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Keywords: tobramycin, sodium stearate, particle engineering, RS01 inhaler, dry powder inhaler, high doses, in vivo inhalation

Corresponding Author: Dr. Francesca Buttini, Ph.D.

Corresponding Author's Institution: University of Parma

First Author: Francesca Buttini, Ph.D.

Order of Authors: Francesca Buttini, Ph.D.; Anna Giulia Balducci; Gaia Colombo; Fabio Sonvico; Serena Montanari; Giovanna Pisi; Alessandra Rossi; Paolo Colombo; Rugero Bettini

Abstract: The purpose of this work was to study a new dry powder inhaler (DPI) of tobramycin capable to simplify the dose administration maneuvers to maximize the cystic fibrosis patient care in antibiotic inhalation therapy.

For the purpose, tobramycin/sodium stearate powder (TobraPS) having a high drug content, was produced by spray drying, characterized and the aerodynamic behavior was investigated in vitro using different RS01 DPI inhalers. The aerosols produced with 28, 56 or 112 mg of tobramycin in TobraPS powder using capsules size #3, #2 or #0 showed that there was quasi linear relationship between the amount loaded and the FPD.

An in vivo study in healthy human volunteers showed that 3 to 6 inhalation acts were requested by the volunteers to inhale 120 mg of TobraPS powder loaded in a size #0 capsule aerosolized with a prototype RS01 device, according to their capability to inhale. The amount of powder emitted at 4 kPa pressure drop at constant air flow well correlated with the in vivo emission at dynamic flow, when the same volume of air passed through the device.

The novel approach for the administration of 112 mg of tobramycin in one capsule could improve the convenience and adherence of the CF patient to the antibiotic therapy.

Prof. Francesca Buttini
University of Parma,
Food and Drug Department
Viale delle Scienze 27/A,
43124 Parma, Italy
Tel. +39 0521 906008
E-mail:
francesca.buttini@unipr.it

Editor-in-Chief
Professor Juergen Siepmann

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Object: Submission of revised manuscript #IJP-D-18-00531R1

Dear Professor Siepmann,

On behalf of all co-authors, I am pleased to submit for your attention the revised version of manuscript entitled "Dose administration manoeuvres and patient care in tobramycin dry powder inhalation therapy" by *Francesca Buttini, Gaia Colombo, Fabio Sonvico, Serena Montanari, Giovanna Pisi, Anna Giulia Balducci, Alessandra Rossi, Paolo Colombo, and Ruggero Bettini.*

For your convenience, I have uploaded the manuscript with the highlighted corrections.

I wish to thank you for the attention given to our paper and the help in making it more valid.

The two reviewers provided an important contribution for improving the paper.

I look forward for your kind feedback,

Yours sincerely,

Francesca Buttini



IJP AUTHOR CHECKLIST*Dose administration maneuvers and patient care in tobramycin dry powder inhalation therapy***Overall Manuscript Details**

- Is this the final revised version? yes
- Are all text pages present? yes
- Are the corresponding author's postal address, telephone and fax numbers complete on the manuscript? yes
- **Have you provided the corresponding author's e-mail address?** yes
- **Manuscript type – please check one of the following:**
 - Full-length article yes
 - Review article
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Manuscript elements

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- 3-6 Keywords enclosed? yes
- Complete reference list enclosed? yes
- Is the reference list in the correct journal style? yes
- Are all references cited in the text present in the reference list? yes
- Are all **original** figures cited in the text enclosed? yes
 - Electronic artwork format? -----jpeg
- Are figure legends supplied? yes
- Are all figures numbered and orientation provided? yes
- Are any figures to be printed in colour? yes
 - If yes, please list which figures here:----- Figure 7, 8, 9
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General

- Can you accept pdf proofs sent via e-mail? yes

RESPONSES TO REVIEWERS of the manuscript entitled “Dose administration manoeuvres and patient care in tobramycin dry powder inhalation therapy” (Ms. Ref. No.: # IJP-D-18-00531)

Dear Editor,

the authors wish to thank the Reviewers for the precious and useful comments which certainly will help to improve to the quality of the manuscript. The points risen by the Reviewers have been taken into account and punctual answers or text modifications have been provided.

Answers to the reviewer comments.

Reviewer # 1

1. Please provide the spray drying condition (e.g. model of spray drier, nozzle, inlet/outlet temperature, gas atomisation rate etc.) in the methods section.
The method of preparation has been revised and spray-dried conditions introduced.
2. For transformation in agglomerates - what was the yield/recovery (i.e. how much powder by mass was collected in sieve 106 µm)? This provides information to readers about the efficiency of the process.
The agglomeration process has been integrated with additional details and the yield has been specified.
3. Section 2.5 - the authors described 'loss of drying' using TGA. Was it the water loss in order to measure the residual moisture? please clarify.
The loss of drying during the TGA analysis was the solvent evaporation; the value obtained has been confirmed by Karl fisher titration to be essentially water.
4. Dissolution experiment - justify the use of medium (why water?), the volume of medium and amount of powder. How did this setting correlate to the human lung? Also, the powder used for dissolution study was not the respirable fraction. Would the authors expect the dissolution profile to be different between the bulk powder and the respirable fraction?
*The dissolution method description has been improved.
The purpose of the dissolution rate measurement was to compare the profile of TobraPS with the reference product TOBI Podhaler.
The authors did not expect different dissolution profile between bulk powder and respirable fraction since the dissolution rate of both powders was very rapid.*
5. XRD, TGA and microbiology data was not shown as figures/tables, but only described in words. Please include those data in the manuscript (or as supplementary data).
These data have been included in supplementary data.

6. Page 12 - the SEM images, authors described that ' in general, these particles were grouped together or adherent to the largest or to their fragments, but never fused together' - I think it is difficult to judge whether the particles were fused or not by visual inspection with SEM. Please rephrase...
The comment is accepted and the reference to fused particle deleted.
7. For powder to be effectively dispersed from the capsule-based inhaler, the mass as well as the volume that the powder occupied in the capsule are important. Can the authors comment on the volume % that was filled by the powders in the capsules?
The filling volume % of the capsule has been calculated on the basis of powder bulk density and capsule body volume. The values have been inserted in table 1 caption.
8. The *in vivo* studies were carried out on three healthy volunteers. Can the authors comment on how they expect their inhalation pattern to be different from CF patients who are the real users?
A reference reporting CF patient profile have been introduced for comparison purpose (Haynes et al. 2016).
9. Can the authors also comment on whether there was major discomfort experienced by the volunteers after successive inhalation acts (coughing? throat irritation?). Also how long did the volunteer wait between successive inhalation?
The point arisen by the review related to the time between successive inhalation and comfort during administration have been addressed.
10. Figure 6 - the authors should include in the figure legend, what the different colour stands for. Do they represent the sequence of successive inhalation?
The explanation of the colours has been inserted in figure legend.
11. Conclusions - the authors mentioned that '... the amount of formulation to inhale is around 120 mg, approximately 40% less than the reference approved product.' - state clearly what is the reference approved product.
The reference product has been specified.
12. Please check grammar and typo.
grammar and typo has been checked.

Reviewer # 2

Author thank this review for his punctual and largely justified observations.

We recognise that the literature overview was lacking; we apologize for this unwanted deficiency. Being in agreement, we provide for a more accurate citation of the literature, in particular, with reference to those devices proposed for the administration of high doses.

Concerning the number of references related to the research group, the ratio in the overall number of citations has been reduced to smaller proportions than what

appeared in the original version of the manuscript. Therefore, numerous other citations were added.

Regarding to the consideration that the manuscript appears as a commercial promotion, the authors disagree with this interpretation in particular because the scientific basis of this research has allowed us to discover a novel method of manufacturing antibiotic dry powders. This process, which employs a small amount of excipient (1%), has a general application that can be used in the manufacture of powders for inhalation of several drugs that require high dose administration.

Probably, the feeling of a commercial promotion to the reviewer derives from the fact that the tobramycin powder described in the manuscript is compared to a commercial product that constitutes the primary reference on the market.

About the use of volunteers, an informed consent was collected under the supervision of the physician Dr. Giovanna Pisi, Parma hospital doctor, leader of the cystic fibrosis in the pneumology department.

Specific Comments:

Materials: Please indicate the complete references of Ca²⁺ and Mg²⁺ salts or eliminate if the point 2.9 is removed as advised before.

The salt have been specified

Please indicate the references of the spray-dryer used for the preparation of TobraPS powder.

The spray dried conditions have been described.

Table 1: Explanations should be given regarding the difference of intrinsic resistances between the different RS01 devices (commercial and prototypes)!? The differences seem not to be dependent on the size of capsule. Are there any differences in the geometry of the prototype devices? Moreover, the authors should mention if the different RS01 devices can be considered as low resistance as it is commonly defined in the literature for the commercial one?

The difference among the inhalers depends only on the dimension of the hole air and not by the capsule size. The geometry of the air inlet port makes the difference in resistance.

The resistance to the prototype and commercial RS01 has been mentioned in the material section as commonly defined in the literature.

Comparative DDU tests should be performed on the different RS01 and on the T-326 inhaler devices.

The answer to this point has been provided below.

PIF and total inhaled volume values determined from the *in vivo* testing seemed low in comparison to data available in the literature. These points should be thoroughly discussed in the results section by giving some references.

The point arisen by the review has been addressed. We agree with this observation, especially for volunteer #3 where the PIF, more than the inhalation volume, was lower than those reported in the literature data of CF patients (the Haynes paper has been added in the reference list). A comment on this point has been inserted in the discussion.

Page 12, Powder characterization: It is not really interesting to mention the PSD of tobramycin raw material as the tobramycin was dissolved prior to spray-drying! More interestingly, the authors should give the PSD of the powder filled in the reference product Tobi Podhaler, which have to be compared to that of the spray-dried TobraPS. The same comparison should be made for SEM analysis regarding the morphology of the particles...

We agree that PSD of tobramycin raw material is not relevant; however, this was the characteristic of API used. We transferred this information in material section.

PSD quality is intrinsic in TOBI Podhaler and it was not our aim to assess the quality of the reference product

SEM analysis of TOBI has been widely published in literature illustrating the typical porous structure of the Pulmosphere particles. Therefore, it is not the case to add this picture.

Page 13: The TobraPS powder solid state cannot be considered as similar to the powder contained in the Tobi Podhaler. Indeed, different and much more excipients are used for the Tobi Podhler, which can have a stabilizing effect on the amorphous state of tobramycin. Moreover, the residual humidity of the TobraPS powder seemed too high to guarantee the physical stability of the formulation (TGA results for Tobi Podhaler?). So, the stability of the amorphous state should be proved for TobraPS!

We agree with the comment. The similarity consideration sentence in the text was deleted, the two formulations have different quality-quantity of excipients. Indication of the chemical stability were introduced and a comment on the amorphous status modification was added.

Pages 13-14: Results and discussion regarding the microbiological activity of the TobraPS powder should be removed (see before).

About the determination of the antibacterial activity of tobramycin against PA in terms of MIC and MBC, the authors agree that it is known in the literature; however, the formulation TobraPS contains sodium stearate which could interfere with this activity. Hence, we believe it is important to keep this data in the text.

Page 14: *In vitro* deposition: The authors should indicate the statistic test used to assert there is no significant differences between the FPD and MMAD results obtained for the Tobi Podhaler and TobraPS (the same for the comparison mentioned in page 16, 1st paragraph).

The details of the statistical test employed were added. Statistic section has been inserted in the experimental section. The comparison between Tobi Podhaler and TobraPS in RS01 inhaler was removed from the text. First, it it was a repetition of a comparison done with T326. Secondly, we considered that opening TOBI capsule and repackaging the formulation could not be acceptable.

Table 2: The table content should be completed with DDU results (see before) and the obtained results thoroughly discussed in the manuscript.

Authors consider not appropriate to perform a DDU test that is typically a product specification test. We are not assessing the intra-inter batch quality of the two products.

