Pioglitazone Prevents Acute and Chronic Cardiac Allograft Rejection
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Despite advances in immunosuppressive agents, acute rejection and chronic rejection remain the major causes of graft failure after cardiac transplantation.1 Graft rejection involves immune responses and inflammation. In acute rejection, expression of adhesion molecules by graft endothelial cells is increased, and inflammatory cells, including T cells and macrophages, infiltrate into the allografts and produce various cytokines and chemokines.2 In chronic rejection, neointimal hyperplasia is characterized by intimal thickening resulting from infiltration of inflammatory cells, proliferation of smooth muscle cells (SMCs), and accumulation of extracellular matrix.3 Therefore, it is important not only to suppress acute rejection with conventional immunosuppressive agents but also to prevent the development of graft vasculopathy to improve prognosis after transplantation.

**Clinical Perspective p 2622**

Peroxisome proliferator–activated receptors (PPARs) constitute a superfamily of ligand-dependent transcription factors.4 Three PPAR isotypes, α, β (or δ), and γ, have been identified. PPARγ is expressed mainly in adipose tissue and is an important determinant of adipocyte differentiation and insulin sensitivity. PPARγ agonists such as pioglitazone, troglitazone, and rosiglitazone are used as insulin-sensitizing compounds. It has been reported that PPARγ is expressed in macrophages, T cells, endothelial cells, and SMCs.4–8 PPARγ agonists inhibit T-cell proliferative responses8 and SMC proliferation and migration.8,9 PPARγ agonists are associated with the expression of adhesion molecules, cytokines, and chemokines.10–13 Furthermore, treatment with PPARγ agonists has been shown to inhibit atherosclerosis, cardiac hypertrophy, experimental autoimmune myocarditis, development of left ventricular remodeling, failure after myocardial infarction, and intimal hyperplasia after vascular injury.13–17 However, it is not known whether PPARγ agonists prevent acute and chronic rejection after cardiac transplantation.

To explore the role of PPARγ agonists in acute and chronic rejection after organ transplantation, we performed cardiac transplantation in mice and found that pioglitazone is asso-
ciated with immune response and SMC proliferation. Furthermore, administration of pioglitazone can prolong cardiac allograft survival and suppress the development of graft vasculopathy.

**Methods**

**Reagents**

Pioglitazone was provided by Takeda Chemical Industries (Tokyo, Japan). Anti-mouse interferon (IFN)-γ, CD4, CD8, and CD11b monoclonal antibodies were purchased from Pharmingen (San Diego, Calif). Anti-goat monocyte chemoattractant protein-1 (MCP-1) and PPARδ antibodies were purchased from Santa Cruz Biotechnology, Inc (Santa Cruz, Calif). Anti-mouse actin monoclonal antibody was purchased from CHEMICON International (Temecula, Calif). Enhanced chemiluminescence was detected with enhanced chemiluminescence reagent (Amer sham Biosciences). Anti-mouse interferon (IFN)-γ, CD4, CD8, and CD11b antibodies were purchased from Santa Cruz Biotechnology, Inc (Santa Cruz, Calif). Anti-mouse actin monoclonal antibody was purchased from CHEMICON International (Temecula, Calif).

**Animals**

Male BALB/c, C3H/He, and C57BL/6 (B/6, H-2b) mice 6 to 8 weeks of age were obtained from Japan Clea (Tokyo, Japan). B6.C-H-2<sup>bm12khEg</sup> (Bm12, H-2<sup>bm12</sup>) mice were obtained from the Jackson Laboratory (Bar Harbor, Me). Animals were maintained in our animal facility and weighed 20 to 25 g. The study protocol conformed to the Guide for the Care and Use of Laboratory Animals of Tokyo Medical and Dental University.

