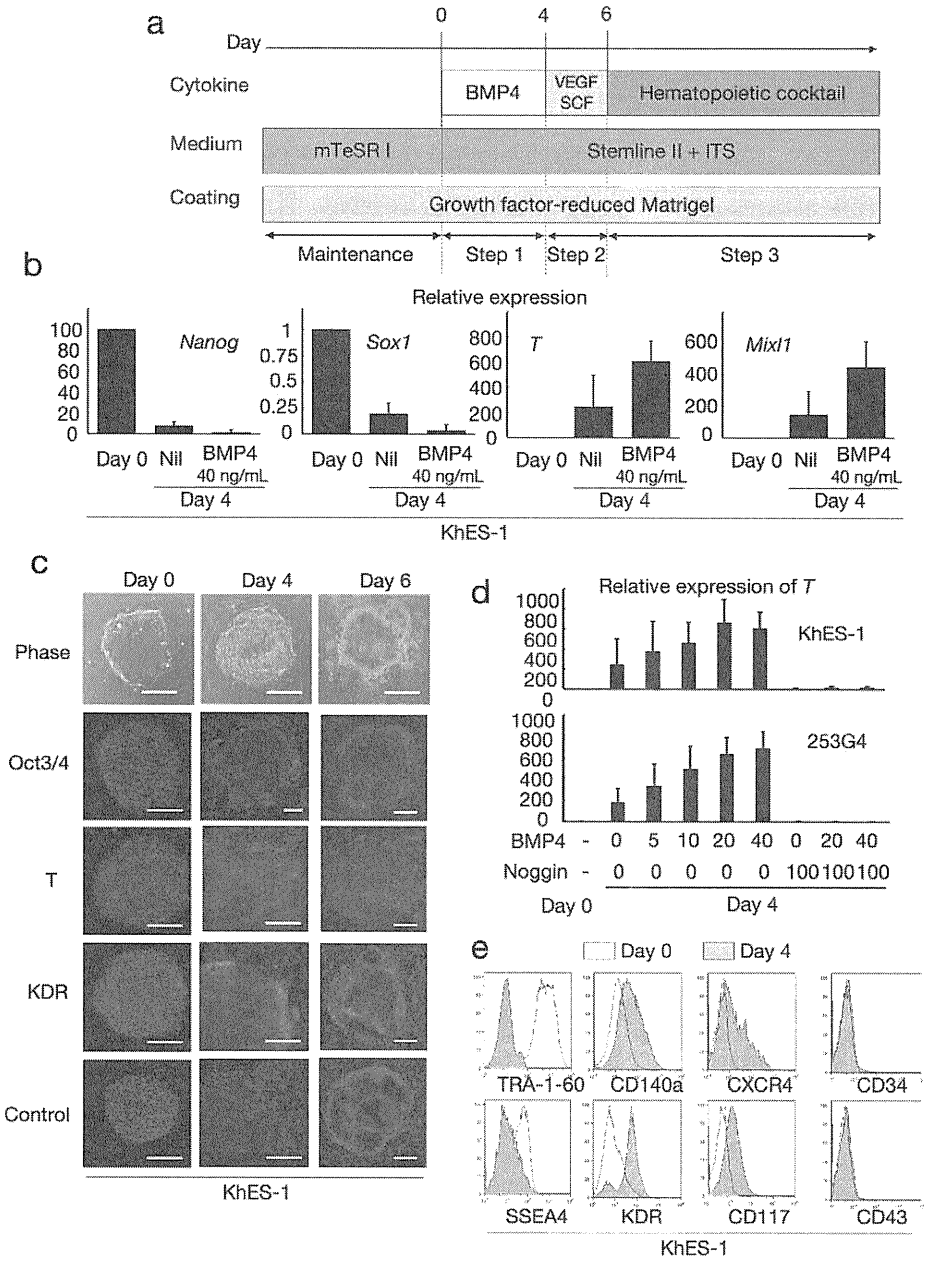

Figure 1. Blood cell induction from pluripotent stem cells starts with commitment into primitive streak. a. A schema of stepwise haematopoietic differentiation of human ES/iPS cells. **b.** Gene expression analysis of colonies at the beginning of differentiation (day 0) and the end of step 1 (day 4) with/without 40 ng/mL BMP4. Data from KhES-1 are shown as representative. **c.** Phase contrast microscopies and immunofluorescence staining of colonies during initial differentiation. Data from KhES-1 are shown as representative. **d.** Relative expression of *T* at day 4 of differentiation with different combinations of BMP4 and its inhibitor Noggin. Where shown, bars represent standard deviation of the mean of three independent experiments; Scale bars, 500 μm. Data from KhES-1 and 253G4 strains are shown as representative. **e.** Flow cytometric analysis of differentiating cells on day 4, indicating the down-regulation of immature cell markers and up-regulation of differentiated progenitor markers. Data from KhES-1 are shown as representative.
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(Figure 2a), and flow cytometric (FCM) analysis demonstrated the emergence of new cell fractions that were positive for KDR, CD117, CXCR4, and CD34 but negative for CD140a, CD43, and CD45 (Figure 2b). Our system robustly supports mesodermal induction from both ES and iPS cells, despite differences in efficacy among cell strains (Figure 2c).

Further, immunohistochemical staining for KDR indicated an uneven distribution of KDR^+ cells at the marginal zone of the plateau area (Figure 1c), suggesting that differentiation polarity within the colonies resulted in site-specific emergence of putative hematopoietic mesodermal progenitors.

Step 3: Production of functional blood cells dependent on cytokine cocktails (day 6 onward). On day 6, we changed the culture medium to another chemically defined medium containing hematopoietic cytokines (Figure 1a). To achieve lineage-directed differentiation, we used 2 combinations of cytokines: a myeloid-

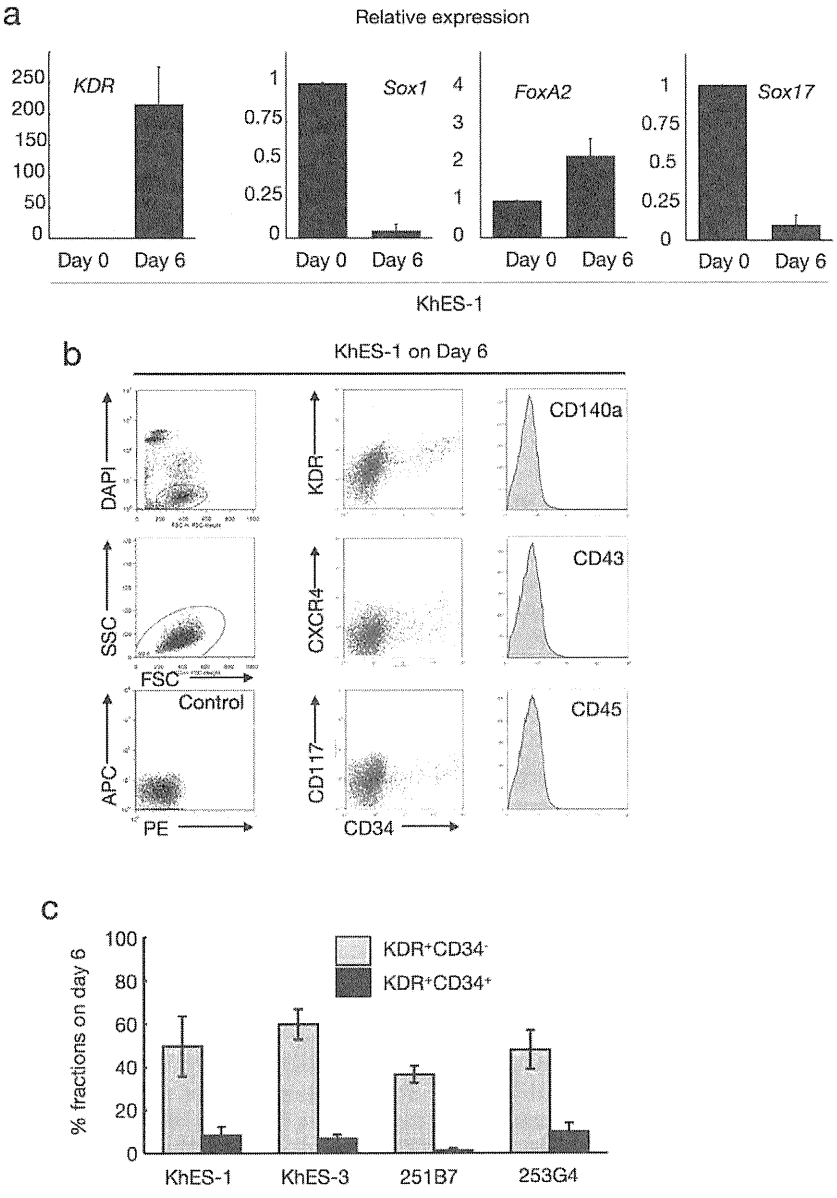

Figure 2. Characterization of cells during initial differentiation with lineage-specific marker expression. a. Expression analysis of lineage-specific marker genes at the beginning of differentiation (day 0) and the end of step 2 (day 6). Bars represent standard deviation of the mean of three independent experiments. Data from KhES-1 are shown as representative. **b.** The development of progenitors on day 6 positive for lateral mesoderm markers but negative for paraxial mesoderm and haematopoietic cell markers. Leftmost column shows the gating strategy for eliminating dead cells and debris. Data from KhES-1 are shown as representative. c. Efficacy of inducing $KDR^{+}CD34^{+\text{ or }-}$ mesodermal progenitors from each two lines of human ES cells and iPS cells. Bars represent standard deviation of the mean of three independent experiments.
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induction cocktail containing SCF, TPO, IL3, FLT-3 ligand, and G-CSF; and an erythropoietic-differentiation cocktail containing SCF, TPO, IL3, FP6, and EPO.

