

Pharmaceutical Chemistry of Antihypertensive Agents

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β-ADRENERGIC ANTAGONISTS (β-BLOCKERS)

I. INTRODUCTION

The β-adrenergic antagonists are commercially available as the water-soluble, absorbable salts of the nonsoluble or only slightly soluble bases. They behave as sympatholytics, i.e., they have the ability to interact with β-adrenergic receptors. The β-blocker compounds that are reasonably often used are to be found in the comprehensive Table 1; a few of them will be detailed in this chapter.

Unlike the agonists, the great majority of the β-blocker compounds may be regarded as 1,2-propanediol derivatives. Only sotalol has a skeleton resembling that of adrenergic agonists, including an ethanolamine moiety. On the basis of the elucidated relations, all those physical-chemical properties which are important in the *in vitro* and *in vivo* interactions of the β-blocker compounds can be deduced from the individual features of the main structural units of the molecules (Table 2).

II. PROPERTIES

The commercial salts of β-blocker agents (chloride, tartrate, maleate, etc.) are generally white or off-white odorless crystalline powders.

These salts are very soluble in water and alcohol. Depending upon their hydrophobicity, they may also be soluble in semi-polar solvents. Metoprolol tartrate (USP) is freely soluble in methylene chloride or chloroform, while propranolol hydrochloride (USP) is only slightly soluble, and timolol maleate (USP) sparingly soluble in chloroform. They are insoluble in ether or apolar solvents such as cyclohexane. Due to the poor water-solubility of their corresponding bases, their water-solubility, as expected, is pH-dependent. This may be illustrated by the data for pindolol:

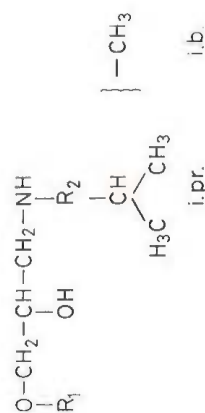
pH	1.5	5.2	7.5
parts of pindolol in 100 parts of water	2	0.03	0.001

The octanol-water partition coefficients of the therapeutic β-blockers show a great variety,¹⁻³ there being a difference of several orders of magnitude between the values for the most hydrophobic and the most hydrophilic compounds (compare the P values of penbutalol, propranolol, and atenolol in Table 3). On this basis β-blockers may be grouped into three classes of lipophilicity.


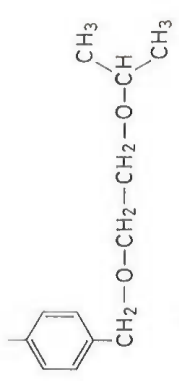

In spite of the often significant discrepancies between the values published for the same compounds by different authors, the octanol-water partition coefficient can be regarded as a good indicator of the predictable pharmacokinetic behavior of β-blocker molecules. The differences that may be encountered in the values for a given compound may stem from the different circumstances applied in the determination (pH of the aqueous phase, duration and temperature of equilibration, purity of the substance, etc.). However, the extremely different numerical values of the compounds in Table 3 arise from the different natures of the values. The data in column A are apparent partition coefficients, which relate to the partition of the protonated form of the compounds, while the much higher values in column B are true partition coefficients, which reflect the partition of the non-protonated (base) form.

A good correlation has been demonstrated between octanol-water partition coefficients

TABLE 1
 β -Blockers in Therapeutic Use



Chemical structure

Generic name	R_1	R_2	Proprietary name [®]	Therapeutic use	Doses
active β_1 -receptor blocking agents cebutolol		i.pr.	IL-17803, Neptal, Prent, Sactal	Preferred in management of angina pectoris, hypertension, and cardiac arrhythmias. Reduces arterial pressure without reducing cardiac output. Exhibits intrinsic sympathomimetic activity (ISA), correlating with baseline plasma renin activity.	Maximum dose: 300—400 mg/day
isopropinol		i.pr.	Concor	Indicated in hypertension and angina pectoris. Does not exhibit any ISA properties.	Initial dose: 10 mg up to 20 mg once a day
etaxolol		i.pr.	Kertlone	Same as bisoprolol.	

aliprolol		i.b. Selectol.	Has some ISA, β_2 - and very slight α_2 -receptor blocking effect. Indications similar to those of bisoprolol and betaxolol	Usual dose: 200—300 mg daily.
atenolol		i.pr. ICI 66082, Tenormin	Three times more potent than propranolol. Used in management of hypertension alone or in combination with thiazide-type diuretics.	Initial dose: 50 mg/day (1 tablet) up to 100 mg/day.
betoprolol tartrate (USP)		i.pr. Beloc, Betaloc, Lopressor, Seloken	Has a preferential effect on β_1 -adrenoreceptors, but inhibits β_2 -receptors too, particularly in higher doses.	Initial dose: 100 mg/day (in single or divided doses) up to a maximum 450 mg/day.
carvedilol		i.pr. Cordialime, Dabric, Eralex, Practol, Pralon, Teranol	Acts selectively on β_1 -receptors of myocardium only. Therefore possesses fewer side effects than other β -blockers. Has some ISA.	Initial dose: 100 mg up to 400 mg/day.
non-selective β -receptor (β_1 and β_2) blocking agents xprenolol		i.pr. Coretal, Trasacor, Trazisensine	Intensity of β -blocking effect similar to that of propranolol. Indicated for all grades of hypertension. Does not cause orthostatic collapse, hypersensitivity, weakness, or fatigue. Cardioprotective. Combination with diuretics gives better hypotensive result and diminished side effects.	Usual dose: 2×80 mg/day
metoprolol		Beta-Cardone, Sotacor, Sotalax, Sotaper	Has screening effect against sympathetic stimulation, and weak negative inotropic and chronotropic effect. Indicated in therapy of hypertension, angina pectoris, and tachycardia arrhythmia.	Usual dose: 300 mg/day

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