

Methotrexate

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Methotrexate (MTX), a structural analogue of folic acid, that inhibits cell division (mainly in the S phase of the cell cycle) is commonly used for the treatment of many cancers as well for severe and resistant forms of autoimmune pathologies and inflammatory disorders. This paragraph of clinical overview presents state of knowledge with regards to different pathways of MTX active transport system, mechanisms of action and its applications as immunosuppressive drug and anticancer agent.

Keywords: methotrexate ; immunosuppressive drug ; anticancer drug ; mechanism ; disease modifying anti-rheumatic drug

1. Introduction

MTX is an anti-metabolite (anti-vitamin) of folic acid (FA, vitamin B9), which acts as anticancer agent and immunosuppressant ^{[1][2]}. MTX indirectly inhibits cell division through the blockage of folate-related enzymes, mainly DHFR, that catalyses the conversion of dihydrofolate to tetrahydrofolate (THF). THF serves as a significant coenzyme in several transmethylation reactions in pyrimidine and purine nucleotide synthesis pathways, essential in synthesis, repair or replication of DNA strands ^{[3][4]}. Actually, the methyl-THF acts as proximal methyl donor in numerous methylation reactions of DNAs, RNAs, proteins, phospholipids and amino acids syntheses. Inhibition of intracellular THF production by MTX results in disruption of cell proliferation and its metabolic imbalance.

MTX crosses the biological barriers very poorly, being highly ionized and generally hydrophilic. Bioavailability and biodistribution of the drug are determined by an active transport system ^{[5][6]}. Intestinal tissue adsorption of MTX occurs by the proton-coupled folate transporters (PCFTs), which are a solute carrier transporter, while a cellular drug penetration is followed mainly by the reduced folate carrier 1 (RFC1), an ATP-binding cassette transporter. To a small extent, MTX also uses receptor-mediated endocytosis via folate receptors (FRs), the glycosyl-phosphatidyl-inositol (GPI)-anchored membrane proteins that may internalize bound folates and folate conjugates ^{[7][8]}. Intracellularly, MTX is metabolized by folylpolyglutamyl synthase (FPGS) to a polyglutamate derivatives (MTX_{Glu}), that show significantly increased cell residence time and bioactivity in comparison to initial MTX form (Figure 1) ^{[9][10][11]}. This is a key pharmacokinetic step that determines the attributed effect of this drug, defining MTX as a representative type 1 prodrug, that undergoes bioactivation inside the cell ^[12]. Polyglutamated MTX is a superior anti-folate agent than MTX, capable of highly potent DHFR inhibition. Moreover, it also induces inhibition of other enzymes like thymidylate synthase (TYMS) ^[13], 5-aminoimidazole-4-carboxamide ribonucleotide transformylase (AICART) ^{[14][15]} and amido-phosphoribosyltransferase ^{[16][17]} participating in de novo biosynthesis of purine and pyrimidine nucleotides. Consequently, it is MTX_{Glu} that deprives a cell of precursors for the synthesis of DNA and RNA necessary for cell proliferation (Figure 1), leading to DNA synthesis disturbances and subsequent cell apoptosis ^[18]. It should not be surprising that MTX activity is most visible in actively dividing cells, mainly in the S phase of the cell cycle, and in fact, that highly proliferating cancer cells are the most susceptible to the cytotoxic effect of this drug, indicating that antagonism of folate is related with the anti-tumour activity of MTX.

