Discovery of a multipotent cell type from the term human placenta

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Abstract

We report a population of multipotent cells isolated from term human placentas, for the first time, that differentiates into cardiomyocytes and vascular cells with clonal ability, migratory ability, and trancriptomic evidence of immune privilege. Caudal-type homeobox-2 (CDX2) is a conserved factor that regulates trophectoderm formation and placentation during early embryonic development but has not previously been implicated in developmentally conserved regenerative mechanisms. We earlier reported that murine Cdx2 cells restored cardiac function after intravenous delivery in male mice with experimental myocardial infarction (MI). Here we demonstrate that CDX2 cells found in human chorion are poised for cardiovascular differentiation. We isolated CDX2 cells from term placentas of 150 healthy patients and showed that they spontaneously differentiate into cardiomyocytes, functional vascular cells, and retain homing ability *in vitro* with a transcriptome that supports enhanced cardiogenesis, vasculogenesis, immune modulation, and chemotaxis gene signatures. They restore cardiac function when administered to NOD/SCID mice subjected to MI. CDX2 cells can be clonally propagated in culture with retention of cardiovascular differentiation. Our data compels further use of this ethically feasible cell source in the design of therapeutic strategies for cardiovascular disease.

One-sentence Summary:

CDX2 cells from human placenta are poised for cardiovascular differentiation and may lead to a novel therapeutic approach for human heart repair.

Introduction

The successful use of cell therapy for cardiac repair hinges on several critical attributes: cells must have the capacity for cardiomyocyte differentiation akin to embryonic stem cells (ES) and induced pluripotent cells (iPSC), they must exhibit clonality, possess an immune-modulatory capacity for allogeneic administration, and ideally the ability to home to sites of injury. Cell therapy for cardiac purposes has been demonstrated to be safe by numerous preclinical and clinical studies(*1-4*), however; there has been a glaring lack of *bona fide* cardiac differentiation amongst cell types administered in clinical trials thus far (*5-7*). Despite a multitude of clinical cell therapy trials, which largely sought to inject stem/progenitor cells or cardiomyocytes derived from such cells into the heart, true progress in actual cardiomyocyte repopulation with a significant restoration of myocardial function has remained a distinct challenge. Injection of cardiomyocyte derivatives from ES or iPS into the complex cardiac milieu is unnatural, and not rooted in developmental pathways supporting organogenesis and tissue healing. Regenerative biology must rely on exploring evolutionarily preserved healing mechanisms to maintain and restore homeostasis. Gestation is one such condition that requires extensive cellular cross-talk to maintain homeostasis. The human placenta is a vital organ responsible for supporting embryonic development and facilitating the exchange of nutrients and waste between the mother and fetus. The placenta and the fetal heart are thought to undergo concurrent evolution sharing major developmental pathways (*8-10*). Studies suggest that the placenta may regulate cardiac ventricular wall expansion once maternal blood flow is established (*11-13*). This implies that cells with regenerative ability within the placenta may be better poised to support cardiogenesis. Our focus turned to placental cells after clinical observations of patients with peripartum cardiomyopathy. This etiology of heart failure enjoys the highest recovery rate (~50%) amongst all forms of heart failure (*14*) and we postulated that progenitor cells from the fetus or placenta might be playing a role in this recovery.

Stem or progenitor cells from the placenta are developmentally closer to embryonic stem cells but functionally different and non-tumorigenic (*15*). Caudal type homeobox-2 (CDX2) is a conserved factor expressed that regulates trophoblast stem cell differentiation and is required for proper placental development (*16, 17*). We discovered a novel role of Cdx2 cells in murine gestation as a preclinical model of MI in pregnant mice elicited the specific migration of fetal placental cells into the injured maternal heart to form cardiovascular cells (*18*) Furthermore, isolated murine placental Cdx2 lineage cells formed spontaneously beating cardiovascular cells *in vitro* and contributed to cardiac repair *in vivo* after intravenous infusion even in male mice subjected to MI (*19*).

In this study, we utilized 150 human term placentas from healthy patients and isolated CDX2-expressing cells from the chorionic regions. For research purposes, we utilized a human CDX2 promoter-driven lentivirus-based mCherry fluorescence reporter. Transcriptomic analyses comparing human embryonic cells, term placental CDX2 cells, and term placental non-CDX2 cells were performed to gain deeper insights into the functional differences between these cell types. We further investigated the stem/progenitor function, cellular heterogeneity at single cell level and

cardiovascular commitment *in vitro* and *in vivo* to ascertain their potential as a novel therapeutic for cardiovascular disease.

Results

Cells expressing CDX2 are clonal and are enriched within the chorionic region of the human placenta

The homeodomain protein CDX2 is involved in embryonic development and placentation. To detect if CDX2 is present in human placentas, we carried out a multi-parametric approach. We examined the transcript expression from an earlier time point in first-trimester chorionic villus samples (CVS) and later within the chorionic cells (fetal) from term healthy placentas. CDX2 mRNA was detected in CVS and chorionic regions **(Fig. 1a).** Sanger sequencing and analysis of the output FASTA sequences confirmed sequences specific to human CDX2 mRNA (Supplemental document 1). Immunoblot analyses detected CDX2 protein in the term chorion (~40kDa) with the conventional doublet pattern representing two isoforms from alternative splicing **(Fig. 1b).** HeLa cells showed a lower endogenous expression of CDX2, whereas human adenocarcinoma cell line DLD1 served as a positive control. Immunohistochemistry revealed that CDX2 protein was enriched in the fetal chorionic region of the human placenta and not in the fetal amnion **Fig. S1 a, b**). CDX2 was detected in the villous region **(Fig. 1c)**, particularly within the cytotrophoblast layer of the chorion **(Fig. S1a -b).** We found that most CDX2-expressing cells co-localized with the trophoblast marker Cytokeratin 7 (**Fig. 1c, d** CKT7- 95 ± 5.0%) and were associated with Human Leukocyte Antigen G (HLA-G) **(Fig. 1e, f**, HLA-G- 50.5±5%), which is primarily expressed in extravillous trophoblast progenitors and is critical for inducing an immune-tolerant microenvironment in the placenta..

The initial isolation of viable cells expressing CDX2 was challenging because no surface markers had been identified for enrichment thus far. In this study, we developed a huCDX2 promoter-driven lentivirus-based approach to select cells expressing CDX2 (**Fig. S2a-c** and methods). Based on the transduction efficiency and mCherry fluorescence, out of three candidates, a sequence containing 612bps of CDX2 promoter (named as promoter 1) was selected (**Fig. S2 d-g**, also see supplemental data) and within the multiplicities of infection (MOI) ranging from 20-100 MOI (**Fig. S2 h-q**), the 50MOI range was further chosen.

Following isolation and initial plating, chorionic cells from term placentas were transduced with the chosen lentivirus to select CDX2mCherry positive cells (simply referred as CDX2 cells henceforth) **(Fig. 1g)** and mCherry negative cells. A representative flow cytometry based sort profile is shown in **Fig.1h.** Transduced chorionic cells from various placentas revealed that the frequency of CDX2 cells ranged from 5% to 80% with a mean frequency of 31.4% ± 3.2 **(Fig. 1i)**. Immunostaining demonstrated that the majority of mCherry signals (red) co-localized with nuclear CDX2 (green, **Fig. 1j)** validating endogenous CDX2 expression. To understand whether CDX2 cells can self-renew similarly to stem/progenitor cells, we examined the clonal proliferation of single isolated CDX2 cells for a period of 14 days. CDX2 cells demonstrated a robust clonal efficiency (54.1 ± 6.78%) as analyzed **(Fig. 1k,m)**. Interestingly, mCherry-negative chorionic cells also showed the ability of clonal proliferation (44 ± 11.45%) albeit to a lower extent than CDX2 cells. The mCherry negative cells as we noted from our transcriptomics analyses expressed significantly higher levels of pan leukocyte marker PTPRC (CD45), myeloid progenitor marker CD33 and higher expression of CD1b suggesting that more of a blood cell or hematopoietic lineage **(Fig. S2r).** In addition, mCherry-negative population likely also included some CDX2 cells as the efficiency of lentivirus transduction is not 100% as clearly reflected in the positive control

DLD1 cell line **(Fig. S2s).** Response to chemotactic signaling is another key feature of stem/progenitor cells. We examined CDX2 cells for their ability to migrate to chemokine stromal-derived factor 1 α (SDF1) using a transwell migration assay. Before assessing chemotaxis, we preconditioned one group of CDX2 cells with 1uM of AMD3100, an antagonist of SDF1 receptor CXCR4. Under normal conditions, CDX2 cells exhibited a significantly higher percentage of cells migrating (22.4 ± 2.68%) to chemokine SDF1 compared to mCherry-negative cells (12.62 ± 2.11%, **Fig. 1n**). Despite the presence of SDF1 in the lower well, blocking of CXCR4 using AMD3100 significantly reduced the ability of these cells to migrate. Overall, the chemotaxis response of CDX2 cells was significantly higher and our data show that this ability may be partly mediated via a functional SDF1-CXCR4 axis. In sum, these data show that CDX2 cells from term placenta expresses pan trophoblast marker cytokeratin 7 and extravillous marker HLA-G suggesting a trophoblast progenitor phenotype with migratory properties and clonal proliferation in vitro

CDX2 cells differentiate into endothelial cells and smooth muscle cells *in vitro* while they display neo-angiogenesis *in vivo*

