

*Original Article*

# Interaction between Amlodipine and Simvastatin in Patients with Hypercholesterolemia and Hypertension

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**3-Hydroxy-3-methylglutaryl-coenzyme A (HMG-CoA) reductase inhibitors are often prescribed in association with antihypertensive agents, including calcium antagonists. Simvastatin is an HMG-CoA reductase inhibitor that is metabolized by the cytochrome P450 (CYP) 3A4. The calcium antagonist amlodipine is also metabolized by CYP3A4. The purpose of this study was to investigate drug interactions between amlodipine and simvastatin. Eight patients with hypercholesterolemia and hypertension were enrolled. They were given 4 weeks of oral simvastatin (5 mg/day), followed by 4 weeks of oral amlodipine (5 mg/day) co-administered with simvastatin (5 mg/day). Combined treatment with simvastatin and amlodipine increased the peak concentration ( $C_{max}$ ) of HMG-CoA reductase inhibitors from  $9.6 \pm 3.7$  ng/ml to  $13.7 \pm 4.7$  ng/ml ( $p < 0.05$ ) and the area under the concentration-time curve (AUC) from  $34.3 \pm 16.5$  ng h/ml to  $43.9 \pm 16.6$  ng h/ml ( $p < 0.05$ ) without affecting the cholesterol-lowering effect of simvastatin. This study is the first to determine prospectively the pharmacokinetic and pharmacodynamic interaction between amlodipine and simvastatin. (*Hypertens Res* 2005; 28: 223–227)**

**Key Words:** drug interaction, simvastatin, amlodipine, hypercholesterolemia

## Introduction

Control of hypercholesterolemia is important for the prevention of coronary artery disease (CAD) (1–5). Currently, 3-hydroxy-3-methylglutaryl-coenzyme A (HMG-CoA) reductase inhibitors are the first-choice therapeutic agents for patients with hypercholesterolemia (6–8). The HMG-CoA reductase inhibitor simvastatin is widely used and has been shown to reduce morbidity and mortality from CAD (9). Simvastatin is an inactive lactone pro-drug that is hydrolyzed by esterases to simvastatin acid, the active competitive inhibitor of HMG-CoA reductase (10–12). Simvastatin and simvastatin acid are mainly metabolized by the cytochrome P450 (CYP) 3A4 to 3',5'-dihydrodiol, 3'-hydroxy and 6'-exometh-

ylene (10–12). The pharmacokinetics of simvastatin has been reported to be affected by potent CYP3A4 inhibitors such as itraconazole (13), erythromycin (14), verapamil (14) and nelfinavir (15). Moreover, we have previously reported that diltiazem, which is a selective inhibitor of CYP3A4 (16, 17), caused a 2-fold increase of the area under the concentration-time curve (AUC) of HMG-CoA reductase inhibitors (18).

Hypercholesterolemia is often accompanied by hypertension, an associated risk factor for CAD (19–21). Calcium antagonists have been widely used in the treatment of hypertension and/or angina pectoris (22–26), and are often prescribed in association with a lipid-lowering agent such as simvastatin. Amlodipine is one of the 1,4-dihydropyridine calcium antagonists with a long elimination half-life (27–29). Amlodipine undergoes the oxidative metabolism of dihydro-

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**Table 1. Patient Demographics and Basic Medical Data**

Age (years old)	64.1±6.0
Sex (male/female)	5/3
Body weight (kg)	61.5±5.9
Total cholesterol (mg/dl)	253±31
LDL-cholesterol (mg/dl)	164±26
HDL-cholesterol (mg/dl)	54±9
Triglyceride (mg/dl)	179±95

Values are mean±SD. LDL, low-density lipoprotein; HDL, high-density lipoprotein.

pyridine to a pyridine analogue by CYP3A4 (30). In an *in-vitro* study, amlodipine was shown to have strong inhibitory effects on CYP1A1, CYP2B6 and CYP2C9, and a weak inhibitory effect on CYP3A4 when using microsomes from human B-lymphoblast cells expressing CYP (31). Although amlodipine is one of the most frequently used calcium antagonists, the drug interaction between amlodipine and substrate drugs for CYP3A4 has not been clinically investigated. In this study we prospectively studied the pharmacokinetic and pharmacodynamic drug interaction between amlodipine and simvastatin in patients with hypercholesterolemia and hypertension.

