Clinical Guideline for the Prescribing of Antiplatelet therapy in
Secondary and Primary Care

This Clinical Guideline is applicable to all health care professionals who will be prescribing
antiplatelet therapy including aspirin in Primary and Secondary Care. It is intended to be
used in conjunction with the Dudley Clinical Pathway for the Management of Cardiovascular
Risk

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Change Control

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### Indication

<table>
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<td>Primary prevention including diabetes (long term treatment)</td>
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| • There is no role for aspirin in primary prevention of CVD in Type 1 diabetes. The only potential exception is in patients with established nephropathy in whom CVD risks are very high, but further trial evidence is required to confirm this.  
• Low dose aspirin is not recommended for primary prevention of CVD in patients with Type 2 diabetes.  
• Routine use of aspirin is not recommended for primary prevention in CKD.  
• Patients with PAD should be started on an antiplatelet agent with clopidogrel being the agent of choice. |
| Secondary prevention in peripheral artery disease or multi-vascular disease. |
| Clopidogrel 75mg daily long term  
If clopidogrel contraindicated or not tolerated aspirin 75mg daily monotherapy long term |
| Secondary Prevention Stable Coronary Artery Disease (long term treatment) |
| Aspirin 75mg daily or clopidogrel 75 mg daily if aspirin not tolerated |
| Secondary Prevention after elective PCI |
| Aspirin 75mg daily long term and Clopidogrel 75mg daily for 6-12 months (as per Cardiology advice) |
| Secondary prevention after STEMI with PPCI (Primary PCI) |
| • Aspirin 75mg daily (long-term) and ticagrelor* 180mg stat then 90mg twice daily (for 12 months) OR "clopidogrel at the discretion of the Cardiologist  
• If patient is intolerant of or has a stent thrombosis whilst on ticagrelor, consider prasugrel 60mg stat then 10mg daily(for 12 months), but only on the advice of a Consultant Cardiologist.  
• If patient has contraindications to, is intolerant of or has a stent thrombosis whilst on prasugrel, seek the advice of a Consultant Cardiologist. |
| Secondary prevention after NSTEMI (NSTEMI and Unstable Angina) with or without PCI |
| • Aspirin 75mg daily (long-term) and clopidogrel 75mg daily (for 12 months) OR ticagrelor at the discretion of the Cardiologist  
• If Aspirin is contra-indicated or not tolerated, clopidogrel 75mg daily (long-term).  
• If patient is intolerant of ticagrelor, consider aspirin 75mg daily (long-term) and unlicensed prasugrel 60mg stat then 10mg daily (12 months-but only on the advice of a Consultant Cardiologist). |
| Prevention of atherothrombotic events in people with coronary or peripheral artery disease [https://www.nice.org.uk/guidance/ta607](https://www.nice.org.uk/guidance/ta607) |
| Rivaroxaban co-administered with aspirin, is indicated for “the prevention of atherothrombotic events in adult patients with coronary artery disease or symptomatic peripheral artery disease at high risk of ischaemic events” (initiation by or following consultation with consultant cardiologist or consultant vascular surgeon and hospital supply only)  
The recommended dosage for rivaroxaban is 2.5 mg taken orally twice daily in combination with a daily dose of 75mg aspirin taken orally. |
| Secondary prevention after Ischaemic stroke (long term treatment) | • Aspirin 300mg daily (for 14 days or until discharge) then Clopidogrel 75mg daily (long-term).
• If Clopidogrel is contraindicated or not tolerated, Aspirin 300mg daily (for 14 days or until discharge) then Aspirin 75mg daily (long-term) and Dipyridamole MR 200mg twice daily (long-term).
• If Clopidogrel and Aspirin are contraindicated or not tolerated, Dipyridamole MR 200mg twice daily (long-term) |
| Secondary prevention after transient ischaemic attack (TIA) (long term treatment) | • Aspirin 300mg stat then Clopidogrel 75mg daily long term (Preferred/ off label use recommended 1st line option- RCP National Clinical Guideline for Stroke 4th Ed. 2012) or Aspirin 75mg daily plus dipyridamole MR 200mg twice daily long term (if patient has a clopidogrel allergy/ resistance)
• If aspirin contraindicated or not tolerated dipyridamole MR 200mg twice daily long term
• If dipyridamole contraindicated or not tolerated aspirin 75mg daily monotherapy long term |

**Notes**

**Dual antiplatelet therapy and anticoagulation**
Prasugrel/Ticagrelor must not be prescribed in combination with Warfarin or DOACs. For patients in whom anticoagulation with an oral anticoagulant is necessary, the P2Y12 inhibitor of choice is Clopidogrel.
Gastroprotection with a PPI must be initiated in all patients prescribed DAPT + OAC.
Treatment durations must be specified, choice of OAC will be determined by the patient’s clinical profile.

**Switching between antiplatelet agents**
There may be occasions in which it is necessary to switch one antiplatelet to another; this **must only take place** following consultation with and agreement of the Consultant.

**Administration of P2Y12 inhibitors**
Initiation of ticagrelor will be restricted to cardiologists only. Therefore a cardiology review is required in all cases in which a myocardial infarction is suspected.

**Exceptions to Ticagrelor**
A clinically significant drug-drug interaction for example, co-administration with a CYP3A4 inhibitor (clarithromycin, atazanavir, ritonavir, ketoconazole). In such a scenario, prasugrel may be considered a suitable alternative (60mg STAT followed by 10mg OD only in patients under the age of 75 years, over 60kg and who have not experienced a previous stroke/TIA/CVA).
A concomitant indication for which the patient is already taking an oral anticoagulant e.g. atrial fibrillation or pulmonary embolism/deep vein thrombosis.

**Exceptions to Clopidogrel**
Rare cases in which the risk of stent thrombosis is considered by the consultant interventional cardiologist to be exceptional.
References

1. JBS2: Joint British Societies on Prevention of Cardiovascular Disease in Clinical Practice http://www.bcs.com/download/651/JBS2final.pdf
4. ASCEND Trial. www.ctsu.ox.ac.uk/ascend