Proton Pump Inhibitors Inhibit Methotrexate Transport by Renal Basolateral Organic Anion Transporter hOAT3

Rym Chioukh, Marie-Sophie Noel-Hudson, Sandy Ribes, Natalie Fournier, Laurent Becquemont, and Celine Verstuyft

ABSTRACT

The coadministration of methotrexate (MTX) and proton pump inhibitors (PPIs) can result in a pharmacokinetic interaction that delays MTX elimination and subsequently increases the MTX blood concentrations. Human organic anion transporters (hOATs) are responsible for the renal tubular secretion of MTX and are thought to be involved in this drug interaction. The aim of this study was to evaluate the inhibitory potencies of PPIs on hOAT1 and hOAT3, which are the two isoforms of OATs predominantly expressed in kidney proximal tubules. Using stably transfected cell systems that express the uptake transporters human embryonic kidney (HEK)-hOAT1 and HEK-hOAT3, we analyzed the inhibitory potencies of omeprazole, lansoprazole, and pantoprazole on hOAT1 in a concentration-dependent manner (IC50 = 4.32 ± 1.26, 7.58 ± 1.06, and 63.21 ± 4.74 µM, respectively). These in vitro results suggest that PPIs inhibit [3H]MTX transport via hOAT3 inhibition, which most likely explains the drug-drug interactions between MTX and PPIs and should be considered for other OATs substrates.

Introduction

Methotrexate (MTX), an antifolate drug, is used in a wide range of doses for the treatment of certain neoplastic diseases, severe psoriasis, and rheumatoid arthritis (Jolivet et al., 1983; Tugwell et al., 1987). High-dose MTX is widely accepted as the first line treatment of lymphoid malignancy, osteogenic sarcoma, and acute leukemia, with intravenous doses ranging from 300 mg/m2 to 12 g/m2. MTX is a highly toxic drug with a low therapeutic index. The therapeutic drug monitoring of MTX is essential to prevent toxicity from high plasma MTX concentrations, because delayed elimination can result in serious and potentially life-threatening toxicities.

Renal excretion is the primary route of MTX elimination. In humans 80 to 90% of the intravenous administered dose is excreted unchanged in the urine within 24 hours (Shen and Azarnoff, 1978). Renal excretion occurs via glomerular filtration and active tubular secretion mediated in proximal tubular cells uptake, followed by active efflux in tubular lumen. Organic anion transporters are responsible for the passage from the blood to proximal tubules (uptake). Many transporters of organic anionic drugs have been identified on the apical side of the human kidney epithelium, including multidrug-resistance–related protein (MRP2, ABCB2, MRP4, ABCB4) and breast cancer resistance protein (BCRP, ABCG2), which are responsible for the secretion into the urine (Takeda et al., 2002a; Burckhardt and Burckhardt, 2003; Launay-Vacher et al., 2006; Nozaki et al., 2007; VanWert and Sweet, 2008). Among human organic anion transporters (hOATs), hOAT1 and hOAT3 localize to the basolateral membrane of proximal tubular epithelial cells and have been shown to transport MTX (Uwai et al., 1998; Nozaki et al., 2007; Rizwan and Burckhardt, 2007). Members of the OAT family transport a variety of endogenous substances and drugs, including antineoplastic agents, antiviral agents, β-lactam–antibiotics, diuretics, and angiotensin-converting enzyme inhibitors (Takeda et al., 2002b; Uwai et al., 2007; Vallon et al., 2008; Vanwert et al., 2008).

Several drugs, including nonsteroidal anti-inflammatory drugs (Nozaki et al., 2007; Uwai et al., 2004; Maeda et al., 2008), penicillin G (Takeda et al., 2002b), and probenecid (Ahene et al., 1978), are known to inhibit the elimination of MTX. The molecular mechanism underlying these interactions partially relies on the blockade of the renal secretion of antifolate via the basal uptake transporters hOAT3 and hOAT1 (Giacomini et al., 2010).
Over the past few years, several case reports in oncology (Reid et al., 1993; Beorlegui et al., 2000; Troger et al., 2002; Bauters et al., 2008) and two retrospective cohort studies (Suzuki et al., 2009; Santucci et al., 2010) have suggested that the coadministration of proton pump inhibitors (PPIs), including omeprazole, pantoprazole, lansoprazole, and rabeprazole, decreased the renal clearance of MTX. The elimination of MTX was significantly delayed during cycles with one PPI but normalized during subsequent cycles after PPI discontinuation or substitution with ranitidine.

