Tissue damage resulting from chemical, mechanical, and biological injury, or from interrupted blood flow and reperfusion, is often life threatening. The subsequent tissue response involves an intricate series of events including inflammation, oxidative stress, immune cell recruitment, and cell survival, proliferation, migration, and differentiation. In addition, fibrotic repair characterized by myofibroblast transdifferentiation and the deposition of ECM proteins is activated. Failure to initiate, maintain, or stop this repair program has dramatic consequences, such as cell death and associated tissue necrosis or carcinogenesis. In this sense, inflammation and oxidative stress, which are beneficial defense processes, can become harmful if they do not resolve in time. This repair program is largely based on rapid and specific changes in gene expression controlled by transcription factors that sense injury. PPARs are such factors and are activated by lipid mediators produced after wounding. Here we highlight advances in our understanding of PPAR action during tissue repair and discuss the potential for these nuclear receptors as therapeutic targets for tissue injury.

An overview of tissue injury
The clinical significance of tissue injury and the need for therapeutic agents to treat organ damage have called for an improved understanding of the causes of tissue injury and subsequent healing. The complex nature of these processes creates a challenge in identifying the specific cell types and biochemical pathways involved. Moreover, tissue protection and regeneration require tight control of cell survival and death, cell growth and differentiation, and ECM remodeling and breakdown. Chemical, biological, and mechanical stress is deleterious to epithelial tissue, and even whole organs are vulnerable to damage. For example, the liver, which metabolizes nutrients and drugs absorbed from the digestive tract, is particularly susceptible to injury, since all blood leaving the intestines and stomach must pass through it before reaching the rest of the body. Organ damage also occurs in response to an inadequate supply of oxygen (hypoxia), usually caused by blood vessel constriction or obstruction (ischemia). Under normal physiological conditions, oxygenation levels and sensitivity to hypoxia differ among the various organs. Since short periods of ischemia and reperfusion (ischemia/reperfusion, or I/R) cause extensive damage, the goal of the survival response is to maintain tissue viability. As a result, the hypoxia response requires optimal revascularization for efficient recovery.

Inflammation is a major component of early healing, and its control is essential for efficient repair. The inflammatory cytokines and eicosanoids produced during the first hours after injury recruit neutrophils and macrophages to the wound. These cells amplify the early response through their production of additional inflammatory mediators. Some of these factors promote cell proliferation and migration and are thus directly involved in wound closure. Others increase pain, delay wound healing, and promote neovascularization (angiogenesis). A full understanding of these responses will help therapeutic interventions through the identification of molecular targets. Among such targets are transcription factors that control various pathways of cellular repair. In particular, PPARs have recently received attention for their protective and healing attributes. The PPAR agonists can be synthetic molecules, such as those used to treat hypertriglyceridemia (fibrates) and insulin resistance (thiazolidinediones), or natural ligands, such as fatty acids (PAs) and their derivatives (eicosanoids). Recent work has unveiled a variety of natural lipid-derived molecules that activate PPARs, but little is known about their action in vivo. Here we summarize the role of PPARs in repair of multistratified and single-cell-layer epithelia, and of injured organs.

PPAR involvement in healing stratified epithelia: skin wound healing as a model
The epidermis is renewed continuously, and its integrity depends on a tightly regulated balance among cell proliferation, differentiation, and apoptosis. During its maturation, the epidermis evolves from a single layer of epithelial cells to a fully stratified and differentiated epithelium. The outermost layer of the epidermis, the stratum corneum, is the end product of keratinocyte differentiation and consists of a layer of cross-linked proteins and lipids, which functions as a barrier to transepidermal water loss and as a defense against physical damage, microbes, and xenobiotics. Several studies have examined the role of PPARs in this process.

No gross defect is seen in epidermal maturation in mice deficient in either PPARα or PPARδ (also called PPARβ). Similarly, PPARγ-null mice born after placental rescue (to prevent lethal placenta maturation defects) show no alterations in epidermal maturation. These results suggest that epidermal maturation is PPAR independent. However, PPARs can stimulate keratinocyte differentiation (1–3). All 3 PPARα are undetectable in adult mouse interfollicular epidermis, but PPARα and PPARγ are found upon proliferative stimuli, such as at wound edges after an injury (1). PPARα expression is only transiently increased after injury. Interestingly, the expression of PPARα is upregulated by antiinflammatory glucocorticoids, which increase during injury (4, 5). The inhibitory
The effect of PPARδ on NF-κB action may create a negative feedback loop, which would explain the transient PPARα expression that allows control of early inflammation (5).

