Glaucoma describes a group of progressive optic neuropathies in which the potential to cause irreversible blindness in which a main risk factor is raised IOP. In POAG, increases in IOP occur when aqueous humour (AqH) outflow through the trabecular meshwork (TM) is reduced, usually as a result of abnormalities in TM cellularity,1–4 TM contraction,5,6 and extracellular matrix (ECM) levels.7–9 The elastic-like fibers in the TM are surrounded by a sheath of fine fibrils embedded in an amorphous ECM made up of collagen IV, laminin, and fibronectin. The presence of plaque material associated with sheaths of the elastic-like fibers in the juxtacanalicular tissue (JCT) within the TM (Sheath-derived [SD] plaques) are also a pathological feature of POAG, with patients presenting with increased outflow resistance since Lujten-Drecoll et al.10 showed that eyes with pseudoxfoliation glaucoma had similar levels of SD-plaque material when compared with healthy eyes, but still had higher levels of IOP. Nevertheless, increased levels of ECM are seen around TM sheaths and this deposition could contribute to increased outflow resistance.13 These cellular and ECM changes in the TM, together with altered TM cell contractile abilities result in a dysfunctional TM and ultimately loss of the tight control of AqH outflow. The mechanisms that lead to TM dysfunction in POAG are probably multifactorial, but pathologically high levels of TGF-β within the AqH are thought to contribute.9,14–24 Some POAG patients have elevated levels of TGF-β in their AqH compared with AqH taken from age-matched patients with cataracts25–27 or other forms of glaucoma.28 A role for TGF-β in increasing TM ECM deposition and IOP has been demonstrated by human eye perfusion experiments29,30 and in rodent models of glaucoma.16,20–22 Gene expression studies from cultured human TM cells also support the assertion that both TGF-β1 and TGF-β2 isoforms induce the overexpression of ECM proteins that may contribute to TM changes seen in glaucoma.9,31,32 Additionally, TGF-β prevents the breakdown of ECM by inhibiting the activation of matrix metalloproteinases (MMP) through increasing levels of plasminogen.
activator inhibitor (PAI-1) and tissue inhibitors of metalloproteinases (TIMP). Plasminogen activator inhibitor-1 inhibits the conversion of plasminogen to plasmin, which is required for the plasmin-dependent activation of MMP.54,55 The IOP-increasing effects of TGF-β have also been attributed to the cytokine’s ability to reduce proliferation56 and induce apoptosis of TM cells,56 thereby reducing the overall numbers of TM cells.19,24

Transforming growth factor-β also stimulates contraction of TM cells through the RhoA-Rho kinase signaling pathway,51 with TM contractility significantly influencing IOP.57–59 Studies that have reduced or ablated RhoA-mediated TM contraction using Rho/ROCK inhibitors, have led to new classes of IOP lowering agents being considered to treat glaucoma.57–60 However, it is unlikely that Rho/ROCK inhibitors alone can address the chronic fibrotic pathology that occurs in some patients with POAG, with their efficacy is still under scrutiny. Ultimately, IOP elevations lead to metabolic and biochemical changes in cells of the optic nerve head and retina,53 which, together with the mechanical axonal compression that affects both retrograde and anterograde axonal transport depriving RGC of neurotrophic factors,54 culminates in RGC apoptosis and optic disc cupping.45,46 which features are diagnostic of glaucoma.

The multifactorial etiology of POAG makes accurate experimental modeling of the condition challenging. One major impediment to testing antifibrotic/fibrolytic agents that address TM fibrosis is the lack of reliable animal models that mimic the fibrotic etiology of POAG. Although not replicating the human condition perfectly, some current rodent models are useful for evaluating therapeutics that reduce IOP and prevent RGC death. For example, Junglas et al.16 used adenovirus to overexpress the profibrotic connective tissue growth factor (CTGF, a downstream mediator of TGF-β effects) in order to demonstrate a link between CTGF and TM fibrosis associated with increased IOP and RGC loss, but they did not evaluate the efficacy of antifibrotic agents. Ideally, fibrolytic treatments would be better assessed in a chronic model of established TM fibrosis, whereby TM fibrosis is sustained without the need for continued administration of the profibrogenic agent.

