ORIGINAL ARTICLE

Corneal Reconstruction with Tissue-Engineered Cell Sheets Composed of Autologous Oral Mucosal Epithelium

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ABSTRACT

BACKGROUND

Ocular trauma or disease may lead to severe corneal opacification and, consequently, severe loss of vision as a result of complete loss of corneal epithelial stem cells. Transplantation of autologous corneal stem-cell sources is an alternative to allograft transplantation and does not require immunosuppression, but it is not possible in many cases in which bilateral disease produces total corneal stem-cell deficiency in both eyes. We studied the use of autologous oral mucosal epithelial cells as a source of cells for the reconstruction of the corneal surface.

METHODS

We harvested 3-by-3-mm specimens of oral mucosal tissue from four patients with bilateral total corneal stem-cell deficiencies. Tissue-engineered epithelial-cell sheets were fabricated ex vivo by culturing harvested cells for two weeks on temperature-responsive cell-culture surfaces with 3T3 feeder cells that had been treated with mitomycin C. After conjunctival fibrovascular tissue had been surgically removed from the ocular surface, sheets of cultured autologous cells that had been harvested with a simple reduced-temperature treatment were transplanted directly to the denuded corneal surfaces (one eye of each patient) without sutures.

RESULTS

Complete reepithelialization of the corneal surfaces occurred within one week in all four treated eyes. Corneal transparency was restored and postoperative visual acuity improved remarkably in all four eyes. During a mean follow-up period of 14 months, all corneal surfaces remained transparent. There were no complications.

CONCLUSIONS

Sutureless transplantation of carrier-free cell sheets composed of autologous oral mucosal epithelial cells may be used to reconstruct corneal surfaces and can restore vision in patients with bilateral severe disorders of the ocular surface.

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Corneal epithelial stem cells reside in the basal layer of the limbus,[1,2] the transitional zone between the cornea and the bulbar conjunctiva. These cells govern renewal of the corneal epithelium[3] by generating progeny (transient amplifying cells, which are cells committed to epithelial differentiation) with limited renewal capabilities that migrate from the limbus into the basal layer of the cornea.[4]

If corneal epithelial stem cells are completely absent owing to limbal disorder from severe trauma (e.g., thermal or chemical burns) or eye diseases (e.g., the Stevens–Johnson syndrome or ocular pemphigoid), then the sources of corneal epithelial cells have been exhausted, the peripheral conjunctival epithelium invades inwardly, and the corneal surface becomes enveloped by vascularized conjunctival scar tissue, resulting in corneal opacification that leads to severe visual impairment. Such pathological characteristics are considered to represent limbal stem-cell deficiencies.[5,6]

In patients with unilateral limbal stem-cell deficiency, autologous limbal transplantation is a method of surface reconstruction of the cornea.[7] This procedure, however, requires a large limbal graft from the healthy eye (incurring a risk of causing limbal stem-cell deficiency in the healthy eye[8]), and it is not possible in patients who have bilateral lesions.[9]

Limbal-allograft transplantation can be performed in patients with unilateral or bilateral deficiencies,[10] but it requires long-term immunosuppression that involves high risks of serious eye and systemic complications including infection and liver and kidney dysfunction.[10] In patients with the Stevens–Johnson syndrome or ocular pemphigoid, graft failure is common, even with immunosuppression, owing to serious preoperative conditions such as persistent inflammation of the ocular surface, abnormal epithelial differentiation of the ocular surface, severe dry eye, and lid-related abnormalities.[11-13]

To avoid allograft rejection and improve surgical outcome, some patients with unilateral stem-cell deficiencies have had corneal epithelial grafts constructed ex vivo by the expansion of autologous limbal stem cells harvested from healthy contralateral eyes and cultivated on cell carriers such as amniotic membranes[14,15] and fibrin gel.[16] This process, however, cannot be used for bilateral total limbal stem-cell deficiencies. Therefore, we studied an alternative replacement strategy for damaged corneal epithelium involving a tissue-engineered epithelial-cell sheet comprising only the patient's own oral mucosal epithelial cells. Transplantation of autologous oral mucosal epithelial cells cultured on amniotic membranes to a rabbit corneal model has recently been reported.[17,18]

We studied a new method of transplantation involving a carrier-free cell sheet by exploiting temperature-responsive culture surfaces. By lowering the temperature, we are able to detach all the cultured cells from the surfaces as an intact transplantable cell sheet, and any carrier or scaffold is excluded from the graft.[19] We report the results of ocular-surface reconstruction in four patients with the use of cultured autologous oral mucosal epithelial cells and carrier-free tissue-replacement sheets.

