Alifano *et al.* speculated that when air from outside enters into the peritoneum through the genital tract due to uterine contractions, physical activity or sexual intercourse, this air can enter into the thorax in the intermenstrual period.[10] We doubted this hypothesis, because we have not experienced any cases of pneumothorax caused by physical activity or sexual intercourse based on our patient interviews. Most of the patients were at their offices working at the time of onset.

We discovered that the only significant difference between the CP and non-CP groups was the proportion of the patients with pleural endometriosis. We could not find any significant difference in the rates of visceral pleural endometriosis. This result is probably due to the difficulty of inspecting for thoracic endometriosis, because these endometriotic implants are very small, as we reported previously.[18] When ectopic endometrial sites are found in the parietal or visceral pleura, the endometrial tissues may extend to both the parietal and visceral pleural surfaces. Thus, TERP patients with pleural endometriosis are likely to develop pneumothorax due to transpleural air passage.

This study had several limitations. First, our subjects were located at the Pneumothorax Research Center, which specializes in the treatment of pneumothorax. Many patients with intractable pneumothorax are referred to this facility. Accordingly, the clinical features for TERP may be biased. Second, this was a retrospective cohort study; as such we failed to detect the temporal relationship between the pneumothorax episodes and menses in some cases. Finally, although we carefully inspected all areas, including the fissure and mediastinal areas inside thoracic cavity in detail using a flexible thoracoscope with a near-sight view function, some endometrial implants may have nevertheless been missed. This could have led to some bias in our findings.

In conclusion, we have clarified the precise distribution of thoracic endometriosis in TERP patients. Furthermore, the ectopic sites of endometriosis differed between the CP group and non-CP group. This study provides a good basis for considering the pathogenesis of TERP.

Acknowledgement

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Results of surgical treatment for secondary spontaneous pneumothorax according to underlying diseases

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Abstract

OBJECTIVES: The outcome of surgical treatment for secondary spontaneous pneumothorax (SSP) has rarely been investigated.

METHODS: We retrospectively reviewed 183 patients who underwent surgery for SSP. We categorized the patients into three groups according to underlying diseases: Group A (chronic obstructive pulmonary disease), Group B (interstitial pneumonia [IP]) and Group C (others). We defined treatment success as surgery without hospital mortality, postoperative complications, death within 6 months or ipsilateral recurrence of pneumothorax within 2 years. We assessed the risk factors for unsuccessful treatment using a Cox regression hazard model.

RESULTS: There were 123 patients in Group A, 20 in Group B and 40 in Group C. The hospital mortality rates were 2, 15 and 0% in Groups A, B and C, respectively. The hospital mortality, morbidity and pneumothorax recurrence rates in the IP group were higher than in the other groups. The 5-year overall survival rates were 78, 32 and 84% in Groups A, B and C, respectively; the prognosis of the IP group was significantly poorer. The treatment success rates were 86, 45 and 83% in Groups A, B and C, respectively. SSPs caused by IP and SSPs requiring open surgery were identified as the risk factors for unsuccessful treatment.

CONCLUSIONS: Surgery for SSP caused by underlying diseases other than IP yielded favourable results. However, a careful examination of surgical indication and a realistic disclosure for informed consent are required for patients with SSP caused by IP, because of the high treatment failure rate.

Keywords: Pneumothorax • Chronic obstructive pulmonary disease • Interstitial pneumonia • Surgery • Thoracoscopy

INTRODUCTION

Secondary spontaneous pneumothorax (SSP) is defined as the presence of air in the pleural space as a consequence of clinically apparent underlying lung disease without iatrogenic or other external chest injuries [1]. In Japan, the proportion of SSP surgeries among pneumothorax surgeries has increased rapidly, from 6% in 2005 to 16% in 2012 (2243 SSP cases in a total of 14 410 pneumothorax cases) [2, 3] probably due to the increase in SSP incidence, advent of less invasive surgery and advancements in anaesthetic techniques. Thus, SSP management has become more important, as the elderly population with chronic obstructive pulmonary disease (COPD) and interstitial pneumonia (IP) has increased. Although it is strongly recommended that surgical intervention should be discussed for patients with persistent air leak at 48 h after chest tube drainage, the outcome of surgical treatment for SSP has rarely been investigated [4]. In the present study, we retrospectively analysed the outcome of surgery for SSP according to underlying diseases, and assessed the risk factors for unsuccessful surgical treatment.

PATIENTS AND METHODS

A total of 183 patients who had undergone surgery for SSP at our institution between 1993 and 2014 were analysed retrospectively. The diagnosis of SSP was determined according to the British Thoracic Society pleural disease guideline 2010, which defined SSP as spontaneous pneumothorax with the evidence of underlying lung disease or with significant smoking history in patients older than 50 [1]. Before the study, the Research Review Board of the University of Tokyo examined and approved the study protocol in accordance with the Declaration of Helsinki (project approval no. 2406). All patients provided their written informed consent for the review of their medical charts before surgery.

Surgery was indicated for SSP with persistent air leak at 48 h after chest tube drainage. We excluded patients with poor condition who were unlikely to tolerate general anaesthesia. Preventive bullectomy for SSP was not performed. Generally, three-port thoracoscopic surgery was performed under general anaesthesia and single-lung ventilation. However, when the patient could not

tolerate single-lung ventilation or a complicated procedure was required, the approach was converted to a minithoracotomy. We first confirmed the air leakage point using saline, repaired the point by bullectomy using stapling devices or by suturing and covered the repaired site with a polyglycolic acid sheet to thicken the visceral pleura and create adhesion to the intrathoracic wall [5]. Fibrin glue was used when we found a small leakage at the repaired site. We did not perform pleurodesis.

We evaluated clinical features including age, gender, smoking index (pack-years), affected side, operation time, surgical procedure, hospital mortality, morbidity, postoperative hospital stay and the recurrence rate of ipsilateral and contralateral pneumothorax. The underlying diseases were divided into three groups: Group A (COPD), Group B (IP) and Group C (others). Group C contained 10 patients with Marfan syndrome, 9 with graft-versus-host disease, 6 with malignant pulmonary tumours, 4 with catamenial pneumothorax, 2 with asthma, 2 with Langerhans cell histiocytosis and 1 each with lymphangioleiomyomatosis, sarcoidosis, non-tuberculous mycobacteria, bronchiectasis, *Pneumocystis* pneumonia, aortitis and yellow nail syndrome. The time period of surgery was divided into the early period (1993-2004) and the later period (2005-14).

In this study, we defined treatment success as surgery without hospital mortality, postoperative complications, death within 6 months or ipsilateral recurrence of pneumothorax within 2 years. Postoperative complications included prolonged air leakage (>7 days), pneumonia, pyothorax, exacerbation of IP, asthma attack, cardiovascular disease, reoperation and stroke. Long-term outcome was measured by overall survival and respiratory disease-specific survival.

To further explore the predictive markers of unsuccessful surgery for SSP caused by IP, the following data of patients in the IP group were obtained as surrogates of disease burden: preoperative white blood cell count (WBC), C-reactive protein (CRP) and KL-6.

Statistical analyses were performed using the JMP 11 software (SAS Institute, Cary, NC, USA). The continuous variables were expressed as median (interquartile range). The clinical features of the patients were compared using Mann–Whitney U-tests for continuous variables of two groups, median tests for continuous variables of three groups and χ^2-tests for categorical variables. Overall survival and respiratory disease-specific survival were estimated using the Kaplan–Meier method followed by the log-rank test. The risk factors for unsuccessful treatment were assessed by a Cox regression hazard model using the following variables: older age (≥75 years), underlying disease, thoracoscopic surgery (yes or no), long operation time (>2 h), lung resection (yes or no) and use of fibrin glue (yes or no).

RESULTS

The clinical characteristics of the 183 patients and comparisons among the groups of underlying diseases are presented in Table 1. There were 123 patients in Group A, 20 in Group B and 40 in Group C. Group C contained younger patients and more females compared with the other groups. The smoking index (pack-years) was higher in Groups A and B. The hospital mortality rates were 2, 15, 0 and 3% in Groups A, B, C and the total cohort, respectively. The morbidity, hospital mortality and total pneumothorax recurrence rates were higher and the interval to initial recurrence was shorter in the IP group compared with those for the other groups.

