Quantification of Nimesulide in Human Plasma by High-Performance Liquid Chromatography with Ultraviolet Detector (HPLC-UV): Application to Pharmacokinetic Studies in 28 Healthy Korean Subjects

Mi-Sun Kim1,2, Yoo-Sin Park2, Shin-Hee Kim2, Sang-Yeon Kim2, Min-Ho Lee3, Youn-Hee Kim1, Do-Wan Kim2,4, Seok-Chul Yang6 and Ju-Seop Kang2*

1Department of Dermatology, Eulji Medical Center, College of Medicine, Seoul 139–872, South Korea, 2Department of Pharmacology & Clinical Pharmacology Lab, College of Medicine; Division of Molecular Therapeutics Development, Hanyang Biomedical Research Institute; Department of Bioengineering, College of Engineering, Hanyang University, Seoul 133–791, South Korea, 3Department of Internal Medicine, College of Medicine, Hanyang University, Seoul 133–791, South Korea, 4Heartscan Healthcare, Kangnam-Gu, Seoul 135–090, South Korea, 5Department of Anesthesiology, College of Medicine, Ajou University, Suwon, South Korea, and 6Department of Internal Medicine, Seoul National University Hospital, Seoul 110–744, South Korea

*Author to whom correspondence should be addressed. Email: jskang@hanyang.ac.kr

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Nimesulide is a selective COX-2 inhibitor that is as effective as the classical non-acidic nonsteroidal anti-inflammatory drugs in the relief of various pain and inflammatory conditions, but is better tolerated with lower incidences of adverse effects than other drugs. After oral dose of 100 mg nimesulide to western subjects, a mean maximal concentration (Cmax) of 2.86 ± 6.5 mg/mL was reached at 1.22 ± 2.75 h and mean t1/2β of 1.8 ± 4.74 h. This study developed a robust method for quantification of nimesulide for the pharmacokinetics and suitability of its dosage in Korea and compared its suitability with other racial populations. Nimesulide and internal standard were extracted from acidified samples with methyl tert-butyl ether and analyzed by high-performance liquid chromatography with ultraviolet detection (HPLC-UV). The 28 healthy volunteers took 2 tablets of 100 mg nimesulide and blood concentrations were analyzed during the 24 h post dose. Several pharmacokinetic parameters were represented: AUC0–∞(mg·h/mL) = 113.0 mg·h/mL, Cmax = 12.06 mg/mL, tmax = 3.19 h and t1/2β = 4.51 h. These were different from those of western populations as follows: AUC was 14.5% and Cmax was 28% that of of Korean subjects and tmax and t1/2β were also different. The validated HPLC-UV method was successfully applied for the pharmacokinetic studies of nimesulide in Korean subjects. Because the pharmacokinetics of nimesulide were different from western populations, its dosage regimen needs to be adjusted for Koreans.

Introduction

Nimesulide (N-[4-nitro-2-phenoxypyphenyl]-methanesulfonamide) is a relatively COX-2 selective, non-steroidal anti-inflammatory drug (NSAID) that is as effective as the classical NSAIDs in the relief of a wide variety of pain and inflammatory conditions, but is better tolerated with lower incidences of adverse effects than other NSAIDs (1–3). Nimesulide shows its pharmacological activity through various mechanisms of action and the major mechanisms concern the selective inhibition of cyclooxygenase-2 (COX-2) with 5–16-fold selectivity for COX-2 (2, 4–9). COX-1, which regulates gastric cytoprotection and vascular hemostasis, is expressed in many tissues. Inhibition of COX-1 reduces the synthesis of cytoprotective compounds, such as prostacyclin, and may result in unwanted gastrointestinal and renal adverse effects. However, selective inhibition of COX-2 reduces the production of pro-inflammatory prostaglandins, and may provide beneficial effects in inflammation and pain relief, with modest gastrointestinal (GI) toxicity (1, 2). Ex vitro measurements in human whole blood after oral administration of 100 mg nimesulide show complete suppression of COX-2 activity and partial reduction in COX-1 activity (10). In vitro, nimesulide does not affect prostaglandin synthesis in the bronchial tree (11), where constitutive COX-1 exerts a bronchoprotective role, or in the gastric mucosa (12, 13), where COX-1 preserves mucosal integrity. In contrast, nimesulide markedly affects prostaglandin production in inflammatory exudates (12), where prostaglandin production is mediated by COX-2. Nimesulide has been reported to inhibit histamine release from human basophils and tissue mast cells (14), platelet-activating factor synthesis in phagocyte-stimulated human neutrophils (15) and metalloproteinase synthesis like collagenase and stromelysin (16).