The matrix-kine Decorin is a small leucine-rich proteoglycan that regulates cell proliferation, survival and differentiation by antagonizing growth factors and/or their receptors, including TGF-β,47,48 epidermal growth factor (EGF),50 vascular endothelial growth factor (VEGF),51 and insulin-like growth factor-I (IGF-I).52 as well as directly interfering with collagen fibrillogenesis.53 Decorin also increases MMP activity by increasing levels of tissue plasminogen activator (tPA), enabling cleavage of plasminogen to plasmin,54,55 a step that is required for plasmin-dependent activation of MMP. Decorin also reduces PAI-1 and TIMP levels, further facilitating MMP activation.54 Decorin’s fibrolytic actions have been noted in many fibroproliferative pathologies, including proliferative vitreoretinopathy,56 renal fibrosis,57 lung fibrosis,58 juvenile communicating hydrocephalus,47 and spinal cord injury.59

Here, we investigated the fibrolytic properties of human recombinant (hr) Decorin in the fibrosed TM using a rodent model in which TM fibrosis is established by repeated intracameral injections (IC) of TGF-β, with the fibrosis being sustained upon withdrawal of the fibrogenic cytokine. We predicted that (1) TGF-β-induced fibrosis of the TM would permanently block AqH drainage, leading to increased IOP and death of RGC, with measurable effects on retinal function, and (2) that treatment with hrDecorin would reduce established TM fibrosis, lower IOP and indirectly protect RGC against progressive death.

**METHODS**

**Animals and Surgery**

Eight- to 10-week-old, male, 175 to 200 g, Sprague Dawley rats (Charles River, Kent, UK), housed with free access to food and water, under a 12-hour dark/light cycle were used for all in vitro and in vivo experiments. Surgery was performed at the Biomedical Services Unit at the University of Birmingham (Birmingham, UK) in accordance with the Home Office guidelines set out in the 1986 Animal Act (UK) and the ARVO Statement for the Use of Animals in Ophthalmic and Vision Research. All ocular surgical procedures, electrophysiology, and IOP measurements were completed under inhalational anesthesia using 2% to 5% isoflurane/95% O2 (National Vet Supplies, Stoke, UK) at a flow rate of 1.5L/min. Preoperative 0.1 mg/kg buprenorphine (National Vet Supplies) was administered and the postoperative welfare of all rats was monitored closely.

**Experimental Design**

At 0 day (0d), one self-sealing incision was made through the cornea into the anterior chamber using a 15° disposable blade enabling repeat twice a week (biweekly) 3.5 µL IC injections through the tunnel generated using self-made disposable sterile glass micropipettes (Harvard Apparatus, Kent, UK) for 30d of either PBS (control group PBS0-30d; Sigma, Poole, UK), active hrTGF-β (treatment group TGF-β20-30d; 5 ng/µL; Peprotech, London, UK), active hrTGF-β1 (5 ng/µL; Peprotech) between 0d and 17d then PBS between 21d and 30d (treatment group TGF-β1-17d/21-30d), or active hrTGF-β2 (5 ng/µL) between 0d and 17d then hrDecorin between 21 and 30d (concentration derived from Ahmed et al.54; 5 µg/µL; treatment group TGF-β2-17d/Decorin21-30d; Catalent Pharma Solutions, Philadelphia, PA, USA).

Although both TGF-β1 and TGF-β2 were used to raise IOP in this study, experiments with each isoform were analyzed separately and induced similarly raised IOP, fibrosis, and RGC death. Uninjured control eyes (intact) were also analyzed for comparison to the PBS0-30d, TGF-β20-17d and TGF-β20-30d groups (Table 1). Intracocular pressure measurements were taken biweekly in all treatment groups timed immediately before the IC injections throughout the 30d experimental period. Visually evoked potentials (VEP) in the PBS0-30d and TGF-β20-17d and TGF-β20-30d groups were measured at 30d for model validation to assess the functional consequences of RGC death and the tissues from all groups were processed for immunohistochemistry (IHC) to assess levels of TM fibrosis and RGC survival.

**IOP Measurements**

Using an iCare Tonolab rebound tonometer (Icare, Helsinki, Finland), IOP was recorded biweekly between 9 AM and 11 AM for the duration of each experiment to avoid confounding the readings with circadian variability. Immediately after induction of anaesthesia with 5% Isoflurane, six rebound measurements were taken with the tonometer from the central cornea on each measurement occasion to give an overall average IOP measurement (mm Hg) and all graphical data points represent the mean ± SEM of three readings (of 6 rebounds each) taken sequentially to ensure accurate measurements (as previously described60).

