Barnsley Clinical Commissioning Group NHS
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Barnsley Guideline for using Antiplatelet drugs in the prevention and treatment of Cardiovascular and Cerebrovascular diseases (February 2020)

(Adapted from the Sheffield Guidelines for the use of Antiplatelets in the prevention and treatment of cardiovascular disease, October 2017)

Indication	Recommendations
Primary prevention including diabetes (long term treatment)	No antiplatelet is generally recommended; where a clinician has assessed an individual patient and considers the balance of risk vs benefit favours treatment with antiplatelet then aspirin 75mg daily is the first line treatment *Note: no antiplatelet is licensed for primary prevention*
Atrial Fibrillation (long term treatment)	DO NOT offer aspirin 75mg monotherapy solely for stroke prevention to people with atrial fibrillation. Please refer to the Stroke Prevention in Atrial Fibrillation Guideline.
Ischaemic stroke, secondary prevention (long term treatment) and Transient ischaemic attack (TIA) (long term treatment)	Clopidogrel 75mg daily first line (licensed post stroke; unlicensed post TIA) **or** Aspirin 75mg daily + dipyridamole MR 200mg twice daily where clopidogrel is C/I or not tolerated **or** Dipyridamole MR as monotherapy if both aspirin & clopidogrel are C/I or not tolerated
Carotid stenosis with stent insert	Clopidogrel 75mg daily long term plus aspirin 75mg daily for 1 month (unlicensed indication)
Carotid endarterectomy patients (long term treatment)	Clopidogrel 75mg daily, any other treatment combinations should be confirmed in writing by the Stroke Specialists or Neurologists (unlicensed indication)
Peripheral Vascular Disease (PVD) – long term treatment	Clopidogrel 75mg daily (first line treatment) **or** Aspirin 75mg daily
Superficial femoral, popliteal and tibial artery stents	Aspirin and clopidogrel (unlicensed indication) for between 2 and 12 months, depending on stent used (duration to be specified on discharge), then clopidogrel alone (long term)
Stable angina (long term treatment)	Aspirin 75mg daily. Consider combination with proton pump inhibitor, or alternatively, clopidogrel 75 mg daily if aspirin not tolerated
Stable angina with elective coronary Stenting (PCI)	Clopidogrel in combination with aspirin 75 mg od (long term). Clopidogrel 75 mg od for 1 month for bare metal stents or up to 6 months for drug-eluting stents – a reduced duration may be considered for management of serious bleeding or long term administration may be considered for high risk ischaemia risk patients; the specialist will clearly communicate the recommended duration of combination treatment to primary care.

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Acute coronary syndrome (ACS); loading doses	Treatment will usually be initiated by a specialist and the length of treatment clearly communicated to primary care prescribers. *Note for ACS where an antiplatelet is indicated the following loading doses are usually appropriate.* • *Aspirin 300mg* • *Clopidogrel 300mg (or 600mg for early invasive strategy) (Omit initial dose in patients over 75 years old with STEMI managed by fibrinolysis)* • *Ticagrelor 180mg* • *Prasugrel 60mg* *Where **Ticagrelor** is prescribed, it is recommended that **renal function is checked <u>1 month</u> after initiation, and thereafter according to routine medical practice** for the duration of treatment. If significant worsening of renal function is evident, change to clopidogrel 75mg OD for the remainder of the treatment course.*
ST-segment-elevation myocardial infarction (STEMI) – defined as ST elevation or new left bundle branch block on electrocardiogram – treated with primary percutaneous coronary intervention (PCI)	Aspirin 75mg daily (long term) and ticagrelor 90mg twice daily for one year (first line) or Aspirin 75mg daily (long term) and prasugrel 10mg daily for one year reduced to 5mg daily for one year if over 75 years old* or weight less than 60kg. or Aspirin 75mg daily (long term) plus clopidogrel 75mg daily and/or Rivaroxaban 2.5mg twice daily**. A decision on continuation of treatment should be taken by the specialist team no later than 12 months after starting treatment.
ST-segment-elevation myocardial infarction (STEMI) – defined as ST elevation or new left bundle branch block on electrocardiogram – that are treated with fibrinolytic therapy	Aspirin 75mg daily (long term) plus clopidogrel 75mg daily and/or Rivaroxaban 2.5mg twice daily**. A decision on continuation of treatment should be taken by the specialist team no later than 12 months after starting treatment.
Non-ST-segment-elevation myocardial infarction (NSTEMI)	Aspirin 75mg daily (long term) and ticagrelor 90mg twice daily for one year (first line) regardless of management strategy (conservative or invasive), **or** For patients treated with PCI or patients presenting with stent thrombosis on clopidogrel who are not eligible for ticagrelor, aspirin 75mg daily (long term) and prasugrel 10mg daily for one year or 5mg daily for one year if age >75 years* or weight less than 60kg, **or** Aspirin 75mg daily (long term) and clopidogrel 75mg daily for one year regardless of management strategy (if ticagrelor and prasugrel are not indicated, contraindicated or not tolerated but clopidogrel is not contraindicated) **or** Aspirin 75mg daily (long term) plus clopidogrel 75mg daily and/or Rivaroxaban 2.5mg twice daily**. A decision on continuation of treatment should be taken by the specialist team no later than 12 months after starting treatment.