Following tissue damage, injured cells release proinflammatory cytokines. These stimulate PPARδ expression via stress-associated protein kinase/JNK–mediated activation of the activator protein-1 (AP-1) transcription complex (6). PPARδ, which is activated by ligands whose production is also triggered by proinflammatory cytokines, then coordinates transcriptional upregulation of integrin-linked kinase and 3-phosphoinositide–dependent kinase (PDK), as well as via activation of the PKB/Akt-1 survival pathway. Right: The initial inflammatory signals that stimulate PPARs are countered by TGF-β1/Smad3-mediated suppression of PPARs in the late re-epithelialization/remodeling stage. This suppression occurs via Smad3/4 complex–mediated abrogation of AP-1 activity. In addition, TGF-β1 released by dermal wound fibroblasts increases macrophage numbers and stimulates ECM production for wound remodeling. The diverse cell types and feedback signals regulating would repair are discussed in detail in the text.

Role of PPARs in different organs after I/R injury

PPARs in kidney I/R. The kidney is vulnerable to damage by toxins, infection, immune reactions, and ischemia. Acute renal failure (ARF) affects about 5% of hospitalized patients and carries a high mortality. Damage to renal tubules alters epithelial cells and is accompanied by the shedding of cells into the tubule lumen and the back-leakage of glomerular filtrate, further increasing epithelial apoptosis and necrosis. Surviving cells participate in regeneration of the epithelium and restoration of renal function. The prognosis for ARF is complicated by secondary injuries induced by free radicals formed during I/R, although inadequate renal cortical-medullary reperfusion may be more deleterious (10). Today, there is no treatment for this devastating clinical syndrome.

A role for PPARs in reducing renal injury and dysfunction is established in animal models. PPARα-null mice subjected to I/R injury by arterial ligation show enhanced cortical necrosis and impaired renal function (11). Conversely, induction of FA oxidation enzymes by PPARs is thought to preserve kidney structure and function during renal I/R injury (11). In humans, nephrotoxicity is a common side effect of treatment with the antitumor agent cisplatin (12). In mice, PPARδ ligands attenuate cisplatin-induced ARF by preventing the inhibition of FA oxidation, reducing apoptosis and necrosis in the proximal tubule (13), and repressing inflammation via inhibition of NF-κB binding activity, which attenuates neutrophil infiltration and cytokine/chemokine release (14).

Consistent with their defect in skin healing, PPARδ-deficient mice exhibit greater kidney injury and dysfunction than wild-type counterparts after renal I/R. Conversely, wild-type mice pretreated with a PPARδ ligand are protected from I/R damage, with a reduction in medullary necrosis, apoptosis, and inflammation. Cell culture studies show that PPARδ ligands activate the PKB/Akt pathway, as they do in keratinocytes, and increase the spread of tubular epithelial cells. In vivo, these events may accelerate healing by suppressing tubular epithelial shedding and anokis (15).

The PPARγ agonists rosiglitazone and pioglitazone have protective effects against not only I/R, but also various kidney injuries including diabetic nephropathy, hypertensive nephropathy, experimental glomerulonephritis, and cyclospermine-induced renal injury (reviewed in refs. 16, 17). This protection reflects both improved glucose metabolism and insulin resistance as well as the antiinflammatory, antifibrotic, and antiproteolytic effects of PPARγ ligands (18). The mechanisms underlying these beneficial properties are similar for synthetic agonists and the natural
cyclopentenone prostaglandin 15d-PGJ2. The pathways involve inhibition of NF-κB activation, together with reduced expression and/or activity of AP-1, TGF-β1, monocyte chemoattractant protein-1 (MCP-1), iNOS, fibronectin, and collagen I. The outcome of these signaling changes includes attenuated infiltration of polymorphonuclear cells into renal tissues, reducing oxidative stress and inflammation (19–23).

