

# Metabolism and Toxicology

Finding a substance that shows an effect *in vitro* does not mean that this is a suitable *drug candidate* as well.

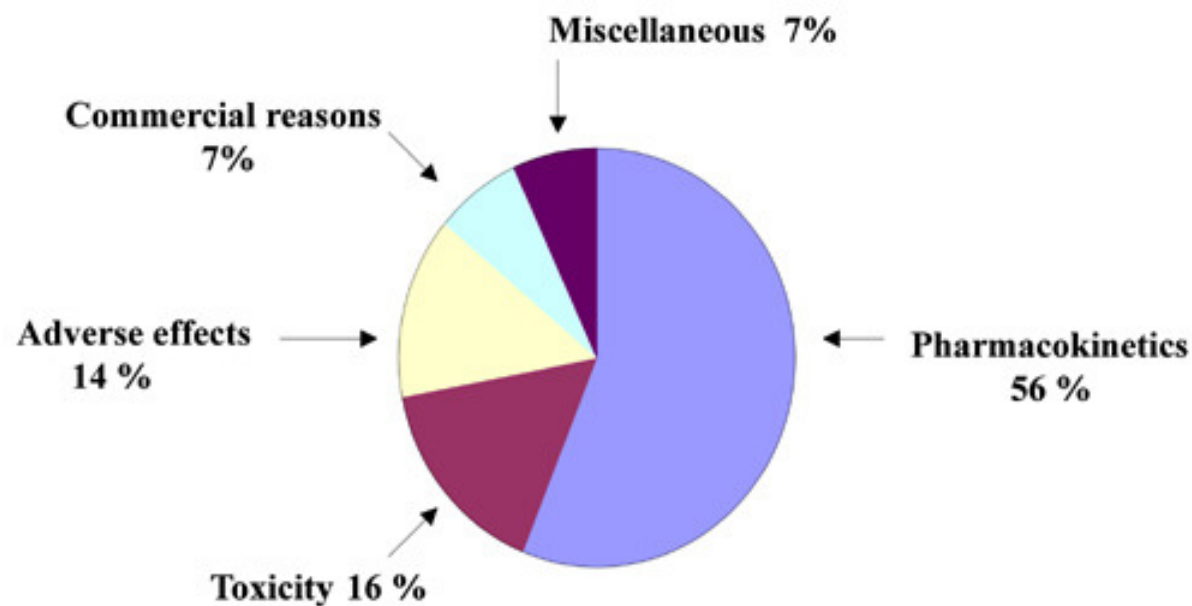
The vast majority of chemical substances undergo biochemical transformations inside the body (metabolisms).

Some of these reactions lead to degradation products (metabolites) that are toxic.

It is therefore important to recognize unsuitable compounds as early as possible:

„Fail early, fail fast, fail cheap“

# Why is the prediction of ADME parameters that important ?



Reasons that lead to failure or withdrawal of a potential drug around 1995 – 2000

## For risks and side effects...

Adverse effects are assumed to be the 5.-6. most frequent cause of death (USA 1994)

Most frequent (natural) cause: cardio-vascular complications

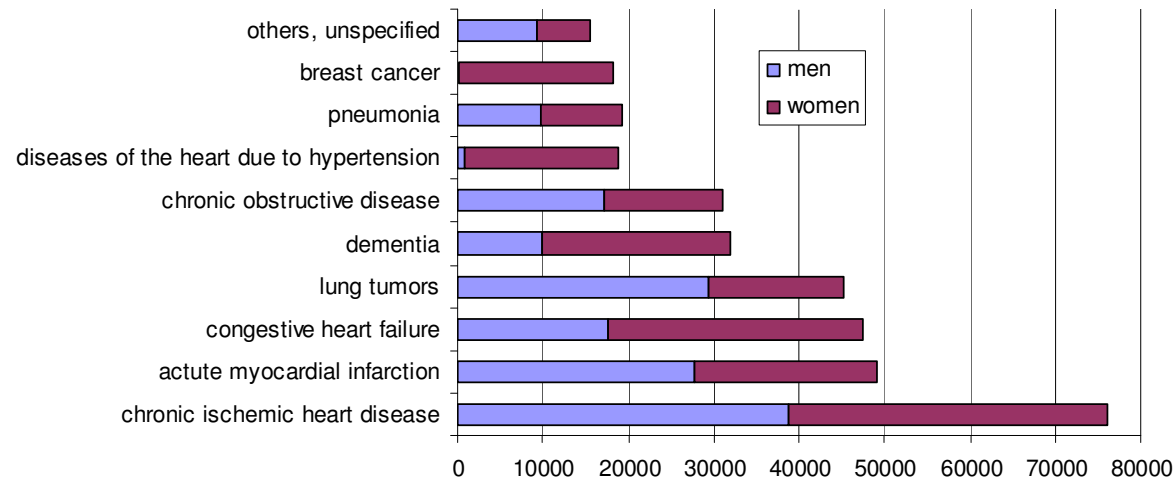
### List of withdrawn drugs (not comprehensive)

trade name	adverse effect	manufacturer	time
rofecoxib	thrombosis, stroke	Merck(USA)	Sep 2004
cerivastatin	rhabdomyolysis	Bayer	Aug 2001
alosetron	ischemic colitis	GSK	Nov 2000
cisapride	cardiac arrhythmia	Janssen	Jun 2000
pemoline	liver toxicity	Warner-Lambert	May 2000
mibefradil	drug/drug Interaction	Roche	Jun 1998
terfenadine	cardiac arrhythmia	Höchst	Dec 1997
fenfluramine	heart valve disease	Wyeth	Sep 1997

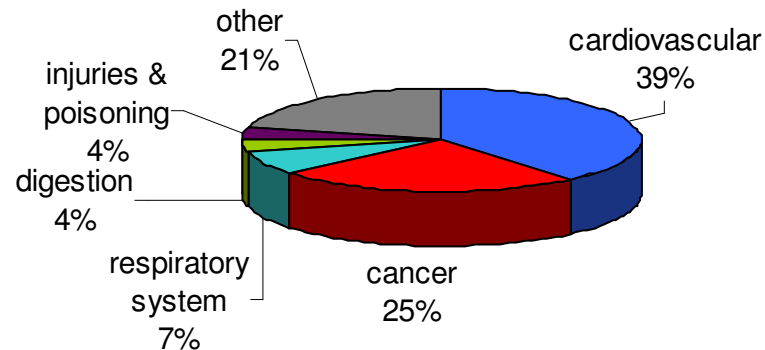
source: J. Gut TheraSTrat AG, Allschwil, CH upto 2001)

# Actual causes of death

Most frequent causes of death in Germany (2015)



According to type of disease



Data sources: Statistisches Bundesamt [www.destis.de](http://www.destis.de)

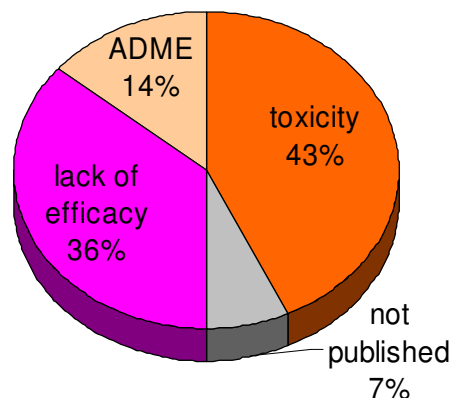
# Why drugs fail

90% of market withdrawals caused by drug toxicity, from that  $\frac{2}{3}$  are due to hepatotoxicity and cardiovascular toxicity

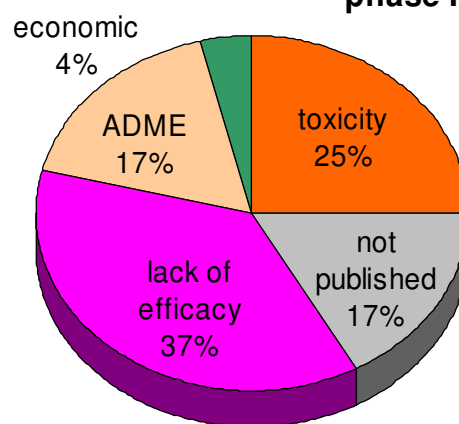
Drugs failing in clinical phases I-III between 1992 to 2002 were mainly due to insufficient efficacy (43%)

→ Drug toxicity must be detected earlier than after market launch

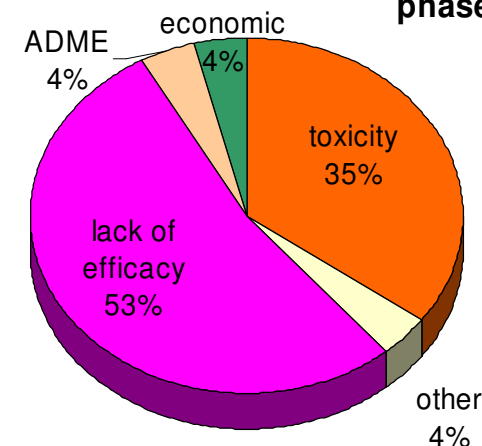
phase I



phase II



phase III



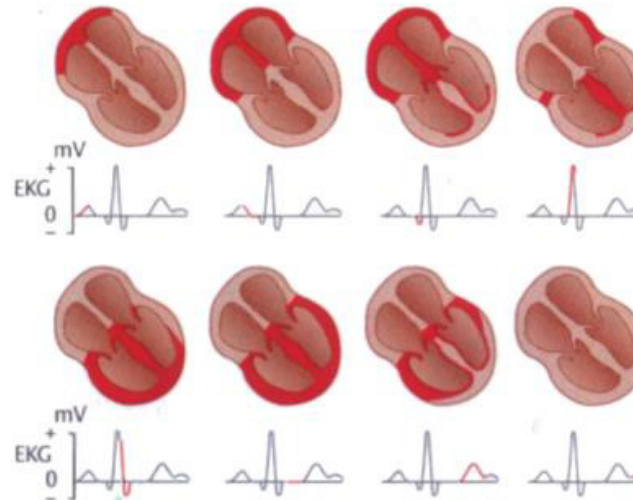
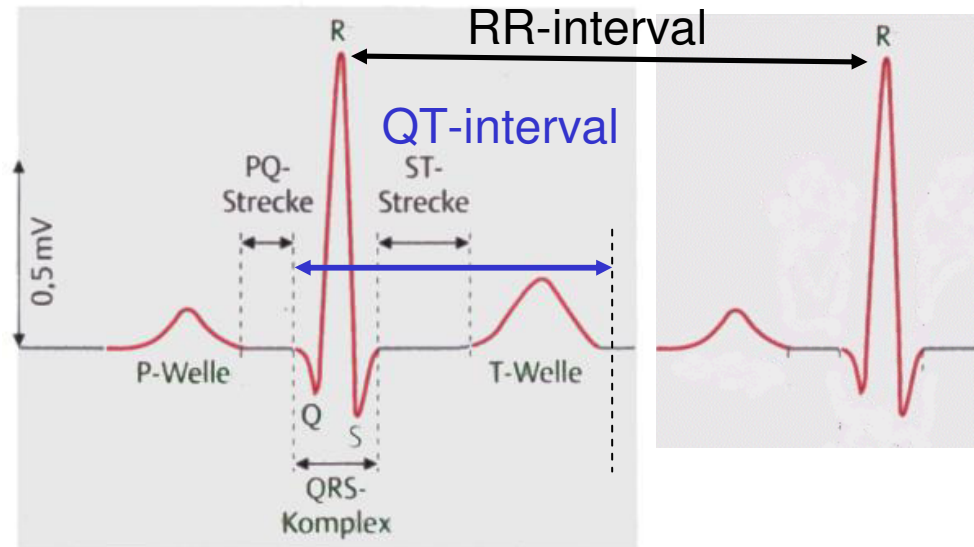
Source: Schuster, Laggner, Langer, *Curr.Pharm.Des.* **11** (2005) 3545.

