IGF2: an endocrine hormone to improve islet transplant survival

Amy Hughes1,2, Darling Rojas-Canales2,5, Chris Drogemuller2,3,4,5, Nicolas H Voelcker5,6, Shane T Grey7,* and P T H Coates2,3,4,5,8,*,†

1Department of Physiology and Biophysics, University of Illinois at Chicago, Chicago, Illinois 60612, USA
2The Centre for Clinical and Experimental Transplantation (CCET) and The Royal Adelaide Hospital, Adelaide, South Australia 5000, Australia
3School of Medicine, University of Adelaide, Adelaide, South Australia 5000, Australia
4School of Medicine, University of Adelaide, Adelaide, South Australia 5000, Australia
5Cooperative Research Centre for Cell Therapy Manufacturing (CRC-CTM), Mawson Lakes, South Australia 5095, Australia
6Mawson Institute, University of South Australia, Mawson Lakes, South Australia 5095, Australia
7Gene Therapy and Autoimmunity Group, Immunology Program, Garvan Institute of Medical Research, Darlinghurst, New South Wales 2010, Australia
8Centre for Stem Cell Research, University of Adelaide, Adelaide, South Australia 5000, Australia

*(S T Grey and P T H Coates contributed equally to this work)
†P T H Coates is now at Department of Nephrology and Transplantation Services, The Royal Adelaide Hospital, Frome Road, Adelaide, South Australia 5000, Australia

Abstract

In the week following pancreatic islet transplantation, up to 50% of transplanted islets are lost due to apoptotic cell death triggered by hypoxic and pro-inflammatory cytokine-mediated cell stress. Thus, therapeutic approaches designed to protect islet cells from apoptosis could significantly improve islet transplant success. IGF2 is an anti-apoptotic endocrine protein that inhibits apoptotic cell death through the mitochondrial (intrinsic pathway) or via antagonising activation of pro-inflammatory cytokine signalling (extrinsic pathway), in doing so IGF2 has emerged as a promising therapeutic molecule to improve islet survival in the immediate post-transplant period. The development of novel biomaterials coated with IGF2 is a promising strategy to achieve this. This review examines the mechanisms mediating islet cell apoptosis in the peri- and post-transplant period and aims to identify the utility of IGF2 to promote islet survival and enhance long-term insulin independence rates within the setting of clinical islet transplantation.

Key Words

- insulin-like growth factor
- apoptosis
- islets
- cell survival
- islet transplantation

Introduction

Islet transplantation is an emerging therapy for highly selected patients with type 1 diabetes mellitus (T1D) and is now a funded treatment in the United Kingdom, France, Switzerland and recently in Australia (McCall & Shapiro 2012, O’Connell et al. 2013). Islet allotransplantation into a recipient with T1D exposes the transplanted islets to a number of apoptotic stresses, including the instant blood-mediated inflammatory reaction (IBMIR), hypoxia, inflammation, hyperglycemia, enzymatic and mechanical injury and immune-mediated rejection that contribute to islet allograft failure in the early post-transplant period (Robertson 2004, Tjernberg et al. 2008, Walters et al. 2013). Thus, inhibition of islet apoptosis is an attractive and potentially effective therapeutic strategy to prevent the loss of functional islet mass post transplantation and improve clinical islet transplant outcomes.
The insulin-like growth factor (IGF) family consists of two IGF peptides (IGF1 and IGF2), the actions of which are regulated by six binding proteins (IGFBP1–6). IGF2 is more highly expressed than IGF1 during development in rodents, ruminants and humans (Delhanty & Han 1993, Hill & Pell 1998), suggesting that it may be the more important IGF during development (Sang et al. 2008). Recently, Hills et al. (2012) have described IGF2 as a more effective anti-apoptotic survival factor compared with IGF1 in human placental villous cytotrophoblasts. While others (Giannoukakis et al. 2000) have shown that adenoviral-mediated IGF1 overexpression was unable to protect isolated human islets from pro-inflammatory cytokine-induced apoptosis in vitro. In comparison, IGF2 exerts a robust anti-apoptotic effect on many cell and tissue types including neurons, ovarian pre-ovulatory cells and pancreatic islets (Jung et al. 1996, Stewart & Rotwein 1996, Petrik et al. 1998). Jourdan et al. (2011) have shown the usefulness of IGF2 as an islet survival factor in a rodent model of islet engraftment, and transgenic overexpression of IGF2 protects against pro-inflammatory cytokine-induced apoptosis in vivo and improves islet transplant outcomes in vivo (Hughes et al. 2013), a process mediated via the interaction of IGF2 with the IGF1 receptor (IGF1R) on the islet cell surface. For these reasons, we believe that IGF2 represents the more promising endocrine growth factor to improve islet transplant survival. This review provides an overview of the current mechanisms of islet cell apoptosis in the peri- and post-transplant period. In addition, this review focuses on the actions of IGF2 within native, isolated and transplanted islets and discusses the therapeutic potential of IGF2 to promote islet cell survival and function post transplantation.

