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Comparison of nonlinear mixed effects models and non-compartmental approaches in detecting pharmacogenetic covariates

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Running head: Approaches to detect pharmacogenetic covariates

Abstract

Genetic data is now collected in many clinical trials, especially in population pharmacokinetic studies. There is no consensus on methods to test the association between pharmacokinetics and genetic covariates. We performed a simulation study inspired by real clinical trials, using the PK of a compound under development having a nonlinear bioavailability along with genotypes for 176 Single Nucleotide Polymorphisms (SNPs). Scenarios included 78 subjects extensively sampled (16 observations per subject) to simulate a phase I study, or 384 subjects with the same rich design. Under the alternative hypothesis (H_1), 6 SNPs were drawn randomly to affect the log-clearance under an additive linear model. For each scenario 200 PK data sets were simulated under the null hypothesis (no gene effect) and H_1 . We compared 16 combinations of four association tests, a stepwise procedure and three penalised regressions (ridge regression, Lasso, HyperLasso), applied to four pharmacokinetic phenotypes, two observed concentrations, area under the curve estimated by noncompartmental analysis and model-based clearance. The different combinations were compared in terms of true and false positives and probability to detect the genetic effects. In presence of nonlinearity and/or variability in bioavailability, model-based phenotype allowed a higher probability to detect the SNPs than other phenotypes. In a realistic setting with a limited number of subjects, all methods showed a low ability to detect genetic effects. Ridge regression had the best probability to detect SNPs, but also a higher number of false positives. No association test showed a much higher power than the others.

Keywords: noncompartmental analysis, nonlinear mixed effects models, penalised regression, pharmacogenetics, pharmacokinetics

Abbreviations: FWER, Family wise error rate; LOQ, Limit of quantification; NCA, Noncompartmental analysis; NLMEM, Nonlinear mixed effects model; PK, Pharmacokinetics; SNP, Single nucleotide polymorphism; α , Type I error; β , Effect size coefficient; λ , γ , ξ , Penalisation parameters.

INTRODUCTION

Personalized care development should improve efficacy of drugs, and limit the risks associated with their use (1), and is particularly beneficial for drugs with narrow therapeutic margin and variability in response. Pharmacogenetics (2,3) studies the proportion of interindividual variability in drug response that can be explained by genetic variation, investigating specifically the link between the genotype and the pharmacokinetic (PK)/ pharmacodynamic (PD) (4) phenotype. In PK/PD studies, phenotypes can be observed (e.g. residual concentrations, biomarker measurements) or estimated (e.g. total exposure or specific PK parameters).

Estimated phenotypes in PK are mainly derived through two methods. The noncompartmental analysis (NCA) (5) calculates for each subject measurements of PK exposure such as the area under the curve (AUC) or maximal and trough observed concentrations through model-free approaches. It requires rich and balanced data per individual, which makes it inappropriate for studies in advanced phases of drug development or in special populations (pediatrics...). Model-based approaches on the other hand describe the dynamic phenomena through a mathematical model and estimate primary PK parameters summarising physiological processes. These methods involve NonLinear Mixed Effects Models (NLMEM) (6), which jointly analyse data obtained on a set of individuals to determine the typical model parameters (fixed effects), and the parameters of inter and intraindividual variability (random effects), as well as the residual error. NLMEM are better suited to sparse and unbalanced data, and clinical studies can be combined to increase the power to detect genetic effect (7).

Unlike monogenic diseases, caused by mutation of a single gene, the variability in PK/ PD is usually the product of a set of markers with low to intermediate effect sizes. The screening of a large number of genetic markers, such as Single Nucleotide Polymorphisms (SNP), is possible thanks to the development of genotyping methods and microarrays (8). This has two major consequences: the number of genetic variants studied tends to be larger than the number of subjects and some of these variants are correlated due to linkage disequilibrium (9).

An exhaustive literature review about clinical pharmacogenetic studies was performed to gain an overview of the methods currently used in this type of study (*see the supplementary*

materials for the literature review methods we used). Information about the phenotypes (obtained by NCA or modelling), the design of studies, the genetic data and the statistical analysis have been extracted from each publication, and summarised through descriptive statistics. During the period 2010-2012, on 85 pharmacogenetic studies using PK parameters as phenotypes, 69% used NCA and 31% used modelling-based phenotypes for association analysis. About two thirds of the studies included less than 50 subjects and only 15% more than 100 subjects. A limited number of genetic covariates were studied (3 genes (minimum = 1; maximum = 45) and 8 SNPs (minimum = 1; maximum = 198) in average). Genes were finely targeted because known to be involved in the PK of studied molecules. Finally, association between NCA-based phenotype and polymorphism were mainly investigated using univariate methods (univariate anova, t-test...) (57%), multivariate methods (multivariate linear regression) (14%) and stepwise or descriptive methods. Model-based phenotypes were explored using mostly stepwise regression (78%), univariate methods applied on individual parameter estimates (7%) or descriptive methods.

So although health authorities strongly recommend studying the pharmacogenetics of new chemical entities in development (10,11), there is no consensus on analysis methods to explore a large number of polymorphisms in association with PK phenotypes. Specific approaches and statistical tools are required, which must take into account the small amount of PK information provided by each individual in relation to the number of genetic covariates, and be able to detect a signal in a large number of possible relationships.

Penalised regression methods analyse all markers simultaneously and use a penalisation function which shrinks most effect coefficients to select a parsimonious set of markers of the phenotype variability. These methods have been especially used in Genome Wide Association Studies (GWAS) to binary outcomes (12) or quantitative traits (13). Here we evaluate three such methods: ridge regression (14) adapted to include a test of significance for its derived estimates (15), the Lasso (16) and the HyperLasso (17), a generalisation of the Lasso.

In the present study, we propose to compare those three penalised regression methods with a stepwise approach through a simulation study, to assess their ability to detect the influence of genetic variables on the PK. We apply them to four possible PK phenotypes (two observed concentrations, AUC estimated by NCA, model parameters estimated by NLMEM).

This work is based on collaboration with the pharmaceutical industry (IRIS, Institut de Recherches Internationales Servier) and thus focuses specifically on issues of clinical trials for drug development. This also provided a real case study to design the simulations which had interesting features, including a nonlinear absorption, resulting from the drug's physicochemical properties, and a large number of SNPs collected thanks to a specific microarray. This could enable a meaningful comparison of phenotypes in a challenging context.

MATERIALS AND METHODS

Overview

In this work, we use a model previously developed to fit the data from a real example for a molecule in early clinical development at IRIS (*Motivating data example* section). For this work we have simulated PK profiles using the model and parameters based on the real data to derive phenotypes (*PK phenotypes* section), on which we have applied different association methods (*Statistical methods for genetic association* section). We have simulated scenarios (*Simulation study* section) for different experimental protocols varying especially the number of subjects and evaluate the methods in term of detection probability (*Evaluation* section).

Motivating data example

The simulation study was inspired by a real dataset which we cannot use for confidentiality issues, but which presented characteristic features encountered during the early phases of drug development, including frequent PK sampling, extensive genetic data, a complex PK profile and a wide range of doses. We start by describing the clinical study and the experimental protocols, as well as the model that will be used in the simulation study.

Drug S developed by IRIS was investigated in three phase I clinical studies performed in a total of 78 adult healthy volunteers. All subjects were genotyped at baseline using a DNA microarray developed by the laboratory. This chip has been developed specifically for PK studies and consists only of SNPs known for being involved in the PK of drugs, i.e. markers of phase I and II metabolic enzymes, of SLC or ABC family transports, as well as nuclear receptor genes. The studies included 8 dose groups (5, 10, 20, 50, 100, 200, 400 or 800 units)

with different allocations (respectively 6, 6, 24, 12, 12, 6, 6 and 6 subjects by dose) and extensive PK sampling.