**Visually Evoked Potentials**

To ascertain if the RGC loss caused by the TGF-β-related IOP rise led to functional retinal deficits, VEP measurements were
compared between the PBS 0-30d and TGF-β2 0-30d treatment groups. Five days before VEP were recorded, the cranial skin was resected and stainless steel screws (Bioanalytical Systems, Inc., Kenilworth, UK) were implanted at 7-mm posterior to the bregma, 3-mm lateral to the midline, at a depth of 0.5 mm into the skull to connect the positive recording electrodes. The reference (negative) screw electrode was inserted into the skull in the midline, 3-mm anterior to bregma. The skin was sutured around the screws. For VEP recordings at 30d, a mini-Ganzfeld stimulator was used with increasing stimulus intensities of 300, 3000, and 25,000 mcd/s/m², which were averaged 100 times at each intensity with a recording duration of 250 ms and an interstimulus interval of 1 second.

Tissue Preparation for Immunohistochemistry

Rats were killed by exposure to increasing concentrations of CO₂ and transcardially perfused with 100 mL of PBS to wash out blood before further perfusion with 100 mL 4% paraformaldehyde (PFA) in PBS at pH 7.4. Dissected eyes for IHC were post fixed by immersion in 4% PFA in PBS for 2 hours at 4°C before cryoprotection by immersion in increasing concentrations of sucrose solutions (PBS with 10%, 20%, and 30% sucrose; all from Sigma) for 24 hours each at 4°C then embedded in optimal cutting temperature (OCT) embedding medium (Thermo Shandon, Runcorn, UK) in peel-away mould containers (Agar Scientific, Essex, UK). Eyes immersed in OCT were rapidly frozen in crushed dry ice before storage at −80°C and later sectioned in the parasagittal plane through the optic nerve head at −22°C using a Bright cryostat microtome (Bright, Huntingdon, UK) at a thickness of 20 μm. Sections were mounted on positively charged glass slides (Superfrost plus; Fisher Scientific, Pittsburgh, PA, USA) left for 2 hours to dry at 37°C and stored at −20°C.

Retinal Cell Culture

Retinal cells were dissociated using a papain dissociation system in accordance with the manufacturer’s protocol (Worthington Biochem, Lakewood, NJ, USA) and 120 to 125 × 10^3 cells/well were cultured on sterile glass chamber slides (BD Biosciences, Oxford, UK) precoated with 100 μg/mL poly-D-lysine, followed by 20 μg/mL Laminin-I (both from Sigma) in Neurobasal-A supplemented with B27-supplement, L-glutamine, and penicillin/streptomycin (all from Invitrogen Ltd., Paisley, UK), at 37°C, in a humidified 5% CO₂ atmosphere. After 24 hours in culture, supplemented Neurobasal-A (sNBA) was removed and retinal cells treated with hrDecorin diluted to the test concentrations in fresh sNBA. Wells were treated with 300 μL of either of sNBA (control) or 1, 10, 100, 1000 μg/mL concentrations of hrDecorin in sNBA, and grown for a further 5d, at 37°C, in a humidified 5% CO₂ atmosphere.

Immunocytochemistry

Retinal cultures were fixed in 4% PFA in PBS at room temperature (RT) for 10 minutes, washed 3 × 5 minutes with 0.1% Triton X-100 (Sigma) in PBS and blocked in 0.1% Triton X-100 with 10% normal goat serum (Serotec, Oxfordshire, UK) and 3% bovine serum albumin (BSA; Sigma) in PBS for 30 minutes at RT. Cultures were incubated in mouse anti–βIII-tubulin antibody (1/500; Sigma) for 1 hour at RT. Cultures were then washed 3 × 5 minutes in PBS and incubated in goat anti-mouse IgG Alexa Fluor 488 secondary antibody (1/400; Invitrogen) for 1 hour. After washing in PBS, slides were mounted using VectaMount containing 4′,6-diamidino-2-phenylindole (DAPI; Vector Labs, Peterborough, UK) and viewed using a Zeiss Axiosplan2 epifluorescent microscope equipped with an AxioCam HRc camera and Axiovision software (all from Carl Zeiss, Hertfordshire, UK). Control tissue sections incubated with secondary antibody alone were all negatively stained (not shown).
Table 2. Antibodies Used in Immunohistochemistry

