1. Introduction

Undoubtedly with the use of antiretroviral drugs of high potency, tolerability, and resistance profiles, lifespan time has increased in HIV patients. However, even after so much advancement in therapy, patients are struggling with an unknown, fear of death (Serrao et al. 2009; Hawkins 2010). Therefore, the need for new antiretroviral agents is still substantial even after more than 20 years into the era of antiretroviral therapy. Present antiretroviral drugs have a better tolerability profile, higher barriers to resistance, and less drug–drug interactions. These principles have inspired the scientists all over the world to develop new agents that are mainly focused on novel therapeutic targets. The drugs targeting on critical steps in the life cycle of HIV-1 include HIV-1 reverse-transcriptase inhibitors (both nucleoside analogue and non-nucleoside inhibitors), HIV-1 protease inhibitors and HIV-1 entry inhibitors (fusion inhibitors and CCR5 antagonists). The newest approved class of drug in HIV treatment is the integrase inhibitor (INI).

Integrase inhibitors (INIs) represent a class of drug used in the treatment of HIV infected people, blocking the HIV genome transfer and integration into the host cell DNA (Powderly 2010). Raltegravir (RAL), first drug of this category which got FDA approval. It is highly convincing drug in treating antiretroviral-naive and experienced subjects and a recent addition is elvitegravir (EVG) (Markowitz et al. 2007; Steigbigel et al. 2008; Mbisa, Martin & Cane 2011; DeJesus et al. 2006; Zolopa et al. 2010). But these first-generation INIs also suffer from some severe drawbacks like they share some common resistance pathways noticed during clinical studies of RAL. Infected subjects found to have virus with 1 of 3 signature mutational pathways like N155H, Q148H/K/R, or Y143C/H/R, in the integrase enzyme gene (Cooper et

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So, in these circumstances continuing RAL treatment may lead to some secondary mutations (Y143 or Q148 pathways) evaluation (DeJesus et al. 2007). In addition to this, EVG does not have any activity against RAL-resistant isolates and same case is with RAL (DeJesus et al. 2007; Marinello et al. 2008; Garrido et al. 2012). Therefore, there is a need for new INIs with a high genetic barrier to resistance as well as high anti-HIV activity. So, recent drug to fulfill all these basic requirements is Dolutegravir (DTG). This review article aims to cover all the aspects related to the dolutegravir which will help the scientists, academicians and common men to satisfy their knowledge pangs, like in vitro activity, pharmacokinetics, drug-drug interactions, MOA, metabolism, excretion, dosing/adverse effects and resistance profile of dolutegravir.

**Figure 2** explains methodology and evaluation of dolutegravir with the help of different information sources.

Dolutegravir (DTG) discovered by Shionogi and GlaxoSmithKline research collaboration, is a second generation novel HIV-1 integrase strand transfer inhibitor having activity against INI resistant viruses as well as favorable pharmacokinetic properties (Sato et al. 2009; Underwood et al. 2009). It is generally recommended in combination with other antiretroviral agents. It is marketed as a small, yellow, 50-mg tablet and can be consumed without any regard to time and food.

There are excellent reviews and research papers recently published which sum up the side effects and other clinical phase studies of Dolutegravir in combination with other drugs (Hoffmann et al. 2017; Sax et al. 2017).

### 2. Different Aspects of Dolutegravir Drug

#### 2.1. Structural and functional analyses of Dolutegravir (DTG)

Dolutegravir (DTG, S/GSK1349572) effectively inhibits HIV-1 IN variants which are resistant to the first-generation INIs. Potency of DTG is mainly attributable to its structure which shares almost the same space within the IN active site as other INIs. DTG also makes strong interactions with the β4-α2 loop of the catalytic core domain. Dolutegravir molecular structure has three main structural parts like tricyclic metal-chelating core, difluorophenyl ring and linker group as shown in **Figure 3**. Tricyclic metal-chelating core binds to the intasome active site with three coplanar oxygen atoms coordinated to Mg<sup>2+</sup> cations. The extended linker region of DTG allows it to enter deeper, into the pocket as vacated by the displaced viral DNA base, to make more compatible bonding with the viral DNA (Hare et al. 2011).

