Spin-Labeling Magnetic Resonance Imaging Detects Increased Myocardial Blood Flow After Endothelial Cell Transplantation in the Infarcted Heart

Hualei Zhang, BS*; Hui Qiao, MD, PhD*; Rachel S. Frank, BS; Bin Huang, MD; Kathleen J. Propert, PhD; Susan Margulies, PhD; Victor A. Ferrari, MD; Jonathan A. Epstein, MD; Rong Zhou, PhD

Background—We quantified absolute myocardial blood flow (MBF) using a spin-labeling MRI (SL-MRI) method after transplantation of endothelial cells (ECs) into the infarcted heart. Our aims were to study the temporal changes in MBF in response to EC transplantation and to compare regional MBF with contractile function (wall motion) and microvascular density.

Methods and Results—We first validated the SL-MRI method with the standard microsphere technique in normal rats. We then induced myocardial infarction in athymic rats and injected 5 million ECs (human umbilical vein endothelial cells) suspended in Matrigel or Matrigel alone (vehicle) along the border of the blanched infarcted area. At 2 weeks after myocardial infarction, MBF averaged over the entire slice (P=0.038) and in the infarcted region (P=0.008) was significantly higher in EC versus vehicle group; the greater MBF was accompanied by an increase of microvasculature density in the infarcted region (P=0.010 versus vehicle). At 4 weeks after myocardial infarction, MBF in the remote region was significantly elevated in EC-treated hearts (P=0.027); this was accompanied by increased wall motion in this region assessed by circumferential strains (P=0.0075). Intraclass correlation coefficients and Bland-Altman plot revealed a good reproducibility of the SL-MRI method.

Conclusions—MBF in free-breathing rats measured by SL-MRI is validated by the standard color microsphere technique. SL-MRI allows quantification of temporal changes of regional MBF in response to EC treatment. The proof-of-principle study indicates that MBF is a unique and sensitive index to evaluate EC-mediated therapy for the infarcted heart. (Circ Cardiovasc Imaging. 2012;5:210-217.)

Key Words: myocardial blood flow ■ spin-labeling ■ MRI ■ myocardial infarction ■ human umbilical vascular endothelial cells ■ microspheres ■ left ventricular ejection fraction

Quantification of absolute myocardial blood flow (MBF, in units of milliliters per minute per gram of tissue) is important when evaluating stem cell mediated treatment of myocardial infarction (MI). First, the ability of local blood supply to match metabolic demand of the tissue will affect the survival of grafted cells. Second, new vasculature formed by either transplanted cells or host cells will improve perfusion, which then facilitates graft survival and expansion. Because an increase in capillary density does not necessarily lead to an increase of blood flow in vivo, a noninvasive quantification of MBF is desirable, and a measurable increase in MBF can be a specific index to determine the success of therapeutic angiogenesis or vasculogenesis in the infarcted heart.

Clinical Perspective on p 217

In the REPAIR-AMI clinical trial,2 bone marrow–derived progenitor cells (BMCs) were infused in patients with reperfused acute MI. By measuring blood flow using an intracoronary Doppler probe, the investigators found that the coronary flow reserve (CFR, defined as the ratio of the maximal to the resting coronary blood flow) of infarct-related arteries recovered to a normal level in BMC-treated patients but not in placebo controls. CFR thus provided direct evidence that BMCs restored microvascular function of infarct-related arteries. Microvascular function, quantified by MBF, could be an important predictor of global functional recovery, which was achieved in some BMC trials3 but not in others.4,5
Whereas BMCS are a mixture of various types of cells, fully differentiated endothelial cells (ECs)³⁰ or endothelial progenitor cells⁷,⁸ represent a more purified cell population and have been suggested to form new vasculature, preserve left ventricular (LV) function, and inhibit apoptosis in the infarcted heart. However, mechanisms underlying the salutary effects of these cells are not well understood: specifically, whether or not neovascularization leads to improved regional MBF has not been studied extensively.

