

8. Relationship to other muscle stem cells

Several types of stem cells have been isolated from skeletal muscle, including SP cells, muscle-derived stem cells (MDSC) [43], multipotent adult precursor cells (MAPC) [44], myogenic-endothelial progenitors [45], CD45-positive Sca-1-positive cells [46], mesoangioblasts [7], and pericytes [47]. Although all these stem cells were isolated from skeletal muscle and showed multi-lineage differentiation potential, use of different cell isolation techniques, different culture conditions, and partial characterization make it difficult to clarify the interrelationships among them. For establishment of effective and safe cell therapy for muscular dystrophies, we must establish a standard protocol for isolation of muscle stem cells.

9. Physiological role of SP cells in muscle regeneration

Interestingly, the number of muscle SP cells increases during muscle regeneration [29,30] (Figure 3). In particular, CD45-negative, CD31-negative SP cells actively proliferate during muscle regeneration. In the later stage of muscle regeneration, however, the double-negative SP cells decrease in number and return to the normal level [29]. Although double-negative SP cells barely differentiate into muscle cells when cultured alone [29, 33], they form myofibers *in vivo* after injection into regenerating muscle of immunocompetent mice, suggesting that endogenous muscle SP cells participate in muscle fiber repair. Intriguingly, CD31-negative CD45-negative SP cells express the genes that are expected to regulate muscle regeneration [29]. These results suggest that CD31-negative CD45-negative SP cells not only act as myogenic progenitors but also regulate muscle regeneration by acting on satellite cells or inflammatory cells. Contrary to expectation, CD31-positive SP cells (the major SP subset in muscle) do not expand in response to muscle injury. Their roles in muscle regeneration remain to be determined. Figure 4 shows our model of the roles for muscle SP cells in muscle regeneration.

10. Muscle SP cells as a tool for cell therapy of muscular dystrophy

Cell-based therapy continues to be a promising avenue for the treatment of DMD, an X-linked skeletal muscle-wasting disease. However, myoblast transplantation into animal models results in local restoration of dystrophin expression [48], and human clinical studies using myoblast transfer performed on DMD patients failed to improve the muscle strength of the treated group [49-51]. An alternative to myoblast transfer is a systemic delivery of precursor cells with myogenic potential. Recently, it was demonstrated that skeletal

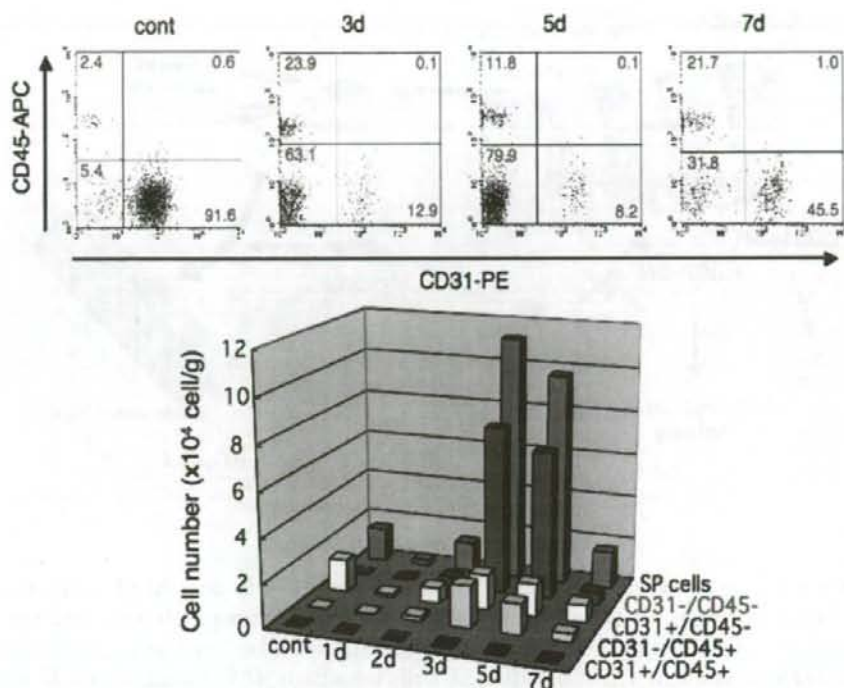


Figure 3. Number of CD31-negative CD45-negative SP subpopulation cells increases during muscle regeneration. Cardiotoxin was injected into hind limb muscles of 8-week-old C57BL/6 mice, muscles were dissected, and SP fractions were analyzed by FACS 1, 2, 3, 5, and 7 days after injection. Upper panel: Muscle SP fraction was further analyzed by CD31 and CD45 expression. Lower panel: The cell numbers of each SP fraction were counted and plotted. Note that CD45-negative CD31-negative SP cells are a minor SP subset, but are significantly increased in response to muscle injury. Reproduced from [29] by permission.

muscle SP cells engraft into dystrophic fibers of nonirradiated *mdx(5cv)* mice after intravenous or intraarterial delivery [52, 53]. SP cells prepared from *mdx(5cv)* muscle were transduced with a recombinant lentivirus encoding microdystrophin or GFP, and transplanted into the femoral artery of non-injured *mdx(5cv)* mice. Sections of the recipient muscles demonstrated that 5-8 % of skeletal muscle fibers expressed donor-derived transgenes. Further, donor muscle SP cells, which did not express any myogenic markers prior to transplant, expressed a satellite cell transcription factor, Pax7, and a muscle-specific intermediate filament, desmin, after extravasation into host muscle. These results indicate that systemic autologous transplantation of SP cells genetically corrected *ex vivo* could be an option for cell therapy of DMD.

