Diabetes: burden of the disease

Diabetes affects at least 400 million people worldwide (about 6% of the human population)

Excess of glucose is responsible for most of the complications - blindness, kidney failure, heart disease, stroke, neuropathy and amputations

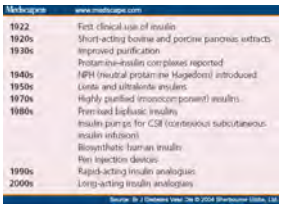
Type 1: juvenile-onset diabetes, autoimmune destruction of beta-cells

Type 2: adult-onset, familiar, insulin-resistance combined with reduced secretion

Current therapy for diabetes

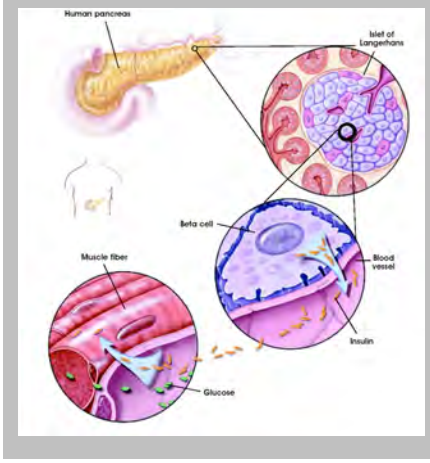
No cure available
Support therapy: insulin (type 1), diet, exercise, oral medications (type 2)
Whole organ transplant requires strong immunosuppression (only in combination with kidney transplant)

Insulin was discovered over 90 years by JJR Macleod at the University of Toronto.
The first patient, Leonard Thompson, at the time of treatment was on a starvation diet that was intended to extend his life for a few years. He was injected with a crude extract of bovine pancreas in January 1922 with an almost immediate effect on his glycosuria, blood glucose levels and general well-being. From that moment onward diabetes was no longer a fatal disease.



There have been many major breakthroughs since 1922, but none more important than the cloning and sequencing of the insulin gene in 1980, which brought about the introduction of unlimited supplies of **bacterially expressed human insulin** and the technology to modify the structure of the protein, such that there are now at least 6 rapid- acting or long-acting analogues.

Pancreas structure



Langherans islets:

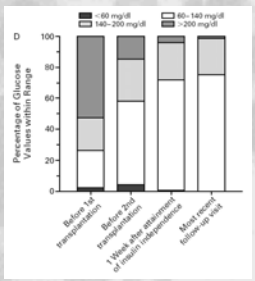
- Different cell types:
  - Alpha cells producing glucagon (15–20% of total islet cells)
  - Beta cells producing insulin and amylin (65–80%)
  - Delta cells producing somatostatin (3–10%)
  - PP cells (gamma cells) producing pancreatic polypeptide (3–5%)
  - Epsilon cells producing ghrelin (<1%)
- Complex interplay in glucose metabolism regulation
- Digestive enzymes secreted by exocrine pancreatic tissue
- Islet transplantation better than whole organ and beta-cell transplantation

Table 1. Synopsis of Reports of Successful Islet Transplantation in Patients with Type 1 Diabetes.*