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<th>Antigen</th>
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Immunohistochemistry

Frozen sections were left to thaw for 30 minutes before 3 × 5 minutes washing in PBS followed by a 20 minutes permeabilization with 0.1% Triton X-100 (Sigma). Nonspecific antibody binding sites in tissue sections were blocked for 30 minutes in 0.5% BSA, 0.3% Tween-20 (all from Sigma), and 15% normal goat serum (Vector Laboratories) in PBS before incubating overnight in primary antibody (Table 2) followed by washing 3 × 5 minutes in PBS and incubating for 1 hour at RT with secondary antibody (Table 2). Sections were then washed 3 × 5 minutes in PBS and mounted in Vectorshield mounting medium containing DAPI (Vector Laboratories). Control tissue sections incubated with secondary antibody alone were all negatively stained (not shown).

Quantification of RGC in Retinal Cultures

βIII-tubulin<sup>+</sup> RGC were counted using Image Pro 6.2 at ×20 magnification in nine equal areas of each well from four random fields of view, totalling 36 images/well. The mean number of βIII-tubulin<sup>+</sup> RGC/mm<sup>2</sup> ± SEM was calculated for each image captured within a 0.2475 mm<sup>2</sup> area of each culture well (36 images per well represented 36 × 0.2475 = 8.91 mm<sup>2</sup>) using previously published methods.<sup>56,64</sup> Retinal ganglion cell counts were performed by an assessor who was blinded to the identity of the treatment groups.

Statistics

All statistical analyses were performed using SPSS 20 (IBM, Chicago, IL, USA). Normal distribution tests were carried out to determine the most appropriate statistical analysis to compare treatments. Statistical significance was determined at P < 0.05. Intraocular pressure data were analyzed for significant differences using the within-subjects repeated measured design or generalized estimated equations. Trabecular meshwork fibrosis, inflammation, RGC survival, and VEP data were tested for significant differences using Student’s t-test or one-way ANOVA for greater than two group comparisons ±SEM and are given in the text or displayed graphically as mean ± SEM. For in vitro RGC survival, between group differences in RGC ± SEM counts were analyzed for significance using ANOVA.

RESULTS

Inflammation Induced by IC Injection

The inflammation induced by repeated IC injection was assessed by counting macrophages/unit area (ED<sup>1</sup> cells) in the angle of eyes from the intact, PBS<sub>0-30d</sub> and TGF-β2<sub>0-30d</sub>-treatment groups. The morphology of the eyes remained macroscopically unchanged between intact and treatment groups and there was no evidence of cataracts, hemorrhage, or inflammation in any of the eyes. There was an increase in ED<sup>1</sup>/DAPI<sup>+</sup> cells within the iridocorneal angle of eyes that received IC injections of PBS<sub>0-30d</sub> and TGF-β2<sub>0-30d</sub> (9 ± 3 and 12 ± 3 cells, respectively) compared with intact eyes (3 ± 3 cells; P < 0.001). However, there were no significant differences in ED<sup>1</sup>/DAPI<sup>+</sup> cell...
counts between the PBS0-30d and TGF-β20-30d groups (Fig. 1). The increase in macrophage numbers noted demonstrates that the IC injection caused an inflammatory response within the angle by 30d, with no added effect of TGF-β2.

**IC Injections of TGF-β Raises IOP**

We evaluated whether IC injection of TGF-β led to the development of TM fibrosis and raised IOP, in order to confirm that our model replicated some of the pathological features of TM fibrosis.
human POAG. Compared with the PBS₀⁻₃₀d group, IOP increased in the TGF-β₂₀⁻₃₀d group, although statistical significance was not achieved until 7d, before which the IOP remained within the normal range of 10.4 ± 0.3 to 12.4 ± 0.7 mm Hg (Fig. 2). From 7d until 30d, IOP increased and was maintained at a significantly higher level of 14 ± 0.3 mm Hg at 30d in the TGF-β₂₀⁻₃₀d–treated group (P < 0.05 at 7–14d; P < 0.001 between 14–30d) when compared with IOP in the PBS₀⁻₃₀d group, which remained within the normal range of 10.5 ± 0.4 to 11.7 ± 0.3 mm Hg throughout. The sustained increase in IOP demonstrates that TGF-β is a suitable agent to induce increased IOP by IC injection in rats.