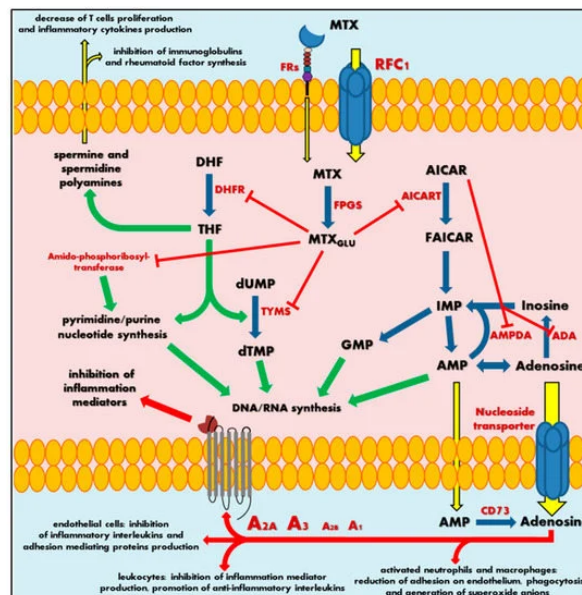


Figure 1. Scheme of mechanism of methotrexate action. MTX—methotrexate; MTX_{Glu}—polyglutamated methotrexate; FRs—folate receptors; RFC₁—reduced folate carrier 1; FPGS—folypolyglutamyl synthase; DHF—dihydrofolate; DHFR—dihydrofolate reductase; THF—tetrahydrofolate; dUMP—deoxyuridine monophosphate; TYMS—thymidylate synthase; dTMP—deoxythymidine monophosphate; DNA—deoxyribonucleic acid; RNA—ribonucleic acid; AICAR—5-aminoimidazole-4-carboxamide ribonucleotide; AICART—5-aminoimidazole-4-carboxamide ribonucleotide transformylase; FAICAR—5-formamidoimidazole-4-carboxamide ribonucleotide; IMP—inosine monophosphate; GMP—guanosine monophosphate; AMPDA—adenosine monophosphate deaminase; ADA—adenosine deaminase; AMP—adenosine monophosphate; CD73—ecto-5'-nucleotidase; A₁, A_{2A}, A_{2B} or A₃—adenosine receptors. Green arrows represent stimulation, red arrows and sticks represent inhibition, blue arrows represent biochemical conversion, yellow arrows represent migration.

At the same time, the continuous action of MTX polyglutamates in cellular biochemistry results in intracellular accumulation of 5-aminoimidazole-4-carboxamide ribonucleotide (AICAR) by AICART inhibition. AICAR has an ability to diminish activity of adenosine deaminase (ADA) and adenosine monophosphate (AMP) deaminase (AMPDA) as well (Figure 1) [14]. An MTX-mediated excess of AICAR promotes the AMP and adenosine increase and subsequent release of these adenine derivatives outside the cell.

2. Methotrexate—Mechanisms of Drug Action

Extracellularly, AMP follows easily dephosphorylation to adenosine via ecto-5'-nucleotidase, also known as the CD73 enzyme [19]. Adenosine, a significant signalling agent that modulates diverse physiological functions, acts as major mediator of anti-inflammatory action associated with MTX. In the local extracellular space, adenosine might interact with its specific receptors (A₁, A_{2A}, A_{2B} or A₃) present on the surface of the origin tissue, but also on immune system cells (Figure 1). Adenosine receptors belong to the seven-transmembrane receptor family, mediating signals into the cell by coupled specific G proteins depending on the receptor subtype. In RA patients, the occurrence of adenosine-specific receptors on immune and synovial cells is elevated, especially A_{2A} and A₃ that highly mediate adenosine regulation of immune response and inflammation [20][21][22][23]. The adenosine action on A_{2A} and A_{2B} stimulates intracellular production of cyclic adenosine monophosphate (cAMP), a significant cellular second messenger, while stimulation of A₃ induces phospholipases C and D or inhibits adenylate cyclase producing cAMP. As a result, adenosine in activated neutrophils and macrophages reduces their ability of adhesion on endothelium and phagocytosis as well as generation of superoxide anions and further reactive oxygen species [24][25]. Moreover, leukocytes decrease the production of tumour necrosis factor α (TNF- α) and interleukin (IL)-12—the mediators of inflammation—and promotes anti-inflammatory IL-4 and IL-10. Additionally, it is observed that an inhibition of IL-1 action and suppression of TNF- α excretion in T cells and macrophages inhibit the prostaglandins and leucotrienes syntheses [25][26][27][28][29][30][31]. At the same time, adenosine disrupts the cytokine-mediated inflammation in endothelial cells by decrease in production of IL-6 and IL-8 and hindering leukocytes' adhesion [32].

Thus, an adenosine-mediated effect seems to be a key mechanism in MTX anti-inflammatory action. Nevertheless, the MTX_{Glu} also has some other impact on immune chemotaxis and reduction of the occurrence of inflammation mediators. Sustained decrease of THF-mediated methylation downregulates an accumulation of spermine and spermidine polyamines in the extracellular fluids and lymphocytes of patients with RA [33][34]. These polyamines are essential cellular

growth factors among others in lymphocytes. MTX action inhibits T cell proliferation and synthesis of immunoglobulins or rheumatoid factor in RA patients ^{[35][36]}, followed by a local reduction in lymphocytes interferon (IFN)- γ and IL-2 production, decrease of inflammation, convergent to adenosine receptor-mediated effects.

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