A two-compartment model with a double absorption function (Fig. 1, Table I) was used to describe the PK of drug S. The nonlinearity with dose was due to the low solubility of drug S, and was modelled through a dependency of the absorption parameters F and FRAC on dose. The relationship of F with dose was expressed through an I_{max} model (5) parameterised in I_{max_F} and D50_F while the relationship of FRAC with dose was expressed with an E_{max} model (5) parameterised in E_{max_{FRAC}} and D50_{FRAC}. T_{k0} is the zero order absorption constant rate and T_{lag₁} the corresponding lag time, K_a the first order absorption constant rate and T_{lag₂} the corresponding lag time, V₁ the central compartment volume, V₂ the peripheral compartment volume, Q the intercompartmental clearance and CL the elimination clearance. Interindividual variability was described by an exponential model on F, T_{k0}, T_{lag₂}, V₂, Q and CL.

Pharmacokinetic phenotypes

To capture the PK signal, we considered 3 types of measures in this study.

Observed concentrations

Observed concentrations are easy to obtain and require no additional analysis step. Here we considered the last concentration at 192h after a single dose administration (C_{192h}), and the concentration at 24h (C_{24h}), which corresponds to a trough concentration when repeated doses are given during routine treatment.

Noncompartmental approach

AUC was calculated using the linear trapezoidal rule and extrapolation to infinity was achieved assuming an exponential decay (5,18).

Normalisation of observed and NCA phenotypes

To take into account the nonlinearity in dose absorption, observed concentrations C_{24h} and C_{192h}, and AUC obtained by NCA were normalised by dose. An E_{max} model (5) of phenotype on dose was fitted for each dataset:

$$Phenotype_{predicted_d} = \frac{Emax \times dose}{ED_{50} + dose}$$

where E_{max} is the maximal value for predicted phenotype, ED_{50} the dose to obtain 50% of this maximum and dose the administrated amount. Phenotypes predicted by the model at

dose d ($Phenotype_{predicted_d}$) and reference dose of 20 units ($Phenotype_{predicted_{20}}$) were used to normalise the phenotype observed at dose d ($Phenotype_{observed_d}$) as follow:

$$Phenotype_{normalized_d} = \frac{Phenotype_{predicted_{20}}}{Phenotype_{predicted_d}} \times Phenotype_{observed_d}$$

Model-based approach

Considering N subjects, sampled at one or n_i times, the concentration y_{ij} measured in a subject i receiving a dose D_i at time t_{ij} , is described by a nonlinear function (19) f such as:

$$y_{ij} = f(\theta_i; D_i, t_{ij}) + \varepsilon_{ij}$$

where θ_i is the vector of individual parameters assumed to follow a log-normal distribution:

$$\theta_i = \mu e^{\eta_i}$$

with μ the population average parameter and η_i the difference between the population average and the individual i parameter. We assumed that PK parameters follow a log-normal distribution to ensure that they are strictly positives (20).

ε_{ij} is the residual effect that quantifies the deviation between the model prediction and the measured value for subject i at time j . The residual variability was described using a proportional model:

$$g(\theta_i; t_{ij}) = \sigma_{slope} (f(\theta_i; t_{ij}))$$

where σ_{slope} represents the proportional component. We typically assume $\eta_i \sim N(0, \omega^2)$ and $\varepsilon_{ij} \sim N(0, \sigma^2)$.

Statistical methods for genetic association

We assume that a linear model links the phenotype to the genetic variants as in:

$$Phenotype_i = \beta_0 + \sum \beta_k \cdot SNP_{ik} + \varepsilon_i ; SNP_{ik} = \{0, 1, 2\}$$

where $Phenotype_i$ is a vector for individual phenotypes, β_0 an intercept, SNP_{ik} a vector for the genetic variants and β_k a vector for the individual genetic effect size associated to the genetic variant and ε_i a residual error following a Gaussian distribution. In this model, the genetic variant takes values 0, 1 or 2, reflecting the number of mutated alleles. All phenotypes are log-transformed to ensure that they follow a normal distribution. To account for type I error inflation due to the multiplicity of tests, all methods used a Sidak correction on the Family Wise Error Rate (FWER) to compute a type I error per SNP α :

$$\alpha = 1 - (1 - FWER)^{\frac{1}{N_t \times P_t}}$$

where N_t and P_t are the numbers of SNPs and PK parameters considered simultaneously.

Ridge regression

Ridge regression imposes a penalty on the size of the β_k to reduce the prediction error (15) without preventing the integration of the model variables. We used the approach proposed by Cule et al. to set semi-automatically the penalty so that the trace of the projection matrix, which relates the predictions to the observations, is equal to the number of components in a principal component analysis (PCA) of the data. From a Bayesian perspective, this correspond to applying a Gaussian prior of identical variance on the eigenvalues issued from the PCA (21). The ridge regression do not shrunk coefficients estimates to 0. Therefore we used a Wald test on these coefficients and their standard error (SE), as proposed by Cule et al. (15) to perform the variable selection with the test statistic T_0 :

$$T_0 = \frac{\beta_k}{SE(\beta_k)}$$

where $SE(\beta_k)$ is the standard error of the regression coefficient β_k . Under the null hypothesis, T_0 follows a Student t distribution with a significant threshold equal to the type I error per SNP α .

Lasso

Lasso (16) also uses a penalty function, which from a Bayesian point of view corresponds to using a double-exponential (DE) probability density as a prior on β_k . The Lasso sets some coefficients to 0 for sufficiently large values of the tuning parameter; this allows variable selection and ensures a parsimonious model. The regularisation parameter ξ is calculated to achieve a target FWER, using the following expression (17):

$$\xi = \Phi^{-1}\left(1 - \frac{\alpha}{2}\right) \sqrt{\frac{N}{\sigma^2}}$$

where α is the type I error per SNP, Φ^{-1} is the inverse normal distribution function, N the number of subjects and σ the standard error of the phenotype considered.

HyperLasso

HyperLasso (17) is derived from the Lasso. Here the penalisation corresponds to using a normal-exponential gamma (NEG) distribution as a prior on β_k and depends on two parameters: a shape parameter λ and a scale parameter γ . The sharp peak at zero and the flatter tail of the NEG distribution favour sparse solutions but the estimates of larger effects

are shrunken less severely than the Lasso. The smaller the shape parameter the heavier the tails of the distribution and the more peaked at zero, which can result in fewer correlated SNPs being selected. The shape parameter λ was set to 1 in our study, which gives realistic effect size distributions (22). As for Lasso, the scale parameter γ is calculated, again depending on a type I error per SNP α , using the following expression (17):

$$\frac{\text{sign}(\beta)(2\lambda + 1)}{\gamma} \frac{D_{-(2\lambda+2)}\left(\frac{|\beta|}{\gamma}\right)}{D_{-(2\lambda+1)}\left(\frac{|\beta|}{\gamma}\right)} = \Phi^{-1}\left(1 - \frac{\alpha}{2}\right) \sqrt{\frac{N}{\sigma^2}}$$

where α is the type I error per SNP and D the parabolic cylinder function (23).

Stepwise procedure

We use the algorithm in Figure 2 inspired by Lehr et al. (24) and based on univariate regression: (i) PK phenotypes are regressed on each SNP and a Wald test is applied with a significance threshold equal to α . To account for linkage disequilibrium, among selected SNPs showing strong correlation ($r^2 > 0.8$), only the most significant is kept. Then (ii) the most significant among selected SNPs is included in the linear regression of the PK phenotype on the SNPs. These iterative steps are performed until no more SNP enter the linear model.

