Comparison between metamizole and triptans for migraine treatment: a systematic review and network meta-analysis

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Abstract

Objective
The aim of this systematic review was to evaluate the efficacy of metamizole and triptans for the treatment of migraine.

Methods
Randomized controlled trials including people who received metamizole or triptan by multiple routes of administration and at all doses as treatment compared to subjects who received another treatment or placebo were included in the systematic review. The primary outcomes were freedom from pain at 2 hours; pain relief at 2 hours; sustained headache response at 24 hours; sustained freedom from pain at 24 hours. The statistical analysis of all interventions of interest were based on random effect models compared through a network meta-analysis.

Results
209 studies meeting the inclusion and exclusion criteria were analyzed. Of these, 130 had data that could be analyzed statistically. Only 3.0% provided enough information and were judged to have a low overall risk of bias for all categories evaluated; approximately 50% of the studies presented a low risk of selection bias. More than 75% of the studies presented a low risk of performance bias, and around 75% showed a low risk of detection and attrition bias.

Conclusion
There is no evidence of a difference between dipyrone and any triptan for pain freedom after 2 hours of medication. Our study suggests that metamizole may be equally effective as triptans in acute migraine treatment.
Introduction

Migraine is a highly prevalent condition manifesting as moderate or severe intermittent headache attacks with associated symptoms, lasting 4 to 72 hours if not properly treated.1-3

Migraine is not only a headache but also a syndrome of various phases, each with its own distinct mechanisms and treatment approaches. Briefly, the migraine prodrome, or premonitory phase, can occur several hours to days before a headache and may be hypothalamically modulated, although other brainstem and limbic structures may play a causal role as well.4

The relationship between migraine and cognition is complex. Cognitive symptoms are part of the subjective experience of migraine attacks and contribute to attack-related disability, interfering with work performance, family and social life, besides self-management of the attacks. This transient impairment may occur along all phases of a migraine attack. While pain is the main determinant of disability, cognitive dysfunction also contributes to attack-related impairment, and should be considered as a migraine therapeutic target, together with pain, to evaluate the efficacy of an acute attack treatment.5

While it is clear that migraine attacks include some degree of cognitive impairment, in the long run, migraine is not associated with any significant impact on cognitive performance or age-associated cognitive decline in the general population. So, acute cognitive dysfunction during a migraine attack is reversible. However, individuals with more severe and frequent migraine attacks and subjects with chronic migraine tend to maintain cognitive difficulties between attacks.5

The acute management of migraines includes the use of non-steroidal anti-inflammatory drugs (NSAIDs), acetaminophen, metamizole, ergots, and triptans. Gepants and ditans have been recently added to the list.6

Metamizole is a well-established and highly used drug to treat acute attacks in emergency settings in Brazil, as well as the most common analgesic medication used for migraine treatment in the population.7,8

Triptans represent a large therapeutic group with a good therapeutic profile, but their vasoconstriction adverse events warrant caution in patients with cardio-vascular risk. Other side effects, such as nausea, dizziness and chest symptoms, preclude some patients from using triptans, while a few patients do not respond well to triptans. Compliance and tolerability of triptans are certainly different for each medicine. Triptans are considered to be safe, with a very low potential risk of clinically significant serious adverse events. Contraindications to triptan use include uncontrolled hypertension, ischemic heart disease, coronary vasospasm, cerebrovascular disease, peripheral vascular disease, and basilar or hemiplegic migraine.9,10

Metamizole and triptans are both major medications in the acute therapy arsenal, however, they have never been directly compared.

To evaluate the efficacy of metamizole and triptans for the treatment of migraine, we conducted this systematic review and network meta-analysis to address the following focused questions: (1) “what is the evidence for the efficacy and safety of metamizole for the treatment of migraines compared with triptans?” and (2) “how effective are those treatments in improving cognitive dysfunction in patients with migraine?”

Methods

The systematic review has been developed in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses Protocols (PRISMA) statement11-13, using methodology described in the Cochrane Handbook for Systematic Review of Interventions.14 This protocol was registered within the PROSPERO database (CRD42020216360).

Study eligibility criteria

Only randomized controlled trials reporting study-specific data for migraine outcomes in people who received metamizole or triptan as treatment were included in the systematic review. The population of interest was participants with migraine, of any age, gender and severity of migraine. We have used investigator-reported definitions (according to accepted diagnostic criteria, such as the International Classification of Diseases, or according to the criteria established by the International Headache Society).15 We examined papers from all countries, subjects who have used metamizole or triptan treatment (test group), by multiple routes of administration (tablets, oral disintegrating tablets, injection, transdermal, nasal spray, rectal suppositories) and at all doses (any frequency or strength), compared to subjects who have
received another treatment or placebo. Metamizole and triptans were not allowed to be used in combination with other drugs. The primary outcomes were freedom from pain at 2 hours; pain relief at 2 hours; sustained headache response at 24 hours; sustained freedom from pain at 24 hours. Secondary outcomes were relief of other symptoms associated with migraine, specifically nausea, vomiting, photophobia and phonophobia, fatigue, dizziness, cognitive impairment, any adverse effects (AEs), withdrawals due to adverse events, use of rescue medication, patient satisfaction, absenteeism, functional disability and quality of life.

We excluded studies in which metamizole or triptan was not the intervention of interest, studies comparing combined metamizole preparations with another treatment, studies comparing combined triptan preparations with another treatment, studies where metamizole or triptan have not been studied in only one separate intervention group, studies in which migraine is not reported as the outcome of interest, studies that do not have adequate information regarding whether metamizole or triptan and its derivatives are not related to migraine improvement, studies involving secondary headache disorders (post-puncture headache, post-traumatic headache, cancer-related headache etc.), studies that do not have adequate information on the classification of primary headache or animal studies. There was no restriction of study setting.

**Information sources**

We searched the literature in the following databases: MEDLINE via PubMed, EMBASE, LILACS, EbscoHost and all references of the included studies, with no language restrictions from inception to November 2020. Mesh terms and keywords were combined with Boolean operators and used as search strategies: #1 - migraine OR headache OR “tension-type headache”; #2 - dipyrone OR metamizole; #3 – triptan OR sumatriptan OR zolmitriptan OR rizatriptan OR naratriptan OR frovatriptan OR almotriptan OR eletriptan; #4 - #1 AND #2; #5 - #1 AND #3; #6 - #4 OR #5. Two reviewers screened all articles identified from the search independently. Any disagreements between reviewers were solved by discussion with a third reviewer to meet a consensus. Studies meeting the inclusion criteria underwent a validity assessment and data extraction. Reasons for rejecting studies were recorded for each study.

**Data extraction (study characteristics and results) / Data management**

Two reviewers extracted data independently. Disagreements were solved with discussion with a third reviewer. Data were transferred to Excel sheets for analysis. Measures of central tendency (mean or median) and dispersion (standard deviations and percentiles) for different biometric parameters were extracted. For continuous outcomes, the following was extracted: means, SD and sample sizes at baseline and follow-up. If these were unavailable, change scores or mean differences were extracted. For dichotomous outcomes, the number of cases and total sample size were extracted. Safety outcomes included the number of participants reporting any or serious AEs or withdrawn from the study because of AEs.

All interventions of interest were compared through a network meta-analysis. A graph summarized the results of interest, allowing us to easily assess the structure of existing evidence.

**Risk of bias within individual studies**

The risk of bias of the included studies was evaluated according to the Cochrane Collaboration’s Tool for Assessing Risk of Bias. Briefly, randomization and allocation methods (selection bias), completeness of follow-up period/incomplete outcome data (attrition bias), masking of patients (performance bias) and examiners (detection bias), selective reporting (reporting bias), and other forms of bias were classified as adequate (+), inadequate (-), or unclear (?). Based on these domains, the overall risk of bias was categorized as follows: 1) low risk of bias; 2) unclear risk of bias; or 3) high risk of bias.

**Summary measures**

To inform on comparative efficacy, effectiveness, and safety between all interventions, we conducted a network meta-analysis. We modeled log odds ratios using the conventional logistic regression network meta-analysis setup. The network meta-analysis was based on logistic model with random study effects.

**Assessment of inconsistency**

Consistency was assessed by comparison of the conventional network meta-analysis model for which consistency was assumed with a model that does not assume consistency (a series of pairwise meta-analyses analyzed jointly). If the trade-off between model fit and complexity favors the model with assumed consistency, this model was preferred. Moreover, we calculated the difference between direct and indirect evidence in all closed loops in the network; inconsistent loops were
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Identified with a significant (95% CI that excludes 0) disagreement between direct and indirect evidence.

Risk of bias across studies

Publication bias or small study effects were assessed by inspection of the funnel plots for asymmetry and with Egger’s test\textsuperscript{18} and Begg’s test\textsuperscript{19}, with the results considered to indicate potential small study effects when $p<0.10$.

Results

The search identified 4,003 articles. After excluding duplicate references, a total of 1,601 titles and abstracts retrieved from electronic databases and hand searching were analyzed. Based on the eligibility criteria, the texts of 450 publications were reviewed in full. Of these, 198 were eligible according to the inclusion and exclusion criteria (see Figure 1). Ten articles published results from more than one study, thus 209 studies were analyzed.\textsuperscript{20-29}

Figure 1. Diagram.

All of the included studies were published between 1991 and 2019. Most of them were large, multicenter, double-blind, placebo-controlled trials conducted in a variety of countries in the five continents.

The number of randomized patients who received some treatment totaled 94,570 subjects, diagnosed with migraine headaches according to the International Headache Society criteria for migraine. Excluding four studies that did not mention participants’ sexes, female participants were the majority, with approximately 84.2%.

The types of treatments varied widely both in dosage and route of administration. The seven types of triptans (almotriptan, eletriptan, frovatriptan, naratriptan, rizatriptan, sumatriptan, and zolmitriptan) appeared among the selected studies. However, sumatriptan was the most common and was found in 18 different variations: it appeared with oral, subcutaneous, nasal spray, iontophoretic transdermal patch (TDS) and suppository administration, combining dosages from 1 mg to 200 mg.

Some treatment arms used triptan in combination therapies with other drugs: frovatriptan 2.5 mg + dexketoprofen 25 mg or 37.5 mg\textsuperscript{34}; naratriptan 2.5 mg orally + rectal suppository of prochlorperazine 25 mg\textsuperscript{35}; rizatriptan 10 mg + acetaminophen 1,000 mg orally\textsuperscript{36}, and rizatriptan 10 mg + dexamethasone 4 mg orally\textsuperscript{37}. All studies with combination therapy included in this review had an exclusive triptan arm and a placebo comparative arm.

Only 6 studies with metamizole to treat migraine (dosage of 500 mg and 1,000 mg orally and IV) met all the inclusion criteria to be considered in this systematic review. Four studies utilizing the intravenous metamizole route were performed in Brazil,\textsuperscript{8,38-40} one in Spain\textsuperscript{41} and the last one in Turkey\textsuperscript{42,43}, with the last two studies including oral metamizole.

Most studies included in this review were conducted in the adult population and only 13 were carried out with adolescents.\textsuperscript{43-55}

Most of the selected studies evaluated improvement or complete relief of headache after 1 hour, 2 hours and in the first 24 hours, although some studies have evaluated different times of symptomatic relief after 30 minutes, in addition to the use of rescue medication in the period. Some studies have evaluated relief of migraine-associated symptoms, such as photophobia, phonophobia, nausea and vomiting. The characteristics of the included studies is in supplementary table (Table 1).

The results of the risk of bias assessment are shown in figure 2. Of all 209 studies, only six (3.0%) provided enough information and were judged to have a low overall risk of bias for all categories evaluated; 146 studies had insufficient information, mainly in the selective reporting domain, so the overall risk of bias was unclear, and 46 presented a high overall risk of bias.
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Approximately 50% of the studies presented a low risk of selection bias. More than 75% of the studies presented a low risk of performance bias, and around 75% have shown a low risk of detection and attrition bias.

The statistical analysis below was based on random effect models from network meta-analyses. The calculations were made with the netmeta package of the R library, developed by Rücker et al. and based on the methodology described in Schwarzer et al.

Since there are no direct comparisons of dipyrone versus any of the triptans, consistency tests were not performed.

**Pain freedom after 2 hours of medication**

Figure 3 illustrates the connections between the active substances. The thickness of the edges indicates the weights of the direct comparisons. Studies with more than two treatments were excluded in this analysis.

There is no evidence of a difference between dipyrone and any triptan.

**Pain relief after 2 hours of medication**

Figure 5 illustrates the connections between the active substances.

The confidence intervals for differences in pain relief ratios after 2 hours of medication between triptan and placebo versus dipyrone are shown in the forest plot. There is no evidence of a difference between dipyrone and any triptan.

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**Figure 2.** Risk of bias graph: review authors’ judgements about each domain presented as percentages across all included studies.

**Figure 4.** Estimates of the effect of triptans and dipyrone in relation to placebo.

**Figure 5.** Network graph for pain relief data after 2 hours of medication.

**Figure 6.** Estimates of the effect of triptans and dipyrone in relation to placebo.
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Table 1. Characteristics of Included Studies

<table>
<thead>
<tr>
<th>Author, publication year</th>
<th>Population</th>
<th>Comparisons</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ahonen et al. 2004</td>
<td>Children/ Adolescents - 12.4 years (SD 2.4, range 8.1 to 17.5) n=94 (51 boys and 43 girls)</td>
<td>Sumatriptan 10 mg (20 to 39 kg)</td>
<td>The primary efficacy endpoint was headache relief by two grades on a 5-grade face scale at 2 hours. Sumatriptan (n=53/83; 64%); placebo (n=32/83; 39%)</td>
</tr>
<tr>
<td>Ahonen et al. 2003</td>
<td>Adolescents - 12.0 years (SD 2.4, range 6.1 to 16.1) n=116 (63 girls and 53 boys)</td>
<td>Oral rizatriptan 5 mg (20 to 39 kg); Oral rizatriptan 10 mg (40 kg or more); Placebo</td>
<td>Ninety-six patients used all three treatments, 10 used two, and 10 only the first. At 2 hours, the primary endpoint (headache relief by two grades on a five-grade face scale at 2 hours) was reached twice as often after both treatments of rizatriptan (first n=71/96 (74%); second n=70/96 (73%); as after placebo (n=35/96 (36%)) (p&lt;0.001). Already at 1 hour, rizatriptan was clearly more effective as headache relief was reported by 50% (n=48/96) and 55% (n=53/96) of children after the first and the second dose of rizatriptan, compared to 29% (n=28/96) after placebo (p=0.004). Rizatriptan was superior at 3 and 4 hours, and the other endpoints also favored rizatriptan. Efficacy of rizatriptan was constant over the two treated attacks, and the findings were similar in children using the dose of 5 and 10 mg. The use of the higher 10 mg adult dose in adolescents caused adverse effects with a frequency comparable to what has been observed in adults. But no serious adverse effects were observed.</td>
</tr>
<tr>
<td>Ahrens et al. 2003</td>
<td>Adults – Placebo - 41.6 (18 to 72) years; Rizatriptan 5 mg - 42.7 (19 to 67) years; Rizatriptan 10 mg 43.1 (19 to 67) years. n=595 (64 male and 491 female)</td>
<td>Rizatriptan 10 mg Rizatriptan 5 mg Placebo Single attack</td>
<td>The primary efficacy endpoint was pain relief at 2 h. From 30 min onwards, significantly more patients experienced pain relief and became pain-free after rizatriptan 10 mg compared to placebo. At 2 h, the percentage of patients with pain relief was significantly higher after rizatriptan 10 mg (74%), 5 mg (59%) compared with placebo (28%). Rizatriptan 10 mg was superior to rizatriptan 5 mg on pain relief at 1.5 and 2 h (p &lt; 0.05). Significantly more patients were pain-free at 2 h after rizatriptan 10 mg (42%), 5 mg water (35%) compared with placebo (10%). Both doses of rizatriptan wafer were well tolerated.</td>
</tr>
<tr>
<td>Alpunon et al. 2005</td>
<td>Adults – Plac - 39.8 (SD 9.4) - 22 to 59 SUM - 39.8 (SD 10) - 22 to 71 years n=136 (17 Male; 119 Female) Sum - Male 10 (11%); Female 78 (89%)</td>
<td>Sumatriptan 6 mg SC Placebo</td>
<td>Np of patients with meaningful relief - Plac 17 (35%); Sum 66 (75%) Time to meaningful relief (min) median- Plac 66; Sum 43 Np of patients with no pain or mild pain at discharge - Plac 17 (35%); Sum 62 (70%) Np of patients with no pain at discharge - Plac 6 (13%); Sum 27 (31%)</td>
</tr>
<tr>
<td>Allais et al. 2004</td>
<td>Adults – 34.92 ± 7.99 years n=122 (all female)</td>
<td>Almotriptan 12.5 mg oral Placebo One single menstrual migraine attack per menstrual cycle was treated in four different menstrual cycles.</td>
<td>Data suggest that almotriptan shows excellent efficacy on menstrual migraine in comparison to the placebo, with a significant reduction in the percentages of suffering patients over a 2 h period of time.</td>
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<tr>
<td>Allais et al. 2005</td>
<td>Adults – 34.9±8.0 (18 to 50) years n=147 (all females)</td>
<td>Almotriptan 12.5 mg oral Placebo One tablet after pain onset during two menstrual cycle</td>
<td>Significantly more patients were pain-free at two hours (risk ratio [RR] = 1.81; p=0.0008), pain-free from 2-24 hours with no rescue medication (RR = 1.99; p=0.0022), and pain-free from 2-24 hours with no rescue medication or adverse events (RR = 1.94; p=0.0061) with almotriptan versus placebo. Nausea (p = 0.007) and photophobia (p=0.0083) at two hours were significantly less frequent with almotriptan. Almotriptan efficacy was consistent between three attacks, with 56.2% of patients pain-free at two hours at least twice. Adverse events were similar with almotriptan and placebo.</td>
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<tr>
<td>Almas et al. 2004</td>
<td>Adults – eletriptan-40 mg; 41.7±10.7 years; eletriptan-80 mg; 41±13.3 years. n=971 (803 females and 168 males) [eletriptan-40 mg: 453 females and 86 males; eletriptan-80 mg: 350 females and 82 males.]</td>
<td>Eletriptan 40 mg or 80 mg Placebo four-attack consistency of response study in which three attacks were treated with ELE-40 or ELE-80, and one randomly chosen attack was treated with placebo</td>
<td>On a repeated measure logistic regression analysis across all treated attacks, the probability of achieving a headache response at 2 hours ranged from 71% to 74% on ELE-40 vs. 17% to 28% on placebo (p&lt;0.0001), and from 66% to 74% on ELE-80 vs. 21% to 27% on placebo (p&lt;0.0001). The incidence, per attack, of adverse events, was low for both ELE-40 and ELE-80. Few adverse events occurred with incidence ≥10% on ELE-40 (asthenia, 5.0%) or ELE-80 (asthenia, 10%; nausea, 5.8%). Discontinuations because of adverse events were 0.2% on ELE-40, and 1.6% on ELE-80. (ELE: eletriptan)</td>
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| Bonjie, Findlay 2002      | Adults - 18 to 65 years (mean 35 years) n=94 (80 female; 14 male) | Sumatriptan 200 mg oral Placebo Up to three attacks | Each patient was treated for a maximum of three separate attacks of migraine with aura within a three months' period. Three attacks were treated so that we could examine consistency of response across more than one attack. For attack 1, 200 mg sumatriptan was significantly more effective, safe and well tolerated than placebo at relieving headache 2 h after treatment was given (p=0.023). In subsequent attacks, i.e. in attacks 2 and 3, there was no such significant effect of sumatriptan compared with placebo in relieving headache.
<table>
<thead>
<tr>
<th>Study</th>
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<th>Main Findings</th>
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<tr>
<td>Barbanti et al.</td>
<td>Adults – Placebo: n=432 (358 females and 74 males)</td>
<td>Placebo</td>
<td>Sumatriptan 50 mg or 100 mg oral; Normal functional ability was restored in a significantly (p&lt;0.05) greater percentage of patients treated with sumatriptan than placebo beginning 45 min postdose for sumatriptan 100 mg and 1 h postdose for sumatriptan 50 mg. During the 24 h after initial dosing, the median (range) last time equivalents for the combination of paid work activities and activities outside of paid work were significantly lower in the groups treated with sumatriptan than placebo; 0.8 [0-36] sumatriptan 50 mg compared with placebo (2.9 [0-24]) (p&lt;0.01 each sumatriptan group versus placebo). The corresponding mean +/- SD values for last time equivalents were 1.9 ± 2.3 and 2.5 ± 4.7 for sumatriptan 100 mg and 50 mg, respectively, compared with 3.5 ± 4.3 for placebo.</td>
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<tr>
<td>Barbanti et al.</td>
<td>Adults – Rizatriptan = 43.95 ± 12.24 Placebo = 41.41 ± 11.7 n=80 (13 male; 67 female)</td>
<td>Rizatriptan 10 mg Placebo Single migraine attack</td>
<td>The primary endpoints were pain freedom at 2 h and total migraine freedom (pain freedom and absence of associated symptoms) at 2 h. Pain freedom 2h - Rizatriptan 54% vs Placebo 8% (p&lt;0.001). Migraine freedom 2h - Rizatriptan -51% vs Placebo 8% (p&lt;0.001). Binomial regression analysis showed that a significantly larger percentage of patients assigned to rizatriptan than to placebo reported pain freedom at 2 h post dosing (54 % [95 % CI 38, 70 %] vs. 8 % [95 % CI -1, 17 %]) (p&lt;0.001) and total migraine freedom at 2 h post dosing (31 % [95 % CI 26, 37 %] vs. 8 % [95 % CI -1, 17 %]) (p&lt;0.001).</td>
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<tr>
<td>Bartolini et al.</td>
<td>Adults – Placebo: n=134 (38 male; 96 female) Dipyrone: 44.2 years; sumatriptan 50 mg, 2.5 mg oral</td>
<td>Dipyrone: intravenous injection of 1 g dipyrone, diluted to 10 mL of 0.9% physiological saline Placebo: intravenous injection of 10 mL of 0.9% physiological saline</td>
<td>Placebo - intravenous injection of 1g dipyrone, diluted to 10 mL of 0.9% physiological saline Dexamethasone 4 mg, intravenous injection of 1 ml saline. Placebo - intravenous injection of 1 mL of 0.9% physiological saline.</td>
</tr>
<tr>
<td>Bigal et al.</td>
<td>Adults – Placebo: n=114 (96 female; 18 male) Dipyrone MO = 35.5 years Dipyrone MA = 35.5 years Placebo MA = 28.2 years</td>
<td>Frovatriptan 2.5 mg Placebo Single migraine attack</td>
<td>The primary study endpoint was the between-treatment comparison of the direction and average strength of preference at the end of the study. Preference score averaged to frovatriptan 3.1 ± 1.3 for vs to almotriptan 3.4 ± 1.3 for (P = NS); 63% of patients expressed a clear preference for a triptan (29% for frovatriptan and 34% for almotriptan, p=NS). Pain free at 2 hours post dose - frovatriptan 30% and almotriptan 32% Pain relief at 2 h post dose - frovatriptan - 54% and almotriptan - 56%</td>
</tr>
<tr>
<td>Bigal, Bordini, Speciali</td>
<td>Adults – Placebo: n=60 (31 women and 29 men)</td>
<td>Almotriptan 12.5 mg Treating 1-3 attacks</td>
<td>Dicyclomine - intravenous injection of 1 g dicyclomine, diluted to 10 mL of 0.9% physiological saline Placebo - intravenous injection of 10 mL of 0.9% physiological saline.</td>
</tr>
<tr>
<td>Bigal et al.</td>
<td>Adults – Placebo: n=35 (all female)</td>
<td>Almotriptan 10 mg + dexamethasone 4 mg Placebo</td>
<td>Rizatriptan 10 mg + dexamethasone 4 mg</td>
</tr>
<tr>
<td>Bigal et al.</td>
<td>Adults – Nausea at Baseline: 40.6±11.7 years; No Nausea at Baseline: 41.1±10.3 years. n=454 (386 female and 68 male)</td>
<td>Almotriptan 5 mg (iontophoretic transdermal system) Placebo TDS</td>
<td>Sumatriptan TDS 6.5 mg (iontophoretic transdermal system) Placebo TDS</td>
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</tbody>
</table>
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### Cady et al. 73

