Role of RBC Partitioning and Whole Blood to Plasma Ratio in Bioanalysis: A Case Study With Valacyclovir and Acyclovir

Arabinda Saha*, Ajay Kumar, Sanjay Jagannath Gurule, Arshad Khuroo and Pratika Srivastava
Department of Clinical Pharmacology and Pharmacokinetics, Sun Pharmaceutical Industries Limited, Gurgaon, Haryana, India

Abstract

A LC-MS/MS method was developed for simultaneous estimation of valacyclovir and acyclovir in human plasma. Plasma sample was extracted with solid phase extraction technique and chromatographic condition was set with Inertsil CN-3 (5 µm) column and mobile phase (1 mM ammonium acetate buffer - methanol, 50:50 v/v). Valacyclovir, acyclovir, Valacyclovir D4 and acyclovir D4 were detected in positive polarity in multiple reactions monitoring mode at mass transitions (m/z) 325.2→152.1, 226.2→152.1, 329.3→152.1 and 230.2→152.1, respectively. The validated calibration curve range for valacyclovir is 4.09 to 725.63 ng/mL and for acyclovir is 50.35 to 10017.29 ng/mL. During method development, stability of acyclovir in whole blood could not be established over the period for 2 hr as the $K_{\text{pl}}$, ratio for acyclovir is greater than 1 and although for valacyclovir it is less than 1. Therefore, the drug distribution, due to high value of blood to plasma ratio of these drugs, is crucial parameter for these antiviral drugs. Henceforth, the blood to plasma ratio is crucial parameter for these antiviral drugs.

Introduction

Valacyclovir the L-valyl ester of acyclovir is an oral prodrug that undergoes rapid and extensive first-pass metabolism to yield acyclovir and the essential amino acid L-valine [1]. Acyclovir, the active antiviral component of valacyclovir, shows good in vitro activity against the HSV-1, HSV-2 and varicella zoster virus. The bioavailability of acyclovir after oral administration of valacyclovir is considerably greater than that achieved after oral administration acyclovir. Thus, valacyclovir delivers therapeutic acyclovir concentrations when administered in a less frequent oral dosage regimen than is required for acyclovir. The estimated plasma concentrations of valacyclovir is very low after 3 hours and practically non-quantifiable. The maximum plasma concentrations (C_{max}) of valacyclovir are usually less than 0.5 µg/mL at all doses [2]. The plasma half-life of acyclovir is approximately 2.5 to 3.3 hrs for all oral doses of valacyclovir [3].

Perrottet et al. [4] investigated the distribution of ganciclovir and acyclovir in red blood cell (RBC) and plasma and concluded that an initial drop of ganciclovir and acyclovir level in plasma (~25%) due to the cellular uptake of acyclovir by erythrocytes. Hence, the spiked comparison samples were allowed to reach equilibrium (between RBC and plasma). After reaching the equilibration time (30.0 min), plasma was harvested from the spiked whole blood and processed as per the proposed protocol. From the blood stability data, we concluded that valacyclovir and acyclovir both are stable in blood for 2 hrs. The developed method was validated as per current regulatory guidelines and applied for valacyclovir and acyclovir bio-equivalence study.

Keywords: Acyclovir; LC-MS/MS; RBC partitioning; Stability; Valacyclovir; Whole blood to plasma ratio

Experimental

Chemicals and reagents

Working standard of valacyclovir (VAL) and acyclovir (ACL) were obtained from USP. Working standard of valacyclovir D4 (VAL D4) and acyclovir D4 (ACL D4) were obtained from Clearsynth labs Ltd, Mumbai, India. were procured from Fluka (Sigma-aldrich, Steinheim, USA). All the reagents (like formic acid, ortho phosphoric acid, acetic acid, ammonium acetate, methanol, acetonitrile, water, methanol, etc) were of analytical grade.

*Corresponding author: Arabinda Saha, Department of Clinical Pharmacology and Pharmacokinetics, Sun Pharmaceutical Industries Limited, GP-5, HSDC, Old Dehi Gurgaon Road, Udyog Vihar Industrial Area, Gurgaon-122 015, Haryana, India, Tel: +912243244324; E-mail: arabinda.saha@sunpharma.com

Received October 18, 2017; Accepted November 22, 2017; Published November 28, 2017


Copyright © 2017 Saha A, et al. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.
acid, hydrochloric acid and liquor ammonia solution) with analytical grade was used for sample preparation and LC-MS grade solvent (like methanol) was used analysis. Oasis MCX cartridge (30 mg/1 cc) were used for extraction purpose. Human K<sub>EDTA</sub> plasma was procured from Yash Path Lab, Mumbai, India.

