Pharmacokinetic Studies during Phase I Trials of High-Dose Thymidine Infusions

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ABSTRACT

Thymidine infusions (75 g/sq m/24 hr) were administered to 12 cancer patients as part of a Phase I study. Thymidine and thymine measurements, by high-pressure liquid chromatography, were made on plasma and urine from eight of these patients. Only the pharmacokinetic aspects of these studies are reported in this paper. Millimolar thymidine and thymine concentrations were achieved in all patients and maintained for 120 hr during each of three courses of infusion. The half-life of thymidine was approximately 100 min following cessation of infusion. The half-life of thymine was much longer but could not be accurately determined because it did not decline as a first-order rate function. The cerebrospinal fluid:plasma ratios at steady state for thymidine and thymine were 0.29 and 1.03, respectively. Total body clearance of thymidine ranged from 95 to 266 ml/min/sq m, and 41 to 67% was by kidney clearance of intact thymidine. Calculations and comparison to other studies at lower infusion rates (micromolar plasma) indicate that thymidine is metabolized significantly by organs in addition to the liver and that, at millimolar plasma thymidine, total body metabolic processes of thymidine are saturated as is the secretory portion of kidney clearance.

INTRODUCTION

Several studies (7, 9, 11, 15) have shown that a high concentration of thymidine has adverse effects on cell growth and cloning ability of a variety of cell types in vitro. Beltz et al. (1) discussed the concept of using such naturally occurring growth inhibitors as potential antineoplastic agents. They emphasized the importance of maintaining therapeutically effective concentrations in vivo by continuous infusion. More recent studies indicate that thymidine is selectively lethal to certain human and mouse tumor cells in vitro as compared to their normal counterparts (5). A large quantity of thymidine infused into thymus-deficient (nude) mice was found to cause regression of human xenografts growing in these mice (6). The plasma concentration of thymidine in these mice was approximately millimolar (19). Subsequent studies in humans suggested that such concentrations of thymidine could be achieved and sustained for days by infusing approximately 100 g/sq m/24 hr i.v. without any dramatic toxicity (3, 19).

As a result of some of the above findings, a Phase I clinical trial of high-dose thymidine was initiated at the Baltimore Cancer Research Program, National Cancer Institute, in October 1978. In this paper, we report the results of some pharmacokinetic measurements made during these trials.

MATERIALS AND METHODS

Thymidine. The Drug Development Branch of the National Cancer Institute provided thymidine as a sterile solution in 500-ml bottles. Each bottle contained 15 g of thymidine made isotonic with NaCl. At the dose administered, 75 g/sq m/day, an average adult patient receives about 5 to 6 liters of this solution each 24 hr.

Patients. The characteristics of patients from which sufficient data were obtained to do pharmacokinetic analysis are shown in Table 1. Most of the patients received thymidine infusions for 120 hr for 3 successive courses with 5 days between each course. It was not always possible to collect plasma and urine samples from these very sick patients as planned. However, analyses of the available data do provide valuable insights.

Assay. The assay system for thymidine and thymine is an adaptation of the method used for the measurement of nucleosides in hydrolysates of RNA and DNA (17). Plasma is precipitated under ice-cold conditions with an equal volume of 1 n perchloric acid. The supernatant is made to pH 9 to 11 (pH electrode) by addition of 4 n KOH. It takes 2 days at 5°C for all the potassium salt to completely precipitate and the pH to stabilize. This supernatant is filtered (0.4 μm type HA with type A prefiter; Millipore Corp., Bedford, Mass.) and 20 μl or less are injected into a high-pressure liquid chromatograph. Urine and CSF samples are treated differently than plasma. They are first diluted at least 10 times and then filtered at room temperature prior to high-pressure liquid chromatography analysis because of the potential insolubility at ice-cold conditions of thymine at the high concentrations seen in these fluids. The high-pressure liquid chromatograph column is 50 cm (length) x 4 mm (inner diameter) packed with Aminex A-7 cation-exchange resin with a particle size of 7 to 11 μm (Bio-Rad Laboratories, Richmond, Calif.). The eluant is 0.02 M (NH₄)₂CO₃ adjusted to pH 9.78 with NH₄OH. The pH must be adjusted daily by addition of NH₄OH. Ambient conditions of 25°C at a pressure of 1000 psi result in a flow rate of 0.215 ml/min. Peak heights of thymidine and thymine at elution times of 23 and 37 min, respectively, were measured by absorbance at 254 nm in a 8-μl flow cell. Peak heights are proportional to the quantity of thymidine and thymine in the solution injected, if 20 μl or less are used. Standard curves were linear in the utilized range from micromolar to millimolar. The concentrations of thymidine and thymine in the unknown extracts were determined by extrapolation between 2 standards whose peak heights spanned the peak height of the unknown extract. Standards were run daily. With an injection volume of 20 μl, solutions with thymidine concentrations below micromolar are undetectable using the above extraction procedure with this high-pressure liquid chromatography system.

