Characterization of the Analgesic and Anti-Inflammatory Activities of Ketorolac and Its Enantiomers in the Rat

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Accepted for publication October 23, 1998

This paper is available online at http://www.jpet.org

ABSTRACT

The marked analgesic efficacy of ketorolac in humans, relative to other nonsteroidal anti-inflammatory drugs (NSAIDs), has lead to speculation as to whether additional non-NSAID mechanism(s) contribute to its analgesic actions. To evaluate this possibility, we characterized (R,S)-ketorolac’s pharmacological properties in vivo and in vitro using the nonselective cyclooxygenase (COX) inhibitors [indomethacin (INDO) and diclofenac sodium (DS)] as well as the selective COX-2 inhibitor, celecoxib, as references. The potency of racemic (R,S)-ketorolac was similar in tests of acetic acid-induced writhing, carrageenan-induced paw hyperalgesia, and carrageenan-induced edema formation in rats; ID_{50} values = 0.24, 0.29, and 0.08 mg/kg, respectively. (R,S)-ketorolac’s actions were stereospecific, with (S)-ketorolac possessing the biological activity of the racemate in the above tests. The analgesic potencies for (R,S)-, (S)-, and (R)-ketorolac, INDO, and DS were highly correlated with their anti-inflammatory potencies, suggesting a common mechanism. (R,S)-ketorolac was significantly more potent than INDO or DS in vivo. Neither difference in relative potency of COX inhibition for (R,S)-ketorolac over INDO and DS nor activity of (S)-ketorolac at a number of other enzymes, channels, or receptors could account for the differences in observed potency. The distribution coefficient for (R,S)-ketorolac was approximately 30-fold less than for DS or INDO, indicating that (R,S)-ketorolac is much less lipophilic than these NSAIDs. Therefore, the physicochemical and pharmacokinetics properties of (R,S)-ketorolac may optimize the concentrations of (S)-ketorolac at its biological target(s), resulting in greater efficacy and potency in vivo.

Received for publication August 6, 1998.

ABBREVIATIONS: COX, cyclooxygenase; 5-HT, hydroxytryptamine (serotonin); NO, nitric oxide; NSAID, non-steroidal anti-inflammatory drug; NMDA, N-methyl-D-aspartate; INDO, indomethacin; DS, diclofenac sodium; i.t., intrathecal; CNS, central nervous system; i.c.v., intracerebroventricular; DMSO, dimethyl sulfoxide.

Racemic ketorolac (Toradol) is a non-steroidal anti-inflammatory drug (NSAID) that is effective in the clinic as an analgesic in the treatment of postsurgical pain (Yee et al., 1986; O’Hara et al., 1987; Stanski et al., 1990). The marked efficacy of (R,S)-ketorolac as an analgesic, relative to other NSAIDs, has lead to speculation regarding the mechanism underlying its analgesic actions. Initially, it was suggested that (R,S)-ketorolac was a highly potent cyclooxygenase (COX) inhibitor (Rooks et al., 1982). Moreover, it was thought that it was this activity alone that accounted for (R,S)-ketorolac’s analgesic potency in vivo, consistent with the mechanism by which NSAIDs were proposed to act (Vane, 1971; Higgs et al., 1976). Subsequently, it was reported that (R,S)-ketorolac was no more potent than indomethacin (INDO) (Parnham, 1993) or diclofenac sodium (DS; Pallapies et al., 1995) as inhibitors of COX-1 or COX-2. Collectively, these results suggest that additional unknown mechanism(s) might contribute to the analgesic actions of (R,S)-ketorolac.

After the introduction of Toradol, evidence accumulated suggesting that the analgesic and anti-inflammatory activities of certain NSAIDs (Brune et al., 1991), specifically (R,S)-ketorolac (McCormack and Uquhart, 1995), could be discriminated. Consequently, several different COX-independent activities of (R,S)-ketorolac were examined in an effort to explain its marked, clinical analgesic efficacy relative to other NSAIDs. These mechanisms included facilitation of extracellular calcium entry (Chavez et al., 1993), indirect activation of κ opioid receptors (Upshall et al., 1993; Tripathi and Welch, 1995), and modulation of nitric oxide (NO) synthase (Granados-Soto et al., 1995). Currently, none of these activities have been conclusively shown to account for the analgesic efficacy or potency of (R,S)-ketorolac in vivo. Although several studies have shown that peripherally administered (R,S)-ketorolac does not readily cross the blood-
brain barrier in either rats or humans (Mroszczak et al., 1987), evidence that (R,S)-ketorolac acts at sites in the central as well as the peripheral nervous system to produce analgesia has accumulated. For example, after intrathecal (i.t.) administration, (R,S)-ketorolac blocks pain states associated with central sensitization: formalin-induced hyperalgesia in rats (Malmberg and Yaksh, 1992, 1993) and thermal hyperalgesia in a neuropathic rat model (Parris et al., 1996). Taken together, it appears that (R,S)-ketorolac produces analgesia in several rodent models when administered centrally, although the mechanism by which it exerts these actions is unclear.

The purpose of this work was to evaluate the pharmacology of (R,S)-, (S)-, and (R)-ketorolac in vivo and in vitro to elucidate possible mechanism(s) underlying its analgesic efficacy.

