KAPLAN MEDICAL

PRECLINICAL PHARMACOLOGY REVIEW 2023



FOR USMLE® STEP 1 AND COMLEX-USA® LEVEL 1

USMLE® and United States Medical Licensing Examination® is a joint program of the National Board of Medical Examiners (NBME) and the Federation of State Medical Boards (FSMB), which are not affiliated with Kaplan and were not involved in the production of, and do not endorse, this product. COMLEX-USA® is a registered trademark of the National Board of Osteopathic Medical Examiners, Inc. (NBOME), which is not affiliated with Kaplan and was not involved in the production of, and does not endorse, this product.

KAPLAN MEDICAL

PRECLINICAL PHARMACOLOGY REVIEW 2023

FOR USMLE® STEP 1 AND COMLEX-USA® LEVEL 1

USMLE® and United States Medical Licensing Examination® is a joint program of the National Board of Medical Examiners (NBME) and the Federation of State Medical Boards (FSMB), which are not affiliated with Kaplan and were not involved in the production of, and do not endorse, this product.
COMLEX-USA® is a registered trademark of the National Board of Osteopathic Medical Examiners, Inc. (NBOME), which is not affiliated with Kaplan and was not involved in the production of, and does not endorse, this product.

USMLE® and United States Medical Licensing Examination® is a joint program of the National Board of Medical Examiners (NBME) and the Federation of State Medical Boards (FSMB), which are not affiliated with Kaplan and were not involved in the production of, and do not endorse, this product. COMLEX-USA® is a registered trademark of the National Board of Osteopathic Medical Examiners, Inc. (NBOME), which is not affiliated with Kaplan and was not involved in the production of, and does not endorse, this product.

This publication is designed to provide accurate information in regard to the subject matter covered as of its publication date, with the understanding that knowledge and best practice constantly evolve. The publisher is not engaged in rendering medical, legal, accounting, or other professional service. If medical or legal advice or other expert assistance is required, the services of a competent professional should be sought. This publication is not intended for use in clinical practice or the delivery of medical care. To the fullest extent of the law, neither the Publisher nor the Editors assume any liability for any injury and/or damage to persons or property arising out of or related to any use of the material contained in this book.

All rights reserved. The text of this publication, or any part thereof, may not be reproduced in any manner whatsoever without written permission from the publisher.

© 2023 by Kaplan North America, LLC
Published by Kaplan Medical, a division of Kaplan North America, LLC
1515 W. Cypress Creek Road
Fort Lauderdale, FL 33309

10 9 8 7 6 5 4 3 2 1

ISBN: 978-1-5062-8458-3

Kit items come as a set and should not be broken out and sold separately.

Kaplan Publishing print books are available at special quantity discounts to use for sales promotions, employee premiums, or educational purposes. For more information or to purchase books, please call the Simon & Schuster special sales department at 866-506-1949.

Editor

Steven R. Harris, PhD
Professor of Pharmacology
Noorda College of Osteopathic Medicine
Provo, UT

Professor Emeritus of Pharmacology and Physiology
Former Associate Dean of Academic Affairs
Kentucky College of Osteopathic Medicine
Pikeville, KY

Contributors

Laszlo Kerecsen, MD
Professor of Pharmacology
Midwestern University AZCOM
Glendale, AZ

Bimal Roy Krishna, PhD, FCP
Professor and Director of Pharmacology
College of Osteopathic Medicine
Touro University, NV

The editors would like to thank
Craig Davis, PhD, *for his previous contributions.*

We want to hear what you think. What do you like or not like about the Notes?
Please email us at **medfeedback@kaplan.com**.

Table of Contents

PART I: GENERAL PRINCIPLES

CHAPTER 1: Pharmacokinetics 3

CHAPTER 2: Pharmacodynamics 17

CHAPTER 3: Practice Questions 25

PART II: AUTONOMIC DRUGS

CHAPTER 1: The Autonomic Nervous System 35

CHAPTER 2: Cholinergic Pharmacology 41

CHAPTER 3: Adrenergic Pharmacology 49

CHAPTER 4: Autonomic Drugs: Glaucoma Treatment and ANS Practice Problems . . 59

CHAPTER 5: Autonomic Drug List and Practice Questions 69

PART III: CARDIAC AND RENAL DRUGS

CHAPTER 1: Diuretics 83

CHAPTER 2: Antihypertensives 89

CHAPTER 3: Heart Failure Drugs 97

CHAPTER 4: Antiarrhythmic Drugs. 101

CHAPTER 5: Antianginal Drugs 111

CHAPTER 6: Antihyperlipidemics 115

CHAPTER 7: Cardiac and Renal Drug List and Practice Questions 119

PART IV: CNS DRUGS

CHAPTER 1: Sedative-Hypnotic-Anxiolytic Drugs 129

CHAPTER 2: Alcohols 133

CHAPTER 3: Antidepressants, Bipolar, and Attention Deficit Hyperactivity Disorder (ADHD) Drugs 135

CHAPTER 4: Parkinson Disease Drugs and Antipsychotics 139

CHAPTER 5: Anticonvulsants 145

CHAPTER 6: Anesthetics and Muscle Relaxants 149

CHAPTER 7: Opioids 153

CHAPTER 8: Drugs of Abuse 157

CHAPTER 9: CNS Drug List and Practice Questions. 159

PART V: ANTIMICROBIAL DRUGS

CHAPTER 1: Antibiotics and Tuberculosis Drugs 173

CHAPTER 2: Antifungal Drugs. 187

CHAPTER 3: Antiviral Drugs 191

CHAPTER 4: Antiprotozoal Drugs 197

CHAPTER 5: Antimicrobial Drug List and Practice Questions. 199

PART VI: INFLAMMATORY DISORDER DRUGS

CHAPTER 1: Antihistamines 211

CHAPTER 2: Gastrointestinal Dysfunction Drugs 213

CHAPTER 3: Serotonin Drugs. 217

CHAPTER 4: Eicosanoid Drugs 219

CHAPTER 5: Rheumatoid Arthritis Drugs. 225

CHAPTER 6: Gout Drugs 227

CHAPTER 7: Glucocorticoids 229

CHAPTER 8: Asthma Drugs 231

CHAPTER 9: Inflammatory Disorder Drug List and Practice Questions 235

PART VII: BLOOD DISORDER DRUGS

CHAPTER 1: Anticoagulants 247

CHAPTER 2: Thrombolytics 251

CHAPTER 3: Antiplatelet Drugs 253

CHAPTER 4: Blood Disorder Drug List and Practice Questions 255

PART VIII: ENDOCRINE DRUGS

CHAPTER 1: Diabetes Drugs 261

CHAPTER 2: Steroid Drugs 267

CHAPTER 3: Antithyroid Drugs 273

CHAPTER 4: Hypothalamic and Pituitary Drugs 275

CHAPTER 5: Osteoporosis Drugs 277

CHAPTER 6: Endocrine Drug List and Practice Questions 279

PART IX: ANTICANCER DRUGS, IMMUNE DRUGS, AND TOXICOLOGY

CHAPTER 1: Anticancer Drugs 287

CHAPTER 2: Immune Drugs 291

CHAPTER 3: Toxicology 293

CHAPTER 4: Anticancer Drugs, Immune Drugs, and Toxicology Practice Questions 299

INDEX 305

Additional resources available at kaptest.com/usmlebookresources

PART I

GENERAL PRINCIPLES

Pharmacokinetics 1

LEARNING OBJECTIVES

- ❑ Apply the concept of drug ionization to drug movement/absorption and drug elimination
- ❑ Solve problems using pharmacokinetic calculations
- ❑ Predict important drug interactions with p450 inducers and inhibitors
- ❑ Predict time to steady state for a drug

PHARMACOKINETICS

Pharmacokinetic characteristics of drug molecules concern the processes of absorption, distribution, metabolism, and excretion. The biodisposition of a drug involves its permeation across cellular membrane barriers.

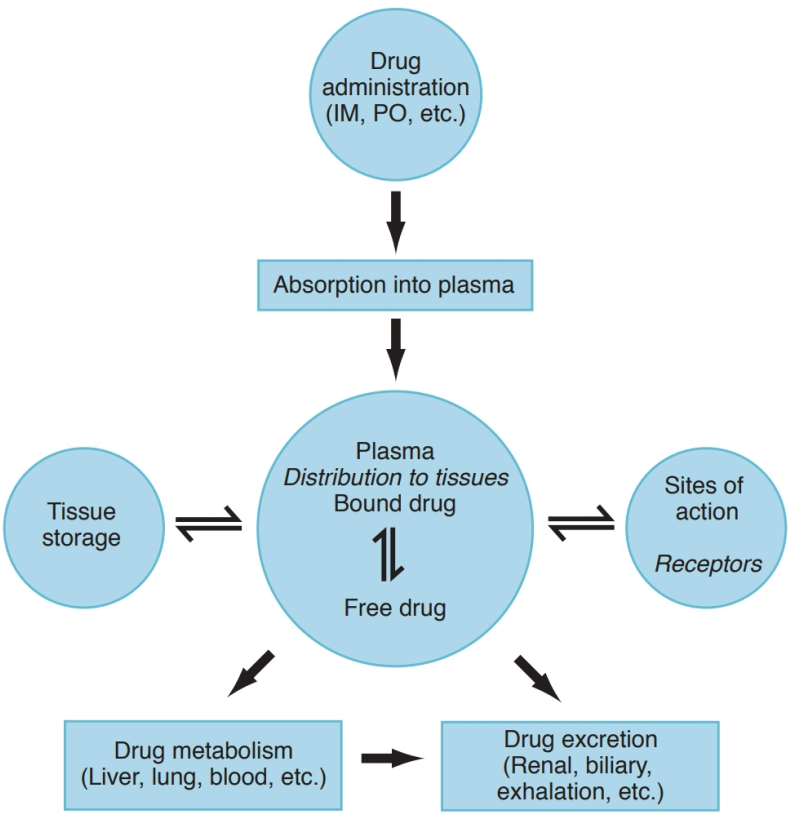


Figure I-1-1. Drug Biodisposition

Permeation

Drug permeation is dependent on the following:

- **Solubility.** The ability to diffuse through lipid bilayers (lipid solubility) is important for most drugs; however, water solubility can influence permeation through aqueous phases.
- **Concentration gradient.** Diffusion down a concentration gradient—only free, unionized drug forms contribute to the concentration gradient.
- **Surface area and vascularity.** Important with regard to absorption of drugs into the systemic circulation. The larger the surface area and the greater the vascularity, the better is the absorption of the drug.

Ionization

High-Yield

Many drugs are weak acids or weak bases, and can exist in either nonionized or ionized forms in an equilibrium, depending on the pH of the environment and the pKa (the pH at which the molecule is 50% ionized and 50% nonionized).

- Only the nonionized (uncharged) form of a drug crosses biomembranes.
- The ionized form is better renally excreted because it is water soluble.

NOTE

For Weak Acids and Weak Bases

Ionized = water soluble

Nonionized = lipid soluble

Weak Acid	$R-COOH$ (crosses membranes)	$\rightleftharpoons$	$R-COO^- + H^+$ (better cleared)
Weak Base	$R-NH_3^+$ (better cleared)	$\rightleftharpoons$	$R-NH_2 + H^+$ (crosses membranes)

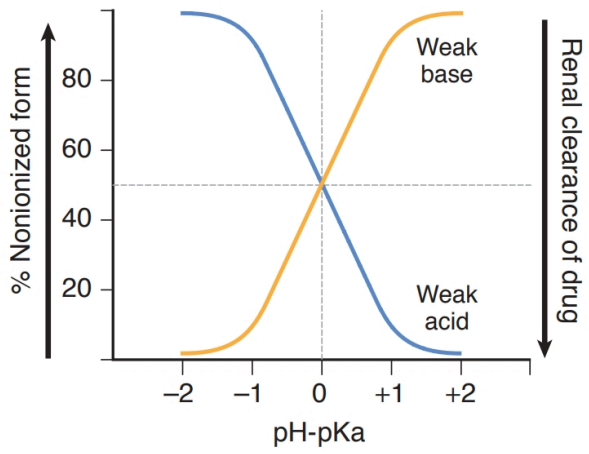


Figure I-1-2. Degree of Ionization and Clearance Versus pH Deviation from pKa

Ionization Increases Renal Clearance of Drugs

High-Yield

Only free, unbound drug is filtered. Both ionized and nonionized forms of a drug are filtered.

- Only nonionized forms undergo active secretion and active or passive reabsorption.
- Ionized forms of drugs are "trapped" in the filtrate.
- Acidification of urine → increases ionization of weak bases → increases renal elimination.
- Alkalinization of urine → increases ionization of weak acids → increases renal elimination.

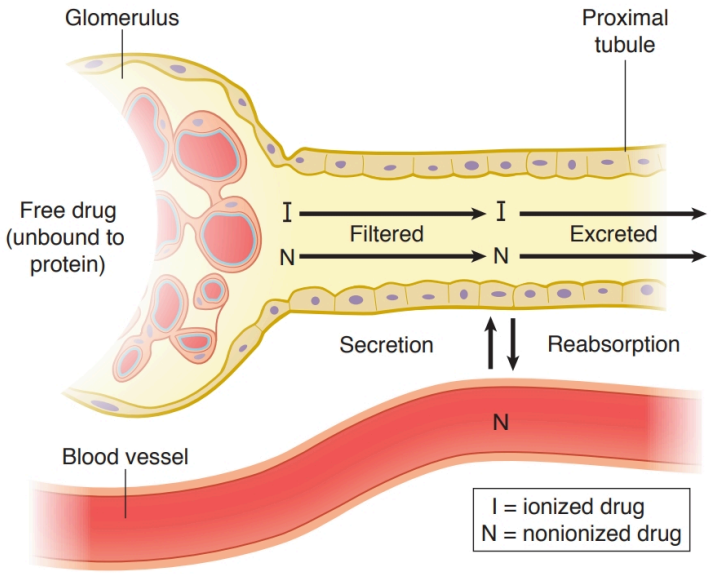


Figure I-1-3. Renal Clearance of Drug

CLINICAL CORRELATE

To Change Urinary pH

- Acidify: NH_4Cl, vitamin C, cranberry juice
- Alkalinize: $NaHCO_3$, acetazolamide (historically)
- *See* Aspirin Overdose and Management in Section VI.

CLINICAL CORRELATE

Gut bacteria metabolize lactulose to lactic acid, acidifying the fecal masses and causing ammonia to become ammonium. Therefore, lactulose is useful in hepatic encephalopathy.

Modes of Drug Transport Across a Membrane

Table I-1-1. The 3 Basic Modes of Drug Transport Across a Membrane

Mechanism	Direction	Energy Required	Carrier	Saturable
Passive diffusion	Down gradient	No	No	No
Facilitated diffusion	Down gradient	No	Yes	Yes
Active transport	Against gradient (concentration/ electrical)	Yes	Yes	Yes

BRIDGE TO PHYSIOLOGY

Ion and molecular transport mechanisms are discussed in greater detail in Part I of Physiology Lecture Notes.

ABSORPTION

Absorption concerns the processes of entry of a drug into the systemic circulation from the site of its administration. The determinants of absorption are those described for drug permeation.

- Intravascular administration (e.g., IV) does not involve absorption, and there is no loss of drug. Bioavailability = 100%
- With extravascular administration (e.g., per os [PO; oral], intramuscular [IM], subcutaneous [SC], inhalation), less than 100% of a dose may reach the systemic circulation because of variations in bioavailability.

Plasma Level Curves

C_{max} = maximal drug level obtained with the dose.

t_{max} = time at which C_{max} occurs.

Lag time = time from administration to appearance in blood.

Onset of activity = time from administration to blood level reaching minimal effective concentration (MEC).

Duration of action = time plasma concentration remains greater than MEC.

Time to peak = time from administration to C_{max}.

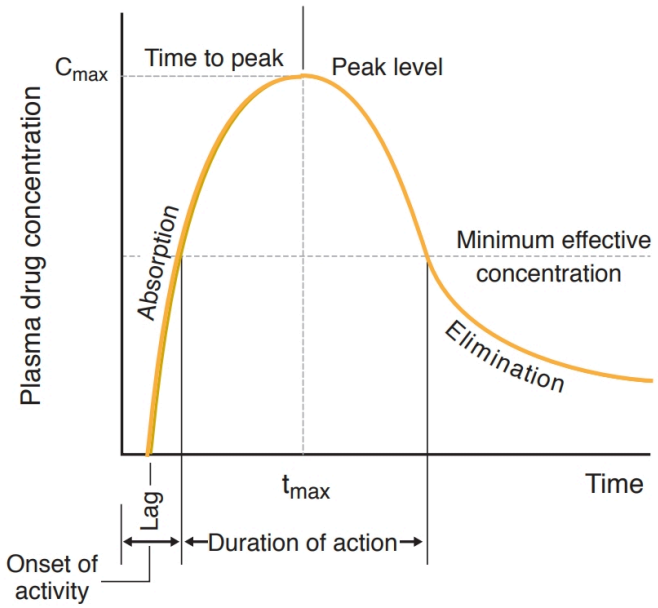


Figure I-1-4. Plot of Plasma Concentration Versus Time

Bioavailability (f)

Bioavailability is the measure of the fraction of a dose that reaches the systemic circulation. By definition, intravascular doses have 100% bioavailability, f = 1.

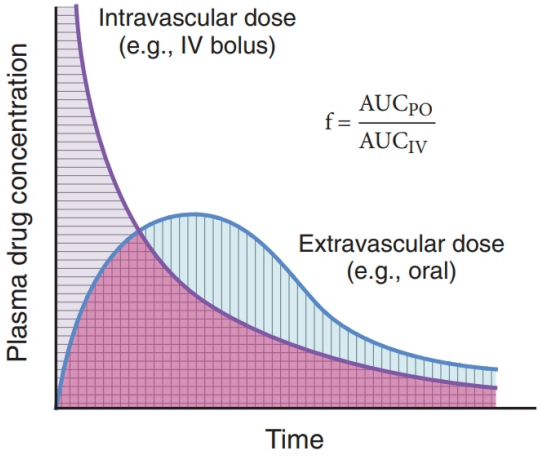


Figure I-1-5. Area Under the Curve for an IV Bolus and Extravascular Doses

AUC: area under the curve

PO: oral

IV: intravenous bolus

AUC_{IV}: horizontally striped area

AUC_{PO}: vertically striped area

First-Pass Effect

With oral administration, drugs are absorbed into the portal circulation and initially distributed to the liver. For some drugs, their rapid hepatic metabolism decreases bioavailability, i.e., the "first-pass" effect.

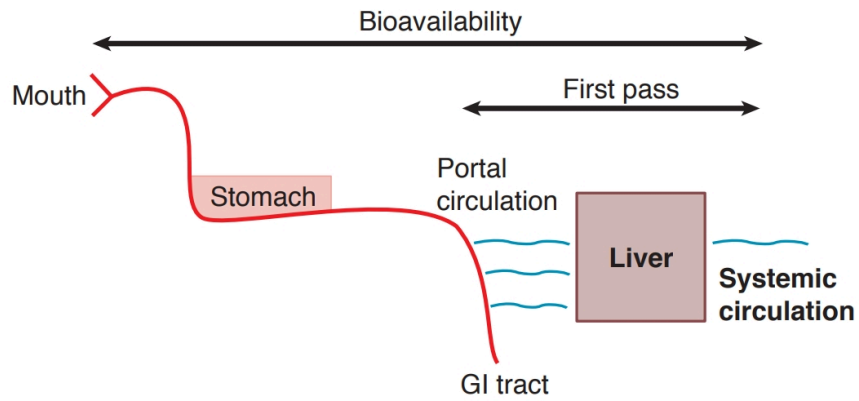


Figure I-1-6. Bioavailability and First-Pass Metabolism

CLINICAL CORRELATE

Lidocaine is given IV and nitroglycerin is given sublingually to avoid extensive first-pass metabolism.

CLINICAL CORRELATE

Drugs with high plasma protein binding and narrow therapeutic range (e.g., warfarin, phenytoin) are prone to drug interactions.

DISTRIBUTION

Distribution is the process of distribution of a drug from the systemic circulation to organs and tissue.

- Under normal conditions, protein-binding capacity is much larger than is drug concentration. Consequently, the free fraction is generally constant.
- Many drugs bind to plasma proteins, including albumin, with an equilibrium between bound and free molecules (recall that only unbound drugs cross biomembranes).

$$\underset{\text{(Active, free)}}{\text{Drug} + \text{Protein}} \rightleftharpoons \underset{\text{(Inactive, bound)}}{\text{Drug-Protein Complex}}$$

- Competition between drugs for plasma protein-binding sites may increase the free fraction, possibly enhancing the effects of the drug displaced. Example: sulfonamides and bilirubin in a neonate

Special Barriers to Distribution

There are some special barriers to distribution:

- **Placental**: most small molecular weight drugs cross the placental barrier, although fetal blood levels are usually lower than maternal (e.g., propylthiouracil [PTU] versus methimazole in pregnancy)
- **Blood–brain**: permeable only to lipid-soluble drugs or those which are transported by facilitated diffusion or active transport (e.g., levodopa versus dopamine)

BRIDGE TO PHYSIOLOGY

Approximate Vd Values (weight 70 kg)

- Plasma volume (3 L)
- Blood volume (5 L)
- Extracellular fluid (ECF 12–14 L)
- Total body water (TBW 40–42 L)

Apparent Volume of Distribution

High-Yield

Apparent volume of distribution (V_d) is a kinetic parameter of a drug, which correlates dose with plasma level at zero time.

$$V_d = \frac{\text{Dose}}{C^0} \quad \text{Where } C^0 = [\text{plasma}] \text{ at zero time}$$

This relationship can be used for calculating V_d by using the **dose** only if one knows C^0.

- V_d is low when a high percentage of a drug is bound to plasma proteins.
- V_d is high when a high percentage of a drug is being sequestered in tissues. This raises the possibility of displacement by other agents; examples: verapamil and quinidine can displace digoxin from tissue-binding sites.
- V_d is needed to calculate a loading dose in the clinical setting (*see* Pharmacokinetic Calculations section, Equation 4).

Redistribution

In addition to crossing the blood–brain barrier (BBB), lipid-soluble drugs redistribute into fat tissues prior to elimination.

In the case of CNS drugs, the duration of action of an initial dose may depend more on the redistribution rate than on the half-life. With a second dose, the blood-to-fat ratio is less; therefore, the rate of redistribution is less and the second dose has a longer duration of action.

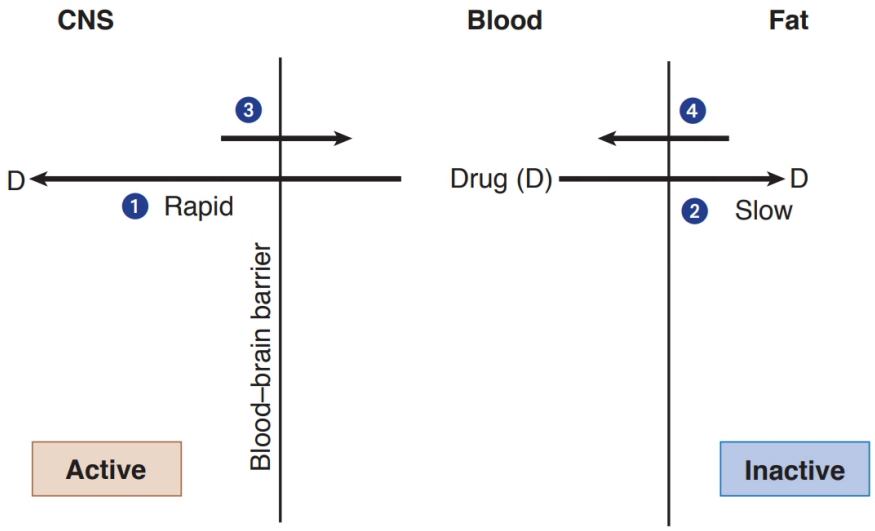


Figure I-1-7. Redistribution

BIOTRANSFORMATION

The general principle of biotransformation is the metabolic conversion of drug molecules to more water-soluble metabolites that are more readily excreted.

- In many cases, metabolism of a drug results in its conversion to compounds that have little or no pharmacologic activity.
- In other cases, biotransformation of an active compound may lead to the formation of metabolites that also have pharmacologic actions.
- A few compounds (**prodrugs**) have no activity until they undergo metabolic activation.
- Some compounds are converted to toxic metabolites, e.g., acetaminophen.

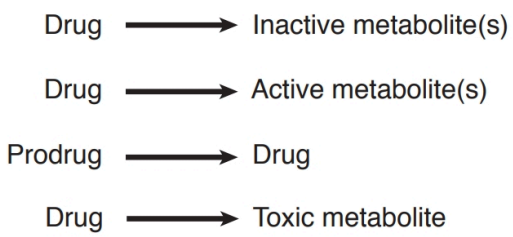


Figure I-1-8. Biotransformation of Drugs

CLINICAL CORRELATE

Active Metabolites

Biotransformation of the benzodiazepine diazepam results in formation of nordiazepam, a metabolite with sedative-hypnotic activity and a long duration of action.

Biotransformation Classification

High-Yield

There are two broad types of biotransformation, phase I and phase II.

Phase I

Phase I biotransformation is modification of the drug molecule via oxidation, reduction, or hydrolysis.

- **Microsomal metabolism**
  - **Cytochrome P450 isozymes**: major enzyme systems involved in phase I reactions; localized in smooth endoplasmic reticulum (microsomal fraction) of cells (especially liver but also GI tract, lungs, kidney)
  - P450s have an absolute requirement for molecular oxygen and NADPH
  - Oxidations include hydroxylations and dealkylations
  - Multiple CYP families differing by amino acid (AA) composition, by substrate specificity, and by sensitivity to inhibitors and to inducing agents

Table I-1-2. Cytochrome P450 Isozymes

CYP450	Substrate Example	CYP450 Inducer	CYP450 Inhibitors
1A2	Theophylline[1] Acetaminophen	Aromatic hydrocarbons (smoking) Cruciferous vegetables	Quinolones Fluvoxamine
2C9	Warfarin[1] NSAIDs	Rifampin[3] St. John Wort[3]	Azole antifungals[4] Amiodarone[4] Sulfamethoxazole
2C19	Proton pump inhibitors Clopidogrel[2]	Rifampin[3] Carbamazepine[3] St. John Wort[3]	Azole antifungals[4] Cimetidine[4] Omeprazole
2D6	Beta blockers Antipsychotics SSRIs, SNRIs	Rifampin[3]	Amiodarone[4] Fluvoxamine Haloperidol
2E1	Ethanol	Chronic ethanol consumption Disulfiram, Metronidazole	Acute ethanol consumption
3A4	Warfarin[1] Statins (except pravastatin) Steroids (cortisol, testosterone)	Rifampin[3] Carbamazepine[3] St. John Wort[3] Phenytoin, Phenobarbital	Azole antifungals[4] Cimetidine[4] Macrolides (except azithromycin) Amiodarone[4] Grapefruit juice[4], Ritonavir[4]

[1] Both theophylline and warfarin have a low therapeutic index.

[2] Clopidogrel is a pro-drug that is converted to an active metabolite by CYP2C19. Omeprazole inhibits this enzyme and decreases the effectiveness of clopidogrel.

[3] Classic inducers of CYP450 include rifampin, carbamazepine, and St. John Wort.

[4] Classic inhibitors of CYP450 include azole antifungals, cimetidine, amiodarone, macrolide antibiotics (except azithromycin), grapefruit juice, and ritonavir.

- **Nonmicrosomal metabolism**
  - **Hydrolysis**: phase I reaction involving addition of a water molecule with subsequent bond breakage; includes esterases and amidases
  - Genetic polymorphism exists with pseudocholinesterases; examples include local anesthetics and succinylcholine
  - **Monoamine oxidases**: metabolism of endogenous amine neurotransmitters (dopamine, norepinephrine, and serotonin); metabolism of exogenous compounds (tyramine)
  - **Alcohol metabolism**: alcohols are metabolized to aldehydes and then to acids by dehydrogenases (*see* CNS Drugs, part IV); genetic polymorphisms exist

Phase II

Phase II biotransformation is conjugation with endogenous compounds via the activity of transferases. It may follow phase I or occur directly. Types of conjugation include:

- **Glucuronidation**
  - Inducible; may undergo enterohepatic cycling (drug: glucuronide → intestinal bacterial glucuronidases → free drug)
  - Reduced activity in neonates, chloramphenicol and gray baby syndrome
  - Morphine is activated to morphine-6 glucuronide
- **Acetylation**
  - Genotypic variations (fast and slow metabolizers)
  - Drug-induced SLE by slow acetylators with hydralazine > procainamide > isoniazid (INH)
- **Glutathione (GSH) conjugation**
  - Depletion of GSH in liver is associated with acetaminophen hepatotoxicity

Recall Question

Which of the following routes of administration has the highest bioavailability?

A. Intramuscular

B. Intravascular

C. Oral

D. Subcutaneous

E. Sublingual

Answer: B

CLINICAL CORRELATE

Slow acetylators are slow to metabolize drugs like hydralazine, procainamide, and isoniazid. The result is longer half-lives and increased risk for drug-induced SLE.

CLINICAL CORRELATE

Elimination of a drug from the body does not always end the therapeutic effect. Irreversible inhibitors, e.g. aspirin, PPIs, MAOIs, have a therapeutic effect long after the drug is eliminated.

ELIMINATION

Elimination concerns the processes involved in the elimination of drugs from the body (and/or plasma) and their kinetic characteristics. The major modes of drug elimination are:

- Biotransformation to inactive metabolites
- Excretion via the kidney
- Excretion via other modes, including the bile duct, lungs, and sweat

The time to eliminate 50% of a given amount (or to decrease plasma level to 50% of a former level) is called the **elimination half-life** ($t_{1/2}$).

Zero-Order Elimination Rate

With zero-order elimination rate, a constant amount of drug is eliminated per unit time. If 80 mg is administered and 10 mg is eliminated every 4 h, the time course of drug elimination is:

$$80\text{ mg} \xrightarrow{4\text{ h}} 70\text{ mg} \xrightarrow{4\text{ h}} 60\text{ mg} \xrightarrow{4\text{ h}} 50\text{ mg} \xrightarrow{4\text{ h}} 40\text{ mg}$$

The rate of elimination is independent of plasma concentration (or amount in the body).

- Drugs with zero-order elimination have no fixed half-life ($t_{1/2}$ is a variable)
- Drugs with zero-order elimination include ethanol (except low blood levels), phenytoin (high therapeutic doses), and salicylates (toxic doses)

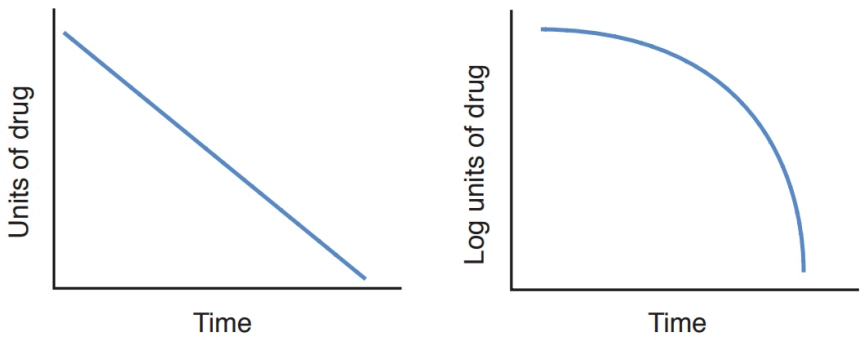


Figure I-1-9a. Plots of Zero-Order Kinetics

NOTE

Elimination Kinetics

- Most drugs follow first order: rate falls as plasma level falls.
- Zero order is due to saturation of elimination mechanisms; e.g., drug-metabolizing reactions have reached V_{max}.
- Zero-order elimination rate is constant; $t_{1/2}$ is a variable.
- First-order elimination rate is variable; $t_{1/2}$ is a constant.

First-Order Elimination Rate

With first-order elimination rate, a constant fraction of the drug is eliminated per unit time ($t_{1/2}$ is a constant). Graphically, first-order elimination follows an exponential decay versus time. If 80 mg of a drug is administered and its elimination half-life = 4 h, the time course of its elimination is:

$$80\text{ mg} \xrightarrow{4\text{ h}} 40\text{ mg} \xrightarrow{4\text{ h}} 20\text{ mg} \xrightarrow{4\text{ h}} 10\text{ mg} \xrightarrow{4\text{ h}} 5\text{ mg}$$

The rate of elimination is directly proportional to plasma level (or the amount present), i.e., the higher the amount, the more rapid the elimination.

- Most drugs follow first-order elimination rates
- $t_{1/2}$ is a constant

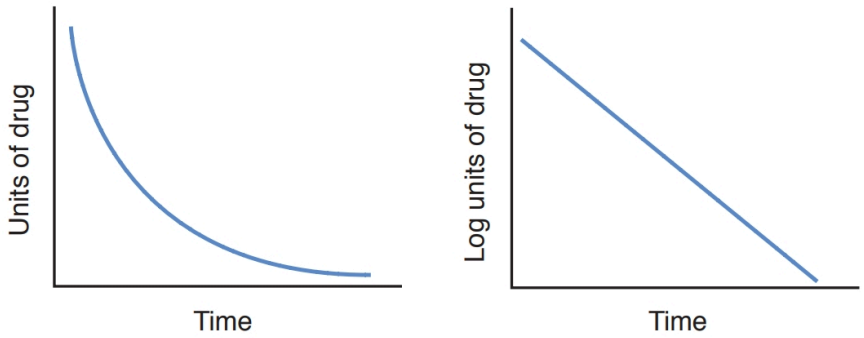


Figure I-1-9b. Plots of First-Order Kinetics

Graphic Analysis

Example of a graphic analysis of $t_{1/2}$:

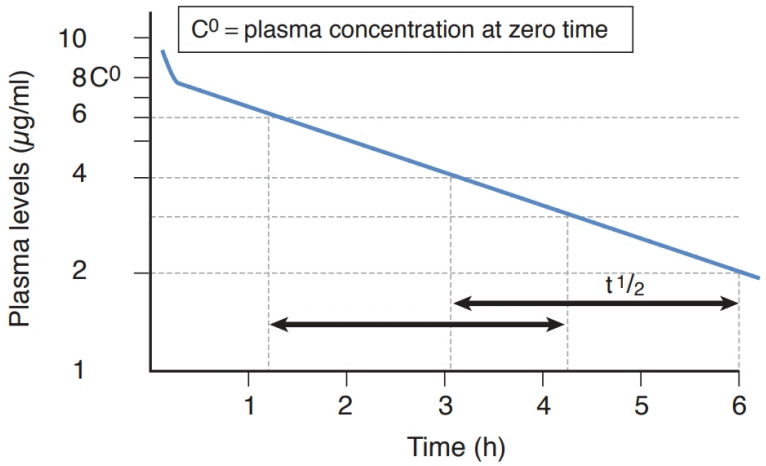


Figure I-1-10. Plasma Decay Curve—First-Order Elimination

The figure shows a plasma decay curve of a drug with first-order elimination plotted on semilog graph paper. The elimination half-life ($t_{1/2}$) and theoretical plasma concentration at zero time (C^0) can be estimated from the graphic relationship between plasma concentrations and time. C^0 is estimated by extrapolation of the linear plasma decay curve to intercept with the vertical axis.

BRIDGE TO RENAL PHYSIOLOGY

Inulin clearance is used to estimate GFR because it is not reabsorbed or secreted. A normal GFR is close to 120 mL/min.

Renal Elimination

The rate of elimination is the glomerular filtration rate (GFR) + active secretion - reabsorption (active or passive).

- Filtration is a nonsaturable linear function. Ionized and nonionized forms of drugs are filtered, but protein-bound drug molecules are not.
- Clearance (Cl) is the volume of blood cleared of drug per unit of time
  - Cl is constant in first-order kinetics
  - Cl = GFR when there is no reabsorption or secretion and no plasma protein binding
  - Protein-bound drug is not cleared; Cl = free fraction × GFR

STEADY STATE

Steady state is reached either when **rate in = rate out** or when values associated with a dosing interval are the same as those in the succeeding interval.

Plateau Principle

High-Yield

The time to reach steady state is dependent only on the elimination half-life of a drug. It is independent of dose size and frequency of administration, assuming the drug is eliminated by first-order kinetics.

NOTE

$$\text{Maintenance dose} = \frac{C^{ss} \times Cl \times \tau}{\text{Bioavailability}}$$

The figure below shows plasma levels (solid lines) achieved following the IV bolus administration of 100 units of a drug at intervals equivalent to every **half-life $t_{1/2}$ = 4 h** (τ). With such intermittent dosing, plasma levels oscillate through peaks and troughs, with averages shown in the diagram by the dashed line.

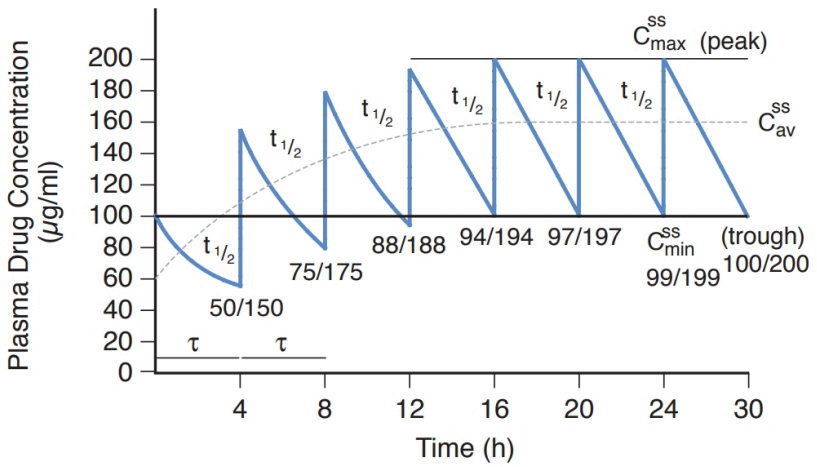


Figure I-1-11. Oscillations in Plasma Levels following IV Bolus Administration at Intervals Equal to Drug Half-Life

Note: Although it takes >7 $t_{1/2}$ to reach **mathematical** steady state, by convention **clinical** steady state is accepted to be reached at 4–5 $t_{1/2}$.

CLASSIC CLUES

Time and Steady State

50% = 1 × half-life

90% = 3.3 × half-life

95% = 4-5 × half-life

"100"% = >7 × half-life

Rate of Infusion

High-Yield

The figure below shows the increase in plasma level of the same drug infused at five rates. Regardless of the rate of infusion, it takes the same amount of time to reach steady state.

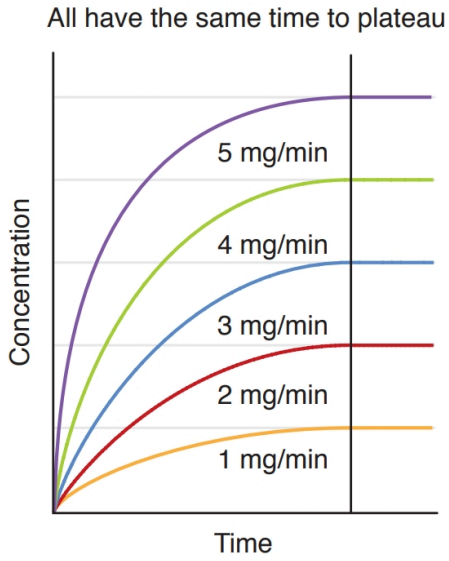


Figure I-1-12. Effect of Rate of Infusion on Plasma

Rate of infusion (k_0) does determine plasma level at steady state. If the rate of infusion is doubled, then the plasma level of the drug at steady state is doubled. A similar relationship can exist for other forms of drug administration (e.g., per oral)—doubling oral doses can double the average plasma levels of a drug. Plotting dose against plasma concentration yields a straight line (linear kinetics).

Effect of Loading Dose

High-Yield

It takes 4–5 half-lives to achieve steady state. In some situations, a higher dose (loading dose) may be needed to more rapidly achieve effective blood levels (C_p).

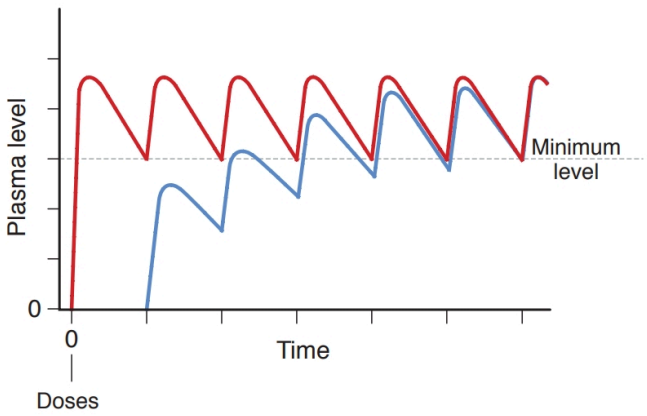


Figure I-1-13. Effect of a Loading Dose on the Time Required to Achieve the Minimal Effective Plasma Concentration

NOTE

Plasma concentration (C^{SS}) is **directly proportional to the dose** and **inversely proportional to the clearance**.

NOTE

$$\text{Loding dose} = \frac{V_d \times C_p}{f}$$

The loading dose equation can be used to calculate the amount of drug in the body at any time by knowing the V_d and plasma concentration.

NOTE

For the exam, if doses are to be administered at each half-life of the drug, and minimum effective concentration is equivalent to C^{SS}_{min}, then the loading dose is twice the amount of the dose used for maintenance (assuming normal clearance and same bioavailability for maintenance doses).

For any other interval of dosing, use the equation listed in the Note above.

Such loading doses are often one time only and are estimated to put into the body the amount of drug that should be there at a steady state.

PHARMACOKINETICS CALCULATIONS

The following relationships are important for pharmacokinetic calculations:

C^0 = conc. at time zero

Cl = clearance

C_p = conc. in plasma

C^{ss} = steady-state conc.

D = dose

f = bioavailability

τ = dosing interval

Single-Dose Equations

Volume of distribution $(V_d) = \frac{D}{C^0}$

Half-life $(t_{1/2}) = 0.7 \times \frac{V_d}{Cl}$

Multiple Dose or (Infusion Rate) Equations

Infusion rate $(k_0) = Cl \times C^{ss}$

Loading dose (LD) $= \frac{V_d \times C_p}{f}$

Maintenance dose (MD) $= \frac{Cl \times C^{ss} \times \tau}{f}$

Pharmacodynamics 2

LEARNING OBJECTIVES

- ❑ Compare affinity, potency, and efficacy on a dose-response curve
- ❑ Distinguish different types of drug antagonism
- ❑ Compare and contrast drug signaling mechanisms

DEFINITIONS

Pharmacodynamics relates to drugs binding to receptors and their effects.

- A drug is called an **agonist** when binding to the receptor results in a response.
- A drug is called an **antagonist** when binding to the receptor is not associated with a response; the drug has an effect only by preventing an agonist from binding to the receptor.
- **Affinity** is the ability of a drug to bind to receptor, shown by the proximity of the curve to the *y* axis (if the curves are parallel); the nearer the *y* axis, the greater the affinity.
- **Potency** shows relative doses of ≥2 agonists to produce the same magnitude of effect, again shown by the proximity of the respective curves to the *y* axis (if the curves do not cross).
- **Efficacy** is a measure of how well a drug produces a response (effectiveness), shown by the maximal height reached by the curve.

GRADED (QUANTITATIVE) DOSE-RESPONSE (D-R) CURVES

Plots of dose (or log dose) versus response for drugs (**agonists**) that activate receptors can reveal information about affinity, potency, and efficacy of these agonists.

BRIDGE TO BIOCHEMISTRY

Affinity is how well a drug and a receptor recognize each other.

- Inversely related to K_d of the drug
- Notice analogy to K_m value used in enzyme kinetic studies

Potency is the quantity of drug required to achieve a desired effect.

- In D-R measurements, the chosen effect is usually 50% of maximal effect but clinically any size response can be sought.

Efficacy is the maximal effect an agonist can achieve at the highest practical concentration.

- Notice analogy to V_{max} used in enzyme kinetic studies

Parallel and Nonparallel D-R Curves

High-Yield

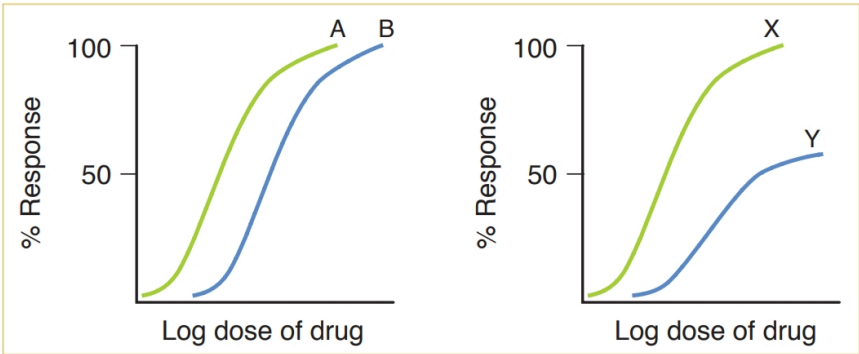


Figure I-2-1. D-R Curves for 2 Drugs Acting on Same (left) and Different (right) Receptors

It may be seen from the log dose-response curves above that:

- When 2 drugs interact with the same receptor (same pharmacologic mechanism), the D-R curves will have parallel slopes. Drugs A and B have the same mechanism; drugs X and Y do not.
- Affinity can be compared only when 2 drugs bind to the same receptor. Drug A has a greater affinity than drug B.
- In terms of potency, drug A has greater potency than drug B, and X is more potent than Y.
- In terms of efficacy, drugs A and B are equivalent. Drug X has greater efficacy than drug Y.

Full and Partial Agonists

Full agonists produce a maximal response, i.e., they have maximal efficacy. Partial agonists are less effective, i.e., they are incapable of eliciting a maximal response.

In the figure below, drug B is a full agonist while drugs A and C are partial agonists.

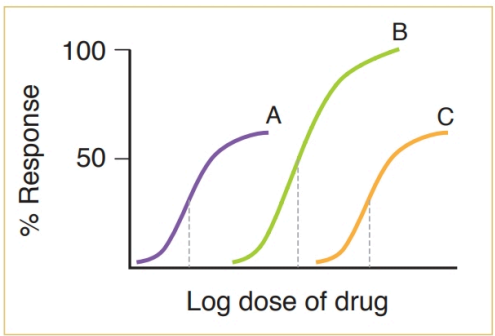


Figure I-2-2. Efficacy and Potency of Full and Partial Agonists

- Drug A is more potent than drug C, and drug B is more potent than drug C.
- However, no general comparisons about potency can be made between drugs A and B because the former is a partial agonist and the latter is a full agonist.
- At low responses, A is more potent than B, but at high responses, the reverse is true.

Duality of Partial Agonists

In the figure below, the lower curve represents effects of a partial agonist when used alone; its **ceiling effect** is 50% of maximal in this example.

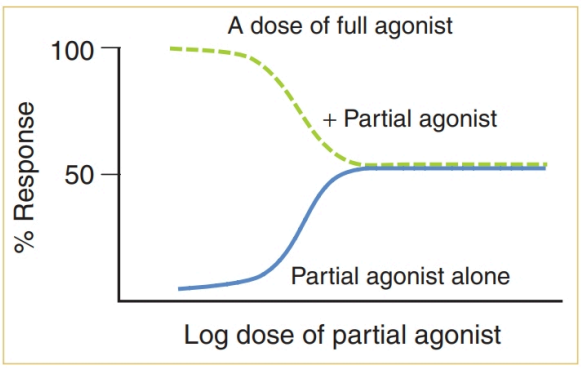


Figure I-2-3. Duality of Partial Agonists

- The upper curve shows the effect of increasing doses of the partial agonist on the maximal response (100%) achieved in the presence of or by pre-treatment with a full agonist.
- As the partial agonist displaces the full agonist from the receptor, the response is reduced—the partial agonist is acting as an **antagonist**.

Antagonism and Potentiation

Graded dose-response curves also provide information about antagonists (drugs that interact with receptors to interfere with their activation by agonists).

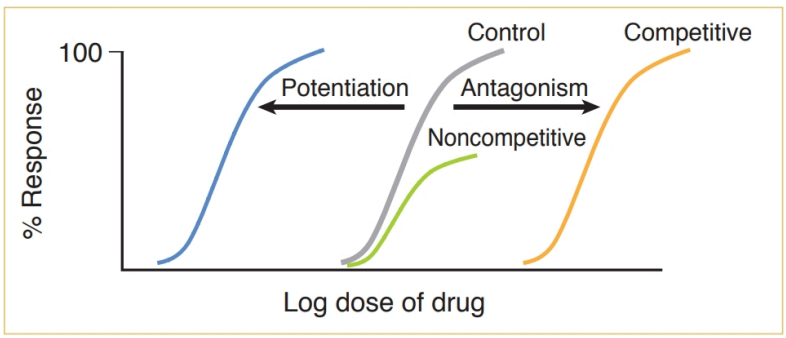


Figure I-2-4. D-R Curves of Antagonists and Potentiators

CLINICAL CORRELATE

Important drugs that are partial agonists include acebutolol, pindolol, buspirone, aripiprazole, buprenorphine, clomiphene, tamoxifen, and raloxifene.

BRIDGE TO BIOCHEMISTRY

Parallels between Receptor Antagonists and Enzyme Inhibitors

Competitive antagonists are analogous to competitive inhibitors; they decrease affinity ($\uparrow K_m$) but not maximal response (V_{max} remains the same).

Noncompetitive antagonists decrease V_{max} but do not change the K_m.

- Pharmacologic antagonism (same receptor)
  - Competitive antagonists (cause parallel shift to the right in D-R curve for agonists)
    - Can be reversed by increasing dose of agonist drug
    - Appear to decrease potency of agonist
  - Noncompetitive antagonists (cause nonparallel shift to the right)
    - Can be only partially reversed by increasing dose of agonist
    - Appear to decrease efficacy of the agonist
- Physiologic antagonism (different receptor)
  - Two agonists with opposing action antagonize each other
  - Example: a vasoconstrictor with a vasodilator
- Chemical antagonism:
  - Formation of a complex between effector drug and another compound
  - Example: protamine binds to heparin to reverse its actions
- Potentiation
  - Causes a parallel shift to the left to the D-R curve
  - Appears to increase potency of agonist

QUANTAL (CUMULATIVE) D-R CURVES

Quantal D-R curves plot the percentage of a population responding to a specified drug effect versus dose or log dose. They permit estimations of the median effective dose, or effective dose in 50% of a population—ED50.

- Can reveal the range of intersubject variability in drug response
- Steep D-R curve reflects little variability
- Flat D-R curve indicates great variability in patient sensitivity to the effects of a drug

Toxicity and Therapeutic Index

Comparisons between ED50 and TD50 values permit evaluation of the relative safety of a drug (the therapeutic index, or TI), as would comparison between ED50 and the lethal median dose (LD50) if the latter is known.

$$\text{TI} = \frac{\text{TD50}}{\text{ED50}} \text{ or } \frac{\text{LD50}}{\text{ED50}}$$

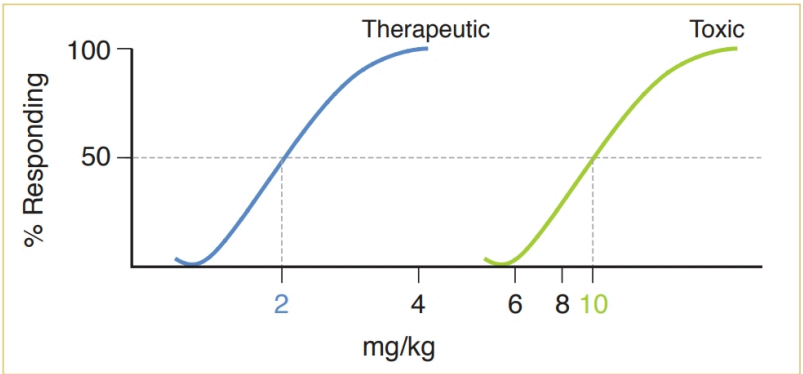


Figure I-2-5. Quantal D-R Curves of Therapeutic and Toxic Effects of a Drug

D-R curves can also show the relationship between dose and toxic effects of a drug. The median toxic dose of a drug (TD50) is the dose that causes toxicity in 50% of a population. From the data above, TI = 10/2 = 5.

Such indices are of most value when toxicity represents an extension of the pharmacologic actions of a drug. They do not predict idiosyncratic reactions or drug hypersensitivity.

Recall Question

Which of the following best describes the effect of a competitive antagonist on the dose-response curve?

A. Non-parallel left shift

B. Non-parallel right shift

C. Parallel left shift

D. Parallel right shift

Answer: D

SIGNALING MECHANISMS

The binding of an agonist drug to its receptor activates an effector or **signaling mechanism**. Several types of drug-responsive signaling mechanisms are known.

Intracellular Receptors

Intracellular receptors include receptors for steroids. Binding of hormones or drugs to such receptors releases regulatory proteins, which permit activation (and in some cases, dimerization) of the hormone-receptor complex.

- Such complexes translocate to the nucleus, where they interact with response elements in spacer DNA. This interaction leads to changes in gene expression.
- For example, drugs interacting with glucocorticoid receptors lead to gene expression of proteins that inhibit the production of inflammatory mediators.

Other examples of intracellular receptors include intracellular receptors for thyroid hormones, gonadal steroids, and vitamin D.

Pharmacologic responses elicited via modification of gene expression are usually slower in onset but longer in duration than many other drugs.

Membrane Receptors Directly Coupled to Ion Channels

Many drugs act by mimicking or antagonizing the actions of endogenous ligands that regulate flow of ions through excitable membranes via their activation of receptors that are directly coupled (no second messengers) to ion channels.

- For example, the nicotinic receptor for ACh (present in autonomic nervous system [ANS] ganglia, the skeletal myoneural junction, and the central nervous system [CNS]) is coupled to a Na+/K+ ion channel. The receptor is a target for many drugs, including nicotine, choline esters, ganglion blockers, and skeletal muscle relaxants.
- Similarly, the $GABA_A$ receptor in the CNS, which is coupled to a chloride ion channel, can be modulated by anticonvulsants, benzodiazepines, and barbiturates.

Receptors Linked Via Coupling Proteins to Intracellular Effectors

Many receptor systems are coupled via GTP-binding proteins (G proteins) to adenyl cyclase, the enzyme that converts ATP to cAMP, a second messenger which promotes protein phosphorylation by activating protein kinase A. These receptors are typically "serpentine," with 7 transmembrane spanning domains, a third of which is coupled to the G-protein effector mechanism.

- Protein kinase A serves to phosphorylate a set of tissue-specific substrate enzymes or transcription factors (CREB), thereby affecting their activity.

NOTE

Key ANS Receptors

M_1, M_3, α_1: G_q activation of phospholipase C

M_2, α_2, D_2: G_i inhibition of adenylyl cyclase

β_1, β_2, D_1: G_s activation of adenylyl cyclase

G_s proteins

- Binding of agonists to receptors linked to G_s proteins increases cAMP production.
- Such receptors include those for catecholamines (beta), dopamine (D_1), glucagon, histamine (H_2), prostacyclin, and some serotonin subtypes.

G_i proteins

- Binding of agonists to receptors linked to G_i proteins decreases cAMP production.
- Such receptors include adrenoreceptors ($alpha_2$), ACh (M_2), dopamine (D_2 subtypes), and several opioid and serotonin subtypes.

G_q proteins

Other receptor systems are coupled via GTP-binding proteins (G_q), which activate phospholipase C. Activation of this enzyme releases the second messengers inositol triphosphate (IP_3) and diacylglycerol (DAG) from the membrane phospholipid phosphatidylinositol bisphosphate (PIP_2). The IP_3 induces release of Ca^{2+}

from the sarcoplasmic reticulum (SR), which, together with DAG, activates protein kinase C. The protein kinase C serves then to phosphorylate a set of tissue-specific substrate enzymes, usually not phosphorylated by protein kinase A, and thereby affects their activity.

- These signaling mechanisms are invoked following activation of receptors for ACh (M_1 and M_3), norepinephrine (alpha$_1$), angiotensin II, and several serotonin subtypes.

BRIDGE TO BIOCHEMISTRY

See Chapter 9 of the Biochemistry Lecture Notes for additional discussion of signal transduction.

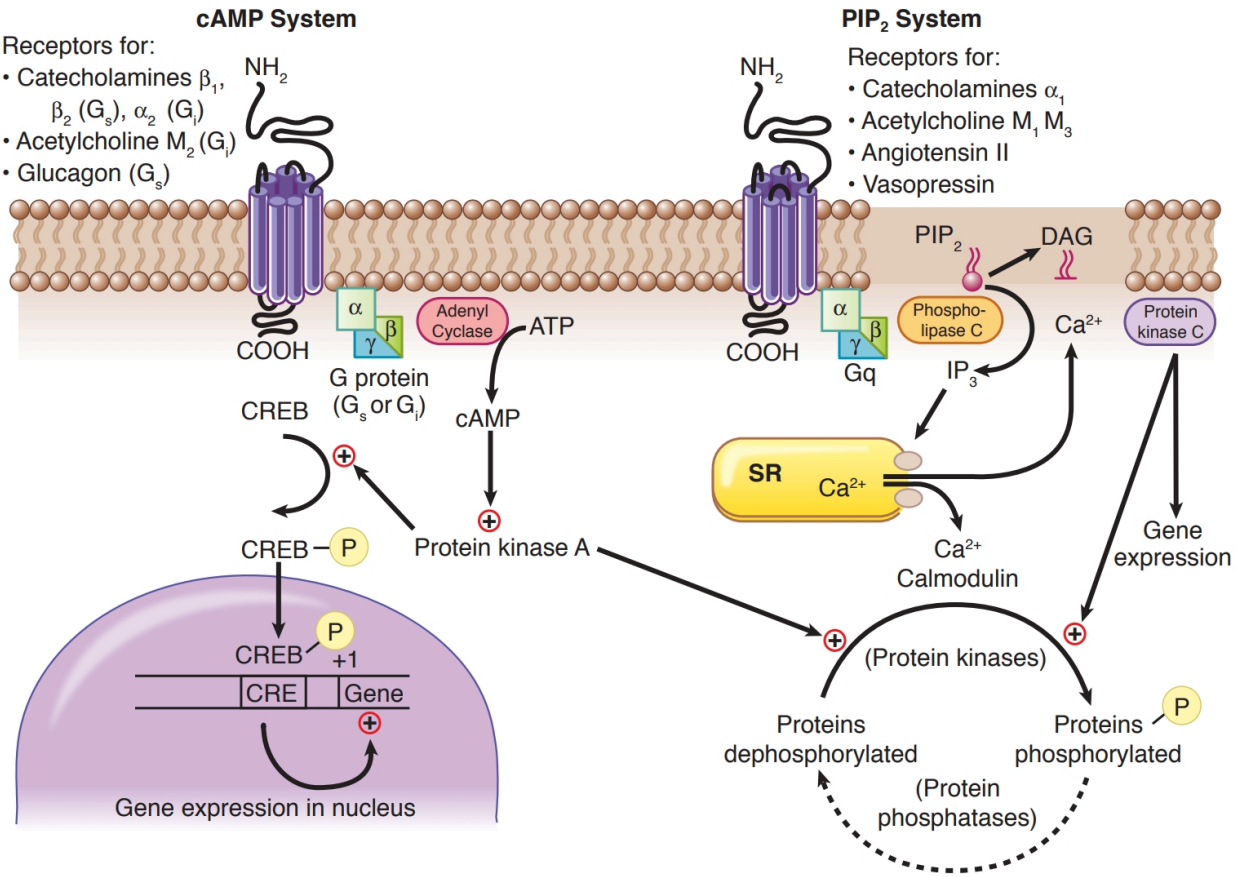


Figure I-2-6. Receptors Using Cyclic AMP and IP_3, DAG, Ca^{2+} as Second Messengers

Cyclic GMP and Nitric Oxide Signaling

Cyclic GMP (cGMP) is a second messenger in vascular smooth muscle that facilitates dephosphorylation of myosin light chains, preventing their interaction with actin and thus causing vasodilation. Nitric oxide (NO) is synthesized in endothelial cells and diffuses into smooth muscle.

- NO activates guanylyl cyclase, thus increasing cGMP in smooth muscle.
- Vasodilators ↑ synthesis of NO by endothelial cells.

CLINICAL CORRELATE

Drugs acting via NO include nitrates (e.g., nitroglycerin) and M-receptor agonists (e.g., bethanechol). Endogenous compounds acting via NO include bradykinin and histamine.

Receptors That Function as Enzymes or Transporters

There are multiple examples of drug action that depend on enzyme inhibition, including inhibitors of acetylcholinesterase, angiotensin-converting enzyme, aspartate protease, carbonic anhydrase, cyclooxygenases, dihydrofolate reductase, DNA/RNA polymerases, monoamine oxidases, Na/K-ATPase, neuraminidase, and reverse transcriptase.

- Examples of drug action on transporter systems include the inhibitors of reuptake of several neurotransmitters, including dopamine, GABA, norepinephrine, and serotonin.

Receptors That Function as Transmembrane Enzymes

- These receptors mediate the first steps in signaling by insulin and growth factors, including epidermal growth factor (EGF) and platelet-derived growth factor (PDGF). They are membrane-spanning macromolecules with recognition sites for the binding of insulin and growth factors located externally and a cytoplasmic domain that usually functions as a tyrosine kinase. Binding of the ligand causes conformational changes (e.g., dimerization) so that the tyrosine kinase domains become activated, ultimately leading to phosphorylation of tissue-specific substrate proteins.
- Guanyl cyclase–associated receptors: stimulation of receptors to atrial natriuretic peptide activates the guanyl cyclase and ↑ cyclic GMP (cGMP)

CLINICAL CORRELATE

Imatinib is a specific tyrosine-kinase (TK) inhibitor, while sorafenib is a non-specific TK inhibitor.

Receptors for Cytokines

Receptors for cytokines include the receptors for erythropoietin, somatotropin, and interferons. Their receptors are membrane spanning, and on activation, can activate a distinctive set of cytoplasmic tyrosine kinases (Janus kinases [JAKs]).

- JAKs phosphorylate signal transducers and activators of transcription (STAT) molecules.
- STATs dimerize and then dissociate, cross the nuclear membrane, and modulate gene transcription.

Practice Questions 3

PRACTICE QUESTIONS

1. A patient was given a 200 mg dose of a drug IV, and 100 mg was eliminated during the first 2 hours. If the drug follows first-order elimination kinetics, how much of the drug will remain 6 hours after its administration?

   A. None
   B. 25 mg
   C. 50 mg
   D. 75 mg
   E. 100 mg

2. Drugs that are administered IV are

   A. rapidly absorbed
   B. subject to first-pass metabolism
   C. 100% bioavailable
   D. rapidly excreted by the kidneys
   E. rapidly metabolized by the liver

3. Drugs that are highly bound to albumin

   A. effectively cross the BBB
   B. are easily filtered at the glomerulus
   C. have a large V_d
   D. often contain quaternary nitrogens
   E. can undergo competition with other drugs for albumin binding sites

4. Most drugs gain entry to cells by

   A. passive diffusion with zero-order kinetics
   B. passive diffusion with first-order kinetics
   C. active transport with zero-order kinetics
   D. active transport with first-order kinetics
   E. passive diffusion through membrane pores

5. A subject in whom the renal clearance of inulin is 120 mL/min is given a drug, the clearance of which is found to be 18 mL/min. If the drug is 40% plasma protein bound, how much filtered drug must be reabsorbed in the renal tubules?

   A. None
   B. 18 mL/min
   C. 36 mL/min
   D. 54 mL/min
   E. 72 mL/min

6. If a drug is known to be distributed into total body water, what dose (mg) is needed to obtain an initial plasma level of 5 mg/L in a patient weighing 70 kg?

   A. 210
   B. 150
   C. 110
   D. 50
   E. 35

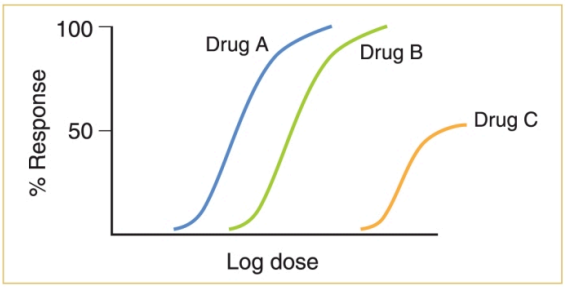
7. Which of the following is a phase II drug metabolism reaction associated with a genetic polymorphism?

   A. Acetylation
   B. Glucuronidation
   C. Oxidation
   D. Reduction
   E. Glutathione conjugation

8. A woman is taking oral contraceptives (OCs). Which of the following drugs is unlikely to reduce the effectiveness of the OCs?

   A. Carbamazepine
   B. Phenytoin
   C. Ketoconazole
   D. Phenobarbital
   E. Rifampin

9. The data presented in the figure below show that:



A. Drugs A and B have equal efficacy
B. Drugs B and C have equal efficacy
C. Drug B is a partial agonist
D. Drugs A and C have the same affinity and efficacy
E. Drugs A and B have equal potency

10. A 500-mg dose of a drug has therapeutic efficacy for 6 h. If the half-life of the drug is 8 h, for how long would a 1-g dose be effective?

A. 8 h
B. 12 h
C. 14 h
D. 16 h
E. 24 h

11. Which statement is accurate for the drug shown in the example below?

100 mg $\xrightarrow{2hr}$ 50 mg $\xrightarrow{2hr}$ 25 mg $\xrightarrow{2hr}$ 12.5 mg

A. The rate of elimination is constant
B. The elimination half-life varies with the dose
C. The volume of distribution varies with the dose
D. The clearance varies with the dose
E. The rate of elimination varies directly with the dose

12. Normally, gentamicin has a V_d = 20 L and Cl = 80 mL/min. If gentamicin was administered to a patient with 50% renal function, what parameter would differ from normal?

A. Loading dose would be higher
B. Maintenance dose would be lower
C. $t_{1/2}$ would be shorter
D. V_d would be 35 L
E. Cl would be 700 mL/min

13. Pharmacokinetic characteristics of propranolol include V_d = 300 L/70 kg, Cl = 700 mL/min, and oral bioavailability f = 0.25. What is the dose needed to achieve a plasma level equivalent to a steady-state level of 20 μg/L?

A. 4 mg
B. 8 mg
C. 12 mg
D. 24 mg
E. 48 mg

14. With IV infusion, a drug reaches 50% of its final steady state in 6 hours. The elimination half-life of the drug must be approximately:

A. 2 h
B. 6 h
C. 12 h
D. 24 h
E. 30 h

15. At 6 h after IV administration of bolus dose, the plasma level of a drug is 5 mg/L. If the V_d = 10 L and the elimination half-life = 3 h, what was the dose administered?

A. 100 mg
B. 150 mg
C. 180 mg
D. 200 mg
E. 540 mg

16. An IV infusion of a drug is started 400 mg/h. If Cl = 50 L/h, what is the anticipated plasma level at steady state?

A. 2 mg/L
B. 4 mg/L
C. 8 mg/L
D. 16 mg/L
E. 32 mg/L

ANSWERS AND EXPLANATIONS

1. **Answer: B.** One-half of the dose is eliminated in the first 2 hours so its elimination half-life equals 2 hours. With the passage of each half-life the amount in the body (or in the blood) will decrease to 50% of a former level. Thus, at 6 hours after administration, 3 half-lives have passed: (1) 200 mg to 100 mg, (2) 100 mg to 50 mg, and (3) 50 mg to 25 mg.

2. **Answer: C.** By definition, IV administration does not involve absorption because there is no movement from the site of administration into the blood. The IV route avoids first-pass metabolism, which is common with orally administered drugs. First-pass greatly reduces the bioavailability of many drugs. Drugs given IV have 100% bioavailability ($f = 1$) since the entire dose is in the systemic circulation. No conclusions can be drawn about renal or hepatic elimination of a drug knowing only that it was administered IV.

3. **Answer: E.** Since most drugs are lipid-soluble, they will need a carrier in the blood, most commonly albumin. Drugs bound to albumin do not get filtered at the glomerulus or cross the blood-brain barrier. Binding to plasma proteins keeps drugs in the plasma, resulting in a lower V_d. Highly protein bound drugs are good candidates for interactions with other drugs that are also highly bound (e.g., warfarin plus sulfonamides).

4. **Answer: B.** The permeation of most drugs through cellular membranes is by the process of passive diffusion, a nonsaturable process that follows first-order kinetics. Concentration gradient and lipid solubility are important determinants for the rate of diffusion. Only a few drugs are substrates for active transport processes such as active tubular secretion (e.g., penicillins) or penetrate membranes via aqueous pores (ethanol).

5. **Answer: D.** The formula to use is $Cl = ff \times GFR$. The drug is 40% protein bound so the ff = 60%: 120 mL/min × 60% = 72 mL/min theoretical clearance of the drug. Since only 18 mL/min was actually cleared, there must have been tubular reabsorption of the drug: 72 − 18 = 54 mL/min of reabsorbed drug.

