RECOMENDACIÓN 5

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 post tratamiento de infarto agudo al miocardio con supradesnivel del segmento ST (SDST) en fase II, ¿se debe realizar rehabilitación cardiaca de duración prolongada (≥ 20 sesiones) en comparación a realizar rehabilitación cardiaca de duración moderada (<20 sesiones)?.

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

Población: Personas en post tratamiento de infarto agudo al miocardio con supradesnivel del segmento ST (SDST) en fase II.
Intervención: Rehabilitación cardiaca de duración prolongada (≥ 20 sesiones).
Comparación: Rehabilitación cardiaca de duración moderada (<20 sesiones).
Desenlace (outcome): Mortalidad

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 que no hay estudios que comparen diferentes duraciones de la rehabilitación cardiaca. Sin embargo, una revisión sistemática [3] realizó un análisis por subgrupo para evaluar este ámbito de la pregunta, por lo que se decidió utilizar este análisis para la construcción de tabla de resumen de resultados.

Metanálisis

No aplica

[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.

Tabla de Resumen de Resultados (Summary of Findings)

REHABILITACIÓN CARDIACA DE DURACIÓN PROLONGADA COMPARADO CON DURACIÓN MODERADA PARA INFARTO AGUDO AL MIOCARDIO			
Población	Personas en post tratamiento de infarto agudo al miocardio con supradesnivel del segmento ST (SDST) en fase II		
Intervención	Rehabilitación cardiaca de duración prolongada (≥ 20 sesiones)		
Comparación	Rehabilitación cardiaca de duración moderada (<20 sesiones)		
Desenlaces	**Efecto**	**Certeza de la evidencia (GRADE)**	**Mensajes clave en términos sencillos**
Mortalidad	No se identificaron ensayos evaluando directamente duración de rehabilitación cardiaca diferente. Sin embargo, en el análisis de subgrupo de una revisión sistemática [3] no se observaron diferencias al analizar por esta variable (Test de interacción p = 0,74)	⊕◯◯◯[1,2,3] Muy baja	Rehabilitación cardiaca prolongada comparado con duración moderada podría tener poco o nulo impacto en mortalidad. Sin embargo, existe considerable incertidumbre dado que la certeza de la evidencia es muy baja.
Hospitalización	No se identificaron ensayos evaluando directamente duración de rehabilitación cardiaca diferente. Sin embargo, en el análisis de subgrupo de una revisión sistemática [3] no se observaron diferencias al analizar por esta variable (Test de interacción p = 1,00)	⊕◯◯◯[1,2,3] Muy baja	Rehabilitación cardiaca prolongada comparado con duración moderada podría tener poco o nulo impacto en hospitalización. Sin embargo, existe considerable incertidumbre dado que la certeza de la evidencia es muy baja.

IC 95%: Intervalo de confianza del 95% //RR: Riesgo relativo.
GRADE: Grados de evidencia Grading of Recommendations Assessment, Development and Evaluation.
*Metarregresión de 47 estudios en una revisión sistemática [3]
[1] Se disminuyó la certeza en un nivel por constituir evidencia indirecta, ya que proviene de un análisis de subgrupos y no de estudios comparativos directos.
[2] Se disminuyó un nivel de certeza de evidencia por riesgo de sesgo, ya que 9 ensayos no estaba clara la generación de secuencia de aleatorización ni ocultamiento de ésta [5, 6, 8, 15, 17, 21-22, 25-26]. Además, 13 ensayos no fueron ciegos o no estaba descrito [5-7, 15, 17-18, 21-26].
[3] Se disminuyó un nivel de certeza de la evidencia por imprecisión, ya que en el estimador original, a ambos extremos del estimador puntual se tomarían diferentes decisiones.
Fecha de elaboración de la tabla: Octubre, 2018.

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