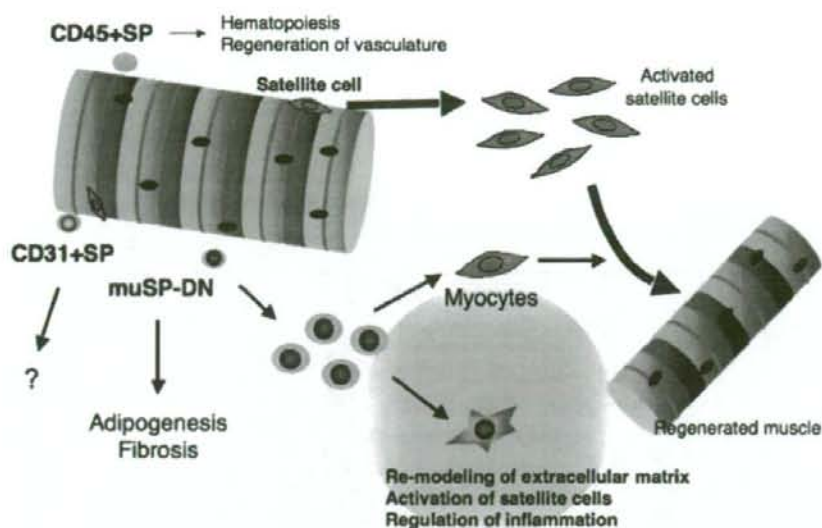


Figure 4. Roles of SP cells in muscle regeneration. Muscle-derived SP cells stained with Hoechst (5 $\mu\text{g}/\text{ml}$) are divided into three distinct subpopulations based on the expression of CD31 and CD45. The main population is CD31-positive. Their roles in muscle remain unclear. CD45-positive SP cells (less than 10% of total muscle SP cells) are shown to be bone marrow-derived and account for hematopoietic activity found in muscle. They are also reported to re-constitute the vasculature after muscle injury. The CD31-negative CD45-negative SP subset actively proliferates during muscle regeneration. These cells differentiate into adipocytes, osteocytes, and myocytes *in vitro*. Their roles in muscle regeneration are just beginning to be elucidated.

III. SP fraction in cultures of primary myoblasts and myogenic cell line C2C12 cells

One can identify a subset of cells with the SP phenotype in both primary myoblasts and cells of a myogenic cell line, C2C12. Benchaour *et al.* stained myoblasts and C2C12 cells with a variety of concentrations of Hoechst (5-30 $\mu\text{g}/\text{ml}$) and analyzed them on a dual-laser MoFlo flow cytometer; they found that 2-3 % of the cells show SP-like phenotypes [54]. Interestingly, gene expression analysis of C2C12-SP cells suggested that *mdr1a*, an ABC transporter is likely responsible for the SP phenotype of C2C12-derived SP cells. Cell cycle analysis by propidium iodide staining revealed that more than 90 % of SP cells in C2C12 cells are in the G0/G1 phase. Electron microscopy showed that they have a high nucleus-to-cytoplasm ratio. C2C12 SP cells express reduced levels of MyoD and exhibit delayed differentiation compared to main population cells in differentiation-promoting conditions. Because forced expression of *mdr1a*

increases the number of SP cells and blocks the differentiation of C2C12 cells, *mdr1a* may regulate the differentiation of C2C12 cells. One possible mechanism for this regulation is that *mdr1a* excludes certain differentiation-promoting substances from the cells. Interestingly, the study also demonstrated that SP and MP cells in C2C12 cells are in a dynamic equilibrium and largely reversible. Moreover, addition of FGF6 to the culture medium increased the ratio of SP cells [55]. C2C12 SP cells might be a useful *in vitro* model to study a reserve pool of muscle progenitor cells in skeletal muscle.

IV. Others

Roles for ABC transporters in SP cells

SP cells in several tissues represent immature, undifferentiated cell fractions [10]. SP-like cells are also found in cancer cells, and are considered to be cancer stem cells [11]. Although not all SP cells are stem cells, the Hoechst efflux phenomenon correlates well with stem cell activities in several tissues or organs. ABC transporters would protect stem/progenitor cells from toxic substances, hypoxia, or other stresses, ensuring long-term survival of the cells, and keeping stem/progenitor cells in an undifferentiated state.

