Insulin independence after living-donor distal pancreatectomy and islet allotransplantation

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Rising demand for islet transplantation will lead to severe donor shortage in the near future, especially in countries where cadaveric organ donation is scarce. We undertook a successful transplantation of living-donor islets for unstable diabetes. The recipient was a 27-year-old woman who had had brittle, insulin-dependent diabetes mellitus for 12 years. The donor, who was a healthy 56-year-old woman and mother of the recipient, underwent a distal pancreatectomy. After isolation, 408 114 islet equivalents were transplanted immediately. The transplants functioned immediately and the recipient became insulin-independent 22 days after the operation. The donor had no complications and both women showed healthy glucose tolerance. Transplantation of living-donor islets from the distal pancreas can be sufficient to reverse brittle diabetes.

Since the success of islet transplantation in 2000,[1] demand for the procedure has risen substantially and donors will soon be in very short supply. Islet transplantation from living donors represents an alternative approach to expand the potential donor pool, particularly in countries such as Japan where access to cadaveric organ donors is especially scarce.[2] We report a successful procedure of living-donor transplantation of islets for unstable diabetes that was undertaken at Kyoto University Hospital on Jan 19, 2005. This study was approved by the ethics committee of the Kyoto University Graduate School and Faculty of Medicine, Japan.

The donor was a healthy 56-year-old woman who was the mother of the recipient and blood-group compatible. To keep to a minimum the risk of impaired glucose tolerance in the donor, and after lessons learned previously by a US study group[3] in living-donor segmental pancreas transplantation, we ensured that: our donor was not obese (body-mass index <25 kg/m^2), she had a healthy glucose pattern and insulinogenic index (ie, [peak insulin–basal insulin]/[blood glucose at peak insulin–blood glucose at basal insulin]) during an oral glucose tolerance test (OGTT), and autoantibody concentrations for GAD (glutamic acid decarboxylase) and insulin were negative.[3] Our donor's insulinogenic index was more than 0·5, and her haemoglobin (Hb) A1c value was less than 5·6%, which met our criteria.

The recipient was a 27-year-old woman who developed chronic pancreatitis aged 4 years and developed insulin-dependent diabetes at age 15 years. Every 2 days, she had hypoglycaemic episodes of which she was unaware, so she was admitted to control her blood glucose. The main aim of this transplantation was to eliminate these frequent hypoglycaemic episodes.

The recipient's glycaemia was very unstable before transplantation (figure 1). Blood C-peptide concentrations were negative after glucagon stimulation, and HbA1c was 9·9%. The recipient was using a mean of 28 U (SD 2) of insulin per day (0·56 U/kg per day). She did not have any renal or retinal complications.

The donor underwent a distal pancreatectomy in which the pancreatic transection plane was made to the left of the portal vein. The pancreatic tail was used for islet isolation.[2] We flushed the resected pancreas graft immediately and protected the main pancreatic duct of the resected pancreas graft by ductal injection.[4] The graft was transported on two-layer preservation,[5] and the cold ischaemic time lasted for 44 min. Islet isolation was done under GMP (good manufacturing practice) conditions in the cell-processing centre of Kyoto University Hospital. Based on the Ricordi method,[5] the pancreas was digested with liberase (Roche Molecular Biochemicals, Indianapolis, IN, USA) containing trypsin inhibitors. Islet purification was avoided because the total tissue volume was less than 10 mL (9·5 mL). Total islet yield was 408 114 islet equivalents (islet viability 99%). The insulin stimulation index after static incubation[5] was 27·4. We transplanted isolated islets into the recipient's liver via access to percutaneous portal vein under local anaesthesia shortly after islet processing was completed.

Although the recipient's response after transplantation was uneventful, temporal bone-marrow suppression (ie, reduction of white blood cells in transit) and increase of liver-enzyme concentrations took place. Both values returned to normal amounts within 1 month. The recipient received sirolimus and tacrolimus treatment 7 days before transplantation to achieve stable target therapeutic values (sirolimus 12–15 mg/L, tacrolimus 4–6 mg/L). Basiliximab (20 mg) was given 4 days before transplantation and repeated on the day of transplantation, and infliximab (5 mg/kg) given 1 day before transplantation.

After transplantation, daily blood glucose was tightly controlled with positive C-peptide (figure 1). We gradually weaned insulin dosage and the recipient became insulin-independent from the 22nd day after transplantation. She has now been insulin-independent for 2 months. She was discharged 37 days after

transplantation with a normal OGTT result (figure 2A) and an insulinogenic index of 0·58 mU/L (figure 2B). The donor's postoperative clinical course was uneventful. She was discharged 18 days after the operation. 37 days after transplantation, the donor's OGTT result was healthy (figure 2A), and her insulinogenic index was 0·77 mU/L (figure 2B).

Historically, two previous attempts at transplantation of living-donor islets were done at the University of Minnesota, MN, USA;[6] however, these events were unsuccessful. Compared with cadaveric pancreas donation, islets from living donors can greatly improve functional viability because of several advantages: there is no exposure to islet-toxic proinflammatory cytokines derived from brain injury, the pancreas can be retrieved under ideal conditions without haemodynamic instability, cold ischaemic injury can be reduced to an absolute minimum, and close matching of human leucocyte antigens (HLA) between donors and recipients might reduce the risk of rejection.

As with all types of transplantations with living donors, donor safety is of great concern. In fact, 3–5% of complications in living donors were reported for segmental pancreas transplantation, including pancreatic fistula, pancreatitis, wound infection, and bleeding, and 3% for relaparotomy.[3] Although no deaths and life-threatening complications occurred in these 130 living pancreas donors,[3] pancreatectomy should still be undertaken safely. Donation of half the pancreas has the potential to induce new diabetes in a healthy donor, which has arisen previously.[3] The risk of diabetes can be reduced substantially if the donor is not obese, the donor islet autoantibody status is negative, and the donor OGTT result is healthy, but these precautions might not eliminate the risk entirely. Even if obese donors have suitable islet masses, surgeons should avoid obese donors for their future health.

A reliable method of islet isolation is critical for living-donor transplantation. To ensure the best conditions after pancreas procurement, we used the two-layer pancreas preservation,[5] ductal pre-injection,[4] and the Ricordi isolation method, with additional use of trypsin inhibitors.[5] As a result of these procedures, we could obtain 12 transplantable islet preparations from 13 cases of pancreata from donors who had died from cardiac arrest in our programme in Japan.

Since transplantation, our recipient has achieved insulin independence and remains insulin-free with excellent glycaemic control. The metabolic effect of this living islet transplant, derived from just half a living pancreas, seems similar to that achieved from the use of two or more whole pancreas isolations in our programme of cadaveric islet transplantation. The difference in organ requirements probably indicates the improved potency of islets prepared from living donors. Because the recipient did not have autoimmune type 1 diabetes, the transplanted islets did not need protection against autoimmune disease. This factor might have been important for the success of this transplantation.

Islet transplantation is only currently applicable for adults because of the potential side-effects of immunosuppressants. Until safe immunosuppressants are available, transplantation of living-donor islets should not be undertaken for children.[7] For islet transplants to become a widespread clinical reality, diabetes reversal needs to be achieved with one donor only, to reduce risks and costs and to increase the availability of transplantation.[8] Our successful transplantation might have implications for the ongoing transition of the procedure, from clinical investigation to routine clinical care.

Long-term follow-up is important because data[9] have suggested a substantial rate of loss in insulin

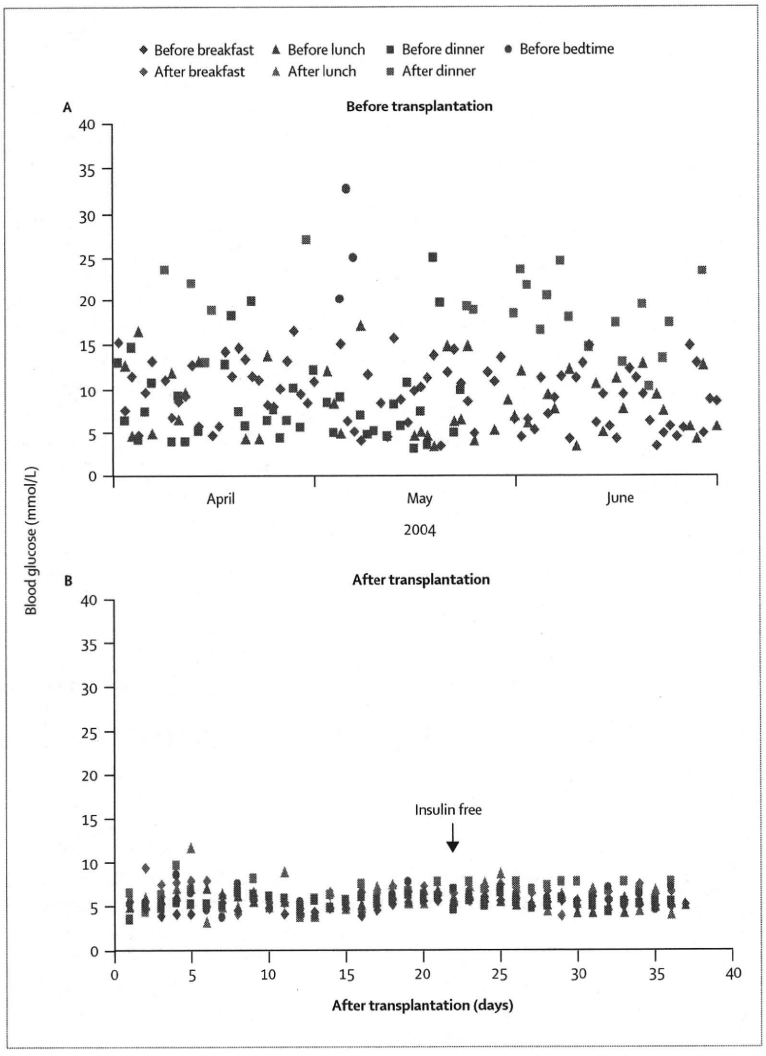

Figure 1: **Daily blood glucose before and after islet transplantation**

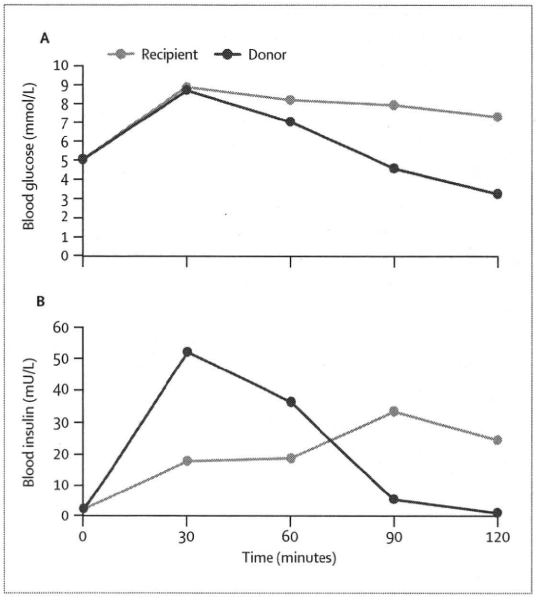

Figure 2: **Concentrations of blood glucose (A) and insulin (B) measured during OGTT**

independence over time. However, the survival of islets that are positive for C-peptide and the good control of glycaemia can both be maintained in more than 80% of individuals 5 years after transplantation.[9] Therefore, we postulate that living-donor islets might survive relatively long (at least for 5 years), and that our recipient would be free from hypoglycaemic unawareness episodes even if she needs insulin injections in the future.

In conclusion, from our successful transplantation of living-donor islets for the treatment of unstable diabetes, our recipient achieved and maintained insulin independence after the procedure. We believe that such transplantation of living-donor islets can be an additional option in the treatment of insulin-dependent diabetes.

Contributors

S Matsumoto participated in the study conception and design, acquisition of data, analysis and interpretation of data, and drafting of the article. T Okitsu, Y Iwanaga, H Noguchi, H Nagata, Y Yonekawa, Y Yamada, and K Tanaka participated in the study conception and design and acquisition of data. K Fukuda, K Tsukiyama, H Suzuki, Y Kawasaki, M Shimodaira, K Matsuoka, T Shibata, Y Kasai, T Maekawa, and A M J Shapiro participated in the acquisition of data. All authors revised the article critically for intellectual content.

Conflict of interest statement

We declare that we have no conflict of interest.

Acknowledgments

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Combined therapy with somatostatin analogues and weekly pegvisomant in active acromegaly

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Pegvisomant monotherapy once daily returns concentrations of insulin-like growth factor I (IGF-I) to normal in most patients with acromegaly, but is very costly. In a 42-week dose-finding study, we assessed the efficacy of the combination of long-acting somatostatin analogues once monthly and pegvisomant once weekly in 26 patients with active acromegaly. Dose of pegvisomant was increased until IGF-I concentration became normal or until a weekly dose of 80 mg was reached. IGF-I reached normal concentrations in 18 of 19 (95%) patients who completed 42 weeks of treatment, with a median weekly dose of 60 mg pegvisomant (range 40–80). No signs of pituitary tumour growth were noted, but mild increases in liver enzymes were observed in ten patients (38%). This combined treatment is effective, might increase compliance, and could greatly reduce the costs of medical treatment for acromegaly in some patients.

