RECOMENDACIÓN 4

BÚSQUEDA Y SÍNTESIS DE EVIDENCIA DE EFECTOS DESEABLES E INDESEABLES

Guía de Práctica Clínica infarto agudo al miocardio con supradesnivel del segmento ST - 2018

A. PREGUNTA CLÍNICA

En personas con infarto agudo al miocardio con supradesnivel del segmento ST (SDST) reciente en post tratamiento que reciben prevención secundaria habitual ¿Se debe realizar rehabilitación cardíaca en comparación a no realizar?

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

Población: Personas con infarto agudo al miocardio con supradesnivel del segmento ST (SDST) reciente en post tratamiento que reciben prevención secundaria habitual.
Intervención: Rehabilitación cardíaca.
Comparación: No realizar rehabilitación.
Desenlace (outcome): Mortalidad, ingresos hospitalarios, infarto agudo al miocardio

B. BÚSQUEDA DE EVIDENCIA

Se realizó una búsqueda general de revisiones sistemáticas asociadas al tema de "Acute coronary syndrome". 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

Se identificaron 4 revisiones sistemáticas que incluyen 83 estudios primarios, de los cuales todos corresponden a ensayos aleatorizados. Para más detalle ver "*Matriz de evidencia*"[2], en el siguiente enlace: Rehabilitación cardiaca para la enfermedad coronaria.

Tabla 1: Resumen de la evidencia seleccionada

Revisión Sistemática	4 [1 - 4]
Estudios primarios	83 [5 - 87]

