Desmopressin/indomethacin combination efficacy and safety in renal colic pain management: A randomized placebo controlled trial

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Abstract

Introduction: Renal colic is a prevalent cause of abdominal pain in the emergency department. Although non-steroidal anti-inflammatory drugs and opioids are used for the treatment of renal colic, some adverse effects have been reported. Therefore, desmopressin—a synthetic analogue of vasopressin—has been proposed as another treatment choice. In the present study, indomethacin in combination with nasal desmopressin was compared with indomethacin alone in the management of renal colic.

Methods: Included in the study were 124 patients with initial diagnosis of renal colic and randomized to receive indomethacin suppository (100 mg) with either desmopressin intranasal spray (4 puffs, total dose of 40 micrograms) and or placebo intranasal spray.

Results: All the included patients were finally diagnosed with renal colic. There was no difference between the two groups in pain at the baseline (p = 0.4) and both treatments reduced pain successfully (p < 0.001). There was no significant difference between the two groups in pain reduction (p = 0.35).

Conclusions: While there was significant pain reduction in both patients groups, pain reduction of NSAIDs (e.g. indomethacin) in renal colic, does not significantly improve when given in combination with desmopressin.

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Keywords:
Renal colic
Desmopressin
Pain
Indomethacin

1. Introduction

Renal colic is a prevalent cause of abdominal pain in the emergency department (ED) [1]. It is caused by local stone irritation and increased ureteropelvic pressure via obstruction. Ureteral obstruction increases the release of prostaglandin (PG) which then triggers a vicious cycle, i.e. increased blood flow results in increased urine production which in turn exacerbates the ureteropelvic pressure [2].

Traditionally, non-steroidal anti-inflammatory drugs (NSAIDs) and opioids have been used for the treatment of renal colic. These agents are generally effective but there are some side effects, such as peptic ulcer, and hypoventilation. Desmopressin (1-desamino-8-D-arginine), a synthetic analogue of vasopressin, has been proposed as another treatment option, assuming that the antidiuretic action of this agent may break the aforementioned vicious cycle and help with pain reduction.

Human studies on the effectiveness of desmopressin, either alone or in combination with other NSAIDs and opioids, have yielded contradictory results. Only one study concluded that diclofenac suppository, when combined with desmopressin, was more effective for pain relief. Indomethacin, a popular NSAID in our country, can easily be administered per rectum, obviating the need for securing venous access. This is especially an advantage for an overcrowded ED.

In this randomized controlled clinical trial, indomethacin in combination with nasal desmopressin was compared with indomethacin alone in the management of renal colic.

2. Methods

2.1. Study design

This is a prospective, double-blinded, randomized, placebo-controlled clinical trial which compared the effectiveness and adverse effects of desmopressin/indomethacin combination with those of indomethacin alone. The trial has been registered in clinicaltrials.gov with registration number NCT01742689. Our institutional review board has approved the trial protocol provided that written informed consent is obtained from all participants.

2.2. Study setting and population

The study was conducted in the EDs of two academic hospitals with >50,000 patients per year. Our study population included patients with renal colic who presented to the ED between March 2012 and March 2014.
All patients aged 15 years and above were considered for inclusion. Exclusion criteria were pregnancy, presence of acute rhinitis and influenza, hereditary or acquired coagulopathy, history of acute myocardial ischemia, hyponatremia, peptic ulcer disease, asthma, renal failure, and severe liver failure. Patients taking any of the following medications were also excluded: seizure medications, chlorpropamide, clofibrate, epinephrine, flurodrocortisone, lithium, alcohol, or analgesics (during the past 4 h).

