Distribution of the Novel Antifolate Pemetrexed to the Brain

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ABSTRACT

Pemetrexed disodium is a novel antifolate that exhibits potent inhibitory effects on multiple enzymes in folate metabolism. Phase II/III clinical trials have shown that pemetrexed is effective against various solid tumors. Like methotrexate, pemetrexed may be useful in treatment of primary and secondary brain tumors. In this study, we examined the central nervous system (CNS) distribution of pemetrexed and the interaction with an organic anion transport inhibitor indomethacin. Male Wistar rats were administered pemetrexed by either single intravenous bolus or constant intravenous infusion. Unbound pemetrexed in blood and brain was measured by simultaneous arterial blood and frontal cortex microdialysis sampling. In the i.v. bolus experiments, indomethacin was administered by i.v. bolus (10 mg/kg) followed by i.v. infusion (0.1 mg/kg/h) in a crossover manner. In the infusion experiments, the same dose of indomethacin was administered after a steady state was reached for pemetrexed. CNS distributional kinetics was analyzed by compartmental and non compartmental methods. Both bolus and infusion studies showed that pemetrexed has a limited CNS distribution. The mean area under concentration-time curve (AUC)brain/AUCplasma ratio of unbound pemetrexed was 0.078 ± 0.038 in the i.v. bolus study. The pemetrexed steady-state brain-to-plasma unbound concentration ratio after i.v. infusion was 0.106 ± 0.054. The distributional clearance into the brain was approximately 10% of the clearance out of the brain in both the compartmental and non compartmental analyses. Indomethacin had no effect on either the brain-to-plasma AUC ratio or the steady-state brain-to-plasma concentration ratio. The distribution of pemetrexed into the brain is limited, and an efflux clearance process, such as an efflux transporter, may be involved.

The antifolate agents, such as methotrexate (MTX), have been widely used in the treatment of various tumors (Bertino, 1993; Chamberlain, 1998; DeAngelis, 1999). MTX-based regimens are the most commonly used chemotherapy for primary lymphoma in the central nervous system (CNS) (Park and Abrey, 2002). However, the prognosis for CNS tumors, including primary CNS lymphoma, is still very poor (Bart et al., 2000). The poor response can be attributed to two reasons: low availability of drug at the site of action and intrinsic or acquired resistance the tumor has against the antitumor agents.

The natural or acquired resistance is often due to the overexpression or mutation of target enzymes (Melera, 1991; Banerjee et al., 1995; Bart et al., 2000). During the last decade, a novel antifolate compound, pemetrexed (LY-231514, multitargeted antifolate, Alimta), has been developed to overcome some of these problems. Pemetrexed targets at least three enzymes in folic acid metabolism (Shih et al., 1998). It is conceivable that such a combinatorial effect of inhibiting three enzymes at multiple sites would give this new antifolate an advantage in overcoming acquired or intrinsic resistance if the resistance is due to overexpression or mutation of one enzyme. In fact, it has been shown that pemetrexed has broad antitumor activity in phase II trials in a variety of solid tumors, including mesothelioma, nonsmall cell lung, breast, cervical, colorectal, head and neck, and bladder cancers (Shih et al., 1997, 1998; Adjei, 2000). Given the spectrum of activity of methotrexate, it can be expected that pemetrexed may also have useful applications in the treatment of CNS tumors with a possible benefit of less acquired resistance. This is important not only for the treatment of primary CNS lymphoma but also for brain metastases, considering lung and breast cancers are the leading source of secondary brain tumors (Greenberg et al., 1999). It is known that more than 25% of patients with lung cancer and 10 to 15% of patients with breast cancer develop a brain metastasis during the course of their disease (Greenberg et al., 1999). Delivery of classic antifolate compounds such as methotrexate to the brain has been a major challenge for the