IC Injections of TGF-β Induces TM Fibrosis

In the control Intact and PBS₀⁻₃₀d groups, the ciliary body, iris, and vascular basement membranes were all laminin⁺, particularly around the outer wall of Schlemm’s Canal, although laminin⁺ immunoreactivity was thin along the inner wall (not shown). Thin linear strands of laminin⁺ tissue were also present within the TM of the intact and PBS₀⁻₃₀d control groups, while increased laminin⁺ immunoreactivity was observed in and about the TM of the TGF-β₂₀⁻¹₇d and TGF-β₂₀⁻₃₀d groups compared with levels in the PBS₀⁻₃₀d control group (P < 0.001; Figs. 3A, 3B, 3C). There were no significant differences in laminin levels between the TGF-β₂₀⁻¹₇d and TGF-β₂₀⁻₃₀d groups. In both TGF-β groups, laminin immunoreactivity was also particularly prominent in the inner wall of Schlemm’s canal.

At 17d and 30d, the TM was also densely packed with fibronectin deposits in the TGF-β₂₀⁻₃₀d group, unlike the Intact and PBS₀⁻₃₀d control groups where little or no fibronectin deposits were observed (Fig. 3D), so that fibronectin levels around the TM were significantly higher in the TGF-β₂₀⁻¹₇d and TGF-β₂₀⁻₃₀d groups compared with the TM of the PBS₀⁻₃₀d control group (P < 0.001; Fig. 3E). There were no significant differences in fibronectin levels between the TGF-β₂₀⁻¹₇d and TGF-β₂₀⁻₃₀d groups. These findings demonstrate that IC injections of TGF-β caused excess ECM deposition within and around the TM and Schlemm’s canal that the ECM deposition occurred by 17d and was maintained at similar levels through to 30d.

TGF-β Induced Fibrosis and Raised IOP Is Associated With RGC Death and Perturbed Retinal Function

Compared with the intact control group (Fig. 4A), Brn3a⁺ RGC counts from the PBS₀⁻₃₀d– (Fig. 4B), and TGF-β₂₀⁻₁₇d– (Fig. 4C) treated groups were not significantly different. However, when
The RGC loss was associated with a significant decrease in the P1/N2 VEP amplitude in the TGF-β20-30d–treated group when compared with the control PBS0-30d group (\( P < 0.01 \); Figs. 5A, B), but there was no change in P1/N2 latency (\( P > 0.05 \)).

**hrDecorin Attenuates TGF-β–Induced IOP Elevation**

We next investigated whether IC hrDecorin delivered over the 21d to 30d period attenuated the IOP elevation and TM fibrosis established by IC TGF-β injections delivered between 0d and 17d, as well as the effects of hrDecorin on RGC survival. Having caused a sustained elevation in IOP through repeated IC TGF-β injections over 17d, administration of hrDecorin between 21d and 30d significantly and contemporaneously decreased IOP to control levels (\( P < 0.001 \); Fig. 6). Accordingly, the IOP in the TGF-β20-17d/Decorin21-30d group was still at 15 ± 2 mm Hg at 21d, indistinguishable from IOP in the TGF-β10-17d/PBS21-30d group at 14 ± 2 mm Hg. However, by 30d the IOP in the TGF-β20-17d/Decorin21-30d group had significantly lowered to 10 ± 0.6 mm Hg compared with an IOP of 16 ± 1 mm Hg in the TGF-β10-17d/PBS21-30d group at 30d. Hence, hrDecorin delivered between 21d and 30d reduced IOP to levels similar to those recorded in the Intact and the PBS0-30d control groups by 30d.

**hrDecorin Causes the Dissolution of Established TM Fibrosis**

In the TGF-β20-17d/Decorin21-30d group, laminin and fibronectin deposits were significantly reduced at 30d (\( P < 0.05 \); Fig. 7A–D) throughout the TM compared with those in the TGF-β10-17d/PBS21-30d and TGF-β20-17d control groups (Fig. 7). Laminin immunoreactivity in the TGF-β10-17d/PBS21-30d control group was observed most prominently throughout the inner wall of Schlemm’s Canal, while fibronectin was deposited throughout the TM but was most prominent within the JCT region. However, TGF-β20-17d/Decorin21-30d regime significantly (\( P < 0.001 \)) reduced these deposits, giving a similar pattern of laminin and fibronectin staining to that observed in the PBS0-30d and intact control groups. The decrease in laminin and fibronectin deposits in the TM shown by immunohistochemistry, together with the lowered IOP, suggests that injections of hrDecorin over the period of 21d to 30d caused the dissolution of established fibrosis induced by IC TGF-β injections over the 0d to 17d period.

