Antinociceptive Synergy, Additivity, and Subadditivity with Combinations of Oral Glucosamine Plus Nonopioid Analgesics in Mice

RONALD J. TALLARIDA, ALAN COWAN, and ROBERT B. RAFFA
Temple University School of Medicine (R.J.T., A.C., R.B.R.) and Temple University School of Pharmacy (R.B.R.), Philadelphia, Pennsylvania
Received May 10, 2003; accepted July 29, 2003

ABSTRACT
Glucosamine (2-amino-2-deoxy-D-glucose) and glucosamine-containing products have been reported to have efficacy in the treatment of various musculoskeletal disorders. Glucosamine’s efficacy, including reduction of pain, is attributed to disease-modifying properties, specifically to cartilage-rebuilding associated with modulation of interleukin-1-induced activation of chondrocytes and to inhibition of proinflammatory effects of the nuclear factor-κB pathway. However, glucosamine has not been shown to have direct analgesic activity. We report here that commercial glucosamine (90.4% glucosamine sulfate + 9.6% excipients) administered as the sole agent (up to 500 mg/kg p.o.) was inactive in the mouse abdominal irritant test but that certain combinations of glucosamine with nonopioid analgesics at the oral doses and ratios tested resulted in a synergistic (ibuprofen and ketoprofen), additive (diclofenac, indomethacin, naproxen, and piroxicam), or subadditive (aspirin and acetaminophen) antinociceptive interaction. In the specific case of ibuprofen, the racemate (standard ibuprofen) produced dose-related antinociception with ED50 = 26.1 ± 3.4 mg/kg. Combinations containing racemic ibuprofen and glucosamine in greater than 1:1 ratio (glucosamine/ibuprofen) were synergistic in the test (e.g., ED50 = 11.0 ± 2.1 for the 9:1 ratio; p < 0.01, analysis of variance). Combinations containing glucosamine and ibuprofen (2:1 and 9:1) yielded plasma levels of ibuprofen that were no different from administration of ibuprofen alone. The possibility that combinations containing certain fixed ratios of glucosamine and certain nonsteroidal anti-inflammatory drugs (NSAIDs) might enhance pain relief in patients with pain or might achieve acceptable levels of pain relief with lower doses of NSAIDs (reduced adverse effects) is presently being pursued in clinical trials.

Glucosamine (2-amino-2-deoxy-D-glucose), an amino derivative of glucose, is found abundantly in the human body, particularly in connective and cartilage tissue. It serves as a substrate for biosynthesis of mucopolysaccharides and biopolymers of the articulations and bones and has been reported to facilitate the hexosamine pathway of proteoglycan synthesis (Noyaszewski et al., 2001). In recent years, glucosamine has been extensively investigated for use as primary or adjunct therapy in the treatment of osteoarthritis (Gottlieb, 1997; Deal and Moskowitz, 1999; Hochberg, 2001; Towheed et al., 2001). Osteoarthritis, the most common arthritic condition (Felson et al., 1989; Lawrence et al., 1989), is characterized by pain and progressive degeneration of cartilage in synovial joints and vertebrae (Brandt and Slemenda, 1993), leading to significant reduction of mobility and quality of life (Steultjens et al., 2001). Although more definitive clinical trials are needed (Barclay et al., 1998; da Cama and Dowless, 1998), much evidence suggests that glucosamine is effective in osteoarthritis. However, the pain reduction that is associated with the use of glucosamine sulfate (Creamer, 2000) and possibly glucosamine hydrochloride (Houpt et al., 1999) has been attributed to disease-modifying properties rather than to a direct analgesic effect. This prompts the following two questions: Does glucosamine possess antinociceptive activity and does it potentiate the antinociceptive action of other (antiarthritic) compounds? To our knowledge glucosamine has not been tested for analgesic (antinociceptive) activity.

