Human Amniotic Membrane–Derived Products in Sports Medicine: Basic Science, Early Results, and Potential Clinical Applications
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What is This?
Human Amniotic Membrane–Derived Products in Sports Medicine

Basic Science, Early Results, and Potential Clinical Applications

Jonathan C. Riboh,* MD, Bryan M. Saltzman,† MD, Adam B. Yanke,‡ MD, and Brian J. Cole,‡ MD, MBA

Investigation performed at Rush University Medical Center, Division of Sports Medicine, Chicago, Illinois, USA

Background: Amniotic membrane (AM)–derived products have been successfully used in ophthalmology, plastic surgery, and wound care, but little is known about their potential applications in orthopaedic sports medicine.

Purpose: To provide an updated review of the basic science and preclinical and clinical data supporting the use of AM-derived products and to review their current applications in sports medicine.

Study Design: Systematic review.

Methods: A systematic search of the literature was conducted using the Medline, EMBASE, and Cochrane databases. The search term amniotic membrane was used alone and in conjunction with stem cell, orthopaedic, tissue engineering, scaffold, and sports medicine.

Results: The search identified 6870 articles, 80 of which, after screening of the titles and abstracts, were considered relevant to this study. Fifty-five articles described the anatomy, basic science, and nonorthopaedic applications of AM-derived products. Twenty-five articles described preclinical and clinical trials of AM-derived products for orthopaedic sports medicine. Because the level of evidence obtained from this search was not adequate for systematic review or meta-analysis, a current concepts review on the anatomy, physiology, and clinical uses of AM-derived products is presented.

Conclusion: Amniotic membranes have many promising applications in sports medicine. They are a source of pluripotent cells, highly organized collagen, antiﬁbrogenic and anti-inﬂammatory cytokines, immunomodulators, and matrix proteins. These properties may make it beneﬁcial when applied as tissue engineering scaffolds, improving tissue organization in healing, and treatment of the arthritic joint. The current body of evidence in sports medicine is heavily biased toward in vitro and animal studies, with little to no human clinical data. Nonetheless, 14 companies or distributors offer commercial AM products. The preparation and formulation of these products alter their biological and mechanical properties, and a thorough understanding of these differences will help guide the use of AM-derived products in sports medicine research.

Keywords: amniotic membrane; stem cell; regenerative medicine; scarless healing

ANATOMY AND FUNCTION OF HUMAN FETAL MEMBRANES

The fetal membranes are a complex structure that plays a critical role in fetal development. The membranes are composed of 2 layers: the outer chorion that is in contact with maternal tissue and the thin (0.02-0.5 mm) inner amniotic membrane (AM) that completely surrounds the embryo and delimits the amniotic cavity.49 The AM forms from the trophoblast—the first group of cells to differentiate from the fertilized egg, which forms the outer layer of the early blastocyst.39 The AM is a translucent structure with no innervation or lymph nodes.61 As a result, it is entirely dependent on diffusion for nutrition.
Structure

The AM consists of 3 histological layers: the epithelial layer, a thick basement membrane, and avascular mesenchymal tissue (Figure 1).61 The innermost epithelial layer contains a single layer of cuboidal epithelial cells with many microvilli that play an active role in secretory and cellular transport functions.38 The underlying basement membrane (BM) is the thickest BM of all human tissues.49 Below the basement membrane is the avascular mesenchymal tissue, which can be divided into compact, fibroblast, and intermediate layers.49 Type I and III collagens produced in the fibroblast layer create parallel bundles that give most of the structural integrity to the AM.49 Type V and VI collagens create cross-links between this network of parallel bundles and the basement membrane. The intermediate layer, also known as the spongy layer, has an abundant content of proteoglycans and glycoproteins with a nonfibrillar network of type III collagen, which is only loosely connected to the adjacent chorion.49 This allows the AM to be easily separated from the chorion by blunt dissection at all stages of development.

