Aortic aneurysms are manifested as progressive dilation with high risk for death caused by rupture. The most common locations are the infrarenal abdominal and ascending aortic regions in humans. This article highlights some recent publications in *ATVB* that have provided insights into understanding mechanisms and potential therapeutic strategies for aortic aneurysms.

**Abdominal Aortic Aneurysms**

**Human Studies**

The incidence of abdominal aortic aneurysms (AAA) is increasing in the elderly population. Independent risk factors for AAA include not only aging but also male and smoking, whereas some risk factors such as hypertension and hypercholesterolemia have not been consistently demonstrated to be independent risk factors. There are several recent population studies that have enhanced or extended insights into risk factors for AAA or associations with AAA.

The ARIC study (Atherosclerosis Risk in Communities) is a 24-year prospective study recruited 15792 participants. Tang et al evaluated lifetime risk and risk factors for AAA in this large cohort. Smoking is not only the most prevalent risk factor but also a lifetime risk for AAA in men. Higher plasma low-density lipoprotein or total cholesterol is also associated with increased risk for AAA.

Inflammation is apparent during the initiation and development of AAA in animal models. Inflammatory cell types and markers have also been detected in human AAA. Psoriasis and asthma have profound inflammatory responses. A previous systematic review and meta-analysis has shown an association between psoriasis and AAA. Recently, retrospective cohort studies using Danish populations reported that psoriasis and asthma were associated with higher risk for AAA.

Animal studies have provided consistent evidence that the renin–angiotensin system plays a critical role in development of AAA. There is also evidence from a retrospective human study that inhibition of angiotensin-converting enzyme in the renin–angiotensin system prevents progression of AAA. In Danish nation-wide registries (1995–2011), Kristensen et al reported that growth rates of AAA were inversely associated with concentrations of hemoglobin A1c. This study provides insights that long-lasting elevated blood glucose concentrations impair progression of AAA in humans.

**Animal Studies**

Three common AAA mouse models were developed in the early 2000s. AAA develops in these mouse models by elastase perfusion into the infrarenal aorta, calcium chloride periaortic application to the infrarenal region, or AngII subcutaneous infusion. A spectrum of potential mechanisms of AAA have been studied using these mouse models in their original or modified forms.

Inflammation is a common characteristic of AAA. Neutrophils are an essential component of the innate immune system. Previous studies have implicated potentially important roles of neutrophils in AAA development. Several studies have demonstrated the contribution of mast cell activation in AAA development.
also one important feature of asthma. A recent study reported an association between active asthma and AAA in humans. This group also studied whether pulmonary inflammation, a distinguishing feature of asthma, contributed to AAA in animal models. The authors reported that lung inflammation augmented AngII and calcium chloride–induced AAA in mice, respectively, accompanied by increases of many inflammatory markers in plasma, lung, and AAA tissues.

**Smooth Muscle Cell, Stem Cell, or Platelet-Related Mechanisms**

Elastin fragmentation and disruption of aortic integrity are prominent components of AAA. In a mouse model infused with both AngII and β-aminopropionitrile, elastin damage of the aortic wall was severe. Hypoxia-inducible factor 1α is a transcription factor responding to hypoxia, which is abundant in vasculature. Deficiency of this transcription factor in smooth muscle cells augmented AAA in mice infused with both AngII and β-aminopropionitrile, accompanied by disruption of elastin fiber formation.

Mesenchymal stem cells are multipotent cells present in bone marrow that have the potential to differentiate into a spectrum of cell types. Sharma et al studied the effects of mesenchymal stem cells on elastase-induced AAA in mice. They first reported that administration of mesenchymal stem cells attenuated elastase-induced AAA and reduced interleukin-17, a T-lymphocyte-produced proinflammatory cytokine. Their recent study provided insights that mesenchymal stem cell infusion inhibited macrophage-produced high mobility group box 1 production and diminished release of proinflammatory cytokines, thereby preventing elastase-induced AAAs.

Aortic rupture is the fatal consequence of AAA. Platelets contribute to thrombosis. Studies in mouse and rat models have demonstrated that platelets play a critical role in AAA development. To extend insights into the contributions of platelets to AAA, Owens et al studied the effects of platelet inhibitors, aspirin and clopidogrel, on established AAA in AngII-infused mice and found that inhibition of platelets profoundly reduced aortic rupture. In addition to effects of platelets in thrombosis and AAA, thrombomodulin, a cofactor of thrombin, has also been reported to contribute to both calcium chloride–induced and AngII-induced AAA in mice. Findings in these studies implicate important roles of hemostatic factors in the development and progression of AAA.

**Enzymes, Proteins, Peptides, and Other Factors**

This section introduces a variety of factors that have been studied for both their unique features and common targets, such as inflammation and oxidative stress, in AAA development. Considering the diversity of their features, we distinguish them in general categories and introduce each molecule in independent paragraphs following the sequences of enzymes, proteins, peptides, and others.

**Enzymes**

Cysteine proteases are present in human AAA. Subramanian et al reported that calpains, calcium-dependent intracellular cysteine proteases, contributed to AngII-induced AAA. Although macrophages are an abundant source of calpains, their effects on AngII-induced AAA were not dependent on their presence in macrophages.
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Lu and Daugherty

cost consuming. Several research groups have reported a new approach for mimicking depletion of low-density lipoprotein receptor in C57BL/6 mice to augment atherosclerosis by inducing hypercholesterolemia through persistent expression of a gain-of-function mutation of PCSK9 (proprotein convertase subtilisin/kexin type 9). This mode of inducing hypercholesterolemia has also been demonstrated to augment AngII-induced AAA. A caveat to the wide application of this approach is the potential for variable response in different strains of mice.