**Apoptosis in islet transplantation**

Apoptosis, also called programmed cell death, refers to a set of events within multicellular organisms, which lead to the breakdown of chromosomal DNA and the cessation of metabolic activity (Sia & Hanninen 2006). The key enzymes mediating the progression of apoptosis within a cell are the cysteine aspartate protease family of enzymes called caspases. Caspases reside within a cell as inactive procaspases (zymogens) until they are activated in response to pro-apoptotic stimuli. Once activated, caspases proceed to activate other caspases in a hierarchical manner, leading to the amplification of the apoptotic signalling cascade and cell death. Immediately following transplantation, islets experience the IBMIR that involves activation of coagulation pathways and complement and infiltration of pro-inflammatory cytokines, such as interleukin-1β (IL1β) and interferon-γ (IFNγ) (Moberg et al. 2002, Johansson et al. 2005). Allogenic rejection of islet grafts involves the activation of the adaptive immune system, in addition perforin and granzyme are primary mediators of islet cell death following transplantation (Sutton et al. 2006). This topic area has been extensively reviewed in the context of islet transplantation (Emamaullee & Shapiro 2006) and more broadly by references (Elmore 2007, Taylor et al. 2008).

**Apoptosis in islet transplantation: the role for pro-inflammatory cytokines**

In the early post-transplant period, multiple mechanisms are at play that negatively impact β-cell function and lead to islet cell apoptosis. Of these mechanisms, pro-inflammatory cytokines such as IL1β, IL6, IFNγ, tumour necrosis factor-α (TNF-α) and cyclooxygenase-2 mount a fierce inflammatory attack against the newly transplanted islet graft, triggering islet cell death (Cowley et al. 2012). The extent of cytokine release by islets in the early post-transplant period is directly related to islet transplant outcome in the recipient (Schroppel et al. 2005).

Experimentally, the release of pro-inflammatory cytokines by resident islet macrophages has been observed in rats following islet transplantation in vivo (Bottino et al. 1998, Montolio et al. 2007a,b). Exposure of rat islets to IL1β in vitro decreases islet insulin content, suppresses glucose-stimulated insulin secretion, induces DNA damage and leads to islet destruction (Bendtzen et al. 1986, Comens et al. 1987, Sandler et al. 1987, Wachlin et al. 2003). Recently, Yeung et al. (2012) have described morphological alterations in human islets following pro-inflammatory cytokine exposure in vitro and these changes are consistent with the cells undergoing apoptosis (i.e. cell shrinkage and chromosomal condensation). Mechanistically, pro-inflammatory cytokines mediate their inflammatory effects largely under the control of the nuclear factor κB (NFκB) and MAPK cell signalling pathways (Fig. 1), activation of which renders islets nonfunctional following the formation of cytotoxic nitric oxide (NO).

