Inhibition of Transporter-Mediated Hepatic Uptake as a Mechanism for Drug-Drug Interaction between Cerivastatin and Cyclosporin A

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ABSTRACT

The mechanism involved in the clinically relevant drug-drug interaction (DDI) between cerivastatin (CER) and cyclosporin A (CsA) has not yet been clarified. In the present study, we examined the possible roles of transporter-mediated hepatic uptake in this DDI. The uptake of [14C]CER into human hepatocytes prepared from three different donors was examined. Kinetic analyses revealed $K_m$ values for the uptake of [14C]CER within the range of 3 to 18 $\mu$M, suggesting that more than 70% of the total uptake at therapeutic CER concentrations was accounted for by a saturable process, i.e., transporter-mediated uptake. This uptake was inhibited by CsA with $K_i$ values of 0.3 to 0.7 $\mu$M. The uptake of [14C]CER was also examined in human organic anion transporting polypeptide-2 (OATP2)-expressing Madin-Darby canine kidney cells (MDCKII). Saturable OATP2-mediated uptake of [14C]CER was observed and was also inhibited by CsA, with a $K_i$ value of 0.2 $\mu$M. These results suggest that the DDI between CER and CsA involves the inhibition of transporter-mediated uptake of CER and, at least in part, its OATP2-mediated uptake. The effect of CsA on the in vitro metabolism of [14C]CER was also examined. The metabolism of [14C]CER was inhibited by CsA with an IC$_{50}$ value of more than 30 $\mu$M. From these results, we conclude that the DDI between CER and CsA is mainly due to the inhibition of transporter (at least partly OATP2)-mediated uptake in the liver.

The reduction of serum cholesterol by inhibiting 3-hydroxy-3-methylglutaryl-coenzyme A (HMG-CoA) reductase, a rate-determining enzyme in cholesterol synthesis, is an effective treatment for hypercholesterolemia (Moghadasian, 1999). Cerivastatin (CER) is a potent HMG-CoA reductase inhibitor (statin) with a high oral bioavailability, which makes it effective at low doses (Moghadasian, 1999). CER is extensively taken up into the liver and subsequently metabolized by two different enzymes, CYP2C8 and CYP3A4 (Mück, 2000). This dual metabolic pathway is a distinctive feature of CER among statins.

Patients who develop hypercholesterolemia after tissue transplantation are sometimes treated with combination therapy with statins and cyclosporin A (CsA). CsA is an inhibitor of CYP3A4, and therefore, this immunosuppressant is likely to cause a drug-drug interaction (DDI) with simvastatin, lovastatin, and atorvastatin, which are all substrates of CYP3A4 (Deseger and Horsmans, 1996). This DDI may also cause an increase in the plasma concentration of statins and result in myopathy and/or fatal rhabdomyolysis. Since CER can undergo metabolism via two pathways, the frequency of DDI was believed to be low. However, Mück et al. (1999) have reported that the plasma concentrations of CER are increased in kidney transplant patients following CsA treatment. That is, the area under plasma concentration-time curve (AUC) of CER was increased 4-fold by the coadministration of CsA compared with the control. The plasma concentrations of CER were not affected by coadministration of erythromycin, a potent mechanism-based inhibitor of CYP3A4 (Kanamitsu et al., 2000), suggesting that it is unlikely that the DDI between CER and CsA is due to CYP3A4-mediated metabolism (Mück et al., 1998). Moreover, the AUC of pravastatin, which is not a substrate of CYP3A4, is also increased approximately 20-fold by CsA (Regazzi et al., 1993). Until now, the mechanism of this DDI between CsA and these statins has remained unknown.

