

INTRODUCTION

von Hippel-Lindau disease is a hereditary multi-cancer syndrome that encompasses central nervous system hemangioblastoma, retinal angioma, renal cell cancer, and pheochromocytoma [1]. The causative gene composed of 3 exons and encoding 213 amino-acids, has been identified at chromosome 3p25 region [2]. The functions of this gene include inhibition of mRNA elongation [3], inhibition of hypoxia inducible factor (HIF)-1 α [4], and induction of neuronal differentiation of neural progenitor cells [5]. These functions are normally controlled under normoxia, but not under hypoxia [4]. VHL protein is expressed in the cytoplasm of not only neural progenitor cells [5] but also in that of adult neurons [6]. The VHL protein is widely expressed in normal human tissues, but the cellular distribution of the protein is confined to the cytoplasm of specific cell types. High-level expression of the protein is observed in neural tissue, especially in Purkinje cells, Golgi type II cells, and cells in the dentate nucleus of the cerebellum, pontine nuclei, and inferior olivary nucleus of the medulla oblongata [6]. However, the significance of the expression of VHL protein in neurons has remained unclear. In addition, strong expression of VHL protein is observed particularly in the cytoplasm of renal tubule cells [6]. Since VHL protein plays an important role during neuronal differentiation [5], neuronal differentiation of somatic stem cells elicited by VHL protein might be useful for neuronal regeneration therapy by transplantation of somatic stem cells transfected with the *VHL* gene [5,7]. Here, in the context of translational research, we review the literature showing that VHL protein or a peptide derived from it promotes the differentiation of somatic stem cells into neuron-like cells [5,7], which ability suggests that these transfected stem cells might be useful as donor cells for neuronal regeneration therapy [8-12]. For use of somatic stem cells as donor cells for neuronal regenerative therapy, it is desirable that these cells differentiate into neuronal cells in the implant site. If naïve somatic stem cells are implanted into the central nervous system (CNS), they rarely survive; and those that do scarcely differentiate into neurons.

Somatic stem cells capable of neuronal differentiation are classified into ectoderm-derived stem cells and mesenchyme/mesoderm-derived stem cells. Endoderm-derived stem cells scarcely show neuronal differentiation. Up to now, somatic stem cells reported to differentiate to neuronal cells when transfected with the *VHL* gene or a peptide derived from VHL protein are the following: rodent neuronal progenitor cells/neural stem cells (NPSs/NSCs) [6,9], human hair follicle stem cells (FSCs) [13], rodent skin-derived precursors (SKPs) [10,12], and rodent bone marrow mesenchymal stem cells (MSCs) [11]. The methods for isolation and culturing of these cells have been previously described [8,10,13,14].

Expression of VHL protein in neuronal progenitor cells

When neuronal progenitor cells (NPCs) were obtained from the forebrain of the E12 rat fetus, the expression levels of VHL protein and microtubule-associated protein (MAP)-2 were

positively correlated during the development of the neuronal progenitor cells [6]. At day 1 after NPCs were placed in primary culture with bFGF, VHL protein and neuron-specific marker microtubule-associated protein (MAP)-2 were expressed at a low level, but by day 14 high levels of them were detected. On the other hand, when NPCs were cultured with EGF instead of bFGF, these cells expressed neither protein at a high level [6].

Neuronal differentiation of neuronal progenitor cells/neural stem cells transfected with the *VHL* gene

Through transfection of NSCs/NPCs with a VHL protein-expressing herpes virus vector or adenovirus vector, these cells differentiated into neuron-like cells *in vitro* and *in vivo* [5,7]. It was first reported that NPCs differentiated into neuronal marker-expressing cells through transfection with the VHL protein-expressing herpes simplex virus vector [5]. Significant expression levels of VHL protein and MAP-2 were observed at 3 and 24 hours, respectively, after transfection with the *VHL* gene; and the expression of both was observed significantly earlier than that in the control ($P < 0.0001$) [6]. In addition, through transfection with a VHL protein-expressing adenovirus vector, NPCs differentiated into neuronal marker-positive cells [7]. On the other hand, the expression levels of astrocytic marker glial fibrillary acidic protein (GFAP) and oligodendroglial marker O4 decreased in NPCs following transfection with the *VHL* gene [7]. MAP-2 and tyrosine hydroxylase (TH) increased in expression in response to the transfection. The ratio of MAP-2 positive NPCs to total NPCs was significantly much higher in VHL gene-transfected NPCs treated with glial cell line-derived neurotrophic factor (GDNF) than in control NPCs without this factor ($P < 0.01$) [7]. In line with these findings, it was also shown that a VHL mRNA antisense oligonucleotide inhibited the differentiation of NPCs [6].

