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Magnesium-L-Aspartate Hydrochloride: Experimental and Clinical Data

H. G. Classen

Epidemiological data suggest that plentiful magnesium (Mg) supply decreases the risk of cardiovascular and other stress-related diseases. Magnesium-L-aspartate hydrochloride (MAH) contains equimolar amounts of Mg and chloride and hence does not affect the equilibrium of non-metabolizable acids and bases. MAH is safe, main pharmacological actions are mediated via Mg-ions and their Ca²⁺-antagonistic activity. MAH does not bind gastric hydrochloric acid and does not interfere with the enteral absorption of iron, potassium and calcium under physiological conditions, nor with the cystotic activity of cisplatin and cyclosporine. “Low utilizers” of oral supplements need higher than standard doses (15 mmol) of MAH, individual doses must be increased up to 30–40 mmol. MAH has been proven to attenuate stress reactions in experimental animals, livestock and in humans. Beneficial effects are proven under numerous clinical conditions, e.g. in obstetrics and gynaecology, in pediatrics, cardiology, internal medicine and traumatology. Oral therapy can be optimized by observing plasma/serum and urine Mg levels.

Key words: acid-base metabolism, kinetics, stress protection, clinical studies, Ca antagonism, compatibility with oral Fe, K, Ca

1 mole of MAH contains equimolar amounts of L-aspartate, chloride and Mg, together with 3 moles of H₂O; on a percental weight basis, the complex contains 53.7 % L-aspartate, 14.4 % chloride, 9.9 % Mg and 22 % H₂O. Due to this favourable composition it can be predicted – and has in fact been proven – that MAH administered orally or parenterally will not affect acid-base metabolism.

MAH is marketed as Magnesiocard® in Germany (since 1977), Switzerland and Portugal, as Emgecard® in Austria, as Trofocard® in Greece, as Magnesit® in South Africa and as Magnex® in the USA.

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* Dedicated to my friends Drs Bela SOGYMOSS and Suzanne VARGA, who readily integrated me into their research team within Hans SELYE’s Institute, Université de Montréal, 1968–69.

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Toxicology

Extensive regulatory toxicology tests on MAH have proven a high degree of safety (unpublished data): single dose toxicity following oral administration revealed LD₅₀ doses of 6.8, 6.9 and 4.5 g MAH/kg b.w. in rats, mice and dogs, corresponding to (rounded) 660, 670 and 440 mg Mg²⁺/kg b.w. Following i.v. administration the LD₅₀ was 216 mg MAH/kg b.w., resp. 21 mg Mg/kg b.w. in rats. Mortality was induced by respiratory paralysis due to neuromuscular blockade, as known from other Mg salts. Repeated dose toxicity was studied in rats and dogs: mild reversible diarrhoea, emesis in dogs and reduced gain of body weight represented major side effects. It should be noted that urine-pH did not reveal treatment-related alkalosis and that daily doses exceeding the single dose LD₅₀ were tolerated after the doses were divided into two or more single doses. Reproduction studies were performed on rats kept on a Mg-deficient diet enriched with increasing concentrations of MAH. Under these experimental conditions underdosing of MAH was significantly more foetotoxic than overdosing as indicated by decreased gain of body weight and the Mg and Ca content of the skeleton of the offspring. Studies on thalidomide-sensitive New Zealand rabbits revealed no teratogenic potential in the offspring, produced by caesarian section, at oral daily doses up to 1710 mg MAH/kg b.w. No mutagenic potential was detectable in the standardized AMES-test with 5 test strains, with and without metabolic activation, nor in the micronucleus test in mice. In view of the absence of a genotoxic potential of MAH and a lack of carcinogenicity of its components – MgCl₂ [8] and L-aspartate [9] – a carcinogenic potential of MAH can be excluded by extrapolation.

Pharmacology

The main pharmacological actions of MAH are mediated by its content of Mg²⁺-ions and their calcium-antagonistic efficacy [6, 10], for example at the level of cerebral, pulmonary or myocardial blood vessels [11, 12]; under in situ conditions, chloride ions associated with Mg exerted a more potent influence on arteriolar reactivity to an agonist (Ba²⁺-ions) than Mg associated with other anions [13]. Tissues of the whole gastrointestinal tract are also very sensitive to extracellular Mg concentrations [14]: for example the contraction amplitude of electrically stimulated rat ileum was inhibited by 50 % when extracellular Mg²⁺ was increased from zero to 0.8 mmol Mg, added as MAH (see MAH in pediatry!). Similarly the amplitude of spontaneously contracting rat ileum was significantly attenuated by increasing extracellular Mg²⁺ from zero to 1.0 mmol/L, as shown in Figure 2. Addition of equimolar amounts of Ca²⁺ restored contractility, thus demonstrating Ca/Mg-antagonism at this tissue.

