Drug Discovery & Development Process: General Overview

- **Discovery**
  - Target Discovery: 2-3 years
  - Lead Discovery: 0.5-1 year
  - Lead Optimisation: 1-3 years

- **Pre-clinical Development**
  - 1-2 years

- **Clinical Development**
  - 5-6 years
  - Clinical Trials
  - FDA Review & Approval: 1-2 years

**Clinical Trials**
- Phase I: 1-2 years
  - Safety & Dosage
  - 20-80 healthy volunteers

- Phase II: 1-2 years
  - Efficacy & Side Effects
  - 100-300 patients

- Phase III: 3-4 years
  - Long-term Effects
  - 1000-5000 patients

**ADMET**
- Absorption, Distribution, Metabolism, Elimination, Toxicity

**Investigational New Drug Application ("IND Filing")**
Sources of ADME-Tox data:

preclinical:  *in vitro* assays (enzymatic, cellular)
            *in vivo* animal studies (rats, dogs, pigs, primates):
            toxicology
            pharmacodynamics

clinical:  toxicology & pharmacodynamics (human, Phase I)
Pharmacokinetics (PK)

Study of the time course of drug concentration within the body. It incorporates the processes of Absorption, Distribution, Metabolism and Excretion (ADME).

- Most drugs are given orally.
- Typically the drug dissolves in the GI tract, and is absorbed through the gut wall.
- It then passes to the liver to get into the circulation. The percentage dose reaching the circulation is called the bioavailability.
- The drug is then distributed to various tissues and organs in the body. The extent of distribution will depend on the structural and physicochemical properties of the drug.
- Some drugs can enter the brain and CNS by crossing the blood-brain barrier (BBB).
- Most drugs will bind to various tissues and in particular to proteins in the blood, such as albumin.
- A good understanding of the physicochemical properties of a drug may help to predict its PK and metabolic fate.
- There is often a tension between ideal PK properties and those required for optimal binding to the target receptor.
Pharmacokinetics (PK): Definitions

- **Clearance** is the removal of the drug from plasma and relates the rate at which a drug is given and eliminated to the resultant plasma levels (volume/time).

- $C_{\text{max}}$ is the maximum concentration reached at the site of infection, usually taken as the peak serum level.

- $t_{\text{max}}$ is the time taken, after dosage, to reach the $C_{\text{max}}$.

- **Half-life** ($t_{1/2}$) is the time taken for the concentration of the drug in the plasma to decrease by half. This is often used as an indicator as to how often the drug should be administered.

Pharmacokinetics: Routes and Bioavailability

- **IV**: intravenous
- **PO**: oral
- **SC**: subcutaneous
- **IP**: intraperitoneal
- **IM**: intramuscular

Bioavailability $F$ [%]:

$$F = \frac{\text{AUC}_{\text{po}}/(\text{Dose})}{\text{AUC}_{\text{iv}}/(\text{Dose})}$$

$$F = 28.6\%$$
Pharmacokinetics: Volume of Distribution (Vd)

Vd (L) = Dosis (mg) / C₀ (mg/L)

Extensive distribution (e.g. intracellular concentrations, tissue binding) leads to
low serum concentrations and
high apparent volume of distribution

<table>
<thead>
<tr>
<th>Drug</th>
<th>Vd (L)</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Warfarin</td>
<td>7</td>
<td>Small Vd: Mainly stays in plasma; little in tissues.</td>
</tr>
<tr>
<td>Gentamicin</td>
<td>16</td>
<td>Medium Vd: Similar concentrations in plasma and tissues</td>
</tr>
<tr>
<td>Theophylline</td>
<td>35</td>
<td></td>
</tr>
<tr>
<td>Cimetidine</td>
<td>140</td>
<td>Large Vd: Mainly in tissues, little in plasma.</td>
</tr>
<tr>
<td>Digoxin</td>
<td>510</td>
<td></td>
</tr>
<tr>
<td>Mianserin</td>
<td>910</td>
<td></td>
</tr>
<tr>
<td>Quinacrine</td>
<td>50,000</td>
<td></td>
</tr>
</tbody>
</table>

