

## Treatment of $\gamma$ -Hydroxybutyrate (GHB) Overdose with the GABA<sub>B</sub> Antagonist SGS742

Kristin E. Follman<sup>1,2</sup> and Marilyn E. Morris<sup>1</sup>

<sup>1</sup>Department of Pharmaceutical Sciences, School of Pharmacy and Pharmaceutical Sciences,  
University at Buffalo, State University of New York, Buffalo, New York.

<sup>2</sup>Current address is Certara Strategic Consulting, Certara USA, Inc., 100 Overlook Center, Suite  
101 Princeton, NJ 08540

Conflict statement:

No author has an actual or perceived conflict of interest with the contents of this article.

## Running Title Page

- a) Running title: SGS742 and Treatment of GHB Overdoses
- b) Correspondence should be addressed to: Marilyn E. Morris

Address: 304 Pharmacy Building

Department of Pharmaceutical Sciences

University at Buffalo

Buffalo, NY 14214-8033

Phone: (716) 645-4839

Fax: (716) 829-6569

E-mail: [memorris@buffalo.edu](mailto:memorris@buffalo.edu)

- c) Pages: 19

Tables: 9

Figures: 8

References: 39

Word count: Abstract: 241

Significance statement: 83

Introduction: 748

Discussion: 1454

- d) Abbreviations:

ABEC: area below the effected curve; AUC: area under the curve; CL: total clearance;  $E_{\max}$ : maximum effect; GABA:  $\gamma$ -aminobutyric acid; GBL:  $\gamma$ -butyrolactone; GHB: gamma-hydroxybutyric acid; i.v.: intravenously; LC/MS/MS: liquid chromatography coupled to tandem mass spectrometry; p.o.: orally; NMDA: N-methyl-D-aspartate; TD: toxicodynamics; TK: toxicokinetics

## **Abstract:**

High doses of the partial agonist of the GABA<sub>B</sub> receptor,  $\gamma$ -hydroxybutyric acid (GHB), causes respiratory depression that can lead to death. Previously, it has been shown that GABA<sub>B</sub> receptor antagonism is able to prevent respiratory depression and sedation when inhibitors are pre-administered. In order to treat GHB overdoses, safety and efficacy of a treatment strategy at various times after GHB administration is necessary, in order to more closely replicate a true overdose situation. Preliminary studies developed an assay for SGS742 and determined its pharmacokinetics in rats. The effects of SGS742 on GHB-induced respiratory depression were evaluated when SGS742 administration was delayed 1 and 2 hours after intravenous or oral administration of GHB or  $\gamma$ -butyrolactone, a GHB prodrug. SGS742 reversed GHB-induced respiratory depression in a dose-dependent manner at both time points tested, with no effects on its toxicokinetics. However, some of the dosing paradigms resulted in toxicity in the form of tremors, seizures or abnormal movements. The tremors/seizures occurred in a manner that was dependent on both the dose and timing of SGS742 administration, and were not altered with pretreatment with gabazine, a GABA<sub>A</sub> receptor inhibitor, and only partially reduced with pretreatment with NCS382, a selective GHB receptor antagonist. Additional studies with a second GABA<sub>B</sub> antagonist SCH50911 demonstrated similar effects, producing reversal of respiratory depression but producing tremors and abnormal movements. Further work is necessary in order to identify the potential use of GABA<sub>B</sub> antagonism as a treatment strategy for GHB overdoses.

## **Significance Statement**

There is no current treatment for overdoses of the drug of abuse  $\gamma$ -hydroxybutyric acid (GHB). Since the toxicodynamic effects of GHB, namely sedation and respiratory depression, are mediated through GABA<sub>B</sub> receptor agonism, GABA<sub>B</sub> receptor antagonists may represent a therapeutic strategy to treat overdoses. This study demonstrates that while GABA<sub>B</sub> receptor

antagonists are effective as a pretreatment, they are less effective when administered at times after GHB administration and their administration is also associated with time- and dose-associated toxicity, namely tremors or seizures.

## Introduction:

$\gamma$ -hydroxybutyric acid (GHB) is a structural analogue of the major inhibitory neurotransmitter  $\gamma$ -aminobutyric acid (GABA) (Waszkielewicz and Bojarski, 2004). Currently, GHB is marketed in the United States, Canada and Europe as Xyrem® for the treatment of narcolepsy, in Austria and Italy as Alcover® for the treatment of alcohol withdrawal and in Germany as an anesthetic Somsanit® (Carter et al., 2009b). Despite these numerous clinical applications, the therapeutic utility of GHB has been limited by its high abuse potential.

GHB has several pharmacological effects that are exploited in abuse; these include euphoria, decreased inhibitions, and growth hormone release (Felmlee et al., 2021; White, 2017). The abuse of GHB carries the risk of severe adverse effects such as sedation, respiratory depression, hypothermia, coma and even death (Trombley et al., 2019; White, 2017). GHB remains in the top five drugs involved with emergency department visits by the European Drug Emergencies Network (White, 2017). This demonstrates that GHB abuse still represents a threat to public health, as the risk of toxicity to users is high (Di Trana et al., 2021). Overdoses following the use of GHB to facilitate date rape, or chemsex-related intoxications magnify the need for a treatment option that is specific to GHB overdose (Drevin et al., 2021; Felmlee et al., 2021). Additionally, the investigation of GHB overdose should also include  $\gamma$ -butyrolactone (GBL) overdose (White, 2017), since GBL is a widely used GHB prodrug (Di Trana et al., 2021; Tini and Del Rio, 2020) that is rapidly converted to GHB upon ingestion (Lettieri and Fung, 1978).

GHB is a weak agonist of GABA<sub>B</sub> and it has been demonstrated that many of the toxicological effects of GHB are mediated through the GABA<sub>B</sub> receptor (Carai et al., 2001; Goodwin et al., 2005; Kaupmann et al., 2003; Morse et al., 2012). This has implicated GABA<sub>B</sub> antagonism as a viable option for GHB overdose treatment. Currently, there are no GABA<sub>B</sub> antagonists clinically available; however, one compound, SGS742 (CGP 36742; Figure 1) with an IC<sub>50</sub> of 38  $\mu$ M (Froestl et al., 1995), has been studied in clinical trials for mild cognitive

impairment; SGS742 was well tolerated in human subjects, with no serious adverse events (Froestl et al., 2004; Gleiter et al., 1996). SGS742 has also been used in clinical trials for the treatment of Succinic Semialdehyde Dehydrogenase (SSADH) deficiency, a pediatric/adult epilepsy disorder with increased GABA and GHB plasma and brain concentrations (Schreiber et al., 2021). When administered prior to the concomitant i.v. administration of GHB and ethanol, an i.v. bolus of 500 or 1000 mg/kg SGS742 has been shown to be effective in reducing sleep time, a sedation endpoint, in rats (Morse and Morris, 2013b). Pretreatment with SGS742 reduces GHB-induced effects such as ataxia and muscle relaxation in baboons (Goodwin et al., 2005; Goodwin et al., 2006). A more potent GABA<sub>B</sub> antagonist, SCH50911, has also been effective in reducing sleep time in rats (Morse and Morris, 2013b), and treatment with SCH50911, prior to GHB administration or 5 minutes after GHB dosing, completely prevents the respiratory depressant effects observed with GHB (Morse et al., 2012). GHB has also been demonstrated to exert effects at GABA<sub>A</sub> and GHB receptors (Absalom et al., 2012; Bay et al., 2014). Pretreatment with the GABA<sub>A</sub> receptor antagonist bicuculline had no effect on GHB-induced sedation or respiratory depression (Morse et al., 2012); however, the impact of GHB at this receptor or at GHB receptors in the presence of GABA<sub>B</sub> antagonists has not been investigated and could play an important role in adverse effects following treatments for GHB overdose.

Our hypothesis was that reversal of GABA<sub>B</sub> receptor agonism due to GHB will result in decreased toxicity and death after overdoses, when the dosing paradigm more closely resembles an overdose situation. In a clinical overdose, pretreatment will not be possible, and immediate treatment is unlikely. The first aim of this research was to investigate the impact of the GABA<sub>B</sub> receptor antagonist SGS742 on GHB toxicokinetics and toxicodynamics (respiratory depression), when administered at times after GHB ingestion. The ideal GHB overdose treatment must be safe and effective when administered at various time points after GHB administration. Our studies demonstrated efficacy, but also toxicity in the form of tremors and

seizures; therefore, our second aim was to investigate the role of GABA<sub>A</sub> and GHB receptors in the toxicity observed following GHB and GABA<sub>B</sub> receptor antagonist administration. Gabazine, a drug that acts as a GABA<sub>A</sub> receptor antagonist, and NCS382, a selective GHB receptor antagonist, were utilized in our studies (Ainslie et al., 2016; Castelli et al., 2004).

## **Materials and Methods:**

### **Chemical and Reagents**

National Institute on Drug Abuse provided sodium GHB, SGS742 and 6,7,8,9-tetrahydro-5-hydroxy-5H-benzocyclohept-6-ylideneacetic acid (NCS382). Deuterated GHB (GHB-d6) was obtained from Cerilliant Corporation (Round Rock, TX). High-performance liquid chromatography grade acetonitrile and acetic acid were purchased from Honeywell Burdick & Jackson (Muskegon, MI). (2S)-(+)-5,5-Dimethyl-2-morpholineacetic acid (SCH50911) and gabazine were purchased from Tocris (Bristol, UK).

### **Animals and Surgery**

Male Sprague–Dawley rats (Harlan, Indianapolis, IN), greater than 60 days of age, (average of 300 grams) were housed under controlled humidity and temperature, with an artificial 12-hour light/dark cycle; food was available ad libitum. Cannulae were surgically implanted in the jugular vein, under ketamine/xylazine anesthesia, and flushed daily with 40 IU/ml heparinized saline to maintain patency. Experiments were performed after a minimal recovery phase of 72 h after surgery. All animal procedures were approved by University at Buffalo Institutional Animal Care and Use Committee.