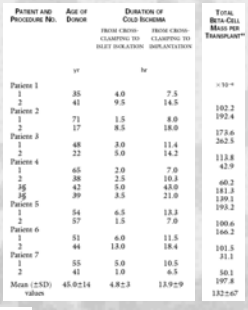
Study	Year of Report	No. of Recipients and Size of Transplant	Outcome
Largiader et al.[14]	1980	1 Recipient of pancreas microfragments containing 200,000 islets	Insulin-independent with normal glucose level at 9½ mo
Scharp et al.[15]	1990	1 Recipient of 800,000 islets	Insulin-independent at 22 days
Tzakis et al.[16]	1990	9 Patients with cancer and abdominal exenteration without diabetes received 205,000–746,000 islets	Normal glycosylated hemoglobin values in 5 patients, with some receiving insulin supplementation
Warnock et al.[17]	1991	1 Recipient of 611,000 islets	Insulin-independent with normal glucose levels at 3 mo
Scharp et al.[18]	1991	First 9 patients receiving 6161±911 to 13,916±556 islets/kg of body weight	3 Transplantations failed; 4 had measurable C-peptide levels for up to 10 mo but not insulin-independent; 2 with normal glucose levels and insulin-independent for 1–5 mo
Warnock et al.[19]	1992	4 Recipients of 261,000–896,000 fresh and cryopreserved islets	3 Had measurable C-peptide levels for 1–8 mo, but not insulin-independent; 1 insulin-independent for 1 yr
Gores et al.[20]	1993	2 Recipients of 502,000–528,000 islets	1 Had measurable C-peptide levels but not insulin-independent at 9 mo; 1 with normal glucose levels and insulin-independent at 8 mo.
Soon-Shiong et al.[21]	1994	1 Recipient of 678,000 encapsulated islets	Insulin-independent with normal glucose levels at 9 mo
Carroll et al.[22]	1995	1 Patient with cancer and abdominal exenteration without diabetes	Insulin-independent with normal glycosylated hemoglobin values at 3 yr
Luzi et al.[23]	1996	15 Recipients of 98,587–1,294,125 islets	8 Had C-peptide levels >1.4 ng/liter; 4 insulin-independent with glycosylated hemoglobin values of 5.6–7.2 percent at 1–8 mo
Alejandro et al.[24]	1997	8 Recipients of 478,000–1,271,000 islet equivalents	2 Insulin-independent at 1 mo and 2 insulin-independent at 6 yr with normal to near-normal glycosylated hemoglobin values
Secchi et al.[25]	1997	20 Recipients of 3461–14,438 islet equivalents/kg	9 Had measurable C-peptide levels with decreased need for insulin; 6 insulin-independent at 3–11 mo; 1 insulin-independent at 48 mo; all with normal or near-normal glycosylated hemoglobin values
Keymeulen et al.[27]	1998	7 Recipients of 2100–5300 islet equivalents/kg	3 Had measurable C-peptide levels for >1 yr; 2 insulin-independent with normal to near-normal glycosylated hemoglobin values for 1 yr
Oberholzer et al.[34]	2000	13 Recipients of 199,000–863,000 islets	All had measurable C-peptide levels for >3 mo; 5 of 8 had normal C-peptide levels >1 yr; 2 patients insulin-independent at 4 and 36 mo
Shapiro et al.[35]	2000	7 Recipients of 11,546±1604 islets	All insulin-independent at 4–15 mo with 6-month glycosylated hemoglobin values of 5.7±0.2 percent.

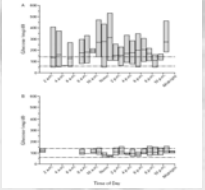

The New England Journal of Medicine

ISLET TRANSPLANTATION IN SEVEN PATIENTS WITH TYPE 1 DIABETES MELLITUS USING A GLUCOCORTICOID-FREE IMMUNOSUPPRESSIVE REGIMEN



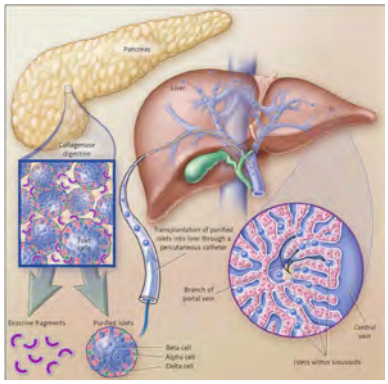
All patients insulin-free at 1 year !!!!



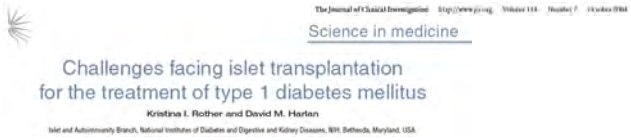


Important limits:
- **2 donors per transplant**
- **11,000 islet equivalents per kilogram body weight**
- **histocompatibility**
- **early explant (max 8 hr)**

The modern islet isolation technology



- Procurement of a healthy pancreas from a brain-dead donor
- Same technique used to procure a pancreas for whole-organ transplantation
- Pancreas duct cannulation and collagenase infusion
- Islet purification by density-gradient centrifugation
- Infusion into the portal vein



Science in medicine

Challenges facing islet transplantation for the treatment of type 1 diabetes mellitus

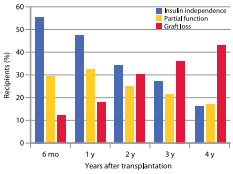
Kristina I. Rother and David M. Harlan

Islet and Autoimmunity Branch, National Institutes of Diabetes and Digestive and Kidney Diseases, NIH, Bethesda, Maryland, USA

Compared to pancreas transplantation, islet transplantation is easier, has lower morbidity and permits storage of the islet graft (cryopreservation for banking)

Worldwide, more than 800 individuals with T1DM have received allogenic islet transplants since 1974

Yet, islet transplantation does not offer permanent cure of hyperglycemia for all diabetic patients in need



