NICE Appraisal Consultation Document
Clopidogrel and modified-release dipyridamole for the prevention of occlusive vascular events (review of Technology Appraisal No. 90)

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The recommendations are fundamentally sound. The issue, however, is whether they could be simpler to make application in 'the real world' easier and therefore achieve greater clinical and cost effective benefit. This is a confusing area as the appraisal excludes atrial fibrillation (AF) and coronary revascularisation which are both common. It also overlaps with CG 48 and 94. It is crucial that the recommendations do not prevent formal (warfarin) anticoagulation of AF or dual antiplatelet therapy in appropriate patients following coronary revascularisation. The differences between the strategies is small compared to the difference in adding other therapy such as statins and ACE inhibitors. Recommendations must facilitate this multi-pronged attack not introduce confusion that reduces it. It is unfortunate that clopidogrel is not licenced for TIA although it is generally accepted that it can be safely and effectively used when the other agents are not tolerated – a form of words needs to be chosen that allows this to happen and certainly does not inhibit it which would be detrimental for a high risk patient group. This is confounded by the fact that the distinction between TIA and ischaemic stroke is not always clear cut (MRI deficit with brief symptoms). The recommendations should probably recognise the arrival of newer agents such as prasugrel which is licenced and used after myocardial infarction – it might continue instead of clopidogrel in multi vessel disease although this will be outside evidence but some flexibility may need to be allowed but avoiding confusion. Not recognising this will make the document look out of date very quickly. It is less clear whether clopigogrel resistance will be a big issue in the near future but if it is then recommending, by implication, that resistant patients swap from prasugrel to clopidogrel will be unhelpful.

For simplicity it would be much easier if 1.1 could recommend Clopidogrel for all as first line therapy. This might now be more cost effective as the price has fallen further so again avoiding the document being out of date. A carefully worded addendum for TIA would be needed and alternatives itemised when not tolerated. If it cannot be this simple then as section 1 will be the most read it should add that aspirin can be used in PAD when clopidogrel not tolerated as in 4.3.8. The definition of PAD may be needed somewhere as this is not as clear as for the other diagnoses in clinical practice. Finally the issue of Proton Pump Inhibitors with Clopidogrel should be covered to avoid confusion.