Use of measurements of ethanol absorption from stomach and intestine to assess human ethanol metabolism

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Claims concerning first-pass gastric metabolism in humans have been based largely on the results of pharmacokinetic studies comparing areas under the curve (AUCs) for blood ethanol. However, the AUC is an accurate indicator of the quantity of a compound reaching the peripheral circulation only when the compound is cleared with first-order (nonsaturating) kinetics. Small doses of alcohol saturate hepatic metabolism, and, in this situation, increases in the amount of ethanol reaching the peripheral circulation produce disproportionate increases in AUC, and faster rates of delivery of identical doses also result in higher AUCs (see Fig. 1). The present lack of precise data on ethanol absorption rates in humans precludes accurate assessment of the site and magnitude of human first-pass metabolism.

The initial goal of the present study was to obtain quantitative data on the rate of ethanol absorption in humans by measuring the rates of gastric emptying and gastric absorption of ethanol administered to subjects with and without food. These absorption data were then used to assess the physiology of ethanol metabolism.

METHODS

Subjects and Meals

Five healthy, nonalcoholic males (21–45 yr of age) took part in this study. After an overnight fast, a nasogastric tube was inserted and one of two meals was instilled into the stomach through the tube. After an interval of 1–2 wk, the other meal was similarly administered. One meal consisted of a standard breakfast: two eggs (fried in butter), two slices of white bread (one tablespoon of butter per slice), two strips of bacon, 120 ml of orange juice, and 360 ml of coffee. This meal was homogenized to form a suspension of ~550 ml. The second meal consisted of 360 ml of water. To each of these meals, we added 500 µCi of 99mTc-DTPA, 5 g of polyethylene glycol 3000 (PEG), 2 µCi of [14C]PEG, and ethanol sufficient to yield a dose of 0.15 g/kg body wt. Gastric instillation of the food-containing meal required ~6 min, and the water meal required ~3 min.

Gastric Emptying Measurements

With the food-containing meal, imaging of 99mTc-DTPA was initiated immediately after instillation of the meal and at 15-min intervals. With the water meal, images were obtained immediately after instillation and at 10-min intervals. Imaging was carried out with the subject in a supine position, using a Siemens 7500 digital gamma camera and a 140 keV ± 10% window. Sixty-second images were processed by an ADAC-PEGasys computer system with a 256 × 256 × 16 matrix. An area of interest was drawn around the stomach on the first image of the series. This area of interest served as the base for subsequent images. The subjects were repositioned for each image so that the stomach was centered in the original area of interest. In successive images, gastric emptying was taken to be proportional to the decrease in counts (decay corrected) within the area of interest. Because appreciable gastric emptying had occurred at the time of the initial scan, emptying during this period was determined from the ratio of the counts in the area of interest to the total counts collected over the entire field. Between gastric emptying measurements, subjects either sat or walked.

Sample Collection

Gastric aspirates were obtained at time 0 and at intervals after ethanol administration. In an attempt to minimize potential errors resulting from poor mixing of gastric con-
Ethanol Absorption to Assess Ethanol Metabolism

Fig. 1. Schematic modeling of the area under the curve (AUC) resulting from intravenous infusion of ethanol at varying doses or rates when metabolism is saturated. The Michaelis constant ($K_m$) for ethanol removal is very low, and metabolism, which is maximum velocity ($V_{max}$) at any appreciable blood concentration, reduces blood concentration by 10 mM/h. Blood concentration curves are shown for bolus infusion of a dose that raises the blood ethanol to 30 mM (A), the same dose infused at a rate of 2/3 over the 1st h and 1/3 over the 2nd h (B), and 1/2 the dose infused as a bolus (C). Note that AUC in A is 2.2 times greater than in B despite administration of identical doses, and 4 times greater than in C although dose difference was only 2-fold. Because ethanol was infused intravenously in these examples, AUC differences are not attributable to first-pass metabolism.

