Predicting Maternal-Fetal Disposition of Fentanyl Following Intravenous and Epidural Administration Using Physiologically Based Pharmacokinetic Modeling

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ABSTRACT
Fentanyl is an opioid analgesic used to treat obstetrical pain in par- 
turient women through epidural or intravenous route, and unfortu-
nately can also be abused by pregnant women. Fentanyl is known 
to cross the placental barrier, but how the route of administration 
and time after dosing affects maternal-fetal disposition kinetics at 
different stages of pregnancy is not well characterized. To address 
this knowledge gap, we developed a maternal-fetal physiologically 
based pharmacokinetic (mf-PBPK) model for fentanyl to evaluate 
the feasibility to predict the maternal and fetal plasma concentra-
tion-time profiles of fentanyl after various dosing regimens. As fen-
tanyl is typically given via the epidural route to control labor pain, 
an epidural dosing site was developed using alfentanil as a refer-
eence drug and extrapolated to fentanyl. Fetal hepatic clearance of 
fentanyl was predicted from CYP3A7-mediated norfentanyl forma-
tion in fetal liver microsomes (intrinsic clearance = 0.20 ± 0.05 µl/
min/mg protein). The developed mf-PBPK model successfully cap-
tured fentanyl maternal and umbilical cord concentrations after 
epidural dosing and was used to simulate the concentrations after intravenous dosing (in a drug abuse situation). The distribution 
kinetcs of fentanyl were found to have a considerable impact on the 
time course of maternal:umbilical cord concentration ratio and 
on interpretation of observed data. The data show that mf-PBPK 
modeling can be used successfully to predict maternal disposition, 
transplacental distribution, and fetal exposure to fentanyl.

SIGNIFICANCE STATEMENT
This study establishes the modeling framework for predicting the 
time course of maternal and fetal exposures of fentanyl opioids 
from mf-PBPK modeling. The model was validated based on fenta-
yl exposure data collected during labor and delivery after intrave-
nous or epidural dosing. The results show that mf-PBPK modeling 
is a useful predictive tool for assessing fetal exposures to fentanyl 
opioid therapeutic regimens and potentially can be extended to 
other drugs of abuse.

Introduction
Fentanyl and other opioid analgesics are commonly used together 
with local anesthetics to relieve pain during surgical procedures. 
Depending on the procedure, fentanyl is typically given epidurally or 
intrathecally for regional anesthesia, although similar plasma concentra-
tions are observed after epidural and intravenous infusions (Ellis et al., 
1990; Baxter et al., 1994). Fentanyl is also used to treat parturient 
women during labor and delivery through epidural and intrathecal

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ABBREVIATIONS: AAFE, absolute average fold error; B/P ratio, blood-to-plasma ratio; CL, clearance; CLint, hepatic intrinsic clearance; CLint,u, 
unbound hepatic intrinsic clearance; CLpd,adipose, unbound permeability clearance from the epidural fluid to the epidural adipose tissue; 
CLpd,vein, unbound permeability clearance from the epidural fluid to the epidural vein; CSF, cerebrospinal fluid; FLM, fetal liver microsomes; fu,
fraction unbound in plasma; HPLC-MS/MS, high performance liquid chromatography with tandem mass spectrometry; IVIVE, in vitro to in 
vivo extrapolation; Km, concentration of substrate at half of the maximal product formation rate; Kp, tissue partitioning coefficients; logP, partition 
coefficient; MA, maternal artery; mf-PBPK, maternal-fetal physiologically based pharmacokinetic; MV, maternal vein; Papp, apparent permeabil-
ity; PBPK, physiologically based pharmacokinetic; PD, pharmacodynamic; PK, pharmacokinetics; pKa, negative logarithm of the acid dissociation 
constant; Qepidural, blood flow to the epidural space; tmax, time to reach Cmax; UA, umbilical artery; UV, umbilical vein; V, volume; Vss, 
steady-state volume of distribution.
was developed with incorporation of a novel epidural dosing site. The pharmacokinetics (PK) of fentanyl after epidural injections in parturient women has been reported in multiple studies (Desprats et al., 1991, 1995; Moisès et al., 2005; Haidl et al., 2018), and the steady-state concentrations after intravenous and epidural infusion (same rate) of fentanyl to women after cesarean-section were shown to be similar (Ellis et al., 1990). Fentanyl crosses the placenta and has been detected in the umbilical vein (UV) within 30 minutes of an epidural dose to parturient women (Desprats et al., 1991, 1995; Moisès et al., 2005; Haidl et al., 2018). However, the UV to maternal venous (MV) plasma concentration ratios after epidural and intravenous fentanyl dosing have only been reported from single timepoints during labor. Notably, the reported UV/MV concentration ratios vary widely after epidural or IV administration of fentanyl; UV/MV ratios were 0.3–3.4 within an hour after epidural bolus dose (Desprats et al., 1991, 1995; Moisès et al., 2005; De Barros Duarte et al., 2009), 0.3–1.9 within an hour after intravenous dosing (Morley-Forster et al., 2000), and 0.6–3.1 at 1–15 hours after epidural infusion (Bader et al., 1995; Loftus et al., 1995; Haidl et al., 2018). Part of the variability could be attributed to rapid changes in maternal and fetal plasma concentrations during distribution of fentanyl to the fetus. At present, fetal pharmacokinetics of fentanyl after intravenous or epidural dosing is not well characterized or understood sufficiently.

We hypothesized that the maternal-fetal disposition of fentanyl after an epidural or intravenous dosing can be predicted using physiologically based pharmacokinetic (PBPK) modeling. To test this hypothesis a maternal-fetal-PBPK (mf-PBPK) model of fentanyl was developed with incorporation of a novel epidural dosing site. The goal of this study was to predict the fetal concentration-time profile of fentanyl after maternal epidural and intravenous doses to aid in understanding maternal and fetal risks of maternal fentanyl exposure during pregnancy.

