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Cognitive decline in patients with Alzheimer’s disease (AD) is associated with elevated brain levels of amyloid β protein (Aβ), particularly neurotoxic Aβ_{1–42}. Angiotensin-converting enzyme (ACE) can degrade Aβ_{1–42}, and ACE overexpression in myelomonocytic cells enhances their immune function. To examine the effect of targeted ACE overexpression on AD, we crossed *ACE^{10/10}* mice, which overexpress ACE in myelomonocytes using the *c-fms* promoter, with the transgenic *APP_{SWE}/PS1_{ΔE9}* mouse model of AD (AD^*+*). Evaluation of brain tissue from these AD^*+* ACE^{10/10} mice at 7 and 13 months revealed that levels of both soluble and insoluble brain Aβ_{1–42} were reduced compared with those in AD^*+* mice. Furthermore, both plaque burden and astrogliosis were drastically reduced. Administration of the ACE inhibitor ramipril increased Aβ levels in AD^*+* ACE^{10/10} mice compared with the levels induced by the ACE-independent vasodilator hydralazine. Overall, AD^*+* ACE^{10/10} mice had less brain-infiltrating cells, consistent with reduced AD-associated pathology, though ACE-overexpressing macrophages were abundant around and engulfing Aβ plaques. At 11 and 12 months of age, the AD^*+* ACE^{10/WT} and AD^*+* ACE^{10/10} mice were virtually equivalent to non-AD mice in cognitive ability, as assessed by maze-based behavioral tests. Our data demonstrate that an enhanced immune response, coupled with increased myelomonocytic expression of catalytically active ACE, prevents cognitive decline in a murine model of AD.

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Angiotensin-converting enzyme overexpression in myelomonocytes prevents Alzheimer’s-like cognitive decline

Kenneth E. Bernstein,1,2 Yosef Koronyo,3 Brenda C. Salumbides,3 Julia Sheyn,3 Lindsey Pelissier,3 Dahabada H. J. Lopes,3 Kandarp H. Shah,1 Ellen A. Bernstein,1 Dieu-Trang Fuchs,3 Jeff J.-Y. Yu,3 Michael Pharm,3 Keith L. Black,3 Xiao Z. Shen,1,2 Sebastien Fuchs,1,2,4 and Maya Koronyo-Hamaoui1,3

1Department of Biomedical Sciences, 2Department of Pathology and Laboratory Medicine, and 3Department of Neurosurgery and the Maxine Dunitz Neurosurgical Research Institute, Cedars-Sinai Medical Center, Los Angeles, California, USA. 4Department of Basic Medical Sciences, College of Osteopathic Medicine, Western University of Health Sciences, Pomona, California, USA.

Cognitive decline in patients with Alzheimer’s disease (AD) is associated with elevated brain levels of amyloid β protein (Aβ), particularly neurotoxic Aβ1–42. Angiotensin-converting enzyme (ACE) can degrade Aβ1–42, and ACE overexpression in myelomonocytic cells enhances their immune function. To examine the effect of targeted ACE overexpression on AD, we crossed ACE10/10 mice, which overexpress ACE in myelomonocytes using the c-fms promoter, with the transgenic APPSWE/PS1E9 mouse model of AD (AD+). Evaluation of brain tissue from these AD+ACE10/10 mice at 7 and 13 months revealed that levels of both soluble and insoluble brain Aβ1–42 were reduced compared with those in AD+ mice. Furthermore, both plaque burden and astrogliosis were drastically reduced. Administration of the ACE inhibitor ramipril increased Aβ levels in AD+ACE10/10 mice compared with the levels induced by the ACE-independent vasodilator hydralazine. Overall, AD+ACE10/10 mice had less brain-infiltrating cells, consistent with reduced AD-associated pathology, though ACE-overexpressing macrophages were abundant around and engulfing Aβ plaques. At 11 and 12 months of age, the AD+ACE10/WT and AD+ACE10/10 mice were virtually equivalent to non-AD mice in cognitive ability, as assessed by maze-based behavioral tests. Our data demonstrate that an enhanced immune response, coupled with increased myelomonocytic expression of catalytically active ACE, prevents cognitive decline in a murine model of AD.

Introduction

Alzheimer’s disease (AD) is the most common cause of dementia in the elderly and is characterized by a progressive deterioration of cognitive and behavioral functions. Indeed, throughout the world, the incidence of AD is rising as the population ages; it is estimated that over 5 million Americans and well above 35 million people worldwide are currently living with AD (1). AD pathogenesis is intimately associated with elevated brain levels of amyloid β protein (Aβ) in both soluble and extracellular aggregated forms (Aβ plaques) (2, 3). Aβ alloforms are most commonly found as peptides of 38 to 43 amino acids, with Aβ1–42 being most closely associated with AD pathology (4–6). These peptides are the cleavage products of the transmembrane amyloid precursor protein (APP) and are naturally produced within the CNS throughout life. Cerebral Aβ accumulation and aggregation are thought to be one of the main causes of the neuronal loss and cognitive decline seen in AD (7). In addition, persistent neuroinflammation, consisting of reactive astrocytes and activated microglia that become cytotoxic in response to chronically elevated amyloidogenic Aβ, is thought to contribute to disease progression (8–11).

It is still unclear whether abnormalities leading to increased production of Aβ or deficits in its clearance are the primary culprits responsible for cerebral Aβ accumulation in nonfamilial AD (12–14). A recent clinical study suggests that the common sporadic cases are associated with insufficient Aβ clearance rather than increased production (15). While there can be poor correlation between the amount of Aβ plaque deposition and cognitive deterioration, a common view is that any strategy that reduces Aβ, particularly soluble and small oligomeric forms of Aβ1–42, will be advantageous in preventing AD progression (7, 16–18). Aβ removal is regulated by multiple mechanisms, including its degradation by several peptidases and phagocytosis by innate immune cells.