We noted that CDX2 cells can develop endothelial vessel-like structures (27.3±5.6%) and express endothelial markers *PECAM1* (CD31) and von Willebrand factor (*vWF*) when co-cultured with murine neonatal cardiomyocytes **(Fig. 2a-c)**. In addition, under feeder-free conditions, CDX2 cells uniformly expressed smooth muscle marker (SM22α, 95.5 ± 1.59%) supporting a mesodermal phenotype **(Fig. 2d-e)**. To examine functional angiogenesis, we assessed whether CDX2 cells could form an angiogenic network *in vitro*. Endothelial cells recapitulate angiogenesis by forming capillary-like structures when seeded onto basement membrane-like surfaces like Matrigel. CDX2 cells displayed tubular extension and loop formation within 3 h and formed endothelial-like networks after 6 h. **(Fig. 2f** and **j, movie S1,** *please watch the video on loop mode*). mCherry-negative cells displayed a less organized network pattern in comparison to CDX2 cells under identical conditions **(Fig. 2g,k).** HUVEC served as positive control, showing a robust tubular network at 3h and 6h time points **(Fig. 2h** and **l, movie S2,** *please watch the video on loop mode***)**. In contrast, unfractionated chorionic cells did not show any events of tube formation **(Fig. 2i, m)**. Ac-LDL uptake serves as the readout for a functional endothelium via receptor-mediated endocytosis. Therefore, CDX2 cells were primed with endothelial media containing 10ng/mL VEGF and were subjected to Ac-LDL for 4 hours, and Ac-LDL uptake was confirmed **(Fig. 2n,** green**)**. Quantification of the meshes within the endothelial network showed a significantly higher number of mesh areas in CDX2 cells **(Fig. 2o,** *$P \leq 0.05$**)** and a higher trend in the branch length, segments, and nodes, as noted **(Fig. 2p-s)**. We next examined the ability of functional angiogenesis of undifferentiated CDX2 cells in an immunocompromised NOD/SCID mouse model using a matrigel plug assay **(Fig. 2t)** with HUVEC cells as a positive control. After day 14, histological analyses of the excised matrigel plugs showed the neoangiogenesis from CDX2 cells and mCherry-negative cells, though lesser than expected compared to the differentiated HUVEC cells **(Fig. 2u)** which form mature, stable blood vessels that are typical in organized angiogenesis. CDX2 cells formed elongated vessel-like structures into and around the matrigel. Quantifying the vessel numbers showed a significant increase in CDX2 cells in comparison with mCherry negative cells (95 ± 1.00 vs 64 ± 4.00, *$P \leq 0.05$, **Fig. 2v**), whereas vessel lumen areas did not show differences **(Fig. 2w)**. Immunostaining and quantification of human-specific CD31 showed that the CDX2 cells and mCherry negative cells that formed vessels also were positive for CD31 expression **(Fig. 2x).** In sum, these data suggest that placental CDX2 cells are more angiogenic and can differentiate

into endothelial and vascular lineages *in vitro* and generate neo-vessels in an *in vivo* angiogenesis assay.

CDX2 cells robustly differentiate into spontaneously beating cardiomyocytes *in vitro* and significantly improve cardiac function after myocardial infarction.

We further examined CDX2 cells' ability for cardiomyocyte differentiation using a neonatal cardiomyocyte feeder system, as described in our murine studies (*19*). CDX2 cells from term healthy chorions were plated on beating neonatal murine cardiomyocyte feeders, providing a niche conducive to differentiation without additional exogenous growth factors or any inducers. We previously reported the successful use of this culture system for proof-of-concept analysis (*18, 19*). Live cell imaging demonstrated CDX2 cells forming beating organoid-like clusters as early as 4-5 days in culture **(Movie S3,** *please play the video on loop mode* and **Fig. 3a)**. Within two weeks, these cell clusters adhered and spread to display an elongated phenotype while they continued to beat in culture **(Fig. 3b** and **Movie S4,** *please play the video on loop mode***)**. After 4 weeks of culture, immunostaining for human-specific sarcomeric actinin, in combination with cardiac troponin T (cTnT- detects both mouse and human myocytes), demonstrated that CDX2-derived cardiomyocytes robustly expressed cardiac sarcomeric proteins with striations **(Fig. 3c-e')**. On the contrary, the mCherry-negative cells displayed a much lower cardiogenic capacity when cultured in identical conditions **(Fig. S3a,d).** Approximately 71.11±12.15% of input CDX2 cells differentiated into cardiomyocytes **(Fig. 3f**) thus displaying a high level of cardiomyogenic capacity.

To understand whether a feeder-free approach can be used to differentiate CDX2 cells, we next used a temporal modulation of Wnt signaling using a modified GiWi method involving small molecule Wnt inhibitors to induce the differentiation. H9 huES cells were used as a positive control for differentiation using identical culture conditions. Based on our observations from the co-culture method above, we focused only on CDX2 positive cells. As shown in the schema **(Fig. 3g)**, CDX2 cells were included in the differentiation from day 0. On day 12 (**Fig. 3h-i)** and day 20 **(Fig. 3j-k)** after the induction, immunostaining and flow cytometry quantification for human-specific cTnT were carried out to examine the percentage of differentiated cardiomyocytes in each group. On day 12, the overall frequency of cTnT+ cells generated from input CDX2 cells was 94.8% and 88.3% as analyzed from two independent patient placenta samples and persisted until day 20 of the differentiation. H9 huES cells showed ~86.3% cTnT+ cells on day 12 that remained at 81.5% after day 20 of differentiation using identical conditions **(Fig. 3l-m)**. This induced differentiation method revealed a higher efficacy of cardiac differentiation in CDX2 cells compared with ES cells. These results demonstrate that human placental CDX2 cells are highly cardiogenic and can robustly differentiate into cardiomyocytes using two different culture conditions.

To directly examine the ability of human placental CDX2 cells to elicit functional cardiac repair, we induced MI in NOD/SCID mice (8 weeks of age, male and female) by ligating the left anterior descending coronary artery (LAD) as we have previously *(19)*. Immediately after MI, the animals underwent intramyocardial injection with 5 μL each of CDX2 cells (100,000 cells) at three equidistant sites around the peri-infarct zone. Equal numbers of mCherry-negative cells were also administered identically in another cohort (n=5). Vehicle control mice (n=2) received phosphate-buffered saline (PBS). Cardiac MRI was carried out immediately in the next day as baseline post-MI and also after 1-month post–MI.

Cardiac function was analyzed by clinical cardiology specialists in cardiac imaging who were blinded to the treatment arm. MRI analyses revealed a significant increase in contractility as measured by increased left ventricular ejection fraction (LVEF) in the CDX2 cell group versus vehicle controls and mCherry negative cell groups. This increase in cardiac function was evident when baseline LVEF of the CDX2 group (41.36 ± 3.60%) was compared to the corresponding 1-month counterparts (50.13 ± 1.001% *P≤0.05) and also between the CDX2 group and mCherry negative groups at 1-month post cell delivery.(**Fig. 4a**; CDX2 EF: 50.13 ± 1.001% vs. vehicle (PBS) controls 35 ± 3.6% in 1 month (***p≤0.001) versus mCherry neg group EF: 31.86 ± 4.38% (P≤0.01, ##). A representative short axis view of MRI images from each group is shown **(Fig. 4b-e)** demonstrating a clear decrease in the ventricular wall dilation in CDX2 cell treated group compared to the mCherry negative and vehicle control group (**Table S1** and **Movies S5-S12**, *please play the videos on loop mode*). One must note here that NOD/SCID mice do not tolerate experimental MI well compared to other strains of mice and animals we have tested (*18-20*) and thus we could not induce a large enough MI to lower the immediate post-MI EF to below ~40% as the mice were unable to tolerate this and would die during the procedure before any intervention could be tested. This is consistent with other reports (*21*).

We further examined the involvement of cellular differentiation in enhanced cardiac function. Human-specific ku80 antibody as well as mCherry was used as a marker to identify injected human cells in the murine NOD/SCID hearts. CDX2 cells and mCherry negative cells were seen engrafted in the injured myocardium after 1 month post-MI **(Fig. 4f,g).** CDX2 cells contributed to vascular differentiation and co-expressed smooth muscle actin, and endothelial marker CD31 **(Fig. 4h).** CDX2 cells also differentiated into cardiomyocytes expressing cTnT and exhibited sarcomere organization. **(Fig. 4j**). mCherry negative cells also showed differentiation into vascular cells **(Fig. 4i)** however the cardiogenic differentiation was very limited **(Fig. 4k**).

Quantifying the percentage of CDX2-derived vascular cells in the injury zone, border zone, and distal zone showed a trend that more CDX2 cells in the infarct and border zone expressed CD31 and SMA compared to mCherry negative cells, however there was no statistical difference with the mCherry negative group. CDX2 cells contributed to 46.25% ± 5.556, 51.74% ± 9.83, and 13.06 % ± 4.3 of CD31+SMA+ cells in the infarct zone, border zone, and distal zone, respectively, in the post-MI heart after 1 month of cell delivery (overall 41.32% ± 5.9, **Fig. 4l,m).**

mCherry negative cells expressed vascular markers with a distribution of 29.4% ± 6.9, 44.03% ± 9.81, and 9.72 % ± 6.2 of CD31+SMA+ cells in the infarct zone, border zone, and distal zone, respectively, contributing to an overall 31.6% ± 5.84 of vascular cells in the injured myocardium **(Fig. 4l,m)**. However, there was a significant increase in the cardiogenic contribution of CDX2 cells versus mCherry-negative cells in the MI heart. CDX2 cells (mCherry/ku80) co-expressed cTnT and showed a distribution of 8.83% ± 4.54, 45.83% ± 7.9, and 24.72% ± 8.5 of cTnT+mCherry+ cells in the infarct zone, border zone, and distal zone, respectively. mCherry-negative cells rarely formed mature cardiomyocytes in the infarcted heart. There was a significant increase in the frequency of CDX2 cTnT+ cardiomyocytes in the border and distal zone compared to the mCherry negative cell group (mCherry neg- 6.25% ± 6.25, 17.22% ± 7.5, and 2.7 % ± 2.7, **Fig. 4n,o**). These data indicate that more CDX2 cells were localized to the injury and border zones to augment cardiac function, as noted on MRI. CDX2-derived cTnT cardiomyocytes displayed more mature CM morphology with sarcomeric structures. We examined the non-injured organs from NOD/SCID mice for any presence of human cells and did not find any based on flow cytometry analyses **(Fig. S3e).** This data suggests that CDX2 cells are multipotent with cardiogenic and vasculogenic potential. In contrast, the mCherry negative cell population could be

vasculogenic and has very negligible cardiac differentiation ability *in vivo*, corroborating our observations of enriched cardiogenesis *in vitro*. These results demonstrate that intramyocardial delivery of human placental CDX2 cells resulted in cardiovascular regeneration, and this was associated with significant enhancement in contractile function on MRI imaging (compared to mCherry negative cells).