### **Pharmacokinetic (PK) Studies of SGS742**

Studies were performed to determine SGS742 PK and dosing regimens. Blood samples were collected over 8 hours, at time points of 3, 11, 21, 31, 61, 121, 181, 241, 301, 331, 361

and 481 minutes. Treatment groups consisted of 3 animals for each of the 100 and 500 mg/kg doses. SGS742 was administered as a sterile 100 or 200 mg/mL solution in normal saline via the jugular vein cannula.

#### Pharmacodynamic Studies for SGS742

The effect of SGS742 on respiration was studied using whole-body plethysmography (model PLY4213; Buxco Research Systems, Wilmington, NC), as previously performed in the Morris laboratory (Morse et al., 2012; Morse and Morris, 2013a; Vijay et al., 2015). Animals were allowed to acclimate for 45 min in plethysmography chambers prior to the collection of five baseline measurements of the respiratory parameters of interest (breathing frequency, tidal volume and minute volume) over 15 min. SGS742 was administered as a sterile 200 or 100 mg/mL solution in normal saline intravenously via the implanted cannulae. Respiratory parameters were measured at 2.5, 5, 7.5, 10, 15, 20, 25, and 30 min and every 15 min thereafter until 8 hours.

#### Impact of SGS742 on GHB Toxicokinetics (TK)

The effect of SGS742 on the toxicokinetics of GHB was investigated. GHB was administered i.v. as a 1500 mg/kg bolus via a jugular vein cannula. The dose was selected to produce plasma concentrations in the range reported after clinical overdoses (Zvosec et al., 2011). The plasma concentration-time profiles in rats have been demonstrated in previous studies, as well as the toxicity observed at the doses used in this study (Morse et al., 2012; Morse and Morris, 2013a; Vijay et al., 2015). The time of administration for GHB was considered to be time 0. An i.v. bolus of 500 mg/kg SGS742 was administered 60 minutes after the GHB dose. Blood samples were collected for 8 hours after GHB administrations including time points of 3, 11, 21, 31, 61, 121, 181, 241, 301, 331, 361 and 481 minutes. GHB was administered as a sterile 300 mg/mL solution in ddH<sub>2</sub>O via the jugular vein cannula. SGS742 was administered as a sterile 300 mg/mL solution in normal saline. Treatment groups were compared to historical data where the



same dose (1500 mg/kg) was administered in the same manner (Morse et al., 2012; Morse and Morris, 2013a; Vijay et al., 2015).

### *Impact of SGS742 and SCH50911 on GHB Toxicodynamics (TD)*

The effect of SGS742 on the TD of GHB was studied using whole-body plethysmography (model PLY4213; Buxco Research Systems, Wilmington, NC). Animals were allowed to acclimate for 45 min in plethysmography chambers prior to the collection of five baseline measurements of the respiratory parameters of interest over 15 min. GHB was then administered intravenously or orally via oral gavage, as a 14.4 mmol/kg bolus. For studies investigating GBL overdose, GBL was administered after baseline readings as a 5.77 mmol/kg oral dose via oral gavage. The time of administration for GHB/GBL was set as the reference time, 0 minutes. (Note that only GHB can be detected in plasma after GBL administration.) Additional studies were performed with a second GABA<sub>B</sub> receptor antagonist SCH50911 with doses of 25 or 50 mg/kg after the administration of i.v. GHB. The treatment compounds, SGS742 or SCH50911, were administered either 60 or 120 minutes after the GHB dose. Blood and urine samples were collected for 8 hours after intravenous GHB or oral GBL administration and for 15 hours after oral GHB administration. The respiratory parameters breathing frequency, tidal volume and minute volume were measured at time 2.5, 5, 7.5, 10, 15, 20, 25, and 30 min and every 15 min thereafter until 8 or 15 h, along with extra measurements at 5 and 10 min following the administration of the treatment compounds. GHB or GBL was administered as a sterile 300 mg/mL solution in ddH<sub>2</sub>O via the jugular vein cannula. SGS742 was administered as a sterile 300, 250, 100, or 50 mg/mL solution in normal saline via the jugular vein cannula. For studies involving pretreatment with gabazine or NCS382, these compounds were administered intravenously via the jugular cannula as sterile solutions in normal saline at concentrations of 1 or 100 mg/mL, respectively. All treatment groups consisted of 1-7 animals. Treatment groups were compared to historical data where the same dose (14.4 mmol/kg) of

GHB was administered in the same manner (Morse et al., 2012; Morse and Morris, 2013a; Vijay et al., 2015).

### Plasma Sample Analysis

GHB and SGS742 plasma concentrations were determined using a dual liquid chromatography coupled to tandem mass spectrometry (LC/MS/MS) assay developed and validated for this purpose. GHB-d6 (125 µg/ml) was used as an internal standard for GHB, and CGP 36216 (40 µg/ml) was used as an internal standard for SGS742. Dual standard stock solutions as well as a dual internal standard solution were used in sample preparation. To prepare a standard curve, 5 µL dual internal standard and 5 µL dual standard stock solution were added to 45 µL blank plasma. For samples obtained at time points up to and including 241 min, 5 µL sample and 5 µL dual internal standard were added to 45 µL blank plasma. For samples obtained after that time, 5 µL dual internal standard were added to 50 µL sample. To precipitate the plasma proteins 800 µL 0.1% formic acid in acetonitrile was added, samples were vortexed and centrifuged at 10,000 rpm for 20 min. An aliquot (750 µL) of the supernatant was dried under a stream of nitrogen gas and then reconstituted in 1 mL of aqueous mobile phase.

The LC/MS/MS assay was performed on Shimadzu Prominence HPLC with binary pump and autosampler (Shimadzu Scientific Instruments (SSI), Portland, OR) in conjunction with a Sciex API 3000 triple-quadrupole tandem mass spectrometer with a turbo ion spray (Applied Biosystems, Foster City, CA). Chromatographic separation was achieved by injecting 4 µL of sample on an Xterra MS C18 column (250×2.1 mm i.d., 5-µm particle size; Waters, Milford, MA). Mobile phase A was 5/95 acetonitrile/water with 0.1% acetic acid and mobile phase B was 95/5 acetonitrile/water with 0.1% acetic acid. The flow rate was set to 230 µL/min with a gradient elution profile. The total run time for the procedure was 15 min. Positive ionization mode was utilized with multiple reaction monitoring. The Q1/Q3 m/z ratios were 105.1/87.2 and 111.1/93.2

for GHB and its internal standard (GHB-d6), respectively. For SGS742 and its internal standard (CGP 36216) the Q1/Q3 ratios were 180.0/163.0 and 152.0/134.9, respectively. The mass spectrometer parameters were optimized at a declustering potential of 15, focusing potential of 50, and entrance potential of 10. The collision energy and collision cell exit potential were specific to each analyte. For GHB, the collision energy and collision cell exit potential were 15 and 5, respectively. The same parameters were 18 and 8 for SGS742, respectively. The ion spray voltage was set at 5500 V and the temperature was 350°C. The nebulizer and curtain gas flow were set at 10 and 8 mL/min, respectively. The data was analyzed using Analyst software versions 1.4.2 (Applied Biosystems, Foster City, CA).

Regression analysis of GHB and SGS742 peak areas to their concentrations were utilized to assess the linearity of the curve. The intra-day and inter-day precision and accuracy were determined using quality control samples at 10, 125 and 250 µg/mL for GHB and 5, 10 and 40 µg/mL for SGS742. Intra-day precision and accuracy were evaluated by analyzing quality control samples in triplicate each day. Inter-day precision and accuracy were determined by performing quality control samples on three separate days. Each analysis consisted of a calibration curve and quality controls. Precision was determined by the relative standard deviation (RSD%) and accuracy was determined by comparing the calculated concentration based on the calibration curve, to the known concentration.

### Data Analysis

Non-compartmental analyses (NCA) for GHB and SGS742 were performed using the PK solver excel plugin published by Zhang et al. (Zhang et al., 2010). The primary toxicodynamic parameter was the area below the effect curve (ABEC) for breathing frequency. This was determined in GraphPad Prism 7, using the area under the curve function. The first observed negative peak was analyzed for all TD parameters. For studies including a delay in the administration of the treatment compound, TD parameters were assessed for the TD curve

beginning at the time of administration of the treatment compound (60 or 120 minutes). Control TD parameters were derived from the control data from previous studies from the Morris laboratory (Morse and Morris, 2013a; Vijay et al., 2015). ABEC was identified using the individual baseline respiration for each animal, ignoring peaks which were less than 10% of the distance from the minimum to the maximum y-value. Duration of effect was defined as the length of time for the first negative peak.  $E_{\max}$  was the minimum value for breathing frequency observed.

Statistical significance was determined using one-way ANOVA with Dunnett's post hoc for comparisons of multiple treatment groups to a control, or Tukey's post hoc when multiple groups were all compared against each other. For comparisons of a single group to a control a Student's t-test was utilized. In cases where treatment was administered at 60 or 120 minutes for the same treatment compound, statistics were assessed separately for these two groups, as there were unique control parameters for comparison with these two times of administration. All statistics were performed in GraphPad Prism 7.

## **Results:**

### SGS742/GHB Plasma Assay

The dual GHB/SGS742 assay exhibited acceptable analyte recovery, accuracy and precision. The assay had a very consistent recovery of both GHB and SGS742; the recovery of SGS742 was nearly complete, ranging from 95.8 – 102%, with a low limit of quantification, and excellent precision and accuracy (Supplemental Table1). A representative spectrum is presented in Supplemental Figure 1. The retention time for GHB and SGS742 were 3.62 and 4.23 min, respectively. The retention times for the internal standards, GHB-d6 and CGP 36216, were 3.61 and 2.48 minutes, respectively. The lower limits of GHB and SGS742 in plasma samples were 1 and 0.1  $\mu\text{g/mL}$ , respectively. Validation of the assay demonstrated acceptable error in accuracy and precision with RSE values 10% or less. The standard curve ranged from

0.1 µg/mL to 50 µg/mL for SGS742, and 1 µg/mL to 500 µg/mL for GHB. The inter- and intra-day precision and accuracy of the assay for SGS742 and GHB are presented in Supplemental Table 2.

