Metabolism And Excretion of the Dipeptidyl Peptidase 4 Inhibitor \[^{14}C\]Sitagliptin in Humans


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ABSTRACT:

The metabolism and excretion of \[^{14}C\]sitagliptin, an orally active, potent and selective dipeptidyl peptidase 4 inhibitor, were investigated in humans after a single oral dose of 83 mg/193 \(\mu\)Ci. Urine, feces, and plasma were collected at regular intervals for up to 7 days. The primary route of excretion of radioactivity was via the kidneys, with a mean value of 87% of the administered dose recovered in urine. Mean fecal excretion was 13% of the administered dose. Parent drug was the major radioactive component in plasma, urine, and feces, with only 16% of the dose excreted as metabolites (13% in urine and 3% in feces), indicating that sitagliptin was eliminated primarily by renal excretion. Approximately 74% of plasma AUC of total radioactivity was accounted for by parent drug. Six metabolites were detected at trace levels, each representing <1 to 7% of the radioactivity in plasma. These metabolites were the \(N\)-sulfate and \(N\)-carbamoyl glucuronic acid conjugates of parent drug, a mixture of hydroxylated derivatives, an ether glucuronide of a hydroxylated metabolite, and two metabolites formed by oxidative desaturation of the piperazine ring followed by cyclization. These metabolites were detected also in urine, at low levels. Metabolite profiles in feces were similar to those in urine and plasma, except that the glucuronides were not detected in feces. CYP3A4 was the major cytochrome P450 isozyme responsible for the limited oxidative metabolism of sitagliptin, with some minor contribution from CYP2C8.

Dipeptidyl peptidase 4 (DPP-4) is a ubiquitous proline-specific serine protease responsible for the rapid inactivation of incretins, including glucagon-like peptide 1 (GLP-1) and glucagon-dependent insulinotropic peptide (Gorrell, 2005). GLP-1, which is released upon nutrient ingestion, stimulates meal-induced insulin secretion and contributes to glucose homeostasis (Kieffer and Habener, 1999). Stabilization of GLP-1 via DPP-4 inhibition is a new therapeutic approach to type 2 diabetes (Drucker, 2003; Holst, 2004; Mest and Mentlein, 2005; Nielsen, 2005).

Sitagliptin (Januvia), also known as MK-0431 (Fig. 1), is an orally active, potent and selective DPP-4 inhibitor with an IC\(_{50}\) value of 18 nM (Kim et al., 2005). Sitagliptin has been shown to inhibit plasma DPP-4 activity in a dose-dependent manner and to enhance active GLP-1 levels in normal volunteers (Bergman et al., 2005, 2006; Herman et al., 2005b) and patients with type 2 diabetes (Herman et al., 2004). Furthermore, in patients with type 2 diabetes, single doses of sitagliptin enhanced insulin and C-peptide release, decreased glucagon secretion, and reduced plasma glucose levels after an oral glucose tolerance test (Herman et al., 2004), whereas 12-week treatment with sitagliptin significantly reduced HbA\(_1c\) and fasting plasma glucose (Herman et al., 2005a; Scott et al., 2005).

The metabolism and excretion of \[^{14}C\]sitagliptin were studied in male human volunteers after oral administration of 83 mg/193 \(\mu\)Ci. In preclinical species, \[^{14}C\]sitagliptin was shown to be eliminated by biliary and/or renal excretion of parent drug (Beconi et al., 2007). Metabolism was minimal, and it involved \(N\)-sulfation (M1), \(N\)-carbamoyl glucuronidation (M4), hydroxylation (M6) followed by ether glucuronidation (M3), and oxidative desaturation followed by cyclization (M2 and M5) (Fig. 1). Synthetic standards of metabolites M1, M2, and M5 were tested for DPP-4 inhibition and shown to be \(\sim\)300-, 1000-, and 1000-fold less active, respectively, than parent drug.