**Adults** - mean age 41.2 and (range 18-67 years)  
n=100 (male 9 and female 91)

**Sumatriptan** 6 mg sc, Placebo  
Four headaches of moderate or severe intensity (grade 2 or 3) were treated in the clinic with a single dose of either 6 mg SC sumatriptan (three attacks) or placebo (one attack) in the upper arm or thigh

**Sumatriptan statistically outperformed placebo on all efficacy measures, including pain severity, presence/absence of nausea, vomiting, phonophobia, and photophobia; rescue medication use; and clinical disability. Efficacy was consistently maintained with repeated administration. For all attacks, pain relief 90 minutes postdose occurred in 86% to 90% of sumatriptan-treated patients, compared with 9% to 38% of placebo-treated patients.**

### Cady et al. 74

**Adults** – 41.5 years (frovatriptan-placebo: 40.4 years, placebo-frovatriptan: 42.5 years)  
n=275 (36 males and 239 females)

**Oral frovatriptan 2.5 mg Placebo**  
The patients could take up to two doses of study medication per migraine attack.

**When patients received frovatriptan as the first dose, it was more effective than placebo in terms of the proportion of patients who were pain free at 2 h (28% vs 20%, p<0.04). This benefit was sustained up to 4 h post-dose (p<0.003). Early use of frovatriptan significantly reduced re-medication (p<0.001). Twenty-four-hour headache recurrence was low in both early (4%) and later use (6%) groups. Sustained pain-free response occurred in 40% of frovatriptan early use patients compared with 31% of later use patients (p<0.05). Early use prevented headache progression: 69%-78% had mild/no headache 2 h after dose 1 frovatriptan compared with 54%-63% taking dose 1 placebo (p<0.001). Early use reduced pain burden and functional disability (p<0.001). More patients rated early use of frovatriptan as excellent or good (57% vs 46%).**

### Cady et al. 75

**Adults – Rizatriptan - 40y; Placebo - 42**  
n=207 (187 female and 20 male)

**Rizatriptan 10 mg ODT (orally disintegrating tablet) Placebo**

The percentage of participants reporting pain freedom at 2 hours after taking study drug was significantly greater for rizatriptan ODT (66%) compared with placebo. The percentage of participants reporting sustained pain freedom between 2 and 24 hours post dose was also significantly greater for rizatriptan ODT (52%) compared with placebo. The proportion of participants reporting 2-hour pain freedom in the placebo groups was similar regardless of education.

### Cady et al. 76

**Adults – 42.0(10.5) years**  
n=212 (Male 55 and Female 177)

**22 mg AVP-825 nasal spray (a drug–device combination of low-dose sumatriptan powder - 22 mg loaded dose) Placebo device**

A significantly greater proportion of AVP-825 patients reported headache relief at 2 hours post-dose compared with those using the placebo device (68% vs 45%, p=0.002, odds ratio 2.53, 95% confidence interval [1.45, 4.42]). Between-group differences in headache relief were evident as early as 15 minutes, reached statistical significance at 30 minutes post-dose (42% vs 27%, p=0.03), and were sustained at 24 hours (44% vs 24%, p=0.002) and 48 hours (34% vs 20%, p=0.01). Patients treated with AVP-825 were pain-free (34%) at 2 hours compared with placebo device (17%; p=0.008). More AVP-825 patients reported meaningful pain relief (patient interpretation) of migraine within 2 hours of treatment vs placebo device (70% vs 45%, p<0.001), and fewer required rescue medication (37% vs 52%, p=0.02). Total migraine freedom (patients with no headache, nausea, phonophobia, photophobia, or vomiting) reached significance following treatment with AVP-825 at 1 hour (19% vs 9%; p=0.04). There were no serious AEs (AEs), and no systemic AEs occurred in more than one patient.

### Cady et al. 77

**Adults – 39.9 (SD 10.4) (Range from 19 to 61 years)**  
n=20 (80% female and 20% male)

**3 mg SC sumatriptan 6 mg SC sumatriptan to treat 1 attack**

The primary efficacy endpoint was the proportion of subjects reporting freedom from pain at 60 min postdose. Pain-free 60 min postdose - 3 mg SC Sumatriptan - 50% vs 52.6%  
6mg SC Sumatriptan (p=0.087) There was no difference in pain-free between treatments in 30, 60, 90 and 120 min postdose. Pain relief 60 min postdose – 3 mg SC Sumatriptan 83.3% vs 6 mg SC Sumatriptan 73.7% (p=0.48). As pain-free there were no difference between treatments at 30, 90 and 120 minutes post dose. No difference also, in patients experienced relief from nausea (p=0.91), phonophobia (p=0.89), or photophobia (p=0.88).

### Carpay et al. 78

**Adults – 18-65 years**  
n=124 (male 23 and female 101)

**Group A: sumatriptan 0.5 ml of the 15 mg/ml subcutaneous first and oral sumatriptan 100 mg during the second period**

**Group B: the order was reversed**

**Efficacy was evaluated 2 h after the administration of subcutaneous and 4 h after the administration of oral sumatriptan. Subcutaneous sumatriptan was significantly more effective than oral sumatriptan in relieving headache (over all 3 attacks 78% vs 61% improvement), improving clinical disability (55% vs 41% improvement) and relieving nausea (69% vs 53%), vomiting (72% vs 32%) and phono or photophobia (67% vs 49%). Median time to recurrence was shorter after subcutaneous (12.5 h) than after oral sumatriptan (18 h); the number of patients experiencing a recurrence was similar. Patients reported more adverse events after subcutaneous sumatriptan (1.32 per attack) than after the oral form (0.85 per attack), but all adverse events were mild to moderate in intensity and of short duration.**

### Carpay et al. 79

**Adults – Sumatriptan 50 mg tablet = 41.5 (SD 11.9)**  
**Sumatriptan 100 mg Placebo**  
**Tablet** = 39.7 (SD10.9)  
**Placebo = 40.6 (SD 10.3) n=432 (358 female and 74 male)**

**Sumatriptan tablets 50 mg and 100 mg were significantly more effective than placebo in relieving pain 2 hours after dosing (primary end point). In the intent-to-treat population, 66.2% of patients who received sumatriptan 100 mg and 51.1% of patients who received sumatriptan 50 mg were pain free 2 hours after dosing, compared with 19.6% of those who received placebo.**
### Adults - Men and women

<table>
<thead>
<tr>
<th>Study</th>
<th>Adults</th>
<th>Zolmitriptan nasal spray</th>
<th>Placebo</th>
<th>Each dose of zolmitriptan nasal spray produced a greater 2-hour headache response rate than placebo (70.3%, 58.6%, 54.8% and 41.5% for zolmitriptan nasal spray 5.0, 2.5, 1.0 and 0.5 mg, compared with 30.6% for placebo [all p&lt;0.001 vs placebo]). The 2-hour headache response rate for zolmitriptan nasal spray 5.0mg was significantly higher than that of the zolmitriptan 2.5mg oral tablet (61.3%, p&lt;0.05), while comparisons of nasal spray 0.5, 1.0 and 2.5 mg with zolmitriptan 2.5 mg oral tablet were not statistically significant. The nasal spray 5.0 and 2.5 mg showed a rapid onset of action, with a significant difference in headache response compared with placebo from 15 minutes through 4 hours after administration and a significant difference between the nasal spray 5.0mg and 2.5 mg oral tablet from 15 minutes through to 2 hours (the other nasal spray doses were not statistically significant compared with 2.5 mg oral tablet). Zolmitriptan nasal spray resulted in pain-free rates that were dose dependent. While all doses from 1.0mg upwards produced significant pain-free outcomes from 30 minutes versus placebo, only the 5.0 mg dose produced pain-free rates significantly superior to both placebo and the 2.5 mg oral tablet.</th>
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<tr>
<td>Charlesworth et al.</td>
<td>Adults - Men and women</td>
<td>Zolmitriptan nasal spray (5.0, 2.5, 1.0, 0.5 mg), Zolmitriptan oral tablets 2.5 mg</td>
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<td>Christie et al.</td>
<td>Adults - mean age 37.3 years (18-70)</td>
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<td>Colman et al.</td>
<td>Adults - Almotriptan: 41.25±10.09 (18 to 71) years; Sumatriptan: 40.26 ± 10.08 (18-65) years;</td>
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<td>Connor et al.</td>
<td>Adults – Telcagepant 280 mg/300 mg - 42.5±10.9 years, Rizatriptan 10 mg - 41.9±11.1 years,</td>
<td>Telcagepant 280/300 mg</td>
<td>Rizatriptan 10 mg</td>
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<td>Cull, Price, Dunbar</td>
<td>Adults – Group A - 41±10.8; Group B - 40.5±10.3 years, n=881 (155 male 726 female)</td>
<td>Dose 1 - Sumatriptan 6 mg sc – both group at the onset of a migraine headache of moderate or severe intensity</td>
<td>Dose 2 (headache recurrence only): Group A Sumatriptan 6 mg SC</td>
<td>Group B Placebo</td>
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<td>Dahlöf, Edwards, Tolth</td>
<td>Adults - 45 ± 11 years n=27 (22 female 5 male)</td>
<td>Sumatriptan SC 8 mg</td>
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<td>Dasbach et al.</td>
<td>Adults – mean age 40,6 years n=407 (84% female and 16% male)</td>
<td>Rizatriptan 10 mg</td>
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<td>Placebo</td>
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Comparison between metamizole and triptans for migraine treatment: a systematic review and network meta-analysis

Peres MFP, Scala WAR, Salazar R

Comparison between metamizole and triptans for migraine treatment: a systematic review and network meta-analysis

Diener et al. 

Adults - mean of 40 years of age
n=1086 (956 females and 130 males)

Sumatriptan nasal spray (5, 10, or 20 mg) Placebo up to 3 migraine attacks. Administered via a 1-shot nasal applicator into either nostril

Across attacks, headache relief in the 20, 10, and 5 mg drug and placebo groups was experienced 120 minutes postdose by 60%, 54%, 44%, and 32% of patients, respectively (p<0.05 for each sumatriptan nasal spray group vs placebo, for the 10-mg vs 5-mg drug group, and for the 20-mg vs 5-mg drug group). Two thirds of the 20 mg patients treating 3 attacks experienced relief at 2 hours postdose for at least 2 of 3 attacks. Clinical disability scores of 120 minutes in the 20, 10, and 5mg drug and placebo groups reflected no or mild impairment in 70%, 67%, 57%, and 50% of patients, respectively (p<0.05 for the 10 or 20 mg drug vs placebo group, and for the 20-mg vs 5-mg drug group). Similar efficacy rates were observed for nausea, photophobia, and phonophobia. The incidence of adverse events was not dose related. The most frequently reported adverse event in the active treatment groups was taste disturbance (bad, bitter, or unpleasant).

Dib et al.

Adults – 38.1±11.4 years n=221 (192 female and 29 males)

Ketoprofen 75 mg; Ketoprofen 150 mg; Zolmitriptan 2.5 mg Placebo; (comparisons between all treatments) four consecutive attacks with severe or moderate headache. Each treatment was enclosed in opaque soft gelatin capsules

Results are based on 838 attacks with a severe or moderate headache that were evaluable at 2 hours. Relief was reported for 62.6% of headaches treated with ketoprofen 75 mg, 61.6% with ketoprofen 150 mg, and 66.8% with zolmitriptan. The difference between the three active treatments and placebo (27.8% relief) was highly significant. Headaches at 2 hours disappeared more frequently for the active treatments than for placebo.

Diener et al.

Adults – LASA = 41.5y (SD: 11.8); Sumatriptan = 46.9y (SD 11); Placebo = 39.8y (SD 11); 276 (55 male and 221 female)

Lysine acetylsalicylate iv 1.8 g Placebo 6 mg Sumatriptan sc 6 mg Placebo One administration

The main result of this study was the significant difference (p<0.001) in efficacy, expressed as headache relief from grade 3 or 2 to grade 1 or 0, within 2 hours after administration of L-ASA and sumatriptan compared to placebo. Placebo was significantly inferior to both verum drugs (p<0.0001). Sumatriptan achieves a higher rate of headache-free patients after 2h, however was associated with a significantly higher incidence of adverse events.

Diener et al.

Adults - ranged from 18 to 64 years (median age 41 years) n=924 (781 females and 143 males)

Alniditan (1.4 mg and 1.8 mg) sc Placebo Sumatriptan (6 mg) sc Placebo one single treatment.

The number of subjects who were pain free at 2 h (primary endpoint) was: 22 (14.1%) with placebo, 174 (55.6%) with alniditan 1.4 mg, 87 (61.7%) with alniditan 1.8 mg and 209 (65.9%) with sumatriptan 6 mg. Alniditan 1.4 mg was significantly better (P < 0.001) than placebo and sumatriptan was significantly better (P = 0.015) than alniditan 1.4 mg. The number of responders (reduction of headache severity from moderate or severe headache before treatment to mild or absent at 2 h), was 59 (37.8%) on placebo, 250 (80.9%) on alniditan 1.4 mg, 120 (85.1%) on alniditan 1.8 mg, and 276 (87.1%) on sumatriptan. Recurrence rates were: 22 (17.3%) with placebo, 87 (34.8%) with alniditan 1.4 mg, 35 (29.2%) with alniditan 1.8 mg and 108 (39.1%) with sumatriptan. Adverse events occurred in 577/924 (62.4%) subjects, 30.5% with placebo, 69.3% with alniditan 1.4 mg, 64.5% with alniditan 1.8 mg and 66.2% with sumatriptan 6 mg.

Diener et al.

Adults – Eletriptan 80 mg - 40 ± 11; Eletriptan 40 mg - 40 ± 11; Colargot 40 ± 10; Placebo 42 ± 11 n=733 (640 female and 93 male)

Eletriptan 80 and 40 mg Colargot (ergotamine tartrate 2 mg, caffeine 200 mg) Placebo tablets

The primary efficacy endpoint was headache response (improvement from severe or moderate to mild or no pain) at 2 h. - Eletriptan 80 mg 68%, Eletriptan 40 mg 54%, Colargot 33% and Placebo 21% (p<0.01 for all comparisons). Secondary efficacy measures: pain-free rates at 2 h - Eletriptan 80mg 38%, eletriptan 40mg 28%, Colargot -10%, Placebo -5%.

Diener et al.

Adults – Acetylsalicylic acid 38.8, Ibuprofen 38.4, Sumatriptan 38.2 and Placebo 38.3 years. n=313

effervescent acetylsalicylic acid (ASA) 500 mg capsule Ibuprofen 400 mg gelatin capsules containing sumatriptan tablets 50 mg Placebo Single dose

The percentage of patients with reduction in headache severity from moderate or severe to mild or no pain (primary endpoint) was 52.5% for ASA, 60.2% for ibuprofen, 55.8% for sumatriptan and 30.6% for placebo. All active treatments were superior to placebo (P<0.0001), whereas active treatments were not statistically different. The number of patients pain-free at 2 h was 27.1%, 33.2%, 37.1% and 12.6% for those treated with ASA, ibuprofen, sumatriptan or placebo, respectively. The difference between ASA and sumatriptan was statistically significant (p=0.025).

Diener

Adults – Almotriptan 12.5mg – 41.1 (SD 11.4); Placebo – 41.4 (SD 12) years n=221 (192 female and 29 male)

Almotriptan 12.5mg Placebo tablets

Efficacy measure was pain relief at 2 h after administration of study medication. An additional endpoint assessed here is complete relief. Pain relief 2h for patients with a severe baseline pain intensity - Almotriptan 46.4% vs Placebo - 25% (p<0.05). Pain relief 2h for patients with a moderate baseline pain intensity - Almotriptan 50% vs Placebo 15% (p<0.05). Complete pain relief 2h - Almotriptan 17.1% vs Placebo 4.4%; (p<0.05).
Comparison between metamizole and triptans for migraine treatment: a systematic review and network meta-analysis

Dowson, Massimo, Aurora

Adults – Group 1 - 37 (19-49); Group 2 - 40 (19-30)

n=115 (female only)

Sumatriptan 100 mg oral Placebo
Four menstrual periods.