## Methods

### Subjects

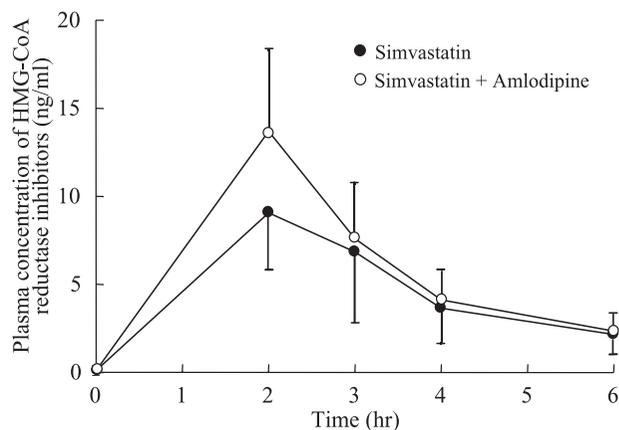
Eight patients with mild hypertension and hypercholesterolemia who had been treated with simvastatin (5 mg/day) and the angiotensin-converting enzyme inhibitor enalapril (5 mg/day) for more than 3 months were enrolled. Before the start of any antihypertensive therapy, the mean systolic and diastolic blood pressure levels (SBP/DBP) were 151±29 mmHg and 88±11 mmHg, respectively. The patient demographics and basic medical data are shown in Table 1. Patients had no history of hepatic or renal disease. The study protocol was approved by the Ethical Committee of Hamamatsu University School of Medicine. All subjects gave written informed consent before participating in the study.

### Study Design

This was a two-phase fixed-order design study. In the first period, patients were administered oral simvastatin (5 mg/day) alone for 4 weeks. In the second period, patients were co-administered amlodipine (5 mg/day) and simvastatin (5 mg/day) for 4 weeks. No drug other than simvastatin and amlodipine was taken during the study period.

### Blood Sampling

Blood samples were obtained on the last day of each of the



**Fig. 1.** Time profiles of the mean plasma concentrations of HMG-CoA reductase inhibitors on the last day of 4 weeks of treatment with simvastatin (5 mg/day) or combined treatment with simvastatin (5 mg/day) and amlodipine (5 mg/day). Each point represents the mean±SD.

trial periods. After an overnight fast, a pre-dosing venous blood sample was taken, which was used to measure serum total cholesterol (TC), high-density lipoprotein cholesterol (HDL-C) and triglyceride (TG) enzymatically, and the low-density lipoprotein cholesterol (LDL-C) concentration was calculated according to the Friedewald formula method (32). All patients drank a glass of water after swallowing the tablets. Blood samples were then taken 2, 3, 4 and 6 h after simvastatin administration. A standardized breakfast and lunch were served 2 and 4 h after drug intake. Plasma was separated within 30 min and stored at -70°C until analysis.

### Determination of Simvastatin HMG-CoA Reductase Inhibitor Concentrations

Plasma concentrations of HMG-CoA reductase inhibitors were determined as previously described (33). An equal volume of methanol was added to the plasma samples and the mixtures were vortexed thoroughly, kept on ice for 10 min, and centrifuged. Fifty microliters of the supernatants were dried in an evaporator (SpeedVac; Savant Instruments, Farmingdale, USA). The reaction mixture (96 µl) was added directly to the dried residues to make a final volume of 100 µl containing 0.1 mol/l KPO<sub>4</sub> (pH 7.4), 10 mmol/l 1,4-dithiothreitol (DTT), 0.2 mmol/l NADH<sup>+</sup> (made fresh daily), 5 mmol/l glucose-6-phosphate, 1.4 U/ml glucose-6-phosphate dehydrogenase and 1 mg/ml bovine serum albumin. The reaction mixture was incubated for 5 min at 37°C, and soluble rat liver HMG-CoA reductase was added to 2 µl buffer A: 0.04 mol/l KPO<sub>4</sub> (pH 7.4), 0.05 mol/l KCl, 0.1 mol/l sucrose, 0.03 mol/l ethylenediaminetetraacetic acid (EDTA) and 0.01 mol/l DTT (added immediately before use). The mixture was incubated at 37°C for 5 min in the presence of the inhibitor-con-

**Table 2. Pharmacokinetic Parameters of Simvastatin HMG-CoA Reductase Inhibitor Concentrations**

	$C_{\max}$ (ng/ml)	$t_{1/2}$ (h)	AUC(0–∞) (ng h/ml)
Simvastatin	9.6±3.7	2.08±0.59	34.3±16.5
Simvastatin+amlodipine	13.7±4.7*	1.97±0.61	43.9±16.6*

Values are mean±SD.  $C_{\max}$ , maximal measured concentration;  $t_{1/2}$ , the elimination half-life; AUC(0–∞), area under the concentration-time curve. \* $p < 0.05$  vs. simvastatin monotherapy.