# QT interval prolongation (I)

Cardiac arrhythmias are among the most frequent adverse effects that lead to the failure of drugs (frequently as late as in clinical phases III or IV).

Often a prolongation of the so-called QT-interval in the ECG is observed.

The upper limit is usually at 440-470 msec for pulse of 60 beats per minute.



Picture source:

<http://medizinus.de/ekg.php>

# QT interval prolongation (II)

Since the heart beat rate is subject to change, the QT-time is normalized to the so-called *QTc interval* via division by the root of the preceeding RR interval (Bazett correction):

$$QTc = QT / RR^{1/2}$$

For pulse of 60 the RR-interval is 1 sec long

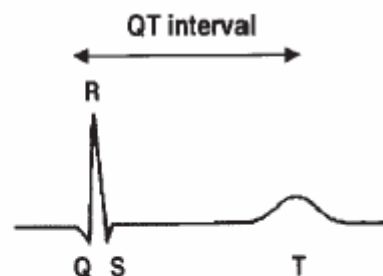
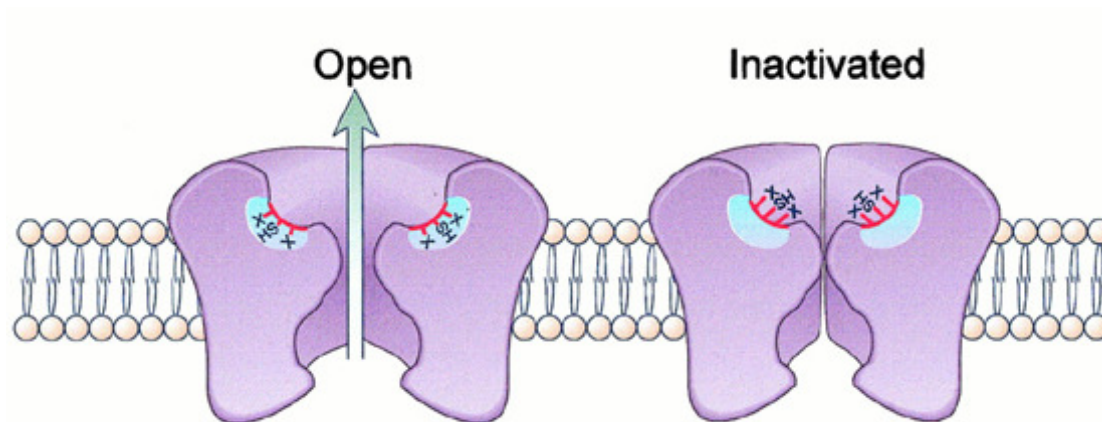
The observed current in the ECG during the QT-time is mainly due to the delayed activity of the cardial potassium channel (*outward repolarizing current*  $I_{Kr}$ ).

This voltage gated channel is coded by the so-called *human ether-a-gogo related gene* (hERG).

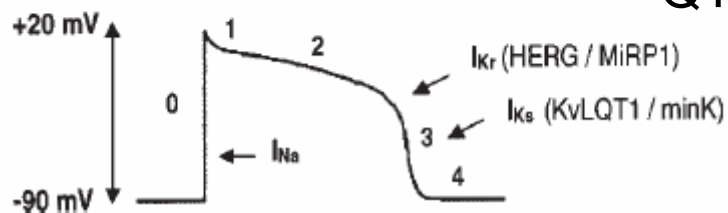
This effect is frequently used by anti-arrhythmic drugs of class III. On the other hand, too long QT-times can lead to fatal distortions of the cardial rhythm itself.

Lit: R.R.Shah *Brit.J.Clin.Pharmacol.* **54** (2002) 188.

# The *h*ERG potassium channel (I)



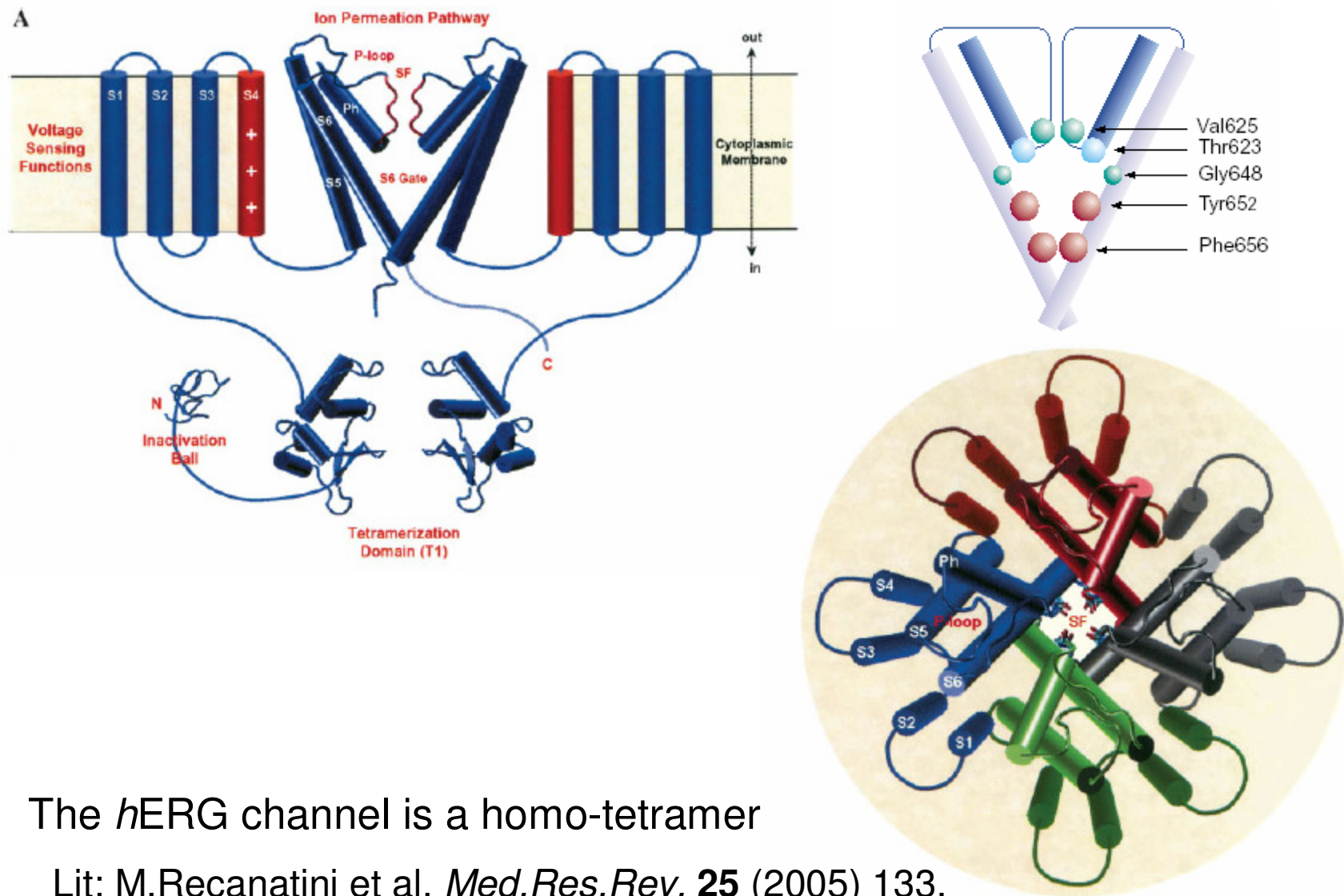
The activity of the *h*ERG channel accounts for the rapid potassium component ( $K_r$  rapid) of the outward repolarizing current I during the QT-interval



Lit: M.Recanatini et al. *Med.Res.Rev.* **25** (2005) 133.



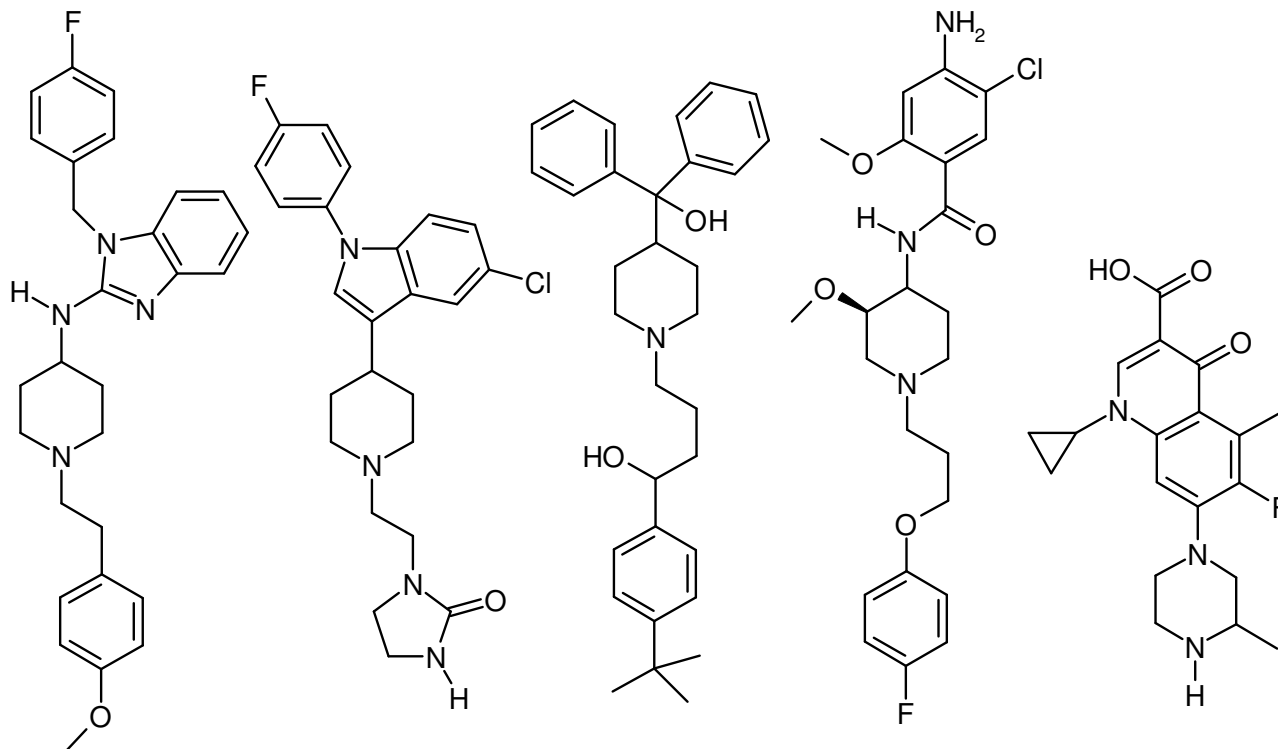
# The *h*ERG potassium channel (II)



The *h*ERG channel is a homo-tetramer

Lit: M.Recanatini et al. *Med.Res.Rev.* **25** (2005) 133.

# ***h*ERG channel blocking drugs**



Astemizole  
Antihistaminic

Sertindole  
Antipsychotic

Terfenadine  
Antihistaminic

Cisapride  
Gastroprokinetic

Grepafloxacin  
Antibiotic

In connection with QT-Interval prolongation withdrawn drugs: all exhibit high binding affinity to the *h*ERG potassium channel.

Lit: A.M.Aronov *Drug Discov. Today* **10** (2005) 149.