### Materials and Methods

#### Compounds Used

(R,S)-ketorolac, (S)-ketorolac, (R)-ketorolac, and celecoxib (Pennig et al., 1997) were synthesized in the Institute of Organic Chemistry, Roche Bioscience (Palo Alto, CA). Gabapentin was purified from a commercial source of Neurontin. [3H](R,S)-ketorolac (49.5 Ci/mmol) was prepared by the Radiopharmacy Group, Roche Bioscience and dissolved in dimethyl sulfoxide (DMSO) to a final specific activity of 0.495 Ci/mmol. DS, INDO, morphine sulfate, and Type IV carrageenan (λ) were obtained from Sigma Chemical Co. (St. Louis, MO). Carprofen 1% was purchased from Cayman Chemical Co., Inc. (Ann Arbor, MD). (R,S)-ketorolac, INDO, and DS were dissolved in a vehicle containing 40% propylene glycol, 10% ethanol, 5% sodium benzoate/benzoic acid buffer, and 1% benzyl alcohol (pH 6.8). Celecoxib was dissolved in a vehicle containing 85% propylene glycol and 5% sodium benzoate/benzoic acid buffer (pH 6.8). Drug doses were calculated from the free base weight and the drugs were administered in a dose volume of 2 ml/kg.

#### Animals and Surgical Preparation

**Animals.** Male Sprague-Dawley rats were purchased from Harlan Sprague-Dawley Inc. (San Diego, CA) and housed at 22°C with a 12-h light/dark cycle for 7 days before the onset of experimentation. All procedures were reviewed and approved by the Roche Bioscience Institutional Animal Care and Use Committee.

**Intracerebroventricular (i.c.v.) Cannulation.** Rats (120 g) were anesthetized with halothane (5%) and administered 50 μl of vehicle or carrageenan (0.5% in saline) s.c. on the plantar surface of the left hindpaw (Vinegar et al., 1976). The rats received vehicle or drug 2 h after carrageenan administration and were evaluated for paw hyperalgesia 1 h later. Hindpaw hyperalgesia was measured as described previously (Randall and Selitto, 1957) using an Ugo Basile Analgesy-meter (Stoeling Co., Wood Dale, IL). The force at which a rat withdrew its hindpaw, vocalized, or struggled was multiplied by 10, as recommended by the manufacturer, and recorded as the withdrawal force (g).

**Carrageenan-Induced Edema Formation.** Rats (130–140 g) were randomly assigned to treatment groups so that each group was weight-balanced and administered vehicle or drug. Immediately thereafter, the rats were anesthetized with halothane (5%) and administered 50 μl of vehicle or carrageenan (0.5% in saline) s.c. on plantar surface of the left hindpaw, essentially, as described earlier (Vinegar et al., 1976). Three hours later, the rats were euthanized and the difference in the weight (g) of the treated and untreated hindpaws was recorded as an expression of edema formation (g).

**Neuropathy-Induced Cold Allodynia.** Rats (220–260 g) were randomly assigned to treatment groups and evaluated for allodynia as described previously (Gogas et al., 1997). The rats were then administered vehicle or drug and evaluated again 1 h later. In each case, the latency (s) to withdrawal of the neuropathic hindpaw from the ice water bath was measured.

### Pharmacokinetics Analysis of (R,S)-Ketorolac

Rats were anesthetized with 5% halothane and administered [3H](R,S)-ketorolac (100 nmol; 0.495 mCi/mmol) by i.c.v. injection. At 0, 5, 20, 35, and 60 min after injection, the rats were anesthetized with CO2/O2 (60:40%); blood was withdrawn into a heparinized syringe and a plasma fraction was obtained by centrifugation of the blood at 2600g for 5 min in a clinical centrifuge. To determine the total [3H](R,S)-ketorolac in each sample, aliquots of plasma were subjected to scintillation spectroscopy and HPLC. Protein was removed from the samples by precipitation with 1 volume of acetone/trimethyl and centrifugation (500g, 15 min). The resulting supernatant was applied to a BDS-Hypersil-C18 (4.6 × 250 mm) reversed phase analytical column run isocratically at a flow rate of 1.0 ml/min with a solvent system consisting of 34% acetonitrile and 66% phosphate buffer (20 mM, pH 7.4). The concentration of (R,S)-ketorolac in the HPLC effluent was determined by comparison with the internal standard and by UV absorption at 317 nm. The [3H](R,S)-ketorolac in the effluent was determined radiometrically using a Radiomatic Flo-One/Beta A-500 radioactive flow detector (Packard Instruments Co., Inc., Meriden, CT) equipped with a 1-ml cell.

