

# **Title      Overview of Model building strategies in population PK/PD analyses: 2002 to 2004 literature survey**

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## **What is already known about this subject?**

The reviews already published on population PK/PD analyses, focused on theory and presented some clinical applications, evaluated validation practices in limited circumstances, defined interest and sometimes complexity of this approach in drug development or proposed a list of relevant articles. None of them has proposed to exhaustively evaluate published analyses and more precisely the model building steps. Considering statistical complexity of population PK/PD methodology, how models are build and how they are reported in the literature deserves much more attention.

## **What this study adds.**

With a strict methodology and by establishing a standardized tool, this survey provides an exhaustive, objective and recent review of model building practices. It reveals also deficiencies in information reporting for a majority of articles and real needs of guidance for publishing. In this context, we suggest a first and very minimal list of items, which can be used for authors and reviewers in pharmacology journals. We believe that value of future published peer reviewed papers could largely be improved by asking the authors to systematically address the suggested item list.

## Structured summary

**Aims:** We conducted a descriptive survey of published population pharmacokinetic and/or pharmacodynamic (PK/PD) analyses from 2002 to 2004 and evaluated how model building was performed then reported.

**Methods:** We selected 324 articles in Pubmed using defined keywords. We then built a Data Abstraction Form (DAF) comprising two parts: general characteristics including article identification, context of the analysis, description of clinical studies from which the data arose, and model building, including description of the processes of modelling. The papers were examined by two readers who extracted the relevant information and transmitted it directly to a MySQL database, from which a descriptive statistical analysis was performed.

**Results:** Most published papers concerned patients with severe pathology and therapeutic classes suffering from narrow therapeutic index and/or high PK/PD variability. Most of the time, modelling was performed for descriptive purpose, with rich rather than sparse data and using NONMEM software. PK and PD models were rarely complex (1 or 2 compartments for PK ; Emax for PD models). Covariates testing was frequently performed and essentially based on the likelihood ratio test. Based on a minimal list of items that should systematically be found in a population PK-PD analysis, it was found that only 39% and 8.5% of the PK and PD analyses published from 2002 to 2004 provided enough details to support the model building methodology.

**Conclusions:** This survey allowed to describe efficiently published population analyses in recent years but revealed also, deficiencies in reporting information on model building.

## Introduction

The earliest work in the field of population pharmacokinetics (PK) appeared in the late 1970's [1;2]. During the 1990's, the number of papers describing the population approach applied to pharmacodynamics (PD) and dose-effect models increased dramatically [3]. Recently, the number of population PK/PD publications has escalated even further. Success in this field can be attributed to the fact that this approach, which can be performed using different techniques (two-stages, non linear mixed effect models, Bayesian hierarchical model), has largely improved efficiency of PK analyses. It leads to quantification of variability and identification of relevant covariates by modelling the PK of a typical patient associated with different levels of variability. The population approach allows to collect integrated information on PK from only a few measurements per subject and it can be applied easily in the clinic and in drug development [4-8]. In the clinic, the population approach can provide prior information for hospital therapeutic drug monitoring; it allows studying PK and/or PD in specific populations of patients, to understand and anticipate drug interactions or tolerances to treatment, and to study compliance issues in oral and long term therapies. In drug development, where it is promoted by drug authorities, it is frequently used along the development to combine data from different clinical trials and is also used in the application process [9-12]. Coupled with Monte-Carlo simulations, it can be used to optimize future clinical trials according to number of patients, inclusion and exclusion criteria, dosage regimen, study length, dates of visits, toxicity and efficacy.

The main drawback of population PK/PD methodology is its statistical complexity [4;13]. It requires the use of many models (structural, inter-individual, intra-individual, and

covariate), numerous statistical assumptions (random and fixed effects distribution) as enumerated by Karlsson *et al* [14], and a variety of estimation methods (algorithms and approximations) [15;16]. In this context, population analyses should be performed carefully and must be precisely reported [17-19]. Ideally, this description should include the purpose of the model and possible model applications, a relevant description of the data used for model building and description of their exploratory examination, a listing of model building steps, a description of all sub-models, of the final model, and of the qualification process [11], the perspective being to allow an independent modeller (with access to the data) to redo the analysis. Faced with the aforementioned complex issues, the quality and completeness of published analyses vary largely between papers. In the 90's, a first exhaustive review of the literature from 1977 to 1996 was performed by Mentré and Ebelin to illustrate and comment on these different points [3].

The main objective of the present study is to perform an exhaustive survey of recently published population PK/PD analyses. A secondary objective is to assess whether model building steps are correctly performed and reported, based on a list of very minimal items that should always be documented. The methodology is as follows: first, we selected papers referred in MEDLINE (Pubmed), from 2002 to 2004 using specific keywords. Secondly, we built a questionnaire in order to establish a Data Abstraction Form (DAF) and thirdly, we carefully read all the selected papers, answered to the questions of the DAF and entered information into a database. This report includes DAF building description and paper selection, presents the survey results in terms of the data used in the modelling and in term of model building. Another paper, using the same database but a different DAF, addresses the question of population PK-PD model qualification [20]. Those present results focus on model building practices, for which no exhaustive and detailed review has ever been performed.

