Personal Statement
(on behalf of the British Association of Stroke Physicians)

Stroke disease has important health, social and personal cost, being an important cause of mortality and the single most important cause of adult disability in the United Kingdom. Effective and timely secondary prevention therapy is an important contribution to the reduction of recurrent stroke, and its associated morbidity and mortality. The use of antiplatelet therapy, principally aspirin, dipyridamole modified release and clopidogrel, is an important component of the secondary prevention strategy, and the current National Institute for Health and Clinical Excellence Technology Appraisal Number 90 reviews the use of these agents in stroke (as well as other causes of occlusive vascular events). In respect of stroke, aspirin is recommended in combination with dipyridamole modified release for a 2 year period before reverting to aspirin monotherapy in the majority of patients. However, in those patients who are dipyridamole intolerant then aspirin monotherapy is recommended; and in those patients who are aspirin intolerant (clearly defined) then clopidogrel monotherapy is recommended.

However, recent new data require further consideration of these guidelines. Principally, this review in respect of stroke secondary prevention should focus on two areas:

1. The duration of combination aspirin and dipyridamole modified release therapy. The ESPRIT[1] Trial compared aspirin with or without dipyridamole within 6 months of transient ischaemic attack or minor stroke of presumed arterial origin with a mean follow-up period of 3.5 years. Combination therapy was associated with a significant risk reduction in the composite of vascular death, stroke or myocardial infarction compared to aspirin monotherapy. The cumulative event rate for both the primary outcome and for ischaemic events continued to diverge after the current 2 year period of dual therapy recommended. Therefore, consideration should be given to removing the 2-year limit on combination therapy.

2. In those patients who are dipyridamole intolerant, aspirin monotherapy is currently recommended. The recent publication of the PRoFESS[2] Trial compared aspirin and modified release dipyridamole with clopidogrel, and demonstrated no significant difference in stroke recurrence (primary outcome) or the composite of stroke, myocardial infarction or vascular death (secondary outcome) between the two treatment groups. Therefore, consideration should be given to patients who are dipyridamole intolerant being prescribed clopidogrel monotherapy rather than aspirin monotherapy.

[1] The ESPRIT Study Group. Aspirin plus dipyridamole versus aspirin alone after cerebral ischaemia of arterial origin (ESPRIT): randomised controlled trial. Lancet 2006; 367:1665-73

[2] Sacco RL, Diener H-C, Yusuf A et al for the PRoFESS Study Group. Aspirin and Extended-Release Dipypridamole versus Clopidogrel for Recurrent Stroke. N Engl J Med 2008; 359:1238-51

[redacted], Scientific Committee, British Association of Stroke Physicians