Angiotensin-converting enzyme (ACE) is a carboxy dipeptidase that is best known for the conversion of angiotensin I into the vasoconstrictor angiotensin II (19). However, ACE is a fairly non-specific peptidase that has been shown to hydrolyze peptides as small as three amino acids and as large as Aβ1–42 (20–22). While large amounts of ACE are made by vascular endothelium, virtually every tissue makes some ACE (23). Because of this and because of the substrate promiscuity of the enzyme, ACE participates in many physiologic processes, though its precise role in clearing Aβ is not well understood.

We previously created a mouse model termed ACE10/10, in which gene targeting was used to inactivate the intrinsic Ace promoter and place Ace expression under the control of the c-fms promoter (24). As a result, ACE was overexpressed in myelomonocytic lineage cells (monocytes, macrophages, microglia, etc.), depending on the degree to which cells normally produce C-FMS. Homozygous ACE10/10 mice lack ACE expression by ECs and other tissues that do not recognize the c-fms promoter, while heterozygous ACE10/WT mice do maintain some endogenous ACE expression.
Using these mouse models, we demonstrated that ACE can also affect immune function (24–26). Specifically, ACE<sup>10/10</sup> mice had an increased immune response and decreased disease after challenge with tumors (24) or bacterial infections (25). This was due to the enhanced immune reactivity of ACE-overexpressing macrophages. The phenotype is transferable by BM transplantation and is directly attributable to ACE catalytic activity.

Numerous studies have suggested that the development of cerebral Aβ plaques elicits both a resident microglial and a blood-borne monocytic response (27–35). Further, we found that following immunization, increased peripheral monocyte–derived macrophages homed to Aβ plaques and facilitated their clearance (31, 36). These and other studies suggest that BM-derived macrophages are more efficient than microglia in restricting Aβ plaques in mouse models of AD (29–31, 34, 36–41). Once recruited to the brain, such cells appear to attenuate neuropathology and improve cognitive function.

ACE<sup>10/10</sup> mice have two features that we hypothesized might contribute to reducing the progression of AD. Their macrophages have a markedly enhanced immune response, achieved by overexpression of ACE, an enzyme directly capable of cleaving Aβ<sub>1–42</sub> into less pathogenic peptides. Thus, we wondered whether the local delivery of an Aβ-cleaving enzyme by inflammatory cells would prove effective at reducing AD progression. Here, we report that the crossing of ACE<sup>10/10</sup> mice with a mouse model of AD results in a marked reduction in AD-like pathology and symptoms. Not only did these mice show a substantial decrease in levels of soluble and insoluble Aβ and diminished astrocytosis, but also a maze-based assessment of cognitive function showed behavior very similar to that of the control non-AD mice. Thus, an approach designed to enhance the peripheral immune response, coupled with increased inflammatory cell expression of an enzyme capable of cleaving Aβ (ACE), resulted in an essentially complete prevention of the cognitive decline observed in a model of AD.

Results

Reduced plaque burden. To study AD in ACE<sup>10/10</sup> mice, these animals were crossed with double-Tg APP<sub>Swe</sub>/PS1<sub>ΔE9</sub> (ADtg) mice. This is a well-established mouse model for AD, in which animals overproduce human Aβ peptides, develop plaques with age, and show progressive memory and learning deficits mimicking some aspects of human AD (42). The mouse cross-breeding eventually yielded ADtg (AD<sup>+</sup>) mice with WT ACE (AD<sup>+</sup>-ACE<sup>WT/WT</sup>) mice heterozygous for the ACE 10 allele (AD<sup>+</sup>-ACE<sup>10/WT</sup>) and mice homozygous for this allele (AD<sup>+</sup>-ACE<sup>10/10</sup>), as well as mice lacking the AD Tgs and WT for ACE (AD<sup>-</sup>-ACE<sup>WT/WT</sup>). All mice were on a C57BL/6 background, and the ACE 10 alleles had no effect on blood pressure (Supplemental Figure 1; supplemental material available online with this article; doi:10.1172/JCI66541DS1), similar to what was previously reported (24). Assessment of cerebral APP levels (43) showed no differences in the expression of APP among the different ACE genotypes (Supplemental Figure 2). At 3 months of age, brain Aβ levels were equivalent in AD<sup>+</sup>-ACE<sup>10/10</sup> and AD<sup>-</sup>-ACE<sup>WT/WT</sup> mice (Supplemental Figure 3).

An initial evaluation of plaque burden was qualitatively assessed in coronal brain sections from AD<sup>+</sup>-ACE<sup>WT/WT</sup> and age- and gender-matched AD<sup>+</sup>-ACE<sup>10/10</sup> mice that were 255 days (8.5 months) old. Paraffin sections were immunolabeled with antihuman Aβ mAb 6F/3D. This showed a marked reduction of cortical and hippocampal Aβ burden in AD<sup>+</sup>-ACE<sup>10/10</sup> mice as compared with that in AD<sup>-</sup>-ACE<sup>WT/WT</sup> mice (Figure 1A).

