Breast Cancer Resistance Protein and P-glycoprotein Influence In Vivo Disposition of $^{11}$C-Erlotinib

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Short running foot line: ABCG2/ABCB1 Transport of $^{11}$C-Erlotinib

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ABSTRACT

$^{11}$C-erlotinib is a PET tracer to distinguish responders from non-responders to epidermal growth factor receptor-targeted tyrosine kinase inhibitors and may also be of interest to predict distribution of erlotinib to tissues targeted for treatment. Aim of this study was to investigate if the known interaction of erlotinib with the multidrug efflux transporters breast cancer resistance protein (humans: ABCG2, rodents: Abcg2) and P-glycoprotein (humans: ABCB1, rodents: Abcb1a/b) affects tissue distribution and excretion of $^{11}$C-erlotinib and has an influence on the ability of $^{11}$C-erlotinib PET to predict erlotinib tissue distribution at therapeutic doses.

Methods: Wild-type and Abcb1a/b and/or Abcg2 knockout mice underwent $^{11}$C-erlotinib PET/MR scans, with or without co-injection of a pharmacological dose of erlotinib (10 mg/kg) or after pretreatment with the ABCB1/ABCG2 inhibitor elacridar (10 mg/kg). Integration plot analysis was used to determine organ uptake ($\text{CL}_{\text{uptake}}$) and biliary excretion ($\text{CL}_{\text{bile}}$) clearances of radioactivity.

Results: $^{11}$C-erlotinib distribution to the brain was restricted by Abcb1a/b and Abcg2 and $\text{CL}_{\text{uptake}}$ into brain was only significantly increased when both Abcb1a/b and Abcg2 were absent (wild-type mice: 0.017±0.004 mL/min/g tissue, $\text{Abcb1a/b}^{-/-}\text{Abcg2}^{-/-}$ mice: 0.079±0.013 mL/min/g tissue, $P<0.001$). Pretreatment of wild-type mice with elacridar increased $\text{CL}_{\text{uptake}}$ to comparable levels as in $\text{Abcb1a/b}^{-/-}\text{Abcg2}^{-/-}$ mice (0.090±0.007 mL/min/g tissue, $P<0.001$). Absence of Abcb1a/b and Abcg2 led to a 2.6-fold decrease in $\text{CL}_{\text{bile}}$ (wild-type mice: 0.025±0.005 mL/min/g tissue, $\text{Abcb1a/b}^{-/-}\text{Abcg2}^{-/-}$ mice: 0.0095±0.001 mL/min/g tissue, $P<0.001$). There were pronounced differences in distribution of $^{11}$C-erlotinib to brain, liver, kidney and lung and hepatobiliary excretion into intestine between animals injected with a microdose and pharmacological dose of erlotinib.

Conclusion: ABCG2, ABCB1 and possibly other transporters influence in vivo disposition of $^{11}$C-erlotinib and thereby affect its distribution to normal and potentially also tumor tissue. Saturable transport of erlotinib leads to non-linear pharmacokinetics which may compromise the
prediction of erlotinib tissue distribution at therapeutic doses from PET with a microdose of $^{11}$C-erlotinib. Inhibition of ABCB1 and ABCG2 is a promising approach to enhance brain distribution of erlotinib to increase its efficacy in the treatment of brain tumors.

**Key Words:** $^{11}$C-erlotinib, PET, breast cancer resistance protein, P-glycoprotein, non-linear pharmacokinetics
INTRODUCTION

Erlotinib is a reversible tyrosine kinase inhibitor (TKI) of the epidermal growth factor receptor (EGFR) which has been approved for treatment of advanced, metastatic non-small cell lung cancer (NSCLC) and advanced, unresectable or metastatic pancreatic cancer. Approximately 10% of NSCLC patients in the Western population harbor an activating mutation in their EGFR genes (e.g. the exon 19 deletion delE746-A750 or the exon 21 point mutation L858R) resulting in higher response rates to treatment with erlotinib or gefitinib, another EGFR-inhibiting TKI, as compared with patients with wild-type EGFR (1). $^{11}$C-erlotinib has been proposed as a PET tracer to distinguish erlotinib-sensitive from erlotinib-resistant NSCLC patients (2,3). In preclinical PET studies higher uptake of $^{11}$C-erlotinib in tumor xenografts with activating EGFR mutations (e.g. delE746-A750, L858R) as compared with tumor xenografts expressing wild-type EGFR or EGFR with secondary resistance causing mutations (exon 20 missense mutation T790M) was found (2,4-6). It has been hypothesized that the binding affinity of $^{11}$C-erlotinib is higher to EGFR with activating mutations as compared with wild-type EGFR resulting in a higher PET signal (3). In NSCLC patients it was shown that distribution volume of $^{11}$C-erlotinib was significantly higher in tumors with an exon 19 deletion than in tumors with wild-type EGFR (3). Apart from visualizing the EGFR mutational status of tumors $^{11}$C-erlotinib PET may also be of interest to predict the distribution of erlotinib to different body tissues targeted for erlotinib treatment (e.g. lung, brain, liver).