ABBREVIATIONS: HMG-CoA, 3-hydroxy-3-methylglutaryl-coenzyme A; DDI, drug-drug interaction; CER, cerivastatin; CsA, cyclosporin A; OATP, organic anion transporting polypeptide; MDCK, Madin-Darby canine kidney; OAT, organic anion transporter; AUC, area under plasma concentration-time curve; CL, clearance.
Statins are taken up into the liver before undergoing metabolism. The hepatic uptake of some statins has already been studied. For example, in rats, the hepatic uptake of CER (Hirayama et al., 2000) and pravastatin (Komai et al., 1992) has been investigated, and their saturable transport systems have been studied. Pravastatin also exhibits saturable uptake in human hepatocytes (Nakai et al., 2001). However, the uptake of CER by human hepatocytes has not yet been investigated.

Recent studies of drug transport in the liver have provided detailed information on drug transporters, including substrate and inhibitor profiles. More recent studies clarifying the mechanism of drug uptake in the liver have used cloning to identify a number of transporters expressed at the sinusoidal membrane of hepatocytes. At present, organic anion transporting polypeptide-2 (OATP2/OATP-C; gene symbol, SLC21A6), OATP8 (SLC21A8), OATP-B (SLC21A9), and organic anion transporter-2 (OAT2; SLC22A7) are reported to be expressed in the human liver and involved in the hepatic uptake of a number of important substrates, including therapeutic drugs (Abe et al., 1999; Hsiang et al., 1999; Kok et al., 2000; König et al., 2000a,b; Tamai et al., 2001). Pravastatin has been shown to be a substrate of OATP2, and this transporter is at least partly responsible for its hepatic uptake (Hsiang et al., 1999; Nakai et al., 2001). As each of these transporters accepts a number of compounds as substrates, they may competitively inhibit the transport of other substrates. Moreover, CsA functions as an inhibitor of rat Oatp1 and Oatp2 (Shitara et al., 2002). It is therefore possible that CsA affects the plasma concentrations of substrates, leading to a clinically relevant DDI (Kusuhara and Sugiyama, 2001).

In the present study, we examined the effect of CsA on the uptake of a number of important substrates, including therapeutically important drugs (Abe et al., 1999; Hsiang et al., 1999; Kok et al., 2000; König et al., 2000a,b; Tamai et al., 2001). Pravastatin has been shown to be a substrate of OATP2, and this transporter is at least partly responsible for its hepatic uptake (Hsiang et al., 1999; Nakai et al., 2001). As each of these transporters accepts a number of compounds as substrates, they may competitively inhibit the transport of other substrates. Moreover, CsA functions as an inhibitor of rat Oatp1 and Oatp2 (Shitara et al., 2002). It is therefore possible that CsA affects the plasma concentrations of substrates, leading to a clinically relevant DDI (Kusuhara and Sugiyama, 2001). In the present study, we examined the effect of CsA on the uptake of CER into human hepatocytes together with its metabolism to clarify the mechanism of their DDI.

Materials and Methods

Materials. [14C]CER (2.03 GBq/mmol) and unlabeled CER were kindly provided by Bayer AG (Wuppertal, Germany). CsA was purchased from Sigma-Aldrich (St. Louis, MO), and all other reagents were of analytical grade.

Hepatocyte Preparation. The human hepatocytes used in the study were isolated from human livers donated for transplantation purposes but not used mainly due to the lack of appropriate recipients. All the donors were free of known liver diseases. All the livers were stored for less than 24 h in University of Wisconsin solution. The hepatocytes were isolated by perfusion using a two-step collagenase digestion procedure (Li et al., 1992). After enzymatic dissociation, the hepatocytes were further separated from nonparenchymal cells by centrifugation through 30% Percoll. The purified hepatocytes were cryopreserved (Li et al., 1992) in liquid nitrogen and stored for less than 24 h in University of Wisconsin solution. The remaining 0.1-ml aliquots of the cell lysate were used for protein assay by the Lowry method with bovine serum albumin as a standard (Lowry et al., 1951).

