RECOMENDACIÓN DG.3

BÚSQUEDA Y SÍNTESIS DE EVIDENCIA DE EFECTOS DESEABLES E INDESEABLES

Guía de Práctica Clínica de Cáncer de Pulmón - 2018

A. PREGUNTA CLÍNICA

En personas mayores de 15 años con diagnóstico de cáncer pulmonar aparentemente localizado según resultados de biopsia ¿Se debe realizar PET/CT para la etapificación del compromiso mediastínico en comparación con no realizarlo?

Análisis y definición de los componentes de la pregunta en formato PICO

Población: Personas mayores de 15 años con diagnóstico de cáncer pulmonar aparentemente localizado según resultados de biopsia.
Intervención: realizar PET/CT para etapificación del compromiso mediastínico.
Comparación: No realizar.
Desenlace (outcome): Mortalidad, sensibilidad, especificidad, likelihood ratio.

B. BÚSQUEDA DE EVIDENCIA

Se realizó una búsqueda general de revisiones sistemáticas asociadas al tema de "Lung cancer". 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; PsyclNFO; 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.[1]

Seleccionadas las revisiones sistemáticas o estudios primarios asociadas a la temática, se clasificaron en función de las potenciales preguntas a las que daban respuesta. Al momento de definir la pregunta la evidencia ya se encontraba previamente clasificada según intervenciones comparadas. Los resultados se encuentran alojados en la plataforma Living Overview of the Evidence (L·OVE), sistema que permite la actualización periódica de la evidencia.

[1] Para revisar la metodología, las estrategias y los resultados de la búsqueda, favor revisar el informe "*Búsqueda sistemática de evidencia de los efectos deseables e indeseables*" en la sección de método de la Guía de Práctica Clínica respectiva.

C. SÍNTESIS DE EVIDENCIA

Resumen de la evidencia identificada

En las preguntas que comparan diagnósticos, el equipo metodológico consideró necesario distinguir dos enfoques para abordar su respuesta: *impacto diagnóstico* y *exactitud diagnóstica*. Se estableció priorizar estudios que evaluarán el *impacto diagnóstico del test*, es decir aquellos que comparan los resultados en salud de los pacientes diagnosticados/tratados en función a un test versus los resultados de pacientes diagnosticados/tratados en función a otro test. En caso de no encontrar este tipo de estudios, se utilizarían estudios que evaluaran la *exactitud diagnóstica del test*, es decir aquellos que evalúan qué tan bien el test clasifica a los pacientes respecto a si tienen o no una condición.[2]

En este caso, no se identificaron estudios de impacto diagnóstico, por lo cual se amplió la búsqueda a exactitud diagnóstica del test, identificando 6 revisiones sistemáticas que incluyen 70 [7-76] estudios primarios, de los cuales 2 corresponden a ensayos aleatorizados [7-8]. Para más detalle ver "*Matriz de evidencia*"[3], en el siguiente enlace: PET/CT para la evaluación del compromiso de linfonodos mediastínicos en cáncer pulmonar no células pequeñas potencialmente resecable

Tabla 1: Resumen de la evidencia seleccionada

Revisión Sistemática	6 [1-6]
Estudios primarios	2 [7-8] ensayos aleatorizados y 68 observacionales [9-76]

Estimador del efecto

Se realizó un análisis de la matriz de evidencia, identificándose que una revisión sistemática [3] que incluye todos los estudios primarios relevantes [9-76]. Si bien no contiene todos los ensayos, la adición de los estudios nuevos no lleva a modificación sustantiva del estimador del efecto, por lo que se decidió reutilizar sus metanálisis para construir la tabla resumen de resultados, que incluía 18 de los estudios primarios identificados [9, 11, 14, 16, 20, 22, 23, 33, 35, 36, 48, 51, 52, 53, 58, 63, 66, 75].

[2] Schünemann HJ, Schünemann AHJ, Oxman AD, Brozek J, Glasziou P, Jaeschke R, et al. Grading quality of evidence and strength of recommendations for diagnostic tests and strategies. BMJ [Internet]. 2008 May 17 [cited 2018 Aug 1];336(7653):1106–10.

[3] **Matriz de Evidencia**, tabla dinámica que grafica el conjunto de evidencia existente para una pregunta (en este caso, la pregunta del presente informe). Las filas representan las revisiones sistemáticas y las columnas los estudios primarios que estas revisiones han identificado. Los recuadros en verde corresponden a los estudios incluidos en cada revisión. La matriz se actualiza periódicamente, incorporando nuevas revisiones sistemáticas pertinentes y los respectivos estudios primarios.

Metanálisis

Exactitud diagnóstica

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)
Plathow 2008	38	0	0	14	1.00 [0.91, 1.00]	1.00 [0.77, 1.00]
Chen 2010	31	1	0	24	1.00 [0.89, 1.00]	0.96 [0.80, 1.00]
Toba 2010	8	4	0	30	1.00 [0.63, 1.00]	0.88 [0.73, 0.97]
De Wever 2007	10	6	1	33	0.91 [0.59, 1.00]	0.85 [0.69, 0.94]
Tasci 2010	17	19	2	89	0.89 [0.67, 0.99]	0.82 [0.74, 0.89]
Lee 2007	24	19	4	79	0.86 [0.67, 0.96]	0.81 [0.71, 0.88]
Yang 2010	5	3	1	22	0.83 [0.36, 1.00]	0.88 [0.69, 0.97]
Lee 2009a	29	40	7	106	0.81 [0.64, 0.92]	0.73 [0.65, 0.80]
Yang 2008	18	11	7	86	0.72 [0.51, 0.88]	0.89 [0.81, 0.94]
Gunluoglu 2011	35	30	14	89	0.71 [0.57, 0.83]	0.75 [0.66, 0.82]
Li 2012a	13	0	6	61	0.68 [0.43, 0.87]	1.00 [0.94, 1.00]
Yi 2008	28	6	17	99	0.62 [0.47, 0.76]	0.94 [0.88, 0.98]
Jeon 2010	32	8	20	150	0.62 [0.47, 0.75]	0.95 [0.90, 0.98]
Kim 2007	110	21	70	473	0.61 [0.54, 0.68]	0.96 [0.94, 0.97]
Kuo 2012	10	17	9	66	0.53 [0.29, 0.76]	0.80 [0.69, 0.88]
Harders 2012	15	22	15	62	0.50 [0.31, 0.69]	0.74 [0.63, 0.83]
Shin 2008	11	8	12	153	0.48 [0.27, 0.69]	0.95 [0.90, 0.98]
Bille 2013	28	13	32	280	0.47 [0.34, 0.60]	0.96 [0.93, 0.98]

