DOSE-DEPENDENT PHARMACOKINETICS OF CYCLOSPORIN A IN RATS: EVENTS IN TISSUES

CHIAKI TANAKA, RYOSEI KAWAI, AND MALCOLM ROWLAND

Drug Metabolism and Pharmacokinetics, Novartis Pharmaceuticals Corporation, East Hanover, New Jersey (C.T.); Novartis Pharma AG, Basel, Switzerland (R.K.); School of Pharmacy and Pharmaceutical Sciences, University of Manchester, Manchester, United Kingdom (M.R.)

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ABSTRACT:

Cyclosporin A (CyA), an immunosuppressive polypeptide, is commonly used for the prevention of allograft rejection. Systemic disposition of CyA has been widely investigated in both animals and humans (Follath et al., 1983; Gupta et al., 1987; Wagner et al., 1987; Kawai et al., 1998). In general, blood concentrations of CyA in rats and humans show a pronounced multiexponential decay after single i.v. doses, which suggests extensive but time-dependent distribution of CyA between blood and tissues. Some peripheral organs, such as adipose, into which CyA partitions extensively (Follath et al., 1983; Gupta et al., 1987; Wagner et al., 1987; Kawai et al., 1998). In general, blood binding saturation (dissociation constant \( K_D = 0.18 \mu g/ml \)) occurred at a lower dose (concentration) than saturation of tissue binding (\( K_D, 0.005-0.77 \mu g/g \)), such that the volume of distribution at steady state first increased as the dose increased from 1.2 to 6 mg/kg, and then decreased as the dose increased to 30 mg/kg. Tissue binding was further investigated by various graphical analyses. Some organs showed a monophasic (single site) Scatchard plot of the tissue data at steady state, with high \( K_D \) values. In other organs, biphasic binding characteristics were observed with the \( K_D \) values of the high-affinity site in the same range as the \( K_D \) reported for the binding of CyA with cyclophilin, the putative target. Saturable tissue binding may therefore influence not only the pharmacokinetics but also the efficacy of CyA.

Cyclosporin A (CyA), an immunosuppressive polypeptide, is commonly used for the prevention of allograft rejection. Systemic disposition of CyA has been widely investigated in both animals and humans (Follath et al., 1983; Gupta et al., 1987; Wagner et al., 1987; Kawai et al., 1998). In general, blood concentrations of CyA in rats and humans show a pronounced multiexponential decay after single i.v. doses, which suggests extensive but time-dependent distribution of CyA between blood and tissues. Some peripheral organs, such as adipose, into which CyA partitions extensively (Follath et al., 1983; Bernareggi and Rowland, 1991), are primarily responsible for the relatively large whole body volume of distribution of CyA (~3–5 l/kg). CyA also binds with high affinity to a class of intracellular proteins, collectively called cyclophilin (CyPh), that exist in lymphocytes residing in essentially all organs throughout the body. This CyA-CyPh complex blocks the phosphatase activity of the enzyme calcineurin, thereby preventing cytokine induction (Schreiber and Crabtree, 1992), which is the most probable mode of CyA action for preventing grafted organ rejection. The extent of CyA binding to CyPh is therefore considered to be relevant to its efficacy. Various CyPh classes have been reported (Schneider et al., 1994), and dissociation constants of CyA with these CyPhs (\( K_D, 0.012–0.036 \mu g/g \)) are within the therapeutic range of unbound CyA concentrations. Indeed, Bernareggi and Rowland (1991) suggested that saturation of tissue distribution occurs in some organs in a 6-day continuous s.c. infusion study in rat. More recently, Kawai et al. (1998) developed a physiologically based pharmacokinetic (PBPK) model for CyA in which they attempted to describe a time-dependent shift in tissue-to-blood drug partition in rat, assuming saturable tissue binding. In their PBPK model analysis, the estimated dissociation constant varied over a wide range (\( K_D, 0.0002–0.06 \mu g/g \)); however, the range overlapped with those reported for CyA-CyPh binding in vitro, as described above. An obvious limitation in their interpretation was that only one CyA dose (6 mg/kg, a therapeutic dose) was studied.

