Interaction between Topically and Systemically Coadministered P-Glycoprotein Substrates/Inhibitors: Effect on Vitreal Kinetics

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ABSTRACT:

The objective of the present study was to investigate the effect of topically coadministered P-glycoprotein (P-gp) substrates/inhibitors on the vitreal kinetics of a systemically administered P-gp substrate. Anesthetized male rabbits were used in these studies. The concentration-time profile of quinidine in the vitreous humor, after intravenous administration, was determined alone and in the presence of topically coadministered verapamil, prednisolone sodium phosphate (PP), and erythromycin. The vitreal pharmacokinetic parameters of quinidine in the presence of verapamil (apparent elimination rate constant (λz), 0.0027 ± 0.0002 min−1; clearance (CL/F), 131 ± 21 ml/min; area under the curve (AUC0–20 min), 39 ± 7.0 μg · min/ml; and mean residence time, 435 ± 20 min) were significantly different from those of the control (0.0058 ± 0.0006 min−1, 296 ± 46 ml/min, 17 ± 3 μg · min/ml, and 232 ± 20 min, respectively). A 1.7-fold decrease in the vitreal λz and a 1.5-fold increase in the vitreal AUC of quinidine were observed in the presence of topical PP. Statistically significant differences between the vitreal profiles of the control and erythromycin-treated group were also observed. Plasma concentration-time profiles of quinidine, alone or in the presence of the topically instilled compounds, remained unchanged, indicating uniform systemic quinidine exposure across groups. This study demonstrates an interaction between topically and systemically coadministered P-gp substrates, probably through the modulation of P-gp on the basolateral membrane of the retinal pigmented epithelium, leading to changes in the vitreal kinetics of the systemically administered agent.

Introduction

Drug delivery to the back of the eye through the systemic route is a challenging task (Hughes et al., 2005). The blood-retinal barrier (BRB), consisting of the inner and outer BRB, prevents access of xenobiotics from the systemic circulation into the back of the eye (Cunha-Vaz, 2004). The retinal pigmented epithelium (RPE), which constitutes the outer BRB, acts as a barrier not only to systemically administered agents but also to compounds administered by the periorcular routes (Majumdar et al., 2009). The RPE is a single layer of hexagonal epithelial cells that forms the outermost layer of the retina and is separated from the choroid by Bruch’s membrane (Cheruvu and Kompella, 2006). It carries out essential biochemical functions such as phagocytosis of photoreceptor outer segments, transport regulation between the photoreceptors and the choriocapillaries, and the uptake and conversion of the retinoids (Pitkänen et al., 2005). However, the RPE also presents a significant barrier to the ocular penetration of many therapeutic agents (Majumdar et al., 2009).

After systemic administration, therapeutic moieties can easily diffuse out of the leaky choriocapillaries into the choroidal stroma (Dey et al., 2003; Duvvuri et al., 2003b; Cunha-Vaz, 2004). However, the tight junctions of the RPE regulate further diffusion of hydrophilic molecules and macromolecules from the choroidal stroma into the retina (Duvvuri et al., 2003b). Furthermore, P-glycoprotein (P-gp), a membrane-bound protein involved in the efflux of many hydrophobic molecules, expressed on the basolateral membrane of the RPE (henceforth referred to as RPE P-gp), plays a vital role in the RPE’s barrier properties toward lipophilic compounds. The physiological role of this efflux protein is to protect the eye from harmful toxic substances. However, through this protective action, RPE P-gp severely limits ocular penetration of many systemically, as well as periorcularly, administered drugs (Majumdar et al., 2009). Thus, modulation of the activity of RPE P-gp could alter the penetration of substrates from the systemic circulation into the vitreous humor and subsequent elimination from the posterior chamber, which could significantly alter the ocular pharmacokinetic parameters of the systemically administered P-gp substrate.

The effect of a drug-drug interaction at the level of the RPE P-gp and its effect on ocular drug pharmacokinetics in vivo has attracted...
attention only in recent years. There are literature reports of the effect of systemic/systemic, systemic/intravitreal, or intravitreal/intravitreal coadministration of inhibitors and model marker compounds on ocular pharmacokinetics (Duvvuri et al., 2003a; Senthilkumar et al., 2008a,b). We recently demonstrated, for the first time, an interaction between topically and intravitreally coadministered P-gp substrates wherein the topically administered P-gp modulators altered the vitreal kinetics of an intravitreally administered P-gp substrate, quinidine (Majumdar et al., 2009).

The objective of the current research project was to determine the effect of topical P-gp inhibitors on the vitreal kinetics of a systemically coadministered P-gp substrate. For this purpose, two currently marketed ophthalmic formulations, erythromycin ophthalmic ointment (USP, 0.5%) and prednisolone sodium phosphate (PP) (USP, 1%), were administered topically. In addition, a 1% verapamil solution was also prepared for topical administration. Erythromycin and PP are routinely administered topically to control ocular infections and inflammation, respectively, and are well established P-gp inhibitors (Schwab et al., 2003; Majumdar et al., 2009). Verapamil is another well known P-gp substrate/inhibitor (Duvvuri et al., 2003a).

Quinidine, which was used in our previous study as the marker compound (Majumdar et al., 2009), was used as a model P-gp substrate in this study also, and its vitreal and plasma pharmacokinetic parameters were determined.