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The abbreviation used is: CSF, cerebrospinal fluid.
RESULTS

Plasma Concentration. The plasma concentrations of thymidine and thymine are illustrated in Chart 1 for 3 male patients and 4 female patients. Millimolar thymidine and thymine concentrations are attained within 12 hr and maintained during the infusion. Once the infusion stops, thymidine concentration rapidly decreases with a half-life of approximately 100 min (Table 2; Chart 1, A and C). A close look at Chart 1, B and D, indicates that thymine concentration in some cases actually rises or stays constant after the infusion stops. These observations suggest that the rate of decrease of thymine is not first order. The data in Table 2 illustrate this phenomenon more clearly and indicate that the calculated half-life for thymine is a function of the time interval used for the calculation. For example, for male patients, if a 4-hr interval after cessation of infusion is used, the mean half-life is 784 min for thymine, whereas if the 4- to 8-hr interval is used the mean half-life is 364 min for thymine. This lack of a first-order decline for thymine coupled with the thymidine half-life of 100 min (compared to 10 min at micromolar plasma concentrations) are indicative of saturable metabolic processes. The variation of values for both the plateau concentrations and half-lives of thymidine and thymine is greater for the female patients than for the male patients.

Volume of Distribution. Past studies indicate that, after thymidine administration, plasma thymidine declines exponentially with only one phase of disappearance. This suggests that an appropriate pharmacokinetic model is one compartment with first-order clearance by excretion and metabolism (2, 4). At millimolar plasma concentrations encountered in this study,
the metabolism of thymidine appears to be saturated and thus zero order, and kidney clearance becomes the dominant form of first-order clearance. This model then can be represented mathematically by

\[
\frac{dx}{dt} = (k_0 - k_m) - K x
\]

where \( x \) is the quantity of thymidine at any time (t), \( k_0 \) is the input of thymidine, \( k_m \) is the zero-order metabolic clearance, and \( K \) is the first-order kidney clearance. Integration gives

\[
x = \frac{k_0 - k_m(1 - e^{-Kt})}{K}
\]

As \( t \to \infty \),

\[
X_{ss} = \frac{k_0 - k_m}{K}
\]

where \( X_{ss} \) is the quantity of thymidine at steady state. Since

\[
X_{ss} = C_w V
\]

where \( C_w \) is the plateau thymidine plasma concentration and \( V \) is volume of distribution, then by substitution of Equation D into Equation C

\[
V = \frac{k_0 - k_m}{C_w K}
\]

A sample calculation using the data in Chart 1A is revealing. \( k_0 \) is known (75 g/sq m/24 hr); \( k_m \) can be estimated from the data in Table 4 as the percentage of total body clearance of thymidine not accounted for by kidney clearance (mean value for male patients, 39%); \( C_w \) is taken from Chart 1A for males (mean value, 1.27 mM); \( K \) is estimated from the thymidine half-life after the cessation of infusion (100 min) and

\[
K = (0.693/t_{1/2}) = 0.00422 \text{ min}^{-1}
\]

Therefore,

\[
V(\text{ml}) = \frac{[0.4 \text{ mmol/min} - 0.39(0.4)]}{1.27 \times 10^{-3} \text{ mmol/ml} \times 0.00422 \text{ min}^{-1}} = 45,500 \text{ ml}
\]

This volume represents about the total body water of an average male. Thymidine is not confined mainly to the plasma compartment, since the average male's plasma volume is about 4500 ml (12). Therefore, at steady-state millimolar thymidine concentration, there is 10 times as much thymidine in other places in the body as there is in the plasma. More data and further pharmacokinetic analysis are required to characterize the nature and disposition of this large extravascular pool of thymidine.