Conclusions

Muscle SP cells are thought to be enriched in stem cells, but they are highly heterogeneous. In addition, variations in techniques for isolation of the muscle SP fraction make the properties of muscle SP cells elusive. To further characterize the origins, phenotypes, the functions of muscle SP cells in physiological and pathological conditions and their therapeutic potential, it might be necessary to find more reliable SP-specific markers and use limited numbers of SP cells in a functional assay to equate muscle SP cells with stem cells.

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CHAPTER XVI

GENE THERAPY FOR DUCHENNE MUSCULAR DYSTROPHY

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Duchenne muscular dystrophy (DMD) is caused by various distinct mutations, ranging from point mutations to large deletions, in the *dystrophin* gene. These mutations have led to a variety of therapeutic modalities for muscular dystrophy, including gene replacement, gene correction, and modification of the gene product. Gene replacement therapy provides an impersonal approach for treating DMD. Adeno-associated virus (AAV) vector-mediated truncated *micro-dystrophin* gene delivery has been successful in some animal models of DMD. However, recent evidence of immune-mediated loss of vector persistence in dogs and humans suggests that immune modulation might be necessary to achieve successful long-term transgene expression in these species. In this chapter, we focus on the methods that have been developed for gene replacement therapy using vectors based on the AAV.

1. Introduction

1.1. Background of Duchenne Muscular Dystrophy

Duchenne muscular dystrophy (DMD) is the most common form of childhood muscular dystrophy. DMD is an X-linked recessive disorder with an incidence of one in 3500 live male births.¹ DMD causes

progressive degeneration and regeneration of skeletal and cardiac muscles due to mutations in the *dystrophin* gene, which encodes a 427-kDa subsarcolemmal cytoskeletal protein.² DMD is associated with severe, progressive muscle weakness and typically leads to death between the ages of 20 and 35 years. Due to recent advances in respiratory care, much attention is now focused on treating the cardiac conditions suffered by DMD patients.

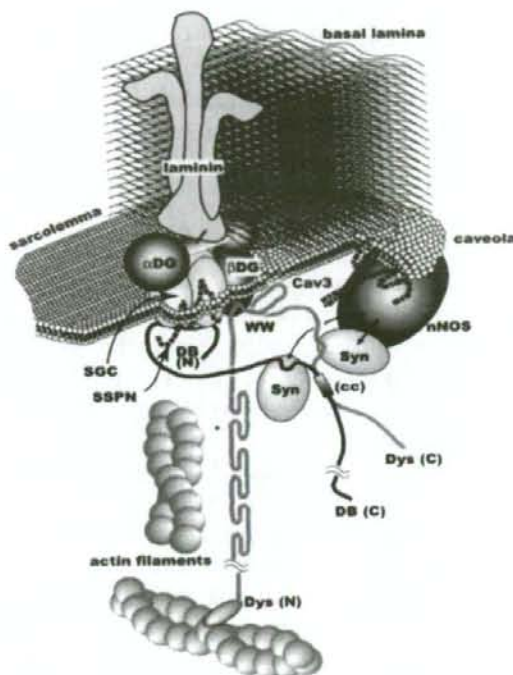


Fig. 1. Dystrophin-glycoprotein complex. Molecular structure of the dystrophin-glycoprotein complex and related proteins superimposed on the sarcolemma and subsarcolemmal actin network (redrawn from Yoshida *et al.*,³ with modifications). cc, coiled-coil motif on dystrophin (Dys) and dystrobrevin (DB); SGC, sarcoglycan complex; SSPN, sarcospan; Syn, syntrophin; Cav3, caveolin-3; N and C, the N and C termini, respectively; G, G-domain of laminin; asterisk indicates the actin-binding site on the dystrophin rod domain; WW, WW domain.

The approximately 2.5-megabase *dystrophin* gene is the largest gene identified to date, and because of its size, it is susceptible to a high sporadic mutation rate. Absence of dystrophin and the dystrophin-glycoprotein complex (DGC) from the sarcolemma leads to severe muscle wasting (Figure 1). Whereas DMD is characterized by the absence of functional protein, Becker muscular dystrophy, which is

commonly caused by in-frame deletions of the *dystrophin* gene, results in the synthesis of a partially functional protein.

