Aspirin
Clinician Guide

July 2018

Introduction

These recommendations were developed to assist primary care physicians and other clinicians in aspirin use. The KP National Integrated Cardiovascular Health Guideline team adopted the 2016 aspirin recommendations developed by the United States Preventive Services Task Force (USPSTF) on "Aspirin Use to Prevent Cardiovascular Disease and Colorectal Cancer: Preventive Medication" for patients without Atherosclerotic Cardiovascular Disease (ASCVD). It is not intended or designed as a substitute for the reasonable exercise of independent clinical judgment by practitioners.

Aspirin Therapy at 81 mg Orally Daily for Adults without ASCVD

Risk Assessment

- **10-year ASCVD Risk** is risk of fatal or nonfatal myocardial infarctions or strokes in adults. A region may choose which tool (and corresponding cut-point) to use for calculating 10-year ASCVD risk based on regional needs. Kaiser Permanente ASCVD Risk Estimator (KPARE) of 10% correlates approximately with ACC/AHA ASCVD Risk of 15% and Framingham Risk Score of 15% (used in SPRINT) at the population level.

Recommendation

Aged 50-59

- Initiate aspirin in adults aged 50-59 years with 10-year ASCVD risk ≥ 10%.

Aged 60-69

- Consider initiating aspirin in adults aged 60-69 years with 10-year ASCVD risk ≥ 10%. Adults who place a higher value on the potential benefits than the potential harms may choose to take low dose aspirin.

Other ages

- There is no recommendation for or against initiating aspirin therapy in adults aged < 50 or ≥ 70 years.

Aspirin Therapy at 81 mg Orally Daily for Adults with ASCVD

Clinical

- Initiate aspirin in adults with clinical ASCVD, which includes acute coronary syndromes, history of MI, stable or unstable angina, coronary or other arterial revascularization, ischemic stroke, TIA, carotid stenosis ≥50%, or symptomatic peripheral artery disease presumed to be of atherosclerotic origin.

Subclinical

- Consider aspirin in adults with subclinical ASCVD, which includes asymptomatic coronary artery disease or peripheral artery disease, e.g., aortic atherosclerosis, or abnormal ankle brachial index (ABI) detected on screening.

Exclusions for Aspirin Therapy

- Exclude adults with increased risk of bleeding. This includes those with a history of gastrointestinal (GI) bleeding, GI ulcers, intracranial bleed, bleeding disorders, renal failure, severe liver disease, thrombocytopenia, or using other medicine to prevent blood clots.

Table 1: Lifetime Events in 10,000 taking aspirin. **Green = start aspirin**, **Blue = consider aspirin**

ASCVD Risk	Gender	MIs Prevented	Ischemic Strokes Prevented	Colorectal Cancer Cases Prevented	Serious GI Bleeding Caused	Hemorrhagic Strokes Caused	Net Life-Years Gained	Quality-Adjusted Life-Years Gained
Age 50-59								
10%	M	225	84	139	284	23	333	**588**
	W	148	137	139	209	35	219	**621**
15%	M	267	86	121	260	28	395	**644**
	W	150	143	135	200	34	334	**716**
Age 60-69								
10%	M	159	66	112	314	31	-20	**180**
	W	101	116	105	230	32	-12	**284**
15%	M	186	80	104	298	24	96	**309**
	W	110	129	93	216	34	17	**324**

Adapted from USPSTF.

TERMINOLOGY		
Recommendation Language	**Strength***	**Action**
Start, initiate, prescribe, treat, etc.	Strong affirmative	Provide the intervention. Most individuals should receive the intervention; only a small proportion will not want the intervention.
Consider starting, etc.	Conditional affirmative	Assist each patient in making a management decision consistent with personal values and preferences. The majority of individuals in this situation will want the intervention, but many will not. Different choices will be appropriate for different patients.
No recommendation for or against	None	Given that the balance between desirable and undesirable effects, the evidence quality, the values and preferences, and the resource allocation implications of an intervention do not drive a recommendation in one particular direction, recommendations will be made at the discretion of the individual clinician.
Consider stopping, etc.	Conditional negative	Assist each patient in making a management decision consistent with personal values and preferences. The majority of individuals in this situation will not want the intervention, but many will. Different choices will be appropriate for different patients.
Stop, do not start, etc.	Strong negative	Do not provide the intervention. Most individuals should not receive the intervention; only a small proportion will want the intervention.
*Refers to the extent to which one can be confident that the desirable effects of an intervention outweigh its undesirable effects.		

DISCLAIMER

This guideline is informational only. It is not intended or designed as a substitute for the reasonable exercise of independent clinical judgment by practitioners, considering each patient's needs on an individual basis. Guideline recommendations apply to populations of patients. Clinical judgment is necessary to design treatment plans for individual patients.