The calcium-antagonistic efficacy of Mg readily explains generally increased tendency towards spasms observed in status of Mg deficiency, and of spasmylytic effects following sufficient supply of MAH. In addition Mg/Ca-antagonism is known at the neuromuscular junction and ganglionic impulse transmission. On the level of the brain, the N-methyl-D-aspartate (NMDA) subtype of the glutamate receptor deserves special interest since this receptor is specifically blocked by Mg²⁺ [15].

Kinetics, Availability, Interactions

Pharmacokinetics describe relations between the dose administered and concentrations resulting in the body; concentration-bioeffect relations are also assumed. When 14 groups of young SD-rats were fed a basal Mg-deficient diet (34 ppm Mg) enriched with increasing amounts of Mg as MAH (logarithmic intervals of 0.07) during 26 days, significant cubic functions could be established between the dose administered and the resulting Mg concentrations in serum (r = 0.98) and bone (r = 0.99) (p < 0.001) [16]. It should be noted that the dose was increased by a constant factor of 1.175, ie not on a linear scale, and that the increase was steeper at low dietary Mg, indicating improved enteral Mg absorption during dietary Mg deficiency (Fig. 3).

When aqueous Mg solutions were administered orally or intraduodenally to cats or rats, plasma/serum Mg increased dose-dependently, concerning the increase, chloride containing compounds were superior to the aspartate or sulfate, and MgCl₂ was more toxic than MAH [17, 18]. Similarly MgCl₂
was absorbed more rapidly than MAH in dogs, but produced a significantly greater urinary Ca excretion [19]. In fact, when acid-base metabolism was studied in rats at high dietary Mg concentrations (20,000 ppm Mg), plasma Mg increased as expected. Interestingly, MgCl₂ induced hyperchloremic compensated extracellular metabolic acidosis (requiring increased renal alkali excretion for compensation) in contrast to MAH which did not significantly affect acid-base parameters nor plasma chloride. 13 other Mg salts, not containing chloride, showed a tendency towards compensated extracellular hypochloremic alkalosis which was most pronounced following the citrate [20]. It is well known that the pH of the extracellular fluid is determined by the concentration and chemical properties of the acids and bases dissolved in it: in general, carbonic acid is regulated by pulmonary ventilation. Metabolizable acids – being absorbed from the diet or arising in intermediary metabolism – are regulated by intermediary metabolism. Non-metabolizable acids and bases are absorbed from the diet: they cannot be disposed of by intermediary metabolism or by pulmonary ventilation and hence must be disposed of by renal mechanisms [21]. The principal inorganic bases contributing to the balance are Na, K, Ca and Mg [22] and the principal non-metabolizable acids are hydrochloric acid, phosphoric acid and sulfuric acid.

In plasma, the concentration of non-metabolizable bases, amounts to:

\[
\begin{align*}
\text{concentration (mmol/L) of non-metabolizable bases} = & cNa^+ + cK^+ + 2 \times cCa^{2+} + 2 \times cMg^{2+} \\
- & cCl^- + 2 \times cSO_4^{2-} + 1.8 \times cP \\
\end{align*}
\]

where \( c \) denotes the concentration (mmol/L). The anion gap is covered by proteins and organic metabolizable acids. From these data it can be concluded that the supply of higher amounts of alkali earth and alkali metals tends to alkalization whereas chloride and o-phosphate favours acidification. As outlined (see section “Product Profile”) MAH contains equimolar amounts of Mg and chloride and accordingly does not significantly affect acid-base balance.

Consistent with the presented animal data, MAH dose-dependently increased plasma Mg in volunteers [23]. When 8 healthy volunteers received daily oral doses of 30 and 45 mmol Mg during 7 days as the oxide or as the MAH, bioavailability (estimated by cumulative urinary Mg excretion) of MAH was better than the availability of MgO (\( p < 0.001 \)); urine pH decreased (–0.5) during MAH and increased (+0.5) during MgO administration [24].

Interactions of Mg salts with gastric hydrochloric acid are therapeutically used in antacids. As outlined, MAH does not possess this property due to its chloride content [25].

Textbooks of pharmacology say that Mg and Fe salts must possess this property due to its chloride content [25].

High Versus Low “Utilizers” of Mg

Studies on families with children presenting with hypomagnesaemia and functional spastic disorders revealed that their mothers suffered more frequently from dysmenorrhoea and nocturnal calf cramps (15.6 and 16.9 %) than controls (6.3 and 3.5 %). Familial case reports also suggest negative hereditary effects on Mg utilization [33, 34] which have been proven also for mice by Henrotte et al. [35, 36]. The underlying mechanisms are probably reduced enteral absorption of Mg and/or increased renal losses. In fact when hypomagnesaemic children were supplemented with 10 mmol of MAH daily their mean plasma Mg levels significantly increased and their symptoms significantly improved in comparison to placebo [37]. However, in a subgroup of 15.2 % of the children, plasma Mg did not normalize despite the supplementation, obviously due to relative underdosing. Fehlinger also reported on patients who had to be titrated with increasing oral Mg doses until their serum Mg increased [34]. Recently we observed a young woman with migraine-like headache attacks and hypomagnesaemia. Oral daily doses of 15 mmol MAH were completely ineffective during one month – and simultaneously, neither her plasma Mg increased nor urinary Mg excretion. Only when the oral dose of MAH was doubled to daily 30 mmol MAH, Mg levels in plasma and urine increased as well as plasma Ca, and headache disappeared [38]! Similarly, Widman et al., using Mg(OH)₂, had to increase oral Mg doses up to daily 40 mmol in order to obtain significant effects on blood pressure [39].

