Pharmacokinetics and Bioequivalence Study of Two Indapamide Formulations after Single-dose Administration in Healthy Chinese Male Volunteers

Abstract

The pharmacokinetics and relative bioavailability/bioequivalence of 2 formulations of indapamide were assessed in this paper. The study was conducted in 20 healthy Chinese male volunteers according to an open, randomized, single-blind, 2-way crossover study design with a wash-out phase of 7 days. Blood samples for pharmacokinetic profiling were taken up to 84 h post-dose, and indapamide concentrations in plasma were determined by a validated liquid chromatography-electrospray ionization-mass spectrometry (LC-ESI-MS) method. Based on the plasma concentration-time data of each individual in each period, pharmacokinetic parameters, $C_{\text{max}}$, $AUC_{0-\infty}$, and $t_{1/2}$, were calculated by non-compartmental analysis. Pharmacokinetic parameters for test and reference formulations were analyzed statistically to assess bioequivalence of the 2 formulations. The values of $C_{\text{max}}$, $T_{\text{max}}$, $AUC_{0-\infty}$, and $AUC_{0-\infty}$ were 49.53 ± 5.53 and 47.79 ± 4.68 ng/mL, 1.9 ± 0.6 and 2.0 ± 0.5 h, 22.49 ± 5.93 and 23.23 ± 4.48 h, 859.51 ± 160.92 and 840.90 ± 170.62 ng·h/mL, 934.35 ± 190.60 and 919.52 ± 179.74 ng·h/mL, respectively. The 90% confidence intervals of the T/R-ratios of logarithmically transformed data were within the accepted range of 80–125%. It showed that the 2 formulations of indapamide were bioequivalent. Both preparations were well tolerated and no adverse reactions were found throughout the study.

Introduction

Indapamide, 4-chloro-N-(2-methyl-1-indolinyl)-3-sulphamoyl benzamide, is a non-thiazide indole derivative of O-chloro benzene sulfonamide, which has diuretic and natriuretic effects and thus exhibits an anti-hypertensive action causing a decrease in systolic, diastolic and mean blood pressure [1,2]. However, specific side chains endow the drug some characteristic properties. Indapamide presents an indolyl ring and uniquely possesses free-radical scavenging activity as well as a direct vasodilator action [2-4], besides it has no adverse lipid effects in contrast to thiazide diuretics [5-7]. Accordingly, indapamide was defined by the 1999 WHO/ISH Hypertension Guidelines and JNC VII as a first-line drug for treating mild-to-moderate hypertension [8].

Indapamide was first developed as 2.5 mg immediate release tablets and subsequently 1.5 mg sustained release tablets. Indapamide is quickly absorbed from the gastrointestinal tract and peak plasma concentrations are seen 1–2 h after dosing immediate release tablets. Indapamide is widely distributed throughout the body, with extensive binding to some specific sites, which leads its relatively highly combination to plasma proteins (79%) in plasma [9]. It has a long half-life (about 20 h) so it is effective in once daily dosing [10]. Indapamide is extensively metabolized, with only about 7% of the total dose administered recovered in the urine as unchanged drug during the first 48 h after administration [10,11]. Although Li Ding et al. [12], Wei-Dong Chen et al. [13] and Tai-Jun Hang et al. [9] have researched the pharmacokinetics and bioavailability of indapamide in the Chinese population, they focus on the method for the quantitation of indapamide in vivo, which is simple, sensitive and rapid. The information concerning the bioavailability and pharmacokinetics of indapamide in the Chinese population has not been reported in detail up to now. In this article, pharmacokinetic parameters of indapamide in Chinese after dosing 5 mg indapamide are presented. Meanwhile, this study also focused on a comparison of the bioavailability of generic drug (test) and original drug (reference) formulations of indapamid of the same
The analytical procedure was performed on an Agilent Zorbax 2010 A) for analysis. The mobile phase of methanol-10 mM ammonium acetate solution (pH = 5.0) (50:50,v/v). Analytes were determined in a single quadrupole mass spectrometer with negative ion and selected ion monitoring (SIM) mode to monitor target ions at m/z of 364.0 for indapamide and 357.0 for prednisone. The MS operating conditions were optimized as follows: drying gas 1.5 L/min, CDL temperature 250 °C, block temperature 200 °C, probe voltage ~4.5 kV.