Materials and Methods

Development of a Maternal-Fetal Physiologically Based Pharmacokinetic Model with an Epidural Dosing Site. An mf-PBPK model was developed in MATLAB and the Simulink platform (R2019b; MathWorks, Natick, MA). The structure of the model was modified from a previously published mf-PBPK model, which includes a 14-compartment maternal PBPK model and a 7-compartment fetal PBPK model linked together by a placenta compartment (Zhang et al., 2017a). A similar structural model without the placenta and fetal PBPK model was used for simulations of drug disposition in nonpregnant population (Fig. 1). Drug distribution to all organs was modeled as perfusion-limited process as validated in a previously developed PBPK model of fentanyl (Huang and Isoherranen, 2020). The clearances into and out of the placenta incorporated potential permeability-limited kinetics using a method established previously (Zhang and Unadkat, 2017) to simulate maternal-fetal disposition using clearance scaled from Caco-2 permeability. Simulated concentrations were sampled from the same site as reported in the observed studies. To accomplish this, a previously developed peripheral sampling site (arm vein) (Huang and Isoherranen, 2020) was incorporated into the maternal PBPK model. Additionally, to model the maternal-fetal disposition after epidural dosing, an epidural dosing site model was developed and incorporated in parallel to the other organ compartments in the maternal PBPK model.

The structure of the epidural dosing site model was developed based on known physiology of the human epidural space. The epidural space is located between the ligamentum flavum posteriorly and the posterior longitudinal ligament anteriorly surrounding the spinal cord outside of the dura mater, which is filled mainly with adipose tissue (Richardson and Groen, 2005; Becske and Nelson, 2009; Desjardins et al., 2011). The epidural space is highly vascularized and receives oxygenated blood from the spinal arteries superiorly from the aorta and drains to the internal vertebral venous plexus that empties into the inferior vena cava (Richardson and Groen, 2005; Becske and Nelson, 2009). An epidural bolus injection is usually given with volume between 4 and 20 ml, which creates a sheath of solution surrounding the epidural space upon injection (Hogan, 2002). The dose will either partition into the epidural adipose tissue or be taken up by the venous system according to the direct connection between the epidural space and the venous system (Buffington et al., 2011). Based on the physiology, the epidural dosing site was modeled such that the dose given was assumed to be evenly distributed fluid surrounding the epidural space. From there, the dose can either passively diffuse into and partition into the epidural adipose tissue or passively diffuse to and be taken up by the epidural vein (i.e., internal vertebral venous plexus) (Fig. 1). Distribution to CSF (through the dura mater) was not included in the model, as most of the volume injected into the epidural space has been shown to stay outside of the dura mater (Hogan, 2002), and the rate of fentanyl transfer from the epidural space to the CSF has been shown to be significantly slower than that to the epidural adipose tissue and venous plasma (Ummenhofer et al., 2000). A sensitivity analysis was also performed to assess whether a direct connection between the CSF and the vasculature can be kinetically discerned from plasma kinetics. The physiologic parameters (i.e., organ volumes and blood flows) of the nonpregnant model (including the arm sampling site model) were adopted from a previously published PBPK model (Huang and Isoherranen, 2020). The physiologic parameters of the mf-PBPK model to match a pregnant woman at term (gestational week 40) were calculated using previously published equations to describe physiologic changes of pregnant women and fetuses during gestation (Abduljalil et al., 2012; Zhang et al., 2017b). A CYP3A4 induction factor of 1.99 was used in the maternal-fetal model based on previous observation that CYP3A4 expression increased by 1.99-fold during late pregnancy (Hebert et al., 2008). Parameters without published values in pregnant women were assigned to be the same as those in the nonpregnant women (Table 1). For the drugs studied, the transplacental clearances were assumed to be mediated by passive processes, although active transport could be incorporated in the model if present, and only unbound drug was assumed to passively diffuse across the placenta (i.e., syncytiotrophoblast monolayer).

The physiologic parameters for the epidural dosing site were taken from those for the lumbar vertebrae region (L1 to L5), which is where epidural injection is typically given. The volume of the epidural adipose tissue (V epidural adipose) in the lumbar region has been reported to be around 3.5 ml (Walker et al., 2019), and the blood flow to the epidural space (Q epidural) was calculated first based on the reported velocity of blood flow in spinal arteries into the lumbar region and the diameter of the arteries (arterial blood flow = 1.12 l/h) (Arslan et al., 2011; Espahbodi et al., 2013). Since the spinal blood drains through the internal vertebral venous plexus (inside the epidural space) and the external vertebral venous plexus (outside of epidural space), the Q epidural was assumed to be 50% of the arterial blood flow (i.e., 0.56 l/h). The volume of the epidural vein (V epidural,vein) was assumed to be the same as V epidural adipose (3.5 ml). The volume of the epidural fluid (V epidural,fluid) was assumed to be the same as the typical epidural injection volume of 10 ml. The clearances from the epidural fluid to the epidural adipose tissue and the epidural vein were assumed to be mediated by passive processes, which allow only unbound drug to cross the adipocyte cell membrane and the venous endothelial lining. The bioavailability after epidural administration was assumed to be 100% based on the previous observations that similar steady-state concentration was observed after intravenous and epidural infusions at the same dosing rate (Ellis et al., 1990; Baxter et al., 1994) (Table 1).

Sensitivity Analyses of the Epidural Dosing Site Model. The absorption profile of epidurally dosed drugs including the rate of absorption and the fraction of dose sequestered in the epidural adipose tissue have been shown to depend on the physicochemical properties (i.e., molecular weight, logP, pKa, etc) of the dosed drug (Ummenhofer et al., 2000; Bernards et al., 2003). Hence, sensitivity analyses were performed for the final epidural dosing site model to identify the sensitive physicochemical and physiologic parameters. To do this, a hypothetical drug X model was developed. Drug X was assumed to be a neutral compound with tissue partitioning coefficients (K tiss) s, blood-to-plasma (B/P) ratio, and plasma fraction unbound (f u) assumed to be 1 unless the parameter was assessed in the sensitivity analysis. The hepatic clearance of drug X was assumed to be 45 l/h (hepatic extraction ratio = 0.5), and the renal clearance of drug X was
Four sets of three-dimensional local sensitivity analyses were performed by varying two parameters at a time to evaluate the impact of covarying parameters on the simulated Cmax and tmax after a single epidural bolus dose of 100 μg of drug X. The Cmax and tmax were chosen as the measurements of the rate of absorption after epidural administration. Then, the CLpd,vein of alfentanil and the Caco-2 permeability of alfentanil and fentanyl, using the observed plasma concentration of alfentanil after epidural administration. Then, the CLpd,vein was scaled using the optimized CLpd,adipose (i.e., 0.003 l/h).