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The effects of cardioactive drugs on cardiomyocytes derived from human induced pluripotent stem cells

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ABSTRACT

Developing effective drug therapies for arrhythmic diseases is hampered by the fact that the same drug can work well in some individuals but not in others. Human induced pluripotent stem (iPS) cells have been vetted as useful tools for drug screening. However, cardioactive drugs have not been shown to have the same effects on iPS cell-derived human cardiomyocytes as on embryonic stem (ES) cell-derived cardiomyocytes or human cardiomyocytes in a clinical setting. Here we show that current cardioactive drugs affect the beating frequency and contractility of iPS cell-derived cardiomyocytes in much the same way as they do ES cell-derived cardiomyocytes, and the results were compatible with empirical results in the clinic. Thus, human iPS cells could become an attractive tool to investigate the effects of cardioactive drugs at the individual level and to screen for individually tailored drugs against cardiac arrhythmic diseases.

Introduction

The long-QT syndrome (LQTS) is characterized by an abnormal prolongation of the QT-interval on the ECG and an increased risk of sudden death, due to ventricular fibrillation known as Torsade de Pointes (TdP) [1]. In a previous study [2], four patients died suddenly (1.3% per year) during an average follow-up period of 26 months per patient and among 196 idiopathic LQTS patients, 27 experienced one or more syncopal episodes (8.6% per year). Molecular genetic studies have revealed several forms of congenital LQTS caused by mutations in genes coding for potassium, sodium and calcium channels or membrane adapters [3–6]. Preliminary clinical studies have since suggested the feasibility of performing genotype-specific therapy with therapeutic agents that abbreviate the QT-interval [7]. But it is difficult to select the correct drug because within the same LQTS subtype, the same drug can sometimes have different effects depending on the patient.

Furthermore, the diagnosis of LQTS subtypes is difficult. Genetic testing can only identify 50–75% of probands [8]. So an epinephrine challenge is needed in some patients to diagnose LQTS in a clinical setting [9]. However, this test sometimes induces TdP, so it must be done under careful patient surveillance.

The generation of iPS cells from human fibroblast using a combination of 4 transcription factors (*Oct3/4*, *Sox2*, *Klf4*, and *c-Myc*) has opened remarkable new avenues for not only basic research but also regenerative medicine, understanding of disease mechanisms, drug screening, and toxicology [10]. A recent study reported the generation of disease-specific iPS cell lines from patients with a variety of diseases [11]. If patient-specific iPS cells could be commonly generated and employed in a clinical setting, they could become a useful tool for selecting the best drug for individual LQTS patients.

But there has been no report that cardiomyocytes derived from human iPS cells respond to drugs in the same way as human cardiomyocytes. It is important to investigate whether cardiomyocytes derived from human iPS cells react to drugs in the same way as human cardiomyocytes, if patient-specific iPS cells are to be used in a clinical setting for drug screening. Previous studies have hinted that some drugs produce the same effects in cardiomyocytes as in cardiomyocytes derived from ES cells [12–14]. In this study, we investigated whether cardiomyocytes derived human iPS cells responded to drugs in the same way as in cardiomyocytes derived from human ES cells with respect to beating frequency and contractility, and we compared these results with previously described clinical empirical results [15].

Materials and methods

Human iPS and human ES cell culture. We used human ES cell line, KhES1, and human iPS cell lines 201B7. Human iPS cells and human ES cells were maintained on mitomycin-C (Kyowa Hakkoh)

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treated mouse embryonic fibroblasts (MEFs) or SNLs on cell culture dishes. In brief, both human iPS and human ES cells were maintained in DMEM/F12 culture medium (SIGMA) supplemented with 20% knock-out serum replacement (Gibco), 0.1 mmol/L nonessential amino acids (Gibco), 4 mmol/L L-glutamine, 0.8 μmol/L basic fibroblast growth factor (bFGF) (Invitrogen).

Embryoid body formation and cardiac differentiation. Colonies were detached from cell culture dishes by incubating them with PBS containing 0.25% trypsin (Gibco) and 1 mg/mL collagenase I (Worthington) at 37 °C for 3–4 min. The cells were then placed in petri dishes (Sterilin) in suspension cultures for 7 days with maintenance medium supplemented with 5 ng/ml bFGF. Embryoid bodies (EBs) were then plated on 0.1% gelatin-coated 6-well culture plates (BD Biosciences) and cultured in cardiac differentiation medium, consisting of alpha MEM (Gibco) supplemented with 0.5 μmol/L 2ME and 10% FCS (Hyclone) (changed once every 7 days). Contractile colonies appeared 15–25 days after plating on gelatin-coated dishes (Fig. 1A).

Reverse transcriptase polymerase chain reaction (RT-PCR). Total RNA was isolated using TRIzol Reagent (Invitrogen) from undifferentiated iPS cells, EBs derived from human iPS cells, the contracting areas of differentiated human iPS cells, and human right ventricular tissue (obtained by a tetralogy of Fallot patient that had received a right flow ventricular tract ventriculotomy). Total RNA was used for oligo (dT) 12–18-primed reverse transcription using the Super Script II First-Strand Synthesis System (Invitrogen). RT-PCR was carried out using Ex Taq (TAKARA BIO). PCR conditions included denaturation at 94 °C for 30 s, annealing at 60 °C for 30 s, and extension at 55–65 °C for 1 min for 25–35 cycles, with a final extension at 72 °C for 7 min. Primers used are listed in Table 3.

Immunohistochemistry. Contractile colonies were partitioned into small particles using collagenase I (Worthington) for 2 h at 37 °C. The cells were then washed and plated on 6-well culture plates coated with 0.1% gelatin for 2 or 3 days to allow attachment. Cells were fixed in 4% paraformaldehyde for 15 min at 4 °C. Then the cells were incubated with primary antibodies, such as polyclonal anti-cardiac Troponin I (IgG, 1:50 dilution; Santa Cruz Biotechnology), polyclonal anti-MLC2v (IgG, 1:50 dilution; Santa Cruz Biotechnology), or polyclonal anti-ANP (IgG, 1:250 dilution; Chemicon) in 2% skim milk with 0.1% Triton X-100 overnight at 4 °C. Secondary antibodies were cyanine 3 (Cy3)-conjugated donkey anti-rat IgG (1:200 dilution; Jackson Immunoresearch), Cy3-conjugated donkey anti-rabbit IgG (1:200 dilution; Jackson Immunoresearch), and Cy3-conjugated donkey anti-goat IgG (1:200 dilution; Jackson Immunoresearch). Nuclei were counter-stained with Hoechst 33342 (Molecular probes).

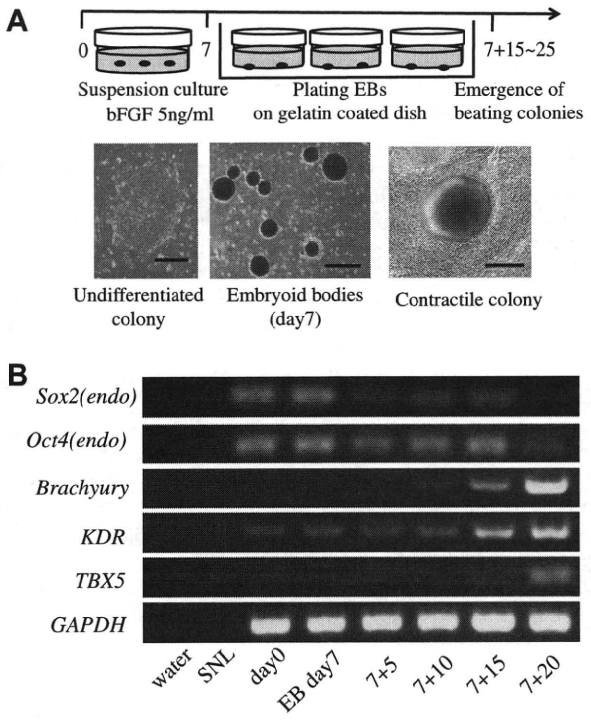

Fig. 1. An outline of the protocol used for the differentiation of human iPS cells and human ES cells. Scale bars = 200 μm (A). Time course analysis of immature gene expression, mesodermal markers, and cardiac progenitor markers during differentiation (B).

Electrophysiological examination. Microelectrode arrays analysis was performed to investigate the electrophysiological potential of cardiomyocytes derived from human iPS cells using the MED 64 system (Alpha MED Sciences) [16–18]. Micro-dissected contracting areas were plated on MED-probe dishes (Alpha MED Sciences) followed by incubation for 3–7 days to allow attachment. The potentials of the contractile colonies derived from these cells were then recorded.

Drug loading test. Differentiation medium was replaced with alpha MEM containing 10 mmol/L HEPES buffer (Nacalai tesque), 7 mol/L NaCl, and 0.5 μmol/L 2ME, which was adjusted to pH 7.4 with NaOH. After 10 min incubation at 37 °C, the frequency and contractility of the contractile colonies were measured in a movie recorded by a VB 7000 (KEYENCE) camera under drug-free medium conditions as well as under drug conditions with three different drug concentrations. Beating colonies were selected when the beating rate was 40/min to 60/min under drug-free medium conditions. Colonies whose contractile motion was distended were excluded. Loading drugs were as follows; isoproterenol (SIGMA), adrenaline (Dai-ichi Sankyo), propranolol (SIGMA), procainamide (Dai-ichi Sankyo), mexiletine (Boehringer Ingelheim), flecainide (Eisai), verapamil (SIGMA), and amiodarone (Sanofi-aventis).

Analysis of beating rate and contractility. Beating rates were counted based on the video recordings. Recently, some papers reported that video-edge detecting systems are useful for calculating the contractility of contractile colonies [12]. We imitated this method and calculated the contractility of colonies. In brief, we extracted the still images of systolic phase and diastolic phase from the recorded video images. The major axis of each phase was measured and the contractile index was defined as $a - b/a$ (a: length of diastolic phase, b: the length of systolic phase) (Fig. 4A).

Statistics. Data are presented as means ± SEM. Statistical significance was determined by the unpaired t-test for two samples and one-way ANOVA followed by the Scheffe test for more than three samples. P values <0.05 were considered to be statistically significant.

Results

Time course analysis of gene expression during cardiac differentiation

First, we examined the time course of gene expression during cardiac differentiation of human iPS cells by RT-PCR to compare it with that of normal embryogenesis (Fig. 1B). Undifferentiated human iPS cells strongly expressed endogenous *Oct4* and *Sox2*, which are undifferentiated cell markers, but did not express the mesodermal marker *Brachyury* or the cardiac progenitor marker *TBX5* (Fig. 1B). *KDR* was weakly expressed. These results show that undifferentiated human iPS cells have similar properties to undifferentiated human ES cells [19]. Endogenous *Oct4* and *Sox2* expression gradually decreased during culture in differentiation medium. The

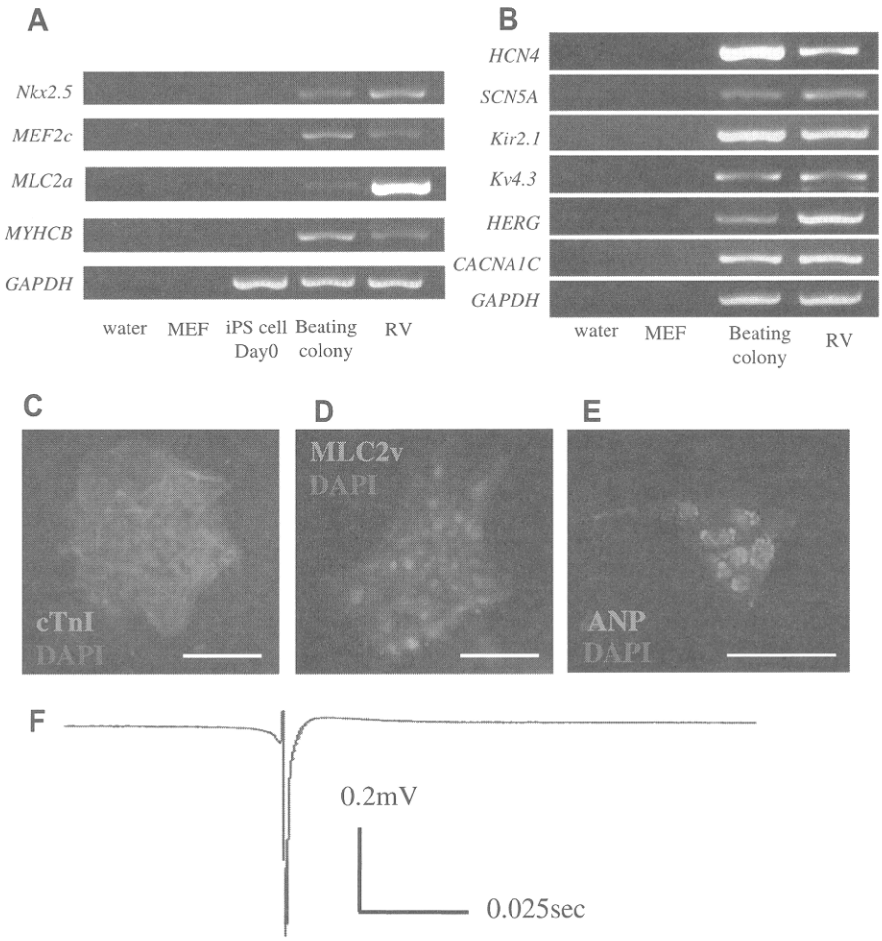

Fig. 2. Gene expression analyses of cardiac markers by RT-PCR (A). Gene expression analysis of ion channel related genes (B). Immunohistochemistry of contractile colonies. Colonies were stained with cTnI (C), MLC2v (D), or ANP (E). Scale bars = 100 μm. Field potentials of contractile colonies measured by the MED 64 system (F).

expression of the mesodermal marker *Brachyury* increased from day 10 after EB formation. The expression of *KDR* also gradually increased from day 10 after EB formation. These patterns of mesodermal marker expression are compatible with those of human ES cells as previously described [19]. The cardiac progenitor marker *TBX5* was expressed from day 20 after EB formation, which is compatible with the gene expression patterns seen during cardiac formation in embryogenesis and human ES cell differentiation as previously described [19]. The result additionally suggests that human iPS cells differentiated into the mesodermal lineage and then differentiated into contractile colonies via cardiac progenitor cells.