Erlotinib undergoes extensive metabolism in humans and is mainly excreted via the hepatobiliary pathway (7). Erlotinib is a substrate (8) and inhibitor (9) of the adenosine triphosphate-binding cassette (ABC) transporters breast cancer resistance protein (humans: ABCG2, rodents: Abcg2) and P-glycoprotein (humans: ABCB1, rodents: Abcb1a/b), resulting in a low extent of brain distribution due to ABCG2- and ABCB1-mediated efflux transport at the blood-brain barrier (BBB) (8,10,11). Apart from the BBB, ABCB1 and ABCG2 are also expressed in excretory organs, such as liver and kidney, where they mediate excretion of drugs.
and their metabolites into bile and urine, respectively (12). For the future diagnostic use of $^{11}$C-erlotinib as a PET tracer in tumor patients it is important to understand the influence of ABCB1 and ABCG2 on organ distribution and excretion of $^{11}$C-erlotinib as patients may undergo $^{11}$C-erlotinib PET scans both without and with concomitant treatment with therapeutic doses of erlotinib which could lead to partial saturation of ABCB1 and ABCG2 causing changes in tissue distribution. Moreover, ABCG2 and ABCB1 may be overexpressed in multidrug resistant tumors and thereby influence tumor distribution of $^{11}$C-erlotinib (13).

In the present study we performed small-animal PET/MR experiments with $^{11}$C-erlotinib without and with co-injection of a pharmacological dose of erlotinib in wild-type and Abcb1a/b and/or Abcg2 knockout mice in order to assess the influence of these transporters on $^{11}$C-erlotinib organ distribution and excretion. We hypothesized that partial transporter saturation at therapeutic doses may lead to non-linear pharmacokinetics of $^{11}$C-erlotinib and failure of a PET microdose to predict the organ distribution of a therapeutic dose.
MATERIALS AND METHODS

Chemicals
Elacridar hydrochloride (Syncom BV, Groningen, NL) was freshly dissolved prior to each administration in propylene glycol/dimethyl sulfoxide/physiological saline (40/30/30, v/v/v) and injected intravenously (i.v.) at a volume of 2 mL/kg body weight. Erlotinib hydrochloride (Apollo Scientific Ltd, Bredbury, UK) was freshly dissolved prior to each administration in 10% (v/v) aqueous ethanol solution and injected i.v. at a volume of 4 mL/kg body weight.

Animals
Female wild-type, Abcb1a/b(-/-), Abcg2(-/-) and Abcb1a/b(-/-)Abcg2(-/-) mice with a FVB genetic background were obtained from Charles River (Sulzfeld, Germany) and Taconic Biosciences Inc. (Germantown, NY, USA). At time of experiment animals had an age of 10-15 weeks and weighted 25±2 g. All animal experiments were approved by the national authorities (Amt der Niederösterreichischen Landesregierung) and all study procedures were performed in accordance with the European Communities Council Directive of September 22, 2010 (2010/63/EU).

Radiotracer Synthesis
11C-erlotinib was synthesized as described before (3) with a radiochemical purity >98% and a specific activity of 47.9±64.1 GBq/μmol (n=29). 11C-erlotinib was formulated in 0.1 mM hydrochloric acid in physiological saline at an approximate concentration of 370 MBq/mL for i.v. injection into animals.

Experimental Design
Groups of wild-type, Abcb1a/b(-/-), Abcg2(-/-) and Abcb1a/b(-/-)Abcg2(-/-) mice (n=4 per group) underwent 90 min dynamic 11C-erlotinib PET scans. One group of wild-type mice (n=6)
underwent 90 min dynamic $^{11}$C-erlotinib PET scans at 20 min after i.v. pretreatment with the
dual ABCB1/ABCG2 inhibitor elacridar (10 mg/kg). Additional groups of wild-type and
$\text{Abcb}1a/b^{-/-}\text{Abcg}2^{-/-}$ mice ($n=4$ per group) underwent 90 min dynamic $^{11}$C-erlotinib PET scans,
in which a pharmacological dose of unlabelled erlotinib (10 mg/kg) was co-injected with $^{11}$C-
erlotinib. The choice of pharmacological dose was based on previous work by Petrulli et al. (5).