taining plasma sample. The reaction was started with 2  $\mu$ l of 1.25 mg/ml HMG-CoA containing 17.5  $\mu$ Ci/ml glutaryl-3- $^{14}$ C]HMG-CoA. After an additional 6-min incubation at 37°C, 20  $\mu$ l of 5 mol/l HCl was added to lactonize the mevalonic acid formed. After 15 min, 3.5 ml of a 1:1 suspension of BioRad AG 1  $\times$  8 resin (200–400 mesh) was added and the tubes (13  $\times$  100) were thoroughly vortexed.  $^{14}$ C]Mevalonolactone was filtered from the resin suspension through polystyrene filters (pore size 70  $\mu$ m; EverGreen, Los Angeles, USA) into scintillation vials containing 15 ml of Aquasol-2 (New England Nuclear, Newton, USA) and counted on a scintillation counter. The percentage of inhibition was converted to the inhibitor concentration using a standard curve constructed by extracting from the control plasma containing known amounts of L-654, 969, the free acid form of simvastatin. The results were expressed as nanograms of inhibitor per milliliter of plasma. The intra- and inter-day coefficients of variation for the HMG-CoA reductase activity assay were less than 6%.

### Data Analysis

The pharmacokinetics of simvastatin was characterized by the peak concentration ( $C_{\max}$ ), the time to  $C_{\max}$  ( $T_{\max}$ ), the elimination half-life ( $t_{1/2}$ ) and the area under the plasma concentration-time curve from 0 to infinity [AUC(0–∞)]. The  $C_{\max}$  and  $T_{\max}$  were obtained directly from the original data. The terminal rate constant ( $k_e$ ) used for the extrapolation was determined by regression analysis of the log-linear part of the concentration-time curve for each subject. The  $t_{1/2}$  was determined by  $0.693/k_e$ . The AUC(0–∞) was calculated by the trapezoidal rule for the observed values and subsequent extrapolation to infinity. Data are represented as the mean±SD. Data were analyzed by a paired  $t$ -test or Wilcoxon signed-rank test where appropriate. Differences with  $p$  values <0.05 were considered statistically significant.

### Results

No subjects reported a serious clinical, laboratory or other adverse effect, and no subjects were discontinued.

### Pharmacokinetics of Simvastatin HMG-CoA Reductase Inhibitor Concentrations

Plasma concentrations of HMG-CoA reductase inhibitors

after oral simvastatin dosing with or without amlodipine are shown in Fig. 1, and pharmacokinetic parameters of simvastatin are shown in Table 2. Co-administration of amlodipine with simvastatin significantly increased the  $C_{\max}$  and AUC(0–∞) of HMG-CoA reductase inhibitors to 1.4- and 1.3-fold, respectively, in simvastatin monotherapy, but did not affect the  $t_{1/2}$  and  $T_{\max}$  of HMG-CoA reductase inhibitors.

### Pharmacodynamics

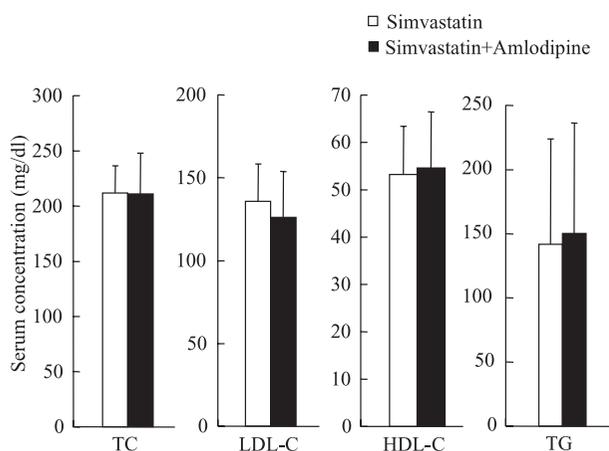
Lipid profile, including TC, LDL-C, HDL-C, and TG during simvastatin monotherapy and combined treatment with simvastatin and amlodipine, are shown in Fig. 2. There were no significant differences in lipid profiles between the two periods.

The SBP and DBP values are shown in Table 3. Both measures were significantly higher during simvastatin monotherapy than during the pretrial control period with enalapril. After administration of amlodipine, both SBP and DBP tended to decline ( $p=0.06$  and  $p=0.08$ , respectively). The blood pressure values during combined treatment with simvastatin and amlodipine did not differ from those during the pretrial control period with enalapril.