The rates of treatment success were 86, 45, 83 and 81% in Groups A, B, C and the total cohort, respectively. More than half of patients in the IP group experienced unfavourable events. Table 2 illustrates the relations between surgical results and clinical variables. Patients with unfavourable results had the tendency of being older, suffering from IP, undergoing shorter and open surgery and longer postoperative hospital stay. The risk factors for unsuccessful treatment were assessed by a Cox regression hazard model (Table 3). Patients with SSP caused by IP or SSP requiring a complicated procedure, which was difficult by thoracoscopic

Table 1: Patient characteristics

	Total (N = 183)	Group A COPD (n = 123)	Group B IP (n = 20)	Group C others (n = 40)	P-value
Age (years)	66 (54–75)	70 (60–76)	71 (61–79)	40 (25–53)	<0.001
Gender, male (%)	158 (86)	118 (96)	18 (90)	22 (55)	<0.001
Smoking index (pack-years)	40 (15–60)	48 (31–67)	35 (18–70)	0 (0–5)	<0.001
Affected side (right/left/bilateral)	102/70/11	67/52/4	11/7/2	24/11/5	0.19
Operation time (min)	86 (64–132)	92 (66–149)	61 (54–95)	87 (64–116)	0.65
Thoracoscopic surgery (%)	174 (95)	119 (97)	19 (95)	36 (90)	0.32
Lung resection (%)	123 (67)	88 (72)	8 (40)	27 (68)	0.021
Covering of the pleura (%)	136 (74)	85 (69)	19 (95)	32 (80)	0.032
Use of fibrin glue (%)	42 (23)	27 (22)	8 (40)	7 (18)	0.13
Blood loss >200 ml (%)	11 (6)	11 (9)	0 (0)	0 (0)	0.017
Postoperative stay (days)	9 (5–16)	8 (5–16)	17 (10–30)	7 (5–11)	0.0020
Postoperative complications (%)	23 (13)	12 (10)	7 (35)	4 (10)	0.0058
Hospital mortality (%)	6 (3)	3 (2)	3 (15)	0 (0)	0.040
Recurrence of pneumothorax					
Total (%)	30 (16)	15 (12)	7 (35)	8 (20)	0.030
Ipsilateral (%)	17 (9)	10 (8)	3 (15)	4 (10)	0.66
Contralateral (%)	14 (8)	6 (5)	4 (20)	4 (10)	0.10
Interval to initial recurrence (months)	9.2 (2–34)	25 (8–54)	1.3 (0.6–3.1)	8.4 (5–19)	0.0085
Treatment success (%)	148 (81)	106 (86)	9 (45)	33 (83)	<0.001
Follow-up time (months)	19 (3–62)	23 (2–62)	12 (2–22)	24 (6–77)	0.17

COPD: chronic obstructive pulmonary disease; IP: interstitial pneumonia.

Table 2: The relations between surgical outcomes and clinical variables

	Successful treatment (*n* = 148)	Unsuccessful treatment (*n* = 35)	*P*-value
Age (years)	66 (53–74)	71 (56–77)	0.12
Gender, male (%)	127 (86)	31 (89)	0.88
Smoking index (pack-years)	40 (15–60)	35 (3–60)	0.71
Underlying diseases (COPD/IP/others)	106/9/33	17/11/7	<0.001
Affected side (right/left/ bilateral)	86/54/8	16/16/3	0.39
Operation time (min)	87 (65–140)	80 (58–113)	0.19
Thoracoscopic surgery (%)	144 (97)	30 (86)	0.02
Lung resection (%)	104 (70)	19 (54)	0.11
Covering of the pleura (%)	108 (73)	28 (80)	0.52
Use of fibrin glue (%)	30 (20)	12 (34)	0.12
Blood loss >200 ml (%)	10 (7)	1 (3)	0.63
Postoperative stay (days)	8 (5–14)	15 (6–28)	0.012

COPD: chronic obstructive pulmonary disease; IP: interstitial pneumonia.

Table 3: Risk factors for unsuccessful treatment

	OR	95% CI	*P*-value
Underlying disease			
IP vs COPD	3.7	1.5–8.5	0.0041
Others vs COPD	1.2	0.4–3.0	0.72
Approach (open vs VATS)	4.1	1.1–11	0.033
Age (≥75 vs <75)	1.6	0.7–3.5	0.26
Operation time (≥2 h vs <2 h)	0.7	0.3–1.6	0.44
Lung resection (yes vs no)	0.9	0.4–1.8	0.69
Use of fibrin glue (yes vs no)	1.1	0.5–2.3	0.75

OR: odds ratio; CI: confidence interval; COPD: chronic obstructive pulmonary disease; IP: interstitial pneumonia; VATS: video-assisted thoracic surgery.

surgery, had a high risk of treatment failure. In the IP group, the markers of preoperative systemic inflammation had the tendency of predicting treatment failure; CRP (median 3.0 vs 1.0 mg/dl for unsuccessful and successful treatment, respectively, $P = 0.07$) and WBC (8500/µl vs 6800/µl, $P = 0.21$) were higher in patients in whom the treatment was unsuccessful, although the sample size was too small to show significant differences. KL-6 levels did not differ according to the outcome. Older patients (63 vs 79 years, $P = 0.06$) and heavy smokers (23 vs 60 pack-years, $P < 0.05$) tended to have an uneventful course. We investigated the relationship between the time period of surgery and clinical variables (Table 4). There was no difference in surgical approach between the early period (1993–2004) and the later period (2005–14). However, in the later period, the proportions of patients with SSP caused by IP increased, covering of the pleura and use of fibrin glue were performed more frequently, hospital stay shortened and hospital mortality decreased to 1.8%. The Kaplan–Meier curves of overall survival and respiratory disease-specific survival according to underlying diseases are shown in Fig. 1. The median follow-up time was 19 months (interquartile range: 3–62). The

5-year overall survival rates were 78, 32 and 84% in Groups A, B and C, respectively, and the 5-year respiratory disease-specific survival rates were 87, 36 and 96% in Groups A, B and C, respectively. The overall survival and respiratory disease-specific survival of the IP group were significantly poorer than the other groups ($P < 0.001$). In the IP group, 5 patients (25%) had already received oxygen therapy and 7 patients (35%) had suffered from severe restrictive ventilatory impairments (vital capacity less than 60% of normal) before they developed SSP. There were no data regarding respiratory function before pneumothorax in the other 8 patients. Sixteen of the 20 cases required oxygen therapy after the onset of pneumothorax. Thirty patients (24%) in Group A, 13 (65%) in Group B and 8 (20%) in Group C died during the follow-up period. Figure 2 shows the distribution of the cause of death according to underlying diseases. Death was due to respiratory diseases in 77% of the patients with IP and due to the original malignancy in 75% of the deaths in Group C. However, 20% of the deaths in the COPD group occurred as a result of lung cancer, 20% were due to other malignancies and 13% due to cardiovascular disease. Eleven male patients developed lung cancer during the postoperative follow-up (10 in Group A and 1 in Group B).

DISCUSSION

In this study, although favourable results were obtained in patients of the COPD group, treatment was unsuccessful in more than half of patients with IP. SSP caused by IP and SSP requiring open surgery were identified as the risk factors for surgical treatment failure.

The aim of surgical treatment for SSP is to shorten the hospital stay, decrease the rate of respiratory diseases caused by prolonged pneumothorax, decrease the recurrence rate of ipsilateral pneumothorax and thus improve survival and quality of life. We defined treatment success as surgery without hospital mortality, postoperative complications, death within 6 months or ipsilateral recurrence of pneumothorax within 2 years. No patients without postoperative complications and recurrence of pneumothorax died of respiratory failure within 6 months after surgery in this study. Our definition of treatment success seems to reflect well whether the surgery was appropriate or not.

The rate of unsuccessful treatment for patients in the IP group was 55% despite thoracoscopic surgery, frequent covering of the pleura and use of fibrin glue. The mortality and morbidity were high mainly because of the acute exacerbation of IP. Moreover, lung tissue with IP was often so fragile and stiff that it was difficult to achieve the full expansion of the lung. In this study, the preoperative systemic inflammation had the tendency to predict treatment failure in the IP group. It may seem strange that older patients and heavy smokers tended to have an uneventful course, but this is probably because of the patient selection for surgical treatment. To evaluate the effectiveness of surgery for SSP, it is important to compare patients treated surgically with patients treated conservatively, particularly in patients with SSP caused by IP. Unfortunately, we have no data on conservative treatment. The comparison with conservative treatment and the risk factors for surgery failure, in cases with SSP caused by IP, need to be investigated in a larger cohort. Surgical indication for patients with SSP caused by IP should be cautiously examined and the disclosure for informed consent for them should be detailed and not optimistic.

