Bioequivalence Study of Two Formulations That Contain Isotretinoin 20 mg Capsules in Healthy Colombian Volunteers

Vargas M*, Villarraga E1, Batista M2, Montenegro L1 and Mantilla P3
1Pharmacology Unit, Universidad de la Sabana, Bogotá, Colombia
2Pharmaceutical Chemistry Support, Procaps, Colombia
3Medical Department, Procaps, Colombia

Abstract

This is a pharmacokinetic test of two formulations that contain 20 mg of Isotretinoin, with the aim to compare the bioavailability between the Test Product (Isoface® from Procaps Laboratory SA, Colombia) and the Reference Product (Roaccutane® from Catalent Laboratory Germany, Eberbach GMBH, Germany), to declare the bioequivalence between both formulations. An open, crossed study was developed, randomized, of two periods and two sequences, with 40 mg single dose of isotretinoin, on fasting conditions, on 24 healthy male Colombian volunteers; the washout was 14 days in between each period. To present the results, curves of the plasma concentration ratio vs. Time until hour 72 were performed; with the aim to identify the concentration provided by the Test formulation, the basal status of each volunteer was eliminated from the analysis, which was built with 3 former concentrations to the test medicine administration. The analytical method used in this study was high resolution liquid chromatography with tandem mass spectrometry detector, HPLC MS/MS, for plasma Isotretinoin identification and quantification. The main pharmacokinetic parameters for the Test Product vs. the Reference Product were Tmáx 2.6 vs. 2.8 h, Cmáx 190.5 vs. 186.5 ng/mL for the AUC0-t 3003.8 vs. 2933.5 ng h/mL and AUC0-∞ 3726.3 vs. 3521.2 h ng/mL.

The confidence interval calculation of data with logarithmic transformation, showed confidence intervals for the variables Tmáx, Cmáx, AUC0-t and AUC0-∞, with values between 80-125; values approved by the FDA and EMA European Medicines Agency, in their Bioavailability and Bioequivalence Guides, to accept the Bioequivalence hypothesis between the two formulations in study, and thereby declare Bioequivalence and interchange ability of the Test Product from Procaps Laboratory, with the Reference Product from Roche Laboratory.

Keywords: Bioequivalence; Isotretinoin; Acne; Bioavailability; Pharmacokinetic

Introduction

Retinoids are intracrine and paracrine mediators of the cell differentiation, intervening in the reproduction, proliferation and apoptosis, by binding to the nuclear retinoic receptors. There are two types of retinoic receptors, the RXRs (x retinoid receptors) and the RARs (retinoic acid receptors). Each one of them, is as well divided into a, b and g. All these receptors are structurally alike, but show different affinities towards the different retinoid types, and, their body distribution differs, which explains the multiplicity of physiological processes they intervene [1].

Isotretinoin acts preferably on RAR receptors. Its effects on acne and other dermatological serious conditions are due to its action on the four pathogenetic factors:

- Sebum suppression
- Inhibition of intraductal hyperkeratinisation
- Inhibition of Propionibacterium acnes
- Anti-inflammatory properties

Isotretinoin is absorbed in the gastrointestinal tract, being the interindividual variation considerable in bioavailability. After the 40 mg oral administration of Isotretinoin to fasting healthy volunteers, the maximum plasma concentrations reported ranged from 167-459 ng/mL, reached in 3.2 h [2]; same dose in acne patients caused maximum plasma concentrations ranging from 98-535 ng/mL (average 262 ng/mL) in 2-9 h average [3]. Isotretinoin bioavailability increases from 1½ to 2 times more, when ingested with food. One of the main metabolites, 4-oxo-isotretinoine, is present in maximum plasma concentrations after 6 h of a single dose, remaining constant after 7 days Isotretinoin’s elimination half-life is 7-37 h. The medicine binds to plasma proteins, almost exclusively to albumin (99.9%). Another characteristic of this drug is that it crosses the placental barrier [2,3]. The elimination half-life on healthy subjects after a 40 mg dose ranges from 10-20 h, being up to 90 h on patients who reach stationary states.