Materials and Methods

Materials. Verapamil hydrochloride and quinidine hydrochloride were obtained from Sigma-Aldrich (St. Louis, MO). PP ophthalmic solution (USP, 1%) and erythromycin ophthalmic ointment (USP, 0.5%), were procured from Butler Animal Health Supply (Dublin, OH). Ketamine hydrochloride and xylazine were purchased from Fort Dodge Animal Health (Fort Dodge, IA) and Lloyd Laboratories (Shenandoah, IA), respectively. Pentobarbital was obtained from Virbac AH, Inc. (Fort Worth, TX). HPLC-grade solvents and other chemicals (analytical grade) were obtained from Thermo Fisher Scientific (Waltham, MA). Microdialysis concentric probes (CMA/20; 20,000-Da cutoff, from Virbac AH, Inc. (Fort Worth, TX). HPLC-grade solvents and other chemicals (analytical grade) were obtained from Thermo Fisher Scientific (Waltham, MA). Microdialysis concentric probes (CMA/20; 20,000-Da cutoff, from Virbac AH, Inc. (Fort Worth, TX). HPLC-grade solvents and other chemicals (analytical grade) were obtained from Thermo Fisher Scientific (Waltham, MA).

Animals. New Zealand male albino rabbits were procured from Myrtle’s Rabbity (Thompson Station, TN). All of the animal experiments conformed to the tenets of the Association for Research in Vision and Ophthalmology statement on the Use of Animals in Ophthalmic and Vision Research and followed the University of Mississippi institutional animal care and use committee-approved protocols.

Microdialysis Probe Implantation and Recovery Studies. In vivo probe implantation. Rabbits (weighing 2–2.5 kg) were anesthetized using ketamine (35 mg/kg)-xylazine (3.5 mg/kg) administered intramuscularly and were maintained under anesthesia throughout the duration of the experiment (ketamine/ xylazine administered intramuscularly every 40 min). Before probe implantation, the median ear artery of the rabbit was cannulated using a 24-gauge 3/4 in. SURFLO Teflon intravenous catheter with an injection plug (Terumo Medical Corp., Somerset, NJ) for collection of blood samples. After cannula, microdialysis probe implantation was performed as described previously (Majumdar et al., 2009). In brief, eyes were proposed, after the pupil was dilated with a 1% tropicamide solution, and a 22-gauge needle was carefully inserted into the vitreous chamber. The point of insertion was approximately 3 mm below the corneal-scleral limbus. The needle was retracted, and the vitreal probe was implanted immediately. The position of the probe was adjusted so that the semipermeable membrane was in the mid-vitreous section. The probes were continuously perfused with sterile isotonic phosphate-buffered saline (IPBS) (pH 7.4) at a flow rate of 2 μL/min using microdialysis pump control module and syringe drives (Bisanalytical Systems, Inc. Mount Vernon, IN). After probe implantation, animals were allowed to stabilize for a period of 2 h before drug administration. Vitreal samples were collected every 20 min for a period of 9 h. Samples were collected in microcentrifuge tubes and stored at −20°C until further analysis. At the end of the study, animals were euthanized with an overdose of sodium pentobarbital administered through the marginal ear vein. A limitation of the anesthetized rabbit model, accompanied with microdialysis, is that only a limited number of terminal elimination half-lives may be reached, particularly for compounds with long half-lives, which could affect half-life calculations. However, considering the goals of this research project, which was to investigate whether the vitreal elimination kinetics are altered, this model and experimental protocol serve the purpose.

In vitro probe recovery. Probe recovery values were determined by placing the probe in an IPBS solution, pH 7.4, at 37°C, containing a known concentration of quinidine. The probe was continuously perfused with sterile IPBS at a flow rate of 2 μL/min, and the dialysate samples were collected every 20 min. Recovery of quinidine was calculated by using eq. 1:

\[
\text{Recovery}_{\text{in vitro}} = \frac{C_i}{C_i - q} \cdot \frac{C_i}{C_i - d}
\]

where \(C_i\) is the quinidine concentration in the dialysate and \(C_i\) is the quinidine concentration in IPBS. The actual concentrations of quinidine in the vitreous humor during the in vivo pharmacokinetic study were calculated using eq. 2:

\[
\text{Quinidine concentration in the vitreous humor} = \frac{C_i}{\text{Recovery}_{\text{in vitro}}}
\]

Drug Administration. After the probe stabilization period, quinidine hydrochloride, formulated in propylene glycol-IPBS (40:60, pH 7.4), was administered intravenously through the marginal ear vein (5 mg/kg b.wt.). Vitreal kinetics of quinidine after intravenous administration was studied alone (control) or in the presence of the topically applied substrates/inhibitors; verapamil (1%, pH 6.0), erythromycin 0.5% ophthalmic ointment, and PP (1%). Four animals were used in each treatment day, and the animals were dosed sequentially by groups (control followed by inhibitor groups). Verapamil and PP (100 μL) were instilled in the conjunctival sac 2, 4, and 6 h after intravenous quinidine administration. In the case of the erythromycin study, a single dose of 0.5 mg of erythromycin (100 mg of ointment) was applied in the conjunctival sac 2 h after the intravenous quinidine injection. Verapamil solution was prepared by dissolving verapamil hydrochloride in sterile IPBS (pH 6.0) to yield a 1% solution; PP and erythromycin ophthalmic formulations were used as such. Verapamil and PP were dosed three times on the basis of data from and as a continuation of our previous work (Majumdar et al., 2009), wherein we demonstrated the effect of topical inhibitor on the vitreal kinetics of an intravitreally administered substrate. Erythromycin was dosed only once because an ointment formulation was used.