- Only 10% maintain insulin independence after 15 months
- High number of islets is required: 850,000 with Edmonton protocol, 300,000 with autotransplantation after pancreatectomy
- Imbalance between supply and demand. Eligible patients have had T1D for >5 years, are aged 18-65, have poor diabetes control
- Significant side effects due to immunosuppression

Source: Collaborative Islet Transplant Registry (CITR)

Immunosuppressive regimen that avoids the use of diabetogenic glucocorticoids

Table 1

Systemic side effects commonly associated with the immunosuppressive agents typically administered following islet transplant

Immunosuppressant (brand name)	Drug classification	Common and important side effects (Phase of drug administration)
Rapamycin, also known as Sirolimus (Rapamune)	Macrocyclic lactone	Hyperlipidemia, antiproliferation (e.g., anemia, diarrhea) (Maintenance)
FK506, also known as Tacrolimus (Prograf)	Calcineurin inhibitor	Hypertension, nephrotoxicity, CNS effects (e.g., tremor), diabetogenicity (Maintenance)
Daclizumab (Zenapax)	mAb-binding IL-2 receptor α subunit	May increase risk of infections; hypersensitivity (Induction)

- An endpoint more rigorous than insulin independence at 1 year after transplant needs to be met
- What do current studies suggest regarding the impact of islet transplantation on patient survival and quality of life?

The net effect of improved glycemia control produced by the transplant, when balanced against the immunosuppressive-associated hypertension, hyperlipidemia, and decreased renal function, may actually decrease quality of life and increase mortality

Alternative sources of cells oh physiologically regulated insulin secretion

1. **Expanding islet cellular mass in vitro**

   Inexorable decline in insulin production
   Islets are mini-organs

2. **Islets from species other than humans**

   Humans express high titers of antibodies against a galactose residue present on most pig cells (*historically pigs were the first source of insulin for diabetes treatment*)

3. **Promotion of β-cell differentiation from stem cells**

XENOTRANSPLANTATION

Problem of immune rejection

- use of transgenic pigs that do not express xenogenic surface antigens

About 100 swine at the University of Minnesota's Schulze Diabetes Institute in Minneapolis constitute the first herd in the country specially bred to supply insulin–secreting pancreatic islets for people with diabetes.

- islet embedding in alginate microcapsules

- influence the recipient's immune system

Prolonged diabetes reversal after intraportal xenotransplantation of wild-type porcine islets in immunosuppressed nonhuman primates

Bernhard J Hering[1], Martin Wijkstrom[1], Melanie L Graham[1], Maria Hårdstedt[2], Tor C Aasheim[1], Tan Jie[2], Jeffrey D Ansite[1], Masahiko Nakano[1], Jane Cheng[2], Wei L P, Kathleen Moran[2], Uwe Christians[2], Colleen Finnegan[2], Charles D Mills[2], David E Sutherland[2], Protima Bansal-Pakala[2], Michael P Murtaugh[2], Nicole Kirchhof[2] & Henk-Jan Schuurman[2]

NATURE MEDICINE VOLUME 12 | NUMBER 3 | MARCH 2006

Research Paper

Clinical Benefit of Islet Xenotransplantation for the Treatment of Type 1 Diabetes

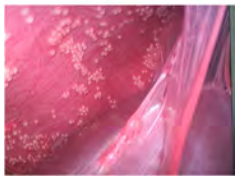
Shinichi Matsumoto MD[a,e], Adrian Abalovich MD[b], Carlos Wechsler MD[b], ShaunWynyard PhD[c], Robert B. Elliott MD[c,d]

EBioMedicine 12 (2016) 255–262

Encapsulated porcine neonatal islets were transplanted into 8 type 1 diabetic patients.

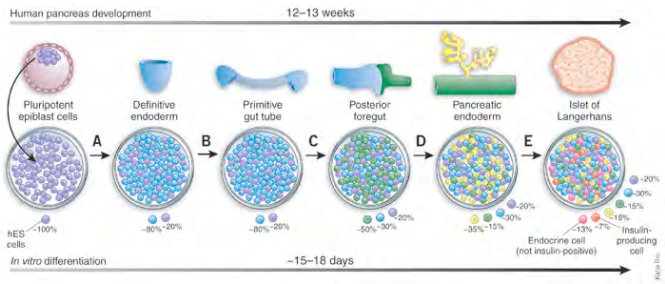
Patients with high dose group could maintain HbA1c < 7% > 600 days with reduced hypoglycemic events.

