Early aspirin (before a diagnosis is established)

Mrs Jones describes a funny turn she had last night that you are pretty sure is a TIA. Should you start her on aspirin before her outpatient appointment next week?

Despite public health campaigns aiming to get people to see strokes as urgent events (‘brain attacks’) and promoting the FAST test as an easy screening tool for strokes, patients still present late with symptoms of stroke.

Since the introduction of routine CT scanning/thrombolysis, clinicians are hesitant to initiate immediate aspirin in those presenting with possible stroke symptoms, in case it interferes with thrombolysis, or the event is haemorrhagic. Yet in the week after a TIA or minor stroke, the risk of recurrent stroke is up to 10%, and often this second stroke is more disabling. Early intervention can reduce this risk significantly.

This paper comes from an analysis of individual patient data from over 15 000 patients in 12 trials who had had a TIA or minor (non-disabling) stroke. It looked at (Lancet 2016;388;365):

- The benefits of aspirin to prevent a second event.
- The importance of timing.
- Whether the addition of dipyridamole gave any extra benefit.

The key messages from the trial are that:

- The benefits of early aspirin have been underestimated.
- The benefits have been demonstrated for aspirin only, not yet for any other antiplatelet agents.
- The benefits occur regardless of the dose of aspirin given.

In more detail, the trial showed that:

- Giving aspirin after a first event reduces the risk of a second stroke (NNT 71 in the first 12w – so, for every 71 people you treat with aspirin after a TIA/minor stroke, you will prevent one further stroke in the first 12w).
- We already knew aspirin was beneficial, but the relative risk reduction was thought to be much smaller (relative risk reduction in this trial was 60%, but in previous trials was only 13%).
- Aspirin reduced the severity of any subsequent stroke. Those on aspirin were less likely to have a subsequent fatal or disabling stroke (NNT 105 in the first 12w).
- Early initiation of aspirin is important. The greatest benefits are seen for those starting within 48h, with a drop off in benefit from then on. However, there is still benefit in starting at any point throughout the 12w studied.
- The benefits have been demonstrated for aspirin alone, not for other antiplatelets – so, early in the recovery, aspirin should be the preferred drug of choice.
  - Adding dipyridamole to aspirin did not give any additional benefit (reduction in events, reduction in severity of events) during the first 12w, although dual therapy was beneficial after 12w (based on data from 3 trials).
  - The benefits were present regardless of the dose of aspirin given or patient characteristics.
- Those with AF had similar benefit to those without AF. (N.B. this is not suggesting we use aspirin to treat AF; it is saying that in people with AF who are not on any antithrombotic treatment and who have a TIA, there is benefit from early aspirin use – although clearly later anticoagulation may be more appropriate.)
- Reassuringly, in those on aspirin there was:
  - No increased risk of intracerebral haemorrhage in the first 12w
  - No increased risk of harm in those unfortunate enough to have a major stroke and require thrombolysis or thrombectomy.

So what does this all mean in practice?

The accompanying editorial suggests that (Lancet 2016;388;312):

- Those with early transient neurological-type symptoms, that resolve within minutes to an hour or so, should self-administer aspirin while awaiting medical assessment.
- In those with persistent stroke-like symptoms that may be due to haemorrhage, the overall benefits of early aspirin could possibly still outweigh the risks, BUT further evaluation of this is recommended before it becomes policy/practice.
- What dose? The benefits were present regardless of the dose of aspirin given.
- This has implications for NICE guidance which recommends clopidogrel first line post TIA/ischaemic stroke (NICE CKS for secondary prevention after TIA/stroke).

So would I give Mrs Jones aspirin?

All other things being equal, on the basis of this evidence, I would.

We make every effort to ensure the information in these pages is accurate and correct at the date of publication, but it is of necessity of a brief and general nature, and this should not replace your own good clinical judgement, or be regarded as a substitute for taking professional advice in appropriate circumstances. In particular check drug doses, side effects and interactions with the British National Formulary. Save insofar as any such liability cannot be excluded at law, we do not accept any liability for loss of any type caused by reliance on the information in these pages.
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With the amount of evidence and literature inundating us, it can be hard to know which bits should change our practice, and how. The GP Update Course is designed to be very relevant to clinical practice and help you meet the requirements for revalidation.

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The Cancer Update Course

Within the next 15 years the need for cancer care will double and you will look after as many cancer survivors as diabetics. Shared care follow up will become the norm, and secondary care will pass responsibility to us. A key 2015 Lancet Oncology commission paper warned that: “GPs are inadequately trained and resourced to manage the growing demand for cancer care in high income countries”.

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This course is able to look in much more detail at the big picture behind the disease perhaps most feared by our patients and, let’s face it, that 1 in 2 of us will be diagnosed with over our lifetime.

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The Telephone Consultation Course

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The Effective Consultation Course

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The Medically Unexplained Symptoms Course

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