Function

The AM is a metabolically active tissue that has the following functions: water and soluble material transport for the fetus, synthesis of growth factors, vasoactive peptides and cytokines, and regulating amniotic fluid pH.39 Amniotic epithelial cells have been shown to produce transforming growth factor–α (TGF-α), basic fibroblast growth factor (bFGF), epidermal growth factor (EGF), transforming growth factor–β (TGF-β), keratinoctye growth factor, and hepatocyte growth factor.26 In addition, nerve growth factor (NGF), brain-derived neurotrophic factor (BDNF), noggin, and activin have also been identified in the AM.28,63

AMNIOgenic MEMBRANES AS A SCAFFOLD FOR COMPLEX TISSUE REGENERATION

AM was first used as a biologic scaffold in 1910 for the treatment of a skin defect.49 Since then, it has gained popularity as a biologic dressing and/or scaffold for tissue regeneration. As for all tissue regeneration scaffolds, great attention must be given to how AM is harvested, processed, and stored, as this can affect its mechanical and biological properties.

AM is harvested from volunteer donors who undergo rigorous screening for human immunodeficiency virus (HIV) 1 and 2, hepatitis B, hepatitis C, human T-cell lymphotrophic virus, syphilis, cytomegalovirus (CMV), and tuberculosis.26 The fetal membranes can be harvested after vaginal or cesarean delivery; however, both commonly undergo terminal radiation sterilization. The amnion is then separated from the placenta by blunt dissection.

The first distinction is between fresh and preserved AM. Fresh AM is extensively washed in phosphate-buffered saline containing penicillin and streptomycin and stored at 4°C.16,44,54,66,88,92 There are several concerns with fresh AM transplantation, including the risk of disease transmission and the need for immediate or near-immediate transplantation.34 The reported infection rate with fresh AM transplantation is 8%, and gram-positive organisms are the most common pathogens.22,40 The main reason for this high infection rate is that AM grafts may be transplanted during the incubation period of an infectious pathogen, and seroconversion may not occur until after AM implantation. As a result, several preservation techniques have been developed, including cryopreservation and freeze-drying (lyophilization).23,47 Cryopreservation involves long-term storage of AM grafts at –80°C with a cryoprotectant such as glycerol or dimethyl sulfide (DMSO).47 Freeze-drying, also known as lyophilization, removes the water from AM tissue by freezing the material, reducing the ambient pressure to allow the frozen water to convert directly from the solid to the liquid phase in a process known as sublimation.47

These methods all have some degree of influence on the mechanical and biological properties of AM grafts.31 An excellent study has compared the effects of cryopreservation and lyophilization on AM grafts.47 Cryopreserved and lyophilized AM both have lower maximal loads to failure and elongation to failure than fresh AM.47 In addition, lyophilized AM grafts are thinner and more fragile than fresh and cryopreserved AM.47 However, all graft types show similar suture retention properties.47 At the microscopic level, graft preservation led to thinning or even disruption of the compact layer with decreased levels of collagens I and III, fibronectin, and laminin.47 Nonetheless, the basement membrane was well preserved by cryopreservation and lyophilization. Integrity of the basement membrane may be crucial for cell adhesion when using AM as a scaffold in tissue regeneration or engineering.47 Interestingly, lyophilized AM allowed for greater host cell adhesion and viability than fresh or cryopreserved AM, perhaps because there is less competition between native AM epithelial cells and donor cells.47

INTRINSIC PROPERTIES OF ACELLULAR AMNIOTIC MEMBRANE GRAFTS

Some benefits of AM are maintained even after the cellular component is no longer viable. This has been evaluated,
TABLE 1
Intrinsic Properties of Preserved Amniotic Membrane Grafts

<table>
<thead>
<tr>
<th>Property</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide a matrix for cellular migration and proliferation</td>
<td>-</td>
</tr>
<tr>
<td>Enhance the wound-healing process</td>
<td>-</td>
</tr>
<tr>
<td>Nonimmunogenic</td>
<td>-</td>
</tr>
<tr>
<td>Reduce inflammation</td>
<td>-</td>
</tr>
<tr>
<td>Reduce scar formation</td>
<td>-</td>
</tr>
<tr>
<td>Antibacterial</td>
<td>-</td>
</tr>
<tr>
<td>Reduce pain at application site</td>
<td>-</td>
</tr>
<tr>
<td>Natural biologic barrier</td>
<td>-</td>
</tr>
</tbody>
</table>

although by testing grafts that have been cryopreserved or lyophilized. This is due, in part, to the preservation of both growth factors and the structure of the extracellular matrix.27 The acellular membrane allows for cell adhesion and proliferation,27 leading to more organized wound healing rather than scar formation.12 While much of the excitement about the use of AM in sports medicine centers on its role as a source of pluripotent cells or as a scaffold for mesenchymal tissue engineering, most of the current uses of AM use the intrinsic properties of preserved grafts.12 A summary of these properties is shown in Table 1.