Regardless of the cocktails, the colonies first exhibited a rosary-like appearance, with small sac-like structures aligned along the margins of the plateau areas, and grew for several days (Figure 3a, left panel). Hematopoietic cell clusters emerged from the edge of these structures on days 10–12, followed by the appearance of floating blood cells a few days later, which increased thereafter; hematopoietic clusters grew in size and number, and some exhibited areas with a cobblestone-like appearance (Figure 3a, right 3 panels; Movie S2). When fresh medium with the cytokines was supplied every 5 days, blood cell production was observed in both ES and iPS cell experiments until day 50 of differentiation, whereas few hematopoietic cells appeared without the cytokines (data not shown).

As expected, the myeloid-induction cocktail induced myelo-monocytic lineages predominantly positive for CD45. Blood cells harvested on day 30 exhibited morphology compatible with myelomonocytic precursors and mature neutrophils, and displayed positive myeloperoxidase staining (Figure 3b). On the other hand, the erythropoietic-differentiation cocktail yielded cell lineages that included hemoglobin-positive (Hb^{+}) erythroid cells and $CD41^{+}$ megakaryocytes (Figure 3b). In the KhES-1 strain (3.5 [standard deviation (SD) = 1.5] undifferentiated colonies 250 μmm in diameter were initially plated in individual wells of 6-well plates

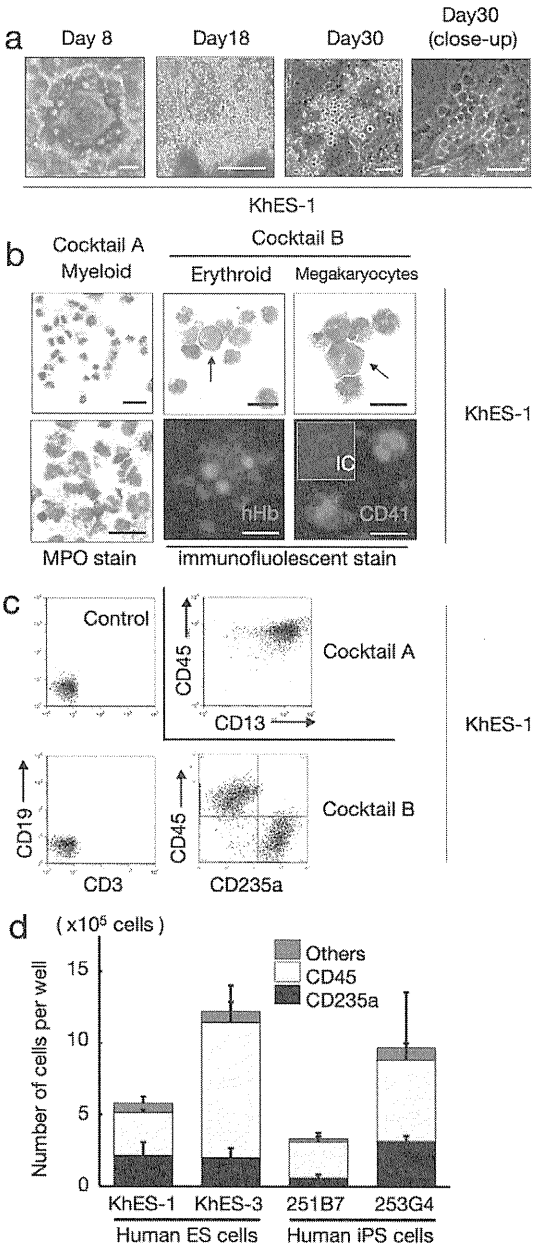

Figure 3. Human ES/iPS cell-derived haematopoiesis in a monolayer culture free from animal serum or stromal cells. a. Sequential phase contrast pictures showing haematopoietic development. Scale bars, 500 μm (left two panels) and 100 μm (right two panels). Data from KhES-1 are shown as representative. **b.** Floating cells harvested on day 30 showing various lineages of haematopoietic cells; MPO-positive myeloid lineage cells (leftmost panels), pan-human Hb-positive erythroid lineage cells (centre panels), and CD41-positive megakaryocytes (rightmost panels). Scale bars, 100 μm. Data from KhES-1 are shown as representative. **c.** Expression of lineage-specific antigens on floating cells harvested on day 30; Myeloid lineages (CD13 and CD45), erythroid lineages (CD235a), T cells (CD3), and B cells (CD19). Data from KhES-1 are shown as representative. **d.** Numbers and fraction of blood cells induced from each two lines of human ES cells and iPS cells. Bars represent standard deviation of the mean of three independent experiments.
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at the start of differentiation), counting and FCM analysis of harvested blood cells on day 30 revealed the existence of 7.7×10^5 (SD = 2.3×10^5) different cell lineages per well, including 36.0% (SD = 6.4%) $CD235a^+$ erythroid and 53.2% (SD = 9.4%) $CD45^+$ myelomonocytic lineages, but no lymphoid lineage cells (Figure 3c). Although the differentiation efficacy and lineage distribution depend not only on the cytokines but also on the cell strains, the data indicates that human ES and iPS cells develop into various lineages of hematopoietic cells, robustly and orderly, in our novel monolayer culture system without xeno-derived serum or stromal cells (Figure 3d).

ES/iPS cell-derived hematopoietic cells have similar potential to in vivo-derived blood cells in function

Considering the use of ES/iPS cell-derived hematopoiesis for various clinical and research applications, it is important to confirm the function of the generated blood cells. Neutrophils derived with the myeloid-induction cocktail exhibited migration activity in response to the chemoattractant fMLP (Figure 4a) and phagosome-dependent reactive oxygen production, which was inhibited by the phagosome destruction agent, cytochalasin B (Figure 4b). On the other hand, erythroid lineage cells derived with the erythropoietic-differentiation cocktail (harvested on day 32 of differentiation) exhibited an oxygen dissociation curve that was similar, despite being slightly left-shifted, to those obtained with adult and cord blood cells (Figure 4c). These data indicate that our culture facilitates robust and orderly development of human ES and iPS cells into functional hematopoietic cells with similar potential to in vivo-derived blood cells.

Clonogenic hematopoietic development from human ES/iPS cell-derived progenitors

The human hematopoietic system is a hierarchy of various component cells from stem or progenitor cells to terminally differentiated cells. For example, $CD34^+$ cells in umbilical cord blood or bone marrow contain putative hematopoietic stem cells and are used as a source of stem cell transplantation. The identification and proliferation of such cells in vitro have been of great interest in medical science research.

To assess the potential of our system for supporting generated immature stem or progenitor cells, we evaluated the colony-forming ability of the cultivated hematopoietic progenitors in the system. Accordingly, the cells were cultured with SCF, TPO, IL3, FLT-3 ligand, and FP6. In these conditions, $CD34^+CD45^+$ hematopoietic cells existed up to day 25, indicating that the immature hematopoietic cells can be maintained in our serum-free culture (Figure 5a).

We harvested adherent blood cells from the previously described culture and transferred them into a methylcellulose-containing medium to perform colony-forming assays with SCF, TPO, IL3, G-CSF, and EPO. As shown in Figure 5b and c, CFU-Mix, BFU-E, CFU-GM, and CFU-G colonies developed from plated cells. The total number of colonies increased dramatically from day 6 to day 10, then gradually increased until day 15 and decreased thereafter. CFU-Mix and BFU-E colonies were mainly observed until day 15 and were thereafter replaced by CFU-GM and CFU-G colonies. Similar tendencies were observed in both ES and iPS cells. These results suggest that our culture system can incubate multipotent hematopoietic stem or progenitor cells over a period of time.

Identification of $KDR^+CD34^+CD45^-$ bipotential hemoangiogenic progenitors derived in serum-free conditions

During embryogenesis, hematopoietic development is closely associated with endothelial lineage commitment [47,48], and

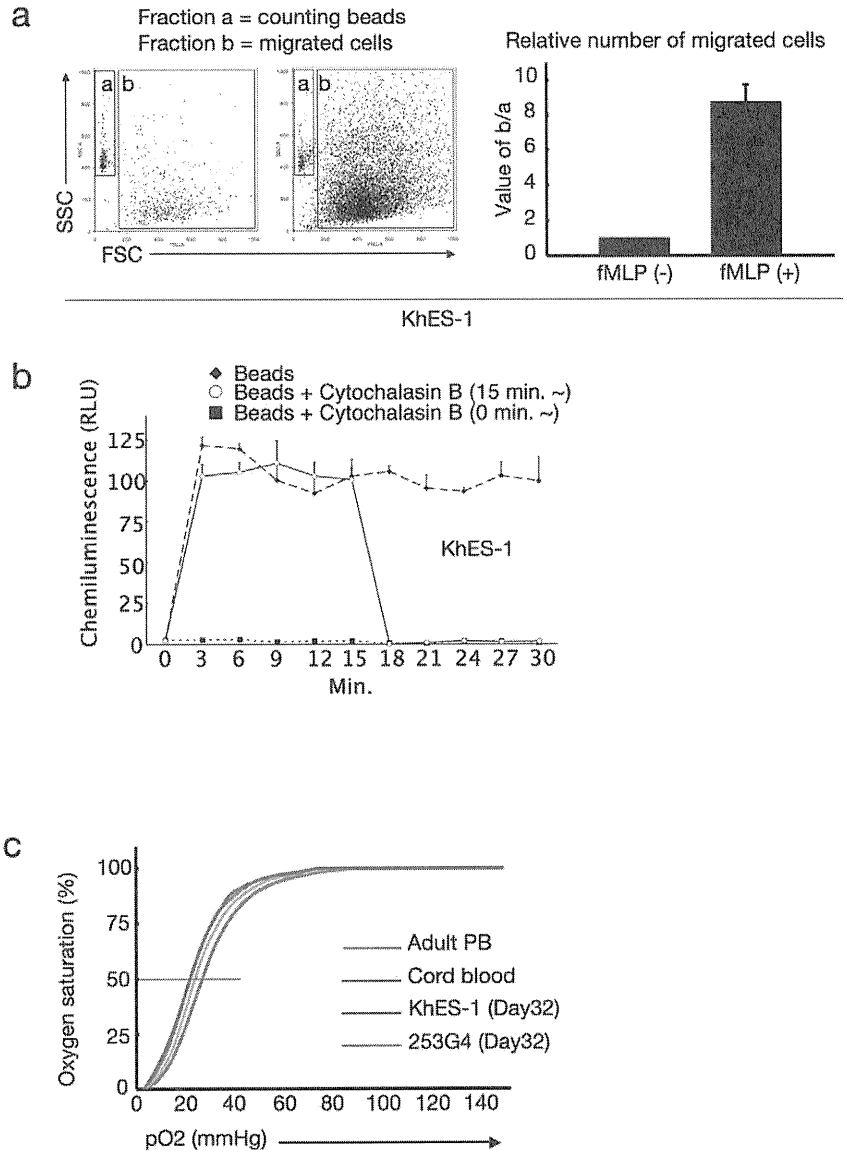


Figure 4. Functional blood cells derived from human ES/iPS cells. a. Number of migrated cells that permeated through the transwell membrane with or without fMLP. Values were normalised to the number of counting beads, and the control values were arbitrarily set to the condition without fMLP. Data from KhES-1 are shown as representative. **b.** Assay for phagocytosis-induced respiratory burst activity using chemiluminescent microspheres (luminol-binding microspheres). Abbreviation: RLU, relative light units. Data from KhES-1 are shown as representative. **c.** Oxygen dissociation curves of erythroid cells derived from human ES/iPS cells (harvested on day32 of differentiation), human cord blood, and adult peripheral blood. Where shown, bars represent standard deviation of the mean of three independent experiments.
doi:10.1371/journal.pone.0022261.g004