6. **Answer: A.** This is a "loading dose" question. The equation for loading dose or the volume of distribution equation can be used ($LD = V_d \times C_p$). Since the patient weighs 70 kg and 60% of body weight is water, he has 42 L (70 L × 60%) of total body water. LD = 42 L × 5 mg/L = 210 mg.

7. **Answer: A.** Phase II drug metabolism involves the transfer of chemical groupings (e.g. acetyl, glucuronide, glutathione) to drugs or their metabolites via conjugation reactions involving transferase enzymes. Acetylation reactions are associated with a genetic polymorphism (slow acetylator). These individuals are slow to metabolize drugs via acetylation and are particularly susceptible to drug-induced SLE when taking hydralazine, procainamide, or isoniazid. Both oxidation and reduction are phase I metabolism reactions.

8. **Answer: C.** Azole antifungals (e.g., ketoconazole) are inhibitors of cytochrome P450 enzymes, especially CYP3A4, the most abundant isozyme form in the human liver. The 3A4 isozyme metabolizes a wide range of drugs. Ketoconazole would actually raise the plasma levels of oral contraceptives, increasing the risk of side effects, but it would not reduce their effectiveness. All other drugs listed are P450 inducers. As such, they would tend to lower plasma levels and decrease effectiveness of oral contraceptives.

9. **Answer: A.** The typical log dose response figure with the parallel nature of the curves suggests that the three drugs are interacting with the same receptor system. Drugs A and B are full agonists because they achieve the maximal response. They have the same efficacy. Drug A is more potent than drugs B or C. Drug B is more potent than drug C. Drug C is a partial agonist with less efficacy than the full agonists.

10. **Answer: C.** The fact that the drug has therapeutic efficacy for 6 h has no direct relationship to its half-life—it simply means that the drug is above its minimal effective concentration for 6 h. Doubling the dose (to 1 g) means that the drug level will be above the minimum for a longer period. Because the elimination half-life is 8 h, 500 mg of the drug will remain in the body 8 h after a dose of 1 g. Thus, the total duration of effectiveness must be $8 + 6 = 14$ h.

11. **Answer: E.** In first-order kinetics, the elimination rate of a drug is directly proportional to its plasma concentration, which in turn is proportional to the dose. Drugs that follow first-order elimination have a constant elimination half-life similar to the example given in the question. Likewise, clearance and volume of distribution are pharmacokinetic characteristics of a drug that do not routinely change with dose, although they may vary in terms of disease or dysfunction.

12. **Answer: B.** The patient has renal dysfunction, which reduces renal clearance. This would necessitate a lower maintenance dose for medications such as gentamicin. The maintenance dose equation $\left(\text{MD} = \frac{\text{Cl} \times C^{ss} \times \tau}{\text{f}}\right)$ factors in renal clearance, while the loading dose equation does not. The $t_{1/2}$ of gentamicin would be increased in this patient due to the decrease in clearance, but the V_d would be unaffected.

13. **Answer: D.** Loading dose $= V_d \times \frac{C_p}{f}$ $\quad LD = 300L \times 20\ \mu g/L \div 0.25$
$= 6000\ \mu g/0.25$ $\quad = 24{,}000\ \mu g$ or 24 mg

14. **Answer: B.** The rules for time to steady state are that it takes 4–5 $t_{1/2}$ to reach clinical steady state. It also takes one $t_{1/2}$ to get half way to steady state. Since the drug got 50% of the way to steady state in 6 hours, its $t_{1/2}$ must be 6 hours.

15. **Answer: D.** At 6 h after IV injection (which corresponds to two half-lives of the drug), the plasma level is 5 mg/L. Extrapolating back to zero time, "doubling" plasma level for each half-life results in an initial plasma level at zero time (C^0) = 5 mg/L × 2 × 2 = 20 mg/L.

$$\text{Dose} = C^0 \times V_d$$

$$= 20 \text{ mg/L} \times 10 \text{ L}$$

$$= 200 \text{ mg}$$

16. **Answer: C.** $MD = Cl \times C^{ss} \times \tau$

Since the drug was given by constant IV infusion, there is no need to consider the dosing interval (τ). Therefore, 400 mg/h = 50 L/h × C^{ss}

$$400 \text{ mg/h} \div 50 \text{ L/h} = 8 \text{ mg/L}$$

Alternatively, you could evaluate the question this way:

An infusion rate (k_0) is given by:

$$k_0 = Cl \times C^{ss}$$

rearrange: $C^{ss} = k_0/Cl$

$$= \frac{400 \text{ mg/h}}{50 \text{ L/h}} = 8 \text{ mg/L}$$

PART II

AUTONOMIC DRUGS

The Autonomic Nervous System

1

LEARNING OBJECTIVES

- ❑ Draw and label neurotransmitters and receptors in the ANS and Somatic Nervous System
- ❑ Explain the role of the ANS in blood pressure control and homeostatic feedback

ANATOMY OF THE ANS

The autonomic nervous system (ANS) is the major involuntary portion of the nervous system, and is responsible for automatic, unconscious bodily functions (e.g., control of heart rate and blood pressure, and both gastrointestinal and genitourinary functions).

It is divided into 2 subcategories:

- **Parasympathetic autonomic nervous system** (PANS)
- **Sympathetic autonomic nervous system** (SANS)

Location of ANS Ganglia

Both the PANS and SANS have relay stations, or ganglia, between the CNS and the end organ, but the somatic system does not. An important anatomic difference between them is that the ganglia of the SANS lie in 2 paravertebral chains adjacent to the vertebral column, whereas most of the ganglia of the PANS system are located in the organs innervated.

ANS and Somatic Innervation

High-Yield

The figure below highlights the major features of the ANS and the somatic systems, and also shows the location of the major receptor types.

- **N_N** Nicotinic receptors are located on cell bodies in ganglia of both PANS and SANS and in the adrenal medulla.
- **N_M** Nicotinic receptors are located on the skeletal muscle motor end plate innervated by somatic motor nerves.
- **M_{1-3}** Muscarinic receptors are located on all organs and tissues innervated by postganglionic nerves of the PANS and on thermoregulatory sweat glands innervated by the SANS.

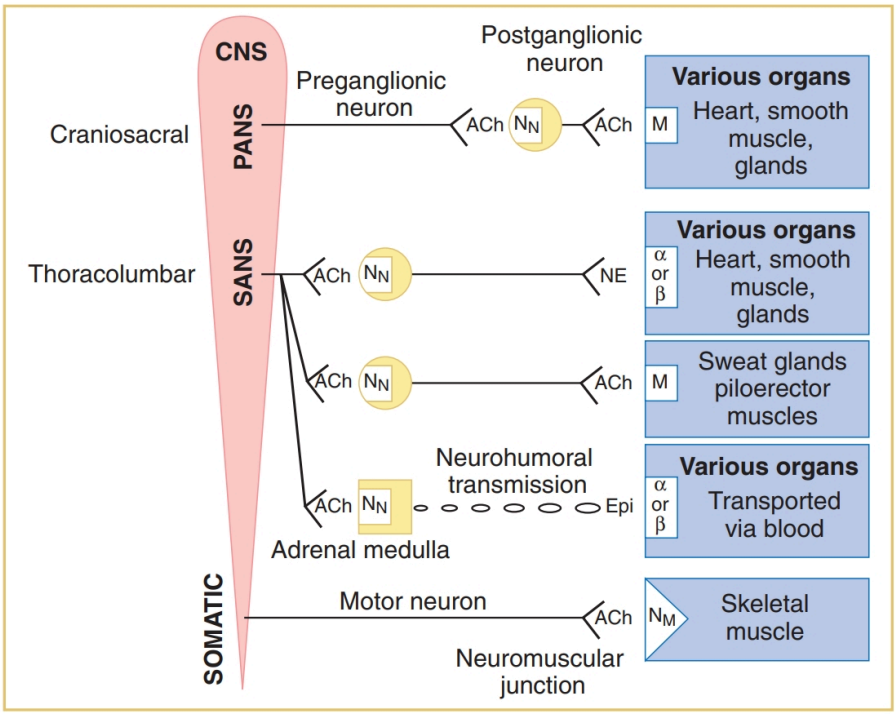


Figure II-1-1. Anatomy of the Autonomic Nervous System

Neurotransmitters

- Acetylcholine (ACh) is the neurotransmitter at both nicotinic and muscarinic receptors in tissues that are innervated. Note that all direct transmission from the CNS (preganglionic and motor) uses ACh, but postganglionic transmission in the SANS system may use one of the organ-specific transmitters described below.
- Norepinephrine (NE) is the neurotransmitter at most adrenoceptors in organs, as well as in cardiac and smooth muscle.
- Dopamine (DA) activates D_1 receptors, causing vasodilation in renal and mesenteric vascular beds.
- Epinephrine (E, from adrenal medulla) activates most adrenoceptors and is transported in the blood.

BLOOD PRESSURE CONTROL MECHANISMS

Autonomic Feedback Loop

High-Yield

Blood pressure (BP) is the product of total peripheral resistance (TPR) and cardiac output (CO). Both branches of the ANS are involved in the autonomic (or neural) control of blood pressure via feedback mechanisms.

- Changes in mean BP are detected by baroreceptors, which relay information to the cardiovascular centers in the brainstem controlling PANS and SANS outflow.
  - For example, an increase in mean BP elicits baroreceptor discharge, resulting in increased PANS activity, leading to bradycardia and

decreased SANS activity, which leads, in turn, to decreased heart rate and force of contraction. The resulting decreases in cardiac output and total peripheral resistance contribute to restoration of mean BP toward its normal level.

- Conversely, a decrease in BP elicits ANS neural feedback involving decreased PANS outflow and increased SANS activity—actions leading to an increase in cardiac output and total peripheral resistance.

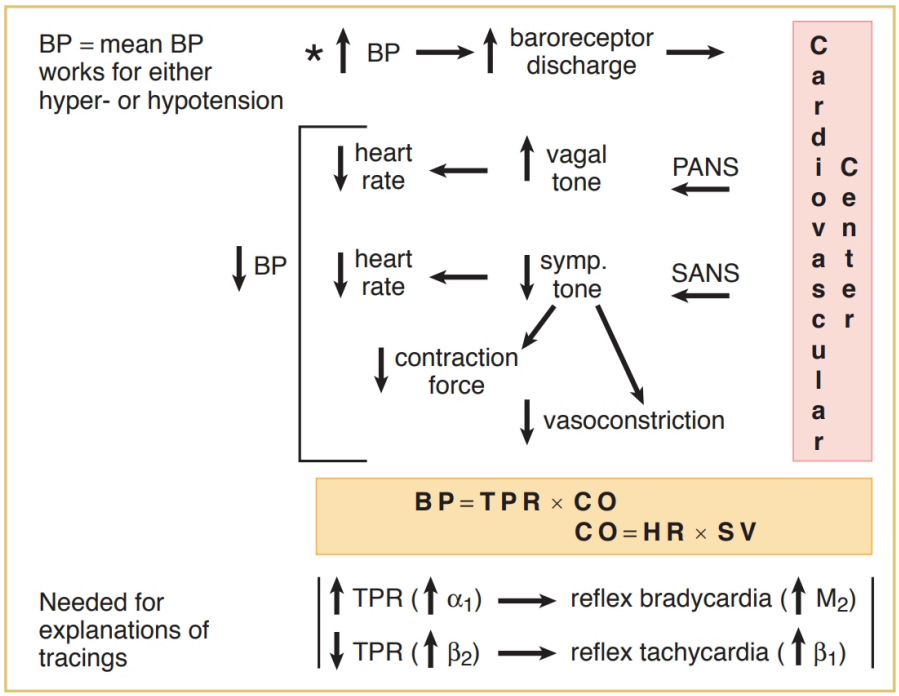


Figure II-1-2. Autonomic Feedback Loop

Hormonal Feedback Loop

Blood pressure is also regulated via the hormonal feedback loop. The system is affected only by **decreases** in mean BP (hypotension), which results in decreased renal blood flow.

- Decreased renal pressure causes the release of renin, which promotes formation of the angiotensins.
- Angiotensin II increases aldosterone release from the adrenal cortex, which, via its mineralocorticoid actions to retain sodium and water, increases blood volume.
- Increased venous return results in an increase in cardiac output.
- Angiotensin II also causes vasoconstriction, resulting in an increase in TPR.

NOTE

Baroreceptor reflexes can be blocked at the ganglionic synapse with N_N receptor antagonists. Alternatively, a reflex bradycardia can be blocked with muscarinic antagonists; a reflex tachycardia can be blocked with β_1 antagonists.

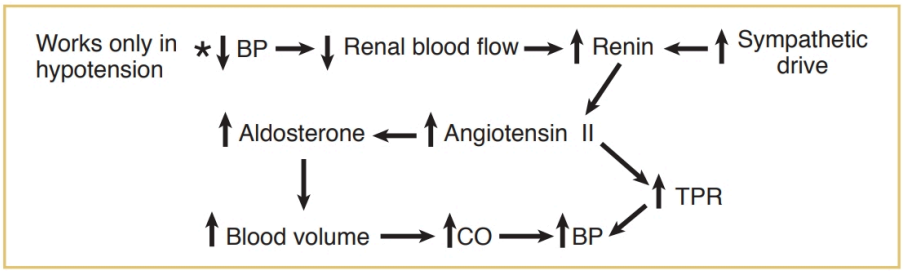


Figure II-1-3. Hormonal Feedback Loop

Blood Pressure/Heart Rate Tracings

NOTE

Both the ANS (neural) and endocrine feedback loops are invoked when patients are treated with **antihypertensive drugs**. Such compensatory mechanisms may result in tachycardia and both salt and water retention.

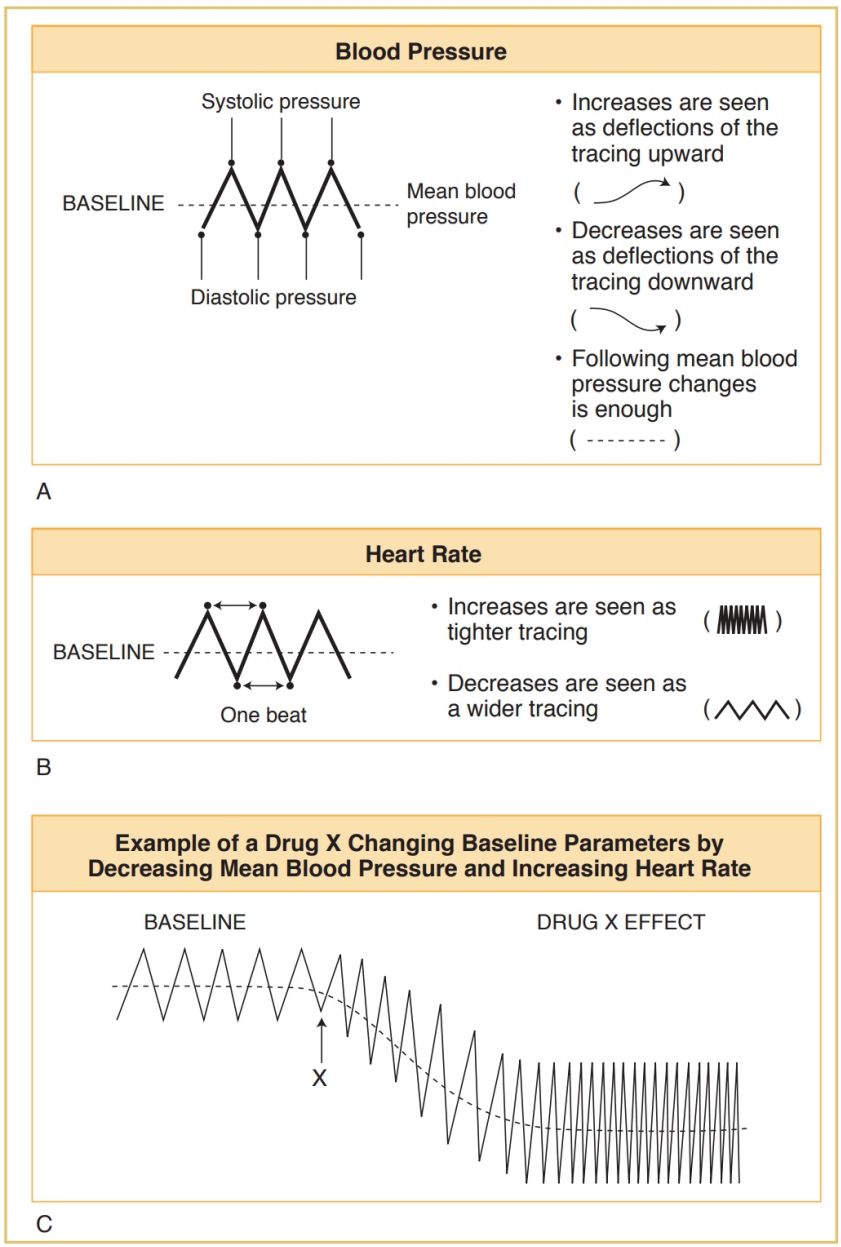


Figure II-1-4. Blood Pressure/Heart Rate Tracings

PUPILLARY SIZE AND ACCOMMODATION MECHANISMS

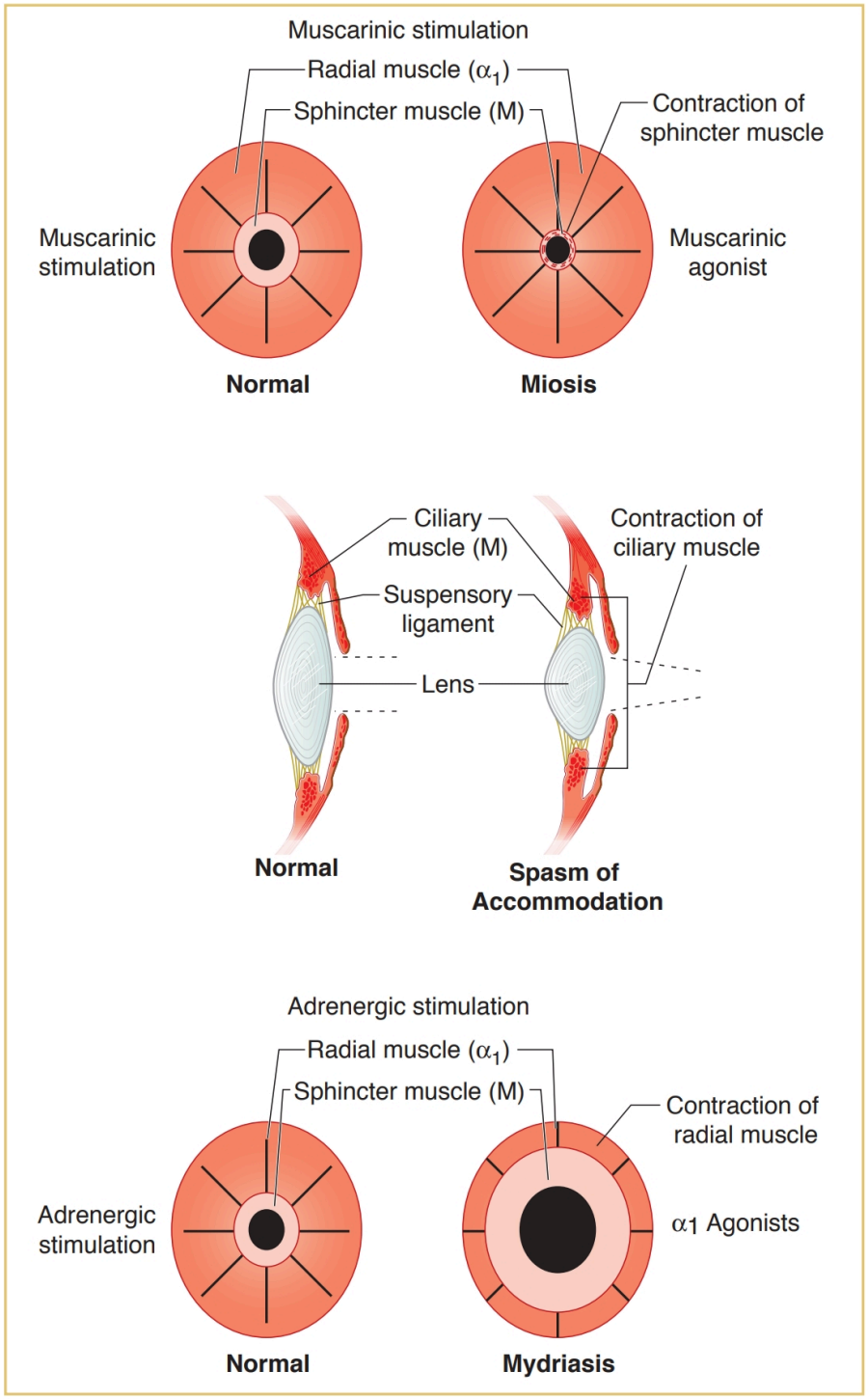


Figure II-1-5. Effect of ANS Drugs on the Eye

Muscarinic stimulation

1. Miosis
2. Accommodation (near vision)

Muscarinic antagonism

1. Mydriasis
2. Accommodation to far vision, leading to cycloplegia (paralysis of accommodation)

α1-agonists

1. Mydriasis
2. No cycloplegia

Cholinergic Pharmacology 2

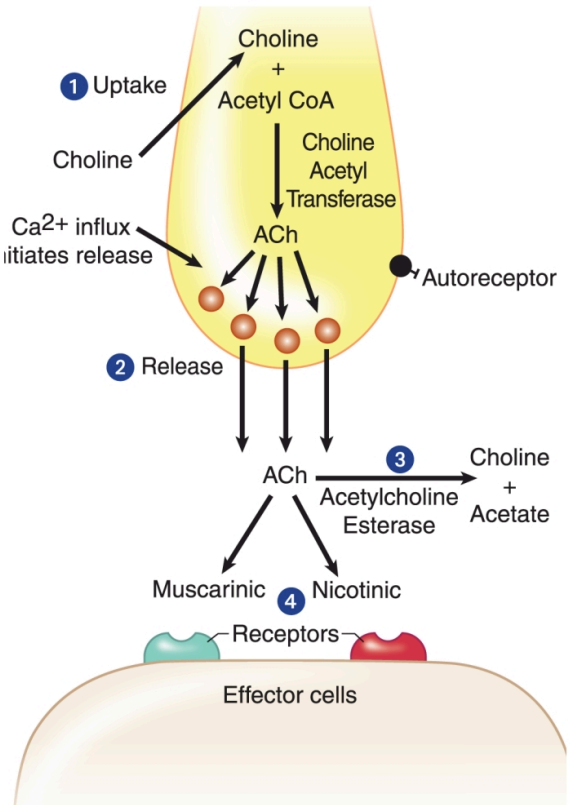
LEARNING OBJECTIVES

- ❑ Describe ACh synthesis, release, and fate
- ❑ Identify location and physiological function of muscarinic receptors
- ❑ Describe mechanism, clinical indications/uses, and side effects of muscarinic agonists, antagonists, and acetylcholinesterase inhibitors

CHOLINERGIC NEUROEFFECTOR JUNCTIONS

Synthesis and Release of ACh

High-Yield



1 Hemicholinium

2 Botulinum toxin

3 Acetylcholinesterase (AChE) inhibitors

4 Receptor agonists and antagonists

Figure II-2-1. Cholinergic Neuroeffector Junction

Choline is accumulated in cholinergic presynaptic nerve endings via an active transport mechanism linked to a Na^+ pump and similar to the sodium-dependent glucose transporter.

NOTE

- M receptor activation →↓ CV function
- ↑ secretions and ↑ smooth muscle contraction
- All M receptor activators and blockers are nonspecific.

- Choline uptake is inhibited by **hemicholinium** (① in Figure II-2-1). ACh is synthesized from choline and acetyl-CoA via choline acetyltransferase (ChAT) and accumulates in synaptic vesicles.
- Presynaptic membrane depolarization opens voltage-dependent Ca^{2+} channels, and the influx of this ion causes fusion of the synaptic vesicle membranes with the presynaptic membrane, leading to exocytosis of ACh. **Botulinum toxin** (② in Figure II-2-1) interacts with synaptobrevin and other proteins to prevent ACh release and is used in blepharospasm, strabismus/hyperhidrosis, dystonia, and cosmetics.
- Some cholinergic nerve endings have presynaptic autoreceptors for ACh that on activation may elicit a negative feedback of transmitter release.
- Inactivation via acetylcholinesterase (AChE) is the major mechanism of termination of postjunctional actions of ACh.
- AChE is a target for inhibitory drugs (indirect-acting cholinomimetics). Note that such drugs can influence cholinergic function only at innervated sites where ACh is released.
- Reversible AChE inhibitors (③ in Figure II-2-1) include edrophonium, physostigmine, and neostigmine. Irreversible AChE inhibitors include malathion and parathion.
- Postjunctional receptors (N and M) (④ in Figure II-2-1) activated by ACh are major targets for both activating drugs (direct-acting cholinomimetics) and blocking agents.

M Receptor Location and Function

High-Yield

Table II-2-1. Muscarinic Receptor Activation

Target		Receptor	Response
Eye	Sphincter	M_3	Contraction—miosis
	Ciliary muscle	M_3	Contraction—accommodation for near vision
Heart	SA node	M_2	↓ Heart rate (HR)—negative chronotropy
	AV node	M_2	↓ Conduction velocity—negative dromotropy
			No effects on ventricles, Purkinje system
Lungs	Bronchioles	M_3	Contraction—bronchospasm
	Glands	M_3	↑ Secretion
GI tract	Stomach	M_3	↑ Motility—cramps
	Glands	M_1	↑ Secretion
	Intestine	M_3	Contraction—diarrhea, involuntary defecation
Bladder		M_3	Contraction (detrusor), relaxation (trigone/sphincter), voiding, urinary incontinence
Sphincters		M_3	Relaxation, except lower esophageal, which contracts
Glands		M_3	↑ Secretion—sweat (thermoregulatory), salivation, and lacrimation
Blood vessels (endothelium)		M_3	Dilation (via NO/endothelium-derived relaxing factor)—no innervation, no effects of indirect agonists

Table II-2-2. Nicotinic Receptor Activation

Target	Receptor	Response
Adrenal medulla	N_N	Secretion of epinephrine and NE
Autonomic ganglia	N_N	Stimulation—net effects depend on PANS/SANS innervation and dominance
Neuromuscular junction	N_M	Stimulation—twitch/hyperactivity of skeletal muscle
Note: N receptors desensitize very quickly upon excessive stimulation.		

Table II-2-3. Cholinergic Receptor Mechanisms

M_1 and M_3	G_q coupled	↑ phospholipase C →↑ IP_3, DAG, Ca^{2+}
M_2	G_i coupled	↓ adenylyl cyclase →↓ cAMP
N_N and N_M	No 2nd messengers	activation (opening) of Na/K channels

MUSCARINIC RECEPTOR ACTIVATORS

Muscarinic Agonists

Table II-2-4. Properties of Direct-Acting Cholinomimetics

Drug	Activity	AChE Hydrolysis	Clinical Uses
ACh	M and N	+++	Short half-life—no clinical use
Bethanechol	M	–	Rx—ileus (postop/neurogenic), urinary retention
Methacholine	M > N	+	Dx—bronchial hyperreactivity
Pilocarpine, cevimeline	M	–	Rx—xerostomia, glaucoma (pilocarpine)

CLINICAL CORRELATE

Alzheimer disease is late-onset dementia with progressive memory loss and cognitive decline. Neuropathology includes neurofibrillary tangles, amyloid plaques, and loss of ACh neurons in the Meynert nucleus—a rationale for the clinical use of AChE inhibitors.

CLASSIC CLUE

AChE inhibitor poisoning: "Dumbbeelss"

Diarrhea

Urination

Miosis

Bradycardia

Bronchoconstriction

Emesis

Excitation (CNS/muscle)

Lacrimation

Salivation

Sweating

Acetylcholinesterase Inhibitors

High-Yield

Table II-2-5. Properties of Indirect-Acting Cholinomimetics

Drug	Characteristics	Clinical Uses
Edrophonium	Short-acting	Dx—myasthenia gravis
Physostigmine	Tertiary amine (enters CNS)	Rx—glaucoma; antidote in atropine overdose
Neostigmine, pyridostigmine	Quaternary amines (no CNS entry)	Rx—ileus, urinary retention, myasthenia gravis, reversal of nondepolarizing NM blockers
Donepezil, rivastigmine	Lipid-soluble (CNS entry)	Rx—Alzheimer disease
Organophosphates	Lipid-soluble, irreversible inhibitors	Note: used as insecticides (malathion, parathion) and as nerve gas (sarin)

Toxicity of AChE Inhibitors

High-Yield

Excessive muscarinic and nicotinic stimulations

- Muscarinic effects:
  - Diarrhea
  - Urination
  - Miosis
  - Bradycardia
  - Bronchoconstriction
  - Lacrimation
  - Salivation
  - Sweating
  - CNS stimulation
- Nicotinic effects:
  - Skeletal muscle excitation followed by paralysis
  - CNS stimulation

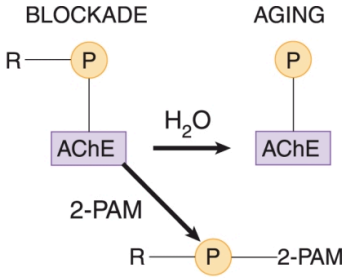
Management

- Muscarinic effects: atropine
- Regeneration of AChE: pralidoxime (2-PAM)
- Time-dependent aging requires use of 2-PAM as soon as possible

Irreversibly Acting Cholinomimetics:

These compounds phosphorylate the esteratic site on AChE, at serine hydroxyl groups

1. phosphorylation; reversible by pralidoxime (2-PAM)
2. removal of a part of the organophosphate molecule (aging); complex no longer reversible by 2-PAM



R = leaving group
P = organophosphate

Figure II-2-2. Effects of Organophosphate on AChE

MUSCARINIC RECEPTOR ANTAGONISTS

Atropine

- Prototype of the class
- As a tertiary amine, it enters CNS
- Other M blockers differ mainly in their pharmacokinetic properties

Pharmacologic Effects

High-Yield

- Atropine effects in order of increasing dose:
  - Decreased secretions (salivary, bronchiolar, sweat)
  - Mydriasis and cycloplegia
  - Hyperthermia (with resulting vasodilation)
  - Tachycardia
  - Sedation
  - Urinary retention and constipation
  - Behavioral: excitation and hallucinations
- Other classes of drugs with antimuscarinic pharmacology:
  - Antihistamines
  - Tricyclic antidepressants
  - Antipsychotics
  - Quinidine
  - Amantadine
  - Meperidine
- Treatment of acute intoxication: symptomatic ± physostigmine

Table II-2-6. Clinical Uses and/or Characteristics of M Blockers

Drug	Clinical Uses and/or Characteristics
Atropine	Antispasmodic, antisecretory, management of AChE inhibitor OD, antidiarrheal, ophthalmology (but long action)
Tropicamide	Ophthalmology (topical)
Ipratropium, tiotropium	Asthma and COPD (inhalational)—no CNS entry, no change in mucus viscosity
Scopolamine	Used in motion sickness, causes sedation and short-term memory block
Benztropine, trihexyphenidyl	Lipid-soluble (CNS entry) used in parkinsonism and in acute extrapyramidal symptoms induced by antipsychotics
Oxybutynin	Used in overactive bladder (urge incontinence)

Recall Question

The action of botulinum toxin is through which of the following mechanisms?

A. Direct action on acetylcholine esterase

B. Direct action on muscarinic receptors

C. Prevention of acetylcholine release

D. Prevention of choline uptake

Answer: C

BRIDGE TO PHYSIOLOGY

ANS Dominance

For effector tissues with dual innervation, PANS is dominant. These include the SA and AV nodes of the heart, the pupil, GI and GU muscles, and sphincters. SANS is dominant only in terms of vascular tone and thermoregulatory sweat glands.

NICOTINIC RECEPTOR ANTAGONISTS

Ganglion Blocking Agents

- Drugs: hexamethonium and mecamylamine
- Reduce the predominant autonomic tone
- Prevent baroreceptor reflex changes in heart rate

Table II-2-7. Effects of Ganglion Blocking Agents

Effector	System	Effect of Ganglion Blockade
Arterioles	SANS	Vasodilation, hypotension
Veins	SANS	Dilation, ↓ venous return, ↓ CO
Heart	PANS	Tachycardia
Iris	PANS	Mydriasis
Ciliary muscle	PANS	Cycloplegia
GI tract	PANS	↓ tone and motility—constipation
Bladder	PANS	Urinary retention
Salivary glands	PANS	Xerostomia
Sweat glands	SANS	Anhydrosis

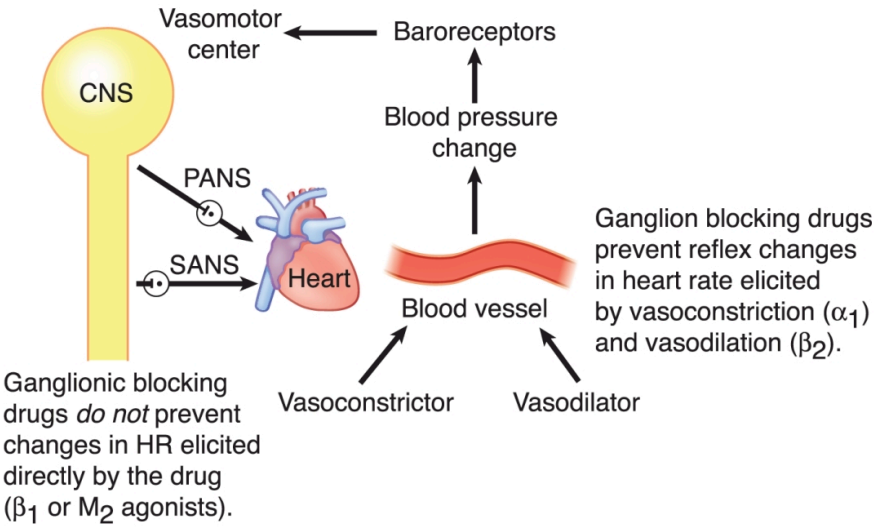


Figure II-2-3. Algorithm: Reflex Control of Heart Rate

Neuromuscular Blocking Drugs

See part IV, CNS Drugs, chapter on Anesthetics and Muscle Relaxants.

Adrenergic Pharmacology

3

LEARNING OBJECTIVES

- ❑ Describe NE synthesis, release, and fate
- ❑ Identify location and function of adrenergic receptors
- ❑ Describe mechanism, clinical indications/uses, and side effects of adrenergic agonists and antagonists

ADRENERGIC NEUROEFFECTOR JUNCTIONS

Synthesis and Release of NE

High-Yield

The important aspects of the adrenergic neuroeffector junction are summarized below.

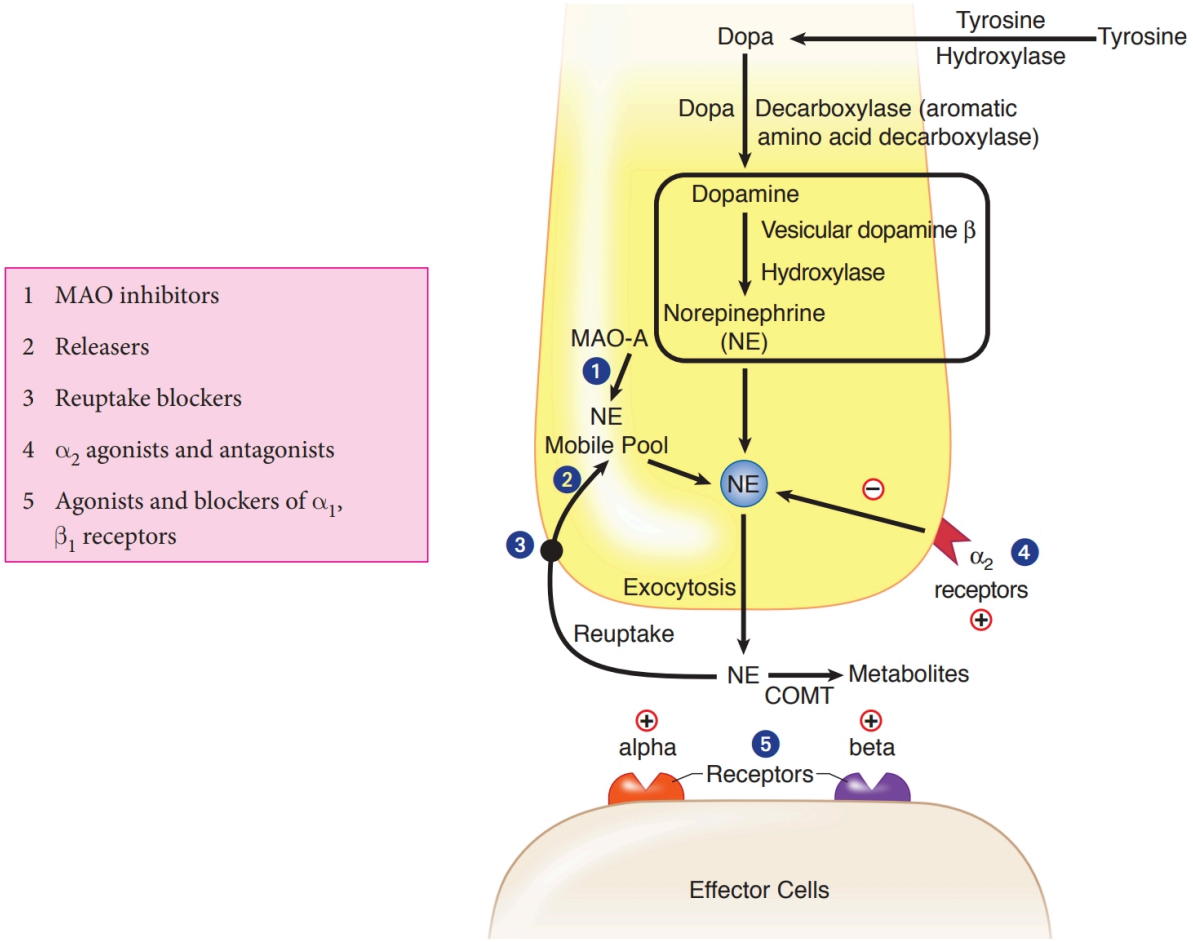


Figure II-3-1. Adrenergic Neuroeffector Junction

NOTE

NE Reuptake

Clearance of NE from the synapse is accomplished primarily by reuptake via an NaCl-norepinephrine co-transporter driven by the sodium gradient, which is maintained by the Na^+K^+ATPase.

Tyrosine is actively transported into nerve endings and is converted to dihydroxyphenylalanine (DOPA) via tyrosine hydroxylase. This step is rate limiting in the synthesis of NE. DOPA is converted to dopamine (DA) via L-aromatic amino acid decarboxylase (DOPA decarboxylase). DA is taken up into storage vesicles where it is metabolized to NE via DA beta hydroxylase. Inactivation of NE via monoamine oxidase A (MAO-A) (1) may regulate prejunctional levels of transmitter in the mobile pool (2) but not the NE stored in granules.

Presynaptic membrane depolarization opens voltage-dependent Ca^{2+} channels. Influx of this ion causes fusion of the synaptic granular membranes, with the presynaptic membrane leading to NE exocytosis into the neuroeffector junction. NE then activates postjunctional receptors (5), leading to tissue-specific responses depending on the adrenoceptor subtype activated.

Termination of NE actions is mainly due to removal from the neuroeffector junction back into the sympathetic nerve ending via an NE reuptake transporter system (3). At some sympathetic nerve endings, the NE released may activate prejunctional alpha adrenoceptors (4) involved in feedback regulation, which results in decreased release of the neurotransmitter. Metabolism of NE is by catechol-O-methyltransferase (COMT) in the synapse or MAO_A in the prejunctional nerve terminal.

Adrenergic Receptor Location and Function

High-Yield

Table II-3-1. Adrenergic Receptor Activation

Receptor	Response
α_1 Eye: radial (dilator) muscle Arterioles (skin, viscera) Veins Bladder trigone and sphincter and prostatic urethra Male sex organs Liver Kidney	Contraction: mydriasis Contraction: ↑ TPR, ↑ diastolic pressure, ↑ afterload Contraction: ↑ venous return, ↑ preload Contraction: urinary retention Vas deferens: ejaculation ↑ glycogenolysis ↓ renin release
α_2 Prejunctional nerve terminals Platelets Pancreas	↓ transmitter release and NE synthesis Aggregation ↓ insulin secretion
β_1 Heart SA node AV node Atrial and ventricular muscle His-Purkinje Kidney	↑ HR (positive chronotropy) ↑ conduction velocity (positive dromotropy) ↑ force of contraction (positive inotropy), conduction velocity, CO and oxygen consumption ↑ automaticity and conduction velocity ↑ renin release
β_2 **(mostly not innervated)** Blood vessels (all) Uterus Bronchioles Skeletal muscle Liver Pancreas	Vasodilation: ↓ TPR: ↓ diastolic pressure, ↓ afterload Relaxation Dilation ↑ glycogenolysis: contractility (tremor) ↑ glycogenolysis ↑ insulin secretion
β_3 Detrusor muscle of the bladder	Relaxation
D_1 **(peripheral)** Renal, mesenteric, coronary vasculature	Vasodilation: in kidney ↑ RBF, ↑ GFR, ↑ Na^+ secretion

NOTE

Adrenoceptor Sensitivity

Beta receptors are usually more sensitive to activators than alpha receptors. With drugs that exert both effects, the beta responses are dominant at low doses; at higher doses, the alpha responses will predominate.

NOTE

Dopamine Use in Shock

D_1 β_1 α_1

→ increasing doses of dopamine

Fenoldopam is a D_1 agonist used for severe hypertension.

Table II-3-2. Mechanisms Used by Adrenergic Receptors

α_1	G_q coupled	↑ phospholipase C →↑ IP_3, DAG, Ca^{2+}
α_2	G_i coupled	↓ adenylyl cyclase → ↓ cAMP
$\beta_1\beta_2$ D_1	G_s coupled	↑ adenylyl cyclase → ↑ cAMP

DIRECT-ACTING ADRENOCEPTOR AGONISTS

α_1 Agonists

High-Yield

Systemically, alpha-1 agonists increase mean BP via vasoconstriction.

- Increased BP may elicit a reflex bradycardia
- Cardiac output may be ↓ but also offset by ↑ venous return
- Drugs and uses:
  - **Phenylephrine:** nasal decongestant and ophthalmologic use (mydriasis without cycloplegia), hypotensive states

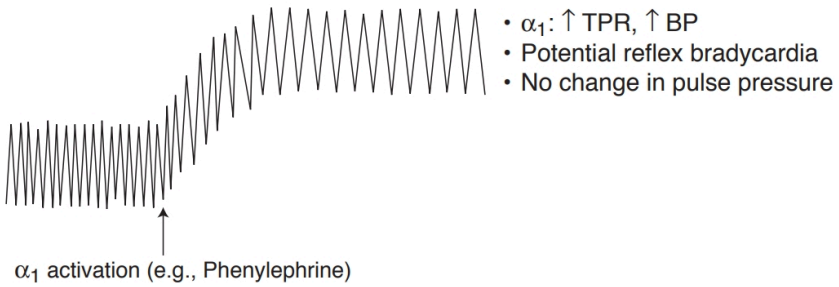


Figure II-3-2. Effect of Alpha Activators on Heart Rate and Blood Pressure

α_2 Agonists

Alpha-2 agonists stimulate prejunctional receptors in the CNS to decrease sympathetic outflow. Their primary use is for mild to moderate HTN.

- Drugs and uses: **clonidine** and **methyldopa** (mild to moderate hypertension)
- *See* Cardiovascular section.

β Agonists

Systemically, beta agonists decrease mean BP via vasodilation (β_2) and increase HR (β_1).

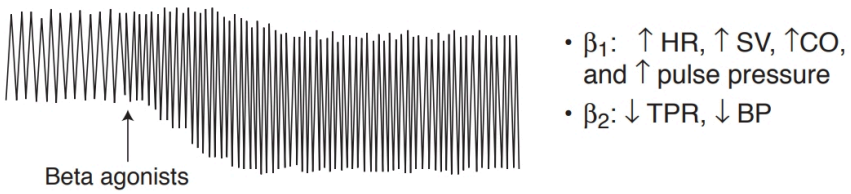


Figure II-3-3. Effect of Beta Receptor Activation on Heart Rate and Blood Pressure

- Drugs and uses:
  - Isoproterenol ($\beta_1 = \beta_2$)
  - Dobutamine ($\beta_1 > \beta_2$): congestive heart failure
  - Selective β_2 agonists: salmeterol, albuterol, terbutaline (asthma); terbutaline (premature labor)
  - Selective β_3 agonist: mirabegron (overactive bladder)

Mixed-Acting Agonists: Norepinephrine vs. Epinephrine

High-Yield

Norepinephrine (α_1, α_2, β_1)

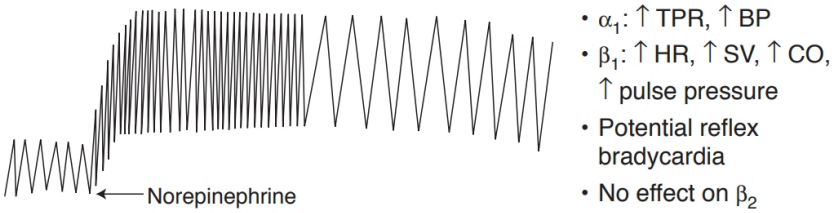


Figure II-3-4. Effect of Norepinephrine on Heart Rate and Blood Pressure

Epinephrine (α_1, α_2, β_1, β_2)

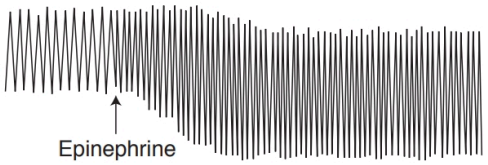


Figure II-3-5a. Effect of Low-Dose Epinephrine on Heart Rate and Blood Pressure

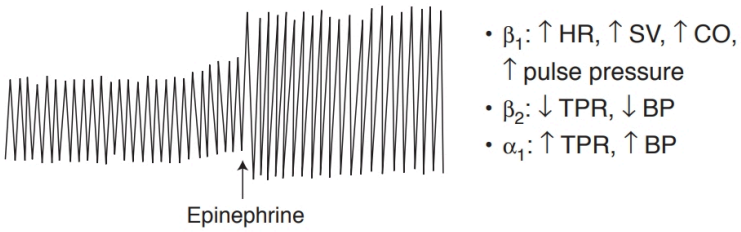


Figure II-3-5b. Effect of Medium-Dose Epinephrine on Heart Rate and Blood Pressure

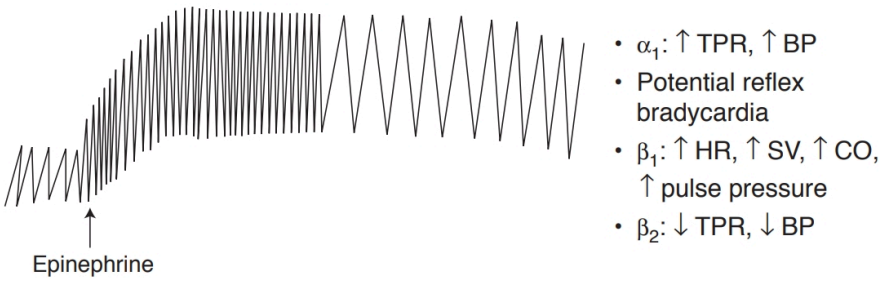


Figure II-3-5c. Effect of High-Dose Epinephrine Is Similar to Norepinephrine

- Dose-dependent effects:
  - Low-dose: β_1, β_2 stimulation (*see* Figure II-3-5a)
  - High-dose: α_1, β_1 (β_2) (*see* Figure II-3-5c)
- β_2-specific effects:
  - Smooth muscle relaxation: bronchioles, uterus, blood vessels
  - Metabolic effects:
    - ↑ glycogenolysis (muscle and liver)
    - ↑ gluconeogenesis
    - ↑ mobilization and use of fat

- Differentiation of high-dose epinephrine versus norepinephrine:
  - Epinephrine reversal: Use of α_1 blocker to reverse hypertension to hypotension in a patient receiving too much epinephrine
  - Hypertension was due to predominant α_1 tone on the vasculature
  - Hypotension results from unmasking β_2 receptors

Uses of Norepinephrine and Epinephrine

- Cardiac arrest
- Adjunct to local anesthetic
- Hypotension
- Anaphylaxis (epinephrine only)
- Asthma (epinephrine only)

INDIRECT-ACTING ADRENERGIC RECEPTOR AGONISTS

Releasers

Releasers displace norepinephrine from the mobile pool.

- Drug interaction: MAO_A inhibitors (hypertensive crisis)
- **Tyramine** (red wine, cheese)
  - Oral bioavailability is limited by MAO-A metabolism in gut and liver
  - MAO-A inhibition ↑ bioavailability, resulting in hypertensive crisis
- **Amphetamines**
  - Clinical use of methylphenidate and other amphetamines in narcolepsy and ADHD
  - Psychostimulant due to central release of DA, NE, 5HT
- **Pseudoephedrine** (cold medication)

Reuptake Inhibitors

- Cocaine
- Tricyclic antidepressant (in part)

ADRENERGIC ANTAGONISTS

α Receptor Antagonists

Alpha-receptor antagonists decrease TPR and decrease mean BP.

- May cause reflex tachycardia and salt and water retention
- Major uses:
  - Hypertension
  - Pheochromocytoma (nonselective α blocker)

CLINICAL CORRELATE

- Indirect-acting adrenoceptor agonists act only on effector tissues innervated by SANS.
- Denervated effector tissues are nonresponsive because these drugs act either to release transmitter from nerve terminals or to inhibit neurotransmitter reuptake.

NOTE

Forms of MAO

- MAO type A: mainly in liver, but Anywhere (metabolizes NE, 5HT, and tyramine)
- MAO type B: mainly in Brain (metabolizes DA)

- Benign prostatic hyperplasia (BPH; selective α_1 blocker)

- Drugs:
  - Nonselective blocker: phentolamine (competitive inhibitor), phenoxybenzamine (noncompetitive inhibitor)
  - Selective α_1 blocker: prazosin, doxazosin, terazosin, tamsulosin
  - Selective α_2 blocker: mirtazapine (used as antidepressant)

CLINICAL CORRELATE

Chronic use of beta blockers (e.g., in angina, HTN) leads to receptor upregulation.

During withdrawal from use, it is important to taper dose to avoid excessive cardiovascular effects (rebound effects) of endogenous amines.

β Receptor Antagonists

High-Yield

- β_1 blockade:
  - ↓ HR, ↓ SV, ↓ CO
  - ↓ renin release
- β_2 blockade:
  - May precipitate bronchospasm (in asthmatics) and vasospasm (in patients with vasospastic disorders)
  - ↓ aqueous humor production
  - Metabolic effects
    - Blocks glycogenolysis, gluconeogenesis
    - ↑ LDLs, TGs

CLINICAL CORRELATE

Glucagon and the Heart

Positive inotropic and chronotropic, not via activation of β_1 receptors, but through glucagon receptors that are G_s-protein linked to adenylyl cyclase → basis for its use in beta-blocker overdose.

Table II-3-3. Characteristics of Some Beta Blockers

Drugs	β1-Selective	ISA	Sedation	Blood Lipids
Acebutolol	+	+ +	+	–
Atenolol	+	–	–	↑↑
Metoprolol	+	–	+	↑↑
Pindolol	–	+ +	+	–
Propranolol	–	–	+ + +	↑↑
Timolol	–	–	+ +	↑↑

- Cardioselectivity (β_1):
  - Less effect on vasculature, bronchioles, uterus, and metabolism
  - Safer in asthma, diabetes, peripheral vascular diseases
- Intrinsic sympathomimetic activity (ISA):
  - Act as partial agonists
  - Less bradycardia (β_1)
  - Slight vasodilation or bronchodilation (β_2)
  - Minimal change in plasma lipids (β_2)

- Pharmacokinetic properties: no CNS entry of atenolol
- General uses of beta blockers:
  - Angina, hypertension, post-MI (all drugs)
  - Antiarrhythmics (class II: propranolol, acebutolol, esmolol)
  - Glaucoma (timolol)
  - Migraine, thyrotoxicosis, performance anxiety, essential tremor (propranolol)
- Combined alpha-1 and beta-blocking activity:
  - Labetalol and carvedilol
  - Use in CHF (carvedilol) and in hypertensive emergencies (labetalol)
- K^+-channel blockade and beta-blocking activity: sotalol

Recall Question

Which of the following directly results from activation of the beta-2 receptor?

A. Decrease in blood pressure

B. Increase in cardiac output

C. Increase in heart rate

D. Increase in stroke volume

Answer: A

Autonomic Drugs: Glaucoma Treatment and ANS Practice Problems

4

LEARNING OBJECTIVES

- ❑ Describe mechanism for drugs used to treat glaucoma
- ❑ Apply strategies for identifying unknown drugs in ANS problems/tracings

GLAUCOMA TREATMENT

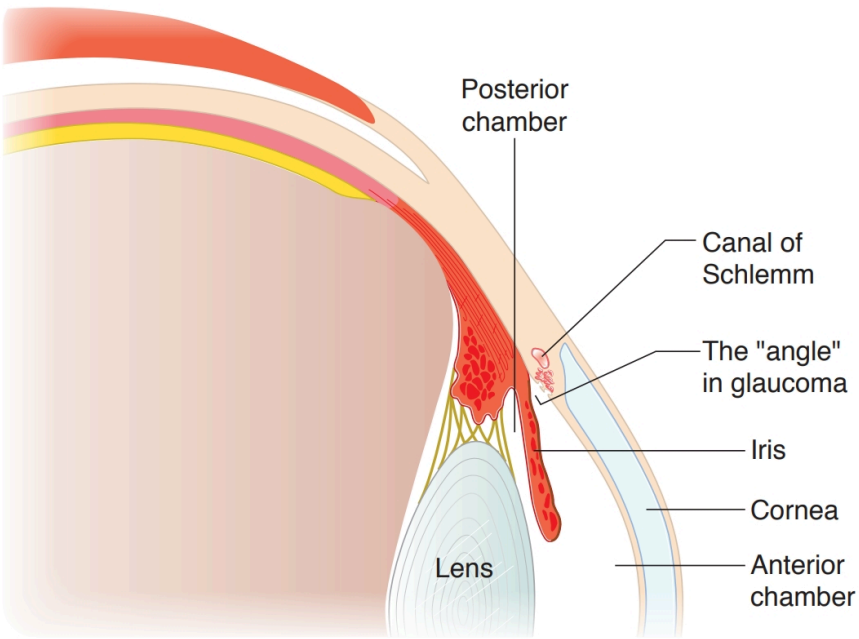


Figure II-4-1. Anatomy of the Eye Showing Irido-Corneal Angle Where Aqueous Humor Is Recirculated

Open-Angle Glaucoma

Open-angle glaucoma is a chronic condition with increased intraocular pressure (IOP) due to decreased reabsorption of aqueous humor. It leads to progressive (painless) visual loss and, if left untreated, blindness. IOP is a balance between fluid formation and its drainage from the globe.

Strategies in drug treatment of glaucoma include the use of beta blockers to decrease formation of fluid by ciliary epithelial cells and the use of $PGF_{2\alpha}$ analogs to improve aqueous humor drainage.

NOTE

Antimuscarinic drugs and α_1 agonists are contraindicated in closed-angle glaucoma.

Closed-Angle Glaucoma

Closed-angle glaucoma is an acute (painful) or chronic (genetic) condition with increased IOP due to blockade of the canal of Schlemm.

Emergency drug management prior to surgery usually involves carbonic anhydrase inhibitors, and/or mannitol.

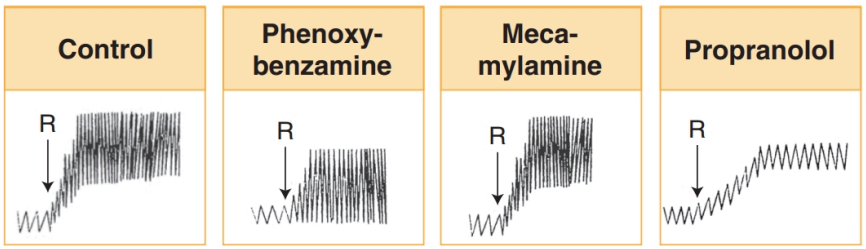
Treatment

Table II-4-1. Mechanism of Action of Drugs Used to Treat Glaucoma

Drug	Drug Class	Mechanism of Action
Timolol	Beta blockers	Block of beta-2 decreases aqueous humor formation
Latanoprost	$PGF_{2\alpha}$ analog	Increases aqueous humor drainage through the uveoscleral pathway
Apraclonidine	Alpha-2 agonist	Decreases aqueous humor formation and increases fluid drainage
Acetazolamide	CAI	Blocking carbonic anhydrase decreases aqueous humor formation

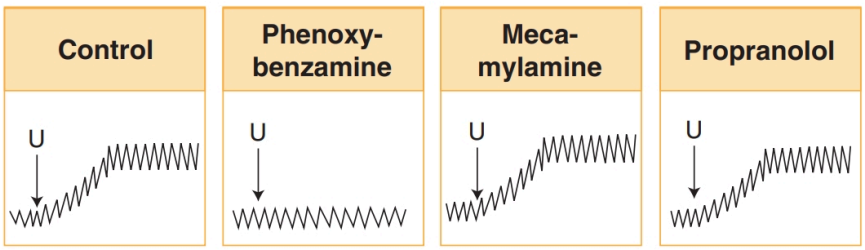
ANS PRACTICE PROBLEMS

1.



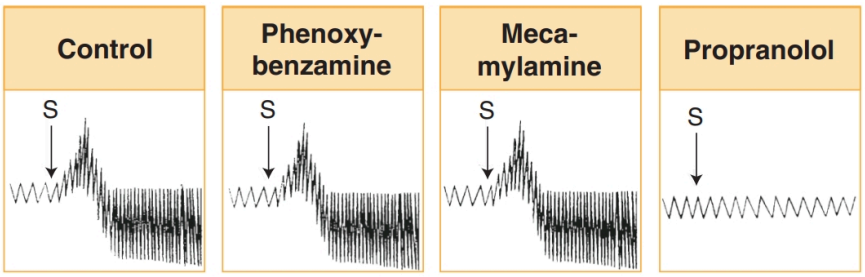
R is
A. Epinephrine
B. Norepinephrine
C. Phenylephrine
D. Isoproterenol
E. Terbutaline

2.



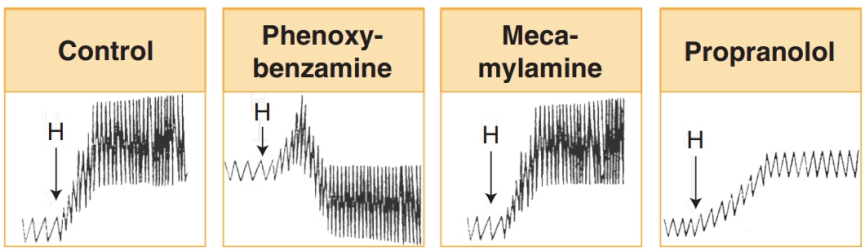
U is
A. Epinephrine
B. Norepinephrine
C. Phenylephrine
D. Isoproterenol
E. Tyramine

3.



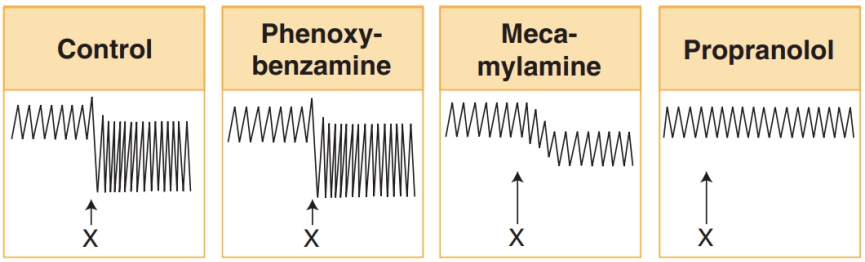
S is A. Epinephrine
B. Norepinephrine
C. Phenylephrine
D. Isoproterenol
E. Terbutaline

4.



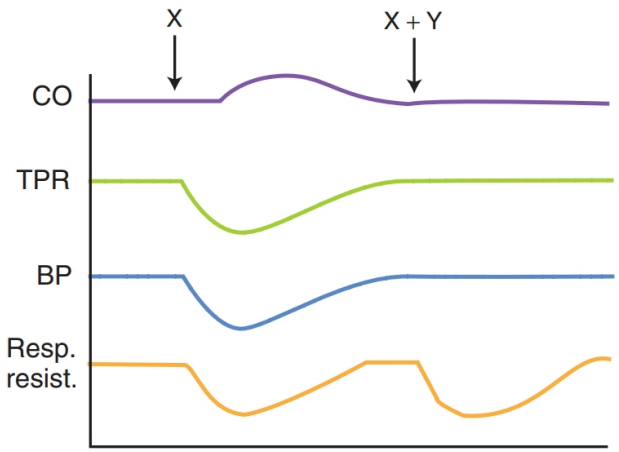
H is A. Epinephrine
B. Norepinephrine
C. Phenylephrine
D. Isoproterenol
E. Albuterol

5.



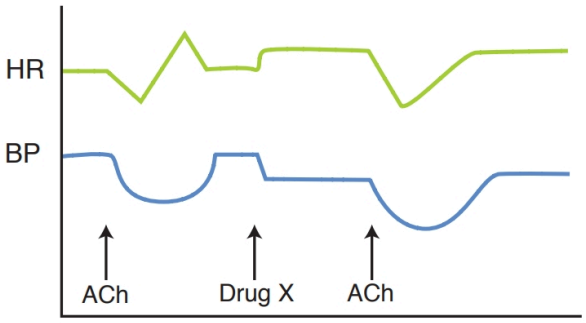
Drug X is most like
A. Epinephrine
B. Isoproterenol
C. Norepinephrine
D. Phenylephrine
E. Terbutaline

6.



X and Y are, respectively:
A. Isoproterenol and Propranolol
B. Epinephrine and Phenoxybenzamine
C. Norepinephrine and Phentolamine
D. Terbutaline and Phenylephrine
E. Acetylcholine and Hexamethonium

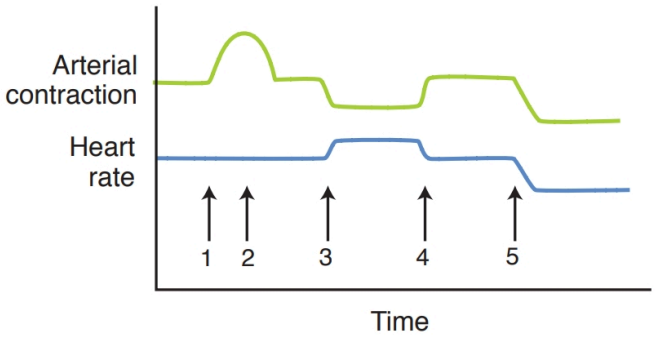
7.



What is drug X?

A. Hexamethonium
B. Neostigmine
C. Atropine
D. Scopolamine
E. Ipratropium

8.



Given the following information:

- Contractile force is measured in an isolated arterial preparation, and heart rate is measured in an isolated heart preparation.
- One drug is added at each specified time.
- No washout between drugs

A. Bethanechol
B. Epinephrine
C. Phenoxybenzamine
D. Pindolol
E. Phenylephrine

What drug is compatible with the response at each of the following times on the graph?

Time 1:

Time 2:

Time 3:

Time 4:

Time 5:

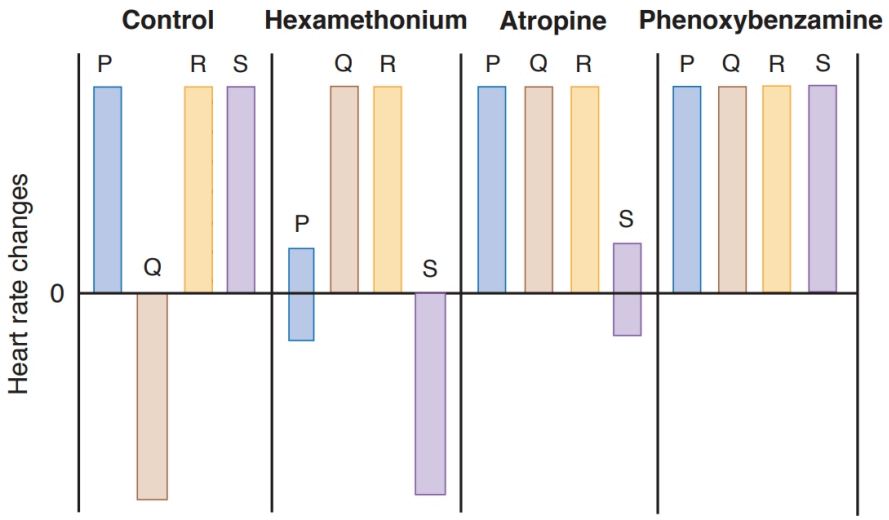
9. The circles below represent the size of the pupils of a patient's eyes, without treatment and with two different treatments.



The responses are compatible with the conclusion that the left eye had

A. been pretreated with atropine.
B. been pretreated with prazosin.
C. been pretreated with propranolol.
D. been pretreated with physostigmine.
E. denervation of the radial muscle.

10.



A. Acetylcholine
B. Hydralazine
C. Norepinephrine
D. Isoproterenol
E. Edrophonium

P is
Q is
R is
S is

ANSWERS AND EXPLANATIONS

1. **Answer: B.** The effects of Drug R are changed by treatment with either an alpha or beta blocker, so Drug R must have activity at both receptors (**choices C**, **D**, and **E** are ruled out). A pressor dose of epinephrine would be "reversed" by an alpha blocker, not just decreased! Drug R is norepinephrine.

2. **Answer: C.** The effects of Drug U are changed by treatment with the alpha blocker, but not by the beta blocker. Drug U must be an alpha-activator with no beta actions—the only choice is phenylephrine.

3. **Answer: D.** The effects of Drug S are changed by treatment with the beta blocker, but not by the alpha blocker (**choices A**, **B**, and **C** are ruled out). Terbutaline is β_2 selective and would not increase heart rate directly. Drug S is isoproterenol. Note that option A would have been a possibility, but one would have to assume a low dose of epinephrine.

4. **Answer: A.** The effects of Drug H are changed by treatment with either an alpha or beta blocker, so Drug H must have activity at both receptors (**choices C**, **D**, and **E** are ruled out). "Reversal" of a pressor effect can only occur if the drug has β_2 activity (**choice B** is ruled out). Drug H is epinephrine.

5. **Answer: E.** Mecamylamine blocked reflexed tachycardia induced by Drug X, which dropped blood pressure by vasodilation. Propranolol prevented all responses. Drug X is a β_2 agonist (terbutaline).

6. **Answer: D.** Drug X decreases TPR and BP, eliciting a reflex sympathetic discharge (note delay in response), resulting in increased CO. There is no direct effect on CO (**choices A**, **B**, **C**, and **E** are ruled out). Drugs X and Y are terbutaline and phenylephrine. Note that the alpha agonist does not antagonize the decrease in respiratory resistance (a β_2 response).

7. **Answer: A.** ACh (used as a drug) decreases blood pressure and heart rate, but the latter effect is overcome and reversed by a sympathetic reflex. Because Drug X abolishes only the reflex tachycardia, it must be the ganglion blocker hexamethonium (**choice A**). Remember, AChE inhibitors do not vasodilate because there is no parasympathetic innervation of the vasculature!

8. No autonomic reflexes are possible in isolated preparations, so every action observed in this experiment is due to a direct action of the drug. **Time 1:** Arterial contraction is due to an alpha-1 agonist (**choice E, phenylephrine**). **Time 2:** Arterial contraction is reversed by an alpha antagonist (**choice C, phenoxybenzamine**). **Time 3:** Tachycardia and arterial dilation are due to beta-1 and beta-2 actions (**choice B, epinephrine,** at a low dose). **Time 4:** Tachycardia and arterial dilation are reversed by a nonselective beta blocker (**choice D, pindolol**). **Time 5:** Bethanechol (**choice A, bethanechol**) causes both arterial relaxation and bradycardia.

9. **Answer: E.** Classic example showing that denervated tissues do not respond to indirect-acting agonists. In this case, amphetamine fails to cause mydriasis in the left eye, but this eye is more responsive than the right eye to phenylephrine (denervation supersensitivity).

10. Block of tachycardia due to Drug P by hexamethonium is indicative of a sympathetic reflex that follows a decrease in BP due to a vasodilator (**choice B, hydralazine**). "Reversal" of bradycardia due to Drug Q by hexamethonium indicates a vagal reflex elicited by vasoconstriction (e.g., alpha activation) masking cardiac stimulation (e.g., beta activation) (**choice C, norepinephrine**). Tachycardia due to Drug R is unaffected by any antagonist, indicative of a beta activator (**choice D, isoproterenol**). "Reversal" of tachycardia due to Drug S by hexamethonium indicates a sympathetic reflex masking a vagomimetic action typical of a muscarinic activator (**choice A, acetylcholine**); this is confirmed by the effect of atropine.