Pharmacokinetics: Half Life (T₁/₂)

<table>
<thead>
<tr>
<th>Species</th>
<th>‘short’</th>
<th>‘medium’</th>
<th>‘long’</th>
<th>‘very long’</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rat</td>
<td>&lt;1h</td>
<td>1-4h</td>
<td>4-10h</td>
<td>&gt;10h</td>
</tr>
<tr>
<td>Dog</td>
<td>&lt;2h</td>
<td>2-6h</td>
<td>6-12h</td>
<td>&gt;12h</td>
</tr>
<tr>
<td>Man</td>
<td>&lt;3h</td>
<td>3-8h</td>
<td>8-14h</td>
<td>&gt;14h</td>
</tr>
</tbody>
</table>
Pharmacokinetics: Half Life of Antibiotics

• The half-life of the early antibiotics were quite short (~ 1h). Therefore the antibiotic had to be administered many times per day.

• With oral versions, this causes problems with patient compliance and with parenteral versions, this becomes expensive in resources.

• Increasingly, the newer antibiotics have much longer half-lives, some up to > 24 h.

• This means that the patient needs to be dosed just once a day in order to maintain sufficient drug concentrations.

Pharmacokinetics: Clearance (Cl)

• The volume of blood/plasma that is completely cleared of drug per unit of time.

• Clearance is inversely proportional to its half-life and directly proportional to its Vd and elimination.

• Clearance reflects the rate of elimination relative to the drug concentration.

\[ Cl = \text{rate of elimination} / \text{concentration of the drug} \ [\text{ml/min}] \]
Pharmacokinetics: Peak Plasma Conc. ($c_{\text{max}}/T_{\text{max}}$)

**Oral**

- $C_{\text{max}} \sim 33 \mu g/ml$
- $T_{\text{max}} \sim 2 \text{ h}$

**PK parameters:**

- $C_{\text{max}}/\text{MIC}$
- $AUC/\text{MIC}$
- $T>\text{MIC}$ (time above MIC)

**Pharmacokinetics: Importance for Antibiotics**

- Time-dependent killing and minimal to moderate persistent effects $\Rightarrow$ Time above MIC ($T>\text{MIC}$)
- Time-dependent killing and prolonged persistent effects $\Rightarrow$ AUC/MIC ratio
- Concentration-dependent killing and prolonged persistent effects $\Rightarrow$ AUC/MIC or Peak/MIC ratio
Pharmacokinetics: Antimicrobial Activity

<table>
<thead>
<tr>
<th>Parameter correlating with efficacy</th>
<th>T&gt;MIC</th>
<th>AUC:MIC</th>
<th>C_max:MIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examples</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Penicillins</td>
<td></td>
<td>Azalides</td>
<td>Fluoroquinolones</td>
</tr>
<tr>
<td>Cephalosporins</td>
<td></td>
<td>Fluoroquinolones</td>
<td>Aminoglycosides</td>
</tr>
<tr>
<td>Carbapenems</td>
<td></td>
<td>Ketolides</td>
<td></td>
</tr>
<tr>
<td>Macrolides</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oxazolidinones</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Organism kill

<table>
<thead>
<tr>
<th>Therapeutic goal</th>
<th>Optimise duration of exposure</th>
<th>Maximise exposure</th>
<th>Maximise exposure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time-dependent</td>
<td>Concentration-dependent</td>
<td>Concentration-dependent</td>
<td></td>
</tr>
</tbody>
</table>

Physicochemical properties influence the development of compounds.

Physicochemical properties influence the development of compounds.

- **Solubility**
  - % absorbed
  - % bioavailable
- **H-bonding**
  - Clearance
  - Log D
- **Mol. Weight**
  - Vol. of Distribution
  - IC_{50}
- **Drug**
  - Dose
  - Toxicity
• Transporter proteins such as P-glycoprotein (P-gp) can either promote or hinder permeability. They are found in most organs and are involved in the uptake and elimination of endogenous compounds and xenobiotics.

