

Low-dose aspirin in pregnancy

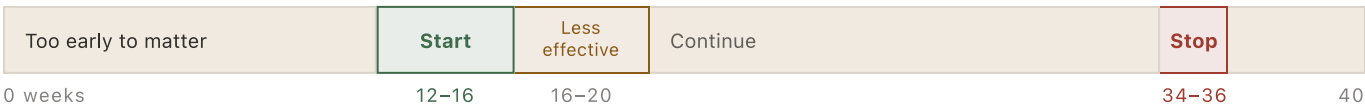
I welcome direct GP referrals and calls for advice.

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AT A GLANCE

- **150 mg at night, started before 16 weeks, ceased between 34 and 36 weeks.**
- Offer to any woman with **one high-risk factor or two moderate-risk factors.**
- The window matters more than the dose. Started before 16 weeks it works; started late it largely doesn't.
- Add **calcium 1 g daily** if dietary calcium is under about 1 g per day — fewer than four serves of dairy.
- Safe in pregnancy and breastfeeding at this dose, and does not need to be stopped before an epidural.

FIGURE 1 · THE WINDOW



ASPRE dosed 150 mg from 11–14 weeks through to 36 weeks. Starting before 16 weeks is what makes aspirin work.

Who to start

HIGH RISK — ONE IS ENOUGH

- Previous preeclampsia, gestational hypertension, HELLP or eclampsia
- Chronic hypertension
- Pre-existing type 1 or type 2 diabetes
- Chronic kidney disease
- Autoimmune disease — SLE, antiphospholipid syndrome, scleroderma
- Multiple pregnancy

MODERATE RISK — TWO OR MORE

- Nulliparity
- Age ≥ 40
- BMI ≥ 35 at booking
- Preeclampsia in mother or sister
- Interpregnancy interval >10 years
- Assisted reproduction, particularly donor oocytes
- Booking BP ≥ 130 systolic or ≥ 80 diastolic
- Previous SGA infant, stillbirth or abruption

Lists vary slightly between guidelines. Where a woman sits near the threshold, the risks of low-dose aspirin are small enough that treating is usually the more defensible choice. This list follows Safer Care Victoria, which is what Victorian services work from.

The regimen

DOSE	150 mg daily
TIMING	At night — bedtime dosing is conditionally recommended and appears to work better than morning dosing
START	Before 16 weeks. Ideally 12–16 weeks, and it may be started from as early as 11–12 weeks
STOP	Between 34 and 36 weeks, individualised. ASPRE continued to 36 weeks
AUS TABLETS	In australia, aspirin is in two formulations. 100 mg: 150 mg means one and a half tablets. 300 mg: 150 mg means one tablet halved (discard the other half, don't keep it for later). Alternatively, 100 mg daily is a reasonable and is what several Victorian services use

If a risk factor emerges after 16 weeks — a new diagnosis, a growth-restricted fetus, abnormal uterine artery Dopplers at the morphology scan — starting aspirin is still reasonable, but the evidence for benefit is weaker and it should not displace closer surveillance.

Ceasing: low-dose aspirin is not a contraindication to epidural or spinal, so there is no need to stop it before neuraxial anaesthesia. Stop it for significant bleeding, and once preeclampsia is diagnosed.

What it actually buys

SCREENED HIGH RISK — ASPRE

150 mg from 11–14 weeks to 36 weeks. Preterm preeclampsia occurred in

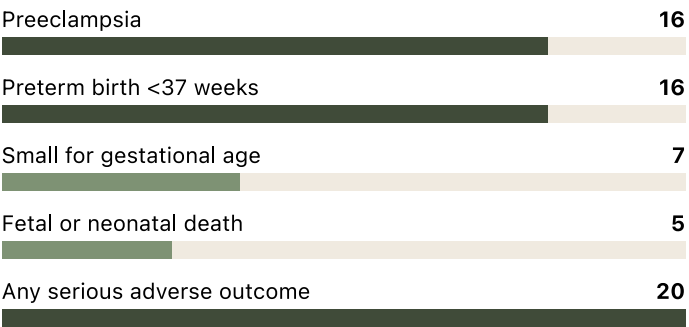
1.6% on aspirin

4.3% on placebo

Odds ratio 0.38 — roughly a 60% relative reduction.

FIGURE 2 · ABSOLUTE BENEFIT

Fewer events per 1000 women treated — Cochrane, 77 trials, 40,249 women



Relative risks: 0.82, 0.91, 0.84, 0.85, 0.90. High-certainty evidence.

PRETERM BIRTH SPECIFICALLY

In the ASPIRIN trial of 11,976 nulliparous women, 81 mg started at 6–13+6 weeks reduced birth before 37 weeks (RR 0.89), before 34 weeks (RR 0.75) and perinatal mortality (RR 0.86). The benefit sits mostly with **medically indicated** preterm birth — aspirin prevents the placental disease that leads to early delivery, rather than preventing spontaneous labour. The SGA reduction is real but modest, and does not replace growth surveillance.

HARMS — WHAT TO TELL HER

- PPH >500 mL: RR 1.06 — a small increase, moderate certainty
- Placental abruption: RR 1.21, confidence interval crossing 1 — marginal at most
- No signal of harm to childhood development in over 5000 children followed to 18 months
- No increase in congenital anomaly

Cautions: aspirin allergy or NSAID-sensitive asthma; active peptic ulceration; bleeding disorder or significant thrombocytopenia. Ask about asthma before prescribing.

CALCIUM

Strongly recommended where dietary intake is low — under 1 g/day, roughly fewer than four serves of dairy. Calcium carbonate **1 g daily**, or 600 mg three times daily in the higher-dose regimens some services use, continued to the end of pregnancy. A cheap, low-risk adjunct — but an adjunct, not a substitute for aspirin.

ON THE HORIZON — NOT CURRENT PRACTICE

The StopPRE trial found that in high-risk women with a normal sFlt-1/PlGF ratio at 24–28 weeks, stopping aspirin then was non-inferior to continuing to 36 weeks, with less minor antepartum bleeding. This is not yet Australian practice and should not change what you do — but expect the question.

REFER TO / DISCUSS WITH THE OBSTETRICIAN

- Previous early-onset (<34 weeks) preeclampsia, or preeclampsia requiring preterm delivery
- Uncertainty about whether the risk profile warrants aspirin
- Chronic hypertension, established renal disease or APLS — these women need a plan beyond aspirin
- Any new hypertension, proteinuria or preeclampsia symptoms at any gestation — same-day discussion

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Sources: SOMANZ Hypertension in Pregnancy Guideline 2023; Safer Care Victoria Hypertension in Pregnancy clinical guidance, October 2024. Key trials: ASPRE (Rolnik, *NEJM* 2017); ASPIRIN (Hoffman, *Lancet* 2020); Cochrane antiplatelet agents review (Duley, 2019).