Abstract
Diabetes mellitus is a metabolic disease in which the pancreas is unable to produce enough insulin due to the destruction of β-cells or the body does not utilize insulin properly. Continuous fluctuation of blood glucose levels is responsible for prolonged complications such as diabetic nephropathy (DN), diabetic retinopathy, or diabetic cardiomyopathy. Approximately, 20-30% of all diabetic patients face DN, which causes the formation of diabetic glomerular lesions and reduced glomerular filtration rate. In the case of renal failure, kidney transplantation is the only available therapy, however, it is expensive and almost unattainable due to unavailability of donors and host immune rejection. Stem cells are an alternative and attractive source of therapy because of their proliferative nature and the ability to produce distinct specialized cells. Mesenchymal stem cells (MSCs), which are derived from bone marrow, possess an anti-inflammatory property and the ability of self-renewal and differentiation into a variety of specialized cells. MSCs are widely used to treat different diseases including DN and they have shown encouraging outcomes. This review provides details about the regenerative efficiency of using MSCs in treating diabetic nephropathy.

Keywords: Diabetes mellitus, Diabetic Nephropathy, Stem cells, Regeneration, Mesenchymal stem cells

Introduction
Diabetes mellitus is a metabolic/autoimmune/hormonal/endocrine disease consisting of elevated blood glucose levels. It is considered as an outbreak with a constant increase both in ratio and frequency around the globe. The number of patients with diabetes in 1980 was 108 million, which rose to 415 million in 2015, and is estimated to reach 642 million by 2040. In 2012, 1.5 million deaths were reported from all over the world due to diabetes. Globally, diabetes was the eighth foremost cause of death among both males and females and was the fifth leading cause of death in women in 2012. There are two types of diabetes mellitus, type 1 (T1D) and type 2 (T2D). T2D is the most common form of diabetes and 90-95% peoples are affected with T2D. It is usually developed due to the permutation of auxiliary insulin opposition which progressively damages pancreatic β-cells and leads to complete failure of endogenous insulin secretary cells. Chronic high blood glucose leads to complications including macroangiopathy and microangiopathy, retinopathy, chronic nephropathy, peripheral and central neuropathy, and cardiomyopathy. At the starting phase of T2D, insulin opposition can be a coup but it ultimately requires exogenous insulin against functional β-cells exhaustion. 5-10% of people are affected by T1D at a younger age and require acute exogenous insulin therapy. Regrettably, though exogenous insulin therapy may hold up disease progression, it does not eliminate the risk of the disease’s chronic convolution.

In pharmacologic therapy, different drugs are developed to control blood glucose levels, blood pressure and obstruction of the renin-angiotensin-aldosterone system (RAAS), however, these strategies only slow the progression of renal damage. Podocytes show a high level of constitutive autophagy, a passageway in which altered proteins, as well as organelles, are transported to lysosomes that represent a defensive system against podocyte aging and glomerular damages. Therefore, modulating autophagy represents a useful therapeutic way to slow the succession of DN. All these strategies can only delay the progression of renal damage but cannot stop or reverse renal damage due to diabetes. Stem cells (SCs) based therapies are expected to bring significant advantages to patients suffering a broad range of diseases and injuries. Various types of stem cells are found in the body and can be utilized for the treatment of numerous diseases (Figure 1).

Stem cells are widely used for the regeneration of cells/tissues damaged due to chronic diseases because of their unique properties:
Figure 1: Therapeutic options for vascular complications in diabetes by Stem Cells Mesenchymal stem cell (MSC); Bone marrow-derived mononuclear cell (BM-MNC); Hematopoietic stem cell (HSC); Induced pluripotent stem cell (iPSC); Embryonic stem cell (ESC); Endothelial progenitor cell (EPC).

Figure 2: Challenges during stem cell therapy.