We know that from the NGI test the emitted dose calculating by summing the drug collected all over the impactor is underestimated. However, ED is a useful parameter to compare the products performances in term of emission efficiency. Moreover, the variability of the emission of the studied powders is present in the tables as emitted powder and emitted dose, represented by mean values and standard deviation.

Page 15: Please explain why the TobraPS bulk density can be considered as favourable? Is this value comparable to the bulk density of micronized tobramycin raw material or of the Tobi Podhaler powder?

We consider the bulk density as favourable since this value allowed to introduced in capsule size 3 the amount of powder corresponding to 28 mg of tobramycin. Favourable has been cancelled.

Page 17, 2nd parag: Why the same strategy of formation of agglomerates was not used for the other drug dose contents filled in capsules 3 and 2? Indeed, the aerodynamic performances of powders could potentially be affected by the filling method, which can affect the comparison between the different capsule/device sizes used in this study!

The reason by which we used the agglomerated powders only in the case of maximum drug to deliver (112 mg capsule size 0) was due to the fact that it was not possible to accommodate this amount of powder as it was unless increasing the bulk density.

Filling the powder or the agglomerates on the base of the results FPD obtained, resulted not to be affecting on the FPD or MMAD obtained.

Page 18-21: The *in vivo* study is performed on a too limited volunteers size and do not bring strong datas. The PIF and total inhaled volumes seemed not comparable to those commonly accepted in the literature (e.g. all the inhalation volumes measured are below 1.2 L) and there is no exhaustive discussion considering the situation with CF patients. Is the in-house system used to measure the inhalation profile validated? Finally, in order to make a more robust *in vivo-in vitro* correlation considering the inhalation profiles of the volunteers, the *in vitro* results generated should advantageously use a dynamic flow generation system rather than a standard constant flow generation system.

As concerning PIF, volume and CF patients this aspect has been taken into consideration as suggested by the reviewer #1 and the comparison with CF patient inserted in the discussion.

The system used for inhalation profile has been regularly validated by the flow meter manufacturer (Copley Scientific, UK).

We agree that the use of dynamic flow in order to measure the amount emitted and the particle size aerodynamic distribution of the aerosol would be closer to the *in vivo* inhalation profiles. However, the *in vivo* collected data regarding the emitted powder amount seemed to be well correlated to the data measured *in vitro* using the compendial constant flow rate. The dynamic flow generation mimicking the inhalation profile of volunteer will be advantageously used to determine the quality of the emitted powder aerosol according to the different profiles.

Page 19: Buttini et al. 2016a cannot be considered as other authors.

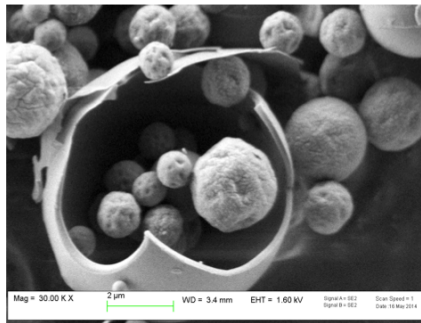
This reference was deleted.

Tobramycin powder production and characterisation

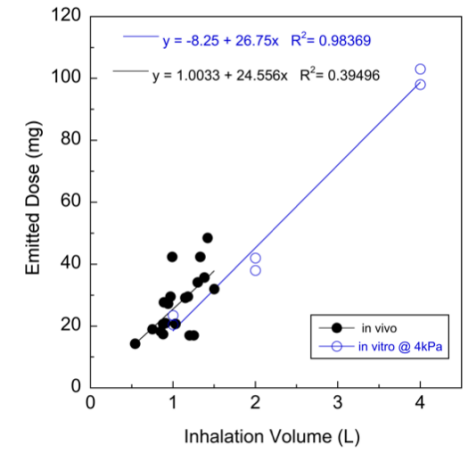
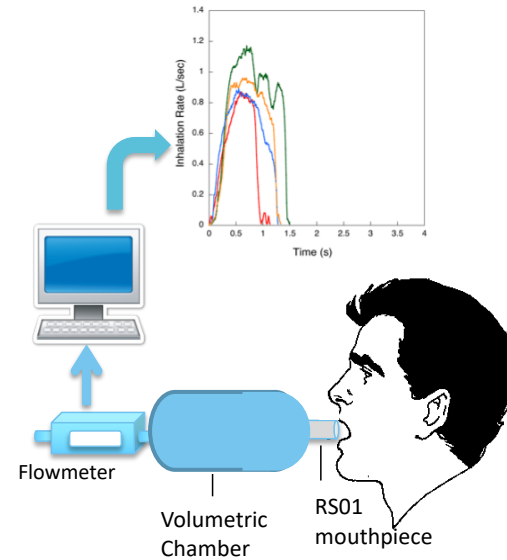
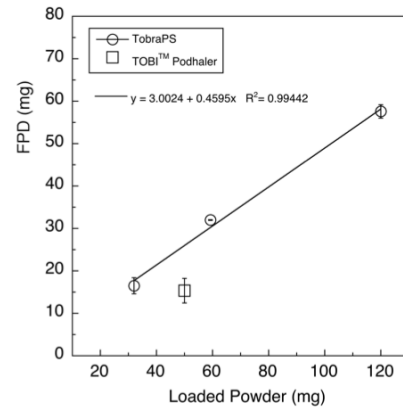
In vitro respirability

In vivo dose extraction by volunteers

In vitro / *in vivo* delivered dose correlation



TobraPS spray-dried powder (tobramycin:sodium stearate 99:1)



*Dose administration ~~maneuvers~~manoeuvres and patient care
in tobramycin dry powder inhalation therapy*

Francesca Buttini^{a,}, Anna Giulia Balducci^{a,§}, Gaia Colombo^b, Fabio Sonvico^a, Serena
Montanari^{a,¥}, Giovanna Pisi^c, Alessandra Rossi^a, [Paolo Colombo^{a,d}](#), Ruggero Bettini^a*

a: Food and Drug Department, University of Parma, Parco Area delle Scienze 27/A, 43124 Parma,
Italy

b: Department of Life Sciences and Biotechnology, University of Ferrara, Via Fossato di Mortara
17/19, 44121 Ferrara, Italy

c: Cystic Fibrotic Centre, University Hospital, Via Gramsci 14, 43126, Parma, Italy

d: PlumeStars Srl, Strada Inzani 1, 43125 Parma, Italy

§ Present address: Chiesi Limited, Bath Road Industrial Estate, Chippenham, Wiltshire, SN14 0AB,
UK

¥ Present address: Department Life Quality Studies, University of Bologna, Corso d'Augusto 237,
47921, Rimini, Italy

*** Corresponding Author**

Dr. Francesca Buttini

Food and Drug Department

University of Parma

Parco Area delle Scienze 27/a, 43124 Parma, IT

Tel. +39 0521 906008; Fax. +39 0521 905006

E-mail: francesca.buttini@unipr.it

Abstract

The purpose of this work was to study a new dry powder inhaler (DPI) of tobramycin capable to simplify the dose administration maneuvers to maximize the cystic fibrosis patient care in antibiotic inhalation therapy.

For the purpose, tobramycin/sodium stearate powder (TobraPS) having a high drug content, was produced by spray drying, characterized and the aerodynamic behavior was investigated *in vitro* using different RS01 DPI inhalers. The aerosols produced with 28, 56 or 112 mg of tobramycin in TobraPS powder using capsules size #3, #2 or #0 showed that there was *quasi* linear relationship between the amount loaded and the FPD.

An *in vivo* study in healthy human volunteers showed that 3 to 6 inhalation acts were requested by the volunteers to inhale 120 mg of TobraPS powder loaded in a size #0 capsule aerosolized with a prototype RS01 device, according to their capability to inhale. The amount of powder emitted at 4 kPa pressure drop at constant air flow well correlated with the *in vivo* emission at dynamic flow, when the same volume of air passed through the device.

The novel approach for the administration of 112 mg of tobramycin in one capsule could improve the convenience and adherence of the CF patient to the antibiotic therapy.

Keywords: tobramycin, sodium stearate, particle engineering, RS01 inhaler, dry powder inhaler, high doses, in vivo inhalation

Abbreviations

CF: cystic fibrosis

ED: emitted dose

FPD: fine particle dose

FPF: fine particle fraction

MMAD: mass median aerodynamic diameter

PA: *Pseudomonas aeruginosa*

PIF: peak inspiratory flow

TobraPS: spray-dried tobramycin powder

1. Introduction

Cystic fibrosis (CF) is a genetic rare disease caused by mutations in the gene coding the CF transmembrane conductance regulator protein leading to viscous mucus presence in airways (Moskowitz et al., 2005; Sheppard and Nicholson, 2002). Thus, CF patients are susceptible to pulmonary infections caused mainly by *Pseudomonas aeruginosa* (PA). Three approaches to the management of infections in CF patients are suggested by the European consensus guidelines (Flume et al., 2007): (i) prophylactic therapy for the prevention of infection and colonization; (ii) intravenous therapy for acute pulmonary infections and (iii) maintenance therapy by inhalation to prolong the interval between exacerbations. Thus, inhalation antibiotic therapy is recommended in exacerbation prevention of PA infection (Doring et al., 2000). Despite different antibiotics are available on the market (aztreonam lysine, colistimethate sodium and levofloxacin) ([Buttini et al., 2016](#); [Hewer, 2012](#))(~~Buttini et al., 2016b~~; ~~Hewer, 2012~~), the aminoglycoside tobramycin remains standard to manage *Pseudomonas aeruginosa* (PA ~~infection in CF patients~~) in order to delay exacerbation infection episodes ([Cheer et al., 2003](#); [Ratjen et al., 2009](#))(~~Ratjen et al., 2009~~).

Local concentrations of tobramycin in the lung of patients higher than intravenous administration is the objective of inhalation administration. The antibiotic deposition in the lung does not elevate the plasma drug concentration and, consequently, drug toxicity is limited (Weers, 2015). A tobramycin dry powder inhaler (TOBI™ Podhaler™, Novartis) has been authorized for the use in CF patients. This tobramycin dry powder inhaler introduced a significant advantage for patient compliance and quality of life, compared with nebulization. This method has been demonstrated satisfactory for PA infection management (Geller et al., 2007), since the inhalation of 112 mg of tobramycin was clinically equivalent to 300 mg of drug administered by nebulization.

From the technological point of view, the large amount of powder (200 mg), carrying 112 mg of tobramycin, could not be loaded in a single hard capsule reservoir of the device and inhaled in one inhalation act. Consequently, in TOBI™ Podhaler, the powder amount was shared in four hard

capsules size #2, each one loading ~50 mg of PulmoSphere™ powder (Galeva et al., 2013). The inhalation ~~maneuvers~~manoeuvres, i.e., to load one capsule into the inhaler, pierce it and inhale twice, have to be repeated four times to administer the entire dose. The therapy has to be done two times per day over 28 days. Despite the advantage for patient towards nebulization, the administration procedure significantly affected the patient adherence to the therapy (Boerner et al., 2014).

These facts evidence that there is a need of novel powders and devices for better managing the lung administration of high dose antibiotics.