**Chromatographic conditions**

Suitable chromatographic conditions was achieved with Inertsil CN-3 (75 mm × 4.6 mm, 5 μm) column and mobile phase composed with 1 mM ammonium acetate buffer and methanol (50:50, v/v). Mobile phase was delivered with 0.8 mL/min flow, where 50% of the flow was split. For autosampler (in injector) 10°C and for column oven 35°C temperature was maintained.

**Mass spectrometric conditions**

Mass spectrometer parameters were optimized, by infusing individual neat solution of each compound (100.0 ng/mL) into the LC-MS/MS. The mass spectrometer (API-3000) equipped with electrospray ionization operated in positive polarity using multiple reaction monitoring (MRM). The mass transitions (m/z) were selected as 325.2 <→ 152.1, 226.2 <→ 152.1, 329.3 <→ 152.1 and 230.2 <→ 152.1 for VAL, ACL, VAL D4 and ACL D4, respectively. The optimized compound parameters for monitoring VAL and VAL D4 were set as follows: declustering potential (DP), 35 V; entrance potential (EP), 10 V; focusing potential (FP), 140 V; collision energy (CE), 23 V; and collision cell exit potential (CXP), 8 V. The optimized compound parameters for monitoring ACL and ACL D4 were set as follows: declustering potential (DP), 20 V; entrance potential (EP), 10 V; focusing potential (FP), 100 V; collision energy (CE), 15 V; and collision cell exit potential (CXP), 8 V. The source parameters of the mass spectrometer were optimized and maintained as follows: collision associated dissociation gas (CAD), 10 psi; curtain gas (CUR), 8 psi; nebulizer gas, 8 psi; turbo ion spray voltage, -5500 V; and source temperature, 475°C.

**Bulk spiking**

All the stock solutions of working standard was prepared in 0.5(N) hydrochloric acid solution at a concentration of 1 mg/mL except for the ACL, for which the strength is 3 mg/mL and were stored in refrigerator (1-10°C). The stock solutions of VAL and ACL were further diluted with methanol-water (50:50, v/v) to yield working solution at different concentration levels. Non zero-calibration standards (CC) and quality control (QC) samples were prepared by spiking (1%, v/v) of secondary solutions in human K<sub>EDTA</sub> plasma. The final concentration for the CC in human K<sub>EDTA</sub> plasma were 4.09, 11.61, 23.22, 58.05, 145.13, 290.25, 580.50, 725.63 ng/mL for VAL and 50.35, 141.04, 320.55, 801.38, 2003.46, 4006.91, 8013.83, 10017.29 ng/mL for ACL. Separate stock solutions were prepared for spiking of QC samples. Working solutions prepared from the stock solutions were used to spike QC samples in human K<sub>EDTA</sub> plasma at 4.10 ng/mL (LOQQC); limit of quantification, 11.72 ng/mL (LQC); lower QC, 285.92 ng/mL (MQC); middle QC and 571.84 ng/mL (HQC); higher QC for VAL and 50.46 ng/mL (LOQQC); limit of quantification, 145.41 ng/mL (LQC); lower QC, 4039.06 ng/mL (MQC); middle QC and 8078.12 ng/mL (HQC); higher QC for ACL. During bulk spiking, ice cold water bath and under low light conditioned was maintained. Bulk spiked CC and QC samples were stored below -50°C and protected from light till use. The secondary solution of ISTD (1000.0 ng/mL of VAL D4 and 2000.0 ng/mL of ACL D4) for regular use was prepared in methanol-water (50:50, v/v) from standard stock solution.

