Single dose treatment with H2 receptor antagonists: is bedtime administration too late?

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SUMMARY Using ambulatory pHmetry, intragastric acidity was measured over three separate 24 hour periods in each of 12 healthy volunteers receiving either (a) placebo (1800 h and 2200 h), (b) 300 mg ranitidine (1800 h) and placebo (2200 h), or (c) placebo (1800 h) and 300 mg ranitidine (2200 h). Ranitidine was significantly more effective in decreasing 24 h median intragastric acidity when the drug was administered at 1800 h rather than at 2200 h. Median pH (and interquartile range) was 1.45 (1.4–1.7) on placebo, 2.55 (2.05–3.2) on ranitidine given at 2200 h and 3.35 (2.5–3.85) on ranitidine given at 1800 h (p<0.004). The total duration of highly acidic electrode readings (pH<1.5) over a 24 h period was reduced significantly by administering the H2-receptor antagonist at 1800 h compared with the later administration. It is suggested that treatment of duodenal ulcers by single administration of ranitidine in the early evening should be evaluated by clinical trial.

Pharmacological and clinical studies have shown that a large single dose of H2-receptor antagonists is at least as good as the twice daily administration in (a) decreasing 24 h intragastric acidity and nocturnal acid output and (b) healing duodenal ulcers.1,2 The current recommended single dose for ranitidine is 300 mg at bedtime. In a recent study3 in our department 46 untreated duodenal ulcer patients were compared with 40 healthy volunteers using the new method of ambulatory intragastric pHmetry. Some previous reports have claimed that the highest acid concentration in patients with duodenal ulcer (DU) is around midnight or shortly thereafter.4,5 Our data show a much longer duration of constantly high acidic electrode readings (pH<1.5) beginning in the early evening (1900 h) and lasting until early morning (0400 h). The results in healthy subjects agree well with earlier reports using the aspiration technique as well as pH-metry.6,7,8

These findings suggest that the current practise of administering antisecretory drugs at bedtime might be too late to control gastric acidity in an optimal manner. The aim of the present study was to evaluate the effect of an early evening dose of ranitidine on 24 h intragastric acidity and to compare it with conventional administration of the drug before sleep.

Methods

SUBJECTS Twelve healthy volunteers (six women, six men, median age 27 years) received, on a given test day, one of the following: placebo (1800 h)+placebo (2200 h), placebo (1800 h)+300 mg ranitidine (2200 h) or 300 mg ranitidine (1800 h)+placebo (2200 h). The study was randomised, double blind and double dummy. None of the subjects had a history of gastrointestinal disease nor were they on any medication. Three women and three men were smokers. All volunteers gave informed consent and the study was approved by the Hospital Ethics Committee.

GASTRIC ACIDITY Gastric acidity was measured every five seconds by miniature combined glass electrodes (diameter
of 60 pH readings (mean of five minutes) was calculated and smoothed according to Hamming.13

Results

Intragastric Acidity

The results of the three treatments are shown in Figure 1 (median pH curves) and the Table (median pH values plus interquartile range for the different time periods). Both treatments with ranitidine led to a significant increase of intragastric mean and median pH compared with placebo (p<0.0002). The difference between the two ranitidine treatments was statistically significant (p<0.004).

The total number of highly acidic electrode readings (pH<1.5) over a 24 h period was reduced significantly with the administration of the drug at 1800 h compared to the bedtime or placebo treatment (p<0.012 or p<0.0002, respectively).

Plasma Ranitidine Concentrations

The plasma ranitidine concentrations correlated well with the time of administration of the drug. On placebo, plasma concentrations were undetectable by radioimmunoassay. The area under the curve was 2704 + 749 (mean + SD) on ranitidine at 2200 hours and 3886 + 711 on ranitidine at 1800 hours (p<0.01).

Peak plasma concentrations were 416 + 118 ng/ml (mean + SD) on ranitidine at 2200 hours and 613 + 124 ng/ml on ranitidine at 1800 hours (p<0.01).

Data Processing and Statistical Analysis

At the end of each run, the five second pH readings (a total of 17 281 readings over 24 hours) were transferred to floppy disks using a Fujitsu computer (Micro 16 s).

