BNSSG Guidelines for the Prescribing of Antiplatelets

https://remedy.bnssgccg.nhs.uk/formulary-adult/local-guidelines/2-cardiovascular-system-guidelines/

CARDIOLOGY

Management following acute coronary syndrome (ACS)	*Dual antiplatelet therapy (DAPT)**	*Duration*
NSTEMI • Non ST Elevation Myocardial Infarction **STEMI with PPCI** • ST Elevation Myocardial Infarction managed with primary percutaneous coronary intervention (PPCI) **STEMI other than above** • ST Elevation Myocardial Infarction managed medically or with scheduled percutaneous coronary intervention (PCI)	**Aspirin 75mg od PLUS** **Ticagrelor 90 mg bd OR Clopidogrel 75 mg od** • The second antiplatelet is chosen according to Trust guidelines but influenced on an individual patient basis. Second antiplatelet usually continues for **12 months** unless stated otherwise on the discharge summary • Please continue the second agent for the duration stated on the discharge summary; this shouldn't be changed without consulting the patient's cardiologist first. Please query if this has not been stated.	**Aspirin to continue indefinitely** • Second antiplatelet usually continues for **12 months** unless stated otherwise on the discharge summary • There is a very small cohort of higher risk patients commenced on ticagrelor that will require 60 mg BD to continue after the initial 12 months, for up to a further 36 months. This will be dictated by secondary care, either on the discharge summary on following an out-patient clinic letter.
Unstable angina	**Aspirin 75mg od PLUS** **Ticagrelor 90 mg bd or Clopidogrel 75 mg od** • The second anti-platelet agent is chosen according to Trust guidelines but influenced on an individual patient basis also. • Please continue the second agent stated on the discharge summary; this shouldn't be changed without consulting the patient's cardiologist first	**Aspirin to continue indefinitely** • Second antiplatelet to continue for **12 months** unless stated otherwise on the discharge summary

*Additional comments regarding antiplatelet therapy:

1. If aspirin is contraindicated or not tolerated the initial plan for antiplatelet therapy will have been decided on an individual basis. Please refer to patients discharge summary/clinic letter for instructions. The long term single antiplatelet will be clopidogrel for these patients.
2. If the patient is diagnosed with peripheral arterial disease or stroke / TIA the single long-term antiplatelet is clopidogrel rather than aspirin.

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Management following scheduled PCI:	*Dual anti-platelet therapy (DAPT)**	*Duration*
Percutaneous coronary intervention with Drug Eluting Stent	**Aspirin 75 mg od PLUS Clopidogrel 75 mg od**	**Aspirin to continue indefinitely** • Clopidogrel for a minimum of **6 months**
Percutaneous coronary intervention with Bare Metal Stent (uncommon)	**Aspirin 75 mg od PLUS Clopidogrel 75 mg od**	**Aspirin to continue indefinitely** • Clopidogrel for a minimum of **28 days** **(N.B. If had a recent ACS event, will require 12 months)**

CARDIAC SURGERY

Management following CABG:	*Antiplatelet therapy**	*Duration*
Coronary Artery By-pass Graft (CABG)	**Aspirin 75 mg od PLUS Clopidogrel 75 mg od** • Patients who are platelet mapped perioperatively who are non-responders to clopidogrel will be commenced on a different P2Y12 inhibitor for 6-12 months. This will be decided on a patient specific basis by the surgical team and specified on the discharge summary.	**Aspirin 75 mg od to continue indefinitely** • Clopidogrel for **12 months post-op** • Please continue as stated on the discharge summary. This shouldn't be changed without consulting the patient's surgical team first.

*Additional comments regarding antiplatelet therapy:

1. If aspirin is contraindicated or not tolerated the initial plan for antiplatelet therapy will have been decided on an individual basis. Please refer to patients discharge summary/clinic letter for instructions. The long term single antiplatelet will be clopidogrel for these patients.
2. If the patient is diagnosed with peripheral arterial disease or stroke / TIA the single long-term antiplatelet is clopidogrel rather than aspirin.