2. Gene-replacement Strategies using Virus Vectors

2.1. Choice of Vector

Successful therapy for DMD requires the restoration of dystrophin protein in skeletal and cardiac muscles. While various viral vectors have been considered for the delivery of genes to muscle fibers, the adeno-associated virus (AAV)-based vector is emerging as the gene transfer vehicle with the most potential for use in DMD gene therapies. The advantages of the AAV vector include the lack of disease associated with a wild-type virus, the ability to transduce non-dividing cells, and the long-term expression of the delivered transgenes.⁴ Serotypes 1, 6, 8 and 9 of recombinant AAV (rAAV) exhibit a potent tropism for striated muscles.⁵ Since a 5-kb genome is considered to be the upper limit for a single AAV virion, a series of rod-truncated micro-dystrophin genes is used in this treatment.⁶

Due to ingenious cloning and preparation techniques, adenovirus vectors are efficient delivery systems of episomal DNA into eukaryotic cell nuclei.⁷ The utility of adenovirus vectors has been increased by capsid modifications that alter tropism, and by the generation of hybrid vectors that promote chromosomal insertion.⁸ Also, gutted adenovirus vectors devoid of all adenoviral genes allow for the insertion of large transgenes, and trigger fewer cytotoxic and immunogenic effects than do those only deleted in the E1 regions (from bases 343 to 2270).⁹ Human artificial chromosomes (HACs) have the capacity to deliver a large gene (roughly 6-10 megabases) into host cells without integrating the gene into the host genome, thereby preventing the possibility of insertional mutagenesis and genomic instability.¹⁰

A goal in clinical gene therapy is to develop gene transfer vehicles that can integrate exogenous therapeutic genes at specific chromosomal loci, so that insertional oncogenesis is prevented. AAV can insert its genome into a specific locus, designated AAVS1, on chromosome 19 of the human genome.¹¹ The AAV Rep78/68 proteins and the Rep78/68-binding sequences are the trans- and cis-acting elements needed for this reaction. A dual high-capacity adenovirus-AAV hybrid vector with full-length human dystrophin-coding sequences

flanked by AAV integration-enhancing elements was tested for targeted integration.¹²

Gene correction is a process whereby sequence alterations in genes can be corrected by homologous recombination-mediated gene conversion between the recipient target locus and a donor construct encoding the correct sequence.¹³ The introduction of a corrective sequence together with a site-specific nuclease to induce a double-stranded break (DSB) at sites responsible for monogenic disorders would activate gene correction. Pairs of designated zinc-finger protein with tandem DNA binding sites fused to the cleavage domain of the FokI protein were introduced into model systems or cell lines and produced corrections in 10–30% of cases tested.¹⁴

2.2. Modification of the dystrophin Gene and Promoter

Due to the large deletion in its genome, the gutted adenovirus vector can package 14-kb of full-length *dystrophin* cDNA. Multiple proximal muscles of seven-day-old utrophin/dystrophin double knockout mice (*dko* mice), which typically show symptoms similar to human DMD, were effectively transduced with the gutted adenovirus bearing full-length murine *dystrophin* cDNA.¹⁵ However, further improvements are needed to regulate the virus-associated host immune response before clinical trials can be performed.

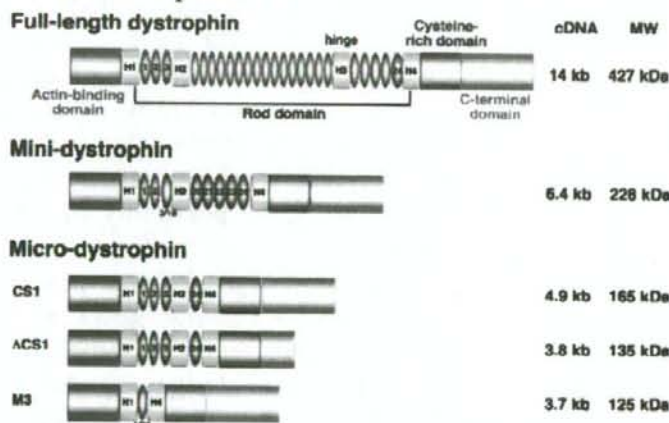


Fig. 2. Structures of full-length and truncated dystrophin. Helper-dependent adenovirus vector can package 14-kb of full-length dystrophin cDNA because of the large-sized deletion in its genome. A mini-dystrophin is cloned from a patient with Becker muscular dystrophy, which is caused by in-frame deletions resulting in the synthesis of partially functional protein. A series of truncated micro-dystrophin cDNAs harboring only four rod repeats with hinge 1, 2, and 4 (CS1); the same components, except that the C-terminal domain is deleted (delta CS1); or one rod repeat with hinge 1 and 4 (M3), are constructed to be packaged in the AAV vector.

A series of truncated *dystrophin* cDNAs containing rod repeats with hinge 1, 2, and 4 were constructed (Figure 2).⁶ Although AAV vectors are too small to package the full-length *dystrophin* cDNA, AAV vector-mediated gene therapy using a rod-truncated *dystrophin* gene provides a promising approach.¹⁶ The structure and, particularly, the length of the rod are crucial for the function of micro-dystrophin.¹⁷ An AAV type 2 vector expressing micro-dystrophin (DeltaCS1) under the control of a muscle-specific MCK promoter was injected into the tibialis anterior (TA) muscles of dystrophin-deficient *mdx* mice,¹⁸ and resulted in extensive and long-term expression of micro-dystrophin that exhibited improved force generation.