previous studies have demonstrated that ES cells can differentiate into the common multipotent progenitors that differentiate into both blood and endothelial cells at the single cell level on OP9 stroma [17,28,49]. Although the experiments described thus far demonstrated that the serum-free, xeno-cell-free culture condition supported human ES/iPS cell-derived hematopoiesis in an orderly manner, as observed during embryogenesis, it was unclear which day 6 fraction(s) developed into blood cells. To clarify this point, human ES cells stably expressing green fluorescent protein (GFP) were cultured, then 1×10^4 cells of $GFP^+KDR^-CD34^-CD45^-$ (Fraction A), $GFP^+KDR^+CD34^-CD45^-$ (Fraction B), and $GFP^+KDR^+CD34^+CD45^-$ (Fraction C) fractions were transferred on day 6 into a synchronous differentiation culture of unlabeled ES cells (Figure 6a). Nineteen days later (day 25 of differentiation), GFP^+ small round cell-containing colonies were observed predominantly in Fractions B and C, and FCM analysis of the entire culture confirmed the emergence of GFP^+CD45^+ cells mainly from Fraction C (Figure 6b). On the other hand, few blood cells positive for GFP were generated from Fraction A. These results were obtained with 2 independent strains of human ES cells (KhES1-EGFPneo on KhES-1 and KhES3-EGFPneo on KhES-3) (Figure 6c) and indicated that hematopoietic progenitors were present in the KDR^+ fraction, particularly in the KDR^+CD34^+ fraction, on day 6 of differentiation.

Finally, we performed a single-cell deposition assay by transferring single sorted human ES/iPS cell-derived $GFP^+KDR^+CD34^+CD45^-$ cells, which were negative for VE-cadherin, on day 6 into individual wells of 96-well plates coated

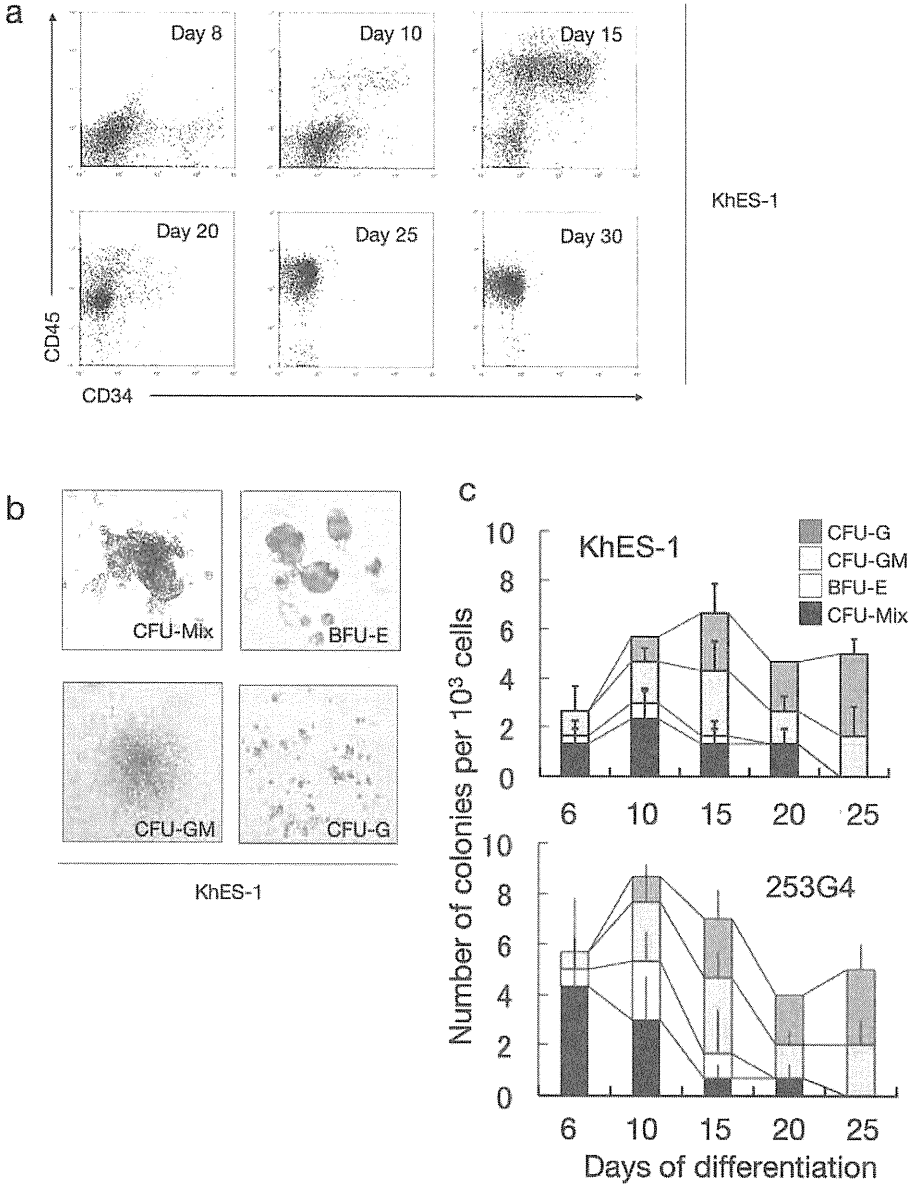


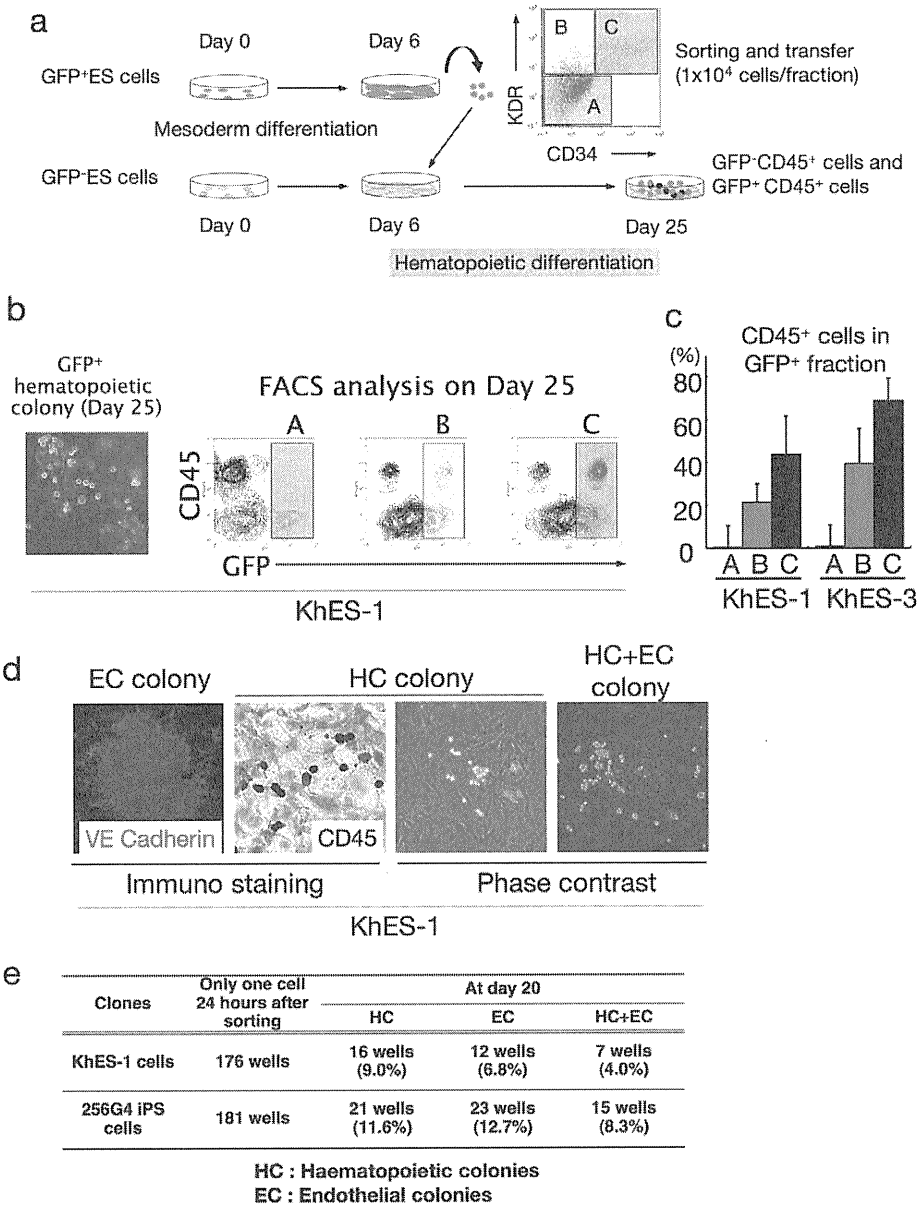
Figure 5. Hematopoietic stem/progenitor cells in culture. a. Sequential FCM analysis of cells harvested on indicated days showing the existence of $CD34^{+}CD45^{+}$ haematopoietic progenitor cells in culture. Data from KhES-1 are shown as representative. **b.** Various colony types on MTC-containing medium clonally emerged from single haematopoietic progenitor cells. Data from KhES-1 are shown as representative. **c.** Numbers of each colony type derived from different days of culture. Bars represent standard deviation of the mean of three independent experiments. Data from KhES-1 and 253G4 strains are shown as representative.
doi:10.1371/journal.pone.0022261.g005

with an OP9 cell layer. As shown in Figure 6d and e, the proportion of hematopoietic cell (HC) development, VE-cadherin^{+} endothelial cell (EC) development, and HC plus EC development on day 20 were 9.0%, 6.8%, and 4.0%, respectively, for KhES-1 and 11.6%, 12.7%, and 8.3%, respectively, for 253G4 iPS cells. These results demonstrate that the common mesodermal progenitors that can differentiate into both blood and endothelial cells at the single-cell level are induced in our culture condition.

