Therapeutics

Review: intravenous metoclopramide is better than placebo for reducing pain in acute migraine in the emergency department


Clinical impact ratings GP/FP/Primary care ★★★★★☆ Neurology ★★★★★☆

Emergency medicine ★★★★★☆

Q In patients with acute migraine, is metoclopramide more effective than a control intervention for reducing symptoms?

Methods

Data sources: Medline; EMBASE/Excerpta Medica; Lilacs; Cinahl; Cochrane Central Register of Controlled Trials; neurology, headache, and emergency medicine conference proceedings (1998–2004); clinical practice guidelines; websites; theses or dissertations; reference lists; and experts in the field.

Study selection and assessment: randomised controlled trials (RCTs) that compared parenteral metoclopramide with placebo, other antiemetics (AEs), non-AEs, or other antimigraine (AM) regimens in adults with an acute migraine in an emergency department (ED) or headache clinic, and distinguished migraine from other types of headaches. Study quality was assessed.

Outcomes: complete relief of headache, significant reduction in headache pain (from moderate or severe to mild or none), and reduction in headache pain on the basis of a 10 cm visual analogue scale (VAS). Secondary outcomes included relapse of migraine within 48 hours of treatment, nausea, number of rescue drugs required, functional status, and adverse effects.

Main results

13 RCTs (n = 655) met the selection criteria. 7 RCTs (54%) were high quality (Jadad score ≥3). Using a random effects model, meta-analysis of 3 RCTs showed that metoclopramide reduced headache pain (table), nausea (odds ratio [OR] 4.20, 95% CI 1.70 to 10.36), and the need for rescue drugs (OR 0.21, CI 0.05 to 0.85) more than placebo. The groups did not differ for complete relief of headache (see table at www.evidence-basedmedicine.com), relapse of migraine, or restlessness. 2 RCTs found that metoclopramide reduced headache pain less than other AEs (chlorpromazine and prochlorperazine) (table). The groups did not differ for complete relief of headache (see table at www.evidence-basedmedicine.com), pain scores on the VAS, relapse of migraine, nausea, or adverse events. Pooled results showed that patients in the metoclopramide groups were more likely to require rescue drugs than those in the other AE groups (OR 2.08, CI 1.70 to 10.36). In 14 RCTs, other AEs provided better relief of migraine than metoclopramide, although the results show a reduction in pain that favours metoclopramide over placebo, the duration of effect and rate of headache relapse is not known. Metoclopramide alone does provide definitive treatment for some patients; however, 3 of 4 patients on average will require alternative or adjunctive treatment. The severity of the migraine should dictate the approach to treatment in the ED. Ketorolac, sumatriptan, dextrohydrogatomine, chlorpromazine, prochlorperazine, and dexamethasone were effective in some studies. Metoclopramide avoids many perceived or actual liabilities of other current treatment choices for acute migraine. It also provides relief of pain and other such migraine associated symptoms as nausea and vomiting. These virtues explain the enduring popularity of metoclopramide for treating migraine in the ED setting.

Colman et al provided a good summary of evidence of the effect of metoclopramide. Although the results show a reduction in pain that favours metoclopramide over placebo, the duration of effect and rate of headache relapse is not known. Metoclopramide alone does provide definitive treatment for some patients; however, 3 of 4 patients on average will require alternative or adjunctive treatment. The severity of the migraine should dictate the approach to treatment in the ED. Ketorolac, sumatriptan, dextrohydrogatomine, chlorpromazine, prochlorperazine, and dexamethasone were effective in some studies. Metoclopramide avoids many perceived or actual liabilities of other current treatment choices for acute migraine. It also provides relief of pain and other such migraine associated symptoms as nausea and vomiting. These virtues explain the enduring popularity of metoclopramide for treating migraine in the ED setting.

The tantalising question of whether metoclopramide might outperform sumatriptan remains unanswered because the single study that reached this conclusion was low quality and lacked a placebo group. Some evidence supports the use of oral sumatriptan-metoclopramide combination product, stating concerns about long term safety.2 This should temper enthusiasm for wide scale use of metoclopramide.

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Abstract and commentary also appear in ACP Journal Club.

Commentary

Metoclopramide avoids many perceived or actual liabilities of other current treatment choices for acute migraine. It also provides relief of pain and other migraine associated symptoms as nausea and vomiting. These virtues explain the enduring popularity of metoclopramide for treating migraine in the ED setting. The tantalising question of whether metoclopramide might outperform sumatriptan remains unanswered because the single study that reached this conclusion was low quality and lacked a placebo group. Some evidence supports the use of oral sumatriptan-metoclopramide combination product, stating concerns about long term safety. This should temper enthusiasm for wide scale use of metoclopramide.


Metoclopramide for acute migraine

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<th>Outcomes at 1 week</th>
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*Abbreviations defined in glossary; weighted event rates, RBI, NNT, and CI calculated from data in article using a random effects model. †Not significant.
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Metoclopramide v placebo, other antiemetics (chlorpromazine, prochlorperazine) (AE), non AEs, and other antimigraine (AM) regimens for acute migraine

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<td>1 (86)</td>
<td>Metoclopramide v placebo</td>
<td>2.16 (0.36 to 12.84)†</td>
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<td>2 (177)</td>
<td>Metoclopramide v other AEs</td>
<td>0.64 (0.23 to 1.76)†</td>
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<td>1 (62)</td>
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