AMNIOTIC MEMBRANES AS A SOURCE OF STEM CELLS

Amniotic membranes have revealed themselves as an excellent source of pluripotent cells.26 The major advantage of AM-derived stem cells over fetal stem cells is the relative lack of ethical concerns over their harvest. Amniotic membrane–derived cells are gathered from the placenta of volunteers after childbirth—tissue that would otherwise be discarded. A key concern when using any pluripotent cell population for clinical applications is the risk of tumorigenesis. As many as 50 cases of amniotic stem cell transplantation have been reported in the treatment of lysosomal storage diseases, with no reports of tumor formation.41 In animal models, AM-derived stem cells have failed to show malignant behavior, even in immunocompromised hosts.43 In addition, studies have confirmed the genetic stability of cultured AM-derived stem cells.41

Amniotic Membrane Stem Cell Types

When discussing AM as a source of stem cells, it is important to distinguish between amniotic epithelial cells (AECs) and amniotic mesenchymal stromal cells (AMSCs).25 AECs are maternal-derived cells that have the stereotypical markers of epithelial cells such as cytokeratin. They also express stem cell markers such as OCT-4, SOX-2, Lefty-A, FGF-4, REX-1, TDGF-1, crypto-1, and Nanog41 and have the ability to differentiate into all 3 germ layers.42 AMSCs, in contrast, are derived from the embryonic mesoderm and also have the ability to differentiate into mature cell lineages from the mesoderm, endoderm, and ectoderm.74 AECs are easily removed from AM by using trypsin enzymatic digestion.25 Isolation of AMSCs requires a 2-step process in which AECs are first removed with trypsin, and AMSCs are released from their surrounding matrix by collagenase and DNAse treatments.25 Both AECs and AMSCs can differentiate into classical mesodermal lineages for orthopaedic tissue engineering, including myocytes, osteocytes, and chondrocytes.18,65

Immunomodulatory Effects

During gestation, the maternal immune system develops a tolerance for the semi-allogeneic fetus, a process that is at least in part regulated at the level of the AM.15 A full review of these mechanisms is beyond the scope of this article, as it involves interactions between the fetus, mother, placenta, and amnion. We focus rather on the intrinsic immunomodulatory properties of AM. These are related at least in part to the depletion or absence of major histocompatibility antigens (human leukocyte antigen [HLA] classes A, B, DR) on the surface of AM-derived stem cells.38 Extensive research into the immunomodulatory properties of AM-derived stem cells has been performed and has shown effects on both the innate and adaptive immune systems.19 In addition, anti-inflammatory cytokines contained within the AM matrix contribute to its privileged immune status.

The effect of AM-derived stem cells on the innate immune system is largely modulated by their ability to prevent the differentiation of monocytes into dendritic cells—a critical cell type for antigen presentation.27 Several putative soluble factors involved in this process are CCL2, CXCL8, or interleukin (IL)–6.19 In addition, AM-derived stem cells are essentially immune to lysis by natural killer (NK) cells, important effector cells of the innate immune system.19 This immunity is thought to be mediated by migration inhibitory factor, a potent inhibitor of NK cell-mediated lysis.19 AM-derived stem cells also have well-documented interactions with the adaptive immune system. When grown in coculture with AM-derived stem cells, T cells show decreased proliferation in response to polyclonal antigens.19 This inhibitory effect is thought to be mediated by cell-to-cell pathways, in contrast to the effect of AM-derived stem cells on the innate immune system.58 This inhibition is dependent on the state of T-cell activation. Indeed, naive and memory T cells are highly sensitive to the effects of AM-derived stem cells, while activated T cells are not.2 The production of cytokines by T cells during a mixed lymphocyte reaction is also affected by co-culture with AM-derived stem cells. There are significant increases in IL-2, IL-4, IL-7, and IL-15 while levels of IL-17 and interferon-γ (IFN-γ) are downregulated.21 TGF-β and IL-10 are also thought to play a critical role in the immunosuppressive abilities of AM-derived stem cells.5