To evaluate EC-mediated or endothelial progenitor cell-mediated vascular repair over time and to be able to translate it to the clinic, noninvasive imaging–based methods for MBF estimation are desirable. At present, positron emission tomography is the clinical standard for MBF measurement.⁹ First-pass contrast-enhanced MRI can be used to quantify MBF only after extensive modeling of the kinetic data.¹⁰ In contrast, spin-labeling–based MRI (SL-MRI) utilizes endogenous water molecules, eliminating the need to inject any exogenous contrast agents. First implemented on the heart by Belle et al.¹¹,¹² on the rat in vivo, this technique has proven effective for mapping MBF in rapidly beating rodent hearts to study cardiovascular diseases in such models.¹³–¹⁷

In this study, we first validated the SL-MRI method with a standard microsphere technique; second, we used SL-MRI to detect changes of MBF over time in the infarcted, border, and remote regions in response to EC transplantation and demonstrated that the improved MBF is corroborated with increased wall motion and microvascular density in the corresponding regions.

Methods

Experimental Design and Study Groups

All animal procedures were approved by the local Institutional Animal Care and Use Committee. This study had 2 aims. Aim 1 was to validate the SL-MRI–based MBF measurement; Aim 2 was to assess the utility of SL-MRI for detecting MBF changes mediated by EC transplantation in an MI model.

For Aim 1, 18 rats were used; 5 rats completed the study, whereas 13 died during procedures (see section: Validation of SL-MRI–Based MBF With the Microsphere Method). For Aim 2, ECs in the form of human umbilical vein endothelial cells (HUVECs, ATCC, Manassas, VA) were expanded (≥6–10 passages) and suspended in serum-free medium in an MI model.

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SL-MRI–Based MBF Quantification

MR experiments were performed on a 4.7-T horizontal bore magnet interfaced to a Varian DirectDrive console. A combination of a transverse electromagnetic volume transmit coil and surface receive coil (InsightMRI, Worcester, MA) was interfaced to a 12-cm gradient insert with maximum strength of 25 G/cm. The rat was maintained under anesthesia by isoflurane mixed with oxygen at a flow rate of 1 L/min through a nose cone. ECG and respiration were monitored (SA Instruments, Stony Brook, NY), and core temperature was maintained at 36.5 ± 0.2°C by warm air. A gel phantom (with relaxation time, T₁, slightly longer than normal myocardium) was fixed on the animal holder.

Data Acquisition

We modified the SL-MRI protocol by Kobert et al.,¹⁹ in which ECG- and respiration-gated gradient echo technique was used to achieve high spatial resolution perfusion maps in free-breathing animals. Instead of referencing the phantom with a known T₁ to derive tissue T₁ values, our protocol directly calculates T₁ from a series of inversion recovery images using a least-squares fitting algorithm.²¹,²² Consequently, the mean perfusion value of the phantom being close to 0 was used as a criterion to evaluate the quality of raw data and T₁ fitting.

MBF was measured from a 3-mm, short-axis slice at mid LV. To map T₁ corresponding to non–slice-selective and slice-selective inversion of the magnetization, a modified TOMROP sequence was used, which consists of an inversion pulse (followed by crusher gradients) and a gradient echo module that samples the same phase-encoding line multiple times along the magnetization recovery. A hyperbolic secant adiabatic pulse lasting 6–7 ms (permitted by RF coil power limit) was used for the inversion. The slice thickness of the inversion pulse was set to a large value (3 × 10⁴ mm) in the case of global inversion and to 2.5 × the imaging slice thickness in the case of slice-selective inversion. The ratio of 2.5 was to compensate the imperfect matching of the inversion and excitation pulse profiles and was determined using the aurose gel phantom (i.e., under the no-flow condition) by stepwise increasing the ratio of inversion to excitation pulse slice width as 1, 1.5, 2, 2.5, 3, and 3.5 and identifying the smallest inversion pulse slice width that can achieve the “zero” flow results in the phantom.

