Twenty four hour intragastric acidity and plasma gastrin concentration in healthy volunteers taking nizatidine 150 mg, nizatidine 300 mg, ranitidine 300 mg, or placebo at 21 00 h

S LANZON-MILLER, R E POUNDER, N A F CHRONOS, F RAYMOND, M R HAMILTON, AND D DALGLEISH

From the Academic Department of Medicine, Royal Free Hospital School of Medicine, London

SUMMARY Nine healthy volunteers were studied on the seventh day of dosing at 21 00 h with nizatidine 150 mg (N 150), nizatidine 300 mg (N 300), ranitidine 300 mg (R 300), or placebo, given in a predetermined random order. The double-blind 24 hour studies, using the Royal Free Hospital standard protocol, simultaneously measured intragastric acidity and plasma gastrin concentration. Compared with placebo, subjects responded to dosing with each H2-antagonist by a significant decrease of 24 hour intragastric acidity (N 150 - 45%; N 300 = 49% R 300 = 56%; p<0.01) and a significant rise of plasma gastrin concentration (N 150+20%; N 300+27%; R 300+58%; p<0.01). All three drug regimens caused similar significant decreases of nocturnal acidity (N 150 - 72%; N 300 - 79%; R 300 - 85%; p<0.01) and increases of nocturnal plasma gastrin concentration (N 150+41%; N 300+52%; R 300+80%; p<0.01). Dosing with ranitidine 300 mg at 21 00 h also caused a simultaneous significant decrease of morning acidity (-32%; p<0.05) with a significant increase of plasma gastrin concentration (+36%; p<0.05), but the antisecretory effects of nizatidine 150 or 300 mg at 21 00 h were only observed during the night, with no effect during the morning. No drug regimen had any effect on acidity or plasma gastrin in the afternoon or early evening.

Nizatidine (Eli Lilly and Company) is a newly-developed histamine H2-receptor antagonist, which inhibits human gastric acid secretion stimulated by sham feeding, pentagastrin, or peptone meal. The oral bioavailability of nizatidine in man exceeds 90% and the drug has a half-life in plasma of 1.6 hours. Nizatidine does not interfere with drug metabolism by binding with cytochrome P-450, nor does it influence male hormone function or fertility.

The purpose of the present double blind placebo controlled study was to compare the effects at a steady state of oral doses of either nizatidine (150 or 300 mg) or ranitidine 300 mg - taken during the evening - on 24 hour intragastric acidity in healthy subjects.

In view of the recent interest in the rise of plasma gastrin concentration and human gastric carcinoids, and the development of enterochromaffin-like cell hyperplasia in some rats treated with high doses of antisecretory drugs, 24 hour intragastric acidity was correlated in this study with simultaneous measurement of 24 hour plasma gastrin concentration.

Methods

SUBJECTS Nine healthy male volunteers took part in the study: they had a median age of 23 years (range 21-24 years), a median height of 1.80 m (range 1.70-1.88 m), and median weight of 73 kg (range 60-94 kg).
24 HOUR INTRAGASTRIC ACIDITY AND PLASMA GASTRIN

The subjects were studied under identical conditions for four 24 hour periods, using the Royal Free Hospital protocol for 24 hour studies. During this series of experiments we observed the effect of dosing with drug or placebo at 21.00 h, hence the 24 hour studies started at 19.00 h and finished at 18.00 h on the following evening. In order to synchronise feeding and subsequent intragastric acidity before the start of each 24 hour study, the subjects ate a standard lunch at 13.15 h and were then admitted to the research ward at 17.00 h.

A 10 French gauge Salem sump nasogastric tube (Argyle Medical) was positioned in the stomach, and from 19.00 h aliquots (5-10 ml) of intragastric contents were aspirated hourly throughout the study. The pH of each aliquot was measured immediately to the nearest 0.01 pH unit by means of a glass electrode and digital pH meter (Radiometer, Copenhagen). The electrode was calibrated with standard buffers (pH 7, 4.01, and 1.09; Radiometer, Copenhagen) before and halfway through each batch of nine samples.

Blood was taken through a venous cannula at hourly intervals between 19.00 h and 18.00 h the next day, except during the night when sampling was omitted at 01.00, 03.00, 05.00, and 07.00 h. Additional samples were taken at 45 and 75 minutes after the start of dinner, breakfast, and lunch. The blood was collected in lithium-heparin glass tubes which contained 0.2 ml aprotinin (Trasylol, Bayer). The tubes were centrifuged immediately, the plasma transferred to plastic tubes and frozen immediately to −20°C. All the plasma samples from each subject were analysed for gastrin in one batch, by radio-immunoassay using antibody GAS 179 in Professor Bloom’s laboratory at the Hammersmith Hospital, London. This antibody cross-reacts equally with G17 and G34, but does not react with cholecystokinin.