The primary study efficacy endpoints were the proportions of patients who reported headache relief at 4h post treatment. A small number of patients had menstrual related migraine, but efficacy analyses were conducted for the whole study sample. Headache relief at 4h - Patients inside menstrual window - Sumatriptan 67% vs Placebo 33% (p=0.0072) Outside menstrual window - Sumatriptan 79% vs Placebo 31% (p=0.0001). Complete headache relief at 4h - Inside menstrual window - Sumatriptan 49% vs Placebo - 10% (p=0.0001). Outside menstrual window - Sumatriptan 60% vs Placebo 9% (p=0.0001)
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<tr>
<th>Study</th>
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<td>Evers et al.18</td>
<td>Adolescents – 13.9 ± 2.8 years (n=52)</td>
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<td>Pain relief after 2 hours.</td>
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<td>Adults – mean age 37.5 years</td>
<td>Ibuprofen 200 or 400 mg (according to child age)</td>
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<td>Facchinetti et al.19</td>
<td>Adults - mean age 37.5 years (n=226)</td>
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<td>Adults – Edltiraptan 80mg</td>
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<td>Färkkilä et al.20</td>
<td>Adults – Dipyrone – male 32.2 years (n=276)</td>
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<td>Primary efficacy endpoint.</td>
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<td>Adults – Edltiraptan 80mg – 40.9 ± 10.6 years</td>
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<td>Ferrari et al.100</td>
<td>Adults – Sumatriptan 100 mg tablets</td>
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<td>Headache improvement.</td>
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<td></td>
<td>Adults – Isometheptene Combination 40.9 ± 9.6 years (n=126)</td>
<td>Isometheptene Combination 65mg</td>
<td>Placebo</td>
<td>Primary outcome.</td>
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<tr>
<td>Freitag et al.101</td>
<td>Adults – Rizatriptan 10 mg</td>
<td>Rizatriptan 10 mg ODT</td>
<td>Single migraine attack</td>
<td>There was a greater percentage of patients with elimination of nausea at 2 hours.</td>
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</table>

**Note:** The table above summarizes studies comparing different treatments for migraine relief. The outcomes measured include pain relief, efficacy, and patient satisfaction. The studies report on the number of patients experiencing 2-hour pain relief, headache improvement, and the percentage achieving sustained pain relief.
Comparison between metamizole and triptans for migraine treatment: a systematic review and network meta-analysis

<table>
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<td>Freitag et al.</td>
<td>Adults – 40.4 (10.8) &lt;br&gt;n=315 (274 female and 41 male)</td>
<td>Almotriptan 12.5 mg &lt;br&gt;Placebo</td>
<td>Attack 1: 2 h posttreatment 54.4%, 32.5%, 13.1%, and 0% of almotriptan-treated patients reported normal function, disturbed function, bed rest required, and ER/hospitalization respectively, compared with 38.1%, 45.2%, 16.1%, and 0.6% of placebo-treated patients. The differences in level of functional disability between the 2 treatment groups were statistically significant at 2 hours (P = 0.0077; Cochran-Mantel-Haenszel, stratified by center) and at 4 hours (P &lt; 0.001). Resolution of pain was associated with a normal level of function; at 2 hours posttreatment, 91.7% of patients in the total population who achieved pain-free reported normal function compared with 44.8%, 8.0%, and 0% of patients with mild, moderate, and severe pain, respectively. The absence compared with the presence of photophobia, phonophobia, and nausea at 2 hours also was associated with less disability (P &lt; 0.0001 for each symptom). Treatment with almotriptan compared with placebo resulted in consistently better 24-hour MIGA2L scores with significant results for all 3 migraine headache attacks in the social function and feelings/concern domains. A logistic regression model determined that pretreatment functional level (P = 0.0117), pretreatment pain intensity (P = 0.0059), and pretreatment MIDAS score (P = 0.0152) were significant covariates of the proportion of patients who achieved normal function at 2 hours posttreatment.</td>
</tr>
<tr>
<td>Freitag et al.</td>
<td>Adults – RA – 41.5 years (SD 10.3); R – 44.3 years (SD 10.6); A – 42 years (SD 11.7); P – 43.3 years (SD 10.9) &lt;br&gt;n=172 (151 female and 21 male)</td>
<td>Rizatriptan 10 mg + Acetaminophen 1000 mg (RA); Rizatriptan 10 mg (R); Acetaminophen 1000 mg (A); Placebo (P)</td>
<td>The primary efficacy endpoint was pain relief (Grade 0 or 1) at 2 h. Pain relief 2 h: RA 90%, R 77%, A 70%, P 45%. RA was statistically superior to A and P. Pain freedom 2 h: RA 54%, R 40%, A 26%, and p 15%. RA was statistically superior to A and P. Pain relief sustained 24 h: RA 62%, R 53%, A 42% and P 15%. RA was statistically superior to P only. RA was statistically superior to A for absence of phonophobia (85% vs 60%, P = 0.009) and statistically superior to P for absence of phonophobia (85% vs 67%, P = 0.09), absence of nausea (92% vs 72%, P = 0.021), and absence of functional disability (65% vs 41%, P = 0.024).</td>
</tr>
<tr>
<td>Friedman et al.</td>
<td>Adults – 31 to 37 years (31-37); Sumatriptan = 34 years (31/37) &lt;br&gt;n=78 (67 female and 11 male)</td>
<td>Metoclopramide 20 mg + diphenhydramine 25 mg administered IV</td>
<td>The primary outcome, a comparison of the change in NRS (numeral rating scale) scores between time 0 and 2 hours in each arm, demonstrated a clinically and statistically insignificant advantage for the metoclopramide arm: 1.0. The secondary outcome, a comparison of the change in NRS (numeral rating scale) score between time 0 and 24 hours, revealed a clinically and statistically insignificant advantage for the metoclopramide arm: 1.1. At 2 hours - 59% of metoclopramide subjects and 35% of sumatriptan subjects were pain-free.</td>
</tr>
<tr>
<td>Friedman et al.</td>
<td>Adults – TMB/DPH: 34 (9.7) years &lt;br&gt;n=40 (37 female and 3 male)</td>
<td>Trimethobenzamid 200 g + diphenhydramine 25 mg (TMB/DPH) as a single intramuscular injection</td>
<td>By 2 hours sumatriptan subjects had improved by a mean of 6.1 and the TMB/DPH subjects had improved by a mean of 4.4 (95% CI for difference of 1.7: −0.1 to 3.4). By 24 hours after medication administration, sumatriptan subjects had a mean improvement from baseline of 4.2 compared with 5.3 for TMB (95% CI for difference of −0.4: −2.4 to 1.6). The need for rescue medication was comparable between the groups. No serious or frequent adverse effects were noted in either group.</td>
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<tr>
<td>Friedman et al.</td>
<td>Adults – 18 to 64 years (18-64) &lt;br&gt;n=166 (144 female and 22 male)</td>
<td>Oral Naproxen 500 mg</td>
<td>Naproxen group improved by a mean of 4.3 NRS (numeral rating scale) points, whereas the sumatriptan group improved by 4.1 points (95% CI for difference of 0.2 points: 0.7 to 1.1 points). Findings were virtually identical among the migraine subset (4.3 versus 4.2 NRS points, 95% CI for difference of 0.1 points: 1.3 to 1.5 points). Would patients want to take the same medication the next time: 71% Naproxen (95% CI 62% to 80%) and 75% (95% CI 66% to 84%) of sumatriptan patients answered yes. Adverse effect profiles were also comparable.</td>
</tr>
<tr>
<td>Friedman et al.</td>
<td>Adults – 18 to 63 years (18-63) &lt;br&gt;n=35 (28 females and 7 males)</td>
<td>Maxillary intraoral chilling (MIC) Sumatriptan 50 mg oral Sham (tongue) chilling</td>
<td>Significant mean headache relief was obtained by maxillary chilling and sumatriptan at all time intervals (1, 2, 4, and 24 hours), with poor relief obtained by placebo. Maxillary chilling was more effective than sumatriptan at all time intervals. Significant nausea relief was obtained by maxillary chilling and sumatriptan at posttreatment and 2 and 4 hours later. At 24 hours, some headache and nausea recurrence were noted with sumatriptan. The repeated-measures analysis of variance indicated that both treatments, drug (P = 0.024) and maxillary chilling (P = 0.001), reduced the headache compared to the control group.</td>
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</table>
Comparison between metamizole and triptans for migraine treatment: a systematic review and network meta-analysis

**Peres MFP, Scala WAR, Salazar R**

**Geraud et al.**

**Gallagher et al.**

**Garcia-Ramos et al.**

**Fujita et al.**

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<td>Fujita et al.(^{6})</td>
<td>Children and adolescents: Sumatriptan 25 mg: 14.5 (2.18); Sumatriptan 50 mg; 14.1 (1.96) and Placebo: 13.9 (2.04) n=144 (female 84 and male 60)</td>
<td>Sumatriptan 25 and 50 mg oral Placebo</td>
<td>Single migraine attack</td>
<td>Patients who report pain relief at 2h post-treatment for the primary endpoint was higher in the placebo group (38.6% vs. 31.1%, 95% CI: 23.02 to 8.04, p=0.035). Patients who reported pain relief at 4h post-dose was higher in the pooled sumatriptan group (63.5%) than in the placebo group (51.4%) but failed to achieve statistical significance (p=0.142). At 4h post-dose, percentages of patients who were pain free or had complete relief of photophobia or phonophobia were numerically higher in the sumatriptan pooled group compared to placebo.</td>
</tr>
<tr>
<td>Gallagher et al.(^{13})</td>
<td>Adults – zolmitriptan 2.5 mg 39.9 (10.0); 5 mg 40.2 (10.5); Sumatriptan 25 mg 39.6 (10.2); 50 mg 40.6 (10.2) years n=1212 (1062 female and 150 male)</td>
<td>Zolmitriptan 2.5 mg, 5mg tablet Placebo</td>
<td>Single and second (recurrence a single migraine attack) migraine attack</td>
<td>A headache response at 2 hours was noted in 67.1% of patients taking zolmitriptan 2.5 mg, and 64.8% of those taking sumatriptan 5 mg, versus 59.6% of patients taking sumatriptan 25 mg, and 63.8% of those taking sumatriptan 50 mg. At 2 and 4 hours, the differences between zolmitriptan 2.5 mg, and sumatriptan 5 mg, were statistically significant (odds ratio=1.49 and 1.67, respectively; both P&lt;0.001). Statistically significant differences between zolmitriptan 2.5 mg, and sumatriptan 50 mg, were seen at 2 and 4 hours post dose (odds ratio=1.21 and 1.23, respectively; both P&lt;0.05). At 1 hour post dose, the headache response rate for zolmitriptan 2.5 mg, was numerically higher than response rates for sumatriptan 25 mg and 50mg (odds ratio=1.16, odds ratio=1.06, though they failed to reach statistical significance; F=0.01, F=0.46 respectively). Differences between sumatriptan 5 mg, and zolmitriptan 25 mg, were statistically significant at 1, 2, and 4 hours (odds ratio=1.13, 1.46, and 1.78, respectively; all P&lt;0.001) and at 1 and 4 hours versus sumatriptan 50 mg (odds ratio=1.26, P=0.002; odds ratio=1.29, P=0.012, respectively). Although not statistically significant at 2 hours, more patients responded to zolmitriptan 5 mg, than to sumatriptan 50 mg (odds ratio=1.16, P=0.064). Patients receiving zolmitriptan 2.5 mg or 5 mg, achieved more pain relief over 24 hours than patients receiving sumatriptan 25 mg (odds ratio=1.47, and 1.54 respectively, both P&lt;0.001) or sumatriptan, 50 mg (odds ratio=1.17, P=0.021; odds ratio=1.22, P=0.005, respectively.</td>
</tr>
<tr>
<td>Garcia-Ramos et al.(^{15})</td>
<td>Adults – Eletriptan – 36.3 ± 11.1; Naratriptan 27.5 ± 11; Placebo 36.4 ± 11.1 years n=483 (390 female and 93 male)</td>
<td>Eletriptan 40mg tablet Naratriptan 2.5mg capsule Placebo</td>
<td>Single migraine attack</td>
<td>The primary efficacy endpoint for the study was headache response at 2 h after the first dose of study medication for the index attack. Headache response 2 h - eletriptan (56%) compared to naratriptan 42%, P &lt; 0.01. Headache response at 1 h - Eletriptan - 34%, Naratriptan - 25% and Placebo - 21% and 4 h - Eletriptan - 80%, Naratriptan - 67% and Placebo - 44%. Eletriptan showed higher pain-free rates at both 2 and 4 h (35% and 56%) compared with both naratriptan (18%, P &lt;0.001 and 41%, P &lt;0.01) and placebo (19%, P &lt;0.001; 24%, P &lt;0.0001). Among patients who achieved a 2 h headache response, headache recurrence rates were consistently low for eletriptan (29%), naratriptan (26%), and placebo (28%).</td>
</tr>
<tr>
<td>Geraud et al.(^{11})</td>
<td>Adults – Zolmitriptan-38.3±10.4 years; Sumatriptan-38.0±10.6 years; Placebo-37.9±9.7 years. n=1058 (174 male, 884 female)</td>
<td>zolmitriptan 5 mg or sumatriptan 100 mg placebo a single oral dose</td>
<td>A headache response at 2 hours was noted in 67.1% of patients taking zolmitriptan 2.5 mg, and 64.8% of those taking sumatriptan 5 mg, versus 59.6% of patients taking sumatriptan 25 mg, and 63.8% of those taking sumatriptan 50 mg. At 2 and 4 hours, the differences between zolmitriptan 2.5 mg, and sumatriptan 5 mg, were statistically significant (odds ratio=1.49 and 1.67, respectively; both P&lt;0.001). Statistically significant differences between zolmitriptan 2.5 mg, and sumatriptan 50 mg, were seen at 2 and 4 hours post dose (odds ratio=1.21 and 1.23, respectively; both P&lt;0.05). At 1 hour post dose, the headache response rate for zolmitriptan 2.5 mg, was numerically higher than response rates for sumatriptan 25 mg and 50mg (odds ratio=1.16, odds ratio=1.06, though they failed to reach statistical significance; F=0.01, F=0.46 respectively). Differences between sumatriptan 5 mg, and zolmitriptan 25 mg, were statistically significant at 1, 2, and 4 hours (odds ratio=1.13, 1.46, and 1.78, respectively; all P&lt;0.001) and at 1 and 4 hours versus sumatriptan 50 mg (odds ratio=1.26, P=0.002; odds ratio=1.29, P=0.012, respectively). Although not statistically significant at 2 hours, more patients responded to zolmitriptan 5 mg, than to sumatriptan 50 mg (odds ratio=1.16, P=0.064). Patients receiving zolmitriptan 2.5 mg or 5 mg, achieved more pain relief over 24 hours than patients receiving sumatriptan 25 mg (odds ratio=1.47, and 1.54 respectively, both P&lt;0.001) or sumatriptan, 50 mg (odds ratio=1.17, P=0.021; odds ratio=1.22, P=0.005, respectively.</td>
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</tbody>
</table>

\(^{6}\) ALAA
Comparison between metamizole and triptans for migraine treatment: a systematic review and network meta-analysis

Geraud, Compagnon, Rossi

Adults – mean age 39.2 years and 40.9±10.7 years; n=666 (100 male and 566 female)

Zolmitriptan 2.5 mg oral
Acetylsalicylic acid 900 mg + metoclopramide 10 mg oral
First and second (recurrence a single migraine attack) migraine attack

The percentage of patients with a 2-hour headache response after the first dose (primary endpoint) was 33.4% with zolmitriptan and 32.9% with acetylsalicylic acid plus metoclopramide (odds ratio 1.06, 95% confidence interval (CI) 0.77–1.47; p = 0.7228).

For most secondary endpoints, the two treatments demonstrated comparable efficacy.

Ghadehibarmi, Tavakkoli, Rossi

Adults – Sumatriptan - 36.17±7.57, Valproate - 38.61 ± 11.41 years.
n=37 (7 male and 30 female)

Sumatriptan 6mg SC
Valproate 15 mg/Kg IV
Single migraine attack

The outcomes including pain severity at 0.5, 1, 2, 4, 24, and 48 hours after injection (VAS score was used to migraine severity).

Sumatriptan VAS Score (before treatment: 0.84) 0.5h - 0.01, 1h - 0.023, 2h - 0.3, 4h -0.99, 24h - 0.68, 48h - 0.46.

Valproate VAS Score (before treatment: 8.31) 0.5h - 3.31, 1h - 2.26, 2h - 2.15, 4h -2.10, 24h -1.68, 48h - 1.31.

Gissman et al.

Adults - mean age 39.2 years
n=418 (Female: 361 and Male: 57)

Rizatriptan 2.5mg, 5 mg, 10 mg
Placebo
Single migraine attack

At the primary timepoint of 2 h after the initial dose, the proportion of patients reporting pain relief was 47.6% for rizatriptan 10 mg; 45.4% for rizatriptan 5 mg; 21.3% for rizatriptan 2.5 mg; and 17.9% for placebo. Seventy percent of patients on rizatriptan 10 mg reported pain relief at 4 h.

Goldstein et al.

Adults – Almotriptan 39 ±11 and Zolmitriptan 40 ± 11 years
n=1062 (Female: 902 and 160 male)

Almotriptan 12.5 mg oral
Zolmitriptan 2.5 mg oral
single migraine attack

The primary endpoint was sustained pain free plus no adverse events, other endpoints included pain relief and pain free at several time points, sustained pain free, headache recurrence, use of rescue medication, functional impairment, time lost because of migraine, treatment acceptability, and overall treatment satisfaction.

Pain relief at 2h – Rizatriptan 5mg - 33%, Sumatriptan 25mg - 25%.

The outcomes were pain relief in comparison between drugs and pain relief at 2 hours.

Pain relief – HR rizatriptan 5mg vs sumatriptan 25 mg = 1.16, suggesting that patients on rizatriptan 5mg are 16% more likely to achieve pain relief in comparison to patients on sumatriptan 25 mg.

HR rizatriptan10mg vs sumatriptan 50mg = 1.14 suggesting that patients on rizatriptan 10 mg are 14% more likely to achieve pain relief in comparison to patients on sumatriptan 50 mg.