There is no PERV infection in all patients



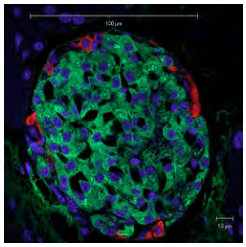
Insulin dependent diabetes mellitus can be successfully treated by human islet cell transplantation. However the shortage of donated human pancreas is the major issue. Islet transplantation using clinical grade porcine pancreas is a promising treatment to alleviate the shortage of donated human pancreas.
In this study, we transplanted encapsulated neonatal porcine islets into 8 insulin dependent diabetic patients. There was no porcine endogenous retrovirus infection. All patients reduced HbA1c levels which indicated glycemic controls were improved.
Encapsulated neonatal porcine islet transplantation appears safe and efficacious to improve glycemic control for insulin dependent diabetic patients.

Directed differentiation of hES or iPS cells to insulin-producing cells by mimicking embryonic development



Vertebrate pancreatic development is highly conserved, and much information has been gained on signaling factors involved in patterning of the early gut tube toward the pancreas. This information can be translated into a stepwise differentiation protocol that includes sequential exposure to (i) FGF10 and the hedgehog-signaling inhibitor cyclopamine, and removal of activin A (inducing the primitive gut-tube markers HNF1B and HNF4A); (ii) retinoic acid and the conditions in (i) (inducing the posterior gut-tube markers HNF6, PDX1 and HLXB9); (iii) exendin-4, a Glp-1 receptor agonist, with or without DAPT-mediated inhibition of Notch signaling (inducing pancreatic epithelial markers including endocrine progenitor markers such as NKX6-1, NKX2-2, NGN3 and PAX4); and finally (iv) exendin-4, IGF1 and HGF (inducing PAX6, NEUROD1, ISL1 and hormone-gene expression).

Protocol for the differentiation of pluripotent cells in functional islets



- D0-2: induce formation of Definite Endoderm by high concentrations (100 ng/ml) of activin A, which mimics the effects of nodal signaling in the early embryo

- D2-4: specification of the pancreas, by adding retinoic acid and inhibiting endogenous sonic hedgehog signaling with cyclopamine

-D4-6:formation of the pancreatic cell types by adding FGF and inhibiting the actions of activin A, which at this stage would push the cells towards liver lineages

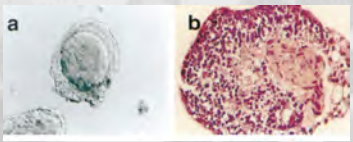
- D7-9: inhibit Delta/Notch signaling, by use of a γ-secretase inhibitor, to enrich for a population of endocrine progenitors

To date it has not been possible to differentiate these progenitors further into fully functional β-cells; however when placed under the kidney capsule or epididymal fat pad of immunocompromised mice, the progenitors, after 12 weeks or so, secrete human C-peptide in a manner that responds to a glucose tolerance test and can rescue hyperglycemia if the mice are subsequently treated with streptozotocin, which kills mouse but not human β-cells

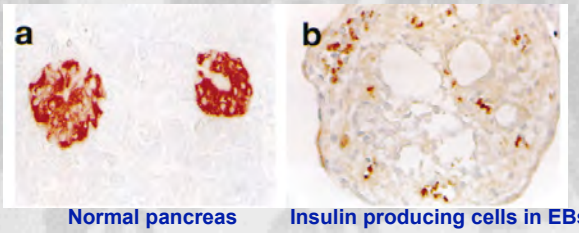
Rapid Publication

Insulin Production by Human Embryonic Stem Cells

Suheir Assady,[1] Gila Maor,[1] Michal Amit,[1] Joseph Itskovitz-Eldor,[1,2] Karl L. Skorecki,[1,2] and Maty Tzukerman[2]



