



Review

Neural stem cells and their use as therapeutic tool in neurological disorders

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Abstract

Spontaneous neural tissue repair occurs in patients affected by inflammatory and degenerative disorders of the central nervous system (CNS). However, this process is not robust enough to promote a functional and stable recovery of the CNS architecture. The development of cell-based therapies aimed at promoting brain repair, through damaged cell-replacement, is therefore foreseen. Several experimental cell-based strategies aimed at replacing damaged neural cells have been developed in the last 30 years. Although successful in promoting site-specific repair in focal CNS disorders, most of these therapeutic approaches have failed to foster repair in multifocal CNS diseases where the anatomical and functional damage is widespread. Stem cell-based therapies have been recently proposed and might represent in the near future a plausible alternative strategy in these disorders. However, before envisaging any human applications of stem cell-based therapies in neurological diseases, we need to consider some preliminary and still unsolved issues: (i) the ideal stem cell source for transplantation, (ii) the most appropriate route of stem cell administration, and, last but not least, (iii) the best approach to achieve an appropriate, functional, and long-lasting integration of transplanted stem cells into the host tissue.

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1. Introduction

Neural stem cells (NSCs) are considered a heterogeneous population of mitotically active, self-renewing, multipotent, immature progenitor cells of both the developing and the adult nervous system showing complex patterns of gene expression that vary in space and time [47,72]. Early in the 1960s, neural cells behaving as stem entities were isolated from the embryonic mammalian central as well as peripheral nervous system [23,51,75,87,94]. Since then, stem cells have been isolated virtually from the entire mammalian adult central nervous system (CNS) and regions such as the subventricular zone (SVZ) of the lateral ventricles, the hippocampus and the cerebral cortex have been shown to contain stem-like cellular elements [10,40,76,77,80,82]. During development, the number of uncommitted endogenous NSCs decreases over time, while the activation of cellular programs of differentiation into lineage (neuronal or glial)-restricted precursors increases [7,71]. In the adult CNS, stem-like cells—although showing modest proliferation characteristics—are capable of driving neurogenesis in specialized regions of the brain (i.e., the olfactory bulb, the hippocampus, the SVZ, the central canal of the spinal cord) which behave as highly specialized tissue niches [5,6,26,33,66,92,107]. On the other hand, cycling progenitor cells of apparent glial lineage, dispersed throughout the whole brain parenchyma, drive adult gliogenesis [42].

Whatever the terminology accepted—stem cells, precursors or progenitors—the origin of this discrete population of undifferentiated neural cells is still being debated. So far, two principal theories have been put forward. One theory claims that the true NSCs of the adult SVZ differentiate from ependymal cells expressing the intermediate filament protein nestin [49], while the other theory—recently supported by human data—identifies NSC as slowly dividing astrocyte-like (type B) subependymal cells expressing glial fibrillary acidic protein (GFAP) and nestin [30,64,82]. These multipotent, type B, NSC—which reside within the SVZ—are believed to generate *in vivo* at least three different populations of lineage-committed transit-amplifying progenitors [type C, type D cells and white matter progenitor cells (WMPC)] of both neuronal and glial phenotype. Proliferating type C neuroblasts migrate from the SVZ to the olfactory bulb through the rostral migratory stream (RMS) of the adult brain and give rise to type A neurons. Mitotically active type D cells remain confined to the subgranular zone (SGZ) of the dentate gyrus and give rise to neuronal progenitors, whereas WMPC derived from SVZ-resident multipotent adult NSC reside within the subcortical parenchyma and give rise to astrocytes and oligodendrocytes. Neuronal and glial progenitors persist in both gray and white matter and their frequency within the adult CNS is maintained during adult life. Signals driving either gliogenesis or neurogenesis in the adult brain are redundantly expressed over time, thus contributing to either physiological stem cell asymmetrical division or finalistic lineage-restricted differentiation for tissue replacement [29,42]. However, the relationship between these pools of endogenous progenitors and the identified endogenous stem cells of the CNS still remains to be elucidated.

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2. Endogenous neural stem cells for brain repair

There is compelling evidence showing that ontogenetic processes governing NSC maintenance, fate, and specification occur in brain repair strategies during adult life. Notably, it has been recently shown that endogenous NSCs may sustain neurogenesis and gliogenesis in response to several different injuries such as those occurring during inflammatory, ischemic, or traumatic events [15,31,44,65,68,91]. These pathogenic events might trigger a cascade of cellular and molecular signals—possibly via the release of soluble mediators (e.g., cytokines, chemokines, metalloproteases, adhesion molecules, etc.)—capable of supporting neurogenesis and gliogenesis that, in turn, drive brain repair.