Regarding the devices~~improvement~~, Twincer®, a disposable inhaler containing two air classifier technology, was developed with the aim to release up to 25 mg of unprocessed micronised particles or soft spherical agglomerates without special particle engineering processes (De Boer et al., 2006). Based on the same principle, Cyclops, a single classifier version of Twincer the inhaler was developed to aerosolize up to 50 mg ~~in one inhalation~~ of pure spray-dried amorphous aminoglycosides (Hoppentocht et al., 2015). FPFs (at 34 L/min) of tobramycin, amikacin or kanamycin with the Cyclops ranged 78-90% ~~of the delivered dose~~. The Orbital device is another single-use, disposable unit containing a “puck” that holds up to 400 mg of drug powder. A key innovative step in the Orbital design is the puck orifice that acts as the rate-limit step for ~~amount of released of powder~~. This system showed to be capable releasing efficiently fixed dose over a series of inhalation acts of both amorphous, crystalline and co-spray dried powder systems (Young et al., 2014a). These include 400 mg of mannitol, 100-400 mg doses of spray-dried ciprofloxacin/mannitol, 200 mg combination co spray-dried azitrohromycin/mannitol (Young et al., 2014b), 200 mg tranexamic acid (Haghi et al., 2015) and 200 mg ~~f~~ of micronized crystalline tobramycin (Zhu et al., 2016). Finally, the fluidized bed DPI is another novel multi-breathe high dose DPI which consists of a formulation reservoir (dosing sphere) that contains up to 100 mg of powder which is released during the inhalation act via 2 to 6 dosing holes into a fluidized device

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[bed. Using this design, the FPF of co-spray dried mannitol and ciprofloxacin reached 93% \(Farkas et al., 2015\).](#)

[On the formulation perspective, a](#) novel tobramycin inhalation powder formulated with a lipophilic adjuvant has been described ([Buttini et al., 2010](#))(~~Buttini et al., 2008~~). The tobramycin powder microparticles, constructed by spray drying, using a minimal amount of sodium stearate, exhibited a very small aerodynamic diameter, low density and ~~favorable~~[favourable](#) shape for aerosolization. Sodium stearate, a surface-active substance, molecularly coated the tobramycin microparticles, due to the preferential accumulation at the droplet air interface during drying. Microparticles with sodium stearate on surface showed a great aerosol performance. Moreover, the excipient provided protection from the environmental humidity determining a superior stability (Parlati et al., 2009), as also recently confirmed by (Yu et al., 2018).

The high drug content in tobramycin/sodium stearate microparticulate powder helps in capturing the patient adherence during PA infection management, if formulation/device combination provides a patient centric product. The driving hypothesis of this research was that the time for the daily antibiotic administration would be minimized by using a highly respirable and high drug content formulation, provided to have a device capable to regulate the amount of powder emitted. Hence, the aim of this work was to study a new dry powder inhaler of tobramycin capable to simplify the dose administration ~~maneuvers~~[manoeuvres](#) and to maximize the patient care in antibiotic inhalation therapy. The first objective was to identify the powder amount per capsule of the novel tobramycin inhalation powder equivalent to TOBI™ Podhaler™ dose of tobramycin; then, selected the device for aerosolization, to set down the most convenient technique of inhalation. Expected result could be that the number of capsules to inhale and time required for the daily tobramycin dose administration in CF patients could be reduced. Thus, the *in vitro* and *in vivo* respirability of the product have been tested and correlated.

2. Materials and Methods

2.1 Materials

Tobramycin base ($D_{v,0.5} 3.55 \pm 0.67 \mu\text{m}$) was supplied by Teva API B.V (Amsterdam, The Netherlands). ~~The particle size distribution was log normal. Tobramycin raw material micronized by jet milling exhibited a $D_{v,0.5}$ of $3.55 \pm 0.67 \mu\text{m}$.~~ Sodium stearate European Pharmacopoeia grade. Mueller Hinton agar (Biokar Diagnostics, Allonne - Beauvais, France), Mueller Hinton broth (DIFCO, Sparks, USA) and ~~calcium chloride dihydrate, magnesium chloride hexahydrate Ca^{2+} and Mg^{2+}~~ (MERCK, Darmstad) were purchased for drug activity test on PA. Water purified by reverse osmosis (MilliQ, Millipore, France). All chemicals were of analytical grade (Sigma-Aldrich S.r.l. Milan, Italy). TOBI™ Podhaler ~~T-326 inhaler medium resistance~~ (Novartis AG, Basel, Switzerland, batch CP0037) was retrieved by the local hospital pharmacy. The three RS01 dry powder inhalers used, namely a size #0 prototype ~~medium resistance~~, a size #2 prototype ~~low resistance~~ and the commercial size #3 ~~medium-high~~ resistance, were kindly donated by Plastiapae Spa (Osnago, LC, Italy). Hypromellose capsules for dry powder inhaler size #3 (Quali V-I) and size #2 and size #0 (Quali-V) were donated by Qualicaps (Madrid, Spain).

2.2 Tobramycin microparticles and agglomerates manufacturing

Tobramycin dissolved with 1% w/w of sodium stearate was spray dried accordingly to ~~(Parlati et al., 2009). Briefly, 4.95 g of tobramycin was dissolved in 350 ml of purified water at 30°C whereas 0.05 g of sodium stearate was dissolved in 150 ml ethanol 95° at 30 °C. The two solutions were heated at 30°C and mixed and the final solution with a solid content of 1% w/v in order to obtain a final solution with solid content of 1% w/v, tobramycin: sodium stearate ratio 99:1 and water: ethanol 70:30, kept at 30°C, was spray-dried using a Buchi B-290 (Buchi, Flawil, Switzerland). The spray-drier conditions were: feed rate 3 ml min⁻¹, aspiration rate 100%; air flow rate 600 l h⁻¹, inlet and outlet temperatures 125° C and 75-78° C.~~

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respectively. The spray-dried powder, coded TobraPS, was used as it is after the production or transformed in agglomerates by mechanical vibration as previously described (Belotti et al., 2014). In detail, 5 g of powder were placed on a stack of two sieves of 600 and 106 µm size and vibrated using a sieve shaker for size analysis (Fritsch GmbH, Oberstein Deutschland) at the amplitude 3 for 5 minutes in a cabinet under nitrogen atmosphere. The agglomerates in the size range 106-610 µm were collected, stored in sealed glass vial at 25°C-60% RH. The yield of the process ranged between was higher than 70-99%.

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Powder characterization

2.3 Assay of tobramycin

The assay of tobramycin was performed by the USP 37 HPLC method. System suitability was performed according to USP 37. The method precision (Relative Standard Deviation calculated following six injections of a 0.5 mg/mL standard solution) was 0.85% and the linearity was in a range from 0.1 to 1.5 mg/mL ($R^2 = 0.9945$). LOD and LOQ values were 0.02 mg/mL and 0.06 mg/mL respectively.

2.4 Particle size distribution

Particle size distribution of TobraPS powders was measured using the laser light scattering apparatus (SprayTec, Malvern Instruments Ltd, UK). Approximately 10 mg of the sample was dispersed in 20 mL solution of 0.1% (w/v) Span 80 in cyclohexane and sonicated for 5 min. The particle size distribution was measured in triplicate with an obscuration threshold of 10%. Data were expressed in terms of median volume diameter and percentiles, $D(v,0.1)$, $D(v,0.5)$, $D(v,0.9)$.

2.5 Loss on drying

The residual solvent of powders was determined as loss on drying ~~of powders was determined~~ with thermo-gravimetric analysis. The instrument used was the Mettler Toledo Thermogravimetric

Analyzer (Mettler Toledo, Switzerland). About 5 mg of powder was introduced in a 70 μ L alumina pans with a pierced cover and analysed from 25°C to 250°C at a heating rate of 10°C/min under a nitrogen stream flowing at 80 ml/min. The weight loss was measured in the range between 25 - 125 °C.

2.6 Crystallinity

The study the crystal form of tobramycin powders was performed by X Ray Powder Diffraction analysis. The instrument employed was a MiniFlex X-Ray Diffractometer (Rigaku, Japan). About 200 mg of powder were loaded on the sample holder and then analysed from a start angle of 2θ to an end angle of 35θ with 0.5θ steps.

2.7 Scanning Electron Microscopy

TobraPS powder morphology was assessed by Scanning Electron Microscopy (SEM) (JSM-6400, JEOL Ltd., Japan) at high magnifications (10000x - 30000x) with a EHT of 1.60 kV. The samples were placed on a double-sided adhesive tape pre-mounted on an aluminium stub and analysed after a 30 min depressurization.

2.8 Dissolution profile

The dissolution rate of tobramycin powders was measured using a Franz cell constituted by a donor compartment separated from receptor compartment by a disc of [high pure](#) filter paper (Albet [LabScience 84](#) g/m²). [The receptor compartment has a sampling port that allows to collect the samples for tobramycin HPLC determination](#)~~The dissolution profile of tobramycin powders was assessed. Approximately 10 mg of powder TobraPS were accurately weighed. The receptor compartment has a sampling port that allows to collect the samples for tobramycin HPLC determination. In the case of TOBITM Podhaler a capsule was opened to recover the powder content.~~

The Franz cell receptor was filled with 20 ml of degassed purified water by reverse osmosis and the filter paper disc was wet with 0.5 ml of purified degassed water to create a thin film above it. The Franz cell was [thermostated](#) at 37°C ~~and~~ a stir-bar rotating at 200 rpm was introduced in the

receptor compartment and the absence of air bubble in the cell under the membrane was verified.
Approximately, 10 mg of powder TobraPS accurately weighed, were distributed on the filter paper.
In the case of TOBI™ Podhaler ~~a capsule and the~~ 10 mg of powder were sampled from the capsule
content.

At time zero, through the sampling port, 2 ml of receptor solution was taken with a syringe and analysed by HPLC. After each sampling, the cell was refilled with an equivalent volume of purified degassed water. The ~~times of~~ sampling were ~~determinate performed~~ at prefixed time of 5, 10, 15 minutes, ~~and~~ Each powder was tested in triplicate.

2.9 Activity of tobramycin formulation on *Pseudomonas aeruginosa* strain

Minimal Inhibitory Concentration (MIC) and the Minimal Bactericidal Concentration (MBC) against PA, reference strain ATCC27853 were determined. Antibiotic stock solutions were prepared dissolving the powders in sterile deionized water at the concentration of 5.12 mg/ml. Stock solutions of antibiotics were diluted ten times with cation-adjusted Mueller Hinton broth to a final volume of 10 ml and then, on base two. Dilutions were 256, 128, 64, 32, 16, 8, 4, 2, 1 and 0.5 µg/ml. 50 µl of each dilution were then transferred in separate wells of a microtiter plate. Three to five colonies of PA grown on Mueller Hinton agar plates were inoculated into tubes containing 6 ml of cation-adjusted Mueller Hinton broth. Tubes were incubated at 37°C on a shaker at 225 rpm for 4 hours. The suspension containing approximately 10⁸ CFU/ml was diluted 1:100 by adding 200 µl of it to 19.8 ml of cation-adjusted Mueller Hinton broth. Within 30 min, 0.05 ml of this suspension (10⁶ CFU/ml) were inoculated for each well, so that the final concentration of bacteria was approximately 5x10⁵ CFU/ml. To verify the correct final inoculum concentration, a 0.01 ml aliquot was remove from the growth-control well immediately after inoculation and diluted in 10 ml of 0.9% sterile saline. After mixing, 0.1 ml of this suspension was spread over Mueller Hinton agar supplemented with Ca²⁺ and Mg²⁺ and incubated overnight at 37°C. The test was considered valid

with a presence of approximately 50 colonies, indicating an inoculum density of 5×10^5 CFU/ml. Plates were read, after incubation at 37°C for 18-24 hours in moistened air, with the aid of a magnifying mirror. The test was considered valid when acceptable growth has occurred in the antibiotic-free growth control well and no contaminant growth was present in the medium sterility control well.

The MIC was defined as the lowest concentration of antimicrobial at which there is no visible growth of PA ATCC 27853 after overnight incubation. The MBC was defined as the lowest concentration of antibacterial agent that reduced the viability of the initial bacterial inoculum by $>99.9\%$.