## Method

**Article selection.** Initial article selection was performed in MEDLINE (Pubmed) using a list of keywords aimed at capturing papers concerning population PK, PD or PK-PD published from 2002-01-01 to 2004-12-31: *((population AND model\*) OR (non AND linear AND mixed AND effect\*) OR bayesian OR hierarchical OR NONMEM OR nlme OR NLMIXED OR P-PHARM OR WinNonMix OR \*bugs OR NPLM OR NPEM OR Kinetica OR ADAPT OR ITRLS OR MP2) AND (PK-PD OR PK-PD OR PBPK OR pharmacokinetic\* OR pharmacodynamic\*)*. Additionally, the search was limited to “English language” and “human data”. Then, based on the abstract, or if necessary, on the full article, papers were further limited to those dealing with medications or analyses performed on original clinical data. Reviews and methodology articles were excluded.

**Data abstraction form building.** The methodology used for building the DAF was based on the work of Boutron *et al* [21] who published several systematic reviews using a checklist of items. The DAF was constructed around a single statistical unit defined as a PK, PD or PK-PD model, rather than the paper itself. The rationale was based on the fact that our work mainly focused on describing the quality of published models and techniques used to qualify them, rather than on the quality of published papers. Consequently, when a paper described more than one model, it had as many entries in our database as the number of models described in the paper. A two-part grid was then created. The first part devoted to general characteristics, included article identification, context of the analysis and, description of clinical studies from which the data arose. Article identification (number of items = 4) contained generalities about the paper and, the journal where it was published. Context of the analysis (number of items = 7) collected information about authors and treatment

administered. It characterized the nature of authors' laboratory (industry/academia), the therapeutic classes and names of administered drugs. Therapeutic classes were defined following the FDA National Drug Code Directory [22]. Clinical study(ies) (number of items = 49) described the clinical trial(s) from which the data arose, including phase of clinical development, objectives of clinical trial(s) (PK, dose finding, therapeutic drug monitoring, etc), target population, treatment summary (routes of administration, treatment duration, number of doses, etc) as well as experimental design. This section provided information about potential complexities of design (sparse data, cross-over study, etc), and then potential difficulties for model building. The second part of the DAF (number of items = 214) aimed to provide precise information about the characteristics of the model building process. Given that this last part was the most interesting with regard to modelling, a larger number of items were defined. Information was collected on the objectives of modelling (predictive or descriptive), the software used, and the drugs included in the model. Added information was related to the PK, PD or PK-PD model, the number of data actually included in the modelling process, the nature of the structural, inter and intra-individual models, and when applicable, the nature of the covariate model. For each model, information was gathered about criteria used for final covariate model building and selection from an exhaustive list including criteria such as graphs, and statistical criteria such as the likelihood ratio test.

This DAF was built and finalized between July 2004 and January 2005 by nine independent PK-PD modellers (authors of this paper). The gamut of the author's backgrounds (Pharmaceutical Science, Veterinary Medicine, Medicine, Statistics, and Engineering) their different experiences and skill levels, positions (permanent or PhD student), and origins (industry and academia) improved relevance of the questions and increased understanding to classify them according to the overall point of view of the modellers. The group especially ensured that the questions, whether single, multiple choice, or open, were as simple and

unambiguous as possible. Moreover, the group prioritized the use of different fields with defined checklists to provide for the efficient recording of information and subsequent automated analysis. Finally, a draft was tested by the two readers (Céline (CD) and Karl (KB)) using 20 additional articles, selected according to the same criteria described above, but published either before 2002 or after 2004. The articles were examined by both readers, which assisted them in agreeing on the interpretation of different questions and resolving differences in answers. The final version of the DAF is available at: <http://www.bichat.inserm.fr/equipes/.../>.

**Data collection.** DAF was implemented in HTML and PHP languages. PhpMyAdmin (version 2.5.3) software was used, which is a tool written in PHP intended to handle the administration of a MySQL database server [23]. In this way, it was possible to enter interactively the items in the DAF while reading the papers through a clear and easily usable local web interface. Then, at the end of reading, answers were directly transmitted to the MySQL database. Variables were encoded as either numeric or character variables, including categorical or continuous data, depending on the answer type. All coding was defined in the PHP script. The 324 articles retrieved were split between the two readers according to a randomization stratified by year. The reading finally selected required 4 months (from March to July 2005).

