NHS Greater Glasgow and Clyde

CLINICAL GUIDELINE

Antiplatelet Therapy Prescribing in the Secondary Prevention of Coronary Artery Disease

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

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Important Note:

The Intranet version of this document is the only version that is maintained.
Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

APPLICABILITY

This guideline is aimed at prescribers working within both acute and primary care settings. It is intended to guide optimal prescribing of antiplatelet therapy in patients with chronic stable angina or an acute coronary syndrome (ACS) and addresses various clinical scenarios which may be encountered. Users should refer to:

- Key recommendations (see below)
- Section 1: Patients receiving combination anticoagulant and antiplatelet therapy
- Section 2: Patients with troponin positive ACS admitted on single antiplatelet therapy

Always **ensure that the duration for all antiplatelet agents** and any specific monitoring requirements are **clearly documented in the patient's discharge letter**.

KEY RECOMMENDATIONS

- For patients in sinus rhythm who have chronic stable angina, standard long-term antiplatelet treatment should consist of aspirin 75mg once daily. If the patient is allergic to, or intolerant of aspirin, prescribe clopidogrel 75mg once daily instead.

- All patients with suspected ACS should be treated with aspirin 300mg stat, then 75mg once daily, plus clopidogrel 300mg stat, then 75mg once daily as per NHSGGC Acute Cardiac Chest Pain Guidelines (2024): Acute Cardiac Chest Pain Guidelines (1111) | Right Decisions

- For ACS patients who are subsequently found to be troponin negative, clopidogrel should be discontinued.

- Patients diagnosed with a troponin positive ACS who are for medical management (i.e. no coronary intervention undertaken) should receive dual antiplatelet therapy (DAPT) consisting of aspirin 75mg once daily plus clopidogrel 75mg once daily for three months. Indefinite single antiplatelet therapy (SAPT) thereafter should consist of aspirin 75mg once daily.

- Patients diagnosed with a troponin positive ACS who undergo percutaneous coronary intervention (PCI), or patients who undergo elective PCI, should receive DAPT consisting of aspirin 75mg once daily plus prasugrel 10mg once daily for six months (5mg once daily if actual body weight < 60kg).

- Prasugrel is generally not recommended in patients ≥ 75 years of age. If prasugrel is deemed necessary for a patient in this cohort, a maintenance dose of 5mg once daily should be prescribed. Prasugrel is contraindicated in patients with history of stroke or transient ischaemic attack and in patients with severe hepatic impairment (Child Pugh class C). No dose adjustment is necessary for patients with renal impairment, including end stage renal disease.

- A small number of patients will require DAPT beyond six months, at the discretion of the interventional cardiologist. Following completion of fixed-course DAPT, indefinite SAPT should consist of aspirin 75mg once daily.

- For patients who are intolerant of prasugrel (or clopidogrel), advice should be sought from a cardiologist on the choice (and possible re-loading) of an alternative antiplatelet agent.

SECTION 1: COMBINATION ANTICOAGULANT AND ANTIPLATELET THERAPY

This combination is associated with a significantly higher major rate of haemorrhage compared with either agent alone, without offering any proven benefit in reducing ischaemic or thromboembolic events (except in some patients with prosthetic heart valves).

1.1 Patients receiving anticoagulant for atrial fibrillation who develop an indication for antiplatelet(s)

Patients with atrial fibrillation (AF) who develop an indication for DAPT should have an assessment of their underlying bleeding risk (e.g. *HAS-BLED* score) and residual ischaemic risk (e.g. previous myocardial infarction and/or diffuse coronary artery disease) undertaken by a cardiologist.

1.1.1 Medically managed ACS and AF

Patients should receive clopidogrel 75mg once daily and oral anticoagulant (OAC) for six months, followed by indefinite OAC monotherapy thereafter.

1.1.2 Post-PCI and AF

Default management strategy is triple therapy with OAC plus DAPT consisting of aspirin 75mg once daily plus clopidogrel 75mg once daily for one week, then dual therapy with OAC plus clopidogrel 75mg once daily for twelve months, then indefinite OAC monotherapy thereafter.

Patients at high bleeding risk should receive triple therapy with OAC plus DAPT consisting of aspirin 75mg once daily plus clopidogrel 75mg once daily for one week, then dual therapy with OAC plus clopidogrel 75mg once daily for six months, then indefinite OAC monotherapy thereafter.

Patients at high ischaemic risk should receive triple therapy with OAC plus DAPT consisting of aspirin 75mg once daily plus clopidogrel 75mg once daily for one month, then dual therapy with OAC plus clopidogrel 75mg once daily for a further eleven months, then indefinite OAC monotherapy thereafter.

Patients prescribed triple therapy should receive gastroprotection with lansoprazole 30mg once daily for the duration of triple therapy. Ongoing prescription of lansoprazole should be reviewed once the patient is receiving dual therapy of clopidogrel plus OAC.

1.2 Patients receiving anticoagulant for venous thromboembolism who develop an indication for antiplatelet(s)

1.2.1 Low thrombosis risk

Patients with venous thromboembolism (VTE) more than three months previously who do not require long-term anticoagulation and who develop an indication for DAPT, should discontinue anticoagulation and receive DAPT and subsequent SAPT as per standard protocols.

1.2.2 High thrombosis risk

Patients with VTE within the preceding three months or previous VTE requiring long-term anticoagulation who develop an indication for DAPT require specialist assessment for the duration of triple therapy.

1.3 Patients receiving anticoagulant for mechanical heart valve(s) who develop an indication for antiplatelet(s)

Patients with mechanical heart valves who develop an indication for DAPT require specialist assessment by a cardiologist to determine the duration of triple therapy.

1.4 Patients receiving antiplatelet(s) who develop an indication for anticoagulant (e.g. AF or VTE)

1.4.1 Stable vascular disease

Patients receiving SAPT with no new vascular presentation and/or PCI more than twelve months previously should have antiplatelet therapy discontinued for the duration of anticoagulant therapy. SAPT should resume following completion of anticoagulant therapy.

1.4.2 Unstable vascular disease

Patients receiving ongoing DAPT or who have had unscheduled vascular presentation, or PCI within the preceding twelve months, should be commenced on anticoagulation, being vigilant for clinical signs and symptoms of bleeding. Discontinuation of any antiplatelet therapy earlier than planned **must** be discussed with an interventional cardiologist.

Some patients at high thrombotic risk and low bleeding risk may merit short-term triple antithrombotic therapy; each case should be individually considered with a full risk versus benefit assessment.

SECTION 2: TROPONIN POSITIVE ACS PATIENTS ADMITTED ON SINGLE ANTIPLATELET THERAPY

2.1 Aspirin monotherapy

Commence additional clopidogrel 300mg stat, then 75mg once daily per Key Recommendations above.

2.2 Clopidogrel monotherapy

Patients receiving clopidogrel monotherapy due to previous gastrointestinal upset with aspirin should receive additional aspirin 300mg stat, then 75mg once daily and gastroprotection with lansoprazole 30mg once daily. For patients with a history of previous gastrointestinal bleed due to aspirin or severe hypersensitivity reaction to aspirin, seek cardiology advice on the optimal antiplatelet regimen.

Patients receiving clopidogrel monotherapy due to previous stroke and/or transient ischaemic attack and/or peripheral vascular disease should also receive additional aspirin 300mg stat, then aspirin 75mg once daily for a specified duration, before reverting to SAPT clopidogrel 75mg once daily following completion of fixed course aspirin.