METHODS

SUBJECTS

This study was approved by the institutional review board of Osaka University Medical School, in Osaka, Japan. Oral and written informed consent were obtained from all patients. Patients with bilateral total limbal stem-cell deficiency were eligible for inclusion. Exclusion criteria included glaucoma or xerophthalmia (a skinlike appearance) of the entire ocular surface. Our results are for the first four consecutive patients enrolled, each of whom had one eye grafted with a tissue-engineered epithelial-cell sheet fabricated in culture from harvested autologous oral mucosal epithelial cells in our hospital from January 2003 through March 2003 (Table 1).

All grafted eyes had been clinically diagnosed as having total limbal stem-cell deficiency with complete disappearance of the palisades of Vogt (a radial infolding at the sclerocorneal junction and a biologic marker of the location of corneal epithelial stem cells) and complete coverage by fibrovascular in-growth from 360 degrees of the limbus over the entire cornea. All patients exhibited chronic conjunctival inflammation immunologically driven by the causative diseases reported previously,[20,21] despite therapy with topical steroids. Three of the four patients (Patients 1, 3, and 4) had severe deficiency of the tear film. Lid abnormalities, including chronic blepharitis, misdirection of the eyelashes, and keratinization of the posterior lid margin, contributed to poor ocular-surface conditions and were also noted in all eyes. Patients 1 and 4 had continuous inflammation with severe tear-film and lid abnormalities and keratinization of the ocular

Table 1. **Preoperative Characteristics of Patients with Total Limbal Deficiency.**

Patient No.	Age	Sex	Diagnosis	Eye	Ocular-Surface Condition			Previous Surgery	Other Eye Diseases
					Symblepharon*	Schirmer's Test without Topical Anesthesia†	Schirmer's Test with Nasal Stimulation‡		
	yr					*mm*			
1	58	M	Stevens–Johnson syndrome (chronic phase)	Right	+	1	2	Allogeneic corneal epithelium (cultivated on amniotic membrane) transplantation in 2000	None
2	69	M	Ocular cicatricial pemphigoid	Left	+	23	26	None	None
3	77	F	Ocular cicatricial pemphigoid	Right	+	1	1	Limbal transplantation with the use of amniotic membrane in 2001	Proliferative diabetic retinopathy, branch-retinal-vein occlusion
4	75	F	Ocular cicatricial pemphigoid	Right	+	1	2	Penetrating keratoplasty in 1999	None

* The plus sign indicates that symblepharon (adhesion of one or both eyelids to the eyeball) was found at the patient's ocular surface.
† Schirmer's test without anesthesia is a commonly used clinical test of lacrimal secretion (tearing). It is performed by measuring the amount of moisture on Whatman filter paper (5 mm by 35 mm) that is placed in the margin of the lower lid for five minutes. A value of less than 5 mm indicates impaired secretion.
‡ Schirmer's test with nasal stimulation is used to measure maximal tearing and is performed by inserting a cotton swab into the nasal cavity. A value of less than 10 mm indicates decreased tearing.

surface. Three of the four patients (Patients 1, 3, and 4) had previously undergone allogeneic grafting, which had failed within one year after surgery, despite systemic and local immunosuppression with cyclosporine (trough levels of 50 to 100 ng per milliliter).

Surgical procedures for all cell-sheet autografts were performed by the same surgeon. A complete ophthalmologic examination included measurement of best corrected visual acuity, slit-lamp biomicroscopy, tonometry, and indirect ophthalmoscopy and was performed in all patients every two to four weeks during the follow-up period, starting two weeks after transplantation. The assessments of visual outcomes were carried out by investigators who were not involved in performing the procedures and were not informed about which eye underwent transplantation or whether the assessment was preoperative or postoperative.

