Regional Stroke Network Champlain | Réseau Régional des AVC

ANTIPLATELET AND ANTICOAGULANT GUIDING PRINCIPLES
FOR TRANSIENT ISCHEMIC ATTACK AND ISCHEMIC STROKE

Purpose Statement The purpose of this tool is to provide guidance on the use of antiplatelet and anticoagulant therapies for patients with TIA/ischemic stroke

Disclaimer: *This tool is for educational purposes only and provides general clinical guidance. It does not replace clinical judgment or specialist consultation—clinicians should seek expert input (e.g., stroke neurology) when management is uncertain or complex.*

APT — ANTIPLATELETS
High Risk TIA/Ischemic Stroke

All patients **not already** on an antiplatelet should be treated with a one-time loading dose

LOADING DOSE

160 mg	300 mg
ASA (Aspirin)	CLOPIDOGREL (Plavix)

DAPT — Dual Antiplatelet Therapy (DAPT) recommended for:
- High risk TIA/Minor Non-Disabling Stroke (NIHSS 0-3)
- Non-cardioembolic source (no afib new or known)
- Not at high bleeding risk
- Carotid plaque (if stenosis >50%, consult physician with stroke expertise for discussion about revascularization)

MONO APT — Antiplatelet Monotherapy (MONO) considered for:
- Patients at high risk of bleeding
- Relevant clinical considerations
- NIHSS ≥4

DUAL ANTIPLATELET MAINTENANCE DOSE

81 mg daily ASA (Aspirin) **AND** 75 mg daily CLOPIDOGREL (Plavix)

Duration: 21 days then transition to monotherapy

FOLLOWED BY MONOTHERAPY

81 mg daily ASA (Aspirin) **OR** 75 mg daily CLOPIDOGREL (Plavix)

Duration: Indefinitely

OAC — ORAL ANTICOAGULANT
TIA/Ischemic Stroke **AND** Atrial Fibrillation (Past or Present)

A direct oral anticoagulant (DOAC) should be prescribed in preference over warfarin for most patients

OAC DOSING

DABIGATRAN (Pradaxa®)	110 mg or 150 mg PO BID
RIVAROXABAN (Xarelto®)	15 mg or 20 mg PO Daily
APIXABAN (Eliquis®)	2.5 mg or 5 mg PO BID
EDOXABAN (Lixiana®)	30 mg or 60 mg PO Daily
WARFARIN (Coumadin®)	Personalized daily dosing

Target Timing of DOAC Initiation
Optimal timing has not been well defined by clinical trial evidence and should be based on individual benefit/risk assessment including a) clinical circumstances, b) stroke severity, c) infarct size, d) imaging appearances, e) risk of hemorrhagic transformation, f) age, g) comorbidities, and h) estimated stroke recurrence risk

According to expert consensus, the target timing of initiation of DOAC therapy post-stroke is:

OAC <24 HOURS	OAC 3 DAYS	OAC 6-7 DAYS	OAC 12-14 DAYS
TIA and no visible infarct or hemorrhage on imaging, **start OAC <24 hours** after event	**Minor clinical stroke/small non-hemorrhagic infarct** on imaging, **start OAC 3 days** post-stroke	**Moderate clinical stroke/ moderate-sized infarct** (without hemorrhage), on imaging, **start OAC 6-7 days** post-stroke	**Severe clinical stroke/ large-sized infarct** (without hemorrhage) on imaging, **start OAC 12-14 days** post-stroke

- Obtain repeat brain imaging if concerns about hemorrhagic transformation prior to OAC initiation
- While waiting to start OAC, consider bridging with antiplatelet therapy

It is reasonable to delay the initiation of anticoagulation for more than 2 weeks post-stroke if in the judgement of the clinician the risk of intracranial bleeding is felt to be high, e.g., for some patients with large infarcts and those with hemorrhagic transformation

Scan this QR code for guidance on anticoagulant therapies for patients with stroke/ TIA and atrial fibrillation. Consult a physician with stroke expertise for patient-specific decisions, if needed.

Gladstone, D. J., Lindsay, M. P., Douketis, J., Smith, E. E., Dowlatshahi, D., Wein, T., Bourgoin, A., Cox, J., Falconer, J. B., Graham, B. R., Labrie, M., McDonald, L., Mandzia, J., Ngui, D., Pageau, P., Rodgerson, A., Semchuk, W., Tebbutt, T., Tuchak, C., ... Poppe, A. Y. (2020). Canadian stroke best practice recommendations: Secondary prevention of stroke (update 2020). Heart and Stroke Foundation of Canada. https://www.strokebestpractices.ca

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CLINICAL **SCENARIOS**

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1 ANTIPLATELET LOADING DOSE

A patient presents to the Emergency Department with unilateral arm numbness and mild speech difficulties

Patient is taking ASA 81 mg daily

No history of atrial fibrillation and it was not identified on ECG. No bleeding risk identified. The patient is diagnosed with a high-risk TIA

Would you give an antiplatelet loading dose?