Statistical analysis was performed after a second transfer of the data to a Harris computer (HS80) using the A programming language (APL). Separate calculations were done for the afternoon (1600–1800 h), the evening (1800–2200 h), the night (2200–0600 h), the day (0600–1600 h) and the whole 24 h period (1600–1600 h).

Percentile pH (including median pH) and mean pH were calculated for all the periods described above. The different drug regimens were compared using the Wilcoxon’s signed-rank-test. The exact distribution was calculated by the algorithm of Streitberg/Röhmel.11 Carryover effects were ignored since presumably non-existent. Since 10 tests were performed, an alpha-adjustment according to Holm-Bonferroni12 was applied. For graphs, the mean pH

![Graph](http://gut.bmj.com/ on June 22, 2017 - Published by group.bmj.com)
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Table Median pH values and interquartile range for different time periods after oral administration of 300 mg ranitidine or placebo at 1800 h and 2200 h (n=12).

<table>
<thead>
<tr>
<th>Drug administration</th>
<th>1600–1600</th>
<th>1800–2200</th>
<th>2200–0600</th>
<th>0600–1600</th>
</tr>
</thead>
<tbody>
<tr>
<td>Placebo</td>
<td>1.4 1.4 1.7</td>
<td>1.2 1.4 2.2</td>
<td>1.1 1.5 1.6</td>
<td>1.5 1.5 1.9</td>
</tr>
<tr>
<td>Placebo ranitidine</td>
<td>2.0 2.5 3.2</td>
<td>1.3 1.4 1.5</td>
<td>4.1 5.6 6.3</td>
<td>1.9 2.8 3.5</td>
</tr>
<tr>
<td>Ranitidine (300 mg)</td>
<td>2.5 3.3 3.8</td>
<td>3.1 3.0 4.3</td>
<td>4.5 5.5 6.1</td>
<td>1.5 2.0 2.4</td>
</tr>
</tbody>
</table>

* p<0.004; ▲ p<0.002; ○ nonsignificant; ■ p<0.05.

Discussion

Although there has been much discussion of single nocturnal dosing with H2-receptor antagonists and the importance of nocturnal gastric acidity in the context of duodenal ulcer disease, the optimal time of administration of antisecretory drugs is still controversial. Thus, recommended drug intake in recently published pharmacological and clinical studies has varied from 1800 h to 2200 h or even later (drug before sleep).1,7,8

In a previous study using 24 h intragastric pHmetry, we were able to show that patients with active duodenal ulcers show high concentrations of acidity from early evening to early morning.9 We speculated that nocturnal acidity could be controlled better with administration of antisecretory drugs after dinner (1800 h).

The present study clearly shows that the early evening dose of ranitidine is superior to bedtime administration in reducing median 24 h intragastric acidity.

The percentage of highly acidic electrode readings over the whole 24 h period was reduced significantly with administration of the drug at 1800 h compared with 2200 h (p<0.012).

A possible explanation for the improved efficacy of the early drug intake is shown in Figures 2 and 3. After dinner, when stimuli to acid secretion are high, oral administration of ranitidine results in high
plasma ranitidine concentrations and a strong suppression of acidity before 2400 hours. After midnight, when stimuli to gastric acid secretion are low, both treatments lead to an equal and nearly total suppression of acidity, independent of whether blood levels are high or low. In the following early morning, the inhibitory effect of the H2 receptor antagonist is surmounted by the meal stimulus of the breakfast in both treatment groups and the expected advantage of acid inhibition due to the later administration is small.

As both the area under curve and peak plasma concentrations of ranitidine are higher after the early administration of the drug, the improved inhibition of acid secretion may be related not only to the time of drug intake, but also to a more efficient absorption of the H2 antagonists from a full rather than from an empty intestinal tract. As other investigators have obtained contrary results on the latter observation, further studies on ranitidine pharmacokinetics are required.

As reduction of intragastric acidity is an important therapeutic effect of H2 antagonists, the present results suggest that healing rates of duodenal ulcers should improve with administration of the drug in the early evening. If these results in normal volunteers with ranitidine at 1800 h are also found in patients with duodenal ulcer, then this dose timing should be evaluated in a clinical trial.

References

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