In chronic experimental autoimmune encephalomyelitis (EAE), the animal model for multiple sclerosis (MS), mitotically active progenitor cells, residing either in the SVZ of the brain or in the subependymal layer of central canal of the spinal cord, change their physiological destiny—which is basically that of migrating along the RMS to the olfactory bulb or to the lateral columns of the spinal cord [5,92], respectively—and migrate specifically into CNS areas of demyelination where they differentiate mostly into glial cells [15,68]. In experimental models of spinal cord injury (SCI) or ischemic stroke, neurogenesis of endogenous NSCs—residing close to the traumatized or ischemic regions and surviving to the injury—occurs within 1 week after the pathogenic event. Nestin-reactive proliferating progenitor cells have been, in fact, found at the border of the ischemic and traumatized areas while supporting post-injury neurogenesis within a zone comprised between the damaged tissue and the surrounding intact cerebral parenchyma [31,65,91].

There is accumulating evidence indicating that endogenous neurogenesis and gliogenesis may occur as part of an “intrinsic” brain self-repair process during adulthood, which supports the idea of developing therapeutic strategies for brain disorders based on the use of NSC transplantation.

3. Neural stem cell transplantation in CNS disorders

In CNS disorders characterized by neuronal or glial loss—e.g., stroke, Parkinson’s disease, MS, SCI—cell-based replacement therapies may represent a promising alternative therapeutic approach. However, there are some preliminary questions that need to be solved before envisaging any potential human application of such therapies: (i) the ideal cell source for transplantation; (ii) the route of cell administration; and (iii) the differentiation and persistence of NSC

into the targeted tissue. Last but not least, functional and long-lasting integration of transplanted cells into the host tissue has to be achieved.

3.1. The source of cells

Whatever the organ or tissue requirements, the ideal cell for replacement therapies has to be plastic in its essence. Stem cells can meet this criterion since they are intrinsically able to adapt their fate to different environmental needs. Both embryonic stem cells (ES) and adult NSC (aNSC) might represent the ideal cell source for cell replacement-based therapies in CNS disorders. Embryo-derived neural cells, although representing a promising source of NSC, have not been consistently used so far for transplantation purposes [38,90,99].

3.1.1. Embryonic stem (ES) cells

ES cells, derived from the inner cell mass of blastocyst-stage embryos, are totipotent cells able to give rise to a differentiated progeny representative of all three embryonic germ layers as well as of the extra-embryonic tissues supporting development. ES cell lines can be established from virtually all mammals [35,79]. In humans, blastocysts for the establishment of renewable human ES cell lines may be obtained from either supernumerary embryos (from *in vitro* fertilization procedures) or from embryos specifically created by research purposes (i.e., nuclear transfer, parthenogenetic activation of egg) [25,85,101,103]. ES cells can be propagated indefinitely under certain *in vitro* conditions while maintaining a normal karyotype and totipotency, as has been recently shown by culturing ES cell lines in presence of leukemia inhibitory factor (LIF) [86]. ES cells can also be induced to differentiate *in vitro* into almost all cell types of the body [74,79] including neural cells that can be obtained by growing cells in the presence of neurotrophic factors such as epidermal growth factor (EGF), platelet-derived growth factor (PDGF)- α , and fibroblast growth factor (FGF)-2 [11,36,37,50,54,75,112]. However, while totipotent ES cells have been used for transplants [57,78], there are no consistent data on the use of ES-derived lineage restricted neural cells.

When ES cells were transplanted into rodents with either genetically-determined or chemically-induced demyelination (both within the brain and the spinal cord), they differentiated into glial cells and remyelinated demyelinated axons [17,54]. However, most of the recent experimental transplantation studies involving ES cells have been complicated by the formation of heterologous tissues and teratomas within the transplantation site [16,27,104,109] suggesting that in certain circumstances cross-talk between transplanted ES cells and parenchymal cells at the site of transplantation has gone awry. To partially overcome such limitation, protocols have been developed to generate *in vitro* high numbers of cell type-specific neural precursors (e.g., oligodendroglial lineage cells, dopaminergic neurons)