Cardiac differentiation of human iPS cells via EBs

Next, we examined the contractile colonies consisting of cardiac-specific cells. Contractile colonies were observed from 15 to 25 days after EB formation both in human iPS and human ES cell populations. This result demonstrates that our differentiation methods could generate contractile colonies from both human iPS cells and human ES cells. Next, we investigated whether these contractile colonies were human cardiomyocytes. For this purpose, we carried out RT-PCR and examined for the expression of cardiac cell markers. RT-PCR showed that contractile colonies expressed cardiac markers *Nkx2.5*, *MEF2c*, *MLC2a*, and *MYHCB* (Fig. 2A). Moreover, we carried out immunohistochemical analysis to confirm that the contractile colonies were human cardiomyocytes. Contractile colonies were stained by the cardiac cell marker, cTnI, the ventricular cell marker, MLC2v, and the atrial cell marker, ANP. The colonies were also stained by cTnI, and some of them were stained by MLC2v or ANP (Fig. 2C–E). These results of immunohistochemical analysis confirmed that the contractile colonies were indeed human cardiomyocytes.

Electrical analysis of contractile colonies

To investigate whether the contractile colonies that expressed cardiac markers were electrically functional cardiac colonies, we measured their electrical potentials by microelectrode array analysis using the MED 64 system (Alpha MED Sciences) [16–18]. The field potentials of the contractile colonies were comparable to those of cardiomyocytes derived from human ES cells as previously reported (Fig. 2F) [16–18]. Moreover, RT-PCR showed that these cells expressed the If channel (*HCN4*), the L-type calcium channel (*CACNA1C*), the sodium channel (*SCN5A*), the inward rectifier (*Kir2.1*), the transient outward channel (*Kv4.3*), and the delayed rectifier IKr (*HERG*) (Fig. 2B).

Effects of drugs on the beating frequency of cardiomyocytes derived from human iPS cells

We next investigated whether the cardiomyocytes derived from iPS cells reacted with cardioactive drugs in the same manner as

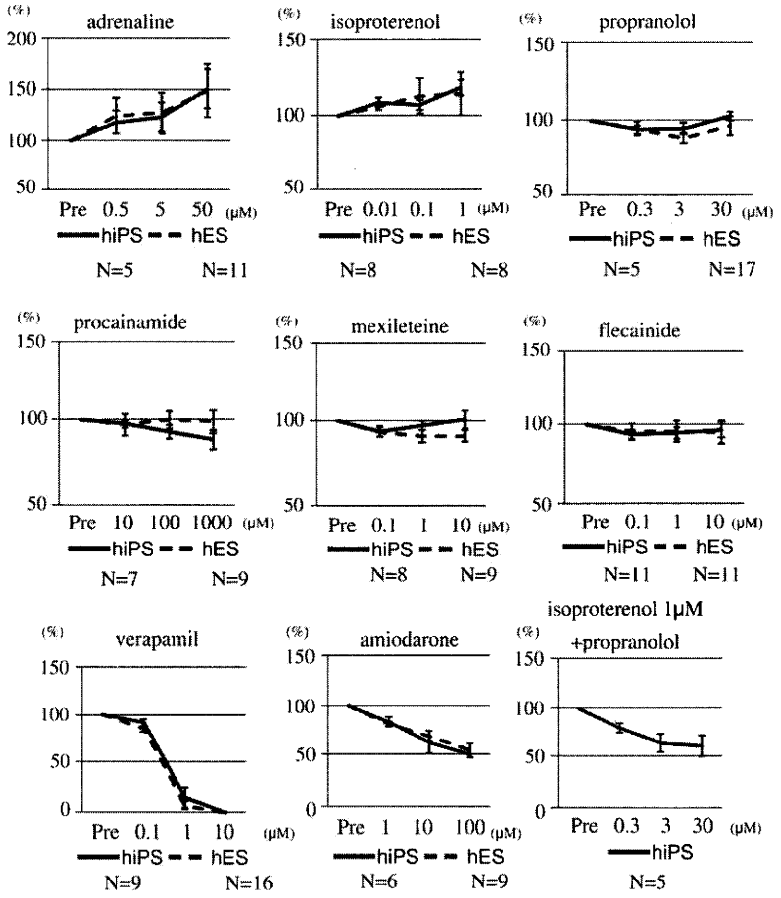

Fig. 3. The effects of cardioactive drugs on the beating rates of contractile colonies derived from human iPS cells and human ES cells. Adrenaline, isoproterenol, verapamil, amiodarone, and isoproterenol + propranolol had statistically significant effects between pre-drug loading and the maximum concentration of the drug used in cardiomyocytes derived from human iPS cells ($P < 0.05$). There were no statistically significant differences between the concentrations of drugs that elicited effects in human iPS cells and those that elicited effects in human ES cells.

cardiomyocytes derived from human ES cells by performing drug loading tests. First we compared the beating frequencies of these two cell populations. A total of eight drugs were tested (see Table 1 for the list of drugs and their concentrations). The β stimulants, adrenaline and isoproterenol increased beating frequency in a dose dependent manner. The β blocker, propranolol, and the Na channel blockers, procainamide, mexiletine, and flecainide had no effect on beating frequency. The Ca channel blocker verapamil decreased beating frequency in a dose dependent manner, and all contractile colonies ceased to contract when 1×10^{-5} M verapamil was loaded. Amiodarone, which mainly acts as a K channel blocker, decreased beating frequency in a dose dependent manner. We carried out β blocker loading in the presence of 1×10^{-6} M isoproterenol in order to mimic conditions *in vivo* [20]. Under this condition, the beating frequency decreased in a dose dependent manner. There were no statistical differences between the drug concentrations required to elicit the effects in human iPS cells and those required to elicit the effects in cardiomyocytes derived from human ES cells (Fig. 3). Previous reports showed that some drugs had similar effects on the beating frequency of cardiomyocytes derived from ES cells and on *bone-fide* human cardiomyocytes, suggesting that human iPS cells and cardiomyocytes respond similarly to these drugs as well [12–14]. Table 2 shows a comparison of the effects of drug loading on human iPS cells and the effects of these drugs in a clinical setting [15]. As the effects are broadly similar and occur within the same range of drug concentrations, we conclude that cardiomyocytes derived from human iPS cells are a good model for testing the effects of drugs on the beating frequency of human cardiomyocytes. The results are also compatible with previously reported clinical empirical results [15].

The effects of drugs on the contractility of cardiomyocytes derived from human iPS cells

Next, we investigated the effects of drugs on the contractility of human iPS cells and cardiomyocytes derived from human ES cells. The results showed that adrenaline and isoproterenol increased contractility in a dose dependent manner. Propranolol, mexiletine, or amiodarone had no effect on contractility. Verapamil decreased contractility in a dose dependent manner, and all contractile colonies ceased to contract when 1×10^{-5} M verapamil was loaded. Procainamide and flecainide also decreased the beating frequency in a dose dependent manner. We also carried out β blocker loading in the presence of 1×10^{-6} M isoproterenol with cardiomyocytes derived from human iPS cells, which showed that contractility again decreased in a dose dependent manner under these conditions. There were no statistical differences between the drug concentrations required to elicit the effects in human iPS cells and those required to elicit the effects in cardiomyocytes derived from human ES cells (Fig. 4B). Previous reports have shown that some

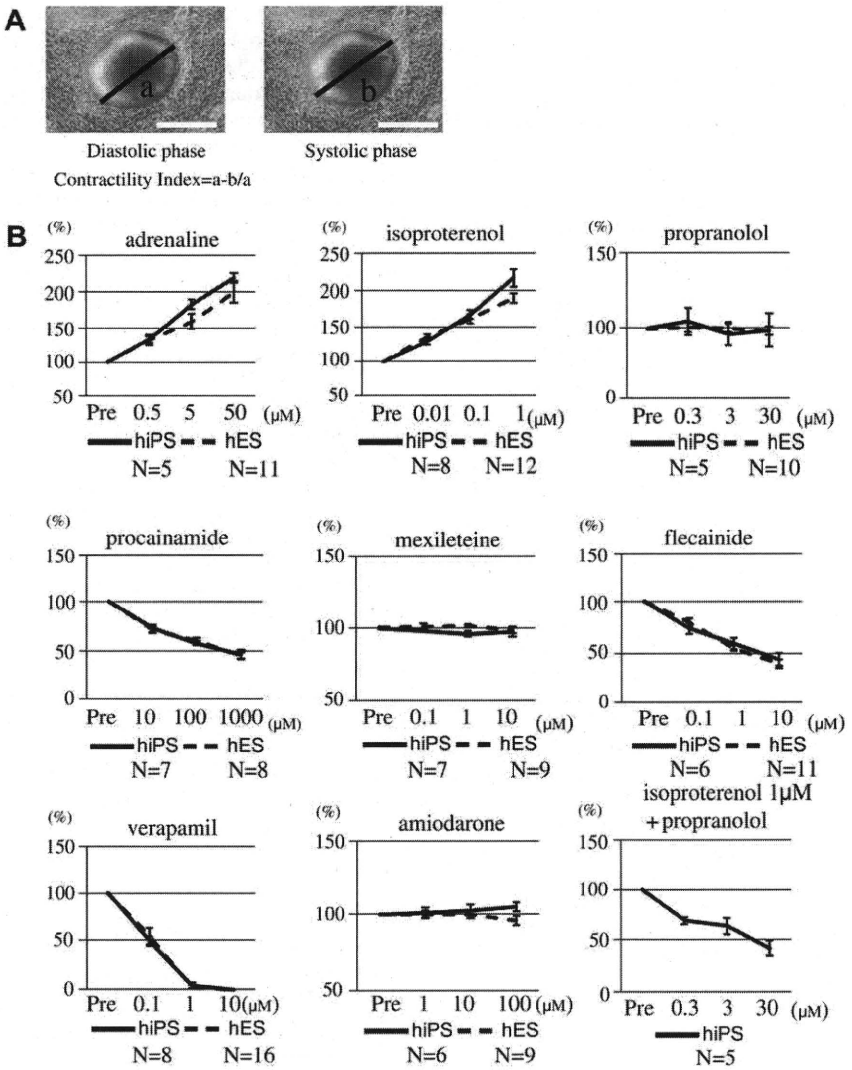

Fig. 4. Calculation of the contractility index. Right panel; diastolic phase, left panel; systolic phase. Scale bars = 200 μm (A). The effects of cardioactive drugs on the contractility of contractile colonies derived from human iPS cells and human ES cells. Adrenaline, isoproterenol, procainamide, flecainide, verapamil, and isoproterenol + propranolol had statistically significant effects on human iPS cells between pre-drug loading and the maximum concentration of the drug used in cardiomyocytes derived from human iPS cells ($P < 0.05$). There were no statistically significant differences between the concentrations of drugs that elicited effects in human iPS cells and those that elicited effects in human ES cells (B).

drugs had similar effects on the beating frequency of cardiomyocytes derived from ES cells and on *bone-fide* human cardiomyocytes, suggesting that human iPS cells and cardiomyocytes respond similarly to these drugs as well [12]. The results were compatible with clinical empirical results [15]. So we conclude that cardiomyocytes derived from human iPS cells respond similarly to drugs that affect contractility in human cardiomyocytes.

Table 1
Drugs and concentrations.