**Plasma:CSF.** Table 3 summarizes the data collected for CSF thymidine and thymine during infusion at steady-state plasma concentrations. The mean CSF:plasma ratio for thymidine is 0.29, whereas for thymine it is 1.03. It is apparent that CSF thymidine comes to equilibrium with plasma at a much lower concentration than does CSF thymine. This may be due to the lesser polarity and molecular weight of thymine relative to thymidine and, hence, its more ready access across the blood-brain barrier.

### Table 2

<table>
<thead>
<tr>
<th>Patients</th>
<th>Half-life from end of infusion to 4 hr (min)</th>
<th>Half-life from 4 to 8 hr (min)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Thymidine</td>
<td>Thymine</td>
</tr>
<tr>
<td>Male</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A2</td>
<td>113</td>
<td>1255</td>
</tr>
<tr>
<td>B1</td>
<td>68</td>
<td>1126</td>
</tr>
<tr>
<td>B2</td>
<td>101</td>
<td>83</td>
</tr>
<tr>
<td>C1</td>
<td>135</td>
<td>103</td>
</tr>
<tr>
<td>G2</td>
<td>72</td>
<td>432</td>
</tr>
<tr>
<td>J1</td>
<td>432</td>
<td>326</td>
</tr>
<tr>
<td>Mean ± S.E.</td>
<td>92 ± 12</td>
<td>784± 237</td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D1</td>
<td>120</td>
<td>863</td>
</tr>
<tr>
<td>E1</td>
<td>174</td>
<td>447</td>
</tr>
<tr>
<td>E2</td>
<td>115</td>
<td>89</td>
</tr>
<tr>
<td>F1</td>
<td>41</td>
<td>139</td>
</tr>
<tr>
<td>G2</td>
<td>126</td>
<td>94</td>
</tr>
<tr>
<td>Mean ± S.E.</td>
<td>103 ± 16</td>
<td>483 ± 209</td>
</tr>
</tbody>
</table>

*Subscript, course of infusion.

∞, infinitely long when calculation is made from data in this time interval; LD, 8-hr plasma thymidine not detectable.

The volume of distribution of thymidine ranges from 95 to 266 ml/min/sq m. There was no apparent relationship between sex and total body clearance of thymidine. However, the highest total body and kidney clearances of thymidine and kidney clearance of thymine were in Patient F, a female. This patient also had one of the highest percent ages (37%) of total body clearance of thymidine not accounted for by kidney clearance of thymidine and thymine. This indi-
Thymidine and thymine in the CSF during infusion of thymidine

<table>
<thead>
<tr>
<th>Patient</th>
<th>CSF time (hr)</th>
<th>Thymidine (mM)</th>
<th>Thymine (mM)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Plasma</td>
<td>CSF¹</td>
<td>Plasma</td>
</tr>
<tr>
<td>A¹,²</td>
<td>21</td>
<td>1.65²</td>
<td>0.30</td>
</tr>
<tr>
<td>A²</td>
<td>72</td>
<td>0.98</td>
<td>0.28</td>
</tr>
<tr>
<td>B¹</td>
<td>21</td>
<td>1.88</td>
<td>0.31</td>
</tr>
<tr>
<td>B²</td>
<td>69</td>
<td>1.35</td>
<td>0.45</td>
</tr>
<tr>
<td>C¹</td>
<td>14</td>
<td>1.05</td>
<td>0.23</td>
</tr>
<tr>
<td>C²</td>
<td>48</td>
<td>1.30</td>
<td>0.48</td>
</tr>
<tr>
<td>C³</td>
<td>64</td>
<td>1.08</td>
<td>0.38</td>
</tr>
<tr>
<td>D¹</td>
<td>70</td>
<td>2.44</td>
<td>0.54</td>
</tr>
<tr>
<td>F¹</td>
<td>71</td>
<td>0.88</td>
<td>0.29</td>
</tr>
<tr>
<td>G¹</td>
<td>76</td>
<td>1.68</td>
<td>0.86</td>
</tr>
</tbody>
</table>

Mean ± S.E.: 0.29² ± 0.03 1.03 ± 0.08

¹ Lumbar spinal tap.
² Subscript, course of infusion.
³ Mean of 2 values bracketing the time of CSF sample.
⁴ Significantly different (p < 0.001) for thymidine and thymine.

