Intramuscular midazolam versus intravenous diazepam for treatment of seizures in the pediatric emergency department: A randomized clinical trial

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KEYWORDS
Seizures; Benzodiazepines; Status epilepticus; Epilepsy

Abstract
Aim: To compare the therapeutic efficacy of intramuscular midazolam (MDZ-IM) with that of intravenous diazepam (DZP-IV) for seizures in children.
Design: Randomized clinical trial.
Setting: Pediatric emergency department.
Patients: Children aged 2 months to 14 years admitted to the study facility with seizures.
Intervention: Patients were randomized to receive DZP-IV or MDZ-IM.
Main measurements: Groups were compared with respect to time to treatment start (min), time from drug administration to seizure cessation (min), time to seizure cessation (min), and rate of treatment failure. Treatment was considered successful when seizure cessation was achieved within 5 min of drug administration.

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Midazolam versus diazepam in pediatric seizures

Introduction

Background

Epileptic seizures are a common cause of pediatric emergency department visits. The vast majority of seizures cease within 5 min; however, some are prolonged and may progress to status epilepticus (SE). SE, defined as continuous or recurring seizure activity lasting longer than 30 min, is associated with major morbidity rate and carries a mortality rate of up to 20%. Prolonged seizure activity leads to failure of cerebral autoregulation, which consequently reduces cerebral blood flow and eventually results in cerebral hypoxia.

Importance

Benzodiazepines (BZDs) have been used in the urgent care of seizures for over 40 years, and are considered first-line therapy for this purpose. The BZDs, which act on GABA<sub>A</sub> receptors, are effective in the treatment of various types of seizure, have a rapid onset of action after intravenous administration, excellent penetration into the central nervous system, and a good safety profile. Persistent generalized seizure activity increases benzodiazepine resistance; therefore, there is a consensus as to the need for immediate treatment of seizures. Lorazepam, diazepam, and midazolam are the three BZDs used in this setting. Lorazepam is the drug of choice due to its rapid...
onset of action and prolonged effect, but no parenteral formulations are available in Brazil. Consequently, intravenous diazepam, which provides seizure control in 85–90% of the cases, is the first-line drug of choice for acute treatment of seizures in Brazilian practice.

Goals of this investigation

When venous access is challenging or cannot be obtained, the most common alternatives have been rectal diazepam and intranasal midazolam, with some studies suggesting intramuscular midazolam as an additional option. The difficulty of administering BZDs rectally or intranasally and the erratic absorption provided by these routes jeopardize anticonvulsant efficacy. Median time to achievement of intravenous access in children ranges from 5 to 7 min. Difficulties in obtaining venous access delay treatment and, consequently, increase the risk of progression to status epilepticus. Thus far, no consensus has been established as to the best route for administration of BZDs in the event of failed intravenous access.

The objective of this study was to compare the therapeutic efficacy of intramuscular midazolam (MDZ-IM) with that of intravenous diazepam (DZP-IV) in children admitted to the referral service of a pediatric emergency department with epileptic seizures.

Patients and methods

Study design and setting

This randomized clinical trial was carried out between August 2010 and August 2011 in a sample of children admitted to the pediatric emergency department of Santa Maria University Hospital (PSPed-HUSM) with epileptic seizures. PSPed is a tertiary referral center in Southern Brazil, staffed by dedicated pediatricians and pediatric residents, which treats approximately 4000 pediatric patients per month. The study was approved by the local Research Ethics Committee (protocol no. 0184.0.243.000-10) in accordance with the Declaration of Helsinki 1964 revised in 2008. In view of the nature of the study condition and to provide the best possible benefit in this urgent setting, the committee authorized immediate patient allocation and treatment without prior consent. Subjects’ parents or legal guardians were then notified of the trial, and those who agreed to the use of patient data for research purposes were asked to provide written informed consent.

The study protocol was presented by the authors and approved by the medical officers and nursing staff of the department, who received specific training in its use.

Selection of participants

Inclusion criteria: children between the ages of 2 months and 14 years who were admitted to the emergency department with seizures, regardless of type or potential trigger, and in whom anticonvulsant medication was indicated and ordered by the attending physician. Children could be enrolled in the study more than once.

