Low-Dose Aspirin for Stroke Prevention

To the Editor:

We have carefully read the interesting article by Sato et al1 aiming at addressing an important and still debated issue in the prevention of atrial fibrillation–related stroke. However, some points, in our view, deserve greater attention. Both ACC/AHA/ESC and ACCP guidelines recommend for low-risk patients 325 mg of aspirin daily and define as “low-risk” a patient <65 years old without any other cardiovascular risk factors.2–3 Thus, the large inclusion of older patients with cardiovascular risk factors in the study by Sato et al contrasts with the overall message of the article (and title as well), ie, that enrolled patients were at low risk. Moreover, both chronic and intermittent atrial fibrillation were considered, thus making the population heterogeneous.

Some other limitations owing to the reliability of results are correctly stated by the authors.

The use of low-dose aspirin in such not so low-risk patients seems hampered by futility. Notwithstanding the fact that current evidence on the efficacy of aspirin is based on the results of a single study,4 all available guidelines agree on a precise risk stratification and unique dosage for aspirin. Thus, it remains unclear why the authors tested a nonevidence-based dosage of aspirin but more likely in a concrete alternative, such as direct thrombin inhibitors,5 or a stricter control of anticoagulation levels by means of specialized clinics and facilities. Moreover, a rigorous control of anticoagulation level warrants even greater attention because today there is no room to be sure that a pharmacological approach may be equally effective/safe for all racial or ethnic groups. In our view, the solution for the suboptimal use of vitamin K antagonists, attributable to their known logistic hurdles and physician frights for bleeding complications, cannot be found in a lower, nonevidence-based dosage of aspirin but more likely in a concrete alternative, such as direct thrombin inhibitors, or a stricter control of anticoagulation levels by means of specialized clinics and facilities. Moreover, a rigorous control of anticoagulation level warrants even greater attention because a “rate control” approach with prolonged anticoagulation therapy currently seems to be preferable.6

In an era of evidence-based medicine and limited resources, only a rigorous methodological approach may preserve the medical readership from contradictory conclusions7 because we still do not know whether low-dose aspirin may be effective or safe in a low-risk population with atrial fibrillation.

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