A first-in-man study to evaluate the safety, tolerability, and pharmacokinetics of pasireotide (SOM230), a multireceptor-targeted somatostatin analog, in healthy volunteers

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Abstract: Pasireotide (SOM230) is a multireceptor-targeted somatostatin analog with high binding affinity for four of the five somatostatin receptor subtypes (sst1,2,3 and sst5), and potential clinical activity in several neuroendocrine and oncologic conditions, including acromegaly, Cushing’s disease, and neuroendocrine tumors (NET). This manuscript reports the first-in-man dose-escalation study of pasireotide, evaluating its safety, tolerability, and pharmacokinetics (PK) in healthy male volunteers. A single dose of pasireotide 1–1200 µg was administered subcutaneously in four to eight subjects per dose level, with two additional subjects per cohort administered placebo. PK and safety evaluations were carried out over 7 days post-dose. Growth hormone (GH) suppression was evaluated using a GH-releasing hormone stimulation test on Day –1 and Day 1 at 3–5 hours post-injection. Seventy-two subjects completed the study. Pasireotide was well tolerated with no serious adverse events observed at any dose. Transient elevations in blood glucose levels were observed 2–6 hours after administration of pasireotide at doses between 200 µg and 1200 µg, but this resolved without intervention by 23 hours post-dosing. The maximum toltable dose was not established within the tested range. Pasireotide demonstrated a favorable PK profile with fast absorption (tmax: 0.25–0.5 hours), low clearance (CL/F: 8–13 L/hour), long effective elimination half-life (mean t½,β: 7–11 hours), and a proportional dose-exposure relationship. GH suppression of 79%–96% was observed at single pasireotide doses between 200 µg and 1200 µg. In conclusion, pasireotide demonstrated favorable safety, tolerability, and PK profiles, as well as promising activity in suppressing the release of GH. The efficacy and safety of pasireotide is currently being evaluated in patients with acromegaly, Cushing’s disease, NET, and various non-neuroendocrine disorders.

Keywords: pasireotide, safety, tolerability, pharmacokinetics, healthy volunteers

Introduction

Pasireotide is a multireceptor-targeted somatostatin analog that exerts its pharmacologic activity through binding to somatostatin receptor subtypes (sst). The rationally designed cyclohexapeptide structure of pasireotide incorporates synthetic amino acids to achieve an enhanced sst binding profile compared with currently available somatostatin analogs octreotide and lanreotide (Table 1, Figure 1). Whereas octreotide and lanreotide bind with greatest affinity to sst2, pasireotide has high binding affinity for four of the five sst.1 Pasireotide has a 39-, 30- and 5-fold higher binding affinity for sst1, sst3, and sst5, respectively, and 2.6 times lower affinity for sst2 compared with octreotide.1 Pasireotide also has a 2-fold higher binding affinity for sst5 than endogenous somatostatin.2,3 More-
over, pasireotide exhibits greater metabolic stability than octreotide because of the presence of a Cys–Cys bridge that protects the stability of the amide bond in the cyclic ring,\textsuperscript{1,4} which may translate into a prolonged pharmacologic effect compared with octreotide.

Because of this unique binding profile and a more metabolically stable chemical structure than octreotide, pasireotide may offer new opportunities for therapeutic application.\textsuperscript{1,5} Pasireotide is being evaluated in patients with acromegaly\textsuperscript{6–9} and neuroendocrine tumors (NET),\textsuperscript{10,11} including patients who are resistant or refractory to octreotide LAR, as well as in medically naïve and/or de novo patients. Pasireotide also has potential to be a tumor-targeted management option for patients with Cushing’s disease, a patient population in whom currently available somatostatin analogs are ineffective. Pasireotide has demonstrated efficacy in patients with Cushing’s disease in a large, randomized, Phase III trial.\textsuperscript{12}

This manuscript reports the results of the first-in-man study investigating the safety, tolerability, pharmacokinetics (PK), and pharmacodynamics (PD) of a single subcutaneous injection of pasireotide administered to healthy volunteers.