Simulation study

Genotypes

SNPs were simulated using the Hapgen2 software (25) based on the DNA microarray used in clinical studies. To simulate genetic variants for the 200 data sets while retaining the correlations between variants found in the human genome, we used a reference panel of Hapmap genotypes data set (Hapmap 3 release 2) for a Caucasian population (26). Hapgen2 simulates genotype with the same LD patterns as the reference data (25).

Summaries of simulated genotypes, i.e. minor allele frequencies, Hardy-Weinberg equilibrium and LD plots, can be found in supplementary file (*Simulated polymorphisms information*).

Pharmacokinetic profiles

Using the model and parameters estimates from the motivating data example (Table I), we simulated concentrations after a single dose administration according to an extensive sampling schedule with 16 samples per subject at 0.5, 1, 1.5, 2, 3, 4, 6, 8, 12, 16, 24, 48, 72,

96, 120 and 192 hours after taking the tablet. We did not include a limit of quantification (LOQ) and the data were simulated without censoring. NCA method was applied on these simulated profiles and for the model-based approach, population and individual parameters were re-estimated using the Monolix software (27) and SAEM estimation algorithm (28). Individual CL, Q and V2 were used as PK phenotype in a post-model covariate analysis step.

In each simulation scenario, we performed two simulations: in the first simulation (null hypothesis H_0) we assumed there was no effect of genetics on the PK parameters; in the second simulation (alternative hypothesis H_1), 6 SNPs were drawn randomly and we assumed they had an impact on the log-transformed clearance according to the following model:

$$\log(CL_i) = \log(\mu_{CL}) + \sum_{k=1}^6 \beta_k \times SNP_{ik} + \eta_{i_{CL}}$$

where CL_i is the individual clearance, μ_{CL} the population clearance, β_k the effect size associated to the genotype SNP_{ik} and $\eta_{i_{CL}}$ the interindividual variability in clearance.

For each SNP, the associated effect size β_k is computed as a function of the coefficient of genetic component (R_{GC_k}) and the minor allele fraction (p_k), according to the following equation:

$$\beta_k = \sqrt{\frac{R_{GC_k} \times \omega_{CL}^2}{2p_k(1-p_k) - R_{GC_k} \times 2p_k(1-p_k)}}$$

where R_{GC_k} is the part of the interindividual variability in CL explained by the SNP (expressed in %) and ω_{CL}^2 is the variance of random effects on CL due to non-genetic sources.

To simulate realistic genetic effects, the 6 SNPs altogether explained a total R_{GC} of 30% with unbalanced effect sizes (R_{GC_k} respectively equal to 1, 2, 3, 5, 7 and 12%). These effect sizes were chosen to be consistent with genetic effects observed in clinical studies. For example warfarin doses has been associated with three genetic variants in the cytochrome P450 warfarin-metabolizing genes CYP4F2 and CYP2C9 and in the warfarin drug target VKORC1, explaining respectively 1.5, 12 and 30% of variability (29).

Simulation scenarios

We simulated different scenarios. In the first scenario S_{real} , the design was chosen to be close to the drug S Phase I clinical trials protocol: 78 subjects (N) receiving 8 different doses (5, 10,

20, 50, 100, 200, 400 or 800 units) with a similar allocation ratio and 16 sampled times (n) at 0.5, 1, 1.5, 2, 3, 4, 6, 8, 12, 16, 24, 48, 72, 96, 120 and 192h. A second scenario S_{large} using the same design but with more subjects ($N = 384$, $n = 16$) was considered as well to investigate a large sample situation. This scenario represents an ideal case from a design perspective, with a large number of subjects and a rich protocol for each subject. Figure 3 represents the PK profiles from a simulated data set with S_{large} design as function of the genotypes of the SNP explaining 12% of the clearance interindividual variability (under the alternative hypothesis H_1). The profiles show an important interindividual variability. As expected last concentrations are lower in heterozygotes and rare homozygotes under H_1 , due to the increase of clearances.

To evaluate the effect of the PK model structure including the nonlinearity of absorption, 3 additional scenarios were simulated using the same design than S_{large} but different structural models: a nonlinear absorption without interindividual variability on F ($S_{large, no IIV_F}$), a linear PK ($S_{linearPK}$: $FRAC=0.5$, $F=0.8$, $\omega(F)=32.9\%$) and a linear PK without variability on F ($S_{linearPK, no IIV_F}$: $FRAC=0.5$, $F=0.8$, $\omega(F)=0$).

Evaluation

Each method: ridge regression, Lasso, HyperLasso and the stepwise procedure was applied to each PK phenotype: observed C24h and C192h, AUC estimated by NCA and model parameters CL, V and Q estimated by NLMEM. To enable proper power comparison the target FWER was set to 20% (with a prediction interval for 200 data sets equal to [14.5-25.5]). Under H_0 , an empirical FWER was estimated as the percentage of data sets where at least one SNP was found significant. If necessary, the type I error per SNP α were corrected empirically until the FWER estimate was not significantly different from 20%. Under H_1 , we recorded for each method and phenotype the number of true positives (TP, corresponding to the selection of a SNP which was indeed associated to CL in the simulation, its maximum over the 200 simulations being 1200) and false positives (FP, corresponding to a SNP selected in the model but not present in the simulation). A 95% confidence interval was also estimated assuming the number of TP or FP follows a Poisson distribution. The true positive rate (TPR) and the false positive rate (FPR) were calculated as follow:

$$TPR = \frac{TP}{TP + FN}$$

$$FPR = \frac{FP}{FP + TN}$$

where FN is the count of false negatives and TN the count of true negatives. The TPR was the main outcome on which we statistically compared the different methods and phenotypes. First, we compared the TPR across the different phenotypes for each method, using Cochran's Q test (30) in the following way: for each dataset and each phenotype, we defined a variable X with value 1 for the phenotype(s) with the maximal TPR, and 0 for the other ones; this was done separately for each method. A global test for each method was performed first, with a significance threshold set to 5%; if the phenotypes were found to be significantly different, pairwise comparisons were then performed with a Wilcoxon test, using a Sidak correction for the number of tests (a corrected threshold of 0.009 for 6 pairwise comparisons).

Once the phenotype yielding the highest TPR across the different methods has been selected, the same approach was applied to compare methods on this phenotype. In each simulation, we also recorded the number of datasets for which all methods detected the same number of SNPs (X=1 for all methods), and the number of datasets for which all methods failed to detect at least one SNP (X=0 for all methods).

The probability to detect a given number x ($x=1, \dots, 6$) of the 6 SNPs which were associated to CL was computed as the percentage of data sets simulated under H_1 where x or more SNPs are selected. **Of note, for the model-based analysis, associations were explored on parameters CL, Q and V2. TP were causal variants associated to CL and FP were non-causal variants associated to CL and any variants associated to Q and V2. The FPR for the model-based phenotype designed by CL were then computed by taking into account the FP on any of the three model parameters.**

RESULTS

Scenario 1: S_{real}

Control of FWER under H_0

Table II shows the estimates of the empirical FWER under H_0 . All methods tended to be too conservative since the FWER was lower than expected for all methods and phenotypes, except on the last concentration parameter C192h. After an empirical correction of thresholds or penalisation parameters depending on the method, FWER was properly

controlled around 20%, as shown in Table II. This correction was applied in the corresponding simulation under H_1 .

