Table des matières

Traitements de référence en gynécologie-obstétrique

1. Endométriose

1.1. Brown 2014

- Brown J, Farquhar C. Endometriosis: an Overview of Cochrane Reviews. Cochrane Database Syst Rev. 2014; MAR 10. [170995]

Objectifs	This overview reports on interventions for pain relief and for subfertility in pre-menopausal women with clinically diagnosed endometriosis. The objective of this overview was to summarise the evidence from Cochrane systematic reviews on treatment options for women with pain or subfertility associated with endometriosis.
Méthodes	Published Cochrane systematic reviews reporting pain or fertility outcomes in women with clinically diagnosed endometriosis were eligible for inclusion in the overview. We also identified Cochrane reviews in preparation (protocols and titles) for future inclusion. The reviews, protocols and titles were identified by searching the Cochrane Database of Systematic Reviews and Archie (the Cochrane information management system) in March 2014.Pain-related outcomes of the overview were pain relief, clinical improvement or resolution and pain recurrence. Fertility-related outcomes were live birth, clinical pregnancy, ongoing pregnancy, miscarriage and adverse events.Selection of systematic reviews, data extraction and quality assessment were undertaken in duplicate. Review quality was assessed using the AMSTAR tool. The quality of the evidence for each outcome was assessed using GRADE methods. Review findings were summarised in the text and the data for each outcome were reported in 'Additional tables'.

Résultats	Seventeen systematic reviews published in The Cochrane Library were included. All the reviews were high quality. The quality of the evidence for specific comparisons ranged from very low to moderate. Limitations in the evidence included risk of bias in the primary studies, inconsistency between the studies, and imprecision in effect estimates. Pain relief (14 reviews) Gonadotrophin-releasing hormone (GnRH) analogues One systematic review reported low quality evidence of an overall benefit for GnRH analogues compared with placebo or no treatment. Ovulation suppressionFive systematic reviews reported on medical treatment using ovulation suppression. There was moderate quality evidence that the levonorgestrel-releasing intrauterine system (LNG-IUD) was more effective than expectant management, and very low quality evidence that danazol was more effective than placebo. There was no consistent evidence of a difference in effectiveness between oral contraceptives and goserelin, estrogen plus progestogen and placebo, or progestogens and placebo, though in all cases the relevant evidence was of low or very low quality. Non-steroidal anti-inflammatory drugs (NSAIDS)A review of NSAIDs reported inconclusive evidence of a benefit in symptom relief compared with placebo. Surgical interventionsThere were two reviews of surgical interventions. One reported moderate quality evidence of a benefit in pain relief following laparoscopic surgery compared to diagnostic laparoscopy only. The other reported very low quality evidence that recurrence rates of endometriomata were lower after excisional surgery than after ablative surgery. Post-surgical medical interventionsTwo reviews reported on post-surgical medical interventions. Neither found evidence of an effect on pain outcomes, though in both cases the evidence was of low or very low quality. Alternative medicineThere were two systematic reviews of alternative medicine. One reported evidence of a benefit from auricular acupuncture compared to Chinese herbal medicine, and the other reported no evidence of a difference between Chinese herbal medicine and danazol. In both cases the evidence was of low or very low quality. Anti-TNF-α drugsOne review found no evidence of a difference in effectiveness between anti-TNF-α drugs and placebo. However, the evidence was of low quality. Reviews reporting fertility outcomes (8 reviews) Medical interventionsFour reviews reported on medical interventions for improving fertility in women with endometriosis. One compared three months of GnRH agonists with a control in women undergoing assisted reproduction and found very low quality evidence of an increase in clinical pregnancies in the treatment group. There was no evidence of a difference in effectiveness between the interventions in the other three reviews, which compared GnRH agonists versus antagonists, ovulation suppression versus placebo or no treatment, and pre-surgical medical therapy versus surgery alone. In all cases the evidence was of low or very low quality. Surgical interventionsThree reviews reported on surgical interventions. There was moderate quality evidence that both live births or ongoing pregnancy rates and clinical pregnancy rates were higher after laparoscopic surgery than after diagnostic laparoscopy alone. There was low quality evidence of no difference in effectiveness between surgery and expectant management for endometrioma. One review found low quality evidence that excisional surgery resulted in higher clinical pregnancy rates than drainage or ablation of endometriomata. Post-surgical interventionsTwo reviews reported on post-surgical medical interventions. They found no evidence of an effect on clinical pregnancy rates. The evidence was of low or very low quality. Alternative medicine A review of Chinese herbal medicine in comparison with gestrinone found no evidence of a difference between the groups in clinical pregnancy rates. However, the evidence was of low quality. Adverse eventsReviews of GnRH analogues and of danazol reported that the interventions were associated with higher rates of adverse effects than placebo; and depot progestagens were associated with higher rates of adverse events than other treatments. Chinese herbal medicine was associated with fewer side effects than gestrinone or danazol.Three reviews reported miscarriage as an outcome. No difference was found between surgical and diagnostic laparoscopy, between GnRH agonists and antagonists, or between aspiration of endometrioma and expectant management. However, in all cases the quality of the evidence was of low quality.