**PET/MR Imaging**

Animals were pre-anesthetized in an induction chamber using isoflurane (2.5-3.5% in oxygen),
placed on a heated animal bed (38°C) and the lateral tail vein was cannulated. Anesthesia and
warming were maintained for the whole imaging period. Anatomical magnetic resonance
imaging (MRI) was performed on a 1 Tesla benchtop MRI (ICON, Bruker BioSpin GmbH,
Ettlingen Germany) using a modified 3D $T_1$-weighted gradient echo sequence ($T_1$-fast low angle
shot, FLASH). Following MRI, the animal bed was transferred into the gantry of a microPET
scanner (Focus 220, Siemens Medical Solutions, Knoxville, TN, USA) and a 10 min
transmission scan using a $^{57}$Co point source was recorded. Subsequently, $^{11}$C-erlotinib (27±8
MBq, 2±1 nmol, 0.10 mL, $n=29$) was administered as an i.v. bolus over 1 min and a 90 min
dynamic PET scan (energy window: 250-750 keV; timing window: 6 ns) was initiated at the start
of radiotracer injection.

**Postimaging Procedures**

At end of PET a terminal blood sample was withdrawn under isoflurane anesthesia from the
retro-orbital sinus vein and animals were sacrificed by cervical dislocation. Aliquots of blood and
plasma were measured for radioactivity in a gamma counter (Wizard 1470, Perkin-Elmer,
Wellesley, MA, USA). The measured radioactivity data were corrected for radioactive decay and
expressed as standardized uptake value (SUV=(radioactivity per g/injected radioactivity) x body
weight).
PET Data Analysis
Dynamic emission PET data were sorted into 25 frames, which incrementally increased in time length from 5 s to 20 min. Images were reconstructed using Fourier rebinning of the 3D sinograms followed by filtered backprojection with a ramp filter resulting in a voxel size of 0.4 x 0.4 x 0.796 mm³. The standard data correction protocol (normalization, injection decay correction and attenuation correction) was applied to the data. Using the image analysis software AMIDE whole brain, right lung, left ventricle of the heart, left kidney, liver, gall bladder, intestine and urinary bladder were manually outlined on co-registered PET/MR images and time-activity curves (TACs), expressed as SUV, were derived. It was assumed that the sum of radioactivity in the gall bladder and the intestine represented radioactivity in the bile excreted from the liver. From the TACs area under the curve from time 0 to 90 min (AUC) was calculated using Prism 5.0 software (GraphPad Software, La Jolla, CA, USA).

Integration Plot Analysis
A previously described graphical analysis approach (integration plot) (14,15) was used to estimate cerebral, hepatic, renal and pulmonary uptake clearances (CLuptake,brain, CLuptake,liver, CLuptake,kidney and CLuptake,lung) and biliary excretion clearance (CLbile) of 11C-erlotinib. Details are given in the Supplemental Data.

Analysis of Metabolites and Plasma Protein Binding
Radiolabelled metabolites of 11C-erlotinib were measured at 25 min after injection with radio-thin-layer chromatography in wild-type mice, pretreated either with vehicle or elacridar (10 mg/kg), and in Abcb1a/b(-/-)Abcg2(-/-) mice as described in the Supplemental Data. Plasma protein binding of 11C-erlotinib was determined as described in the Supplemental Data.
**Statistical Analysis**

Differences between groups were analyzed by one-way analysis of variance (ANOVA) followed by Bonferroni’s multiple comparison test using Prism 5.0 software. The level of statistical significance was set to $P<0.05$. All values are given as mean ± standard deviation (SD).
RESULTS