Method validation
The method was validated in our analytical laboratory according to the United States Food and Drug Administration (FDA) bioanalytical method validation guidance [14] on specificity, matrix effect, linearity, accuracy, precision, extraction recovery and stability. Specificity was assessed by testing 6 different drug-free plasma batches. The matrix effect caused by ionization competition between analytes (indapamide and IS) and co-eluted compounds was evaluated at 3 QC concentrations. 5 calibration curves (1, 2, 5, 10, 20, 50, 100 ng/mL) were generated in 5 consecutive days to test the linearity. The limit of detection (LOD) and the lower limit of quantification (LLOQ) were determined as the concentrations with a signal-to-noise ratio (S/N) no less than 3 and 10, respectively. The accuracy and precision were evaluated by analyzing QC standards 5 times daily and over 3 consecutive days. Extraction recovery was evaluated by comparing the indapamide-IS peak area ratios obtained from extracted samples to those from the samples containing the same amount of indapamide which was added after the extraction step (IS was added after the extraction step in both batches). Stability was evaluated at each QC concentration under different conditions that occurred during sample analysis. The short-term stability and long-term stability was evaluated by keeping QC samples at room temperature for 8 h and low temperature (~20 °C) for 15 days respectively. The post-preparative stability was measured by placing prepared QC samples under the autosampler conditions (15 °C) for 48 h. The freeze and thaw stability was tested by analyzing QC samples undergoing 3 freeze (~20 °C)-thaw (room temperature) cycles on consecutive days. The working solutions and stock solutions of indapamide and the IS were also evaluated at room temperature for 24 h and at 4 °C for 15 days, respectively.

Experimental design
This open, randomized, single-dose, 2-sequence, 2-period crossover study was performed in strict accordance with the Declaration of Helsinki, Good Clinical Practice (GCP) Guidelines and Good Laboratory Practice (GLP) Guidelines. The protocol and the consent form of the study were approved by the Research Ethics Committee of Nanjing Command General Hospital, Nanjing (P. R. China). Enrolled in this study were 20 healthy, male, adult Chinese volunteers provided written informed consent prior to study participation. All of them completed the study and were evaluable for this pharmacokinetics and bioequivalence study. Their mean age ± SD was 23.60 ± 1.39 years. Their mean body weight was 66.15 ± 7.01 kg and their mean height was 172.85 ± 3.18 cm, giving a mean Body Mass Index (BMI) of 22.11 ± 1.94 kg/m². Screening at study start included medical history, physical examination, vital signs, ECG, laboratory safety tests (routine hematology: glucose, creatinine, sodium, potassium, chloride, CO₂, ALT, ALP, and total bilirubin level; and urinalysis). Subjects were excluded if they smoked, used alcohol, had a history or evidence of hepatic, renal, gastrointestinal, or hematological deviations, had acute or chronic disease, allergies to any medications, and/or had any clinically significant abnormality. Subjects were instructed to abstain from using any other reagents were prepared as required.

Analytical method
Preparation of stock solutions, calibration standards and quality control samples
The stock solution of indapamide and IS were prepared in methanol at a concentration of 1.0 mg/mL. Working solutions of indapamide (0.05, 0.1, 0.25, 0.5, 1, 2.5, 4 and 5 μg/mL) and IS (30 μg/mL) were prepared daily by appropriate dilution. Calibration standards (1, 2, 5, 10, 20, 50 and 100 ng/mL) were prepared by spiking 500 μL blank plasma with 10 μL working solutions (0.05, 0.1, 0.25, 0.5, 1, 2.5 and 5 μg/mL) of indapamide. In each run, a blank plasma sample (processed without IS) was analyzed to confirm absence of interference but not used to construct the calibration function. Quality control (QC) samples were prepared by spiking 500 μL blank plasma with 10 μL working solutions (0.1, 1 and 4 μg/mL) to produce a final concentration equivalent to 2 ng/mL (low level), 20 ng/mL (middle level) and 80 ng/mL (high level) of indapamide.

Sample preparation and instrumental conditions
A simple, sensitive and specific liquid chromatography–electrospray ionization–mass spectrometry (LC-ESI-MS) method has been developed and validated for the determination of indapamide in human plasma. The plasma samples were prepared by liquid–liquid extraction. After the addition of prednisone as the internal standard (IS, 10 μL × 30 μg/mL) and 100 μL saturated Na₂CO₃, 500 μL plasma samples were extracted with 4.0 mL diethyl ether. Then the upper organic phase was transferred and evaporated to dryness. The residue was reconstituted in 100 μL of mobile phase, and an aliquot of 10 μL was injected to LC-ESI-MS (SHIMADZU LCMS-2010A) for analysis.

