

# Adult Aspirin

## DEFINITIONS

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- **Clinical ASCVD** includes acute coronary syndromes, history of myocardial infarction (MI), stable or unstable angina, coronary or other arterial revascularization, ischemic stroke, transient ischemic attack (TIA), peripheral arterial disease (PAD), or aortic aneurysm, all of atherosclerotic origin.
- **10-year ASCVD risk** is risk of fatal or nonfatal myocardial infarctions or strokes in adults and is used to risk stratify in **primary prevention** those without clinical ASCVD. Diabetes Mellitus is a variable in 10-year ASCVD risk and part of primary prevention.

*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 16% and Framingham Risk Score of 16% (used in SPRINT) at the population level.*

- **Increased bleeding risk** includes a history of gastrointestinal (GI) bleeding, GI ulcers, bleeding from other sites, thrombocytopenia, coagulopathy or bleeding disorders, chronic kidney disease (CKD), severe liver disease, and concurrent use of other medications that increase bleeding risk, such as daily NSAIDs, steroids, direct oral anticoagulants, and warfarin.
- **Subclinical atherosclerosis** includes abnormal coronary artery calcium score, aortic atherosclerosis, and low ankle brachial index (ABI) detected on screening. These and other **risk-enhancing factors** may influence risk-based treatment decisions while still falling under primary prevention. For additional details see [Cholesterol and Cardiovascular Risk Guideline](#).

## ADULTS WITHOUT CLINICAL ASCVD (PRIMARY PREVENTION)

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- In adults aged 40-59 years with 10-year ASCVD risk  $\geq 10\%$ , (including risk-enhancing factors) and not at increased bleeding risk, consider aspirin 81 mg daily.
- In adults aged 60-69 years, regardless of 10-year ASCVD risk, there is no recommendation for or against aspirin therapy because bleeding risk is higher than in adults younger than 60 years, and there is approximate equipoise in benefits and risk.
- In adults aged  $\geq 70$  years, stop or do not start aspirin for primary prevention of ASCVD.
- In adults with increased bleeding risk, stop or do not start aspirin for prevention of ASCVD.

## ADULTS WITH CLINICAL ASCVD (SECONDARY PREVENTION)

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- In adults with clinical ASCVD, use at least one anti-platelet medication (such as aspirin 81 mg daily), unless contraindicated.

**Table 1: TERMINOLOGY**

<b>Recommendation Language</b>	<b>Strength*</b>	<b>Action</b>
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.

## ABOUT THIS RESOURCE

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This Clinician Guide is based on the 2019 KP National Aspirin recommendations. These recommendations were developed to assist primary care physicians and other clinicians in aspirin use. They were revised after review of the 2019 ACC/AHA Guideline on the Primary Prevention of Cardiovascular Disease and the 2016 ACC/AHA Guideline on the Management of Patients with Lower Extremity Peripheral Artery Disease. It is not intended or designed as a substitute for the reasonable exercise of independent clinical judgment by practitioners.

- **Last Review:** June 2019
- **Next Review:** June 2021

## DISCLAIMER

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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.

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This guideline expires within two years of the posted month.

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