**Antiplatelet guidelines for primary care**

- Antiplatelet therapy is indicated for the prevention of thrombotic events, and should be restricted to those with vascular disease and those with atrial fibrillation if anticoagulation is not indicated or refused.
- These guidelines represent the most up to date opinions on antiplatelet prescribing for the prevention of secondary cardiovascular events, at the time of publication, and can be used as a desktop reference for the indications and recommendations for their use.
- Antiplatelet agents such as clopidogrel, prasugrel and ticagrelor MUST be initiated in secondary care by a consultant cardiologist, but continued in primary care.

### Acute coronary syndrome (ACS)

**The choice** of antiplatelet agent will depend on the type of ACS and percutaneous coronary intervention (PCI). Check hospital discharge plan.

**All these agents:**
- SHOULD be used in combination with aspirin.
- Are licensed for use in ACS, for up to 12 months, after which they should be stopped. The patient should continue on low dose aspirin (75mg) daily, indefinitely.
- Must not be stopped earlier than recommended without discussion with the initiating clinician.
- Must have a stop date documented on EMIS.

#### Dose & Duration:

**Clopidogrel:** 75mg daily for 12 months. (For STEMI, optimal duration has not been established, but many local consultants now recommend continuing up to 12 months – check the hospital discharge plan).

**Prasugrel:** 10mg daily for 12 months.

**Ticagrelor:** 90mg twice daily for 12 months.

**Additional Monitoring** in patients taking ticagrelor – renal function should be measured 4 weeks after initiation and thereafter according to routine monitoring. Dyspnoea could occur and is usually transient, but if persistent or severe, seek advice from the initiating team.

See BNF/SPC for cautions, contraindications, side effects and drug interactions.

**Post-coronary artery bypass & grafting (CABG), if initiated prior to hospital discharge**

Clopidogrel 75mg od and aspirin 75mg od for 1 month, thereafter aspirin 75mg od indefinitely. (Optimal duration has not been established, and some local consultants may recommend continuing up to 3 months – check the hospital discharge plan).

**Stable coronary artery disease**

Aspirin 75mg od indefinitely.

**Ischaemic Stroke**

Aspirin 300mg od for up to 14 days following ischaemic stroke (initiated in hospital within 48 hours of event), followed by clopidogrel 75mg od monotherapy, indefinitely.

If clopidogrel is contraindicated or not tolerated, use dipyridamole 200mg MR bd and aspirin 75mg od indefinitely.

If clopidogrel AND aspirin are contraindicated or not tolerated, dipyridamole 200mg MR bd alone indefinitely.

**Transient Ischaemic Attack (TIA)**

The Royal College of Physicians (2012) has recommended the use of clopidogrel monotherapy post-TIA on the basis that stroke and TIA are different manifestations of the same disease and should be treated in a uniform manner.

**Note:** TIA secondary prevention is an unlicensed indication for clopidogrel.

Aspirin 300mg od starting as soon as possible after a suspected TIA and followed by clopidogrel monotherapy, once diagnosis is confirmed in hospital.

**Peripheral arterial disease (PAD)**

Clopidogrel 75mg od indefinitely.

If clopidogrel is contraindicated or not tolerated, aspirin 75mg daily can be used as an alternative, if appropriate.

**Atrial fibrillation**

Patients with a history of atrial fibrillation require thromboprophylaxis and in most cases anticoagulation is the choice of therapy. Antiplatelet therapy is relatively ineffective for thromboprophylaxis in AF. Validated assessment tools of thromboembolic and bleeding risk, such as CHADS2 or CHA2DS2-VASc, and HAS-BLED, should be used to assess appropriate thromboprophylaxis on an individual patient basis. Seek specialist advice for patients requiring both antiplatelet therapy and anticoagulation.

**Primary prevention**

Clopidogrel, prasugrel and ticagrelor are NOT licensed for primary prevention.

Aspirin:

The current evidence for primary prevention suggests the benefits and harms of aspirin in this setting may be more finely balanced than previously thought, even in individuals estimated to be at high risk of experiencing cardiovascular events, including those with diabetes or elevated blood pressure.

**Low-dose aspirin should not be routinely initiated for primary prevention.** Any decision to prescribe should be at the discretion of the clinician, based on the balance of risks and benefits for an individual patient.

**Dyspepsia**

For patients with dyspepsia or who are at risk from gastrointestinal haemorrhage, ensure medication is taken with food and consider co-prescription of a proton pump inhibitor (PPI). There is no evidence of benefit in using enteric coated or MR aspirin in preference to dispersible aspirin. If aspirin is not tolerated despite the co-prescription of a PPI or is contraindicated, for example in true aspirin hypersensitivity (bronchospasm, angio-oedema or rash, associated with administration of aspirin), use clopidogrel 75mg od alone indefinitely.

**Note:**

- clopidogrel also increases the risk of bleeding disorders. The concomitant use of clopidogrel with omeprazole or esomeprazole should be avoided.
- Consider co-prescribing an alternative PPI e.g. lansoprazole capsules, or ranitidine 300mg bd for patients with dyspepsia on clopidogrel, or who are at risk from gastrointestinal haemorrhage.

The term acute coronary syndromes (ACS) encompasses a range of conditions from unstable angina to ST-segment-elevation myocardial infarction (STEMI).

**Elderly patients**, patients with a high alcohol intake, patients using SSRIs, NSAIDS and/or corticosteroids, and patients with a past history of GI bleeding, have an increased risk of GI haemorrhage.

References:
