Liver cirrhosis is a major cause of mortality and a common end of various progressive liver diseases. Since the effective treatment is currently limited to liver transplantation, stem cell-based therapy as an alternative has attracted interest due to promising results from preclinical and clinical studies. However, there is still much to be understood regarding the precise mechanisms of action. A number of stem cells from different origins have been employed for hepatic regeneration with different degrees of success. The present review presents a synopsis of stem cell research for the treatment of patients with liver cirrhosis according to the stem cell type. Clinical trials to date are summarized briefly. Finally, issues to be resolved and future perspectives are discussed with regard to clinical applications.

1. Introduction

Liver fibrosis results from sustained injury, which can be inflicted by various factors such as viruses, drugs, alcohol, metabolic diseases, and autoimmune attacks [1]. Prolonged exposure to these harmful factors causes hepatocyte apoptosis, inflammatory cell recruitment, endothelial cell impairment, and, lastly, activation of hepatic stellate cells, the major cells involved in liver fibrosis. Liver fibrosis is a kind of scar tissue formation in response to liver damage [2–9]. Histologically, it is caused by an imbalance between extracellular matrix synthesis and degradation [10–12].

Liver cirrhosis is a condition where scar tissue replaces the healthy tissue of the liver and regenerative nodules with surrounding fibrous bands develop as a result of the injury [13]. Cirrhosis is the common end of progressive liver disease of various causes, resulting in chronic liver failure entailing complications such as hepatic encephalopathy, spontaneous bacterial peritonitis, ascites, and esophageal varices [14]. Unfortunately, the majority of cases are usually in an irreversible state when diagnosed. Despite current advancements in its management [15, 16], cirrhosis was the 14th leading cause of death worldwide in 2012 [17]. Orthotopic liver transplantation is known to be the only definite solution to end-stage cirrhosis.

However, several problems preclude the prevalent application of the procedure, including immunological rejection and the scarcity of donor sources [18].

In fact, the liver has an inherent regenerative capacity to a substantial degree [19], and, thus, the cessation of those harmful factors may prevent further progression of fibrosis and reverse the situation in some cases [20]. In cases where hepatocyte proliferation is insufficient for recovery from liver injury, bipotent resident liver progenitor cells (LPC) are activated and participate in liver regeneration by differentiating into hepatocytes and biliary epithelial cells [19, 21–23]. However, fibrosis is inevitable when regeneration is exceeded by destruction. Clinical signs of liver failure usually appear after about 80 to 90% of the parenchyma has been destroyed.

Hepatocyte transplantation has been proposed as an alternative approach to transplantation, since hepatocytes
have been proven to be strongly associated with liver repair [24–28]. While hepatocyte transplantation is safe in humans, its applicability remains limited due to organ availability, failure of donor engraftment, weak viability in cell culture, and vulnerability to cryopreservation damage [25, 26, 29–32].

Instead of hepatocytes, the transplantation of stem cells has shown therapeutic potential for liver function improvement according to recent experimental studies and human studies [20, 26, 33–40]. Although they remain unclear, the major potential mechanisms have been proposed as a twofold; one is the improvement of the microenvironments through paracrine effects, and the other is the replacement of functional hepatocytes [20].

To date, several kinds of stem cells have been investigated for their therapeutic feasibility and clinical potential in liver cirrhosis [41–43]. The present article briefly reviews the current literature according to the types of stem cells and discusses the future perspectives of stem cell-based therapy in liver cirrhosis.

2. Sources of Stem Cells

Hepatocytes obtained via autopsy of patients who received bone marrow transplantation suggested that they are pluripotent cells in bone marrow [44, 45]. Currently, at least three types of bone marrow-derived cells are known to differentiate into hepatocyte-like cells (HLCs): hematopoietic stem cells (HSCs), mesenchymal stem cells (MSCs), and endothelial progenitor cells (EPCs), though early infusion trials did not discriminate the origins of those cells from bone marrow-derived stromal cells with some improvement [32, 46–52]. A large number of preclinical studies have proven the feasibility of HSCs, MSCs, and EPCs to restore hepatic function in models of liver injury [53–57]. In addition, other stem cells including embryonic stem cells (ESCs) and induced pluripotent stem cells (iPSCs) can also be differentiated into HLCs [58–60]. HLCs can contribute to the remodeling of cirrhotic liver [20, 61–68].

