Matrix Remodeling in Vascular Calcification Associated with Chronic Kidney Disease

Ashwini S. Pai and Cecilia M. Giachelli
Department of Bioengineering, University of Washington, Seattle, Washington

ABSTRACT
Vascular calcification is a major contributor to cardiovascular disease, a leading cause of death in patients with chronic kidney disease. Mechanistic studies highlight the importance of dysregulated mineral metabolism, vascular osteochondrogenic processes, apoptosis, and deficiencies in calcification inhibitors as potential mediators of calcification in renal disease. However, the contribution of the extracellular matrix in vascular calcification associated with chronic kidney disease is less understood. Here we examine evidence that suggests important roles for elastin and elastin-degrading enzymes as potential key regulators of calcification. Additional studies aimed at further understanding their role are critical for the design of therapeutic interventions.


ROLE OF ELASTIN IN VASCULAR CALCIFICATION

Elastin, a key constituent of the extracellular matrix in elastic arteries, is secreted from VSMCs as a soluble monomer called tropoelastin. Tropoelastin interacts with fibrillin or microfibril-associated glycoprotein and is oriented into proper alignment by lysyl oxidase. This cross-linked structure provides elastin with extensive tensile strength critical for the contractile function of VSMCs and hemodynamic properties of the vessel. The calcium-binding capacity of elastin was initially observed in the early 1970s, where it was proposed that the positively charged calcium ions attract phosphate ions, thereby facilitating apatite nucleation and subsequent calcification. Thus, calcification of elastin leads to increased stiffness that can create a focal point for the initiation of calcification. Finally, recent studies implicate elastin and elastolysis as mediators of vascular calcification in CKD, and are thus the main focus of the present discussion.
ultimately lead to loss of vessel compliance.  

**ELASTIN DEGRADATION AND MATRIX METALLOPROTEINASES IN VASCULAR CALCIFICATION**

Elastin degradation is also important for the initiation and progression of vascular calcification. Matrix metalloproteinases (MMPs) are implicated in vascular calcification. Members of the MMP family, including gelatinases (metalloelastases and matrilysins), degrade insoluble elastin. Tissue inhibitors of MMPs regulate MMP activity by providing a feedback mechanism to prevent excessive matrix degradation. In disease conditions, an imbalance between MMPs and tissue inhibitors of MMPs could cause excessive MMP activity and may lead to pathologic changes in the vessel wall.10

Simionescu et al. first observed the association between elastin calcification and increased MMP expression.11 They demonstrated that subdermally implanted glutaraldehyde-treated bovine parietal pericardium expresses an array of matrix proteinases including serine proteinases and MMPs. Later, Vyavahare et al. identified the overexpression of MMP-2 and -9 co-localizes with calcifying elastin fragments in subcutaneous purified elastin implants. Not surprisingly, local delivery of synthetic MMP inhibitors significantly mitigates this elastocalcinosis.12 Aluminum chloride pretreatment of elastin also leads to inhibition of MMP-mediated elastocalcinosis in a subdermal implantation model as well as in mitral valve replacement studies13 since aluminum binds irreversibly to elastin, altering the spatial structure and rendering it resistant to MMP cleavage and calcification. Basalgya et al. also demonstrated that periadventitial treatment of abdominal aortas with low concentrations of calcium chloride induces chronic degeneration and calcification of elastic fibers. This occurs in the absence of aneurysm formation and inflammation, which is phenotypically similar to arterial medial calcification. Consistent with the importance of elastin degradation in vascular calcification, aortas from MMP-2 and -9 single null mice do not calcify, presumably because MMP-9 is not active to degrade the elastin.14

More recently, Qin et al. observed that aortic calcification in two different arterial medial calcification models is significantly reduced compared with untreated controls after systemic treatment with the MMP inhibitors, doxycycline and GM6001.15 Likewise, Bouvet et al. examined the role of MMPs in medial elastocalcinosis using warfarin/vitamin K treatment in rats, an experimental model of matrix-gla protein deficiency. MMP-9 activity and TGF-β signaling increase early and before calcification, and blocking MMP activation with doxycycline or TGF-β signaling with SB-431542 mitigates calcification.16