During the study the subjects were fully ambulant around the research ward. The food and environmental conditions for all four studies were identical to those used in earlier studies at the Royal Free Hospital. The following meals were served: dinner, a bedtime snack, breakfast, coffee, lunch, and afternoon tea at 1915, 2215, 0915, 1115, 1315, and 1615 h respectively.

DOSENG

The study was carried out double blind, the dosing being given in a predetermined random order. The subjects were studied on the seventh day of dosing with either placebo, nizatidine 150 mg, nizatidine 300 mg, or ranitidine (Zantac, Glaxo, Greenford UK) 300 mg. An earlier human volunteer study had established that the ranitidine 150 mg capsule had the same oral bioavailability as a Zantac 150 mg tablet (Dr P Keohane, personal communication). Each dose of treatment was given as two capsules: two placebo capsules, nizatidine 150 mg capsule and one placebo capsule, two nizatidine 150 mg capsules, or two ranitidine 150 mg capsules, respectively.

ETHICAL APPROVAL AND STATISTICAL ANALYSIS

The study was approved by the Ethical Committee of the Royal Free Hospital and written consent was obtained from each subject before entry to the study. Routine safety studies were performed before and after each of the four seven day courses of treatment.

A 24 hour profile of intragastric acidity and plasma gastrin concentration was obtained for each subject. The integrated area under the curve (AUC) for each profile was calculated by the trapezoid rule to provide the integrated 24 hour value, with acidity expressed as mmol/h/l and plasma gastrin as pmol/h/l. Comparisons between 24 hour periods were made using the Wilcoxon’s matched pairs signed-rank test.

The results of plasma gastrin and acidity were also divided into four meal related intervals (2200–0800, 0900–1300, 1300–1900, 1900–2200 h). The integrated AUC was calculated for each of these intervals. These results were compared using the Kruskal Wallis non-parametric one-way analysis of variance. In the text ‘significant’ relates to any difference where p<0.05.

RESULTS

The experiments were well tolerated. No adverse
event was reported, and no clinically significant abnormality was detected in routine haematology and biochemistry profiles before and after treatment with each drug regimen.

**INTRA GaSTRIC ACIDITY**

Figure 1 shows the median hourly intragastric acidity for the three treatment groups, compared with placebo. Each H₂-blocker regimen caused a similar decrease of nocturnal acidity with recovery during the following day.

Figure 2 shows that all subjects responded to treatment with an antisecretory drug by a decrease of

Table 1: Meal related integrated intragastric acidity (mmol/h/l, with 95% confidence limits) in nine healthy volunteers on the seventh day of dosing with either placebo, nizatidine 150 mg, nizatidine 300 mg, or ranitidine 300 mg at 2100 h

<table>
<thead>
<tr>
<th>Interval</th>
<th>Evening (1900–2200 h)</th>
<th>Night (2200–0800 h)</th>
<th>Morning (0900–1300 h)</th>
<th>Afternoon (1300–1900 h)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Placebo</td>
<td>25</td>
<td>414</td>
<td>98</td>
<td>219</td>
</tr>
<tr>
<td></td>
<td>15–34</td>
<td>377–632</td>
<td>64–113</td>
<td>152–238</td>
</tr>
<tr>
<td>Nizatidine 150 mg</td>
<td>35†</td>
<td>118*</td>
<td>95†</td>
<td>217†</td>
</tr>
<tr>
<td>Nizatidine 300 mg</td>
<td>25†</td>
<td>87*</td>
<td>112†</td>
<td>195†</td>
</tr>
<tr>
<td></td>
<td>22–36</td>
<td>42–106</td>
<td>64–139</td>
<td>168–295</td>
</tr>
<tr>
<td>Ranitidine 300 mg</td>
<td>33†</td>
<td>60*</td>
<td>67*</td>
<td>211†</td>
</tr>
<tr>
<td></td>
<td>12–38</td>
<td>22–90</td>
<td>39–91</td>
<td>124–249</td>
</tr>
</tbody>
</table>

*p<0.01, compared with placebo; †NS, compared with placebo; ‡p<0.05, compared with placebo, and nizatidine 150 or 300 mg.

integrated 24 hour intragastric acidity. Median 24 hour integrated intragastric acidity was 805 mmol/h/l on placebo, 445 and 408 mmol/h/l (−45 and −49%) on nizatidine 150 and 300 mg respectively, and 356 mmol/h/l (−56%) on ranitidine 300 mg. The decreases of 24 hour acidity were all significant (p<0.01).

