Pulmonary pharmacokinetics of desfuroylceftiofur acetamide after nebulisation or intramuscular administration of ceftiofur sodium to weanling foals

L. FULTZ, S. GIGUÈRE*, L. J. BERGHAUS, G. S. GROVER† and D. A. MERRITT†

Department of Large Animal Medicine, College of Veterinary Medicine, University of Georgia, Athens, USA
*Metabolism and Safety, Zoetis, Kalamazoo, Michigan, USA.

*Correspondence email: gigueres@uga.edu; Received: 23.03.14; Accepted: 20.06.14

Summary

Reasons for performing study: Administration of ceftiofur sodium via nebulisation has been recommended for the treatment of bronchopneumonia in horses, despite the lack of pharmacokinetic and safety data.

Objectives: To compare concentrations of desfuroylceftiofur acetamide (DCA) in plasma and pulmonary epithelial lining fluid (PELF) of foals after nebulisation or i.m. administration of ceftiofur sodium and to determine if nebulisation of ceftiofur sodium induces airway inflammation.

Study design: Randomised experimental study.

Methods: Six weanling foals received ceftiofur sodium (2.2 mg/kg bwt daily for 5 doses) by the i.m. route and 6 foals received the same dose by nebulisation. Concentrations of DCA in plasma and PELF were measured after Doses 1 and 5, and differential cell counts were performed on bronchoalveolar lavage samples obtained after Dose 5.

Results: Foals receiving ceftiofur sodium via nebulisation had significantly lower peak concentrations (0.15 ± 0.12 vs. 6.15 ± 0.75 mg/l) and area under the curve (1.26 ± 0.96 vs. 37.63 ± 4.01 mg·h/ml) in plasma compared with those receiving the drug by the i.m. route. In contrast, foals receiving ceftiofur sodium via nebulisation had significantly higher peak concentrations (4.52 ± 2.91 vs. 0.73 ± 0.73 mg/l) and area under the curve (24.14 ± 14.09 vs. 5.91 ± 3.28 mg·h/ml) in PELF compared with those receiving the drug by the i.m. route. Cell concentration and differential cell count in bronchoalveolar lavage fluid of foals nebulised with ceftiofur sodium were not significantly different from those of foals nebulised with saline.

Conclusions: Administration of ceftiofur sodium via nebulisation is well tolerated and DCA concentrations in PELF remain below the minimum inhibitory concentration of the drug required to inhibit the growth of 90% of Streptococcus zooepidemicus for approximately 24 h after administration. Nebulised ceftiofur sodium warrants further investigation for the treatment of bacterial infections of the lower respiratory tract in horses.

Introduction

Pneumonia is the leading cause of morbidity and mortality in foals in the USA [1]. The mortality rate has been estimated to be about 6% across the USA [1]. It is likely, however, that the true incidence of infection is much higher and that many cases of infection go unrecognised. Indeed, careful weekly physical examination of more than 200 Thoroughbred foals on 10 farms demonstrated an average morbidity from bacterial infection of the distal respiratory tract of 82% [2]. Streptococcus equi ssp. zooepidemicus (S. zooepidemicus) is by far the most common bacterial pathogen isolated from pneumonia in older foals [3]. A variety of other bacterial pathogens such as Rhodococcus equi, Klebsiella spp., Escherichia coli, Pasteurella spp., Bordetella bronchiseptica and Actinobacillus spp. may be isolated as primary pathogens, or may occur in association with S. zooepidemicus [3].