Materials and Methods

Chemicals and Dose Preparation. \[^{14}C\]Sitagliptin was synthesized as the phosphate salt with a specific activity of 2.36 \(\mu\)Ci/mg free base (1.9 \(\mu\)Ci/mg salt) by the Labeled Compound Synthesis Group [Merck Research Laboratories (MRL), Rahway, NJ]. The chemical purity was 99.7%, as determined by HPLC. The dose was prepared as a capsule formulation containing 20 mg/48.3 \(\mu\)Ci \[^{14}C\]sitagliptin (25 mg of phosphate salt). The 2.5-difluoro analog of sitagliptin used to saturate nonspecific binding sites on the solid phase extraction cartridges was provided by Process Research (MRL, Rahway, NJ). The
synthetic standard of metabolite M1 was synthesized by the Labeled Compound Synthesis Group (MRL, Rahway, NJ), and M2 and M5 were synthesized by Basic Chemistry (MRL, Rahway, NJ). The solid phase extraction cartridges, Varian C18 Bond Elut columns, were purchased from Varian Inc. (Harbor City, CA).

**Subjects and Dose Administration.** The study was conducted at Clinical Pharmacology Associates in Miami, FL, in six healthy male volunteers, 27 to 43 years old, weighing 60 to 95 kg. Subjects were admitted to the clinical research unit the evening before dosing and remained in the unit until the completion of all laboratory collections for the duration of the study (approximately 7 days). Subjects abstained from food and drink except water from midnight the evening before dosing, and consumed approximately 240 ml of water approximately 2 h before drug administration. Water was restricted 1 h before and 1 h after drug administration. Each subject ingested four capsules containing a total of 83 mg/193 μCi [14C]sitagliptin with approximately 240 ml of water. A standardized lunch was given at approximately 4 h postdose, and a snack was allowed in the evening. Blood was collected in EDTA-coated tubes at selected time points up to and including 7 days postdose, and spun in a centrifuge to obtain plasma. Urine and feces were collected daily for 7 days. Plasma was stored at −70°C, and urine and feces at −20°C. Safety and tolerability were assessed by clinical and laboratory evaluations prestudy, predose, postdose, and post-study. Vital signs and ECGs were also evaluated at selected intervals.

Radioactivity excretion data from one subject (AN 803) showed that there was substantially lower overall recovery compared with the other five subjects, suggesting incomplete collection of radioactivity. This subject was subsequently re-dosed with a nonlabeled 100-mg dose of sitagliptin, followed by collection of blood and urine samples for 72 h postdose.

**Determination of Radioactivity and Sample Processing for Metabolite Profiling.** The concentration of radioactivity in aliquots (0.5 ml) of plasma taken at 0, 0.5, 1.5, 2, 3, 5, 6, 10, 15, 24, 36, 48, 60, 72, 96, 120, 144, and 168 h after dosing was determined by liquid scintillation counting. For metabolite profiling, approximately 4 ml of plasma taken at 1, 4, 8, 12, and 18 h from the six subjects were pooled for each time point. The resulting pools were mixed with 4 ml of 8 M urea and applied to 20-g Varian C18 Bond Elut columns, using the following procedure: 1) two washes with 15 ml of methanol; 2) two washes with 15 ml of water; 3) equilibration with 30 ml of 50 μM 2,5-difluoro analog of sitagliptin (to saturate sites of nonspecific adsorption); 4) washes with methanol (two times, 15 ml) and water (two times, 15 ml); 5) loading of the plasma; 6) three washes with 15 ml of water; and 7) elution with 12 ml of
methylene containing 10% formic acid. Previous studies had shown that sitagliptin and its metabolites were stable under acidic conditions (5% HClO4). The column eluates were evaporated under N2 and the samples were reconstituted in 0.3 ml of water/methanol/acetic acid (90:10:0.1, by volume) and analyzed by LC-MS/MS and radiometric detection.