Metabolism of [14C]CER and Testosterone in Human Microsomes. To measure the effect of CsA on the metabolism of [14C]CER and testosterone, its in vitro metabolism was examined. Prior to the metabolism study, human microsomes (final 0.5 mg of protein/ml; BD Gentest, Woburn, MA) were incubated at 37°C for 10 min in 100 mM potassium phosphate buffer, pH 7.4, containing 3.3 mM MgCl2, 3.3 mM glucose 6-phosphate, 0.1 mM phenacetin, 1.3 mM NADPH, and 0.8 mM NADH. A 500-µl volume of incubation mixture was transferred into a polyethylene tube, and [14C]CER (final 1 µM) or testosterone (final 30 µM; Wako, Osaka, Japan) were added to initiate the reaction with or without inhibitors. After incubation for a designated time, the reaction was terminated by the addition of 500 µl of ice-cold acetonitrile and 200 µl of ice-cold methanol for the metabolism of [14C]CER and testosterone, respectively, followed by centrifugation. To measure the metabolic rate of [14C]CER, the supernatant was collected and concentrated to approximately 20 µl in a centrifugal concentrator, followed by thin layer chromatography. The analytes were separated on silica gel 60F254 (Merck KGaA, Darmstadt, Germany) using a mobile phase (toluene/acetone/acetonic acid, 79:30:5, v/v/v). The intensity of the bands for intact [14C]CER separated by thin layer chromatography was determined by the BAS 2000 system (Fuji Film, Tokyo, Japan).

To measure the metabolic rate of testosterone, 6β-hydroxytestosterone in the incubation mixture was determined by a high-performance liquid chromatography-UV detection method. To a 100-µl volume of supernatant, 100 µl of internal standard (10 µg/ml phenacetin) was added and subjected to a high-performance liquid chromatography system (VP-5; Shimadzu, Kyoto, Japan). The analyte was separated by a C18 column (Cosmosil 5C18-AR; 5-mm, 4.6-mm i.d. × 250 mm; Nakalai Tesque, Kyoto, Japan) at 45°C. The mobile phase consisted of water and methanol for 3 min. A pilot experiment confirmed that the 3-min preincubation was sufficient to raise the temperature of the cells to 37°C.

Uptake of [14C]CER into Hepatocytes. Prior to starting the uptake studies with [14C]CER, the cell suspensions were prewarmed in an incubator at 37°C for 3 min. A pilot experiment confirmed that a 3-min preincubation was sufficient to raise the temperature of the cells to 37°C. The uptake studies were initiated by adding an equal volume of [14C]CER solution containing various concentrations of unlabeled CER or CsA to the cell suspension. At 0.5 and 2 min, the reaction was terminated by separating the cells from the substrate solution. For this purpose, an aliquot of 100 µl of incubation mixture was collected and placed in a centrifuge tube containing 50 µl of 2 N NaOH under a layer of 100 µl of oil (density, 1.015; a mixture of silicone oil and mineral oil; Sigma-Aldrich), and subsequently, the sample tube was centrifuged for 10 s using a tabletop centrifuge (10,000g; Beckman Microfuge E; Beckman Coulter, Inc., Fullerton, CA). During this process, the hepatocytes pass through the oil layer into the alkaline solution. After an overnight incubation in alkaline to dissolve the hepatocytes, the centrifuge tube was cut, and each compartment was transferred to a scintillation vial. The compartment containing the dissolved cells was neutralized with 50 µl of 2 N HCl, mixed with scintillation cocktail, and the radioactivity was determined in a liquid scintillation counter (LS6000SE; Beckman Coulter, Inc.).
The uptake of [14C]CER was examined in three lots of cryopreserved human hepatocytes. Closed circles, triangles, and squares (●, △, and ■) represent the data for lot numbers HH-088, -106, and -117, respectively. Each symbol represents the mean value of two independent experiments. Solid lines represent the fitted lines.

