Serum Penicillin G Concentrations Are Below Inhibitory Concentrations by Two Weeks After Benzathine Penicillin G Injection in the Majority of Young Adults: A Population Pharmacokinetic Modeling Approach

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Serum penicillin G falls to low levels two weeks after injection as benzathine penicillin G (BPG) in young adults. Using Pmetrics and previously published penicillin G pharmacokinetic data after 1.2 million units given as BPG to 329 male military recruits, we here develop the first published population pharmacokinetic model of penicillin G after BPG injection. We simulated time-concentration profiles over a broad range of pediatric and adult weights after alternative doses and dose frequencies to predict the probability of maintaining serum penicillin G concentrations above 0.02 mg/L, a proposed protective threshold against group A Streptococcus pyogenes (GAS). The final population model included linear absorption into a central compartment, distribution to and from a peripheral compartment, and linear elimination from the central compartment, with allometrically scaled volumes and rate constants. With 1.2 million units of intramuscular BPG given every 4 weeks for 4 total doses, only 23.2% of 5000 simulated patients maintained serum penicillin G trough concentration >0.02 mg/L 4 weeks after the last dose. When the dose was 1.8 million units and with 2.4 million units, the percentages were 30.2% and 40.7%, respectively. With repeated dosing of 1.2 million units every 3 or every 2 weeks for 4 doses, the percentages with a penicillin G trough >0.02 mg/L were 37.8% and 65.2%, respectively. Our simulations support recommendations for more frequent rather than larger BPG doses to prevent recurrent rheumatic heart disease in areas of high GAS prevalence or during outbreaks.
The studies performed during the 60 years since the original investigations (1) of the persistence of serum penicillin G after parenteral administration of benzathine penicillin G (BPG) had generally found that serum concentrations remain above a putative minimum protective level for the prevention and treatment of Group A Streptococcus pyogenes (GAS) infections. This minimum threshold differs among authorities, but is usually set as greater than 0.01 to 0.03 μg/ml (2) for between 3 and 4 weeks after a dose.

Recently, we reported that the serum penicillin G levels in 329 military trainees fell more rapidly than expected during the 29 days following a 1.2 million unit intramuscular injection of the only formulation of BPG currently available in the United States (2). That study was prompted by observations of unexpectedly high GAS treatment failures with BPG, defined as a failure to eradicate GAS from the throat (3-6), and prior reports of undetectable serum penicillin G three weeks after the same dose (5, 7).

In this report, we develop a population pharmacokinetic (PK) model of penicillin G concentrations following intramuscular administration of 1.2 million units of BPG in healthy young adult males, using the data from our prior study. We set three objectives: (1) to find the optimal body-size metric, i.e. weight, body-surface area, or allometry for scaling PK parameter values, (2) to use the final model for Monte Carlo simulations to explore alternative BPG dosing regimens and their probabilities of maintaining serum penicillin G concentrations above 0.02 μg/mL (as the middle of the typical target range) at all times during the month following an injection of 1.2 million units, and (3) to understand the kinetic distribution of penicillin outside of the serum (i.e., in tissues) in relation to the serum time-concentration profile. These objectives may be relevant to future dosing for adults and children, both for therapy of GAS upper
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respiratory tract infections and for secondary rheumatic fever prophylaxis, as well as for treatment of syphilis.

MATERIALS AND METHODS

Subjects. As described previously (2), we enrolled 329 male military trainees in two cohorts and followed them for the 29 days after their enrollment and injection of 1.2 million units of BPG. None of the subjects were allergic to penicillin.

Procedures. We enrolled the first cohort in January 2007 (165 subjects) and the second in February 2007 (164 subjects). The Naval Health Research Center institutional review board approved the study (protocol number NHRC.2007.0022), and all subjects provided written informed consent. On day 0 for each subject, we gave a gluteal intramuscular dose of 900 mg of penicillin G as 2 mL of solution containing 1.2 million units of BPG (Monarch Pharmaceuticals, a subsidiary of King Pharmaceuticals, L-A Bicillin; NDC number 60793070110; mfg. cat. no. 1138883). This was the only BPG dose each subject received in the study. On day 1, which was sample 1, we withdrew one blood sample from all subjects by venipuncture. Samples 2 and 3 were taken on different days for cohorts of 12-18 subjects, to cover the entire time-concentration profile, as shown in Table 1.