**Statistical analysis.** Once the reading was completed, the MySQL database was exported into SAS (version 8) and S-plus (version 6.2) statistical packages for statistical analysis. For each item within the different parts, descriptive statistics (mean, SD, minimum and maximum values) were used to report the results for continuous variables, whereas frequencies were used to describe categorical variables. New variables were generated and cross analyses were performed in order to highlight the results. For instance, covariates were regrouped according to treatment characteristics, demographics, and clinical or biological

characteristics of the patients. Journals were classified as statistical, pharmacological or clinical [24] and the time was split by year of publication. Differences across journals or years were tested with a  $\chi^2$  test.

## Results

**Generalities.** Among the 482 articles initially selected, some were excluded (see Figure 1). The remaining articles were distributed evenly across years: 108 for 2002, 100 for 2003 and 116 for 2004 (list available at: <http://www.bichat.inserm.fr/equipes/.../>). The articles came primarily from pharmacological (58%) and clinical journals (41%), with a majority coming from leading journals in the fields of cancer, anaesthesiology and antimicrobials (see Figure 2A). Only three articles came from statistical journals. Authors were primarily from academia (71%), or a mix of industry and academia (16%). The distribution of therapeutic classes is presented on Figure 2B. Consistent with Figure 2A, oncolytics, antimicrobials and pain relief drugs were among those where a population model has been most often published.

**Clinical studies.** Generally, the data used for modelling came from clinical studies with a majority of pharmacokinetic objectives (68%), and the rest being PK-PD (23%) or pharmacodynamics (9%). Clinical phases of these studies were reported for 66% of the models. The majority were in post marketing authorization (34%) or in phase I studies (20%). A typical model was characterized from the data of a single clinical study (77%), with single arm (57%), performed on patients (78%) and adults (68%). About 25% of the screened models dealt with paediatric patients while only 2% concerned elderly patients. Drugs were administered as multiple doses (68%) or as a single dose (24%) (8% not reported). The routes of administration included IV infusion (52%), oral (39%) or IV bolus (7%). When studies included more than one arm, subjects were often randomized (65%). About 21% of clinical

studies were typical dose escalation studies and prospective design optimization (as described in [25]) was recovered for 9% of the models .

**Modelling.** Articles included a majority of models with a descriptive purpose (81%), or predictive and descriptive purposes (17%). Models with a descriptive purpose presented parameter estimates, as expected, for 99% of cases, then defined PK/PD variability (21%), and tested covariates (58%). The most frequent methodology was non linear mixed-effect models (92%), rarely preceded by a two-stage approach (2%) or replaced by this one (5%). These models included one compound in 89% of cases and more than two compounds for only 5% of cases. The most frequently used software was NONMEM. Distribution of software and associated methods across models is presented in Table 1. Of note is that for NONMEM analyses, algorithms were not reported in 32% of the cases. Among reported algorithms, FOCE (First Order Conditional Estimation) was the most often used (with or without interaction), closely followed by FO (First Order). Looking at the evolution across years, the use of “FOCE INTERACTION” increased over time from 2002 to 2004 (from 7 to 24%,  $p=0.006$ ). The use of FOCE (INTERACTION) seemed less frequent for PD models, but the absence of estimation method reporting in this latter case was more frequent than for PK models.

**PK models.** Out of the 324 articles selected, 360 PK models were retrieved. Nearly all studies (99%) reported the number of included subjects. The median was approximately 50 and only 26% of datasets included more than 100 subjects. The number of samples per subject (usually over 3) was defined on observed data in 16% of the cases and on scheduled design in 3% of the cases. Quantiles 10, 25, 50, 75 and 90% of number of points per subject were 2, 4, 9, 14, and 17, respectively. When the model included only one drug, the number of compartments was mostly limited to less than 2 (Figure 3). Conversely, when parent and metabolite compounds were modelled together (10% of the models), the number of

compartments could reach a maximum of 13 as for irinotecan [26]. Linking the number of points per subject with the number of compartments, we observed a rise of the number of samples per subject when the number of compartments increased. For 1 compartment, the median was 4, for 2 compartments it was 10 and for 3 compartments it was 12 points per subject. Parent and metabolite were modelled either simultaneously (51% of the published models) or sequentially (34%). With regard to random effect models, Inter-Individual Variability (IIV) model type was often reported whereas the nature of the IIV matrix was not often reported (only 18% of the PK models). IIV models were either exponential (53%) or multiplicative (11%). Residual error was modelled mainly as additive (17%), combined (additive and multiplicative) (21%) or multiplicative (24%). Criteria used for selecting the final model were, when reported, graphics (43%), Akaike criterion, Bayesian information criteria, the likelihood, or objective function (38%), the likelihood ratio test (22%), or residuals distribution (15%). Finally, if each item is considered separately, the majority of analyses showed an adequate description (see data, inter-individual variability, error model or building criteria in Figure 4, left plot).

