Kliiniline küsimus nr

Kas kroonilise neeruhaigusega patsientidel järgmiste ravimite kasutamise ja annustamise otsustamisel tuleb arvestada neerufunktsiooni (kreatiniin, eGFR) väärtusi vs mitte:
- aspiriin

Kriitilised tulemusnäitajad: kroonilise neeruhaiguse ravi tulemuslikkus, põhihaiguse ravi tulemuslikkus, äge neerukahjustus, kroonilise neeruhaiguse progresseerumine, neeruasendusravi, hospitaliseerimine, patsiendi elukvaliteet, ravikulu, elulemus, üldsuremuse vähenemine

Lisa: vastavalt töörühma suunistele otsitud lisamaterjali aspiriini kohta.

Uuringud

Preventing Cardiovascular Disease in Patients with Diabetes: Use of Aspirin for Primary Prevention
Dhaval Desai & Haitham M. Ahmed & Erin D. Michos

Table 1 Summary of trials evaluating use of aspirin in primary prevention

Study	Mean follow-up period	Study design	Aspirin dose	Number of patients	Number (%) enrolled with diabetes	Female (%)	ASCVD endpoint	RR (95 % CI) of ASCVD with aspirin therapy in patients with diabetes
BMD (1988)	5.6	Randomized, open-label, no placebo	500 mg daily	5139	101 (2)	0	Major cardiac event	1.00 (0.42–2.40)
PHS (1989)	5.0	Randomized, double-blind, placebo controlled, 2 × 2 (evaluating beta-carotene)	325 mg every other day	22,071	533 (2.5%)	0	Fatal and nonfatal MI	0.59 (0.33–1.06)
TPT (1998)	6.7	Randomized, double-blind, placebo -controlled, 2 x 2 (evaluating warfarin)	75 mg daily	5085	Not recorded	0	Major cardiac event	0.90 (0.28–2.89)
HOT (1998)	3.8	Randomized, double-blind, placebo controlled, 2 x2 (evaluating intensive blood pressure lowering)	75 mg daily	19,790	1501 (8.0%)	47%	Major cardiac event	0.77 (0.44–1.36)
PPP (2003)	3.7	Randomized, open-label, no placebo, 2 x 2 (evaluating vitamin E)	100 mg daily	4495	1031 (17%)	58%	Fatal and nonfatal MI	0.85 (0.73–1.00)
WHS (2001)	10.1	Randomized, double-blind, placebo-controlled, 2 x 2 (evaluating vitamin E)	100 mg every other day	39,876	1027 (2.6%)	100%	Fatal and nonfatal MI	1.34 (0.85-2.12); stroke events 0.45 (0.25–0.82)
AAA (2010)	8.2	Randomized, double-blind, placebo-controlled,	100 mg daily	3350	98 (3%)	72%	Major cardiac event	Event rate in diabetics not reported
JPPP (2014)	5.0	Randomized, double-blind, placebo-controlled	100 mg daily	14,464	4903 (34%)	58%	Death, nonfatal MI, nonfatal CVA	0.89 (0.66–1.18)
ETDRS (1992)	5.0	Randomized, double-blind, placebo controlled,	650 mg daily	3711	3711 (100%)	44%	Fatal and nonfatal MI	0.82 (0.65–1.03)
JPAD (2008)	4.4	Randomized, open-label, blinded, placebo controlled,	81 or 100 mg daily	2539	2539 (100%)	45%	Major cardiac event	0.80 (0.58–1.10)
POPADAD (2008)	6.7	Randomized, double-blind, placebo controlled. 2 x 2 (evaluating antioxidants)	100 mg daily	1276	1276 (100%)	56%	ASCVD death + nonfatal MI	0.87 (0.40–1.87)

Table adapted from Pignone M, Alberts MJ, Colwell JA, et al. Aspirin for primary prevention of cardiovascular events in people with diabetes: a position statement of the American Diabetes Association, a scientific statement of the American Heart Association, and an expert consensus document of the American College of Cardiology Foundation. J Am Coll Cardiol. 2010;55 [25]:2878–86, with permission from Elsevier [30•]

Shaded rows indicated clinical trials that enrolled diabetes exclusively

Rootsi kohort ja juht-kontroll uuringus hinnati aspiriini ja atsetaminofeeni mõju neerufunktsioonile. Osalejate arv: 1898 (918 CKD ja 980 kontrolli) ja 801. Uuringute tulemused näitasid, et mitteregulaarne aspiriini ja atsetaminofeeni kasutamine ei põhjusta CKD progresseerumist.
Gooch: kohort uuring, 10 000 osalejat, vanus >66 a.