Bulk and Single Cell RNA sequencing support a role for cardiovascular commitment in CDX2 cells

CDX2 is involved in trophectoderm development, leading to trophoblast-mediated placentation, whereas embryonic stem cells are derived from the inner cell mass that significantly downregulated CDX2 expression. To understand the developmental gene signatures we compared CDX2 cells with H9 human embryonic cells (hESCs) and mCherry negative placenta cells in a bulk RNA sequencing analyses (supplemental document 2 and 3). Using the DESeq2 binomial tool, comparing differentially expressed genes (DEGs) showed that approximately 1065 genes were upregulated (154 genes downregulated) in CDX2 cells compared with hESCs. Meanwhile, 46 genes were found to be upregulated (529 genes showing downregulation) in CDX2 cells compared to mCherry-negative cells **(Table S2).**

The top 30 DEGs across individual samples in a bi-clustering heatmap in comparison with hESCs are presented in **(Fig. 5a,)**. The functional pathways in which the differentially expressed genes were involved revealed tissue organization, differentiation, angiogenesis, cell survival, and cardiac development. The highlighted genes **(Fig. 5a)** upregulated in CDX2 cells (and seen downregulated in hESCs involved *TBX3* and *NR2F2*, which are specifically involved in mesoderm commitment and early heart development. The downregulated genes in CDX2 cells involved pluripotency markers, including *POU5F1, FOXD3AS1, CLAUDN6, PHC1*, and others, as shown in **Fig. 5a**, lowering concerns of tumorigenicity, unlike hESCs or iPSC cells. Gene ontology analyses also corresponded to functions related to immune modulation, and angiogenesis **(Fig. S4a,b)** Interestingly, migration and chemotaxis are the other key features upregulated in CDX2 cells, versus H9 ES cells, which we have functionally demonstrated above. Examining the transcriptome of mCherry-negative cells further, we noted an upregulated expression of genes involved in immune activation and inflammatory responses. Genes such as *RAB44*, a member of the Ras family of oncogenes, are involved in immune cell activation. Other immune activation response genes, including *EPX, CD80* (a potent immune cell marker in T and B cell activation), and acute phase genes *ORM1, HP*, and *APOA2* (involved in HDL metabolism and atherosclerotic burden) were upregulated in mCherry-negative cells **(Fig. 5b).**

Vasculogenesis-related genes were differentially expressed in CDX2 cells versus mCherry-negative cells: *PECAM1* (CD31). VE-cadherin *(CDH5),* von Willebrand Factor *(vWF),* and *ACTA2* **(Fig. 5c),** which specify the angiogenic/vascular program. Pathways and genes involved in endothelial-to-mesenchymal (EndMT) transition like *SNAI2, KLF4, YAP1, VCAN* (Versican), *EGFR, CD44, TGFB2,* and *BMP4* that are implicated in valvular development were found to be significantly upregulated in CDX2 cells when compared with mCherry-negative cells **(Fig. S4c,d-corroborated by our scRNAseq- performed as below, Fig. S4e,f).** A remarkable cluster of key genes implicated in mesodermal and cardiac commitment (*HAND2, DKK1, STC2, FHL1, ITGA, MYOCD, EDN1,* and *TGFB2*) was preferentially upregulated in CDX2 cells **(Fig. 5d).** These gene signatures are implicated in cardiac differentiation and cardiac tissue growth in the fetal and adult heart. CDX2 cells still retained a significant upregulation of mesodermal, cardiac, and sarcomere organization genes, including *FHL1, STC2, DKK1, TGFB2,* and *EDN1* **(Fig. 5d)** in comparison to mCherry-negative cells. These data also suggest that, in contrast to undifferentiated ES cells,

300 chorionic CDX2 cells are farther along the mesodermal/cardiac commitment pathway and that CDX2 cells are enriched for a committed cardiovascular gene signature.

While culturing CDX2 cells, we noticed the overall retention of mCherry fluorescence through passages **(Fig. 5e,f,g)** with a significant increase in cell yield after each passage until approximately 1 million cells were generated by passage 6 based on input cell number 50,000 from
305 only 5 gram chorionic tissue (total weight of chorionic plate is ~150 gram). Further, in a proof-of-concept experimental run, we used the Distek BioOne (Distek Inc., NJ, USA) single-use benchtop bioreactor system (BioOne1250 2L) to carry out expansion of the placental CDX2mCherry cells on microcarriers (Corning synthamax II) for 10 days. CDX2 cells showed efficient attachment and started to proliferate within the microcarrier-based bioreactor run showing a significant increase
310 in cell yield from $7.5x10^5$/mL cells to 50 $x10^5$ cells/mL **(Fig. 5h)** showing ~7 fold increase. CDX2mCherry cells+ microcarriers were visualized under a fluorescent microscope and we noted a significant increase in cell attachment and aggregation onto the microcarriers **(Fig.5i, j).** Even though this was a trial run without optimization of any conditions, these data support the expansion of CDX2 cells to clinically viable numbers.

315 As we wished to explore further translational potential, we examined the cellular heterogeneity and cardiovascular gene program in fresh versus expanded CDX2 cells since *ex vivo* expansion will be critical to the design of a cell therapy strategy. Therefore, we performed single-cell RNA sequencing (scRNA-seq) on freshly isolated (n=2) and expanded CDX2 (passage 3, n=3) cells using 10x Genomics **(Fig. 5k).** Unsupervised clustering analysis, using the t-SNE method,
320 revealed an unbiased distribution of 19,594 cells from the combined fresh and expanded CDX2 samples **(Fig. 5l).** Clustering of transcriptionally related cells enabled us to classify 19 subpopulations, including distinct cell populations **(Fig. S5 a,b and** supplemental document 4**).** Comparative analysis of gene expression profiles allowed us to identify specific trophoblast subtypes **(Fig. 5 m,n)** including extravillous trophoblasts (EVTs: expressing markers *PSG1,*
325 *DIO2*) constituting approximately 57.77% of the cells, and endovascular extravillous trophoblasts that are derived from EVTs (enEVT: *PRDM6*) and fibroblast-like extravillous trophoblasts (FB-like EVT: *COL1A1, CCN2*). Additionally, we identified extravillous trophoblast progenitor-like cells (EVT-TPLC: *MKI67, TOP2A*), villous cytotrophoblasts (CTB: *KRT7, EFEMP1*) (9.63%), and syncytiotrophoblasts (STB: *PGF, CGB2*) (10.51%) within the CDX2 cells. Intermediate
330 trophoblasts, which share fewer markers of EVT, STB, and CTB, represented 19% of the total cells, with a minority of unknown cell types comprising 3%.

No significant downregulation in CDX2 expression was observed between fresh and expanded samples, although CDX2 was predominantly expressed in the STB2 cluster **(Fig. 5 o,p)**. CDX2 cells expressed several key genes associated with cardiac mesoderm development, including
335 *HAND2, GATA4, BMP4, ROR2, SMAD4, TBX3, DKK1, MSX1, MESP1, SFRP1, NKX2-5, KDR, HEY1, IRX3,* and *TBX6*. Importantly, there were no significant differences in the expression of these cardiac genes between fresh and expanded samples **(Fig. 5q)** except for *SFRP1*, which was notably upregulated in the expanded CDX2 population **(Fig. 5r and S6a)**. *SFRP1*, a known antagonist of the Wnt/β-catenin pathway (*22*) and was consistent with our bulk RNA sequencing
340 results. We observed no significant differences in angiogenesis and vasculogenesis gene expression between fresh and expanded CDX2 cells **(Fig. 5s).** We noted that the cardiac mesoderm genes were differentially expressed across subclusters. In particular, *NKX2-5, IRX3, MSX1, GATA4, BMP4, HAND2, DKK1,* and *SFRP1* were highly expressed in STB clusters, with the highest levels in the STB2 subset **(Fig. 5r)**. These genes are critical regulators of cardiogenesis,
345 essential for the specification of cardiac mesoderm and cardiomyocyte differentiation. In contrast,

EVT clusters (EVT1-EVT6, enEVT2, EVT-TPLC, and FB-EVT) showed minimal or no expression of *NKX2-5*, with enEVT1 exhibiting the lowest levels. However, some cardiac mesoderm genes, such as *HAND2, ROR2, SMAD4, TBX3, SFRP1*, and *DKK1,* were variably expressed across the EVT clusters, with minimal *DKK1* expression in EVT3, suggesting EVT3 to be more angiogenic than cardiogenic. CTB clusters expressed fewer cardiac mesoderm genes than other clusters, although they still expressed *HAND2, GATA4, BMP4, MSX1*, *SMAD4, ROR2,* and *SFRP1* **(Fig. 5r).** Key genes associated with these processes, including *PECAM1, EGFR, PTGFR, KDR, HIF1A,* and *EMP1,* were highly expressed in EVT populations, while *FGF2* was significantly elevated in the STB2 subset **(Fig. 5r)**.