**TABLE 1**

Kinetic parameters for the uptake of cerivastatin in cryopreserved human hepatocytes

<table>
<thead>
<tr>
<th>Lot No.</th>
<th>$K_m$ (μM)</th>
<th>$V_{max}$ (pmol/min/10⁶ cells)</th>
<th>$V_{max}/K_m$ (µl/min/10⁶ cells)</th>
<th>$P_{dif}$ (µl/min/10⁶ cells)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HH-088</td>
<td>18.3 ± 6.9</td>
<td>5200 ± 1970</td>
<td>284 ± 108</td>
<td>70.2 ± 13.9</td>
</tr>
<tr>
<td>HH-106</td>
<td>2.61 ± 1.48</td>
<td>553 ± 161</td>
<td>212 ± 62</td>
<td>65.1 ± 8.3</td>
</tr>
<tr>
<td>HH-117</td>
<td>3.72 ± 1.29</td>
<td>362 ± 120</td>
<td>97.3 ± 32.3</td>
<td>41.7 ± 3.4</td>
</tr>
</tbody>
</table>

Noncompetitive inhibitor can be fitted to the following equation to calculate the inhibition constant ($K_i$).

$$CL_{uptake}(+\text{inhibitor}) = \frac{CL_{uptake}(\text{control}) - CL_{uptake}(\text{resistant})}{1 + I/K_i} + CL_{uptake}(\text{resistant})$$

where $CL_{uptake}(+\text{inhibitor})$ is the $CL_{uptake}$ estimated in the presence of inhibitor, $CL_{uptake}(\text{control})$ is the $CL_{uptake}$ estimated in the absence of CsA, $CL_{uptake}(\text{resistant})$ is the $CL_{uptake}$ that is not affected by CsA, and $I$ is the CsA concentration. Using this equation, the $K_i$ value of CsA for the uptake of [14C]CER was calculated.
The data were fitted to these equations by a nonlinear least-squares method using a computer program, MULTI, to obtain the kinetic parameters or inhibition constant with computer-calculated S.E. values (Yamaoka et al., 1981). The input data were weighted as the reciprocal of the observed values, and the Damping Gauss-Newton method was used as the fitting algorithm. The uptake of [14C]CER into OATP2-expressing MDCKII cells was also expressed as the uptake volume (microliters per milligram of protein) for the radioactivity in the cell lysate (disintegrations per minute per milligram of protein) divided by that in the incubation buffer (disintegrations per minute per milliliter).

**Results**

**Uptake into Human Hepatocytes.** Eadie-Hofstee plots for the uptake of [14C]CER into human hepatocytes prepared from three donors are shown in Fig. 1. Both the saturable and nonsaturable components were observed in all of three lots (Fig. 1). The obtained kinetic parameters were 3 to 18 μM, 360 to 5200 pmol/min/10^6 viable cells, and 42 to 70 ml/min/10^6 viable cells for K_m, V_max, and P_dif, respectively (Table 1). The obtained kinetic parameters were from three donors are shown in Fig. 1. Both the saturable and nonsaturable components were observed in all of three lots (Fig. 1). The obtained kinetic parameters were 3 to 18 μM, 360 to 5200 pmol/min/10^6 viable cells, and 42 to 70 ml/min/10^6 viable cells for K_m, V_max, and P_dif, respectively (Table 1). The obtained kinetic parameters were from three donors are shown in Fig. 1. Both the saturable and nonsaturable components were observed in all of three lots (Fig. 1). The obtained kinetic parameters were 3 to 18 μM, 360 to 5200 pmol/min/10^6 viable cells, and 42 to 70 ml/min/10^6 viable cells for K_m, V_max, and P_dif, respectively (Table 1).