Fig. 1. Model structure of the maternal-fetal PBPK (mf-PBPK) model with an arm and the intravenous and epidural dosing sites to the mother, and the red arrows indicate plasma sampling sites for the fetus. A nonpregnant PBPK model used in this study of the placenta and fetal PBPK model was removed as indicated by the dashed line. The arm bypassing the arm compartment.
studies did not specify the sampling site, and comparison was done to the simulated plasma concentrations at the arm vein sampling site.

After validation of the PBPK model of alfentanil, an epidural dosing model was developed for alfentanil. The CL\textsubscript{pd,adipose} of alfentanil was extrapolated to be 0.3 l/h (same as CL\textsubscript{pd,adipose}) to 0.3 l/h and validated using the nonpregnant PBPK model and the same dose and sampling site as specified in the original studies. All observed mean plasma concentrations throughout were digitized using WebPlotDigitizer (version 4.3, https://apps.automeris.io/wpd/). The performance of all simulations was quantitatively evaluated based on the absolute average fold error (AAFE) calculated for each study according to eq.

\[
\text{AAFE} = 10^{\frac{1}{5} \sum \log_{10} \left( \frac{\text{Simulated concentration}}{\text{Observed concentration}} \right)}
\]

An AAFE of \(\leq 2\) was considered acceptable for the alfentanil model based on the interstudy variability of alfentanil CL observed in the above five intravenous dosing studies (CV = 17.4%). The 99.998% geometric confidence interval of the area under the plasma concentration-time curve was calculated according to (Abduljalil et al., 2014) to be 48% to 2.1-fold of the mean.

**Validation of the Epidural Dosing Model of Fentanyl.** To develop the epidural dosing PBPK model of fentanyl, a previously reported and validated PBPK model of fentanyl was adopted (Huang and Isoherranen, 2020) (Table 2). This model was previously validated for arterial and venous sampling of fentanyl after intravenous and buccal administration, defining the distribution parameters of fentanyl. The B/P ratio, \(f\text{p}_{a}\), in plasma, and \(K\text{p}_{a}\)’s for fentanyl in different tissues were adopted as previously reported. The previous model only considered overall plasma CL in each study and it did not define the enzymatic pathways of fentanyl CL. Therefore, a hepatic clearance of fentanyl was calculated from the average observed plasma clearance (CL = 62 l/h) after intravenous administration of fentanyl to healthy subjects from four studies (McClain and Hug, 1980; Ziesenitz et al., 2015; Rauck et al., 2017; Nozari et al., 2019). Fentanyl renal clearance was set to an earlier reported value of 3 l/h (Ziesenitz et al., 2015). The CL\textsubscript{int,u} was back calculated from the mean hepatic clearance using the hepatic well stirred model resulting in an estimate of 1,055 l/h. Of the calculated CL\textsubscript{int,u}, 80% was assumed to be mediated by CYP3A4 based on the result of a drug-drug interaction study (Ziesenitz et al., 2015) (CL\textsubscript{int,u,CYP3A4} = 844 l/h) and the remaining 20% was assigned to unknown pathways (CL\textsubscript{int,u,other} = 211 l/h). The modified fentanyl PBPK model was validated using the plasma concentrations observed in the above four intravenous studies. Simulations of fentanyl plasma concentration-time profiles after intravenous dose were performed using the nonpregnant PBPK model using the same dose and sampling site as specified in the original studies [three studies reported venous concentrations (Ziesenitz et al., 2015; Rauck et al., 2017; Nozari et al., 2019) and one study reported arterial concentrations (McClain and Hug, 1980)]. An acceptable AAFE was decided based on the interstudy variability of fentanyl CL observed in the above mentioned four intravenous studies (CV = 22.0%). The 99.998% geometric confidence interval of the area under the plasma concentration-time curve was calculated according to (Abduljalil et al., 2014) to be 40% to 2.5-fold of the mean. Therefore, an AAFE of \(\leq 2\) was used as an acceptance criterion for validation of the fentanyl model.

**TABLE 1**

<table>
<thead>
<tr>
<th>Nonpregnant Model</th>
<th>Maternal Model (GW 40)</th>
<th>Fetal Model (GW 40)</th>
</tr>
</thead>
<tbody>
<tr>
<td>l Volume l/h Blood flow</td>
<td>l Volume l/h Blood flow</td>
<td>l Volume l/h Blood flow</td>
</tr>
<tr>
<td>Adipose 15 16.2</td>
<td>22.6 24.4</td>
<td>– –</td>
</tr>
<tr>
<td>Bone 10 13.1</td>
<td>10 13.1</td>
<td>– –</td>
</tr>
<tr>
<td>Brain 1.4 35.6</td>
<td>1.4 35.6</td>
<td>0.375 13.28</td>
</tr>
<tr>
<td>Gut 1.2 46.8</td>
<td>1.2 46.8</td>
<td>0.1 3.95</td>
</tr>
<tr>
<td>Heart 0.33 12.5</td>
<td>0.33 12.5</td>
<td>– –</td>
</tr>
<tr>
<td>Kidney 0.31 60</td>
<td>0.31 64.7</td>
<td>0.031 4.16</td>
</tr>
<tr>
<td>Liver 1.8 90</td>
<td>1.8 90</td>
<td>0.129 16.42</td>
</tr>
<tr>
<td>Lung 0.53 308</td>
<td>0.53 391</td>
<td>– –</td>
</tr>
<tr>
<td>Pancreas 0.098 3.1</td>
<td>0.098 3.1</td>
<td>– –</td>
</tr>
<tr>
<td>Skin 2.6 18.1</td>
<td>2.6 18.1</td>
<td>– –</td>
</tr>
<tr>
<td>Muscle 28 57.3</td>
<td>28.17 57.3</td>
<td>– –</td>
</tr>
<tr>
<td>Spleen 0.18 6.2</td>
<td>0.18 6.2</td>
<td>– –</td>
</tr>
<tr>
<td>Blood 5 –</td>
<td>5.64 –</td>
<td>0.42 –</td>
</tr>
<tr>
<td>Rest of body – –</td>
<td>2.384 47.41</td>
<td>– –</td>
</tr>
<tr>
<td>Arm adipose 0.0338 0.0709</td>
<td>0.0338 0.0709</td>
<td>– –</td>
</tr>
<tr>
<td>Arm muscle 0.268 0.29</td>
<td>0.268 0.29</td>
<td>– –</td>
</tr>
<tr>
<td>Arm skin 0.0363 0.218</td>
<td>0.0363 0.218</td>
<td>– –</td>
</tr>
<tr>
<td>Arm anastomoses – 0.06432</td>
<td>– 0.06432</td>
<td>– –</td>
</tr>
<tr>
<td>Epidural adipose 0.0035 –</td>
<td>0.0035 –</td>
<td>– –</td>
</tr>
<tr>
<td>Epidural fluid 0.01</td>
<td>0.01</td>
<td>– –</td>
</tr>
<tr>
<td>Epidural vein 0.0035 0.56</td>
<td>0.0035 0.56</td>
<td>– –</td>
</tr>
<tr>
<td>Placenta – –</td>
<td>0.659 49.1</td>
<td>0.151 20.21</td>
</tr>
<tr>
<td>Ductus venosus – –</td>
<td>– –</td>
<td>8.73</td>
</tr>
<tr>
<td>Syncytiotrophoblast – 0.08</td>
<td>– 0.08</td>
<td>– –</td>
</tr>
<tr>
<td>Amniotic fluid – 0.758</td>
<td>– 0.758</td>
<td>– –</td>
</tr>
</tbody>
</table>

