

Review Article

A Brief Chronological Overview of Buccal Film Formulations

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DOI: https://doi.org/10.24321/2278.2044.202241

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How to cite this article:

Basha DC, Sudha BN. A Brief Chronological Overview of Buccal Film Formulations. Chettinad Health City Med J. 2022;11(4):53-60.

Date of Submission: 2022-09-27 Date of Acceptance: 2022-12-07

ABSTRACT

The bioadhesive buccal film drug delivery technology that increases the safety, effectiveness, and stability of active pharmaceutical ingredients is the main focus of the current article. The buccal film is cuttingedge technology since it offers a better way to maximise treatment effectiveness. The medications that are used to increase bioavailability and have a high first-pass metabolism are ideal for this drug delivery strategy. Rolling, hot-melt extrusion, solid dispersion, solvent casting, or semi-solid casting can all be used to make Bioadhesive Buccal Films (BBF). The solvent casting method is the most popular of them. Organoleptic valuation, thickness, transparency, surface pH, moisture content, tensile strength, per cent elongation, folding endurance, swelling assets, drug content, and in vitro dissolution tests are a few of the mechanical assets that are assessed for the BBF. A small amount of material on earlier work on BBF has been provided in the article. This article will be useful for quick references to prior BBF attempts and guidance on how to assess them.

Keywords: Buccal, Bioadhesive, Bioavailability, Evaluation, Film, Literature

Introduction

Bioadhesive Buccal Films (BBF) are a type of dosage form that, when applied to the tongue or oral cavity, uses a water-dispersible polymer to quickly hydrate, attach, and dissolve, resulting in systemic drug delivery.¹

The most recent development in buccal administration is BBF. They are now more important than ever as patient-friendly, cost-effective, and cutting-edge Active Pharmaceutical Ingredient (API) delivery techniques.² Since BBFis designed to hold to the BBF, it can be made to have both local and systemic activity.³ The BBF may be more flexible and pleasant than buccal pills. Instead of going through the liver's first-pass processing, BBF injects API directly into the bloodstream via the internal jugular vein. The BBF's large surface area also makes it easier to quickly moisten, which speeds up the API's absorption. The buccal mucosa is an important region for medicine absorption because of its rich blood supply. Its bioavailability is increased by prolonging its residence time at the site of absorption since the dosage form is simple to provide to paediatric and geriatric patients, as well as those who are intellectually challenged, uncooperative, or have physical or mental disabilities.⁴ The difficulty of combining large doses of API with BBF is its main disadvantage. Depending on how they are made, BBF's API dissolving speeds might

Chettinad Health City Medical Journal (P-ISSN: 2277-8845 & E-ISSN: 2278-2044) Copyright (c) 2022: Author(s). Published by Advanced Research Publications



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range from minutes to hours.⁵ Orally administered dosage forms have the following drawbacks:^{6,7}

- Due to slow absorption or delayed onset of action, it is not suitable for emergencies or patients who are unconscious
- It is challenging for a patient to undergo oral dosage formif they suffer from gastrointestinal issues such as diarrhoea, constipation, ulcers, or hyperacidity in the stomach
- In many cases, the API itself causes these issues, such as aspirin and several NSAIDs, which may eventually lead to stomach ulcers with prolonged use
- Patients with malabsorption syndrome, in which it is impossible to absorb nutrients through the small intestine, shouldn't have an oral dosage form
- It is insufficient for API that might be inactivated or damaged in the gut. An example of a protein is insulin. Orally ingested protein from foods like meat and fish is broken down in the stomach
- Children or infants that are uncooperative should not receive it
- Patients with chronic vomiting should not have it

The BBF have the following advantages:^{8,9}

- In addition to the area's high blood supply, it is also possible to accomplish a rapid commencement of the therapeutic action because there are no Gastrointestinal (GI) components that could impede absorption (gastric emptying, presence of food, gastric disease, etc.)
- Some APIs (like peptides) that would usually be damaged by the gastric pH or enzymes can be delivered buccally due to the absence of exposure to the hostile gastric milieu
- Regarding the oral route, by avoiding intestinal and first-pass hepatic processing, avoiding portal circulation can boost bioavailability

Evaluation

The BBF is assessed using the following tests:

API Excipient Compatibility

After choosing the Active Pharmaceutical Ingredient (API) and excipients for BBF, analytical measures must be used to determine whether the API and its mix with excipients are compatible. DSC, or differential scanning calorimetry, is used to verify if the API has been impregnated with the excipients. To determine the API presence as its crystalline nature in the excipient blend, they have to confirm by powder XRD. Later, FTIR spectra have to be acquired to verify the API's characteristic stretches and peaks undisturbed in the blend.