Pain relief at 2h – Rizatriptan 5mg - 33%, Sumatriptan 25mg - 28%, Rizatriptan 10mg - 72%, Sumatriptan 50mg - 68%, Placebo - 38%.
<table>
<thead>
<tr>
<th>Study</th>
<th>Characteristics</th>
<th>Medication</th>
<th>Comparison</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goldstein et al.</td>
<td>Adults – mean age 38.1 years (136 female and 35 male)</td>
<td>Sumatriptan 50mg – 44 ± 10.7 years</td>
<td>Sumatriptan tablets (100 mg)</td>
<td>AAC group experienced significantly greater pain intensity reduction or pain relief than those taking 500 or placebo. Pain intensity reduction and pain relief score for Sumatriptan 50mg group were higher than placebo group, but not to a statistically significant degree. Reduction of headache pain intensity from moderate/severe to mild/none - Sumatriptan 50mg group was significantly superior to AAC (30 minutes postdose). AAC group was significantly greater than in the Sumatriptan 50mg group (2, 3 and 4 hours postdose). The response rate of AAC versus placebo was significant from 90 minutes. The rate of response in the Sumatriptan 50mg group was greater than that in the placebo group at all time points, but not to a statistically significant degree. Utilization of the rescue medication showed statistically significant difference between Sumatriptan 50mg group (11.7% subjects) versus the AAC group (1.5% of subjects), at 4 hours postdose.</td>
</tr>
<tr>
<td>Goldstein et al.</td>
<td>Adults – Sumatriptan IT - 40.7 years (117, 112) Placebo - 41 (SD 11) years</td>
<td>Sumatriptan transdermal system 6.5 mg</td>
<td>Sumatriptan 50mg tablets</td>
<td>Significantly greater proportion of patients who received the sumatriptan transdermal system were headache pain-free 2 hours after patch activation compared with placebo (18% vs 9%, respectively; p=0.0092). The sumatriptan transdermal system was associated with a significantly higher percentage of patients reporting headache pain relief 2 hours postdose (32.9% vs 28.6%, respectively; P &lt;0.0001).</td>
</tr>
<tr>
<td>Gross et al.</td>
<td>Adults – had been less than 50 years old</td>
<td>Sumatriptan 6 mg sc</td>
<td>Sumatriptan 100mg oral and Sumatriptan 6 mg subcutaneous</td>
<td>Over 70% of patients who treated attack 1 in both treatment periods of the crossover phase reported headache relief with each formulation at 4 h. Only 3% of patients failed to respond to at least one of the formulations at this time point. At the end of the crossover phase patient preference for the injection more than doubled from the pretreatment level in those patients who were previously naïve to sumatriptan. During the optional phase of the study, 38% of patients chose to treat some attacks with oral and some with subcutaneous sumatriptan</td>
</tr>
<tr>
<td>Gruffydd-Jones et al.</td>
<td>Adults – had been less than 50 years old</td>
<td>Zolmitripant 5mg = 41.7 ± 10.6; Zolmitriptan 2.5mg = 42.1 ± 10.7; Zolmitriptan 1.25mg = 41.9 ± 10.7 years</td>
<td>Zolmitriptan 5 and 2.5mg tablets</td>
<td>There were 2 primary efficacy endpoints: headache response at 2 h after treatment and proportion of patients with a headache response at 2 h after the first dose of study medication across all attacks treated. Headache response at 2h: Zolmitriptan 5mg – 65.7% vs Zolmitriptan 2.5mg – 62.9% vs Sumatriptan 50mg - 66.6% (there were no difference between response rates in all treated attacks with 3 study medications, there were no statistically difference post 1 or 4h). Proportion of patients with 2h response: Zolmitriptan 5mg – 44.4% patients had a response in &gt;80% of attacks, Zolmitriptan 2.5mg - 38.6% patients had a response in &gt;80% of attacks treated. Headache-free - Sumatriptan 5/23 (22%) vs placebo 1/23 (22%) (difference 9%, 95% CI for difference 21 to 38%, p = ns).</td>
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<tr>
<td>Hamalainen, Hoppi, Santavuori</td>
<td>Adolescents - 12.3 (8.3 - 16.4) years</td>
<td>Sumatriptan 50 mg oral for a body surface area of 0.75 to 1.5 m²</td>
<td>Sumatriptan 50mg tablets</td>
<td>The primary endpoint of clinical efficacy was reduction of pain intensity by at least 50% after 2 hours. At 2 hours, reduction of pain intensity by 50% - Sumatriptan 7/23 (30%) vs placebo 5/23 (22%) (difference 9%, 95% CI for difference 21 to 38%, p = ns). Headache-free - Sumatriptan 5/23 (22%) vs placebo 2/23 (9%) (difference 13%, 95% CI for difference 9 to 35%, p = ns).</td>
</tr>
<tr>
<td>Havranka et al.</td>
<td>Adults – 18 to 65 years</td>
<td>Naratriptan tablets (1, 2.5, 5, 7.5, and 10 mg)</td>
<td>Naratriptan tablets (100 mg)</td>
<td>1 hour headache relief: Narat 1 mg (25/85); Narat 2.5 mg (30/87); Narat 5 mg (34/93); Narat 7.5 mg (68/93); Narat 10 mg (69/96); Sumat 100 mg (35/98); Placebo (70/91). 2 hours headache relief: Narat 1 mg (58/85); Narat 2.5 mg (52/87); Narat 5 mg (54/93); Narat 7.5 mg (68/93); Narat 10 mg (69/96); Sumat 100 mg (60/98); Placebo (51/91). 4 hours headache relief: Narat 1 mg (64/85); Narat 2.5 mg (63/87); Narat 5 mg (65/93); Narat 7.5 mg (80/93); Narat 10 mg (80/96); Sumat 100 mg (80/98); Placebo (39/91).</td>
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<td>Study</td>
<td>Population</td>
<td>Intervention</td>
<td>Outcome</td>
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<td>Henry, d'Allens</td>
<td>Adults – mean age was 43.7 years (range 20-65)</td>
<td>Sumatriptan 6mg SC</td>
<td>Headache relief was achieved within 2 hours after Sumatriptan in 26 patients (70%) compared to 8 patients (21%) in the placebo group (p&lt;0.001). Of these patients, 19 (51%) and 3 (8%) were, respectively, pain free at this time. A secondary injection of Sumatriptan was used respectively by 13 (35%) and 22 (58%) patients (p&lt;0.024).</td>
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<tr>
<td>Ho et al</td>
<td>Adolescents 6-17 years old and mean age of 13.0 (2.9) years. n=977 (female 550 and male 427)</td>
<td>Rizatriptan (5 mg for &lt;40 kg, 10 mg for ≥ 40 kg) Placebo</td>
<td>A higher proportion of 12–17 year old on rizatriptan had pain freedom at 2 hours compared with those on placebo. 87/284 (30.6%) vs 63/286 (22.0%), odds ratio = 1.55 (95% CI: 1.06 to 2.26), p = 0.025. Adverse events within 14 days of dose in 12–17 year old were similar for rizatriptan and placebo. The pattern of findings was similar in 6–17 year old.</td>
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<tr>
<td>Ishkanian et al</td>
<td>Adults – sumatriptan 39.6±12.3 years; placebo 41.0±11.3 years. n=215 (151 females and 64 males)</td>
<td>Sumatriptan 50 mg tablet Placebo</td>
<td>Significantly more patients treated with sumatriptan 50 mg achieved a positive headache response at 2 and 4 hours after administration compared with those treated with placebo (65% vs 43% at 2 hours and 76% vs 49% at 4 hours, respectively; both, P &lt; 0.001). Significantly more sumatriptan-treated patients were free from sinus pain compared with placebo recipients at 2 hours (63% vs 49% placebo, P = 0.049) and 4 hours (77% vs 55%, P = 0.001). All treatments were generally well tolerated. The most common drug-related AE reported in the sumatriptan and placebo groups, respectively, were dizziness (5% vs &lt;1%), nausea (3% vs 2%). No patients experienced any serious adverse effects.</td>
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<tr>
<td>Jelinski et al</td>
<td>Adults – mean age of 40 years (39.8±9.7 years sumatriptan 50 mg, 39.8±11.4 years sumatriptan 100 mg, 40.7±9.8 years placebo)</td>
<td>Sumatriptan 50 mg Placebo</td>
<td>Two-hour pain free rates were 16%, 40%, and 50% in the placebo group, sumatriptan 50 mg group, and the sumatriptan 100 mg group respectively (p &lt; 0.001), active treatment groups vs placebo. The percentage of subjects who sustained a pain-free response for both 50 mg and 100 mg sumatriptan groups (24% and 27%) was significantly higher than in the placebo group (6%). After 4 hours, 25% of the 50 mg sumatriptan group and 13% of the 100 mg sumatriptan group experienced worsening of their migraine pain, compared to 46% of placebo patients (both p&lt;0.001).</td>
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<tr>
<td>Jensen et al</td>
<td>Adults – 43 years (range 20-65) n=138 (125 female and 13 male)</td>
<td>Sumatriptan 6 mg subcutaneous Placebo</td>
<td>Sumatriptan 6 mg sc was significantly better than placebo at 30, 60, 90 and 120 min after injection in relieving moderate or severe headache to mild or none as well as relieving any headache to none. At 60 min after injection, the treatment response rate was 61% for sumatriptan and 6% for placebo. During the following open-phase trial of four attacks treated with sumatriptan, treatment response rates were 68-74%. During the total of 538 attacks treated, 12 attempts at using the self-injector failed. In the double-blind and open phases, 81% and 90% of patients respectively found the device easy or very easy to use. Adverse effects were benign and short lasting, but led 7 patients to discontinue the study.</td>
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<tr>
<td>Kelly et al</td>
<td>Adults – mean age sumatriptan 32 and chlorpromazine 35 years n=43 (29 Female and 14 male)</td>
<td>Sumatriptan 6 mg JM Chlorpromazine 12.5 mg increments to a maximum of 37.5 mg</td>
<td>No difference in efficacy between the sumatriptan regimen and the chlorpromazine regimen was found. Adverse effects were mild and equally distributed between the groups.</td>
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<tr>
<td>Klapper, O’Connor</td>
<td>Subjects age not mentioned. n=30</td>
<td>Rizatriptan 10 mg wafer sublingual Placebo</td>
<td>The primary efficacy measure was pain relief in 1 hour. Pain relief in 1 hour – Rizatriptan 50% (8/16) vs Placebo 50% (7/14). The average time to onset of significant relief - Rizatriptan was 25 min vs. Placebo 27 min (t=1.25, NS).</td>
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<tr>
<td>Klapper et al</td>
<td>Adults – Zolmitriptan 2.5mg – 41.1±11.3 years; Placebo - 42 ± 10.3 years n=280 (39 male and 241 female)</td>
<td>Zolmitriptan 2.5 mg oral Placebo</td>
<td>Primary endpoint was pain-free rate (i.e. ‘no pain’) at 2 h after the first dose of zolmitriptan 2.5 mg or placebo. Pain-free at 2 h – Zolmitriptan 43.4% vs. Placebo 18.4%; odds ratio (OR) 3.28, 95% CI 1.90–5.66, P &lt; 0.0001. Progressed to more severe intensity within 2 h after treatment - Zolmitriptan 53.7% vs. Placebo 70.4%, P &lt; 0.01. At 2 h after dosing patients able to perform normal activities -Zolmitriptan 68.4% vs Placebo 50.7%, P &lt; 0.01.</td>
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<td>Study</td>
<td>Adults</td>
<td>Treatment</td>
<td>Outcome</td>
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<tr>
<td>Klassen et al.</td>
<td>40.2 years (613 female and 80 male)</td>
<td>Naratriptan tablets 2.5mg, 1 mg, 0.25 mg or 0.1 mg</td>
<td>Headache relief (moderate or severe pain at dosing reduced to mild or no pain) 4 hours postdose was reported in 60% of patients receiving naratriptan. 2.5 mg compared with 50%, 35%, 32%, and 34% of patients receiving sumatriptan 1 mg, 0.25 mg, 0.1 mg, and placebo, respectively. (P&lt;0.05 naratriptan 2.5 mg and 1 mg versus placebo, 1 mg versus 0.1 mg, and 2.5 mg versus 0.1 mg and 0.25 mg). Clinical disability 4 hours postdose was reported as mild or none for 70% of patients receiving naratriptan 2.5 mg compared with 63%, 47%, 48%, and 48% of patients receiving sumatriptan 1 mg, 0.25 mg, 0.1 mg, or placebo, respectively (P&lt;0.05 naratriptan 2.5 mg and 1 mg versus placebo, 1 mg versus 0.1 mg, and 2.5 mg versus 0.1 mg and 0.25 mg). Four-hour efficacy for absence of nausea, photophobia, and phonophobia was similar to efficacy for headache relief at each dose. The adverse event profile of each dose of naratriptan was similar to that of placebo. No clinically relevant change in any safety measure was reported.</td>
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<tr>
<td>Kolodny et al.</td>
<td>40 years (n=1,447, 1,244 female and 203 male)</td>
<td>Lysine clonixinate (LC) 200 mg IV, Dipyone (metamizol) 1000 mg IV</td>
<td>The primary outcome measure was the mean change in pain intensity from baseline to 60 minutes. The mean decrease in pain intensity in the IV prochlorperazine with diphenhydramine group was 73 mm compared with 50 mm in the subcutaneous sumatriptan group.</td>
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<tr>
<td>Kostic et al.</td>
<td>40 years (n=613, 533 female and 80 male)</td>
<td>Prochlorperazine 10 mg IV with diphenhydramine (DPH) 25 mg</td>
<td>The primary objective of the study was to compare rizatriptan 10 mg and sumatriptan 50 mg in terms of time-to-pain relief during the 2 h after taking study drug. Hazard ratio (rizatriptan 10 mg vs sumatriptan 50 mg) = 1.10 (95% confidence interval (CI) 1.06, 1.14; P&lt;0.001). Hazard ratio (Rizatriptan 5 mg vs sumatriptan 25 mg) = 1.22 (95% CI 1.06, 1.41; P=0.007). Pain-free rates at 2h - Rizatriptan 5 mg 33.4% vs Sumatriptan 25 mg 27.4% [OR=1.34 - 95%CI 1.05, 1.72; p=0.002] / Rizatriptan 10 mg - 38% vs Sumatriptan 50 mg 33.6% [OR=1.23 - 95% CI 0.99, 1.52; p=0.059].</td>
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<tr>
<td>Krymchantowski, Filho, Bigal</td>
<td>39.7 years (n=32, 25% female and 25% male)</td>
<td>Rizatriptan 10 mg tablet plus trimebutine 200 mg capsule</td>
<td>At 1 h postdose, 30 (46.8%) of 64 attacks treated with the combination resolved completely, vs. eight (12.5%) of the rizatriptan-treated attacks, a difference of 34% (P&lt;0.01). At 2 h postdose, 47 (73.4%) attacks treated with the combination vs. 20 (31.2%) of those treated with rizatriptan alone resolved completely, a difference of 42% (95% confidence interval 36, 58, P&lt;0.001). Regarding nausea and photophobia, the combination was also associated with significantly better response</td>
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<tr>
<td>Lainez et al.</td>
<td>33.15 years (n=229, 199 females and 30 males)</td>
<td>Almotriptan 12.5 mg Ergotamine 2 mg plus caffeine 200 mg</td>
<td>Treatment with almotriptan was associated with a significantly greater proportion of patients achieving 2h pain-free (20.3% vs. 13.7%; P&lt;0.05) and 2h pain relief (57.7% vs. 44.5%; P&lt;0.01) compared with ergotamine plus caffeine therapy; significant differences were not seen at 1h. Rates for sustained pain-free plus no adverse events (AEs) also were significantly greater after almotriptan treatment than after the use of ergotamine plus caffeine (P&lt;0.05). Almotriptan was associated with a significantly lower rate of photophobia at 90 min (P&lt;0.05), phonophobia at 60, 90, and 120 min (P&lt;0.05 to &lt;0.001), and nausea and vomiting at 90 and 120 min (P&lt;0.01) compared with ergotamine plus caffeine. A significantly greater proportion of patients were more satisfied with almotriptan (55.7% and 64%, 1st and 2nd attacks, respectively) than with ergotamine plus caffeine (36% and 44.3%, 1st and 2nd attacks, respectively) - (P&lt;0.05). Sixteen patients reported adverse events during almotriptan treatment and 27 patients during the ergotamine plus caffeine therapy. Most adverse events were mild-to-moderate and did not result in treatment-related discontinuations.</td>
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</table>
### Adults – 37 years (37.8±8.5 years sumatriptan 50 mg; 37.9±8.4 years sumatriptan 100 mg; 37.6±7.6 placebo) n=447 (403 females and 44 male)

<table>
<thead>
<tr>
<th>Sumatriptan 50 mg tablets</th>
<th>Placebo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single migraine attack</td>
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</table>

### Sumatriptan 50 mg and 100 mg tablets were significantly more effective than placebo at conferring pain-free response 2 h post-dose (p<0.001 each sumatriptan group vs. placebo). The onset of efficacy vs. placebo for pain-free response was observed by 1 h post-dose for sumatriptan 100 mg (p<0.05). Sustained freedom from pain from 2 through 24 h post-dose was reported by 30 and 35% of patients in the sumatriptan tablets 50mg and 100mg groups, respectively, compared with 8% of placebo-treated patients (p<0.001 each sumatriptan group vs. placebo).

Both doses of sumatriptan were well tolerated. The adverse events were generally slightly higher in the sumatriptan groups than in the placebo groups.

### Adolescents – Placebo - 14.4 (12-17) years; Almotriptan 25 mg - 14.4 (12-17) years; Almotriptan 12.5 mg - 14.2 (12-17) years; Almotriptan 25 mg - 14.4 (12-17) years; n=548 (227 male and 321 female)

<table>
<thead>
<tr>
<th>Almotriptan 6.25 mg oral</th>
<th>Placebo</th>
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<tbody>
<tr>
<td>Almotriptan 12.5 mg oral</td>
<td>Placebo</td>
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<tr>
<td>1 dose of study medication</td>
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</tbody>
</table>

**Linder et al.**

The 2-hour pain-relief rate was significantly higher with almotriptan 25 mg compared with placebo (66.7% vs 55.3%; p = 0.028, respectively). The incidence of nausea, photophobia, and phonophobia at 2 hours (adjusted for baseline pain intensity) for the almotriptan 25 mg and placebo groups was not significantly different. The 2-hour pain-relief rates (unadjusted) were significantly higher with almotriptan 6.25 mg (71.8%), 12.5 mg (72.9%), and 25 mg (66.7%) than with placebo (55.3%; P = 0.01, P < 0.001, and P = 0.028, respectively).

Rates for sustained pain relief also were significantly greater with almotriptan 6.25 mg (67.2%), 12.5 mg (66.9%), and 25 mg (64.5%) than with placebo group (52.4%). P < 0.01 for the 6.25- and 12.5-mg doses and P < 0.05 for the 25-mg dose. Age group subanalysis demonstrated significantly greater 2-hour pain relief rates with all 3 doses of almotriptan compared with placebo for patients aged 15 to 17 years, a significantly lower incidence of photophobia and phonophobia at 2 hours with almotriptan 12.5 mg compared with placebo for patients aged 15 to 17 years, and a significantly lower incidence of photophobia with almotriptan 1.25 mg compared with placebo for those aged 12 to 14 years.

Almotriptan treatment was well tolerated, with the most common adverse events nausea, dizziness, and somnolence.

### Adults – mean age: 14.2 years n=171 (98 female and 73 male)

<table>
<thead>
<tr>
<th>Zolmitriptan 5 mg nasal spray</th>
<th>Placebo</th>
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<tr>
<td>Crossover study 2-attacks</td>
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</table>

**Lewis et al.**

The onset of significant pain relief was apparent 15 minutes after treatment with zolmitriptan nasal spray. At 1 hour after the dose, zolmitriptan nasal spray produced a higher headache response rate than did placebo (59.1% vs 43.3%). Zolmitriptan nasal spray was also significantly superior to placebo in improvement in pain intensity, pain-free rates, sustained resolution of headache, and resolution of associated migraine symptoms. Return to normal activities was also consistently faster with zolmitriptan nasal spray than with placebo, with less use of any escape medication. Treatment with zolmitriptan nasal spray was well tolerated.

### Adolescents – Placebo - 14.4 (12-17) years; Almotriptan 6.25 mg - 14.4 (12-17) years; Almotriptan 12.5 mg - 14.2 (12-17) years; Almotriptan 25 mg - 14.4 (12-17) years; n=548 (227 male and 321 female)

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<td>1 dose of study medication</td>
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</tbody>
</table>

**Linder et al.**

Active drugs were superior to placebo at reducing headache pain and were similarly effective.

### Adults - mean age 40 years n=872 (715 female and 157 male)

<table>
<thead>
<tr>
<th>Oral rizatriptan 5 mg, Oral sumatriptan 50 mg Placebo</th>
<th>Single migraine attack</th>
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</table>

**Lines, Vandormael, Malbecq**

The onset of significant pain relief was apparent 15 minutes after treatment with zolmitriptan nasal spray. At 1 hour after the dose, zolmitriptan nasal spray produced a higher headache response rate than did placebo (59.1% vs 43.3%). Zolmitriptan nasal spray was also significantly superior to placebo in improvement in pain intensity, pain-free rates, sustained resolution of headache, and resolution of associated migraine symptoms. Return to normal activities was also consistently faster with zolmitriptan nasal spray than with placebo, with less use of any escape medication. Treatment with zolmitriptan nasal spray was well tolerated.

### Adults – mean age, 38.1 years n=249 (female 86% and male 14%)

<table>
<thead>
<tr>
<th>Sumatriptan 50 mg tablets Placebo Series of 5 headaches</th>
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</thead>
</table>

**Lipton et al.**

The 2-hour pain-relief rate was significantly higher with almotriptan 25 mg compared with placebo (66.7% vs 55.3%; P = 0.028, respectively). The incidence of nausea, photophobia, and phonophobia at 2 hours (adjusted for baseline pain intensity) for the almotriptan 25 mg and placebo groups was not significantly different. The 2-hour pain-relief rates (unadjusted) were significantly higher with almotriptan 6.25 mg (71.8%), 12.5 mg (72.9%), and 25 mg (66.7%) than with placebo (55.3%; P = 0.01, P < 0.001, and P = 0.028, respectively).