In our previous publication (Majumdar et al., 2009), to delineate the effect of the vehicle on the ocular tissue barrier properties we had studied the vitreal kinetics of intravitreally administered fluorescein (marker compound to monitor the integrity and tightness of blood-retinal barrier), alone or in the presence of topically coadministered verapamil (1% w/v, vehicle-IPBS, pH 6.0). The vitreal pharmacokinetic parameters of fluorescein remained unchanged in the presence of topically coadministered verapamil (Majumdar et al., 2009), indicating that the tightness and integrity of the blood-retinal barrier were not altered. None of the other components of the vehicle would interact with P-gp. Because the vehicle used in the current study is the same, a separate vehicle control was thus not included.

Vitreal microdialysis samples were collected every 20 min for a period of 9 h. Blood samples (0.5 ml) were also collected concurrently, in both control and inhibition study groups, from the catheter implanted in the central ear artery of each rabbit. Blood samples were drawn and then collected in heparinized vials at approximately 10, 15, 30, 60, 90, 120, 240, 360, and 480 min after intravenous quinidine administration. The exact time of blood collection was noted, and a plasma concentration-time profile was constructed accordingly. Plasma was separated from the whole blood by centrifugation at 13,000 rpm for 10 min at 4°C (accurSpin Micro 17R; Thermo Fisher Scientific) and was stored at −20°C until further analysis.
Distribution of Prednisolone/PP and Erythromycin in the Ocular Tissues after Topical Administration. In a separate set of studies, after the probe stabilization period, PP and erythromycin ophthalmic ointment were applied topically in the conjunctival sac of the rabbit eye at 2, 4, and 6 h and at 2 h, respectively. At the end of 9 h after quinidine administration, animals were euthanized, eyes were enucleated, and ocular tissues were collected and analyzed for drug content. No further attempts were made to understand the time course of levels of inhibitors in plasma, vitreous, and other ocular tissues after topical application.

Enzymatic Conversion of PP to Prednisolone. Prednisolone rather than PP, a phosphate ester of prednisolone, is known to interact with P-gp. Therefore, bioconversion rates of PP to prednisolone were determined in the aqueous humor, vitreous humor, lens, RPE/choroid, and iris-ciliary body following previously described procedures (Majumdar et al., 2009; Majumdar and Srirangam, 2009). Studies were performed in triplicate at 37°C in a shaking water bath (75 reciprocations/min). PP stock solution (100 μl) was added to the required volume of the tissue homogenates and aqueous and vitreous humor to obtain a final PP concentration of 5 μg/ml. The protein content in the tissue homogenates was determined using the Bradford method (Bradford, 1976). At predetermined time points, 100-μl aliquots were withdrawn, and an equal volume of ice-cold methanol was immediately added to the sample to arrest the enzymatic degradation process. Stability of PP (5 μg/ml) in IBPS was also studied as a control, and the values were subtracted from the overall reaction rates to estimate the enzyme-mediated degradation rates. The bioconversion rates were normalized to the protein content in the tissue homogenates.

Analytical Procedures. Ocular tissue collection and sample preparation. With respect to studies involving ocular distribution of PP and erythromycin after topical application, vitreous and aqueous humor were collected as described previously (Majumdar et al., 2009). Ocular tissues, such as iris-ciliary bodies, lens, and retina/choroid, were weighed and homogenized in ice-cold IPBS or methanol using a Tissuemiser (Thermo Fisher Scientific). Homogenates were further diluted with an ice-cold acetonitrile-methanol (50:50) mixture, centrifuged, and analyzed for drug content. Centrifugation was performed at 13,000 rpm for 20 min at 4°C. Aqueous and vitreous humor samples were used as such or diluted with methanol and taken for analysis. The extraction efficiency of PP and erythromycin from ocular tissues was >95%.

HPLC analysis. Microdialysis and plasma samples were analyzed for quinidine content using a reverse-phase HPLC procedure as described previously (Duvvuri et al., 2003a). The HPLC system comprised a Waters 717 Plus autosampler, a Waters 2475 multil λ fluorescence detector, a Waters 600 controller pump (Waters Corporation, Milford, MA), and an Agilent 3395 integrator (Agilent Technologies, Santa Clara, CA). A Symmetry C18 4.6 × 250-mm column was used, and the mobile phase consisted of 20 mM phosphate buffer (pH 2.5) with 12% acetonitrile at a flow rate of 1 ml/min. Excitation and emission wavelengths were set at 250 and 440 nm, respectively. Microdialysis samples were directly injected into the high-performance liquid chromatography (HPLC) system. The mobile phase consisted of water with 0.1% formic acid (A) and acetonitrile with 0.1% formic acid (B) at a flow rate of 0.3 ml/min, with the following gradient elution: 0 min, 75% A/25% B to 20% A/80% B over 10 min. Each run was followed by a 5-min wash with 100% B and an equilibration period of 11 min with 75% A/25% B. The total run time for analysis was 10 min. Ten microliters of the sample was injected, and peaks were assigned with respect to the mass of the compounds and comparison of the retention times. The limit of detection of erythromycin was 0.05 ng/ml, and each sample contained 100 ng/ml IS. This method involved the use of the [M + H]+ ions in the positive ion mode with extractive ion monitoring. In the positive ion mode, the protonated species [M + H]+ at m/z 734.4680 for erythromycin and 837.5324 for IS was observed.

