

# Uncertain role of aspirin for primary prevention

It is recommended that patients discuss with their doctor if primary prevention of vascular disease with aspirin is appropriate for them. In 2010, what we should recommend is far from straightforward.

Enthusiasm for aspirin for primary prevention increased through the late 1990s. In 2002 the US Preventive Services Task Force (USPSTF) strongly recommended doctors discuss both the potential benefit and harm. They found good evidence that aspirin decreased the incidence of coronary heart disease but increased the incidence of GI bleeding. There was fair evidence that aspirin increased the incidence of hemorrhagic strokes. They concluded the risk/benefit ratio was best in patients with a five-year risk >3%.

Uptake of advice in the community was such that it raised the concern that the message was not getting out to the community enough – that aspirin is not without its risks.

In addition in 2007, evidence emerged that men and women respond differently to aspirin. There was reasonable evidence that in men at increased risk, low-dose aspirin decreases the risk of a first myocardial infarction with little effect on the risk of ischemic stroke. A large randomised trial in women, however, showed no significant effect on the risk of myocardial infarction but did detect a reduction in the risk of stroke!

In March 2009, the USPSTF issued an update to its 2002 recommendations. They concluded

that aspirin was likely of benefit for preventing MI in men age 45 to 79 and preventing stroke in women 55 to 79, when the benefits outweigh the bleeding risks on an individual-patient basis.

However in May 2009, a meta-analysis from Oxford concluded that in primary prevention aspirin is of uncertain net value as the reduction in occlusive vascular events needs to be weighed against any increase in major bleeds. This suggests the risk/benefit ratio of low dose aspirin treatment may be less favourable than suggested by the USPSTF recommendations.

Since then some studies have even warned against routine aspirin use in some of the key primary prevention populations, including patients with asymptomatic atherosclerosis, type 2 diabetes and peripheral artery disease.

We need better guidelines that incorporate this new knowledge.

At the moment I do not think we should “throw out the baby with the bath water” and abandon aspirin for primary prevention completely, but I would now only recommend considering it in patients with a >20% five-year vascular risk. After assessing the bleeding risk, acknowledging the uncertainty about

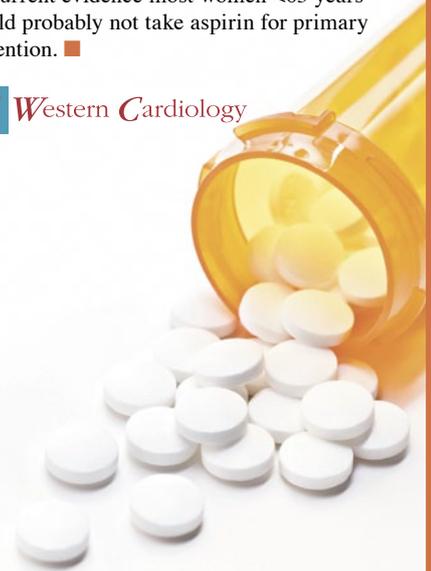


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aspirin for primary prevention and the risks, you can then make an individualised clinical judgement. There is a useful calculator at <http://www.cvdcheck.org.au/>

On current evidence most women <65 years should probably not take aspirin for primary prevention. ■

 Western Cardiology



## GP guidelines on prostate cancer testing

### Guest Column

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**A review of the available medical literature soon reveals** that, as yet, there is no clear-cut evidence that finding prostate cancer early actually saves lives. For many doctors and most patients this might appear to be a logical process, but, as with life, not everything is that straightforward.

An American Urology Association expert panel reviewed over 12,000 scientific publications on the management of clinically localized prostate cancer. They concluded that a lack of evidence precluded making specific recommendations for optimal treatment but felt that patient preferences should guide decision making.

In recent years, the US Preventive Services Task Force modified its recommendations to conclude that ‘... the evidence is insufficient to recommend for or against screening for prostate cancer in men age 50 to 75.’ They recommend against screening men over 75 as they felt the evidence suggested more harm than benefits for such men.

The UK National Institute for Health and Clinical Excellence (NICE) Guideline 58 for prostate cancer recommends urological

cancer multi-disciplinary teams ‘... should be available to advise, support and review the diagnosis, risk category and treatment options available to an individual patient.’

The New Zealand prostate cancer guidelines for men presenting to primary care with signs or symptoms suggestive of prostate cancer contains a useful algorithm with recommendations based on a range of clinical scenarios and early detection test results. Such an approach has a lot of merit and reflects the individual encounters in general practice as opposed to a blanket population health approach.

The RACGP *Guidelines for Preventive Activities in General Practice* state ‘routine screening for prostate cancer with digital rectal examination, serum tumour markers (PSA) and trans-abdominal ultrasound is

not recommended.’ Unfortunately, a lack of evidence seems to be equated with evidence against with no consideration for known risk factors.

The adoption of a New Zealand style algorithm into the Australian guidelines might serve a more useful purpose to help GPs when men present with genuine concerns such as a strong family history of prostate cancer, a rising PSA or a suspicious DRE. Younger men with aggressive cancers are known to have better outcomes if their cancer is detected and treated at an early stage. Turning such men away with false re-assurance that we no longer undertake early detection tests is bad practice – at the very least encourage them to see a colleague who may have an interest in investigating them further or refer for urological opinion.

GPs would be served better with the RACGP adopting patient-centred guidelines that focus on the reality of everyday clinical practice – this is the essence of what general practice is all about. ●