Exclusion criteria: children in whom venous access had been obtained in the prehospital setting and those with a known history of coagulopathy or hepatic and/or renal impairment.

Interventions

Patients admitted to the pediatric emergency department with seizures were randomly allocated to one of the two treatment groups: (a) Intravenous diazepam (DZP-IV), 0.5 mg/kg IV (maximum dose 10 mg) at a concentration of 5 mg/ml and with an application speed of 5 mg/min, or (b) intramuscular midazolam (MDZ-IM), 0.5 mg/kg IM (maximum dose 15 mg) at a concentration of 5 mg/ml.

Patients were randomized in blocks of 10. Five slips of paper marked “DZP-IV” and five slips marked “MDZ-IM” were placed into a brown paper envelope. At the time of admission, the nurse in charge of medication administration took a slip of paper from the envelope at random and administered the corresponding drug as standardized in the study protocol, after adjusting the dose for weight and age.

Methods and measurements

Identifying information and physiological parameters were recorded. The following variables were used as outcome measures: time from admission to drug administration (including time required to obtain intravenous access), time from drug administration to cessation of seizures, and total time from admission to cessation of seizures.

Heart rate and pulse oximetry were monitored in all patients throughout treatment. Vital signs were recorded on admission and every 5 min thereafter until discharge or transfer. Airway suctioning, supplemental oxygen, or tracheal intubation were provided as necessary or when ordered by the attending physician. Immediate adverse drug reactions were assessed in the first 10 min after administration of MDZ-IM or DZP-IV. The emergency department where the study was performed is equipped with crash carts containing all the necessary equipment and medications for treatment of cardiorespiratory instability.

Outcomes and analysis

Treatment was considered successful when cessation of seizures was achieved within 5 min of administration of a single dose of study drug (DZP or MDZ). Requirement of a second dose of study drug or additional medications was defined as treatment failure.

Inability to obtain venous access within 4 min was defined as “failed intravenous access.” This 4-min cutoff was chosen on the basis of mean time to establish intravenous access by Pediatric Emergency nursing staff during emergency care.

Statistical analysis: continuous variables were expressed as means and standard deviations. Comparisons were performed using Student’s t-test (for normally distributed variables) or the Mann–Whitney U test (in case of wide variability). Categorical variables were expressed as percentages and comparisons were performed with the chi-square or Fisher’s exact tests.
Midazolam versus diazepam in pediatric seizures

Results

Characteristics of study subjects

Of the 180 children admitted to the Pediatric Emergency Department at Santa Maria University Hospital (Brazil) with a chief complaint of convulsive seizures, 144 were postictal on admission. The remaining 36 children were enrolled in the study. Of these, 16 were allocated to the MDZ-IM group and 20 to the DZP-IV group. All children allocated to the midazolam group completed the study. Of those allocated to the diazepam arm, four (20%) were excluded due to failed intravenous access, and the remaining 16 completed the study (Fig. 1). The parents or guardians of all 32 children who completed the study had provided informed consent for participation.

There were no significant between-group differences in age, weight, sex, seizure etiology, vital signs, or blood glucose levels on admission. In both groups, most children were under the age of 5 (Table 1).

Main results

In 14 patients in each group (87.5%), seizure activity ceased after administration of a single BZD dose, which shows that both intramuscular midazolam and intravenous diazepam are effective anticonvulsants. Two patients in each group (12.5%) required a second dose of study drug or additional medications for seizure control (treatment failure).

In the MDZ-IM group, active treatment was instituted significantly sooner than in the DZP-IV group (2.8 versus 7.4 min; p = 0.001). Total time to cessation of seizures was also significantly shorter in the MDZ-IM group (time between admission and seizure cessation, 7.3 versus 10.6 min; p = 0.006) (Table 2). However, time from drug administration to cessation of seizures was significantly shorter in the DZP-IV group (3.3 versus 4.4 min; p = 0.001).

As noted above, two patients in each group (12.5%) were considered to have failed treatment due to persistence of seizures more than 5 min after BZD administration. The between-group differences in time to active treatment and time to cessation of seizures held true regardless of inclusion or exclusion of the patients that failed treatment (Table 2).