Covariates were considered for most of PK models with a median number of 6 covariates tested. Although sometimes information was not reported, their selection was in majority performed based on graphs of post-hoc estimates (see Table 2), followed by stepwise inclusion using only the likelihood ratio test (43% of cases). Other criteria independent of the likelihood, like decrease of IIV or SE, or clinical relevance of the covariates were also used. A median of 2 covariates was kept in final models. Characteristics of the covariates tested finally retained in the model are reported in Table 3. For a majority of models, demographic covariates or covariates on liver and kidney functions were the most often considered. Overall, very few papers, (see for example the nice paper published by Kerbusch *et al* [27]), provided a complete and relevant description of covariates model building .

**PD models.** In the selected articles, only 118 PD models were reported, 77% of which concerned PK and PD models built simultaneously. For these models, 33% of the datasets included more than 100 subjects. For 60% of the cases, the number of observations was not reported. PD model types were various, but showed a majority of Emax models followed by models for non-continuous data (defined and presented in Figure 3, right side). In 20% of cases, the PD models included an effect compartment model. With regard to random effect models, IIV model type was most frequently exponential (in 25% of the PD models), IIV matrix was rarely reported (in only 5%) and residual error was mainly modelled as additive (18%). Criteria used for selecting the final model were, when reported, graphics (22%), Akaike criterion, Bayesian information criteria, the likelihood, objective function (19%), or the likelihood ratio test (14%). Overall, the description of model building was less well reported than for PK ones (Figure 4, right plot). However, it is encouraging to note that for the residual error model, deficiencies in reporting information decreased from 2002 to 2004 (75% to 44%, of the models  $p=0.02$ ).

Covariates were tested for 36% of the PD models with a median number of 5 covariates. Covariate selection, not always clearly described, was often performed with graphs of post-hoc estimates and their inclusion, by either the stepwise or forward approach using only the likelihood ratio test (in 49% of the cases, see Table 2). Most of the time, the number of covariates selected in the final model was very limited (i.e, 0 for 54% and 1 for 27% of the PD covariates models) and they included demographic, liver or kidney function, biological parameters or disease. Tested and retained covariates are reported in Table 3.

## Discussion

The only method for obtaining an overview of a research area is through exhaustive reading of recent literature. For this purpose, a DAF presents multiple advantages. It allows one to target all interesting questions and to discard information irrelevant to the study. Simple questions and a standardized DAF format ensure objectivity. Our interactive DAF has other advantages in that it avoids errors in transferring data from paper to computer and allows for presentation of the data in a format compatible for statistical analysis. The number of experienced scientific modellers involved in the modelling of the DAF and in the interpretation of the results, as well as the diversity of their backgrounds ensured the quality and reliability of our approach.

Overall, the models published in the screened papers were primarily built with clinical data from post marketing studies. This can be explained partly for confidentiality issues with data from pharmaceutical industry. Academicians, whose activity is evaluated according to publishing frequency, not surprisingly, represented the majority of the authors. They often used data from hospital for therapeutic drug monitoring or data from public clinical trials. With regard to therapeutic classes, oncolytics, antimicrobial agents and anaesthetics were modelled most frequently. These classes can present a narrow therapeutic index as well as severe toxicities. Modelling in this context is very useful. One can optimize clinical trials, sampling times, dosing, rhythm of administration and number of patients in different arms. One can either perform therapeutic drug monitoring, limit toxicity or reduce to a certain extent tolerance and resistance. The data were often homogenous (in majority from one single clinical trial, one arm, including only one compound) and rich rather than sparse (number of points per patients equal to 4, 10 and 12 for 1, 2 and 3 compartments, respectively). This

homogeneity probably explains why the majority of models are solely descriptive and are not used to predict data in other populations, since model usefulness is limited. With regard to methodology, the one stage nonlinear mixed-effect approach was most frequently used over the 2002-04 time period. Despite the fact that it has been demonstrated several times that the two-stage approach has many drawbacks in practical situations (including sparse data, data imbalance and subject specific dosing history), 5% of models reviewed were built with it. Actually, the two stage approach provides a poorly approximated asymptotic covariance matrix [17;28] and it is considered less efficient than the one stage nonlinear mixed-effect modelling method [29]. In some cases, like in animal studies, the two-stage approach is still used due to limited number of subjects (often  $n \leq 6$ ) and samples per subject (often  $n \leq 3$ ). In our case, complexity of implementation of population analysis seems to be the main reason of the ongoing popularity of the two-stage approach. Concerning the software, NONMEM remains the most largely used for analysis both in academia and industry. It has been used for quite some time and is considered to be overall highly flexible with regard to the NM-TRAN scripting language and data input system which allows one to define any type of dosage regimen, PK, PD or PK-PD models [30]. Surprisingly, there were still instances where this software was reported as misused, despite all the training and references which are available to users. For instance, the FO method was used with multiplicative as well as exponential inter-individual variability model, although it is known that it can induce biases on parameter estimates [31]. This may be linked to convergence problems method or excessive computation time for the more advanced FOCE method, even with fast, modern CPUs [32;33]. Model complexity, however, did not seem to be an issue as we did not notice that a PK model with high number of compartments was systematically associated with the use of FO.