2.10 *In vitro* aerodynamic drug deposition

The dispensing and dispersion performance assessments were performed using Next Generation Impactors (NGI) (Copley Scientific, Nottingham, UK). The methodology employed followed USP38 General Chapters, Physical tests and determinations for dry powder inhalers (Apparatus 5). The collection stages were coated with Span 85 in cyclohexane solution (1% w/v) to prevent particle bounce. Powder formulations were aerosolised by the inhaler(s) while attached to the NGI and the tobramycin retained in the capsule, inhaler, and impactor was collected using a H_2SO_4 0.01N and assayed by HPLC. Furthermore, A fast screening impactor (FSI, Copley Scientific Ltd, Nottingham, UK) was used as an abbreviated impactor to assess the aerodynamic performance of different loaded dose of TobraPS powders. FSI is constituted of a Coarse Fraction Collector (CFC) that captures particles with an aerodynamic diameter larger than $5 \mu\text{m}$ and a Fine Fraction Collector (FFC) that collects particles with an aerodynamic diameter smaller than $5 \mu\text{m}$.

TobraPS powder was studied in combination with T-326 inhaler (Podhaler) and with different types of RS01 device, able to load different sizes of HPMC capsules. The flow rate used during each test was adjusted with a Critical Flow Controller TPK (Copley Scientific, Nottingham, UK) in order to

produce a pressure drop of 4 kPa across each inhaler used. The flow rate corresponding to these pressures were measured before each experiment (DFM 2000 Flow Meter, Copley Scientific, Nottingham, UK) and test duration time was adjusted so that a volume of 4 L of air was drawn through each inhaler during each test. Capsule were manually filled with the test powder in a glove box (RH 10±5%, temperature 20°C) using an analytical balance, precision 0.1 mg.

The DPI devices, capsule size, intrinsic resistance and flow rate adopted is reported in Table 1.

The tobramycin mass deposited inside the impactor and inhaler allows the calculation of aerodynamic parameters. The Emitted Dose (ED) is the amount quantified by HPLC of drug leaving the device entering the impactor (induction port, stages 1 to 7 and MOC). The mass median aerodynamic diameter (MMAD) was determined by plotting the cumulative percentage of mass less than the stated aerodynamic diameter for each stage on a probability scale versus aerodynamic diameter of the stage on a logarithmic scale. The Fine Particle Dose (FPD) is the mass of drug <5 µm calculated from log-probability plot and the Fine Particle Fraction (FPF) is the ratio of the FPD to the ED. Finally, the emitted amount of powder was checked as well by weighting the device before and after aerosolisation.

[Table 1. Device, capsule size and flow rate adopted.](#)

Formulation	Inhaler/capsule size	R (kPa^{0.5}/LPM)	Loaded powder /capsule	Powder capsule filling (%)*	Flow rate at 4 kPa (L/min)
TOBI Podhaler	T-326 Inhaler size #2	0.025	50	-	78
TobraPS	T-326 Inhaler size #2	0.025	32	48	78
TobraPS	RS01 size #3	0.033	32	60	60
	RS01 size #2	0.022	60	94	90
	RS01 size #0	0.027	120	88	72

• [Calculated as fraction of the capsule body volume](#)

2.11 *In vivo* testing for powder emission

The *in vivo* study was performed in 3 healthy volunteers (two male and one female of 72, 42 and 32 years old respectively) in order to assess the number of inhalation acts required to inhale 120 mg of TobraPS powder loaded in a size #0 capsule and aerosolized by RS01 prototype device. The amount of powder extracted after each inhalation was also measured. The work has been carried out in accordance with The Code of Ethics of the World Medical Association (Declaration of Helsinki) and a signed informed consent was obtained by each volunteer after carefully explanation of the purpose of the study and its execution.

Preliminary, the capsule was inserted in the device but not pierced, and the volunteers were instructed to inhale twice the capsule with a deep single breath with an inspiratory flow sufficient to hear the capsule spinning. In such a way, subjects become confident with the inspiratory effort required to lift and rotate the capsule in the device. The minimum airflow suitable for this was *in vitro* experimentally measured to be > than 20 L/min. The effective capsule rotation was easy to verify by listening to the noise produced during capsule spinning.

After the training session, volunteers were requested to inhaled TobraPS powder and an apparatus suitable for the measurement of airflow rate produced by the inhalation act during the dose extraction was an in-house developed (Fig 1). The latter consists in a 1.25 L chamber in which the RS01 was tightly inserted, leaving the mouthpiece out. The chamber air was supplied through a flowmeter (DFM Flow Meter, Copley Scientific, UK) connected to a PC computer (LabVIEW version 10.0.1, National Instruments, US) for time and airflow data collection. Using this set-up equipment, we could measure the inhalation profile and determined the peak inspiratory flow (PIF) and the air volume inhaled. Then, the RS01 prototype device was loaded with a size #0 capsule containing 120 mg of TobraPS agglomerated corresponding to 112 mg of tobramycin. The capsule was pierced and the device was weighted before to be introduced in the inhaler and sealed in the chamber connected to flowmeter, leaving out the mouthpiece. After the first inhalation act, the amount of powder emitted was measured by weighting the device recovered from the apparatus.

Then, the system was reassembled and the procedure was repeated until the capsule was emptied.

~~The waiting time for the volunteers between two inhalation acts of the volunteers was approximately of not less than 14 min.~~

2.12 Statistic

Statistical calculations were performed with the software KaleidaGraph (Synergy Software, U.S).

~~To identify~~For statistically significant differences, ~~one way ANOVA with~~ t-test analysis was performed. ~~Probability values of $p < 0.05$ Significance level of 5% were considered significant.~~ was set.

3. Results and Discussion

Powder characterization

Using the lab scale spray-drier, several batches up to 10 g of tobramycin solution containing 1% of sodium stearate were dried and the process yields was in the range 68-72%, similar to (Parlati et al., 2009). The powder recovered (TobraPS) from the spray drier collector appeared as irregular large clusters of micronized particles; the drug content was of 91.1% w/w. The microparticle 10%, 50% and 90% size distribution percentiles, measured as D_v by laser diffraction, were $1.03 \pm 0.21 \mu\text{m}$, $2.40 \pm 0.36 \mu\text{m}$ and $5.29 \pm 0.91 \mu\text{m}$, respectively: ~~the particle size distribution was log normal.~~

However, the scanning electron images (Fig. 2) showed numerous particles larger than $5 \mu\text{m}$, spherical and with smooth surfaces. Apparently, the particles were empty since many of them were inflated and exploded. Their fragments were visible as flat flakes in the particle population. Curiously, frequently smaller particles were observed inside the cavity of the exploded larger ones. Together with large particles, there are small ones with less smooth surface; in general, these particles are grouped together or adherent to the largest or to their fragments, ~~but never fused together.~~

This morphology was recently observed also in spray dried amikacin powders for inhalation prepared in the same conditions and it was attributed to the amikacin solubility in the water-alcohol solutions used for spray drying. Since the alcohol solubility of aminoglycoside is lower than in water, during the drying of sprayed droplet, an early precipitation of drug took place at droplet surface creating a crust that obstructs the solvent evaporation. Thus, the increase of vapor pressure inflated the particle during drying causing its explosion, more frequent when alcohol was present in the drug solution (Belotti et al., 2014; 2015). Morphology and volume diameter of tobramycin spray-dried microparticles contributed to the powders favourable characteristics for pulmonary deposition.

X-ray diffraction analysis ~~of TobraPS powder showed evidenced~~ the amorphous state of spray dried tobramycin powder (see supplementary data). ~~Thus, TobraPS powder solid state was similar to TOBI™ Podhaler™ powder formulation that~~ was described to have an amorphous state ~~as well~~ (Geller et al., 2011) and to be stable at low relative humidity storage conditions. ~~TobraPS, packed in a sealed glass vial, showed a chemical stability unmodified at 25°C for 9 months; the physical stability, in particular the aerodynamic performance, showed a significant decrease of 15% during this storage time, hence requesting a specific air tight store conditions. The DSC comparison of the powder stored during this time period showed~~ ~~any~~no variation indicating recrystallization (see supplementary data) ~~and subsequent melting of tobramycin.~~

TobraPS powder batches presented an average loss of weight during TGA analysis of $7.93 \pm 1.35\%$, confirmed as water by Karl Fisher titration.

The administration of antibiotic solid particles requires for activity a quick local availability of dissolved drug molecules. For this purpose, the dissolution profiles of TobraPS powders, compared to tobramycin formulation of TOBI™ Podhaler™, are reproduced in Fig. 3.

Both powders dissolved rapidly and more than 85% of drug was in solution in 15 minutes. However, in the first ten minutes, tobramycin spray dried powders with sodium stearate reached almost complete dissolution (92.2%), whereas TOBI™ powder dissolution was slightly slower (67.8%). Moreover, in the case of TobraPS, all the powder was dissolved without any visible residue on the diffusion cell membrane where the powder was deposited; differently, with TOBI™ powder left a white solid residue at the end of the dissolution. Likely, some excipients from tobramycin Pulmosphere™ remained on the filter of the cell donor compartment. In summary, the availability at the lung deposition site from TobraPS powder is expected to be prompt and complete.

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The microbiological activity of the TobraPS powder was assessed in an experiment in which the powder was dissolved before to contact the microorganisms. The results demonstrated a microbiological activity not different from the non-processed raw material: the MIC value obtained for TobraPS (0.5 µg/ml) was consistent with EUCAST data (Leclercq et al., 2013) and were similar to tobramycin raw material and TOBI™ powder. MBC values were of 1 µg/ml and similar as well for all the tested formulations (tobramycin raw material, TobraPS and TOBI™). Thus, the spray drying processes did not affect the antimicrobial activity of the tobramycin in the TobraPS formulation. It was reported that the maximum tobramycin concentrations in sputum 30 min after single-dose administration of TOBI™ (4 x 28 mg tobramycin) have was 1048-1080 µg/g. This exceeds, by several times, the MIC of tobramycin measured *in vitro* in the vast majority of isolates from infected CF patients (Konstan et al., 2010).

Aerodynamic *in vitro* deposition and dose definition

The aerodynamic ~~behavior~~behaviour of TobraPS powder was compared to the reference product. The aerodynamic performance of TOBI™ Podhaler™ was investigated with its registered device at flow rate of 78 L/min, equivalent at 4kPa pressure drop. Each TOBI™ contained about 50 mg of powder correspondent to 28 mg of tobramycin. The respirable dose (FPD) of TOBI™, i.e., the amount of tobramycin having aerodynamic size lower than 5 µm, was 14.7 mg, corresponding to a FPF of 65.2%. (Table 2). For correctness of comparison, the aerosolization performance of TobraPS formulation was also studied using the T-326™ inhaler loading the same dose of 28 mg of tobramycin in a size #2 capsule. According to drug content, 32 mg of TobraPS powder were weighed and aerosolized. Comparing the aerodynamic parameters (Table 2), no significant difference concerning FPD (p=0.52) or MMAD (p=0.65) were observed. Therefore, the two tobramycin formulations, aerosolized in the same conditions, had similar respirability parameters. However, it has to be noted that the similar deposition of tobramycin was obtained using significantly different mass of powders, since TOBI™ capsule contained 50 mg, whereas TobraPS

was loaded with 32 mg of formulation, which represents a decreased of 36% of powder to inhale. In summary, the results demonstrated that using the same device, TobraPS formulation deposits a sensibly lower mass of powder in the lungs for allowing a similar antibiotic activity. On the basis of drug content of TOBI™ (60.6%) and TobraPS (91.1%), the 39.4 % of the emitted powder from TOBI™ powder were excipients, versus 8.9% of TobraPS.

Table 2. Aerodynamic parameters of TOBI™ and TobraPS powders using the Podhaler™ T-326 inhaler [and capsule size #2](#) (mean value and st.dev.; n = 3). Each capsule contained 28 mg of tobramycin but different excipients.