\* Physiologic parameters used in the nonpregnant PBPK model with arm sampling site model for a 66.8 kg nonpregnant individual were adopted from (Huang and Isoherranen, 2020).

\# Physiologic parameters used in the maternal-fetal PBPK model for a 75.2 kg pregnant woman and a 3.44 kg fetus were calculated from equations published in (Abduljalil et al., 2012) and (Zhang et al., 2017b).
Physicochemical and pharmacokinetic parameters of alfentanil and fentanyl used in the PBPK models

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Alfentanil</th>
<th>Fentanyl</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physicochemical properties</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MW (g/mol)</td>
<td>416.52</td>
<td>336.47</td>
</tr>
<tr>
<td>log P</td>
<td>2.16</td>
<td>4.05</td>
</tr>
<tr>
<td>pKa</td>
<td>6.5</td>
<td>8.99</td>
</tr>
<tr>
<td>B/P ratio</td>
<td>0.55</td>
<td>1</td>
</tr>
<tr>
<td>( f_u,\text{plasma} )</td>
<td>0.01</td>
<td>0.16e</td>
</tr>
<tr>
<td>( f_u,\text{umbilicalplasma} )</td>
<td>0.14</td>
<td>1</td>
</tr>
<tr>
<td>( f_u,\text{epithelialfluid} )</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>( f_u,\text{syncytiotrophoblast} )</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>( f_u,\text{amnioticfluid} )</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>Tissue partitioning coefficient (K_p)\text{'}</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adipose</td>
<td>2.1</td>
<td>26.7</td>
</tr>
<tr>
<td>Bone</td>
<td>0.1</td>
<td>1</td>
</tr>
<tr>
<td>Brain</td>
<td>0.13</td>
<td>3.5</td>
</tr>
<tr>
<td>Gut</td>
<td>2.12</td>
<td>8.4</td>
</tr>
<tr>
<td>Heart</td>
<td>0.55</td>
<td>12.1</td>
</tr>
<tr>
<td>Kidney</td>
<td>0.82</td>
<td>1</td>
</tr>
<tr>
<td>Liver</td>
<td>1</td>
<td>3.8</td>
</tr>
<tr>
<td>Lung</td>
<td>0.78</td>
<td>13.5</td>
</tr>
<tr>
<td>Muscle</td>
<td>0.31</td>
<td>3.1</td>
</tr>
<tr>
<td>Skin</td>
<td>0.1</td>
<td>2.1</td>
</tr>
<tr>
<td>Spleen</td>
<td>0.73</td>
<td>27.6</td>
</tr>
<tr>
<td>Pancreas</td>
<td>0.96</td>
<td>21.3</td>
</tr>
<tr>
<td><strong>Metabolism and excretion</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>( CL_{\text{r,adipose}} ) (L/h)</td>
<td>185</td>
<td>1055</td>
</tr>
<tr>
<td>( CL_{\text{r,vein}} ) (L/h)</td>
<td>3.3</td>
<td></td>
</tr>
<tr>
<td>( CL_{\text{syncytiotrophoblast}} ) (L/h)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>Passive permeability clearance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>( CL_{\text{p,adipose}} ) (L/h)</td>
<td>0.010</td>
<td>0.0012</td>
</tr>
<tr>
<td>( CL_{\text{p,vein}} ) (L/h)</td>
<td>0.20</td>
<td>0.023</td>
</tr>
<tr>
<td>( CL_{\text{p,placenta}} ) (L/h)</td>
<td>0.357</td>
<td></td>
</tr>
</tbody>
</table>

**Table 2**

*CLr, renal clearance.

**MF model specific parameters are marked with *.

* Alfentanil and fentanyl model parameters were collected from literature as described in the methods section.

** For nonpregnant population. Fentanyl \( f_u,\text{plasma} \) in pregnant women was 0.12, measured in a group of 40 parturient women as described in the methods section.

\( K_{p,\text{alf}} \) of alfentanil were adopted from values measured in rats (Bjorkman et al., 1990) as described in the methods section. \( K_{p,\text{alf}} \) of bone and skin were not reported and were assigned as 0.1 based on the observed \( K_{p,\text{alf}} \) of alfentanil (0.7 L/kg) in humans.

* Predicted from measured norfentanyl formation in FLM.

