 (R) | 64/M | ASO | 34 (1) | 2 weeks | Major amputation, wound healed | – | – |

Lu left upper limb, L left lower limb, R right lower limb, ASO arteriosclerosis obliterans
Discussion

In the last decade cell-based therapies have been investigated as a promising treatment option for patients with CLI who are refractory to other treatment modalities. It provides encouraging therapeutic possibilities to enhance the repair of damaged or diseased tissues in CLI patients. Several studies have suggested beneficial effects of autologous BM-MSC based therapies [12, 13]. However, the percentage of MSCs in bone marrow is quite low and decreases with age [14]. Furthermore, after isolation, BM-MSCs need 2–3 weeks of in vitro culture to reach an amount sufficient for transplantation. Moreover, bone marrow suction is an invasive procedure. These drawbacks limit the possibility of wide clinical application of BM-MSCs [15]. In addition, the neovascularization capacity of transplanted BM-MNCs is reduced with aging; therefore this cell treatment is less appropriate in the older patients [16]. Last but not least, meta-analysis of randomized placebo controlled trials showed no advantage of bone marrow derived cell therapy on the primary outcome measures of amputation, survival, and amputation free survival in CLI patients [17]. Compared with bone marrow, subcutaneous adipose tissue can provide enough dosage for therapy without cell culture. This tissue is now recognized as an abundant and accessible source of multipotent stromal cells suitable for regenerative medicine [18]. Nevertheless, adipose tissue is routinely discarded as a medical waste. In this pilot study, we used autologous uncultured adipose-derived SVF cells as a potential treatment option for patients with CLI. Obtained results show the beneficial role of SVF cell therapy in reducing the rate of major amputations and improving quality of life in CLI patients. 86.7% of treated patients avoided the amputation of limbs. Previously it was demonstrated that SVF cell therapy accelerated diabetic wound healing [19]. In our study, complete wound healing occurred in all SVF cell—treated CLI patients. Previous studies have shown that ASCs exert their effects mainly via paracrine mechanisms and make beneficial contributions to tissue repair, regeneration and immunomodulation [11, 20, 21]. We have shown that injection of SVF cells is an effective way to promote healing of ulcer and skin regeneration.
Moreover, this study, for the first time, showed that injections of uncultured SVF cells could accelerate angiogenesis. Digital subtraction angiography performed before and after SVF treatment showed that the transformation of preexistent collateral arterioles into functional collateral arteries occurred in CLI patients. The principle that justifies the therapeutic application of stem cells is the restoration of vascular cellularity, the control and the support of the newly formed vessels, which ensure an adequate supply of oxygen in critical ischemic areas [22]. Previous researchers have reported that SVF cells could secrete various angiogenic growth factors in vitro and enhance neovascularization of ischemic tissue in vivo [23, 24]. Our data supports previously published reports showing that SVF cells promote angiogenesis and tissue repair. In a study performed by Sheng et al., enhanced angiogenesis and cell proliferation were observed in the tissue treated by transplantation of SVF [15]. We used uncultured SVF cells directly injecting them into ischemic limb. Injections were placed along the occluded native arteries, because the density of preformed collaterals is highest in parallel orientation to the axial arteries. This is the preferred location for collateral growth [22]. Moreover, we suppose that uncultured heterogeneous SVF cells can be more effective than a purified cell population due to the fact that heterogeneous population contains fibroblasts, stem cells, endothelial cells, pericytes, mast cells, preadipocytes, smooth muscle cells, macrophages, and progenitor cells, which are known to accelerate wound healing [15]. SVF cells injected near the wound could not only stimulate host cells around the wound, but also provide growth factors and extracellular matrix. The principle of intramuscular injection is the creation of a cell depot with paracrine activity in the ischemic area [22]. Moreover, in order to obtain more beneficial effect, we diluted SVF cells with autologous serum, which also contains growth factors and cytokines. The results obtained from this pilot study have demonstrated

![Fig. 2](image1.png)

**Fig. 2** Collateral vessel formation after SVF cell therapy. Case 6: DSA images before (A) and 10 months after SVF cell injections (B). Images of occluded limb right after SVF administration (C) and 10 months after SVF cell injections (D).

