Endothelial Progenitor Cells and Vascular Health in Dialysis Patients

To the Editor: Patients with end-stage kidney disease (ESKD) are at increased risk for cardiovascular disease (CVD) compared to the general population, because of a number of factors including endothelial dysfunction. Endothelial cells (ECs) arise from progenitors that reside in both the bone marrow and vascular niches, including that of the kidney, and are classified according to specific morphological and functional differences. Endothelial progenitor cells (EPCs) can form “blood-like” islands, which can be measured in a colony-forming unit (CFU) assay in vitro, and late outgrowth ECs (OECs) can home to sites of ischemic injury and contribute to neovascularization. EPCs identified in peripheral blood can be used as indicators of risk of CVD in dialysis patients and play a role in vascular repair by releasing pro-angiogenic growth factors; yet the effect of clinical parameters on OEC appearance in culture has been lacking. OECs have angiogenic properties and as such have been investigated as a source for cell therapy; however, their success has been limited because of their early senescence in culture. In this study, we investigate the effect of patient clinical parameters on OEC appearance as a means of furthering the understanding of OECs as a source of cell therapy for vascular injury.

PATIENTS, MATERIALS, AND METHODS
ESKD patients, treated with hemodialysis were recruited (n = 20) from Monash Medical Centre and participated in this study under informed consent. Patients were excluded from the study if their original diagnosis of ESKD was type I or II diabetes, were on antibiotics, or had a recent infection or inflammatory flare-up. Parameters such as patient age, time of dialysis, erythropoietin (EPO) and statin use, and smoking status were collected, as these are known to influence the percentage of circulating EPCs, in addition to height, weight, and blood pressure. All human studies were approved by the Monash Health Human Research Ethics Committee (CF16/402-2016000182). A 10-ml quantity of blood was collected prior to a single hemodialysis session, and the peripheral blood mononuclear cell (PBMC) fraction was isolated, seeded onto fibronectin (2 µg/cm²)—coated, 6-well plates and cultured in Endothelial Growth Media (EGM)—2 Microvascular Bullet Kit medium (Lonza, Mount Waverly, Australia) containing 5% fetal bovine serum, 0.04% hydrocortisone, 0.4% human fibroblast growth factor, and 0.1% of vascular endothelial growth factor (VEGF), R3—insulin-like growth factor—1, human epidermal growth factor, gentamicin, and amphotericin-B (catalog no. CC-3202, Lonza). Medium was changed after 72 hours and every second day thereafter. At 7 days after PBMC seeding, a CFU assay was performed. Cell culture continued for a total of 21 days or until OECs appeared, as identified by their extensive proliferation and cobblestone morphology. A small volume of whole blood (100 µl) was analyzed by flow cytometry for markers of EPCs, as identified by a subpopulation of CD31+/CD34+/KDR+/CD45− cells.

RESULTS
Clinical Data
The patient cohort had a mean age of 64.2 (± 15.5) years; 80% were male and 20% female. The mean blood pressure of patients prior to dialysis was 139.1 (± 27.1)/75.2 (± 18.9), and the mean time on hemodialysis was 46 months (± 69.5). Half of the patients received EPO, 30% were administered statins, 15% were taking other medication including anticoagulants or blood thinners, and 65% had a history of smoking or were current smokers (Table 1).

Circulating EPC Number Negatively Correlates With Systolic Blood Pressure and Does Not Affect CFU or OEC Transformation
The percentage of EPCs was identified using flow cytometry. EPCs were classified according to positive expression of both CD31 and CD34, in addition to positive or negative expression of vascular endothelial growth factor receptor. EPCs also had dim expression of CD45 (Figure 1a). The percentage of circulating EPCs in patients with ESKD ranged from 0.15% to 3.8% (Figure 1b). Because of the impact that circulating EPC percentage has on the health of hemodialysis patients, we investigated whether any clinical parameters had an effect on patient EPC levels in our cohort. Although patient age and time on dialysis have previously correlated with a decreased circulating EPC percentage, we did not find that these parameters influenced circulating EPC percentage in this cohort (Figure 2a and b). However, patients receiving EPO had a significantly lower percentage of circulating EPCs compared to
patients who were not administered EPO (mean difference $1.487 \pm 0.538$, 95% confidence interval [CI] $= 0.3–2.7$, $P = 0.0184$; Figure 2c), and systolic blood pressure negatively correlated with EPC percentage, whereby, as systolic pressure increased, the percentage of EPCs decreased ($r = -0.59$, $P = 0.033$; Figure 2d). There were no correlations observed between the starting EPC percentage and the number of CFUs formed ($P = 0.27$; Figure 2d), nor was the circulating EPC percentage a factor in determining whether patient cells successfully formed OEC colonies ($P = 0.19$; Figure 2e).