### In Vitro Assays

#### Inhibition of Prostaglandin Formation.

Recombinant COX-1 and COX-2 from rat (rCOX) and human (hCOX) were expressed in a baculovirus system and purified as described previously (Barnett et al., 1994). The specific activity of the final enzyme preparations used was between 20,000 and 35,000 units (1 unit = 1 nmol of oxygen consumed/min protein/min) with a purity of > 80% as judged by sodium dodecyl sulfate-polyacrylamide gel electrophoresis and silver staining.
The purified COX enzymes were reconstituted with 2 mM phenol and 1 μM hematin and the cyclooxygenase activity was measured using a radiometric assay (Barnett et al., 1994). Putative inhibitors (2–15 μl) were diluted in DMSO and preincubated with the appropriate recombinant COX (3–15 ng) at a final concentration of 0.01 to 1000 μM in a reaction mixture (150 μl) containing 50 mM Tris-HCl buffer (pH 7.9), 2 mM EDTA, 10% glycerol, 2 mM phenol, and 1 μM hematin for 10 min. The reaction was initiated by addition of [14C]arachidonic acid (Amersham, 50–60 μCi/ml in a final concentration of 20 μM) and was terminated 45 s later by the addition of 100 μl of 0.2 N HCl and 750 μl of distilled water. The total reaction volume was then applied to a 1 M CsCl Sep-pak column that had previously been washed with 2 ml of methanol followed by 5 ml of deionized water. Oxygenated products were eluted with 3 ml of a mixture of acetonitrile/water/acidic acid (50:50:0.1, v/v/v) and quantified by liquid scintillation spectroscopy. All inhibitors were assayed in triplicate using at least three independent samples.

**Ligand Binding and Enzyme Assays.** Membrane preparations enriched with the target receptor or channel (Table 3) were isolated and incubated with selective radioligands (Table 3) in the absence or presence of (S)-ketorolac (10 μM) or an appropriate positive control (Panlabs Inc. Pharmacology Services, Bothell, WA). Nonspecific binding was estimated using an excess of unlabeled, receptor-selective ligands. Details of the specific binding assays are described in the following references: adenosine A1 (Lohse et al., 1987), A2 (Jarvis et al., 1989); α2-adrenergic (Greengrass and Bremner, 1979); α2-adrenergic (Boyajian and Leslie, 1987); β-adrenergic (UPrichard et al., 1978); calotonin gene-related peptide (Yoshizaki et al., 1987); γ-aminobutyric acidA, benzodiazepine site (Damm et al., 1978); galanin (Servin et al., 1987); glutamate-α-amino-3-hydroxy-5-methylisoxazole-4-propionic acid (Oisen et al., 1987); glutamate-kainate (London and Coyle, 1979); glutamate-N-methyl-D-aspartate (NMDA), agonist site (Jones et al., 1989); glutamate-NMDA, glycine site (Snell et al., 1988); glutamate-NMDA, phencyclidine site (Goldman et al., 1985); glycine (Young and Snyder, 1974); histamine H1 (Hill, 1978); H3 (Korte et al., 1990); muscarinic (Luthin and Wolfe, 1984); neurokinin NK1 (Lee et al., 1983); neuropeptide Y1 (Sheikh et al., 1989); opiate (Pasternak et al., 1975); hydroxylprotein (serotonin; 5-HT1); (Middlemiss, 1984); 5-HT1A (Hall et al., 1985); 5-HT2 (Leysen et al., 1982); 5-HT3 (Pinkus et al., 1989); sigma (Weber et al., 1986) receptors as well as L type calcium channel, benzothiazepine site (Schomaker and Langer, 1985); L type calcium channel, dihydropyridine site (Gould et al., 1982); N type calcium channel (Moreno et al., 1990); and sodium channel, site 2 (Catterall et al., 1981).

The effects of (S)-ketorolac on the activity of selected enzymes was also evaluated (Panlabs Inc. Pharmacology Services). (S)-ketorolac (10 μM) was tested with the constitutive isofor of NO synthase from rat cerebellum (Nathan, 1992) and with the inducible isofor of NO synthase from mouse macrophages (Nathan, 1992). (S)-ketorolac (300 μM) was also evaluated for its effects on porcine pancreatic phospholipase A2 (Katsumata et al., 1986), and rat brain protein kinase C (Hannu et al., 1985).

**Estimation of the Distribution Coefficient.** Partition coefficients for (R,S)-ketorolac, DS, and INDO were determined experimentally in a 1-octanol/water system at 25°C and an ionic strength of 0.1 M KCl, using a SIRIUS PCA 101 (SIRIUS Analytical Instruments Ltd., East Sussex, UK), and calculated as follows:

\[
V_o/V_w = \frac{P}{P_i} \left(\frac{P_K - P_K'}{P_K'}\right) - P_i
\]

where:

- \(V_o\): volume of water
- \(V_w\): volume of 1-octanol
- \(P\): partition coefficient of a compound as neutral species
- \(P_i\): partition coefficient of a compound as ionized species
- \(P_K\): acidity constant in water
- \(P_K'\): acidity constant in the presence of 1-octanol

These values were then used to calculate the distribution coefficient (D) at pH 7.4, using the following equation:

\[
D = \frac{(P[H^+] + P_K')/([H^+] + K_1)}{([H^+] + K_1)}
\]

**Data Analysis**

All treatment groups were compared using a one-way ANOVA. Pairwise comparisons for the drug-treated groups to the vehicle group were then performed using Fisher's least significant difference test. Bonferroni's adjustment for multiple comparisons was made if the overall difference was not significant. In the writhing and paw edema tests, the analysis was carried out with ranked data. The following sigmoidal model was used: % Inhibition = MAX/(1 + (dose/ID50)2), where ID50 is the dose of the compound needed to achieve half of the maximum response in the dose-response curve; MAX is the curvature parameter; % Inhibition is the maximum response and is assumed to be 100% in the writhing and paw hyperalgesia tests. All analyses were performed using SAS/STAT (SAS Institute Inc., 1989).

