



Prevention of perinatal death and adverse perinatal outcome using low-dose aspirin: a meta-analysis

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ABSTRACT

Objective To compare early vs late administration of low-dose aspirin on the risk of perinatal death and adverse perinatal outcome.

Methods Databases were searched for keywords related to aspirin and pregnancy. Only randomized controlled trials that evaluated the prophylactic use of low-dose aspirin (50–150 mg/day) during pregnancy were included. The primary outcome combined fetal and neonatal death. Pooled relative risks (RR) with their 95% CIs were compared according to gestational age at initiation of low-dose aspirin (≤ 16 vs > 16 weeks of gestation).

Results Out of 8377 citations, 42 studies (27 222 women) were included. Inclusion criteria were risk factors for pre-eclampsia, including: nulliparity, multiple pregnancy, chronic hypertension, cardiovascular or endocrine disease, prior gestational hypertension or fetal growth restriction, and/or abnormal uterine artery Doppler. When compared with controls, low-dose aspirin started at ≤ 16 weeks' gestation compared with low-dose aspirin started at > 16 weeks' gestation was associated with a greater reduction of perinatal death (RR = 0.41 (95% CI, 0.19–0.92) vs 0.93 (95% CI, 0.73–1.19), $P = 0.02$), pre-eclampsia (RR = 0.47 (95% CI, 0.36–0.62) vs 0.78 (95% CI, 0.61–0.99), $P < 0.01$), severe pre-eclampsia (RR = 0.18 (95% CI, 0.08–0.41) vs 0.65 (95% CI, 0.40–1.07), $P < 0.01$), fetal growth restriction (RR = 0.46 (95% CI, 0.33–0.64) vs 0.98 (95% CI, 0.88–1.08), $P < 0.001$) and preterm birth (RR = 0.35 (95% CI, 0.22–0.57) vs 0.90 (95% CI, 0.83–0.97), $P < 0.001$).

Conclusion Low-dose aspirin initiated at ≤ 16 weeks of gestation is associated with a greater reduction of perinatal death and other adverse perinatal outcomes than when initiated at > 16 weeks. Copyright © 2013 ISUOG. Published by John Wiley & Sons Ltd.

INTRODUCTION

The leading causes of perinatal death are preterm birth, fetal abnormalities and impaired placentation leading to pre-eclampsia and fetal growth restriction (FGR)^{1–4}. Meta-analyses of randomized studies suggest that prophylactic use of low-dose aspirin initiated at or before the 16th week of pregnancy is associated with significant reduction in the prevalence of severe pre-eclampsia, FGR and preterm birth, all placenta-related complications of pregnancy^{5–7}. The mechanism of action of aspirin remains unclear but it could include an improvement of the transformation of uterine spiral arteries, which is typically incomplete in pre-eclampsia^{8,9}. Haapsamo *et al.* observed that low-dose aspirin could lead to an improvement of uterine artery blood flow that is related to the transformation of uterine spiral arteries^{10,11}. Trophoblastic invasion of uterine spiral arteries normally starts at around 8–10 weeks; is mostly completed by 16–18 weeks; but can continue until 22 weeks¹². We believe that intervention aiming at the improvement of this process should probably be initiated as early as 8–10 weeks and no later than 16–18 weeks, when possible. We suggest that improvement of deep placentation could lead to a reduction of several adverse pregnancy outcomes and to a reduction of perinatal death.

The objective of the current work was to perform a systematic review and meta-analysis including recent randomized trials and to compare the effect of early and late administration of aspirin on the risk of perinatal death and other adverse perinatal outcomes.

METHODS

We generated a list of keywords and MeSH terms 'aspirin', 'antiplatelet', 'acetylsalicylic acid', 'ASA', 'pregnancy-complication' and 'pregnancy', for extensive databases search. EMBASE, PubMed, the Cochrane Central Register of Controlled Trials (CENTRAL) and Web of Science

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were used and relevant citations were extracted from 1965 to October 2011. No language restriction was imposed. A first reviewer (S.R.) screened all titles and selected citations for more detailed evaluation. The second sort retrieved citations and abstracts and was revised by two reviewers (S.R. and S.D.). The same two reviewers read and selected all relevant trials. Other systematic reviews were used for additional search^{5-7,13-16}. Corresponding or primary authors were contacted for additional information when necessary. The quality and integrity of this review were validated with PRISMA: preferred reporting items for systematic reviews and meta-analyses¹⁷.

