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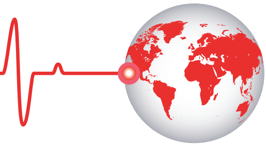

LETTER TO THE EDITOR

Aspirin underuse in secondary prevention: beyond access and adherence

Fasih Mehmood,[1] Nayab Magsi,[2] Arslan Tariq[3]

[1]PEMH/CMH Rawalpindi, Islamabad, Pakistan; [2]Jinnah Sindh Medical University, Karachi, Pakistan; 3I.K. Akhunbaev Kyrgyz State Medical AcademyBishkek, Kyrgyzstan

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**Correspondence to: Correspondence to: Fasih Mehmood, Faculty of General Medicine, I.K. Akhunbaev Kyrgyz State Medical Academy, Bishkek, Kyrgyzstan.*
E-mail: Sattifasihmehmood@gmail.com

To the Editor,
Cardiovascular disease (CVD) remains the leading cause of mortality worldwide, yet aspirin, one of the most effective and inexpensive therapies for secondary prevention, continues to be underused across diverse healthcare settings and patient populations.[1] Importantly, this underuse reflects not only limited access to therapy, but also disparities in adherence, persistence, and uncertainty regarding benefit in certain high-risk groups.
Recent multinational evidence highlights striking global inequities in aspirin use. In a pooled patient-level analysis of 124,505 adults with established CVD across 51 countries, overall aspirin use for secondary prevention was only 40.3%, ranging from 16.6% in low-income countries to 65.0% in high-income countries. Women, individuals living in rural areas, and patients with lower educational attainment were significantly less likely to receive aspirin therapy, with prevalence ratios of 0.80 for women *versus* men and 0.72 for rural *versus* urban populations. These findings emphasize persistent socioeconomic and geographic disparities in evidence-based cardiovascular care.[1]
Equally concerning is poor long-term persistence with therapy. A population-based cohort study from Germany and the United Kingdom demonstrated that only 35-58% of patients remained on aspirin five years after initiation.[2] This highlights the need for sustained follow-up, patient education, and adherence-focused interventions. Current prevention guidelines continue to support individualized antiplatelet decisions in selected cardiovascular patients.[3,4]
Emerging evidence also suggests that aspirin's benefits may not be uniform across all high-risk populations. In the Chronic Renal Insufficiency Cohort study, aspirin use among patients with chronic kidney disease was not associated with a significant reduction in cardiovascular events or mortality (HR 0.88; 95%CI : 0.77-1.02), while also not increasing major bleeding risk.[5]
Similar treatment gaps are evident in low- and middle-income countries, including Pakistan. In a Karachi-based observational study of post-myocardial infarction patients, higher educational status and participation in cardiac rehabilitation were associated with greater low-dose aspirin use.[6]

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