Impact of aspirin use on clinical outcomes in patients with vasospastic angina: a systematic review and meta-analysis

Yaowang Lin,1,2 Yang Chen,2 Jie Yuan,1 Haiyan Qin,3 Shaohong Dong,1 Qiuling Chen4

ABSTRACT

Objectives The use of aspirin to prevent cardiovascular disease in vasospastic angina (VSA) patients without significant stenosis has yet to be investigated. This study aimed to investigate the efficacy of aspirin use among VSA patients.

Design Systematic review and meta-analysis.

Data sources PubMed, Web of Science and Cochrane Central Register of Controlled Trials were searched for relevant information prior to October 2020.

Eligibility criteria for selecting studies Aspirin use versus no aspirin use (placebo or no treatment) among VSA patients without significant stenosis.

Data extraction and synthesis Two investigators extracted the study data. ORs and 95% CIs were calculated and graphed as forest plots. The Newcastle-Ottawa Quality Assessment Scale tool and Begg’s funnel plot were used to assess risk of bias.

Results Four propensity-matched cohorts, one retrospective analysis and one prospective multicentre cohort, in total comprising 3661 patients (aspirin use group, n=1695; no aspirin use group, n=1966) were included in this meta-analysis. Aspirin use and the incidence of major cardiovascular adverse events with follow-up of 1–5 years were not significantly correlated (combined OR=0.90, 95% CI: 0.55 to 1.68, p=0.829, I²=82.2%; subgroup analysis: OR=1.09, 95% CI: 0.81 to 1.47, I²=0%). No significant difference was found between aspirin use and the incidence of myocardial infarction (OR=0.62, 95% CI: 0.09 to 4.36, p=0.615, I²=73.8%) or cardiac death (OR=1.73, 95% CI: 0.61 to 4.94, p=0.444, I²=0%) during follow-up.

Conclusion Aspirin use may not reduce the risk of future cardiovascular events in VSA patients without significant stenosis.

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INTRODUCTION

Coronary spasm characterised by vasospastic angina (VSA) is one cause of ischaemia in a non-obstructive coronary artery.1 2 VSA patients who also suffer from endothelial dysfunction or coronary atherosclerosis commonly use aspirin,3 4 as per the guidelines of the European Society of Cardiology, for the management of chronic stable angina and acute coronary syndromes.5 6

The ASCEND study showed that the use of low-dose aspirin leads to a lower risk of serious vascular events (8.5% vs 9.6%; p=0.01) compared with placebo among persons with diabetes in primary treatment, but the absolute benefits of aspirin are largely counterbalanced by the bleeding hazard (4.1% vs 3.2%; p=0.003).7 The ARRIVE study also suggested that aspirin use may result in a higher incidence of gastrointestinal bleeding (0.97% vs 0.46%; p=0.0007) or overall incidence of treatment-related adverse events (16.75% vs 13.54%; p=0.0001) compared with control groups.8 Owing to the latest controversy and reduced usage of aspirin in preventing cardiovascular events,9 10 aspirin’s efficiency in VSA patients without significant stenosis has not yet been reported.11–16 Therefore, this meta-analysis was designed to assess the correlation between aspirin use and cardiovascular events and cardiac death among VSA patients during long-term follow-up.
MATERIALS AND METHODS

Search strategy
A comprehensive search of PubMed, Web of Science and Cochrane Central Register of Controlled Trials databases for related research articles conducted before October 2020 was conducted to gather data. The keywords were ‘vasospastic angina’, ‘coronary vasospasms’, ‘vasospasm’, ‘variant angina’, ‘Prinzmetal’s variant angina’, ‘spastic coronary angina’, ‘coronary artery spasm’, as well as ‘aspirin’ and ‘antiplatelet therapy’. Certain additional-related publications, such as review articles and editorials, were also assessed.

Patient and public involvement
Study participants met the eligibility criteria as outlined above. All included patients were diagnosed with epicardial coronary vasospasms by provocation test. Participants and other members of the public were not involved in the recruitment, design, conduct, reporting, or dissemination of this study.