Conclusion	For women with pain and endometriosis, suppression of menstrual cycles with gonadotrophin-releasing hormone (GnRH) analogues, the levonorgestrel-releasing intrauterine system (LNG-IUD) and danazol were beneficial interventions. Laparoscopic treatment of endometriosis and excision of endometriomata were also associated with improvements in pain. The evidence on NSAIDs was inconclusive. There was no evidence of benefit with post-surgical medical treatment.In women with endometriosis undergoing assisted reproduction, three months of treatment with GnRH agonist improved pregnancy rates. Excisional surgery improved spontaneous pregnancy rates in the nine to 12 months after surgery compared to ablative surgery. Laparoscopic surgery improved live birth and pregnancy rates compared to diagnostic laparoscopy alone. There was no evidence that medical treatment improved clinical pregnancy rates.Evidence on harms was scanty, but GnRH analogues, danazol and depot progestagens were associated with higher rates than other interventions.

2. Douleur du travail

Articles connexes : évaluation de l'acupuncture dans les douleurs du travail

2.1. Jones 2012

- Jones L, Othman M, Dowswell T, Alfirevic Z, Gates S, Newburn M, Jordan S, Lavender T, Neilson JP.. Pain Management for Women in Labour: An Overview of Systematic Reviews Cochrane Database Syst Rev. 2012;mar 14:CD009234.160360

Objectifs	The pain that women experience during labour is affected by multiple physiological and psychosocial factors and its intensity can vary greatly. Most women in labour require pain relief. Pain management strategies include non-pharmacological interventions (that aim to help women cope with pain in labour) and pharmacological interventions (that aim to relieve the pain of labour). *Objectives*: To summarise the evidence from Cochrane systematic reviews on the efficacy and safety of non-pharmacological and pharmacological interventions to manage pain in labour. We considered findings from non-Cochrane systematic reviews if there was no relevant Cochrane review.
Méthodes	We searched the Cochrane Database of Systematic Reviews (The Cochrane Library 2011, Issue 5), The Cochrane Database of Abstracts of Reviews of Effects (The Cochrane Library 2011, Issue 2 of 4), MEDLINE (1966 to 31 May 2011) and EMBASE (1974 to 31 May 2011) to identify all relevant systematic reviews of randomised controlled trials of pain management in labour. Each of the contributing Cochrane reviews (nine new, six updated) followed a generic protocol with 13 common primary efficacy and safety outcomes. Each Cochrane review included comparisons with placebo, standard care or with a different intervention according to a predefined hierarchy of interventions. Two review authors extracted data and assessed methodological quality, and data were checked by a third author. This overview is a narrative summary of the results obtained from individual reviews.

Résultats	We identified 15 Cochrane reviews (255 included trials) and three non-Cochrane reviews (55 included trials) for inclusion within this overview. For all interventions, with available data, results are presented as comparisons of: 1. Intervention versus placebo or standard care; 2. Different forms of the same intervention (e.g. one opioid versus another opioid); 3. One type of intervention versus a different type of intervention (e.g. TENS versus opioid). Not all reviews included results for all comparisons. Most reviews compared the intervention with placebo or standard care, but with the exception of opioids and epidural analgesia, there were few direct comparisons between different forms of the same intervention, and even fewer comparisons between different interventions. Based on these three comparisons, we have categorised interventions into: " What works" ,"What may work", and "Insufficient evidence to make a judgement".*What works* Evidence suggests that epidural, combined spinal epidural (CSE) and inhaled analgesia effectively manage pain in labour, but may give rise to adverse effects. Epidural, and inhaled analgesia effectively relieve pain when compared with placebo or a different type of intervention (epidural versus opioids). Combined-spinal epidurals relieve pain more quickly than traditional or low dose epidurals. Women receiving inhaled analgesia were more likely to experience vomiting, nausea and dizziness.When compared with placebo or opioids, women receiving epidural analgesia had more instrumental vaginal births and caesarean sections for fetal distress, although there was no difference in the rates of caesarean section overall. Women receiving epidural analgesia were more likely to experience hypotension, motor blockade, fever or urinary retention. Less urinary retention was observed in women receiving CSE than in women receiving traditional epidurals. More women receiving CSE than low-dose epidural experienced pruritus. *What may work***There is some evidence to suggest that immersion in water, relaxation, acupuncture, massage and local anaesthetic nerve blocks or non-opioid drugs may improve management of labour pain, with few adverse effects. Evidence was mainly limited to single trials**. These interventions relieved pain and improved satisfaction with pain relief (immersion, relaxation, acupuncture, local anaesthetic nerve blocks, non-opioids) and childbirth experience (immersion, relaxation, non-opioids) when compared with placebo or standard care. Relaxation was associated with fewer assisted vaginal births and acupuncture was associated with fewer assisted vaginal births and caesarean sections.*Insufficient evidence* There is insufficient evidence to make judgements on whether or not hypnosis, biofeedback, sterile water injection, aromatherapy, TENS, or parenteral opioids are more effective than placebo or other interventions for pain management in labour. In comparison with other opioids more women receiving pethidine experienced adverse effects including drowsiness and nausea.

