One aspect of the present invention relates to a method of treating or preventing pathologic effects of hyperglycemia and/or acute increases of free fatty acid flux.

This method involves administering a composition containing a therapeutically effective amount of a ROS inhibitor to a subject in need thereof.
Figure 1
HYPOXIA

Glucose Metabolism

HIF

EPO

Erythropoiesis

iNOS

Other cytokines

Vascular Reactivity

VEGF

Angiogenesis

Vasculogenesis

Figure 2
FIG. 4
Figure 5
FIG. 6
Figure 7

Oxygen tension

0  p1  p2  p3  p4  p5  NL Skin

Ischemia zones

- Akita mice
- C57BL6 mice
Figure 8
FIG. 9
Figure 10
Figure 11
Figure 12
Figure 13
Figure 14
**FIG. 17A**

- Normal Migration
  - Collagen vs. Fibronectin
  - NMDF vs. db/db

**FIG. 17B**

- Hypoxic Stimulation of Haptotaxis
  - Collagen
  - NMDF vs. db/db
FIG. 18A

FIG. 18B
FIG. 19D

FIG. 19C
EFFECT OF DEFEROXAMINE ON HYPERGLYCEMIA-INDUCED ROS

FIG. 21
Figure 22
We...
PARP Activity

pmol/mg protein

5mM glucose  30mM glucose  30mM glucose + 30mM glucose + deferox  DMSO

Figure 25
Figure 26
Figure 27
ENOS activity (pmol/min/2x10^6 cells)

* Here

5 mM glucose 30 mM glucose 30 mM glucose + deferoximine

Figure 28
Figure 29
**FIG. 30A**

[Bar chart showing data for different p1, p2, p3, and p4 with pO2 (mmHg) on the x-axis.]

**FIG. 30B**

[Bar chart showing data for different p1, p2, p3, and p4 with pO2 (mmHg) on the x-axis.]
**Fig. 30E**

- **NI**
- **Area C**

**Capillary Density (500 μm²)**

**Fig. 30F**

- **NI**
- **Area C**

**Capillary Density (500 μm²)**
FIG. 31A

FIG. 31B
FIG. 31C
STZ Deferoxamine

FIGURE 33A - 33B
METHOD OF TREATING OR PREVENTING PATHOLOGIC EFFECTS OF ACUTE INCREASES IN HYPERGLYCEMIA AND/OR ACUTE INCREASES OF FREE FATTY ACID FLUX

[0001] This application is a continuation in part of U.S. Ser. No. 11/136,254 filed May 24, 2005, which claims benefit to and priority from U.S. Provisional Patent Application Ser. No. 60/573,947, filed May 24, 2004.

FIELD OF THE INVENTION

[0002] The present invention relates to a method of treating or preventing pathologic effects of acute increases in hyperglycemia and/or acute increases of fatty acid flux in a subject.

BACKGROUND OF THE INVENTION

[0003] Cardiovascular Complications Associated with Diabetes are a Major Public Health Problem.


[0005] The greatest impact of diabetes is on the vascular system (Caro et al., “Lifetime Costs of Complications Resulting From Type 2 Diabetes in the U.S. Diabetes Care 25:476-81 (2002)). Diabetic patients have an increased risk for vascular disease affecting the heart, brain, and peripheral vessels (Howard et al., “Prevention Conference VI: Diabetes and Cardiovascular Disease: Writing Group I: Epidemiology,” Circulation 105:e132-7 (2002)). The relative risk of cardiovascular disease in diabetics is 2-8 times higher than age-matched controls (Howard et al., “Prevention Conference VI: Diabetes and Cardiovascular Disease: Writing Group I: Epidemiology,” Circulation 105:e132-7 (2002)). Diabetes accounts for 180 billion dollars in annual health costs in the U.S., with 85% of this amount attributable to vascular complications (Caro et al., “Lifetime Costs of Complications Resulting From Type 2 Diabetes in the U.S. Diabetes Care 25:476-81 (2002)). Indeed, if macrovascular complications (stroke, MI, TIAs, angina) and microvascular complications (nephropathy, neuropathy, retinopathy, wound healing) are considered together, the vast majority of diabetes related healthcare expenditures result from vasculopathies.

One of the reasons why diabetic patients have poor outcomes is because of impaired compensatory vascular growth.


[0007] The concept that these impairments result from a poorly adapting diabetic vasculature has both clinical and experimental support. Since angiogenesis and collateral development are the processes that restore blood flow to watershed areas of the heart, the rapid restoration of a normal vascular density in the microvasculature ultimately determines patient outcome following ischemia (Helfant et al., “Functional Importance of the Human Coronary Collateral Circulation,” N Engl J Med 284:1277-81 (1971); Chilian et al., “Microvascular Occlusions Promote Coronary Collateral Growth,” Am J Physiol 258:H1103-1 (1990)). Indeed, the theoretical basis for therapeutic angiogenesis is the belief that augmenting the microvascular network in ischemic and watershed areas of the heart would be beneficial. Clinical as well as experimental studies provide conclusive evidence that diabetes impairs ischemia-driven neovascularization (Abaci et al., “Effect of Diabetes Mellitus on Formation of Coronary Collateral Vessels,” Circulation 99:2239-42 (1999); Tooke, “Microvasculature in Diabetes,”


**TABLE 1**

<table>
<thead>
<tr>
<th>Study</th>
<th>Type of Study</th>
<th>Major Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abaci et al.</td>
<td>Clinical</td>
<td>Angiographic demonstration of decreased collaterals in the hearts of diabetic patients</td>
</tr>
<tr>
<td>Abaci et al.</td>
<td>Clinical</td>
<td>Cardiac failure is more common following an M1 in diabetic patients</td>
</tr>
<tr>
<td>Altavilla et al.</td>
<td>Experimental</td>
<td>Diabetic mice have less VEGF, less angiogenesis and impaired wound healing compared to normal mice</td>
</tr>
<tr>
<td>Aroz et al.</td>
<td>Clinical</td>
<td>Diabetes undergoing lower-extremity bypass maintain an impaired vascular reactivity even after successful surgical grafting, highlighting the limits of surgical interventions</td>
</tr>
<tr>
<td>Bradley et al.</td>
<td>Clinical</td>
<td>Diabetic patients have worse survival after an M1</td>
</tr>
<tr>
<td>Chou et al.</td>
<td>Experimental</td>
<td>First demonstration that myocardial tissue and cells from diabetic animals express less VEGF and its receptors</td>
</tr>
<tr>
<td>Frank et al.</td>
<td>Experimental</td>
<td>Diabetic mice express much less VEGF RNA and protein in their wounds</td>
</tr>
<tr>
<td>Goova et al.</td>
<td>Experimental</td>
<td>Blockade of the RAGE receptor accelerated wound healing, augmented VEGF expression, and increased angiogenesis in diabetic mice.</td>
</tr>
<tr>
<td>Guzik et al.</td>
<td>Clinical</td>
<td>Blood vessels from diabetic patients produce augmented levels of superoxide, a marker/cause of oxidative stress</td>
</tr>
<tr>
<td>Haffner et al.</td>
<td>Clinical</td>
<td>Diabetic patients have a greatly increased incidence of experiencing an M1 and dying from an M1</td>
</tr>
<tr>
<td>Hillier et al.</td>
<td>Clinical</td>
<td>Epidemiologic study suggesting that diabetic microangiopathy is greatly increased in diabetics</td>
</tr>
<tr>
<td>Jude et al.</td>
<td>Clinical</td>
<td>Diabetic patients have an increased incidence, severity, and poorer outcomes in peripheral arterial disease of the lower extremities</td>
</tr>
<tr>
<td>Kip et al.</td>
<td>Clinical</td>
<td>Angiographic and epidemiologic study demonstrating that diabetic patients have more diffuse atherosclerotic disease, and worse outcomes after seemingly successful interventional revascularization</td>
</tr>
<tr>
<td>Lerman et al.</td>
<td>Experimental</td>
<td>First demonstration that cells isolated from diabetic animals and patients produce attenuated levels of VEGF in hypoxia</td>
</tr>
<tr>
<td>Mantle et al.</td>
<td>Experimental</td>
<td>Monocytes from diabetic patients without retinopathy express less VEGF in hypoxia compared to monocytes from patients with diabetic retinopathy</td>
</tr>
<tr>
<td>Partumian et al.</td>
<td>Clinical</td>
<td>Diabetic patients have increased peri-infarct complications and decreased long-term survival</td>
</tr>
<tr>
<td>Rivard et al.</td>
<td>Experimental</td>
<td>Diabetes decreases reactive angiogenesis and tissue survival following hindlimb ischemia</td>
</tr>
<tr>
<td>Schatzteman et al.</td>
<td>Experimental</td>
<td>Angioblasts from diabetic humans show decreased proliferation and differentiation to mature endothelial cells in culture. Also, diabetic mice have less tolerance hindlimb ischemia than nondiabetic mice</td>
</tr>
<tr>
<td>Tepper et al.</td>
<td>Experimental</td>
<td>First demonstration that endothelial progenitor cells from diabetic patients show decreased function with assays that measure functions important for angiogenesis</td>
</tr>
</tbody>
</table>
TABLE 1-continued

<table>
<thead>
<tr>
<th>Study Type</th>
<th>Study Major Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical</td>
<td>Autopsy pathologic study demonstrating that diabetic patients have decreased ischemia-induced reactive angiogenesis</td>
</tr>
</tbody>
</table>


Ischemia-Induced Neovascularization Occurs by Two Mechanisms: Angiogenesis and Vasculogenesis.

[0008] After the appropriate hypoxic signaling cascade is initiated, compensatory vascular growth in response to ischemic insult occurs by two different mechanisms (FIG. 1). In angiogenesis, mature resident endothelial cells proliferate and sprout new vessels from an existing vessel in response to an angiogenic stimulus. In a more recently described mechanism, termed vasculogenesis, circulating cells with characteristics of vascular stem cells (endothelial progenitor cells, or EPCs) are mobilized from the bone marrow in response to an ischemic event, and then home specifically to ischemic vascular beds and contribute to neovascularization (Asahara et al., “Isolation of Putative Progenitor Endothelial Cells for Angiogenesis,” Science 275:964-7 (1997); Shi et al., “Evidence for Circulating Bone Marrow-Derived Endothelial Cells” Blood 92:362-7 (1998); Asahara at al., “Bone Marrow Origin of Endothelial Progenitor Cells Responsible for Postnatal Vasculogenesis in Physiological and Pathological Neovascularization,” Circ Res 85:2214 (1999); Isner et al., “Angiogenesis and Vasculogenesis as Therapeutic Strategies for Postnatal Neovascularization,” J Clin Invest 103:1231-6 (1999); Crosby et al., “Endothelial Cells of Hematopoietic Origin Make a Significant Contribution to Adult Blood Vessel Formation,” Circ Res 87:728-30 (2000); Pelosi et al., “Identification of the Hemangioblast in Postnatal Life,” Blood 100:3203-8 (2002)).