The underlying diseases were severe in most of the patients with SSP. In the IP group, one-fourth had received oxygen therapy and one-third had suffered from severe restrictive impairments

Table 4: The relations between the time period of surgery and clinical variables

	Early period 1993–2004 (n = 70)	Latter period 2005–14 (n = 113)	P-value
Age (years)	67 (55–75)	65 (54–75)	0.61
Gender, male (%)	61 (87)	97 (86)	0.80
Smoking index (pack-years)	50 (32–86)	31 (0–55)	<0.001
Underlying diseases (COPD/IP/others)	56/4/10	67/16/30	0.014
Affected side (right/left/bilateral)	39/25/6	63/45/5	0.49
Operation time (min)	110 (70–169)	76 (58–109)	<0.001
Thoracoscopic surgery (%)	66 (94)	108 (96)	0.71
Lung resection (%)	47 (67)	76 (67)	0.99
Covering of the pleura (%)	32 (46)	104 (92)	<0.001
Use of fibrin glue (%)	4 (5.7)	38 (34)	<0.001
Blood loss >200 ml (%)	11 (16)	0 (0)	<0.001
Postoperative stay (days)	14 (8–21)	7 (4–11)	<0.001
Postoperative complications (%)	7 (10)	16 (14)	0.41
Hospital mortality (%)	4 (5.7)	2 (1.8)	0.17
Recurrence of pneumothorax (%)	8 (11)	21 (19)	0.19
Treatment success (%)	60 (86)	88 (78)	0.19
Follow-up time (months)	27 (1–95)	17 (6–56)	0.33

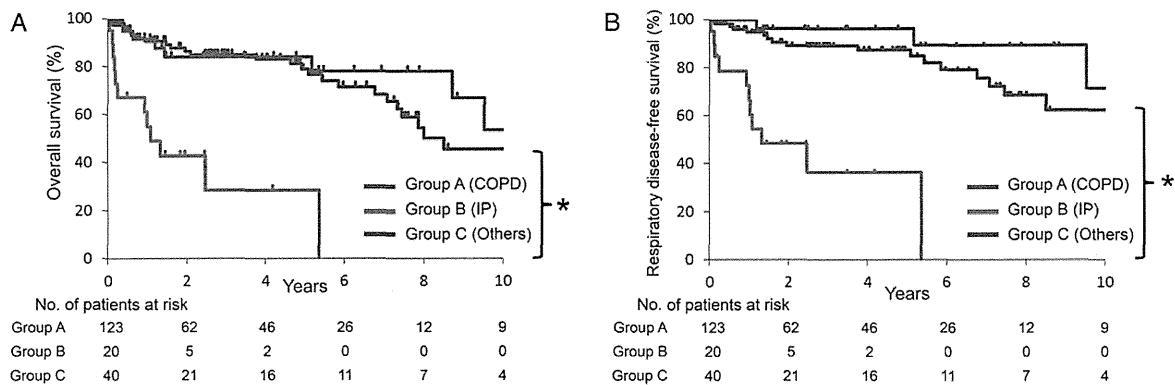COPD: chronic obstructive pulmonary disease; IP: interstitial pneumonia.

Figure 1: The Kaplan–Meier curves of (**A**) overall survival and (**B**) respiratory disease-specific survival according to underlying diseases. The 5-year overall survival rates for Groups A, B and C were 78, 32 and 84%, respectively and the 5-year respiratory disease-specific survival rates for Groups A, B and C were 87, 36 and 96%, respectively. The prognosis of Group B was significantly poorer than Groups A and C. *P < 0.001. COPD: chronic obstructive pulmonary disease; IP: interstitial pneumonia.

before pneumothorax. The pre-pneumothorax severity of concomitant IP appears to be an interesting parameter. However, severity is often difficult to evaluate because some patients were diagnosed retrospectively with IP after they had developed SSP.

In the last decade, the proportion of patients with SSP caused by IP has increased, hospital stay has shortened and hospital mortality has decreased. Advances in perioperative management and anaesthetic technique have enabled surgical treatment of patients who were formerly excluded from surgery.

The type of surgery was decided by the presence or absence of bulla, the lung stiffness around the air leak point and the degree of adhesion to the chest wall. We tended to perform lung resection in the COPD group, whereas we tended to perform ligation or closure of pulmonary fistula using PGA sheet and fibrin glue in the IP group. The air leak point was usually located in the destroyed lung in patients with IP and the parenchyma was too stiff and fragile to resect using a stapler. Our methods were not designed to compare surgical effectiveness.
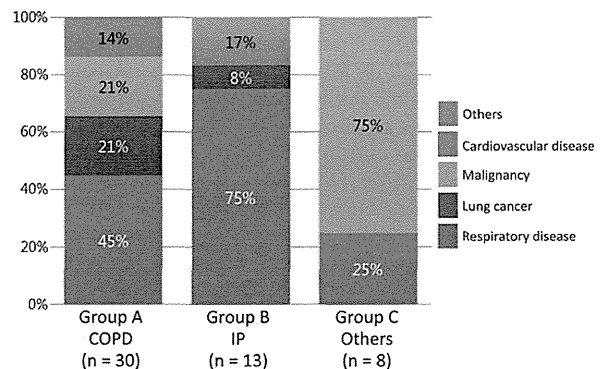

Figure 2: The distribution of the cause of death in patients who underwent surgery for SSP according to underlying diseases. The respiratory disease and malignancy categories excluded lung cancer. COPD: chronic obstructive pulmonary disease; IP: interstitial pneumonia; SSP: secondary spontaneous pneumothorax.

The distribution of the cause of death according to underlying diseases is interesting. It is reasonable that most of the patients with IP died from respiratory diseases and many of the patients in Group C died from the original malignancy. However, it is noteworthy that lung cancer, other malignancies and cardiovascular disease were considerable causes of death in the COPD group, whereas about half of the patients in the COPD group died from respiratory diseases. Postoperative regular check-ups and health guidance is especially important for patients with SSP caused by COPD, because cigarette smoke is well known to be a strong risk factor for various diseases including cardiovascular diseases and malignancies [6–11].

The long-term outcome of surgical treatment for SSP has rarely been investigated. This may be because regular follow-ups of patients with SSP are frequently difficult. Many patients with SSP have poor performance status and their medical management tends to be consigned to family doctors.

There were some limitations in this study. The study design was retrospective, observational and single-institutional. This study included only surgically treated patients. The protocol used for postoperative follow-up was not standardized, and some patients did not receive regular check-ups. Thirty-six patients (20%) were lost to follow-up before 3 months post-surgery. Therefore, the pneumothorax recurrence rate might have been underestimated. Nevertheless, the outcome of clinical experience should be shared, since a clinical trial for SSP is not realistic.

In conclusion, the outcome of surgical treatment for SSP caused by underlying diseases other than IP was favourable. However, the rate of unsuccessful treatment was more than 50% in patients with SSP caused by IP. Their surgical indication should be determined carefully, and a detailed and realistic disclosure for informed consent is required.

Conflict of interest: none declared.

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human
reproduction   ORIGINAL ARTICLE *Reproductive biology*

Enhanced miR-210 expression promotes the pathogenesis of endometriosis through activation of signal transducer and activator of transcription 3

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STUDY QUESTION: What are the roles of the microRNA miR-210—an miRNA that is up-regulated in endometriotic cyst stromal cells (ECSCs)—in the pathogenesis of endometriosis?

SUMMARY ANSWER: Up-regulated miR-210 expression in ECSCs is involved in their proliferation, resistance to apoptosis and angiogenesis through signal transducer and activator of transcription (STAT) 3.

WHAT IS KNOWN ALREADY: In the pathogenesis of endometriosis, a number of roles for microRNAs (miRNAs) are becoming apparent.

STUDY DESIGN, SIZE, DURATION: ECSCs and normal endometrial stromal cells (NESCs) were isolated from ovarian endometriotic tissues (patients aged 24–40 years undergoing salpingo-oophorectomy or evisceration for the treatment of ovarian endometriotic cysts, $n = 10$) and the eutopic endometrial tissues without endometriosis (premenopausal patients aged 35–45 years undergoing hysterectomies for subserosal leiomyoma, $n = 13$), respectively.

PARTICIPANTS/MATERIALS, SETTING, METHODS: We used a global gene expression microarray technique to identify down-stream targets of miR-210, and we assessed the functions of miR-210 in the pathogenesis of endometriosis by using the miR-210-transfected NESCs.

MAIN RESULTS AND THE ROLE OF CHANCE: Gene expression microarray analysis revealed that one of the key target molecules of miR-210 is STAT3. In the NESCs, in comparison to the control, miR-210 transfection resulted in the induction of cell proliferation ($P < 0.0005$), the production of vascular endothelial cell growth factor (VEGF) ($P < 0.0005$) and the inhibition of apoptosis ($P < 0.05$) through STAT3 activation [increased levels of mRNA ($P < 0.0005$), and protein ($P < 0.005$)]. In the ECSCs, inhibitors of STAT3 inhibited the cell proliferation and VEGF production ($P < 0.05$), and induced the apoptosis of these cells ($P < 0.05$).

LIMITATIONS, REASONS FOR CAUTION: The roles of aberrant miR-210 expression were investigated only in the stromal component of ectopic and eutopic endometrium. Control endometrial tissues were obtained from premenopausal patients who had subserosal leiomyoma and NESC gene expression patterns may be altered in these women. Furthermore, the effects of STAT3 inhibitors were evaluated only in ECSCs and not in NESCs.

WIDER IMPLICATIONS OF THE FINDINGS: The present findings indicate that miR-210 induces NESCs to differentiate into the endometriotic phenotype and we speculate that up-regulated miR-210 expression in ECSCs is involved in the creation of the endometriosis-specific cellular dysfunctions through epigenetic mechanisms. The data indicate that STAT3 inhibitors may be promising candidates for the treatment of endometriosis.

Introduction

Endometriosis is an estrogen-dependent disease exhibiting the benign ectopic growth of proliferative endometrial tissue. As a disease most frequently observed in women of reproductive age, endometriosis is most commonly based in the peritoneum, ovaries and rectovaginal septum (Giudice and Kao, 2004). Dysmenorrhea, chronic pelvic pain, subfertility and/or dyspareunia are the main symptoms, often greatly decreasing the quality of life of the affected women (Giudice and Kao, 2004).