To precisely quantitate Aβ plaques pathology, cohorts of 7- to 8-month-old mice were studied, the age at which ADtg mice start to develop cognitive deficits and exhibit substantial neuropathology (44). To measure cerebral Aβ burden, serial coronal brain sections were immunolabeled with antihuman Aβ mAb 6E10. Sections were colabeled with thioflavine-S (Thio-S), which binds to fibrillar Aβ aggregates that are typical of mature plaques. Representative histologic sections showed a substantial reduction in 6E10<sup>+</sup> and Thio-S<sup>+</sup> plaque burden in both AD<sup>+</sup>-ACE<sup>10/10</sup> and AD<sup>+</sup>-ACE<sup>10/WT</sup> mice as compared with that seen in AD<sup>-</sup>-ACE<sup>WT/WT</sup> mice (Figure 1B). Quantitation of cortical and hippocampal plaque areas indicated a significant reduction in both 6E10<sup>+</sup> and Thio-S<sup>+</sup> plaque load in ADtg mice bearing the ACE 10 allele(s) (Figure 1, C and D). Plaque area was reduced by 31% and 56%, respectively, in mice with a single ACE 10 allele (AD<sup>+</sup>-ACE<sup>10/WT</sup>) versus AD<sup>-</sup>-ACE<sup>WT/WT</sup> mice. A greater reduction in plaque area was observed in AD<sup>+</sup>-ACE<sup>10/10</sup> mice, which showed a reduced plaque burden of 69% to 79% compared with AD<sup>-</sup>-ACE<sup>WT/WT</sup> mice (<i>P < 0.0001</i>).

We also assessed brain-insoluble Aβ<sub>1–42</sub> levels by quantitative ELISA analysis (Supplemental Figure 4). We found that 7-month-old AD<sup>+</sup>-ACE<sup>10/WT</sup> and AD<sup>+</sup>-ACE<sup>10/10</sup> mice had a respective average of 33% and 64% less insoluble Aβ<sub>1–42</sub> compared with AD<sup>-</sup>-ACE<sup>WT/WT</sup> mice. At 13 months of age, AD<sup>+</sup>-ACE<sup>10/10</sup> mice averaged 30% less insoluble Aβ<sub>1–42</sub> as compared with AD<sup>-</sup>-ACE<sup>WT/WT</sup> mice. These data substantiate our immunohistochemical analysis.

Analysis of ACE levels in the brain confirmed the expected ACE level increase in AD<sup>+</sup>-ACE<sup>10/WT</sup> and AD<sup>+</sup>-ACE<sup>10/10</sup> mice (Supplemental Figure 5). While there appeared to be an inverse relationship between parenchymal Aβ plaque burden and ACE levels in the brain, differences between AD<sup>+</sup>-ACE<sup>10/WT</sup> and AD<sup>+</sup>-ACE<sup>10/10</sup> mice reached significance only in the Thio-S analysis of cortical and hippocampal plaque areas (Figure 1D).

Perivascular Aβ deposition. Deposition of Aβ in the wall of blood vessels has been associated with neuroinflammation and dementia (45). Vascular Aβ was first investigated in Aβ-stained paraffin brain sections from 8.5-month-old AD<sup>+</sup>-ACE<sup>10/10</sup> and age- and gender-matched AD<sup>+</sup>-ACE<sup>WT/WT</sup> mice (Figure 2A). While the AD<sup>-</sup>-ACE<sup>10/10</sup> mice had substantially less overall parenchymal Aβ, they presented with perivascular deposition of Aβ. To more completely characterize vascular Aβ, PFA-fixed hippocampal sections of 7- to 8-month-old AD<sup>+</sup>-ACE<sup>WT/WT</sup>, AD<sup>-</sup>-ACE<sup>10/10</sup>, and AD<sup>+</sup>-ACE<sup>10/10</sup> mice were stained with Thio-S, anti-CD31 (an endothelial marker), and 6E10. Here, serial sections were studied by fluorescence microscopy, and perivascular Aβ was quantified by Thio-S<sup>+</sup> area (Figure 2, B and C). Separate histologic sections were stained for anti-CD31 and 6E10 (antihuman Aβ), and perivascular Aβ was quantified by 6E10<sup>+</sup> area (Supplemental Figure 6). Both studies produced the same result; whether assessed by Thio-S staining or by staining with an anti-Aβ antibody, AD<sup>-</sup>-ACE<sup>10/10</sup> mice had substantially less perivascular Aβ than either AD<sup>-</sup>-ACE<sup>WT/WT</sup> or AD<sup>+</sup>-ACE<sup>10/10</sup> mice (Figure 2C, <i>P values < 0.0001</i>). In contrast, there was no significant difference in the amount of perivascular Aβ between AD<sup>-</sup>-ACE<sup>WT/WT</sup> and AD<sup>-</sup>-ACE<sup>10/10</sup> mice. One of the major differences between AD<sup>-</sup>-ACE<sup>WT/WT</sup> and AD<sup>+</sup>-ACE<sup>10/10</sup> mice is that AD<sup>-</sup>-ACE<sup>10/10</sup> mice lack ACE expression in vascular endothelium.

Reduced astrogliosis. Astrocytes are the main type of glial cells in the brain. Associated with AD progression, astrocytes migrate to Aβ plaques and exhibit increased reactivity and cytotoxicity (termed
astrogliosis or astrocytosis) (11, 46, 47). These astrocytes also increase expression of the astrocyte-specific glial fibrillary acidic protein (GFAP). To evaluate astrogliosis, coronal sections from 7- to 8-month-old mice were stained with an anti-GFAP antibody and assessed for both the number of positive cells and the immunoreactive area. Representative histologic sections are shown in Figure 3A, while quantitative analysis is presented in Figure 3B. These data showed a very significant reduction (45%–57%) in both cell numbers and area of astrogliosis in AD+ mice that were either heterozygous or homozygous for the ACE 10 allele (Figure 3B; P values < 0.001). In fact, AD+ACE10/WT and AD+ACE10/10 were not significantly different from age-matched non-Tg control mice (AD–ACEWT/WT).