Neuronal differentiation of somatic stem cells by intracellular delivery of the VHL peptide having the sequence of the elongin C-binding site

Through intracellular delivery of the 15 amino-acid peptide comprising the binding site for elongin C within the VHL protein (VHL peptide), the induction of neuronal differentiation of NPCs was examined. Elongin C, a ligand of the VHL protein, forms the elongin BC complex with elongin B, which complex then binds to elongin A, a transcription factor that elongates mRNA, or to BC-box proteins, which inhibit signal transcription factors such as Stat3, a transcription factor related to astrocytic differentiation [15]. Therefore, a peptide containing the binding site for elongin C was speculated to have the capability to induce neuronal differentiation owing to its neuronal differentiation-inducing domain [8]. For the intracellular delivery of the VHL peptide, dilooeyl phosphatidyl ethanolamine lipid reagent for encapsulating molecules (BioPorter) was used. The BioPorter-peptide complexes become attached to the negatively charged cell surface and fuse with it, resulting in delivery of the captured protein into the cells. Four hours after the intracellular delivery, neurite outgrowth from NPCs was observed when the VHL peptide was used at a 0.3- μ M concentration or above. Immunocytochemically, NPCs showed increased expression of

MAP-2 after the delivery of the peptide, but decreased expression of GFAP [8]. In the electrophysiological study, voltage-gated inward and outward currents were recorded in the whole-cell patch-clamp configuration. In whole-cell recordings of the VHL peptide-containing NPCs, the depolarizing voltage steps elicit both large outward potassium currents and fast inward Na⁺ currents, which are hallmark features of differentiated neurons [8]. Furthermore, through the intracellular transfer of the protein transduction domain (PTD) linked to the VHL peptide (PTD-VHL peptide), NSCs differentiated into neuronal marker-positive neuron-like cells *in vitro* [9]. The majority of NSCs with transferred PTD-VHL peptide expressed neuron-specific markers such as neurofilament (NF)-H, MAP2, and Tuj-1, whereas the minority were positive for the stem cell marker nestin or the astrocytic marker GFAP. By western blotting for NSCs done 7 days after treatment with PTD-VHL peptide, a significantly greater amount of NF-H protein was observed in the PTD-VHL-peptide-bearing cells than in the PTD-peptide alone-treated group. In addition, a significantly greater amount of MAP2-protein was seen in the former than in the latter [9].

Similarly, the transfer of PTD-VHL peptide induced neuronal differentiation in skin-derived precursors (SKPs) [10,12]. Morphological analysis of SKPs by use of phase-contrast microscopy revealed that after the treatment of SKPs with PTD-VHL peptide these cells showed significant neurite outgrowth by 24 hours after the start of treatment, whereas a peptide from another part of the sequence of the VHL protein or the PTD-alone peptide did not elicit such outgrowth. Immunocytochemical analysis of NFM in SKPs 7 days after treatment with PTD-VHL-peptide indicated significantly higher expression of these neurofilaments in PTD-VHL peptide-treated cells than in the control ones [10] (Figure 1). Reverse transcription polymerase chain reaction (RT-PCR) analysis revealed up-regulation of basic helix-loop-helix (bHLH) determination factors (neurogenin3; Ngn3) and that of bHLH differentiation factor (NeuroD) as well as down-regulation of inhibitory bHLH (Hes1) in PTD-VHL peptide-

treated SKPs compared with their respective levels in the control cells [10].

In a study on human hair follicle stem cells (FSCs), neuronal differentiation of the stem cells was examined after the intracellular delivery of PTD-VHL peptide [13]. Two days after delivery of 1- μ M peptide, observation by phase-contrast microscopy showed that most cells extended neurite-like cellular processes; whereas the control cells receiving just the PTD peptide elaborated significantly fewer of these processes. In this same immunocytochemical *in vitro* study, the PTD-VHL peptide-treated FSCs highly expressed various neuronal markers (MAP2, NFM, NFH, and Tuj-1); whereas those treated with PTD peptide alone showed only low expression of these markers [13].

In addition, neuronal differentiation of rat bone marrow mesenchymal stem cells (MSCs) by intracellular delivery of PTD-VHL peptide was examined *in vitro* [11]. One week after the intracellular delivery of the peptide, MSCs changed their morphology into multiple process-bearing neuron-like cells and expressed neuronal lineage markers, Tuj-1 and MAP-2. PTD-VHL peptide-bearing MSCs showed significantly higher rates of expression of both Tuj-1 and NFH than the control peptide-treated ones. Quantitative RT-PCR evaluation indicated that the MSCs with transferred PTD-VHL peptide expressed significantly more NFH mRNA or MAP2 mRNA than the ones treated with the control peptide. Western blot analysis indicated that the PTD-VHL peptide-bearing MSCs distinctly expressed NFH and MAP2 proteins, whereas the cells treated with the PTD peptide alone scarcely did so [11].

Transplantation of somatic stem cells transfected with VHL gene and that of PTD-VHL peptide-treated ones into the rodent brain

Yamada et al. transplanted somatic stem cells into the rodent brain to examine whether these cells could differentiate into functional neuronal cells and repair the damage caused by

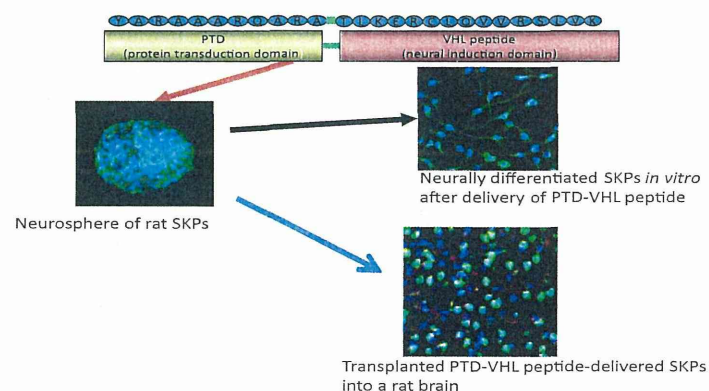


Figure 1 Intracellular delivery of PTD-VHL peptide into peptide-delivered skin-derived precursors (SKPs) causes the cells to differentiate into neuron-like cells *in vitro* and *in vivo*. A neurosphere of SKP cells with some cells showing nestin positive (green) is shown. *In vitro* neurally differentiated cells from SKPs are positive for showing NFM positive (green). Transplanted PTD-VHL peptide-bearing delivered SKPs transplanted into a rat brain are showing NeuN positive. The transplanted cells had been pre-labelled to emit with red fluorescence. Cellular nuclei were stained with DAPI (blue) in all figures.

