



SDI Review Form 1.6

Journal Name:	Cardiology and Angiology: An International Journal
Manuscript Number:	Ms_CA_36200
Title of the Manuscript:	Acetyl Salicylic acid and Omega 3 Fatty Acids in the pro resolving pathway of Cardiovascular Disorders
Type of the Article	Review Paper

General guideline for Peer Review process:

This journal's peer review policy states that **NO** manuscript should be rejected only on the basis of '**lack of Novelty**', provided the manuscript is scientifically robust and technically sound.

To know the complete guideline for Peer Review process, reviewers are requested to visit this link:

(<http://www.sciencedomain.org/page.php?id=sdi-general-editorial-policy#Peer-Review-Guideline>)



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PART 1: Review Comments

	Reviewer's comment	Author's comment (if agreed with reviewer, correct the manuscript and highlight that part in the manuscript. It is mandatory that authors should write his/her feedback here)
Compulsory REVISION comments		
Minor REVISION comments		
Optional/General comments	The Authors have well dressed an important of an old and most common drug: Aspirin. The paper is well written. However; the paragraph discussing the current recommendations of Aspirin would have been with more details to bring up the efficiency of this common drug.	Respected Sir The following language is added in the Current recommendations. Another indication of aspirin is prevention of pregnancy-induced hypertension. The USPSTF recommends the use of low-dose aspirin (81 mg/d) as preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia. (B recommendation)(40,41,42). If the women is identified to be high risk later in pregnancy Aspirin still needs to be started as various multi centric stratified comparisons did not show that the timing of aspirin initiation (<16 weeks) or dosage had any effect on reducing the efficacy of aspirin for the prevention of preeclampsia (43,44). Evidence dose not suggest benefit of starting aspirin earlier (12 -16 weeks) rather than later in pregnancy. World health Organization recommends the use of low dose aspirin (75 mg) as early as 12 -20 weeks of gestation for high risk women (previous preeclampsia, diabetes, chronic hypertension, renal or auto immune disease, or multifetal gestation). There is limited evidence regarding the benefit of aspirin in low risk women (43). The National Institute for Health and Care Excellence recommends that women at high risk for preeclampsia (i.e., those with a history of hypertension in a previous Pregnancy, chronic kidney disease, autoimmune disease, type 1 or 2 diabetes, or chronic hypertension) take 75mg/d of aspirin from 12 weeks until delivery. It recommends the same for women with more than one moderate risk factor (first pregnancy, age >40 years, pregnancy interval>10 years, body mass index >35 kg/m2, family history of preeclampsia, or multifetal pregnancies) (44). The American Heart Association and the American Stroke Association recommend that women with chronic primary or secondary hypertension or previous pregnancy related hypertension take low-dose aspirin from 12 weeks until delivery. The American Academy of Family Physicians recommends low-dose aspirin (81 mg/d) after 12 weeks of gestation in women who are at high risk for preeclampsia. Another clinical use of low dose aspirin (75-81mg/day) is diagnosed antiphospholipid antibody syndrome. Antiphospholipid antibody syndrome is characterized by clinical evidence of vascular thrombosis and obstetrical complications like early pregnancy miscarriage, intrauterine growth restriction, preeclampsia and preterm births (45,46). Serology study reveals persisting antiphospholipid antibodies on two occasions 6 weeks apart. The diagnosis of obstetric antiphospholipid antibody syndrome includes presence of both clinical and serological



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		criteria (47). The pathophysiology involves activation of endothelial cells, platelets, monocytes and complement pathways (48). The anticoagulant proteins are inhibited. It has been suggested that the obstetric complications are associated with placental ischemia and inflammation rather than thrombosis at the fetomaternal interphase (49,50,51). Low dose aspirin with low molecular weight heparin is the preferred treatment in pregnancy with antiphospholipid antibody syndrome (52,53).
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