We also examined astrogliosis in a cohort of 13-month-old mice (Figure 3C). Even at this stage of disease, both the area of astrogliosis and the number of GFAP + cells were reduced by 50% in AD+ACE10/10 mice as compared with those in AD+ACEWT/WT mice. Thus, the analysis of GFAP+ cells at both 7 and 13 months showed a consistent reduction in astrocytosis in AD+ mice overexpressing ACE in myelomonocytic cells.

Reduced soluble brain Aβ1–42 and Aβ1–40. Soluble Aβ1–42 peptide is thought to be particularly neurotoxic, and elevated cerebral levels of this peptide have been associated with cognitive deficits in AD (5, 7). We measured soluble human Aβ1–42 in the brains of AD+ mice at 5, 7, and 13 months of age (Figure 4, A–C). At 5 months of age, we observed relatively low levels of Aβ1–42 in all groups. However, even at this point, AD+ACE10/10 mice had a 45% reduction in soluble Aβ1–42. By 7 months of age, the trend was clearer, with the AD+ACE10/WT and AD+ACE10/10 mice having 38% and 44% reductions, respectively, in soluble Aβ1–42 levels as compared with those in ADtg mice WT for ACE (AD+ACE WT/WT). These differences are highly statistically significant (P < 0.001). By 13 months of age, the percentage difference between the AD+ACEWT/WT and AD+ACE10/10 mice had contracted (15%), though it remained significant (P < 0.05). At this age, the nature of the aggressive genetic model of AD is such that there is abundant soluble Aβ1–42 that swamps the ability of both groups of animals to clear the peptide. However, the absolute reduction in soluble Aβ1–42 concentrations (i.e., the difference of the means) between AD+ACEWT/WT and AD+ACE10/10 mice at 5, 7, and 13 months of age is 23, 109, and 324 pg/mg protein, respectively, and thus increases with age.

Studies have suggested that ACE not only converts Aβ1–42 to Aβ1–40 but can also cleave Aβ1–40 into smaller fragments (20–22). Cerebral levels of Aβ1–40 were measured by ELISA in 7-month-old...
mice than in the AD\textsuperscript{ACEWT/WT} mice. However, treatment of AD\textsuperscript{ACE10/10} mice with the ACE inhibitor ramipril resulted in an increase of plaque burden as compared with that observed in untreated AD\textsuperscript{ACE10/10} mice or AD\textsuperscript{ACE10/10} mice treated with hydralazine. We also measured brain-insoluble and -soluble levels of A\textsubscript{β}1–42 in the drug-treated mice (Figure 5, C and D) and found that insoluble A\textsubscript{β}1–42 levels were equivalent in mice treated for 28 days with either ramipril or hydralazine. However, by 60 days, we observed that insoluble A\textsubscript{β}1–42 levels were higher in the ramipril-treated mice than in the mice treated with hydralazine, consistent with the greater plaque burden seen in these animals (Figure 5B). Soluble A\textsubscript{β}1–42 levels were also higher in the ramipril-treated AD\textsuperscript{ACE10/10} mice as compared with those in equivalent mice treated with hydralazine (Figure 5D), and we observed this in both the 28-day- and 60-day-treatment cohorts. Thus, in the AD\textsuperscript{ACE10/10} mouse model, inhibiting ACE catalytic activity with ramipril markedly reduced the beneficial effects on plaque burden and on soluble and insoluble levels of A\textsubscript{β}1–42 as compared with the effects seen in the hydralazine-treated mice.

**Blood-borne monocytic cell infiltration and cellular Aβ uptake.** Cerebral inflammation is a prominent feature in AD. To assess the infiltration of blood-borne monocytic cells, we isolated and disassociated brains from age-matched 9.9- to 14.5-month-old AD\textsuperscript{ACEWT/WT} and AD\textsuperscript{ACE10/10} mice. We then studied resident and peripherally derived inflammatory cells by flow cytometry after antibody labeling for the immune surface markers CD45, CD11b, and Ly6C (49, 50). Initial gating defined two populations: infiltrating hematopoietic cells (CD45\textsuperscript{hi}) and microglia (CD11b\textsuperscript{hi}CD45\textsuperscript{lo-mid}) (Supplemental Figure 8A). The CD45\textsuperscript{hi} cells were further gated for CD11b\textsuperscript{hi} and Ly6C\textsuperscript{hi} expression (Supplemental Figure 8B). Several published studies indicate that CD45\textsuperscript{hi}Ly6C\textsuperscript{hi}CD11b\textsuperscript{hi} cells are monocytes originating from peripheral blood (51, 52). Quantification of these cells as a percentage of all CD11b\textsuperscript{hi} cells showed a decrease in the percentage of these cells in AD\textsuperscript{ACE10/10} mice as compared with that observed in AD\textsuperscript{ACE10/10} mice (Supplemental Figure 8C). This is not surprising, given the substantial disease burden we observed in AD\textsuperscript{ACEWT/WT} mice and the reduction of this burden in AD\textsuperscript{ACE10/10} mice. Another way to assess infiltrating monocytic cells is to measure the CD11b\textsuperscript{hi}Ly6C\textsuperscript{hi} cells as a percentage of total CD11b\textsuperscript{hi} cells. This assessment produced the same result of decreased inflammation in the AD\textsuperscript{ACE10/10} mice (Supplemental Figure 8D). Thus, the decreased AD we observed in AD\textsuperscript{ACE10/10} mice (reduced plaque numbers, reduced astroglisis, etc.) was also associated with a reduction in total cerebral inflammation.
Phages had very high ACE expression in addition to CD45hi staining in the ACE 10 model, while the monocytes and macrophages in AD+ACE10/WT and AD+ACE10/10 mice had a reduced plaque burden, less astrogliosis, and lower amounts of soluble amyloidogenic Aββ42. While the macrophages in AD+ACE10/WT mice appeared to be engulfment of Aββ42, suggesting that these nonresident inflammatory cells were engulfing and possibly clearing part of the plaque. We also saw an ACEhi monocytic-like cell in the vicinity of the plaque. Figure 6D, which shows an AD+ACE10/WT mouse cortical plaque surrounded by CD45hi macrophages (arrows), costained for intracellular Aββ42, suggesting that these nonresident inflammatory cells were engulfing and possibly clearing part of the plaque. The plaques in the AD+ACE10/10 model (Figure 6F). While we found that macrophage association with plaques was occasionally present in AD+ACEWT/WT mice (Figure 6E), it was less prominent.