**Results**

**Tests of Nociception, Hyperalgesia, and Inflammation**

To determine the relationship between (R,S)-ketorolac's analgesic and anti-inflammatory actions, (R,S)-ketorolac and (R)-ketorolac as well as selected reference compounds were evaluated in tests of nociception (i.e., acetic acid-induced writhing), hyperalgesia (i.e., carrageenan-induced paw hyperalgesia), and inflammation (i.e., carrageenan-induced paw edema formation). The tests were optimized for use with NSAIDs; however, celecoxib did not significantly affect the writhing response at the doses tested (3–30 mg/kg p.o.). Under the same conditions, however, celecoxib effectively blocked carrageenan-induced paw hyperalgesia: 75% inhibition at 30 mg/kg p.o. with an ID50 value of 7.9 ± 1.2 mg/kg (Table 1).

![Image](https://via.placeholder.com/150)

**Fig. 1.** Effects of (S)-ketorolac (0.01–1 mg/kg p.o.; ●), INDO (0.3–5 mg/kg p.o., ▲), and celecoxib (1–30 mg/kg p.o.; ■) in the acetic acid-induced abdominal constriction in rats. The results are expressed as a percentage of inhibition from control values, where the control writhing responses were 9.13 ± 0.83, 12.57 ± 1.34, and 14 ± 0.62 writhes/15 min for (S)-ketorolac, INDO, and celecoxib, respectively. Each point represents the mean ± S.E.; n = 5 to 8 per group.
Injection of carrageenan into the rat hindpaw elicits a persistent inflammatory response, as reflected by mechanical hyperalgesia and edema formation (Vinegar et al., 1976), which are mediated by COX-2 (Seibert et al., 1994). To characterize the mechanical hyperalgesia, (S)-ketorolac (0.01–1 mg/kg s.c.), or INDO (0.3–6 mg/kg s.c.) were administered 2 h after carrageenan treatment and 1 h before testing (therapeutic regimen). To characterize edema formation elicited by carrageenan treatment, the same drugs were administered immediately before carrageenan treatment and 3 h before testing (prophylactic regimen). Under these conditions, (S)-ketorolac and INDO completely blocked mechanical hyperalgesia (Fig. 2A), but reduced edema formation by only 50 to 60% (Fig. 2B), as has been reported previously (Higgs et al., 1994). To characterize edema formation (inflammation) or hyperalgesia and edema formation (Table 1). The potencies of these compounds in the tests of nociception or hyperalgesia were compared with the potencies obtained in the test of edema formation. The potencies of these compounds as inhibitors of acute nociception and edema formation (inflammation) or hyperalgesia and edema formation were highly correlated with Pearson correlation coefficients of 0.968 (Fig. 3A) and 0.994 (Fig. 3B), respectively.

In each test, (S)-ketorolac was the most potent compound evaluated, being 200- to 378-fold more potent than (R)-ketorolac and ~4-fold more potent than the racemate (Table 1). (R,S)-ketorolac was also significantly (p < .05) more potent than DS, INDO, or celecoxib in the tests of nociception, hyperalgesia, and edema formation (Table 1).

**Mechanism(s) Underlying the Actions of Ketorolac**

**Inhibition of COX-1 and COX-2.** (R,S)-, (S)-, and (R)-ketorolac, as well as DS, INDO, and celecoxib were assessed for their ability to inhibit both isofoms of COX in recombinant rat and human enzyme systems (Table 2). The compounds were similar as inhibitors of rat COX (rCOX) and human COX (hCOX) under the conditions used. Each compound also exhibited a similar pattern of activity in the two enzyme systems. (R,S)-ketorolac inhibited rCOX-1 with an IC$_{50}$ of 0.27 ± 0.06 μM, a value not significantly different from that exhibited by DS or INDO (i.e., 0.20 ± 0.11 and 0.22 ± 0.14 μM, respectively). (R,S)-ketorolac also inhibited rCOX-1 in a stereoselective manner. The (S) enantiomer of ketorolac with an IC$_{50}$ value of 0.10 ± 0.08 μM was approx-

**TABLE 1**

Antinociceptive, antihyperalgesic, and anti-inflammatory actions of (R,S)-, (S)-, and (R)-ketorolac