**Cardiac Transplantation**

Donor hearts were heterotopically transplanted into recipient mice as described previously. The aorta and pulmonary artery of donor hearts were anastomosed to the recipient abdominal aorta and inferior vena cava, respectively. Survival of cardiac allografts was evaluated by daily palpation, and cessation of beating was interpreted as rejection. Recipient mice were given standard chow or chow containing pioglitazone (3 mg · kg⁻¹ · d⁻¹) beginning 1 day before cardiac transplantation. We measured body weight of the mice twice a week, and adjusted the daily dose of pioglitazone accordingly. Serum total cholesterol, triglycerides, and glucose were measured by enzymatic assays. After 5 days in total allograft combinations and 8 weeks in major histocompatibility complex (MHC) class II-mismatched combinations, pioglitazone did not affect serum concentrations of total cholesterol, triglycerides, and glucose (data not shown).

In total allograft combinations, allografts were harvested at 5 days after transplantation or at the time of graft failure. In MHC class II–mismatched combinations, allografts were harvested at 2 and 8 weeks after transplantation. After harvest, allografts were sectioned transversely into 3 parts. The basal section was fixed in 10% formalin and embedded in paraffin for morphological examination. The midsection was embedded immediately in OCT compound according to the manufacturer’s instructions. The apical section was used to extract proteins for Western blot analysis.

**Immunohistochemistry**

Frozen sections (5 μm) were fixed in acetone for 10 minutes at 4°C. After sections were washed in phosphate-buffered saline, they were incubated with primary antibodies overnight at 4°C. Sections were then incubated with biotinylated secondary antibodies at room temperature for 30 minutes. Antibody–antigen conjugates were detected with avidin-biotin-horseradish peroxidase complex (Nichirei, Tokyo, Japan) according to the manufacturer’s instructions. We used 3-amino-9-ethylcarbazole as chromogen and counterstained sections with hematoxylin.

**Histological Evaluation**

Grafts and arteries were analyzed by Mallory staining, hematoxylin and eosin, and elastica van Gieson staining. The areas within the internal elastic lamina (IEL), the external elastic lamina, and the lumen were carefully traced, and planimetric areas were calculated with an image analysis system (Scion Image Beta 4.02). The cross-sectional area of luminal stenosis was calculated as follows: luminal occlusion=(IEL area−lumen area)/IEL area×100 (%). The intima-to-media (I/M) ratio was calculated as follows: I/M=(IEL area−lumen area)/external elastic lamina area−IEL area).

Parenchymal rejection (PR) was assessed in allografts at 5 days after transplantation and at the time of failure in total allomismatch combinations. PR severity was graded with a scale modified from the International Society for Heart and Lung Transplantation (0=no rejection, 1=focal mononuclear cell infiltrates without necrosis, 2=focal mononuclear cell infiltrates with necrosis, 3=multifocal infiltrates with necrosis, 4=widespread infiltrates with hemorrhage and/or vasculitis). We measured the fibrotic areas with an image analysis system (Scion Image Beta 4.02). The fibrotic area ratio (fibrotic areas/entire area as a percentage) was calculated in allografts at 8 weeks after transplantation.

**Mixed Lymphocyte Reaction**

Splenocyte suspensions were obtained by disrupting spleens between sterile glass slides. Red blood cells were lysed with ammonium chloride. Mixed lymphocyte–reaction (MLR) cells were performed with responder splenocytes from C3H/He mice (n=5) at 5 days after transplantation and mitomycin-C–inactivated stimulator splenocytes from naïve BALB/c mice. A total of 3×10⁵ responder and an equal number of stimulator cells were cocultured in 96-well plates at 37°C under 5% CO₂ for 4 days. Pioglitazone was added to each well at various concentrations on day 0. T-cell proliferation was assessed with Cell Counting Kit-8 (Dojindo, Kumomoto, Japan) according to the manufacturer’s instructions. Cell proliferation was expressed as the optical density of the responder cells.

**Coculture of SMCs and Splenocytes**

Primary SMCs were obtained from the thoracic aortas of Bm12 mice by collagenase digestion previously. Cells were grown in Dulbecco’s modified Eagle’s medium (Sigma Chemical Co, St Louis, Mo) containing 50 μg/mL streptomycin, 50 IU/mL penicillin, and 10% fetal bovine serum at 37°C and 5% CO₂. Cultured SMCs were identified by the typical villi-and-valley morphology and by immunostaining with monoclonal antibody to α-smooth muscle actin. All experiments were performed with cells between passages 3 and 8.