Combining analgesics of proven efficacy is a strategy that is intended to achieve one or more therapeutic goals such as facilitating patient compliance, simplifying prescribing, improving efficacy without increasing adverse effects, or decreasing adverse effects without loss of efficacy (Raffa, 2001). Most of these combinations result in purely additive analgesic effect. For example, drugs that have similar joint action (Tallarida, 2000), such as the two opioid agonists morphine and methadone, generally display an additive interaction.
(Taber et al., 1969). However, in certain cases, the combination results in an unexpected greater-than-additive (synergistic) analgesic effect (Bolan et al., 2002). The demonstration of synergistic drug interactions between drugs (e.g., Tallarida et al., 1999), enantiomers of the same drug (e.g., Raffa et al., 1993), or between sites of administration (Tallarida et al., 1989; Raffa et al., 2000) and the underlying statistical analyses needed for this demonstration have been the focus of our group for several years as summarized in a recent monograph (Tallarida, 2000) and review (Tallarida, 2001). A consistent finding that has emerged from this series of studies is that drug synergism is not an intrinsic property of the constituent drugs. Rather, it depends also on the proportion of each in the combination. Another notable finding is that synergism may occur with combinations in which one of the constituents lacks efficacy as a sole agent. Although rare when the active drug is an analgesic, this situation is especially interesting.

We report here that glucosamine sulfate in doses up to 500 mg/kg p.o. had no antinociceptive effect in the mouse abdominal irritant test when it was administered as the sole agent but that certain fixed ratio combinations of glucosamine with certain NSAIDs, but not all, displayed statistically significant antinociceptive synergy. Within the class of NSAIDs, the propionic acid derivatives ibuprofen and ketoprofen were most synergistic when tested in combination with glucosamine. The combination of glucosamine and ibuprofen is presently being evaluated in clinical trials.

Materials and Methods

Animals. Male Swiss-Webster mice (Ace Animals, Inc., Boyertown, PA), 25 to 30 g, were used. They were housed in groups of five at 22 ± 1°C for a minimum of 7 days before testing. The animals were maintained on a 12-h light/dark cycle (lights on at 7:00 AM) and fed mouse chow and water ad libitum until 3 h before experimentation began (at noon). All testing was performed in accordance with the recommendations and policies of the National Institutes of Health for the care and use of laboratory animals and was approved by the Temple University Institutional Animal Care and Use Committee. Each animal was tested only once. They were maintained on a 12-h light/dark cycle (lights on at 7:00 AM) and were fed mouse chow and water ad libitum until 3 h before experiment began (at noon).

Compounds. The following compounds were purchased from Sigma-Aldrich (St. Louis, MO): acetylcholine bromide, acetylsalicylic acid, diclofenac sodium, ibuprofen, indomethacin, ketoprofen, S(+)-naproxen, and piroxicam. Acetaminophen USP was obtained from Mallinckrodt (St. Louis, MO) and glucosamine (90.4% glucosamine sulfate + 9.6% excipients) was purchased from Nature’s Purest (Los Angeles, CA). All compounds were suspended in distilled water containing 2% by volume of Tween 80.

Abdominal Irritant Test. The procedure was similar to that described by Collier et al. (1968) with minor modifications. Groups of 10 mice received by gavage (0.01 ml/g) glucosamine, test compound, or vehicle alone. Additional groups of 10 mice each received one of a series of combined doses of glucosamine and test compound. After 30 min, each mouse was injected i.p. (0.25 ml/25 g) with an aqueous solution of acetylcholine bromide (5.5 mg/kg). The animals were then observed for 10 min for the presence or absence of a characteristic behavioral response (a wave of constriction and elongation passing caudally along the abdominal wall, accompanied by a twisting of the trunk and followed by extension of the hindlimbs) (Collier et al., 1968). Percentage antinociception was calculated for each dose based on the percentage of mice displaying no nociceptive response.

Evaluation. Antinociceptive testing consisted of combinations containing glucosamine and one of several different antinociceptive compounds of proven efficacy. In most experimental designs, the combinations contained fixed ratio amounts of the constituents. Experiments designed to (statistically) demonstrate synergism usually require complete dose-response curves of the active agent alone and that same agent in a fixed-ratio combination with glucosamine. When preliminary tests showed no evidence of synergism, or in cases where the experiment was run merely to confirm a related finding, we did not aim to obtain complete dose-response curves to avoid inefficiency and unnecessary animal utilization. All of the antinociceptive results described here were based on binary responses (quantal dose-response data) in mice observed for the absence or presence of nociception.