The analytical procedure was performed on an Agilent Zorbax Eclipse XDB-phenyl (150 mm × 2.1 mm I.D., 5 μm) at 40 °C with a mobile phase of methanol-10 mM ammonium acetate buffer solution (pH=5.0) (50:50,v/v). Analytes were determined in a single quadrupole mass spectrometer with negative ion and...
medications for at least 2 weeks prior to and during the study; and from smoking and taking alcohol, caffeine, related xanthines-containing beverages or food for at least 48 h before administering the study drug and throughout the study. This was a single-dose, single-blind, randomized, 2-way crossover trial in which the subjects were randomly assigned to the treatment sequences R/T or T/R. The subjects received a single dose of 5 mg indapamide as 2 tablets of formulation R (2 indapamide reference tablets) or a single dose of 5 mg indapamide as 2 tablets of formulation T (2 indapamide test tablets) under supervision by study investigators. The reference formulation and test formulation were administered alternately in the second period. The wash-out period between the 2 dosing periods was 1 week. In each treatment period, volunteers were required to fast for approximately 10 h prior to the dosing. The formulations were administrated with 250 mL water; then water was not allowed until 2 h after administration. Standardized lunch and dinner were served after a 6- and 12-h blood sampling, respectively. For the measurement of pharmacokinetic parameters, venous blood samples were collected by study nurses via an indwelling cannula or direct venipuncture into the heparinised tubes from all subjects prior to the dosing (T0) and then after 0.33, 0.67, 1, 1.5, 2, 3, 4, 6, 8, 12, 24, 48, 72 and 84 h from administration during each treatment period. Samples were centrifuged at 3000 g for 5 min immediately then the plasma was transferred and stored at −20 °C until assay.

Pharmacokinetic and statistical analysis
Pharmacokinetic parameters
Pharmacokinetic assessment of indapamide was estimated from the concentration-time data using non-compartmental methods. Maximum plasma concentrations (Cmax) and time to reach this value (Tmax) were considered as the observed highest concentration and time of its occurrence, respectively. The elimination half-life (t1/2) was calculated as t1/2 = (ln 2)/Kel, where the apparent elimination rate constant, Kel was calculated as the slope of the linear regression line of natural log-transformed plasma concentration against time. AUC0–∞ was calculated using the linear trapezoidal rule from zero to the last sampling time-point (Tlast) at which a concentration was measurable (C) and from smoking and taking alcohol, caffeine, related xanthines-containing beverages or food for at least 48 h before administering the study drug and throughout the study. In the present study, Tmax values in this study population.

Clinical observations
20 subjects completed the study so that 20 cases were available for each treatment. No clinically significant adverse effects were reported in the present study population. All subjects were discharged in good health after repeating physical examination and laboratory analysis after period 2. A clinically relevant difference in both tolerability and safety of 2 treatments was not detected.

Pharmacokinetic and statistical results
The plasma concentration-time profiles of indapamide following single-dose oral administration of the test and reference formulations are presented in Fig. 2. A summary of the pharmacokinetic parameters, AUC0–τ, AUC0–∞, Cmax, Tmax, t1/2, MRT, AUC0–τ/AUC0–∞, F0–τ and F0–∞ derived from the 2 formulations is shown in Table 2. The calculated Cmax values for the test and reference formulations were 49.53 ± 5.53 ng/mL and 47.79 ± 4.68 ng/mL, AUC0–∞ of 934.35 ± 190.60 ng·h/mL (test) and 919.52 ± 179.74 ng·h/mL (reference) were achieved. Elimination half-lives and elimination rate constants were not significantly different between the preparations. In addition, the mean Tmax values in this study were 1.9 ± 0.6 h for test formulation and 2.0 ± 0.5 h for reference formulation. The results of ANOVA for assessment of treatment, period and subject (within sequence) effects and 90% CIs for the ratio of Cmax, AUC0–τ, and AUC0–∞ values for test and reference formulations, using logarithmic transformed data, are shown in Table 3.
Discussion and Conclusion

The proposed method for determination of indapamide in human plasma was selective, accurate, and precise. And it was proved to be reliable and suitable for the pharmacokinetics and bioequivalence study of indapamide in healthy Chinese male volunteers. In our method, liquid-liquid extraction was necessary and important, because this technique can purify and concentrate indapamide.
peak (showed in

To exclude the interference of unknown peak to indapamide
tation in terms of precise, consistent and reproducible recoveries
and saturated NaHCO₃ solution were attempted. Finally, 100 μL of saturated Na₂CO₃ solution was adopted for sample prepara-