Study selection and data extraction
The patient inclusion criteria were as follows: (i) diagnosis with VSA on provocation test, (ii) absence of significant stenosis (≤50%), (iii) the treatment group was administered oral aspirin and the control group received no aspirin or placebo and (iv) articles published in English. The exclusion criteria were as follows: significant stenosis (≥50%), intravenous aspirin, case report and case series. The study data were independently extracted by two investigators, namely Lin and Chen, using predefined extraction forms; any conflict was resolved by a third reviewer.

Data analysis and risk of bias assessment
Major cardiovascular adverse events (MACE) were the primary endpoints, while myocardial infarction (MI) and cardiac death during follow-up were the secondary endpoints. MACE have been described as cardiac death, acute coronary syndrome and hospitalisation due to unstable angina, percutaneous coronary intervention, symptomatic arrhythmia, appropriate implantable cardioverter defibrillator and shock. The Newcastle-Ottawa Quality Assessment Scale (NOS) tool was utilised to assess the risk of bias, and Begg’s funnel plot was used to evaluate publication bias.

Statistical analysis
STATA software (V.14.0; StataCorp, College Station, TX, USA) was used for the meta-analysis. MACE (primary endpoints) and MI and cardiac death (secondary endpoints) were evaluated as combined ORs with 95% CIs. Heterogeneity between studies was derived using the I² statistic. If I²>50%, the random effect model was used to assess heterogeneity; if I²<50%, the fixed effect model was utilised to evaluate heterogeneity. Subgroups were studied to reduce the heterogeneity if I²>50%. P values<0.05 were considered statistically significant.

RESULTS

Characteristics of included studies
The search engines were reviewed to identify 3645 related studies, among which 1303 articles were duplicates and 2414 articles did not fulfil the inclusion criteria and were excluded from the study. After removing these studies, four propensity-matched cohorts,11 13 14 16 one retrospective analysis12 and one prospective multicentre cohort15 (figure 1), including a total of 3661 patients (aspirin group, n=1095; no aspirin group, n=1966, table 1) were included in the study. Four studies underwent coronary provocation test, except for one study (Seong-Sik Cho, 2019) that used the electrocardiograph provocation test. All studies provided a primary endpoint, with follow-up durations ranging from 1 to 5 years (table 2).

Primary and secondary endpoints
No significant correlation was recorded between aspirin use and MACE incidence within the follow-up of 1–5 years (combined OR=0.90, 95% CI: 0.55 to 1.68, p=0.829, I²=82.2% (figure 2)); subgroup analysis: OR=0.89, 95% CI: 0.40 to 2.02, I²=86.9% and OR=1.09, 95% CI: 0.81 to 1.47, I²=0% (figure 3A,B)).

MI was reported in four studies, and cardiac death was reported in five studies for the secondary endpoint. No significant difference was found between aspirin use and the incidence of MI (OR=0.62, 95% CI: 0.90 to 4.36, p=0.615, I²=73.8%) or cardiac death (OR=1.73, 95% CI: 0.61 to 4.94, p=0.444, I²=0%) during the follow-up (figure 4).

Risk of bias assessment and heterogeneity analysis
The NOS scores for study quality assessment of the included studies ranged from 7 to 9 (table 3). Publication bias is presented by asymmetry in the funnel plot (figure 5). Between-study heterogeneity in MACE-related
DISCUSSION

Our meta-analysis showed that aspirin had no significant effect on reducing MACE, MI and cardiac death in VSA patients without significant stenosis. Coronary artery spasm (CAS) has been reported to play a significant role in the pathogenesis of ischaemic heart disease, including acute coronary syndrome and chronic coronary syndrome.17 A common mechanism by which MI or MINOCA manifests is platelet aggregation, which leads to coronary thrombus formation. Aspirin inhibits cyclooxygenase-1 by reducing the production of thromboxane A2 and therefore has been extensively used in primary or secondary prevention of thrombosis among patients with atherosclerosis or coronary artery disease.18 19 However, the benefit of low dosage aspirin in primary prevention was counterbalanced by higher rates of treatment-related adverse events.7 8 Earlier studies have shown that aspirin use can aggravate CAS due to the lowered production of thromboxane A2 and increased MACE incidence in VSA patients.20 21 Thus, the use of aspirin in VSA patients remains controversial.

