imbalance. Including the Class II studies in a meta-analysis decreased the precision of the estimate; therefore, the conclusion was based solely on the 1 Class I study.

Conclusion: gabapentin is probably more likely than placebo to improve pain (SMD 0.53; 95% CI, 0.22–0.84; medium effect, moderate confidence; 1 Class I study).

Pregabalin

Eight Class I[24-31] and 7 Class II studies[22, 32-37] were identified, including 11 new studies since the systematic review for the 2011 guideline[14] was performed. In the 15 studies, participants were randomized to a range of pregabalin doses from 150 to 600 mg/d (n = 2,076) compared with placebo (n =1,682) and followed for a range of 4–13 weeks. Adverse events included dizziness, somnolence, peripheral edema, weight gain, and balance disorder. Including Class I and Class II studies, 6 studies revealed a SMD CI that did not include 0, whereas the other 9 studies did include 0. Overall, a significant small reduction in pain was observed when combining all studies (SMD 0.29; 95% CI, 0.13–0.45).

Conclusion: pregabalin is possibly more likely than placebo to improve pain (SMD 0.29; 95% CI, 0.13–0.45; small effect, low confidence; 8 Class I and 7 Class II studies).

Mirogabalin

Two new Class II studies included 557 participants randomized to mirogabalin and 200 to placebo.[36,37] Doses from 5 to 30 mg/d were used, and pain was measured at 5 and 7 weeks, respectively. A significant small reduction in pain was observed (SMD 0.21; 95% CI, 0.02–0.40). Adverse events included dizziness and somnolence.