Data analysis. Noncompartmental pharmacokinetic analysis was performed for the quinidine concentration-time profile in the vitreous humor using WinNonlin (version 5.2; Pharsight, Mountain View, CA). The pharmacokinetic parameters were calculated using the formulae described earlier (Majumdar et al., 2009). In brief, terminal slopes of the vitreous concentration-time profile were estimated by log-linear regression, and the apparent elimination rate constant (λ1) was then derived from the slope. Elimination half-life (t1/2) was calculated from the equation: t1/2 = 0.693/λ1. The area under the vitreal concentration-time curve (AUC0–t) and the area under the moments curve (AUMC0–t) were estimated by the trapezoidal rule. The mean residence time (MRT) was calculated using the equation MRT = AUMC0–t/AUC0–t. The total clearance was calculated as CL = Dose/AUC0–t. The peak vitreal concentration (Cmax) and the time to reach the peak concentration (tmax) were determined from the observed values.

The time course of plasma quinidine concentration, after a single systemic dose was best described by a two-compartment open model as expressed in eq. 3:

[C] = Ae−at + Be−bt

(3)

where A and B are zero-time concentration coefficients, t is the time (minutes), and a and b are the disposition rate constants of the initial and terminal phases, respectively. The rate constant of drug transfer from the apparent peripheral to the apparent central compartment (k12), elimination rate constant from the apparent central compartment (k21), and rate constant of quinidine transfer from the apparent central compartment to the apparent peripheral compartment (k12) were calculated as described previously (Majumdar et al., 2009). Data obtained were analyzed statistically using one-way analysis of variance followed by a post hoc Dunnnett’s test for multiple comparison (IMP software;
VENOUSLY ADMINISTERED QUINIDINE, TOPICALLY INSTILLED VERAPAMIL (100 mg/ml), AND, THEREFORE, SOLUTIONS WERE PREPARED IN STERILE IPBS AT pH 6.0. WITH RESPECT TO THE VITREAL PHARMACOKINETIC PARAMETERS OF INTRA-VENOUSLY ADMINISTERED QUINIDINE, TOPICALLY INSTILLED VERAPAMIL (100 μL OF 1%, w/v), ADMINISTERED AT 2, 4, AND 6 h AFTER SYSTEMIC QUINIDINE ADMINISTRATION, PRODUCED A 1.9-FOLD INCREASE IN THE MRT (FROM 232 ± 20 TO 435 ± 20 min), A 2.2-FOLD DECREASE IN THE $\lambda_e$ FROM 0.0058 ± 0.0006 TO 0.0027 ± 0.0002 min$^{-1}$ AND A 2.3-FOLD INCREASE IN THE AUC$_{0-\infty}$ OF QUINIDINE IN THE VITREOUS HUMOR.

**Effect of Topically Applied PP on Vitreal Kinetics of Systemically Administered Quinidine.** PP is a phosphate ester of prednisolone and is currently marketed in the United States as an ophthalmic anti-inflammatory formulation. Therefore, the effect of topically administered PP on the vitreal kinetics of systemically administered quinidine (5 mg/kg) was investigated (Fig. 2). One hundred micromolars of a 1% w/v PP solution was instilled at 2, 4, and 6 h after quinidine administration. Table 1 presents the vitreal pharmacokinetic parameters of quinidine. Topical PP coadministration produced a 1.7-fold decrease in $\lambda_e$ (from 0.0058 ± 0.0006 to 0.0035 ± 0.0001 min$^{-1}$), a 1.7-fold increase in $t_{1/2}$, and a 1.3-fold increase in the MRT. Moreover, a 1.5-fold increase in the vitreal AUC$_{0-\infty}$ of quinidine, compared with that of the control, was observed when PP was coadministered.

**Effect of Topical Erythromycin on Vitreal Kinetics of Systemically Administered Quinidine.** Vitreal kinetics of intravenous quinidine (5 mg/kg) was also studied either alone or in the presence of topically administered erythromycin in the form of the marketed erythromycin ophthalmic ointment. In this set of studies, 100 mg of the ointment (0.5% w/w) was applied topically 2 h after systemic quinidine administration. Figure 3 depicts the vitreous concentration-time profile of quinidine alone or in the presence of topically administered erythromycin. The vitreal pharmacokinetic parameters are presented in Table 1. In the control group, the $\lambda_e$ for quinidine was found to be 0.0058 ± 0.0006 min$^{-1}$ whereas in the presence of topical erythromycin, it was found to be 0.0040 ± 0.0002 min$^{-1}$. A corresponding 1.5-fold increase in the vitreal elimination half-life ($t_{1/2}$) was also observed. In addition, a significant increase in the AUC$_{0-\infty}$ and MRT of quinidine in the vitreous humor was evident.

**Results**

**Effect of Topically Applied Verapamil on the Vitreal Kinetics of Systemically Administered Quinidine.** The vitreal concentration-time profile of quinidine after systemic administration (5 mg/kg) alone (control) or in the presence of topically administered verapamil is illustrated in Fig. 1, and the pharmacokinetic parameters are provided in Table 1. Verapamil HCl displayed low solubility at pH 7.4 (1% w/v), administered at 2, 4, and 6 h after systemic quinidine administration. Figure 1 illustrates the vitreal concentration-time profile of quinidine alone or in the presence of topically coadministered verapamil, PP, and erythromycin.

