Low dose aspirin prophylaxis in pregnant women with chronic hypertension: the importance of high-quality research.

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PII: S0002-9378(22)02592-3
DOI: https://doi.org/10.1016/j.ajog.2022.12.314
Reference: YMOB 14903


Received Date: 3 December 2022
Accepted Date: 19 December 2022

Please cite this article as: Richards EMF, Thilaganathan B, Low dose aspirin prophylaxis in pregnant women with chronic hypertension: the importance of high-quality research., American Journal of Obstetrics and Gynecology (2023), doi: https://doi.org/10.1016/j.ajog.2022.12.314.

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Low dose aspirin prophylaxis in pregnant women with chronic hypertension: the importance of high-quality research.

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Conflicts of interest: The authors report no conflict of interest.

Funding sources: The authors report no funding sources.

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Word count: 400
Thank you to the authors of the letter to the Editor for their thoughts on our publication “Low-dose aspirin for the prevention of superimposed preeclampsia in women with chronic hypertension: a systematic review and meta-analysis.” (1) The authors describe some acknowledged limitations which are relevant to many systematic reviews, including variation in intervention classification and loss to follow-up, which are already discussed through our paper’s risk of bias assessments.

The authors ask how the ethnicities of the women included in the review impacted the results. The evidence for the relationship between ethnicity and pre-eclampsia is limited, but acknowledged to be complex due to the interaction with socioeconomic deprivation. Our review was not designed to, and would have been extremely underpowered to, examine the impact of the behavioural, environmental, and healthcare factors involved in the relationship between ethnicity, racism, and pre-eclampsia. (2) We also caution readers not to assume that “the health of laboring women in developing countries may not be paramount to their families”, as suggested by the authors of the letter, without appropriate evidence.

The authors have raised concerns regarding the number of studies used for the analyses, and we do agree that ideally, we would have many more large, well-designed, randomized controlled trials with which to work. Should such work exist, then a systematic review of the current evidence would not be required. The authors have incorrectly suggested that only four studies in the review included women with chronic hypertension (cHTN); in fact, all the studies included either only women with cHTN or a population with a variety of risk factors for pre-eclampsia. The Banala paper referenced by the authors was indeed reviewed but
unfortunately it did not present the pre-eclampsia outcome differentiated by groups that
received aspirin or did not and therefore could not be included.

As preterm birth was a secondary outcome in our protocol, and our search strategy was
written with the outcome of pre-eclampsia in mind, only two of our identified studies
reported on this. Our paper raises interesting questions about the impact of aspirin on
preterm birth in women with cHTN, the value of which is supported with increasing
evidence,(3,4) and so we recommend this relationship be directly investigated with an
appropriately designed trial for women with cHTN. Such a trial may include data on the
safety outcomes the authors also mention, which were not reported in the majority of
studies included in our review.

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