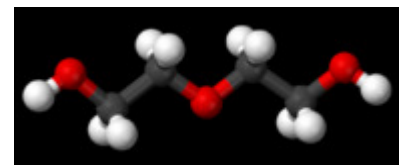
# Historical development in the USA

As a consequence of about 105 deaths caused by poisoning from an elixir of sulphanilamide in 72% diethylene glycole (Massengill incident), the United States Federal Food, Drug and Cosmetic Act of 1938 was passed, that regulates the passive approvement of substances by the Food and Drug Administration (FDA).

According to that, drugs have to be safe (at least) for their indicated use.

The approvement for (chemical) substances that are manufactured in larger quantities is subject to the Environmental Protecting Agency (EPA).

Lethal dose LD50  $\approx$  1 ml/kg body weight



# Historical development in Germany

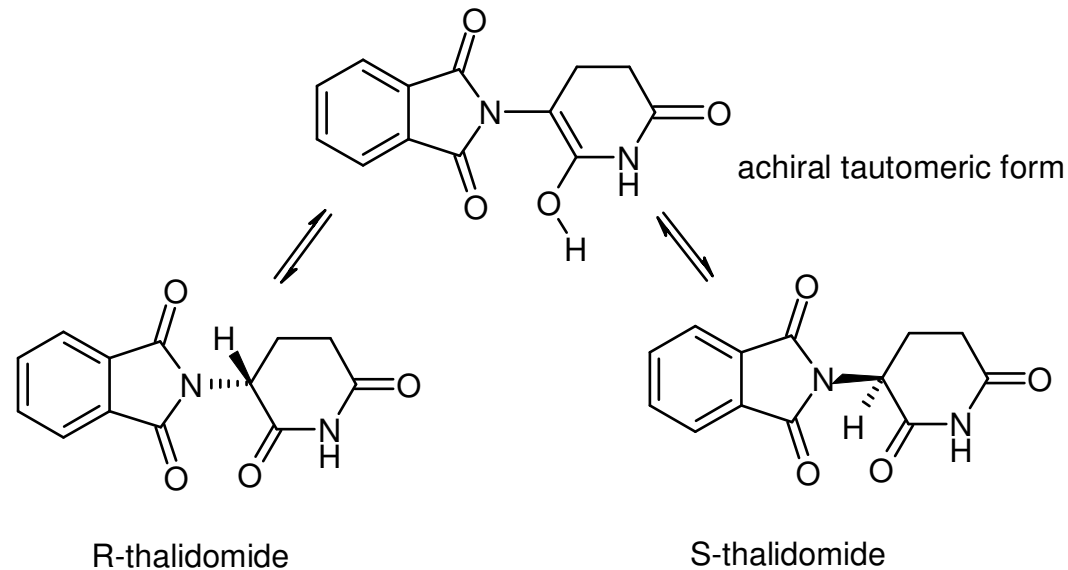
Until 1961 there was no comprehensive legislation regarding marketing of medical drugs in the former Federal Republic of Germany.

Decisive for the new legislation was the so-called Contergan-scandal: The responsible substance thalidomid (a sedative) did not show any indications in the original animal tests (mice), but showed to be teratogen in humans.

The *Arzneimittelgesetz* regulates among other things:

- requirements for clinical studies and tests
- prove of efficacy [Wirksamkeit]
- prove of non-existent toxicity for humans

# Interconversion of thalidomide



Racemization within few hours

New indications:

Antineoplastic, antiangiogenetic (both anti-tumor)

# Pre-clinical phase

After completing the *lead optimization* there are studies *in vitro* (model system of single and multiple cells) and *in vivo* (testing on animals) on the *lead candidate(s)*.

During this stage filing for patent also occurs, whereby always a series of compounds is claimed in order to

- not stick to one single substance
- reserve similar potential substances
- complicate generic drugs („*me-too*“)  
[Nachahmungspräparate]

At the lastest compounds receive an United States Adopted Name (USAN) at this stage. Example: cisapride

# **clinical studies / tests (I)**

Phase I: Validation if the animal model can be transferred to human. Deriving dosage guidelines  
(10-50 test persons, „healthy male“, no risk group)

Phase II: Validation of efficacy and relative harmlessness on some patients

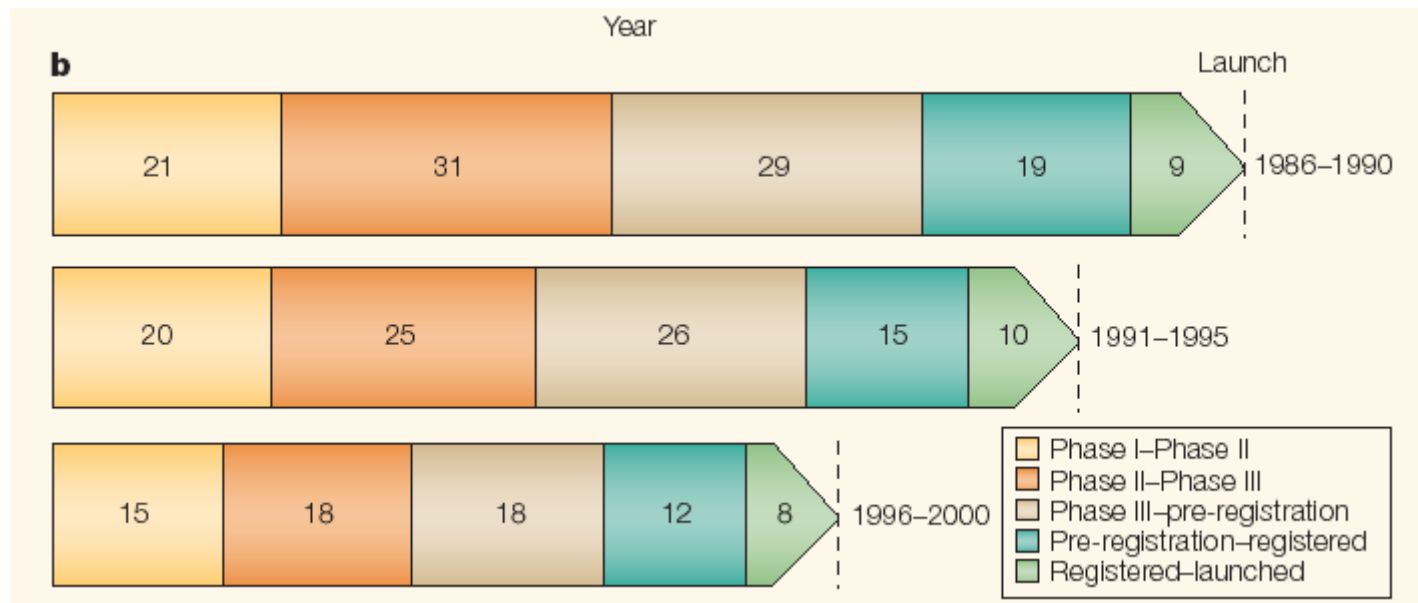
Phase III: Validation of efficacy and relative harmlessness on a larger number of patients. (as well as adverse effects upon co-administration with other medications)

After the market launch

Phase IV: As in phase III, but more comprehensive number of patients, recording of rare side effects, long term studies, validation of cost efficiency

## clinical studies / tests (II)

Duration (in months) for the clinical and pre-clinical development



Source: P.Preziosi *Nature Rev.Drug.Discov.* **3** (2004) 521.



# Approval and launch (I)

The approval in the USA is regulated by the Food and Drug Administration, in the EU now centrally the Bundesinstitut für Arzneimittel und Medizinprodukte as well as the Deutsche Institut für medizinische Dokumentation und Information.

A new medication is only approved if,

- the field of application or the mode of action is new
- it shows a better efficacy than existing drugs
- it is better tolerated or shows less adverse effects
- it has a different administration [Darreichungsform] (Galenik)

The result of an approval process is more and more decisive for the financial future of the manufacturer.

## Approval and launch (II)

A new medication is also referred to as *new chemical entity* (NCE).

Investment per new chemical entity: >500,000 \$

New chemical entities per year: ca. 15

World Drug Index 58,000 compounds

USAN <10,000 in clinical trial

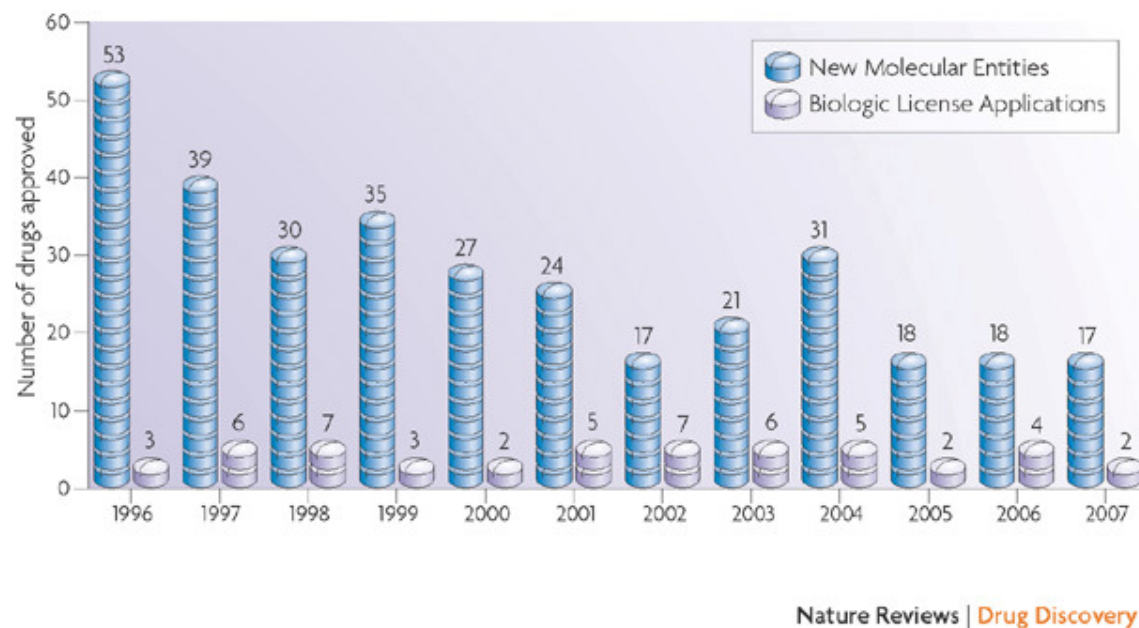
Drugs approved by  
the FDA

expenses for research and  
development (USA)

1996	53	1980	2 Mrd US\$
1997	39	1985	4 Mrd US\$
1998	30	1990	8 Mrd US\$
1999	35	1995	15 Mrd US\$
2000	27	2000	26 Mrd US\$
2001	24	2001	30 Mrd US\$
2002	17	2002 estimated	32 Mrd US\$

# Approval and launch (III)

Trend in approval of new chemical entities

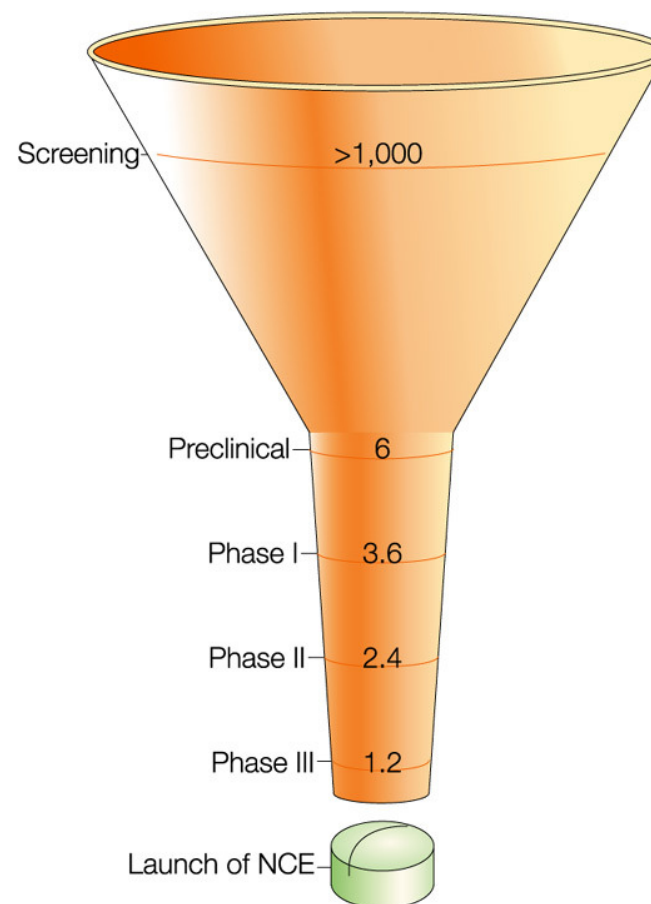


Lit: B. Hughes *Nature Rev.Drug.Discov.* **7** (2008) 107-109.