Rates for sustained pain relief also were significantly greater with almotriptan 6.25 mg (67.2%), 12.5 mg (66.9%), and 25 mg (64.5%) than with placebo group (52.4%). P < 0.01 for the 6.25- and 12.5-mg doses and P < 0.05 for the 25-mg dose. Age group subanalysis demonstrated significantly greater 2-hour pain relief rates with all 3 doses of almotriptan compared with placebo for patients aged 15 to 17 years, a significantly lower incidence of photophobia and phonophobia at 2 hours with almotriptan 12.5 mg compared with placebo for patients aged 15 to 17 years, and a significantly lower incidence of photophobia with almotriptan 1.25 mg compared with placebo for those aged 12 to 14 years.

Almotriptan treatment was well tolerated, with the most common adverse events nausea, dizziness, and somnolence.

### Adults – mean age 37.3 years n=524 (429 female and 95 male)

<table>
<thead>
<tr>
<th>Rizatriptan ODT 10 mg Sumatriptan 50 mg tablet Two migraine attacks</th>
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</thead>
</table>

**Loder et al.**

Percentage of patients who preferred rizatriptan ODT 10 mg (57%, n=213) was significantly greater than those who preferred sumatriptan 50-mg tablet (43%, n=161) (P<0.01).

A significantly greater percentage of patients reported pain relief after taking rizatriptan ODT than sumatriptan at the 45- and 60-minute time points (38% versus 29% and 38% versus 49%, respectively) (P<0.01). In addition, a significantly greater percentage of patients taking rizatriptan ODT reported a pain-free status at the 60- and 120-minute time points (23% versus 17% [P<0.05] and 60% versus 52% [P<0.01], respectively).
### Comparison between metamizole and triptans for migraine treatment: a systematic review and network meta-analysis

<table>
<thead>
<tr>
<th>Study Authors</th>
<th>Sample Characteristics</th>
<th>Intervention</th>
<th>Key Findings</th>
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</thead>
<tbody>
<tr>
<td>Loder et al. 19</td>
<td>Adults – mean: 37 years range: 18 to 55 years [zolmitriptan: 37±7.4 (18-55) years and placebo: 37±7.2 (19-51) years] n=510 (all female)</td>
<td>Zolmitriptan 2.5 mg orally disintegrating tablets (ODT) Placebo</td>
<td>A 2-hour headache response was achieved in 48% of zolmitriptan-treated attacks as compared with 27% of placebo-assigned attacks (P &lt; 0.001). Zolmitriptan was superior to placebo in achieving a headache response as early as 3 minutes (18% versus 14%, P = 0.03) and at 1 hour (33% versus 23%, P &lt; 0.001). Drug-related adverse events were reported in 16% of subjects receiving zolmitriptan and 9% of subjects receiving placebo.</td>
</tr>
<tr>
<td>Loder et al. 140</td>
<td>Adults – 40.0 ± 10.6 (Zolmitriptan 2.5 mg); 42.7 ± 10.5 (Placebo). n=565 (482 female and 83 male)</td>
<td>Zolmitriptan 2.5 mg orally disintegrating tablets (ODT) Placebo</td>
<td>Zolmitriptan 2.5mg ODT demonstrated a significant pain-free rate vs. placebo at 2h (40% vs. 20%, p &lt; 0.001), 1.5h (25% vs. 15%, p &lt; 0.001), and 1h (13% vs. 8%, p = 0.004). Sustained pain-free rate was significantly higher than placebo (31% vs. 15%, p &lt; 0.001). Significantly more patients treated with zolmitriptan 2.5 mg ODT were able to return to routine activities (work, school, or other daily activities) when compared with placebo at 1h (p = 0.004), 1.5h (p &lt; 0.001), and 2h (p &lt; 0.001). Zolmitriptan 2.5 mg ODT was well tolerated. Overall, 33% (92/282) of patients treated with zolmitriptan 2.5 mg ODT experienced adverse events versus 14% (41/284) of placebo-treated patients. The adverse events most commonly reported in patients treated with zolmitriptan 2.5 mg ODT were those commonly associated with the use of triptans, including dizziness, somnolence, paresthesia, tightness, and asthenia.</td>
</tr>
<tr>
<td>Maghbooli et al. 13</td>
<td>Adults Ginger group – 33.9 ± 8.3 Sumatriptan Group – 35.1 ± 6.2 n=100 (71 female and 29 male)</td>
<td>Ginger 250 mg powder capsule Sumatriptan 50 mg capsule</td>
<td>Frequency distribution of mean headache severity at 2 h after drug use demonstrated similar effectiveness for sumatriptan and ginger groups (P = 0.116). Comparing mean headache severity before and 2 h after treatment revealed a 4.7 unit reduction (according to VAS) in the sumatriptan group (P&lt;0.0001) and a 4.6 unit reduction in the ginger group (P&lt;0.0001).</td>
</tr>
<tr>
<td>Mannix et al. 21</td>
<td>Adults – mean age Rizatriptan - 36 years Placebo - 37 years n=403 (Female only)</td>
<td>Rizatriptan 10mg tablet Placebo</td>
<td>The primary endpoint for efficacy analysis was pain relief at 2h. 2h pain relief - Rizatriptan 70% vs 53% placebo (OR 2.11, 95% CI 1.34, 3.32 P = 0.001); 24h Sustained pain relief - Rizatriptan 46% vs Placebo 33% (OR 1.75, 95% CI 1.11, 2.77, P = 0.016).</td>
</tr>
<tr>
<td>Mannix et al. 21</td>
<td>Adults – Rizatriptan - 37 years; Placebo – 37 5 n=399 (Female only)</td>
<td>Rizatriptan 10mg tablet Placebo</td>
<td>The primary endpoint for efficacy analysis was pain relief at 2h. 2h pain relief - Rizatriptan 73% vs Placebo - 50% (OR 2.69, 95% CI 1.66, 4.36, P = 0.001); 24h Sustained pain relief - Rizatriptan 46% vs Placebo 33% (OR 1.74, 95% CI 1.08, 2.82, P = 0.024).</td>
</tr>
<tr>
<td>Marin et al. 42</td>
<td>Adults – mean age 35.9 years n=42 (Male 3 and Female 39)</td>
<td>Eletriptan Relpax 80 mg oral Placebo oral and intranasal spray Tetracaine 0.80 mg intranasal spray</td>
<td>After 30 minutes of therapeutic intervention both groups were compared by an unpaired Student t to obtain an average pain in the tetracaine group and an average of 1.952 for the pain group eletriptan of 4.0, with p = 0.0715. The improvement in pain and quality of life were correlated by Pearson’s method with the following results r = 0.7833 and p &lt; 0.0001y for eletriptan group r = 0.5143, p = 0.0171.</td>
</tr>
<tr>
<td>Martinez et al. 41</td>
<td>Adults – 18 to 65 years of age n=360 (271 women and 89 men)</td>
<td>Metamizole (0.5 and 1 g) oral Acetylsalicylic acid (1 g) oral Placebo</td>
<td>The pain intensity reduced steadily for all three active treatments in comparison with placebo up to 4h after administration. The analgesic efficacy of 0.5 and 1 g metamizol versus placebo was highly statistically significant for sum of pain intensity differences, maximum pain intensity difference, number of patients with at least 50% pain reduction, time to 50% pain reduction, maximum pain relief and total pain relief. A trend towards an earlier onset of a more profound pain relief of 0.5 and 1 g metamizol over 1 g Acetylsalicylic acid was noticed. Adverse events were experienced during the treatment phase of the study in all groups, but differences statistics were not observed. Global assessment of tolerability by the patients was good or satisfactory in more than 90% of all patients.</td>
</tr>
<tr>
<td>Massiou et al. 143</td>
<td>Adults - aged 18 to 65 years n=257 (Female only)</td>
<td>Naratriptan 2.5 mg Placebo</td>
<td>A higher percentage of subjects in the naratriptan group (58%) reported complete pain relief 4 h after medication than in the placebo group (30%) (P &lt; 0.001). Significant differences between the naratriptan and placebo groups and in favor of naratriptan were also found for: total pain relief at 2 h (P = 0.004), sustained pain-free response within 4–24 h (p &lt; 0.001), absence of all associated symptoms at 2 and 4 h (P =0.004), ability to work and carry out daily activities at 2 h (P =0.036), and patient overall satisfaction (P&lt;0.001).</td>
</tr>
<tr>
<td>Mathew et al. 144</td>
<td>Adults – mean age 41.2 years (SD = 9.6) n=682 (614 female and 68 male)</td>
<td>Naratriptan tablet 2.5, 1 and 0.25 mg Placebo</td>
<td>Headache relief 4 hours postdose occurred in 68% naratriptan 2.5 mg vs 57% naratriptan 1.0 mg vs 33% naratriptan 0.25 mg vs 33% placebo (p &lt; 0.001 naratriptan 2.5 mg and 1 mg versus placebo or 0.25 mg). Headache was eliminated 4 hours postdose - 45% naratriptan 2.5 mg vs 33% naratriptan 1 mg, 20% naratriptan 0.25 mg and 15% Placebo (p &lt; 0.001 naratriptan 2.5 mg and 1 mg versus placebo or 0.25 mg).</td>
</tr>
<tr>
<td>Mathew et al. (^{1,43})</td>
<td>Adults - aged to 18 to 65</td>
<td>Eletriptan 40 mg tablet</td>
<td>Headache response rates at 2 hours postdose were significantly higher for eletriptan 40 mg (67%) than for sumatriptan 100 mg (59%; P = 0.001) and placebo (26%; P = 0.001). Eletriptan 40 mg consistently showed significant (P &lt; 0.01) efficacy over sumatriptan 100 mg across secondary clinical outcomes, including 1-hour headache response; 2-hour pain-free response; absence of nausea, photophobia, and phonophobia; functional improvement; use of rescue medication; treatment acceptability; and sustained headache response (P = 0.05). Overall, treatment-related adverse events were low.</td>
</tr>
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</table>
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<p>| Mathew, Kailasam, Meadows (^{146}) | Adults - mean age 40.4 years | Rizatriptan 10 mg tablets | Pain-free response at 2 hours after early treatment was noted in 70% of attacks in the rizatriptan group and in 22% in the placebo group (P &lt; 0.01). Pain-free response at 1 hour occurred in 45% and 8% attacks, respectively (P &lt; 0.01). When the attacks were categorized by headache severity at the time of treatment, the pain-free response at 2 hours was higher for mild attacks than for moderate or severe attacks (P &lt; 0.01). Sustained pain-free response after treatment was significantly higher for attacks treated with rizatriptan (60%) than for those treated with placebo (17%) (P &lt; 0.001). Adverse events were reported in 62 attacks (29%) in the rizatriptan group and 15 attacks (14%) in the placebo group. |
| Mathew et al. (^{147}) | Adults – mean age 40.0 (12.3) years | Sumatriptan 22 mg nasal powder | The primary outcomes for these analyses were migraine pain intensity and migraine-related disability. Average pain intensity for sumatriptan 22 mg nasal treated attacks was significantly lower than sumatriptan treated ones at all time points from 10 to 90 minutes (P &lt; 0.05 for all). The mean portion of the models showed that sumatriptan 22 mg nasal had significantly lower disability from 10 to 90 minutes. |
| McGirley et al. (^{148}) | Adults – mean age 40.0 (12.3) years | Sumatriptan 20 mg nasal powder | The primary outcomes for these analyses were migraine pain intensity and migraine-related disability. Average pain intensity for sumatriptan 22 mg nasal treated attacks was significantly lower than sumatriptan treated ones at all time points from 10 to 90 minutes (P &lt; 0.05 for all). The mean portion of the models showed that sumatriptan 22 mg nasal had significantly lower disability from 10 to 90 minutes. |
| Meredith, Wait, Brewer (^{149}) | Adults - mean age of 33 years (18-54 years) | Ketorolac 30 mg intravenous | Higher percentage of patients was completely free of the headache 2 hours after dose administration in the ergotamine-based medication group compared to the sumatriptan group, regardless whether all (51.12% vs 33.70%) or only repeated attacks were taken into account (30.91% vs 23.73%). The surgical therapy (diclofenac) utilization rate was also lower in the ergotamine-based medication group (relative risk 0.61). |
| Miljkovic et al. (^{150}) | Adults - 18 to 64 years | Naproxen 500mg | Naproxen, rizatriptan and sumatriptan were better than ergotamine in causing freedom from the associated symptoms of nausea, vomiting, photophobia and phonophobia at 2hour postdose. Naproxen, rizatriptan and sumatriptan were also efficacious in causing functional normalization at 2 hours postdose as compared to ergotamine. |
| Mira et al. (^{151}) | Adults - mean age of 32.6 ± 2.57 years. | Sumatriptan 10 mg | Efficacy was assessed by headache relief and headache freedom at 2h and 24h. Two-hour headache relief was noted in 73% in rizatriptan, 53.8% in ibuprofen and 8% in placebo groups. Headache freedom was achieved in 37.7% in rizatriptan, 30.8% in ibuprofen and 2% in placebo groups. |
| Mira, Kalita, Yadav (^{152}) | Adults - Rizatriptan 29.15± 8.7, Ibuprofen 30.5 ± 10.6 and control 31.78 ± 9.9 years | Ketorolac 30 mg | Efficacy was assessed by headache relief and headache freedom at 2h and 24h. Two-hour headache relief was noted in 73% in rizatriptan, 53.8% in ibuprofen and 8% in placebo groups. Headache freedom was achieved in 37.7% in rizatriptan, 30.8% in ibuprofen and 2% in placebo groups. |
| Monda et al. (^{153}) | Adults - 34.6 years (SD 9.6) | Indomethacin 25 mg + prochlorperazine 4mg and caffeine 75 mg suppository | Pain-free response at 2 hours postdose - Indomethacin 25 mg + prochlorperazine 4mg and caffeine 75 mg suppository was superior to sumatriptan in the second attack (52% versus 33%; P &lt; 0.05) and in the total attacks (49% versus 34%; P &lt; 0.01). The time to a pain-free response was significantly (P &lt; 0.05) higher with Indomethacin 25 mg + prochlorperazine 4mg and caffeine 75 mg suppository than with sumatriptan in the first, second, and total attacks. Headache relief rates in the total attacks at 2 hours postdose were 71% with Indomethacin 25 mg + prochlorperazine 4mg and caffeine 75 mg suppository and 65% with sumatriptan, without any statistically significant difference between the drugs. |</p>
<table>
<thead>
<tr>
<th>Study Authors</th>
<th>Participants</th>
<th>Treatments</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moon et al. 154</td>
<td>Adults - aged 18 to 65 years; females: 207 males; 22</td>
<td>Frovatriptan 2.5 mg Placebo</td>
<td>Frovatriptan significantly increased the 2-hour headache response rate compared with placebo (52.9% vs. 34.0%, p=0.004). The headache response rates at 4, 6, and 12 hours were significantly higher in the frovatriptan group than in the placebo group, as was the rate-free pain at 2 hours (19.0% vs. 5.7%, p=0.004), 4 hours (40.7% vs. 23.0%, p=0.006), and 6 hours (56.1% vs. 34.0%, p=0.002). The median time to a headache response was significantly shorter in the frovatriptan group than in the placebo group (2.00 hours vs. 3.50 hours, p&lt;0.001). The use of rescue medications was more common in the placebo group (p=0.005).</td>
</tr>
<tr>
<td>Mashallah et al. 155</td>
<td>Adults - sumatriptan group 33.36 ± 7.91 and Propofol group 33.08 ± 8.12 years; females: 68 and 22</td>
<td>Sumatriptan 6 mg SC Placebo</td>
<td>Pain intensity was significantly lower in the propofol group 30 minutes after treatment (P = 0.001); however, after 1 and 2 hours, there were no significant differences between the groups. The need for antiemetic therapy and the recurrence of symptoms were significantly lower in the propofol group (P = 0.045 and P = 0.001, respectively).</td>
</tr>
<tr>
<td>Muller, Lohse 156</td>
<td>Adults - Men = 45.31 ± 13.89 years; Women = 41.98 ± 13.08 years; females: 13 and 44</td>
<td>Sumatriptan 100 mg tablet Placebo</td>
<td>No significant differences were observed in accompanying symptoms. Both drugs were well tolerated with the frequency of nausea, phonomiosis, and photophobia. No serious or unusual adverse events occurred, and no clinically relevant abnormalities in laboratory test values were reported.</td>
</tr>
<tr>
<td>Mushet et al. 157</td>
<td>Adults - 40 (18 to 65) years; females: 69 and 11</td>
<td>Sumatriptan 6 mg SC Placebo</td>
<td>By 120 minutes after SC dosing, 73% of sumatriptan-treated patients compared with 28% of placebo-treated experienced headache relief (P≤0.05). Clinical disability scores 120 minutes after dosing showed that 75% of sumatriptan-treated patients, compared with 30% of placebo-treated patients, were normal or only mildly impaired (P≤0.05). Similar efficacy rates were observed for nausea, phonomiosis, and photophobia. No serious or unusual adverse events occurred, and no clinically relevant abnormalities in laboratory test values were reported.</td>
</tr>
<tr>
<td>Mushet et al. 158</td>
<td>Adults - 40 (18 to 65) years; females: 68</td>
<td>Sumatriptan 6 mg SC Placebo</td>
<td>By 120 minutes after SC dosing, 79% of sumatriptan-treated patients, compared with 37% of placebo-treated patients experienced headache relief (P≤0.05). Clinical disability scores 120 minutes after dosing showed that 65% of sumatriptan-treated patients, compared with 42% of placebo-treated patients, were normal or only mildly impaired (P≤0.05). Similar efficacy rates were observed for nausea, phonomiosis, and photophobia. No serious or unusual adverse events occurred, and no clinically relevant abnormalities in laboratory test values were reported.</td>
</tr>
<tr>
<td>Myllylä et al. 159</td>
<td>Adults - Toltenamic Acid Rapid Release - 39.2 ± 3.9 years; Placebo - 39.9 ± 9.5 years; females: 126 and 14</td>
<td>Toltenamic acid rapid release tablets 200 mg Placebo</td>
<td>For first attack, 77% of patients receiving toltenamic acid experienced a reduction of the initial severe or moderate headache to mild or no headache after 2 hours, as compared to 79% in the sumatriptan group and 29% in the placebo group. No significant difference was found between active treatments (P = 0.85, 95% CI [22%, 18%]), however, both active treatments were significantly better than placebo; P = 0.001, 95% CI [26%, 69%] for toltenamic acid and P = 0.001, 95% CI [28%, 71%] for sumatriptan. For second attack, results were similar with 70% of patients receiving toltenamic acid experiencing relief, as compared to 64% in the sumatriptan group and 39% in the placebo group. No significant differences were observed in accompanying symptoms. Both drugs were well tolerated with the frequency of adverse events, 30% for toltenamic acid and 41% for sumatriptan (nonsignificant difference).</td>
</tr>
<tr>
<td>Nappi et al. 160</td>
<td>Adults - 18 and 65 year; mean age 38 (11) placebo and Sumatriptan 58 (9); females: 188 and 56</td>
<td>Sumatriptan 100 mg tablet Placebo</td>
<td>Sumatriptan was significantly more effective than placebo at relieving headache (defined as reduction in severity from severe or moderate pain to mild or no pain) at 2 h (51% versus 21%, P = 0.003) and 4 h (71% versus 35%, P &lt; 0.001). Fewer sumatriptan-treated patients required a second dose compared with placebo-treated patients (49% versus 74%, P = 0.001). More sumatriptan-treated patients were completely pain-free compared with placebo-treated patients at both 2 h (24% versus 12%) and 4 h (48% versus 18%).</td>
</tr>
<tr>
<td>Nett et al. 161</td>
<td>Adults - Placebo = 36.8 ± 7.7; Sumatriptan 50mg = 35.3 ± 7.8; Sumatriptan 100mg = 37.1 ± 8.8; females: 349 (Female only)</td>
<td>Sumatriptan 50 and 100 mg Placebo</td>
<td>Sumatriptan was superior to placebo in providing patients with pain-free relief at 2 hours. Pain-free relief at 2 hours - sumatriptan 100mg (61%) and sumatriptan 50mg (51%) compared with the placebo (29%) (both P&lt;0.001). Sustained pain-free - Sumatriptan 100mg (31%) and 50mg (30%) compared with Placebo (14%) (100 mg versus placebo P = 0.004; 50 mg versus placebo P = 0.007).</td>
</tr>
</tbody>
</table>
Comparison between metamizole and triptans for migraine treatment: a systematic review and network meta-analysis