Conclusion	Most methods of non-pharmacological pain management are non-invasive and appear to be safe for mother and baby, however, their efficacy is unclear, due to limited high quality evidence. In many reviews, only one or two trials provided outcome data for analysis and the overall methodological quality of the trials was low. High quality trials are needed.There is more evidence to support the efficacy of pharmacological methods, but these have more adverse effects. Thus, epidural analgesia provides effective pain relief but at the cost of increased instrumental vaginal birth.It remains important to tailor methods used to each woman's wishes, needs and circumstances, such as anticipated duration of labour, the infant's condition, and any augmentation or induction of labour.A major challenge in compiling this overview, and the individual systematic reviews on which it is based, has been the variation in use of different process and outcome measures in different trials, particularly assessment of pain and its relief, and effects on the neonate after birth. This made it difficult to pool results from otherwise similar studies, and to derive conclusions from the totality of evidence. Other important outcomes have simply not been assessed in trials; thus, despite concerns for 30 years or more about the effects of maternal opioid administration during labour on subsequent neonatal behaviour and its influence on breastfeeding, only two out of 57 trials of opioids reported breastfeeding as an outcome. We therefore strongly recommend that the outcome measures, agreed through wide consultation for this project, are used in all future trials of methods of pain management

3. Médicaments non-opioïdes

3.1. Othman 2012

- Othman M, Jones L, Neilson JP. Non-Opioid Drugs for Pain Management in Labour. Cochrane Database Syst Rev. 2012. [166544]

Objectifs	Labour is a normal physiological process, but is usually associated with pain and discomfort. Numerous methods are used to relieve labour pain. These include pharmacological (e.g. epidural, opioids, inhaled analgesia) and non-pharmacological (e.g. hypnosis, acupuncture) methods of pain management. Non-opioid drugs are a pharmacological method used to control mild to moderate pain. *Objectives*: To summarise the evidence regarding the effects and safety of the use of non-opioid drugs to relieve pain in labour.
Méthodes	We searched the Cochrane Pregnancy and Childbirth Group's Trials Register (15 February 2012).SELECTION CRITERIA: Randomised controlled trials (RCTs) using non-opioid drugs (non-steroidal anti-inflammatory drugs (NSAIDs); paracetamol; antispasmodics; sedatives and antihistamines) in comparison with placebo or standard care; different forms of non-opioid drugs (e.g. sedatives versus antihistamines); or different interventions (e.g. non-opioids versus opioids) for women in labour. Quasi-RCTs and trials using a cross-over design were not included. Cluster-randomised RCTs were eligible for inclusion but none were identified for inclusion. DATA COLLECTION AND ANALYSIS: Two review authors independently assessed for inclusion all studies identified by the search strategy, carried out data extraction and assessed risk of bias. We resolved any disagreement through discussion with a third author. Data were checked for accuracy.

Résultats	Nineteen studies randomising a total of 2863 women were included in this review. There were three main comparison groups: 15 studies compared non-opioid drugs with placebo or no treatment (2133 women); three studies compared non-opioid drugs with opioids (563 women); and three studies compared one type of non-opioid drug with a different type or dose of non-opioid drug (590 women). Some of the studies included three or more groups and so have been put in more than one comparison. Overall, there was little difference between groups for most of the comparisons. Any differences observed for outcomes were mainly limited to one or two studies. Non-opioid drugs (sedatives) were found to offer better pain relief (mean difference (MD) -22.00; 95% confidence interval (CI) -35.86 to -8.14, one trial, 50 women), better satisfaction with pain relief (sedatives and antihistamines) (risk ratio (RR) 1.59; 95% CI 1.15 to 2.21, two trials, 204 women; RR 1.80; 95% CI 1.16 to 2.79, one trial, 223 women) and better satisfaction with the childbirth experience (RR 2.16; 95% CI 1.34 to 3.47, one trial, 40 women) when compared with placebo or no treatment. However, women having non-opioid drugs (NSAIDs or antihistamines) were less likely to be satisfied with pain relief compared with women having opioids (RR 0.50; 95% CI 0.27 to 0.94, one trial, 76 women; RR 0.73; 95% CI 0.54 to 0.98, one trial, 223 women). Women receiving the antihistamine hydroxyzine were more likely to express satisfaction with pain relief compared with the antihistamine promethazine (RR 1.21; 95% CI 1.02 to 1.43, one trial, 289 women). Women receiving sedatives were more likely to express satisfaction with pain relief compared with antihistamines (RR 1.52; 95% CI 1.06 to 2.17, one study, 157 women). The majority of studies were conducted over 30 years ago. The studies were at unclear risk of bias for most of the quality domains.Opioids appear to be superior to non-opioids in satisfaction with pain relief, while non-opioids appear to be superior to placebo for pain relief and satisfaction with the childbirth experience. There were little data and no evidence of a significant difference for any of the comparisons of non-opioids for safety outcomes.
Conclusion	Overall, the findings of this review demonstrated insufficient evidence to support a role for non-opioid drugs on their own to manage pain during labour.