signs, and an assessment of foot deformity were evaluated.

Patients with an abnormal monofilament test result (n=16) developed ulcers at a higher rate than patients with a normal monofilament test result (n=370) (87.5% vs 22%; P<.001).³

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Is there a benefit from antiplatelet therapy for preeclampsia prophylaxis in patients at risk for developing preeclampsia?

Evidence-Based Answer
The use of low-dose aspirin in the late first or early second trimester in women at high risk for preeclampsia reduces the incidence of preeclampsia, preterm birth, and intrauterine growth restriction (SOR: B, systematic reviews of RCTs at risk of bias).

A 2014 systematic review and meta-analysis of 21 RCTs (N=24,666) investigated aspirin prophylaxis during pregnancy for women at high risk of preeclampsia.¹ Each woman’s risk of preeclampsia was defined as high (previous preeclampsia, chronic or gestational diabetes, chronic hypertension, renal disease, autoimmune diseases, or multiple gestation) or moderate (primigravid, advanced maternal age [≥35 years], pregnancy interval ≥10 years, pre-pregnancy BMI ≥35 kg/m², or preeclampsia in a first-degree relative). Most of the trials used an aspirin dose of 60 or 100 mg, but doses ranged from 0.5 mg/kg to 150 mg daily. Most trials started aspirin at 12 to 16 weeks’ gestational age and discontinued aspirin at delivery, but some stopped aspirin at 35 weeks’ gestational age or once preeclampsia developed.

Low-dose aspirin reduced the incidence of preeclampsia, preterm birth, and intrauterine growth restriction (IUGR) compared with placebo (see TABLE). No statistically significant differences were noted in perinatal mortality, placental abruption, postpartum hemorrhage, or neonatal intracranial hemorrhage. The optimal dose of aspirin was not identified because secondary comparisons between different doses were underpowered. There was evidence of small-study effects, based on funnel plot asymmetry, in the preterm birth and IUGR outcomes, which means that future results could reduce the estimated benefit.¹

The 2014 US Preventive Services Task Force statement on prevention of preeclampsia recommended the use of low-dose aspirin (81 mg/d) after 12 weeks of gestation in women who are at high risk for preeclampsia (Grade B, moderate certainty of substantial net benefit).²

The 2013 task force recommendation from the American College of Obstetricians and Gynecologists recommended initiating daily low-dose (60–80 mg) aspirin in the late first trimester for women with a medical history of early-onset preeclampsia and preterm delivery or preeclampsia in more than 1 pregnancy (Quality of Evidence: Moderate Strength of Recommendation: Qualified).³

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<table>
<thead>
<tr>
<th>Outcome</th>
<th>Trials</th>
<th>N</th>
<th>RR</th>
<th>95% CI</th>
<th>RD</th>
<th>NNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preeclampsia</td>
<td>13</td>
<td>12,184</td>
<td>0.76</td>
<td>0.62–0.95</td>
<td>–1.9%</td>
<td>53</td>
</tr>
<tr>
<td>Preterm birth</td>
<td>10</td>
<td>11,779</td>
<td>0.86</td>
<td>0.76–0.98</td>
<td>–2.7%</td>
<td>38</td>
</tr>
<tr>
<td>IUGR</td>
<td>13</td>
<td>12,504</td>
<td>0.80</td>
<td>0.65–0.99</td>
<td>–0.9%</td>
<td>111</td>
</tr>
</tbody>
</table>

IUGR=intrauterine growth restriction; NNT=number needed to treat; RD=risk difference; RR=relative risk.