Angiopoietin 1 causes vessel enlargement, without angiogenic sprouting, during a critical developmental period

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Summary

Early in development, endothelial cells proliferate, coalesce, and sprout to form a primitive plexus of undifferentiated microvessels. Subsequently, this plexus remodels into a hierarchical network of different-sized vessels. Although the processes of proliferation and sprouting are well studied and are dependent on the angiogenic growth factor VEGF, the factors involved in subsequent vessel remodeling are poorly understood. Here, we show that angiopoietin 1 can induce circumferential vessel enlargement, specifically on the venous side of the circulation. This action is due to the ability of angiopoietin 1 to promote endothelial cell proliferation in the absence of angiogenic sprouting; vessel growth without sprouting has not been ascribed to other vascular growth factors, nor has specificity for a particular segment of the vasculature.

Moreover, angiopoietin 1 potently mediates widespread vessel enlargement only during a brief postnatal period, in particular, prior to the fourth postnatal week, corresponding to stages in which VEGF inhibition causes widespread vessel regression. These findings show that angiopoietin 1 has a potentially unique role among the vascular growth factors by acting to enlarge blood vessels without inducing sprouting, and also define a critical window of vascular plasticity in neonatal development. Finding the key molecular factors that regulate this plasticity may prove crucial to the further development of pro- and anti-angiogenic therapies.

Key words: Angiogenesis, TIE2 receptor, Endothelial cells, Venules

Introduction

The blood vasculature is formed during early embryonic development when endothelial cells coalesce and sprout to form networks of small, undifferentiated vessels (Risau, 1997). Soon after their formation, these undifferentiated vessels undergo changes in their size and structure, resulting in a hierarchy of arteries, capillaries and veins. These changes are required to meet increased oxygen and metabolic requirements as the embryo grows.

Most studies of blood vessel development have focused on the sprouting phase of angiogenesis. The best-characterized angiogenic agent, vascular endothelial growth factor (VEGF), plays a key role in the formation of a primitive vascular plexus by promoting endothelial cell proliferation, sprouting and initial tube formation (Nehls et al., 1994; Wilting et al., 1993). Genetic deletion studies have confirmed that VEGF is required for these developmental processes in vivo (Carmeliet et al., 1996; Ferrara et al., 1996). Furthermore, even when VEGF is administered to adult animals, it retains its ability to induce sprouting and the formation of new vessels in normal tissues (Pettersson et al., 2000; Springer et al., 1998; Springer et al., 2000). Reciprocally, inhibition of VEGF signaling potently inhibits angiogenic sprouting in many situations of normal or pathological angiogenesis, such as that associated with tumors (Asano et al., 1995; Holash et al., 2002; Kim et al., 1993; Wood et al., 2000).

In contrast to abundant data indicating that VEGF is a crucial mediator of sprouting angiogenesis, much less is known about which factors may be involved in subsequently regulating the diameter and remodeling the structure of the primitive vessels, thereby allowing them to become specialized for their position in the vascular network. On the arterial side of the circulation the remodeling process is known as arterialization, and appears to involve the interactions of flow, pressure, and agents such as platelet derived growth factor B (PDGFB) that promote the interaction of endothelial tubes with smooth muscle cells (Hellstrom et al., 1999; Lindahl et al., 1997). An analogous process presumably occurs on the venous side, although even less is known about this process.

Gene deletion studies have shown that vascular-specific growth factors or receptors, such as angiopoietin 1 (Davis et al., 1996; Dumont et al., 1994; Sato et al., 1995; Suri et al., 1996), angiopoietin 2 (Gale et al., 2002) and ephrin B2 (Shin et al., 2001; Wang et al., 1998), act later than VEGF during embryonic vascular remodeling and maturation. Genetic deletion of these growth factors or their receptors results in embryonic lethality and/or defects in vascular remodeling subsequent to the key initial vasculogenic and angiogenic steps that are dependent on VEGF. Although the precise roles of
these other factors in regulating the vasculature have yet to be clearly defined, gene deletion studies suggest that angiopoietin 1 (ANG1; ANGPT1 – Mouse Genome Informatics/Human Gene Nomenclature Database) and its receptor TIE2 (TEK – Mouse Genome Informatics/Human Gene Nomenclature Database) are involved in establishing a hierarchy of vessels, and are required for the normal interactions between perivascular cells and endothelial cells (Dumont et al., 1994; Sato et al., 1995; Suri et al., 1996). While potent inhibitors are not yet available for the ANG1/TIE2 system, treatment of adult mice with soluble TIE2 receptor (a weak inhibitor) does not cause obvious vascular changes in normal organs (Lin et al., 1997) (G.T., D.J.-G. and Q.W., unpublished).