Formulation	Loaded Powder mg	Powder Emitted [#] mg	Emitted Dose mg	FPD mg	MMAD μm	FPF %
TOBI™ Podhaler	≈50	46.7 ± 4.8	22.4 ± 0.7	14.7 ± 0.3	1.61 ± 0.20	65.2 ± 2.3
TobraPS	≈32	26.9 ± 4.7	20.6 ± 0.1	15.4 ± 1.9	1.56 ± 0.03	74.9 ± 8.8

[#]: determined by weighing

It's well know that the reduction of operation steps and [manoeuvres](#) decrease the probability of serious errors with DPI (Voshaar et al., 2014). As well as, it was reported that the patient adherence to the antibiotic therapy in cystic fibrosis PA management was negatively affected by sharing the dose to administer: only 52% of 288 patients enrolled in the study declared to inhale 4 capsules (Boerner et al., 2014). Hence, with the goal to attempt a reduction of the number of capsules constituting the dose, TobraPS was loaded in increasing doses in capsules of augmented size and aerosolized using the appropriate RS01 device.

The set of experiments was started by testing the performance of TobraPS powder with the commercial [medium-high](#) resistance (0.033 kPa^{0.5}/LPM) device RS01 using a capsule size #3, loaded with 32 mg of (corresponding to 28 mg of tobramycin, i.e., the same dose of TOBI™). Due to the TobraPS [favourable](#) bulk density (0.17 g/ml), this size of capsule size could easily accommodate [this](#) mass of powder. In RS01 device, the capsule, pierced in correspondence of the cap and body extremities, due to the inhalation air flow rate rotated on the main axis inside the

device, so centrifuging out the powder. Conversely in the low-medium resistance T-326 inhaler (0.025 kPa^{0.5}/LPM), has the same powder emission mechanism of Turbospin[®] device (PH&T, Milan, Italy), i.e. the capsule pierced at the bottom, rattles and swirls for powder emission (Martinelli et al., 2015). Thus, Table 3 shows the performance of 32 mg of TobraPS powder aerosolized using the RS01 device with capsule size #3. Again, for comparative purpose, TOBI[™] Pulmosphere[™] (32 mg) was tested using this device/capsule combination and as previously demonstrated using the T-326 inhaler, no statistical difference could be assigned to the aerodynamic performance of the two devices and products. However, it has to be again stressed that, in the case of the TobraPS a consistent lower amount of powder has to be aerosolized to deliver the same dose of TOBI[™], due to the high drug content.

Aiming at the reduction of the number of capsules, the amount of powder correspondent to the entire dose (112 mg) had to be increased in the capsule. Capsules #3 could not accommodate an amount of TobraPS powder larger than 40 mg without compacting the powder, thus affect the aerodynamic performance. Hence, the switch to the use of larger capsule was a forced choice. Capsule #2 and #0 were adopted and the content aerosolized using novel RS01 inhalers, having the same emission mechanism, but capable of accommodate the larger capsule size.

Thus, 56 mg of formulation, that would correspond to the entire dose shared in two capsules, were loaded in capsule #2. The results of the aerodynamic assessment of this capsule are illustrated in Table 3. The fine particle dose obtained after inhalation of 56 mg tobramycin was approximately doubled, resulting 32.0 mg. These results could make possible to propose the halving the entire dose from four to two capsules to be inhaled by the patients.

Table 3. Aerodynamic assessment of TobraPS using RS01 devices and capsules of different size (4 L of air through the device at flow rate corresponding to the pressure drop of 4 kPa).

Loaded TobraPS (as tobramycin) mg	Powder Emitted [#] mg	ED mg	FPD mg	MMAD μm	FPF (%)

Capsule size #3 32.0 (28.0)	27.8 ± 2.4	20.1 ± 1.9	16.5 ± 1.9	1.79 ± 0.17	81.8 ± 5.1
Capsule size #2 59.3 (56.0)	54.1 ± 1.2	41.8 ± 1.6	32.0 ± 0.1	1.85 ± 0.02	76.6 ± 3.1
Capsule size #0* 120.0 (112.0)	94.7 ± 0.7	75.4 ± 0.3	57.6 ± 1.6	1.82 ± 0.03	76.3 ± 1.8

* powder agglomerates; # determined by weighing

The therapy could reach a more relevant benefit in term of convenience and adherence by the patient if the dose could be administered employing only one capsule for the total dose delivery. Therefore, a RS01 device capable to accommodate a capsule size 0 or 00 was tested for delivery of high payload formulations (Parumasivam et al., 2017). A similar prototype with a resistance of 0.027 kPa^{0.5}/LPM was employed in this work in order to administer 112 mg of tobramycin (as 120 mg of TobraPS), the equivalent of 4 capsules 28 mg each.

It was not possible to load the entire dose of microparticles in one capsule size #0, unless an agglomeration process were applied in order to increase the powder bulk density. Agglomerates are soft pellets in which the microparticles are hold together by weak interaction forces (Russo et al., 2004); they can be destroyed into the device by the air turbulence produced by patient inhalation. This technology permitted to introduce 120 mg of formulation inside the capsule #0. The agglomerates or pellets are free flowing and the homogeneity of the powder was substantially increased, so facilitating the loading of the capsule to inhale.

In details, approximately 120 mg of agglomerated TobraPS were loaded in the capsule #0 and the entire content was aerosolized in one shot of 4 L of air at pressure drop of 4 kPa. The FPD value obtained was 57.6 ± 1.6 mg (Table 3). This value was not far away from the FPD accumulated from four capsules containing 28 mg of TobraPS each aerosolized with RS01 size #3 that was 66 mg (16.5 mg x 4). More interestingly, the value was similar to TOBI™ Podhaler™ FPD that, following

the emission of four capsules, was 58.8 mg. The FPD from one capsule with RS01 size #0 corresponded to 97.8% of the expected dose from four capsules with Podhaler™.

The inclusive comparison of the fine particle dose of the aerosols produced with 28, 56 or 112 mg of tobramycin in TobraPS powder and agglomerates with the RS01 device using capsules size #3, #2 or #0 (Table 3) shows that the FPD at the same 4 kPa pressure drop slightly decreased by increasing the amount of drug in the capsule. The FPD of TobraPS aerosolized with the RS01 devices was plotted versus the different amounts of powder and compared with the FPD of TOBI™ Podhaler™ (Fig. 4). There is a quasi linear relationship ($R^2=0.99442$) between the amount loaded in RS01 devices and the FPD. The “position” in the graph of TOBI™ Podhaler™ illustrates the difference existing between this formulation and TobraPS.

The comparison among the three different doses has been tested also by using the Fast Screening Impactor that could allow to determine the amount of drug remaining in the device, in the IP, emitted as coarse fraction and as fine fraction (less than 5 µm). It was confirmed that the fine particles approximately doubled by doubling the dose, such as the coarse fraction. The amount of formulation remaining in the device was also correlated with the amount loaded, but not the amount deposited in the IP (Fig. 5).

In vivo powder emission after multiple inhalation acts

TobraPS cumulated in one capsule size #0 could be extracted by the device *in vitro* with one single actuation at 72 L/min per 3.3 seconds. However, *in vivo* this amount of powder should be delivered to the patient in successive inhalation acts. Recently, the antibiotic colistimethate sodium powder for inhalation at the dose of 125 mg was introduced in a single capsule in order to be extracted by the user in 6-7 successive inhalation acts (Tappenden et al., 2013). The tobramycin deposition data reported until now have been collected *in vitro*. *In vivo*, with the high tobramycin dose, all the powder extracted in one shot would be unfeasible and unsafe. A graduation of the emission could

be done by performing successive inhalation acts through the same loaded RS01 device. Therefore, for the *in vivo* test measurements, the air flow profiles of three [healthy](#) volunteers during powder inhalation were recorded, using the device RS01 capsule size #0 loaded with 120 mg of TobraPS. [These obtained profiles of healthy volunteers were paralleled to the amount of drug extracted or emitted and could ~~can~~ be compared to the CF patient profiles published by Haynes \(Haynes et al., 2016\).](#)

Fig. 6 illustrates the air flow rate versus time of four inhalation acts successively performed by the three volunteers during powder inhalation. The volunteers repeated the test more times. The flow rate variability of inhalation through the loaded DPI can be appreciated both individually than among the volunteers. In general, the PIF value of inhalation through the device was in the range of 0.4 to 1.4 L/s, over a time interval of 1 to 4 seconds. Two volunteers were able to perform successive inhalation acts giving consistent air flow profiles. One volunteer inhaled slowly for a longer time, still maintaining a flow rate (> 20 L/min) capable to lift and rotate the capsule. [In comparison with *in vivo* profile of CF patient \(\(Haynes et al., 2016\)\), these data in particular the PIF values are slightly lower. However, the aim on the *in vivo* test was to relate the amount of powder extracted with the PIF and total inhaled volume values provided by the ~~patients~~volunteers.](#)

Using the set up described in the experimental, the measurement of the amount of powder emitted during the volunteer inhalation together with the air flow profile was performed. All the replicated experiments are reproduced in Fig. 7 versus the inhalation act number. Volunteer 1, constantly performing the inhalation acts (Fig. 7, blue symbols), was able to extract the drug dose in three-four acts. Volunteer 2 employed four acts (Fig. 6, red symbols), whereas volunteer 3 (Fig. 7, green symbols), inhaling slowly due to personal apprehension, required from five to six inhalations in order to extract the entire dose. [Any evident discomfort has been observed by the three volunteers enrolled in the test.](#)

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In order to identify the determinant of the dose emission in correspondence on each inhalation act, the emitted dose after inhalation from the different volunteers and successive replicas were plotted versus the PIF value of the inhalation profile (Fig. 8a). For assuring the comparison in the same conditions, only the first inhalation act of each volunteer was considered. There was a quite expected dependence of the emitted amount from PIF, albeit the significance of the linear relationship was low ($R^2 = 0.36857$). Despite the scattering of the values, this result underlines the relevance of PIF for the dose extraction. The PIF activated the rotation of the capsule in RS01 device, but PIF could not be the only determinant for powder emission from device. The flow profile during powder emission allows the calculation of the area under the curve, i.e., the volume of air passed through the device during the inhalation act. The measured volumes were plotted versus the emitted dose (Fig. 8b). This plot shows a more significant linear relationship between the powder amount emitted and the volume of air passed through the device, at PIF values higher than 20 L/min. This aspect, noticed by other authors ([Sosnowski, 2018](#); [Weers and Clark, 2017](#)) (~~[Buttini et al., 2016a](#); [Weers and Clark, 2017](#)~~), supports the importance of the air volume for the quantitative emission of powder. In fact, the linearity of the relationship between powder emitted at first inhalation versus air volume inhaled, supported the relevant role of air volume, together with the PIF presented.

In summary, using RS01 device, that has a mechanism of powder emission dictated by the rotation of the pierced capsule in a spinning chamber, the air flow through the device guarantees the lift of the capsule and its rotation at threshold values of flow rate higher than 20 L/min. Increasing the PIF value, the amount emitted increased, but the relationship was less predictable. There was a stricter correlation between the amount emitted and the volume of air passed through the device. This meant that the device emission was not only dependent on the air PIF, but the dose extracted at low PIF depended also by the duration of the inhalation act. Repetition of the inhalation act on the same capsule make more reliable the amount of drug inhaled.

Finally, the amount of powder emitted *in vivo* was compared with the amount of powder emitted *in vitro* at a flux corresponding to three established pressure drops. The plot shows as well the *in vitro* emitted powder when the inhaler was activated at pressure drop values lower than 4 kPa, i.e. 3.3 and 2 kPa. In these cases, for all the air volumes passed through the device, the *in vitro* emitted powder was lower than the one measured at 4 kPa. The powder amounts extracted at first inhalation act by the three volunteers correlate with the *in vitro* emitted dose values obtained at similar air volume for 4 kPa pressure drop (Fig 9a). This relationship is limited at a volume of air between 0.5 and 1.5 L, that is the range of air volumes measured in the three volunteers. The *in vitro* values of emitted powder were obtained at constant flow, whereas *in vivo* the air flow was dynamic increasing to PIF and decreasing. This *in vivo-in vitro* relationship indicates that the dynamic inhalation flow achieved *in vivo* through the RS01 DPI produces the emission of powder amount similar to the 4 kPa constant flow at the same volume of air.

