NHS
South West Yorkshire
Area Prescribing Committee

Prescribing Anti-Platelet Agents Following an Ischaemic Stroke or 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. Wherever appropriate, these patients should be considered for recruitment into clinical trials.

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
- 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 very high risk.

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

- **Post Stroke**: NICE (2010) recommends the use of clopidogrel monotherapy post-stroke.[1] Clopidogrel monotherapy should be started when the initial course of aspirin therapy finishes.
- **Post TIA:** The Royal College of Physicians (2012) has recommended the use of clopidogrel monotherapy post-TIA on the basis that stroke and TIA are different manifestations of the same disease and should be treated in a uniform manner.[2]
  Note: TIA secondary prevention is an unlicensed indication for clopidogrel.
- 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.[3] For patients requiring a PPI whilst taking clopidogrel, consider a H_2-antagonist 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. 200mg MR once daily) and increase to the standard maintenance dose of 200mg MR twice daily after one week.
- If both clopidogrel and modified-release dipyridamole are contraindicated or not tolerated, offer aspirin 75mg daily.
- If both clopidogrel and aspirin are contraindicated or not tolerated offer modified-release dipyridamole 200mg twice daily.

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.

References

1. NICE 2010. TA210: Vascular Disease -Clopidogrel and modified release dipyridamole for the prevention of vascular events. http://guidance.nice.org.uk/TA210/QuickRefGuide/pdf/English
2. Royal College of Physicians Intercollegiate Stroke working Group: 2012. National Clinical Guideline for Stroke 4th edition. http://www.rcplondon.ac.uk/sites/default/files/national-clinical-guidelines-for-stroke-fourth-edition.pdf
3. MHRA Drug Safety Update 2010. Clopidogrel and proton pump inhibitors: interaction—updated advice http://www.mhra.gov.uk/Safetyinformation/DrugSafetyUpdate/CON087711

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