**The Best Predictor of OEC Appearance in Culture Is Blood Pressure**

We observed a 45% conversion of EPCs to OECs, which were identified according to their cobblestone morphology and high proliferation rate. OECs appeared

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**Table 1.** Clinical characteristics of all patients recruited to this study

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>All subjects</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>20</td>
</tr>
<tr>
<td>Male</td>
<td>16 (80%)</td>
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<tr>
<td>Female</td>
<td>4 (20%)</td>
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<tr>
<td>Age, yr</td>
<td>$64 \pm 15$</td>
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<tr>
<td>Height, cm</td>
<td>$172 \pm 9$</td>
</tr>
<tr>
<td>Weight, kg</td>
<td>$78 \pm 18$</td>
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<tr>
<td>Systolic BP, mm Hg</td>
<td>$139 \pm 27$</td>
</tr>
<tr>
<td>Diastolic BP, mm Hg</td>
<td>$75 \pm 19$</td>
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<tr>
<td>EPO use</td>
<td>10 (50%)</td>
</tr>
<tr>
<td>Statin use</td>
<td>6 (30%)</td>
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<tr>
<td>Other drugs</td>
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<tr>
<td>Smoking status</td>
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<tr>
<td>Never smoked</td>
<td>7 (35%)</td>
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<tr>
<td>Previous smoker</td>
<td>11 (45%)</td>
</tr>
<tr>
<td>Current smoker</td>
<td>2 (10%)</td>
</tr>
</tbody>
</table>

ACEI, angiotensin-converting enzyme inhibitor; BP, blood pressure; EPO, erythropoietin. Data are mean $\pm$ SD, or number with percentage in parentheses.

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**Figure 1.** Frequency analysis of endothelial progenitor cells (EPCs) from patients with end-stage kidney disease (ESKD). (a) Flow-cytometric protocol used to determine the percentage of circulating EPCs from whole blood. All cells were visualized on a forward versus side scatter plot and assessed for viability by gating on DAPI-negative cells. Viable vascular endothelial growth factor receptor-2 (VEGFR2$^{+/+}$) cells subgated with CD34$^+$ cells. Of these, the CD45$^{{\text{dim}}}$ population was subgated, and CD31$^+$ expression on the resulting cells was confirmed on a CD31 histogram. This flow-cytometric protocol was used and established by Yoder et al. Analysis was conducted using FlowJo software, and isotypes were used to for compensation. (b) Percentage of circulating EPCs for all patients in whole blood. The range of EPCs is spread from 3.8% down to 0.15% of whole blood in these patients ($n = 13$) with ESKD. Data are mean $\pm$ SD. APC, allophycocyanin fluorescent protein; FSC-A, forward scatter area; FSC-H, forward scatter height; PE, phycoerythrin fluorescent protein.
as early as 7 days and as late as 17 days in culture (Figure 3a). The number of CFUs counted at 7 days did not affect the appearance of OECs ($P = 0.24$; Figure 3b), nor did patient age, time on dialysis, or any other clinical parameter collected except for blood pressure (Figure 3c). Patient cells that transformed into OECs had significantly lower systolic (mean difference 24.95 mm Hg, 95% CI = 1.7–48.1, $P = 0.0365$) and diastolic (mean difference 18.9 mm Hg, 95% CI = 3.2–34.6, $P = 0.0208$) blood pressures compared to patient cells that did not (Figure 3c).

**DISCUSSION**

The primary aim of this study was to investigate whether patient clinical parameters affected circulating EPC percentage and the ability of isolated PBMCs to differentiate into angiogenic OECs. Interestingly, we found that patients administered EPO
Figure 3. Observations of a late-outgrowth endothelial cell (OEC) colony correlate with low blood pressure. (a) OECs were identified by their cobblestone morphology and proliferative potential and converted in 9 of 20 patients from 7 to 17 days in culture. (b) Investigations between an observed proliferative colony and colony-forming units (CFUs) at 7 days and (c) clinical parameters were investigated for (continued)
had a significantly lower percentage of circulating EPCs than patients who were not, and that high blood pressure was negatively correlated with EPC percentage. The overall number and function of EPCs was reduced in patients with ESKD compared to healthy controls, which was suggested to be related to exposure to uremic toxins. In addition, it has been reported that patients with hypertension have reduced EPC numbers and limited vascular regenerative potential when isolated EPCs are challenged in vitro, which has also been found in patients who are obese or diabetic. However, the use of angiotensin-converting enzyme inhibitors has previously been shown to reduce oxidative stress, increase EPC number and function, and reduce vascular damage in hypertensive patients. There is evidence to suggest that dialysis modality can affect circulating EPC numbers, with hemodialysis significantly reducing EPCs compared to continuous peritoneal dialysis. Furthermore, patients who have controlled blood pressure on hemodialysis have a reduced risk of cardiovascular events. Our findings further suggest that high blood pressure reduces EPC numbers, and therefore may contribute to negative vascular health outcomes in the hemodialysis population, although this needs to be tested further in the clinical setting.