Immediately after the inversion pulse and under ECG-gating, a series of images was acquired for at least 7 seconds, followed by a 4-second delay to ensure that the spins in myocardium were recovered to >99% of the equilibrium magnetization before the next inversion pulse. The respiratory waveform and k-space acquisitions were simultaneously recorded (SA Instrument, Stony Brook, NY) for retrospective elimination of images acquired outside the quiescent phase of expiration. The following parameters were used: field of view (FOV) = 35 × 35 mm², acquisition matrix = 192 × 80, TE = 2.19 ms, bandwidth = 96 kHz, inversion time spacing = 2 heart beats, Gaussian excitation pulse of 800 μs and 10° flip angle; each pair of T₁ measurements took about 25 minutes, 2 signal averages.

Data Processing

A 3-parameter fitting algorithm was used to calculate pixel-wise T₁ values under non–slice-selective and slice-selective inversion, designated as T₁ss and T₁s, respectively. The pixel-wise blood flow was quantified using the formula below:

\[
\text{MBF} = \frac{\lambda}{\text{MBF}} \times \frac{T_1}{T_1^{ss}} \times \frac{1}{T_1} \times \frac{1}{T_1^{ss}}
\]

where \(\lambda\) is the tissue-blood partition coefficient of water and was set to 0.83 mL/g for rat myocardium, \(T_1\) is the blood T₁ under global inversion and was set to 1.6 seconds at 200 MHz. The phantom was included for flow calculation (Figure 1A), and an MBF measurement was accepted if the phantom had a mean flow value within ±0.5 mL/min/g; if
Validation of SL-MRI–Based MBF With the Microsphere Method

Before the SL-MRI session, the carotid artery (for direct injection of microspheres into LV) and femoral artery (for withdrawal of reference blood as well as the reference blood withdrawal rate) were cannulated. Placement of the catheter inside LV was verified by proper length of the inserted catheter and rapid blood pulsations in the catheter.

Immediately after SL-MRI, 200 000 fluorescent microspheres (FMs) of 15-μm diameter (Dye-Trak, Triton Technology, San Diego, CA) in 200 μL saline was infused in 10 seconds, followed by 500 μL saline flush for 20 seconds. Meanwhile, reference blood was withdrawn through the femoral artery catheter at 330 μL/min through a syringe pump (Harvard Apparatus, Boston, MA) starting 30 seconds before the FM injection and lasting for 180 seconds. On completion of blood sampling, the heart was harvested and embedded in 1% agarose gel.

A fluorescent plate/slide imaging protocol was used to quantify the number of FMs. The heart was sectioned into ~100-μm-thick sections on a vibratome (Leica VT1000S, Leica Microsystems GmbH, Wetzlar, Germany). Sections corresponding to the imaging slice were determined by their positions relative to the apex and mounted on microscope slides. FMs in the reference blood were retrieved by membrane filters, which were also mounted on slides. The slides were then scanned on a fluorescent plate reader (Alpha Innotech, San Leandro, CA). The number of microspheres in slides was counted by manually identifying on the adjacent hematoxylin and eosin section; the border region encompassed the remaining myocardium.

Cardiac Function After EC Transplantation Evaluated by MRI

MBF was measured at 1 day, 2 weeks, and 4 weeks after MI; infarct size and LV ejection fraction (LVEF) were estimated at 1 day and 4 weeks. Regional wall motion was measured at 4 weeks only, from the same slice position as MBF but with 1.5-mm thickness. The MRI protocol for wall motion, which was detailed previously, was updated to a tag spacing of 0.9 mm (k=1.11 cycle/mm) and 10 cardiac frames (15 ms per frame). To obtain regional MBF and wall motion, LV myocardium was segmented into I-B-R; where infarcted (I) region was defined on the LGE image (at the same position as MBF slice), border region (B) as two 60° sectors on each side of the infarcted segment, and the remote region (R) encompassed the remaining myocardium.