Effect of Abcb1a/b and/or Abcg2 knockout on \(^{11}\)C-erlotinib disposition

We performed \(^{11}\)C-erlotinib PET/MR scans in wild-type, \(\text{Abcb1a/b}^{(-/-)}\), \(\text{Abcg2}^{(-/-)}\) and \(\text{Abcb1a/b}^{(-/-)}\text{Abcg2}^{(-/-)}\) mice. Distribution of \(^{11}\)C-erlotinib to the brain was very low in wild-type mice and significantly higher in \(\text{Abcb1a/b}^{(-/-)}\text{Abcg2}^{(-/-)}\) mice (brain AUC, wild-type: 18.5±1.3, \(\text{Abcb1a/b}^{(-/-)}\text{Abcg2}^{(-/-)}\): 51.0±8.1, \(P<0.001\)) (Fig. 1 and Fig. 2A). In mice lacking only Abcb1a/b or Abcg2, brain AUCs were only moderately and not significantly increased as compared with wild-type mice (\(\text{Abcb1a/b}^{(-/-)}\): 24.7±0.7, \(\text{Abcg2}^{(-/-)}\): 25.9±0.7). To quantitatively evaluate brain distribution of \(^{11}\)C-erlotinib we used a graphical analysis approach (integration plot) to estimate the rate constants for transfer of radioactivity from blood into brain (cerebral uptake clearance, \(\text{CL}_{\text{uptake,brain}}\)). \(\text{CL}_{\text{uptake,brain}}\) corresponds to \(K_1\) from kinetic modelling of PET data, which has been shown in previous work to be a sensitive parameter of efflux transporter function at the BBB (15,16). To determine radioactivity concentrations in blood we generated an image-derived blood curve by placing a region of interest into the left ventricle of the heart. Radioactivity concentrations measured with PET in the heart showed very good correlation (\(r=0.942, P<0.0001\)) with blood radioactivity concentrations measured at end of PET in a gamma counter (Supplemental Fig. 1). In Supplemental Fig. 2, representative integration plots are shown. In Supplemental Table 1, uptake and excretion clearances in different organs of all studied mouse groups are given.

\(\text{CL}_{\text{uptake,brain}}\) was significantly higher in \(\text{Abcb1a/b}^{(-/-)}\text{Abcg2}^{(-/-)}\) than in wild-type mice (Supplemental Fig. 2A) but not significantly increased in \(\text{Abcb1a/b}^{(-/-)}\) and \(\text{Abcg2}^{(-/-)}\) mice (Fig. 2C). Absence of Abcg2 had a pronounced effect on biliary excretion of radioactivity from the liver into the intestine (Fig. 3 and Fig. 4C). Both in \(\text{Abcg2}^{(-/-)}\) and \(\text{Abcb1a/b}^{(-/-)}\text{Abcg2}^{(-/-)}\) mice, biliary excretion clearances (\(\text{CL}_{\text{bile}}\)) were significantly reduced as compared with wild-type mouse (Supplemental Fig. 2B, Fig. 5C) resulting in prolonged liver retention of radioactivity (Fig. 3). \(\text{Abcg2}^{(-/-)}\) and \(\text{Abcb1a/b}^{(-/-)}\text{Abcg2}^{(-/-)}\) mice showed in contrast to all other mouse groups urinary excretion of
radioactivity (Fig. 3, Fig. 4D). In the lung no significant differences in $^{11}$C-erlotinib distribution were observed between wild-type and transporter knockout mice (Supplemental Fig. 3).

**Differences in $^{11}$C-erlotinib disposition after administration of a microdose and pharmacological dose**

We performed $^{11}$C-erlotinib PET/MR scans in wild-type and $Abcb1a/b^{(-/-)} Abcg2^{(-/-)}$ mice receiving either a microdose or a pharmacological dose (10 mg/kg) of erlotinib. $^{11}$C-erlotinib distribution was visually different for the two dose groups (Fig. 3). Blood radioactivity concentrations were significantly higher ($P<0.001$) for the pharmacological dose than for the microdose (heart AUC, wild-type microdose: 91.0±2.4, pharmacological dose: 135.8±13.3; $Abcb1a/b^{(-/-)} Abcg2^{(-/-)}$ microdose: 105.6±19.2, pharmacological dose: 149.6±7.2). In the brain, AUCs and $CL_{uptake,brain}$ were significantly higher in animals receiving the pharmacological dose (Fig. 2C), both in wild-type mice (4.5-fold increase in $CL_{uptake,brain}$) and in $Abcb1a/b^{(-/-)} Abcg2^{(-/-)}$ mice (1.5-fold increase in $CL_{uptake,brain}$).