(i) self-renewal (capability to generate symmetric daughter cells),
(ii) long-term viability and
(iii) potentiality to produce distinct specialized cells. However, the selection of stem cell types, techniques of cell isolation, culturing and injection into a patient are delicate and require expertise. Challenges faced during stem cell therapy are mentioned in Figure 2.
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<td>↑ pancreatic insulin content and islet cell number ↓ renal macrophage infiltration Improvement in renal histology</td>
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<td>C57BL/6 mice</td>
<td>BM-MSCs</td>
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<td>-</td>
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<td>C57BL/6 mice</td>
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<td>$0.5 \times 10^6$</td>
<td>-</td>
<td>↓ albuminuria Improvement in renal histology No improvement in β-cell function and histology</td>
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<td>Sprague-Dawley Rats</td>
<td>ADMSCs</td>
<td>$1 \times 10^7$</td>
<td>p-ERK, p-JNK, p-p-38</td>
<td>↓ renal p-p-38, p-ERK and p-JNK ↓ renal MDA and carbonyl protein ↓ renal TNF-α, IL-1β, IL-6 ↓ renal MnSOD and CuZn-SOD</td>
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<td>Sprague-Dawley Rats</td>
<td>h-UCB-SCs</td>
<td>$1 \times 10^6$</td>
<td>Fibronectin, α-SMA, E-cadherin</td>
<td>↓ blood glucose levels ↓ albuminuria ↓ renal fibronectin, α-SMA ↑ renal E-cadherin</td>
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<tr>
<td>Sprague-Dawley Rats</td>
<td>h-UCB-SCs</td>
<td>$5 \times 10^5$</td>
<td>TGF-β1, α-SMA, E-cadherin, BMP-7</td>
<td>↔ blood glucose levels ↔ albuminuria Improvement in renal histology ↓ renal TGF-β1, α-SMA ↑ renal E-cadherin, BMP-7</td>
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<td>Sprague-Dawley Rats:</td>
<td>BM-MSCs</td>
<td>$1 \times 10^6$</td>
<td>TGF-β1, synaptopodin, and IL-10</td>
<td>↓ blood glucose levels ↑ plasma insulin Attenuated β-cell damage ↓ albuminuria ↓ renal TGF-β1 ↑ renal synaptopodin, IL-10 After UTMD: MSC homing was increased to kidneys (~2x) Permeability of renal interstitial capillaries and VCAM-1 expression ↑ after UTMD</td>
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<td>Wistar rats</td>
<td>BM-MSCs</td>
<td>$2 \times 10^6$</td>
<td>Fibronectin, Collagen I, TGF-β1</td>
<td>↓ renal fibronectin and collagen I ↓ renal MDA content ↓ renal TGF-β1 ↓ renal ROS fluorescence ↑ renal SOD activity ↓ cellular glucose uptake mediated by GLUT1 in kidneys</td>
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<td>Female Wistar rats</td>
<td>BM-MSCs</td>
<td>$2 \times 10^6$</td>
<td>collagen I, collagen IV, α-SMA, TGF-β, P-smad3/smad2/3, E-cadherin, BMP7</td>
<td>↓ renal collagen I, collagen IV, α-SMA, TGF-β, P-smad3/smad2/3 ↑ renal E-cadherin, BMP7</td>
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<td>Sprague-Dawley Rats</td>
<td>BM-MSCs</td>
<td>$1 \times 10^6$</td>
<td>-</td>
<td>Improvement in renal histology</td>
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<td>Sprague-Dawley Rats</td>
<td>(SDF-1-loaded</td>
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<td></td>
<td>microbubbles)</td>
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Table 1 continued

<table>
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<tr>
<th>Male Sprague-Dawley (SD) rats</th>
<th>Male albino rats</th>
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<tr>
<td>ADMSCs 1 × 10^5</td>
<td>BM-MSCs 1 × 10^6</td>
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<tr>
<td>Bax -3, Bcl-2, klotho</td>
<td>-</td>
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↓ the rate of cellular apoptosis, ↓ Bax and Wnt/β-catenin levels, ↑ Bcl-2 and klotho levels. klotho knockdown reversed the effects of ADMSCs on the expression of apoptosis-related proteins and Wnt/β-catenin pathway members. blood glucose level was improved, renal function was retained, body weight loss was ↓, insulin level and HBA1C percentage were ameliorated with improved oxidative stress in kidney tissue.
**MESENCHYMAL STEM CELLS (MSCS)**

MSCs are multipotent in nature and can be obtained from different sources. Many preclinical studies have demonstrated that mesenchymal stem cells (MSCs) enhance the regenerative wound microenvironment. In different animal models, full thickness excisional wounds, diabetic foot ulcers, pressure ulcers and burn injuries can be treated by the administration of MSCs, which improves wound healing by the accelerated wound closure, reduced scarring, promoted collagen synthesis, angiogenesis, and improved tensile strength.