CULTURE AND FABRICATION OF AUTOLOGOUS ORAL MUCOSAL EPITHELIAL-CELL SHEETS

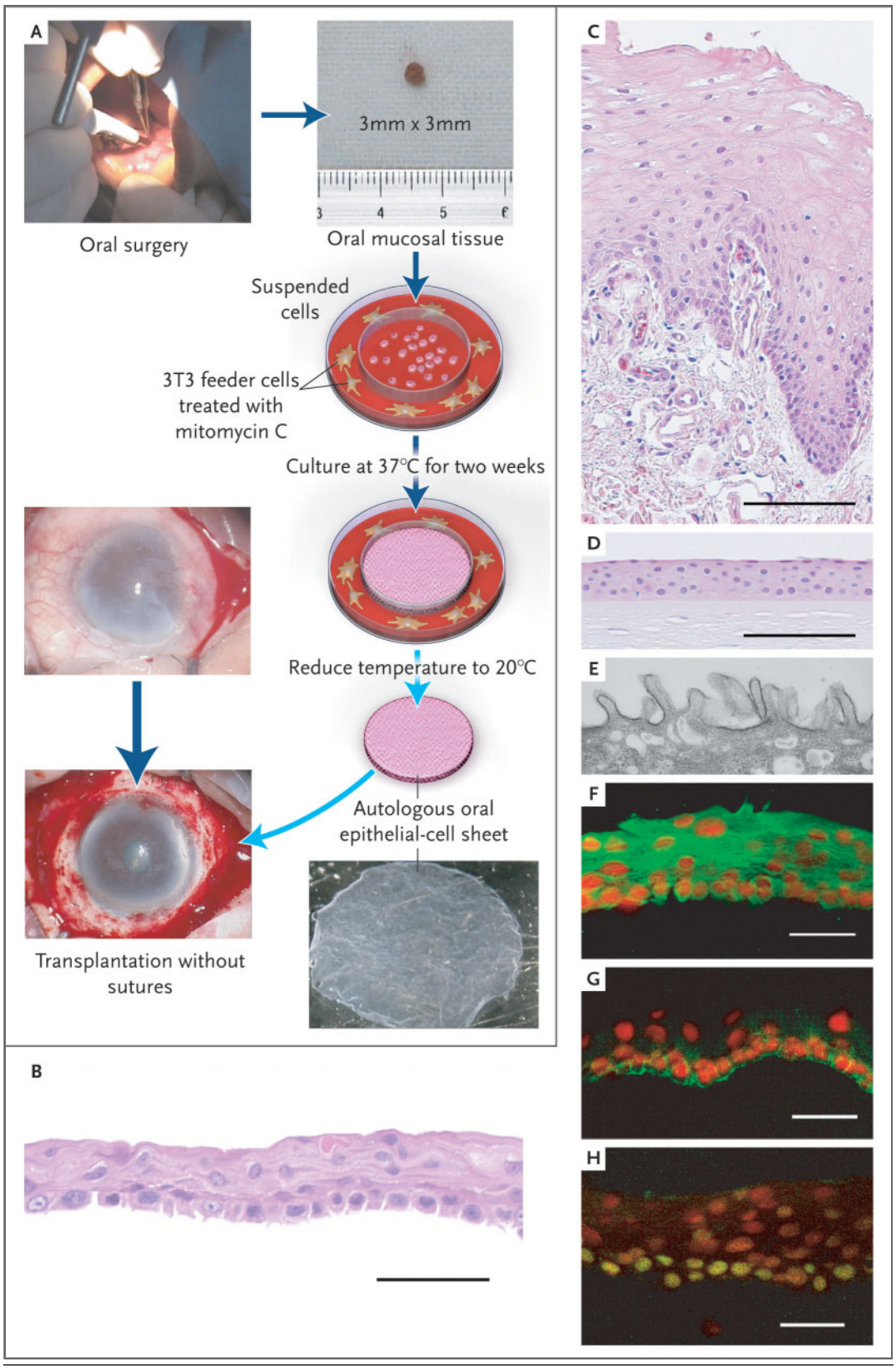
After each patient's oral cavity was sterilized with topical povidone-iodine, a 3-by-3-mm specimen of oral mucosal tissue was surgically excised from the interior buccal mucosal epithelium while the patient was under local anesthesia with xylocaine (Fig. 1A). Oral mucosal epithelial cells were collected by removing all epithelial layers after treatment with dispase II (3 mg per milliliter, Roche), at 37°C for one hour. Collected materials were placed in trypsin and EDTA for 15 minutes to form single-cell suspensions. Temperature-responsive cell-culture inserts (CellSeed) were prepared with the use of commercial cell-culture inserts (Falcon, Becton Dickinson) according to specific procedures described previously.[22] The temperature-responsive polymer poly(*N*-isopropylacrylamide), which reversibly alters its hydration properties with temperature, is chemically immobilized in thin films on cell-culture surfaces, facilitating cell adhesion and growth in normal culture conditions at 37°C. Reducing the temperature of the culture below 30°C causes this surface to hydrate and swell rapidly, prompting complete detachment of adherent cells without the use of typical proteolytic enzymes or treatment with EDTA. Confluent cell cultures on these surfaces can be conveniently harvested as a single, unsupported contiguous cell sheet, retaining cell-to-cell junctions as well as deposited extracellular matrix on the basal surface of the sheet.[23] Enzyme-free harvest permits the cell sheets to be readily manipulated, transferred, layered, or fabricated, because they adhere rapidly to other surfaces, such as traditional culture plastics,[22] other cell sheets, and tissues in vivo.[19]