ANTIMICROBIAL AND ANTIVIRAL EFFECTS

AM has well-documented antimicrobial effects. It has antibacterial efficacy against gram-positive cocci, including Streptococci and Staphylococcus aureus, as well as gram-negative bacilli, including Escherichia coli and Pseudomonas aeruginosa.22,24 These effects can be attributed to the production of antimicrobial molecules by AM cells, including bactricidin,
β-lysin, transferrin, and 7S immunoglobulin. Other secreted factors that may have antimicrobial properties are elastin, leukocyte proteinase inhibitor, human β3 defensin, and cystatin C. However, some investigators believe that the antimicrobial properties of AM are only related to its properties as a barrier against microbial inoculation.

REGULATORY EFFECTS OF AMNIOTIC MEMBRANES ON ANGIogenesis

Angiogenesis, also known as neovascularization, involves the formation of capillaries from preexisting microvessels. In contrast, excessive, pathologic angiogenesis is involved in tumor processes as well as inflammatory arthropathies and chronic inflammatory conditions. The effects of AM grafts and AM-derived cells on angiogenesis are poorly understood. Most AM-derived cells express proangiogenic factors such as vascular endothelial growth factor (VEGF), IL-8, angiogenin, IFN-γ, IL-6, bFGF, EGF, and platelet-derived growth factor (PDGF). In an elegant animal study, it has been shown that the epithelial component of AM is an inhibitor of angiogenesis, while the mesenchymal component increases angiogenesis. This provides a unifying theory for the seemingly contradictory data from earlier studies. It is clear that depending on the intended use for AM grafts or AM-derived cells, the epithelial or mesenchymal subunits may be best suited based on their role in neovascularization.

ANTISCARRING EFFECTS OF AMNIOTIC MEMBRANES

One of the purported advantages of AM grafts is their ability to promote scar-free healing. TGF-β is a soluble factor that is known to induce fibrotic responses through activation of fibroblasts. AM, in turn, inhibits the expression of TGF-β, reducing scar formation. Hyaluronic acid in the mesenchymal portion of AM is thought to be the primary inhibitor of TGF-β. In addition, amniotic mesenchymal and epithelial cells contain growth factors involved in epithelialization and wound healing such as EGF, keratinocyte growth factor (KGF), keratinocyte growth factor receptor (KGFR), hepatocyte growth factor (HGF), and hepatocyte growth factor receptor (HGFR).

COMMERCIALY AVAILABLE HUMAN AMNIOTIC MEMBRANE–DERIVED PRODUCTS

As of February 2015, there were 14 companies or distributors that provide commercially available AM-derived products (Table 2; see also the online Appendix, available at http://ajsm.sagepub.com/supplemental). Many use proprietary processing methods, and most others have not made their processing methods public. Given the known effects of AM processing on its mechanical, biological, and cellular properties, clinicians and investigators are encouraged to communicate with vendors about their tissue processing before using an AM product. A variety of formulations are available, including sheets, dehydrated sheets, tubes, liquids, and powders (Table 2). To date, little to no research has been done on the effect of AM formulation on intended clinical use, and one cannot assume equivalency of the different formulations.

CURRENT CLINICAL USES OF HUMAN AMNIOTIC MEMBRANE–DERIVED PRODUCTS

One common use of AM is in ophthalmology as a treatment of corneal surface injury, as a reconstructive scaffold after resection of ocular surface lesions, and as a promoter of limbal stem cell regeneration. AM has also been widely applied by plastic surgeons and wound specialists. Its use in wound care is now a US$100 million market as it has been successfully used in humans as a biological dressing for burns as well as acute and chronic wounds. Furthermore, it has been shown to reduce adhesion formation after flexor tendon repair and has been used as a nerve wrap or conduit. Podiatrists and orthopaedic foot and ankle surgeons have demonstrated the efficacy of AM in accelerating and improving healing of diabetic foot ulcers and postoperative infected or nonhealing wounds.