Hypoxia-Inducible Factor-4 (HIF-1) is the Central Mediator of the Hypoxia Response Including Subsequent Blood Vessel Growth.

[0009] The observation that ischemia regulates blood vessel growth has been known for many years, yet the responsible factor eluded identification until 1992, when Semenza and colleagues described a hypoxia-responsive transcription factor (HIF-1) which mediates erythropoietin gene upregulation (Semenza et al., “A Nuclear Factor Induced by Hypoxia via de Novo Protein Synthesis Binds to the Human Erythropoietin Gene Enhancer at a Site Required for Transcriptional Activation,” Mol Cell Biol 12:5447-54 (1992); Semenza et al., “Hypoxia-Inducible Nuclear Factors Bind to an Enhancer Element Located 3’ to the Human Erythropoietin Gene,” Proc Natl Acad Sci USA 88:5680-4 (1991)). HIF-1 proved to be a novel transcription factor conserved in all metazoan phyla and is ubiquitously present in all cells examined thus far (Carmeliet et al., “Abnormal Blood Vessel
Development and Lethality in Embryos Lacking a Single VEGF Allele,” *Nature* 380:435-9 (1996)). Evidence for its involvement in angiogenesis stemmed from the initial observation that VEGF was strongly upregulated by hypoxic conditions (Shweiki et al., “Vascular Endothelial Growth Factor Induced by Hypoxia May Mediate Hypoxia-Initiated Angiogenesis,” *Nature* 359:843-5 (1992)). Soon thereafter, HIF-1 was shown to be the transcription factor responsible for VEGF upregulation by hypoxia and hyperglycemia (Forsythe et al., “Activation of Vascular Endothelial Growth Factor, Gene Transcription by Hypoxia-Inducible Factor 1.” *Mol Cell Biol* 16:4604-13 (1996)). It is now clear that HIF-regulated VEGF expression is essential for vascular development during both embryogenesis and postnatal neovascularization in physiologic and pathologic states (Carmeliet et al., “Abnormal Blood Vessel Development and Lethality in Embryos Lacking a Single VEGF Allele,” *Nature* 380:435-9 (1996); Carmeliet et al., “Abnormal Blood Vessel Development and Lethality in Embryos Lacking a Single VEGF Allele,” *Nature* 380:435-9 (1996); Iyer et al., “Cellular and Developmental Control of O2 Homeostasis by Hypoxia-Inducible Factor 1 Alpha,” *Genes Dev* 12:149-62 (1998)). HIF-1 consists of the oxygen-regulated HIF-1α subunit and the HIF-1β subunit, which is not regulated by oxygen. HIF-1 is now believed to be the master transcription factor directing the physiologic response to hypoxia by upregulating pathways essential for adaptation to ischemia, including angiogenesis, vasculogenesis, erythropoiesis and glucose metabolism (FIG. 2).

Regulation of HIF-1α Transcriptional Activation.

**[0010]** The HIF-1 transcriptional complex is comprised of HIF-1α/β and more than seven other factors that modulate gene transcription. The two predominant functional components of this complex are HIF-1α and CBP/p300, which directly interact to transactivate gene expression. HIF-1α function is predominantly regulated by oxygen via protein stabilization and post-translational modification. Recent reports demonstrate that HIF-1α is activated by phosphorylation in vitro, enhancing HIF-mediated gene expression (Richard et al., “p42/p44 Mitogen-Activated Protein Kinases Phosphorylate Hypoxia-Inducible Factor I alpha (HIF-1 alpha) and Enhance the Transcriptional activity of HIF-1,” *J Biol Chem* 274:32631-7 (1999)). Whether this modification results in a direct stimulation of the transactivation function of HIF-1α itself or facilitates recruitment of co-activators is not clear (Richard et al., “p42/p44 Mitogen-Activated Protein Kinases Phosphorylate Hypoxia-Inducible Factor I alpha (HIF-1 alpha) and Enhance the Transcriptional activity of HIF-1,” *J Biol Chem* 274:32631-7 (1999); Seng et al., “Signaling Up-Regulates the Activity of Hypoxia-Inducible Factors by Its Effects on p300,” *J Biol Chem* 278:14013-9 (2003)).

**[0011]** It has also been recently demonstrated that CBP/p300 also undergoes phosphorylation in vitro, enhancing its ability to function as a transcriptional activator in association with HIF-1α (Sang et al., “Signaling Up-Regulates the Activity of Hypoxia-Inducible Factors by Its Effects on p300,” *J Biol Chem* 278:14013-9 (2003)). Thus, cellular states that promote phosphorylation of these two factors likely increase hypoxia-induced gene expression, while those that favor dephosphorylation have the opposite effect. Although HIF-1 mediated gene expression is essential for both angiogenesis and vasculogenesis, the role of its regulation in diabetic states has not been previously examined.

Both Angiogenesis and Vasculogenesis are Modulated by VEGF.

**[0012]** It is well known that angiogenesis is mediated by VEGF and this mechanism has been extensively investigated (Ferrara et al., “The Biology of VEGF and its Receptors,” *Nat Med* 9:669-76 (2003)). Recently, VEGF has also been implicated in regulation of vasculogenesis (FIG. 2). Ischemia is a potent mobilizer of endothelial progenitor cells from the bone marrow. This appears to be mediated through VEGF signaling, as EPCs express both VEGF receptor I and 2 on their cell surface (Asahara et al., “VEGF Contributes to Postnatal Neovascularization by Mobilizing Bone Marrow-Derived Endothelial Progenitor Cells,” *Embryo J* 18:3964-72 (1999); Takahashi et al., “Ischemia- and Cytokine-Induced Mobilization of Bone Marrow-Derived Endothelial Progenitor Cells for Neovascularization,” *Nat Med* 5:434-8 (1999); Kalka et al., “Vascular Endothelial Growth Factor(165) Gene Transfer Augments Circulating Endothelial Progenitor Cells in Human Subjects,” *Circ Res* 86:1198-202 (2000); Gill et al., “Vascular Trauma Induces Rapid but Transient Mobilization of VEGFR2(+)AC133(+) Endothelial Precursor Cells,” *Circ Res* 88:167-74 (2001); Halter et al., “Vascular Endothelial Growth Factor and Angiopoietin-1 Stimulate Postnatal Hematopoiesis by Recruitment of Vasculogenic and Hematopoietic Stem Cells,” *J Exp Med* 193:1005-14 (2001)). Given that VEGF production is impaired in diabetic mellitus, it seems likely that various aspects of vasculogenesis, including EPC mobilization, may also be impaired. Indeed, recent evidence has demonstrated that the incorporation of these vascular progenitors into blood vessels is decreased in diabetic states.

VEGF Expression May be Regulated in a Tissue-Specific Manner.

Factor Mediates Angiogenic Activity During the Proliferative Phase of Wound Healing.” Am J Pathol 152:1445-52 (1998)). This so-called “diabetic paradox,” by which the diabetic phenotype exhibits both excessive and impaired new blood vessel formation in different tissues, leads to different types of complications. It is believed that this phenomenon represents a cell- and tissue-specific difference in the transcriptional regulation of VEGF.

Hyperglycemia Results in Specific Impairments of Cellular Function Through Overproduction of Reactive Oxygen Species: a Potential Link to VEGF.

[0014] The cellular mechanism that accounts for impaired hypoxia-induced VEGF and SDF-1 expression has not yet been determined. Recently, the biochemical basis for hyperglycemia-induced cellular damage was described, demonstrating that many of the effects of high glucose are mediated through four specific cellular pathways (FIG. 3) (Brownlee, “Biochemistry and Molecular Cell Biology of diabetic Complications,” Nature 414:813-20; Nishikawa et al. “Normalizing Mitochondrial Superoxide Production Blocks Three Pathways of Hyperglycaemic Damage,” Nature 404: 787-90). Intracellular elevations in glucose increase flux of metabolites through glycolysis and Kreb’s cycle, resulting in overproduction of ROS by the mitochondria. Overproduction of ROS inhibits GAPDH activity, resulting in accumulation of early glucose metabolites in the initial phases of glycolysis. The abundance of these metabolites and their inability to progress through glycolysis causes shunting of these intermediates into alternative pathways of glucose utilization (polyol pathway, hexosamine pathway, protein kinase C pathway, and AGE pathway, FIG. 3). Accumulation of end products in each of these pathways leads to specific changes in cellular function, including gene expression (Nissen et al., “Vascular Endothelial Growth Factor Mediates Angiogenic Activity During the Proliferative Phase of Wound Healing” Am J Pathol 152:1445-52 (1998)), and are implicated in the pathophysiology of diabetic complications (Brownlee, “Biochemistry and Molecular Cell Biology of diabetic Complications,” Nature 414: 813-20; Nishikawa et al. “Normalizing Mitochondrial Superoxide Production Blocks Three Pathways of Hyperglycaemic Damage,” Nature 404: 787-90). Indeed, specific blockades of one or more of all of these pathways has been shown to prevent diabetic complications in an animal model, including those complications that result from ischemic injury (Hammes et al., “Benfotiamine Blocks Three Major Pathways of Hyperglycemic Damage and Prevents Experimental Diabetic Retinopathy,” Nat Med 9:294-9 (2003); Obrosova et al., “Aldose Reductase Inhibitor Fidaresat Prevents Retinal Oxidative Stress and Vascular Endothelial Growth Factor Overexpression in Streptozotocin-Diabetic Rats,” Diabetes 52:864-71 (2003)).

[0015] Hyperglycemia-induced reactive oxygen species also impair the ability of HIF-1α to mediate appropriate upregulation of VEGF and the chemokine SDF-1 that are required for neovascularization in ischemic settings. This impairment also affects hypoxia-specific functions of vascular effector cells. This results in impaired angiogenesis, vasculogenesis, and diminished tissue survival in diabetic states. Increased free fatty acid flux has been shown to increase ROS by identical mechanisms (Du t et al., “Insulin Resistance Causes Proatherogenic Changes in Arterial Endothelium By Increasing Fatty Acid Oxidation-Induced Superoxide Production” J. Clin. Invest. in press).

[0016] The present invention is directed to treating or preventing the pathologic sequelae of acute hyperglycemia and/or increased fatty acid flux in a subject, thus, preventing metabolite-induced reactive oxygen species-mediated injury.

SUMMARY OF THE INVENTION

[0017] One aspect of the present invention relates to a method of treating or preventing pathologic sequelae of acute hyperglycemia and/or increased fatty acid flux in non-diabetic subjects, metabolic syndrome/insulin resistance subjects, impaired fasting glucose subjects, impaired glucose tolerance subjects, and diabetic subjects. This method involves administering an ROS inhibitor to the subject under conditions effective to treat or prevent pathologic sequelae of acute hyperglycemia and/or increased fatty acid flux in the subject.

[0018] Another aspect of the present invention relates to a method of promoting neovascularization in a subject prone to hyperglycemia or increased fatty acid flux. This method involves administering an ROS inhibitor to the subject under conditions effective to promote neovascularization in the subject.