neuronal diseases [7]. First of all, after NPCs had been transfected with VHL protein-expressing adenovirus vectors, the cells were transplanted into the striatum of rats modeling Parkinson's disease (PD). Prior to the transplantation, these cells were labeled with bromodeoxyuridine (BrdU). The results revealed that numerous BrdU-tyrosine hydroxylase (TH) double-labeled cells could be seen close to the transplant site, showing that the transplanted cells had efficiently generated new dopaminergic neurons within the host striatum. Moreover, all of the animals transfected with NPCs with the *VHL* gene showed a remarkable decrease in apomorphine-induced rotations. These findings thus indicate that NPCs transfected with the *VHL* gene could efficiently differentiate into dopaminergic neurons [7].

In other studies exploring the possibility that SKPs could survive and function *in vivo*, SKPs treated with PTD-VHL peptide were transplanted into the striatum of PD model rats [10,12]. The transplanted SKPs differentiated into not only TH- or dopamine transporter (DAT)-positive cells in the rat brain, but also secreted dopamine and repaired symptoms (e.g., apomorphine-induced rotations) in this PD model (unilateral 6-OHDA-lesioned rats) [12]. Two weeks after the 6-OHDA lesioning, the rats were depleted of dopaminergic innervations in their ipsilateral striatum and exhibit a characteristic rotation behavior as a response to the apomorphine challenge [12]. Functional analysis of this apomorphine-induced rotation behavior revealed that rats in the PTD-VHL-peptide-treated SKP group showed a slight but significantly greater improvement at 4 weeks after the transplantation than the rats in the non-treated SKP group or sham-operation group. To evaluate the survival and morphological maturation of SKPs grafted in the striatum of PD model rats, the cells were prelabeled with red fluorescence before grafting. The animals were then sacrificed for histological analysis 8 weeks after the engraftment. No tumor formation by the grafts was found in these animals [10]. Immunohistochemical analysis of sections by use of confocal microscopy revealed that more than 5% of the fluorescence-labeled transplanted cells survived in the PD rats. In the PTD-VHL-peptide-SKP group, fluorescence-labeled cells showed high positive rate for NeuN as well as for TH; and the sprouting of dopaminergic neurons surrounding the fluorescence-labeled cells was enhanced; whereas in the sections prepared from the naive SKP group, the fluorescence-labeled cells showed a low positive rate for NeuN as well as for TH [10] (Figure 1).

PTD-VHL peptide-bearing FSCs and control ones were prelabelled with red fluorescence and separately implanted into rodent brains [13]. Three weeks later, after perfusion/ fixation, the brains were frozen with liquid nitrogen and sectioned. The number of surviving implanted cells (red fluorescence-prelabelled cells) among the implanted PTD-VHL-peptide-treated FSCs was significantly greater than that of the cells treated with PTD alone. In addition, prelabelled cells expressing Tuj-1 represented $38.8\% \pm 3.5\%$ of the PTD-VHL peptide-treated cell population, which percentage was significantly greater ($p < 0.01$) than the $9.3\% \pm 1.5\%$ found for the one treated with PTD peptide alone [13].

Transplantation of somatic stem cells into the spinal cord

Immunohistochemical results obtained by confocal analysis four weeks after transplantation of NSCs into striatum revealed that the number of surviving (red fluorescence-prelabeled cells) PTD-VHL-peptide-treated NSCs was significantly greater than that of the non-treated cells ($P < 0.05$). In addition, the PTD-VHL-peptide-treated fluorescence-prelabeled NSCs co-localized more with neuronal markers than with a glial marker suggesting that these NSCs had differentiated into neurons rather than into astrocytes in the injured spinal cord [9].

Similarly, four weeks after transplantation of MSCs into the rat spinal cord, confocal analysis of MSCs treated with PTD-VHL peptide or PTD peptide alone showed that the number of the surviving cells (red fluorescence-prelabeled cells) was significantly greater for the former than for the latter ($P < 0.01$). The data also indicated that more PTD-VHL peptide-MSCs had differentiated into NFH-positive cells than the cells treated with PTD peptide alone [11].

Correlation of functional recovery in PD-model rats with dopamine levels in the lesioned striatum

The behavior of a novel population of VHL gene-transfected NPCs compared with that of non-transfected NPCs was investigated after their implantation into the adult rat striatum previously lesioned by 6-OHDA [7]. Most non-transfected transplanted NPCs differentiated into astrocytes, and only a few of them differentiated into neurons. In contrast, *VHL* gene-transfected-NPCs differentiated into neurons, with more TH-positive cells formed *in vivo* than *in vitro*. The physiological function of TH-positive cells generated from these latter NPCs was assessed in this study by analysis of recovery from apomorphine-induced rotation behavior in a rat model of PD. All of the animals transplanted with *VHL* gene-transfected-NPCs showed a remarkable decrease in apomorphine-induced rotations for up to 16 weeks. In contrast, no behavioral improvements were noted in rats after sham surgery or after transplantation with non-transfected NPCs. Therefore, the behavioral improvement after transplantation of the former NPCs was considered to relate primarily to the survival of grafted TH-positive cells, neuritic outgrowth with synaptic connectivity, and graft-derived dopamine production. As the data indicated that numerous TH-positive cells had differentiated from the *VHL* gene-transfected NPCs, this method using NPCs transfected with the *VHL* gene can be expected to likely supply a sufficient number of dopaminergic neurons to treat PD patients [7].