**Sample plasma extraction**

The SPE method was used to extract VAL, ACL and their respective internal standard from human plasma. For this purpose, 100 μL of plasma and 50 μL of internal standard was added in labeled polypropylene tubes. Thereafter, 750 μL of solution-1 (5% ortho phosphoric acid in water, v/v) was added to each sample and vortexed for 10 sec. The pretreated samples was loaded on the equilibrated Oasis MCX cartridge (30 mg/1 cc) and centrifuged at 4000 rpm for 1 min. After that 1 mL of methanol and 1 mL of water were used to washed the SPE cartridges and 1 mL of elution solution (5% ammonia in methanol, v/v) was used to elute the analyte and internal standard from the cartridges. The eluted samples were evaporated to dryness at 30°C under nitrogen gas and then reconstituted with 500 μL of reconstitution solution (1 mM ammonium acetate buffer-methanol, 50:50 v/v). Reconstituted sample was transferred into autosampler vials and 10 μL of sample was injected into the LC-MS/MS for analysis.

**Impact of RBC partitioning and whole blood to plasma ratio in bioanalysis**

After spiking of ACL working solution into human whole blood, a substantial decrease in ACL concentration was observed in vitro plasma sample. It may be due to the reason of drug uptake by erythrocyte before reaching the equilibrium between erythrocyte and plasma, that is, the value of blood to plasma ratio (K<sub>WB/p</sub>) for ACL is high. This it could lead to pseudo estimation of ACL and VAL in human plasma after oral dose of VAL. To avoid such occurrence, it is essential to identified the time to reach equilibrium between RBC and plasma before separation of plasma from the incurred blood samples. Therefore, it was essential to determine the RBC partitioning, whole blood to plasma ratio and equilibrium time for VAL and ACL.

**Phase I: Determination of RBC partitioning and K<sub>WB/p</sub> ratio**

Aliquots of fresh whole blood and control plasma (separated from fresh whole blood in parallel) were spiked with working solutions of ACL and VAL (at HQC level) and then incubated at 37°C. After completion of the incubation period, plasma was separated from the incubated whole blood. Four aliquots of each sample (that is, isolated plasma from whole blood and control plasma) were processed as per proposed sample processing technique and the concentrations of target analytes in plasma samples was analyzed by LC-MS/MS. The K<sub>WB/p</sub> ratio and RBC partitioning were calculated using following equations:

\[
\text{Whole blood to plasma ratio: } K_{WB} / P = \frac{C_{p}}{C_{WB}}
\]

Where, \(C_{p}\) is the concentration of the drug in control plasma and \(C_{WB}\) is the concentration of the drug in separated plasma.

**RBC partitioning:**

\[
K_{RBC} / P = 1 + \left( \frac{1}{H} \frac{C_{p}}{C_{WB}} \right)
\]

Where, \(H\) is the hematocrit value.

**Phase II: Determination of equilibrium time:**

Working solutions of VAL and ACL were spiked into human K<sub>EDTA</sub> whole blood (at LQC and HQC level). After spiking, samples were shaken gently for drug distribution and incubated at 37°C. Blood samples were then centrifuged at 4 ± 2°C and 4000 rpm for 15 minutes to separate plasma from the blood. At 0.0 min and 15.0 min, 30.0 min, 45.0 min and 60.0 min after spiking, the blood samples were centrifuged for plasma isolation and samples were kept in ice cold water bath till processing. Plasma samples separated at each time points (including both QC levels) were processed as per proposed processing protocol and analyzed in LC-MS/MS system. Peak area ratio (peak area response of analyte/ peak area response of internal standard) was obtained at each time interval was compared with the adjacent time point that is, 0.0 min.
When AME value is >1, ionization of the analyte in mass spectrometer ion source is suppressed by the co-elute matrix components (that is, ion-suppression).

Case II: When AME value is <1, ionization of the analyte in mass spectrometer is enhanced by the co-elute matrix components (that is, ion-enhancement).

Required number of aliquots of human plasma with different lots were processed as per our developed sample processing technique till drying step and after drying the analyte and internal standard dilution were added into the dried plasma samples to prepare the post-extracted samples and analyzed in LC-MS/MS system along with the neat samples. The neat samples prepared by assuming the 100% extracted concentrations for analyte as well as internal standard in LQC, MQC and HQC levels.