Analyses and Data Presentation

Ethanol concentrations were determined by gas chromatography, as described previously (23). Gastric samples were centrifuged at 4°C for 10 min at 1,000 g. A 0.02-ml aliquot of the supernatant or 0.02 ml of whole blood was added to a gas chromatography (GC) vial containing 0.80 g of NaCl, 0.02 ml of 4.0 mM n-propanol (internal standard), and 0.02 ml of 50 mM sodium azide. The samples were sealed with Teflon-faced septa and heated for 10 min at 55°C in the heating block of the autosampler. Ethanol was then quantified by headspace GC analysis. The following chromatography conditions were used: column (2 mm ID × 2 m), glass packed with Tenax GC, 80–100 mesh (Alltech); column temperature, 110°C; carrier gas, nitrogen; and carrier gas flow rate, 40 ml/min. Blood ethanol values were computed using peak area ratios with $n$-propanol as the internal standard. The concentration of [14C]PEG was determined by scintillation counting (after the $^{99m}$Tc decayed). All results are presented as means ± SE.

Calculations

Gastric emptying and gastric absorption of ethanol. The fraction of the dose of ethanol emptied from the stomach and the fraction absorbed from the stomach over the initial time period ($t_0$–$t_1$) were calculated as follows. The fractional gastric emptying (FE) of the two nonabsorbable, water-soluble radiopharmaceuticals, $^{99m}$Tc-DTPA and [14C]PEG, were assumed to be equal. To the extent that ethanol was absorbed from the stomach, the fraction of the ethanol dose emptied during the period (FE$_{Eth}$) will be less than that of the other two probes as indicated by the fall in the ratio of concentrations of ethanol to [14C]PEG (Eth/PEG). FE$_{Eth}$ was assumed to be proportional to the arithmetic mean [Eth/PEG] during the interval

$$FE_{Eth, t_0–t_1} = FE_{99mTc-DTPA, t_0–t_1} \text{0.5}\left[\frac{\text{Eth/PEG}_{t_0}}{\text{Eth/PEG}_{t_1}}\right]$$

where [Eth] and [PEG] at $t_0$ were assumed to be the concentrations present in the infusate.

The fraction of the ethanol dose not emptied into the duodenum (FNE$_{Eth, t_0–t_1}$) over the time period was calculated as

$$FNE_{Eth, t_0–t_1} = 1 - FE_{Eth, t_0–t_1}$$

The fraction of the ethanol dose actually remaining in the stomach at the end of the time period (FR$_{Eth,t_1}$) was calculated from the fraction of [14C]PEG remaining in the stomach (FR$_{PEG,t_1}$) and the decline in the concentration ratio of ethanol to [14C]PEG ([Eth/PEG])

$$FR_{Eth,t_1} = FR_{PEG,t_1}\left[\frac{\text{Eth/PEG}_{t_0}}{\text{Eth/PEG}_{t_1}}\right]$$

Finally, the fraction of the ethanol absorbed from the stomach over the time period (FA$_{Eth,t_1}$) was calculated from the difference between the fraction that was not emptied into the duodenum and the fraction remaining in the gastric lumen

$$FA_{Eth,t_1} = FNE_{Eth,t_1} - FR_{Eth,t_1}$$

Similar calculations were made for each time period utilizing the values obtained for the fraction of the initial dose of $^{99m}$Tc-DTPA emptied during that time period and the [14C]PEG and ethanol concentrations of the gastric aspirates obtained at the beginning and end of the time period.