Studies using overexpression systems have shed some light on the functions of the ANG1/TIE2 signaling system in vivo, but have also raised key questions. Constitutive transgenic overexpression of angiopoietin 1 in the skin of mice (K14-ANG1 mice), starting in the early embryo, results in a dramatically reddened appearance due to increased numbers of enlarged dermal microvessels (Suri et al., 1998; Thurston et al., 1999). These vessels are also resistant to leakage induced by VEGF or inflammatory agents (Thurston et al., 1999). However, angiopoietin 1 treatment of adult mice does not change the morphology of the skin vessels nor make the mice red, although it does make the dermal blood vessels resistant to plasma leakage (Thurston et al., 2000b).

In contrast to the effects in adult mice, we now report that systemic angiopoietin 1 treatment of neonatal mice and rats results in conspicuously reddened pups containing enlarged blood vessels in the skin and in numerous other organs. The dramatic increases in vessel diameter are apparently caused by endothelial cell proliferation in the absence of vessel sprouting. Notably, the enlargement is largely restricted to the venous side of the microvasculature, and is not accompanied by changes in the number or pattern of vessels. By postnatal day (P) 30, vessels in most organs no longer enlarge in response to angiopoietin 1, indicating the passing of a critical period for vessel plasticity. VEGF-dependency of the vasculature in some organs of neonatal mice corresponds to a similar critical period of vessel plasticity. These findings show that angiopoietin 1 has a potentially unique role among the vascular growth factors, by acting to specifically increase blood vessel diameters without inducing sprouting, and also reveal a window of vascular plasticity in neonatal mice for multiple growth factors in multiple organs.

Materials and methods

Angiopoietin 1 reagents

For most treatments, a recombinant form of angiopoietin 1 called ANG1^{4FD}, which contains two human angiopoietin 1 fibrinogen-like receptor-binding domains coupled to a human Fc domain of IgG [also designated Ang-F1-Fc-F1 (Davis et al., 2003)], was produced in transfected Chinese hamster ovary (CHO) cells. Prolonged treatments of adult mice with angiopoietin 1 were generally performed using a single intravenous injection of adenosine encoding a genetically engineered version of human angiopoietin 1, referred to as ANG1*, which contains the receptor-binding domain of ANG1 coupled to the coiled-coil oligomerization domain of ANG2 (Thurston et al., 2000b).

ANG1* has similar receptor binding and activation properties as ANG1. Adenovirus expressing green fluorescent protein (Ad-GFP) was used as a control. ANG1^{3FD}, which contains only one angiopoietin 1 fibrinogen-like receptor-binding domain coupled to a human Fc domain of IgG, binds to the activating site of TIE2 but does not cluster the receptor, and therefore acts as a competitive inhibitor (Davis et al., 2003). ANG1^{3FD} was also produced in transfected CHO cells, VEGF-Trap was produced as described elsewhere (Holash et al., 2002).