Concentrations of radioactivity and percentage of radioactive dose excreted into the urine and feces were determined at Charles River Laboratories (Waltham, MA). Feces were homogenized with water (4 ml/g feces) and weighed aliquots were analyzed by combustion followed by liquid scintillation counting of the trapped 14CO2. Radioactivity in weighed aliquots of urine was determined directly by liquid scintillation counting.

For metabolite profiling, 0- to 168-h pools of urine and 0- to 96-h pools of fecal homogenates were prepared for each subject based on the volume recovered at each time point. Aliquots from each urine or feces pool were treated with an equal volume of acetonitrile. The mixtures were placed on melting ice for 10 min and centrifuged at 3000 rpm for 10 min. The resulting supernatants were dried under N2 at 30°C overnight, reconstituted in 350 μl (urine) or 600 to 750 μl (feces) of water/methanol/acetic acid (90:10:0.1, by volume), and analyzed by LC-MS/MS coupled with radiometric detection. Also, representative metabolite profiles were generated by analyzing samples consisting of equal volumes of urine or feces extracts from each subject (excluding subject 803) or all six subjects. For confirmation of metabolites by MRM transition monitoring and MS/MS fragmentation, fecal samples were subjected to solid phase extraction, using a procedure similar to the method described for plasma.

**Qualitative LC-MS/MS Analysis.** LC-MS analysis was conducted on a PE Sciex API 3000 mass spectrometer (PerkinElmerSciex Instruments, Boston, MA), which was interfaced with a PerkinElmer HPLC system (PerkinElmer Life and Analytical Sciences, Boston, MA) equipped with two Series 200 micro pumps and a PerkinElmer Series 200 autosampler. A Thermo Hypersil Fluophase PFP column (3.0 × 150 mm, 5 μm; Thermo Electron Corporation, Waltham, MA) was used for chromatographic separation. The column was eluted with a mixture of 5 mM ammonium acetate in water plus 0.05% acetic acid (mobile phase A) and 5 mM ammonium acetate in methanol plus 0.05% acetic acid (mobile phase B). The gradient was begun with 18% B for 2 min, and increased linearly to 80% B over 33 min and then to 95% B in 5 min, followed by a hold at 95% B for 5 min. The effluent from the HPLC, pumped at a rate of 0.6 ml/min, was diverted at a 5:1 ratio into the radiometric flow detector and into the mass spectrometer, respectively. Scintillation cocktail (Packard Ultima Flo-M, Downers Grove, IL) was pumped at a rate of 1.2 ml/min in the radiometric detector. The contributions of parent drug and metabolites were calculated from the amount of radioactivity eluting in each peak relative to the total radioactivity in the HPLC chromatogram. LC-MS and LC-MS/MS experiments were carried out using the TurbolonSpray interface operated in the positive ion mode. The source voltage was 3500 V and the probe temperature, 300°C. Metabolites were identified by selective ion monitoring of the following precursor—product transitions (MRM): M1, m/z 488.2→408.2 and m/z 488.2→193.0; M2, M3, and M5, m/z 406.2→174 and m/z 406→191; M4, m/z 628.2→408 and m/z 628.2→452; and M6, m/z 424.2→406.1 and m/z 424.2→191.

**Pharmacokinetic Calculations.** Plasma concentrations of sitagliptin and radioactivity were converted into molar units (nM or nM Eq) using the molecular weight of 407.321 before pharmacokinetic analysis. Area under the plasma concentration-time curve to the last time point where radioactivity was above the lower limit of quantitation (AUC0-last) was calculated for both plasma concentration-time curve to the last time point where radioactivity was above the lower limit of quantitation (AUC0-last) was calculated for both plasma and urine concentration-time curves using the log trapezoidal method for ascending concentrations and the linear log trapezoidal method for descending concentrations. Sitagliptin and radioactivity plasma Cmax and Tmax were obtained by inspection of the plasma concentration data.

