RECOMENDACIÓN 1

BÚSQUEDA Y SÍNTESIS DE EVIDENCIA DE EFECTOS DESEABLES E INDESEABLES

Guía de Práctica Clínica Prevención del Parto Prematuro - 2017

PREGUNTA 1.- ASPIRINA INICIADA PRECOZMENTE EN MUJERES

Pregunta solicitada: En embarazadas menores de 16 semanas de edad gestacional con alto de riesgo de parto prematuro no idiopático, ¿Se debe usar aspirina en comparación a no dar?

BÚSQUEDA DE LA EVIDENCIA

Se realizó una búsqueda general de revisiones sistemáticas asociadas al tema de "Preterm labour and delivery". Las bases de datos utilizadas fueron: Cochrane database of systematic reviews (CDSR); Database of Abstracts of Reviews of Effectiveness (DARE); HTA Database; PubMed; LILACS; CINAHL; PsychlNFO; EMBASE; EPPI-Centre Evidence Library; 3ie Systematic Reviews and Policy Briefs Campbell Library; Clinical Evidence; SUPPORT Summaries; WHO institutional Repository for information Sharing; NICE public health guidelines and systematic reviews; ACP Journal Club; Evidencias en Pediatría; y The JBI Database of Systematic Reviews and implementation Reports. No se aplicaron restricciones en base al idioma o estado de publicación. Dos revisores de manera independiente realizaron la selección de los títulos y los resúmenes, la evaluación del texto completo y la extracción de datos. Un investigador experimentado resolvió cualquier discrepancia entre los distintos revisores. En caso de considerarse necesario, se integraron estudios primarios.

Seleccionadas las revisiones sistemáticas o estudios primarios asociadas a la temática, se clasificaron en función de las potenciales preguntas a las que daban respuesta. Los resultados se encuentran alojadas en la plataforma Living Overview of the Evidence (L·OVE). Por lo tanto, al momento de definir la pregunta, la evidencia ya se encontraba clasificada según intervenciones que comparadas.

SÍNTESIS DE LA EVIDENCIA

Análisis de los componentes de la pregunta en formato PICO

Población

Mujeres embarazadas de 22 semanas

Intervención

Aspirina

Comparación

Placebo

Desenlace (outcome)

Parto prematuro, pre-eclampsia, mortalidad perinatal

Resumen de la evidencia identificada

Se identificaron 18 revisiones sistemáticas, que en conjunto incluyen 92 estudios primarios, de los cuales 85 son ensayos controlados aleatorizados pertinentes a la pregunta específica.

Tabla resumen de la evidencia identificada

Revisión Sistemática	18 [1-18]
Estudios primarios	85 ensayos [19-103]