MACE incidence in patients administered low-dose aspirin was significantly higher than that among patients

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**Table 1** Clinical characteristics of patients in included studies

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>aspirin vs no</th>
<th>Kim12</th>
<th>Ishii14</th>
<th>Lim13</th>
<th>Lee11</th>
<th>Choi15</th>
<th>Mori16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (year)</td>
<td>/</td>
<td>66.0±9.5 vs 67.0±8.4, p=0.428</td>
<td>49.0–62.0 vs 49.0–62.5, p=0.61</td>
<td>51.3±6.7 vs 50.8±7.5, p=0.70</td>
<td>57.2±11.2 vs 53.5±11.3, p=0.001</td>
<td>65.4±9.9 vs 66.7±10.3, p=0.07</td>
<td></td>
</tr>
<tr>
<td>Males, n (%)</td>
<td>/</td>
<td>47 (42.0) vs 47 (42.0), p=1.000</td>
<td>359 (82.7) vs 243 (84.7), p=0.49</td>
<td>60 (78) vs 55 (71), p=0.354</td>
<td>412 (64.3) vs 590 (58.4), p=0.055</td>
<td>247 (73.7%) vs 253 (75.5%), p=0.66</td>
<td></td>
</tr>
<tr>
<td>Hypertension, n (%)</td>
<td>/</td>
<td>52 (46.4) vs 57 (50.9), p=0.504</td>
<td>156 (36.0) vs 104 (36.2), p=0.96</td>
<td>22 (29) vs 20 (26), p=0.717</td>
<td>294 (45.9) vs 320 (31.7), p=0.001</td>
<td>158 (47.2%) vs 166 (49.6%), p=0.59</td>
<td></td>
</tr>
<tr>
<td>Diabetes mellitus, n (%)</td>
<td>/</td>
<td>26 (23.2) vs 27 (24.1), p=0.875</td>
<td>98 (22.6) vs 66 (23.0), p=0.91</td>
<td>17 (22) vs 16 (19), p=0.547</td>
<td>73 (11.4) vs 83 (8.2), p=0.037</td>
<td>56 (16.7%) vs 56 (16.7%), p=1.00</td>
<td></td>
</tr>
<tr>
<td>Smoking, n (%)</td>
<td>/</td>
<td>59 (52.7) vs 52 (46.4), p=0.350</td>
<td>127 (29.3) vs 87 (30.3), p=0.78</td>
<td>55 (71) vs 57 (74), p=0.717</td>
<td>183 (28.9) vs 250 (24.7), p=0.005</td>
<td>202 (60.3%) vs 202 (60.3%), p=1.00</td>
<td></td>
</tr>
<tr>
<td>Dyslipidaemia, n (%)</td>
<td>/</td>
<td>62 (55.4) vs 60 (53.6), p=0.788</td>
<td>91 (21.0) vs 62 (21.6), p=0.84</td>
<td>/</td>
<td>98 (15.4) vs 160 (15.8), p=0.800</td>
<td>156 (46.6%) vs 142 (42.4%), p=0.31</td>
<td></td>
</tr>
<tr>
<td>Ca channel blocker, n (%)</td>
<td>/</td>
<td>104 (92.9) vs 101 (90.2), p=0.472</td>
<td>420 (96.9) vs 275 (95.8), p=0.46</td>
<td>50 (65) vs 48 (62), p=0.738</td>
<td>152 (24.2) vs 162 (16.12), p=0.001</td>
<td>316 (94.3%) vs 313 (93.4%), p=0.75</td>
<td></td>
</tr>
<tr>
<td>Statin, n (%)</td>
<td>/</td>
<td>38 (33.9) vs 40 (35.7), p=0.779</td>
<td>182 (42.0) vs 113 (39.4), p=0.49</td>
<td>/</td>
<td>123 (19.7) vs 119 (11.9), p=0.001</td>
<td>103 (30.7%) vs 95 (28.4%), p=0.55</td>
<td></td>
</tr>
<tr>
<td>ACEI/ARB, n (%)</td>
<td>/</td>
<td>33 (29.5) vs 25 (22.3), p=0.288</td>
<td>69 (15.9) vs 43 (15.0), p=0.74</td>
<td>/</td>
<td>152 (24.3) vs 126 (12.6), p=0.001</td>
<td>73 (21.8%) vs 71 (21.2%), p=0.93</td>
<td></td>
</tr>
<tr>
<td>Beta-blocker, n (%)</td>
<td>/</td>
<td>6 (5.4) vs 7 (6.3), p=0.775</td>
<td>1 (0.2) vs 0 (0.0), p=0.48</td>
<td>17 (22) vs 23 (30), p=0.270</td>
<td>54 (8.65) vs 59 (5.88), p=0.065</td>
<td>/</td>
<td></td>
</tr>
</tbody>
</table>

