Dexmedetomidine inhibits gastric emptying and oro-caecal transit in healthy volunteers


1 Department of Anaesthesiology, Intensive Care, Emergency Care and Pain Medicine, University of Turku and Turku University Hospital, Turku, Finland
2 Department of Clinical Physiology and Nuclear Medicine, Turku University Hospital, Turku, Finland
3 Department of Clinical Pharmacology, University of Helsinki and Helsinki University Central Hospital, Helsinki, Finland
4 Department of Pharmacology, Drug Development and Therapeutics, University of Turku and Unit of Clinical Pharmacology, TYKSLAB, Turku, Finland

* Corresponding author. E-mail: tiirola@utu.fi

Editor’s key points

- Dexmedetomidine is a potent and selective α2-adrenoceptor agonist used for perioperative and intensive care sedation with certain beneficial qualities. However, based on preclinical observations, it might inhibit gastric emptying and gastrointestinal transit, which could result in unwanted effects in intensive care patients. This study evaluated the effects of dexmedetomidine on gastric emptying and oro-caecal transit in healthy volunteers.

Methods. Twelve healthy male subjects were given 1 μg kg⁻¹ of dexmedetomidine i.v. over 20 min followed by a continuous i.v. infusion of 0.7 μg kg⁻¹ h⁻¹ for 190 min. For comparison, subjects were also given 0.10 mg kg⁻¹ of morphine hydrochloride i.v. over 20 min and a placebo infusion in a randomized order. Gastric emptying was assessed with the paracetamol absorption test and oro-caecal transit time with the hydrogen breath test.

Results. The time to maximum paracetamol concentration in plasma was significantly longer, maximum paracetamol concentration was significantly lower, the area under the plasma paracetamol concentration–time curve was significantly smaller, and oro-caecal transit time was significantly longer during dexmedetomidine infusion compared with morphine or placebo infusion.

Conclusions. Dexmedetomidine markedly inhibits gastric emptying and gastrointestinal transit in healthy volunteers.

Keywords: dexmedetomidine; gastric emptying; gastrointestinal transit

Accepted for publication: 4 January 2011

Dexmedetomidine is a potent and selective α2-adrenoceptor agonist used for perioperative and intensive care sedation. Compared with other drugs currently used for intensive care sedation, it has certain beneficial qualities such as lack of respiratory depression, improved haemodynamic stability, reduced stress responses to noxious stimuli, alleviation of pain, reduced incidence of delirium compared with benzodiazepines, and possibly shorter length of stay in the intensive care unit (ICU).

There are reports suggesting that dexmedetomidine inhibits gastric emptying and gastrointestinal transit in rats, but its effects on gastric emptying and gastrointestinal transport are unclear.

In a study of 12 healthy volunteers, i.v. infusion of dexmedetomidine significantly delayed gastric emptying and gastrointestinal transit.

Further studies with lower doses in critically ill patients are necessary to determine the clinical relevance of these findings.

Dexmedetomidine is a potent and selective α2-adrenoceptor agonist used for perioperative and intensive care sedation. Compared with other drugs currently used for intensive care sedation, it has certain beneficial qualities such as lack of respiratory depression, improved haemodynamic stability, reduced stress responses to noxious stimuli, alleviation of pain, reduced incidence of delirium compared with benzodiazepines, and possibly shorter length of stay in the intensive care unit (ICU).

There are reports suggesting that dexmedetomidine inhibits gastric emptying and gastrointestinal transit in rats, but its effects on gastric emptying and gastrointestinal transport are unclear.

In a study of 12 healthy volunteers, i.v. infusion of dexmedetomidine significantly delayed gastric emptying and gastrointestinal transit.

Further studies with lower doses in critically ill patients are necessary to determine the clinical relevance of these findings.