Evaluation of relative Matrix effect (RME) was carried out in four different levels of QC (that is, LOQQC and HQC) in each plasma lot (including hemolyzed and lipemic plasma). Two aliquots of matrix effect QC samples were processed along with freshly spiked CC set and control QC samples and analyzed in LC-MS/MS system.
Stability

Stability of analytes was investigated in stock solutions as well as in human plasma under different storage conditions and for internal standard only stock solution and working solution stability were performed. In stock solution stability, secondary working solution of analyte as well as internal standard were prepared from the old and new stock solution and the peak area response observed in stability sample was compared with the comparison sample. Stability QC samples were retrieved from the deep freezer (below -50°C) and stored in ice cold water bath to performed the bench top stability and after completion of the required time (for ~7.1 hr), stability samples were processed with the freshly spiked QC samples. Stability QC samples were processed and stored in auto sampler (at 10°C) and after complete the required storage time (~98 hr), freshly spiked QC samples (comparison sample) and CC set were processed and analyzed with the stability samples. The freeze-thaw stability was performed by comparing the concentrations of the stability samples that were frozen (at -50°C) and thaw (in ice cold water bath) for three times with freshly prepared QC samples. To demonstrate the long term stability experiment, QC samples were stored in deep freezer (below -50°C) for longer duration. After completion of the storage period, freshly spiked CC set and comparison QC samples were processed with the stability QC samples. For evaluation purpose, the observed concentrations of stability QC samples were compared with the original spiked concentrations. Stability experiment in human plasma were performed at both level of QC (that is. LQC and HQC). % Change was determined by following formula:

\[ \% \text{ change} = \frac{|S - F|}{F} \times 100\]

If % change is within 15, then analyte is considered as stable in that storage condition. Where, S=Mean observed concentration of stability samples and F=Mean observed concentration of comparison samples.

Results and Discussion

Optimization of mass parameters

Chemical structures of VAL, VAL D4, ACL and ACL D4 are shown in Figure 1. Due to presence of an amino moiety in the chemical structure of the analyte, scanning also performed in positive polarity. During daughter ion scan, the major ions was observed at m/z 152.1, 146.2 and 174.1 for VAL and ACL. The predominant and most intense ion of m/z 152.1 was selected as a daughter ion for both analytes. During product ion scan of both the internal standards, similar fragmentation pattern was observed and thus 152.1 was also selected as daughter ion for both the internal standard. During mass parameter optimization it was noted that compound parameters like CE and CAD are the most crucial compound parameters to achieve peak sensitivity and stable response for all analytes. The parent ion (Q1 mass) /daughter ion (Q3 mass) 325.2->152.1, 226.2->152.1, 329.3->152.1 and 230.2->152.1 were selected for VAL, ACL, VAL D4 and ACL D4, respectively. The daughter ion mass spectra of VAL, ACL, VAL D4 and ACL D4 are shown in Figure 2.

Optimization of sample extraction

Initially, the extraction of VAL and ACL was carried out via protein precipitation with common solvents like acetonitrile, methanol and acetone, but the recovery was poor (<15%) in all solvents with frequent clogging of the column. LLE technique was also evaluated for extraction purpose using organic solvents like isopropl alcohol, diethyl ether, dichloromethane, tert methyl butyl ether. However, due to ion enhancement the recovery was inconsistent at all three level of QC (%CV >40) for ACL. Finally, optimization of the SPE process was done on Waters Oasis HLB, Waters Oasis’ MCX, Waters Oasis’ MAX and Phenomenex Strata cartridges. Addition of strong acid like ortho phosphoric acid (5%, v/v) during sample preparation helped in breaking the drug-protein binding and maintaining the analyte in the ionized form. Thus, better retention was provided on the Waters Oasis’ MCX as compared to other cartridges. Elution step was optimized with different solvent/solutions and it was observed that 2% ammoniated methanol is optimum to get higher and consistent recovery for both analytes.

Selection of internal standard

According to the US FDA guideline, the internal standard should ideally mirror the analyte in as many ways as possible. Henceforth, the isotopic labeled compound VAL D4 and ACL D4 were selected as internal standards for simultaneous estimation of VAL and ACL in human plasma.

Estimation of RBC partitioning and $K_{WB/P}$ ratio

The estimated value of $K_{WB/P}$ is less than 1 for VAL, but for ACL it is greater than 1. Due to high value of $K_{WB/P}$, ACL is available in low concentration in separated plasma samples which was harvested...
from the whole blood before reaching the equilibrium time. VAL is rapidly converted to its active metabolite ACL, therefore it is required to estimate the ACL concentration in incurred sample in plasma. Henceforth, it is essential to determine the equilibration time for ACL to avoid any pseudo concentration in incurred plasma samples.