The impact of codon usage optimization on micro-dystrophin expression and function in the *mdx* mouse was assessed to compare the function of two different configurations of codon-optimized *micro-dystrophin* genes under the control of a muscle-restrictive promoter (Spc5-12).¹⁹ Codon optimization of micro-dystrophin significantly increased micro-dystrophin mRNA and protein levels after intramuscular and systemic administration of plasmid DNA or rAAV8. By randomly assembling myogenic regulatory elements into synthetic promoter recombinant libraries, several artificial promoters were isolated whose transcriptional potencies greatly exceed those of natural myogenic and viral gene promoters.²⁰

2.3. Use of Surrogate Genes

An approach using a surrogate gene would bypass the potential immune responses associated with the delivery of exogenous dystrophin. Methods to increase expression of utrophin, a dystrophin paralog, show promise as a treatment for DMD. rAAV6 harboring a murine codon-optimized micro-utrophin transgene was intravenously administered into adult *dko* mice to alleviate the pathophysiological abnormalities.²¹ The paralogous gene efficiently acted as a surrogate for *dystrophin*. Myostatin is extensively documented as being a negative regulator of muscle growth. Systemic gene delivery of myostatin propeptide, a natural inhibitor of myostatin, enhanced body-wide skeletal muscle growth in both normal and *mdx* mice.²² The delivery of various growth factors, such as insulin-like growth factor-I (IGF-I), has been successful in promoting skeletal muscle regeneration after injury.²³

Matrix metalloproteinases (MMPs) are key regulatory molecules in the formation, remodeling and degradation of all extracellular matrix

(ECM) components in pathological processes. MMP-9 is involved predominantly in the inflammatory process during muscle degeneration.²⁴ In contrast, MMP-2 is associated with ECM remodeling during muscle regeneration and fiber growth.

3. AAV-mediated transduction of animal models

3.1. Vector Production

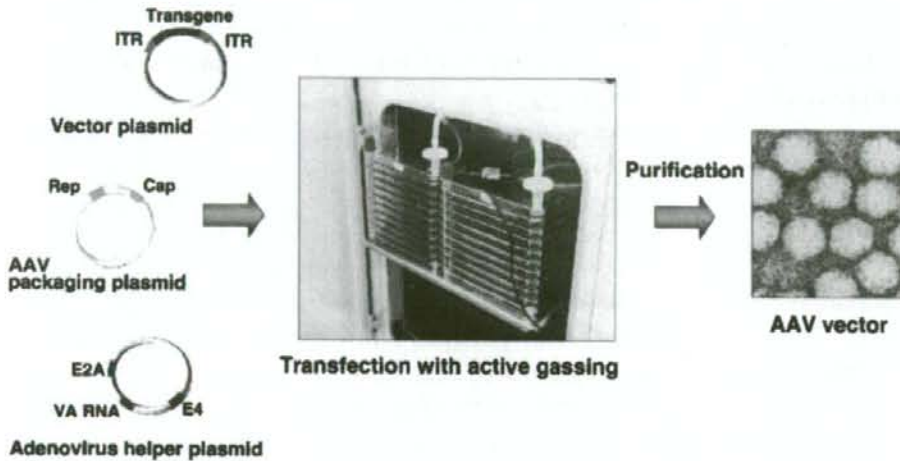


Fig. 3. A scalable triple plasmid transfection system using active gassing. When adenovirus helper plasmid is co-transfected into human embryonic kidney 293 cells along with a vector plasmid encoding the AAV vector and an AAV packaging plasmid harboring *rep-cap* genes, the AAV vector is produced as efficiently as when using adenovirus infection. A large-scale transduction method to produce AAV vectors with an active gassing system makes use of large culture vessels for labor- and cost-effective transfection in a closed system. Samples containing vector particles are further purified with a two-tier CsCl gradient or dual ion-exchange chromatography to obtain highly purified vector particles.

To gain acceptance as a medical treatment with a dose of over 1×10^{13} genome copies (g.c.)/kg body weight, AAV vectors require a scalable and economical production method. A production protocol of AAV vectors in the absence of a helper virus²⁵ is widely employed for triple plasmid transduction of human embryonic kidney 293 cells.⁴ The adenovirus regions that mediate AAV vector replication (namely, the VA, E2A and E4 regions) were assembled into a helper plasmid. When this helper plasmid is co-transfected into human embryonic kidney 293 cells along with plasmids encoding the AAV vector genome and *rep-cap* genes, the AAV vector is produced as efficiently as when using

adenovirus infection (Figure 3). Importantly, contamination of most adenovirus proteins can be avoided in AAV vector stock made by this helper virus-free method. Samples containing vector particles are further purified with a two-tier CsCl gradient or dual ion-exchange chromatography to obtain highly purified vector particles.⁴