**hrDecorin Induces Fibrolysis of TM ECM by Increasing the MMP/TIMP Ratio**

We next investigated whether hrDecorin modulated lysis of TGF-β–induced TM fibrosis through modulation of the MMP axis. Immunostaining was undertaken to localize hrDecorin in the TM at 30d (Figs. 8A, 8E). In the PBS0-30d and TGF-β10-17d/PBS21-30d control groups, little hrDecorin+ immunoreactivity was observed. By contrast, levels of hrDecorin in the TGF-β20-17d/Decorin21-30d group were significantly higher within the TM compared with the PBS0-30d and TGF-β10-17d/PBS21-30d control groups (\( P < 0.001 \)), reflecting the local accumulation of injected hrDecorin in the TGF-β20-17d/Decorin21-30d group (Fig. 8E). The constitutive levels of total MMP2 staining in the TM seen in the control PBS0-30d group (Figs. 8B, E) and the intact group (not shown) were suppressed in the TGF-β10-17d/PBS21-30d group, an
effect that was neutralized by TGF-β20-17d/Decorin21-30d treatment, increasing levels of MMP2 to those seen in the PBS0-30d group (Figs. 8B, 8E). Similarly, the TM of the TGF-β10-17d/PBS21-30d group had significantly lower levels of immunoreactive MMP9 than did the PBS0-30d and TGF-β20-17d/Decorin21-30d groups (Figs. 8C, 8E). Conversely, TIMP2 immunoreactivity was similar in both PBS0-30d and TGF-β10-17d/PBS21-30d groups, but was significantly lowered in the TGF-β20-17d/Decorin21-30d group (Figs. 8D, 8E). Quantitation of the immunoreactivity confirmed these changes in the TGF-β20-17d/Decorin21-30d group, so that there was a significant (P < 0.05) increase of the MMP2/9:TIMP2 ratio in the TM, favoring MMP activation (Table 3). Thus, TGF-β suppressed MMP2/9 activation in the TM favoring fibrogenesis and hrDecorin reversed this effect, suggesting a mechanism for hrDecorin-mediated lysis of established TM fibrosis.

hrDecorin Treatment Is Indirectly RGC Neuroprotective

In the TGF-β20-17d/Decorin21-30d group there were significantly higher numbers of surviving RGC at 30d compared with the TGF-β10-17d/PBS21-30d control group, with 41 ± 4 RGC/mm and 27 ± 2 RGC/mm, respectively (P < 0.001; Figs. 9A–C), demonstrating that IC hrDecorin attenuated RGC loss between 21d and 30d as observed in Figure 4D. To assess whether this reflected a direct or indirect effect of hrDecorin on RGC, the neuroprotective effects were tested in vitro.
sustained elevation in IOP induced by 17d of TGF-β1 injections was reversed by subsequent IC Decorin injections in the TGF-β1_{10-17d}/Decorin_{21-30d} group. Retinal cell cultures with increasing concentrations of exogenous hrDecorin did not significantly change the β-III tubulin+ RGC frequency in any of the Decorin treatment groups (1, 10, 100, or 1000 μg/mL) compared with controls (P = 0.849). Thus, there was no direct neuroprotective effect of hrDecorin on RGC apparent in vitro (Fig. 9D), implying that the RGC protection observed in vivo was indirect and a consequence of hrDecorin-mediated IOP reduction.

**DISCUSSION**

Repeated IC injection of TGF-β in adult rats induced TM fibrosis and elevated IOP leading to RGC death and retinal dysfunction, shown by IHC, IOP measurements, RGC counts, and VEP recordings. We have demonstrated that IC hrDecorin treatment decreased fibrosis established by IC TGF-β within the TM (an effect accompanied by increased local levels of MMP2 and MMP9 and reduced levels of TIMP2 implying increased fibrolysis), lowered the raised IOP and, by lowering IOP, indirectly protected the retina from progressive RGC death.