The main Isotretinoin metabolites detected in blood and urine are 4-oxo-isotretinoin and 4-hydroxi-isotretinoin, while other glucuronide conjugates are detected in bile. The 4-oxo-isotretinoin half-life is 29
Bioequivalence Study of Two Formulations That Contain Isotretinoin 20 mg Capsules in Healthy Colombian Volunteers

Vargas M, Villarraga E, Batista M, Montenegro L, Mantilla P (2016) Bioequivalence Study of Two Formulations That Contain Isotretinoin 20 mg Capsules in Healthy Colombian Volunteers. J Bioequiv Availab 8: 274-277. doi: 10.4172/jbb.1000308

Isotretinoin’s transportation in plasma occurs through union with albumin. Epidermic concentration is very low, and has not been found a progressive accumulation in serum, epidermic or subcutaneous cell tissue. Once treatment is discontinued, Isotretinoin disappears from serum and skin in 2-4 weeks [2,3]. According to FDA and EMA, two products that contain the same active principle are bioequivalent if they meet the conditions above [4,5].

Materials and Methods

Study Design

It was used an open, randomized, two periods, two sequences, crossed and 14 days washout in between periods design. Three days before the beginning of each period, the volunteers had to abstain from medicines, alcohol and any food or beverage containing methylxanthines. These restrictions were maintained throughout the time that the samples were obtained. All volunteers were randomized to be assigned to the treatment sequence.

Medical examination and laboratory tests: The requested clinical laboratory tests were complete blood count, total and direct bilirubin, creatinine, glucose, total protein, and complete urinalysis, Elisa for HIV, antibodies to hepatitis C and B, and electrocardiogram.

Obtaining informed consent

The Protocol and Informed Consent were authorized by the Ethics Committee in Clinical Investigation (CEIC) of Clinica de La Universidad de La Sabana, which is governed by the legal and ethical guidelines in Resolutions 008430 of 1993 and 002378 of 2008 of the Ministerio de la Protección Social de Colombia [6], the World Conference on Harmonization for good clinical practices in institutions that conduct research in humans, and by the principles of World Medical Assembly published in the Declaration of Helsinki, last reviewed in 2013 [7].

Drug administration

For the drug administration, the volunteers kept fasting for 10 h. A 40 mg [8] dose was ingested with 200 mL of water, meaning 220 mg capsules to each volunteer; and 4 h later, each volunteer was provided with standardized food. During the stay period in the clinic, two meals (breakfast and lunch) and two snacks (one in the morning, one in the afternoon) were provided.

Validation of the analytical method

Validation was performed according to the bioanalytical methodology validation procedure established by QUASFAR M&F SA.

Testing of the analytical method

- Selectivity No interference was evident in the different analysed targets.
- Matrix Effect ±15% of the nominal concentration.
- Calibration proportionality between the response and the level of concentration is evident.
- The lowest curve point does not deviate in ±20% and the other levels do not deviate in ±15%.
- Accuracy ±15% of the nominal concentration.
- Precision ±15% of the nominal concentration.

Calibration: Calibration was performed over enriched samples at levels 10, 50, 100, 150, 300 ng/mL. Applying analytical method, 5 calibration curves were run at different days linear regression was performed to each curve.

Analytical conditions: Quantification limit was 1 ng/mL [3,9,10].

h (11-50 h), being its metabolism performed predominantly in the liver. The 4-oxo-isotretinoin seric concentration is usually higher to isotretinoin after 6 h [2].

Subjects: Before the clinical phase, the volunteers went under medical examination and laboratory tests in order to confirm their health status. Histories of alcoholism, diseases with compromised liver or kidney function, blood dyscrasias or proteinuria were the considered exclusion factors.

Subjects: Before the clinical phase, the volunteers went under medical examination and laboratory tests in order to confirm their health status. Histories of alcoholism, diseases with compromised liver or kidney function, blood dyscrasias or proteinuria were the considered exclusion factors.
Pharmacokinetic analysis

The Pharmacokinetic Analysis was performed by WinNonlin 5.3 program (Pharsight Corporation, Cary USA), adjusted to a non-compartmental analysis. The maximum concentration (C
máx) and the time to reach it (t
máx) were directly obtained from the serum concentrations results, as currently recommended by the FDA [4] and the EMA (European Medicines Agency) [5]. UC total was calculated by the sum of the partial AUC.

- AUC
máx, between time zero and the last time with detectable concentrations, calculated by the trapezoidal rule, and ensuring the calculation of at least the 80% of the AUC with the last sample.