• Plasma-protein binding – drugs bind to a variety of particles in addition to proteins such as albumin (particularly acidic drugs) and \( \alpha_1 \)-acid glycoproteins (basic drugs).

• Cytochrome P450 (CYP450) inhibition – these enzymes are primarily located in the liver and catalyse oxidation reactions to produce polar products, which are metabolised further (e.g. sulphation, glucoronidation) or excreted.

• CYP450 induction - binding of drugs to the pregnane receptor (PXR) or the constitutive androstane receptor (CAR) can induce expression of CYP450’s. In particular, PXR is a key regulator of CYP3A4, which metabolises 50-60% of all prescription drugs. PXR binding can highlight potential drug-drug interactions.

\[ \text{Metabolism} \]

Drugs Metabolism

• Lipophilic drugs are rendered more hydrophilic, thus more easily excreted.
• Inactive, active and toxic metabolites
Drug Metabolism: Phase I & II Processes

**Phase I: Mainly oxidative processes**

Generate metabolites that are more polar than the parent compound.

Functional group added that can undergo phase II reaction.

Phase I reaction can lead to the formation of toxic metabolites.

**Phase II: Conjugation of parent molecule or phase I metabolite**

- Glucoronic Acid
- Glutathione
- Sulfate

Conjugates are more water-soluble and less active (less toxic) than (phase I) nonconjugated compounds.

Drug Metabolism: Cytochrome P450 Substrates

CYP450 enzymes (various isoforms) catalyse heme-dependent oxidative reactions on many different substrates – normally epoxidation or hydroxylation.

<table>
<thead>
<tr>
<th>Functional Group</th>
<th>Product</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image1.png" alt="Image" /></td>
<td><img src="image2.png" alt="Image" /></td>
</tr>
</tbody>
</table>
Preclinical Development: *In vitro* ADME Tests

- **Metabolism** – incubation of compound with rat or human liver microsomes commonly used in combination with LC-MS analysis of incubates.

- **CYP450 inhibition** - many isoforms have been cloned and expressed. Kinetic assays are available for the most important isoforms, namely, CYP3A4, CYP2D6, CYP2C9, CYP1A2 and CYP2C19. These five enzymes are the predominant drug-metabolising enzymes in the human liver.

- **Plasma-binding** – compound activity in presence/absence of plasma proteins.

- **Absorption** – Caco-2 or Madin-Darby canine kidney MDCK monolayers to model gastrointestinal (GI) permeability (→).

Preclinical Development: Permeability Testing

“**A-to-B**” setup: the solution of a drug is applied to the apical (A) side of the Caco-2 monolayer. The progress of the drug permeation through the monolayer is monitored by taking the samples of the basolateral (B) solution and quantitating the drug by LCMS. The *P*₂<sub>app</sub> then is calculated based on the kinetics curve of the parent drug appearance in the basolateral side.

“**B-to-A**” setup: transport of compound from the basolateral side to the apical side by cellular efflux pumps can be determined.

Comparison of the “A-to-B” and “B-to-A” permeability provides information on active efflux processes for the studied compounds.
Toxicity

- **Cytotoxicity** – gross cell cytotoxicity can be measured in mammalian cells using MTT (cell proliferation) assays.

- **Mutagenicity** – microbiological Ames test used to assess genotoxicity.