[0019] A further aspect of the present invention pertains to a method of inhibiting oxidation or excessive release of free fatty acids in a subject. This method involves administering to the subject certain compounds under conditions effective to inhibit excessive release of free fatty acids in the subject. These compounds include thiazolidinediones nicotinic acid, etomoxir, and ranolazine.

[0020] A further aspect of the present invention is directed to a method of identifying compounds suitable for treatment or prevention of ROS-mediated injury. This method involves providing a diabetic animal model and inducing diabetes in the animal model. A compound to be tested is then administered to the animal model. Compounds which achieve recovery of local oxygen tension, blood flow, increase in vessel density, and tissue survival in the animal model as therapeutic candidates for treating or preventing ROS-mediated injury are then recovered.

[0021] The present invention provides a means of restoring deficient angiogenesis in response to ischemia in patients with disorders of glucose and fatty acid metabolism. This would drastically reduce the rate of lower limb amputation, and reduce the extent of cardiac and brain damage due to heart attacks and strokes. In addition, it would result in healing of intractable diabetic foot ulcers, a major clinical problem for which there is currently no available effective medical treatment.

BRIEF DESCRIPTION OF THE DRAWINGS

[0022] FIG. 1 shows a schematic of angiogenesis and vasculogenesis.

[0023] FIG. 2 shows the central role of HIF and VEGF in the ischemic response.

[0024] FIG. 3 shows pathways of hyperglycemic damage.

[0025] FIG. 4 shows an overall experimental plan.

[0026] FIG. 5 shows a murine model of graded cutaneous ischemia. Regions A, B, and C reflect increasingly ischemic tissue regions, as measured by direct tissue oxygen tension at reference points p1 (27 mm Hg)-p5 (6 mm Hg).

[0027] FIG. 6 shows tissue survival in diabetic mice.
FIG. 7 shows oxygen tension measurements in ischemic tissue from least ischemic (p1) to most ischemic (p5) compared to normal skin oxygen tension (NL Skin).

FIG. 8 shows the number of blood vessels identified by CD31 staining in areas A, B, and C of ischemic flaps.

FIG. 9 shows oxygen tension measurements postoperatively in wild type and MnSOD transgenic mice with streptozotocin-induced diabetes.

FIG. 10 shows JC-1 staining of C2C12 myoblasts cultivated in normal glucose (5 mM), as well as acute and chronic high glucose (25 mM).

FIG. 11 shows VEGF mRNA in high and low glucose in response to hypoxia.

FIG. 12 shows VEGF mRNA half life in cells cultivated in normal glucose (●) or high glucose (○) conditions.

FIG. 13 shows VEGF promoter activity in C2C12 myoblasts in normal (5 mM, grey) and high glucose (25 mM, black) after hypoxic stimulus.

FIG. 14 shows HIF-1α is preferentially glycosylated in high glucose conditions (HG, 25 mM) compared to normal glucose (NG, 5 mM).

FIGS. 15 A-B show high glucose (30 mM) impairs the association between p300 and PPARY. This effect was abolished by inhibiting GPER.

FIGS. 16A-C show pathways of cellular damage resulting from reactive oxygen species can be selectively targeted and prevented.

FIGS. 17A-B show fibroblasts from diabetic mice do not demonstrate a normal hypoxia-induced increase in migration seen in non-diabetic cells (p<0.05).

FIGS. 18A-B show fibroblasts from diabetic mice produce more proMMP-9, but not active MMP-9 (p<0.001).

FIGS. 19A-D show FPCs from Type II diabetic proliferate less during expansion (A) which inversely correlated with HBA1c levels (B). Fewer FPC clusters formed in culture (C), which was also inversely correlated to the total number of years with diabetes.

FIGS. 20A-C show FPCs from Type II diabetic patients are impaired in their ability to adhere, migrate, and proliferate in response to hypoxic stimuli (κp<0.001, κκp<0.05).

FIG. 21 shows the effect of deferoxamine on hyperglycemia-induced ROS.

FIG. 22 shows the free intracellular iron measurement in bovine aortic endothelial cells after infection with UCP-1, Mn-SOD or empty adenoviral vectors and subsequent treatment with 5 mM or 30 mM glucose. The x-axis shows the different treatments. The y-axis shows fluorescence units indicating the amount of free iron.

FIGS. 23A-C show the free intracellular iron measurement in bovine aortic endothelial cells after incubation with 5 mM or 30 mM glucose (FIGS. 23A and 23B, respectively) or 30 mM glucose plus 100 μM deferoxamine (FIG. 23C) for 24 hours. Detection of free iron was accomplished by visualizing the fluorescent marker fura-2 AM.

FIGS. 24A-D show, respectively, DNA strand breakage in aortic endothelial cells after incubation with 5 mM or 30 mM glucose or 30 mM glucose plus 100 μM deferoxamine for 7 days.

FIG. 25 shows PARP activity in aortic endothelial cells after incubation with 5 mM or 30 mM glucose, 30 mM glucose plus 100 μM deferoxamine, or 30 mM glucose plus 100 μM DMSO for 6 days. 1H NAD incorporation was used to assess PARP activity. The x-axis shows the different treatments. The y-axis shows the PARP activity as measured in pmol/mg protein.

FIG. 26 shows prostacyclin synthase activity in aortic endothelial cells after 24 hour incubation with 5 mM or 30 mM glucose, or 30 mM glucose plus 100 μM deferoxamine. The x-axis shows the different treatments. The y-axis shows the prostacyclin synthase activity expressed as concentration of the prostacyclin synthase product PGI2-1α.

FIG. 27 shows prostacyclin synthase activity in aortas of diabetic and control mice after daily deferoxamine injections for 7 days. The x-axis shows the different treatments. The y-axis shows the prostacyclin synthase activity as measured by the concentration of the prostacyclin synthase product PGI2-1α.

FIG. 28 shows eNOS activity in aortic endothelial cells after incubation with 5 mM or 30 mM glucose or 30 mM glucose plus 100 μM deferoxamine for 24 hours. The x-axis shows the different treatments. The y-axis shows the eNOS activity as a function of 1H-citrulline generated per minute per 106 cells.

FIG. 29 shows eNOS activity in aortas of diabetic and control mice after daily deferoxamine injections for 7 days. The x-axis shows the different treatments. The y-axis shows the eNOS activity as a function of 1H-citrulline generated per minute per mg of protein.

FIGS. 30A-F show a diabetes-induced defect in mouse angiogenesis response to ischemia. FIGS. 30A-B show oxygenation levels in non-diabetic and diabetic mice, respectively. P1-P4 on the y-axis designate adjacent quadrants of the ischemic skin flap starting closest to the site of attachment to the animal, i.e., P1, and proceeding distally to P4. FIGS. 30C-D show mobilization of bone marrow-derived endothelial cells in response to ischemia. FIGS. 30E-F show the amount of capillary formation in non-diabetic and diabetic mice, respectively. N1 on the y-axis represents capillary density of a non-ischemic control. Area C on the y-axis represents the capillary density in an ischemic skin flap after 7 days.

FIGS. 31A-C show that deferoxamine treatment corrects the diabetes-induced defect in mouse angiogenesis response to ischemia. The treatment groups were wild-type mice (WT), streptozotocin-induced diabetic mice (shown as STZ in FIG. 31 C, and DM in FIGS. 31 A-B), and deferoxamine-treated streptozotocin-induced diabetic mice (shown as STZ+deferox in FIG. 31 C, and DM+DEF in FIGS. 31A-B).

FIG. 32 shows CD31 positive blood vessel counts in wild-type mice (WT C), wild-type mice treated with deferoxamine (WT Def C), streptozotocin-induced diabetic mice (STZ C), and streptozotocin-induced diabetic mice treated with deferoxamine (STZ Def C). The y-axis shows the CD31 positive blood vessel counts per hpf (high powered field).

FIGS. 33A-B show that deferoxamine treatment corrects the diabetes-induced defect in mouse angiogenesis response to ischemia. Diabetes was induced in the mice by streptozotocin (abbreviated STZ in FIG. 33 A-B). The mouse shown in FIG. 33A was treated with vehicle alone,
while the diabetic mouse shown in FIG. 33B was treated with deferoxamine (labeled as STZ Deferoxamine in FIG. 33 B).

[0055] FIGS. 34 A-C, and E show that diabetes-induces defects in mouse angiogenic response to ischemia. FIGS. 34B,D, and E that these defects are corrected by treatment with deferoxamine. FIGS. 34 A-B show oxygenation levels in streptozotocin-induced diabetic (FIG. 33 A) and deferoxamine-treated streptozotocin-induced diabetic mice (FIG. 33 B) respectively. PI-P4 on the y-axis designate adjacent quadrants of the ischemic flap starting closest to the site of attachment to the animal, i.e., P1, and proceeding distally to P4. FIGS. 34 C-D show mobilization of bone marrow derived endothelial cells in response to ischemia. Flk-1 on the y-axis is a marker for bone-marrow derived endothelial precursor cells. CD11b on the x axis is a general marker for bone-marrow derived cells of the myeloid, macrophage, and granulocytic lines. FIGS. 34 E-F show the amount of capillary formation in vehicle-treated streptozotocin-induced diabetic and deferoxamine-treated streptozotocin-induced diabetic mice respectively. NI on the y-axis represents capillary density of a non-ischemic control. Area C on the y-axis represents the capillary density at the most distal third of an ischemic skin flap after 7 days.

[0056] FIG. 35 is a bar chart showing EPC mobilization for control, STZ, and STZ-deferoxamine mice. EPC mobilization was determined at day 7 postischemic insult. Diabetes resulted in a 3-fold decrease in EPC mobilization. Deferoxamine restores ischemia specific EPC mobilization as compared to untreated STZ mice (p<0.05).

DETAILED DESCRIPTION OF THE INVENTION

[0057] One aspect of the present invention relates to a method of treating or preventing pathologic effects of acute increases in hyperglycemia and/or acute increases of fatty acid flux in non-diabetic subjects, metabolic syndrome/insulin resistance subjects, impaired fasting glucose subjects, impaired glucose tolerance subjects, and diabetic subjects. This method involves administering an ROS inhibitor to the subject under conditions effective to treat or prevent pathologic effects of acute increases in hyperglycemia and/or acute increases in fatty acid flux in the subject.

[0058] As noted above, in this aspect of the present invention, the claimed method can be applied to non-diabetic subjects, metabolic syndrome/insulin resistance subjects, impaired fasting glucose subjects, impaired glucose tolerance subjects, and diabetic subjects. In each case, the subject has a base line level of hyperglycemia and/or fatty acid flux. The present invention is directed to the prevention or treatment of pathologic conditions in subjects whose base line levels of hyperglycemia and/or fatty acid flux undergo a rapid and relatively short-term (i.e. acute) increase.