Autonomic Drug List and Practice Questions

5

Cholinergic Receptor Activators

Direct activators: bethanechol (M), methacholine (M and N), nicotine (N), pilocarpine (M), cevimeline (M)

AChE inhibitors: reversible—edrophonium, physostigmine, neostigmine, pyridostigmine, donepezil, rivastigmine

AChE inhibitors: irreversible—malathion, parathion

Cholinergic Receptor Antagonists

Muscarinic blockers: atropine, benztropine, ipratropium, scopolamine

Ganglionic blockers: hexamethonium, mecamylamine

Adrenergic Receptor Activators

α_1 agonists: phenylephrine

α_2 agonists: clonidine, methyldopa

β agonists: isoproterenol, ($\beta_1 = \beta_2$), dobutamine ($\beta_1 > \beta_2$)

β_2 agonists: albuterol, terbutaline, salmeterol

β_3 agonist: mirabegron

Mixed: dopamine (D_1, β_1, α_1), epinephrine (α_1, α_2, β_1, β_2), norepinephrine (α_1, α_2, β_1)

Indirect-acting: amphetamine, cocaine, ephedrine, tyramine

Adrenergic Receptor Antagonists

$\alpha_1$antagonists: doxazosin, prazosin, terazosin

α_2 antagonists: mirtazapine

Mixed α antagonists: phenoxybenzamine, phentolamine

β_1 (cardioselective) antagonists: acebutolol, atenolol, metoprolol

β_1, β_2 (nonselective): pindolol, propranolol, timolol

α_1 and β antagonists: carvedilol, labetalol

PRACTICE QUESTIONS

1. Alpha-1 agonists cause reflex bradycardia, which can be blocked by

   A. atenolol
   B. atropine
   C. mirtazapine
   D. phenylephrine
   E. propranolol

2. Which one of the following effects is caused by the ingestion of mushrooms that contain pilocarpine?

   A. Tachycardia
   B. Bronchodilation
   C. Diarrhea
   D. Hypertension
   E. Hyperthermia

3. Increasing the concentration of norepinephrine in adrenergic synapses leads to

   A. activation of dopa decarboxylase
   B. increased release of norepinephrine
   C. activation of presynaptic G_i coupled receptors
   D. stimulation of MAO
   E. activation of tyrosine hydroxylase

4. Urination in the human subject is decreased by

   A. muscarinic agonists
   B. muscarinic antagonists
   C. AChE inhibitors
   D. Nicotinic agonists
   E. Spider venom

5. A 5-year-old child becomes ill while visiting relatives who have a farm in Arkansas. His symptoms include severe abdominal cramps with vomiting and diarrhea and profuse lacrimation and salivation. Pupillary constriction is marked. The most likely cause is exposure to

   A. herbicides
   B. antifreeze
   C. lead-based paint
   D. insecticides
   E. rat poison

6. The activation of muscarinic receptors in bronchiolar smooth muscle is associated with

   A. activation of adenylyl cyclase
   B. decrease in cAMP formation mediated by G-proteins
   C. increase in IP_3 and DAG
   D. inhibition of protein kinase C
   E. opening of Na^+/K^+ cation channels

7. Ganglion blocking agents are of little clinical value today, but they are important drugs to know for solving cardiovascular drug problems because they can block

   A. all muscarinic receptors
   B. all nicotinic receptors
   C. all autonomic reflexes
   D. the direct actions of drugs on blood vessels
   E. the direct actions of drugs on the heart

8. An 11-year-old boy was brought to the ER by some of his friends because he "started going crazy" after eating seeds from a plant while "trying to get high." The boy was incoherent; his skin was hot and dry. His pupils were dilated and unresponsive to light. Blood pressure was 180/105 mm Hg, pulse was 150/min, and rectal temp was 40 C (104 F). The presumptive diagnosis was drug toxicity due to the ingestion of a compound similar to

   A. cannabis
   B. digoxin
   C. mescaline
   D. phencyclidine
   E. scopolamine

9. Reflex tachycardia caused by the systemic administration of albuterol can be blocked by what drug?

   A. Dobutamine
   B. Prazosin
   C. Phenylephrine
   D. Metoprolol
   E. Low-dose epinephrine

10. Cardiovascular effects of a new drug (X) that activates autonomic receptors are shown in the table below:

Parameter	Control	Drug X
Systolic BP	120 mm Hg	110 mm Hg
Diastolic BP	85 mm Hg	55 mm Hg
Heart rate	60/min	120/min

The most probable receptor affinities of drug X are

A. α_1, α_2
B. α_1, α_2, β_1
C. β_1, β_2
D. M_2
E. N_M

11. Thermoregulatory sweat glands in the body utilize what type of pathway?

A. Cholinergic nerves and muscarinic receptors
B. Adrenergic nerves and alpha-1 receptors
C. Adrenergic nerves and beta-2 receptors
D. Cholinergic nerves and N_M receptors
E. Neurohumorally released epinephrine

12. Activation of postsynaptic M_2 receptors on the heart is associated with

    A. activation of adenylyl cyclase
    B. decrease in cAMP formation
    C. increase in IP_3 and DAG
    D. inhibition of protein kinase C
    E. opening of Na^+/K^+ cation channels

13. The data in the table below show the effects of four drugs (#1–4) on mean blood pressure administered as individual agents before and after treatment with prazosin. The arrows denote the direction and intensity of drug actions on blood pressure.

Condition	Drug #1	Drug #2	Drug #3	Drug #4
Before prazosin	↑↑	↑↑	↓↓	↑
After prazosin	↑	↑	↓↓	↓

    The order of drug #1 through drug #4 is best represented by

    A. epinephrine—tyramine—isoproterenol—norepinephrine
    B. tyramine—isoproterenol—norepinephrine—epinephrine
    C. norepinephrine—isoproterenol—epinephrine—tyramine
    D. isoproterenol—epinephrine—tyramine—norepinephrine
    E. norepinephrine—tyramine—isoproterenol—epinephrine

14. Prior to an eye exam a patient is given a drug that causes mydriasis but has no effect on accommodation. What is the most likely identity of this drug?

    A. Mecamylamine
    B. Neostigmine
    C. Pilocarpine
    D. Phenylephrine
    E. Tropicamide

15. Following a myocardial infarct, a 40-year-old man is being treated prophylactically with propranolol. You would be concerned about the use of this drug if the patient also had what comorbid condition?

    A. Essential tremor
    B. Glaucoma
    C. Classic/stable angina
    D. Supraventricular tachycardia
    E. Diabetes

16. Following pretreatment with a muscarinic receptor blocking agent, the IV administration of norepinephrine is likely to result in

    A. ↑HR and ↑ BP
    B. ↑ HR and ↓ BP
    C. ↓ HR and ↓ BP
    D. ↓ HR and ↑ BP
    E. No effect on HR, but ↑ BP

17. A 45-year-old man has recently been the recipient of a heart transplant. Which one of the following drugs is least likely to cause tachycardia in this patient?

    A. Amphetamine
    B. Dobutamine
    C. Epinephrine
    D. Isoproterenol
    E. Norepinephrine

18. A colleague with myasthenia gravis wants you to assist him to the ER because he is experiencing muscle weakness and has found it difficult to titrate his drug dosage because he has had the "flu." You note that he has a slight temperature, shallow respirations, and a gray-blue skin pallor. What would be the most appropriate drug to give to your colleague at this time?

    A. Albuterol
    B. Edrophonium
    C. Propranolol
    D. Physostigmine
    E. Scopolamine

19. Carvedilol is an effective antihypertensive agent that, like propranolol, is capable of blocking beta receptors. An important difference between the two drugs is that carvedilol

    A. is a selective blocker of cardiac β_1 receptors
    B. has intrinsic sympathomimetic activity
    C. is available only as eye drops
    D. has α_1 receptor blocking actions
    E. stimulates β_2 receptors in bronchioles

20. Neostigmine differs from pilocarpine in having effects on

    A. bladder tone
    B. bowel motility
    C. heart rate
    D. salivary glands
    E. skeletal muscle

Questions 21–23

The table below shows the effects of three receptor activators on heart rate in anesthetized animals, administered as individual drugs and following pretreatment with one of four different receptor antagonists. The arrows denote the direction of effects on heart rate; the symbol (–) denotes no change from normal HR.

Antagonist Pretreatment	Agonist 1	Agonist 2	Agonist 3
None	↑	↓	↓
Atropine	↑	–	↑
Prazosin	↑	–	↑
Propranolol	–	↓	↓
Mecamylamine	↑	–	↑

Identify the agonist drugs from the following list:

A. Acetylcholine
B. Low-dose epinephrine
C. Norepinephrine
D. Phenylephrine
E. Physostigmine

21. Agonist 1

22. Agonist 2

23. Agonist 3

ANSWERS AND EXPLANATIONS

1. **Answer: B.** Bradycardia due to vagal stimulation is elicited by activation of muscarinic receptors in the heart. Atropine, which is an antagonist at M receptors, blocks bradycardia elicited by stimulation of the vagus, including reflex bradycardia due to increases in mean BP caused by vasoconstrictors.

2. **Answer: C.** Pilocarpine is present in several mushroom species including *Amanita muscaria*, the ingestion of which is associated with the stimulation of M receptors (parasympathomimetic effects). Activation of muscarinic receptors in the GI tract causes diarrhea. The activation by pilocarpine of M receptors present on vascular endothelial cells would lead to hypotension (not hypertension) via the release of NO. All of the other effects listed are typical of muscarinic antagonists.

3. **Answer: C.** In sympathetic nerve endings, presynaptic α_2 receptors are coupled to inhibitory G-proteins. These receptors serve an autoregulatory function to inhibit further neurotransmitter release and also to decrease the synthesis of norepinephrine.

4. **Answer: B.** Urinary retention is a well-known adverse effect of drugs that have antagonist effects on muscarinic receptors. In addition to the prototypic drug atropine, M blockers include drugs used in Parkinson disease, such as benztropine. Acetylcholine directly and AChE inhibitors (edrophonium, physostigmine) indirectly activate M receptors in the GU system, causing bladder contraction with voiding and incontinence. Activation of nicotinic receptors in ANS ganglia would lead to the stimulation of PANS functions.

5. **Answer: D.** The symptoms of cholinergic excess seen in this child are indicative of exposure to insecticides such as the organophosphate parathion, which cause irreversible inhibition of acetylcholinesterase. Other symptoms may include CNS excitation and stimulation of the skeletal NMJ, ultimately leading to paralysis of respiratory muscles—"DUMBBEELSS." In addition to symptomatic support, management of AChE inhibitor poisoning involves the use of atropine and 2-PAM.

6. **Answer: C.** Muscarinic receptors present in bronchiolar smooth muscle are of the M_3 subtype coupled via G_q proteins to phospholipase C. Activation of this enzyme causes hydrolysis of phosphatidylinositol bisphosphate, with release of IP_3 and DAG (the latter activates protein kinase C). Decreased formation of cAMP mediated via a G_i protein occurs with activation of M_2 receptors such as those in the heart. Cation channel opening occurs in response to activation of nicotinic receptors.

7. **Answer: C.** Ganglion blockers (hexamethonium, mecamylamine) block N_N receptors at autonomic ganglia and the adrenal medulla. As such, they can block all autonomic reflexes, including those elicited by changes in blood pressure. They have no effect on nicotinic receptors at the neuromuscular junction (N_M) or on the direct actions of drugs on the blood vessels or heart.

8. **Answer: E.** The signs and symptoms experienced by this boy are highly suggestive of the ingestion of a compound with strong muscarinic receptor-blocking actions. The leaves and seeds of jimsonweed (*Datura stramonium*) contain anticholinergic compounds, including atropine, hyoscyamine, and scopolamine—approximately 50 seeds may cause severe toxicity. In addition to symptomatic support, management of poisoning (or drug overdose) due to M blockers may involve use of the AChE inhibitor physostigmine.

9. **Answer: D.** Although used primarily via inhalation for asthma, systemic effects of albuterol include vasodilation due to its β_2 receptor activation. This can result in a decrease in TPR and mean BP, which elicits a reflex tachycardia. Reflex tachycardia could be blocked at the heart with a beta blocker such as metoprolol or by ganglion blockers (mecamylamine), which prevent all autonomic reflexes. Dobutamine stimulates beta-1 receptors causing tachycardia. Phenylephrine stimulates alpha-1 receptors, which would raise TPR and BP and evoke a reflex bradycardia that doesn't block tachycardia caused by albuterol. Prazosin blocks alpha-1 receptors decreasing TPR and BP and causing a reflex tachycardia. Low-dose epinephrine stimulates beta-1 and beta-2 receptors and will cause tachycardia.

10. **Answer: C.** A decrease in mean blood pressure, an increase in pulse pressure, plus a marked increase in heart rate are characteristic of a drug such as isoproterenol. PVR and mean BP are decreased because of activation of β_2 receptors in the vasculature. Systolic BP decreases less than diastolic BP because of activation of β_1 receptors in the heart, leading to an increase in stroke volume, as well as the increase in heart rate.

11. **Answer: A.** Thermoregulatory sweat glands are innervated only by the sympathetic nervous system. The pathway is unusual in that the postganglionic neuron releases acetylcholine. Thus, the receptors on sweat glands are muscarinic (M_3). The term *neurohumoral* means "nerve-blood." The only site in the ANS where neurohumoral transmission occurs is the adrenal medulla, where sympathetic nerve activity elicits the release of catecholamines (mostly epinephrine) into the blood. Epinephrine cannot bind to muscarinic receptors.

12. **Answer: B.** Postsynaptic muscarinic receptors on the heart (M_2) are G_i protein coupled to inhibition of adenylyl cyclase and decreased formation of cAMP.

13. **Answer: E.** Of the drugs listed, only isoproterenol causes a decrease in mean blood pressure, because it activates beta receptors and has no effect on alpha receptors. This permits identification of drug #3 as isoproterenol. Prazosin is an alpha blocker, so one can anticipate that this drug would antagonize any increases in blood pressure that result from activation of α_1 receptors in the vasculature. Epinephrine (high dose), norepinephrine, and tyramine all exert pressor effects via activation of α_1 receptors. However, only epinephrine is active on β_2 receptors, and this action would be revealed by vasodilation and a reversal of its pressor effects following treatment with an alpha blocker—"epinephrine reversal." Thus, drug #4 can be identified as epinephrine.

14. **Answer: D.** Mydriasis can be caused by either a muscarinic antagonist or an alpha-1 agonist. Cycloplegia (paralysis of accommodation) is caused by a muscarinic antagonist, but accommodation is unaffected by an alpha-1 agonist such as phenylephrine. Remember accommodation is a parasympathetic function only. Ganglionic blockade with mecamylamine would cause mydriasis and cycloplegia similar to a muscarinic blocker.

15. **Answer: E.** Propranolol is a nonselective beta blocker that causes hypoglycemia by blocking glycogenolysis and gluconeogenesis in the liver and skeletal muscle. This is of particular concern in a patient with diabetes. The other conditions listed are all potential uses for beta blockers, including essential tremor where it is important to use a nonselective beta blocker.

16. **Answer: A.** Norepinephrine activates α_1 and β_1 receptors, causing increases in PVR and CO. The increase in mean BP can elicit reflex bradycardia (vagal outflow leads to stimulation of cardiac M receptors), which may overcome the direct stimulatory effects of NE on the heart. However, reflex bradycardia is not possible following pretreatment with an M blocker. Thus, HR increases because of the direct activation of cardiac β_1 receptors by NE.

17. **Answer: A.** This question is to remind you that indirect-acting sympathomimetics require innervation of the effector organ to exert effects. In this case, amphetamine would not be effective because the transplanted heart lacks sympathetic innervation; thus, there is no "mobile pool" of NE capable of being released by a drug. However, transplanted hearts retain receptors, including those (β_1) responsive to direct-acting sympathomimetics. Heart transplants are not responsive to AChE inhibitors because they, too, are indirect acting and require vagal innervation to exert effects on the heart.

18. **Answer: B.** Edrophonium is a very short-acting (reversible) AChE inhibitor that has been used in the diagnosis of myasthenia gravis. The drug is useful for distinguishing between muscle weakness attributable to excessive cholinergic receptor stimulation (usually due to overdose of a AChE inhibitor) and the symptoms of myasthenia (reflecting inadequate treatment). If symptoms improve with a single dose of edrophonium, then an increase in the dose of neostigmine or pyridostigmine is indicated. If symptoms worsen, then the dose of neostigmine should be reduced.

19. **Answer: D.** The effectiveness of carvedilol in the management of hypertension and in congestive heart failure appears to be due to a combination of antagonistic actions at both alpha and beta adrenoceptors. Carvedilol is not a β_1 selective blocking agent (unlike atenolol and metoprolol), and (unlike pindolol and acebutolol) it lacks intrinsic sympathomimetic activity.

20. **Answer: E.** As an inhibitor of AChE, neostigmine exerts effects to enhance the actions of ACh at all innervated effector sites where ACh is a neurotransmitter. These include all ANS ganglia, PANS postganglionic neuroeffector junctions, and SANS innervation of thermoregulatory sweat glands. Pilocarpine activates M receptors and has no effects at conventional dose levels on nicotinic receptors such as those in ANS ganglia and the skeletal NMJ.

21. **Answer: B.**

22. **Answer: D.**

23. **Answer: C.** Agonist 1 increases HR, presumably through direct activation of cardiac β_1 receptors because the effect is blocked by propranolol but is not influenced by the alpha blocker (prazosin), the ganglion blocker (mecamylamine), or blockade of M receptors (atropine). Only two of the listed drugs directly activate cardiac receptors: epinephrine and norepinephrine. For NE, any direct cardiac stimulation is counteracted by reflex bradycardia resulting from the increase in mean BP via its activation of α_1 receptors in blood vessels (it has no effects on β_2 vascular receptors). Therefore, agonist 1 is identified as epinephrine, which activates both β_1 and β_2 receptors directly at low doses.

    To identify agonists 2 and 3, recognize that although the alpha blocker prazosin simply neutralizes the effect of agonist 2 on HR, it reverses the effect of agonist 3. This could occur only if agonist 3 was capable of β_1 receptor activation in the heart. Direct cardiac stimulation could occur with norepinephrine (agonist 3) but not with phenylephrine (agonist 2), which is a selective alpha-1 agonist.

PART III

CARDIAC AND RENAL DRUGS

1 Diuretics

LEARNING OBJECTIVES

- ❑ Identify sites of action of diuretics in the nephron
- ❑ Describe mechanism, clinical indications/uses, and side effects for different types of diuretics

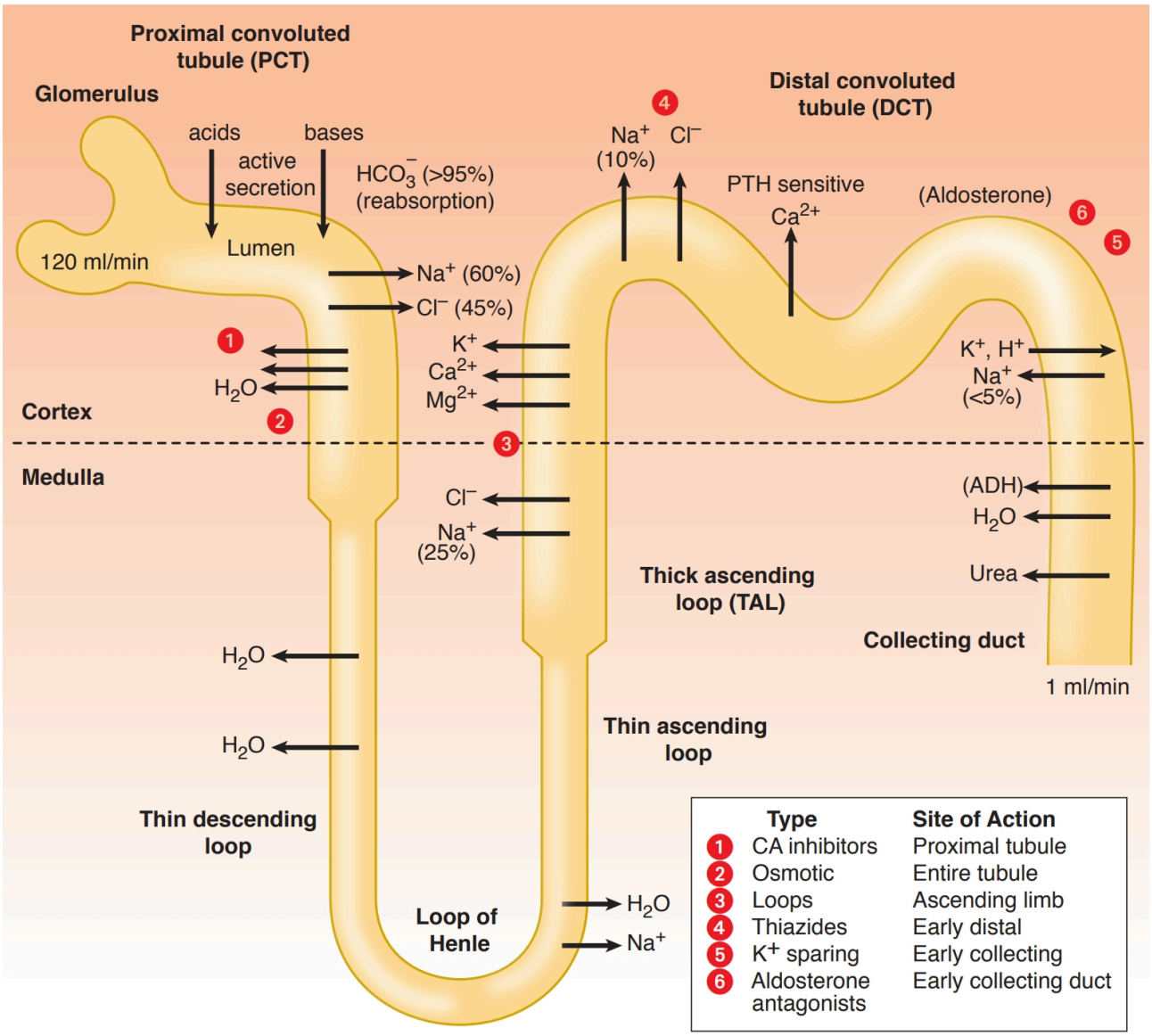


Figure III-1-1. Actions of Diuretics at the Various Renal Tubular Segments

TYPES OF DIURETICS

Osmotic Diuretics

- Mannitol (IV) inhibits water reabsorption throughout the tubule.
- It increases urine volume.
- Uses:
  - ↓ IOP in glaucoma
  - ↓ intracerebral pressure
  - Oliguric states (e.g., rhabdomyolysis)
- Side effects: acute hypovolemia

CLINICAL CORRELATE

Osmotic diuretics are contraindicated in CHF and pulmonary edema because they draw water from the cells and increase the filling pressure of the heart.

Carbonic Anhydrase Inhibitors

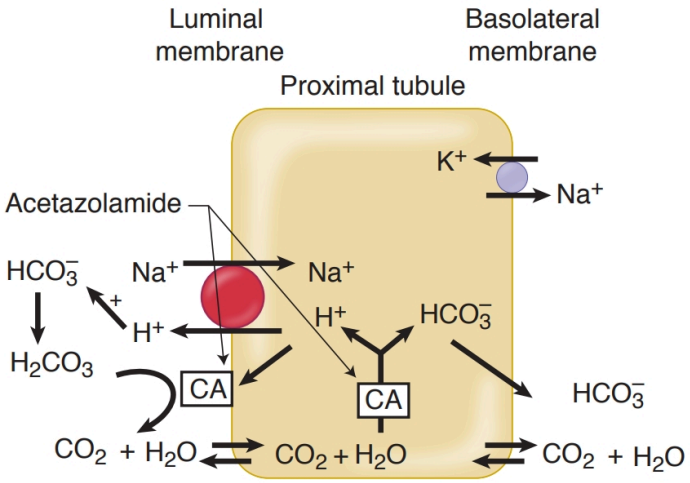


Figure III-1-2. Actions of Carbonic Anhydrase Inhibitors

- Drugs: **acetazolamide** and **dorzolamide**
- Mechanism: carbonic anhydrase inhibition, results in:
  - ↓ H^+ formation inside PCT cell
  - ↓ Na^+/H^+ antiport
  - ↑ Na^+ and HCO_3^- in lumen
  - ↑ diuresis
- Uses:
  - Glaucoma
  - Acute mountain sickness
  - Metabolic alkalosis
- Side effects:
  - Bicarbonaturia and acidosis
  - Hypokalemia

- Hyperchloremia
- Paresthesias
- Renal stones
- Sulfonamide hypersensitivity

Loop Diuretics

High-Yield

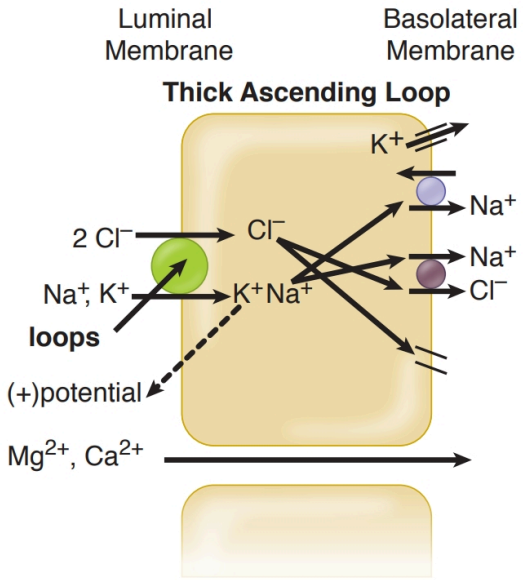


Figure III-1-3. Actions of Loop Diuretics on the Thick Ascending Loop (TAL)

- Drugs: **furosemide**, **torsemide**, and **ethacrynic acid**
- Mechanism: $Na^+/K^+/2Cl^-$ transporter inhibition, results in:
  - ↓ intracellular K^+ in TAL
  - ↓ back diffusion of K^+
  - ↓ positive potential
  - ↓ reabsorption of Ca^{2+} and Mg^{2+}
  - ↑ diuresis
- Uses:
  - Acute pulmonary edema
  - Heart failure
  - Hypertension
  - Refractory edemas
  - Hypercalcemic states (limited use)

NOTE

Sulfonamide-containing drugs have cross allergenicity with:

- Carbonic anhydrase inhibitors
- All loop diuretics (except ethacrynic acid)
- Thiazides
- Sulfa antibiotics
- Celecoxib

- Side effects:
  - Sulfonamide hypersensitivity (not ethacrynic acid)
  - Hypokalemia and alkalosis
  - Hypocalcemia
  - Hypomagnesemia
  - Hyperuricemia (actively secreted by the OAT)
  - Ototoxicity (ethacrynic acid > furosemide)
- Drug interactions
  - Aminoglycosides (enhanced ototoxicity)
  - Lithium (chronic loop administration, ↓ clearance)
  - Digoxin (↑ toxicity due to electrolyte disturbances)

CLINICAL CORRELATE

An important difference between loops and thiazides is that loops **promote** calcium excretion, while thiazides **decrease** calcium excretion.

Thiazides

High-Yield

CLINICAL CORRELATE

Thiazides also hyperpolarize both smooth muscle cells (vasodilation) and pancreatic beta cells (decrease insulin release)

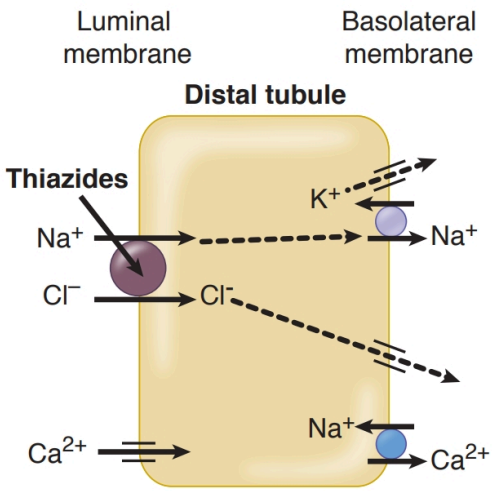


Figure III-1-4. Actions of Thiazides on the Distal Convoluted Tubule (DCT)

- Drugs: **hydrochlorothiazide**, **chlorthalidone**, and **indapamide**
- Mechanism: Na^+/Cl^- transporter inhibition, results in:
  - ↑ luminal Na^+ and Cl^- in DCT
  - ↑ diuresis
- Uses:
  - Hypertension, CHF
  - Nephrolithiasis (calcium stones)
  - Nephrogenic diabetes insipidus
- Side effects:
  - Sulfonamide hypersensitivity
  - Hypokalemia and alkalosis

- Hypercalcemia
- Hyperuricemia (actively secreted by the OAT)
- Hyperglycemia
- Hyperlipidemia (except indapamide)

• Drug interactions and cautions:

- Digoxin (↑ toxicity due to electrolyte disturbances)

Recall Question

Furosemide inhibits water reabsorption at which part of the renal anatomy?

A. Collecting duct

B. Thin ascending loop

C. Thin descending loop

D. Thick ascending loop

Answer: D

K^+-Sparing Agents

High-Yield

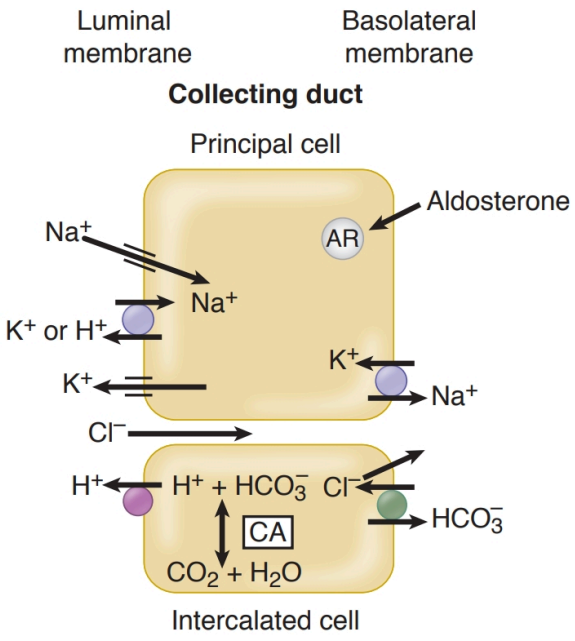


Figure III-1-5. Actions of Potassium-Sparing Agents on Collecting Tubules

CLINICAL CORRELATE

Combining K^+-sparing diuretics with ACEIs or ARBs may cause hyperkalemia.

NOTE

Diuretics that block Na^+ reabsorption at segments above the collecting ducts will increase sodium load to the collecting tubules and ducts ("downstream"). This results in increased loss of $K^+ \rightarrow$ **hypokalemia**. In the case of both loop and thiazide diuretics, the associated loss of H^+ results in **alkalosis**.

NOTE

Eplerenone is a selective aldosterone receptor blocker devoid of antiandrogenic effect.

- Drugs:
  - **Spironolactone:** aldosterone-receptor antagonist
    - Uses: hyperaldosteronic state; adjunct to K^+-wasting diuretics; antiandrogenic uses (female hirsutism); congestive heart failure
    - Side effects: hyperkalemia and acidosis; antiandrogen
  - Amiloride and triamterene: Na^+-channel blockers
    - Uses: adjunct to K^+-wasting diuretics, lithium-induced nephrogenic diabetes insipidus (amiloride)
    - Side effects: hyperkalemia and acidosis

Table III-1-1. Modes of Action and Effects of Various Classes of Diuretics

Drug	Mechanisms of Action	Urinary Electrolytes	Blood pH
Acetazolamide	Inhibition of carbonic anhydrase in PCT	↑ Na^+ ↑ K^+ ↑↑ HCO_3^-	Acidosis
Ethacrynic acid, furosemide, torsemide	Inhibition of $Na^+/K^+/2Cl^-$ cotransporter in TAL	↑↑ Na^+ ↑ K^+ ↑ Ca^{2+} ↑ Mg^{2+} ↑ Cl^-	Alkalosis
Hydrochlorothiazide, indapamide, chlorthalidone	Inhibition of Na^+/Cl^- cotransporter in DCT	↑ Na^+ ↑ K^+ ↑ Cl^- ↓ Ca^{2+}	Alkalosis
Amiloride, triamterene, spironolactone, eplerenone	Block Na^+ channels, block aldosterone receptors in collecting tubule	↑ Na^+ (small) ↓ K^+	Acidosis

2 Antihypertensives

LEARNING OBJECTIVES

- ❑ Identify key pharmacologic strategies for lowering blood pressure
- ❑ Describe mechanism and side effects for antihypertensive drugs
- ❑ Identify drugs indicated/useful in comorbidities
- ❑ Describe mechanism of drugs used in primary pulmonary hypertension

DRUG STRATEGY

- ↓ TPR
- ↓ CO
- ↓ body fluid volume
- ↓ BP may result in homeostatic regulation:
  - Reflex tachycardia (↑ sympathetic activity)
  - Edema (↑ renin activity)

CLINICAL CORRELATE

Current recommendations are to use thiazide diuretics, ACEIs, or long-acting CCBs as first-line therapy (all equally effective).

FIRST-LINE ANTIHYPERTENSIVES

Thiazide Diuretics

High-Yield

Thiazide diuretics are commonly used in the management of hypertension.

Angiotensin-Converting Enzyme Inhibitors (ACEIs) and Angiotensin-Receptor Blockers (ARBs)

High-Yield

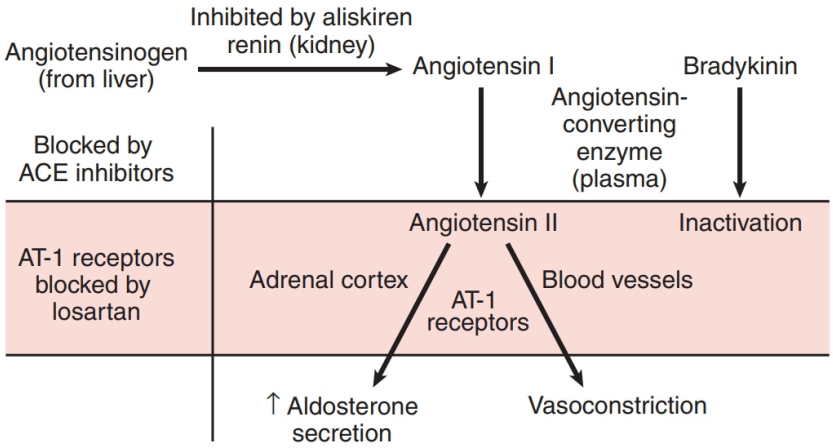


Figure III-2-1. The Angiotensin System

- Drugs:
  - ACEIs: **captopril, lisinopril** (and other "–prils")
    - Block formation of angiotensin II
    - Resulting in prevention of AT_1-receptor stimulation
    - ↓ aldosterone, vasodilation
    - ACEIs prevent bradykinin degradation
  - ARBs: **losartan** (and other "–sartans")
    - Block AT_1 receptors
    - Same results as ACEIs on BP mechanisms
    - ARBs do not interfere with bradykinin degradation
  - Renin inhibitor: aliskiren
    - Blocks formation of angiotensin I
    - Same results as ACEIs on BP mechanisms
    - Aliskiren does not interfere with bradykinin degradation
- Uses:
  - Mild-to-moderate hypertension (all)
  - Protective of diabetic nephropathy (ACEI/ARBs)
  - CHF (ACEI/ARBs)

- Side effects:
  - Dry cough (ACEIs)
  - Hyperkalemia
  - Acute renal failure in renal artery stenosis
  - Angioedema
- Contraindication: pregnancy

Calcium-Channel Blockers

High-Yield

Calcium-channel blockers (CCBs) block L-type Ca^{2+} channels in heart and blood vessels.

- Results in ↓ intracellular Ca^{2+}
- Causes ↓ CO (verapamil and diltiazem), ↓ TPR (all CCBs)
- Drugs: verapamil, diltiazem, **dihydropyridines** (–"dipines," prototype: **nifedipine**)

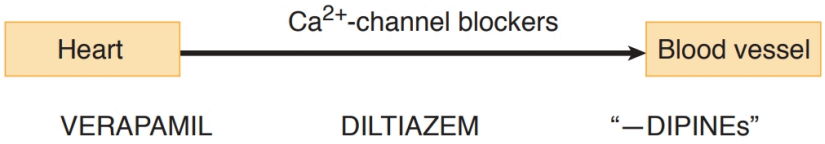


Figure III-2-2. Cardiac or Vascular Selectivity of Major Ca^{2+}-Channel Blockers

- Uses:
  - Hypertension (all drugs)
  - Angina (all drugs)
  - Antiarrhythmics (verapamil, diltiazem)
- Side effects:
  - Reflex tachycardia ("–dipines")
  - Gingival hyperplasia ("–dipines")
  - Constipation (verapamil)

BRIDGE TO PHYSIOLOGY

Vasodilators may have specificity.

- Arteriolar: Ca^{2+}-channel blockers, hydralazine, K^{+}-channel openers
- Venular: nitrates
- Both arteriolar and venular: "the rest"

Orthostatic (postural) hypotension results from venular dilation (not arteriolar) and mainly results from α_1 blockade or decreased sympathetic tone.

DRUGS ALTERING SYMPATHETIC ACTIVITY

CLINICAL CORRELATE

Beta blockers are not considered first-line antihypertensives but are used in hypertensive patients with selective comorbidities such as stable angina, CHF, and post-MI.

Beta Blockers

- Mechanism (*See* ANS section)
  - Side effects:
    - Cardiovascular depression
    - Fatigue
    - Sexual dysfunction
    - ↑ LDLs and TGs
  - Cautions in use:
    - Asthma
    - Vasospastic disorders
    - Diabetics (alteration of glycemia and masking of tachycardia due to hypoglycemic events)

Alpha-1 Blockers

- Decrease arteriolar and venous resistance
- Reflex tachycardia
- Drugs: **prazosin, doxazosin, terazosin**
- Uses:
  - Hypertension
  - BPH: relax the smooth muscle of the prostate and bladder neck, which allows urine to flow more easily
- Side effects: "first-dose" syncope; orthostatic hypotension; urinary incontinence
- Advantage: good effect on lipid profile (↑ HDL, ↓ LDL)

Alpha-2 Agonists

- Drugs: **clonidine** and **methyldopa** (prodrug)
- α_2 stimulation: ↓ in sympathetic outflow; ↓ TPR but also ↓ HR
- Uses:
  - Mild-to-moderate hypertension (both)
  - Opiate withdrawal (clonidine)
  - Hypertensive management in pregnancy (methyldopa)
- Side effects: positive Coombs test (methyldopa); CNS depression (both); edema (both)
- Drug interactions: tricyclic antidepressants ↓ antihypertensive effects of α_2 agonists

DIRECT-ACTING VASODILATORS

Drugs Acting Through Nitric Oxide

- **Hydralazine**
  - ↓ TPR via arteriolar dilation
  - Use: moderate-to-severe hypertension
  - Side effects: SLE-like syndrome in slow acetylators; edema; reflex tachycardia
- **Nitroprusside**
  - ↓ TPR via dilation of both arterioles and venules
  - Use: hypertensive emergencies (used IV)
  - Side effects: cyanide toxicity

Drugs Acting to Open Potassium Channels

- Drugs: **minoxidil** and diazoxide
  - Open K^+ channel, causing hyperpolarization of smooth muscle
  - Results in arteriolar vasodilation
  - Uses:
    - Insulinoma (diazoxide)
    - Severe hypertension (minoxidil)
    - Baldness (topical minoxidil)
  - Side effects:
    - Hypertrichosis (minoxidil)
    - Hyperglycemia (↓ insulin release [diazoxide])
    - Edema
    - Reflex tachycardia

CLINICAL CORRELATE

Chronic (preexisting) hypertension in pregnancy is often treated with methyldopa or labetalol, while preeclampsia (new-onset hypertension in pregnancy) is treated with labetalol or hydralazine.

CLINICAL CORRELATE

Hydroxocobalamin + sodium thiosulfate are recommended for **cyanide poisoning**. The cobalt molecule in hydroxocobalamin binds cyanide-forming cyanocobalamin, which is readily excreted in the urine.

ANTIHYPERTENSIVE DRUGS IN COMORBID CONDITIONS

CLINICAL CORRELATE

A hypertensive emergency occurs when hypertension is severe enough to cause end-organ damage. Most commonly, nitroprusside, labetalol, or the D1 agonist fenoldopam is given intravenously as therapy.

Table III-2-1. Use of Antihypertensive Drugs in Comorbid Conditions

Indication	Suitable Drug(s)
Angina	Beta blockers, CCBs
Diabetes	ACEIs, ARBs
Heart failure	ACEIs, ARBs, beta blockers
Post-MI	Beta blockers
BPH	Alpha blockers
Dyslipidemias	Alpha blockers, CCBs, ACEIs/ARBs
Chronic kidney disease	ACEI, ARBs

Recall Question

Angiotensin converting enzyme inhibitors (ACEIs) have the side effect of dry cough due to preventing degradation of what substance?

A. Angiotensinogen

B. Angiotensin I

C. Bradykinin

D. Renin

Answer: C

TREATMENT OF PRIMARY PULMONARY HYPERTENSION

Bosentan

Endothelin (ET)-1 is a powerful vasoconstrictor through ET-A and -B receptors. Bosentan is an ET-A receptor antagonist.

- Administered orally
- Side effects: those associated with vasodilation (headache, flushing, hypotension)
- Contraindication: pregnancy

Prostacyclin (PGI_2): Epoprostenol

- Administered via infusion pumps

Sildenafil

- Inhibits type V PDE
- Increases cGMP
- Pulmonary artery relaxation
- Decreases pulmonary hypertension

Heart Failure Drugs

3

LEARNING OBJECTIVES

- ❑ Describe strategies for managing CHF and match to specific indications of corresponding drugs
- ❑ Compare and contrast mechanism for positive inotropes
- ❑ Describe digoxin toxicity and management

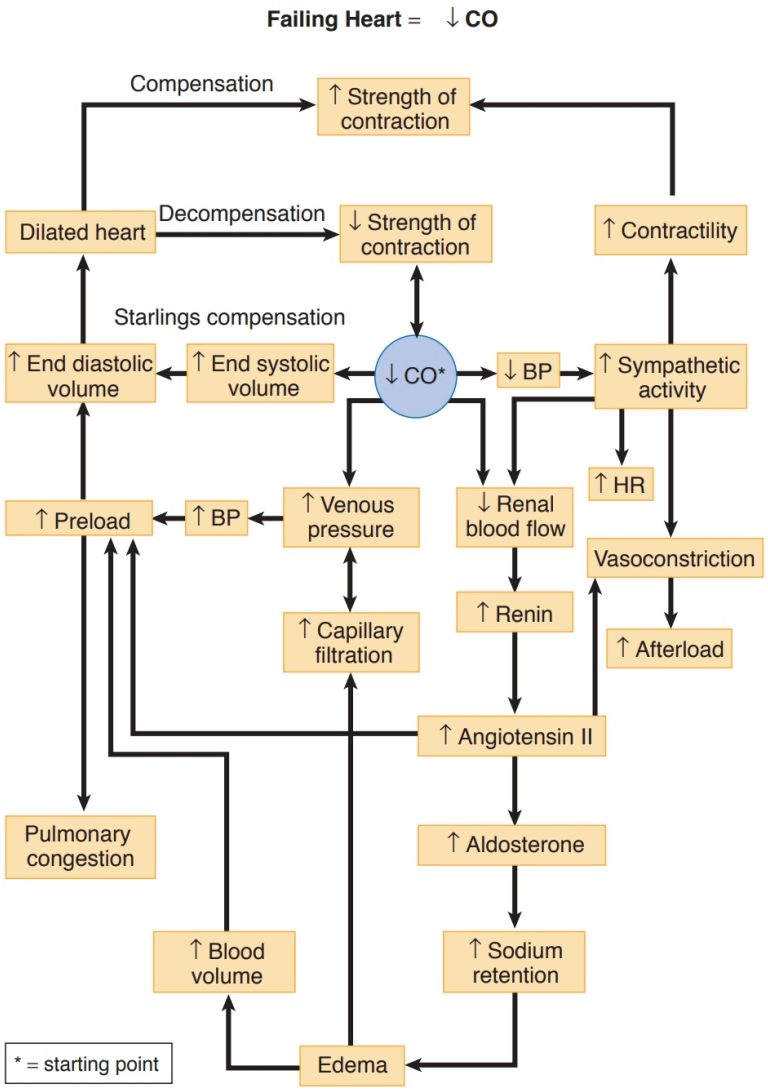


Figure III-3-1. The Failing Heart

CLINICAL CORRELATE

Left systolic dysfunction secondary to coronary artery disease is the most common cause of heart failure.

Pharmacotherapy aimed at:

- ↓ preload: diuretics, ACEIs, ARBs, and venodilators
- ↓ afterload: ACEIs, ARBs, and arteriodilators
- ↑ contractility: digoxin, beta agonists, PDE III inhibitors
- ↓ remodeling of cardiac muscle: ACEIs, ARBs, spironolactone, beta blockers

Whereas digoxin does not improve survival, ACEIs, ARBs, beta blockers, and spironolactone have been proven beneficial in CHF. ACEIs and ARBs are currently drugs of choice for the chronic management of CHF. Inotropes are more beneficial in management of acute CHF.

PRIMARY TREATMENTS FOR CHF

- ACEI (ARB as an alternative)
- Beta blockers (metoprolol, bisoprolol, carvedilol)
  - Provide antiarrhythmic effect and also ↓ remodeling
- Diuretics
  - Loop or thiazide diuretics to decrease preload
  - Spironolactone or eplerenone to block aldosterone receptors and ↓ remodeling (used in advanced CHF)
- Hydralazine + isosorbide dinitrate
  - Preferred for chronic therapy in patients who cannot tolerate an ACEI or ARB

INOTROPES

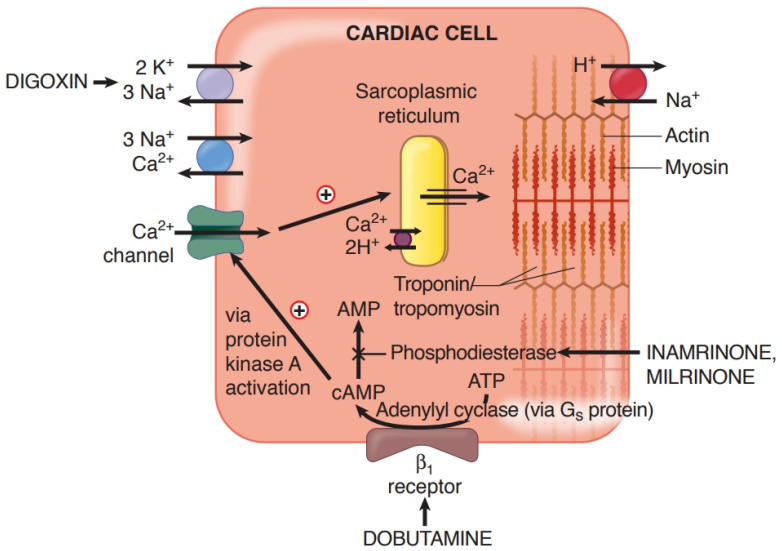


Figure III-3-2. Mechanism of Action of Inotropes

Digoxin

High-Yield

- Direct effect: inhibition of cardiac Na^+-K^+ ATPase
  - Results in ↑ intracellular Na^+
  - Decreases Na^+/Ca^{2+} exchange
  - Increases intracellular Ca^{2+}
  - Increases Ca^{2+} release from sarcoplasmic reticulum
  - Increases actin-myosin interaction
  - Increases contractile force
- Indirect effect: inhibition of neuronal Na^+-K^+ ATPase (results in ↑ vagal activity)
- Pharmacokinetics:
  - Renal clearance: caution in renal impairment
  - Long $t_{1/2}$: need loading dose (LD)
  - Tissue protein binding (large V_d): displacement by other drugs (verapamil, quinidine)
- Uses: CHF; supraventricular tachycardias, except Wolff-Parkinson-White syndrome
- Side effects:
  - Early signs include anorexia, nausea, ECG changes
  - Later signs include disorientation, visual effects (yellow-green color disturbances, blurry vision)
  - In toxic doses, any cardiac arrhythmias
- Management of toxicity: use of Fab antibodies toward digoxin; supportive therapy (electrolytes and antiarrhythmics class IB)
- Drug interactions:
  - Diuretics: ↓ K^+, ↓ Mg^{2+}, ↑ Ca^{2+}
  - Quinidine and verapamil

Phosphodiesterase Inhibitors: Inamrinone and Milrinone

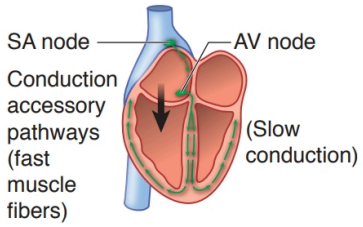
- Use: acute CHF only
- Increase cAMP in heart muscle; results in ↑ inotropy
- Increase cAMP in smooth muscle; results in ↓ TPR

Sympathomimetics: Dobutamine and Dopamine

- Use: acute CHF only

NOTE

Wolff-Parkinson-White Syndrome



- **Do** block accessory pathway with I_A or III
- **Do not** slow AV conduction (avoid digoxin, β-blocker, Ca^{2+}-channel blocker, adenosine)

CLINICAL CORRELATE

Diastolic dysfunction (CHF with preserved ejection fraction) is best treated with β blockers and diuretics.

OTHER DRUGS FOR CHF

Sacubitril

- Neprilysin inhibitor: neprilysin is an enzyme that degrades atrial and brain natriuretic peptide (2 blood pressure-lowering peptides that work mainly by reducing blood volume); also inhibits bradykinin metabolism
- Used in combination with valsartan (ARB) for CHF with reduced ejection fraction (combination is called an angiotensin receptor-neprilysin inhibitor [ARNI])
- Side effects: hypotension, cough, angioedema

Ivabradine

- Pacemaker "funny" sodium channel blocker; the If channel is responsible for the automaticity of the SA node; these channels are upregulated in CHF patients
- Decreasing the diastolic depolarization slope in the SA node decreases heart rate without direct effects on contractility or intracardiac conduction
- Used for chronic HF patients where, in spite of taking highest tolerable dose of beta blockers, have the following conditions:
  - Left ventricular ejection fraction $\leq$35%
  - In sinus rhythm
  - Resting heart rate $\geq$70 bpm
- Side effects: bradycardia, blurred vision, increased incidence of atrial fibrillation

4 Antiarrhythmic Drugs

LEARNING OBJECTIVES

- ❑ Utilize cardiac action potentials to explain actions of antiarrhythmic drugs and their effects on the ECG
- ❑ Identify antiarrhythmic drugs by their classification (Ia, Ib, Ic, II, III, IV, other)
- ❑ Describe side effects of antiarrhythmic drugs
- ❑ Predict antiarrhythmic drugs likely to cause *torsades de pointes*

CARDIAC ACTION POTENTIAL

Fast-Response Fibers: Cardiac Muscle, His-Purkinje System

High-Yield

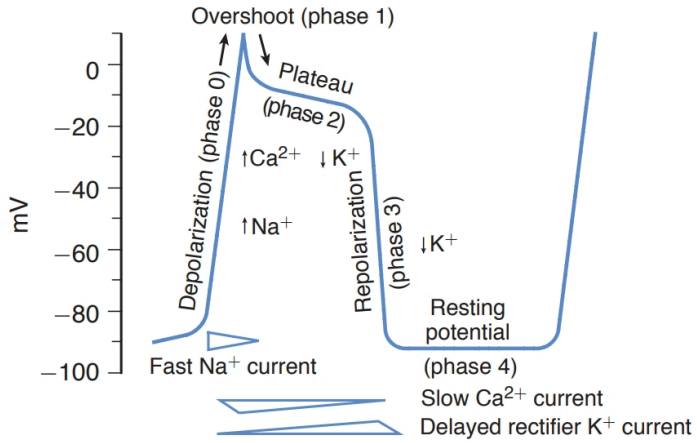


Figure III-4-1. Cardiac Action Potentials in Fast-Response Fibers

Phase 0

- Na^+ channels open: sodium enters the cell down its concentration gradient (fast I_{Na}), causing membrane depolarization.
- Rate of depolarization depends on number of Na^+ channels open, which in turn depends on resting membrane potential of the cell.
- Class I antiarrhythmic drugs can slow or block phase 0 in fast-response fibers.

Phase 1

- Na^+ channels are inactivated.
- In some His-Purkinje cells, transient outward K^+ currents and inward Cl^- currents contribute to the "notch" and overshoot.
- Antiarrhythmic drugs have no significant effects on these transient currents.

Phase 2

- Plateau phase in which a slow influx of Ca^{2+} ($I_{Ca\text{-}L}$) is "balanced" by a late-appearing outward K^+ current (the delayed rectifier current I_K).
- Antiarrhythmic drugs have no significant effects on these currents during this phase of the action potential (AP).

Phase 3

- Repolarization phase in which the delayed rectifier K^+ current rapidly increases as the Ca^{2+} current dies out because of time-dependent channel inactivation.
- Class III antiarrhythmic drugs slow this repolarization phase.
- Note that during phases 0 through 3 a slow Na^+ current ("window current") occurs, which can help prolong the duration of the action potential.

Phase 4

- Return of membrane to resting potential—maintained by activity of the Na^+/K^+-ATPase.

Responsiveness

- Capacity of a cell to depolarize, associated with the number of Na^+ channels in a ready state (*see* Figure III-4-4).
- This in turn depends on resting membrane potential: the more negative the resting potential (RP), the faster the response.

Conductance

Rate of spread of an impulse, or conduction velocity—3 major determinants:

- Rate of phase 0 depolarization—as V_{max} decreases, conduction velocity decreases and vice versa.
- Threshold potential—the less negative, the slower the conduction velocity.
- Resting potential—the more negative the RP, the faster the conduction.

Slow-Response Fibers (SA and AV Nodes, Specialized Cells)

High-Yield

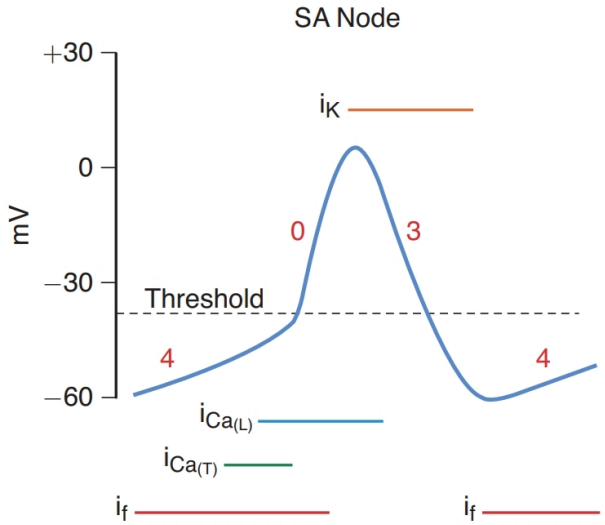


Figure III-4-2. Cardiac Action Potentials in Slow-Response Fibers

- No appreciable Na^+ current during phase 0 in these cells because the Na^+ channels are either absent or in an inactive form because of the existing voltage.
- Depolarization depends on activation of Ca^{2+} channels ($I_{Ca\text{-}L}$ and $I_{Ca\text{-}T}$).
- Class IV antiarrhythmic drugs can slow or block phase 0 in slow-response fibers.
- During repolarization, the Ca^{2+} currents are opposed and overcome by the delayed rectifier K^+ current. The relative magnitudes of these opposing currents determine the "shape" of the action potential.
- The major distinctive feature of slow fibers is their spontaneous depolarization, shown by the rising slope of phase 4 of the AP, referred to as the pacemaker potential or "pacemaker current." Although not completely understood, pacemaker potential is a composite of inward Na^+ (I_f) and Ca^{2+} ($I_{Ca\text{-}T}$) currents and outward K^+ currents (I_K).
- Class II and IV antiarrhythmic drugs can slow phase 4 in pacemaker fibers.

Automaticity

The ability to depolarize spontaneously confers automaticity on a tissue. The fastest phase 4 slope will determine the pacemaker of the heart (normally the SA node).

Refractoriness

Refractoriness is the inability to respond to a stimulus—a property of all cardiac cells.

Effective Refractory Period (ERP)

- No stimulus, of any magnitude, can elicit a response.
- Lasts into late stage 3 of the AP because Na^+ channels are effectively inactivated and not in the "ready" state.
- Blockers of K^+ channels prolong the ERP.

Relative Refractory Period (RRP)

- A strong stimulus can elicit a response, but the timing will be out of sync with the rest of the heart and arrhythmias may occur.
- Ratio of ERP to the action potential duration (APD) is a measure of refractoriness, as illustrated in Figure III-4-3. Decreases in ERP favor the formation and propagation of premature impulses.

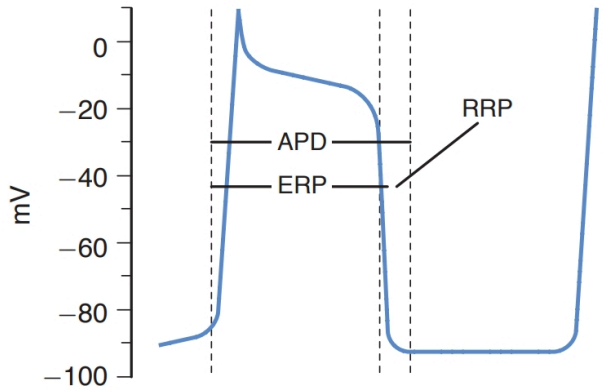


Figure III-4-3. Relationship of ERP to APD

NA^+ CHANNELS

Activation

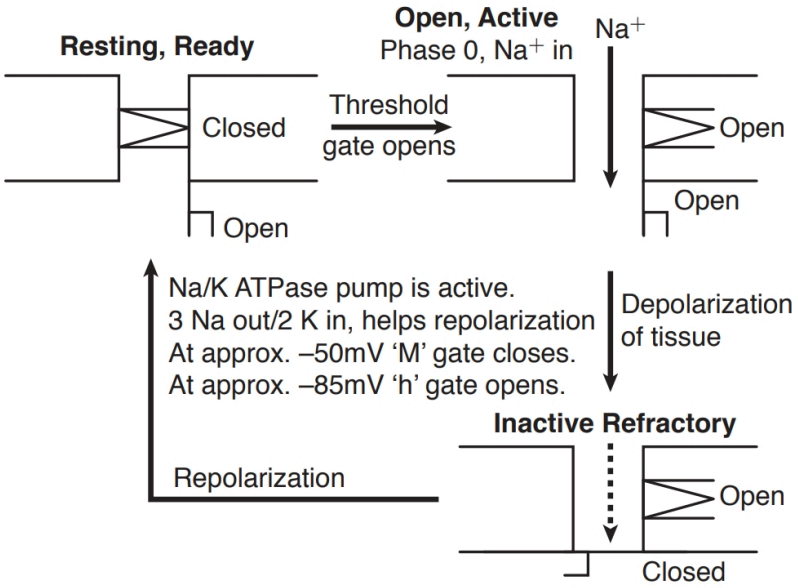


Figure III-4-4. Mechanism of Action of Voltage-Gated Na^+ Channels

- This voltage-gated channel, which is responsible for the fast Na^+ current (I_{Na}), exists in 3 conformations: resting or ready state; open or active state; and inactivated or refractory state.
- The channel has 2 gates: M (activating) and h (inactivating), both of which are sensitive to voltage changes.
- Inactivation of the h gate is slower; therefore, it stays open longer and the Na^+ channel is active.

Recovery

Rate of recovery of the Na^+ channel is dependent on the resting potential (RP).

- Fastest rate of recovery occurs at normal RP, and recovery slows as membrane voltage increases.
- Rate of recovery is slower in ischemic tissue because cells may be partly depolarized at rest. This reduces the number of channels able to participate in the next depolarization, which leads to a decrease in conduction rate in ischemic tissue.
- Na^+ channel blockers also slow the rate of recovery in such tissues.

ANS REGULATION OF HEART RATE

Nodal tissue, especially that of the SA node, is heavily innervated by both PANS and SANS fibers activating M_2 and β_1 receptors, respectively. Phase 4 slope is increased by an increase in cAMP resulting from β_1 receptor activation and slowed by a decrease in cAMP resulting from M_2 receptor activation.

- Increase in cAMP will:
  - Increase upstroke velocity in pacemakers by increase of $I_{Ca\text{-}L}$
  - Shorten AP duration by increase of I_K
  - Increase HR by increase of I_f, thus increasing slope of phase 4
- Decrease in cAMP:
  - Does the opposite plus produces a K^+ current ($I_{K/ACh}$), which slows the rate of diastolic depolarization and thus decreases HR
  - Beta blockers prevent cAMP formation, with primary effects on SA and AV nodal tissues.

CLASS I: NA^+ CHANNEL BLOCKERS

Class 1A

High-Yield

- Antiarrhythmic: block fast Na^+ channels ($\downarrow I_{Na}$)
- Preferentially in the open or activated state—"state-dependent" blockade
- Also blocks K^+channel (prolongs repolarization), $\uparrow$ action potential duration and effective refractory period
- Drugs:
  - **Quinidine**
    - In addition to the above, causes muscarinic receptor blockade, which can $\uparrow$ HR and AV conduction.
    - May also cause vasodilation via alpha block with possible reflex tachycardia.
    - Orally effective; in atrial fibrillation need initial digitalization to slow AV conduction.
    - Adverse effects: cinchonism (GI, tinnitus, ocular dysfunction, CNS excitation), hypotension, prolongation of QRS and $\uparrow$ QT interval associated with syncope (torsade).
    - Drug interactions: hyperkalemia enhances effects and vice versa; displaces digoxin from tissue binding sites, enhancing toxicity.
  - **Procainamide**
    - Less muscarinic receptor block
    - Metabolized via *N*-acetyltransferase (genotypic variation) to *N*-acetyl procainamide (NAPA), an active metabolite
    - Adverse effects: systemic lupus erythematosus (SLE)–like syndrome (30% incidence) more likely with slow acetylators; hematotoxicity (thrombocytopenia, agranulocytosis); CV effects (torsade)

NOTE

For the exam, know which effect is **antiarrhythmic** (eliminates irregular heartbeat) and which is **proarrhythmic** (promotes irregular heartbeat).

NOTE

Quinidine is a weak base, and antacids increase its absorption, thus greatly increasing its toxicity.

Class 1B

- Antiarrhythmic: block fast Na^+ channels ($\downarrow I_{Na}$)
- Block inactivated channels—preference for tissues partly depolarized (slow conduction in hypoxic and ischemic tissues). This results in an increased threshold for excitation and less excitability of hypoxic heart muscle.
- ↓ APD—due to block of the slow Na^+ "window" currents, but this increases diastole and extends the time for recovery.
- Drugs and uses:
  - **Lidocaine**
    - Post-MI, open-heart surgery, digoxin toxicity–ventricular arrhythmias only
    - Side effects: CNS toxicity (seizures); least cardiotoxic of conventional anti-arrhythmics
    - IV use because of first-pass metabolism
  - **Mexiletine**
    - Same uses as lidocaine
    - Oral formulations

Class 1C

- Block fast Na^+ channels ($\downarrow I_{Na}$), especially His-Purkinje tissue
- No effect on APD
- No ANS effects
- Drug:
  - **Flecainide**
    - Limited use because of proarrhythmogenic effects, leading to ↑ in sudden death post-MI and when used prophylactically in VT

CLASS II: BETA BLOCKERS

- Prevent β-receptor activation, which would normally ↑ cAMP
- ↓ SA and AV nodal activity
- ↓ Slope of phase 4 (diastolic currents) of AP in pacemakers
- Drugs:
  - Propranolol (nonselective) and the cardioselective drugs: atenolol, metoprolol, and esmolol
  - Uses:
    - Prophylaxis post-MI and in supraventricular tachyarrhythmias (SVTs)
    - Esmolol (IV) is used in acute SVTs

CLINICAL CORRELATE

Long QT Syndrome

A familial condition associated with increased risk of ventricular arrhythmias may result from a mutation in the gene encoding cardiac potassium channels.

In such patients, class IA and class III antiarrhythmic drugs may increase the risk of torsades. Drugs which cause torsades include:

- Potassium-channel blockers (class 1A and class III)
- Antipsychotics (thioridazine)
- Tricyclic antidepressants

To **treat the torsades**, correct the hypokalemia, correct the hypomagnesemia, and discontinue drugs that prolong the QT interval.

CLASS III: K^+ CHANNEL BLOCKERS

- Decrease I_K (delayed rectifier current) slowing phase 3 (repolarization) of AP
- Increase APD and ERP, especially in Purkinje and ventricular fibers

Amiodarone, Dronedarone

High-Yield

- Mimics classes I, II, III, and IV
- Increase APD and ERP in all cardiac tissues
- Uses: any arrhythmia
- $t_{1/2}$ >80 days (amiodarone)
- Binds extensively to tissues (large V_d and multiple effects)
- Side effects: interstitial pneumonitis and pulmonary fibrosis, phototoxicity, corneal deposits, hepatic necrosis, iodine-related side effects including blue skin pigmentation and thyroid dysfunction (amiodarone)

Sotalol

- Decreases I_K, slowing phase III
- Nonselective beta blocker: β1 blockade, leading to ↓ HR, ↓ AV conduction
- Use: life-threatening ventricular arrhythmia
- Side effects: Torsade

CLASS IV: CA^{2+} CHANNEL BLOCKERS

- Block slow cardiac Ca^{2+} channels
- Decrease phase 0, ↓ phase 4
- Decrease SA, ↓ AV nodal activity

Verapamil and Diltiazem

- Prototype Ca^{2+}-channel blockers (*see* Antihypertensives and Antianginal Drugs chapters in this section)
- Uses: supraventricular tachycardias
- Side effects: constipation (verapamil), dizziness, flushing, hypotension, AV block
- Drug interaction:
  - Additive AV block with β-blockers, digoxin
  - Verapamil displaces digoxin from tissue-binding sites

UNCLASSIFIED

Adenosine

- Activates adenosine receptors: causes G_i-coupled decrease in cAMP
- Decreases SA and AV nodal activity
- Uses: DOC for paroxysmal supraventricular tachycardias and AV nodal arrhythmias
- Administered IV: $t_{1/2}$ <10 seconds
- Side effects: flushing, sedation, dyspnea
- Adenosine is antagonized by methylxanthines (theophylline and caffeine)

Magnesium

- Use: torsades

Recall Question

Which of the following drugs is associated with an SLE-like syndrome?

A. Captopril

B. Lidocaine

C. Procainamide

D. Quinidine

Answer: C

CLINICAL CORRELATE

Potassium

Both hyperkalemia and hypokalemia are arrhythmogenic.

CLINICAL CORRELATE

Atrial fibrillation is the most common arrhythmia in the United States. There are 2 primary goals:

- Ventricular rate control with beta blocker, CCB, or digoxin
- Anticoagulation

Antianginal Drugs 5

LEARNING OBJECTIVES

- ❑ Describe drug strategies for treating different types of angina
- ❑ Describe mechanism, side effects, and cautions for nitrates
- ❑ Explain drug-related mechanisms that cause smooth muscle relaxation

RATIONALE FOR USE

Angina pectoris is the principal syndrome of ischemic heart disease, anginal pain occurring when oxygen delivery to the heart is inadequate for myocardial requirement.

- Stable/classic angina (angina of effort or exercise) is due to coronary atherosclerotic occlusion
- Vasospastic or variant angina (Prinzmetal) is due to a reversible decrease in coronary blood flow

Drug Strategies in Stable and Vasospastic Angina

Drug strategies in stable and vasospastic angina involve:

- ↓ oxygen requirement by ↓ TPR, CO, or both (nitrates, CCBs, and beta blockers).
- ↑ oxygen delivery by ↓ vasospasm (nitrates and CCBs).

KEY ANTIANGINAL DRUGS

Nitrates

High-Yield

Nitrates are prodrugs of nitric oxide.

