Dose conversion from aminophylline to theophylline in preterm infants

J Reese, G Prentice, V Y H Yu

Abstract
Twenty two preterm infants were prospectively evaluated to assess the need for dose adjustment when converting enteral and parenteral routes of methyloxanthine administration. Serum theophylline concentrations remained unchanged in 18 infants after conversion from intravenous aminophylline to theophylline by mouth without dose reduction, as is currently recommended. Intravenous aminophylline and theophylline by mouth may therefore be prescribed at equivalent doses, with a possible reduction in drug errors, and improved stability of serum concentrations.

(Patients and methods
Serum theophylline concentrations were measured in infants in whom the same doses of theophylline by mouth and intravenous aminophylline were given. Those who received intravenous aminophylline for long enough to achieve a steady state concentration (for this study, considered to be four days2 4) and who were subsequently changed to theophylline by mouth for a similar period were evaluated. Patients were excluded if they concurrently received erythromycin, phenobarbitone, phenytoin, cimetidine, or other drugs suspected of altering theophylline metabolism.5 Similarly, infants with asphyxia were excluded due to suspicion of altered theophylline clearance rates.2

Intravenous aminophylline (David Bull Laboratories) was given as a 10 mg/kg loading dose over 15 minutes, and then a maintenance treatment of 2.5 mg/kg every 12 hours, begun 12 hours after the loading dose. When the infant tolerated enteral feeding, theophylline by mouth (Elixophylline, Schering) was ordered at the same dose and frequency as the most recent aminophylline prescription. Doses by mouth were given at the same time as milk feeds.

Serum theophylline concentrations were determined 30 minutes before a dose by dry chemical assay (Ektachem 700, Eastman Kodak Company, Rochester, NY). An acceptable therapeutic range for our assay was 45–90 μmol/l (8–16 μg/ml), with a desired concentration of 70 μmol/l (12.5 μg/ml). Data were analysed using Student’s t test (paired, two tailed).

Results
Eighteen infants were changed from intravenous aminophylline to theophylline by mouth at equivalent doses and met the steady state criteria for both routes. A second set of measurements were included in one infant who was changed from the intravenous to oral route on a second occasion. Five additional infants who met the steady state criteria when the drugs were changed from the oral to intra-
Theophylline serum concentrations during intravenous administration and administration by mouth. Upper panel: conversion from intravenous aminophylline to theophylline by mouth (open boxes represent means, with SD bars). Lower panel: conversion from by mouth to intravenous route of administration.

Theophylline serum concentrations were also studied. The table gives the patient characteristics.

There was no significant difference between mean serum theophylline concentrations while receiving intravenous aminophylline and after conversion to theophylline by mouth (70.9 (9.0) v 70.5 (15.2) μmol/l; p=0.92) (fig). No infant showed clinical signs of toxicity while receiving the drug intravenously or by mouth. When controlled for postnatal age, five infants who had measurements taken while receiving the drug intravenously or by mouth before 3 weeks of age showed no difference between mean serum values (p=0.94), nor did eight remaining infants with both measurements taken after three weeks (p=0.60). Eight infants showed an increase and 10 infants showed a decrease in serum concentrations after chang- ing to receiving the drug by mouth. There was also no significant difference between mean serum theophylline concentrations while receiving theophylline by mouth and after conversion to intravenous aminophylline (77.2 (14.4) v 72.6 (17.5) μmol/l; p=0.44) (fig).

Discussion

Theophylline has been reported to be one of the paediatric drugs most frequently associated with prescription errors.8 Owing to alterations in the tolerance of enteral feeding in the neonatal period, the oral and intravenous routes of administration are frequently interchanged. As theophylline has potentially serious side effects and a narrow therapeutic window,3,5 our earlier practice has been to reduce the theophylline dose by mouth to 80% of the aminophylline dose, based on the chemical composition of the drug. The bioavailability of drugs given by mouth, however, depends on factors such as pH, microbial flora, and gastric motility. Older infants and children are assumed to have 100% absorption of theophylline given by mouth. It was suggested that 100% bioavailability was possible for theophylline by mouth in preterm infants,6 but other studies have found it to be approximately 80% bioavailable.1,3 The bioavailability of aminophylline from rectal suppositories is similarly 70–80%.8 The present study showed that serum theophylline concentrations remained constant after changing from the intravenous to the oral route without dose adjustment. No toxicity was noted, as might be expected if theophylline by mouth was 100% bioavailable. In addition, data from a small number of patients showed that conversion from oral to intravenous administration may also be carried out without altering the drug dose.

Whether enteral feeding alters the bioavailability of theophylline given by mouth is unclear. A delayed absorption of theophylline was noted when given with enteral feeds, but only the rate and not the total amount was affected.7

Although current recommendations are an alteration in dose when converting between intravenous and oral administration, our data support the hypothesis that intravenous aminophylline may be converted to oral theophylline without a reduction in dose. In preterm infants, whose clinical status is often labile, this policy should help reduce prescription errors and ensure more predictable serum theophylline concentrations despite frequent changes between enteral and parenteral drugs.


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