We thank Petricevic et al. for their comments [1] on our manuscript [2]. We also appreciate the editor giving us the opportunity to reply. For patients undergoing coronary artery bypass grafting (CABG), current guidelines recommend aspirin monotherapy in doses of 75–162 mg per day starting within 48 h of surgery [3]. This has been based on the clopidogrel in unstable angina to prevent recurrent ischemic events (CURE) trial, which indicated that dual antiplatelet therapy was beneficial in reducing adverse outcomes in patients presented with acute coronary syndrome and those who ultimately underwent CABG. However, that benefit was totally preoperative while patients were awaiting surgery, and no benefit for clopidogrel was demonstrated for CURE patients after coronary surgery [4]. In our study, only patients who developed aspirin resistance were prescribed clopidogrel. And laboratory assays of aspirin resistance and the results will not be in on-treatment with acetyl salicylic acid: a prospective study. Heart Vessels 2011;26:516–22.


In summary, we thank Petricevic et al. for their valuable recommendation which might be of great value in further studies. We concur that it is necessary to make sure of the risk factors of aspirin resistance and reach the aim of individual antiplatelet therapy.

REFERENCES


LETTER TO THE EDITOR RESPONSE

Reply to Petricevic et al.

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Keywords: Aspirin resistance • Coronary artery bypass grafting • Platelet aggregation

We thank Petricevic et al. for their comments [1] on our manuscript [2]. We also appreciate the editor giving us the opportunity to reply. For patients undergoing coronary artery bypass grafting surgery (CABG), current guidelines recommend aspirin monotherapy in doses of 75–162 mg per day starting within 48 h of surgery [3]. This has been based on the clopidogrel in unstable angina to prevent recurrent ischemic events (CURE) trial, which indicated that dual antiplatelet therapy was beneficial in reducing adverse outcomes in patients presented with acute coronary syndrome and those who ultimately underwent CABG. However, that benefit was totally preoperative while patients were awaiting surgery, and no benefit for clopidogrel was demonstrated for CURE patients after coronary surgery [4]. In our study, only patients who developed aspirin resistance were prescribed clopidogrel. And laboratory assays of aspirin resistance (0.5 mg/dl arachidonic acid-induced platelet aggregation) were used very commonly. It is effective to evaluate aspirin resistance and the results will not be influenced by clopidogrel, because the pathway of clopidogrel (adenosine diphosphate (ADP)-induced platelet aggregation) is different.

In our study, only one dose of aspirin (100 mg/day) was used. This is one of the limitations of our article which has been mentioned in the discussion. The generation of new platelets after surgery make the common dosage of aspirin not suitable for antiplatelet therapy. That is a plausible mechanism for aspirin resistance. There are also other risk factors of aspirin resistance such as female gender, smoking and genetic background. They will be evaluated in our further research including ischaemic and bleeding events.

In summary, we thank Petricevic et al. for their valuable recommendation which might be of great value in further studies. We concur that it is necessary to make sure of the risk factors of aspirin resistance and reach the aim of individual antiplatelet therapy.

REFERENCES