- **QT interval prolongation** – prolongation of cardiac repolarisation has been associated with specific and potentially fatal tachycardia in humans. There is a growing use of the hERG-K+ conductance assay using CHO cells to assess this (→).
**QT Interval Prolongation**

**Electrocardiogram (ECG):**

- P wave
- QRS
- T wave

**Ventricular Arrhythmia**

- molecular genetics of congenital Long QT Syndrome clarified mechanisms for drug-induced QT interval prolongation
- the rapid component of the delayed rectifier K+ current, or hERG, is the target of most QT interval-prolonging drugs

**QT Interval Prolongation**

- Drugs that prolong QT interval are associated with increased risk for ventricular arrhythmias (TdP) and sudden death.
- IKr/hERG K+ channel is the target for QT interval-prolonging drugs
- Nonclinical testing (electrophysiological assay using voltage clamp; ECG telemetry in animal) cannot reliably exclude clinical risk.
- In many cases drugs have to be evaluated for possible effects on the QT interval in an early clinical trial.
- Drug-induced QT interval prolongation is the most important cause of approval delays and the 2nd most important cause for approved drug withdrawal.

**Homology model of hERG based on KvaP structure.**

Large central cavity with hydrophobic surface critical for drug binding.
Clinical Development: IND Filing

IND = Application to begin testing of a new drug in humans.

Current Federal law requires that a drug be the subject of an approved marketing application before it is transported or distributed across state lines. Because a sponsor will probably want to ship the investigational drug to clinical investigators in many states, it must seek an exemption from that legal requirement. The IND is the means through which the sponsor technically obtains this exemption from the FDA.
Clinical Development: IND Filing

The IND application must contain information in three broad areas:

Animal Pharmacology and Toxicology Studies - Preclinical data to permit an assessment as to whether the product is reasonably safe for initial testing in humans. Also included are any previous experience with the drug in humans (often foreign use).

Manufacturing Information - Information pertaining to the composition, manufacturer, stability, and controls used for manufacturing the drug substance and the drug product.

Clinical Protocols and Investigator Information - Detailed protocols for proposed clinical studies to assess whether the initial-phase trials will expose subjects to unnecessary risks. Also, information on the qualifications of clinical investigators--professionals (generally physicians) who oversee the administration of the experimental compound--to assess whether they are qualified to fulfill their clinical trial duties. Finally, commitments to obtain informed consent from the research subjects, to obtain review of the study by an institutional review board (IRB), and to adhere to the investigational new drug regulations.

Clinical Trials - Historical

Historical Drug Trials:
- 1909: Paul Ehrlich - Salvarsan
- 1929: Alexander Fleming - Penicillin
- 1935: Gerhard Domagk - Sulfonamide
- 1944: Waksman – Streptomycin
Clinical Trial Designs & Terminology

- Randomized/blinded trial
- Randomized/double blinded trial
- Non-randomized concurrent controlled trial
- Placebo trial
- ...

**Randomized:** Schemes used to assign participant to one group
  example: every 3rd participant gets higher dose

**Nonrandomized:** All with disease = cases; others = control

**Blinded:** Participants do not know if in experimental or control group

**Double Blinded:** Participants AND staff do not know group assignment

**Placebo:** Inactive pill w/ no therapeutic value (rare in trials of antibiotics)

Clinical Trial Protocols

- Investigating two or more conditions: several treatment groups
  - example: drug vs. placebo; low dose vs. high dose

- Specific inclusion/exclusion criteria

- Sample size & power calculations: probability that a clinical trial will have a significant (positive) result, that is, have a *p*-value of less than the specified significance level (usually 5-10%) .

- Endpoint definition
  - example: clearance of infection
## Clinical Trial Phases - Summary

<table>
<thead>
<tr>
<th>Phase</th>
<th># Subjects</th>
<th>Length</th>
<th>Purpose</th>
<th>% Drugs Successfully Tested</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase I</td>
<td>20 – 100</td>
<td>Several months – 2 years</td>
<td>Mainly Safety; pharmacokinetics</td>
<td>70%</td>
</tr>
<tr>
<td>Phase II</td>
<td>Up to several 100</td>
<td>Several months- 2 years</td>
<td>Short term safety; mainly effectiveness</td>
<td>33%</td>
</tr>
<tr>
<td>Phase III</td>
<td>100s – several 1000</td>
<td>1-4 years</td>
<td>Safety, dosage &amp; effectiveness</td>
<td>25-30%</td>
</tr>
</tbody>
</table>