#### Pharmacokinetics of SGS742

SGS742 was administered as an intravenous bolus at doses of 500 and 100 mg/kg. The plasma profiles for both doses are shown in Figure 2. Clearance was linear, as the dose-normalized plasma profiles overlapped (data not shown). Overall, CL was 6.8 mL/min/kg, and the average observed half-life was 171 min or 2.84 hours (Table 1).

#### Impact of SGS742 on GHB Toxicokinetics

SGS742 was administered as a 500 mg/kg intravenous bolus 60 minutes after the intravenous administration of 1500 mg/kg GHB. There was no effect of SGS742 administration on the exposure, clearance or half-life of GHB (Table 2). However, there was a small but statistically significant increase in  $V_{ss}$  with SGS742 treatment (Table 2).

#### Impact of SGS742 on Intravenous GHB Toxicodynamics

The impact of SGS742 on GHB induced respiratory depression was dependent on the time of administration and dose of the treatment compound. Doses ranging from 25 to 500 mg/kg of SGS742 were investigated, with a 60- or 120-minute delay of treatment (Figure 3). While SGS742 had no direct effect on respiration (data not shown), SGS742 administered at the earlier treatment time and at the higher doses had the largest effect on GHB TD (Figure 3, Table 3). Improvement in  $t_d$  was observed for both doses of SGS742 (100 and 500 mg/kg) at the earliest time of administration (60 min) (Table 3). When the 500mg/kg dose was administered 120 minutes after GHB, a seizure was observed. Twitching movement was observed at the lower doses for SGS742 when administered at 120 minutes after GHB, with the exception of the lowest dose (25 mg/kg).

#### Impact of SCH50911 on Intravenous GHB Toxicodynamics

Studies examined the influence of a second GABA<sub>B</sub> antagonist SCH50911 on GHB TD to confirm the effects observed with SGS742. SCH50911 administration (25 or 50 mg/kg) reduced the effect of GHB induced respiratory depression when administered 60 or 120 minutes after intravenous GHB (Figure 4). Breathing frequency increased at the time of SCH50911 administration with both doses tested (25 and 50 mg/kg SCH50911). Analysis of the TD parameters resulted in a significant improvement for ABEC only for the higher dose (50 mg/kg) of SCH50911 administered at the earlier treatment time (60 min) (Table 4). This dose elicited a seizure when it was administered 120 minutes after GHB in one animal and was not tested further. No seizures were observed when SCH50911 was administered 120 minutes after GHB at a dose of 25 mg/kg and this dose also resulted in a significant reduction in both ABEC and  $t_d$  (Table 4).

#### Impact of SGS742 on Oral GHB Toxicodynamics

The effect of SGS742 on oral GHB TD was dose-dependent, as it was with i.v. administered GHB. Higher doses of SGS742 resulted in a greater reduction of the effect of GHB induced respiratory depression (Figure 5, Table 5). Due to the high variability, statistically significant improvements in ABEC and  $t_d$  we only achieved for the highest dose of SGS742 (250 mg/kg) when administered 120 minutes after oral GHB (Table 5). The lower doses did not result in an improvement in GHB TD regardless of time of administration (Table 5). Some twitching was observed in the majority of animals administered 100 or 250 mg/kg SGS742 with both time points of administration.

#### Impact of SGS742 on Oral GBL Toxicodynamics

SGS742 was administered 120 minutes after oral GBL administration at a dose of 100 mg/kg. There was an increase in breathing frequency following the dose of SGS742 (Figure 6, Table 6). All TD parameters were improved with SGS742 administered 120 minutes after dosing of GBL, but this was only statistically significant for  $E_{max}$  (Table 6).

#### Impact of Gabazine Pretreatment and SGS742 Treatment on Intravenous GHB Toxicodynamics

When the GABA<sub>A</sub> antagonist gabazine was administered 5 minutes prior to intravenous GHB, there was no effect on SGS742 treatment of GHB overdose (Figure 7, Table 7). With gabazine pretreatment, there was a slight reduction in ABEC, further than what was observed with SGS742 treatment, but this was not statistically significant (Table 7). There was no effect of gabazine pretreatment on the observation of abnormal movements after SGS742 treatment. In order to assess the impact of gabazine pretreatment on GHB TD, the data was analyzed up to the time of administration of SGS742 at 120 minutes. There was no effect of gabazine pretreatment on GHB induced respiratory depression (data not shown).

#### Impact of NCS382 Pretreatment and SGS742 Treatment on Intravenous GHB Toxicodynamics

Pretreatment with NCS382 (100 mg/kg) prior to administration of intravenous GHB did not have an effect on the SGS742-mediated reduction of GHB induced respiratory depression, when SGS742 (100 mg/kg) was administered 60 minutes after GHB (Figure 8A, Table 8). When SGS742 treatment was delayed to 120 minutes after GHB, there was a statistically significant reduction in ABEC and  $t_d$  for the group that was pretreated with NCS382 (Figure 8B, Table 8). There was a statistically significant increase in all TD parameters for the pretreated group, indicating a reduction in respiratory depression for the pretreated group, when it was compared to the group treated with SGS742 without pretreatment (Table 8). In animals with NCS382 pretreatment, fewer animals exhibited twitching movements which could be related to seizures, although one animal (out of 5) still exhibited these movements.

The impact of pretreatment with NCS382 was assessed by analyzing the data prior to administration of SGS742. No differences were observed when data was analyzed for 60 minutes after GHB administration between pretreated and control groups (Table 9). When data was analyzed to 120 minutes after GHB, there was a statistically significant reduction in ABEC for the group that was pretreated with NCS382. There was no difference in  $E_{max}$  or  $t_d$  for the pretreated group compared to the control.

## Discussion.

Abuse of GHB is associated with severe adverse effects including sedation, respiratory depression, hypothermia, coma and even death, due to the steep concentration-toxicity relationship (Trombley et al., 2019; White, 2017). The majority of the toxicodynamic effects of exogenous GHB, including decreased respiration, locomotion and body temperature, have been shown to be dependent on partial agonism at the GABA<sub>B</sub> receptor and pretreatment with GABA<sub>B</sub> antagonists has been demonstrated to reverse sedation, respiratory depression and lethality observed in mouse, rat and baboon studies. (Carai et al., 2001; Goodwin et al., 2005; Goodwin et al., 2006; Jensen and Mody, 2001; Kaupmann et al., 2003; Morse and Morris, 2013b; Morse et al., 2012). Since GHB exerts most of its pharmacological/toxicological effects as a partial agonist of GABA<sub>B</sub> receptors in the brain and this receptor represents a potential target for the treatment of GHB overdose. Two GABA<sub>B</sub> receptor antagonists, SCH50911 and SGS742, have been evaluated in preclinical studies. Although there are no commercially available GABA<sub>B</sub> receptor antagonists used clinically, SGS722 has been investigated in clinical trials, demonstrating a lack of toxicity (Froestl et al., 2004) and therefore was the focus of the current studies.

Initial studies characterized the pharmacokinetics of SGS742 in rats following the administration of 100 and 500 mg/kg intravenously. The results indicated dose-proportional pharmacokinetics and minimal to no effects of SGS742 on the toxicokinetics of GHB. SGS742 also had no direct effect on respiration, our toxicological endpoint in these studies. Importantly, no adverse effects of SGS742 administration were observed in rats even at the highest doses used. Based on the plasma concentrations achieved in this study and the brain penetration of SGS742, as determined in brain microdialysis studies by Anden et al. (Andren et al., 1998), and the rapid reversal of respiratory depression observed at doses of 250 and 500 mg/kg, effective brain concentrations were achieved to reverse respiratory depression caused by GHB.



In the present study, the administration of the GABA<sub>B</sub> receptor antagonists, SGS742 and SCH50911, were able to reduce the effects of GHB (after i.v. and oral administration) in a dose- and administration time- dependent manner. Higher doses were associated with both increased efficacy and increased toxicity of SGS742 and SCH50911. Similar efficacy was observed with the administration of the GHB prodrug, GBL. However, abnormal movements, tremors or seizures were observed after the delayed administration of GABA<sub>B</sub> antagonists to animals receiving GHB or GBL, and effects were dose-dependent. These findings contrast with a lack of toxicity observed following pre-treatment of GABA<sub>B</sub> receptor antagonists prior to GHB/GBL administration (Morse et al., 2012; Morse and Morris, 2013a; Vijay et al., 2015).

GHB is known to cause seizures on its own, and is even used to produce experimental models of absence epilepsy in rats (Venzi et al., 2015). Mice with succinic semialdehyde dehydrogenase (SSADH) deficiency, a condition that leads to elevated GHB and GABA brain concentrations, have been shown to present with rodent absence epilepsy (Cortez et al., 2004). In humans, SSADH deficiency can also lead to generation of seizures, and nearly half of patients develop epilepsy (Pearl et al., 2011). While GHB has been clearly demonstrated to be influential in the processes that generate seizures, in this study the seizures were precipitated by the administration of the GABA<sub>B</sub> antagonist, not simply GHB alone. It may be that the rapid reversal of action of GHB at the GABA<sub>B</sub> receptor is causing these seizures. The interruption of balance between the action of GHB at GABA<sub>B</sub> receptors and the action of GHB at other receptor sites may also be the cause of toxicity.

Several other GHB binding sites have been identified in the central nervous system: these include a subset of GABA<sub>A</sub> receptors, characterized by the  $\alpha 4$ ,  $\delta$  and  $\beta 1$  subunits, as well as a novel GHB receptor (Absalom et al., 2012; Bay et al., 2014). The action of GHB at these other sites may be contributing to the generation of seizures following GABA<sub>B</sub> antagonist administration. The impact of blocking the effects of GHB at these receptors by pretreatment with gabazine and NCS382, GABA<sub>A</sub> and GHB receptor antagonists, respectively, was

investigated in the present study. Gabazine pretreatment had no effect of the efficacy of SGS742 treatment following i.v. GHB administration. When data prior to the administration of SGS742 was compared to control, it revealed there was no impact of GABA<sub>A</sub> pretreatment itself on the TD effects of GHB. There was also no difference in the abnormal movements associated with SGS742 treatment after gabazine pretreatment. These data suggest that GABA<sub>A</sub> receptors are not playing a role in GHB TD or the possible toxicity observed with SGS742 treatment. On the other hand, NCS382 pretreatment appeared to reduce respiratory depression and, following the delayed administration of SGS742, decreased the abnormal movements in animals; only one out of 5 animals with NSC382 pretreatment exhibited abnormal movements/tremors. These results suggest that the GHB receptor may play a role in GHB-induced respiratory depression, and may also be implicated in the potential seizure generation with SGS742 treatment. GHB receptors are generally associated with the physiological effects of GHB, but Ainslie et al. reported that NCS382 may reverse loss of motor function following GHB administration (Ainslie et al., 2016), suggesting a potential reversal of toxicity.