Class	Drugs	Concentration (M)
Na channel blocker	Procainamide	1×10^{-5}–1×10^{-3}
	Mexiletine	1×10^{-7}–1×10^{-5}
	Flecainide	1×10^{-7}–1×10^{-5}
β blocker	Propranolol	3×10^{-7}–3×10^{-5}
K channel blocker	Amiodarone	1×10^{-6}–1×10^{-4}
Ca channel blocker	Verapamil	1×10^{-7}–1×10^{-5}
α, β stimulant	Adrenaline	5×10^{-7}–5×10^{-5}
β stimulant	Isoproterenol	1×10^{-8}–1×10^{-6}

Table 2
Comparison with clinical empirical result.

Drugs	Result		Clinical efficacy	
	Contractility	Beating frequency	Contractility	Beating frequency
Procainamide	↓	→	↓	→
Mexiletine	→	→	→	→
Flecainide	↓	→	↓	→
Propranolol	↓	↓	↓	↓
Amiodarone	→	↓	→	↓
Verapamil	↓	↓	↓	↓
Isoproterenol	↑	↑	↑	↑
Adrenaline	↑	↑	↑	↑

Table 3
Primers for RT-PCR.

Genes	Direction	Sequence
Oct4 (endo)	Forward	GACAGGGGGAGGGGAGGAGCTAGG
	Reverse	CTTCCCTCCAACCAGTTGCCCCAAAC
Sox2 (endo)	Forward	GGGAAATGGGAGGGGTGCAAAAGAGG
	Reverse	TTGCGTGAGTGTGGATGGGATTGGTG
C-KIT	Forward	ATTCCCAGCCCATGAGTCCTTGA
	Reverse	ACACGTGGAACACCAACATCCT
Brachyury	Forward	AAGGTGGATCTTCAGGTAGC
	Reverse	CATCTCATTGGTGAGCTCC
KDR	Forward	AAAACCTTTTGTTGCTTTTGG
	Reverse	GAAATGGGATTGGTAAGGATG
Nkx2.5	Forward	GCGATTATGCAGCGTGCAATGAGT
	Reverse	AACATAAATACGGGTGGGTGCGTG
TBX5	Forward	AAATGAAACCCAGCATAGGAGCTGGC
	Reverse	ACACTCAGCCTCACATCTTACCCT
MEF2c	Forward	TTTAACACCGCCAGCGCTCTTCACCTTG
	Reverse	TCGTGGCGCGTGTGTTGTGGGTATCTCG
MLC2a	Forward	ACATCATCACCCACGGAGAAGAGA
	Reverse	ATTGGAACATGGCCTCTGGATGGA
MYHCB	Forward	CTGGAGGCCGAGCAGAAGCGCAACG
	Reverse	GTCCGCCCGCTCCTCTGCCTCATCC
HCN4	Forward	GGTGTCCATCAACAACATGG
	Reverse	TGTACTGCTCCACCTGCTTG
SCN5A	Forward	CCTAATCATCTTCCGCATCC
	Reverse	TGTTCATCTCTCTGTCCTCATC
Kir2.1	Forward	GACCTGGAGACGGACGAC
	Reverse	AGCCTGGAGTCTGTCAAAGTC
Kv4.3	Forward	GCCAGTCCCTGTGATTGTTT
	Reverse	CTCCATGCAGTTCTGCTCAA
HERG	Forward	TCCAGCGGCTGTACTCGGGC
	Reverse	TGGACCAGAAGTGGTCGGAGAACTC
CACNA1C	Forward	AACATCAACAACGCCAACAA
	Reverse	AGGGCAGGACTGTCTTCTGA
GAPDH	Forward	CACCAGGGCGCTTTTAACTCTG
	Reverse	ATGGTTCACACCCATGCGAAC

Discussion

In this report, we differentiated human iPS cells into cardiomyocytes, and compared the effects of drugs on cardiomyocytes derived from these cells and on cardiomyocytes derived from human ES cells, as well as with empirical results obtained in a clinical setting. The time course analysis of gene expression during cardiac differentiation was compatible to that seen during cardiogenesis of normal embryogenesis, and the results of the drug loading tests showed that cardiomyocytes derived from human iPS cells responded to drugs in much the same way as cardiomyocytes derived from human ES cells. The results were also compatible to empirical results obtained in a clinical setting.

Human iPS cells can be generated from somatic cell by introducing transcriptional factors. This technology is expected to generate patient-specific iPS cells suitable for the study of disease mechanisms, drug screening, and toxicology studies. This technology is easier to implement for the generation of patient-specific pluripotent cells than current technology which relies on nuclear transplantation technology to generate patient-specific pluripotent cells from ES cells. If cardiomyocytes derived from iPS cells could be shown to respond to drugs in the same way as human derived cardiomyocytes, then this technology would also constitute a major advance because it would allow the use of patient-specific iPS cell for the screening of patient-specific drugs against arrhythmic diseases, especially for lethal arrhythmic diseases such as LQTS where it is often very difficult to select for the best drug.

As the generation of cardiomyocytes from human iPS cells relies on the introduction of exogenous genes, we addressed the troublesome issue of whether cardiomyocytes derived from human iPS cells would respond to drugs in the same way as normal human cardiomyocytes. We considered the beating frequency and contractility to be very important indicators, because heart pump function is defined by beating frequency and contractility. So we investigated the effects of drugs on these two indicators, and found that drugs affect the beating frequency and contractility of cardiomyocytes derived from human iPS cells in much the same way as they do in a clinical setting. This result suggests that cardiomyocytes derived from human iPS cells could be used for drug screening tests instead of current screening procedures in a clinical setting. Cardiomyocytes derived from ES cells also responded to drugs in the same way as cardiomyocytes derived from human iPS cells.

Thus, these results suggest that patient-specific iPS cells could be used to select for the best drug to treat arrhythmic disease at the individual level, and would have the additional advantage of allowing the massive and rapid screening of drugs at concentrations that would be normally prohibitive in patients. However, until further studies are carried out, it is probably still too early to conclude that the drug effects on human iPS cell lines and patients are identical.

In conclusion, cardiomyocytes derived from human iPS cells have tremendous potential for drug screening, which should open the possibility of using patient-specific iPS cells in a clinical setting. The best drugs could be selected safely and rapidly by using human iPS cells from individual patients.

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Orderly Hematopoietic Development of Induced Pluripotent Stem Cells via Flk-1$^+$ Hemoangiogenic Progenitors

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Induced pluripotent stem (iPS) cells, reprogrammed somatic cells with embryonic stem (ES) cell-like characteristics, are generated by the introduction of combinations of specific transcription factors. Little is known about the differentiation of iPS cells in vitro. Here we demonstrate that murine iPS cells produce various hematopoietic cell lineages when incubated on a layer of OP9 stromal cells. During this differentiation, iPS cells went through an intermediate stage consisting of progenitor cells that were positive for the early mesodermal marker Flk-1 and for the sequential expression of other genes that are associated with hematopoietic and endothelial development. Flk-1$^+$ cells differentiated into primitive and definitive hematopoietic cells, as well as into endothelial cells. Furthermore, Flk-1$^+$ populations contained common bilineage progenitors that could generate both hematopoietic and endothelial lineages from single cells. Our results demonstrate that iPS cell-derived cells, like ES cells, can follow a similar hematopoietic route to that seen in normal embryogenesis. This finding highlights the potential use of iPS cells in clinical areas such as regenerative medicine, disease investigation, and drug screening.
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Because of their pluripotency and potential for self-renewal, embryonic stem (ES) cells have been used in various fields of science, including developmental biology (Evans and Kaufman, 1981). ES cells can differentiate into multiple cell types in a similar way to that observed in vivo. Previous studies using normal or gene-manipulated ES cells have helped to elucidate the process of normal embryogenesis and the genetic mechanisms of some diseases (Lensch and Daley, 2006).

Hematopoietic and endothelial development are regarded as particularly good processes for comparing the potential of ES cells cultivated in vitro with those grown in vivo (Nakano et al., 1994, 1996; Nishikawa et al., 1998). During embryogenesis, the developmental progression to a hematopoietic lineage is closely associated with progression to an endothelial lineage (Shalaby et al., 1997; Wood et al., 1997; Choi et al., 1998; Garcia-Porrero et al., 1998). Both cell lineages emerge from common mesodermal progenitors called hemangioblasts, which are positive for the vascular endothelial growth factor receptor Flk-1 (Flamme et al., 1995; Risau, 1995; Risau and Flamme, 1995; Choi et al., 1998; Huber et al., 2004). Thereafter, the site of hematopoiesis shifts from the yolk sac (primitive hematopoiesis) to the fetal liver, the spleen, and finally to the bone marrow (definitive hematopoiesis), and is accompanied by a change in the type of hemoglobin produced by erythrocytes (Moore and Metcalf, 1970; Matsuoka et al., 2001). Orderly hematopoietic development can be induced from murine and primate ES cells by various culture methods (Doetschman et al., 1985; Leder et al., 1985, 1992; Nakano et al., 1994, 1996; Xu et al., 2001; Umeda et al., 2004, 2006; Shinoda et al., 2007).

ES cells have been proposed as a potential new source of transplantable cells in regenerative medicine. It is anticipated that in the future such ES-derived cells may be used as sources of hematopoietic cells for stem cell transplants, or of mature blood cells for transfusion therapies. Recent studies have already shown that hematopoietic cells derived from murine ES cells overexpressing HoxB4 or Stat5 can replenish the bone marrow of lethally irradiated recipient mice (Kyba et al., 2002, 2003). However, there are various impediments to the clinical application of ES cells. For example, because they are established from the inner-cell masses of blastocysts, ES cells are subject to the controversy surrounding the manipulation of oocytes. Furthermore, the therapeutic use of ES cells from other individuals carries the risk of immunological complications.

Murine and human induced pluripotent stem (iPS) cells have recently been established from somatic cells by retrovirally introducing certain combinations of genes, such as octamer 3/4

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(*Oct3/4*), sex-determining region Y-box 2 (*Sox2*), Krüppel-like factor 4 (*Klf4*), and the v-Myc avian myelocytomatosis viral oncogene homolog (*c-Myc*) (Takahashi and Yamanaka, 2006; Meissner et al., 2007; Okita et al., 2007; Park et al., 2007; Takahashi et al., 2007; Yu et al., 2007; Aoi et al., 2008; Hanna et al., 2008; Nakagawa et al., 2008). The cloned cells display properties of self-renewal and pluripotency similar to ES cells, and yield germ-line adult chimeras. However, because iPS cells are "unnatural" cells that are reprogrammed from once-differentiated cells, their differentiation processes must first be analyzed and compared before any true relationship between iPS and ES cells can be made.

The concept of patient-specific stem cells is of great clinical interest, and has engendered considerable research within the scientific community. The applications of these cells are expected to contribute to patient-oriented disease investigations, drug screenings, toxicology, and transplantation therapies (Jaenisch and Young, 2008). For example, a recent study demonstrated that autologous iPS cells can be used to treat mice with sickle cell anemia (Hanna et al., 2007). Despite such encouraging results, little is known about the in vitro hematopoietic differentiation of iPS cells. In particular, it is currently unclear whether iPS and undifferentiated embryonic cells follow the same process toward hematopoietic commitment.

In this study, we compared the hematopoietic differentiation of iPS and ES cells in vitro during their coculture with OP9 stromal cells (Nakano et al., 1994, 1996; Umeda et al., 2004, 2006; Vodyanik et al., 2005; Shinoda et al., 2007; Vodyanik and Slukvin, 2007). Sequential fluorescence-activated cell sorting (FACS), immunostaining, and reverse transcription (RT)-polymerase chain reaction (PCR) analyses demonstrated that iPS cell-derived hematopoietic and endothelial cells emerge from a common mesodermal progenitor that is positive for Flk-1, as is the case in ES cells and in normal embryogenesis.

Materials and Methods

Generation of iPS cells

Murine iPS cells were established from murine fibroblasts as described previously (Takahashi and Yamanaka, 2006; Okita et al., 2007; Nakagawa et al., 2008). In brief, to generate Nanog-iPS cells (clones 20D17, 38C2, and 38D2), murine embryonic fibroblasts carrying the Nanog-GFP-IRES-Puro^r reporter were incubated in retrovirus-containing supernatants for Oct3/4, Sox2, Klf4, and c-Myc for 24 h. After 2–3 weeks, clones were selected for expansion in medium containing 1.5 μg/ml of puromycin. To generate three-factor (without c-Myc) iPS cells (clone 256H18), murine tail tip fibroblasts (TTFs) were first isolated from adult *Discosoma* sp. red fluorescent protein (DsRed)-transgenic mice. Retrovirus containing supernatants for Oct3/4, Sox2, Klf4, and GFP were then added to the TTF cultures for 24 h. Four days after transduction, TTFs were replated on SIM mouse embryo-derived thioguanine and ouabain-resistant (STO)-derived feeder cells producing leukemia inhibitory factor (LIF; designated as SNL cells). Thirty days after transduction, the colonies were selected for expansion.

