**Abstract:**

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**Use of aspirin as primary prevention prior to an acute coronary syndrome**

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Introduction: The use of aspirin as primary prevention of cardiovascular events in certain subgroups of patients is currently controversial. This study aimed to evaluate the prognostic impact of prior use of AAS as primary prevention in patients with an acute coronary syndrome (ACS).

Methods: This was a retrospective study of patients with non-fatal ACS between October 2010 and November 2017. We excluded patients with prior history of myocardial infarction (MI), percutaneous or surgical coronary revascularization, stroke and peripheral arterial disease. The endpoints evaluated were MI, stroke, decompensation of heart failure (DHF), major bleeding and all-cause mortality, at a median follow-up of 42 months (IQR 24-59).

Results: A total of 444 patients were selected, 72.5% were male, with a mean age of 65.0±13.5 years old, and 11.7% was previously medicated with aspirin. This group had more patients with history of arterial hypertension (86.5% vs 54.1%, p<0.001) and diabetes (40.4% vs 24.2%, p<0.05), less smokers (7.7% vs 24.7%, p<0.05), without significant differences in dyslipidemia (61.5% versus 47.4%, p=0.133). Compared to patients who were not treated with aspirin, during hospitalization, a higher incidence of new-onset atrial fibrillation occurred (15.4% vs. 4.6%, p<0.05). There were no differences in the overall treatment prescribed at discharge between the two groups.

In a multivariate analysis, we haven’t found any statistically significant differences for any of the proposed endpoints, namely MI (HR 1.1, 95% CI 0.4-3.6), stroke (HR 1.0, 95% CI 0.2-5.1) and DHF (HR 1.0, 95% CI 0.5-2.4). There was even a tendency for greater overall mortality (HR 1.7, 95% CI 0.9 -3.4) as well as for major bleeding (HR 1.8, 95% CI 0.8 -4.0).

Conclusion: In this study the use of aspirin as primary prevention prior to an ACS did not hold any long-term beneficial effect, as it couldn’t reduce, in an independent and significant manner, the incidence of ischemic or hemorrhagic events.