![Fig. 3](image2.png)

**Fig. 3** Wound healing after SVF cell therapy. Case 11: non-healing ulcer before treatment (A) and completely healed ulcer at 2 months after SVF cell injections (B). Case 7: non-healing ulcer before treatment (C) and improved healing ulcer at 5 months after SVF cell injections (D).
the beneficial role of SVF cell therapy in reducing the rate of amputations, reducing pain, improving ABI and overall quality of life in CLI patients.

Conclusion
Our data indicate that uncultured SVF cells diluted with autologous serum represent a potent therapeutic combination for CLI patients. The multiple intramuscular SVF cell injections are effective alternative to achieve therapeutic angiogenesis in CLI patients for which surgical bypass and/or PTA are not possible, and that this treatment modality is appropriate and safe. Bearing in mind the easy procedure of cell isolation and preparation, SVF cells may provide a promising therapeutic option for CLI. However, to establish this cell therapy as a standard treatment, more investigation with a larger number of patients is necessary.

Abbreviations
ABI: ankle-brachial pressure index; ASCs: adipose-derived stromal/stem cells; ASO: arteriosclerosis obliterans; BM-MNCs: bone marrow-derived mononuclear cells; BM-MSCs: bone marrow-derived mesenchymal stem cells; CLI: critical limb ischemia; DSA: digital subtraction angiography; MSCs: mesenchymal stem cells; PAD: peripheral artery disease; PB-MNCs: peripheral blood mononuclear cells; PTA: percutaneous transluminal angioplasty; SVF: stromal vascular fraction.

Authors’ contributions
AD, MP, GA, OV, LL, TJ and RR participated in the design of the study and analyzed the data. MP prepared all the figures. AD wrote the manuscript. All authors read and approved the final manuscript.

Author details
1 Laboratory of Immunology, National Cancer Institute Santarosists, Dr D., 08660 Vilnius, Lithuania. 2 Department of Vascular Surgery, Vilnius University Clinic Hospital, Antakalnio Str. 57, 10207 Vilnius, Lithuania. 3 Northway Medical and Surgical Center, S.Zukausko Str. 19, 08234 Vilnius, Lithuania. 4 Clinics of Cardiovascular Diseases, Vilnius University, Santariskiu Str. 2, 08661 Vilnius, Lithuania. 5 Department of Plastic and Reconstructive Surgery, Lithuanian University of Health Sciences, Medical Academy, University Clinics of Kaunas, Eivenu Str. 2, 50009 Kaunas, Lithuania. 6 Immune Advisors LLC, San Diego, CA 92121, USA.

Acknowledgements
Not applicable.

Competing interests
The authors declare that they have no competing interests.

Availability of data and materials
The datasets analyzed during the current study are available from the corresponding author on reasonable request.

Consent for publication
Informed consent was obtained from all participants.

Ethics approval and consent to participate
This study was approved by the medical ethics committee of Vilnius City Clinical Hospital, Lithuania. Informed consent was obtained from all patients before entry into the study in accordance with the Declaration of Helsinki.

Publisher’s Note
Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.