Nimesulide is usually administered orally and the usual dosage is 100 mg twice daily, increasing to 200 mg twice daily, depending on the severity of symptoms and patient response. The pharmacokinetic studies have been performed using various formulations. Some papers have described the pharmacokinetic profile of nimesulide in healthy volunteers after single and multiple administrations (17) and the effects of age and disease on the pharmacokinetic variable (18). Nimesulide is rapidly absorbed from GI tracts. After oral administration of a 100 mg dose to healthy fasting individuals, a mean maximal concentration (Cmax) of 2.86 ± 6.50 mg/L was achieved within 1.22 ± 2.75 h (19). The plasma concentration of nimesulide is usually determined using various high-performance liquid chromatography (HPLC) methods developed by Castoldi et al. (20) and Pandya et al. (21). Therefore, the aims of present study were to develop and validate a sensitive, robust and simple isocratic HPLC-UV method for quantification of nimesulide in human plasma and to dramatically increase sample throughput and efficiency in analyzing large amounts of plasma samples obtained from clinical pharmacokinetic or bioequivalence studies. We tried to apply this method to study pharmacokinetic studies after single oral doses of 2 tablets of 100 mg nimesulide to 28 healthy Korean volunteers.
extracts were injected into the HPLC column in the HPLC-UV sodium phosphate (57:43, methyl (1 mL), and the nimesulide and IS were extracted with 5 mL of 2.0 M hydrochloric acid was added to the plasma samples were dissolved in 500 μL of a mixture of methanol and 500 mM sodium phosphate (57:43, v/v) and 40 μL of aliquots of final extracts were injected into the HPLC column in the HPLC-UV system.

**Figure 1.** Chemical structures of nimesulide (a; N-[4-nitro-2-phenoxypyphenyl]-methanesulfonamide, MW = 308.311, C13H12N2O5S and IS (b; zaltoprofen, 10, 11-Dihydro-a-methyl-10-oxobenz[a]thiepin-2-acetic Acid, MW = 298.36, C17H14O3S).

**Experimental**

**Chemicals and reagents**

Nimesulide (C13H12N2O5S, MW 308.311 g/mol) and zaltoprofen [internal standard (IS), C17H14O3S, MW 298.356 g/mol] were purchased from Sigma-Aldrich (St. Louis, MO) (Figure 1). Purity was found to be more than 99% in all compounds. Hydrochloric acid, methyl tert-butyl ether, methanol and sodium phosphate were all HPLC-grade and purchased from Sigma (St. Louis, MO). All aqueous solutions, including the buffer for the HPLC mobile phase, were prepared with water that was purified by a Milli-Q water purification system (Millipore, Milford, MA). Reference drugs (Zanitip, LG Life Science, South Korea) containing 100 mg nimesulide per tablet were used in this study.

**Stock solutions and standards**

Primary stock solutions of nimesulide and IS were prepared with methanol solution to final concentrations of 1 mg/mL and 300 μg/mL, respectively, and stored at –20°C. A set of six non-zero calibration standards ranging from 0.2 to 40 μg/mL was prepared by spiking the blank drug-free human plasma containing ethylenediamine tetraacetic acid with an appropriate amount of nimesulide. The quality control samples at four concentration levels (0.2, 0.6, 20 and 36 μg/mL) were prepared in a similar manner to the calibration standards. Blank human plasma was tested before spiking to ensure that no endogenous interference was found at retention times of nimesulide and IS.

**Preparation for plasma samples**

After dilution of stock solution of nimesulide to its concentration of 0.2 ~ 40 μg/mL with blank plasma, a 0.5 mL aliquot of human plasma was pipetted into a screw cap glass tube. Briefly, 0.1 mL of IS working solution (IS, 300 μg/mL) and 50 μL of 2.0 M hydrochloric acid was added to the plasma samples (1 mL), and the nimesulide and IS were extracted with 5 mL of methyl tert-butyl ether by shaking in a vortex mixer for 10 min. After centrifugation at 4,000 rpm for 5 min, the upper organic phases were collected and evaporated to dryness, residues were dissolved in 500 μL of a mixture of methanol and 50 mM sodium phosphate (57:43, v/v) and 40 μL of aliquots of final extracts were injected into the HPLC column in the HPLC-UV system.

**HPLC system and quantifications**

The HPLC system was a Waters (Milford, MA) LC system equipped with a Waters 510 pump, Waters 717 Plus autosampler, Waters TCM column oven and Waters 486 UV detector. The data were acquired and processed with Empower 3 software. The analytical column was a C18 5 μm (150 × 4.6 mm, 5 μm; Shiseido, Japan). The mobile phase consisted of methanol and 50 mM sodium phosphate (57:43, v/v, pH = 6.03); the flow rate was 1.0 mL/min at 35°C and the injection volume was 40 μL. An elution was monitored by the UV detector set at 334 nm and total run time was set to 15 min.

