Lecture 6: Antibiotic agents & Immunomodulators (immunomodulators act very differently)

1. Macrolide antibiotics – generally considered non-cell cycle specific but S-phase sensitive

Dactinomycin (Cosmegen):

![Chemical structure of dactinomycin]

Uses: Wilm’s tumor (nephroblastoma), rhabdomyosarcoma (connective tissue sarcomas), Ewing’s sarcoma (bone and soft tissue sarcomas). Administered IV; very potent agent and often dosed at mcg/kg levels.

Mechanism: Intercalates into DNA very well, dissociates from DNA slowly; and can bind irreversibly through quinone system (see Figure 1). Interferes with the transcription of DNA into mRNA; can also form some reactive oxygen species (ROS) and is a substrate of P450 reductase (more on this later).

Toxicities: Myelosuppression, hepatotoxicity, fatigue, N/V, infection*, local inflammation if extravasation occurs, veno occlusion disease can occur but rarely.

ADME: Long t1/2 due to minimal metabolic breakdown.

Note(s): Originally isolated from various bacteria, especially Streptomyces. *Because dactinomycin is also a bacterial antibiotic, it can interfere with diagnostic assays used to identify the bacteria causing an infection.

Figure 1. Example of an intercalating drug (red and grey) into a DNA helix (green).
**Mithramycin (Plicamycin, Mithracin):** not in the text; withdrawn in 2000*

*Uses:* *Was used for testicular cancer, Paget’s bone disease*. 

*Mechanism:* Not well understood but thought to be like dactinomycin, intercalates into DNA, and can bind irreversibly through quinone system. Interferes with the transcription of DNA in mRNA.

*Toxicities:* Severe myelosuppression (especially thrombocytopenia), hemorrhagic (bleeding syndrome), hepatotoxicity, nephrotoxicity.

*ADME:* Not well studied but excreted rapidly by the kidneys.

*Note(s):* *Now being studied in different cancers and as an inhibitor of metastasis.*

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**Mitomycin (Mutamycin):**

*Uses:* *Gastric cancer, pancreatic cancer, bladder cancer*. Administered IV. Also, intravesically for bladder cancer.

*Mechanism:* Like other macrolide antibiotics, intercalates into DNA, and can bind irreversibly through quinone system. Interferes with the transcription of DNA in mRNA. Can be activated by P450 reductase and NADPH quinone oxidoreductase (NQO1) and for ROS. Also a substrate of thioredoxin reductase.
(see clearance below). However, note presence of aziridine in the molecule. Thus, recent research has shown that mitomycin need not enter the nucleus and it can also inhibit cytosolic ribosomal (rRNA). This can cause inhibition of all (genome wide) translational silencing. This could be the most important mechanism.

**Toxicities:** *Myelosuppression, nephrotoxicity, pulmonary toxicity, mucositis, alopecia; rare but potentially serious cardiotoxicity.*

**ADME:** Metabolism is hepatic and extrahepatic; renal excretion of parent and metabolites is important and about 10% of parent drug excreted renally. Metabolism routes are easily saturated and clearance of the agent is inversely proportional to dose (higher the dose → slower the clearance); recent data (2012) show that mitomycin can irreversibly inhibit thioredoxin reductase.

**Note(s):** *Cardiotoxicity almost always in association with previous anthracycline use.* Remember the important cardiotoxicity of the anthracyclines (daunorubicin, doxorubicin, idarubicin).

**Bleomycin:** actually a mixture but mainly bleomycin A2; isolated commercially as Cu^{++} chelate

![Bleomycin Structure](image)

**Uses:** Hodgkin’s lymphoma as component in **ABVD** (adriamycin/bleomycin/vinblastine/dacarbazine) regimen, **NHL**, squamous head and neck cancer, **testicular cancer**. A small test dose of bleomycin can be given to check for an allergic reaction to the agent prior to full dose.

**Mechanism:** *Intercalates into DNA, then binds DNA covalently.* Importantly, the agent also binds Fe^{++} and in vivo the chelate leads to generation of reactive oxygen species (ROS). Iron can catalyze the addition of electrons to oxygen (see Figure 2).
Figure 2. How molecular oxygen is reduced by stepwise addition of electrons.

![Formation and Elimination of Reactive Oxygen Species (ROS)](image)

**Toxicities:** Myelosuppression, but mild (neutropenia, thrombocytopenia), pulmonary toxicity.* Allergic reaction can occur (rarely) but can lead to anaphylaxis.

