

## RECOMENDACIÓN T2

### BÚSQUEDA Y SÍNTESIS DE EVIDENCIA DE EFECTOS DESEABLES E INDESEABLES

#### Guía de Práctica Clínica Ataque cerebrovascular - 2018

##### A. PREGUNTA CLÍNICA

En personas con diagnóstico de ataque cerebrovascular (ACV) isquémico, ¿Se debe realizar trombolisis asistida neurólogo a través de telemedicina en comparación a realizar trombolisis por neurólogo presencial?

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

**Población:** Personas con diagnóstico de ataque cerebrovascular (ACV) isquémico.

**Intervención:** Realizar trombolisis asistida neurólogo a través de telemedicina.

**Comparación:** Realizar trombolisis por neurólogo.

**Desenlace (outcome):** Mortalidad, hemorragia intracraneal.

##### B. BÚSQUEDA DE EVIDENCIA

Se realizó una búsqueda general de revisiones sistemáticas asociadas al tema de “Stroke”. 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; PsycINFO; 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.<sup>1</sup>

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.

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<sup>1</sup> 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 20 revisiones sistemáticas que incluyen 157 estudios primarios, de los cuales 17 corresponden a ensayos aleatorizados. Para más detalle ver “*Matriz de evidencia*”<sup>2</sup>, en el siguiente enlace: [Telemedicina para el manejo del accidente cerebrovascular agudo](#).

Tabla 1: Resumen de la evidencia seleccionada

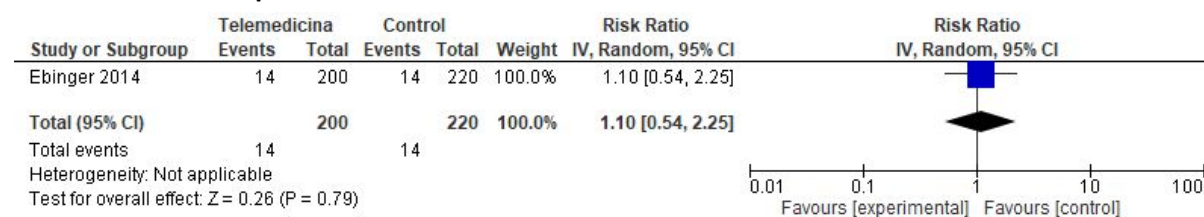
Revisión Sistemática	20 [1-20]
Estudios primarios	17 ensayos aleatorizados [21-37], 140 observacionales [38-177]

### Estimador del efecto

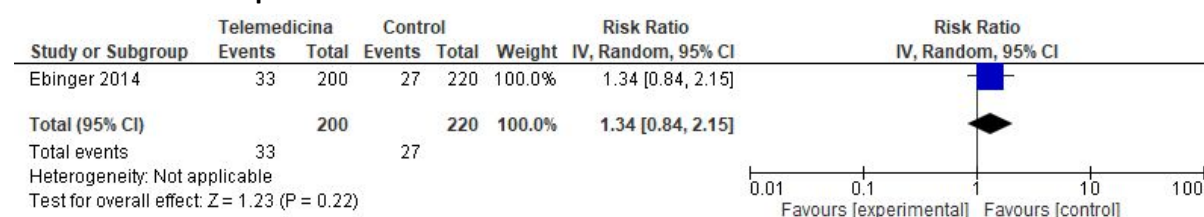
Se realizó un análisis de la matriz de evidencia, decidiendo excluir 3 ensayos ya que utilizan la telemedicina con fines del diagnóstico [34, 36, 37], y 12 ensayos ya que evalúan la rehabilitación después del evento [21-23, 25-28, 30-33, 35]. Finalmente, 2 ensayos fueron relevantes para la pregunta [24, 29], observándose que ninguna revisión sistemática presentó los datos suficientes para construir la tabla de resultados, por lo que se decidió extraerlos directamente de sus estudios primarios [24, 29]. Se realizó un análisis de los estudios observacionales, los cuales llegan a similares estimadores de efecto.