We also performed a quantitation test, in which serial tissue sections were stained with anti-CD45, Aββ42, and IBA1, and we calculated the area of IBA1+CD45hi cells (Figure 6, G and H). Such cells are often considered infiltrating myeloid cells. Our data showed fewer such cells in the AD+ACE10/10 mice, but these data did not reach statistical significance. However, when we corrected this number for the total area of 6E10+ plaques to assess the number of infiltrating monocytic cells per plaque area, we found a significant increase in these numbers in the AD+ACE10/10 mice (Figure 6J). In summary, our microscopic analysis suggests that, in AD+ACE10/10 mice, the infiltrating cells are increasingly found to be associated with Aββ plaque and are probably engaged in phagocytosis of Aββ.

*Retained cognitive function by the Barnes maze test. While the AD+ACEWT/WT and AD+ACEACE10/10 mice have a reduced plaque burden, less astrogliosis, and lower amounts of soluble amyloidogenic Aββ in the brain, the most crucial measure of resistance to AD progression is cognitive behavior. Spatial learning and memory were assessed in two separate cohorts of mice. One cohort of 11-month-old mice was tested by independent evaluators from the Cedars-Sinai Behavioral Core (Figure 7, A–F). A second cohort of 12-month-old mice was independently evaluated by members of our research group (Figure 8, A–F). All observers were blinded to the mouse genotype. The evaluators of each cohort arrived at the same conclusions. First, an open field test of ambulatory and rearing behavior

![Image](https://example.com/image.png)
was performed to verify that the mice could be further assessed for cognitive function (Figure 7, A and B, and Figure 8, A and B). This test showed no significant differences between the groups, except for a mild increase in ambulatory activity of the 12-month-old AD+ACEWT/WT mice as compared with that of the AD–ACEWT/WT mice (Figure 8A). Next, the mice were assessed using a Barnes maze, which tests hippocampal-based ability to learn and remember the location of an escape box using spatial cues (54–56). There was a training phase of 4 days, in which mice became progressively more efficient at finding the escape box (Figure 7C and Figure 8C), resulting in a shorter escape latency time. After a hiatus of 2 days, the mice were assessed for memory retention (day 7; Figure 7D and Figure 8D). This was followed on days 8 and 9 by the reversal phase, in which the position of the escape box was altered to test the ability of the mice to re-learn a new location. The analyses of two separate cohorts of mice by two different evaluating groups revealed that there was a marked difference in cognitive function, especially in the memory retention and reversal phases, between AD+ACEWT/WT and AD+ACE10/10 mice. The AD+ACEWT/WT mice demonstrated less cognitive ability to learn and retain the ability to solve the Barnes maze test (Figure 7C, C–F, and Figure 8, C–F). In contrast, the AD+ACE10/10 mice evaluated in Figure 7 and the AD+ACE10/10 mice evaluated in Figure 8 demonstrated significantly improved cognitive behavior. In fact, mice having at least one ACE 10 allele showed maze-solving cognitive abilities that were not statistically different from those of control (WT) non-AD mice. Thus, not only does the presence of the ACE 10 allele reduce AD-like neuropathology, but it also appears to preserve cognitive ability.

Discussion
The goal of AD treatment is to retard or prevent the cognitive decline that is such a debilitating part of the disease. Thus, the results we obtained when ACE10/10 mice were crossed with ADtg mice were extremely encouraging, in that the spatial learning and memory of 11- and 12-month-old animals were almost identical to those of mice without any genetic predisposition to AD. ACE10/10 mice over-express ACE in myelomonocytic lineage cells; these mice lack ACE expression by ECs. In contrast, ACE10/WT mice maintain some endogenous endothelial ACE expression. Because of the targeted high ACE levels in monocytes and the unusual tissue pattern of ACE expression in ACE10/10 mice, care must be taken in extrapolating to the normal function of ACE. Indeed, the high expression of ACE in mouse and ACE10/WT in monocytes is best considered as ACE in a pharmacologic fashion.

A number of studies have shown that ACE10/10 mice have a marked enhancement of both their innate and adaptive immune responses. When challenged with a mouse model of melanoma, ACE10/10 mice showed an increased inflammatory response characterized by more aggressive monocyte and macrophage infiltration of the tumor (24). The result was a very substantial reduction in tumor growth. An enhanced innate immune response was also observed when ACE10/10 mice were challenged with L. monocytogenes or methicillin-resistant S. aureus (25). This appeared to be due to an intense mononuclear/macrophagic response, and again, this resulted in reduced disease. While the precise biochemical details of how ACE changes the immune response are not yet known, a substantial feature is that ACE overexpression tilts the development of monocytes and macrophages toward a more inflammatory phenotype (57).