Only prospective, randomized, controlled trials involving pregnant women treated with low-dose aspirin (150 mg or less), with or without dipyridamole (300 mg or less), were included. The control group had to be allocated to placebo or no treatment. Trials that involved other treatment, such as subcutaneous heparin or calcium, were excluded. All studies that involved women who initiated treatment at ≤ 16 weeks of gestation and at > 16 weeks of gestation were included in the meta-analysis. The quality of studies was evaluated using Cochrane Handbook Criteria tool for judging risk of bias, and studies with high risk of bias were considered for sensitivity analysis^{18,19}.

The principal outcome of interest was perinatal mortality defined as fetal death after 16 weeks' gestation or neonatal death before 28 days of age or similar definition. We collected the reasons for perinatal death when available. Our secondary outcomes included pre-eclampsia, severe pre-eclampsia, FGR (reported as below the 10th, the 5th or the 3rd percentile), preterm birth, placental abruption, birth weight and gestational age at delivery.

Statistical analysis

Review Manager 5.0.25 software (The Nordic Cochrane Centre, The Cochrane Collaboration, Copenhagen, Denmark) and the SAS 9.2 software (SAS Institute Inc., Cary, NC, USA) were used for analysis. Relative risks (RR) were calculated for each study and were pooled for global analysis with 95% CIs and stratified according to gestational age at entry (≤ 16 weeks *vs* > 16 weeks; determined pre-hoc). Difference between subgroups of gestational age at entry was evaluated by mixed regression, weighted by the size of each study. Global RR was calculated according to DerSimonian and Laird random-effect models in case of significant heterogeneity and with fixed effect in case of homogeneity between studies^{20,21}. Heterogeneity between studies was analyzed using the Higgins I² statistic^{22,23}. The distribution of trials was examined using funnel plots to assess publication bias²⁴. Sensitivity analysis was conducted to investigate robustness of the findings and heterogeneity between studies, with comparison for the dose of aspirin, use of dipyridamole, blinding, statistical model, trial size and risk of bias.

RESULTS

The literature search identified 8377 citations from which we identified 1104 potentially eligible studies that were completely reviewed (Figure 1). The inclusion criteria were met by 66 studies, but only 42 of those were included (27 222 women randomized)²⁵⁻⁶⁸ in the final analysis because several studies recruited over a range of gestational age overlapping 16 weeks. Studies included nulliparous women or women identified at high risk for pre-eclampsia based on medical history and/or ultrasonographic findings (Table S1). In two

