

BRINGING CLINICIANS TOGETHER TO DISCUSS CURRENT DRUG THERAPY

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The following succinct analysis appeared in *Pharmacist's Letter*. Based on vol. 34, No. 7

ASPIRIN

New data and talk of OTC label changes will reignite debate about whether NSAIDs reduce the CV protective effect of aspirin.

Many of us remember when FDA warned that ibuprofen may interact with aspirin. This is because aspirin binds to COX-1 to inhibit platelet aggregation...and nonselective NSAIDs can compete for the same receptor.

OTC ibuprofen labels even say it may decrease aspirin's CV benefit.

Now FDA will likely require a similar warning for OTC naproxen labels...due to a recent study suggesting naproxen may interfere with the antiplatelet effects of aspirin 81 mg/day.

Continue to recommend limiting NSAIDs in patients at high CV risk

But put this interaction in perspective.

Using a chronic NSAID with aspirin only leads to a small decrease in platelet inhibition. It doesn't seem to reduce aspirin's CV benefit.

If patients on low-dose aspirin need a chronic NSAID, don't be too concerned about the interaction. Emphasize adherence to aspirin instead.

But tell worried patients that taking nonenteric-coated aspirin about 30 minutes before the NSAID may let aspirin reach platelets first.

Don't suggest going to a higher aspirin dose or a different antiplatelet med (clopidogrel, etc). There's no evidence either approach leads to better CV outcomes...but may cause more bleeding.

Reassure patients that aspirin does not interact with PRN or topical NSAIDs...or with celecoxib, since it's COX-2 selective.

Suggest a PPI for patients who need aspirin and any chronic NSAID... since the combo increases GI bleeding risk, even with celecoxib.

Listen to *PL Voices* to hear us discuss this issue with a CV expert. And see our chart, *Managing NSAID Risks*, for more advice on safe use.

(For more on this topic, see Clinical Resource #340702 at PharmacistsLetter.com.)

Primary Reference – Reed GW, Abdallah MS, Shao M, et al. Effect of aspirin coadministration on the safety of celecoxib, naproxen, or ibuprofen. *J Am Coll Cardiol* 2018;71:1741-51.

See LEADER NOTES for answers to discussion questions.

DISCUSSION QUESTIONS

OVERVIEW OF CURRENT THERAPY

1. What is known about using a chronic NSAID in patients who need low-dose aspirin for cardiovascular prevention?

ANALYSIS OF NEW STUDY

2. What type of study was this? How were the patients selected for inclusion?

3. How were the study groups defined?

4. How were the outcomes evaluated?

See [LEADER NOTES](#) for answers to discussion questions.

5. What were the outcomes of this trial?

6. What were the strengths and weaknesses of this study?

7. Were the results expressed in terms we care about and can use?

HOW SHOULD THE NEW FINDINGS CHANGE CURRENT THERAPY?

8. Do the results change your practice? How?

See LEADER NOTES for answers to discussion questions.

APPLY THE NEW FINDINGS TO THE FOLLOWING CASE

M.P. is a 56-year-old male in the clinic today for evaluation of low back pain. He has a past medical history of hypertension, type 2 diabetes, CAD with two cardiac stents placed four years ago, and opioid abuse for which he underwent treatment fifteen years ago. His current medications are lisinopril 20mg daily, aspirin 81mg daily, metformin 1,000mg BID, glipizide 5mg BID, atorvastatin 80mg daily, and acetaminophen 1,000 mg QID.

M.P. reports that his back pain has developed over the past two weeks, and that it is affecting his ability to do his job as a landscaper. He denies any trauma to his low back, but reports that his pain is worse with bending, twisting, and picking up heavy loads. He also denies neurologic symptoms such as bladder or bowel incontinence. He rates his pain a 7/10 when he's at work, and 4/10 when he gets up in the morning.

M.P. has been icing his back nightly, as well as taking acetaminophen around-the-clock, but feels that he's getting little relief.

9. What should you suggest for M.P.'s acute back pain?

You discuss that acute back pain often improves in two to four weeks. You also discuss that imaging isn't needed at this time, since M.P.'s symptoms don't suggest a serious underlying cause. You advise continuing nonpharmacologic measures, along with trying an NSAID such as naproxen 375 mg twice daily for two to four weeks since his scheduled acetaminophen hasn't provided much relief.

M.P. expresses concern about naproxen, since his primary care doctor told him NSAIDs increase his CV risk and interact with his aspirin.

10. What should you tell M.P. about using NSAIDs in patients who need aspirin for CV prevention?

See [LEADER NOTES](#) for answers to discussion questions.

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Additional Pharmacist's Letter Resources available at PharmacistsLetter.com

- Chart, The Truth About Aspirin. *Pharmacist's Letter/Prescriber's Letter*. April 2018.
- PL Voices, Frequently Asked Questions About Aspirin. *Pharmacist's Letter/Prescriber's Letter*. April 2018.
- PL Voices, Celecoxib and Cardiovascular Risk. *Pharmacist's Letter/Prescriber's Letter*. November 2017.
- Chart, Treatment of Acute Low Back Pain. *Pharmacist's Letter/Prescriber's Letter*. April 2017.
- PL Voices, Safety of NSAIDs in Patients with CV Risks. *Pharmacist's Letter/Prescriber's Letter*. January 2017.
- Chart, Managing NSAID Risks. *Pharmacist's Letter/Prescriber's Letter*. December 2016.
- Chart, Safety Comparison of NSAIDs. *Pharmacist's Letter/Prescriber's Letter*. December 2016.
- PL Voices, Aspirin to Reduce Cardiovascular Risk After a GI Bleed. *Pharmacist's Letter/Prescriber's Letter*. November 2016.
- Chart, Aspirin for Primary Prevention. *Pharmacist's Letter/Prescriber's Letter*. November 2016.
- PL Voices, Duration of Dual Antiplatelet Therapy. *Pharmacist's Letter/Prescriber's Letter*. June 2016.
- Chart, Dual Antiplatelet Therapy for Coronary Artery Disease. *Pharmacist's Letter/Prescriber's Letter*. June 2016.
- Chart, Proton Pump Inhibitors: Appropriate Use and Safety Concerns. *Pharmacist's Letter/Prescriber's Letter*. March 2016.

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TEL (209) 472-2240 ~ FAX (209) 472-2249
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