**The role of IGF2 in the native, isolated and transplanted islet**

IGF2 is highly expressed in the islet cells during embryonic development, coincidently; during this period, there is also substantial growth and structuring of the endocrine
growth-promoting effects (Han et al. 1988, Hogg et al. 1993, Miettinen et al. 1993). IGF2 has been shown to promote pancreatic β-cell survival against apoptotic stimuli in vitro and in vivo (Rabinovitch et al. 1982, Swenne et al. 1987, Hogg et al. 1993, Ilieva et al. 1999, Robitaille et al. 2003, Jourdan et al. 2011) and induce proliferation in a growth-arrested mouse β-cell line (Milo-Landesman & Efrat 2002). IGF2 protects pre-diabetic NOD mouse islets from the cytotoxic actions of IL1β by the mechanisms that include a reduction in apoptosis (Hill et al. 1999b). Similarly, adenoviral-mediated overexpression of IGF2 in isolated rat islets conferred significant protection against IL1β-induced apoptosis (Estil les et al. 2009) and increased β-cell replication and β-cell mass regeneration in transplanted islets, effectively reducing the β-cell mass required to achieve normoglycemia in diabetic rats (Estil les et al. 2012). Recently, data from our laboratory has shown the ability of adenoviral-mediated IGF2 overexpression to protect islets from pro-inflammatory cytokine-induced apoptosis in vitro and improve transplant outcomes in a minimal mass islet transplant model in vivo (Hughes et al. 2013). Most of the biological actions of IGF2, including its anti-apoptotic effects are mediated via the IGF1R (O’Dell & Day 1998, Braulke 1999). All endocrine pancreas cell types express the IGF1R (Van Schravendijk et al. 1987, Fehmann et al. 1996), providing support for an IGF2-mediated anti-apoptotic strategy to promote islet survival post transplantation. In the context of IGF2 function, binding of IGF2 to the IGF1R leads to phosphorylation of insulin receptor substrate-2, which activates the phosphoinositide 3-kinase/Akt cell signalling pathway to mediate cell survival (van Haeften & Twickler 2004).

In addition to its anti-apoptotic properties, IGF2 upregulates the expression of vascular endothelial growth factor (VEGF), an endothelial cell-specific mitogen involved in vasculogenesis and angiogenesis (Kwon et al. 2004). The production of VEGF in this manner is particularly advantageous when considering the reduction in islet vascular density and function that occurs following the islet isolation procedure. Mechanistically, IGF2 upregulates VEGF by increasing the expression of hypoxia-inducible factor-1α (HIF1α), a master regulator of cellular and systemic homeostatic response to hypoxia. Interestingly, HIF1α itself has been shown to play a protective role in various experimental settings of apoptosis, including islet transplantation (Kim & Kim 2005, Czibik et al. 2009, Franke et al. 2013, Stokes et al. 2013). To our knowledge, there have been no studies aiming to identify whether a synergistic role of IGF2 with HIF1α exists in the context of islet transplant survival;
However, when considering the significant crosstalk that occurs between both systems (Feldser et al. 1999), it would be an interesting hypothesis to explore.

The optimal delivery method(s) for IGF2 expression in pancreatic islet cells

Protecting islets from early transplant stresses such as apoptosis is crucial to prevent islet allograft failure and ensure long-term insulin independence in diabetic patients. IGF2 is a promising candidate molecule to fulfill this need; however, the question remains regarding the optimal delivery method that should be paired with IGF2 to provide adequate protection against apoptosis. Theoretically, IGF2 could be delivered in a variety of ways to protect against islet cell death, including viral or non-viral gene therapy methods, islet encapsulation methods or within polymeric scaffolds, via supplementation of culture medium with IGF2 before transplantation or under islet coculture conditions, each with their own advantages and disadvantages (Table 1).

The culture of isolated islets before transplantation allows the islets to recover following the aggressive islet isolation procedure that leads to destruction of the islet microenvironment and contributes significantly to islet cell apoptosis in the early post-transplant period. Thus, the islet culture before transplantation provides an excellent window of opportunity to supplement the islet culture medium with anti-apoptotic molecules such as IGF2. This approach has been confirmed by Ilieva et al. (1999) who demonstrate that the presence of IGF2 during culture protects islets from isolation-induced apoptosis and necrosis. A possible disadvantage with pre-culture incubation of islets is the risk of islet fusion, which may lead to hypoxia, islet necrosis and significant loss of islet viability (Ichii et al. 2007). In addition, when considering the short half-life of growth factors (McGeachie & Tennant 1997), it is likely that the in vitro benefit would be short lived in vivo.