To prepare lethally treated feeder layers, subconfluent NIH 3T3 cells were incubated with 16 μg of mitomycin C per milliliter for two hours at 37°C and then trypsinized and seeded onto tissue-culture wells (35-mm diameter, Becton Dickinson) at a density of 2×10^4 cells per square centimeter. Oral epithelial cells were separated from these feeder-layer cells during culture with temperature-responsive cell-culture inserts. We confirmed that multilayered cell sheets were fabricated only in the presence of 3T3 cells in the culture system. After culture in vitro for 14 days, epithelial-cell sheets (23.4 mm in diameter) were harvested by reducing the temperature to 20°C.

For colony-forming assays, treatment with trypsin and EDTA was used to isolate single cells from oral mucosal epithelium. Cells were counted, seeded onto culture dishes (35-mm diameter, Becton Dickinson), and cultured with feeder layers treated with mitomycin C. After cultivation for 10 to 12 days, dishes were fixed and stained with rhodamine B. Colony formation in the entire dish was screened under a dissecting microscope.

Figure 1 (facing page). Transplantation of Autologous Tissue-Engineered Epithelial-Cell Sheets Fabricated from Oral Mucosal Epithelium.

Panel A shows the removal of oral mucosal tissue (3 by 3 mm) from patient's cheek. Isolated epithelial cells are seeded onto temperature-responsive cell-culture inserts. After two weeks at 37°C, these cells grow to form multilayered sheets of epithelial cells. The viable cell sheet is harvested with intact cell-to-cell junctions and extracellular matrix in a transplantable form simply by reducing the temperature of the culture to 20°C for 30 minutes. The cell sheet is then transplanted directly to the diseased eye without sutures. In Panel B (the scale bar represents 50 μm), harvested cell sheets have three to five cell layers and do not resemble the original oral mucosa as shown in Panel C (the scale bar represents 100 μm) as closely as they resemble normal corneal epithelium as shown in Panel D (the scale bar represents 100 μm). Panel E shows a transmission electron micrograph of developed microvilli on the apical surface of the cell sheet. Specimens of human tissue-engineered epithelial-cell sheets harvested by reducing the temperature of the culture are immunostained green with anti–keratin 3 antibodies (Panel F), anti–β_1 integrin antibodies (Panel G), and anti-p63 antibodies (Panel H). The nuclei in Panels F, G, and H are shown in red. The scale bars represent 50 μm in Panels F, G, and H. The specimens in Panels B, C, and D are stained with hematoxylin and eosin.



