

# Oral Drug Absorption

## Prediction and Assessment



edited by  
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# 1

## Gastrointestinal Transit and Drug Absorption

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### I. INTRODUCTION

The human gut has evolved over many thousands of years to provide an efficient system for the extraction of nutrients from a varied diet. Functionally, the gut is divided into a preparative and primary storage region (mouth and stomach), a secretory and absorptive region (the midgut), a water reclamation system (ascending colon), and finally, a waste-product storage system (the descending and sigmoid colon regions and the rectum). The organization of the upper gut facilitates the controlled presentation of calories to the systemic circulation allowing the replete person to perform physical work, to undergo social activities, and to go to sleep. In spite of this wondrous organization it is still necessary, or at least desirable, in a modern lifestyle to take three meals a day. On the other hand, most of us wish to take our medications only once a day.

Although the human race has relied on medicines for an indeterminate number of years, the physiology of the digestive process is less than convenient for the efficient absorption of many of the modern therapeutic entities we wish to administer. The influence of feeding and temporal patterns on gastrointestinal transit, therefore, is of great relevance in attempting to optimize drug absorption. In this chapter, we will consider how data from recent experiments might have an influence on how we think about dosing issues.

1

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We will start with swallowing a medicine and finish with transit through the large intestine.

## II. ESOPHAGEAL TRANSIT

After the dosage form leaves the buccal cavity, which is a relatively benign environment, transit through the esophagus is normally complete within 5–15 s, depending on posture. It has been known for many years that disorders of normal motility (dysphagia), left-sided heart enlargement, or stricture of the esophagus can result in impaired clearance of formulations. In some cases this can lead to damage of the esophageal wall. The elderly have a decreased ability to swallow large dosage forms, a phenomenon that may be related to the loss of secondary peristaltic mechanisms. Impairment of the ability to swallow with advancing age has been identified as a major health care problem in an aging population. Radiological studies of an asymptomatic group of 56 patients, mean age 83 years, showed that a normal pattern of deglutition was present in only 16% of individuals (1). Oral abnormalities, which included difficulty in controlling and delivering a bolus to the esophagus following ingestion were noted in 63% of cases. Structural abnormalities capable of causing esophageal dysphagia include neoplasms, strictures, and diverticula, although several workers have commented that only minor changes of structure and function are associated with aging. The difficulty, therefore, appears to relate to neurological mechanisms associated with the coordination of tongue, oropharynx, and upper esophagus during a swallow.

In scintigraphic studies of transit rates of hard gelatin capsules and tablets, elderly subjects were frequently unable to clear the capsules (2,3). This appears to be due to the separation of the bolus of water and capsule in the oropharynx, resulting in a “dry” swallow. As a result, capsule adherence occurred in the lower third of the esophagus. In this region, adherence is not sensorially detected: subjects were unaware of sticking. The importance of buoyancy in capsule formulation has hitherto been ignored and may be an additional risk factor in dosing the elderly.

## III. GASTRIC RETENTION

Our understanding of the behavior of dosage forms in the stomach has been gained largely from scintigraphic studies in which phases of a meal and formulations are labeled with different radionuclides, particularly technetium-99m



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