Table 1 shows the acidity data analysed according to 'meal-related intervals' and that all three drugs caused a significant decrease of nocturnal intragastric acidity, but there was no significant difference between either dose of nizatidine, nor between nizatidine and ranitidine. Neither dose of nizatidine had any effect on daytime acidity, however, whilst ranitidine 300 mg given at 2100 h not only decreased nocturnal acidity, but it also caused a significant decrease of morning intragastric acidity. During treatment with ranitidine 300 mg at 2100 h, intragastric acidity was not significantly different from placebo during the afternoon and early evening.

**P L A S M A  G A S T R I N  C O N C E N T R A T I O N**

Figure 3 shows the median plasma gastrin concentra-
Table 2  

<table>
<thead>
<tr>
<th>Interval</th>
<th>Evening 1900–2200 h</th>
<th>Night 2200–0800 h</th>
<th>Morning 0900–1300 h</th>
<th>Afternoon 1300–1900 h</th>
</tr>
</thead>
<tbody>
<tr>
<td>Placebo</td>
<td>39</td>
<td>117</td>
<td>55</td>
<td>84</td>
</tr>
<tr>
<td>Nizatidine 150 mg</td>
<td>34†</td>
<td>165*</td>
<td>51†</td>
<td>92†</td>
</tr>
<tr>
<td>Nizatidine 300 mg</td>
<td>28–45</td>
<td>149–225</td>
<td>44–70</td>
<td>68–123</td>
</tr>
<tr>
<td>Ranitidine 42†</td>
<td>211*</td>
<td>75†</td>
<td>102†</td>
<td></td>
</tr>
</tbody>
</table>

Table 2 records integrated plasma gastrin concentration according to ‘meal related intervals’. All three drugs caused a significant rise of nocturnal plasma gastrin concentration compared with placebo treatment throughout the 24 hours and Figure 4 the integrated 24 hour plasma gastrin concentration for each subject. The subjects responded to dosing with an H2-antagonist by a rise of integrated 24 hour plasma gastrin concentration: median 24 hour integrated plasma gastrin concentration was 291 pmol/l on placebo, 349 and 370 pmol/l (+20 and +27%) on nizatidine 150 mg and 300 mg respectively, and 461 pmol/l (+58%) on ranitidine 300 mg – these increases of 24 hour plasma gastrin concentration were all significant (p<0.01).

The results of this study show that, at steady state, nizatidine 150 or 300 mg in the evening causes a significant decrease in nocturnal intragastric acidity, but has no effect on daytime acidity during the following day. Earlier experiments have shown that nizatidine 150–300 mg inhibits nocturnal acid secretion as assessed by continuous aspiration11 (rather than the hourly sampling of acidity used in the present study). The present study could detect no significant difference between nizatidine 150 and 300 mg, suggesting that these doses must be towards the top of the dose response curve for this drug. In a double blind multicentre trial in the United States, the four week duodenal ulcer healing rates for nizatidine 25 mg bd, 150 mg bd, 300 mg nocte and placebo were 50, 68, and 67%, respectively.15

In the present study ranitidine 300 mg during the evening caused a similar decrease of nocturnal acidity to either dose of nizatidine. If it is true that control of nocturnal acidity relates closely to duodenal ulcer healing at four weeks,16 it could be anticipated that nizatidine 300 mg nocte will be similar (in terms of ulcer healing) to ranitidine 300 mg nocte. The only published controlled study in 777 patients reported four week duodenal ulcer healing rates of 81 and 80%, and eight week healing rates of 92 and 93%, for nizatidine 300 mg and ranitidine 300 mg nocte, respectively.17

There are three potential disadvantages of decreasing intragastric acidity in man: allowing pathogens access to the small and large intestine,18 allowing bacterial proliferation in the stomach,19 and inducing a rise in plasma gastrin concentration.20 The advantage of the evening or nocturnal administration of a relatively short acting antisecretory drug is that there is a pulse of inhibition of gastric acid secretion overnight. Thus, in terms of the present experiments, either nizatidine 150–300 mg or ranitidine 300 mg in

Fig. 4  Integrated 24 hour plasma gastrin concentration on the seventh day of dosing with placebo, nizatidine 150 mg, nizatidine 300 mg, or ranitidine 300 mg at 2100 h in nine healthy subjects. The open circle indicates the median value for each group.
the evening can control nocturnal acidity, with essentially normal daytime acidity. The normal intragastric acid present during the daytime should ensure not only the 'sterilisation' of pathogens in the main meals of the day, but it should eliminate any chance of bacterial colonisation in the stomach.