IMMUNOHISTOLOGY

Cryosections from cell sheets were immunostained with monoclonal anti–keratin 3 antibodies (AE5, Progen Biotechnik), anti–β_1 integrin antibodies (P5D2, Santa Cruz Biotechnology), or anti-p63 antibodies (4A4, Santa Cruz Biotechnology) and fluorescein isothiocyanate–labeled or rhodamine-labeled secondary antibodies (Jackson ImmunoResearch Laboratories). Nuclei were costained with Hoechst 33342 (Molecular Probes) or propidium iodide (Sigma). Stained cells were observed using confocal laser scanning microscopy (LSM-510, Zeiss). The same concentration of corresponding normal nonspecific IgG provided negative controls, and native human corneal and limbal tissues were used as positive controls.

TRANSPLANTATION OF CELL SHEETS TO THE EYE

We removed the conjunctival and subconjunctival scar tissue from the cornea up to 3 mm outside the limbus to reexpose corneal stroma (Fig. 2, and a video clip in the Supplementary Appendix, available with the full text of this article at www.nejm.org). Subsequently, the harvested sheet of autologous oral mucosal epithelial cells was placed directly onto the exposed transparent stromal bed as described previously.[6,23] No sutures were required. The grafted corneal surface was then covered with a soft contact lens for protection during healing. After surgery, topical antibiotics (0.3 percent ofloxacin) and steroids (0.1 percent betamethasone) were initially applied four times a day and then tapered to three times a day. During the first week after surgery, betamethasone (1 mg per day) was administered orally to reduce postoperative inflammation. One month after surgery, the administration of topical corticosteroids was changed from 0.1 percent betamethasone to 0.1 percent fluorometholone. Because the patients had severe dry eye, proper wound healing could not be expected without tear supplementation. Preservative-free artificial tears were frequently used, and the puncta lacrimale of all the patients were occluded to increase tear retention.

RESULTS

CHARACTERIZATION OF TISSUE-ENGINEERED EPITHELIAL-CELL SHEETS

We compared cultured autologous oral mucosal-cell sheets with endogenous tissue both functionally and phenotypically. Oral mucosal epithelial cells cultured under these culture conditions resemble corneal epithelium, with three to five cell layers, small basal cells, flattened middle cells, and polygonal and flattened superficial cells (Fig. 1B), more than they resemble native oral mucosal epithelium (Fig. 1C), which is much thicker than corneal epithelium (Fig. 1D). The optical transparency of harvested cell sheets was equal to that of corneal epithelial-cell sheets originating from limbal stem cells (data not shown).[23]

Ultrastructural examination revealed an architecture of well-structured, compact, multilayered cell sheets with the expected microstructures of the native cells, including microvilli (Fig. 1E), tight junctions, desmosomes, and basement membrane. Such morphologic characteristics are similar to those of corneal epithelium in vivo. Native corneal epithelial cells and oral mucosal epithelial cells express keratin 3 as a characteristic phenotypic marker, and harvested epithelial-cell sheets also express keratin 3 (Fig. 1F).

The mean (±SE) colony-forming efficiency, calculated as the ratio of the number of stem or progenitor cells that can produce colonies to the total number of cells in the harvested tissue, was 2.1±0.9 percent for all four patients (with measurements performed in triplicate in each patient), confirming the presence of progenitor cells among the isolated oral mucosal epithelial cells. Correspondingly, β_1 integrin, reported to be an epithelial stem-cell and progenitor-cell marker[24] susceptible to digestion by trypsin, remained intact in the basal cells (Fig. 1G). The basal cells in the multilayered cell sheets also express p63 (Fig. 1H), a putative epithelial stem-cell marker.[25]

CLINICAL RESULTS OF TRANSPLANTATION OF THE CELL SHEET TO THE CORNEAL SURFACE

Attachment of the cell sheet to the stromal bed was spontaneous and uniform (Fig. 2, and video clip in the Supplementary Appendix). Within several minutes after placement without sutures, the grafted cell sheets remained intact and stably bound to the stromal surfaces, even after the extensive application of eyedrops. This observation is consistent with previous experiments with rabbit models, in which transplanted sheets of oral mucosal epithelial cells readily resisted outward displacement when the perimeters were pulled with forceps.

