advices, as measured by a point-of-care assay and according to the SYNTAX Score. There were evidences in studies in line with the present study done in Egypt and South Africa concluded that PCI or CABG increased risk of "aspirin-resistance" AR [34, 39].

Chronic kidney disease were recognized to be one of high disease interaction which increased the rate of AR in all population with elderly patients (2.84%) 211 aspirin resistance CKD in end stage. In the present study (p value =0.244) which was not significant in the present study, but many other study were supported this result. [36,40]

This study showed that certain disease such as GIT ulcers was important factor behind aspirin resistance. This finding was not significant (p value= 0.08), but it was complied with some studies already published in literature.[45-47].

All drug interaction were managed in the study by pharmacy department using the electronic system for food and drug –drug interactions and physicians were informed to change any medication which had either major drug or food interaction. Those with minor drug interaction, administration time for drugs and food were managed also in inpatient and outpatient counseling. This study also revealed coadministration of certain drugs like NSAID increased aspirin resistance and others like diuretics delayed aspirin resistance such as Angiotensin I & II which in line with other studies published in literature. [35, 48-49].

Some patients in this study developed antiplatelet resistance when they use aspirin with Clopidogrel after cardiac intervention, they shifted to Ticagrelor, There were evidences in some studies in Saudi Arabia and others countries matching with this result.[33, 43, 51-52]

In Arab countries the knowledge of aspirin resistance is very poor from patient side and from clinicians' practices usually they neglected. Considering all these we argue with our clinicians to highlighted this issue and more intervention should be done for patient compliance and noncompliance to discover if we need to measure Aspirin resistance after prescribing the low dose for primary CAD to avoid the sudden death for the patients when CAD events were progress and aspirin not working because of anyone from the previous reasons.

CONCLUSION

Previous studies have demonstrated clinical importance of "aspirin resistance" AR which has similar frequency in men and women and increases with age (50-89). Risk factors for AR are similar to other atherosclerotic diseases. Patients with risk factor have more risk to develop AR and underwent for cardiac procedures. AR detection needs improving life style for cardiovascular prevention and treatment.

The study showed that causes for aspirin resistance which had been discussed in this study were: risk factors, drug-drug interactions, food drug interaction, and disease interaction. All patients in these population represent main causes of aspirin resistance were received aspirin regularly for cardiovascular prevention with the majority using it for primary prevention.

Overall, 76.78% patients with cardiovascular events were recorded on antiplatelet treatment versus 23.22% without cardiovascular event.

This study may showed that the maximum failure of treatment in primary and secondary CAD (162 patients) from (211 patients) may perceived "resistance", when compliance and other causes managed assured, 23.22 % of these populations showed response to prophylactic by a dose of 81mg aspirin enteric-coated. This result is agreed with other studies which showed that the maximum prevalence of true AR is between (5%-45%).

In conclusion, in our trial involving patients with stable CAD was not found to be superior to aspirin in reducing the risk of the composite end point of ACS which lead to cardiac interventions.

CONFLICT OF INTEREST

The authors declare no conflict of interest in this study.

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