CURRENT INVESTIGATIVE USES OF HUMAN AMNIOTIC MEMBRANE–DERIVED PRODUCTS IN SPORTS MEDICINE

The use of AM products in sports medicine is far less documented and to date is entirely experimental. A summary of the in vivo and in vitro studies pertaining to the use of AM products in sports medicine is shown in Table 3. The primary indications being explored are cartilage restoration, ligament and tendon healing, nonoperative treatment of knee osteoarthritis, and plantar fasciitis.

The use of AM products for cartilage restoration has gathered momentum in recent years. Since 2007, ten studies have been published investigating this approach. Four of these studies used animal models (rat or sheep) while the others were cell culture studies. Three major strategies have been employed in these early studies: (1) using AM as a scaffold for bone marrow–derived mesenchymal stromal cell (MSCs), (2) using AM as a scaffold for delivery of chondrocytes, and (3) inducing AM-derived pluripotent cells toward a chondrogenic phenotype. The cell culture studies provide robust evidence that in vitro, AM-derived pluripotent cells (both amniotic epithelial cells and AMSCs) can be directed toward a chondrogenic fate using bone morphogenetic protein (BMP)–2.
### TABLE 3
Basic Science and Clinical Studies on the Use of AM-Derived Products in Sports Medicine

<table>
<thead>
<tr>
<th>Authors (Year)</th>
<th>Journal</th>
<th>Study Design</th>
<th>Amniotic Product Type</th>
<th>Study Subjects</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cartilage regeneration</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Liu et al (2014)</td>
<td>Genet Mol Res</td>
<td>Animal model (rabbit)</td>
<td>Control vs human acellular AM vs human acellular AM loaded with hMSCs</td>
<td>24 rabbits</td>
<td>AM loaded with hMSCs resulted in greater cartilage repair and improved Wakitani cartilage scores compared with control and AM alone in femoral condyle defects</td>
</tr>
<tr>
<td>Garcia et al (2014)</td>
<td>Curr Stem Cell Res Ther</td>
<td>Animal model (sheep)</td>
<td>Control vs fresh AM vs cryopreserved AM vs cryopreserved AM loaded with hMSCs</td>
<td>12 sheep</td>
<td>All treatments resulted in improved ICRS and O’Driscoll scores compared with control in femoral condyle defects; no difference between groups</td>
</tr>
<tr>
<td>Nogami et al (2012)</td>
<td>Transplantation</td>
<td>Cell culture</td>
<td>Human amniotic MSCs</td>
<td>NA</td>
<td>Human amniotic MSCs can be induced to a chondrocyte phenotype with chondrogenic medium and BMP-2</td>
</tr>
<tr>
<td>Zhou et al (2011)</td>
<td>Int Orthop</td>
<td>Cell culture</td>
<td>Human amniotic epithelial cells</td>
<td>NA</td>
<td>Human amniotic epithelial cells expressed chondrocyte markers (SOX-9, collagen II and X) when grown in the presence of BMP-7</td>
</tr>
<tr>
<td>Tan et al (2011)</td>
<td>Cell Tissue Bank</td>
<td>Cell culture</td>
<td>Air-dried AM vs freeze-dried AM in culture with hMSCs</td>
<td>NA</td>
<td>hMSCs adhered to dried AM and when grown in chondrogenic medium led to increased GAG production</td>
</tr>
<tr>
<td>Krishnamurthy et al (2011)</td>
<td>J Biomed Mater Res A</td>
<td>Cell culture</td>
<td>Air-dried human AM vs freeze-dried human AM vs control seeded with rabbit chondrocytes</td>