### Methods

#### Subjects

Study subjects were male volunteers aged 18–40 years, in good health as determined by a suitable medical history and normal findings from evaluations performed at screening (eg, physical examination, vital signs, electrocardiograph, and laboratory tests). Subjects were enrolled only if their liver function tests, including serum glutamic oxaloacetic transaminase (SGOT, ie, aspartate transaminase) and serum glutamic pyruvic transaminase (SGPT, ie, alanine transaminase), were within the normal range; gamma-glutamyl transpeptidase (GGT) and alkaline phosphatase (ALP) did

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### Table 1 Binding affinities of somatostatin (SRIF-14), pasireotide, octreotide, and lanreotide to the five human sst\textsuperscript{1}

<table>
<thead>
<tr>
<th>Compound</th>
<th>sst\textsubscript{1}</th>
<th>sst\textsubscript{2}</th>
<th>sst\textsubscript{3}</th>
<th>sst\textsubscript{4}</th>
<th>sst\textsubscript{5}</th>
</tr>
</thead>
<tbody>
<tr>
<td>Somatostatin (SRIF-14)</td>
<td>0.93 ± 0.12</td>
<td>0.15 ± 0.2</td>
<td>0.56 ± 0.17</td>
<td>1.50 ± 0.4</td>
<td>0.29 ± 0.04</td>
</tr>
<tr>
<td>Pasireotide</td>
<td>9.3 ± 0.1</td>
<td>1.0 ± 0.1</td>
<td>1.5 ± 0.3</td>
<td>&gt;1000</td>
<td>0.16 ± 0.01</td>
</tr>
<tr>
<td>Octreotide</td>
<td>280 ± 80</td>
<td>0.38 ± 0.08</td>
<td>7.1 ± 1.4</td>
<td>&gt;1000</td>
<td>6.3 ± 1.0</td>
</tr>
<tr>
<td>Lanreotide</td>
<td>180 ± 20</td>
<td>0.54 ± 0.08</td>
<td>14 ± 9</td>
<td>230 ± 40</td>
<td>17 ± 5</td>
</tr>
</tbody>
</table>

Notes: Results are the mean ± SEM of IC\textsubscript{50} values expressed as nmol/L. © European Society of Endocrinology 2002, reproduced with permission.\textsuperscript{1}

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\[1\] Golor et al.

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### Figure 1 Chemical structures of pasireotide, somatostatin (SRIF-14) and other somatostatin analogs.

Notes: The molecular weights of pasireotide free base, somatostatin, octreotide and lanreotide are 1047 kDa, 1638 kDa, 1019 kDa, and 1096 kDa, respectively. The molecular weight of the pasireotide diaspurate salt form is 1313 kDa.
not exceed twice the upper limit of the normal (ULN) range and serum bilirubin did not exceed 27 μmol/L (1.6 mg/dL). Subjects underwent a right-upper-quadrant abdominal ultrasound to rule out any cholelithiasis (symptomatic or asymptomatic gallstone disease).

Subjects were excluded from the trial if they had previous/current gall bladder disease, pancreatic injury/pancreatitis, liver disease/injury, impaired renal function, autonomic dysfunction, acute or chronic bronchospastic disease, a clinically significant drug/atopic allergy or had undergone major gastrointestinal tract surgery. Subjects were also excluded if they had taken any prescription or over-the-counter drugs (excluding paracetamol) within 2 weeks prior to dosing or if they had taken any prescription or over-the-counter drugs within 2 weeks prior to pasireotide administration. Before enrolment into the trial, subjects were to abstain from strenuous physical exercise, alcohol, and caffeine starting 7 days, 72 hours, and 48 hours before pasireotide administration, respectively.

Study design
This was a single-center, randomized, double-blind, placebo-controlled, time-lagged, parallel-group, ascending, single-dose study of pasireotide subcutaneously administered to healthy volunteers. Pasireotide was administered between 8 am and 9 am, approximately 1 hour after eating a light standardized meal. As such, the effect of pasireotide on blood glucose was investigated in a post-prandial state.

The study design called for eight subjects each to be randomized into seven cohorts of pasireotide 1, 2.5, 10, 30, 100, 300, or 600 μg administered subcutaneously. Of these eight subjects, six in each cohort were to receive pasireotide and two were to receive placebo. A dispensing error resulted in four subjects being administered 200 μg pasireotide instead of 100 μg pasireotide. A protocol amendment allowed administration of 100 μg pasireotide to be restudied in new subjects, and an additional cohort administered 1200 μg pasireotide was included.

Pasireotide doses were administered to cohorts in ascending order. Before escalation to the next cohort, at least six subjects from the previous cohort had to demonstrate adequate safety/tolerability for up to 48 hours post-dose. Subjects were confined to the study center from approximately 36 hours before administration until the availability of 48-hour post-dose safety results.