### Discussion

Calcium antagonists and HMG-CoA reductase inhibitors are often prescribed together for the treatment of hypertension and/or angina pectoris in patients with hypercholesterolemia (1, 6, 7). Amlodipine is used with many drugs, such as oral hypoglycemic drugs,  $\beta$ -blockers, angiotensin-converting enzyme inhibitors, and so on. However, there have been no reports on the interaction between amlodipine and any other drug, with the exception that the interaction of amlodipine with grapefruit juice was shown to increase the AUC of amlodipine (34). This study is the first to report that amlodipine affected the plasma concentrations of HMG-CoA reductase inhibitors.

Simvastatin is hydrolyzed by esterases to simvastatin acid, which is an active inhibitor of HMG-CoA reductase (10–12). Simvastatin is extensively metabolized to several oxidative products by CYP3A4 (10–12). Some of the hydroxyl acid forms of these products also inhibit HMG-CoA reductase (10, 11). In this study, we measured the total HMG-CoA reductase inhibitory activity resulting from simvastatin acid and all other active acid metabolites of simvastatin, since this level is



**Fig. 2.** Mean levels of serum lipid parameters on the last day of 4 weeks of treatment with simvastatin (5 mg/day) or combined treatment with simvastatin (5 mg/day) and amlodipine (5 mg/day). TC, total cholesterol; LDL-C, low-density lipoprotein cholesterol; HDL-C, high-density lipoprotein cholesterol; TG, triglycerides. Each column represents the mean  $\pm$ SD.

believed to be relevant to the systemic adverse effects for this class of agents (35).

The pharmacokinetics of simvastatin has been shown to be affected by potent CYP3A4 inhibitors (13–15, 18). Amlodipine, which is metabolized by CYP3A4, has been reported to show inhibitory effects on CYP3A4 *in vitro* (31). However, the influence of amlodipine on the substrate drugs of CYP3A4 has not been clarified yet. In this study, amlodipine significantly increases the AUC of HMG-CoA reductase inhibitors after co-administration of simvastatin by 30%. It has been reported that the AUC of HMG-CoA reductase inhibitors was increased 4-fold with itraconazole (13), which is known to be a potent inhibitor of CYP3A4. Some studies have shown adverse effects, including rhabdomyolysis, in patients treated with simvastatin and CYP3A4 inhibitors such as itraconazole and ketoconazole (8). These reports suggested that the co-administration of simvastatin with these inhibitors enhanced the risk of adverse effects, because of the dose-dependent toxicity of HMG-CoA reductase inhibitors. In our previous study, diltiazem increased the AUC of HMG-CoA reductase inhibitors 2-fold (18). On the other hand, amlodipine increased the AUC of HMG-CoA reductase inhibitors by only 30% in this study. In addition, it has been reported that the CYP3A4 inhibitory effect of diltiazem was higher than that of amlodipine after therapeutic doses (36). Therefore, the difference of the impact on the plasma concentrations of HMG-CoA reductase inhibitors may depend on the difference of the CYP3A4 inhibitory potency between amlodipine and diltiazem.

It has been reported that an increase in the plasma concentrations of HMG-CoA reductase inhibitors following co-

**Table 3.** Systolic BP and Diastolic BP during Pretrial Control Period with Enalapril, Simvastatin Monotherapy and Combined Treatment with Simvastatin and Amlodipine

	Systolic BP (mmHg)	Diastolic BP (mmHg)
Simvastatin+enalapril (pretrial control period)	135 $\pm$ 19	78 $\pm$ 13
Simvastatin	152 $\pm$ 22*	89 $\pm$ 13*
Simvastatin+amlodipine	140 $\pm$ 17	81 $\pm$ 11

Values are mean  $\pm$ SD. BP, blood pressure. \* $p$ <0.05 vs. simvastatin+enalapril.

administration of simvastatin and diltiazem resulted in a reduction of TC and LDL-C levels (18). However, we did not observe such a reduction of TC and LDL-C levels, despite the fact that amlodipine increased the plasma concentrations of HMG-CoA reductase inhibitors. The pharmacokinetic interactions observed in the present study, such as the 30% increase in the AUC of HMG-CoA reductase inhibitors, may not have been sufficient to alter the pharmacodynamic response. Moreover, we cannot exclude the possibility that the number of patients was not sufficient to detect the pharmacodynamic differences. Further investigations will be needed to clarify the pharmacodynamic impact of simvastatin with amlodipine on TC and LDL-C.

In conclusion, this study is the first report of the drug interaction between simvastatin and amlodipine after a long-term treatment. Although amlodipine increases the plasma concentrations of HMG-CoA reductase inhibitors, the impact of amlodipine on simvastatin is smaller than that of diltiazem. Since these drugs are often used concomitantly for patients with hypertension and hypercholesterolemia, amlodipine could be used more safely with simvastatin than diltiazem.

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