Estimation of gastric unstirred layer. The thickness of the unstirred fluid layer through which ethanol diffused to reach the gastric mucosa was estimated from the standard Fick diffusion equation

$$Absorption \ rate = \frac{DA (C_l - C_M)}{\text{unstirred layer thickness}}$$

where absorption rate (from the stomach) was measured, $D$ is the diffusion constant for ethanol, is $1.0 \times 10^{-5}$ cm²/s; $A$ is the surface area of the gastric mucosa; and $C_l$ and $C_M$ are the ethanol concentrations in bulk luminal contents and the mucosa, respectively. $A$ was assumed to be the surface area of a sphere with a volume equal to the volume of the gastric luminal contents. Only moderate alterations of area result from the stomach, which has a somewhat cylindrical, rather than spherical, shape. For example, if the stomach took the form of a cylinder with a length twice its width, the surface area of a 500-ml volume would be only 18% greater than that of a 500-ml sphere. $C_l$ was measured directly, and $C_M$ was calculated as described below.
Estimation of ethanol concentration and metabolism in gastric mucosa. Ethanol concentration in the gastric mucosa was calculated on the assumption that concentrations of ethanol in the mucosa and mucosal blood flow are in near-perfect equilibrium. In this situation, the concentration of ethanol in the mucosa can be estimated for each time period from the observed ethanol absorption from the stomach during that period and a gastric mucosal blood flow of 50 ml/min (estimated from a blood flow of 0.7 ml/min at a gastric mucosal weight of 1 g/kg (12)).

\[
\text{Mucosal [Eth]} = \text{absorption rate/mucosal blood flow} \quad (7)
\]

The above calculation assumed negligible ethanol metabolism in the gastric mucosa; appreciable mucosal metabolism would have reduced these concentrations.

The gastric metabolism of ethanol expected for a given mucosal concentration was calculated for three reported (8, 19, 24) sets of kinetic data for human gastric mucosal alcohol dehydrogenase (ADH). Thuluvath and co-workers (24) reported a Michaelis constant \(K_m\) of 7.8 mM and a maximum velocity \(V_{\text{max}}\) of \(-5 \text{ nmol} \cdot \text{mg protein}^{-1} \cdot \text{min}^{-1}\). The weight of human gastric mucosa averages \(-1 \text{ g/kg body wt and tissue is } \sim 20\%\text{ protein. Thus the entire gastric mucosa contains } \sim 14 \text{ g of protein and would have a } V_{\text{max}} \text{ for ADH of } \sim 4.2 \text{ mmol/h.}\)

Frezza et al. (8) reported that human gastric ADH has a \(K_m\) of \(-500 \text{ mM and an activity of } 2.6 \mu\text{m} \cdot \text{g mucosa}^{-1} \cdot \text{min}^{-1} \) at an ethanol concentration of 500 mM. Assuming Michaelis kinetics, the \(V_{\text{max}}\) would be \(-5.2 \mu\text{m} \cdot \text{g}^{-1} \cdot \text{min}^{-1}\) or \(21 \text{ mmol} \cdot \text{h}^{-1} \cdot 70\) g\(^{-1}\) of gastric mucosa. Moreno and Parés (19) reported that gastric ADH has a \(K_m\) for ethanol of 41 mM and that the entire human gastric mucosa would metabolize \(-20 \mu\text{mol} \cdot \text{min}^{-1} \) at an ethanol concentration of 100 mM. This yields a \(V_{\text{max}}\) of 140 \(\mu\text{mol/h}\) for the entire mucosa. The predicted gastric mucosal metabolism for each of these three sets of kinetic data was then calculated for each time period from the predicted ethanol concentration in the gastric mucosa (\(\text{[Eth}_{\text{muc}}\)) and Michaelis-Menten kinetics.

\[
\text{Ethanol metabolism} = \frac{V_{\text{max}}[\text{Eth}_{\text{muc}}]}{(K_m + [\text{Eth}_{\text{muc}}])} \quad (8)
\]