Angiopoietin 1 and VEGF-Trap treatments

For treatment of mice aged P7 to P49, pups from litters of C57BL/6 mice (Taconic Laboratories, NY) were randomized and injected intraperitoneally with ANG1^{4FD} (20, 50 or 200 µg) daily, or with PBS for controls. Rats (Sprague-Dawley, Taconic) aged P7 were injected either daily or every other day with ANG1^{4FD} [200 or 500 µg intraperitoneally (ip)]. Mice treated with VEGF-Trap were given ip injections of 25 mg/kg every second day. For experiments with adult mice, male pathogen-free FVB/N, C57BL/6 or CD-1 nude mice (Taconic Laboratories, NY, or Charles River, Hollister, CA) were used at age 7–12 weeks. For adeno virus treatments, mice were anesthetized with ketamine/xylazine, then injected into the jugular vein with 10^9 plaque forming units (pfu) of adenosine encoding ANG1* diluted to 150 µl in sterile saline (Thurston et al., 2000b). Injection of Ad-ANG1* via the tail vein of mice had very similar effects on blood vessel morphology to jugular vein injection. In some mice, adenovirus was given locally, either via injections into the ear skin (2×10^3 pfu in 5–8 µl) or intranasally (1×10^3 pfu in 50 µl). Systemic VEGF was not used because of toxicity (Thurston et al., 2000b).

ELISA for ANG1^{4FD} and ANG1* in serum

To confirm delivery of angiopoietin reagents and measure circulating levels, blood (0.2 ml) was withdrawn from the right ventricle of anesthetized mice and rats immediately prior to perfusion, centrifuged to obtain plasma, and frozen until analysis. ANG1* and ANG1^{4FD} were measured by ELISA, using recombinant TIE2 for capture, and an antibody against the N terminus of ANG2 (which is present in ANG1*) or the human Fc domain of IgG (in ANG1^{3FD}) to report.

Staining and measurement of neonatal vessels

Tissues from mouse and rat pups were harvested and immersion-fixed in paraformaldehyde (1% in PBS, pH 7.4) for 1 hour to overnight. Tissues were permeabilized with 0.3% Triton-X100, stained as wholemounts with hamster anti-mouse PECAM antibody (Serotec, used at 1:500) or mouse RECA antibody (Serotec), and, for mice, Cy3-labeled mouse anti-α-smooth muscle cell actin antibody (Sigma, used at 1:500), followed by FITC-labeled goat anti-hamster or goat anti-mouse antibodies (Jackson Immunoresearch, West Grove, PA; used at 1:500), and mounted in Vectashield. Staining blood vessels with this method clearly labels the endothelial cells of the vessels, as well as any endothelial sprouts that emanate from the vessels into the interstitium. Confocal fluorescence images were collected using an inverted confocal microscope (Leica) and a 40× oil immersion lens. Measurements of vessel diameter were performed on the tracheal vasculature (McDonald, 1994; Thurston et al., 1998). Measurements were made on three tracheas per group on four representative regions across the cartilaginous rings. Average vessel diameter was expressed as means±s.e.m.

BrdU labeling

A thymidine analog, 5-bromo-2′-deoxyuridine (BrdU; Sigma) was injected intravenously (1 mg in 100 µl PBS) into mice. Three hours later, mice were fixed by vascular perfusion of 1% paraformaldehyde in PBS. Tissues were permeabilized with 0.3% Triton-X100, washed in PBS, embedded in paraffin wax, cut into 8-µm-thick sections and stained for BrdU (Staining Bulk Kit; Zymed Laboratories, San Francisco, CA). Retinas were removed and stained whole, using Cy3-labeled secondary antibodies and no counterstaining, or were counterstained with FITC-labeled lectin (GSL I – isoelectric B4, Vector Laboratories). To quantify the number of nuclei labeled by BrdU, low magnification images of whole retinas could be used.
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were recorded digitally, and software was used to demarcate the inner half of the retina. Labeled nuclei were counted in the inner half of the retinas for three mice per group, and the average number of labeled nuclei was expressed as mean ± s.e.m.

Western blots for phosphotyrosine
One day after the final ip injection of ANG1FD or ANG12FD, mice were sacrificed, and the trachea and lungs were removed and rapidly frozen. Tissue was homogenized in buffer containing protease and phosphatase inhibitors plus 0.1% NP40, and protein levels in each homogenate were assessed using a micro-BCA assay (Pierce, Rockford, IL). TIE2 was immunoprecipitated overnight from 1 mg of lung lysate with 2 µg of the anti-TIE2 antibody mab33 (K. Peters, Proctor and Gamble) and protein G beads (Pharmacia), electrophoresed under reducing conditions, and transferred to Immobilon-P membranes (PVDF; Owl Separation Systems, Portsmouth, NH). Phosphotyrosine immunoreactivity was detected using an anti-phosphotyrosine antibody (Upstate Biotechnology, Lake Placid, NY) and an HRP-conjugated goat anti-mouse secondary antibody (Promega, Madison, WI), followed by chemiluminescent detection (Amersham, Arlington Heights, IL). Total TIE2 protein was detected by stripping the blots and re-probing with the mab33 anti-TIE2 antibody.