<td>NA</td>
<td>Chondrocytes adhered to both freeze-dried and air-dried AM, and cell proliferation and GAG production were increased in both AM groups compared with monolayer culture on plastic</td>
</tr>
<tr>
<td>Diaz-Prado et al (2010)</td>
<td>Cell Tissue Bank</td>
<td>Cell culture</td>
<td>Freeze-dried human AM seeded with human chondrocytes</td>
<td>NA</td>
<td>Chondrocytes grew on the stromal side of AM, not on the epithelial side; AM seeded with chondrocytes maintained a chondrocyte phenotype in an OA cartilage tissue culture system, and the membrane integrated with surrounding cartilage</td>
</tr>
<tr>
<td>Wei et al (2009)</td>
<td>Cloning Stem Cells</td>
<td>Cell culture and animal model (rat)</td>
<td>Human amniotic MSCs</td>
<td>NA</td>
<td>Amniotic MSCs expressed more chondrocyte markers than did amniotic epithelial cells; BMP-2 can induce a chondrocyte phenotype in amniotic MSCs in vitro and in vivo; collagen I gels loaded with amniotic MSCs and BMP-2 can fill cartilage defects in rat femoral condyles</td>
</tr>
<tr>
<td>Jin et al (2007)</td>
<td>Tissue Eng</td>
<td>Cell culture and animal model (rabbit)</td>
<td>Fresh vs denuded human AM seeded with rabbit chondrocytes</td>
<td>12 rabbits</td>
<td>Chondrocytes preferentially grew and expressed collagen II on the stromal side of denuded AM; denuded AM seeded with chondrocytes regenerated hyaline cartilage in femoral condyles</td>
</tr>
<tr>
<td>Tendon and ligament healing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kueckelhaus et al (2014)</td>
<td>Eplasty</td>
<td>Animal model (rat)</td>
<td>Amnion-derived cellular cytokine solution (supernatant of amniotic MSCs in culture) vs control</td>
<td>NA</td>
<td>Amnion-derived cellular cytokine solution improved the mechanical properties of Achilles tendon repairs and increased collagen production and cross-linking at the repair site</td>
</tr>
<tr>
<td>Philip et al (2013)</td>
<td>Eplasty</td>
<td>Animal model (rat)</td>
<td>Amniotic MSCs vs amnion-derived cellular cytokine solution vs control</td>
<td>NA</td>
<td>Amniotic MSCs improved the Young modulus and ultimate failure strength of Achilles tendon repairs compared with amnion-derived cellular cytokine solution and control</td>
</tr>
<tr>
<td>Lange-Coniglio et al (2013)</td>
<td>Cytotherapy</td>
<td>Animal model (horse)</td>
<td>Horse amniotic MSCs vs bone marrow-derived MSCs</td>
<td>95 horses</td>
<td>Amniotic MSCs resulted in decreased re-injury rates compared with hMSCs when injected into sport-induced superficial digital flexor tendon lesions</td>
</tr>
<tr>
<td>Lange-Coniglio et al (2013)</td>
<td>Stem Cells Dev</td>
<td>Animal model (horse)</td>
<td>Horse amniotic MSCs conditioned medium vs control</td>
<td>13 horses</td>
<td>Conditioned medium reduced re-injury rate after spontaneous tendon and ligament injuries</td>
</tr>
<tr>
<td>Barboni et al (2012)</td>
<td>Cell Transplant</td>
<td>Animal model (sheep)</td>
<td>Ovine amniotic epithelial cells vs control</td>
<td>NA</td>
<td>Ovine amniotic epithelial cells injected into Achilles tendon defects resulted in improved mechanical properties, ECM remodeling, and collagen maturation compared with controls</td>
</tr>
</tbody>
</table>