These examples clearly demonstrate that standard oral doses of 15 mmol Mg may not suffice to normalize the Mg status of “low utilizers”. Such patients can only be diagnosed if their plasma and urinary Mg levels are monitored. The drawback of controlled supplemental studies on symptomatic patients using fixed Mg doses without monitoring their biochemical efficacy is obvious, and the reason for insignificant clinical effects may frequently be simply underdosing of subgroups.

MAH Attenuates Stress Reactions

Already in 1932, Kruse et al. observed that Mg-depleted rodents became increasingly sensitive to stress, especially to noise stress [40]. As already discussed, this effect is certainly due to increased sensitivity of the NMDA-receptor [15]. In 1979, Kraemer et al. studied the efficacy of orally administered MAH in cats [41]. The authors could show that Mg levels increased in serum and brain tissue; simultaneously, electrophysiological parameters revealed tranquilizing effects. These effects have been proven by measuring stress hormone levels and related parameters in rats and volunteers [1, 14, 42–44] and in livestock, eg pigs [42]. These CNS effects together with systemic Ca-antagonistic effects readily explain various stress-protecting effects of MAH, especially in hypomagnesaemic individuals.
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MAH in Obstetrics and Gynecology

Eclamptic seizures can be evoked by noise stress. Since Mg deficiency sensitizes and plentiful supply protects against noise stress [40]. Mg is the drug of choice for this indication in the US. Splitting and co-workers were able to demonstrate tocolytic effects of oral and parenteral MAH as well as beneficial effects of MAH supplements on pregnancy outcome under controlled conditions. In addition nocturnal calf cramps could be attenuated [45–47]. Pregnancy conditions for Mg deficiency [48]; further losses occur during lactation [49]. Since no unwanted side effects of oral Mg supplements have been reported, plentiful supply of MAH is recommended under these conditions, and also for the treatment of dysmenorrhea [50].

MAH in Pediatrics

Children frequently present with so-called neurovegetative disorders like stomach-ache, headache, chest complaints, leg cramps and neurasthenia. For example an increased frequency of hypomagnesemia plus hypercalcaemia was detected in children, hospitalized under the tentative diagnosis of acute appendicitis [51]. Epidemiological studies on a total of 2,481 children revealed hypomagnesemia at a frequency of 21.9 % in children with functional disorders versus 14.3 % in controls [52]. When hypomagnesemic children presenting with these complaints were supplemented with daily 10 mmol MAH for three weeks mean plasma Mg and Ca levels significantly increased. Relief of complaints was reported by 80.2 % (pediatricians) respectively 82.9 % (parents/patients) significantly increased. Relief of complaints was reported by 80.2 % (pediatricians) respectively 82.9 % (parents/patients), these effects were significantly superior to placebo treatment with a corresponding Ca-salt (p = 0.04, resp. p = 0.006) [37]. These clinical data, corresponding to earlier remarks on "Pharmacology", deserve more attention by pediatricians. The subgroup of “low utilizers” certainly needs higher oral doses of MAH.

MAH in Cardiology

As discussed (see section “Pharmacology”) hypomagnesemia potentiates, whereas increased extracellular Mg attenuates vasoconstrictor effects of various transmitters on blood vessels, eg coronaries. In addition, Ca-overload and excessive consumption of energy-rich phosphates are facilitated during Mg deficiency and blocked by high extracellular Mg [6]. Correspondingly, the production of myocardial necroses by Mg deficiency plus stress (eg injections of catecholamines) could be attenuated [45–47]. Pregnancy conditions for Mg deficiency [48]; further losses occur during lactation [49]. Since no unwanted side effects of oral Mg supplements have been reported, plentiful supply of MAH is recommended under these conditions, and also for the treatment of dysmenorrhea [50].

Cappuccio et al. [59]. These contradictions can be partly explained by the fact that normomagnesaemic patients or “low utilizers” were included and underdosing of MAH might have occurred [see 39]. Further clinical studies are needed considering the actual level of knowledge to confirm the conclusion and speculation of Weisz et al. [60]: “Thus, the possible therapeutic applications of an orally effective Mg2+ salt such as MAH include established indications in frank hypomagnesemic states. In addition, MAH has a potentially broad range of therapeutic activity as an orally effective Ca2+-like membrane stabilizer and as a physiological cellular Ca2+-antagonist.”

References


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