We found three times more PK than PD models, and most of the PD models were simultaneous PK-PD models. These were primarily Emax models, with effect compartments. Although such models can be really useful to help understand drug effect relationships and to quantify inter-individual variability in clinical response, PD models are less frequent than PK ones. This frequency can be explained by numerous reasons [34]. The first is the difficulty involved in measuring and modelling drug effects compared to drug and metabolite concentrations for which PK methodology is well established and standardized. A second reason is the absence of apparent causal relationships between intermediate effects quantified by biomarkers, most often utilized in PD models, and clinical endpoints, which can be expressed as survival data and can often not be modelled with a methodology-like population PK-PD.

Covariate testing remains one of main objectives of population PK modelling (70%) and it is used to explain variability, but was involved in only 36% of the PD models. Indeed, among the 118 PD models, 80% were part of a PK-PD model and in these, testing covariates on the PK or PD model was performed in 67% of the cases. It was understandable that after covariates have been included in the PK model, it was more difficult to find any potential covariates specific to PD models (test in only 32%). PK often explains main part of PD variability except if there is substantial heterogeneity in the disease or in the response. It explains why only few covariates were found to be significant in the PD models (Table 3).

Given that the methodology of PK/PD population models is complex, involves many assumptions, and can be used to make important decisions in drug development, it is crucial that it be reliable. As a first step, readers of published analysis should be able to understand and evaluate the numerous choices made in the analysis through detailed descriptions. The most recent FDA guidelines giving an overall description of what is expected in population

PK study reports dates back to 1999 [17]. Recently, pharmacometricians from the Swedish medical product agency and from EMEA reported on what their agencies look for when assessing a population PK analysis in an article, and a draft guideline [18;35]. Consulting also some reviews in the field [3;4;13;30;36], we established the DAF by defining the items we considered as interesting for a literature survey. But through the review we performed, we observed a lot of deficiencies in the quality of reported information. Due to importance of this result we judged as required to quantify and illustrate this observation. For this purpose, we defined a limited list of items that we considered as really mandatory to be addressed by authors in any type of journals. Those items extracted from the DAF were:

- subject characteristics (healthy/patient),
- dosage (single/multiple) and route of administration,
- total number of subjects and total number of observations or number of observations per patient,
- criteria used for model selection,
- nature of the structural, IIV and error models,
- estimation method and software.

Our survey revealed that only 39% of the published PK reports and only 8.5% of the PD models reported the aforementioned items (see for instance the excellent paper of Van Kesteren [32]). Since this information looked very reasonable, those low percentages were very surprising and demonstrate the real need for establishing some guidelines when reporting population PK-PD analysis in literature.

This minimal item list description should be found in all population PK/PD papers published in peer reviewed journals. As a perspective, it could be completed by some other items as: description of raw data exploration, untested covariates, handling of missing data and data below the limit of quantification, different model building steps and all aspects of

model qualification. This last item is one of the most important and has been addressed in a separate paper that analyses the same database with similar methodology but a different DAF [20]. However, establishment of as such a check list for population PK-PD publications would require consensual decisions between experts and editorial committees of journals publishing population analysis. Numerous meetings would probably be required before addressing this challenge and reaching some consensus. It was not the purpose of the present study, but results of the present survey naturally conducts to this conclusion.

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## Tables

**Table 1**

Softwares and methods most used in model building among the PK (n=360) and PD (n=118) population models. For each method, we report the number of models and in brackets, the percentage referring to the corresponding category.

Softwares	PK models		PD models	
NONMEM	<b>247</b>	<b>(68.6)</b>	<b>92</b>	<b>(78.0)</b>
FO	58	(23.5)	22	(23.9)
FOCE	71	(28.7)	12	(13.0)
FOCEI	47	(19.0)	13	(14.1)
FOCE centered	2	(0.8)	1	(1.1)
LAPLACE	4	(1.6)	5	(5.4)
NR*	65	(26.3)	39	(42.4)
NPEM	<b>20</b>	<b>(5.6)</b>	<b>2</b>	<b>(1.7)</b>
ADAPT	<b>17</b>	<b>(4.7)</b>	<b>8</b>	<b>(6.8)</b>
PPharm/Kinetica	<b>14</b>	<b>(3.9)</b>	<b>4</b>	<b>(3.4)</b>
MP2	<b>13</b>	<b>(3.6)</b>	<b>0</b>	<b>(0.0)</b>
WinNonMix	<b>10</b>	<b>(2.8)</b>	<b>1</b>	<b>(0.9)</b>
Other	<b>32</b>	<b>(8.9)</b>	<b>8</b>	<b>(6.8)</b>
NR*	<b>7</b>	<b>(1.9)</b>	<b>3</b>	<b>(2.5)</b>

\* NR: Not Reported

**Table 2**

Building steps in the 251 (out of 360) PK models and in the 43 (out of 118) PD models when a covariate model is performed. For each method, we report the number of models and in brackets, the percentage referring to the corresponding category.