Fig. 9b shows the correlation between the *in vitro* emitted powder at different air volume, obtained at 4 kPa pressure drop, and the amount of powder emitted on the first and all successive inhalation acts by the three volunteers. The *in vivo* emitted powder is linearly correlated with the volume of air used for emission. The straight line describing this relationship, despite the variability of the *in vivo* data, is not significantly different from the straight line describing the relationship between the *in vitro* emission and the volume of air used for extracting the powder from device. Performing the *in vitro* measurements at 4 kPa pressure drop, passing the same air volume through the device, provides a close emulation of the *in vivo* behaviour ~~but~~ only in quantitative terms. However, this *in vivo-in vitro* relationship could allow to assess *in vitro* the qualitative performance of the powder in terms of respirable dose during successive inhalation acts.

Conclusions

The increase of tobramycin content in TobraPS inhalation dry powder contributed to a significant reduction of the mass of powder entering the lung of patient for administering the prescribed dose of tobramycin. ~~TobraPS-I in the TobraPS tobramycin strength 56 mg/capsule, contains 60 mg of powder per capsule, while in the strength~~ 112 mg/capsule, the amount of formulation to inhale is around 120 mg, approximately 40% less than the reference approved product ([TOBI Podhaler](#)).

The RS01 emission mechanism, based on the spinning of the reservoir capsule, demonstrated to be able to control the amount of powder emitted during the inhalation act. The number of acts to perform in order to inhale the entire high dose of powder is dependent on the capability of the patient to inhale. A minimum air flow rate value of 20 L/min through the inhaler was requested to make the capsule lifting and rotating. The amount of powder emitted at 4 kPa pressure drop, at constant air flow rate, well correlated with the *in vivo* emission in dynamic flow conditions, when the same volume of air passed through the device.

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Figure Captions

Fig. 1. System in-house assembled capable to register the inhalation profile during the powder extraction by the volunteer. TobraPS powder was loaded in a capsule, inserted in RS01 size 0 device that was sealed inside a volumetric chamber leaving only the mouthpiece outside. When the volunteer was inhaling the supplied air passed through a flowmeter capable to register the air velocity and to transfer the data to a software.

Fig. 2. Tobramycin spray-dried powder (TobraPS) morphology pictured by scanning electron microscopy: (left) magnification 10,000 x; (right) 30,000 x.

Fig. 3. Dissolution profiles of tobramycin from TobraPS and TOBI™ Podhaler™ powder (n=3, mean value ± st.dev.).

Fig. 4. Fine particle dose versus the amount of loaded powder in the capsule of tobramycin DPIs. TobraPS was aerosolized by RS01 devices and TOBI by Podhaler device (n=3, mean value ± st.dev.).

Fig. 5. Fast Screening Impactor deposition of three different doses of TobraPS using RS01 devices (IP = induction port; CFC= coarse fraction collector; FFC=fine fraction collector), (n=3, mean value ± st.dev.).

Fig. 6. Air flow profiles of four dynamic inhalation acts successively performed by the three volunteers during TobraPS powder emission. [Inhalation sequence progression: 1 red, 2 green, 3 blue, 4 yellow.](#)

Fig. 7. Cumulative percent of TobraPS dose extracted *in vivo* by three volunteers in successive inhalation acts. Capsule size 0 filled with 120 mg of powder delivered by RS01 prototype inhaler.

Fig. 8. Relationship between the first act emitted dose and (A) the inspiratory flow (PIF), ($y = 4.4012 + 0.37116x$; $R^2 = 0.36857$) and (B) the inhalation volume, ($y = -6.4252 + 33.514x$; $R^2 = 0.86771$).

Fig. 9. Emitted dose TobraPS vs. air inhalation volume. Data *in vivo* (full symbol) and *in vitro* (open symbol) by activation of RS01 size 0 at different pressure drops (4, 3.3 and 2 kPa). (A) first *in vivo* inhalation act and (B) all *in vivo* inhalation acts versus air volumes.

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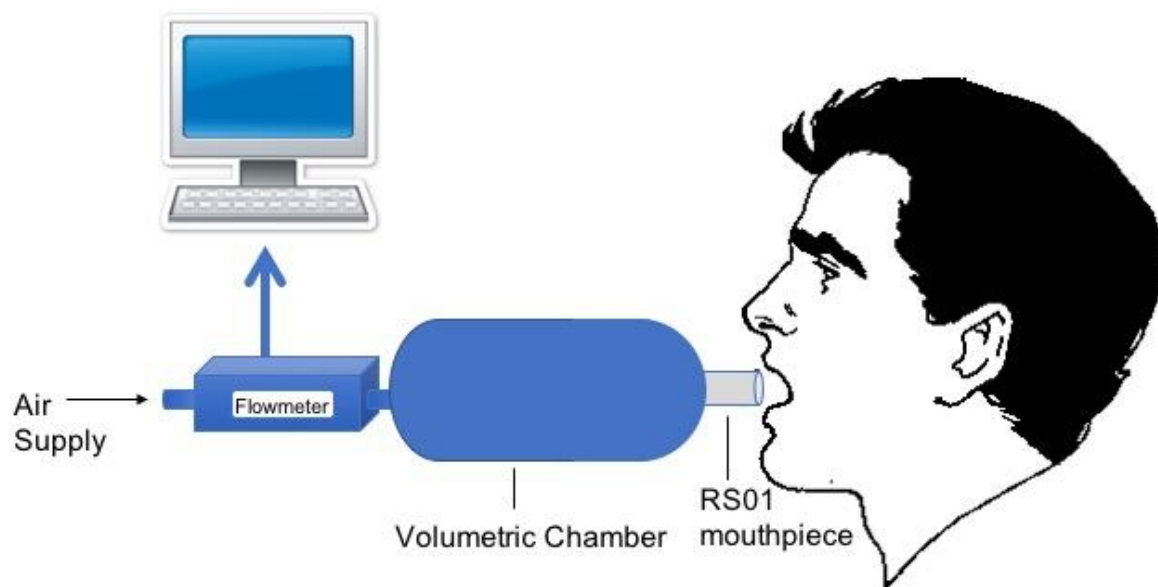


Fig 1

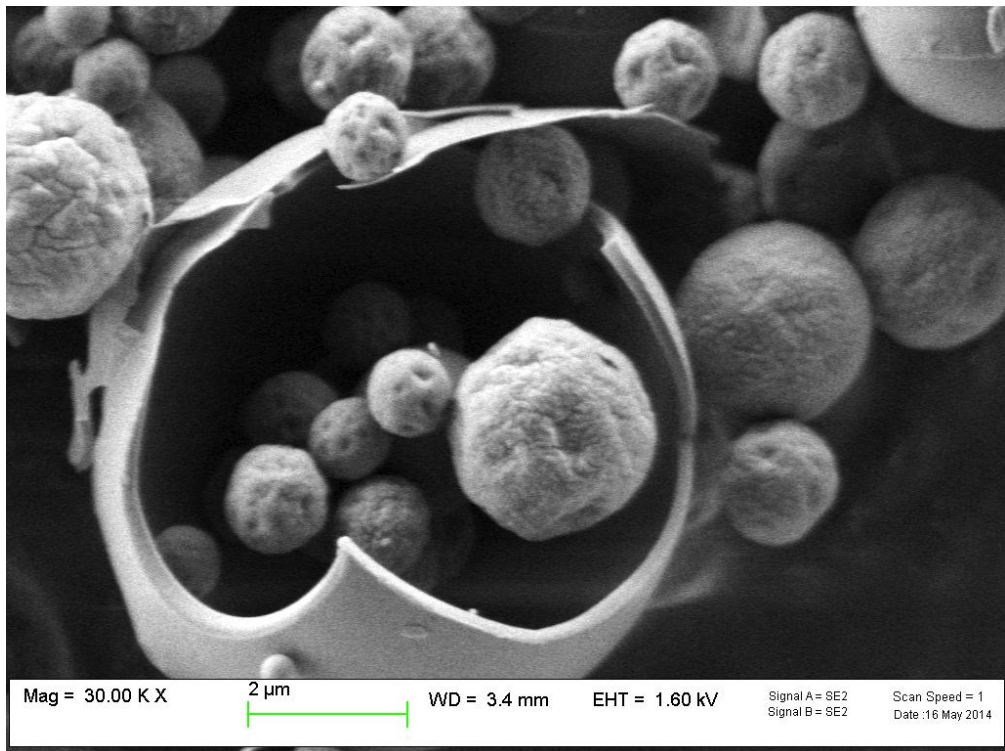
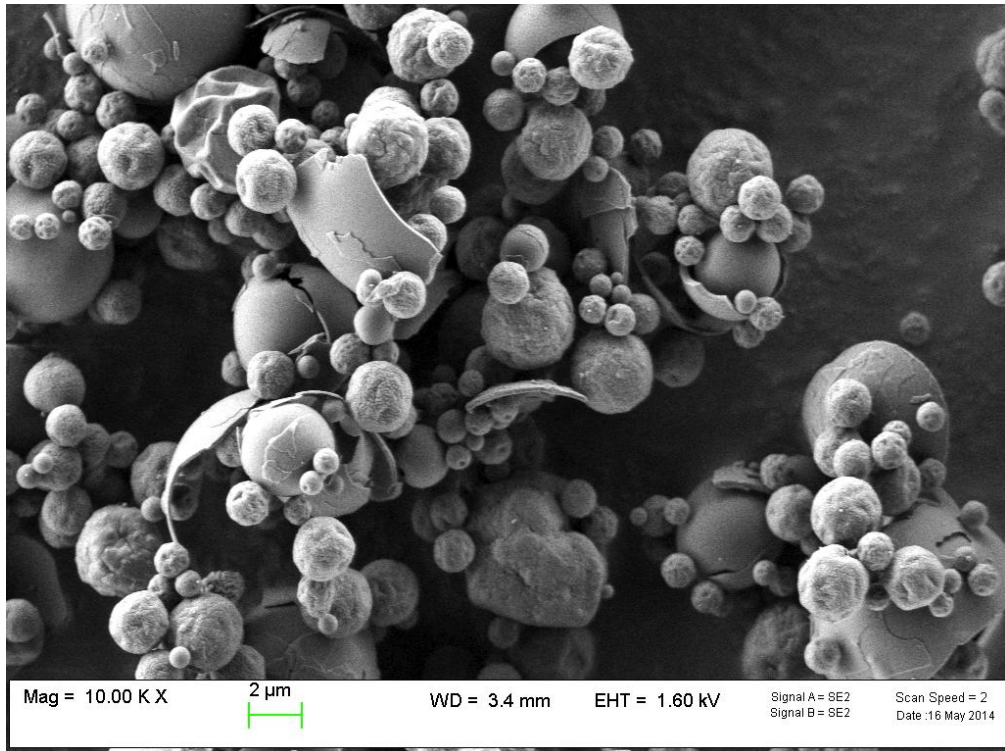