In other studies, apomorphine-induced rotational behavior of 6-OHDA-lesioned rats in the group implanted with PTD-VHL peptide-treated SKPs (PTD-VHL-SKP group) was compared with that in control group rats [10,12]. In the PTD-VHL-SKP group, the mean number of rotations per minute was significantly decreased. Extracellular dopamine levels in the lesioned striatum post-transplantation were evaluated by measuring the dopamine content in dialysates. Dopamine levels in the PTD-VHL-SKP

group were significantly greater than those in the non-treated SKP group, thus suggesting that transplantation of PTD-VHL peptide-treated SKPs increased the dopamine concentration in the lesioned striatum [12]. The reduction in the numbers of apomorphine-induced rotations in each rat was plotted against the dopamine level in the engrafted striatum, and linear regression analysis was performed. The analysis indicated that these 2 parameters were significantly positively correlated [12]. Therefore, these data suggest that the increased dopamine production induced by transplantation of SKPs treated with PTD-VHL peptide contributed to the behavioral recovery in the PD rats [10,12].

Evaluation with Basso-Beattie-Bresnahan (BBB) locomotion scores in rats transplanted with NSCs or MSCs

In rats transplanted with NSCs, at 1 week after spinal cord injury, the BBB scores, which reflect rat locomotor function, were 0 points in the sham-operated rats, and at 1 week after transplantation, there were no significant differences in the BBB scores of the NSC transplantation groups. From 35 days after transplantation, in the BBB scores, a significant difference was recognized between rats transplanted with PTD-VHL-peptide-treated NSCs and rats transplanted with non-treated NSCs ($P < 0.05$) or sham-operated rats ($P < 0.01$) [9].

Similarly, in rats transplanted with MSCs, postoperative locomotor function evaluated in terms of the BBB score was judged as 0 points in each group 7 days after surgery. The rats transplanted with the PTD-VHL peptide-treated MSCs showed significant improvement of their BBB scores ($P < 0.01$) compared with the score for each of the other groups [11].

DISCUSSION

Expression of VHL protein was progressively observed in cultured NPCs. VHL protein was initially undetectable in freshly harvested E12 cells, which were mostly nestin positive. By day 14, expression of VHL protein was increasingly evident. In addition, expression of VHL protein was correlated with expression of MAP-2, and VHL protein and MAPs were expressed in the same cells. However, expression of VHL protein was shown in the nucleus and the cytoplasm, whereas MAPs expression was shown in the cytoplasm and the dendrites. Their expression in the same cell type suggested that the VHL protein might be involved in central nervous system (CNS) development [5]. The study on VHL gene transfection of NPCs revealed that the VHL protein potentially induced neuronal differentiation. In contrast, suppression of the VHL gene inhibited neuronal differentiation and promoted cell-cycle transition in NPCs [5]. In addition, it has been shown that expression of the VHL protein correlates with neuronal differentiation but not with glial differentiation [5]. It was also shown that VHL gene transfection can efficiently produce not only MAP-2-positive cells but also TH-positive cells [7]. Moreover, when GDNF was added to the medium, dopamine production remarkably increased. This fact shows that VHL and GDNF acted synergistically to direct NPC differentiation into dopaminergic neurons [7]. A previous report showed that progenitor cells isolated from the developing human brain, and transplanted into the rat striatum, produced very few TH-positive cells, and those

cells in the striatum mostly differentiated into astrocytes [16].

All of the animals transplanted with VHL gene-transfected NPCs showed a remarkable behavioral improvement. In contrast, no behavioral improvements were noted in rats after sham surgery or after transplantation with non-treated NPCs. Therefore, the behavioral improvement after transplantation of VHL gene-transfected NPCs is suggested to be related to the survival of grafted TH-positive cells, neuritic outgrowth with synaptic connectivity, and graft-derived dopamine production. The finding that numerous TH-positive cells differentiated from the grafted VHL gene-transfected NPCs suggested that there would likely be an adequate supply of dopaminergic neurons formed for regenerative therapy of PD patients.