Because PPIs are frequently used among patients treated with MTX for cancer or autoimmune diseases, we aimed to investigate the drug-drug interaction of MTX with PPIs.

To elucidate the PPI-MTX drug interaction, we used cell systems that stably express the human uptake transporters OAT1 and OAT3 and investigated the effect of the three more commonly prescribed PPIs (omeprazole, lansoprazole, and pantoprazole) on the uptake of OAT substrates.

Materials and Methods

Radiolabeled.

\[ \text{[3H]} \] estrone sulfate ([3H]ES; 250 μCi; 9.25 MBq; 54.26 Ci/mmol, 2.0762 TBq/nmol); 99.5% purity; [3H]-[3H]-aminophenylurate ([3H]-HPAH; 1 μCi/ml; 37 mBq; 4.53 Ci/mmol, 167.61 GBq/nmol); 99% purity, were purchased from Perkin Elmer (Waltham, MA). [3H]methotrexate ([3H]MTX; 250 μCi; 9.25 MBq; 32.32 Ci/mmol; 99% purity) was purchased from Moravek Biochemicals (Brea, CA).

Unlabeled. p-Aminophenyluracil and estrone sulfate, which are both well-established substrates of hOAT1 and hOAT3, respectively (Burchardt, 2012), were purchased from Sigma-Aldrich (St. Louis, MO). Methotrexate ((2S)-2-[(2,4-diaminophenotetritin-6)-methyl][methyllamino][phenyl]formamido)[pentanedic acid] was obtained from Interchem (Monto-la-Chaine, France).

The inhibitory chemicals, probenecid ([4-dipropylsulfamoyl][benzoic acid], ibuprofen (2-[4-(2-methylpropyl)phenyl]propanoic acid), omeprazole (6-methoxy-32.3 Ci/mmol); sulfonamide [H]-sulfonic acid (DMSO). The concentration of DMSO in the final study was 1% of the aliquots was determined in 4 ml of Ultimia-Gold, a scintillation fluid, using a scintillation counter (liquid scintillation counter, Tri-carb 2900TR, Perkin Elmer). The cellular protein content was determined using the BCA-protein quantification system. Uptake was then normalized to the protein content in the lysates.

Transformations for kinetic calculations were performed using GraphPad Prism software version 4 (GraphPad Software, San Diego, CA), and the Km and Vmax values were calculated from the x and y intercepts of the Lineweaver-Burk plot, respectively. The Kp values were calculated assuming competitive inhibition.

Western Blotting Analysis. Total proteins were extracted from the pellets containing HEK293 cells by homogenizing the pellets in TENTS [10 mM Tris-HCl at pH 7.4, 5 mM EDTA at pH 8, 126 mM NaCl, 1% (v/v) Triton X-100, and 0.1% (v/v) SDS]) supplemented with leupeptin, aprotinin, pepstatin, and phenyl methyl sulfonate fluoride (Sigma-Aldrich). The suspensions were gently agitated for 1 hour at 4°C and then centrifuged at 12,000g for 20 minutes. The protein content of the supernatant was determined using the BCA assay. Next, 25 μg of protein was separated by electrophoresis using the NuPage Novex Bis Tris MiniGels (Invitrogen) according to the manufacturer’s protocol and transferred electrophoretically onto nitrocellulose membranes. Free binding sites on the membranes were blocked by incubation with Tris-buffered saline containing 0.1% of Tween-20 (TTBS) and 10% nonfat dried milk for 1 hour at 20–25°C. The membranes were washed with TTBS and incubated with primary antibodies (anti-hOAT1 rabbit OAT3 (P-13), Santa Cruz Biotechnology, Inc. Santa Cruz, CA) and anti-hOAT1 rabbit (Sigma-Aldrich, Inc.) overnight at 4°C. The secondary antibodies were diluted 1:500. The membranes were then washed with TTBS (5 times for 10 minutes each) and then incubated with secondary antibodies diluted at 1:1,000 for 1 hour at 20–25°C. The secondary antibodies were purchased from Dako (Glostrup, Denmark).