Despite improvements in vector production, including the development of packaging cell lines expressing Rep/Cap, and of methods that induce the expression and regulation of Rep/Cap,²⁶ maintaining such cell lines remains difficult, as the early expression of Rep proteins is toxic to cells. A scalable method, using active gassing and large culture vessels, was developed to transfect rAAV in a closed system, in a labor- and cost-effective manner.²⁷ This vector production system achieved a yield of more than 5×10^{13} g.c./flask by improving gas exchange to maintain the physiological pH in the culture medium. Recent developments also suggest that AAV vector production in insect cells would be compatible with current good manufacturing practice production on an industrial scale.²⁸

3.2. Animal Models for the Gene Transduction Study

Dystrophin-deficient canine X-linked muscular dystrophy was found in a golden retriever with a 3' splice-site point mutation in intron 6.²⁹ The clinical and pathological characteristics of dystrophic dogs are more similar to those of DMD patients than are those of *mdx* mice. A beagle-based model of canine X-linked muscular dystrophy, which is smaller and easier to handle than the golden retriever-based muscular dystrophy dog (GRMD) model, has been established in Japan, and is referred to as CXMD_J.³⁰ The limb and temporal muscles of CXMD_J are affected by two-months-old, which is the age corresponding to the second peak of serum creatine kinase.

Interestingly, we found extensive lymphocyte-mediated immune responses to rAAV2-*lacZ* after direct intramuscular injection into CXMD_J dogs, despite successful delivery of the same viral construct into mouse skeletal muscle.³¹ In contrast to rAAV2, rAAV8-mediated transduction of canine skeletal muscles produced significantly higher transgene expression with less lymphocyte proliferation than rAAV2.³²

It is increasingly important to develop strategies to treat DMD that consider the effect on cardiac muscle. The pathology of the conduction system in CXMD_J was analyzed to establish the therapeutic target for DMD.³³ Although dystrophic changes of the ventricular

myocardium were not evident at the age of 1 to 13 months, Purkinje fibers showed remarkable vacuolar degeneration when dogs were as young as four-months-old. Furthermore, degeneration of Purkinje fibers was coincident with overexpression of Dp71 at the sarcolemma. The degeneration of Purkinje fibers could be associated with the distinct deep Q waves present in ECGs and the fatal arrhythmias seen in cases of dystrophin deficiency.³³

3.3. Immunological Issues of rAAV

Neo-antigens introduced by AAV vectors evoke significant immune reactions in DMD muscle, since increased permeability of sarcolemma allows leakage of the transgene products from the dystrophin-deficient muscle fibers.³⁴ rAAV2 transfer into skeletal muscles of normal dogs resulted in low and transient expression, together with intense cellular infiltration, and the marked activation of cellular and humoral immune responses.³¹ Furthermore, an *in vitro* interferon-gamma release assay showed that canine splenocytes respond to immunogens or mitogens more strongly than do murine splenocytes. In fact, co-administration of immunosuppressants, cyclosporine (CSP) and mycophenolate mofetil (MMF) improved rAAV2 transduction. The AAV2 capsids can induce a cellular immune response via MHC class I antigen presentation with a cross-presentation pathway, and rAAV2 has also been proposed to have an effect on human dendritic cells (DCs). In contrast, other serotypes, such as rAAV8, induced T-cell activation to a lesser degree.³² Immunohistochemical analysis revealed that the rAAV2-injected muscles showed higher rates of infiltration of CD4⁺ and CD8⁺ T lymphocytes in the endomysium than the rAAV8-injected muscles.³²

Resident antigen-presenting cells, such as DCs, myoblasts, myotubes and regenerating immature myofibers, might play a role in the immune response. A recent study also showed that mRNA levels of MyD88 and co-stimulating factors, such as CD80, CD86 and type I interferon, are elevated in both rAAV2- and rAAV8-transduced dog DCs *in vitro*.³² A brief course of immunosuppression with a combination of anti-thymocyte globulin (ATG), CSP and MMF was effective in permitting AAV6-mediated, long-term and robust expression of a canine micro-dystrophin in the skeletal muscle of a dog DMD model.³⁵