To improve functional recovery after cell transplantation into the injured spinal cord, it is critical that transplanted cells survive and differentiate into neuronal cell lineages beneficial for remyelination, functional synaptic replacement, neurotrophic factor delivery, and axon elongation, all of which contribute to the promotion of spinal cord regeneration [2]. Therefore a strategy using implantation of neuronal lineage-restricted stem cells has been advocated, and it was shown that neuronal differentiation on NSCs by intracellular delivery of PTD-VHL peptide into NSCs could be used as an alternative method to the gene transfection [11]. VHL-peptide-treated NSCs show a higher rate of survival when engrafted into the spinal cord than non-treated NSCs. This higher survival rate of transplanted VHL-peptide delivered NSCs was also recognized in the intracerebral transplantation of VHL gene-transfected NSCs [7]. These neurally differentiated NSCs might become acclimatized to the environment of the neuronal tissue. In addition, a statistically significant behavioral difference between rats transplanted with PTD-VHL-peptide-treated NSCs and rats with non-treated NSCs was found in terms of locomotion. This fact suggested that these cells brought about an improvement in the motor function in rats with acute spinal cord injury. The finding of the neuronal differentiation of NSCs through VHL-peptide transfer could well contribute to the cure of spinal cord injuries. Similarly, neuronal differentiation of MSCs before cell transplantation is fundamental for therapy aimed at regeneration. Compared with NPCs/NSCs [8,9] SKPs [10] and MSCs showed less neuronal differentiation by intracellular delivery of the VHL peptide. Untreated naive MSCs were unsatisfactorily differentiated into neuron-like cells when transplanted into the spinal cord and were insufficient in causing behavioral recovery of model rats with spinal cord injury, whereas VHL peptide-treated MSCs were significantly more differentiated into neuron-like cells and sufficiently recovered normal behavior. These results suggest that neuronal differentiation of MSCs before grafting for spinal cord injury could contribute to repair of the injured spinal cord. In comparison with other reports on the transplantation of treated MSCs for the repair of spinal cord injuries, the method using VHL peptide showed equal or greater functional recovery in terms of the BBB locomotor scale than other methods [11].

SKPs are the ideal precursor cell populations that can be derived in an autologous fashion from small amounts of accessible tissue biopsies and are pluripotent somatic stem cells capable of differentiating into both neural and mesodermal

progenies. In our previous studies [10,12, SKPs with specific induction via PTD-VHL peptide were shown to be differentiated into dopamine neuron-like cells *in vitro* and after being transplanted into PD model rats. Such studies contribute to cell therapy for PD [17,18].

In addition, neuronal differentiation of human FSCs occurred when the PTD-VHL peptide was intracellularly delivered into them [13]. These cells are promising as donor cells for the treatment of intractable neuronal diseases. However, if these cells without neuronal differentiation are implanted, they scarcely survive or differentiate into functional neuronal cells, similar to the case of other stem cells. Therefore, before implantation for cell therapy of intractable neuronal diseases, such cells would be required to differentiate into neuronal cells. Intractable neuronal diseases such as PD disease develop more frequently in elderly patients. Therefore, it is significant that multipotent somatic stem cells obtained from elderly humans can be used as donor cells for cell transplantation therapy [13].

The neuronal-differentiation method using PTD-VHL peptide is very simple because only the PTD-VHL peptide needs to be added to basic medium lacking serum, and it is also rapid compared with previously reported methods using various neurotrophic factors and other neuronal-differentiation-inducing agents. Thus, the use of PTD-VHL peptide is recommended for the neuronal differentiation of multipotent somatic stem cells.

Although there is much evidence that intracellularly delivered VHL peptide induced neuronal differentiation of various somatic stem cells, the molecular mechanism underlying this induction has not been clarified. The VHL peptide was designed to specifically bind to elongin C. Activation of elongin C by VHL peptide is necessary and sufficient for formation of the elongin BC complex and subsequent ubiquitin-dependent signal regulation for cellular growth and differentiation [12]. In the crystal structure, the VHL peptide forms a helix that fits into a concave surface present on elongin C. It seems likely that inhibition of elongin A contributes to function of VHL protein, and that competition between VHL peptide and elongin A may be related to the effects of the peptide on neuronal differentiation of somatic stem cells. In addition, the elongin BC complex binds to various kinds of proteins that can induce the ubiquitination and degradation of Stat 3 [12]. It has been reported that Stat3 promotes astrocytic differentiation, and that degradation of Stat 3 directly inhibits astrocytic differentiation and accelerates neuronal differentiation [19]. Further study will be required to investigate whether those pathways involving Stat 3 play an important role in neuronal differentiation induced by the VHL peptide [12].

In conclusion, it was shown that when somatic stem cells treated *in vitro* with the VHL gene or PTD-VHL peptide were implanted into the rat brain or spinal cord, they differentiated into neuronal marker-positive cells. The neuronal differentiation method using PTD-VHL peptide is very simple, rapid, and superior to the methods using transfection with the VHL gene or neuronal differentiation-inducing agents. Thus, the use of PTD-VHL peptide for the neuronal differentiation of multipotent somatic stem cells is to be recommended.

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Special Issue on von Hippel Lindau Disease

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Research Article

von Hippel-Lindau Disease-Associated Pheochromocytoma: Epidemiology, Clinical Characteristics, and Screening and Surveillance Protocols in Japan

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Abstract

von Hippel-Lindau (VHL) disease is an autosomal dominantly inherited syndrome characterized by a predisposition to various neoplastic lesions. To clarify the epidemiology and clinical characteristics of VHL-associated pheochromocytoma (PHEO) in Japan, we have summarized VHL-PHEO characteristics from a nationwide cross-sectional survey for VHL disease on the basis of the epidemiological study program for incurable disease by the Japanese Ministry of Health, Labour and Welfare. The details of the survey included age of onset, sex, living area, treatment modalities, and patient outcome. The incidence rate of PHEO in VHL disease was 15% (62/409). Males and females were equally affected. The mean and median ages of onset were 29.7 and 31.5 years, respectively. The age of onset was distributed between 10 and 75 years and presented two peaks between 15-20 and 35-40 years. Twenty-six (42%) bilateral cases, 8 (13%) extra-adrenal paragangliomas, and 4 (6.4%) malignant cases were observed. Forty-one (65%) patients underwent surgical resection once and 13 (19%) underwent 2 or 3 surgeries, whereas six (10%) were surveyed without surgical treatment. Fourteen of 26 bilateral PHEOs (56%) received steroid replacement therapy following bilateral adrenal surgeries. Four cases died from metastatic PHEOs and one from a severe infection during steroid replacement therapy. None of the patients died of cardiovascular complications due to PHEO crisis. From the current survey results, it is concluded that VHL-PHEO characteristics in Japan are similar to those in Western countries. Based on the above, we propose a screening and surveillance protocol for VHL-PHEO in Japan. Due to its rare incidence and unique characteristics, the continuous survey and registration of VHL-PHEO will remain important to understanding the disease's nature.

