Current Guidelines for the Use of Antiplatelet Agents in Primary/Secondary Prevention

The American Heart Association's last statement regarding aspirin use as a therapeutic agent in cardiovascular disease for healthcare professional was published in Circulation in 1997 **(http://circ.ahajournals.org/cgi/content/full/96/8/2751)**. Since that time, any new thoughts on aspirin use have been added to subsequent lipid guidelines. Below are the most current guidelines regarding the use of antiplatelet agents for both primary and secondary prevention.

AHA/ACC Secondary Prevention Guidelines 2006: J Am Coll Cardiol 2006;47:2130 –9.

Start aspirin 75 to 162 mg/d and continue indefinitely in all patients unless contraindicated. I (A)
For patients undergoing coronary artery bypass grafting, aspirin should be started within 48 hours after surgery to reduce saphenous vein graft closure. Dosing regimens ranging from 100 to 325 mg/d appear to be efficacious. Doses higher than 162 mg/d can be continued for up to 1 year. I (B)

• Start and continue clopidogrel 75 mg/d in combination with aspirin for up to 12 months in patients after acute coronary syndrome or percutaneous coronary intervention with stent placement (> or equal 1 month for bare metal stent, (> or equal 3 months for sirolimus-eluting stent, and (> or equal 6 months for paclitaxel-eluting stent). I (B)

Patients who have undergone percutaneous coronary intervention with stent placement should initially
receive higher-dose aspirin at 325 mg/d for 1 month for bare metal stent, 3 months for sirolimus-eluting
stent, and 6 months for paclitaxel-eluting stent. I (B)

• Manage warfarin to international normalized ratio2.0 to 3.0 for paroxysmal or chronic atrial fibrillation or
flutter, and in post–myocardial infarction patients when clinically indicated (eg, atrial fibrillation, left ventricular
thrombus). I (A)

• Use of warfarin in conjunction with aspirin and/or clopidogrel is associated with increased risk of bleeding and should be monitored closely. I (B)

AHA WOMENS GUIDELINES 2007 (Circulation. 2007;115:1481-1501.)

Preventive drug interventions
Aspirin, high risk
Aspirin therapy (75 to 325 mg/d)¶ should be used in high-risk‡ women unless contraindicated (Class I, Level A).
If a high-risk‡ woman is intolerant of aspirin therapy, clopidogrel should be substituted (Class I, Level B).

Aspirin— other at-risk or healthy women
In women 65 years of age, consider aspirin therapy (81 mg daily or 100 mg every other day) if blood pressure is controlled and benefit for ischemic stroke and MI prevention is likely to outweigh risk of gastrointestinal bleeding and hemorrhagic stroke (Class IIa, Level B) and in women 65 years of age when
benefit for ischemic stroke prevention is likely to outweigh adverse effects of therapy (Class IIb, Level B).

AHA PRIMARY PREVENTION GUIDELINES (Circulation. 2002;106:388-391.)

Aspirin
Goal: Low-dose aspirin in persons at higher
CHD risk (especially those with 10-y risk of CHD 10%).

Do not recommend for patients with aspirin intolerance. Low-dose aspirin increases risk for gastrointestinal bleeding and hemorrhagic stroke. Do not use in persons at increased risk for these diseases. Benefits of cardiovascular risk reduction outweigh these risks in most patients at higher coronary risk.25–27 Doses of 75–160 mg/d are as effective as higher doses. Therefore, consider 75–160 mg aspirin per day for persons at higher risk (especially those with 10-y risk of CHD of 10%).