Ceftiofur sodium is a third-generation cephalosporin approved for the treatment of lower respiratory tract infections caused by susceptible strains of S. zooepidemicus in horses. Once administered parenterally, ceftiofur is rapidly metabolised into desfuroylceftiofur [4]. The in vitro activity of desfuroylceftiofur against common Gram-negative pathogens and streptococci is almost identical to that of ceftiofur [5]. With the exception of R. equi, ceftiofur exerts good in vitro activity against all the pathogens associated with pneumonia in foals [6]. The outcome of respiratory tract infection is more closely associated with antimicrobial drug concentrations in the airways than with concentrations in serum [7]. Measurement of drug concentration in pulmonary epithelial lining fluid (PELF) is a widely used method to estimate antimicrobial concentrations at the site of infection for antimicrobials intended to treat lower respiratory tract infections caused by extracellular pathogens [8]. Nebulisation of antimicrobial agents has been proposed as a method to increase drug concentrations in the lungs while minimising systemic concentrations and potential toxicity. In calves inoculated intrabronchially with Mannheimia haemolytica, nebulised ceftiofur sodium was more effective at preventing mortality than i.m. administration of the same drug [9].

As a basis for this study, we hypothesised that nebulised ceftiofur sodium would achieve higher concentrations of desfuroylceftiofur acetamide (DCA) in PELF than i.m. administration. The objectives of this study were to determine and compare concentrations of DCA in plasma and PELF of foals after nebulisation or i.m. administration of ceftiofur sodium and to determine if nebulisation of ceftiofur sodium induces airway inflammation in weanling foals.

Materials and methods

Animals and experimental design

Twelve healthy weanling foals aged 4–6 months, ranging in weight from 163–257 kg were used in the study. Foals were considered healthy on the basis of a thorough physical examination, complete blood count, and biochemical profile. The animals were housed in individual stalls during periods of sample collection and in a group paddock for the remainder of the study. Ceftiofur sodium (Naxcel Sterile Suspension)a was reconstituted in sterile water to a concentration of 50 g/l and administered within 24 h of reconstitution at a dose of 2.2 mg/kg bwt once a day for 5 days (5 doses) to all foals. Foals were randomly assigned to one of 2 treatment groups. Six foals were administered ceftiofur sodium by nebulisation using a commercially available mask and nebuliser specifically designed for use in foals (Flexineb)b. The same 6 foals received the same volume of saline by other 6 foals received ceftiofur sodium by i.m. injection in the neck muscles reconstitution at a dose of 2.2 mg/kg bwt once a day for 5 days (5 doses) to all foals. Foals were randomly assigned to one of 2 treatment groups. Six foals were administered ceftiofur sodium by nebulisation using a commercially available mask and nebuliser specifically designed for use in foals (Flexineb)b. The same 6 foals received the same volume of saline by i.m. injection in the neck muscles using a 2.5 cm 20 gauge needle. The other 6 foals received ceftiofur sodium by i.m. injection in the neck muscles and were nebulised with the same volume of 0.9% NaCl. Particle size of nebulised ceftiofur sodium was verified using laser diffraction (Spraytec)c. Blood samples were obtained from a catheter placed in a jugular vein at 0, 15, 30, 60 and 90 min, and 2, 3, 4, 6, 8, 12 and 24 h after administration of the first and last dose of the drug and placed in 8 ml collection tubes containing EDTA. Blood samples were centrifuged at 500 × g for 10 min
and plasma was stored at -80°C until assayed. Bronchoalveolar (BAL) fluid was collected at 2, 8 and 24 h after administration of the last dose of the drug.

**Bronchoalveolar lavage**

Foals were sedated by i.v. administration of xylazine hydrochloride (0.5 mg/kg bw) and butorphanol tartrate (0.04 mg/kg bw) prior to BAL fluid collection. A 10 mm diameter, 2.4 mm BAL catheter was passed via nasal approach until wedged into a bronchus. The lavage solution consisted of 4 aliquots of 60 ml physiological saline (0.9% NaCl) solution infused and aspirated immediately. The volume of BAL fluid was measured using a graduated cylinder. The BAL fluid was centrifuged at 200 × g for 10 min and supernatant fluid was frozen at -80°C until assayed.

Total nucleated cell count in BAL fluid was determined from an aliquot of the sample obtained 2 h after the fifth dose of ceftiofur sodium by use of an automated cell counter (Cellometer Auto T4)®. The remainder of the aliquot was cytocentrifuged (Shandon Cytospin) for 2 min onto a microscope slide for cytological examination. Preparations were stained with a Diff-Quick kit according to the manufacturer’s directions and a manual differential count of 200 cells was performed.