[0059] Subjects where acute increases in hyperglycemia and/or acute increases of fatty acid flux take place may be suffering from any of the following conditions: diabetes-specific microvascular pathology in the retina (i.e. diabetic retinopathy), renal glomerulus (i.e. diabetic nephropathy), peripheral nerve (i.e. diabetic neuropathy), accelerated athrotherosclerotic macrovascular disease affecting arteries that supply the heart, brain, and lower extremities (i.e. diabetic macrovascular disease), or nonalcoholic fatty liver disease ("NAFLD") which includes a wide spectrum of liver injury ranging from simple steatosis to steatohepatitis ("NASH"), fibrosis, and cirrhosis. The pathologic effect of acute increases in hyperglycemia and/or acute increases of fatty acid flux may also be prevented or treated where the subject has a critical care illness, an acute myocardial infarction, an acute stroke, or who has undergone arterial bypass or general surgery.

[0060] Acute increases in hyperglycemia and/or acute increases of fatty acid flux impairs mobilization of vascular endothelial cell precursors from the bone marrow. This may take the form of impairing mobilization of vascular endothelial cell precursors from the bone marrow, impairing HIF-1α and SDF-1-mediated upregulation of vascular endothelial growth factor, and/or ROS-mediated injury which inhibits neovascularization. The subject can also have an ischemic condition which includes coronary artery disease, peripheral vascular disease, cerebral vascular disease, non-healing foot ulcers, or a wound (acute or chronic).

[0061] The ROS generation by hyperglycemia or increased fatty acid flux takes place in the mitochondria. The most common ROS are hydrogen peroxide (H₂O₂), hydroxyl radicals (OH·), lipid peroxy radicals (LOO·), and peroxynitrates (ONOO·)

[0062] H₂O₂ is relatively stable and can diffuse through membranes. In most cells, H₂O₂ is detoxified by enzymatic reduction to H₂O and O₂. In mitochondria, the enzyme glutathione peroxidase is primarily responsible for this reaction. In the cytosol and peroxisomes, both glutathione peroxidase and the enzyme catalyse mediate this reaction. However, in the presence of free d-block transition metals, such as iron, the oxidized form of the metal is thought to react with superoxide, producing the oxidized form of the metal and molecular oxygen (O₂). The reduced metal then reacts with H₂O₂ to regenerate the initial oxidized metal, hydroxyl ions (OH·) and hydroxyl radicals (OH·). It is important to note, however, that this chemistry is still far from being understood.

[0063] It is well known that iron and other d-block transition metals can function as free-radical catalysts, potentially generating toxic species such as hydroxyl radicals. Transition metals are the large block of elements in the Periodic Chart that have group numerical designations ending with B, such as IB, IIIB, IIIIB, and so on. They are the four rows of ten elements located in the heart of the chart. They are also the elements whose final electron enter the d orbital (called d-block metals). All first row d-block metals (except zinc) have unpaired electrons (Sc, Ti, V, Cr, Mn, Fe, Co, Ni, and Cu) which removes spin restrictions and allows then to function in free radical catalysis, both as elements bound at the active site of enzymes, and free in solution.

[0064] Iron has been the focus of many chemical studies because this chemistry was first demonstrated by H. J. H. Fenton in 1876 using unchelated Fe²⁺/H₂O₂ mixture in aqueous solution. To distinguish between the iron (II) and iron (III) combinations, the convention is to use Fenton-like reagent for the Fe³⁺/H₂O₂ mixture and restrict the use of Fenton’s reagent to denote the Fe²⁺/H₂O₂. The Fenton-like reagent is also capable of oxidizing organic substrates, but it is somewhat less reactive than Fenton’s reagent. As iron(III) can be produced in applications of Fenton’s reagent, Fenton chemistry and Fenton-like chemistry often occur simultaneously.

[0065] Fenton reagent chemistry is still far from being fully understood, and Fenton-like reagent chemistry even
less well understood. Numerous reaction mechanisms have been proposed for Fenton reagent chemistry based on different active intermediates such as OH- and OOH. radicals and high-valent iron species. Haber and Weiss’s OH. radical mechanisms (citation) is probably the most popular candidate for the Fenton reaction:

\[
\text{Fe}^2+\text{H}_2\text{O}_2\rightarrow\text{Fe}^3+\text{H}_2\text{O}+\text{OH}^-
\]

[0066] A popular alternative mechanistic candidate is that first suggested by Bray and Gorin (citation), in which the ferrous ion, [Fe(F)O]^2-, is supposed to be the active intermediate:

\[
\text{Fe}^2+\text{H}_2\text{O}_2\rightarrow[\text{Fe}(\text{F})\text{O}]^+\text{H}_2\text{O}
\]

[0067] In addition to reducing hydrogen peroxide, ferrous iron can also react with alkyld hydroperoxides, to produce alkoxyl radicals. These alkoxyl radicals can then initiate the oxidation of polyunsaturated lipids by a free radical chain reaction (citation).

[0068] Despite its appearance in numerous biochemistry textbooks, the biological significance of the Fenton chemistry has been questioned by many free radical chemists in part because the rate constants for the reaction of reduced metals and their complexes with H2O2 are not rapid, and their in vivo metal ligands are unknown (citation). However, it has been shown recently that 

\[
\text{HCO}_3^-\text{ and CO}_2 \text{ greatly accelerate the rate of \ } \text{H}_2\text{O}_2 \text{ reduction by Mn}^2+ \text{ and other transition metals (citation). It is probable that many of the proposed mechanisms compete with each other in complex and unpredictable ways, depending on the reaction conditions, such as the metal ligands, their valence, the solvent, the pH and the organic substrate to be oxidized (citation).}
\]

[0069] The ROS inhibitor can be alpha lipoic acid, a superoxide dismutase mimetic, or a catalase mimetic. The superoxide dismutase mimetic or the catalase mimetic can be MnTBAP (Mn(III)tetrakis[4-benzoic acid]porphyrin chloride) (produced by Calbiochem), ZnTBAP (Zn(III)tetrakis[4-benzoic acid]porphyrin chloride), SC-5558 (manganese (II) dichloro (2SR,3SR,RR,9R-bis-cyclohexano-1,4,7,10,13-pentaazacyclododecane) or Euk-134 (3,3'-methoxyoxalnMn(III)) (produced by Eukarion).

[0070] Alternatively, the ROS inhibitor can be an iron chelator or a composition comprising a mixture of iron chelators. Chelators are small molecules that bind very tightly to metal ions. The key property shared by all chelators is that the reactivity of the metal ion bound to the chelator is greatly reduced, although in some cases and under certain conditions, chelator-metal complexes themselves can generate reactive oxygen free radicals. Clinically useful chelators must be highly specific for one d-block transition metal such as iron. Chelators which are non-specific are highly toxic.

[0071] The basic property of a chelator consists in having the ability of forming a heterocyclic ring structure with a metal ion as the closing member. The chelator must possess two or more functional groups (ligands) with atoms which can donate a pair of electrons for the formation of a bond with the metal ion. Donor atoms are usually N, O and S, which can function either as members of an acidic group such as: —COOH, OH (phenolic, enolic), —SH, —NH—O, —NOH in which case the proton is displaced by the metal ion, or as lone pair of electron donors (Lewis base) such as: —C—O, —NH2, —O—R, —OH (alcoholic), —S-thio-

[0072] Ideally, tight binding of iron to a chelator should completely inhibit its ability to function as a free-radical catalyst. Iron chelators are classified according to the stoichiometry of binding with iron. Iron ions have six-electrochemical coordination sites. Thus, a chelator molecule that binds to all six sites in a 1:1 ratio is called “hexidentate.” A chelator molecule that binds to only two of the six sites is called “bidentate,” and chelators that bind to three of the six sites are called “tridentate.” In theory, three molecules of a bidentate chelator should reduce free iron reactivity as completely as one molecule of a hexidentate chelator. However, with bidentate iron chelators, formation of an intermediate catalyzing partial reduction products often occurs. Practically, this means that a large chemical excess of such chelators is needed in order to avoid the formation of these reactive chelator iron complexes.

[0073] Iron chelators can be classified using a number of criteria such as their origin (synthetic versus biologically produced molecules), their interaction with solvents such as water (hydrophobic versus hydrophilic) or their stoichiometric interaction (bidentate versus hexadentate).

[0074] A general structure of an effective iron chelator comprises the generic structure R-L-C-M and all the combinations thereof.

[0075] For example, C can represent the iron-chelating moiety bi, tri or hexidentate characterized by selective iron-binding affinity and avidity as described in Current Medicinal Chemistry, 2004, 11, 2161-2183. The combination C-M can represent a bi-functional drug structure containing an iron-chelating moiety C bound to a masking group M which could be an electron-donor atom or other low valent hydroxyl radicals OH. can be reduced by the electrons of M, cleave M from C which, once unmasked, can bind free iron ions.

[0076] The combination R-C can represent the iron chelating moiety C bound to a backbone side-chain R, wherein R can be H, a linear aliphatic chain structure, or an aliphatic chain including aromatic, aliphatic and/or heterocyclic rings. Because the relative potency of chelators appears to be related to the hydrophilicity of the molecule, the chemical structure of R can facilitate or hinder the penetration of the chelators in target cells and/or target cell compartments. Finally, the combination R-L-C can represent the iron chelating moiety C bound to a side-chain R through a linker L. The linker L can facilitate a rapid cellular intake and delay the cellular exit of C as described in J. Am. Chem. Soc. 2002, 124, 12666-12667, incorporated herein by reference in its entirety. For example, R-L-C can represent a polyhydrophilic drug (a pro-drug). L can be an ester bond, R an ester moiety and C an iron chelating moiety. Upon entrance in the cell, R-L-C can turn highly hydrophilic upon esterase-mediated hydrolysis of the lipophilic moiety R. Thus, L is hydrolyzed, C is chemically detached from the molecule and the more hydrophilic C is retained inside the cell where it can perform its chelating function.

[0077] Other general structures of effective iron chelators comprise the family of 3,5-diphenyl-1,2,4-triazoles of the formula I described in U.S. Pat. No. 6,465,504 incorporated herein by reference in its entirety.
Of the iron chelators, deferoxamine or DFO may be the most important, because it is FDA-approved for treatment of iron excess in thalassemia.

When deferoxamine is employed, a patient (e.g., a patient with an acute myocardial infarction) can be treated with intramuscular injections of 1,000 to 10,000 mg of deferoxamine or with intravenous injections of 100 to 10,000 mg of deferoxamine. Such patients can be treated within 24 hours of symptoms by intravenous injection of deferoxamine in liquid form at a concentration between 100 to 10,000 mg/liter of deferoxamine. Deferoxamine can also be administered together with DFP, ICL-670, a poly (ADP-ribose) polymerase inhibitor, and a glucagon-like peptide-1 fragment that prevents hyperglycemia-induced ROS production, for example, GLP-1 (9-36 amide), and GLP-1 9-37).

Alternatively, deferoxamine can be administered together with a poly (ADP-ribose) polymerase inhibitor including, but not limited to, nicotinamide, 3-aminobenzamide, P134 (N-(6-oxo-5,6-dihydro-phenanthridin-2-yl)-N N-dimethyl-acetamide), and mixtures thereof.