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ABBREVIATIONS

VHL: von Hippel-Lindau disease; PHEO: Pheochromocytoma.

INTRODUCTION

Von Hippel-Lindau disease (VHL) (MIM 193300) is an autosomal dominantly inherited disorder characterized by a predisposition to develop multiple tumors and cystic lesions in many organ systems [1,2]. These lesions include retinal angiomas, central nervous system (CNS) (cerebellar, brainstem, and spinal cord) hemangioblastomas, endolymphatic sac tumors, pancreatic neuroendocrine tumors, pheochromocytomas, renal cell carcinomas (RCCs), endolymphatic sac tumors, epididymal cystadenomas in males, and broad ligament cystadenomas in females [1-5]. The disease incidence is estimated at 1 in 36,000-46,000 live births in Western countries, and the disease penetrance is over 90% by 65 years of age [2,6,7].

The gene responsible for VHL is located on the short arm of chromosome 3 (3p25.3); in 1993 the gene was identified as a VHL tumor suppressor by a positional cloning approach [8,9]. The VHL gene is categorized as a classic tumor suppressor. According to Knudson's two-hit mechanisms, germline mutation in one allele is present in all the cells of affected individuals who inherit the genetic trait. The second VHL allele is somatically inactivated in tumors associated with VHL patients [10]. On the other hand, both VHL alleles are found to be inactivated by two independent somatic alterations in tumors with non-inherited sporadic occurrence, including clear cell subtype RCC, CNS hemangioblastoma, and pheochromocytoma [11-15].

VHL disease (or the VHL family) is clinically classified into two major categories, depending on the absence or presence of pheochromocytoma as a tumor manifestation [16-18]. Type 1 patients have almost no risk of developing pheochromocytoma, but present other cardinal manifestations. Approximately 80% of VHL families are type 1, while the remaining 20% of families are categorized as type 2, having a high risk of pheochromocytoma. The frequency of pheochromocytoma is 10-20% among all VHL patients, whereas it rises to as many as 70-80% of affected members in the type 2 family. Type 2 is further classified into three subtypes, labeled 2A, 2B, and 2C. Type 2A patients have a low risk of developing RCC, while type 2B patients have a high risk. Both types of patients develop CNS and retinal hemangiomas. On the other hand, Type 2C patients develop pheochromocytomas exclusively [17,19,20]. Genotype-phenotype correlation analyses demonstrated that VHL type 1 families have a variety of mutational types, including missense, nonsense, and frameshift mutations in the highly conserved region and large genomic deletions. These mutations are likely to result in a gross alteration or complete loss of pVHL functions. In contrast, the majority of type 2 families have missense mutations at specific amino acid positions in the pVHL, affecting particular pVHL functions [17-20].

VHL-associated pheochromocytomas (VHL-PHEOs) have been characterized mainly in the Western population; as such, the epidemiology and clinical features in Japanese Asian population have not previously been elucidated. In this study, we first performed nationwide surveillance of VHL patients in Japan. We summarize the current epidemiology and clinical status of VHL-PHEO herein, and we also propose a screening and surveillance protocol for VHL-PHEO patients in Japan.

MATERIALS AND METHODS

Nationwide surveillance of VHL patient in Japan

We performed nationwide, cross-sectional surveillance of VHL patients in Japan. In the first survey, we asked a total of 4,545 medical doctors with specialties in urology (n=1,200), neurosurgery (1,141), ophthalmology (1,149), and pancreatic diseases (1,055) whether they had treated any VHL patients during the 2 years from April 2009 to March 2011. Subsequently, in a second survey, an inquiry-based investigation was carried out with 240 doctors who replied that they had been treating patients diagnosed with VHL. The final response rate was 70.4% for the 2nd questionnaire. In each VHL patient, investigations of all VHL-related diseases were performed, including the onset age of each VHL-related disease, living prefecture, sex, family history of VHL, with or without genetic testing, information on survival and outcome, and the types of treatment modalities. The status of corticosteroid replacement therapy after surgery was also asked for the VHL-PHEO patients. The study protocol was approved by the institutional ethics committee of the Koch University School of Medicine.

RESULTS AND DISCUSSION

Epidemiology

In total, 409 VHL patients were registered by corresponding doctors. Among them, 62 (15%) were suffering from PHEO and considered to be VHL type 2 patients. The distribution of onset age in VHL-PHEO was from 10 to 75 years (median=31.5, mean=29.7±2.0 years), and 2 major age peaks (15-20 and 35-40 years) were observed (Figure 1-A). There was a tendency for the type 2A (without RCC) patients to belong to the younger age peak and type 2B (with RCC) to the elder peak, respectively (Figure 1-B, C).