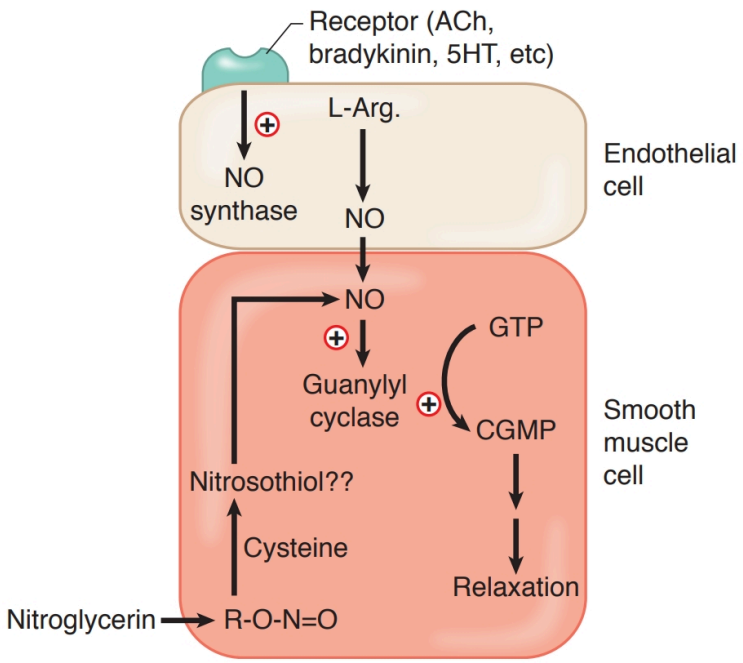


Figure III-5-1. Nitrates and the Nitric Oxide Pathway

- Venodilation →↓ preload →↓ cardiac work →↓ oxygen requirement
- Nitrates ↓ infarct size and post-MI mortality
- Drugs:
  - **Nitroglycerin:** sublingual, transdermal, and IV formulations
  - Isosorbide: oral, extended release for chronic use
  - Side effects:
    - Flushing, headache, orthostatic hypotension
    - Reflex tachycardia and fluid retention
  - Cautions and contraindications:
    - Tachyphylaxis with repeated use
    - Cardiovascular toxicity with sildenafil

CLINICAL CORRELATE

Sildenafil, Vardenafil, Tadalafil

Phosphodiesterase 5 (PDE5) is found in blood vessels supplying the corpora cavernosa. Sildenafil inhibits PDE 5 → ↑ cGMP → vasodilation → ↑ blood flow → ↑ erectile response.

If used concomitantly with nitrates or other potent vasodilators, the excessive fall in BP may lead to death from cardiovascular causes, including myocardial infarct.

Beta Blockers and Carvedilol

- Used in angina of effort
- β-blockers are contraindicated in vasospastic angina
- Carvedilol is clinically equivalent to isosorbide in angina of effort

Calcium Channel Blockers (CCBs)

- All CCBs can be used
- Dipines are important for vasospastic angina
- *See* Antihypertensives chapter in this part

Ranolazine

- Blocks late inward Na^+ current in cardiac myocytes and decreases calcium accumulation, thereby reducing oxygen requirements; also blocks K^+ channels
- Side effects include constipation and nausea; increased QT makes the drug contraindicated in patients with long QT syndrome or taking drugs that increase QT (*see* Magnesium discussion in Chapter 4, Antiarrhythmic Drugs)

CLINICAL CORRELATE

Drugs that decrease mortality in patients with stable angina include aspirin, nitroglycerin, and beta blockers. Nitroglycerin is the preferred drug for acute management of both stable (decreased oxygen consumption) and vasospastic (direct coronary vasodilation) angina.

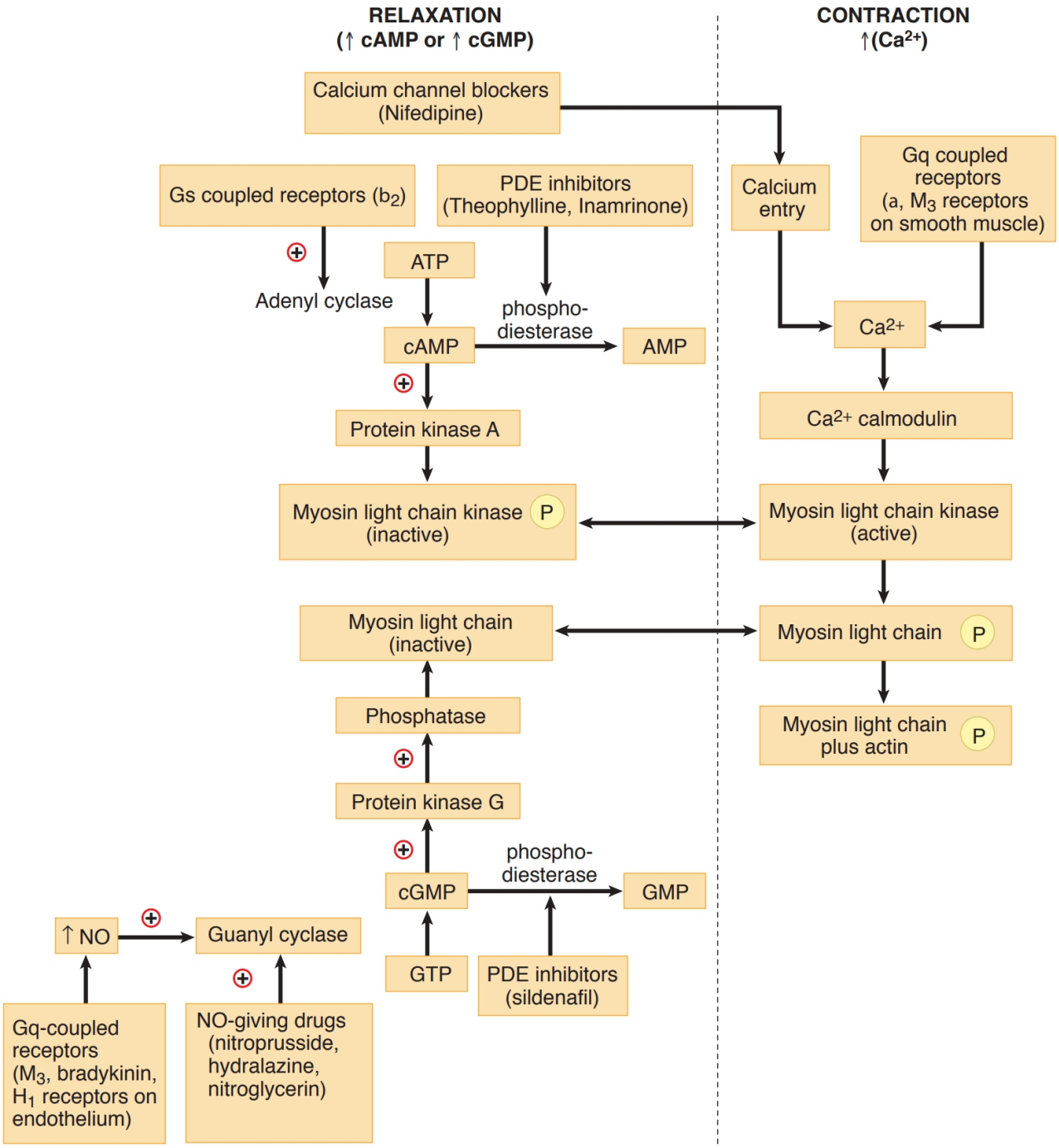


Figure III-5-2. Mechanisms of Smooth Muscle Contraction and Relaxation and Drugs Affecting Them

Antihyperlipidemics 6

LEARNING OBJECTIVES

- ❑ Describe mechanism and side effects for hyperlipidemia drugs
- ❑ Explain mechanism, use, and side effects of orlistat

CARDIOVASCULAR RISKS OF HYPERLIPIDEMIA

- Increased risk of atherosclerosis is associated with hypercholesterolemia
- Increased risk of cardiovascular and cerebrovascular diseases
- Treatment goal is to ↓ LDL cholesterol and atheroma plaque formation

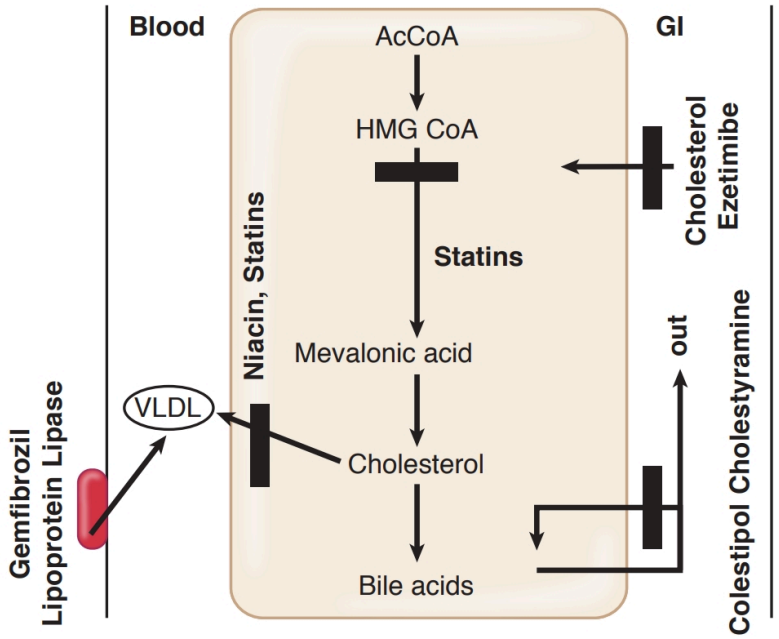


Figure III-6-1. Site of Action of Statins, Niacin, and Gemfibrozil on the Synthesis of Lipids

LIPID-LOWERING DRUGS

HMG-CoA Reductase Inhibitors

High-Yield

- Drugs: **atorvastatin, rosuvastatin,** and other "**–statins**"
  - At their highest therapeutic doses, atorvastatin and rosuvastatin are considered "high-intensity" statins and can lower LDL-C by $\geq$ 50%
  - Lower doses of statins are classified as "low" or "moderate" intensity
- Mechanisms:
  - HMG-CoA reductase inhibition, results in:
    - Decreased liver cholesterol
    - Increased LDL-receptor expression
    - Decreased plasma LDL
  - Decreased VLDL synthesis results in: ↓ triglyceridemia
- Side effects:
  - Myalgia, myopathy (check creatine kinase)
  - Rhabdomyolysis
  - Hepatotoxicity (check liver function tests)
- Drug interaction:
  - Gemfibrozil (↑ rhabdomyolysis)
  - Cytochrome P450 inhibitors enhance toxicity of statins

Bile Acid Sequestrants

- Drugs: **cholestyramine** and **colestipol**
- Mechanism: complexation of bile salts in the gut, results in:
  - Decrease enterohepatic recirculation of bile salts
  - Increase synthesis of new bile salts by the liver
  - Decrease liver cholesterol
  - Increase LDL-receptor expression
  - Decrease blood LDL
- Side effects:
  - Increase VLDL and triglycerides
  - Gastrointestinal disturbances
  - Malabsorption of lipid-soluble vitamins
- Drug interactions with orally administered drugs (warfarin, thiazides, digoxin, etc.)
- Contraindication: hypertriglyceridemia

CLINICAL CORRELATE

Nonstatin drugs have not been shown to improve cardiovascular outcomes when added to statin therapy. These drugs are most often used in patients who cannot tolerate a statin.

Nicotinic Acid (Niacin, Vitamin B3)

  - Mechanism: decreases cAMP and inhibits lipolysis in adipose tissue; with fewer free fatty acids, hepatic TG and VLDL synthesis decreases

- Side effects:
  - Flushing, pruritus, burning pain (use aspirin)
  - Hepatotoxicity
  - Hyperglycemia

Gemfibrozil, Fenofibrate (Fibrates)

- Mechanism: bind to the PPARα and increase expression of lipoprotein lipases, results in:
  - Decreased VLDL and IDL
  - Modest ↓ LDL (however, in some patients with combined hyperlipidemias, ↑ LDL)
  - Increased HDL (most patients)
  - Used in hypertriglyceridemia
- Side effects: gallstones, myositis

Ezetimibe

- Mechanism: prevents intestinal absorption of cholesterol, results in ↓ LDL
- Side effect: gastrointestinal distress

PCSK9 Inhibitors (Alirocumab, Evolocumab)

- Proprotein convertase subtilisin kexin 9 is a hepatic protease that promotes the destruction of LDL receptors
- Block of PCSK9 can lower LDL 50-60% above that achieved by statin therapy alone

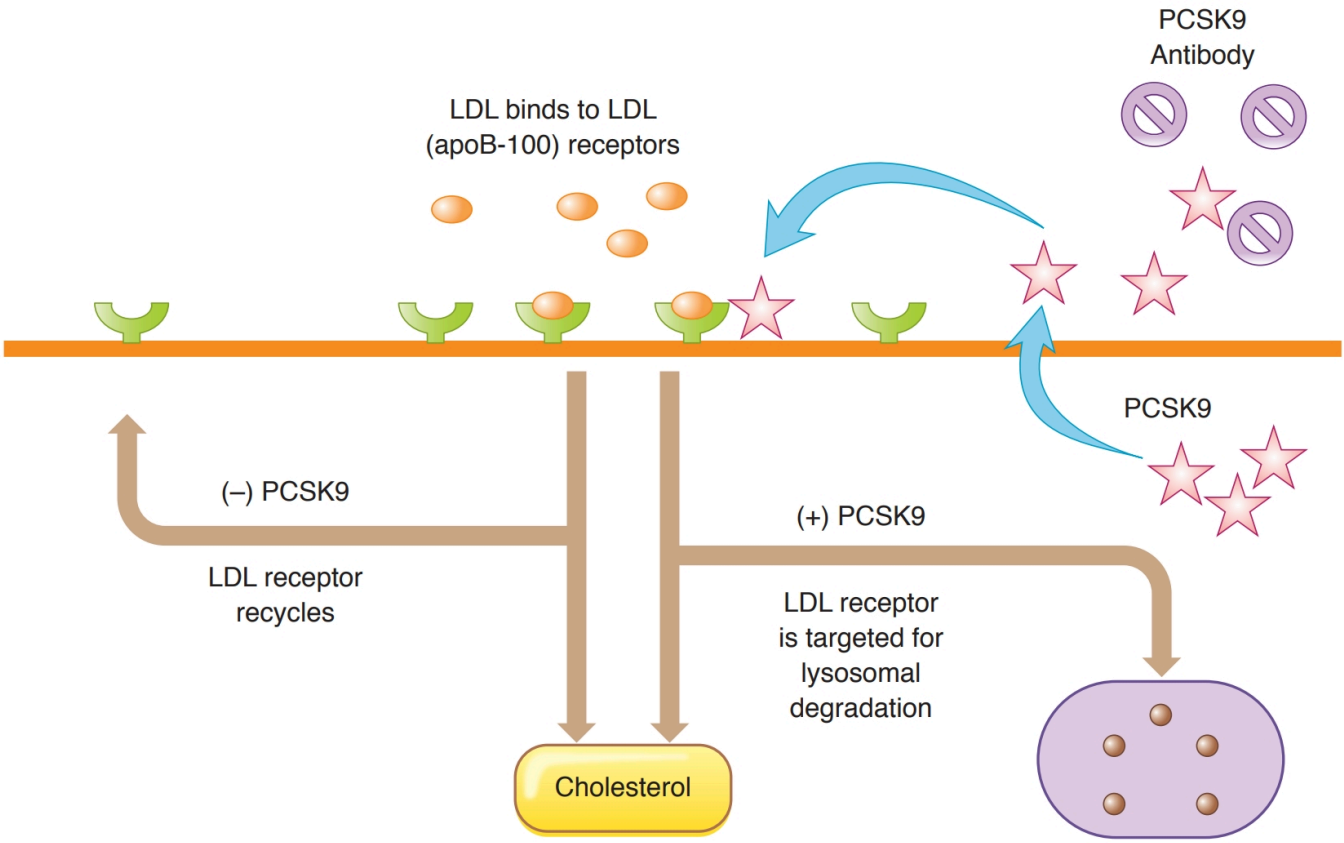


Figure III-6-2. Action of PCSK9 Inhibitors

Orlistat

- Therapeutic use: weight loss
- Mechanism: inhibits pancreatic lipase → ↓ triglyceride breakdown in the intestine
- Side effects: oily stools (steatorrhea), diarrhea; ↓ absorption of lipid-soluble vitamins

Cardiac and Renal Drug List and Practice Questions

7

Table III-7-1. The Major Cardiovascular and Renal Drugs

Antiarrhythmics	Antihypertensives	Antianginals
1A quinidine, procainamide	Thiazide diuretics	Nitrates: nitroglycerin, isosorbide
1B lidocaine, mexiletine	ACEIs: captopril, etc., and ARBs: losartan, etc. Renin inhibitor: aliskiren	CCBs: verapamil, nifedipine
1C flecainide	CCBs: verapamil, nifedipine, etc	β blockers: atenolol, etc.
II propranolol, atenolol, metoprolol, esmolol	β blockers: atenolol, metoprolol, acebutolol, etc.	
III amiodarone, sotalol	α blockers: prazosin, doxazosin, etc.	
IV verapamil, diltiazem	α2 agonists: clonidine, methyldopa	
Adenosine	Vasodilators: hydralazine, nitroprusside, diazoxide, minoxidil	
	Pulmonary hypertension: bosentan, epoprostenol, sildenafil	
Diuretics	**Drugs for Heart Failure**	**Antihyperlipidemics**
CA inhibitors: acetazolamide	ACEI or ARBs	Statins
Loops: ethacrynic acid, furosemide, torsemide	β blockers	Resins: cholestyramine, colestipol
Thiazides: hydrochlorothiazide, indapamide, chlorthalidone	Diuretics	Other: nicotinic acid, ezetimibe, gemfibrozil, fenofibrate
K^+ sparing: amiloride, triamterene, spironolactone, eplerenone	Digoxin, bipyridines: inamrinone, milrinone; β agonists: dobutamine, dopamine	Weight loss: orlistat

PRACTICE QUESTIONS

1. A patient has a genetic polymorphism such that they cannot rapidly metabolize drugs by acetylation. You would be most concerned about this polymorphism if the patient was taking which drug?

   A. Sotalol
   B. Clonidine
   C. Nitroglycerin
   D. Hydralazine
   E. Prazosin

2. Which side effect is associated with spironolactone?

   A. Alkalosis
   B. Hirsutism
   C. Hyperkalemia
   D. Hypercalcemia
   E. Hyperglycemia

3. Lidocaine is an effective antiarrhythmic because it

   A. suppresses excitability in hypoxic areas of the heart
   B. prolongs the QT interval
   C. prolongs the PR interval
   D. depresses the slope of phase 0 in slow response tissues
   E. acts on inhibitory G-protein coupled receptors

4. Sildenafil has been prescribed for years to treat erectile dysfunction. Recently, this drug is also being used for what condition?

   A. Vasospastic angina
   B. Supraventricular tachycardia
   C. Cyanide poisoning
   D. Raynaud disease
   E. Pulmonary hypertension

5. A patient with hypertension also suffers from essential tremor. Optimal treatment of the patient should include management with

   A. prazosin
   B. clonidine
   C. metoprolol
   D. lidocaine
   E. propranolol

6. Selective β-1 blockers are preferred over nonselective beta blockers in some patients because they

   A. cause less cardiodepression
   B. are less likely to cause bronchoconstriction
   C. are more effective for migraine prophylaxis
   D. are more effective as an antiarrhythmics
   E. have greater prophylactic value post-MI

7. Which drug will utilize the same signaling pathway as endogenous bradykinin on smooth muscle?

   A. Minoxidil
   B. Nitroprusside
   C. Theophylline
   D. Phenylephrine
   E. Cocaine

8. A 75-year-old patient suffering from congestive heart failure accidentally ingests a toxic dose of digoxin. Clinical consequences due to the toxic effects of cardiac glycosides are likely to include

   A. seizures
   B. hypercalcemia
   C. bicarbonaturia
   D. intermittent claudication
   E. visual disturbances

9. In the management of a cardiac arrhythmia, lidocaine is to be administered by way of an IV loading dose. What variable must be known to calculate an appropriate loading dose?

   A. Renal clearance
   B. Bioavailability
   C. Volume of distribution
   D. Lag time
   E. Time to steady state

10. Both dobutamine and inamrinone increase cardiac contractility by

    A. activation of adenylyl cyclase
    B. inactivation of Na channels
    C. inhibition of Na^+/K^+-ATPase
    D. increasing cAMP
    E. activation of Na/Cl cotransporter

11. Which one of the following is likely to occur following treatment of a hypercholesterolemic patient with cholestyramine?

    A. Increased recycling of bile salts
    B. Increased circulating cholesterol
    C. Decreased VLDL synthesis
    D. Downregulation of LDL receptors
    E. Elevation of plasma triglycerides

12. A new diuretic is being studied in human volunteers. Compared with placebo, the new drug increases urine volume, increases urinary Ca^{2+}, increases plasma pH, and decreases serum K^{+}. If this new drug has a similar mechanism of action to an established diuretic, it probably

    A. blocks the NaCl cotransporter in the DCT
    B. blocks aldosterone receptors in the CT
    C. inhibits carbonic anhydrase in the PCT
    D. inhibits the $Na^{+}/K^{+}/2Cl^{-}$ cotransporter in the TAL
    E. acts as an osmotic diuretic

13. Which one of the following drugs is most likely to block K+ channels in the heart responsible for cardiac repolarization, and also blocks calcium channels in the AV node?

    A. Amiodarone
    B. Quinidine
    C. Lidocaine
    D. Sotalol
    E. Verapamil

14. The treatment of hyperlipidemic patients with nicotinic acid (niacin) results in

    A. increases in VLDL
    B. decreases in both plasma cholesterol and TGs
    C. inhibition of HMG-CoA reductase
    D. decreases in HDL
    E. no change in total cholesterol in the plasma

15. Which drug is useful for patients with congestive heart failure because it reduces both preload and afterload, and also inhibits cardiac remodeling?

    A. Hydralazine
    B. Hydrochlorothiazide
    C. Prazosin
    D. Nifedipine
    E. Captopril

16. Enhancement of the effects of bradykinin is most likely to occur with drugs like

    A. clonidine
    B. diazoxide
    C. lisinopril
    D. losartan
    E. propranolol

17. Outpatient prophylaxis of a patient with an SVT is best accomplished with the administration of

    A. adenosine
    B. diltiazem
    C. esmolol
    D. lidocaine
    E. mexiletine

18. Which one of the following is the most appropriate drug to use for the patient described in parentheses?

    A. Captopril (60-year-old woman with diabetic nephropathy)
    B. Nitroprusside (50-year-old man with BP of 140/95 mm Hg)
    C. Losartan (29-year-old pregnant woman)
    D. Propranolol (40-year-old patient with peripheral vascular disease)
    E. Milrinone (57-year-old patient with chronic CHF)

19. In a patient suffering from angina of effort, nitroglycerin may be given sublingually because this mode of administration

    A. bypasses the coronary circulation
    B. causes less reflex tachycardia than oral administration
    C. improves patient compliance
    D. has a decreased tendency to cause methemoglobinemia
    E. avoids first-pass hepatic metabolism

20. A patient with a supraventricular tachycardia has an atrial rate of 280/min with a ventricular rate of 140/min via a 2:1 AV nodal transmission. After treatment with a drug, the atrial rate slowed to 180/min, but the ventricular rate increased to 180/min. Which of the following drugs was most likely to have been given to this patient?

    A. Adenosine
    B. Digoxin
    C. Esmolol
    D. Quinidine
    E. Verapamil

ANSWERS AND EXPLANATIONS

1. **Answer: D.** Hydralazine is metabolized by *N*-acetyltransferase (a phase II drug metabolism reaction) associated with a genetic polymorphisms. Patients who are classified as slow acetylators may develop SLE-like symptoms when treated with hydralazine. Other drugs metabolized via *N*-acetyltransferase, including isoniazid and procainamide, have also been associated with lupus-like symptoms in slow acetylators.

2. **Answer: C.** Spironolactone blocks aldosterone receptors, thereby inhibiting the production of Na^+ channels in the collecting duct and is used as a K^+-sparing agent because the reabsorption of Na^+ in the CT is coupled (indirectly) to the secretion of K^+ ions. Hyperkalemia is characteristic of this drug and may lead to clinical consequences at high doses, or if patients fail to discontinue K^+ supplements or ingest foodstuffs high in K^+. Because Na^+ reabsorption is associated with secretion of protons, spironolactone causes retention of H^+ ions, leading to acidosis. It has no significant effect on the renal elimination of Ca^{2+} or on the plasma level; of glucose.

3. **Answer: A.** Lidocaine, a class IB drug, effectively targets ischemic areas of the heart. Its major effect is on sodium channels in fast response fibers such as ventricular muscle. It has no significant effect on the PR or QT intervals.

4. **Answer: E.** Sildenafil (a PDE5 inhibitor) is used for erectile dysfunction but has been recently approved for use in pulmonary hypertension. Other useful drugs in pulmonary hypertension are epoprostenol and bosentan.

5. **Answer: E.** Propranolol is a nonselective beta blocker useful in a variety of cardiac conditions including hypertension. The drug is also useful in essential tremor where blocking the beta-2 receptor is beneficial. Metoprolol, beta-1 selective, is useful in hypertension but not in essential tremor. Clonidine and prazosin are second-line drugs for hypertension and not effective in essential tremor. Lidocaine, an antiarrhythmic, is not effective in either condition.

6. **Answer: B.** β1-selective blockers like atenolol and metoprolol are less likely to block receptors in the bronchiolar smooth muscle and therefore less likely to cause bronchoconstriction, especially in asthmatic patients. Nonselective beta blockers are considered to be equally as effective as selective beta-1 blockers in arrhythmias, migraine prevention, and in post-MI prophylaxis. Both types of drugs are cardiodepressant.

7. **Answer: B.** Bradykinin binds to endothelial receptors and causes the formation of nitric oxide, which signals through the cGMP pathway to relax smooth muscle. Nitroprusside utilizes nitric oxide and cGMP in a similar fashion to relax smooth muscle.

8. **Answer: E.** Digoxin toxicity is associated with CNS consequences including disorientation and visual dysfunctions such as halos around lights and blurry, yellow vision. More serious manifestations include life-threatening arrhythmias.

9. **Answer: C.** Back to basic principles! Recall that to calculate a loading dose you must know volume of distribution and target plasma concentration. Since lidocaine is being given IV, its bioavailability is 100% (f=1) so no adjustment is required to the equation. Renal clearance is needed to calculate a maintenance dose, and time to steady state applies only when using a maintenance dose. There is no lag time for an IV drug.

10. **Answer: D.** Dobutamine acts as a beta-1 agonist to activate adenylyl cyclase and increase cAMP. Inamrinone inhibits phosphodiesterase III, which increases the amount of cAMP in the heart. In each case, there is an increase in intracellular Ca^{2+} being sequestered in the SR, which leads to enhance contractility.

11. **Answer: E.** Cholestyramine and colestipol are resins that sequester bile acids in the gut, preventing their reabsorption. This leads to release of their feedback inhibition of 7-alpha hydroxylase and the diversion of cholesterol toward new synthesis of bile acids. Increase in high-affinity LDL receptors on hepatocyte membranes decreases plasma LDL. These drugs have a small but significant effect to increase plasma HDL rather than decrease it, but their ability to increase TGs precludes their clinical use in the management of hypertriglyceridemias.

12. **Answer: D.** The effects described are typical of loop diuretics, which inhibit the $Na^{+}K^{+}2Cl^{-}$ cotransporter in the thick ascending limb. This action prevents the reabsorption of Ca^{2+} from the paracellular pathway and provides for the use of these drugs in hypercalcemia. The increased load of Na^{+} in the collecting tubules leads to increased excretion of both K^{+} and H^{+}, so hypokalemia and alkalosis may occur.

13. **Answer: A.** Amiodarone is a highly effective antiarrhythmic drug, in part because of its multiple actions, which include Na+ channel block, beta adrenoceptor block, K^{+} channel block, and Ca^{2+} channel block. Drugs that block K^{+} channels prolong APD and ERP and predispose toward torsades de pointes ventricular arrhythmias. Quinidine, class Ia, can block both sodium and potassium channels but not calcium channels. Lidocaine, class Ib, blocks only sodium channels. Sotalol is both a beta blocker and a potassium channel blocker. It is a class III drug that also has class II properties. Verapamil is a class IV calcium channel blocker with no effect on potassium.

14. **Answer: B.** Nicotinic acid inhibits the synthesis of the VLDL apoprotein and decreases VLDL production. Its use results in decreases of both cholesterol and triglycerides, so total cholesterol in the plasma decreases. The drug is not an inhibitor of HMG-CoA reductase, and it increases plasma HDL to a greater extent than any other available antihyperlipidemic drug.

15. **Answer: E.** Captopril and other ACE inhibitors are primary treatment options for congestive heart failure because they reduce preload by dilating veins and reduce afterload by dilating arterioles. They inhibit cardiac remodeling, which results in improved survival for patients with heart failure. Hydralazine reduces afterload but does not affect preload. Hydrochlorothiazide reduces preload but does not affect afterload and does not inhibit remodeling. Neither prazosin nor nifedipine has any significant role in heart failure.

16. **Answer: C.** ACE inhibitors prevent the conversion of angiotensin I to angiotensin II and lower blood pressure by decreasing both the formation of aldosterone and the vasoconstrictive action of AII at AT-1 receptors. ACEIs also inhibit the metabolism of bradykinin, and this leads to additional hypotensive effects, because bradykinin is an endogenous vasodilator. Unfortunately, increases in bradykinin are associated with side effects, including cough and angioedema. Losartan, which blocks AT-1 receptors, does not increase bradykinin levels.

17. **Answer: B.** Supraventricular tachycardias (SVTs) are treated effectively by class II and class IV antiarrhythmics. In addition, adenosine is indicated for SVTs and nodal tachycardias but only acutely since it must be administered IV and has an extremely short duration. The primary actions of both beta blockers (esmolol) and CCBs (diltiazem) are at the AV node, but esmolol is too short-acting to be useful as prophylaxis. Lidocaine and mexiletine are both class Ib drugs that are used in ventricular arrhythmias.

18. **Answer: A.** ACEIs slow the progression of diabetic nephropathy and are indicated for management of HTN in such patients. Nitroprusside is used IV in severe HTN or hypertensive crisis, not for management of mild-to-moderate HTN. Losartan, which blocks AT-1 receptors, is associated with teratogenic effects during fetal development, as are the ACEIs. Nonselective beta blockers are not ideal for patients who suffer from peripheral vascular disease, diabetes, or asthma. Milrinone, like most inotropes, is not useful long-term in CHF patients. The drug has been shown to increase mortality with chronic use, and thus is indicated for acute CHF. Digoxin is currently the only inotrope used chronically.

19. **Answer: E.** The sublingual administration of a drug avoids its absorption into the portal circulation and hence eliminates the possibility of first-pass metabolism, which can often have a major impact on oral bioavailability. Given sublingually, nitroglycerin is more effectively absorbed into the systemic circulation and has improved effectiveness in angina by this mode of administration. Effective absorption is unlikely to decrease reflex tachycardia or propensity toward methemoglobinemia. There is no bypass of the coronary circulation—nitrates actually decrease coronary vasospasm, which makes them effective in variant angina.

20. **Answer: D.** An increase in AV conduction is characteristic of quinidine, which exerts quite marked blocking actions on muscarinic receptors in the heart. Thus, an atrial rate, formerly transmitted to the ventricles in a 2:1 ratio, may be transmitted in a 1:1 ratio after quinidine. This effect of quinidine can be offset by the prior administration of an antiarrhythmic drug that decreases AV nodal conduction, such as digoxin or verapamil. All of the drugs listed (except quinidine) slow AV nodal conduction, but adenosine and esmolol (a beta blocker) are very short-acting agents used IV only.

PART IV

CNS DRUGS

Sedative-Hypnotic-Anxiolytic Drugs

1

LEARNING OBJECTIVES

- ❑ Compare and contrast mechanism for benzodiazepines and barbiturates
- ❑ Identify properties of benzodiazepines
- ❑ Describe mechanism, uses, and side effects of zolpidem, zaleplon, and buspirone

DRUGS USED FOR SEDATION, SLEEP, ANXIETY

Drugs used for sedation, sleep, and anxiety can cause dose-dependent CNS depression that extends from sedation to anesthesia to respiratory depression and even death. Benzodiazepines (BZs) reach a plateau in CNS depression, while barbiturates and alcohol do not.

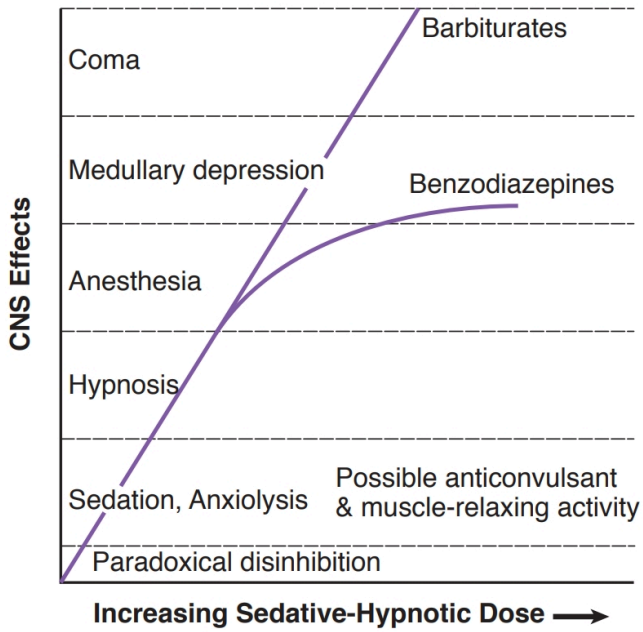


Figure IV-1-1. CNS Effects Associated with Increasing Doses of Sedative-Hypnotic (S-H) Drugs

Mechanisms

High-Yield

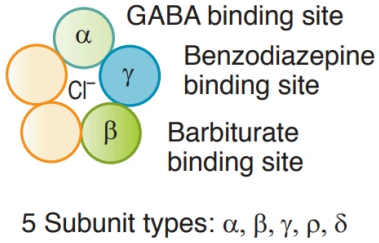


Figure IV-1-2. Site of Action of Drugs on the $GABA_A$ Complex

- $GABA_A$ activation ↑ Cl^- influx
- $GABA_B$ activation ↑ K^+ efflux
- Both mechanisms result in membrane hyperpolarization
  - BZs:
    - Potentiate GABA
    - ↑ the frequency of Cl^- channel opening
    - Have no GABA mimetic activity
    - Act through BZ receptors
    - These receptors are part of the $GABA_A$ complex
    - BZ_1 mediates sedation
    - BZ_2 mediates antianxiety and impairment of cognitive functions
  - Barbiturates:
    - Prolong GABA activity
    - ↑ duration of Cl^- channel opening
    - Have GABA mimetic activity at high doses
    - Do not act through BZ receptors
    - Have their own binding sites on the $GABA_A$ complex
    - Also inhibit complex I of electron transport chain

CLINICAL CORRELATE

Flumazenil is a nonspecific BZ receptor antagonist used to reverse the CNS depression caused by BZs in anesthesia and BZ overdose, and to reverse BZ1 agonists. It cannot reverse the CNS depression caused by barbiturates and alcohols.

Uses of Benzodiazepines

High-Yield

Table IV-1-1. Uses of Various Benzodiazepines

Drug	Indications
Alprazolam	Anxiety, panic, phobias
Diazepam	Anxiety, preop sedation, muscle relaxation, withdrawal states
Lorazepam	Anxiety, preop sedation, status epilepticus (IV)
Midazolam	Preop sedation, anesthesia IV
Temazepam	Sleep disorders
Oxazepam	Sleep disorders, anxiety

Other Properties

- Pharmacokinetics of BZs: liver metabolites are also active compounds, except for oxazepam, temazepam, and lorazepam
- Uses of barbiturates: phenobarbital for seizures
- Pharmacokinetics of barbiturates:
  - Liver metabolized, sometimes to active compounds
  - General inducers of cytochrome P450s
  - Contraindication in porphyrias
- Tolerance to and dependence on sedative-hypnotics:
  - Chronic use leads to tolerance
  - Cross-tolerance occurs between BZs, barbiturates, and ethanol
  - Psychologic and physical dependence occur
  - But abuse liability of BZs is < ethanol or barbiturates
- Withdrawal signs of BZs:
  - Rebound insomnia
  - Anxiety
  - Seizures when BZs were used as antiepileptic or in high doses
- Withdrawal signs of barbiturates and ethanol: anxiety, agitation, life-threatening seizures (delirium tremens with alcohol)
  - Management of withdrawal: supportive and long-acting BZs
- Drug interactions: $GABA_A$ drugs are:
  - Additive with other CNS depressants (possible life-threatening respiratory depression), such as anesthetics, antihistamines, opiates, β-blockers, etc.
  - Barbiturates induce metabolism of most lipid-soluble drugs, such as oral contraceptives, carbamazepine, phenytoin, warfarin, etc.

Non-BZ Drugs

- Zolpidem and zaleplon
  - BZ_1 receptor agonist
  - Less effect on cognitive function (BZ_2-mediated)
  - Overdose reversed by flumazenil
  - Used in sleep disorders
  - Less tolerance and abuse liability (sleepwalking)
- Buspirone
  - No effect on GABA
  - 5-HT_{1A} partial agonist
  - Used for generalized anxiety disorders
  - Nonsedative
  - Takes 1 to 2 weeks for effects

NOTE

BZs are effective in the treatment of acute anxiety, while SSRIs and SNRIs are more commonly used as preventive medications for chronic anxiety.

- Suvorexant
  - Orexin receptor antagonist; orexin promotes wakefulness
  - Used for insomnia
  - Side effects: somnolence

2 Alcohols

LEARNING OBJECTIVES

- ❑ Identify features of alcohol poisoning
- ❑ Compare and contrast properties of ethylene glycol, methanol, and ethanol
- ❑ Explain the use of ethanol or fomepizole in methanol and ethylene glycol poisoning

All alcohols cause CNS depression, in part through GABA mimetic activity.

All alcohols cause metabolic acidosis.

CLINICAL CORRELATE

Alcohol and Pregnancy

Fetal alcohol syndrome is characterized by growth restriction, midfacial hypoplasia, microcephaly, and marked CNS dysfunction, including the frequent occurrence of mental retardation.

NOTE

Drugs that cause disulfiram-like effects:

- Metronidazole
- Griseofulvin

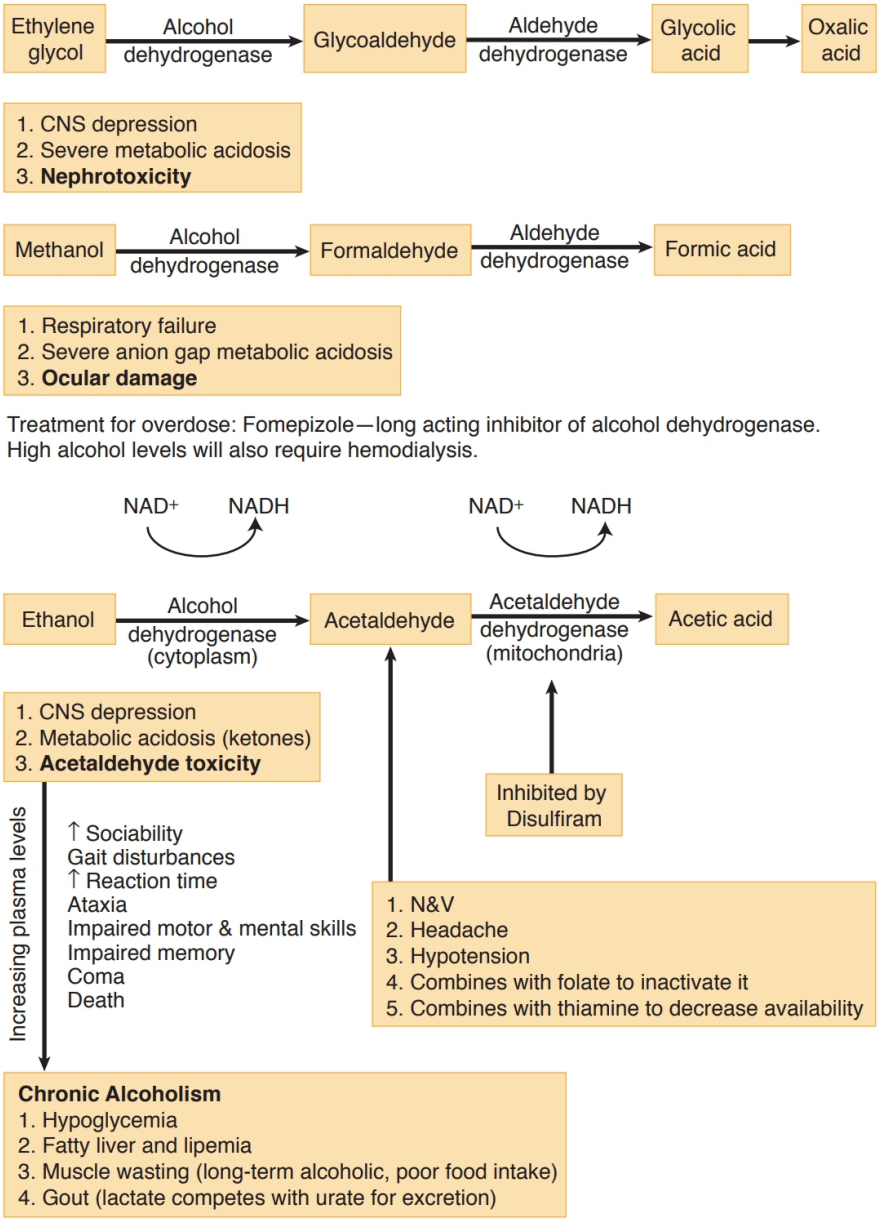


Figure IV-2-1. Metabolism and Pharmacologic Actions of the Alcohols

Antidepressants, Bipolar, and Attention Deficit Hyperactivity Disorder (ADHD) Drugs

3

LEARNING OBJECTIVES

- ❑ Describe mechanism and side effects of antidepressants
- ❑ Identify key features of serotonin syndrome
- ❑ Explain mechanism, use, and side effects of lithium
- ❑ Identify main drugs used for ADHD

- "Amine hypothesis" of depression:
  - Reserpine: depletes NE, 5HT, DA, and causes severe depression
  - Acute mechanism of antidepressants: ↑ NE, ↑ 5HT
  - However, antidepressant effect takes several weeks to occur.

DRUGS USED IN DEPRESSION

Selective Serotonin Reuptake Inhibitors (SSRIs)

High-Yield

- Drugs: **fluoxetine, paroxetine, sertraline, citalopram, fluvoxamine**
- Mechanism: selective blockade of 5HT reuptake
- Uses:
  - Major depression
  - OCD
  - Bulimia
  - Anxiety disorders (chronic treatment/acute, benzodiazepines)
  - Premenstrual dysphoric disorder (PMDD)
- Side effects: anxiety, agitation, bruxism, sexual dysfunction, weight loss
- Toxicity: serotonin syndrome
- Drug interactions
  - ↑ 5HT: serotonin syndrome
    - Symptoms: sweating, rigidity, myoclonus, hyperthermia, ANS instability, seizures
    - Drugs: MAOIs, TCAs, and meperidine

- Most inhibit cytochrome P450 enzymes (in particular, fluvoxamine and fluoxetine)
- Important interaction includes increased levels of benzodiazepines in treatment of anxiety disorders
- Citalopram is safer for interactions

Tricyclic Antidepressants (TCAs)

- Drugs: amitriptyline, imipramine, and clomipramine
- Mechanism: nonspecific blockade of 5HT and NE reuptake
- Uses:
  - Major depressions
  - Phobic and panic anxiety states
  - Obsessive-compulsive disorders (OCDs)
  - Neuropathic pain
  - Enuresis
- Side effects: muscarinic and α blockade
- Toxicity: the "3 Cs": coma, convulsions, and cardiotoxicity
- Drug interactions:
  - Hypertensive crisis with MAO inhibitors
  - Serotonin syndrome with SSRIs, MAO inhibitors, and meperidine
  - Prevent antihypertensive action of α_2 agonists

Serotonin and Norepinephrine Reuptake Inhibitors (SNRIs)

High-Yield

- Drugs: venlafaxine, desvenlafaxine, duloxetine
- Mechanism: inhibit reuptake of both serotonin and NE
- Uses: similar to SSRIs
- Side effects: anorexia, somnolence, increased blood pressure, inappropriate antidiuretic hormone secretion (SIADH); hepatotoxicity (duloxetine)
- Toxicity: serotonin syndrome (increased 5-HT interaction with MAOIs, TCAs, and meperidine)

MAO Inhibitors

- Drugs: **phenelzine** and **tranylcypromine**
- Mechanism: irreversible inhibition of MAO_A and MAO_B
- Use: atypical depressions
- Drug interactions

- Serotonin syndrome: SSRIs, TCAs, and meperidine
- ↑ NE: hypertensive crisis
  - Symptoms: ↑ BP, arrhythmias, excitation, hyperthermia
  - Drugs: releasers (i.e., tyramine), TCAs, α_1 agonists, levodopa

Other Antidepressants

High-Yield

- Trazodone: associated with cardiac arrhythmias and priapism
- **Bupropion:** dopamine and norepinephrine reuptake blocker; fewer sexual side effects; used in smoking cessation
- Mirtazapine: α_2 antagonist, associated with weight gain

CLINICAL CORRELATE

Varenicline is a partial agonist of nicotinic receptors and is used in smoking cessation.

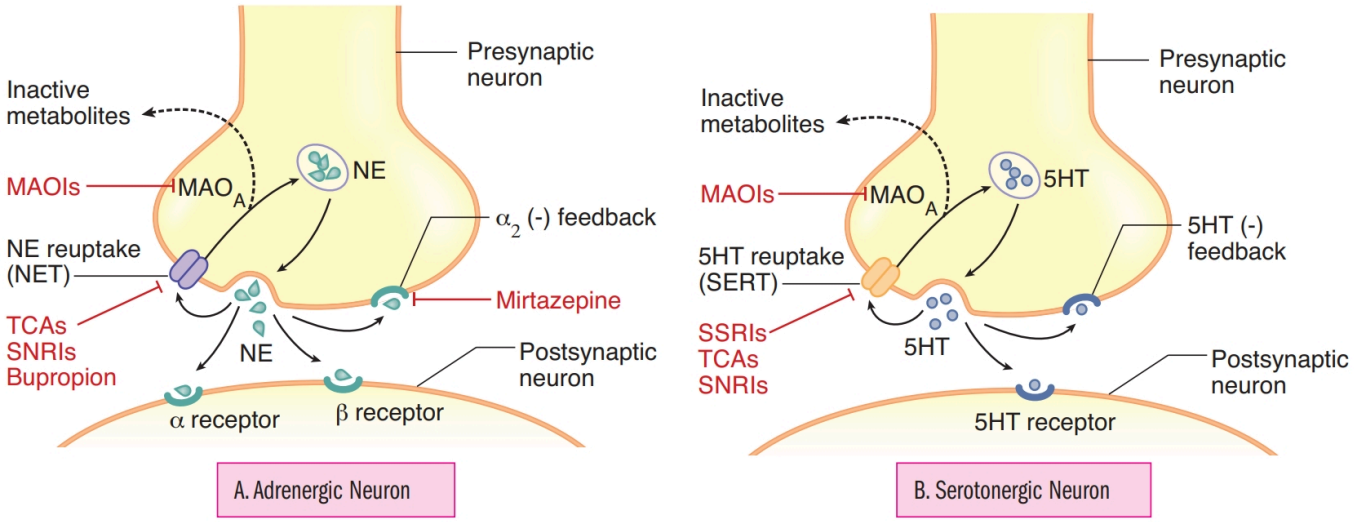


Figure IV-3-1. Mechanism of Action of Antidepressants

Antidepressant drugs work on one or both of the pathways shown here. The pathways are distinct, although they do share some common features (explaining why some drugs work on both pathways).

DRUGS USED IN BIPOLAR DISORDERS

Lithium

High-Yield

Lithium remains DOC for bipolar disorders. Antidepressants/antipsychotics are also usually required.

- Mechanism:
  - Prevents recycling of inositol (↓ PIP_2) by blocking inositol monophosphatase
  - ↓ cAMP
- Side effects:
  - Narrow therapeutic index; requires therapeutic monitoring
  - Tremor, flu-like symptoms, life-threatening seizures
  - Hypothyroidism with goiter (↓ TSH effects and inhibition of 5′-deiodinase)
  - Nephrogenic diabetes insipidus (↓ ADH effect); manage with amiloride
- Teratogenicity: Ebstein anomaly (malformed tricuspid valve)

Other drugs used in bipolar disorders include valproic acid and carbamazepine.

NOTE

Lithium is cleared entirely by the kidneys, so drugs that decrease GFR or inhibit sodium reabsorption in the nephron may decrease lithium clearance and increase its $t_{1/2}$. Notable interactions occur with NSAIDs, ACEI, ARBs, and most diuretics.

DRUGS USED IN ADHD

Methylphenidate, Amphetamine

- Amphetamine-like
  - Side effects: agitation, restlessness, insomnia, cardiovascular toxicity

Atomoxetine

- Selective NE reuptake inhibitor
  - Side effects: *See* Tricyclic Antidepressants (TCAs) in this chapter

Recall Question

A drug that can cause serotonin syndrome is:

A. Bupropion

B. Lithium

C. Fluoxetine

D. Trazodone

Answer: C

Parkinson Disease Drugs and Antipsychotics

4

LEARNING OBJECTIVES

- ❑ Explain actions of dopamine agonists and antagonists in various neural pathways
- ❑ Describe drug mechanisms used in Parkinson disease and schizophrenia
- ❑ Explain drug side effects due to increased or decreased dopamine levels

DOPAMINERGIC NEURAL PATHWAYS

In the CNS, dopamine (DA) is a precursor to NE in diffuse noradrenergic pathways and is an inhibitory neurotransmitter in the major dopaminergic pathways.

Nigrostriatal Tract

- Cell bodies in the substantia nigra project to the striatum, where they release DA, which inhibits GABA-ergic neurons. In Parkinson disease, the loss of DA neurons in this tract leads to excessive ACh activity → extrapyramidal dysfunction.
- DA receptor antagonists → pseudoparkinsonism (reversible).
- DA agonists may cause dyskinesias.

Mesolimbic-Mesocortical Tract

- Cell bodies in midbrain project to cerebrocortical and limbic structures
- Functions include regulation of affect, reinforcement, cognitive functions, and sensory perception. Psychotic disorders and addiction are partly explained by ↑ DA in these pathways.
- Drugs that ↑ DA functions →↑ reinforcement and, at high doses, may cause psychoses.
- DA antagonists →↓ cognitive function

Tuberoinfundibular

- Cell bodies in hypothalamus project to anterior pituitary and release DA →↓ prolactin.
- DA agonists are used in hyperprolactinemic states.
- DA antagonists may cause endocrine dysfunction, including gynecomastia and amenorrhea/galactorrhea.

BRIDGE TO PHYSIOLOGY

Increased prolactin will decrease GnRH, which decreases production of FSH and LH, resulting in amenorrhea.

Chemoreceptor Trigger Zone

- Activation of DA receptors →↑ emesis.
- DA agonists (e.g., apomorphine) are emetic, and DA antagonists are antiemetic.

DOPAMINE RECEPTORS

- D_1-like: G_s coupled
- D_2-like: G_i coupled
  - D_{2A}: nigrostriatal
  - D_{2C}: mesolimbic

DRUGS USED IN PARKINSON DISEASE

Signs and symptoms of Parkinson disease include bradykinesia, muscle rigidity, and resting tremor.

The pathology of Parkinson involves the degeneration of nigrostriatal dopamine tracts with imbalance between dopamine (decreased) and ACh (increased).

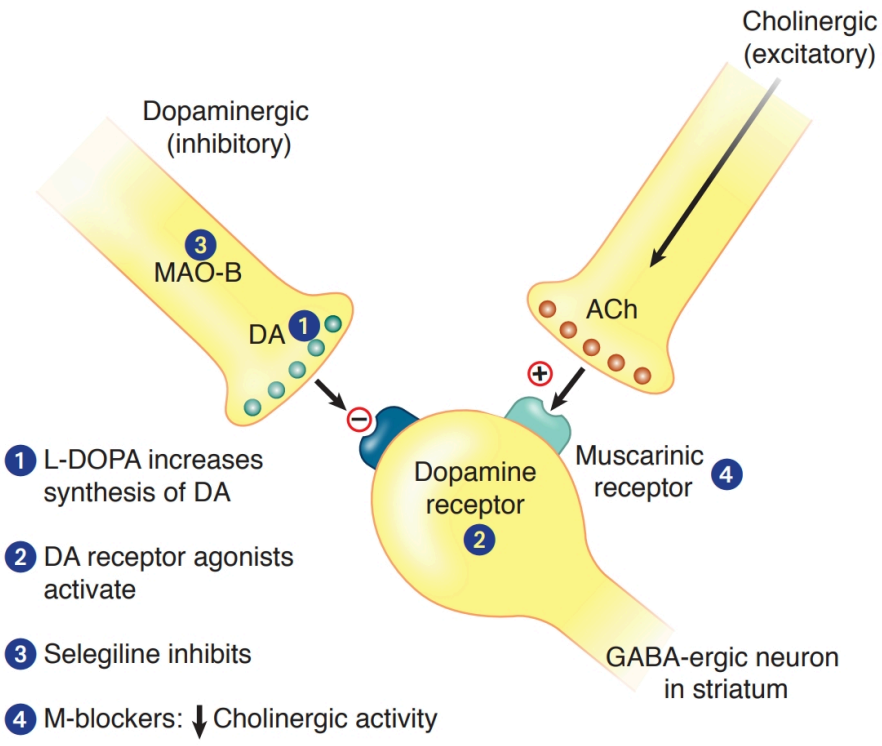


Figure IV-4-1. CNS Targets for Antiparkinsonian Drugs

The pharmacologic strategy for Parkinson disease is to restore normal dopamine and decrease ACh activity at muscarinic receptors in the striatum.

Drugs Increasing Dopamine Function

High-Yield

- **Levodopa**
  - Prodrug converted to dopamine by aromatic amino acid decarboxylase (AAAD)
  - Given with carbidopa
  - Side effects: dyskinesias, "on-off" effects, psychosis, hypotension, vomiting

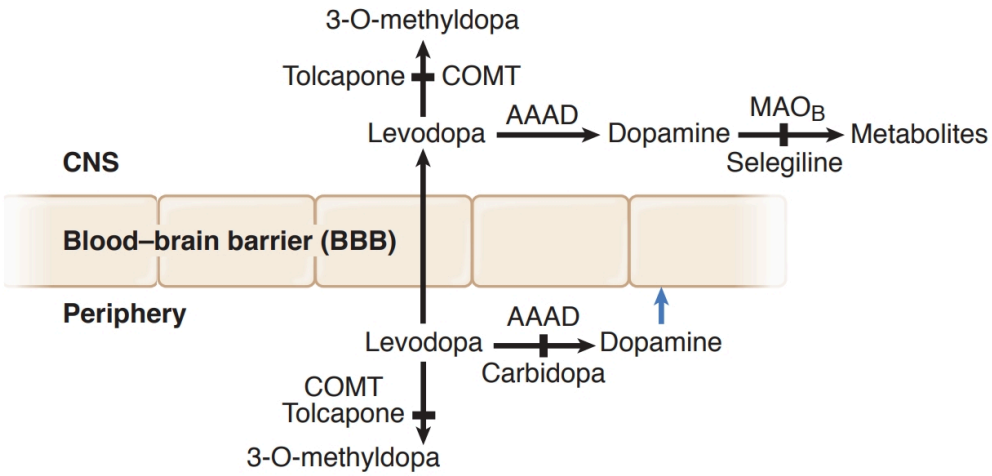


Figure IV-4-2. Inhibitors of Levodopa Metabolism

- **Tolcapone** and **entacapone**
  - COMT converts L-dopa to 3-O-methyldopa, a partial agonist at dopamine receptors.
  - These drugs inhibit COMT and enhance levodopa uptake and efficacy.
  - Tolcapone is hepatotoxic.
- **Selegiline**
  - MAO_B-selective inhibitor (no tyramine interactions)
  - Initial treatment and adjunct to levodopa
  - Side effects: dyskinesias, psychosis, insomnia (metabolized to amphetamine)

Dopamine-Receptor Agonists

High-Yield

- **Pramipexole** and **ropinirole**
- **Bromocriptine**
  - Use: hyperprolactinemia and acromegaly
- Side effects: dyskinesias and psychosis

Drugs Decreasing ACh Function

- **Benztropine** and **trihexyphenidyl**, which are muscarinic blockers
  - Actions: ↓ tremor and rigidity but have little effects on bradykinesia
  - Side effects: atropine-like
- **Amantadine**
  - Antiviral, which block muscarinic receptors and ↑ dopamine release
  - Side effects: atropine-like and livedo reticularis

ANTIPSYCHOTIC DRUGS

Schizophrenia

Positive symptoms of schizophrenia include thought disorders, delusions, hallucinations, and paranoia. Negative symptoms include amotivation, social withdrawal, flat affect, and poverty of speech.

The "dopamine hypothesis" of schizophrenia states that symptoms arise because of excessive dopaminergic activity in mesolimbic system. Dopamine agonists cause psychosis. Dopamine antagonists have antipsychotic actions.

Serotonin is increasingly seen as a part of the etiology of schizophrenia.

Mechanisms

High-Yield

- Blockade of dopamine receptors
- Blockade of $5HT_2$ receptors

Uses

- Schizophrenia
- Schizoaffective states
- Bipolar disorder
- Tourette syndrome and Huntington disease
- Drug or radiation emesis

Side Effects

High-Yield

- From dopamine blockade
  - Dyskinesias (extrapyramidal symptoms [EPS])
    - **Acute EPS:** pseudoparkinsonism, dystonia, akathisia (management: antimuscarinic drugs [benztropine or diphenhydramine])
    - **Chronic EPS:** tardive dyskinesia (TD) (management: discontinuation/switch to atypical)
  - Dysphoria
  - Endocrine dysfunction
    - Temperature regulation problems (neuroleptic malignant syndrome [NMS], treated with dantrolene and bromocriptine) (*see* Bridge to Pathology/Genetics, chapter 6)
    - Increased prolactin (galactorrhea, amenorrhea, gynecomastia)
    - Eating disorders (weight gain)
- From muscarinic blockade (particularly tachycardia and decreased seizure threshold)
- From alpha blockade (particularly hypotension)

Table IV-4-1. Characteristic Properties of Antipsychotic Drugs

Drug Group Examples	EPS*	M Block	Sedation	Alpha Block	Other Characteristics
Typicals					
Chlorpromazine	++	++	+++	+++	NA
Thioridazine	+	+++	+++	+++	• Cardiotoxicity (torsades—"quinidine-like") • Retinal deposits
Fluphenazine	+++	+	+	+	NA
Haloperidol	+++	+	+	+	Most likely cause of neuroleptic malignant syndrome (NMS) and TD
Atypicals					
Clozapine	+/–	++	+	+++	• Blocks D_{2c} and $5HT_2$ receptors • No TD • Agranulocytosis—(weekly WBC count) requirement for weekly blood test, weight gain • Increased salivation ("wet pillow" syndrome) • Seizures
Olanzapine	+/–	+	+	++	Blocks $5HT_2$ receptors, improves negative-symptoms
Risperidone	+	+/–	++	++	Blocks $5HT_2$ receptors, improves negative symptoms, increased prolactin
Aripiprazole	+	+/–	+/–	+/–	Partial agonist of D_2 receptor; blocks $5HT_2$ receptors
Other atypicals: quetiapine, ziprasidone					

* Extrapyramidal symptoms

CLINICAL CORRELATE

Parenteral formulations of certain antipsychotic drugs (e.g., fluphenazine, haloperidol) are available for rapid initiation of treatment and for maintenance therapy in noncompliant patients. Depot forms of both drugs exist.

Anticonvulsants 5

LEARNING OBJECTIVES

- ❑ Describe common anticonvulsant mechanisms
- ❑ Describe mechanism, uses, and side effects of anticonvulsants

DRUGS USED IN SEIZURES

Seizures result from episodic electrical discharges in cerebral neurons associated with prolonged depolarization, during which sustained, high-frequency, repetitive firing (SHFRF) occurs, followed by prolonged hyperpolarization. The goal of drug management is restoration of normal patterns of electrical activity.

Mechanisms of Action

High-Yield

- Decreased axonal conduction by preventing Na^+ influx through fast Na channels: carbamazepine, phenytoin
- Increased inhibitory tone by facilitation of GABA-mediated hyperpolarization: barbiturates, benzodiazepines
- Decreased excitatory effects of glutamic acid: lamotrigine, topiramate (blocks AMPA receptors); felbamate (blocks NMDA receptors)
- Decreased presynaptic Ca^{2+} influx through type-T channels in thalamic neurons: ethosuximide and valproic acid

Table IV-5-1. Seizure States and Effective Drugs

Seizure Type	Effective Drugs
Partial—simple or complex	Valproic acid, phenytoin, carbamazepine, lamotrigine
General—tonic-clonic	Valproic acid, phenytoin, carbamazepine, lamotrigine
General—absence	Ethosuximide, valproic acid
Status epilepticus	Intravenous lorazepam, diazepam, phenytoin, or fosphenytoin*

* IV fosphenytoin is more water soluble.

Primary Anticonvulsants

High-Yield

- **Phenytoin**
  - Blocks axonal Na^+ channels in their inactivated state
  - Prevents seizure propagation
  - Uses: seizure states
  - Pharmacokinetics:
    - Variable absorption
    - Nonlinear kinetics
    - Induction of cytochrome P450s
    - Zero-order kinetic of elimination
  - Side effects:
    - CNS depression
    - Gingival hyperplasia
    - Hirsutism
    - Osteomalacia (↓ vitamin D)
    - Megaloblastic anemia (↓ folate)
    - Aplastic anemia (check hematology lab results)
  - Teratogenicity: cleft lip and palate
- **Carbamazepine**
  - Mechanism identical to phenytoin
  - Uses:
    - Seizure states
    - DOC for trigeminal neuralgia
    - Bipolar disorder
  - Pharmacokinetics: induces cytochrome P450, including its own metabolism
  - Side effects:
    - CNS depression
    - Osteomalacia
    - Megaloblastic anemia
    - Aplastic anemia
    - Exfoliative dermatitis
    - ↑ ADH secretion (dilutional hyponatremia)
  - Teratogenicity: cleft lip and palate; spina bifida

- **Valproic acid**
  - Mechanism:
    - Similar to phenytoin
    - But also inhibition of GABA transaminase
    - Blockade of T-type Ca^{2+} channels
  - Uses:
    - Seizure states
    - Mania of bipolar disorders
    - Migraine prophylaxis
  - Pharmacokinetics: inhibits cytochrome P450s
  - Side effects:
    - Hepatotoxicity (from toxic metabolite)
    - Thrombocytopenia
    - Pancreatitis
    - Alopecia
  - Teratogenicity: spina bifida
- **Ethosuximide**
  - Mechanism: blockade of T-type Ca^{2+} channels in thalamic neurons
  - Use: absence seizures

Other Anticonvulsants

- **Lamotrigine**
  - Blocks Na^{+} channels and glutamate receptors
  - Used in various seizures
  - Side effects: Stevens-Johnson syndrome
- **Topiramate**
  - Blocks Na^{+} channels and glutamate receptors and enhances GABA activity
  - Used in focal seizures in adults and children $>$ age 2; also used in migraine prophylaxis
  - Side effects: weight loss

- **Felbamate**
  - Block Na^+ channels and glutamate receptors
  - Used in seizure states (often adjunct therapy)
  - Side effects: Aplastic anemia
- **Gabapentin**
  - May affect calcium channels and neurotransmitter release, GABA effects
  - Used in seizure states, neuropathic pain (such as postherpetic neuralgia)

General features of anticonvulsant drug use include:

- Anticonvulsants are additive with other CNS depressants
- Avoid abrupt withdrawal, which may precipitate seizures
- ↓ efficacy of oral contraceptives via induction of cytochrome P450

Anesthetics and Muscle Relaxants

6

LEARNING OBJECTIVES

- ❑ Compare and contrast MAC values and blood-gas ratios for inhaled anesthetics
- ❑ Identify key features of IV and local anesthetics
- ❑ Describe mechanism for local anesthetics
- ❑ Distinguish nondepolarizing from depolarizing skeletal muscle relaxants

GENERAL ANESTHETICS

Inhaled Anesthetics

High-Yield

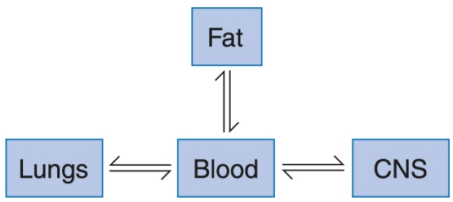


Figure IV-6-1. Compartmentalization of Anesthetics in the Body

Table IV-6-1. Properties of Specific Inhaled Anesthetics

Anesthetic	MAC Value	Blood–Gas Ratio	CV Effects	Specific Characteristics
Nitrous oxide	104%	0.5	Minimal	Rapid onset and recovery, no metabolism Diffusional hypoxia Spontaneous abortions
Sevoflurane	2%	0.6	Minimal	
Desflurane	6%	0.5	Minimal	

Anesthesia protocols include several agents in combinations.

- Inhaled anesthetics have varying potency in proportion to their lipid solubility.
- A MAC (minimal alveolar anesthetic concentration) is defined as the concentration of inhaled anesthetic (as a % of inspired air) at which 50% of patients do not respond to a surgical stimulus.
  - MAC is a measure of potency: ED50.
  - The more lipid soluble the anesthetic, the lower the MAC and the greater the potency.
  - MAC values are additive.
  - MAC values are lower in the elderly and in the presence of opiates or sedative-hypnotics.
- Rates of onset and recovery depend on the blood–gas ratio:
  - The more soluble the anesthetic in the blood, the slower the anesthesia.
  - Anesthetics with high blood–gas ratios are associated with slow onset.
  - Anesthetics with high blood–gas ratios are associated with slow recovery.
  - Anesthetics with low blood–gas ratios have fast onset and recovery.

Intravenous Anesthetics

- Midazolam
  - Benzodiazepine used for:
    - Preoperative sedation
    - Anterograde amnesia
    - Induction
    - Outpatient surgery
  - Depresses respiratory function
- Propofol
  - Used for induction and maintenance of anesthesia
  - Antiemetic
  - CNS and cardiac depressant
- Fentanyl
  - Opiate used for induction and maintenance of anesthesia
  - Depresses respiratory function
  - *See* Opioid Analgesics, chapter 7 in this section
- Ketamine
  - Dissociative anesthetic
  - NMDA-receptor antagonist
  - Induction of anesthesia
  - Emergent delirium, hallucinations
  - Cardiovascular stimulation
  - ↑ intracranial pressure

NOTE

Etomidate is an IV anesthetic that has minimal cardiac effects and is useful in patients with cardiovascular disease.

LOCAL ANESTHETICS

Local anesthetics provide regional anesthesia. Drugs come in 2 types. Esters include procaine, cocaine, benzocaine, which are metabolized by plasma and tissue esterases. Amides include lidocaine, bupivacaine, mepivacaine, which metabolized by liver amidases.

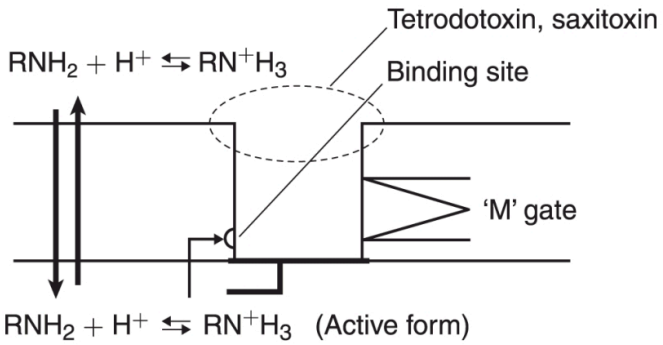


Figure IV-6-2. Mode of Action of Local Anesthetics

Mechanisms

The nonionized form of the drug crosses the axonal membrane. Once inside the nerve, the ionized form blocks the inactivated Na^+ channel. The drug slows recovery and prevents propagation of action potentials.

- Nerve fiber sensitivity:
  - Nerve fibers most sensitive to blockade are of smaller diameter and have high firing rates
  - The order of sensitivity is:

    type B and C > type A_δ > type A_β and A_γ > type A_α
  - Recovery is in reverse order
- Absorption:
  - Coadministration of α_1 agonists:
    - ↓ local anesthetic absorption into the systemic circulation
    - Prolong effects and ↓ toxicity

Side Effects

- Neurotoxicity
- Cardiovascular toxicity (bradycardia)
- Allergies (esters via PABA formation)

NOTE

Esters and Amides

Local anesthetics that are esters have just one "i" in their names (e.g., procaine, cocaine); amide local anesthetics have more than one "i" (e.g., lidocaine, bupivacaine).

NOTE

Na+ Channel Toxins

- Tetrodotoxin (from puffer fish) and saxitoxin (algae toxin, "red tide")
  - Block activated Na^+ channels
  - ↓ Na^+ influx
- Ciguatoxin (exotic fish) and batrachotoxin (frogs)
  - Bind to activated Na^+ channels
  - Prolong Na^+ influx

NOTE

Cocaine intrinsically causes vasoconstriction by blocking norepinephrine uptake.