**Concentration of DCA**

Samples were analysed for concentrations of ceftiofur, desfuroylceftiofur and related metabolites by reduction and derivatisation to DCA using a validated ultrahigh pressure liquid chromatography tandem mass spectrometry detection assay performed as described previously [10]. The lower limits of quantification of the assay were 0.01 mg/l for plasma and 0.0002 mg/l for BAL fluid supernatant, respectively. Intrarun bias of standards, including samples at the lower limit of quantification, ranged from 7.7 to 10.1%. The inter-run coefficient of variation ranged from 1.6 to 9.1%.

**Calculation of desfuroylceftiofur acetamide concentrations in PELF**

Estimation of the volume of PELF was determined by urea dilution method [11]. Urea nitrogen concentrations in BAL fluid (UreaBAL) and concurrent plasma samples (UreaPLASMA) were determined by use of a commercial quantitative colorimetric kit®. The volume of PELF (VPELF) in BAL fluid was derived from the following equation: 

\[ V_{PELF} = V_{BAL} \times \left( \frac{\text{UreaBAL}}{\text{UreaPLASMA}} \right) \]

where V_{BAL} is the volume of recovered BAL fluid. The concentration of DCA in PELF (DCABAL) was derived from the following relationship: 

\[ \text{DCABAL} = \text{DCAC} \times \left( \frac{V_{PELF}}{V_{BAL}} \right) \]

where DCAC is the measured concentration of DCA in BAL fluid supernatant.

**Pharmacokinetic analysis**

For each foal, plasma and PELF concentration vs. time data were analysed based on noncompartmental pharmacokinetics using computer software (PK Solutions 2.0). The rate constant of the terminal phase (\( \lambda_z \)) was determined by linear regression of the logarithmic plasma concentration vs. time curve using a minimum of 3 data points. Half-life of the terminal phase (t_{1/2}) was calculated as In 2/\( \lambda_z \). The area under the concentration-time curve (AUC) was calculated using the trapezoidal rule, with extrapolation to infinity using C_{\text{max}}/\lambda_z, where C_{\text{max}} is the final measurable DCA concentration. Mean residence time (MRT) was calculated as: 

\[ \text{MRT} = \frac{\text{AUMC}}{C_{\text{max}}} \]

where AUMC is the area under the first moment of the concentration-time curve. Systemic bioavailability of nebulised ceftiofur sodium relative to i.m. was calculated as: 

\[ \text{F_{neb}} = \frac{C_{\text{max}} \times \text{AUC}_{\text{i.m.}}}{C_{\text{max}} \times \text{AUC}_{\text{neb}}} \]

and expressed as the ratio of the area under the curve (AUC) for the i.m. route to the nebulised route. The accumulation factor in plasma after administration of 5 doses of ceftiofur sodium was 1.74 ± 0.24 for i.m. administration and 2.27 ± 1.78 for nebulisation. Terminal half-life, maximum concentration of DCA (C_{\text{max}}, C_{\text{min}}), AUC and MRT were significantly higher after Dose 5 than after Dose 1 (Table 1). In contrast, time to maximum concentration was significantly shorter after Dose 5 than after Dose 1. Foals that received ceftiofur sodium via nebulisation had significantly lower plasma C_{\text{max}}, C_{\text{min}} and AUC compared with those administered the drug by the i.m. route (Table 1). In contrast, MRT was significantly longer for the nebulised route (Table 1). The systemic bioavailability of nebulised ceftiofur sodium relative to i.m. administration was 2.7 ± 1.8%. Nebulisation resulted in plasma DCA concentrations below the minimum inhibitory concentration (MIC) required to inhibit the growth of 90% of organisms (MIC_{90}) of the drug against S. zooepidemicus (0.12 mg/l) for most of the dosing interval (Fig 1).