### Clinical Trial Phases

**Phase I:**
- small group of **healthy volunteers**
- evaluate drug safety
- determine a safe dosage range
- identify side effects
- collect data for pharmacokinetic analysis

**Phase II:**
- larger group of **people with disease**
- evaluate drug effectiveness
- further evaluate drug safety
- further evaluate dosage

**Phase III:**
- large groups of **people with disease**
- confirm drug’s effectiveness
- monitor side effects
- compare drug to commonly used treatments
- monitor interactions with other drugs
- multicenter trial – many hospitals
Clinical Trial Phases

**Phase IV:**
- after the drug has been marketed
- information about drug effect in various populations
- side effects associated with long-term use.
- new indications: potential to extend patent protection

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New Drug Application (NDA), FDA Review and Approval

**Investigational New Drug Application (“IND Filing”)**
- IND = Application to begin testing of a new drug in humans.

**New Drug Application (“NDA Filing”)**
- NDA = Application to market a new drug for use in humans.
"Riluvonin? I don't like the sound of it—let's reject it."

Center for Drug Evaluation and Research (CDER) of the FDA

- Medical
- Biochemical
- Pharmacology
- Statistical
- Chemistry
- Microbiology

Advisory Committee Meeting

Meetings with Sponsor

Sponsor Review

Labeling Complete and Acceptable?

Review Complete and Acceptable?

Inspection of Site Acceptable?

- Yes
- No

- Yes
- No

- Yes
- No

- Yes
- No

NDA Action

Additional Info or Revisions Requested or Submitted (Amendment)

Pending Satisfactory Results

Recommendation
Clinical Development & Approval Times

Mean Clinical Development and Approval Times by Therapeutic Category, 1990-1999

<table>
<thead>
<tr>
<th>Category</th>
<th>Development</th>
<th>Optimisation</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>CNS</td>
<td>9.3</td>
<td>2.1</td>
<td>11.4</td>
</tr>
<tr>
<td>Analgesic/Anesthetic</td>
<td>9.4</td>
<td>2</td>
<td>11.4</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>8.8</td>
<td>2.3</td>
<td>11.1</td>
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<tr>
<td>All</td>
<td>8.6</td>
<td>1.8</td>
<td>10.4</td>
</tr>
<tr>
<td>Antimicrobial</td>
<td>5.9</td>
<td>1.4</td>
<td>7.3</td>
</tr>
</tbody>
</table>

Years
- 1st in Human to NDA
- Approval Phase


Clinical Development: Overall Success

Clinical development evolution
More attrition - Less success

Success Rate %

Why Drugs Fail

1991

<table>
<thead>
<tr>
<th>Reason</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacokinetics</td>
<td>39%</td>
</tr>
<tr>
<td>Animal Toxicity</td>
<td>11%</td>
</tr>
<tr>
<td>Adverse Effects in Man</td>
<td>10%</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>5%</td>
</tr>
<tr>
<td>Lack of Efficacy</td>
<td>30%</td>
</tr>
<tr>
<td>Commercial Reasons</td>
<td>5%</td>
</tr>
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2001

<table>
<thead>
<tr>
<th>Reason</th>
<th>Percentage</th>
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<td>Pharmacokinetics</td>
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<tr>
<td>Animal Toxicity</td>
<td>7%</td>
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<tr>
<td>Adverse Effects in Man</td>
<td>13%</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>11%</td>
</tr>
<tr>
<td>Lack of Efficacy</td>
<td>30%</td>
</tr>
<tr>
<td>Commercial Reasons</td>
<td>20%</td>
</tr>
</tbody>
</table>

Reasons for failure per development phase

- Clinical safety
- Efficacy
- Formulation
- Market potential
- PK/Bioavailability
- Strategic
- Resources
- Toxicology
- COGS
- Unknown
- Other

Development Phase:
- Preclinical
- Phase I
- Phase II
- Phase III
- Registration
Antibiotics Are Relatively Successful Candidates

Trends in probability of success from 'first human dose' to market by therapeutic area