MVD and Incorporation of Grafted ECs Into the Vasculature

MVD was estimated at 2 and 4 weeks. Upon euthanasia, a 5-μm-thick slab centered at the midventricular level was embedded in Optimal Cutting Temperature media and cut in short-axis orientation. After 1 mm trimmed off the top layer, 3 sections (each 10 μm thick) were cut at 3 levels with 1-mm spacing. Sections were immunostained using the following antibodies: (1) rabbit polyclonal anti–von Willebrand Factor (vWF) antibody (Sigma, St Louis, MO) and FITC-conjugated goat anti-rabbit secondary antibody and (2) mouse monoclonal anti-human CD34 antibody (Abcam, Cambridge, MA) and Cy3-conjugated goat anti-mouse secondary antibody. One section at each level was stained with hematoxylin and eosin.

To estimate regional MVD, each section was segmented into the I-B-R region under 2× objective lens: the infarcted region was identified on the adjacent hematoxylin and eosin section; the border and remote regions were defined in the same way as on MRI. Then, under 10×, at least 6 FOVs (each covering 1.1 mm²) were captured including 3 in the Remote, 2 in the Border, and 1–3 in the Infarcted region, depending on the infarct size. Clustered cells or continuous branching structures with positive vWF staining were counted as 1 capillary. To visualize engrafted ECs, double immunostaining for human CD34 and vWF was performed.
Table 1. Intraclass Correlation Coefficients Derived From Slice-Averaged and Segmental Myocardial Blood Flow

<table>
<thead>
<tr>
<th></th>
<th>Slice-Averaged</th>
<th>Septum</th>
<th>Lateral</th>
<th>Anterior</th>
<th>Posterior</th>
</tr>
</thead>
<tbody>
<tr>
<td>Validation study</td>
<td>0.975</td>
<td>0.624</td>
<td>0.946</td>
<td>0.708</td>
<td>0.878</td>
</tr>
<tr>
<td>Reproducibility</td>
<td>0.913</td>
<td>0.850</td>
<td>0.711</td>
<td>0.635</td>
<td>0.889</td>
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Statistical Analyses

Data are presented as mean±SD in text and figures. The Bland-Altman plot and intraclass correlation coefficients (ICC, MedCalc 11.6, Mariakerke, Belgium), calculated from segmental and slice-averaged MBF, were used to evaluate the agreement between MRI- and FM-based MBF measurements. The same approaches were applied to 12 animals (6 in EC and 6 in the vehicle group), each having 2 serial scans in the same imaging session at 2 weeks after MI, for assessing the reproducibility of the SL-MRI method. To assess the treatment effect (EC versus the vehicle group), a mixed-effect model with repeated measures (PROC MIXED, SAS Institute Inc, Cary, NC) was applied. This model allows inclusion of data from all time points under data missing and evaluates the treatment effect between groups (subjects) and regions (within subject) over time; P<0.05 is considered to be statistically significant.

Results

Validation of SL-MRI by the Microsphere Method

To validate SL-MRI as a method to accurately measure MBF in living animals, we directly compared SL-MRI measurements with the standard microsphere method in 5 animals: we cannulated the carotid and femoral arteries right before the SL-MRI session and injected FMs immediately after SL-MRI. MR images were first cropped, and the region defined by the blue box (Figure 1A) was processed to derive T1 maps corresponding to non–slice-selective (T1ns, Figure 1B) and slice-selective inversion (T1ss, Figure 1C). Pixel-wise MBF was calculated by Equation 1 (Figure 1D). MBF was also calculated by counting the number of FMs in myocardium (1 section is shown in Figure 1E). A strong correlation between SL-MRI and FM technique (R=0.972) was revealed for MBF averaged from the entire slice; a slope close to unity suggests agreement between the 2 techniques (Figure 1F). To obtain regional MBF measurements, the LV wall on the MBF map and corresponding micrographs were divided into septal, lateral, anterior, and posterior quadrants. The anterior and posterior quadrants were combined into 1 segment because they were not distinguishable on tissue sections. Averaged MBF in the septal, lateral, and combined anterior/posterior segments obtained by the 2 methods remain well correlated, with an R value of 0.753 (Figure 1G). A good agreement between the 2 methods was also demonstrated by the ICC derived from slice-averaged MBF (Table 1) and by Bland-Altman plot (Figure 1H): it revealed a bias of −0.065 mL/min/g, which is not statistically significant from zero (P=0.897), with 95% limits of agreements including all but 1 data point. To facilitate correlation studies, the percentage of isoflurane applied to individual animals was varied from 1–2.5% because MBF is shown to be regulated by levels of anesthesia.13 For each animal, however, the percentage of isoflurane was kept the same. The heart and respiration rate were stably maintained during the experiments (Table 2).