(continued)
Amniotic Membrane Products in Sports Medicine

### TABLE 3
(continued)

<table>
<thead>
<tr>
<th>Authors (Year)</th>
<th>Journal</th>
<th>Study Design</th>
<th>Amniotic Product Type</th>
<th>Study Subjects</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Muttini et al35 (2010)</td>
<td><em>Vet Res Commun</em></td>
<td>Animal model (sheep)</td>
<td>Ovine amniotic epithelial cells vs control</td>
<td>3 sheep</td>
<td>1 mo after injection of AECs into Achilles tendon defects, the AECs were still alive without adverse reaction; abundant ECM and collagen deposition in the defect were seen</td>
</tr>
<tr>
<td>Coban et al7 (2009)</td>
<td><em>Foot Ankle Surg</em></td>
<td>Animal model (rat)</td>
<td>Human fresh AM vs amniotic fluid vs control</td>
<td>36 rats</td>
<td>Injection of fresh AM with or without amniotic fluid did not improve the histological appearance of healing Achilles tendons</td>
</tr>
<tr>
<td>Demirkiran et al9 (2002)</td>
<td><em>Arch Orthop Trauma Surg (chicken)</em></td>
<td>Animal model (chicken)</td>
<td>Human fresh AM vs control</td>
<td>NA</td>
<td>Application of fresh human AM reduced adhesion formation in flexor tendon repairs without compromising the biomechanical properties of the repaired tissues</td>
</tr>
<tr>
<td>Knee osteoarthritis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Willett et al37 (2014)</td>
<td><em>Arthritis Res Ther</em></td>
<td>Animal model (rat)</td>
<td>Micronized dehydrated human AM vs control</td>
<td>NA</td>
<td>Micronized dehydrated human AM had no effect on intact cartilage; in an OA model, however, the micronized AM reduced the number and severity of chondral lesions and helped maintain higher proteoglycan levels</td>
</tr>
<tr>
<td>Plantar fasciitis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hanselman et al16 (2015)</td>
<td><em>Foot Ankle Int</em></td>
<td>Human RCT</td>
<td>Cryopreserved human AM</td>
<td>23 patients</td>
<td>No difference between cryopreserved AM and corticosteroids for the treatment of plantar fasciitis; no adverse side effects from AM injection</td>
</tr>
<tr>
<td>Zelen et al39 (2013)</td>
<td><em>Foot Ankle Int</em></td>
<td>Human RCT</td>
<td>Micronized dehydrated human AM</td>
<td>45 patients</td>
<td>AOFAS and pain scores improved with micronized AM compared with saline injections</td>
</tr>
</tbody>
</table>

**BMP-7, or chondrogenic medium.**

Chondrogenic differentiation was confirmed by the expression of SOX-9, type II and type X collagen, and aggrecan.14,29,35,65

In addition, it has been shown that AM is a suitable scaffold for bone marrow–derived MSC adhesion and chondrogenic differentiation,35 as well as mature chondrocyte adhesion and proliferation.10,30,39 All of these strategies led to filling of full-thickness chondral defects in animal models. However, these treatments have not been compared against other standard approaches such as microfracture, and to date, there are no human studies available. In summary, AM offers promise as an alternative to collagen I/III membrane scaffolds for 2-stage cartilage repair and as a source of pluripotent cells that does not require a morbid harvest (such as a bone marrow aspirate or a cartilage biopsy specimen).

Another promising field of investigation with wide applicability in sports medicine is the use of AM-derived products to enhance tendon and ligament healing. A single-cell culture study showed that AM-derived epithelial cells assume a tenocyte phenotype when cocultured with mature tenocytes.3 The 11 other studies available investigated the use of various AM-derived products in animal models (horse, sheep, rabbit, chicken, and rat).3,4,7,39,50-54,46,51-53 These studies totaled approximately 100 horses and showed that reinnjury rates were reduced with amniotic epithelial cells, AMSCs, and even conditioned medium extracted from AMSC cultures.31,32,45 These products had better clinical outcomes than placebo and bone marrow–derived MSCs.31,32,45 The remaining animal studies were controlled laboratory experiments using Achilles tendons9,51,52 as healing models. While an injection of fresh AM into a healing Achilles tendon did not improve the histologic appearance of the tendon, conditioned medium from AMSC cultures and, to a greater degree, the MSCs themselves increase collagen production and cross-linking in the healing tendon, resulting in improved biomechanical characteristics.7,30,53 Fresh AM membranes were used for...
a different purpose in flexor tendon healing models. In this scenario, the membranes were used for their ability to reduce adhesion formation, which they reliably did in rabbit and chicken models, without compromising the mechanical properties of the healing tendons.9,31,52