Although endometriotic tissues share many histological characteristics with normal proliferative endometrial tissues (Giudice and Kao, 2004), they show several interesting molecular differences such as those concerning gene expression and protein production, synthesis and responsiveness to steroids and cytokines, immune components, adhesion molecules, and proteolytic enzymes and their inhibitors; endometriotic tissues also have a tissue structure and cell proliferation rates that differ from those of normal endometrial tissues (Nasu et al., 2011a,b). The occurrence and development of endometriosis may be based on these aberrations in molecular processes, which have been rather stable and consistent in endometriosis, and some sort of unknown trigger(s) that initiate these molecular alterations might exist. To identify the responsible mechanism(s) of the pathogenesis of endometriosis, our research has been focused on the dysregulation of microRNA (miRNA) expression (Abe et al., 2013), histone modification (Nasu et al., 2014) and DNA methylation (Nasu et al., 2011a) in endometriotic cells from the viewpoint of epigenetics. We hypothesized that the acquisition of aberrant gene expression by epigenetic mechanisms may induce the endometrial cells to differentiate into an endometriotic phenotype (Nasu et al., 2014).

miRNAs are short RNAs that comprise a class of regulatory genes characterized as endogenous, single-stranded, non-coding RNA (Bartel, 2004). They function by regulating the translation of specific targeted protein-coding genes (Bartel, 2004). It has been estimated that, as components of epigenetic mechanisms, miRNAs regulate the expression of 50–60% of the human genes without changing DNA sequences (Pillai, 2005; Engels and Hutvagner, 2006). Dozens of genes can be targeted by a single miRNA and, by the perfect or partial base-pairing with the 3'-untranslated region (UTR) of the target mRNAs, various cellular functions are induced or promoted (Pillai, 2005; Engels and Hutvagner, 2006). A broad range of physiological and pathological processes have been shown to involve one or more essential roles for miRNAs: the entire cell cycle (including embryogenesis, development, differentiation and proliferation), metabolism, cell–cell communication, cell survival and apoptosis, immune responses and oncogenesis (Bartel, 2004; Engels and Hutvagner, 2006; Burney et al., 2009; Ohlsson Teague et al., 2009, 2010).

A group of miRNAs that are differentially expressed among normal endometrium without endometriosis, eutopic endometrial tissues with endometriosis and endometriotic lesions have been demonstrated in microarray studies (Pan et al., 2007; Toloubeydokhti et al., 2008; Burney et al., 2009; Ohlsson Teague et al., 2009, 2010; Filigheddu

et al., 2010; Kuokkanen et al., 2010; Hawkins et al., 2011; Braza-Boïls et al., 2014), indicating the importance of miRNAs in the pathogenesis of endometriosis. In our recent miRNA microarray analysis (Abe et al., 2013), we identified a number of miRNAs that are aberrantly expressed in human endometriotic cyst stromal cells (ECSCs) compared with human normal endometrial stromal cells (NESCs) in primary culture. We found that miR-196b, one of the repressed miRNAs in the ECSCs, had anti-proliferative and pro-apoptotic functions in these cells.

We designed the present study to evaluate the role of miR-210, one of the up-regulated miRNAs in ECSCs (Abe et al., 2013), in the pathogenesis of endometriosis. Using the miR-210-transfected NESCs, we observed the proliferative, anti-apoptotic and angiogenic functions of miR-210 and the possible downstream targets of this miRNA. We also evaluated the efficacy of signal transducer and activator of transcription (STAT) 3 inhibitors as promising drugs for the treatment of endometriosis.

Materials and Methods

ECSC and NESC isolation procedure and cell culture conditions

Endometriotic tissues were obtained from patients with regular menstrual cycles who had undergone a salpingo-oophorectomy or evisceration for the treatment of ovarian endometriotic cysts ($n = 10$, aged 24–40 years), as described (Nishida et al., 2004). For ethical reasons, it was difficult to obtain endometrial tissues from healthy women; therefore, eutopic endometrial tissues were obtained from premenopausal patients who had undergone hysterectomies for subserousal leiomyoma and had no evidence of endometriosis ($n = 13$, aged 35–45 years), as described (Nishida et al., 2004). None of the patients had received any hormonal treatments for at least 2 years prior to the operation. All of the specimens were confirmed as being in the mid- to late-proliferative phases according to pathological observation and/or menstrual cycles. The patients in the present study were chosen without randomization. This study was approved by the institutional review board (IRB) of the Faculty of Medicine, Oita University, and written informed consent was obtained from all patients.

ECSCs and NESCs were isolated from ovarian endometriotic tissues and the eutopic endometrial tissues, respectively, by enzymatic digestion with collagenase as previously described (Nishida et al., 2004). Isolated ECSCs and NESCs were cultured in Dulbecco's modified eagle medium supplemented with 100 IU/ml of penicillin, 50 mg/ml of streptomycin and 10% heat-inactivated fetal bovine serum (all obtained from Gibco-BRL, Gaithersburg, MD, USA) at 37°C in 5% CO_2 in air. ECSCs and NESCs in the monolayer culture after the third passage were >99% pure as determined by immunocytochemical staining with antibodies to vimentin, CD10, cytokeratin, factor VIII and leukocyte common antigen (Nishida et al., 2004). Each experiment was performed in triplicate and repeated at least three times with the cells from at least three separate patients, except for gene expression microarray study.

Reverse transfection of miRNA precursors

NESCs were transfected with precursor hsa-miR-210 (Pre-miR miRNA precursor-hsa-miR-210, Ambion, Austin, TX, USA) or negative control

precursor miRNA (Pre-miR miRNA precursor-negative control #1, Ambion) at a final concentration of 10 nM, using Lipofectamine RNAiMAX (Invitrogen, Carlsbad, CA, USA) using the reverse transfection method, as previously described (Abe *et al.*, 2013).

Isolation of total RNA and the gene expression microarray analysis

Forty-eight hours after transfection, total RNA from cultured NESCs transfected with precursor hsa-miR-210 ($n = 3$) and NESCs ($n = 3$) transfected with negative control precursor miRNA was extracted with an RNeasy Mini kit (Qiagen, Valencia, CA, USA). The quality of the extracted RNA was confirmed by measuring the absorbance at 230, 260, and 280 nm using a spectrophotometer (NanoDrop 2000, Thermo Scientific, Wilmington, DE, USA) and by an Experion System (Bio-Rad Laboratories, Hercules, CA, USA). The samples were then subjected to a gene expression microarray analysis with a commercially available human mRNA microarray (G4845A, Human Gene Expression 4 × 44 K v2, Agilent Technologies, Santa Clara, CA, USA), which consists of 44 000 probes for 27 958 human RNAs, based on RefSeq Build 36.3, Ensemble Release 52, Unigene Build 216 and GenBank (April 2009).

Briefly, the total RNA was amplified, labeled and hybridized to a 44 K Agilent 60-mer oligomicroarray according to the manufacturer's instructions. All hybridized microarray slides were scanned by an Agilent scanner. Relative hybridization intensities and background hybridization values were calculated using Agilent Feature Extraction Software (9.5.1.1). Raw signal intensities and Flags for each probe were calculated from hybridization intensities (gProcessedSignal), and spot information (glsSaturated), according to the procedures recommended by Agilent Technologies. The flag criteria on the GeneSpring Software were, Absent (A), 'Feature is not positive and significant' and 'Feature is not above background'; Marginal (M), 'Feature is not Uniform', 'Feature is Saturated', and 'Feature is a population outlier'; Present (P), others. The raw signal intensities of six samples were then $\log_2$-transformed and normalized by a quantile algorithm with the 'preprocess-Core' library package on Bioconductor software (Gentleman *et al.*, 2004).

We selected probes that call the 'P' flag in both of two samples. To identify up- or down-regulated genes, we calculated Z-scores and ratios (non-log scaled fold-change) from the normalized signal intensities of each probe for comparison between NESCs transfected with precursor hsa-miR-210 and NESCs transfected with negative control precursor miRNA (Quackenbush, 2002). We then established the criteria for regulated genes: Z-score ≥ 2.0 and ratio ≥ 1.5-fold for up-regulated genes and Z-score less than or equal to -2.0 and ratio ≤ 0.66 for down-regulated genes. All data are available at Gene Expression Omnibus via the National Center for Biotechnology Information under Accession No. GSE56854 (http://www.ncbi.nlm.nih.gov/geo/query/acc.cgi?acc=GSE56854).

Ingenuity pathways analysis

To investigate possible biological interactions of differentially expressed genes, we imported data sets representing genes with an altered expression profile derived from the microarray analyses into the ingenuity pathways analysis (IPA) software (Ingenuity Systems, Redwood City, CA, USA) with the IPA knowledgebase (IPA Winter Release 2012).