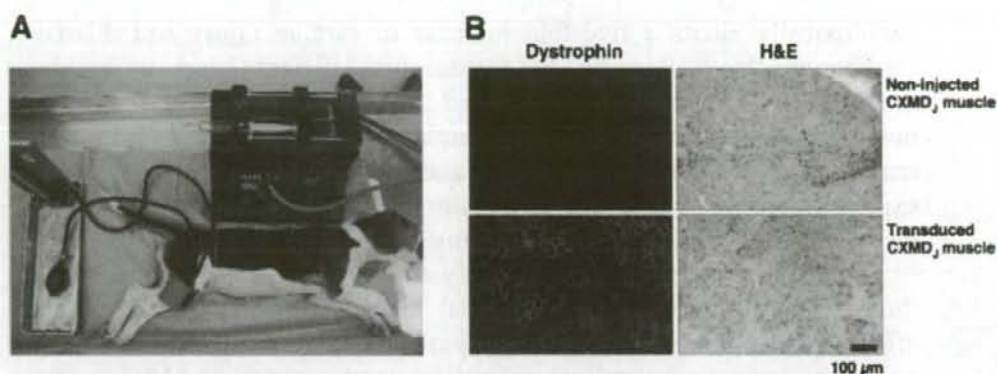


Fig. 4. Intravascular vector administration by limb perfusion. (A) A blood pressure cuff is applied just above the knee of an anesthetized CXMD_j dog. A 24-gauge intravenous catheter is inserted into the lateral saphenous vein, connected to a three-way stopcock, and flushed with saline. With a blood pressure cuff inflated to over 300 mmHg, saline (2.6 ml/kg) containing papaverine (0.44 mg/kg, Sigma-Aldrich, St. Louis, MO) and heparin (16 U/kg) is injected by hand over a 10 second period. The three-way stopcock is connected to a syringe containing rAAV8 expressing micro-dystrophin (1×10^{14} vg/kg, 3.8 ml/kg). The syringe is placed in a PHD 2000 syringe pump (Harvard Apparatus, Edenbridge, UK). Five minutes after the papaverine/heparin injection, rAAV8 is injected at a rate of 0.6 ml/sec. (B) Administration of rAAV8-micro-dystrophin by limb perfusion produces extensive transgene expression in the distal limb muscles of CXMD_j dogs without obvious immune responses at four weeks after injection.

3.4. Intravascular Vector Administration by Limb Perfusion

Although recent studies suggest that vectors based on AAV are capable of body-wide transduction in rodents, translating this finding into large animals remains a challenge. Intravascular delivery can be performed as a form of limb perfusion, which might bypass the immune activation of DCs in the injected muscle.³² We performed limb perfusion-assisted intravenous administration of rAAV8-lacZ into the hind limb of normal dogs and rAAV8-micro-dystrophin into the hind limb of CXMD_j dogs (Figure 4).³² Administration of rAAV8-micro-dystrophin by limb perfusion produced extensive transgene expression in the distal limb muscles of CXMD_j dogs without obvious immune responses for as long as eight weeks after injection.

3.5. Global Muscle Therapies

In comparison with fully dystrophin-deficient animals, targeted transgenic repair of skeletal muscle, but not cardiac muscle,

paradoxically elicits a five-fold increase in cardiac injury and dilated cardiomyopathy.³⁶ Because the dystrophin-deficient heart is highly sensitive to increased stress, increased activity by the repaired skeletal muscle provides the stimulus for heightened cardiac injury and heart remodeling. In contrast, a single intravenous injection of AAV9 vector expressing micro-dystrophin efficiently transduces the entire heart in neonatal *mdx* mice, thereby ameliorating cardiomyopathy.³⁷

Since a number of muscular dystrophy patients can be identified through newborn screening, neonatal transduction may lead to an effective early intervention in DMD patients. After a single intravenous injection, robust skeletal muscle transduction with AAV9 vector throughout the body was observed in neonatal dogs.³⁸ Systemic transduction was achieved in the absence of pharmacological intervention or immune suppression and lasted for at least six months, whereas cardiac muscle was barely transduced in the dogs.

4. Safety and Potential Impact of Clinical Trials

The initial clinical studies lay the foundation for future studies, providing important information about vector dose, viral serotype selection, and immunogenicity in humans. The first virus-mediated gene transfer for muscle disease was carried out for limb-girdle muscular dystrophy type 2D using rAAV1. The study, consisting of intramuscular injection of virus into a single muscle, was discharged to establish the safety of this procedure in phase I clinical trials.³⁹ The first clinical gene therapy trial for DMD began in March 2006.³⁹ This was a Phase I/IIa study in which an AAV vector was used to deliver micro-dystrophin to the biceps of boys with DMD. The study was conducted on six boys with DMD, each of whom was transduced with mini-dystrophin genes in a muscle of one arm in the absence of serious adverse events.

While low immunogenicity was considered a major strength supporting the use of rAAV in clinical trials, a number of observations have recently provided a more balanced view of this procedure.⁴⁰ An obvious barrier to AAV transduction is the presence of circulating neutralizing antibodies that prevent the virion from binding to its cellular receptor.⁴¹ This potential threat can be reduced by prescreening patients for AAV serotype-specific neutralizing antibodies or by performing procedures such as plasmapheresis before gene transfer. Another challenge recently revealed is the development of a cell-mediated cytotoxic T-cell (CTL) response to AAV capsid peptides. In the human

factor IX gene therapy trial in which rAAV was delivered to the liver, only short-term transgene expression was achieved and levels of therapeutic protein declined to baseline levels 10 weeks after vector infusion.⁴⁰ This was accompanied by elevation of serum transaminase levels and a CTL response toward specific AAV capsid peptides. To overcome this response, transient immunosuppression may be required until AAV capsids are completely cleared. Additional findings suggest that T-cell activation requires AAV2 capsid binding to the heparan sulfate proteoglycan (HSPG) receptor, which would permit virion shuttling into a DC pathway, as cross-presentation.⁴² Exposure to vectors from other AAV clades, such as AAV8, did not activate capsid-specific T-cells.