#### 2.2. In vitro activity

Dolutegravir has shown potent in vitro activity against many INI-resistant mutants as well as against wild-type HIV-1. It has shown potent in vitro activity against HIV-1 with mean EC<sub>50</sub> of 0.5 nM to 2.1 nM, IC<sub>50</sub> of 2.7 nM and an IC<sub>50</sub> of 2.0 nM in peripheral blood mononuclear cells (PBMC) and MT-4 cells. The drug also shows activ-
ity against HIV-2 viruses (EC\textsubscript{50} of 0.09 nM to 0.61 nM) in PBMC assays. Cellular toxicity value is in the micromolar range in variant cells, which indicates that the antiviral effect of S/GSK1349572 is not due to cytotoxicity. S/GSK1349572 shows potency against all integrase resistant single mutants with an FC as high as 3.6-fold. 32 nM or higher concentrations of S/GSK1349572 reported not a single virus with high resistance. In vitro experimental studies have shown no toxicity when used with other antiretrovirals, but found a synergistic effect with nevirapine, efavirenz, abacavir, stavudine, lopinavir, amprenavir and enfuvirtide drugs and an additive effect with maraviroc. Results indicated no effect on efficacy on exposure to the adeovir and ribavirin (Kobayashi et al. 2011).

2.3. Pharmacokinetics
Dolutegravir has a favourable pharmacokinetic profile with terminal half-life of approximately 13–15 h (Min et al. 2010; Min et al. 2011). AUC\textsubscript{0–24h} and C\textsubscript{max} values are slightly less than the dose in the range of 2–50 mg following single and multiple doses. One notable change is the nonlinearity in C\textsubscript{max} and AUC with the increase in dose. So, phase 3 clinical trial selected a twice-daily 50 mg dose instead of a once-daily 100 mg dose (Min et al. 2011; Patel, Song and Borland 2012; Song et al. 2012). Dosing interval (C\textsubscript{tau}) for a 50 mg dose reported 1.6 μg/ml as the geometric mean steady-state concentration, which is about 25-fold higher than the protein-adjusted IC\textsubscript{90} (0.064 μg/ml). A monotherapy study of, 10 days of dolutegravir 50


Table 1: Dolutegravir (DTG) drug interaction with integrase inhibitors and other category drugs.

| S.No | Interacting drug class | Interacting drug | Effect on dolutegravir |
|------|------------------------|------------------|------------------------|
| 1    | Antiretrovirals NRTIs  | Tenofovir        | No significant effect observed (Song et al. 2010) |
| 2    | Antiretrovirals NNRTIs | Efavirenz        | DTG AUC, $C_{max}$ and $C_{min}$ decreased 57, 39, and 75% (Song et al. 2011) |
|      |                        | Etravirine       | DTG AUC, $C_{max}$ and $C_{min}$ decreased 70.6, 51.6, and 87.9%. (Song et al. 2011) |
|      |                        |                  | ETR/DRV/r administration results in 25, 11.8, and 37.1% decrease in DTG AUC, $C_{max}$ and $C_{min}$ |
|      |                        |                  | ETR/LPV/r administration results in 11, 7, and 28% increase in DTG AUC, $C_{max}$ and $C_{min}$ (Song et al. 2011) |
| 3    | Antiretrovirals PIs    | Darunavir/r      | DTG AUC, $C_{max}$ and $C_{min}$ decreased 22, 11, and 38% (Song et al. 2011) |
|      |                        | Atazanavir       | DTG AUC, $C_{max}$ and $C_{min}$ increased 91, 50, and 180% (Song et al. 2011) |
|      |                        | Lopinavir/r      | No significant effect observed (Song et al. 2011) |
|      |                        | Fosamprenavir    | DTG AUC, $C_{max}$ and $C_{min}$ decreased 35, 24, and 49% (Song et al. 2014) |
|      |                        | Tipranavir       | DTG AUC, $C_{max}$ and $C_{min}$ decreased 59, 46, and 76% (Song et al. 2011) |
| 4    | Antituberculosis drugs| Rifampin         | DTG AUC and $C_{min}$ increased 33 and 22% with DTG 50 mg b.i.d. + rifampin 600 mg q.d. compared with DTG 50 mg daily (Dooley et al. 2013) |
|      |                        | Rifabutin        | DTG AUC and $C_{min}$ decreased 5 and 30%, $C_{max}$ increased 15% (Dooley et al. 2012) |
| 5    | Acid-reducing agents-  | Omeprazole       | No significant effect observed (Patel et al. 2011) |
|      | PPIs/H2 RA             | Antacids         | DTG AUC, $C_{max}$ and $C_{min}$ decreased 73.6, 72.4, and 74.4% (Patel et al. 2011) |

