ANTI-PLATELET THERAPY IN DIABETES

Treatment with anti-platelet therapy should be considered in the following situations:

a) Secondary prevention of atherosclerotic vascular disease (NICE)

b) Primary prevention of atherosclerotic vascular disease where the 10yr CHD (coronary heart disease) risk is ≥ 20% (SIGN)**

c) Diabetic Nephropathy

Some local diabetologists and nephrologists would consider Diabetic Nephropathy an indication for anti-platelet therapy

The local consensus is that primary care clinicians should in these cases explain:

1. The rationale for prescribing aspirin i.e. the increased risk of cardiovascular disease in nephropathy
2. The lack of current evidence of benefit in nephropathy in the absence of other indications
3. The risks of treatment i.e. intracranial and gastrointestinal bleeding
4. That in cases of doubt advice from a specialist could be sought

In this way individual patients are helped to make an informed decision which both they and their clinician can feel comfortable with

Additional Information

1. Before initiation of treatment exclude contraindications and balance benefit against the risk of bleeding
2. Also ensure that blood pressure is controlled to 145/90 mmHg (NICE)
3. Use low dose dispersible aspirin 75mg daily as first line treatment
4. If aspirin is contraindicated due to an allergic reaction e.g. bronchospasm then use generic clopidogrel
5. For GI intolerance use aspirin plus omeprazole rather than switching to clopidogrel
6. ** A 10YR CHD (coronary heart disease) risk of ≥ 20% is roughly equivalent to a 10yr CVD (cardiovascular disease) risk of ≥ 30%
7. To estimate CHD risk NICE advises use of UKPDS risk engine for type 2 diabetes
8. Alternatively Qrisk2 at www.qrisk.org can be used for type 1 and 2 diabetes to estimate the CVD risk