Yamanouchi et al modified the traditional calcium chloride–induced AAA mouse model by adding phosphate buffered saline after the introduction of calcium chloride onto the infrarenal aorta, which led to the formation of calcium phosphate. Their recent study has also provided evidence that calcification is present in human AAA, and pharmacological inhibition of osteoclastogenesis prevents the development of calcium phosphate–induced AAA in mice.

Kawasaki disease is an inflammatory disease, which is manifested by myocarditis and coronary arteritis. A Kawasaki disease mouse model induced by stimulation with Lactobacillus casei cell wall extract mimics myocarditis and coronary arteritis of the human disease. Wakita et al reported that this Kawasaki disease mouse model also developed AAA in the infrarenal aortic region, which was associated with interleukin-1 signaling. This finding provides new insights into understanding inflammation-mediated mechanisms of AAA.

Thoracic Aortic Aneurysms

Genetic disorders are a prevalent cause of thoracic aortic aneurysms (TAA). Recognized representative genetic disruptions include mutations in fibrillin-1 (Fbn1) gene and TGF-β receptor–related genetic changes, which cause progressive aortic dilation in the aortic root and ascending aortic regions.

Models have been developed based on some of the genetic disruptions identified in humans. In addition to identified genetic disruptions, bicuspid aortic valves in humans are associated with increased risk for TAA. A recent study compared a set of TGF-β–related genes between patients with bicuspid and tricuspid aortic valve diseases. The findings implicate that TGF-β–related genes and classic signaling pathway are lower in TAA patients with bicuspid aortic valves.

Marfan Mouse Models

There are 2 common mouse models representing Marfan syndrome. One is called Fbn1C1039G/+ mouse containing a transgene with cysteine to glycine mutation on amino acid 1041 of the Fbn1 gene (Fbn1C1041G/+; equivalent to C1039Y in humans). This transgene leads to modest aortic root and ascending aortic dilation in adult mice. The other common model is an Fbn1 hypomorphic mouse model, which has profound dilation in the aortic root and ascending aortic regions with high rates of aortic rupture. Recent studies using these 2 mouse models report that multiple potential therapeutic strategies hold promise for the treatment of TAA. These include AT1 receptor blockade, caspase inhibition, and administration of resveratrol. Although TGF-β signaling activation has been postulated in the aortic pathologies, whether inhibition of TGF-β preventing or augmenting TAA in Marfan mouse models has not been consistently reported in the literature.

Genetic Disruptions of TGF-β or Its Receptors

TGF-β–related manipulations induce aortic aneurysms in the ascending aortic region in mice that also recapitulate the aortic pathologies in humans such as Loeys–Dietz syndrome. An earlier study reported that haploinsufficient Tgfb2 (+/-) mice had aortic root dilation. Subsequent studies from several independent laboratories have demonstrated that genetic disruption of TGF-β receptor 2 in smooth muscle cells induced in adult mice exhibits profound aortic root and ascending aortic dilation and disruption of aortic structural integrity.

Wei et al also provided direct evidence that deletion of TGF-β receptor 2 in smooth muscle cells of Fbn1C1041G/+ mice accelerated aortic pathologies. Another recent study reported that TGF-β receptor 1 deficiency in smooth muscle cells caused severe aortopathy in mice.

Angiotensin II or Other Chemical-Induced TAA

Recently, several groups have reported that AngII induces TAA that is restricted to the ascending aortic region. In contrast to AngII-induced AAA, TAA induced by AngII is independent of hypercholesterolemia. In addition to AngII-induced TAA, confusion of AngII and β-aminopropionitrile also induces TAA in mice. Ikonomidis et al developed a mouse model of TAA by applying calcium chloride onto the ascending thoracic aortic region. Using these mouse models, recent studies discovered that genetic depletion of AT1 receptor reduced AngII-induced TAA, nucleotide oligomerization domain-like receptor family, pyrin domain containing 3 caspase-1 inflammasome contributed to AngII-induced TAA, smooth muscle cell–specific deficiency of low-density lipoprotein receptor–related protein 1 augmented AngII-induced TAA, genetic MMP-2 (matrix metalloproteinase) deficiency accelerated AngII-induced TAA, but attenuated calcium chloride–induced TAA, and smooth muscle cell–specific deficiency of hypoxia-inducible factor-1 increased TAA in mice confounded with AngII and β-aminopropionitrile.

Summary

Aortic aneurysms in both abdominal and thoracic regions have complex pathophysiological features. There are still many unanswered questions and conflicting findings that need to be clarified. We hope that this brief review prompts interest in reading these highlighted articles to understand potential mechanisms of the 2 aortic pathologies from a broad viewpoint. We also hope the introduction of these recent publications helps develop experiments based on current findings to explore new mechanisms and effective therapeutics.

Sources of Funding

The authors’ research study was supported by the National Institutes of Health under award number HL133723 and HL107319. The content in this article is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health.
Disclosures

None.

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Recent Highlights of ATVB: Aortic Aneurysms


Key Words: aortic aneurysms ◼ humans ◼ mice
Aortic Aneurysms
Hong Lu and Alan Daugherty

doi: 10.1161/ATVBAHA.117.309578

Arteriosclerosis, Thrombosis, and Vascular Biology is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
Copyright © 2017 American Heart Association, Inc. All rights reserved.
Print ISSN: 1079-5642. Online ISSN: 1524-4636

The online version of this article, along with updated information and services, is located on the World Wide Web at:
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