DTG, Dolutegravir; ETR, Etravirine; EVG, Elvitegravir; LPV, Lopinavir; NNRTI, Non-nucleoside reverse transcriptase inhibitor; NRTI, Nucleos(t)ide reverse transcriptase inhibitor; PI, Protease Inhibitor; PPI, Proton pump inhibitor; r, Ritonavir; RAL, Raltegravir; AUC, Area under the Curve; $C_{max}$, Maximum concentration; $C_{min}$, Minimum concentration, LPV, Lopinavir; DRV, Darunavir; ETR, Etravirine.
Yadav et al: Dolutegravir, Second Generation Integrase Inhibitor

24 mg daily dose in integrase inhibitor naïve HIV-1-infected subjects demonstrated a reduction in HIV-1 RNA. This reduction sustained for 4 days after discontinuation of dolutegravir only because of plasma concentrations which remained above the protein adjusted IC₉₀. Variability in exposure was minimum like 50 mg dosing is achieved a geometric mean Cₚ₅₀₀ of 3.34 mg/ml (16% coefficient of variation), an AUC₀–₂₄h of 43.4 mg/ml (20% coefficient of variation), a t½ of 12.0 h (22% coefficient of variation) and a C₂₄h of 0.83 mg/ml (26% coefficient of variation) (Min et al. 2011; Patel, Song and Borland 2012; Song et al. 2012). According to reports, a pediatric granule formulation of dolutegravir is currently under development phase and preliminary data investigation also reported the increased exposure of granules when mixed with purified water in comparison to the tablet formulation (Patel, Song and Borland 2012; Song et al. 2012).

2.4. Drug–drug interactions
The dolutegravir pharmacokinetic study evaluated the effect of food on its absorption according to fat content. (Song et al. 2012). Fat content affects the absorption of dolutegravir as noticed by the increased median Tₚ₅₀₀ from 2h to 5h for low, moderate and high-fat meals respectively. Whereas dolutegravir AUC increases from 33 to 66% when administered with low-fat (300 kcal, 7% fat), moderate fat (600 kcal, 30% fat) and high fat food (870 kcal, 53% fat), respectively (Min et al. 2011; Song et al. 2012). But these changes are not expected to affect safety or efficacy. Dolutegravir can be prescribed without any regard to food. Dolutegravir causes drug-drug interactions with integrase inhibitors and some other drugs as shown in Table 1.

2.5. Mechanism of Action
Dolutegravir inhibits HIV integrase enzyme by binding to specific amino acids in the active site and block the strand transfer step which results in no formation of integrated proviral DNA, which is essential for the HIV replication cycle as demonstrated in Figure 4. In this process, the integrase inhibitor chelates with two Mg⁺⁺ ions in the integrase catalytic active site and unable the integrase enzyme to complete the strand transfer (Min et al. 2010). Accumulation of 2-long terminal repeat (2-LTR) circles in treated cells indicate the integrase strand transfer reaction inhibition by less DTG concentration in comparison to that causes cell toxicity (Bar-Magen et al. 2009; Sloan & Wainberg 2011).