**Table 3**

Clearance values are means ± S.E. calculated from three to six 24-hr urine collections during the plateau phase, usually the 24- to 48-hr and the 96- to 120-hr intervals. Each patient underwent three 120-hr courses of thymidine infusion and at least one, usually 2, clearance values were calculated for each course.

**Table 4**

Knowledge of plasma concentrations of thymidine in patients, of the mechanisms by which these plasma concentrations are achieved, and of the variability among individuals in these mechanisms is necessary if rational chemotherapy with thymidine is to be attempted. Recent interest in the conjoint use of thymidine with methotrexate (16, 18) and 5-fluorouracil (8, 14), in addition to its use alone (6) in the treatment of experimental tumors, makes this kind of information in humans timely. It would appear logical that the concentration of thymidine is critical in determining its action, either as an agent to modify action of other drugs or to reverse toxicity of antimetabolites or as an antineoplastic agent itself.

Our investigations show that millimolar plasma thymidine can be achieved in most patients and maintained for 5 days without any major toxic manifestations. This is indeed remarkable when one considers that the normal plasma concentration of thymidine in humans is 10,000 times less, i.e., 0.1 ,uM (10). At such low normal concentrations or even at concentrations 10 to 20 times higher, i.e., 1.5 ,uM, clearance processes are different than at the high thymidine concentrations seen in this study. At micromolar plasma concentrations of thymidine, half-life was 10 min after the cessation of infusion (8 g/sq m/24 hr), and only 2% of the dose appeared in the urine (2). Calculations on such data indicate a total body clearance of thymidine of about 24,000 ml/min/subject. Contrast this to about 200 to 500 ml/min/subject from our data at millimolar plasma thymidine. These differences indicate the saturation of some clearance processes at millimolar concentrations. Further calculations using the fact that 98% of the thymidine at 8 g/sq m/24 hr is...
cleared by metabolic processes indicate that 0.04 mmol/min are removed by metabolism. In contrast, our data at 75 g/sq m/24 hr indicate that 39% of the dose is removed by metabolism (0.2 mmol/min). Therefore, an increase in plasma thymidine concentration from micromolar to millimolar (1000-fold increase) only increased the amount of thymidine cleared by metabolic processes by a factor of 5 (0.04 to 0.2 mmol/min), an indication that metabolic clearance of thymidine at millimolar plasma concentration is completely saturated. This conclusion is also supported by data (Chart 1B; Table 2) which show that thymine concentration in several cases was maintained for some time after the thymidine infusion stopped. These data indicate that the first catabolite of thymidine, thymine, is being produced at a constant rate, even though its substrate, thymidine, is rapid declining. This is obvious, however, in only some patients, which suggests some variability in saturation from patient to patient. Ensminger and Frei (3) have recently shown that hepatic extraction processes for thymidine are saturable as dose rates increase from 16 to 32 g/sq m/day. As stated earlier, data from these same investigators showed that, at infusion rates of 8 g/sq m/day, total body clearance of thymidine was approximately 24,000 ml/min/subject. Since total liver blood flow is only about 1,400 ml/min/subject (13) (plasma flow, approximately 700 ml/min), then only 700/24,000 or 1/30 of the clearance of thymidine at micromolar plasma concentrations can be accounted for by liver metabolism. Thymidine must be metabolized by many other organs in the body. Our data indicate that other significant thymidine metabolic sites in the body are also saturated at millimolar thymidine concentrations. Once these sites become saturated, the primary route for elimination of thymidine becomes kidney excretion. It appears that the body can handle about 40% of the dose given (75 g/sq m/24 hr) by the metabolic route; however, some variation exists from patient to patient.

ACKNOWLEDGMENT

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REFERENCES


Pharmacokinetics of High-Dose Thymidine

Inhibitors rapidly inactivated by the host as potential antineoplastic agents in intra-arterial infusion chemotherapy. Oncology (Basel), 26: 121–133, 1977.
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