The membranes were washed again (5 times for 10 minutes) with TTBS and probed with the Western Lightning Chemiluminescence Reagent (Perkin Elmer).

Quantitative Real-Time Polymerase Chain Reaction. Quantitative real-time polymerase chain reaction (PCR) was performed for hOAT1 and hOAT3. RNA prepared from HEK mock, HEK-hOAT1, and HEK-hOAT3 was purified on RNeasy columns (Qiagen, Valencia, CA) and then reverse transcribed using Transcriptor First Strand cDNA Synthesis Kit (Roche Applied Science, Nutley, NJ) using oligo-dT as a primer. Each cDNA sample was subjected to duplicate real-time PCR reactions using a CFX96 (Bio-Rad, Hercules, CA) thermal cycler with the following conditions: initial denaturation (95°C for 30 seconds) followed by 44 cycles of denaturation (95°C for 2 seconds), hybridization-extension (60°C for 5 seconds).

Gene expression values were normalized to that of GAPDH in the corresponding cDNA samples.

Kinetic Analyses. Transformations for kinetic calculations were performed using GraphPad Prism software version 4 (GraphPad Software, and the Km and Vmax values were calculated from the x and y intercepts of the Lineweaver-Burk plot, respectively. The IC50 values were calculated assuming competitive inhibition. The kinetic parameters were obtained using the following Michaelis-Menten equation: one saturable component,
\[
V = \frac{V_{\text{max}} [S]}{K_m + [S]}
\]

Where \(V\) is the uptake velocity of the substrate (pmoles per milligram of protein per minute), \(S\) is the substrate concentration of the medium (micromolar), \(K_m\) is the Michaelis constant (micromolar), \(V_{\text{max}}\) is the maximal uptake velocity (pmoles per milligram of protein per minute).

**Statistics.** The uptake experiments were performed in triplicate, where the values are expressed as the mean of these replicates with error bars representing the standard error. All experiments were performed at least three times over three independent experiments in triplicate. Statistical significance was calculated using unpaired Student’s t-test. Differences were considered statistically significant if \(P < 0.05\).

**Results**

**Characterization of hOAT1- and hOAT3-Expressing HEK Cells.** To test the inhibitory potencies of PPIs in vitro, we stably transfected HEK cells with cDNAs encoding human OAT1, the SLC22A6 gene, or human OAT3, the SLC22A8 gene. We validated these models by examining the presence of the proteins and the function of HEK-hOAT1– or HEK-hOAT3–transfected cells. The gene and protein expression levels of hOAT1 and hOAT3 were evaluated with quantitative real-time PCR and Western blot analysis. The respective recombinant OAT proteins were detected in the membrane fractions from OAT-expressing HEK cells but not in the HEK-mock control cells, at molecular masses of 60 kDa in the membrane fractions from hOAT1-expressing HEK cells, and 62 kDa in the membrane fractions obtained from hOAT3-expressing HEK cells (Supplemental Data). The quantitative real-time PCR analysis demonstrated SLC22A6 and SLC22A8 mRNA expression in HEK hOAT1 and HEK hOAT3 clones, respectively, which were not detected in the vector-transfected HEK-mock cells.

Both transfected HEK cell lines expressed functionally active organic anion transporters, as demonstrated by the time-dependent PAH and ES uptake, which are both well-established substrates of hOAT1 and hOAT3, respectively (Supplemental Data). The stably transfected hOAT1 and hOAT3 expressing cell lines also accumulated significantly more standard substrates \([^{3}H]\text{p-aminophosphonic acid (}^{3}\text{H}\text{PAH})\) for HEK-hOAT1 and \([^{3}H]\text{estrone sulfate (}^{3}\text{H}\text{ES})\) for HEK-hOAT3 than the control cells. The estimated \(K_m\) values of PAH uptake by hOAT1 and uptake of ES by hOAT3 were 15.18 \(\pm\) 1.93 and 28.32 \(\pm\) 7.11 \(\mu\)M, respectively (Fig. 1A). Similar to previous in vitro studies, probenecid and ibuprofen inhibited all mediated transport. Probenecid significantly inhibited the uptake of \([^{3}H]\text{PAH}\) by HEK-hOAT1 and uptake of \([^{3}H]\text{ES}\) by HEK-hOAT3, with \(IC_{50}\) values of 9.02 \(\pm\) 2.28 and 0.76 \(\pm\) 0.28 \(\mu\)M, respectively (Fig. 1B). In addition, ibuprofen inhibited these uptakes with \(IC_{50}\) values of 1.45 \(\pm\) 1.54 \(\mu\)M for hOAT3 and \(IC_{50} = 15.74 \pm 4.35 \mu\text{M}\) for hOAT1 (Supplemental Data).