Immediately after surgery, the transplanted corneal surface was clear and smooth, without observable vascularization. Within one week, slit-lamp ex-

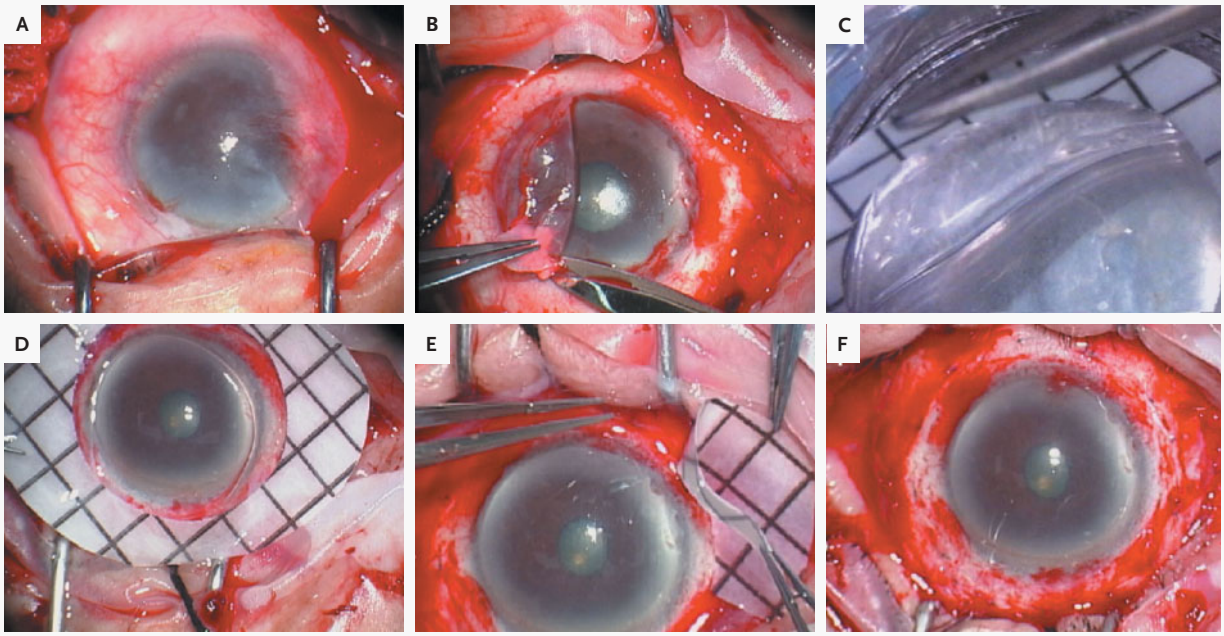


Figure 2. Transplantation Procedures for Tissue-Engineered Autologous Epithelial-Cell Sheets.

Preoperatively, the entire corneal surface was covered by conjunctival tissue with neovascularization (Panel A). In Panel B, conjunctival tissue over the cornea is surgically removed to reexpose transparent corneal stroma. Then, the sheet of tissue-engineered epithelial cells is harvested from a temperature-responsive culture insert with the use of a doughnut-shaped supporter ([black-and-white squares] Panel C) and placed on the stromal bed (Panel D). The sheet adheres to corneal stroma in a few minutes without sutures, and the supporter is removed (Panel E), leaving the cell sheet on the stroma (Panel F). A video clip can be viewed in the Supplementary Appendix, available with the full text of this article at www.nejm.org.

amination with fluorescein sodium staining showed complete reepithelialization of the corneal surface in all four eyes, revealing the tight junction-mediated barrier function. Corneal transparency was restored without any defects of the corneal epithelium. In all eyes, stromal vascularization gradually recurred in the peripheral cornea but not in the central zone. This vascularization was unlike subepithelial vascularization accompanied by conjunctival ingrowth, since it was localized to the deeper stroma and did not show the abnormally high fluorescein permeability characteristic of conjunctival epithelium.

During a mean follow-up period of 14 months, corneal transparency was maintained (Fig. 3 and Table 2). Maximally improved visual acuity was obtained 6, 2, 10, and 8 weeks after transplantation for Patients 1 through 4, respectively, and became stable thereafter. The length of time until visual acuity improved seemed to correspond to the length of time until the corneal stroma became less opaque. No complications were observed.