The involvement of PHEO in bilateral adrenal glands was observed in 26 out of 62 (42%) patients, and extra-adrenal PHEO (paraganglioma) was observed in 8 (13%). There was no difference between the sex distribution (31 cases each in males and females). Malignant PHEOs with distant metastasis were present in 4 cases (6.5%) with ages of onset of 21, 26, 33, and 50 years, respectively.

Treatments and patient outcomes

The frequency of surgical intervention for PHEO was once in 41 patients, twice in 10, and three times in 1. There was no patient registered who underwent 4 or more PHEO surgeries.

Continuous corticosteroid replacement therapies after surgical intervention were carried out in 14 (56%) of 26 patients with bilateral adrenal PHEOs (Table 1). Steroids were not administered, however, for the remaining 12 cases. Of these 12 patients, adrenal-sparing surgery was done in 8, unilateral adrenal surgery plus watchful surveillance of the contralateral tumor in 3, and observation only in 1.

Regarding patient outcomes, 4 patients with malignant PHEO died of metastases; in addition, another patient died of severe cholecystitis during the steroid replacement therapy after bilateral adrenalectomy. However, no patient was reported to have died of

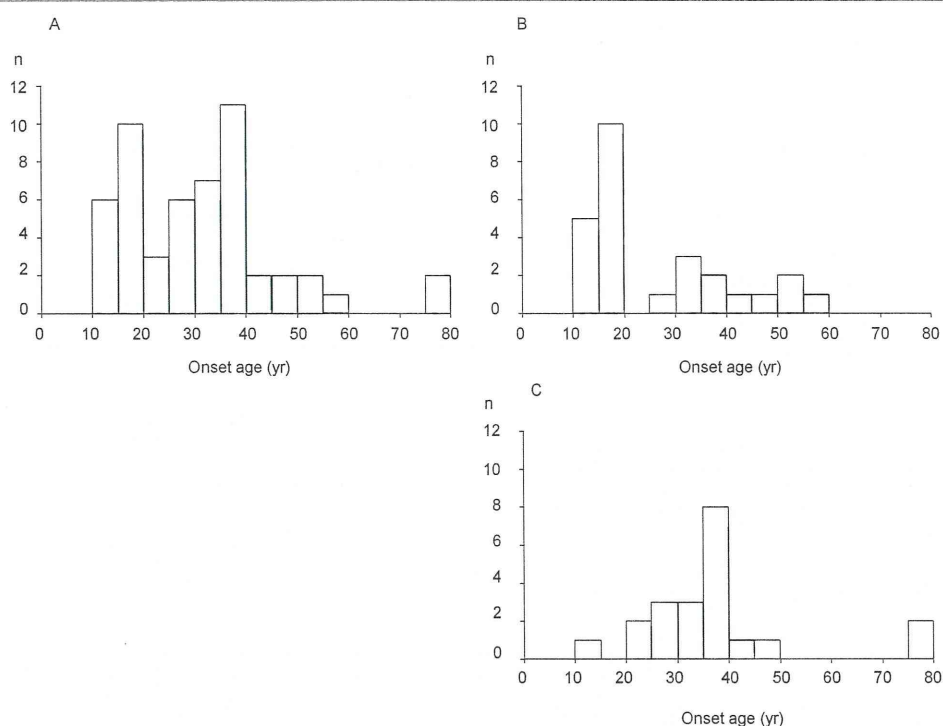


Figure 1 The onset-age distribution of von Hippel-Lindau disease-associated pheochromocytoma in Japan.

Data was available for a total of 52 patients (A), type 2A (without renal cell carcinoma) patients (n=26) (B), and type 2B (with renal cell carcinoma) patients (n=21) (C).

Table 1: Adrenal Surgery and corticosteroid replacement therapy in VHL patient with pheochromocytoma.

Surgery	Number of Patients with/without corticosteroid	
	With	Without
Bilateral adrenalectomy	5	0
Unilateral adrenalectomy +contralateral partial adrenalectomy or tumor enucleation	2	7
Unilateral adrenalectomy	1	27
Bilateral partial adrenalectomy or tumor enucleation	0	1
unilateral partial adrenalectomy or tumor enucleation	0	3

cardiovascular complications due to PHEO crisis. At the patient-registration time, a total of 10 VHL-PHEOs were following up, including 4 with the administration of antihypertensive agents and 6 with watchful observation without any treatment due to asymptomatic PHEO.

In this study, we first conducted a nationwide surveillance study of VHL patients in Japan. As a result, a total of 409 VHL patients were registered. We then identified the epidemiological and clinical characteristics of VHL patients with PHEO; i.e. VHL type 2, in the Japanese Asian population. Epidemiological characteristics observed in a Japanese patient cohort seem to be basically the same as those reported previously for Western patients, although some older patients (age of onset: range= 10-75 years) and a somewhat higher incidence of malignant PHEO (6.4%) was seen in the Japanese patient cohort compared to the U.S. and European series (age of onset: range 3-60 years and malignant PHEO: 1.6-3.6%) [21,22]. Another interesting point is

that we observed that the VHL type 2A patients (without RCC) tended to have a relatively younger onset age (10-19 years), while type 2B (with RCC) patients tended to have an older age of onset (30-39 years) in the Japanese population.

