The pharmacologic spectrum of furosemide

Lisa M. Abbott, DVM, MRCVS and Jan Kovacic, DVM, DACVECC

Abstract

Objective: To review the clinical spectrum and mechanisms of action of furosemide in human and small animal veterinary patients.

Data sources: Review of human and veterinary literature.

Data synthesis: Furosemide is used primarily for its properties as a loop diuretic; however, it has many other actions that may be clinically applicable. Furosemide has a vasodilatory effect that precedes diuresis that may confer its immediate benefit in patients with volume overload. Furosemide can be inhaled to relieve dyspnea in patients with bronchospasm. Furosemide also shows promise as an adjunct to antiseizure therapy to help control epilepsy, status epilepticus, and acute ischemic damage related to seizures. It has activity as an antioxidant, iodine depletive, and may increase thoracic lymph duct flow. Reported furosemide side effects include altered drug metabolism, electrolyte depletion, ototoxicity, mucociliary impairment, endocrine and exocrine pancreatic effects, delayed wound healing, sulfonamide toxicity, and thyroid binding interference. It is worthwhile to consider the implications of these effects when using furosemide either alone or in combination with other drugs.

Conclusions: Despite the research in animal models that demonstrates a wide spectrum of pharmacologic activity, furosemide has not been widely recognized or used clinically in veterinary medicine except as a loop diuretic.

Keywords: antiseizure, bronchospasm, frusemide, loop diuretic, vasodilator

Introduction

Furosemide is well known as a sulfamoylbenzoic acid loop diuretic that inhibits the renal Na\(^+\)-K\(^+\)-2Cl\(^-\) co-transporter (NKCC) in the luminal membrane of the ascending loop of Henle. However, furosemide has effects in multiple organ systems, not just the kidney. There is renewed interest in its clinical use following the discovery of furosemide-inhibited NKCCs in non-renal tissues. Furosemide also demonstrates pharmacologic activity that appears to be unrelated to this co-transporter. To date, many of the mechanisms of furosemide’s effects have not been fully established.

Pharmacology

Furosemide has diuretic properties in all mammalian species.\(^1\) It is administered to remove excess body fluid in patients with volume overload. Classified as a high ceiling loop diuretic for its rapid onset and short duration of action, it inhibits the NKCC on the luminal side of the thick ascending loop of Henle. Furosemide is active from inside the tubular lumen, as are all other diuretics except spironolactone.\(^2,3\) The degree of diuresis is determined by the amount of furosemide that reaches the renal tubular lumen, not the plasma concentration.\(^4\) Adequate urinary levels must be sustained for maximal diuresis.\(^4\) Inhibition of this co-transporter results in increased renal excretion of water, sodium, chloride, potassium, calcium, magnesium, ammonium, hydrogen ion, and possibly phosphate.\(^2,5\)

There are two isoforms of NKCC. NKCC1 has been identified in the mammalian kidney, heart, vascular endothelium, lung, brain, skeletal muscle, stomach, colon, red blood cells, smooth muscle, epithelia, fibroblasts, and neurons.\(^6\) NKCC2 is specific to the luminal (apical) membrane of the thick ascending limb of the loop of Henle in the kidney.\(^6-9\) The two isoforms have molecular weights between 120–190kDa and 50–60% amino acid sequence homology.\(^7\) NKCC1 is the larger of the two co-transporters, with an additional 80 amino acids at the amino terminus.\(^6\) The variation between these receptors is responsible for differing
co-transporter ion affinities and inhibition responses. NKCC1, the secretory co-transporter, is located in the basolateral cellular membrane, and NKCC2, the absorptive co-transporter, is in the apical cellular membrane.

Characteristics of all NKCCs are: (1) ion translocation depends upon simultaneous occupation of all three ion-binding sites on the same side of the membrane; (2) electroneutrality in binding with 1 sodium, 1 potassium, and 2 chloride ions (NH$_4^+$ can substitute for K$^+$ in acidemic conditions); (3) an ion flux driving force supplied in part by the inward sodium gradient maintained by the sodium−potassium−ATPase pump elsewhere in the cell membrane; (4) the ability to create a chloride gradient (this acts as a driving force for chloride secreting epithelial cells); (5) chloride delivery as the rate-limiting step; (6) the potential for competition at the second chloride-binding site by loop diuretics that results in co-transport inhibition. NKCC is electrically silent, as co-transport is not driven by transmembrane voltage and does not generate a membrane current.

Loop diuretics inhibit NKCC and the K$^+$$-2$Cl$^-$ co-transporter (KCC) in a dose-dependent manner, with a higher affinity and potency against the NKCC. KCC shares 25% amino acid homology with NKCC$^6$ and has four identified isoforms. KCCs have been found in cells of normal brain, heart, kidney, liver, spleen, stomach, colon, red blood cells, epithelia, and in Ehrlich ascites tumor cells. The two co-transporters differ in their response to loop diuretics. NKCCs show greater inhibition by bumetanide than furosemide, while KCCs have greater inhibition by furosemide than bumetanide.

The sustained delivery of furosemide depends on both glomerular filtration rate and active secretion of furosemide by renal tubular cells. Furosemide is 90–95% protein bound and the free furosemide concentration in plasma is inversely proportional to the plasma albumin concentration. Only the free furosemide is filtered at the glomerulus and available to the receptors at the luminal membrane.

Paradoxically, however, sustained furosemide delivery to the renal tubule, and therefore maximal diuretic effect, are not improved with low plasma albumin concentration. Protein binding is necessary to trap a significant percentage of circulating furosemide in the vascular compartment, enhancing delivery to proximal tubular cells over time through sustained secretion. With marked hypoalbuminemia (plasma albumin <2 g/dL), even though free furosemide levels are initially high in both the plasma and ultrafiltrate, the effect is not sustained and much of the free furosemide is excreted unchanged in the urine. This decreases the total diuretic effect. Diuretic efficacy in humans with marked hypoalbuminemia can be increased by co-administration of furosemide and albumin, with most protocols mixing 40 mg furosemide with at least 6.25 g albumin before administration.