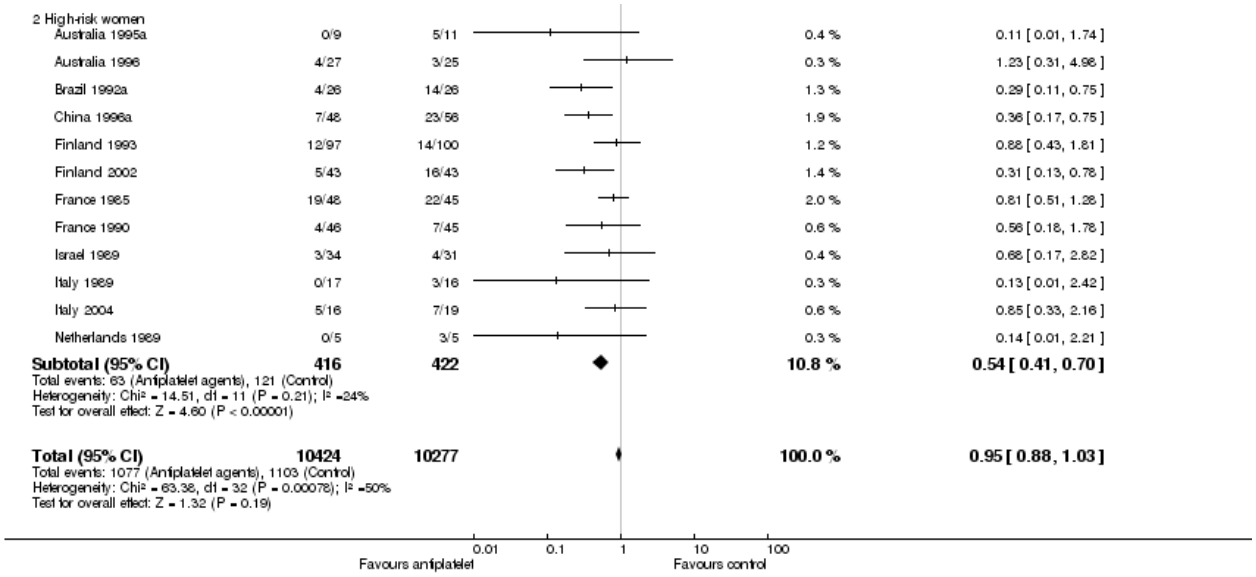
Link a la pregunta en L·OVE

Estimador del efecto

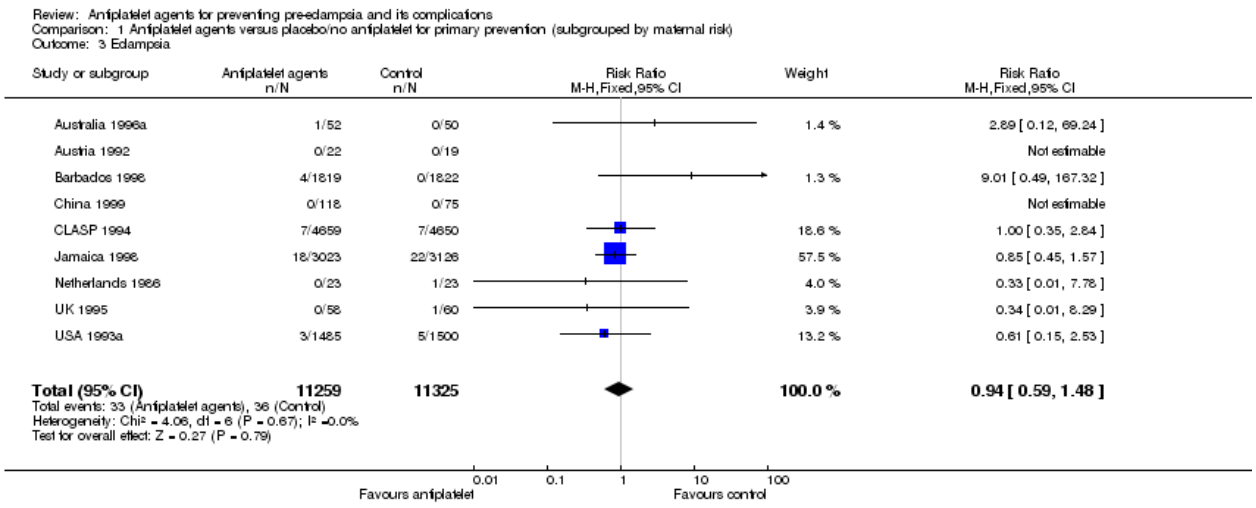
Se realizó un análisis de la matriz de evidencia (Ver detalle en: Antiplaquetarios solos para la prevención de preeclampsia). Una de las revisiones sistemáticas identificadas [12] contiene la mayoría de los ensayos relevantes. Se realizó un análisis de los estudios no incluidos por esta, concluyendo que todos fueron explícitamente excluidos por diseño, por utilizar cointervenciones, o por no presentar los desenlaces clínicos de interés. Debido a esto, se decidió utilizar los estimadores del efecto reportados en ella, en particular del análisis por subgrupo de alto y moderado riesgo. Se presentan ambos escenarios en la medida de lo posible.

Metanálisis

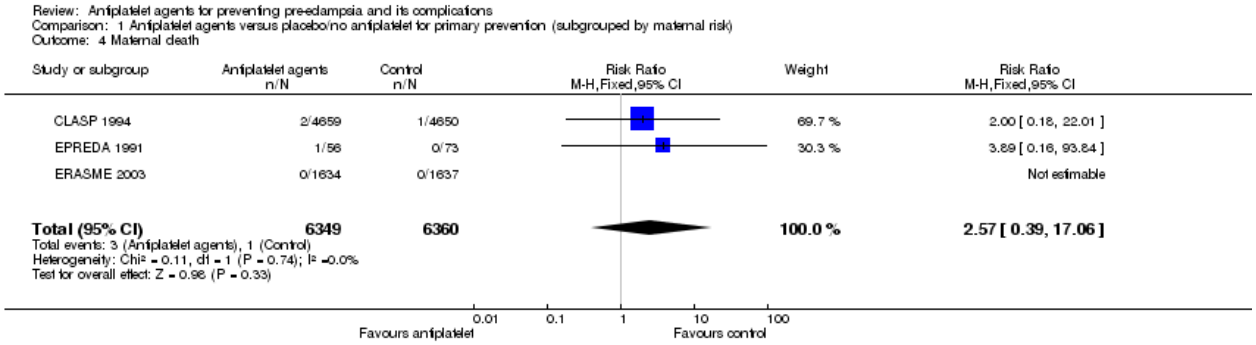
Hipertensión gestacional



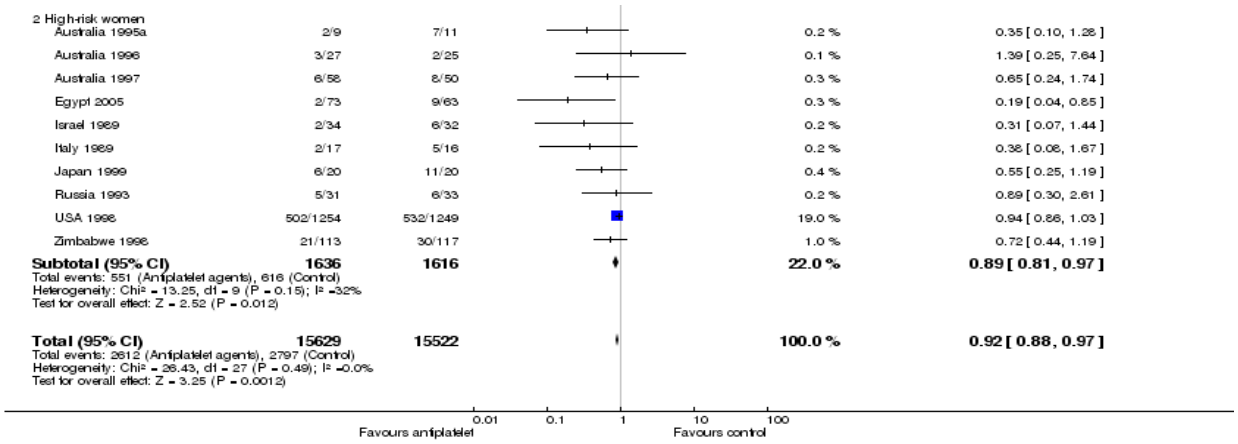
Eclampsia



Mortalidad materna



Parto prematuro



Mortalidad neonatal

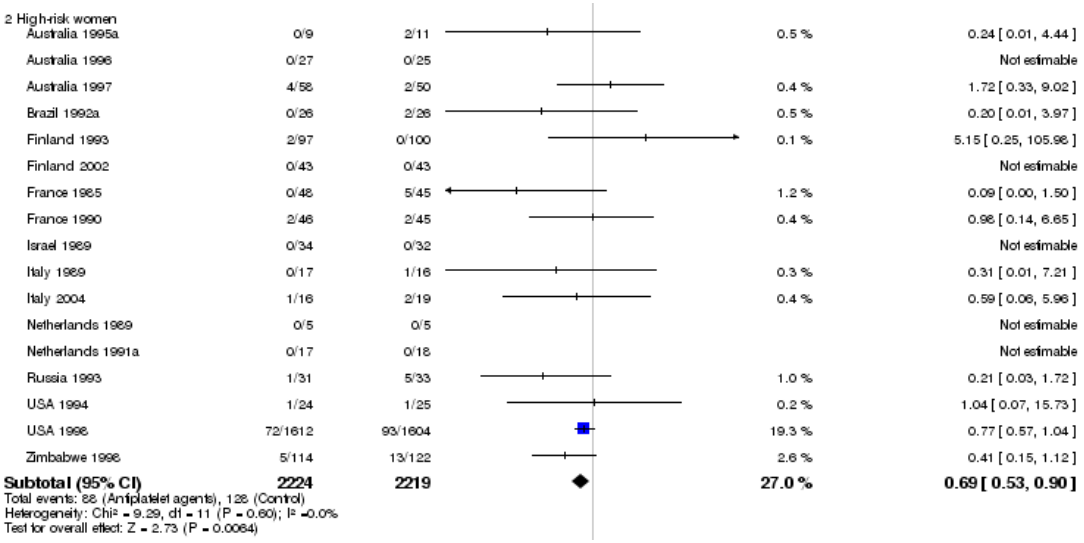


Tabla de Resumen de Resultados (Summary of Findings)

Aspirina precoz en mujeres con alto riesgo de parto prematuro						
Pacientes **Intervención** **Comparación**	Mujeres embarazadas con alto riesgo de parto prematuro Aspirina Placebo					
Desenlaces	**Efecto relativo (IC 95%)**	**Efecto absoluto estimado***			**Certeza de la evidencia (GRADE)**	**Mensajes clave en términos sencillos**
		SIN aspirina	**CON aspirina**	**Diferencia (IC 95%)**		
Hipertensión gestacional	RR 0,54 (0,41 a 0,70) (12 ensayos/ 838 pacientes) [12]	287 por 1000	155 por 1000	Diferencia: 132 pacientes menos por 1000 (169 menos 86 a menos)	⨁⨁⨁⨁[3] Alta	La aspirina disminuye la incidencia de hipertensión gestacional.
Eclampsia	RR 0,94 (0,59 a 1,48) (9 ensayos/ 22584 pacientes) [12]	3 por 1000	3 por 1000	Diferencia: 0 pacientes por 1000 (1 menos a 2 más)	⨁⨁◯◯[1,2,3] Baja	La aspirina podría tener poco o nulo efecto en la incidencia de eclampsia
Mortalidad materna	RR 2,57 (0,39 a 17,06) (3 ensayos/ 12709 pacientes) [12]	0 por 1000	0 por 1000	Diferencia: 0 pacientes por 1000 (0 a 3 más)	⨁⨁⨁◯[1,3] Moderada	El uso de aspirina probablemente no impacta en la mortalidad materna