**Fig. 3.** Uptake of [14C]CER in OATP2-expressing MDCKII cells. The uptake of [14C]CER into OATP2-expressing MDCKII cells and vector-transfected cells are shown in Fig. 3. The uptake of [14C]CER into OATP2-expressing cells was 2.6 times higher at 9 min than that into vector-transfected cells (Fig. 3). In OATP2-expressing cells, the uptake of [14C]CER observed in the presence of excess unlabeled CER (30 μM) was reduced to the same level as that in vector-transfected cells (Fig. 3). OATP2-mediated uptake of [14C]CER was also inhibited by CsA in a concentration-dependent manner (Fig. 4). The K_i value for the OATP2-mediated uptake of [14C]CER was 0.238 ± 0.129 μM (mean ± computer-calculated S.E.) (Fig. 4).

**Fig. 4.** Inhibitory effect of CsA on OATP2-mediated uptake of [14C]CER. The inhibitory effect of CsA on the uptake of [14C]CER in MDCKII cells transfected with human OATP2 or vector was examined. Each symbol represents the mean ± S.E. of three independent experiments. A solid line represents the fitted line for OATP2-mediated uptake of CER.

**Metabolic Stability of [14C]CER.** The metabolic stability of [14C]CER in human microsomes is examined. As a linear metabolic rate in human microsomes was observed for up to 45 min (Fig. 5), the inhibitory effects of CsA, 10 μM quercetin (a CYP2C8 inhibitor; Ohyama et al., 2000), and 0.2 μM ketoconazole (a CYP3A4 inhibitor; Kawahara et al., 2000) on the metabolism of [14C]CER were followed for 45 min. In Fig. 6a, the metabolic rates of [14C]CER when incubated in human microsomes in the absence or presence of inhibitors are shown. CsA did not alter the metabolic rate of [14C]CER up to a concentration of 3 μM and reduced it to, at most, 71% of the control value at 10 to 30 μM, whereas 10 μM quercetin and 0.2 μM ketoconazole reduced it to 63 and 72% of the control value, respectively (Fig. 6a). The effect of CsA on testosterone 6β-hydroxylation, which is mediated by CYP3A4, was also followed for 2 min (Fig. 6b). The metabolic rate of testosterone 6β-hydroxylation measured in the absence of inhibitors was 1560 pmol/min/mg of protein, and it was reduced to 30 and 5.9% of the control value in the presence of 3 and 30 μM CsA, respectively (Fig. 6b). It was also reduced to 6.5% of the control value by 0.2 μM ketoconazole and 52% by 10 μM quercetin (Fig. 6b).
In kidney transplantation patients undergoing CsA treatment, the plasma concentrations of CER are increased (Mück et al., 1999) due to a DDI between the two drugs. In the present study, we examined the effect of CsA on the hepatic uptake and metabolism of CER, especially on its hepatic uptake, to clarify the mechanism underlying this DDI.

In vitro uptake studies in isolated hepatocytes revealed saturable transport of [14C]CER in human hepatocytes (Fig. 1), suggesting the involvement of transporters in the uptake process. In this study, we found that transporter-mediated uptake accounted for 70 to 80% of the total hepatic uptake. In clinical situations, the maximum plasma concentration (C_max) of CER is approximately 4 nM (after a single oral dose of 0.2 mg; Mück et al., 1999), which is much lower than the K_m values (2.6–18 μM) obtained in the present study (Fig. 1 and Table 1), suggesting that the hepatic uptake of CER is largely mediated by transporters over the therapeutic range.