The study was randomized by a validated system. All subjects provided informed consent, and the study was conducted in accordance with the Declaration of Helsinki (World Medical Association Inc, Ferney-Voltaire, France).

Study medication
Doses of 1, 2.5, 10, 30, 100, 300, 600, and 1200 μg of pasireotide were administered subcutaneously. Pasireotide was provided as either 0.15 mg or 3 mg per 3 mL vials. For the 1 μg and 2.5 μg doses, pasireotide solutions were prepared by diluting a 0.15 mg per 3 mL solution 5-fold in the matching placebo solution to a final concentration of 0.03 mg per 3 mL; doses of 1 μg and 2.5 μg were then administered as 0.1 mL and 0.25 mL of the 5-fold diluted solution. Doses of 10 μg and 30 μg were administered as 0.2 mL and 0.6 mL of the 0.15 mg per 3 mL solution, respectively, while doses of 100, 200, 300, 600, and 1200 μg were administered as 0.1, 0.2, 0.3, 0.6, and 1.2 mL of the 3 mg per 3 mL solution, respectively.

Safety, PK, and PD assessments
The primary objective of the study was to evaluate the safety and tolerability of a single subcutaneous dose of pasireotide in healthy subjects. Safety was assessed continuously throughout the study by physical examination, vital signs, blood pressure, laboratory parameters, and electrocardiogram (ECG) recordings at screening, baseline, regular intervals throughout the study day, and at the end-of-study visit (Day 7). Hematology, blood chemistry and urinalysis evaluations were also performed regularly. Adverse events (AEs) were recorded throughout the study, as reported by patients, identified by investigator questioning, or detected through physical examination, laboratory test or other means. Abnormal laboratory values were considered as AEs only if they produced clinical signs or symptoms, or required therapy. Serious AEs (SAEs) were recorded up to 4 weeks after the conclusion of the trial.

The secondary objectives were to assess the PK and PD profiles associated with a single dose of pasireotide, and to identify the pharmacologically active range of pasireotide doses. Blood samples for PK assessment were taken at designated time points up to 144 hours post-dose by either direct venipuncture or an indwelling cannula inserted in a forearm vein. Plasma samples were obtained after centrifugation of blood samples. Plasma concentrations of pasireotide were determined by a validated radioimmunoassay with the lower limit of quantification (LLOQ) of 0.03 ng/mL (30 pg/mL). PK parameters were derived by non-compartmental analysis using WinNonlin software (v 5.2; Pharsight Corporation, Mountain View, CA) and included maximum observed plasma concentration after drug administration (Cmax), time to reach Cmax (tmax), half-life (t1/2α, t1/2β, t1/2p), area under the plasma concentration-time
curve calculated to the last quantifiable concentration point (AUC_{last}), area under the plasma concentration-time curve extrapolated to infinity (AUC_{inf}), apparent volume of distribution (V/F), and apparent total body clearance (CL/F). All blood samples taken for laboratory samples were assessed centrally by W & T GmbH (Berlin, Germany).

A growth hormone-releasing hormone (GHRH) stimulation test was performed on Day −1 and 3–5 hours after pasireotide administration on Day 1 for PD assessment. Subjects were administered a GHRH bolus of 1 µg/kg at approximately 3 hours after pasireotide administration. Plasma GH levels were obtained at −60 minutes and 0 minutes (just before injection of GHRH), and at designated time points up to 120 minutes after GHRH administration (ie, up to approximately 5 hours after pasireotide administration). Plasma GH levels were determined by a chemiluminescence assay with a LLOQ of 0.06 ng/mL.

Blood glucose measurement was part of the standard laboratory assay. Blood glucose levels were measured immediately before and 60 minutes after a standard lunch on Day −1 and Day 1, as well as 2 hours after pasireotide administration on Day 1, to evaluate possible drug effects on glycemia. Glucose levels were also measured on Day 2 at 23 hours after pasireotide administration.

Statistical analyses

Descriptive statistics were provided for vital signs, ECG evaluations, standard clinical laboratory evaluations, and AEs. The assessment of safety/tolerability was based on the frequency of AEs and on the number of laboratory values that fell outside pre-determined ranges.