ACEI/ARB, angiotensin-converting enzyme inhibitor/angiotensin receptor blocker.
<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Design</th>
<th>Participants</th>
<th>Total</th>
<th>Aspirin</th>
<th>Without aspirin</th>
<th>Dosage of aspirin (mg)</th>
<th>MACE definition</th>
<th>MACE</th>
<th>Myocardial infarction</th>
<th>Cardiac death</th>
<th>All cause death</th>
<th>Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kim</td>
<td>2013</td>
<td>Retrospective analysis</td>
<td>Vasospastic angina (stenosis ≤70%)</td>
<td>240</td>
<td>96</td>
<td>144</td>
<td>100</td>
<td>Readmission rate associated with recurrent angina, cardiac death, percutaneous coronary intervention</td>
<td>20 (20.8) vs 29 (20.1)</td>
<td>/</td>
<td>1 (1.0) vs 1 (0.7)</td>
<td>1 year</td>
<td></td>
</tr>
<tr>
<td>Ishii</td>
<td>2016</td>
<td>Retrospective analysis, propensity score matched analysis</td>
<td>Vasospastic angina (stenosis ≤50%)</td>
<td>224</td>
<td>112</td>
<td>112</td>
<td>81-100</td>
<td>Cardiac death, non-fatal acute myocardial infarction and unstable angina</td>
<td>4 (3.6) vs 6 (5.4)</td>
<td>0 vs 0</td>
<td>2 (1.8) vs / 0 (0)</td>
<td>1 year</td>
<td></td>
</tr>
<tr>
<td>Lim</td>
<td>2016</td>
<td>Retrospective analysis, propensity score matched analysis</td>
<td>Coronary artery spasm (stenosis ≤50%)</td>
<td>721</td>
<td>434</td>
<td>287</td>
<td>100</td>
<td>Cardiac death, acute myocardial infarction, revascularisation or rehospitalisation due to recurrent angina</td>
<td>100 (23.0) vs 34 (11.8)</td>
<td>9 (2.1) vs 6 (0.7)</td>
<td>4 (0.9) vs 10 (2.2) vs 9 (1.5)</td>
<td>5 year</td>
<td></td>
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<tr>
<td>Lee</td>
<td>2018</td>
<td>Retrospective study, propensity score-matched analysis</td>
<td>Coronary artery spasm (stenosis ≤50%)</td>
<td>154</td>
<td>77</td>
<td>77</td>
<td>100</td>
<td>Chest pain recurrence, myocardial infarction and cardiac death</td>
<td>9 (11.7) vs 33 (42.9)</td>
<td>2 (3) vs 13 (17)</td>
<td>0 vs 0</td>
<td>0 vs 0</td>
<td>4 year</td>
</tr>
<tr>
<td>Cho</td>
<td>2019</td>
<td>Prospective multicentre cohort</td>
<td>Coronary artery spasm (stenosis ≤50%)</td>
<td>1652</td>
<td>641</td>
<td>1011</td>
<td>100</td>
<td>All cause death, acute coronary syndrome and symptomatic arrhythmia</td>
<td>29 (4.5) vs 44 (4.4)</td>
<td>/</td>
<td>3 (0.5) vs 7 (0.7)</td>
<td>3 year</td>
<td></td>
</tr>
<tr>
<td>Mori</td>
<td>2020</td>
<td>Retrospective study, propensity score-matched analysis</td>
<td>Coronary artery spasm (stenosis ≤50%)</td>
<td>670</td>
<td>335</td>
<td>335</td>
<td>100</td>
<td>Cardiac death, non-fatal myocardial infarction, hospitalisation due to unstable angina pectoris and appropriate ICD shock</td>
<td>19 (5.7) vs 12 (3.6)</td>
<td>1 (0.3) vs 2 (0.6)</td>
<td>2 (0.6) vs 2 (0.6) vs 6 (1.8)</td>
<td>32 months</td>
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<td></td>
</tr>
</tbody>
</table>