<table>
<thead>
<tr>
<th>Compound</th>
<th>Route</th>
<th>Test of Nociception ID$_{50}$</th>
<th>Test of Hyperalgesia ID$_{50}$</th>
<th>Test of Edema Formation$^{a}$ ID$_{50}$</th>
</tr>
</thead>
<tbody>
<tr>
<td>(R,S)-ketorolac</td>
<td>s.c.</td>
<td>0.24 (0.20, 0.27)</td>
<td>0.29 (0.19, 0.39)</td>
<td>0.08 (0.05, 0.11)$^{b}$</td>
</tr>
<tr>
<td>(S)-ketorolac</td>
<td>s.c.</td>
<td>0.06 (0.04, 0.07)$^{a}$</td>
<td>0.07 (0.04, 0.09)$^{a}$</td>
<td>0.02 (0.01, 0.03)$^{a}$</td>
</tr>
<tr>
<td>(R)-ketorolac</td>
<td>s.c.</td>
<td>20.8 (14.1, 26.5)$^{a}$</td>
<td>26.5 (16.9, 36.1)$^{a}$</td>
<td>4.0 (1.4, 6.6)$^{a,b,c}$</td>
</tr>
<tr>
<td>DS</td>
<td>s.c.</td>
<td>5.89 (4.46, 7.33)$^{a}$</td>
<td>4.40 (1.62, 7.17)$^{a}$</td>
<td>0.27 (0.17, 0.37)$^{a,b,c}$</td>
</tr>
<tr>
<td>INDO</td>
<td>s.c.</td>
<td>1.10 (0.60, 1.60)$^{a}$</td>
<td>2.6 (2.1, 3.1)$^{b,c}$</td>
<td>0.46 (0.16, 0.76)$^{a,b,c}$</td>
</tr>
<tr>
<td>Celecoxib</td>
<td>p.o.</td>
<td>&gt;30</td>
<td>7.9 (5.5, 10.3)$^{a}$</td>
<td>8.4 (4.9, 11.9)$^{a,b,c}$</td>
</tr>
<tr>
<td></td>
<td>i.v.</td>
<td></td>
<td>2.8 (1.7, 3.8)$^{a}$</td>
<td>7.5 (4.0, 11.0)$^{a,b,c}$</td>
</tr>
</tbody>
</table>

$^{a}$ Estimation of ID$_{50}$ values assumes a maximum response of 50 to 60% inhibition.

$^{b}$ Significantly different from values in the test of nociception (p < .05).

$^{c}$ Significantly different from (R,S)-ketorolac (p < .05).

Fig. 2. Effect of (S)-ketorolac (0.01–1 mg/kg s.c.) and INDO (0.3–6 mg/kg s.c.) on carrageenan-induced paw hyperalgesia (A) and carrageenan-induced paw edema formation (B). Each point represents the mean ± S.E. percentage of inhibition; n = 10 to 16 rats/group.
A coefficient was calculated for each comparison. DS (100 mg/kg p.o.) were also ineffective. In contrast, morphine sulfate (6 mg/kg p.o.) completely blocked the carba-prostacyclin-induced writhing response.

**Central Actions of Ketorolac.** To investigate the possibility that the analgesic actions of ketorolac are mediated by central COX or as yet unidentified mechanisms within the central nervous system (CNS), the binding profile of (S)-ketorolac to ion channels and receptors known to be involved in central mechanisms of analgesia was determined (Table 3). In each case, the channel or receptor membrane preparation was incubated in the presence of 10 μM (S)-ketorolac. Under these conditions, (S)-ketorolac did not significantly inhibit selective ligand binding to the channels and receptors evaluated. Neither did it inhibit the activity of the constitutive or inducible isoforms of NO at 10 μM synthase (2 and −19% inhibition, respectively), phospholipase A<sub>2</sub> at 300 μM (4% inhibition) or protein kinase C at 100 μM (−6% inhibition).

Because central mechanisms, perhaps not included in the binding or enzyme activity assays, might contribute to the analgesic actions of ketorolac, the effect of (S)-ketorolac (i.c.v.) on the acetic acid-induced writhing response was assessed. (S)-ketorolac (1–100 nmol i.c.v.) significantly inhibited the acid-induced writhing with an ID<sub>50</sub> of 21.1 ± 6.0 nmol. Under the same conditions, neither INDO nor DS, at 300 nmol, significantly affected the writhing response. These results suggest that either (S)-ketorolac had produced central analgesic actions or that centrally administered (S)-ketorolac had entered the systemic circulatory system and blocked the writhing response by inhibiting the peripheral COX-1.

To test this latter possibility, [3H](R,S)-ketorolac (100 nmol) was administered i.c.v. and its appearance in peripheral blood was measured using both radiometric and HPLC methods of quantification. As seen in Fig. 5, [3H](R,S)-ketorolac entered the peripheral circulatory system and reached peak levels of 0.3 to 0.4 μg/ml within 5 min of dosing and steady-state levels of 0.2 to 0.3 μg/ml within 30 min of dosing. These levels of (R,S)-ketorolac in peripheral blood must be considered significant, because the C<sub>max</sub> achieved with a near maximally effective dose of (R,S)-ketorolac (1 mg/kg i.v.) is approximately 3 μg/ml (Mroszczak et al., 1987). The egress of radiolabeled (R,S)-ketorolac from the CNS after i.t. administration via a chronically implanted cannula was virtually indistinguishable from that described in Fig. 5 (data not shown).

To further explore the possibility that peripherally administered (R,S)-ketorolac could exert its analgesic actions via a central mechanism, the effect of peripherally administered (S)-ketorolac on mononeuropathy-induced cold allodynia (Gogas et al., 1997) was assessed. Normally, rats are able to remain in a cold bath (0–4°C) for 20 s without signs of discomfort. After induction of the mononeuropathy, the rats develop cold allodynia, as reflected by rapid withdrawal of the affected hindpaw from the cold bath in less than 20 s (Fig. 6). Under the conditions used, (S)-ketorolac (1, 3, and 10 mg/kg p.o.) did not significantly affect cold allodynia in rats rendered neuropathic, although in a parallel study, the centrally acting antiepileptic drug gabapentin (30, 100, and 300 mg/kg p.o.) effectively reversed the allodynia.