**Development of the mf-PBPK Model of Fentanyl.** After validation of the PBPK model with epidual dosing of fentanyl, the mf-PBPK model was applied to predict fentanyl disposition in pregnant women and the maternal-fetal disposition of fentanyl at term. The \( K_{p,\text{alf}} \) and B/P ratio of fentanyl were assumed to be the same as those validated using the nonpregnant model. The maternal and fetal plasma \( f_u \) were set as 0.12 and 0.14, respectively, as the mean \( f_u \) values reported in a group of 40 parturient women and their newborns (Fernando et al., 1997). Additional simulations were performed using the fetal plasma \( f_u \) values of 0.01 and 0.34 (observed range in the above study). The maternal hepatic \( CL_{\text{int,FLM}} \) of fentanyl was predicted to be 1.891 L/h based on the built-in 1.99 induction factor for CYP3A4, and the reported calculated \( CL_{\text{int}} \) for CYP3A4 described in the above sections. The fetal \( CL_{\text{int,FLM}} \) was scaled from the measured \( CL_{\text{int,FLM}} \) described above. The syncytiotrophoblast metabolism (\( CL_{\text{syncytiotrophoblast}} \)) of fentanyl was considered as negligible (Table 2).

**The unbound transplacental clearance \( CL_{\text{p,placenta}} \) of fentanyl (\( CL_{\text{p,placenta}} \)) was scaled using midazolam as the scaler as previously described (Zhang and Unadkat, 2017) using eq. 3:**

\[
CL_{\text{p,placenta}} = CL_{\text{p,placenta}} \times \left( \frac{P_{\text{app,\text{fentanyl}}} \times f_u,\text{placenta}}{P_{\text{app,\text{midazolam}}} \times f_u,\text{midazolam}} \right)
\]

**Validation of the mf-PBPK Model of Fentanyl and Simulation of Maternal-Fetal Disposition of Fentanyl.** The mf-PBPK model of fentanyl was validated by comparing the simulated MV, UV, and umbilical arterial (UA) plasma fentanyl concentrations with the same dose and sampling site (Fig. 1) to the respective plasma concentration observed in seven PK studies (Desprats et al., 1991, 1995; Bader et al., 1995; Loftus et al., 1995; Moisès et al., 2005; De Barros Duarte et al., 2009; Haidl et al., 2018). These studies were performed in parturient women at the first two stages of labor, administered with either a bolus epidural injection or continuous infusion of fentanyl. Four out of the seven studies reported maternal venous plasma concentrations during labor (Desprats et al., 1991, 1995; Moisès et al., 2005; Haidl et al., 2018), and all seven studies reported MV, UV, and/or UA concentrations at delivery. The reported mean maternal plasma concentrations were digitized, except one study that reported individual plasma concentrations for which mean plasma concentrations were calculated from individual data. One of the seven studies reported individual MV
and UV concentrations at the time of delivery (Bader et al., 1995), and the reported concentrations were digitized. The AAFE was calculated by comparing the simulated and individual observed concentrations. For the remaining six studies, the mean delivery time and the mean MV, UV, and UA plasma concentrations were reported as numerical values and used as is. The absolute fold error was calculated by comparing the simulated concentration at the mean time of delivery with the mean observed plasma concentration at delivery. Since the interstudy variability of maternal-fetal disposition of fentanyl cannot be

![Fig. 2. Sensitivity analysis for epidural dosing site parameters of drug X. The effect of altered CL_{pd,adipose} and CL_{pd,vein} (ranging from 0.00003 to 0.3 l/h) on C_{max} and t_{max} of drug X is shown in (A) and (B). The impact of varying K_p (0.01 to 100) and f_u (0.1 to 1) (C and D), and the Q_{epidural} (0.056 to 5.6 l/h) and CL_{pd,vein} (0.00003 to 0.3 l/h) (E and F), and asymmetric CL_{pd,vein} with CL_{pd,fluidtovein} (10% to 100% of CL_{pd,fluidtovein}) (G and H) on C_{max} and t_{max} of drug X are shown in (C–H). The parameters were kept constant unless stated otherwise (CL_{pd,adipose} = 0.003 L/h, CL_{pd,vein} = 0.003 l/h, K_p = 1, f_u = 1, Q_{epidural} = 0.56 l/h). For comparison, the scales of the heat map for C_{max} and t_{max} were kept unchanged across the sensitivity analyses.](image)
estimated based on the available data, the same AAFE (≤2-fold) as the nonpregnant model was adopted as an acceptance criterion for validation of the fentanyl mf-PBPK model.

After validation of the mf-PBPK model of fentanyl, the maternal-fetal disposition of fentanyl at term was simulated after a single 500 mg intravenous bolus dose of fentanyl using the mf-PBPK model, and plasma fentanyl concentrations were sampled from the maternal artery (MA), MV, UV, and UA. The absolute concentrations and concentration ratios were assessed to explore potential fetal fentanyl exposures in cases of illicit use of fentanyl by pregnant women.

**Results**

**Development of an Epidural Dosing Site Model.** A novel epidural dosing site model was developed according to the physiology of the epidural space and incorporated into a full PBPK model to simulate drug disposition after epidural administration (Fig. 1). To evaluate the impact of physicochemical properties on drug disposition after epidural administration, sensitivity analyses were performed using the PBPK model of a hypothetical drug X (Fig. 2). First, the effect of apparent permeability ($P_{app}$) of drug X was tested by increasing $CL_{pd,adipose}$ and $CL_{pd,vein}$ (Fig. 2, A and B). The $C_{max}$ of drug X increased by 282-fold, whereas the $t_{max}$ decreased from 10 to 0.2 hours when $CL_{pd,vein}$ increased from 0.00003 to 0.3 l/h, suggesting that increasing $P_{app}$ increases the rate of absorption after epidural administration and that $CL_{pd,vein}$ is a sensitive parameter in the model. In contrast, the $C_{max}$ and $t_{max}$ of drug X were relatively insensitive to changes in $CL_{pd,adipose}$. Second, the effect of increasing adipose tissue partitioning and increasing plasma $f_a$ were tested (Fig. 2, C and D). The $C_{max}$ and $t_{max}$ of drug X were insensitive to changes in $K_{p,adipose}$ (increased from 0.01 to 100) and $f_a$ (increased from 0.1 to 1), suggesting that sequestration of drug X in the adipose tissue and plasma protein...
binding have minimal effect on the rate of absorption after epidural administration. As such, neither $K_{p,adipose}$ nor $f_a$ are sensitive parameters in the model. Third, the effect of decreasing epidural blood flow ($Q_{epidural}$ decreased from 5.6 to 0.056 $l/h$) was tested (Fig. 2, E and F). The $C_{max}$ of drug X was not affected by decreasing $Q_{epidural}$ when $CL_{pd,vein}$ was low ($<0.01 l/h$, $P_{app} = 3 \times 10^{-6}$ cm/s), but $C_{max}$ was sensitive to $Q_{epidural}$ under high $CL_{pd,vein}$ conditions. This suggests that the rate of absorption becomes limited by blood flow for drugs with a high $P_{app}$ and hence, correct parameterization for blood flow is important for high permeability compounds. Last, sensitivity analysis was performed to evaluate whether uptake through CSF to the venous system is kinetically discernable by introducing asymmetric $CL_{pd,fluid}$ and $CL_{pd,vein/flu}$ (Fig. 2, G and H). The simulations showed that the $C_{max}$ and $t_{max}$ of drug X were not affected by the asymmetric $CL_{pd,vein}$ suggesting that an alternative route of drug absorption through the CSF is not kinetically discernable after epidural dosing.