Only a small amount of plasma furosemide is metabolized via hepatic conjugation with glucuronic acid. Half of the delivered furosemide is excreted unchanged in the urine and 20–50% is inactivated by renal glucuronidation. Thus, the kidney is the major site of action, metabolism, and excretion of furosemide.

Heart failure, renal failure, cirrhosis, or hypoalbuminemia with reduced renal blood flow and/or proteinuria may require higher doses to achieve therapeutic levels due to a reduction of free drug entry into the tubular lumen. This effect may be opposed by the prolonged half-life in renal patients, reported to increase up to 3-fold due to reduced glomerular filtration rate. Proteinuria may also reduce the diuretic response due to intratubular drug binding to the protein. Another concern in human cardiac patients is the co-administration of furosemide and other protein-bound drugs, such as warfarin, that compete for the same albumin-binding site. The clinical significance of protein-binding displacement with furosemide administration is not known, but may be an important consideration.

Furosemide, a weak organic acid, is actively secreted by renal organic anion transporters (OAT). Movement from the basolateral to the luminal membrane in the proximal tubule is mediated by OAT3 and to a lesser extent OAT1. Human OAT1 has been localized at the S$_2$ segment of the proximal tubule, while human OAT3 is found at the S$_1$, S$_2$, and S$_3$ proximal tubule segments. There are interspecies differences in OAT1 expression between humans and rats that has led to speculation of other potential differences still to be determined.

Co-administration and retention of organic acids reduces proximal tubular secretion of furosemide due to OAT binding site competition. Renal failure patients may show limited diuretic excretion in part due to retention of hippurate, an organic anion that competes for secretion. OAT transporters are also responsible for movement of non-steroidal anti-inflammatory drugs, angiotensin-converting enzyme inhibitors, and β-lactam antibiotics. The effect of co-administration of these agents on furosemide transport is unknown.

Oral absorption in humans is approximately 50% with a range among individuals of 10–100% that makes dosing difficult to calculate and necessitates titration to desired effect. An increased bioavailability of furosemide with oral co-administration of ascorbic acid may improve absorption.
acid in canine studies is attributed to potential decreased gastric first-pass metabolism, increased renal tubular reabsorption, or an increase in the unionized fraction present at receptor sites. The current recommendation for human patients is to administer oral furosemide until the desired clinical effect is achieved, or to add a diuretic agent acting at another receptor site when approaching the upper dosage range limits of furosemide.

Furosemide acts differently in different species. Canine patients show increased sodium excretion as compared with potassium, and must be monitored more closely for development of secondary hyponatremia. Canine saluresis and diuresis will occur over a broad therapeutic range, starting at 0.625 mg/kg as compared with cats at 1.25 mg/kg. Despite having a narrower therapeutic range, cats have increased diuretic sensitivity, showing stronger and more rapid saluresis and diuresis as compared with dogs. A reported upper limit to feline dosing tolerance is 10 mg/kg intramuscular (IM), with lethargy and decreased appetite noted for 24–48 hours following administration of higher doses. Dogs are reported to show apathy, staggering and decreased blood pressure, suggesting a dosing tolerance, at 50 mg/kg IM. The decrease in blood pressure following furosemide injection in anesthetized cats given 25 mg/kg IM is more dramatic than the similar effect in dogs at 50 mg/kg IM. Rats are reported to be less sensitive; an important fact because many studies are performed in murine models.

Route of administration is an important consideration in determining therapeutic effect. The half-life of furosemide in humans is 1.5-2 hours and a maximal natriuretic response is defined as excretion of about 20% of filtered sodium. Owing to bioavailability, the maximal oral dose is usually twice the intravenous (IV) dose, although dosages can be doubled up to 5 times until adequate diuresis is achieved. Intestinal absorption delay may reduce urinary excretion to suboptimal levels; absorption delay may be the result of decreased intestinal perfusion, increased intestinal motility, and/or mucosal edema. IV administration in dogs results in a 1–2 hour half-life, with potential for rebound sodium and water retention that can be attributed to neurohumoral activation. Constant rate infusion (CRI) has been shown in humans and dogs to cause more diuresis, natriuresis, and calciuresis, with less kaliuresis as compared to intermittent bolus delivery.

**Loop Diuretic Properties**

Furosemide reduces symptomatic volume overload secondary to moderate and severe heart failure in all mammalian species and improves exercise tolerance in humans. Increasing sodium and water excretion results in reduced circulating volume, reducing preload, and edema formation. A debate in human medicine exists concerning the beneficial effects versus potential complications in long-term administration for chronic heart failure. Increased hospitalization rates and death from worsening chronic heart failure are reported to be higher with long-term furosemide administration. There is no proof of causation between increased mortality and furosemide dose, as patients with more severe illness and diuretic resistance related to chronicity of administration require higher doses. Morbidity associated with higher doses is reported secondary to volume contraction, hypotension, electrolyte abnormalities, neuroendocrine activation, and diuretic resistance. Chronic administration is associated with distal tubule hypertrophy and collecting duct overexpression of NKCC. Current canine research is exploring co-administration with brain natriuretic peptide to enhance furosemide’s effects, with the goal of increasing glomerular filtration without aldosterone activation. Furosemide, administered for volume overload due to acute myocardial decompensation, should not be the sole agent given to chronic heart failure patients. Administration of a single agent that reduces vascular volume results in short-term improvement. Over time, this reduction may result in a reduction of effective circulating volume, contributing to the progression of cardiac disease. Agents that support other components of cardiac output should also be utilized. At this time, furosemide is recommended only for patients with acute or chronic decompensation with clinical evidence of volume overload. Thus, it should be considered as an adjunct to primary therapy in all congestive heart failure patients.