To investigate why the FWER was not controlled under H_0 despite the calibration step within each method, we simulated a scenario $S_{\text{independent}}$ similar in design to S_{real} but with independent SNPs. The FWER estimates in $S_{\text{independent}}$ were non-significantly different from 20% (*results in supplementary materials*). This suggests that correlations between SNPs lead to a decrease in FWER.

Performance under H_1

In each scenario, the total number of SNP associated with the PK was 1200, but only a small number was effectively detected, as shown in Table III. This was even more apparent for associations based on NCA parameter or observed concentrations. The TPR was significantly different between the different phenotypes ($p < 0.001$ for each of the 4 methods, according to **Cochran's Q test**) and was highest for CL in each 2 by 2 phenotype tests ($p < 0.002$ for all pairwise comparisons). The FPR on the other hand was similar for all phenotypes (figure 4a). The methods were then compared for CL, and the TPR was found to be significantly different between the four methods ($p < 0.001$). Ridge regression yielded a higher TPR more often than other methods ($p < 0.003$ for all pairwise comparison), while Lasso, HyperLasso and the stepwise procedure were comparable.

The probability to detect at least one genetic variant on CL estimates was low, around 40% for all methods (Fig. 5a). This probability decreased quickly when trying to detect more variants and reached 0 for 3 variants or more.

Scenario 2: S_{large}

Control of FWER under H_0

As expected due to the larger number of subjects, the estimated FWER increased with comparison to the scenario S_{real} , but remained below the target of 20% for some methods. Empirically corrected thresholds and penalty terms were determined for each combination of phenotype and method to obtain FWER estimates of 20% and were then used for the simulations under H_1 (*results in supplementary materials*).

Performance under H_1

The number of TP increased clearly compared to the previous scenario (Table IV). Concerning the comparison between phenotypes we found similar results as for S_{real} : all

methods were more powerful when applied to CL compared to the other phenotypes ($p < 0.001$ for all pairwise comparison). The number of FP also increased and was quite high, but increased proportionally less than the number of TP for the model-based phenotypes, C192h and AUC. For C24h on the other hand, the number of FP exceeded the number of TP. Thus for a similar FPR between all phenotypes, the TPR was higher for CL (Fig. 4b). The TPR for ridge regression was higher than Lasso and HyperLasso ($p < 0.001$ with methods applied to CL). The TPR for the stepwise procedure was intermediate, the 2 by 2 tests were not significant for the comparison of the stepwise procedure versus ridge regression or Lasso. As expected, with increasing the number of subjects the power of all methods increased to reach almost 100% to detect at least one genetic variant (Fig. 5b). Then, the power decreased when trying to detect more variants. Departure in methods was observed on the power to detect at least 3 and more variants, with the ridge regression and stepwise procedure showing higher power.

Influence of the structural PK model under H_1

In both scenarios, regardless of the association method, the power to detect a gene effect was higher using PK parameter obtained by NLMEM than AUC estimated by NCA or observations. We investigated whether this was due to the specific features in the PK model, *i.e.* the non-linearity in the absorption model and/or the variability in the bioavailability. When we assumed no variability on the bioavailability parameter F (scenario $S_{\text{large, noIV}_F}$), the difference in the number of TP between CL and AUC was smaller (Fig. 4c), but the TPR for CL remained higher compared to AUC. Assuming a linear absorption, while retaining variability on F, also reduced this difference (scenario S_{linearPK} , Fig. 4d) but only when we used a linear absorption model without variability on F did the benefit of CL over AUC disappear (scenario $S_{\text{linearPK, noIV}_F}$, *results in supplementary materials*). Changes in the PK structural model did not affect the number of TP for C192h, while removing the variability on bioavailability increased the number of TP for C24h, although it remained very low.

DISCUSSION

Many analysis methods have been proposed in the pharmacogenetic literature, depending on the phenotypes studied and the association test. NCA is mainly used to represent the PK exposure, univariate association methods are still widely applied and sample sizes are

limited. This work aimed to evaluate 16 combinations of four phenotypes and four methods and the design of the different simulation scenarios was based on actual clinical studies. This realistic setting enabled a meaningful comparison, providing at the same time a challenging context of nonlinear PK and a custom set of polymorphisms.

This work takes place in context of exploratory analyses, and we therefore chose a high FWER for variable selection (20%). The four association methods use estimated phenotypes after an initial estimation step without covariates included in the model. Work on alternative approaches which simultaneously estimate the PK model parameters and the genetic size effects are ongoing (31); they require iterative selection and estimation which increases the computational burden. We decided to study the most common association methods based on a maximum likelihood approach, the ridge regression and Lasso, together with a specific extension for genetic covariates (HyperLasso). Other penalized regression methods have been proposed such as the elastic net method (32), which has shown intermediate performances between ridge regression and Lasso. Other approaches to investigate include modifications of the penalised methods we used, such as the significance test very recently developed for the Lasso (33). In the present work, we did not consider gene-gene and gene-environment interactions. Model-based approaches have been proposed in such contexts, and evaluated on real pharmacogenetic data sets (34). These methods or clustering based algorithms should be compared to penalized regression methods in simulations close to those presented in this work. Frequentist approaches are most often used in population PK/PD analysis. Bayesian methods (35) may also be worth considering for variable selection but their use remains limited in population PK/PD studies. The estimate of entire distributions of parameters adds an additional numerical complexity requiring further development beyond the scope of the present work.

Several methodological works associating pharmacogenetics and NLMEM have been published (36–39). Lehr et al. have suggested an adaptation of the classical stepwise covariate selection on PK phenotype in NLMEM (24) and a method inspired from Lasso has already been used for the selection of non-genetic covariates in NLMEM (40). But this is the first work comparing model-based approach with NCA in this area. In our study, all methods showed a higher number of TP when used on individual clearances CL from NLMEM, compared to the other phenotypes (AUC, C24h, and C192h). Furthermore, relatively to the number of TP, the number of FP was lower for model-based phenotypes (CL, Q and V2) than

other phenotypes, also improving the TPR. This finding indicates that using a modelling approach enables better power. Indeed, the modelling approach allows separating the different phases of the PK process (absorption, distribution, metabolism, excretion), improving the interpretation of the genetic effects by the comprehension of mechanisms behind the association between a genetic and a primary PK parameter. The benefits provided by this approach compared to the NCA in terms of power have also been shown in other areas (41,42), especially when the number of samples per subject is limited, but remained to be demonstrated in the field of pharmacogenetics. In the simulation we did not include a LOQ and the data were simulated without censoring. In practice however late measurement of last concentrations could entail a significant number of data below LOQ which would decrease the ability to detect genetic differences. We would expect the NCA approach to be also impacted, as data below the LOQ are usually omitted in NCA, resulting in bias in parameters estimated through such approach (43). In NLMEM on the other hand different methods based on likelihood have been developed to impute values below the LOQ in NLMEM (44), resulting in unbiased estimates. With such methods, presence of data below the LOQ should not modify the probability to detect genetic effects on phenotypes estimated through NLMEM.

AUC is highly correlated with CL ($AUC = \frac{Dose}{CL}$) when the number of samples per subject is large, as in design used in simulations. Despite this the power to detect a gene effect was higher for the model-based approach than for the phenotypes estimated by NCA or observed due to the specific features in the PK model, the nonlinearity in the absorption model and the variability in the bioavailability. Indeed, with a linear absorption and no variability on the bioavailability parameter F (scenario $S_{linearPK, noIIV_F}$), the TPR is similar between CL and AUC (*results in supplementary materials*). Still in the linear case, an interindividual variability on F reduces the TPR of AUC (scenario $S_{linearPK}$). In the nonlinear case, although the phenotypes observed or estimated by NCA are normalised, because of estimation errors in the Emax model used for the normalisation, their respective TPR are lower than CL, even with no variability on F (scenario $S_{large, noIIV_F}$). In such a rich design, where the subjects are extensively sampled, AUC is appropriate when the PK is simple (linear, without variability on the absorption process).