**Results**

**Excretion of Radioactivity.** The excretion of radioactivity in human urine and feces after a single 83 mg/193 μCi oral dose of [14C]sitagliptin is summarized in Table 1. The results indicated that most of the radioactive dose was excreted via the kidneys, with a mean value of ~87% of the administered dose recovered within 7 days in urine (range: ~83–94%) in five of six subjects who participated in this study. Fecal excretion averaged ~13% (n = 5) of the

### Table 1

<table>
<thead>
<tr>
<th></th>
<th>0800%</th>
<th>0801%</th>
<th>0802%</th>
<th>0803*</th>
<th>0804%</th>
<th>0805%</th>
<th>Mean</th>
<th>S.D.</th>
<th>n = 5</th>
</tr>
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<tbody>
<tr>
<td>Urine</td>
<td>43</td>
<td>38</td>
<td>44</td>
<td>16</td>
<td>46</td>
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<td>44</td>
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<td></td>
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<td>0–6 h</td>
<td>4.2</td>
<td>18</td>
<td>26</td>
<td>14</td>
<td>21</td>
<td>26</td>
<td>20</td>
<td>3.9</td>
<td></td>
</tr>
<tr>
<td>0–168 h</td>
<td>82</td>
<td>82</td>
<td>93</td>
<td>25</td>
<td>85</td>
<td>90</td>
<td>87</td>
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<tr>
<td>Feces</td>
<td>2.1</td>
<td>0.1</td>
<td>0.3</td>
<td>4.4</td>
<td>0.3</td>
<td>0.3</td>
<td>0.6</td>
<td>0.9</td>
<td></td>
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<tr>
<td>0–24 h</td>
<td>15</td>
<td>18.2</td>
<td>3.1</td>
<td>&lt;0.1</td>
<td>3.0</td>
<td>1.6</td>
<td>2.7</td>
<td>2.6</td>
<td></td>
</tr>
<tr>
<td>0–168 h</td>
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<tr>
<td>Total</td>
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<td>102</td>
<td>103</td>
<td>30</td>
<td>94</td>
<td>99</td>
<td>100</td>
<td>4.1</td>
<td></td>
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</table>

* Includes radioactivity on fecal wipes.
administered dose (range: ~9–20%), with a mean total recovery of radioactivity in urine and feces of ~100% (range: ~94–105%).

The recovery of radioactivity in one of the subjects (subject 803) was much lower than the average recovery in the other five subjects (30 versus 100% of the dose). The data from this subject were not used in the calculation of the mean and standard deviation values reported in Table 1 and Fig. 2. In a subsequent study with nonradio-labeled sitagliptin (100 mg), it was determined that the pharmacokinetics and renal excretion of sitagliptin in this subject were similar to historical data. Pharmacokinetic analysis of the plasma and urine samples after this dosing revealed that approximately 66% of the sitagliptin dose was excreted unchanged in urine over the 72-h collection period (data not shown). Also, the renal clearance of MK-0431 was generally similar to that observed in other subjects (439 ml/min).

These results suggested that the results obtained for this subject after the 83.04-mg [14C]sitagliptin were very likely spurious, and therefore, this subject was excluded from the primary analysis.

Radioactivity and Sitagliptin Levels in Plasma. Concentrations of radioactivity (expressed as [14C]sitagliptin nmol-Eq) and sitagliptin (nM) in human plasma after oral dosing of [14C]sitagliptin are depicted in Fig. 2, and pharmacokinetic parameters are summarized in Table 2. The highest concentrations in plasma (Cmax) were achieved at 2 to 4 h postdose and ranged from 706 to 993 nmol-Eq (total radioactivity) and 523 to 930 nM (sitagliptin) in five of the six subjects (excluding subject AN 803). Radioactivity levels at 60 to 168 h postdose were below the limit of quantification, ~25 nm Eq. Plasma AUC0-last Values in the five subjects ranged from 7.19 to 9.21 μmol-Eq · h, with a mean value of 8.20 μmol Eq · h for total radioactivity, and from 5.12 to 6.83 (mean 6.04) μM · h for sitagliptin. The mean AUC0-last of radioactivity was 74% of the AUC0-last of sitagliptin. Data from subject AN803 were not used in the calculation of mean and standard deviation values, because of the low recovery of the radioactive dose in this subject.