**MTX Uptake.** To evaluate the uptake of MTX in HEK-hOAT1 and HEK-hOAT3, the cells were incubated in a solution containing 0.5 \(\mu\)M MTX (for HEK-hOAT1) (Fig. 2A) or 25 nM MTX (for HEK-hOAT3; Fig. 2B). The affinity of MTX for hOAT3 was higher than that for
hOAT1 (Fig. 2A). The $K_m$ values of MTX uptake by hOAT3 was 21.17 ± 5.65 μM (Fig. 2C). The higher concentration tested on HEK-hOAT1 was 0.5 μM, with an accumulation of MTX in HEK-hOAT1, which was approximately twofold higher than that in the control cells. The $K_m$ was not determined for HEK-hOAT1, because the difference in the accumulation of MTX was too low (data not shown). The transporter-mediated uptake of [3H]MTX over time in HEK-hOAT3 is presented in Fig. 2B and was linear up to 10 minutes.

Inhibition of hOAT1- and hOAT3-Mediated Transport by PPIs. The inhibition of hOAT1 and hOAT3 uptake of their specific substrate by PPIs was measured within the linear uptake phase.

Regarding the inhibition of [3H]PAH uptake by hOAT1, omeprazole, lansoprazole, and pantoprazole inhibited the transport of PAH in HEK-hOAT1 in a concentration-dependent manner, with IC$_{50}$ values of IC$_{50}$ = 4.32 ± 1.26, 7.58 ± 1.06, and 63.21 ± 4.74 μM, respectively (Fig. 3).

Each tested PPI significantly inhibited hOAT3-mediated [3H]JES transport in a concentration-dependent manner (Fig. 4). The calculated half-maximal inhibitory concentration values were in the micromolar range. We obtained an IC$_{50}$ of 20.59 ± 4.07 μM for omeprazole, an IC$_{50}$ of 3.96 ± 0.96 μM for lansoprazole, and an IC$_{50}$ of 7.89 ± 2.31 μM for pantoprazole. Likewise, omeprazole, lansoprazole, and pantoprazole inhibited the transport of [3H]MTX in HEK-hOAT3 cells, with IC$_{50}$ values of 6.8 ± 1.16, 1.14 ± 0.26, and 4.45 ± 1.62 μM, respectively (Fig. 4).

Discussion

MTX is currently used in wide range of doses, and high-dose MTX schedules are associated with an incidence of nephrotoxicity of 1.8% and a fatality rate of almost 0.1%, despite therapeutic drug monitoring and supportive therapy (Widemann and Adamson, 2006). Although drug interactions between MTX and PPIs have been described in the clinic, the specific mechanism for this drug-drug interaction remains unknown.

Our major finding indicates that hOAT3, an uptake transporter expressed at the basolateral side of renal proximal tubular cells, selectively mediates the uptake of MTX, and this transporter is dramatically inhibited in the presence of PPIs. Different studies have suggested the involvement of multiple drug transporters in the elimination of MTX (Breedveld et al., 2004; Suzuki et al., 2009), but the uptake transporters have been well established to be the first limiting step of MTX elimination (VanWert and Sweet, 2008). The involvement of OATs, OAT1 and OAT3 localize to the basolateral membrane of proximal tubular cells and have been shown to play a central role in the renal uptake of anionic drugs, namely MTX.