**PPARs in lung I/R and fibrosis.** Patients with end-stage pulmonary diseases are often treated with lung transplantation. Although improvements in techniques such as the preservation of vascular endothelium have significantly improved survival, I/R lung injury still occurs in over 20% of patients and remains the main cause of death during the first month after transplantation (24). Rodent models show that PPAR ligands, such as rosiglitazone and pioglitazone, can significantly attenuate I/R-induced lung injuries (17). Furthermore, treatment with the PPARγ agonist pioglitazone before ischemia reduces I/R-induced lung damage in rats. The mechanism involves inhibition of proinflammatory cytokines (TNF-α, cytokine-induced neutrophil chemoattractant 1) and polymorphonuclear cell infiltration into the lung interstitium, resulting in reduced pulmonary edema (25). Similarly, in a murine I/R model, pretreatment with the PPARγ agonist troglitazone prevents induction of the zinc finger transcription factor *early growth response gene-1* (*Egr-1*), a master switch for the inflammatory response in ischemic vessels. Thus, PPARγ neutralizes the potential for harm caused by *Egr-1* target genes such as *IL-1β*, *MCP-1*, and *macrophage inflammatory protein-2*. As a consequence of this protection, leukostasis is decreased, while oxygenation and overall survival are increased (26).

The term pulmonary fibrosis covers several life-threatening diseases for which no effective therapy exists. All have a similar pathology characterized by an immune response closely resembling a Th2-type phenotype, with proliferation and accumulation of myofibroblasts and excessive deposition of ECM proteins in the lung parenchyma. The clinical features are shortness of breath, evident diffuse pulmonary infiltrates, and varying degrees of inflammation and fibrosis (27). In humans, bleomycin treatment for cancer chemotherapy induces interstitial lung fibrosis (28). In human pulmonary fibroblast cultures, PPARγ agonists interrupt the profibrotic effects of TGF-β (29). Similarly, mice subjected to intratracheal administration of bleomycin develop lung fibrosis, which is significantly reduced by PPARγ agonists. As expected, this beneficial effect is attenuated by the PPARγ antagonist bisphenol A diglycidyl ether (BADGE), suggesting that PPARγ activity is required for protection (30).

**PPARs in digestive tract I/R.** Acute mesenteric ischemia, abdominal aortic aneurysm, hemorrhagic, traumatic, or septic shock, small bowel transplantation, and severe burns cause intestinal I/R, a severe condition characterized by endothelial cell swelling, capillary plugging, and mucosal barrier dysfunction (31). In rodent...
models of intestinal I/R injury, PPARγ activation downregulates TNF-α and ICAM-1 (probably via inhibition of NF-κB), and pre-treatment with a PPARγ agonist before ischemia significantly reduces neutrophil infiltration (32, 33). These protective effects are attenuated by PPARγ antagonists or reduction of PPARγ levels in mutant PPARγ heterozygous animals (32, 34). Similarly, activation of PPARγ attenuates I/R injury by reducing ICAM-1 expression, peroxynitrite activity, and the production of proinflammatory cytokines (35). Additionally, enteral nutrition is beneficial when administered soon after severe gut I/R insults, showing that PPARγ attenuates fibrosis through not only direct action on matrix-producing cells, but also modulation of the epithelial-mesenchymal interactions in chronic obstructive cholestasis (52).

The function of PPARβ in fibrogenesis is less well studied, but PPARβ expression is strongly induced after HSC activation. In a model of carbon tetrachloride–induced acute liver damage, PPARβ activation induces HSC proliferation during early fibrogenesis and enhances expression of fibrotic markers (53). Thus, PPARγ and PPARβ appear to have antagonistic effects that require further investigation using PPARγ- and PPARβ-deficient mice. The possibility of manipulating the balance of PPARα and PPARβ pharmacologically signifies a promising development for the attenuation of liver fibrosis. Future studies should improve our understanding of pathways regulating HSC survival, death, and clearance, leading to potential therapies to induce HSC apoptosis (41).

PPARγ ligands also have antiinfective effects in the rat thioacetemide model of liver cirrhosis, probably via their antioxidant action associated with enhanced catalase expression and activity (54). Interestingly, in a mouse model of I/R, PPARα regulates hepatic neutrophil accumulation and reduces iNOS expression after hepatocellular injury. This finding is important because activation of PPARα in hepatocytes protects against oxidant injury, indicating that parenchymal cells might impact the inflammatory response (55). Finally, the function of PPARγ in liver regeneration after partial hepatectomy remains unclear. PPARγ is not necessary for compensatory hyperplasia induced by partial hepatectomy, yet PPARγ-dependent regulation of genes associated with cell cycle progression, cytokine signaling, and metabolic changes appears to be involved (56–59).

