How do you decide which patients should take low dose aspirin prophylactically? (I know what the USPSTF Guidelines say but I was wondering how you operationalize those recommendations.)

1) Most patients don't read the guidelines. I'm always amazed to see 65 yo patients with at least one or more risk factors who come in for their first Medicare visit and they have never heard of taking an ASA a day. All diabetics over age 40, All men over 50, All women over 65. I have been pushing this for 10 years and I still see patients on a daily basis who haven't heard or aren't doing it. ASA is probably the single most cost effective preventive drug we can prescribe. The TIMI trial showed that $1000 TPA alone was no better than 5 cent ASA. It's like smoking cessation, if it's that important you better have a method of addressing it at every visit. It's on my med list, if not, I ask about it and I ask from time to time if they are still taking it. I also reinforce that it is one of the most important medicines they can take.

2) All patients that have cerebrovascular disease or cardiovascular disease should be on an aspirin. I put almost all diabetics on an aspirin (some patients under the age of 30 I won't). For primary prevention I use Epocrates® and calculate their 10 year risk. I do not start aspirin until the risk is over 10%. The literature shows that the risk may need to be higher than 10% for women for the benefit to out way the risk. There is a risk calculator for women on the internet called the Reynolds's risk score but it requires measuring a c reactive protein which is not always covered by insurance. There is a new test which shows if a patient has aspirin insensitivity, the truth is every patient that we consider to put on aspirin should have the test but up to this point I have not seen any recs about the test.