ABBREVIATIONS: MTX, methotrexate; CNS, central nervous system; BBB, blood-brain barrier; ECF, extracellular fluid; HPLC, high-performance liquid chromatography; AUC, area under concentration time curve; CL, clearance; DHFR, dihydrofolate reductase; MRP, multidrug resistance-associated protein; OAT, organic anion transporter; hOAT, human organic anion transporter.
effective efforts have been made to increase the penetration of methotrexate into the brain, including the use of Ommaya reservoirs for direct intraventricular infusion (Dakhil et al., 1981; Stone et al., 1999), intrathecal injection and infusion (Wilson and Norrell, 1969; Bleyer et al., 1997), reversible osmotic breaching of the BBB using high-dose mannitol (Hasegawa et al., 1979), and very high dose intravenous infusion with leucovorin rescue (Wang et al., 1976; Allen et al., 1980). All of these CNS drug delivery strategies are complicated by serious side effects (Bleyer et al., 1978; Allen et al., 1980; Browne et al., 1987; Stone et al., 1999).

Although the low distribution of MTX into brain may be attributed to its hydrophilic nature and its interaction with various transporters expressed in BBB (Hooijberg et al., 1999; Kool et al., 1999; Chen et al., 2002), the factors that influence the distribution of the new antifolate pemetrexed to the CNS have not been mechanistically studied. Compared with MTX, pemetrexed is a structurally similar antifolate; however, it could have different physicochemical properties that may affect its CNS distribution, particularly when considering active transport into or out of the brain. Information regarding CNS penetration and distribution would be important in developing effective therapy for CNS tumors.

In this study, we examined the CNS distribution of this new antifolate. We also investigated the effects of a known inhibitor, indomethacin, of some active organic anion efflux transport systems that exist in the BBB, on the distribution of pemetrexed to the brain. A more complete and in depth understanding of the CNS distribution of new and possibly more effective antifolate compounds should result in more successful treatments of primary and secondary cancers in the CNS, and in other tissues that have similar issues regarding drug transport and therefore drug delivery.

**Materials and Methods**

**Chemicals**

Pemetrexed disodium (N-[4-[2-(2-amino-4,7-dihydro-4-oxo-1H-pyrrrolo[2,3-d]pyrimidin-5-yl)ethyl]benzoyl]-l-glutamic acid) and 3H-pemetrexed disodium were kindly provided by Eli Lilly & Co. (Indianapolis, IN). Raltitrexed (N-[5-[N-(3,4-dihydro-2-methyl-4-oxoquinazolin-6-ylmethyl)-N-methylamino]-2-thenoyl]-l-glutamic acid) was kindly provided by AstraZeneca Pharmaceuticals LP (Wilmington, DE). Indomethacin was purchased from Sigma-Aldrich (St. Louis, MO). Solvents were HPLC grade, and all other chemicals were reagent grade or better.

**Microdialysis Studies**

Microdialysis is a powerful tool to measure the unbound drug concentration in the plasma and tissue. The unbound drug in the tissue is the active entity that exerts its pharmacological effect, whereas the unbound drug concentration in the plasma is the driving force for unbound drug to distribute into the tissue. It would be beneficial in the study of CNS drug distribution if the unbound drug in the plasma and brain ECF can be simultaneously measured. This was done in this study using simultaneous blood and brain microdialysis sampling using a novel blood probe (Dai and Elmqquist, 2003).

Quantitative microdialysis requires the determination of the recovery of drug that is the fraction of drug that is gained through microdialysis probe from the site of measurement (Wang et al., 1993). One of the approaches to measure the in vivo recovery is through retrodialysis, where the loss of a retrodialysis calibrator is measured and used as the recovery for calculation of the concentration of drug. Therefore, loss of a retrodialysis calibrator has to be shown to be equal to the recovery of the drug of interest before it can be rationally used. In this study, raltitrexed was chosen as a retrodialysis calibrator because of its similarity with pemetrexed in chemical structure (Fig. 1), and was validated in the in vitro and in vivo microdialysis studies described below.