Discussion

In this study, we demonstrated the orderly mesodermal and hematopoietic differentiation of human ES and iPS cells in a novel serum-free monolayer culture condition. Simple manipulation of cytokine combinations facilitated robust, reproducible, and highly directed stepwise commitment to specific lineages of functional blood cells.

There are several reports on hematopoietic differentiation of human ES/iPS cells, such as murine-derived OP9 stromal cell coculture and feeder/serum-free EB formation systems [20,22,23,24,30,31,32,50]. However, two-dimensional cultures containing xeno-serum/cells often cause dependency on their lots, while complicated three-dimensional structures inside EBs make it difficult to assess and control conditions for inducing specific progenitors. Actually, few in vitro systems have been able to reliably reproduce hematopoietic development from mesodermal progenitors or model the in vivo coexistence of developing hematopoietic cells and their autologous microenvironments in



e

Clones	Only one cell 24 hours after sorting	At day 20		
		HC	EC	HC+EC
KhES-1 cells	176 wells	16 wells (9.0%)	12 wells (6.8%)	7 wells (4.0%)
256G4 iPS cells	181 wells	21 wells (11.6%)	23 wells (12.7%)	15 wells (8.3%)

HC : Haematopoietic colonies
EC : Endothelial colonies

Figure 6. Haematopoietic differentiation from KDR$^+$CD34$^+$ mesodermal progenitors. a. Schema of the protocol for measuring haematopoietic activities of depicted fractions on day 6. **b.** Each sorted fraction-derived haematopoiesis on day 25 detected by fluorescent microscopy and FCM analysis. Data from KhES-1 are shown as representative. **c.** Ratio of CD45$^+$ cells in GFP$^+$ fraction on day 25 showing the strongest haematopoietic activity of fraction C followed by fraction B. **d.** Single KDR$^+$CD34$^+$CD45$^-$ cell-derived haematopoietic colonies (HC), VE-cadherin$^+$ endothelial colonies (EC), and HC+EC colonies generated on OP9 cell layers. Data from KhES-1 are shown as representative. **e.** Number of wells that showed HC, EC, and EC+HC development.
doi:10.1371/journal.pone.0022261.g006

serum-free conditions. Our less labor-intensive and clearly defined monolayer culture facilitates observation of the stepwise development of pluripotent cells to blood cells via common hemoangiogenic progenitors and the behavior of hematopoietic cells on autologous stromal cells. Consequently, assays for elucidating differences in lineage specification of various ES/iPS cell strains, including hematopoietic potential, can be performed with high reproducibility. This is particularly important because individual pluripotent cell strains vary in differentiation potentials [51,52,53]. This study demonstrated quantitative differences in hematopoietic differentiation efficacy and lineage commitment among 4 ES/iPS cell strains.

Because human ES/iPS cells are feasible cell sources for various clinical applications, scientific and medical communities have shown continuing interest in hematopoietic stem cell induction from ES/iPS cells. Previous trials have indicated that murine ES cell-derived hematopoietic cells overexpressing HoxB4 [54] can replenish the bone marrow of lethally irradiated recipient mice. However, it remains a challenge to develop bona fide human hematopoietic stem cells with bone marrow reconstitution activity at the single-cell level. In our study, we observed many cobblestone area-forming cells, which reportedly indicate the existence of very immature hematopoietic progenitors. Moreover, FCM analyses and colony-forming assays suggested that ES and iPS human cell-

derived hematopoiesis in our method occurs through clonogenic hematopoietic stem/progenitor cells. We are in the process of determining in vivo repopulating ability of cells harvested from our culture by using serial transplantation into immunodeficient mice to assess the possibility of inducing feasible cell sources for various clinical applications, such as cell therapies and disease investigation.

Finally, time-lapse imaging strongly indicated crosstalk between hematopoietic cells and the autologous microenvironment composed of non-hematopoietic cells. Emerged blood cells move about actively and generate colonies in surrounding cell layers, suggesting the importance of a direct interaction between blood cells and microenvironmental cells for the maintenance, proliferation, and differentiation of stem or progenitor cells (Movie S3). In fact, a model of hematopoietic disorders triggered by mutation in the bone marrow microenvironment has been recently reported [55]. However, further investigation is necessary to identify the mechanisms responsible for such phenomena. Our culture may aid these investigations as it facilitates simple and sequential harvest of hematopoietic cells with minimal contamination by autologous adherent cell layers.

In conclusion, this study presents novel methods for analyzing the mechanisms of normal hematopoiesis in a robust, reproducible, and stepwise manner. Furthermore, employing gene-manipulated ES cells or disease-specific iPS cells will supply in vitro models of disease pathology, thereby providing further insights into hematological defects in conditions such as aplastic anemia and myelodysplastic syndromes.

Supporting Information

Movie S1 Time-lapse microscopic movie showing the morphological change in a single colony from day 0 to day 6 (initial differentiation). In this period, a colony begins forming a rosary-like morphology as it differentiates. The pictures were automatically taken every 8 minute by Biostation IM (Nikon Instruments, Tokyo, Japan).
(MOV)

Movie S2 Time-lapse microscopic movie showing the morphological change in a single colony from day 6 to day 25 (hematopoietic differentiation). After adding hematopoietic cytokines on day 6, hematopoietic cells first emerge from the areas near the edge of stratified zone. The pictures were automatically taken every 8 minute by Biostation IM (Nikon Instruments, Tokyo, Japan).
(MOV)

Movie S3 Close-up time-lapse microscopic movie showing hematopoietic cells moving about and generating colonies in surrounding cell layers. The pictures were automatically taken every 8 minute by Biostation IM (Nikon Instruments, Tokyo, Japan).
(MOV)

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Author Contributions

Conceived and designed the experiments: AN TH KU TN MKS. Performed the experiments: AN H. Sakai. Analyzed the data: AN TH KU KO IK H. Sakai. TN MKS. Contributed reagents/materials/analysis tools: H. Suemori H. Sakai. Wrote the manuscript: AN TN MKS.

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High Incidence of *NLRP3* Somatic Mosaicism in Patients With Chronic Infantile Neurologic, Cutaneous, Articular Syndrome

Results of an International Multicenter Collaborative Study

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Objective. **Chronic infantile neurologic, cutaneous, articular (CINCA) syndrome, also known as neonatal-onset multisystem inflammatory disease (NOMID), is a dominantly inherited systemic autoinflammatory disease. Although heterozygous germline gain-of-function *NLRP3* mutations are a known cause of this disease, conventional genetic analyses fail to detect disease-causing mutations in ~40% of patients. Since somatic *NLRP3* mosaicism has been detected in several mutation-negative NOMID/CINCA syndrome patients, we undertook this study to determine the precise contribution of somatic *NLRP3* mosaicism to the etiology of NOMID/CINCA syndrome.**

Methods. **An international case–control study was performed to detect somatic *NLRP3* mosaicism in NOMID/CINCA syndrome patients who had shown no mutation during conventional sequencing. Subcloning and sequencing of *NLRP3* was performed in these mutation-negative NOMID/CINCA syndrome patients and their healthy relatives. Clinical features were analyzed to identify potential genotype–phenotype associations.**

Results. **Somatic *NLRP3* mosaicism was identified in 18 of the 26 patients (69.2%). Estimates of the level of mosaicism ranged from 4.2% to 35.8% (mean ± SD 12.1 ± 7.9%). Mosaicism was not detected in any of the 19 healthy relatives (18 of 26 patients versus 0 of 19**

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relatives; $P < 0.0001$). In vitro functional assays indicated that the detected somatic *NLRP3* mutations had disease-causing functional effects. No differences in *NLRP3* mosaicism were detected between different cell lineages. Among nondescript clinical features, a lower incidence of mental retardation was noted in patients with somatic mosaicism. Genotype-matched comparison confirmed that patients with somatic *NLRP3* mosaicism presented with milder neurologic symptoms.

***Conclusion.* Somatic *NLRP3* mutations were identified in 69.2% of patients with mutation-negative NOMID/CINCA syndrome. This indicates that somatic *NLRP3* mosaicism is a major cause of NOMID/CINCA syndrome.**

Chronic infantile neurologic, cutaneous, articular (CINCA) syndrome (MIM no. #607715), also known as neonatal-onset multisystem inflammatory disease (NOMID), is a dominantly-inherited autoinflammatory disease that is characterized by neonatal onset and the triad of urticarial-like skin rash, neurologic manifestations, and arthritis/arthropathy. Patients often experience recurrent fever and systemic inflammation. NOMID/CINCA syndrome is the most severe clinical phenotype of the cryopyrin-associated periodic syndromes (CAPS) that also include the 2 less severe but phenotypically similar syndromes familial cold autoinflammatory syndrome (FCAS; MIM no. #120100) and Muckle-Wells syndrome (MIM no. #191900). CAPS are caused by mutations in the *NLRP3* gene, which is a member of the nucleotide-binding oligomerization domain–like receptor (NLR) family of the innate immune system (1,2).

