Urinary Metabolites of Chloroprocaine

To the Editor:—In their recent article, Krogh and Jellum1 reported no evidence of conjugated 2-chloro-4-amino benzoic acid (CABA) in either maternal or neonatal urine following epidural anesthesia with 2-chloroprocaine. In addition, they found only small amounts of unmetabolized CABA in neonatal urine. They studied four mothers and one neonate. In contrast to their data, we are finding on the average 36 per cent of the total excreted CABA to be conjugated. Our data are from a similar ongoing study which presently includes 22 mothers. O'Brien et al.2 have reported similar findings in four subjects. In addition, we have observed that the urine from the resulting infants contains amounts of unmetabolized CABA comparable to those excreted by the mother (data expressed on a μg drug/mg creatinine basis). In agreement with Krogh and Jellum, we did not find significant amounts of conjugated CABA in neonatal urine during the first 48 h of life. However, on the third day of life, trace amounts of conjugated CABA were detectable.

There are two differences between our methodology3,* and the methodology used by Krogh and Jellum which may explain these conflicting results. First, Krogh and Jellum collected specimens from mothers at the time of delivery and two hours later which corresponds to approximately one and three hours after epidural injection. Only one neonatal urine sample was studied and it was “VOIDED shortly after delivery.” In contrast, we collect urine samples from delivery through the first 72 h postpartum in both mother and neonate. Possibly, there was not enough time for sufficient amounts of conjugated CABA to be produced, concentrated, and excreted by Krogh and Jellum’s patients. In support of this interpretation, O'Brien et al. reported that the proportion of conjugate to free metabolite increased with time following intravenous administration of chloroprocaine. Secondly, to free conjugated CABA, we pretreat 1-ml aliquots of diluted urine for 20 h at 90°C prior to extraction; O'Brien et al. used even harsher hydrolysis conditions. However, no mention is made of conjugate hydrolysis techniques by Krogh and Jellum.

For these reasons, it does not seem reasonable at this time to accept Krogh and Jellum’s conclusions regarding maternal levels of conjugated CABA and neonatal levels of unmetabolized CABA.

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REFERENCES

(Accepted for publication November 21, 1981.)

* Technique modified to include 4-amino-3,5-diodobenzoic acid as the internal standard and detection by electron capture gas chromatography.

In reply:—In reply to the letter from Kuhnert, Kuhnert, and Reese we have the following comments. The above authors claim to find on the average 36 per cent of the total CABA to be conjugated, but they have been unable to identify the conjugate. We have conclusively shown using gas chromatography—mass spectrometry and reference compound that the major metabolite is N-acetyl CABA.

Whether this should be called a conjugate or not is a matter of definition. One should realize that N-acetyl CABA readily undergoes alkaline hydrolysis to yield free CABA (shown by GC-MS experiments in our labo-
Pharmacogenetics and Halothane Hepatitis

To the Editor:—There is now published evidence in humans that pharmacogenetics may be a factor in human halothane hepatitis.¹ In addition to our recent report of differences in halothane hepatotoxicity among three different strains of rats,² we now have evidence within one rat strain (Fischer 344) of considerable variability in hepatic damage following halothane.³ In a study of the time course of changes in liver function and structure following halothane, maximum values for serum alanine amino-transferase (ALT) varied from 143 IU/l to over 28,000 IU/l. Although mean peak serum ALT was 5,180 IU/l, three of 128 animals studied had values of 28,925; 18,550; 7,650 IU/l, respectively. These high serum ALT values in three animals were accompanied by massive hepatic necrosis, whereas animals with moderate increases in serum ALT had focal necrosis.³ This provides further evidence of a genetic influence in halothane hepatitis, since the conditions of anaesthesia and oxygenation were identical for all animals.

Clinical studies of repeated halothane anaesthesia report that mild liver injury occurs with a frequency as high as 24–40 per cent of patients; yet severe liver injury is rare. It now seems that pharmacogenetics may provide a key that predisposes a small number of individuals to severe liver injury. Even in such individuals it seems likely that a complex set of factors, such as high rate of reductive bio-transformation and low oxygen concentration in the liver, may be conditional to the development of massive hepatic necrosis. This is entirely in keeping with a multifactorial etiology of halothane hepatitis as discussed by commentators in both the field of anesthesiology⁴ ⁵ and general medicine.⁶ ⁷

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References