2.6. Metabolism/Excretion
Dolutegravir metabolism follows a major pathway CYP3A4 (UGT1A1 glucuronidation) and two minor pathways (UGT1A3 and UGT1A9) catalyse by UDP-glucuronosyl transferase (UGT) 1A1 enzyme as shown in Figure 5. In vitro studies report DTG as neither a cytochrome P₄₅₀ inducer nor an inhibitor. However, dolutegravir is a OCT2 inhibitor (Song, Borland & Chen 2012). Dolutegravir is also a substrate of UGT1A3, UGT1A9, BCRP, and P-gp (ULC, V.H., 2013). It is the predominant circulating compound in plasma and the renal elimination of unchanged drug is extremely low (<1% of the dose). Recovery rate of DTG in feces and urine is approximately 53% and 31% of a dose respectively, primarily as DTG-glucuronide and other minor metabolites (Castellino et al. 2013).

2.7. Dose/Adverse effects
Dolutegravir tablets are usually taken unboosted, orally and without regard to food (Quashie, Sloan & Wainberg 2012). Different dose combination studies with other drugs performed to find the best combination with high resistance barrier as shown in Table 2. Dolutegravir Phase III SPRING-2 trial study showed common adverse effects like nausea, headache, diarrhea, nasopharyngitis and also a slight increase in creatinine level due to inhibition of creatinine secretion. However, it has no effect on glomerular filtration rate (Raffi et al. 2012; Walmsley et al.

![Figure 4: Mechanism of action of DTG.](image-url)
Some common drug-related adverse events such as diarrhea, nausea, and headache also notified during Phase III VIKING-3 trial in treatment-experienced subjects (Walmsley et al. 2012).

### 2.8. Resistance

Dolutegravir (DTG) found to show a higher genetic barrier to resistance than raltegravir and elvitegravir (Tang & Shafer 2012). As such resistance mutations associated with dolutegravir have not yet been identified, but viruses containing G140S, E138K, R148H, R263K, and G140S/Q148HRK mutations have been found to show some level of resistance to dolutegravir (Tang & Shafer 2012; Quashie, Sloan & Wainberg 2012). Raltegravir-resistant virus carries a number of mutations, among which a mutation at position Q148 had more reduced susceptibility to dolutegravir (Underwood et al. 2012). In vitro selection studies reported R263K mutation which commonly emerges in integrase in the presence of dolutegravir. R263K confers low-level resistance against dolutegravir.
and diminishes HIV DNA integration and viral fitness. As well as no secondary mutation H51Y and E138K has been found to compensate for the defects associated with the R263K primary resistance mutation against dolutegravir. All secondary mutations have a modest effect on resistance against this drug (Mesplède et al. 2013; Quashie et al. 2012).

3. Future of Dolutegravir
ViiV Healthcare has requested US regulatory for the approval of a new single-tablet regimen (STR), a combination of dolutegravir, lamivudine and abacavir drugs. According to the company reports, a European regulatory application has also been submitted. In the aforementioned trials this combination worked well as separate pills. So, if approved, this new formulation would give the first single-pill, once-daily regimen that does not contain tenofovir/Emtricitabine and but could be beneficial especially for people suffering from kidney disease or osteoporosis. Results presented at Interscience Conference on Antimicrobial Agents and Chemotherapy (ICAC), also proved the statistical superiority of dolutegravir over darunavir/ritonavir. Based on these findings the researchers conclude that a single pill of dolutegravir may provide a new option for first-line HIV treatment (Boyd & Cooper 2013).

4. Conclusion
HIV-1 integrase enzyme is a unique target for antiretroviral therapy. Dolutegravir, a once-daily HIV strand integrase inhibitor currently approved for HIV-1 infected patients, provides equivalent antiviral efficacy and better tolerability in comparison to the already approved antiretroviral drugs. Incessant efforts are going on for the approval of new single-tablet regimen (STR) containing dolutegravir, abacavir and lamivudine and also it would reduce the number of pills required for effective antiretroviral treatment. Because of its unique mechanism of action, demonstrated virologic activity, resistance profile and tolerability, it is a significant advancement in HIV-1 therapeutics which will help HIV patients in the long run.

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Competing Interests
The authors have no competing interests to declare.

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