All children in both groups exhibited cyanosis and psychomotor agitation on admission and required supplemental oxygen by nasal cannula or non-rebreather mask. One child in the DZP-IV group progressed to SE of 40-min duration, requiring phenytoin for seizure control, and one child had a seizure duration of 6 min, requiring only an additional dose of IV diazepam. In the MDZ-IM group, one child had a seizure lasting 10 min, requiring intravenous diazepam and phenytoin. Additionally, one child in the MDZ group had SE that lasted 55 min and did not respond to intravenous diazepam. In this case, cessation was achieved after rectal diazepam and an additional dose of intramuscular midazolam.

One child (6.25%) in the MDZ group required intubation, artificial ventilation, and ICU admission due to respiratory failure on admission to the ED (SaO2 = 64%). Two children (12.5%) in the DZP group required intubation and ICU admission (one due to severe head trauma and one due to respiratory failure with SaO2 = 80%).

All children were monitored until cessation of seizures or discharge. There were no significant between-group differences in vital signs (Fig. 2).

Possible immediate adverse drug reactions (those occurring within 10 min of study drug administration) included hypotension in one child (6.3%) in the MDZ-IM group, two children (12.6%) with hyperactivity and salivation, one (6.3%) with nausea, and two (12.6%) with vomiting in the DZP-IV group. Nevertheless, the between-group difference in adverse reactions did not reach statistical significance (Table 2).

Discussion

In this randomized clinical trial where intramuscular midazolam was compared with intravenous diazepam for treatment of seizures in the pediatric emergency department, the following findings were observed: (a) in a reasonably high percentage of patients (20%), intravenous access cannot be achieved within 5 min of admission; (b) time from admission to active treatment and time from admission to cessation of seizures are significantly shorter with IM midazolam; and, the previous finding notwithstanding, (c) time from drug administration to cessation of seizures is significantly shorter with IV diazepam instead of IM midazolam.

Current treatment protocols propose that all children with convulsive seizures of >5 min duration should be managed according to established treatment algorithms for status epilepticus, in view of the complications and risk of neurological damage associated with prolonged seizure activity. The first 10 min of management should focus on protecting the airway and maintaining its patency, providing supplemental oxygen, measuring blood glucose, obtaining intravenous access, and treating the seizure with an intravenous benzodiazepine.

One may presume that the minimum time required for a child to reach the emergency department after the onset of seizures, when transported from the home by parents, is 5 min. Studies have estimated that at least 5–7 min are required to obtain intravenous access in pediatric patients. The sum of these times means at least 10–12 min will have elapsed between seizure onset and active treatment, which increases the risk of complications. When intravenous access cannot be obtained, buccal or intranasal administration of midazolam has been advocated, with an effectiveness rate in the region of 60%. Despite good absorption through the mucous membranes of
the mouth and nose, administration of midazolam through these routes can be extraordinarily challenging due to the involuntary movements of the convulsing child and due to the presence of airway secretion, which impedes proper absorption.\(^\text{6,11}\) Rectal administration of diazepam is associated with erratic absorption and poor therapeutic success rates (27%).\(^\text{4,12}\)

Midazolam has been used in the treatment of seizures since the 1980s,\(^\text{14}\) with a good safety profile in terms of respiratory depression and good absorption via several routes (intranasal, buccal, rectal, and intramuscular).\(^\text{13,15-17}\) A study conducted in pediatric emergency departments in Australia and New Zealand showed that, when venous access could not be obtained, 49% of the physicians used rectal diazepam and 41% used intramuscular midazolam, which shows increasing preference for the intramuscular route.\(^\text{18}\)

As in previous studies, IV diazepam has a faster onset of action than IM midazolam after administration (3.3 min versus 4.4 min), due to the shorter time to peak serum levels and, consequently, earlier achievement of therapeutic levels in the CNS.\(^\text{17,18,19}\) Nevertheless, actual time to cessation of seizures (i.e. time from admission to the emergency department to cessation of seizure activity) was significantly shorter in the IM midazolam group (7.3 min versus 10.6 min), which corroborates the observations of a similar trial.\(^\text{20}\)

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**Table 1** Sample profile by group.