**In Vitro Microdialysis.** The procedure for in vitro microdialysis was similar to previously published protocols (Dai and Elmqquist, 2003). Briefly, the microdialysis probe (CMA-12 or home-made blood probe) was placed in a 2-ml vial containing well stirred artificial cerebrospinal fluid (119.5 mM NaCl, 4.75 mM KCl, 1.27 mM CaCl2, 1.19 mM KH2PO4, 1.19 mM MgSO4, and 1.6 mM Na2HPO4, pH 7.4, for the brain probe) or Ringer’s solution (142 mM NaCl, 4.0 mM KCl, 2.38 mM CaCl2, and 2.38 mM NaHCO3, pH 7.2, for the blood probe) for perfusion at 37°C.

A Harvard 22 syringe pump (Harvard Apparatus Inc., Holliston, MA) was used to perfuse the probe at different rates. The concentration of the pemetrexed or raltitrexed in the out-flowing dialysate was measured by online HPLC. The mobile phase was 5% acetonitrile, 4.5% tetrahydrofuran in 30 mM sodium phosphate, pH 3 (w/w). The UV absorption of pemetrexed and raltitrexed was measured by UV detection (SPD-10A; Shimadzu, Kyoto, Japan) at a wavelength of 245 nm. The loss of each compound through the microdialysis probe is calculated in eq. 1.

\[
\text{Loss} = \frac{(\text{Cin} - \text{Cout})}{\text{Cin}}
\]

![Fig. 1. Chemical structures of pemetrexed (top) and raltitrexed (bottom).](image-url)
where Cout and Cm are the concentrations of the compound in the dialysate and in perfusate, respectively. Similarly, the gain of pemetrexed and raltitrexed was measured when a probe was placed in a medium containing pemetrexed (2 μg/ml) or raltitrexed (2 μg/ml) and perfused with drug-free medium. The dialysate was measured for the drug concentrations. The gain is calculated in eq. 2,

\[
\text{Gain} = \frac{C_{\text{o}}}{C_{\text{m}}}
\]

where Cout is the concentration of the compound in the dialysate, and Cm is concentration of the compound in the medium surrounding the probe in the vial, respectively.

In Vivo Microdialysis to Measure Unbound Pemetrexed in Blood and Brain. Microdialysis probe placement. Male Wistar rats weighing from 275 to 340 g were used in this study. The surgical procedures for implantation of the microdialysis probe guide cannula, probe placement, and the cannulation of the femoral vein were similar to Yang et al. (1997), except that an arterial microdialysis probe, instead of a cannula, was placed in the femoral artery (Dai and Elmquist, 2003). All surgical procedures were done using aseptic technique. The stereotaxic coordinates for the frontal cortex were 3 mm (anterior) and 1.5 mm lateral (right) to the bregma. The tip of guide cannula was 1 mm ventral from the brain surface. The rat was allowed to recover for 3 to 4 days after the placement of the guide cannula. After this recovery period, the cortical probe was placed in the guide cannula, the femoral vein was cannulated for dosing, and a blood probe was placed in the femoral artery for microdialysis. CMA-12 microdialysis probes (CMA/Microdialysis, Acton, MA) of 3 mm length were used for cortex sampling. A newly designed blood probe was used for sampling the unbound concentration of pemetrexed in the arterial circulation (Dai and Elmquist, 2003). The blood microdialysis probe was implanted in the femoral artery in a similar procedure by which a probe is placed in the femoral vein as described previously (Yang et al., 1997) with slight modification (Dai and Elmquist, 2003).

In the in vivo microdialysis, raltitrexed was perfused as the retrodialysis calibrator through both blood and brain probes. The perfusion rate was 0.5 μl/min for the brain probe, and 1 μl/min for the blood probe, so that no net flux of water across the membrane occurred. This was verified gravimetrically. The dialysate was simultaneously collected every 26 min and measured for pemetrexed and raltitrexed by two online HPLCs. Retrodialysis recovery of the calibrator (raltitrexed) was calculated using eq. 1.