SKELETAL MUSCLE RELAXANTS

Nicotinic receptors have 5 subunits. Two ACh bind each to 2 α subunits in order to open the Na^+ channel. This depolarizes the muscle.

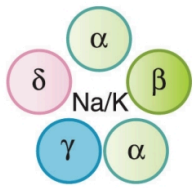


Figure IV-6-3. Nicotinic ACh Receptor of the Neuromuscular Junction

Muscle relaxants are used mainly in anesthesia protocols or in the ICU to afford muscle relaxation and/or immobility. They interact with nicotinic ACh receptors at the neuromuscular junction.

Drugs

High-Yield

- **Nondepolarizing (competitive) nicotinic antagonists**
  - Rocuronium is the prototype
  - Reversible with AChE inhibitors
  - Progressive paralysis (face, limbs, respiratory muscle); train-of-four stimulation shows fade
  - No effects on cardiac and smooth muscle; no effects on CNS
  - Specific drugs: **atracurium** (rapid recovery, safe in hepatic or renal impairment, spontaneous inactivation to laudanosine [laudanosine can cause seizures]); **cisatracurium** forms less laudanosine
- **Depolarizing (noncompetitive) nicotinic agonists**
  - Specific drug: **succinylcholine**
  - Two phases: **phase I** is depolarization, fasciculation, prolong depolarization, flaccid paralysis; **phase II** is desensitization
    - No fade in phase I with train-of-four stimulation
  - AChE inhibitors ↑ phase I; may reverse phase II
  - Rapidly hydrolyzed by pseudocholinesterase: short duration
  - Cautions: atypical pseudocholinesterase; hyperkalemia; malignant hyperthermia

Centrally Acting Skeletal Muscle Relaxants

- Benzodiazepines through $GABA_A$ receptors
- Baclofen through $GABA_B$ receptors
- Use: spasticity

BRIDGE TO PATHOLOGY/GENETICS

Malignant hyperthermia is a life-threatening syndrome characterized by muscle rigidity, hyperthermia, hypertension, acidosis, and hyperkalemia.

- Associated with the use of skeletal muscle relaxants, especially succinylcholine, used in anesthesia regimens
- Genotypic susceptibility may be related to mutations in the genes, encoding ryanodine receptors and/or a protein component of L-type calcium channel in skeletal muscle

Treatment

Dantrolene acts directly on skeletal muscle to decrease contractility by blocking Ca^{2+} release from the sarcoplasmic reticulum. It is used in states that include extreme muscle rigidity, such as malignant hyperthermia associated with inhaled anesthetics and skeletal muscle relaxants or neuroleptic malignant syndrome associated with antipsychotics.

Opioids 7

LEARNING OBJECTIVES

- ❑ Describe mechanism and side effects for full mu agonists
- ❑ Compare and contrast full, partial, and mixed opioid agonists
- ❑ Identify features of opioid overdose and treatment

PROPERTIES OF OPIOIDS

Opioid analgesics are endogenous opiate peptides represented by endorphins, enkephalins, and dynorphins. There are 3 receptor families: **μ**, **κ**, and **δ**.

Presynaptic and postsynaptic inhibition occurs through G_i coupling. **Mu pharmacology** is the most important. Morphine is the prototype μ-agonist.

Morphine

High-Yield

- Analgesia: ↑ pain tolerance and ↓ perception and reaction to pain
- Sedation
- Respiratory depression: ↓ response to ↑ pCO_2 (do not give O_2; give naloxone)
- Cardiovascular: minimal effects on heart but vasodilation (avoid in head trauma)
- Smooth muscle: longitudinal relaxes; circular constricts
  - GI: ↓ peristalsis, constipation, cramping
  - GU: urinary retention, urgency to void
  - Biliary: ↑ pressure
  - Pupils: miosis
- Cough suppression: antitussive action, independent of analgesia and respiratory depression
- Nausea and vomiting: stimulation of the chemoreceptor trigger zone (CTZ) in the area postrema
- Increased histamine release
- Pharmacokinetics: glucuronidation; morphine-6-glucuronide is highly active; caution in renal dysfunction

CLINICAL CORRELATE

Contraindications for Opioids

- Head injury (possible increased intracranial pressure)
- Pulmonary dysfunction (except pulmonary edema)
- Hepatic/renal dysfunction (possible accumulation)
- Adrenal or thyroid deficiencies (exaggerated responses)
- Pregnancy (possible neonatal depression or dependence), except meperidine, which does not inhibit uterine contractions in delivery and causes less respiratory depression in newborn

CLINICAL CORRELATE

Seizures caused by meperidine cannot be treated with opioid antagonists; use benzodiazepines.

CLINICAL CORRELATE

Codeine and codeine derivatives are prodrugs metabolized by CYP2D6 into morphine derivatives. Drug interaction with CYP2D6 inhibitors like fluoxetine and paroxetine.

CLINICAL CORRELATE

Suboxone is a combination of buprenorphine and naloxone, used for opiate addiction.

Other Opioids and Analgesics

High-Yield

Table IV-7-1. Other Opioids and Analgesics

Receptor Action	Drug	Characteristics
Full agonists	Meperidine Methadone Codeine	• Also antimuscarinic • No miosis • Tachycardia • No spasm GI/GU/gallbladder • Metabolized by cytochrome P450 to normeperidine, a serotonin reuptake inhibitor; normeperidine may cause serotonin syndrome and seizures • Used in maintenance of opiate addict • Cough suppressant • Analgesia • Used in combination with NSAIDs
Partial Agonist	**Buprenorphine**	**Precipitation of Withdrawal**
Mixed agonist-antagonists	Nalbuphine, pentazocine	• κ agonist spinal analgesia dysphoria • μ antagonist precipitation of withdrawal
Antagonists	Naloxone Naltrexone Methylnaltrexone	• IV, reversal for respiratory depression • PO, ↓ craving for alcohol and used in opiate addiction • Treatment of opioid-induced constipation (does not cross BBB and won't precipitate withdrawal)

Other Features of Opioid Analgesics

- Side effects of opioid analgesics:
  - Acute toxicity: classic triad
    - Pinpoint pupils
    - Respiratory depression
    - Coma
  - Management of acute toxicity: supportive, IV naloxone

- Abuse liability of opioid analgesics:
  - Tolerance: pharmacodynamic; occurs to all effects, except miosis and constipation
  - Dependence: physical and psychologic
  - Withdrawal:
    - Yawning
    - Lacrimation, rhinorrhea, salivation
    - Anxiety, sweating, goose bumps
    - Muscle cramps, spasms, CNS-originating pain
  - Management of withdrawal: supportive, methadone, clonidine
- Opiate-related drugs with specific indications
  - Loperamide: diarrhea
  - Dextromethorphan: cough

Drugs of Abuse

8

LEARNING OBJECTIVES

- ❑ Describe mechanism and toxicity for drugs of abuse
- ❑ Identify withdrawal features of stimulants, depressants, opioids, and marijuana

Table IV-8-1. Properties of Drugs of Abuse

CNS Stimulants	Cocaine	Amphetamines
Neurotransmitters involved	NE, DA, 5HT	
Mechanism(s) of action	Blocks DA, NE, and 5HT reuptake in CNS; local anesthetic action from Na+ channel blockade	Blockade of reuptake of NE and DA, release amines from mobile pool, weak MAO inhibitors
Effects	1. Increase NE: sympathomimetic effect with increased heart rate and contractility, blood pressure changes, mydriasis, and central excitation, hyperactivity 2. Increase DA: psychotic episodes, paranoia, hallucinations, possible dyskinesias, and endocrine disturbances 3. Increase 5HT: behavioral changes, aggressiveness, dyskinesias, and decreased appetite	
Toxicity	1. Excess NE: cardiac arrhythmias, generalized ischemia with possible MI and strokes; acute renal and hepatic failures 2. Excess DA: major psychosis, cocaine delirium 3. Excess 5HT: possible serotonin syndrome 4. All of the above: convulsion, hyperpyrexia, and death	
Withdrawal	Craving, severe depression, anhedonia, anxiety; manage with antidepressants	
CNS Depressants	**Benzodiazepines**	**Barbiturates and Ethanol**
Neurotransmitters involved	GABA	
Mechanism of action	Potentiation of GABA interaction with $GABA_A$ receptors involves BZ_1 and BZ_2 binding sites	Prolongation of GABA, GABA mimetic at high doses, on $GABA_A$ receptors
Effects	Light to moderate CNS depression	Any plane of CNS depression

Table IV-8-1. Properties of Drugs of Abuse (continued)

CNS Depressants	Benzodiazepines	Barbiturates and Ethanol
Toxicity	Sedation, anterograde amnesia; in severe OD (or IV use), reverse with **flumazenil**	Severe CNS depression, respiratory depression, and death
Withdrawal	Rebound insomnia, rebound anxiety	Agitation, anxiety, hyperreflexia, and life-threatening seizures + in ethanol withdrawal delusions/ hallucinations—delirium tremens (DTs)
Opioids	**Morphine, Heroin, Methadone, Fentanyls, Other Opioids**	
Neurotransmitters involved	NE, DA, 5HT, GABA, and many others	
Mechanism of action	Activate opioid μ, κ, and δ receptors. Potent μ receptor activators have the most intense abuse and dependence liability, possibly effected via an increase in dopaminergic transmission in the mesolimbic tracts	
Effects	Euphoria, analgesia, sedation, cough suppression, and constipation; strong miosis (except meperidine)	
Toxicity	Severe respiratory depression (reverse with **naloxone**), nausea, vomiting	
Withdrawal	Lacrimation, yawning, sweating, and restlessness, rapidly followed with centrally originating pain, muscle cramping, and diarrhea; not life-threatening	
Hallucinogens	**Marijuana**	**Hallucinogens**
Neurotransmitters involved	Many	5HT
Mechanism of action	Interaction of THC with CB_1 and CB_2 cannabinoid receptors in CNS and periphery	Interaction with several subtypes of 5HT receptors
Effects	Sedation, euphoria, ↑ HR, conjunctival irritation, delusions, hallucinations	Hallucinogen, sympathomimetic, causes dysesthesias
Toxicity	Associated with smoking, possible flashbacks	Poorly described, flashbacks likely
Withdrawal	Irritability, anxiety	Poorly characterized
Miscellaneous Abused Drugs		
1. PCP: NMDA-receptor antagonist; extremely toxic, horizontal and vertical nystagmus, analgesia, paranoia, rhabdomyolysis; overdose is common, with convulsions and death 2. Ketamine: similar to but milder than PCP, with hallucinations, glutamate-receptor antagonist 3. Anticholinergics: scopolamine, atropine-like 4. MDMA ("Ecstasy"), MDA, MDEA: amphetamine-like with strong 5HT pharmacology and therefore hallucinogenic; generally neurotoxic 5. Inhalants: solvent abuse, multiple organ damage; see Toxicology, section IX		

CNS Drug List and Practice Questions

9

Table IV-9-1. CNS Drug List

Sedative-Hypnotics	Anticonvulsants
Barbiturates: phenobarbital Benzodiazepines: alprazolam, diazepam, lorazepam, oxazepam	Carbamazepine, ethosuximide, valproic acid, phenytoin, diazepam, lorazepam, gabapentin, lamotrigine, felbamate, topiramate, tiagabine, vigabatrin
Others: buspirone, zolpidem, zaleplon BZ receptor antagonist: flumazenil	
Anesthetics (IV)	**Anesthetics (Inhaled)**
Fentanyl, ketamine, midazolam, propofol, thiopental	Desflurane, sevoflurane, nitrous oxide
Local Anesthetics	**Skeletal Muscle Relaxants**
Lidocaine, bupivacaine, mepivacaine, procaine, cocaine	Depolarizing: succinylcholine Nondepolarizing: rocuronium, atracurium
Opioid Analgesics	**Antipsychotics**
Full agonists: morphine, meperidine, methadone, fentanyl, and heroin Partial agonists: buprenorphine, codeine Mixed agonist-antagonists: nalbuphine Antagonists: naloxone, naltrexone, methylnaltrexone	Typicals: chlorpromazine, fluphenazine, thioridazine, haloperidol Atypicals: clozapine, risperidone, olanzapine, aripiprazole, quetiapine, ziprasidone
Antiparkinsonian Drugs	**Antidepressants**
DA agonists: levodopa, bromocriptine, pramipexole MAO-B inhibitor: selegiline AAAD inhibitor: carbidopa M blockers: benztropine, trihexyphenidyl COMT inhibitor: tolcapone DA releaser and M blocker: amantadine	MAOIs: phenelzine, tranylcypromine TCAs: amitriptyline, imipramine, clomipramine SSRIs: fluoxetine, paroxetine, sertraline Others: bupropion, mirtazapine, trazodone, venlafaxine
Bipolar Disorder	**ADHD**
Lithium	Methylphenidate Atomoxetine

PRACTICE QUESTIONS

1. Lorazepam can be safely used as a preanesthetic medication in a patient undergoing liver transplantation without fear of excessive CNS depression because the drug is

   A. excreted in unchanged form
   B. actively secreted into the GI tract
   C. conjugated extrahepatically
   D. a selective anxiolytic devoid of CNS depressant actions
   E. reversible by naloxone

2. Midazolam is an effective anesthetic because it acts by

   A. increasing functional activity at $GABA_B$ receptors
   B. enhancing the actions of dopamine
   C. blocking the NMDA glutamate receptor subtype
   D. acting as a partial agonist at 5HT receptors
   E. facilitating GABA-mediated increases in chloride ion conductance

3. Which one of the following is an established clinical use of morphine?

   A. Management of generalized anxiety disorders
   B. Relief of pain associated with biliary colic
   C. Pulmonary congestion
   D. Treatment of cough associated with use of ACE inhibitors
   E. Suppression of the ethanol withdrawal syndrome

4. A 40-year-old man was given a drug that binds to a subunit of the $GABA_A$ receptor. When used at a high dose, the drug can open Cl^- channels independent of GABA. What drug was the man given?

   A. Diazepam
   B. Ethanol
   C. Phenobarbital
   D. Baclofen
   E. Dronabinol

5. Which one of the following is characteristic of both phenytoin and carbamazepine?

   A. Inhibition of hepatic cytochrome P450
   B. First-order elimination at high therapeutic doses
   C. Enhances the effects of oral contraceptives
   D. Safe to use in pregnancy
   E. Prevent sodium influx through fast sodium channels

6. A patient comes to the ER with a painful stab wound. The ER resident administers pentazocine for the pain. Soon after administration the patient experiences sweating, restlessness, and an increase in pain sensations. What is the most likely explanation for his symptoms?

   A. The patient is probably tolerant to pentazocine.
   B. The patient is a heroin addict.
   C. Pentazocine is an ineffective analgesic.
   D. Pentazocine was used at the wrong dose.
   E. Pentazocine doesn't cross the blood-brain barrier.

7. The data shown in the table below concern the effects of drugs on transmitter function in the CNS. Which one of the drugs is most likely to alleviate extrapyramidal dysfunction caused by typical antipsychotics? (The + signs denote intensity of drug actions.)

Drug	Activation of DA Receptors	Activation of GABA Receptors	Block of ACh M Receptors
A.	++++	0	0
B.	++	++	0
C.	0	0	++++
D.	0	+++++	0
E.	+	+	0

8. Tricyclic antidepressants

   A. have anticonvulsant activity
   B. should not be used in patients with glaucoma
   C. may increase oral absorption of levodopa
   D. are sometimes used as antiarrhythmics

9. Which one of the following statements about lithium is accurate?

   A. It causes symptoms of mild hyperthyroidism in up to 25% of patients.
   B. Plasma levels are increased by a high-Na diet.
   C. Adverse effects include acne, polydipsia, and polyuria.
   D. Spina bifida is major concern in fetal development.
   E. Sedative actions calm manic patients within 24 h.

10. Ingestion of methanol in wood spirits would cause which of the following to happen?

    A. The formation of formaldehyde
    B. Nephrotoxicity
    C. Hypotension and vomiting
    D. The production of glycolic acids
    E. Inhibition of aldehyde dehydrogenase

11. What is the rationale for combining levodopa with carbidopa?

    A. Carbidopa stimulates dopamine receptors
    B. Carbidopa increases levodopa entry into the CNS by inhibiting peripheral dopa decarboxylase
    C. Carbidopa enhances levodopa absorption
    D. Carbidopa enhances the peripheral conversion of levodopa to dopamine
    E. Carbidopa blocks peripheral COMT

12. A 29-year-old man is being treated with an antidepressant drug, and his mood is improving. However, he complains of feeling "jittery" and agitated at times, and if he takes his medication in the afternoon he finds it difficult to get to sleep at night. He seems to have lost weight during the 6 months that he has been taking the drug. He has been warned not to take other drugs without consultation because severe reactions have occurred with opioid analgesics including meperidine. This patient is probably taking

    A. alprazolam
    B. chlorpromazine
    C. paroxetine
    D. amitriptyline
    E. trazodone

13. The ability of several drugs to inhibit the reuptake of CNS amine neurotransmitters is shown in the table below (number of arrows ↓ indicates the intensity of inhibitory actions). Which one of the drugs is most likely to have therapeutic effectiveness in the management of both obsessive-compulsive disorders (OCD) and major depressive disorders?

Drug	DA Reuptake	NE Reuptake	5HT Reuptake	GABA Reuptake
A.	↓↓	0	0	↓↓
B.	0	↓↓↓↓	↓	0
C.	0	0	↓↓↓↓	0
D.	0	0	↓	↓↓↓↓
E.	↓↓↓↓	↓↓	0	0

14. A patient suffering from attention deficit hyperactivity disorder is placed on atomoxetine. A drug that has a similar mechanism of action to atomoxetine is

A. methylphenidate
B. botulinum toxin
C. clonidine
D. amitriptyline
E. entacapone

15. A patient suffering from generalized anxiety disorder (GAD) has a history of drug dependence that includes the illicit use of secobarbital ("reds") and a variety of other drugs. Psychotherapy is indicated, but the physician also prescribes a drug that can be helpful in GAD and that has the advantage of no abuse liability. The drug prescribed was most likely to have been

A. bupropion
B. buspirone
C. baclofen
D. buprenorphine
E. phenobarbital

16. A patient has been diagnosed as having "long QT syndrome." The patient is experiencing significant pain following a bout with shingles. What would be an appropriate drug for his pain?

    A. Amitriptyline
    B. Fentanyl
    C. Acyclovir
    D. Diazepam
    E. Gabapentin

17. A habitual user of a schedule-controlled drug abruptly stops using it. Within 8 h, she becomes anxious, starts to sweat, and gets severe abdominal pain with diarrhea. These symptoms intensify over the next 12 h, during which time she has a runny nose, is lacrimating, and has uncontrollable yawning and intensification of muscle cramping and jerking. Assuming that these are withdrawal symptoms in the patient due to her physical dependence, the drug most likely to be involved is

    A. alprazolam
    B. amphetamine
    C. ethanol
    D. meperidine
    E. secobarbital

18. A 57-year-old patient, living at home, has severe pain due to a metastatic carcinoma that is being managed with fentanyl, delivered transdermally from a patch. He should also be taking, or at least have on hand

    A. apomorphine
    B. docusate
    C. loperamide
    D. morphine
    E. naloxone

19. A hospital nurse is taking imipramine for a phobic anxiety disorder, and her patient is being treated with chlorpromazine for a psychotic disorder. Which of the following adverse effects is likely to occur in both of these individuals?

    A. Excessive salivation
    B. Pupillary constriction
    C. Orthostatic hypotension
    D. Seizure threshold
    E. Weight loss

20. Which one of the following pairs of "drug/mechanism of action" is most accurate?

    A. Carbamazepine/facilitation of the actions of GABA
    B. Ethosuximide/blocks Na channels in axonal membranes
    C. Phenelzine/inhibits dopa decarboxylase
    D. Procaine/blocks Ca channels (type T) in thalamic neurons
    E. Lithium/inhibits recycling of inositol

21. A 30-year-old man is brought to the ER with the following symptoms attributed to a drug overdose: HR and BP, mydriasis, behavioral excitation, aggressiveness, paranoia, and hallucinations. Of the following drugs, which one is most likely to be responsible for these symptoms?

    A. Amphetamine
    B. Ethanol
    C. Fentanyl
    D. Flunitrazepam
    E. Marijuana

22. Which one of the following CNS receptors is directly coupled to an ion channel so that the effects of its activation do not involve second messenger systems?

    A. N(ACh)
    B. α (NE)
    C. D_{2A} (DA)
    D. μ (beta endorphin)
    E. $5HT_2$ (serotonin)

ANSWERS AND EXPLANATIONS

1. **Answer: C.** Most benzodiazepines are metabolized by liver cytochrome P450. In a patient lacking liver function, benzodiazepines that are metabolized via extrahepatic conjugation (e.g., lorazepam, oxazepam) are safer in terms of the possibility of excessive CNS depression. Lorazepam is metabolized, probably in the lungs, via glucuronidation. Although benzodiazepine actions can be reversed, the drug that acts as an antagonist is flumazenil, not naloxone.

2. **Answer: E.** Benzodiazepines interact with components of the GABA receptor–chloride ion channel macromolecular complex. Binding of BZs leads to an increase in the frequency of chloride ion channel opening elicited by the inhibitory transmitter GABA. Benzodiazepines do not act on $GABA_B$ receptors; baclofen, a centrally acting muscle relaxant, is an agonist at these receptors. Buspirone, the selective anxiolytic, may be a partial agonist at 5HT receptors.

3. **Answer: C.** Morphine continues to be used in pulmonary congestion, in part because of its sedative (calming) and analgesic effects and also because of its vasodilating actions, which result in favorable hemodynamics in terms of cardiac and pulmonary function. Similarly, morphine is of value in an acute MI, especially its ability to relieve pain. However, morphine is not suitable for pain of biliary origin because it causes contraction of the sphincters of Oddi, leading to spasms. None of the other proposed indications are appropriate.

4. **Answer: C.** Benzodiazepines, barbiturates, and ethanol all modulate the actions of the $GABA_A$ receptor, while baclofen works at the $GABA_B$ receptor, and dronabinol works on cannabinoid receptors. Of the $GABA_A$ drugs, only barbiturates have GABA-mimicking activity and this occurs at high doses. This is one of the reasons why barbiturates are a more dangerous group of drugs than benzodiazepines since benzos lack GABA-mimicking activity.

5. **Answer: E.** Phenytoin has the unusual characteristic of following first-order elimination kinetics at low doses but zero-order kinetics at high doses because of saturation of the liver enzymes involved in its metabolism. Carbamazepine, like most drugs, follows first-order kinetics. Both drugs are P450 inducers and can increase the metabolism of oral contraceptives, making them less effective. Both drugs are teratogenic, causing structural abnormalities during fetal development including cleft palate. Both drugs block inactivated sodium channels, preventing sodium entry, thereby prolonging the time to recovery.

6. **Answer: B.** Pentazocine is an agonist at κ (kappa) opioid receptors and an antagonist at μ opioid receptors. Mixed agonist-antagonists can displace μ receptor agonists such as heroin from receptors, resulting in the rapid development of symptoms of withdrawal in patients who are physically dependent on such drugs—"precipitated withdrawal." Symptoms include yawning, lacrimation, salivation, restlessness, anxiety, sweating, goosebumps, muscle cramps, and pain.

7. **Answer: C.** Muscarinic receptor antagonists such as benztropine, trihexyphenidyl, and diphenhydramine are used to manage the reversible extrapyramidal dysfunction (e.g., pseudoparkinsonism) that results from treatment with drugs that block DA receptors in the striatum (typical antipsychotics). Drugs that activate DA receptors, although theoretically possible, require doses that are toxic and exacerbate psychoses. Because the actions of DA in the striatum lead to inhibition of GABA-ergic neurons, drugs that activate GABA receptors are unlikely to be effective in this situation, although they may well have both anxiolytic and anticonvulsant properties.

8. **Answer: B.** In addition to blocking reuptake of NE and 5HT, pharmacodynamic actions of the tricyclic antidepressants include block of peripheral adrenergic and muscarinic receptors—the former resulting in postural hypotension and the latter, via mydriasis, exacerbating glaucoma. TCAs may cause arrhythmias in overdose. They have no effect on the absorption of levodopa.

9. **Answer: C.** Lithium causes goiter in a significant number of patients; however, thyroid dysfunction does not occur in all such patients, and when it does it presents as hypothyroidism (not hyper-T). High-Na diets increase lithium elimination; low Na increases lithium plasma levels. Uncoupling of vasopressin receptors is characteristic of lithium, leading to a nephrogenic diabetes insipidus. Although potential teratogenicity is a concern during pregnancy, lithium does not cause neural tube defects but may cause abnormalities in heart valves. Lithium takes 10 to 20 days for effectiveness, and in acute mania it is often necessary to calm the patient with parenteral antipsychotic drugs such as fluphenazine or haloperidol.

10. **Answer: A.** Methanol is metabolized by alcohol dehydrogenase to formaldehyde and then further metabolized to formic acid by aldehyde dehydrogenase. Its major toxicity is severe vision damage. Ethylene glycol ingestion is associated with nephrotoxicity, while ethanol ingestion causes nausea, vomiting, and hypotension.

11. **Answer: B.** Carbidopa inhibits peripheral dopa decarboxylase, which enhances uptake of levodopa into the CNS and therefore its conversion to dopamine. Carbidopa doesn't cross the blood-brain barrier and therefore has no direct benefit at dopamine receptors.

12. **Answer: C.** The patient is probably taking an SSRI such as paroxetine. SSRIs rarely cause sedation and commonly cause agitation and the "jitters," which sometimes necessitates concomitant use of drugs that are strongly sedating, such as trazodone. SSRIs are best taken in the morning to avoid problems of insomnia, and they appear to cause weight loss, at least during the first 12 months of treatment. Severe drug interactions leading to the "serotonin syndrome" have been reported when SSRIs have been used together with MAO inhibitors, tricyclics, and the opioid meperidine.

13. **Answer: C.** Drug C appears to be a selective inhibitor of the reuptake of serotonin, and existing drugs of this class (SSRIs) are approved for use in both major depressive and obsessive-compulsive disorders. The tricyclic antidepressant clomipramine, a potent inhibitor of 5HT reuptake, was formerly the drug of choice for OCD until replaced by the SSRIs. Drugs A and E may have value in the treatment of Parkinson disease because they block the reuptake of DA. Drug D may be effective in anxiety and seizure states because it is an effective blocker of GABA reuptake.

14. **Answer: D.** Atomoxetine is used in attention deficit hyperactivity disorder (ADHD) and works by blocking the reuptake of norepinephrine into nerve terminals. This mechanism is how both cocaine and the tricyclic antidepressants such as amitriptyline work. Amphetamines such as methylphenidate are also commonly used in ADHD and work by displacing norepinephrine from the mobile pool.

15. **Answer: B.** Buspirone has selective anxiolytic activity that is slow in onset. The drug has no abuse liability and will not suppress withdrawal symptoms in patients who have become physically dependent on barbiturates, benzodiazepines, or ethanol. Bupropion is an antidepressant, also approved for management of dependence on nicotine. Baclofen is a spinal cord muscle relaxant that activates $GABA_B$ receptors. Buprenorphine is a long-acting opioid analgesic with no effectiveness in GAD, and phenobarbital is a barbiturate that may cause dependence.

16. **Answer: E.** The patient is experiencing postherpetic neuralgia. While acyclovir is effective at eradicating the herpes virus, it is ineffective against the pain of shingles. Appropriate drugs are TCAs such as amitriptyline and gabapentin. Patients with long QT syndrome have a genetic flaw in cardiac inward rectifying K current, leading to increased APD. Drugs that accentuate this by inhibiting the repolarizing K current (phase 3), which include thioridazine and the tricyclic antidepressants, are likely to have enhanced cardiotoxic potential in such patients. As a result, this patient should be placed on gabapentin.

17. **Answer: D.** The signs and symptoms described are typical of withdrawal from physical dependency on an opioid that has efficacy equivalent to a full agonist—in this case, meperidine. Although anxiety, agitation, and even muscle jerking may occur in withdrawal from dependence on sedative-hypnotics such as alprazolam and secobarbital, the symptoms of GI distress, rhinorrhea, lacrimation, and yawning are not characteristic (seizures are more typical). Symptoms of withdrawal from high-dose use of CNS stimulants such as amphetamine or cocaine include lassitude and severe depression of mood. The phrase "schedule-controlled" refers to FDA classifications of drugs that have abuse liability, including both licit and illicit drugs.

18. **Answer: B.** Fentanyl is a full agonist at opioid receptors and provides analgesia in cancer pain equivalent to morphine, so there is no good reason to have morphine on hand, and it would be a danger to the patient in terms of accidental overdose. Apomorphine is an emetic, hardly appropriate given the stimulatory effects of opioids on the emetic center. Likewise, loperamide is used in diarrheal states, and patients on strong opioids are almost certain to be constipated; for this reason, a stool softener like docusate should be available to the patient. The opioid antagonist naloxone is used IV in overdose situations but would not be provided to the patient for use PRN.

19. **Answer: C.** Orthostatic hypotension occurs with both tricyclic antidepressants and phenothiazines because both types of drugs can block alpha-adrenergic receptors in venous beds. Their ability to block M receptors leads to xerostomia (not salivation) and mydriasis (not miosis). Tricyclics and phenothiazines also share a common tendency to decrease seizure threshold and cause weight gain (not loss).

20. **Answer: E.** Lithium inhibits the dephosphorylation of IP_2 (needed for the recycling of inositol), leading to depletion of membrane PIP_2. Consequently, the activation of receptors by neurotransmitters such as ACh, NE, and 5HT fails to release the second messengers IP_3 and DAG. Carbamazepine and the local anesthetic procaine block axonal Na channels; ethosuximide may block Ca channels in thalamic neurons. Phenelzine is a nonselective inhibitor of MAO.

21. **Answer: A.** The signs and symptoms are characteristic of a CNS stimulant that facilitates the activity of amines in both the CNS and the periphery. Amphetamines promote the release of NE from sympathetic nerve endings, causing CV stimulation and pupillary dilation. In the CNS, they enhance the actions of DA, NE, and 5HT, causing behavioral excitation and a psychotic state that may be difficult to distinguish from schizophrenia. Ethanol, marijuana, fentanyl, and flunitrazepam (a benzodiazepine that has been used in "date rape") are all CNS depressants.

22. **Answer: A.** ACh receptors in the CNS are present on less than 5% of the neuronal population. Most of them are of the muscarinic subtype, M_1 (excitatory) and M_2 (inhibitory), via G-protein coupled changes in cAMP. Nicotinic receptors are excitatory via direct coupling to cation channels (Na/K), and their activation does not initiate second messenger pathways. Other CNS transmitter receptors that are directly coupled to ion channels include those for GABA and glutamic acid. Almost all CNS receptors for DA, NE, 5HT, and opioid peptides are coupled to ion channels via second messenger systems.

PART V

ANTIMICROBIAL DRUGS

Antibiotics and Tuberculosis Drugs

1

LEARNING OBJECTIVES

- ❑ Describe mechanism and side effects for various antibiotics
- ❑ Identify resistance mechanisms for select antibiotics
- ❑ Identify the most common antibiotics for treating sexually transmitted infections, *pseudomonas*, MRSA, pneumonia, and urinary tract infection
- ❑ Describe mechanism and side effects for antitubercular drugs

PRINCIPLES OF ANTIMICROBIAL CHEMOTHERAPY

- Bactericidal
- Bacteriostatic
- Combinations: **additive**; **synergistic** (penicillins plus aminoglycosides); and **antagonistic** (penicillin plus tetracyclines)

Mechanisms

High-Yield

Table V-1-1. Mechanism of Action of Antimicrobial Agents

Mechanism of Action	Antimicrobial Agents
Inhibition of bacterial cell-wall synthesis	Penicillins, cephalosporins, imipenem/meropenem, aztreonam, vancomycin
Inhibition of bacterial protein synthesis	Aminoglycosides, chloramphenicol, macrolides, tetracyclines, streptogramins, linezolid
Inhibition of nucleic acid synthesis	Fluoroquinolones, rifampin
Inhibition of folic acid synthesis	Sulfonamides, trimethoprim, pyrimethamine

Resistance

Table V-1-2. Mechanisms of Resistance to Antimicrobial Agents

Antimicrobial Agents	Primary Mechanism(s) of Resistance
Penicillins and cephalosporins	Production of beta-lactamases, which cleave the beta-lactam ring structure; change in penicillin-binding proteins; change in porins
Aminoglycosides (gentamicin, streptomycin, amikacin, etc.)	Formation of enzymes that inactivate drugs via conjugation reactions that transfer acetyl, phosphoryl, or adenylyl groups
Macrolides (erythromycin, azithromycin, clarithromycin, etc.) and clindamycin	Formation of methyltransferases that alter drug binding sites on the 50S ribosomal subunit Active transport out of cells
Tetracyclines	Increased activity of transport systems that "pump" drugs out of the cell
Sulfonamides	Change in sensitivity to inhibition of target enzyme; increased formation of PABA; use of exogenous folic acid
Fluoroquinolones	Change in sensitivity to inhibition of target enzymes; increased activity of transport systems that promote drug efflux
Chloramphenicol	Formation of inactivating acetyltransferases

INHIBITORS OF CELL-WALL SYNTHESIS

All cell-wall synthesis inhibitors are bactericidal. They are divided into B-lactam and non-B-lactam drugs.

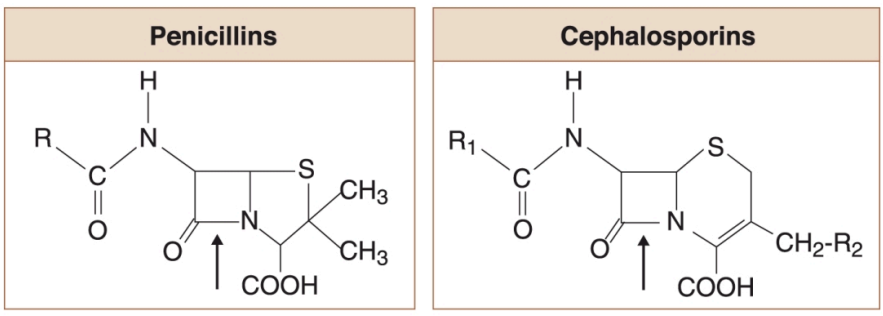


Figure V-1-1. Beta-Lactam Antibiotics

Penicillins

High-Yield

- Mechanisms of action:
  - Bacterial cell wall is cross-linked polymer of polysaccharides and pentapeptides
  - Penicillins interact with cytoplasmic membrane-binding proteins (PBPs) to inhibit transpeptidation reactions involved in cross-linking, the final steps in cell-wall synthesis

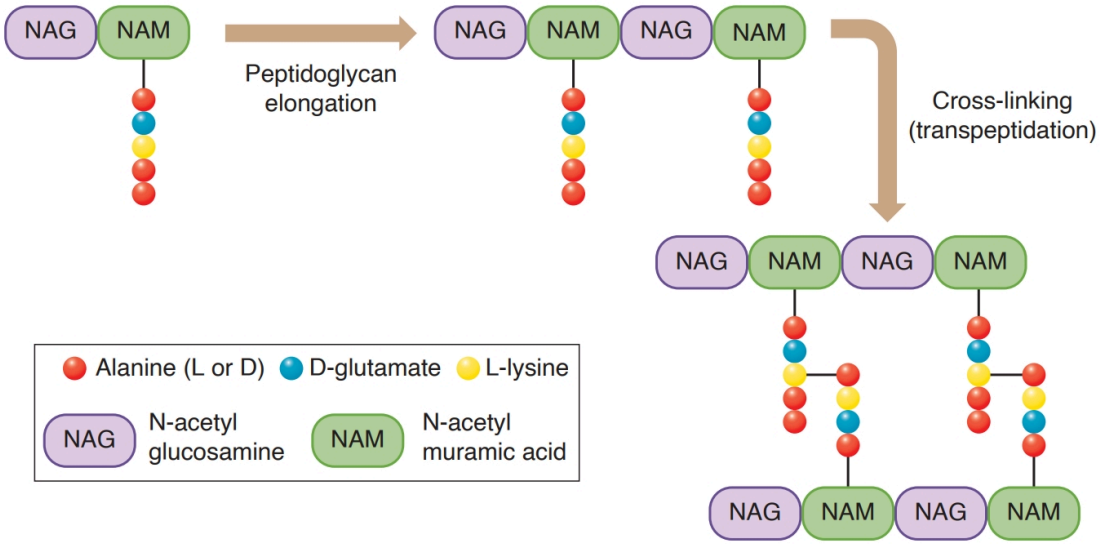


Figure V-1-2. Bacterial Cell Wall Synthesis

- Mechanisms of resistance:
  - Penicillinases (beta-lactamases) break lactam ring structure (e.g., staphylococci)
  - Structural change in PBPs (e.g., methicillin-resistant *Staphylococcus aureus* [MRSA], penicillin-resistant pneumococci)
  - Change in porin structure (e.g., *Pseudomonas)*

Table V-1-3. Properties of Penicillins

Type	Drugs	Beta Lactamase	Spectrum
Antistaph Penicillins	Nafcillin Oxacillin Methicillin	Resistant	**Very narrow:** Staphylococci (not MRSA)
Natural Penicillins	Penicillin G Penicillin V	Sensitive	**Narrow:** *Streptococci, Pneumococci, Treponema*
Aminopenicillins	Amoxicillin Ampicillin	Sensitive	**Broad:** Gram (+) *cocci, Listeria, E. coli, Borrelia, H. pylori*
Antipseudomonal Penicillins	Piperacillin	Sensitive	**Very broad:** Gram (+) cocci, Gram (-) rods, *Pseudomonas*

BRIDGE TO BIOCHEMISTRY

Suicide Inhibitors

Metabolism of a substrate by an enzyme to form a compound, which irreversibly inhibits that enzyme. Penicillinase inhibitors, such as clavulanic acid and sulbactam, are **suicide inhibitors**.

BRIDGE TO IMMUNOLOGY

Drug Hypersensitivity Reactions

I. IgE mediated: rapid onset; anaphylaxis, angioedema, laryngospasm

II. IgM and IgG antibodies fixed to cells: vasculitis, neutropenia, positive Coombs test

III. Immune complex formation: vasculitis, serum sickness, interstitial nephritis

IV. T-cell mediated: urticarial and maculopapular rashes, Stevens-Johnson syndrome

- General considerations:
  - Activity enhanced if used in combination with beta-lactamase inhibitors (clavulanic acid, sulbactam)
  - Synergy with aminoglycosides against pseudomonal and enterococcal species
- Pharmacokinetics:
  - Most are eliminated via active tubular secretion with secretion blocked by probenecid; dose reduction needed only in major renal dysfunction
  - Nafcillin and oxacillin eliminated largely in bile; ampicillin undergoes enterohepatic cycling, but excreted by the kidney
  - Benzathine penicillin G—repository form (half-life of 2 weeks)
- Side effects:
  - Hypersensitivity
    - Incidence 5 to 7% with wide range of reactions (types I–IV). Urticarial skin rash common, but severe reactions, including anaphylaxis, are possible.
    - Assume complete cross-allergenicity between individual penicillins
  - Other:
    - GI distress (NVD), especially ampicillin
    - Jarisch-Herxheimer reaction in treatment of syphilis

Cephalosporins

High-Yield

- Mechanisms of action and resistance: identical to penicillins
- Subgroups and antimicrobial activity:
  - First generation: cefazolin, cephalexin
    - Spectrum: gram-positive cocci (not MRSA), *E. coli, Klebsiella pneumoniae*, and some *Proteus* species
    - Common use in surgical prophylaxis
    - Pharmacokinetics: none enter CNS
  - Second generation: cefotetan, cefaclor, cefuroxime, cefoxitin
    - Spectrum: ↑ gram-negative coverage, including some anaerobes
    - Pharmacokinetics: no drugs enter the CNS, except cefuroxime
  - Third generation: ceftriaxone (IM) and cefotaxime (parenteral), cefdinir and cefixime (oral)
    - Spectrum: gram-positive and gram-negative cocci (*Neisseria gonorrhea*), plus many gram-negative rods (ceftazidime for *Pseudomonas*)
    - Pharmacokinetics: most enter CNS; important in empiric management of meningitis and sepsis
    - Ceftazidime (IV or IM)

  - Fourth generation: cefepime (IV)
    - Even wider spectrum (including *Pseudomonas*)
    - Resistant to most beta-lactamases
    - Enters CNS
- Pharmacokinetics:
  - Renal clearance similar to penicillins, with active tubular secretion blocked by probenecid
  - Dose modification in renal dysfunction
  - Ceftriaxone is largely eliminated in the bile
- Side effects:
  - Hypersensitivity:
    - Incidence: 2%
    - Wide range, but rashes and drug fever most common
    - Positive Coombs test, but rarely hemolysis
    - Assume complete cross-allergenicity between individual cephalosporins and partial cross-allergenicity with penicillins (about 5%)
    - Most authorities recommend avoiding cephalosporins in patients allergic to penicillins (for gram-positive organisms, consider macrolides; for gram-negative rods, consider aztreonam)

Imipenem and Meropenem

- Mechanism of action:
  - Same as penicillins and cephalosporins
  - Resistant to beta-lactamases
- Spectrum:
  - Gram-positive cocci, gram-negative rods (e.g., *Enterobacter, Pseudomonas* spp.), and anaerobes
  - Important in-hospital agents for empiric use in severe life-threatening infections
- Pharmacokinetics:
  - Imipenem is given with cilastatin, a renal dehydropeptidase inhibitor, which inhibits imipenem's metabolism to a nephrotoxic metabolite
  - Both drugs undergo renal elimination— ↓ dose in renal dysfunction
- Side effects:
  - GI distress
  - Drug fever (partial cross-allergenicity with penicillins)
  - CNS effects, including seizures with imipenem in overdose or renal dysfunction

CLINICAL CORRELATE

Ceftaroline is an unclassified (fifth-generation) cephalosporin that can bind to the most often seen mutation of the PBP in MRSA.

Aztreonam

- Mechanism of action:
  - Same as for penicillins and cephalosporins
  - Resistant to beta-lactamases
- Uses:
  - IV drug mainly active versus gram-negative rods
  - No cross-allergenicity with penicillins or cephalosporins

Recall Question

Which of the following changes will result in methicillin-resistant *S. aureus*?

A. Change in muramyl pentapeptide

B. Change in porin structure

C. Presence of penicillinase

D. Structural changes in penicillin-binding proteins (PBP)

Answer: D

Vancomycin

High-Yield

- Mechanism of action:
  - Binding at the D-ala-D-ala muramyl pentapeptide to sterically hinder the transglycosylation reactions (and indirectly preventing transpeptidation) involved in elongation of peptidoglycan chains
  - Does not interfere with PBPs
- Spectrum: MRSA, enterococci, *Clostridium difficile*
- Resistance:
  - Vancomycin-resistant staphylococcal (VRSA) and enterococcal (VRE) strains emerging
  - Enterococcal resistance involves change in the muramyl pentapeptide "target," such that the terminal D-ala is replaced by D-lactate
- Pharmacokinetics:
  - Used IV and orally (not absorbed) in colitis
  - Enters most tissues (e.g., bone), but not CNS
  - Eliminated by renal filtration (important to decrease dose in renal dysfunction)
- Side effects:
  - "Red man syndrome" (histamine release)
  - Ototoxicity (usually permanent, additive with other drugs)
  - Nephrotoxicity (mild, but additive with other drugs)

INHIBITORS OF BACTERIAL PROTEIN SYNTHESIS

Site of Action

High-Yield

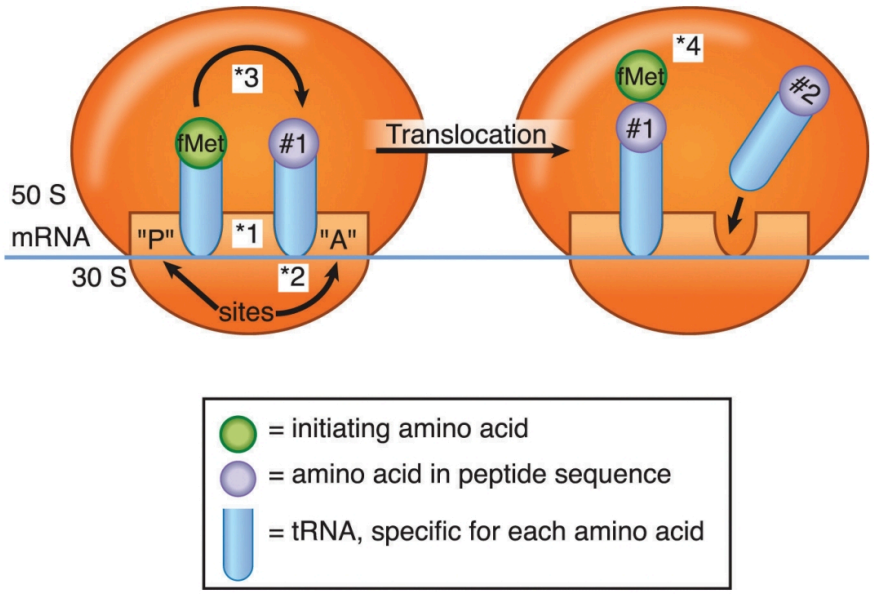


Figure V-1-3. Bacterial Protein Synthesis

Mechanisms

High-Yield

Table V-1-4. Mechanisms of Protein Synthesis Inhibition

Event	Antibiotic(s) and Binding Site(s)	Mechanism(s)
1. Formation of initiation complex	Aminoglycosides (30S) Linezolid (50S)	Interfere with initiation codon functions—block association of 50S ribosomal subunit with mRNA-30S (static); misreading of code (aminoglycosides only)—incorporation of wrong amino acid (–cidal)
2. Amino-acid incorporation	Tetracyclines (30S) Dalfopristin/ quinupristin (50S)	Block the attachment of aminoacyl tRNA to acceptor site (–static)
3. Formation of peptide bond	Chloramphenicol (50S)	Inhibit the activity of peptidyltransferase (–static)
4. Translocation	Macrolides and clindamycin (50S)	Inhibit translocation of peptidyl-tRNA from acceptor to donor site (–static)

Aminoglycosides

High-Yield

- Activity and clinical uses:
  - Bactericidal, accumulated intracellularly in microorganisms via an O_2-dependent uptake → anaerobes are innately resistant
  - Useful spectrum includes gram-negative rods; **gentamicin**, **tobramycin**, and **amikacin** often used in combinations
  - Synergistic actions occur for infections caused by enterococci (with penicillin G or ampicillin) and *P. aeruginosa* (with an extended-spectrum penicillin or third-generation cephalosporin)
  - **Streptomycin** used in tuberculosis; is the DOC for bubonic plague and tularemia
- Pharmacokinetics:
  - Are polar compounds, not absorbed orally or widely distributed into tissues
  - Renal elimination proportional to GFR, and major dose reduction needed in renal dysfunction
- Side effects:
  - Nephrotoxicity (6 to 7% incidence) includes proteinuria, hypokalemia, acidosis, and acute tubular necrosis—usually reversible, but enhanced by vancomycin, amphotericin B, cisplatin, and cyclosporine
  - Ototoxicity (2% incidence) from hair cell damage; includes deafness (irreversible) and vestibular dysfunction (reversible); toxicity may be enhanced by loop diuretics
  - Neuromuscular blockade with ↓ release of ACh—may enhance effects of skeletal muscle relaxants

BRIDGE TO MICROBIOLOGY

Once-Daily Dosing of Aminoglycosides

Antibacterial effects depend mainly on peak drug level (rather than time) and continue with blood levels < MIC—a postantibiotic effect (PAE).

Toxicity depends both on blood level and the time that such levels are > a specific threshold (i.e., total dose).

Tetracyclines

High-Yield

- Activity and clinical uses:
  - Bacteriostatic drugs, actively taken up by susceptible bacteria
  - "Broad-spectrum" antibiotics, with good activity versus chlamydial and mycoplasmal species, *H. pylori* (GI ulcers), *Rickettsia*, *Borrelia burgdorferi*, *Brucella*, *Vibrio*, and *Treponema* (backup drug)
- Specific drugs:
  - **Doxycycline:** more activity overall than tetracycline HCl and has particular usefulness in prostatitis because it reaches high levels in prostatic fluid
  - **Minocycline:** in saliva and tears at high concentrations and used in the meningococcal carrier state
  - Tigecycline: used in complicated skin, soft tissue, and intestinal infections due to resistant gram + (MRSA, VREF), gram –, and anaerobes

CLINICAL CORRELATE

Don't Use in Pregnancy

Aminoglycosides, fluoroquinolones, sulfonamides, tetracyclines

- Pharmacokinetics:
  - Kidney for most (↓ dose in renal dysfunction)
  - Liver for doxycycline
  - Chelators: tetracyclines bind divalent cations (Ca^{2+}, Mg^{2+}, Fe^{2+}), which ↓ their absorption
- Side effects:
  - Tooth enamel dysplasia and possible ↓ bone growth in children (avoid)
  - Phototoxicity (demeclocycline, doxycycline)
  - GI distress (NVD), superinfections leading to candidiasis or colitis
  - Vestibular dysfunction (minocycline)
  - Have caused liver dysfunction during pregnancy at very high doses (contraindicated)

Chloramphenicol

- Activity and clinical uses:
  - Bacteriostatic with a wide spectrum of activity
  - Currently a backup drug for infections due to *Salmonella typhi, B. fragilis, Rickettsia*, and possibly in bacterial meningitis
- Pharmacokinetics:
  - Orally effective, with good tissue distribution, including CSF
  - Metabolized by hepatic glucuronidation, and dose reductions are needed in liver dysfunction and in neonates
  - Inhibition of cytochrome P450
- Side effects:
  - Dose-dependent bone marrow suppression common; aplastic anemia rare (1 in 35,000)
  - "Gray baby" syndrome in neonates (↓ glucuronosyltransferase)

Macrolides

High-Yield

- Drugs: erythromycin, azithromycin, clarithromycin
- Activity and clinical uses: wide-spectrum antibiotics
  - Gram-positive cocci (not MRSA)
  - Atypical organisms (*Chlamydia, Mycoplasma,* and *Ureaplasma* species)
  - *Legionella pneumophila*
  - *Campylobacter jejuni*
  - *Mycobacterium avium-intracellulare (MAC)*
  - *H. pylori*

CLASSIC CLUES

Phototoxicity

- Tetracyclines
- Sulfonamides
- Quinolones

BRIDGE TO MICROBIOLOGY

Community-Acquired Pneumonia

With no comorbidity, the most common organisms associated with community-acquired pneumonia are *M. pneumoniae*, *C. pneumoniae*, and viruses. In smokers, the pneumococcus is a more frequent pathogen. Macrolide antibiotics have activity against most strains of these organisms (other than viruses) and are therefore commonly used in the treatment of a community-acquired pneumonia.

- Pharmacokinetics: inhibit cytochrome P450s
- Side effects:
  - Gastrointestinal distress (erythromycin, azithromycin > clarithromycin) due to stimulation of motilin receptors
  - Reversible deafness at high doses
  - Increased QT interval
- Telithromycin: a ketolide active against macrolide-resistant *S. pneumoniae*

Clindamycin

- Not a macrolide, but has the same mechanisms of action and resistance
- Narrow spectrum: gram-positive cocci (including community-acquired MRSA) and anaerobes, including *B. fragilis* (backup drug)
- Concentration in bone has clinical value in osteomyelitis due to gram-positive cocci
- Side effect: pseudomembranous colitis (most likely cause)

Linezolid

- Mechanism of action:
  - Inhibits the formation of the initiation complex in bacterial translation systems by preventing formation of the N-formylmethionyl-tRNA-ribosome-mRNA ternary complex
- Spectrum:
  - Treatment of VRSA, VRE, and drug-resistant pneumococci
- Side effects: bone marrow suppression (platelets), MAO-A and B inhibitor

Quinupristin–Dalfopristin

- Mechanism of action:
  - Binding to sites on 50S ribosomal subunit, they prevent the interaction of amino-acyl-tRNA with acceptor site and stimulate its dissociation from ternary complex
  - May also decrease the release of completed polypeptide by blocking its extrusion
- Spectrum:
  - Treatment of vancomycin-resistant staphylococci (VRSA) and other drug-resistant gram (+) cocci
- Side effects: diarrhea, jaundice, severe headache

NOTE

- Streptogramins for *E. faecium*, including VRE faecium, but not for *E. faecalis*
- Linezolid for both types of enterococci

INHIBITORS OF NUCLEIC ACID SYNTHESIS

Inhibitors of Folic Acid Synthesis

High-Yield

- Drugs: sulfonamides, trimethoprim, and pyrimethamine

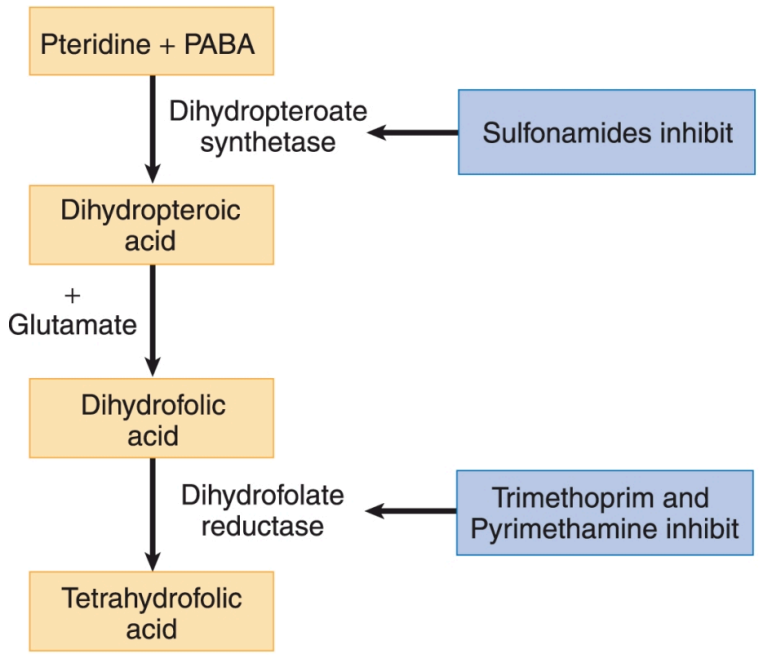


Figure V-1-4. Inhibitors of Folic Acid Synthesis

- Activity and clinical uses:
  - Sulfonamides alone are limited in use because of multiple resistance
  - Sulfasalazine is a prodrug used in ulcerative colitis and rheumatoid arthritis
  - Ag sulfadiazine used in burns

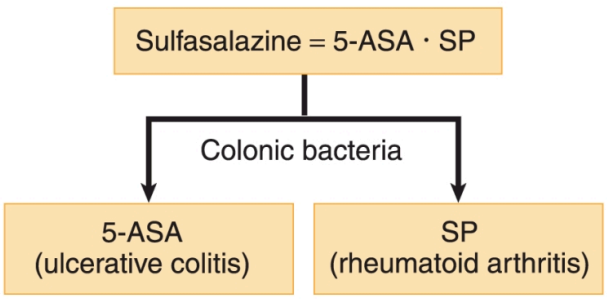


Figure V-1-5. Metabolism and Uses of Sulfasalazine

BRIDGE TO BIOCHEMISTRY

Antimetabolites are substances which inhibit cell growth by competing with, or substituting for, a natural substrate in an enzymatic process

Sulfonamides and trimethoprim are antimetabolites, as are many antiviral agents and drugs used in cancer chemotherapy.

CLINICAL CORRELATE

Sulfasalazine is useful in ulcerative colitis as well as Crohn disease that is confined to the colon. Most cases of mild to moderate Crohn are treated with mesalamine (5-ASA), which works throughout the GI tract.

5-ASA: 5-aminosalicylic acid

SP: sulfapyridine

  - Combination with dihydrofolate reductase inhibitors:
    - ↓ resistance
    - Synergy
  - Uses of trimethoprim-sulfamethoxazole (cotrimoxazole):
    - Bacteria:

      DOC in *Nocardia*

      Listeria (backup)

      Gram-negative infections (*E. coli, Salmonella, Shigella, H. influenzae*)

      Gram-positive infections (*Staph.*, including community-acquired MRSA, *Strep.*)
    - Fungus: *Pneumocystis jiroveci* (backup drugs are pentamidine and atovaquone)
    - Protozoa: *Toxoplasma gondii* (sulfadiazine + pyrimethamine)
- Pharmacokinetics:
  - Sulfonamides are hepatically acetylated (conjugation)
  - Renally excreted metabolites cause crystalluria (older drugs)
  - High protein binding
    - Drug interaction
    - Kernicterus in neonates (avoid in third trimester)
- Side effects:
  - Sulfonamides
    - Hypersensitivity (rashes, Stevens-Johnson syndrome)
    - Hemolysis in G6PD deficiency
    - Phototoxicity
  - Trimethoprim or pyrimethamine
    - Bone marrow suppression (leukopenia)

Direct Inhibitors of Nucleic Acid Synthesis: Quinolones

- Drugs: ciprofloxacin, levofloxacin, and other "–floxacins"
- Mechanisms of action:
  - Quinolones are bactericidal and interfere with DNA synthesis
  - Inhibit topoisomerase II (DNA gyrase) and topoisomerase IV (responsible for separation of replicated DNA during cell division)
  - Resistance is increasing
- Activity and clinical uses:
  - Urinary tract infections (UTIs) and other gram (-), especially in cases of drug resistance
  - Drug-resistant pneumococci (levofloxacin)

NOTE

The activity of quinolones includes *Bacillus anthracis*. Anthrax can also be treated with penicillins or tetracyclines.

- Pharmacokinetics:
  - Iron, calcium limit their absorption
  - Eliminated mainly by kidney by filtration and active secretion (inhibited by probenecid)
  - Reduce dose in renal dysfunction
- Side effects:
  - Tendonitis, tendon rupture, nerve damage (peripheral neuropathy)
  - Phototoxicity, rashes
  - CNS effects (insomnia, dizziness, headache)
  - Contraindicated in pregnancy and in children (inhibition of chondrogenesis)

UNCLASSIFIED ANTIBIOTIC

Metronidazole

High-Yield

- In anaerobes, converted to free radicals by ferredoxin, binds to DNA and other macromolecules, bactericidal
- Antiprotozoal: *Giardia*, *Trichomonas*, *Entamoeba*
- Antibacterial: strong activity against most anaerobic gram-negative *Bacteroides* species, *Clostridium* species (DOC in pseudomembranous colitis), *Gardnerella*, and *H. pylori*
- Side effects: metallic taste, disulfiram-like effect

CLINICAL CORRELATE

Antibiotics for *H. pylori*

Gastrointestinal Ulcers

- "BMT" regimen: bismuth, metronidazole, and tetracycline
- Clarithromycin, amoxicillin, omeprazole

ANTITUBERCULAR DRUGS

Combination drug therapy is the rule to delay or prevent the emergence of resistance and to provide additive (possibly synergistic) effects against *Mycobacterium tuberculosis*.

- The primary drugs in combination regimens are isoniazid (INH), rifampin, ethambutol, and pyrazinamide. Regimens may include 2–4 of these drugs, but in the case of highly resistant organisms, other agents may also be required. Backup drugs include aminoglycosides (streptomycin, amikacin, kanamycin), fluoroquinolones, capreomycin (marked hearing loss), and cycloserine (neurotoxic).
- Prophylaxis: rifampin (4 months) or isoniazid (9 months); both drugs can be used in combination as well.

Features of Antitubercular Drugs

High-Yield

NOTE

Mycobacterium avium-intracellulare (MAC)

- Prophylaxis: azithromycin or clarithromycin
- Treatment: clarithromycin + ethambutol + rifabutin

Table V-1-5. Actions, Resistance, and Side Effects of Antitubercular Drugs

Drug	Mechanisms of Action and Resistance	Side Effects
Isoniazid (INH)	• Inhibits mycolic acid synthesis • Prodrug requiring conversion by catalase • High level resistance—deletions in *katG* gene (encodes catalase needed for INH bioactivation)	• Hepatitis (age-dependent) • Peripheral neuritis (use vitamin B6) • Sideroblastic anemia (use vitamin B6) • SLE in slow acetylators (rare)
Rifampin	• Inhibits DNA-dependent RNA polymerase (nucleic acid synthesis inhibitor)	• Hepatitis • Induction of P450 • Red-orange metabolites
Ethambutol	• Inhibits synthesis of arabinogalactan (cell-wall component)	• Dose-dependent retrobulbar neuritis → ↓ visual acuity and red-green discrimination
Pyrazinamide		• Hepatitis • Hyperuricemia
Streptomycin	• Protein synthesis inhibition (*see* Aminoglycosides)	• Deafness • Vestibular dysfunction • Nephrotoxicity

Recall Question

Which of the following is a side effect of linezolid?

A. Bone marrow suppression

B. Cardiotoxicity

C. Nephrotoxicity

D. Retinopathy

Answer: A

Antifungal Drugs 2

LEARNING OBJECTIVES

- ❑ Describe mechanism and side effects for antifungal drugs
- ❑ Identify the most common antifungals used for candidiasis, cryptococcal meningitis, aspergillosis, and dermatophytic infections

PROPERTIES OF ANTIFUNGAL DRUGS

Mechanism of Action

High-Yield

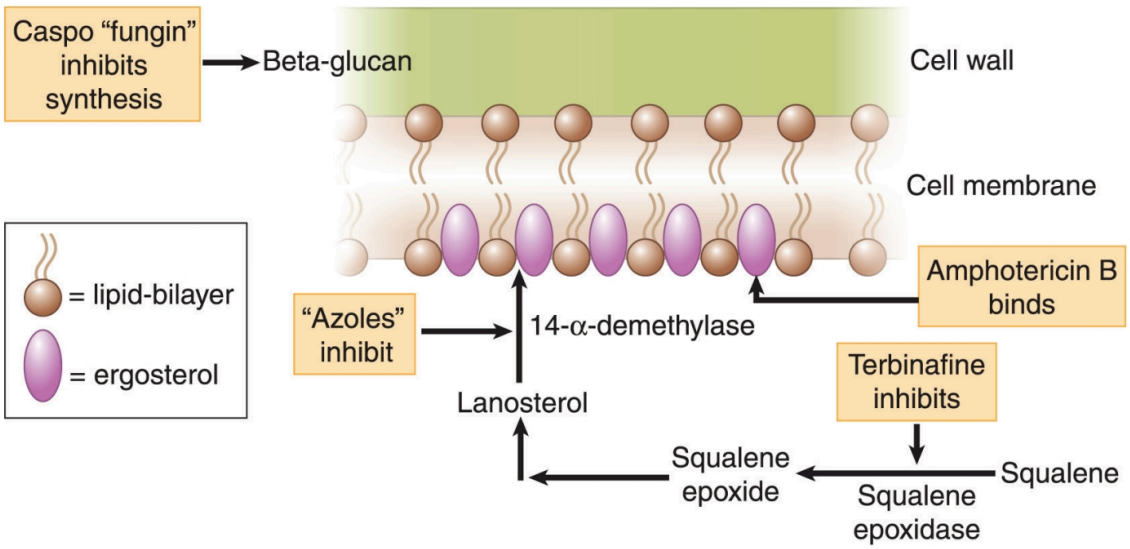


Figure V-2-1. Mechanism of Action of Antifungal Drugs

Polyenes (Amphotericin B, Nystatin)

- Mechanisms:
  - Amphoteric compounds with both polar and nonpolar structural components: interact with **ergosterol** in fungal membranes to form artificial "pores," which disrupt membrane permeability
  - Resistant fungal strains appear to have low ergosterol content in their cell membranes

- Activity and clinical uses:
  - Amphotericin B (Amp B) has wide fungicidal spectrum; remains the DOC (or co-DOC) for severe infection caused by *Cryptococcus* and *Mucor* (is synergistic with flucytosine in cryptococcoses)
  - Nystatin (too toxic for systemic use): used topically for localized infections (e.g., candidiasis)
- Pharmacokinetics:
  - Amp B given by slow IV infusion: poor penetration into the CNS (intrathecal possible)
  - Slow clearance (half-life >2 weeks) via both metabolism and renal elimination
- Side effects:
  - Infusion-related
    - Fever, chills, muscle rigor, hypotension (histamine release) occur during IV infusion (a test dose is advisable)
    - Can be alleviated partly by pretreatment with NSAIDs, antihistamines, meperidine, and adrenal steroids
- Dose-dependent
    - Nephrotoxicity includes ↓ GFR, tubular acidosis, ↓ K^+ and Mg^{2+}, and anemia through ↓ erythropoietin
    - Protect by Na^+ loading, use of liposomal amp B, or by drug combinations (e.g., + flucytosine), permitting ↓ in amp B dose

Azoles (Ketoconazole, Fluconazole, Itraconazole, Voriconazole)

- Mechanism:
  - "Azoles" are fungicidal and interfere with the synthesis of ergosterol by inhibiting 14-α-demethylase, a fungal P450 enzyme, which converts lanosterol to ergosterol
  - Resistance occurs via decreased intracellular accumulation of azoles
- Activity and clinical uses:
  - Ketoconazole
    - Co-DOC for *Paracoccidioides* and backup for *Blastomyces* and *Histoplasma*
    - Oral use in mucocutaneous candidiasis or dermatophytoses
  - Fluconazole
    - DOC for esophageal and invasive candidiasis and coccidioidomycoses
    - Prophylaxis and suppression in cryptococcal meningitis
  - Itraconazole and Voriconazole
    - DOC in blastomycoses, sporotrichoses, aspergillosis
    - Backup for several other mycoses and candidiasis

  - Clotrimazole and miconazole
    - Used topically for candidal and dermatophytic infections
- Pharmacokinetics:
  - Effective orally
  - Absorption of ketoconazole ↓ by antacids
  - Absorption of itraconazole ↑ by food
  - Only fluconazole penetrates into the CSF and can be used in meningeal infection; fluconazole is eliminated in the urine, largely in unchanged form
  - Ketoconazole and itraconazole are metabolized by liver enzymes.
  - Inhibition of hepatic P450s
- Side effects: decreased synthesis of steroids, including cortisol and testosterone →↓ libido, gynecomastia, menstrual irregularities; increased liver function tests and rare hepatotoxicity

Other Antifungals

- Flucytosine
  - Activated by fungal cytosine deaminase to 5-fluorouracil (5-FU), which after triphosphorylation is incorporated into fungal RNA
  - 5-FU also forms 5-fluorodeoxyuridine monophosphate (5-Fd-UMP), which inhibits thymidylate synthase →↓ thymine.
  - Resistance emerges rapidly if flucytosine is used alone.
  - Use in combination with amphotericin B in severe candidal and cryptococcal infections—enters CSF
  - Toxic to bone marrow (*see* Anticancer Drugs, Section IX).
- Griseofulvin
  - Active only against dermatophytes (orally, not topically) by depositing in newly formed keratin and disrupting microtubule structure
  - Side effects: disulfiram-like reaction
- Terbinafine
  - Active only against dermatophytes by inhibiting squalene epoxidase →↓ ergosterol
  - Possibly superior to griseofulvin in onychomycoses
  - Side effects: GI distress, rash, headache, ↑ liver function tests → possible hepatotoxicity
- Echinocandins (caspofungin and other "fungins")
  - Inhibit the synthesis of beta-1,2 glucan, a critical component of fungal cell walls
  - Backup drugs given IV for disseminated and mucocutaneous *Candida* infections or invasive aspergillosis
  - Monitor liver function

Antiviral Drugs 3

LEARNING OBJECTIVES

- ❑ Describe mechanism antiherpetic drugs, drugs for HIV, drugs for influenza, and hepatitis C drugs
- ❑ Identify key side effects for antiherpetic drugs and HIV drugs

ANTIVIRAL DRUG PROPERTIES

Many antiviral drugs are antimetabolites which resemble the structure of naturally occurring purine and pyrimidine bases or their nucleoside forms. Antimetabolites are usually prodrugs requiring metabolic activation by host-cell or viral enzymes; commonly, such bioactivation involves phosphorylation reactions catalyzed by kinases.