Table 1 Potential delivery method(s) for IGF2 expression in pancreatic islet cells

<table>
<thead>
<tr>
<th>Approach</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supplementation of culture medium with exogenous IGF2</td>
<td>Minimises islet cell loss during pre-transplant culture, leading to increased islet survival (Ilieva et al. 1999)</td>
<td>Effect limited by biological half-life of growth factors (McGeachie &amp; Tennant 1997)</td>
</tr>
<tr>
<td>Islet encapsulation</td>
<td>Effective as a pre-transplant method to ensure viable islet mass for application in downstream strategies, such as islet encapsulation</td>
<td>Residual IGF2 expression unlikely to have additional anti-apoptotic benefit in vivo</td>
</tr>
<tr>
<td>Tissue engineering scaffolds</td>
<td>Immunoprotection (cellular and humoral; McGeachie &amp; Tennant 1997)</td>
<td>Bioincompatibility, characterised by fibrotic overgrowth upon the microcapsule surface and reduced diffusion of oxygen and nutrients (Sakata et al. 2012)</td>
</tr>
<tr>
<td>Gene therapy to overexpress IGF2 (viral/non-viral)</td>
<td>Can reduce or prevent chronic administration of immunosuppressants and their associated side effects (i.e. islet toxicity and malignancy)</td>
<td>Unable to revascularise after transplantation, exacerbating islet hypoxia and subsequent islet cell death (Narang &amp; Mahato 2006)</td>
</tr>
<tr>
<td></td>
<td>Provide a supportive microenvironment for transplanted cells</td>
<td>Cell seeding to scaffolds can be time consuming and inefficient due to the limited penetration ability of cells into the scaffolds (Chan &amp; Leong 2008)</td>
</tr>
<tr>
<td></td>
<td>Can be designed with varying biocompatible and biodegradable materials, allowing them to be tailored for specific applications (Salvay &amp; Shea 2006, Hutmacher &amp; Cool 2007)</td>
<td>Non-viral vectors are associated with poor transduction efficiency compared with their viral vector counterparts (Mahato et al. 2003)</td>
</tr>
<tr>
<td></td>
<td>Ex vivo gene therapy ensures that the expression of IGF2 would be localised to the islets, providing cell protection while leaving the immune system and other organs unaffected (Hughes et al. 2013)</td>
<td>Stimulation of the immune system (viral vectors) (Muruve et al. 1999)</td>
</tr>
<tr>
<td></td>
<td>Option for transient (adenoviral) or stable (adeno associated viral and lenti-viral) transgene expression to suit required application</td>
<td>Results in permanent transgene expression by the transduced cells which raises potential concern for malignancy as the cells permanently overexpress an anti-apoptotic factor (Bergmann et al. 1996)</td>
</tr>
<tr>
<td>Cell line overexpressing IGF2</td>
<td>Can be combined with other anti-apoptotic strategies, such as islet encapsulation or co-culture transplantation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Provides the option to overexpress genes alone or in combination</td>
<td></td>
</tr>
</tbody>
</table>
Another interesting approach involves the use of biomaterials, designed to entrap or encapsulate growth factors into, or adsorb them onto biological scaffolds (Hutmacher & Cool 2007, Chan & Leong 2008). Significant work in this area has been undertaken using the sister compound IGF1 (Jaklenec et al. 2008, Chen et al. 2009, Sun et al. 2011, Kim et al. 2012). In one example, Nelson et al. (2011) used porous poly(ester urethane)urea scaffolds to demonstrate the long-term delivery of bioactive IGF1 in vitro. Likewise, the Meinel group showed that IGF1 releasing silk fibroin scaffolds initiated chondrogenesis from human mesenchymal stem cells in vitro (Uebersax et al. 2008). Adsorbing IGF1 onto porous hydroxyapatite, or chitosan scaffolds, enhanced osseointegration in vivo due to enhanced osteoblastic proliferation and vascularisation (Damien et al. 2003, Nandi et al. 2013). Kodama et al. (2009) engineered functional islets from single-cell suspensions using a protocol that involved seeding islets onto a polyglycolic acid scaffold and supplementing the islet culture medium with growth factors including IGF2. The resulting islets restored normoglycemia in diabetic mice.