2.1. Hematopoietic Stem Cells. HSCs are the predominant population of stem cells within bone marrow and express CD34 as the cell surface marker. They can renew themselves and differentiate into progenitor cells [69, 70]. HSCs can easily be made to leave the bone marrow and circulate into the blood. The mobilization of HSCs resident in bone marrow can be brought about at a low magnitude through tissue injury [71, 72] or in high amounts after artificial priming [73, 74]. Granulocyte-colony stimulating factor is the most widely studied and widely used mobilizing agent [75–80].

HLCs derived from HSCs have been demonstrated to contribute to liver regeneration [65, 81–83]. In general, two mechanisms were proposed with substantial support. One was the de novo generation of hepatocytes through transdifferentiation, and the other was the genetic reprogramming of resident hepatocytes through cell fusion [45, 46, 84]. However, the infused HSCs do not seem to be a primary source of newly generated hepatocytes [85, 86]. Rather, their roles are likely to be associated with macrophages, which produce collagenases, phagocytose dead cells, and facilitate liver regeneration [87–89]. Therefore, the clinical benefit of HSC therapy occurs through paracrine signaling interactions involving various cytokines and growth factors [86, 90, 91]. Furthermore, HSCs likely stimulate neoangiogenesis [92].

2.2. Endothelial Progenitor Cells. EPCs are immature endothelial cells that can be found in both peripheral blood vessels and bone marrow. They arise from hemangioblasts and participate in the neovascularization of damaged tissue throughout the whole body [93–99]. Due to their common expression of CD34, EPCs and HSCs are assumed to have a common precursor [94, 100–106]. However, EPCs are likely to be differentiated from various cell lineages, as evidenced by their diverse surface markers [102, 104, 107–113].

The transplantation of EPCs led to the suspension of liver fibrosis by suppressing activating HSCs, according to an animal study [55]. They also promoted hepatocyte proliferation and increased matrix metalloproteinase activity [114]. These effects were associated with increased secretion of growth factors [115–117].

2.3. Mesenchymal Stem Cells. MSCs are a rarer population in bone marrow compared to HSCs, which are capable of self-renewal and differentiation into HLCs as well as cell types of mesenchymal origin [68, 118–128]. Traditionally, MSCs have frequently been isolated from bone marrow [129], but, recently, they have been obtained from many other tissues including umbilical cord blood, adipose tissue, and placenta [130–142]. There seems to be source-dependent differences among MSCs [143].

As a therapeutic advantage, MSCs can easily be expanded ex vivo without losing their differentiation potential, and they can also be migrated to the injured areas in response to homing signals [1]. Furthermore, the MSCs have immunomodulatory properties [144–156], through both adaptive and innate immune systems [157, 158], and secrete a variety of trophic factors such as growth factors and cytokines beneficial for liver regeneration [159–164]. Some of these trophic factors are known to revive hepatocytes reaching their replicative senescence [38, 165, 166]. With these advantages as a cell therapy source, the MSCs are the most widely studied stem cells, both experimentally and clinically [59, 167–174]