Animal Studies

Intravenous Bolus Study. The rats (n = 4) received an intravenous bolus dose of pemetrexed with or without cotreatment of indomethacin in a crossover manner. In the control phase, pemetrexed disodium (60 mg/kg, dissolved in 0.9% sodium chloride at a concentration of 10 mg/ml) was given by intravenous bolus into the femoral vein. After 12 h of continuous brain and blood sampling using the microdialysis probes, the rats again received pemetrexed as above. However, 30 min before pemetrexed dosing, the rats were pretreated with indomethacin [a bolus dose of indomethacin (10 mg/kg i.v.) diluted in 0.9% saline chloride] followed by a continuous i.v. infusion of indomethacin (0.1 mg/kg/h) for another 3 h (treatment phase). After a minimum of a 12-h washout period, another intravenous infusion of pemetrexed (same infusion rate) was given until steady state was achieved (control phase II). This second control phase was to determine whether the experimental procedure was stable with time (treatment order effect) and to see whether any effect of indomethacin was reversible.

During the whole experiment, the unbound concentrations of pemetrexed in brain extracellular fluid and blood were monitored by simultaneous brain and blood microdialysis. The unbound concentrations of pemetrexed in the brain and blood were calculated after correction for each probe recovery measured with the retrodialysis calibrator, raltitrexed.

Data Analysis

Compartmental Analysis. Compartmental modeling was performed using SAAMII nonlinear regression software (SAAM Institute, Seattle, WA). First, a two-compartment model with first-order elimination in the central compartment was fit to the unbound pemetrexed plasma concentration-time data (Fig. 2). The purpose of this first stage was solely to obtain parameters to be used as a forcing function in the second stage, where a one-compartment model for drug disposition in the brain was fit to the unbound pemetrexed concentrations in brain ECF (Fig. 2). For purposes of this modeling, the apparent volume of brain ECF was assumed to be 1.44 ml/kg body weight, which is 20% of brain weight (Wang and Sawchuk, 1995; Malhotra et al., 1997; Bouw et al., 2001), where brain weight in the rat is 1.8 g/250 g body weight (Sharp and La Regina, 1998). Even though an inaccuracy in this value may affect the estimation of the efflux clearance out of the brain (CLout,brain), the comparison between the controls and the treated regarding CInf/CLout or the ratio of CInf to CLout will not be affected by the choice of value for the brain ECF.

Noncompartmental Analysis. The terminal rate constant is determined by linear regression of the last three or four log-transformed data points. AUC was calculated by using eq. 3 (Shih et al., 1998).

\[
\text{AUC} = \sum C_i \times A \text{t} + Clast/k
\]

where Δt is the microdialysis collection interval, Ci is the concentration at the midpoint of the interval, Clast is the last concentration time point, and k is the terminal rate constant. In the infusion study, the ratio of the clearance of entering and efflux out of brain can be calculated from the brain-to-plasma ratio of steady state unbound concentration, i.e., CLinf/CLout = CInf,brain/CInf,plasma.

Statistics

The nonparametric alternative of the paired t test, the Wilcoxon signed rank test, was used to test difference between the control and treated groups, with a chosen level of significance of p < 0.05.
Results