The present study revealed a concentration-dependent inhibition of transporter-mediated [14C]CER uptake by CsA in human hepatocytes, with K_i values of 0.28 to 0.69 μM (Fig. 2). The obtained data may at least partly explain the clinically observed DDI (Mück et al., 1999). Mück et al. (1999) reported that the C_max and the AUC of CER in kidney transplant patients given CsA was increased 4- and 3-fold, respectively, when the C_max of CsA was approximately 1 μM. In the present study, the saturable component of the uptake of [14C]CER was mostly inhibited in the presence of 1 μM CsA (Fig. 2). However, considering that approximately 90% of the CsA in blood is bound to plasma proteins that consist of mainly lipoproteins (Lemaire and Tillement, 1982), the clinically relevant unbound concentration of CsA is estimated to be 0.1 μM, which may not be enough to inhibit hepatic uptake of CER. This discrepancy may be explained by a number of factors. First, in the case of oral administration, the plasma concentration of CsA in the circulating blood and portal vein are different, and therefore, the concentration exposed to the liver may be much higher than that observed in the circulating blood (Ito et al., 1998; Sugiyama et al., 2002). Second, the increase in the plasma concentration of CER reported by Mück et al. (1999) could be partly due to the change in the intrinsic hepatic clearance associated with renal failure and/or kidney transplantation. In the present study, although the increase in the plasma concentration observed clinically cannot be fully predicted from the in vitro uptake study, the results suggest that the increase in the plasma concentration of CER is at least partly due to the interaction between CER and CsA involving transporter-mediated hepatic uptake.

The range of CL_uptake values for [14C]CER observed among human hepatocytes from the three donors (Fig. 1; Table 1) may be due to the interindividual differences in the expression level and/or function of transporters, although it may be caused by other factors, such as the cell integrity being affected during the cryopreservation process. Indeed, the fact that the interindividual differences were greater for the V_max/K_m values, which reflect transporter-mediated uptake and can be affected by the expression level and/or intrinsic function of transporters, than for the F_air values, which mainly represent passive diffusion, supports our hypothesis (Table 1). If this hypothesis is correct, there must be a wide
range of interindividual differences in the hepatic clearance and/or the extent of transporter-mediated DDI. Human hepatocytes may represent an important experimental system in the near future for evaluating the genetic and environmental factors that may be responsible for the interindividual differences in transporter functions.

In the present study, CER was shown to be a substrate of human OATP2 (Fig. 3), like pravastatin (Hsiang et al., 1999; Nakai et al., 2001). OATP2-mediated uptake of [14C]CER was also inhibited by CsA (Fig. 4), and the obtained Ki value (0.24 μM) was within the same range as the values obtained in the inhibition study using human hepatocytes (0.28–0.69 μM) (Fig. 2). These results suggest that the inhibition by CsA on the uptake of CER in human hepatocytes is partly due to OATP2-mediated transport. Since OATP2 accepts a wide variety of compounds as substrates (Abe et al., 1999; Hsiang et al., 1999), these substrates in addition to CER may possibly exhibit DDI. Indeed, a DDI between pravastatin, a substrate of OATP2, and CsA was reported, which could also be due to OATP2-mediated uptake in the liver (Regazzi et al., 1993). To avoid this kind of DDI, the characterization of transporters, which are responsible for the drug uptake, and their contributions to total hepatic uptake are very important (Kouzuki et al., 1999a,b; Kusuhara and Sugiyama, 2002; Mizuno and Sugiyama, 2002; Shitara et al., 2002). The increase in the plasma concentration of drugs associated with a transporter-mediated DDI may be quantitatively predicted from in vitro studies that determine the extent of inhibition of transport in hepatocytes and/or in transporter-expressing cells (Ueda et al., 2001).