Maintenance of cells

The iPS cells and the murine ES cell line D3 were maintained on confluent SNL cells at a concentration of 1×10^4 cells/cm^2 in Dulbecco's modified Eagle's medium (DMEM; Sigma–Aldrich, St. Louis, MO), containing 15% fetal calf serum (FCS; Sigma–Aldrich) and 0.1 μM 2-mercaptoethanol (2ME) (Takahashi and Yamanaka, 2006; Okita et al., 2007; Nakagawa et al., 2008). OP9 stromal cells, which were a kind gift from Dr. Kodama (Osaka University, Osaka), were maintained as reported previously (Umeda et al., 2004).

Antibodies

The primary antibodies used for flow cytometric (FCM) analysis included an unconjugated anti-stage-specific mouse embryonic antigen (SSEA1) mouse monoclonal immunoglobulin M (IgM) antibody (sc-21702; Santa Cruz Biotechnology, Santa Cruz, CA), and the following anti-mouse antibodies from Becton–Dickinson (Franklin Lakes, NJ): unconjugated rat monoclonal anti-E-cadherin, rat monoclonal allophycocyanin (APC)-conjugated anti-c-kit, unconjugated rat monoclonal anti-spinocerebellar ataxia type 1 (Sca1), unconjugated rat monoclonal anti-CD31, biotin-conjugated anti-Flk-1, biotin-conjugated anti-CD34, and biotin-conjugated anti-CD45. Two secondary antibodies against the unlabeled primary antibodies were also from Becton–Dickinson: an APC-conjugated anti-mouse IgM antibody and an APC-conjugated anti-rat IgG antibody.

The primary antibodies used to immunostain the floating erythrocytes included rabbit anti-mouse embryonic hemoglobin (a gift from Dr. Atsumi, Miwa et al., 1991) and rat anti-mouse hemoglobin β (sc31116; Santa Cruz Biotechnology). Cy3-conjugated goat anti-rabbit or anti-rat antibodies (Jackson ImmunoResearch Laboratories, Inc., West Grove, PA) were used as secondary antibodies.

The primary antibodies for immunostaining endothelial cells included anti-mouse antibodies from BD (Becton–Dickinson), an unconjugated anti-VE-cadherin rat monoclonal antibody, an unconjugated anti-CD31 rat monoclonal antibody, and an anti-eNOS rat monoclonal antibody. Horseradish peroxidase (HRP)-conjugated goat anti-rat antibodies (Jackson ImmunoResearch Laboratories, Inc.) were used as secondary antibodies.

Cytostaining

Floating cells were centrifuged onto glass slides using a Shandon Cytospin® 4 Cytocentrifuge (Thermo, Pittsburgh, PA), and analyzed by microscopy after staining with May–Giemsa, myeloperoxidase (MPO), or acetylcholine esterase (Maherali et al., 2007). Staining was performed as described previously (Jackson, 1973; Yang et al., 1999; Xu et al., 2001). For immunofluorescence staining, cells fixed with 4% paraformaldehyde (PFA) were first permeabilized with phosphate-buffered saline (PBS) containing 5% skimmed milk (Becton–Dickinson) and 0.1% Triton X-100, and then incubated with primary antibodies against embryonic or β-major globins, followed by incubation with Cy3-conjugated secondary antibodies. Nuclei were counterstained with 4,6-diamidino-2-phenylindole (Sigma–Aldrich). Fluorescence was detected and images obtained with an AxioCam photomicroscope (Carl Zeiss Vision GmbH, Hallbergmoos, Germany).

FACS

The adherent cells were treated with 0.25% trypsin/ethylenediaminetetraacetic acid (EDTA) and harvested. They were incubated in a new tissue-culture dish (Becton–Dickinson) for 30 min to eliminate adherent OP9 cells (Suwabe et al., 1998). Floating cells were then collected and stained with primary antibodies, followed by incubation with APC-conjugated anti-mouse IgM or anti-rat IgG antibodies. Dead cells were excluded by propidium iodide (Kyba et al., 2002, 2003) staining. Samples were analyzed using a FACSCalibur and Cell Quest software (Becton–Dickinson). Cell sorting with the Flk-1 antibody was performed using a FACSVantage flow cytometer (Becton–Dickinson).

Differentiation of iPS and ES cells

For initial differentiation, iPS or ES cells were treated with 0.25% trypsin/EDTA (Gibco, Grand Island, NY) and transferred onto semi-confluent OP9 cell layers at a concentration of 6×10^3 cells/cm^2 in α-minimum essential medium (α-MEM;

Gibco) supplemented with 10% FCS and 5×10^{-2} μM 2ME and without LIF. After 5 days, the induced cells were treated with 0.25% trypsin/EDTA, and 1.2×10^4 total cells/cm^2 or 1.2×10^3 sorted Flk-1$^+$ cells/cm^2 were transferred onto fresh semi-confluent OP9 cell layers, and cultured thereafter for hematopoietic differentiation in α-MEM supplemented with 10% FCS, 5×10^{-2} μM 2ME, and the following four recombinant growth factors: 100 ng/ml mouse stem-cell factor (mSCF), 4 ng/ml human thrombopoietin (hTPO), 20 ng/ml mouse interleukin 3 (mIL3), and 2 U/ml human erythropoietin (hEPO). These cytokines were kindly provided by Kirin Brewery (Tokyo, Japan).

RNA extraction and RT-PCR analysis

RNA samples were prepared using silica gel membrane-based spin-columns (RNeasy Mini-Kit™; Qiagen, Valencia, CA) and subjected to RT with a Sensiscript-RT Kit™ (Qiagen). All procedures were performed following the manufacturer's instructions. For RT-PCR, yields were adjusted by dilution to produce equal amounts of the glyceraldehyde-3-phosphate dehydrogenase (GAPDH) amplicon. Complementary DNA (cDNA) templates were initially denatured at 94°C for 5 min, followed by 29–35 amplification reactions consisting of 94°C for 15 sec (denaturing), 55–64°C for 15 sec (annealing), and 72°C for 30 sec (extension), with a final extension at 94°C for 7 min. The oligonucleotide primers were as follows: *GAPDH*, 5′-TCC AGA GGG GCC ATC CAC AGT C-3′ and 5′-GTC GGT GTG AAC GGA TTT GGC C-3′ (Baba et al., 2007a); *Rex1*, 5′-AAA GTG AGA TTA GCC CCG AG-3′ and 5′-TCC CAT CCC CTT CAA TAG CA-3′ (Baba et al., 2007a); *Brachyury*, 5′-CAT GTA CTC TTT CTT GCT GG-3′ and 5′-GGT CTC GGG AAA GCA GTG GC-3′ (Ku et al., 2004); *Flk-1*, 5′-CAC CTG GCA CTC TCC ACC TTC-3′ and 5′-GAT TTC ATC CCA CTA CCG AAA G-3′ (Baba et al., 2007a); *Scl*, 5′-ATG GAG ATT TCT GAT GGT CCT CAC-3′ and 5′-AAG TGT GCT TGG GTG TTG GCT C-3′ (Baba et al., 2007a); *Myb*, 5′-CAC CAT TCT GGA CAA TGT TAA GAA C-3′ and 5′-GTA AGG TAG GTG CAT CTA AGC-3′; *Tie1*, 5′-ATA CCC TAG ACT GGC AAG AG-3′ and 5′-TTT TGA CAC TGG CAC TGG A-3′; *Gata1*, 5′-GCT GAA TCC TCT GCA TCA AC-3′ and 5′-TAG GCC TCA GCT TCT CTG TA-3′ (Shimizu et al., 2001); *Gata2*, 5′-GCA ACA CAC CAC CCG ATA CC-3′ and 5′-CAA TTT GCA CAA CAG GTG CCC-3′ (Shimizu et al., 2004); *ε-globin*, 5′-GGA GAG TCC ATT AAG AAC CTA GAC AA-3′ and 5′-CTG TGA ATT CAT TGC CGA AGT GAC-3′ (Hansen et al., 1982); *ζ-globin*, 5′-GCT CAG GCC GAG CCC ATT GG-3′ and 5′-TAG CGG TAC TTC TCA GTC AG-3′ (Leder et al., 1985); *α-globin*, 5′-CTC TCT GGG GAA GAC AAA AGC AAC-3′ and 5′-GGT GGC TAG CCA AGG TCA CCA GCA-3′ (Nishioka and Leder, 1979); *β-globin*, 5′-CTG ACA GAT GCT CTC TTG GG-3′ and 5′-CAC AAC CCC AGA AAC AGA CA-3′ (Konkel et al., 1978); *Oct3/4* (Tg), 5′-AAA AAG CAG GCT CCA CCT TCC CCA TGG CTG GAC ACC-3′ and 5′-AGA AAG CTG GGT TGA TCA ACA GCA TCA CTG AGC TTC-3′ (Takahashi and Yamanaka, 2006); *Sox2* (Tg), 5′-AAA AAG CAG GCT TGT ATA ACA TGA TGG AGA CGG-3′ and 5′-AGA AAG CTG GGT TTC ACA TGT GCG ACA GGG GCA GT-3′ (Takahashi and Yamanaka, 2006); *c-Myc* (Tg), 5′-CAC CAT GCC CCT CAA CGT GAA CTT CAC C-3′ and 5′-TTA TGC ACC AGA GTT TCG AAG CTG TTC G-3′ (Takahashi and Yamanaka, 2006); *Klf4* (Tg), 5′-CAC CAT GGC TGT CAG CGA CGC TCT GCT C-3′ and 5′-ACA TCC ACT ACG TGG GAT TTA AAA-3′ (Takahashi and Yamanaka, 2006).

Real-time quantitative RT-PCR analysis

Forward and reverse primers for *Rex1* and *Flk-1* and the fluorogenic probes were designed according to PerkinElmer guidelines (Primer Express Software; PerkinElmer Life and Analytical Sciences, Boston, MA, http://www.perkinelmer.com), and those of *Brachyury* and *Scl* were described in a previous report (Nakanishi et al., 2009; Redmond et al., 2008). The *GAPDH* primers and probes were purchased from Applied Biosystems (Foster City, CA, http://www.appliedbiosystems.com). Quantitative RT-PCR experiments were performed using the ABI-Prism 7300 system (Applied Biosystems) following the manufacturer's instructions. Quantitative assessment of mRNA expression was performed using a GAPDH internal standard. The expression of each mRNA was compared with each day 0 mRNA expression.

The oligonucleotide primers were as follows: mouse *Rex1*, 5′-AAG CAG GAT CGC CTC ACT GT-3′ and 5′-CCG CAA AAA ACT GAT TCT TGG T-3′ (Baba et al., 2007a); mouse *Brachyury*, 5′-TAC CCC AGC CCC TAT GCT CA-3′ and 5′-GGC ACT CCG AGG CTA GAC CA-3′ (Nakanishi et al., 2009); mouse *Scl*, 5′-CAC TAG GCA GTG GGT TCT TTG-3′ and 5′-GGT GTG AGG ACC ATC AGA AAT CT-3′ (Redmond et al., 2008); mouse Flk-1, 5′-AAG CAG GAT CGC CTC ACT GT-3′ and 5′-CCG CAA AAA ACT GAT TCT TGG T-3′ (Baba et al., 2007a).

Colony-forming assay

Every other day of culture, from days 5 through 15, the adherent cells were treated with 0.25% trypsin/EDTA and harvested. They were incubated in a new tissue-culture dish (Becton–Dickinson) for 30 min to eliminate adherent OP9 cells (Suwabe et al., 1998). Floating cells were then collected and cultured at a concentration of 1×10^4 cells/ml in semi-solid α-MEM supplemented with 1.3% methylcellulose, 30% FCS, 10% bovine serum albumin, 100 μM 2ME, and a mixture of the following growth factors: 10 ng/ml human granulocyte colony-stimulating factor (hG-CSF), 2 U/ml hEPO, 20 ng/ml mIL3, 100 ng/ml mSCF, 100 ng/ml hIL6, and 10 ng/ml hTPO. Colony types were determined according to the criteria described previously (Nakahata and Ogawa, 1982a,b,c) by in situ observation using an inverted microscope. The abbreviations used for the clonogenic progenitor cells were as follows: CFU-Mix, mixed colony-forming units; BFU-E, erythroid burst-forming units; CFU-GM, granulocyte–macrophage colony-forming units; and CFU-G, granulocyte colony-forming units.

Single-cell deposition assay

The single-cell deposition assay was performed as described previously (Nishikawa et al., 1998; Umeda et al., 2006; Shinoda et al., 2007). In brief, single sorted cells were deposited in individual wells of 96-well plates with confluent OP9 layers, and cultured for 5 days in the medium described in the "Differentiation of iPS and ES Cells" Section. Each well was stained with a mixture of anti-CD45, CD41, and Ter119 rat antibodies for hematopoietic lineage detection or anti-VE-cadherin rat-antibodies for endothelial lineage detection, respectively. HRP-conjugated goat anti-rat antibodies (Jackson ImmunoResearch Laboratories, Inc.) were used as secondary antibodies.

Statistics

Statistical analyses were conducted using the Student's *t*-test or the Fisher's exact test. Statistical significance was defined as $P < 0.05$.