Unstable angina	Aspirin 75mg daily (long term) and clopidogrel 75mg daily for one year regardless of management strategy (conservative or invasive). **or** For patients with moderate to high risk unstable angina, defined as ST or T wave changes on ECG suggestive of ischaemia plus one of the following characteristics: • Age 60 years or older • Previous myocardial infarction or previous coronary artery bypass grafting (CABG) • Coronary artery disease with stenosis of 50% or more in at least two vessels • Previous ischaemic stroke • Previous TIA • Carotid stenosis of at least 50%, or cerebral revascularisation • Diabetes mellitus • Peripheral arterial disease • Chronic renal dysfunction (defined as eGFR of less than 60mls/min) Give aspirin 75mg daily (long term) plus ticagrelor 90mg twice daily for one year regardless of management strategy (conservative or invasive). NB – before ticagrelor is continued beyond initial prescription, the diagnosis of unstable angina should be confirmed by a Cardiologist. **or** For patients with PCI, aspirin 75mg (long term) and prasugrel 10mg daily for one year (or 5mg once daily for one year if body weight less than 60kg). *
Extended Treatment with ticagrelor after MI (STEMI or NSTEMI) for patients at high risk.	Extended treatment with ticagrelor 60mg twice daily may be indicated for patients who have had an MI and are assessed as being at high risk of further coronary events. These patients would usually have received dual antiplatelet therapy with a combination of ticagrelor 90mg twice daily and aspirin 75mg once daily for one year and require down - titration to ticagrelor 60mg twice daily in combination with aspirin 75mg once daily for a maximum of a further three years (i.e. four years post index MI). Identification of patients requiring extended prophylaxis, and the duration required, will be made by the Cardiologist during the hospital admission for the index MI.

* The use of prasugrel in patients $\geq$ 75 years of age is generally not recommended – please refer to SPC for additional information.

Clinicians should carefully assess the person's **risk of bleeding before treatment with Rivaroxaban is started. The decision to start treatment should be made after an informed discussion between the clinician and the patient about the benefits and risks of Rivaroxaban in combination with Aspirin plus Clopidogrel or with Aspirin alone, compared with Aspirin plus Clopidogrel or Aspirin alone.

Additional Notes for using this guidance:

Clopidogrel Interaction with Omeprazole and Esomeprazole:

- Co-administration of clopidogrel with omeprazole or esomeprazole should be avoided. Other PPI's may weakly interact with clopidogrel and therefore potential risk reduction in the efficacy of clopidogrel should be weighed against the GI benefit of a PPI. PPI's are, however, indicated in patients taking aspirin and clopidogrel who have a high risk of GI bleeding.
- If indicated, lansoprazole is considered the PPI of choice for patients requiring or likely to require clopidogrel.
- Prasugrel and ticagrelor have no adverse interactions with PPI's.

Antiplatelet use in patients with hypersensitivity to aspirin:

- Patients admitted to hospital following an acute coronary syndrome will usually require dual antiplatelet therapy with aspirin. Patients with a documented aspirin allergy are most likely to have undergone aspirin desensitisation in hospital prior to discharge.
- It is therefore recommended that patients with aspirin allergy who have undergone desensitisation continue aspirin 75mg daily thereafter without any break in treatment.
- Advise patients that they will require further desensitisation in the future if they stop or miss doses of aspirin and then need to restart treatment for any reason.

Rivaroxaban as an option for the prevention of atherothrombotic events:

- Clinicans should regularly assess the relative benefits and risks of continuing treatment with rivaroxaban and discuss them with the patient.
- Rivaroxaban is an anticoagulant rather than an antiplatelet drug. It is included in this guideline for completeness as it is recommended in NICE TA 335 for the management of ACS.

References

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8. NICE GG126. Management of stable angina. July 2011 (updated August 2016) available at https://www.nice.org.uk/guidance/cg126
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