The precise therapeutic mechanisms of MSCs in liver regeneration have yet to be sufficiently elucidated. Accumulating evidence strongly supports the inference that the effects of MSCs are mediated mostly via paracrine mechanisms rather than transdifferentiation [175–179], although the infused bone marrow-derived MSCs (BM-MSCs) have been shown to engraft into host livers and ameliorate fibrosis in experimental animal models of liver fibrosis [54, 180–183]. MSC transplantation has also demonstrated preclinical efficacy in mitigating liver fibrosis as in other organs [53, 54, 181, 184–187]. Strategies to enhance the effects of MSC in cirrhosis have been investigated, including the facilitation of transdifferentiation into functional hepatocytes [59, 68, 120, 168, 188]. Interestingly, however, the in vivo transdifferentiation of MSCs into hepatocytes has been rarely observed in animal models [54, 189–192].
Rather, the MSCs downregulate proinflammatory and fibro-
genic cytokine activity, stimulate hepatocellular proliferation,
and promote collagen degradation by matrix metallopro-
teinase [53, 54, 181, 190–193]. The paracrine effects modu-
late the functioning of activated hepatic stellated cells [56,
194, 195]. Evidence from treatment with MSC-conditioned
medium reconfirmed the paracrine effects of MSCs such
as the increased proliferation and reduced apoptosis of
hepatocytes subsequent to the upregulation of several anti-
inflammatory and antiﬁbrotic cytokines [196, 197]. How each
of these signaling molecules individually contributes to hep-
atic regeneration, however, remains to be further elucidated
[46].

2.4. Embryogenic Stem Cells. Thomson et al. derived and
characterized human ESCs from the inner mass of a blas-
tocyst for the ﬁrst time in 1998 [198]. ESCs have pluripo-
tency and can differentiate into hepatocyte-like cells, which
possess some properties of mature hepatocytes [199–205].
Hepatocytes generated from ESCs in vitro and hepatocytes
differentiated from ESCs have been demonstrated to express
a number of hepatocyte-related genes and mimic hepatic
functions. ESC-derived hepatocytes bear the typical mor-
phology of mature hepatocyte and colonized liver tissue
upon transplantation. The cardinal pathways associated with
activin A and Wnt3a and FGF signaling are essential for
ESC to differentiate into hepatic lineage [200, 206–217].
ESC-derived hepatocyte-like cells promoted the cell recovery
of injured liver by cell replacement [201, 210, 218, 219] and
paracrine mechanism to stimulate endogenous regen-
eration. However, it still remains unclear whether ESCs-
derived hepatocytes have the origin of deﬁnitive endoderm or
primitive endoderm. The recent study using ESCs combined
with MSCs showed promising results [201, 220]. Human
ESCs are likely resistant to cryopreservation, which mature
hepatocytes can hardly endure. Studies using ESCs have
provided the molecular basis of hepatic differentiation.
Despite the promising results, the application of human ESCs
has always been precluded by practical and ethical barriers.

2.5. Induced Pluripotent Stem Cells. The iPSCs were ﬁrst
developed by Dr. Yamanaka from mouse ﬁbroblasts in 2006,
which were reprogrammed into a state of pluripotency
like that of ESCs [98]. These iPSCs have been reported to
be differentiated to neuron cells [221], neurospheres [222],
cardiomyocytes [223–225], hematopoietic and endothelial
cells [226], and insulin-secreting islet-like clusters [227].
A number of protocols to differentiate iPSCs into HLCs
have been described [60, 228–242]. Unfortunately, the iPSC-
derived HLCs showed minimal activity, reaching around 0.3
to 10% of the activity of primary hepatocytes [231].

In animal experiments, the iPSC-derived HLC trans-
plantation halted lethal fulminant hepatic failure, promoted
regeneration, and improved function [234, 235, 243–245].
Due to immunosuppression and possible unlimited supply,
the patient-corrected human iPSCs have great potential to
be utilized in personalized cell therapy [230, 246, 247].
However, several issues regarding iPSC usage should be
properly addressed prior to clinical application, including
teratoma formation and tumorigenicity, controversy about
immunogenicity, long-term safety and efﬁcacy, and optimal
reprogramming and manufacturing processes [248–250].

2.6. Other Cells. Fetal hepatic progenitor cells have been of
terest due to their ease of isolation, high proliferation rate,
superior repopulation capacity, lower immunogenicity, and
resistance to cryopreservation in contrast to adult counter-
parts [251–256]. Annex stem cells derived from umbilical
cord, placenta, and amniotic liquid have easily accessible
sources, but they can be categorized as MSCs with respective
differences according to their origin [257–261].