Results

iPS cells differentiate into hematopoietic cells in coculture with OP9 stromal cells

We initially compared iPS and ES cells by microscopic examination and FACS analysis. The Nanog-iPS cell lines (Okita

et al., 2007) (20D17, 38C2, and 38D2) were positive for green fluorescent protein (GFP) expression only when Nanog was activated. 256H18, which was established by introducing only Oct3/4, Sox2, and Klf4, expressed DsRed (Nakagawa et al., 2008) constitutively. The pMx-GFP retrovirus was introduced into this clone as a silencing indicator. The control D3 ES cells were constitutively positive for GFP. All four of the iPS clones formed ES-like colonies over more than 15 passages (Fig. 1A). The FACS analysis revealed that all of the clones expressed SSEA1, E-cadherin, and CD31 (Fig. 1B), thus demonstrating the phenotypic similarity between iPS and ES cells.

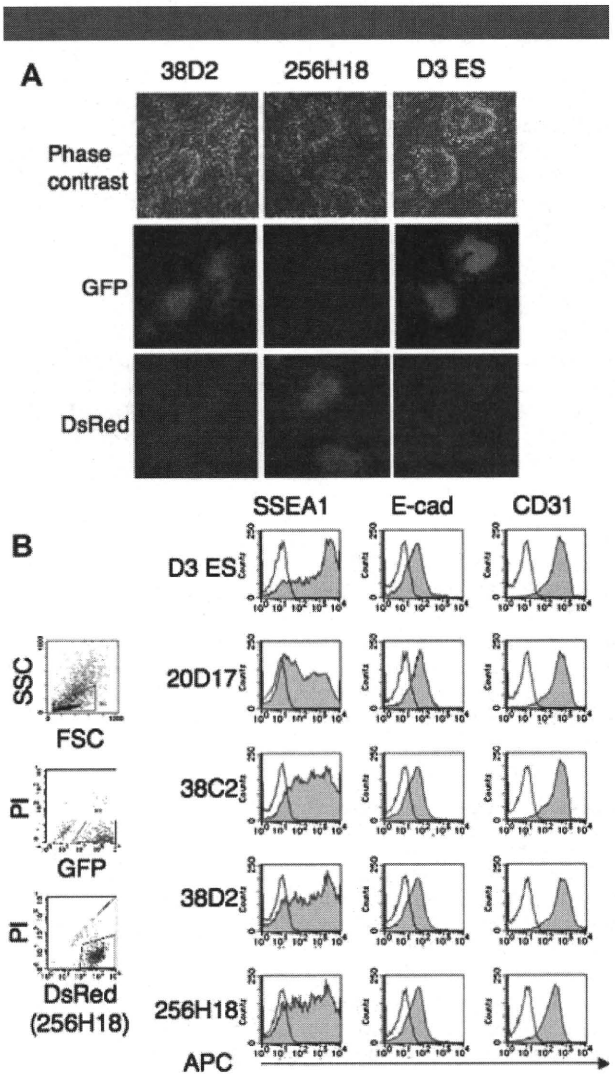


Fig. 1. Formation of ES-like colonies from iPS cells. A: Phase contrast (top row) and fluorescence (middle row: GFP, bottom row: DsRed) micrographs of Nanog-iPS cells (38D2), three-factor (without Myc) iPS (256H18) cells, and D3 ES cells maintained on SNL feeder cells. The D3 ES cells were derived from GFP^+ mice. Nanog-iPS cells express GFP only in the undifferentiated state. The three-factor iPS cells were derived from $DsRed^+$ mice, with additional infection by the pMx-GFP virus as a silencing marker. B: FACS analysis showing the phenotypic similarity of iPS and ES cells. The left parts show the gates for eliminating dead cells and contaminated feeders. GFP^+PI^- cells (R2) and $DSRed^+PI^-$ cells (R4) were gated as ES- and iPS-derived viable cells, respectively. SSEA1, E-cadherin, and CD31 were positive in all strains (shaded bars). Open bars show staining with isotype control antibodies. Representative results from one of three independent experiments performed are presented.

To analyze the hematopoietic differentiation potential of iPS cells, we adapted the OP9 coculture system originally reported by Nakano et al. (1994, 1996). We cocultured iPS cells with OP9 stromal cells for 5 days and transferred the entire culture onto fresh OP9 layers in the presence of mSCF, mIL3, hTPO, and hEPO. Small, round cell colonies first appeared 2 days later (on day 7; Fig. 2A). These colonies gradually grew in both size and number, and a few exhibited areas with a cobblestone-like appearance. Floating cells also appeared on day 7 and thereafter. May–Giemsa staining of the floating cells on day 15 revealed enucleated red blood cells, macrophages, granulocytes, and megakaryocytes (Fig. 2B). The presence of granulocytes and megakaryocytes was confirmed by MPO and acetylcholine esterase (Maherali et al., 2007) staining, respectively. FACS analysis on day 15 confirmed the existence of various types of blood cells, including erythoid and myeloid lineage cells, but not of lymphoid lineage cells (Fig. 2C). These above results demonstrate that iPS cells, like ES cells, can produce hematopoietic cells of various lineages in vitro.

Efficient production of hematopoietic cells from sorted Flk-1^+ cells

To thoroughly investigate iPS cell-derived hematopoietic development, we analyzed the expression of Flk-1, a marker of hemoangiogenic progenitors. Although the proportion of Flk-1^+ cells in the iPS clones on day 5 varied between $20 \pm 2\%$ and $48 \pm 9\%$ (Fig. 3A), the temporal patterns of expression were similar in iPS and ES cells. No Flk-1^+ cells were detected at

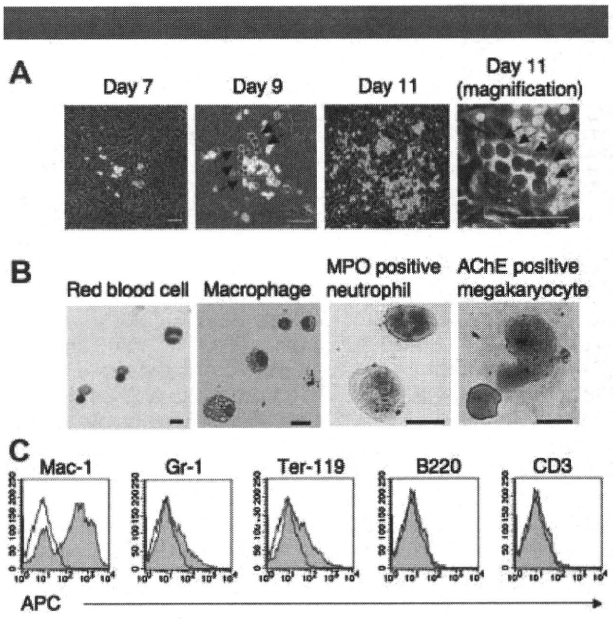


Fig. 2. Hematopoietic cells develop from iPS cells on OP9 feeders. Data from clone 38D2 are shown as representative of iPS-derived hematopoiesis. A: Small colonies first appeared on day 7 (2 days after Flk1$^+$ sorting) and then grew larger. Dark, round hematopoietic progenitors (indicated by arrows) appeared on days 9 and 11, lying beneath the OP9 layer and presenting cobblestone-like areas. Scale bars, 200 μm (left three parts) and 100 μm (rightmost part). B: Floating cells on day 15 included various lineages of hematopoietic cells; enucleated red blood cells, macrophages, MPO^+ neutrophils, and $AChE^+$ megakaryocytes were observed. Scale bars, 50 μm. C: Expression of lineage-specific antigens. Floating cells on day 15 were stained with antibodies against macrophages (Mac-1), granulocytes (Gr-1), erythrocytes (Ter-119), B cells (B220), and T cells (CD3). Expression of each antigen (shaded bars) was analyzed using FACS. Open bars show staining with isotype control antibodies.

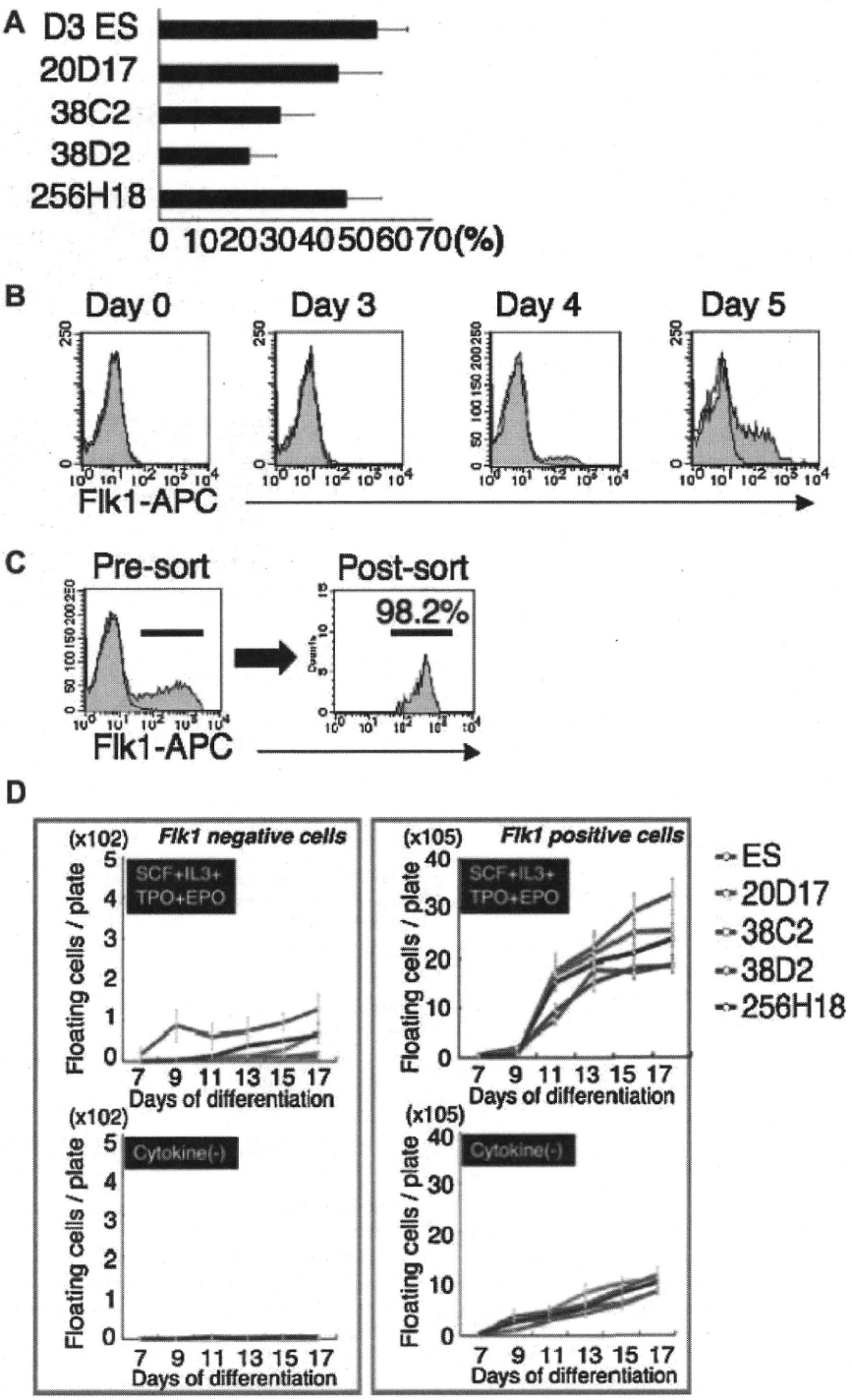


Fig. 3. Efficient production of hematopoietic cells from Flk-1$^+$ populations. A: The amounts of Flk-1$^+$ cells generated from ES and iPS cells at day 5 of differentiation were analyzed by FACS after eliminating OP9 stromal cells as described in Materials and Methods Section. Data are shown as a percentage in the total ES- and iPS-derived viable cells. B: Sequential FACS analysis reveals the emergence of Flk-1$^+$ population after day 4 of differentiation (shaded bars). Open bars show staining with isotype control antibodies. C: Purification of Flk-1$^+$ fractions by FACS on day 5. Reanalysis of the sorted cells confirmed the purity as 93.0–98.2%. D: Sequential analysis of the number of floating cells from ES and iPS cells after sorting with Flk-1 antibody. Sorted Flk-1$^+$ and Flk-1$^-$ cells were cultured in the presence or absence of SCF, IL-3, TPO, and EPO. In (A) and (D), data are presented as mean ± SE of three independent duplicate experiments. In (B) and (C), representative data from clone 38D2 are shown.

the outset, but they appeared on day 4 of culture and increased in number until day 5 (Fig. 3B).

We next sorted the Flk-1$^+$ cells on day 5 and cocultured them with fresh OP9 cells. Reanalysis of the sorted Flk-1$^+$ cells by FACS showed that their purity ranged from 93.0% to 98.2% (Fig. 3C). Regardless of the percentage of Flk1$^+$ cells before sorting, all of the iPS cell lines and ES cells could produce similar yields of hematopoietic cells predominantly from Flk-1$^+$ fractions, and exogenous cytokines increased the hematopoietic efficacy fourfold (Fig. 3D).