5. Challenges and limitations of related strategies

5.1. Design of Read-through Drugs

To suppress premature stop codon mutations, treatments involving aminoglycosides and other agents have been attempted. PTC124, a novel drug capable of suppressing premature termination and selectively inducing ribosomal read-through of premature, but not normal, termination codons, was recently identified using nonsense-containing reporters.⁴³ The selectivity of PTC124 for premature termination codons, its oral bioavailability and its pharmacological properties indicate that this drug may have broad clinical potential for the treatment of a large group of genetic disorders with limited or no therapeutic options.

5.2. Modification of mRNA Splicing

By inducing the skipping of specific exons during mRNA splicing, antisense compounds against exonic and intronic splicing regulatory sequences were shown to correct the open reading frame of the DMD gene and thus to restore truncated yet functional dystrophin expression *in vitro*.⁴⁴ Intravenous infusion of an antisense phosphorothioate oligonucleotide created an in-frame *dystrophin* mRNA via exon skipping in a 10-year-old DMD patient possessing an out-of-frame exon 20 deletion of the *dystrophin* gene.⁴⁵ Moreover, the adverse-event profile and local dystrophin-restoring effect of a single intramuscular injection of an antisense 2'-O-methyl phosphorothioate oligonucleotide, PRO051, in patients with DMD were explored.⁴⁶ Four patients received a dose of 0.8 mg of PRO051 in the TA muscle. Each patient showed specific

skipping of exon 51 of dystrophin in 64 to 97% of myofibers, without clinically apparent adverse side effects.

The efficacy and toxicity of intravenous injection of stable morpholino phosphorodiamidate (morpholino)-induced exon skipping were tested using CXMD₁ dogs, and widespread rescue of dystrophin expression to therapeutic levels was observed.⁴⁷ Furthermore, a morpholino oligomer with a designed cell-penetrating peptide can efficiently target a mutated *dystrophin* exon in cardiac muscles.⁴⁸

Long-term benefits can be obtained through the use of viral vectors expressing antisense sequences against regions within *dystrophin* gene. The sustained production of dystrophin at physiological levels in entire groups of muscles as well as the correction of muscular dystrophy were achieved by treatment with exon-skipping AAV1-U7.⁴⁹

5.3. Ex Vivo Gene Therapy

Transplantation of genetically corrected autologous myogenic cells is a possible treatment for DMD. Freshly isolated satellite cells transduced with lentiviral vectors expressing micro-dystrophin were transplanted into the TA muscles of *mdx* mice, and these cells efficiently contributed to the regeneration of muscles with micro-dystrophin expression at the sarcolemma.⁵⁰ Mesoangioblasts are vessel-associated stem cells and might be candidates for future stem cell therapy for DMD.⁵¹ Intra-arterial delivery of wild-type canine mesoangioblasts resulted in the extensive recovery of *dystrophin* expression, normal muscle morphology and function in the GRMD. Multipotent mesenchymal stromal cells (MSCs) are less immunogenic and have the potential to differentiate and display a myogenic phenotype.⁵²

6. Future perspectives

6.1. Pharmacological Intervention

The use of a histone deacetylase (HDAC) inhibitor would likely enhance the utility of rAAV-mediated transduction strategies in the clinic.⁵³ In contrast to adenovirus-mediated transduction, the improved transduction with rAAV induced by the HDAC inhibitor is due to enhanced transgene expression rather than to increased viral entry. The enhanced transduction was proposed to be related to the histone-associated chromatin form of the rAAV concatemer in transduced cells. Since various HDAC inhibitors are currently being tested in clinical trials for

many diseases, the use of such agents in rAAV-mediated DMD gene therapy is theoretically and practically reasonable.

6.2. Capsid modification

A DNA shuffling-based approach for developing cell type-specific vectors is an intriguing possibility to achieve altered tropism. Capsid genomes of AAV serotypes 1-9 were randomly reassembled using PCR to generate a chimeric capsid library.⁵⁴ A single infectious clone (chimeric-1829) containing genome fragments from AAV1, 2, 8, and 9 was isolated from an integrin minus hamster melanoma cell line previously shown to have low permissiveness to AAV.

7. Conclusions and Outlook

DMD remains an untreatable genetic disease that severely limits motility and life expectancy in affected children. The systemic delivery of rAAV to transduce truncated dystrophin is predicted to ameliorate the symptoms of DMD patients in the future. To translate gene transduction technologies into clinical practice, development of an effective delivery system with improved vector constructs as well as efficient immunological modulation must be established. A novel protocol that considers all of these issues would help improve the therapeutic benefits of DMD gene therapy.

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