

## Aspirin for primary prevention: No

I read with interest the article in the *Journal of Primary Health Care* about aspirin and its use in primary prevention.<sup>1</sup> I note that there is still a recommendation to consider aspirin in those with a cardiovascular risk over 15%. I am not sure where the evidence for this statement comes from.

In most other countries, the use of aspirin in primary prevention has fallen rapidly. In the UK it is no longer used, following the *BMJ* article 'Don't use Aspirin for Primary Prevention'.<sup>2</sup> This position has been reaffirmed by Kausik Ray's meta-analysis<sup>3</sup>—here are his thoughts on the matter in an interview with Medscape.<sup>4</sup>

*Medscape:* After the results of the ATT meta-analysis were published, and now with these new data just published, the prevailing message already seems to be that aspirin should be abandoned as primary prevention altogether. But other investigators have suggested that the benefits of long-term use of daily aspirin for prevention of chronic disease may outweigh the consequences associated with the increased risk for bleeding, particularly gastrointestinal bleeding.

*Prof. Ray:* They are wrong. If you had a bleed in your eye I would say that is pretty important. If you had a bleed into your brain that didn't kill you, I would say that is also important, and obviously fatal bleeds are included as well. And if you come into hospital needing a blood transfusion, are you likely to take aspirin again? No. What is your risk? It is preventing a heart attack that wouldn't have killed me; that is how people need to think about this. If you give someone a statin, you are reducing cardiovascular deaths and you are also reducing nonfatal MIs. There is really no flip side, apart from dysglycemia and nonfatal side effects like myalgia. That is not the same as bleeding. This is the information patients should be given. Hopefully, it is very clear: aspirin is not the same as the antihypertensive, and it is not the same as the statin.

Recent European Society of Cardiology guidelines also don't recommend using aspirin for primary prevention for coronary heart disease.<sup>5</sup> This is the line also adopted by the Australian Heart Foundation.<sup>6</sup>

I wonder if it could be explained how the figure of a CV risk of 15% as the threshold for prescribing aspirin was arrived at and where the evidence of benefit for it is derived from?

*Bill Cartledge, general practitioner, Avon Medical Centre Stratford, Taranaki; bill.cartledge@pbcl.health.nz*

## References

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2. Barnett H, Burrill P, Iheanacho I. Don't use aspirin for primary prevention. *BMJ* 2010;340:c1805.
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6. Australian Heart Foundation. Coronary heart disease. [Cited 2013 Feb]. Available from: [www.heartfoundation.org.au/information-for-professionals/Clinical-Information/pages/coronary-heart-disease.aspx](http://www.heartfoundation.org.au/information-for-professionals/Clinical-Information/pages/coronary-heart-disease.aspx).

## Author's Response

Thank you, Dr Cartledge, for raising this controversial aspect of aspirin for primary prevention. There is good evidence for aspirin after a cardiovascular event, and evidence that risk outweighs benefit for people who have not had an event. The dilemma is around those people who are at high risk of a cardiovascular event, but have not had an event yet.

For many years the New Zealand guidelines have taken a holistic approach to cardiovascular risk and when to treat along the continuum of risk, recommending the addition of pharmacological treatment at a calculated cardiovascular risk greater than 15%. This has added to the complexity because the research usually focuses on one medical condition—high blood pressure, dyslipidaemia or use of an antithrombotic. This means that in primary prevention trials, and particularly the older trials, there is no analysis according to level of holistic cardiovascular risk—an unfortunate gap in the evidence.

Bringing this into the New Zealand concept of treating high cardiovascular risk, a pragmatic approach is to treat cardiovascular risk greater than 15% with statins and/or blood pressure-lowering medicines, and if the risk continues above 15%, then add aspirin to reduce the risk a further 1%.<sup>1</sup>

The work by Selak et al.<sup>1</sup> reviewed the risks and benefits of aspirin according to age. A rider that was not included in the article, but should have been, is that harm may outweigh benefit for primary prevention and a cardiovascular risk over 15% for men over 80 years old. Usual clinical judgement applies for those with a history of peptic ulcer disease or bleeding disorders.