**Determination of equilibration time**

No significant difference was observed within mean area ratio in all the processed samples (including all time points) for VAL. But, concentration dependent partitioning was observed for ACL, that is, at high QC level RBC partitioning value is more as compare to low QC level. This is probably due to the high protein binding characteristic of ACL or within the blood active transport of drug is take place. At high drug concentration, this process is become saturate. For evaluation purpose, an through investigation was carried out with complete concentration range.

Mean peak area ratio was compared between two neighboring time points and similar peak area ratio was observed between time point 30.0 min and 45.0 min for ACL and represented graphically in Figure 3. So, it was concluded that equilibration was achieved after 30 min between RBC and plasma (Tables 1a and 1b). For this reason, during whole blood stability the comparison samples (freshly spiked) were kept in ice cold water bath for 30 min to achieve equilibrium between erythrocyte/plasma before plasma seperation.

Whole blood stability: In human K$_3$EDTA whole blood, the target analytes (that is, VAL and ACL) were found to be stable for ~2.45 h and the calculated % stability is within ± 15% for both the analytes. Whole blood stability data are presented in Table 2.
Results of method validation

The calculated % peak area response at the RT of VAL and ACL in the processed human plasma lots are less than 20% when compared with mean peak area of analyte that was observed at LOQ levels. The chromatograms of double blank samples, single blank samples (where double blank samples are processed with internal standard) and LOQ are shown in Figure 4. The evaluation of a representative calibration curve for weighing factor was statistically determined using the formula \[ \text{r} = \frac{\sum \text{dev}^2 + \sum (\% \text{dev})^2}{n} \]. The least value was chosen for best fit by statistically evaluation. The r-square was greater than 0.99.

In Table 3, precision and accuracy data for intra-day and inter-day run VAL and ACL are tabulated. The process efficiency at LQC, MQC and HQC levels were 81.5%, 77.9%, 76.7% for VAL and 70.2%, 70.1%, 73.2% for ACL, whereas it was 92.0% and 83.0% for VAL D4 and ACL D4, respectively. The process efficiencies were consistent and reproducible with this extraction method (Table 4).

In LC-MS/MS method, ionization of analyte is effected by the co-elute matrix ions specially when, ESI is applied as an ionization mode.

---

<table>
<thead>
<tr>
<th>Time (min)</th>
<th>Mean peak area ratio (At LQC level)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Acyclovir</td>
</tr>
<tr>
<td>0.00</td>
<td>0.2420</td>
</tr>
<tr>
<td>15.00</td>
<td>0.1924</td>
</tr>
<tr>
<td>30.00</td>
<td>0.1579</td>
</tr>
<tr>
<td>45.00</td>
<td>0.1572</td>
</tr>
<tr>
<td>60.00</td>
<td>0.1571</td>
</tr>
</tbody>
</table>

Table 1a: Time v/s area ratio (n=4).

<table>
<thead>
<tr>
<th>Time intervals</th>
<th>% Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Acyclovir</td>
</tr>
<tr>
<td>LQC level</td>
<td>HQC level</td>
</tr>
<tr>
<td>0.0 min vs 15.0 min</td>
<td>5.71</td>
</tr>
<tr>
<td>15.0 min vs 30.0 min</td>
<td>4.93</td>
</tr>
<tr>
<td>30.0 min vs 45.0 min</td>
<td>0.11</td>
</tr>
<tr>
<td>45.0 min vs 60.0 min</td>
<td>0.01</td>
</tr>
</tbody>
</table>

Table 1b: %Difference of area ratio with time (n=4).

<table>
<thead>
<tr>
<th>Analyte</th>
<th>QC level</th>
<th>Mean area ratio</th>
<th>% Stability</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Stability sample</td>
<td>Comparison sample</td>
<td></td>
</tr>
<tr>
<td>VAL</td>
<td>LQC</td>
<td>0.0364</td>
<td>0.0371</td>
</tr>
<tr>
<td></td>
<td>HQC</td>
<td>1.9628</td>
<td>2.0238</td>
</tr>
<tr>
<td>ACL</td>
<td>LQC</td>
<td>0.1408</td>
<td>0.1322</td>
</tr>
<tr>
<td></td>
<td>HQC</td>
<td>7.9912</td>
<td>8.2579</td>
</tr>
</tbody>
</table>

Table 2: Whole blood stability (n=4).