Primitive and definitive hematopoietic development of iPS cells

In the developing mouse embryo, primitive hematopoiesis originates in the extra-embryonic yolk sac on day 7.5 of gestation (Moore and Metcalf, 1970). Thereafter, definitive hematopoiesis emerges as a second wave in the aorta-gonad-mesonephros (AGM) region and replaces primitive hematopoiesis (Muller et al., 1994; Medvinsky and Dzierzak, 1996; Matsuoka et al., 2001). Primitive and definitive erythrocytes are morphologically distinguishable, and show distinct patterns of hemoglobin gene expression: the former are larger, nucleated cells that express not only embryonic ε-globin and ζ-globin but also adult α-globin, whereas the latter are smaller, enucleated cells expressing only adult α-globin and β-globin (Doetschman et al., 1985; Leder et al., 1992; Nakano et al., 1996; Xu et al., 2001).

To investigate whether primitive and definitive erythropoiesis can occur in iPS cells, we initially examined floating hematopoietic cells (Fig. 4A). May–Giemsa staining revealed that on day 7 the cells were large and nucleated, resembling primitive erythrocytes, whereas on day 15 they were smaller, enucleating or enucleated, and similar to definitive erythrocytes. Immunostaining revealed that day 7 cells were strongly positive for embryonic hemoglobin but negative for β-major hemoglobin, while day 15 cells expressed β-major hemoglobin strongly, with little or no expression of embryonic hemoglobin.

We also examined globin gene expression in the floating cells by sequential RT-PCR (Fig. 4B). The expressions of ε-globin and ζ-globin were strongest on day 7, decreased thereafter until day 11, and were undetectable on days 13–17. In contrast, α-globin and β-major globin expression were observed from days 9 through 17. These expression patterns were similar in iPS and ES cells, suggesting that iPS cells in vitro, like ES cells, can undergo primitive followed by definitive erythropoiesis.

Hematopoietic stem/progenitor cells develop from iPS-derived Flk-1$^+$ cells

To verify the formation of hematopoietic stem/progenitor cells in our culture system, we initially examined the expressions of c-kit, Sca1, CD34, and CD45, which are expressed by early hematopoietic progenitors (van de Rijn et al., 1989; Motro et al., 1991; Ling and Neben, 1997). FACS analysis revealed that undifferentiated iPS and ES cells expressed c-kit and Sca1, but not CD34 or CD45. Subsequent examination revealed the transient downregulation of Sca1 and c-kit on day 3, with Sca1 expression increasing again on day 5. On day 13 (8 days after cell sorting), we detected a new cell population that was positive for c-kit, Sca1, CD34, and CD45 (Fig. 5A,B).

We next investigated whether clonogenic hematopoietic cells were also produced in our culture system. Methylcellulose colony-forming assays showed that CFU-Mix, BFU-E, CFU-GM, and CFU-G colonies, as described in Materials and Methods Section, developed from the iPS-derived cells (Fig. 5C), and their numbers were not much lower than those formed by ES-derived cells (Fig. 5D). CFU-Mix and BFU-E colonies predominated the Flk-1$^+$ cells on days 7 and 9, but then

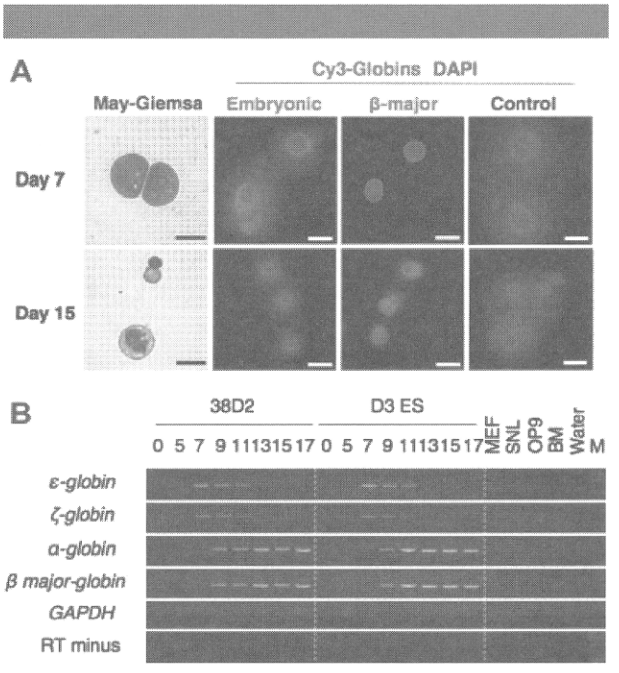


Fig. 4. Primitive and definitive erythrocytes formed from iPS cells. A: iPS-derived floating hematopoietic cells on day 7 (upper row) and day 15 (lower row) are shown. Erythrocytes on day 7 were larger and nucleated, and strongly positive for embryonic hemoglobin, but negative for β-major globin. Red blood cells on day 15 were smaller and enucleating or enucleated, and positive for β-major globin. B: Sequential RT-PCR analysis of globin gene expressions. RNA was isolated from all cells during the initiation culture (days 0 and 5), and from floating cells during the hematopoietic culture (day 7 and thereafter). GAPDH was used as a loading control. MEF, murine embryonic fibroblasts; SNL, SNL feeder cells; OP9, OP9 feeder cells; BM, adult murine bone marrow; M, 200-bp size marker. Representative results are shown from one of three independent experiments performed on clone 38D2.

decreased; the majority of cells after day 11 were from the CFU-GM and CFU-G colonies. These results suggest that iPS cells can generate multipotent hematopoietic progenitors almost as efficiently as ES cells.

Concomitant development of endothelial cells from iPS-derived Flk-1$^+$ cells

We next evaluated the development of endothelial lineages in our system. At 5 days after sorting, sheet-like colonies appeared that took up Dil-acetylated low-density lipoprotein (Dil-Ac-LDL) and were positive for anti-endothelial nitric oxide synthase (eNOS), CD31, and VE-cadherin (Fig. 6A). As shown in Figure 6B, iPS-derived Flk-1$^+$ cells produced many more VE-cadherin$^+$ colonies than Flk-1$^-$ cells ($P < 0.05$).

We also analyzed the expression of the following genes that are associated with the development of hematopoietic and endothelial lineages (Fig. 6C): required for excision 1 (*Rex1*; undifferentiated cells), *Brachyury* (primitive streak and mesoderm), *Flk-1* (mesoderm), GATA-binding protein 2 (*GATA2*; hematopoietic and endothelial), *SCL* (hematopoietic), *Myb* (hematopoietic), *GATA1* (hematopoietic), and tyrosine kinase with Ig-like and endothelial growth factor-like domains 1 (*Tie1*; endothelial). Both ES and iPS cells expressed *Rex1* strongly in the undifferentiated state. *Rex1* expression gradually decreased during differentiation, and *Brachyury*, *Flk-1*, and *SCL* expressions initially appeared on day 3. Quantitative real-time PCR analyses confirmed that *Brachyury* expression increased to

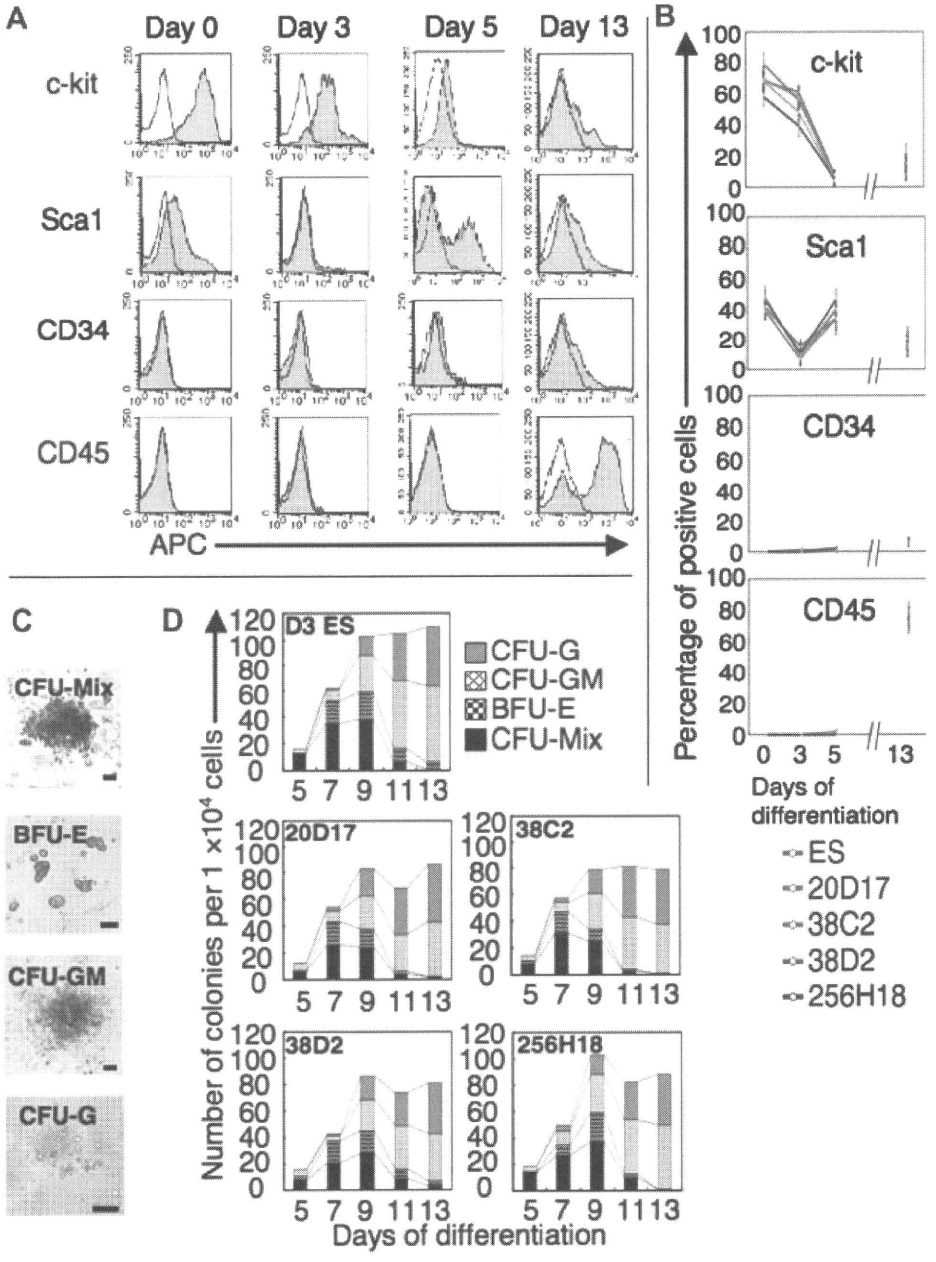


Fig. 5. Hematopoietic stem/progenitor cells emerge from Flk-1$^+$ cells. Sequential FACS analysis of c-kit, Sca1, CD34, and CD45 in ES and iPS-derived cells during differentiation. Whole culture were harvested on indicated days and analyzed by FACS as described in Materials and Methods Section. A: Representative data from clone 38D2 are shown. Histograms show the isotype control staining profile (open bars) versus the specific antibody staining profiles (shaded bars). B: Percentages of each antigen positive cells generated from ES and iPS cells are presented as mean ± SE of three independent duplicate experiments. C: The iPS cells formed various colony types on MTC-containing medium. Data from clone 38D2 are shown as representative. Scale bars, 200 μm. D: Numbers of each colony type derived from ES and iPS cells. Data represent mean of three independent triplicate experiments.

a maximum on day 3, followed by the upregulation of *Flk-1* and *SCL* (Fig. 6D). *Brachyury* expression continued until day 7, whereas that of *Flk-1* and *SCL* could be detected until day 9. *GATA2*, *Myb*, *GATA1*, and *Tie1* expressions were initially detected on day 5, and persisted thereafter. Taken together, these results demonstrate that, in our system, hematopoietic and/or endothelial differentiation of iPS cells occurs in a similar manner to that observed during embryogenesis.