**Newman et al.**<sup>140</sup>  
Adults - Naratriptan 2.5mg – 36.3  
Naratriptan 1mg - 38  
Placebo – 36.4  
n=206 (all female)  
| Naratriptan 1 and 2.5mg oral Placebo | Menstrual associated migraine | Headache-free Naratriptan 1mg 50% versus Placebo 25%, (P=.003). More patients treated with naratriptan 1 mg were headache free compared with placebo (23% versus 8%), although statistical tests were not performed. Significantly more patients treated with naratriptan 1 mg reported menstrual associated migraine 50% or less compared with placebo-treated patients. Patients treated with naratriptan 1 mg, also had significantly fewer menstrual associated migraine days compared with placebo-treated patients. |

**The Finnish Sumatriptan Group and the Cardiovascular Clinical Research Group**<sup>160</sup>  
Adults - 18-60 years [sumatriptan: 38±10; placebo: 40±9.5] n=74 (11 male and 63 female)  
| Sumatriptan (insufflation 20 mg plus 20mg) Intranasal Placebo | Sumatriptan (20 mg plus 20 mg) was more effective than placebo at relieving headache, defined as reduction in severity from moderate or severe to mild or none, at 60 and 120 min. At 120 min, 75% of patients in the sumatriptan group reported headache relief, compared with 32% of patients in the placebo group (P<0.001); 53% of patients in the sumatriptan group were completely pain-free compared with 11% in the placebo group. Nausea incidence was significantly lower in sumatriptan group compared with placebo at both 60 min (17 vs. 43%; p=0.014) and 120 min (14 vs. 36%; p=0.021). Photophobia was significantly lower in sumatriptan group, compared with placebo at 60 min (28 vs. 57%; p=0.013) and 120 min (19vs. 51%; p=0.005). Sumatriptan was significantly more effective at reducing functional disability of patients at 30 min (p=0.024) and at 60 and 120 min (p<0.001). However, similar number of patients reported migraine recurrence, within 24 h in both treatment groups. |

**The Subcutaneous Sumatriptan International Study Group**<sup>161</sup>  
Adults - (41±11 years sumatriptan 6 mg; 40±11 years sumatriptan 8 mg; 39±11 years placebo) n=639 (521 females and 118 males)  
| Sumatriptan 6 or 8 mg SC Placebo | After 60 minutes, the severity of headache was decreased in 72% of the 422 patients given 6 mg of sumatriptan, 79% of the 109 patients given 8 mg of sumatriptan, and 25% of the 105 patients given placebo. As compared with the placebo group, 47% more patients who had received 6 mg of sumatriptan and 54% more patients who had received 8 mg of sumatriptan had a decrease in the severity of headache (P<0.001 for both comparisons). After 120 minutes, 86 to 92% of the 511 patients treated with sumatriptan had improvement in the severity of headache, as compared with only 37% of the 104 patients who received placebo once or twice (P<0.001 for all comparisons). |

**The Multinational Oral Sumatriptan and Cafergot Comparative Study Group**<sup>162</sup>  
Adults - mean age: 39.5 years [sumatriptan: 39±10 years; cafergot: 40±10 years] n=577 (98 males and 479 females)  
| Sumatriptan 100 mg oral Cafergot (ergotamine tartrate 2 mg + caffeine 200 mg) capsules Three migraine attacks | Sumatriptan was significantly more effective than Cafergot at reducing the intensity of headache from severe or moderate to mild or none; 66% [145/220] of those treated with sumatriptan improved by 2 h, compared with 48% [118/246] of those treated with Cafergot (p<0.001). The onset of headache resolution was more rapid with sumatriptan, whereas recurrence of migraine headache within 48 h was lower with Cafergot. Sumatriptan was also significantly more effective at reducing the incidence of nausea (p<0.001), vomiting (p<0.001) and photophobia/phosphorobias (p<0.001) 2h after treatment, and fewer patients on sumatriptan (24%) than on Cafergot (44%; p<0.001) required other medication after 2h. The overall incidence of patients reporting adverse events was 45% after sumatriptan and 39% after Cafergot; the difference was not significant. |

**Pascual et al.**<sup>144</sup>  
Adults - Rizatriptan 10mg 38.5 years; Zolmitriptan 2.5mg 39.4 years; Placebo 38.2 years; n=766 (639 female and 127 males)  
| Rizatriptan 10mg tablet Zolmitriptan 2.5mg tablet Single migraine attack | The primary efficacy endpoint was pain free within 2h. Rizatriptan was superior to zolmitriptan in this respect. Rizatriptan was 26% more likely to be eliminated in the next few minutes than in a patient taking zolmitriptan. Headache relief at 2h - Rizatriptan 70.5% vs Zolmitriptan 66.8% vs Placebo 29.5%. Headache recurrence at 24h - Rizatriptan 28%, Zolmitriptan 29% and placebo 26%. |

**Pascual et al.**<sup>145</sup>  
Adults - placebo 41.2 years (19±63); Almotriptan 6.25 mg 40.8 years (19±66); Almotriptan 12.5 mg 41.9 years (18±65); n=909 (788 female and 121 male)  
| Almotriptan 6.25 and 12.5 mg tablet Placebo Three consecutive migraine attacks | The total number of attacks relieved (severe or moderate pain reduced to mild or no pain) at 2 h post-dose was significantly higher (P<0.001) after treatment with almotriptan 6.25 or 12.5 mg compared with placebo (60% and 70% vs. 38%, respectively). Moreover, a consistent response was achieved across and within patients for almotriptan 6.25 or 12.5 mg compared with placebo (pain relief in at least 2 out of 3 attacks within 2h for 64% and 75% vs. 36%, respectively) and less than one-third of the patients relapsed within 24h. Almotriptan was well tolerated with no significant differences between the almotriptan and placebo treatment groups in the percentage of patients reporting adverse events. |
Comparison between metamizole and triptans for migraine treatment: a systematic review and network meta-analysis

Peres MFP, Scala WAR, Salazar R

Pascual et al.164

Adults - 33.7 years (16–66)
n=481 (399 female and 82 male)

Rizatriptan 10mg (rapidly disintegrating tablets)
Sumatriptan 30mg (tablets)
Single migraine attack

The patients preferred rizatriptan 10mg rapidly disintegrating tablet to sumatriptan 50mg tablet (64.3 vs. 35.7%, p < or = 0.001). Faster relief of headache pain was the most important reason for the preference, cited by 46.9% of patients preferring rizatriptan and 43.4% of patients who preferred sumatriptan. Headache relief at 2h was 75.9% with rizatriptan and 66.6% with sumatriptan (p < or = 0.001), with rizatriptan being superior to sumatriptan within 30 min of dosing. Fifty-five percent of patients were pain free 2 h after rizatriptan, compared with 42.1% treated with sumatriptan (p < or = 0.001), rizatriptan being superior within 1 h of treatment. Forty-one percent of patients taking rizatriptan were pain free at 2 h and had no recurrence or need for additional medication, compared to 32.3% of patients on sumatriptan. Rizatriptan was also superior to sumatriptan in terms of the proportions of patients with no nausea, phonophobia or photophobia, and patients with normal function 2h after treatment intake (p < 0.05).

More patients were satisfied 2 h after treatment with rizatriptan (73.3%) than 2 h after treatment with sumatriptan (59.0%) (p < or = 0.001). Both active treatments were well tolerated. The most common side effects with rizatriptan and sumatriptan were nausea (6.6 and 6.9% of patients, respectively), dizziness (6.1% and 5.8%) and somnolence (7.4 and 6.7%).

Pini et al.167

Adults - mean age 37.0 years, range 18 – 65 years,
n=238 (52 males and 186 females)

Sumatriptan 100 mg oral
Placebo
Single migraine attack

Reduction in headache intensity - sumatriptan 65% versus placebo 40%. Reductions in accompanying symptoms of migraine - nausea/vomiting (33 versus 53%) and photophobia/phonophobia (37 versus 62%), respectively. Sumatriptan was very effective in reducing headache severity in patients with a history of prolonged migraine attacks (sumatriptan 67% versus 26% placebo).

Pini et al.168

Adults - male 33.6±10.5 and female 35.6 ±9.6 years.
n=92 (Male 31 and Female 61)

Paracetamol 1000mg + caffeine
130 mg sachet
Sumatriptan 30 mg soft gel capsule
Two migraine attacks

There was no difference between the two treatments regarding total pain relief pain during the 4-hour observation period.

Rahimdel et al.169

Adults - sodium valproate 31.3±3.5 years, Sumatriptan 6 mg 30.1±3.1 years
n=90 (67 female and 23 male)

Sodium valproate 400 mg IV
Sumatriptan 6 mg SC
Single migraine attack

In both groups, pain decrement at the mentioned time points was significant (P<0.001) but had no significant difference (P=0.05), indicating the similar effect of both drugs on pain improvement. In the Sodium valproate group, photophobia, phonophobia, nausea, and vomiting were improved significantly, while in the Sumatriptan group, only photophobia and vomiting were decreased significantly. Nausea, vomiting, facial paresthesia, and hypotension were more significantly frequent in the Sumatriptan group than in the Sodium valproate group (P<0.05).

Rao et al.170

Adults - 36.3±9.8 years
n=54 (Female 98.1 % and Male 1.9 %)

Ketorolac nasal spray 31.5 mg
Sumatriptan nasal spray 20 mg
Placebo
At least one attack

Both ketorolac (72.5%, P= .001) and sumatriptan (69.4%, P= .001) were more effective than placebo (38.3%) for 2-hour pain relief and 2-hour pain freedom (ketorolac: 43.1%, P= .004; sumatriptan: 36.7%, P= .046; placebo: 18.4%). Ketorolac but not sumatriptan was more effective than placebo in 2-hour absence of nausea. Both ketorolac and sumatriptan were more effective than placebo for 24-hour sustained pain relief (ketorolac: 49%, P< .001; sumatriptan: 31%, P=. 01; placebo: 20%). Only ketorolac was superior to placebo for 24-hour (ketorolac: 35.3%, P=.003; sumatriptan: 22.4%, P=. 18; placebo: 12.2%) sustained pain freedom. Nasal burning and dysgeusia were the most common adverse effects for active treatments.

Rapoport et al.171

Adults - 18 to 65 years (sumatriptan 6mg+placebo: 42.3 years; sumatriptan-6mg+100mg:42.5 years)
n=657 (118 male and 549 female)

Sumatriptan 6 mg SC +
Sumatriptan 100 mg (oral - 4hs later)
Sumatriptan 6 mg SC + Placebo (oral - 4hs later)
Three migraine attacks

The primary efficacy endpoint was the number of successfully treated patients without headache recurrence (HR) within 24 hours after the initial SC injection for the first study attack. 237/317 patients who received oral sumatriptan at 4 hours (75%) and 249/312 patients who received placebo at 4 hours (80%) reported no or mild headache pain at 2 hours after the initial open dose of 6 mg SC sumatriptan. By 4 hours, relief was reported by 78% of the patients who received oral sumatriptan and 82% of the patients who received placebo. Of 442 assessable patients, 82/212 in the sumatriptan-treated group (39%) and 89/230 in the placebo-treated group (39%) reported HR in attack 1. Median times to recurrence were 15.6 hours after sumatriptan and 10.3 hours after placebo (p = 0.006). After placebo, 58% of the recurrences occurred within 12 hours, compared with only 32% within 12 hours after sumatriptan. Similar results were observed for attacks 2 and 3.
<table>
<thead>
<tr>
<th>Study</th>
<th>Study Population</th>
<th>Study Design</th>
<th>Intervention</th>
<th>Primary Endpoint</th>
<th>Secondary Endpoints</th>
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<tr>
<td>Rapoport et al.</td>
<td>Adults 41.3 ± 9.5 (12-66) years, n=999 (123 Male and 876 Female)</td>
<td>Single dose</td>
<td>Sumatriptan 1, 2.5, 5, or 10 mg oral tablet</td>
<td>The headache response rates with zolmitriptan doses ≥ 2.5 mg were 44 to 51% at 1 h, 65 to 67% at 2 hours, and 75 to 78% at 4 hours (all significantly superior to placebo). Also, zolmitriptan effectively relieved migraine-associated symptoms such as nausea, photophobia and phonophobia, and reduced activity impairment. Rates of headache recurrence, headache persistence, and use of escape medication were lower with zolmitriptan doses ≥ 2.5 mg than with placebo. In patients with persistent or recurrent headache, a second zolmitriptan dose effectively treated both headache and nonheadache symptoms.</td>
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<tr>
<td>Rothner et al.</td>
<td>Adolescents - aged 12 to 17 years (14.2±1.7 years zolmitriptan 10 mg, 14.3±1.7 years zolmitriptan 5 mg, 14.3±1.7 years zolmitriptan 2.5 mg; 14.2±1.7 years placebo), n=696 (408 females and 288 males)</td>
<td>Single dose</td>
<td>Zolmitriptan 2.5, 5, or 10 mg oral tablet</td>
<td>There was no statistically significant improvement between zolmitriptan 10 mg (2 x 5 mg tablet) and placebo for the primary efficacy variable headache response at 2 hours, nor any of the secondary variables tested. Two-hour headache response rates were 54%, 53%, and 57% for zolmitriptan 10, 5, and 2.5 mg, respectively, and 56% for placebo. Two-hour pain-free rates were 25%, 19%, and 23% for zolmitriptan 10, 5, and 2.5 mg, respectively, and 20% for placebo. Zolmitriptan was well tolerated, with a tolerability profile similar to the pattern seen in adults.</td>
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<tr>
<td>Russell et al.</td>
<td>Adults – mean age 44 years (±9.7 years), n=209 (females 189 and males 20)</td>
<td>Single dose</td>
<td>Sumatriptan 6 mg SC</td>
<td>When sumatriptan was compared to placebo, significantly more of the 209 evaluable patients reported headache relief at 1 h (56% vs 8%, p &lt; 0.001) and 2 h (62% vs 15%, p &lt; 0.001) after the first injection. Resolution of nausea, photophobia, and phonophobia was significantly more common in patients on sumatriptan than in those on placebo (p &lt; 0.001 for all comparisons).</td>
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<tr>
<td>Ryan et al.</td>
<td>Adults - Suma20mg - 39.8/ Suma10mg – 40.4/ Placebo – 40.2 years, n=409 (58 male and 351 female)</td>
<td>Single dose</td>
<td>Sumatriptan 20 and 10mg nasal spray</td>
<td>The primary efficacy endpoint was headache relief 120 minutes after the first administration of study drug. Headache relief - 62 to 63% patients in the sumatriptan 20-mg, 43 to 54% sumatriptan 10-mg, 29 to 35% of placebo (p &lt; 0.05). Pain-free 2h - 31 to 32% sumatriptan 20-mg groups, 20 to 23% sumatriptan 10-mg, 4 to 20% placebo (p &lt; 0.05). Incidence of nausea, photophobia, and phonophobia reduced after sumatriptan 20mg (p &lt; 0.05), sumatriptan nasal spray 10 mg compared with placebo reduced the incidence of nausea (p &lt; 0.05).</td>
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<tr>
<td>Ryan et al.</td>
<td>Adults - Suma20mg – 41.1/ Suma10mg – 41.2/ Placebo – 41.6, n=436 (63 male and 373 female)</td>
<td>Single dose</td>
<td>Sumatriptan 20 and 10mg nasal spray</td>
<td>The primary efficacy endpoint was headache relief 120 minutes after the first administration of study drug. Headache relief - 62 to 63% patients in the sumatriptan 20-mg, 43 to 54% sumatriptan 10-mg, 29 to 35% of placebo (p &lt; 0.05). Sumatriptan 20 mg vs placebo. Pain-free 2h - 31 to 32% sumatriptan 20-mg groups, 20 to 23% sumatriptan 10-mg, 4 to 20% placebo (p &lt; 0.05). Incidence of nausea, photophobia, and phonophobia reduced after sumatriptan 20mg (p &lt; 0.05), sumatriptan nasal spray 10 mg compared with placebo reduced the incidence of nausea (p &lt; 0.05).</td>
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<tr>
<td>Ryan et al.</td>
<td>Adults - Frovatriptan 42.3 (SD 9.9 – Range 18 – 69)/ Placebo 40.2 (SD 10.3 – Range 18 - 65), n=322 (42 male and 280 female)</td>
<td>Single dose</td>
<td>Frovatriptan 2.5mg tablet</td>
<td>Response at 2 hours range from 27% to 46% for frovatriptan compared with 21% to 27% for placebo. Likewise, at 4 hours, frovatriptan was consistently significantly more effective than placebo to provide headache relief. Response for frovatriptan ranged from 56% to 65% compared with 31% to 38% for placebo (p&lt;0.001). Frovatriptan was also significantly superior to placebo at rendering patients pain-free. At 2 hours, the proportion of patients pain-free was 9% to 14% for frovatriptan compared with 2% to 3% for placebo (p&lt;0.001). At 4 hours post dose, 27% to 32% of patients taking frovatriptan were pain-free compared with 9% to 14% in the placebo group (p&lt;0.001).</td>
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<tr>
<td>Ryan et al.</td>
<td>Adults - Frovatriptan 41.1 (SD 10 - Range 18 - 69)/ Placebo 41.1 (SD 10.4 - Range 18 - 69), n=1148 (131 male and 1017 female)</td>
<td>Single dose</td>
<td>Frovatriptan 2.5mg tablet</td>
<td>Response at 2 hours ranged from 27% to 46% for frovatriptan compared with 21% to 27% for placebo. Likewise, at 4 hours, frovatriptan was consistently significantly more effective than placebo to provide headache relief. Response for frovatriptan ranged from 56% to 65% compared with 31% to 38% for placebo (p&lt;0.001). Frovatriptan was also significantly superior to placebo at rendering patients pain-free. At 2 hours, the proportion of patients pain-free was 9% to 14% for frovatriptan compared with 2% to 3% for placebo (p&lt;0.001). At 4 hours post dose, 27% to 32% of patients taking frovatriptan were pain-free compared with 9% to 14% in the placebo group (p&lt;0.001).</td>
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</table>
Comparison between metamizole and triptans for migraine treatment: a systematic review and network meta-analysis