Calibration of the Microdialysis Probe. First, the suitability of raltitrexed to be used as a retrodialysis calibrator was examined. As seen in Fig. 3, the loss of both pemetrexed and raltitrexed across the microdialysis probe from the perfusate to the well stirred medium was similar at different flow rates. These flow rates ranged from 0.5 to 4 μl/min, and the two compounds tested had similar permeability-area products (dialysis clearance), as indicated by the slopes of the regression lines in Fig. 3B (0.21 versus 0.22 μl/min). Moreover, the linear correlation between Ln(1 - loss) and the reciprocal of flow rates (Fig. 3) indicates the clearance of both drugs is independent of the flow rate (Sawchuk and Elmquist, 2000). Also, the gain of pemetrexed was shown to be similar to its loss, and, importantly, to the loss of raltitrexed as tested in the in vitro microdialysis (Fig. 4). This suggests that the transport of these two antifolates across the dialysis membrane is a diffusion-controlled process and indicates the suitability of using raltitrexed as a retrodialysis calibrator for measuring pemetrexed in vivo. This was further confirmed by the in vivo study, where the loss of these two compounds through the probe placed in the frontal cortex was similar (Fig. 4), although the in vivo loss of pemetrexed and raltitrexed was lower than their in vitro values. Others have also observed that in vivo loss of the calibrator is lower than that of in vitro (Fox et al., 2002), which may be due to the increased resistance to the diffusion of the compound in the cortical tissue (Sun et al., 2001a; Fox et al., 2002).

Intravenous Bolus Studies. Rats were given intravenous bolus administration of pemetrexed (60 mg/kg) with or without coadministration of an inhibitor of organic anion transporters, indomethacin, in a crossover manner. The un-
bound pemetrexed concentration-time profile in the brain cortex and blood is shown in Fig. 5. Pemetrexed concentration in the brain ECF rose rapidly to its maximum and declined more slowly than the unbound concentration in the blood. Table 1 summarizes the pharmacokinetic parameters for unbound pemetrexed. The clearances of unbound pemetrexed entering (CLin) and exiting the brain ECF (CLout) were estimated by compartmental modeling. As shown in Table 1, the ratio of CLin/CLout is 0.094 ± 0.04 in the control phase and 0.080 ± 0.03 in the indomethacin-treated phase.

Table 2 summarizes the noncompartmental determination of the brain penetration of unbound pemetrexed and the terminal rate constant for unbound pemetrexed in brain ECF. Consistent with the ratio of CLin/CLout determined by compartmental modeling, the equilibrium distribution coefficient of pemetrexed in the brain, expressed by tissue-to-plasma area ratio, is low with the mean ± S.D. unbound AUCbrain/AUCplasma ratio being 0.078 ± 0.038. Indomethacin treatment did not affect this ratio or the terminal rate constant of pemetrexed in the brain (Table 2). From these data taken together, it can be concluded that indomethacin treatment did not change the distribution of unbound pemetrexed into brain.

**Intravenous Infusion Studies.** To further investigate the CNS distribution of pemetrexed, and the possible influence of organic anion transporters on that distribution, an intravenous infusion study was conducted in combination with indomethacin treatment. As shown in Fig. 6 and Table 3, the mean ± S.D. of the Css,brain/Css,plasma ratio of unbound pemetrexed was 0.106 ± 0.054, which agrees with the CLin/CLout determined from the compartmental modeling from the intravenous bolus experiments (Table 1). Furthermore, the ratio of Css,brain/Css,plasma was not affected by indomethacin treatment (P > 0.1) (Table 3). The stability of the experimental system was not affected by time, as seen by a second infusion of pemetrexed administered after a 12-h washout period, where the brain-to-plasma ratio of steady-state concentrations did not change with time (P > 0.1; Fig. 6; Table 3). These data confirm that pemetrexed has a limited CNS distribution and that indomethacin does not affect the CNS penetration of pemetrexed.

**Discussion**

The classic antifolate MTX has been used for the treatment of various solid tumors (Bertino, 1993; Chamberlain, 1998;
DeAngelis, 1999). However, previous studies have shown that tumor cells can acquire resistance to MTX (Banerjee et al., 1995). It has further been shown that one important resistance mechanism is associated with the overexpression of the target enzyme, dihydrofolate reductase (DHFR), or a variant DHFR with a low affinity for MTX (Melera, 1991; Banerjee et al., 1995). During the last decade, several new antifolates have been developed so that they would overcome the acquired and natural resistance to methotrexate. Pemetrexed is one of these new analogs. It has been demonstrated that pemetrexed inhibits three enzymes: DHFR, thymidylate synthetase, and glycinamide-ribonucleotide-formyl transferase. Each is an important enzyme in the folic acid pathway, which is critical in purine and pyrimidine nucleotide synthesis, leading to the replication of DNA, particularly for rapidly dividing cells (Shih et al., 1997, 1998; Adjei, 2000). Inhibition of multiple enzymes by pemetrexed could preclude the development of drug resistance caused by overexpression or mutation of a single enzyme. In this regard, pemetrexed has demonstrated broad spectrum of clinical activities against nonsmall cell lung, breast, colorectal, neck, bladder, and cervical cancer as a first line or second line therapeutic agent (O'Dwyer et al., 1999).