In this study, blood and tissue kinetics of CyA have been extensively investigated after single, short i.v. infusions covering a wide dose range, including a subtherapeutic (1.2 mg/kg), therapeutic (6 mg/kg), and supertherapeutic (30 mg/kg) dose in rats. The data were then analyzed by various graphical methods with the object of estimating specific tissue distribution parameters, as well as thoroughly assessing the multiple kinetic factors contributing to the complex and nonlinear CyA disposition.

Materials and Methods

Chemicals. CyA was supplied by Novartis Pharma AG (Basel, Switzerland). The vehicle for infusion was ethyl alcohol/polyethoxylated castor oil...
As seen from this equation, \( f_{un} \), which is the unbound fraction in blood and relates \( C_B \) to \( C_u \), becomes concentration-dependent when blood cell binding is saturated, i.e., when the ratio \( C_P/C_B \) varies over the in vivo concentration range, despite the linear plasma protein binding. Such nonlinear blood cell distribution of CyA was studied formerly (Kawai and Lemaire, 1993) and is characterized by the relationship

\[
C_B = (Cu/f_{un}) \cdot (1 - Hct) + Cu \cdot (1 + nP_2/(K_0 + Cu)) \cdot Hct \tag{2}
\]

where \( K_0 \) and \( nP_2 \) are the dissociation constant and binding capacity, respectively, of the saturable blood cell binding, and Hct is the hematocrit (given as a fractional value). In this study, only whole blood CyA concentrations and the value of Hct were measured. The values of \( Cu \) were calculated from the corresponding quadratic solution, eq. 3, using the parameter values \( f_{un} (0.062) \), \( K_0 \) (0.185 \( \mu \)g/ml), and \( nP_2 \) (4.64 \( \mu \)g/ml), determined previously in vitro (Kawai and Lemaire, 1993).

\[
Cu = 0.5 \cdot \left[ C_B - \left( 1 - (1 - Hct) \cdot f_{un} + Hct \cdot K_0 - Hct \cdot nP_2 + \left| C_B - \left( 1 - Hct \right) \cdot f_{un} + Hct \right| \right) \right]^{1/2} \tag{3}
\]

and where appropriate, \( f_{un} \) was calculated from the ratio \( Cu/C_B \),

**Blood kinetic analysis.** A triexponential equation was fitted to the concentration-time data for both \( C_B \) and \( Cu \)

\[
C_B \text{(or } Cu \text{)} = C_1 \cdot e^{-\lambda_1 t} + C_2 \cdot e^{-\lambda_2 t} + C_3 \cdot e^{-\lambda_3 t} \tag{4}
\]

where \( t \) denotes time after the end of the 2-min i.v. dose. The parameters \( C_1, C_2, \) and \( C_3 \) denote constant coefficients, and \( \lambda_1, \lambda_2, \) and \( \lambda_3 \) denote the exponential coefficients.

The terminal elimination half-life (\( t_{1/2} \)) was calculated from the smallest exponential coefficient, \( \lambda_1 \), as 0.693/\( \lambda_1 \). The area under the blood concentration-time curve from the time of dosing until infinite time (AUC\(_{0\rightarrow\infty} \)) was calculated by the linear trapezoidal rule with extrapolation beyond the last measurable concentration, according to

\[
\text{AUC}_{0\rightarrow\infty} = \text{AUC}_{0\rightarrow t} + C_{\text{inf}}/\lambda_1 \tag{5}
\]

where \( \text{AUC}_{0\rightarrow t} \) is the area under the blood concentration-time curve from the time of dosing until the last measurable blood concentration (\( C_{\text{inf}} \)). Systemic clearance (CL) and the volume of distribution at steady state (\( V_{su} \)) were calculated according to

\[
\text{CL} = \text{Dose}/\text{AUC}_{0\rightarrow\infty} \tag{6}
\]

and

\[
\text{AUMC}_{0\rightarrow\infty} = \text{AUMC}_{0\rightarrow t} + t_{\text{last}} \cdot C_{\text{inf}}/\lambda_1^3 \tag{7}
\]

where \( t_{\text{last}} \) is the time corresponding to \( C_{\text{last}} \).