References
1. Monya J, Minamino T, Tateno K, Shimizu N, Kuwabara S, Tanaka Y, Komuro I. Long-term outcome of therapeutic neovascularization using peripheral blood mononuclear cells for limb ischemia. Circ J. 2009;2:245–54.
2. Nishida T, Ueno Y, Kimura T, Ogawa R, Ko Y, Tomita S. Efficacy and long-term effects of the autologous peripheral stem cell implantation for critical limb ischemia. Ann Vasc Dis. 2011;4:319–24.
3. Gupta PK, Chulkikana A, Parakh R, Desai N, Das AK, Sopithapramu S, Krishnamurthy S, Anthony MM, Verma SK, Masrmar AS. A double blind randomized placebo controlled phase II study assessing the safety and efficacy of allogeneic bone marrow-derived mesenchymal stem cell in critical limb ischemia. Int J Clin Pract. 2013;11:143.
4. Samura M, Hosoynia T, Hirauchi Y, Ueno K, Morikage N, Hamano K. Therapeutic strategies for cell-based neovascularization in critical limb ischemia. J Vasc Med. 2017;7:549.
5. Liu A, Bortynska M, Gao J, Stansby G. Cell therapy for critical limb ischemia: a real-world analysis of randomized controlled trials. Angiology. 2016;67:444–59.
6. Gimble JM, Guadagnoli B, Bunnell BA. Clinical and preclinical translation of cell-based therapies using adipose tissue-derived cells. Stem Cell Res Ther. 2010;1:39.
7. Gimble JM, Katz AJ, Bunnell BA. Adipose-derived stem cells for regenerative medicine. Circ Res. 2007;100:1249–60.
8. Bourin P, Bunnell BA, Casteilla L, Dominici M, Katz AJ, March KL, Redl H, Rubin JP, Yoshimura K, Gimble JM. Stromal cells from the adipose tissue-derived stromal vascular fraction and culture expanded adipose tissue-derived stromal/stem cells: a joint statement of the International Federation for Adipose Therapeutics and Science (IFATS) and the International Society for Cellular Therapy (ISCT). Cytotherapy. 2013;15:641–8.
9. Han J, Koy YJ, Moon HJ, Ryu PG, Cho CH, Kim I, Koh GY. Adipose tissue is an extramedullary reservoir for functional hematopoietic stem and progenitor cells. Blood. 2010;115:957–64.
10. Michalek J, Moster R, Lukac L, Proefrock K, Petrasovic M, Rybar J, Capkova M, Chaloupka A, Daniskas A, Michalek J, Sr et al. Autologous adipose tissue-derived mesenchymal stem cell application in patients with osteoarthritis. Cell Transpl. 2015;20:1–36.
11. Lee HC, An SG, Lee HW, Park JS, Cha KS, Hong TJ, Park JH, Lee SY, Kim SP, Kim YD, et al. Safety and efficacy of adipose tissue-derived stem cell implantation in patients with critical limb ischemia: a pilot study. Circ J. 2012;76:1750–60.
12. Tateishi-Yuyama E, Matsuura H, Murohara T, Ikeda U, Shintani S, Masaki H, Amano K, Kishimoto Y, Yoshimoto K, Akashi H, et al. Therapeutic angiogenesis for patients with limb ischemia by autologous transplantation of bone-marrow cells: a pilot study and a randomized controlled trial. Lancet. 2002;360:427–33.
13. Dash NR, Dash SN, Routray P, Mohapatra S, Mohapatra PC. Targeting nonhealing ulcers of lower extremity in human through autologous bone marrow-derived mesenchymal stem cells. Rejuvenation Res. 2009;12:359–66.
14. Stolzing A, Jones E, McGonagle D, Scott A. Age-related changes in human bone marrow-derived mesenchymal stem cells. Rejuvenation Res. 2008;11:163–73.
15. Sheng L, Yang M, Du Z, Yang Y, Li Q. Transplantation of stromal vascular fraction as an alternative for accelerating tissue expansion. J Plast Reconstr Aesthet Surg. 2013;66:551–7.
18. Zuk PA, Zhu M, Ashjian P, De Ugarte DA, Huang JI, Mizuno H, Alfonso ZC, Fraser JK, Benhaim P, Hedrick MH. Human adipose tissue is a source of multipotent stem cells. Mol Biol Cell. 2002;13:4279–95.
19. Han SK, Kim HR, Kim WK. The treatment of diabetic foot ulcers with uncultured, processed lipoaspirate cells: a pilot study. Wound Repair Regen. 2010;18:342–8.
20. Kapur SK, Katz AJ. Review of the adipose derived stem cell secretome. Biochimie. 2013;95:2222–8.
21. Gamble JM, Bunnett NA, Guilak F. Human adipose-derived cells: an update on the transition to clinical translation. Regen Med. 2012;7:225–35.
22. Compagna R, Amato B, Massa S, Amato M, Grande R, Butrico L, de Franciscis S, Serra R. Cell therapy in patients with critical limb ischemia. Stem Cells Int. 2015;2015:931420.
23. Rehman J, Traktuev D, Li J, Merfeld-Clauss S, Temm-Grove CJ, Bovenkerk JE, Pell CI, Johnstone BH, Considine RV, March KL. Secretion of angiogenic and antiapoptotic factors by human adipose stromal cells. Circulation. 2004;109:1292–8.
24. Premaratne GU, Ma LP, Fujita M, Lin X, Bollano E, Fu M. Stromal vascular fraction transplantation as an alternative therapy for ischemic heart failure: anti-inflammatory role. J Cardiothorac Surg. 2011;6:43.