**Distribution Coefficient of (R,S)-Ketorolac.** The distribution coefficient is a measure of the extent to which a compound partitions into an organic medium at pH 7.4 and
predicts the ability of a compound to penetrate lipophilic, biological membranes (Avdeef, 1996). To compare the partition coefficient of (R,S)-ketorolac with those of INDO and DS, the three compounds were evaluated in a 1-octanol/water system (pH 7.4) at 25°C with an ionic strength of 0.15 M KCl. Under these conditions, the respective distribution coefficients for INDO and diclofenac were 30- and 35-fold greater than that for (R,S)-ketorolac (Table 4).

### Discussion

**Mechanism(s) Underlying the Actions of (R,S)-Ketorolac**

During the initial pharmacological evaluation of (R,S)-ketorolac, it was suggested that the drug’s potency in vivo relative to other NSAIDs resulted from its relative potency as a COX inhibitor (Rooks et al., 1982). In the present work, (R,S)-ketorolac was a potent inhibitor of COX-1 and COX-2 from rat or human in vitro. It was, however, no more potent than INDO or DS as an inhibitor of COX-1. Neither was (R,S)-ketorolac highly selective for COX-1 over COX-2 (i.e., COX-1/COX-2 activity ratios were 0.13 and 0.33, respectively), consistent with earlier reports (Parnham, 1993; Pallapies et al., 1995). Therefore, (R,S)-ketorolac is a potent, nonselctive COX inhibitor, like other NSAIDs.

To what extent, then, do the analgesic and anti-inflammatory actions of (R,S)-ketorolac result from inhibition of COX-1 or COX-2 in vivo? First, in the acute abdominal con-

### Potency of (R,S)-Ketorolac Relative to Other NSAIDs

Based on the relative potencies of (R,S)-ketorolac, INDO, and DS as inhibitors of rCOX-1 (i.e., ID₅₀ values of 0.27, 0.20, and 0.22 μM, respectively), one would predict that (R,S)-ketorolac would be no more potent than INDO or DS as an inhibitor of nociception, hyperalgesia, and inflammation in vivo. Yet, (R,S)-ketorolac was ~3- to 24-fold more potent than these reference compounds in vivo, depending on the test. This greater potency for (R,S)-ketorolac in vivo may be due to important differences in the pharmacokinetics for the three compounds. Differences in plasma protein binding can not explain the differences in potency, as all three compounds are highly bound to plasma proteins in humans (Physicians’ Desk Reference, 1995a,b,c). (R,S)-ketorolac is, however, 30- to 35-fold less lipophilic than INDO or DS. As such, it may partition less extensively into body tissues and fluids, resulting in prolonged circulating concentrations of the drug and enhanced biological activity.
TABLE 3

Binding profile of \((S)-ketorolac\)

