Antiplatelet properties

Anti-inflammatory properties

Antipyretic properties

Analgesic properties

The Wonder Drug®
Now More Than Ever

For free patient samples, click here: bayeraspirinhcp.com
Aspirin is one of the most versatile drugs ever discovered. It is also one of the most extensively studied medications, with several new clinical trials across numerous therapeutic areas currently underway.¹⁻⁵

Aspirin can help save a life during a suspected heart attack and can lower the risk of secondary cardiovascular (CV) events.

Aspirin also has the power to relieve pain and even temporarily alleviate fevers from colds.⁵⁻⁶ This is possible because aspirin’s combination of properties includes:

- Analgesic
- Anti-inflammatory
- Antipyretic
- Antiplatelet
Aspirin has long been known for its analgesic properties. Overstimulated tissue produces prostaglandins, which in turn produce inflammation and pain. Aspirin interrupts this process by inhibiting prostaglandin production, thereby reducing inflammation and alleviating pain.\(^4\)

Because of its analgesic properties, aspirin can be used for the temporary relief of\(^6\):
- Headache
- Muscle pain
- Toothache
- Menstrual pain
- Pain and fever of colds
- Menstrual pain
- Minor pain of arthritis
- Rheumatoid arthritis (RA)
- Juvenile rheumatoid arthritis (JRA)
- Osteoarthritis (OA)
- Spondyloarthropathies
- Arthritis and pleurisy associated with systemic lupus erythematosus (SLE)
Patients experience a fever when concentrations of prostaglandin E2 (PGE2) increase within certain areas of the brain. These elevations alter the firing rate of neurons that control thermoregulation in the hypothalamus. By inhibiting prostaglandin production, aspirin exerts an antipyretic effect that temporarily alleviates fevers.

Aside from its antipyretic benefits, patients with the common cold can take aspirin to help relieve:

- Headache
- Body aches
- Sore throat pain
Aspirin is a more potent inhibitor of platelet aggregation than other salicylic acid derivatives. Aspirin affects platelet aggregation by irreversibly inhibiting prostaglandin cyclo-oxygenase-1 (COX-1). This effect lasts for the life of the platelet and prevents the formation of the platelet aggregating factor thromboxane A2 (TXA2). This powerful antiplatelet is clinically proven to help prevent CV events and continues to be highly recommended as a first-line therapy.

**Major CV guidelines recommend aspirin as a first-line treatment for the secondary prevention of CV events**

Aspirin is recognized as a first-line (Class 1/Grade 1A level) therapy, higher than other treatments, by the following professional organizations:

- AHA/ASA—Class 1, Level of Evidence A recommendation
- AHA/ACC—Grade 1A recommendation
- AHA/ACCF—Class 1, Level of Evidence A recommendation
- ACCP—Class 1, Level of Evidence A recommendation
In the United States, 700,000 people experience an MI each year; of these cases, 210,000 are recurrent MIs. Aspirin is proven to help protect patients who have suffered an MI:

Aspirin is proven to reduce the risk of recurrent MI by 31% \(^{13*}\)

Patients who discontinue low-dose aspirin can increase their risk of MI by 63% \(^{14}\)

While patients can take aspirin on its own, it is also recommended as an adjunctive therapy for many prescription antiplatelets, including \(^{15-17}\):

- Plavix® (clopidogrel bisulfate)
- Brilinta® (ticagrelor)
- Effient® (prasugrel)
In the United States, more than 690,000 people experience an ischemic stroke each year. Of these cases, 210,000 are recurrent strokes. Aspirin remains the most studied and widely used antiplatelet for the secondary prevention of stroke.

A combination of 5 factors, including aspirin, can result in an 80% cumulative risk reduction of recurrent ischemic stroke:

- Aspirin regimen
- Dietary modification
- Regular exercise
- Statin therapy
- Antihypertensive therapy
Aspirin is indicated:

1. To reduce the combined risk of death and nonfatal stroke in patients who have had ischemic stroke or transient ischemia of the brain due to fibrin platelet emboli

2. To reduce the risk of vascular mortality in patients with suspected acute MI

3. To reduce the combined risk of death and nonfatal MI in patients with a previous MI or unstable angina pectoris

4. To reduce the combined risk of MI and sudden death in patients with chronic stable angina pectoris

5. In patients who have undergone revascularization procedures (ie, coronary artery bypass graft [CABG], percutaneous transluminal coronary angioplasty [PTCA], or carotid endarterectomy [CEA]) when there is a preexisting condition for which aspirin is already indicated
Each dose of aspirin should be taken with a full glass of water, unless the patient is fluid restricted. Anti-inflammatory and analgesic dosages should be individualized. When aspirin is used in high doses, the development of tinnitus may be used as a clinical sign of elevated plasma salicylate levels, except in patients with high-frequency hearing loss.

**Ischemic Stroke and Transient Ischemic Attack (TIA)**
50-325 mg once a day. Continue therapy indefinitely.

**Suspected Acute MI**
The initial dose of 160-162.5 mg is administered as soon as an MI is suspected. The maintenance dose of 160-162.5 mg a day is continued for 30 days post-infarction. After 30 days, consider further therapy based on dosage and administration for prevention of recurrent MI.

**Prevention of Recurrent MI**
75-325 mg once a day. Continue therapy indefinitely.

**Unstable Angina Pectoris**
75-325 mg once a day. Continue therapy indefinitely.

**Chronic Stable Angina Pectoris**
75-325 mg once a day. Continue therapy indefinitely.

**Coronary Artery Bypass Graft**
325 mg daily, starting 6 hours post-procedure. Continue therapy for 1 year post-procedure.

**Percutaneous Transluminal Coronary Angioplasty**
The initial dose of 325 mg should be given 2 hours pre-surgery. The maintenance dose is 160-325 mg daily. Continue therapy indefinitely.
Carotid Endarterectomy
Doses of 80 mg once daily to 650 mg twice daily, starting pre-surgery, are recommended. Continue therapy indefinitely.

Rheumatoid Arthritis
The initial dose is 3 g a day in divided doses. Increase as needed for anti-inflammatory efficacy with target plasma salicylate levels of 150-300 mcg/mL. At high doses (ie, plasma levels of greater than 200 mcg/mL), the incidence of toxicity increases.

Juvenile Rheumatoid Arthritis
The initial dose is 90-130 mg/kg a day in divided doses. Increase as needed for anti-inflammatory efficacy with target plasma salicylate levels of 150-300 mcg/mL. At high doses (ie, plasma levels of greater than 200 mcg/mL), the incidence of toxicity increases.

Spondyloarthropathies
Up to 4 g a day in divided doses.

Osteoarthritis
Up to 3 g a day in divided doses.

Arthritis and Pleurisy of Systemic Lupus Erythematosus
The initial dose is 3 g a day in divided doses. Increase as needed for anti-inflammatory efficacy with target plasma salicylate levels of 150-300 mcg/mL. At high doses (ie, plasma levels of greater than 200 mcg/mL), the incidence of toxicity increases.
Aspirin has been studied alone and in combination with a wide range of drugs and for numerous conditions. There are many clinical trials currently underway, including, but not limited to:

- A Study of Cardiovascular Events in Diabetes (ASCEND)
- Aspirin in Reducing Events in the Elderly (ASPREE)
- A Study to Assess the Efficacy and Safety of Enteric-coated Acetylsalicylic Acid in Patients at Moderate Risk of Cardiovascular Disease (ARRIVE)

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References:

17. Effient® (prasugrel) [prescribing information]. Indianapolis, IN: Eli Lilly and Company; 2015.
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