Assessment of the cell viability of NESCs after miR-210 transfection and ECSCs after treatment with STAT3 inhibitors

WP1066 (573097; Merck Millipore, Darmstadt, Germany), S31-201 (573102; Merck Millipore) and cryptotanshinone (79852; Sigma-Aldrich Co., St Louis, MO, USA) were chosen as the representative STAT3 inhibitors in the present study. These STAT3 inhibitors were dissolved in dimethyl sulfoxide (DMSO, Wako Pure Chemical, Osaka, Japan) at the concentration of 100 mM as the stock solutions. The cell viability of NESCs after miRNA transfection and ECSCs after treatment with STAT3 inhibitors [WP1066 (1–8 μM), S31-201 (20–160 μM) and cryptotanshinone (8–64 μM)] was determined by a modified methylthiazoletetrazolium (MTT) assay using the CellTiter 96® AQ$_{ueous}$ One Solution Cell Proliferation Assay (Promega, Madison, WI, USA). Briefly, 5 × 10³ NESCs transfected with precursor hsa-miR-210 or negative control precursor miRNA by reverse transfection method were placed on 96-well flat-bottomed microplates (Corning, New York, NY, USA) and incubated for 72 h, as previously described (Abe *et al.*, 2013). ECSCs (5 × 10³ cells) were placed in 96-well flat-bottomed microplates and incubated with STAT3 inhibitors and 0.1% DMSO for 72 h. Thereafter, 20 μl of CellTiter 96® AQ$_{ueous}$ One Solution Reagent was added to each well and the cells were further incubated for 1 h. Cell viability was determined by measuring absorbance at 490 nm.

Assessment of the apoptosis of NESCs after miR-210 transfection and ECSCs after treatment with STAT3 inhibitors

We determined the apoptosis of NESCs after miRNA transfection and ECSCs after treatment with STAT3 inhibitors [WP1066 (1–8 μM), S31-201 (20–160 μM) and cryptotanshinone (8–64 μM)] by the direct determination of nucleosomal DNA fragmentation using an enzyme-linked immunosorbent assay (ELISA) (Cell Death Detection ELISA, Roche Diagnostics) (Abe *et al.*, 2013). NESCs after miRNA transfection (5 × 10³ cells) were placed on 96-well flat-bottomed microplates (Corning). After 72 h of culture, the cells were lysed according to the manufacturer's instructions, followed by centrifugation (200g, 5 min). The mono- and oligonucleosomes contained in the supernatants were determined using an anti-histone-biotin antibody. The concentration of nucleosomes–antibody was evaluated by measuring the absorbance at 405 nm using 2,2′-azino-di(3-ethylbenzthiazoline-sulphonate) as a substrate. The effects of STAT3 inhibitors on ECSCs were also examined.

Assessment of the activities of caspase-3 and caspase-7 in NESCs after miR-210 transfection and ECSCs after treatment with STAT3 inhibitors

The apoptosis of NESCs after miRNA transfection and ECSCs after treatment with STAT3 inhibitors [WP1066 (1–8 μM), S31-201 (20–160 μM) and cryptotanshinone (8–64 μM)] was evaluated by the Caspase-Glo 3/7 Assay (Promega) as described (Abe *et al.*, 2013). The assay is a luminescent assay that measures the activities of caspase-3 and caspase-7. NESCs after miRNA transfection (5 × 10³ cells) were placed on 96-well flat-bottomed microplates (Promega). After 72 h of culture, Caspase-Glo 3/7 reagent was added to each well. The plates were gently shaken for 60 min at room temperature, and then we measured the luminescence in a plate-reading luminometer. The effects of STAT3 inhibitors on ECSCs were also examined.

Assessment of the effects of miR-210 on the STAT3 and VEGF-A mRNA expression in NESCs

The effects of miR-210 on the expressions of possible downstream target genes in NESCs were evaluated by quantitative RT–PCR. The STAT3 and vascular endothelial growth factor A (VEGF-A) were chosen as candidate molecules for evaluation. Briefly, NESCs transfected with precursor hsa-miR-210 or negative control precursor miRNA were cultured in 10-cm culture dishes (Corning). Forty-eight hours after incubation, total RNA was extracted from the cultured NESCs using an miRNeasy Mini kit (Qiagen),

as described above. cDNA was then synthesized from 1 μg of total RNA using the Reverse Transcription System (Promega).

The quantitative RT–PCR was carried out with a LightCycler 480 (Roche Diagnostics GmbH, Penzberg, Germany) using TaqMan Universal PCR Master Mix II with specific primers for STAT3 (Assay ID: Hs00374280_m1, Applied Biosystems, Carlsbad, CA, USA), VEGF-A (Assay ID: Hs00900055 _m1, Applied Biosystems), or glyceraldehyde 3-phosphate dehydrogenase (GAPDH) (Assay ID: Hs02758991_g1, Applied Biosystems), as described (Abe et al., 2013). The expression levels of STAT3 and VEGF-A mRNA relative to GAPDH mRNA were calculated from a standard curve.

Assessment of the effects of miR-210 on the phosphorylated and total STAT3 protein levels in NESCs

The effects of miR-210 on the phosphorylated and total STAT3 protein levels in NESCs were also evaluated, using the Cell-Based Human/Mouse/Rat STAT3 (Tyr705) Phosphorylation ELISA Kit (RayBiotech, Inc., Norcross, GA, USA). Briefly, 3×10^4 cells transfected with precursor hsa-miR-210 or negative control precursor miRNA were placed on a white-walled 96-well microplate (RayBiotech). After 48 h of culture, the plates were processed to measure the absorbance at 405 nm, according to the manufacturer's instructions.

Assessment of the VEGF-A protein levels in the supernatant of NESCs after miR-210 transfection and ECSCs after treatment with STAT3 inhibitors

The VEGF-A protein levels in the supernatant of NESCs after miRNA transfection and those of ECSCs after treatment with STAT3 inhibitors were determined by ELISA.

Briefly, subconfluent NESCs after miRNA transfection or ECSCs after treatment with STAT3 inhibitors were cultured in 24-well culture plates (Corning). After a 24-h culture, the supernatants were then collected and stored at −70°C until assay. The concentration of VEGF-A was determined using commercially available ELISA kits (Human VEGF Immunoassay, R&D systems, Minneapolis, MN, USA). The sensitivity of the assay for VEGF was 9.0 pg/ml.

Statistical analysis

Data were obtained from triplicate samples and are presented as percentages relative to the corresponding controls, as mean ± SD, and were appropriately analyzed by the Bonferroni test and the Student t-test with Sigmaplot 11.2 (Systat Software, San Jose, CA, USA). Values of $P < 0.05$ were considered significant.

Results

Identification of candidate genes regulated by miR-210 transfection in NESCs

Among the 27 958 mRNAs examined by the gene expression microarray, 94 up-regulated mRNAs and 229 down-regulated mRNAs were identified statistically by using the criteria described above. Using the IPA software to find the known target and candidate downstream signaling networks of miR-210, we identified 29 downstream molecules (Table I).

Atrophin 1 (ATN1), elongation factor, RNA polymerase II, 2 (ELL2), histone deacetylase 2 (HDAC2), STAT3 and STAT6 were detected as the transcription factors regulated by miR-210 (Table I). Of these

Table I Regulation of candidate miR-210-target molecules in NESCs detected by microarray and ingenuity pathways analyses.

Gene family	Gene symbol	Regulation[a]	Z-score	Ratio
Transcription regulator	ATN1	↓	−3.29	0.36
	ELL2	↓	−3.05	0.49
	HDAC2	↑	3.95	3.61
	STAT3	↑	2.14	2.01
	STAT6	↓	−2.45	0.51
Growth factor	PGF	↑	6.18	7.19
Cytokine	IL11	↑	3.56	3.15
Kinase	ERBB2	↓	−2.27	0.52
	MAP4K4	↓	−2.47	0.45
	RPS6KA5	↑	3.58	2.53
	PTPRF	↓	−2.59	0.55
Peptidase	PLAU	↑	4.77	1.98
Transmembrane receptor	THBD	↑	3.56	2.84
Enzyme	GNA13	↑	2.21	1.9
	HMGCR	↑	2.56	1.93
	IRS2	↓	−3.39	0.38
	MX1	↓	−3.0	0.45
	PNPLA3	↑	2.87	2.3
	PPAT	↑	2.51	2.05
Other	ANGPTL2	↑	2.52	1.96
	ANGPTL4	↑	3.75	2.77
	COL8A1	↓	−2.66	0.51
	DAB2	↓	−2.49	0.57
	IGFBP3	↓	−2.58	0.41
	NF2	↓	−2.72	0.57
	SKP2	↑	3.18	2.79
	SYNPO	↓	−3.65	0.34
	THBS1	↓	−4.24	0.47
	U2AF2	↓	−3.78	0.42