As the gastrointestinal effects of high-dose infusions of dexmedetomidine in humans were unknown, we designed this study using clinically relevant doses of dexmedetomidine to assess its effects on gastric emptying and oro-caecal transit in healthy volunteers. We chose a dosage of dexmedetomidine equal to the maximum suggested dose for sedation of ICU patients. A three-way cross-over study design was used to compare dexmedetomidine infusions with placebo (presumably no effect) and morphine (presumably a
significant effect). Absorption of paracetamol was used as a measure of gastric emptying, and the hydrogen breath test was used to determine oro-caecal transit time.

Methods

Study subjects

The study (EudraCT number 2009-018170-66/ClinicalTrials.gov identifier NCT01084473) was conducted according to the revised Declaration of Helsinki of the World Medical Association and ICH guidelines for good clinical trial practice. The study protocol was approved by the Ethics Committee of the Hospital District of Southwest Finland and the Finnish Medicines Agency. The study underwent limited monitoring by a qualified representative of Turku Clinical Research Centre.

Healthy, unmedicated males older than 18 yr and weighing more than 60 kg were eligible for the study. Subjects candidates with drug allergy, alcohol or drug abuse, significant psychological problems, positive urine drug screen, a ‘yes’ answer to any of the questions of a modified Finnish version of the Abuse Questionnaire, a special diet or lifestyle, a BMI >30 kg m\(^{-2}\) or clinically significant abnormal findings in physical examination, ECG, or routine laboratory screening were not considered eligible for the study. Smoking was prohibited during and within 4 weeks before the study.

Subjects had to avoid drugs known to cause enzyme induction or inhibition for 30 days, any medications and some natural products (including grapefruit products) for at least 14 days, and alcohol and caffeine-containing products for at least 24 h. Ibuprofen was allowed for occasional headache or other conditions.

On the day before each study session, subjects were not allowed to eat foods rich in fibre or long-chain carbohydrates (such as rye bread, porridge, other full grain products, pasta, vegetables, fruits, berries). Eating and physical exercise were not allowed for 12 h, water intake for 4 h, and sleeping for 1 h before session start. On study days, subjects had to fast until an increase in exhaled hydrogen was detected or at least 4 h after lactulose administration.

A venous catheter was inserted into a large forearm vein for study drug administration and another into an antecubital vein in the opposite extremity for blood sampling. ECG, non-invasive arterial pressure, and arteriolar oxygen saturation (\(S_pO_2\)) were monitored for safety purposes.

Study treatments

A three-period cross-over design with balanced randomization was used. The wash-out period between consecutive administrations was at least 7 days. Subjects were given three different treatments in a randomized order:

(i) Dexmedetomidine: 1 \(\mu g\) kg\(^{-1}\) dexmedetomidine (dexmedetomidine 100 \(\mu g\) ml\(^{-1}\), Precedex\(^{\text{R}}\), Abbott Laboratories, North Chicago, IL, USA) infused over 20 min, followed by a continuous infusion of 0.7 \(\mu g\) kg\(^{-1}\) h\(^{-1}\) for 190 min.

(ii) Morphine: 0.10 mg kg\(^{-1}\) morphine (morphine hydrochloride 2 mg ml\(^{-1}\), Morphin\(^{\text{R}}\), Nycomed Austria GmbH, Linz, Austria) infused over 20 min, followed by a placebo (saline) infusion for 190 min.

(iii) Placebo: 0.9% saline infused in the same manner as the active drugs.

After running the infusions for 30 min, the subjects were given paracetamol 1 g per os (Panadol Forte\(^{\text{R}}\), GlaxoSmithKline Consumer Healthcare A/S, Copenhagen, Denmark) with 100 ml of tap water (25°C), and 10 g of lactulose (Laktulos Merck NM\(^{\text{R}}\) 667 mg ml\(^{-1}\), Merck NM AB, Stockholm, Sweden) with 50 ml of tap water.

Assessment of gastric emptying

Venous blood samples were collected immediately before administration of paracetamol (baseline) and thereafter at 10, 20, 30, 40, 50, 60, 70, 80 min and 1.5, 2, 2.25, 2.5, 2.75, 3, 3.5, and 4 h. Plasma paracetamol concentrations were measured using reversed-phase high-performance liquid chromatography. The lower limit of plasma paracetamol quantification was 0.1 mg litre\(^{-1}\). Gastric emptying was assessed by the rate of paracetamol absorption using the time to peak plasma concentration, the peak plasma concentration, and the area under the plasma concentration-time curve.