In our simulations we introduced effects from six SNPs on CL parameter in the PK model to simulate concentrations profiles under the alternative hypothesis. These settings may favour the model-based phenotypes and also by extension AUC which is directly correlated with CL. With a nonlinear PK model model-based phenotypes proved much more powerful compared to the phenotype estimated by NCA, even correcting the AUC by dose to take into account the nonlinearity. On the other hand, when the PK model was linear, we found similar results in terms of TPR and FPR for both phenotypes, but only when there was no interindividual variability on bioavailability. Concerning the observed phenotypes we expected the late concentration C192h to be a good reflection of clearance, and to give similar performance than CL after correction for nonlinearity. However, this was not the case in our results, even with a linear PK. The reason for this is probably that the influence of the other parameters dilutes the impact of the genotypes on this observed phenotype, while AUC only depends on CL. But the results in term of TP obtain on C192h were better than on C24h. This concentration is not informative for elimination clearance because occurring for many subjects during the rebound simulated using our PK model, so that the poor performance for this phenotype could be expected.

In the model-based approach, using NLMEM individual parameter estimates are derived after the estimation of the population parameters and their precision depends on the amount of individual information available in the data (45). In the scenarios we simulated, the number of sampling points per subject was large, so that all model parameters, included the phenotype, were well estimated. The number of TP obtained using the simulated clearances (without the estimation step) in both scenarios was only slightly higher than when using the estimated clearance.

The estimates of the probability to detect causal variants were similar between methods in scenario S_{real} , while a departure was noticed in scenario S_{large} to detect at least 3 variants. The ridge regression method exhibited the highest count of TP but to the cost of a higher number of FP. In scenario S_{real} the estimates were rather low and fell to nearly 0% for the probability to detect at least 3 of the 6 SNPs, indicating a low ability to detect multiple effects in a realistic design. As expected, increasing the number of subjects (scenario S_{large}) strongly increased the probability of the different methods to detect more variants. But detecting all the 6 simulated variants remained very rare, due to the small percentage of variability explained by some variants. Our simulations illustrate the importance of the

number of subjects in pharmacogenetic studies : infrequent mutations are unobserved in a small population and association methods are sensitive to the frequency of the variant allele (39).

All methods were fast to run, requiring several minutes to several hours depending on the number of subjects in the scenario. Despite its iterative algorithm, stepwise procedure using univariate regression was the simplest and fastest method in all scenarios. However, the use of a full stepwise procedure using model estimation like proposed by Lehr et al. (24) causes a sharp increase in run time (39). Ridge regression and Lasso were intermediate methods in term of run time and HyperLasso was the slowest method.

There have been few papers comparing association methods in pharmacogenetics applied to PK/PD. The present work complements a previous study by Bertrand and Balding (39), who compared four association methods (ridge regression, Lasso, HyperLasso and a stepwise procedure) on only one kind of PK phenotype, CL estimated by NLMEM. Their setup is close to our scenario S_{large} in terms of the number of subjects ($N=300$), but each subject was sampled only 6 times. We compared the number of TP and FP between our studies. Our results for model-based phenotypes are partly different from those presented in this study. Bertrand and Balding found both fewer TP and less FP than in the S_{large} scenario. These differences result from our respective calculations of TP and FP. In Bertrand and Balding (39) causal variants were removed from the analysis data sets and TP were defined as SNPs correlated with the causal variants with an $r^2 > 0.05$. In our study on the other hand, the causal variants were present in the analysis data sets. Using the calculations of Bertrand and Balding, we obtained similar numbers of FP but the numbers of TP remained higher. Bertrand and Balding also explored 1227 SNPs, i.e. 7 times more SNPs in a similar number of subjects. In the ridge regression, the threshold for the Wald test proposed by Cule et al. (15) was therefore much more stringent which could explain that ridge regression detected fewer TP than the other shrinkage based approaches in their study.

In conclusion this work shows the critical importance of using modeling approaches for pharmacogenetic studies. They allow detecting associations between genetic variants and PK more efficiently, in particular in the presence of complex PK involving non-linearity, where the AUC even corrected for the dose effect was much less sensitive to the genetic effect. In addition the use of models allows for the analysis of intrinsic parameters with physiological meaning as an elimination or an absorption rate. Our results also reinforce the importance

of the number of subjects in pharmacogenetic studies, and suggest that it may not be reasonable to expect to detect even strong genetic effects and/or genetic effect due to rare alleles with small sample sizes. In addition, this work has highlighted statistical difficulties; FWER was not properly controlled and lower than expected. An empirical correction had to be performed to target 20% for the FWER. This decrease was due to the correlation between SNPs, as we showed in an additional simulation with uncorrelated genotypes. Consequently, to enable the comparison across the different methods, the FWER was set empirically for the 16 combinations of methods and phenotypes. A final message from this work is that in our simulation settings no association method showed a much higher power than the others.

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REFERENCES

1. Aarons L. Population pharmacokinetics: theory and practice. *Br J Clin Pharmacol*. 1991;32(6):669-70.
2. Motulsky AG. Drugs and genes. *Ann Intern Med*. 1969;70(6):1269-72.
3. Motulsky AG, Qi M. Pharmacogenetics, pharmacogenomics and ecogenetics. *J Zhejiang Univ Sci B*. 2006;7(2):169-70.
4. Rowland M, Tozer T. *Clinical Pharmacokinetics: Concepts and Applications*. Lippincott Williams & Wilkins; 1995.
5. Gabrielson J, Weiner D. *Pharmacokinetic and Pharmacodynamic Data Analysis: Concepts and Applications*. Fourth Edition. Swedish Pharmaceutical Press; 2007.
6. Sheiner LB, Rosenberg B, Melmon KL. Modelling of individual pharmacokinetics for computer-aided drug dosage. *Comput Biomed Res Int J*. 1972;5(5):411-59.
7. Sheiner LB, Steimer JL. Pharmacokinetic/pharmacodynamic modeling in drug development. *Annu Rev Pharmacol Toxicol*. 2000;40:67-95.
8. Shalon D, Smith SJ, Brown PO. A DNA microarray system for analyzing complex DNA samples using two-color fluorescent probe hybridization. *Genome Res*. 1996;6(7):639-45.
9. Daly MJ, Rioux JD, Schaffner SF, Hudson TJ, Lander ES. High-resolution haplotype structure in the human genome. *Nat Genet*. 2001;29(2):229-32.