In addition to potential action of GHB at receptors other than GABA<sub>B</sub>, there are other factors that could be playing a role in the generation of seizures. One of the metabolites of GHB, d-2-hydroxyglutarate (D2HG), has been shown to activate the recombinant N-methyl-D-aspartate (NMDA) receptors (NR1/NR2A, NR1/NR2B) in HEK293 cells (Kolker et al., 2002). D2HG is of interest as this compound is elevated in the inherited neurometabolic disease D-2-hydroxyglutaric aciduria, which is characterized by hypotonia, epilepsy and psychomotor retardation (Kolker et al., 2002). It has also been shown that hypoxia, which would be induced by the respiratory depression with GHB, can lead to a rise in extracellular glutamate levels in the dorsal hippocampus of rats (Lopez-Perez et al., 2012). GHB itself has also been shown to modulate extracellular glutamate levels in a concentration- dependent manner in the CA1 region of the hippocampus in rats (Ferraro et al., 2001). Dose-dependent modulation of glutamate levels in rat hippocampus appears to be a result of differential activation of the various receptors

with which GHB interacts. At high (mM) concentrations, the interaction of GHB at GABA<sub>B</sub> receptors dominates, leading to a decrease in extracellular glutamate. When GABA<sub>B</sub> receptors are blocked, the same concentration of GHB leads to an increase in extracellular glutamate. Although brain concentrations of GHB were not determined in this study, previous studies have shown that frontal cortex extracellular fluid (ECF) concentrations are in the mM range for a dose of 800 mg/kg (7.68 mmol/kg) GHB, and the dose used in the current study was higher at 1500 mg/kg (14.4 mmol/kg) (Roiko et al., 2012). Therefore, it is highly likely that mM concentrations of GHB were present in the brain ECF in this study. The complex effects of GHB on the extracellular concentration of glutamate, the major excitatory neurotransmitter and agonist of the NMDA receptor, as well as the possible involvement of the GHB metabolite and NMDA agonist D2HG, may both be significant with regards to the generation of seizures in this study.

The current study demonstrated that the GABA<sub>B</sub> antagonists SGS742 and SCH50911 can reverse GHB induced respiratory depression, even when administered 60 or 120 minutes after GHB administration. In addition, SGS742 had no effect on respiration in the absence of GHB. However, the potential toxicity observed in the form of tremors or seizures for these compounds presents a major challenge to utilizing GABA<sub>B</sub> antagonism for the treatment of GHB overdose. The generation of seizure-like activity with the administration of SGS742 and SCH50911 was dependent on the dose and timing of administration of the antagonist with respect to GHB administration. The doses used of the two GABA<sub>B</sub> receptor antagonists differed in this study, reflecting their differences in potency for the inhibition of GABA<sub>B</sub> receptors. Both compounds are selective, competitive and orally-active first generation GABA<sub>B</sub> inhibitors, that block both central and peripheral GABA<sub>B</sub> receptors. (Bolser et al., 1995; Froestl, 2010). Although both compounds have been reported to have minimal effects on other neuroreceptors, there are GABA<sub>B</sub> receptor subtypes with different distribution and function, and the specificity of these two GABA<sub>B</sub> inhibitors for the receptor subtypes is not known (Carter et al., 2009a).

There are many possible explanations for the dose- and time-dependent toxicity observed with GABA<sub>B</sub> receptor antagonists, which include but are not limited to the action of GHB at other receptors and the modulation of extracellular glutamate levels by GHB. Further mechanistic studies are necessary to elucidate which pathways are contributing to the generation of seizures in order to assess the potential of GABA<sub>B</sub> receptor antagonism as a treatment option for GHB overdose.

**Authorship Contributions:**

*Participated in research design:* Morris, Follman

*Conducted experiments:* Follman

*Contributed new reagents or analytic tools:* Morris, Follman

*Performed data analysis:* Morris, Follman

*Wrote or contributed to the writing of the manuscript:* Morris, Follman

## References:

- Absalom N, Eghorn LF, Villumsen IS, Karim N, Bay T, Olsen JV, Knudsen GM, Brauner-Osborne H, Frolund B, Clausen RP, Chebib M and Wellendorph P (2012) alpha4betadelta GABA(A) receptors are high-affinity targets for gamma-hydroxybutyric acid (GHB). *Proc Natl Acad Sci U S A* **109**:13404-13409.
- Ainslie GR, Gibson KM and Vogel KR (2016) A pharmacokinetic evaluation and metabolite identification of the GHB receptor antagonist NCS-382 in mouse informs novel therapeutic strategies for the treatment of GHB intoxication. *Pharmacol Res Perspect* **4**:e00265.
- Andren PE, Emmett MR, DaGue BB, Steulet AF, Waldmeier P and Caprioli RM (1998) Blood-brain barrier penetration of 3-aminopropyl-n-butylphosphinic acid (CGP 36742) in rat brain by microdialysis/mass spectrometry. *J Mass Spectrom* **33**:281-287.
- Bay T, Eghorn LF, Klein AB and Wellendorph P (2014) GHB receptor targets in the CNS: focus on high-affinity binding sites. *Biochem Pharmacol* **87**:220-228.
- Bolser DC, Blythin DJ, Chapman RW, Egan RW, Hey JA, Rizzo C, Kuo SC and Kreutner W (1995) The pharmacology of SCH 50911: a novel, orally-active GABA-beta receptor antagonist. *J Pharmacol Exp Ther* **274**:1393-1398.
- Carai MA, Colombo G, Brunetti G, Melis S, Serra S, Vacca G, Mastinu S, Pistuddi AM, Solinas C, Cignarella G, Minardi G and Gessa GL (2001) Role of GABA(B) receptors in the sedative/hypnotic effect of gamma-hydroxybutyric acid. *Eur J Pharmacol* **428**:315-321.
- Carter LP, Koek W and France CP (2009a) Behavioral analyses of GHB: receptor mechanisms. *Pharmacol Ther* **121**:100-114.
- Carter LP, Pardi D, Gorsline J and Griffiths RR (2009b) Illicit gamma-hydroxybutyrate (GHB) and pharmaceutical sodium oxybate (Xyrem): differences in characteristics and misuse. *Drug Alcohol Depend* **104**:1-10.
- Castelli MP, Pibiri F, Carboni G and Piras AP (2004) A review of pharmacology of NCS-382, a putative antagonist of gamma-hydroxybutyric acid (GHB) receptor. *CNS Drug Rev* **10**:243-260.
- Cortez MA, Wu Y, Gibson KM and Snead OC, 3rd (2004) Absence seizures in succinic semialdehyde dehydrogenase deficient mice: a model of juvenile absence epilepsy. *Pharmacol Biochem Behav* **79**:547-553.
- Di Trana A, Beck R and Del Rio A (2021) Management of GHB acute intoxications. *Clin Ter* **171**:e49-e51.
- Drevin G, Rossi LH, Ferec S, Briet M and Abbara C (2021) Chemsex/slamsex-related intoxications: A case report involving gamma-hydroxybutyrate (GHB) and 3-methylmethcathinone (3-MMC) and a review of the literature. *Forensic Sci Int* **321**:110743.
- Felmlee MA, Morse BL and Morris ME (2021) gamma-Hydroxybutyric Acid: Pharmacokinetics, Pharmacodynamics, and Toxicology. *AAPS J* **23**:22.
- Ferraro L, Tanganelli S, O'Connor WT, Francesconi W, Loche A, Gessa GL and Antonelli T (2001) gamma-Hydroxybutyrate modulation of glutamate levels in the hippocampus: an in vivo and in vitro study. *J Neurochem* **78**:929-939.
- Froestl W (2010) Chemistry and pharmacology of GABAB receptor ligands. *Adv Pharmacol* **58**:19-62.
- Froestl W, Gallagher M, Jenkins H, Madrid A, Melcher T, Teichman S, Mondadori CG and Pearlman R (2004) SGS742: the first GABA(B) receptor antagonist in clinical trials. *Biochem Pharmacol* **68**:1479-1487.
- Froestl W, Mickel SJ, von Sprecher G, Diel PJ, Hall RG, Maier L, Strub D, Melillo V, Baumann PA, Bernasconi R and et al. (1995) Phosphinic acid analogues of GABA. 2. Selective, orally active GABAB antagonists. *J Med Chem* **38**:3313-3331.