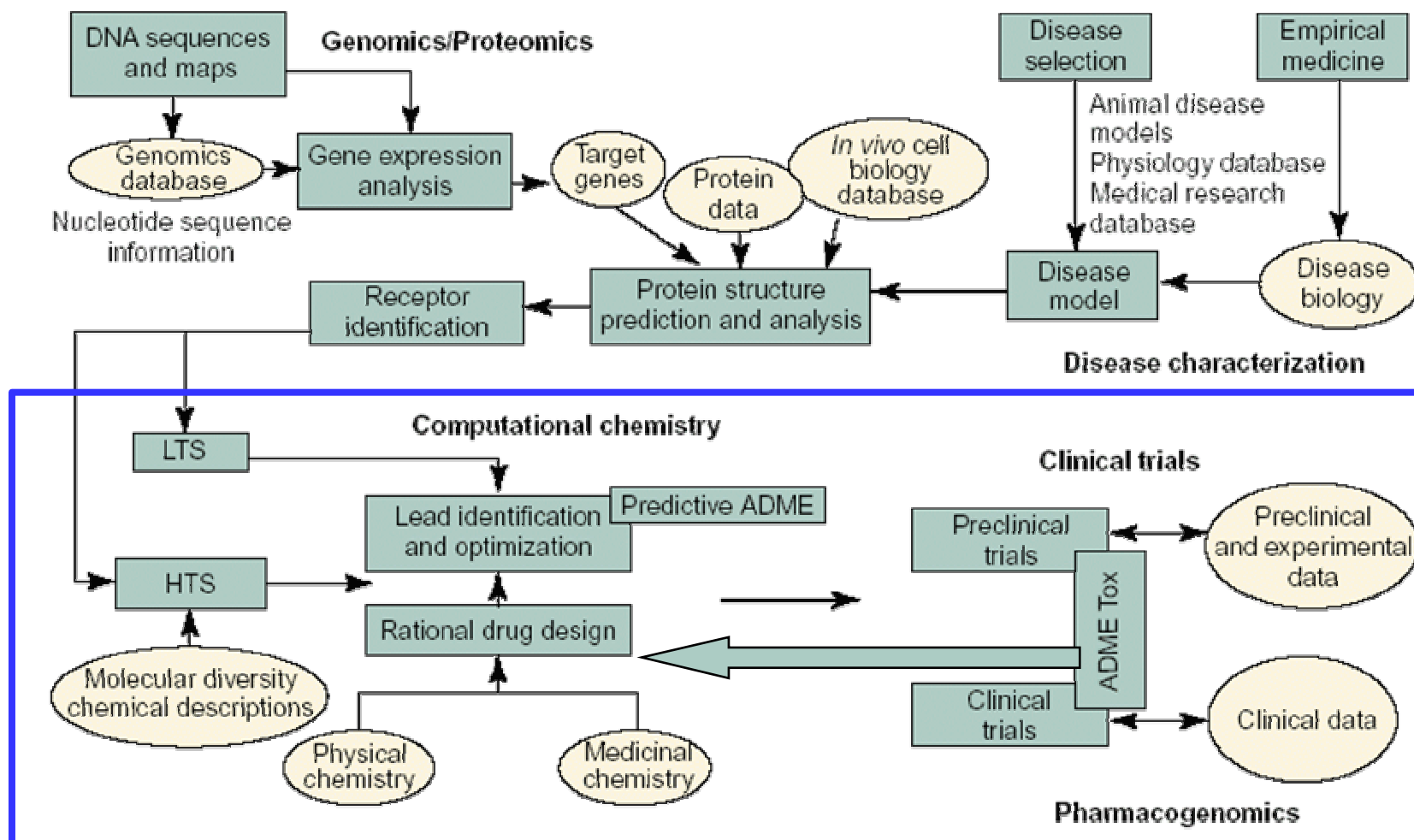
# From the *pipeline* to the market launch

Counting from the number of actually approved drugs (*new chemical entity, NCE*) back to the number of *in vitro* screened compounds, results in more than 1,000 per drug.

Without the available computer-aided ADMET filters, this number would be even larger.

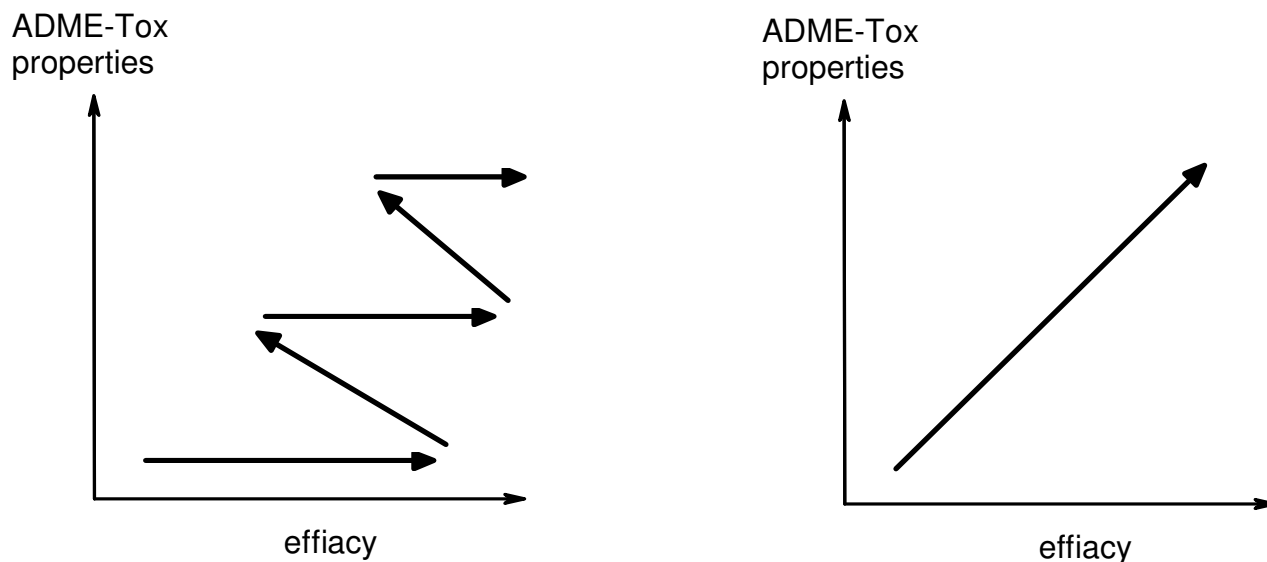


# Flow of information in a *drug discovery pipeline*



*Drug Discovery Today*

# Process of optimization from the *lead candidate* to the *drug candidate*



Past: optimization of efficacy first, then improvement of ADME-Tox criteria

Today: simultaneous optimization of efficacy and ADME-Tox properties (requires *in silico* AMDET models)