**Protection Against Renal Ischemia**

Furosemide administration in animal studies protects the kidney from ischemic damage. Renal oxygen consumption has been positively correlated to tubular sodium reabsorption and glomerular filtration rate. Sodium is actively transported out of the cells into the interstitium by the Na⁺-K⁺-ATPase-dependent pump on the basolateral membrane. Reducing sodium reabsorption results in a proportional decrease in renal oxygen consumption. Loop diuretic administration decreases renal tubular cell metabolic demand by blocking the NKCC transporter and thus turning off the need for ATPase pump activity. This reduces renal tubular oxygen demand and helps to maintain the balance between oxygen delivery (DO₂) and oxygen demand (VO₂) in the high-risk medullary and juxtaglomerular regions. Under normal circumstances these
tissues are relatively hypoxic due to low blood flow, oxygen requirements for concentrating mechanisms in the medulla, and a countercurrent effect in the vasa recta. NKCC2 activity is normally reduced in renal ischemic conditions by a locally produced, non-prostaglandin, cytochrome p450 arachidonic acid metabolite. Furosemide, through inhibition of NKCC2, increasing renal blood flow, and decreasing tubular sodium reabsorption may be useful in preserving cell viability by protecting ischemic kidneys under conditions of inadequate perfusion.\textsuperscript{29}

A recent study in human postoperative mechanically ventilated patients with normal renal function confirmed this renal-protective effect.\textsuperscript{29} Furosemide was administered at 0.5 mg/kg IV loading dosage, then infused at 0.5 mg/kg/hr for three 30-minute periods. Despite a 12% decrease in both cardiac output and glomerular filtration rate, there were no significant changes in mean arterial pressure, heart rate, renal blood flow, or renal vascular resistance. Urine flow and fractional sodium excretion increased by 10–15-fold. Renal oxygen consumption and tubular sodium reabsorption were reduced.\textsuperscript{29} Reduction in renal oxygen demand may be clinically important to protect against further damage in conditions of ischemic renal insufficiency. Unfortunately, rat studies indicate this protective effect does not occur with co-administration of furosemide and contrast media, a cause of human nephropathy.\textsuperscript{30}

Despite its proposed benefits, the administration of furosemide to humans with acute renal failure is controversial. Many conclude it does not appear to shorten the duration of renal failure nor demonstrate effectiveness in prevention or treatment of toxic or ischemic renal failure.\textsuperscript{31,32} A prospective, multicenter, multinational human study in 1743 acute renal failure patients has shown no association between diuretic usage and increased risk of mortality.\textsuperscript{33} Although increasing tubular flow rates may help flush out tubular casts and ameliorate intratubular obstruction, it may worsen cast formation in myeloma and light chain nephropathy. Patients with renal insufficiency and nephrotic syndrome show a decreased responsiveness to furosemide due to decreased renal diuretic delivery, decreased peritubular diuretic uptake, enhanced renal metabolism to inactive glucuronide, and decreased free diuretic.\textsuperscript{15} Unfortunately, these are the patients that would most benefit from protection from further renal damage. Recommendations for treatment of human patients with acute renal failure include furosemide to increase urine output in oliguric or anuric patients; a result of its diuretic properties to relieve or prevent fluid overload. Controversy exists as to the presence of any clinical benefit from its ability to preserve renal blood flow and oxygen concentration, with no documented evidence of improved overall outcome. Despite the controversy, furosemide remains the diuretic of choice for treatment of volume overload in patients with oliguria or anuria.\textsuperscript{3}

Most recently, furosemide has been evaluated for its effects on genes that control angiogenesis. Rats were evaluated to determine which genes were expressed or down-regulated under conditions of ischemia–reperfusion. Furosemide administration at 30 \(\mu g/kg/min\) initiated before ischemia and continued for 6 hours of reperfusion showed enhanced expression of genes that may help to restore renal vascularity and perfusion. Although the study did not evaluate renal function, the study raises the possibility of a molecular mechanism of renal protection.\textsuperscript{34}

**Vasodilator Properties**

Administration of furosemide causes vasodilation and a decrease in total peripheral vascular resistance.\textsuperscript{35–38} It also causes renal venodilation and a transient increase in glomerular filtration rate that may be due to vasodilatory prostaglandins.\textsuperscript{3}\textsuperscript{29} This intrarenal effect may or may not occur in dogs.\textsuperscript{39,40} Furosemide is also used clinically and in a research setting to interrupt tubuloglomerular feedback,\textsuperscript{41} the macula densa response to sodium chloride elevations.

It may be the significant non-diuretic effect of furosemide (rapid vasodilation) that contributes to immediate symptomatic improvement of volume overload.\textsuperscript{36,42} Diuretics have been used since the 1960s in the treatment of acute cardiogenic pulmonary edema.\textsuperscript{25,35} Furosemide is documented in human and veterinary cardiac patients to reduce pulmonary congestion and left ventricular filling pressures.\textsuperscript{42,43} The vasodilation that precedes diuresis appears to be due to venous pulmonary dilation and an increase in peripheral vascular capacitance. Preload is reduced before a measurable increase in urinary output. There are studies that indicate these effects are preserved in anephric patients at a furosemide dosage of 2 mg/kg IV.\textsuperscript{44,45} In contrast, the literature also reports a requirement for renal involvement, with no dilation occurring in anephrics.\textsuperscript{46,47} Both in vitro and in vivo studies report an indirect, immediate venodilator effect, with significant variability in different vascular beds, including those affecting renal blood flow.\textsuperscript{37,38,48,49} The debate continues concerning the magnitude, mechanism of action, and clinical significance of this vasodilatory effect in various species and tissues.

Species and age variations have been discovered relating to the magnitude of vasodilation. Based on these differences, some researchers are doubtful that
in vitro results will have human therapeutic relevance beyond that of relief of dyspnea. High concentrations of furosemide in one study were found to exert a weak direct relaxant effect on isolated human resistance arteries, as compared with a more pronounced effect in guinea pigs, and especially rats. Guinea pig studies in isolated pulmonary artery relaxation illustrated an age-related effect with the greatest relaxation response in the adult, a lesser effect in the newborn, and the fetus showing the least relaxation. There is concern furosemide may not reach in vivo therapeutic levels in the vascular compartment as it is 95% protein bound and not concentrated locally as it is in the kidney. There may also be varying responsiveness in different vascular beds.

The acute hemodynamic response after systemic administration is believed to be a direct relaxant effect. Furosemide-induced vasoactivity has been measured immediately after IV and within 15 minutes after oral administration. Some studies suggest an indirect response, in which furosemide stimulates production of a secondary agent with vasodilatory properties. There may be a balance of direct and indirect effects, with a variation based on the model, type of patient, species, or other variables. Venodilation has been shown at clinically relevant concentrations. Arterial dilation has been reported not to occur, or only to occur at supratherapeutic doses. Veins appear to have a higher concentration of NKCC1 as compared with arteries, potentially explaining the variation in cotransporter inhibition and the predominately venodilatory effect. However, more potent co-transporter inhibitors such as bumetanide do not cause more potent vasodilation.