<i>Covariate models</i>	<i>PK models</i>		<i>PD models</i>	
	251	(69.7)	43	(36.4)
Selection based on post-hoc*	<b>144</b>	<b>(57.4)</b>	<b>25</b>	<b>(58.1)</b>
graphs	102	(70.8)	12	(48.0)
GAM (or bootstrap of GAM)	32	(22.2)	5	(20.0)
univariate test	17	(11.8)	1	(4.0)
tree	1	(0.7)	0	(0.0)
other	30	(20.8)	6	(24.0)
NR**	31	(21.5)	9	(36.0)
Building approach described	<b>138</b>	<b>(55.0)</b>	<b>15</b>	<b>(34.9)</b>
stepwise	106	(76.8)	10	(66.6)
forward	28	(20.3)	5	(33.3)
backward	4	(2.9)	0	(0.0)
Building criteria reported*	<b>208</b>	<b>(82.9)</b>	<b>31</b>	<b>(72.1)</b>
LRT	168	(80.8)	26	(83.9)
AIC, BIC (or SC), OF, L***	63	(30.3)	5	(16.1)
IIV decrease	56	(26.9)	4	(12.9)
SE decrease	26	(12.5)	2	(6.5)
clinical relevance	17	(8.2)	1	(3.2)
Wald test	0	(0.0)	0	(0.0)
other	30	(14.4)	6	(19.4)

\* Under each category, the percentages in one column sum up to more than 100% because several different methods could be used in the same model.

\*\* NR: Not reported

\*\*\* AIC: Akaike criterion, BIC (or SC): Bayesian information criteria (or Schwarz criteria), OF: objective function, L: likelihood.

**Table 3**

Type of covariate tested and selected in the 251 (out of 360) PK models and in the 43 (out of 118) PD models when a covariate model is performed. For each method, we report the number of models and in brackets, the percentage referring to the corresponding category.

<i>Covariate models</i>	<i>PK models</i>		<i>PD models</i>	
	251 (69.7)		43 (36.4)	
Covariates	Tested*	Kept*	Tested*	Kept*
Demographic	233 (92.8)	186 (74.1)	31 (72.1)	10 (23.3)
Liver/Kidney function	122 (48.6)	105 (41.8)	12 (27.9)	8 (18.6)
Biological parameter	41 (16.3)	34 (13.6)	7 (16.3)	6 (14.0)
Drug interaction	58 (23.1)	47 (18.7)	9 (20.9)	3 (7.0)
Dose	33 (13.1)	26 (10.4)	4 (9.3)	3 (7.0)
Metabolism induction/inhibition	24 (9.6)	19 (7.6)	3 (7.0)	2 (4.7)
Disease	45 (17.9)	37 (14.7)	12 (27.9)	6 (14.0)
Food	14 (5.6)	13 (5.2)		
Performance status	21 (8.4)	18 (7.2)	2 (4.7)	1 (2.3)
Time	22 (8.8)	17 (6.8)	3 (7.0)	2 (4.7)
Administration	10 (4.0)	10 (4.0)	6 (14.0)	3 (7.0)
Adverse events	1 (0.4)	0 (0.0)		
PK parameters			4 (9.3)	3 (7.0)

\* Under each category, the percentages in one column sum up to more than 100% because several different covariates could be tested and kept in the same model.