Common hemoangiogenic progenitors are present in iPS-derived Flk-1$^+$ populations

Previous work has demonstrated that common hemoangiogenic progenitors are present in Flk-1$^+$ cells during ES-cell differentiation (Nishikawa et al., 1998). To investigate whether iPS-derived Flk-1$^+$ cells possess the same differentiation potential, we performed a single-cell deposition

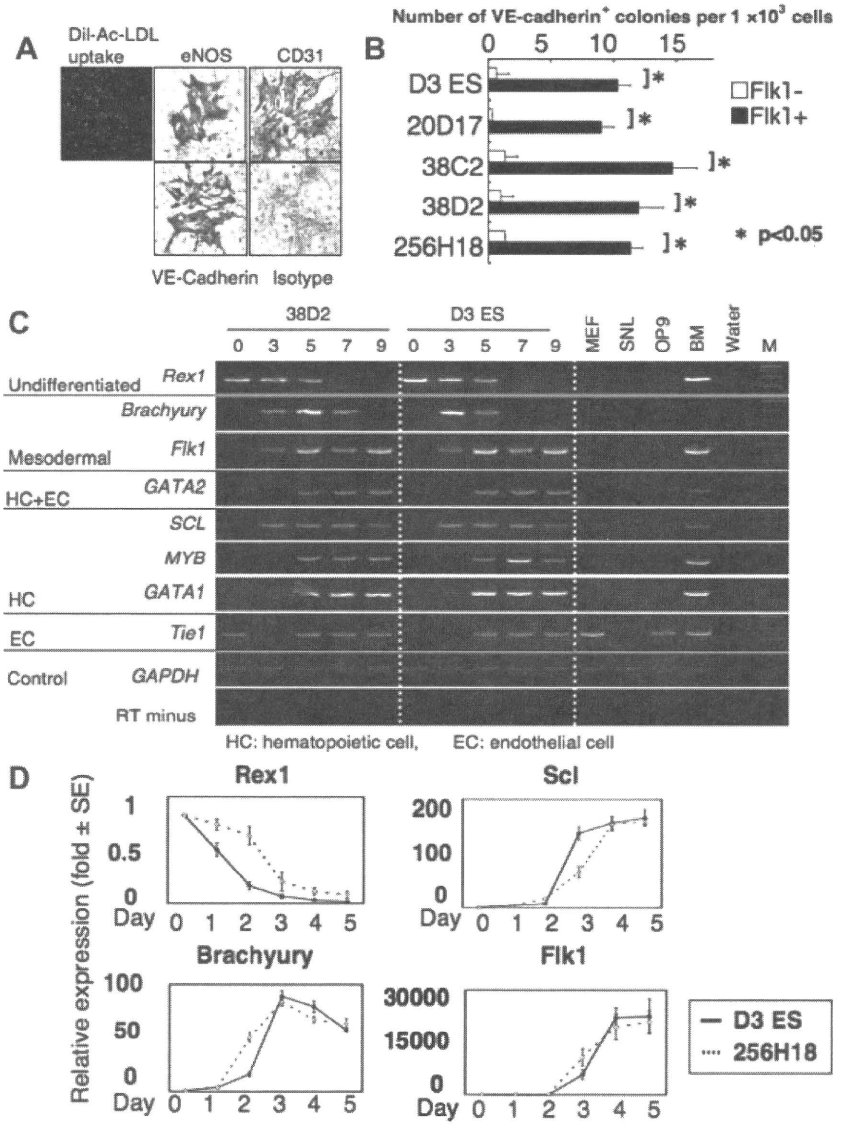


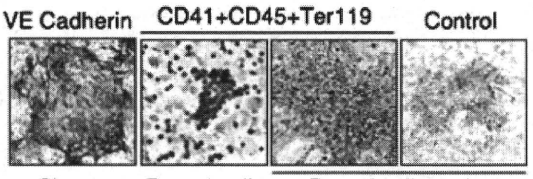
Fig. 6. Concomitant endothelial and hematopoietic development from iPS-derived Flk-1$^+$ cells. A: The sheet-like colonies took up Dil-Ac-LDL and were positive for eNOS, CD31, and VE-cadherin. Data from clone 38D2 are shown as representative. B: Number of VE-cadherin$^+$ colonies per 1×10^3 Flk1$^+$ or Flk1$^-$ cells derived from ES and iPS cells. Data are presented as mean ± SD of three independent experiments. C: RT-PCR using mRNA isolated from ES and iPS-derived cells during culture. HC and EC means hematopoietic and endothelial cells, respectively. GAPDH was used as a loading control. M: 200 bp size marker. Representative results from one of three independent experiments performed on clone 38D2 are shown. D: The expressions of *Rex1*, *Brachyury*, *Scl*, and *Flk-1* were evaluated by real-time quantitative RT-PCR. mRNA samples were harvested from D3 ES-derived GFP$^+$ cells or clone 256H18-derived DsRed$^+$ cells sorted by FACS on indicated days. Values were normalized to *gapdh* mRNA, and the control values were arbitrarily set to day 0 (undifferentiated ES cells). Data represent the mean ± SE of three independent duplicate experiments.

assay using the DsRed$^+$ clone 256H18. Single Flk-1$^+$ cells were deposited in four 96-well culture dishes (384 wells) containing OP9 feeder cells. Each well was observed by fluorescence microscopy 24 h after cell deposition, and wells that contained more than one DsRed$^+$ cell were excluded from further analysis. The presence of hematopoietic (Woodard et al., 2000) and endothelial (Maherali et al., 2007) colonies was confirmed not only morphologically, but also by immunostaining with a mixture of anti-CD41, CD45, and Ter119 antibodies, and anti-VE-cadherin antibodies, respectively, as previously reported (Fig. 7A) (Nishikawa et al., 1998). After 5 days of culture, the clonal outgrowth rates were 10.2% and 8.9% from 256H18 iPS and D3 ES cells, respectively. The frequencies of EC development alone, HC development alone, and HC plus EC development, respectively, were 2.7%, 5.2%, and 2.2%, respectively, from iPS cells and 2.4%, 3.5%, and 2.9%, respectively, from ES cells (Fig. 7B). Thus, the potential for mono- or bipotential progenitor development from iPS cells was almost equivalent to that from ES cells.

Discussion

Induced PS cells may serve as a novel cell source in both research and the clinic because, like ES cells, they have an

A



B

Clones	Only one cell 24 hours after sorting	After 5 days		
		HC	EC	HC+EC
DsRed iPS cells (256H18)	361 wells	10 wells (2.7%)	19 wells (5.2%)	8 wells (2.2%)
D3 ES cells	369 wells	9 wells (2.4%)	13 wells (3.5%)	11 wells (2.9%)

HC: Hematopoietic cells
EC: Endothelial cells

Fig. 7. Common hemoangiogenic progenitors are present in Flk-1$^+$ cells during iPS-cell differentiation. A: Single Flk-1$^+$ cells were cultured on OP9 layers in the wells of 96-well plates and immunostained with anti-VE-cadherin antibodies, or a cocktail of anti-CD41, anti-CD45, and anti-Ter119 antibodies, 7 days after sorting. B: Number of wells that showed EC (endothelial cells), HC (hematopoietic cells), and EC + HC development were counted as described in text.

unlimited capacity for self-renewal (Takahashi and Yamanaka, 2006; Meissner et al., 2007; Okita et al., 2007; Park et al., 2007; Takahashi et al., 2007; Yu et al., 2007; Aoi et al., 2008; Hanna et al., 2008; Nakagawa et al., 2008). The use of customized pluripotent stem cells would avoid the controversies surrounding ES cells. A recent study demonstrated that, after additional genetic manipulation and hematopoietic stem/progenitor cell expansion, autologous iPS cells could be used to treat mice with sickle-cell anemia, clearly revealing the advantage of these cells in regenerative medicine (Hanna et al., 2007).

One significant advantage of iPS cells is that cells from each patient can be used to screen drugs or to examine the effects of novel procedures against various diseases. Many diseases have a complex genetic etiology that affects the development, differentiation, and maturation of different tissues and organs, and require an experimental model system to faithfully reproduce their altered developmental processes (Lensch and Daley, 2006). In light of the heterogeneity of disease phenotypes and drug toxicity, it is desirable to establish defined sources of cells for drug discovery and research. In this area, immortalized cell lines and tissue-specific stem/progenitor cells that have been used for such studies are now being replaced by pluripotent stem cells.

The present study demonstrates that murine iPS cells can recapitulate early hematopoietic development in vitro. We confirmed the step-wise development of primitive and definitive hematopoietic cells, as well as endothelial cells, from Flk-1$^+$ hemoangiogenic progenitors, together with the upregulation of genes related to both lineages. Both lineages could be generated from individual Flk-1$^+$ cells, strongly suggesting the existence of common progenitor "hemangioblasts," as was previously reported for ES cells and embryos (Flamme et al., 1995; Risau, 1995; Risau and Flamme, 1995; Choi et al., 1998; Huber et al., 2004).

Step-wise development of primitive and definitive hematopoiesis from iPS-derived intermediate mesodermal progenitors

During embryogenesis, primitive hematopoiesis emerges in the yolk sac on 7.5 d.p.c. Following this process, definitive hematopoiesis, which is the major hematopoietic process throughout life, originates on 8.5 d.p.c. in the AGM region (Muller et al., 1994; Medvinsky and Dzierzak, 1996; Matsuoka et al., 2001). When the site of hematopoiesis shifts to the fetal liver on 10.5 d.p.c. and finally to the bone marrow, the number of blood cells massively increases; erythroid cell lineages are the major products in the fetal liver, and myeloid lineages appear at later stages. Here we demonstrated that Flk-1$^+$ mesodermal cells derived from iPS cells can lead to both primitive and definitive hematopoiesis.

Interestingly, the time courses of the hematopoietic differentiation of iPS and ES cell lines in our experiments were almost precisely synchronized with those seen in embryonic development. Hematopoietic colonies on the OP9 layer were first observed on day 7 of differentiation, and the number of cells produced increased explosively from day 11. Immunostaining and RT-PCR indicated a shift from primitive to definitive hematopoiesis as differentiation progressed over time. Moreover, the results of the MTC colony-forming assay also suggested that hematopoietic differentiation in our system reflects that occurring in embryogenesis: CFU-Mix and BFU-E colonies were mainly observed until day 9, while CFU-GM and CFU-G colonies became dominant on day 11 and thereafter.

Identifying and inducing hematopoietic stem cells (HSCs) in vitro is of great biological interest. Previous studies have suggested that the cobblestone area forming cells (CAFCs) observed in the OP9 system are indicative of the existence of primitive hematopoietic progenitors (Suwabe et al., 1998); CD34, c-kit, and Sca1 are among the characteristic markers of HSCs or very immature progenitors. In our study, we observed CAFCs derived from iPS cells, and FACS analyses revealed that many of the iPS-derived hematopoietic cells expressed the progenitor markers mentioned above. Taken together, these findings suggest that iPS cells can produce very immature hematopoietic progenitors in vitro. In the future, further study will be necessary to investigate whether iPS cells can generate true HSCs that demonstrate long-term multilineage marrow reconstitution in lethally irradiated mice without any additional gene manipulation.

Concomitant differentiation of iPS cells into hematopoietic and endothelial lineages

Several in vivo and in vitro studies have demonstrated a close association between hematopoietic and endothelial differentiation. Previous experiments have shown that murine and primate ES cells differentiate into hematopoietic cells via common Flk1$^+$ hemoangiogenic progenitors (Nishikawa et al., 1998; Umeda et al., 2006). Using RT-PCR and the single-cell deposition assay, our study demonstrated that iPS cells, like ES cells, can generate hematopietic and endothelial cells concomitantly, as is observed in embryogenesis.

The RT-PCR data demonstrated that the expression of the early mesodermal marker *Brachyury* was followed by that of *flk-1* and *scl*, both of which are crucial for the development of common progenitors (Nishikawa et al., 1998; Chung et al., 2002). The expression of genes associated with both lineages began thereafter. These results suggest that the orchestrated process from mesoderm development to the specification of either lineage during embryogenesis is also recapitulated in the iPS-cell model.

The single-deposition assay demonstrated that iPS cells possess an equivalent capacity to ES cells to develop bipotent progenitors at the single cell level. However, the frequency of progenitor development was unexpectedly low. One possible reason for this is the low clonal growth rate in our single-cell culture condition. Another possibility is that the sorted Flk-1$^+$ cells included, besides hemangioblasts, progenitors that contribute to other mesodermal lineages. Recent studies on murine ES and iPS cells demonstrated the development of cardiac muscles, vascular smooth muscles, and pericytes from Flk-1$^+$ fractions (Yamashita et al., 2000; Iida et al., 2005; Baba et al., 2007b; Narazaki et al., 2008). We also observed the formation of contractile colonies from Flk-1$^+$ fractions (data not shown). This may be one alternative reason for the observed low frequency of differentiation of either lineage. Further studies will enhance our understanding of the developmental biology of iPS cells.

Hematopoietic potential of iPS-derived Flk-1$^+$ progenitors is equivalent, regardless of the clone

In our experiments, the efficacy of Flk-1$^+$ cell induction varied between the clones, although the timing of their differentiation was the same. This may be potentially due to contamination by the SNL feeder cells. As these feeder cells were not eliminated at the start of differentiation, they would have remained throughout the assay and might have inhibited differentiation. However, to address these problems, it will be necessary to study the biological characteristics of iPS cells further, including their epigenetic behavior during differentiation. The most interesting and encouraging finding in our study was that the sorted Flk-1$^+$ cells derived from all analyzed iPS and ES clones were similar in their ability to generate hematopoietic cells.

In conclusion, our results demonstrate that iPS cells can develop into hematopoietic cells in vitro via hemoangiogenic progenitors, the so-called "hemangioblasts." Furthermore, iPS cells traverse the primitive and definitive hematopoietic stages in a manner similar to that observed during embryogenesis. Although future investigations at the biological and molecular levels are highly desirable, our study suggests that iPS cells hold great promise in medicine, and may aid in attaining the long sought goal of patient-specific stem cells.

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