99 THE CHANGING FACE OF ANTI-PLATELET PRESCRIPTIONS IN ENGLAND: 1998–2015

[1]Christopher P Primus*, [1]Krishnaraj S Rathod, [2]Hitesh C Patel, [3]Ketna Patel, [3]Sanjeev Bhattacharyya, [4]Carl Hayward. [1]*Barts Heart Centre and Queen Mary, University of London*; [2]*Royal Brompton NHS Trust*; [3]*Barts Heart Centre*; [4]*Barts Heart Centre and Royal London Hospital*

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Introduction Aspirin has been widely prescribed for primary and secondary prevention of cardiovascular (CV) events for decades. In recent years, attitudes around its efficacy and safety have changed in two important areas: primary prevention of vascular events and stroke prevention in patients with atrial fibrillation (AF). In particular, two meta-analyses and a large randomised-control trial (RCT) suggested that in primary prevention, the modest reduction in CV events afforded by aspirin was accompanied by a modest increase in the risk of serious bleeding

Aim We sought to describe the trends of aspirin and other anti-platelet prescribing in England over the 18 year period, 1998–2015.

Methods We conducted a comprehensive nationwide retrospective study. Data were obtained from the Prescription Cost Analysis system, which holds information on every prescription dispensed in the community in England, covering a population of more than 50 million (m) people. We obtained data for 5 anti-platelet agents from 1998–2015.

Results From 1998–2008 annual aspirin prescriptions increased linearly, peaking at 33.9 million in 2009 (Figure 1). Since 2009, aspirin prescribing has fallen to 28m (2015). Over this latter period, clopidogrel use has risen to a peak of 8.2m scripts in 2015. More recently prasugrel and ticagrelor have been prescribed but comprise a small proportion of total prescriptions (Table 1). Total anti-platelet prescriptions have plateaued since 2009 (39.3m in 2009 and 37.4m in 2015).

Conclusion Anti-platelet prescribing increased linearly from 1998–2009 and plateaued thereafter. The decline in aspirin prescribing coincides with the publication of two meta-analyses and a large RCT that cast doubt on its efficacy in primary prevention and raised concerns about the increased risk of bleeding in this population (Antithrombotic Trialists Collaboration 2009; de Berardis *et al* 2009; Fowkes *et al* 2010). Our data are limited given the indication for each prescription is unavailable, but we can hypothesise that the reduction in aspirin use from 2009 is due to a reduction in primary prevention prescribing.

Changes in CV guidelines have had further impact on total anti-platelet prescribing. NICE guidance in AF advocates formal anticoagulation for stroke prevention, with no role for anti-platelets (NICE CG180, 2014). In the absence of AF, clopidogrel now supercedes aspirin ± dipyridamole in the prevention of occlusive events in stroke and peripheral arterial disease (NICE TA210, 2010). With rising rates of coronary intervention, these changes explain escalating clopidogrel use over this period.

Whilst the new anti-platelet agents contribute relatively little to current prescribing, the landscape is likely to change as their role beyond acute myocardial infarction is investigated.

100 POWERFORM FOR REAL-TIME ENTRY OF ROUTINE CARDIAC OUTPATIENT DATA INTO THE ELECTRONIC HEALTH RECORD: APPLICATION FOR AUDIT AND RESEARCH

[1]Neil Bodagh*, [2]Andrew Archbold, [1]Roshan Weerackody, [3]Mike Barnes, [3]John Robson, [2]Adam Timmis. [1]*Bart's Heart Centre*; [2]*Bart's Heart centre*; [3]*Queen Mary University*

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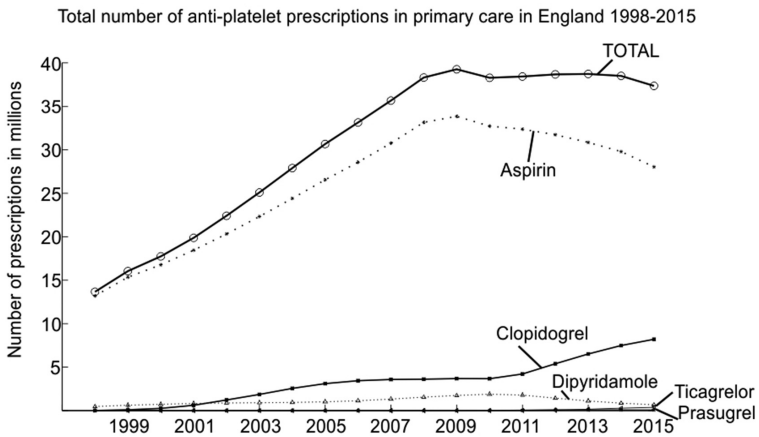
Abstract 99 Table 1 Prescriptions of each anti-platelet agent as a proportion of total anti-platelets prescribed

	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Aspirin	86.6	86.2	86.3	86.5	86.2	85.5	84.2	82.0	79.7	77.4	75.0
Clopidogrel	10.1	10.4	10.0	9.4	9.4	9.6	11.0	13.9	16.8	19.4	22.0
Dipyridamole	3.3	3.4	3.7	4.0	4.4	4.9	4.6	3.7	2.8	2.2	1.8
Ticagrelor	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.4	0.7	1.0
Prasugrel	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.3	0.3	0.2	0.2



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