Metabolite Profiles in Plasma. Metabolite profiles in plasma pooled across subjects at 1 and 8 h are illustrated in Fig. 3. Similar profiles were observed at 4, 12, and 18 h. Due to the low levels of radioactivity and the limited volume of plasma, it was not possible to obtain individual metabolite profiles. Radioactivity in plasma was composed primarily of parent drug at all time points examined, with approximately 90% of circulating radioactivity detected at 1 h, approximately 80% detected at 4, 8, and 18 h, and approximately 78% detected at 12 h. Six known metabolites were detected, each accounting for <1 to 8% of the circulating radioactivity between 1 and 18 h postdose (Table 3). The most abundant metabolites in plasma were M5 (4–7% of radioactivity) and M2 (1–6%), both of which are formed by oxidative desaturation of the piperazine ring followed by cyclization (Fig. 1). Other metabolites include M6 (a group of hydroxylated derivatives; 1–4%), M1 (N-sulfate conjugate; 2–4%), M4 (N-carbamoyl glucuronide conjugate; 1%), and M3 (ether glucuronide conjugate of a hydroxylated derivative; <1%).

Metabolite Profiles in Urine and Feces. The metabolite profile of a pooled sample of urine collected at 0 to 168 h postdose is shown in Fig. 4. Similar profiles were obtained for urine collected from individual subjects, including subject AN 803. Parent drug was the major radioactive component, comprising ~84 to 88% of the urinary radioactivity. All six metabolites detected in plasma were excreted in small amounts into urine (<1–5% of the urinary radioactivity, <1 to ~4% of the dose, each).

The metabolite profile of a pooled human fecal sample collected at 0 to 96 h is illustrated in Fig. 4. Feces collected between 4 and 7 days postdose contained negligible amounts of radioactivity and were not analyzed. Parent drug was the major radioactive component in feces,

### Table 2

<table>
<thead>
<tr>
<th>Subject</th>
<th>Sitagliptin</th>
<th>Radioactivity</th>
<th>Sitagliptin/Radioactivity</th>
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<tr>
<td></td>
<td>AUC0-last</td>
<td>Cmax</td>
<td>Tmax</td>
</tr>
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<td>800</td>
<td>5.27</td>
<td>869</td>
<td>2</td>
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<tr>
<td>801</td>
<td>6.83</td>
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<td>2</td>
</tr>
<tr>
<td>802</td>
<td>6.67</td>
<td>702</td>
<td>5</td>
</tr>
<tr>
<td>803&lt;sup&gt;a&lt;/sup&gt;</td>
<td>3.45</td>
<td>447</td>
<td>1.5</td>
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<tr>
<td>804</td>
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<td>970</td>
<td>1.5</td>
</tr>
<tr>
<td>805</td>
<td>5.12</td>
<td>523</td>
<td>4</td>
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<tr>
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<td>6.04</td>
<td>759</td>
<td>2&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td>S.D.&lt;sup&gt;c&lt;/sup&gt;</td>
<td>0.80</td>
<td>158</td>
<td>N.C.</td>
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<tr>
<td>GM&lt;sup&gt;c&lt;/sup&gt;</td>
<td>6.00</td>
<td>745</td>
<td>N.C.</td>
</tr>
</tbody>
</table>

<sup>a</sup> last = last time point where plasma radioactivity is above the lower limit of quantitation.

<sup>b</sup> Subject 803 was considered an outlier and data from this subject were not used for the calculation of the arithmetic mean (AM), geometric mean (GM), or S.D. values.