SMCs were trypsinized and seeded into 96-well plates. At confluence, SMCs were arrested in medium with 0.4% fetal bovine serum for 5 days. Mitomycin-C–inactivated splenocytes from B/6 mice (n=3) after transplantation (total, 5×10⁵) were washed with phosphate-buffered saline and added with pioglitazone to each well. We investigated SMC proliferation in response to anti–IFN-γ (1 μg/mL) or MCP-1 antibody (2 μg/mL). After 4 days, SMC proliferation was assessed with Cell Counting Kit-8 (Dojindo) according to the manufacturer’s instructions. Cell proliferation was expressed as the optical density.

**Western Blot Analysis**

Heart sections were homogenized in extraction buffer containing 50 mmol/L Tris-HCl (pH 7.5), 150 mmol/L NaCl, 1% Triton X-100, 2 mmol/L EGTA, 10 mmol/L EDTA, 100 mmol/L NaF, 1 mmol/L Na<sub>2</sub>PO<sub>4</sub>, 2 mmol/L Na<sub>2</sub>VO<sub>4</sub>, 100 μg/mL phenylmethylsulfonyl fluoride, and cocktail tablets (Roche, Basel, Switzerland). After centrifugation, the supernatant was stored. The protein concentration of each sample was measured with a Bio-Rad Protein Assay Kit (Bio-Rad, Milan, Italy). Protein concentrations of all samples were equal in subsequent experiments.

Proteins were separated by sodium-dodecyl sulfate–polyacrylamide gel electrophoresis, transferred to nitrocellulose membranes, and incubated with primary antibodies at 4°C overnight. The membranes were then incubated with secondary antibody for 2 hours and developed with enhanced chemiluminescence reagent (Amer sham Biosciences). Enhanced chemiluminescence was detected with LAS-1000 (Fujifilm, Tokyo, Japan). The level of MCP-1 protein was normalized to that of actin.

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Ribonuclease Protection Assay
mRNA was isolated with TRIzol (Invitrogen, Rockville, Md) according to the manufacturer’s protocol. In vitro transcription was performed with the template set, T7 polymerase, and [α-32P]UTP. Total RNA (10 μg) was hybridized with probes at 56°C for 16 hours. All samples were then treated with RNase before treatment with proteinase K. Samples were separated by electrophoresis on denaturing gels containing 5% polyacrylamide. Detection of the mRNA bands was performed with an image analyzer (BAS2000, Fujiﬁlm). Levels of cytokine mRNAs were normalized to that of glyceraldehyde-3-phosphate dehydrogenase mRNA.

Enzyme-Linked Immunoassay Procedure
Production of IFN-γ and MCP-1 was measured in supernatants of MLR or coculture of SMCs and splenocytes. Supernatants were stored at −80°C before enzyme-linked immunoassay (ELISA) analysis. The concentrations of IFN-γ and MCP-1 were determined with an ELISA kit (BioSource International, Camarillo, Calif) according to the manufacturer’s instructions.

Statistical Analysis
All data are expressed as mean±SEM. Kaplan-Meier analysis was used to estimate graft survival, and the Mann-Whitney U test was used for survival differences between the 2 groups. Differences between groups for PR scores, infiltrating cell number, normalization of RNase protection assays and Western blot data, luminal occlusion, I/M ratio, and ﬁbrotic areas were analyzed by Student t test. For infiltrating cell number and ELISA data, logarithmic transformation was performed before statistical analysis. One-way ANOVA was used for comparisons between groups for MLR, cytokine ELISA, and SMC proliferation. Values of P<0.05 were considered statistically significant.

The authors had full access to the data and take full responsibility for their integrity. All authors have read and agree to the manuscript as written.

