Recommended Antiplatelet Regimens for Acute Coronary Syndrome

The following recommendations are based on current NICE[1], ESC[2] and AHA[3] guidance. Antiplatelet choice in Acute Coronary Syndrome must be individualised based on patient risk factors for thrombosis and bleeding and, as such, the Interventional Cardiologist may deviate from these recommendations. In all cases, the intended antiplatelet regimen must be clearly documented and communicated to the patient / carer and all relevant Healthcare Professionals.

Indication	Recommended Antiplatelet Regimen
STEMI Treated with Primary PCI	**Aspirin** 75mg OD indefinitely + **Prasugrel** 10mg* OD for 12 months *Use prasugrel 5mg OD if patient 75 years and older, or less than 60kg If prasugrel not suitable (e.g. history of stroke or TIA), offer ticagrelor as an alternative If patient has a high risk of bleeding**, offer clopidogrel as an alternative
STEMI No Primary PCI	**Aspirin** 75mg OD indefinitely + **Ticagrelor** 90mg BD for 12 months If patient has a high risk of bleeding**, offer clopidogrel as an alternative
NSTEMI or Unstable Angina Treated with PCI	**Aspirin** 75mg OD indefinitely + **Ticagrelor** 90mg BD for 12 months Prasugrel may be offered as an alternative If patient has a high risk of bleeding**, offer clopidogrel as an alternative
NSTEMI or Unstable Angina No PCI performed	**Aspirin** 75mg OD indefinitely + **Ticagrelor** 90mg BD for 12 months If patient has a high risk of bleeding**, offer clopidogrel as an alternative

Patients who have a separate indication for anticoagulation (e.g. atrial fibrillation):

Indication	Recommended Antiplatelet / Anticoagulant Regimen
Acute Coronary Syndrome Treated with PCI	**Aspirin** 75mg OD for up to 1 month + **Clopidogrel** 75mg OD for up to 12 months + **DOAC** long term (see local DOAC guidance)
Acute Coronary Syndrome No PCI performed	**Clopidogrel** 75mg OD for 6 to 12 months + **DOAC** long term (see local DOAC guidance)

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****High Bleeding Risk**

According to the Academic Research Consortium for High Bleeding Risk (ARC-HBR) definition, patients undergoing PCI are considered to have a high bleeding risk if they meet:

- ≥1 major criteria, or
- ≥2 minor criteria

Major criteria	**Minor criteria**
• Anticipated long term oral anticoagulant use • Severe CKD (eGFR <30) • Hb <110 g/L • Spontaneous bleeding requiring hospitalisation or transfusion in the past 6 months or at any time if recurrent • Baseline platelet count <100 x10^9/L • Chronic bleeding diathesis • Liver cirrhosis with portal hypertension • Active malignancy within 12 months • Previous spontaneous ICH (at any time) • Previous traumatic ICH within 12 months • Brain arteriovenous malformation • Moderate or severe ischaemic stroke within 6 months • Recent major surgery or major trauma within 30 days before PCI.	• Age ≥ 75 years • Moderate CKD (eGFR 30 – 59) • Hb 110 - 129 g/L for men and 110 -119 g/L for women • Spontaneous bleeding requiring hospitalisation or transfusion within 12 months not meeting major criterion • Long term NSAID or steroid use • Prior ischaemic stroke not meeting major criterion

References:

1. NICE guideline NG185. Acute coronary syndromes. 18th November 2020. https://www.nice.org.uk/guidance/ng185 (accessed 6th May 2026)
2. Byrne RA, Rossello X, Coughlan JJ, et al. 2023 ESC Guidelines for the management of acute coronary syndromes: Developed by the task force on the management of acute coronary syndromes of the European Society of Cardiology (ESC) *European Heart Journal* 2023;44(38):3720–3826 https://academic.oup.com/eurheartj/advance-article/doi/10.1093/eurheartj/ehad191/7243210
3. Rao SV, O'Donoghue ML, Ruel M, et al. 2025 ACC/AHA/ACEP/NAEMSP/SCAI Guideline for the Management of Patients With Acute Coronary Syndromes: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. *Circulation* 2025;151(13):e771-e862 https://pubmed.ncbi.nlm.nih.gov/40014670/