Results
Angiopoietin 1 induces widespread vessel enlargement in pups, but not adult mice, in a time- and dose-dependent manner
Previously, we reported that K14-ANG1 mice had a reddened appearance (Fig. 1A,B) associated with increased numbers of enlarged dermal microvessels, and that these vessels were resistant to vascular leak (Thurston et al., 1999). The vascularization of internal organs was not affected in these mice, because of the restricted diffusion of ANG1 in the skin. By contrast, although acute or chronic treatment of adult mice with recombinant angiopoietin 1 proteins [ANG1* and ANG14FD (Davis et al., 2003; Thurston et al., 2000b)] replicated the anti-leak effects, these treatments did not induce an obvious reddened appearance of the mice (Fig. 1C), or obvious vascular morphologic changes (Davis et al., 2003; Thurston et al., 2000b). To address this apparent paradox, in which angiopoietin 1 induces hypervascularity when delivered transgenically but not when delivered to adults, we treated newborn mouse and rat pups with recombinant angiopoietin 1 (ANG14FD). In mouse pups treated daily beginning from P7, the snout, tongue, paws and ear skin began to obviously redden after 2 days by injection (P9), and were dramatically reddened after 7 days (P14, Fig. 1D). Similarly, rat pups treated from P7 were also dramatically reddened at P14 on the snout, tongue, paws and ears (Fig. 1E,F).

Associated with the angiopoietin 1-induced reddening, we observed enlargement of the blood vessels of numerous organs, such as the trachea (Fig. 2A,B), tongue (Fig. 2C,D), diaphragm (Fig. 2E,F), retina (Fig. 2G,H), skin of the snout and mucosa of the bladder (data not shown). Of the tissues examined [ear skin, snout skin, tongue (mucosal, muscle), eye (cornea, retina), pancreas (islets, acinar), small intestine (mucosal, submucosal, muscular), bladder (mucosal), trachea (mucosal), diaphragm (central tendon, muscular), esophagus (muscular), kidney (glomerulus, medulla)], the vasculature of the brain and intestine (data not shown) was not notably enlarged. In the affected organs, the enlarged vessels were obvious in whole-mount views, as well as in thick and thin sections (Fig. 2, and results not shown). Strikingly, the vessel enlargement was largely restricted to the venous side of the circulation, including venular capillaries, postcapillary venules and collecting venules (arrows in Fig. 2), whereas arterioles (arrowheads in Fig. 2) were not enlarged by angiopoietin 1 treatment.

The enlargement of the vessels following treatment of neonatal mice with recombinant angiopoietin 1 occurred in a time-dependent (Fig. 3A) and dose-dependent (Fig. 3B) fashion. The maximum dose of angiopoietin 1 (200 micrograms per day) that was used in neonatal mice and the longest treatment duration (7 days) resulted in a 7-fold increase in average vessel diameter (Fig. 3A). In contrast to the dramatic increases in venule size, arterioles did not increase in size (not shown), nor did the pattern or the number of vessels change. Thus, angiopoietin 1 increased vessel diameter in the absence of angiogenic sprouting.

Fig. 1. Reddened skin in mouse and rat pups treated with angiopoietin 1. (A–C) Snouts of wild-type adult mice (A) are pale compared with the reddened snout of the transgenic K14-ANG1 mouse (B), which overexpresses angiopoietin 1 in the skin. Prolonged treatment (10 days) of normal adult mice with ANG1FD protein (C) or Adeno-ANG1* adenovirus (not shown) does not cause reddening. (D) Snouts of mouse pups treated for 7 days (beginning at P7) with PBS or ANG1FD (200 µg ip). The snout (arrow), gums and tongue of the pups treated with ANG1FD are markedly reddened compared with the PBS-treated pup. (E,F) Snouts and ears of rat pups treated for 7 days (beginning at P7) with PBS or ANG1FD. The snouts (arrow), gums, tongues, paws (arrow) and ears (arrow) of rat pups treated with ANG1FD (200 µg ip) are markedly reddened compared with PBS-treated pups.
Angiopoietin 1-induced vessel enlargement is blocked by specific antagonists

