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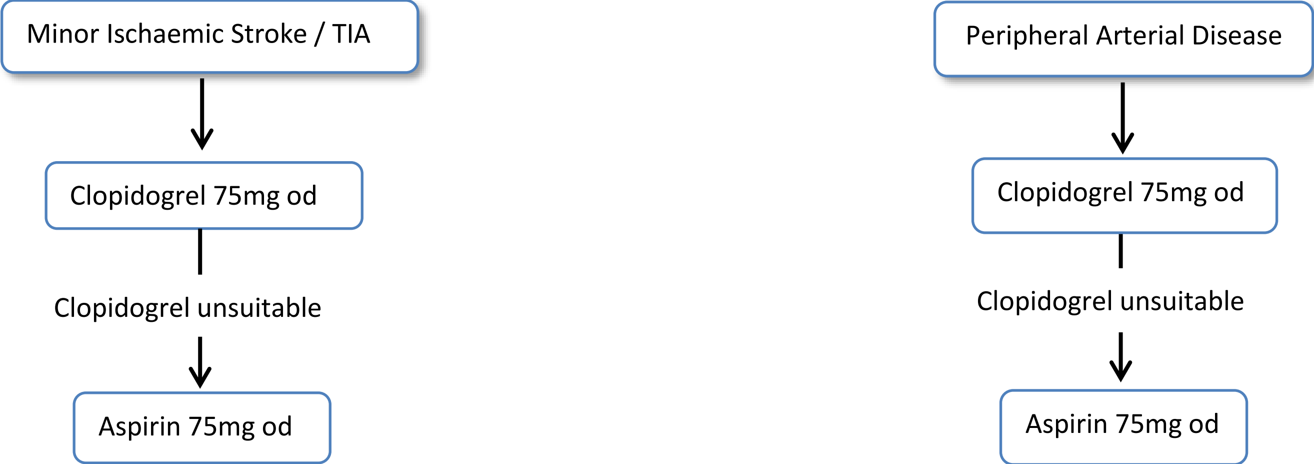
Antiplatelets for the Prevention of Occlusive Vascular Events

Please note this guideline covers secondary prevention not acute management



Patients at high risk of ischaemic events but low risk of bleeding may be recommended rivaroxaban 2.5mg BD in addition to aspirin 75mg

Adapted from the National Clinical Guideline for Stroke 2023 and NICE TA210

- The choice of antiplatelet for patients on clopidogrel who have subsequent strokes or TIAs will be based on individual patient assessment.
- Patients who require 'dual antiplatelet therapy' (e.g., clopidogrel and aspirin) post MI who were previously taking clopidogrel for Stroke/TIA/PAD should continue with clopidogrel monotherapy after 12 months of dual antiplatelet therapy.

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Indication	Antiplatelets only**	Antiplatelets PLUS oral anticoagulation (prescribe a PPI for all patients, avoid omeprazole/esomeprazole with clopidogrel)
STEMI (treated with Primary PCI)	Aspirin 75mg OD indefinitely **PLUS** Prasugrel for 12 months (If prasugrel not suitable, offer ticagrelor or clopidogrel as alternatives)	Aspirin 75mg OD *(for up to 1 month[+])* **PLUS** Clopidogrel 75mg OD for up to 12 months
STEMI (no Primary PCI)	Aspirin 75mg OD indefinitely **PLUS** Clopidogrel 75mg OD for 12 months	Aspirin 75mg OD for up to 12 months if not high bleeding risk (clopidogrel if aspirin is contraindicated)
NSTEMI or Unstable Angina (treated with PCI)		Aspirin 75mg OD *(for up to 1 month[+])* **PLUS** Clopidogrel 75mg OD for up to 12 months
NSTEMI or Unstable Angina (no PCI performed)		Aspirin 75mg OD for up to 12 months if not high bleeding risk (clopidogrel if aspirin is contraindicated)

**Patients at particularly high risk of CV events (and with low bleeding risk) may receive the following alternative regimen at the Interventional Cardiologist's discretion: Aspirin 75mg OD indefinitely plus ticagrelor 90mg BD for 1 year, followed by ticagrelor 60mg BD for up to a further 3 years.

[+] For people who have a separate indication for anticoagulation, take into account all of the following when thinking about the duration and type (dual or single) of antiplatelet therapy in the 12 months after an acute coronary syndrome; bleeding risk, thromboembolic risk, cardiovascular risk, person's wishes.

Be aware that the optimal duration of aspirin therapy has not been established, and that long-term continuation of aspirin, clopidogrel and oral anticoagulation (triple therapy) significantly increases bleeding risk. In practice aspirin is often given for 1 month, clopidogrel 1 year and DOAC lifelong but a plan should be individualised for each patient.