Laboratory analysis. Samples were stored at -70 degrees Celsius for up to 18 months until analysis. They were analyzed in batches of 20 in random order to remove any confounding
due to penicillin G degradation. We used our previously described and validated liquid chromatography/tandem mass spectrometry (LC/MS/MS) assay (2).

**Population PK model building.** For the population PK modeling, we used the Non-Parametric Adaptive Grid algorithm (8) in the Pmetrics package for R (version 1.2.7) (9) to fit candidate PK models to the time-concentration data for penicillin G. For all models, we set the time units to be days rather than the more typically used hours.

We began with the simplest structural model, which was a two-compartment model that had a depot/dosing compartment and a central compartment. We then tested a model with an additional peripheral tissue compartment. Although each subject only had three samples, the distribution of sampling times over the entire time-concentration profile allowed us to at least test these two models. All models had linear rate constants of absorption (Ka) from dosing to central compartment with a volume of distribution (V), a linear elimination rate constant from the central compartment (Ke), and, as applicable, linear transfer rate constants to and from the peripheral compartment (KCP and KPC). We assumed that measured penicillin G concentrations represented the central compartment. Finally, we tested scaling of PK parameters to three different size models: weight (V=V0*wt), body-surface area (V=V0*BSA), or allometric size (V=V0*wt, Ke=Ke0*wt^{-0.25}), where wt was weight in kg normalized to 70 kg, and BSA was the Mosteller body-surface area (10) calculated from the height and weight of each subject, normalized to the population mean of 1.94 m².

In Pmetrics, a portion of the random error in the model is attributed to the drug assay, with a multiplicative error term, \( \gamma \), to capture process noise associated with measurement of serum concentration such as uncertainty in dose times. Pmetrics weights each observation by the
reciprocal of this total assay variance (the Fisher information), calculated as \((\gamma \times SD)^2\), where

\[
SD = C_0 + C_1 \times [PCN] + C_2 \times [PCN]^2 + C_3 \times [PCN]^3,
\]

are coefficients and \([PCN]\) is the measured penicillin G concentration. We fixed \(C_0=0.00025\) as half the assay limit of quantification of 0.005 ng/mL, \(C_1=0.10\), \(C_2=C_3=0\) for an assay with 10% coefficient of variation.

We selected the final model on the basis of minimizing the Akaike Information Criterion (AIC) (11), which is a function of the likelihood of the model, penalized by the number of parameters in the model. Additionally, we factored bias (mean weighted predicted-observed error) and imprecision (bias-adjusted, mean weighted squared predicted-observed error) into the selection of the final model.

Visual predictive checks. To provide some assessment of the ability of the final model to accurately represent the study population, we used the simulation module of Pmetrics to create 5000 sets of PK parameter values by randomly selecting them from the probability-weighted normalized distribution and covariance of values for each parameter in the model, a technique known as Monte Carlo Simulation (12). As in the study, each simulated adult was administered 1.2 million units of intramuscular BPG once, and penicillin G concentrations were simulated daily thereafter for 1 month. We calculated and plotted the 10th, 50th, and 90th percentiles of the concentrations of penicillin G in all 5000 simulated patients vs. time. Superimposed upon these plots were the actual concentrations of penicillin G measured in the 329 actual subjects. This visual predictive check (13) was considered good if the distribution of concentrations in the simulated population was similar to that in the actual population.
Probability of target attainment. Using the final model, the simulator, and the probability of target attainment (PTA) functions in Pmetrics, we explored various alternative dosing regimens for BPG. For each dosing regimen, we simulated 5000 patients. Pmetrics allows simulation with covariates, using the correlation matrix of Bayesian posterior parameter values and covariates in the study population, together with the specified mean and standard deviation of any covariates, all to calculate the correct covariate-parameter covariance matrix for simulations. In this case the only covariate was weight, which we set for simulations to a mean of 50 kg and a standard deviation of 50, truncating simulated values to be within the range of 25 to 110 kg. This resulted in a uniform distribution of weight between our specified limits, i.e. a homogeneously mixed group of sizes corresponding to children, adolescents, and adults. We used the population distributions for the model pharmacokinetic parameters, limiting simulated values to be between 0 and 5 times the maximum in order to simulate a more diverse population than the original study population. For each set of simulated pharmacokinetic parameters and weight, we calculated the proportion that maintained a serum penicillin G concentration $\geq 0.02$ mg/L at all times during the subsequent 28 days. For doses higher than 1.2 million units, we assumed that concentrations would increase proportionally to the dose, since we did not have data with higher doses.