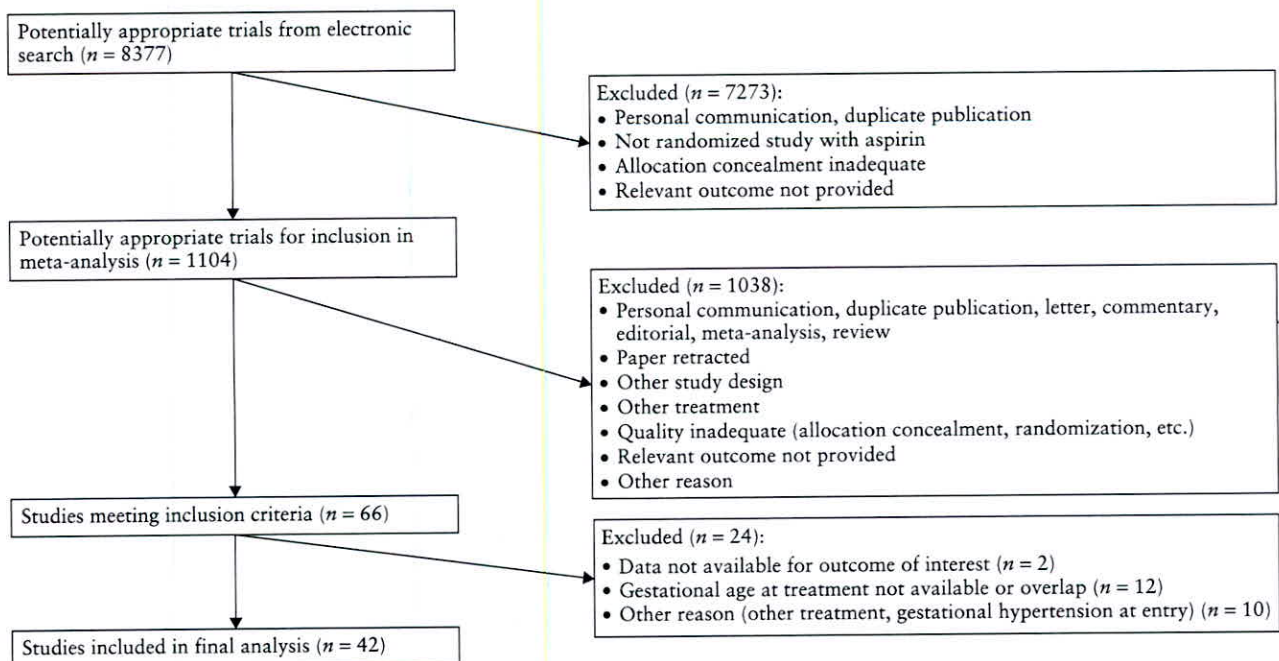


Figure 1 Flow diagram showing selection process of articles.