Table 2. Cardiac and Respiratory Period of Animals During the Validation Study

<table>
<thead>
<tr>
<th></th>
<th>Cardiac Cycle, ms</th>
<th>Respiratory Cycle, ms</th>
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<tr>
<td>1</td>
<td>212±15</td>
<td>1083±169</td>
</tr>
<tr>
<td>2</td>
<td>210±9</td>
<td>1071±128</td>
</tr>
<tr>
<td>3</td>
<td>160±14</td>
<td>723±47</td>
</tr>
<tr>
<td>4</td>
<td>170±7</td>
<td>1414±50</td>
</tr>
<tr>
<td>5</td>
<td>178±2</td>
<td>1101±62</td>
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Changes in Regional MBF in Response to EC Transplantation

To establish the utility of SL-MRI to measure MBF in the setting of EC therapy, we injected ECs or vehicle into the border zone of infarcted hearts and performed serial evaluations over the ensuing 4 weeks. At 1 day after MI, a relatively uniform infarct size distribution in the 2 groups was obtained: 18±4.7% in the EC (n=12) versus 17±5.6% in vehicle (n=10) group (Table 3, P=0.553), which facilitated a fair comparison for EC-mediated effects. At 1 day after MI, shown in the inset of Figure 2A, regional MBF was depressed in the infarcted versus remote region. In comparison of slice-averaged MBF over time in EC versus the vehicle group, the MBF is significantly higher in the EC group at 2 weeks (P=0.0380). A significant treatment effect on regional MBF was revealed at 2 weeks across regions (P=0.0057) and in the remote region across time points (P=0.0402). When the analysis was refined to specific region or time point, a significant treatment effect in the infarcted region at 2 weeks (P=0.0086) and in the remote region at 4 weeks (P=0.0277) were observed. Representative MBF maps at 2 weeks indeed showed higher MBF in the infarcted segment in the EC-treated heart, which had similar infarct size as the vehicle-treated one (Figure 2B through 2E). More capillaries in the infarcted region in EC-treated hearts were revealed by vWF immunostaining (Figure 2F and 2G); quantitative analysis confirmed a significantly higher MVD in the infarcted region (P=0.0105 EC versus vehicle group, Figure 2J). Furthermore, double staining for vWF and human CD34 demonstrated incorporation of ECs into capillaries in the infarcted (Figure 2H) and border region (Figure 2I). Taken together, these data provide convincing evidence that EC engraftment enhanced new vessel formation, leading to improved perfusion in the infarcted region detected by SL-MRI.

At 4 weeks after MI, whereas MBF in the infarcted region was no longer different between the 2 groups, an elevated MBF in the remote region was detected in EC-treated hearts as visualized in MBF maps from individual rats (Figure 3A)

Table 3. Infarct Size and Global Function Estimated by MRI at 1 Day and 4 Weeks After Myocardial Infarction

<table>
<thead>
<tr>
<th></th>
<th>Day 1</th>
<th>Week 4</th>
</tr>
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<tbody>
<tr>
<td>Infarct Size*</td>
<td>LVEF†</td>
<td>Infarct Size*</td>
</tr>
<tr>
<td>EC</td>
<td>18.3±4.7%</td>
<td>57.3±6.9%</td>
</tr>
<tr>
<td>Vehicle</td>
<td>16.8±5.6%</td>
<td>55.6±4.8%</td>
</tr>
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</table>

LVEF indicates left ventricular ejection fraction; EC, endothelial cell.