Table 2

<table>
<thead>
<tr>
<th>Plasma samples</th>
<th>2 ng/mL</th>
<th>20 ng/mL</th>
<th>80 ng/mL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Accuracy (%)</td>
<td>Precision (%)</td>
<td>Accuracy (%)</td>
</tr>
<tr>
<td>Intra-batch (n=5)</td>
<td>100.8</td>
<td>10.8</td>
<td>102.2</td>
</tr>
<tr>
<td>Inter-batch (n=15)</td>
<td>100.6</td>
<td>9.1</td>
<td>101.4</td>
</tr>
<tr>
<td>Extraction recovery¹</td>
<td>83.2</td>
<td>5.3</td>
<td>82.7</td>
</tr>
<tr>
<td>Long-term stability²</td>
<td>97.3</td>
<td>7.3</td>
<td>102.2</td>
</tr>
<tr>
<td>Short-term stability³</td>
<td>100.0</td>
<td>3.7</td>
<td>107.4</td>
</tr>
<tr>
<td>Freeze and thaw stability⁴</td>
<td>97.9</td>
<td>6.2</td>
<td>101.3</td>
</tr>
<tr>
<td>Post-preparative stability⁵</td>
<td>101.0</td>
<td>6.2</td>
<td>104.7</td>
</tr>
</tbody>
</table>

¹n=5; ²15 days, -20°C, n=6; ³8 h, room temperature, n=6; ⁴3 cycles, -20°C-room temperature, n=6; ⁵48 h, 15°C, n=9, ⁶24 h, room temperature, n=3; ⁷15 days, 4°C, n=3

the sample. A preliminary evaluation of different extraction sol-
vent such as diethyl ether, ethyl acetate or dichloromethane
under alkalizing and neutral conditions showed that extraction
with diethyl ether in alkalizing condition exhibited higher
extraction efficiency. Then, 1M NaOH, saturated Na₂CO₃ solution
and saturated NaHCO₃ solution were attempted. Finally, 100 μL
of saturated Na₂CO₃ solution was adopted for sample prepara-
tion in terms of precise, consistent and reproducible recoveries
and specific.

To exclude the interference of unknown peak to indapamide
peak (showed in Fig. 1c), a mobile phase consisting of 50%
methanol and 50% 10 mM ammonium acetate buffer solution
(pH=5.0) was adopted, achieved good resolution, symmetric
peak shape and suitable retention time without matrix effects.
Several articles [15, 16] have reported the pharmacokinetics of
pharmacokinetics of sustained and immediate release formulas-
tions (1.5 mg and 2.5 mg respectively) of indapamide, indicating
much higher values of C max/dose and AUC 0–∞/dose (39 ± 11 ng/mL
and 564 ± 146 ng·h/mL after dosing one 2.5 mg immediate release
tablet, determined and calculated by use of concentrations in
whole blood) than this study. The main reason should be that
indapamide is preferentially and reversibly taken up by the
erythrocytes in the blood [17]. Moreover, Dragica Zendelovska
[18] developed a new method for determining indapamide in
biological fluids to confirm that the C max in blood was much
higher than in serum. Consequently, it should be remarked that
blood samples should avoid hemolysis until to obtain the plasma.
Moreover, bioequivalence study of indapamide in plasma
requires a more sensitive analytical method than in whole blood.
LLOQ of 1 ng/mL in this study is enough for plasma concentra-
tion determination. In contrast, HPLC-UV methods [9, 18], giving
a higher LLOQ of 10 ng/mL, are not suitable for pharmacokinetics
study of indapamide in plasma. Florin Albu [16] and Deepak S.
Jain [19] reported HPLC-MS/MS methods with LLOQ of 1 ng/mL
and 0.5 ng/mL respectively, but they adopted a superior instru-
ment (HPLC-MS/MS), which is more expensive than HPLC-MS.
Consequently, HPLC-MS is economic and suitable for pharma-
cokinetics study of indapamide.

The results from the ANOVA found that formulation, period, and
sequence had no statistically significant effect on AUC 0–∞ and C max at the significance level of 0.05. However, as might be
expected, the subject variability of those pharmacokinetic
parameters was significant (P<0.0001). This was further
explored by calculating the inter-subject and intra-subject coeffi-
cient of variations. The mean ratio of AUC 0–∞/AUC 0–∞ for test
and reference formulations were both above 90%, indicated that
the sampling time was adequate. The 90% CIs for AUC 0–∞ and C max were within the FDA acceptable bioequivalence range
of 80–125% and the results of the Schuirmann’s test indicated
that the lower and upper limits of the calculated t-test were
greater than the critical t-value.

Therefore, it can be concluded that the test and reference formul-
ations are bioequivalent according to both of the rate and extent
of absorption and consequently can be used interchangeably in
medical practice. The results of this study, obtained from samples of healthy Chinese volunteers, might serve as a reference for future controlled studies of indapamide in the Chinese population.

Acknowledgement

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Conflict of Interest Statement

The authors declare that they have no conflict of interest with respect to this paper.

References