Embryoid bodies

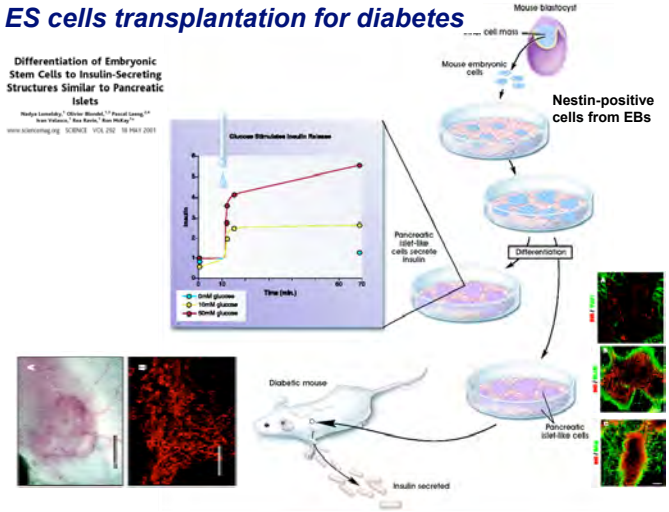


Pdx-1 expression

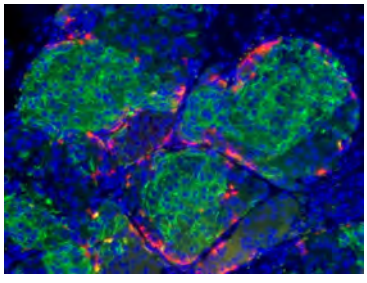
Normal pancreas

Insulin producing cells in EBs

ES cells transplantation for diabetes



From stem cells to billions of human insulin-producing cells



The generation of insulin-producing pancreatic β cells from stem cells in vitro would provide an unprecedented cell source for drug discovery and cell transplantation therapy in diabetes. However, insulin-producing cells previously generated from human pluripotent stem cells (hPSC) lack many functional characteristics of bona fide β cells. Here, we report a scalable differentiation protocol that can generate hundreds of millions of glucose-responsive β cells from hPSC in vitro. These stem-cell-derived β cells (SC-β) express markers found in mature β cells, flux Ca^{2+} in response to glucose, package insulin into secretory granules, and secrete quantities of insulin comparable to adult β cells in response to multiple sequential glucose challenges in vitro. Furthermore, these cells secrete human insulin into the serum of mice shortly after transplantation in a glucose-regulated manner, and transplantation of these cells ameliorates hyperglycemia in diabetic mice.

Generation of Functional Human Pancreatic β Cells In Vitro

Felicia W. Pagliuca,[1,3] Jeffrey R. Millman,[1,3] Mads Gürtler,[1,3] Michael Segel,[1] Alana Van Dervort,[1] Jennifer Hyoje Ryu,[1] Quinn P. Peterson,[1] Dale Greiner,[2] and Douglas A. Melton[1,*]
[1]Department of Stem Cell and Regenerative Biology, Harvard Stem Cell Institute, Harvard University, 7 Divinity Avenue, Cambridge, MA 02138, USA
[2]Diabetes Center of Excellence, University of Massachusetts Medical School, 368 Plantation Street, AS7-2051, Worcester, MA 01605, USA
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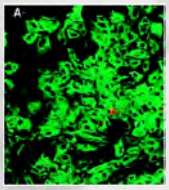
http://dx.doi.org/10.1016/j.cell.2014.09.040

Cell *159*, 428–439, October 9, 2014 ©2014 Elsevier Inc.

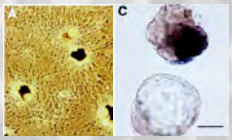
In vitro cultivation of human islets from expanded ductal tissue

Susan Bonner-Weir*, Monica Taneja, Gordon C. Weir, Krystyna Tatarkiewicz, Ki-Ho Song, Arun Sharma, and John J. O'Neil

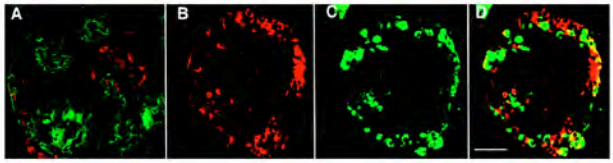


Primary ductal cells
green = cytokeratin
red = insulin

Insulin secretion according to G concentration
In vitro expansion, autologous transplantation



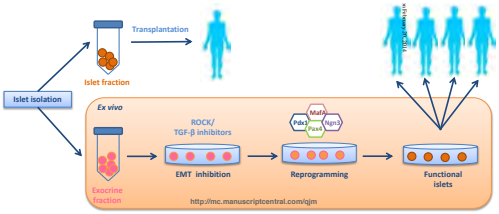
CHIBs rising from a monolayer of ductal cells
(dithizone staining)



green = cytokeratin
red = insulin

red = insulin
green = non beta-cell hormones (glucagons, somatostatin, PP)

Reprogramming Adult Cell Types towards β-Cells



Suppression of Epithelial-to-Mesenchymal Transitioning Enhances Ex Vivo Reprogramming of Human Exocrine Pancreatic Tissue Toward Functional Insulin-Producing β-Like Cells

Lima MJ, Muir KR, Docherty HM, Drummond R, McGowan NW, Forbes S, Heremans Y, Houbracken I, Ross JA, Forbes SJ, Ravassard P, Heimberg H, Casey J, Docherty K.

Diabetes. 2013 Aug;62(8):2821-33.