Finally, since the final model included a peripheral tissue compartment, we sought to understand how much penicillin G kinetically distributes from the serum to extravascular tissue and if penicillin G accumulates in bodily fluids outside the serum over time with repeated BPG dosing. To do this, we simulated one additional population of 5000 adults who received 1.2 million units of BPG monthly for 6 months, to achieve steady state. From this population we simulated the amount of penicillin G in the peripheral compartment at two times: 1 month after
the first dose and again after the final (sixth) dose. For each of the 5000 simulated adults at each of the two time points, we calculated the relative distribution of penicillin G to the peripheral compartment as the ratio of model-calculated amount of penicillin G in the peripheral compartment to the amount in the central (serum) compartment. We also assessed accumulation of penicillin G in the peripheral compartment over time as the ratio of the amounts of penicillin G 1 month after the final dose and also 1 month after the first dose.

RESULTS

Characteristics of the study population are shown in Table 2. The distribution of penicillin G concentrations per day is included in Fig. 1 as the open circles. There was one outlier subject whose measured penicillin G on day 22 was $0.14 \mu g/ml$, versus the mean of the other subjects of $0.006 \mu g/ml$. However, we retained this outlier measurement in the analysis as we did not have a defined reason to exclude it.

Population model. We compared the AIC, bias, and imprecision for five models after allowing the population-fitting algorithm to iterate 1000 times toward the convergent, maximally likely distribution of parameter values. Details of the models and their AICs are shown in Table 3. On the basis of the AIC, bias, imprecision, and stronger a priori justification for scaling to children, we chose model 5, which had a peripheral tissue compartment and allometrically scaled central compartment volume and elimination from that compartment. We then allowed model 5 to cycle until convergence, which took 9429 cycles. The final cycle estimated $\gamma$ from the pooled participant concentration data was 1.08. A value of 1.0 indicates that there is no additional
process noise in the study, such as errors in the recorded times of samples, and that study procedures were carried out very precisely.

The population parameter value distributions for the final model are summarized in Table 4, and the full marginal distributions are shown in Fig. 2. The parameter values appeared to most closely approximate a log-normal distribution. The half-life of penicillin G absorption after dosing as BPG is much longer than the half-life of elimination, as would be expected. Using the parameter-value distributions in Table 4, the visual predictive check of 5000 concentration–time profiles versus the observed penicillin G concentrations in the study population (329 subjects) is shown in Fig. 1. The simulated distribution of concentrations matches the observed distribution well, suggesting that the model describes the study data adequately and can be used for meaningful probability of target attainment analysis.

**Probability of target attainment.** In addition to the standard dose of 1.2 million units of BPG every 4 weeks, we studied simulated doses of 1.8 or 2.4 million units every 4 weeks, as well as 1.2 million units given every 2 or 3 weeks. The results are shown in Table 5 and Fig. 3. All of the regimens resulted in substantial proportions of the study population predicted to fall below 0.02 mg/L of penicillin G in the serum at the end of the dosing interval, including only 23.2% above this threshold 4 weeks after the fourth dose of 1.2 million units. The regimen with the highest success rate was 1.2 million units of BPG every 2 weeks, with 65.2% over 0.02 mg/L 2 weeks after the previous dose at steady state.