# eADMET Prediction

early

Absorption

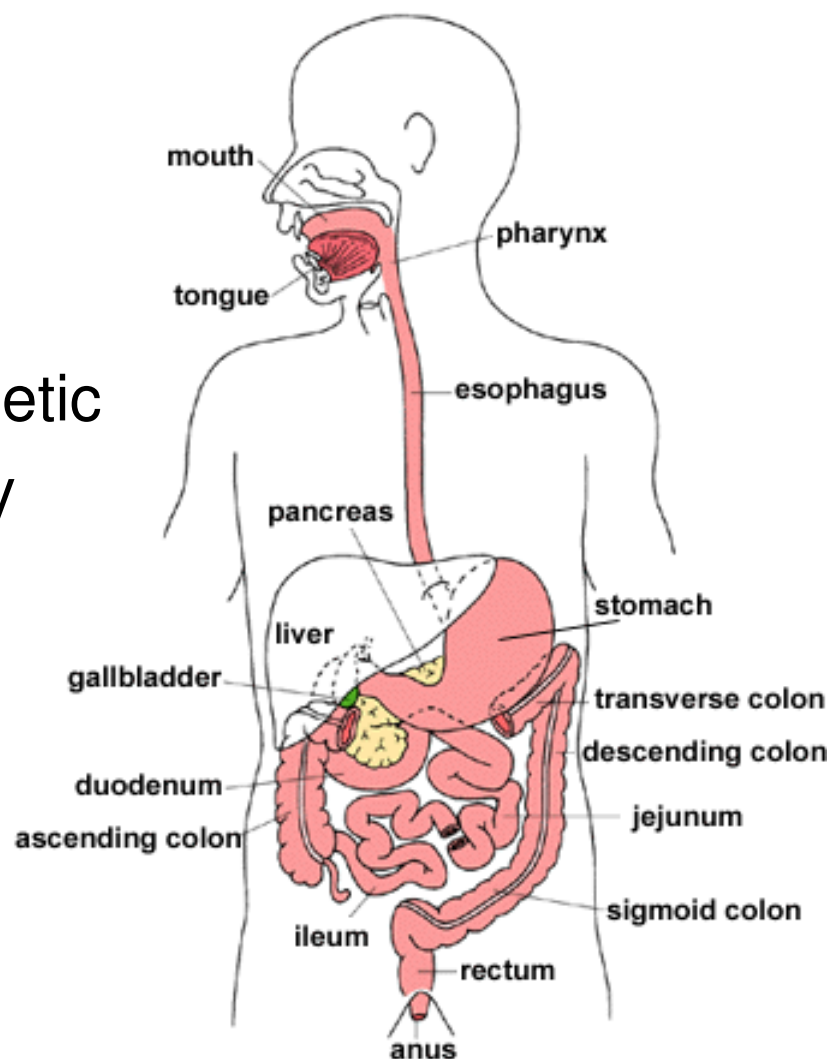
Distribution

Metabolism

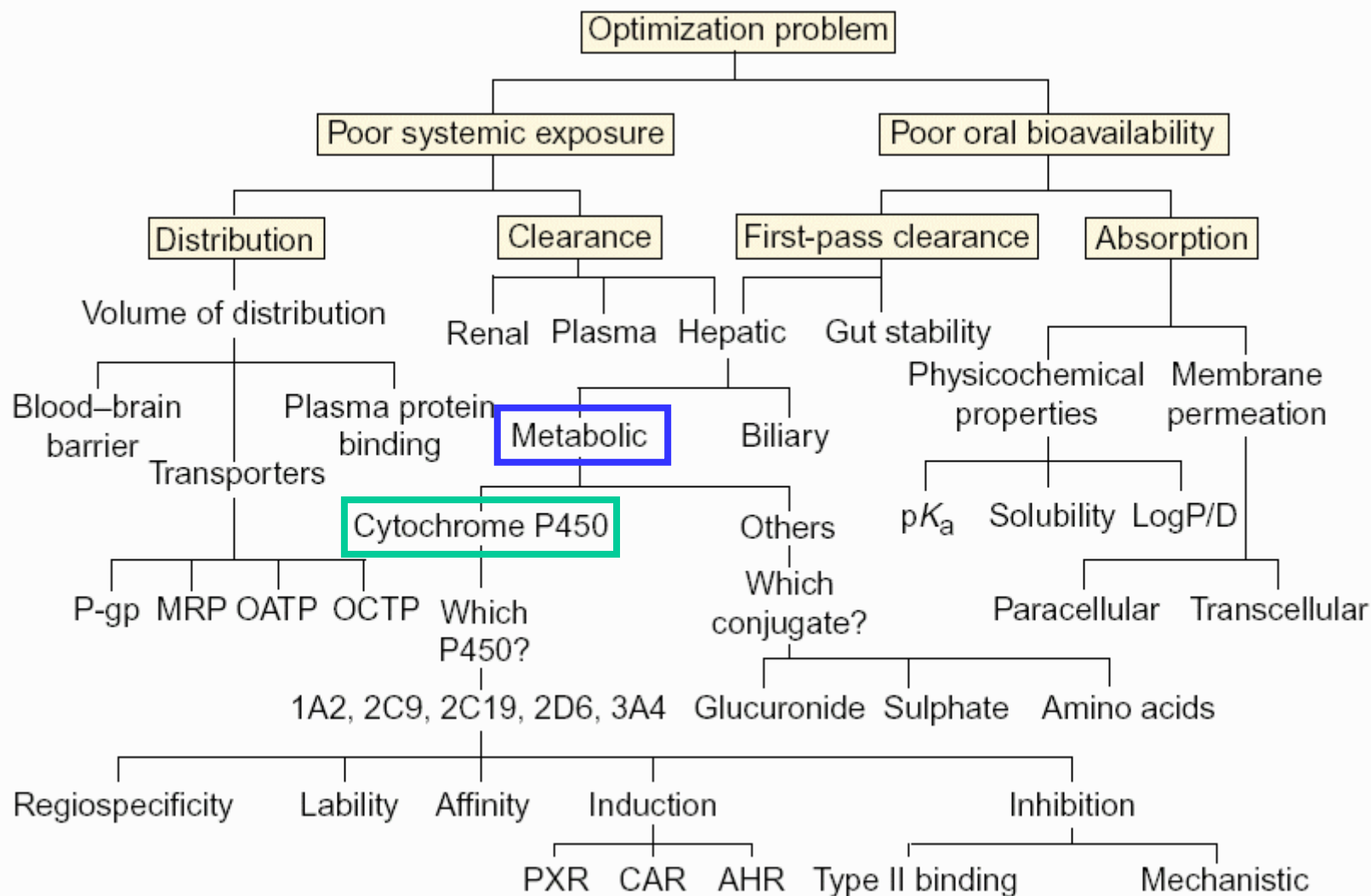
Elimination

Toxicology

Pharmacokinetic  
Bioavailability



# Scope of ADME-Tox models





# ADMET models

„ ... the modification of organic compounds by the microsomal enzymes can be understood in terms of physico-chemical constants in a quantitative fashion.“

C. Hansch (1972)

Lit: H. van de Waterbeemd, E. Gifford „ADMET *in silico* Modelling: Towards Prediction Paradise ?“  
*Nature Reviews Drug Discovery* **2** (2003) 192-204

# Metabolism (I)

(bio-)chemical reactions of xenobiotics in the body

*First pass effect:*

Extensive metabolization of mainly lipophilic molecules, such with  $MW > 500$ , or those that have a specific affinity to certain transporters, during the first passage through the liver

Phase I:

Oxidation, reduction and hydrolysis  
esp. cytochrome P450 enzymes

Phase II:

Conjugation with small molecules (e.g. glutamine)

Phase III:

elimination by transporters

# Enzymes contributing to metabolism

## Phase I:

oxidation, reduction and hydrolysis

cytochrome P450 enzymes (see lecture 10)

dihydropyrimidin-, alcohol-, and aldehyde dehydrogenases

epoxide hydrolases, esterases and aminases

flavine monooxygenases

## Phase II:

conjugation with small molecules (e.g. amino acids)

N-acetyltransferase, glutathione S-transferase

uridinediphosphate-glucuronosyltransferases

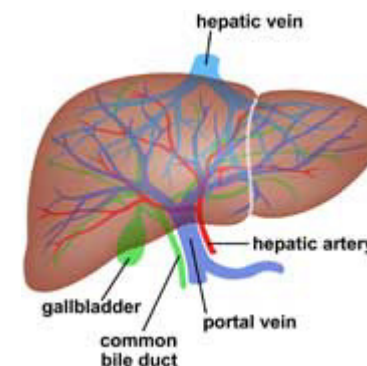
sulfotransferases, methyltransferases

## Phase III:

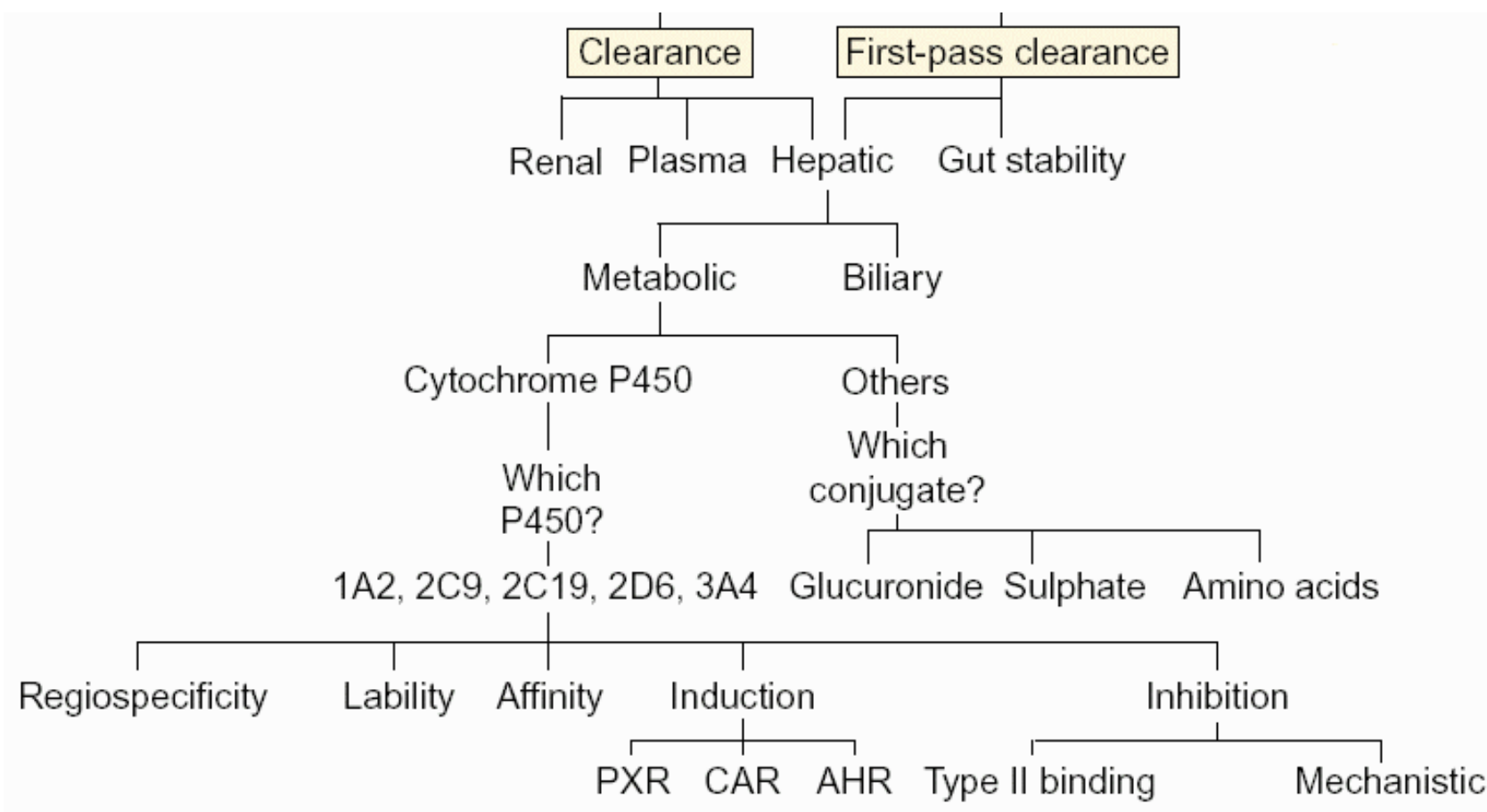
elimination by transporters

P-glycoprotein (MDR1)

All of these enzymes are subject to individual and sometimes large variations.



# Metabolisms (II)



experimental (*in vitro*) methods:

human liver microsomes, hepatocytes and recombinant P450 enzymes (expressed in *E. coli*)

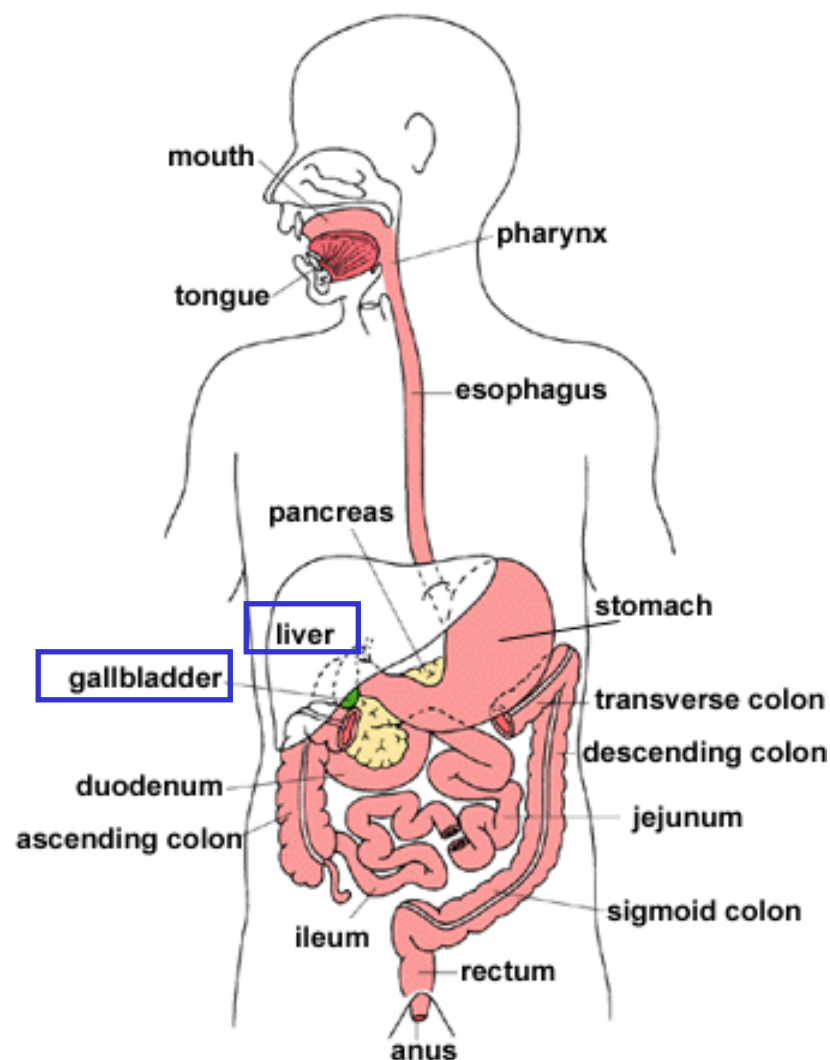
# Elimination / Excretion

Elimination comprises all processes that lead to removing of a substance from a compartment. These can also be **metabolic**.

