Too Few People With HIV Take Aspirin to Prevent Heart Attacks and Strokes

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Most HIV-positive people who should be taking aspirin to prevent a heart attack or stroke are not doing so, according to a University of Alabama at Birmingham (UAB) study published online ahead of print by Clinical Infectious Diseases. In fact, fewer than one in five who met the U.S. criteria for aspirin therapy were taking advantage of the cheap, over-the-counter medication.

"Aspirin for primary prevention of cardiovascular events is underutilized in HIV-infected patients," summarized Greer Burkholder, MD, of UAB and his colleagues. Compared with their HIV-negative peers, those with HIV are at increased risk for heart attacks and strokes—particularly those 50 and older. As a result, Burkholder's team wrote, it's important to alert HIV care providers about aspirin therapy and existing guidelines.

Currently, there are no specific guidelines to help people living with HIV prevent and manage cardiovascular disease. In the absence of population-specific guidelines, clinicians are encouraged to draw upon those available for the general U.S. population, including recommendations approved by the U.S. Preventive Service Task Force (USPSTF) in 2009.

These USPSTF guidelines recommend that men between the ages of 45 and 79 take aspirin to prevent a first heart attack and women between the ages of 55 and 79 take aspirin to prevent stroke. These recommendations apply when the cardiovascular disease benefit outweighs the risk of one potentially serious side effect of continued aspirin dosing: hemorrhaging in the gut.

Of note, a study presented in July at the XIX International AIDS Conference (AIDS 2012) in Washington, DC, found that aspirin may help reduce the excessive risk of a heart attack and stroke associated with blood clots, immune activation and inflammation in people living with HIV.

But are clinicians who treat HIV actually recommending aspirin to their at-risk patients? To begin answering this question, Burkholder and his colleagues conducted Framingham risk analyses—the same 10-year coronary disease risk calculator recommended by the USPSTF to determine aspirin therapy eligibility—involving 471 patients actively retained in care at a UAB clinic in 2010.

A total of 402 (85 percent) patients met the USPSTF criteria for starting aspirin therapy, 397 of whom were included in the final analysis. They averaged 52 years of age, 36 percent were black, and 94 percent were male. Most patients (96 percent) were taking antiretrovirals, and roughly 60

percent had undetectable viral loads; CD4 counts were above 350 cells in 70 percent.

Only 66 (17 percent) of the 397 who met the USPSTF criteria were prescribed aspirin for primary heart attack or stroke prevention. Notably, Burkholder and his colleagues found, half of the 397 patients qualifying for aspirin had an intermediate-to-high risk for a heart attack or stroke—the risk of at least 10 percent in the next decade. Thirty-nine percent were current smokers, 16 percent had diabetes, 62 percent had high blood pressure, 63 percent had elevated cholesterol/triglyceride levels, and 20 percent were obese—all risk factors for cardiovascular disease. Of the highest risk patients, only 22 percent were prescribed aspirin.

Current smokers and patients with diabetes or high cholesterol/triglyceride levels were more likely to be receiving aspirin, compared to those without these specific risk factors.

Though the authors caution that their results from a single clinic in a southeastern state may not be applied to other geographic regions, they noted a “significant underutilization of [aspirin] among HIV-infected persons engaged in medical care.”

Burkholder and his colleagues stressed that HIV-specific guidelines regarding the use of aspirin are needed. “In the short term,” they added, “interventions to improve HIV provider knowledge of and adherence to existing recommendations governing CVD prevention and management for the general population would be beneficial.”

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