<sup>c</sup> Median.

N.C., not calculated.
comprising ∼51 to 86% of the radioactivity. The metabolite profiles in feces were similar in all subjects (not shown) and were also similar to the profiles in urine and plasma, with the exception that the conjugates M3 and M4 were not detected in feces, presumably because they had been hydrolyzed to their corresponding aglycones, M6 and sitagliptin, respectively. Metabolites M1, M2, M5, and M6 were detected in small amounts (∼1–12% of the fecal radioactivity, <1 to ∼1.6% of the dose, each).

**Safety Evaluation.** There were no clinical or laboratory adverse experiences reported in this study. In addition, there were no apparent treatment-related clinically relevant changes in vital signs, ECG, or laboratory safety parameters.

**Identification of Cytochrome P450 Involved in Sitagliptin Metabolism.** After 1-h incubations of 10 μM [14C]sitagliptin with NADPH-enriched human liver microsomes, ∼2% turnover was observed. The only metabolites detected by LC-MS/MS were a hydroxylated derivative (M6), and the cyclized products M2 and M5 (Beconi et al., 2007). Incubations with recombinant P450s indicated that CYP3A4 and, to a much smaller extent, CYP2C8 were capable of catalyzing the formation of M2, M5, and M6. Due to the low turnover, the relative contribution of these P450s could not be determined accurately. However, based on LC-MS/MS analysis, it could be discerned that the formation of M2 and M5 in human liver microsomes could be inhibited to a much larger extent by anti-CYP3A4 than anti-CYP2C8 antibody. Also, the formation of M6 could be inhibited by anti-CYP3A4 only.

**Discussion**

After oral administration of [14C]sitagliptin to healthy volunteers, the total recovery of radioactivity was approximately 100%. The results of this study demonstrate that the primary route of elimination of sitagliptin in healthy subjects is via renal excretion of intact drug. Approximately 16% of the oral radioactive dose was excreted as metabolites (13% in urine, 3% in feces), and ∼10% of the radioactivity dose was excreted unchanged in feces. The unchanged sitagliptin found in feces may represent unabsorbed material, drug cleared by biliary excretion, or back-converted M1 (N-sulfate) and/or M4 (N-carbamoyl glucuronide). Nonetheless, these results indicated that sitagliptin was well absorbed after oral administration, as ∼87% of the radioactivity was recovered in urine. These data are corroborated by
the high bioavailability (Bergman et al., 2005) and high recovery of parent drug in urine after the administration of unlabeled sitagliptin to healthy subjects (Herman et al., 2005a; Bergman et al., 2006).

Examination of the sitagliptin and radioactivity pharmacokinetic data indicate that sitagliptin makes up the majority (74%) of the radioactivity in plasma after an oral dose (as determined by the ratio of sitagliptin AUC and radioactivity AUC), with the remaining radioactivity accounted for by the metabolites shown in Fig. 1. Due to their low affinity for the DPP-4 enzyme (M1, M2, and M5) and their low levels in plasma, these metabolites would not be expected to contribute to the pharmacological activity of sitagliptin.

Similar observations were made in rats and dogs (Beconi et al., 2007), where, as in humans, sitagliptin was eliminated primarily unchanged into urine (dog) or urine and bile (rat). Also, all the metabolites observed in human plasma, urine, and feces were observed also in rat and/or dog plasma, urine, bile, and feces, as well as in incubations in vitro with rat, dog, and human liver preparations (Beconi et al., 2007). Results from in vitro experiments with recombinant P450s and monoclonal anti-P450 antibodies indicated that the oxidative metabolism of sitagliptin in human liver microsomes is catalyzed primarily by CYP3A4 with some minor contribution from CYP2C8. Because sitagliptin is eliminated primarily unchanged into urine, it is not expected to be a victim of metabolism-based drug interactions.

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References


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