Within the CDX2 cell population, we discovered STB2, as highly enriched in essential cardiac mesoderm genes with FGF2, which underscores their specificity in cardiomyocyte differentiation. STB2 also expresses a higher level of CDX2 within all subclusters and co-expresses the cardiac progenitor marker *NKX2-5*. The STB2 cluster also exhibited higher levels of *MYC* and *KLF4*, transcription factors linked to cell proliferation, reprogramming, differentiation, and cardiogenesis, making it unique. In contrast, EVT populations are more associated with angiogenesis and vasculogenesis. We noted EVT3 do not express cardiogenic induction genes NKX2-5, *IRX3*, *GATA4* AND a minimal expression of *DKK1* and *BMP4* and thus appear to be enriched in vascular commitment. Additionally, we identified a unique population of EVT-TPLC characterized by proliferative gene signatures, including *MKI67, KIF23, TOP2A, ANLN, AURKA, AURKB, TEAD4, CCNA2, CDK1,* and *PCNA* **(Fig. S7a, b)** suggesting a cluster with highly proliferative genes.

Since placental cells are immune modulatory in function, we observed immune-modulatory genes like *TGFB1, CXCL10, CCL2, IL6, IL10, TNF,* and *HLA-A, -B,* and *-C,* with higher levels of *CCL2* observed in the FB-like EVT population, highlighting potential roles in immune regulation and chemotaxis **(Fig. 5r).** There were no significant differences in the freshly isolated and expanded CDX2 cells within these genes **(Fig. 5t)**. Analyses at single cell level also revealed several surface genes, including *SERPINE1, CD9*, *AQP1*, and *HMMR*. The surface marker *AQP1*, which plays a role in ion transport and cell migration, shows elevated expression in specific STB subsets. Increased expression of HMMR is known to regulate cell motility, extracellular matrix remodeling, and cell proliferation. Notably, *HMMR* is highly expressed in the STB clusters, particularly in STB2 and the progenitor cluster EVT-TPLC suggesting potential translational significance in identification of such a unique population (**Fig. S7c).** We identified additional homing genes in addition to CXCL12 and CXCR4 in our single cell analysis (**Fig. S7d**) which may help optimize homing for different subsets of CDX2 cells in future studies. These findings have significant implications, as they enable us to envision multipotent human placenta-derived CDX2 cells as an innovative approach for cardiovascular regeneration.

Discussion

In this study, we have demonstrated that CDX2-expressing cells isolated from term human placentas possess key characteristics of stem/progenitor cells and differentiate into cardiovascular lineages in addition to migrating to the chemokine SDF1α. CDX2 is essential in embryonic development and is found in the trophectoderm, which in turn regulates placentation. During embryonic development, the placenta and fetal heart progress in parallel (placenta-heart axis) with the placenta regulating fetal cardiomyocyte proliferation, signifying a key functional association between these organs (*8-13*). Our findings lend credence to such a scenario as placenta-derived

390 CDX2 cells are uniquely poised to drive cardiovascular commitment and can now be viewed as a cellular target for cardiogenesis.

Various cell sources for therapeutic approaches have been studied in cardiac regeneration for decades, and the safety of such approaches has been established in clinical trials. However, finding an ideal and readily accessible cell type that can give rise to cardiovascular cells, aside from ESCs 395 and iPSCs, has proven difficult. Prenatal placental cells, particularly placental mesenchymal stem cells (PMSCs) and amniotic epithelial cells (AECs) have anti-inflammatory, angiogenic, and paracrine mechanisms that are beneficial for cardiac regenerative approaches but have not been shown to generate *de novo* cardiomyocytes (*23-25*). On the other hand, endogenous trophoblast progenitors in the placenta have not been explored for their differentiation into other cell types. Our 400 previous studies demonstrated the potential of murine Cdx2 lineage cells in the placenta to migrate to the sites of cardiac injury and produce new cardiovascular cells, significantly improving cardiac function (*19*). In a paradigmatic shift, we have now shown that multipotent human CDX2 cells are retained in the cytotrophoblasts of the human placenta through term. Our observation of the localization of CDX2 to the cytotrophoblast region is consistent with the studies of the early-405 gestation placenta (*25*). Cytotrophoblast cells are proliferative stem cells that migrate and invade maternal spiral arteries during placentation (*26*). Similarly, we observed that CDX2 cells from human term placentas expressed villous trophoblast markers, and exhibit clonal proliferation and migration, supporting the stem/progenitor characteristics required for cardiac regenerative approaches.

410 CDX2 cells and mCherry-negative cell populations were examined in our studies using a lentivirus-based isolation method. Even though sourced from healthy placentas, differences in proliferation among various samples existed. In this study, we have also incorporated a sizable group of healthy donors of varied races which included 150 placentas, to account for any biological diversity. This approach may facilitate a more inclusive analysis as the placenta samples are 415 representative of a broader population. The selection of cells that were CDX2mCherry positive also made it easier to study the functional competency of mCherry-negative counterparts from the same anatomical region of the chorion. Even though this population also exhibited clonal proliferation, we could conclusively determine that CDX2 cells have significantly enhanced cardiovascular differentiation capability compared with mCherry-negative cells as well as a higher 420 rate of clonal proliferation. The transcriptomic profile of mCherry-negative cells did show a reduced degree of commitment to the mesodermal lineage compared to CDX2mCherry-positive cells and their development into cardiomyocytes was minimal **(Fig. S3a-d and Fig. 5).** This could also be attributed to the incomplete targeting of all CDX2-positive cells using the lentivirus system and thus there is also a smaller number of CDX2-positive cells included in our mCherry-negative 425 group which is a limiting factor in this study. Nonetheless, in comparison with mCherry-negative cells and with additional hESC stem cell controls, CDX2 cells significantly upregulated chemotaxis, migration, and cardiovascular gene signatures.

Consistent with transcript analyses, human CDX2 cells generated spontaneously beating cardiomyocyte cell clusters within 5 days followed by approximately 70% of CDX2 cells 430 differentiating into cardiomyocytes on neonatal murine cardiomyocyte feeders. Remarkably, the time frame for the emergence of beating clusters was relatively shorter in CDX2 cells compared with other inductive co-culture approaches or standard protocols using pluripotent stem cells, which demonstrate the onset of beating within 8–12 days (*27-29*). It is conceivable that this is because of the enriched pre-existing cardiogenic transcriptome present in the isolated CDX2 cells. 435 These findings suggest that CDX2 cells may be a promising population for generating

cardiomyocytes in a shorter time frame, which could have significant implications for regenerative medicine. We also analyzed CDX2 cell differentiation using a feeder-free, Wnt-modulated differentiation method and observed a robust differentiation into cTnT+ cardiac myocytes **(Fig. 3).** Notably, two different subpopulations of cTnT+ cells; mCherry+cTnT+ and those downregulated mCherry to become cTnT+ cells (mCherry-cTnT+) were observed. These two subpopulations may indicate different maturation stages that may need further characterization. Most importantly, this standardized differentiation protocol for ES and iPS cells *(24-26)* demonstrated greater efficacy of cardiac differentiation in CDX2 cells compared with ES cells.

We investigated functional cardiac repair properties of these cells by administering them to NOD/SCID mice subjected to experimental MI. There was significant enhancement of cardiac function noted by MRI assessment and greater *in vivo* cardiomyocyte differentiation in the experimental group that received CDX2 cells compared to the two separate controls we used: mCherry-negative cells and vehicle control, which exhibited worsening cardiac function at 1 month post-MI. As the CDX2 cells were human, we used NOD/SCID mice which we noted did not tolerate large infarcts well compared to previous mouse strains and animals we have utilized (*19, 20, 30*). As such we could not induce large infarcts as in our previous studies and had to limit the injury to small-moderate sized infarcts such that average baseline EF after MI was ~40%. We also administered the cells via intramyocardial injection for proof-of-concept whereas in mouse-to-mouse transfer previously (*19*) we administered them intravenously as the significantly larger size of human CDX2 cells were not able to traverse the mouse tail vein. It is our hope that for further preclinical studies, human CDX2 cells can be tested via intravenous administration versus intramyocardial delivery in a large animal model where the larger sized veins will accommodate this mode of delivery.

Since the placenta becomes an increasingly vascular organ during the course of gestation, cells from the placenta can be highly angiogenic. As we noted from the data from our transcriptomic analyses, endothelial tube formation from CDX2 cells suggested a strong angiogenic commitment and Ac-LDL uptake confirmed that the CDX2-derived endothelial cells are functional. In order to understand neoangiogenesis potential in non-injury conditions, we utilized the *in vivo* matrigel plug assay which revealed significantly greater vessel density induced by CDX2 cells but no significant differences in vessel area compared to mCherry-negative cells. Angiogenesis is a crucial feature in cell therapy and cardiac repair, as the engraftment of adoptively transferred cells into the surrounding microenvironment is highly dependent on establishing *de novo* vasculature. Interestingly, angiogenesis and the invasive nature of trophoblast cells are interlinked as the migration potential of trophoblast cells directs endothelialization/angiogenesis during placentation (*31, 32*). On the other hand, *SDF1*-mediated chemotaxis is further involved in stem cell-mediated homing for regeneration (*33-35*) and CDX2 cells demonstrated significantly higher *SDF1*-mediated migration compared to our two control populations.

Once we established the greater cardiovascular differentiation potential of CDX2 cells by bulk RNA sequencing compared to both ESCs and mCherry-negative cells, we targeted the kinetics of proliferation and differentiation at the single-cell level of freshly isolated and expanded CDX2 cells to ensure the genetic signals for cardiac differentiation were retained in expanded CDX2 cells and to provide valuable clues to address cellular heterogeneity within the placenta samples. We identified 19 subpopulations and noted there was no downregulation of CDX2 expression after expansion. Of these 19 subpopulations, there were distinct clusters that were highly cardiogenic (STBs) and others that expressed more vasculogenic genes (EVTs). There were no significant differences between angio/vasculogenesis genes and cardiogenic genes between fresh and

expanded CDX2 cells. Within CDX2 cells, we discovered STB2 to be the most highly enriched cluster in essential cardiac mesoderm genes (*NKX2-5, IRX3, MSX1*, *GATA4, BMP4, HAND2, DKK1,* and *SFRP1)* along with *FGF2. FGF2* not only influences local angiogenesis and vascular stability by promoting communication with maternal tissues but also plays a crucial role in the expansion and survival of cardiac progenitor cells during development (*36*) interacting with essential pathways like Wnt and BMP (*37*), which are critical for mesodermal differentiation into cardiac lineages. Our scRNAseq also revealed immune-modulatory genes, highlighting potential roles in immune regulation and chemotaxis with no significant differences after expansion. Remarkably, single cell analysis also revealed several cell surface markers, such as *AQP1* which plays a role in ion transport and migration with elevated expression in specific STB subsets.