**Assay validation**

A calibration curve was constructed from a blank sample (a plasma sample processed without IS), a zero sample (a plasma processed spiked with IS) and six non-zero samples covering the total range from 0.2 to 40 mg/mL, including the lower limit of quantification (LLOQ). The acceptance criterion for each concentration was 15% deviation from the nominal value, except for the LLOQ, which was set at 20%. Plots of plasma concentrations versus peak area ratios of nimesulide to IS for calibration range for nimesulide in human plasma were constructed and linear regression lines (weighting factor 1/√y2) were used for the determination of nimesulide concentration in plasma samples. The specificity was performed and six randomly selected blank human samples, which were collected under controlled conditions, were carried through a similar extraction procedure and analyzed to determine the extent to which endogenous plasma components could interfere with the analyte or IS at the retention time. To evaluate the inter-day precision and accuracy, validation control samples with drug concentrations of 0.2, 0.6, 20 and 40 mg/mL and IS (300 mg/mL) solutions were analyzed together with one independent calibration curve. The accuracy and precision of the inter-day assay were evaluated at the same concentration and calculated for five different days. Inter-day and intra-day precision were expressed as relative standard deviation (RSD). The accuracy was expressed as the percent ratio between the experimental and nominal concentrations for each sample. The LLOQ was defined as the lowest plasma concentration of each nimesulide analyzed with an error of 20% or lower that corresponds to a signal 5 times greater than the analytical background noise in our experiment (22, 23). Recovery of nimesulide in plasma was evaluated by comparing the mean detector response of different quality control samples extracted with those prepared by adding the compound to post-extracted drug free plasma at the corresponding concentrations. Similarly, the recovery of IS from plasma was also evaluated.

**Pharmacokinetic studies in healthy Korean volunteers**

The pharmacokinetic study was conducted according to the revised Declaration of Helsinki for biomedical research involving human subjects (24) and the rules of Good Clinical Practice (25). The protocol of this study was approved by the Institutional Review Board of Hanyang University Medical Center. Twenty-eight healthy male volunteers, 19 ~ 29 years (mean ± SD, 23 ± 2.5 years), with height of 166.1 ~
The molecular structures of nimesulide and zaltoprofen (IS) are shown in Figure 1. Thus far, published analytical methods of nimesulide determination in plasma apply separation on reversed phases using acidic mobile phases (pH 3 − 5.5) and spectrophotometric detection at 230 − 290 nm. Those methods demonstrate several disadvantages in the application of the pharmacokinetic studies with bioequivalence testing, such as a complex extraction procedure involving extensive sample preparation with large amounts of solvents, or an IS not available commercially like NS-398 or DRF-4367 (30, 31). However, this method used a different IS (zaltoprofen), different UV-visible spectrum corresponding to 334 nm and a less acidic mobile phase (pH 6.03) than reported methods (30, 32).

Sample handling involved extraction of nimesulide and IS from acidified plasma using methyl tert-butyld ether. After solvent evaporation, extract residue was dissolved in the mobile phase and analyzed on a C18-reversed-phase HPLC column under isocratic elution conditions and UV (334 nm) detection. The HPLC system was operated isocratically at a controlled column temperature of 35°C using methanol−50 mM sodium phosphate buffer (57:43, v/v, pH 6.03) as mobile phase, filtered through a 0.45 μm membrane filter and run at a flow rate of 1.0 mL/min. An injection volume of 40 μL was used for the standard and samples and all determinations were carried out with three to five replicates.

Figure 2 shows typical chromatograms of extracted samples of human plasma without nimesulide or IS (A), plasma spiked with IS (300 μg/mL) (B), plasma spiked with nimesulide (0.2 μg/mL) and IS (300 μg/mL) (C) and plasma drawn from subject on 2 h after oral dose of 2 tablets of 100 mg nimesulide (D). No significant interfering peaks from endogenous materials in the plasma were found at the retention time. A sharp symmetrical peak corresponding to nimesulide and IS was well separated and clear on the chromatogram with stable retention time.