**Accumulation and peripheral compartment penicillin G.** In our model, 4 weeks after the first dose of 1.2 million units of BPG, the serum penicillin G concentration in the simulated adult
population (using the median population weight of 74 kg) was a median (interquartile range [IQR]) of 0.005 (0.001 to 0.01) mg/L. For comparison as a validation, in the real subjects it was very similar: 0.004 (0.002 to 0.009) mg/L. In the peripheral compartment of the simulated population, penicillin G was 0.02 (0.005 to 0.04) mg/kg. Note that this does not correspond to an actual concentration in any specific tissue, but it is a weight-normalized amount of drug that has kinetically distributed outside of the measureable serum, i.e. this is a mathematical phenomenon used to explain the shape of the observed serum concentrations with respect to time. Nevertheless, we examined the characteristics of the peripheral distribution of penicillin to determine if the drug was likely to be accumulating outside the serum. The median (IQR) ratio of peripheral to serum penicillin G after 4 weeks was 3.8 (2.6 to 5.1). The ratio of peripheral concentration to serum concentration 4 weeks after the sixth dose was 3.7 (2.7 to 5.0)—the same as 4 weeks after the first dose, which indicates that the drug amount in peripheral tissues is not higher after six doses when compared with only one dose. This lack of substantial accumulation over time is further supported by comparing the median (IQR) ratio of serum penicillin G 4 weeks after the sixth dose to the serum penicillin G 4 weeks after the first dose, which was 1.23 (0.97 to 1.73). In the peripheral compartment, this ratio was 1.08 (1.01 to 1.40). In other words, in both serum and peripheral tissues, penicillin G is similar 4 weeks after the sixth dose as it was 4 weeks after the first dose. Together, these data show that there is very little accumulation of penicillin G in the serum or peripheral tissue compartment over time at the dose used in this study. This is because the drug is nearly fully cleared from the body with monthly dosing, and the weight-normalized amount of penicillin G kinetically distributed to the peripheral compartment is stable with respect to time at ≈2.5 to 5 times the serum concentration.
DISCUSSION

We present the first published population model of penicillin G when administered as BPG. This model was developed in over 300 young, active and healthy adults who each contributed three serum samples covering the period from the first day after administration and weekly thereafter until 1 month after dosing. To explore the dose-exposure relationships with the currently available preparation of BPG, we scaled the penicillin G PK parameters to weight, BSA, and allometric size, and found them roughly equivalent. In our model, however, allometric scaling was slightly better, and it allowed for better extrapolation from adult to pediatric populations (14-16).

It is clear from our data that with the exception of biweekly BPG dosing, the majority of patients will not sustain serum penicillin G concentrations above the MIC of greater than or equal to 0.02 mg/L for GAS during the entire dosing interval. We have here demonstrated this in young healthy adults, and by modeling and simulation, extrapolated our conclusion to patients ranging between 25 and 110 kg. This extrapolation appears valid, since our predictions of the proportions of patients falling below 0.02 mg/L 3 to 4 weeks after doses of 1.2 to 2.4 million units of BPG (Table 4) are in close agreement with observations made by others (3, 17).

Penicillin G is a “time-dependent” beta-lactam antibiotic, which is a class of antibiotics whose anti-bacterial kill rates are maximized when the serum concentration is above the MIC of the organism for 30 to 70% of the dosing interval (18), depending on the drug and the organism. However, this PK/PD linkage is really only relevant to drugs that are administered daily or multiple times a day. There is no such time-dependent model of the effects against GAS of repository penicillin G when administered as BPG. Prolonged concentrations below the MIC of
the organism for 1 to 2 weeks are likely not optimal, as suggested by a study over a 32-week period from November 1956 to June 1957, where the breakthrough rate for GAS infections in military recruits within the month after 1.2 million units of BPG averaged 3.7 per 100 patient-years (19), and almost all GAS infections occurred more than 2 weeks after injection when concentrations were lower. In 1996, Lue et al. reported 7.5 and 12.7 breakthroughs per 100 patient-years among children and adults receiving 1.2 million units of BPG every 3 weeks or every 4 weeks, respectively (20), i.e., those with a longer inter-dose interval had more breakthroughs (P<0.01). In a comparison of twice- versus once-monthly BPG, Kassem et al. reported 3.7 breakthroughs per 100 patient years, and 50% of the infections occurred during the third or fourth week after injection vs. only 21% in the first 2 weeks (21). Despite the use of BPG formulations from different manufacturers, which can affect serum penicillin G concentrations (22), these studies clearly suggest that protection against GAS wanes after the first 2 weeks following a dose, which is consistent with our own observations.