Theory and Statistical Analysis. All dose-response data included at least 10 animals at each dose of the drug or drug combination tested from which the number protected (absence of nociceptive behavioral response) was observed, thereby yielding a quantal data set for each test condition. Dose-response data analysis used probit regression from which the value of ED50 (with 95% confidence limits) could be assessed and this value (ED50) for each active agent, formed the basis for its subsequent use in fixed ratio combinations with glucosamine. The two-dose-response regression lines, that of the active agent alone and that of the active agent plus glucosamine, permitted statistical testing (ANOVA) to distinguish between synergism and simple additivity based on the positions of the lines. Additively, the ED50 values, before and after the addition of glucosamine, were compared from the t distribution. Where differences between the proportions for two groups were needed, the χ2 distribution (with Yates correction) was used. The significance level in all tests was taken to be p < 0.05. The term “additive” effect is unambiguous and based entirely on the potencies of two drugs even when one of them lacks efficacy. In this case, there is no mathematical definition of the potency of the latter drug as infinite and all of the mathematics and statistics apply as they do to two active drugs. The use of additive in this kind of situation is well established. Details of the calculations are described by Tallarida (2000), and all calculations were carried out with the assistance of the program package PharmTool Pro (The McCary Group, Elkins Park, PA).

Measurement of Ibuprofen Plasma Levels. Twelve groups of five mice received by gavage the ED50 dose of ibuprofen (26.1 mg/kg) as the sole agent or two different fixed ratio combinations (1:2 and 1:9) with glucosamine administered at the same time. At either 30, 60, 90, or 120 min later, each animal was lightly anesthetized with pentobarbital sodium (0.1–0.2 ml s.c.), and blood was drawn into a heparinized syringe by direct heart puncture. Each of the five mice in each group received 0.2 ml of blood to a pooled total of 1 ml of blood per group. Blood levels of ibuprofen were quantitated using high-performance liquid chromatography with UV detection by National Medical Services (Willow Grove, PA).

Results

Ibuprofen and Glucosamine

Ibuprofen was administered in seven doses as the sole agent and exhibited significant and marked dose dependence with ED50 = 26.1 ± 3.4 mg/kg p.o. (Table 1). In contrast, glucosamine sulfate, in doses up to 500 mg/kg, produced no effect, i.e., no animals from at least 10 tested at each dose were protected from a behavioral response indicative of nociception. Combinations consisting of glucosamine and ibuprofen would therefore be expected to yield a dose-response relation theoretically identical to that of the active agent alone. When the combination of glucosamine and ibuprofen in a 9:1 ratio was tested the combination also exhibited significant dose dependence and a pronounced potency enhancement as indicated by the reduced ED50 of 11.0 ± 2.1 (Table 1). Figure 1 illustrates the probit regression lines for ibuprofen alone and for this combination. The combination...
Antinociception was measured 30 min after dosing and is expressed according to antinociception = (number of nonresponders)/(number in group). The ED$_{50}$ (±95% confidence interval) was determined from probit regression analysis.

### Table 1

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Antinociception</th>
<th>ED$_{50}$ (mg/kg, p.o.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ibuprofen (alone)</td>
<td>1/10</td>
<td>6.5 with Yates correction</td>
</tr>
<tr>
<td>10.0</td>
<td>1/10</td>
<td>6.1 ± 3.4</td>
</tr>
<tr>
<td>13.9</td>
<td>1/10</td>
<td></td>
</tr>
<tr>
<td>20.0</td>
<td>4/10</td>
<td></td>
</tr>
<tr>
<td>27.8</td>
<td>6/10</td>
<td>26.1 ± 3.4</td>
</tr>
<tr>
<td>30.0</td>
<td>6/10</td>
<td></td>
</tr>
<tr>
<td>41.7</td>
<td>8/10</td>
<td></td>
</tr>
<tr>
<td>100</td>
<td>9/10</td>
<td></td>
</tr>
<tr>
<td>Glu/Ibu (9:1)</td>
<td>31.2/3.5</td>
<td>2/10</td>
</tr>
<tr>
<td>62.5/7.0</td>
<td>4/10</td>
<td></td>
</tr>
<tr>
<td>93.7/10.4</td>
<td>4/10</td>
<td>11.0 ± 2.1*</td>
</tr>
<tr>
<td>125/13.9</td>
<td>5/10</td>
<td></td>
</tr>
<tr>
<td>154/18.0 (8:6:1)</td>
<td>6/10</td>
<td></td>
</tr>
<tr>
<td>250/27.8</td>
<td>17/20</td>
<td></td>
</tr>
</tbody>
</table>