NLRP3 is an intracellular "sensor" of danger signals arising from cellular insults, such as infection, tissue damage, and metabolic deregulation, and it has been highly conserved throughout evolution. NLRP3 associates with ASC and procaspase 1 to constitute a large multiprotein complex termed the NLRP3 inflammasome. When activated, the NLRP3 inflammasome converts the biologically inactive procaspase 1 into active caspase 1. Caspase 1 produces the cytokines interleukin-1β (IL-1β) and IL-18, which are mainly involved in the inflammatory response (3). Available research suggests that mutated *NLRP3* induces autoactivation of the NLRP3 inflammasome in CAPS patients, resulting in an uncontrolled overproduction of IL-1β.

Most CAPS patients carry heterozygous germline missense mutations in the *NLRP3* coding region ("mutation-positive" patients) (4,5). More than 80 different disease-causing mutations have been reported to date (6). However, ~40% of clinically diagnosed NOMID/CINCA syndrome patients show no heterozygous germline *NLRP3* mutation during conventional Sanger-sequencing-based genetic analyses ("mutation-negative" patients). Comparisons of NOMID/CINCA syndrome patients with and without heterozygous germline *NLRP3* mutations have revealed no differences in clinical features or response to treatment (4,7).

In a previous study, we identified a high incidence of somatic *NLRP3* mosaicism in "mutation-negative" NOMID/CINCA syndrome patients in Japan (8). We therefore hypothesized that somatic *NLRP3* mosaicism may be implicated in the etiology of the disorder, although its precise contribution remains unclear. The aim of the present study was to evaluate both the frequency of *NLRP3* somatic mosaicism in NOMID/CINCA syndrome patients and the association between somatic mosaicism and clinical phenotype using an international cohort of mutation-negative NOMID/CINCA syndrome patients.

PATIENTS AND METHODS

Study design and participants. International collaborators were contacted to identify mutation-negative NOMID/CINCA syndrome cases. A total of 20 DNA samples were received from 4 centers: France (n = 6), The Netherlands (n = 4), Spain (n = 3), and the US (n = 7). DNA samples had been extracted from peripheral blood mononuclear cells or whole blood. All 20 samples had been subjected to conventional sequencing, and no *NLRP3* mutations had been identified. In each case, the accuracy of the clinical diagnosis had been confirmed according to the diagnostic criteria (7). The 6 previously reported Japanese cases and 1 Spanish case with *NLRP3* somatic mosaicism were also included (8,9). DNA samples were also collected from 19 healthy relatives of 8 patients (8 from France, 5 from Japan, 2 from Spain, and 4 from the US) to evaluate the causality of somatic *NLRP3* mosaicism in a case–control manner, since the clinical features may be modified by genetic and environmental factors.

Written informed consent for *NLRP3* gene analysis was obtained from all patients and controls. The study was approved by the Institutional Review Board of the Kyoto University Graduate School of Medicine and was conducted in accordance with the Declaration of Helsinki.

Data collection. *Demographic and clinical data.* The clinicians responsible for each mutation-negative NOMID/CINCA syndrome patient completed a questionnaire to document characteristics such as age, sex, race, symptoms, clinical findings, clinical course, and prognosis. No clinical data were obtained from the healthy controls.

Investigation of NLRP3 gene mosaicism. Disease-causing mutations in NOMID/CINCA syndrome patients have

only been reported in exons 3, 4, and 6 of *NLRP3* (6). Thus, the present sequencing was focused on a search for somatic mosaicism of these 3 exons and their flanking intronic regions. After amplifying these genomic regions with the proofreading polymerase chain reaction (PCR) enzyme KOD-Plus polymerase (Toyobo) and dA addition with an LA *Taq* polymerase (Takara Bio), the amplicons were subcloned into pCR2.1-TOPO vector (Invitrogen). Ninety-six clones were selected at random for each amplicon. The subcloned amplicons were retrieved by PCR with LA *Taq* polymerase. They were then treated with ExoSAP-IT (USB) and proteinase K (Promega) prior to direct sequencing. The cloned exons were sequenced at the Kazusa DNA Research Institute using a BigDye Terminator kit (version 3.1) and an ABI 3730 DNA sequencer (Life Technologies). Mosaicism was indicated by the detection of >2 subclones carrying the same base variation at the same position in 96 clones.

To purify leukocyte subpopulations, freshly drawn whole blood was separated using sequential dextran and Ficoll-Hypaque density-gradient centrifugation methods. Cell sorting to select T cells, B cells, and monocytes was performed with an AutoMACS Pro Separator (Miltenyi Biotec) or a FACSVantage System (BD Biosciences), as described elsewhere (8,9). The purity of each cell lineage was >90%. The level of mosaicism was determined by sequencing each source of genomic DNA from 80 clones.

Plasmids and cell lines. To determine whether the identified NLRP3 mutants cause disease, experiments for assessing 2 pathologic functions were performed as described elsewhere (8). Briefly, ASC-dependent NF-κB activation was performed by a dual-luciferase reporter assay in HEK 293FT cells transfected with NLRP3 mutants. Transfection-induced cell death in the human monocytic cell line THP-1 was performed by transfecting green fluorescent protein–fused mutant NLRP3 into THP-1 cells and then measuring the dead cells with 7-aminoactinomycin D.

Statistical analysis. The study was designed to detect mosaicism at a 5% allele frequency with >95% possibility. To satisfy this condition, it was necessary to sequence at least 93 clones per patient. The following calculation was used to estimate the number of clones that had to be sequenced: $P = 1 - (1 - 0.05)^n - n(0.05)(1 - 0.05)^{n-1}$ ($n = 93$, $P = 0.956$). The study was designed to analyze 96 PCR-fragment clones from each patient. The error rate of the PCR reactions was estimated using a proofreading KOD-Plus enzyme. We analyzed a plasmid vector carrying a normal *NLRP3* exon 3, in which 2 distinct errors were detected by sequencing 91 clones. The calculated error rate for this result was 1/87,451 (2/[1,922 bp × 91 clones]). Thus, the probability was negligible that the same errors would be detected more than twice in 96 clones from 1 patient.

To calculate the sample size, we calculated the prevalence of somatic mosaicism among mutation-negative NOMID/CINCA syndrome patients. Eight cases of somatic mosaicism were identified among 15 mutation-negative NOMID/CINCA syndrome patients who were subsequently analyzed by the subcloning method described above. It was assumed that the maximum number of possible somatic mosaicism cases among family controls was 1. On the basis of these data and this assumption, it was calculated that 19 controls were required to ensure a 2-sided alpha level of 0.05 and a power of 0.8.

Continuous variables are presented as the mean ± SD or as the median and interquartile range. Categorical variables are presented as numbers and ratios (with percentages). To compare clinical data between patients with and patients without mosaicism, the Wilcoxon rank sum test was used for continuous variables and Fisher's exact test was used for categorical variables. Fisher's exact test was used to compare the difference in mosaicism ratio between cases and controls. The chi-square test was used to compare the difference in the level of mosaicism between different sources of genomic DNA from each patient.

Table 1. Somatic mosaicism among mutation-negative NOMID/CINCA syndrome patients*

Country, patient	Sequence variant	Protein variant	Mosaicism, %
France			
F1	1298C>T	T433I	5.2
F2	907G>C	D303H	4.2
F3	1315G>C	A439P	21.9
F4	1216A>G	M406V	9.2
F5	1698C>A	F566L	11.5
F6	None	–	–
Japan			
J1	1709A>G	Y570C	12.2
J2	790C>T	L264F	4.3
J3	919G>A	G307S	10.7
J4	1699G>A	E567K	6.5
J5	907G>C	D303H	11.9
J6	None	–	–
Spain			
S1	920G>T	G307V	9.6
S2	907G>C	D303H	19.1
S3	None	–	–
S4	None	–	–
US			
A1	1065A>T	K355N	18.8
A2	1698C>A	F566L	14.6
A3	1704G>C	K568N	9.4
A4	2263G>A	G755R	35.8
A5	None	–	–
A6	None	–	–
The Netherlands			
N1	1699G>A	E567K	6.3
N2	2263G>A	G755R	6.3
N3	None	–	–
N4	None	–	–

* *NLRP3* mosaicism was detected in 18 of 26 patients (69.2%) with neonatal-onset multisystem inflammatory disease (NOMID)/chronic infantile neurologic, cutaneous, articular syndrome (CINCA syndrome). When samples from 19 healthy relatives of these patients were investigated, no somatic mosaicism was detected. The *P* value from the comparison of the cases and the controls (18 of 26 versus 0 of 19) was statistically significant ($P < 0.0001$).

RESULTS

Somatic *NLRP3* mosaicism in mutation-negative NOMID/CINCA syndrome patients. A heterozygous germline *NLRP3* mutation was detected in 1 of the 27 samples, and this was therefore excluded from the analyses. For each patient, 96 clones were selected at random for each amplicon. These were then sequenced. *NLRP3* mosaicism was detected in 18 of 26 patients (69.2%), and the level of allelic mosaicism ranged from 4.2% to 35.8% (mean ± SD 12.1 ± 7.9%; median 10.2%) (Table 1). Seven of the detected *NLRP3* mutations were novel (p.G307S, p.K355N, p.M406V, p.T433I, p.F566L, p.E567K, and p.K568N). The remaining mutations have been reported previously in NOMID/CINCA syndrome patients as disease-causing heterozygous germline mutations (p.L264F, p.D303H, p.G307V, p.A439P, p.Y570C, and p.G755R). Each of the 3 *NLRP3* mutations, p.F566L, p.E567K, and p.G755R, was detected in 2 unrelated patients. *NLRP3* mutation p.D303H was detected in 3 unrelated patients.