Advantages of MSCs for therapeutic uses include simple culturing technique, multilineage repopulation (differentiation), the potential of immunosuppressive effects, protection after inoculation of allogeneic cells and no ethical problems that transpire in case of human ESC application. Previous studies on disease models and clinical trials showed a positive therapeutic value of MSCs. MSCs can be isolated from different sources such as bone marrow, adipose tissues, umbilical cord blood, peripheral blood and amniotic fluid. However, bone marrow is the richest source of MSCs. Previous studies showed that MSCs can differentiate into insulin-producing β-cells, mesangial cells, tubular epithelial cells, endothelial cells, and podocytes. Due to its effectiveness and safety, allogeneic MSCs are also used in the treatment of acute kidney injury, clinical trials and cardiomyopathy patients, who are at elevated risk of post-operative chronic kidney diseases.

**MESENCHYMAL STEM CELLS FOR DIABETIC NEPHROPATHY**

Diabetic nephropathy is one of the complications of diabetes mellitus, which leads to end-stage renal damage in extreme case. Around 25–40% of diabetic patients will develop DN. Until now, therapies for DN remain limited and none of them can completely reduce the risk of developing DN. Nowadays, the full renin-angiotensin system blockage, strict blood glycemic and lipid control are the main treatments of DN. On the other hand, DN gives rise to kidney failure, which requires kidney transplantation and inflicts huge medical and socio-economic encumbers. There is an instant need to develop a regenerative strategy for which MSCs play a vital role. In animal models, streptozotocin (STZ) was induced to cause T1D in mice. Toxicity of streptozotocin was reduced by the administration of MSCs, which regenerated damaged nephrons due to DN and resulted in enhanced renal and pancreatic function. Injection of human-derived MSCs in NOD/SCID mice reduced both mesangial thickening and macrophage infiltration.

Transplantation of MSCs enhanced proteinuria and podocyte injury in T1D rat model. The effect of MSCs on the regeneration of glomerular podocyte injury was investigated on Sprague-Dawley rats, the diabetic model was developed by the induction of STZ injection (65 mg/kg, intraperitoneally). Nephrin and podocin expression levels, two major proteins involved in the formation of incision diaphragm were investigated. MSC injection extensively reduced diabetic-induced glomerular nephrin and podocin expression. Most importantly, MSC injection increased BMP-7 but not VEGF levels (BMP-7 and VEGF are podocyte survival factors). The intrarterial administration of MSCs averted the progression of albuminuria and the impairment of podocytes, although blood sugar levels were not improved. MSC protective role may be intervened by the rise of BMP-7 secretion.

MSC administration enhanced kidney weight, renal to body weight index, urinary albumin to creatinine ratio and clearance in rats, moreover, the loss of podocytes was reduced. MSC therapy also eliminated foot processes and its widening, glomerular basal membrane thickening, and glomerular nephrin and podocin loss. Similar results were observed when MSCs and ciclosporin A were injected intracardially in combination in rats.

In another study, MSCs were used to treat impaired podocytes by the induction of PAN (0.5 mg/g weight) in BALB/C mice via tail vein. The expressions of nephrin, CD2AP, synaptopodin and TRPC6 were investigated. After administration of BMSCs, the expression of nephrin, CD2AP, and synaptopodin was up-regulated, while TRPC6 was down-regulated. Administration of BMSCs reduced excretion of protein through urine and protected podocytes from deleterious effects of PAN.

