Appendix 2Ga - Guidance on Medication Post MI

For Guidance on Medication Post MI in Patients with Heart Failure see Appendix 2Gb

<table>
<thead>
<tr>
<th>ANTI-PLATELET</th>
<th>Maintenance dose:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clopidogrel</td>
<td>75mg once daily</td>
</tr>
<tr>
<td>Ticagrelor (Brilique®)</td>
<td>90mg twice daily</td>
</tr>
<tr>
<td>Prasugrel (Efient®)</td>
<td>10mg once daily</td>
</tr>
</tbody>
</table>

Prescribing Notes:

**Clopidogrel and Aspirin**
- Aspirin 75mg should be taken, long-term, unless contraindicated
- Clopidogrel 75mg should be continued for the period specified in the discharge letter. Where no duration is given – follow advice below.

A combination of clopidogrel and aspirin will usually be prescribed for a defined period. In the absence of a specific recommendation assume:
- 4 weeks for ST elevated myocardial infarction (STEMI). If revascularisation with stent follow guidance below.
- 3-12 months for Non-ST elevation myocardial infarction (NSTEMI)
- 3 months for Bare metal stent insertion (BMS)
- 12 months for Drug eluting stent insertion (DES)
- Ensure that the proposed stop date for clopidogrel is clearly marked in the patient records.
- If a PPI is required for a patient prescribed clopidogrel, lansoprazole is the preferred choice. Omeprazole and esomeprazole should be avoided due to the risk of a potential drug interaction.

**Ticagrelor and Aspirin**
- Clopidogrel and aspirin remains the combination of choice in most patients with Acute Coronary Syndrome.
- Ticagrelor should only be initiated by Cardiologists for use in patients with a NSTEMI who are considered at high risk of an atherothrombotic event.
- The combination of ticagrelor and aspirin should be prescribed for a maximum of 12 months. A stop date should be entered onto prescribing systems to ensure patients are reviewed and the ticagrelor discontinued 12 months after patients have been initiated on ticagrelor.

**Prasugrel and Aspirin**
- Prasugrel in combination with aspirin should only be prescribed to patients with acute coronary syndrome undergoing primary or delayed percutaneous coronary intervention. Use is restricted to patients eligible to receive the 10mg dose of prasugrel only.

N.B. Combined anti-platelet therapy following stent implantation should not be discontinued or interrupted without discussion with a Cardiologist.
## ACE INHIBITOR (ACE I)

<table>
<thead>
<tr>
<th></th>
<th>Usual starting dose:</th>
<th>Target dose:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ramipril</td>
<td>2.5 mg once a day</td>
<td>10 mg once a day</td>
</tr>
<tr>
<td>Perindopril</td>
<td>4 mg once a day</td>
<td>8 mg once a day</td>
</tr>
</tbody>
</table>

Prescribing Notes:
- Use a lower starting dose (half normal starting dose) if patient is hypotensive (SBP <100mmHg) or elderly.
- If patient on a beta-blocker and low BP an issue try giving ACE I in the evening.
- Refer to Fife Formulary for additional prescribing points.
- Start at the appropriate dose and titrate upwards at short intervals (e.g. every 1–2 weeks) until the target dose or the maximum tolerated dose is reached.
- It is better to take some ACE I than none at all.
- On each upward titration, monitor the patient’s renal function and blood pressure.

For patients unable to take ACE I, an Angiotensin-II Receptor Antagonist may be considered.

## ANGIOTENSIN-II RECEPTOR ANTAGONIST (AIIRA)

<table>
<thead>
<tr>
<th></th>
<th>Usual starting dose:</th>
<th>Target dose:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Losartan*</td>
<td>50mg once daily</td>
<td>100mg once daily</td>
</tr>
<tr>
<td>Candesartan*</td>
<td>8mg once daily</td>
<td>32mg once daily</td>
</tr>
<tr>
<td>Telmisartan*</td>
<td>80 mg once daily</td>
<td>80 mg once daily</td>
</tr>
</tbody>
</table>

*Telmisartan is the only AIIRA with an evidence base for use in patients post MI. However, the effect is likely to be a class effect. Losartan and candesartan are Fife Formulary choice AIIRAs.

Prescribing Notes:
- An AIIRA should only be considered in patients unable to take an ACE I.
- Use a lower starting dose (half normal starting dose) if patient is hypotensive (SBP <100mmHg) or elderly.
- If patient on a beta-blocker and low BP an issue try giving AIIRA in the evening.
- Refer to Fife Formulary for additional prescribing points.
- On each upward titration, monitor the patient’s renal function and blood pressure.
- If a patient is unable to tolerate an ACE I and an AIIRA, A beta-blocker should be titrated to the maximum tolerated dose.
**BETA - BLOCKER**

<table>
<thead>
<tr>
<th>Drug</th>
<th>Usual starting dose:</th>
<th>Target dose:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bisoprolol</td>
<td>2.5 mg once daily</td>
<td>10 mg once daily</td>
</tr>
<tr>
<td>Atenolol</td>
<td>50mg once daily</td>
<td>100 mg once daily or 50 mg twice daily</td>
</tr>
</tbody>
</table>

Prescribing Notes:
- Use a lower starting dose (half normal starting dose) if patient is hypotensive (SBP <100mmHg) or elderly.
- Withhold beta-blocker if resting heart rate is <50 bpm.
- Refer to Fife Formulary for additional prescribing points.
- Titrate the dose of beta-blocker to the target dose (or maximum tolerated dose), according to the person's response and heart rate control.
- Target a heart rate of 50-70 beats per minute (bpm) at rest.
- Do not increase the dose if there are signs of symptomatic hypotension (such as dizziness) or excessive bradycardia (heart rate less than 50 bpm).
- Atenolol – twice-daily dosing may provide better symptom control.

Continue treatment at the target dose or highest tolerated dose indefinitely unless complications occur.

**RATE LIMITING CALCIUM CHANNEL BLOCKER**

<table>
<thead>
<tr>
<th>Drug</th>
<th>Usual starting dose:</th>
<th>Maintenance dose:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verapamil</td>
<td>40mg three times daily (standard tablets)</td>
<td>120 mg once daily (Modified release preparation)</td>
</tr>
</tbody>
</table>

- May be used instead of a beta-blocker when a beta-blocker is contraindicated as long as the patient has preserved left ventricular ejection fraction (LVEF).

**STATIN**

Intensive statin therapy will be initiated in secondary care post MI – see appendix 2F of the Fife Formulary (Management of Cholesterol Guidance) ([http://www.fifeadtc.scot.nhs.uk/](http://www.fifeadtc.scot.nhs.uk/)).

Local specialist advice is that a total cholesterol level of < 3.5mmol/l should be targeted. However if treatment is poorly tolerated, patient should be maintained on their maximum tolerated dose of statin.

**BLOOD PRESSURE**

Target blood pressure is <140/80 mmHg – see appendix 2A of the Fife Formulary (Management of Hypertension Guidance) ([http://www.fifeadtc.scot.nhs.uk/](http://www.fifeadtc.scot.nhs.uk/)).

**LIFESTYLE ADVICE**

See appendix 2B of the Fife Formulary (Prevention of Cardiovascular Disease) ([http://www.fifeadtc.scot.nhs.uk/](http://www.fifeadtc.scot.nhs.uk/)).