- Gleiter CH, Farger G and Mobius HJ (1996) Pharmacokinetics of CGP 36,742, an orally active GABAB antagonist, in humans. *J Clin Pharmacol* **36**:428-438.
- Goodwin AK, Froestl W and Weerts EM (2005) Involvement of gamma-hydroxybutyrate (GHB) and GABA-B receptors in the acute behavioral effects of GHB in baboons. *Psychopharmacology (Berl)* **180**:342-351.
- Goodwin AK, Griffiths RR, Brown PR, Froestl W, Jakobs C, Gibson KM and Weerts EM (2006) Chronic intragastric administration of gamma-butyrolactone produces physical dependence in baboons. *Psychopharmacology (Berl)* **189**:71-82.
- Jensen K and Mody I (2001) GHB depresses fast excitatory and inhibitory synaptic transmission via GABA(B) receptors in mouse neocortical neurons. *Cereb Cortex* **11**:424-429.
- Kaupmann K, Cryan JF, Wellendorph P, Mombereau C, Sansig G, Klebs K, Schmutz M, Froestl W, van der Putten H, Mosbacher J, Brauner-Osborne H, Waldmeier P and Bettler B (2003) Specific gamma-hydroxybutyrate-binding sites but loss of pharmacological effects of gamma-hydroxybutyrate in GABA(B)(1)-deficient mice. *Eur J Neurosci* **18**:2722-2730.
- Kolker S, Pawlak V, Ahlemeyer B, Okun JG, Horster F, Mayatepek E, Kriegelstein J, Hoffmann GF and Kohr G (2002) NMDA receptor activation and respiratory chain complex V inhibition contribute to neurodegeneration in d-2-hydroxyglutaric aciduria. *Eur J Neurosci* **16**:21-28.
- Lettieri J and Fung HL (1978) Improved pharmacological activity via pro-drug modification: comparative pharmacokinetics of sodium gamma-hydroxybutyrate and gamma-butyrolactone. *Res Commun Chem Pathol Pharmacol* **22**:107-118.
- Lopez-Perez SJ, Morales-Villagran A, Ventura-Valenzuela J and Medina-Ceja L (2012) Short- and long-term changes in extracellular glutamate and acetylcholine concentrations in the rat hippocampus following hypoxia. *Neurochem Int* **61**:258-265.
- Morse BL and Morris ME (2013a) Effects of monocarboxylate transporter inhibition on the oral toxicokinetics/toxicodynamics of gamma-hydroxybutyrate and gamma-butyrolactone. *J Pharmacol Exp Ther* **345**:102-110.
- Morse BL and Morris ME (2013b) Toxicokinetics/Toxicodynamics of gamma-hydroxybutyrate-ethanol intoxication: evaluation of potential treatment strategies. *J Pharmacol Exp Ther* **346**:504-513.
- Morse BL, Vijay N and Morris ME (2012) gamma-Hydroxybutyrate (GHB)-induced respiratory depression: combined receptor-transporter inhibition therapy for treatment in GHB overdose. *Mol Pharmacol* **82**:226-235.
- Pearl PL, Shukla L, Theodore WH, Jakobs C and Michael Gibson K (2011) Epilepsy in succinic semialdehyde dehydrogenase deficiency, a disorder of GABA metabolism. *Brain Dev* **33**:796-805.
- Roiko SA, Felmler MA and Morris ME (2012) Brain uptake of the drug of abuse gamma-hydroxybutyric acid in rats. *Drug Metab Dispos* **40**:212-218.
- Schreiber JM, Wiggs E, Cuento R, Norato G, Dustin IH, Rolinski R, Austermeuhle A, Zhou X, Inati SK, Gibson KM, Pearl PL and Theodore WH (2021) A Randomized Controlled Trial of SGS-742, a gamma-aminobutyric acid B (GABA-B) Receptor Antagonist, for Succinic Semialdehyde Dehydrogenase Deficiency. *J Child Neurol*:8830738211012804.
- Tini A and Del Rio A (2020) Has GBL replaced GHB in recreational settings? *Arh Hig Rada Toksikol* **71**:167-168.
- Trombley TA, Capstick RA and Lindsley CW (2019) DARK Classics in Chemical Neuroscience: Gamma-Hydroxybutyrate (GHB). *ACS Chem Neurosci*.
- Venzi M, Di Giovanni G and Crunelli V (2015) A critical evaluation of the gamma-hydroxybutyrate (GHB) model of absence seizures. *CNS Neurosci Ther* **21**:123-140.
- Vijay N, Morse BL and Morris ME (2015) A Novel Monocarboxylate Transporter Inhibitor as a Potential Treatment Strategy for gamma-Hydroxybutyric Acid Overdose. *Pharm Res* **32**:1894-1906.

- Waszkielewicz A and Bojarski J (2004) Gamma-hydrobutyric acid (GHB) and its chemical modifications: a review of the GHBergic system. *Pol J Pharmacol* **56**:43-49.
- White CM (2017) Pharmacologic, Pharmacokinetic, and Clinical Assessment of Illicitly Used gamma-Hydroxybutyrate. *J Clin Pharmacol* **57**:33-39.
- Zhang Y, Huo M, Zhou J and Xie S (2010) PKSolver: An add-in program for pharmacokinetic and pharmacodynamic data analysis in Microsoft Excel. *Comput Methods Programs Biomed* **99**:306-314.
- Zvosec DL, Smith SW, Porrata T, Strobl AQ and Dyer JE (2011) Case series of 226 gamma-hydroxybutyrate-associated deaths: lethal toxicity and trauma. *Am J Emerg Med* **29**:319-332.

**Footnotes:** This work was supported by the National Institutes of Health National Institute on Drug Abuse (NIDA) [grant R01DA023223].

## Figure Legends

**Figure 1.** Chemical structure of SGS742 (3-aminopropyl-*n*-butyl phosphinic acid)

**Figure 2.** SGS742 Pharmacokinetics. SGS742 was administered as an i.v. bolus at a dose of 500 mg/kg (closed circles) and 100 mg/kg (open circles). Data is represented as mean  $\pm$  standard deviation, with  $n = 3$  for both doses.

**Figure 3.** Effect of SGS742 on Intravenous GHB-Induced Respiratory Depression. GHB was administered as an i.v. dose of 1500 mg/kg. SGS742 was administered as an i.v. bolus 60 (A) or 120 (B) minutes after GHB at a dose of 25 (open diamonds), 50 (open squares), 100 (open circles), 250 (open inverted triangles) or 500 mg/kg (open triangles). Breathing frequency control data (closed circles) were obtained from (Morse et al, 2012; Vijay et al., 2015). Data are represented as mean  $\pm$  standard deviation with  $n = 3-6$ .

**Figure 4.** Effect of SCH50911 on Intravenous GHB-Induced Respiratory Depression. GHB was administered at 0 min as a 1500 mg/kg i.v. bolus. Breathing frequency, tidal volume and their product, minute volume were recorded. SCH50911 was administered as an i.v. bolus 60 (A) or 120 (B) minutes after GHB at a dose of 25 (open circles) or 50 (open triangles) mg/kg. Breathing frequency control data (closed circles) were obtained from (Morse et al, 2012; Vijay et al., 2015). Data are represented as mean  $\pm$  standard deviation, with  $n = 4-5$ .

**Figure 5.** Effect of SGS742 on Oral GHB Induced Respiratory Depression. GHB was administered at 0 min as a 1500 mg/kg oral bolus. SGS742 was administered as an i.v. bolus 60 (A) or 120 (B/C) minutes after GHB at a dose of 25 (open circles), 100 (open triangles), or 250 mg/kg (open squares). Breathing frequency control data (closed circles) were obtained



from (Morse and Morris, 2013a). Data are represented as mean +/- standard deviation, with n = 3-4.

**Figure 6.** Effect of SGS742 on GHB Induced Respiratory Depression with Oral GBL

Administration. GBL was administered at 0 min as a 5.77 mmol/kg oral bolus. An i.v. bolus of SGS742 was administered 120 minutes after GBL at a dose of 100 mg/kg (open circles). Breathing frequency control data (closed circles) were obtained from Morse and Morris, 2013a). Data are represented as mean +/- standard deviation with n = 4.

**Figure 7.** Effect of SGS742 on Intravenous GHB Induced Respiratory Depression with

Gabazine Pretreatment. GHB was administered at 0 min as a 14.4 mmol/kg i.v. bolus. SGS742 was administered as an i.v. bolus 120 minutes after GHB at a dose of 100 mg/kg with (open triangles) or without (open circles) 1 mg/kg gabazine administered 5 minutes prior to GHB administration. Breathing frequency control data (closed circles) were obtained from (Morse et al, 2012; Vijay et al., 2015). Data are represented as mean +/- standard deviation, with n = 4.

**Figure 8.** Effect of SGS742 on Intravenous GHB Induced Respiratory Depression with NCS382

Pretreatment. GHB was administered at 0 min as a 14.4 mmol/kg i.v. bolus. SGS742 was administered i.v. at 60 (A) or 120 (B) minutes after GHB, at a dose of 100 mg/kg with (open triangles) or without (open circles) 100 mg/kg NCS382 administered 5 minutes prior to GHB administration. Control data (closed circles) for breathing frequency was obtained from (Morse et al, 2012; Vijay et al., 2015). Data are represented as mean +/- standard deviation, with n = 4-5.

**Tables:**

**Table 1. Pharmacokinetic parameters of SGS742.**

SGS742 Dose	AUC <sub>0-∞</sub> (mg*min/ml)	CL <sub>T</sub> (ml/min/kg)	V <sub>ss</sub> (ml/kg)	t <sub>1/2</sub> (min)
500 mg/kg	69.7 (3.11)	7.18 (0.312)	494 (30.6)	128 (51.2)
100 mg/kg	15.7 (1.46)	6.41 (0.581)	473 (198)	213 (133)

Data presented as mean (standard deviation). No statistical significance between parameters (excluding AUC<sub>0-∞</sub>) as determined by a Student's t-test.

AUC<sub>0-∞</sub> - Area under the curve extrapolated to infinity; CL<sub>T</sub> – total clearance; t<sub>1/2</sub> – half-life of elimination; V<sub>ss</sub> – Volume of distribution at steady state

**Table 2. Pharmacokinetic parameters describing the disposition of GHB with and without SGS742 Treatment 60 minutes after GHB administration.**

Treatment	AUC <sub>0-∞</sub> (mg*min/ml)	CL <sub>T</sub> (ml/min/kg)	V <sub>ss</sub> (ml/kg)	t <sub>1/2</sub> (min)
1500 mg/kg GHB <sup>a</sup>	295 (40.1)	5.15 (0.706)	400 (22.0)	36.5 (22.8)
1500 mg/kg GHB + SGS742 500 mg/kg 60 min Post GHB	274 (32.2)	5.78 (0.914)	485 (22.4)**	41.5 (11.6)

a. Data obtained from Vijay and Morris 2015 (Vijay et al., 2015)

Data presented as mean (standard deviation); \*\* p < 0.01 as determined by a Student's t-test.

PK parameters abbreviations are described in Table 1 footnote.