**Verification of the Epidural Dosing Model Using Alfentanil as the Model Compound.** The epidural dosing site model was optimized and verified using alfentanil as the model drug. The final parameters of the alfentanil model are listed in Table 2. First, a PBPK model of alfentanil was developed to simulate the plasma concentration-time profile of alfentanil after intravenous administration to nonpregnant healthy subjects (Fig. 3, A–C). The simulated venous plasma concentration-time profiles captured the observed mean venous alfentanil plasma concentration-time profiles from five studies with intravenous dosing of alfentanil within the acceptance criterion (AAFE 1.20–1.98), validating the alfentanil model. Then, the $CL_{pd,vein}$ of alfentanil was optimized to 0.2 $l/h$ based on the observed venous plasma concentration-time profile.
after epidural administration in nonpregnant healthy subjects reported in two epidural dosing studies (Fig. 3, D and E). The simulated plasma concentration-time profiles using the optimized PBPK model of alfentanil captured the observed mean alfentanil plasma concentration-time profiles after epidural dosing acceptably (AAFE: 1.21–1.31) validating the epidural dosing model.

Development and Validation of an Epidural Dosing Model of Fentanyl. After verification of the epidural dosing site model and validation of the alfentanil model, the fentanyl model for intravenous and epidural administration was developed and validated. First, a previously published (Huang and Isoherranen, 2020) fentanyl PBPK model was adopted and modified with refined hepatic clearance parameters reflecting the CYP3A4 intrinsic clearance (Table 2). The fentanyl model was validated using the mean venous plasma concentrations observed in three studies and the mean arterial plasma concentrations observed in one study after intravenous dosing of fentanyl (Fig. 4, A–C). All simulations met the acceptance criterion of AAFE ≤2 (AAFE: 1.25–1.84) when compared with the observed data validating the fentanyl model. Then, the epidural dosing model of fentanyl was developed using alfentanil as a scaler. The simulated plasma concentration-time profiles after epidural administration of fentanyl to healthy nonpregnant subjects captured the observed venous plasma concentration-time profiles (Fig. 4, D–F) with all AAEFs within the acceptance criteria of ≤2 (AAFE: 1.21–1.99) validating the epidural dosing model of fentanyl in nonpregnant women.

FLM Metabolism of Fentanyl and IVIVE to Predict Fetal Hepatic Intrinsic Clearance. Fentanyl is mainly metabolized by CYP3A4 to norfentanyl in the adult liver (Labroo et al., 1997), and we hypothesized that fentanyl is also a substrate for CYP3A7 in the fetal liver. To test this hypothesis, norfentanyl formation was measured with recombinant CYP3A7 and in FLM. Norfentanyl was formed from fentanyl by recombinant CYP3A7 with CL_{int} of 0.019 ± 0.001 μL/min/pmol CYP (Fig. 5). Using the previously established inter-system extrapolation factor of 0.044 for CYP3A7 and the measured CYP3A7 expression in the pooled FLM (359 pmol/mg protein) (Shum and Isoherranen, 2021), norfentanyl formation CL_{int} was predicted to be 0.3 μL/min/mg protein in FLM. The formation CL_{int} of norfentanyl in FLM (0.20 ± 0.05 μL/min/mg protein) was 0.7-fold of the predicted CL_{int} (Fig. 5), suggesting that CYP3A7 is the main enzyme responsible for norfentanyl formation in the fetal liver. The measured norfentanyl formation CL_{int} in FLM was used to predict the fetal hepatic CL_{int,u} resulting in a predicted fetal hepatic CL_{int,u} of 0.028 l/h. This CL_{int,u} was incorporated in the fetal liver of the mf-PBPK model of fentanyl (Table 2).

Validation of the mf-PBPK Model of Fentanyl and Simulations of Fentanyl Disposition. The developed mf-PBPK model of fentanyl was validated by comparing simulated MV plasma concentrations and UV and UA concentrations to available observed data after epidural bolus or epidural infusion of fentanyl (Fig. 6). The simulations captured the observed maternal plasma concentration-time profiles (AAFE 1.18–1.86) and the observed UV (AAFE: 1.15–2.36) and UA (AAFE: 1.3–1.65) concentrations within the reported time window of sampling. Several studies also reported the UV/MV and UA/UV ratios in the above studies. To further explore the time course of maternal-fetal distribution of fentanyl, the UV/MA ratio was also calculated using the simulated UV and MA plasma concentrations (Fig. 7). The simulations show that the concentration ratios vary with time, particularly the UV/MV ratio that rises rapidly over the initial few minutes following dosing to about 2.6 and then gradually declines to <1 at around 30 minutes, capturing the variability of the observed UV/MV ratios of 0.43–0.89 at around 30 minutes postdose reported in the above studies. To further explore the time course of maternal-fetal distribution of fentanyl, the UV/MA ratio gradually increases with time to 0.7 at 2 hours postdose.