Quantifiable DCA concentrations were present in PELF at all sampled time points after both i.m. administration and nebulisation of ceftiofur sodium. Compared with the administration of ceftiofur sodium via the i.m. route, nebulisation of the drug resulted in significantly higher PELF concentrations and AUC (Table 2). In contrast, terminal half-life and MRT in PELF were significantly shorter after nebulisation than after i.m. administration (Table 2). Average concentrations of DCA in PELF were higher after nebulisation than after i.m. administration and above the MIC_{90} of the drug against S. zooepidemicus for 24 h after administration by nebulisation (Fig 2). Cell concentration and differential cell count of foals nebulised with ceftiofur sodium were not significantly different from those of foals administered ceftiofur sodium i.m. and nebulised with 0.9% NaCl (Table 3).

**Discussion**

The optimal dosing of an antimicrobial agent is determined by both the pharmacokinetics and pharmacodynamics of the drug. Currently, most pharmacokinetic/pharmacodynamic models rely on plasma concentrations and MIC. The most important factor determining the efficacy of β-lactam antimicrobials such as ceftiofur is the duration that plasma concentrations of the drug exceed the MIC of a given pathogen [12,13]. However, only the free (unbound) fraction of the drug in interstitial fluids at the target site is responsible for therapeutic success. Free desfuroylceftiofur accounts for only about 10% of the total desfuroylceftiofur-related metabolites found in plasma obtained from mature cattle. However, protein binding of desfuroylceftiofur is reversible and protein bound desfuroylceftiofur acts as a reservoir for release of active drug at the site of infection [14]. This phenomenon may explain the apparent discrepancy between documented clinical efficacy of ceftiofur after once a day dosing in cattle and pharmacokinetic evaluation based on microbiological assay, which suggests rapid disappearance of the drug. The discrepancy is resolved if efficacy is compared with measurement of DCA regardless of protein binding. In the latter case, plasma concentrations remain above the MIC_{90} for the entire dosing interval.
consistent with clinical efficacy arising from once daily dosing [15]. Hence, measurement of DCA is preferred for dose optimisation based on the pharmacokinetic/pharmacodynamic relationship.

Because most infections occur in tissues rather than in plasma, the ability of antimicrobial agents to reach the target site is a key determinant of clinical outcome [13]. For pulmonary infections caused by extracellular bacteria such as Strep. zooepidemicus, concentrations of antimicrobial agents in the extracellular or interstitial space within the lungs would provide additional relevant information. While it is common practice to measure drug concentration in tissue homogenates, the homogenisation procedure disrupts cell membranes and produces a suspension containing both intracellular and extracellular components [16]. This typically results in unreliable estimation of antimicrobial drug concentrations in the extracellular environment [16,17]. Measurement of drug concentration in PELF collected by BAL is the most widely used method to estimate antimicrobial concentrations at the site of infection for antimicrobial agents intended to treat lower respiratory tract infections caused by extracellular bacterial pathogens in people [8,18]. Damage to cells during BAL collection or processing may lead to drug leakage from the cells and overestimation of true PELF concentration for drugs that concentrate intracellularly [18]. This is unlikely to have