In a novel study, BM-MSCs along with human umbilical cord extract were used to enhance the proliferative capability of BM-MSCs against DN. The therapeutic potential of BM-MSCs was reduced in diabetic patients due to oxidative stress, while umbilical cord extract contained different growth factors, extracellular matrices, and exosomes, which enhanced the proliferation of BM-MSCs. The relative mRNA expression of Iqf-1 was downregulated, whereas Ifn-γ, Il1β, Il-2, and Rantes were up-regulated in treated rats as compared to controls. The expressions of α-Sma, which represented the stress fiber of MSCs, was also increased.
The mechanism of the renoprotective role of MSCs was not clear until a study showed a relationship between MSCs and macrophages in diabetic nephropathy. The hepatocyte growth factor (HGF) and pro-inflammatory cytokines expression at molecular and protein levels were studied, and animal groups administered with MSCs showed elevated expression of HGF. Meanwhile, the expressions of IL-1β, IL-6, and TNFα were extensively decreased. The results explained that in diabetic rats, MSC transplantation minimized DN through HGF secretion, which inhibited MCP-1 expression and reduced macrophages infiltration in renal tissue.

In rats, the effect of BMSCs on PAI-1 and renal fibrosis with DN was studied. Expressional levels of PAI-1, TGF-β1 and Smad3 genes in a kidney of rat model were determined; in control group, the expression of PAI-1, TGF-β1 and Smad3 were down-regulated as compared to the DN group. The pathway may be associated with the inhibition of TGF-β1/Smad3 as the expression of PAI-1 protein was decreased and the accretion of ECM reduced, thus, balancing the fibrinolytic system.

**CONCLUSION**

It is reported that MSC isolation methods in different laboratories or from different donors are highly diverse. Cell passage and in vitro culture conditions affect the phenotypes of bone marrow-derived MSCs. Moreover, aging and aging-related disorders drastically impair the survival and proliferative and differentiation potential of BM-MSCs, which limits its therapeutic efficiency. In diabetes, reactive oxygen species are generated, which affects the regenerative properties and survival of stem cells in patients with diabetes. The microenvironment under diabetic conditions is harsh for stem cells to survive or migrate to the targeted site and exert their reparative functions. Limited synthesis of proteoglycans and glycosaminoglycans in the surrounding environment causes minimal proliferation and viability of MSCs in vivo. The production of advanced glycosylated end products also inhibits proliferation of MSCs by activating apoptotic mechanism and reactive oxygen species production. In diabetic patients, oxidative stress may also influence the paracrine effects of MSCs under hypoxic conditions. In addition, the migratory capacity of MSCs is also impaired. High osteoprogerin in diabetic patients neutralizes the pro-migratory activity of TNF-related apoptosis-inducing ligands, which promotes the migration of bone marrow stem cells.

The current review is based to summarize the work done for treatment of diabetic nephropathy and the gaps available for research. Accordingly, the use of antioxidants, growth factors or hormones along with MSCs in optimal combinations and concentrations will be appreciated.

**FUTURE PROSPECTS**

Stem cell-based therapy holds promising treatments for DN. Although kidney-specific stem cells have been identified in recent years, the involvement of these stem cells in the regeneration of the kidney is still in doubt. It is required to continue seeking a better and ideal cell source or to develop optimized manipulation methods for existing cells to treat DN. No matter whether the target is podocytes, PTECs or other cell types in DN, the ideal cell candidate for cell replacement should have the following properties: easy access with no safety or ethical issues, high survival rate during diabetic stress and differentiation potential into the desired cell types both in vitro and in vivo. Recently, iPSCs generated from somatic cells as well as functional kidney cells and tissues differentiation from pluripotent stem cells (ESCs and iPSCs) provide a wonderful platform to explore disease mechanisms and potential cell sources. However, the safety issue remains unsolved. Criteria for the validation of induced renal progenitor cells need to be established. The tumorigenic property of iPSCs based on viral transduction technology must be eliminated before clinical transplantation. The development of iPSCs without viral vectors might be helpful in the generation of iPSCs from an autologous source. Bone marrow-derived MSCs remain an attractive autologous cell source mainly due to the ease of harvesting and their low immunogenicity. USCs or urine-derived iPSCs from DN patients might also serve as a suitable source of cells for investigating the pathogenetic mechanisms, screening new treatments and offering possibilities for future personalized regenerative therapies.

**COMPETING INTERESTS**

The authors declare no conflict of interest.

**AUTHORS’ CONTRIBUTIONS**

All the authors contribute equally to this paper.

**ACKNOWLEDGMENTS**

The authors are thankful to Muhammad W for his continuous support.
REFERENCES