<table>
<thead>
<tr>
<th>Receptor</th>
<th>Selective Ligand</th>
<th>Tissue</th>
<th>% Inhibition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adenosine (A_1)</td>
<td>([^H]DPCPX)</td>
<td>Brain</td>
<td>–11</td>
</tr>
<tr>
<td>Adenosine (A_{2A})</td>
<td>([^H]CGS-21680)</td>
<td>Striatum</td>
<td>4</td>
</tr>
<tr>
<td>Adrenergic (\alpha_1) (nonselective)</td>
<td>([^H]Prazosin)</td>
<td>Brain’</td>
<td>–17</td>
</tr>
<tr>
<td>Adrenergic (\beta) (nonselective)</td>
<td>([^H]Rauwolscine)</td>
<td>Cortex’</td>
<td>–7</td>
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<tr>
<td>CRF</td>
<td>([^H]DHA)</td>
<td>Brain</td>
<td>2</td>
</tr>
<tr>
<td>Type L calcium channel (benzothiazepine site)</td>
<td>([^{125}I]CGRP)</td>
<td>Cortex’</td>
<td>4</td>
</tr>
<tr>
<td>Type L calcium channel (dihydropyridine site)</td>
<td>([^H]Nitrendipine)</td>
<td>Cortex’</td>
<td>16</td>
</tr>
<tr>
<td>Type N calcium channel (\gamma)-aminobutyric acid(_4) (benzodiazepine site)</td>
<td>([^H]Flunitrazepam)</td>
<td>Brain’</td>
<td>27</td>
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<tr>
<td>Galanin</td>
<td>([^{125}I]Galalin)</td>
<td>Brain</td>
<td>6</td>
</tr>
<tr>
<td>Glutamate-AMPA</td>
<td>([^H]AMPA)</td>
<td>Cortex’</td>
<td>11</td>
</tr>
<tr>
<td>Glutamate-Kainate</td>
<td>([^H]Kainate)</td>
<td>Brain’</td>
<td>13</td>
</tr>
<tr>
<td>Glutamate-NMDA (agonist site)</td>
<td>([^H]CGS-19755)</td>
<td>Cortex’</td>
<td>2</td>
</tr>
<tr>
<td>Glutamate-NMDA (glycine site)</td>
<td>([^H]Glycine)</td>
<td>Cortex’</td>
<td>–2</td>
</tr>
<tr>
<td>Glutamate-NMDA (phencyclidine site)</td>
<td>([^H]TCP)</td>
<td>Cortex’</td>
<td>22</td>
</tr>
<tr>
<td>Glycine</td>
<td>([^H]Strychnine)</td>
<td>Spinal cord</td>
<td>19</td>
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<tr>
<td>Histamine (H_1)</td>
<td>([^H]Pyrilamine)</td>
<td>Brain’</td>
<td>–2</td>
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<tr>
<td>Histamine (H_3)</td>
<td>([^H]NAMH)</td>
<td>Brain</td>
<td>21</td>
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<tr>
<td>Muscarinic (nonselective)</td>
<td>QNB</td>
<td>Cortex’</td>
<td>2</td>
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<td>Neurokinin (NK_3)</td>
<td>([^H]Substance P)</td>
<td>Submaxillary glands’</td>
<td>–16</td>
</tr>
<tr>
<td>Neuropeptide (Y_1)</td>
<td>([^{125}I]PYY)</td>
<td>SK-N-MC cells’</td>
<td>8</td>
</tr>
<tr>
<td>Opiate (nonselective)</td>
<td>Naloxone</td>
<td>Brain’</td>
<td>6</td>
</tr>
<tr>
<td>5-HT(_1)</td>
<td>([^H]5-HT)</td>
<td>Cortex’</td>
<td>–12</td>
</tr>
<tr>
<td>5-HT(_1) (_A)</td>
<td>([^H]8-OH-DPAT)</td>
<td>Cortex’</td>
<td>–7</td>
</tr>
<tr>
<td>5-HT(_2)</td>
<td>([^H]Retanserin)</td>
<td>Brain’</td>
<td>16</td>
</tr>
<tr>
<td>5-HT(_3)</td>
<td>([^{125}I]GR-65630)</td>
<td>Real musculariae’</td>
<td>5</td>
</tr>
<tr>
<td>Sigma (nonselective)</td>
<td>([^H]DTG)</td>
<td>Brain’</td>
<td>11</td>
</tr>
<tr>
<td>Sodium channel (site 2)</td>
<td>([^H]BTX)</td>
<td>Brain’</td>
<td>3</td>
</tr>
</tbody>
</table>

\[^{a}\] AMPA, \((\pm)-3\)-amino-5-hydroxy-5-methylisoxazole-4-propionic acid

\[^{b}\] All tissues were from rat except where noted.

\[^{c}\] Average of two determinations.

\[^{d}\] Except cerebellum

\[^{e}\] From brain

\[^{f}\] Guinea pig

\[^{g}\] Human

\[^{h}\] Rabbit

inflammatory activity (Rooks et al., 1985; Young and Yee, 1994). This was based on observations that \((R,S)\)-ketorolac was less effective than other NSAIDs, such as INDO or DS, at reducing paw inflammation in a rat model of adjuvant-induced arthritis involving the therapeutic administration of drugs (Rooks et al., 1985; Young and Yee, 1994). The results presented here suggest that the association or dissociation of the analgesic and anti-inflammatory activities of \((R,S)\)-ketorolac depends on whether the drug is administered prophylactically or therapeutically.

When \((R,S)\)-ketorolac was administered prophylactically, its anti-inflammatory and analgesic potencies were only marginally different. This difference was not unique to \((R,S)\)-ketorolac, because INDO and DS were also somewhat more potent as anti-inflammatory than analgesic drugs when administered prophylactically. Second, the analgesic potencies for \((R,S)\)-ketorolac, \((R)\)-ketorolac, \((S)\)-ketorolac, INDO, and DS were highly correlated with their anti-inflammatory potencies, suggesting that these compounds share a common mechanism. Third, the \((S)\) enantiomer of \((R,S)\)-ketorolac produced the biological effects of the racemate in tests of nociception and hyperalgesia as well as in tests of inflammation, consistent with previous reports (Guzman et al., 1986). Together these results suggest that there is no dissociation of the anti-inflammatory and analgesic activities of \((R,S)\)-ketorolac when the drug is administered prophylactically.

There remains, however, clear evidence for dissociation of these activities when \((R,S)\)-ketorolac is administered therapeutically (Rooks et al., 1985; Young and Yee, 1994; McCor-
mack and Urquhart, 1995). The fact that (R,S)-ketorolac is less lipophilic than other NSAIDs, specifically INDO and DS, may help explain this apparent dissociation of activities. In chronic inflammatory conditions, NSAIDs, including (R,S)-ketorolac, are administered after the inflamed tissue is “walled off” by edema formation and swelling. (R,S)-ketorolac, being less lipophilic, does not distribute well beyond the vascular bed (Mroszczak et al., 1987) and may not partition into inflamed joints and tissues (Avdeef, 1996) as well as INDO or DS. This would effectively reduce (R,S)-ketorolac’s potency as an anti-inflammatory drug relative to INDO and DS, as has been shown previously (Young and Yee, 1994). If (R,S)-ketorolac exerted its analgesic actions only at the site of inflammation, then its analgesic and anti-inflammatory potencies should be similar. The fact that (R,S)-ketorolac remains a potent analgesic in chronic inflammatory conditions (Rooks et al., 1985), but loses its potency as an anti-inflammatory agent relative to other NSAIDs (Rooks et al., 1985; Young and Yee, 1994) suggests that (R,S)-ketorolac can act elsewhere to produce analgesia. One possibility is that it acts peripherally to block COX activity in the dorsal root ganglia, as has been proposed recently for other COX inhibitors (Willingdale et al., 1997).