Predictions of blood ethanol concentrations and first-pass hepatic metabolism of ethanol using a model of human hepatic ethanol metabolism. We have previously described extensively (16) the model employed to predict the metabolism of ethanol by the human liver and the resulting peripheral blood ethanol curves. The model consists of a 1,000 g liver that receives ethanol via the portal vein and hepatic artery, which have blood flows of 1,000 and 500 ml/min, respectively. Hepatic ethanol metabolism is assumed to follow Michaelis-Menten kinetics with a \(V_{\text{max}}\) of 2.75 mmol \cdot \text{min}^{-1} \cdot 80 \text{ kg}^{-1} \) and a \(K_m\) of 0.1 mM, values that we (9) derived from the work of Wilkinson et al. (25). The overall rate of hepatic metabolism of ethanol at any moment is determined from the \(K_m\), the \(V_{\text{max}}\), and the concentration of ethanol that would exist at the hepatic cell, assuming the liver to be a well-mixed pool. To distinguish first-pass metabolism from total metabolism, alcohol arriving at the liver directly from the gastrointestinal tract must be distinguished from that from the recirculation of ethanol that previously escaped first-pass metabolism. First-pass metabolism is defined as the additional ethanol metabolism that occurs due to the higher hepatic ethanol concentration that results from delivery of ethanol directly to the liver from the gut as opposed to the concentration that would result from an intravenous infusion of ethanol. The total system is described by three first-order differential equations that were solved numerically using a fourth-order Runge-Kutta routine with adaptive step size control (21).

RESULTS

Figure 2 shows the data for gastric emptying of the radiopharmaceutical \(\text{\(^{99}\)Tc-DTPA}\) and ethanol, gastric absorption of ethanol, and disappearance of ethanol from the stomach (gastric emptying plus absorption of ethanol) when the alcohol was administered with water. Ethanol disappearance from the stomach was extremely rapid in the fasting state with \(-47\%, 85\%,\) and \(-96\%\) leaving the stomach by 3, 13, and 23 min, respectively. Of the total dose of ethanol, \(-89\%\) left the stomach via emptying into the duodenum and \(-10\%\) was absorbed across the gastric mucosa. Ethanol disappearance from the stomach was appreciably slower when the ethanol was administered with food (see Fig. 3). A sizable fraction \(-23\%\) of the ethanol ingested with a meal was emptied into the duodenum during the \(-6\)-min period elapsing between the initiation of the
instillation of the meal and the first image. Subsequently, of the ethanol remaining in the stomach at any time point, ~10%/15 min was emptied into the duodenum and 6%/15 min was absorbed from the stomach. Ethanol removal from the stomach was nearly complete by 126 min with averages of 66% and 28% being emptied into the duodenum and absorbed from the stomach, respectively.

The blood ethanol curves obtained with the two meals are shown in Fig. 4. The blood ethanol concentration curves confirmed the very rapid gastric emptying of ethanol observed in the period immediately after ethanol administration (Figs. 2 and 3), with peak blood levels occurring within 20 min of the administration of the meals. When administered with water, the peak ethanol level and AUC were, respectively, ~2.5 and 2.8 times greater than when ethanol was administered with food. In addition, Fig. 4 also shows the blood ethanol curves predicted when the observed rates of disappearance of ethanol from the stomach (gastric disappearance assumed to equal absorption) were applied to the model of hepatic alcohol metabolism. The blood ethanol values predicted by the model were very close to the observed values when ethanol was administered with water. However, the blood levels predicted by the model for the first 45 min of the study with food were somewhat lower than the observed values.

Figure 5A shows hepatic ethanol concentration and first-pass and total ethanol metabolism predicted by the hepatic model for the observed rate of absorption of an ethanol dose of 0.15 g/kg. For the first hour of the study, hepatic ADH activity would have been nearly saturated and ethanol metabolism was near the \( V_{\text{max}} \). Cumulative first-pass metabolism accounted for ~30% of the total dose. Figure 5B shows similar data for the 0.15 g/kg dose administered with water. The rapid early absorption causes a rapid rise in peripheral blood ethanol that saturates hepatic ADH and limits first-pass metabolism to a cumulative total of only 3.5% of the dose. Similarly, if twice the dose (i.e., 0.3 g/kg) were absorbed at the same rate as the 0.15 g/kg administered with food, first-pass metabolism would fall to only 2% of the dose, primarily due to inhibition of this metabolism by peripheral ethanol returning to the liver (see Fig. 5C). When the AUC of the time curve for predicted hepatic ethanol concentration is used as a measure of the exposure of the liver to ethanol, the hepatic exposure is four times greater for the 0.15 dose ingested with water (Fig. 5B) and 11 times greater for the 0.30 g/kg dose (Fig. 5C) for the 0.15 g/kg dose ingested with food.