In liver and kidney, $CL_{uptake}$ was significantly lower for the pharmacological dose than for the microdose, both in wild-type mice and $Abcb1a/b^{(-/-)} Abcg2^{(-/-)}$ mice (Fig. 5A,B). In the liver of wild-type but not $Abcb1a/b^{(-/-)} Abcg2^{(-/-)}$ mice, $CL_{bile}$ was significantly lower for the pharmacological dose than for the microdose (Fig. 4C and Fig. 5C). In $Abcb1a/b^{(-/-)} Abcg2^{(-/-)}$ but not in wild-type mice radioactivity excreted into urine was significantly lower in animals injected with a pharmacological dose than with a microdose (urinary bladder AUC, wild-type microdose: 260±65, pharmacological dose: 407±258, $Abcb1a/b^{(-/-)} Abcg2^{(-/-)}$ microdose: 1888±370, pharmacological dose: 41±9, $P<0.001$). In the lungs, $CL_{uptake}$ was significantly increased in animals receiving the pharmacological dose, both in wild-type and in $Abcb1a/b^{(-/-)} Abcg2^{(-/-)}$ mice (Supplemental Fig. 3).

**Effect of elacridar on $^{11}$C-erlotinib disposition**
We assessed the effect of the dual ABCB1/ABCG2 inhibitor elacridar on tissue distribution of $^{11}$C-erlotinib in wild-type mice, which underwent $^{11}$C-erlotinib PET scans after i.v. pretreatment with elacridar (10 mg/kg). Elacridar administration resulted in a significant increase in brain AUCs ($45.2\pm3.3$ versus $18.5\pm1.3$, $P<0.001$) and $CL_{\text{uptake,brain}}$, to similar levels as in $\text{Abcb1a/b}^{-/-}\text{Abcg2}^{-/-}$ mice (Fig. 2A,C). In the other studied organs, elacridar pretreatment exerted no significant effect on $^{11}$C-erlotinib distribution (Fig. 5) except for the lung (Supplemental Fig. 3), in which $CL_{\text{uptake,lung}}$ was significantly increased in elacridar treated as compared with untreated mice.

Metabolism and plasma protein binding of $^{11}$C-erlotinib

Radiolabelled metabolites of $^{11}$C-erlotinib were assessed with radio-thin-layer chromatography in plasma, brain, liver, bile and urine of vehicle treated and elacridar treated wild-type mice, and $\text{Abcb1a/b}^{-/-}\text{Abcg2}^{-/-}$ mice (Supplemental Table 2). In plasma and brain, the majority of radioactivity was in the form of unmetabolized $^{11}$C-erlotinib. In liver and bile, approximately one third to one half of radioactivity was in the form of unmetabolized $^{11}$C-erlotinib, whereas almost no unmetabolized $^{11}$C-erlotinib was detected in urine (Supplemental Table 2). No significant differences were observed between the three studied mouse groups in percentage of unchanged $^{11}$C-erlotinib in different organs and liquids. The percentage of $^{11}$C-erlotinib that was not bound to plasma proteins was low (<1%) and independent of presence or absence of elacridar or unlabelled erlotinib (Supplemental Table 3).
DISCUSSION

Among several different radiolabelled reversible and irreversible TKIs tested for PET imaging of receptor tyrosine kinases, $^{11}$C-erlotinib has emerged as a promising candidate tracer to distinguish responders from non-responders to treatment with EGFR-targeted TKIs (e.g. gefitinib, erlotinib) (17). Preclinical as well as clinical data indicate that $^{11}$C-erlotinib binds specifically to EGFR with activating mutations (e.g. delE746-A750, L858R), whereas it lacks specific binding to wild-type EGFR (2-6). Preclinical studies have shown that specific binding of $^{11}$C-erlotinib to mutated EGFR is reduced when pharmacological doses of erlotinib are co-administered, presumably due to saturation of EGFR-specific binding sites (5,6). Consequently, $^{11}$C-erlotinib PET imaging in patients undergoing TKI treatment may prohibit the visualization of EGFR-specific binding in tumors. In addition to binding to mutated EGFR, the known interaction of erlotinib with ABC and solute carrier (SLC) transporters (8,9,18) may exert an influence on the distribution of $^{11}$C-erlotinib to tumoral and non-tumoral tissue. These transporters are widely expressed all over the body, such as at blood-tissue barriers (e.g. BBB or blood-testis barrier) and in excretory organs (liver, kidney, intestine), and may also become overexpressed in multidrug resistant tumors where they restrict intracellular distribution of anticancer agents (12,13). Transport of drugs by ABC and SLC transporters is of concern as this may lead to inter-individual variability in drug pharmacokinetics due to genetic polymorphisms or to transporter-mediated drug-drug interactions potentially causing adverse reactions (12). Moreover, dose-dependent partial saturation of drug transporters may lead to non-linear pharmacokinetics of transporter substrates, which may result in differences in organ distribution between a microdose and therapeutic dose.

In the present study we assessed the effect of ABCG2 and ABCB1 on whole-body distribution and excretion of $^{11}$C-erlotinib and investigated if PET imaging with a microdose of $^{11}$C-erlotinib is capable of predicting the organ distribution of a therapeutic erlotinib dose. We addressed these questions by performing small-animal PET/MR experiments with $^{11}$C-erlotinib without and with
co-injection of a pharmacological dose of unlabelled erlotinib (10 mg/kg) in wild-type and Abcb1a/b and/or Abcg2 knockout mice. Previous work has shown that Abcb1a/bΔ/Δ, Abcg2Δ/Δ and Abcb1a/bΔ/ΔAbcg2Δ/Δ mice lack compensatory alterations in expression levels of other ABC and SLC transporters and are useful tools to study the effects of ABCB1 and ABCG2 on drug disposition (19). A potential limitation of using mice is their small blood volume which prohibits arterial blood sampling, which is needed for quantitative analysis of PET data. We overcame this problem by generating an image-derived blood curve from the left ventricle of the heart. The use of a previously described graphical analysis approach (integration plot) (14,15) (Supplemental Fig. 2) allowed us to estimate the rate constants for transfer of radioactivity from blood into different organs (brain, liver, kidney, lungs) (CLuptake) as well as for transfer of radioactivity from liver into the intestine (CLbile) to quantitatively evaluate the effects of Abcb1a/b and Abcg2 on 11C-erlotinib disposition (Fig. 2C, Fig. 5, Supplemental Table 1).

We were able to confirm earlier data that brain distribution of erlotinib is restricted by Abcb1a/b and Abcg2 (8,10,11). It has now been documented for many dual ABCB1/ABCG2 substrates that these two transporters are capable of mutually compensating their function when one transporter is knocked out or inhibited (20,21). This phenomenon causes only small increases in brain distribution of ABCB1/ABCG2 substrates when only one transporter is absent and disproportionally large increases when both transporters are absent, as was the case for 11C-erlotinib (Fig. 2C). Importantly, we could show that radioactivity in the brain following injection of 11C-erlotinib is mainly in the form of unmetabolized 11C-erlotinib (Supplemental Table 2) thus making 11C-erlotinib PET suitable to assess the effect of ABCB1 and ABCG2 on 11C-erlotinib brain distribution. It is now known that most currently available TKIs (e.g. sorafenib, gefitinib, sunitinib) are dual ABCB1/ABCG2 substrates resulting in very low brain distribution (20,21). This is of concern as poor BBB penetration may render these drugs ineffective in the treatment of primary or secondary brain tumors (e.g. gliomas, NSCLC brain metastases) (11,22). Pharmacological inhibition of ABCB1 and ABCG2 has been suggested as a promising approach...
to enhance brain distribution of TKIs and thereby increase their efficacy to treat brain tumors (20,22). However, a limitation in realizing this therapeutic concept is the current lack of clinically usable, marketed dual ABCB1/ABCG2 inhibitors. The most potent dual ABCB1/ABCG2 inhibitor known to date is elacridar, which has shown great promise in enhancing brain distribution of dual ABCB1/ABCG2 substrates in preclinical studies (20-22). We found that 10 mg/kg elacridar given i.v. 20 min before 11C-erlotinib injection can increase brain distribution of 11C-erlotinib to a similar extent as in Abcb1a/b(-/-)Abcg2(-/-) mice indicating complete inhibition of Abcb1a/b and Abcg2 at the BBB (Fig. 1, Fig. 2A,C). An oral formulation of elacridar has been used in clinical studies in cancer patients to increase oral bioavailability of concomitantly administered anticancer drugs (e.g. topotecan) by inhibition of ABCG2 and ABCB1 in the intestine (23). However, as the oral bioavailability of elacridar is very low resulting in low plasma concentrations, future use of elacridar as an inhibitor of ABCB1 and ABCG2 at the human BBB will most likely require an i.v. formulation of the drug (22).