10. EMA. Guideline on the use of pharmacogenetic methodologies in the pharmacokinetic evaluation of medicinal products. 2012. Report No.: EMA/CHMP/37646/2009.
11. FDA. Guidance for Industry and FDA Staff: Pharmacogenetic Tests and Genetic Tests for Heritable Markers. 2007.
12. Omoyinmi E, Forabosco P, Hamaoui R, Bryant A, Hinks A, Ursu S, et al. Association of the IL-10 gene family locus on chromosome 1 with juvenile idiopathic arthritis (JIA). *PloS One*. 2012;7(10):e47673.
13. Yao T-C, Du G, Han L, Sun Y, Hu D, Yang JJ, et al. Genome-wide association study of lung function phenotypes in a founder population. *J Allergy Clin Immunol*. 2014;133(1):248-55.e1-10.
14. Hoerl AE, Kennard RW. Ridge Regression: Biased Estimation for Nonorthogonal Problems. *Technometrics*. 1970;12(1):55.
15. Cule E, Vineis P, De Iorio M. Significance testing in ridge regression for genetic data. *BMC Bioinformatics*. 2011;12:372.
16. Tibshirani R. Regression Shrinkage and Selection Via the Lasso. *J R Stat Soc Ser B*. 1994;58:267-88.
17. Hoggart CJ, Whittaker JC, De Iorio M, Balding DJ. Simultaneous analysis of all SNPs in genome-wide and re-sequencing association studies. *PLoS Genet*. 2008;4(7):e1000130.
18. Jaki T, Wolfsegger MJ. Estimation of pharmacokinetic parameters with the R package PK. *Pharm Stat*. 2011;10(3):284-8.
19. Dubois A, Bertrand J, Mentré F. Mathematical expressions of the pharmacokinetic and pharmacodynamic models implemented in the PFIM software. 2011. <http://www.pfim.biostat.fr/>
20. Duffull SB, Graham G, Mengersen K, Eccleston J. Evaluation of the pre-posterior distribution of optimized sampling times for the design of pharmacokinetic studies. *J Biopharm Stat*. 2012;22(1):16-29.
21. Cule E, De Iorio M. Ridge regression in prediction problems: automatic choice of the ridge parameter. *Genet Epidemiol*. 2013;37(7):704-14.
22. Vignal CM, Bansal AT, Balding DJ. Using penalised logistic regression to fine map HLA variants for rheumatoid arthritis. *Ann Hum Genet*. 2011;75(6):655-64.
23. Gradshteyn I, Ryzik I. *Tables of Integrals, Series and Products: Corrected and Enlarged Edition*. New York: Academic Press. 1980.
24. Lehr T, Schaefer H-G, Staab A. Integration of high-throughput genotyping data into pharmacometric analyses using nonlinear mixed effects modeling. *Pharmacogenet Genomics*. 2010;20(7):442-50.

25. Su Z, Marchini J, Donnelly P. HAPGEN2: simulation of multiple disease SNPs. *Bioinforma Oxf Engl*. 2011;27(16):2304-5.
26. International HapMap Consortium. The International HapMap Project. *Nature*. 2003;426(6968):789-96.
27. Lavielle M, Mesa H, Chatel K. The MONOLIX software. 2010. <http://www.lixoft.eu/>
28. Kuhn E, Lavielle M. Coupling a stochastic approximation version of EM with an MCMC procedure. *ESAIM Probab Stat*. 2004;8:115-31.
29. Takeuchi F, McGinnis R, Bourgeois S, Barnes C, Eriksson N, Soranzo N, et al. A genome-wide association study confirms VKORC1, CYP2C9, and CYP4F2 as principal genetic determinants of warfarin dose. *PLoS Genet*. 2009;5(3):e1000433.
30. Cochran WG. The Comparison of Percentages in Matched Samples. *Biometrika*. 1950;37(3-4):256-66.
31. Bertrand J, Bading D, De Iorio M. Penalized regression implementation within the SAEM algorithm to advance high-throughput personalized drug therapy. 22th PAGE Meet Glasg Scotl. 2013;Abstract 2932.
32. Zou H, Hastie T. Regularization and variable selection via the elastic net. *J R Stat Soc Ser B Stat Methodol*. 2005;67(2):301-20.
33. Lockhart R, Taylor J, Tibshirani RJ, Tibshirani R. A significance test for the lasso. *Ann Stat*. 2014;42(2):413-68.
34. Knights J, Chanda P, Sato Y, Kaniwa N, Saito Y, Ueno H, et al. Vertical Integration of Pharmacogenetics in Population PK/PD Modeling: A Novel Information Theoretic Method. *CPT Pharmacomet Syst Pharmacol*. 2013;2(2):e25.
35. O'Hara RB, Sillanpää MJ. A review of Bayesian variable selection methods: what, how and which. *Bayesian Anal*. 2009;4(1):85-117.
36. Bertrand J, Comets E, Mentre F. Comparison of model-based tests and selection strategies to detect genetic polymorphisms influencing pharmacokinetic parameters. *J Biopharm Stat*. 2008;18(6):1084-102.
37. Bertrand J, Comets E, Laffont CM, Chenel M, Mentré F. Pharmacogenetics and population pharmacokinetics: impact of the design on three tests using the SAEM algorithm. *J Pharmacokinet Pharmacodyn*. 2009;36(4):317-39.
38. Bertrand J, Comets E, Chenel M, Mentré F. Some alternatives to asymptotic tests for the analysis of pharmacogenetic data using nonlinear mixed effects models. *Biometrics*. 2012;68(1):146-55.

39. Bertrand J, Balding DJ. Multiple single nucleotide polymorphism analysis using penalized regression in nonlinear mixed-effect pharmacokinetic models. *Pharmacogenet Genomics*. 2013;23(3):167-74.
40. Ribbing J, Nyberg J, Caster O, Jonsson EN. The lasso--a novel method for predictive covariate model building in nonlinear mixed effects models. *J Pharmacokinet Pharmacodyn*. 2007;34(4):485-517.
41. Dubois A, Gsteiger S, Pigeolet E, Mentré F. Bioequivalence tests based on individual estimates using non-compartmental or model-based analyses: evaluation of estimates of sample means and type I error for different designs. *Pharm Res*. 2010;27(1):92-104.
42. Panhard X, Mentré F. Evaluation by simulation of tests based on non-linear mixed-effects models in pharmacokinetic interaction and bioequivalence cross-over trials. *Stat Med*. 2005;24(10):1509-24.
43. Humbert H, Cabiac MD, Barradas J, Gerbeau C. Evaluation of pharmacokinetic studies: is it useful to take into account concentrations below the limit of quantification? *Pharm Res*. 1996;13(6):839-45.
44. Ahn JE, Karlsson MO, Dunne A, Ludden TM. Likelihood based approaches to handling data below the quantification limit using NONMEM VI. *J Pharmacokinet Pharmacodyn*. 2008;35(4):401-21.
45. Savic RM, Karlsson MO. Importance of shrinkage in empirical bayes estimates for diagnostics: problems and solutions. *AAPS J*. 2009;11(3):558-69.

Table I. Population values (μ) and interindividual variability (ω) for drug S model (units not disclosed for confidentiality reasons)

Parameters		μ	ω (%)
F^a	$Imax_F$	0.8	32.9
	$D50_F$	41.7	
$FRAC^b$	$E_{max_{FRAC}}$	0.45	-
	$D50_{FRAC}$	18.6	
$Tlag_1$		0.401	35.1
$Tk0$		1.59	31.6
$Tlag_2$		22.7	-
Ka		0.203	-
$V1$		1520	-
Q		147	89.9
$V2$		2130	44.2
CL		94.9	25.1
σ_{slope} (%)		20	-

a. For doses strictly inferior to 20 units $F = 1$, for doses superior or equal to 20 units

$$F = 1 - \frac{Imax_F (dose - 20)}{D50_F + dose - 20}, \text{ where dose is the administrated amount.}$$

b. $FRAC = \frac{E_{max_{FRAC}} dose}{D50_{FRAC} + dose}$, where dose is the administrated amount.

Table II. Empirical estimates of Family-Wise Error Rate under H_0 for S_{real} scenario

Method		FWER			
		C24h	C192h	AUC	CL
Ridge regression	without correction ^a	13	21	15.5	9.5
Lasso	without correction ^a	12	20.5	11.5	12
HyperLasso	without correction ^a	10.5	17.5	11	11
Stepwise procedure	without correction ^a	14.5	23.5	14.5	14.5
Ridge regression	after empirical correction ^b	19	21	20.5	19.5
Lasso	after empirical correction ^b	18	20.5	18.5	19.5
HyperLasso	after empirical correction ^b	18	17.5	18	19
Stepwise procedure	after empirical correction ^b	18.5	23.5	19	18

a. Set of empirical family wise error rates (FWER) obtain without correction.

b. Set of empirical FWER obtain after correction of thresholds or penalisation parameters. The 95% prediction interval around 20 for 200 simulated data sets is [14.5-25.5].