PPARs in ischemic brain injury and neurodegenerative disease. Brain injury resulting from insufficient blood (oxygen) supply can be transient (from syncope or ischemic attack) or permanent (from infarct or irreversible stroke). The latter is a major cause of disability and death in developed countries, and because of limited therapeutic strategies there is increasing interest in prophylactic pharmacological treatment (60). It was first observed that the fibrate gemfibrozil reduces stroke incidence in men with low HDL cholesterol and low LDL cholesterol who suffer from coronary heart disease (61). In mice this outcome is associated with improved endothelial relaxation, reduced brain oxidative stress, and decreased VCAM-1 and ICAM-1 expression and is thus independent of lipid metabolism (62). Similarly, the PPARα and PPARγ agonist resveratrol, a polyphenol found in grapes, protects the murine brain from stroke, in a PPARα-dependent manner (63). Thus, PPARα agonists may prevent or reduce the severity of ischemic stroke in humans. In rat hippocampal neurons, the PPARα agonist Wy-14,463 induces peroxisomal proliferation that attenuates β-amyloid peptide–dependent neurotoxicity and decreases intraneuronal oxidative stress (64). In addition, PPARγ ligands have neuroprotective effects in experimental models of ischemic injury, Alzheimer disease, multiple sclerosis, and autoimmune encephalomyelitis. The benefits result from suppressing inflammation (65–68). In addition, in a mouse model of amyotrophic lateral sclerosis for which neuro-
inflammation may contribute to motor neuron death, the PPARγ ligand pioglitazone improves muscle strength and body weight, delays disease onset, and increases lifespan (69).

PPARs in cardiac I/R. Myocardial I/R is a clinically relevant problem associated with reestablishment of blood flow by coronary bypass surgery, thrombolysis, and angioplasty, and with the need to minimize myocardial damage after heart infarct. Heart tissue normally uses FAs as the major energy source. However, hypoxia or pressure overload in the heart results in a substrate switch from FAs to glucose, caused by downregulation of PPARα (70). It is thought that partial inhibition of FA oxidation improves the functional recovery of the heart during reperfusion (71). In support of this idea, experimental overexpression of PPARα in the heart impairs cardiac recovery after ischemia (72). Thus, pharmacological treatments that stimulate glucose oxidation and repress FA oxidation appear to be beneficial for cardiac recovery (73). Along this line of thought, it has been proposed that downregulation of PPARγ coactivator-1 and PPARα may shift myocytes toward a more glycolytic metabolism (74). However, beneficial effects of PPARα agonists on I/R damage have been reported as well (75–77). Experimentally, this contradiction could be resolved by determination of whether PPARα agonists improve myocardial function via metabolic and antiinflammatory actions, and whether cardiac overexpression of PPARα has deleterious effects on the heart when circulating FA levels are high. Nevertheless, these observations suggest that cardiac PPARα antagonism could be a therapy for treating I/R damage (72).

In healthy, diabetic, or obese animals (76, 78–82), PPARγ agonists reduce myocardial infarct size. These effects are associated with increased glucose uptake and improved insulin sensitivity. In addition, PPARγ agonists reduce postschismic myocardial apoptosis (83). However, the role of PPARγ in heart failure is debated, particularly with regard to patients with type 2 diabetes mellitus. The Prospective Pioglitazone Clinical Trial in Macrovascular Events (PROactive) study concluded that pioglitazone may improve cardiovascular outcome (84), while a retrospective cohort study suggested that thiazolidinediones (TZDs) may increase the risk of heart failure. Since type 2 diabetes patients are at increased risk of heart failure, those with underlying myocardial disease may be especially vulnerable to the effects of TZDs (85). Exacerbation of heart failure is documented in animal studies. TZDs are associated with increased post–myocardial infarction mortality in rats (86), and increased susceptibility to ventricular fibrillation during myocardial I/R in pigs (87). Finally, PPARα or PPARγ stimulation prevents or attenuates cardiac fibrosis by reducing endothelin-I, collagen type I, and MMP-1 production,

Figure 3
Role of PPARs in repair of liver, brain, and heart damage. Various systemic states such as shock or sepsis can lead to organ injury and failure. These injuries, as well as tissue-specific insults such as cirrhosis, fibrosis, and I/R injury, can be partially alleviated or prevented through the actions of PPARs.