<table>
<thead>
<tr>
<th>Age (months)</th>
<th>Intramuscular midazolam (n = 16)</th>
<th>Intravenous diazepam (n = 16)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median (range)</td>
<td>46.4 ± 53.1 (13.9 (10.7–70.0))</td>
<td>45.0 ± 49.2 (14.3 (4.4–90.8))</td>
<td>0.451†</td>
</tr>
<tr>
<td>Weight (kg)</td>
<td>15.9 ± 10.6 (11.5 (8.1–19.2))</td>
<td>17.7 ± 13.0 (13.2 (7.2–26.5))</td>
<td>1.000†</td>
</tr>
<tr>
<td>Male sex, n (%)</td>
<td>12 (75.0%)</td>
<td>8 (50.0%)</td>
<td>0.273†</td>
</tr>
<tr>
<td>Systolic blood pressure (mmHg)</td>
<td>99.5 ± 21.6</td>
<td>102.0 ± 16.4</td>
<td>0.715†</td>
</tr>
<tr>
<td>Diastolic blood pressure (mmHg)</td>
<td>61.6 ± 16.1</td>
<td>63.9 ± 12.6</td>
<td>0.735‡</td>
</tr>
<tr>
<td>Body temperature (°C)</td>
<td>37.3 ± 1.4</td>
<td>37.0 ± 1.4</td>
<td>0.670‡</td>
</tr>
<tr>
<td>Heart rate (bmp)</td>
<td>149.2 ± 29.0</td>
<td>137.6 ± 31.6</td>
<td>0.289‡</td>
</tr>
<tr>
<td>Respiratory rate (bmp)</td>
<td>37.0 ± 16.5</td>
<td>37.1 ± 9.7</td>
<td>0.985‡</td>
</tr>
<tr>
<td>Oxygen saturation (%)</td>
<td>90.9 ± 8.7</td>
<td>90.4 ± 5.3</td>
<td>0.846‡</td>
</tr>
<tr>
<td>Blood glucose (mg/dL)</td>
<td>116.6 ± 51.6</td>
<td>116.8 ± 39.1</td>
<td>0.955‡</td>
</tr>
<tr>
<td>Age &lt; 5 years, n (%)</td>
<td>12 (75.0%)</td>
<td>10 (62.5%)</td>
<td>0.702‡</td>
</tr>
<tr>
<td>Febrile seizures, n (%)</td>
<td>7 (43.7%)</td>
<td>6 (37.5%)</td>
<td>0.718‡</td>
</tr>
</tbody>
</table>

* Non-normal continuous variables (Mann–Whitney U).
† Categorical variables (chi-square or Fisher’s exact tests).
‡ Normally distributed continuous variables (Student’s t-test).

**Table 2** Main outcomes.

<table>
<thead>
<tr>
<th>Per-protocol analysis (treatment success only)</th>
<th>MDZ-IM (n = 14)</th>
<th>DZP-IV (n = 14)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time from admission to active treatment (min)</td>
<td>2.8 ± 1.5</td>
<td>7.4 ± 4.1</td>
<td>0.001†</td>
</tr>
<tr>
<td>Time from active treatment to cessation of seizures (min)</td>
<td>4.4 ± 0.5</td>
<td>3.3 ± 0.8</td>
<td>&lt;0.001†</td>
</tr>
<tr>
<td>Time from admission to cessation of seizures (min)</td>
<td>7.3 ± 1.4</td>
<td>10.6 ± 3.9</td>
<td>0.006†</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Intention-to-treat analysis (including treatment failures)</th>
<th>MDZ-IM (n = 16)</th>
<th>DZP-IV (n = 16)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time from admission to active treatment (min)</td>
<td>3.8 ± 2.8</td>
<td>7.4 ± 4.0</td>
<td>0.001†</td>
</tr>
<tr>
<td>Time from active treatment to cessation of seizures (min)</td>
<td>7.9 ± 12.6</td>
<td>5.7 ± 9.1</td>
<td>0.003†</td>
</tr>
<tr>
<td>Time from admission to cessation of seizures (min)</td>
<td>11.7 ± 14.6</td>
<td>13.1 ± 10.5</td>
<td>0.007†</td>
</tr>
<tr>
<td>Failed intravenous access (n, %)</td>
<td>4 (25%)</td>
<td></td>
<td>0.0001†</td>
</tr>
<tr>
<td>Treatment failure (n, %)</td>
<td>2 (12.5%)</td>
<td>2 (12.5%)</td>
<td>1.000†</td>
</tr>
<tr>
<td>ICU transfer (n, %)</td>
<td>1 (6.25%)</td>
<td>2 (12.5%)</td>
<td>1.000†</td>
</tr>
<tr>
<td>Adverse drug reactions (n, %)</td>
<td>1 (6.3%)</td>
<td>5 (31%)</td>
<td>0.171†</td>
</tr>
</tbody>
</table>