* Significantly different from ibuprofen alone (p < 0.01, ANOVA).

### Table 2

<table>
<thead>
<tr>
<th>Group</th>
<th>Glu</th>
<th>Ibuprofen</th>
<th>Ratio</th>
<th>Antinociception</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>13.1</td>
<td>26.1</td>
<td>0.5:1</td>
<td>5/10</td>
</tr>
<tr>
<td>B</td>
<td>26.1</td>
<td>26.1</td>
<td>1:1</td>
<td>5/10</td>
</tr>
<tr>
<td>C</td>
<td>52.2</td>
<td>26.1</td>
<td>2:1</td>
<td>5/10</td>
</tr>
<tr>
<td>D</td>
<td>131</td>
<td>26.1</td>
<td>5:1</td>
<td>5/10</td>
</tr>
<tr>
<td>E</td>
<td>250</td>
<td>27.8</td>
<td>9:1</td>
<td>10/20</td>
</tr>
<tr>
<td>F</td>
<td>500</td>
<td>26.1</td>
<td>19:1</td>
<td>5/10</td>
</tr>
</tbody>
</table>

* Significantly different from A and B combined (p < 0.01, χ$^2$ with Yates correction).

**Tests with other NSAIDs**

**Ketoprofen.** Table 3 shows the data obtained from tests with ketoprofen, alone and in a combination of glucosamine sulfate, to ketoprofen of 2.63:1 by weight. Probit regression revealed a highly significant difference in the two regressions, with ED$_{50}$ values of 94.8 ± 30.0 mg/kg for ketoprofen (alone) and 24.2 ± 11.7 mg/kg for ketoprofen in the combination. Thus, ketoprofen, like ibuprofen, is synergistic with glucosamine in this test of antinociception.

**Indomethacin.** Indomethacin (alone) produced dose-response data as follows: 2.5 mg/kg, 4/10; 5.0 mg/kg, 6/10; and 10.0 mg/kg, 7/10. Probit regression led to ED$_{50}$ = 3.7 mg/kg. When this quantity, 3.7 mg/kg, was combined with 182.5 mg/kg glucosamine, the result was 5/10 protected (graph not shown), which is consistent with simple additivity.

**Diclofenac.** Diclofenac (0.5–5 mg/kg), given alone, gave dose dependence (data not shown) that yielded an ED$_{50}$ = 1.1 mg/kg. When this quantity of diclofenac was administered with 125 mg/kg glucosamine the protection was only 25% (among 20 animals tested). Doubling this combination dose (2.2, 250) produced protection in only 60% (of 10 animals tested). These results are consistent with a simply additive interaction.