Assessment of oro-caecal transit time

Hydrogen is produced and exhaled when lactulose, an absorbable disaccharide, is fermented by colonic bacteria. The time between ingestion of lactulose and an increase in exhaled hydrogen represents the oro-caecal transit time. The hydrogen concentration in exhaled air was measured with a hand-held device (Gastro\(^{\text{R}}\) Gastrolyzer\(^{\text{R}}\), Bedfont Scientific Ltd, Rochester, Kent, UK) immediately before administration of lactulose (baseline) and thereafter at 15 min intervals, and the time between lactulose intake and the first occurrence of a sustained increase in exhaled hydrogen concentration (i.e. an increase of >10 ppm above baseline in at least three consecutive measurements) was taken as a measure of the oro-caecal transit time.

Pharmacokinetic analysis of paracetamol

The peak plasma paracetamol concentrations (\(C_{\text{max}}\)) and the corresponding time points (\(T_{\text{max}}\)) were measured. Areas under the paracetamol plasma concentration–time curves from 0 to 90 min were estimated using the trapezoidal rule (\(AUC_{0–90\text{ min}}\)). We used the linear trapezoidal rule when successive concentration values were increasing and the logarithmic trapezoidal rule when successive concentration values were decreasing after the observed peak concentration. Data were analysed using the WinNonlin pharmacokinetic program (version 4.1; Pharsight, Mountain View, CA, USA).

Statistical analysis

On the basis of previous studies, we calculated that 10 subjects would be required to demonstrate a 30% difference in
paracetamol AUC₀–₉₀ min values between the placebo and dexametomidine phases at a level of significance of \( P=0.05 \) and power of 80%. In the study of Memis and colleagues,⁹ the mean value for paracetamol AUC₀–₁₂₀ min in the control group was 895 min mg litre⁻¹ with a standard deviation of 500 min mg litre⁻¹. For calculation of the sample size, we assumed that the standard deviation of the difference between the phases would be equal to the mean value of the difference. Hence, 12 healthy volunteers were enrolled in the study after written informed consent.

The results are expressed as median (range). Differences between treatments were evaluated using Friedman’s test followed by pair-wise comparisons with Dunn’s test, with adjustment for multiple comparisons. Differences were regarded as significant at \( P<0.05 \). All data were analysed using the statistical program R (R Development Core Team (2010). R: A Language and Environment for Statistical Computing. R Foundation for Statistical Computing, Vienna, Austria. ISBN 3-900051-07-0, URL http://www.R-project.org).

The protocol-specified outcome variables were time to peak paracetamol concentration, peak paracetamol concentration, area under the plasma concentration–time curve of paracetamol, and oro-caecal transit time.

### Results

#### Study subjects

The median age of the 12 subjects was 21 (20–26) yr, median weight was 77 (61–85) kg, and height was 1.84 (1.69–1.93) m.

#### Gastric emptying

Median concentrations of paracetamol in plasma during the three phases of the study are shown in Figure 1. Individual times to reach maximal concentration of paracetamol in plasma, maximal concentration values, and the areas under the plasma paracetamol concentration–time curves (AUC₀–₉₀ min) are depicted in Figure 2.

The time to reach maximal concentration of paracetamol in plasma was significantly longer (300% increase), the maximal observed paracetamol concentrations were significantly lower, and values of AUC₀–₉₀ min were significantly smaller (95% reduction) during dexametomidine infusion than during the morphine and placebo infusion (Table 1). No statistically significant differences were observed in these parameters between placebo and morphine.

#### Oro-caecal transit time

Individual oro-caecal transit times are depicted in Figure 2. Oro-caecal transit times were significantly longer (325% increase) during dexametomidine infusion than during morphine and placebo phases (Table 1). No statistically significant differences were observed between placebo and morphine.

### Discussion

Administration of dexametomidine markedly inhibited gastric emptying and oro-caecal transit compared with placebo and morphine. The effect of dexametomidine on gastrointestinal motility was consistent across all 12 subjects for changes in paracetamol \( T_{\text{max}} \), AUC₀–₉₀ min, and oro-caecal transit time.

Early enteral feeding has been associated with reduced ICU and hospital mortality,¹⁹ but gastrointestinal motility is often inadequate in ICU patients, making nasogastric feeding impossible because of the risk of aspiration. Propofol as single agent and opioid–benzodiazepine combinations are commonly used for ICU sedation. In healthy volunteers, low-dose propofol did not inhibit gastric emptying,²⁰ suggesting that propofol should be relatively safe in this respect, even though oro-caecal transit time was somewhat prolonged.²⁰ A combination of morphine and midazolam inhibited gastric emptying in critically ill patients compared with propofol.²²

Dexametomidine strongly inhibited gastric emptying in healthy volunteers in the present study. This result contrasts with previous results regarding the effects of clonidine in humans.¹⁰ ¹¹ However, clonidine is less selective than dexametomidine towards \( \alpha₂ \)-adrenoceptors (\( \alpha_1: \alpha_2 \) selectivity ratio 1:200 for clonidine vs 1:1600 for medetomidine)²² and is also a weaker partial agonist than dexametomidine²³ which might contribute to its lesser effect on gastric emptying. Dexametomidine has been reported to have either small⁷ or no¹² effects on gastric emptying in rodents. This discrepancy could be due to inter-species variation in the effects of dexametomidine or differences in dosing.

The dose of dexametomidine used in the current study was clinically relevant, at the high end of the recommended dose (0.2–0.7 \( \mu \)g kg⁻¹ h⁻¹) for ICU sedation. When given at...
lower doses, dexmedetomidine might not inhibit gastric emptying. In the previous study by Memis and colleagues, there was no difference in gastric emptying between ICU patients sedated with dexmedetomidine or with propofol, suggesting that the gastrointestinal effects of the two agents are similar. These findings are in contrast with the present results, as light propofol sedation does not inhibit gastric emptying in healthy volunteers. A likely explanation for this discrepancy is the lower dose of dexmedetomidine used by Memis and colleagues: their patients were given only 0.2 mg kg⁻¹ h⁻¹ of dexmedetomidine after a loading dose of 0.42 mg kg⁻¹, compared with our dosage of 0.7 mg kg⁻¹ h⁻¹ after a loading dose of 1 mg kg⁻¹. The inhibitory effect of dexmedetomidine on gastrointestinal motility is thus likely to be dose dependent.

This study has several limitations. The study involved a rather small number of healthy volunteers, so the results cannot be directly extrapolated to critically ill patients. Another weakness is that we were not able to detect significant differences in the gastrointestinal effects of morphine and placebo. There was a tendency for impaired gastric emptying and gastrointestinal transit after morphine, but the differences compared with placebo were not statistically significant.

Morphine was selected as a control drug because of its well-known inhibitory effects on gastric emptying and gastrointestinal transit as a positive control. Dexmedetomidine, in turn, was given at the highest dose recommended by the manufacturer for sedation. No statistically significant differences emerged between placebo and morphine in the current

![Graphs showing gastric emptying data](https://example.com/graphs)

Table 1: Effects of i.v. dexmedetomidine and morphine on the gastrointestinal absorption of paracetamol and oro-caecal transit time. Dexmedetomidine was given by i.v. infusion over 210 min (1 μg kg⁻¹ over 20 min followed by 0.7 μg kg⁻¹ h⁻¹ for 190 min). Morphine 0.10 mg kg⁻¹ was given by infusion over 20 min followed by saline infusion for 190 min. Data are given as median (range). ***P<0.001 vs placebo