ICD, implantable cardioverter defibrillator; MACE, major cardiovascular adverse events.
not administered aspirin (HR (HR)=1.54; CI: 1.04 to 2.28; p=0.037) during a 52-month median follow-up period.13 In contrast, MI (HR=0.13; CI: 0.03 to 0.61; p=0.014) and chest pain recurrence (HR=0.29; CI: 0.12 to 0.71; p=0.006) were observed by Lee et al to have been significantly reduced by aspirin use among VSA patients during follow-up.11 Lee et al showed that acute intimal tears and erosion identified by optical coherence tomography are susceptible to thrombosis leading to MI. Therefore, aspirin was evidenced to reduce adverse events in VSA patients with a greater number of thrombotic intracoronary lesions. Nevertheless, aspirin use was not significantly correlated with the occurrence of cardiovascular events among VSA patients with non-significant stenosis during a 49-month mean follow-up period (p=0.541).14 Moreover, the aspirin-treated group exhibited a similar MACE incidence compared with the non-antiplatelet agent group (HR=0.96; CI: 0.59 to 1.55, p=0.872) as reported by Cho et al.15 Antiplatelet therapy was recently shown by Mori et al to have no beneficial effects on MACE (5.7% vs 3.6%, p=0.20) among VSA patients during a 32-month median follow-up period.16

Our meta-analysis indicates that aspirin use may not be linked to a lower risk of MACE and cardiac death. The subgroup analysis of MACE indicated that the studies by Lee11 and Lim13 were heterogeneous. The origin of heterogeneity in these studies may be attributable to chest pain recurrence in the MACE, which results in an entirely different outcome due to the definition. The following may potentially explain the lack of beneficial effects of aspirin use: (i) Aspirin use is known to damage the gastric mucosal barrier and increase risk of erosions, ulcers and bleeding by inhibiting cyclooxygenase-1 enzyme activity.22 Several meta-analyses have indicated that aspirin’s efficacy in primary prevention of cardiovascular disease should be weighed against any increase in major bleeding.23–25 (ii) The adverse effects of asthma and dyspnoea may lead to CAS and increase the occurrence of MACE or cardiogenic death with aspirin use.26 27 (iii) The synthesis of prostacyclin, a well-known vasodilator released by endothelial cells, is inhibited by aspirin28 and CAS is induced.
Aspirin use may not reduce the risk of cardiovascular events in VSA patients without significant stenosis. Despite these limitations, the merit of this study is that it is the first to evaluate the prognosis of VSA patients using low-dose aspirin.

### Table 3: Newcastle-Ottawa Quality Assessment Scale (NOS) for included studies

<table>
<thead>
<tr>
<th>Study</th>
<th>Selection</th>
<th>Representativeness of the exposed cohort</th>
<th>Selection of the non-exposed cohort</th>
<th>Ascertainment of exposure</th>
<th>Demonstration that outcome of interest was not present at start of study</th>
<th>Comparability of cohorts on the basis of the design or analysis</th>
<th>Assessment of outcome</th>
<th>Was follow-up long enough for outcomes to occur</th>
<th>Adequacy of follow-up of cohorts</th>
<th>Total scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kim12</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td>8</td>
</tr>
<tr>
<td>Ishii14</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td>8</td>
</tr>
<tr>
<td>Lim13</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td>★</td>
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<td>8</td>
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<tr>
<td>Lee11</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td>9</td>
</tr>
<tr>
<td>Cho15</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td>★</td>
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<tr>
<td>Mor16</td>
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<td>★</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td>7</td>
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</table>

The bold star = 1 score. The hollow star = 0 score.
REFERENCES