Sites of Action

High-Yield

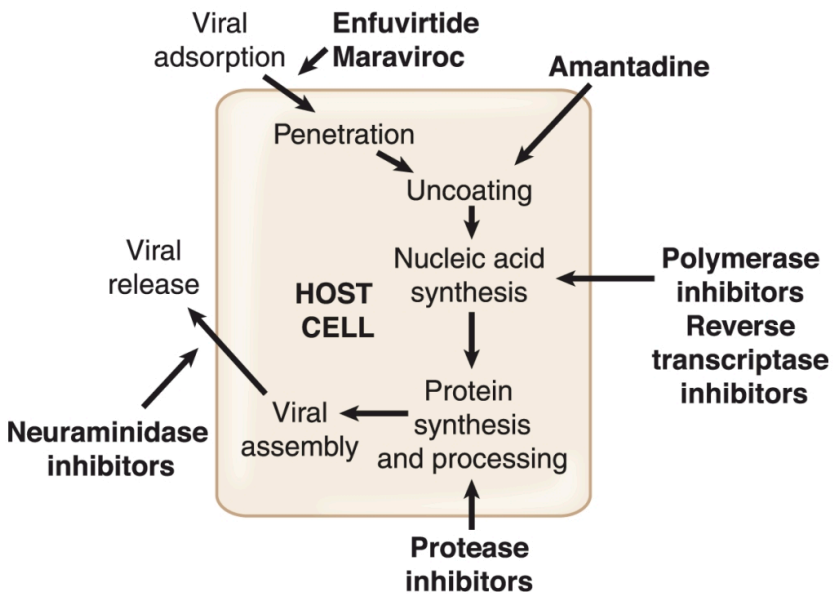


Figure V-3-1. Sites of Antiviral Drug Actions

Table V-3-1. Mechanism of Action of Antiviral Drugs

Mechanism of Action	Major Drugs
Block viral penetration/uncoating	Amantadine, enfuvirtide, maraviroc
Inhibit viral DNA polymerases	Acyclovir, foscarnet, ganciclovir
Inhibit viral RNA polymerases	Foscarnet, ribavirin
Inhibit viral reverse transcriptase	Zidovudine, didanosine, zalcitabine, lamivudine, stavudine, nevirapine, efavirenz
Inhibit viral aspartate protease	Indinavir, ritonavir, saquinavir, nelfinavir
Inhibit viral integrase	Raltegravir
Inhibit viral neuraminidase	Zanamivir, oseltamivir

ANTIHERPETICS

Acyclovir

High-Yield

- Mechanisms of action:
  - Monophosphorylated by viral thymidine kinase (TK), then further bioactivated by host-cell kinases to the triphosphate
  - Acyclovir-triphosphate is both a substrate for and inhibitor of viral DNA polymerase
  - When incorporated into the DNA molecule, acts as a chain terminator because it lacks the equivalent of a ribosyl 3′ hydroxyl group
  - Resistance possibly due to changes in DNA polymerase or to decreased activity of TK
  - >50% of HSV strains resistant to acyclovir completely lack thymidine kinase (TK^- strains)

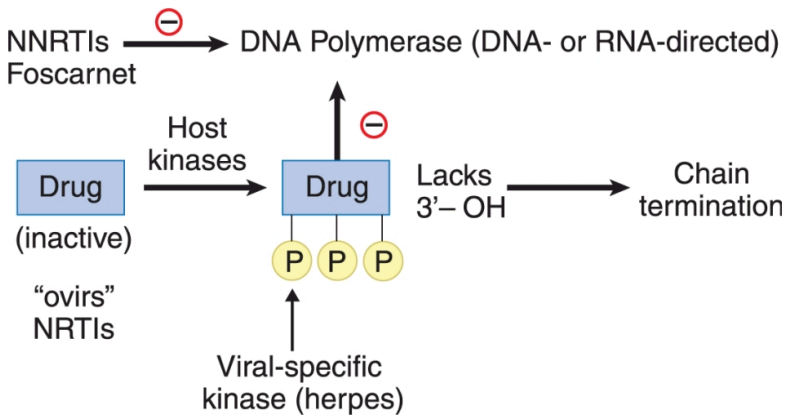


Figure V-3-2. Common Mechanism for "ovirs" and NRTIs

- Activity and clinical uses:
  - Activity includes herpes simplex virus (HSV) and varicella-zoster virus (VZV)
  - There are topical, oral, and IV forms; has a short half-life
  - Reduces viral shedding in genital herpes; ↓ acute neuritis in shingles but has no effect on postherpetic neuralgia
  - Reduces symptoms if used early in chickenpox; prophylactic in immunocompromised patients
- Side effects: minor with oral use, more obvious with IV; crystalluria (maintain full hydration) and neurotoxicity (agitation, headache, confusion [seizures in OD]); is **not** hematotoxic
- Newer drugs: famciclovir and valacyclovir are approved for HSV infection and are similar to acyclovir in mechanism (may have activity against strains resistant to acyclovir but not TK^- strains; may have longer $t_{1/2}$ than acyclovir)

Ganciclovir

- Mechanisms of action:
  - Similar to that of acyclovir
  - First phosphorylation step is viral-specific; involves thymidine kinase in HSV and a phosphotransferase (UL97) in cytomegalovirus (CMV)
  - Triphosphate form inhibits viral DNA polymerase and causes chain termination
  - Resistance mechanisms similar to acyclovir
- Activity and clinical uses:
  - HSV, VZV, and CMV
  - Mostly used in prophylaxis and treatment of CMV infections, including retinitis, in AIDS and transplant patients—relapses and retinal detachment occur
- Side effects: dose-limiting hematotoxicity (leukopenia, thrombocytopenia), mucositis, fever, rash, crystalluria (maintain hydration); seizures in overdose

Foscarnet

- Mechanisms and clinical uses:
  - Not an antimetabolite, but still inhibits viral DNA and RNA polymerases
  - Uses identical to ganciclovir, plus > activity versus acyclovir-resistant strains of HSV
- Side effects: dose-limiting nephrotoxicity with acute tubular necrosis, electrolyte imbalance with hypocalcemia (tremors and seizures); avoid pentamidine IV (→↑ nephrotoxicity and hypocalcemia)

TREATMENT OF HIV

Highly active antiretroviral therapy (HAART) decreases viral RNA, reverses the decline in CD4 cells, and decreases the risk of opportunistic infections. Treatment is done in 3-4 drug combinations.

Reverse Transcriptase Inhibitors (RTIs)

- **Nucleoside reverse transcriptase inhibitors (NRTIs)**
  - Mechanism of action: phosphorylated to a triphosphate that can inhibit reverse transcriptase by competing with natural nucleotides; can also be incorporated into viral DNA causing chain termination
  - Are components of most drug regimens

CLINICAL CORRELATE

Tenofovir is an NtRTI commonly coformulated with an NRTI. Tenofovir has a single phosphate on its sugar residue and must be further phosphorylated to the triphosphate form.

Table V-3-2. Side Effects of NRTIs

Drug	Side Effects
Zidovudine, AZT	• Hematotoxicity (major and dose-limiting) • Headache, asthenia, myalgia, myopathy, and peripheral neuropathy
Didanosine, DDI	• Pancreatitis (major and dose-limiting) • Peripheral neuropathy, hyperuricemia, liver dysfunction
Lamivudine, 3TC; emtricitabine, FTC	• Least toxic of the NRTIs, but some GI effects and neutropenia • Active in hepatitis B (lamivudine)

- **Nonnucleoside reverse transcriptase inhibitors (NNRTIs): efavirenz, nevirapine**
  - Mechanism of action: inhibit reverse transcriptase at a site different from the one NRTIs bind to; additive or synergistic when used in combination with NRTIs or protease inhibitors
  - Side effects: maculopapular rash, CNS effects (including vivid dreams)

Protease Inhibitors (PI)

- Mechanisms of action:
  - Aspartate protease (*pol* gene encoded) is a viral enzyme that cleaves precursor polypeptides in HIV buds to form the proteins of the mature virus core.
  - Resistance occurs via specific point mutations in the *pol* gene, such that there is not complete cross-resistance between different PIs.
- Clinical uses:
  - Ritonavir and other -avirs
  - Lopinavir, atazanavir, and darunavir are the PIs most commonly co-formulated with ritonavir
- Side effects:
  - Indinavir
    - Crystalluria (maintain hydration)
  - Ritonavir
    - Major drug interactions: induces CYP 1A2 and inhibits the major P450 isoforms (3A4 and 2D6)
  - General: syndrome of disordered lipid and CHO metabolism with central adiposity and insulin resistance

CLINICAL CORRELATE

HIV Prophylaxis

Postexposure prophylaxis: emtricitabine + tenofovir + raltegravir

Pregnancy: 2 NRTIs (emtricitabine or lamivudine) + (zidovudine or tenofovir) + ritonavir-boosted atazanavir or lopinavir

Integrase Inhibitors

- Mechanism of action: prevents integration of viral genome in host cell DNA
  - Raltegravir and other "*tegravirs*"

CLINICAL CORRELATE

Integrase inhibitors combined with 2 NRTIs are used as complete treatment regiments.

Fusion Inhibitors

- Enfuvirtide: binds to gp41 and inhibits the fusion HIV-1 to CD4+ cells
- Maraviroc: blocks the binding of the gp120 HIV protein to CCR5 on macrophage surface to prevent viral entry
- Enfuvirtide and maraviroc block the entry of HIV into cells.

NOTE

Amantadine and rimantadine are no longer recommended as prophylaxis or treatment for influenza A viruses.

OTHER ANTIVIRALS

Zanamivir and Oseltamivir

- Mechanisms of action:
  - Inhibit neuraminidases of influenza A and B (enzymes that prevent clumping of virions so that more particles are available for infecting host cells)
  - Decreases likelihood that the virus will penetrate uninfected cells
- Clinical uses: prophylaxis mainly, but may decrease duration of flu symptoms by 2–3 days

Ribavirin

- Mechanism of action: inhibits IMP dehydrogenase and RNA polymerase
- Clinical uses: combined with alpha-interferons for hepatitis C; Lassa fever and Hantavirus
- Side effects: anemia

Hepatitis C Treatment

- Sofosbuvir: nucleotide analog that inhibits RNA polymerase
- Simeprevir: hepatitis C protease inhibitor
- Ledipasvir: inhibits HCV NS5A protein that plays a key role in RNA replication and secretion

Recall Question

Which of the following best describes the mechanism of action of ribavirin?

A. Inhibits viral aspartate protease

B. Inhibits viral RNA polymerases

C. Inhibits viral DNA polymerases

D. Inhibits viral reverse transcriptase

Answer: B

Antiprotozoal Drugs

4

LEARNING OBJECTIVES

- ❑ Identify drug of choice for giardiasis, trichomoniasis, and toxoplasmosis
- ❑ Identify key drugs used for prophylaxis or treatment of malaria

OVERVIEW

Table V-4-1. Major Protozoal Infections and the Drugs of Choice

Infection	Drug of Choice	Comments
Amebiasis	Metronidazole	Diloxanide for noninvasive intestinal amebiasis
Giardiasis	Metronidazole	"Backpacker diarrhea" from contaminated water or food
Trichomoniasis	Metronidazole	Treat both partners
Toxoplasmosis	Pyrimethamine + sulfadiazine	—
Leishmaniasis	Stibogluconate	—
Trypanosomiasis	Nifurtimox (Chagas disease) Arsenicals (African)	—

Antimalarial Drugs

- Clinical uses:
  - Chloroquine-sensitive regions
    - Prophylaxis: chloroquine +/– primaquine
    - Backup drugs: hydroxychloroquine, atovaquone-proguanil, mefloquine, and doxycycline

- Specific treatment:

Table V-4-2. Treatment of Chloroquine-Sensitive Malaria

P. falciparum	Chloroquine
P. malariae	Chloroquine
P. vivax	Chloroquine + primaquine
P. ovale	Chloroquine + primaquine

  - Chloroquine-resistant regions
    - Prophylaxis: atovaquone-proguanil, mefloquine, and doxycycline
    - Treatment: artemisinin combination, atovaquone-proguanil, quinine +/– doxycycline or clindamycin
- Side effects:
  - Hemolytic anemia in G6PD deficiency (primaquine, quinine)
  - Cinchonism (quinine)

Drugs for Helminthic Infections

- Most intestinal nematodes (worms)
  - Albendazole (↓ glucose uptake and ↓ microtubular structure), mebendazole
  - Pyrantel pamoate (N_M agonist → spastic paralysis)
- Most cestodes (tapeworms) and trematodes (flukes)
  - Praziquantel (↑ Ca^{2+} influx, ↑ vacuolization)

Antimicrobial Drug List and Practice Questions

5

Table V-5-1. Antimicrobial Drug List

Penicillins	Cephalosporins	Other Cell Wall Inhibitors	
Penicillin G Nafcillin, oxacillin Amoxicillin, ampicillin Ticarcillin, piperacillin	Cefazolin (1st) Cefaclor (2nd) Ceftriaxone (3rd)	Imipenem, meropenem Vancomycin	
Macrolides	**Aminoglycosides**	**Tetracyclines**	**Others**
Erythromycin Azithromycin Clarithromycin	Gentamicin Tobramycin Streptomycin	Tetracycline HCl Doxycycline	Metronidazole
Fluoroquinolones	**Antifolates**	**Antimycobacterials**	
Ciprofloxacin Levofloxacin	Sulfamethoxazole Trimethoprim	Isoniazid, rifampin Ethambutol, pyrazinamide	
Antifungals	**Anti-Herpes**	**Anti-HIV**	
Amphotericin B Ketoconazole Fluconazole	Acyclovir Ganciclovir Foscarnet	Zidovudine (NRTI), didanosine (NRTI) Lamivudine (NRTI) Indinavir (PI), ritonavir (PI) Enfuvirtide, maraviroc	

PRACTICE QUESTIONS

1. A patient suffering from invasive aspergillosis is first administered NSAIDs, antihistamines, and adrenal glucocorticoids prior to administration of an antifungal drug. The antifungal drug works by

   A. binding to tubulin
   B. inhibiting squalene epoxidase
   C. inhibiting thymine synthesis
   D. binding to ergosterol
   E. inhibiting 14α-demethylase

2. A patient is prescribed isoniazid prophylactically since another family member currently has tuberculosis. When the patient ends up getting tuberculosis despite prophylaxis, resistance to isoniazid is suspected. In what way did this resistance likely develop?

   A. Decreased intracellular accumulation of the drug
   B. Inactivation of the drug via *N*-acetyltransferases
   C. Increased synthesis of mycolic acids
   D. Mutations in the gene coding for DNA-dependent RNA polymerase
   E. Reduced expression of the gene that encodes a catalase

3. A 7-year-old child presents with pharyngitis and fever of 2 days' duration, and microbiology reveals small, translucent, beta-hemolytic colonies sensitive in vitro to bacitracin. History includes a severe allergic reaction to amoxicillin when used for an ear infection. The physician needs to treat this infection but prefers not to use a drug that needs parenteral administration. Which one of the following agents is most likely to be appropriate in terms of both effectiveness and safety?

   A. Azithromycin
   B. Cefaclor
   C. Doxycycline
   D. Penicillin G
   E. Vancomycin

4. A woman has a sexually transmitted disease, and the decision is made to treat her with antibiotics as an outpatient. She is warned that unpleasant reactions may occur if she consumes alcoholic beverages while taking this drug. The antibiotic can be identified as which of the following?

   A. Ceftriaxone
   B. Doxycycline
   C. Metronidazole
   D. Ofloxacin
   E. Pen G

5. An 82-year-old hospitalized patient with creatinine clearance of 25 mL/min has a microbial infection requiring treatment with antibiotics. Which of the following drugs is least likely to require a dosage adjustment, either a smaller dose than usual or an increased interval between doses?

   A. Amphotericin B
   B. Ceftriaxone
   C. Gentamicin
   D. Imipenem-cilastatin
   E. Vancomycin

6. What drug is most likely to be effective in most diseases caused by nematodes?

   A. Chloroquine
   B. Mebendazole
   C. Metronidazole
   D. Praziquantel
   E. Pyrimethamine

7. What antibiotic effectively treats a variety of causative organisms for bacterial pneumonia, and also works at the 50S ribosomal subunit?

   A. Azithromycin
   B. Ceftriaxone
   C. Doxycycline
   D. Ofloxacin
   E. Clindamycin

8. In bacterial meningitis, third-generation cephalosporins are common drugs of choice. However, in neonatal meningitis they would not provide coverage if the infection was due to which of the following organisms?

   A. Meningococci
   B. *L. monocytogenes*
   C. Pneumococci
   D. *E. coli*
   E. Group B streptococci

9. Which one of the following drugs inhibits bacterial protein synthesis, preventing the translocation step via its interaction with the 50S ribosomal subunit?

   A. Clindamycin
   B. Gentamicin
   C. Chloramphenicol
   D. Imipenem
   E. Tetracycline

10. Which of the following is a mechanism underlying the resistance of strains of *S. pneumoniae* to the widely used antibiotic ciprofloxacin?

    A. Reduced topoisomerase sensitivity to inhibitors
    B. Increased synthesis of PABA
    C. Formation of methyltransferases that change receptor structure
    D. Structural changes in porins
    E. Formation of drug-inactivating hydrolases

11. Gentamicin would be an ineffective drug for which of the following organisms?

    A. *E. coli*
    B. *B. fragilis*
    C. *Pseudomonas*
    D. *Listeria* if combined with ampicillin
    E. *Proteus*

12. In the treatment of a urinary tract infection in a patient known to have a deficiency of glucose-6-phosphate dehydrogenase, it would not be advisable to prescribe which of the following?

    A. Ciprofloxacin
    B. Amoxicillin
    C. Cephalexin
    D. Doxycycline
    E. Sulfamethoxazole

13. What is the most likely mechanism of resistance for methicillin-resistant *Staphylococcus aureus* to antistaph penicillins?

    A. Methylation of the binding site
    B. Active efflux of the drug from the bacteria
    C. β-lactamase production
    D. Phosphorylation of the drug by bacterial enzymes
    E. Structural modifications of PBPs

14. Highly active antiretroviral therapy (HAART) in HIV infection is associated with which of the following?

    A. A decrease in viral mRNA copies/mL of blood
    B. A decrease in the rate of emergence of drug resistance
    C. A possible increase in CD4 cell count
    D. A reduced incidence of opportunistic infections
    E. All of the above

15. Oseltamivir and zanamivir are available for treatment of infections due to influenza A and B. The mechanism of their antiviral action is inhibition of which of the following?

    A. RNA polymerase
    B. Reverse transcriptase
    C. Thymidine kinase
    D. Neuraminidase
    E. Aspartate protease

16. In a patient who has an established hypersensitivity to metronidazole, what is the most appropriate drug to use for the management of pseudomembranous colitis?

    A. Ampicillin
    B. Clindamycin
    C. Doxycycline
    D. Ofloxacin
    E. Vancomycin

17. An AIDS patient who is being treated with multiple drugs, including AZT, lamivudine, indinavir, ketoconazole, and cotrimoxazole, develops breast hypertrophy, central adiposity, hyperlipidemia, insulin resistance, and nephrolithiasis. If these changes are related to his drug treatment, which of the following is the most likely cause?

    A. Azidothymidine
    B. Indinavir
    C. Ketoconazole
    D. Sulfamethoxazole
    E. Trimethoprim

18. Which one of the following drugs is most suitable in an immunocompromised patient for prophylaxis against infection due to *Cryptococcus neoformans?*

    A. Amphotericin B
    B. Ampicillin
    C. Fluconazole
    D. Nystatin
    E. Flucytosine

19. Which one of the following drugs is most likely to be associated with elevations of pancreatic enzymes, including amylase and lipase?

    A. Erythromycin
    B. Didanosine
    C. Isoniazid
    D. Zidovudine
    E. Pyrazinamide

20. The major mechanism of HSV resistance to acyclovir is

    A. a structural change in viral thymidine kinase
    B. a mutation in the gene that encodes DNA polymerase
    C. the loss of ability to produce viral thymidine kinase
    D. changes in reverse transcriptase
    E. mutations in the gene that codes for phosphotransferase

21. Despite its "age," penicillin G remains the drug of choice in the treatment of infections caused by which of the following organisms?

    A. *B. fragilis*
    B. *T. pallidum*
    C. *H. influenzae*
    D. *E. coli*
    E. *S. aureus*

22. Which one of the following drugs is most likely to be equally effective in the treatment of amebic dysentery and "backpacker diarrhea"?

    A. Ciprofloxacin
    B. Diloxanide
    C. Metronidazole
    D. Quinacrine
    E. Trimethoprim-sulfamethoxazole

ANSWERS AND EXPLANATIONS

1. **Answer: D.** Life-threatening invasive aspergillosis, with necrotizing pneumonia, most commonly occurs in severely immunocompromised patients. The mortality rate approaches 50%, but high intravenous doses of amphotericin B may be lifesaving. Intravenous amphotericin B causes infusion-related hypotension (via histamine release), fever, and chills, which may be attenuated by the prior administration of NSAIDs and antihistamines. Adrenal steroids may provide supplementary stress support. Amphotericin B binds to ergosterol in fungal membranes, opening pores and disrupting membrane permeability.

2. **Answer: E.** For antitubercular activity, isoniazid (INH) must first be metabolically activated via a catalase present in mycobacteria. A decrease in expression of the *cat* G gene that encodes this enzyme is the mechanism of high-level resistance to INH.

3. **Answer: A.** Azithromycin is highly effective as an oral agent in the management of pharyngitis caused by gram-positive cocci and may necessitate only a short course of therapy. In patients who have marked hypersensitivity to penicillins, it is inappropriate to use a cephalosporin, even though cefaclor is active against common oropharyngeal pathogens. Doxycycline should not be used in children. One must assume that complete cross-allergenicity exists between different members of the penicillin class of antibiotics, and, in any case, penicillin G is not usually given orally because of its lability in gastric acid. Vancomycin would need parenteral administration, and this antibiotic should be reserved for more serious bacterial infections.

4. **Answer: C.** Organisms associated with sexually transmitted diseases include Chlamydia, *Neisseria gonorrhea, Treponema* (syphilis), *Trichomonas,* and *Gardnerella vaginalis.* The latter two organisms are effectively treated with the drug metronidazole. Metronidazole has a chemical structure that results in a disulfiram-like effect on aldehyde dehydrogenase, causing reactions with ethanol. Patients should be cautioned not to consume alcoholic beverages while on this drug.

5. **Answer: B.** Ceftriaxone is eliminated largely via biliary excretion, and decreases in renal function do not usually require a dose reduction. All of the other antimicrobial drugs listed are eliminated by the kidney, at rates proportional to creatinine clearance, so major dose reductions would be needed in patients with renal dysfunction to avoid toxicity.

6. **Answer: B.** Mebendazole is the drug of choice for treatment of all nematode infections (hookworm, roundworm, pinworm, whipworm). Pyrantel is considered equally effective as mebendazole for nematodes. Praziquantel is used for tapeworms (cestodes) and flukes (trematodes).

7. **Answer: A.** Macrolides (azithromycin) are effective for common causes of pneumonias such as *Strep pneumonia, Haemophilus influenzae, Mycoplasma, Legionella, and Chlamydophila*. The drugs work at the 50S ribosomal subunit to inhibit translocation of the peptidyl tRNA from the acceptor to the donor site.

8. **Answer: B.** The most common pathogens implicated in bacterial meningitis in a neonate (age <1 month) are group B streptococci, followed by *E. coli.* Meningococci and pneumococci become prevalent after 1 month of age, and *H. influenzae* is becoming rarer since the availability of a vaccine. A third-generation cephalosporin (e.g., cefotaxime) would be administered because it provides coverage for most of the organisms mentioned. However, ampicillin is also needed to cover for *Listeria monocytogenes,* which occurs with an incidence of 7 to 8% in neonatal meningitis.

9. **Answer: A.** Clindamycin has a mechanism of action similar to, if not identical with, erythromycin and related macrolides. They bind to rRNA bases on the 50S subunit to prevent translocation of peptidyl-mRNA from the acceptor to the donor site. Chloramphenicol also binds to the 50S subunit but interferes with the activity of peptidyltransferase. Gentamicin and tetracyclines bind to the 30S ribosomal subunit. Imipenem is a cell-wall synthesis inhibitor, acting similarly to beta-lactams.

10. **Answer: A.** Microbial resistance to fluoroquinolones is increasing, and some strains of *Streptococcus pneumoniae* are now resistant to ciprofloxacin. The mechanism can involve changes in the structure of topoisomerase IV, one of the "targets" of fluoroquinolones, which inhibit nucleic acid synthesis. Pneumococcal resistance to penicillins is also increasing via changes in penicillin-binding proteins (PBPs). The other mechanisms listed underlie microbial resistance to other antibiotics as follows: sulfonamides **(choice B)**, macrolides **(choice C)**, extended-spectrum penicillins **(choice D)**, and beta-lactams **(choice E)**.

11. **Answer: B.** Aminoglycosides like gentamicin work on aerobic gram negative rods. They require oxygen to enter bacteria, and, as such, do not treat any anaerobes including *Bacteroides fragilis*. They can be used with penicillins such as ampicillin against *Listeria* for a synergistic effect.

12. **Answer: E.** Drugs that cause oxidative stress may precipitate acute hemolysis in patients who lack G6PD because they have a limited ability to generate NADPH, which restricts the formation of glutathione. Drugs in this category include primaquine, quinine, nitrofurantoin, sulfonamides, and TMP-SMX.

13. **Answer: E.** Antistaph penicillins are inherently resistant to cleavage by bacterial beta-lactamases. Instead, resistance develops when the target for these drug, PBPs, is altered such that the drug doesn't bind effectively.

14. **Answer: E.** HAART in the management of HIV infection is reported in many but not all patients to decrease viral load, increase CD4 cells, slow disease progression, and reduce opportunistic infections. However, in terms of the chemotherapy of AIDS, the word *cure* has little meaning. Discontinuance of HAART, after suppression of viral RNA copies below the sensitivity of the best current methods of analysis, is followed by the reemergence of detectable viral RNA in the blood within a few months.

15. **Answer: D.** Neuraminidase is an enzyme on the lipid envelope of influenza A and B virions that prevents their clumping together and also their binding to the surface of cells that have been already infected. Neuraminidase inhibitors interfere with this activity and reduce the availability of virions for entry into noninfected cells. Oseltamivir and zanamivir decrease the severity and duration of symptoms if given within a day or two of onset.

16. **Answer: E.** Vancomycin is usually considered to be a backup drug to metronidazole in colitis due to *Clostridium difficile* on the grounds that it is no more effective, is more costly, and should be reserved for treatment of resistant gram-positive coccal infections. None of the other drugs has activity in pseudomembranous colitis—indeed, they may cause it!

17. **Answer: B.** AIDS patients being treated with protease inhibitors (e.g., indinavir) have developed a syndrome involving derangement of lipid and CHO metabolism. Changes in lipid metabolism and distribution occur quite commonly, and type 2 diabetes has also been reported. Indinavir is also notable for its tendency to precipitate in the urinary tract, causing nephrolithiasis, unless the patient is maintained in a high state of hydration.

18. **Answer: C.** Fluconazole is distinctive in terms of its ability to penetrate into the cerebrospinal fluid, reaching levels similar to those in the blood. It is effective against *C. neoformans* and has become the most appropriate drug to use in both prophylaxis and suppression because of its oral efficacy and low toxicity compared with amphotericin B. Flucytosine is also active against *C. neoformans* but is not used alone because of rapid emergence of resistance. Nystatin is too toxic for systemic use.

19. **Answer: B.** Pancreatic dysfunction, heralded by large increases in serum amylase and lipase, is associated with the use of several reverse-transcriptase inhibitors (RTIs). Didanosine appears to be the worst offender, and pancreatitis is the most characteristic adverse effect of this particular NRTI. Conditions enhancing susceptibility to drug-induced pancreatic dysfunction include hypertriglyceridemia, hypercalcemia, and history of excessive ethanol use. Liver dysfunction including hepatitis may occur with the antitubercular drugs, isoniazid, and pyrazinamide. Cholestasis is associated with the estolate form of erythromycin.

20. **Answer: C.** To inhibit DNA polymerases in HSV, acyclovir must undergo initial monophosphorylation by a viral specific thymidine kinase (TK). Most HSV strains resistant to acyclovir lack this enzyme and are thus TK^- strains. A few strains of HSV are resistant to acyclovir by structural changes in TK that lower substrate affinity or by mutations in the gene that encode viral DNA polymerases.

21. **Answer: B.** Indications for the use of penicillin G are currently limited for a number of reasons. The drug has a narrow spectrum, is susceptible to beta-lactamases, and may cause hypersensitivity. Also, alternative antibiotics are available. However, penicillin G remains the drug of choice in syphilis, usually given IM as benzathine penicillin G, but as the Na^+ or K^+ salt IV in neurosyphilis. What would you do for patients who are highly allergic to penicillins? (Consider tetracyclines, or possibly desensitization.)

22. **Answer: C.** In amebic dysentery caused by *Entamoeba histolytica* and gastrointestinal infections with diarrhea ("backpacker diarrhea") due to *Giardia lamblia,* metronidazole is the drug of choice. Diloxanide is a backup drug for noninvasive intestinal amebiasis, but it has minimal activity in *Giardia* infections. Quinacrine has effectiveness in giardiasis but not amebiasis. TMP-SMX has antiprotozoal effectiveness in *Pneumocystis jiroveci,* pneumonia. Ciprofloxacin is devoid of antiprotozoal activity.

PART VI

INFLAMMATORY DISORDER DRUGS

1 Antihistamines

LEARNING OBJECTIVES

- ❑ Distinguish the properties of first- and second-generation antihistamines
- ❑ Identify therapeutic uses for antihistamines

HISTAMINE

Histamine is an autacoid present at high levels in the lungs, skin, and gastrointestinal tract. It is released from mast cells and basophils by type I hypersensitivity reactions, drugs, venoms, and trauma.

- Histamine receptors are of the serpentine family, with 7 transmembrane–spanning domains with G-protein–coupled second messenger effectors.
  - H_1 activation
    - ↑ capillary dilation (via NO) →↓ BP
    - ↑ capillary permeability →↑ edema
    - ↑ bronchiolar smooth muscle contraction (via IP_3 and DAG release)
    - ↑ activation of peripheral nociceptive receptors →↑ pain and pruritus
    - ↓ AV nodal conduction
  - H_2 activation
    - ↑ gastric acid secretion →↑ gastrointestinal ulcers
    - ↑ SA nodal rate, positive inotropism, and automaticity

H_1 Antagonists

High-Yield

- Mechanism of action:
  - H_1 antagonists act as competitive antagonists of histamine and therefore may be ineffective at high levels of histamine.
  - Vary in terms of both pharmacologic and kinetic properties, but all require hepatic metabolism and most cross the placental barrier.

Table VI-1-1. Properties of Major Antihistamines

Drug	M Block	Sedation	Antimotion	Other Characteristics
Diphenhydramine	+++	+++	+++	Widely used OTC drug
Promethazine	+++	+++	++	Some α block and local anesthetic action
Chlorpheniramine	++	++	++	Possible CNS stimulation
Meclizine	++	++	++++	Highly effective in motion sickness
Cetirizine	+/–	+	0	
Loratadine	+/–	0	0	No CNS entry
Fexofenadine	+/–	0	0	No CNS entry

- Uses:
  - Allergic reactions: hay fever, rhinitis, urticaria
  - Motion sickness, vertigo
  - Nausea and vomiting with pregnancy
  - Preoperative sedation
  - OTC: sleep aids and cold medications
  - Acute EPSs
- Side effects: extensions of M block and sedation (additive with other CNS depressants)

Gastrointestinal Dysfunction Drugs

2

LEARNING OBJECTIVES

- ❑ Describe mechanism for drugs used in peptic ulcers or GERD
- ❑ Describe mechanism of/for antiemetic drugs
- ❑ Identify key drugs used in inflammatory bowel disease

DRUGS USED IN PEPTIC ULCER DISEASE (PUD)

Drug Mechanisms

High-Yield

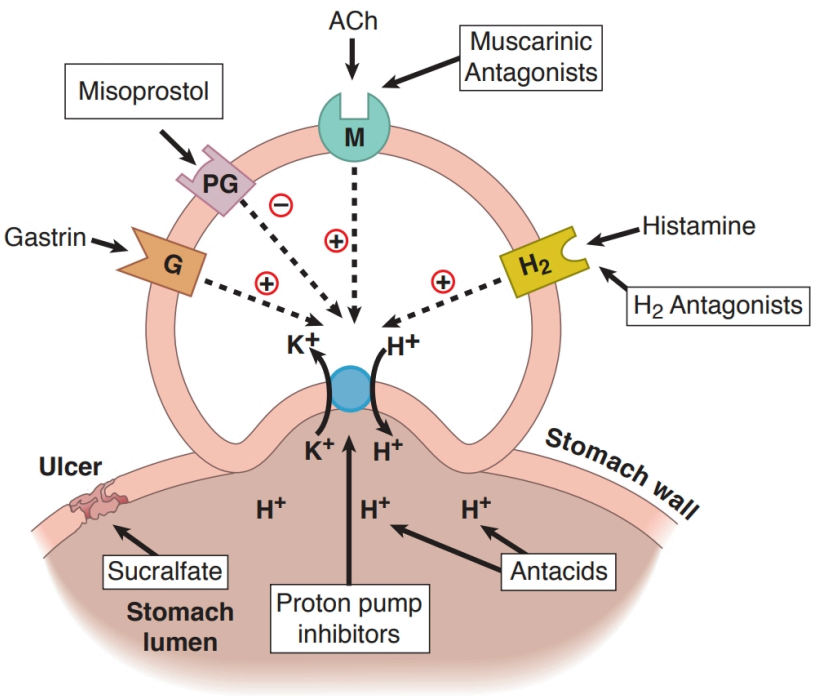


Figure VI-2-1. Drug Actions in PUD

H_2 Antagonists (Cimetidine, Ranitidine, Famotidine)

- Mechanisms of action:
  - Suppress secretory responses to food stimulation and nocturnal secretion of gastric acid via their ability to decrease (indirectly) the activity of the proton pump.
  - Also partially antagonize HCl secretion caused by vagally or gastrin-induced release of histamine from ECL-like cells (GI mast cells)
  - No effects on gastric emptying time
- Uses:
  - PUD (overall less effective than proton pump inhibitors)
  - Gastroesophageal reflux disease (GERD)
  - Zollinger-Ellison syndrome
- Side effects:
  - Cimetidine is a major inhibitor of P450 isoforms → drug interaction via ↑ effects
  - Cimetidine →↓ androgens → gynecomastia and ↓ libido

Proton Pump Inhibitors

- Mechanism of action:
  - **Omeprazole** and related "–prazoles" are irreversible, direct inhibitors of the proton pump (K^+/H^+ antiport) in the gastric parietal cell
- Uses:
  - More effective than H_2 blockers in peptic ulcer disease (PUD)
  - Also effective in GERD and Zollinger-Ellison syndrome
  - Eradication regimen for *H. pylori*

Misoprostol

- Mechanism of action: PGE_1 analog, which is cytoprotective →↑ mucus and bicarbonate secretion and ↓ HCl secretion
- Uses: previously for NSAID-induced ulcers, but PPIs are now used

Sucralfate

- Mechanism of action: polymerizes on gastrointestinal luminal surface to form a protective gel-like coating of ulcer beds. Requires acid pH (antacids may interfere)
- Uses: ↑ healing and ↓ ulcer recurrence

Bismuth Subsalicylate

- Mechanism of action: like sucralfate, binds selectively to ulcer, coating it, and protecting it from acid and pepsin
- Combined with metronidazole and tetracycline to eradicate *H. pylori* (BMT regimen)

Antacids: Al $(OH)_3$, Mg $(OH)_2$, $CaCO_3$

- Mechanism of action: bases that neutralize protons in the gut lumen
- Side effects: constipation (Al^{+++}), diarrhea (Mg^{++}); rebound hyperacidity

ANTIEMETICS

Antiemetic Mechanisms

High-Yield

The figure below shows the complexity of the emetic pathways with an impact on the vomiting center and reveals the multiplicity of receptor types involved, including those activated by ACh, DA, 5HT, histamine, and endogenous opiopeptides.

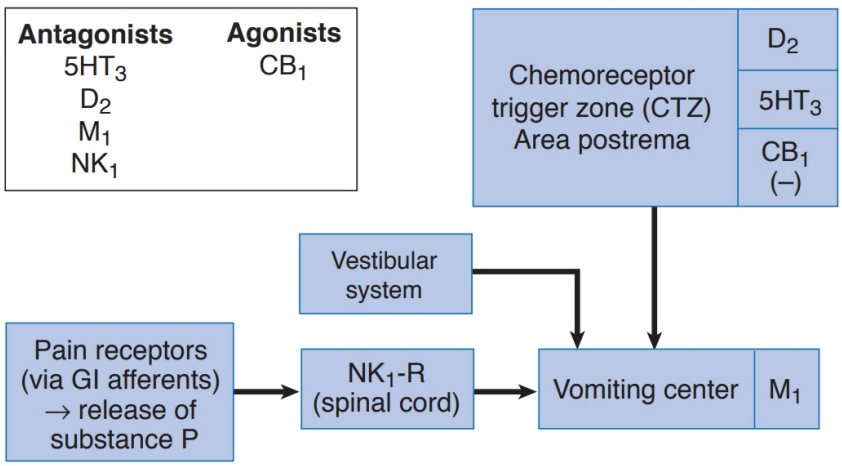


Figure VI-2-2. Emetic Pathways and Drug Action

Drugs for Nausea and Vomiting

Drugs for nausea and vomiting include:

- $5HT_3$ (a serotonin receptor: *see* next chapter) antagonists: ondansetron (commonly used in cancer chemotherapy), granisetron
- DA antagonists: prochlorperazine, metoclopramide (also used in cancer chemotherapy; also prokinetic in GERD)
- H_1 antagonists: diphenhydramine, meclizine, promethazine
- Muscarinic antagonists: scopolamine
- Cannabinoids: dronabinol
- NK_1-receptor antagonist: aprepitant (NK_1 is a receptor to substance P)

CLINICAL CORRELATE

Antacids and Drug Absorption

- ↑ oral absorption of weak bases (e.g., quinidine)
- ↓ oral absorption of weak acids (e.g., warfarin)
- ↓ oral absorption of tetracyclines (via chelation)

CLINICAL CORRELATE

Opioid analgesics (e.g., morphine) have duality of action: ↓ emesis by activating receptors that decrease pain transmission and ↑ emesis by activating receptors in the CTZ.

INFLAMMATORY BOWEL DISEASE

Crohn disease (CD) and **ulcerative colitis (UC)** are inflammatory bowel diseases.

For CD, the terminal ileum is the most common site, but it may occur in any part of the GI tract. Patients with CD often have normal bowel separating segments of diseased bowel, i.e., the disease is discontinuous.

UC is confined to the rectum and colon and affects the mucosa and submucosa.

Drugs

- Mesalamine: 5-aminosalicylic acid (5-ASA); acts as an anti-inflammatory agent; useful for mild to moderate CD and UC
- Sulfasalazine: composed of 5-ASA and sulfapyridine; metabolized by colonic bacteria to 5-ASA; works locally in the colon; useful for mild to moderate UC
- Immunosuppressants: corticosteroids, cyclosporine, anti-TNF alpha drugs; reserved for moderate to severe CD and UC

Serotonin Drugs

3

LEARNING OBJECTIVES

- ❑ Match serotonin drugs to specific serotonin receptors
- ❑ Identify key drugs used in migraine treatment and prevention

- Serotonin (5-hydroxytryptamine, 5HT) is an autacoid synthesized and stored in gastrointestinal cells, neurons, and platelets. Metabolized by MAO type A, its metabolite 5-hydroxyindoleacetic acid (5HIAA) is a marker for carcinoid.
- Of the 7 receptor subtype families, all are G-protein coupled except $5HT_3$, which is coupled directly to an ion channel.

DRUG ACTIONS ON 5HT RECEPTORS

$5HT_{1(a-h)}$

- Found in CNS (usually inhibitory) and smooth muscle (excitatory or inhibitory)
- Drug: **buspirone**
  - Partial agonist at $5HT_{1a}$ receptors → anxiolytic (generalized anxiety disorder [GAD])
- Drug: **sumatriptan and other triptans**
  - Agonist at $5HT_{1d}$ receptors in cerebral vessels →↓ migraine pain
  - Side effects of "–triptans": possible asthenia, chest or throat pressure or pain

$5HT_{2(a-c)}$

- Found in CNS (excitatory)
- In periphery, activation → vasodilation, contraction of gastrointestinal, bronchial, and uterine smooth muscle, and platelet aggregation

- Drugs:
  - **Olanzapine** and other atypical antipsychotics: antagonist at $5HT_{2a}$ receptors in CNS →↓ symptoms of psychosis
  - **Cyproheptadine**
    - $5HT_2$ antagonist used in carcinoid, other gastrointestinal tumors, and postgastrectomy; also used for anorexia nervosa; serotonin syndrome
    - Has marked H_1-blocking action: used in seasonal allergies

$5HT_3$

- Found in area postrema, peripheral sensory and enteric nerves
- Mechanism of action: activation opens ion channels (no second messengers)
- Drugs: **ondansetron** and "–setrons": antagonists →↓ emesis in chemotherapy and radiation and postoperatively

DRUGS USED IN MIGRAINE HEADACHES

Sumatriptans and other triptans are agonists at $5HT_{1d}$ receptors and used as first-line treatment for acute migraines.

NOTE

- The mechanism of action of **ergonovine** is uterine smooth muscle contraction
- Give intramuscularly after placental delivery.

Calcitonin Gene-Related Peptide (CGRP) Antagonists

- Ubrogepant and rimegepant are small molecule inhibitors for acute migraine treatment
- Erenumab is a monoclonal antibody indicated for migraine prophylaxis

Ergot Alkaloids

- **Ergotamine**
  - Mechanism of action: acts as partial agonist at both α and $5HT_2$ receptors in the vasculature and possibly in CNS; vasoconstrictive actions to decrease pulsation in cerebral vessels may be relevant to acute actions of ergotamine during migraine attack
  - Uses: acute attacks
  - Side effects: gastrointestinal distress, prolonged vasoconstriction → ischemia and gangrene, abortion near term

Other Medications

In addition to the "–triptans" and ergots:

- Analgesics: ASA (+/– caffeine, or butabarbital), other NSAIDs, acetaminophen (+/– caffeine), oral or injectable opioid-analgesics, and butorphanol (spray)
- Prophylaxis: propranolol, topiramate, valproic acid

Eicosanoid Drugs

4

LEARNING OBJECTIVES

- ❑ Describe mechanism and side effects for NSAIDs and acetaminophen
- ❑ Explain features of aspirin or acetaminophen overdose, and strategies and/or antidotes used in management

EICOSANOIDS

Eicosanoids are cell-regulating polyunsaturated fatty acids primarily synthesized from arachidonic acid and released by the action of phospholipase A_2 from lipids in cell membranes.

- Are present in low concentrations in most cells but are synthesized and released "on demand" in response to stimuli, including IgE-mediated reactions, inflammatory mediators, trauma, heat, and toxins
- Interact with specific receptors, which are G-proteins coupled to second messenger effector systems

Eicosanoid Mechanisms

High-Yield

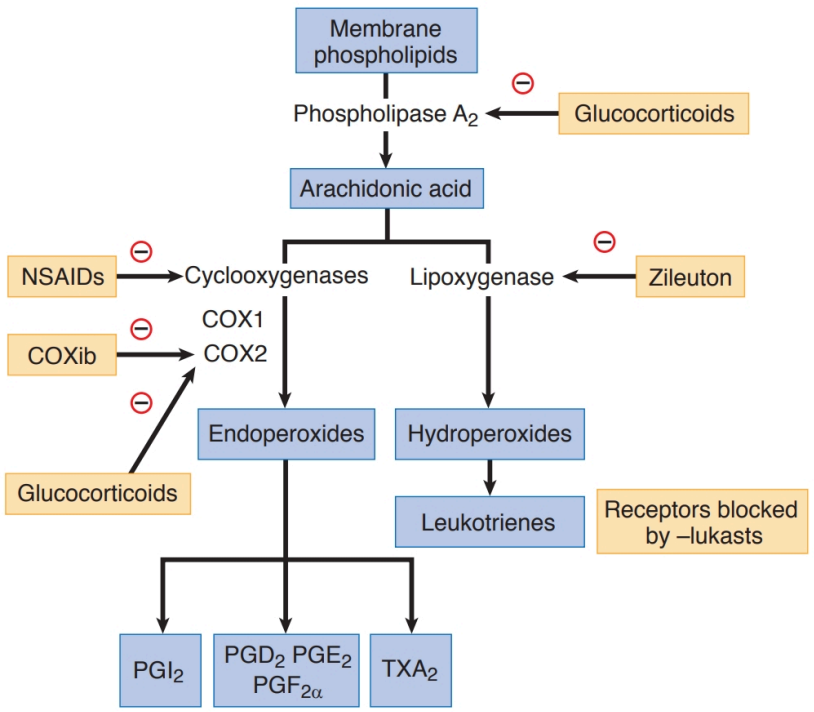


Figure VI-4-1. Drugs Acting on Eicosanoids

BRIDGE TO PHYSIOLOGY

Prostaglandins (PGs) are cytoprotective in the stomach, dilate renal vasculature, contract the uterus, and maintain the ductus arteriosus. Thromboxane (TxA_2) causes platelet aggregation. GI PGs and platelets TxA_2s are synthesized by COX 1 (constitutive). COX 2 (inducible) synthesizes PGs involved in inflammation, fever, and pain. Both enzymes synthesize renal PGs $\rightarrow \uparrow$ RBF.

Leukotrienes (LTs)

Leukotrienes (LTs) are formed (via hydroperoxides) from the action of lipoxygenases on arachidonic acid.

- LTB_4:
  - Mechanism of action: inflammatory mediator → neutrophil chemoattractant; activates PMNs; ↑ free radical formation → cell damage
- LTA_4, LTC_4, and LTD_4
  - Cause anaphylaxis and bronchoconstriction (role in asthma)

Leukotrienes are "targets" for the following:

- Glucocorticoids: →↓ phospholipase A_2 activity → contributes to both antiinflammatory and immunosuppressive actions
- Zileuton: inhibits lipoxygenase →↓ LTs and is used in treatment of asthma
- Zafirlukast and "–lukasts": LT-receptor antagonists used in treatment of asthma

Prostaglandins

Prostaglandins (PGs) are formed (via endoperoxides) from the actions of cyclooxygenases (COXs).

- COX 1 is expressed in most tissues, including platelets and stomach, where it acts to synthesize thromboxane and cytoprotective prostaglandins, respectively.
- COX 2 is expressed in the brain and kidney and at sites of inflammation.

PGE_1

- Drugs:
  - **Misoprostol** used previously in treatment of NSAID-induced ulcers (protective action on gastric mucosa)
  - **Alprostadil**
    - Maintains patency of ductus arteriosus
    - Vasodilation; used in male impotence
- Contraindicated in pregnancy, unless used as an abortifacient (misoprostol in combination with mifepristone)

NOTE

Indomethacin is used to close a patent ductus arteriosus.

PGE_2

- Mechanism of action: uterine smooth muscle contraction
- Uses: **dinoprostone** can be used for "cervical ripening" and as abortifacient

$PGF_2\alpha$

- Mechanism of action: uterine and bronchiolar smooth muscle contraction
- Drugs:
  - **Carboprost** used as abortifacient
  - **Latanoprost** for treatment of glaucoma (↓ intraocular pressure)

PGI_2 (Prostacyclin)

- Platelet stabilizer and vasodilator
- Drug: **epoprostenol**
- Uses: pulmonary hypertension

PGE_2 and PGF_2

- Both ↑ in primary dysmenorrhea
- Therapeutic effects of NSAIDs may be due to inhibition of their synthesis

Thromboxanes (TXAs)

TXA_2

- Platelet aggregator (inhibition of synthesis underlies protective role of acetylsalicylic acid [ASA] post-MI)

NONSTEROIDAL ANTIINFLAMMATORY DRUGS

Most nonsteroidal antiinflammatory drugs (NSAIDs) are nonselective inhibitors of cyclooxygenases, acting on both COX 1 and COX 2 isoforms to decrease formation of PGs and thromboxanes.

- Are analgesic, antipyretic, and antiinflammatory
- Have antiplatelet effects
- Acetylsalicylic acid (ASA) is prototype of the group, which includes more than 20 individual drugs

Acetylsalicylic Acid (ASA; Aspirin)

High-Yield

- Causes irreversible inhibition of COX
- Covalent bond via acetylation of a serine hydroxyl group near the active site
- Actions are dose-dependent:
  - **Inhibition of platelet aggregation**. Low dose, the basis for post-MI prophylaxis and to reduce the risk of recurrent TIAs
  - **Analgesia and antipyresis**. Moderate dose

BRIDGE TO PHYSIOLOGY AND BIOCHEMISTRY

Platelet Stability and Eicosanoids

Activation of TxA_2 receptors → stimulation of phospholipase C →↑ PIP_2 hydrolysis →↑ IP_3→ mobilization of bound Ca^{2+}→↑ free Ca^{2+}→ platelet aggregation.

Activation of PGI_2 receptors → stimulation of adenylyl cyclase →↑ cAMP →↑ activity of internal Ca^{2+} "pumps" →↓ free Ca^{2+}→ platelet stabilization.

- **Antiinflammatory**. High doses
- **Uric acid elimination**
  - Low to moderate doses: ↓ tubular secretion → hyperuricemia
  - High doses: ↓ tubular reabsorption → uricosuria
- **Acid-base and electrolyte balance**
  - Dose-dependent actions
  - High therapeutic: mild uncoupling of oxidative phosphorylation →↑ respiration →↓ pCO_2→**respiratory alkalosis**→ renal compensation →↑ HCO_3^- elimination →**compensated** respiratory alkalosis (pH = normal, ↓ HCO_3^-, ↓ pCO_2)
  - In adults, this can be a stable condition; in children →↑ toxicity.
  - Toxic doses: inhibits respiratory center →↓ respiration →↑ pCO_2→**respiratory acidosis** (↓ pH, ↓ HCO_3^-, normalization of pCO_2) plus inhibition of Krebs cycle and severe uncoupling of oxidative phosphorylation (↓ ATP) →**metabolic acidosis**, hyperthermia, and hypokalemia (↓ K^+).

- Side effects:
  - Gastrointestinal irritation: gastritis, ulcers, bleeding
  - Salicylism: tinnitus, vertigo, ↓ hearing—often first signs of toxicity
  - Bronchoconstriction: exacerbation of asthma
  - Hypersensitivity, especially the "triad" of asthma, nasal polyps, rhinitis
  - Reye syndrome: encephalopathy
  - ↑ bleeding time (antiplatelet)
  - Chronic use: associated with renal dysfunction
  - Drug interactions: ethanol (↑ gastrointestinal bleeding), warfarin (↑ effects), and uricosurics (↓ effects)
- Aspirin overdose and management:
  - Extensions of the toxic actions described above, plus at high doses vasomotor collapse occurs, with both respiratory and renal failure.
  - No specific antidote. Management includes gastric lavage (+/− activated charcoal) plus ventilatory support and symptomatic management of acid-base and electrolyte imbalance, and the hyperthermia and resulting dehydration. Increased urine volume and its alkalinization facilitate salicylate renal elimination. (Note: ASA follows zero-order elimination kinetics at toxic doses.)

Other NSAIDs

Types

- Reversible inhibitors of COX 1 and COX 2, with analgesic, antipyretic, and antiinflammatory actions, include:
  - Ibuprofen
  - Naproxen
  - Indomethacin
  - Ketorolac
  - Sulindac
- Comparisons with ASA:
  - Analgesia: ketorolac > ibuprofen/naproxen > ASA
  - Gastrointestinal irritation: < ASA, but still occurs (consider misoprostol)
  - Minimal effects on acid-base balance; no effects on uric acid elimination
  - Allergy: common, possible cross-hypersensitivity with ASA
  - Renal: chronic use may cause nephritis, nephritic syndrome, acute failure (via ↓ formation of PGE_2 and PGI_2, which normally maintain GFR and RBF)—does not occur with sulindac
- Specific toxicities:
  - Indomethacin: thrombocytopenia, agranulocytosis, and > CNS effects
  - Sulindac: Stevens-Johnson syndrome, hematotoxicity

CLINICAL CORRELATE

NSAIDs are associated with an increased risk of adverse cardiovascular thrombotic events such as MI and stroke.

Selective COX 2 Inhibitors: Celecoxib

- Compared with conventional NSAIDs, it is no more effective as an antiinflammatory agent.
- Primary differences are:
  - Less gastrointestinal toxicity
  - Less antiplatelet action
- However, it may possibly exert prothrombotic effects via inhibition of endothelial cell function (MI and strokes).
- Cross-hypersensitivity between celecoxib and sulfonamides

NOTE

Meloxicam is also COX 2 selective and has fewer GI side effects than other NSAIDs.

Recall Question

Which of the following drugs is used in the management of pulmonary hypertension?

A. Alprostadil

B. Dinoprostone

C. Epoprostenol

D. Latanoprost

Answer: C

OTHER DRUGS

Acetaminophen

High-Yield

CLINICAL CORRELATE

"Tot" Toxicity

Young children are gustatory explorers. Among the compounds responsible for toxicity in children age <3 are common household items: aspirin, acetaminophen (people know about Reye syndrome!), and supplementary iron tablets.

- Mechanisms:
  - No inhibition of COX in peripheral tissues and lacks significant antiinflammatory effects
  - Equivalent analgesic and antipyretic activity to ASA due to inhibition of cyclooxygenases in the CNS
- Comparisons with ASA:
  - No antiplatelet action
  - Not implicated in Reye syndrome
  - No effects on uric acid
  - Not bronchospastic (safe in NSAID hypersensitivity and asthmatics)
  - Gastrointestinal distress is minimal at low to moderate doses
- Overdose and management:
  - Hepatotoxicity—Acetaminophen is metabolized mainly by liver glucuronyl transferase to form the inactive conjugate. A minor pathway (via P450) results in formation of a reactive metabolite (*N*-acetylbenzoquinoneimine), which is inactivated by glutathione (GSH). In overdose situations, the finite stores of GSH are depleted. Once this happens, the metabolite reacts with hepatocytes, causing nausea and vomiting, abdominal pain, and ultimately liver failure due to centrilobular necrosis. Chronic use of ethanol enhances liver toxicity via induction of P450.
  - Management of the hepatotoxicity: *N*-acetylcysteine (supplies –SH groups), preferably within the first 12 hours (*N*-acetylcysteine is also used as a mucolytic for cystic fibrosis)

Rheumatoid Arthritis Drugs

5

LEARNING OBJECTIVES

- ❑ Describe treatment strategies for managing rheumatoid arthritis and refractory RA
- ❑ Identify key drugs used to slow the progression of rheumatoid arthritis and their mechanisms

RHEUMATOID ARTHRITIS

Treatment Strategies

NSAIDs are commonly used in the initial management of rheumatoid arthritis (RA), but the doses required generally result in marked adverse effects. NSAIDs decrease pain and swelling but have no beneficial effect on the course of the disease or bone deterioration.

- Disease-modifying anti-rheumatic drugs (DMARDs) are thought to slow disease progression.
- DMARDs may be started with NSAIDs at the time of initial diagnosis if symptoms are severe because DMARDs take 2 weeks to 6 months to work.
- Methotrexate (MTX) is usually the first choice DMARD.
- Other DMARDs are used less frequently, sometimes in combination regimens for refractory cases.

DMARD Mechanisms

High-Yield

Table VI-5-1. Disease-Modifying Antirheumatic Drugs (DMARDs)

Drug	Mechanism(s)	Side Effects
Hydroxychloroquine	Stabilizes lysosomes and ↓ chemotaxis	GI distress and visual dysfunction (cinchonism), hemolysis in G6PD deficiency
Methotrexate	Cytotoxic to lymphocytes	Hematotoxicity, hepatotoxicity
Sulfasalazine	Sulfapyridine →↓ B-cell functions; 5-ASA possibly inhibits COX	Hemolysis in G6PD deficiency
Glucocorticoids	↓ LTs, ILs, and platelet-activating factor (PAF)	ACTH suppression, cushingoid state, osteoporosis, GI distress, glaucoma
Leflunomide	Inhibits dihydro-orotic acid dehydrogenase (DHOD) →↓ UMP →↓ ribonucleotides → arrests lymphocytes in G_1	Alopecia, rash, diarrhea, hepatotoxicity
Etanercept	Binds tumor necrosis factor (TNF); is a recombinant form of TNF receptor	Infections
Infliximab, adalimumab	Monoclonal antibody to TNF	Infections
Anakinra	IL-1 receptor antagonist	Infections
Tofacitinib	Janus kinase (JAK) inhibitor	Infections, lymphomas

Gout Drugs

6

LEARNING OBJECTIVES

- ❑ Identify drugs used for acute gout and for chronic gout prevention
- ❑ Describe mechanism for gout drugs

GOUT

Acute Inflammatory Episodes

High-Yield

NSAIDs are used as initial therapy for acute gout attacks; colchicine and intra-articular steroids are alternatives.

- Colchicine
  - Mechanism of action: binds to tubulin →↓ microtubular polymerization, ↓ LTB_4, and ↓ leukocyte and granulocyte migration
  - Side effects: diarrhea and gastrointestinal pain (acute); hematuria, alopecia, myelosuppression, gastritis, and peripheral neuropathy (longer use)

Chronic Gout

High-Yield

- Drug strategy (**prophylaxis**): reduction of uric acid pool
- Allopurinol and febuxostat
  - Mechanism: inhibit xanthine oxidase →↓ purine metabolism →↓ uric acid (also useful in cancer chemotherapy and radiation)
  - Side effects: rash, hypo[xanthine] stones
  - Drug interactions: inhibits 6-mercaptopurine (6-MP) metabolism

CLINICAL CORRELATE

Rasburicase is a recombinant urate-oxidase enzyme for the prevention of tumor lysis syndrome. This drug rapidly reduces serum uric acid; by contrast, the action of allopurinol and febuxostat is to decrease uric acid formation.

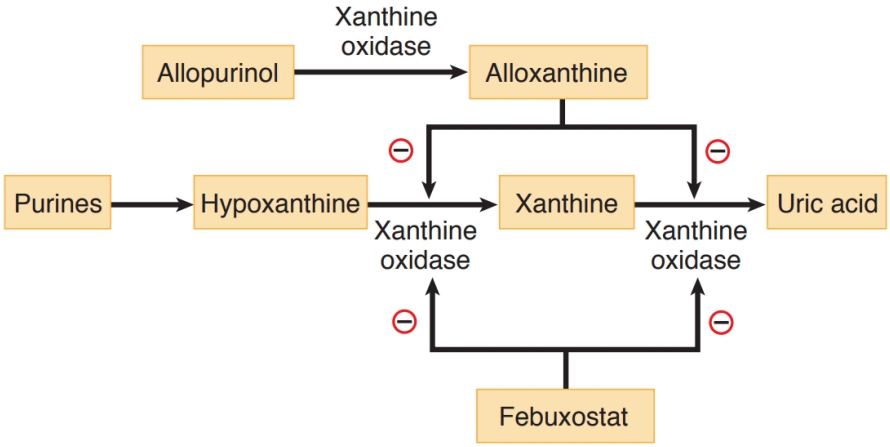


Figure VI-6-1. Mechanism of Action of Allopurinol

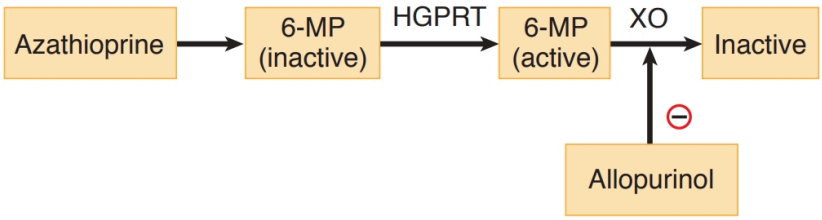


Figure VI-6-2. Drug Interaction between Allopurinol and 6-Mercaptopurine

- Pegloticase
  - Mechanism: recombinant urate-oxidase enzyme for refractory gout; metabolizes uric acid to allantoin →↓ plasma uric acid
  - Side effects: anaphylaxis, urticaria
- Probenecid
  - Mechanism: inhibits proximal tubular reabsorption of urate, but ineffective if GFR <50 mL/min
  - Drug interactions: inhibits secretion of weak acid drugs such as penicillins, cephalosporins, and fluoroquinolones

Glucocorticoids 7

LEARNING OBJECTIVES

- ❑ Compare and contrast the properties of glucocorticoids
- ❑ Describe mechanism and side effects of glucocorticoids

GLUCOCORTICOID PROPERTIES

Table VI-7-1. Synthetic Derivatives of Cortisol

Drugs	Glucocorticoid Activity	Mineralocorticoid Activity	Duration
Cortisol, hydrocortisone	1	1	Short
Prednisone	4	0.3	Intermediate
Triamcinolone	5	0	Intermediate
Betamethasone	25	0	Long-acting
Dexamethasone	30	0	Long-acting

- Mechanisms of action:
  - Cellular effects
    - ↓ leukocyte migration
    - ↑ lysosomal membrane stability →↓ phagocytosis
    - ↓ capillary permeability
  - Biochemical actions
    - Inhibit PLA_2 (via lipocortin expression) →↓ PGs and ↓ LTs
    - ↓ expression of COX 2
    - ↓ platelet-activating factor
    - ↓ interleukins (e.g., IL-2)
- Uses: antiinflammatory and immunosuppressive
- Side effects:
  - Suppression of ACTH: cortical atrophy, malaise, myalgia, arthralgia, and fever; may result in a shock state with abrupt withdrawal
  - Iatrogenic cushingoid syndrome → fat deposition, muscle weakness/atrophy, bruising, acne

CLINICAL CORRELATE

Minimize Steroidal Toxicity

- Alternate-day therapy; local application (e.g., aerosols)
- Dose-tapering to avoid cortical suppression

- Hyperglycemia due to ↑ gluconeogenesis → increased insulin demand and other adverse effects
- Osteoporosis: vertebral fractures; aseptic hip necrosis
- ↑ gastrointestinal acid and pepsin release → ulcers, gastrointestinal bleeding
- Electrolyte imbalance: Na^+/water retention → edema and hypertension, hypokalemic alkalosis, hypocalcemia
- ↓ skeletal growth in children
- ↓ wound healing, ↑ infections (e.g., thrush)
- ↑ glaucoma, ↑ cataracts (via ↑ sorbitol)
- ↑ mental dysfunction

8 Asthma Drugs

LEARNING OBJECTIVES

- ❑ Describe treatment strategies for asthma and match with appropriate drugs
- ❑ Describe mechanism and side effects of asthma and COPD drugs

ASTHMA TREATMENTS

Asthma Overview

High-Yield

Asthma is an inflammatory disease associated with bronchial hyperreactivity (BHR), bronchospasm, increased mucus secretion, edema, and cellular infiltration.

- Early asthmatic responses (EAR) lasting 30–60 minutes are associated with bronchospasm from the actions of released histamine and leukotrienes.
- Late asthmatic responses (LAR) involve infiltration of eosinophils and lymphocytes into airways → bronchoconstriction and inflammation with mucous plugging.

Management of asthma includes bronchodilators to provide short-term relief and antiinflammatory agents to reduce bronchial hyperactivity and protect against cellular infiltration.

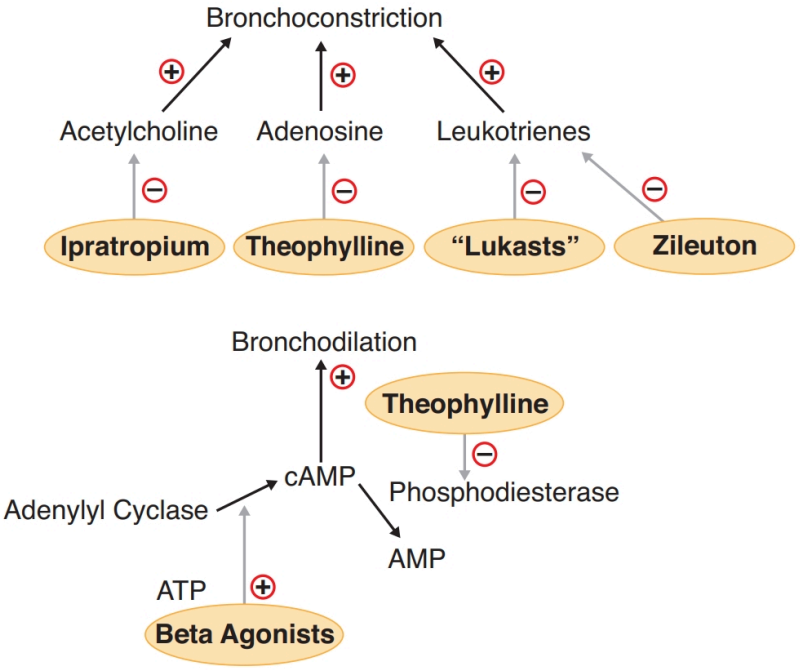


Figure VI-8-1. Drug Actions on Bronchiolar Smooth Muscle

Beta-Receptor Agonists

- Beta-2 selective drugs (albuterol, metaproterenol, terbutaline) are widely used for relief of acute bronchoconstriction and in prophylaxis of exercise-induced asthma (*see* Figure VI-8-1).
- Longer-acting drugs (e.g., salmeterol) may decrease nighttime attacks (prophylaxis only) and permit dosage reduction of other agents.
- Aerosolic forms have low potential for systemic toxicity but may cause anxiety, muscle tremors, and cardiovascular toxicity with overuse.

Muscarinic-Receptor Blockers

- Ipratropium and tiotropium used via inhalation cause bronchodilation in acute asthma, especially in COPD patients, and they may be safer than β agonists are in patients with cardiovascular disease.
- They are the drugs of choice in bronchospasm caused by β blockers.
- There are minor atropine-like effects.

Theophylline

- Bronchodilates via inhibition of phosphodiesterase (PDE) →↑ cAMP and also by antagonism of adenosine (a bronchoconstrictor)
- Mainly adjunctive; regular use may decrease symptoms, but narrow therapeutic window predisposes to toxicity → nausea, diarrhea, CV (↑ HR, arrhythmias) and CNS excitation

- Many drug interactions; toxicity ↑ by erythromycin, cimetidine, and fluoroquinolones
- Aminophylline IV sometimes used in bronchospasm or status asthmaticus

Cromolyn and Nedocromil

- Prevent degranulation of pulmonary mast cells and ↓ release of histamine, PAF, and LTC_4 from inflammatory cells
- Prophylactic use:
  - Decreased symptoms and bronchial hyperactivity (BHR), especially responses to allergens
  - Minimal systemic toxicity but may cause throat irritation and cough
  - Relieved by a β_2 agonist

Glucocorticoids

- Block mediator release and ↓ BHR via ↓ PGs, LTs, and inflammatory interleukins (ILs)
- Surface-active drugs (budesonide, flunisolide) used via inhalation for both acute attacks and for prophylaxis
- May cause oropharyngeal candidiasis (prevented with spacers and gargling)
- Low dosage may also prevent the desensitization of β receptors that can occur with overuse of β_2 agonist
- Prednisone (oral) and IV steroids generally reserved for severe acute attacks

CLINICAL CORRELATE

All asthmatics need a short-acting beta-2 agonist for acute attacks. For prophylaxis, glucocorticoids are most often used.

Antileukotrienes

- Zafirlukast and montelukast are antagonists at LTD_4 receptors with slow onset of activity used prophylactically for many forms of asthma, including antigen, exercise, or drug-induced (e.g., ASA).
- Zileuton is a selective inhibitor of lipoxygenases (LOX), ↓ formation of all LTs. It has a more rapid onset (1–3 hours) and is adjunctive to steroids.

Roflumilast

- Phosphodiesterase 4 (PDE-4) inhibitor that increases cAMP in pro-inflammatory cells and decreases inflammation
- Used in COPD

CLINICAL CORRELATE

For COPD (emphysema, chronic bronchitis), multiple bronchodilators are used including beta-2 agonists and M blockers.

Inflammatory Disorder Drug List and Practice Questions

9

Histamine and Antihistamines

- H_1 antagonists: diphenhydramine, promethazine, meclizine, hydroxyzine, loratadine
- H_2 antagonists: cimetidine, ranitidine, famotidine

Drugs Used in Gastrointestinal Dysfunction

- Proton pump inhibitor: omeprazole and other prazoles
- PGE_1 analog: misoprostol
- Polymer: sucralfate

Drugs Acting on Serotonergic Systems

- $5HT_{1a}$ partial agonist: buspirone
- $5HT_{1d}$ agonist: sumatriptan and other triptans
- $5HT_2$ antagonist: cyproheptadine, atypical antipsychotics
- $5HT_3$ antagonist: ondansetron and other setrons

Antiemetics

- DA antagonist: metoclopramide, prochlorperazine
- H_1 antagonist: meclizine, promethazine
- Muscarinic antagonist: scopolamine
- Cannabinoid: dronabinol
- $5HT_3$ antagonist: ondansetron
- NK_1 antagonist: aprepitant

NSAIDs

- Aspirin, indomethacin, ibuprofen, naproxen, sulindac
- COX 2 inhibitor: celecoxib

Other

- Acetaminophen

Glucocorticoids

- Prednisone, triamcinolone, dexamethasone, hydrocortisone

Drugs Used for Treatment of Gout

- Acute: colchicine, indomethacin
- Chronic: allopurinol, probenecid, febuxostat, pegloticase

Drugs Used for Treatment of RA

- NSAIDs
- DMARDs: methotrexate, etanercept, infliximab, anakinra, and others

Drugs Used for Treatment of Asthma

- β_2 agonists: albuterol, terbutaline
- M-blocker: ipratropium, tiotropium
- Methylxanthine: theophylline
- Mast-cell stabilizer: cromolyn
- Steroids: flunisolide
- LT modifiers: montelukast, zafirlukast, zileuton

PRACTICE QUESTIONS

1. A patient using NSAIDs for chronic pain develops a bleeding ulcer. What drug is designed to selectively treat ulcers of this type?