<table>
<thead>
<tr>
<th>Variable</th>
<th>Placebo</th>
<th>Dexmedetomidine</th>
<th>Morphine</th>
</tr>
</thead>
<tbody>
<tr>
<td>( T_{\text{max}} ) (min)</td>
<td>60 (30–120)</td>
<td>240 (135–240)***</td>
<td>80 (30–210)</td>
</tr>
<tr>
<td>( C_{\text{max}} ) (mg litre⁻¹)</td>
<td>15.2 (7.6–21.0)</td>
<td>4.3 (2.0–15.0)***</td>
<td>11.1 (8.2–17.5)</td>
</tr>
<tr>
<td>AUC₀–90 min (min mg litre⁻¹)</td>
<td>545 (195–1022)</td>
<td>29 (15–215)***</td>
<td>325 (34–887)</td>
</tr>
<tr>
<td>Oro-caecal transit time (min)</td>
<td>90 (30–180)</td>
<td>383 (285–420)***</td>
<td>203 (105–285)</td>
</tr>
</tbody>
</table>

Fig 2: Individual values for time to peak plasma paracetamol concentration \( (T_{\text{max}}) \), peak plasma paracetamol concentration \( (C_{\text{max}}) \), area under the paracetamol plasma concentration–time curve from 0 to 90 min \( (\text{AUC₀–90 min}) \), and oro-caecal transit time measured by hydrogen breath test in 12 healthy male volunteers after ingestion of 1 g of paracetamol and 10 g of lactulose after i.v. infusion of saline placebo, dexmedetomidine or morphine. Dexmed, dexmedetomidine.
study, even though the morphine dose (0.10 mg kg\(^{-1}\)) was twice that shown to inhibit gastric emptying\(^{25}\) and gastrointestinal transit\(^{26}\) in healthy volunteers. We gave morphine as a 20 min infusion in order to avoid high peak plasma concentrations, which could have caused typical opioid adverse effects; this slow infusion might partially explain its unexpectedly small gastrointestinal effects. The morphine treatment arm was included to ensure that the used methods were appropriate to detect drug effects on gastric emptying and gastrointestinal transit. This would have been especially important, had dexmedetomidine not had significant effects. There was a non-significant trend in the expected direction with morphine, but the study was not sufficiently powered to achieve statistical significance for the morphine effect. This does not invalidate the conclusions of the study with regard to dexmedetomidine.

For logistic reasons, we wanted to assess the absorption of paracetamol and metabolism of lactulose in the same experimental session—we therefore administered paracetamol and lactulose simultaneously. Lactulose is marketed as a laxative, but it has also been shown to slow gastric emptying.\(^{27}\) This property of lactulose might have obscured the effect of morphine on gastric emptying compared with placebo, but we have no definitive explanation for why the gastrointestinal effects of morphine did not differ from placebo.

In conclusion, dexmedetomidine markedly inhibited gastric emptying and gastrointestinal transit in healthy volunteers. The clinical significance of this finding should be evaluated in critically ill patients, using clinically relevant doses of dexmedetomidine and relevant comparators, and stratifying for all co-administered drugs.

Conflict of interest
T.I., R.A., and K.T.O. have ongoing contract research relationships with Orion Corporation (Espoo, Finland), the original developer of dexmedetomidine. T.I. has received speaker fees from Orion Corporation (Espoo, Finland). R.A. has been a paid consultant for Orion Corporation (Espoo, Finland) and Abbott Laboratories (Abbott Park, IL, USA), the original co-developers of dexmedetomidine, and also for Hospira (Lake Forest, IL, USA). Hospira has a license agreement with Orion Corporation concerning dexmedetomidine (Precedex\(^{\circ}\)). P.J.N. is a shareholder of Orion Corporation (Espoo, Finland). The laboratory of M.S. has contract research relationships with Orion Corporation (Espoo, Finland) and Hospira (Lake Forest, IL, USA). M.S. has also received speaker fees and consulting fees from Orion Corporation.

Funding
This work was financially supported by Turku University Hospital research funds (grant number 13821), Turku, Finland, and by the Instrumentarium Research Foundation, Helsinki, Finland.

References
13 Mann NS, Shinkle JM. Effect of clonidine on gastrointestinal transit time. Hepatogastroenterology 1998; 45: 1023–5