3. Clinical Trials Using Stem
Cell-Based Therapy

Early autologous bone marrow-derived stem cell transplan-
tation resulted in amelioration of liver injury and functional
improvements, and they probably included a mixed cell
population of HSCs, MSCs, and EPCs [53, 55, 82, 124,
262, 263]. A number of single-arm, phase I clinical studies
with small samples have been performed and have shown
some promise in patients with liver cirrhosis [31, 48, 49,
123, 264–270]. The infusion of bone marrow-derived stem
cells has sometimes been used as a supportive measure
for patients with partial hepatectomy [271–273]. Although
the precise mechanisms are still unresolved, the ﬁndings
from those studies with small sample sizes have provided
assurance that no critical complications occurred after the
procedures. Furthermore, the posttransplantation incidence
of hepatocellular carcinoma was not increased despite the
enduring concern [68, 274, 275].

A trial using human fetal liver-derived stem cells
enrolling 25 patients with cirrhosis demonstrated improved
mean model for end-stage liver disease (MELD) scores [276],
although long-term outcomes were not properly reported
[277]. There have been several clinical studies using HSCs
with promising results [278–281] since Pai et al. [37] reported
that the autologous infusion of CD34+ cells improved the
serum albumin level and the Child-Pugh score. However,
most results have shown only temporary effects and there still
remains many questions yet to be answered [280].

The most frequently studied stem cells are the MSCs;
thus, their mechanisms of actions are also better understood.
In particular, BM-MSCs have been prevalently utilized.
In two early pilot studies, autologous injections of BM-MSCs
in a few patients were reported to result in improvement of
liver function [35, 267]. The safety and short-term efﬁcacy
of BM-MSCs were evidenced in two groups of 20 patients
each, which showed signiﬁcantly improved Child-Pugh and
MELD scores [47]. Subsequent studies continued to conﬁrm
the efﬁcacy of BM-MSC transplantation in varying sizes
of samples [282–285]. Notably, one randomized controlled
trial using autologous MSCs in cirrhotic patients failed to
demonstrate beneﬁcial effects, in contrast to the prior reports
[286].

The transplanted cells were mostly infused intravenously,
except in three studies using the hepatic artery [284, 285]
and one featuring direct injection into the spleen [282]. Not a small variation existed in the numbers of infused cells and the administration frequencies. Although the overall study qualities did not surpass the level of moderate or poor, the results seemed promising in terms of MELD scores and liver function improvements [1]. Specifically, most studies did not include histologic evaluations [287].

As other kinds of MSCs, umbilical cord-derived MSCs (UC-MSCs) were evaluated in clinical trials. UC-MSC infusion was well tolerated and resulted in significant functional improvement and increased survival rates [288–289].

To summarize, stem cell trials in patients with liver cirrhosis have demonstrated generalized functional improvements. In addition, improvements were also found in the MELD and Child-Pugh scores. Unfortunately, these beneficial effects were attenuated with time or were not measured. Therefore, it can be temporarily concluded that treatment using stem cells might be slightly superior to current conventional treatment according to two systematic reviews [1, 42] (Table 1).

4. Discussion

Liver cirrhosis is a major cause of mortality and incurs great healthcare burdens across the world [291–294]. Liver transplantation is the only effective treatment. The survival rate after liver transplantation has progressively increased and the rate of survival after one year of surgery is currently 83% after one year. However, the shortage of organs is a serious problem contributing to the increasing mortality rate of patients on the waiting list [295, 296]. Allogeneic hepatocyte transplantation [297, 298] also entails limited availability with only modest benefits reported [26, 299, 300].