The ability of recombinant angiopoietin 1 to induce vessel enlargement correlated with its ability to promote phosphorylation of the TIE2 receptor in vivo (Fig. 3C). To verify the specificity of the vessel response to treatment with recombinant angiopoietin 1, and to determine whether potential inhibitors of angiopoietin 1 would cause vessel shrinkage, we examined the effects on neonatal vessels of active and inactive versions of angiopoietin 1. Daily treatment of P7 pups with ANG12FD, an inactive dimeric form of angiopoietin 1, and to determine whether the enlargement was accompanied by endothelial cell proliferation, the number of endothelial cells was estimated whether the vessels contained more endothelial cells and whether the enlargement was accompanied by endothelial cell proliferation. The number of endothelial cells was estimated in tracheal wholemounts stained for PECAM immunoreactivity, which outlines the endothelial cell junctions (see Fig. S1 in the supplementary material). Normal postcapillary venules in the airways were lined circumferentially by one or two endothelial cells. By comparison, after angiopoietin 1 treatment, the enlarged vessels had three or more endothelial cells lining their circumference (see Fig. S1 in the supplementary material). In addition, BrdU-labeled endothelial cells were more abundant in enlarged vessels of the retina (Fig. 4A,B) and tongue (see Fig. S1) in mice treated with angiopoietin 1 than in the corresponding vessels from control pups. The increased numbers of BrdU-labeled endothelial cells were clearly preferentially distributed on the venous side of the circulation (Fig. 4C,D, arrows). Because the retina was amenable to whole-mount BrdU staining, we quantified BrdU labeling in corresponding vessels from control pups. The increased vessel size without more endothelial cells or increased the number of endothelial cells, we determined whether the vessels contained more endothelial cells and whether the enlargement was accompanied by endothelial cell proliferation. Mouse pups were treated daily for 7 days with 200 µg of ANG14FD protein. Arteries and veins were readily identified in wholemounts by virtue of the differential coating of the smooth muscle cell layer (arterioles had a regular layer of elongated smooth muscle cells wrapped circumferentially around the vessels, whereas venules had an irregular layer of spread, branched smooth muscle cells associated with the vessels) and by vessel morphology (arteries were straighter and smaller in diameter than the corresponding veins). (A,B) Whole-mount views of tracheas from P14 mice, with blood vessels immunostained for PECAM (green) and α-smooth muscle cell actin (red/orange). The straight capillaries traverse the cartilaginous rings. The venular ends of the capillaries are enlarged in the tracheas of ANG14FD-treated mice (arrows, B) compared with PBS controls (A), and the draining venules are also enlarged, whereas the arterioles (arrowheads) are not enlarged. (C,D) Cross-sections of tongue from P14 mice, with blood vessels immunostained for PECAM (green) and α-smooth muscle cell actin (red/orange). The upper epidermal surface of the tongue is at the upper part of the image. The draining venules and the vessel loops in the dermal papillae (arrows) in the muscosa and muscle layers are enlarged in the tongues of ANG14FD-treated mice (D) compared with PBS controls (C). By contrast, the feeding arterioles (arrowheads) are similar in size in both ANG14FD-treated and control mice. (E,F) Whole-mount views of diaphragm from P14 mice, with blood vessels immunostained for PECAM (green) and α-smooth muscle cell actin (red/orange). The straight capillaries are in the skeletal muscle and the draining venules (arrows) are at the boundary with the central tendon. The venules (arrows) in the central tendon are enlarged in the diaphragms of ANG14FD-treated mice (F) compared with PBS controls (E). By contrast, the muscle capillaries in ANG14FD-treated mice and control mice are similar in size. (G,H) Whole-mount views of retinas from P14 mice, with blood vessels stained with Griffonia simplicifolia isolecitin B4 (green). The capillaries traverse between arterioles (arrowheads) and venules (arrows). The venular networks (arrows) are enlarged in retinas of ANG14FD-treated mice (H) compared with PBS controls (G).
ANG1-induced enlargement of vessels

Increased numbers of endothelial cells and endothelial cell proliferation, and is not due to vasodilation alone.

