Review: several drugs, especially triptans, are effective for pain relief in acute migraine


QUESTION: In patients with acute migraine, are pharmacological treatments better than placebo for short and long term pain relief?

Data sources
Studies in any language were identified by searching Medline (1966–2000), EMBASE/Excerpta Medica (1980–2000), the Cochrane Library, and the Oxford Pain Relief Database. Pfizer Inc. was contacted for data on all randomised controlled trials (RCTs) of eletriptan.

Pharmacological treatment v placebo for acute migraine (range)*

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Treatment</th>
<th>Placebo</th>
<th>RBI</th>
<th>NNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headache relief at 2 h</td>
<td>34% to 79%</td>
<td>22% to 35%</td>
<td>150% to 280%</td>
<td>2 to 6</td>
</tr>
<tr>
<td>Headache relief at 1 h</td>
<td>14% to 70%</td>
<td>8.9% to 26%</td>
<td>110% to 320%</td>
<td>3 to 11</td>
</tr>
<tr>
<td>Pain free at 2 h</td>
<td>11% to 60%</td>
<td>4.7% to 12%</td>
<td>240% to 640%</td>
<td>3 to 9</td>
</tr>
<tr>
<td>Sustained relief at 24 h</td>
<td>35% to 53%</td>
<td>14% to 27%</td>
<td>150% to 300%</td>
<td>4 to 9</td>
</tr>
</tbody>
</table>

*Abbreviations defined in glossary.

COMMENTS

Which of the many drugs available for treatment of acute migraine should a busy clinician use? In the absence of a large, government-funded, super trial comparing all currently available treatments, we must synthesise information from other sources to assess their relative merits. The conclusions of the systematic review by Oldman et al are broadly consistent with head to head trial results, clinical experience, and the results of another systematic review. Firstly, triptans as a class outperform such non-specific medications as non-steroidal anti-inflammatory drugs; secondly, subcutaneous sumatriptan is the most effective treatment for acute migraine; and thirdly, with the important exception of naratriptan, which is less effective than the others, available oral triptans have similar efficacy. Rank orderings of these drugs based on the number needed to treat or other derived variables have limited clinical relevance because differences are small and confidence intervals overlap. Comparative inferences are also limited because the data do not represent head to head RCTs and placebo responses vary between trials, indicating differences in study populations.

Through no fault of its authors, this review provides no information about several important issues in abortive treatment of migraine. No trials of such treatments as narcotics met the quality standards for inclusion in this analysis, so information enabling us to put these drugs in context is lacking. This review also did not identify results for interventions and subcutaneous sumatriptan. All interventions, intranasal sumatriptan, and subcutaneous sumatriptan. All interventions were better than placebo except for Cafergot. For sustained pain relief for 24 hours, information was available for 13 oral interventions, intranasal sumatriptan, and subcutaneous sumatriptan. All interventions were better than placebo except for zolmitriptan, 5 mg. Triptans seemed to be the most effective drugs, but no drug to drug comparisons were reviewed. No trials reported freedom from pain for 24 hours. Side effects could not be analysed because data were collected for a 7 to 10 day period and could not be separated from contamination with rescue medication or second doses.

Conclusions

Most pharmacological treatments, except Cafergot, are effective for pain relief in patients with acute migraine. Subcutaneous sumatriptan and newer oral triptans seem to be the most effective drugs for aborting migraine attacks, but drug to drug comparisons have not been done. Data on adverse effects are lacking.
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