**Aspirin.** Aspirin (ASA) alone and ASA in a fixed ratio combination with glucosamine were also tested. Doses of ASA (milligrams per kilogram) were 50, 100, 150, and 200. In combination ratios. To conduct these tests efficiently, we used a fixed quantity of ibuprofen equal to its ED$_{50}$ value (26.1 mg/kg) along with six different quantities of glucosamine sulfate. As seen in Table 2, of the six different combinations, two (denoted A and B) produced the expected (additive) response of 50%, whereas each of groups C to F exhibited responses greater than 50%. It is notable that the two additive responses occurred with the lowest proportions of glucosamine (groups A and B). When A and B were combined and C to F combined, these two groupings lead to response proportions 10/20 and 43/50, respectively. The difference between these proportions is highly significant (p < 0.01 from χ$^2$ with Yates correction; Tallarida, 2000). It seems that increasing the dose of glucosamine greater than 52.2 mg/kg did not further increase the antinociceptive effect, possibly suggesting a threshold effect. However, our experiments used a fixed ratio because synergism is most often a property of the two chemicals and the ratio of these and because the use of fixed ratio provides the design needed in a rigorous statistical analysis of results. It follows from the results that combinations containing Glu/Ibu greater than 1:1 are synergistic in this antinociceptive test.
the combination experiment, the respective doses of glucosamine added to ASA were 125, 250, 375, and 500 mg/kg so that the ratio, ASA/Glu, was maintained at 1.0:2.5. As seen in Fig. 2, ASA alone exhibited a clear dose dependence with an ED$_{50}$ = 109.2 mg/kg. In the combination experiment, the efficacy of ASA was reduced to approximately 20% and was essentially flat over the dose range tested, indicating a pronounced antagonism. Because glucosamine, in doses up to 500 mg/kg, is devoid of antinociceptive activity in this test it is expected that an additive combination should produce theoretically coincident dose-response lines. The severe depression of the combination line that occurred was significantly below the ASA dose-response line, and thus no estimate of ED$_{50}$ was possible for this combination. These results represent a marked subadditivity, i.e., antagonism by glucosamine of the antinociceptive action of piroxicam.

**Acetaminophen.** The results of experiments with acetaminophen, alone and in combination with different fixed ratios of glucosamine, are shown in Fig. 3. It is seen that acetaminophen (APAP) alone shows significant dose dependence with an ED$_{50}$ = 146.1 ± 21.4 mg/kg. The addition of glucosamine, in all fixed ratio combinations tested, diminished the APAP response. When the APAP/Glu ratio was 4:1, the diminution in response was evident from the downwardly translated dose-response line. When the APAP proportion of the combination was further reduced (1:1 and 1:4, as shown in Fig. 3), the antinociception was virtually abolished. These results show that glucosamine strongly antagonizes the antinociceptive activity of acetaminophen in this test.

**Plasma Levels of Ibuprofen.** A blood sample (0.2 ml) was obtained from each mouse and pooled with the four others in its group (1.0 ml total) at 30, 60, 90, and 120 min after oral administration of the ED$_{50}$ dose of ibuprofen as the sole agent, and in two different fixed ratio combinations (2:1 and 9:1) with glucosamine administered at the same time. The plasma level of ibuprofen at each time point was essentially unaffected by coadministration with glucosamine (Fig. 4). The plasma level of ibuprofen rose rapidly after administration to 35 to 40 µg/ml at 30 min and then progressively declined with no significant difference with or without glucosamine (2:1 or 9:1 fixed ratio) over the subsequent 100 min.
Fig. 4. Blood concentration of ibuprofen in mice at four times after administration of its ED$_{50}$ dose (26.1 mg/kg p.o) as the sole agent (open circles) and in two different fixed ratio combinations of 2:1 (filled squares) and 9:1 (filled circles) with glucosamine administered at the same time. Each point (ibuprofen concentration value) is from a sample containing 1.0 ml of blood obtained by pooling 0.2 ml from each of five animals sacrificed at the indicated time after oral dosing.

**Discussion**

The pain that is commonly associated with damaged tissue that accompanies arthritis, sports injuries, and other conditions often originates from multiple sources and can involve multiple “types.” For example, in the case of osteoarthritis of a joint, potential sources of pain include the synovial membrane, joint capsule, periarticular ligaments or muscle, periosteum, and subchondral bone (Brandt and Slemenda, 1993). It also involves multiple types, both inflammatory and non-inflammatory, and the signal is transmitted via multiple pain transmission pathways (such as A$\delta$- and C-fiber primary afferents). Because of the multifaceted nature of this type of pain, treatment can often benefit from, or necessitate, a combination of mechanistic approaches. Combining analgesic agents to achieve this goal is a rational therapy for pain (Raffa, 2001). The potential benefits of analgesic combinations are straightforward, such as the opportunity for better patient compliance, enhanced efficacy, or efficacy against a broader spectrum of pain types. Combinations also provide the potential for a reduction of unwanted effects. Combination analgesic therapy has been recommended as part of a comprehensive pain management paradigm by the World Health Organization (Schug et al., 1990), the American Pain Society (1999), and the American College of Rheumatology Subcommittee on Osteoarthritis (2000).