Intriguingly, we could show that co-injection of a pharmacological dose of erlotinib results in similar increases in CL_{uptake,brain} of 11C-erlotinib as in elacridar treated animals (Fig. 2C). This suggests that erlotinib may be of potential use as a clinically available inhibitor of ABCB1 and ABCG2 to enhance brain distribution of other dual ABCB1/ABCG2 substrates (24). After a comparably high initial brain uptake washout of radioactivity was faster from brains of erlotinib co-injected wild-type mice than from Abcb1a/b(-/-)Abcg2(-/-) mice (Fig. 2A,B), which indicated that the Abcb1a/b/Abcg2 inhibitory effect of erlotinib is reversible. For future use of erlotinib as an ABCB1/ABCG2 inhibitor in human PET studies it may therefore be preferable to administer erlotinib as a continuous i.v. infusion which is maintained for the duration of the PET scan, as we have done in a previous PET study with the ABCB1 inhibitor tariquidar (16). Importantly, we could demonstrate that brain distribution of 11C-erlotinib was non-linear between a microdose and a pharmacological dose, i.e. for the pharmacological dose brain exposure (Fig. 2B) and CL_{uptake,brain} (Fig. 2C) was significantly higher.
We also found an influence of Abcg2 and Abcb1 on distribution of $^{11}$C-erlotinib to peripheral organs. Our data clearly indicated that $^{11}$C-erlotinib and/or its radiolabelled metabolites undergo hepatobiliary excretion into the intestine mediated by Abcg2 and Abcb1a/b (Fig. 4C). Absence of both Abcg2 and Abcb1a/b caused a 2.6-fold reduction in CL$bile$ (Fig. 5C), suggesting that $^{11}$C-erlotinib PET may be useful to study the functional activity of Abcg2 and Abcb1a/b in the liver. Interestingly, co-administration of a pharmacological dose of erlotinib caused a 5-fold reduction in CL$bile$ in wild-type mice (Fig. 5C), indicating that the influence of Abcg2 and Abcb1a/b on hepatobiliary excretion of erlotinib may be more important when a microdose is administered. It should be noted, however, that determination of CL$bile$ was based on the assumption that excretion of radioactivity into the intestine occurs exclusively via bile and not by direct secretion from blood. To confirm this assumption it would be necessary to examine bile duct cannulated mice, which is technically challenging and which was not done in the present study.

In absence of Abcg2 (i.e. in Abcg2$^{-/-}$ and Abcb1a/b$^{-/-}$Abcg2$^{-/-}$ mice) a shift from hepatobiliary to renal excretion of $^{11}$C-erlotinib was observed, which otherwise showed negligible excretion into urine (Fig. 3, Fig. 4D). This suggested that other transporters than Abcg2 and Abcb1a/b accounted for urinary excretion of radioactivity. As radio-thin-layer chromatography analysis showed that the majority of radioactivity in urine was in the form of radiolabelled metabolites (Supplemental Table 2) it appears likely that not $^{11}$C-erlotinib itself but one or several radiolabelled metabolites underwent active transport at the brush border membrane of kidney proximal tubule cells, with multidrug resistance-associated proteins 4 and 2 (Abcc4 and Abcc2) as the most likely candidate transporters.

Both in liver and kidney, CL$_{uptake}$ was significantly lower for the pharmacological dose than for the microdose (Fig. 4A,B, Fig. 5A,B). This suggests partial saturation of basolateral uptake transporters in hepatocytes and kidney cells, such as organic anion transporting polypeptides (e.g. OATP2B1, SLCO2B1) and organic anion transporter 3 (SLC22A7). This is in line with previous findings that TKIs including erlotinib are competitive inhibitors of these SLC
transporters (18). This most likely also accounted for the significantly higher blood AUCs for the pharmacological dose as compared with the microdose. An increase in systemic exposure of drugs upon inhibition of basolateral uptake transporters in hepatocytes has been observed for several different drugs (25).

Lung tissue can be considered as a target tissue for treatment of NSCLC with erlotinib. It is known that several different ABC and SLC transporters are expressed in lung tissue (e.g. multidrug resistance-associated protein 1 (ABCC1), and ABCG2), where they control pulmonary absorption of inhaled drugs as well as transport of drugs from epithelial cells to the circulating blood (26). We found no influence of Abcb1a/b and Abcg2 on distribution of $^{11}$C-erlotinib to the lung (Supplemental Fig. 3). However, co-injection of a pharmacological dose caused significant increases in $\text{CL}_{\text{uptake,lung}}$ pointing to partial saturation of other unknown efflux transporter(s). Interestingly, elacridar led also to an increase in $\text{CL}_{\text{uptake,lung}}$, but it is not known by which mechanism.

