

USPSTF recommends aspirin for those at high risk for preeclampsia

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(HealthDay)—The U.S. Preventive Services Task Force (USPSTF)

recommends low-dose aspirin for reducing the risk for preeclampsia among those at high risk. This recommendation forms the basis of the final recommendation statement published in the Sept. 28 issue of the *Journal of the American Medical Association*.

Jillian T. Henderson, Ph.D., M.P.H., from the Kaiser Permanente Evidence-based Practice Center in Portland, Oregon, and colleagues conducted a [systematic review](#) to update evidence for the USPSTF on the effectiveness of aspirin for preventing preeclampsia in individuals at increased risk based on clinical risk factors or measurements. Data were included from 23 randomized clinical trials with 26,952 participants, including 18 trials among participants at increased preeclampsia risk. The researchers found that the incidence of preeclampsia ranged from 4 to 30 percent in the trials of participants at increased risk. Aspirin use was significantly associated with reduced risks for preeclampsia, [perinatal mortality](#), [preterm birth](#), and intrauterine growth restriction (pooled relative risks, 0.85, 0.79, 0.80, and 0.82, respectively). No significant association was seen for aspirin use with the risk for postpartum hemorrhage or other bleeding-related harms.

Based on these findings, the USPSTF concludes with moderate certainty that daily low-dose aspirin has a considerable net benefit for reducing the risk for preeclampsia, preterm birth, small for gestational age/[intrauterine growth restriction](#), and perinatal mortality among those at high risk for preeclampsia (B recommendation).

"It's important for clinicians to take into account a number of health factors that increase preeclampsia risk when determining whether to recommend [low-dose aspirin](#)," USPSTF member Aaron Caughey, M.D., Ph.D., said in a statement.

One author from the evidence review disclosed financial ties to Pfizer.

More information: [Evidence Report](#)
[Final Recommendation Statement](#)
[Editorial](#)

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