   A. Famotidine
   B. Bismuth
   C. Aluminum hydroxide
   D. Misoprostol
   E. Muscarinic antagonists

2. Acute poisoning with acetaminophen often requires the use of a specific antidote. The beneficial property of this antidote is that it

   A. supplies sulfhydryl groups to detoxify a reactive metabolite
   B. induces P450 enzymes to enhance elimination
   C. blocks the metabolism of acetaminophen
   D. enhances renal clearance of acetaminophen
   E. chelates acetaminophen

3. Which glucocorticoid is most likely to cause sodium and water retention?

   A. Dexamethasone
   B. Betamethasone
   C. Cortisol
   D. Celecoxib
   E. Desmopressin

4. A patient with RA is being treated with ibuprofen, but joint pain and stiffness are increasing. His physician prescribes another drug to be used with ibuprofen that may slow progression of the disease. Unfortunately, side effects develop, including dizziness, tinnitus, blurred vision, and pruritus. Ocular examination reveals corneal deposits and slight retinal pigmentation. What is the drug?

   A. Gold salts
   B. Etanercept
   C. Hydroxychloroquine
   D. Methotrexate
   E. Thioridazine

5. A patient suffers from troublesome allergic rhinitis due to pollen, and you want to prescribe a drug for her that is least likely to cause sedation. What would your best choice be?

   A. Betamethasone
   B. Cimetidine
   C. Hydroxyzine
   D. Loratadine
   E. Metoclopramide

6. The widely used anticoagulant warfarin is often implicated in drug interactions. If a patient takes warfarin but later begins self-medicating for ulcer pain, what drug useful for ulcers would increase the risk for bleeding?

   A. Ranitidine
   B. Sucralfate
   C. Misoprostol
   D. Cimetidine
   E. Metoclopramide

7. A patient with a migraine headache is treated with sumatriptan. This drug is beneficial because it

   A. blocks $5HT_3$ receptors
   B. stimulates $5HT_{1D}$ receptors
   C. blocks $5HT_4$ receptors
   D. stimulates $5HT_2$ receptors
   E. blocks muscarinic receptors

8. A child suffering from asthma is to be treated with a drug that blocks the synthesis of leukotrienes. What drug would be an appropriate choice?

   A. Cromolyn
   B. Montelukast
   C. Ipratropium
   D. Zileuton
   E. Theophylline

9. Which one of the following is likely to be used in motion sickness, and nausea and vomiting of pregnancy?

   A. Loratadine
   B. Ondansetron
   C. Meclizine
   D. Fexofenadine
   E. Cimetidine

10. For temporary maintenance of a patent ductus arteriosus prior to cardiac surgery in an infant, what is the drug of choice?

    A. Alprostadil
    B. Indomethacin
    C. Epoprostenol
    D. Celecoxib
    E. Zileuton

11. Following an overdose of an over-the-counter drug, a young college student has marked gastrointestinal distress and is lethargic and confused, with an elevated body temperature. Lab analysis of blood reveals: pCO_2, $\downarrow HCO_3^-$, $\downarrow K^+$, and an anion gap acidosis. The most likely cause of these signs and symptoms is a toxic dose of

    A. acetaminophen
    B. acetylsalicylic acid
    C. diphenhydramine
    D. pseudoephedrine
    E. naproxen

12. Which statement below is accurate regarding aspirin overdose?

    A. N-acetylcysteine should be given immediately
    B. The metabolism rate of aspirin is first-order
    C. Elimination rate is directly proportional to plasma concentration.
    D. Increasing urinary pH would be beneficial
    E. Plasma concentrations decrease exponentially with time.

13. Which one of the following antiinflammatory drugs used in rheumatoid arthritis can bind directly tumor necrosis factor?

    A. Etanercept
    B. Sulfasalazine
    C. Prednisone
    D. Celecoxib
    E. Penicillamine

14. When used in the management of asthma, glucocorticoids are likely to cause

    A. hypoglycemia
    B. decreases in blood pressure
    C. anabolic actions in wound healing
    D. oral thrush
    E. sedation

15. A reasonable explanation for the therapeutic effects of ibuprofen or naproxen in primary dysmenorrhea is that these drugs

    A. $\downarrow PGE_2$ and $PGF_{2\alpha}$
    B. selectively inhibit COX 2
    C. $\downarrow LTB_4$
    D. inhibit PLA_2
    E. PI_2

16. When a patient is started on an appropriate drug for chronic gout, it is observed that the plasma levels of uric acid decrease while the urine levels of uric acid increase. What drug was the patient treated with?

    A. Allopurinol
    B. Acetylsalicylic acid
    C. Indomethacin
    D. Colchicine
    E. Probenecid

17. The plasma levels of ketoconazole are lower than normal following its oral absorption in patients treated with lansoprazole. What is the reason for this?

    A. The induction of enzymes that metabolize ketoconazole
    B. Ketoconazole requires an acid environment for its oral absorption
    C. Lansoprazole binds acidic drugs in the gastrointestinal tract
    D. Increased gastrointestinal transit time because of the prokinetic effects of lansoprazole
    E. Competition for transport mechanisms in the gastrointestinal tract

18. Cromolyn useful in many patients with asthma because it

    A. inhibits COX 2
    B. blocks adenosine receptors in bronchiolar smooth muscle
    C. prevents antigen-induced degranulation of mast cells
    D. inhibits phosphodiesterase
    E. ↓ mRNA for IL-2

19. Which one of the following is able to effectively lower intraocular pressure?

    A. Latanoprost
    B. Ergonovine
    C. Atropine
    D. Terbutaline
    E. Morphine

20. Cancer patients being treated with 6-MP may require a dosage adjustment if they are concurrently treated for which of the following?

    A. Constipation
    B. Malaria
    C. Chronic gout
    D. Arthritis
    E. Headache

21. Constipation is highly unlikely to occur with the use of which of the following?

    A. Diphenhydramine
    B. Docusate
    C. Promethazine
    D. Loperamide
    E. Scopolamine

22. A 2-year-old child is brought into the emergency department in convulsions. According to her mother, she had ingested most of a bottle of "sleeping pills," an over-the-counter preparation. What do the sleeping pills she ingested probably contain?

    A. Caffeine
    B. Chlorpromazine
    C. Diphenhydramine
    D. Meperidine
    E. Temazepam

23. In a person who regularly consumes ethanol daily, the potential for hepatotoxicity due to acetaminophen is greater than normal. What is the most likely explanation for this?

    A. Cirrhosis of the liver
    B. Ethanol inhibits the metabolism of acetaminophen
    C. Most beer drinkers are smokers, and nicotine sensitizes the liver to toxins
    D. Nutritional deficiency
    E. Ethanol induces P450 enzymes that form a toxic metabolite

ANSWERS AND EXPLANATIONS

1. **Answer: D.** Misoprostol is a prostaglandin analog indicated for specific use in NSAID-induced ulcers since NSAIDs inhibit the synthesis of protective GI prostaglandins. Other answer choices may be of benefit in this type of ulcer but none are selectively used for NSAIDs.

2. **Answer: A.** Acetaminophen is metabolized primarily by glucuronidation to an inactive metabolite. A minor pathway for metabolism involves cytochrome P450 conversion of acetaminophen to a reactive metabolite that damages the liver. The reactive metabolite is rapidly inactivated normally by glutathione. Prompt administration of N-acetylcysteine is useful because, like glutathione, it supplies sulfhydryl groups to bind the reactive species.

3. **Answer: C.** Various glucocorticoids have different abilities to affect the mineralocorticoid receptor to cause sodium and water retention (an aldosterone-like effect). Generally, the more potent the glucocorticoid, the less likely it is to have an aldosterone effect. Cortisol is a weak glucocorticoid that is equally effective at stimulating mineralocorticoid receptors and thus has sodium and water retention as a property.

4. **Answer: C.** Ocular toxicity is characteristic of chloroquine and hydroxychloroquine. Corneal deposits are reversible, but retinal pigmentation can ultimately lead to blindness. Patients will complain about gastrointestinal distress, visual dysfunction, ringing in the ears (note that tinnitus also occurs in salicylism), and "itchy skin." Hydroxychloroquine also promotes oxidative stress that can lead to hemolysis in G6PD deficiency. DMARDs include gold salts (e.g., auranofin), methotrexate, and etanercept, but thioridazine is a phenothiazine used as an antipsychotic; it lacks an antiinflammatory effect, but does cause retinal pigmentation.

5. **Answer: D.** The usual choice for pollen-induced allergies would be an H_1 antagonist. Of the two listed, loratadine would be the best choice in this case because it does not cross the blood–brain barrier and is nonsedating; hydroxyzine is an effective CNS depressant used for preoperative sedation. Cromolyn (not listed) can also be used in allergic rhinitis and is also nonsedating. Betamethasone, a potent antiinflammatory steroid, is less effective than antihistamines in this situation and would cause more serious side effects. Metoclopramide is a DA-receptor antagonist and prokinetic used as an antiemetic and in GERD. Cimetidine is the prototype H_2 antagonist used in gastrointestinal ulcers.

6. **Answer: D.** Cimetidine is an inhibitor of the hepatic cytochrome P450 isoform that metabolizes warfarin, consequently decreasing its clearance and thus increasing its elimination half-life. The hepatic metabolism of many other drugs can be inhibited by cimetidine, possibly necessitating dose reductions to avoid toxicity, including beta blockers, isoniazid, procainamide, metronidazole, tricyclic antidepressants, and phenytoin.

7. **Answer: B.** It is important to be able to match the serotonin drugs with their respective receptors. The "triptans" used in migraine headaches are agonists at the $5HT_{1D}$ receptor.

8. **Answer: D.** Zileuton blocks the enzyme 5-lipoxygenase, which prevents the formation of leukotrienes. This drug is one of many adjuncts available in asthma. Montelukast blocks leukotriene receptors but has no effect on the synthesis of leukotrienes.

9. **Answer: C.** Meclizine is a first-generation antihistamine that effectively penetrates the CNS. Like all first-generation drugs it also blocks muscarinic receptors. Blocking the H_1 and muscarinic receptors are beneficial in motion sickness, and nausea and vomiting in pregnancy. Second-generation drugs like loratadine and fexofenadine don't effectively penetrate the CNS and are of no benefit in these conditions.

10. **Answer: A.** During fetal development, the ductus arteriosus is kept open by prostaglandins. For temporary maintenance of patency in the infant, the PGE_1 analog alprostadil is used. Closure of the ductus in the infant can often be accomplished by intravenous indomethacin, which ↓ PG synthesis by inhibiting COX. Epoprostenol is a prostacyclin analog used in primary pulmonary hypertension.

11. **Answer: B.** If the patient had been able to mention tinnitus, this would be a classic case of aspirin poisoning. At high salicylate blood levels, the combination of effects leading to respiratory depression (respiratory acidosis) and metabolic acidosis results in the observed pH and electrolyte changes, the anion gap (a marker for acidosis), and hyperthermia.

12. **Answer: D.** Back to basic principles. Zero-order elimination means that plasma levels of a drug decrease linearly with time. This occurs with ASA at toxic doses, with phenytoin at high therapeutic doses, and with ethanol at all doses. Enzymes that metabolize ASA are saturated at high plasma levels → constant rate of metabolism = zero-order kinetics. Remember that application of the Henderson-Hasselbalch principle can be important in drug overdose situations. In the case of aspirin, a weak acid, urinary alkalinization favors ionization of the drug →↓ tubular reabsorption → renal elimination. N-acetylcysteine is the antidote for acetaminophen.

13. **Answer: A.** Etanercept binds directly to tumor necrosis factor (TNF), resulting in the inactivation of this cytokine, which plays a major role in a number of inflammatory disorders, including Crohn disease and rheumatoid arthritis. In the synovium, TNF recruits inflammatory cells and leads to angiogenesis and joint destruction. Infliximab, a monoclonal antibody, also inactivates TNF.

14. **Answer: D.** Most often glucocorticoids are used in the treatment of asthma not controlled by a beta-2 agonist inhaler alone. The glucocorticoid is often given by metered dose inhaler, which enhances the risk of oral candidiasis (thrush). This can be avoided by rinsing the mouth thoroughly and by using spacers. All of the other effects listed are "opposites," so anticipate possible hyperglycemia, hypertension, decreased wound healing, and CNS excitatory effects that have been interpreted as psychosis.

15. **Answer: A.** PGE_2 and $PGF_{2\alpha}$ both increase in primary dysmenorrhea, and the therapeutic effects of NSAIDs appear to be due to inhibition of the synthesis of these prostaglandins. Both ibuprofen and naproxen are nonselective COX inhibitors that can inhibit the synthesis of prostacyclin (PGI_2). NSAIDs do not inhibit phospholipase A_2, and they do not decrease leukotrienes.

16. **Answer: E.** In chronic gout, the strategy is to decrease uric acid formation from purines by inhibiting xanthine oxidase with allopurinol or increasing urate elimination with uricosurics such as probenecid. Probenecid blocks the tubular reabsorption of uric acid, which lowers blood levels of uric acid but results in uricosuria. Colchicine and NSAIDs are less effective and cause more side effects when used in chronic gout. These are preferred in acute gout attacks. Although ASA is uricosuric at antiinflammatory doses, its toxicity makes the drug a poor choice.

17. **Answer: B.** Several drugs, including ketoconazole and fluoroquinolones, require an acidic environment in the gastrointestinal tract for effective absorption into the systemic circulation. Drugs used in treatment of gastrointestinal ulcers such as proton pump inhibitors (lansoprazole) commonly increase gastric pH, leading to the ↓ absorption of such drugs and, consequently, a ↓ in their effects.

18. **Answer: C.** Cromolyn is a mast-cell stabilizer used in asthma (especially antigen-induced) and in food allergies. Inhibition of degranulation with decreased release of histamine and eicosanoids contributes to its antiinflammatory effectiveness in asthma, where it is used for prophylaxis. Methylxanthines, such as theophylline, exert bronchodilating effects via their inhibition of phosphodiesterases and their antagonism of adenosine receptors. Steroids used in asthma ↓ bronchial hyperactivity by several mechanisms, including inhibition of interleukin synthesis. COX 2 inhibitors have no established role in asthma management.

19. **Answer: A.** Latanoprost is a prostaglandin $F_{2\alpha}$ analog that is used in glaucoma to lower intraocular pressure. Ergonovine causes smooth muscle contraction (both uterine and vascular) and is used for control of postpartum hemorrhage. Atropine has the potential to raise intraocular pressure and precipitate glaucoma. Neither a β_2 agonist (terbutaline) nor an opioid (morphine) is useful in glaucoma.

20. **Answer: C.** Allopurinol is a uricosuric drug used in chronic gout that prevents formation of uric acid from purines by acting as a suicide substrate of xanthine oxidase. The drug is commonly used in patients undergoing treatment of cancer to slow down formation of uric acid derived from purines released by the cytotoxic action of drugs or radiation. The metabolism of 6-mercaptopurine (6-MP), a substrate for xanthine oxidase, is also inhibited by allopurinol, necessitating a major dose reduction to avoid its toxic effects.

21. **Answer: B.** Docusate is a stool-softening laxative that facilitates mixing of oil and water via its surfactant properties. Drugs that have muscarinic blocking effects, such as scopolamine and the antihistamines diphenhydramine and promethazine, tend to cause constipation by decreasing gastrointestinal motility. Loperamide is an opioid derivative, with no analgesic activity, used in the treatment of diarrheal states.

22. **Answer: C.** Over-the-counter (OTC) sleep aids invariably contain sedating antihistamines such as diphenhydramine. Sometimes called sedative-autonomics, overdoses of such drugs are dangerous, especially in small children. They usually have muscarinic-blocking (atropine-like) effects causing hyperthermia, and they lower the seizure threshold, leading to convulsions. Chlorpromazine is very similar in its pharmacology but is not available OTC and would not be appropriate as a sleeping aid because of its autonomic side effects. Temazepam, a benzodiazepine, is used as a sleeping pill but requires a prescription and raises the seizure threshold. Meperidine is an opioid-analgesic that can cause seizures in OD, but it is not used as a sleeping aid or available OTC. Caffeine is a CNS stimulant.

23. **Answer: E.** Ethanol has mixed effects on liver metabolism of drugs. Acutely, it can act as an enzyme inhibitor, but chronic use may lead to enzyme induction. Acetaminophen is metabolized mainly via conjugation reactions, but a minor pathway involving P-450 (probably the CYP2E1 isoform) results in formation of small amounts of the reactive metabolite, which is (normally) rapidly inactivated by GSH. The chronic ingestion of more than average amounts of ethanol induces the formation of the P-450 isozyme that converts acetaminophen to its reactive metabolite. Thus, more-than-normal amounts of *N*-acetyl-benzoquinoneimine would be formed in an overdose situation, resulting in enhanced hepatotoxicity.

PART VII

BLOOD DISORDER DRUGS

1 Anticoagulants

LEARNING OBJECTIVES

- ❑ Describe mechanism for anticoagulants
- ❑ Predict interactions between warfarin and p450 inducers vs inhibitors

ANTICOAGULANT OVERVIEW

Blood coagulates by transformation of soluble fibrinogen into insoluble fibrin. Circulating proteins interact in a "cascade," where clotting factors undergo limited proteolysis to become active serine proteases. Anticoagulants are drugs that decrease the formation of fibrin clots.

- Warfarin inhibits the hepatic synthesis of clotting factors II, VI, IX, and X.
- Heparin inhibits the activity of several activated clotting factors (especially factors IIa and Xa) via its activation of antithrombin III.
- Newer anticoagulants target the common pathway (IIa or Xa).
- The endogenous anticoagulants, protein C and protein S, cause proteolysis of factors Va and VIIIa.

Clotting Cascade

High-Yield

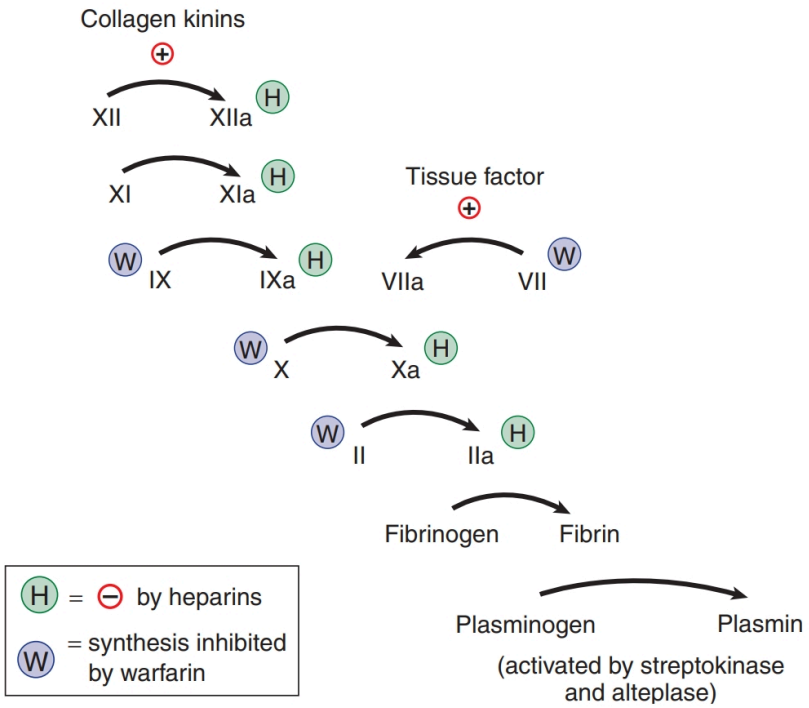


Figure VII-1-1. Actions of Blood Drugs

Comparative Properties of Heparin and Warfarin

High-Yield

Table VII-1-1. Properties of Heparin and Warfarin (Coumarins)

Feature	Heparin(s)	Warfarin (Coumarins)
Chemical nature	Large polysaccharide, water-soluble	Small molecule, lipid-soluble derivatives of vitamin K
Kinetics	Given parenterally (IV, SC), hepatic and reticuloendothelial elimination, half-life = 2 h, no placental access	Given orally, 98% protein bound, PO, liver metabolism, half-life = 30+ h, placental access
Mechanism	Heparin catalyzes the binding of antithrombin III (a serine protease inhibitor) to factors IIa, IXa, Xa, XIa, and XIIa, resulting in their rapid inactivation	↓ Hepatic synthesis of vitamin K–dependent factors II, VII, IX, X—coumarins prevent γ-carboxylation by inhibiting vitamin K epoxide reductase; no effect on factors already present *In vivo* effects only
Monitoring	Partial thromboplastin time (PTT)	Prothrombin time (PT); INR
Antagonist	Protamine sulfate—chemical antagonism, fast onset	Vitamin K—↑ clotting factor synthesis, slow onset; fresh frozen plasma (fast)
Uses	Rapid anticoagulation (intensive) for thromboses, emboli, unstable angina, disseminated intravascular coagulation (DIC), open-heart surgery, etc.	Longer-term anticoagulation (controlled) for thromboses, emboli, post-MI, heart valve damage, atrial arrhythmias, etc.
Toxicity	Bleeding, osteoporosis, heparin-induced thrombocytopenia (HIT), hypersensitivity	Bleeding, skin necrosis (if low protein C), drug interactions, teratogenic (bone dysmorphogenesis)

Heparin

- Heparin is a mixture of sulfated polysaccharides with molecular weight of 15–20,000 daltons.
- Enoxaparin is a low-molecular-weight (LMW) heparin given subcutaneously with a longer half-life, less thrombocytopenia, and enhanced activity against factor Xa.

Warfarin

High-Yield

- Drug interactions:
  - Acidic molecule: oral absorption ↓ by cholestyramine
  - Extensive (but weak) plasma protein binding: displacement by other drugs may increase free fraction →↑ PT (e.g., ASA, sulfonamides, phenytoin)
  - Slow hepatic metabolism via P450:
    - Inducers (barbiturates, carbamazepine, rifampin) →↓ PT
    - Inhibitors (cimetidine, macrolides, azole antifungals) →↑ PT
- Protein C deficiency:

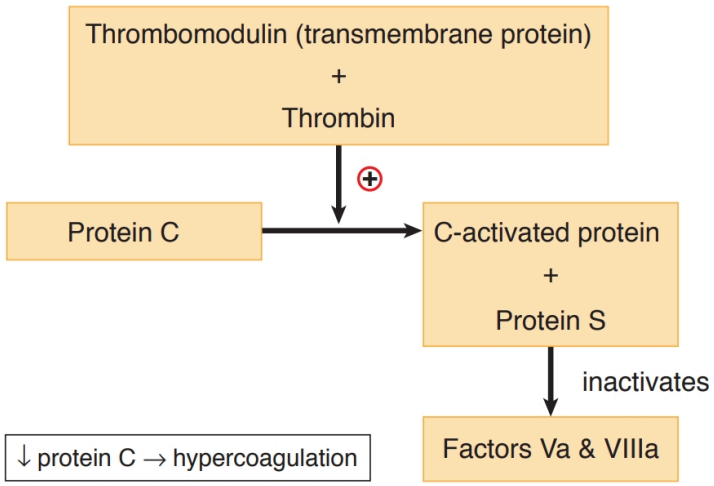


Figure VII-1-2. Activation and Role of Protein C

  - Transient protein C deficiency can be induced when initiating treatment with warfarin because factors VII and protein C have the shortest half-lives of the coagulation factors.
  - Consequently, the extrinsic pathway and protein C system are inactivated, whereas the intrinsic system remains active for a few days. Hypercoagulability occurs, which may result in dermal vascular thrombosis and skin necrosis.

Table VII-1-2. Coagulation Factor Half-Lives

Factor	IIa	VIIa	IXa	Xa	C	S
Half-life (h)	60	8	24	40	8	30

Direct Inhibitors of Activated Clotting Factors

Direct thrombin inhibitors

- Directly inhibit thrombin and do not require antithrombin III
- Drugs
  - Argatroban
    - Does not interact with heparin-induced antibodies
    - Used in HIT
  - Dabigatran
    - Oral anticoagulant that does not require monitoring of PT or INR
    - Used in atrial fibrillation as an alternative to warfarin
    - Rapidly reversed by idarucizumab
  - Bivalirudin
    - Used with aspirin in unstable angina when undergoing percutaneous transluminal coronary angioplasty (PTCA)

Direct Factor Xa Inhibitors: Rivaroxaban and Other "-xabans"

- Factor Xa inhibitor, does not require monitoring of PT or INR
- Used to prevent DVTs after knee/hip surgery; prevention of stroke and systemic embolism in non-valvular atrial fibrillation
- Rapidly reversed by andexanet alfa

Thrombolytics 2

LEARNING OBJECTIVES

- ❑ Describe mechanism for thrombolytic drugs
- ❑ Identify therapeutic use for thrombolytic drugs

THROMBOLYTIC OVERVIEW

Also called fibrinolytics, thrombolytics lyse thrombi by catalyzing the formation of the endogenous fibrinolytic plasmin (a serine protease) from its precursor, plasminogen. These agents include tissue plasminogen activator (tPA, recombinant) and streptokinase (bacterial). They are used intravenously for short-term emergency management of coronary thromboses in myocardial infarction (MI), deep venous thrombosis, pulmonary embolism, and ischemic stroke (tPA).

Drugs

High-Yield

- Streptokinase
  - Acts on both bound and free plasminogen (not clot specific), depleting circulating plasminogen and factors V and VIII
  - Is antigenic (foreign protein derived from β-hemolytic streptococci); may cause a problem if recent past use or infection—strep antibodies may ↓ activity
- Alteplase (tPA)
  - Clot specific, acting mainly on fibrin-bound plasminogen, the natural activator, so few allergy problems

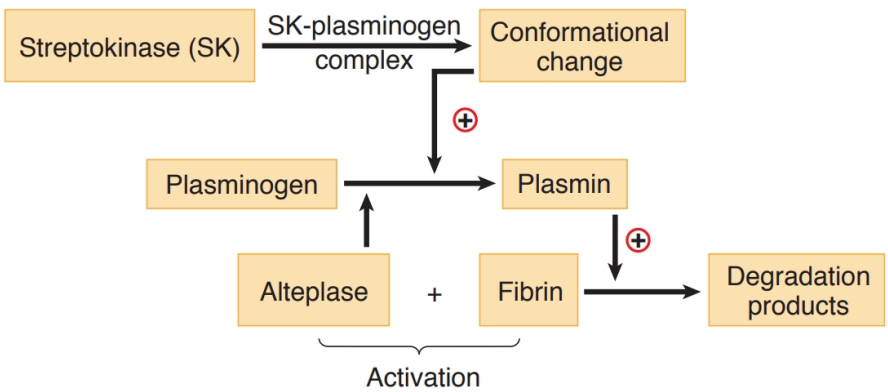


Figure VII-2-1. Actions of Streptokinase and Alteplase

Clinical Features

The overriding factor in effectiveness is early administration, e.g., >60% decrease in mortality post-MI if used within 3 hours.

- ASA, beta blockers, and nitrates further ↓ mortality, and adenosine ↓ infarct size
- Complications include bleeding, possible intracerebral hemorrhage
- Streptokinase may cause hypersensitivity reactions and hypotension
- Antifibrinolysins (aminocaproic and tranexamic acids)—possible antidotes in excessive bleeding

Antiplatelet Drugs 3

LEARNING OBJECTIVES

- ❑ Describe mechanism for antiplatelet drugs
- ❑ Identify therapeutic use for antiplatelet drugs

ANTIPLATELET OVERVIEW

Thrombus (clot) formation involves:

- Platelet adhesion to site of vascular injury
- Activation of platelets by factors that include TXA_2, ADP, collagen, 5HT, and thrombin $\rightarrow\uparrow$ expression of glycoprotein IIb/IIIa receptors
- Aggregation of platelets by a cross-linking reaction due to fibrinogen binding to glycoprotein IIb/IIIa receptors

Platelet Activation

High-Yield

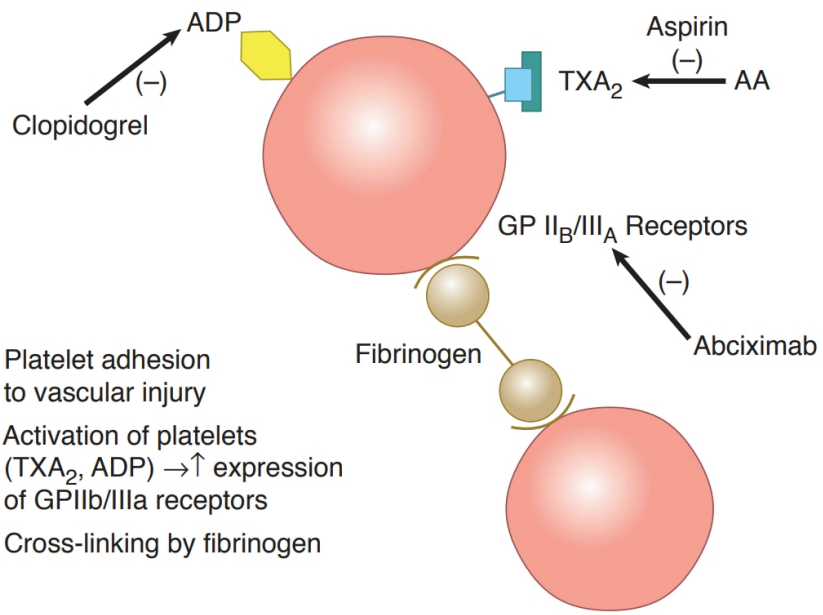


Figure VII-3-1. Platelet Activation

NOTE

Platelet Aggregation

Increased↑ by ADP, 5HT, TXA_2, thrombin, $\alpha_2$agonists

Decreased by PGI_2, cAMP, ASA, clopidogrel, GP IIb/IIIa blockers

Drugs

High-Yield

- Aspirin
  - Irreversibly inhibits COX in platelets →↓ activation
  - Low doses prevent MI and recurrence; prophylaxis in atrial arrhythmias and TIAs
  - Adverse effects (*see* Section VI, Inflammatory Disorder Drugs)
- Clopidogrel, prasugrel, ticagrelor
  - Block ADP receptors on platelets →↓ activation
  - Alternatives to ASA in TIAs, post-MI, and unstable angina
  - Aspirin + ADP receptor blockers are used in patients with non-ST elevation ACS
  - Hemorrhage, leukopenia, and thrombocytopenic purpura
- Abciximab, eptifibatide, and tirofiban
  - Antagonists that bind to glycoprotein IIb/IIIa receptors →↓ aggregation by preventing the cross-linking reaction
  - Used mainly in acute coronary syndromes and postangioplasty

Blood Disorder Drug List and Practice Questions

4

Anticoagulants

- Heparin
- Warfarin
- Argatroban
- Bivalirudin
- Dabigatran
- Rivaroxaban

Thrombolytics

- Alteplase (tPA)
- Streptokinase

Antiplatelet

- Aspirin
- Clopidogrel
- Abciximab
- Prasugrel
- Ticagrelor

PRACTICE QUESTIONS

1. Which of the following compounds is most likely to block ADP receptors and prevent platelet aggregation?

   A. Clopidogrel
   B. Aspirin
   C. Prostacyclin
   D. Abciximab
   E. Montelukast

2. A woman who has a mechanical heart valve and who is taking warfarin informs you that she hopes to get pregnant in the near future. What advice should she receive regarding her antithrombotic medication during the anticipated pregnancy?

   A. Warfarin should be continued until the third trimester.
   B. Warfarin should be replaced with aspirin at analgesic doses.
   C. All medications that affect the blood should be discontinued.
   D. Warfarin should be replaced with heparin.
   E. Warfarin should be discontinued, and supplementary vitamin K taken throughout the pregnancy.

3. The primary advantage of enoxaparin over heparin is that it

   A. is unlikely to cause bleeding
   B. more effectively inhibits the synthesis of clotting factors
   C. has a more rapid onset
   D. does not case thrombocytopenia
   E. has a longer half-life

4. Which of the following statements regarding warfarin is true?

   A. It is a prodrug converted to its active metabolite spontaneously in the blood.
   B. It has low lipophilicity and does not cross the placental barrier.
   C. It causes a depletion in protein C before it decreases prothrombin.
   D. It inhibits release of vitamin K–dependent clotting factors from hepatocytes.
   E. It is inactivated by protamine.

5. Which of the following statements is true regarding the parenteral administration of alteplase?

   A. It increases the formation of plasminogen.
   B. It is less effective than streptokinase when given after a myocardial infarction.
   C. It causes a high incidence of thrombocytopenia.
   D. It may cause bleeding reversible by aminocaproic acid.
   E. It activates free plasminogen.

6. Following a myocardial infarction, a patient is stabilized on warfarin, the dose being adjusted to give a prothrombin time of 22 seconds. Which of the following statements regarding potential drug interactions in this patient is accurate?

   A. Cholestyramine will increase prothrombin time.
   B. Cimetidine is likely to decrease prothrombin time.
   C. Antibacterial sulfonamides may enhance the effects of warfarin.
   D. Vitamin K would restore prothrombin time to normal within 30 minutes.
   E. If this patient takes half an aspirin tablet daily, the dose of warfarin will need to be increased.

ANSWERS AND EXPLANATIONS

1. **Answer: A.** Platelet aggregation is stimulated by many compounds, including ADP, thromboxane A_2, fibrin, and serotonin. Clopidogrel, along with ticlopidine, block ADP receptors and prevent platelet activation. Prostacyclin (PGI_2) from endothelial cells is a naturally occurring compound that inhibits platelet aggregation by stimulating PGI_2 receptors. Aspirin inhibits the synthesis of thromboxane A_2. Abciximab is a monoclonal antibody targeted to the glycoprotein IIb/IIIa receptor, which inhibits aggregation. Montelukast blocks leukotriene receptors and is used in asthma.

2. **Answer: D.** Discontinuing warfarin is appropriate during pregnancy because it is a known teratogen that causes bone dysmorphogenesis. The patient will need continued protection against thrombus formation, and heparin (or a related low molecular weight compound) is usually advised, despite the fact that the drug will require parenteral administration and can cause thrombocytopenia.

3. **Answer: E.** Enoxaparin is a low-molecular weight heparin. As such, it is smaller and will have a longer half-life compared to heparin. It still has a risk of causing bleeding and thrombocytopenia, but is not more rapid in onset. Heparins do not affect the synthesis of clotting factors, but rather rapidly inactivate existing factors.

4. **Answer: C.** Warfarin inhibits the hepatic synthesis of factors II (prothrombin), VII, IX, and X. Its onset of anticoagulation activity is slow, and its impact on individual coagulation factors depends on their half-lives. Factor VII and protein C have much shorter half-lives than prothrombin, and so the extrinsic pathway and protein C system are the first to be affected by warfarin. The intrinsic pathway continues to function for 2 to 3 days, causing a state of hypercoagulability and possible vascular thrombosis.

5. **Answer: D.** Alteplase is thrombolytic (or "fibrinolytic") because it activates plasminogen, resulting in the increased formation of plasmin. Its efficacy is equivalent to that of streptokinase, but alteplase has the advantage of only activating plasminogen bound to fibrin (clot specific) but not free plasminogen. All thrombolytics can cause bleeding, which may be counteracted to some extent by administration of antifibrinolysins, such as aminocaproic acid.

6. **Answer: C.** Warfarin binds extensively (98%) but weakly to plasma proteins and can be displaced by other drugs (e.g., ASA, chloral hydrate, phenytoin, sulfinpyrazone, and sulfonamides), resulting in an increase in its anticoagulant effects. Bile acid sequestrants bind acidic drugs such as warfarin, preventing their gastrointestinal absorption (↓ prothrombin time [PT]), and cimetidine, which inhibits the metabolism of warfarin, causing an increase in PT. Vitamin K restores levels of prothrombin and several other coagulation factors, but the action is slow (24 to 48 hours). Due to antiplatelet effects, even low doses of ASA may enhance bleeding in patients on warfarin.

PART VIII

ENDOCRINE DRUGS

Diabetes Drugs 1

LEARNING OBJECTIVES

- ❑ Describe mechanism and side effects of drugs used in type 2 diabetes
- ❑ Identify drugs used to treat diabetic nephropathy, neuropathy, and gastroparesis

DIABETES MELLITUS

Type 1 (IDDM)

- Early onset
- Loss of pancreatic B cells → absolute dependence on insulin (diet + insulin)
- Ketoacidosis-prone

Type 2 (NIDDM)

- Usually adult onset
- Decreased response to insulin → (diet → drugs ± insulin)
- Not ketoacidosis-prone

INSULIN FORMS

Table VIII-1-1. Kinetics (in Hours) of Insulin Forms with Subcutaneous Injection

Form	Onset	Peak Effect	Duration
Lispro*	0.3–0.5	1–2	3–4
Regular*	0.5–1	2–4	5–7
Glargine	1	no peak	≥24

* Only forms that can be used intravenously; peak action in 2 to 4 min.

NOTE

Insulin Release

- Increased by glucose, sulfonylureas, M-agonists, β_2-agonists
- Decreased by α_2-agonists

CLINICAL CORRELATE

Diabetic Ketoacidosis

- Symptoms: polyuria, polydipsia, nausea, fatigue, dehydration, Kussmaul breathing, "fruity" breath
- Treatment: regular insulin IV, fluid and electrolyte replacement

- Glargine:
  - Insulin analog with no peak ("peakless," i.e., broad plasma concentration plateau)
  - Ultralong duration of action
  - Used to supply a constant background level
- Mechanism: insulin binds to transmembrane receptors which activate tyrosine kinase to phosphorylate tissue-specific substrates

DRUGS FOR TYPE 2 DIABETES

Metformin

High-Yield

- "Euglycemic," ↓ postprandial glucose levels, but does not cause hypoglycemia or weight gain
- Mechanisms: may involve ↑ tissue sensitivity to insulin and/or ↓ hepatic gluconeogenesis
- Use: monotherapy or combinations (synergistic with sulfonylureas)
- Side effects: possible lactic acidosis; gastrointestinal distress is common

Acarbose

- No hypoglycemia
- Mechanisms: inhibits α-glucosidase in brush borders of small intestine →↓ formation of absorbable carbohydrate →↓ postprandial glucose →↓ demand for insulin
- Side effects: gastrointestinal discomfort, flatulence, diarrhea; recent concern over potential hepatotoxicity

Sulfonylureas

High-Yield

- Mechanisms:
  - Normally, K^+ efflux in pancreatic β cells maintains hyperpolarization of membranes, and insulin is released only when depolarization occurs.
  - Glucose acts as an insulinogen by increasing intracellular ATP → closure of K^+ channels → membrane depolarization →↑ Ca^{2+} influx → insulin release.
  - The acute action of sulfonylureas is to block K^+ channels → depolarization → insulin release.
- Effects of increased insulin:
  - →↓ glucagon release from pancreatic α cells
  - Continued use of sulfonylureas ↑ tissue responses to insulin (especially muscle and liver) via changes in receptor function
- Drugs:
  - Second generation:
    - Glipizide (↓ dose in hepatic dysfunction)
    - Glyburide (active metabolite, ↓ dose in renal dysfunction)
- Side effects:
  - Hypoglycemia
  - Weight gain
  - Drug interactions mainly with first-generation drugs →↑ hypoglycemia with cimetidine, insulin, salicylates, sulfonamides

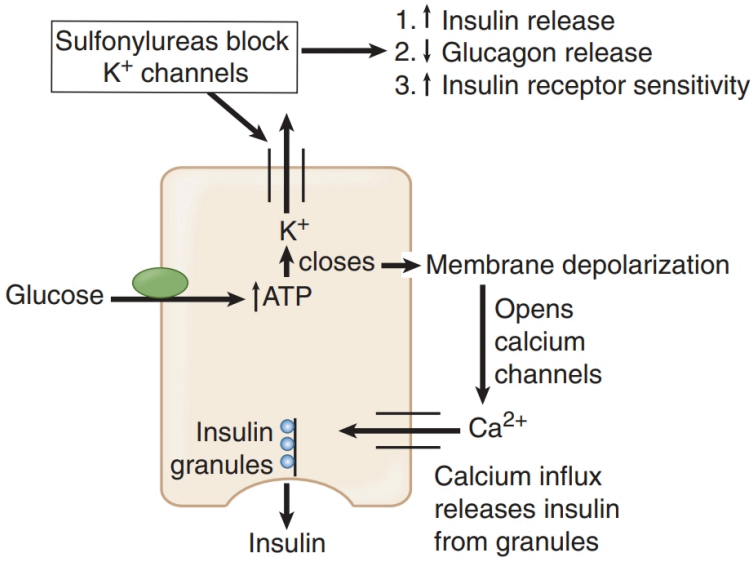


Figure VIII-1-1. Mode of Action of Sulfonylureas

NOTE

Repaglinide

- Mechanisms: stimulates insulin release from pancreatic beta cells
- Use: adjunctive use in type 2 diabetes–administer just before meals due to short half-life

NOTE

Hypoglycemic Reactions

- Symptoms: lip/tongue tingling, lethargy, confusion, sweats, tremors, tachycardia, coma, seizures
- Treatment: oral glucose, IV dextrose if unconscious, or glucagon (IM or inhalation)

Thiazolidinediones: Pioglitazone and Rosiglitazone

High-Yield

- Mechanisms: bind to nuclear peroxisome proliferator-activating receptors (PPARγ) involved in transcription of insulin-responsive genes → sensitization of tissues to insulin, plus ↓ hepatic gluconeogenesis and triglycerides and ↑ insulin receptor numbers
- Side effects: less hypoglycemia than sulfonylureas, but weight gain and edema reported

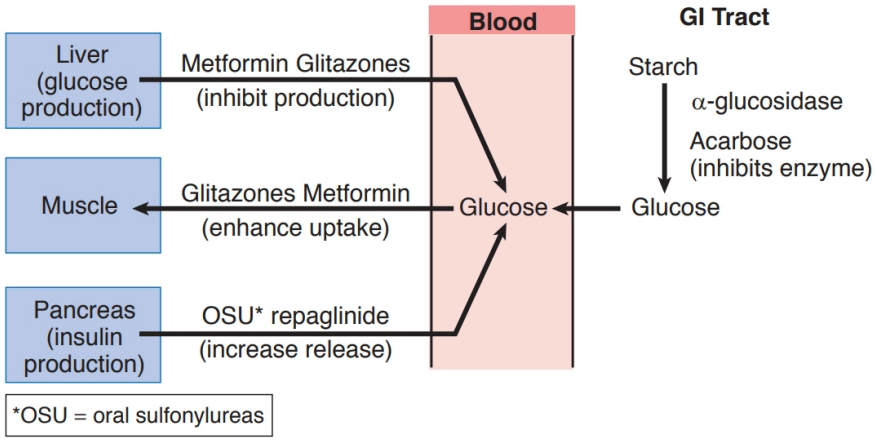


Figure VIII-1-2. Modes of Action of Drugs Used to Treat Diabetes

Recall Question

Which of the following is a side effect of sulfonylureas?

A. Weight loss
B. Bradycardia
C. Hyperglycemia
D. Confusion

Answer: D

Agents Affecting Glucagon-Like Peptide-1 (GLP-1)

Liraglutide and Other Glutides

- Mechanism: GLP-1 is an incretin released from the small intestine. It augments glucose-dependent insulin secretion. Liraglutide is a long-acting GLP-1 receptor full agonist used in combination with other agents in type 2 diabetes.
- Side effects: nausea, hypoglycemia when used with oral sulfonylureas

Sitagliptin and Other Gliptins

- Mechanism: inhibits dipeptidyl peptidase (DPP-4) thereby inhibiting the inactivation of GLP-1

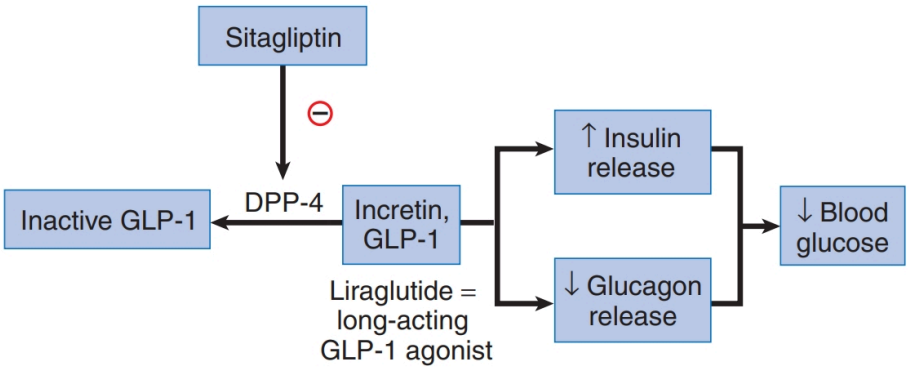


Figure VIII-1-3. Action of Drugs Affecting GLP-1

Sodium-Glucose Cotransporter-2 (SGLT-2) Inhibitor: Canagliflozin and Other Gliflozins

- Blocks SGLT-2 in the proximal tubule, increasing glucose excretion
- Side Effects: UTIs

NOTE

Pramlintide is a synthetic version of amylin that slows the rate at which food is absorbed from the intestine, decreases glucose production, and decreases appetite. It is used in type 1 and type 2 diabetes.

Steroid Drugs 2

LEARNING OBJECTIVES

- ❑ Describe mechanism and use of steroid hormone antagonists
- ❑ Explain the actions of SERMs on bone, breast, and endometrium

ADRENAL STEROIDS

Uses

- Nonendocrine uses: inflammatory disorders (and accompanying adverse effects), *see* Section VI, Inflammatory Disorder Drugs.
- Endocrine uses of glucocorticoids (e.g., prednisone, dexamethasone, hydrocortisone) and the mineralocorticoid (fludrocortisone) include:
  - Addison disease: replacement therapy
  - Adrenal insufficiency states (infection, shock, trauma): supplementation
  - Premature delivery to prevent respiratory distress syndrome: supplementation
  - Adrenal hyperplasia: feedback inhibition of ACTH

Antagonists

High-Yield

- Adrenal steroid antagonists:
  - Spironolactone
  - Blocks aldosterone and androgen receptors (*see* Section III, Cardiac and Renal Drugs)
- Mifepristone: blocks glucocorticoid and progestin receptors
- Synthesis inhibitors: metyrapone (blocks 11-hydroxylation); ketoconazole

ESTROGENS

Estradiol is the major natural estrogen. The rationale for synthetics is to increase oral bioavailability, increase half-life, and increase feedback inhibition of FSH and LH.

Primary drugs include conjugated equine estrogens (Premarin) and ethinyl estradiol and mestranol.

Clinical uses for estrogens include female hypogonadism, hormone replacement therapy (HRT) in menopause leading to decreased bone resorption (decreased PTH), contraception, dysmenorrhea, uterine bleeding, and acne.

Side effects include nausea, breast tenderness, endometrial hyperplasia, increased gallbladder disease, cholestasis, migraine, and bloating. There is an increased risk of blood coagulation via decreased antithrombin III and increased factors II, VII, IX, and X (only at high dose).

There is an increased risk of endometrial cancer with the use of estrogens (unless progestins are added). The increased risk of breast cancer is controversial, but use caution if other risk factors are present.

Estrogen Antagonists

High-Yield

- Anastrozole
  - Mode of action: aromatase inhibitor →↓ estrogen synthesis
  - Use: estrogen-dependent, postmenopausal breast cancer

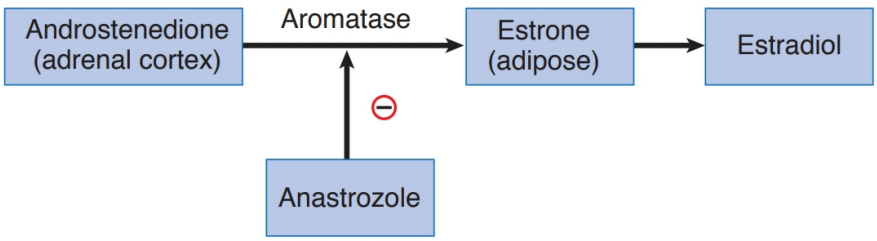


Figure VIII-2-1. Mechanism of Action of Anastrozole

- **Clomiphene** (fertility pill)
  - Mode of action: ↓ feedback inhibition →↑ FSH and LH →↑ ovulation → pregnancy
  - Use: fertility drug
  - Adverse effect: ↑ multiple births

Selective Estrogen-Receptor Modulators (SERMs)

High-Yield

- **Tamoxifen**
  - Variable actions depending on "target" tissue
  - E-receptor agonist (bone), antagonist (breast), and partial agonist (endometrium)
  - Possible ↑ risk of endometrial cancer
  - Used in estrogen-dependent breast cancer and for prophylaxis in high-risk patients
- Raloxifene
  - E-receptor agonist (bone), antagonist breast and uterus
  - When used in menopause, there is no increased cancer risk
  - Use: prophylaxis of postmenopausal osteoporosis, breast cancer

Table VIII-2-1. Comparison of Tamoxifen and Raloxifene in Various Tissues

Drug	Bone	Breast	Endometrium
Tamoxifen	Agonist	Antagonist	Agonist
Raloxifene	Agonist	Antagonist	Antagonist

PROGESTINS

Progesterone is the major natural progestin. The rationale for synthetics is to increase oral bioavailability and increase feedback inhibition of gonadotropins, especially luteinizing hormone (LH).

Primary drugs include medroxyprogesterone, norethindrone, and desogestrel (a synthetic progestin devoid of androgenic and antiestrogenic activities common to other derivatives).

Clinical uses for progestins include contraception (oral with estrogens or depot contraception with medroxyprogesterone IM every 3 months) and HRT (combine with estrogens to decrease endometrial cancer risk).

Side effects include decreased HDL and increased LDL (antiestrogenic), glucose intolerance, breakthrough bleeding, androgenic (hirsutism and acne), weight gain, and depression.

The progestin antagonist mifepristone is used as an abortifacient (with prostaglandins [PGs]).

ORAL CONTRACEPTIVES

Oral contraceptives are combinations of estrogens (ethinyl estradiol, mestranol) with progestins (norgestrel, norethindrone) in varied doses, with mono-, bi-, and triphasic variants. Oral contraceptives suppress gonadotropins, especially midcycle LH surge.

- Side effects: those of estrogens and progestins, as seen previously
- Interactions: ↓ contraceptive effectiveness when used with antimicrobials and enzyme inducers
- Benefits:
  - ↓ risk of endometrial and ovarian cancer
  - ↓ dysmenorrhea
  - ↓ endometriosis
  - ↓ pelvic inflammatory disease (PID)
  - ↓ osteoporosis

ANDROGENS

Androgens include methyltestosterone and 17-alkyl derivatives with increased anabolic actions, e.g., oxandrolone, nandrolone.

- Uses:
  - Male hypogonadism and for anabolic actions →↑ muscle mass, ↑ RBCs, ↓ nitrogen excretion
  - Illicit use in athletics
- Side effects: excessive masculinization, premature closure of epiphysis, cholestatic jaundice, aggression, dependence

Antagonists

High-Yield

- **Flutamide:** androgen receptor blocker: used for androgen-receptor–positive prostate cancer
- **Leuprolide:** GnRH analog: repository form used for androgen-receptor–positive prostate cancer
- **Finasteride**
  - 5-alpha reductase inhibitor, preventing conversion of testosterone to dihydrotestosterone (DHT)
  - DHT is responsible for hair loss and prostate enlargement
  - Uses: BPH, male pattern baldness
  - Caution: teratogenicity

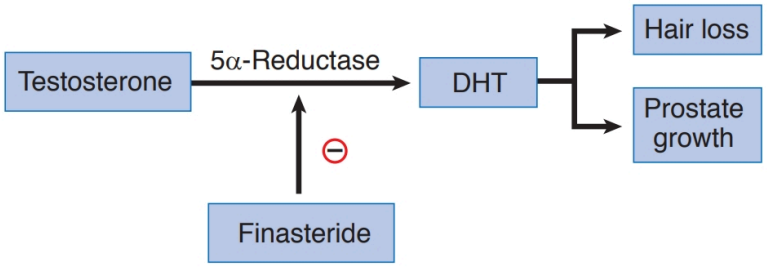


Figure VIII-2-2. Mechanism of Action of Finasteride

Recall Question

Which of the following medications is given to increase the chance of a woman getting pregnant?

A. Mifepristone

B. Clomiphene

C. Tamoxifen

D. Anastrozole

Answer: B

3 Antithyroid Drugs

LEARNING OBJECTIVES

- ❑ Describe mechanism for drugs used to treat hyperthyroidism
- ❑ Identify side effects of PTU and methimazole
- ❑ Recall the effects of amiodarone and lithium on thyroid function

THYROID HORMONES

Synthesis and Release

High-Yield

Table VIII-3-1. Synthesis of Thyroid Hormone and Effects of Antithyroid Agents

Thyroid Hormone Synthesis	Effects of Antithyroid Agents
1. Active accumulation of iodide into gland	Basis for selective cell destruction by ^{131}I
2. Oxidation of iodide to iodine by peroxidase	Inhibited by thioamides
3. Iodination of tyrosyl residues (organification) on thyroglobulin to form MIT and DIT	Inhibited by thioamides
4. Coupling of MIT and DIT to form T_3 and T_4	Inhibited by thioamides
5. Proteolytic release of T_3 and T_4 from thyroglobulin	Inhibited by high doses of iodide*
6. Conversion of T_4 to T_3 via 5´ deiodinase in peripheral tissues	Inhibited by propranolol* and propylthiouracil*

MIT, monoiodotyrosine; DIT, diiodotyrosine; T_3, triiodothyronine; T_4, thyroxine

*Thyroid storm management may include the use of any or all of these agents.

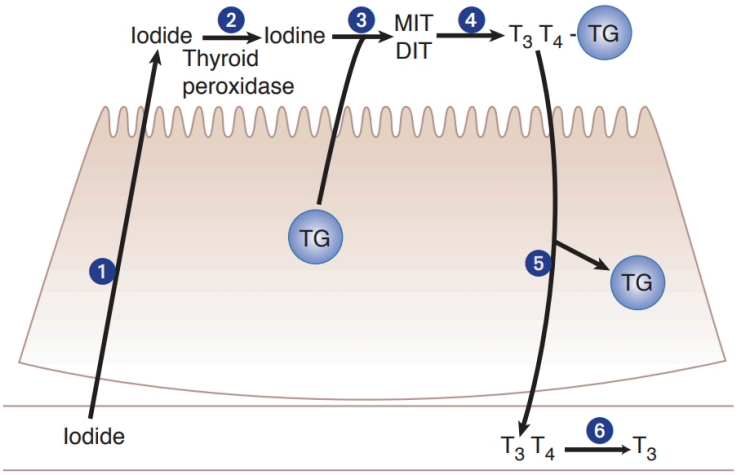


Figure VIII-3-1. Thyroid Hormone Synthesis

Drugs for Hyperthyroidism

- Thioamides: propylthiouracil and methimazole
  - Use: uncomplicated hyperthyroid conditions; slow in onset
  - High-dose propylthiouracil inhibits 5′ deiodinase
  - Common maculopapular rash; agranulocytosis, liver failure (PTU)
  - Both drugs cross the placental barrier, but propylthiouracil is safer in pregnancy because it is extensively protein bound
- Iodide
  - Potassium iodide plus iodine (Lugol solution) possible use in thyrotoxicosis: used preoperatively →↓ gland size, fragility, and vascularity
  - No long-term use because thyroid gland "escapes" from effects after 10 to 14 days
- I^{131}: most commonly used drug for hyperthyroidism

Hypothalamic and Pituitary Drugs

4

LEARNING OBJECTIVES

- ❑ Identify therapeutic uses for octreotide
- ❑ List pharmacologic treatments for hyperprolactinemia, central diabetes insipidus, and SIADH

Table VIII-4-1. Drugs Related to Hypothalamic and Pituitary Hormones

Hormone	Pharmacologic Agent	Clinical Uses
GH	Somatrem or somatropin	Pituitary dwarfism, osteoporosis
Somatostatin	Octreotide	Acromegaly, carcinoid and secretory-GI tumors
ACTH	Cosyntropin	Infantile spasms
GnRH	Leuprolide, nafarelin	Endometriosis, prostate carcinoma (repository form)
FSH and LH	Urofollitropin (FSH), placental HCG (LH), menotropins (FSH and LH)	Hypogonadal states
PIH (DA)	Cabergoline	Hyperprolactinemia
Oxytocin	Oxytocin	Labor induction
Vasopressin	Desmopressin (V2 selective)	• Neurogenic (pituitary) diabetes insipidus • Hemophilia A (↑ factor VIII from liver) • von Willebrand disease (↑ vW factor from endothelium) • Primary nocturnal enuresis

ACTH, adrenocorticotropin hormone; DA, dopamine; FSH, follicle-stimulating hormone; GH, growth hormone; GnRH, gonadotropin-releasing hormone; LH, luteinizing hormone; PIH, prolactin-inhibiting hormone

CLINICAL CORRELATE

Drugs useful in the syndrome of inappropriate secretion of ADH (SIADH) include demeclocycline and tolvaptan, which block V2 receptors in the collecting duct. Loop diuretics, salt tablets, and fluid restriction are also useful.

Osteoporosis Drugs 5

LEARNING OBJECTIVES

- ❑ Describe mechanism for drugs used in the treatment of osteoporosis
- ❑ Identify side effects of bisphosphonates

OSTEOPOROSIS TREATMENT

Bisphosphonates: Alendronate and Other Dronates

High-Yield

- Mechanisms: are analogs of pyrophosphate
  - Directly inhibit bone resorption by inhibiting the enzyme farnesyl pyrophosphate (FPP) synthase in the mevalonate pathway (cholesterol biosynthetic pathway)
  - Inhibition of FPP synthase disrupts protein prenylation, which creates cytoskeletal abnormalities in the osteoclast, promotes detachment of the osteoclast from the bone perimeter, and leads to reduced bone resorption
- Clinical uses:
  - Considered first-line therapy for the management of osteoporosis
  - Beneficial in Paget disease
  - Side effects: bone mineralization defects (etidronate and pamidronate); gastrointestinal distress including esophageal ulcers (alendronate)

Teriparatide

- Mechanism: recombinant DNA PTH analog
- Clinical use: 1x daily to stimulate osteoblasts and new bone formation
- Continuous infusion would stimulate osteoclast activity
- Recommended use for <2 years; may increase risk of osteosarcoma

Denosumab

- Inhibits RANK ligand, a protein that acts as the primary signal for bone removal

CLINICAL CORRELATE

Cinacalcet activates the calcium-sensing receptor (CaSR) in the parathyroid gland and inhibits PTH secretion. It is approved for hyperparathyroidism in chronic kidney disease and for hypercalcemia in patients with parathyroid carcinoma.

Endocrine Drug List and Practice Questions

6

Table VIII-6-1. Endocrine Drug List

Drugs Used in Diabetes	Antithyroid Drugs
Insulins, glargine Sulfonylureas—glipizide, glyburide Metformin Acarbose Thiazolidinediones—pioglitazone, rosiglitazone GLP-1 drugs—exenatide, sitagliptin	Propylthiouracil Methimazole KI and I (Lugol) I^{131}
Steroid Hormones	**Hypothalamic/Pituitary Drugs**
Adrenosteroids Cortisol Triamcinolone Fludrocortisone Prednisone Dexamethasone Hydrocortisone *Estrogens* Ethinyl estradiol Mestranol Tamoxifen (SERM) Raloxifene (SERM) *Progestins* Medroxyprogesterone Norgestrel Norethindrone Desogestrel Mifepristone (antagonist) *Androgens* Methyltestosterone Oxandrolone Flutamide (antagonist) Finasteride (5-α-reductase inhibitor)	Somatropin Octreotide Leuprolide Oxytocin, vasopressin
	Drugs Used in Bone and Mineral Disorders
	Alendronate Teriparatide

PRACTICE QUESTIONS

1. A 70-year-old man is diagnosed with benign prostatic hyperplasia (BPH), and his physician is considering drug treatment of the condition. It was decided that the drug finasteride will be used. The effects of finasteride will result in a decrease in the synthesis of what substance?

   A. Epinephrine
   B. Norepinephrine
   C. Dihydrotestosterone
   D. Testosterone
   E. GnRH

2. Which of the following statements is accurate regarding drug management of hyperthyroidism?

   A. The actions of thyroid peroxidase are inhibited by I^{131}
   B. Propylthiouracil inhibits the conversion of thyroxine to triiodothyronine
   C. Methimazole is unable to cross the placental barrier
   D. Iodide salts can be used for long-term management
   E. The iodination of tyrosyl residues to form MIT and DIT are inhibited by beta blockers

3. What drug is useful to distinguish neurogenic from nephrogenic diabetes insipidus?

   A. Amiloride
   B. Demeclocycline
   C. Desmopressin
   D. Hydrochlorothiazide
   E. Lithium

4. The release of insulin from pancreatic beta cells would most likely be stimulated by which of the following?

   A. Clonidine
   B. Norepinephrine
   C. Diazoxide
   D. Glipizide
   E. Hypoglycemia

5. When used at higher doses than commonly employed for other purposes, what drug can effectively inhibit steroidogenesis in a variety of tissues?

   A. Flutamide
   B. Misoprostol
   C. Clomiphene
   D. Tamoxifen
   E. Ketoconazole

6. In a patient with type 2 diabetes, which drug mimics the action of incretins to augment glucose-dependent insulin secretion?

   A. Acarbose
   B. Glucagon
   C. Exenatide
   D. Metformin
   E. Rosiglitazone

7. To supplement other oral type 2 diabetes medication, a patient is prescribed a drug to inhibit the intestinal absorption of carbohydrates. What would be an appropriate drug?

   A. Metformin
   B. Acarbose
   C. Repaglinide
   D. Insulin lispro
   E. Pioglitazone

8. What is the drug of choice for management of adrenal glucocorticoid-induced osteoporosis?

   A. Alendronate
   B. Calcitonin
   C. Estrogen
   D. Ketoconazole
   E. Vitamin D

9. Which drug has utility in inhibiting the severe secretory diarrhea of hormone-secreting tumors of the pancreas and GI tract, as well as in the treatment of acromegaly?

   A. Octreotide
   B. Leuprolide
   C. Bromocriptine
   D. Sertraline
   E. Anastrozole

ANSWERS AND EXPLANATIONS

1. **Answer: C.** The drug finasteride inhibits the enzyme 5-α reductase, the enzyme that converts testosterone to dihydrotestosterone (DHT). DHT is responsible for prostate enlargement in BPH. The other commonly used drugs in BPH are alpha-1 antagonists such as prazosin and tamsulosin.

2. **Answer: B.** Thioamides used at conventional doses in Graves disease are slow to act; they inhibit iodination and the coupling reactions in hormone synthesis and do not affect the release of stored thyroxine. At high doses, propylthiouracil may act more rapidly because of its inhibition of 5′-deiodinase, preventing the conversion of T_4 to T_3. Thioamides are not teratogenic, and they do not decrease glandular size or vascularity; KI plus iodine (Lugol solution) is used preoperatively to this end. Use of iodide in hyperthyroidism is only temporary because the thyroid gland "escapes" from its actions within a week or two.

3. **Answer: C.** Neurogenic diabetes insipidus is treated with desmopressin, a drug that is similar to vasopressin (ADH), yet is a selective activator of V_2 receptors in the kidney. Remember that V_1 receptors are present in smooth muscle, and their activation leads to vasoconstriction and bronchoconstriction. Nephrogenic diabetes insipidus (decreased response of vasopressin receptors) is treated with thiazides, except in the case of that induced by lithium, when amiloride is preferred (because thiazides increase blood levels of lithium). In cases where it is necessary to distinguish between neurogenic and nephrogenic, desmopressin is used. Desmopressin would alleviate the symptoms of neurogenic but have no effect in nephrogenic diabetes insipidus.

4. **Answer: D.** The release of insulin from the pancreas is stimulated by insulinogens (glucose), sulfonylurea hypoglycemics (glipizide), activators of beta-2 adrenoceptors (e.g., albuterol), and activators of muscarinic receptors (e.g., pilocarpine). Activation of alpha-2 receptors inhibits insulin release (clonidine and norepinephrine). Hypokalemia, and diazoxide, keep potassium channels on beta cells open resulting in decreased insulin release

5. **Answer: E.** Ketoconazole is an antifungal drug that decreases the synthesis of various steroids including cortisol and testosterone by inhibiting cytochrome P450 enzymes. Flutamide is an androgen-receptor antagonist, and tamoxifen is a partial agonist (or mixed agonist-antagonist) at estrogen receptors. Misoprostol is a prostaglandin analog used in NSAID-induced ulcers. Clomiphene is used to induce ovulation.

6. **Answer: C.** Exenatide is a glucagon-like peptide-1 (GLP-1) analog. GLP-1 is an incretin released from the small intestine that enhances glucose-dependent insulin secretion. Metformin is "euglycemic," lowering elevated glucose levels to the normal range, and acarbose simply prevents postprandial hyperglycemia. Glucagon causes hyperglycemia, an effect that is sometimes employed in management of hypoglycemia. Rosiglitazone increases the sensitivity to insulin by increasing insulin receptor numbers.

7. **Answer: B.** Acarbose inhibits the enzyme α-glucosidase in the brush borders of the small intestine. This decreases the formation of absorbable carbohydrate and thereby decreases glucose absorption. The net effect is that glucose levels after a meal don't rise as significantly and therefore the insulin demand is reduced.

8. **Answer: A.** Alendronate is currently the drug of choice to prevent osteoporosis in patients who must be maintained on steroids for their antiinflammatory and immunosuppressive effects. The drug also decreases bone resorption during menopause and is sometimes favored in patients who are at risk for neoplasias if treated with sex hormones. Care must be taken with alendronate to avoid esophageal ulceration. Estrogen hormone replacement therapy ± vitamin D also has proven valuable for slowing bone resorption in menopause, and increases in bone mass have been reported for combinations of estrogens with alendronate.

9. **Answer: A.** Octreotide is a somatostatin analog that is effective for carcinoid and other secretory GI tumors. It has been used to varying degrees in other forms of secretory diarrhea such as chemotherapy-induced and the diarrhea of HIV and diabetes. Octreotide has proven to be of major importance in the management of acromegaly and can significantly decrease the levels of growth hormone.

PART IX

ANTICANCER DRUGS, IMMUNE DRUGS, AND TOXICOLOGY

Anticancer Drugs 1

LEARNING OBJECTIVES

- ❑ Describe mechanism for anticancer drugs
- ❑ Recognize distinctive toxicities for anticancer drugs
- ❑ Identify drugs used as immunostimulants

PRINCIPLES

Log-Kill Hypothesis

Cytotoxic actions of anticancer drugs follow first-order kinetics: They kill a fixed percentage of tumor cells, not a fixed number, which is one rationale for drug combinations.

Growth Fraction

Cytotoxic drugs are more effective against tumors that have a high growth fraction (large percentage actively dividing). Normal cells with a high growth fraction (e.g., bone marrow) are also more sensitive to anticancer drugs.

DRUGS AND DRUG PROPERTIES

Cell-Cycle Specificity

- Drugs that act specifically on phases of the cell cycle are called cell-cycle specific (CCS) and are more effective in tumors with high-growth fraction (leukemias, lymphomas).
- Drugs that are cell-cycle nonspecific (many bind to and damage DNA) can be used in tumors with low-growth fraction, as well as tumors with high-growth fraction.