The developed and validated method proved to be efficient for the determination of nimesulide in human plasma and can readily be applied to pharmacokinetic or bioavailability studies. The proposed method was simple, rapid, sensitive, specific and reproducible. Nimesulide and IS were separated well from other plasma components with retention times of 6.8 and 9.9 min, respectively. The linearity of nimesulide curves ranged from 0.2 to 40 μg/mL (y = 0.03776x − 0.00167, r² = 0.9994, 1/x weighting). The LLOQ for nimesulide was 0.1 μg/mL in the plasma, the accuracy was 108.5% and the intra-day and inter-day precision were 1.0% and 5.5%, respectively. The intra-day accuracy ranged from 97.25 to 106.71%, while inter-day accuracy ranged from 97.96 to 108.50%, and the recovery of nimesulide and IS were determined and the averages were excellent. The AUC measured from 0 to the last sampling time (24 h) was approximately 94.5% of the value of AUC extrapolated from 0 to infinity, which means the analytical method is suitable for pharmacokinetic studies (Table 1). The mean plasma concentration-time curves of nimesulide obtained from the blood of 28 normal subjects are shown in Figure 3. Several calculated pharmacokinetic parameter values are shown in Table II and were inconsistent with previously reported values (17, 19, 33, 34). The pharmacokinetic assessment of nimesulide in this study was different from that reported by Bernareggi (19), who showed, after oral dose of 100 mg tablet, values of Cmax at 2.78 − 7.48 μg/mL, AUC0−∞ at 21.99 − 70.07 μg·h/mL and T1/2 at 2.0 − 3.5 h. Gandini et al. (1991) obtained mean values of Cmax at 6.17 μg/mL, AUC0−∞ at 50.93 μg·h/mL and Tmax at 2.5 h after oral dose of 100 mg tablet (33). In the current study, after oral dose
of two tablets of 100 mg nimesulide in healthy Korean volunteers, \(C_{\text{max}}\) was 12.06 \(\mu g/mL\), AUC\(_{0-\infty}\) was 113.0 \(\mu g\cdot h/mL\), \(T_{\text{max}}\) and 3.19 h. Therefore, some pharmacokinetic inconsistency with other reports was ascertained and it is possible that the dosage regimen of nimesulide in the Korean population needs to be changed.

**Conclusion**
The results indicate that present HPLC-UV method is very simple and sensitive and readily applicable to routine pharmacokinetic and bioavailability studies of nimesulide with reliable analytical results. Therefore, HPLC-UV detection for nimesulide allowed this simple and reliable method to reach a low detection limit of 0.2 \(\mu g/mL\) level and a stable run time within 10.0 min per sample for the pharmacokinetic or bioavailability studies for nimesulide in various laboratory or clinical settings.
Table II
Pharmacokinetic Characteristics after Oral Administration of 2 Tablets of 100 mg Nimesulide in 28 Healthy Subjects

<table>
<thead>
<tr>
<th>*Parameters</th>
<th>Mean ± SD (n = 28)</th>
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<tbody>
<tr>
<td>AUC$_{0-24h}$ (μg·h/mL)</td>
<td>106.26 ± 39.65</td>
</tr>
<tr>
<td>AUC$_{0-6h}$ (μg·h/mL)</td>
<td>113.00 ± 44.85</td>
</tr>
<tr>
<td>Extrapolation [AUC$<em>{0-24h}$/AUC$</em>{0-6h}$] %</td>
<td>5.55 ± 4.30</td>
</tr>
<tr>
<td>AUMC$_{20-240h}$ (μg·h²/mL)</td>
<td>1007.8 ± 220.98</td>
</tr>
<tr>
<td>AUMC$_{0-6h}$ (μg·h²/mL)</td>
<td>1021.9 ± 246.48</td>
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<tr>
<td>MRT (h)</td>
<td>8.7 ± 3.37</td>
</tr>
<tr>
<td>C$_{max}$ (μg/mL)</td>
<td>12.06 ± 3.05</td>
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<tr>
<td>F/Vd</td>
<td>0.0733</td>
</tr>
<tr>
<td>T$_{max}$ (h)</td>
<td>3.19 ± 1.32</td>
</tr>
<tr>
<td>T$_{1/2}$ (h)</td>
<td>4.51 ± 1.38</td>
</tr>
<tr>
<td>k$_{e}$ (h$^{-1}$)</td>
<td>0.954 ± 0.056</td>
</tr>
<tr>
<td>k$_{a}$ (h$^{-1}$)</td>
<td>0.167 ± 0.047</td>
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</tbody>
</table>

* AUC = area under plasma concentration-time curve; AUMC = area under first moment of plasma concentration-time curve; MRT = mean residence time; C$_{max}$ = maximal plasma concentration; T$_{max}$ = time for the maximal plasma concentration; T$_{1/2}$ = half-life; k$_{e}$ = absorption rate constant; k$_{a}$ = elimination rate constant.

Acknowledgments
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24. WHA; Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Subjects. World Medical Association (WHA); 2004 (revised), 1964 (initiated), (2007).