The mechanism by which degraded elastin promotes vascular calcification is not certain but at least two possibilities exist. First, elastinolysis increases elastin affinity for calcium binding thereby facilitating epitactic growth of hydroxyapatite along the elastic lamellae.17 Second, elastinolysis induces the release of soluble elastin peptides and TGF-β that interact with elastin-laminin receptor and TGF-β receptor, respectively.18 It has also been shown that TGF-β stimulates bovine aortic medial cells to calcify in culture.19 Although the exact mechanism responsible for this effect is not yet known, several pieces of data support the idea that elastinolysis directly affects the phenotype of VSMCs, thereby regulating their potential to direct matrix calcification. Simionescu et al. demonstrated that aortic VSMCs incubated with elastin peptides exhibit an increased expression of elastin-laminin receptor, MMP-2, and bone-related proteins, including Runx2/Cbfa1, osteocalcin, and alkaline phosphatase.18 Expression of osteogenic genes in VSMCs is further enhanced by the addition of TGF-β along with the elastin peptides, even in the absence of any other mineralizing agent. More recently, elastinolysis is implicated directly in phosphate-induced VSMC calcification in vitro. VSMCs cultured with high phosphate show significantly accelerated calcification upon treatment with α-elastin, a degradation product of elastin. Furthermore, expression of osteoblast differentiation markers significantly increases in the presence of α-elastin. No calcification was observed with α-elastin under normal phosphate conditions.20 These in vitro data indicate that pathologic degradation of elastin leading to generation of elastin peptides may either initiate or accelerate calcification by inducing a phenotypic change in VSMCs.

**ELASTIN DEGRADATION AND VASCULAR CALCIFICATION IN CKD**

Is elastin degradation a potential mechanism contributing to vascular calcification in CKD? Although very few studies have examined artery wall elastin in experimental models of uremia, Amann et al. notes that subtotally nephrectomized rats display decreased relative content and focal rupture of elastin fibers compared with sham-operated rats, although these changes occurred in the absence of calcification.21 Similarly, our group has shown that elastin turnover, as measured by desmosine content and histochemical staining, elevates in uremic, high-phosphate-fed mice and precedes arterial medial calcification. In these studies, levels of both MMP-2 and MMP-9 elevate with time in the calcified artery (unpublished findings). Finally, Aikawa et al. investigated the role of cathepsin-S, a major macrophage elastase, in atherosclerotic calcification in uremic mice. Uremic, cathepsin-S−deficient ApoE−/− mice show significantly less arterial and aortic valve calcification as compared with controls. Cathepsin-S expression co-localizes with calcifying cells and fragmented elastin in the atheroma and inflamed aortic valves. Furthermore, human VSMCs treated with cathepsin-S fragmented elastin undergo osteogenic changes, a process augmented in phosphate-enriched culture medium.22

In humans, Ilbels et al. observed disruption and reduplication of the internal elastic lamina in autopsy specimens of elastic arteries from uremic patients.23 Similarly,
thinning and fragmentation of medial elastic fibers are present in epi gastric arteries of dialysis patients undergoing renal transplantation, producing a strong correlation between MMP-2 upregulation and elastic fiber disorganization, stiffness, calcification, and vasomotor dysfunction. Chung et al. also showed that diabetic arteries of a different set of patients with CKD demonstrated increased MMP-2 and MMP-9 activities by 42 and 116%, respectively, compared with nondiabetic arteries of patients with CKD. This enhanced MMP expression is highly correlated with arterial stiffness and pulse wave velocity. Recently, Peiskerova et al. report that serum MMP-2 levels are higher in 80 patients with CKD stages 1 to 5 and 44 healthy control subjects.

CONCLUSIONS

There is growing evidence for the importance of matrix remodeling in the initiation and progression of vascular calcification. However, our understanding of the matrix effects in arterial medial calcification associated with CKD is nascent. On the basis of the existing literature, a paradigm can be envisioned for the potential role of elastin, elastases, and matrix remodeling in arterial medial calcification associated with CKD (Figure 1). Clearly, future studies aimed at testing key components of this model are required to understand the importance of matrix remodeling in arterial medial calcification and potential mechanisms for its regulation.

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REFERENCES