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REPORT OF A MEETING

J. vet. Pharmacol. Therap. 28, 453–460, 2005. DRUGS ACTING ON THE CENTRAL AND PERIPHERAL NERVOUS SYSTEMS

PK-PD modeling of buprenorphine in cats: intravenous and oral transmucosal administration¹

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The pharmacokinetics and thermal antinociceptive effects of buprenorphine after intravenous (i.v.) or oral transmucosal (OTM) administration were studied in six adult cats. Plasma buprenorphine concentrations were measured using radioimmunoassay in a crossover study after a dose of 20 µg/kg given by the i.v. or OTM route. Oral pH was measured. Blood for drug analyses was collected before, and at 1, 2, 4, 6, 10, 15, 30, and 60 min and at 2, 4, 6, 8, 12, and 24 h after treatment. Thermal thresholds were measured before treatment, then following treatment every 30 min to 6 h, every 1 hour to 12 h and at 24 hours postadministration. Plasma buprenorphine concentration effect relationships were analyzed using a log-linear effect model. Oral pH was 9 in each cat. Peak plasma buprenorphine concentration was lower and occurred later in the OTM group but median bioavailability was 116.3%. Thermal thresholds increased significantly between 30 and 360 min in both groups. Peak effect was at 90 min and there was no difference at any time between the two groups. There was distinct hysteresis between plasma drug concentration and effect in both groups. Overall, OTM administration of buprenorphine is as effective as i.v. treatment and offers a simple, noninvasive method of administration which produces thermal antinociception for up to 6 h in cats.

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INTRODUCTION

The number of pet owning households has increased by over 10% in the past 15 years (Wise *et al.* 2002) and cats are now the most popular pet with current numbers estimated at between 70 and 77.7 million in the US alone. Concurrent with this has been a long awaited increase in the publication of studies relevant to the treatment of pain in this species, which has previously lagged behind the information available for dogs. The misconception that opioids cause excitement or 'morphine mania' in cats has been difficult to dispel. Such reports were based on early literature when large doses were administered (Eastman *et al.* 1974; Farnish *et al.* 1979) but

Robertson *et al.*, 2005). However, a recent European survey of opioid use in veterinary practice reveals that few practitioners (8.1%) used opioids in cats because of lack of knowledge of their pharmacology, fear of side-effects and controlled drug legislation despite the fact that almost 60% of respondents considered their control of pain in this species inadequate (Hugonnard *et al.*, 2004). In these authors opinion, opioids should comprise the backbone of acute pain management and butorphanol, buprenorphine, fentanyl, meperidine (pethidine), morphine, hydromorphone, and oxymorphone have all been used clinically in cats (Lascelles & Waterman, 1997; Lamont, 2002).

Buprenorphine is a semi-synthetic partial µ opioid agonist

uncommon after buprenorphine, meperidine or butorphanol (Taylor *et al.*, 2001; Dixon *et al.*, 2002; Robertson *et al.*, 2003a). In contrast to hydromorphone, buprenorphine has not been associated with hyperthermia (Wegner *et al.* 2004; Niedfeldt & Robertson, In press). The disposition of buprenorphine (10 µg/kg) after intravenous (i.v.) and intramuscular (i.m.) administration in cats has been reported (Taylor *et al.* 2001). Buprenorphine (10 µg/kg) has been administered to cats by the oral mucosal route and was well accepted (Robertson *et al.*, 2003b). In that study uptake was verified by plasma drug analysis but no efficacy data were reported. Based on changes in thermal thresholds i.m. doses of 10 µg/kg resulted in a slow onset (2 h) of analgesia but once established this lasted at least 6 h (Robertson *et al.*, 2003a). The slow onset but long duration of this opioid is thought to be related to slow receptor binding and disassociation (Nolan *et al.*, 1987). Based on the positive attributes of buprenorphine the purpose of this study was to compare the pharmacokinetic and analgesic effects of a higher dose than previously reported in cats given by the i.v. and oral transmucosal (OTM) route and to model the kinetic data with drug effect.

METHODS

All procedures were approved by, the Institutional Animal Care and Use committee at the University of Florida. Six cats (five spayed females, one castrated male), aged 1–3 years with a weight range 4.1–6.6 kg were used in this study. All cats were considered healthy based on clinical examination and hematological and biochemical analyses.

On the day before each study, cats were anesthetized with isoflurane vaporized in oxygen. A 20 g 12 cm polyurethane catheter (Arrow International, Reading, PA, USA) was inserted in the jugular vein and secured with suture material and a light bandage (Vetrap™ bandaging tape, 3M™, St Paul, MN, USA). A cephalic catheter was placed in the contralateral vein in those cats scheduled to receive i.v. buprenorphine. In both the i.v. and OTM administration groups the forelimb was bandaged so that the researcher performing thermal threshold testing was unaware whether or not a catheter was in place. The left or right lateral thorax was shaved according to a predetermined randomized schedule and cats were weighed before recovering from anesthesia.

Food but not water was withheld for 6 h before each study, and both food and water were offered 1 h after drug administration. All cats received 20 µg/kg of buprenorphine hydrochloride (Buprenex®, Reckitt Benckiser Pharmaceuticals Inc., Richmond, VA, USA) administered from a 1 mL syringe

with the standard pH chart and recorded. After treatment, cats were observed for vomiting, salivation and behavioral changes. Pharmacokinetic and thermal threshold studies were conducted concurrently.

Pharmacokinetic study

Blood samples were withdrawn from the jugular catheter before and at 1, 2, 4, 6, 10, 15, 30, 45, and 60 min. and at 2, 4, 6, 12, and 24 h after drug dosing. The volume of blood collected was adjusted for each individual so that less than 10% of the cat's total blood volume was removed over the 24-hour study period (1.5–2.0 mL per sample). An equal volume of 0.9% saline was injected after each sample was withdrawn. Blood was transferred to lithium heparin tubes and centrifuged (2000 *g*) for 10 min. Plasma was separated and stored at –20 °C for a maximum of 3 months before buprenorphine assays were performed.

Drug analysis

Plasma buprenorphine concentrations were measured using an Iodine¹²⁵-labeled radio-immunoassay (Buprenorphine double antibody RIA kit, EuroDPC Ltd, Glyn Rhonwy, Gwynnedd, UK). The limit of detection of the assay was 0.1 ng/mL. In the concentration range of 0.1–6.0 ng/mL the inter- and intra-assay coefficient of variation (CV) was 5.9–7.4%; at higher concentrations the inter-assay CV was 7.7–18% (Taylor *et al.*, 2001). Plasma concentrations were linear over one and twofold dilutions and recovery was greater than 95%. The radioimmunoassay shows some cross-reactivity with buprenorphine-3-glucuronide (B-3-G) (DPC Product Characteristics). The metabolites of buprenorphine in cats have not been identified.

Thermal threshold testing

The thermal threshold testing system used was that described by Dixon *et al.* (2002). Briefly, a heater element and temperature sensor housed in a small probe was held against the cats' thorax with an elasticized band and pressure bladder to ensure consistent contact. The skin temperature was recorded before each test, then the heater activated. When the cat responded by flinching, turning or jumping the stimulus was terminated and the threshold temperature recorded. The testing system was designed to terminate heating when a temperature of 55 °C was reached. Three baseline temperatures were recorded at 15-minute intervals before treatment. A single person (BDXL) performed the thermal threshold tests and was blinded to the treatment. Thermal thresholds were measured every 30 min to 6 h, every 1 hour to 12 h and at 24 h postadministration. The

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