2.3. Study protocol

A convenience sample of 124 patients was enrolled during the shifts of two of the investigators (HM and MRH). Patients were included based on the initial diagnosis of renal colic by the treating physicians after arrival to the ED and absence of exclusion criteria. Patients’ enrollment and flow in the study is further illustrated in Fig. 1. Since rectal administration of indomethacin alone was one of the popular treatment options in renal colic at our institution, patients were randomized to receive indomethacin suppository (100 mg) plus either desmopressin intranasal spray (4 puffs with 10 microgram per puff, total dose of 40 microgram) or placebo intranasal spray. Block randomization was performed using computer generated sequence of 4 numbers. The sprays were covered by manufacturer to appear similarly and named A and B with the patients and physician blinded to the content of them.

An emergency physician (EP) enrolled the patient and documented patient demographic data. Before treatment, the pain was recorded using an 11-point verbal numeric rating scale. Then, 4 spray puffs were applied in patient’s nostril, and indomethacin suppository was administered per protocol. Pain was recorded 5, 10, 15, 30, 45, and 60 min afterwards. In addition, during the 1 h period, adverse effects (e.g. dry mouth, nausea, drowsiness, hypotension, and anaphylaxis) were logged in a data collection sheet. In case of insufficient pain relief or patient’s demand for further analgesia 30 min after medication administration, 5 mg of morphine sulfate was administered intravenously. Other medications such as anti-emetics were administered according to the patients’ complaints.

In this study, the primary outcome measures were patient pain reduction as measured by 11-point verbal numeric rating scale with 0 representing “no pain” and 10 meaning “worst possible pain”. Secondary outcomes were the occurrence of adverse effects and the need for rescue analgesia.

2.4. Data analysis

Data were analyzed using SPSS (SPSS Inc., Chicago, IL) and values were expressed as number (%) or mean ± standard deviation (SD). Previous studies showed that desmopressin-NSAID co-administration and indomethacin were effective in about 95% and 73% of patients with renal colic, respectively [3,4]. Therefore, a sample size of 49 in each treatment arm was needed for a power of 80% and alpha level of 0.05 for statistical significance. Assuming an estimated 20% drop-out rate, we decided to include 60 patients in each arm. Post-treatment and analysis of covariance and Chi-square were employed for comparison of pain measurements and need for rescue treatment, respectively. Statistical significance was accepted at p values < 0.05.

3. Results

After obtaining informed consent, 124 patients with primary diagnosis of renal colic were randomly assigned to either treatment or
control group in equal proportions (Fig. 1). Patients’ characteristics have been provided in Table 1. There was no difference between the two groups in pain severity at presentation. All patients who had received renal colic diagnosis at the time of admission, had final diagnosis of renal colic, completed the study, and were analyzed. Seven patients in desmopressin/indomethacin group and 5 patients in indomethacin group received intravenous morphine as rescue treatment. Table 2 represents the pain scores at different time points. Although pain scores in desmopressin/indomethacin group were lower at the baseline and at each time point afterward, this difference was not statistically significant (p = 0.4) (Table 2). Comparing pain scores between the two groups showed that both treatments arms reduced pain significantly (p < 0.001) with no difference in pain reduction between two treatment arms (p = 0.35). No severe adverse event (e.g. chest pain, anaphylaxis, and dyspnea) occurred for any of the patients; other less serious events are listed in Table 3.

4. Discussion

Excruciating pain is one of the most common complaints in patients with urolithiasis [5]. It is believed that the pain results mainly from increased ureteropelvic pressure due to hyperperistalsis and distension of obstructed ureter. This, in turn, will result in stimulation of PG2 secretion, further renal vasodilatation, subsequent increase in diuresis and exacerbation of pain [6,7].

Rapid pain relief is considered as the main step in management of these patients [8]. NSAIDs and opioids are commonly used for pain management in renal colic patients [9]. Inhibition of PGE2 synthesis by NSAIDs and inhibition of excitatory neurotransmitters release (e.g. substance P) by opioids are the main mechanisms of action [10,11]. Despite their vast usage, NSAIDs can induce gastrointestinal bleeding and renal failure, and opioids are associated with potential for abuse [12].

Considering these drawbacks, desmopressin has been proposed as an alternative medication for renal colic pain relief. The antiinflammatory action of the agent may break the vicious cycle of PG release, diuresis, and exacerbation of pain [6,7].