DISCUSSION

Our study shows that tissue-engineered cell sheets from autologous oral mucosal epithelium may serve as effective substitutes for allografts of limbal tissue in the reconstruction of the corneal and limbal surfaces. Four patients (four eyes) were consecutively treated with this approach, and corneal transparency was restored and postoperative visual acuity improved remarkably (Table 2). During the follow-up period, all corneal surfaces remained transparent, and there were no serious complications.

We developed this strategy on the basis of several observations from cell biology and medicine. First, in vivo oral mucosal epithelium expresses keratin 3, which is also expressed by the corneal epithelium but not by the epidermis.[1,27] Second, the excision of a small piece of oral mucosal tissue from the patient is straightforward, and the resulting wound heals within several days without incident or scarring. Third, transplantation of autologous

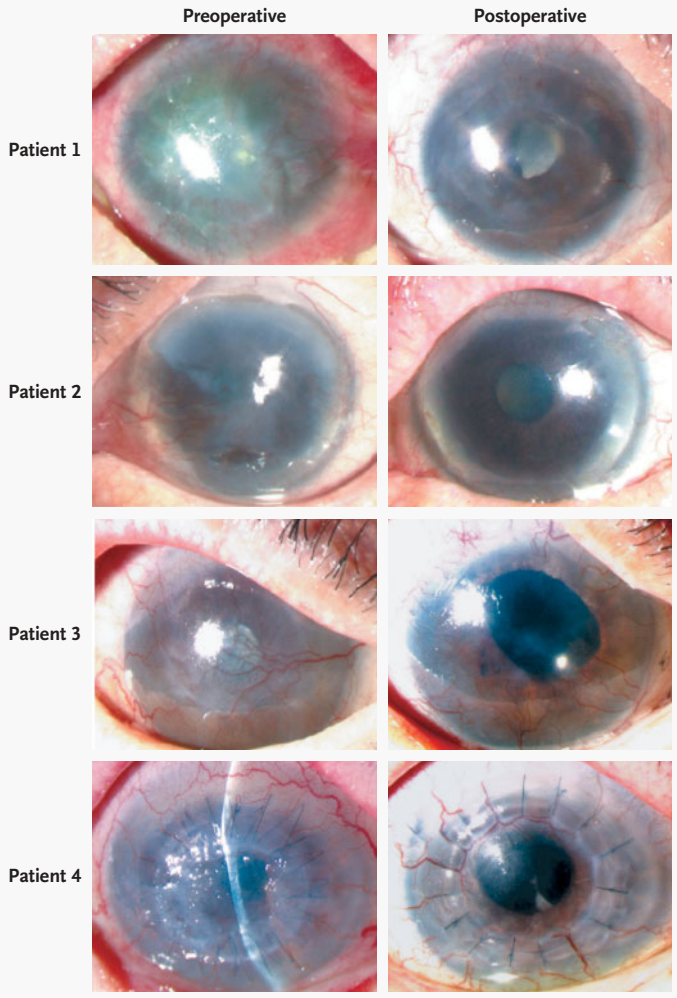


Figure 3. Eyes of Patients before and after Transplantation of Sheets of Tissue-Engineered Autologous Epithelial Cells.

These photographs were taken just before transplantation of the cell sheets and postoperatively at 13, 14, or 15 months.

buccal mucosal grafts directly onto ocular surfaces was previously reported in human patients[28] for the purposes of treating corneal ulcers, corneal perforations, and lid abnormalities (e.g., marginal entropion and trichiasis); these grafts are not useful for improving vision, since they contain opaque subepithelial fibrous tissue. In contrast, the transparency of carrier-free sheets of tissue-engineered epithelial cells fabricated from oral mucosal epithelial cells is similar to the transparency of corneal epithelial-cell sheets originating from limbal stem cells.[23]

Reconstruction with autologous oral mucosal epithelial cells offers substantial clinical advantages over allogeneic transplantation for treating severe diseases such as the Stevens–Johnson syndrome and ocular pemphigoid. It averts the risks of allogeneic immunorejection and immunosuppression. Severe tear-film and lid abnormalities often associated with these diseases continue to be a challenge, since immunologically driven inflammation of the ocular surface persists chronically in these patients.