Efforts have been made to develop antifibrotic therapies. Unfortunately, there are no antifibrotic drugs available in a current clinical setting [301–303] even if several reports have been published from preclinical and clinical studies [304–306]. The targets of the drug are primarily associated with the activities of hepatic stellate cells: the downregulation of cell activation [307–309], neutralization of fibrogenic and proliferative cell responses [310–311], promotion of cell apoptosis [312], and promotion of matrix degradation [313, 314]. Clinical studies have, however, failed to yield meaningful results compared with preclinical studies [287, 315–319].

In this regard, stem cell-based therapy is considered a promising therapeutic alternative based on the discrepancy between the demand and supply of donor livers for transplantation. Stem cell clinical trials have resulted in promising outcomes [20, 209, 230, 246, 277, 300–325]. There are advantages and disadvantages depending on which source of stem cells is used in the cell-based therapies. For example, ethical issues and behavioral uncertainties in vivo are major problems of ESCs or iPSCs to be used clinically although they are the most capability of producing HLCs [20]. Teratoma formation and the use of immunomodulatory drugs are other concerns of stem cell uses. For all kinds of stem cell-based therapies, the progressive liver fibrosis and hepatocellular carcinoma are still the fearful medium- or long-term adverse effects. Prior to clinical use, the in vivo safety should be confirmed including toxicity and tumorigenicity. Regulatory challenges and financial burden cast somewhat different kinds of translational barrier.

Among stem cells of various origins, MSCs have attracted attention due to their advantages and have been extensively investigated in experimental studies and in clinical trials. Nevertheless, there are still a number of issues to be addressed. First, the ideal delivery route of MSCs has not been elucidated, and it is unstandardized in clinical trials to date. MSCs differentiate into myofibroblasts instead of hepatocytes depending on the injection route [326, 327]. The optimal dose and number of injections are another practical issue when comparing the results from clinical trials. In addition, sophisticated methods of tracking engrafted MSCs are still lacking. Therefore, it is impossible to predict the fate of transplanted cells, although the survival duration is important for sustained efficacy [328–330]. Recently, labeling cells with superparamagnetic iron oxide nanoparticles and reporter genes have been suggested with advanced imaging technologies [331–336]. Finally, the quality of the clinical studies reported to date is far from sufficient to reach a definite conclusion. Patient enrollment must differentiate clearly between patients with compensated cirrhosis and patients with impaired function. Only randomized controlled designs can assess the reliable clinical benefit. Long-term follow-up and histologic evidence should be recommended in cases where they are available [42, 250, 337].

With advances in novel biotechnology, strategies have been devised to enhance the effects of stem cell-based therapy. For example, the microencapsulation of MSCs in microspheres was proposed to evade unwanted differentiation into myoblasts [338]. To promote the homing of MSCs, the use of MSCs modified by liver-specific receptors has been suggested [339]. Genome editing using CRISPR/Cas9 is a very promising technology widely used in current functional genomics [18, 340, 341]. The three-dimensional culture technique is another example for providing an expansion and differentiation platform for hepatocytes [342, 343].

Rapidly developing iPSC technologies provide an unprecedented opportunity for researchers and clinicians [344]. Recent studies have shown that iPSC-derived hepatocytes can be used for the investigation of the genetic and molecular mechanisms of liver disorders [240, 242, 244, 345–356]. They can be utilized for multiple applications, including drug safety screening of new drugs [214, 357–359] and disease modeling [240, 360]. Disease-specific iPSCs could provide invaluable opportunities to elucidate the pathologic mechanism of disease and develop curative treatment options.