from ES cells [63,75,88,112]. A protein called stromal cell-derived inducing activity (SDIA) which promotes neural differentiation of mouse ES cells into dopaminergic neurons *in vivo*, has been recently identified [63]. When SDIA-induced dopaminergic neurons were transplanted into the 6-hydroxydopamine (6-OHDA)-lesioned mouse striatum, they integrated into the host tissue and remained positive for tyrosine hydroxylase (TH) expression [63]. Moreover, dopaminergic neurons have been obtained by generating stable nuclear receptor related (Nurr)1 ES cell lines. Nurr1 is a transcription factor that has been shown to have a role in the differentiation of midbrain precursors into dopamine neurons [111] and its overexpression in mouse ES cells promotes an increase in the proportion of TH⁺ neurons from 5 to 50% *in vitro*. Once transplanted into the striatum of (6-OHDA)-lesioned hemiparkinsonian rats, Nurr1-overexpressing cells integrated into the tissue of transplantation and showed immunoreactivity for TH. They displayed electrophysiological characteristics similar to those of mesencephalic neurons and mediated a significant amelioration of amphetamine-induced behavioral tests as compared to (6-OHDA)-lesioned hemiparkinsonian rats transplanted with naive ES cells [52].

3.1.2. Adult neural stem cells (aNSC)

Mammalian aNSC support neurogenesis and gliogenesis within restricted areas of the CNS throughout adulthood. They can undergo extensive *in vitro* expansion upon epigenetic stimulation and possess the capacity to generate a progeny of neural cells which can integrate into and repair the tissue of origin [40,44,45,98]. These cells can be isolated from fetal and adult human brains and can be expanded and maintained safely in a chemically defined medium for years possibly providing a renewable source of uncommitted NSCs, that can be used for transplantation procedures [81,100]. These cells show: (i) growth factor (GF)-dependent proliferation and a stable growth rate; (ii) transcriptionally-regulated capacity for self-renewal; (iii) multipotentiality; and (iv) functional plasticity either over serial *in vitro* passaging or after several freeze–thaw cycles [40,43,62]. aNSC plasticity and functional flexibility can be modulated *in vitro* by the exposure to different growth factors [98]. LIF, brain-derived neurotrophic factor (BDNF), ciliary neurotrophic factor (CNTF), neurotrophin (NT)-3, NT-4, sonic hedgehog (Shh), and fibroblast-derived growth factor (FGF)-8 drive aNSCs through a neuronal fate (up to 40–60% of cells in culture), whereas bone morphogenetic proteins (BMPs), CNTF, and LIF increase the number of aNSC-derived astrocytes [20,39,53].

In vivo experiments aimed at repairing injured CNS by transplanting multipotent aNSC have shown that these cells may survive to transplantation procedures within the host CNS. They display notable migratory properties from the site of grafting and maintain their multipotency. While aNSC, transplanted either intraparenchymally or intrathecally in healthy rodents show precise pathways of tissue

invasion and neuronal (i.e., dopaminergic) differentiation [32,34,110], there are data showing that these differentiation patterns change when aNSC are transplanted into rodents suffering from experimental CNS diseases. In experimental autoimmune, chemical, or traumatic CNS demyelination, aNSCs transplanted intraparenchymally, intracerebroventricularly (i.c.), or intravenously (i.v.) show ability to migrate selectively to CNS areas of tissue damage and to differentiate into axon-ensheathing oligodendrocytes that promote functional recovery [2,12,18,69,108]. Similarly, site-specific dopaminergic neuronal differentiation has been obtained by intrastriatal transplantation of undifferentiated syngenic or xenogenic (human) aNSC in rats affected by experimental parkinsonism [56,89,110]. More recently, i.v.-injected human aNSC have been efficacious in promoting functional recovery in rats affected by both experimental intracerebral hemorrhage or transient cerebral ischemia via terminal differentiation into neurons (10%) and astrocytes (75%) [24,48]. Notably, aNSC transplants into both healthy and diseased rodents did not result in tumor formation in immunodeficient mice, thus strongly suggesting that the tumorigenic potential of these cells in vivo is minimal [99].

3.2. The route of cell administration

The route of cell administration represents another key issue when considering therapeutic NSC transplantation for CNS diseases.