## Figures

### Legends

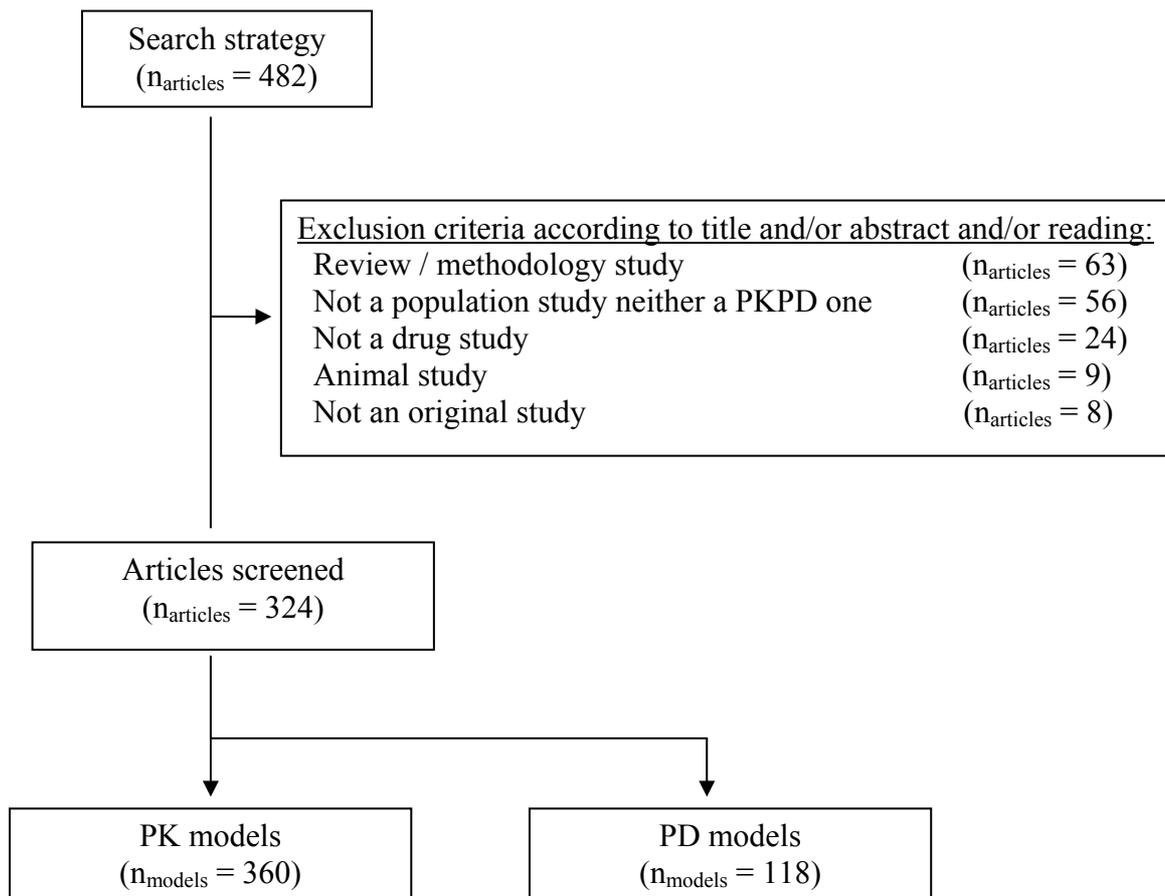
**Figure 1.** Screening of the articles selected in Pubmed using exclusion criteria (Exclusion criteria were not mutually exclusive).

**Figure 2. A.** Journals in which articles of population PK/PD (n=324) were most frequently published, other: journals in which less than 5% of the papers were found.

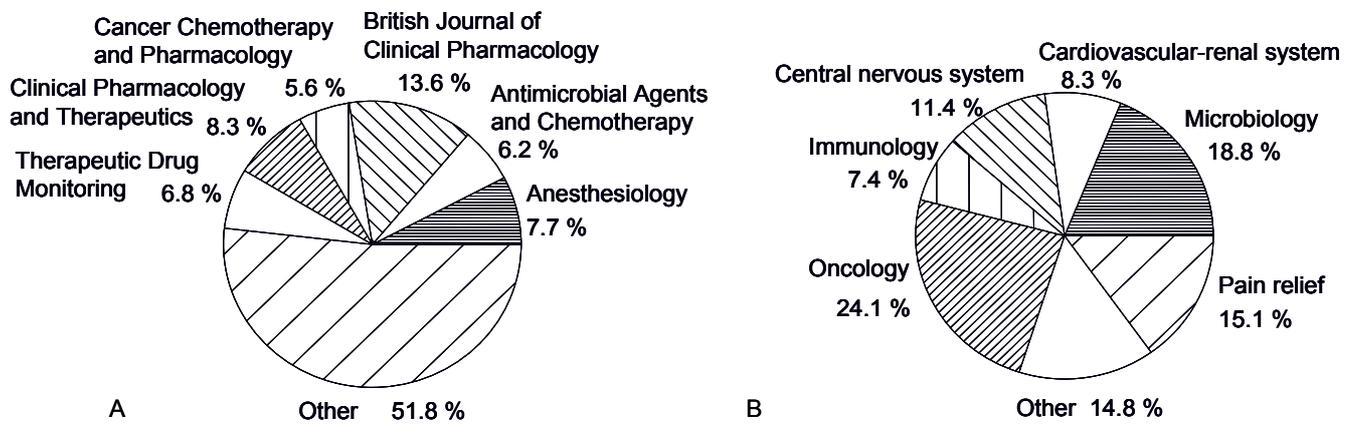
**B.** Therapeutic classes most frequently studied in population PK/PD articles (n=324), other: therapeutic classes found in less than 5% of the papers.

**Figure 3.** Number of compartments of each PK model (n=360, left side) and PD model types (n=118, right side). The different types of PD models are defined by: Emax models (1), indirect models (2), physiologic models (3), other models for continuous data (including linear, exponential, power and log linear models) (4), or models for non-continuous data (including Cox, logistic and time to event models, and models for count or ordered categorical data) (5). The percentage is indicated if only  $\geq 5\%$ .