**Tissue distribution kinetic analysis.** The measured tissue concentrations were analyzed without correction for the drug in residual blood because either the tissue-to-blood concentration ratio of CyA was high, the vascular space relative to tissue volume was low, or a combination of both conditions existed, such that there was no more than 4%, and often less, of the drug in the tissue blood of all the organs studied. Tissue-to-unbound drug concentration ratios at each tissue sampling time (\( Kpu_{\text{app}} \)) were determined by dividing the tissue concentrations (\( C_T \)) by the corresponding \( Cu \). More universal tissue distribution parameters, i.e., tissue-to-blood partition coefficients (\( Kp \)) and tissue-to-unbound-drug concentration partition coefficients (\( Kpu \)), were calculated by an AUC method (Gallo et al., 1987) using finite AUC values (\( \text{AUC}_{0\rightarrow24h} \)) for \( Cu \) and \( C_B \), respectively, versus those for individual tissue concentrations. A graphical analysis (Patlak and Blasberg, 1983) was also applied by plotting \( Kpu_{\text{app}} \) versus normalized time for \( Cu \), the normalized time was calculated using

\[
\text{Normalized time (h)} = [\text{AUC}_{\text{normalized}}]/[Cu] \tag{9}
\]

that is, the ratio of AUC (calculated by a linear trapezoidal method) to the concentration at time \( t \) for unbound drug. \( Kpu_{\text{app}} \) itself varies with time, due

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**TABLE 1**

**Blood sampling schedule**

<table>
<thead>
<tr>
<th>Time Group</th>
<th>Sampling Time</th>
<th>Sampling Site</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 min</td>
<td>-1, 0, 1, 2 min*</td>
<td>Arterial catheter</td>
</tr>
<tr>
<td>30 min</td>
<td>5, 10, 20, 30 min*</td>
<td>Arterial catheter</td>
</tr>
<tr>
<td>2 h</td>
<td>0, 5, 1, 2, 3 h*</td>
<td>Jugular vein</td>
</tr>
<tr>
<td>8 h</td>
<td>2, 4, 6, 8 h*</td>
<td>Jugular vein</td>
</tr>
<tr>
<td>24 h</td>
<td>8, 12, 18, 24 h*</td>
<td>Jugular vein</td>
</tr>
</tbody>
</table>

* Terminal sampling from aortal bleeding except for 2-min group (arterial catheter).
value at 30 mg/kg, which may lead to the conclusion that CyA pharmacokinetics is linear over this dose range. However, when based on unbound drug, there was a clear dose-dependence, with the 30-mg/kg dose yielding a dose-normalized AUC (0.68 μg·h/ml) approximately twice that for the lower two doses (0.37 and 0.36 μg·h/ml), which were very similar. Not unexpectedly, the same dose-response findings applied to clearances of total and unbound drug in blood, as these values are merely reciprocals of the corresponding dose-normalized AUCs. These results suggested that the systemic blood clearance of CyA was constant within the dose range 1.2 to 6 mg/kg (142–165 ml/h/kg) and slightly lower at 30 mg/kg (114 ml/h/kg), presumably due to saturation of the metabolic enzymes (CL for unbound drug was 2.7, 2.8, and 1.5 l/h/kg at 1.2, 6, and 30 mg/kg, respectively), and that saturable blood cell binding had partly masked this fact when analysis was based on total blood concentration-time data.

In contrast, \( V_{ss} \) seemed to peak at the middle dose, regardless of any correction for unbound drug in blood (2.0 l/kg for total and 30 l/kg for unbound drug). The terminal \( t_{1/2} \), a hybrid parameter of clearance and distribution volume, increased moderately with increase in dose, with or without the correction for unbound fraction in blood (from 7.4 to 12 h for total and from 6.5 to 10 h for unbound). Dose- or concentration-nonlinear tissue distribution was also likely. However, this was not readily observed when assessment was based on blood pharmacokinetic data alone.

Tissue concentrations of CyA in various organs are shown in Fig. 3. CyA tissue concentration-versus-time profiles varied considerably among the organs and were not always similar in shape to the blood concentration-time profiles (see Fig. 1). Overall tissue profiles seemed to roughly parallel each other for the three doses, with a slight tendency toward a slower decay at the higher doses. Brain displayed a distinctive dose-response, i.e., the highest dose showed a concave downward profile, the middle dose was concave upward, whereas all of the measurements following the lowest dose were under the limit of quantification except for that at 2 min. The last value corresponded to the concentration calculated from drug in the capillary blood and vascular volume in brain, suggesting no substantial tissue distribution.