ANGPTL2, angiopoietin-like 2; ANGPTL4, angiopoietin-like 4; ATN1, atrophin 1; ELL2, elongation factor, RNA polymerase II, 2; COL8A1, collagen, type VIII, α 1; DAB2, disabled homolog 2; ERBB2, v-erb-b2 erythroblastic leukemia viral oncogene homolog 2; GNA13, guanine nucleotide binding protein, α 13; HDAC2, histone deacetylase 2; IGFBP3, insulin-like growth factor binding protein 3; IL11, interleukin 11; IRS2, insulin receptor substrate 2; HMGCR, 3-hydroxy-3-methylglutaryl-CoA reductase; MAP4K4, mitogen-activated protein kinase kinase kinase kinase 4; MX1, myxovirus resistance 1, interferon-inducible protein p78; NF2, neurofibromin 2; PGF, placental growth factor; PLAU, plasminogen activator, urokinase; PNPLA3, patatin-like phospholipase domain containing 3; PPAT, phosphoribosyl pyrophosphate amidotransferase; PTPRF, protein tyrosine phosphatase, receptor type, F; RPS6KA5, ribosomal protein S6 kinase, 90 kDa, polypeptide 5; SKP2, S-phase kinase-associated protein 2; STAT, signal transducer and activator of transcription; SYNPO, synaptopodin; THBD, thrombomodulin; THBS1, thrombospondin 1; U2AF2, U2 small nuclear RNA auxiliary factor 2.
[a]Genes with Z-score ≥ 2.0 and ratio ≥ 1.5-fold were defined as up-regulated, and those with Z-score less than or equal to −2.0 and ratio ≤ 0.66 were defined as down-regulated.

transcription factors, we focused on STAT3 as a key molecule regarding the pathogenesis of endometriosis (Fig. 1) and used it in the further experiments. Downstream targets of STAT3 include collagen type IV, interleukin 11 (IL11), myxovirus resistance 1, interferon-inducible protein p78 (MX1), plasminogen activator, urokinase (PLAU), ribosomal protein S6 kinase, 90 kDa, polypeptide 5 (RPS6KA5), sterol regulatory element binding transcription factor 1 (SREBF1), synaptopodin (SYNPO), thrombospondin 1 (THBS1) and VEGF.
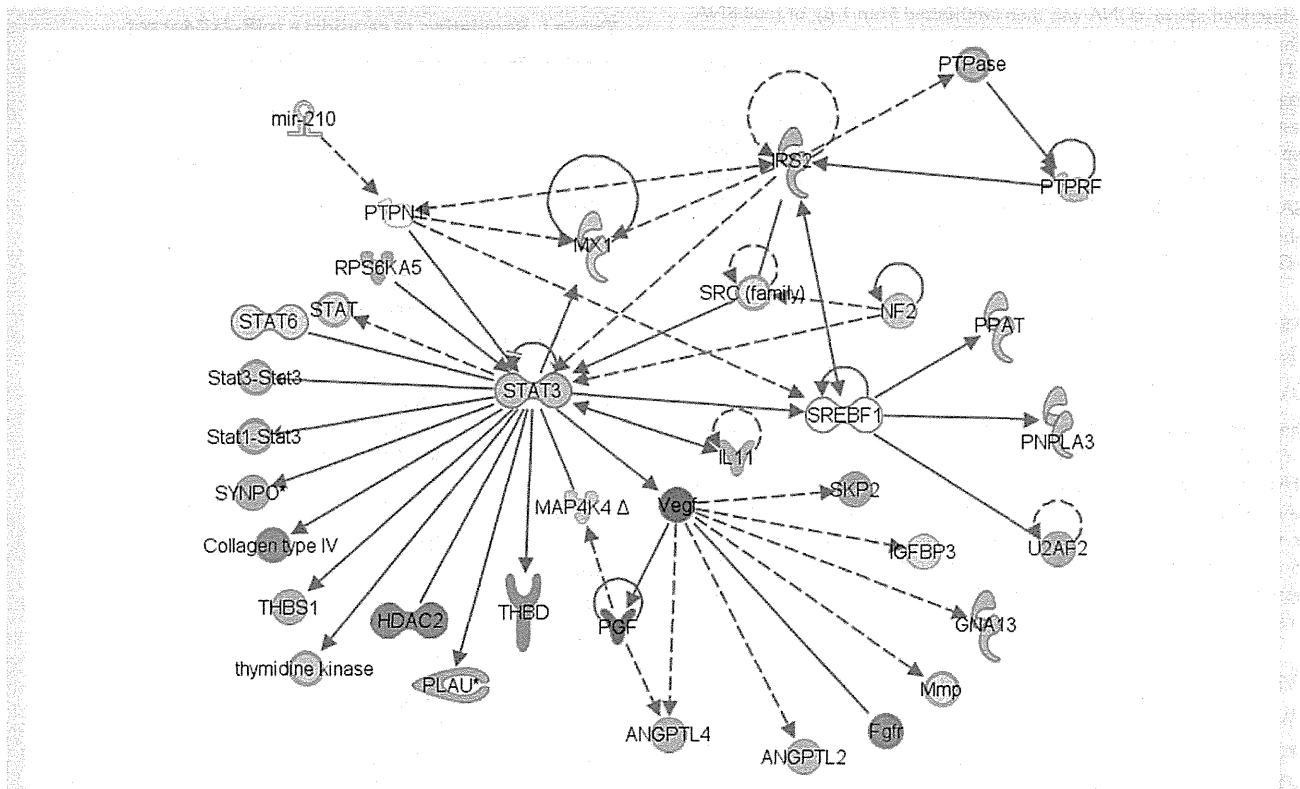
Figure I The downstream network of the micro RNA (miR)-210-STAT3 signaling pathway detected by Ingenuity pathways analysis. The genes that are shaded were determined to be significant from the statistical analysis. The genes in red are up-regulated and those in green are down-regulated. The intensity of the shading shows to what degree each gene was up- or down-regulated. A solid line represents a direct interaction between the two gene products, and a dotted line means that there is an indirect interaction. ANGPTL2, angiopoietin-like 2; ANGPTL4, angiopoietin-like 4; Fgfr, fibroblast growth factor receptor; GNA13, guanine nucleotide binding protein, α 13; HDAC2, histone deacetylase 2; IGFBP3, insulin-like growth factor binding protein 3; IL11, interleukin 11; IRS2, insulin receptor substrate 2; MAP4K4, mitogen-activated protein kinase kinase kinase kinase 4; Mmp, matrix metallopeptidase; MX1, myxovirus resistance 1, interferon-inducible protein p78; NF2, neurofibromin 2; PGF, placental growth factor ; PLAU, plasminogen activator, urokinase; PNPLA3, patatin-like phospholipase domain containing 3; PPAT, phosphoribosyl pyrophosphate amidotransferase; PTPase, phosphotyrosine phosphatase; PTPN1, protein tyrosine phosphatase, non-receptor type 1; PTPRF, protein tyrosine phosphatase, receptor type, F; RPS6KA5, ribosomal protein S6 kinase, 90 kDa, polypeptide 5; SKP2, S-phase kinase-associated protein 2; SRC, v-src sarcoma; SREBF1, sterol regulatory element binding transcription factor 1; SYNPO, synaptopodin; THBD, thrombomodulin; THBS1, thrombospondin 1; U2AF2, U2 small nuclear RNA auxiliary factor 2; VEGF, vascular endothelial cell growth factor.

The mRNA expression of some molecules, such as early growth response 2 (EGR2), homeobox A1 (HOXA1), sterol regulatory element binding transcription factor 1 (SREBF1) and protein tyrosine phosphatase, non-receptor type 1 (PTPN1), seem to be unaffected by miR-210 transfection. It is speculated that miR-210 may affect the function of these downstream target molecules without changing their mRNA expression.

Enhanced cell viability of NESCs by miR-210 transfection

The effects of miR-210 on the cell viability of NESCs were evaluated by a modified MTT assay. As shown in Fig. 2A, the viable cell number was significantly increased by the transfection of miR-210 precursor.

Inhibition of apoptosis of NESCs by miR-210 transfection

The anti-apoptotic effects of miR-210 on NESCs were determined by the Cell Death Detection ELISA assay. As shown in Fig. 2B, the transfection of miR-210 precursor significantly inhibited the apoptosis of ECSCs.

