Plasma concentrations of fluticasone propionate and budesonide following inhalation from dry powder inhalers by healthy and asthmatic subjects

T W Harrison, A E Tattersfield

Background: All currently available inhaled corticosteroids reach the systemic circulation and have the potential to produce adverse effects with long term use. This risk is often assessed by measuring the effect of different inhaled corticosteroids on the hypothalamic-pituitary-adrenal (HPA) axis in healthy subjects. Absorption of fluticasone propionate and its effects on the HPA axis are greater in healthy subjects than in subjects with moderately severe asthma whereas budesonide plasma levels are similar in the two groups of subjects. In contrast, the AUC and Cmax for budesonide were almost identical between the two groups (mean differences 826 (95% CI –1493 to 3143) pg/ml/h (p=0.5) and 157 (95% CI –1026 to 1339) pg/ml (p=0.8).

Conclusions: Following inhalation, healthy subjects have higher plasma levels of fluticasone propionate than subjects with asthma whereas budesonide plasma levels are similar in the two groups of subjects. Comparing the systemic effects of budesonide and fluticasone propionate in healthy subjects is unlikely to be relevant to subjects with asthma.

METHODS

Subjects

Twelve subjects with moderately severe asthma were matched by age and sex to 12 healthy control subjects. Subjects with asthma had to be taking a high dose of an inhaled corticosteroid (beclomethasone dipropionate or budesonide 1000–2000 µg/day or fluticasone propionate 500–1000 µg/day) and have a forced expiratory volume in 1 second (FEV1) less than 75% predicted with an increase of more than 12% after 200 µg inhaled salbutamol. All subjects had to be non-smokers and have a past smoking history of less than 10 pack years. Subjects using oral or topical steroids were excluded. All subjects gave written informed consent to the study, which was approved by Nottingham City Hospital ethics committee.

Protocol

Subjects with asthma were changed to an equivalent dose of beclomethasone dipropionate 5 days before the first of the two study visits, which were at the same time of day and at least 3 days apart. At each visit a venous cannula was inserted and asthma subjects had their FEV1 measured. Fluticasone propionate 1000 µg or budesonide 1200 µg were then inhaled via the Accuhaler (GlaxoWellcome, Uxbridge, UK) and the Turbuhaler (Astra-Zeneca, Lund, Sweden), respectively. Venous blood samples were taken over the next 8 hours, centrifuged at 1500 rpm for 10 minutes at 4°C, and plasma samples were frozen at –70°C. Corticosteroid drug assays were performed blind to the nature of the subjects by liquid chromatography tandem mass spectrometry at the Department of International Bioanalysis, GlaxoWellcome Research, Ware, UK. The lower limits of detection for the assays were between 10 and 30 pg/ml for fluticasone propionate and 50 and 100 pg/ml for budesonide.
Budesonide was absorbed much faster than fluticasone propionate with maximum plasma concentration (Cmax) occurring at 5–10 minutes and 1–2 hours, respectively (fig 1). The mean budesonide Cmax and area under the budesonide concentration-time curve were approximately 20 times higher than those for fluticasone propionate (table 1).

For fluticasone propionate Cmax and the AUC were lower by 39% and 43%, respectively, in subjects with asthma compared with healthy control subjects (fig 1, table 1). In contrast, following inhalation of budesonide Cmax and AUC were almost identical in healthy control and asthmatic subjects (fig 1, table 1).

**DISCUSSION**

This study has shown a number of interesting differences in the pharmacokinetics of budesonide and fluticasone propionate following the inhalation of single doses of drug from their respective dry powder inhalers: (1) plasma concentrations of fluticasone propionate peak later than those of budesonide; (2) plasma levels of fluticasone propionate are lower than those of budesonide; (3) healthy subjects have higher fluticasone propionate plasma levels than subjects with moderately severe asthma, whereas budesonide plasma levels are similar in healthy and asthmatic subjects.

The first two findings can be explained by differences in the lipophilicity of the two drugs. When compared with budesonide, fluticasone propionate is considerably more lipophilic leading to a much slower rate of dissolution in bronchial fluid and greater retention in pulmonary tissue. As the systemic bioavailability of both drugs is largely due to drug absorbed from the pulmonary tract, these differences probably explain the difference in time taken to reach peak plasma concentration. Once absorbed, the lipophilic nature of fluticasone propionate probably explains why its plasma levels are some 20-fold lower than those of budesonide. However, in our previous study there was little difference in systemic activity when the same doses of fluticasone propionate and budesonide were compared, which suggests that systemic activity is related to other variables such as drug potency and the concentration of drug at the steroid receptor rather than steroid plasma levels.

Higher plasma levels of fluticasone propionate in healthy subjects compared with subjects with asthma confirms the previous findings of Brutsche et al. and explains the greater systemic activity seen following inhalation of fluticasone propionate in healthy subjects than in subjects with asthma in our previous study. Similar budesonide plasma levels in healthy and asthmatic subjects in this study is consistent with the lack of any difference in morning budesonide plasma levels in our last study, and explains why we found no difference in systemic activity following the inhalation of budesonide in healthy and asthmatic subjects.

In both our studies we used dry powder inhalers to reduce variability in inhaler technique. Poor functioning of the Accuhaler compared with the Turbuhaler in patients with airflow obstruction and limited inspiratory flow is therefore a possible explanation for our findings. Against this, however, are data showing more variable performance with the Turbuhaler than with the Accuhaler.
the Accuhaler at low inspiratory flow, and the almost identical results obtained by Brutsche et al following inhalation of fluticasone propionate from a metered dose inhaler. Differences in the pattern of distribution of inhaled drugs between subjects with and without asthma combined with differences in the rate of absorption of fluticasone propionate and budesonide may provide an alternative explanation for our findings. Radiolabelled studies have shown a more central deposition pattern following inhalation in subjects with airflow obstruction than in healthy subjects. The reduced systemic absorption of fluticasone propionate in subjects with asthma compared with healthy subjects may therefore result from increased deposition of fluticasone propionate in the proximal airways leading to clearance of the drug by mucociliary mechanisms. Budesonide may not be affected in the same way either because airflow obstruction does not affect the peripheral to central deposition ratio when budesonide is delivered by Turbuhaler or because the rapid absorption of budesonide across the bronchial mucosa reduces the amount of drug cleared by mucociliary mechanisms.

Thus, we have shown that the relative systemic activity of single doses of fluticasone propionate and budesonide will vary depending on the nature of the subjects being studied. Our results explain why studies performed on healthy subjects have concluded that the systemic activity of fluticasone propionate exceeds that of budesonide whereas studies performed on subjects with asthma have concluded that the systemic activity of fluticasone propionate is less than or equal to that of budesonide.

Taken together, our two studies suggest that the relative systemic activity of fluticasone propionate and budesonide in healthy subjects is not relevant to subjects with asthma and that studies comparing the systemic activity of these two drugs should be performed in subjects with asthma.

ACKNOWLEDGEMENTS

We thank S Pacey (Senior Pharmacist) for supplying the inhalers and randomisation schedule and GlaxoWellcome for funding the study and performing the fluticasone propionate and budesonide assays.

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Supported by a grant from GlaxoWellcome, UK.

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Thorax 2003 58: 258-260
doi: 10.1136/thorax.58.3.258

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