Prescribing Anti-Platelet Agents
Following Stroke and Transient Ischaemic Attack (TIA)

The guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

Acute Phase of Ischaemic Stroke

- All patients should be prescribed aspirin 300mg daily, initiated within 48 hours of acute ischaemic stroke and continued for up to 14 days (after which clopidogrel or alternative therapy should be initiated as below)
- Aspirin should be avoided within 24 hours of the administration of intravenous or intra-arterial thrombolytic therapy.
- Consider use of a PPI in patients with a history of aspirin-induced GI dyspepsia or ulceration – review PPI when aspirin therapy is stopped
- The combination of clopidogrel and aspirin in acute stroke is not recommended for routine use, but may be considered for short-term use (up to 3 months) at the discretion of the lead clinician for individual patients at high risk.

Secondary Prevention of Ischaemic Stroke and Transient Ischaemic Attack (TIA)
Preferred Options

- **Post Stroke**: Clopidogrel monotherapy is the preferred secondary prevention strategy Clopidogrel monotherapy post-stroke should be started when the initial course of aspirin therapy finishes
- **Post TIA:** NICE recommend the combination of aspirin and modified release dipyridamole following a TIA. Clinical consensus at the Surrey Heart & Stroke Network is that clopidogrel monotherapy can also be used for this indication as it will be better tolerated, reduce daily pill burden and also achieve significant savings for the NHS. *Note: TIA secondary prevention is an unlicensed indication for clopidogrel monotherapy.*
- The routine maintenance dose of clopidogrel is 75mg daily
- Once initiated, clopidogrel monotherapy should be continued indefinitely
- There is no evidence to support the use of aspirin and clopidogrel combination therapy for routine secondary prevention post-stroke or TIA; however, combination therapy is used for other indications, for example, acute coronary syndromes (ACS)
- Advice from the MHRA (2009) recommends that omeprazole and esomeprazole should be avoided in patients taking clopidogrel. For patients requiring a PPI whilst taking clopidogrel consider a H_2antagonist or an alternative PPI in line with local guidelines

Alternative Strategies

- Low dose aspirin (75mg daily) and dipyridamole (200mg modified release twice daily) should be considered in patients unable to tolerate clopidogrel first-line
- Dose titration of dipyridamole may help to reduce the incidence and severity of headaches – initiate at a lower dose of dipyridamole (e.g. 25mg three times daily or 200mg MR once daily) and increase to the standard maintenance dose of 200mg MR twice daily after one week.
- Patients unable to tolerate clopidogrel monotherapy or aspirin and dipyridamole combination therapy should receive treatment with aspirin monotherapy. There is no evidence to support the use of dipyridamole monotherapy – therefore it should ONLY be considered for patients unable to tolerate all other options.

Stable Patients with Prior Stroke or TIA

Patients currently stable on aspirin and dipyridamole following stroke or TIA should be considered for a switch to clopidogrel monotherapy (Note: this is an unlicensed indication post TIA). The decision to switch therapy should only be made with the agreement of the patient.

References

- NICE TA210: Clopidogrel and modified release dipyridamole for the prevention of occlusive vascular events Dec 2010
- PROFESS: Aspirin and Extended-Release Dipyridamole versus Clopidogrel for Recurrent Stroke. Engl J Med 2008; 359:1238-1251
- MHRA (2010) Clopidogrel and Proton Pump inhibitors Interaction - updated advice accessed on 15th Feb 2011 at http://www.mhra.gov.uk/Safetyinformation/DrugSafetyUpdate/CON087711

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