![Figure 1. Vitreal concentration-time profile of quinidine (5 mg/kg, systemic administration) alone (control) or in the presence of topically coadministered verapamil (1% w/v; 100 μl administered at 2, 4, and 6 h after quinidine administration). Arrows indicate time of inhibitor administration. Data points represent mean ± S.D. of four determinations.](image-url)

**TABLE 1**

Vitreal pharmacokinetic parameters of systemically administered quinidine (5 mg/kg) alone or in the presence of topically coadministered verapamil, prednisolone sodium phosphate ophthalmic solution (USP, 1% w/v), and erythromycin ointment

Verapamil and prednisolone sodium phosphate were administered at 2, 4, and 6 h after systemic quinidine administration. A single dose of erythromycin ophthalmic ointment (100 mg) was applied at 2 h after quinidine administration. A single control group (quinidine) was compared with each treatment group. Values represent means ± S.D. (n = 4).

<table>
<thead>
<tr>
<th>Kinetic Parameters</th>
<th>Quinidine</th>
<th>Quinidine + Verapamil (1% w/v)</th>
<th>Quinidine + Prednisolone (1% w/v)</th>
<th>Quinidine + Erythromycin (0.5% w/v)</th>
</tr>
</thead>
<tbody>
<tr>
<td>$A_l$ (min$^{-1}$)</td>
<td>0.0058 ± 0.0006</td>
<td>0.0027 ± 0.0002***</td>
<td>0.0035 ± 0.0001**</td>
<td>0.0040 ± 0.0002***</td>
</tr>
<tr>
<td>$\lambda_e$ half-life (min)</td>
<td>120 ± 14</td>
<td>256 ± 24***</td>
<td>198 ± 21*</td>
<td>173 ± 11*</td>
</tr>
<tr>
<td>$t_{1/2}$ (min)</td>
<td>115 ± 30</td>
<td>146 ± 23</td>
<td>120 ± 40</td>
<td>115 ± 30</td>
</tr>
<tr>
<td>$C_{max}$ (μg/ml)</td>
<td>0.06 ± 0.02</td>
<td>0.08 ± 0.01</td>
<td>0.07 ± 0.007</td>
<td>0.08 ± 0.02</td>
</tr>
<tr>
<td>AUC$_{0-\infty}$ (μg·min/ml)</td>
<td>17 ± 3</td>
<td>39 ± 7.0*</td>
<td>26 ± 2.0*</td>
<td>32 ± 9*</td>
</tr>
<tr>
<td>AUC$_{0-t}$ (μg·min/ml)</td>
<td>16 ± 2</td>
<td>28 ± 5.0*</td>
<td>22 ± 1.6*</td>
<td>28 ± 9*</td>
</tr>
<tr>
<td>VZ, F (ml)</td>
<td>50.64 ± 2486</td>
<td>47,661 ± 4490</td>
<td>47,708 ± 5245</td>
<td>38,592 ± 10690</td>
</tr>
<tr>
<td>CL, F (ml/min)</td>
<td>296 ± 46</td>
<td>131 ± 21***</td>
<td>193 ± 15*</td>
<td>161 ± 50***</td>
</tr>
<tr>
<td>AUMC$_{0-\infty}$ (μg·min²/ml)</td>
<td>4024 ± 926</td>
<td>17225 ± 4230***</td>
<td>7519 ± 1289*</td>
<td>10328 ± 3424*</td>
</tr>
<tr>
<td>MRT$_{z}$ (min)</td>
<td>232 ± 20</td>
<td>435 ± 20***</td>
<td>288 ± 30*</td>
<td>310 ± 23**</td>
</tr>
</tbody>
</table>

VZ, F, volume of distribution; CL, F, clearance.
* $P < 0.05$, difference from control.
** $P < 0.01$.
*** $P < 0.001$ (difference from control).
information criterion and the Schwarz Bayesian criterion values (minimum for the two-compartment model compared with one- and three-compartment models). Therefore, a two-compartment open model was used to calculate the pharmacokinetic parameters. The plasma pharmacokinetic parameters of quinidine, such as elimination half-life, CL, AUC, $k_{10}$, $k_{21}$, $k_{12}$, steady-state volume of distribution, and apparent elimination rate constant remained unchanged in the presence of the topically coadministered inhibitors (Table 2).

**Ocular Tissue Distribution of PP and Erythromycin after Topical Administration.** Table 3 presents concentrations of PP and
TABLE 2

Plasma pharmacokinetic parameters of systemically administered quinidine (5 mg/kg) alone or in the presence of topically coadministered verapamil, prednisolone sodium phosphate ophthalmic solution (USP, 1% w/w), and erythromycin ointment

Verapamil and prednisolone sodium phosphate were administered at 2, 4, and 6 h after systemic quinidine administration. A single dose of erythromycin ophthalmic ointment (100 mg) was applied at 2 h after quinidine administration. No significant differences in the parameters were observed. A single control group (quinidine) was compared with each treatment group. Values represent means ± S.D. (n = 4).