MTX has been used for the treatment of primary CNS lymphomas and other primary or secondary brain tumors (Bertino, 1993; Chamberlain, 1998; DeAngelis, 1999). It is conceivable that pemetrexed might also be used for such tumors with the added benefit of less acquired resistance. However, its therapeutic effect will depend largely on the targeted bioavailability of the drug to the CNS site of action, and effective delivery of antitumor compounds across blood-brain barrier to the brain remains a major challenge in the treatment of brain tumors, including secondary brain tumors (Lesniak et al., 2001). The purpose of this study was to examine the CNS distribution of pemetrexed and to identify the factors that may limit the brain penetration of this compound by using simultaneous arterial blood and brain microdialysis.

Microdialysis is a useful tool to study the tissue distribution of drug, especially CNS distribution (Sawchuk and Elmquist, 2000). It measures the unbound drug concentration that is the active moiety in the brain. If only total drug concentration in plasma or tissue is measured, as previous experiments have done, problems in interpretation of the distributional processes could arise. For instance, when nonlinear protein binding or drug-drug interaction in the level of protein binding occurs, the total drug concentration in the plasma may not reflect the change in unbound concentration in blood, the driving force for the drug to distribute into the brain. In this regard, simultaneous blood and brain microdialysis was conducted to measure the unbound drug concentration in plasma and brain. In doing so, the effect of binding of drug to the plasma or tissue protein on the distributional kinetics was addressed. With the novel design of the blood microdialysis probe (Dai and Elmquist, 2003), the simulta-

**TABLE 2**

<table>
<thead>
<tr>
<th>Rat No.</th>
<th>AUC&lt;sub&gt;brain&lt;/sub&gt;/AUC&lt;sub&gt;plasma&lt;/sub&gt;</th>
<th>Terminal Rate Constant</th>
<th>Unbound Pemetrexed in ECF</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Control</td>
<td>Treated</td>
<td>Control</td>
</tr>
<tr>
<td>1</td>
<td>0.073</td>
<td>0.074</td>
<td>0.0244</td>
</tr>
<tr>
<td>2</td>
<td>0.083</td>
<td>0.076</td>
<td>0.0179</td>
</tr>
<tr>
<td>3</td>
<td>0.032</td>
<td>0.043</td>
<td>0.0152</td>
</tr>
<tr>
<td>4</td>
<td>0.125</td>
<td>0.107</td>
<td>0.0075</td>
</tr>
<tr>
<td>Mean</td>
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<td>0.075</td>
<td>0.0163</td>
</tr>
<tr>
<td>S.D.</td>
<td>0.038</td>
<td>0.026</td>
<td>0.0070</td>
</tr>
</tbody>
</table>

**TABLE 3**

<table>
<thead>
<tr>
<th>Rat no.</th>
<th>Control I</th>
<th>Treated</th>
<th>Control II</th>
</tr>
</thead>
<tbody>
<tr>
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<td>0.055</td>
<td>0.061</td>
</tr>
<tr>
<td>2</td>
<td>0.170</td>
<td>0.152</td>
<td>0.178</td>
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<td>0.072</td>
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<td>0.064</td>
</tr>
<tr>
<td>4</td>
<td>0.130</td>
<td>0.130</td>
<td>0.150</td>
</tr>
<tr>
<td>Mean</td>
<td>0.106</td>
<td>0.101</td>
<td>0.113</td>
</tr>
<tr>
<td>S.D.</td>
<td>0.054</td>
<td>0.047</td>
<td>0.060</td>
</tr>
</tbody>
</table>