Every subject responded in this study to dosing with either nizatidine or ranitidine by a decrease of integrated 24 hour intragastric acidity (Fig. 2) and by a rise of integrated 24 hour plasma gastrin concentration (Fig. 4). There was a significant inverse correlation between intragastric acidity and plasma gastrin concentration (Fig. 5). Similar results have been observed during treatment with ranitidine 150 mg bid, omeprazole 20 mg om, and famotidine 40 mg nocte. Although all these antisecretory drugs cause a significant rise of plasma gastrin concentration, the degree of elevation is mild compared with that observed in patients with pernicious anaemia. Of these drug regimens, nizatidine 150 and 300 mg at 2100 h have the shortest duration of antisecretory activity and they cause the least rise in 24 hour plasma gastrin concentration. Cimetidine 800 mg or 400 mg nocte are also short acting antisecretory regimens, but neither has been tested under the conditions of the Royal Free Hospital standard protocol for 24 hour intragastric acidity and plasma gastrin concentration.

In conclusion, evening administration of nizatidine 150 or 300 mg, or ranitidine 300 mg, cause similar decreases of nocturnal acidity, with associated nocturnal elevation of plasma gastrin concentration. Ranitidine 300 mg has a longer duration of action than the other dosing regimens, causing changes of acidity and plasma gastrin not only in the night but also the morning.

Capsules containing placebo, nizatidine and ranitidine were supplied by Drs P Keohane and Dr R John of Eli Lilly and Company, who also provided financial support for the study. The manuscript was processed by Mrs Julia Young. Technical support was provided by Nurse Judy Sercombe and Mr David Smart.

**References**

5. Van Thiel DH, Gavaler JS, Heyl A, Susen B. An


Twenty four hour intragastric acidity and plasma gastrin concentration in healthy volunteers taking nizatidine 150 mg, nizatidine 300 mg, ranitidine 300 mg, or placebo at 21:00 h.

S Lanzon-Miller, R E Pounder, N A Chronos, F Raymond, M R Hamilton and D Dalgleish

Gut 1988 29: 1364-1369
doi: 10.1136/gut.29.10.1364

Updated information and services can be found at: http://gut.bmj.com/content/29/10/1364

These include:

Email alerting service
Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

Errata
An erratum has been published regarding this article. Please see next page or: /content/30/1/144.2.full.pdf

Topic Collections
Articles on similar topics can be found in the following collections
Gastrointestinal hormones (848)

Notes

To request permissions go to: http://group.bmj.com/group/rights-licensing/permissions

To order reprints go to: http://journals.bmj.com/cgi/reprintform

To subscribe to BMJ go to: http://group.bmj.com/subscribe/
The effect that response obtained by jejunal biopsies from CF children (Figure), an effect that was not significantly different from the response obtained in biopsies from a control group.

It therefore appears that the increased SCC across CF jejunum induced by A23187 is unlikely to result from the opening of basolateral K⁺ channels alone, but could represent a Cl⁻ secretory response brought about by the elevation of intracellular Ca²⁺. Patch clamp analysis of the luminal membranes of enterocytes affected by CF would provide a more definitive answer to this problem.

**References**


**News**

**International Bilirubin Workshop**

This workshop will be held in Trieste, Italy, 6–8 April, 1989. For inquiries and registration forms contact either of the Directors: Claudio Tiribelli, MD, Istituto Patologia Medica, University of Trieste, 34100 Trieste, Italy. Tel: (40)-776-4525, Fax: (40)-910-690; or J Donald Ostrow, MD, V.A. Lakeside Medical Center, 333 East Huron Street, Chicago, IL 60611, USA. Tel: (312)-943-6600, Ext 358, Fax: (312)-908-0365.

**31st International Congress of Physiological Sciences**

Will be held in Helsinki, Finland, on 7–14 July, 1989. Information from The Congress Secretariat, PO Box 722, SF-00101 Helsinki, Finland. (Telefax: 358-0-611 188).

**Correction**

24 h Intragastric acidity and plasma gastrin concentration . . . Lanzon-Miller et al. October 1988 issue pp 1364-9. The fourth column in Figures 3 and 4 should be correctly labelled ranitidine 300 mg.