DZP-IV, intravenous diazepam; ICU, intensive care unit; MDZ-IM, intramuscular midazolam.
† Non-normal continuous variables (Mann–Whitney U).
‡ Categorical variables (chi-square or Fisher’s exact tests).
‡ Normally distributed continuous variables (Student’s t-test).
These results suggest that, when treating children with
convulsive seizures in whom venous access is expected to be
difficult or unlikely, IM administration of midazolam is safe,
effective, and perhaps superior to intravenous diazepam.
It bears stressing that seizure duration is directly asso-
ciated with the speed of benzodiazepine administration.5
Similar findings have been reported in the treatment of
behavioral disturbances in adult patients (where intravenous
access is also challenging), where IM administration was
superior to IV sedation in terms of time to cessation of
psychomotor agitation (21 min versus 30 min).21 Therefore,
even though BZDs act more rapidly when administered by
the intravenous route, early intramuscular administration
of midazolam provides superior therapeutic efficacy, due to
faster administration as well as due to the excellent absor-
tion of midazolam by this route.
Failed intravenous access is widely recognized as a
hindrance to implementation of urgent care protocols in
the pediatric emergency department. It is estimated that
2.5–16 min are required to obtain peripheral venous access
in adults, with a failure rate of 10–40%. In children, this
rate ranges from 14% to 70%, with failure being most com-
mon in infants.13,22–24 Venous access could not be obtained
in 20% of the 20 children randomized to the DZP-IV arm of
this study, which provides further evidence of the impor-
tance of intramuscular administration of anticonvulsants in
this setting.
Adverse effects were more frequent in the diazepam
group, as expected in view of previous comparisons with
midazolam and lorazepam,9,19 although the difference did
not reach statistical significance. The adverse effects
of BZDs are usually dose-dependent and associated with
repeated administration, and manifest most commonly as
reduced oxygen saturation and central hypoventilation.2,3
These findings are rapidly reversed with administration of
supplemental oxygen, airway suctioning and positional
maneuvers and, in a minority of cases, bag-valve-mask ven-
tilation.
The etiology of seizures varies according to age and
geographical region. However, most studies report that
approximately one-third of children admitted to an emer-
gency department with convulsions are having a febrile
seizure,25–27 as was the case in the present study.
One limitation of this study is that the sample size
precludes any conclusions about adverse effects and drug
safety, which would require a larger population. Further-
more, due to the design and nature of the study, personnel
in charge of administering drugs were not blinded to
allocation, which may have introduced bias. Despite this lim-
itation, the times to seizure cessation obtained in this study
were highly favorable, especially in view of the study setting
(the dedicated pediatric emergency department of a large,
university-affiliated tertiary care center). One may presume
that at smaller hospitals, where staff might have less skill
or experience obtaining intravenous access in children, the
difference would be even more significant.
Another limitation of the present study is the fact that,
although the cause of seizure could be initially identified
at the emergency room in most patients, this initial iden-
tification does reach a 100% level of certainty. Therefore,
emergency room professionals may have failed to identify, at first, a child with an underlying neurological disease leading to unresponsiveness to seizure treatment.

The results of the study suggest that intramuscular midazolam significantly shortens seizure duration in children as compared with intravenous diazepam. Therefore, intramuscular midazolam is a good alternative to intravenous diazepam, in view of its anticonvulsant efficacy and speed and ease of administration in the pediatric emergency care setting.

Conflicts of interest

The authors have no conflicts of interest to declare.

Authors’ contribution

All authors took part in data collection and analysis, literature review, and drafting of the manuscript.

References