![Fig. 6. A representative concentration time profile of unbound pemetrexed in plasma and brain ECF in the intravenous infusion study. Pemetrexed (III, 20 mg/kg/h) was given by intravenous infusion. After the steady state was achieved, the rat further received coadministration of indomethacin (I), an i.v. bolus dose of indomethacin (10 mg/kg) followed by a continuous i.v. infusion of indomethacin (0.1 mg/kg/h) for another 3 h. After 12-h washout period, another intravenous infusion of pemetrexed (III, 20 mg/kg/h) was given to reach the steady state. During the whole experiment, the unbound concentrations of pemetrexed in brain extracellular fluid (C) and plasma (○) were measured by simultaneous brain and blood microdialysis.](image-url)
neous sampling by microdialysis of arterial blood and brain extracellular fluid has provided a powerful tool to study the CNS distributional kinetics in this study. The microdialysis probe was validated by three criteria: independence of the recovery on the perfusion flow rate, the equal recovery of the analyte across the dialysis membrane both regarding loss from and, gain to, the perfusate and equal loss between the drug and calibrator in either the in vitro or in vivo situation. It is worthy to note that the in vivo loss from the perfusate to the tissue (brain cortex) is lower than the loss from the perfusate to the aqueous medium in vitro. This is most likely due to the greater resistance of the transport of the drug in the tissue (in vivo) compared with that in the aqueous medium (in vitro). Fox and others have reported similar phenomenon (Fox et al., 2002).

This is the first reported study to characterize the brain penetration of pemetrexed in animals. This study demonstrates that pemetrexed has a limited CNS distribution, which is indicated by brain-to-plasma AUC ratio of pemetrexed and the brain-to-plasma ratio of steady-state concentrations. The brain penetration of pemetrexed is slightly higher than that of the classic antifolate MTX. This may be partly due to the fact that pemetrexed is more lipophilic than that of MTX (data not shown). Previous microdialysis studies have shown that the ratio of unbound MTX level in brain versus the total MTX level in plasma ranges from 0.01 to 0.02 in terms of the AUC_{ECF,unbound}/AUC_{plasma,total} when it was administered by intravenous bolus dose (Devineni et al., 1996; Dukic et al., 1999, 2000). In our intravenous bolus study, the AUC_{ECF,unbound}/AUC_{plasma,unbound} is 0.078, which would give a ratio of AUC_{ECF,unbound}/AUC_{plasma,total} of approximately 0.05, given the free fraction of pemetrexed in rat plasma of 0.36 (data not shown). Similarly, in the i.v. infusion study, the ratio of C_{ss,brain}/C_{ss,plasma} for unbound pemetrexed is about 0.106, further indicating a limited distribution of pemetrexed into brain ECF. Of note, the brain level of pemetrexed rose to maximum rapidly in the i.v. bolus study and also achieved a rapid steady state in the infusion study even though the clearance into the brain is low (about 2.9 µl/min/kg; Table 1). This may be due to the small volume of distribution of pemetrexed in the brain, allowing a rapid achievement of distributional equilibrium in this tissue. Moreover, this kinetic behavior could be a result of an efficient efflux clearance process, such as active efflux transporters at the blood-brain barrier.