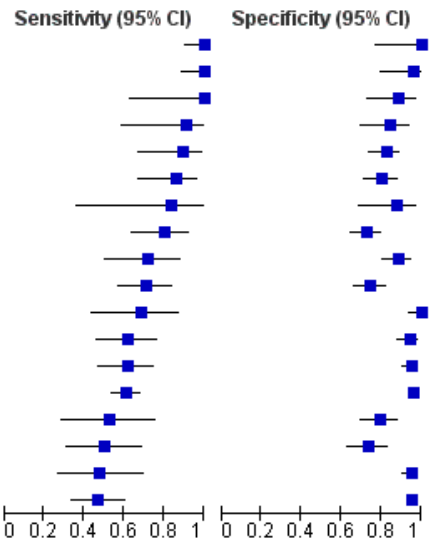

Tabla de Resumen de Resultados (Summary of Findings)

PET/CT PARA ETAPIFICACIÓN DEL COMPROMISO MEDIASTÍNICO EN CÁNCER DE PULMÓN.			
Pacientes	Personas mayores de 15 años con diagnóstico de cáncer pulmonar aparentemente localizado según resultados de biopsia.		
Test	PET/CT para etapificación del compromiso mediastínico.		
Comparación	No realizar PET/CT		
Impacto diagnóstico			
Desenlaces	**Efecto**		
Morbilidad o mortalidad	No se identificaron estudios evaluando el impacto del test, por lo que el desenlace se estimó este en base a su exactitud diagnóstica, y de las consecuencias esperadas a partir de cada resultado.		
Exactitud diagnóstica			
Gold standard	Biopsia		
Desenlaces	Efecto por 1000 pacientes testeados (IC 95%) Prevalencia hipotética 30%*	**Certeza de la evidencia (GRADE)****	**Mensajes clave en términos sencillos**
Sensibilidad: 77,4% (IC 95% de 65,3 a 86,1%) Especificidad: 90,1% (IC 95% de 85,3 a 93,5%) LR (+): 7,82 (IC 95% de 6,72 a 9,10) LR (-): 0,25 (IC 95% de 0,22 a 0,29) 2328 pacientes (18 estudios [9, 11, 14, 16, 20, 22, 23, 33, 35, 36, 48, 51, 52, 53, 58, 63, 66, 75]) Población compuesta de 300 pacientes con compromiso mediastínico y 700 personas sin compromiso mediastínico*.			
Compromiso mediastínico correctamente detectado (verdaderos positivos)	232 (196 a 258)	⨁⨁◯◯[1,2,3] Baja	La etapificación mediastínica mediante PET/CT podría diagnosticar correctamente a 232 de 300 pacientes con compromiso mediastínico, pero la certeza de la evidencia es baja.
Compromiso mediastínico correctamente descartado (verdaderos negativos)	631 (597 a 655)	⨁⨁◯◯[1,2,3] Baja	La etapificación mediastínica mediante PET/CT podría descartar correctamente a 631 de 700 pacientes sin compromiso mediastínico, pero la certeza de la evidencia es baja.
Metástasis mediastínica incorrectamente detectada (falsos positivos)	69 (45 a 103)	⨁⨁◯◯[1,2,3] Baja	La etapificación mediastínica mediante PET/CT podría clasificar equivocadamente a 69 de 700 pacientes sin compromiso mediastínico, pero la certeza de la evidencia es baja.
Metástasis mediastínica incorrectamente descartada (falsos negativos)	68 (42 a 104)	⨁⨁◯◯[1,2,3] Baja	La etapificación mediastínica mediante PET/CT podría no detectar a 68 de 300 pacientes con compromiso mediastínico, pero la certeza de la evidencia es baja.

IC: Intervalo de confianza del 95%.
GRADE: grados de evidencia del GRADE Working Group.
*La prevalencia corresponde al promedio aproximado de prevalencia de los estudios (679/2328).
** Certeza de exactitud diagnóstica.
[1] Se decidió no disminuir la certeza de la evidencia por inconsistencia, ya que existen razones clínicas que la justifican (Diferentes estadíos clínicos o tipo histológico).
[2] Se disminuyó un nivel de certeza de evidencia por riesgo de sesgo, ya que la selección de pacientes en 11 estudios [9, 14, 16, 23, 33, 35, 48, 58, 63, 66, 75] era dudosa, en seis estudios no estaba claro si la interpretación del test fue ciega del gold standard [16, 23, 48, 58, 66, 75], en un estudio no está claro si el gold standard fue aplicado a todos los pacientes [75] y en 7 estudios [11, 16, 35, 52, 53, 63, 75] el seguimiento era insuficiente.
[3] Se disminuyó un nivel de certeza por imprecisión debido al intervalo de confianza amplio.
Fecha de elaboración de la tabla: Agosto, 2018

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