We also examined the effect of CsA on the metabolism of [14C]CER in human microsomes (Fig. 6a). CsA did not markedly reduce the metabolic rate of [14C]CER up to a concentration of 3 μM, and 10 to 30 μM CsA reduced it only to 70% of the control value (Fig. 6a). On the other hand, 30 μM CsA markedly reduced testosterone 6β-hydroxylation, which was mediated by CYP3A4, to 30% of the control value (Fig. 6b). To explain this different effect of CsA on the metabolisms of CER and testosterone, we examined the effect of ketocazole, a potent CYP3A4 inhibitor (Kawahara et al., 2000). As the Ki values of ketocazole for the inhibition of CYP2C8 and CYP3A4 functions are 2.5 and 0.03 μM, respectively (Kawahara et al., 2000; Ong et al., 2000), 0.2 μM ketocazole should be enough to inhibit most of the CYP3A4-mediated metabolism of [14C]CER and have only a slight effect on that mediated by CYP2C8. Indeed, we have confirmed that 0.2 μM reduced the CYP3A4-mediated metabolism of testosterone to 7% of the control value. However, 0.2 μM ketocazole reduced the metabolism of [14C]CER only to 72% of the control (Fig. 6a). This study supports that CYP3A4 plays a limited role in the metabolism of CER as previously reported by Mück (2000), and CYP3A4 inhibitors, such as ketocazole and CsA, reduce the metabolism of CER to only a limited extent. From the present study, the contribution of CYP3A4 to the total metabolism of CER is estimated to be approximately 38% (Fig. 6a). We also examined the effect of quercetin, a CYP2C8 inhibitor (Ohyama et al., 2000). As the Ki value of quercetin for the inhibition of CYP2C8-mediated metabolism is 1.3 μM (Rahman et al., 1994), 10 μM quercetin should be enough to inhibit most of the CYP2C8-mediated metabolism of [14C]CER, although it also reduces the CYP3A4-mediated metabolism of testosterone to 50% of the control value (Fig. 6b). In the presence of 10 μM quercetin, the metabolism of [14C]CER was reduced to 63% of the control value (Fig. 6a). This result supports a contribution of CYP2C8 to the metabolism of CER is less than 37%, considering that the CYP3A4-mediated metabolism is partly inhibited by 10 μM quercetin (Fig. 6b). The present study suggests that at low concentrations (<3 μM), CsA does not inhibit the metabolism of CER (Fig. 6a), although it does inhibit its transporter-mediated hepatic uptake with a much lower concentration (<1 μM) (Fig. 2). This confirms that it is less likely that the DDI between CER and CsA is due to the metabolism of CER.

Recently, a severe DDI between CER and gemfibrozil was reported, and in the USA, 31 deaths from severe rhabdomyolysis in patients taking CER were reported, of whom 12 were taking concomitant gemfibrozil (Charatan, 2001). This resulted in the withdrawal of CER from the market. It is still unknown whether this severe DDI is mainly due to the pharmacokinetic event (i.e., the change of the plasma concentration of CER caused by gemfibrozil) or due to the nonpharmacokinetic event (for example, an increased formation of toxic metabolites of CER or the effects on the energy of the cell, which may lead to rhabdomyolysis). In the present study, however, we tried to clarify the mechanism of the effect of CsA on the pharmacokinetics of CER and found that the inhibition of the OATP2-mediated hepatic uptake of CER by CsA was the major mechanism. There is also a report that the AUC of CER was increased 4.2-fold when coadministered with gemfibrozil (Mueck et al., 2001), which may be one mechanism of this serious DDI. At the time of this report, Prueksaritanont et al. (2002) reported that both oxidation and glucuronidation of CER in human liver microsomes were inhibited by gemfibrozil with IC50 values of 82 and 87 to 220 μM, respectively, which at least in part explains the mechanism of DDI between CER and gemfibrozil. However, considering the relatively high plasma protein binding of gemfibrozil (plasma unbound fraction of 1.4–3%; Todd and Ward, 1988), the unbound therapeutic concentration of gemfibrozil is estimated to be less than 7.5 μM (total Cmax, up to 250 μM; Prueksaritanont et al., 2002), which is much lower than the recently reported IC50 values (80–220 μM) for CER metabolism. Therefore, the increase in the AUC of CER caused by the DDI may not necessarily be accounted for only by the inhibition of metabolism. Although there has been no report concerning the effect of gemfibrozil on the transporter-mediated hepatic uptake of CER, this should also be examined in a future study. In conclusion, we should pay more attention to DDI that may originate from the inhibition of transporter-mediated hepatic uptake, since it may occur with a large number of drug combinations when their elimination (metabolism and/or biliary excretion) takes place following transporter-mediated hepatic uptake.

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References


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