Results
Pioglitazone Prolongs Cardiac Allograft Survival
To investigate the effect of pioglitazone on acute rejection, we performed cardiac transplantation using C3H/He recipients and BALB/c donors. In the total allomismatch combination, the survival of cardiac allografts in mice given pioglitazone was signiﬁcantly prolonged (34.6±7.8 days; n=8) compared with allografts in mice fed standard chow (8.4±0.38 days; n=8; P<0.005; Figure 1A). PR scores were signiﬁcantly lower in allografts treated with pioglitazone (1.6±0.27) than in controls (3.1±0.23) at 5 days after transplantation (P<0.001; Figure 1B). However, PR scores were comparable in allografts at the time of failure (Figure 1C).

Pioglitazone Prevents Expression of IFN-γ and MCP-1 in Allografts From Total Allomismatch Combination
Expression of PPARγ was enhanced in infiltrating cells in cardiac allografts at 5 days after transplantation (Figure 2A). The numbers of infiltrating CD4−, CD8−, and CD11b-positive cells in pioglitazone-treated allografts at 5 days after transplantation were signiﬁcantly lower than in controls (Figure 2B and 2C). The numbers of infiltrating CD4−, CD8−, and CD11b-positive cells in pioglitazone-treated allografts at the time of failure did not differ between the 2 groups (Figure 2D and 2E). We examined whether pioglitazone was associated with cytokine expression in allografts at 5 days after transplantation. Expression of IFN-γ mRNA and MCP-1 was signiﬁcantly lower in allografts treated with pioglitazone than in controls (Figure 3A and 3B). Expression of interleukin (IL)-10, IL-15, and IL-6 mRNAs did not differ between the 2 groups (Figure 3A).
Figure 2. Expression of PPARγ and inhibition of infiltration by CD4-, CD8-, and CD11b-positive cells in donor hearts in the total allomismatch combination. A, Immunohistochemical staining of PPARγ in cardiac allografts at 5 days after transplantation. Representative frozen sections stained with antibody against PPARγ (left) and isotype-matched control IgG (right) are shown. PPARγ expression was identified in cells infiltrating the allografts. Original magnification ×400. B, D, Immunohistochemical staining of CD4-, CD8-, CD11b-positive cells in allografts at 5 days after transplantation (B) and the time of failure (D). Top, Allografts in mice that received standard chow; bottom, allografts in mice that received chow with pioglitazone. Representative frozen sections stained with antibodies against CD4, CD8, and CD11b are shown. Original magnification ×400. C, E, Quantitative analysis of CD4-, CD8-, and CD11b-positive cells. Data are expressed as mean ± SEM of 20 fields per graft. *P<0.0001 vs control.
Pioglitazone Inhibits MLR

To assess the effect of pioglitazone on allogeneic responses in vitro, we performed MLR with sensitized splenocytes after cardiac transplantation. Pioglitazone at concentrations >1 μmol/L significantly inhibited MLR proliferation (Figure 4A). Production of IFN-γ and MCP-1 in supernatants of MLR was suppressed significantly by pioglitazone (Figure 4B).

Pioglitazone Attenuates Graft Vasculopathy

To investigate the effect of pioglitazone on chronic rejection, we performed cardiac transplantation with B6 recipients and Bm12 donors. In the MHC class II–mismatched combination, neointimal hyperplasia developed characteristically in mice that received standard chow (n = 8), whereas neointimal thickening was significantly reduced in mice that received chow containing pioglitazone (n = 8; Figure 5A and 5B). The degree of luminal occlusion was 65.8 ± 7.3% for standard chow and 25.1 ± 8.8% for chow containing pioglitazone (P < 0.001; Figure 5C). The I/M ratio was significantly lower in allografts treated with pioglitazone than in controls (Figure 5D). The fibrotic areas did not differ between the 2 groups (Figure 5E).

Pioglitazone Prevents Expression of IFN-γ, IL-10, and MCP-1

Expression of PPARγ was enhanced in infiltrating cells in cardiac allografts at 2 weeks after transplantation (Figure 6A). Infiltration of inflammatory cells was examined immunohistochemically in allografts at 2 and 8 weeks after transplantation. Pioglitazone-treated allografts at 2 and 8 weeks after transplantation showed significantly lower numbers of CD4-, CD8-, and CD11b-positive cells than controls (Figure 6B and 6E).