Our findings are clinically relevant in that they suggest that future therapy guidance with $^{11}$C-erlotinib in tumor patients needs to take into account the influence of drug transporters on $^{11}$C-erlotinib disposition. Concomitant treatment of tumor patients with therapeutic doses of erlotinib or other TKIs may lead to partial saturation of drug transporters, which could cause changes in $^{11}$C-erlotinib PET signal in the tumor, which may be unrelated to treatment response or the mutational status of EGFR. However, because a standard oral therapeutic dose of erlotinib used in the clinic (150 mg) is lower than the presently employed pharmacological dose in mice, it appears likely that less pronounced effects on drug transporters will be observed in humans.
CONCLUSION
ABCG2, ABCB1 and possibly other transporters influence in vivo disposition of ¹¹C-erlotinib and thereby affect its distribution to normal and potentially also tumor tissue. Saturable transport of erlotinib leads to non-linear pharmacokinetics, which needs to be considered when attempting to predict the organ distribution of erlotinib in tumor patients using PET scans with a microdose of ¹¹C-erlotinib. Inhibition of ABCB1 and ABCG2 is a promising approach to enhance brain distribution of erlotinib to increase its efficacy in the treatment of brain tumors.

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FIGURE 1. Representative coronal $^{11}$C-erlotinib PET summation images (0-90 min) and corresponding planes of $T_1$-weighted gradient echo MR images of the brain region in a wild-type mouse (upper row), a wild-type mouse pretreated 20 min before PET with 10 mg/kg elacridar (middle row) and a $Abcb1a/b^{-/-} Abcg2^{-/-}$ mouse (bottom row). Brain is highlighted with white broken line.
FIGURE 2. Time-activity curves (mean SUV ± SD) of $^{11}$C-erlotinib in whole brain of wild-type mice, $Abcb1a/b^{(-/-)}Abcg2^{(-/-)}$ mice and wild-type mice pretreated 20 min before PET with 10 mg/kg elacridar (A). Time-activity curves (mean SUV ± SD) of $^{11}$C-erlotinib in whole brain of wild-type mice injected with a microdose or pharmacological dose of erlotinib (10 mg/kg) (B). Cerebral uptake clearances of $^{11}$C-erlotinib in wild-type mice (WT), wild-type mice pretreated with elacridar (10 mg/kg, 20 min before PET) ($WT_{elacr}$), wild-type mice co-injected with a pharmacological dose of unlabelled erlotinib (10 mg/kg) ($WT_{erlot}$), $Abcb1a/b^{(-/-)}$ mice, $Abcg2^{(-/-)}$ mice, $Abcb1a/b^{(-/-)}Abcg2^{(-/-)}$ mice and $Abcb1a/b^{(-/-)}Abcg2^{(-/-)}$ mice co-injected with a pharmacological dose of unlabelled erlotinib (10 mg/kg) ($Abcb1a/b^{(-/-)}Abcg2^{(-/-)}_{erlot}$) (C). (***, $P<0.001$, one-way ANOVA with Bonferroni’s multiple comparison test).
FIGURE 3. Serial coronal whole-body PET/MR images of \(^{11}\text{C}\)-erlotinib in a wild-type mouse (upper row), a wild-type mouse co-injected with a pharmacological dose of unlabelled erlotinib (10 mg/kg) (middle row) and a Abcb1a/b\(^{-/-}\)Abcg2\(^{-/-}\) mouse (bottom row). Anatomical structures are indicated by arrows: L = liver, I = intestine; UB = urinary bladder.
FIGURE 4. Time-activity curves (mean SUV ± SD) of $^{11}$C-erlotinib in liver (A), kidney (B), intestine (C) and urinary bladder (D) of wild-type mice injected with a microdose (WT) or pharmacological dose of erlotinib (10 mg/kg) ($WT_{erlot}$) and of $Abcb1a/b^{-/-}Abcg2^{-/-}$ mice.
FIGURE 5. Hepatic (A) and renal (B) uptake clearances and biliary (C) excretion clearances of $^{11}$C-erlotinib in wild-type mice (WT), wild-type mice pretreated with elacridar (10 mg/kg, 20 min before PET) (WT$_{elacr}$), wild-type mice co-injected with a pharmacological dose of unlabelled erlotinib (10 mg/kg) (WT$_{erlot}$), Abcb1a/b$^{(-/-)}$ mice, Abcg2$^{(-/-)}$ mice, Abcb1a/b$^{(-/-)}$Abcg2$^{(-/-)}$ mice and Abcb1a/b$^{(-/-)}$Abcg2$^{(-/-)}$ mice co-injected with a pharmacological dose of unlabelled erlotinib (10 mg/kg) (Abcb1a/b$^{(-/-)}$Abcg2$^{(-/-)}$$_{erlot}$). (***, $P$ <0.001, one-way ANOVA with Bonferroni’s multiple comparison test).
Breast Cancer Resistance Protein and P-glycoprotein Influence In Vivo Disposition of 11C-Erlotinib

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