*†No statistical significance was observed between the 2 study groups (P>0.1).
through 3D) and confirmed by statistical analysis (P=0.0277, Figure 3E). Interestingly, elevated MBF was matched by a significant increase (greater absolute values) in circumferential strains (Ecc) in the remote region (P=0.0075) as well as Ecc averaged over the entire slice (P=0.0123, Figure 3G). The enhanced MBF and Ecc, however, did not lead to an increase in LVEF in EC group (Table 3), suggesting that LVEF is not sensitive to detect local changes in perfusion and wall motion. Although MVD was greater in all regions of EC-treated hearts, statistical significance was not obtained in any region (Figure 3F). Compared with 1 day after MI, infarct size decreased in both EC and vehicle groups (Table 3), probably as the result of wall thinning in the infarcted region observed frequently in both groups. Compared with 2 weeks after MI, CD34-positive cells were rarely found in sections (data not shown), suggesting that the vast majority of transplanted cells were dead or removed.

Finally, the SL-MRI method is shown to have a high degree of reproducibility by ICC (Table 1) and by the Bland-Altman plot of regional MBF, which revealed a uniform distribution of differences in MBF (scan 2 - or minus scan 1) around a bias very close to zero (Figure 4). For reproducibility as well as validation study, segment-specific ICC values are relatively low in 1 or 2 segments, suggesting a decreased agreement in these segments.

**Discussion**

HUVECs are commercially available and can be expanded to a large number in vitro, therefore providing a convenient EC source for this proof-of-principle study to examine...
whether or not SL-MRI is able to detect temporal changes of regional MBF in response to EC engraftment in the infarcted heart. Our results suggest that EC transplantation induces a strong neovascularization response in the infarcted region detectable at 2 weeks after injection, leading to a substantial increase of regional blood flow and capillary density accompanied by incorporation of grafted ECs into capillaries in the infarcted and border regions (Figure 2). The localized responses, although strong, appear to be short-termed and transit to a prominent increase of MBF in the remote territory (Figure 3E). This finding is novel because it is generally expected that only infarcted and border zones would benefit from EC engraftment. However, there is compelling evidence that the remote region is affected during unfavorable post-MI remodeling, and stem cells may partially rescue/stabilize

Figure 3. A through G. Regional myocardial blood flow (MBF) and wall motion estimated by MRI and microvasculature density (MVD) at 4 weeks after myocardial infarction. MBF maps and corresponding late gadolinium enhancement (LGE) images are shown for a representative heart from the endothelial cell (EC) group (A and B) and the vehicle group (C and D). Regional MBF (E), MVD (F), and Ecc (G) from the EC and vehicle groups is shown. *Statistically significant comparing the EC group versus the vehicle group (E and G).

Figure 4. Bland-Altman plot demonstrating the test-retest reproducibility of spin-labeling MRI method. Average myocardial blood flow (MBF) was obtained from the septal, anterior, posterior, and lateral segments for each animal. The bias between the retest and test scan is 0.088 mL/min/g, with standard deviation (STD)=0.533 mL/min/g.
that region. Consistently, an increase in MBF was accompanied by a recovery of wall motion \((E_c)\) in the remote region.

SL-MRI (also called arterial spin-labeling) has achieved a great success in measuring blood flow in the brain. In conventional brain SL, the RF inversion pulse is typically introduced at an upstream location proximal to the tissue of interest. For MBF measurement, however, on-slice SL, namely, the flow-sensitive alternating inversion recovery technique, can minimize the magnetization transfer artifact and the underestimation of flow when feeding arteries have tortuous paths. SL-based MBF in small rodents is based on T1 mapping, and the arterial transit time (ATT) is ignored. This approach might be justified by the fact that small rodents have much higher MBF \((3–5 \text{ mL/min/g})\) than humans \((0.7–1 \text{ mL/min/g})\) and are studied at higher field strength than clinical scanners, leading to prolonged blood T1. Therefore, the ATT of uninvolved blood spins is much shorter than blood T1, which allows a measurable inflow effect in slice-selective T1 values. ATT of human heart was estimated at blood T1, which allows a measurable inflow effect in slice-selective T1 values. ATT of human heart was estimated at 1.5 T recently. Although further study is necessary to evaluate the effect of ATT on MBF quantification in small rodents, our validation study suggests the T1 mapping approach is in excellent agreement with standard microsphere method.