On one hand, the anatomy of focal CNS disorders, such as Parkinson's disease or SCI, would suggest that direct intralesional cell transplantation might facilitate regeneration of dopaminergic neurons within the substantia nigra or protection of demyelinated axons within a specific segment of the spinal cord, respectively. ES-cell-derived TH⁺ neuronal precursors, when focally transplanted into the striatum of 6-OHDA-lesioned rats release dopamine, extend axons, form functional synaptic connections and modulate spontaneous and pharmacologically induced behavior [13,52]. After SCI and experimental ischemia in rodents, intralesionally-transplanted aNSC integrate within the host tissue, differentiate preferentially into glial cells, release neurotrophic growth factors [e.g., BDNF, glial-derived neurotrophic factor (GDNF), nerve growth factor (NGF)], promote neurogenesis, and inhibit reactive astrogliosis thus favoring motor recovery [9,21,55,95]. Furthermore, when either neural-differentiated or fibroblast feeder-grown ES cells are engrafted into acutely injured or chemically-demyelinated spinal cords of rats, transplanted cells survive, integrate, migrate (as far as 8 mm away from the lesion edge), and finally differentiate into multiple neural cell types (i.e., astrocytes, oligodendrocytes, and neurons) [54,58,76]. However, heterotopic migration or dispersion of transplanted cells has to be viewed as a potential risk of aNSC transplants that could lower the therapeutic efficacy of aNSC-based therapies.

On the other hand, the multifocality of certain CNS disorders, such as amyotrophic lateral sclerosis, MS, or Alzheimer's disease, severely limits aNSC-based therapies. However, some recent experiments have shown that in multifocal inflammatory brain disorders, these limitations can be overcome by injecting therapeutic somatic stem cells (e.g., bone marrow cells, mesenchymal cells, NSC) into the blood stream (i.v.) or into the cerebrospinal fluid circulation (i.c.). aNSC transplanted in this fashion can reach multiple inflamed areas in the brain and the spinal cord. This specific homing can be explained, at least in part, by the constitutive expression by aNSC of a wide array of inflammatory molecules such as adhesion molecules (i.e., integrins, selectins, immunoglobulins, etc.), chemokines, cytokines, and chemokine receptors [69,96]. These molecules, which mobilize precursors along patterned migration and differentiation pathways during development [70,84,96], may promote selective CNS homing because they support aNSC interactions with integrin receptor-expressing activated endothelial and ependymal cells surrounding inflamed brain tissues [19,28,70]. Thus, aNSC are very likely to follow a gradient of chemoattraction at the site of inflammatory brain lesions [73,97]. This "chemoattractive" hypothesis is strongly supported by a recent study showing that i.v.-administered mouse aNSC promote anatomical and functional recovery of the myelin sheath—in an experimental model of autoimmune demyelination (namely, EAE)—by selectively homing into inflamed brain and spinal cord areas via membrane expression of CD44 and very late antigen (VLA)-4 [69]. Since these two latter molecules are crucial for the specific homing of encephalitogenic lymphocytes into the CNS parenchyma during EAE, one might suggest that aNSC recapitulate encephalitogenic lymphocyte homing pathways for reaching areas of inflammation. As a further confirmation of this phenomenon, it has been recently shown that aNSC are capable to target both intracranial and extracranial tumors, when administered into the peripheral vasculature [1,14]. The well-characterized clonal NSC line C17.2 was injected into the tail vein of adult nude mice with established experimental intracranial and/or subcutaneous flank tumors of neural and non-neural origin and the cells were subsequently found in various tumor sites with very little accumulation in normal tissues [14].

3.3. Differentiation and persistence of neural stem cells in the targeted tissue

Ideally, once in the target organ, therapeutic NSCs should differentiate into the appropriate daughter cells and persist as long as needed at the site of engraftment. However, although very little is known about the mechanisms instructing the terminal differentiation of NSC in vivo, there is strong evidence that the local environment might dictate the fate choice of transplanted uncommitted NSC. In this respect, undifferentiated multipotent aNSC or even totipotent ES cells, transplanted in different experimental

neurological conditions, have shown considerable capacity to restrict their fate to tissue-specific cues and replace non-functioning neural cells of different lineages.

Totipotent ES cells display a preferential terminal differentiation into either myelinating oligodendrocytes or TH⁺ neurons when transplanted into rodents affected by experimental acute SCI or 6-OHDA-induced Parkinsonism, respectively [13,16,50,52,54,57]. Even more efficiently, multipotent growth factor-responsive aNSCs show neuronal- or glial-restricted fate when transplanted in animal models of neuronal (e.g., Parkinson's disease, stroke) or myelin dysfunction (e.g., EAE, SCI) [21,24,32,48,55,95,108,110], respectively. Thus, the local environment may dictate the fate choice of transplanted NSC. However, transplanted NSC might exert their therapeutic effect not only by differentiating into lineage-restricted daughter cells and by functionally integrating into the host tissue. Whatever the characteristics of the model of transplantation, it has been recently shown aNSCs may also remain in an undifferentiated state *in vivo*. Discrete numbers of transplanted aNSCs fail to express differentiation antigens, retain a rounded morphology, as well as perivascular localization, but continue to release neurotrophic growth factors (FGF-2, BDNF, GDNF, etc.) [9,55,67,95]. This evidence suggests that aNSCs might repair brain damage even when they remain in their undifferentiated state, essentially acting as bystander regulators of neuron and/or oligodendrocyte rescue via the release of neurotrophic molecules.