Our findings demonstrate the functional competency of CDX2 cells from several angles critical to the development of a novel cell therapy approach, thus laying the foundations for further clinical development. The most exciting outcome of these studies is that a new progenitor cell type has been identified from a limitless source (term placenta) that differentiates into spontaneously beating cardiomyocytes as well as functional vascular cells *in vitro* and *in vivo* with enhancement of cardiac function. The diverse cellular functions exhibited by CDX2 cells provide the underpinnings for more precision-guided clinical trials of cardiac regeneration.

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Reference for Supplemental Method:

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Author contributions

Conceptualization: HWC and SVM

Methodology: SVM, EB, BJW, MO

Investigation: HWC, SVM, FD, RB, SG, RS

Visualization: SVM, EB, BJW

Cardiac Imaging: CSG, MH, LC

Funding acquisition: HWC, SVM

Project administration: HWC, SVM, FD, RB, SG, RS

Supervision: HWC

Writing – original draft: SVM, EB, BJW

Writing – review & editing: SVM, EB, BJW, HWC

Competing interests

HWC the senior and co-corresponding author of this study is the inventor of an issued EU patent and US patent owned by Icahn School of Medicine at Mount Sinai (Methods of Cardiac Repair, No. 12847330.3) regarding the use of CDX2 cells for heart repair. She is also the founder of a biotech VentriNova, Inc. that may benefit from the publication of the results presented regarding human CDX2 cells. Although the company is still in the early stages and seeking institutional financing, HWC owns stock in the company.

Data and materials availability

The new plasmids generated in this study will be made available upon publication. No unique reagents were generated from this study. Bulk sequencing and scRNA-Seq data will be made available in the NCBI Sequencing Read Archive (SRA). De-identified placental information along with the patient's age and race/ethnicity data will be available upon request. All other data are available in the main text or the supplementary materials.

Supplementary Materials

Materials and Methods

650 Figs. S1 to S7

Tables S1 to S3

Movies S1 to S12

Data S1- Sanger sequencing, PEAKON and primer sequence data

Data S2 – Excel data DEG bulk RNAseq CDX2 versus H9 ES

655 Data S3 – Excel data DEG bulk RNAseq CDX2 versus mCherry neg cells

Data S4 – Excel data scRNA-seq- cluster based DEG of CDX2 cells

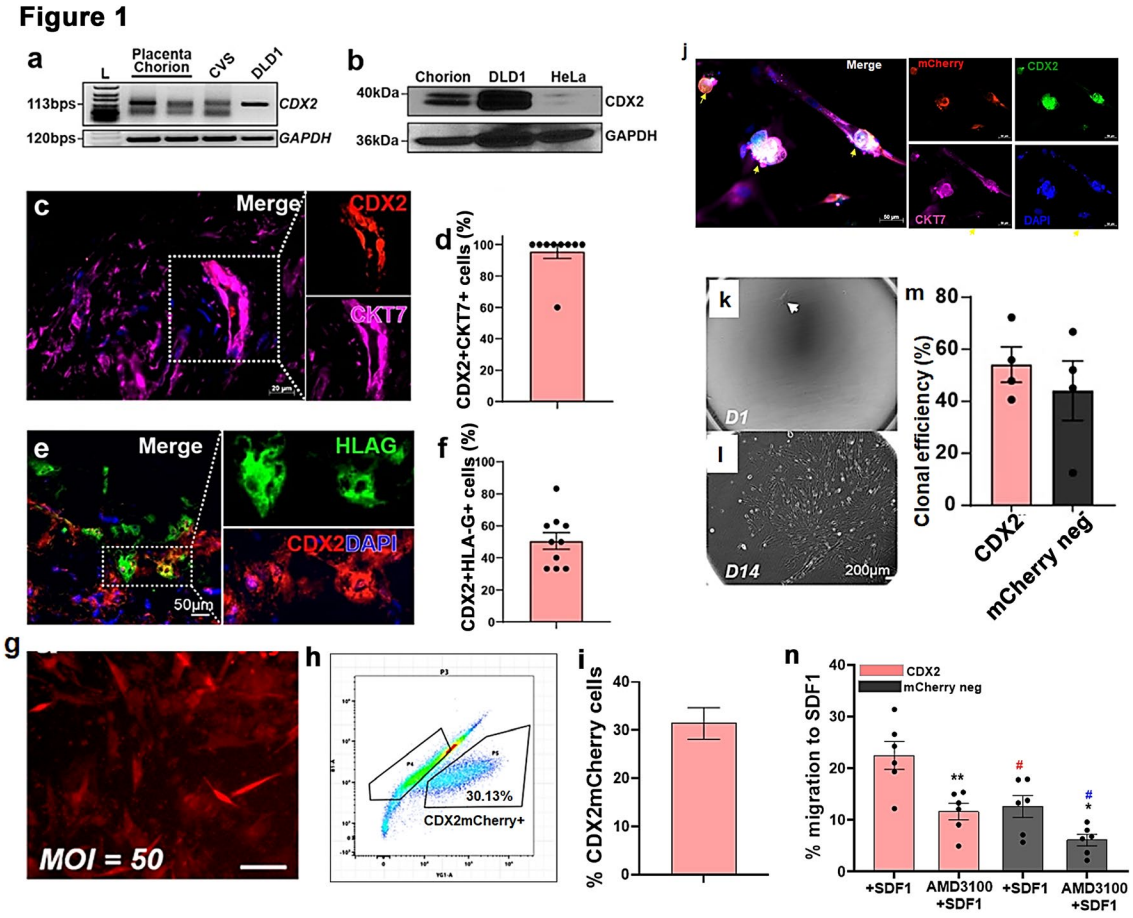

Figure 1. CDX2 cells are clonal and are enriched in term human chorionic tissues. **a)** CDX2 mRNA expression in the first-trimester chorionic villous sample and term chorion from the healthy placenta. L=DNA ladder (Gene Ruler ultralow DNA ladder). Human adenocarcinoma cell line DLD1 displays a higher expression of CDX2 and hence serves as a positive control. *GAPDH* served as an internal control. **b)** Western blot analyses on term healthy chorionic samples showed CDX2 protein (40KDa) with a doublet pattern indicative of the alternate splicing. DLD1 served as a positive control, while HeLa cells as a control with low endogenous CDX2 expression. **c)** Immunofluorescence detection of CDX2 in term chorion showed that CDX2 (clone CDX88-red) is mainly expressed in the villi region encompassing the cytotrophoblast cells and co-express trophoblast marker Cytokeratin 7 (pink -CKT7). **d)** Quantification of tissue sections showing the percentage of CDX2 cells co-expressing CKT7. **e)** Immunofluorescence images showing CDX2 cells co-expressing HLA-G, a crucial marker identifying extravillous trophoblast progenitors in the placenta. n=3 independent placental samples wherein 3 different ROIs from each section were

screened. CDX2 –Red; HLA-G –Green; DAPI –Blue). **f)** Bar graph representing the percentage of CDX2 cells co-expressing HLA-G, approximately 50% (50.5±5.0%) of CDX2 cells co-expressed HLA-G. **g)** CDX2 lenti mCherry was used to transduce chorionic cells (50 MOI), and cells expressing CDX2 displayed mCherry fluorescence. h-i**)** Flow cytometry-based isolation of mCherry+ cells and quantification of CDX2mCherry positive cells from various placentas. Data are presented as mean ± SEM (n=30 independent samples). **j)** The specificity of the lentivirus-based selection of CDX2 cells was validated using CDX2mAb (CDX-88clone). Co-localization of mCherry fluorescence with CDX2 antibody (Green) and trophoblast marker Cytokeratin 7 (CKT7-pink). **k-l)** Representative phase contrast image for clonal proliferation of CDX2 cells on day 1 compared to an increase in clonal proliferation of CDX2 cells in day 14 in culture. **m)** Clonal efficiency was analyzed on day 14 and found to be 54.1 ± 6.78% in CDX2 cells versus 44 ± 11.45% in mCherry-negative cells. Data are presented as mean ± SEM (n=4 independent samples). **n)** In vitro homing of CDX2 cells and mCherry-negative cells to chemokine SDF1 is partially dependent on the CXCR4 axis. CDX2 cells show significantly higher migration in both conditions compared to mCherry-negative cells. Data are presented as mean ± SEM (n=3 biological replicates comprising 3 independent samples *$p<0.05$, **$p<0.01$).