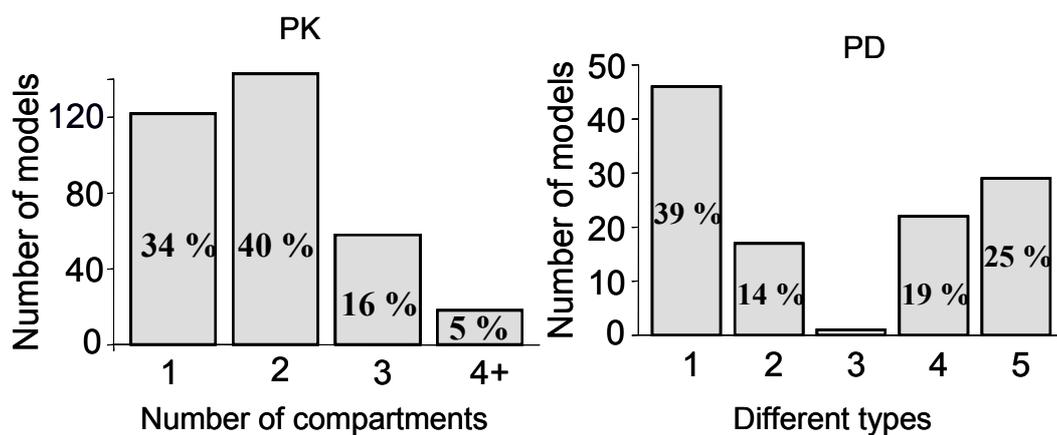
**Figure 4.** Description level of PK (n=360) and PD (n=118) model building. Gray part of each column represents percentage of models with reported information, white part: models with no reported information. Information is defined by number of subjects and number of observations (total or per patient) included in the model, in respective columns (1) and (2), type of IIV model in column (3), nature of error model in column (4), and description of criteria used in model building in column (5). The percentage is indicated only if  $\geq 5\%$ .



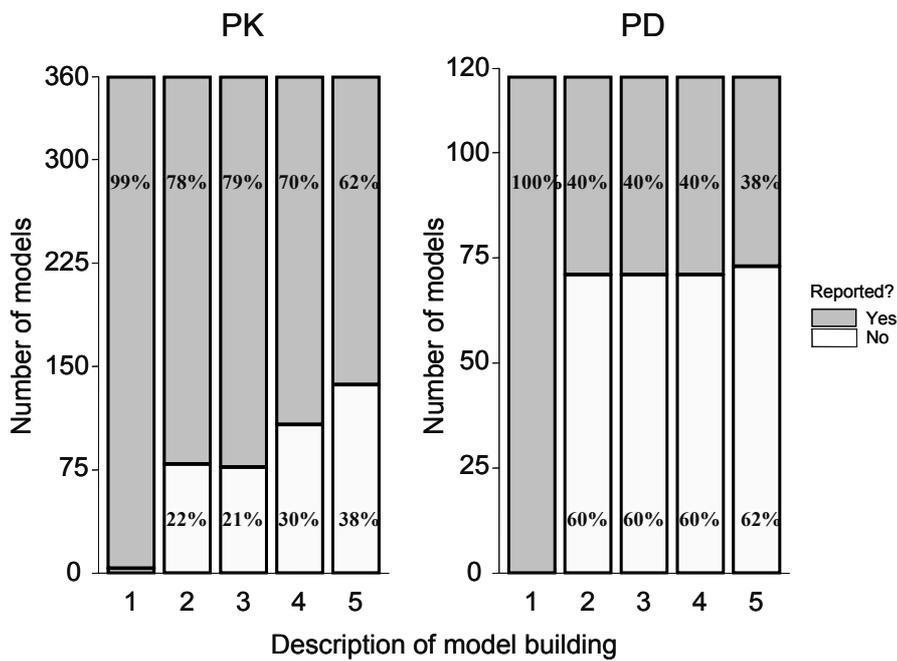
**Figure 1** Screening of the articles selected in Pubmed using exclusion criteria.



**Figure 2 A.** Journals in which articles of population PK/PD (n=324) were most frequently published, other: journals in which less than 5% of the papers were found. **B.** Therapeutic classes most frequently studied in population PK/PD articles (n=324), other: therapeutic classes found in less than 5% of the papers.



**Figure 3** Number of compartments of each PK model (n=360, left side) and PD model types (n=118, right side). The different types of PD models are defined by: Emax models (1), indirect models (2), physiologic models (3), other models for continuous data (including linear, exponential, power and log linear models) (4), or models for non-continuous data (including Cox, logistic and time to event models, and models for count or ordered categorical data) (5). The percentage is indicated if only  $\geq$  5%.



**Figure 4** Description level of PK (n=360) and PD (n=118) model building. Gray part of each column represents percentage of models with reported information, white part: models with no reported information. Information is defined by number of subjects and number of observations (total or per patient) included in the model, in respective columns (1) and (2), type of IIV model in column (3), nature of error model in column (4), and description of criteria used in model building in column (5). The percentage is indicated only if  $\geq 5\%$ .