All concentrations below the LLOQ were treated as zero in the concentration data listings. Summary descriptive statistics were provided for PK parameters. In order to determine the dose-proportional relationship for the PK exposures (C_{max}, AUC_{last} and AUC_{inf}), linear models were fitted on the log-transformed PK parameters with log-transformed dose as the independent variable (Equation 1):

\[ \ln(\text{PK parameter}) = \ln(a) + b \times \ln(\text{dose}) + \text{error} \] (1)

The slope b and the relative 90% confidence interval (CI) for b were estimated. Given the dose–range ratio considered (highest dose/lowest dose = Rd), the critical region, within which the 90% CI for the slope needs to be contained in order to conclude dose proportionality, can be derived as 1 + ln(0.8)/ln(Rd), 1 + ln(1.25)/ln(Rd), where (0.80, 1.25) is the standard acceptance interval for Rd.

Lack of fit of the model was tested for deviation from linearity on the log scale at the 5% significance level. This was done by adding a factor (dose) in the log-transformed linear regression model. The type I test for dose is the test for lack of fit. The final dose range kept in the model was the one for which the lack of fit test did not meet the 5% significance level.

The relationship between the dose of pasireotide and the effect on GHRH-stimulated GH secretion was investigated using appropriate graphical and exploratory statistical methods. Analysis of the data was performed using SAS® (v 8.2; SAS Institute Inc, Cary, NC). The GH ratio was calculated as the 2-hour GH AUC (AUC_{2h}; taken between 3–5 hours post-dose) in each dose group divided by the 2-hour AUC on the control day (Day −1). A non-linear E_{max} sigmoid model (Equation 2) was used to describe the relationship between the pasireotide dose and the GH AUC ratio, where E_{max} is the maximum GH reduction and ED_{50} is the pasireotide dose to yield half of the maximum GH reduction:

\[ \text{GH ratio AUC} = \frac{\text{AUC}_{2h,\text{treat}}}{\text{AUC}_{2h,\text{cont}}} = 1 - \frac{\text{E}_{\max}}{\text{ED}_{50} + \text{dose}} \] (2)

A similar analysis was performed using the equation above (Equation 2) with the average pasireotide plasma concentration over the 2-hour window during the GHRH challenge test (C_{avg}) as the independent parameter in place of dose, and EC_{50} (defined as the pasireotide concentration to yield half of the maximum GH reduction) in place of ED_{50}.

Results

Subject demographics

Seventy-two healthy male subjects were enrolled. All subjects completed the study for one in the lowest pasireotide dose cohort (1 µg) who did not return for the end-of-study visit. The demographic details of the volunteers are summarized in Table 2. All 72 subjects were included in all analyses.

Safety/Tolerability

Pasireotide was generally well tolerated and there were no reports of death, SAEs, or clinically significant changes in laboratory values, vital signs or ECG parameters. Nine subjects experienced a total of 12 AEs, eight of which were considered related to the study drug. Drug-related AEs were observed in the 1200 µg dose group only. Five AEs were of moderate severity and seven AEs were considered mild.

Among subjects administered pasireotide at doses lower than 1200 µg, two experienced an AE (one subject experienced two episodes of abdominal discomfort with pasireotide...
### Table 2 Demographic characteristics for all subjects included in the study

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Placebo</th>
<th>Pasireotide 1</th>
<th>Pasireotide 2</th>
<th>Pasireotide 3</th>
<th>Pasireotide 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Race, n (%)</strong></td>
<td>7.2 (6.3–7.9)</td>
<td>7.9 (7.0–8.6)</td>
<td>7.4 (6.9–8.1)</td>
<td>7.3 (6.8–8.0)</td>
<td>7.3 (6.8–8.0)</td>
</tr>
<tr>
<td><strong>Body frame, n (%)</strong></td>
<td>7.3 (6.9–7.8)</td>
<td>7.3 (6.9–7.8)</td>
<td>7.3 (6.9–7.8)</td>
<td>7.3 (6.9–7.8)</td>
<td>7.3 (6.9–7.8)</td>
</tr>
</tbody>
</table>
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Pharmacokinetics

At a dose of 1 µg, pasireotide concentrations were below the LLOQ (0.03 ng/mL) and this dose was therefore excluded from the calculation of PK parameters. As shown in Figure 2 following a single dose of pasireotide 2.5–1200 µg, the mean plasma concentration versus time profiles of pasireotide appeared to demonstrate mono-exponential disposition for doses 2.5–10 µg (with an α phase), bi-exponential disposition for doses 30–300 µg (with α and β phases), and tri-exponential disposition for doses 600–1200 µg (with α, β, and γ phases), which appeared to depend on the pasireotide plasma concentration levels in reference to the LLOQ of 0.03 ng/mL.