5. Conclusion

Liver fibrosis progresses to cirrhosis, which is the result of the extracellular matrix deposition in the parenchyma. Curative treatment for cirrhosis is currently limited to orthotopic liver transplantation, and a worldwide shortage of donor organs results in the deaths of patients waiting for organs. Stem cell-based therapy has emerged as a promising alternative with accumulating evidence from experimental and clinical
| Trial number | Study phase (type) | Cell source | # | Eligibility criteria                                                                                      | Primary outcome measure               | Secondary outcome measure                                                                 | Time frame   | Start date   | End date   | Location   |
|--------------|-------------------|-------------|---|----------------------------------------------------------------------------------------------------------|---------------------------------------|-------------------------------------------------------------------------------------------|--------------|--------------|------------|------------|
| NCT01875081 | Phase II (randomized open) | BM-MSC     | 72 | Histologically or clinically diagnosed as alcoholic liver cirrhosis Classified as Child-Pugh grade B or C | Histopathological evaluation          | Histopathological evaluation score, MELD score, Child-Pugh grade, and so on               | 6 months     | 2012.11       | 2016.03    | Korea      |
| NCT02943889 | Phase I/II (non-randomized open) | BM-MSC     | 40 | Decompensated liver cirrhosis Child class b or c                                                       | Improvement of liver function in form of improvement in Child score | Postpone or overcome liver transplantation complications                                     | 6, 24 months | 2016.10       | 2017.08 (not yet recruiting) | None       |
| NCT02786017 | Phase I/II (randomized double-blinded controlled) | UC-MSC     | 40 | Subjects who are decompensated cirrhosis of any cause Child-pugh score ≥7                              | Change in the model for end-stage liver disease (MELD) score | Change in Child-Pugh score, clinical laboratory parameters of liver function               | 1 and 3 days 1 and 2 weeks 1, 3, 6, 12, and 24 months | 2016.05       | 2018.12 (recruiting) | China      |
| NCT01591200 | Phase II (randomized open) | AlloMSC     | 40 | Child class B or C, Child-Pugh scores of ≥7 and <14 MELD scores of at least 10                         | Safety                                | Liver function improvement, Child-Pugh score, MELD score, SF36-QOL, and so on            | 24 months    | 2012.06       | 2016.04 (completed) | India      |
| NCT01120925 | Phase I/II (randomized quadruple blind controlled) | BM-MSC     | 30 | MELD score of 12 or Child score B or C Serum ALT 1/5 times more than normal                             | Liver function test                  | Cirrhosis mortality                                                                        | 6 months     | 2010.05       | 2013.07 (completed) | Iran       |
| NCT00420134 | Phase I/II (randomized single-blinded) | MSC         | 30 | MELD score of at least 10                                                                             | Liver function test                  | Cirrhosis mortality                                                                        | 6 months     | 2006.02       | 2009.06 (completed) | Iran       |
| Trial number | Study phase (type) | Cell source | # | Eligibility criteria                                                                 | Primary outcome measure | Secondary outcome measure                                                                 | Time frame | Start date  | End date   | Location |
|--------------|--------------------|-------------|---|-------------------------------------------------------------------------------------|-------------------------|------------------------------------------------------------------------------------------|------------|-------------|------------|----------|
| NCT01013194 | Phase I/II (non-   | FLC         | 25| A score ≥ 88 based on the Child-Pugh-Turcotte classification and/or MELD score ≥ 14| Survival                | Analysis of Child-Pugh score, MELD score from baseline to 1-year follow-up               | 6 and 12 months | 2007.02     | 2011.07    | Italy    |
|              | randomized open)   |             |   |                                                                                      |                         |                                           |            |             |            |          |