### Metanálisis

#### Mortalidad intrahospitalaria

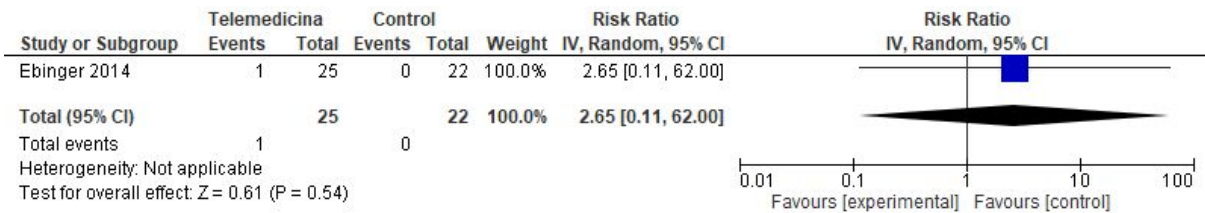


#### Mortalidad intrahospitalaria

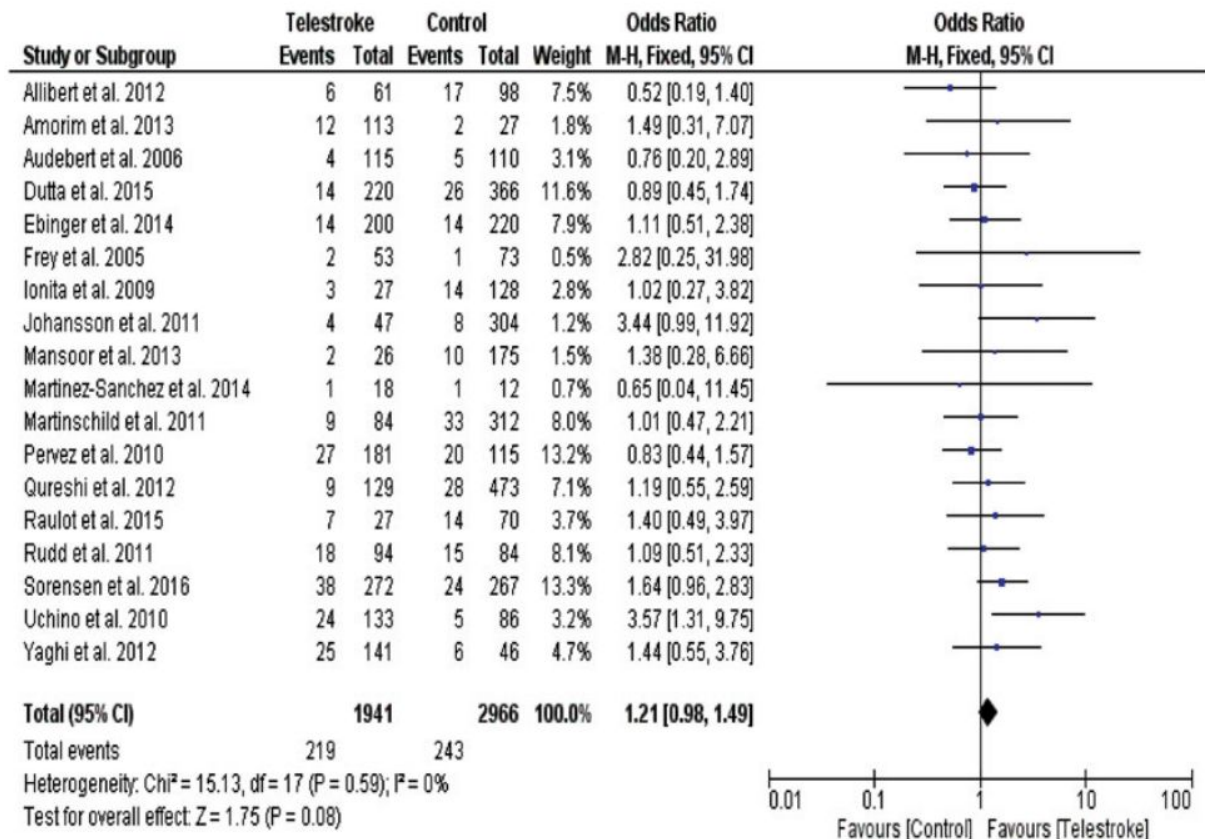


<sup>2</sup> **Matriz de Evidencia**, tabla dinámica que grafica el conjunto de evidencia existente para una pregunta (en este caso, la pregunta del presente informe). Las filas representan las revisiones sistemáticas y las columnas los estudios primarios que estas revisiones han identificado. Los recuadros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

