Aspirin Used Incorrectly for Cardioprotection

BY SHARON WORCESTER
Tallahassee Bureau

ORLANDO, FLA. — Many primary care physicians do not prescribe aspirin appropriately for cardioprotection, a national survey suggests.

Many of the 1,000 primary care physicians who responded are unaware of—or disregard—data about the use of aspirin for cardioprotection and recommend to their patients doses that are too high, William D. Chey, M.D., said at the annual meeting of the American College of Gastroenterology.

The lowest cardioprotective dose of aspirin is 81 mg/day in healthy patients and in those at risk for gastrointestinal complications. Those with gastrointestinal risk should receive gastroprotection, such as a proton pump inhibitor (PPI), Dr. Chey said.

About half of those responding to the Internet survey were internists, and half were family physicians or general practitioners. Respondents, generally between 35 and 54 years old and evenly distributed geographically across the United States, had previously agreed to participate in survey research.

Overall, 95% said they recommend aspirin for cardioprotection in patients over age 60 years, with 62% always recommending aspirin therapy and 33% usually recommending aspirin therapy, said Dr. Chey of the University of Michigan, Ann Arbor. Nearly 70% said they recommend 81 mg daily, but 30% said they recommend 325 mg daily. "This is relevant because there may be a dose-response relationship between aspirin and the likelihood of developing ulcer disease and, consequently, gastrointestinal bleeding," Dr. Chey said.

Another troubling finding was that 62% of respondents said they would recommend enteric-coated aspirin for a patient at high risk for gastrointestinal bleeding due to a previous ulcer bleed despite a lack of data showing any benefit of coated aspirin over regular aspirin. Also only 28% recommended concurrent gastroprotective therapy, such as with a proton pump inhibitor or misoprostol. Most said they would put the patient on aspirin alone, he said.

"I guess the good news is that [gastroenterologists] are going to stay in business if this is truly representative of primary care physicians," he said, noting that a study last year showed that the likelihood of such a high-risk patient developing recurrent gastrointestinal bleeding when put on aspirin therapy alone is about 15%.

Aspirin cardioprotection in those who require treatment with an NSAID is more controversial, Dr. Chey said. In one study of patients with a history of ulcer bleeding, the use of a PPI and NSAID and the use of a cyclooxygenase-2 (COX-2) selector alone were both associated with a recurrent bleeding rate of about 5% at 6 months.

The withdrawal of Vioxx from the market has highlighted concerns about COX-2 inhibitors and myocardial infarction risk. For now, avoid using COX-2 inhibitors in those with known coronary artery disease, Dr. Chey advised. In those without coronary artery disease who are at high risk for gastrointestinal complications, the use of a COX-2 inhibitor and PPI is warranted, but there is little or no incremental gastrointestinal safety benefit from aspirin and a COX-2 inhibitor vs. a traditional NSAID alone.

When physicians in the survey were asked about their knowledge of the effects of aspirin in patients using a COX-2 inhibitor, 69% of respondents said they were aware of the data showing that aspirin decreases or eliminates the gastrointestinal safety benefits of the COX-2 inhibitors (31% were unaware, or thought that aspirin improved the effects of COX-2 inhibitors).

Yet when asked how they would manage a patient with no history of peptic ulcer disease, but with a need for nonsteroidal antiinflammatory drug treatment for arthritis, 45% said they would recommend aspirin and a COX-2 inhibitor.

"Even more interesting, in a high-risk patient with a history of ulcer bleeding, 60% said they would recommend a proton pump inhibitor with a coxib and aspirin—even though there are no published data to support this strategy, and 24%, disturbingly, would choose a coxib and aspirin without gastroprotection," Dr. Chey said.

There is no logic to this combination, he said, adding that further educational efforts are necessary to correct these "important knowledge deficits." ■

References: 1. Scharf MB, Roth T, Vogel GW, Walsh JK. A multicenter, placebo-controlled study evaluating zolpidem in the treatment of chronic insomnia. *J Clin Psychiatry.* 1994;55:192-199. **2.** Roth T, Roehrs T, Vogel G. Zolpidem in the treatment of transient insomnia: a double-blind, randomized comparison with placebo. *Sleep.* 1995;18:246-251. **3.** Elie R, Rüther E, Farr I, Emilien G, Salinas E, for the Zaleplon Clinical Study Group. Sleep latency is shortened during 4 weeks of treatment with zaleplon, a novel nonbenzodiazepine hypnotic. *J Clin Psychiatry.* 1999;60:536-544. **4.** AMBIEN Prescribing Information, Sanofi-Synthelabo Inc. **5.** Office of Applied Studies, Drug Abuse Warning Network (DAWN). Substance Abuse and Mental Health Services Administration, US Department of Health and Human Services. Reports & tables from DAWN emergency department component. Table 2.6.0. Available at: http://dawninfo.samhsa.gov/pubs_94_02/edpubs /2002final/files/PubTablesCh2.xls. Accessed December 9, 2003. **6.** Hajak G, Müller WE, Wittchen HU, Pittrow D, Kirch W. Abuse and dependence potential for the non-benzodiazepine hypnotics zolpidem and zopiclone: a review of case reports and epidemiological data. *Addiction.* 2003;98:1371-1378. **7.** IMS Health, National Prescription Audit Plus, MAT May 2004. **8.** Data on file, Sanofi-Synthelabo Inc.