Although the potential advantages of combinations are well known, actual evidence of synergy (anticipociceptive or analgesia statistically greater than the expected additivity) have rarely been documented. An exception is the recently approved combination of tramadol with acetaminophen (Tallarida and Raffa, 1996). Part of the problem has been the relative lack of methodology to test for synergy with efficiency or with any degree of statistical rigor. With new methodology (Tallarida, 1992; Tallarida et al., 1997a,b, 1999) this has been resolved to a great extent (Tallarida, 2000). The analysis covers the condition in which one agent does not demonstrate antinociceptive activity when administered as the sole agent, such as glucosamine in the present situation.

Each of the NSAIDs tested in the present study (diclofenac, ibuprofen, indomethacin, ketoprofen, piroxicam, and naproxen) and acetaminophen induced antinociception in the mouse abdominal irritant test. Glucosamine sulfate was inactive up to the highest dose tested (500 mg/kg). Fixed ratio combinations of glucosamine with the NSAIDs and acetaminophen were evaluated for an additive effect (i.e., the same as the analgesic administered as the sole agent) or an effect suggestive of an interaction.

The significant antinociceptive synergism that was elicited by fixed ratio combinations of glucosamine + ibuprofen and glucosamine + ketoprofen stand in stark contrast to the additive or subadditive interactions produced by combinations of glucosamine with the other analgesics tested. Moreover, the synergism was shown to depend strongly on the proportions of the agents in the combination, thereby emphasizing that a synergistic interaction is not merely a property of the constituents; it also depends on their relative concentrations. Whereas the chief mechanistic characteristic shared by the NSAID group is inhibition of prostaglandin biosynthesis, there are other mechanisms associated with the individual agents to varying degrees. Each agent has its own pharmacodynamic and pharmacokinetic characteristics. The most obvious attribute that distinguishes ibuprofen and ketoprofen from the other analgesics from the other analyses was that each is a propionic acid derivative ($\alpha$-methyl-4-(2-methylpropyl)benzeneacetic acid and 3-benzoyl-$\alpha$-methyl-benzeneacetic acid, respectively). However, the other propionic acid derivative naproxen ([(S)-6-methoxy-$\alpha$-methyl-2-naphthalenecarboxylic acid], did not synergize with glucosamine (at least at the ratios tested). Indomethacin, which is an indole acetic acid derivative [1-(4-chlorobenzoyl)-5-methoxy-2-methyl-1H-indole-3-acetic acid]; diclofenac, which is a phenylacetic acid derivative [2-[2,6-dichlorophenyl]amino]benzeneacetic acid]; and piroxicam, which is an enolic acid [4-hydroxy-2-methyl-N-2-pyridinyl-2H-1,2-benzothiazine-3-carboxamide], exhibited only additive antinociception with glucosamine. The salicylic acid derivative aspirin [2-(acetyloxy)benzoic acid] and the non-NSAID $p$-aminophenyl derivative acetaminophen [N-(4-hydroxyphenyl)acetamide] demonstrated subadditive effects with glucosamine. Hence, a simple chemical structure-based classification of synergy is not possible at present. Likewise, although the doses of glucosamine that affected the analgesics fell within a relatively narrow range despite the variation in ED$_{50}$ values, it is difficult to relate this to mechanism because the outcomes were different (synergistic with two analgesics, additive with four analgesics, and subadditive with the two other analgesics).