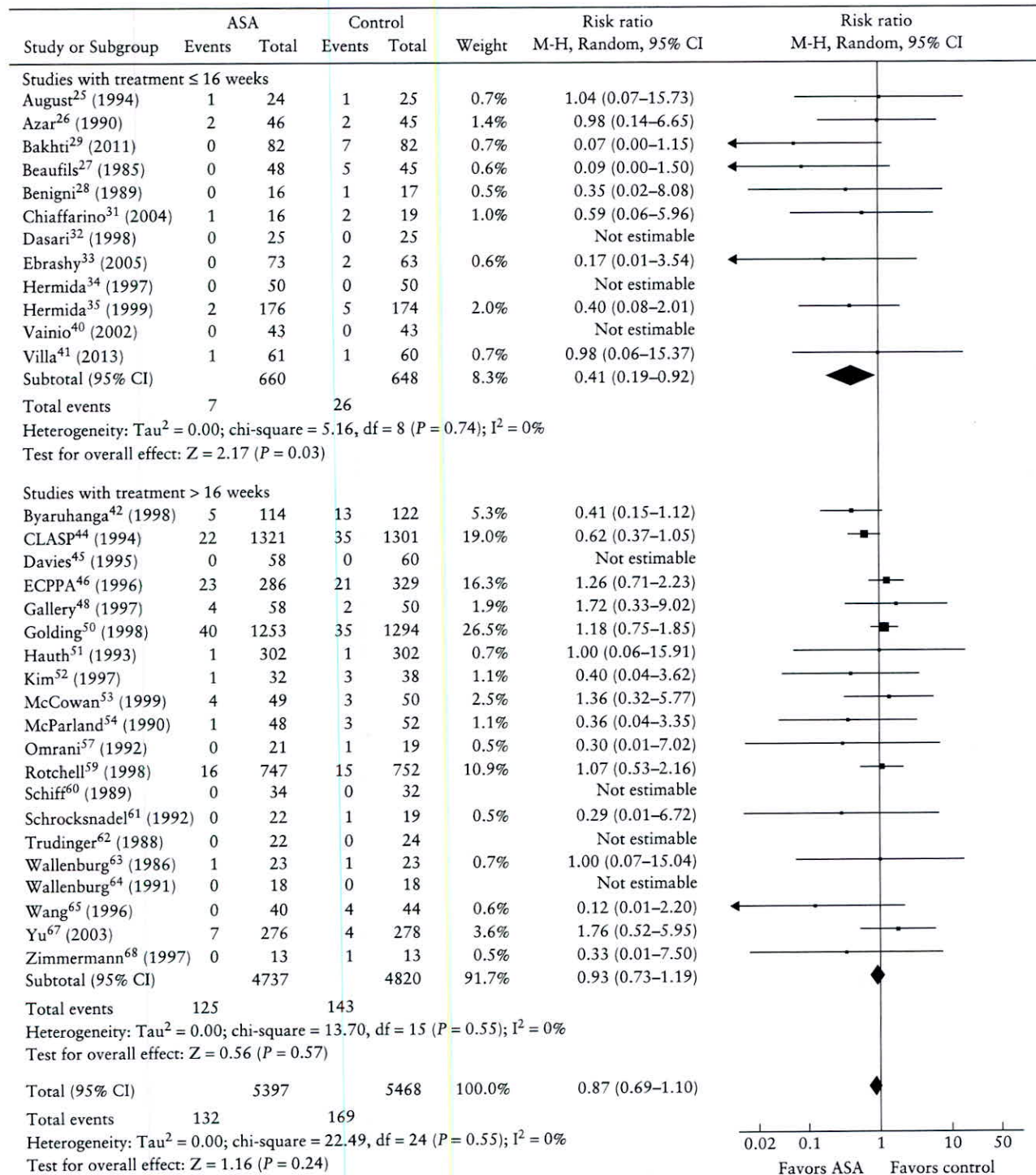


Figure 2 Forest plot of effect of low-dose aspirin on risk of perinatal death, subgrouped by gestational age at initiation of treatment. Only the first author of each study is given. df, degrees of freedom; M-H, Mantel-Haenszel.

studies the intervention was aspirin in combination with dipyridamole, and in the other studies aspirin was the only medication administered. In 32 studies, women allocated to the control group received a placebo and in 10 studies they received no treatment. The follow-up rate was greater than 80% in 14 out of 15 studies that initiated the treatment at ≤ 16 weeks and in 26 out of 27 studies that initiated the treatment after 16 weeks.

The trial characteristics, including number of patients, inclusion criteria, treatment for cases and controls, and outcome measure in the studies where aspirin treatment was initiated at ≤ 16 weeks' gestation and > 16 weeks are summarized in Table S1.

Administration of low-dose aspirin starting at ≤ 16 weeks was associated with a significant reduction in the risk of perinatal death, but the effect of treatment was

Table 1 Perinatal outcomes associated with low-dose aspirin according to gestational age (GA) at initiation of intervention

Outcome/ GA at initiation of intervention	Trials (n)	Participants (n)	Prevalence		Relative risk (95% CI) (random effect)	P	I ² (Higgins test)	P (between subgroups)
			Treated (%)	Controls (%)				
Perinatal death	32	10 865	2.4	3.1	0.87 (0.69 to 1.10)	NS	0%	
≤ 16 weeks	12	1308	1.1	4.0	0.41 (0.19 to 0.92)	0.03	0%	0.02
> 16 weeks	20	9557	2.6	3.0	0.93 (0.73 to 1.19)	NS	0%	
Pre-eclampsia	33	12 152	7.5	9.6	0.62 (0.49 to 0.78)	<0.001	53%	
≤ 16 weeks	13	1479	7.6	17.9	0.47 (0.36 to 0.62)	<0.001	0%	<0.01
> 16 weeks	20	10 673	7.5	8.4	0.78 (0.61 to 0.99)	0.04	49%	
Severe pre-eclampsia	11	2143	2.8	7.5	0.36 (0.20 to 0.63)	<0.001	24%	
≤ 16 weeks	6	649	1.5	12.3	0.18 (0.08 to 0.41)	<0.001	0%	<0.01
> 16 weeks	5	1494	3.3	5.5	0.65 (0.40 to 1.07)	NS	0%	
Fetal growth restriction	27	8260	10.7	12.3	0.86 (0.75 to 0.99)	0.04	28%	
≤ 16 weeks	10	1064	8.0	17.6	0.46 (0.33 to 0.64)	<0.001	0%	<0.001
> 16 weeks	17	7196	11.1	11.5	0.98 (0.88 to 1.08)	NS	0%	
Preterm birth	22	11 302	17.4	20.3	0.81 (0.71 to 0.92)	<0.01	39%	
≤ 16 weeks	6	904	4.8	13.4	0.35 (0.22 to 0.57)	<0.001	0%	<0.001
> 16 weeks	16	10 398	18.6	20.8	0.90 (0.83 to 0.97)	<0.01	0%	
Placental abruption	10	4175	2.3	1.9	1.24 (0.79 to 1.95)	NS	3%	
≤ 16 weeks	4	592	2.3	5.1	0.55 (0.21 to 1.47)	NS	5%	NS
> 16 weeks	6	3583	2.3	1.4	1.56 (0.96 to 2.55)	NS	0%	
			Mean difference (95% CI)					
Birth weight (g)	23	2787	124 (68 to 180)		<0.001	45%		
≤ 16 weeks	10	1061	209 (100 to 319)		<0.001	69%	NS	
> 16 weeks	13	1726	71 (18 to 124)		<0.01	0%		
GA at delivery (weeks)	18	1860	0.57 (0.13 to 1.01)		0.01	88%		
≤ 16 weeks	9	959	1.06 (0.40 to 1.72)		0.002	93%	0.048	
> 16 weeks	9	901	-0.01 (-0.55 to 0.52)		NS	55%		

NS, not significant.

