risk of preterm delivery by 8% (RR=0.92; 95% CI, 0.87–0.97), neonatal death by 14% (RR=0.87; 95% CI, 0.76–0.99), and SGA infants by 10% (RR=0.90; 95% CI, 0.83–0.98).  

Another 2007 meta-analysis involving 31 RCTs of preeclampsia (32,217 women, of which 29,068 [90%] had at least 1 risk factor) revealed that women who received LDA had a 10% reduction in the risk of preeclampsia (RR=0.90; 95% CI, 0.85–0.97). For the main outcome of preeclampsia, no pre-specified subgroups (preexisting renal disease, diabetes mellitus, hypertension, previous SGA, maternal age, singleton or multiple pregnancy, or previous preeclampsia) benefited more or less from use of LDA. In this review, LDA dosing ranged between 50 and 150 mg; however, no evidence suggested that using more than 75 mg aspirin conferred a greater effect. Initiating aspirin therapy before 20 weeks’ gestation was no more or less beneficial than starting later in pregnancy.

A third meta-analysis identified 14 trials with a total of 12,416 women with historical risk factors that placed them at increased risk of developing preeclampsia. Preeclampsia was reduced by 14% over placebo (RR=0.86; 95% CI, 0.79–0.96). There was no evidence of clinical harm from LDA, including placental abruption, postpartum hemorrhage, fetal intraventricular hemorrhage, and other neonatal bleeding complications.

The 2002 American College of Obstetricians and Gynecologists Practice Bulletin makes no specific recommendation for the use of LDA for prevention of preeclampsia in women at increased risk. They do not recommend LDA therapy in low-risk women.

What is the most effective treatment for adjustment disorder with depressed mood?

Evidence-Based Answer

At present, evidence is insufficient regarding the most effective treatment for this condition. Timely treatment with an antidepressant medication, with or without psychotherapy, is associated with symptom improvement. (SOR B, based on a cohort study.)

Adjustment disorder (AD) differs from minor depression or subthreshold depression in that it refers to marked distress or significant impairment from exposure to a specified stressor. The prevalence of AD is approximately 2% to 8% in community samples and up to 50% in special populations that have experienced specific stressors, such as cardiac surgery.

A Cochrane review currently in progress is examining return-to-work intervention studies for AD. In a preliminary report, the authors identified 8 studies (n=1,077) that met the criteria for “controlled trials” of “occupational health interventions” for “adjustment disorder,” and determined that the data were too heterogeneous to be pooled.

A recent outcomes cohort study examined 96 patients who experienced depressive symptoms in a primary care setting. Patients were evaluated at 1 week using the 9-item Patient Health Questionnaire (PHQ-9) and Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) checklists, which categorized patients into major depression (MD) and adjustment disorder with depressed mood (AD) cohorts. The patients were treated with antidepressants alone or a combination of antidepressants and psychotherapy as determined by the treating physician. Symptoms were reassessed at 4, 8, and 16 weeks.

In the AD cohort, no significant difference was observed between the medication group and the combination therapy group (P=.652), nor were any significant outcome differences noted among the various selective serotonin reuptake inhibitors used (P=.399). However, a significant difference between the AD and MD groups was noted: 67% of AD patients sustained response over 4 months to either medication alone or combination treatment, compared with 36% of MD patients (P=.012). The authors did not comment on the natural course of AD; however, expert opinion holds that AD symptoms usually subside within

Robert Gauer, MD
Womack FMR Clinic
Fort Bragg, NC

The opinions and assertions contained herein are the private views of the author and are not to be construed as official or as reflecting the views of the Medical Department of the U.S. Army or the U.S. Army at large.
What are the best nonpharmacologic treatments for urinary incontinence in women?

Evidence-Based Answer
Pelvic floor muscle training (PFMT) is superior to no treatment or inactive controls, and is effective in non-pregnant, pregnant, and postpartum women. (SOR A, based on meta-analyses.) The clinical value of habit retraining, timed voiding, or mechanical devices for treatment of urinary incontinence is unknown.

PFMT is a common nonpharmacologic treatment for women with urinary incontinence (UI). One Cochrane review identified 6 trials with 403 (nonpregnant) women that compared PFMT with no treatment, placebo/sham treatments, or other inactive controls. PFMT involved a supervised program to guide patients with repeated voluntary pelvic floor muscle contractions. The primary outcome was subjective improvement in symptoms.

In 1 trial, 56% (14/25) of the PFMT group stated “incontinence was now unproblematic,” compared with 3% (1/30) of the control group (P=.001). Four other trials analyzed the perception of cure or improvement with PFMT. In 1 trial, 90% (57/65) of PFMT participants reported improvement of symptoms compared with 62% (40/65) of controls (P=.002). Secondary outcome measures looked at the number of leakages in 24 hours, voids per day, and pelvic floor muscle function. Women in the PFMT group experienced about 1 less leakage episode per 24 hours compared with controls.¹

In another study, UI episode frequency decreased by 35% in the PFMT group compared with 29% in the controls (P=.004).¹

Another Cochrane review of randomized trials examined the effects of PFMT in pregnant and postpartum women. Fifteen randomized controlled trials involving 6,181 women were analyzed, and divided into 3 categories. The first category involved 5 trials (n=802) of primary or secondary prevention of UI in asymptomatic women. Overall, women randomized into the PFMT group were 56% less likely to report UI than controls (relative risk (RR) 0.44; 95% confidence interval (CI), 0.30–0.65). PFMT women in the early postpartum period were 50% less likely to have UI (RR 0.50; 95% CI, 0.31–0.80) and PFMT women 3 to 6 months postpartum were 30% less likely to have UI (RR 0.71; 95% CI, 0.52–0.97).

The second category involved 3 trials of PFMT for incontinent women 3 or more months postpartum. PFMT women were 20% less likely to have UI after treatment compared with controls at 12 months postpartum (RR 0.79; 95% CI, 0.70–0.90).²

The third category involved 8 trials of prevention and treatment: 4 involving pregnant women and 4 involving postpartum women. There was a 10% risk reduction of UI in late pregnancy for women who received PFMT (RR 0.88; 95% CI, 0.81–0.96). The remaining 4 trials examined PFMT in the postpartum group, but no difference in symptoms was noted between controls and PFMT participants.²

Cochrane has also published reviews of other nonpharmacologic treatments for UI: habit retraining,³ mechanical devices,⁴ and timed voiding.⁵ Each review found that evidence was insufficient to recommend their use.

1. Hay-Smith EJ, Dumoulin C. Pelvic floor muscle training versus no treatment, or inactive controls, for urinary incontinence in women. Cochrane Database Syst Rev. 2006; (1):CD005654. [LOE 1a]