Lipophilic substances can be excreted using bile [Gallensaft], hydrophilic compounds via urine.

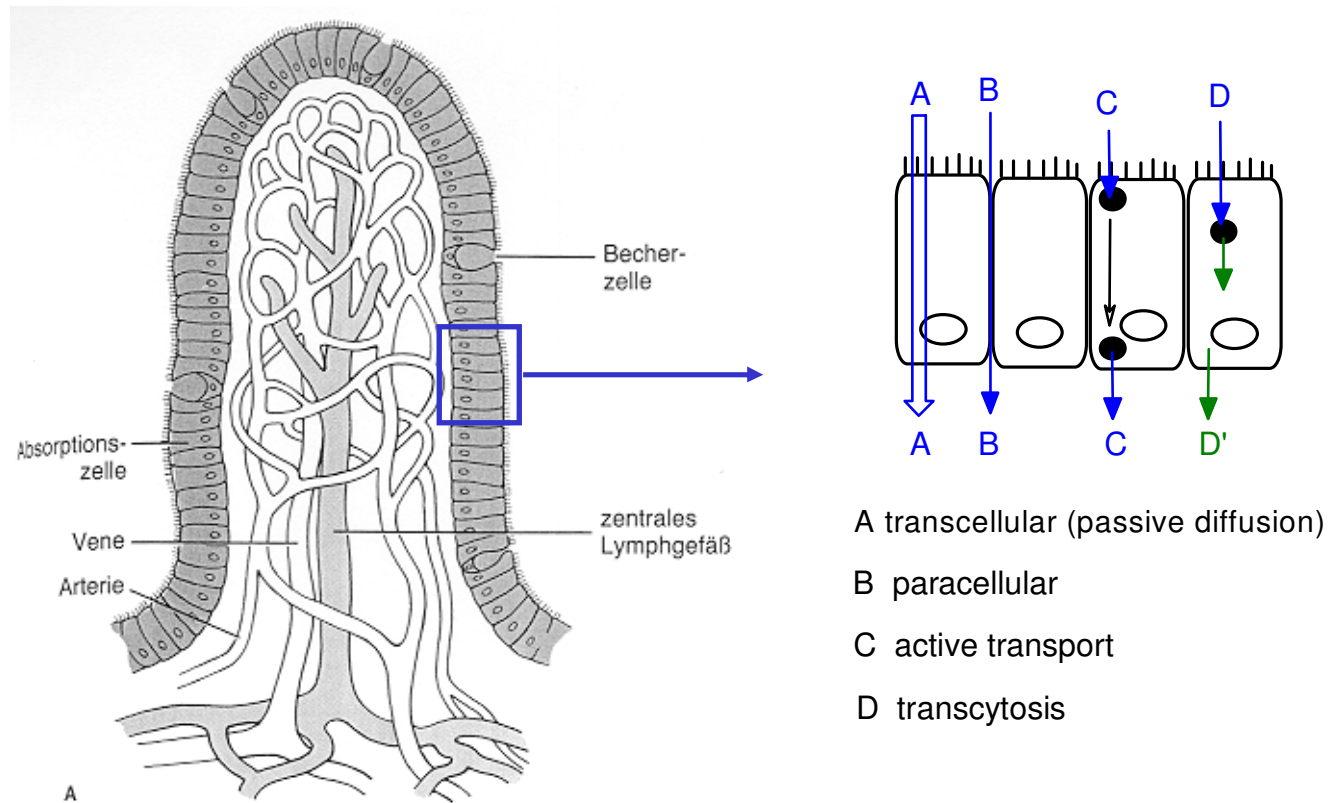
In general:

MW <300	300-500	>500
bile	bile & urine	urine



# Metabolismus during absorbtion (I)

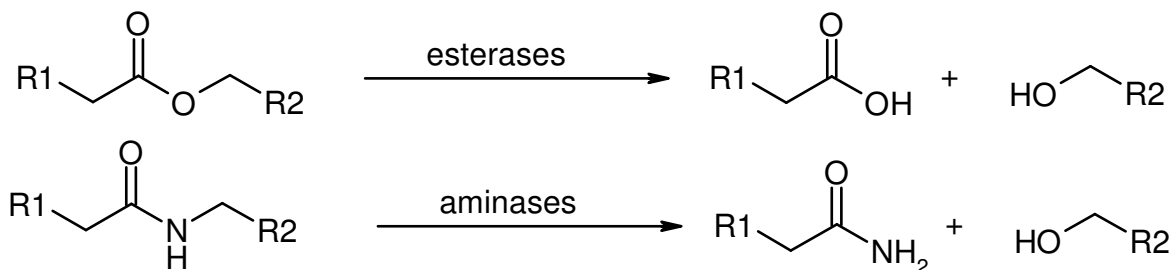
Transcytosis (see D)



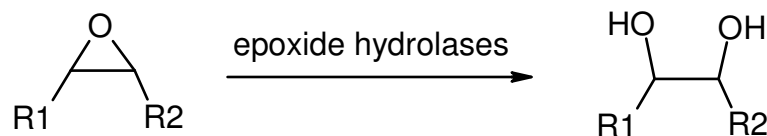
Cross-section from the  
colon wall

# Phase I processes (I)

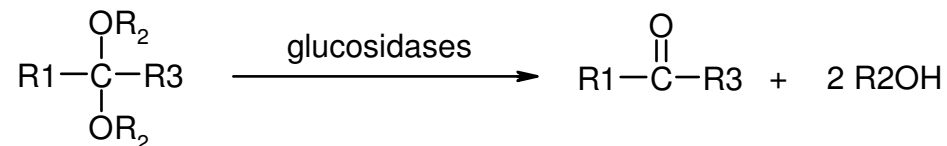
**hydrolysis** (formal addition of H<sub>2</sub>O) of esters and amides by esterases and aminases



epoxides by epoxide hydrolases



acetals by glycosidases



# Phase I processes (II)

**decarboxylation** (release of  $\text{CO}_2$ ) of  
carboxylate groups of amino acids, etc.

**reduction** (formal addition of  $\text{H}_2$ ) of  
carbonyl compounds by alcohol dehydrogenases or  
aldo-keto reductases  
azo compounds (via hydrazo compounds to amines) by  
NADPH-cytochrome c reductase and other enzymes  
nitro compounds

**reductive dehalogenation** (replacing halogens by hydrogen) of  
aliphatic compounds

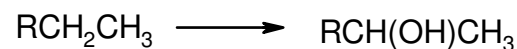


# Phase I processes (III)

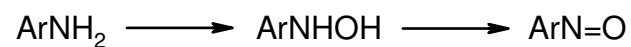
**Oxidative reactions of**  
alcohols and aldehydes to carboxylates



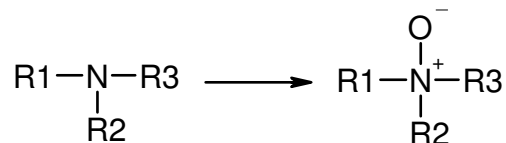
aliphatic chains



aromatic amines



tertiary amines



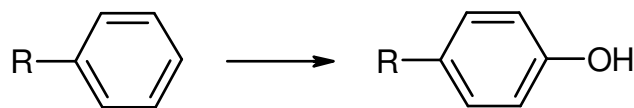
sulfides



alkenes to epoxides

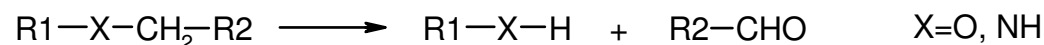


phenyl groups to phenol (in para position)



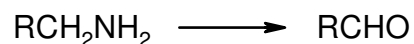
# Phase I processes (IV)

## Oxidative O- and N-dealkylation

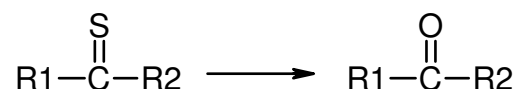


## Oxidative deamination

by the monoamine dehydrogenase (MAO)



## Oxidative desulfuration



Further oxidases are

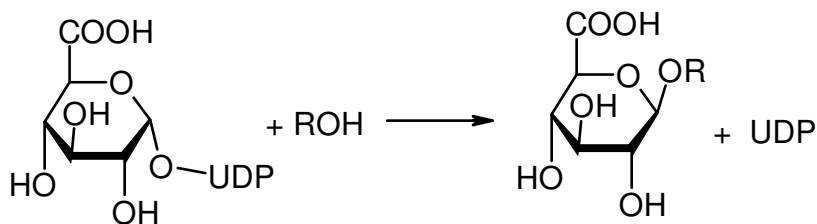
flavine monooxygenase isoenzyme

aldehyde oxidase

superfamily of cytochrome P450 enzymes

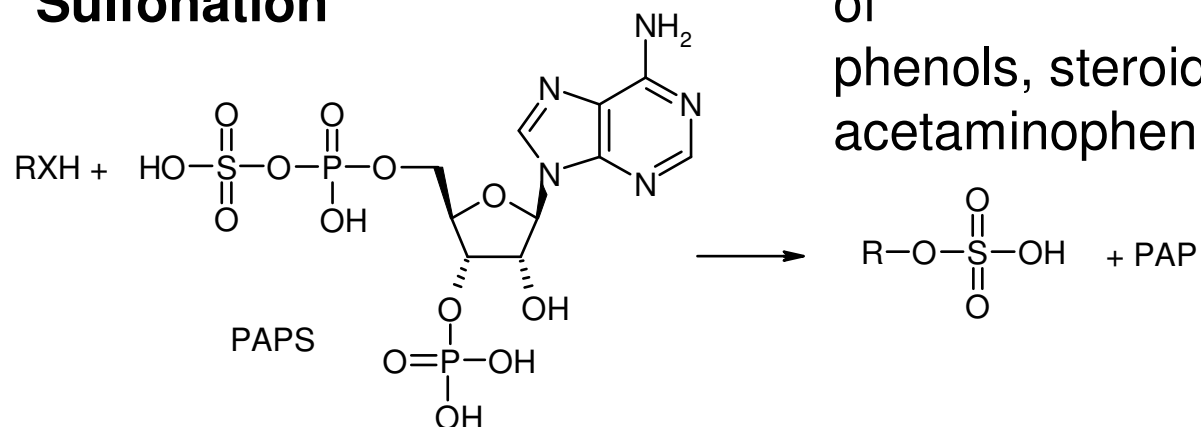
# Phase II processes (I)

## Glucuronidation



e.g. of  
acetaminophen, morphium,  
diazepam, trichlorethanol  
phenol groups in general

## Sulfonation

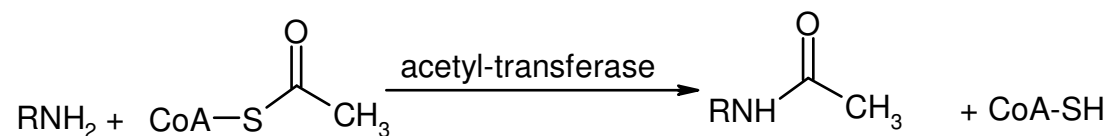


of  
phenols, steroids,  
acetaminophen, methyldopa

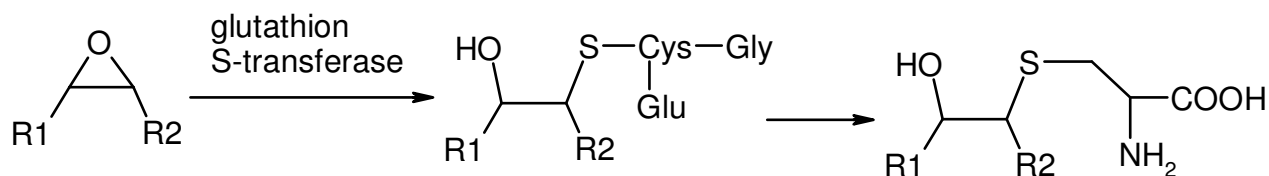
# Phase II processes (II)