Waning serum penicillin G concentrations may also be reflected in a relatively high rate of failure to eradicate GAS from the pharynx. One study found a 37% failure to eradicate pharyngeal GAS 10-14 days or 29-31 days after a single injection of 600,000 (if <60 lbs) or 1.2 million units (if >60 lbs) of BPG in 271 children who presented with acute pharyngitis and who were culture-positive for GAS (6).

Despite this evidence that waning penicillin G concentrations are linked with increased breakthrough infections and failure to eradicate GAS in those with established pharyngeal/throat infections, the overall failure rates in the setting of BPG injections monthly or every 3 weeks are still relatively low compared with the proportion of the population that have concentrations below the MIC threshold of 0.02 mg/L by 2 weeks after an injection. We have several
hypotheses why the ability of BPG to protect against GAS infections appears better than one
would expect from associated serum penicillin G concentrations. First, the MIC of any particular
GAS may be below 0.02 mg/L, since the MIC in 90% of over 4000 strains was reported as <0.06
mg/L in 2004 (23). Only one strain of 282 had an MIC of >0.012 mg/L (0.024 mg/L) in 1992
(24). No isolates had an MIC >0.01 mg/L in 1965 (25). More than twice as many patients will be
expected to maintain serum penicillin G concentrations above 0.01 mg/L compared to 0.02 mg/L
for 1 month (data not shown).

The second hypothesis is that the young healthy military males in this study may have
cleared penicillin G faster than other populations after injection as BPG. Other patients may
retain higher concentrations for longer periods. In one of the only published clinical studies of
the same doses that we used for our simulations (1.2, 1.8 and 2.4 million units), higher
proportions (10 to 20 percentage points) of adolescents and young adults maintained therapeutic
serum penicillin G concentrations 2, 3, and 4 weeks after injection than the subjects in our study,
although the other study used a bioassay to measure pencillin G (26).

The third hypothesis is that tissue penicillin G concentrations are likely to be different
from blood (17, 27). Since most GAS infections such as tonsillitis occur in tissues other than
blood, we attempted to relate the serum kinetics of penicillin G to the kinetics outside of the
measureable serum compartment over time. Specifically, we tried to address the question of
whether there is kinetic accumulation of penicillin G with repeated dosing such that tissue
concentrations might persist after the clearance of drug from the serum, extending the functional
efficacy of the drug to prevent GAS infection and/or disease. However, our data suggest that
there is little residual drug in the serum or peripheral compartments by the end of a 28-day
dosing interval, even with monthly dosing. That is, the drug is nearly fully cleared from the body.
within 1 month. In our model, we did find that the average amount of penicillin G in the peripheral compartment 1 month after a dose of 1.2 million units of BPG, when normalized to bodyweight, is nearly 4-fold higher than the serum concentrations; again, however, this is a kinetic observation, and one cannot draw specific conclusions about the concentrations of penicillin G in any specific tissue. For example, Peloso et al. reported that the average measured concentration ratio of tonsillar to serum penicillin G in children was only about 33% for the first 2 weeks, and by 21 days 70% of children did not have detectable tonsillar penicillin G despite measureable serum penicillin G (17).

The fourth hypothesis is that GAS disease rates depend not only upon the concentration of penicillin G in the serum, but also upon a combination of location- and season-dependent GAS prevalence, individual infection rates, and risk of progression from infection to disease (28-31). Even for a patient with sub-therapeutic serum penicillin G, it is not 100% certain that GAS infection and disease will follow. However, in areas with higher GAS prevalence, more frequent BPG injections are recommended, consistent with our observations of the waning of serum penicillin G at the end of the monthly dose interval (4, 20, 32). Future work to combine our PK model with GAS pharmacokinetic/pharmacodynamic (PK/PD) modeling (33, 34) and epidemiology may be able to more quantitatively predict optimal BPG dosing frequency based on local GAS prevalence.