**ADME:** *Important inactivating enzyme (bleomycin hydrase); hydrolysis of terminal amide leads to the inactive carboxylate metabolite (change in pKa of amine from 7.3 to 9.4) alters binding to DNA in a major way; low levels of this enzyme in skin and lung tissues.* Finally, typical t1/2 is about 2-4 hrs; renal excretion is important for the agent and impairment of renal function can increase t1/2 to more than 20 hrs.

**Note(s):** Pulmonary toxicity is perhaps the most serious complication of bleomycin. It is specifically involves pulmonary fibrosis. Studies support the role of proinflammatory cytokines (IL-18 and IL-1 beta) in the mechanism of lung injury.

Figure 3. Hydrolysis of terminal amide group produces inactive carboxylate metabolite

![Neutral molecule](image) \[→\] ![Negative charge on molecule](image)
**Immunomodulators** (largely not involved in the cell cycle)

**Thalidomide**

- **Uses**: Mainly multiple myeloma in combination with dexamethasone. Being studied in several other cancers because of new mechanism. Administered PO. Because of its notable toxicity involving teratogenesis (see Toxicities below) a special program is in place that physicians and pharmacists must enter in order to dispense this drug. Program is called STEPS (System for Thalidomide Education and Prescribing Safety).

- **Mechanism**: An immunomodulator and can increase in the number of circulating natural killer cells, and increase plasma levels of interleukin-2 and interferon-gamma. Both these cytokines are associated with cytotoxic activity. Thalidomide also possesses anti-inflammatory and **antiangiogenic properties**.

- **Toxicities**: **Teratogenic** (phocomelia), but also can cause venous **thrombolic events** (deep vein thrombosis and pulmonary emboli). In addition, it can cause **peripheral neuropathy**, **sedation**, **constipation**. **Absence or minimal myelosuppression**. Any agent without myelosuppression is interesting to study further.

- **ADME**: Spontaneously hydrolyses in vivo to multiple “metabolites”; also a substrate of CYP2C19 so potential PM concern. However, pathway is not major. Notice the molecule has a chiral center but it is located adjacent to a carbonyl group. This causes the enantiomers of the molecule to racemize easily in solution. Therefore, there is no rationale for pursuing pure enantiomeric forms as potential drugs.

**Note(s)**: Originally developed as a sedative and an anti-emetic for morning sickness in pregnant women but found to cause extreme birth defects in the late 1950s and early 1960s. Notably, the agent was never approved by FDA. However, some U.S. citizens did get access to the drug in Europe however. Also has some activity against leprosy.

*Angiogenesis is the formation of new blood vessels in tissues. As solid cancers grow they need to generate additional vasculature to supply the growing mass of cells with sufficient nutrients and oxygen. Inhibiting the angiogenesis process with antiangiogenic drugs is therefore a reasonable approach (more on this topic later).
**Lenolinamide (Revlimid):** analog of thalidomide

![Chemical structure of Lenolinamide](image)

**Uses:** Mainly multiple myeloma in combination with dexamethasone, melphalan, and doxorubicin. Being studied in several other cancers, in particular myelodysplastic syndrome (MDS), Hodgkin’s lymphoma, non-Hodgkin’s lymphoma, chronic lymphocytic leukemia, pancreatic cancer. Interestingly, with MDS, the best results of lenalidomide were obtained in patients with deletion 5q*. Administered PO.

**Mechanism:** Multiple anti-cancer effects: A direct anti-tumor effect by inhibition of the microenvironment support for tumor cells, an immunomodulatory role like thalidomide, induces tumor cell apoptosis directly and indirectly by inhibition of bone marrow stromal cell support, anti-angiogenic and anti-osteoclastogenic effects. Nearly 10-fold more potent than thalidomide (e.g. 25 mg for L vs 200 mg for T daily dose).

**Toxicities:** Myelosuppression (neutropenia and thrombocytopenia) is much more severe than that of thalidomide and can be dose-limiting. Can be assumed to be teratogenic because so close in structure to thalidomide. Also causes venous thrombolic events (deep vein thrombosis and pulmonary emboli).

**ADME:** Much less breakdown compared to thalidomide; about 2/3 of the drug is excreted in the urine. Lenolinamide is not a substrate or an inducer of CYP450 enzymes.

**Note(s):** *Approved by the FDA on December 27, 2005 for patients with low or intermediate-1 risk MDS with 5q- with or without additional cytogenetic abnormalities. Presently under review by FDA because it might be associated with an increased incidence of acute myelogenous leukemia and B-cell lymphoma.

**Pomalidomide (Pomalyst):** analog of thalidomide; approved in 2013

![Chemical structure of Pomalidomide](image)

**Uses:** Multiple myeloma.