## acetylation

e.g. of  
sulfonamides, isoniazid,  
dapson, clonazepam



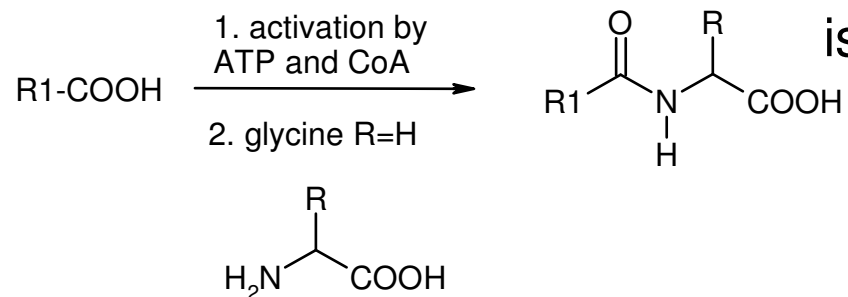
## formation of mercapto acids



# Phase II processes (III)

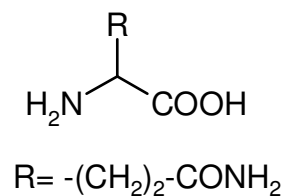
## conjugation with glycine

e.g. of  
benzoic acid,  
isonicotinic acid



## conjugation with glutamine

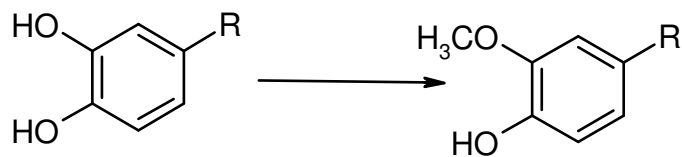
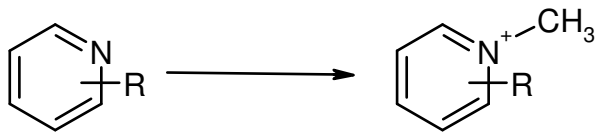
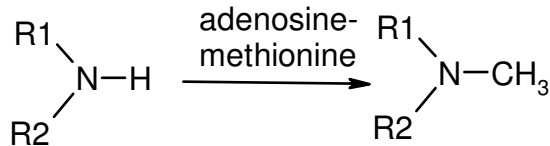
e.g. of  
indolyl acetic acid,  
phenyl acetic acid



# Phase II processes (IV)

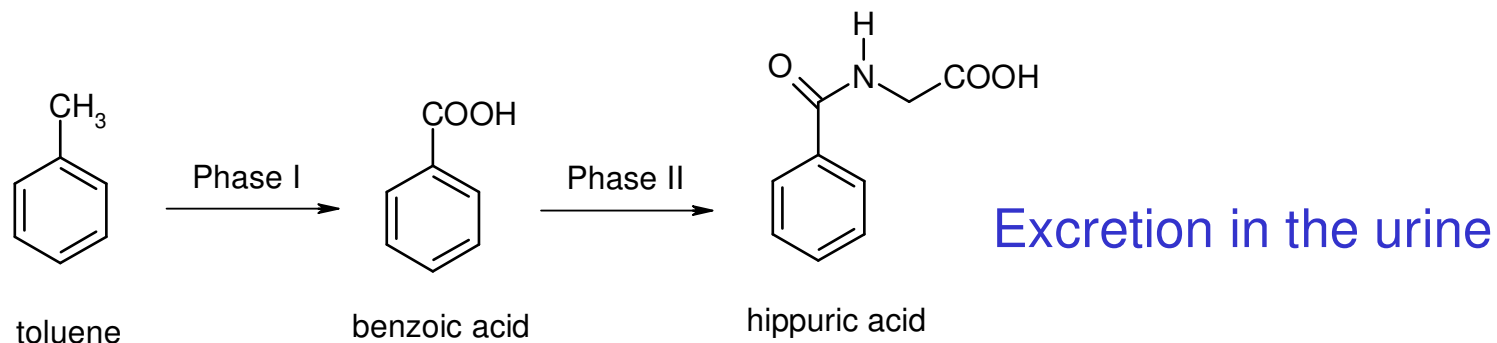
## O-, N-, and S-methylation

e.g. of  
methadon, nicotinamide,  
norepinephrine

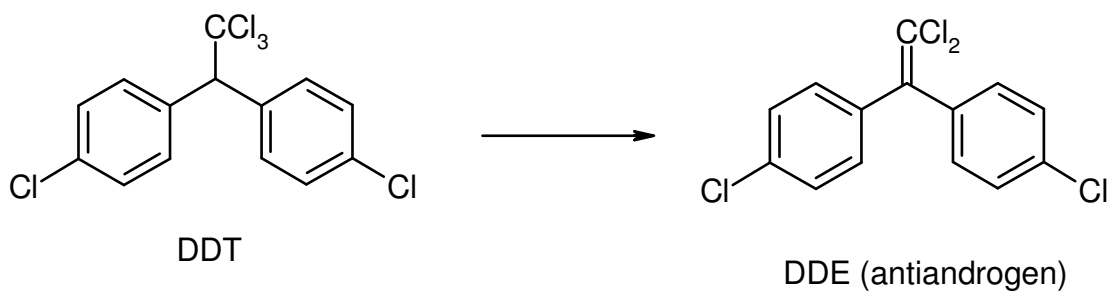
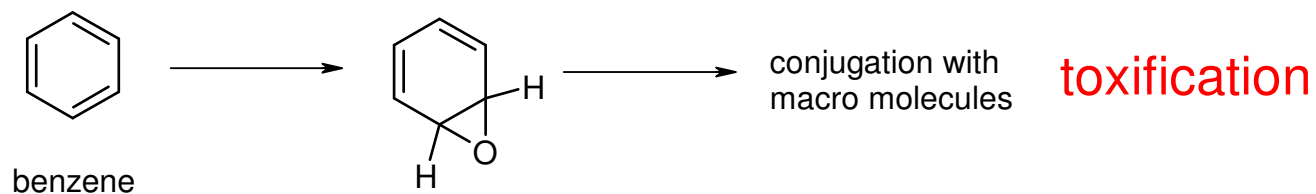


catechloamine (by  
catechlol-O-methyl transferase)

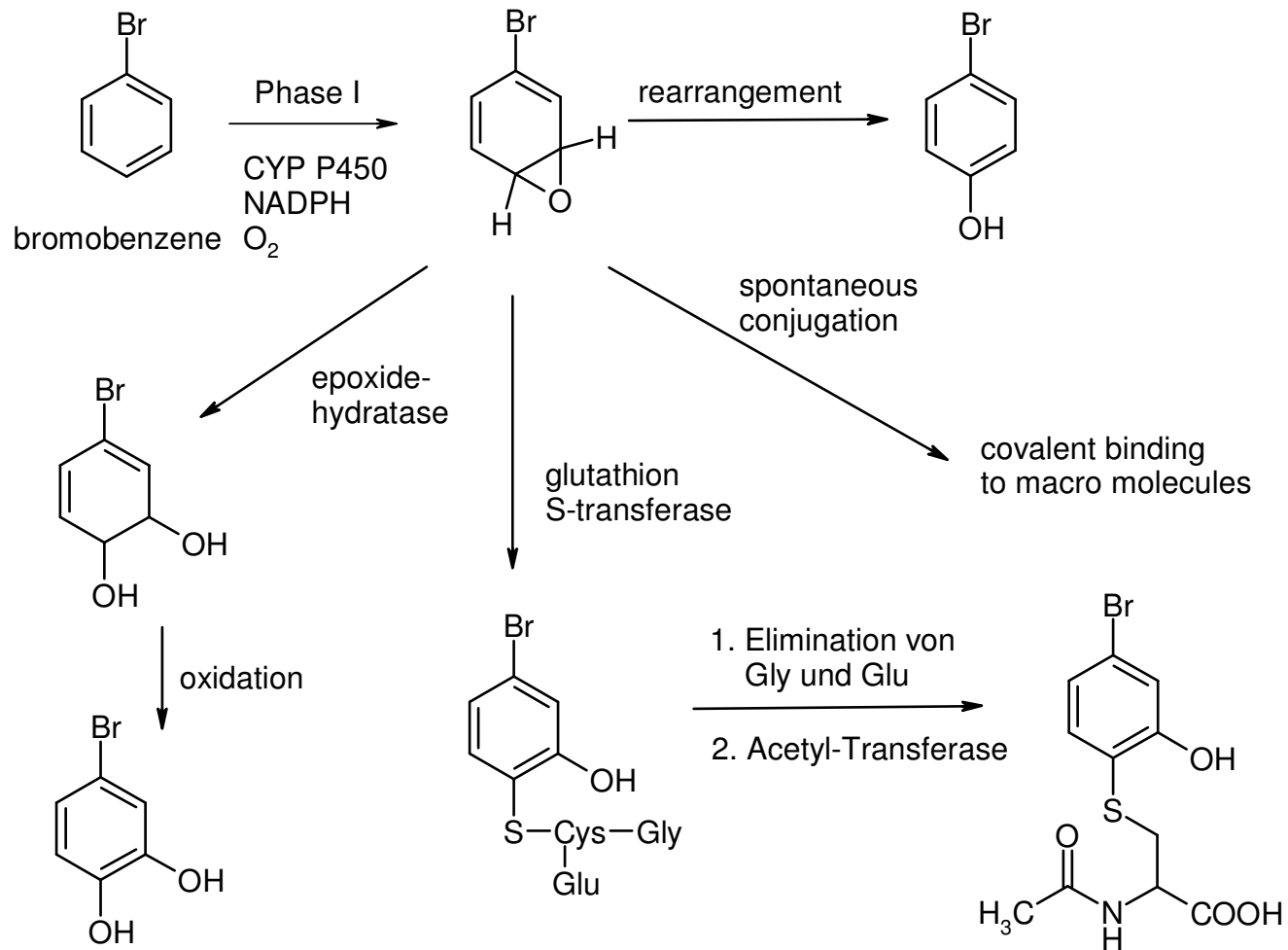
# Metabolization of Xenobiotica (I)