<table>
<thead>
<tr>
<th>Analyte name</th>
<th>QC level</th>
<th>Nominal conc. (ng/mL)</th>
<th>Intra-run (n=6)</th>
<th>Inter-run (n=18)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Mean observed conc. (ng/mL) % CV</td>
<td>Accuracy</td>
<td>Mean observed conc. (ng/mL) % CV</td>
</tr>
<tr>
<td>VAL</td>
<td>LOQQC</td>
<td>4.10</td>
<td>4.26</td>
<td>84.1</td>
</tr>
<tr>
<td></td>
<td>LQC</td>
<td>11.72</td>
<td>11.81</td>
<td>2.7</td>
</tr>
<tr>
<td></td>
<td>MQC</td>
<td>285.92</td>
<td>289.16</td>
<td>0.6</td>
</tr>
<tr>
<td></td>
<td>HQC</td>
<td>571.84</td>
<td>585.49</td>
<td>2.6</td>
</tr>
<tr>
<td>ACL</td>
<td>LOQQC</td>
<td>50.46</td>
<td>47.43</td>
<td>1.9</td>
</tr>
<tr>
<td></td>
<td>LQC</td>
<td>145.41</td>
<td>141.08</td>
<td>1.3</td>
</tr>
<tr>
<td></td>
<td>MQC</td>
<td>4039.06</td>
<td>3991.93</td>
<td>1.1</td>
</tr>
<tr>
<td></td>
<td>HQC</td>
<td>8078.12</td>
<td>8175.51</td>
<td>3.1</td>
</tr>
</tbody>
</table>

Table 3: Intra-and inter-day precision and accuracy data.
Figure 2c: MSMS scan of Valacyclovir D4.

Figure 2d: MSMS scan of Acyclovir D4.

Figure 3a: Erythrocyte/plasma equilibration curve (at LQC level).
Figure 3b: Erythrocyte/plasma equilibration curve (at HQC level).

Figure 4a: Representative chromatograms of extracted double blank sample.
Figure 4b: Representative chromatograms of extracted single blank sample (processed with internal standard).

Figure 4c: Representative chromatograms of extracted LOQ sample.
So, it is essential to eliminate the effect of co-elute matrix in ionization, to get the exact concentration of analyte in the incurred samples. Hence, the two most important validation parameters like, AME and RME were evaluated during validation. The % CV of AME at each level QC were in the range of 0.9-1.6 and 0.7-1.9 for VAL and ACL, respectively and between three QC levels it was 2.5 and 2.8 for VAL and ACL, respectively. This data suggested that, when the target analytes are ionized in ion source no interference (that is, ion-suppression or ion-enhancement) was observed from the co-elute matrix ions. The AME data is tabulated in Table 5. The relative matrix effect (RME) data was also acceptable as per regulatory guidelines and tabulated in Table 6.

Stock solution stability of VAL, VAL D4, ACL and ACL D4 were stable for 22 days at refrigerated temperature (1-10°C) and the calculated % stability were 96.1%, 100.7% and 105.8%, respectively. After retrieval of the spiked plasma samples from the deep freezer were found stable for ~7.17 h in ice cold water bath and under low light conditions and for atleast
three freeze (below -50°C) and thaw (in ice cold water bath) cycles. The final extracted samples was stable for ~98 h in auto sampler temperature (10°C) without any drug loss. To perform the long term stability, spiked plasma samples were stored below -30°C and were found stable for 107 days. All the stability experiment in human plasma were performed at two levels of QC (LQC and HQC) and the data are shown in Table 7.

### Conclusion

The work described in this article for simultaneous estimation of valacyclovir and acyclovir in human plasma that reports a significant advancement over existing LC-MS/MS methods for simultaneous analysis of VAL and ACL in human plasma. From the experimental data it reflects that K<sub>ACL</sub>/K<sub>VAL</sub> ratio of ACL is high, hence it is recommended that plasma to be separated from the spiked and/or clinical blood sample after equilibration attained between RBC and plasma.

Overall the developed method is highly selective and sensitive with no matrix interference and successfully applied for estimation of VAL and ACL in human plasma to conduct a bioequivalence study.

### Acknowledgements

The authors thank Sun Pharmaceutical Industries Ltd. for giving permission to publish in-house data.

### References


