

Summary of Antithrombotic Options for Adults with Cardiovascular Disease

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

This guidance summarises the common regimens in use for cardiovascular disease (CVD) prevention in South East London across primary and secondary care. Primary care colleagues are encouraged to contact the relevant specialist teams for case-by-case queries or clarification where needed.

All patients initiated on dual or triple antithrombotic therapies must leave hospital with a documented plan that includes the indication and duration of treatment.

Clear guidance from the initiating team on when to stop the dual/triple antithrombotic therapies must be communicated to primary care.

Cardiac

Indication	First line options	Alternatives
Stable coronary artery disease – secondary prevention	<ul style="list-style-type: none"> Aspirin 75mg daily 	<ul style="list-style-type: none"> Clopidogrel 75mg daily OR <ul style="list-style-type: none"> Rivaroxaban 2.5mg twice daily + aspirin 75mg daily for patients who are at a high risk of ischaemic events**, but not a high risk of bleeding
Acute coronary syndrome (ACS) including: <ul style="list-style-type: none"> ST elevation MI (STEMI) Non-ST elevation MI (NSTEMI) (Troponin +ve) Unstable angina 	<ul style="list-style-type: none"> Aspirin 75mg daily + Prasugrel (see Prasugrel Drugs BNF NICE for dosing) for up to 12 months OR <ul style="list-style-type: none"> Aspirin 75mg daily + Ticagrelor 180mg loading followed by 90mg twice daily for up to 12 months then: <ul style="list-style-type: none"> Aspirin 75mg daily long-term* OR <p>In patients who are at high risk of atherothrombotic events:</p> <ul style="list-style-type: none"> Aspirin 75mg daily + ticagrelor 60mg twice daily for up to 3 years; followed by aspirin 75mg daily long-term* <p>The decision to extend treatment beyond the first year should be made by the cardiologist at the index event</p>	<ul style="list-style-type: none"> Aspirin 75mg daily + clopidogrel 75mg daily for 12 months; then continue aspirin 75mg daily long term* OR <ul style="list-style-type: none"> Rivaroxaban 2.5mg twice daily and Aspirin 75mg daily with or without Clopidogrel 75mg daily for up to 12 months <p>Longer durations may be recommended for selected patients at the discretion of the consultant cardiologist then Aspirin 75mg daily long-term*</p>
Thrombotic MI / MI with Non-Obstructive Coronary Arteries (MINOCA)	<ul style="list-style-type: none"> As per cardiologist and/or haematologist advice. <p>Varied underlying causes, including thrombophilia or spontaneous coronary artery dissection. This condition is not covered by NICE guidance. Treatment will be tailored to the individual patient depending on the underlying cause.</p>	
Elective Percutaneous Coronary Intervention (PCI) with drug eluting stent insertion or drug eluting balloons	<ul style="list-style-type: none"> Aspirin 75mg daily + clopidogrel 75mg daily for up to 6 months then aspirin 75mg daily long-term* <p>Longer durations may be recommended for selected patients at the discretion of the consultant cardiologist</p>	Seek advice from cardiology
Post-Coronary Artery Bypass Graft	<ul style="list-style-type: none"> Aspirin 75mg daily + clopidogrel 75mg daily for up to 12 	<ul style="list-style-type: none"> Aspirin 75mg daily + clopidogrel