Parto prematuro (< 37 semanas)	RR 0,89 (0,81 a 0,97) (10 ensayos/ 3252 pacientes) [12]	381 por 1000	339 por 1000	Diferencia: 42 pacientes menos por 1000 (72 menos a11 menos)	⨁⨁⨁⨁[3] Alta	La aspirina disminuye la incidencia de parto prematuro
Mortalidad neonatal y fetal	RR 0,69 (0,53 a 0,90) (17 ensayos/ 4443 pacientes) [12]	58 por 1000	40 por 1000	Diferencia: 18 pacientes menos por 1000 (27 menos a 6 menos)	⨁⨁⨁⨁[3] Alta	La aspirina disminuye la mortalidad neonatal y fetal

IC 95%: Intervalo de confianza del 95%.
RR: Riesgo relativo.
GRADE: grados de evidencia del GRADE *Working Group* (ver más adelante).
*Los riesgos **SIN aspirina** están basados en los riesgos del grupo control en los estudios. El riesgo **CON aspirina** (y su intervalo de confianza) está calculado a partir del efecto relativo (y su intervalo de confianza).
[1] Se disminuyó un nivel de certeza de evidencia por indirecta, ya que el estimador de efecto proviene de la población de cualquier mujer embarazada y no exclusivamente de mujeres de alto riesgo, escenarios que el panel de expertos considera diferentes.
[2] Se disminuyó un nivel de certeza de evidencia por imprecisión ya que a cada extremo del intervalo de confianza pudiese conllevar una decisión diferente.
[3] Se decidió no disminuir certeza de evidencia por riesgo de sesgo, pese a que algunos ensayos presentaban secuencia de aleatorización no clara, ya que la mayoría de los ensayos grandes presentaban menor sesgo.
Fecha de elaboración de la tabla: 8 de Mayo de 2018

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