As compared with non-AD mice, we found that AD+ACE10/WT and AD+ACE10/10 mice still had relatively high levels of cerebral-soluble and -insoluble Aβ. Yet, despite this, these mice had near-normal cognitive function, as measured by the Barnes maze test. A striking feature of the AD+ACE10/WT and AD+ACE10/10 mice is that, even at 13 months of age, these animals showed a significant decrease in insoluble and soluble Aβ as compared with the levels seen in the AD+ACEWT/WT mice and that this was accompanied by a marked reduction in argiostrogia. This may help explain why the cognitive abilities of these genotypes were so well preserved.

Recently, there has been an appreciation that the inflammatory response, including the participation of blood-borne macrophages, can affect the progression of AD. In particular, BM-derived monocytic cells can infiltrate the brain and reduce Aβ plaque burden (29–32, 34, 36, 38–41, 58). Macrophages readily absorb amyloid fibrils in vitro (59, 60) and seem more efficient than microglia at restricting Aβ plaques in models of AD (30, 31, 36, 38). ADtg mice immunized with glatiramer acetate or DCs loaded with the peptide MOG45S had an increased cerebral...
infiltration of monocytes that resulted in substantial attenuation of AD pathology (31, 36, 61). These mice also had reduced cognitive impairment (62). Importantly, depletion of peripheral monocyte inflammatory cells or insufficient recruitment of BM-derived myeloid-derived cells to the brain led to accelerated AD pathology (31, 38). Taken together, these ideas led to our testing of the effect of the ACE10/10 phenotype in AD.

Our analysis of cerebral inflammation showed an overall lower number of blood-borne inflammatory monocytes in AD+ACE10/10 mice compared with that seen in AD+ACEWT/WT mice. This is not surprising, given the difference in pathology between the two genotypes. In addition, there was histologic evidence showing that in the AD+ACE10/10 mice, the CD45hiACEhi-expressing cells present in the brain associated with amyloid plaques in a manner suggesting an increase in the number of monocyteic cells per plaque area and compared with those seen with hydralazine treatment, a blood pressure–lowering drug that does not affect ACE. This is not surprising, since overexpression of catalytically active ACE is the key mechanistic feature of ACE10/10 mice, and previous studies have shown that ACE10/10 mice treated with ACE inhibitors exhibit the phenotype of WT mice (24, 25). In WT mice and humans, ACE is normally produced by vascular endothelium, but what role this plays in the biology of Aβ, including pathogenic forms such as Aβ1-42, is not known.

In our model, the analysis of perivascular Aβ was striking in that AD+ACE10/10 mice had substantially less perivascular Aβ than either AD+ACEWT/WT or AD+ACE10/10 mice. This was surprising, since by all other measures, AD+ACE10/10 mice showed equal or less AD pathology. As mentioned, endothelium in AD+ACE10/10 mice produces no ACE, and it is possible that this contributes to more perivascular Aβ in this genotype than in AD+ACE10/WT mice, which produce some enhanced phagocytosis of amyloid. In the ACE10/10 model, both the IBA1-CD45hi and the ACEhi phenotypes marked monocyteic cells as originating in the BM. Thus, a more effective immune response of inflammatory cells overexpressing ACE can explain, at least in part, the beneficial phenotype observed in the AD+ACE10/WT and AD+ACE10/10 mice.

There is a second feature of the ACE10/10 mice that should contribute to protection against AD. Several studies have identified ACE as being capable of cleaving a variety of amyloid peptides, including Aβ1-42 and Aβ1-40, into smaller fragments; at least in vitro, ACE can have both carboxypeptidic and endopeptidic activity against these larger amyloidogenic peptides (20–22, 63). In ACE10/10 mice, the serum levels of Aβ are no different from WT mice. However, monocytes and macrophages express 16-fold to more than 50-fold greater amounts of normal surface ACE (24). Thus, a second advantage of the ACE10/10 model in AD is the potential for enzymatic elimination of pathogenic peptides. In fact, our findings of reduced cerebral levels of Aβ in 5-, 7-, and 13-month-old AD+ACE10/10 mice are consistent with this hypothesis.

As shown in Figure 5, treatment of AD+ACE10/10 mice with the high-affinity and specific ACE catalytic inhibitor ramipril, known to cross the blood-brain barrier (48), significantly reduced the beneficial effects observed in this model (plaque burden and Aβ1-42) as
endothelial ACE due to the presence of one WT ACE allele. Further, the decreased perivascular Aβ we observed in AD'ACE10/WT mice, together with the substantial reductions in soluble Aβ and astrogliosis, may help explain why the cognitive abilities of this genotype, as measured by the Barnes maze test, were equivalent to those of both AD'ACE10/10 and non-AD mice.

Microglia differentiate from myeloid progenitor cells, and in the ACE10/10 mice, they expressed more ACE than WT microglia, but less ACE than monocytes and macrophages. When microglia from non-AD ACE10/10 brains were studied in vitro following exposure to LPS, they also appeared more inflammatory than similarly treated cells from ACE WT mice (Supplemental Figure 9). Additional experiments, including BM transfer, will be necessary to define the contribution of BM monocytes versus microglia in the AD'ACE10/10 phenotype.

