Visual summary

Combining antiplatelets and anticoagulants

Antiplatelets

APL

Monotherapy

ASP Aspirin

Aspirin should be prescribed as the first-line antiplatelet agent unless the patient is intolerant or has a compelling contraindication

Dual therapy

For dual antiplatelet therapy, a $P2Y_{12}$ inhibitor can be added:

CLO Clopidogrel

PRA Prasugrel

TIC Ticagrelor

Combining novel $P2Y_{12}$ inhibitors with oral anticolaguants increases risk of bleeding, and cannot currently be recommended

Oral anticoagulants

OAC

WAR Warfarin

Warfarin is the most commonly used anticoagulant

DOAC

Direct oral anticoagulants

These are thought to be a safe alternative to warfarin, although there remains uncertainty about risks versus benefits

Patients should be prescribed the lower licenced dose of a DOAC when combined with an antiplatelet

API Apixaban

DAB Dabigatran

RIV Rivaroxaban

Example clinical scenarios

1 Cardiovascular disease

Primary prevention

ASP

Antiplatelets are not licensed for the primary prevention of cardiovascular disease. However, there is weak evidence that aspirin may confer some benefit in patients who are hypertensive and have impaired renal function or elevated risk of CVD

If a patient develops an indication for an OAC, this should replace the antiplatelet agent

~~APL~~ OAC

Secondary prevention

APL

Antiplatelet therapy is recommended for the secondary prevention of cardiovascular disease

If a patient develops an indication for an OAC:

~~APL~~ OAC

Stable coronary artery disease

OAC monotherapy is recommended instead of antiplatelet

Very high risk for coronary events

Consider adding aspirin or clopidogrel to OAC

OAC + ASP/CLO

2 Non-valvular atrial fibrillation

Generally, patients who have an acute coronary syndrome and/or undergo percutaneous coronary intervention could benefit from:

4-6 months
Triple therapy
ASP + CLO + OAC

To complete 12 months
Dual therapy
APL + OAC

After 12 months
As per secondary prevention of CVD

Combination and duration depends on stroke risk, bleeding risk, and clinical setting

In patients who are at high risk of bleeding, the use of bare-metal stents over drug-eluting stents is recommended to shorten dual antiplatelet and anticoagulant therapy to four weeks.

3 Deep vein thrombosis

APL + OAC

DVT in patients prescribed antiplatelets should be treated with OACs for a minimum of three months

In patients with intermediate-to-high bleeding risk, consider stopping any antiplatelet for the duration of the treatment – unless there is an acute indication (such as a recent cardiac event)

~~APL~~

4 Valvular heart disease

WAR Warfarin is recommended for all patients with native valvular heart disease and atrial fibrillation

Clinical trials for direct oral anticoagulants (DOACs) in valvular heart disease have not been undertaken

DOAC ?

+ ASP/CLO

The addition of an antiplatelet reduces risk of valve thrombosis and arterial thromboembolism but at an increased risk of major bleeding

OAC

Oral anticoagulants are recommended lifelong for patients with a mechanical prosthesis

Bioprosthetic values might not require oral anticoagulants beyond three months after insertion

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