OECs are being investigated as a source for cell therapy with limited success due to senescence of cells in culture. Here, we observed a 45% conversion rate of EPCs to OECs after an average of 12 days of PBMC culture. The success of conversion is thought to be associated with the starting volume of blood, and because EPCs are rare in the circulation, it has been suggested that large volumes of blood are required to obtain proliferative OEC colonies. Unlike previous studies, in our study we did not observe a correlation between starting EPC numbers and CFU after 7 days of culture. However, we showed that OEC colony transformation did occur if the blood pressure of the patient was lower before dialysis. A controlled blood pressure is linked with reduced cardiovascular events and a decrease in all-cause mortality in patients with stages 1 to 5 CKD, and evidence suggests that controlling blood pressure, and therefore pulse pressure, in the dialysis population has similar outcomes.

Figure 3 (continued) correlations (n = 20). Blood pressure was significantly lower in patients whose cells went on to form OECs (systolic blood pressure, $P < 0.0365$; diastolic blood pressure, $P < 0.0208$). Data are mean ± SD and were analyzed using the Student t-test. Bar = a: 500 μm; b: 50 μm. **$P < 0.01$, *$P < 0.05$.  

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DISCLOSURE

All the authors declared no competing interests.

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REFERENCES


Acute Kidney Injury Ascertainment Is Affected by the Use of First Inpatient Versus Outpatient Baseline Serum Creatinine

To the Editor: An important methodological issue concerning acute kidney injury (AKI) definitions is the choice of “baseline” serum creatinine (SCr). The most recent consensus definition proposes a rolling 48-hour window for AKI ascertainment during hospitalization, or the use of a baseline value that is “known or presumed to have occurred in the past 7 days.” However, significant misclassification in assigning AKI status can occur when admission or nadir inpatient SCr (as has been done in a number of studies) is used rather than a preadmission outpatient baseline. A well-recognized concern with the use of admission SCr to define baseline kidney function is that it will be higher than a patient’s true baseline if community-acquired AKI is present, and therefore community-acquired AKI will be missed if the admission SCr is used to define baseline. However, animal and human studies have recently shown that creatinine generation can also quickly fall with acute illness, so falsely low readings may result. It is unknown whether changes in creatinine generation affect AKI ascertainment. Therefore, to quantitate variation in first inpatient SCr level and the impact on AKI ascertainment (Figure 1a), we compared preadmission baseline and first inpatient SCr in a large, population-based, hospitalized cohort. We also identified predictors of lower first inpatient SCr.

We identified all hospitalized adults without end-stage renal disease at 21 Kaiser Permanente Northern California hospitals between 2006 and 2011 (Supplementary Figure S1); only the first eligible hospitalization per subject was included. Kaiser Permanente Northern California is a large integrated health care delivery system caring for > 4.1 million persons in the San Francisco Bay Area that is highly representative of the statewide population. The study was approved by the institutional review boards of the Kaiser Foundation Research Institute and the University of California, San Francisco.

Baseline SCr was the most recent outpatient SCr from a maximum of 365 days and a minimum of 7 days pre-admission. We selected this as the gold standard because this definition has been used in prior studies examining the impact of baseline SCr on AKI ascertainment, including the prospective Assessment, Serial Evaluation, and Subsequent Sequelae of Acute Kidney Injury (ASSESS-AKI) study. A peak inpatient SCr $\geq 50\%$ relative, $\geq 0.3$ mg/dl absolute increase from the outpatient baseline, or need for acute dialysis defined AKI for this analysis. Covariates included demographics, comorbidities, severity of illness, preadmission estimated glomerular filtration rate (eGFR), and proteinuria. Comorbidities (diabetes, hypertension, cancer, coronary disease, chronic heart failure, prior ischemic stroke) were asccertained for up to 5 years before hospitalization using previously validated methods based on inpatient and ambulatory diagnoses and procedures, laboratory results, and pharmacy databases (codes available upon request). We identified coronary revascularization, sepsis, and acute heart failure occurring during the index hospitalization using relevant diagnosis and procedure codes. To further describe acute severity of illness, we determined whether patients were admitted to the intensive care unit during their stay and calculated the Laboratory-based Acute Physiology Score (LAPS) and COmorbidity Point Score (COPS), along with a validated predicted mortality score based on automated inpatient, outpatient and laboratory data.

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