STROKE / CARDIOVASCULAR

Management following:	*Antiplatelet therapy*	*Duration*
Transient Ischaemic Attack (TIA) high risk **High risk patients include** • more than 1 episode in 24 hours • ABCD2 score of 4 or more	**Aspirin 300 mg STAT PLUS Clopidogrel 300 mg STAT** **THEN** **Aspirin 75 mg od PLUS Clopidogrel 75 mg od for 1 month** **THEN** **Clopidogrel 75 mg od long term** • If Clopidogrel intolerant, use Aspirin 75mg od **and** Dipyridamole MR 200mg bd. If Aspirin and Clopidogrel intolerant use Dipyridamole MR 200 mg bd monotherapy. If both Clopidogrel and Dipyridamole MR are C/I or not tolerated, give low dose Aspirin alone.	Dual antiplatelet therapy for **one month** then monotherapy indefinitely
Transient Ischaemic Attack (TIA) excluding high risk	**Aspirin 300 mg od for two weeks** **THEN** **Clopidogrel 75 mg od long term** • If Clopidogrel intolerant, use Aspirin 75 mg od **and** Dipyridamole MR 200 mg bd. If Aspirin and Clopidogrel intolerant use Dipyridamole MR 200 mg bd monotherapy. If both Clopidogrel and Dipyridamole MR are C/I or not tolerated, give Aspirin alone.	Monotherapy Indefinitely
Ischaemic stroke: MAJOR	**Aspirin 300 mg STAT then od for two weeks** **THEN** **Clopidogrel 75 mg od long term** • If Aspirin intolerant, use Clopidogrel 75 mg od monotherapy	Monotherapy Indefinitely
Ischaemic stroke: MINOR • Only used if very minor stroke NIH Stroke Scale ≤ 3 **and** 48 hours or less from onset **and** bleeding risk not excessive	**Aspirin 300mg STAT PLUS Clopidogrel 300mg STAT** **THEN** **Aspirin 75 mg od PLUS Clopidogrel 75 mg od for two weeks** **THEN** **Clopidogrel 75 mg od** • If Aspirin intolerant, use Clopidogrel 75 mg od monotherapy	Dual antiplatelet therapy for two weeks then monotherapy indefinitely
Peripheral Arterial Disease (PAD)	**Clopidogrel 75 mg od** • If Clopidogrel is C/I or not tolerated, give low dose Aspirin alone.	Indefinitely
Multivascular disease	**Clopidogrel 75 mg od** • If Clopidogrel is C/I or not tolerated, give low dose Aspirin alone.	Indefinitely

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Additional Notes

- Please refer to the Summary of Product Characteristics (SPC) for the latest approved prescribing information.
- The time-frame of dual anti-platelet therapy for patients who also have an indication for a NOAC/warfarin will be explicitly stated on the discharge summary, following local/national recommendations, and patient specific considerations. Please note, if a patient is to continue on DAPT plus an anticoagulant, the DAPT combination should be aspirin and clopidogrel. A PPI (lansoprazole) should be prescribed whilst on triple therapy. More information on dual anticoagulant and anti-platelet prescribing can be found here https://remedy.bnssgccg.nhs.uk/media/1545/dwac_antithrombotic_therapy.pdf
- **Aspirin intolerance** is defined as either a proven hypersensitivity to aspirin (rash, bronchospasm, angioedema) **or** a history of severe indigestion caused by low-dose aspirin, persisting after addition of a Proton Pump Inhibitor (PPI). For patients with a history of aspirin induced healed ulcer & H Pylori negative consider full dose PPI & aspirin 75mg
- It is vital that when patients transfer between care settings and medication is reviewed and reconciled, that special consideration is given to any combined anticoagulant and antiplatelet prescribing.
- Combined anticoagulant/antiplatelet therapy should only be initiated or continued on an individualised patient basis considering both the condition being treated, cardiovascular, thrombotic and bleeding risks. Where medication is stopped this should be clearly documented within the patient notes and the medication record amended as appropriate (this could include archiving medications to prevent accidental re-ordering of medicines)Gastro-protective medication such as PPIs should be considered where appropriate, and reviewed once DAPT has stopped. When combinations are used, this should be continually reviewed, especially with ageing patients and any risks minimised where possible. For example; the lowest appropriate dose of antiplatelet should be considered, blood pressure should be optimally controlled, renal function and electrolytes monitored as clinically appropriate and the INR tightly controlled if warfarin used.
- Patients most vulnerable to bleeding on anticoagulant/antiplatelet combination
  - Older patients (e.g. those aged over 65 years)
  - Poor or declining renal or liver function
  - Bleeding disorders
  - Concurrent medications which increase bleeding risk such as NSAIDs or SSRIs
  - Other concurrent clinical characteristics such as previous stroke or hypertension
  - The HAS-BLED scoring system may help to assess a patient's bleeding risk.

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