Guidelines for Antiplatelet/Anticoagulant Therapy for Primary and Secondary Prevention of Ischaemic Stroke and Transient Ischaemic Attack (TIA)

Patient with no history of Atrial Fibrillation (AF)

Primary Prevention
i.e. No previous history of cardiovascular disease

Do not routinely prescribe antiplatelet treatment.¹

See Page 2 for further Information

Consider other stroke prevention strategies
e.g. Lipid modification, BP management, smoking cessation and diabetes control.

See Page 2 for further Information

Patient with a history of non-valvular Atrial Fibrillation (AF)

Secondary Prevention
Of occlusive vascular event following ischaemic stroke or TIA

1st Line: Clopidogrel 75mg once daily *
OR (if clopidogrel is contraindicated or not tolerated)

2nd Line: Aspirin 75mg (dispersible tablet) once daily after food + dipyridamole 200mg MR capsule one twice daily after food
OR (if both clopidogrel and dipyridamole are contraindicated or not tolerated)

3rd Line: Aspirin 75mg daily after food alone
OR (if aspirin and clopidogrel are contraindicated or not tolerated)

4th Line: Dipyridamole MR 200mg capsule one twice daily alone after food³

N.B. Treatment with modified-release dipyridamole in combination with aspirin for people who have had an ischaemic stroke or a transient ischaemic attack is no longer limited to 2 years' duration from the most recent event.

1st Line: Clopidogrel 75mg once daily *

See LMMG Consensus Statement for Oral Anticoagulants for the Prevention of Stroke and Systemic Embolism in Adults with Non-valvular AF:
1. Assess stroke risk using CHA₂DS₂-VASc
2. Assess bleeding risk using HAS-BLED – modify and monitor risk factors, where appropriate
3. Consider anticoagulation for males with a CHA2DS2VASc score of 1 (take bleeding risk into account).
4. Offer anticoagulation to males & females with CHA2DS2VASc score ≥ 2 (take bleeding risk into account).
5. If, on discussion, anticoagulation is rejected because of bleeding risks or other factors review the decision annually & document the reasoning.
6. Do NOT offer aspirin monotherapy solely for stroke prevention in AF. For patients currently taking aspirin, consider anticoagulation, taking account of co-morbidities & other reasons for using aspirin.
7. Stop aspirin if being prescribed solely as monotherapy for stroke prevention for AF patients as per NICE QS93. The risks of taking aspirin outweigh any benefits of taking it as monotherapy for stroke prevention in adults with atrial fibrillation.⁴
8. The decision about which oral anticoagulant to start should be based on the patients clinical features & preferences. There should be an informed discussion between the clinician & patient, with consideration of the risks & benefits of different therapies. See LMMG Anticoagulation Decision Support Tool.

¹Secondary prevention of TIA is not a licensed indication of clopidogrel 75mg tablets and for this reason is not recommended by NICE TA210. However LMMG and the Royal College of Physicians Intercollegiate Stroke Working Party National Clinical Guidelines For Stoke recommend clopidogrel first line for this indication.⁵
Management of Patients with non-valvular AF and Cardiovacular Disease

AF and stable vascular disease (i.e. no acute events or revascularization for >12 months, whether coronary or peripheral artery disease):

- The European Society of Cardiology ESC guidelines for the management of AF recommend that patients with stable vascular disease can be managed with OAC alone. In such stable patients, there is no need for concomitant aspirin, which could increase the risk of serious haemorrhage, including intracranial haemorrhage.

AF and unstable cardiovascular disease (Acute Coronary Syndrome and/or PCI/stent procedure in the preceding year):

- It is expected that a cardiologist will advise on the most appropriate treatment strategy for this patient group.

- Data on triple therapy with oral anticoagulants (OACs) (when given at stroke prevention doses in AF patients) are limited. ESC Guidelines based on expert consensus opinion recommend a period of triple therapy is needed (OAC plus aspirin plus clopidogrel), followed by the combination: OAC plus single antiplatelet drug. After one year, management can be with OAC alone in stable patients. **Combination therapy with any OAC and antplatelets significantly increases the risk of bleeding.**

Other Stroke Prevention Strategies

In addition to the use of antplatelets/anticoagulation for the primary and secondary prevention of stroke/TIA, other risk management strategies should also be considered e.g. Blood Pressure management, lipid modification, control of diabetes and lifestyle interventions:

- **NICE CG181** (July 2014) Lipid modification: cardiovascular risk assessment and the modification of blood lipids for the primary and secondary prevention of cardiovascular disease covers lifestyle modifications as well as lipid modifications for the primary and secondary prevention of CVD and links to **NICE CG127** Hypertension guidance.

- Lifestyle advice and further drug treatments (including statins and BP management) for secondary prevention of stroke/TIA is available from **NICE CKS**.
Version Control
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References
2. National Institute for Health and Care Excellence Clinical Knowledge Summary Antiplatelet Treatment http://cks.nice.org.uk/antiplatelet-treatment#scenario accessed 04/06/15