Other potential mechanisms reported include vascular structural changes, weak angiotensin receptor blocking, prostaglandin release, competitive thromboxane A2 contraction inhibition, renin–aldosterone–angiotensin activation, sympathetic stimulation, and/or co-factor presence. Plasma renin elevation secondary to prostaglandins is documented within minutes of furosemide administration irrespective of venodilation or arterial constriction. Plasma renin levels, but not venodilation, increase in a dose-dependent manner. It is possible that the vasodilatory prostaglandin release is either a direct or indirect in vitro endothelial compensation to angiotensin II-mediated contraction. The acute venodilator effect appears to be blocked by non-steroidal anti-inflammatory drugs in human patients with chronic heart failure, supporting some form of cyclooxygenase mediation. Concentration-dependent arterial resistance vessel dilation in vitro has been reported as dependent of membrane potential, prostaglandin release, or intact endothelium, suggesting a relation to cellular calcium metabolism or sensitivity. A study in bovine aortic endothelial cells suggested a dilatory response secondary to enhanced synthesis and release of endothelium-derived kinins that then trigger cytosolic calcium release and the formation of the vasodilators nitric oxide and prostaglandin I2. However, other studies suggest that the vasodilatory response does not appear to be related to nitric oxide or prostaglandin I2 production. Studies in human vascular preparations show a vasodilatory effect in the absence of functional endothelium, indicating a response not related to kinins or prostaglandins.

Changes in blood viscosity induced by furosemide may also play a role in the vasodilatory response. A feline femoral artery study suggested that diuresis causes an increase in sheer stress that triggers endothelium-mediated vasodilation. A human study explored this idea in healthy versus elderly hypertensive patients by giving members of each group a CRI of 0.5 mg/min until their hematocrit increased 2%. Only the healthy patients experienced secondary carotid vasodilation, suggesting that chronic endothelial or arterial wall alterations may also be variables to consider.

The potential for furosemide-induced vasoactivity is a concern in chronic cardiac patients. A worsening of myocardial perfusion may follow the initial benefit related to relief of acute pulmonary edema. A reduction in circulating volume is contraindicated in patients who are not volume overloaded. Acute heart failure results in a reduction in stroke volume that activates sympathetic maintenance of systemic arterial pressure. Chronic heart failure patients may not exhibit predictable vasodilation in response to furosemide and the risks of increasing myocardial oxygen demand or reducing renal blood flow and glomerular filtration rate make chronic administration potentially harmful. If volume overload does occur in these patients, their response to acute administration of furosemide is influenced by their preexisting renin–angiotensin–aldosterone system activation. This suggests that chronic use of furosemide may blunt its effectiveness when it is needed in the acute setting of volume overload.

Furosemide has been suggested to promote hemodynamic deterioration in human chronic cardiac failure patients. In heart failure studies, plasma norepinephrine is measured as an indicator of neuroendocrine stimulation, an initial physiologic response to maintain effective circulating volume. The degree of renin–angiotensin–aldosterone stimulation is measured using plasma renin and plasma aldosterone levels. With furosemide dosages of 1.3 mg/kg IV, transient elevations of plasma renin, norepinephrine, and arginine vasopressin have been measured in human chronic heart failure patients within the first 20 minutes of...
administration. Although all values returned to baseline over a maximum of 4 hours, this stimulation of the neurohumoral axis may contribute to cardiac dysfunction.\textsuperscript{59} Diuresis, in the absence of pulmonary edema, may reduce circulating blood volume and renal blood flow, further stimulating the renin–angiotensin–aldosterone system. Use without maintenance of vascular volume is contraindicated, especially in cardiac patients. Additionally, chronic heart patients should also receive an angiotensin-converting enzyme inhibitor or angiotensin receptor blocker. Current recommendations for use of furosemide in acute and chronic heart failure depend on the degree of edema. At this time, furosemide has not been validated as safe or efficacious for long-term administration in the absence of volume overload.

Furosemide is currently being studied as an adjunct therapy for acute lung injury (ALI) and acute respiratory distress syndrome (ARDS). Mechanically ventilated dogs given a CRI of 0.2 mg/kg/hr showed significantly improved lung injury scores, increased pulmonary gas exchange, and decreased intrapulmonary shunt fraction in a research model of ARDS.\textsuperscript{45} In another study of ALI, administration of furosemide with albumin compared with furosemide alone was shown to significantly improve oxygenation, hemodynamic stability, and provide a greater net fluid balance.\textsuperscript{60} Unfortunately, this study was not powered sufficiently to evaluate clinical endpoints, such as mortality or duration of mechanical ventilation. The concentration of albumin has been suggested to be the main cofactor required to facilitate the furosemide-induced in vitro endothelium-independent vasodilation.\textsuperscript{61} Rabbit studies, however, showed that furosemide’s attenuation of the vascular smooth muscle relaxation was weakened by the presence of albumin.\textsuperscript{62} It has been suggested that the inconsistency and variability of in vitro studies may relate to the difficulty with completely removing albumin from tissue preparations.\textsuperscript{61}

Canine studies have repeatedly demonstrated furosemide-induced dilation in gastrointestinal vascular beds that has an unknown clinical significance.\textsuperscript{48,49} This effect is believed to be related to prostaglandin production, because the effect is blocked by prostaglandin synthetase inhibitors.\textsuperscript{48} With an onset of 24–30 seconds, maximal dilation of gastric vasculature occurred at 36 seconds, duodenum at 66 seconds, small intestines at 78–84 seconds, and large intestines at 90 seconds.\textsuperscript{48} Oxygen consumption was not altered, despite maximal blood flow elevations of 60% in the stomach and duodenum and 80% in the small and large intestines.\textsuperscript{48} Elevations in blood flow did not appear dependent on perfusion pressure, as no quantitative change to mean abdominal aortic pressure was identified.\textsuperscript{48,49} An increase in canine biliary secretion and pancreatic blood flow (with no appreciable increase in pancreatic exocrine secretion) was initiated at a dosage of 2.4 mg/kg IV. It is suggested that this is not due to a direct effect on the pancreas, but a consequence of increased circulation through the superior pancreaticoduodenal artery.\textsuperscript{49} A conflicting study reported a reduction of blood flow to all pancreatic regions, which did not appear to impact endocrine function.\textsuperscript{63} Hepatic, splenic, and renal arterial blood flows appeared to be unchanged.\textsuperscript{48} The clinical relevance of these studies is unknown, especially under pathologic conditions.