<table>
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<tr>
<th>Kinetic Parameters</th>
<th>Quinidine</th>
<th>Quinidine + Verapamil (1% w/v)</th>
<th>Quinidine + Prednisolone (1% w/v)</th>
<th>Quinidine + Erythromycin (0.5% w/w)</th>
</tr>
</thead>
<tbody>
<tr>
<td>( k_i ) (min(^{-1}))</td>
<td>0.015 ± 0.003</td>
<td>0.015 ± 0.007</td>
<td>0.015 ± 0.002</td>
<td>0.027 ± 0.02</td>
</tr>
<tr>
<td>( k_{12} ) (min(^{-1}))</td>
<td>0.021 ± 0.015</td>
<td>0.027 ± 0.011</td>
<td>0.040 ± 0.009</td>
<td>0.047 ± 0.04</td>
</tr>
<tr>
<td>( k_{32} ) (min(^{-1}))</td>
<td>0.024 ± 0.016</td>
<td>0.020 ± 0.007</td>
<td>0.031 ± 0.015</td>
<td>0.02 ± 0.004</td>
</tr>
<tr>
<td>AUC (( \mu g \cdot min/ml ))</td>
<td>210 ± 20</td>
<td>233 ± 65</td>
<td>235 ± 54</td>
<td>231 ± 35</td>
</tr>
<tr>
<td>( k_{i0} \cdot t_{1/2i} ) (min)</td>
<td>52 ± 21</td>
<td>52 ± 20</td>
<td>48.5 ± 9</td>
<td>37 ± 15</td>
</tr>
<tr>
<td>CL (ml/min)</td>
<td>25 ± 3</td>
<td>23 ± 8</td>
<td>22 ± 5.5</td>
<td>22 ± 4</td>
</tr>
<tr>
<td>MRT(_h) (min)</td>
<td>144 ± 58</td>
<td>170 ± 63</td>
<td>189 ± 44</td>
<td>142 ± 33</td>
</tr>
<tr>
<td>( V_e ) (ml)</td>
<td>3756 ± 1636</td>
<td>3588 ± 487</td>
<td>3719 ± 1314</td>
<td>3196 ± 1276</td>
</tr>
<tr>
<td>( \beta ) (min(^{-1}))</td>
<td>0.006 ± 0.001</td>
<td>0.005 ± 0.002</td>
<td>0.0055 ± 0.001</td>
<td>0.0057 ± 0.001</td>
</tr>
<tr>
<td>( \beta \cdot t_{1/2} ) (min)</td>
<td>135 ± 83</td>
<td>142 ± 53</td>
<td>134 ± 38</td>
<td>124 ± 23</td>
</tr>
</tbody>
</table>

TABLE 3

Ocular distribution of verapamil, prednisolone sodium phosphate, and erythromycin ophthalmic ointment after topical administration

Prednisolone sodium phosphate (100 μl of a 1% w/v solution applied 2, 4, and 6 h after systemic administration) and erythromycin (100 mg of 0.5% w/w ointment applied at 2 h after systemic administration) tissue concentrations were determined 9 h after topical administration. PP values are reported for both intact PP and free prednisolone concentrations observed.

Verapamil tissue concentrations were determined 7 h after topical administration (100 μl of a 1% w/v solution applied 2, 4, and 6 h after intravitreal quinidine administration). Values represent means ± S.D. (n = 4).

<table>
<thead>
<tr>
<th>Tissues</th>
<th>Topical Application of 1% w/v Verapamil(^a)</th>
<th>Topical Application of 0.5% w/w Erythromycin</th>
<th>Topical Application of 1% w/v PP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aqueous humor (μg/ml)</td>
<td>7.9 ± 3.2</td>
<td>4.7 ± 1.0</td>
<td>11 ± 5.4</td>
</tr>
<tr>
<td>Iris-ciliary body (μg/g)</td>
<td>4.4 ± 1.6</td>
<td>1.53 ± 0.31</td>
<td>4.1 ± 0.6</td>
</tr>
<tr>
<td>Lens (μg/g)</td>
<td>6.3 ± 1.2</td>
<td>0.26 ± 0.04</td>
<td>16.0 ± 4.0</td>
</tr>
<tr>
<td>Vitreous humor (μg/ml)</td>
<td>0.086 ± 0.003</td>
<td>1.4 ± 0.15</td>
<td>1.8 ± 0.01</td>
</tr>
<tr>
<td>Retina-choroid (μg/g)</td>
<td>47.0 ± 8.1</td>
<td>1.74 ± 0.05</td>
<td>3.0 ± 1.2</td>
</tr>
</tbody>
</table>

\(^a\) Values from our previous study (Majumdar et al., 2009).

\(^b\) Generated as a result of bioconversion of PP in the ocular tissues.

TABLE 4

Apparent first-order degradation rate constants and half-lives of PP in ocular tissue homogenates (1 mg/ml protein content)

Values represent means ± S.D. (n = 4).

<table>
<thead>
<tr>
<th>Drug/Kinetic Parameters</th>
<th>Control</th>
<th>Aqueous Humor</th>
<th>Vitreous Humor</th>
<th>Iris-Ciliary Body</th>
<th>RPE/Choroid</th>
</tr>
</thead>
<tbody>
<tr>
<td>( k ) (×10(^{-3}) min(^{-1}))</td>
<td>0.36 ± 0.03</td>
<td>22.5 ± 4.0</td>
<td>0.83 ± 0.02</td>
<td>2.9 ± 0.09</td>
<td>3.17 ± 0.05</td>
</tr>
<tr>
<td>( t_{1/2} ) (min)</td>
<td>1933 ± 160</td>
<td>31 ± 6.0</td>
<td>835 ± 17.0</td>
<td>239 ± 8.0</td>
<td>218 ± 4.0</td>
</tr>
</tbody>
</table>

Discussion

The role of RPE P-gp in limiting the penetration of systemically or periocularly administered substrates into the posterior chamber of the eye is well established (Majumdar et al., 2009). We were surprised to find that very few studies have focused on strategies to overcome the efflux activity of this RPE P-gp. Duvvuri et al. (2003a) reported inhibition of the RPE P-gp with the help of an intravitreal inhibitor. In another in vivo study, Senthikumari et al. (2008a) demonstrated that systemically administered P-gp inhibitors significantly altered the ocular tissue concentrations of an intravitreally injected P-gp substrate. However, both routes of inhibitor administration have major drawbacks such as concerns associated with intravitreal injections and nonspecific systemic exposure of the inhibitor from intravenous administration and the limited, clinically relevant, inhibitor dose that can be administered (Majumdar et al., 2009).