CLINICAL RECOMMENDATION

ASA (Aspirin)
In this case, you would not give a loading dose of ASA

CLOPIDOGREL (Plavix)
If patient meets criteria for DAPT, you can load with Clopidogrel 300 mg

Do not prescribe a loading dose of an antiplatelet that the patient is already taking

2 STROKE WHILE TAKING AN OAC

Based upon clinical assessment and diagnostic imaging, you have diagnosed the patient with an ischemic stroke

The patient has known atrial fibrillation and was already taking a DOAC

Should you change anticoagulant therapies and/or add an antiplatelet?

CLINICAL RECOMMENDATION

For patients with atrial fibrillation, who experience ischemic stroke or TIA despite anticoagulant therapy, guidelines support two reasonable options

a) continue the current agent **OR** b) switch to a different anticoagulant agent

The addition of antiplatelet therapy is not (X) recommended due to increased bleeding risk unless there is a specific medical indication, examples include: recent vascular stent; certain mechanical heart valves or symptomatic carotid stenosis in addition to atrial fibrillation

Review with physician with stroke expertise/Neurology prior to starting an antiplatelet, if patient is already taking an OAC

3 ANTITHROMBOTICS IN CORONARY ARTERY DISEASE (CAD) OR PERIPHERAL VASCULAR DISEASE (PVD)

You have diagnosed a patient with a high risk TIA or minor stroke

No atrial fibrillation identified

Should you continue with current anticoagulant and antiplatelet therapies?

Due to CAD or PVD, the patient is taking daily:
2.5 mg BID
RIVAROXABAN (Xarelto®)
✚
ASA (Aspirin)

CLINICAL RECOMMENDATION

Stop Rivaroxaban for a period of 21 days. Prescribe DAPT for 21 days. Then after 21 days, resume combination of Rivaroxaban 2.5 mg BID and ASA, in most circumstances depending on mechanism of the TIA/stroke event

Do not add another antiplatelet (X)

Do not switch to **full-dose** anticoagulant, unless patient identified to have atrial fibrillation. In this case, ASA would need to be stopped when the DOAC is started

For carefully selected patients with CAD or PVD meeting the eligibility criteria of the COMPASS trial, including a low estimated bleeding risk and no history of lacunar stroke or hemorrhagic stroke, the combination of rivaroxaban 2.5 mg BID plus daily Aspirin is a reasonable treatment option in the long-term, but in the short-term DAPT is preferred

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4 INITIATION OF ANTIPLATELET OR ANTICOAGULANT POST THROMBOLYSIS

Intravenous (IV) thrombolysis was administered 12 hours ago for acute ischemic stroke

When will you start antiplatelets and anticoagulants?

CLINICAL RECOMMENDATION

Patients receiving IV thrombolysis should avoid antiplatelet and anticoagulant therapy within the first 24 hours

X x 24 hours

APT could then be initiated after brain imaging has excluded secondary hemorrhage

Timing of DOAC initiation should be based on individual benefit/risk assessment. Refer to Canadian Stroke Best Practice Guidelines, section Timing of Initiation of Oral Anticoagulant Therapy following Acute Stroke

5 EMBOLIC STROKE OF UNDETERMINED SOURCE (ESUS)

You have diagnosed a patient with and ESUS stroke and there is no known atrial fibrillation

Should you prescribe an anticoagulant?

CLINICAL RECOMMENDATION

Anticoagulant therapy (OAC) is not X currently recommended over antiplatelet

ASA (Aspirin) OR CLOPIDOGREL (Plavix)

6 EXTENDED DAPT

The CT angiogram for your patient demonstrates **symptomatic** intracranial atherosclerotic stenosis, and they have a low estimated bleeding risk

How long do you prescribe DAPT?

CLINICAL RECOMMENDATION

DAPT should be considered for 3 months

ASA (Aspirin) AND CLOPIDOGREL (Plavix)

followed by antiplatelet monotherapy thereafter

***RECOMMENDATION:** Review with physician with stroke expertise/Neurology prior to prescribing extended DAPT