- AUC
máx, calculated as the ratio C/K, being C the last detectable concentration and K the slope of the line, obtained by linear regression, from the points corresponding to the elimination phase of the drug, by linear regression of the natural logarithm of the concentrations [11]. The elimination rate constant (K), half-life (t
½), the clearance (CI) and the mean residence time (MRT), adjusted to Bioavailability, were calculated after the non-compartmental analysis.

Statistical analysis

Variance Analysis (ANOVA) was used to determine possible effects for each variation factor, per sequence, period or subjects. The F-test was used with a statistical significance level of 5% (α=0.05). The statistical comparison of the transformed pharmacokinetic parameters on both formulations was performed using the statistical program WinNonlin version 5.3.

The following bioequivalence criteria were established on the protocol the Confidence Interval of 90% of C máx test/C máx Reference and last test AUC/last reference AUC, relations must be in the range of 80-125% of acceptability Plus, AUC, must not be less than 80% of AUC total [11,12].

Results

24 healthy male volunteers with Colombian nationality completed the two periods and were included in the pharmacokinetic and statistical analyses (Graph 1).

Table 1 shows the pharmacokinetic parameter averages obtained from all volunteers (average ± SD), with both studied formulations. For the pharmacokinetic analysis, the three baseline points were taken (-10,-2 years, 0 h) and an average value was obtained. This average value was eliminated from the obtained individual values for each volunteer and for each formulation, and thus we obtained the plasma concentrations provided by the studied formulations.

Table 2 shows confidence intervals of 90%, of the logarithmically transformed pharmacokinetic parameters, analyzes to determine if bioequivalence exists between Test Product, Isoface® of Procaps SA, and Reference Product, Roaccutane® of Catalent Germany, Eberbach GMBH, Germany.

Discussion

Health resources control is a need for all nations. Bioequivalence studies are the surrogate proof that makes us think with a high degree of probability, that the two generic drugs will have a similar efficacy and safety profile, i.e., are therapeutic equivalents [12].
2. Abo-Talib N, Tammam M, Hassan E (2012) Determination of isotretinoin in human plasma: Application to pharmacokinetic study. Bull Fac Pharmacy 50: 127-132.
3. Agarwal US, Besarwal RK, Bhola K (2011) Oral isotretinoin in different dose regimens for acne vulgaris: A randomized comparative trial. Indian J Dermatol Venereol Leprol 77: 688-694.
4. Food and Drugs Administration (2001) Guidance for industry: Statistical Approaches to Establishing Bioequivalence. U.S. Department of Health and Human Services.
5. The European Agency for the Evaluation of Medicinal Products (EMA) (2001) Committee for Proprietary Medicinal Products (CPMP): Note for Guidance on the Investigation of Bioavailability and Bioequivalence, London, UK.
6. Republic of Colombia Ministry of Health (1993) Why scientific and administrative rules, established techniques for health research. Resolution No. 008430.
7. World Medical Assembly (2013) Declaration of Helsinki of the AMM-Ethical Principles for Medical Research in humans, 64th General Assembly, Fortaleza, Brazil.
8. Jones K, O'Donovan D, Horowitz M, Russo A, Lei Y, et al. (2006) Effects of posture on gastric emptying, transpyloric flow, and hunger after a glucose drink in healthy humans. Dig Dis Sci 51: 1331-1338.
9. U.S. Department of Health and Human Services Food and Drug Administration Center for Drug Evaluation and Research (CDER) Center for Veterinary Medicine (CVM) (2013) Guidance for Industry: Bioanalytical Method Validation.
10. Committee for Medicinal Products for Human Use (CHMP), European Medicines Agency (EMEA) (2009) Guidance on Validation of Bioanalytical Methods, London UK.
11. Perry R (2010) Perspectives on the bioequivalence and therapeutic equivalence of generic formulations: An overview of the landscape. Clin Ther Sep 32: 1796-1797.
12. World Health Organization (2005) Multisource (Generic) Pharmaceuticals Products Guidelines on Registration Requirements to Establish Interchangeability. WHO Technical Report Series.
13. World Health Organization (2006) Public Health: Innovation and Intellectual Property Rights. Commission on Intellectual Property Rights and Public Health pp: 1-188.
14. Julious SA (2004) Tutorial in biostatistics: Sample sizes for clinical trials with normal data. Stat Med 23: 1921-1986.