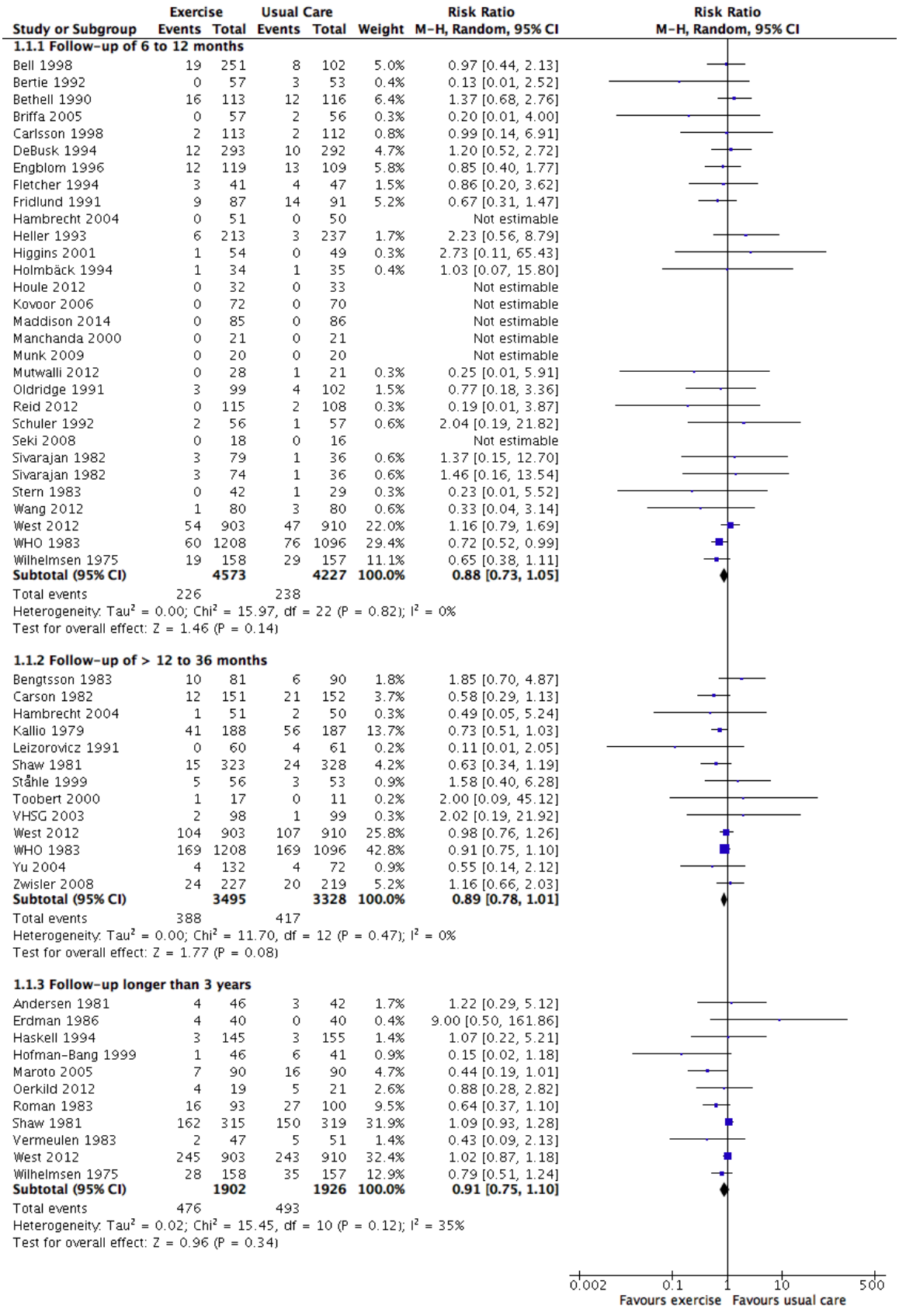
Estimador del efecto

Se realizó un análisis de la matriz de evidencia, identificando una revisión sistemática que incluye la mayoría de los ensayos [3]. Sin embargo, la inclusión de estos probablemente no modifica la estimación del efecto y es complejo replicar los criterios de inclusión debido a la diversidad de intervenciones que pueden considerarse o no rehabilitación cardiaca. Debido a esto, se decidió utilizar la definición dada por la revisión