Inhibition of caspase-3/7 activity in NESCs by miR-210 transfection

The anti-apoptotic effects of miR-210 on ECSCs were also assessed by evaluating the activities of caspase-3 and caspase-7. As shown in Fig. 2C, the transfection of miR-210 precursor significantly inhibited the activities of caspase-3 and caspase-7 in ECSCs.
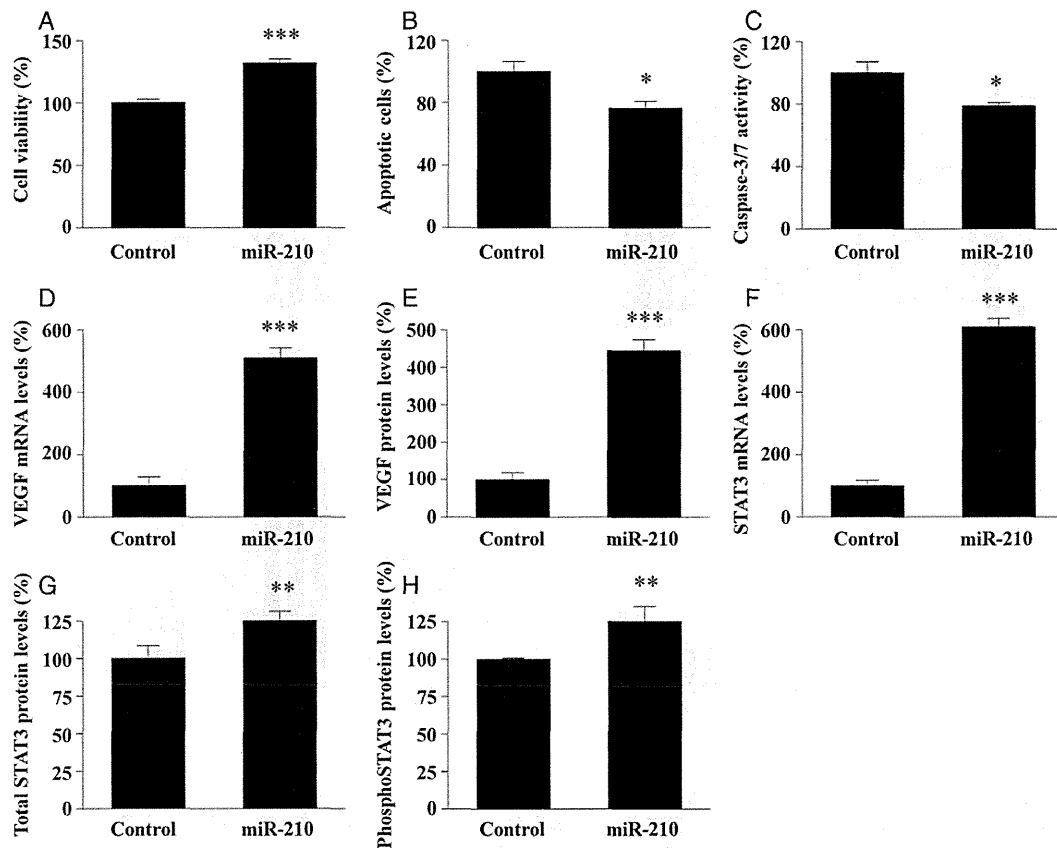
Figure 2 The effects of miR-210 transfection on human NESCs. (**A**) cell viability, (**B**) apoptotic cells, (**C**) caspase-3/7 activity, (**D**) VEGF mRNA levels, (**E**) VEGF protein levels, (**F**) STAT3 mRNA levels, (**G**) total STAT3 protein levels and (**H**) phosphorylated STAT3 protein levels of NESCs after miR-210 transfection ($n = 3$). The data are presented as percentages relative to the values of NESCs transfected with negative control precursor miRNA ($n = 3$). $*P < 0.05$, $**P < 0.005$, $***P < 0.0005$ versus negative controls (Student's t-test). Representative results are shown.

Enhanced VEGF mRNA and protein expression in NESCs by miR-210 transfection

The effects of miR-210 transfection on the VEGF mRNA and protein expression in NESCs were assessed by RT–PCR and ELISA, respectively. The transfection of miR-210 precursor significantly enhanced the VEGF mRNA and protein expression in NESCs (Fig. 2D and E).

Induction of STAT3 expression and activation in NESCs by miR-210 transfection

The effects of miR-210 transfection on the STAT3 mRNA and protein expression and STAT3 activation in NESCs were assessed. As shown in Fig. 2F–H, the transfection of miR-210 precursor significantly enhanced the STAT3 mRNA and protein expression and STAT3 activity in NESCs.

Suppression of cell viability of ECSCs by STAT3 inhibitors

The effects of STAT3 inhibitors on the cell viability of ECSCs were evaluated by a modified MTT assay. As shown in Fig. 3A, the viable

cell number was significantly decreased by the addition of STAT3 inhibitors.

Induction of apoptosis of ECSCs by STAT3 inhibitors

The effects of STAT3 inhibitors on the apoptosis of ECSCs were determined by the Cell Death Detection ELISA assay. As shown in Fig. 3B, the STAT3 inhibitors significantly induced the apoptosis of ECSCs.

The pro-apoptotic effects of STAT3 inhibitors on ECSCs were also assessed by evaluating the activities of caspase-3 and caspase-7. The STAT3 inhibitors significantly enhanced the activities of caspase-3 and caspase-7 in ECSCs (Fig. 3C).

Suppression of VEGF production in ECSCs by STAT3 inhibitors

The effects of STAT3 inhibitors on the VEGF protein secretion of ECSCs were assessed by ELISA. As shown in Fig. 3D, the STAT3 inhibitors
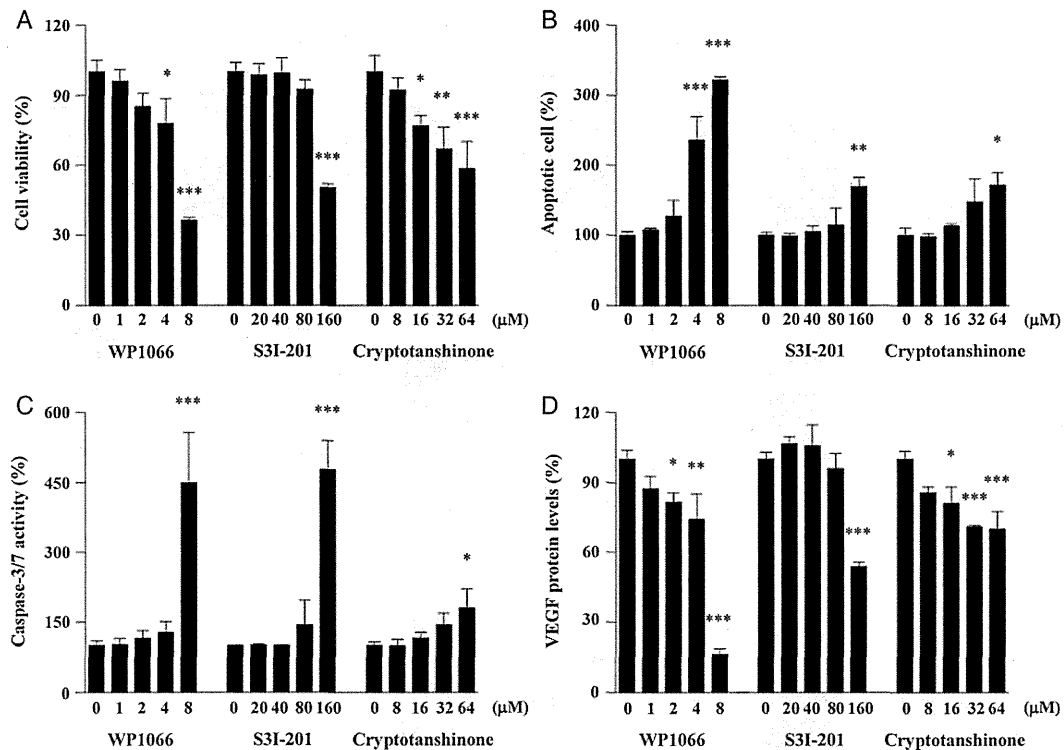
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Figure 3 The effects of STAT3 inhibitors on human ESCSs. (**A**) cell viability, (**B**) apoptotic cells, (**C**) caspase-3/7 activity and (**D**) VEGF protein levels of ECSCs treated with STAT3 inhibitors [WP1066 (1–8 μM), S3I-201 (20–160 μM) and cryptotanshinone (8–64 μM)] ($n = 3$). The data are presented as percentages relative to the values of untreated ECSCs ($n = 3$). $*P < 0.05$, $**P < 0.005$, $***P < 0.0005$ versus negative controls (Bonferroni's test). Representative results are shown.

significantly decreased the VEGF protein levels in the supernatant of ECSC culture.

Discussion

We conducted the present study to identify the role of miR-210, one of the up-regulated miRNAs in ECSCs (Abe et al., 2013), in the pathogenesis of endometriosis. By examining the miR-210 transfection in NESCs, the gene expression microarray technique and an IPA, we found a variety of candidate molecules as the downstream targets of miR-210. We then focused on STAT3 and performed further functional experiments. We found that miR-210 promoted the proliferation, resistance to apoptosis and VEGF production through STAT3 activation in NESCs, whereas STAT3 inhibitors inhibited the proliferation and VEGF production of ECSCs and induced the apoptosis of these cells. These findings suggest that miR-210 induces NESCs to differentiate into the endometriotic phenotype, which is characterized by proliferative, anti-apoptotic and angiogenic features. We also suggest that up-regulated miR-210 expression in ECSCs is involved in the creation of the endometriosis-specific cellular dysfunctions as part of epigenetic mechanisms. It is considered that activation of the miR-210-STAT3-VEGF axis is important in the pathogenesis of endometriosis. Based on our findings, we speculate that STAT3 inhibitors could be promising for the treatment of endometriosis.

As summarized in Table II, the roles of several miRNAs in the pathogenesis of endometriosis have been demonstrated (Lin et al., 2012, 2014; Abe et al., 2013; Adammek et al., 2013; Shen et al., 2013; Hsu et al., 2014; Shi et al., 2014). We showed that miR-196b, one of the repressed miRNAs in ECSCs, has anti-proliferative and pro-apoptotic functions in these cells by targeting c-myc and Bcl-2 (Abe et al., 2013). Given the diverse roles that miRNAs play in numerous aspects of cellular functions, it is not surprising that they play key regulatory roles in the pathogenesis of endometriosis. All the miRNAs listed in Table II belong to a different cluster from miR-210. VEGFA was the only target molecule shared with miR-210 and miR-199a-5p. Evaluations of the functions of each aberrantly expressed miRNA are necessary in further research on endometriosis.