Table 3 Quantification of High Daily Use (Upper Decile of Defined Daily Dose) for Several Common NSAIDs

NSAID	Dose per Tablet (mg)	Total Quantity for Study Duration (n tablets)	Mean Tablets per Day (n)	Mean Dose per Day (mg)
Celecoxib	100	1180	1.2	120
Celecoxib	200	590	0.6	120
Rofecoxib	12.5	1180	1.2	15
Rofecoxib	25	590	0.6	15
Naproxen	250	1180	1.2	300
Diclofenac	25	2360	2.3	60
Diclofenac	50	1180	1.2	60
Ibuprofen	200	3540	3.5	700

Ravijuhendid

KDIGO

4.1.3: We suggest that adults with CKD at risk for atherosclerotic events be offered treatment with antiplatelet agents unless there is an increased bleeding risk that needs to be balanced against the possible cardiovascular benefits. (2B)

Soovitame, et KNHga täiskasvanutele kellel on riks südame-veresoonkonna haigusteks pakutakse antiagregantravi kui ei ole tõusnud veritsuse riski ja mistõttu risk veritsuseks on kõrgem kui kardiovaskulaarne kasu.

AHA/ASA Guideline

Guidelines for the Primary Prevention of Stroke (2014) lk. 45

A Guideline for Healthcare Professionals From the American Heart Association/American Stroke Association

1. The benefit of aspirin for reduction of stroke risk has not been satisfactorily demonstrated for patients with diabetes; however, administration of aspirin may be reasonable in those at high CVD risk (also see section on aspirin) (Class IIb; Level of Evidence B).

Recommendations

1. The use of aspirin for cardiovascular (including but not specific to stroke) prophylaxis is reasonable for people whose risk is sufficiently high (10-year risk >10%) for the benefits to outweigh the risks associated with treatment. A cardiovascular risk calculator to assist in estimating 10-year risk can be found online at http://my.americanheart.org/cvriskcalculator (Class IIa; Level of Evidence A).

2. Aspirin (81 mg daily or 100 mg every other day) can be useful for prevention of a first stroke among women whose risk is sufficiently high for the benefits to outweigh the risks associated with treatment (Class IIa; Level of Evidence B).

3. Aspirin might be considered for the prevention of a first stroke in people with chronic kidney disease (ie, estimated glomerular filtration rate <45 mL/min/1.73 m2) (Class IIb; Level of Evidence C). This recommendation does not apply to severe kidney disease (stage 4 or 5; estimated glomerular filtration rate <30 mL/min/1.73 m2). HOT

4. Aspirin is not useful for preventing a first stroke in persons at low risk (Class III; Level of Evidence A).

5. Aspirin is not useful for preventing a first stroke in people with diabetes mellitus in the absence of other high-risk conditions (Class III; Level of Evidence A).

6. Aspirin is not useful for preventing a first stroke in persons with diabetes or diabetes plus asymptomatic peripheral artery disease (defined as an ankle brachial pressure index ≤0.99) in the absence of other established CVD (Class III; Level of Evidence B).

7. The use of aspirin for other specific situations (eg, atrial fibrillation, carotid artery stenosis) is discussed in the relevant sections of this statement

Atherosclerotic cardiovascular disease (ASCVD) http://tools.acc.org/ASCVD-Risk-Estimator/

The information required to estimate ASCVD risk includes age, sex, race, total cholesterol, HDL cholesterol, systolic blood pressure, blood pressure lowering medication use, diabetes status, and smoking status.