Several groups have studied the in vivo effect of natural levels of ACE on the incidence of AD, and evidence has been presented both for and against the idea that natural ACE levels affect disease

Figure 6
Infiltrating monocyctic cells are increasingly associated with Aβ plaque and cellular uptake of Aβ. (A–F) Fluorescent micrographs of hippocampal and cortical plaques from 7-month-old mice. Sections were immunolabeled for ACE (green), CD45 (red), human Aβ (4G8; cyan), and nuclei (DAPI; blue). A–D show the composite picture and images from the individual color channels. (A) In AD'ACEWT/WT brains, the plaques were generally larger and composed of highly aggregated Aβ. CD45hiACElo cells were colocalized with amyloid plaques. (B and C) In AD'ACE10/10 mice, the plaques were generally smaller and had a more diffuse morphology. CD45hiACElo infiltrating monocyte–derived macrophages were more frequently present in the vicinity of amyloid plaques. ACE was also expressed in the brain by resident CD45lointermedACEhi microglia. In AD'ACE10/10 mice, infiltrating monocytes expressed high levels of ACE (arrowheads). (D) Cortical region from an AD'ACE10/10 mouse showed increased CD45hiACElo infiltrating macrophages at the amyloid lesion site. Colocalization of CD45hiACElo cells and intracellular Aβ immunoreactivity (arrows in insert) were observed, indicating cellular uptake of Aβ. (E and F) Enlargements of boxed areas in A and B. (F) In the AD'ACE10/10 plaque region, macrophages (MΦ) and microglia (MG) overexpressed ACE. Internalization of Aβ (white) by plaque-associated CD45hiACElo macrophages was observed. (G) Multichannel image shows recruitment of blood-derived IBA1+ (green) CD45hi (red) macrophages to 6E10+ plaque (cyan) in AD'ACE10/10 brain. Scale bars: 10 μm. (H) Quantitation of IBA1-CD45hi immunoreactive area. The ratio of IBA1-CD45hi area to the 6E10-immunoreactive area showed a significant increase (2.3-fold) in the number of macrophages per plaque area in AD'ACE10/10 versus that observed in AD'ACEWT/WT mice. *P < 0.05.
risk (20, 64–67). Several meta-analyses have consistently found that lower serum and tissue ACE levels, as determined by an ACE gene polymorphism, were associated with a small increased risk of developing AD (68–71). On the other hand, recent genome-wide association studies have failed to find involvement of ACE genetic variation in AD (64, 72). However, these studies reflect an evaluation of the normal levels of ACE present in humans. As mentioned, we found that ACE expression in the ACE^10/10^ model was markedly increased, and it is likely that the catalytic activity of ACE, selectively expressed on the surface of macrophages and microglia, benefits the AD^ACE^10/10^ mice by reducing Aβ levels. This conclusion is supported by the higher brain Aβ_{1-42} levels seen in mice treated with the ACE inhibitor ramipril as compared with the levels observed in mice treated with hydralazine. At the very least, our studies in ACE 10 mice emphasize the advantage of combining two separate approaches to reduce Aβ burden in AD: an enhanced immune response resulting from ACE overexpression in monocytes and macrophages combined with the direct enzymatic effect of ACE in cleaving Aβ peptides. The effect in the AD^ACE^10/WT^ and AD^ACE^10/10^ mice was a reduction of Aβ plaques, soluble amyloidogenic Aβ, astrogliosis, and most remarkably, a retention of cognitive abilities that were virtually equivalent to those of non-AD mice.

Our study has limits, in that we did not evaluate the role of local angiotensin II production or angiotensin receptor expression in the mice heterozygous or homozygous for the ACE 10 allele. Also, we did not investigate the effects of this allele on the regulation of angiotensinogen. Several studies have suggested that angiotensin II AT1 receptor antagonists may be beneficial in AD by inhibiting the effects of angiotensin II, while permitting continued ACE cleavage of Aβ (73). The precise role of angiotensin II in the mouse models we studied is not understood.

In ACE^10/10^ mice, activated macrophages have an enhanced inflammatory response (19). Use of monocytic cells overexpressing ACE in humans could conceivably have side effects. However, our evidence from the AD^ACE^10/10^ mice showed the opposite, namely, a decrease in overall cerebral inflammation. Also, ACE inhibitors would probably be an effective countermeasure, as ACE^10/10^ mice treated with such inhibitors have the phenotype of WT mice (24, 25). Further, we have never seen any evidence of autoimmune disease in ACE^10/10^ mice. While it is possible to envision a strategy for delivering ACE-overexpressing monocytes to patients, perhaps the most informative finding of our studies is the effectiveness of combining an approach to enhance the immune response with that of delivering inflammatory cells to enzymatically destroy Aβ.

Methods

Mice. ACE^10/10^ mice have been previously described (24). In this strain, targeted homologous recombination was used to insert a c-fms promoter to direct tissue overexpression of ACE in myelomonocytic cells. The ACE genotypes are WT (ACE^WT/WT^), heterozygous (ACE^10/WT^), and homozygous for the targeted allele (ACE^10/10^). These mice were backcrossed at least ten generations to C57BL/6j mice (The Jackson Laboratory).

The ADtg strain was originally purchased from The Jackson Laboratory (B6.Cg-TgAPPsw,PS1E9^85Dbo/J; stock no. 005864); then bred and maintained at Cedars-Sinai Medical Center. The Tgs contain familial AD mutations and are expressed in CNS tissue under the control of the mouse prion protein (PrP) promoter. They contain cDNA sequences for the mutant human/mouse chimeric Aβ (A4) precursor protein (Swedish dou-
Preservation of cognitive function in 11-month-old AD−ACEWT/WT and AD−ACE10/10 mice. Open field test assessing ambulatory (A) and rearing (B) behavior. No significant differences were observed. (C–F) Barnes maze assessment of spatial learning and memory. (D) During the training and acquisition phase, the mice became more efficient at finding and entering the escape box, resulting in reduced escape latency. Analysis by 2-way ANOVA showed a significant difference between genotypes \( (P = 0.0042) \). One-way ANOVA analysis of individual days 1–4 showed no significant differences between the genotypes. (D) A memory retention test was performed on day 7 after a hiatus of 2 days. The reduction in mean latency between AD−ACEWT/WT and AD−ACE10/10 mice was 67% and 64%, respectively, versus that of AD−ACEWT/WT mice. There was no statistical difference between AD−ACE10/WT or AD−ACE10/10 mice and WT mice. \( (P < 0.0001) \). One-way ANOVA of days 8 and 9 showed significant differences between AD−ACEWT/WT and the other groups. Again, there was no statistical difference between AD−ACE10/WT or AD−ACE10/10 mice and WT mice. (F) On day 9, the significant reduction in mean latency between AD−ACE10/WT or AD−ACE10/10 mice was 66% and 50%, respectively, versus that of AD−ACEWT/WT mice. \( n = 6–10 \) mice per group. \( * P < 0.05; ** P < 0.001; *** P < 0.0001. \)