sistemática Cochrane, reutilizando sus metanálisis para la construcción de tabla de resumen de resultados.

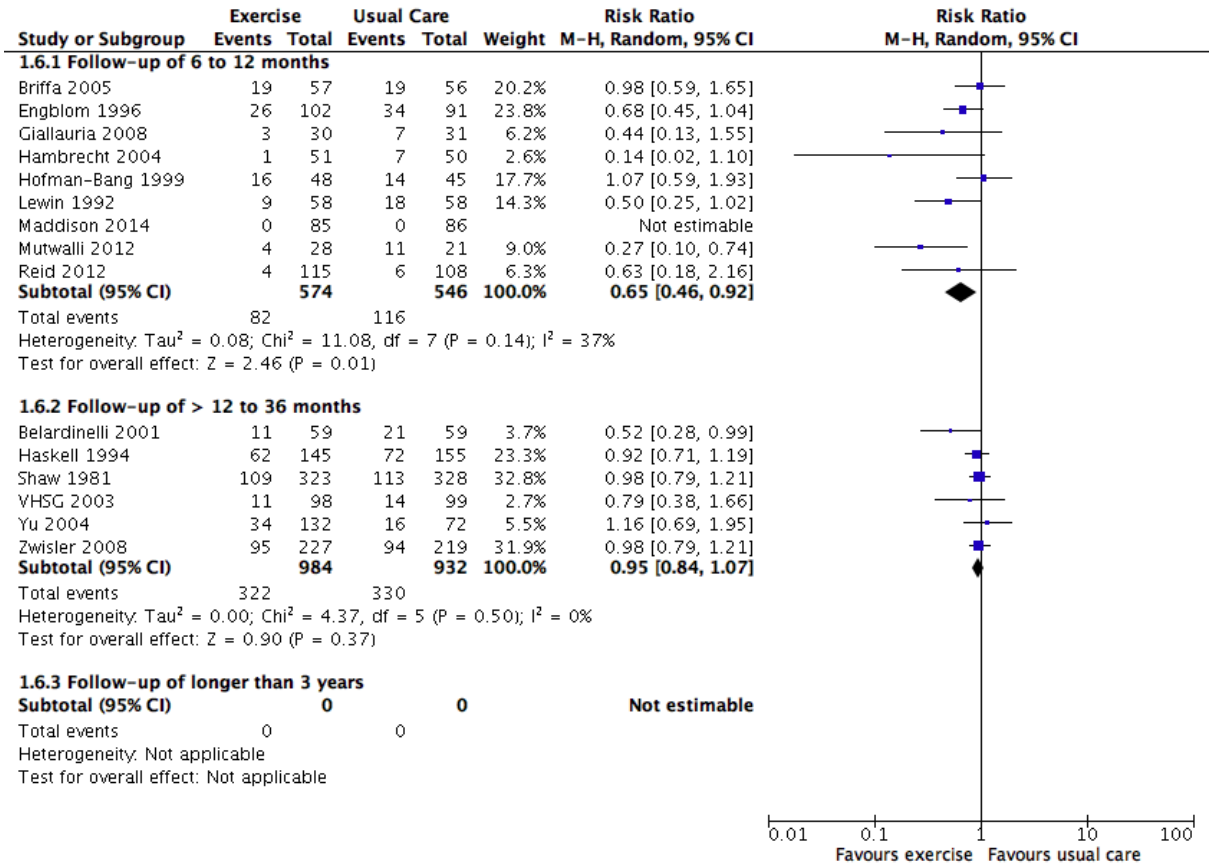
[2] **Matriz de Evidencia**, tabla dinámica que grafica el conjunto de evidencia existente para una pregunta (en este caso, la pregunta del presente informe). Las filas representan las revisiones sistemáticas y las columnas los estudios primarios que estas revisiones han identificado. Los recuadros en 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