Although decisive epithelial stem-cell markers that could provide evidence of the presence of these stem cells in grafted cell sheets have not yet been established,[29] results from colony-forming assays for oral mucosal epithelium show that excised oral tissue contains epithelial stem cells or at least progenitor cells. Since ocular surfaces that have been grafted with cell sheets retain their transparency for more than one year, and because the life spans of transient amplifying cells (cells committed to epithelial differentiation) are believed to be less than one year,[30] we conclude that progenitor cells with the potential to differentiate into new corneal epithelial phenotype are present in autografts of cell sheets.

Conjunctival epithelial cells invade the cornea after allogeneic transplantation because of the gradual depletion of allogeneic corneal epithelial cells due to epithelial rejection or stem-cell depletion.[31-33] It is unknown whether this also applies to autologous transplants. In the four eyes we studied, limited stromal vascularization occurred within a few months after transplantation of the cell sheet and reached a stable state within six months, with no appreciable growth thereafter. This stromal vascularization was observed only beneath cell sheets on peripheral corneas and should be distinguished from the subepithelial neovascularization accompanied by conjunctival ingrowth that results from the stem-cell loss associated with allografts, which occurs several months after transplantation. This finding suggests that grafted oral mucosal epithelial cells remained on the ocular surface.

It is possible that the reduction in host immunologic reactions associated with the grafting of autologous cells may minimize epithelial rejection, but further study is needed. The limited stromal neovascularization that we observed is probably caused by angiogenic factors secreted from tissue-engineered epithelial-cell sheets fabricated from oral mucosal epithelial cells originally located in

Table 2. Surgical Outcome in Four Patients Who Received Transplants of Tissue-Engineered Autologous Oral Mucosal-Cell Sheets.

Patient No.	Best Corrected Visual Acuity in Damaged Eye		Corneal Opacity (Grade)*			Complication	Months of Follow-up
	Preoperative†	Postoperative	Preoperative	1 Month after Surgery	At Last Observation		
1	Counting fingers	20/100	3	2	1	None	15
2	20/2000	20/25	3	1	1	None	14
3	Hand motion	20/300	3	1	1	None	14
4	20/2000	20/50	3	1	1	None	13

* The extent of corneal opacity was graded by three masked observers on the basis of the slit-lamp examination with a previously described system[26] and modifications for ocular-surface diseases. Grade 0 indicates clear or trace haze, grade 1 mild opacity, grade 2 moderately dense opacity partially obscuring details of the iris, and grade 3 severely dense opacity obscuring details of the intraocular structure. Grading is based on the opacity observed in all corneal layers, including epithelium, stroma, and endothelium.

† The visual acuity of patients who could not read a visual-acuity chart at a distance of 0.5 m was assessed by asking whether they could see the number of fingers held up by the examiner. If they could not, visual acuity was assessed by the patient's ability to see hand movement by the examiner.

vivo on the substantia propria, which is rich in vessels. However, the production of antiangiogenic factors such as thrombospondin by keratocytes[34] may limit vascularization to peripheral areas.

We observed that the transplanted cell sheets became more transparent and achieved smoother, integrated surfaces on the corneal stroma, further resembling normal corneal epithelium; a plateau was reached one to three months after transplantation. Originally, oral mucosal epithelium, located on substantia propria, is morphologically distinct from corneal epithelium in that it is much thicker and multilayered and has an irregular surface (Fig. 1C). The use of temperature-responsive harvesting allows the grafted carrier-free oral mucosal epithelial cells to interact immediately and directly with patients' corneal stromal keratocytes without interference from cell carriers such as fibrin gel and amniotic membranes.

Our transplantable epithelial-cell sheets used the common 3T3 feeder-layer method originally developed for the production of autologous epidermal-cell grafts[35] and used in the culture of other epithelial cells from various tissue sources, including the limbus.[16] This method has been clinically applied since the 1980s for the treatment of various skin conditions, including burns and giant nevi, although the Food and Drug Administration classifies these grafts as xenografts.

In summary, we have shown that sheets of tissue-engineered epithelial cells fabricated ex vivo from autologous oral mucosal epithelium are effective for reconstructing the ocular surface and restoring vision in patients with bilateral total stem-cell deficiencies. Long-term follow-up and experience with a large series of patients are needed to assess further the benefits and risks of this method, which offers the potential to treat severe ocular diseases that are resistant to standard approaches.

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