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(CABG) surgery (if initiated prior to hospital discharge)	months then continue aspirin 75mg daily long-term*	75mg daily for up to 12 months then continue clopidogrel 75mg daily long-term
Post-Patent Foramen Ovale (PFO) closure	<ul style="list-style-type: none"> Aspirin 75mg daily and/or clopidogrel 75mg daily for up to six months then either aspirin 75mg daily or clopidogrel 75mg daily long-term with a review in outpatient clinic at 12 months to review ongoing duration 	<ul style="list-style-type: none"> Seek advice from cardiology
Following Transcatheter Aortic Valve Implantation (TAVI) with no recent PCI If patient has had recent PCI: follow PCI guidance above	<p>If patient is not on long term anticoagulation (DOAC or warfarin) for any indication:</p> <ul style="list-style-type: none"> Aspirin 75mg daily long term <p>OR</p> <ul style="list-style-type: none"> Clopidogrel 75mg daily long-term <p>If patient is on long term anticoagulation (DOAC or Warfarin) for any indication: continue anticoagulation with no additional antiplatelet cover</p>	<p>Switch to the alternative antiplatelet agent not used first line:</p> <ul style="list-style-type: none"> Clopidogrel 75mg daily long term <p>OR</p> <ul style="list-style-type: none"> Aspirin 75mg daily long term <p>If not tolerated, seek advice from cardiology</p>

* **Clopidogrel 75 mg once daily** may be preferred over aspirin as long-term therapy in patients with multiple vascular beds

****High risk of ischaemic events** defined as aged over 65 years and /or atherosclerosis in 2 or more vascular territories and / or 2 or more risk factors (current smoker, diabetes mellitus, kidney dysfunction (CrCl less than 60ml/min), heart failure, previous non-lacunar ischaemic stroke more than 1 month ago)

Triple therapy

The decision to prescribe triple therapy should be made by a consultant cardiologist. The duration of triple therapy should be as short as possible.

Indication	First line options	Alternatives
Left Ventricular Thrombus (LVT)	<ul style="list-style-type: none"> Aspirin 75mg daily + clopidogrel 75mg daily + oral anticoagulation for up to 1 week then continue oral anticoagulation + clopidogrel 75mg daily for up to 6 months Triple therapy duration may be extended to up to 1 month for selected patients at the discretion of the consultant cardiologist. Apixaban and Rivaroxaban is approved as off-label use (AF therapeutic dose) for treatment of LVT in adults in SEL (LVT post MI + PCI) Warfarin remains first line for LVT secondary to dilated cardiomyopathy or left ventricular dysfunction <p>At 6 months:</p> <ul style="list-style-type: none"> If repeat echocardiogram or MRI confirms LVT resolution and anticoagulation is discontinued: → Restart aspirin in addition to clopidogrel to complete 1 year 	<ul style="list-style-type: none"> Seek advice from cardiology or haematology

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	<p>of dual antiplatelet therapy post-PCI.</p> <p>Special consideration: In cases of severe LV dysfunction, long-term anticoagulation may be considered due to risk of recurrence.</p>	
AF patient with ACS undergoing uncomplicated PCI	<ul style="list-style-type: none"> Aspirin 75mg daily + clopidogrel 75mg daily + oral anticoagulation for up to 1 week then continue oral anticoagulation + clopidogrel 75mg daily for up to 12 months <p>Triple therapy duration may be extended to up to 1 month for selected patients at the discretion of the consultant cardiologist. For full details, refer to the ESC Guidelines for the management of atrial fibrillation.</p>	<ul style="list-style-type: none"> Seek advice from cardiology
AF patient undergoing uncomplicated PCI (not ACS-specific)	<ul style="list-style-type: none"> Aspirin 75mg daily + clopidogrel 75mg daily + oral anticoagulation for up to 1 week then continue oral anticoagulation + clopidogrel 75mg daily for up to 6 months <p>Triple therapy duration may be extended to up to 1 month for selected patients at the discretion of the consultant cardiologist. For full details, refer to the ESC Guidelines for the management of atrial fibrillation.</p>	<ul style="list-style-type: none"> Seek advice from cardiology