Measurement of Mechanical Properties

Elongation at break and tensile strength are the two

mechanical characteristics of the films that are measured (tensile tester-Vantage NX). The film strip is trimmed to the required proportions (60x10 mm), made free of visible flaws, and placed between two clamps spaced 3 cm apart. The top clamp drags the strips apart until they break at a rate of 2 mm/sec, at which point the force and lengthening of the film at that location are recorded. Clamps enable the BBF to maintain film integrity throughout the test without squeezing it.¹⁰

Surface pH

On an agar plate, BBFs are permitted to swell for two hours. A pH paper is placed on the surface of the swollen area to measure the surface pH.¹¹

Thickness Measurements

Using an electronic digital micrometre, the thickness of each film is measured in five separate places (the centre and the four corners). For this test, either a vernier calliper or a screw gauge is employed.¹²

Swelling Study

BBF is weighed individually (W1), placed separately in 2% agar gel plates, maintained at $37\pm1^{\circ}$ C, and examined for any physical changes in weight gain (W2). Every hour for up to three hours, films are removed from the gel dishes, and any excess surface water is carefully cleaned away with filter paper (eq. 1).¹³

Swelling Index = (W2-W1)/W1 X 100----(1)

Water Absorption Capacity Test

In an incubator that is kept at $37\pm0.5^{\circ}$ C, circular films with a surface area of 2.3 cm² are preserved. These films are indorsed to protrude on the surface of agar plates prepared in simulated saliva (2.38 g Na₂HPO₄, 0.19 g KH₂PO₄, and 8 g NaCl per litre of distilled water adjusted with phosphoric acid to geta pH of 6.7). The final constant weights are recorded after samples are dried for 7 days in a desiccator over anhydrous CaCl₂ at room temperature. Samples are weighed (wet weight) at various time intervals (0.25, 0.5, 1, 2, 3 and 4 hours). (eq. 2).¹⁴

Water Uptake (%) = (Wf-Wi)/Wi X 100----(2)

Where Wf = Final weight of BBF, and Wi = initial weight of BBF.

Ex Vivo Bioadhesion Test

Phosphate buffer isused to separate and clean the young sheep's mouth (pH 6.8). The open entrance of a glass vial holding phosphate buffer has a bit of gingival mucosa twisted inside it (pH 6.8). This glass vial hardly touches the mucosal surface since it is designed to fit tightly inside a glass beaker filled with phosphate buffer (pH 6.8 at 37 \pm 0.5°C). A rubber stopper's bottom side is attached to

the film using cyanoacrylate adhesive. A 5 g weight is balanced using two balance pans. The left side pan, which was loaded with the pan attached with the film over the mucosa, has had its 5 g weight removed. Throughout the five-minute contact period, the balance is held in this position. Water is gradually added to the right-side pan at a rate of 100 drops per minute until the film is detached from the mucosal surface. By weighing the film in grams, until it could be removed from the mucosal surface, the bioadhesive strength is ascertained.¹⁵

In Vitro Drug Release

The API released from bilayered and multilayered films is investigated using the rotating paddle method. The dissolving agent that is used hasa pH of 6.8, which is phosphate buffer. At a speed of 50 rpm and a temperature of 37 ± 0.5 °C, the release is carried out. Using an instant adhesive, the glass disc is fastened to the BBF's supporting layer. The disintegration vessel's bottom encloses the disc. At predetermined intervals, 5 ml samples are removed and replaced with new media. After being adequately diluted, the samples are filtered using Whatman filter paper, and their API content is then analysed.¹⁶

Pervasion Study of BBF

Buccal permeation through the buccal mucosa of sheep and rabbits is examined in vitro at a temperature of $37 \pm$ 0.2°C using a glass diffusion cell of the Keshary-Chien/Franz type. The fresh buccal mucosa is connected and held in place between the donor and receptor compartments by magnetic bead churning at 50 rpm. Samples are removed and their API content is checked regularly.¹⁷

Ex Vivo Bioadhesion Time

Ex vivo bioadhesion tests are carried out on freshly cut buccal mucosa after the BBF isapplied (sheep and rabbit). Fresh buccal mucosa must be moistened with 1 drop of phosphate buffer (pH 6.8) before applying the bioadhesive film. This process takes 30 sec. The glass slide is then attached to the bioadhesive film and placed in the beaker with 200 ml of phosphate buffer (pH 6.8 and $37 \pm 0.5^{\circ}$ C). Film adherence is observed for 12 h after the application of a 50 rpm stirring rate for 2 min to mimic the buccal cavity environment. When the film alters in colour, shape, collapse, and contain API is mentioned.¹⁸

The earlier attempts made on BBF are illustrated in Table 1.

Drug	Polymer
Rizatriptanbenzoate ¹⁹	Sodium starch glycolate
Sertraline HCl ²⁰	Polyvinyl Pyrrolidone (PVP), and Carbopol P 934 (CP-934)
Amiloride ²¹	Hydroxypropyl Methyl Cellulose (HPMC K4M), CP-934, and PVP
Ropinirole HCl ²²	Pullulan
Diclofenac sodium ²³	Sodium Alginate (SA) and pectin
Norethindrone ²⁴	SA, Carboxy Methyl Cellulose (CMC), HPMC, and PVP
Carvedilol ²⁵	HPMC and CP-934
Ivabradine HCl ²⁶	НРМС
Amlodipine besylate ²⁷	CMC and HPMC
Valsartan ²⁸	CP-934, HPMC, SA, and CMC
Ondansetron HCl ²⁹	НРМС
Rizatriptan benzoate ³⁰	Tamarind seed xyloglucan and CP-934
Lisinopril ³¹	HPMC K4M, sodium CMC, PVP K30, eudragit RL 100, andCP-934
Selegiline HCl ³²	Polyvinyl Alcohol (PVA), and poly(d,l-lactide-co-glycolide)
Lidocaine HCl ³³	HPMC, CMC, and Chitosan (CS)
Simvastatin ³⁴	CMC and PVP
Metformin HCl ³⁵	CS
Saxagliptin HCl ³⁶	HPMC K100M and Eudragit RL-100
Omeprazole ³⁷	НРМС
Metoprolol ³⁸	PVP K-30
Ondansetron HCl ³⁹	НРМС
Sumatriptan succinate ⁴⁰	НРМС

Table I.Previous Work on BBF

Dimenhydrinate41	Hydroxyethyl Cellulose (HEC) and Xanthan gum (XG)
Rizatriptan benzoate ⁴²	HPMC, PVA, and Polyethene Oxide (PEO)
Tramadol ⁴³	CS and PVP K-90
Baclofen ⁴⁴	CP-934 and PVP
Aceclofenac ⁴⁵	HPMC and CP-934
Amlodipine besylate ⁴⁶	CS and PVP K-30
Risperidone47	CP-934 and SA
Propranolol ⁴⁸	PVP, PVA, and CS
TizanidineHCl and meloxicam ⁴⁹	НРМС
Resveratrol ⁵⁰	Hydroxypropyl cellulose (HPC) and Ethyl cellulose (EC)
Palonosetron ⁵¹	Proloc 15 and Eudragit [®] RL 100
Atenolol ⁵²	Fenugreek (Trigonellafoenum-graecum L.) seedMucilage, HPMC K4M and EC
Ornidazoleand dexamethasone ⁵³	EC
Fexofenadine ⁵⁴	PVA, HPMC K4M, K15M and Eudragit L100
Benzydamine HCl ⁵⁵	НРМС
Lamivudine ⁵⁶	Methylcellulose and PVP
Triamcinolone acetonide57	Pectin and gellan gum
Captopril ⁵⁸	Acritamer 940, manugel, and hypromellose
Rizatriptan benzoate ⁵⁹	PEO andHPMC K4M
Diazepam ⁶⁰	НРМС
Domperidone ⁶¹	PVP K-90
Cetylpyridinium chloride ⁶²	CS, HPMC, methylcellulose (MC), HEC, and PVA
Losartan potassium ⁶³	PVP, HPMC, pectin
Tenofovirdisoproxilfumarate ⁶⁴	HPMC3cps,
Lisinopril ⁶⁵	HPMC F4M, HPMC K4M and HPMC K100M
Etilefrine HCl ⁶⁶	Sodium alginate
Candesartan cilexetil ⁶⁷	Carboxymethyl Cellulose (CMC)
Ciclopirox olamine68	Poly(Ethylene Oxide) (PEO) and Eudragit
Clobetasolpropionate ⁶⁹	HPMC K4M
Terbinafine HCl ⁷⁰	НРМС
Ibuprofen ⁷¹	Hydroxypropylcellulose (HPC), CS, and methylcellulose
Clotrimazole ⁷²	CS and pectin
Ondansetron HCl ⁷³	НРМС
ltraconazole ⁷⁴	HPMC and chitosan
Sumatriptan succinate ⁷⁵	HPMC and XG
Fluconazole ⁷⁶	CS

Conclusion

According to the results of the current investigation, buccal film is the most precise and palatable dose form since it avoids the hepatic first-pass impact and exhibits good absorption. This is the most innovative and promising technology, beneficial to people of all ages, particularly children, the elderly, and people who have trouble swallowing. Due to their advantages over conventional dosage forms and their ability to be produced at a cheap cost, buccal films can take the place of conventional dosage forms, including rapid disintegrating tablets. This technique offers a useful tool for maintaining the pharmacoeconomic and therapeutic value of drugs.

Acknowledgement

The authors thank the college management for their encouragement and support.

Source of Funding: None

Conflict of Interest: None

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