The validated mf-PBPK model of fentanyl was then used to simulate the maternal (MA and MV) and fetal (UV and UA) plasma concentration-time profiles in pregnant women following a single intravenous bolus dose of 500 μg fentanyl to explore the maternal-fetal disposition of fentanyl in a potential drug abuse scenario (Fig. 8A). The simulations captured the UV/MV and MA plasma concentrations (AAFE: 1.05–1.18) and UA (AAFE: 1.24) concentrations with acceptable variability throughout the 2-hour sampling period (Fig. 8A). Notably, the UV/MA ratio also increased with time approaching 2 hours after dosing.

Discussion

In recent years, there has been an increasing interest to use mf-PBPK modeling to study maternal-fetal disposition of xenobiotics because of...
the ethical concerns and challenges in conducting clinical pharmacokinetic studies in pregnant women (Ke et al., 2014, 2018). Fentanyl is of particular interest (Fleet et al., 2011) because it is used to manage pain during labor and delivery and it is an opioid abused by pregnant women. The fetal disposition of fentanyl and alternative opioid analgesics is of interest to better predict, prevent, and manage fetal side effects of opioids. However, information on the fetal disposition of fentanyl is limited to measurements of single timepoint UV/MV ratios at time of delivery. Moreover, the reported UV/MV ratios appear to be dependent on the sampling time postdose due to distribution kinetics, which makes it difficult to assess overall fetal exposure. We used mf-PBPK modeling to simulate maternal and fetal disposition of fentanyl to define fetal exposures to fentanyl after various routes of administration and to establish a modeling and simulations workflow that could be used for other drugs administered to pregnant women.

To simulate the maternal-fetal disposition of fentanyl following epidural dose, an epidural PBPK model was developed. Drug absorption following epidural administration is a complex process because of the unique physiology of the epidural space. The sensitivity analyses using a hypothetical drug X demonstrated that CLpd,vein is the major rate-determining factor of drug absorption following epidural injection. Since there is currently no information on the surface area of the

Fig. 6. Simulated maternal venous (m), UV, and UA plasma concentration-time profiles following epidural administration of fentanyl overlaid with observed plasma concentrations. The simulated (solid black lines) and observed (black open circles) m concentrations, simulated (blue solid lines) and observed (blue open circles) UV concentrations, and simulated (red solid lines) and observed (red open circles) UA concentrations following (A) a single epidural bolus dose of 100 μg fentanyl (n = 16), (B) a single epidural bolus dose of 100 μg fentanyl (n = 10), (C) a single epidural bolus dose of 100 μg fentanyl (n = 10), (D) a single epidural bolus dose of 100 μg fentanyl (n = 19). The observed fentanyl concentrations are from (Desprats et al., 1991) (A), (Desprats et al., 1995) (B), (Mosés et al., 2005) (C), (de Barros Duarte et al., 2009) (D), (Bader et al., 1995) (E), and (Haidl et al., 2018) (F). The AAFE reported in (A–D) and (F) (m only) were calculated from the simulated and the mean observed m, ua, uv concentrations at each timepoint of each respective study. The AAFE reported in (E) and (F) (UV only) were calculated from the simulated and observed concentration of each individual subject. The Y-axis error bars in (A and B) and (F) represent the S.D. and in (C and D) represent the 25th and 75th quartile as reported in the respective studies. (E) shows the simulated m and UV concentrations (solid lines) in comparison with individual subject data at delivery (open circles) and (F) shows the simulated UV (blue solid line) and observed individual subject uv concentrations at delivery (blue open circles). The X-axis error bars in panels (A–C) represent the window of the reported sampling time (i.e., time of delivery). Insets in all panels show the simulated UV (dashed blue lines) and UA (dashed red lines) plasma concentrations with unbound fraction in fetal plasma (ffu) of 0.01 and 0.34 illustrating the impact of plasma protein binding on umbilical cord concentrations and observed concentrations.
epidural venous system, the CL_{pd,vein} of fentanyl was defined using a
scaler compound alfentanil. The observed Caco-2 permeability for
alfentanil and fentanyl together with alfentanil optimized CL_{pd,vein}
were deployed in accordance to a method previously established to predict
transplacental clearance (Zhang and Unadkat, 2017). The optimized
CL_{pd,vein} was 20-fold higher than the estimated CL_{pd,adipose} scaled
on the surface area of the adipose tissue likely reflecting higher barrier
permeability due to larger venous surface area and fenestration in the
blood vessels (Becske and Nelson, 2009). The scaling approach yielded
a fentanyl model that successfully simulated fentanyl PK after epidural
dosing. This suggests that epidural absorption kinetics is directly gov-
erned by endothelial permeability, and that this method and the devel-
oped epidural dosing model can be used more broadly for other drugs
and for dosing in nonpregnant individuals to aid in the design of dosing
strategies. The model can also be coupled with a pharmacodynamic
(PD) model to allow PK-PD simulations for pain management.

Fetal liver metabolism of fentanyl has been suggested based on the
high CYP3A4 mediated hepatic CL_{int,u} of fentanyl observed in adults
(Labroo et al., 1997) and similar substrate specificity of CYP3A4 and
CYP3A7 (Williams et al., 2002). However, no metabolism of fentanyl
by CYP3A7 has been reported. This study showed that both CYP3A7
and pooled FLM metabolize fentanyl to norfentanyl, the major fentanyl
metabolite formed by CYP3A4 in adults. Fentanyl metabolism in FLM
is likely mediated by CYP3A7 based on the extrapolation from super-
somes to FLM using a measured CYP3A7 expression and established
intersystem extrapolation factor for CYP3A7. The extraplated fetal
hepatic CL_{int,u} (0.028 l/h) was significantly less than the observed adult
hepatic CL_{int,u} (1.055 l/h), and the predicted extraction ratio by fetal
liver was very low, <0.01. Although it is possible that the predicted fetal hepatic CL_{int,u} is an underprediction of the the CL_{int,u}, such
underprediction would be unlikely to affect the overall simulations. Even
if the predicted CL_{int,u} is only 10% of the in vivo CL_{int,u}, the fetal liver is
unlikely to quantitatively contribute to the maternal-fetal clearance
of fentanyl. Moreover, the fetal hepatic CL_{int,u} is low in comparison with
fetal hepatic blood flow and transplacental clearance, suggesting that
fetal liver metabolism does not affect fetal drug disposition. The minor
role of fetal liver metabolism was also confirmed through the simulations
using the mf-PBPK model that the U/A/U ratio was unity following
epidural infusion to steady state.

