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In Focus

Mesenchymal Stem Cells and their Potential for Microengineering the Chondrocyte Niche

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Musculoskeletal disorders including osteoarthritis (OA) represent a major cause of disability and morbidity, and cause an enormous burden for health and social care systems globally. In the Global Burden of Disease 2010 study, hip and knee OA was ranked as the 11th highest contributor to global disability (Cross et al., 2014), and its prevalence is set to increase in parallel with the number of people aged 60 years and older. Articular cartilage within synovial joints has limited self-repair capacity because of its avascular nature and the low proliferation rate of chondrocytes, the main cell type responsible for its maintenance. Chondrocytes reside in a unique niche of cartilage extracellular matrix (ECM) that consists of collagen type II, large aggregating proteoglycans (e.g. aggrecan), glycosaminoglycans, hyaluronan, other non-collagenous proteins (e.g. COMP), and a large amount of water and mobile cations (i.e. Na\textsuperscript{+}, K\textsuperscript{+}, Ca\textsuperscript{2+}); this composition allows cartilage to resist biomechanical forces (Jahr et al., 2015). Cell-based therapies are rapidly being developed in a number of diseases including bone and joint disorders. As OA is currently incurable, novel biological and cell-based therapies that can effectively treat joint degeneration are high priorities in regenerative medicine.

Multipotent mesenchymal stem cells (MSCs) derived from bone marrow, adipose tissue and umbilical cord (UC) show considerable promise for use in cartilage repair. Under appropriate micro-environmental conditions they can proliferate and give rise to chondrocytes and other related mesenchymal cell phenotypes, allowing them to act as key players in regenerating injured tissue following injury and trauma (Richardson et al., 2015). Another key feature of MSCs is their capacity to modulate immune responses in vitro and in vivo, making them well-suited for the treatment of systemic inflammatory and autoimmune conditions that affect synovial joints. Their immunosuppressive nature extends to both the innate and adaptive immune system through interactions with dendritic cells, natural killer cells, macrophages and B and T lymphocytes by means of cell–cell contacts or soluble mediators (Burr et al., 2013). Given the avascular and alymphatic characteristics of articular cartilage and the specific features of the ECM that can shield the MHC molecules from recognition by host cells, an immune response against allogeneic chondrocytes or osteochondral constructs in the host has not been reported. However, the immunomodulatory effects of MSCs may have critical outcomes in diseases of the musculoskeletal system where an inflammatory or autoimmune process is at the core of the main disease. The molecular mechanisms underlying the effects of MSCs on the immune system are diverse and employ the release of soluble factors such as interleukin-10, tumour necrosis factor-alpha, transforming growth factor-beta, prostaglandin-E\textsubscript{2} and indoleamine-2,3-dioxygenase by MSCs. UC-MSCs express the HLA-E, HLA-F and HLA-G non-canonical type I MHC receptors. In addition, the fact that B7-H3 (CD276), a co-stimulatory molecule that inhibits T cell activation, was demonstrated to be expressed not only in undifferentiated UC-MSCs but persisted following differentiation towards the chondrogenic lineage indicate that differentiated UC-MSCs continue to have immunosuppressive characteristics, which is an added advantage with potentially important clinical implications (La Rocca et al., 2013).
The integration of mechanical and topographical properties of materials in scaffold design, and incorporation of biochemical cues such as cytokines in tethered, soluble, or time-released forms (Edalat et al., 2012; Zorlutuna et al., 2013). For example, fibrous poly(glycerol sebacate):poly(caprolactone) (PGS:PCL) scaffolds containing aligned fibres are able to direct the growth of primary human valvar interstitial cells along the scaffold axis (Masoumi et al., 2014). A similar approach could be used to mimic the zonal structure and mechanical properties of native articular cartilage.

There are still many technical challenges associated with the clinical use of MSCs for the regeneration of degenerate joints. However, we are starting to overcome some of the practical and conceptual difficulties. Interdisciplinary approaches based on the combination of new biomaterials and cell-based therapies are more likely to lead to breakthroughs in regenerating musculoskeletal tissues in the future.

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