Our study confirmed that hOAT3 is a high-affinity type transporter of MTX. In our study, the estimated $K_m$ value for hOAT3 was 21.17 ± 5.65 μM, which was consistent with the $K_m$ values of MTX uptake (10.9 and 21.1 μM) previously described by Cha et al. (2001) and Takeda et al. (2002a), respectively. Because this $K_m$ value determined in human kidney sections was similar to that observed for hOAT3 in this study rather than that observed for hOAT1 (553.8 ± 43.2 μM) by Takeda et al. (2002a) in transfected S2 cells, OAT3 likely more
significantly contributes to the net uptake process involved in MTX elimination. We failed to detect MTX transport in HEK-hOAT1 below a concentration of 50 nM; because the uptake experiment required the use of 0.5 μM of MTX according to a study described by El-Sheikh et al. (2013), we could observe an uptake transport by incubating HEK-OAT1 with only 0.5 μM MTX. Unfortunately the difference from the mock cells was not sufficient to evaluate the drug-drug interaction. Moreover, we believe that a MTX concentration above 100 μM is not clinically relevant for therapeutic drug monitoring, because a slow elimination of MTX was defined as plasma concentrations exceeding 15 μM at 24 hours (Santucci et al., 2010). These concentrations are much higher than the human plasma concentrations of MTX and seem unlikely clinical practice. Our current results were also consistent with the findings of Lu et al. (1999), who cloned hPAHT (p-aminophenylphosphate transporter, the first name of hOAT1), which exhibited no significant MTX uptake activity. Uwai et al. (2004) determined the $K_m$ value for hOAT1-mediated MTX uptake using a Xenopus laevis oocytes expression system to be 724 μM. In fact, this higher value of $K_m$ for hOAT1 supported our result, i.e., this concentration was not clinically relevant (Uwai et al., 2004). More recently Kurata et al. (2014) confirmed the same result with HEK-hOAT1. Nozaki et al. (2007) also examined MTX uptake using human tissue sections and estimated $K_m$ values within the same range (48.9 ± 17.3 μM) we observed for hOAT3 (Nozaki et al., 2007). As mentioned previously by various authors, the discrepancy may be due to species differences in the transport activity between rat and human OAT1 or differences in the expression system (Takeda et al., 2002a; Uwai et al., 2004; Uwai and Iwamoto, 2010).

The most striking result of our study was the potent inhibition of MTX uptake transport by all 3 PPIs in HEK-hOAT3 cells. The observed PPI IC$_{50}$ values for MTX uptake were in the micromolar range (6.80, 1.14, and 4.45 μM for omeprazole, lansoprazole, and pantoprazole, respectively). Interestingly, the IC$_{50}$ values for the three PPIs of the MTX uptake transport of by hOAT3 were higher. The observed PPI IC$_{50}$ values were higher for MTX than ES but were within the same concentration range as the plasma circulating concentrations. Moreover, the IC$_{50}$ values observed for each PPI were compared with the plasma concentrations of PPIs according to the CYP2C19 genotype (Ishizaki and Horai, 1999) (see Table 1). Indeed, PPIs are mainly metabolized by CYP2C19, and because the impact of CYP2C19 polymorphism on drug concentrations has been well established, different concentrations should be considered (Goldstein, 2001; Simon et al., 2011). A previous group described the maximum concentration of carriers of a loss of function allele in the plasma for omeprazole (3.1 μM), lansoprazole (4.9 μM), and pantoprazole (11.5 μM) according to the CYP2C19 "poor metabolizer" phenotype (Regardh et al., 1990; Pue et al., 1993; Yasuda et al., 1995; Ieiri et al., 2001; Freston et al., 2003). The plasma concentrations were lower in carriers of the normal allele with an "extensive metabolizer" phenotype, 1.6, 2.4, and 5.4 μM for omeprazole, lansoprazole, and pantoprazole, respectively.