The simulations undertaken to explore fetal exposure to fentanyl after
intravenous bolus dose (500 μg) that may occur in drug abuse scenarios
show that fetal fentanyl concentrations are likely to reach pharmacologi-
cally active concentrations that may cause a risk to the fetus. The simul-
ated total C_{max} of fentanyl in UV was ~33nM (11 ng/ml), a
concentration that exceeds the reported fentanyl EC_{50} (20–24 nM)
(Lötsch, 2005; Kalvass et al., 2007). However, the umbilical cord
plasma protein binding had a significant impact on the concentrations
simulated in UV and UA. As the values reported in the literature for
fentanyl protein binding in the umbilical cord vary considerably, these
simulations suggest that more data are needed regarding fentanyl protein
binding in fetal circulation.

The simulations of maternal-fetal disposition of fentanyl illustrate an
important concept that the umbilical venous and arterial concentrations
(commonly collected to reflect fetal exposure) and the maternal arterial
and venous concentrations and their ratios following a bolus dose
depend on the distribution kinetics in the mom, fetus, and across the
placenta. The UV/MV ratio is most commonly reported in clinical stud-
ies to reflect the transplacental transfer from the mom to the fetus, but
the results of the simulations shown here demonstrate that this ratio can
be very misleading and confound interpretation of maternal-fetal distri-
bution if measured under nonsteady-state circumstances and based on a

Fig. 7. Simulated maternal to umbilical vein and artery plasma concentration
ratio-time profiles following an epidural bolus dose of 100 μg fentanyl overlaid
with observed concentration ratios. The simulated (blue line) and observed (blue
open circles) umbilical venous/maternal venous (UV/MV) concentration ratios,
the simulated (red line) and observed (red open circles) umbilical arterial/umbilical
venous (UA/UV) concentration ratios, and the simulated (black line) umbilical
venous/maternal arterial (UV/MA) concentration ratios over time (0–2h) follow-
ing a single epidural bolus dose of 100 μg fentanyl. The observed ratios are from
(Desprats et al., 1991) (n = 16), (Desprats et al., 1995) (n = 16), (Moisés et al.,
2005) (n = 10), and (de Barros Duarte et al., 2009) (n = 10). The Y-axis error
bars represent the S.D. or the 25th and 75th percentiles, and the X-axis error bars rep-
resent the window of the reported sampling time (i.e., time of delivery). Insets
show the simulated UV/MV (dashed blue line) and UA/UV (dashed red lines)
ratios with unbound fraction in fetal plasma (ffu) of 0.01 and 0.34 and observed
ratios.

Fig. 8. Simulated maternal and umbilical cord fentanyl plasma concentrations and concentration ratios following a single IV bolus dose of 500 μg fentanyl using the
validated mf-PBPK model. (A) shows the simulated MA (solid magenta line), MV (solid black line), UV (solid blue line), and UA (solid red line) plasma concen-
tration-time profiles (0–2h) following a single intravenous bolus dose of 500 μg fentanyl. (B) shows the UV/MA (solid black line), UV/MV (solid blue line), and UA/
UV (solid red line) ratio-time profile of the simulated plasma concentrations. The insets show the simulated data until 24 hours after dosing.
single time point. The simulations also illustrate that time dependent variation in UV/MV ratio likely explains the variability in experimentally measured values. Physiologically, the placenta is perfused with maternal arterial blood instead of venous blood, and hence, the maternal arterial blood concentration is the main driver of the distribution kinetics across the placenta (i.e., syncytiotrophoblast monolayer). Depending on the PK properties of the drug, the arteriovenous concentration difference in the mother could be large (Huang and Isoherranen, 2020), resulting in very different UV/MV and UV/MA concentration ratios. The arteriovenous concentration difference of fentanyl was captured by these simulations and is also supported by the observed 2-fold higher placental intervillous space plasma fentanyl concentration (maternal side) (2.02 nM) compared with the MV plasma concentration (0.92 nM) at about 30 minutes post epidural bolus dose (De Barros Duarte et al., 2009). Hence, the high UV/MV ratio of fentanyl does not reflect a rapid transplacental transfer, but rather the arteriovenous distribution kinetics in the mother, and hence can be misleading for assessing fetal exposure to fentanyl. As illustrated by the UV/MV ratio, the transplacental distribution of fentanyl to the fetus is relatively slow taking several hours to reach distribution equilibrium. Notably, the simulated UV/MV ratios were different than the commonly reported UV/MV ratios, in particular during the earlier time points suggesting the potential for systematic errors in assessing transplacental permeability from UV/MV ratios.

The UA/UV ratio reflects the distribution kinetics (and metabolism) in the fetus. The UV concentration is the concentration on the fetal side of the placenta after the drug crosses the placenta and before fetal distribution and metabolism. The UA concentration is the fetal arterial concentration after fetal distribution and metabolism. The UV/UA ratio following a bolus dose of fentanyl suggest that the fetal distribution of fentanyl is slow, as distribution equilibrium was not reached until 30 hours postdose. The data presented suggests that to best capture maternal-fetal distribution and potential fetal clearance, steady-state concentration ratios should be measured. An early measurement of UA/UV ratio that is $<1$ could be misinterpreted to imply metabolism in the fetus.

In conclusion, our study demonstrates that maternal-fetal disposition of drugs can be predicted using mf-PBPK modeling, and this tool can be used to study maternal-fetal disposition of drugs that are difficult to study in the clinic. The simulations using the mf-PBPK model illustrate that the umbilical cord/maternal plasma concentration ratio is significantly impacted by maternal, fetal, and transplacental distribution kinetics after a bolus dose. Any fetal-maternal concentration ratios should be interpreted with caution, as they must take into account the time course of drug distribution which can be accomplished through mf-PBPK modeling.

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Authorship Contributions

Participated in research design: Shum, Shen, and Isoherranen. Conducted experiments: Shum. Performed data analysis: Shum. Wrote or contributed to the writing of the manuscript: Shum, Shen, and Isoherranen.

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