Analyses in family controls. To validate the clinical relevance of the *NLRP3* mosaicism identified in mutation-negative NOMID/CINCA syndrome patients, samples from 19 healthy relatives were investigated. No somatic mosaicism was detected in any of these samples. The *P* value from the comparison of cases and controls (18 of 26 versus 0 of 19) was statistically significant ($P < 0.0001$).

Functional effects of the identified somatic *NLRP3* mutations. Since disease-causing heterozygous germline mutations in *NLRP3* have been implicated in necrosis-like programmed cell death and ASC-dependent NF-κB activation (8), experiments were performed to determine whether the mutations identified in patients with somatic mosaicism showed the same effects. All of the identified mutations induced both THP-1 cell death (Figure 1A) and ASC-dependent NF-κB activation (Figure 1B). The in vitro effects of these novel mutations were similar to or even more pronounced than those of previously reported *NLRP3* mutations. This strongly suggests that all mutations showing somatic mosaicism have pathogenic effects, including the novel mutations identified in the present study.

Mutation frequency of *NLRP3* among various cell lineages and 1 tissue type. To explore the origin of the *NLRP3* mosaicism, mutational frequency was evaluated in various cell lineages and 1 tissue type from 4 Japanese patients with *NLRP3* somatic mosaicism. In each patient, the same mutations were found in all of the cell lineages investigated (neutrophils, monocytes, T cells, B cells) and in the buccal mucosa tissue, and no significant difference in mutation frequency was observed between these sources (Table 2).

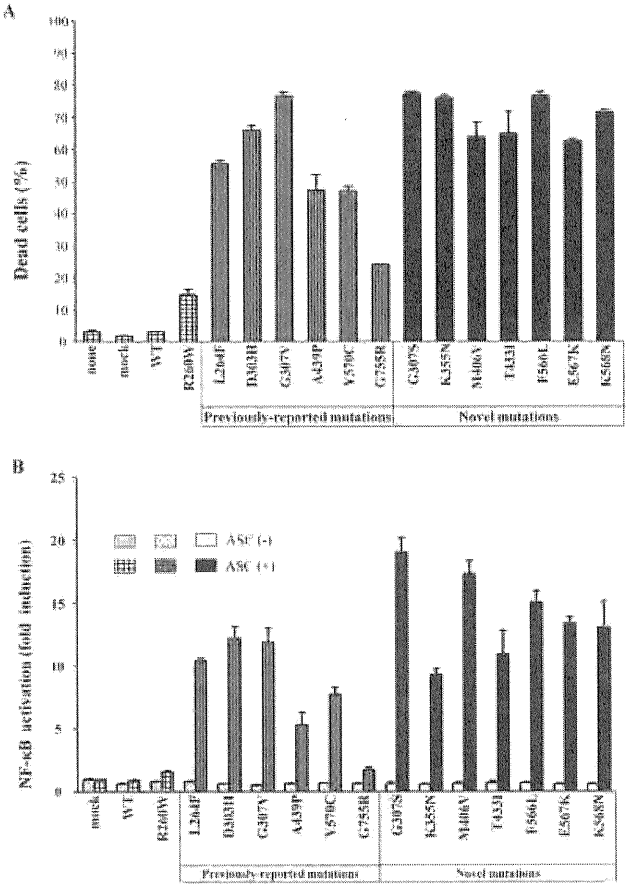

Figure 1. In vitro functional assessment of the identified *NLRP3* mosaicism mutations. **A,** Necrotic cell death of THP-1 cells induced by the identified somatic *NLRP3* mosaicism mutations. Green fluorescent protein (GFP)–fused mutant NLRP3 was transfected into THP-1 cells. The percentage of dead cells (7-aminoactinomycin D positive) among GFP-positive cells is shown. Values are the mean ± SD of triplicate experiments, and data are representative of 2 independent experiments. None = nothing transfected; mock = vector without NLRP3; WT = wild-type NLRP3; R260W = NLRP3 with p.R260W (frequent mutations in patients with cryopyrin-associated periodic syndromes). **B,** ASC-dependent NF-κB activation induced by the identified somatic *NLRP3* mosaicism mutations. HEK 293FT cells were cotransfected with WT or mutant NLRP3 in the presence or absence of ASC. The induction of NF-κB is shown as the fold change compared with cells that were transfected with a control vector without ASC (set at 1). Values are the mean ± SD of triplicate experiments, and data are representative of 2 independent experiments.

Table 2. Distribution and quantification of *NLRP3* mutations among sources of genomic DNA (4 cell lineages and 1 tissue type)*

Patient	Sequence variant	Protein variant	Mosaicism, %				
			Neutrophils	Monocytes	T cells	B cells	Buccal mucosa
J1	1709A>G	Y570C	12.6	9.8	8.0	9.5	8.3
J3	919G>A	G307S	9.1	10.8	6.9	10.6	9.0
J4	1699G>A	E567K	3.5	2.3	3.7	3.4	2.2
J5	907G>C	D303H	14.4	8.7	7.7	8.5	13.5

* No significant differences in the level of mosaicism were observed among the sources of genomic DNA.

Phenotype–genotype analysis. Given the previously reported genotype–phenotype association between the *NLRP3* gene and CAPS, the clinical characteristics of NOMID/CINCA syndrome patients with somatic *NLRP3* mutations were compared with those of patients from previous reports who had the same *NLRP3* mutations but with heterozygous germline status (1,4,10–13) (Figure 2) (further information is available at http://web16.kazusa.or.jp/download/). All of the patients in these 2 groups had an early onset of the disease, fever, and urticarial rash. The presence of arthritis, bony overgrowth, contractures, hearing loss, and seizure varied in each group of patients, and no significant difference was detected. However, whereas most patients with heterozygous germline *NLRP3* mutations presented with mental retardation, this was not the case for patients with somatic *NLRP3* mosaicism. A comparison was also made between the clinical data from patients with somatic *NLRP3* mosaicism and the data from patients with neither germline nor somatic *NLRP3* mutations. Again, a lower incidence of mental retardation was observed in patients with somatic *NLRP3* mosaicism

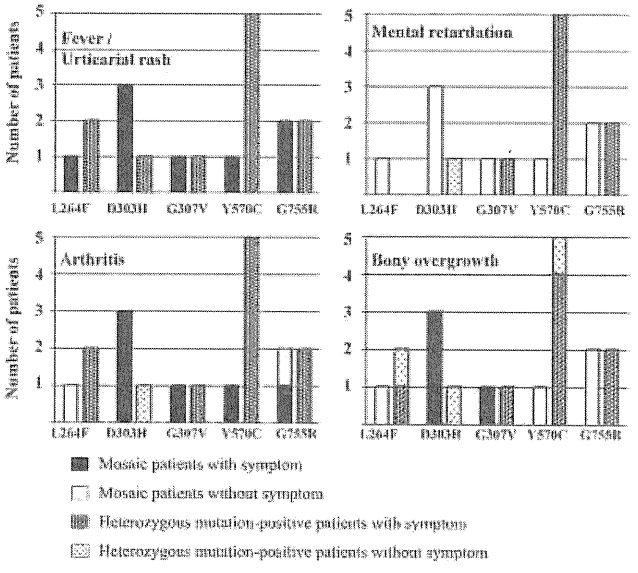

Figure 2. Comparison of the clinical profiles of patients carrying somatic *NLRP3* mutations and patients carrying the same mutation, but with germline status. Clinical profiles of patients with mosaicism and those of patients with heterozygous germline mutations are compared for each protein variant (L264F, D303H, G307V, Y570C, and G755R). The data on 4 typical clinical symptoms are shown. Total numbers of patients with mosaicism and total numbers of patients with heterozygous mutation examined are shown as a bar for each protein variant. Each bar is stratified according to the presence or absence of the symptom. For the protein variant L264F, no data on mental retardation were available for the patient with a heterozygous germline mutation.

Table 3. Clinical profiles of patients with somatic *NLRP3* mosaicism and patients with neither germline nor somatic *NLRP3* mutations*

	Patients with somatic *NLRP3* mosaicism (n = 18)	Patients with neither germline nor somatic *NLRP3* mutations (n = 8)
Age, median (IQR) years	12 (1–30)	10 (3–21)
No. of men/women	10/8	3/5
Age at onset, median (IQR) months	0 (0–24)	0.5 (0–33)
Fever	17/17	7/7
Urticarial rash	14/14	8/8
Mental retardation	4/17	6/8
Meningitis	13/17	5/8
Seizures	2/18	1/7
Hearing loss	10/18	2/7
Arthritis	14/17	7/8
Bony overgrowth	12/17	6/7
Contractures	7/17	4/7
Walking disability	8/18	3/7
Biologic therapy	10/15	3/8

* Except where indicated otherwise, values are the number with the feature/the total number of patients assessed. A lower incidence of mental retardation was observed in patients with somatic *NLRP3* mosaicism ($P = 0.03$). No other significant differences were detected between the groups. IQR = interquartile range.

($P = 0.03$). No other significant differences were detected (Table 3) (further information is available at http://web16.kazusa.or.jp/download/).

DISCUSSION

The present international multicenter study investigated 26 NOMID/CINCA syndrome patients who were mutation negative according to conventional sequencing along with 19 family controls to determine whether low-level mosaicism is a disease-causing genetic mechanism. Following our first report of low-level somatic mosaicism in a NOMID/CINCA syndrome patient (14), we reported a new method of detecting low-level *NLRP3* mosaicism, in which lipopolysaccharide (LPS) induced cell death specifically in *NLRP3* mutation–positive monocytes (8). However, this method requires fresh live monocytes, special equipment such as a cell sorter, and experience in its use due to the rapid time course of LPS-induced necrotic monocytic death. For these reasons, application of this method was not feasible in an international collaborative study. We therefore opted to use genomic DNA, since it is easier to handle and can be stored and shipped. Based on our previous study in Japanese patients showing that the frequency of mutant alleles could be <5%, we designed a subcloning and Sanger-sequencing strategy that could detect this very low allelic mutation frequency.