Furosemide is administered in humans for chronic heart failure, acute pulmonary edema, and hypertension.\textsuperscript{36} Despite suggestions that venodilation provides the acute benefit of furosemide administration, there are currently no double-blind, placebo-controlled trials studying these hemodynamic effects. The mechanism of action remains unknown, and yet furosemide shows promise in many other areas of critical care, such as in ALI and ARDS.

**Bronchial Antispasmodic Properties**

Inhaled furosemide attenuates or prevents bronchospasm, stimulates bronchodilation, alleviates the sensation of dyspnea,\textsuperscript{64,65} and inhibits allergen-induced, exercise-induced,\textsuperscript{66} and adenosine-induced bronchoconstriction.\textsuperscript{67} Administration results in a 14% rise in forced expiratory volume over 1 second in human asthmatic patients.\textsuperscript{68} Doubling the inhaled dose from 15 to 30 mg resulted in a longer duration of action, but no measurable difference in degree of protective effect in patients with chronic obstructive pulmonary disease or exercise-induced asthma.\textsuperscript{64,66} An inhalation study in healthy, anesthetized cats showed a blunted behavioral reaction to airway occlusion without an alteration in inhaled noxious stimulus response for 3 hours after administration.\textsuperscript{68} Anesthetized rat studies report inhibition of pulmonary irritant receptors and activation of pulmonary stretch receptors at end-expiratory volume.\textsuperscript{69} Canine studies have also demonstrated inhibition of laryngeal irritant receptors in anesthetized animals.\textsuperscript{65} Human studies examining furosemide’s effect on attenuation of allergic rhinitis symptoms report results that vary from no effect\textsuperscript{70} to a protective effect on nasal mucosa reactivity.\textsuperscript{71} The nasal variability may be the result of a more rapid rate of mucosal absorption and a shortened exposure time or the result of a weaker benefit masked by the ability to induce more severe symptoms in nasal rhinitis volunteers as compared with asthmatics.\textsuperscript{70}

One suggested mechanism for the benefit of inhaled furosemide in asthma is based on ionic alterations in
airway epithelium sensory receptors and/or modulation of pulmonary vagal afferent nerve stimulation.\textsuperscript{65,68,69} NKCC1 is expressed on sensory neurons, with the potential for furosemide-induced chloride alterations inhibiting sensory nerve activation.\textsuperscript{72,73} Inhaled furosemide may also relieve dyspnea by mimicking the effects of large tidal volumes that relieve air hunger in humans.\textsuperscript{74} Other postulated mechanisms for beneficial human asthmatic effects include induction of relaxant prostaglandins, inflammatory cell mediator production blockade, alterations of airway epithelial ion exchange, or production of local inhibitory prostaglandins.\textsuperscript{67,75,76} Damaged epithelium may also have a different pharmacokinetic profile than healthy tissues.\textsuperscript{76} Diuretics with greater potency against NKCC1 have been less effective than furosemide in blocking the asthmatic response.\textsuperscript{67,77} Despite the current findings, studies supporting nebulized furosemide are limited by small sample sizes and conflicting results. At this time it is not routinely used in human asthmatics. If proven clinically, this effect could be beneficial in veterinary patients with asthma, chronic bronchitis, lower airway diseases and pulmonary edema secondary to left heart failure.

Parenteral furosemide has also shown some bronchodilatory action. Studies examining cats are lacking, and potentially clinically significant given their increased airway responsiveness in pathologic condition when compared with other species. Feline hyperreactivity may be explained by the extension of smooth muscle toward the distal airways.\textsuperscript{78} Bronchial response differences have been discovered between species and even stage of life. An \textit{in vitro} study of guinea-pig tracheal and bronchial response found significant differences between adults, newborns, and fetuses with the equivalent of 1 mg/kg IV application. Airway segment relaxation was greatest in the fetus, lesser in the newborn, and least in adults.\textsuperscript{51} Canine tracheal epithelial sheets are more effected by serosal than luminal application due to a basolateral linked sodium chloride entry process; the canine tracheal epithelium actively secretes chloride and alterations of this transcellular pathway led to a decline in tissue conductance.\textsuperscript{79} Anatomic, physiologic, and stage of life differences in pulmonary responsiveness may provide further applications or further contraindications of furosemide.

**Anticonvulsant Properties**

Furosemide has anticonvulsant properties\textsuperscript{80–82} that avoid the common side effects of generalized neuronal suppression associated with antiepileptic drugs.\textsuperscript{83} One study in humans undergoing surgery for medically intractable epilepsy showed that administration of furosemide (0.18–0.45 mg/kg IV) significantly suppressed both spontaneous epileptic spikes and electrical stimulation-evoked epileptiform discharges in all subjects, with complete blockage in some.\textsuperscript{83} It has been shown in laboratory models to suppress different forms of epileptiform activity.\textsuperscript{81,84} Furosemide is believed to increase the minimal current required to elicit ictal discharges, increasing the threshold and possibly decreasing the ability of brain cortical tissues to maintain and propagate seizure activity.\textsuperscript{83} It may represent an important adjunctive therapeutic agent in specific circumstances, such as status epileptics.\textsuperscript{82} A human epidemiological study has also reported that past or present furosemide use is considered protective against development of a first unprovoked seizure in older adults, regardless of therapeutic indication.\textsuperscript{80,83}

Non-synaptic modulation may play a critical role in controlling different manifestations of epileptogenesis.\textsuperscript{83,85} Furosemide is lipid soluble, protein bound, and crosses the blood–brain barrier under normal circumstances and with an enhanced rate in status epilepticus.\textsuperscript{84,86} The nervous system NKCC isoform is NKCC1. It is believed to be responsible for maintaining neuronal intracellular chloride in pyramidal and non-pyramidal neurons. It is also involved in astrocyte and oligodendrocyte potassium uptake and intracellular sodium maintenance.\textsuperscript{7} NKCC1 is an important component to activity-evoked cell volume changes in glial cells that lead to further spontaneous evoked potentials.\textsuperscript{83,86} There is a transient NKCC1 down-regulation 12 hours after human focal cerebral ischemic reperfusion believed to be a compensatory mechanism against neuronal excitotoxicity.\textsuperscript{7} Furosemide administration may be neuroprotective of further cell swelling and secondary damage.