In our previous study exploring the feasibility of a novel approach for inhibiting the RPE P-gp, we demonstrated that topical inhibitors could decrease the elimination rate of intravitreally administered P-gp.
substrates (Majumdar et al., 2009). In the present study, we carried this investigation further to examine the effect of administration of a topical substrate/inhibitor on the ocular penetration of a systemically administered P-gp substrate. Although systemic administration of ophthalmic drugs also poses nonspecific systemic exposure concerns, this novel topical substrate/inhibitor coadministration approach could help decrease the systemic dose necessary to achieve an ocular therapeutic response.

The $C_{\text{max}}$ and $T_{\text{max}}$ of quinidine in the vitreous humor were observed to be 0.06 ± 0.02 $\mu$g/ml and 115 ± 30 min, respectively. The vitreal AUC of quinidine was found to be 8% of the systemic AUC (Tables 1 and 2). These results are consistent with previous literature reports (Duvvuri et al., 2003a). Coadministration of topical verapamil and PP at 2, 4, and 6 h after systemic (intravenous) quinidine administration resulted in a significant decrease in the apparent vitreal $\lambda_2$ and in an increase in the vitreal $t_{1/2}$ and MRT of quinidine (Table 1; Figs. 1 and 2). Consistent with this result, erythromycin also produced a significant decrease in the vitreal $\lambda_2$ and an increase in the vitreal $t_{1/2}$ and MRT of quinidine (Table 1; Fig. 3). These findings strongly suggest that topically coadministered P-gp inhibitors interact with the RPE P-gp, resulting in decreased vitreal elimination of the systemically administered P-gp substrate.

Duvvuri et al. (2003a) reported a significant increase in the $C_{\text{max}}$ and the rate of entry of quinidine into the vitreous and a significant decrease in the $T_{\text{max}}$ of quinidine after systemic administration of quinidine and intravitreal administration of the inhibitor. However, in the present study a statistically significant difference in the $C_{\text{max}}$ and $T_{\text{max}}$ of quinidine in the vitreous humor, on topical coadministration of the three inhibitors, was not observed (Table 1). This result may be explained by the fact that Duvvuri et al. (2003a) administered the intravitreal inhibitor 20 min before systemic quinidine administration, whereas in the present study the inhibitors were applied 2 h after quinidine administration, by which time the vitreal quinidine absorption phase would have been over.

Significant differences in the central compartment pharmacokinetic parameters of quinidine in the presence and absence of topically coadministered verapamil, PP, or erythromycin were not observed (Table 2; Fig. 4). These findings strongly suggest that the quinidine doses administered across groups were uniform and that the observed effect of the topically coadministered verapamil, PP, and erythromycin on the vitreal kinetics of quinidine was a result of modulation of the efflux activity of RPE P-gp.

Topically coadministered verapamil produced a 1.7-fold decrease in the terminal elimination rate constant of intravitreally administered quinidine, whereas $AUC_{0-\infty}$ and CL remained unchanged (Majumdar et al., 2009). Here, however, verapamil, with a similar dosing regimen, generated a greater (2.2-fold) decrease in the elimination rate constant of quinidine from the vitreous humor and also a significant increase in the vitreal $AUC_{0-\infty}$ and a decrease in CL. These are probably due to lower quinidine concentrations generated at the P-gp binding site in the RPE cytosol on intravenous administration. At the end of 2 h, when the topical inhibitors were administered, the free plasma quinidine concentration was 0.05 $\mu$g/ml [considering almost 80 to 90% protein binding (Guentert and Oie, 1980; Ochs et al., 1980)], and the free vitreal quinidine concentration achieved was 0.06 $\mu$g/ml after systemic administration (current study), whereas the vitreal free concentration of quinidine was 0.3 $\mu$g/ml (as estimated using microdialysis) after intravitreal injection. If we assume that similar verapamil concentrations were generated at the RPE/choroid after topical administration in both studies, the verapamil/quinidine ratio would be significantly higher at the RPE P-gp binding site when quinidine is administered systemically. This results in greater inhibition and thus a significant decrease in the CL and elimination rate constant and a significant increase in the vitreal $AUC_{0-\infty}$ in the presence of verapamil compared with the effects of intravitreal administration (Majumdar et al., 2009).

Interestingly, 1% w/v PP produced a greater decrease in the vitreal $\lambda_2$ compared with 1% w/v prednisolone hemisuccinate sodium (PHS) in our earlier study (Majumdar et al., 2009). In addition, a statistically significant difference in the $AUC_{0-\infty}$ and CL of quinidine was also observed in the presence 1% w/v PP. This can be explained by the low concentrations of quinidine generated in the vitreous humor (after systemic administration), by the rapid bioreversion rates of PP to prednisolone, and by the formulation components of the PP ophthalmic solution. Prednisolone and not PP is known to interact with P-gp (Majumdar et al., 2009). In vitro metabolism studies confirmed faster bioreversion of PP to prednisolone in the RPE/choroid (t1/2 218 min) compared with that of the hemisuccinate ester (PHS) (t1/2 578 min) (Majumdar et al., 2009), possibly as a result of differences in the phosphatase and esterase levels in the ocular tissues (Attar et al., 2005).