Figure 2

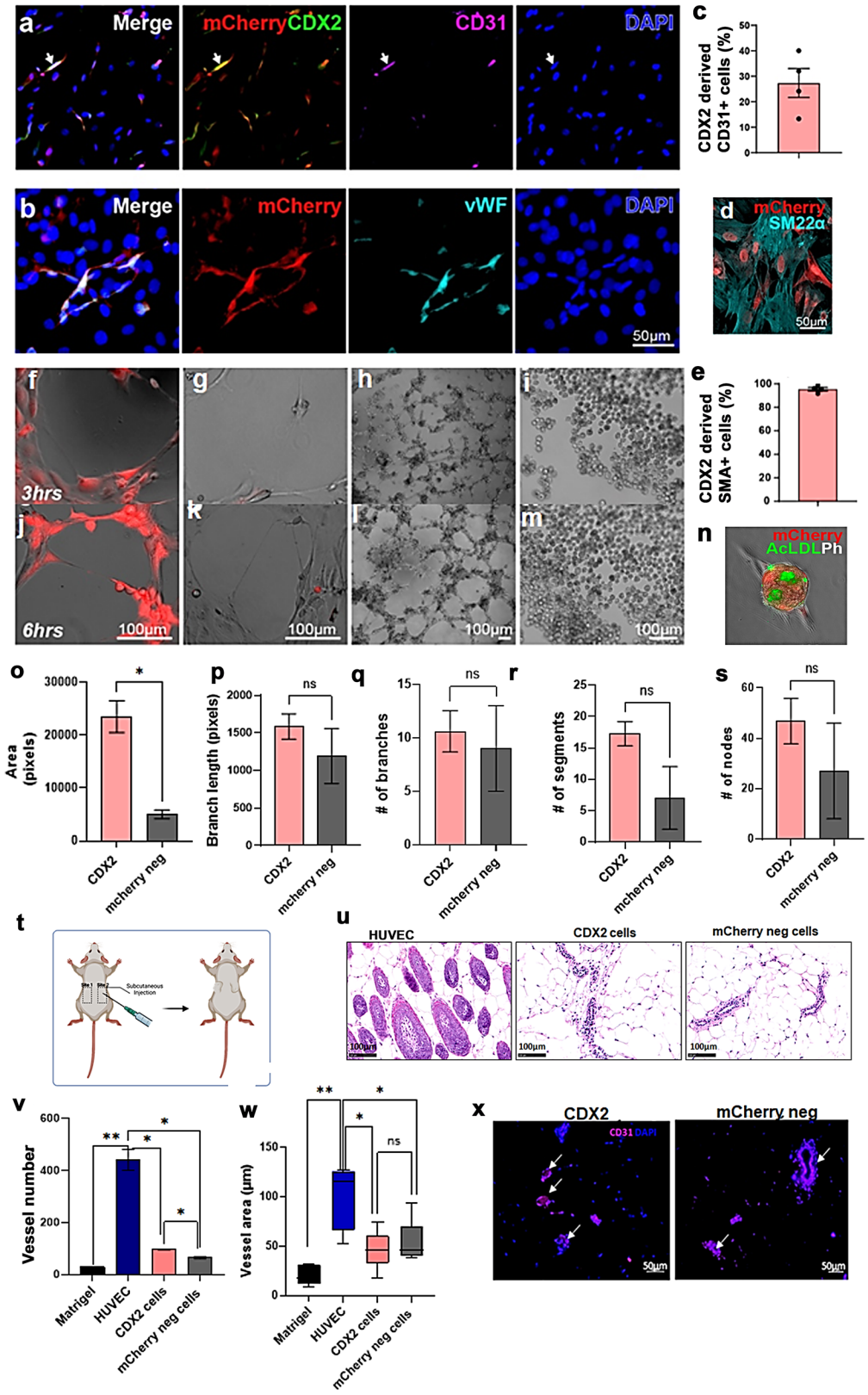
a
Merge
mCherryCDX2
CD31
DAPI
b
Merge
mCherry
vWF
DAPI
50µm
c
CDX2 derived CD31+ cells (%)
d
mCherry
SM22α
50µm
e
CDX2 derived SMA+ cells (%)
f
g
h
i
3hrs
j
k
l
m
6hrs
100µm
n
mCherry
AcLDL
Ph
o
Area (pixels)
p
Branch length (pixels)
q
# of branches
r
# of segments
s
# of nodes
ns
CDX2
mcherry neg
t
Subcutaneous Injection
u
HUVEC
CDX2 cells
mCherry neg cells
v
Vessel number
Matrigel
HUVEC
CDX2 cells
mCherry neg cells
w
Vessel area (µm)
x
CDX2
mCherry neg
CD31 DAPI
50µm

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Figure 2. CDX2 cells are angiogenic and display endothelial tube formation in vitro and in vivo. **a**) Subset of CDX2mCherry cells (red) expressed vascular lineage marker CD31 (pink) and further gave rise to blood vessel-like assembly (and stained positive for endothelial marker von Willebrand Factor (vWF-green) upon co-culture with neonatal cardiomyocytes **(b, c)**. Data represented as mean±SEM of four independent samples (n=4). **d,e)** CDX2mCherry cells also expressed smooth muscle marker (SM22α) upon feeder-free culture using IMDM+10%FBS. **f)** Endothelial tube formation by CDX2mCherry cells on matrigel in 3hrs and **j)** the formation of endothelial-like networks within 6hrs, also refer to movie S1. **g,k)** mCherry-negative cells showing networks, albeit not as intact and optimal as their CDX2mCherry counterpart on matrigel. **h,l)** Human umbilical vein endothelial cells (HUVEC) served as a positive control, also refer to movie S2). **i,m)** Total chorionic cells from the placenta did not exhibit endothelial tube formation at both time points. **n)** Ac-LDL (Alexa-488) uptake by primed (M200 medium +LSGS+ 10ng/mL VEGF) CDX2mCherry cells suggesting the formation of a functionally active endothelium. **o-s)** Quantification of the endothelial network using ImageJ software with an angiogenesis analyzer showed a higher endothelial loop-like area and branching segments compared to mCherry-negative cells (n=5 independent CDX2mCherry positive and n=2 independent mCherry-negative samples with biological triplicates per assay). **t**) Schematic image overview of the experimental plan of the matrigel plug assay for angiogenesis assessment. **u)** Representative microscopic images of hematoxylin and eosin (H&E) (20× magnification) of HUVEC, CDX2 cells, and negative cells. **v)** Bar graph showing the vessel numbers and **w)** a box and whisker plot representing the vessel areas in HUVEC cells, CDX2 cells, and negative cells., where CDX2 cells showed significant increase in vessel numbers,*P≤0.05 x) Representative immunofluorescence images showing CD31 (purple) and DAPI (blue) staining in both CDX2 and mCherry-negative cells.

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Figure 3

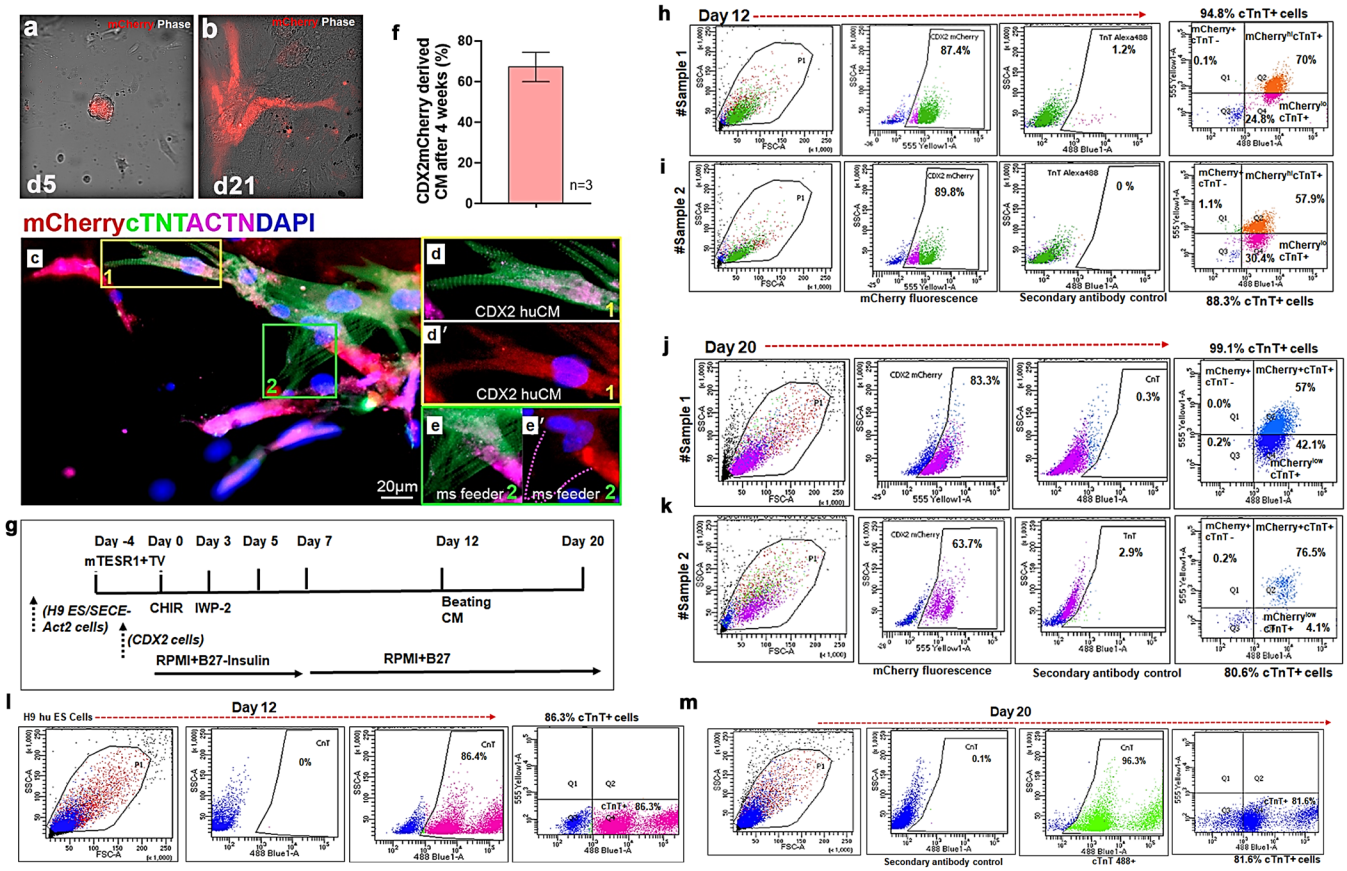
a
mCherry Phase
d5
b
mCherry Phase
d21
f
CDX2mCherry derived CM after 4 weeks (%)
n=3
mCherrycTNTACTNDAPI
c
d
CDX2 huCM
d′
CDX2 huCM
e
e′
ms feeder
ms feeder
20μm
g
Day -4
Day 0
Day 3
Day 5
Day 7
Day 12
Day 20
mTESR1+TV
(H9 ES/SECE-Act2 cells)
CHIR
IWP-2
(CDX2 cells)
Beating CM
RPMI+B27-Insulin
RPMI+B27
h
Day 12
94.8% cTnT+ cells
#Sample 1
87.4%
1.2%
70%
24.8%
i
#Sample 2
89.8%
0 %
57.9%
30.4%
88.3% cTnT+ cells
mCherry fluorescence
Secondary antibody control
j
Day 20
99.1% cTnT+ cells
#Sample 1
83.3%
0.3%
57%
42.1%
k
#Sample 2
63.7%
2.9%
76.5%
4.1%
80.6% cTnT+ cells
mCherry fluorescence
Secondary antibody control
l
H9 hu ES Cells
Day 12
86.3% cTnT+ cells
0%
86.4%
cTnT+ 86.3%
m
Day 20
0.1%
96.3%
cTnT+ 81.6%
Secondary antibody control
cTnT 488+
81.6% cTnT+ cells