As shown in Table 3, the \( t_{1/2} \) values of pasireotide in the α phase \( (t_{1/2,\alpha}; 1–2 \text{ hours}) \) and β phase \( (t_{1/2,\beta}; 7–11 \text{ hours}) \) were similar across dose levels. The mean values of \( t_{1/2} \) in the γ phase \( (t_{1/2,\gamma}) \) were 31.7 hours and 65.8 hours for the 600 µg and 1200 µg doses, respectively. Since the partial AUC in the γ phase at the higher dose levels (600 µg and 1200 µg) contributed <15% of the total AUC, the \( t_{1/2,\gamma} \) could be considered as the effective elimination \( t_{1/2} \).

The peak concentration \( C_{\text{max}} \) was achieved rapidly, with \( t_{\text{max}} \) occurring at approximately 0.25–0.5 hours post-dose. PK exposures \( (C_{\text{max}}, \text{AUC}_{\text{last}}, \text{and } \text{AUC}_{\infty}) \) were increased as the dose increased. The mean value of CL/F was 8–13 L/hour across the tested doses from 100 µg to 1200 µg. Depending on which phase was the detectable terminal phase, the mean values of V/F varied across doses: 40 L for the low doses (10 µg); 100–180 L for the intermediate doses (30–300 µg); and 450–1200 L for the higher doses (600–1200 µg).

The dose proportionality assessments based on statistical analyses were performed for PK exposures \( (\text{AUC}_{\infty}, \text{AUC}_{\text{last}}, \text{and } C_{\text{max}}) \), Table 4. Across the dose range from 2.5 µg to 1200 µg, all three PK exposure parameters exhibited good proportionality with the regression slope values in the log(exposure)-dose model being close to one, although statistically the 90% confidence limits for the slopes fell slightly outside the pre-defined acceptance boundary (0.964, 1.036). Considering the variability and small sample size per dose group, the slight statistical deviations from proportionality were not considered clinically significant. Therefore, the PK exposures \( (\text{AUC}_{\infty}, \text{AUC}_{\text{last}}, \text{and } C_{\text{max}}) \) of pasireotide could be considered to be approximately dose proportional.

Pharmacodynamics

On Day 1 in the placebo group, the mean GH AUC \( _{2h} \) was 22.7 ng·h/mL. No reduction in GH AUC \( _{2h} \) was observed with pasireotide doses between 1 µg and 10 µg. The GH AUC \( _{2h} \) decreased by approximately 45% in subjects administered pasireotide 30–100 µg. At pasireotide doses of 200 µg and higher, the GH AUC \( _{2h} \) values decreased substantially to between 4.6 ng·h/mL and 1.0 ng·h/mL. As shown in Table 5, suppression of GH AUC \( _{2h} \) was seen with pasireotide 200, 300, 600, and 1200 µg.

The dose-response (defined as GH AUC reduction) and exposure-response relationships of pasireotide were well fitted by a direct inhibitory effect sigmoid E_{max} model (Table 6). The pasireotide dose to yield half the maximal GH reduction \( (\text{ED}_{50}) \) was estimated to be 70.7 µg (approximate 95% confidence interval [CI]: 51.4–97.3 µg). The average pasireotide concentration expected to yield half the maximal
GH reduction (EC₅₀) was 0.3 ng/mL (approximate 95% CI: 0.2–0.7 ng/mL).

Discussion

Following subcutaneous injection, pasireotide was well tolerated in healthy volunteers at doses up to 1200 µg. Among subjects receiving a dose of pasireotide ≤600 µg, two experienced an AE, neither of which was considered related to pasireotide. All six subjects who were administered pasireotide 1200 µg experienced drug-related AEs, with nausea being the most frequently reported. These events were mild to moderate in severity and did not require intervention. No SAEs were observed in any dose group.