Fig 2

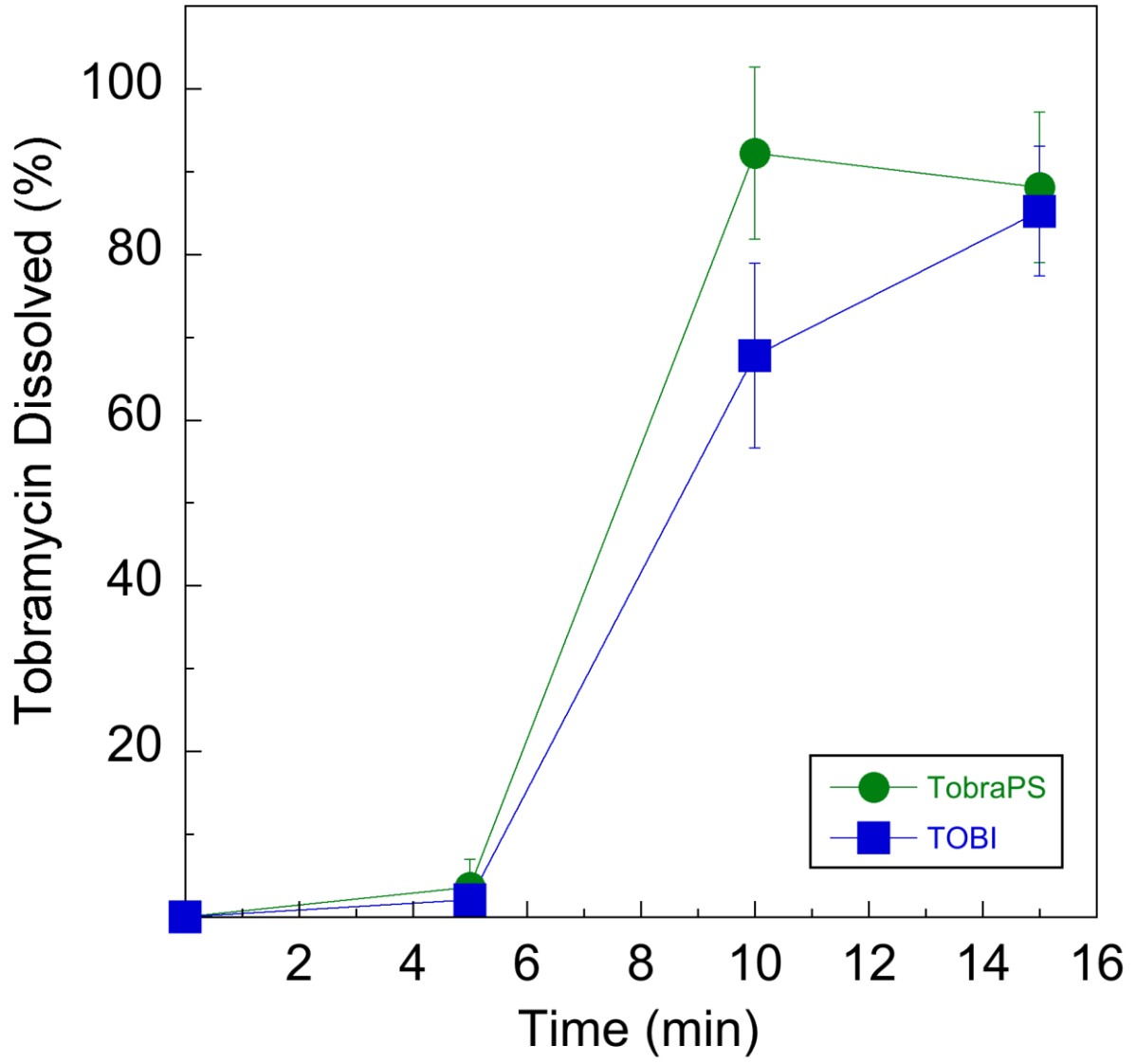


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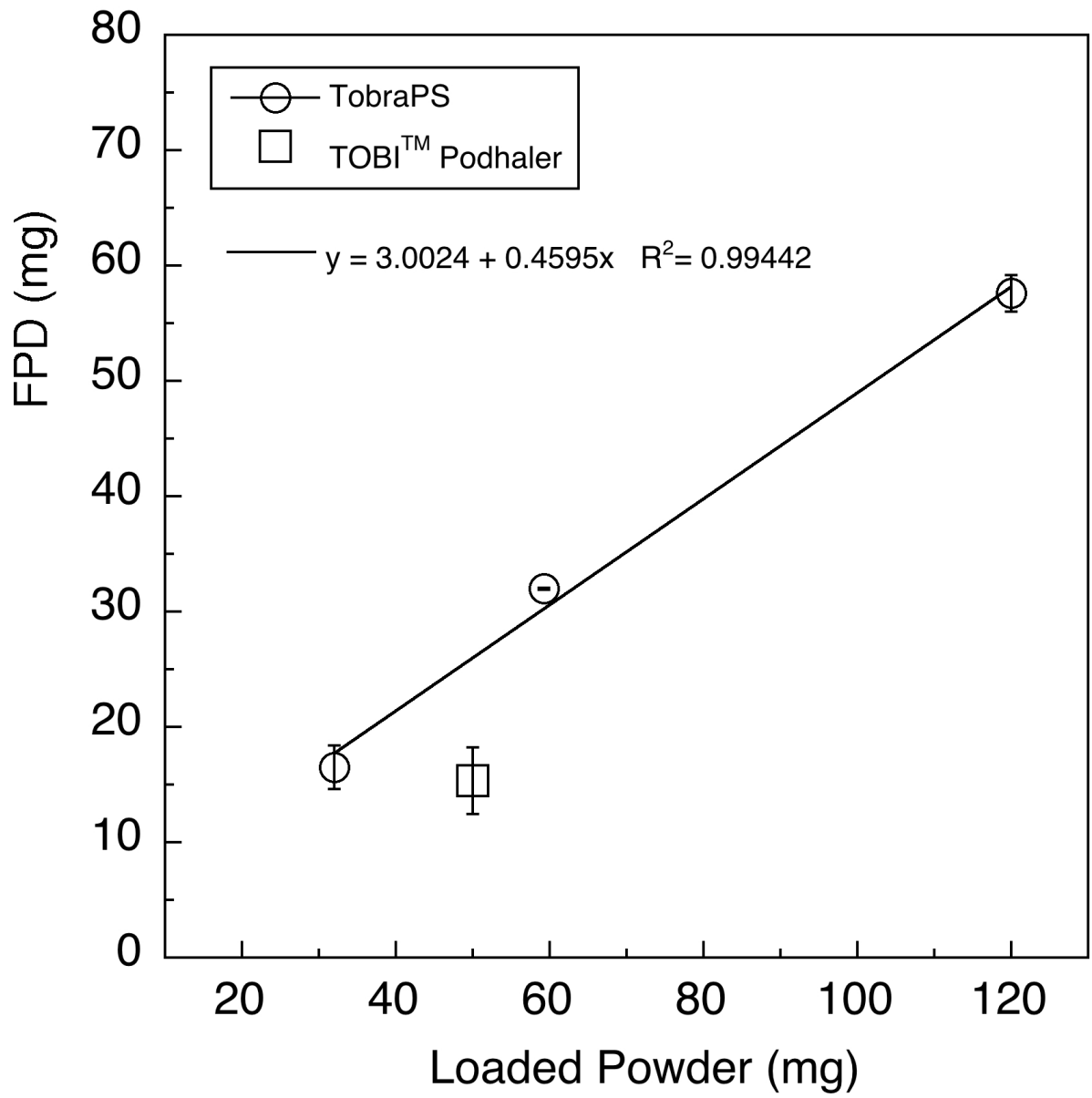


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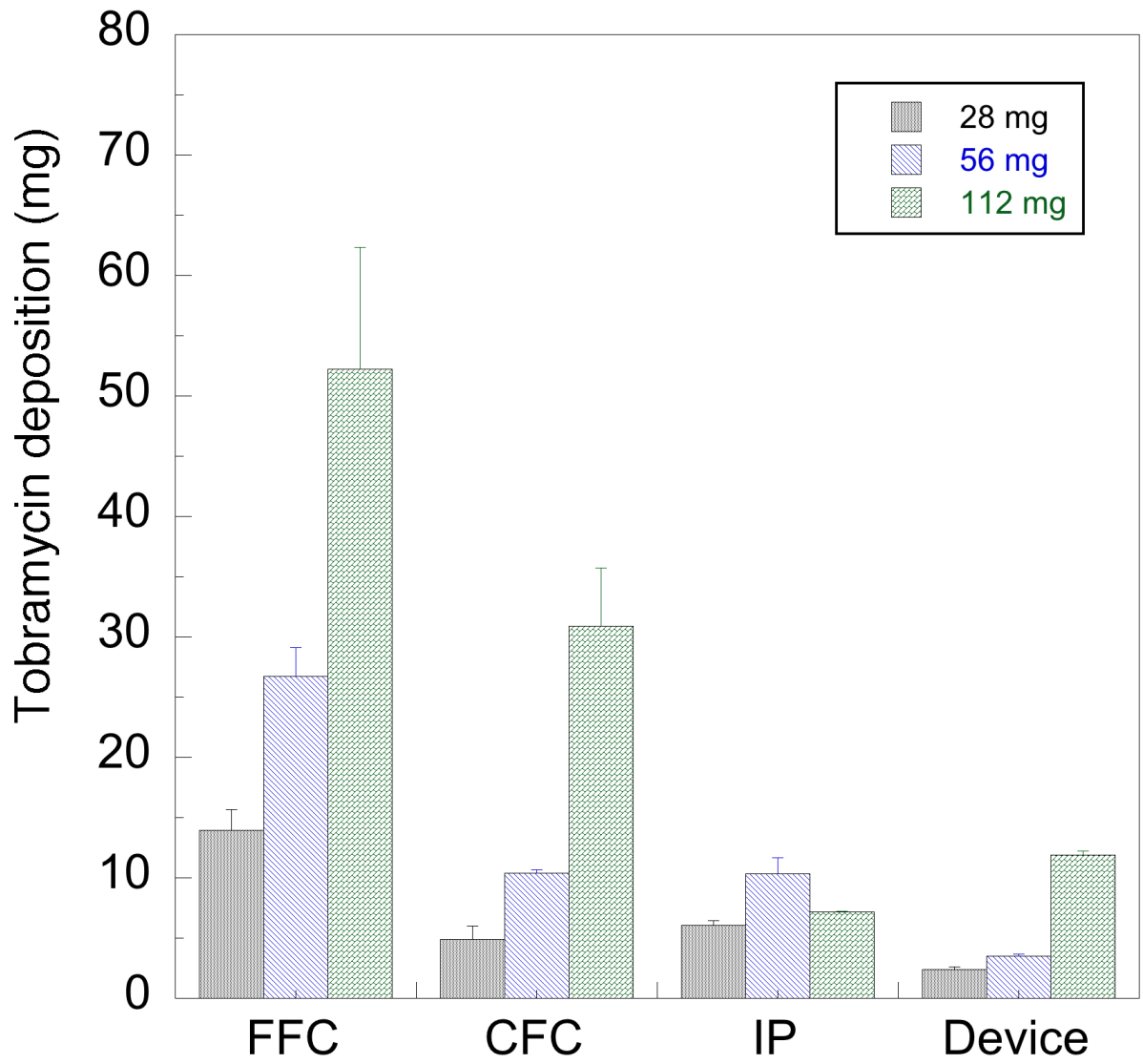