Biochemical determination of Aβ1−40 and Aβ1−42 levels by sandwich ELISA. For brain-soluble and -insoluble ELISA analysis, brain tissues were homogenized in PBS buffer with 0.5% Triton X-100 and a 1X protease inhibitor cocktail set I (Calbiochem). After removal of cell debris, the homogenate was centrifuged at 10,000 \( g \) for 20 minutes at 4°C (36, 61). The supernatant was considered the soluble fraction and was used to assess soluble Aβ. The pellet was diluted with the above homogenizing buffer. This was the insoluble fraction and was used to assess insoluble Aβ. After determination of the protein concentration (Thermo Fisher Scientific), soluble and insoluble Tg-derived Aβ1−42 levels were determined using an anti-human Aβ1−42 end-specific sandwich ELISA kit (KHB3442; Invitrogen) according to the manufacturer’s instructions. This kit does not recognize mouse Aβ, nor does it recognize human Aβ1−40 or Aβ1−43. The kit uses two antibodies and is specific for the N- and COOH-termini of the Aβ1−42 sequence; bound rabbit antibody was detected using an HRP-labeled anti-rabbit antibody and was read at 450 nm with a microplate reader (SpectraMax Plus384; Molecular Devices). Soluble Aβ1−40 levels were measured using a similar Invitrogen ELISA kit (KHB3482).
Figure 8
Retained cognition in 12-month-old AD-ACE<sup>WT/WT</sup> mice. Open field test assessing ambulatory (A) and rearing (B) behavior. Only the ambulatory count for AD-ACE<sup>WT/WT</sup> versus AD-ACE<sup>10/10</sup> mice was significantly different. (C–F) Barnes maze assessment of spatial learning and memory following the same protocol as Figure 7. (C) Analysis of days 1–4 by 2-way ANOVA showed a significant difference between genotypes (P < 0.0001). Analysis of data from individual days by 1-way ANOVA showed significant differences between AD-ACE<sup>WT/WT</sup> and AD-ACE<sup>10/10</sup> mice. There was no significant difference between the AD-ACE<sup>10/10</sup> mice and the two populations of non-AD control mice. (D) After a hiatus of 2 days, memory retention was assessed on day 7. There was a 58% difference in the reduction of mean latency between AD-ACE<sup>10/10</sup> and AD-ACE<sup>WT/WT</sup> mice. No statistical difference was observed between AD-ACE<sup>10/10</sup> mice and the two non-AD control groups. (E and F) During the reversal phase, the location of the escape box was changed, and escape latency was measured. Data analysis by 2-way ANOVA showed a significant difference between genotypes (P < 0.0001). Again, there was no statistical difference between AD-ACE<sup>10/10</sup> mice and the two control groups. On day 8, no significant differences were observed by 1-way ANOVA. Day 9 data analysis showed significant differences between AD-ACE<sup>WT/WT</sup> mice and the other groups. There was a 50% difference in the reduction of mean latency between the AD-ACE<sup>WT/WT</sup> and AD-ACE<sup>10/10</sup> mice. n = 10–11 mice per group. *P < 0.05; **P < 0.001; ***P < 0.0001.
of the escape box remained the same for a mouse during every trial of the training phase, but was shifted between mice to reduce the potential for unintended intramaze cues. Training was repeated three times per day, with a 15-minute interval separating each trial. Data from each trial were recorded and averaged. The training phase was conducted for 4 days, followed by a 2-day break with no exposure to the maze. On day 7, each animal was re-tested in a three-trial session using the same escape box location and method from the training phase. On day 8 following the retention phase, the reversal phase began, in which the escape box was placed in a different quadrant than the original escape box location. Using the same procedure as above, reversal trials were repeated three times per day over two consecutive days (days 8 and 9). Data were recorded both manually and by a video camera located above the maze.

Statistical Analysis. Data were analyzed using GraphPad Prism software, version 5.0b (GraphPad Software). Values are presented for the individual mice and/or expressed as the means ± SEM. ANOVA with Tukey’s post-hoc tests were used for multiple comparisons. The behavioral data were analyzed using both repeated-measures 2-way and 1-way ANOVA with Tukey’s post-hoc tests for each day. Two-group comparisons were analyzed by 2-tailed, unpaired Student’s t-tests. A P-value of less than 0.05 was considered statistically significant.

Study approval. All experimental protocols were approved by and conducted according to the instructions of the IACUC of Cedars-Sinai Medical Center.

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Address correspondence to: Maya Kornoyo-Hamaoui, Cedars-Sinai Medical Center, 127 S. San Vicente Blvd., Los Angeles, California 90048, USA. Phone: 310.423.7473; Fax: 424.315.4569; E-mail: maya.kornoyo@cshs.org.