Fig. 4. Observed vs. predicted blood ethanol concentrations when ethanol was administrered with water or with a meal. Shown are blood ethanol concentrations observed (open symbols) and predicted (filled symbols) from model of hepatic ethanol metabolism when 0.15 g/kg in 360 ml of water (circles) or in 550 ml of homogenized breakfast (triangles) was instilled into the stomach. Data are means ± SE.

Fig. 5. Predictions of hepatic model of hepatic ethanol concentrations (A) and cumulative total (○) and first-pass (●) metabolism of ethanol. A: data for 0.15 g/kg of ethanol administered with food. B: data for 0.15 g/kg of ethanol administered with water. C: data for 0.30 g/kg of ethanol absorbed at fractional rate observed when 0.15 g/kg dose was administered with food. %Total metabolism that occurred during first-pass was estimated to be 27%, 3.6% and 2.2% for A, B, and C, respectively. AUCs for hepatic ethanol concentration for A, B, and C were 44, 163, and 487 mM/min, respectively.
must be similarly distributed in the aqueous phase of gastric contents. This assumption was correct in that analysis of the water phase of the meal showed the expected concentration ratios of [14C]PEG, ethanol, and 99mTc-DTPA. It also was assumed that [14C]PEG and 99mTc-DTPA are nonabsorbable, an assumption supported by the wide use of PEG 3000 as a dilutional marker in perfusion studies and 99mTc-DTPA for gastric emptying measurements of water-soluble compounds (5). Finally, our sampling of gastric contents was assumed to be representative of total gastric contents. A large quantity of gastric material (150 ml, when possible) was withdrawn and mixed, and a small aliquot was saved for analysis. Presumably, the large quantity of withdrawn material provided a true representation of the total contents.

An average of 85% of the ethanol instilled with water was emptied into the duodenum by 23 min, whereas, when instilled with food, a mean of only ~30% was emptied over the same time period (see Figs. 2 and 3). The roughly 50-min half-time of emptying of the liquid phase of our instilled, homogenized meal is similar to the half-time reported for the liquid phase of a meal ingested in physiological fashion (8). The percentage of the dose emptied into the duodenum averaged 69% and 89% for the food and water meals, respectively, and the respective fractions undergoing gastric absorption were 30% and 10%. These latter values represent the maximal fraction that could have undergone gastric mucosal metabolism. Claims that up to 90% of an ethanol dose undergoes gastric metabolism (2) can be excluded a priori.

When administered with food, ~6% of the ethanol in the stomach was absorbed per 15-min interval. This value is slightly less than the gastric clearance of 4.7 ml/min reported by Cooke (5), who used a gastric aspiration technique to assess ethanol absorption from a 350-ml meal.

Our gastric absorption measurements permitted several apparently novel calculations concerning the gastric handling of ethanol. First, it was possible to estimate the diffusion barrier separating bulk luminal contents and the gastric mucosa. This barrier appeared to have a resistance equivalent to that of an unstirred layer ~400 µm thick, a value ~16 times greater than the 25-µm thickness reported for the human small intestine (15). This difference presumably reflects more efficient luminal stirring in the small bowel, although the thick mucus layer in the stomach may have accounted for some of the difference. The very thin intestinal unstirred layer plus a greater surface-to-volume ratio explains the virtually instantaneous intestinal absorption of ethanol vs. the slower gastric absorption rate.