Because infiltration of inflammatory cells was decreased by treatment with pioglitazone, we examined whether pioglitazone could modulate expression of cytokines in allografts at 2 and 8 weeks after transplantation. IFN-γ mRNA and MCP-1 protein levels were significantly reduced in pioglitazone-treated allografts at 2 weeks after transplantation (Figure 7A and 7B). Expression of IL-10, IL-15, and IL-6 mRNAs was not altered (Figure 7A). At 8 weeks after transplantation, expression of IFN-γ and IL-10 mRNAs was significantly lower in allografts treated with pioglitazone than in controls. Expression of IL-6 and IL-15 mRNAs did not differ significantly between control and pioglitazone-treated mice (Figure 7C). Furthermore, Western blotting showed that MCP-1 expression was significantly suppressed in allografts treated with pioglitazone compared with controls (Figure 7D).

Pioglitazone Suppressed the Proliferation of SMCs Induced by Splenocytes

We previously reported that interaction between SMCs and T cells or splenocytes induces SMC proliferation.22,23 In the

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Figure 3. Expression of cytokines and MCP-1 in allografts in the total allomismatch combination. A, Representative data of 3 independent RNase protection assays showing cytokine mRNA expression. Expression of IFN-γ mRNA was significantly reduced in allografts treated with pioglitazone compared with controls. Expression of each cytokine mRNA was normalized to that of GAPDH mRNA. *P < 0.05 vs control. B, Representative data of 3 independent Western blots showing MCP-1 expression. MCP-1 expression was significantly reduced in allografts treated with pioglitazone compared with controls. MCP-1 levels were normalized to those of actin. †P < 0.05 vs control.

Figure 4. Inhibition of MLR by pioglitazone (Pio). A, MLR responder (R) splenocytes (C3H/He mice) and mitomycin-C–inactivated stimulator (S) splenocytes (BALB/c mice) were incubated. Cell proliferation was significantly suppressed by pioglitazone. *P < 0.01 vs R+S+Pio 10⁻⁶. †P < 0.0001 vs R, R+S+Pio 10⁻⁶, and R+S+Pio 10⁻⁵. B, Production of IFN-γ and MCP-1 in supernatants was suppressed significantly by pioglitazone. Data are expressed as mean ± SEM in each group. *P < 0.05 vs R and R+S+Pio.

Figure 6. Infiltration of inflammatory cells in cardiac allografts at 2 weeks after transplantation (Figure 6A). Infiltration of inflammatory cells was examined immunohistochemically in allografts at 2 and 8 weeks after transplantation. Pioglitazone-treated allografts at 2 and 8 weeks after transplantation showed significantly lower numbers of CD4-, CD8-, and CD11b-positive cells than controls (Figure 6B and 6E).
suppressed significantly by pioglitazone (Figure 8B). Supernatants of coculture of SMCs and splenocytes was associated with SMC proliferation. Production of IFN-γ and MCP-1 in supernatants of coculture of SMCs and splenocytes was suppressed significantly by pioglitazone (Figure 8B).

Discussion
Organ allograft rejection limits long-term survival after transplantation, and immunosuppressive agents have been used clinically to prevent allograft rejection. Although 1-year survival after transplantation has improved substantially, long-term administration of immunosuppressive agents does not prevent chronic rejection, which is characterized by neointimal thickening and fibrosis, and may have adverse side effects, including development of opportunistic infections and neoplasms. Therefore, it is important to improve prognosis by inhibiting acute and chronic allograft rejection with agents other than conventional immunosuppressive drugs.