Until recently, most studies investigated the effects of PPIs on different in vivo or in vitro models and suggested some effect of PPIs on efflux transporters. The effect of PPIs on the uptake transporter was poorly understood. The present finding also confirms that PPIs potentially interact with different uptake transporters (hOAT1 and hOAT3) and their well-established substrates. Among the three PPIs tested for the PAH uptake by HEK-hOAT1, two elicited a strong inhibitory effect (omeprazole IC$_{50} = 4.32 \pm 1.26$ μM and lansoprazole 7.58 ± 1.06 μM). In agreement with our results, Nies et al. (2011) recently published that PPIs inhibited hOCT-mediated metformin uptake in vitro. All five tested PPIs (omeprazole, pantoprazole, lansoprazole, rabeprazole, and tenatoprazole) significantly inhibited metformin uptake by HEK-hOCT1, -hOCT2, and -hOCT3 in a concentration dependent manner. Consistent with our result, the IC$_{50}$ values of these PPIs were in the low micromolar range (3–36 μM) (Nies et al., 2011). In addition, the IC$_{50}$ values of potent OAT drug inhibitors, such as ibuprofen, ketoprofen, piroxicam, indomethacin, and probenecid, described for adefovir uptake transport by hOAT1 were 8.0, 1.3, 20.5, 3.0, and 7.4 μM, respectively (Takeda et al., 2002a), which agrees with our results.

Although the clinical consequences are not easily predicted based on in vitro data, detailed advantages and limitations of various in vitro systems for evaluation of drugs as substrates, as inhibitors, or for their potential for drug-drug interactions have been delineated (Brouwer Fig. 3. Inhibition of hOAT1-mediated [3H]PAH uptake by PPIs. Inhibitory effect of omeprazole, lansoprazole, and pantoprazole on hOAT1-mediated [3H]PAH uptake after 2-minute incubation. IC$_{50}$ values were calculated by fitting the data to a sigmoidal dose-response regression curve. Data points are the means ± S.E.M. of three independent experiments.
et al., 2013; Giacomini and Huang, 2013; Hillgren et al., 2013; Zamek-Gliszczynski et al., 2013). According on the decision trees of the recommendations of the International Transporter Consortium (Giacomini et al., 2010), the values of the ration \[ I \] / IC50 of the three PPIs tested on the uptake of MTX on HEK hOAT3 are lower than 0.1 except for lansoprazole in poor metabolizers, for which the ratio is higher than 0.1, giving thought to a clinical interaction between lansoprazole and MTX. It would be very interesting to confirm if this in vitro drug-drug interaction would be relevant in humans in a prospective study. Some factors support such an assumption, because

### TABLE 1

IC50 values for hOAT3 in MTX uptake and plasmatic concentrations of proton pump inhibitors according to CYP2C19 genetic polymorphism and plasma unbound fraction

<table>
<thead>
<tr>
<th>Compounds</th>
<th>Uptake MTX IC50 hOAT3</th>
<th>Dose</th>
<th>Genotype CYP2C19</th>
<th>Cmax Observed in Humans</th>
<th>[ I ]</th>
<th>[ I ] / IC50</th>
<th>References</th>
</tr>
</thead>
<tbody>
<tr>
<td>Omeprazole</td>
<td>6.80 ± 1.16 mg</td>
<td>20</td>
<td>EM</td>
<td>1.6 ± 1.0</td>
<td>0.05 ± 0.03</td>
<td>0.007 (Regardh et al., 1990; Yasuda et al., 1995)</td>
<td></td>
</tr>
<tr>
<td>Lansoprazole</td>
<td>1.14 ± 0.26 mg</td>
<td>30</td>
<td>EM</td>
<td>2.44 ± 0.7</td>
<td>0.07 ± 0.02</td>
<td>0.061 (Ieiri et al., 2001; Freston et al., 2003)</td>
<td></td>
</tr>
<tr>
<td>Pantoprazole</td>
<td>4.45 ± 1.62 mg</td>
<td>40</td>
<td>EM</td>
<td>5.4 ± 1.4</td>
<td>0.11 ± 0.03</td>
<td>0.025 (Regardh et al., 1990; Pue et al., 1993)</td>
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</table>