\( K_{pu,app} \) values were calculated as the ratio of measured tissue concentrations versus calculated \( Cu \) (see Materials and Methods). The values of \( K_{pu,app} \) were plotted against the normalized time (Patlak plot, see Materials and Methods). The results of six major organs are shown in Fig. 4. For most organs, \( K_{pu,app} \) increased rapidly with normalized time and approached a certain level within the study period, at least for the lowest dose, indicating that equilibrium of drug between blood and tissues was achieved in these organs. For skin, in contrast, \( K_{pu,app} \) increased progressively until the last sampling point, suggesting that equilibrium had not been achieved within the study period (24 h); fat, muscle, and thymus showed profiles similar to that of skin.

Regardless of whether equilibrium was achieved by the end of the sampling period, \( K_p \) and \( K_{pu} \) values (Table 2) were also calculated by an AUC method (Gallo et al., 1987). These latter time-averaged distribution parameters decreased with increasing dose for all tissues except for the brain. \( V_{ss} \) values were calculated from these parameters, i.e., the sum of \( K_p \) or \( K_{pu} \) multiplied by the actual mass of the corresponding organ. Comparison of these volumes of distribution (calculated from actual tissue distribution data) clearly demonstrated that an increase of dose reduces overall tissue distribution of CyA within the dose range studied. This effect occurred to a lesser extent when based on whole blood data (\( K_p \)) than when based on unbound concentration data (\( K_{pu} \), due to the saturable blood cell binding. From these data analyses, it was concluded that the distribution
volume of unbound CyA decreased on increasing dose, presumably
due to greater saturation of tissue binding. Saturation in blood cell
binding occurred over the same concentration range and counteracted
the saturation in tissue binding when the volume of distribution was
assessed on the basis of whole blood data.

Additional graphical analyses were performed to characterize this
saturable tissue binding. As shown in Fig. 5, $K_{p,u,app}$ values in
various organs were plotted against the respective tissue concentrations,
assuming steady-state conditions. Data from all doses were
pooled. However, only those values associated with steady-state conditions, based on the Patlak plot (Fig. 4), were used. For some organs (e.g., lung, heart, liver, and skin), this Scatchard-type plot portrayed a biphasic binding isotherm consisting of high- and low-affinity sites, whereas plots for other organs (e.g., kidney and bone) were either monophasic or too scattered to discriminate different phases. In either case, nonlinear tissue distribution was obvious for all organs, giving the negative slopes observed in the Scatchard plots.

The common tissue-binding parameters, assuming a two-site binding model (eq. 10), were estimated for all organs that showed attainment of steady state (Fig. 4). Typical examples of data fitting, for liver and kidney, are shown in Fig. 6, and estimated binding parameters for these and various other organs are summarized in Table 3. The estimated $K_{D,T}$ values ranged from 0.005 to 0.77 $\mu$g/g, and the specific binding potential ($B_{\text{max}}/K_{D,T}$) was larger than the linear binding coefficient ($\alpha$), indicating that saturable binding is a dominant feature of overall tissue distribution. In this parameter estimation, the value of $\alpha$ was set to 1 for kidney, spleen, bone, and gut. Scatchard plots (Fig. 5) for these organs were monophasic, and thus the organ volume was assigned to the linear term (i.e., $\alpha = 1$) for spatial distribution of the unbound drug.

Discussion

This wide-ranging (1.2–30 mg/kg) i.v. dose study in rats confirms
earlier suggestions (Bernareggi and Rowland, 1991; Kawai et al.,
1998) that individual elements involved in the pharmacokinetics of
CyA, such as tissue distribution, distribution within blood, and un-
bound clearance, are dose-nonlinear. Evidently, however, these non-
linearities interact in such a way that the systemic pharmacokinetic
parameters, such as clearance and volume of distribution, based on
whole blood measurements and assessed in the conventional way,
appear to be essentially independent of dose. That is, events assessed
in whole blood mask the underlying nonlinearities.