Central Effects of (R,S)-Ketorolac. The lipophilicity of small compounds determines in large part their ability to cross the blood-brain barrier and exert central effects (Pardridge, 1991; Avdeef, 1996). (R,S)-ketorolac is less lipophilic than either INDO or DS and does not readily cross the blood-brain barrier in rodents (Mroszczak et al., 1987) or humans (Physicians’ Desk Reference, 1995b). In fact, the levels of (R,S)-ketorolac in cerebrospinal fluid are 0.002 times less than those in the plasma of humans (Physicians’ Desk Reference, 1995b), suggesting that plasma levels would have to be raised 500-fold to obtain therapeutic levels of (R,S)-ketorolac in the cerebrospinal fluid. Taken together, these data suggest that it is unlikely that peripherally administered (R,S)-ketorolac acts at a central site to produce its analgesic effects.

Although the physicochemical and pharmacokinetic properties of (R,S)-ketorolac greatly limit its ability to enter the CNS, this does not preclude the possibility that the drug can act centrally. Several studies have shown that central administration of (R,S)-ketorolac reduces pain-related behaviors in both rats (Malmberg and Yaksh, 1993; Parris et al., 1996) and mice (Uphouse et al., 1993; Tripathi and Welch, 1995). Our efforts to further characterize the centrally mediated antinociceptive actions of (R,S)-ketorolac were confounded by the rapid egress of drug from the CNS to the periphery. This work demonstrates some of the difficulties associated with studying the central actions of (R,S)-ketorolac, particularly when the pain-related behavior being measured depends on peripheral COX activity.

The fact that (R,S)-ketorolac acts centrally to block pain-related behaviors in rat models involving central sensitization (Malmberg and Yaksh, 1993; Parris et al., 1996) provides a basis for determining whether peripherally administered (R,S)-ketorolac can act centrally to exert its analgesic actions. We demonstrated that peripherally administered (S)-ketorolac at a supramaximal dose (10 mg/kg) does not ameliorate the neuropathy-induced cold allodynia. This contrasts with a previous report showing that centrally administered (R,S)-ketorolac decreases thermal hyperalgesia in the same neuropathic rat model (Parris et al., 1996).

<table>
<thead>
<tr>
<th>Compound</th>
<th>pK_a</th>
<th>logP_i^a</th>
<th>logP_e</th>
<th>D (pH 7.4)</th>
<th>Ratio^c</th>
</tr>
</thead>
<tbody>
<tr>
<td>(R,S)-ketorolac</td>
<td>3.5</td>
<td>2.74 ± 0.02</td>
<td>-0.52 ± 0.07</td>
<td>0.40</td>
<td>1</td>
</tr>
<tr>
<td>DS</td>
<td>4.0</td>
<td>4.33 ± 0.01</td>
<td>-0.56 ± 0.02</td>
<td>14.1</td>
<td>35</td>
</tr>
<tr>
<td>IND</td>
<td>4.2</td>
<td>4.08 ± 0.01</td>
<td>0.47 ± 0.02</td>
<td>12.5</td>
<td>30</td>
</tr>
</tbody>
</table>

^a pK_a values for (R,S)-ketorolac (Muchowski et al., 1985), DS, and INDO (Sallmann, 1979) were obtained from previously published reports.

^b logP_i, partition coefficient of the neutral species.

^c D, Distribution coefficient determined at pH 7.4.

^d Ratio = (D/(Dketorolac)) where x is INDO or DS, respectively.
suggest that peripherally administered (R,S)-ketorolac acts peripherally to produce its analgesic actions.

Acknowledgments

We thank Claudia Kermes, Jennifer McGuirr, Stanford Bingham, Kindra Brusseau, Laura Kassotakis, Lupita O. Jacobson, and Cynthia Rocha.

References

Alvan et al. (1975).

suggest that peripherally administered (R,S)-ketorolac acts peripherally to produce its analgesic actions.

TABLE 5

Distribution volumes of (R,S)-ketorolac, DS, and INDO

<table>
<thead>
<tr>
<th>Compound</th>
<th>Vdav (Route)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(R,S)-ketorolac</td>
<td>0.149 ± 0.05 (i.v.)*</td>
</tr>
<tr>
<td>DS</td>
<td>0.157 ± 0.023 (p.o.)*</td>
</tr>
<tr>
<td>INDO</td>
<td>1.15 ± 0.033 (i.v.)*</td>
</tr>
</tbody>
</table>

* Mroszczak et al., 1996.

**Physician's Desk Reference, 1995a.

† Oktolk et al., and Maunuskel, 1991.

‡ Alvan et al., 1975.
Pharmacology of (R,S)-, (R)-, and (S)- Ketorolac