A single study has investigated the use of micronized dehydrated AM for intra-articular use in knee osteoarthritis.67 In a rat osteoarthrosis model, micronized AM reduced the number and severity of chondral lesions and maintained higher circulating proteoglycan levels.67

The highest level of clinical evidence supporting the use of AM in sports medicine is for its use in plantar fasciitis. Two randomized clinical trials have been performed in this setting. The first demonstrated that micronized AM resulted in improved functional outcome scores compared with saline injections.70 The most recent study demonstrated that injection of cryopreserved human AM had similar functional outcomes as corticosteroid injections for plantar fasciitis, without any documented adverse effects.16

ONGOING CLINICAL TRIALS USING HUMAN AMNIOTIC MEMBRANE–DERIVED PRODUCTS

A query of www.clinicaltrials.gov indicates that 40 clinical trials investigating the use of AM are registered with the site. Of these, only 3 are in the field of orthopaedics. One study investigating the use of AM in reducing scar formation after total knee arthroplasty has completed enrollment, but the data are not yet available. The other study has not yet opened to enrollment and will assess the effects of AM on outcomes of zone II flexor tendon repairs. Finally, a study comparing injection of AM allograft with hyaluronic acid and placebo in the treatment of knee osteoarthrosis will soon be open to patient enrollment. A study investigating the use of particulate AM injections for lateral epicondylitis was prematurely terminated by the supplier in March 2014.

REGULATORY AND ETHICAL ISSUES IN THE USE OF HUMAN AMNIOTIC MEMBRANE–DERIVED PRODUCTS

Fresh human AM falls under the supervision of the Center for Biologics Evaluation and Research (CBER) at the US Food and Drug Administration (FDA). Specifically, fresh AM falls under Section 361 as it is an intact human tissue. Similar “361 products” include ligaments, tendons, cartilage, and bone. All other variations of human AM products are categorized as Section 361 only if they satisfy the FDA’s regulatory definitions. This decision is made based on the concept of “minimal manipulation”—meaning that anything more than minimal manipulation of AM categorizes it as a drug or biologic, which is the 351 pathway, requiring a more onerous and costly route to approval. Specifically, a Biologics License Application (BLA) and an Investigational New Drug (IND) application need to be completed.

Since 2000, the FDA has indicated its position on several questions that may help guide researchers and companies intending to use human AM products. The first principle is that AMs seeded with allogeneic cells (including stem cells) are considered a biologic “351 product” and require a BLA and IND. However, dehydrated and decellularized AM is considered a “361 product” only as a wound covering. All other uses are considered nonhomologous. Finally, micronized cryopreserved AM products are more than minimally manipulated and have to undergo a BLA and IND for any intended clinical use.

On the basis of these guidelines, essentially all of the investigational uses of AM in sports medicine would be considered off-label. Early adopters using AM products therefore have an ethical obligation to disclose to patients when these products are being used off-label. In addition, all patients should be educated about the origin and preparation of AM products, given the potential for personal, religious, or political opposition to their use.

Finally, given the expense associated with the use of AM, the sports medicine community should focus on identifying the correct indications for its use and demonstrating clinical efficacy and cost-effectiveness through rigorous studies before encouraging its widespread use.

CONCLUSION

Human AM-derived products represent a wide variety of tissues and cell populations that show promise in the field of sports medicine. Broadly speaking, human AM can be used as a source of pluripotent cells, but the relative benefits and drawbacks of amniotic epithelial cells and AMSCs have yet to be elucidated. Growth factor–rich medium from pluripotent amniotic cell cultures also shows promise in enhancing tissue healing and regeneration and may find similar applications as platelet-rich plasma. Finally, AM can be used in fresh, cryopreserved, or lyophilized forms as a barrier against adhesion formation, a scaffold for musculoskeletal tissue engineering, or a carrier for biologics and therapeutic cell populations.

Amniotic membrane–derived products have the advantage of minimizing the ethical issues shared by embryonic stem cells while still having the promise of an easily attainable population of pluripotent cells and soluble factors that promote scarless, fetal-type healing. Nonetheless, the regulatory environment around AM products is complex and evolving, and translational applications should be carefully assessed before recommending their clinical application.

REFERENCES