In summary, we have developed a population PK model to calculate serum penicillin G exposure after intramuscular BPG dosing in healthy young adults. Although this model also appears to be relevant to children, there is a paucity of actual supportive pediatric PK data (17). With the current dose of 1.2 million units, serum concentrations of penicillin G will fall below a threshold 0.02 mg/L in the majority of adults and likely in children after 2 weeks. Larger
monthly doses seem unlikely to substantially increase the proportion of patients who remain above 0.02 mg/L for the entire dosing interval, but dosing every 3 or even 2 weeks will be more successful. However, it may well be that a minimum level of 0.02 mg/L is unnecessarily high; answering this question will require further mechanistic and epidemiologic PK/PD modeling of penicillin G and GAS disease.
This work was supported by NIH grants GM068968 and HD070886 (M.N.) and U10-HD-031323-15 (J.B.) as well as Department of Defense grant W911QY-08-P0281 (M.B. and D.F.). The data used in this manuscript can be made available to collaborators upon request. The work was supported by a grant from the Military Vaccine Agency to Naval Health Research Center (work unit #60501). The views expressed in this work are those of the authors and do not reflect the official policy of the Department of the Navy, Department of Defense, or the U.S. Government. Approved for public release; distribution is unlimited. This research has been conducted in compliance with all applicable federal regulations governing the protection of human subjects in research (protocol NHRC.2007.0022). The raw data used in this manuscript can be made available to collaborators upon request.

We declare no conflicts of interest.

**Author contributions:** M.N. performed the modeling and simulation, the statistical analyses and wrote the manuscript. D.F. designed the clinical study and contributed to manuscript preparation. J.B. performed the laboratory analysis. M.B. performed the initial data analysis and contributed to manuscript preparation. E.K. contributed to the study design and manuscript preparation.
REFERENCES


26. **Currie BJB, Burt TT, Kaplan ELE.** 1994. Penicillin concentrations after increased


**TABLE 1** Sampling schedule for Samples 2 and 3. All subjects were dosed on day 0 and sampled on day 1.

<table>
<thead>
<tr>
<th>Group</th>
<th>Day for Sample 2</th>
<th>Day for Sample 3</th>
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<tr>
<td>1</td>
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<td>10</td>
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**TABLE 2** Characteristics of study subjects (n = 329)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean (SD)</th>
<th>Range</th>
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<tr>
<td>Age (yrs)</td>
<td>20 (1.9)</td>
<td>17–32</td>
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<tr>
<td>Height (cm)</td>
<td>176.8 (7.8)</td>
<td>144.8–195.6</td>
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<tr>
<td>Weight (kg)</td>
<td>76.7 (11.6)</td>
<td>50.0–109.1</td>
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<tr>
<td>BSA (m²)</td>
<td>1.94 (0.17)</td>
<td>1.53–2.42</td>
</tr>
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</table>

BSA, body surface area.
### TABLE 3  Model statistics after 1000 cycles

<table>
<thead>
<tr>
<th>Model</th>
<th>Parameters</th>
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<th>Bias</th>
<th>Imprecision</th>
<th>Bias</th>
<th>Imprecision</th>
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<td>1</td>
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<td>2</td>
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<td>4.81</td>
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<td>3</td>
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<tr>
<td></td>
<td>KCP, KPC</td>
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<td>5</td>
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<td>Ke=Ke0/wt^{0.25},</td>
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<td>V=V0*wt,</td>
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<tr>
<td></td>
<td>KCP=KCP/wt^{0.25},</td>
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<tr>
<td></td>
<td>KPC=KPC0/wt^{0.25}</td>
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*aAll size-scaled models (3 to 5) are similar, but model 5, with allometric scaling for body size, is preferable based on minimization of AIC and favorably low bias and imprecision.*

**AIC**, Akaike Information Criterion with the lowest value indicating the most likely model; **Bias**, mean weighted error of predictions minus observations; **BSA**, body surface area in m² normalized to mean population BSA of 1.94 m²; **Imprecision**, bias-adjusted mean weighted squared error of predictions minus observations; **Ka**, absorption from dosing to central compartment; **KCP**,
transfer from central to peripheral compartment; $K_e$, elimination from central compartment;

$KPC$, transfer from peripheral to central compartment; $V$, volume of central compartment; $wt$, weight in kg normalized to 70 kg.
TABLE 4  Population parameter values after a single dose of 1.2 million units of benzathine penicillin G in adults