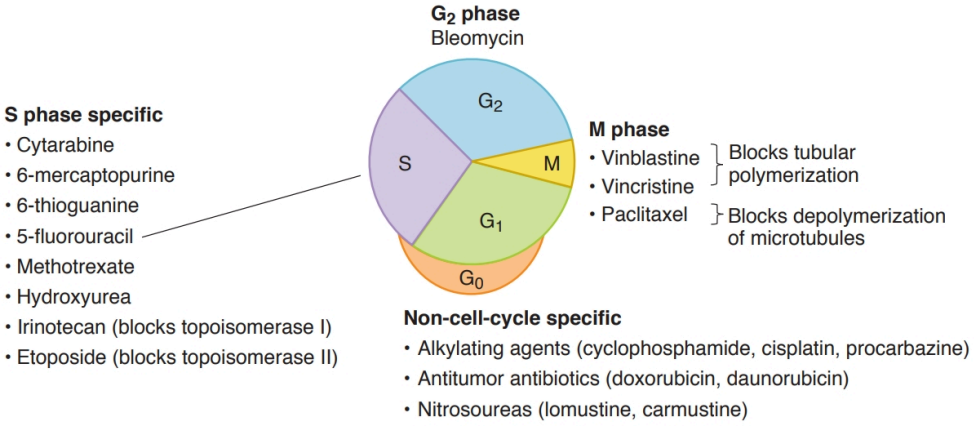


Figure IX-1-1. Cell-Cycle Specificity of Anticancer Drugs

Cancer Drug Characteristics

High-Yield

Table IX-1-1. Characteristics of Important Anticancer Drugs

Drug	Mechanism	Uses	Side Effects
Cyclophosphamide	Alkylating agent—attacks guanine N7—dysfunctional DNA	Non-Hodgkin, ovarian, breast cancer, neuroblastoma	BMS, hemorrhagic cystitis (**mesna,** traps acrolein and is protective)
Cisplatin	Alkylating agent— cross-links DNA strands	Testicular, ovarian, bladder, lung cancer	Nephrotoxicity (use **amifostine**); neurotoxicity (deafness)
Procarbazine	Alkylating agent	Hodgkin	BMS, leukemogenic
Doxorubicin	Intercalator, forms free radicals, inhibits topoisomerase	Hodgkin, breast, endometrial, lung, and ovarian cancers	BMS—delayed CHF (**dexrazoxane** is an iron-chelating agent preventing the formation of free radicals; it is not a free radical "trapper")
Methotrexate (CCS)	Antimetabolite—inhibits DHF reductase (S phase)	Leukemias, lymphomas, breast cancer; rheumatoid arthritis, psoriasis	BMS, **leucovorin** (folinic acid) rescue
5-Fluorouracil (CCS) Capecitabine (oral)	Pyrimidine antimetabolite (S phase) bioactivated to inhibit thymidylate synthetase	Breast, ovarian, head, and neck cancer—topical for basal cell cancer and keratoses; colorectal cancer	BMS
6-Mercaptopurine (CCS)	Purine antimetabolite (S phase) bioactivated by HGPR transferase	Acute lymphocytic leukemia; immunosuppression	BMS
Bleomycin (CCS)	Complexes with Fe and O_2 → DNA strand scission (G_2 phase)	Hodgkin, testicular, head, neck, skin cancer	Pneumonitis, pulmonary fibrosis
Vinblastine (CCS) Vincristine	↓ Microtubular polymerization—spindle poisons (M phase)	Vinblastine—Hodgkin, testicular cancer, Kaposi Vincristine—Hodgkin, leukemias, Wilms	BMS Neurotoxicity
All-trans retinoic acid (ATRA)	Differentiating agent, promotes differentiation of promyelocytes	Acute myelogenous leukemia (AML), M3	"Differentiation syndrome" with respiratory distress, pleural and pericardial effusions, CNS symptoms

Definition of abbreviations: BMS, bone marrow suppression; CCS, cell-cycle specific

Targeted Cancer Therapy

High-Yield

Table IX-1-2. Targeted Anticancer Drugs

Drug	Target
Imatinib	BCR-ABL
Cetuximab	ErbB1
Trastuzumab	ErbB2 (HER2/neu)
Bevacizumab	VEGF-A
Sorafenib	RAF kinase

Toxicity of Anticancer Drugs

High-Yield

Table IX-1-3. Other Dose-Limiting or Distinctive Toxicities

Toxicity	Drug(s)
Renal	Cisplatin*, methotrexate
Pulmonary	Bleomycin*, busulfan, procarbazine
Cardiac	Doxorubicin, daunorubicin
Neurologic	Vincristine*, cisplatin
Immunosuppressive	Cyclophosphamide, methotrexate
Other	Cyclophosphamide (hemorrhagic cystitis); procarbazine (leukemia); asparaginase* (pancreatitis)

*Less BMS: "marrow sparing"

Rapidly proliferating cells such as the bone marrow, gastrointestinal tract mucosa, hair follicles, and gonads are the most sensitive to cytotoxic drugs. Most often **bone marrow suppression** (BMS) is dose-limiting.

Cytokines

Anticancer drug dosage is usually carefully titrated to avoid excessive neutropenia (granulocytes <500/mm^3) and thrombocytopenia (platelets <20,000/mm^3). Colony-stimulating factors, erythropoietin, and thrombopoietin can be supportive →↓ infections and need for antibiotics.

CLINICAL CORRELATE

Thymineless Death of Cells

Flucytosine (FC) and 5-fluorouracil (5-FU) are bioactivated to 5-fluorodeoxyuridine (5-FdUMP), which inhibits thymidylate synthetase → "thymineless death" of fungal cells (FC) or neoplastic cells (5-FU).

Table IX-1-4. Clinical Uses of Cytokines

Cytokine	Clinical Uses
Aldesleukin (IL-2)	↑ lymphocyte differentiation and ↑ NKs: used in renal cell cancer and metastatic melanoma
Interleukin-11	↑ platelet formation: used in thrombocytopenia
Filgrastim (G-CSF)	↑ granulocytes: used for marrow recovery
Sargramostim (GM-CSF)	↑ Granulocytes and macrophages—used for marrow recovery
Erythropoietin	Anemias, especially associated with renal failure
Thrombopoietin	Thrombocytopenia

Recall Question

Which of the following medications has the major side effect of nephrotoxicity rather than bone marrow suppression?

A. Doxorubicin

B. Cisplatin

C. Methotrexate

D. Vinblastine

Answer: B

Immune Drugs 2

LEARNING OBJECTIVES

- ❑ Describe mechanism for immunosuppressants
- ❑ Identify side effects of calcineurin inhibitors
- ❑ Match therapeutic use with select antibody-based drugs

IMMUNOSUPPRESSANTS

Cyclosporine and Tacrolimus

High-Yield

- Mechanism of action:
  - Bind to cyclophilin (cyclosporine) or FK-binding protein (tacrolimus) →↓ calcineurin (cytoplasmic phosphatase) →↓ activation of T-cell transcription factors →↓ IL-2, IL-3, and interferon-γ
- Uses:
  - Cyclosporine is DOC for organ or tissue transplantation (+/− mycophenolate, +/− steroids, +/− cytotoxic drugs)
  - Tacrolimus used alternatively to cyclosporine in renal and liver transplants
- Side effects: nephrotoxicity (both), gingival overgrowth (cyclosporine)

Mycophenolate

An inhibitor of de novo synthesis of purines, has adjunctive immunosuppressant actions, permitting dose reductions of cyclosporine to limit toxicity.

Azathioprine

Immunosuppressant converted to 6-mercaptopurine (same properties as 6-MP)

Anti-D Immunoglobulin

- Human IgG antibodies to red cell D antigen (rhesus antigen)
- Uses: administer to Rh-negative mother within 72 hours of Rh-positive delivery to prevent hemolytic disease of newborn in subsequent pregnancy

Monoclonal Antibodies

Table IX-2-1. Clinical Uses of Monoclonal Antibodies

Mab	Clinical Uses
Abciximab	Antiplatelet: antagonist of IIb/IIIa receptors
Infliximab	Rheumatoid arthritis and Crohn disease: binds TNF
Adalimumab	Rheumatoid arthritis and Crohn disease: binds TNF
Trastuzumab	Breast cancer: antagonist to ERB-B2 (Her 2/neu)
Idarucizumab	Rapid reversal of dabigatran
Muromonab	Kidney transplant: blocks allograft rejection
Palivizumab	Respiratory syncytial virus: blocks RSV protein
Rituximab	Non-Hodgkin lymphoma: binds to surface protein
Basiliximab	Prevent organ rejection: IL-2 receptor antagonist

Cytokines (Recombinant Forms)

Table IX-2-2. Clinical Uses of Interferons

Interferon-α	Hepatitis B and C, leukemias, melanoma
Interferon-β	Multiple sclerosis
Interferon-γ	Chronic granulomatous disease $\rightarrow\uparrow$ TNF

Toxicology 3

LEARNING OBJECTIVES

- ❑ Recognize signs, symptoms, and therapeutic strategies for common toxic syndromes
- ❑ Recognize signs, symptoms, and therapeutic strategies for heavy metal poisoning
- ❑ Match antidotes with their therapeutic use

TOXICOLOGY

Common Toxic Syndromes

High-Yield

Table IX-3-1. Signs, Symptoms, and Interventions or Antidotes for Common Toxic Syndromes

Compound	Signs and Symptoms	Interventions and Antidotes
AChE inhibitors	Miosis, salivation, sweats, GI cramps, diarrhea, muscle twitches → seizures, coma, respiration failure	Respiratory support; atropine + pralidoxime (for irreversible AChE inhibitors)
Atropine and muscarinic blockers	↑ HR, ↑ BP, hyperthermia (hot, dry skin), delirium, hallucinations, mydriasis	Control cardiovascular symptoms and hyperthermia + physostigmine (crosses blood–brain barrier)
Carbon monoxide (>10% carboxyHb)	Nausea and vomiting, dyspnea with hyperventilation, mydriasis, vertigo; cardiovascular signs prominent, ↓ BP, syncope, ↑ HR, arrhythmias	Hyperbaric O_2 and decontamination (humidified 100% O_2 okay in mild overdose)
CNS stimulants	Anxiety/agitation, hyperthermia (warm, sweaty skin), mydriasis, ↑ HR, ↑ BP, psychosis, seizures	Control cardiovascular symptoms, hyperthermia, and seizures— +/− BZs or antipsychotics
Opioid analgesics	Lethargy, sedation, ↓ HR, ↓ BP, hypoventilation, miosis, coma, respiration failure	Ventilatory support; naloxone at frequent intervals
Salicylates (ASA)*	Confusion, lethargy, hyperventilation, hyperthermia, dehydration, hypokalemia, acidosis, seizures, coma	Correct acidosis and electrolytes: urinary alkalinization, possible hemodialysis
Sedative-hypnotics and ethanol	Disinhibition (initial), lethargy, ataxia, nystagmus, stupor, coma, hypothermia, respiratory failure	Ventilatory support: flumazenil if BZs implicated
SSRIs	Agitation, confusion, hallucination, muscle rigidity, hyperthermia, ↑ HR, ↑ BP, seizures	Control hyperthermia and seizures: possible use of cyproheptadine, antipsychotics, and BZs
Tricyclic antidepressants	Mydriasis, hyperthermia (hot, dry skin), 3 Cs (convulsions, coma, and cardiotoxicity) → arrhythmias	Control seizures and hyperthermia, correct acidosis and possible arrhythmias

*More details in antiinflammatory section

Heavy Metal Poisoning

High-Yield

Signs and symptoms are distinctive but usually result from inhibition of –SH groups on enzymes and regulatory proteins.

Table IX-3-2. Signs, Symptoms, and Interventions or Antidotes for Heavy Metal Poisoning

Metals and Source	Signs and Symptoms	Interventions and Antidotes
Arsenic (wood preservatives, pesticides, ant poisons)	**Acute:** gastroenteritis, hypotension, metabolic acidosis, garlic breath, "rice water" stools, torsades, seizures **Chronic:** pallor, skin pigmentation (raindrop pattern), alopecia, stocking glove neuropathy, myelosuppression	Activated charcoal, **dimercaprol** **Penicillamine** or succimer
Iron (medicinal for anemias and prenatal supplements)	**Acute** (mainly children): severe GI distress → necrotizing gastroenteritis with hematemesis and bloody diarrhea, dyspnea, shock, coma	Gastric aspiration + carbonate lavage, **deferoxamine** IV
Lead (tap water, leaded paint chips, herbal remedies, gas sniffing, glazed kitchenware, etc.)	**Acute:** nausea and vomiting, GI distress and pain, malaise, tremor, tinnitus, paresthesias, encephalopathy (red or black feces) **Chronic:** multisystem effects: anemia (↓ heme synthesis), neuropathy (wrist drop), nephropathy (proteinuria, failure), hepatitis, mental retardation (from pica), ↓ fertility and ↑ stillbirths	Decontamination—gastric lavage + **dimercaprol** (severe) or EDTA or succimer (penicillamine if unable to use dimercaprol or succimer) Children: **succimer** PO
Mercury (elemental in instruments); salts used in amalgams, batteries, dyes, electroplating, fireworks, photography	**Acute:** vapor inhalation: chest pain, dyspnea, pneumonitis **Acute:** inorganic salt ingestion: hemorrhagic gastroenteritis, acute tubular necrosis, shock **Chronic:** organic Hg—CNS effects, ataxia, paresthesias, auditory and visual loss, loosening of teeth	**Succimer** PO or **dimercaprol (IM)** Activated charcoal for oral ingestion, then support with succimer PO or dimercaprol (not IV) → causes redistribution of Hg to the CNS →↑ neurotoxicity

Antidotes

High-Yield

Table IX-3-3. Antidotes

Antidote	Type of Poisoning
Acetylcysteine	Acetaminophen
Atropine + pralidoxime (for irreversible AChE inhibitors)	AChE inhibitors—physostigmine, neostigmine, and pyridostigmine; organophosphates, including insecticides, such as malathion and parathion
Deferoxamine	Iron and iron salts
Digoxin immune F(ab)	Digoxin
Dimercaprol (BAL)	Arsenic, gold, mercury, lead; oral succimer for milder lead and mercury toxicity
EDTA	Backup in lead poisoning, then for rarer toxicities (Cd, Cr, Co, Mn, Zn)
Esmolol	Theophylline, beta agonists
Ethanol, fomepizole	Methanol or ethylene glycol
Flumazenil	Benzodiazepines, zolpidem, zaleplon
Naloxone	Opioid analgesics
Oxygen	Carbon monoxide
Penicillamine	Copper (e.g., Wilson disease), iron, lead, mercury
Physostigmine	Anticholinergics: atropine, antihistamine, antiparkinsonian—*not* tricyclics
Protamine	Heparins
Vitamin K	Warfarin and coumarin anticoagulants
Activated charcoal	Nonspecific: all oral poisonings except Fe, CN, Li, solvents, mineral acids, or corrosives

Recall Question

Which of the following is the drug of choice for iron poisoning?

A. Deferoxamine

B. Dimercaprol (BAL)

C. EDTA

D. Penicillamine

Answer: A

Natural Medicinals

"Natural" medicinals are available without prescription and are considered to be nutritional supplements rather than drugs. Herbal (botanic) products are marketed without FDA review of safety and efficacy, and there are no requirements governing the purity or the chemical identities of constituents.

Evidence supporting the clinical effectiveness of herbal products is commonly incomplete.

Table IX-3-4. Characteristics of Selected Herbals

Name	Medicinal Use(s)	Possible Mechanism(s)	Side Effects
Echinacea	↓ Cold symptoms	↑ ILs and TNF	GI distress, dizziness, headache
Garlic	Hyperlipidemias, cancer (evidence is weak)	Inhibits HMG-CoA reductase and ACE	Allergies, hypotension, antiplatelet actions; use caution when used with anticoagulants
Gingko	Intermittent claudication; Alzheimer disease (evidence is weak)	Antioxidant, free radical scavenger, ↑ NO	Anxiety, GI distress, insomnia, antiplatelet actions; **use caution when used with anticoagulants**
Ginseng	Possible ↑ in mental and physical performance (evidence is weak)	Unknown	Insomnia, nervousness, hypertension, mastalgia, vaginal bleeding
Saw palmetto	Symptomatic treatment of BPH	5α-reductase inhibitor and androgen receptor antagonist	GI pain, decreased libido, headache, hypertension
St. John wort	Depressive disorder (variable evidence for clinical efficacy)	May enhance brain 5HT functions	Major drug interactions: **serotonin syndrome** with SSRIs; induces P450, leading to ↓ effects of multiple drugs

Table IX-3-5. Purified Nutritional Supplements

Name	Pharmacology	Side Effects
Dehydroepiandrosterone (DHEA)	Androgen precursor advocated for treatment of AIDS (↑ CD4 in women), Alzheimer disease and "aging," diabetes, hypercholesterolemia, and SLE (↓ in symptoms and "flare-ups" in women)	• **Women:** androgenization and concern regarding CV disease and breast cancer • **Men:** feminization in young and concern in elderly regarding BPH and cancer
Melatonin	Serotonin metabolite used for jet lag and sleep disorders	• Drowsiness, sedation, headache • Contraindicated in pregnancy, in women trying to conceive (↓ LH), and in nursing mothers (↓ prolactin)

Anticancer Drugs, Immune Drugs, and Toxicology Practice Questions

4

ANTICANCER DRUGS

1. Which of the following chemotherapeutic drugs inhibits the polymerization of microtubules but is not associated with causing bone marrow suppression?

   A. Cyclophosphamide
   B. Cisplatin
   C. 5-Fluorouracil
   D. Vinblastine
   E. Vincristine

2. A patient with non-Hodgkin lymphoma is to be started on the CHOP regimen, which consists of cyclophosphamide, doxorubicin, vincristine, and prednisone. Which one of the following agents is most likely to be protective against the toxicity of doxorubicin?

   A. Amifostine
   B. Dexrazoxane
   C. Leucovorin
   D. Mesna
   E. Vitamin C

3. A drug used in a chemotherapy regimen works by complexing with iron and oxygen to promote DNA strand breaks. While on this drug the patient must be monitored closely due to pulmonary side effects. In what phase of the cell cycle does this drug work?

   A. G_1
   B. S
   C. G_2
   D. M
   E. This drug is not cell-cycle dependent.

4. Resistance to which anticancer drug used in leukemias, lymphomas, and breast cancer is associated with increased production of dihydrofolate reductase?

   A. Doxorubicin
   B. Vinblastine
   C. 6-MP
   D. Cytarabine
   E. Methotrexate

5. A patient undergoing cancer chemotherapy has an increase in urinary frequency with much discomfort. No specific findings are apparent on physical examination. Laboratory results include hematuria and mild leukopenia, but no bacteria or crystalluria. If the symptoms experienced by the patient are drug related, what is the most likely cause?

   A. Cyclophosphamide
   B. 5-FU
   C. Methotrexate
   D. Prednisone
   E. Tamoxifen

IMMUNE DRUGS

6. A patient is treated with an immunosuppressant drug following a liver transplant. The drug is known to bind to cyclophilin and inhibit the actions of calcineurin. For what drug toxicity should this patient be monitored?

   A. Pulmonary fibrosis
   B. Hypotension
   C. Hypoglycemia
   D. Nephrotoxicity
   E. CHF

7. Which one of the following agents has utility in the management of acute coronary syndromes such as unstable angina?

   A. Abciximab
   B. Interferon-α
   C. Aldesleukin
   D. Filgrastim
   E. Trastuzumab

TOXICOLOGY

8. Chronic ingestion of lead-based paint chips will result in which of the following?

   A. Garlic breath
   B. Changes in skin pigmentation
   C. Accumulation of δ-aminolevulinate and inhibition of heme synthesis
   D. Auditory and visual loss
   E. Interstitial pneumonitis and neurological effects

9. A 3-year-old child was brought to the ER following the ingestion of several pills. The child is suffering from severe gastrointestinal discomfort and has thrown up twice, each time producing a bloody vomitus. Questioning of the mother reveals the child got into the mother's old prenatal vitamins. What antidote should be given?

   A. Dimercaprol
   B. Deferoxamine
   C. EDTA
   D. Penicillamine
   E. Succimer

ANSWERS AND EXPLANATIONS

1. **Answer: E.** Only two of the drugs listed do not cause bone marrow suppression: cisplatin and vincristine. Only two of the drugs listed inhibit microtubule polymerization: vinblastine and vincristine. The drug that fits both categories is vincristine. Patients on vincristine should be monitored for neurotoxicity, especially peripheral neuropathies.

2. **Answer: B.** Dexrazoxane is an iron-chelating agent that prevents the formation of free radicals and reduces the cardiotoxicity of anthracyclines such as doxorubicin. Amifostine is protective of nephrotoxicity caused by cisplatin. Folinic acid (leucovorin) reduces the toxicity of methotrexate because it provides an active form of folate to normal (nonneoplastic) cells, resulting in "leucovorin rescue." Mesna, which inactivates acrolein, is available for protection against hemorrhagic cystitis in patients treated with cyclophosphamide.

3. **Answer: C.** It helps to know which anticancer drugs are cell-cycle specific and which have characteristic toxicities. Bleomycin forms a complex with iron and oxygen and promotes DNA strand breaks. Its major side effects are pulmonary toxicities including pneumonitis and fibrosis. It acts mainly in the G_2 phase of the cell-cycle.

4. **Answer: E.** Methotrexate is a widely used chemotherapy drug that is also commonly used in moderate to severe rheumatoid arthritis. It inhibits the enzyme dihydrofolate reductase (DHFR), thereby reducing the synthesis of tetrahydrofolate and thus inhibiting DNA synthesis. Resistance occurs when cancer cells upregulate DHFR or alter the binding of methotrexate to DHFR.

5. **Answer: A.** These symptoms are those of a mild case of hemorrhagic cystitis. Bladder irritation with hematuria is a fairly common complaint of patients treated with cyclophosphamide. It appears to be due to acrolein, a product formed when cyclophosphamide is bioactivated by liver P450 to form cytotoxic metabolites. Mesna is the antidote used to detoxify acrolein and protect against hemorrhagic cystitis.

6. **Answer: D.** This patient is being treated with cyclosporin, a drug that binds to cyclophilin and inhibits calcineurin. As a result, the transcription of various T-cells factors such as IL-2, IL-3, and Interferon-γ are inhibited. Cyclosporin is associated with nephrotoxicity, gingival hyperplasia, hyperglycemia, hypertension, and hirsutism.

7. **Answer: A.** Abciximab is an antibody-based drug that targets glycoprotein IIb/IIIa receptors. Binding of the drug to these receptors results in decreased platelet aggregation by preventing the cross-linking reaction. It is useful in acute coronary syndromes such as unstable angina and post-angioplasty.

8. **Answer: C.** Chronic poisoning with lead will result in a multitude of effects including inhibition of heme synthesis and accumulation of δ-aminolevulinate in the plasma. Arsenic poisoning is associated with garlic breath and changes in skin pigmentation. Organic mercury causes auditory and visual loss and loosening of the teeth, while inhaled mercury vapor can cause interstitial pneumonitis and neurological effects.

9. **Answer: B.** The child is suffering from iron poisoning. Deferoxamine chelates iron and is the antidote in iron poisoning. The other choices are all metal chelators with utility in other types of heavy metal poisoning. Dimercaprol is useful for a variety of metals including lead, arsenic, and mercury. EDTA is a backup in lead poisoning. Penicillamine is useful in copper poisoning, and succimer is preferred for lead poisoning in kids.

Index

Note: Page numbers followed by *f* and *t* refer to figures and tables, respectively.

A

Abciximab, 254, 292*t*
Absorption of drugs, 6–7
  antacids and, 215
  bioavailability, 7
  plasma level curves, 6, 6*f*
Acarbose, 262
Accommodation mechanisms, papillary size, 39*f*
Acebutolol, 56*t*
Acetaminophen, 224, 235
Acetazolamide, 60, 84, 88
Acetylation, 11
Acetylcholine (ACh), 36
  antiparkinson drugs and, 142
  as cholinomimetic, 43*t*
  synthesis and release, 41–43, 41*f*
Acetylcholinesterase, 42–44, 44*t*
Acetylcysteine, 295*t*
Acetylsalicylic acid (ASA; aspirin), 221–222
  platelet activation, 254
  toxicity, 293*t*
AChE inhibitors, 42–44, 43*t*
  direct-acting, 43*t*
  drug list, 69
  indirect-acting, 44*t*
  toxicity, 44, 293*t*
Acid-base balance, 222
Acidification, of urine, 5
Acidosis, 222
Acids and bases, ionization, 4
Action potential duration (APD), 104, 104*f*
Activated charcoal, 295*t*
Activated clotting factors, inhibitors, 250
Active metabolites, biotransformation, 9
Acyclovir, 192–193, 192*f*
Adalimumab, 226*t*, 292*t*
Addison disease, 267
Adenosine, arrhythmias and, 109
Adrenal steroids, 267
Adrenergic neuroeffector junctions, 49–52, 50*f*
Adrenergic pharmacology
  adrenergic antagonists, 55–57
  adrenergic receptor location and function, 51*t*–52*t*
  direct-acting adrenoceptor agonists, 52–55
  drug list, 69
  indirect-acting adrenoceptor agonists, 55
  neuroeffector junctions, 49–52, 50*f*
Adrenergic receptor activators
  α1 agonists, 52, 52*f*, 60, 92
  α2 agonists, 52, 52*f*, 92
  β agonists, 53
  direct-acting, 52–55
  drug list, 69
  indirect-acting, 55
  mixed-acting, 53–55
Adrenergic receptor antagonists, 55–57
  α1 antagonists, 55–56, 60, 92
  β antagonists, 56
  drug list, 69
Adrenergic receptors
  activation, 51*t*
  α1 agonists, 60
  mechanisms, 52*t*
Adrenoceptor agonists
  α1 agonists, 52, 60, 92
  α2 agonists, 52, 92
  β agonists, 53
  direct-acting, 52–55
  indirect-acting, 55
  mixed-acting, 53–55
Adrenoceptors, sensitivity, 51
Affinity, defined, 17
Agonists
  α1 agonists, 39
  beta-receptor agonists, 232
  defined, 17
  duality, partial agonists, 19
  emetic pathways and, 215*f*
  full and partial, 18–19, 18*f*
  graded (quantitative) dose-response curves, 17–20
  opioid analgesics, 154
Albendazole, 198
Albuterol, 232
Alcohol
  abuse, 157*t*
  as antidote, 295*t*
  CNS drugs, 133–134, 134*f*
  metabolism, 11
Aldesleukin, 290*t*
Aldosterone
  in hormonal feedback loop, 37–38
  receptor blockers, 88
Alendronate, 277
Alirocumab, 117
Alkalinization, of urine, 5
Alkalosis, 87–88, 222
Allopurinol, 227, 228*f*
All-trans retinoic acid (ATRA), 288*t*
Alpha blockers, 55–56, 60, 92
Alprazolam, 130*t*
Alprostadil, 220
Alteplase, 251–252, 251*f*
Alzheimer disease, acetylcholinesterase inhibitors, 44
Amantadine, 142, 196
Amenorrhea, 139
Amides, local anesthetics, 151
Amifostine, 288*t*
Amikacin, 180
Amiloride, 88
Aminoglycosides, 180, 199*t*
Amiodarone, 108
Amitriptyline, 136
Amphetamine, 138
Amphetamines, 55
  abuse, 157*t*
Amphotericin B, 187–188
Amyl nitrite, 93
Anakinra, 226*t*
Analgesics
  NSAIDs, 221–224
  opioid analgesics, 153–155, 154*t*
Anastrozole, 268, 268*f*
Androgens, 270–271
Anesthesia drugs, 149–152
  drug list, 159
  general anesthetics, 149–151, 149*f*
  inhaled anesthetics, 149–150, 149*f*, 149*t*
  intravenous, 150
  local anesthetics, 151, 151*f*
  skeletal muscle relaxants, 152
Angina
  antianginal drugs, 111–114
  antihypertensives and, 94
  stable and vasospastic angina, 111
Angiotensin-converting enzyme inhibitors (ACEIs), 90–91, 90*f*
  for heart failure, 98
Angiotensin II, in hormonal feedback loop, 37–38
Angiotensin-receptor blockers (ARBs), 90

Angiotensin receptor-neprilysin inhibitor (ARNI), 100
Angiotensin system, 90*f*
Antacids, 215
Antagonists
  adrenal steroids, 267
  adrenergic, 55–57
  alpha receptor, 55
  androgens, 270–271
  calcitonin gene-related peptide, 218
  defined, 17
  emetic pathways and, 215*f*
  enzyme inhibitors and receptors of, 20
  estrogen, 268
  graded (quantitative) dose-response curves, 19–20
  muscarinic receptors, 45–46, 46*t*
  opioid analgesics, 154
  partial agonist as, 19
  potentiation and, 19–20
Anthrax, quinolones for, 184–185
Antianginal drugs, 111–114
  beta blockers, 113
  calcium channel blockers, 113
  drug list, 119*t*
  nitrates, 112, 112*f*
  ranolazine, 113
  smooth muscle contraction and relaxation, 114*f*
Antiarrhythmic drugs, 101–109
  adenosine, 109
  ANS heart rate regulation, 106
  beta blockers, 107
  calcium channel blockers, 107
  cardiac action potential, 101–104, 101*f*, 103*f*, 104*f*
  drug list, 119*t*
  magnesium, 109
  potassium channel blockers, 108
  sodium channel blockers, 105, 105*f*
Antibacterial agents, 173–186
  antitubercular drugs, 185–186, 186*t*
  bacterial protein synthesis inhibitors, 179*f*, 179*t*, 180–182
  cell-wall synthesis inhibitors, 174–178
  nucleic acid synthesis inhibitors, 183–185, 183*f*
  unclassified, 185
Antibiotics
  beta-lactam antibiotics, 174–178, 174*f*
  for *H. pylori* gastrointestinal ulcers, 185
  unclassified, 185
Anticancer drugs, 287–290
  cell-cycle specificity, 287, 288*f*
  characteristics, 288*t*
  growth fraction, 287
  log-kill hypothesis, 287
  targeted cancer therapy, 289*t*
Anticoagulants, 247–250
  direct factor Xa inhibitors, 250
  direct thrombin inhibitors, 250
  drug list, 255
  heparin, 248, 248*t*
  warfarin, 248*t*, 249
Anticonvulsants, 145–148
  drug list, 159
Antidepressants, 135–136, 137*f*
  drug list, 159
Anti-D immunoglobulin, 291
Antidotes, 295, 295*t*
Antiemetics, 215
  drug list, 235
Antifolates, 183*f*, 199*t*
Antifungal agents, 199*t*
  properties, 187–189
Antiherpetics, 192–193, 192*f*, 199*t*
Antihistamines
  drug list, 235–236
  properties, 212*t*
Antihyperlipidemics, 115–117
  bile acid sequestrants, 116
  drug list, 121
  hyperlipidemia, 115*f*
Antihypertensive drugs, 38, 89–96
  comorbid conditions, 94*t*
  direct-acting vasodilators, 93
  drug list, 121
  first-line antihypertensives, 90–91
  indications for, 94
  pulmonary hypertension management, 95
  strategy, 89
  sympathetic activity alteration, 92
Antileukotrienes, 233
Antimalarial drugs, 197–198, 198*t*
Antimetabolites, 183
Antimicrobial agents
  antibacterials, 173–186
  antifungals, 187–189
  antiprotozoals, 197–198, 197*t*
  antivirals, 191–197
  chemotherapy principles, 173–174
  drug list, 199*t*
  mechanism of action, 173*t*
  resistance to, 174*t*
Antimuscarinic drugs, 60
Antiparkinsonian drugs, 139–143, 140*f*
  dopaminergic neural pathways, 139–140
  drug list, 159
Antiplatelet aggregation, 221
Antiplatelet drugs
  drug list, 255
  overview, 253–254
Antiprotozoal agents, 197–198, 197*t*
Antipsychotic drugs, 142–143, 144*t*
  drug list, 159
  M blockers as, 45–46, 46*t*
Antipyresis, 221
Antithyroid agents
  hyperthyroidism, 274
  thyroid hormones, 273, 273*t*
Antithyroid agents, drug list, 279
Antitubercular drugs, 185–186, 186*t*, 199*t*
Antiviral agents
  antiherpetics, 192–193, 192*f*
  basic properties, 191–192
  hepatitis C therapy, 196
  HIV therapy, 194–195
  mechanism of action, 192*t*
  sites of action, 191*f*
Apparent volume of distribution (Vd), 8
Apraclonidine, 60
Area under curve, IV and extravascular administration, 7*f*
Argatroban, 250
Aripiprazole, 144*t*
Arsenic toxicology, 294*t*
Asthma therapy, 231–233, 236
Atazanavir, 195
Atenolol, 56*t*
Atomoxetine, 138
Atorvastatin, 116
Atracurium, 152
Atrial fibrillation, 109
Atropine, 45, 46*t*
  as antidote, 295*t*
  toxicity, 293*t*
Attention deficit hyperactivity disorder (ADHD), 138
Automaticity, cardiac action potential, 103
Autonomic feedback loop, 36–37, 37*f*
Autonomic nervous system (ANS)
  anatomy, 35–36, 36*f*
  blood pressure control, 36–38
  dominance, 46
  heart rate regulation, 106
  pupillary size and accommodation, 39*f*
  receptors, 22
Autonomic drugs
  cholinergic neuroeffector junctions, 41–43, 41*f*
  glaucoma, 59–60, 59*f*, 60*t*
Azathioprine, 291
Azidothymidine (AZT), 194
Azole drugs, 188–189
Aztreonam, 178

B

Baclofen, 152
Bacterial cell wall synthesis, 175*f*
Bacterial protein synthesis inhibitors, 179*f*, 179*t*, 180–182
Barbiturates
  abuse, 157*t*–158*t*
  uses of, 130–131
Baroreceptor reflexes, 37
Barriers to distribution, 8
Basiliximab, 292*t*
Benign prostatic hyperplasia (BPH), antihypertensives and, 94
Benzodiazepines (BZs)
  abuse, 157*t*–158*t*
  as anesthetics, 150
  biotransformation, 9

skeletal muscle relaxants, 152
uses, 130–131, 130*t*
Benztropine, 46*t*, 142
Beta blockers, 56–57
antianginals, 113
as antihypertensive, 92
cardiac arrhythmias, 107
characteristics, 56*t*
in glaucoma treatment, 59–60, 60*t*
for heart failure, 98
ivabradine and, 100
Beta-lactam antibiotics, 174–178
Betamethasone, 229
Beta-receptors
agonists, 232
sensitivity, 51
Bethanechol, as cholinomimetic, 43*t*
Bevacizumab, 289*t*
Bile acid sequestrants, 116
Bioavailability (f), 7, 7*f*
Biodisposition of drugs, 3, 3*f*
Biotransformation, 9–11
Bipolar disorders, drugs for, 138
Bismuth subsalicylate, 215
Bivalirudin, 250
Bladder, muscarinic receptor activation, 42*t*
Bleomycin, 288*t*
Blood-brain barrier
distribution, 8
redistribution, 9
Blood disorders, drugs for treating, 245–255
anticoagulants, 247–250
antiplatelet drugs, 253–254
drug list, 255
thrombolytics, 251–252
Blood pressure
α1 agonists, 52, 60, 92
α2 agonists, 92
β agonists, 53
control mechanisms, 36–38, 37*f*, 38*f*
mixed-acting agonists, 53–55
Blood vessels, muscarinic receptor activation, 42*t*
Bone disorders, drugs for, 277, 279*t*
Bone marrow suppression, 289
Bosentan, 95
Botulinum toxin, 41*f*, 42
Bromocriptine, 142
Bronchiolar smooth muscle, drug actions on, 232*f*
Buprenorphine, 154
Buproprion, 137
Buspirone, 131, 217

C

Calcitonin gene-related peptide (CGRP), 218
Calcium-channel ($Ca2^{++}$) blockers (CCBs)
angina, 113
antihypertensive agents, 89, 91
cardiac arrhythmias, 106
Calcium metabolism, thiazides, 86
Calcium-sending receptor (CaSR), 277
CAMP system, 22–23, 23*f*
Canagliflozin, 265
Capecitabine, 288*t*
Captopril, 90
Carbamazepine, 145*t*, 146
Carbonic anhydrase inhibitors, 84–85, 84*f*
Carbon monoxide poisoning, 293*t*
Carboprost, 221
Cardiac action potential, 101–104, 101*f*, 103*f*, 104*f*
Cardiac muscle, 101–102
Cardiac output, 36–37
Cardiac drugs
ANS heart rate regulation, 106
antiarrhthymic drugs, 101–109
antihyperlipidemics, 115–117
antihypertensive drugs, 38, 89–96
cardiac action potential, 101–104, 101*f*, 103*f*, 104*f*
cytochrome P450 isozymes, 10
diuretics, 83–88
drug list, 119*t*
heart failure drugs, 97–99
NSAIDs and, 223
sodium (NA^{+}) channels, 105, 105*f*
Carvedilol, 113
Catechol-O-methyltransferase (COMT), 50
Ceftaroline, 177
Ceiling effect, 19
Celecoxib, 223
Cell-cycle specificity, anticancer drugs, 287, 288*f*
Cell wall synthesis, bacterial, 175*f*
Cell-wall synthesis inhibitors, 174–178
drug list, 199*t*
Cephalosporins, 176–178
drug list, 199*t*
resistance, 176–178
Cetuximab, 289*t*
CGMP, nitric oxide signaling, 23–24
Chemical antagonism, 20
Chemoreceptor trigger zone, 140
Chloramphenicol, 181
Chloroquine agents, 197–198, 198*t*
Chlorpromazine, 144*t*
Chlorthalidone, 86, 88
Cholestyramine, 116
Choline, 41–42
Choline acetyltransferase (ChAT), 42
Cholinergic neuroeffector junctions, 41–43, 41*f*
Cholinergic pharmacology, 41–47
cholinergic neuroeffector junctions, 41–43, 41*f*
drug list, 69
muscarinic receptor activators, 43–44, 43*t*
muscarinic receptor antagonists, 45–46, 46*t*
nicotinic receptor antagonists, 43*t*, 46–47, 47*f*, 47*t*
Cholinergic receptor activators
AChE inhibitors, 42, 43*t*
drug list, 69
Cholinergic receptor antagonists, drug list, 69
Cholinomimetics
direct, 42, 43*t*
indirect, 42, 44*t*
irreversibly-acting, 44
Chronic hypertension, in pregnancy, 93
Chronic kidney disease, antihypertensives and, 94
Chronic obstructive pulmonary disease (COPD), 233
Ciguatoxin, 151
Cimetidine, 214
Cinacalcet, 277
Cisatracurium, 152
Cisplatin, 288*t*
Citalopram, 135–136
Class I antiarrhythmic drugs, 106
Class IB antiarrhythmic drugs, 107
Class IC antiarrhythmic drugs, 107
Class II antiarrhythmic drugs, 107
Class III antiarrhythmic drugs, 108
Class IV antiarrhythmic drugs, 108
Clearance (Cl), 14
Clindamycin, 182
Clinical steady state, 14
Clomiphene, 268
Clomipramine, 136
Clonidine, 52, 92
Clopidogrel, 254
Closed-angle glaucoma, 60
Clotting cascade, 247, 247*f*
Clozapine, 144*t*
CNS drugs
ADHD drugs, 138
alcohols, 133–134
anesthesia drugs, 149–152
anticonvulsants, 145–148
antidepressants, 135–136
antiparkinsonian drugs, 139–143
bipolar disorders, 138
drug list, 159
drugs of abuse, 157*t*–158*t*
opioid analgesics, 153–155, 154*t*
redistribution, 9
sedative-hyponotic-anxiolytic drugs, 129–131
toxicity of stimulants, 293*t*
Cocaine
abuse of, 157*t*
as indirect-acting adrenergic agonist, 55
vasoconstriction from, 151
Codeine, 154
Colchicine, 227
Colestipol, 116

Collecting tubules, 87–88, 87*f*
Community-acquired pneumonia, 181
Comorbid conditions, antihypertensives and, 94*t*
Concentration gradient, drug permeation, 4
Conductance, cardiac action potential, 102
Congestive heart failure (CHF), primary treatments, 98
Coronary artery disease, left systolic dysfunction, 98
Cortisol, 229, 229*t*
Crohn disease (CD), drugs for, 183, 216
Cromolyn, 233
Cyanide poisoning, 93
Cyanomethemoglobin, 93
Cyclooxygenase (COX 1/COX 2) inhibitors, 219*f*, 220, 223–224
Cyclosphosphamide, 288*t*
Cyclosporine, 291
Cyproheptadine, 218
Cytochrome P450 isozymes, microsomal metabolism, 10, 10*t*
Cytokine receptors, 24
Cytokines
  anticancer therapy, 289, 290*t*
  recombinant forms, 292*t*

D

Dabigatran, 250
Dantrolene, 152
Darunavir, 195
Deferoxamine, 294*t*
  as antidote, 295*t*
Dehydroepiandrosterone (DHEA), 297*t*
Denosumab, 277
Depression, drugs used in, 135–136
Desflurane, 149*t*
Desvenlafaxine, 136
Dexamethasone, 229*t*
Dexrazoxane, 288*t*
Diabetes
  antihypertensives and, 94
  drug list, 279
  drugs for, 261–265, 264*f*
  glucagon-like peptide-1 agents, 265
  insulin forms, 261–262, 261*t*
  sodium-glucose cotransporter-2 (SGLT-2) inhibitors, 265
  type 2, drugs for, 261–264
Diabetic ketoacidosis, 261
Diacylglycerol, 22, 23*f*
Diastolic dysfunction, 99
Diazepam, 130*t*, 145*t*
  biotransformation, 9
Diazoxide, 93
Didanosine (DDI), 194*t*
Digoxin, 99
  as antidote, 295*t*
Dihydropyridines, 91
Diltiazem, 108
Dimercaprol, 294*t*, 295*t*
Dinoprostone, 220
Direct Factor Xa inhibitors, 250
Direct thrombin inhibitors, 250
Disease-modifying antirheumatic drugs (DMARDS), 225, 226*t*
Distal convoluted tubule (DCT), 86, 86*f*
Distribution, 8–9
  apparent volume of, 8
Diuretics, 83–88, 83*f*
  carbonic anhydrase inhibitors, 84–85
  drug list, 119*t*
  for heart failure, 98
  loop, 85–86
  mechanism of action, 88*t*
  osmotics, 84
  postassium-sparing agents, 87–88
  thiazides, 86–87
Dobutamine, 99
Donezepil, 44*t*
Dopamine, 36
  adrenergic neuroeffector junctions, 50
  drugs increasing function of, 141
  for heart failure, 99
  receptors, 140
  use in shock, 51
Dopamine antagonists, 142–143, 144*t*
Dopamine hypothesis, schizophrenia, 142
Dopamine-receptor agonists, 142
Dopaminergic neural pathways, 139–140
Dorzolamide, 84
Dosage
  aminoglycosides, 180
  apparent volume of distribution, 8
  infusion rate, 15, 15*f*
Dose and plasma concentration, 15
Dose-response curves
  graded (quantitative), 17–20
  parallel and non-parallel, 18, 18*f*
  quantal (cumulative), 20–21
  signaling mechanisms, 21–24
Doxazosin, 92
Doxycycline, 180
Dronedarone, 108
Drugs of abuse, 157*t*–158*t*
  opioid analgesics, 153–155, 154*t*
Duloxetine, 136
"dumbbeelss" for AChe inhibitor poisoning, 44
Dyslipidemias, antihypertensives and, 94

E

Early asthmatic response (EAR), 231–232
Echinacea, 296*t*
Echinocandins, 189
EDTA, as antidote, 295*t*
Efavirenz, 194
Effective refractory period (ERP), cardiac action potential, 104, 104*f*
Efficacy
  defined, 17
  of full and partial agonists, 18–19
Eicosanoid drugs, 219–224
  drug list, 235–236
  eicosanoid mechanisms, 219–221, 219*f*
  leukotrienes, 220
  nonsteroidal antiinflammatory drugs, 221–224
  platelet stability and, 221
  prostaglandins, 219–220
Electrolyte balance, 222
Elimination, 12–14
  half-life, 12–13
  kinetics, 12
Endocrine drugs, 259–277
  antithyroid agents, 273*t*, 274
  bone and mineral disorders, 277
  diabetes drugs, 261–265
  drug list, 279
  hypothalamic and pituitary hormones, 275*t*
  steroid hormones, 267–271
End-organ damage, hypertension and, 94
Enfuvirtide, 195
Entacopone, 141
Enzyme receptors, 24
Epinephrine, 36
  as mixed-acting agonist, 53–55, 54*f*
Eplerenone, 88
Epoprostenol, 95
Eptifibatide, 254
Erdophonium, 44*t*
Ergonovine, 218
Ergosterol, 187–188
Ergot alkaloids, 218
Ergotamine, 218
Erythropoietin, 290*t*
Esmolol, 107
  as antidote, 295*t*
Esters, local anesthetics, 151
Estradiol, 268
Estrogens, 268
Etanercept, 226*t*
Ethacrynic acid, 85, 88
Ethambutol, 185, 186*t*
Ethanol. *See* alcohol
Ethosuximide, 145*t*, 147
Etomidate, 150
Evolocumab, 117
Extrapyramidal symptoms (EPS), antipsychotics, 143
Extravascular administration, absorption, 6
Eye, muscarinic receptor activation, 42, 42*t*
Ezetimibe, 117

F

Factor Xa inhibitors, 250
Famciclovir, 193
Famotidine, 214
Fast-response fibers, 101–102, 101*f*
Febuxostat, 227
Felbamate, 148

Fenofibrate, 115*f*, 117
Fenoldopam, 94
Fentanyl, 150
  abuse, 158
Fetal alcohol syndrome, 134
Fibrates, hyperlipidemia and, 117
Filgrastim, 290*t*
Finasteride, 270–271, 271*f*
First-order elimination rate, 12–13, 13*f*
First-pass effect, 7, 7*f*
Flecainide, 107
Fluconazole, 188–189
Flucytosine, 189
Flumazenil, 130, 158
  as antidote, 295*t*
Fluoroquinolones, 184–185, 199*t*
5-Fluorouracil, 288*t*
Fluoxetine, 135–136, 154
Fluphenazine, 144*t*
Flutamide, 270
Fluvoxamine, 135–136
Folic acid synthesis, inhibitors, 183*f*
Fomeprizole, 295*t*
Foscarnet, 192*f*, 193
Fosphenytoin, 145*t*
Full agonists, 18–19, 18*f*
Furosemide, 85, 88
Fusion inhibitors, 195

G

GABA activation
  sedative-hypnotic-anxiolytic drugs, 130–131, 130*f*
  skeletal muscle relaxants, 152
Gabapentin, 148
Ganciclovir, 192*f*, 193
Ganglia, in ANS, 35
Ganglion blocking agents, 46, 47*f*, 47*t*
  drug list, 69
Garlic, 296*t*
Gastrointestinal (GI) tract
  antiemetics, 215
  drug list, 235
  drugs for dysfunction in, 213–215, 213*f*
  muscarinic receptor activation, 43*t*
  peptic ulcer disease, 185, 213–215, 213*f*
Gemfibrozil, hyperlipidemia and, 115*f*, 117
General anesthetics, 149–151, 149*f*
Gentamicin, 180
Gingko, 296*t*
Ginseng, 296*t*
Glands, muscarinic receptor activation, 43*t*
Glaucoma, autonomic drugs, 59–60, 59*f*, 60*t*
Gliflozins, 265
Gliptin agents, 265
Glomerular filtration rate (GFR), 14
Glucagon, heart and, 56
Glucagon-like peptide-1 (GLP-1), agents affecting, 265, 265*f*
Glucocorticoids, adrenal conditions, 267
  antirheumatics, 225, 226*t*
  asthma therapy, 233
  properties, 229–230
Glucuronidation, 11
Glutathione (GSH) conjugation, 11
Glutides, 265
Gout, drugs for, 227–228, 228*f*, 236
G proteins
  eicosanoid interaction, 219*f*
  histamines, 211–212
  receptor links to intracellular effectors, 22–23, 23*f*
Graded (quantitative) dose-response
  agonists, 17–18
  antagonism and potentiation, 19–20, 19*f*
  curves, 17–20
  duality of partial agonists, 19, 19*f*
  parallel and nonparallel, 18*f*
Griseofulvin, 134, 189
GTP-binding proteins, 22–23

H

H. pylori gastrointestinal ulcers, antibiotics for, 185
Half-life
  coagulation factor, 249*t*
  elimination, 12–13
  plateau principle, 14
  steady state, 14–16
Hallucinogens, 158
Haloperidol, 144*t*
H1 antagonists
  antiemetics, 215
  peptic ulcer disease, 214
  properties, 211–212
Heart
  glucagon and, 56
  muscarinic receptor activation, 43*t*
Heart failure
  antihypertensives and, 94
  inotropes for, 98–99, 98*f*
  primary treatments, 98
  processes in, 97*f*
Heart rate
  α1 agonists, 52
  ANS regulation, 106
  β agonists, 53
  blood pressure and, 38*f*
  mixed-acting agonist, 53–55
  reflex control algorithm, 47*f*
Heavy metal poisoning, 294
Helminthinc infections, drugs for, 198
Hemocholinium, 41*f*, 42
Heparin, 248, 248*t*
Hepatitis C, antiviral therapy, 196
Heroin, 158
Highly active antiretroviral therapy (HAART), 194
His-Purkinge System, 101–102, 101*f*
Histamines
  drug list, 235–236
  properties, 211–212
HIV therapy
  antiviral agents, 194–195, 199*t*
  prophylaxis, 195
HMG-CoA reductase inhibitors, 116
Hormones
  feedback loop, 37–38, 38*f*
  hypothalamic, 275*t*
  intracellular receptors, 21–22
  pituitary, 275*t*
  steroid hormones, 267–271
  thyroid hormones, 273*t*, 274, 274*f*
5HT1(a-h), 217
5HT2(a-c), 217–218
5HT3, 218
5HT receptors, drug action on, 215, 217–218
Hydralazine, 93
  for heart failure, 98
Hydrochlorothiazide, 86, 88
Hydrocortisone, 229*t*
Hydrolysis, 11
Hydroxychloroquine, 226*t*
Hyperkalemia, 87–88
  arrhythmias and, 109
Hyperlipidemia, 115
Hypersensitivity reactions, to drugs, 175–178
Hyperthyroidism, drugs for, 274, 279
Hypoglycemic reactions, 263
Hypokalemia, 87–88
  arrhythmias and, 109
Hypothalamus, hormones, 275*t*

I

Idarucizumab, 292*t*
Imatinib, 24, 289*t*
Imipenem, 177
Imipramine, 136
Immune Drugs, 291–292
Immunosuppressants, 216, 291–292
Inamrinone, 99
Indapamide, 86, 88
Indomethacin, 220
Inflammatory bowel disease, drugs for, 216
Inflammatory disorders, drugs for
  asthma, 231–233
  drug list, 235–236
  eicosanoid drugs, 219–224
  gastrointestinal dysfunction, 213–215
  glucocorticoids, 229–230
  gout treatments, 227–228
  histamines and antihistamines, 211–212, 212*t*
  rheumatoid arthritis, 225–226
  serotonergic systems, 217–218
Infliximab, 226*t*, 292*t*
Influenza A viruses, antiviral therapy, 196
Infusion
  multiple dose equations, 16
  rate of, 15–16, 15*f*

Inhaled anesthetics, 149–150, 149*f*, 149*t*
Inositol triphosphate (IP3), 22–23, 23*f*
Inotropes, 98–99, 98*f*
Insulin
  forms of, 261–262, 261*t*
  release, 261
Insulin-dependent diabetes mellitus (IDDM, Type 1), 261
Integrase inhibitors, 195
Interferons, 292*t*
Interleukin-11, 290*t*
Intracellular effectors, coupling proteins linked to, 22–23
Intracellular receptors, 22–23, 23*f*
Intravascular administration
  absorption, 6
  bioavailability (f), 7
Intravenous anesthetics, 150
Intrinsic sympathomimetic activity (INS), 56
Iodide, 274
Ion channels, membrane receptor coupling, 22
Ionization
  acids and bases, 4, 4*f*
  renal drug clearance, 5, 5*f*
Ipratropium, 46*t*
Iron toxicology, 294*t*
Irreversible AChE inhibitors, 42, 43*t*
Isoniazid, 185, 186*t*
Itraconazole, 188–189
Ivabradine, 100

J

Janus kinases (JAKs), 24

K

Ketamine, 150
Ketoconazole, 267
Ketonazole, 188–189

L

Labetalol, 94
Lactic acid, 4
Lactulose, 4
Lamivudine, 192, 194*t*
Lamotrigine, 145*t*, 147
Latanoprost, 60
Late asthmatic response (LAR), 231–232
Lead toxicology, 294*t*
Ledipasvir, 196
Leflunomide, 226*t*
Left systolic dysfunction, 98
Leukotrienes, 220
Leuprolide, 270
Levodopa, 141, 141*f*
Lidocaine, 107
Linezolid, 182
Lipid-lowering drugs, 116
Liraglutide, 265
Lisinopril, 90
Lithium, 138
Loading dose, 15, 15*f*
Local anesthetics, 151, 151*f*
Log-kill hypothesis, 287
Long QT syndrome, 108
Loop diuretics, 85–86, 85*f*
  for heart failure, 98
Lopinavir, 195
Lorazepam, 130*t*, 145*t*
Losartan, 90
Lungs, muscarinic receptor activation, 43*t*

M

Macrolides, 181–182, 199
  drug list, 199*t*
Magnesium, arrhythmias and, 109
Malathion, 42
Malignant hyperthermia, 152
Maraviroc, 195
Marijuana, 158
Mathematical steady state, 14
M blockers
  clinical uses and properties of, 45–46, 46*t*, 142
  drug list, 69
  histamines, 211–212
Melatonin, 297*t*
Meloxicam, 223
Membrane transport, drugs, 5, 5*t*
Meperidine, 154
6-Mercaptopurine, 227, 228*f*, 288*t*
Mercury toxicology, 294*t*
Meropenem, 177
Mesalamine, 183, 216
Mesolimbic-mesocortical tract, 139
Metaproterenol, 232
Metformin, 262
Methacholine, as cholinomimetic, 43*t*
Methadone, 158
Methemoglobin, 93
Methotrexate, 225, 226*t*, 288*t*
Methyldopa, 52, 92
Methylphenidate, 138
Metoprolol, 56*t*
Metronidazole, 134, 185, 197*t*, 199*t*
Metyrapon, 267
Mexiletine, 107
Microsomal metabolism, 10
Midazolam, 130*t*, 150
Mifepristone, 267, 269
Migraine headaches, drugs for, 218
Milrinone, 99
Mineral disorders, drugs for, 277, 279*t*
Minocycline, 180
Minoxidil, 93
Miosis, 39*f*
Mirtazapine, 137
Misoprostol, 214, 220
Mixed agonist-antagonist, opioid analgesics, 154
Monoamine oxidases (MAO), 11, 50, 55
  inhibitors, 50*f*, 136–137
Monoclonal antibodies, 292*t*
Montelukast, 233
Morphine, 153
  abuse, 158
Multiple dose equations, 16
Mu pharmacology, 153
Muromonab, 292*t*
Muscarinic agonists, 39
Muscarinic antagonists, 43*t*, 215
  toxicity, 293*t*
Muscarinic receptors
  AChE toxicity and, 44
  activators, 42*t*
  agonists, 43*t*
  antagonists, 45–46, 46*t*
  blockers, asthma therapy, 232
  location and function, 42, 42*t*, 43*t*
Muscarinic stimulation, 39
Mycophenolate, 291
Mydrasis, 39*f*
Myocardial infarction, antihypertensives and, 94

N

Naloxone, 154
  as antidote, 295*t*
  drug reversal, 158
Natural medicinals, 296–297
Nausea, drugs for, 215
Nedocromil, 233
Neostigmine, 44*t*
Neprilysin, 100
Neuroeffector junctions
  adrenergic, 49–52, 50*f*
  cholinergic, 41–43, 41*f*
Neuromuscular blocking agents, 159
Neurotransmitters, in ANS, 36
Nevirapine, 194
Nicotinic acid (niacin, vitamin B3), hyperlipidemia and, 115*f*, 117
Nicotinic receptor antagonists, 46–47, 47*t*
  AChE toxicity and, 44
Nicotinic receptors, skeletal muscle relaxants, 152
Nifedipine, 91
Nifurtimox, 197*t*
Nigrostriatal tract, 139
Nitrates, as antianginals, 112, 112*f*
Nitric oxide
  direct-acting vasodilators, 93
  pathway, 112*f*
  signaling mechanisms, 23
Nitroglycerine, 112
Nitroprusside, 93–94
Nitrous oxide, 149*t*
Noncompetitive antagonists, 20
Noninsulin-dependent diabetes mellitus (NIDDM, Type 2), 261–264
Nonmicrosomal metabolism, 11
Nonnucleoside reverse transcriptase inhibitors (NNRTIs), 194, 194*t*

Nonsteroidal antiinflammatory drugs (NSAIDs), 221–224
drug list, 235
gout, 227–228
rheumatoid arthritis, 225, 226*t*
Norepinephrine, 36
inactivation, 50
as mixed-acting agonist, 53–55, 53*f*
Nucleic acid synthesis inhibitors, 183–185, 183*f*
Nucleoside reverse transcriptase inhibitors (NTRIs), 194, 194*t*
Nutritional supplements, 297
Nystatin, 187–188

O

Olanzapine, 144*t*, 218
Ondansetron, 218
Open-angle glaucoma, 59
Opioid analgesics, 153–155, 154*t*
abuse, 158
drug list, 159
duality of action, 215
toxicity, 293*t*
Oral contraceptives, 270
Organophosphates, as cholinomimetic, 44*f*, 44*t*
Orlistat, 118
Orthostatic hypotension, 91
Oseltamivir, 196
Osmotic diuretics, 84
Osteoporosis, 277
Oxazepam, 130*t*
Oxybutynin, 46*t*
Oxygen, as antidote, 295*t*

P

Paraoxon, 43*t*
Parasympathetic autonomic nervous system (PANS), 35
blood pressure control and, 36–38, 37*f*, 38*f*
heart rate regulation, 106
Parathion, 42
Paraziquantel, 198
Parkinson disease
dopamine receptors, 140–141
dopaminergic neural pathways, 139–140
drugs used in, 139–143, 140*f*
Paroxetine, 135–136, 154
Partial agonists, 18–19
duality, 19, 19*f*
Pavlizumab, 292*t*
PCSK9 inhibitors, 117, 118*f*
Pegloticase, 228
Penicillamine, 294*t*, 295*t*
Penicillins, 175–176
drug list, 199*t*
hypersensitivity reactions, 175–178
properties of, 175*t*
resistance, 175–176
Peptic ulcer disease (PUD), 213–215, 213*f*
Permeation of drugs, 4
Pharmacodynamics
definitions, 17
graded (quantitative) dose-response curves, 17–20
quantal (cumulative) dose-response curves, 20–21
signaling mechanisms, 21–24
Pharmacokinetics
absorption, 6–7
basic principles, 3–5
biotransformation, 10–11
calculations, 16
distribution, 8–9
drug disposition, 3
elimination, 12–14
metabolism, 10–11
permeation, 4
redistribution, 9
steady state, 14–16
Pharmocologic antagonism, 20
Phase II biotransformation, 11
Phenelzine, 136–137
Phenylephrine, 52
Phenytoin, 145*t*, 146
pH levels
absorption, 6–7
ionization, 4–5, 4*f*
urinary pH levels, 5
Phosphoatidylinosotol bisphosphate (PIP3), 22–23, 23*f*
Phosphodiesterase inhibitors, 99
Phosphodiesterase 5 (PDE5), 112
Phospholipase C, 22–23
Phototoxicity, antibacterial agents, 181
Physiologic antagonism, 20
Physiology, ion and molecular transport, 5
Physostigmine, 44*t*
Pilocarpine
as cholinomimetic, 43*t*
Pindolol, 56*t*
Pioglitazone, 264
Pituitary gland, hormones, 275
Placental barrier to distribution, 8
Plasma concentration
loading dose, 15, 15*f*
rate of infusion, 15, 15*f*
time *vs.*, 6
Plasma decay curve, 13, 13*f*
Plasma levels
curves, 6, 6*f*
plateau principle, 14, 14*f*
Plasma protein binding, distribution, 8
Plateau principle, 14, 14*f*
Platelet activation, 253, 253*f*
Platelet aggregation, 254
Platelet stability
acetylsalicylic acid (ASA; aspirin), 221–222
eicosanoids and, 221
Polyenes, 187–188
Postantibiotic effect, 180
Postjunctional receptors, 42
Potassium (K^+) channel blockers, 108
Potassium (K^+) channels, direct-acting vasodilators, 93
Potassium-sparing agents, 87–88
Potency
defined, 17
full and partial agonists, 18–19
Potentiation, antagonism, 19–20
Potentiators, graded (quantitative) doseresponse curves, 19–20
Pramipexole, 142
Pramlintide, 265
Prasugrel, 254
Prazosin, 92
Prednisone, 229*t*
Preeclampsia, 93
Pregnancy
alcohol and, 134
chronic hypertension in, 93
drug contraindications in, 180, 184, 195
Presynaptic membrane depolarization, 42
Proarrhthymic agents, 106
Probenecid, 228
Procainamide, 106
Procarbazine, 288*t*
Prodrugs, 9
Progesterone, 269
Progestins, 269–270
Propofol, 150
Propranolol, 56*t*, 107
Prostacyclin (PGI2), 95, 221
Prostaglandins (PGs), 219–221
Protease inhibitors (PIs), 195
Protein C, warfarin activation and, 249, 249*f*
Protein kinase A, 22
Proton pump inhibitors (PPI), 214
Pseudoephedrine, 55
Psychosis, drugs used in, 139–143
Pulmonary edema, osmotic diuretics, 84
Pulmonary hypertension, antihypertensive drugs, 95
Pupillary size, accommodation mechanisms, 39*f*
Pyrantel pamoate, 198
Pyrazinamide, 185, 186*t*
Pyrimethamine, 183, 197*t*

Q

Quantal (cumulative) dose-response curves, 20–21, 21*f*
Quantitative D-R curves. *See* graded (quantitative) dose-response curves
Quinidine, 106
Quinolones, 184–185, 199*t*
Quinupristin-dalfopristin, 182

R

Raloxifene, 269, 269*t*
Raltegravir, 195
Ranitidine, 214
Ranolazine, 113
Rasburicase, 228
Rate in = rate out, steady state, 14
Redistribution, 9, 9*f*
Red Man syndrome, 178
Refractoriness, cardiac action potential, 103
Relative refractory period (RRP), 104
Releasers, 55
Renal clearance, drug ionization, 5, 5*f*
Renal drug list, 119*t*
Renal elimination, 14
Renal tubular system, 83*f*
Repaglinide, 263
Resistance to antibiotics
  cell-wall synthesis inhibitors, 174–178
  cephalosporins, 176–178
  penicillin, 175–176
Respiratory acidosis, 222
Respiratory alkalosis, 222
Resting potential (RP), 105
Reuptake, of neuroeffctors, 50
Reuptake inhibitors, 55
Reverse transcriptase inhibitors (RTIs), 194
Reversible AChE inhibitors, 42, 43*t*
Reye syndrome, 224
Rheumatoid arthritis, drugs for, 225, 226*t*, 236
Ribavirin, 196
Rifampin, 185, 186*t*
Rimantadine, 196
Risperidone, 144*t*
Ritonavir, 195
Rituximab, 292*t*
Rivaroxaban, 250
Rocuronium, 152
Roflumilast, 233
Ropinirole, 142
Rosiglitazone, 264
Rosuvastatin, 116

S

Sacubitril, 100
Salmeterol, 232
Sargramostim, 290*t*
Saw palmetto, 296*t*
Schizophrenia, drugs for, 142–143, 144*t*
Scopolamine, 46*t*
Second messenger system, 23, 23*f*
Sedative-hyponitic-anxiolytic drugs, 129–131, 129*f*
  drug list, 159
  toxicity, 293*t*
Seizure disorders
  anticonvulsants and, 145–146
  opioid antagonists, 154
Selective estrogen-receptor modulators (SERMs), 269
Selective serotonin reuptake inhibitors (SSRIs), 135–136
  toxicity, 293*t*
Selegiline, 141
Serotonergic systems
  drug actions, 217–218
  drug list, 235–236
Serotonin and norepinephrine reuptake inhibitors (SNRIs), 136
Serotonin syndrome, 135, 296*t*
Sertraline, 135–136
Sevoflurane, 149*t*
Signaling mechanisms, 21–24
  cGMP and nitric oxide signaling, 23
  coupling proteins, receptor links to intracellular effectors, 22–23
  cytokine receptors, 24
  enzyme or transporter receptors, 24
  intracellular receptors, 21–22
  membrane receptors, ion channel coupling, 22
  transmembrane enzyme receptors, 24
Signal transducers and activators of transcription (STAT) molecules, 24
Sildenafil, 95, 112
Simeprevir, 196
Single-dose equations, 16
Sitagliptin, 265
Skeletal muscle relaxants, 152
  drug list, 159
Slow-response fibers (SA and AV nodes), 103, 103*f*
Smoking cessation, antidepressants for, 137
Smooth muscle contraction and relaxation
  antianginals and, 114*f*
  bronchiolar smooth muscle, 232*f*
Sodium-glucose cotransporter-2 (SGLT-2)
  inhibitors, 265
Sodium (NA^+) channel
  activation, 105, 105*f*
  recovery, 105
  toxins, 151
Sodium (NA^+) channel blockers, cardiac arrhythmias, 100, 106–107
Sodium nitrite, 93
Sofosbuvir, 196
Somatic innervation, ANS and, 35
Sorafenib, 24, 289*t*
Sotalol, 108
Sphincters, muscarinic receptor activation, 43*t*
Spironolactone, 88, 267
  for heart failure, 98
St. John's wort, 296*t*
Statins, hyperlipidemia and, 115*f*, 116
Steady state, 14–16
  infusion rate, 15
  loading dose, 15
Steroids, 267–271
  adrenal, 267
  androgens, 270–271
  drug list, 279
  estrogens, 268–269
  intracellular receptors, 21–22
  oral contraceptives, 270
  progestins, 269
  properties, 229–230, 229*t*
  toxicity, 229
Stibogluconate, 197*t*
Streptogramins, 182
Streptokinase, 251–252, 251*f*
Streptomycin, 180, 185, 186*t*
Subonxone, 154
Succimer, 294*t*
Succinylcholine, 152
Sucralfate, 214
Suicide inhibitors, 176
Sulfadiazine, 197*t*
Sulfasalazine, 183–184, 216, 226*t*
Sulfonamides, 85
  folic acid synthesis inhibition, 183–184
Sulfonylureas, 263, 263*f*
Sumatriptan, 217
Surface area and vascularity, drug permeation, 4
Sympathetic autonomic nervous system (SANS), 35
  blood pressure control, 36–38, 37*f*, 38*f*
  heart rate regulation, 106
  indirect-acting adrenergic receptor agonists, 55
Sympathomimetics, 99
Synaptobrevin, 42
Syndrome of inappropriate secretion of ADH (SIADH), 275*t*

T

Tacrolimus, 291
Tadalafil, 112
Tamoxifen, 269, 269*t*
Targeted cancer therapy, 289*t*
Temazepam, 130*t*
Tenofovir, 192*f*, 194–195
Terazosin, 92
Terbinafine, 189
Terbutaline, 232
Teriparatide, 277
Tetracyclines, 180–181, 199*t*
Tetrodotoxin, 151
Theophylline, 232–233
Therapeutic index, quantal (cumulative) dose-response curves, 20–21
Thiazides, 86, 90–91
  for heart failure, 98
Thiazolidinediones, 264
Thick ascending loop, 85–86, 85*f*
Thioamides, 274
Thioridazine, 144*t*
Thrombin inhibitors, 250

Thrombolytics
drug list, 255
overview, 251–252
Thrombopoietin, 290*t*
Thromboxanes, 219, 221
Thymineless cell death, 289
Thyroid hormones, 273*t*, 274, 274*f*
intracellular receptors, 22
Ticagrelor, 254
Tigecycline, 180
Timolol, 56*t*, 60
Tirofiban, 254
Tobramycin, 180
Tofacitinib, 226*t*
Tolcapone, 141
Topiramate, 147
Torsades, 108
Torsemide, 85, 88
Toxicology
AChE inhibitors, 44
anticancer drugs, 289*t*
antidotes, 295*t*
common toxic syndromes, 293*t*
heavy metal poisoning, 294
natural medicinals, 296–297
NSAIDs, 224
quantal (cumulative) dose-response curves, 20–21
steroids, 229
Transmembrane enzyme receptors, 24
Transporter receptors, 24
Tranylcypromine, 136–137
Trastuzumab, 289*t*, 292*t*
Trazodone, 137
Triamcinolone, 229*t*
Triamterene, 88
Tricyclic antidepressants (TCAs)
for depression, 136
as indirect-acting adrenergic agonist, 55
toxicity, 293*t*
Trihexyphenidyl, 46*t*, 142
Trimethoprim, 183–184
Triptans, 217–218
Tropicamide, 46*t*
Tuberoinfundibular tract, 139
Tyramine, 55
Tyrosine
adrenergic neuroffector junction, 50, 50*f*
Tyrosine kinase inhibitors, 24

U

Ulcerative colitis (UC), drugs for, 216
Ulcers, gastrointestinal, 185
Uric acid
gout prophylaxis, 227–228
NSAIDs and, 222

V

Valacyclovir, 192*f*, 193
Valproic acid, 145*t*, 147
Valsartan, 100
Vancomycin, 178
Vardenafil, 112
Varenicline, 137
Vasodilators, 91
direct-acting, 93
Venlafaxine, 136
Verapamil, 108
Viagra. *See* sildenafil
Vinblastine, 288*t*
Vincristine, 288*t*
Vitamin B3, hyperlipidemia therapy and, 115*f*, 117
Vitamin D, 22
Vitamin K, 295*t*
Voltage-gated sodium channels, 105, 105*f*
Volume of distribution (Vd), 8
Vomiting, drugs for, 215
Voriconazole, 188–189

W

Warfarin, 248*t*, 249
Weak acids and bases, 4
Wolff-Parkinson-White syndrome, 99, 99*f*

Z

Zafirlukast, 220, 233
Zaleplon, 131
Zanamivir, 196
Zero-order elimination rate, 12, 12*f*
Zidovudine (ZDV), 192, 194, 194*t*
Zileuton, 220, 233
Zolpidem, 131