*Linda Bryant*

## Reference

1. Selak V, Elley C, Wells S, Rodgers A, Sharpe N. Aspirin for primary prevention: yes or no? *J Prim Health Care*. 2010;2(2):92–99.

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### Communication with non-English-speaking patients

The article from Ete-Rasch and Nelson<sup>1</sup> was a great addition to the literature examining the reasons behind the admission of Pacific children to hospital because of severe skin infection, and noting the ethnic disparities in admissions. The researchers noted that four of the 11 mothers had English as a second language, and that the research interview was conducted in Samoan for three of those women. Unfortunately no information was provided about how these women managed to communicate with their primary care service. Did they believe that their limited English interfered with the consultation? Did they have a language-concordant clinician? Was an interpreter used; if so, was it a family member or a professional? One of the conclusions related to the provision of health information. This is extraordinarily difficult if the clinician does not share a language with the patient. Written information is not necessarily of use, because without a shared language an assessment of literacy cannot be done. Interpreter services are significantly underutilised in New Zealand.<sup>2</sup> With DHB funding of interpreters in primary care in Auckland and PHO funding in many other areas it is important that, in research projects such as this, the important issue of adequacy of communication is properly assessed, and that we all expect nothing less than the same level of communication with our Pacific patients as we expect with English-speaking patients, by the use of a professional interpreter if necessary.

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### References

- 1 Ete-Rasch E, Nelson K. Management of skin infections of Pacific children prior to hospitalisations. *J Prim Health Care*. 2013;5(1):43–51.
- 2 Gray B, Hilder J, Donaldson H. Why do we not use trained interpreters for all patients with limited English proficiency? Is there a place for using family members? *Aust J Prim Health*. 2011;17(3):240–249.

### Authors' Response

Dr Gray has raised a relevant point that was not covered in our article. However, while the study didn't pursue the use of interpreters for the four mothers with English as their second language, mothers themselves didn't mention this during the interviews. Therefore, we can only assume interpreters were not made available to them. In our view, the use of interpreters would probably not have made a difference in the outcome of the study as mothers' experiences were similar whether English was their first or second language.

We acknowledge that health literacy is a barrier to health care and the use of interpreters is one way of addressing this. However, as written health information available in other languages is usually translated from the English versions, we consider clinicians should be familiar with the information provided. Such written information should not only be available at consultation but in the community generally. We applaud Dr Gray's support in ensuring that people with English as a second language are provided with the same level of care as everyone else by encouraging the use of interpreters. While spoken language is important in communication and understanding, culture also has a role. Language and culture go hand in hand. Understanding and interpreting something spoken in one language (English, for example) can be understood and interpreted differently by people from different cultures and background. Shared language together with shared understanding is better for better health outcomes.

*Elaine Ete-Rasch and Katherine Nelson*

### An alarming symptom

I was asked to visit an 80-year-old lady complaining of unilateral tinnitus. She suffered with cardiac failure and had been receiving home visits for a while on account of her reduced mobility. She also had a past history of contralateral mastoid surgery and subsequent hearing loss. New auditory symptoms in her one good ear were understandably of particular concern for her.

Upon letting me in to her three-bedroom semi-detached house she described her symptoms. She had been experiencing an intermittent high-pitched beeping sound over the past 24 hours. Intrigued I unpacked my auroscope to examine further. As I peered towards a healthy looking tympanic membrane I was surprised to hear a beep for myself. Looking directly above the patient's sofa there was a smoke alarm flashing; a second beep a minute later clinched the diagnosis.

The role of home visits has been a subject of ongoing debate.<sup>1</sup> However, this case served as a reminder of the possible role of home visits not only in serving our less mobile patients, but also in securing an unusual diagnosis that otherwise might have led to unnecessary further investigation. It also enabled the important public health preventative measure of ensuring a functioning battery in the smoke alarm, even though it required the patient's son to come round and fit it.

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### References

- 1 Theili G, Kruschinski C, Buck M, Müller CA, Hummers-Pradier E. Home visits—central to primary care, tradition or an obligation? A qualitative study. *BMC Fam Pract*. 2011;12:24.