Presuming that the present cohort is representative of the 40% of NOMID/CINCA syndrome patients who are mutation negative according to conventional sequencing, the results suggest that ~28% of all NOMID/CINCA syndrome patients may carry somatic *NLRP3* mosaicism. CAPS patients present with a continuous spectrum of symptoms, and a degree of genotypic overlap is observed between disease subtypes. Although the present study focused on the most severe NOMID/CINCA syndrome phenotype, it is possible that somatic *NLRP3* mosaicism may also occur in milder forms of CAPS. The presence of somatic mosaicism should also be investigated in patients with other dominantly inherited autoinflammatory diseases caused by gain-of-function mutations and who are mutation negative according to conventional sequencing.

Among the 18 patients with somatic *NLRP3* mosaicism, we found 6 mutations that have previously been identified in NOMID/CINCA syndrome patients as heterozygous germline mutations. We also identified 7 novel mutations, which were confirmed as being functionally active and presumably pathogenic. Functional in vitro assays showed that these novel mutations had greater disease-causing capacity than the previously described mutations. This suggests that the novel mutations may be deleterious and unrecognized if inherited as heterozygous germline mutations.

The present study also addressed the important question of how somatic *NLRP3* mosaicism modifies clinical presentation. Although no statistically significant differences in age at disease onset, skin symptoms, joint involvement, or response to IL-1 blockade were detected, milder neurologic involvement was observed in patients with somatic mosaicism. Comparisons with NOMID/CINCA syndrome patients carrying the same *NLRP3* mutations but with heterozygous germline status made this tendency more prominent. Although the level of somatic mosaicism in blood leukocytes was relatively low, it remains unclear how these low-level mutations influence clinical presentation, including disease severity. One interesting hypothesis is that the difference in the severity of neurologic manifestations is a function of the level of mosaicism. For ethical and technical reasons, it was not possible to evaluate the level of mosaicism in central nervous system (CNS) cells or glial cells in the present study, and this therefore awaits investigation in future studies.

The mechanism through which *NLRP3* somatic mosaicism occurs also requires elucidation. The present study demonstrated that similar proportions of neutrophils, T cells, B cells, monocytes, and buccal cells carried the mutated allele. Therefore, the mutation leading to mosaicism must have arisen before the pluripotent stem cells committed to hematopoietic progenitor stem cells or ectoderm-derived nonhematopoietic cells. Several mechanisms for mosaicism have been proposed, including chimerism due to cell fusion with an aborted dizygotic twin and a mutational event during early embryogenesis (15). The latter mechanism is more likely in the present cohort, since mosaicism at similar frequency was detected in several cell types. To verify the hypothesis of a mutational event during embryogenesis, and to determine the point at which this occurred, it would be helpful to analyze other tissues. However, obtaining such tissues from patients may be ethically problematic.

Approximately 12% of the patients in the present cohort carried neither germline nor somatic *NLRP3* mutations and may therefore be considered to be genuinely mutation negative. However, it is possible that these patients have *NLRP3* mutations that have been overlooked. A recent report described a mutation in the 5′-untranslated region of *NLRP3* in a patient with FCAS

(16), although it remains unclear how this noncoding mutation causes disease. Another possibility is that an extremely low frequency of NLRP3 mosaicism may have been missed. The subcloning and Sanger-sequencing strategy used in this study set the detection limit of mosaicism at 5%. Considering the range of *NLRP3* mosaicism detected (4.2–35.8%), the median (10.2%), and the identification of 2 patients with <5% mosaicism, it is indeed likely that patients with an even lower level of *NLRP3* mosaicism may have been overlooked. Recent advances in next-generation DNA sequencing technology may resolve this technical problem, although the associated error rate could be problematic. Another possibility is that *NLRP3* mutations were present in uninvestigated cell lineages, such as those from CNS tissue, bone tissue, or skin. Future studies of NOMID/CINCA syndrome should investigate these tissues while searching for mutations in other genes.

In conclusion, the present study has clearly demonstrated that a significant proportion of NOMID/CINCA syndrome patients who were mutation negative according to conventional sequencing carried somatic *NLRP3* mutations with a variable degree of mosaicism. Clinicians should therefore consider somatic mosaicism as a possible cause of disease in mutation-negative NOMID/CINCA syndrome patients and implement appropriate therapy. The early diagnosis of NOMID/CINCA syndrome and prompt initiation of therapy would improve clinical outcome. Further goals in this research field are the refinement of genetic screening and the verification of the functional consequences of all detected somatic mutations. Systematic screening for somatic mosaicism will provide new insights into the etiology of human disease.

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AUTHOR CONTRIBUTIONS

All authors were involved in drafting the article or revising it critically for important intellectual content, and all authors approved the final version to be published. Drs. Ohara and Nishikomori had full access to all of the data in the study and take responsibility for the integrity of the data and the accuracy of the data analysis.

Study conception and design. Saito, Ohara, Nishikomori, Kambe.

Acquisition of data. Tanaka, Izawa, Saito, Oshima, Ohara, Nishikomori, Goldbach-Mansky, Aksentijevich, de Saint Basile, Neven, van Gijn, Frenkel, Aróstegui, Yagüe, Merino, Ibañez, Pontillo, Takada, Imagawa.

Analysis and interpretation of data. Sakuma, Morimoto, Kawai, Yasumi, Nakahata, Heike.

ROLE OF THE STUDY SPONSOR

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特集　最先端医療の進歩ー臓器移植・再生医療・遺伝子治療

Ⅱ．再生医療の進歩

総論：再生医療の進歩

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要旨　再生医療の基盤となる細胞は幹細胞であり，この細胞は自己複製能とさまざまな細胞への分化能を併せもった細胞として知られている．現在わが国で行われている再生医療は体性幹細胞を利用したものであるが，ヒトES細胞を用いた再生医療が2010年に米国で開始された．受精卵を滅失して作成するES細胞に比し倫理的問題の少ないiPS細胞の再生医療への応用も，近い将来開始されようとしている．

Key words　再生医療，体性幹細胞，ES細胞，iPS細胞

はじめに

従来の医療は，臓器障害をできるだけ早期に発見し，その原因の除去および生体防御反応の修飾により，障害を受けた臓器の自然回復を待つものであった．そのための薬物療法や外科的手法を用いた患部の除去などの医療が行われてきた．しかしながら，臓器障害も一定の限度を超えると不可逆的となり，臓器の機能回復は困難となる．このような患者に対して障害を受けた細胞，組織，さらには臓器を体内で再生し（*in vivo*法），あるいは人為的に再生させた細胞や組織などを移植したり，臓器としての機能を有するようになった再生組織で置換すること（*ex vivo*法）で，治療しようというのが再生医療である．このための基礎研究が盛んに行われ，その成果が続々と臨床の場に持ち込まれようとしている．再生医療の基盤となる細胞は幹細胞であり，この細胞は自己複製能とさまざまな細胞への分化能を併せもった細胞として知られている．現在行われている再生医療の多くはわれわれの身体の中に存在する体性幹細胞を利用したものであるが，ほぼ無限の自己複製能をもつ胚性幹細胞（embryonic stem cell，以下ES細胞と略す）を用いた再生医療が2010年に米国で開始され，人工多能性幹細胞（induced pluripotent stem cell，以下iPS細胞と略す）の再生医療への応用も近い将来開始されようとしている．

幹細胞

再生医療の基盤となる幹細胞には，大きく分けると多能性（pluripotent）幹細胞であるES細胞，iPS細胞と，分化の方向性が限定された（multipotent）体性幹細胞（組織幹細胞）がある（図1）．

幹細胞には階層性（hierarchy）があり，より未分化な幹細胞は自己複製能が高く，非常に広範な細胞系列に分化できる多分化能を有するが，幹細胞も下位になるに従い自己複製能は低下し，分化できる細胞系列も限定されてくる．後述するES細胞やiPS細胞はほぼ無限の自己複製能をもち，未分化な状態でいくらでも増やすことができ，分

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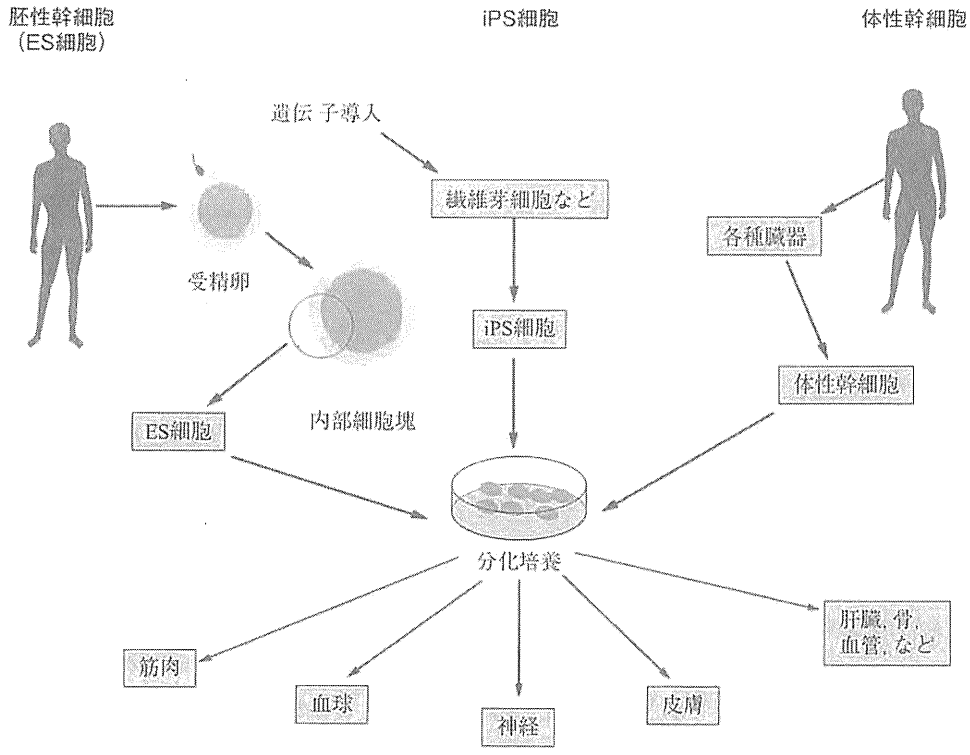