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Figure 3. CDX2 cells differentiate into spontaneously beating cardiomyocytes. a) Snapshot of a beating CDX2mcherry cell cluster on day 5 on co-culture with murine neonatal cardiomyocytes feeder (non-mCherry-gray cells in the background), also see movie S3. *Please watch in loop mode* **b)** Snapshot of beating adhered and elongated CDX2mCherry cardiomyocytes 3 weeks in culture (movie S4, *Please watch in loop mode*). **c)** Most of the CDX2-derived cardiomyocytes (mCherry-red) stain positive for human cardiac sarcomeric actinin (pink-Alexa 647) and (cTnT-green Alexa 488). The specificity of the human actinin antibody was detected by a lack of staining on murine feeder myocytes in the background, while cTnT (green) detects both mouse and human cardiomyocytes. Yellow box 1 is further highlighted to the right. **d** and **d')** showing the striated sarcomeres visible on human CDX2 mCherry-derived cardiomyocytes (actinin pink + cTnT green+). Meanwhile, green box 2 and the expanded panels point to the endogenous murine feeder myocyte that expresses only cTnT (green). **e** and **e').** Nuclei are counterstained using DAPI (blue). **f)** Quantification revealed that approximately 71.11±12.15% of input CDX2 cells differentiated into cardiomyocytes, as shown. Data are represented as mean ± SEM (n=5 independent samples). **g)** Feeder-free differentiation of CDX2 cells using temporal modulation of Wnt signaling. Schema of GiWi experimental outline. H9ES cells were used as controls under identical culture conditions. CDX2 cells isolated from two different term placenta samples were included on day 0 with the beginning of the Wnt activation step followed by sequential induction steps until day 20. **h-i)** Cardiac-specific markers were used to quantify differentiation at two different time points' day 12 and day 20. Representative flow cytometry profiles showing robust differentiation of CDX2 cells into cTnT expressing cells on day 12 and day 20 **j,k)** in comparison to H9ES cells **l,m)** using identical culture conditions.

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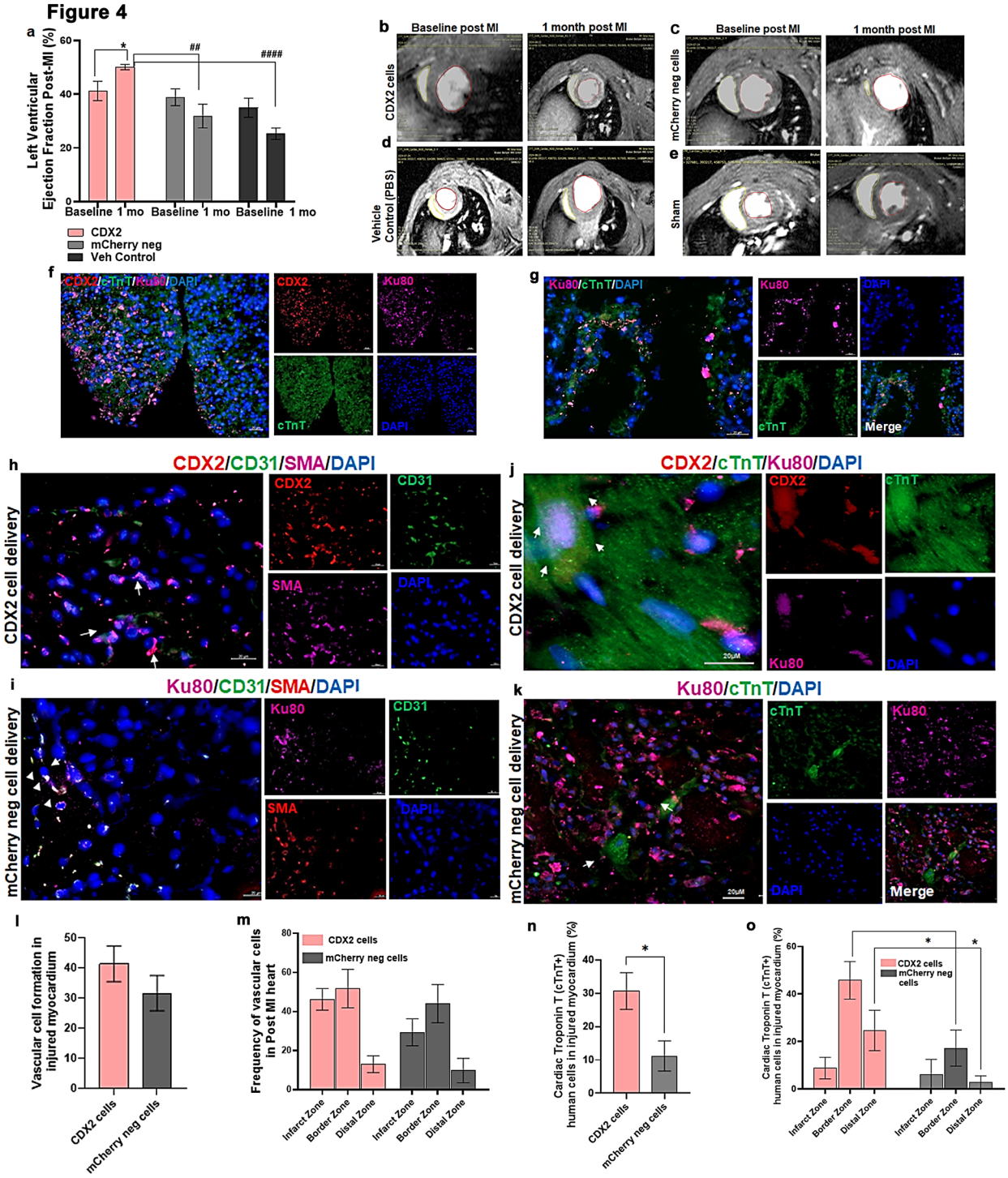
Figure 4
a
Left Ventricular Ejection Fraction Post-MI (%)
Baseline 1 mo Baseline 1 mo Baseline 1 mo
CDX2
mCherry neg
Veh Control
b
Baseline post MI
1 month post MI
CDX2 cells
c
mCherry neg cells
d
Vehicle Control (PBS)
e
Sham
f
CDX2/cTnT/Ku80/DAPI
CDX2
Ku80
cTnT
DAPI
g
Ku80/cTnT/DAPI
Merge
h
CDX2/CD31/SMA/DAPI
CDX2 cell delivery
CD31
SMA
j
CDX2/cTnT/Ku80/DAPI
i
Ku80/CD31/SMA/DAPI
mCherry neg cell delivery
k
Ku80/cTnT/DAPI
l
Vascular cell formation in injured myocardium
m
Frequency of vascular cells in Post MI heart
Infarct Zone
Border Zone
Distal Zone
n
Cardiac Troponin T (cTnT+) human cells in injured myocardium (%)
o

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Figure 4. CDX2 cell delivery significantly improved cardiac function after myocardial infarction. a) Cardiac MRI analyses showing a significant increase in left ventricular ejection fraction (EF) in CDX2 cell-injected mice versus the control animals at 1-mo time points compared
830 with the baseline MI timeline (CDX2 group, n = 5; mCherry neg group, n = 5, Vehicle control PBS n=2). Data are represented as mean ± SEM. *P≤0.05 (CDX2 baseline MI vs. 1 mo post-MI), ##P≤0.01 (CDX2 at 1 mo vs.mCherry neg at 1 mo post-MI and ####P≤0.001CDX2 1mo post-MI vs. PBS group 1 mo post-MI). **b–e)** Mid-ventricular short axis view of MRI images showing ventricular wall dilation (higher dilation and thinning) in PBS group and mCherry neg cell treated
835 group in comparison to CDX2 cell injected group and Sham group **f-g)** Engraftment of CDX2 cells (mCherry red, Ku80 pink) and mCherry negative cells (Ku80-pink) in the injured myocardium 1 month post-MI. cardiomyocytes (CMs) are immunostained for (cTnT-green). **h-i)** CDX2 cells and mCherry negative cells contributed to vascular differentiation in vivo. (Scale bar: 20 µm) (Right) Border zone shows CD31+ SMA+ cells associated with mCherry (CDX2 group) or Ku80
840 (mCherry neg group) highlighted with white arrows. **j)** CMs expressing cTnT derived from CDX2 cells in the border zone are shown (cTnT-green, CDX2 (mCherry), Ku80 (pink), and DAPI blue. Scale bar: 20 µm). **k)** Limited cardiogenic contribution of mCherry negative cells in injured myocardium. **l)** Quantification of the overall vascular cells, **(m)** distribution of CDX2 and mCherry neg derived vascular cells. (**n**) Quantification of overall cardiomyocytes and **(o**) distribution of
845 CDX2 and mcherry neg cell-derived cardiomyocytes in the infarct zone, border zone, and distal zone, demonstrating significantly higher cardiogenic potential of CDX2 cells *P≤0.05. Data are presented as mean ± SEM, n=5.