Consistent with other fibrotic models of raised IOP,20,22 our rodent model of IC TGF-β injections generated a sustained and significant increase in IOP by 14d compared with controls. The baseline level of IOP (before any treatment) reported in the rat by Robertson et al.20 is similar to that seen in our study. However, overexpression of TGF-β by gene transfer in the Robertson et al.20 study led to sustained IOP elevations of greater than 20 mm Hg at 14d, higher than our recordings of greater than 14 mm Hg at 14d, probably explained by the constant production of TGF-β through gene transcription compared with our discontinuous bolus regime of biweekly IC injections. Nevertheless, our protocol did cause TM fibrosis accompanied by a sustained rise in IOP, significant RGC loss and retinal dysfunction. An advantage of our model is that TGF-β treatment could be stopped at 17d to reveal that by this time point the IOP was elevated, probably through established TM fibrosis and perturbed AqH drainage. It could be argued that the cessation of TGF-β treatment once fibrosis was established in our model would, over longer time periods, lead to a natural resolution of fibrosis and IOP (due to continued ECM turnover in the TM). However, such resolution was not apparent in the TGF-β1_{10-17d}/PBS_{21-30d} treatment group.

We found that raised levels of TGF-β in the AqH induced a robust amount of TM fibrosis. Trabecular meshwork cells contain a high density of TGF-β receptors, making the TM particularly sensitive to raised levels of AqH TGF-β1/TGF-β2.25,27,31 Binding to a common receptor, TGF-β1/TGF-β2 activates a common intracellular Smad signaling pathway in TM cells, increasing synthesis and local accumulation of ECM proteins, as well as suppressing local ECM protease activity by downregulating MMP-11 resulting in increased TM fibrosis and enhanced resistance to AqH outflow. In our study, TGF-β1-induced TM fibrosis led to an increase in IOP by 17d that was sustained through to 30d and was associated with 42% RGC death at 30d. The functional VEP deficits seen at 30d validate the retinal effects of our TM fibrotic model and are consistent with VEP deficits seen in other experimental models of raised IOP.

Another important factor to consider in our model was the inflammation caused by repeated IC injections. In our study inflammation was measured by counting the number of ED1+ macrophages found in the iridocorneal angle. Our results showed that IC injections increased the number of macrophages in the angle compared with numbers in the intact control eyes, but there were no differences in macrophage numbers between the PBS_{0-30d} and TGF-β2_{0-30d} groups. In light of this, we concluded that any measured differences seen between the two treatments were a consequence of differences in the effects of the delivered agents and were not due to inflammatory effects related to the surgical procedure.

Decorin is naturally found as part of the TM ECM and its presence here is essential to maintain the integrity of the AqH outflow system under normal physiology. However, Decorin also regulates many signalling pathways associated with TM pathologies (e.g., by sequestering TGF-β and inhibiting its associated signalling through Smad2 and Smad3 pathways),47,48 thereby preventing TM cells from becoming...
Decorin reduces trabecular meshwork fibrosis

Interferes with related receptors, as well as directly binding to collagen to alter fibrillogenesis. The direct dissolution of ECM by Decorin-induced MMPs is also well documented. In addition to the Decorin-induced reduction of laminin and fibronectin in the scarred TM, we demonstrated that Decorin altered MMP/TIMP ratios in the TM that were favorable to TM fibrolysis, which probably accounted for the dissolution of established ECM protein deposits in and around the TM. Multiple rodent central nervous system injury models have also demonstrated similar antifibrogenic and fibrolytic actions of Decorin in pathological scenarios of both acute and chronic scarring.

Others have shown that Decorin lowers IOP through attenuation of conjunctival scarring in a rabbit model of glaucoma filtration surgery, supporting our observation of reduced IOP through antifibrotic effects of Decorin in the TM. Sequential staging of the injections of TGF-β and Decorin injections in the TGF-β0-17d/Decorin21-30d group exclude the possibility of direct antagonism of exogenously delivered TGF-β by Decorin, implying that the IOP reduction observed with Decorin treatment was not related to direct antagonism of TGF-β, but was a consequence of lysis of the established TM fibrosis, probably by activation of locally produced fibrolytic MMP and coincident inactivation of TIMP.