Several studies showed that in various cell types, hypoxia was followed by the induction of miR-210 expression through hypoxia-inducible factors (Crosby et al., 2009; Zhang et al., 2009; Huang et al., 2010). A variety of tumors exhibit increased miR-210 expression (Gee et al., 2010; Stephen and Joseph, 2010; Buffa et al., 2011; Yuk et al., 2012). The identified functions of miR-210 include the modulation of cell proliferation, differentiation, cell cycle arrest, cell migration, DNA repair, chromatin remodeling, apoptosis, angiogenesis and metabolism (Fasanaro et al., 2008; Crosby et al., 2009; Zhang et al., 2009; Huang et al., 2010). A large number of target molecules of miR-210 have been reported: apoptosis-inducing factor, mitochondrion-associated, 3 (AIFM3), caspase-8 associated protein-2 (CASP8AP2), death-associated

Table II Reported function of aberrantly expressed miRNAs in endometriosis.

miRNA	Expression	Target gene expression	Function	References
miR-20a	Up-regulated in ESCs	Down-regulation of DUSP2	Augmentation of PGE2-induced FGF-9 expression, induction of prolonged ERK phosphorylation and induction of EGR-1, CYR61 and osteopontin	Lin et al. (2012)
miR-23a/b	Down-regulated in endometriotic tissues and eutopic endometrium of endometriosis patients	Down-regulation of steroidogenic factor-1	Inhibition of estrogen biosynthesis	Shen et al. (2013)
miR-145	Down-regulated in endometriotic tissues	Down-regulation of fascin-1, SOX2, MSI2, OCT4, KLF4, podocalyxin, JAM-A, and PAI-1 Up-regulation of ACTG2 and transgelin	Inhibition of proliferation Induction of invasiveness Reduction of side population and aldehyde dehydrogenase-1 activity	Adammek et al. (2013)
miR-183	Down-regulated in endometriotic tissues	ND	Induction of apoptosis, Inhibition of invasiveness	Shi et al. (2014)
miR-196b	Down-regulated in ESCs	Suppression of c-myc and bcl-2	Inhibition of proliferation Induction of apoptosis	Abe et al. (2013)
miR-199a-5p	Down-regulated in serum of endometriotic patients	VEGFA	Inhibition of proliferation, motility and angiogenesis	Hsu et al. (2014)
miR-302a	Up-regulated in ESCs	Suppression of COUP-TFII	Induction of COX-2	Lin et al. (2014)

ACTG2, smooth-muscle actin isoform γ2; COUP-TFII, chicken ovalbumin upstream promoter-transcription factor II; COX-2, cyclooxygenase-2; CYR61, cysteine-rich angiogenic inducer 61; DUSP2, dual-specificity phosphatase-2; EGR-1, early growth response protein-1; ESCs, endometriotic stromal cells; FGF-9, fibroblast growth factor-9; JAM-A, junctional adhesion molecule A; KLF4, Kruppel-like-factor 4; MSI2, Musashi-2; ND, not described; OCT4, octamer 4; PAI-1, plasminogen activator inhibitor 1; PGE2, prostaglandin E2; SOX2, SRY-box 2; VEGFA, vascular endothelial growth factor-A.

protein kinase 1 (DAPK1), E2F transcription factor 3 (E2F3), ephrin-A3 (EFNA3), fibroblast growth factor receptor-like 1 (FGFRL1), HOXA1, HOXA3, iron–sulfur cluster scaffold proteins (ISCU), MAX binding protein (MNT), PTPN1, RAD52 homolog (RAD52), tumor protein p53-inducible protein 11 (TP53I11), VEGF and VEGF receptor 2 (VEGFR2) (Fasanaro et al., 2008; Chan et al., 2009; Crosby et al., 2009; Zhang et al., 2009; Huang et al., 2010; Noman et al., 2012). Since miR-210 is well known as an angiogenic miRNA, we focused on the regulatory mechanism of VEGF expression by miR-210. In this setting, we found miR-210-STAT3-VEGF axis to be an important pathway (Fig. 1). Interestingly, STAT3 has been also shown to regulate cell proliferation and apoptosis (Siveen et al., 2014).

The treatment of endometriosis has been a challenge. Non-steroidal anti-inflammatory agents, agonists of GnRH, progestogens, androgens and contraceptive steroids have all been tried for patients with endometriosis (Committee of the American Society for Reproductive Medicine, 2004), and several surgical and medical strategies have been conducted, with varying degrees of efficacy. The results of the present study suggest that STAT3 inhibitors have potential as a treatment for endometriosis. In fact, several STAT3 inhibitors are now in preclinical use as anticancer drugs (Furqan et al., 2013). BBI608 (Langleben et al., 2013) is now in phase III trial, whereas OPB-31121 (ClinicalTrials.gov Identifier: NCT00955812, Food and Drug Administration, USA) and BBI503 (Laurie et al., 2014) are in phase I trial.

Siveen et al. (2014) demonstrated that the activation of STAT3 inhibits apoptosis and induces cell proliferation, angiogenesis, metastasis and invasion. The STAT family of transcription factors, in their inactive form, is initially located in the cytoplasm of the cell. With the stimulation provided by extracellular signals, such as cytokines, Janus kinases (JAKs), growth factors

and hormones are activated thereby inducing the phosphorylation of STAT3 on a tyrosine residue in its COOH terminus (Siveen et al., 2014). Phosphorylated STAT3 proteins activate the transcription of their target genes after they dimerize, translocate into the nucleus and bind with DNA. As shown in Fig. 1, it is suggested that miR-210 induces STAT3 mRNA and protein expression/phosphorylation through protein tyrosine phosphatase, non-receptor type 1 (PTPN1). Interestingly, as shown in Table 1, PTPN1 mRNA expression was not affected by miR-210 transfection in NESCs. Further examinations are necessary to elucidate the precise mechanisms. In the present study, we chose three representative STAT3 inhibitors with diverse mechanisms of action. WP1066 inhibits STAT3 activity by inhibiting its upstream transcription factor JAK (Ferrajoli et al., 2007), whereas S3I-201 inhibits STAT3 activity by inhibiting STAT3 dimerization (Fletcher et al., 2009). Cryptotanshinone inhibits STAT3 activity by inhibiting its phosphorylation (Lu et al., 2013). These STAT3 inhibitors show stronger effects in comparison with miR-210 transfection, suggesting that STAT3 can regulate cell viability by a mechanism independent of miR-210. Additional studies are necessary to fully understand the action of STAT3 inhibitors.

Another promising potential strategy for treating endometriosis is miRNA-targeting therapeutics in part because the use of small miR-inhibitor oligomers (e.g. DNA, DNA analogs and RNA) can readily accomplish miRNA inhibition (Hemida et al., 2010; Kota and Balasubramanian, 2010). In addition, the DNA analogs known as peptide nucleic acids (PNAs)—in which the sugarphosphate backbone is replaced by N-(2-aminoethyl)glycine units (Gambari et al., 2011)—efficiently hybridize with their target miRNAs and inhibit their functioning. The in vitro and in vivo effects of PNAs targeting miR-210 have been described (Gambari et al., 2011).

Angiogenesis is a critical step in the establishment of endometriosis, and endometriotic lesions are highly vascularized (Donnez et al., 1998). Endothelial cell proliferation and migration for neovascularization are stimulated by VEGF, the main sources of which are endometriotic tissue and peritoneal macrophages, and mesothelial cells (Donnez et al., 1998). As yet another endometriosis treatment strategy, anti-angiogenic therapy against VEGF holds great promise. miR-210-targeting molecules and STAT3 inhibitors can also act as anti-angiogenic argents by suppressing ECSCs' production of VEGF.

For ethical reasons, it is difficult to obtain endometrial tissues from healthy women. Instead, control endometrial tissues were obtained from premenopausal patients who had undergone hysterectomies for subserosal leiomyoma and had no evidence of endometriosis. Gene expression patterns of NESCs may be altered by the presence of leiomyoma (Karmon et al., 2014). Further limitations of the present study are that we have not performed a loss-of-function study using ECSCs transfected with miR-210-antagonist and the effects of STAT3 inhibitors were evaluated only in ECSCs and not in NESCs.

In conclusion, by using miR-210 transfection in NESCs, a gene expression microarray technique and an IPA, we found that STAT3 is one of the key target molecules of miR-210. The miR-210 transfection directed the induction of cell proliferation and VEGF production and the inhibition of apoptosis in NESCs through STAT3 activation, whereas STAT3 inhibitors blocked the proliferation and VEGF production of ECSCs and induced apoptosis of these cells. These findings suggest that up-regulated miR-210 expression in human ECSCs is involved in the creation of cellular dysfunctions that are disease-specific features of endometriosis, and we propose these may involve epigenetic mechanisms. In addition, STAT3 inhibitors are promising candidates for the treatment of endometriosis. Further studies on the repertoire of aberrantly expressed miRNAs, interacting miRNA–target mRNA associations and the regulation and mechanisms of action of miRNA may provide useful information about the pathogenesis of endometriosis.

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