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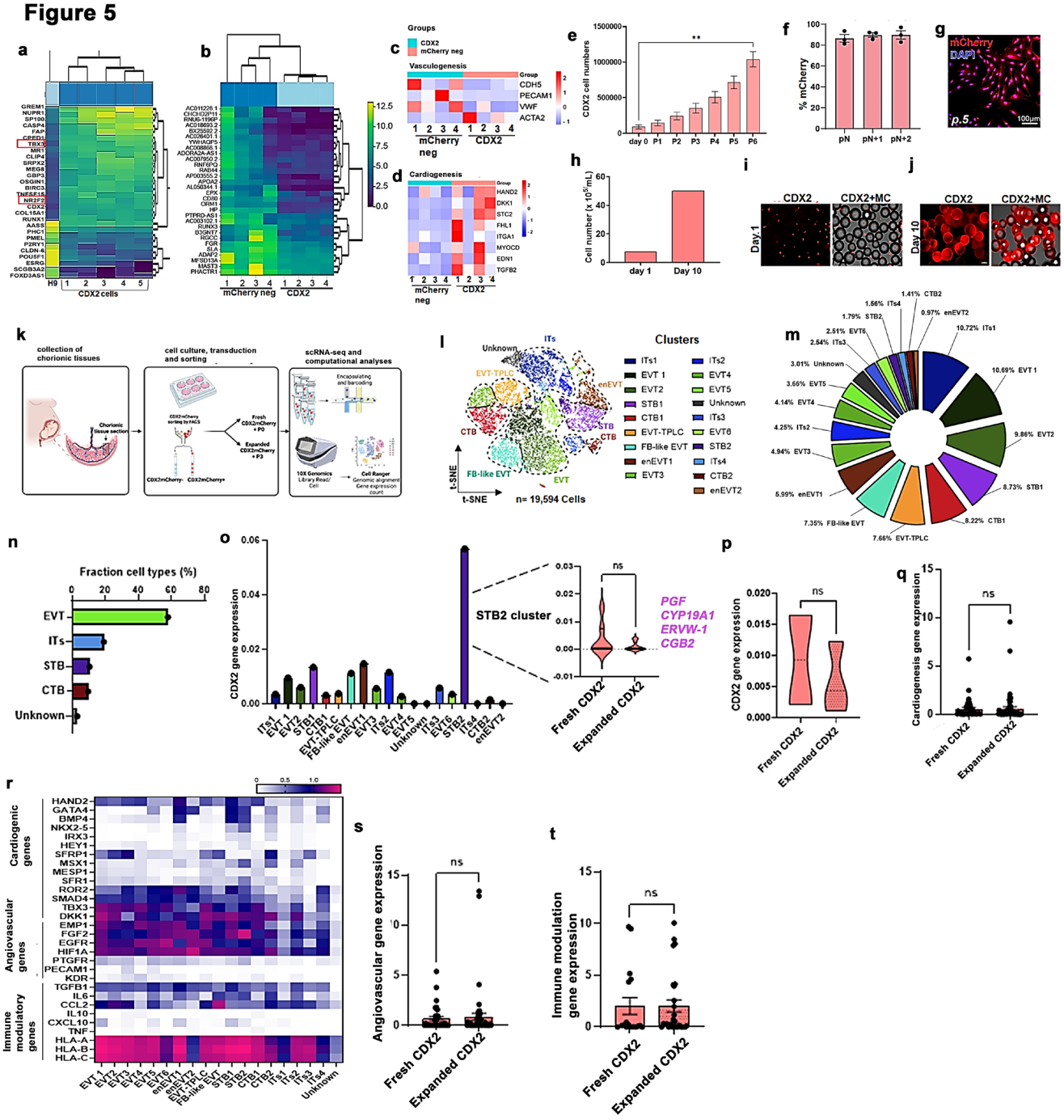
Figure 5


a
b
c
Groups
CDX2
mCherry neg
Vasculogenesis
CDH5
PECAM1
VWF
ACTA2
mCherry neg
CDX2
d
Cardiogenesis
HAND2
DKK1
STC2
FHL1
ITGA1
MYOCD
EDN1
TGFB2
e
CDX2 cell numbers
day 0
P1
P2
P3
P4
P5
P6
f
% mCherry
pN
pN+1
pN+2
g
mCherry
DAPI
p.5
100µm
h
Cell number (x 10^5/mL)
day 1
Day 10
i
CDX2
CDX2+MC
Day 1
j
CDX2
CDX2+MC
Day 10
k
collection of chorionic tissues
cell culture, transduction and sorting
scRNA-seq and computational analyses
l
Clusters
Unknown
ITs
EVT-TPLC
enEVT
STB
CTB
FB-like EVT
EVT
t-SNE
n= 19,594 Cells
m
1.41% CTB2
1.56% ITs4
1.79% STB2
0.97% enEVT2
2.51% EVT6
10.72% ITs1
2.54% ITs3
3.01% Unknown
10.69% EVT 1
3.66% EVT5
4.14% EVT4
4.25% ITs2
9.86% EVT2
4.94% EVT3
8.73% STB1
5.99% enEVT1
7.35% FB-like EVT
8.22% CTB1
7.66% EVT-TPLC
n
Fraction cell types (%)
EVT
ITs
STB
CTB
Unknown
o
CDX2 gene expression
STB2 cluster
ns
PGF
CYP19A1
ERVW-1
CGB2
Fresh CDX2
Expanded CDX2
p
CDX2 gene expression
ns
Fresh CDX2
Expanded CDX2
q
Cardiogenesis gene expression
ns
Fresh CDX2
Expanded CDX2
r
Cardiogenic genes
Angiovascular genes
Immune modulatory genes
HAND2
GATA4
BMP4
NKX2-5
IRX3
HEY1
SFRP1
MSX1
MESP1
SFR1
ROR2
SMAD4
TBX3
DKK1
EMP1
FGF2
EGFR
HIF1A
PTGFR
PECAM1
KDR
TGFB1
IL6
CCL2
IL10
CXCL10
TNF
HLA-A
HLA-B
HLA-C
s
Angiovascular gene expression
ns
Fresh CDX2
Expanded CDX2
t
Immune modulation gene expression
ns
Fresh CDX2
Expanded CDX2

875 **Figure 5. Transcriptomic analysis support cardiovascular commitment and revealed unique cellular sub clusters in placental CDX2 cells at single cell level. a)** Bi-clustering heatmap showing the expression profile of the top 30 differentially expressed genes in CDX2 cells (labeled 1-5) versus hESCs (H9 ES ctrl pooled extreme left) in bulk RNAseq analyses. Genes were sorted by their adjusted p-value by plotting the log2 transformed expression values. The yellow-green 880 color code indicates the upregulated and the blue-gray color code indicates the downregulated genes across the samples. CDX2 cells showed upregulated cardiac mesoderm commitment genes *(NR2F2* and *TBX3,* highlighted in red box*)* while downregulating pluripotent markers *CLDN6*, *POU5F1,* and *ESRG.* **b)** A bi-clustering heatmap with the top 30 differentially expressed genes showing the upregulated function of inflammatory response and immune genes in mCherry-885 negative cells (n=4 independent samples in each group). c) Heatmap depicting the vasculogenic genes *(PECAM1, CDH5,vWF* and *ACAT2)* in both CDX2 and negative cells. **d)** Heatmap showing cardiogenic genes *(HAND2, DKK1, STC2, FHL1, ITGA1, MYOCD EDN1,* and *TGFB2)* in both CDX2 and negative cells. **e**) Quantification of mCherry cells after expansion showed a significant increase of up to 1 million cells by passage 6 compared to day 0 of isolation. Data represented as 890 mean±SEM (n=3, *p<0.05, **p<0.01). **f)** Retention of mCherry expression over the various passages as analyzed by flow cytometry and **g)** representative fluorescent microscopy image at p5. **h**) A representative bar graph showing the cell yield of CDX2 cells on day 1 versus day 10 of the bioreactor culture. **i)** Representative fluorescence microscopy images showing a remarkable difference in cell attachment and proliferation of CDX2 cells (mCherry) on synthemax II 895 microcarriers at the beginning (1 day) and the **j)** end (day 10) of culture expression. Data are representative of pooled CDX2 cells isolated and expanded from 3 different placenta samples.**k**) Schematic representation of the workflow for isolating and analyzing human placental CDX2 cells using single-cell transcriptomics. **l**) T-distributed Stochastic Neighbor Embedding (t-SNE) analysis of human placental CDX2 cells, both fresh (n=2) and expanded (n=3) and the different 900 cluster groups. Each dot represents a single cell, with different colors indicating distinct cell types. Villous cytotrophoblasts (CTB), syncytiotrophoblasts (STB), extravillous trophoblasts (EVT), Endovascular extravillous trophoblast (enEVT), EVT-trophoblast progenitor-like cells (EVT-TPLC), Fibroblasts like trophoblasts (FB-like EVT), Intermediate trophoblasts (ITs) and Unknown cells. **m**) Pie chart showing the percentages of CDX2 subclusters. **n**) Column chart showing the 905 fraction of indicated cell types **o)** Bar graph depicting CDX2 expression levels across different clusters in both fresh and expanded CDX2 cells, with emphasis on the STB2 cluster, which exhibits higher CDX2 expression and is present in both fresh and expanded populations **p**) Violin plot showing CDX2 gene expression in both fresh and expanded CDX2 cells. **q**) Representative graph illustrating cardiogenic gene expression levels in fresh versus expanded CDX2 cells. **r**) Heatmap 910 displaying the expression levels of cardiogenic, angiogenic/vasculogenic, and immune-modulatory genes across various clusters of CDX2 cells**. s)** Bar graph depicting the expression levels of vasculogenic genes in fresh and expanded CDX2 cells. **t**) Bar graph showing the expression levels of immune-modulatory genes in fresh and expanded CDX2 cells.

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