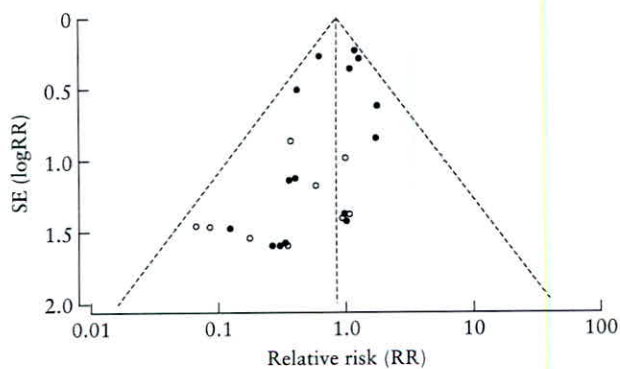


Figure 3 Funnel plot of distribution of relative risk for perinatal death associated with aspirin treatment for studies included in our analysis. Black circles represent studies in which aspirin treatment was initiated at or before 16 weeks' gestation and white circles represent studies in which treatment was initiated after 16 weeks. SE, standard error.

not significant when aspirin was initiated after 16 weeks (Figure 2 and Table 1). The difference in RR according to gestational age at entry (≤ 16 weeks *vs* > 16 weeks) was statistically significant ($P = 0.02$). The difference in RR according to gestational age at entry remained statistically significant ($P = 0.03$) when comparing women recruited at ≤ 16 weeks with those recruited between 17 and 24 weeks ($RR = 1.01$ (95% CI, 0.49–2.08), $P = 0.99$). Only seven (22%) studies reported the reasons for perinatal death and therefore few conclusions can be drawn^{25,48,50,57,60,63,64}. However, 17 (65%) out of 26

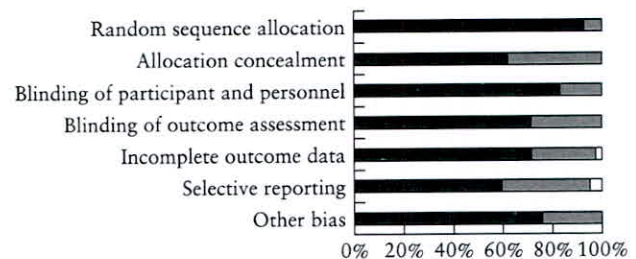


Figure 4 Assessment of risk of bias in studies included in our analysis (low (■), unclear (▒), high (□)) following the Cochrane Handbook¹⁸.

perinatal deaths reported in those studies were related to placental-mediated complications of pregnancy (pre-eclampsia, FGR and/or placental abruption). Significant risk reductions were also observed for pre-eclampsia, severe pre-eclampsia, FGR, preterm birth, birth weight and gestational age at delivery when aspirin was administered at or before 16 weeks (Table 1). Low-dose aspirin administered after 16 weeks was associated with a modest, but significant, reduction of pre-eclampsia and preterm birth and with no significant reduction of FGR. There is insufficient evidence to conclude on the effect of low-dose aspirin given after 16 weeks on the risk of severe pre-eclampsia ($RR = 0.65$; 95% CI, 0.40–1.07).

The Higgins I^2 statistic did not show significant heterogeneity between studies in the global and the subgroup analyses ($I^2 = 0\%$) for perinatal death. However, for several outcomes there was significant

heterogeneity between studies that recruited after 16 weeks and consequently random effect was used. Analysis of the funnel plot for perinatal death suggests the possibility of publication bias because small studies with no beneficial effect were missing (Figure 3)⁶⁹. According to the Cochrane Handbook Criteria tool for judging risk of bias, the majority of included studies were judged to have low or unclear risk of bias, except for one study with more than 20% of individuals lost to follow-up and two with a risk of selective reporting (Figure 4)^{18,29,30,41,53}. Exclusion of these three studies did not affect the results. No statistical difference was observed between any of the subgroups identified in the sensitivity analysis (Figure 5).