4. Bone marrow stem cell therapies for brain repair

Bone marrow stem cells (BMSCs) have recently been shown to have the capacity to differentiate into other specific cell lineages (e.g., muscle, skin, liver, lung), including neural cells, when transplanted in both rodents and humans [59,60,106]. Although it is not yet clear which fraction of BMSCs is more prone to differentiate into cell types of a different embryonic origin *in vivo* (e.g., haematopoietic vs. mesenchymal cells), transdifferentiation of BMSCs into neural cells deserves special attention due to the potential importance of this biological event in cell-based regenerative therapies for brain disorders.

The first and most challenging example of a possible contribution of BMSCs to the cytoarchitecture of the brain comes from a recent report showing Y-chromosomes in cerebellar Purkinje neurons of women who had received bone marrow transplants from male donors [106]. Along with this evidence of BMSC plasticity, there are other reports that collectively suggest that these cells could contribute to generate new neurons in the adult brain by means of (i) transdifferentiation (direct conversion of transplanted cells into neurons) [59,60,105,106]; (ii) transdetermination (direct conversion of transplanted stem cells into a stem cell of a different embryonic origin) [105]; and/

or (iii) cell fusion (assimilation of transplanted cells or their progeny into existing neurons and formation of heterokaryons) [8].

The demonstration that BMSCs are developmentally plastic has encouraged many attempts to use BMSCs for brain repair. BMSCs have recently been injected into animals affected by experimental demyelination, ischemic stroke, amyotrophic lateral sclerosis (ALS), and SCI [3,4,41,46,83,113]. In rats with focal chemical demyelination of the spinal cord, collagen type I⁺/fibronectin⁺/CD44⁺ mouse BMSCs gave rise to new myelin forming cells *in vivo* and determined improvement of axonal conduction velocity, when transplanted *i.v.* or by direct microinjection into the demyelinated spinal cord of immunosuppressed rats [3,4,46]. When injected into adult mice in which focal cerebral ischemia had been induced, transplanted Tie2-lacZ-positive BMSCs—immunoreactive for von Willebrand factor endothelial antigenic marker—were found in areas of neovascularization at the border of the infarct [113]. Human umbilical cord blood cells and hematopoietic stem cells—directly transplanted into the spinal cord of rodent models of SCI—survived within the host tissue, expressed specific markers for astrocytes, oligodendrocytes, and neural precursors and promoted functional recovery [3,4,83]. Human umbilical cord blood cells delivered *i.v.* into mice with experimental ALS survived 10–12 weeks after infusion, delayed disease progression and increased lifespan of diseased mice. They entered regions of motor neuron degeneration—both in the brain and in the spinal cord—and expressed neural and astrocytic markers [41].

Although the abovementioned studies demonstrate that BMSCs differentiating into brain cells might support functional CNS repair, the real “brain repair” potential of this cell source has been recently challenged by the demonstration that transdifferentiation *in vivo* of BMSCs into mature, and properly functioning, neural cells is a very rare event (e.g., 1 out of 500,000 cells) and may depend on cell fusion rather than on “real” transdifferentiation [22,61,102].

5. Conclusions

The identification and isolation of a discrete population of uncommitted self-renewing NSCs both in embryos and in specialized areas of the adult mammalian CNS—along with the demonstration of their therapeutic potential in several experimental models of human CNS diseases (e.g., SCI, Parkinson's disease, EAE, stroke, brain tumors)—has represented a milestone in the field of regenerative medicine [77,87,93,94]. However, this is still a baby science suffering from growing pain, and before envisaging any therapeutic application of such cells in humans with brain disorders, we need to confront with several, and still unsolved, problems: (i) the ideal “stem” cell source for transplantation; (ii) the most appropriate *in vivo* and/or *in vitro* manipulations to obtain the appropriate cells to transplant; (iii) a clinically

applicable transplantation strategy (e.g., route of cell transplantation in focal and multifocal CNS disorders); (iii) the right timing for cell transplantation; and, finally, (iv) the appropriate number of cells to transplant.

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