**Most vascular beds lose responsiveness to angiopoietin 1 by postnatal day 30**

The above data indicate that although blood vessels in many organs of mouse and rat pups can dramatically enlarge in response to angiopoietin 1, the blood vessels of adults generally do not. To determine the age when most vessel beds lose their responsiveness to angiopoietin 1, mice were treated for 7 days starting at ages P14, P21, P30 and P49. The mice in the P14 group (Fig. 5A) and the P21 group (not shown) became notably reddened, although not as conspicuously as when treatment was initiated earlier. However mice in the P30 (Fig.
Development occurs in P14 mice, as well as in veins (arrows). (B) In ANG1FD-treated mice, intense BrdU labeling is apparent in veins (arrows) and in microvessels near veins. (C) Higher magnification of retinal vessels (labeled with isolectin B4, green) shows occasional BrdU-labeled (red) endothelial cells in veins (arrow), and few BrdU cells in arterioles (arrowhead) in control mice. (D) By contrast, in retinal vessels of mice treated with ANG1FD, BrdU-labeled endothelial cells are abundant in venous capillaries and veins (arrows). (E) Quantification of BrdU labeling shows approximately four times as many BrdU-labeled endothelial cells in retinal vessels from mice treated with ANG1FD as in PBS-treated mice.

Fig. 4. Vessel enlargement is associated with increased numbers of endothelial cells and endothelial cell proliferation. Retinal vessels in wholemounts of PBS- or ANG1FD-treated mice, stained with BrdU and Cy3-labeled secondary antibody. (A) In control mice, BrdU label (red) is apparent near the retinal periphery where active angiogenesis occurs in P14 mice, as well as in veins (arrows). (B) In ANG1FD-treated mice, intense BrdU labeling is apparent in veins (arrows) and in microvessels near veins. (C) Higher magnification of retinal vessels (labeled with isolectin B4, green) shows occasional BrdU-labeled (red) endothelial cells in veins (arrow), and few BrdU cells in arterioles (arrowhead) in control mice. (D) By contrast, in retinal vessels of mice treated with ANG1FD, BrdU-labeled endothelial cells are abundant in venous capillaries and veins (arrows). (E) Quantification of BrdU labeling shows approximately four times as many BrdU-labeled endothelial cells in retinal vessels from mice treated with ANG1FD as in PBS-treated mice.

Discussion

Compared with the abundant information on angiogenic sprouting, the processes and growth factors involved in
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adjusting the size of developing vessels remain relatively obscure. Here, we show that angiopoietin 1 can rapidly induce circumferential vessel enlargement and that the enlargement is relatively specific to the venous side of the circulation. This action is apparently caused by the ability of angiopoietin 1 to promote endothelial cell proliferation in the absence of angiogenic sprouting. To our knowledge, vessel growth without sprouting has not been ascribed to other vascular growth factors, nor has specificity for a particular segment of the vasculature. Angiopoietin 1 can mediate widespread vessel enlargement only during a brief postnatal period, before approximately 4 weeks of age in mice, corresponding to developmental stages in which we find that treatment with a VEGF inhibitor causes dramatic vessel regression, similar to that described in previous studies (Gerber et al., 1999). These findings show that angiopoietin 1 has a potentially unique role among the vascular growth factors by acting to enlarge vessel diameters without inducing any associated angiogenic sprouting, and also define a critical window of vascular plasticity in neonatal mice for multiple growth factors in multiple organs.