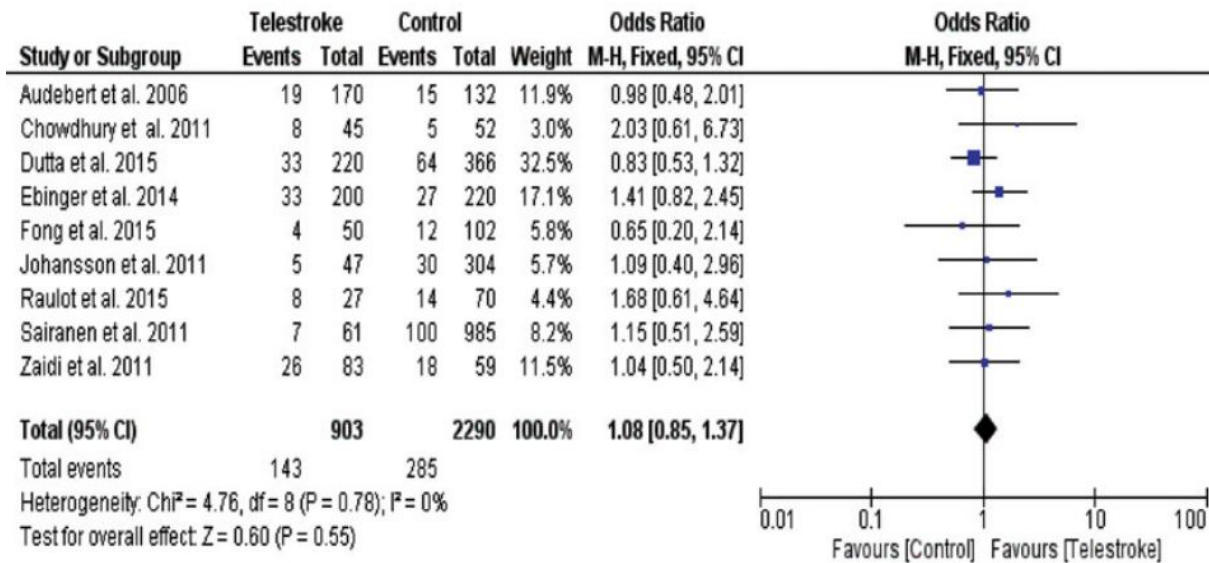
## Hemorragia intracraneal



## Mortalidad intrahospitalaria a partir de estudios observacionales



### Mortalidad a los 90 días a partir de estudios observacionales



**Tabla de Resumen de Resultados (Summary of Findings)**

REALIZAR TROMBOLISIS ASISTIDA NEURÓLOGO A TRAVÉS DE TELEMEDICINA COMPARADO CON REALIZAR TROMBOLISIS NO ASISTIDA NEURÓLOGO A TRAVÉS DE TELEMEDICINA PARA PERSONAS CON DIAGNÓSTICO DE ATAQUE CEREBROVASCULAR ISQUÉMICO.						
Población	Personas con diagnóstico de ataque cerebrovascular (ACV) isquémico.					
Intervención	Realizar trombolisis asistida neurólogo a través de telemedicina.					
Comparación	Realizar trombolisis por neurólogo presencial.					
Desenlaces	Efecto relativo (IC 95%) -- Estudios/ pacientes	Efecto absoluto estimado*			Certeza de la evidencia (GRADE)	Mensajes clave en términos sencillos
		SIN telemedicina	CON telemedicina	Diferencia (IC 95%)		
Mortalidad intrahospitalaria	RR 1,10 (0,54 a 2,25) -- 1 ensayo/ 420 pacientes [24]	64 por 1000	70 por 1000	Diferencia: 6 más (29 menos a 80 más)	⊕⊕○○ <sup>1,2</sup> Baja	Realizar trombolisis asistida por neurólogo a través de telemedicina podría aumentar la mortalidad intrahospitalaria, pero la certeza de la evidencia es baja.
Mortalidad a los 90 días	RR 1,34 (0,84 a 2,15) -- 1 ensayo/ 420 pacientes [24]	123 por 1000	164 por 1000	Diferencia: 41 más (20 menos a 141 más)	⊕⊕○○ <sup>1,2</sup> Baja	Realizar trombolisis asistida por neurólogo a través de telemedicina podría aumentar la mortalidad a los 90 días, pero la certeza de la evidencia es baja.
Mortalidad a partir de estudios observacionales	Se estimó el efecto a partir de estudios observacionales, concluyendo para mortalidad intrahospitalaria un OR 1,21 (0,98 a 1,49) I <sup>2</sup> : 0% basado en 4907 pacientes y para mortalidad a los 90 días un OR de 1,08 (0,85 a 1,37) I <sup>2</sup> : 0% basado en 3193 pacientes.				⊕○○○ <sup>2,3</sup> Muy baja	--
Hemorragia intracraneal	RR 2,65 (0,11 a 62,00) -- 1 ensayo/ 420 pacientes [24]	1 por 1000	1 por 1000	Diferencia: 0 (0 a 31 más)	⊕○○○ <sup>1,2</sup> Muy baja	Realizar trombolisis asistida por neurólogo a través de telemedicina podría tener poco impacto en hemorragia intracraneal. 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.  
 \* El **riesgo SIN telemedicina** está basado en el riesgo del grupo control en los estudios. El **riesgo CON telemedicina** (y su intervalo de confianza) está calculado a partir del efecto relativo (y su intervalo de confianza).  
<sup>1</sup> Se disminuyó un nivel de certeza de evidencia por riesgo de sesgo, ya que el ensayo no estaba clara la generación de secuencia de aleatorización ni ocultamiento de ésta. Además, el ensayo no fue ciego.  
<sup>2</sup> Se disminuyó un nivel de certeza de evidencia por imprecisión, ya que cada extremo del intervalo de confianza conlleva una decisión diferente. En el caso de hemorragia intracraneal se decidió disminuir dos, ya que adicionalmente el evento fue poco frecuente en ambos grupos e intervalo de confianza muy amplio.  
<sup>3</sup> Diseño observacional.  
**Fecha de elaboración de la tabla:** Octubre, 2018.

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