Aspirin is the main drug used for the treatment of renal colic, does not significantly improve pain relief [12]. Kumar et al. believes that these differences in results can stem from several causes such as different time intervals for assessment of pain, individual variations in absorption of drug or the dose of drugs [13]. Of note, while a study showed that desmopressin effectiveness reaches to its peak in 60 min after administration, most studies (including one that used diclofenac suppository) did not follow participants for 1 h. Furthermore, some studies have evaluated the analgesic efficacy of desmopressin through different administration routes. In an interesting study conducted by Pricop et al., it has been shown that sublingual desmopressin can cause an analgesic effect as efficiently as NSAIDs in renal colic [19].

The investigators also demonstrated improved analgesic effect of desmopressin in combination with NSAIDs as compared to NSAIDs alone [19]. These studies suggest that desmopressin efficacy in pain relief and its additive potential as an adjunct, can be related to the route of administration [19,20].

In this study, we observed no significant difference in pain reduction between the two groups. Also, with regard to the need for rescue treatment, we did not detect any remarkable difference between the groups, i.e. the number of patients needing rescue treatment was not significantly different in the two groups. Patients were enrolled in the study based on the clinical symptoms of renal colic and the clinical judgment of the emergency medicine attending physician. Since clinical judgment in not highly accurate in the diagnosis of nephrolithiasis or ureterolithiasis, and considering the fact that no confirmatory study was performed to identify the presence of stone in these patients, this is a limitation for our study and could potentially affect the results. Furthermore, all the cases have been recruited during the clinical shifts of two of the investigators; this can add to the aforementioned limitation. In addition, another limitation of this study was the absence of follow-up data on the patients’ condition after 1 h; whether there was any difference between the two groups after 1 h and whether there were any cases of return visit for the same problem is unknown.

In summary, although there was significant improvement in pain score in both groups, desmopressin as an adjunct to NSAIDs in the management of renal colic, does not significantly improve pain relief.

Conflict of interest

None.

Funding

None.

Table 1

<table>
<thead>
<tr>
<th></th>
<th>Participants’ baseline characteristics.</th>
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<tbody>
<tr>
<td></td>
<td>Desmopressin/indomethacin group (62 patients)</td>
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<tr>
<td>Age (year), mean ± SD</td>
<td>34.67 ± 10.03</td>
</tr>
<tr>
<td>Male (%)</td>
<td>70.15</td>
</tr>
<tr>
<td>Pain at presentation, mean ± SD</td>
<td>7.7 ± 1.3</td>
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Table 2

<table>
<thead>
<tr>
<th></th>
<th>Pain measurements during trial, mean (SD).</th>
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<tbody>
<tr>
<td></td>
<td>Time 0</td>
</tr>
<tr>
<td>Desmopressin/indomethacin</td>
<td>7.7 (1.3)</td>
</tr>
<tr>
<td>Indomethacin</td>
<td>8 (1.7)</td>
</tr>
</tbody>
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Table 3

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<th>Incidence of adverse effects in the two study groups.</th>
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<tbody>
<tr>
<td>Adverse effect</td>
<td>Desmopressin/indomethacin</td>
</tr>
<tr>
<td>Dry mouth</td>
<td>4 (6.5%)</td>
</tr>
<tr>
<td>Nausea</td>
<td>14 (22.6%)</td>
</tr>
<tr>
<td>Vomiting</td>
<td>1 (1.6%)</td>
</tr>
<tr>
<td>Dizziness</td>
<td>1 (1.6%)</td>
</tr>
<tr>
<td>Chest pain</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Anaphylaxis</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Headache</td>
<td>3 (4.8%)</td>
</tr>
<tr>
<td>Lightheadedness</td>
<td>1 (1.6%)</td>
</tr>
<tr>
<td>Dyspnea</td>
<td>0 (0%)</td>
</tr>
</tbody>
</table>

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References