| NCT01342250 | Phase I/II (randomized open) | UC-MSC | 20| Decompensated liver cirrhosis, Child-Pugh B/C (7–12 points) or MELD score ≤ 21 | Survival                | Liver function improvement, Child-Pugh score, MELD score, SF36-QOL, and so on          | 24 months  | 2010.10     | 2011.10    | China    |
| NCT02652351 | Phase I (open)     | UC-MSC      | 20| Clinical, radiological, or biochemical evidence of liver cirrhosis                  | Severity of adverse events | Hepatic function, liver fibrosis index                                                  | 1, 3, 6, and 12 months | 2016.03     | 2016.10    | China    |
| NCT01147380 | Phase I (non-      | NK          | 18| Subjects who need to meet the liver transplant eligibility criteria Cardiac and pulmonary function | Side effect of cadaveric donor liver NK cell infusion | NK cell infuson-related toxicity, anti-HCC, HCV effect                                  | 12 and 24 months | 2010.06     | 2014.12    | USA      |
|              | randomized open)   |             |   |                                                                                      |                         |                                           |            |             |            |          |
| NCT03254758 | Phase I/II (open)  | AD-MSC      | 15| Chronic hepatitis C or nonalcoholic steatohepatitis (NASH) Child-Pugh grade B liver cirrhosis | Child-Pugh score, safety profile | Child-Pugh score, safety profile                                                       | 6 months  | 2017.07     | 2018.12    | Japan    |
| NCT01333228 | Phase I (open)     | BM-EPC      | 14| Liver cirrhosis (Child-Pugh 8 or above)                                             | Safety and tolerability | Effect on liver function, portal hypertension, complications of liver cirrhosis         | 12 months  | 2012.06     | 2015.03    | Spain    |
| NCT01503749 | Phase I (randomized open) | PB-MNC (G-CSF) | 9 | Advanced liver cirrhosis with Child-Pugh score 8 or 9                                | Severe adverse events    | Change in Child-Pugh score and MELD score                                               | 1–4 weeks  | 2012.01     | 2014.08    | -        |
| NCT00713934 | Phase I/II (randomized single-blinded) | BMMNC BMHSC | 7 | Liver biopsy showing histological cirrhosis, grade B or C (Child-Pugh score) Liver cirrhosis in sonography study | Liver function test MELD score | Cirrhosis mortality                                                                       | 6 months  | 2008.01     | 2009.02    | Iran     |
| Trial number | Study phase (type) | Cell source | # | Eligibility criteria | Primary outcome measure | Secondary outcome measure | Time frame | Start date | End date | Location |
|--------------|--------------------|-------------|---|----------------------|-------------------------|--------------------------|------------|------------|----------|----------|
| NCT02297867  | Phase I (open)     | ADSC        | 6 | Investigators without HBV, HCV, HIV, syphilis, and so on | MELD                    | None                     | 1–6 months | 2015.07    | 2018.01  | Taiwan   |
| NCT02705742  | Phase I/II (open)  | AD-MSC      | 5 | Clinical, radiologic, and pathologically proven liver cirrhosis due to HCV hepatitis | All cause mortality     | -                        | 12 months  | 2016.01    | 2017.12  | Turkey   |
| NCT01454336  | Phase I (open)     | BM-MSC      | 3 | Approved cirrhosis by elastography, biopsy, sonography | ALT, AST, serum albumin, liver fibrosis | Progression of fibrosis | 12 months  | 2010.06    | 2013.07  | Iran     |

*Number of enrollments; MELD, model for end-stage liver disease; UC-MSC, umbilical cord mesenchymal stem cell; AlloMSC, allogeneic MSC; FLC, fetal liver cell; BM-EPC, bone marrow-derived endothelial progenitor cells; PB-MNC, peripheral blood mononucleated cells; BMHSC, bone marrow CD133+ hematopoietic stem cell.
studies. Varieties of stem cells including MSCs, HSCs, EPCs, ESCs, and iPSCs have been investigated for their feasibility and/or clinical potentials. Among them, MSCs have been most studied and are relatively well understood. A primary mechanism of action has been proposed as paracrine effects rather than transdifferentiation. The results from clinical trials seem very promising from the perspectives of functional improvement and clinical parameters. However, long-term efficacy has not yet been proven, and standardized trial protocols are needed. Novel technologies are expected to overcome the current hurdles related to clinical application of stem cell-based therapy.

Conflicts of Interest
All authors have no conflicts of interest relevant to this article.

Authors’ Contributions
Kyeong-Ah Kwak and Hyun-Jae Cho contributed equally to this work.

Acknowledgments
This research was supported by Ministry of Food and Drug Safety of Korea (Grant 17172MFDS202).

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