Does angiopoietin 1 play a role in the normal regulation of vessel size? Genetic deletion of either angiopoietin 1 or its receptor TIE2 seems to support this possibility, as the vasculature of the resulting embryos fails to properly remodel from the initial rather primitive and homogenous plexus. However, these embryos suffer from early lethality, making it difficult to define more precisely the roles of angiopoietin 1 during later remodeling. Further support comes from the report that venous malformations, an abnormal vascular enlargement in segments of the venules and small veins, can arise in cases of constitutive activation of TIE2 due to a point mutation in the kinase domain (Vikku et al., 1996). Thus, angiopoietin 1 may play a particular role in remodeling the venous side of the circulation, where the forces of blood flow and pressure are not as significant, and where we see vessel enlargement in response to exogenous angiopoietin 1. Unfortunately, although current inhibitors of angiopoietin 1 (such as TIE2-Fc and ANG14FD) can block exogenously added angiopoietin 1 from activating endogenous TIE2 receptors, they do not seem to be capable of competing with endogenous angiopoietin 1 to block the ongoing constitutive phosphorylation of the TIE2 receptors. Further exploration of the role of angiopoietin 1 during remodeling awaits the development of better inhibitors, or the conditional deletion of the angiopoietin 1 or TIE2 genes.

Despite previous reports that angiopoietin 1 might be able to induce vessel sprouting and migration in vitro (Koblizek et al., 1998), the data herein indicate that any such effects would...
Development protease activation may force dividing endothelial cells to extracellular matrix, the inability of angiopoietin 1 to induce the induction of specific proteases that can degrade through the vascular basement membrane is likely to require (Mandriota et al., 1995; Zucker et al., 1998). Because sprouting lack the ability to induce protease activation in endothelial cells come from the finding that angiopoietin 1, unlike VEGF, may growth effects of VEGF versus angiopoietin 1. One clue may to define the mechanistic differences underlying the differential reflect actions of growth factors in vivo makes it more difficult to proliferative actions of FGF remain to be validated. promoting endothelial proliferation in vivo, whereas the in vivo growth factors such as FGF, they both seem to be capable of actions on cultured endothelial cells when compared with other growth factors such as FGF, they both seem to be capable of mediating its actions independently of VEGF. Interestingly, although both factors have relatively minor proliferative actions on cultured endothelial cells when compared with other growth factors such as FGF, they both seem to be capable of promoting endothelial proliferation in vivo, whereas the in vivo proliferative actions of FGF remain to be validated. The limitations of current in vitro systems to accurately reflect actions of growth factors in vivo makes it more difficult to define the mechanistic differences underlying the differential growth effects of VEGF versus angiopoietin 1. One clue may come from the finding that angiopoietin 1, unlike VEGF, may lack the ability to induce protease activation in endothelial cells (Mandriota et al., 1995; Zucker et al., 1998). Because sprouting through the vascular basement membrane is likely to require the induction of specific proteases that can degrade extracellular matrix, the inability of angiopoietin 1 to induce protease activation may force dividing endothelial cells to remain within their original vessel, thus allowing angiopoietin 1 to regulate vessel size without causing angiogenic sprouting. By contrast, VEGF may empower proliferating endothelial cells to break through the vessel wall by inducing necessary proteases, thereby allowing for sprouting angiogenesis.

The vessel enlargement induced by angiopoietin 1 appears to be rather specific to the venous side of the microcirculation. Venules are specialized functionally, morphologically and molecularly (Thurston et al., 2000a). Functionally, venules are most leaky to plasma proteins under baseline conditions and are the site of inflammation-induced plasma leak (Majno et al., 1969). Venular endothelial cells have a distinct molecular profile, including increased expression of P-selectin, von Willebrand factor (Thurston et al., 2000a), and receptors for inflammatory mediators (Bowden et al., 1994; Heltianu et al., 1982). In addition, venules are the segment most likely to sprout during angiogenesis (Folkmann, 1982; Phillips et al., 1991). Previous studies have suggested that the venous side of the circulation may be most responsive to, or dependent upon, angiopoietin 1 during development (Loughna and Sato, 2001; Moyon et al., 2001; Thurston et al., 1999). The enlargement of the venules could be due to an abundance of TIE2 receptors on the endothelial cells of venules, to increased accessibility to the abluminal surface, to localized expression of angiopoietin 1, or to general plasticity due to specialized pericytes and the basement membrane. Alternatively, previous studies have noted that angiopoietin 2, which can act as an antagonist of angiopoietin 1, is expressed in arterial smooth muscle cells, with much weaker expression on the venous side (Gale et al., 2002; Moyon et al., 2001). Thus, the arterial expression of angiopoietin 2 may act to inhibit angiopoietin 1 in these vessels, and thus may explain why the venous side of the circulation is more responsive to angiopoietin 1 stimulation.