Table III. Counts of true and false positives under the alternative hypothesis for S_{real} scenario

Method		C24h	C192h	AUC	CL	Q	V2
Ridge regression	TP	25 [16;37]	70 [55;88]	49 [36;65]	107 [88;129]	-	-
Lasso	TP	20 [12;31]	50 [37;66]	43 [31;58]	86 [69;106]	-	-
HyperLasso	TP	14 [8;23]	42 [30;57]	33 [23;46]	79 [63;98]	-	-
Stepwise procedure	TP	17 [10;27]	52 [39;68]	33 [23;46]	80 [63;100]	-	-
Ridge regression	FP	79 [63;98]	125 [104;149]	97 [79;118]	97 [79;118]	42 [30;57]	29 [19;42]
Lasso	FP	70 [55;88]	73 [57;92]	76 [60;95]	54 [41;70]	34 [24;48]	22 [14;33]
HyperLasso	FP	57 [43;74]	55 [41;72]	54 [41;70]	32 [22;45]	32 [22;45]	19 [11;30]
Stepwise procedure	FP	65 [50;83]	72 [56;91]	66 [51;84]	36 [25;50]	36 [25;50]	19 [11;30]

Total number of true positives (TP) and false positives (FP) with their 95% confidence interval under the alternative hypothesis. On 200 simulated data sets, overall 1200 SNPs were set to impact clearance (maximum TP number).

Table IV. Counts of true and false positives under the alternative hypothesis for S_{large} scenario

Method		C24h	C192h	AUC	CL	Q	V2
Ridge regression	TP	96 [78;117]	427 [387;469]	313 [279;350]	624 [576;675]	-	-
Lasso	TP	89 [71;110]	403 [365;444]	301 [268;337]	563 [517;611]	-	-
HyperLasso	TP	80 [63;100]	373 [336;413]	277 [245;312]	545 [500;593]	-	-
Stepwise procedure	TP	91 [73;112]	388 [350;429]	292 [259;327]	590 [543;640]	-	-
Ridge regression	FP	114 [94;137]	253 [223;286]	206 [179;236]	320 [286;357]	32 [22;45]	51 [38;67]
Lasso	FP	97 [79;118]	163 [139;190]	148 [125;174]	159 [135;186]	40 [29;54]	46 [34;61]
HyperLasso	FP	84 [67;104]	97 [79;118]	99 [80;121]	86 [69;106]	36 [25;50]	42 [30;57]
Stepwise procedure	FP	90 [72;111]	115 [95;138]	127 [106;151]	111 [91;134]	39 [28;53]	43 [31;58]

Total number of true positives (TP) and false positives (FP) with their 95% confidence interval under the alternative hypothesis. On 200 simulated data sets, overall 1200 SNPs were set to impact clearance (maximum TP number).

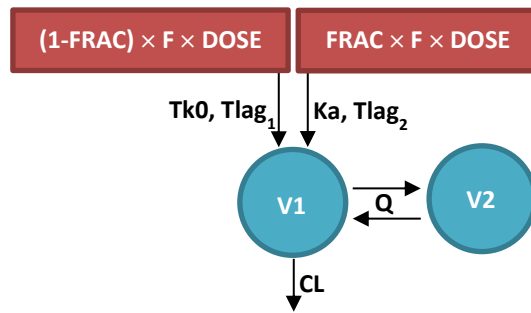


Fig. 1. Structural PK model of drug S. Double absorption compartments in red and disposition compartments in blue

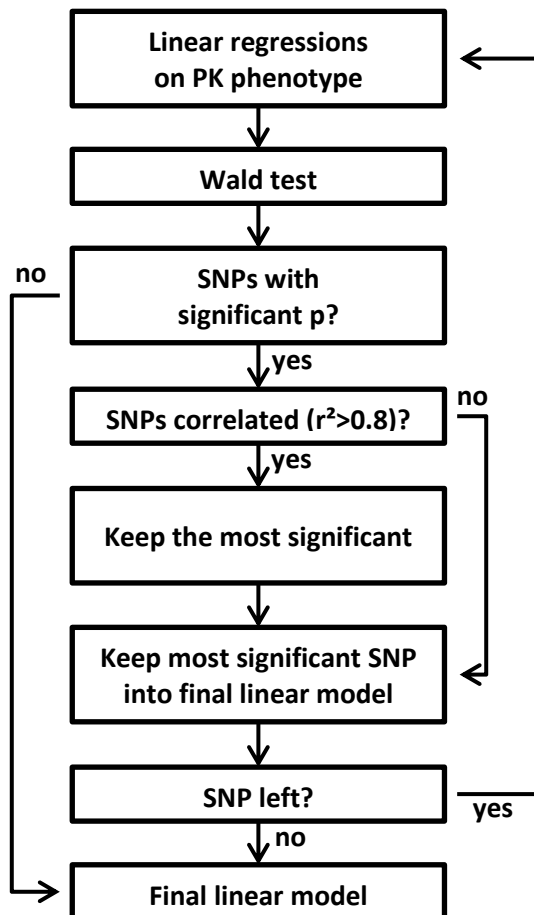


Fig. 2. Stepwise procedure algorithm, adapted from Lehr et al. (24)

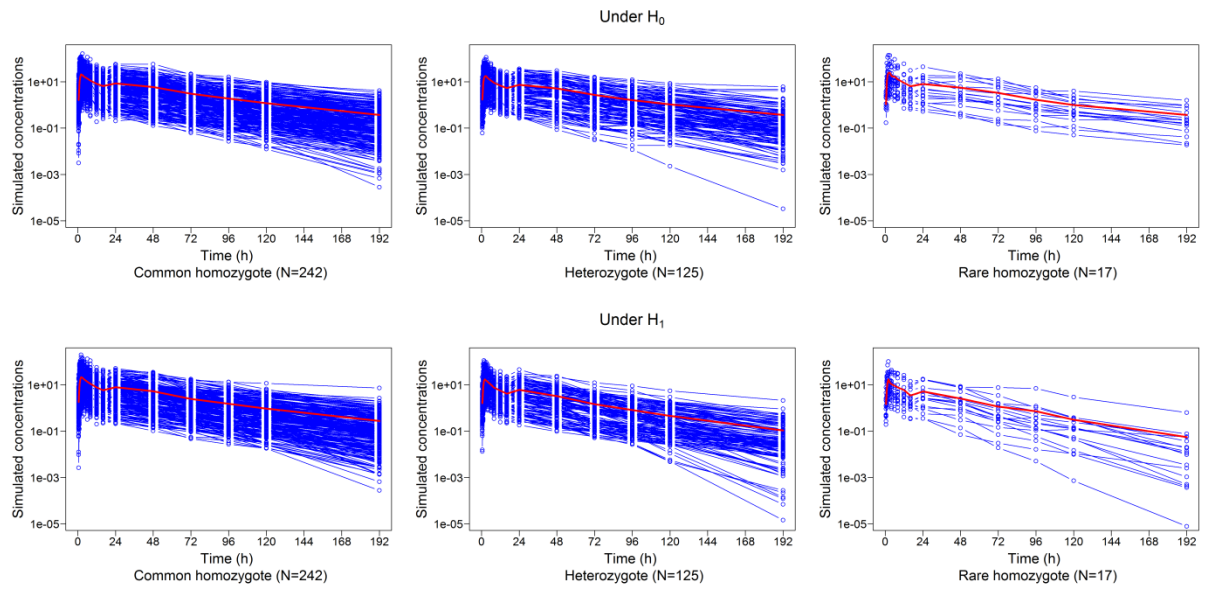


Fig. 3. Individual concentration versus time profiles (blue lines) and mean profiles (red lines) for one simulated dataset under H_0 (top) and under H_1 (bottom), in scenario S_{large} . The profiles are plotted in log-scale for the Y-axis. The three panels show the profiles for common homozygotes (*left*), heterozygotes (*middle*) and rare homozygotes (*right*)