**Table 3. Impact of SGS742 Administration on Intravenous GHB Toxicodynamics**

Toxicodynamic Parameter	GHB 14.4 mmol/kg (60 min)	GHB 14.4 mmol/kg + 100 mg/kg SGS742 60 PD	GHB 14.4 mmol/kg + 500 mg/kg SGS742 60 PD	GHB 14.4 mmol/kg (120 min)	GHB 14.4 mmol/kg + 25 mg/kg SGS742 120 PD	GHB 14.4 mmol/kg + 50 mg/kg SGS742 120 PD	GHB 14.4 mmol/kg + 100 mg/kg SGS742 120 PD	GHB 14.4 mmol/kg + 250 mg/kg SGS742 120 PD
ABEC (breaths)	8.63 x 10 <sup>3</sup> (2.64 x 10 <sup>3</sup> )	2.44 x 10 <sup>3</sup> (3.95 x 10 <sup>3</sup> )	2.39 x 10 <sup>3</sup> (4.57 x 10 <sup>3</sup> )	4.92 x 10 <sup>3</sup> (2.42 x 10 <sup>3</sup> )	6.67 x 10 <sup>3</sup> (2.96 x 10 <sup>3</sup> )	3.61 x 10 <sup>3</sup> (1.97 x 10 <sup>3</sup> )	3.96 x 10 <sup>3</sup> (1.65 x 10 <sup>3</sup> )	2.66 x 10 <sup>3</sup> (2.29x 10 <sup>3</sup> )
E <sub>max</sub> (breaths/min)	18.0 (9.45)	25.2 (12.1)	24.3 (10.9)	32.9 (10.6)	26.5 (6.88)	29.9 (9.79)	20.6 (8.37)	24.4 (8.68)
T <sub>d</sub> (min)	223 (77.5)	60.6 (88.8)*	32.0 (59.8)**	163 (77.5)	177 (76.1)	136 (75.5)	121 (35.1)	94.2 (79.6)

Data presented as mean (standard deviation); \*p < 0.05; \*\*p < 0.01 determined by One-way ANOVA with Dunnett's post hoc  
 PD – minutes post GHB dose  
 Parameter abbreviations: T<sub>d</sub> – duration of effect; ABEC – Area below the effect curve;  
 E<sub>max</sub> – Maximum effect of GHB on breathing frequency

**Table 4. Impact of SCH50911 Administration on Intravenous GHB Toxicodynamics**

Toxicodynamic Parameter	GHB 14.4 mmol/kg (60 min)	GHB 14.4 mmol/kg + 25 mg/kg SCH50911 60 PD	GHB 14.4 mmol/kg + 50 mg/kg SCH50911 60 PD	GHB 14.4 mmol/kg (120 min)	GHB 14.4 mmol/kg + 25 mg/kg SCH50911 120 PD
ABEC (breaths)	$8.63 \times 10^3$ (2.64 x 10 <sup>3</sup> )	$3.27 \times 10^3$ (2.36 x 10 <sup>3</sup> )	889 (1.05 x 10 <sup>3</sup> )***	$4.92 \times 10^3$ (2.42 x 10 <sup>3</sup> )	951 (1.43 x 10 <sup>3</sup> )*
E <sub>max</sub> (breaths/min)	18.0 (9.45)	28.3 (19.4)**	17.3 (2.01)	32.9 (10.6)	34.9 (15.1)
t <sub>d</sub> (min)	223 (77.5)	125 (107)	40.2 (40.6)**	163 (77.5)	38.9 (53.3)*

Data presented as mean (standard deviation); \*p < 0.05; \*\*p<0.01; \*\*\*P<0.001 determined by One-way ANOVA with Dunnett's post hoc (60 min) or a Student's t-test (120 min)  
 Parameter abbreviations are described in Table 3 footnote.

**Table 5. Impact of SGS742 on Oral GHB Toxicodynamics**

Toxicodynamic Parameter	GHB 14.4 mmol/kg (60 min)	GHB 14.4 mmol/kg + 100 mg/kg SGS742 60 PD	GHB 14.4 mmol/kg (120 min)	GHB 14.4 mmol/kg + 25 mg/kg SGS742 120 PD	GHB 14.4 mmol/kg + 100 mg/kg SGS742 120 PD	GHB 14.4 mmol/kg + 250 mg/kg SGS742 120 PD
ABEC (breaths)	$9.07 \times 10^3$ (6.55 x $10^3$ )	$6.24 \times 10^3$ (6.32 x $10^3$ )	$7.89 \times 10^3$ (5.78 x $10^3$ )	$3.48 \times 10^3$ (4.09 x $10^3$ )	$1.79 \times 10^3$ (1.35 x $10^3$ )	40 (36)*
$E_{\max}$ (breaths/min)	32.7 (9.02)	35.0 (2.76)	32.7 (9.02)	44.0 (8.60)	40.6 (5.51)	46.7 (6.75)
$T_d$ (min)	341 (214)	165 (156)	300 (180)	101 (102)	116 (86.4)	4.8 (4.3)*

Data presented as mean (standard deviation). \*p < 0.05 determined by Student's t-test (60 min)  
 One-way ANOVA with Dunnett's post hoc (120 min)  
 Abbreviations are described in Table 3 footnote.

**Table 6. Impact of SGS742 on Oral GBL Toxicodynamics**

Toxicodynamic Parameter	GBL 5.77 mmol/kg	GBL 5.77 mmol/kg + 100 mg/kg SGS742 120 PD
ABEC (breaths)	$3.42 \times 10^3$ ( $1.62 \times 10^3$ )	$1.96 \times 10^3$ ( $1.82 \times 10^3$ )
$E_{\max}$ (breaths/min)	23.4 (5.61)	33.8 (6.11)*
$T_d$ (min)	125 (22.7)	71.7 (54.4)

data presented as mean (standard deviation)

\*p < 0.05 as determined by a Student's t-test

PD – minutes post GHB dose

Abbreviations are described in Table 3 footnote.

**Table 7. Impact of SGS742 Administration on Intravenous GHB Toxicodynamics with Gabazine Pretreatment**

Toxicodynamic Parameter	GHB 14.4 mmol/kg	GHB 14.4 mmol/kg + 100 mg/kg SGS742 120 PD	GHB 14.4 mmol/kg + 100 mg/kg SGS742 120 PD with 1 mg/kg gabazine 5 min prior to GHB
ABEC (breaths)	4.92 x 10 <sup>3</sup> (2.42 x 10 <sup>3</sup> )	3.96 x 10 <sup>3</sup> (1.65 x 10 <sup>3</sup> )	1.47 x 10 <sup>3</sup> (1.61 x 10 <sup>3</sup> )
E <sub>max</sub> (breaths/min)	32.9 (10.6)	20.6 (8.37)	44.0 (21.6)
T <sub>d</sub> (min)	163 (77.5)	121 (35.1)	61.2 (60.9)

Data presented as mean (standard deviation); Statistical significance determined by One-way ANOVA with Tukey's post hoc  
 Abbreviations are described in Table 3 footnote.

**Table 8. Impact of SGS742 Administration on Intravenous GHB Toxicodynamics with NCS382 Pretreatment**

Toxicodynamic Parameter	GHB 14.4 mmol/kg (60 min)	GHB 14.4 mmol/kg + 100 mg/kg SGS742 60 PD	GHB 14.4 mmol/kg + 100 mg/kg SGS742 60 PD with 100 mg/kg NCS382 5 min prior to GHB	GHB 14.4 mmol/kg (120 min)	GHB 14.4 mmol/kg + 100 mg/kg SGS742 120 PD	GHB 14.4 mmol/kg + 100 mg/kg SGS742 120 PD with 100 mg/kg NCS382 5 min prior to GHB
ABEC (breaths)	$8.63 \times 10^3$ (2.64 x 10 <sup>3</sup> )	$2.44 \times 10^3$ (3.95 x 10 <sup>3</sup> )	$5.65 \times 10^3$ (3.45 x 10 <sup>3</sup> )	$4.92 \times 10^3$ (2.42 x 10 <sup>3</sup> )	$3.96 \times 10^3$ (1.65 x 10 <sup>3</sup> )	417 (586)**†
E <sub>max</sub> (breaths/min)	18.0 (9.45)	25.2 (12.1)	26.7 (12.2)	32.9 (10.6)	20.6 (8.37)	36.5 (3.28)†
T <sub>d</sub> (min)	223 (77.5)	60.6 (88.8)	147 (106)	163 (77.5)	121 (35.1)	23.1 (32.9)**†

Data presented as mean (standard deviation). \*\* p < 0.01 compared with control; † p < 0.05 compared with no pretreatment; determined by One-way ANOVA with Tukey's post hoc. Abbreviations are described in Fig. 3 footnote.



**Table 9. Impact of NCS382 Pretreatment on Intravenous GHB Toxicodynamics**

Toxicodynamic Parameter	60 minutes		120 minutes	
	GHB 14.4 mmol/kg	100 mg/kg NCS Pretreatment	GHB 14.4 mmol/kg	100 mg/kg NCS Pretreatment
ABEC (breaths)	3.51 x 10 <sup>3</sup> (313)	3.17 x 10 <sup>3</sup> (928)	7.28 x 10 <sup>3</sup> (587)	5.04 x 10 <sup>3</sup> (887)**
E <sub>max</sub> (breaths/min)	16.1 (6.98)	22.6 (5.37)	15.6 (7.05)	23.4 (5.81)
T <sub>d</sub> (min)	57.5 (0.00)	57.1 (1.11)	118 (0.00)	117 (0.244)
N	4	9	4	5

Data presented as mean (standard deviation)

\* p < 0.05 compared with control determined by One-way ANOVA with Dunnett's post hoc data presented as mean (standard deviation)

Parameter abbreviations are described in Fig. 3 footnote.