Finally, we found similar effects of early aspirin prophylaxis in women who received ≤ 80 mg daily and those who received ≥ 100 mg daily (Table 2) and in women who were selected using abnormal uterine artery Doppler as an inclusion criterion as compared with those selected using anamnesis factors only (Table 3).

DISCUSSION

Our meta-analysis suggests that the prophylactic use of low-dose aspirin is associated with a significant decrease in perinatal death, provided the treatment is initiated at or before 16 weeks of gestation. Low-dose aspirin initiated at or before 16 weeks is also associated with a significant and greater reduction of pre-eclampsia, FGR and preterm birth than is low-dose aspirin started after

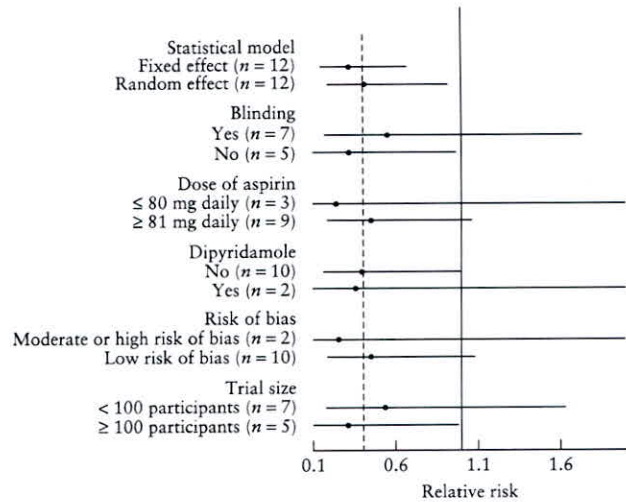


Figure 5 Sensitivity analysis of relative risk for perinatal death for studies in which aspirin treatment was initiated at ≤ 16 weeks. The dashed vertical line shows the relative risk obtained from random effects meta-analysis of all included studies.

16 weeks of gestation. This finding is in agreement with a similar meta-analysis published in 2010⁷. Since then, four additional randomized trials that recruited high-risk women prior to 16 weeks' gestation were published and their findings were consistent with our previous results^{29,30,36,37,41}. Moreover, the addition of two trials changed the conclusion regarding the effect of aspirin

Table 2 Perinatal outcomes associated with aspirin started before 16 weeks according to dose of aspirin prescribed

Outcome/ dose of aspirin	Trials (n)	Participants (n)	Prevalence		Relative risk (95% CI) (random effect)	P	P (between subgroups)
			Treated (%)	Controls (%)			
Perinatal death							
≤ 80 mg	3	255	0	2.4	0.24 (0.03 to 2.14)	NS	
≥ 100 mg	9	1053	1.3	4.4	0.45 (0.19 to 1.06)	NS	NS
Pre-eclampsia							
≤ 80 mg	5	401	14.1	31.8	0.35 (0.16 to 0.76)	<0.001	
≥ 100 mg	8	1078	5.2	12.9	0.46 (0.30 to 0.71)	<0.01	NS
Severe pre-eclampsia							
≤ 80 mg	2	222	0.9	10.4	0.12 (0.02 to 0.65)	0.01	
≥ 100 mg	4	427	1.8	13.2	0.20 (0.08 to 0.53)	0.02	NS
Fetal growth restriction							
≤ 80 mg	4	301	12.2	22.8	0.52 (0.32 to 0.87)	0.01	
≥ 100 mg	6	763	6.2	15.6	0.41 (0.26 to 0.64)	<0.001	NS
Preterm birth							
≤ 80 mg	2	169	4.4	17.7	0.27 (0.09 to 0.77)	0.01	
≥ 100 mg	4	735	4.9	13.7	0.38 (0.20 to 0.69)	<0.01	NS
Placental abruption							
≤ 80 mg	0	—	—	—	—	—	N/A
≥ 100 mg	4	592	2.3	5.1	0.55 (0.21 to 1.47)	NS	
			Mean difference (95% CI)			P	
Birth weight (g)							
≤ 80 mg	4	321		104 (-47 to 254)		NS	
≥ 100 mg	6	740		278 (114 to 442)		0.001	NS
GA at delivery (weeks)							
≤ 80 mg	2	119		2.00 (-1.61 to 5.62)		NS	
≥ 100 mg	6	719		1.09 (0.28 to 1.89)		<0.001	NS

GA, gestational age; N/A, not applicable; NS, not significant.