Detailed data interpretation, taking into account the concentration
dependence of binding within blood ($f_{u,B}$), reveals many insights.
First, unbound CyA clearance, which approximates to intrinsic clear-
ance because CyA is a low-clearance compound dominated by the
hepatic enzyme system (Vickers et al., 1992), was obviously lower at
the highest dose (Fig. 2). However, because of a corresponding
diminished blood binding (i.e., higher $f_{u,B}$), blood clearance remained
virtually unchanged with dose. Second, tissue distribution comprised
two parallel nonlinear components. The dose-dependent nature of
these components was determined by their $K_D$ values, which were
0.18 $\mu$g/ml for blood cell binding (Kawai and Lemaire, 1993) and
ranged from 0.005 to 0.77 $\mu$g/ml (Table 3) for various organs.
Although some organs (e.g., lung, liver, and heart) possessed a smaller
$K_D$ value than blood cells, for the majority of organs that contributed
the greatest to body mass, such as muscle and skin, the $K_D$ value was
much larger. Accordingly, saturation of blood cell binding occurred at
lower doses than saturation of some tissue binding sites, thereby
altering the whole body tissue distribution space of CyA in a dose-
dependent manner. These effects explain why the estimated $V_{ss}$ in-
creased as the dose increased from 1.2 to 6 mg/kg, and then subse-
quently decreased as the dose increased to 30 mg/kg (Fig. 2). However, this fails to explain why an initial increase was also ob-
served for the $f_{u,B}$-corrected volume of distribution, which may be due
to experimental limitations, such as intersubject variation.

Certainly, the alternative form of analysis to estimate the distribu-
tion volume, based on the AUC (moment) approach (Gallo et al.,
1987), showed a consistent decrease in $V_{ss}$ for blood unbound CyA
with doses increasing from 1.2 to 30 mg/kg (Table 2). The $V_{ss}$, esti-
imated from $K_p$ values for the lowest dose (1.2 mg/kg) was 2.4
l/kg, which is somewhat lower than the reported distribution volume.

![Fig. 2. Pharmacokinetic parameters for CyA disposition after 1.2- (open column), 6- (stippled column), and 30- (hatched column) mg/kg i.v. infusion to rats, which were estimated from mean blood data of total and unbound CyA concentration.](Image)
of CyA (3–5 l/kg). The immunoassay method, a highly specific assay (see Materials and Methods), is unlikely to be the explanation. The answer may be due, at least in part, to the limited duration of the study (24 h). In addition, the assumption of linear or nonlinear distribution appears to be important. For example, $K_{pu}$ values estimated by the linear AUC method for liver and kidney at the lowest dose were 218 and 142, respectively. These values are, respectively, 60 and 30% smaller than those estimated from the present nonlinear model analysis (Table 3); i.e., $\alpha + B_{max}/K_D,T$ which yielded values for $K_{pu}$ of 543 (liver) and 204 (kidney), assuming that linear conditions prevail after administration of the lowest dose.

Another focus of this work is the ways in which the specific CyA binding to tissue constituents in vivo can be linked with in vitro efficacy parameters. One of the major factors differentiating in vivo from in vitro systems is that drug distribution equilibrium is often not reached between physiologic and/or biologic compartments in vivo, whereas most in vitro (efficacy) studies are performed under steady-state conditions. In vivo tissue-to-blood CyA exchange is known to reach a pseudo steady state within the first few hours postdose for many but not all organs (Kawai et al., 1998). A graphical method (Patlak and Blasberg, 1983) was thus used to evaluate whether or when steady-state conditions prevail in vivo. This plot not only allows an estimate of the blood-to-tissue influx clearance from the initial slope but also provides a visual assessment as to what extent steady state, i.e., influx and efflux balance, is achieved. In this study, the normalized time was calculated based on $C_u$, considering unbound

![Graph](image-url)
drug in systemic circulation to be the driving force for drug uptake. As shown previously (Kawai et al., 1998), the initial rapid increase in $K_{pu,app}$ ceased within the first few time points; beyond those time points, the values either remained constant or increased gradually. Under linear conditions, the existence of a plateau denotes attainment of steady state. However, in the case of nonlinear distribution, the value of $K_{pu,app}$ may increase, even though the blood-to-tissue drug exchange is at steady state, because the drug concentrations in blood and tissues decrease at later time points. This was particularly so for the plots of the highest dose data, which generally showed a continual increase in $K_{pu,app}$ at later times. Even for those cases, however, drug distribution was assumed to be at steady state, if steady state had already been achieved at the lowest dose, because the distribution volume should then be the largest and the time taken to reach steady state should therefore be the longest (Kawai et al., 1991). Although there are obvious limitations, we considered this evaluation of steady state worthwhile for defining the following assessment of specific tissue binding.