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Units</th>
<th>Mean (SD)</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ke0</td>
<td>1/(day*70kg^{0.25})</td>
<td>4.11 (2.22)</td>
<td>3.96</td>
</tr>
<tr>
<td>Ka</td>
<td>1/day</td>
<td>0.40 (0.25)</td>
<td>0.32</td>
</tr>
<tr>
<td>KCP0</td>
<td>1/(day*70kg^{0.25})</td>
<td>6.91 (6.30)</td>
<td>4.71</td>
</tr>
<tr>
<td>KPC0</td>
<td>1/(day*70kg^{0.25})</td>
<td>0.27 (0.34)</td>
<td>0.12</td>
</tr>
<tr>
<td>V0</td>
<td>L/70kg</td>
<td>260.96 (96.45)</td>
<td>239.43</td>
</tr>
</tbody>
</table>

Calculated from full-fitted concentration profiles

- AUC$_{0-\infty}$ mg*h/L 19.33 (6.09)  18.68
- Clearance L/h/kg 0.68 (0.24)  0.65
- Half-life of absorption hours 72.55 (202.21)  50.79
- Half-life of elimination hours 6.03 (4.29)  4.19
- Cmax mg/L 0.14 (0.09)  0.13
- Tmax hours 22.90 (32.10)  9.60

AUC, area under the concentration–time curve; Ka, absorption from dosing to central compartment; Ke, elimination from central compartment; KCP, transfer from central to peripheral compartment; KPC, transfer from peripheral to central compartment; V, volume of central compartment, Cmax, maximum concentration, Tmax, time of maximum concentration.
TABLE 5 Proportion of 5000 simulated subjects between 25 and 110 kg with trough serum penicillin G concentration over 0.02 mg/L for various dosing regimens

<table>
<thead>
<tr>
<th>Dose</th>
<th>%Trough &gt;0.02 mg/L</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.2 million units monthly</td>
<td>23.2%</td>
</tr>
<tr>
<td>1.2 million units every 3 weeks</td>
<td>37.8%</td>
</tr>
<tr>
<td>1.2 million units every 2 weeks</td>
<td>65.2%</td>
</tr>
<tr>
<td>1.8 million units monthly</td>
<td>30.2%</td>
</tr>
<tr>
<td>2.4 million units monthly</td>
<td>40.7%</td>
</tr>
</tbody>
</table>

*Trough is defined as the serum penicillin G concentration just prior to the next dose.*
FIGURE CAPTIONS

FIG 1  Distribution of measured penicillin G concentrations (circles) in the population. Lines are the indicated percentiles of 5000 simulated concentration-time profiles. The grey shading around the percentile lines represents the 95% confidence interval around each percentile. The dotted horizontal line at 0.02 mg/L is the suggested minimum protective concentration of penicillin G against Group A streptococcus. Note that the majority of measured concentrations fall below this threshold. The dashed horizontal line is the limit of the assay, which is below all measured concentrations, but is above some simulated values at the end of the dosing interval. As a visual predictive check (13) of the model, the distribution of the simulated profiles is similar to the observed concentrations, suggesting that the model describes the data well.

FIG 2  Marginal distributions of parameter values in the final model. $K_{e0}$, elimination of BPG from the central compartment scaled to body weight (h$^{-1} \cdot$kg$^{-0.25}$); $K_a$, absorption from muscle to central compartment (h$^{-1}$); $K_{CP}$ and $K_{PC}$, distribution of BPG from the central compartment to the peripheral compartment and back (h$^{-1}$); $V_0$, volume of the central compartment (L/kg).

FIG 3  Proportions of simulated patients with penicillin G trough concentration > 0.02 mg/L for varying dosage regimens of BPG on a given day after the fourth dose, i.e. at steady state.
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FIG 2  Marginal distributions of parameter values in the final model. $Ke_0$, elimination of BPG from the central compartment scaled to body weight (h$^{-1}$*kg$^{-0.25}$); $Ka$, absorption from muscle to central compartment (h$^{-1}$*kg$^{-0.25}$); $KCP0$ and $KPC0$, distribution of BPG from the central compartment to the peripheral compartment and back scaled to body weight (h$^{-1}$*kg$^{-0.25}$); $V_0$, volume of the central compartment (L/kg).
FIG 3 Proportions of simulated patients with penicillin G trough concentration > 0.02 mg/L for varying dosage regimens of BPG on a given day after the fourth dose, i.e. at steady state.