PM, poor metabolizer phenotype; EM, extensive metabolizer phenotype. \[ I \], unbound inhibitor concentration.
plasma MTX is predictive of the risk of toxicity; therapeutic drug monitoring is often used for patients to evaluate the delayed elimination. Recently, the delayed elimination of MTX associated with serious side effects was described in three retrospective clinical studies of patients treated with high doses of MTX and PPIs (Joerger et al., 2006; Suzuki et al., 2009; Santucci et al., 2010; Leveque et al., 2011) and one prospective study of low dose MTX (Vakily et al., 2005). Although conflicting data were reported in some case reports for either omeprazole or pantoprazole (Whelan et al., 1999; Beorlegui et al., 2000; Troger et al., 2002; Bauters et al., 2008), recent clinical studies are in line with our results suggesting that PPIs might decrease MTX renal clearance via OAT3-mediated inhibition. In the first study, Joerger et al. (2006) described 76 patients who received high-dose MTX, 13 of whom received omeprazole or lansoprazole. Patients that received MTX and PPIs were associated with a 27% decrease in the clearance of MTX, which resulted in a significantly higher plasma concentration of MTX (Joerger et al., 2006). The second study is a retrospective noninterventional cohort study that included 79 French patients with cancer treated with high-doses of MTX. The coprescription of PPIs ( pantoprazole, lansoprazole, omeprazole, or esomeprazole) was found in half of the cycles with delayed elimination and only in 15% of the cycles without delayed elimination (Santucci et al., 2010). The third study examined 74 Japanese patients with cancer. MTX was administered intravenously with a concomitant administration of omeprazole, lansoprazole, and rabeprazole. The MTX residual concentrations (311 measurements of plasma MTX) were analyzed in 171 cycles of high dose MTX. They found that PPI coadministration was still a significant risk factor for delayed elimination after adjustment for six variables (Suzuki et al., 2009). Interestingly, the delayed elimination of plasma MTX previously mentioned in these studies was not observed in all patients who received PPIs; based on our results, this finding may be due to higher concentrations of PPIs in carriers of CYP2C19 loss of function variant alleles (Ieiri et al., 2001; Simon et al., 2011).

Renal tubular secretion involves different uptake transporters. A recent study showed that the basolateral localization of mouse reduced folate carrier (RFC-1) in the kidney is responsible for the uptake of MTX (Nozaki et al., 2004). Other uptake transporters that are mainly expressed in the liver (OATP1B1) or intestine (OATP1A2) were found to transport MTX in vitro. These transporters were very recently found in vivo in transgenic mice that expressed liver-specific human OATP1B1, OATP1B3, and OATP1A2. Further studies are necessary to confirm the influence of this transporter on the pharmacokinetics of MTX in humans.

Conversely, some ATP binding cassette transporters, such as breast cancer resistance protein [ABCG2 (Suzuki et al., 2009)], multiludrug resistance–associated protein (MRP) 2 and MRP4, which are expressed on the apical membranes of kidneys, are reportedly also involved in the excretion of MTX (Ito et al., 2001; Chen et al., 2002). Suzuki et al. (2009) tested the effect of PPIs on the uptake of MTX into BCRP-expressing membrane vesicles. The observed IC50 for each PPI was considerably higher than the plasma concentrations of the PPIs. They also concluded that the inhibitory effects of PPIs on BCRP-mediated MTX transport alone could not explain this drug–drug interaction (Suzuki et al., 2009). Reports on the drug–drug interaction between PPIs-MTX and MRP transporters are lacking, and the role of these transporters should be clarified in subsequent studies.

In conclusion, we identified PPIs as an important class of drugs that inhibits OAT transporters and confirmed that MTX has a greater affinity for OAT3 than OAT1. Taken together our results indicate that hOAT1 is likely not involved in the interaction between MTX and PPIs. The growing use of PPIs to treat peptic ulcers and the widespread use of MTX for a variety of diseases, namely cancers, suggest that a number of patients may be at risk for MTX toxicity, and more intensive therapeutic drug monitoring is advised. Thus, further studies are required to evaluate the clinical consequences of the pharmacological interaction between PPIs and other OAT3 substrates, such as antiviral drugs.

Authorship Contributions

Participated in research design: Chioukh, Noel-Hudson, Verstuyft.
Conducted experiments: Chioukh, Noel-Hudson, Ribes, Verstuyft.
Contributed new reagents or analytic tools: Fournier.

Performed data analysis: Chioukh, Noel-Hudson, Becquemont, Verstuyft.
Wrote contributed to the writing of the manuscript: Chioukh, Noel-Hudson, Becquemont, Verstuyft.

References