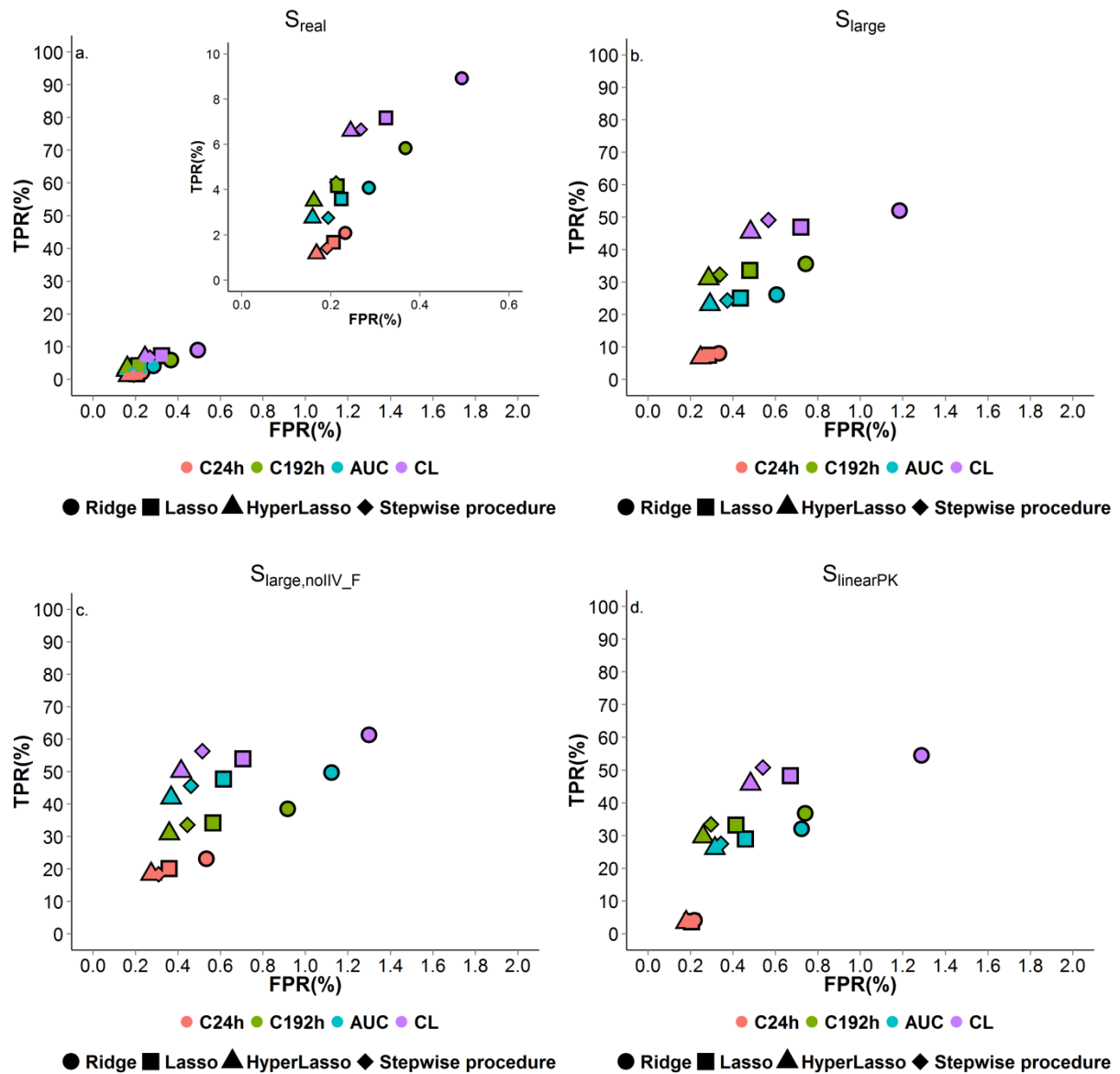


Fig. 4. Percentage of True Positive Rate (TPR) versus False Positive Rate (FPR) (dots). Each PK phenotype is represented by one color and each association method by one symbol. The S_{real} scenario on top-left with a focus on lower values of TPR and FPR (a), the S_{large} scenario on top-right (b), the $S_{large, noIV_F}$ scenario on bottom-left (c) and the $S_{linearPK}$ scenario on bottom-right (d)

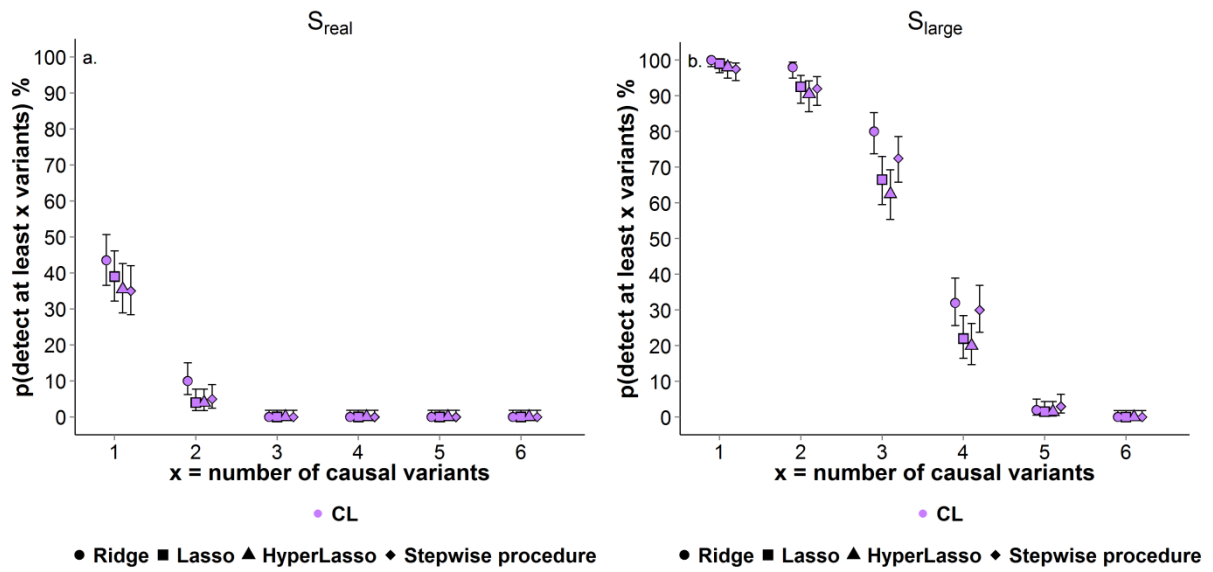


Fig. 5. Probability Estimates (dots) and 95% confidence interval (bars) under H_1 with each method to detect at least x variants explaining interindividual variability of CL, with x varying from 1 to 6. The S_{real} scenario on left (a) and the S_{large} scenario on right (b)