It is becoming widely accepted that dysfunctional ECM remodelling leads to TM fibrosis in open angle glaucoma. We believe that the rise in IOP seen by 14d and sustained through 30d in this study was due to the development of TM scarring over this period, a contention supported by the fibrosis data shown in both the TGF-β0-17d/PBS21-30d and TGF-β0-17d/PBS21-30d groups. The rebalancing of MMP:TIMP ratios toward fibrolytic activity mediated by Decorin treatment is mirrored by the pathology of POAG in which MMPs, released from the TM cells, regulate AqH outflow resistance by modulating ECM turnover in the TM. Studies that involve stretching of TM cells by eye perfusion have shown that increased IOP leads to upregulated levels of MMP2 and downregulated TIMP2 levels, thus favoring ECM degradation with consequent lowering of IOP. In the present study, Decorin treatment similarly reversed established TM fibrosis, making Decorin a candidate drug to reverse the pathology of ocular hypertension and various forms of open-angle glaucoma.

Although Decorin treatment lowered IOP and increased RGC survival compared with controls in vivo, our in vitro study demonstrated that Decorin was not directly neuroprotective. Seidler et al. reported an antiapoptotic effect of Decorin in cultured fibroblasts by prevention of DNA fragmentation. Others have also shown that Decorin promotes survival of endothelial and epithelial cells but, conversely, there is a body of literature from cancer cell studies that convincingly demonstrates the ability of Decorin to induce apoptosis. However, in situ cell context is seemingly important to Decorin actions. Given that, in our primary retinal cultures Decorin did not demonstrate any significant RGC survival, we infer that the Decorin-related neuroprotection observed in vivo was probably indirect and attributable to the IOP-lowering effects that reflected restoration of normal AqH outflow as a result of Decorin's antifibrotic effects.

### Table 3. MMP:TIMP Ratio After PBS0-30d, TGF-β10-17d/PBS21-30d, and TGF-β20-17d/Decorin21-30d Treatments

<table>
<thead>
<tr>
<th>Condition</th>
<th>MMP/TIMP Ratio</th>
<th>PBS0-30d</th>
<th>TGF-β10-17d/PBS21-30d</th>
<th>TGF-β20-17d/Decorin21-30d</th>
</tr>
</thead>
<tbody>
<tr>
<td>MMP2/TIMP2</td>
<td>1.33</td>
<td>0.81</td>
<td>4.66</td>
<td></td>
</tr>
<tr>
<td>MMP9/TIMP2</td>
<td>1.33</td>
<td>0.85</td>
<td>6.16</td>
<td></td>
</tr>
</tbody>
</table>
FIGURE 8. Decorin and protease levels in the TM. Panels show representative images of immunoreactive (green). (A) Decorin in the angle, (B) total MMP2, (C) total MMP9, and (D) total TIMP2 within the TM of the PBS0-30d and TGF-β10-17d/PBS21-30d control groups and in the TGF-β20-17d/Decorin21-30d–treated groups, with (E) quantification of pixel intensities above the threshold from a defined region within the TM that was set in intact control eyes. The data demonstrate that in the TGF-β20-17d/Decorin21-30d–treated group there was increased levels of both MMPs and decreased levels of TIMP2 in the TM tissues (**P < 0.001); Scale bar: 100 μm for (A) and 50 μm for (B–D).
FIGURE 9. In vivo and in vitro RGC survival after Decorin treatment. The panels illustrate Brn3a+/DAPI+ staining in the GCL of the (A) TGF-β10-17d/PBS21-30d-treated group and (B) TGF-β20-17d/Decorin21-30d-treated group. The graphs show quantitation of RGC survival (C) in vivo in the TGF-β10-17d/PBS21-30d-treated and the TGF-β20-17d/Decorin21-30d-treated groups and (D) in vitro after retinal cell culture with various concentrations of Decorin. Retinal ganglion cell death was significantly reduced in the TGF-β20-17d/Decorin21-30d group compared with the TGF-β10-17d/PBS21-30d group (**P < 0.001; Scale bar: 100 μm). However, there was no significant direct neuroprotective effect of Decorin on RGC in vitro.
consequence of MMP-induced dissolution of TM fibrosis. Currently, there is no precise explanation of why high IOP causes RGC death, a multitude of factors may contribute, including compromised retrograde axonal transport of target-derived neurotrophic factors, activation of apoptosis and mitochondrial dysfunction after biomechanical and ischemic insults caused by compression of the optic nerve head as a result of raised IOP.^

In conclusion, our observations suggest that IC Decorin effectively reversed established TM fibrosis and normalized IOP, thereby indirectly protecting RGC from progressive IOP-related death. Thus, Decorin has the potential to be developed into an effective therapy for patients with ocular hypertension and forms of open-angle glaucoma associated with TM fibrosis.

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