<table>
<thead>
<tr>
<th>Study</th>
<th>Participants</th>
<th>Treatments</th>
<th>Outcomes</th>
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<tr>
<td>Ryan et al.</td>
<td>Adults - Frovatriptan 41.1 (SD 10.4 - Range 18 - 69) / Placebo 40.3 (SD 10.8 - Range 19 - 69) n=724 (106 male and 618 female)</td>
<td>Frovatriptan 2.5mg tablet Placebo</td>
<td>Response at 2 hours ranged from 27% to 46% for frovatriptan compared with 21% to 27% for placebo. Likewise, at 4 hours, frovatriptan was consistently significantly more effective than placebo or providing headache relief. Response for frovatriptan ranged from 56% to 65% compared with 31% to 38% for placebo (p=0.001). Frovatriptan was also significantly superior to placebo at rendering patients pain-free. At 2 hours, the proportion of patients pain-free was 9% to 14% for frovatriptan compared with 2% to 3% for placebo (p=0.001). At 4 hours post dose, 27% to 32% of patients taking frovatriptan were pain-free compared with 9% to 14% in the placebo group (p=0.001).</td>
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<tr>
<td>Sandrini et al.</td>
<td>Adults - 18 to 65 years</td>
<td>Eletriptan 40mg Eletriptan 80mg tablets Sumatriptan 50mg Sumatriptan 100mg Placebo gelatin capsules Multiple migraine attack</td>
<td>Headache recurrence rates were 12% at 1 hour and 31% at 2 hours for placebo at 24% at 1 hour and 42% at 2 hours for sumatriptan 50 mg; 27% at 1 hour and 53% at 2 hours for sumatriptan 100 mg; 30% at 1 hour and 64% at 2 hours for eletriptan 40 mg; and 37% at 1 hour and 67% at 2 hours for eletriptan 80 mg. More patients receiving eletriptan 80 mg achieved a 1-hour headache response than did patients receiving sumatriptan 50 mg (p &lt; 0.05). All doses of eletriptan were superior to sumatriptan at 2 hours for headache recurrence and complete pain relief (p &lt; 0.05). Significantly more patients on eletriptan 80 mg achieved headache relief in all attacks than did patients receiving sumatriptan. Eletriptan 40 mg was superior to both sumatriptan doses in functional improvement (p &lt; 0.05). The 40- and 80-mg doses of eletriptan were significantly more effective than placebo or sumatriptan in reducing the associated migraine symptoms of nausea, photophobia, and phonophobia after 2 hours. The 40- and 80-mg doses of eletriptan were significantly superior to oral sumatriptan or placebo in achieving and sustaining both headache recurrence and pain-free response at 24 hours. The superior efficacy of both eletriptan doses was associated with higher rates of patient acceptability than sumatriptan 50 mg (p &lt; 0.05). Eletriptan and sumatriptan were well tolerated.</td>
</tr>
<tr>
<td>Sandrini et al.</td>
<td>Adults – mean age 35 ± 9.8 years n=281 (78% female and 22% male)</td>
<td>Sumatriptan 50mg tablets Indoprocal-coated tablets Indoprocal-effervescent tablets</td>
<td>Pain-free rates at 2 h (all attacks) - 34% Indoprocal and 37% sumatriptan (p=NS). Headache relief at 2 h (all attacks) postdose - 62% Indoprocal and 56% with sumatriptan (p=NS). Pain free 2h post first attack (indoprocal-coated tablets vs effervescent tablets) - Indoprocal-effervescent tablets 41% vs. Coated-tablets 22% (P&lt;0.05). Headache relief rate at 2 h postdose in the first attack - Effervescent tablets 66% vs. Coated-tablets 49% (p &lt; 0.05). Pain-free rate total attacks - Effervescent tablet 84% vs. Coated-tablets 73%. The total pain-free rate of Indoprocal-coated tablets was lower than that of effervescent tablets, but higher than sumatriptan.</td>
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<tr>
<td>Song et al.</td>
<td>Adults - mean age 40 ± 9 years n=44 (20 male and 24 female)</td>
<td>ly293558 (nonselective AMPA/KA (GluR5) receptor antagonist with 1.2 mg/kg IV Sumatriptan 6 mg SC Placebo Single migraine attack</td>
<td>The primary efficacy variable was the headache response rate, i.e. headache score improvement from moderate/severe at baseline to mild/none at 2 h. Response rates were 69% for LY293558 (P = 0.07 vs. placebo), 86% for sumatriptan (P &lt; 0.01 vs. placebo) and 75% for placebo. LY293558 and sumatriptan were superior to placebo (P &lt; 0.01 for all comparisons) on all other measures of improvement in pain and migraine associated symptoms. Fifteen percent of patients who took LY293558 reported adverse events, 53% patients who took sumatriptan and 31% of those who received placebo reported adverse events.</td>
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<tr>
<td>Santanello et al.</td>
<td>Adults - Rizatriptan 10mg – 36.8 (SD 9); Rizatriptan 5mg – 37.6 (SD 8.2); Rizatriptan 2.5mg – 38.7 (SD 9.1); Placebo – 39.7 (SD 9.7) years n=247 (222 female and 25 male)</td>
<td>Rizatriptan 2.5, 5 and 10mg Placebo Oral One migraine attack</td>
<td>Statistically significant mean improvements were observed for those treated with rizatriptan 10mg compared with those treated with placebo on three of five domains: social functioning (p=0.007), migraine symptoms (p =0.005), and feeling/concerns (p=0.015). Patients who took the 5-mg and 10mg rizatriptan doses were significantly less disabled as 2h than those who took placebo (p=0.003, however, the patients who took 2.5mg rizatriptan remained about as functionally disabled as patients on placebo.</td>
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<tr>
<td>Savi et al.</td>
<td>Adults – 37±9 years n=125 (99 female 26 male)</td>
<td>Frovatriptan 2.5 mg Rizatriptan 10 mg Capsules Treat 1–3 attacks</td>
<td>Patient’s preference for one drug or the other did not differ between the study treatments. Frovatriptan was chosen mainly because of the rapid speed of action (71% of patients), good tolerability (42% of patients), and reduction in pain severity (33%). A relevant result of study was that recurrence rate within 48 h were significantly lower under frovatriptan than under rizatriptan. These differences may be explained by the different pharmacokinetics of the two drugs. Frovatriptan has a time to maximum concentration typically of 2 to 3 h, but the longest half-life among triptans, greater 5-HT1B binding receptor potency, and multiple pathways metabolism. The headache recurrence was significantly less frequent with frovatriptan than under rizatriptan.</td>
</tr>
<tr>
<td>Study</td>
<td>Adults – aged 18-66 years</td>
<td>Frovatriptan 2.5 mg</td>
<td>The primary endpoint of interest was the correlation between plasma concentration of each triptan (and more specifically the concentration: maximum concentration (Cmax) ratio and the pain-free (PF) and pain-relief (PR) rates at each time point. PF 4h – Frovatriptan 38.4% vs Rizatriptan 5.6% (p=0.045). PR at 4h – Frovatriptan 61.1% vs Rizatriptan 72.2% (p=NS). There was a positive correlation between frovatriptan concentration. Cmax ratio (%) and the proportion of patients that were either pain free or experienced pain relief over the entire study period. No such correlation was seen for rizatriptan.</td>
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<td>Adults – SS(S): 41.0 + 10.5 years; Group SP(S): 40.6 ± 10.6 years; n=1440 (214 male and 1226 female)</td>
<td>Sumatriptan transdermal patch oral lyophilisate</td>
<td>Placebo Single migraine attack</td>
</tr>
<tr>
<td>Seeburger et al.</td>
<td>Adults – 43.8 years (20-68); Riza/placebo/riza 44.8 years (28-61); Placebo/riza/placebo 43.5 years (23–64); n=102 (female 88 and 14 male)</td>
<td>Eletriptan 20, 40 and 80mg oral tablets rapid release</td>
<td>Placebo Three migraine attack crossover</td>
</tr>
<tr>
<td>Shetler, Ryan, Pitman et al.</td>
<td>Adults – mean age 43.8 years (SD 11.6) (Range from 18 to 66); n=100 (92 female and 8 male)</td>
<td>Frovatriptan 10 mg ODT tablet</td>
<td>Placebo Multiple-attack study</td>
</tr>
<tr>
<td>Shetler et al.</td>
<td>Adults – SS(S): 41.0 ± 7.8 years; Group SS(P): 40.4 ±10.7 years; Group SP(S): 40.6 ± 10.5 years; Group SP(P): 41.0 ±10.6 years; n=1440 (214 male and 1226 female)</td>
<td>Sumatriptan 100 mg tablet oral tablets rapid release</td>
<td>Placebo Single migraine attack</td>
</tr>
<tr>
<td>Scott et al.</td>
<td>Adults – 43.8 years (20-68); Riza/placebo/riza 44.8 years (28-61); Placebo/riza/placebo 43.5 years (23–64); n=1440 (214 male and 1226 female)</td>
<td>Eletriptan 20mg – 41 (19-73); 40mg – 42 (18-78); 80mg – 41 (19-75); Placebo – 42 (18 – 69) years; n=1190 (1037 female and 153 male)</td>
<td>Sumatriptan 50mg tablets rapid release</td>
</tr>
<tr>
<td>Shetler et al.</td>
<td>Adults – SS(S): 41.0 ± 7.8 years; Group SS(P): 40.4 ±10.7 years; Group SP(S): 40.6 ± 10.5 years; Group SP(P): 41.0 ±10.6 years; n=1440 (214 male and 1226 female)</td>
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<td>Eletriptan 20mg – 41 (19-73); 40mg – 42 (18-78); 80mg – 41 (19-75); Placebo – 42 (18 – 69) years; n=1190 (1037 female and 153 male)</td>
<td>Sumatriptan 100mg tablets rapid release</td>
</tr>
<tr>
<td>Silbertsein et al.184</td>
<td>Adults – mean age 40 years n=1419 (female only)</td>
<td>Rizatriptan 5mg and 10 mg oral Placebo</td>
<td>In the subgroup of 335 women with menstrually associated migraine, rizatriptan was effective compared with placebo. At 2 hours after dosing, 68% of 139 women taking rizatriptan 10 mg and 70% of 115 women taking rizatriptan 5 mg with a menstrually associated migraine had pain relief compared with 44% of 81 patients taking placebo (P &lt; .05). In all women, rizatriptan was as effective in treating menstrual as well as nonmenstrual migraine: 68% of 139 patients taking rizatriptan 10 mg with a menstrually associated migraine had pain relief at 2 hours after dosing compared with 69% of 393 patients with nonmenstrually associated attacks (test of menstrual association 5 nonsignificant; the analysis had 80% power to detect a difference of six percentage points between groups). Similar results were found for rizatriptan 5 mg (menstrual 70%, nonmenstrual 66%; not statistically significant).</td>
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<tr>
<td>Smith et al.187</td>
<td>Adults - Sumatriptan 50 mg E + Naproxen sodium 500 mg - 42.5±11.0; Sumatriptan 50 mg E - 41.2±11.3; Naproxen sodium 500 mg - 42.1±10.7; Placebo - 41.2±10.2 years. n=972 (880 female and 92 male)</td>
<td>Sumatriptan 50 mg tablet Naproxen 500 mg tablet Sumatriptan 50 mg + Naproxen sodium 500 mg Placebo Single migraine attack</td>
<td>Treatment with sumatriptan 22mg nasal powder provided greater reduction in migraine pain intensity, which was statistically significant vs oral sumatriptan in the first 30 minutes postdose, regardless of whether attacks were treated when pain was mild (least squares mean SPID-30 = 3.90 vs 0.24, P = 0.0013) or moderate/severe (least squares mean SPID-30 = 13.63 vs 10.07, P = 0.0002). At every time point from 15 to 90 minutes postdose, the proportion of attacks achieving total migraine freedom was greater and statistically significant after treatment with sumatriptan 22mg nasal powder vs 100 mg oral sumatriptan. Sumatriptan 22 mg nasal powder treatment resulted in greater odds of achieving pain freedom (odds ratio, OR = 1.29, P &lt; 0.01) and meaningful pain relief (OR = 1.32, P &lt; 0.001), which were also statistically significant compared with oral sumatriptan. In addition, a greater proportion of attacks treated with sumatriptan 22mg nasal powder vs oral sumatriptan was associated with sustained pain freedom, achieving statistical significance when assessed from 1 h postdose through 24 hours postdose (33.3% vs 27.9%, P &lt; 0.05) and through 48 hours postdose (32.7% vs 27.4%, P &lt; 0.05).</td>
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<td>Solomon et al.188</td>
<td>Adults - Zolmitriptan 2.5 mg 40.7 ± 11.26; Placebo 40.2 ± 11.84 years n=301 (45 male and 256 female)</td>
<td>Zolmitriptan 2.5 mg oral Placebo Single migraine attack</td>
<td>Patients treated a single moderate or severe migraine headache with 2.5 mg zolmitriptan or placebo and recorded clinical efficacy and adverse events on a diary form. Headache response at 2 hours was 62% for zolmitriptan compared with 36% for placebo (p &lt; 0.001). At 4 hours, headache response was 70% with zolmitriptan and 37% with placebo (p &lt; 0.001). Headache recurrence in patients treated with 2.5 mg zolmitriptan was 22% (versus placebo 30%). The headache response at 4 hours, pain-free rate, and response rate of nonheadache symptoms favored zolmitriptan over placebo.</td>
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</table>
Comparison between metamizole and triptans for migraine treatment: a systematic review and network meta-analysis

Peres MFP, Scala WAR, Salazar R

**Table 1: Study Characteristics and Treatments**

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<thead>
<tr>
<th>Study Authors</th>
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<th>Treatment</th>
<th>Outcome Measures</th>
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| Speirings et al. | Adults - mean age 41.2 ±10.1 years (albumin-triptan) and 40.3 ±10.1 years (sumatriptan) | Almotriptan 12.5 mg capsule oral | At 2 hours, almotriptan treatment provided headache relief in 58.0% of the subjects and sumatriptan in 57.3%. Headache freedom was provided by the medications in 17.9% and 24.6%, respectively (P = 0.005). Rescue medications were taken by 36.7% of the subjects in the almotriptan-treated group and by 33.2% in the sumatriptan-treated group; headaches returned to moderate or severe intensity in 27.4% and 24.0%, respectively.
| Stark et al. | Adults - mean age 41.7 ± 8.7 years | Frovatriptan 2.5 mg oral Placebo | With regard to the first attack treated, 173 (36%) of the 486 subjects in the study did not take a second dose at 2 hours for nonresponse. At 2 hours and 4 hours, these "rapid responders" experienced a decrease in headache intensity from moderate to severe or mild to no pain in 84% and 98%, respectively. Open-label relief during the first hours after intake of the study medication was high and significantly better after either eletriptan 40 mg compared with placebo (80 mg 21% vs. placebo 40%, P = 0.001) and 62% and 32%, 80 mg 65% and 34%, placebo 19% and 3%; the interval between treatment and relief was significantly shorter for the eletriptan 40 mg group compared with placebo (80 mg 21% vs. placebo 40%, P = 0.001). Treatment-emergent adverse events occurred in 15.2% of the subjects in the almotriptan-treated group and in 19.4% in the sumatriptan-treated group (P = 0.06); treatment-related adverse events occurred in 9.1% and 15.5% of the subjects, respectively (P = 0.001), including chest pain, which occurred in 0.3% and 2.2%, respectively (P = 0.004).
| Stark et al. | Adults - placebo: 42 [20 to 62] years; eletriptan 40 mg: 42 [18 to 68] years; eletriptan 80 mg: 42 [19 to 66] years. | Eletriptan (40 mg and 80 mg) Placebo Oral Up to 2 doses of study medication | In the initial attack, significantly more eletriptan patients reported headache relief and complete pain relief at 2 h vs placebo (40 mg 62% and 32%, 80 mg 65% and 34%, placebo 19% and 3%; P = 0.0001). Headache relief occurred faster after eletriptan, with more patients at both doses reporting relief 30 min (40 mg 8%, 80 mg 11% vs. placebo 2%, P < 0.01 and P < 0.001, respectively) and 1 h (33% of patients in both eletriptan groups vs. 9% in placebo group, P = 0.0001) after treatment than after placebo. There was a significantly lower recurrence rate with eletriptan 80 mg compared with placebo (80 mg 21% vs. placebo 40%, P < 0.01). Treatment acceptability for patients taking one or two doses was high and significantly better after either eletriptan 40 mg or 80 mg than placebo (78% and 83% vs. 38%, P = 0.001 for each analysis).
| Steinor et al. | Adults - Eletriptan 40 mg - 40.3 ±10.4 (19-64) years; Eletriptan 80 mg - 40.4 ±10.5 (18-64) years; Zolmitriptan 2.5 mg - 40.1 ±10.5 (18-64) years; Placebo - 39.9 ±10.6 (19-61) years. | Eletriptan 80 mg Eletriptan 40 mg Zolmitriptan 2.5 mg Placebo Single migraine attack | The primary analysis was between eletriptan 80 mg and zolmitriptan. For the primary efficacy endpoint of 2h headache response, rates were 74% on eletriptan 80 mg, 64% on eletriptan 40 mg, 60% on zolmitriptan (P < 0.0001 vs. eletriptan 80 mg) and 22% on placebo (P < 0.0001 vs. all active treatments). Eletriptan 80 mg was superior to zolmitriptan on all secondary endpoints at 1, 2 and 24 h, in most cases with statistical significance. Eletriptan 40 mg had similar efficacy to zolmitriptan 2.5 mg in earlier endpoints, and significantly (P < 0.05) lower recurrence rate and need for rescue medication over 24 h. All treatments were well tolerated: 30-42% of patients on active treatments and 40% on placebo reported all-causality adverse events that were mostly mild and transient.
| Stronks et al. | Adults - 42.2 years (SD 9.8; range, 20 to 59). n=12 patients | Naratriptan 2.5 mg tablet Naproxen 500 mg capsule | During the first hours after intake of the study medication, the objective behavioral parameters showed no significant effect time and no significant differences between naproxen and naratriptan, but naratriptan showed improve of symptoms and the interval between treatment and relief was significantly shorter after intake of naratriptan.
### Table 1. Comparison of Sumatriptan with Placebo and Rizatriptan 10mg

<table>
<thead>
<tr>
<th>Study Authors</th>
<th>Comparator 1</th>
<th>Comparator 2</th>
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<tr>
<td>Teall et al.</td>
<td>Placebo</td>
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<td>Talabi et al.</td>
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<td>Tepper et al.</td>
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<td>Rizatriptan</td>
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### Table 2. Comparison of Sumatriptan ODT 100mg with Placebo

<table>
<thead>
<tr>
<th>Study Authors</th>
<th>Comparator 1</th>
<th>Comparator 2</th>
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<tbody>
<tr>
<td>Tfelt-Hansen et al.</td>
<td>Placebo</td>
<td>Sumatriptan</td>
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### Table 3. Comparison of Aspirin plus Metoclopramide with Placebo

<table>
<thead>
<tr>
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### Table 4. Comparison of Sumatriptan 6mg SC with Placebo

<table>
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<tr>
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### Table 5. Comparison of Metoclopramide with Placebo

<table>
<thead>
<tr>
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### Table 6. Comparison of Sumatriptan 25mg, 50mg, and 100mg with Placebo

<table>
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<th>Comparator 2</th>
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### Table 7. Comparison of Zolmitriptan 2.5 and 5mg with Placebo

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<tbody>
<tr>
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### Table 8. Comparison of Metoclopramide with Placebo

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### Table 9. Comparison of Sumatriptan 34% vs Aspirin plus metoclopramide 12% (p<0.001)

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### Table 10. Comparison of Sumatriptan 50mg with Placebo

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<tr>
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### Table 11. Comparison of Sumatriptan 25mg with Placebo

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### Table 12. Comparison of Sumatriptan 6mg SC with Placebo

<table>
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<tr>
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### Table 13. Comparison of Metoclopramide with Placebo

<table>
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<tbody>
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### Table 14. Comparison of Sumatriptan 25mg with Placebo

<table>
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### Table 15. Comparison of Sumatriptan 50mg with Placebo

<table>
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<tbody>
<tr>
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<td>Sumatriptan</td>
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### Table 16. Comparison of Sumatriptan 100mg with Placebo

<table>
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### Table 17. Comparison of Sumatriptan 25mg with Placebo

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<td>Placebo</td>
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### Table 18. Comparison of Sumatriptan 50mg with Placebo

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### Table 19. Comparison of Sumatriptan 100mg with Placebo

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### Table 20. Comparison of Sumatriptan 25mg with Placebo

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### Table 21. Comparison of Sumatriptan 50mg with Placebo

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### Table 22. Comparison of Sumatriptan 100mg with Placebo

<table>
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<tbody>
<tr>
<td>Tepper et al.</td>
<td>Placebo</td>
<td>Sumatriptan</td>
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</tbody>
</table>
| Study Group | Adults – mean age ± years | Sumatriptan 6 mg SC Placebo | The primary measure of treatment efficacy was based on a comparison of the number of patients in the two treatment groups who had a reduction in headache severity from severe or moderate to mild or none at 1 and 2 h. At 1 h, 77% of patients treating with 6 mg sumatriptan compared to 26% treating with placebo (p=0.001). Had mild headache or none. At 2 h, the response rates for all patients had risen to 83 and 30%, respectively.

Tieljen et al.25 | Adults - 36.7 years (range 24 to 52 years) n=12 (female only) | Naratriptan 2.5 mg oral + Prochlorperazine 25 mg rectal suppository Naratriptan 2.5 mg oral + placebo Multiple migraine attack | Reduction in headache severity was observed at 2 hours (p < .001) and at 4 hours (p < .001) from headache onset, with no difference between the two treatment regimens (p = .28). A significant decrease in clinical disability at 2 hours (p < .001) and at 4 hours (p < .001) was observed, with no difference between the two treatment regimens (p = .28). The pain-free state of 4 hours was reported in a higher proportion with the naratriptan/ placebo regimen (50 vs 25%), but the trial size would need to be doubled to significantly prove the endpoints. Resolution of adverse effects was similar with both regimens at 2 hours and at 4 hours, although nausea resolved more often for those using the naratriptan/prochlorperazine regimen.