Previous work has demonstrated that the subset of VHL-associated PHEO shows relatively low hormonal activity compared with other inherited forms of PHEO, including multiple neuroendocrine neoplasia type II (MEN2), paraganglioma syndromes (PGLs), and neurofibromatosis type I (NF1) as well as to PHEO in sporadic occurrence [23-25]. According to the NIH/NCI in the U.S.A. series, among VHL-PHEO patients newly diagnosed by family screening, 35% were asymptomatic and non-functioning with a relatively small tumor size [21]. Our surveillance also demonstrated that a substantial number of Japanese VHL-PHEO patients present an asymptomatic non-functioning phenotype, and these patients were subsequently followed by observation. Unfortunately, in the current survey, we

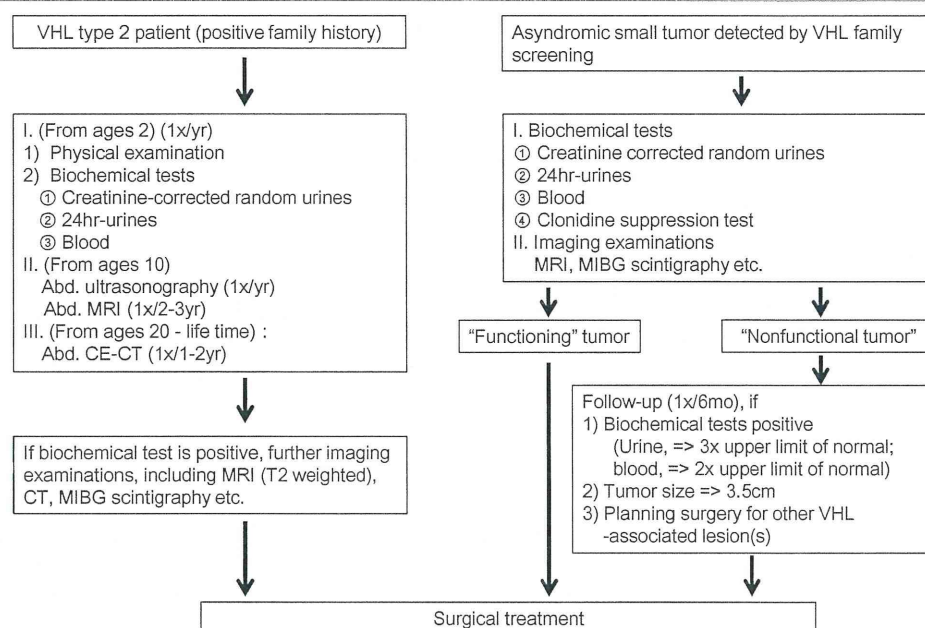


Figure 2 Screening and surveillance algorithm for von Hippel-Lindau disease-associated pheochromocytoma.

did not collect other detailed information such as the PHEO tumor size and location, tumor doubling time, followup period, exact values of catecholamines, and so on. It is our hope that, in the next survey, additional precise data will be collected to further our understanding of this unique and rare disease condition.

Screening and surveillance protocol for VHL-associated PHEO

Based on previous findings together with the current survey results regarding Japanese VHL-PHEO, we propose the following protocol for the screening and surveillance of the disease (Figure 2). In the type 2 VHL family, annual i) physical examination, ii) biochemical tests, including adrenaline, noradrenaline, dopamine, metanephrine, and normetanephrine, for ① blood and ② urine (24-hr urines or alternatively, creatinine corrected random urine specimens), from age 2. Abdominal ultrasonography (yearly) or plain magnetic resonance imaging (MRI) (1x/2-3yr) should start from age 10. MRI is preferred to computed tomography (CT) in children to avoid radiation exposure during development. From age 20, Abdominal CT with contrast enhancement (CE) (1x/1-2yr) is begun. CT-CE can allow for the screening of other VHL abdominal lesions, including simultaneous screening of the pancreas and kidneys. MIBG scintigraphy is not recommended for screening due to radiation exposure and cost. It should be done to provide a definitive diagnosis for PHEO localization. For a patient who is planning surgery for other VHL lesion(s) or a female patient planning a pregnancy, the absence of a biochemically "functioning" tumor within the 6 month should be confirmed.

Diagnosis and treatment

Diagnosis and treatment for VHL-PHEO is basically the same as that for PHEO in the sporadic form. Surgical resection remains the mainstay of treatment for VHL-PHEO. Due to the relatively early onset age, frequent bilateral occurrences, and

a lifetime multiple surgical operations not only for PHEOs but other organ lesions, adrenal-preserving and minimally invasive surgery such as laparoscopic partial adrenalectomy, should be considered whenever possible [26,27]. Additionally, in cases with asyndromic non-functioning PHEO with relatively small size detected by family screening, watchful observation can be selected with both biochemical and imaging evaluations at 6-month intervals. Surgical treatment is then recommended when i) urine or blood biochemical tests become positive (urine, =>3x upper limit of normal; blood, =>2x upper limit of normal), ii) tumor size becomes =>3.5cm, or iii) planning surgery for other VHL-associated lesion(s).

In conclusion, we conducted a first nationwide survey of VHL-PHEO in Japan. We collected a total of 62 VHL-PHEO patients. The epidemiology in Japanese patients seems to be basically the same as that previously reported in Western patients. In addition, some unique characteristics are also emerging from the current survey. Since the relatively rare incidence and unique nature of disease, prospective continuous registrations as well as a phenotype-genotype correlation study in Japanese VHL will be quite important. We have also for the first time proposed a screening and surveillance protocol for Japanese VHL-PHEO patients. We hope that the protocol will be prospectively validated and updated continuously according to the new diagnostic and therapeutic procedures.

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