**TABLE 2**

Tissue-to-blood and tissue-to-unbound blood concentration ratios ($K_p$ and $K_{pu}$, respectively)

<table>
<thead>
<tr>
<th>Dose, mg/kg</th>
<th>$K_p$</th>
<th>$K_{pu}$</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.2</td>
<td>6</td>
<td>30</td>
</tr>
<tr>
<td>Lung</td>
<td>7.14</td>
<td>5.10</td>
</tr>
<tr>
<td>Heart</td>
<td>5.88</td>
<td>4.63</td>
</tr>
<tr>
<td>Kidney</td>
<td>7.69</td>
<td>10.4</td>
</tr>
<tr>
<td>Bone</td>
<td>2.27</td>
<td>3.03</td>
</tr>
<tr>
<td>Muscule</td>
<td>0.98</td>
<td>1.18</td>
</tr>
<tr>
<td>Spleen</td>
<td>7.38</td>
<td>6.97</td>
</tr>
<tr>
<td>Liver</td>
<td>11.8</td>
<td>11.0</td>
</tr>
<tr>
<td>Gut</td>
<td>5.15</td>
<td>5.23</td>
</tr>
<tr>
<td>Skin</td>
<td>4.17</td>
<td>2.45</td>
</tr>
<tr>
<td>Fat</td>
<td>6.74</td>
<td>6.27</td>
</tr>
<tr>
<td>Thymus</td>
<td>3.62</td>
<td>5.23</td>
</tr>
<tr>
<td>Brain</td>
<td>N.D.</td>
<td>0.24</td>
</tr>
<tr>
<td>$V_{ss}$ (l/kg)</td>
<td>2.40</td>
<td>2.24</td>
</tr>
</tbody>
</table>

* Time- and subject-averaged values obtained from pooled concentration-time data in each dose group ($n = 15$; three animals per time point).  
* N.D., not determined (because most brain measurements were below the limit of quantification).  
* Calculated from the sum of $V_Kp$ or $V_{pu}$ for all organs measured, including blood, where $V_T$ is organ mass.
Regarding saturable CyA binding, two categories of organs were identified by Scatchard analysis of the in vivo steady-state tissue data. The first category was characterized by its biphasic tissue binding (Fig. 5), demonstrating both high- and low-affinity binding sites. $K_{D,T}$ values estimated from the high-affinity site varied within a narrow range (0.005–0.17 mg/g), which overlapped approximately with the reported $K_D$ for CyA-CyPh binding measured in vitro (0.012–0.048 mg/g; Dalgarno et al., 1986; Ryffel, 1993). It was thus probable that CyA-CyPh binding could also be measured in vivo. If this is the case, the approach used in this study allows an evaluation of in vivo efficacy based on target occupancy, referring to in vitro data. In contrast, the biological meaning of the second category of organs remains unclear. For these organs, the Scatchard plot was essentially monophasic, and the estimated $K_D$ values (0.42–0.77 mg/g) were one order of magnitude larger than those reported for CyA-CyPh binding. In these organs, saturable binding site(s) with high affinity probably exist but are undetectable based on the current in vivo data. A number of CyPh subclasses are currently known (Schneider et al., 1994); however, the affinity of CyA to all of these has not been systematically investigated. This leaves a possible explanation if they have different affinities for CyA and distribute in tissues in an organ-specific manner. In addition to different CyPh classes, other saturable binding sites with high capacity and low affinity may also exist in some organs.