# Figure 1.

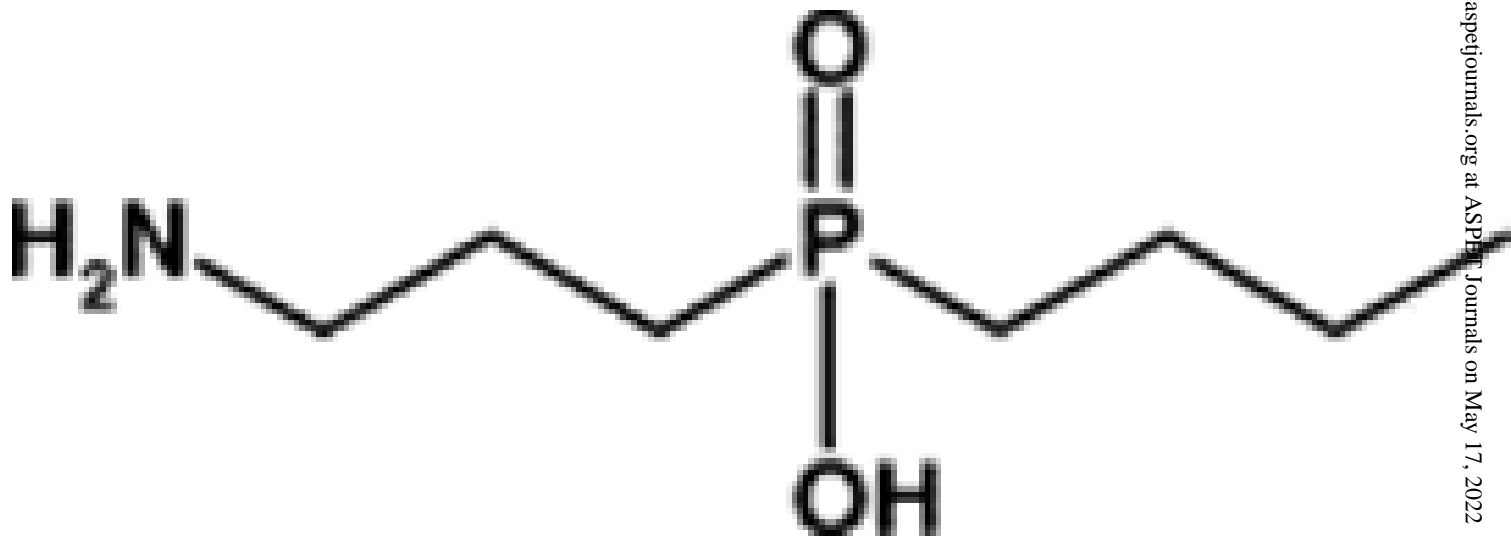


Figure 2.

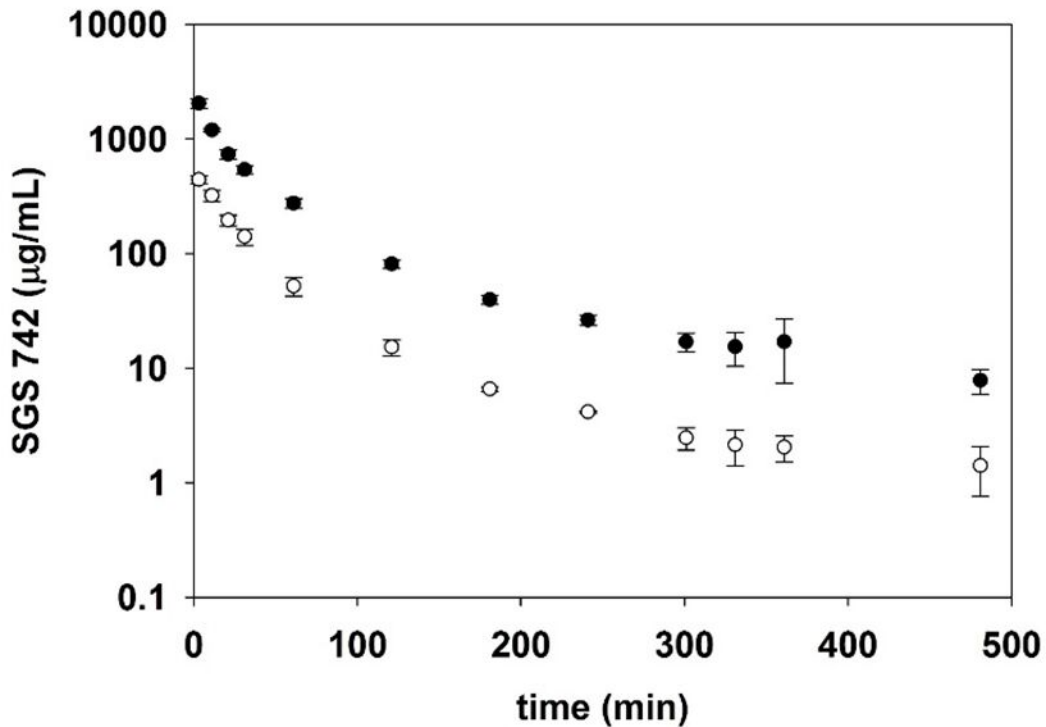


Figure 3.

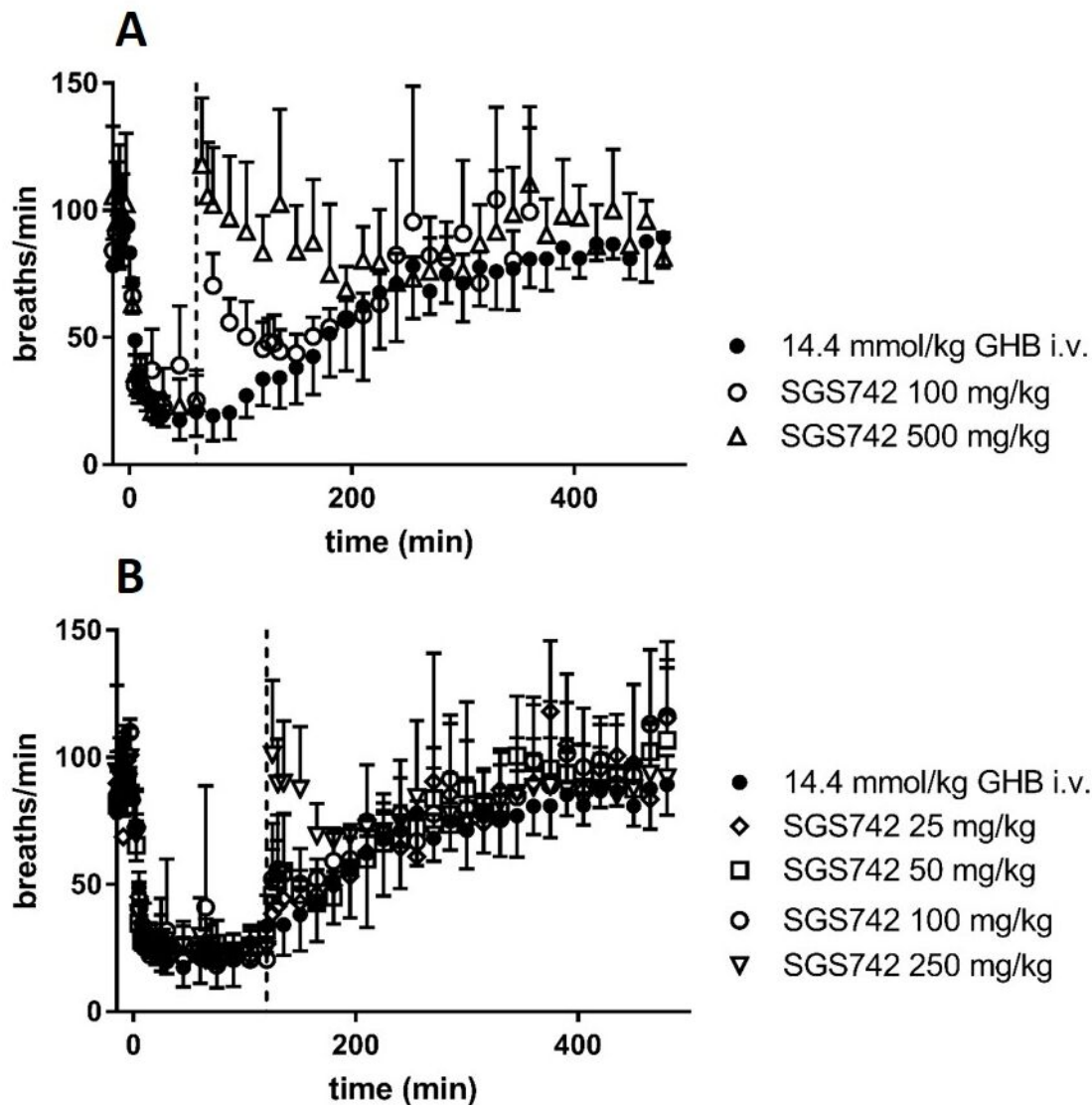


Figure 4.