Factors limiting the CNS distribution of pemetrexed remain unidentified. Various reasons for the low CNS distribution of pemetrexed could be protein binding in the blood, low passive permeability (diffusional influx clearance) due to the hydrophilicity of the compound, and high efflux clearance. The results from intravenous bolus study showed that the efflux clearance (CL_{out}) is about 10-fold greater than influx clearance for pemetrexed. The efflux clearance may include components such as bulk flow, possible efflux transport system in BBB, and/or metabolism. The rate of brain ECF bulk flow in the rat is about 0.3 µl/min (Szentistvanyi et al., 1984; Rosenberg, 1990) which is much smaller than efflux clearance (approximately 31 µl/min/kg or 9.2 µl/min for a 300-g rat; Table 1) and thus is not considered to be a major factor in this process. The active efflux transporters expressed in the BBB and blood-cerebrospinal fluid barrier could be an important factor. Previously, MTX has been shown to be a substrate of many efflux transporters such as MRP1 (Hooijberg et al., 1999), MRP2 (Hooijberg et al., 1999), MRP3 (Kool et al., 1999), MRP4 (Chen et al., 2002), and organic anion transporters (OATs) (Masuda et al., 1999; Takeda et al., 2002). As an analog of MTX, pemetrexed may also be the substrate of these efflux transporters that are expressed in BBB and may limit the distribution of pemetrexed into the CNS.

To examine this hypothesis, indomethacin, an established inhibitor with activity against some organic anion transporters (Hamilton et al., 2001; Sun et al., 2001b; Berger et al., 2003), was coinjected with pemetrexed to see whether the CNS distribution of pemetrexed would be affected. Indomethacin has been shown to inhibit effectively the transport of various organic anion compounds in vitro and in vivo, including MRP1 (Draper et al., 1997), MRP2 (Berger et al., 2003), MRP4 (Reid et al., 2003), oat2 (Morita et al., 2001), and human OATs (hOAT1, hOAT2, hOAT3, and hOAT4) (Khamdang et al., 2002). It has been shown that indomethacin can sensitize MRP or OAT-overexpressed cell and affect the transport of MTX (Khamdang et al., 2002; Takeda et al., 2002; Sosogi et al., 2003), anionic fluorescent dye carboxy-2',7'-dichlorofluorescein (Payen et al., 2000), and adefovir (Mulato et al., 2000). If pemetrexed is a substrate of indomethacin-sensitive organic anion transporter, its brain penetration would be expected to increase in the presence of indomethacin. Surprisingly, our studies, including intravenous bolus and steady-state infusion, showed that the CNS distribution of unbound pemetrexed was not affected by coinjection of indomethacin. One concern may be raised about the availability of indomethacin in the brain. Using the published pharmacokinetic parameters of indomethacin in rats (Ogiso et al., 1989), the starting plasma concentration (C_{0}) of indomethacin at the dose given in this study is predicted to be 83.3 µg/ml. Given that indomethacin is about 90% bound in plasma (Mason and McQueen, 1974), the free concentration of indomethacin would be 8.3 µg/ml. It has also been shown that indomethacin can interact with MRP4 at a concentration low as 0.375 µg/ml (1 µM) (Reid et al., 2003). Thus, at this dose regimen, indomethacin seems more than likely to be in sufficient concentration at the site of action to interact with organic transporters. From a pharmacodynamic perspective, it has been shown that at the same dose of indomethacin used in this study, indomethacin levels in the brain are high enough to effectively protect brain from ischemic damage (Chung et al., 2001). Therefore, the lack of effect by indomethacin on the CNS distribution of pemetrexed seems less likely to be due to the inadequate concentration of indomethacin in the brain. However, it is possible that efflux mediated by transporters other than organic transporters or metabolism may be responsible for the limited penetration of pemetrexed in the brain. Previous studies have indicated that MTX is a substrate of breast cancer resistance protein that is expressed in BBB (Volk et al., 2002; Volk and Schneider, 2003). This warrants further investigation regarding the role of breast cancer resistance protein in the transport of pemetrexed in BBB in vivo.

In summary, our study showed that the novel antifolate, pemetrexed, has a limited CNS distribution, although it is greater than that of MTX. Cotreatment with indomethacin does not significantly affect this distribution, suggesting indomethacin-sensitive organic anion transporters may not...
-play a significant role in limiting the distribution of pem-
etoxin to the brain.

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