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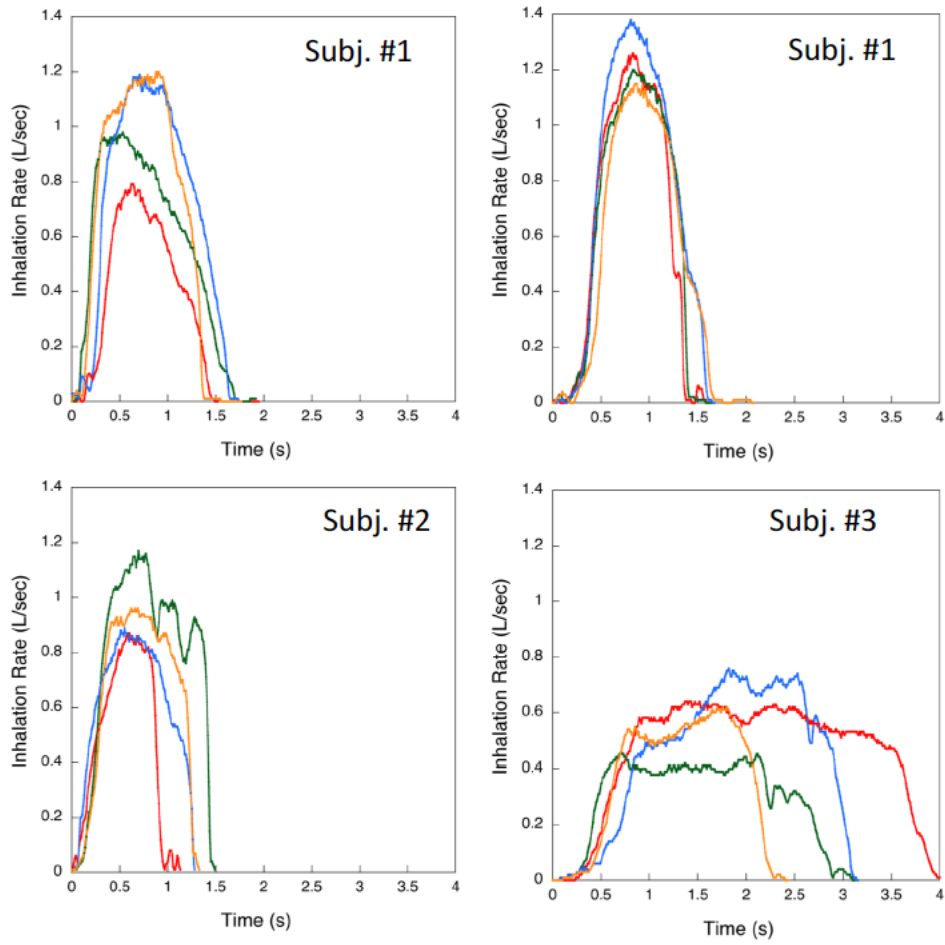


Fig 6

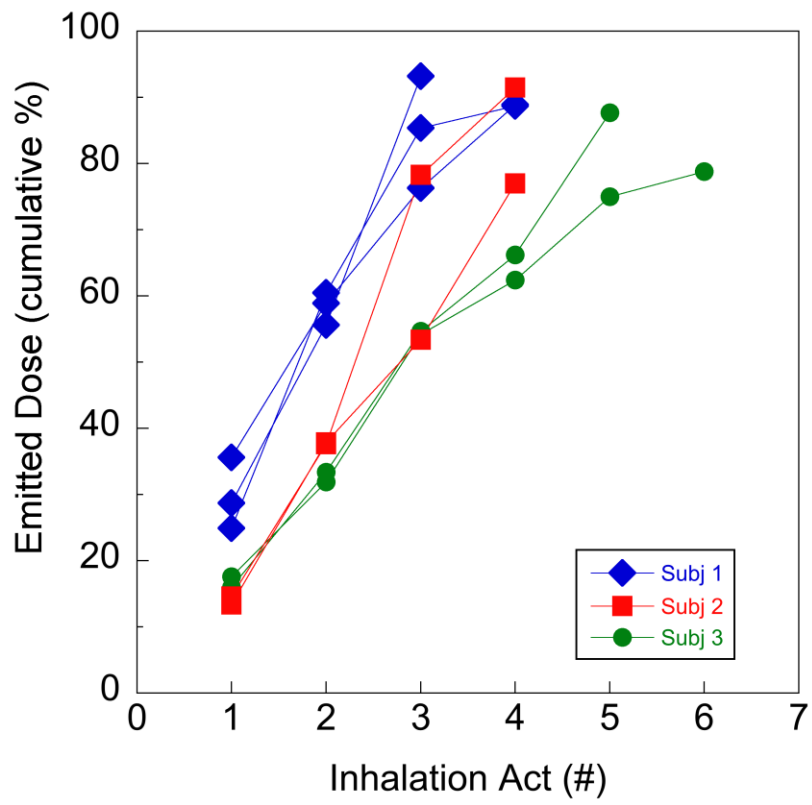


Fig 7

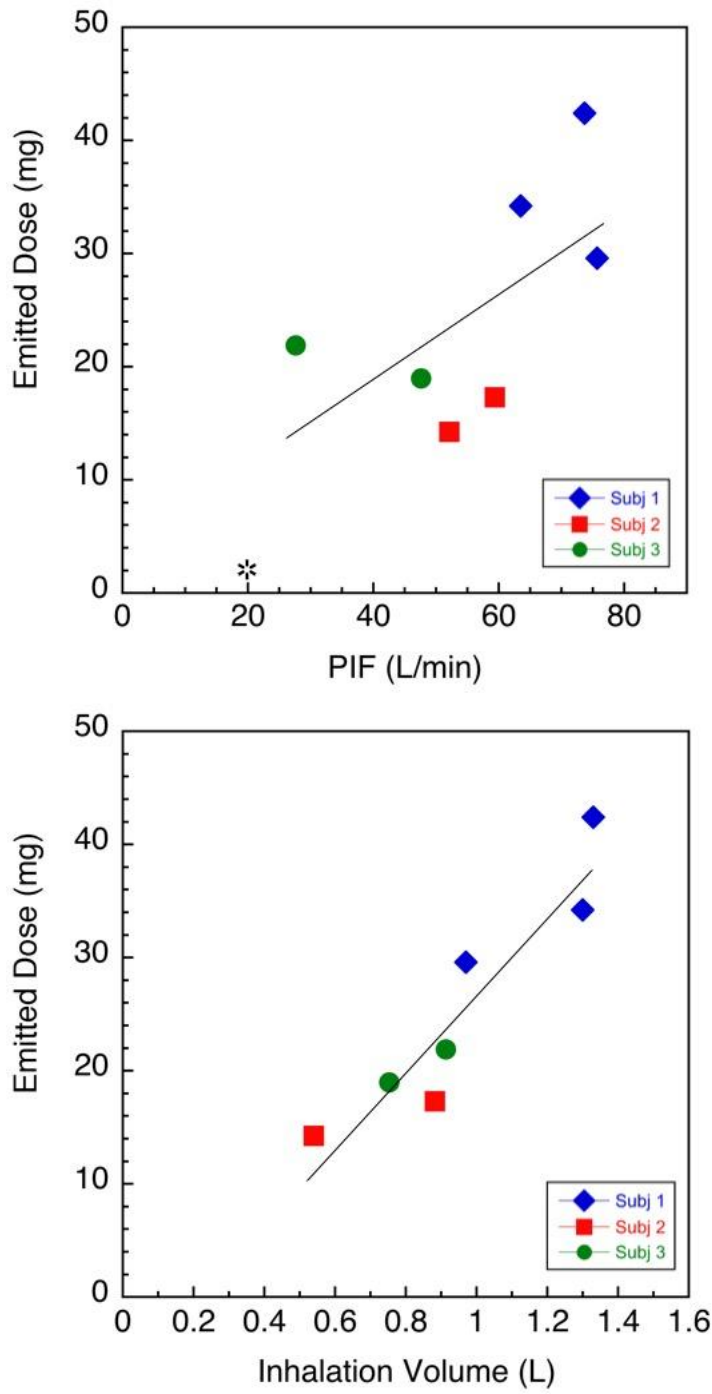


Fig 8

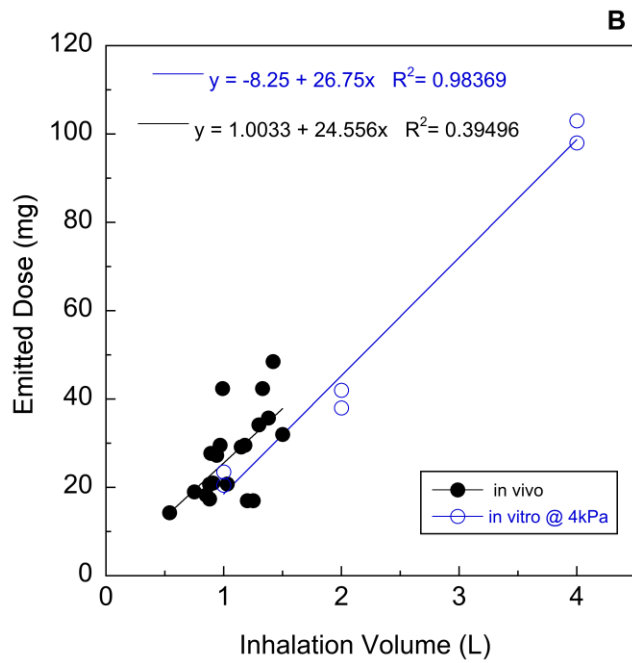
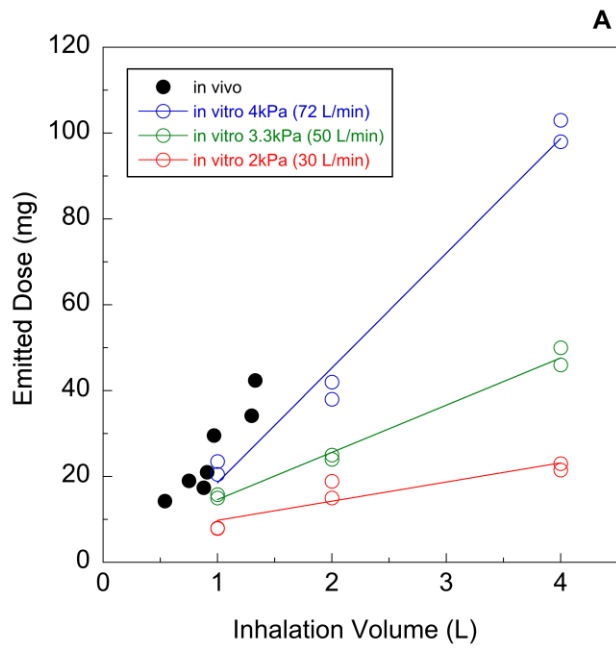


Fig 9

Supplementary Material

[Click here to download Supplementary Material: Supplementary Data.docx](#)

Informed consent form

Title of the study: Evaluation of the dynamic flow profile of an inhalation act and the corresponding dose extracted from a tobramycin DPI 112 mg to inhale in short successive acts

Investigators: Giovanna Pisi (Cystic Fibrotic Centre, University Hospital, Parma)
Francesca Buttini (Associate Prof. University of Parma, Department of Pharmacy)

The purpose of this "Informed Consent" form is to inform me about a medical research project and to invite me to consent to participate in the project. The research project is to evaluate the dynamic flow profile of an inhalation act and the corresponding dose extracted from a tobramycin DPI 112 mg to inhale in short successive acts. Each subject will inhale maximum of three doses not in the same day.

I fully understand the information contained in this consent form, the investigator, Dr. Giovanna Pisi and Prof. Francesca Buttini discussed this information with me after I have had the chance to read it and before I decide whether or not to participate.

I understand that I am a healthy volunteer participating in this study. It has been explained to me that, by taking the medication in relation to the study the only expected adverse effect could be a cough episode.

CONFIDENTIALITY

Any information that is obtained in connection with this study and that can be identified with me will remain confidential. My participation is entirely on a voluntary basis.

On signing this consent form, I acknowledge to understand the contents of the participant information.

I acknowledge that this treatment and study have been fully explained to me, that I understand all aspects of the treatment and follow-up and that I have been given an opportunity to ask questions and that all questions that I have asked have been answered to my satisfaction.

Name of Subject: Fabio Sonvico

Date 6 June 2016

Signature of Subject: Fabio Sonvico

Date 6 June 2016

Signature of Investigator: [Signature]

Date 6 June 2016

Informed consent form

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Name of Subject: Anna Giulia Balducci

Date 27 June 2016

Signature of Subject: Anna Giulia Balducci

Date 27 June 2016

Signature of Investigator: [Signature]

Date 27 June 2016

Informed consent form

Title of the study: Evaluation of the dynamic flow profile of an inhalation act and the corresponding dose extracted from a tobramycin DPI 112 mg to inhale in short successive acts

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Name of Subject: Paolo Colombo

Date 11 May 2016

Signature of Subject: 

Date 11 May 2016

Signature of Investigator: 

Date 11 May 2016