Four isoforms of the furosemide-sensitive KCC have been identified.\textsuperscript{11} KCC2 is neuron-specific through the cortex, hippocampus, and cerebellum.\textsuperscript{92} Its main function is chloride movement into the extracellular space under normal physiologic conditions and does not appear to be involved in cell volume regulation.\textsuperscript{87} The KCC2 found in oligodendrocytes is involved in extracellular volume regulation under normal and pathologic conditions.\textsuperscript{5,11,85} KCC2 accumulates intracellular chloride, potentially providing the chloride gradient for hyperpolarization and inhibition of \(\gamma\)-aminobutyric acid (GABA) receptors.\textsuperscript{6,87} Furosemide blockade of KCC is also neuroprotective, improving outcomes in rat anoxia studies.\textsuperscript{11}

Furosemide inhibits seizure-induced (also called activity-evoked) cell swelling through inhibition of NKCC and KCC that are responsible for maintaining chloride concentrations.\textsuperscript{11,82,83} With the hyperactivity of pathologic condition, such as status epilepticus, there is...
an activity-dependent cell swelling and elevation of extracellular potassium believed to predispose to additional epileptiform activity. Furosemide modulates ionic perturbations, neuronal excitability, and extracellular volume changes independent of its diuretic effect.\cite{81,83} It alters the extracellular electrical field interactions involved in neuronal hyposynchrony and changes the ionic gradients that have indirect and direct effects on neuronal discharge.\cite{82,88} Multiple studies have shown no blood pressure alterations\cite{86} and brain histopathology does not show a significant change in extracellular space volume.\cite{81,83}

Ischemic damage and increased neuronal activity result in a stimulus-induced elevation of extracellular potassium that is considered to be proconvulsant.\cite{81,83} Elevation of extracellular potassium results in glutamate release and astrocyte swelling.\cite{7} Furosemide plays a significant role in potassium redistribution from the extracellular space.\cite{7,81,83,89} High extracellular potassium activates the NKCC1 co-transporter, moving sodium, potassium, and chloride back into the cells.\cite{92} This NKCC1-related potassium scavenging does not occur unless extracellular potassium is elevated.\cite{90} KCC2 is also believed to have a high affinity for extracellular potassium, contributing to the removal of excess potassium.\cite{87} The beneficial effect of reducing elevation of extracellular potassium may be a species-specific response, as astrocyte culture studies showed a 50% reduction in potassium in rats and no reduction in mice,\cite{91} or a dose-dependent response as the same researchers achieved a reduction in mice cultures exposed to double the dose.\cite{90}

Conflicting experimental evidence also surrounds the use of furosemide to reduce choroid plexus cerebrospinal fluid (CSF) production, alter CSF ionic composition, and/or lower intracranial pressure.\cite{92} NKCC1 is present on the choroid plexus epithelium, suggesting inhibition may reduce CSF production or alter CSF ionic content.\cite{89,94} Human OAT1 and OAT3 have been discovered in the cytoplasmic membrane and cytoplasm of human choroid plexus cells but their significance is unknown.\cite{93} Human dosages varying from 5 to 50 mg/kg have been reported to reduce CSF production.\cite{92,93} One study reported an initial CSF reduction of 50% within 30 minutes in cats administered either 50 mg/kg IV or a comparable dosage administered intraventricularly. The rate of CSF production continued to decrease for 1.5 hours and a reduction of CSF potassium was observed. The study concluded with washing of the choroid plexus and demonstrating a return to baseline production after 1 hour.\cite{94} Nephrectomized, normocapnic dogs are reported to have no changes in CSF composition at 2.5 mg/kg IV or 0.125 mg/kg instilled into the lateral cerebral ventricles.\cite{95} High dosages of furosemide (50 and 400 mg/kg IV) did not significantly alter ionic composition in nephrectomized dogs, but CSF production was reduced.\cite{94} Dogs given 0.25 mg/kg intraventricularly had a reduction in CSF chloride.\cite{93} Although the CSF alterations do not relate to its antiepileptic effects,\cite{86} furosemide’s ability to reduce CSF production and thus improve cerebral blood flow under pathologic conditions warrants further examination.

Current proposed mechanisms for reduction of intracranial pressure include a reduction in normal and edematous brain water by reducing ion penetration across either an intact or altered blood–brain barrier. Of concern is a reported feline study where 1 mg/kg furosemide reduced mean arterial pressure by 10% causing decreased edema by reducing cerebral perfusion pressure and tissue pressure gradients.\cite{92} Care should be taken to monitor for the development of hypotension that would contraindicate the use of furosemide.\cite{93}

Furosemide is more effective at reducing elevations in intracranial pressure when it is administered at a 1 mg/kg IV dosage 15 minutes after an IV mannitol infusion.\cite{93} A canine study reported a reduction in maximum intracranial pressure due to a synergism between furosemide and mannitol. Anesthetized dogs received 0.7 mg/kg IV furosemide 15 minutes after receiving 1 gm/kg IV mannitol. Together they produced a greater (62.4% as compared with 56.6% for mannitol alone) and longer duration (5 hours versus 2 hours for mannitol alone) of intracranial pressure reduction.\cite{92}

Transcranial Doppler ultrasound, a non-invasive evaluation of intracerebral blood flow, has been used to evaluate furosemide’s effect on cerebral vascular resistance. Healthy dogs given 1 mg/kg IV showed no significant vascular resistance changes.\cite{96} Clinical and experimental studies are conflicting, with potential variations based on species and alterations in normal versus edematous brain tissues. Current recommendations include furosemide administration as a component of elevated intracranial pressure therapy, despite inconsistent findings.\cite{93}

**Antioxidant Properties**

Furosemide has direct *in vitro*\cite{97} and *in vivo*\cite{31} antioxidant properties and may reduce elimination of other free radical scavengers.\cite{98} It has been shown *in vitro* to have dose-dependent antioxidant effects.\cite{31} Furosemide provides partial protection against free radical damage in rats when administered during the course of oxidative damage.\cite{97} Dosages as low as 0.1 mg/kg/day intraperitoneally for 6 days before oxidative damage have been shown to be protective. The mechanism may be
direct free radical scavenging, ion channel modification, membrane fluidity changes, or induction of or reduced elimination of another free radical scavenger.  