Mortalidad



Ingresos hospitalarios



Infarto agudo al miocardio

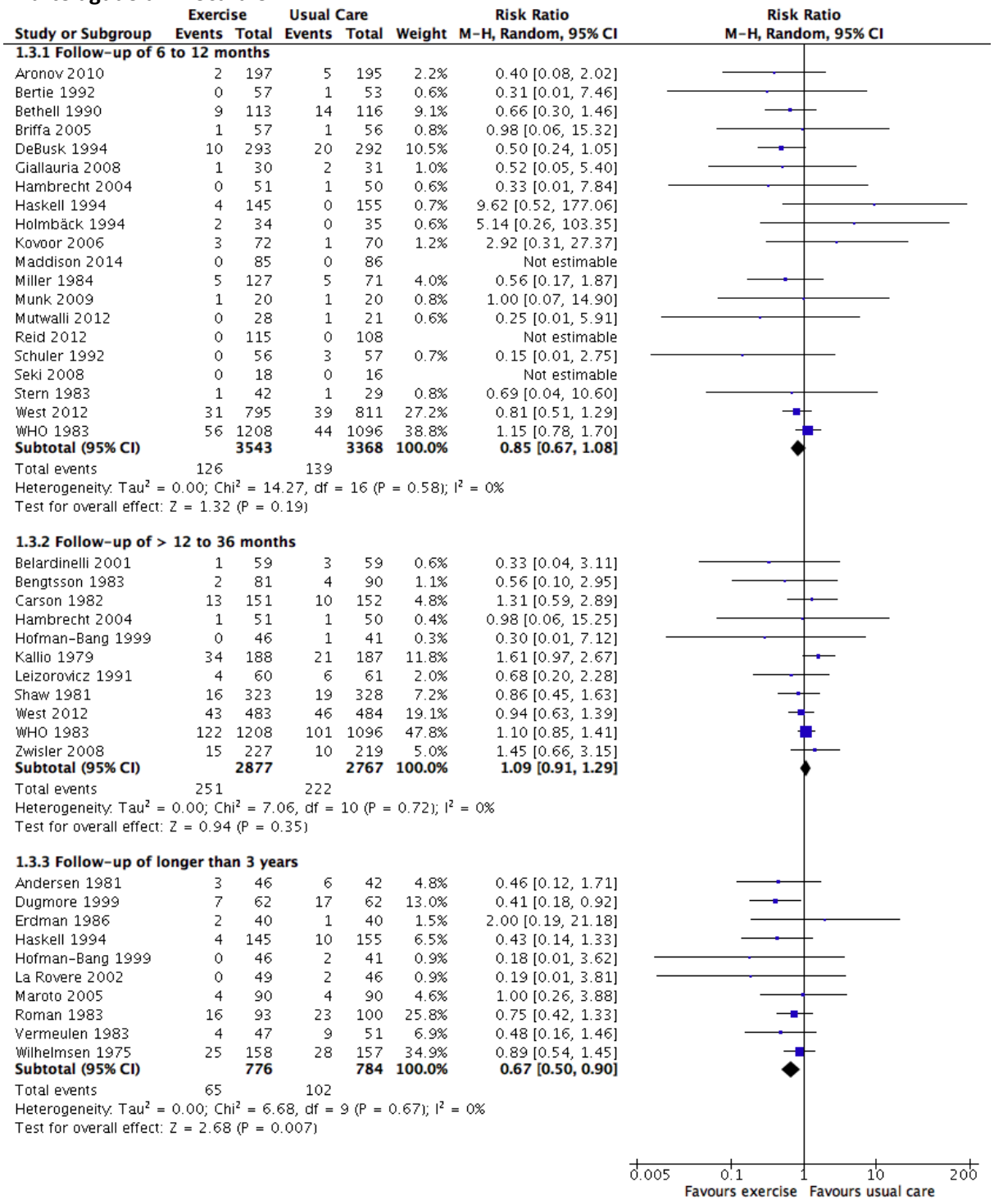


Tabla de Resumen de Resultados (Summary of Findings)

REHABILITACIÓN CARDIACA PARA LA ENFERMEDAD CORONARIA.						
Población	Personas con infarto agudo al miocardio con supradesnivel del segmento ST (SDST) reciente en post tratamiento que reciben prevención secundaria habitual.					
Intervención	Rehabilitación cardíaca.					
Comparación	No realizar rehabilitación.					
Desenlaces	**Efecto relativo (IC 95%) -- Estudios/ pacientes**	**Efecto absoluto estimado***			**Certeza de la evidencia (GRADE)**	**Mensajes clave en términos sencillos**
		SIN rehabilitación cardiaca	**CON Rehabilitación cardiaca**	**Diferencia (IC 95%)**		
Mortalidad (seguimiento de 12 a 36 meses)	RR 0,89 (0,78 a 1,01) -- 13 ensayos/ 5644 pacientes de una revisión sistemática [3]	125 por 1000	112 por 1000	Diferencia: 13 menos (28 menos a 1 más)	⨁⨁◯◯[1,2,3] Baja	La rehabilitación cardiaca podría disminuir la mortalidad, pero la certeza de la evidencia es baja.
Hospitalizaciones (seguimiento de 12 a 36 meses)	RR 0,95 (0,84 a 1,07) -- 6 ensayos/ 1855 pacientes de una revisión sistemática [3]	354 por 1000	336 por 1000	Diferencia: 18 menos (57 menos a 25 más)	⨁⨁◯◯[1,2] Baja	Rehabilitación cardiaca podría disminuir las hospitalizaciones, pero la certeza de la evidencia es baja.
Infarto agudo al miocardio (seguimiento de 12 a 36 meses)	RR 1,09 (0,91 a 1,29) -- 11 ensayos/ 2989 pacientes de una revisión sistemática [3]	80 por 1000	87 por 1000	Diferencia: 7 más (65 menos a 23 más)	⨁⨁◯◯[1,2] Baja	Rehabilitación cardiaca podría aumentar los infartos agudos al miocardio, pero la certeza de la evidencia es baja.

IC 95%: Intervalo de confianza del 95% // RR: Riesgo relativo // GRADE: Grados de evidencia Grading of Recommendations Assessment, Development and Evaluation.

* El **riesgo no realizar rehabilitación** está basado en el riesgo del grupo control en los estudios. El **riesgo rehabilitación cardíaca** (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 riesgo de sesgo ya que en la mayoría de los ensayos incluidos no está clara la generación de secuencia de aleatorización y ocultamiento de ésta. Además, el ensayo no fue ciego.

[2] Se disminuyó un nivel de certeza de la evidencia por imprecisión puesto que a ambos extremos del estimador puntual se tomarían diferentes decisiones.

Fecha de elaboración de la tabla: Diciembre, 2018.

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