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PPAR-mediated effects

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<td>Systemic effects: Decreased circulating FA</td>
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<td>Increased apoptosis</td>
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<th>PPARγ</th>
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<td>Systemic effects: Decreased glycemia</td>
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<td>Increased insulin sensitivity</td>
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and by improving myocardial inflammation in anoxia/reoxygenation and pressure-overloaded hearts (88–91).

These experimental studies suggest that PPARs exert beneficial effects in reducing infarct size, myocardial reperfusion injury, and hypertrophic signaling and inflammatory responses. However, clinical applications have revealed some undesirable side effects, suggesting that TZDs should be used with caution in diabetic patients predisposed to heart failure (92). Obviously, there are uncertainties that require additional research (93). The protective effects of PPARs on liver, brain, and heart injury are summarized in Figure 3.

PPARs in shock and sepsis

Sepsis and shock are intrinsically complex, causing failure of multiple organs, including the gastrointestinal tract, kidneys, pancreas, heart, and brain. Since these conditions are a major cause of death in intensive care units, they are high-priority targets for new therapies. Mortality levels increase with the number of failed organs, reaching over 80% when dysfunction occurs in 4 or more organs (94). Preclinical studies have investigated the protective effects of activated PPARs against multiple-organ failure resulting from septicemic and hemorrhagic shocks. Several studies provide evidence for an amelioration through pharmacological treatment with 15d-PGJ2 of endotoxic shock induced in rodents by bacterial products such as LPS, and wall fragments of Gram-positive and Gram-negative bacteria (reviewed in refs. 95, 96). The 15d-PGJ2 likely counteracts the inflammatory response by activating PPARγ, repressing NF-κB, and enhancing the heat shock response (97). Evidence for direct involvement of PPARγ in organ protection is provided by a reduction of the beneficial action of 15d-PGJ2 in the presence of the PPARγ antagonist GW9662 (95). Similarly, pretreatment with the PPARγ agonist fenofibrate protects the endothelia in rabbit E. coli endotoxin–induced shock (98). Severe hemorrhage and subsequent resuscitation also causes multiorgan injury. A study in rats suggested that treatment with 15d-PGJ2 before hemorrhagic shock attenuates liver injury and kidney dysfunction, an effect that is reduced by GW9662 (99). Although none of these sepsis or shock models is ideal, they can improve our knowledge of disease mechanisms and help us identify patient populations that would most benefit from therapeutically trials (100).

PPARs in cancer

Wound healing after injury is a high-priority survival response. In this situation, epithelial cells change their intercellular contacts, modify their matrix, proliferate, and migrate over the wound. In addition, new blood vessels form rapidly. Interestingly, each of these healing behaviors is similarly involved in tumorigenesis and metastasis. As mentioned earlier, epithelia are highly susceptible to, and are efficient healers of, injury, which correlates with the observation that 95% of all cancer deaths are from epithelial tumors. This suggests that the repair mechanisms activated in response to injury may promote cancer if uncontrolled. Indeed, some tumors, especially those prone to metastasis, activate wound-healing genes (101). Although the PPARs may be involved in tumor-associated pathways, their regulation of wound-healing genes within specific tumor types remains largely unexplored (102).