図1　幹細胞の種類

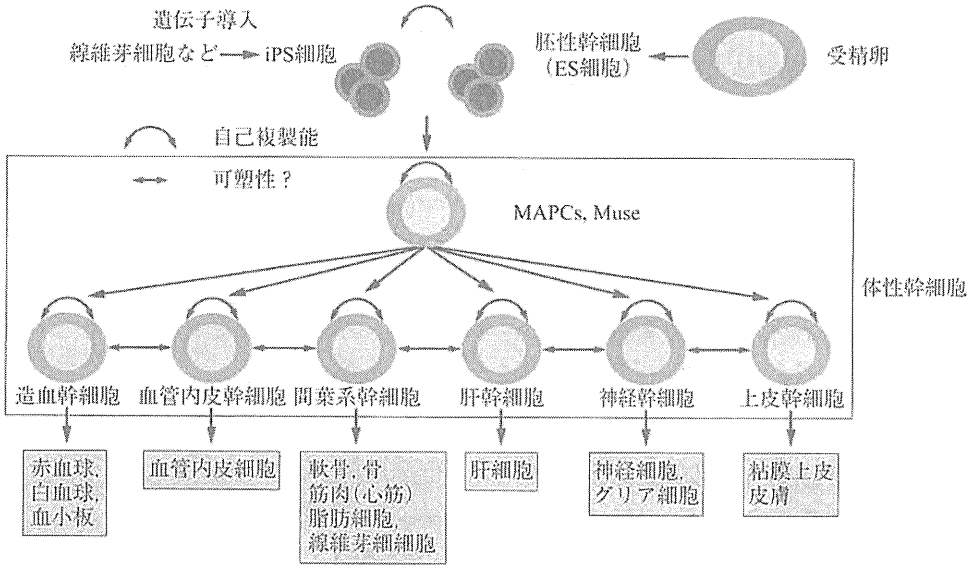

図2　幹細胞のhierarchy（階層性）

化させる培養系に転換すれば多くの細胞系列へ分化できる多分化能を有することから，hierarchyの上位に位置していると考えられる．一方，多くの体性幹細胞は限定された自己複製能と分化能をもつことから，下位に位置する幹細胞と考えられている（図2）．

1．体性幹細胞

われわれの多くの臓器には，組織特異的な体性

幹細胞が存在し，臓器が障害を受けた際にはその修復を担っていると考えられている．体性幹細胞は固有の系列への分化能をもつとともに，分裂した際，自分と同じ能力をもった細胞を再生（自己複製）することにより，それぞれの組織を維持していると考えられている．造血幹細胞はもっとも研究の進んでいる体性幹細胞であり，すべての血液細胞の母細胞である．すでに世界的に骨髄，末梢血，臍帯血中の造血幹細胞を用いた移植が盛んに行われ，さまざまな難治性疾患に対する根治を目指す治療法としての地位が築かれている．造血幹細胞移植が成功すれば，骨髄に生着したドナーの造血幹細胞から一生にわたり各種血球が供給されることとなる．このような造血幹細胞移植はまさに再生医療の先駆けと位置づけることができるし，さらに造血幹細胞を体外で増幅する研究が盛んに行われ，増幅した細胞を用いた実際の臨床応用も開始されている．その他，血管内皮，皮膚，腸上皮クリプトの基底細胞，生殖器などにそれぞれ固有な体性幹細胞が存在することが知られ，最近では，肝臓，腎臓，網膜のような三次元構造をもった組織や成人の神経組織においても幹細胞が存在することが報告されている．骨髄や脂肪組織などに存在し，骨，軟骨，脂肪細胞に分化できる間葉系幹細胞（mesenchymal stem cell：MSC）の中に，通常の体性幹細胞よりさらに未分化な性質をもつ幹細胞の存在も示唆されている[1]．このようなさまざまな幹細胞を用いて再生医学を目指す研究が盛んに行われている．欧米では死亡胎児の脳組織中の神経幹細胞を用いたParkinson病などに対する再生医療が行われているが，わが国では死亡胎児（中絶胎児）を用いた医療についての社会的合意は得られていない．現在，わが国で実際の患者に対して行われている再生医療は，すべて体性幹細胞を利用したものである．

2．胚性幹細胞（ES細胞）

1981年，Evansらは，マウス胚盤胞の将来胎仔を構成する内部細胞塊（inner cell mass：ICM）の細胞を取りだして*in vitro*で培養することにより，多能性幹細胞の樹立に成功した[2]．この細胞は生殖細胞を含むすべての組織・細胞に分化しうる能力をもつことが明らかにされた．初期胚の胚盤胞の内部細胞塊へES細胞を注入し，それを子宮に戻せば，発生への寄与が可能になり，キメラマウスが誕生し，生殖細胞に分化したES細胞はキメラマウスの交配により，その遺伝情報が次世代個体に伝達されることが確認された．このことによりDNA相同組換えによる遺伝子破壊や外来遺伝子が導入されたES細胞クローンを選択し，個体に戻すことで生体における未知の新規遺伝子の機能解析が可能となり，ES細胞は分子生物学の発展に大きく寄与することとなった．

マウスES細胞は，適切な条件下で培養すればさまざまな細胞に分化していく様子を観察することができる．われわれは血液，心筋，骨格筋，各種神経細胞やグリア細胞などへの分化を報告してきた[3][4]．

1998年，米国ウイスコンシン大学のThomsonらにより，はじめてヒト胚盤胞からのES細胞の樹立が報告された．彼らは不妊治療で不用となり廃棄される前のヒト胚盤胞を使ってES細胞株の樹立に成功した[5]．今では多数の国からヒトES細胞の樹立が報告されている．

ヒト受精卵を用いたES細胞の樹立は社会的，倫理的に多くの問題を抱えているが，一方，いったん樹立されるとES細胞はほぼ無限に増やせることから，これらの細胞から特定の細胞や特定の組織幹細胞だけに分化させる培養系を確立することができれば，幅広い再生医療への応用が可能になると期待されている（図3）．しかし，ヒトES細胞が再生医療や生物学の発展に大きく貢献する可能性がある反面，人間の生命の萌芽であるヒト胚を使用することなどの生命倫理上の問題点が存在する．とくに，ES細胞由来の細胞を用いた再生医療を考えた場合には，当然，ヒト組織適合白血球抗原（human histocompatibility leukocyte antigen,

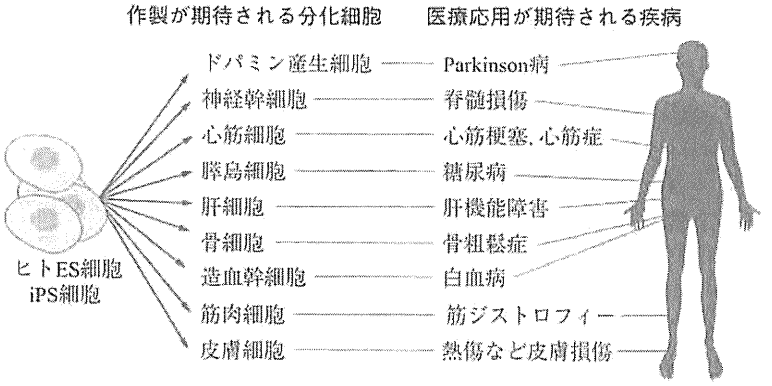

図3 ES/iPS細胞による再生医療

以下HLAと略す）の合致した細胞を移植に用いる必要がある．そのためには膨大な数の受精卵を滅失してHLAの異なるES細胞株を樹立せねばならず，二重の生命倫理的問題が生じてしまう．一方，受精卵の核を除き代りに患者体細胞の核を移植する方法で患者に合致したHLAをもつES細胞の樹立も試みられたが成功していない．また，このような方向での医療は，膨大な数の受精卵を必要とすることから，とても社会的に受け入れられるものではない．

わが国ではヒトES細胞の樹立および使用に関して，文部科学省により「ヒトES細胞の樹立および使用に関する指針」が公表されている．すでにこの指針を遵守したヒトES細胞が京都大学の末盛，中辻らにより樹立され，広く使われるようになった．最近，わが国における2番目のヒトES細胞樹立機関として，国立成育医療研究センターでヒトES細胞が樹立された．

筆者らは平成15年よりヒトES細胞を用いた研究を行ってきた．ヒトES細胞は培養条件を変化させると，神経細胞，筋肉細胞（とくに心筋細胞），血管内皮細胞，軟骨や骨の細胞，膵島細胞，肝細胞，各種血液細胞などさまざまな細胞に*in vitro*で分化可能である．ヒトES細胞からの血球系の細胞分化の過程を検討すると，ほぼ*in vivo*における発生過程を模倣する形で血球が作られてくることがわかった[6]．

ES細胞の再生医療への応用を考えた場合，ES細胞の未分化性を維持した細胞が一つでも残っていると移植後腫瘍を形成してしまうし，目的とする細胞系列以外の細胞への分化能を残したままでは医療への応用はむずかしいことから，特定の細胞系列だけに分化させる系の確立が急がれている．

現在のわが国の指針ではヒトES細胞の使用は研究に限られており，臨床に使用することはできない．

2010年10月，米国食品医薬品局（Food and Drug Administration，以下FDAと略す）の認可を受け，米国ジェロン社が脊髄損傷に対するヒトES細胞由来オリゴデンドロサイトを用いた移植試験を多施設で開始した．同年11月にはAdvanced Cell Technology（ACT）社がFDAからヒトES細胞由来網膜色素上皮細胞を用いた家族性黄斑萎縮症治療の臨床試験申請の承認が得られたと発表した．前述したようにES細胞を用いた再生医療は倫理的な問題を多く抱えているものの，これらの発表は再生医療を待つ患者さんにとっては記念碑的な出来事といえよう．

わが国では「ヒト幹細胞を用いる臨床研究に関する指針」の改正が2010年11月1日に行われた．後述するヒトiPS細胞はこの指針に盛り込まれたものの，ES細胞については，ヒト胚の臨床利用に関する基準が定められるまではヒトES細胞を