No subjects had clinically significant changes in laboratory parameters, vital signs, and ECG findings between administration of pasireotide and the end-of-study evaluation. Single doses of pasireotide 200–1200 µg were associated with glucose elevations in the first 2–6 hours post-dose compared with placebo, but this effect was transient and resolved within 23 hours post-dose, at which time glucose levels were normal for all groups. This profile is similar to the well-established safety profiles of currently available somatostatin analogs.13–17

Similar elevations in blood glucose levels have been observed in clinical trials of subcutaneous pasireotide (200–900 µg bid) in patients with Cushing’s disease2,18 and acromegaly.7

The PK profile of pasireotide was characterized by fast absorption, low clearance, long half-life, and extensive distribution in healthy volunteers. Compared with octreotide, which has a mean t½ of approximately 1.7 hours,19 pasireotide has a much longer half-life, which is not surprising considering that its chemical structure is more metabolically stable than that of octreotide. Pasireotide concentrations showed multi-exponential declines following a subcutaneous injection, and the γ phase was not always observed at low dose levels. Since the γ phase only contributes a small portion of the total AUC, it is appropriate to consider that the effective elimination t½ is similar to the t½,γ of approximately 7–11 hours. Based on this effective elimination t½, subcutaneous pasireotide is suitable for a twice-daily (bid) dosing regimen, which is less frequent than subcutaneous octreotide (3–4 times/day dosing) and can thus provide greater convenience.

Table 3 Summary of pharmacokinetic parameters in healthy subjects administered a single subcutaneous dose of pasireotide 2.5–1200 µg

<table>
<thead>
<tr>
<th>Dose (µg)</th>
<th>n</th>
<th>tmax (h)</th>
<th>Cmax (ng/mL)</th>
<th>AUClast (ng⋅h/mL)</th>
<th>AUC (ng⋅h/mL)</th>
<th>CL/F (L/h)</th>
<th>t1/2α (h)</th>
<th>t1/2β (h)</th>
<th>t1/2γ (h)</th>
<th>Vz/F (L)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.5</td>
<td>6</td>
<td>0.25 (0.25–0.50)</td>
<td>0.06 ± 0.01</td>
<td>0.11 ± 0.09</td>
<td>NA*</td>
<td>NA*</td>
<td>2.6 ± 1.4</td>
<td>NA*</td>
<td>NA*</td>
<td>NA*</td>
</tr>
<tr>
<td>10</td>
<td>6</td>
<td>0.25 (0.25–0.25)</td>
<td>0.24 ± 0.06</td>
<td>0.66 ± 0.25</td>
<td>NA*</td>
<td>NA*</td>
<td>2.0 ± 0.5</td>
<td>NA*</td>
<td>NA*</td>
<td>38 ± 0.0</td>
</tr>
<tr>
<td>30</td>
<td>6</td>
<td>0.25 (0.25–0.50)</td>
<td>0.72 ± 0.17</td>
<td>2.78 ± 1.02</td>
<td>NA*</td>
<td>NA*</td>
<td>2.2 ± 0.8</td>
<td>7.4 ± 2.2</td>
<td>NA*</td>
<td>105.0 ± 5.7</td>
</tr>
<tr>
<td>100</td>
<td>8</td>
<td>0.50 (0.25–0.50)</td>
<td>2.23 ± 0.45</td>
<td>9.10 ± 2.37</td>
<td>9.59 ± 2.44</td>
<td>11.00 ± 2.67</td>
<td>1.6 ± 0.3</td>
<td>8.1 ± 1.4</td>
<td>NA*</td>
<td>131.0 ± 41.0</td>
</tr>
<tr>
<td>200</td>
<td>4</td>
<td>0.38 (0.25–1.00)</td>
<td>3.73 ± 0.90</td>
<td>16.8 ± 6.65</td>
<td>17.5 ± 3.82</td>
<td>11.90 ± 2.56</td>
<td>1.7 ± 0.6</td>
<td>7.8 ± 2.1</td>
<td>NA*</td>
<td>161.5 ± 33.9</td>
</tr>
<tr>
<td>300</td>
<td>6</td>
<td>0.38 (0.25–1.50)</td>
<td>4.71 ± 1.79</td>
<td>26.0 ± 6.87</td>
<td>27.1 ± 6.98</td>
<td>11.9 ± 3.88</td>
<td>2.4 ± 0.7</td>
<td>10.7 ± 1.0</td>
<td>NA*</td>
<td>180.5 ± 4.43</td>
</tr>
<tr>
<td>600</td>
<td>6</td>
<td>0.50 (0.25–1.00)</td>
<td>15.6 ± 3.25</td>
<td>75.6 ± 11.2</td>
<td>78.6 ± 12.3</td>
<td>7.82 ± 1.39</td>
<td>2.2 ± 0.6</td>
<td>9.1 ± 5.2</td>
<td>31.7 ± 6.5</td>
<td>464.0 ± 439.6</td>
</tr>
<tr>
<td>1200</td>
<td>6</td>
<td>0.50 (0.50–1.00)</td>
<td>22.2 ± 5.53</td>
<td>90.4 ± 13.2</td>
<td>93.6 ± 13.6</td>
<td>13.1 ± 2.09</td>
<td>1.7 ± 0.4</td>
<td>9.1 ± 2.1</td>
<td>65.8 ± 69.5</td>
<td>1190.0 ± 1572.3</td>
</tr>
</tbody>
</table>