Knowledge of gastric absorption rates of ethanol also made possible the estimation of in vivo metabolism of ethanol in the gastric mucosa. Although several in vitro determinations of the Vmax and Km of ADH have been performed, extrapolation of these data to the in vivo situation requires knowledge of gastric mucosal ethanol concentrations. The high diffusivity of ethanol...
should result in a near-perfect equilibrium between the ethanol concentrations of mucosal tissue and blood perfusing the mucosa. Thus the mucosal concentration equals gastric ethanol absorption divided by gastric mucosal blood flow. Resting gastric mucosal blood flow in adult males is ~0.6 ml·g⁻¹·min⁻¹ (20), and both food and ethanol ingestion should enhance this flow rate. Utilizing a value of 0.7 ml·g mucosa⁻¹·min⁻¹ and a mucosal weight of 70 g (11), the flow for the entire gastric mucosa would be ~50 ml/min. At this flow rate, the maximal gastric mucosal concentration after ingestion of the ethanol with food was ~19 mM, and this value declined to <5 mM by 2 h (Fig. 6). Previous estimations of gastric ethanol metabolism assumed, without evidence, gastric mucosal ethanol concentrations of 200–500 mM for a 3-h period (9, 10). Given the high $K_m$ of gastric ADH, such inflated concentrations resulted in marked overestimations of gastric ethanol metabolism.

Utilizing three recently published (8, 19, 24) sets of gastric ADH kinetic data with our calculated concentrations of mucosal ethanol, we estimated gastric mucosal ethanol metabolism from the Michaelis-Menten equation. When administered with food, total ethanol metabolism in the gastric mucosa was 0.7, 0.9, and 5.3 mmol for the kinetic data of Moreno and Pares (19), Frezza et al. (8), and Thuluvath et al. (24), respectively. This metabolism accounted for only 0.3%, 0.4%, and 2% of the 250-mmol dose. Thus the stomach appeared to metabolize a negligible fraction of a very low dose of ethanol (0.15 g/kg) ingested with food, the situation in which first-pass metabolism is maximal.

The more rapid absorption of ethanol administered with water vs. food was associated with higher blood ethanol levels and a 70% greater AUC (see Fig. 4). These higher blood concentrations could reflect either a reduction in the efficiency of first-pass hepatic metabolism and/or simply the increased AUC observed with more rapid and/or greater delivery of ethanol to the peripheral circulation when clearance is saturated (see Fig. 1).

Determination of hepatic first-pass metabolism vs. metabolism of recirculating ethanol requires knowledge of ethanol absorption and the kinetics of hepatic ethanol metabolism. We have employed a model of hepatic ethanol metabolism in which total metabolism at any moment is determined from the ethanol concentration at the hepatocyte, the $K_m$ of the hepatocyte, and $V_{max}$ (16). Many studies (10, 18, 22) assessed hepatic ethanol metabolism utilizing the apparent $K_m$, the peripheral blood ethanol concentration that yields the half-maximal metabolic rate. However, at nonsaturating concentrations liver metabolism may reduce the liver ethanol concentration to only a small fraction of that of peripheral blood. Thus sizable errors occur when estimates of first-pass metabolism are based on calculations employing peripheral blood concentrations and apparent $K_m$ (16).

In our modeling, first-pass ethanol metabolism was defined as the extra metabolism that results when newly absorbed ethanol is delivered to the liver via the portal vein as opposed to the delivery at the same rate via an intravenous infusion. First-pass metabolism occurs to the extent that the higher hepatic concentrations resulting from portal delivery allow more rapid hepatic metabolism of ethanol. This model also permits prediction of blood ethanol levels, and in studies using a rat hepatic model (analogous to that employed for humans), predicted blood ethanol concentrations were similar to observed values (17).