**Iodine Depletive Properties**

Furosemide administration results in total body iodine depletion by reducing the reabsorption of filtered iodide in the thick ascending loop of Henle. Administration of furosemide may be useful for the treatment of toxic ingestion of iodine compounds. Furosemide is also under study as a therapeutic adjunct to radioiodine treatment for human thyrotoxicosis to reduce radioactive doses and provide more efficacious therapy.  

By reducing total body iodine content before therapy, patients showed increased uptake of administered radioiodine. Administration of 40 mg/day oral furosemide for 5 days was more effective than 14 days of a low-iodine diet. Furosemide was also shown to enhance human elimination of radioiodine after ablation treatment, reducing radiation burden and shortening hospital stays. There are no studies in veterinary patients receiving radioactive iodine therapy. The iodine-depleting effect of furosemide is also important to neonates because iodine is a requirement for neonatal growth and development. Furosemide administration should be avoided in lactating animals, as it reduces iodide delivery into the milk.

**Effect on Thoracic Duct Lymph Flow**

Furosemide increases lymph flow through the canine thoracic duct. Following dosages of 8–10 mg/kg, thoracic duct lymph flow increases significantly within 6 minutes, persisting at maximal flow for 20 minutes. This effect is not dependent on renal function based on the mean lymph flow increase in intact dogs and in dogs with bilateral ureteral ligation and nephrectomy. Canine studies also report an increase in intestinal, but not hepatic, lymph flow.

**Effect on Neoplastic Effusions**

An Ehrlich ascites tumor is a research cell line derived from a mouse mammary carcinoma. It is a transplantable, poorly differentiated malignant tumor line used in the examination of neoplastic cell responses, ascitic fluid production, and responses to ascitic fluid. These cells contain NKCC and KCC, with known furosemide responses such as altered chloride fluxes, and changes in cell volume. Furosemide is known to decrease ascitic transudate from some neoplasms, it is possible that the presence of these receptors in certain neoplastic tissues may explain this effect.

**Adverse Effects of Furosemide**

**Electrolyte alterations**

Fluid and electrolyte alterations represent the most common adverse effect of furosemide. Patients should be monitored for hypovolemia, hyponatremia, hypokalemia, hypocalcemia, hypomagnesemia, and hyperglycemia. Neonates and patients with disease processes that prolong the serum half-life of furosemide are more likely to develop these alterations. Furosemide’s impairment of sodium and chloride reabsorption decreases the medullary osmolar gradient, which limits antidiuretic hormone’s ability to increase water reabsorption. Dogs have an increased incidence of secondary hyponatremia, rather than hypokalemia, as compared with other species. Furosemide administration results in elevated levels of sodium, chloride, and water delivered to the distal collecting ducts, resulting in enhanced renal secretion of potassium and hydrogen. This may result in a hypokalemic, hypochloremic metabolic alkalosis in some patients. Although rarely clinically significant, potassium supplementation may be required, especially in patients with a pro-arrhythmic condition such as preexisting hypokalemia.

Patients may require thiamine supplementation due to a flow-dependent, non-specific increase in urinary excretion of thiamine, the significance of which has not been examined in clinical veterinary patients.

A furosemide-induced reduction of divergent cation reabsorption may be useful in treating toxic ingestions of bromide, fluoride, or iodide.

**Hypocalcemia**

Furosemide increases urinary calcium excretion, but clinical secondary hypocalcemia is not usually recognized with routine use because calcium is actively reabsorbed in the distal convoluted tubule. There are compensatory mechanisms to prevent calcium loss that include solute-induced up-regulation of calcium channels and calcium-binding proteins in the distal convoluted tubule and enhanced intestinal calcium absorption, without alteration in serum vitamin D levels. Calcium can be induced by a combination of furosemide with 0.9% saline administration, so furosemide is an adjunct to other therapies that are described for hypercalcemia. Chronic heart failure patients should be monitored for potential osteopenia, secondary hyperparathyroidism, and nephrocalcinosis due to secondary hyperaldosteronism.

**Hypomagnesemia**

Furosemide is associated with increased urinary magnesium excretion and impaired magnesium
A reduction in magnesium concentration of any etiology may lead to excessive calcium accumulation, reported in humans to potentially cause perivascular and/or interstitial fibrosis that may result in abnormal vasomotor reactivity, arrhythmias, and/or ventricular dysfunction.

**Alterations in drug metabolism**
Furosemide decreases human patient sensitivity to aspirin therapy, potentially due to competition for the same OAT site, production of local vasodilators, protein binding competition, or renin-angiotensin activation. Furosemide diuresis in dogs is attenuated by aspirin, but the degree of this effect is variable as reported studies are not consistent regarding administration of fluid therapy and anesthetic agents that could have impaired renal autoregulation. Low-dose aspirin is administered to human and feline cardiac patients to prevent pathologic clot formation. Unfortunately, low- and high-dose aspirin therapy for 1 week has also been shown to inhibit the beneficial furosemide-induced acute venodilation in humans with CHF. Administration of both non-steroidal COX-1 and COX-2 inhibitors in humans blunts the furosemide diuretic response; however, furosemide kinetics and actions have shown no clinically significant alterations with coadministration of meloxicam in healthy or compensated cardiac failure humans, perhaps making this the non-steroidal anti-inflammatory drug of choice with concomitant furosemide administration.

Parenteral furosemide has also been reported to decrease, then increase, thiorurine methyltransferase levels in canine red blood cells potentially altering metabolism of thiorurine medications such as azathioprine.

