**UPDATE ON ASPIRIN IN THE PRIMARY PREVENTION OF CARDIOVASCULAR DISEASE**

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*Background*: In secondary prevention among a wide range of patients who have survived a prior occlusive vascular event, as well as during acute myocardial infarction and acute occlusive stroke the absolute reductions far exceed the absolute risks. In primary prevention, tbe balance is less clear.

*Methods*: Meta-analyses of serious vascular events (myocardial infarction, stroke, or vascular death) and major bleeds in the primary prevention trials.

*Findings*: In the primary prevention trials, aspirin yielded a 12% reduction in serious vascular events (0·51% aspirin vs 0·57% control per year, p=0·0001), due mainly to a reduction of about a fifth in non-fatal myocardial infarction (0·18% vs 0·23% per year, p<0·0001). The net effect on stroke was not significant (0·20% vs 0·21% per year, p=0·4: hemorrhagic stroke 0·04% vs 0·03%, p=0·05; other stroke 0·16% vs 0·18% per year, p=0·08). Vascular mortality did not differ significantly (0·19% vs 0·19% per year, p=0·7). Aspirin increased major gastrointestinal and extracranial bleeds (0·10% vs 0·07% per year, p<0·0001), and the main risk factors for coronary disease were also risk factors for bleeding. The benefits were similar for men and women.

*Interpretation*: In primary prevention, the reduction in occlusive events needs to be weighed against any increase in major bleeds Specifically, the average absolute risk of subjects randomized was so low that it is not possible to get reliable estimates of the benefit to risk ratio in subjects at moderate risk Until the results of ongoing trials are available, nobody would disagree that a non-fatal myocardial infarction or stroke is more likely to be disabling than a non-fatal bleed. Thus, at present in primary prevention, the appropriate and judicious prescription of aspirin by clinicians should be based on individual clinical judgments that weigh their absolute benefits against the absolute risks.