For more complicated PCI, seek advice from specialist

Stroke

Indication	First line options	Alternatives
<p>Post Minor Ischaemic Stroke (NIHSS is less than or equal to 5) / Transient Ischaemic Attack (TIA) in the absence of Atrial Fibrillation</p>	<p>If CYP2C19 Genotype testing is available, see appendix A.</p> <p>If CYP2C19 genotype testing is <u>not</u> available: For patients ideally within 24 hours of onset of TIA or minor ischaemic stroke and with a <u>low</u> risk of bleeding:</p> <ul style="list-style-type: none"> Clopidogrel (initial dose 300 mg followed by 75 mg per day) plus aspirin (initial dose 300 mg followed by 75 mg per day for 21 days) then clopidogrel 75mg daily long term <p>For patients with TIA or minor ischaemic stroke with a <u>high</u> risk of bleeding:</p> <ul style="list-style-type: none"> Seek advice from stroke team. <p>Dual therapy with aspirin plus clopidogrel (for up to 90 days) may be initiated in secondary care for some people (for example with intracranial arterial stenosis) followed by antiplatelet monotherapy.</p>	<ul style="list-style-type: none"> Aspirin 75 mg daily with modified-release dipyridamole 200 mg twice daily may be used if clopidogrel cannot be tolerated. Modified-release dipyridamole 200 mg twice daily may be used if both clopidogrel and aspirin are contraindicated or cannot be tolerated. Aspirin 75 mg daily may be used if both clopidogrel and modified-release dipyridamole are contraindicated or cannot be tolerated.

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Post Major Ischaemic Stroke (NIHSS is more than 5) in the absence of Atrial Fibrillation	Aspirin 300mg daily for 14 days followed by: Clopidogrel 75mg daily or if CYP2C19 genotype testing is available then long term single antiplatelet therapy guided by CYP2C19 status.	
Post-stroke or TIA with Atrial Fibrillation	Apixaban (dose as per BNF) long term or Rivaroxaban (dose as per BNF) long term	<ul style="list-style-type: none"> • Warfarin

Peripheral Arterial Disease

Indication	First-line options	Alternatives
Peripheral arterial disease (PAD)	<ul style="list-style-type: none"> • Clopidogrel 75mg daily long term for patients with asymptomatic PAD or symptomatic PAD** without increased risk of CVD and all patients with a high bleeding risk <p>OR</p> <ul style="list-style-type: none"> • Rivaroxaban 2.5mg twice daily + aspirin 75mg daily long term for patients with symptomatic PAD*** who are at high risk of ischaemic events** but do not have a high bleeding risk 	Aspirin 75mg daily long term

*****Symptomatic confirmed PAD definition:** Previous aorto-femoral bypass surgery, limb bypass surgery, or percutaneous transluminal angioplasty revascularisation of iliac, or infra-inguinal arteries, or previous limb or foot amputation for arterial vascular disease or history of intermittent claudication and 1 or more of ankle/arm brachial pressure index (ABPI)) less than 0.9 or more than or equal to 50% peripheral artery stenosis or carotid revascularisation or asymptomatic carotid artery stenosis greater than or equal to 50%.

Other Considerations

Regular reviews: For antithrombotic drugs prescribed long term, the benefit–risk ratio may change over time, so patients should receive regular reviews.

Gastroprotection: Consider prescribing gastroprotection when dual or triple antithrombotic therapy is used for example a proton pump inhibitor (PPI), e.g. lansoprazole 15 or 30 mg daily or equivalent. Risk factors such as age (65 years or older), history of ulcer or GI bleed, use of NSAIDs, steroids, SSRIs, chronic renal failure, baseline/pre-existing anaemia and alcohol excess should be taken into account. If PPI is unsuitable, consider alternative gastroprotective agents.

Deprescribing antithrombotics:

- Assess bleeding risk (especially in older or renally impaired patients), thrombotic risk, therapy indication and duration, and obtain patient/caregiver consent. Use the [STOP/START Toolkit](#) to support deprescribing.
- Antiplatelets are not recommended for primary prevention for coronary heart disease. Aspirin offers minimal stroke prevention benefit in frail older adults with atrial fibrillation and increases bleeding risk.
- In some cases, patients prescribed antiplatelets for CVD are later diagnosed with AF and initiated on anticoagulation. In such instances, deprescribing of antiplatelets should be considered. For guidance, refer to the [UCLPartners Proactive Care Framework: Atrial Fibrillation – Stroke Prevention and Managing Cardiovascular Risk](#)

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References

- ESC Guidelines for the management of acute coronary syndromes. Aug 2023 <https://www.escardio.org/Guidelines/Clinical-Practice-Guidelines/Acute-Coronary-Syndromes-ACS-Guidelines>
- ESC Guidelines for the management of chronic coronary syndromes. Aug 2024 <https://www.escardio.org/Guidelines/Clinical-Practice-Guidelines/Chronic-Coronary-Syndromes>
- ESC Guidelines for the management of atrial fibrillation developed in collaboration with EACTS. Aug 2024 <https://www.escardio.org/Guidelines/Clinical-Practice-Guidelines/Atrial-Fibrillation>
- Royal College of Physicians Intercollegiate Stroke Working Party: 2023. National Clinical Guideline for Stroke for the UK and Ireland. Partial update of the 5th edition. [National-Clinical-Guideline-for-Stroke-2023.pdf](#)
- NICE TA236: Ticagrelor for the treatment of acute coronary syndromes. Oct 2011 <https://www.nice.org.uk/guidance/ta236>
- NICE TA210: Clopidogrel and modified release dipyridamole for the prevention of vascular events. Dec 2010 <https://www.nice.org.uk/guidance/Ta210>
- NICE TA317: Prasugrel with percutaneous coronary intervention for treating acute coronary syndromes Jul 2014 <https://www.nice.org.uk/guidance/ta317>
- NICE TA420: Ticagrelor for preventing atherothrombotic events after myocardial infarction. Dec 2016 <https://www.nice.org.uk/guidance/ta420>
- NICE TA607, Rivaroxaban for preventing atherothrombotic events in people with coronary or peripheral artery disease, Oct 2019 <https://www.nice.org.uk/guidance/ta607/chapter/1-Recommendations>
- NICE TA335, Rivaroxaban for preventing adverse outcomes after acute management of acute coronary syndrome, Mar 2025, [Overview | Rivaroxaban for preventing adverse outcomes after acute management of acute coronary syndrome | Guidance | NICE](#)
- NICE DG59: CYP2C19 genotype testing to guide clopidogrel use after ischaemic stroke or transient ischaemic attack. July 2024 <https://www.nice.org.uk/guidance/dg59>
- Summary of Product Characteristics (SPC) Xarelto 2.5mg. Bayer. <https://www.medicines.org.uk/emc/product/3410/smpc> last updated Nov 2024.
- Summary of Product Characteristics (SPC) Brilique 90mg. AstraZeneca. <https://www.medicines.org.uk/emc/product/5767/smpc> last updated Jan 2025
- NICE CKS guidance Stroke and TIA management; [Stroke and TIA | Health topics A to Z | CKS | NICE](#) updated Nov 2025
- Rivaroxaban and apixaban for the treatment of left ventricular thrombus (LVT) in adults (off-label use) (Rivaroxaban and apixaban are anticoagulants) [South East London Area Prescribing Committee](#) latest issue April 2025
- Antiplatelet Drugs, South East London Joint Medicines Formulary, [South East London Joint Medicines Formulary Formulary](#)
- [Apixaban and Rivaroxaban for LVT in adults](#) South East London Joint Medicines Formulary
- Position statement, choice of DOAC for AF: [IMOC-PS-029-DOACs-Aug-2024-FINAL-v2.pdf](#)

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Appendix A

Poor or intermediate metabolisers of CYP2C19 in ischaemic stroke or transient ischaemic attack (TIA) – information for healthcare professionals working in primary care

This information aims to support healthcare professionals working in primary care who may be requested to continue prescribing of long-term antiplatelet treatment in patients with either a poor or intermediate CYP2C19 metaboliser status following ischaemic stroke or TIA.

Background

In line with NICE HealthTech guidance 724 – [CYP2C19 genotype testing to guide clopidogrel use after ischaemic stroke or transient ischaemic attack](#), genetic testing has been implemented to support medicines optimisation in patients following acute ischaemic stroke or TIA. **This testing is currently only available at Guy's & St Thomas' NHS Foundation Trust (GSTT).**

CYP2C19 is a gene that encodes a cytochrome P450 enzyme responsible for metabolising many commonly prescribed medicines, including clopidogrel. CYP2C19 expression varies between individuals which impacts on drug efficacy and may increase the risk of adverse effects. Due to variations in the CYP2C19 gene, people may be classified as poor, intermediate, normal, rapid or ultra-rapid metabolisers.

CYP2C19 metabolises clopidogrel, a pro-drug, to its active form. Poor or intermediate metabolisers of CYP2C19 are less likely to receive a therapeutic benefit from clopidogrel due to reduced exposure to the active metabolite and are recommended to use alternative antiplatelet therapy. Normal, rapid and ultra-rapid metabolisers can be treated with clopidogrel.

Patient pathway and testing

Patients with confirmed ischaemic stroke or TIA will be tested for their CYP2C19 status once atrial fibrillation (AF) or paroxysmal atrial fibrillation (PAF) has been ruled out. All tests will be performed in secondary care via a blood test and sent to the genomics laboratory at GSTT.

Antiplatelet drug choice and dosing recommendations

Treatment recommendations for those with poor/intermediate CYP2C19 metabolism or status unknown, takes into account guidance from the [Clinical Pharmacogenetic Implementation Consortium \(CPIC\)](#), [CERSI-PGx](#), [National Clinical Guideline for Stroke 2023](#), [THALES](#) study and [CHANCE-2](#) study. All treatment will be initiated in secondary care – see [Appendix B](#) (flow chart).

- **Unknown/poor/intermediate metaboliser status:** Patients appropriate for dual antiplatelet therapy will be prescribed [ticagrelor](#) (initial dose 180mg once only followed by 90mg twice daily) plus [aspirin](#) (initial dose 300mg once only followed by 75mg daily) for 28 days from onset of symptoms. Patients will be provided with the full supply from secondary care.

In terms of longer-term prescribing, after 28 days, and once the CYP2C19 result is available, an antiplatelet plan to be continued in primary care will be recommended as follows:

- **Normal/rapid/ultra-rapid CYP2C19 metaboliser:** Start [clopidogrel](#) 75mg daily long term.
- **Poor/intermediate CYP2C19 metaboliser:** Continue [aspirin](#) 75mg daily long term

If a patient declines genetic testing, they will be provided with clopidogrel for long term secondary prevention.

Refer to Summary of antithrombotic options in cardiovascular disease for all recommended regimens for use across South East London.

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A secondary care stroke clinician will follow up with the patient in a face-to-face clinic or telephone appointment with the result and subsequent antiplatelet plan. All genotype results will be communicated to the primary care team via clinic/discharge letter.

Management of other medicines metabolised by CYP2C19

There are a number of medicines that are metabolised by CYP2C19 and examples include selective serotonin-reuptake inhibitors, tricyclic antidepressants, proton pump inhibitors, antiepileptics and antifungals. Information on medications affected by CYP2C19 metabolism can be accessed via the drug's [summary of product characteristics](#), [CERSI-PGx](#) and international guidelines ([CPIC](#), [ClinPGx](#)).

If patients are already on stable and effective doses of drugs affected by CYP2C19 metabolism without tolerability issues, they may not benefit from changes based on metaboliser status alone.

The secondary care stroke team will review all existing medications based on the CYP2C19 result and will inform the primary care team of any changes to medications via letter.

Primary care – coding recommendations

The patient's metaboliser status should be coded in their primary care medical record. Clinicians should be aware that current electronic prescribing systems do not flag drug-gene interactions, so these should be considered when making prescribing decisions.

There is currently no national standard on how records should be maintained around pharmacogenomic testing. However, until a national approach to this topic is agreed, it is advisable to use the existing SNOMED-CT terms to annotate CYP2C19 pharmacogenomic results in the patient record. These include the following codes, in descending order of CYP2C19 activity:

Ultrarapid	Cytochrome P450 family 2 subfamily C member 19 ultra-rapid metaboliser (finding) SCTID: 738790007
Rapid	Cytochrome P450 family 2 subfamily C member 19 rapid metaboliser (finding) SCTID: 738789003
Normal	Cytochrome P450 family 2 subfamily C member 19 normal metaboliser (finding) SCTID: 738788006
Intermediate	Cytochrome P450 family 2 subfamily C member 19 intermediate metaboliser (finding) SCTID: 738787001
Poor	Cytochrome P450 family 2 subfamily C member 19 poor metaboliser (finding) SCTID: 738786005

The Royal College of General Practitioners have produced a position statement to support prescribers outside of the acute Stroke setting which can be found here: [CYP2C19 Genotyping Implementation Position Statement](#)

Patient information

Patients with a CYP2C19 genetic variant will be provided with access to a patient information leaflet, which is available here: *xxx (in development)*

Further advice and guidance

If further advice or guidance is required, contact the GSTT Stroke Clinic via advice and guidance or call the TIA contact number on 07825023845 (between Monday-Friday 9-5pm). In an emergency, GPs can speak to an on-call stroke registrar by calling GSTT switchboard in hours or King's College Hospital switchboard out of hours.

GSTT switchboard (between Monday – Friday, 9-5pm): 0207 188 7188

KCH switchboard (outside of Monday – Friday, 9-5pm): 0203 299 9000

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References and resources

CYP2C19 genotype testing for clopidogrel: A guideline developed by the UK Centre of Excellence for regulatory science and innovation in pharmacogenomics (CERSI-PGx) (December 2025). Available at: <https://bpspubs.onlinelibrary.wiley.com/doi/10.1002/bcp.70370>, last accessed 05/12/25

Clinical Pharmacogenetic Implementation Consortium. CPIC® Guideline for Clopidogrel and CYP2C19 (January 2022). Available at: <https://cpicpgx.org/guidelines/guideline-for-clopidogrel-and-cyp2c19/>, last accessed 06/10/25

ClinPGx: Available at: www.clinpgx.org, last accessed 06/10/25

CYP2C19 Genotyping Implementation Position Statement. Royal College of General Practitioners (RCGP). Available at: <https://www.rcgp.org.uk/representing-you/policy-areas/genomic-position-statement>, last accessed 10/11/25

National Clinical Guideline for Stroke (May 2023). Available at: <https://www.strokeguideline.org/>, last accessed 06/10/25

NHS England, National Genomics Education Programme, Knowledge hub: CYP2C19, available at: <https://www.genomicseducation.hee.nhs.uk/genotes/knowledge-hub/cyp2c19/>, last accessed 06/10/25

NICE HTG74:CYP2C19 genotype testing to guide clopidogrel use after ischaemic stroke or transient ischaemic attack (July 2024). Available at: <https://www.nice.org.uk/guidance/htg724>, last accessed 11/12/25

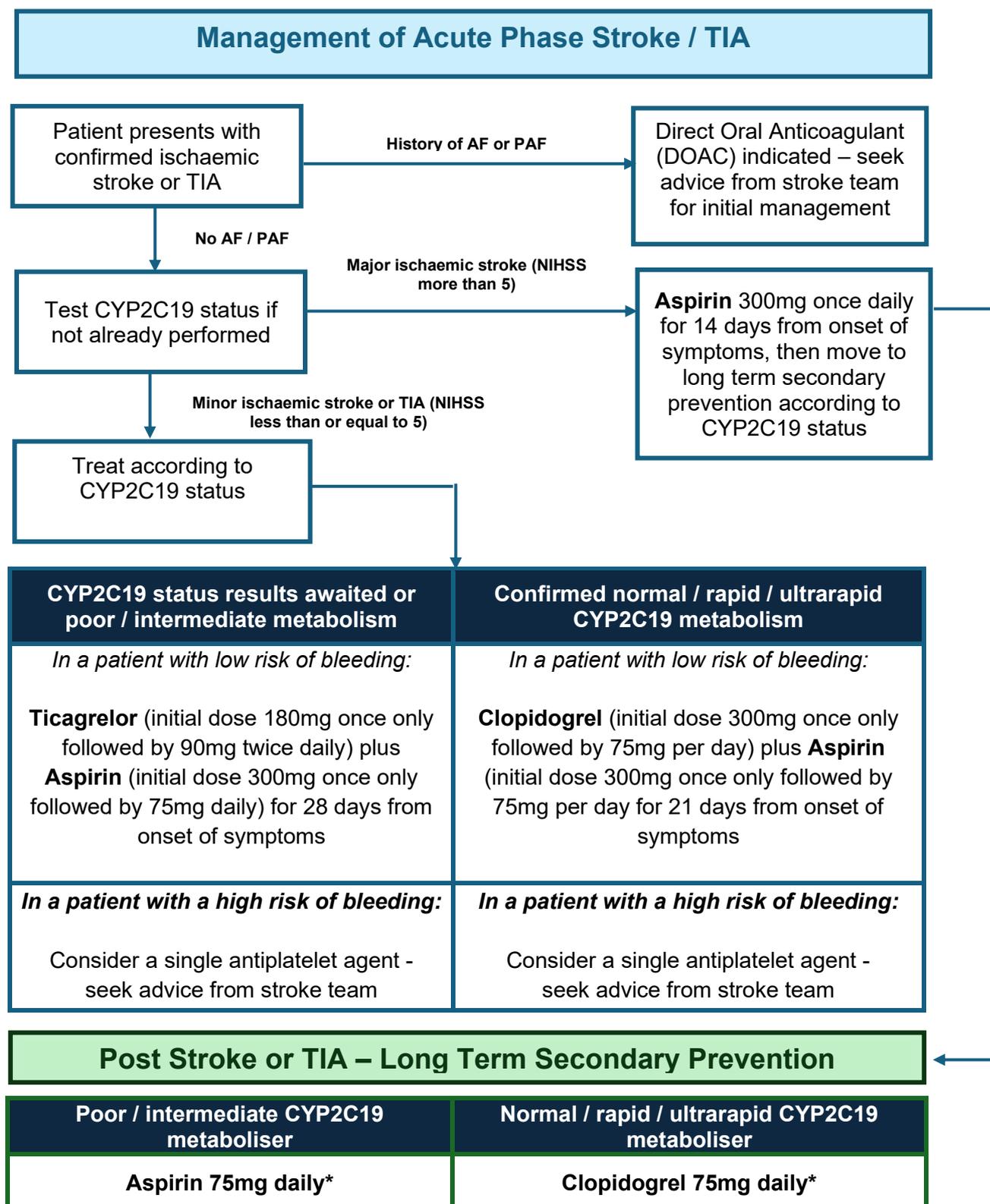
Summary of Product Characteristics via Electronic Medicines Compendium. Available at: [Home - electronic medicines compendium \(emc\)](#), last accessed 06/10/25

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Appendix B. Antithrombotic management for ischaemic stroke and TIA at GSTT



*An antiplatelet plan to be continued in primary care will be recommended by the stroke team. Refer to **Summary of antithrombotic options in cardiovascular disease** for all recommended regimens for use across South East London.

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