While deferoxamine can provide life-saving treatment for patients in iron overload situations, numerous deferoxamine derivatives can also be employed. Aliphatic, aromatic, succinic, and methyl/sulphonic analogs of DFO have been synthesized to enhance the lipophilicity of DFO (Ihnat et al., “Solution Equilibria of Deferoxamine Amides,” J. Pharm Sci. 91:1733-1741 (2002), which is hereby incorporated by reference in its entirety). Specifically, these derivatives include formamide-deferoxamine, acetamide-deferoxamine, propylamide deferoxamine, butylamide-deferoxamine, benzylamide-deferoxamine succinamide-deferoxamine, and methylsulfonamide-deferoxamine. Hydroxyethyl starch (HES)-deferoxamine has been synthesized which was shown to have a greater plasma half-life than deferoxamine (Pecchenko et al., “Desferrioxamine Suppresses Experimental Allergic Encephalomyelitis Induced by MBP in SJL mice,” J. Neuroimmunol. 84:188-197 (1998), which is hereby incorporated by reference in its entirety). An aminoxyacetyl-ferroxamine has also been prepared allowing for site-specific conjugation to antibodies (Pochon et al., “A novel Derivative of the Chelone Desferrioxamine for Site-specific Conjugation to Antibodies,” Int. J. Cancer. 43:1188-1194 (1989), which is hereby incorporated by reference in its entirety. Fluorescent deferoxamine derivatives have also been synthesized for free iron measurements in a range of biological experimental conditions (Al-Mehdi et al., “Depolarization-associated iron release with abrupt reduction in pulmonary endothelial shear stress in situ,” Antioxid. Redox Signal. 2:335-345 (2000), which is hereby incorporated by reference in its entirety.

Other suitable iron chelators include those set forth in Table 2:

<table>
<thead>
<tr>
<th>Name</th>
<th>Formula</th>
<th>Chem. structure</th>
<th>MW</th>
<th>Dose</th>
<th>Route</th>
</tr>
</thead>
<tbody>
<tr>
<td>DFO</td>
<td>4-(13,5-</td>
<td><img src="image" alt="DFO structure" /></td>
<td>560</td>
<td>6</td>
<td>parent al</td>
</tr>
<tr>
<td>HBED</td>
<td>N,N- bis[(hydroxy</td>
<td><img src="image" alt="HBED structure" /></td>
<td>388</td>
<td>6</td>
<td>oral/ parent al</td>
</tr>
<tr>
<td>PIH</td>
<td>pyrido-</td>
<td><img src="image" alt="PIH structure" /></td>
<td>262</td>
<td>3</td>
<td>oral</td>
</tr>
</tbody>
</table>
### PHARMACOLOGY

<table>
<thead>
<tr>
<th>Name</th>
<th>Formula</th>
<th>Chem. Structure</th>
<th>MW</th>
<th>Dose</th>
<th>Route</th>
</tr>
</thead>
<tbody>
<tr>
<td>DPT</td>
<td>4'-hyd-</td>
<td><img src="image" alt="DPT_structure" /></td>
<td>238</td>
<td>3</td>
<td>oral</td>
</tr>
<tr>
<td>DFP</td>
<td>1,2-</td>
<td><img src="image" alt="DFP_structure" /></td>
<td>139</td>
<td>2</td>
<td>oral</td>
</tr>
<tr>
<td>S-DFO</td>
<td>hydroxy-ethyl-starch-bound-deferoxamine</td>
<td><img src="image" alt="S-DFO_structure" /></td>
<td>250,000</td>
<td>6</td>
<td>i.v.</td>
</tr>
<tr>
<td>ICL-</td>
<td>4-(3,5-</td>
<td><img src="image" alt="ICL_structure" /></td>
<td>373</td>
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<td>oral</td>
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<tr>
<td>670</td>
<td>bis-(hy-</td>
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<td></td>
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<tr>
<td></td>
<td>droxy-</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>GT56-</td>
<td>4,5-di-</td>
<td><img src="image" alt="GT56_structure" /></td>
<td>252</td>
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</tr>
<tr>
<td>252</td>
<td>hydroxy-2-</td>
<td></td>
<td></td>
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<td></td>
<td>(2,4-</td>
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<tr>
<td></td>
<td>dihy-</td>
<td></td>
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<tr>
<td></td>
<td>droxi-</td>
<td></td>
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<tr>
<td></td>
<td>lphenyl-</td>
<td></td>
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<td></td>
<td>4-</td>
<td></td>
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<tr>
<td></td>
<td>methyl-thio-</td>
<td></td>
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<tr>
<td></td>
<td>car-</td>
<td></td>
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<tr>
<td></td>
<td>boxylic</td>
<td></td>
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</tbody>
</table>

[0082] HEBED is a synthetic chelator that appears to have higher efficacy than DFO, and fewer adverse effects. However, in primate studies, it still had to be administered by subcutaneous infusion (Chaston, et al., “Iron Chelators for the Treatment of Iron Overload Disease: Relationship Between Structure, Redox Activity, and Toxicity” *Am J Hematol.* 73:200-210 (2003), which is hereby incorporated by reference in its entirety.)
PIH is an orally active, triedentate chelator which crosses membranes much better than does DFO. PCHI (i.e., analogues of 2-pyridylcarboxaldehyde isonicotinoyl hydrazone) compounds (which are not shown in Table 2) are substantially similar to PIH. This class of chelators can also access mitochondrial iron pools, making it a potential drug for the rare genetic disease Friedrich’s Ataxia (caused by a mutation in the mitochondrial iron-sulfur complex chaperone frataxin).

Like HBED, DFT and GT56-252 are both second generation hydroxyypyridones that are in preclinical or phase I trials.

DEP or Deferiprone, is approved for clinical use in Europe under the trade name Ferriprox. It is a bidentate chelator that is administered orally. However, the efficacy and toxicity of the drug are still controversial. Combined use of DFO and DEP has been proposed.

S-DFQ is a starch-bound DFO derivative that has a longer half-life after intravenous administration.

ICL-670 is a tridentate chelator of the triazole family currently in phase II trials. It is orally available and is administered once a day (Hershko, C., et al., Blood 97:1115-1122 (2001), which is hereby incorporated by reference in its entirety).

Another class of iron chelator is the biomimetic class (Meijer, M M, et al. “Synthesis and Evaluation of Iron Chelators with Masked Hydrophilic Moieties” J. Amer. Chem. Soc. 124:1266-1267 (2002), which is hereby incorporated by reference in its entirety). These molecules are modified analogues of such naturally produced chelators as DFO and ferriochrome. The analogues allow attachment of lipophilic moieties (e.g., acetoxymethyl ester) which greatly enhance passage through membranes. The lipophilic moieties are then cleaved intracellularly by endogenous esterases, converting the chelators back into hydrophilic molecules which cannot leak out of the cell. These compounds appear to be highly effective, and reduce free-iron mediated oxidative damage much more efficiently than does DFO.

Lastly, a number of compounds developed as inhibitors of advanced glycation endproduct (AGE) formation and/or degradation and tested in animal models of diabetic complications appear to act via chelation (Price, D L., et al., JBC 276:48967-72 (2001), which is hereby incorporated by reference in its entirety). These include (in order from weakest to strongest copper chelation): aminoguanidine and pyridoxamine, carnosine, phenazineimidine, OPB-9195, and tenuistatin. The so-called AGE-breakers, phenacylthiazolium and phenacylimethylthiazolium bromide, and their hydrolysis products, were among the most potent inhibitors of copper-catalyzed autoxidation of ascorbate. Aminoguanidine has been through Phase II/III trials, pyridoxamine has been through Phase II trials, and the AGE breakers are currently in Phase II trials.

The inhibitors can be administered orally, parenterally, transmurally, subcutaneously, intravenously, intramuscularly, intraperitoneally, by intravascular instillation, intracutaneously, intranasally, intraocularly, intralesionally, or by application to mucous membranes, such as that of the nose, throat, and bronchial tubes. The inhibitors can be administered alone or with a pharmaceutically acceptable salt, carrier, excipient, or stabilizer, and can be in solid or liquid form, including, for example, tablets, capsules, powders, solutions, suspensions, or emulsions.

The solid unit dosage forms can be of the conventional type. The solid form can be a capsule, such as an ordinary gelatin type containing the inhibitors of the present invention and a carrier, for example, lubricants and inert fillers such as lactose, sucrose, or cornstarch. In another embodiment, the inhibitors are tableted with conventional tablet bases such as lactose, sucrose, or cornstarch in combination with binders like acacia, cornstarch, or gelatin, disintegrating agents such as, cornstarch, potato starch, or alginate acid, and a lubricant like stearic acid or magnesium stearate.

In another aspect, the inhibitors of the present invention may be orally administered, for example, with an inert diluent, or with an assimilable edible carrier, or they may be enclosed in hard or soft shell capsules, or they may be compressed into tablets, or they may be incorporated directly with the food of the diet. For oral therapeutic administration, the inhibitors of the present invention may be incorporated with excipients and used in the form of tablets, capsules, elixirs, suspensions, syrups, and the like. In one aspect, such formulations should contain at least 0.1% of the inhibitors of the present invention. The percentage of the inhibitors in the formulations of the present invention may, of course, be varied and may conveniently be between about 2% to about 60% of the weight of the unit. The amount of inhibitors in the formulations of the present invention is such that a suitable dosage will be obtained. As one example, formulations according to the present invention are prepared so that an oral dosage unit contains between about 1 and 250 mg of the inhibitors.

The tablets, capsules, and the like may also contain a binder such as gum tragacanth, acacia, corn starch, or gelatin; excipients such as dicalcium phosphate; a disintegrating agent such as corn starch, potato starch, alginic acid; a lubricant such as magnesium stearate; and a sweetening agent such as sucrose, lactose, or saccharin. When the dosage unit form is a capsule, it may contain, in addition to materials of the above type, a liquid carrier, such as a fatty oil.

Various other materials may be present as coatings or to modify the physical form of the dosage unit. For instance, tablets may be coated with shellac, sugar, or both. A syrup may contain, in addition to active ingredient, sucrose as a sweetening agent, methyl and propylparabens as preservatives, a dye, and flavoring such as cherry or orange flavor.

As described above, in one aspect of the present invention, the formulations containing the inhibitors may be administered parenterally. Solutions or suspensions of the inhibitors can be prepared in water suitably mixed with a surfactant, such as hydroxypropylcellulose. Dispersions can also be prepared in glycerol, liquid polyethylene glycols, and mixtures thereof in oils. Illustrative oils are those of petroleum, animal, vegetable, or synthetic origin, for example, peanut oil, soybean oil, or mineral oil. In general, water, saline, aqueous dextrose and related sugar solution, and glycols such as propylene glycol or polyethylene glycol, are preferred liquid carriers, particularly for injectable solutions. Under ordinary conditions of storage and use, these preparations contain a preservative to prevent the growth of microorganisms.

