NHS
Greater Glasgow and Clyde

CLINICAL GUIDELINE

Antiplatelet Therapy in the Secondary Prevention of Coronary Heart 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.
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ANTIPLATELET THERAPY IN SECONDARY PREVENTION OF CORONARY HEART DISEASE

NHS Greater Glasgow and Clyde

APPLICABILITY:

This guidance is aimed at prescribers working within both the acute setting and primary care to guide antiplatelet therapy in patients with Chronic Stable Angina or an Acute Coronary Syndrome (ACS)

KEY RECOMMENDATIONS:

- For patients in sinus rhythm who have chronic stable angina, the standard long-term antithrombotic treatment should be **aspirin 75mg once daily**.
- For patients in sinus rhythm who have chronic stable angina, **who have an allergy to, or are intolerant of aspirin**, the standard long-term antithrombotic treatment should be **clopidogrel 75mg once daily**.
- All patients admitted with suspected ACS should be treated with **aspirin 300mg stat then 75mg once daily** plus **ticagrelor 180mg stat then 90mg twice daily** until the results of a 12 hour troponin test are known; see ACS guideline in NHSGGC Therapeutics Handbook.
- For ACS patients who are subsequently found to be **troponin negative**, ticagrelor should be discontinued.
- For patients who are diagnosed with a **troponin positive ACS**, the antithrombotic treatment of choice is dual antiplatelet therapy (DAPT) consisting of **aspirin 75mg once daily plus ticagrelor 90mg twice daily.**
  - Patients with a diagnosis of troponin positive ACS who are treated **medically or undergo PCI with a bare metal stent (or balloon angioplasty alone)** should receive DAPT for **12 weeks.** Long-term antiplatelet therapy thereafter should be aspirin 75mg once daily.
  - Patients with a diagnosis of troponin positive ACS who undergo PCI with a **drug eluting stent** should receive DAPT for **26 weeks.** Long-term antiplatelet therapy thereafter should be aspirin 75mg once daily.
- For patients who undergo **elective PCI,** dual antiplatelet therapy consists of **aspirin 75mg daily and clopidogrel 75mg daily.**
  - Patients treated with a **bare metal stent** (or balloon angioplasty alone) should receive DAPT for four weeks. Long-term antiplatelet therapy should be aspirin 75mg once daily.
  - Patients treated with a **drug eluting stent** should receive DAPT for **26 weeks**. Long-term antiplatelet therapy should be aspirin 75mg once daily.

Continues on next page

COMBINATION ANTIPLATELET AND ANTICOAGULANT THERAPY:

- This combination is associated with a significantly higher major haemorrhage complication rate than either agent alone, without offering any proven benefit in reducing ischaemic or thrombo-embolic events (except in patients with metallic prosthetic heart valves).

Patients on warfarin who develop an indication for an anti-platelet agent (e.g. thrombotic stroke, ACS)

- Low thrombosis risk patients (e.g. moderate risk AF, DVT > three months previously) who develop an indication for DAPT (e.g. AF patient requiring coronary stent) should stop warfarin or receive triple therapy for as short a time as possible. Consideration should be given to the use of a bare metal stent; see NHSGGC AF guideline for further advice.
- High thrombosis risk patients (e.g. high risk AF, recent VTE) developing an ACS, require specialist advice and should be considered for triple therapy.

Patients on anti-platelet agents who develop an indication for warfarin therapy (e.g. AF, DVT)

- Patients with stable vascular disease on a single anti-platelet agent - this agent should be discontinued for the duration of warfarin therapy.
- Patients with unstable vascular disease (e.g. recent ACS or stent) receiving DAPT warfarin should be commenced cautiously with close monitoring. Discontinuation of aspirin +/- ticagrelor / clopidogrel earlier than planned should be discussed with an interventional cardiologist.

It is accepted that some high thrombotic risk patients, with low inherent bleeding risk, may merit short term triple therapy, however each case should be considered individually with a full risk: benefit assessment.

TROPONIN POSTIVE ACS PATIENTS ADMITTED ON ANTIPLATELET THERAPY:

On aspirin monotherapy

- Add ticagrelor 90mg twice daily as per above guidance.

On clopidogrel monotherapy due to previous aspirin gastrointestinal intolerance

- Re-start aspirin 75mg daily (with PPI cover if required) and change clopidogrel to ticagrelor 90mg twice daily as per guidance above.

On clopidogrel monotherapy due to previous TIA / CVA

- Stop clopidogrel.
- Add aspirin 75mg daily and ticagrelor 90mg twice daily.
- Stop aspirin and ticagrelor after DAPT course complete.
- Restart clopidogrel 75mg daily.

On aspirin and clopidogrel after previous ACS admission

- Switch clopidogrel to ticagrelor 90mg twice daily as per above guidance.

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