**TABLE 1: Pharmacokinetic variables (mean ± s.d. unless otherwise specified) for desfuroylceftiofur acetamide (DCA) in the plasma of foals after administration of the first and fifth dose of ceftiofur sodium (2.2 mg/kg bwt) by the i.m. (n = 6) or nebulised route (n = 6)**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Dose</th>
<th>Route</th>
<th>Route</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>λₚ (1/h)</strong></td>
<td>1</td>
<td>0.097 ± 0.005⁷</td>
<td>0.091 ± 0.026¹</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>0.077 ± 0.007²</td>
<td>0.064 ± 0.014²</td>
<td>0.4</td>
</tr>
<tr>
<td>tₑ₂₅₀ (h)</td>
<td>1</td>
<td>7.2 ± 0.365⁶</td>
<td>8.1 ± 2.0¹</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>9.0 ± 0.8⁷</td>
<td>11.3 ± 2.6¹</td>
<td>0.2</td>
</tr>
<tr>
<td>Cₘₚ (mg/l)</td>
<td>1</td>
<td>4.49 ± 0.68⁷</td>
<td>0.08 ± 0.05¹</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>6.15 ± 0.75⁶</td>
<td>0.15 ± 0.12³</td>
<td>0.08</td>
</tr>
<tr>
<td>Cₘₚ (mg/l)</td>
<td>1</td>
<td>0.23 ± 0.03⁵</td>
<td>&lt;0.01 (&lt;0.01–0.02)⁷</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>0.40 ± 0.04⁷</td>
<td>0.02 ± 0.01²</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Tₘₚ (h)*</td>
<td>1</td>
<td>1.25 (1.0–2.0)²</td>
<td>1.5 (1.0–8.0)¹</td>
<td>0.009</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>1.0 (1.0–1.5)²</td>
<td>0.75 (0.25–1.0)²</td>
<td>0.07</td>
</tr>
<tr>
<td>MRT (h)</td>
<td>1</td>
<td>8.2 ± 0.4¹</td>
<td>11.2 ± 3.0¹</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>10.2 ± 0.8²</td>
<td>14.7 ± 3.6²</td>
<td>0.2</td>
</tr>
<tr>
<td>AUC₂₄ₙ (mg•h/l)</td>
<td>1</td>
<td>29.3 ± 3.14⁴</td>
<td>0.64 ± 0.52¹</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>37.6 ± 4.01²</td>
<td>1.26 ± 0.96²</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>AUC₂₄ₙ (mg•h/l)</td>
<td>1</td>
<td>71.70 ± 3.38⁴</td>
<td>0.82 ± 0.55¹</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>42.85 ± 4.10²</td>
<td>1.56 ± 1.03³</td>
<td>0.2</td>
</tr>
</tbody>
</table>

*Median and range. λₚ = rate constant of the terminal phase; tₑ₂₅₀ = half-life of the terminal phase; Cₘₚ = maximum concentration of DCA; Cₘₚ = minimum concentration of DCA; Tₘₚ = time to maximum concentration; MRT = mean residence time; AUC₂₄ₙ = area under the concentration vs. time curve from time 0 to the last quantifiable time point. AUC₂₄ₙ = area under the concentration vs. time curve extrapolated to infinity. **Different superscript letters within a given row indicate significant differences (P<0.05) between i.m. and nebulised for a given dose. †Different superscript numbers within a given column indicate significant differences (P<0.05) between doses (Dose 1 and Dose 5) for a given route of administration.

**TABLE 2: Pharmacokinetic variables (mean ± s.d. unless otherwise specified) for desfuroylceftiofur acetamide (DCA) in the pulmonary epithelial lining fluid (PELF) of foals after administration of ceftiofur sodium (2.2 mg/kg bwt) for 5 days by the i.m. (n = 6) or nebulised route (n = 6)**

<table>
<thead>
<tr>
<th>Variable</th>
<th>i.m.</th>
<th>Nebulised</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>λₚ (1/h)</td>
<td>0.078 ± 0.025</td>
<td>0.135 ± 0.051</td>
<td>0.03</td>
</tr>
<tr>
<td>tₑ₂₅₀ (h)</td>
<td>9.5 ± 2.4</td>
<td>5.8 ± 2.2</td>
<td>0.02</td>
</tr>
<tr>
<td>Cₘₚ (mg/l)</td>
<td>0.73 ± 0.73</td>
<td>4.52 ± 2.91</td>
<td>0.01</td>
</tr>
<tr>
<td>Cₘₚ (mg/l)</td>
<td>0.09 ± 0.02</td>
<td>0.16 ± 0.11</td>
<td>0.2</td>
</tr>
<tr>
<td>Tₘₚ (h)*</td>
<td>2.0 (2.0–2.0)</td>
<td>2.0 (2.0–2.0)</td>
<td>1.0</td>
</tr>
<tr>
<td>MRT (h)</td>
<td>13.4 ± 4.1</td>
<td>7.0 ± 3.7</td>
<td>0.02</td>
</tr>
<tr>
<td>AUC₂₄ₙ (mg•h/l)</td>
<td>5.91 ± 3.28</td>
<td>24.14 ± 14.09</td>
<td>0.009</td>
</tr>
<tr>
<td>AUC₂₄ₙ (mg•h/l)</td>
<td>7.05 ± 3.15</td>
<td>25.75 ± 13.77</td>
<td>0.004</td>
</tr>
</tbody>
</table>