When the inhibition is deferoxamine, deferoxamine compositions for parenteral use can be in the form of a solution or a suspension. Such solutions or suspensions may
also include sterile diluents such as water for injection, saline solution, fixed oils, polyethylene glycols, glycerine, propylene glycol or other synthetic solvents. Parenteral formulations may also include antibacterial agents such as benzyl alcohol or methyl parabens, or antioxidants such as a sodium bisulfite. Buffers such as acetates, citrates, or phosphates and agents for the adjustment of tonicity such as sodium chloride or dextrose may also be added. The parenteral preparation can be enclosed in ampules, disposable syringes, or multiple dose vials made of glass or plastic.

[0097] The pharmaceutical forms suitable for injectable use include sterile aqueous solutions or dispersions and sterile powders for the extemporaneous preparation of sterile injectable solutions or dispersions. In all cases, the form must be sterile and must be fluid to the extent that easy syringability exists. It must be stable under the conditions of manufacture and storage and must be preserved against the contaminating action of microorganisms, such as bacteria and fungi. The carrier can be a solvent or dispersion medium containing, for example, water, ethanol, polyol (e.g., glycerol, propylene glycol, and liquid polyethylene glycol), suitable mixtures thereof, and vegetable oils.

[0098] Slow-release deferoxamine compositions for intramuscular administration may be formulated by standard methods, such as a microcrystalline composition. Deferoxamine preparations with longer half-lives may be formulated by conjugation of deferoxamine with, for example, dextran or polyethylene glycols. In addition, deferoxamine derivatives with great ability to permeate cell membranes can be made by linking deferoxamine to a lipophilic ester moiety such as acetyloxymethyl ester, which is then removed by intracellular esterases once the compound is inside the cell (Meijler et al., “Synthesis and Evaluation of Iron Chelators with Masked Hydrophilic Moieties”, J. Am. Chem. Soc. 124:1266-1267 (2002)).

[0099] The formulations containing the inhibitors of the present invention may also be administered directly to the airways in the form of an aerosol. For use as aerosols, the inhibitors of the present invention in solution or suspension may be packaged in a pressurized aerosol container together with suitable propellants, for example, hydrocarbon propellants like propane, butane, or isobutane with conventional adjuvants. The inhibitors of the present invention also may be administered in a non-pressurized form such as in a nebulizer or atomizer.

[0100] In carrying out this method, an ROS-mediated injury can be treated or prevented. Hyperglycemic conditions which can be so treated or prevented include chronic hyperglycemia. This includes hyperglycemic diabetes or acute hyperglycemia (such as stress hyperglycemia). Resistance to insulin is another form of a metaboliite-induced excessive ROS production in accordance with this aspect of the present invention. This can be where there is resistance to insulin resulting in increased free fatty acid flux and increased free fatty acid oxidation by vascular cells.

[0101] Another aspect of the present invention relates to a method of promoting neovascularization in a subject prone to hyperglycemia or increased fatty acid flux. This method involves administering an ROS inhibitor to the subject under conditions effective to promote neovascularization in the subject.

[0102] Here, neovascularization can be in response to hypoxic signaling, and involve both angiogenesis (e.g. cardiac or lower limb) or vasculogenesis. The subject can have an ischemic condition, such as coronary artery disease, peripheral vascular disease, cerebral vascular disease, or a wound which is either chronic or acute.

[0103] The ROS inhibitor, its formulation, and its modes of administration for this embodiment of the present invention are the same as those described above.

[0104] Here the subject is preferably a human prone to hyperglycemia or fatty acid flux.

[0105] A further aspect of the present invention pertains to a method inhibiting oxidation or excessive release of free fatty acids in a subject. This method involves administering to the subject certain compounds under conditions effective to inhibit oxidation excessive release of free fatty acids in the subject. These compounds include thiazolidinedione, nicotinic acid, etomoxir, and ranolazine.

[0106] In this embodiment of the present invention, the above-identified compounds are formulated and administered in substantially the same way as noted above.

[0107] In this aspect of the present invention, the subject is a mammal, preferably a human.

[0108] A further aspect of the present invention is directed to a method of identifying compounds suitable for treatment or prevention of ROS-mediated injury. This method involves providing a diabetic animal model and inducing diabetes in the animal model. A compound to be tested is then administered to the animal model. Compounds which achieve recovery of local oxygen tension, blood flow increase in vessel density, and tissue survival in the animal model as therapeutic candidates for treating or preventing ROS-mediated injury are then recovered.

EXAMPLES

Example 1—Three Different Murine Models of Diabetes Exhibit Increased Tissue Necrosis in Response to Ischemia

Analysis,” Arch Dermatol 136:1531-5 (2000), which are hereby incorporated by reference in their entirety. Clinically, this results in increased rates of heart failure, increased mortality and prolonged wound healing. While this relationship has been studied in animal models of cardiac and hindlimb ischemia (Rivard et al., “Rescue of Diabetes-Related Impairment of Angiogenesis By Intramuscular Gene Therapy With Adeno-VEGF,” Am J Pathol 154:355-63 (1999); Schratzerberger, et al., “Reversal of Experimental Diabetic Neuropathy by VEGF Gene Transfer,” J Clin Invest 107:1083-92 (2001), which are hereby incorporated by reference in their entirety), there are limitations to these models. Due to the variations in large vessel anatomy, the resultant pattern of necrosis is unpredictable, leading to discrepancies in the experimental results. In addition, it is not possible to determine tissue survival except at sacrifice. Furthermore, indirect measures of perfusion such as a laser doppler must often be utilized to estimate ischemia, but these techniques do not provide direct information regarding tissue oxygenation.

[0110] To address these problems, a novel model of graded ischemia in the dorsal soft tissue of mice has been created (FIG. 5) (Teppe et al., “Human Endothelial Progenitor Cells From Type II Diabetics Exhibit Impaired Proliferation, Adhesion, and Incorporation Into Vascular Structures,” Circulation 106:2781-6 (2002), which is hereby incorporated by reference in its entirety). Since the vascular anatomy of the mouse dorsum is precisely known, and the major axial vessels can be easily visualized, one can create a reliable zone of ischemia with a reproducible oxygen gradient in the tissue. This has been confirmed with direct tissue oxygen tension measurements utilizing five reference points (p1-p5) spaced 0.5 cm apart proceeding from the least to most ischemic regions. This also allows for the study of discrete microenvironments of ischemia (Areas A, B, C), with Area A being the least ischemic and Area C being the most ischemic portion of the soft tissue. The design of this model facilitates direct dynamic measurement of oxygen tension, quantification of tissue survival, with a degree of reproducibility that allows correlation of specific oxygen tensions with changes in gene expression.

[0111] Using this model, it has been observed that the response too ischemia is dramatically impaired in three different murine models of diabetes, all characterized by significant hyperglycemia. In the db/db mouse, a leptin receptor deficient model of Type 2 diabetes, it has been demonstrated that ischemia produces significant necrosis of nearly all of the tissue, whereas all the tissue survived in non-diabetic animals. Similar results were noted in the streptozotocin-induced diabetic mouse model (Stz), as well as an Akita mouse model of Type 1 diabetes with tissue survival approximately 30% of that observed in non-diabetic mice (FIG. 6). Importantly, oxygen tensions and vascular density (as determined by CD31 staining and FITClectin perfusion) were identical in all four groups prior to surgery, suggesting that the differences in tissue survival were due to an impaired response to ischemia rather than baseline differences in vascular density.

Example 2—Diabetic Mice have a Diminished Neovascular Response to Ischemia

[0112] The decrease in tissue survival observed in this model was also associated with diminished neovascularization in the surviving tissue. Seven days following surgery, the oxygen tension in ischemic soft tissue of non-diabetic mice approaches that of normal skin (FIG. 7, grey plot), while the diabetic mice demonstrate a significant reduction in oxygen tension at the same reference points (black plot). These findings correlated with a reduction in the number of blood vessels observed in the surviving tissue in diabetic mice (FIG. 8, black plot) as determined by CD31 staining. This suggests that ischemia-induced neovascularization is impaired in diabetic mice.

Example 3—Prevention of Hyperglycemia-Induced Reactive Oxygen Species Restores Tissue Survival in a Diabetic Animal Model

[0113] It has been examined whether increased oxidative damage was an upstream modulator of the impaired tissue response to ischemia in diabetic animals. To address this question, a transgenic mouse that overexpress mitochondrial manganese superoxide dismutase (MnSOD) was used. MnSOD catalyzes the formation of molecular oxygen from superoxide, preventing the generation of ROS, and effectively blocks all four pathways of hyperglycemic damage. Diabetes was induced in wild type and MnSOD transgenic mice via streptozotocin injection, and hyperglycemia (>400 mg/dl) was maintained for one month. Following ischemic surgery, tissue was monitored by direct oxygen tension measurements on days 1, 3, and 7. Compared to wild type diabetic mice, MnSOD diabetic mice demonstrated a rapid recovery of local tissue oxygen tensions, neovascularization, and increased tissue survival that was similar to that observed in non-diabetic mice (FIG. 9). Non-diabetic MnSOD control mice were similar to wild type mice. This suggests that the prevention of hyperglycemia-induced ROS improves tissue survival in diabetic animals following ischemic events.

Example 4—Chronic High Glucose Levels Also Correlate with Increased Mitochondrial Membrane Potential

[0114] The effects of high glucose culture on mitochondrial membrane potential were also examined in C2C12 cells exposed to acute or chronic high glucose using the potential-dependent cationic dye JC-1. This has been used as an indicator of oxidative stress. In concordance with recent reports (Du et al., “Hyperglycemia Inhibits Endothelial Nitric Oxide Synthase Activity by Posttranslational Modification at the Akt Site,” J Clin Invest 108:1341-8 (2001), which is hereby incorporated by reference in its entirety), chronic high glucose profoundly increases the mitochondrial proton electrochemical gradient (evidenced by a shift to orange-red fluorescence) compared to normal glucose culture or acute exposure to high glucose (FIG. 10) (Du et al., “Hyperglycemia Inhibits Endothelial Nitric Oxide Synthase Activity by Posttranslational Modification at the Akt Site,” J Clin Invest 108:1341-8 (2001), which is hereby incorporated by reference in its entirety). Thus, a correlation exists between hyperglycemia, oxidative stress, and VEGF impairment in vitro.

Example 5—Impaired VEGF Production Lies at the Level of RNA Transcription

[0115] With evidence implicating decreased VEGF production as a contributor to impaired angiogenesis in hyperglycemia states, the mechanism by which high glucose alters
VEGF expression was examined. Analysis of VEGF mRNA transcripts present in normal and high glucose culture under hypoxic conditions revealed a substantial reduction in VEGF mRNA production in cells cultivated in high glucose (FIG. 11). Possible explanations for this finding included abnormal mRNA stabilization or decreased promoter activity in high glucose. To address the issue of mRNA stabilization, the RNA half-life in C2C12 myoblasts was examined by inhibiting transcription with actinomycin D. Results of these experiments showed no differences in VEGF mRNA stability between normal and hyperglycemic cells despite significant differences in VEGF protein levels (FIG. 12). VEGF promoter activity was then examined using a reporter construct containing the full length VEGF promoter fused to a luciferase gene. This construct was transiently co-transfected into C2C12 myoblasts cultivated in normal and high glucose with a constitutively expressed Renilla plasmid to control for transfection efficiency. Hypoxia-induced luciferase production was significantly impaired in high glucose conditions compared to normal glucose controls (FIG. 13). This demonstrates that the impaired VEGF protein production in hypoxia resulted from decreased VEGF transcription in vivo.