Notes: *Not applicable due to limited data points in the terminal phase or the number of subjects with available parameters was less than 50% of the total enrolled subjects

Abbreviations: AUC, area under the concentration–time curve; CL/F, apparent total body clearance; LLOQ, lower limit of quantification.

Table 4 Summary of linear regression values between log-parameters and log-dose (doses of pasireotide 2.5–1200 µg)

<table>
<thead>
<tr>
<th>PK parameters</th>
<th>Slope</th>
<th>Confidence interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>AUC, (ng⋅h/mL)</td>
<td>1.01</td>
<td>0.93 - 1.08</td>
</tr>
<tr>
<td>AUClast, (ng⋅h/mL)</td>
<td>1.14</td>
<td>1.09 - 1.19</td>
</tr>
<tr>
<td>Cmax, (ng/mL)</td>
<td>0.96</td>
<td>0.93 - 1.00</td>
</tr>
</tbody>
</table>

Abbreviations: AUC, area under the concentration–time curve; Cmax, maximum observed plasma concentration after drug administration.

Table 5 Percentage change in median GH AUC₂₄h by dose group following a single subcutaneous dose of pasireotide or placebo

<table>
<thead>
<tr>
<th>Dose (µg)</th>
<th>n</th>
<th>Change in median GH AUC₂₄h, %</th>
<th>Range of change in median GH AUC₂₄h, % min, max</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.5</td>
<td>6</td>
<td>−1.9</td>
<td>−74.4, 170.0</td>
</tr>
<tr>
<td>10</td>
<td>6</td>
<td>8.1</td>
<td>−76.3, 33.6</td>
</tr>
<tr>
<td>30</td>
<td>6</td>
<td>23.8</td>
<td>−41.5, 125.8</td>
</tr>
<tr>
<td>100</td>
<td>8</td>
<td>1.0</td>
<td>−26.1, 70.4</td>
</tr>
<tr>
<td>200</td>
<td>4</td>
<td>−45.3</td>
<td>−66.5, 24.7</td>
</tr>
<tr>
<td>300</td>
<td>6</td>
<td>−46.2</td>
<td>−72.8, 575.9</td>
</tr>
<tr>
<td>600</td>
<td>6</td>
<td>−79.1</td>
<td>−85.3, −67.9</td>
</tr>
<tr>
<td>1200</td>
<td>6</td>
<td>−86.7</td>
<td>−93.6, −64.9</td>
</tr>
</tbody>
</table>

Abbreviations: AUC, area under the concentration–time curve; GH, growth hormone.
nience and potentially lead to improved patient compliance during long-term treatment.

The exploratory GHRH stimulation test demonstrated that pasireotide has dose-dependent activity in suppressing GH secretion. The effect was not evident at the lower doses (1, 2.5, and 10 μg), and only a small effect was observed for the 30 μg and 100 μg doses. The suppression of GH secretion was significant for the higher dose levels (≥200 μg), suggesting that the exposure achieved at pasireotide doses ≥200 μg may be therapeutic for GH suppression. A Phase II study in patients with acromegaly has confirmed these findings, and a large, randomized, Phase III trial using a long-acting formulation of pasireotide (pasireotide long-acting release) is ongoing. It is possible that the administration of high doses of pasireotide could induce GH suppression in patients with normal GH levels prior to treatment (ie, patients with Cushing’s disease), and further investigation in future studies may be of interest.

Conclusion

In summary, pasireotide demonstrated good safety, tolerability, and PK profiles in healthy volunteers. The enhanced binding profile of pasireotide, targeting SST1,2,3 and SST5, makes this agent a potential therapy for patients with acromegaly and NET who are untreated or refractory/resistant to octreotide or lanreotide, a potential therapy for patients with acromegaly and NET who have carcinoid syndrome.

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Disclosure

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