*Median and range. λₚ = rate constant of the terminal phase; tₑ₂₅₀ = half-life of the terminal phase; Cₘₚ = maximum concentration of DCA; Cₘₚ = minimum concentration of DCA; Tₘₚ = time to maximum concentration; MRT = mean residence time; AUC₂₄ₙ = area under the concentration vs. time curve for the first 24 after administration. AUC₂₄ₙ = area under the concentration vs. time curve extrapolated to infinity.

Equine Veterinary Journal •• (2014) ••© 2014 EVJ Ltd
Nebulised ceftiofur sodium in foals

Fig 2: Mean (± s.d.) desfuroyl-ceftiofur acetamide (DCA) concentrations in the pulmonary epithelial lining fluid of foals after administration of 5 doses of ceftiofur sodium (2.2 mg/kg bwt) by the i.m. (n = 6) or nebulised route (n = 6). The dotted horizontal line represents the minimum inhibitory concentration required to inhibit the growth of 90% of Streptococcus equi ssp. zooepidemicus (0.12 mg/l).

Influenced the results of the present study because concentrations of DCA in equine bronchoalveolar cells are negligible and considerably below concentrations measured in PELF [10]. The plasma Cₘ₉₀ obtained after i.m. administration of the first dose of ceftiofur sodium in the present study (4.49 ± 0.68 mg/l) was almost identical to that achieved after administration of the same dose of ceftiofur sodium to mature horses [4.46 ± 0.93 mg/l] [4]. Despite almost identical plasma concentrations, peak DCA concentration of lung tissue homogenate in the aforementioned study (1.40 ± 0.36 mg/l) [4] was considerably higher than peak PELF concentration in this study (0.73 ± 0.73 mg/l), suggesting that DCA concentrations in lung tissue homogenates overestimate PELF concentrations. In the present study, concentrations of DCA in PELF remained above the MIC₉₀ of S. zooepidemicus (0.12 mg/l), Pasteurella spp. (<0.03 mg/l), and Actinobacillus spp. (<0.03 mg/l) [4,19] for most of the 24 h dosing interval regardless of the route of administration. Treatment of infections caused by microorganisms with higher MICs might require more frequent administration. Additional studies will be required to determine the optimal dose and dosing interval of nebulised ceftiofur sodium in horses with bronchopneumonia. Peak concentrations of DCA in PELF achieved after i.m. administration of ceftiofur sodium in this study were slightly higher than those achieved after administration of a single dose of ceftiofur crystalline free acid to weaning foals (0.46 ± 0.03 mg/l) [10].

In healthy horses, nebulisation of 20 ml of the commercially available i.v. gentamicin sulfate solution (diluted to 50 g/l) using an ultrasonic nebuliser resulted in bronchial lavage fluid concentrations approximately 12 times higher than concentrations achieved by i.v. administration at a dose of 6.6 mg/kg bwt [20]. However, the major limitation to the use of aerosolised gentamicin in horses is its lack of activity against S. zooepidemicus, the most common bacterial pathogen of the equine respiratory tract. In the present study, daily administration of ceftiofur sodium via nebulisation resulted in concentrations of DCA in PELF significantly (approximately 6-fold) higher than those obtained after administration by the i.m. route. Maximum concentrations of DCA in PELF were observed 2 h post administration, regardless of the route. However, the accuracy of reported pharmacokinetic variables in PELF was limited by the small number of BAL samples obtained.