Tuchman et al.26 | Adults – mean age 42 ± 10 years n=206 (36 male and 230 female) | Sumatriptan 2.5mg tablet oral Placebo Menstrual migraine attacks | Primary efficacy endpoint was headache response at 2 hours after initial treatment, using a 4-point severity scale.

Tullo et al.27 | Adults – mean age 38.3 ± 9.9 years n=107 (85 female and 22 male) | Frovatriptan 2.5mg Zolmitriptan 2.5mg Three migraine attacks | Patients (77%) expressed a preference for a triptan. Average preference - Frovatriptan – 2.9 ± 1.3 vs Zolmitriptan – 3.0 ± 1.3. Most common reasons - Rapid activity (83% F vs 72% Z), reduction of headache severity (53 F vs 42% Z) and no side effects (40 F vs 40% Z).

Tullo et al.28 | Adults - 38.6 ± 10 years n=314 (272 female and 42 male) | Frovatriptan 2.5mg Zolmitriptan 2.5mg + dextroprofen 25 mg (FroDex25) Frovatriptan 2.5mg + dextroprofen 37.5 mg (FroDex37.5) oral At least one migraine attack | The proportions of subjects without pain at two hours (primary endpoint) were 29% (27/93) with Frovatriptan alone compared with 51% (48/95 FroDex25 and 46/91 FroDex37.5) with each combination therapies (p < 0.05). FroDex25 and FroDex37.5 showed a similar efficacy both for primary and secondary endpoints. It seems there is no dose response curve for the addition of dextroprofen.

Tulunay et al.29 | Adults – mean age 32.7 ± 8.7 years n=56 (47 female and 9 male) | Dipyrone 1g mg (2 tablets of 500 mg) oral Placebo | Total pain relief and pain relief were primary outcomes. Pain relief at 2h - Dipyrone 59/112 (52.7%) vs Placebo 13/56 (23.2%) (p<0.01). At 4h - Dipyrone 64/112 (57.1%) vs Placebo 16/56 (28.6%) (p<0.001). Total pain relief at 2h - Dipyrone 42/112 (37.5%) vs Placebo 6/56 (10.7%) (p<0.001). At 4h - Dipyrone 45/112 (40.2%) vs Placebo 7/56 (12.5%) (p<0.001).

**Comparison between metamizole and triptans for migraine treatment: a systematic review and network meta-analysis**

**Table:**

| Adults – mean age 32.7 ± 8.7 years n=56 (47 female and 9 male) | Dipyridamole 1g mg (2 tablets of 500 mg) oral Placebo | Total pain relief and pain relief were primary outcomes. Pain relief at 2h - Dipyridamole 59/112 (52.7%) vs Placebo 13/56 (23.2%) (p<0.01). At 4h - Dipyridamole 64/112 (57.1%) vs Placebo 16/56 (28.6%) (p<0.001). Total pain relief at 2h - Dipyridamole 42/112 (37.5%) vs Placebo 6/56 (10.7%) (p<0.001). At 4h - Dipyridamole 45/112 (40.2%) vs Placebo 7/56 (12.5%) (p<0.001). Pain recurrence after total pain relief - Dipyridamole 16.7% (7/42 attacks) and Placebo 33.3% (2/6 attacks).
### Comparison between metamizole and triptans for migraine treatment: a systematic review and network meta-analysis

Peres MFP, Scala WAR, Salazar R

<table>
<thead>
<tr>
<th>Adults – Placebo: 39 (SD 10); Sumatriptan 1mg: 41 (SD 11); Sumatriptan 2mg: 40 (SD 11); Sumatriptan 3mg: 39 (SD 10); n=685 (165 male and 520 female)</th>
<th>Sumatriptan 1, 2 and 3 mg SC Placebo One migraine attack</th>
<th>By 30 minutes post dose 17% (95% CI 6% to 27%) more patients had improved with 1 mg sumatriptan, 22% (95% CI 13% to 32%) with 2 mg sumatriptan and 34% (95% CI 24% to 44%) with 3 mg sumatriptan than with placebo (p &lt; 0.001 for all three comparisons versus placebo). The number of patients who were improved increased significantly with increasing dose (p &lt; 0.002, chi-square test for trend). Complete resolution of pain was obtained at 30 min by 5% of placebo-treated patients, 9% of patients treated with 1 mg sumatriptan and by 14% treated with 2 mg or 3 mg sumatriptan, respectively.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults - range: 18 to 55 years [Placebo: 39±9 years; Rizal-R10mg: 40±9 years; Rizal-20mg: 40±8 years; Riza-40 mg: 41±9 years; Suma-100 mg: 41±10 years;] n=449 (402 female and 47 male)</td>
<td>Rizatriptan 10, 20, 40 mg Sumatriptan succinate 100 mg Placebo oral One migraine attack</td>
<td>The proportion of patients with headache relief was 18% for placebo; 46% for sumatriptan; and 52% for 10-mg, 56% for 20-mg, and 67% for 40-mg rizatriptan. All differences with placebo were statistically significant (P&lt;0.001), and 40-mg rizatriptan was superior to sumatriptan (P=0.01). The proportion of patients who became free of pain at 2 hours was 3% for the placebo-treated group; 22% for the sumatriptan-treated group; and 26%, 35%, and 47% for the group of patients who took the 10-, 20-, and 40-mg doses of rizatriptan, respectively (all differences with placebo, P&lt;0.005; 40-mg rizatriptan vs sumatriptan, P=0.001). The recurrence of headache within 24 hours was found to be equal across all treatment groups—approximately 40%. Adverse events (most commonly short-lasting mild or moderate dizziness and drowsiness) occurred more frequently after a 40-mg dose of rizatriptan was given than after other treatments.</td>
</tr>
<tr>
<td>Adolescents - Rizatriptan 14.3 (SD 1.7) / Placebo – 14.1 (SD 1.8) years n=476 (264 female and 212 male)</td>
<td>Rizatriptan 5mg oral Placebo Single attack</td>
<td>Primary efficacy measure was 2h pain relief: Rizatriptan 68.2% vs Placebo 68.8% (P=NS). Considering just patients who treated migraine on weekend - Rizatriptan 74% vs Placebo 58.3% (p=0.022). There was no difference in adverse events - Rizatriptan 34.3% vs Placebo 30.2%.</td>
</tr>
<tr>
<td>Adults - Sumatriptan 20mg: 37.0 ± 10.8 years; Placebo: 37.4 ± 9.8 years. n=56 (48 female and 8 male)</td>
<td>Sumatriptan 20mg spray Placebo spray</td>
<td>A significant difference in headache relief rates between the 2 groups was observed at 30 minutes postdose (46% vs. 21%, P &lt; 0.05). One-hour postdose, 61% of sumatriptan recipients experienced headache relief compared with 43% of placebo recipients (p = 0.181). The difference in relief rates between groups diminished over time, mainly due to a high placebo response (54% at 2 hours postdose). Nausea, photophobia and phonophobia were alleviated in the majority of patients in the sumatriptan nasal spray group, although the benefit in comparison to placebo did not reach statistical significance. Most of the adverse events reported in the sumatriptan group were mild and transient, and none were considered serious.</td>
</tr>
<tr>
<td>Adults - mean age 18 – 29 (13.9%); 30 – 45 (48.7%); &gt;45 (37.4%) years n=674 (565 female and 109 male)</td>
<td>Eletriptan 40mg Placebo 80mg Placebo</td>
<td>Patients receiving either dose of the active compound were unable to perform their usual activities for a median period of 4 hours compared with 9 hours experienced by those taking placebo. This difference was highly statistically significant (p = 0.001). The time saving associated with eletriptan usage reflected the differences in efficacy findings in the clinical component of the study.</td>
</tr>
<tr>
<td>Adults - Sumatriptan 4mg: 38.3 (SD 9.5 - Range 18-59) Placebo – 38.1 (SD 9.7 - Range 18-59). n=577 (501 female and 76 male)</td>
<td>Sumatriptan 4mg SC Placebo SC Single migraine attack</td>
<td>The primary efficacy measurement was pain relief at 2 hours. Pain relief at 2h: Sumatriptan 4mg - 70% (95% CI 68% and Placebo - 22% (n = 42) (P &lt; 0.001), Pain Free at 2h: Sumatriptan - 50% (n = 192) and placebo - 11% (n = 21) (P &lt; 0.001). Use of rescue medication: Placebo - 45% (n = 86) Sumatriptan - 22% (n = 84). Adverse events: Sumatriptan - 66% (n = 265) and Placebo - 39% (n = 75) (P &lt; 0.001).</td>
</tr>
<tr>
<td>Adults - DHE-45: 40.5±8.6 years and range of 20 to 63 years; sumatriptan: 41.5 years and range of 22 to 59 years. n=310 (272 females and 38 males)</td>
<td>Dihydroergotamine mesylate (DHE-45) 1 mg SC Sumatriptan succinate 6 mg SC Single migraine attack</td>
<td>At 2 hours, 73.1% of the patients treated with dihydroergotamine and 85.3% of those treated with sumatriptan had relief (P=0.002). There was no statistical difference in headache relief between the groups at 3 or 4 hours. Headache relief was achieved by 85.5% of those treated with dihydroergotamine and by 83.3% of those treated with sumatriptan by 4 hours. By 24 hours 89.7% of dihydroergotamine-treated patients and 76.7% of sumatriptan-treated patients had relief (P=0.004). Headache recurrence within 24 hours after treatment in 45% of the sumatriptan-treated patients and in 17.7% of the dihydroergotamine-treated patients (P=0.001).</td>
</tr>
<tr>
<td>Study</td>
<td>Participants</td>
<td>Interventions</td>
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<tr>
<td>Winner et al.</td>
<td>Adolescents - mean age 14 years, n=296 (161 female and 135 male)</td>
<td>Sumatriptan 5mg, 10mg, or 20mg nasal spray Placebo</td>
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<tr>
<td>Winner et al.</td>
<td>Adults - mean age 40.3 years, n=354 (311 females and 43 males)</td>
<td>Sumatriptan 50 mg and 100 mg tablets Placebo</td>
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<tr>
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<td>Adults - mean age 42.6 years, n=297 (247 female and 50 males)</td>
<td>Sumatriptan 6mg SC Placebo</td>
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<tr>
<td>Winner et al.</td>
<td>Adults - Sumatriptan: 40.2 (SD 9.7)/ Placebo: 41.1 (SD 10.4) years, n=287 (38 male and 249 female)</td>
<td>Sumatriptan 6mg SC Placebo</td>
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<tr>
<td>Winner et al.</td>
<td>Adolescents - mean age 14 years, n=267 (157 female and 117 male)</td>
<td>Sumatriptan 20 and 5mg Nasal Spray Placebo</td>
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<tr>
<td>Winner et al.</td>
<td>Adolescents – Eletriptan: 14 ± 1.65 years; Placebo: 14 ± 1.6 years, n=221 (157 female and 117 male)</td>
<td>Eletriptan 40mg oral Placebo</td>
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### Adolescents - Zolmitriptan

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<td>229</td>
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<tr>
<td>Zolmitriptan 2.5mg nasal spray</td>
<td>14.6 (1.77)</td>
<td>229</td>
</tr>
<tr>
<td>Zolmitriptan 0.5mg nasal spray</td>
<td>14.5 (1.72)</td>
<td>229</td>
</tr>
<tr>
<td>Placebo</td>
<td>14.3 (1.67)</td>
<td>229</td>
</tr>
</tbody>
</table>

n = 798 (305 male and 493 female)

The primary outcome variable is pain-free status 2 hours post-treatment.

- Pain-free 2 hours post treatment: Zolmitriptan nasal spray 5mg - 68/229 (29.7%) vs Placebo 42/253 (OR 2.18; 95% CI 1.40, 3.39 (16.6%) (P< .001).
- Headache response at 2h: Zolmitriptan nasal spray 5mg 51% \[116/229\] vs Placebo 39% \[99/253\]; P =0.010.
- Sustained headache response 2h: Zolmitriptan (any dose) - 30% (120/396) vs Placebo 24% (59/251) - not statistically significant.

### Adults - Rizatriptan

<table>
<thead>
<tr>
<th>Group</th>
<th>Mean (SD)</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rizatriptan 5mg oral</td>
<td>36.6±12.8 years</td>
<td>148</td>
</tr>
<tr>
<td>Propacetamol (1 g) IV</td>
<td>35.6±10.8 years</td>
<td>148</td>
</tr>
</tbody>
</table>

n = 148 (76 female and 72 male)

Propacetamol showed superior efficacy at 1 h and there was no significant difference at 30 min or at 2 h. This indicates that propacetamol is at least as effective as rizatriptan in the treatment of acute migraine attacks.
Discussion

Our study suggests that overall response to triptans is as effective as that observed with dipyrone in acute migraine treatment.

Several studies involving triptans have evaluated the efficacy of different doses compared to placebo or included an evaluation of comparative efficacy between different triptans or doses. In general, all types of triptan were more effective than placebo in relieving migraine, with a good safety standard, although some drugs have achieved similar results as those for placebo. Attention to exceptional positive results for placebo in migraine treatment in some double-blind studies should be given, especially in the adolescent population. Symptoms related to migraine (nausea and vomiting, phonophobia and photophobia) also had a good response with triptans. In general, triptans were effective in relieving associated symptoms and reducing clinical disability compared to placebo. A poor response to one triptan does not predict a poor response to other agents belonging to the class.

Regarding dipyrone (metamizole) results, Bigal showed that the number of patients required to be treated with dipyrone 1 g by intravenous injection compared to placebo for at least one to benefit was 3.3 in 30 min and 2.2 in 60 min. There were statistically significant reductions in recurrence (dipyrone = 25%, placebo = 50%) and use of rescue medication (dipyrone = 20%, placebo = 47.6%) for the dipyrone group.28

A few studies have evaluated the restoration of functional ability after a migraine crisis and, to a lesser extent, lost time from work. A good number of studies evaluated the possibility of returning to normal functions or the number of patients who were able to return to normal activities after an average of 2 hours from initial treatment for a migraine episode. All studies involved triptans and no study was performed with dipyrone.24, 35, 36, 55, 68, 69, 73, 85, 129, 130, 135, 140, 143, 145, 152, 161, 166, 177, 211

Barbanti et al evaluated equivalent work time loss after a migraine attack, and the results showed 1.9 ± 2.3 and 2.5 ± 4.7 hours lost from work for sumatriptan 100 mg and 50 mg, respectively, compared with 3.5 ± 4.3 for placebo. Sumatriptan 100 mg was also able to better restore functional ability.54

Freitag et al. (REF) evaluated normal function disability, bed rest required, and ER/hospitalization resulting from a migraine attack in order to compare almotriptan and placebo responses at 2h- and 4h-posttreatment. The study showed that pain resolution was associated with a normal level of function, and the absence of phonophobia, photophobia, and nausea at 2 hours was also associated with less disability. In the study, treatment with almotriptan compared with placebo resulted in consistently better 24-hour quality of life scores, with restored social function. A logistic regression model determined that pretreatment functional level and pretreatment pain intensity were significant covariates of the proportion of patients who achieved normal function at 2 hours posttreatment.103

Dasbaci et al.84 demonstrated that rizatriptan decreased the total number of lost work hours by 1.1h per treated migraine attack compared with placebo.

Most studies that evaluated migraine in the menstrual period involved triptans,97, 159, 160, 185, 206 Silverstein et al. demonstrated that treatment results with rizatriptan in menstrual period migraine were similar compared to those for migraine unrelated to the menstrual period.185

Some studies have associated hormonal drugs and mainly NSAIDs with the use of triptan in one of the tested arms, with good therapeutic results in general, especially when there was an association of a triptan with a NSAID, with superior results when compared to the drug alone. Naproxen, ketoprofen and ibuprofen were the most common NSAIDs evaluated in the studies.20, 30, 33, 34, 48, 86, 106, 187

Tullo et al. evaluated the factors that influenced the selection of a treatment for migraine, comparing frovatriptan and zolmitriptan in the selected study, and found the following order of priority: 1) speed of action; 2) reduction in pain intensity and 3) absence of side effects.207 On the other hand, Savi et al.178 demonstrated the following order of choice by patients: rapid speed of action, good tolerability and reduction in pain severity, being decisive for the selection of frovatriptan over rizatriptan. Although these studies have evaluated triptans, rapid pain relief appears to be the main attribute of drug selection for migraine relief.2

Regarding the question presented in this study: “what is the evidence for the efficacy and safety of metamizole for the treatment of migraines compared with triptans?” The result is that overall response to metamizole is as effective as that observed with triptans in acute migraine treatment. The second point of evaluation in this systematic review was: “how effective are those treatments in improving cognitive...
dysfunction in patients with migraine?" Unfortunately, cognitive improvement is not a goal evaluated in most studies included in the review. A few triptan studies showed that pain resolution was associated with a normal level of function, and also a logistic regression model determined that pretreatment functional level and pretreatment pain intensity were significant covariates of the proportion of patients who achieved normal function at 2 hours posttreatment. There are no data regarding cognitive dysfunction improvement related to metamizole utilization, so it may just be an inference related to metamizole.

This systematic review involved different forms of administration and doses of metamizole and triptans, which allowed us to have a complete and comprehensive view of studies involving both studied medications in migraine treatment, but limits some more direct comparisons between doses and routes of administration. Most studies performed with triptans utilized oral administration and most studies with metamizole in this review utilized the intravenous route of administration.

No direct comparisons between metamizole and triptans have been performed in a controlled and randomized clinical study and most studies involving triptans have been conducted in European countries and the US.

The main weakness of this systematic review and meta-analysis is the small number of studies involving metamizole included. The literature on metamizole is scarce. In the setting of the present analyses, only 5 articles with metamizole had a placebo arm and the estimates obtained were all indirect. This fact is directly related to the absence of drug availability in expressive markets, such as the US and some European countries. Studies with metamizole included in this review were limited to Brazil, Spain and Turkey.8, 37, 39-42

Despite the adverse event of agranulocytosis being the main reason for metamizole withdrawal from the market in some countries, this health risk was not proven true in the pharmacovigilance data and other scientific evidence generated in countries that maintained product commercialization.215,217

The data did not show a significant difference between metamizole and triptans in neither pain relief nor pain absence 2 hours after medication. In support of relief within 24 hours after medication, eletriptan, rizatriptan and zolmitriptan showed statistically different proportions from metamizole. There is no evidence of a difference between metamizole and triptans in absence of pain 24 hours after medication.

Considering the equivalence of therapeutic benefit and adverse events with triptans, especially cardiovascular ones, in addition to pharmacoeconomic aspects, as metamizole is far cheaper than triptans, metamizole could be a good medicine option for migraine treatment.

**Conclusion**

Metamizole may be equally effective as triptans in acute migraine treatment, with a good tolerability profile and a potentially better cost-benefit ratio with significant implications to healthcare policies. More studies are necessary to confirm our results.

**Conflict of interest statement**: MP has received consultant fees from Sanofi, Lundbeck, Ache, Eurofarma, Libbs, Novartis, Eli Lilly, Allergan Abbie, Teva, Hefesto Medtech. WS and RS are employees of Sanofi, Sanofi financed the study.

**Abbreviations**

AEs, adverse effects
Bid, twice daily
CI, Confidence Interval
IV, intravenous
NS, nasal spray
NSAIDs, non-steroidal anti-inflammatory drugs
ODT, orally disintegrating tablet
PRISMA, Preferred Reporting Items for Systematic Reviews and Meta-Analyses Protocols
qd, once daily
SC, subcutaneous
TDS: iontophoretic transdermal patch
US, United States

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Summary

Objectives: To systematically review the evidence comparing metamizole vs. triptans for migraine treatment. Methods: A systematic review and network meta-analysis were performed. Results: The network meta-analysis showed superior efficacy of triptans compared to metamizole. Conclusion: Triptans are more effective than metamizole for migraine treatment.


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