The model accurately predicted the observed blood ethanol levels for the studies in which ethanol was administered with food (see Fig. 4). However, when administered with food, observed blood ethanol concentrations were ~0.7 mM greater than that predicted during the first 45 min of the study (see Fig. 4). To account for this discrepancy, we first examined our hepatic modeling. The sizable alterations in $K_m$ or $V_{max}$ required to appropriately increase predicted values caused marked discrepancies between predicted and observed values during the latter phase of the study. Alterations in liver blood flow did not appreciably influence predicted results. Additional evidence that factors other than our modeling played a role in this discrepancy was as follows. When distributed in body water (60% of body wt), the blood ethanol concentration (1.7 mM) at 10 min represents 34% of the dose. During this 10-min period, ethanol was metabolized at near the $V_{max}$ rate. Thus the liver would have cleared an additional 10% of the dose. The sum of ethanol in body water plus hepatic metabolism at 10 min equals 44% of the dose in contrast to the observed 30% absorption (see Fig. 3). Thus the major cause of the discrepancy between the observed and predicted blood ethanol values appeared to have been an ~15% underestimation of ethanol absorption early in the study, although incomplete distribution cannot be excluded.

When the absorption of 0.15 g/kg of ethanol was applied to the hepatic model, 30% of the dose was predicted to undergo first-pass metabolism. Because this small dose nearly saturated hepatic removal (Fig. 5), increments in ethanol absorption would escape first-pass metabolism and, on returning to the liver, compete for metabolism with newly absorbed ethanol. Thus ethanol dosages >0.15 g/kg (absorbed at the fractional rate of our study with food) or increases in the rate of absorption of the 0.15 g/kg dose are associated with precipitous falls in first-pass metabolism. For example, the more rapid absorption observed when ethanol was administered with water reduced predicted first-pass metabolism from 30% to only 3%. If twice the ethanol dosage (i.e., 0.3 g/kg) were absorbed at the same fractional rate as in our food study, only ~2% would have undergone first-pass metabolism (see Fig. 5). Thus appreciable first-pass metabolism is limited to the situation where there is slow absorption of a very small dose of ethanol (0.15 g/kg). The accuracy of this theoretical concept is supported by studies showing that the apparent inhibition of first-pass metabolism by H₂ antagonists is demonstrable only when the ethanol dosage is limited to 0.15 g/kg and absorption is slowed via meal ingestion (14).
The model of hepatic metabolism indicates that the peak and total hepatic exposure to ethanol increases dramatically with more rapid absorption of identical alcohol dosages (see Fig. 5). Using the AUC of hepatic ethanol concentration as an indicator of liver exposure, we found that the predicted exposure was fourfold greater for the 0.15 g dose administered with water vs. food. Furthermore, similar fractional absorption rates of modestly greater doses of ethanol dosage can cause markedly disproportionate increases in hepatic ethanol exposure (see Fig. 5). Thus, to the extent that liver damage is a function of hepatic ethanol concentration (as opposed to hepatic ethanol metabolism), subtle factors other than total daily intake could influence ethanol toxicity.

It should be axiomatic that the AUC provides an inaccurate assessment of first-pass metabolism of a compound such as ethanol, which is removed largely with saturation kinetics. For example, the difference in AUC of the two meals used in the present study was 70%, whereas the true difference in first-pass metabolism, calculated from the hepatic model, was only ~26%. Nevertheless, multiple recent reports (1, 2, 9) continue to use the difference between the AUCs of ingested vs. a rapid intravenous infusion of ethanol to assess first-pass metabolism. As a result, first-pass metabolism of ethanol appears to have been repeatedly overstated. Similar misapplication of the difference between AUCs obtained when ethanol was administered via the stomach vs. an intraduodenal or intraportal infusion initially led to the proposal that the stomach was the major site of first-pass metabolism of ethanol (3, 12). The present study indicates that this first-pass metabolism occurs almost entirely in the liver and this metabolism removes only a minor fraction of potentially inebriating doses of ethanol.

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