Policy Statement: Use of Clopidogrel following an Occlusive Vascular Event

This guidance applies to all patients who have had an occlusive vascular event, or who have established Peripheral Arterial Disease, and is based on NICE TA 210 published in Dec 2010.

The NICE TA states that clopidogrel should be used as an option for people who have had an ischaemic stroke, who have Peripheral Arterial Disease (PAD) or who have cardiovascular disease (CVD) in more than one vascular site (multivascular disease).

Modified-release dipyridamole plus aspirin is given as an option for people who have had a transient ischaemic attack (TIA). Following the Royal College of Physicians Clinical Guidelines for Stroke 4th edition[1] the decision has been made locally to use clopidogrel in this group of patients, although unlicensed in this indication.
For people who have had an ischaemic stroke or TIA, modified-release dipyridamole plus aspirin should **only** be used where clopidogrel is contraindicated or not tolerated. Modified-release dipyridamole alone is an option for people who have had an ischaemic stroke **only** where treatment with aspirin and clopidogrel is contraindicated or not tolerated.

What this means in practice

For patients who have had an ischaemic stroke or TIA, recommended treatment options are as follows:

First line	Clopidogrel tablets 75mg once daily
Second line; where clopidogrel is contra-indicated or not tolerated	Dipyridamole MR 200mg twice daily plus aspirin 75mg once daily
Third line; where treatment with aspirin and clopidogrel is contra-indicated or not tolerated.	Dipyridamole MR 200mg twice daily

Practices may wish to review patients currently receiving dipyridamole (capsules, tablets or liquid) **for stroke/TIA prevention** and if appropriate change patients to clopidogrel tablets 75mg daily. Contra-indications to the use of clopidogrel include hypersensitivity, severe hepatic impairment and active pathological bleeding such as peptic ulceration or intracranial haemorrhage.

Concurrent medication should also be reviewed and if the patient is currently receiving omeprazole or esomeprazole for gastric protection this should be changed to an alternative PPI. Additional precautions for carrying out a switch would be co-prescribing of dipyridamole with warfarin where referral to the stroke physician may be appropriate, and those taking dipyridamole as monotherapy should have their bleeding risk assessed by their GP (i.e. was aspirin stopped previously due to bleeding complications).

[1] http://www.rcplondon.ac.uk/sites/default/files/national-clinical-guidelines-for-stroke-fourth-edition.pdf; accessed 4th January 2016