Although the goals of this study have been fulfilled, several limitations should be discussed. First, compared with the resting MBF, CFR might be more representative of coronary microvascular function than the resting MBF. CFR measurement can be implemented by means of pharmacological stimulation in SL-MRI protocol for future studies. Second, single-slice MBF was obtained in the current protocol due to relatively lengthy acquisition time (\(\approx 25\) minutes), which could lead to concerns that MBF may vary during acquisition. Inversion recovery–based T1 mapping, while being the most robust method, is inherently time-consuming. Noncartesian k-space trajectory such as spiral or radial imaging techniques can reduce acquisition time and resist respiratory motion. Third, due to inflammatory reactions induced by acute MI and/or the use of human cells in a rat model (albeit immune-compromised), injection of ECs during MI surgery might have a negative impact on EC survival. Therefore, better EC engraftment is expected if they are injected 7 days after MI, as we have shown with embryonic stem cell–derived cardiomyocytes. Finally, the high postsurgery mortality rate and the exclusion of 7 rats from the Aim 2 analysis because of unqualified infarct size raise the possibility of selection bias in addition to impacting statistical power.

In summary, our results indicate excellent agreement among MBF in free-breathing rats measured by SL-MRI and by the standard color microsphere technique. Noninvasive SL-MRI allows serial assessments of regional MBF in response to EC treatment. The presented method offers a promising framework to quantify MBF as a specific and sensitive index to evaluate EC-mediated therapy for the infarcted heart.

Acknowledgments
We are grateful to Xiaoling Hou, MS, Saran Vardhanabhuti, PhD, and Amy Praestgaard, MS, for performing statistical analyses. Special thanks to Dr Ronald Morris from SA Instruments for modifications of breakout module to allow recordings of respiration waveform with gate bits. We are indebted to Drs Stephanie Eucker and William M. Armstead for help with FM protocol. We thank Dr Jifu Yang for tissue sectioning and the Small Animal Imaging Facility for technical support.

Sources of Funding
This work was funded by National Institutes of Health grants R01-HL081185A1 and R01-HL081185S1 (Dr Zou).

Disclosures
None.

References


**CLINICAL PERSPECTIVE**

Endothelial cells (ECs) and endothelial progenitor cells (EPCs) have been isolated or derived from various sources including blood, bone marrow, embryonic stem cells and induced pluripotent stem cells. ECs and EPCs have been postulated to form new vasculature, preserve cardiac function, and inhibit apoptosis in the infarcted heart. However, mechanisms underlying the salutary effects of these cells are not well understood: in fact, whether neovascularization leads to improved regional myocardial blood flow (MBF) has yet to be clearly demonstrated. To evaluate EC- or EPC-mediated cardiovascular repair over time and to improve clinical translation for cell-based therapies, noninvasive imaging methods for estimating MBF are desirable. At present, positron emission tomography is the clinical standard for MBF measurement. However, radioactive perfusion tracers such as N-13 ammonia, O-15 water, or Rb-82 have short half-lives and hence require an on-site cyclotron or Rubidium generator. Optimally, a method that permits serial MBF evaluations without accruing radiation exposure/risk is most useful. In the present report, we first validate a spin-labeling MRI (SL-MRI) technique for quantification of MBF; we then demonstrate that this technique is highly reproducible and sensitive for detecting regional MBF changes in response to EC engraftment in a rat model of myocardial infarction. Because SL-MRI utilizes endogenous blood (water) as a perfusion tracer, it eliminates the need to inject exogenous tracers. The clinical feasibility of SL-MRI–based MBF measurement has recently been demonstrated in humans. Our study provides evidence that MBF is a unique and sensitive index to evaluate the impact of EC-mediated therapy on regional microvascular function after infarction.
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Circ Cardiovasc Imaging. 2012;5:210-217; originally published online February 6, 2012; doi: 10.1161/CIRCIMAGING.111.966317

Circulation: Cardiovascular Imaging is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
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Print ISSN: 1941-9651. Online ISSN: 1942-0080

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