Excretion in the urine



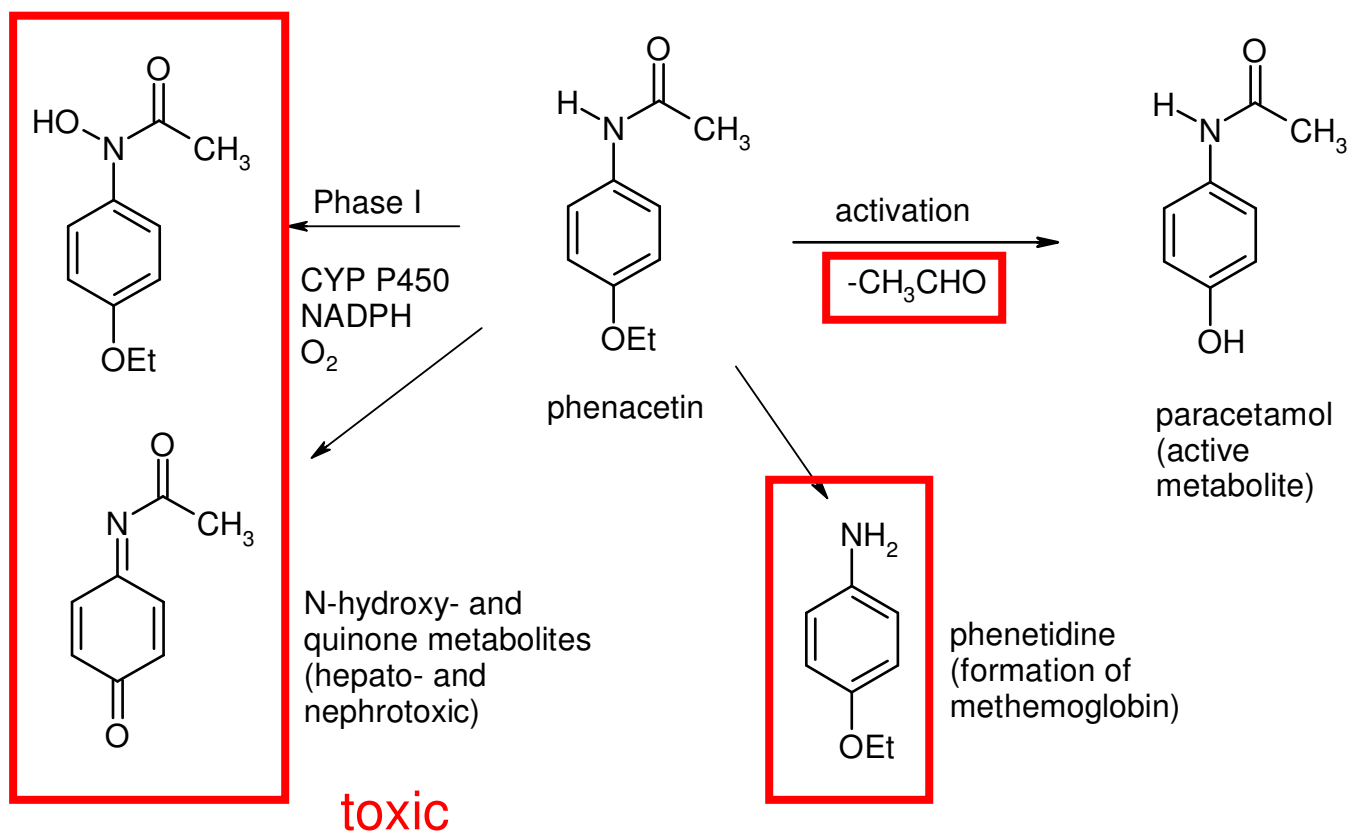
# Metabolization of Xenobiotica (II)





# Metabolization of Xenobiotica (III)

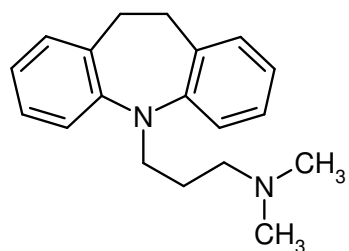
Example for particularly awkward metabolites



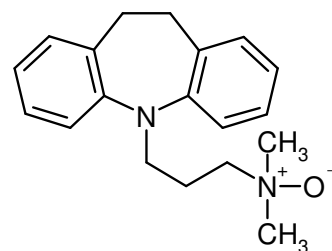
Therefore phenacetin is discontinued

# Metabolization of Xenobiotica (IV)

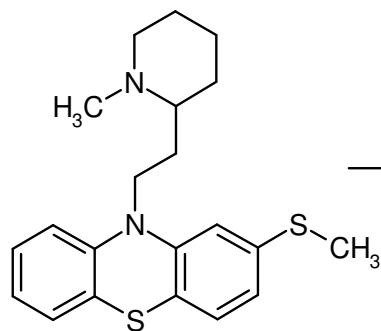
Examples where metabolites of drugs are also pharmacologically active



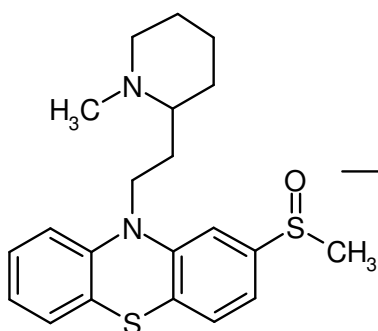
Imipramine



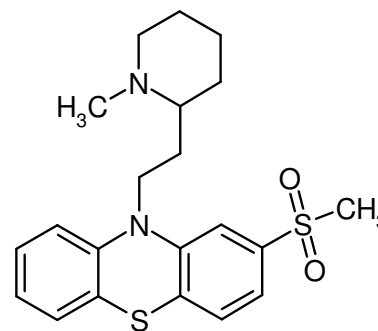
Imipramine N-Oxide



Thioridazine



Mesoridazine

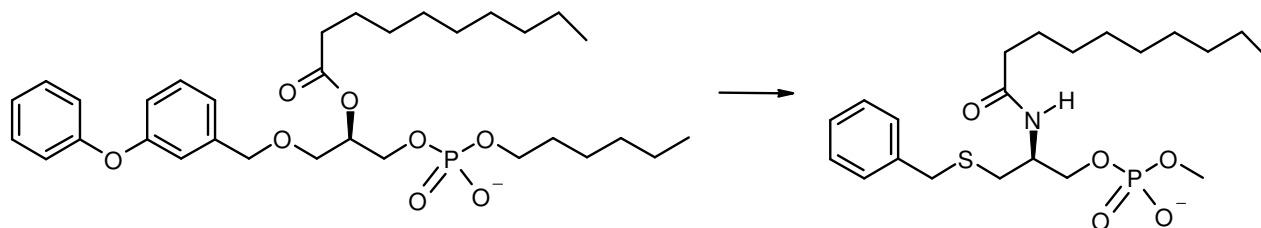


Sulfuridazine

# Improved metabolic stability

Increasing the bioavailability through:

Replacing esters by amides



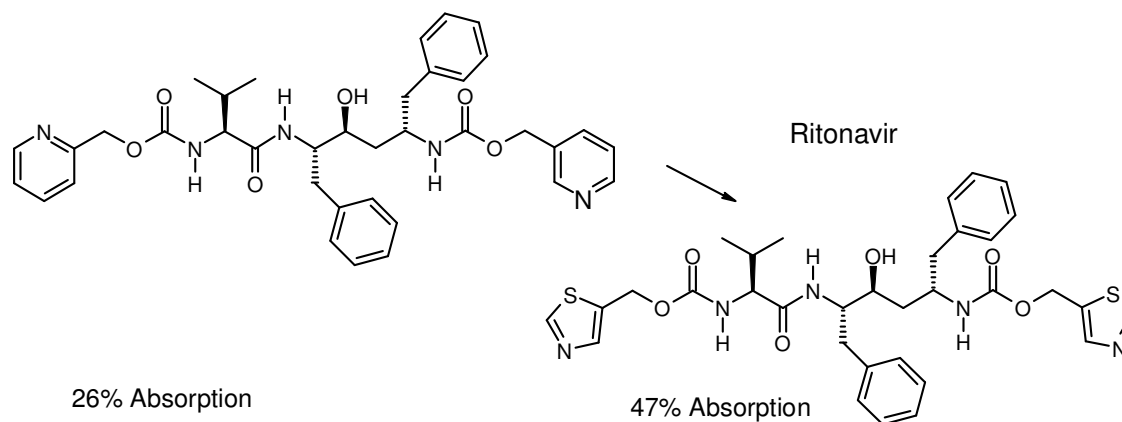
$C_{\max} = 465 \text{ ng ml}^{-1}$

4% Absorption

$C_{\max} = 3261 \text{ ng ml}^{-1}$

90% Absorption

Avoiding *N*-oxidation



26% Absorption

47% Absorption

Lit: A.-E.Nassar et al. *Drug Discov. Today* **9** (2004) 1020

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# Toxicological endpoints

effects on the body: Modifications

- of the metabolism (e.g. hormones)

- of the organs

- of the behaviour

Common toxicity, acute poisoning,  
irritation of skin and eyes

cytotoxic

cardial toxicity (*h*ERG channel)

hepatotoxic (PXR, CAR)

nephrotoxic

immunotoxicity (sensibilization, allergens)

neurotoxic (neural receptor binding)

drug-drug interactions (cytochrome P450 induction)

genotoxic

cancerogen / mutagen

teratogen

## ADMET models (II)

The vast amount of possible reactions make prediction of metabolic and toxic properties difficult.

Characteristic reactions of specific compounds are summarized in data bases

Commercial expert systems (selection)

DEREK, METEOR	<a href="http://www.chem.leeds.ac.uk/luk/">http://www.chem.leeds.ac.uk/luk/</a>
HazardExpert	CompuDrug Ltd.
TOPKAT	Accelrys
M-CASE	Multicase
ToxPredict	Idea Consult
GastroPlus	Simulations Plus, Inc.

# ADMET models (III)

## metabolic aspects

## descriptors

biotransformation

chemical structure of some metabolites to derive a *decision tree*

physico-chemical properties

binding to enzymes

esp. to human serum albumin (HSA),  
cytochrome P450 enzymes  
(see lecture 10)

catalytic reactions

reaction mechanism  
turn over rate

drug-drug interaction

inhibition or induction

# ADMET models (IV)

## Reappearing descriptors in QSAR equations

$$\log(T) = a(H) + b(E) + c(S) + \text{constant}$$

- T: (specific) toxicity
- H: hydrophobicity  $\rightarrow \log P$
- E: electronic terms
- S: steric terms

C. Hansch et al. *J.Am.Chem.Soc.* **86** (1964) 1616

Over time nothing has changed on this elementary equation!

Dominance of a single term indicates a mode of action like in other QSAR equations

# ADMET models (V)

Experimental assays:

aquatic toxicity:	uni-cellular organisms: <i>Tetrahymena pyriformis</i> : growth inhibition <i>Vibrio fischeri</i> : bioluminescence
mutagenicity (AMES):	<i>Salmonella typhimurium</i> + S9 (liver enzymes)
Skin irritation:	guinea pig [Meerschweinchen]
Eye irritation:	rabbit eye
<i>in vivo</i> ADMET:	zebra fish

Review of QSAR-methods regarding toxicology:

T.W. Schultz et al. *J.Mol.Struct.(THEOCHEM)* **622** (2003) 1

T.W. Schultz et al. *idem* **622** (2003) 23



# Toxicity models

Publicly funded prediction server:

[www.opentox.org](http://www.opentox.org) hosts models for:

- Oral toxicity
- Mutagenicity
- Cytochrome P450 metabolism

[www.cosmostox.org](http://www.cosmostox.org) for long-term toxicity of cosmetic ingredients

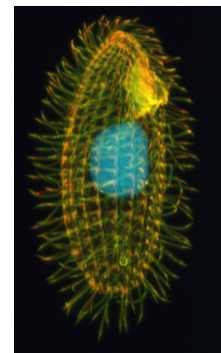
Currently all available machine learning algorithms including QSAR, decision trees, random forest, Naive Bayes, support vector machines, neural networks, etc. are applied.

Lit. X.Li et al. *J.Chem.Inf.Model.* **54** (2014) 1061-1069.

# Environmental Toxicity

Experimental assays/endpoints routinely applied (e.g. for EPA and REACH legislation in the EU):

- 96-hour fathead minnow (*Pimephales promelas*) 50 percent lethal concentration (LC50)
- 48-hour *daphnia magna* LC50 concentration
- *Tetrahymena pyriformis* 50 percent growth inhibition concentration (ICG50)
- Oral rat 50 percent lethal dose (LD50)
- Bioaccumulation factor



Source of pictures: wikipedia

# Drug Safety

Drug-Drug interactions:

Co-administration with other medications

Drug Interaction Database

<http://depts.washington.edu/ventures/pfolio/didb.htm>

Ecotoxicology:

How do the excreted drugs and their metabolites react in the environment ?

→ biodegradability of drugs, e.g. antibiotics