Nebulisation of ceftiofur sodium resulted in low systemic bioavailability of DCA with plasma concentrations well below therapeutic levels. Low systemic bioavailability after nebulisation of ceftiofur sodium has also been documented in calves [21]. Therefore, nebulisation of ceftiofur sodium increases the amount of drug that is present within the respiratory secretions while minimising the amount of drug in plasma, thereby decreasing the risk of systemic adverse effects. In an experimental model of Escherichia coli pneumonia in mechanically ventilated piglets, nebulisation of amikacin was found to be more effective than systemic administration and even poorly ventilated and consolidated areas of the lungs contained higher antimicrobial drug concentrations after nebulisation than after i.v. administration [22]. Nevertheless, the administration of antimicrobial agents by inhalation alone may not be sufficient in patients with severe parenchymal involvement or substantial consolidation. In these cases, nebulisation may be more appropriate if used as an adjunct to systemic administration.

Use of systemic formulations of drugs for nebulisation can lead to exposure to potentially irritant substances, toxic additives and inappropriate pH or osmolality ranges. In the present study nebulisation with the formulation of ceftiofur sodium commercially available for systemic use did not result in clinical signs of respiratory disease or airway inflammation as assessed by cytological examination of BAL fluid. The BAL cell concentrations and differential cell counts of foals nebulised with ceftiofur sodium were not significantly different from those of foals nebulised with saline and were within established reference ranges for foals and mature horses [23–25]. Similarly, once daily nebulisation of gentamicin or ceftiofenvme to healthy horses for 5–7 consecutive days did not result in pulmonary inflammation [26,27]. Antimicrobial delivery by inhalation is greatly influenced by the product formulation and type of nebuliser. The pattern of deposition of aerosol particles in the airway is influenced by characteristic of the patients (inspiratory flow, tidal volume, respiratory rate, breathing pattern etc.) and by the size of the aerosol particles. Particles >10 μm are typically filtered in the nose and nasopharynx, particles of 5–10 μm generally reach the larger airways, and particles of 1–5 μm reach the periphery of the lungs [28]. In the current study, approximately 50% of the particles were 1–5 μm with 89.4% of the particles being <10 μm. In one study, the particle size distribution and particle density of gentamicin sulfate and ceftiofur sodium aerosols were affected by the antimicrobial concentration of the solution [29]. Gentamicin concentrations of 50 g/l or ceftiofur concentrations of 25 g/l produced the optimal combinations of particle size and aerosol density when using a medical ultrasonic nebuliser when compared with more concentrated solutions [29]. In the present study, dilution of the ceftiofur sodium concentration to 25 g/l did not improve particle size. Differences between the 2 studies likely relates to the type of nebuliser used. Nebulisation of a 50 g/l solution instead of 25 g/l offers the advantage of decreasing the time of administration in half.

In conclusion, administration of ceftiofur sodium via nebulisation is well tolerated and results in significantly higher drug concentrations in PELF when compared with administration of the same dose by the i.m. route. Nebulised ceftiofur sodium warrants further investigation for the treatment of susceptible bacterial infections of the lower respiratory tract in horses.

Authors’ declaration of interests

G.S. Grover and D.A. Merritt are employees of Zoetis.

Ethical animal research

The study was approved by the Animal Care and Use Committee at the University of Georgia.
Sources of funding
The study was funded by a grant from the Veterinary Comparative Respiratory Society and by Zoetis.

Acknowledgements
The authors would like to thank Gavan O’Sullivan from Nortev Ltd for providing the Flexineb mask and nebuliser as well as Scott Foster, Jessie Davis, Emily Hart, Jacqueline Johnson and Loralei Branch for technical assistance.

Authorship
L. Fultz and S. Giguère were involved in all phases of the study. L.J. Berghaus, G.S. Grover and D.A. Merritt contributed to study execution, data analysis and manuscript preparation.

Manufacturers’ addresses
1Zoetis, Madison, New Jersey, USA.
2Nortev Ltd, Galway, Ireland.
3Malvern Instrument Limited, Malvern, Worcestershire, UK.
4Jorgenson Laboratories, Loveland, Colorado, USA.
5Fisher Scientific, Pittsburg, Pennsylvania, USA.
6Thermo Fisher Pittsburg, Pennsylvania, USA.
7Fisher Scientific, Pittsburg, Pennsylvania, USA.
8Biochain, Hayward, California, USA.
9Summit Research Services, Montrose, Colorado, USA.

References