Alginate microcapsules represent an alternative yet versatile approach to biological scaffolds, designed to encapsulate one or a few islets within a semi permeable membrane. In one strategy, bioengineered TM4 cells stably overexpressing IGF2 were cocapsulated with islet cells into alginate microcapsules, leading to significantly improved islet survival in vitro and in vivo, and improved normoglycemia maintenance (Jourdan et al. 2011). Since their introduction over 30 years ago, significant advances have been made in the engineering of alginate microcapsules including refinement of their sophisticated multi-layer architectures leading to enhanced biocompatibility and biodegradability in vivo (Schneider et al. 2001). However, the current major limitation of encapsulated islets is the fact that they are unable to revascularise after transplantation, exacerbating islet hypoxia and subsequent β-cell death (Sakata et al. 2012).

Viral and non-viral-mediated transduction of isolated islets to overexpress IGF2 represents another interesting option to enhance islet survival. Non-viral vectors offer the major advantage of high clinical safety and lack of vector-mediated immunogenicity, but they are significantly disadvantaged by their low-efficiency transduction (10–20%) in pancreatic islets (Narang & Mahato 2006). On the other hand, viral vectors offer the advantage of high-efficiency transduction but are limited by their unstable expression, need for repeated administration and stimulation of the immune system (Muruve et al. 1999). The major difficulty of any gene therapy strategy lies in the requirement for all or most cells to express the gene in order to gain protection. However, in this regard, IGF2 proves optimal as it mediates its anti-apoptotic effect via autocrine and paracrine mechanisms which negate the need for every islet cell to express the therapeutic gene. In the context of islet transplantation, the isolated islets are transduced ex vivo outside the body and any remaining viral particles are ‘washed off’ or removed before transplantation. This considerably limits the likelihood of any viral vector-mediated systemic response, which can be potentially life threatening in vivo (Raper et al. 2003).

Moreover, considering that up to 70% of islets can die due to apoptosis and necrosis in the immediate post-transplant period, a potential major advantage of a gene therapy approach is that islets would be exposed to a constitutively produced supply of anti-apoptotic IGF2 before transplantation and during the immediate post-transplant period (Hughes et al. 2013).

Engineering of β-cell lines that can protect against pro-inflammatory cytokine-mediated damage represents an interesting alternative to isolated islets for transplantation. Chen et al. (2000) developed a cytokine resistant rat insulinoma INS-1 cell line capable of protecting against IL1β- and IFNγ-mediated apoptosis more efficiently than cells stably overexpressing the anti-apoptotic gene Bcl2. There was an enhanced anti-apoptotic effect when the cytokine selection strategy was applied to the Bcl2 overexpressing cells. Importantly, the cells displayed no loss of glucose responsiveness, a critical function that ordinarily disappears very early during apoptosis. Combining this cytokine-resistant selection strategy with a cell line overexpressing IGF2, such as that used by Jourdan et al. (2011), could provide a novel approach for improving islet cell survival in the early post-transplant period.

**Conclusions and future perspectives**

The primary goal of islet transplantation is to achieve stable and long-term normoglycaemia in diabetic patients without the risks of hypoglycaemia. The first barrier that must be overcome to accomplish this is to improve the survival of islets in the immediate transplant period. The endocrine growth factor IGF2 represents a promising candidate molecule to promote islet survival post transplantation, but additional investigation is required to identify the optimal delivery approach to ensure sufficient expression of IGF2 within the islet microenvironment. As such, the full therapeutic potential of IGF2 to promote
islet survival and function post transplantation may not be realised until improvements are made in the efficacy, biocompatibility and safety of the gene delivery technologies currently under investigation.

Declaration of interest
The authors declare that there is no conflict of interest that could be perceived as prejudicing the impartiality of the research reported.

Funding
This research did not receive any specific grant from any funding agency in the public, commercial or not-for-profit sector.

References


Chen G, Hohmeier HE, Gasa R, Tran VV & Newgard CB 2000 Selection of inducible factor 1α and -cell line (INS-1) is regulated by glucose. *Diabetologia* 43 316–323. (doi:10.2337/diabetes.47.3.316)


Hill DJ, Petrik J, Arany E, McDonald TJ & Delovitch TL 1999b Insulin-like growth factors prevent cytokine-mediated cell death in isolated islets of...


Received in final form 5 February 2014
Accepted 11 February 2014