Inflammation is characterized by the expression of adhesion molecules and infiltration by inflammatory cells such as macrophages and T cells. PPARγ agonists play important roles in regulating inflammation. It has been reported that PPARγ agonists suppress expression of vascular cell adhesion molecule-1 and intercellular adhesion molecule-1 by activated human endothelial cells. PPARγ agonists also inhibit synthesis of inflammatory cytokines, including IFN-γ, IL-1β, and TNF-α, in human peripheral blood mononuclear cells. Shiomi et al reported that treatment with pioglitazone reduced the expression of MCP-1 in an experimental model of chronic heart failure. PPARγ agonists also are associated with T-cell activation. Expression of PPARγ mRNA occurs in human peripheral blood T cells. PPARγ agonists inhibit IL-2 secretion by T cells and decrease cell proliferation. Several studies have shown the effects of PPARγ agonists on neointimal hyperplasia after vascular injury; however, the role of PPARγ agonists in allograft rejection is not known. To the best of our knowledge, we are the first to show that PPARγ agonists play an important role in suppressing allograft rejection after cardiac transplantation.

To explore the effects of PPARγ agonists on allograft rejection, we performed murine cardiac transplantation. In the total allograft rejection, treatment of mice with pioglitazone significantly prolonged cardiac allograft survival compared with controls. Because PPARγ agonists are associated with T-cell responses, we then examined the allogeneic response of T cells by MLR with splenocytes. Pioglitazone significantly suppressed MLR proliferation at a concentration of 1 μmol/L. This result indicates that pioglitazone is associated with T-cell responses and may be useful as an immunosuppressive agent in organ transplantation.

In the MHC class II–mismatched combination, neointimal thickening in mice treated with pioglitazone was significantly attenuated compared with that in mice fed normal chow. Neointimal formation is associated with proliferation of SMCs. It has been reported that PPARγ is expressed in SMCs, and PPARγ agonists inhibit migration and proliferation of SMCs. We previously reported that coculture of SMCs and T cells induces SMC proliferation. In the present study, we examined whether pioglitazone suppressed the SMC proliferation induced by the interaction of SMCs with splenocytes. We showed that SMC proliferation was increased by interactions of SMCs with splenocytes and that pioglitazone suppressed this proliferation.

Allograft rejection contributes to the expression of cytokines and chemokines. In the present study, during acute
Figure 6. Expression of PPARγ and inhibition of infiltration by CD4-, CD8-, and CD11b-positive cells in donor hearts in the MHC class II-mismatched combination. A, Immunohistochemical staining of PPARγ in cardiac allografts at 2 weeks after transplantation. Representative frozen sections stained with antibody against PPARγ (left) and isotype-matched control IgG (right) are shown. PPARγ expression was identified in cells infiltrating the allografts. Original magnification ×400. B, D, Immunohistochemical staining for CD4, CD8, and CD11b in allografts at 2 and 8 weeks after transplantation. Top, Allografts in mice that received standard chow; bottom, allografts in mice that received chow containing pioglitazone. Representative frozen sections stained with antibodies against CD4, CD8, and CD11b are shown. Original magnification ×400. C, E, Quantitative analysis of CD4-, CD8-, and CD11b-positive cells. Data are expressed as mean ± SEM of 20 fields per graft. *P<0.0001 vs control. **P<0.001 vs control.
In acute rejection, expression of IFN-γ and MCP-1 was significantly lower in allografts treated with pioglitazone than in controls.

In chronic rejection, treatment with pioglitazone significantly reduced the expression of IFN-γ and MCP-1 in allografts compared with controls. We also found that infiltration of CD4-, CD8-, and CD11b-positive cells was significantly reduced in allografts treated with pioglitazone in acute and chronic rejection; suppression of IFN-γ expression in allografts treated with pioglitazone may be associated with the decrease of graft infiltrating cells, and suppression of MCP-1 expression is associated with infiltration of monocytes. Saubermann et al. showed that treatment of PPARγ agonist was associated with reduced expression of Th1 cytokines and increased expression of Th2 cytokines in a murine model of acute colitis. Th2 cytokines play a pivotal role in improving allograft survival and inducing tolerance. However, the effect of IL-10 is controversial. Although IL-10 treatment attenuated the development of autoimmune myocarditis, blockade of IL-10 activity did