Angiopoietin 1 appears to be able to regulate vessel size in most organs only during a critical developmental window. This window coincides with a period during which vessels in many organs are dependent on VEGF for survival. Subsequent maturation of the vessels in many organs makes them less responsive to vessel enlargement after angiopoietin 1 treatment and less dependent on VEGF for survival. The evidence strongly suggests that these mature vessels do not lose all responsiveness to angiopoietin 1, because angiopoietin 1 treatment of mature vessels results in a reduced plasma-leakage response (Thurston et al., 2000b). Thus, the developmental window appears to be a period when vessels maintain plasticity to remodel morphologically in response to angiopoietin 1. By comparison, even mature vessels appear to maintain plasticity to remodel in response to VEGF, because robust angiogenesis occurs when exogenous VEGF is applied to adult tissues that are not responsive to angiopoietin 1, for example, the skin and the heart (Pettersson et al., 2000) (data not shown).

So what reduces plasticity as vessels mature? Based on previous studies (Benjamin et al., 1998; Hirsch and D’Amore, 1997), it is possible that vessel maturation involves changes in the association of endothelial cells with the surrounding perivascular support cells. Although our preliminary data indicate that the neonatal vessels responsive to angiopoietin 1 are already associated with perivascular cells, it is likely that the interactions between endothelial cells and perivascular cells continue to mature after initial investment. Indeed, even in adulthood, the blood vessels of the airways continue to respond to angiopoietin 1 by enlarging, although these vessels are

**Fig. 6.** Vessel morphology in mouse tissues treated with VEGF-Trap. Mouse pups were treated every 2 days for 7 days with 25 mg/kg ip of VEGF-Trap protein. Tissue is from P14 mice, with blood vessels immunostained for PECAM (green) and α smooth muscle cell actin (red/orange). (A,B) Whole-mount views of tracheas, showing straight vessels (arrowheads) across the cartilaginous rings in control mice (A). The vessels across the cartilaginous region (asterisks) in tracheas of VEGF-Trap-treated mice (B) are completely absent. (C,D) Cross-sections of tongue, with the upper epidermal surface of the tongue at the upper part of the image. The vessel loops in the dermal papillae (C, arrowheads) in tongues of VEGF-Trap-treated mice are almost abolished (D, asterisks), and the vascularity of the dermis and muscle layers is also reduced.
covered by seemingly mature pericytes. The response of the vasculature does not seem to depend on the route of delivery, because the ear skin vessels are unresponsive to both local and systemic delivery of ANG1, whereas the trabecular vessels are responsive to both local and systemic delivery. Thus, the responsiveness of blood vessels to angioptotin 1 may be regulated by complex and poorly understood interactions between endothelial and smooth muscle cells, and/or basement membrane.

The ability to further characterize the maturity of blood vessels, the nature of the interactions between endothelial cells and pericytes and basement membrane, and the signals that underlie responsiveness to VEGF and angiopoietin 1, seems likely to have important therapeutic implications. The success of pro- and anti-angiogenic approaches in the clinic may well depend on the ability to manipulate the state of vessel maturation, i.e. to revert mature vessels to a more plastic state, or to induce plastic vessels to mature. For example, in ischemic settings in which it is desirable to promote vessel sprouting as well as increases in vessel size [such as of collaterals feeding the ischemic tissue (Carmeliet, 2000)], one would want to induce a greater state of vessel plasticity. Similarly, in tumors and other settings in which it may be desirable to regress an existing vasculature, it may be useful to once again induce vessel plasticity that would be associated with vascular instability and increased responsiveness to VEGF blockade.

Finding the key molecular and cellular factors that regulate this plasticity switch may prove crucial to the further development of pro- and anti-angiogenic therapies.

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Supplementary material
Supplementary material for this article is available at http://dev.biologists.org/cgi/content/full/132/14/3317/DC1

References