The widespread usage of ibuprofen guided its selection for our more detailed study. Toward that end, our initial focus was on pharmacokinetics, i.e., does the presence of glucosamine significantly alter (increase) the concentration of ibuprofen in the blood and is that the reason for the potency enhancement. That experiment (Fig. 4) showed virtual identical blood concentration-time relations for the two cases, negating a pharmacokinetic explanation. That finding prompted additional experiments designed to illuminate the mechanism of this drug interaction. In that regard, we conducted experiments involving combinations of glucosamine with each of the enantiomers of ibuprofen as a basis for comparing these with the combination containing racemic (standard) ibuprofen. The results of pilot experiments were...
suggestive of synergy between glucosamine and each of the R-(-) and S-(+) enantiomers of ibuprofen. These are viewed as preliminary experiments and no statistical significance is attached to these data at this time. Our studies of the enantiomers are, instead, first steps aimed at elucidating the mechanism(s) underlying racemic ibuprofen’s synergism with glucosamine. It is interesting to note, however, that both of the enantiomers of ibuprofen were active in the mouse abdominal irritant test and that the R-(-) enantiomer was more potent than the S-(+) enantiomer (ED_{50} = 18.5 and 48.7 mg/kg p.o., respectively). The enantiomers of ibuprofen differ in terms of their pharmacological properties. For example, at clinically relevant concentrations, the S-(+) enantiomer of ibuprofen inhibits cyclooxygenase (COX), whereas the R-(-)-enantiomer is not a COX inhibitor (Evans, 2001). The antinociceptive potency demonstrated by the R-(-)-enantiomer, and its possible synergism with glucosamine, further suggest that the synergy is via some mechanism other than COX inhibition. This might partly explain glucosamine’s synergy obtained with ibuprofen (and ketoprofen), and lack of synergy with the other analgesic compounds we tested. Future studies of mechanism, already begun, are examining the enantiomers in more detail, including the “metabolic inversion” of R-(-)-ibuprofen to S-(+) ibuprofen (Evans, 2001), as well as a detailed study of ibuprofen pharmacokinetics in synovial fluid.

Acknowledgments

We thank Dennis Stone and Saadet Inan for technical assistance and Dr. Antonio M. Goncalves for constructive suggestions.

References


Collier HOJ, Dinneen LC, Johnson CA, and Schneider C (1968) The abdominal irritant test and that the S-(+)-ibuprofen inhibits cyclooxygenase (COX), whereas the R-(-)-enantiomer is not a COX inhibitor (Evans, 2001). The antinociceptive potency demonstrated by the R-(-)-enantiomer, and its possible synergism with glucosamine, further suggest that the synergy is via some mechanism other than COX inhibition. This might partly explain glucosamine’s synergy obtained with ibuprofen (and ketoprofen), and lack of synergy with the other analgesic compounds we tested. Future studies of mechanism, already begun, are examining the enantiomers in more detail, including the “metabolic inversion” of R-(-)-ibuprofen to S-(+) ibuprofen (Evans, 2001), as well as a detailed study of ibuprofen pharmacokinetics in synovial fluid.

Acknowledgments

We thank Dennis Stone and Saadet Inan for technical assistance and Dr. Antonio M. Goncalves for constructive suggestions.

References


Collier HOJ, Dinneen LC, Johnson CA, and Schneider C (1968) The abdominal irritant test and that the S-(+)-ibuprofen inhibits cyclooxygenase (COX), whereas the R-(-)-enantiomer is not a COX inhibitor (Evans, 2001). The antinociceptive potency demonstrated by the R-(-)-enantiomer, and its possible synergism with glucosamine, further suggest that the synergy is via some mechanism other than COX inhibition. This might partly explain glucosamine’s synergy obtained with ibuprofen (and ketoprofen), and lack of synergy with the other analgesic compounds we tested. Future studies of mechanism, already begun, are examining the enantiomers in more detail, including the “metabolic inversion” of R-(-)-ibuprofen to S-(+) ibuprofen (Evans, 2001), as well as a detailed study of ibuprofen pharmacokinetics in synovial fluid.

Acknowledgments

We thank Dennis Stone and Saadet Inan for technical assistance and Dr. Antonio M. Goncalves for constructive suggestions.

References


Address correspondence to: Dr. Ronald J. Tallarida, Department of Pharmacology, Temple University School of Medicine, 3420 N. Broad St., Philadelphia, PA 19140-5104. E-mail: ronald.tallarida@temple.edu