Tumor development involves changes in noncancerous cells and tissues of the transformed mass, including activation of stromal cells, inflammation, and angiogenesis. As a result, these changes are popular targets for cancer therapy design. For example, as angiogenesis is necessary for wound healing and tissue repair, inhibition of angiogenesis represents a promising feature of anticancer therapy. Indeed, PPARγ agonists have received much attention in this field (reviewed in ref. 103). Surprisingly, although they upregulate VEGF in cultured cells, PPARγ agonists such as 15d-PGJ2, pioglitazone, rosiglitazone, ciglitazone, and BRL-49653 are potent angiogenesis inhibitors. These data are obtained from in vitro and in vivo models (104–108). Several direct and indirect actions of PPARγ ligands are reported in these studies, such as decreased VEGF-C and angiogenic chemokine production by tumor cells, inhibition of urokinase plasminogen activator, reduction of VEGF receptors 1 (Flt-1) and 2 (fetal liver kinase-1/KDR), increased plasminogen activator inhibitor type 1, and inhibition of tube formation (reviewed in ref. 103). In addition, PPARγ agonists downregulate leptin gene expression and block leptin-induced endothelial cell migration by inhibiting Akt and iNOS (109, 110). Unfortunately, PPARγ involvement is not yet validated by gene deletion or antagonists. Finally, PPARγ upregulates expression of several fibrinogen/angiopoietin-related proteins (111–113). Although the function of these proteins in angiogenesis is unclear, they share structural homologies with angiopoietins, a family of proteins with roles in vascular development. Much less is known about the effects of PPARα and PPARδ. The PPARγ agonist fenofibrate inhibits capillary tube formation in vitro and angiogenesis in vivo. The mechanism involves disorganization of the actin cytoskeleton with decreased bFGF–induced Akt activity and COX-2 gene expression (114). Fenofibrate also inhibits constrictive remodeling after angioplasty through repression of inflammation and neovascularization (115). Like PPARγ, PPARα controls expression of a protein known as fasting-induced adipose factor/angiopoietin-like protein (FIAF) (111). A study of 35 individuals found that microvessel density among PPARδ–immunoreactive squamous cell carcinomas (SCCs) was higher than that of nonreactive SCCs (116), consistent with an association between VEGF and PPARδ in head and neck SCCs (117). PPARδ may also be involved in vascular development via modulation of the angiogenesis-associated PKBα/Akt-1 pathway (7, 118). Together, these results suggest that the PPARα and PPARγ agonists already used in clinics may be harnessed for angiogenic diseases.

Conclusions

PPARs are major regulators of lipid, glucose, and amino acid metabolism. Here we have presented some of their less well known functions in tissue protection and repair. A majority of the studies reviewed herein are descriptive, and even the use of specific ligands does not necessarily distinguish between PPAR isotypes or between PPAR-dependent and -independent mechanisms. However, collectively, the studies have improved our understanding of the role of PPARs in healing. Their actions are simultaneously systemic and cellular. Systemic effects are antinflammatory, antioxidant, and metabolic, such as the normalization of circulating lipids and insulin resistance. During the early postinjury inflammatory phase, lipoxigenases and cyclooxygenases stimulate production of PPAR ligands. Indeed, perhaps the most striking action of PPARs is the control of inflammation, an event first observed 10 years ago (119). Inhibition of the NF-κB pathway appears to be central to this process. Although protective against infections, the inflammatory milieu is a hostile environment for resident host cells at the injury site. This insult is abrogated by the antiapoptotic role of PPARδ. These PPARδ effects are best described in skin repair, where PKBα/Akt-1

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activity is central. Fibroblasts in inflamed wound areas further support healing. These cells transdifferentiate to activated myofibroblasts with elevated α-SMA expression and contractility to constrict the exposed wound surface. They secrete growth factors, inflammatory cytokines, and ECM components that provide a scaffold for migration of epithelial cells (120). Chronic injury, repetitive injury-repair cycles, or failure to shut off the healing signals leads to fibrosis, during which there are antagonistic actions of PPARy and PPARδ. PPARα sustains fibroblast quiescence and promotes the reversal of myofibroblasts to quiescent cells, while PPARγ expression is high in differentiated myofibroblasts (although its functions are unclear). After skin injury, the interaction of PPAR and TGF-β1 pathways is indispensable for spatiotemporal control of the repair program, suggesting a role for PPARs in fibrosis. Studies to determine how PPAR pathways communicate with TGF-β1, angiotensin II, leptin, and endothelin pathways may inspire novel therapeutic strategies for tissue fibrosis (121–124).

A recurrent observation in wound-healing studies is the protective effect of PPAR ligands. Today, the precise nature and function of natural lipid activators of PPARs in repair are unclear. This knowledge should assist the development of truly selective drugs for inflammatory cytokines, and ECM components that provide a scaffold for migration of epithelial cells (120). Chronic injury, repetitive injury-repair cycles, or failure to shut off the healing signals leads to fibrosis, during which there are antagonistic actions of PPARy and PPARδ.

Identifying the distinct signals that trigger or block gene expression during the wound response will improve our understanding for critical reading of the manuscript and Nathalie Constantin for help in manuscript preparation.

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34. Cuzzocrea, S., et al. 2003. Rosiglitazone and 15-deoxy-delta12,14-prostaglandin J2, ligands of the peroxisome proliferator-activated receptor-gamma (PPAR-gamma), reduce ischemia/reperfusion...
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