Example 6—p300 and HIF-1α are Substrates for O-linked Glycosylation, Potentially Linking the Hexosamine Pathway of Hyperglycemic Oxidative Damage to Impairments in Hypoxia-Induced VEGF Expression

Based on findings implicating impaired HIF-1α transactivation in high glucose as the mechanism for impaired hypoxia-induced VEGF expression, potential post-translational modifications of HIF-1α were examined under these conditions. It was initially examined whether HIF-1α is a substrate for O-linked glycosylation. HIF-1α was immunoprecipitated from cells grown in normal or high glucose conditions, and Western blots were probed with an antibody that specifically recognizes residues containing the O-linked glycosylation modification. While no glycosylated HIF-1α was present under normal glucose conditions, there was significant glycosylation in high glucose (FIG. 14). This is the first demonstration that HIF-1α is a substrate for O-linked glycosylation, and is preferentially glycosylated under conditions of high glucose.

Since the HIF-1 transcriptional complex is comprised of several coactivators, it was also examined whether p300, the major co-activator of the HIF-1, was also glycosylated. While many transcription factors have been found to associate with p300 constitutively, some cases have been identified where this interaction is modulated by post-translational modification. CREB Binding Protein Recruitment to the Transcription Complex Requires Growth Factor-Dependent Phosphorylation of its OF Box,” Mol Cell 7:551-8 (2001); Soutoglou at al., “Acetylation Regulates Transcription Factor Activity at Multiple Levels,” Mol Cell 5:745-51 (2000), which are hereby incorporated by reference in their entirety. Repeating the HIF-1 experiments, it was also found that p300 also serves as a substrate for post-translational O-linked glycosylation in conditions of high glucose. This was physiologically significant since the association of p300 with the transcription factor peroxisome proliferator-activated receptor gamma (PPARγ) was reduced in conditions of high glucose compared to normal glucose by co-immunoprecipitation assays (FIG. 15A-B). Interestingly, blockade of the rate-limiting enzyme of hexosamine biosynthesis, glutamine:fructose-6-phosphate amidotransferase (GFAT) with antisense oligonucleotides reduced the amount of O-linked glycosylation of p300 in high glucose nearly three-fold, and restored the p300/PPARγ interaction to levels comparable to cells grown in normal glucose (FIG. 15A-B). This suggests that the recruitment of p300 to transcriptional complexes is impaired in conditions of high glucose, which can be reversed by preventing glucose-induced O-linked glycosylation. The physiologic relevance of O-linked glycosylation of HIF-1α is unclear. However, the demonstration that glycosylation modifies p300 function suggests a possible mechanism by which the HIF-1 transcriptional complex fails to upregulate VEGF expression, due to its inability to recruit and/or associate with co-activators required for transcriptional activation (i.e. p300).

Example 7—Hyperglycemia-Induced Reactive Oxygen Species Activate Pathways of Cellular Damage, Impairing Endothelial Cell Function

The data presented thus far have examined the mechanisms responsible for initial observations that high glucose levels, both in vivo and in vitro, produce profound deficits in the ability to upregulate VEGF under hypoxic conditions.

Although there is significant literature examining hyperglycemia-induced vascular damage in non-ischemic settings, very few studies have examined the effect of hyperglycemia-induced cellular damage on vascular functions in ischemic settings. This is of clinical importance, as most situations requiring new vascular growth occur in scenarios characterized by significant tissue hypoxia. It has been demonstrated that endothelial cells grown in high glucose in vitro show increased mitochondrial production of ROS. This results in increased hexosamine pathway activity with increased glycosylation of certain transcription factors (SP1) and signaling molecules (eNOS), increased PKC activity resulting in part in increased NFκB activity, greater accumulation of AGEs, and increased flux through the sorbitol pathway (FIG. 16A-C). The downstream consequences of these intracellular events likely result in impaired neovascularization observed in vivo, but the intermediate steps remain unclear.

Example 8—Diabetic Cells are Impaired in Functions Critical for Angiogenesis

While it is clear that VEGF expression is altered in diabetic states, it has also been demonstrated that diabetic cells are impaired in other ways. Fibroblasts isolated from diabetic mice (db/db) show dramatic decreases in migration (four-fold less) than normal fibroblasts on collagen and fibronectin using a gold salt phagokinetic migration assay. When the haaptotactic response of these cells was examined using a modified Boyden chamber migration assay, a similar decrease of 77% in migration in response to serum and PDGF was observed (Lerman et al., “Cellular Dysfunction in the Diabetic Fibroblast: Impairment in Migration, Vascular Endothelial Growth Factor Production, and Response to Hypoxia,” Am J Pathol 162:303-12 (2003), which is hereby incorporated by reference in its entirety).

Once again, this difference was accentuated by hypoxia (FIG. 17A-B). Whereas migration in normal cells
was upregulated by hypoxia (two-fold), diabetic cells showed no difference in the rate of migration in hypoxia. These assays again emphasize the profound impact that diabetes has on cellular function, and that this impact is magnified under hypoxic conditions.

These migration differences may be due to differential expression of members of the matrix metalloproteinase (MMP) family in diabetic fibroblasts. It has been demonstrated that diabetic fibroblasts have higher levels of pro-MMP-9 than normal fibroblasts, but no differences in active MMP-9 or active/pro-MMP-2. This confirms similar findings in endothelial cells cultured in high glucose (Uemura et al., “Diabetes Mellitus Enhances Vascular Matrix Metalloproteinase Activity: Role of Oxidative Stress.” Circ Res 88:1291-8 (2001), which is hereby incorporated by reference in its entirety). Furthermore, these findings suggest that diabetic cellular dysfunction is not characterized by a simple downregulation of all cellular proteins or functions, but involves selective modulation of specific genes and proteins.

Example 9—Endothelial Progenitor Cells from Type II Diabetic Patients are Impaired in their Ability to Proliferate, Adhere, and Incorporate into Vascular Structures

Hyperglycemic alterations in the effector cells of vasculogenesis, the endothelial progenitor cell or precursor cell remain poorly defined. Recently, it was demonstrated that endothelial progenitor cells (EPCs) harvested from Type 1 diabetic patients exhibit reduced proliferation, adhesion, and incorporation into vascular structures as compared to age matched controls under normoxic conditions (Tepper et al., “Human Endothelial Progenitor Cells From Type II Diabetics Exhibit Impaired Proliferation, Adhesion, and Incorporation Into Vascular Structures,” Circulation 106: 2781-6 (2002), which is hereby incorporated by reference in its entirety). Diabetic cultures contained significantly fewer EPCs after 7 days of expansion (FIG. 19A-D), and this was inversely correlated with HbaA1c. Additionally, significantly fewer EPC-bearing clusters were noted in the cultures of diabetic patients. This was inversely correlated with the number of years of clinical diabetes (R = -0.471, P<0.01). Functionally, these cells were found to adhere less to TNF-α-activated endothelial monolayers but exhibited normal adhesion to quiescent endothelial monolayers, which suggests that their ability to respond to environmental cues is deficient. This was confirmed in vivo angiogenesis assays, which demonstrated that fewer diabetic EPCs were incorporated into tubules on Matrigel when compared to age-matched controls.

Example 10—Endothelial Progenitor Cells from Diabetic Patients have an Impaired Ability to Respond to Hypoxia

Given preliminary data suggesting that diabetic cells have an impaired response to hypoxia, studies in EPCs have been performed to specifically examine the response of these cells to an ischemic environment. It was demonstrated that EPCs from Type II diabetic patients were impaired in their ability to adhere to hypoxic endothelial monolayers, migrate towards conditioned media from hypoxic endothelial cells, and proliferate a hypoxic environment (FIG. 10A, B, C, respectively). This may be reflective of an impaired ability of these cells to sense and respond appropriately to hypoxic environmental cues, resulting in poor neovascularization.

Example 11—Deferoxamine Prevents Hyperglycemia-Induced Reactive Oxygen Production in Vascular Endothelial Cells

Cultured vascular endothelial cells were treated with deferoxamine to determine the effect of deferoxamine on hyperglycemia-induced reactive oxygen production by those cells.

Cell culture conditions: For ROS measurement, bovine aortic endothelial cells (BAECs, passage 4-10) were plated in 96 well plates at 100,000 cells/well in Eagle’s MEM containing 10% FBS, essential and nonessential amino acids, and antibiotics. Cells were incubated with either 5 mM glucose, 30 mM glucose, 30 mM glucose plus 100 micromolar deferoxamine, 30 mM glucose plus 250 micromolar deferoxamine. The deferoxamine was freshly prepared and added to the cells on three consecutive days. The ROS measurements were performed 72 hrs after the initial treatment.

Intracellular reactive oxygen species measurements: The intracellular formation of reactive oxygen species was detected using the fluorescent probe CMH2DCFDA (Molecular Probes). Cells (1x105 ml-1) were loaded with 10 μM CM-H2DCFDA, incubated for 45 min at 37°C, and analyzed in an HTS 7000 Bio Assay Fluorescent Plate Reader (Perkin Elmer) using the HTSsoft program. ROS production was determined from an H2O2 standard curve (10-200 nmol ml-1).

As shown in FIG. 21 deferoxamine inhibited production of ROS in vascular endothelial cells in culture. Diabetic levels of hyperglycemia cause increased ROS (superoxide) production in these cells (FIG. 21, bar 2). Adding 250 μM deferoxamine completely prevents this damaging effect (FIG. 21, bar 4).

Thus, the iron chelator deferoxamine has a profound effect on vascular endothelial cells—i.e. it prevents completely hyperglycemia-induced overproduction of hydroxyl radicals (FIG. 21).

Example 12—Normalizing Excess Mitochondrial Superoxide Production Inhibits Hyperglycemia-Induced Increases in Intracellular Free Iron in Aortic Endothelial Cells

For free intracellular iron measurement, bovine aortic endothelial cells (“BAECs”, passage 4-10) were plated in 24 well plates at 500,000 cells/well in Eagle’s MEM containing 10% FBS, essential and nonessential amino acids, and antibiotics. Cells were infected with UCP-1, Mn-SOD or empty adenoviral vectors, respectively, for 48 hours. 30 mM glucose was added to each well that was infected with the adenovirus Uninfected cells were incubated with 5 mM and 30 mM glucose as controls. The free intracellular iron was detected after 24 hours.