Figure 7. Expression of cytokines and MCP-1 in allografts in the MHC class II-mismatched combination. A, C, Representative data of 3 independent RNase protection assays for expression of cytokine mRNAs. Expression of cytokine mRNAs was normalized to that of GAPDH mRNA. A, Expression of IFN-γ mRNA was significantly lower in allografts treated with pioglitazone than in controls at 2 weeks after transplantation. *P<0.01 vs control. C, Expression of IFN-γ and IL-10 mRNAs was significantly lower in allografts treated with pioglitazone than in controls at 8 weeks after transplantation. *P<0.001 vs control. B, D, Representative data of 3 independent Western blots showing MCP-1 expression. MCP-1 levels were normalized to those of actin. B, MCP-1 levels were significantly lower in allografts treated with pioglitazone than in controls at 2 weeks after transplantation. *P<0.001 vs control. D, MCP-1 expression was significantly lower in allografts treated with pioglitazone than in controls at 8 weeks after transplantation. *P<0.05 vs control.

Figure 8. Proliferation of SMCs induced by interactions with splenocytes. A, SMCs and activated splenocytes (Sp) were incubated for 4 days. SMC proliferation was significantly suppressed by pioglitazone (Pio). *P<0.05 vs Sp+SMCs+Pio 10⁻⁶. †P<0.0001 vs SMCs, Sp+SMCs+Pio 10⁻⁶, and Sp+SMCs+Pio 10⁻³. B, Production of IFN-γ and MCP-1 in supernatants was suppressed significantly by pioglitazone. Data are expressed as mean±SEM in each group. *P<0.05 vs SMCs and Sp+SMCs+Pio. †P<0.01 vs Sp+SMCs+Pio and Sp+Pio. **P<0.05 vs SMCs+Pio and Sp+Pio. ‡P<0.05 vs SMCs and Sp+SMCs+Pio.
not attenuate neointimal thickening after transplantation.\textsuperscript{30} In the present study, treatment with pioglitazone significantly suppressed the expression of IL-10 in allografts compared with that in controls in chronic rejection. Suppression of IL-10 expression may be associated with a decrease in the number of graft-infiltrating cells. Further studies are needed to clarify the mechanism involved in the development of neointimal thickening after transplantation.

In conclusion, the present study provides evidence that pioglitazone plays important roles in preventing acute and chronic rejection in a murine model of cardiac transplantation. Several mechanisms are involved in the prevention of allograft rejection by pioglitazone. Pioglitazone suppresses T-cell responses and proliferation of SMCs. Treatment with pioglitazone suppresses the expression of cytokines by allografts in vivo and in vitro. In addition, pioglitazone inhibits recruitment of inflammatory cells in allografts. Suppression of cytokine expression may be associated not only with the regulation of inflammation but also with the decrease in numbers of graft-infiltrating cells. Treatment with pioglitazone may provide a novel strategy for managing acute and chronic rejection in clinical cardiac transplantation.

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Disclosures
None.

References
Cardiac transplantation developed as a therapy for end-stage congestive heart failure. Although the survival rate has improved by administration of immunosuppressive agents, long-term survival is still not satisfactory. Therefore, alternative strategies are needed to regulate acute and chronic allograft rejection. Peroxisome proliferator–activated receptor-γ (PPARγ) plays a crucial role in regulating inflammation. It has been reported that treatment of PPARγ agonists suppresses expression of inflammatory cytokines and the development of atherosclerosis and neointimal hyperplasia after vascular injury. However, the effect of PPARγ agonists on allograft rejection after transplantation has not been fully elucidated. We observed that pioglitazone prolongs allograft survival and attenuates the development of graft vasculopathy in a murine cardiac transplantation model. Furthermore, pioglitazone suppresses T-cell responses and smooth muscle cell proliferation. Our present study provides evidence that treatment of PPARγ agonists prevents acute and chronic allograft rejection after transplantation. However, further studies are necessary to evaluate the therapeutic usefulness of PPARγ agonists in clinical cardiac transplantation.