**Mucociliary impairment**
Parenteral administration for resolution of positive fluid balance in mechanically ventilated patients may result in alteration of mucociliary clearance through mucosal dehydration, systemic dehydration, or altered membrane ionic concentrations. Conflicting studies report no effect versus impairment of mucociliary function for up to 4 hours after furosemide administration.

**Ototoxicity**
Furosemide may cause dose-dependent, usually transient deafness, via endolymph electrolyte alterations. Canine dosages of 20 mg/kg IV have been reported to cause ototoxicity while cats may exhibit signs at much lower doses due to the increased sensitivity of this species. Potentiators of ototoxicity include renal insufficiency, hypoalbuminemia, neonates, high dosages, or the presence of other ototoxic or nephrotoxic drugs. Current recommendations for human patients at risk for ototoxicity include lower dosing, slower administration, or use of an alternative agent.

**Pancreatic effects**
Parenteral furosemide is reported in humans in rare instances to cause nausea and acute pancreatitis. Induction of acute pancreatitis may be related to its sulfonamide structure, or potentially direct stimulation of pancreatic secretion. Furosemide is reported to alter insulin and anti-hyperglycemic agent requirements, potentially resulting in hyperglycemia.

**Delayed wound healing**
Furosemide has been used to alter chloride ion concentrations in studies focused on the pharmacologic alteration of ionic electric currents and their effect on the rate of wound healing. A 2005 study of rat corneal lacerations found that topical furosemide (1 mM) to wounded corneas resulted in a 36% reduction in wound edge size with a 29% slower healing rate. Altered wound currents are thought to directly correlate with in vivo wound healing rate. No published reports on alteration of wound healing rates in veterinary or human patients receiving parenteral or oral furosemide therapy were identified.

**Reproductive effects**
Furosemide is used in a research setting as an inhibitor of rat oxytocin-induced myometrial contractions by unknown mechanisms. NKCC1-deficient mice show significant male and female infertility. The implication for reproductive safety in reproductive or pregnant animals and humans receiving furosemide is unreported.
Human pediatric physicians warn against using furosemide in the first few days of life, as it displaces bilirubin, potentially increasing the severity or incidence of neurotoxicity in patients with neonatal jaundice.123

**Sulfonamide toxicity/side effects**

Cross-allergy sulfonamide hypersensitivity has been reported rarely in humans with an incidence of <0.5%.124 There is no reported cross-reactivity with other sulfonamide compounds in dogs, presumably due to furosemide’s lack of the primary arylamine structure.125 Reported veterinary side effects include skin reactions126 (blisters, skin lesions),2 hematologic effects (anemia, leukopenia), weakness, gastrointestinal disturbances,3 and restlessness.5 Human reported side effects also include rare interstitial nephritis and anxiety.2 Subsequent administration of furosemide in human patients after non-anaphylactic-type reactions has been successful without recurring reaction.124 Approximately one-third of human patients receiving chronic furosemide therapy may experience a subclinical haptenic immunologic reaction.127

**Thyroid binding interference**

Care must be taken interpreting thyroid function tests in patients receiving either short- or long-term furosemide. Furosemide interferes with thyroid function tests via competitive binding with serum thyroxine (T₄) and serum triiodothyronine (T₃) for thyroxine-binding globulin (TBG) and albumin.128,129 This low affinity reversible binding is proportional to plasma drug concentration.130,131 Patients may potentially be misdiagnosed with hypothyroidism and receive unwarranted treatment especially if serum T₄ alone is measured.

Protein binding provides a thyroid hormone circulating buffer pool, extending the half-life of T₄ and T₃, and providing a T₄ plasma reserve. Protein-binding interference results in a greater concentration of unbound free hormone, which shortens the circulating half-life. This results in a transient increase in free serum thyroid hormone levels, leading to a potential for feedback modification to the hypothalamus and anterior pituitary ultimately reducing thyroid stimulating hormone (TSH) secretion.128 The resultant laboratory profile can be mistaken for that of the hypothyroid patient.

On thyroid panels, the furosemide patient may initially show a decrease in serum T₄ despite increased free T₄ (fT₄) concentrations.129 Continued administration may result in decreased serum T₄, increased fT₄, and normal TSH levels.126 Dogs have been reported to show a similar response to acute administration, with a decreased serum T₄ and increased fT₄.132 If only T₄ and TSH levels are evaluated, the canine patient may be incorrectly diagnosed as hypothyroid or sick euthyroid, a condition associated with illness and a reduction in T₄ with normal TSH levels.131 This interference is magnified in hypoalbuminemic states as T₄, T₃, and furosemide are extensively and competitively albumin bound. Careful interpretation must also occur with hepatic insufficiency as albumin and TBG are produced by the liver.128 Human in vitro tests have suggested that furosemide may have no effect at usual therapeutic doses. However, single large dosages given to human renal failure patients resulted in a 26% increase in fT4 within 4 hours.130 Some authors have also recommended cessation of treatment with furosemide for 7–10 days before thyroid testing.129 An alternative includes performing a complete thyroid panel on furosemide patients, including T₄, fT₄, and TSH levels to accurately assess thyroid function. A thyroid panel showing decreased serum T₄ with normal to increased serum fT₄ and TSH is consistent with impaired plasma protein binding.131

**Conclusion**

Furosemide inhibits NKCC and KCC, resulting in a wide range of therapeutic effects and research implications. Furosemide is widely used in veterinary medicine as a loop diuretic, reducing the symptoms of volume overload in renal and cardiac disease. The acute improvement of clinical symptoms may be the result of vasodilation and relief of dyspnea before diuresis.

Animal models and current human research support anecdotal reports of antiseizure properties and use in status epilepticus in veterinary patients. Other effects of furosemide include its activity as an antioxidant and as an iodine depletive, and its effects on thoracic lymph duct flow.

Side effects include altered drug metabolism, electrolyte depletion, ototoxicity, mucociliary impairment, endocrine and exocrine pancreatic effects, delayed wound healing, sulfonamide toxicity, and thyroid binding interference. It is worthwhile to consider the implications of these effects when administering furosemide.

**References**

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