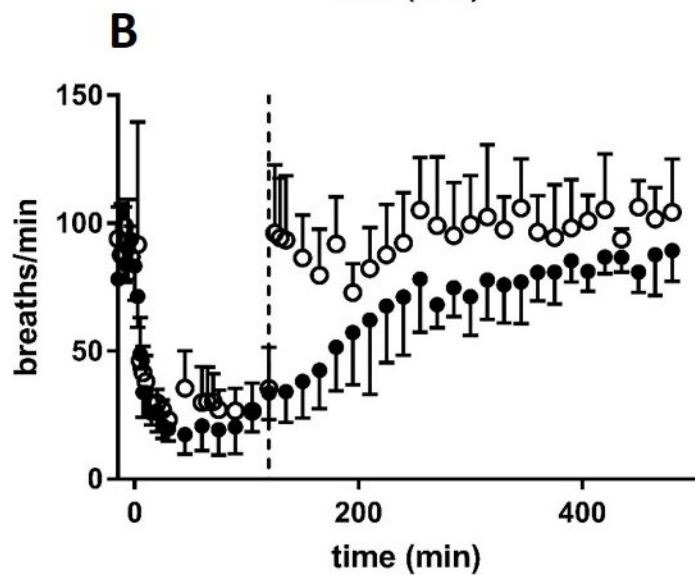
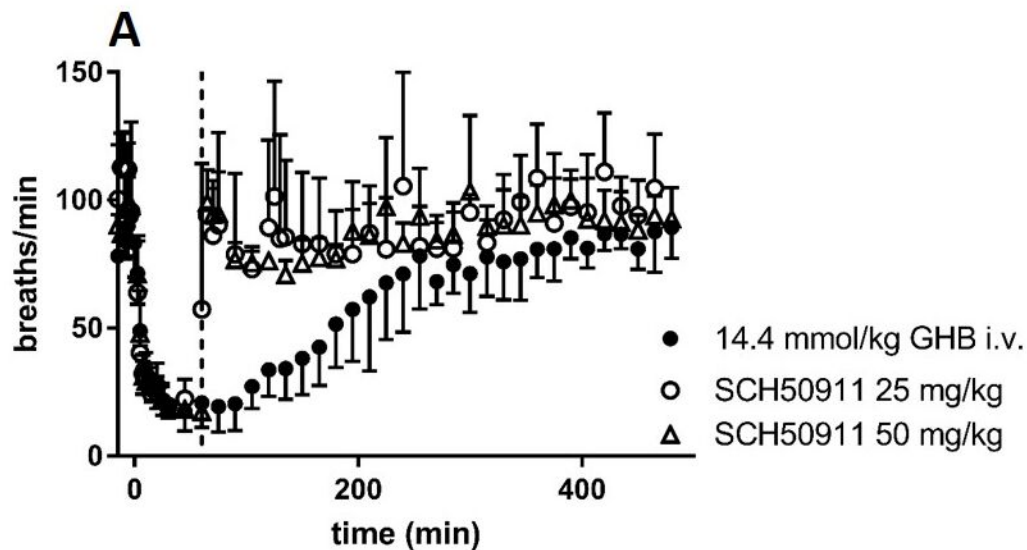


Figure 5.

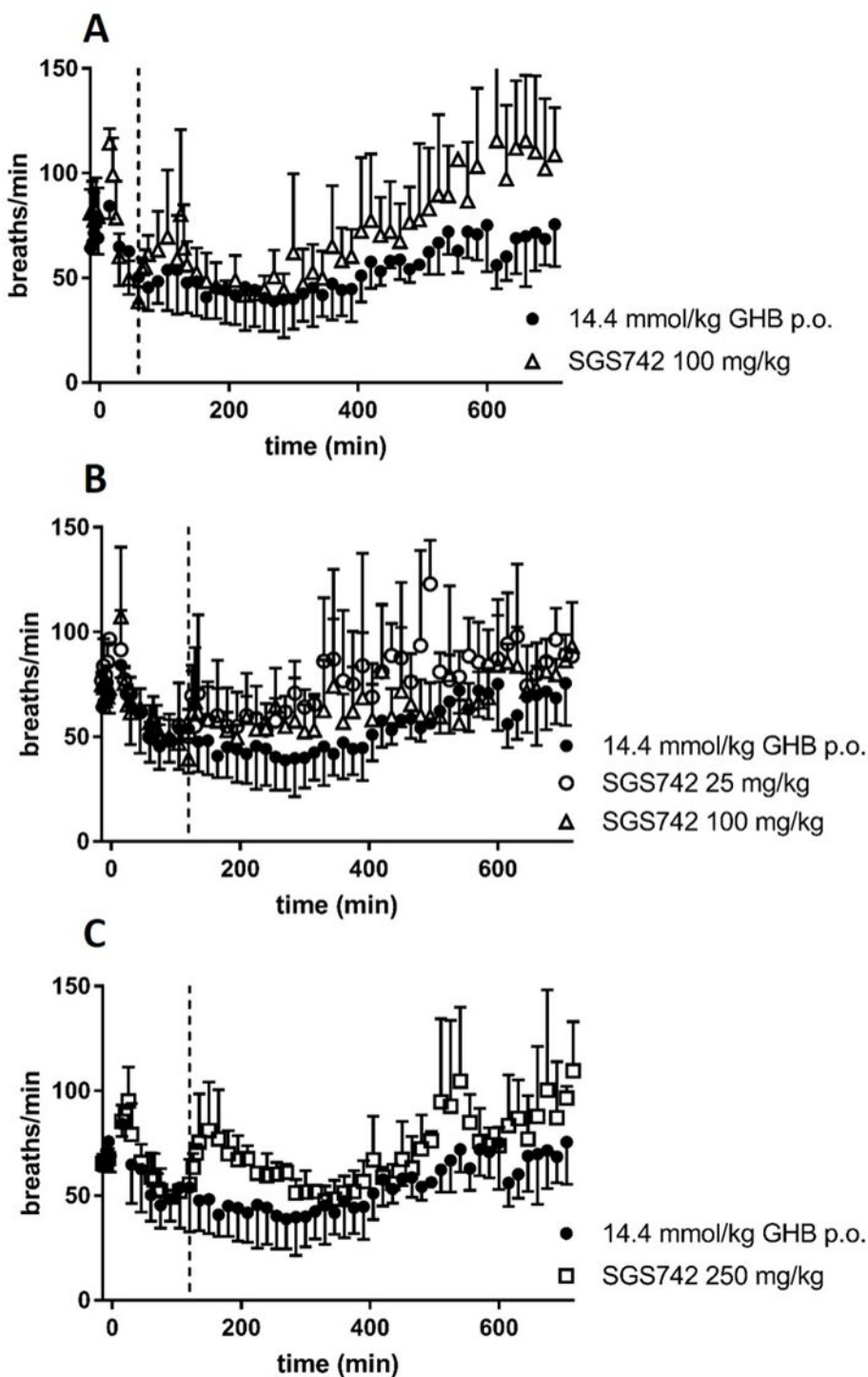
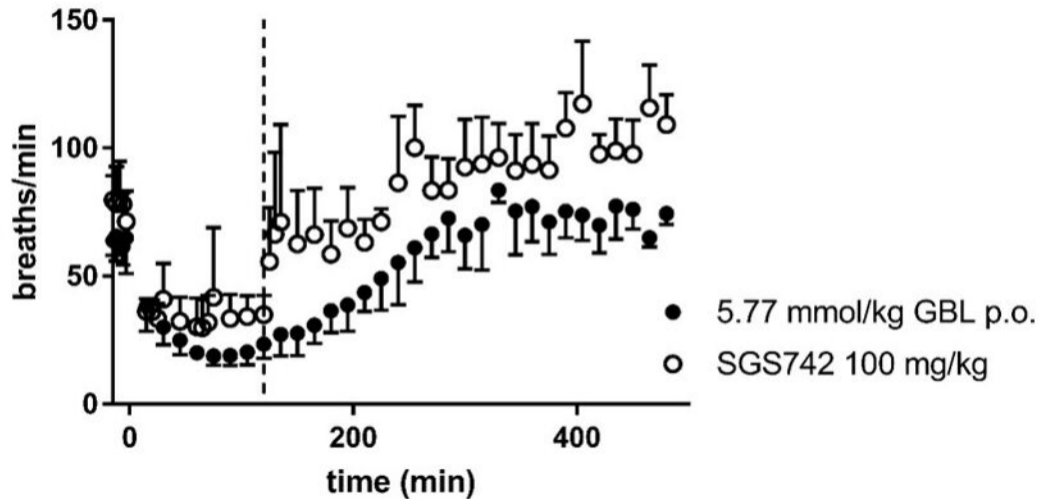


Figure 6.



**Supplemental Information**

**Treatment of  $\gamma$ -Hydroxybutyrate (GHB) Overdose with the GABA<sub>B</sub> Antagonist SGS742**

Kristin E. Follman and Marilyn E. Morris

Journal of Pharmacology and Experimental Therapeutics

Manuscript number: JPET-AR-2022-001108



**Tables:**

**Table 1 Suppl. Recovery for SGS742 and GHB**

SGS742 Recovery (%)		
Low (5 µg/mL)	Mid (10 µg/mL)	High (40 µg/mL)
98.0	95.8	99.6
99.0	96.1	102
97.0	96.1	101
GHB Recovery (%)		
Low (10 µg/mL)	Mid (125 µg/mL)	High (250 µg/mL)
59.4	49.8	34.3
30.5	32.7	31.1
43.9	36.3	31.2

**Table 2 Supp. Intra-day and inter-day accuracy and precision for SGS742 and GHB in rat plasma**

<b>SGS742</b>					
	<b>Nominal Concentration (µg/mL)</b>	<b>Average Measured concentration (µg/mL)</b>	<b>SD</b>	<b>Precision (RSD%)</b>	<b>Accuracy(%)</b>
Intra-day	5	5.1	0.369	7.29	101.3
	10	10.4	0.415	4	103.9
	40	39.6	2.1	5.29	99
Inter-day	5	5.0	0.144	2.87	100.2
	10	10.3	0.086	0.84	103.1
	40	39.6	0.038	0.1	99.1
<b>GHB</b>					
	<b>Nominal Concentration (µg/mL)</b>	<b>Average Measured concentration (µg/mL)</b>	<b>SD</b>	<b>Precision (RSD%)</b>	<b>Accuracy(%)</b>
Intra-day	10	10.8	0.947	8.76	108.1
	125	129.3	12.9	9.97	103.5
	250	257.3	9.29	3.61	102.9
Inter-day	10	10.9	0.13	1.19	109.3
	125	129.6	2.67	2.06	103.6
	250	255.3	1.86	0.73	102.1

**Supplemental Figure 1.** Representative chromatogram for GHB and SGS742. This chromatogram shows the peaks for each analyte, GHB and SGS742 and their respective internal standards, GHB-d6 and CGP36216. The retention times are indicated on the figure as 2.48, 3.61, 3.62 and 4.23 for CGP36216, GHB-d6, GHB and SGS742, respectively.

Supplemental Figure 1. Representative chromatogram for GHB and SGS742. This chromatogram shows the peaks for each analyte, GHB and SGS742 and their respective internal standards, GHB-d6 and CGP36216. The retention times are indicated on the figure as 2.48, 3.61, 3.62 and 4.23 for CGP36216, GHB-d6, GHB and SGS742, respectively.