In order to detect intracellular free iron, cells were loaded with fern-2 AM in the dark at 37°C for 15 min in 1 ml of TBSS containing 5 μM furrs-2 AM. After loading, cells were incubated with TBSS with 1 ml of 20 μM EDTA for 5 min. (Kress et al., “The Relationship between Intracellular Free Iron and Cell Injury in Cultured Neurons, Astrocytes, and Oligodendrocytes”, J. Neuro., 22(14):5848-5855 (2002), which is hereby incorporated by reference in
its entirety). Fluorescence was detected using an Olympus IX70 with 10x planapo objectives, run by I.P. Lab Spectrum on a Power PC computer. Analysis was performed with I.P. Lab Spectrum.

Example 15—Deferoxamine Inhibits Hyperglycemia-Induced Increases in Intracellular Free Iron in Aortic Endothelial Cells

Bovine aortic endothelial cells ("BAECs", passage 4-10) were plated in 24 well plates at 500,000 cells/well in Eagle's MEM containing 10% FBS, essential and nonessential amino acids, and antibiotics. Cells were incubated with either 5 mM glucose, 30 mM glucose, or 30 mM glucose plus 100 μM deferroxamine. Free intracellular iron measurement was performed 24 hours later. To detect intracellular free iron, cells were loaded with fura-2 AM as described above in Example 12.

Example 14—Deferoxamine and the Hydroxyl Radical Scavenger DMSO Both Inhibit Hyperglycemia-Induced Increases in DNA Strand Breakage in Aortic Endothelial Cells

Bovine aortic endothelial cells ("BAECs", passage 4-10) were plated in 10 mm cell culture plates until confluent. Cells were incubated with either 5 mM glucose, 30 mM glucose, 30 mM glucose plus 100 μM deferroxamine (DFO), or 30 mM glucose plus 100 μM DMSO, a hydroxyl radical scavenger, for 7 days. Medium with reagents was changed daily. DNA strand breakage was detected using the Comet assay method.

Example 16—Deferoxamine Prevents Hyperglycemia-Induced Inhibition of Prostaglandin Synthase (PGF-1α) in Aortic Endothelial Cells

Bovine aortic endothelial cells ("BAECs", passage 4-10) were plated in a 24-well plate (50,000 cell/well). Cells were incubated with either 5 mM glucose, 30 mM glucose, or 30 mM glucose plus 100 μM deferoxamine. The prostacyclin synthase product, PGF-1α, was measured 24 hours later.
electron transport chain completely inactivates the endothelial enzyme prostacyclin synthase, which is a major natural defense against the development of atherosclerosis. In bar 2 of FIG. 26, hyperglycemia is shown to decrease the activity of this enzyme by over 90%. In contrast, bar 3 shows that hyperglycemia does not inhibit the activity of this important antiatherogenic enzyme at all when the superoxide-induced increase in free Fe²⁺ is prevented by deferoxamine.

Example 17—Deferoxamine Prevents Diabetes-Induced Inhibition of Prostacyclin Synthase (PGF-1α) in Aortas of Diabetic Mice

Male C57B16 mice (6-8 weeks old) were made diabetic by daily injections of 50 mg/kg streptozotocin in 0.05 M NaCitrate pH 4.5 after an eight-hour fast, for five consecutive days. Two weeks after the initial injection the blood glucose was determined and the diabetic mice were randomized into two groups with equal mean blood glucose levels. Deferoxamine (10 mg/kg) was injected subcutaneously once per day for 7 days in one group of diabetic animals. The aortas were collected, for prostacyclin synthase activity measurement.

Prostacyclin synthase activity measurement A competitive immunnoassay method (Correlate-EIA) was used for the quantitative determination of 6-keto-PGF₁α. Mouse aortas were washed with PBS and incubated at 37°C for 3 hours in 400 µl incubation buffer containing 20 mM TRIS buffer (pH 7.5), and 15 µM arachidonic acid. 100 µl of sample was used to measure the PGI₁α.

It has previously been shown that diabetes-induced superoxide production by the mitochondrial electron transport chain completely inactivates the endothelial enzyme prostacyclin synthase in aortas of diabetic mice. In bar 2 of FIG. 27, hyperglycemia is shown to decrease the activity of this enzyme in vivo by over 90%. In contrast, bar 3 of FIG. 27 shows that hyperglycemia does not inhibit the activity of this important antiatherogenic enzyme at all when the superoxide-induced increase in free Fe²⁺ is prevented by deferoxamine.

Example 18—Deferoxamine Prevents Hyperglycemia-Induced Inhibition of Endothelial Nitric Oxide Synthase (eNOS) in Aortas of Diabetic Cells

Bovine aortic endothelial cells (“BAECs”, passage 4-10) were plated in 24-well plate (50,000 cell/well). Cells were incubated with either 5 mM glucose, 30 mM glucose alone, or 30 mM glucose plus 100 µM deferoxamine, for 24 hour. Six hours before eNOS activity determination, media without arginine was added to the cells to deplete endogenous arginine.

Measurement of eNOS activity was accomplished as follows. BAECs were incubated with 400 µl of PBS-²H-arginine (1.5 µCi/ml) buffer for 30 min at 37°C C. The reaction was stopped by adding IN TCA (500 µl/well, ice cold), the cells were freeze fractured in liquid nitrogen for 2 min and thawed at 37°C C. for 5 min to obtain the cell lysate. After extraction with ether, the cell lysate was adjusted to pH 5.5 using Heps buffer containing 2 mM EDTA and 2 mM of EGTA, then loaded onto Tris-formed DOWEX 50WX8 ion-exchange columns and ²H-citrulline collected. Detection of ²H-citrulline was performed using a liquid scintillation counter, and eNOS activity was calculated from the amount of ²H-citrulline generated.

It has previously been shown that hyperglycemia-induced superoxide formation significantly inactivates another critical endothelial enzyme, endothelial nitric oxide synthase (eNOS). This enzyme plays a critical role in acute dilation of blood vessels in response to hypoxia, and a chronic role as another major defense against development and progression of atherosclerosis. In bar 2 of FIG. 28, hyperglycemia is shown to decrease eNOS activity by 65%. In contrast, bar 3 shows that hyperglycemia does not inhibit the activity of this important antiatherogenic enzyme at all when the superoxide-induced increase in free Fe³⁺ is prevented by deferoxamine.

Example 19—Deferoxamine Prevents Diabetes-Induced Inhibition of Endothelial Nitric Oxide Synthase (eNOS) in Aortas of Diabetic Mice

Male C57B16 mice (6-8 weeks old) were made diabetic by daily injections of 50 mg/kg streptozotocin in 0.05 M NaCitrate pH 4.5 after an eight-hour fast, for five consecutive days. Two weeks after the initial injection, the blood glucose was determined and the diabetic mice were randomized into two groups with equal mean blood glucose levels. Deferoxamine (10 mg/kg) was injected subcutaneously once per day for 7 days in one group of diabetic animals. The aortas were collected for endothelial nitric oxide synthase (eNOS) activity measurement.

Measurement eNOS activity was accomplished as follows. Aortas were collected in liquid-nitrogen and tissue proteins isolated. Immunoprecipitation methods were used to purify the eNOS from tissue lysates. The purified eNOS immuno-complex was incubated with 100 µl of reaction buffer (3 mM Tris(hydroxymethyl)aminomethane, 1 mM NADPH, 2.5 mM CaCl₂, 200 U Calmodulin, 2H-L-arginine 0.2 µCi) for 45 min at 37°C C. with rolling. After the incubation, samples were loaded onto Tris-formed DOWEX 50WX8 ion-exchange column and ²H-citrulline was collected. ²H-citrulline was quantitated using a liquid scintillation counter and eNOS activity was calculated from the amount of ²H-citrulline generated.

It has previously been shown that diabetes-induced superoxide production by the mitochondrial electron transport chain inactivates the endothelial enzyme eNOS in aortas of diabetic mice. In bar 2 of FIG. 29, diabetic hyperglycemia is shown to decrease the activity of this enzyme in vivo by 65%. In contrast, bar 3 shows that hyperglycemia does not inhibit the activity of this important antiatherogenic enzyme at all when the superoxide-induced increase in free Fe²⁺ is prevented by deferoxamine.

Example 20—Diabetes-Induced Defect in Angiogenic Response to Ischemia

Researchers have created a novel model of graded ischemia in the dorsal soft tissue of mice. Since the vascular
anatomy of the mouse dorsum is precisely known, and the major axial vessels can be easily visualized, this model creates a reliable zone of ischemia with a reproducible oxygen gradient in the tissue. This has been confirmed with direct tissue oxygen tension measurements utilizing four reference points (p1-p4) spaced 0.5 cm apart, proceeding from the least to most ischemic regions.

[0155] The mechanisms underlying this diabetes-induced defect are complex and incompletely understood, but appear to involve mitochondrial superoxide overproduction, since the defect is significantly prevented in diabetic transgenic mice which overexpress the mitochondrial isomerase of SOD.

Example 22—Deferoxamine Normalizes Diabetic Wound Healing and Diabetes-Induced Defect in Angiogenic Response to Ischemia

[0160] The effect of reducing the wound healing in diabetic mice (db/db) by treating them with deferoxamine was also studied in the novel model of graded ischemia in the dorsal soft tissue of mice of Example 20. The animals were made diabetics as described in Example 21. Deferoxamine-treated diabetic mice demonstrated complete wound closure at day 16, whereas untreated db mice did not close their wounds until day 26 (FIGS. 33A-B). FIGS. 34A-B show that diabetic animals do not increase oxygenation by forming new vessels the way deferoxamine-treated diabetic mice do. FIGS. 34C-D show that deferoxamine-treated diabetic animals mobilize 1.12% of bone marrow-derived endothelial precursor cells in response to ischemia compared to 0.22% of diabetic deferoxamine-untreated mice. FIG. 34E-F show (black bar) that deferoxamine-treated diabetes mice substantially increase capillary formation in ischemic tissue compared to diabetic deferoxamine-untreated mice.

[0161] Although preferred embodiments have been depicted and described in detail herein, it will be apparent to those skilled in the relevant art that various modifications, additions, substitutions and the like can be made without departing from the spirit of the invention and these are therefore considered to be within the scope of the invention as defined in the claims which follow.

1-19. (canceled)

20. A composition of matter comprising the compound R-L-C-M or a pharmaceutically acceptable salt thereof, wherein R is H or a biocompatible moiety capable of facilitating or hindering the penetration of said composition of matter in target cells, L is a linker connecting R to C, wherein L is capable of facilitating a rapid cellular intake and delaying a cellular exit of said composition of matter, C is an iron chelating moiety, and M is a functional-masking group susceptible to cleavage by (OH).

21. (canceled)

22. A therapeutic composition comprising:

(a) a compound of the formula R-L-C-M or a pharmaceutically acceptable salt thereof; wherein R is H or a biocompatible moiety capable of facilitating or hindering the penetration of said therapeutic composition in target cells, L is a linker connecting R to C, wherein L is capable of facilitating a rapid cellular intake and delaying a cellular exit of said therapeutic composition, C is an iron chelating moiety, and M is a functional-masking group susceptible to cleavage by (OH), and

(b) a pharmaceutical carrier.

23. (canceled)