It is also interesting to note that topical PP (1%) generated significantly higher concentrations of prednisolone (15.0 ± 2.0 $\mu$g/ml) in the vitreous humor compared with the vitreal prednisolone levels achieved with topical 2% PHS (0.49 ± 0.29 $\mu$g/ml) (Majumdar et al., 2009). Moreover, 2% PHS generated only 16.7 ± 1.6 $\mu$g/ml prednisolone in the RPE/choroid tissue (Majumdar et al., 2009), whereas 1% w/v PP generated 43 ± 10 $\mu$g/ml (Table 3) of prednisolone. The higher levels of prednisolone obtained in the posterior segment ocular tissues support our earlier observation that hydrophilic moieties on topical application tend to permeate to the back-of-the-eye tissues better (Majumdar et al., 2009). In addition, the PP formulation used in this study contains benzalkonium chloride (BAK) (0.01% w/v) and EDTA as formulation components. The role of BAK and EDTA in enhancing corneal, conjunctival, and scleral permeation of compounds is well documented (Scholz et al., 2002; Okabe et al., 2005; Majumdar et al., 2008). Thus, PP might have diffused across the conjunctiva and into the sclera much more efficiently, generating higher PP and prednisolone concentrations in the RPE/choroid. The significantly higher PP and prednisolone concentrations in the aqueous humor, lens, and iris-ciliary body also support enhanced transcorneal PP permeation in the presence of BAK and EDTA and rapid generation of prednisolone in the aqueous humor. Prednisolone, being very lipophilic, would then rapidly partition into the anterior segment ocular tissues and then laterally migrate along the iris-ciliary body to the sclera and then to the RPE and vitreous humor. Thus, overall, the results suggest that BAK and EDTA enhanced penetration of PP into the back-of-the-eye tissues.

The levels of verapamil (approximately 0.2 $\mu$M) obtained in the vitreous humor (1 h after the last dose) (Majumdar et al., 2009) were much lower compared with those of PP (approximately 3.7 $\mu$M) and prednisolone (approximately 41 $\mu$M) in the vitreous humor even at 3 h after the last dose. Although similar concentrations of prednisolone (43 ± 10.0 $\mu$g/l; approximately 120 $\mu$M) and verapamil (47 ± 8.1 $\mu$g/l; approximately 95 $\mu$M) (Majumdar et al., 2009) were generated at the RPE/choroid in both studies, the extent of RPE P-gp inhibition was less with prednisolone than with verapamil (Table 1), probably because verapamil is a more potent P-gp inhibitor (prednisolone IC50 is 300 $\mu$M compared with IC50 of 4.7 $\mu$M for verapamil; a 65-fold difference) (Schwab et al., 2003; Harirahan et al., 2009).

Furthermore, in our previous study, erythromycin, at a concentration of 0.2% w/v, applied at 2, 4, and 6 h after intravitreal quinidine administration did not significantly affect the pharmacokinetic param-
ers of quinidine (Majumdar et al., 2009). On the contrary, in the present investigation erythromycin ophthalmic ointment produced a statistically significant difference in the vitreal $\lambda_{o}$, AUC$_{0-\infty}$, CL, and MRT of systemically administered quinidine. A single application of the ointment, 100 mg of 0.5% w/v applied 2 h after systemic quinidine administration, produced significant levels of erythromycin in the vitreous humor and RPE/choroid, even 7 h after erythromycin application, suggesting depot formation and sustained release of the drug from the residual formulation in the cul-de-sac. The observed effect on quinidine pharmacokinetics can probably be explained by the higher ocular tissue concentrations of erythromycin achieved in this study and the low concentrations of free quinidine in the plasma and RPE (as discussed earlier) and thus a higher erythromycin/quinidine ratio in the RPE P-gp microenvironment.

Besides P-gp, the RPE is known to express other transporters (e.g., multidrug-resistant proteins and organic anion-transporting polypeptides) (Hughes et al., 2005) with which quinidine may interact (Makhey et al., 1998; Vezmar and Georges, 2000; Shitara et al., 2002). Although quinidine is a preferred substrate of P-gp and has been widely used as a P-gp substrate/inhibitor (Kusuhara et al., 1997; Duvvuri et al., 2003a; Jain et al., 2004; Suzuki et al., 2007), some involvement of other transporters cannot be ruled out completely. Future studies to optimize this approach will involve more specific P-gp/multidrug-resistant protein inhibitors and substrates. In addition, the effect of inhibitor type, concentration, time of application, and time course of inhibitors in the vitreous, plasma, and other ocular tissues after topical application on ocular kinetics of systemically/intravitreally administered P-gp substrates will also be the object of consideration in our future studies.

In conclusion, this study demonstrates for the first time that topically applied P-gp inhibitors can diffuse to the RPE and alter the elimination kinetics of a systemically administered P-gp substrate, probably through inhibition of the RPE P-gp. The degree of inhibition will depend on the physicochemical characteristics of the inhibitor and its affinity for P-gp and the concentration of the therapeutic agent in the plasma or vitreous humor. Formulation factors such as inclusion of permeation and viscosity enhancers may play a major role in yielding effective levels of the inhibitor at the RPE. This interaction may be used positively for drug delivery purposes through the use of potent, pharmacologically inactive, efflux inhibitors.

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References
