

Experts say abandon aspirin for stroke prevention in atrial fib

By: Bruce Jancin, Internal Medicine News Digital Network
January 20, 2016

Expert Analysis From The Cardiovascular Conference At Snowmass

SNOWMASS, COLO. – It's time to eliminate the practice of prescribing aspirin for stroke prevention in patients with atrial fibrillation and a CHA₂DS₂-VASc score of 1, two eminent cardiologists agreed at the Annual Cardiovascular Conference at Snowmass.

“The European guidelines have done away with aspirin for stroke prevention in atrial fibrillation. It barely made it into our current U.S. guidelines. I don't think aspirin should be in there and I don't think it will be there in the next guidelines. The role of aspirin will fall away,” predicted Dr. Bernard J. Gersh, professor of medicine at the Mayo Clinic in Rochester, Minn.

“It's not that aspirin is less effective than the oral anticoagulants, it's that there's no role for it. There are no good data to support aspirin in the prevention of stroke in atrial fibrillation,” he declared.

Dr. N.A. Mark Estes III agreed the aspirin evidence is seriously flawed.

“The use of aspirin has probably been misguided, based upon a single trial which showed a profound effect and was probably just an anomaly,” according to Dr. Estes, a past president of the Heart Rhythm Society who is professor of medicine and director of the New England Cardiac Arrhythmia Center at Tufts University, Boston.

The sole positive clinical trial of aspirin versus placebo, the 25-year-old Stroke Prevention in Atrial Fibrillation (SPAF) study (Circulation. 1991 Aug;84[2]:527-39), found an unrealistically high stroke protection benefit for aspirin, a result made implausible by multiple other randomized trials showing no benefit, the cardiologists agreed.

“In our current guidelines for atrial fibrillation (Circulation. 2014 Dec 2;130[23]:2071-104), aspirin can be considered as a Class IIb level of evidence C recommendation in patients with a CHA₂DS₂-VASc of 1. But I would just take it off of your clinical armamentarium because the best available data indicates that it doesn't prevent strokes. I'm certainly not using it in my patients. Increasingly in my patients with a CHA₂DS₂-VASc of 1, I'm discussing the risks and benefits of a NOAC [novel oral anticoagulant],” Dr. Estes said.

Dr. Gersh was also critical of another common practice in stroke prevention in atrial fibrillation: concomitant use of aspirin with an oral anticoagulant.

“We use too much aspirin in patients on oral anticoagulation. Aspirin is perhaps the major cause of bleeding in patients on an oral anticoagulant. Other than in people with a drug-eluting stent, there's no role at all for aspirin in stroke prevention,” he asserted.

He was coauthor of an analysis of 7,347 participants in the Outcomes Registry for Better Informed Treatment of Atrial Fibrillation (ORBIT-AF) who were on an oral anticoagulant. Fully 35% of them were also on aspirin. In a multivariate analysis, concomitant aspirin and oral anticoagulation was independently associated with a 53% increased risk of major bleeding and a 52% increase in hospitalization for bleeding, compared with atrial fibrillation patients on an oral anticoagulant alone (Circulation. 2013 Aug 13;128[7]:721-8).

Moreover, the widespread use of dual therapy in this real-world registry didn't appear to be rational. Thirty-nine percent of those on aspirin plus an oral anticoagulant had no history of atherosclerotic disease, the presence of which would be an indication for considering aspirin. And 17% of dual therapy patients had an elevated Anticoagulation and Risk Factors in Atrial Fibrillation

(ATRIA) risk score of 5 or more, making dual therapy particularly risky.

This clinically important interaction between aspirin and oral anticoagulation was recently underscored in an analysis of rivaroxaban-treated patients in the ROCKET AF trial, Dr. Gersh observed. Long-term use of aspirin at entry into this pivotal randomized trial of rivaroxaban (Xarelto) versus warfarin in patients with atrial fibrillation proved to be an independent predictor of a 47% increase in the risk of gastrointestinal bleeding, compared with patients on rivaroxaban alone (J Am Coll Cardiol. 2015 Dec 1;66[21]:2271-81).

He added that there is no evidence that combining aspirin and oral anticoagulation enhances stroke prevention beyond the marked benefit achieved with oral anticoagulation alone.

Dr. Gersh reported serving on the leadership of the ORBIT-AF Registry, which was sponsored by Janssen Pharmaceuticals. Dr. Estes reported having no financial conflicts relevant to this discussion.

bjancin@frontlinemedcom.com

Ref: <http://www.internalmedicineneeds.com/?>

[id=495&tx_ttnews\[tt_news\]=470577&cHash=a6c1b435c3e22fa5eefa5b37f917355c](http://www.internalmedicineneeds.com/?id=495&tx_ttnews[tt_news]=470577&cHash=a6c1b435c3e22fa5eefa5b37f917355c)