Compared with other organs, brain revealed a unique dose-response in the distribution profile, showing a disproportionately higher tissue concentration at higher doses. The result, however, is consistent with the current knowledge of the blood-brain barrier at which P-glycoprotein efficiently pumps out substrates (Cordon-Cardo et al., 1989; Thiebaut et al., 1989), including CyA (Saeki et al., 1993; Sakata et al., 1994).

**Fig. 5.** Tissue-to-unbound blood concentration ratios ($K_{pu,app}$) at steady state versus tissue concentration in major target organs for transplantation. Each point represents a value from an individual rat. The points from 1.2-, 6-, and 30-mg/kg dose groups were shown as ●, □, and ▲, respectively.

**Fig. 6.** Tissue CyA concentration profiles in liver and kidney as a function of unbound concentration in blood. The solid lines represent simulations using best-fit parameters generated from fitting a two-site binding model (eq. 10) to the data. The symbols represent average values from three rats with S.D. (vertical bar).
1994). The present data suggest that such an efflux system limits CyA entry into the brain at subtherapeutic to therapeutic doses and that more than a dose-proportional increase in brain exposure occurs, once the efflux system is saturated.

Overall, we have described CyA disposition over a wide dose range by interpreting the data cautiously in terms of individual elements, i.e., tissue distribution, blood distribution, and clearance. This wide dose range, especially the highest dose (30 mg/kg), is not directly applicable to the therapeutic situation, e.g., the reported highest in peak blood concentration in human was 2 μg/ml after oral administration of a microemulsion formulation of CyA (Mueller et al., 1994). However, based on blood distribution modeling in human (Legg and Rowland, 1988), this concentration corresponds to 0.12 μg/ml unbound CyA, which is comparable with the K_D for blood cell binding (0.185 and 0.128 μg/ml in rat and human, respectively) as well as the K_D,T in some organs (i.e., lung, heart, and liver; Table 3). In addition, this study provides important insights into the pharmacokinetics of CyA, which appears simple but is actually a complex hybrid of various nonlinear kinetic processes. The study also suggests that, in vivo, nonlinear factors are likely to be involved in the delivery of CyA to the target protein cyclophilin. Once the location of the target cells has been identified, whether local (organ) or otherwise (e.g., lymph nodes), the approach used here should facilitate the integration of in vitro efficacy parameters (such as target occupancy) into the pharmacokinetic and pharmacodynamic evaluation of CyA in vivo.

References


<table>
<thead>
<tr>
<th>Organ</th>
<th>α</th>
<th>b_{max}</th>
<th>K_{D,T}</th>
<th>b_{max}/K_{D,T}</th>
<th>K_{p,a}</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lung</td>
<td>82.5 (7.5)</td>
<td>0.919 (0.573)</td>
<td>0.0054 (0.0062)</td>
<td>170</td>
<td>253</td>
</tr>
<tr>
<td>Heart</td>
<td>33.8 (11.0)</td>
<td>15.8 (10.4)</td>
<td>0.172 (0.117)</td>
<td>91.9</td>
<td>126</td>
</tr>
<tr>
<td>Kidney</td>
<td>1.0^a</td>
<td>157 (31)</td>
<td>0.772 (0.179)</td>
<td>203</td>
<td>204</td>
</tr>
<tr>
<td>Liver</td>
<td>157 (6)</td>
<td>2.20 (0.98)</td>
<td>0.0057 (0.0050)</td>
<td>386</td>
<td>543</td>
</tr>
<tr>
<td>Spleen</td>
<td>1.0^a</td>
<td>116 (36)</td>
<td>0.715 (0.261)</td>
<td>162</td>
<td>163</td>
</tr>
<tr>
<td>Bone</td>
<td>1.0^a</td>
<td>31.6 (3.9)</td>
<td>0.424 (0.064)</td>
<td>74.5 (75.5)</td>
<td>129</td>
</tr>
<tr>
<td>Gut</td>
<td>1.0^a</td>
<td>99.1 (37.7)</td>
<td>0.767 (0.336)</td>
<td>130</td>
<td></td>
</tr>
</tbody>
</table>

^ Calculated as α = b_{max}/K_{D,T}.

The value was set to 1 assuming the physical tissue space for nonspecific distribution; independent estimation resulted in values smaller than 1 with commonly large estimation errors, exceeding the magnitude of the estimate.