

POSITION STATEMENT

STATINS IN PATIENTS WITH INTRACEREBRAL HAEMORRHAGE

Position statement summary

Intracerebral haemorrhage (ICH) alone is not an indication for statin therapy. However, statin therapy should not be routinely withheld in patients with ICH; in the absence of specific contraindications, initiation or continuation is appropriate where clinically indicated.

- For those not on treatment, if cardiovascular risk assessment (e.g. **QRISK3**) suggests benefit, a statin **should be offered** in line with NICE primary prevention guidance (e.g. **atorvastatin 20 mg once daily**).
- **Primary prevention** - there is **no general contraindication** to prescribing a statin for patients who have suffered an ICH
- **Secondary prevention or another indication** - there is **no general contraindication** to prescribing a statin for patients who have suffered an ICH
- **Initiation and continuation** – clinicians should consider both starting and continuing statins in patients with prior ICH, balancing cardiovascular benefit against individual bleeding risk
- There is **no trial evidence** that aggressive lipid modification is helpful in patients with prior intracerebral haemorrhage (ICH) alone to specifically reduce the risk of further ICH. If a patient with ICH has no other indication for statin therapy, practices should consider exception reporting in line with QOF rules, documenting the clinical rationale.
- **Cerebral Amyloid Angiopathy (CAA)** - the only circumstance requiring **caution** is when the ICH is attributed to CAA, as less is known about statin safety in this subgroup. These cases should be managed on an **individual risk vs benefit basis with stroke team input**.

** ICH is also known as haemorrhagic stroke and refers to spontaneous haemorrhage within the brain parenchyma in the absence of aneurysm, vascular malformation or other structural abnormality. This excludes aneurysmal subarachnoid haemorrhage, subdural haemorrhage and extradural haemorrhage.*

Document details

Title of position statement	Statins in patients with intracerebral haemorrhage
Position statement reference number	NEL/MO/DOC/2026-14
Version	1.0
Agreed by	North East London Formulary and Pathways Group (FPG)
Authorised/ratified by	07/07/26
Date authorised	North East London System Prescribing and Medicines Optimisation (SyPMO) Board
Date of last review	N/A
Review date	07/07/2029
Key words	Stroke, intracerebral haemorrhage, statins, lipid lowering medicine
Location of publication	Medicines Position Statements – NEL – North East London
Date added to intranet	

1. BACKGROUND with SPECIFIC DETAILS

Introduction

Statins are a class of medications used to lower cholesterol and indicated for the primary and secondary prevention of cardiovascular disease, hypercholesterolaemia and dyslipidaemia.

Uncertainty about statin use after intracerebral haemorrhage (ICH) has been influenced by the SPARCL trial (High-Dose Atorvastatin after Stroke or Transient Ischaemic Attack)^[1], in which a post-hoc finding showed an increased frequency of haemorrhagic strokes in the high dose atorvastatin arm compared with placebo.

However, meta-analysis of randomised controlled trials have not demonstrated a statistically significant increase in intracerebral haemorrhage with statin therapy overall.

In stroke populations (including prior ICH), systematic review and meta-analysis data report no significant increase in recurrent ICH and show favourable associations with mortality and functional outcome, acknowledging limitations of observational evidence^[2,3].

Recommendations

Intracerebral haemorrhage alone is not an indication for statin therapy. However, statin therapy should not be routinely withheld in patients with ICH; in the absence of specific contraindications, initiation or continuation is appropriate where clinically indicated.

There is **no general contraindication** to prescribing a statin for patients who have suffered an ICH where it is required for **primary prevention**, and likewise **no contraindication to continuing** a statin in a patient already taking one for secondary prevention or another indication.

For those not on treatment, if cardiovascular risk assessment (e.g. **QRISK3**) suggests benefit, a statin **should be offered** in line with NICE primary prevention guidance (e.g. **atorvastatin 20 mg once daily**).

There is **no trial evidence** that aggressive lipid modification is helpful in patients with prior intracerebral haemorrhage alone to specifically reduce the risk of further ICH. If a patient with ICH has no other indication for statin therapy, practices should consider exception reporting in line with QOF rules, documenting the clinical rationale.

Higher-dose atorvastatin (e.g. 80 mg) may be used for secondary prevention if clinically indicated, provided there are no contraindications such as drug interactions. Clinicians should consider both initiate on and continuation of statins in patients with prior ICH.

Additional Information

- **Cerebral Amyloid Angiopathy (CAA):**

Caution is required in patients where ICH is attributed to cerebral amyloid angiopathy. Evidence regarding statin safety in this subgroup is limited.

In such cases, decisions should be made on an **individualised risk-benefit basis**, with input from a stroke specialist or neurologist. An advice and guidance request would be appropriate.

- **Shared decision-making** should be undertaken with patients, particularly where uncertainty exists regarding recurrence risk.

2. SCOPE

This position statement applies to all healthcare professionals responsible for prescribing statins across NEL.

Healthcare professionals should continue to prescribe statins in ICH patients as per the National Lipid Management Pathway^[4,5].

3. ROLES AND RESPONSIBILITIES

Monitoring

For most patients, monitoring requirements should be in line with the national and local guidance. Please see the Specialist Pharmacy Service (SPS) guidance below for an example: <https://www.sps.nhs.uk/monitorings/statins-monitoring/>^[6].

For those with **Cerebral Amyloid Angiopathy (CAA)**, monitoring and follow up should be individualised and discussed with stroke team/consultant.

For individuals who are unable to take statins for primary or secondary prevention alternative lipid lowering therapies are considered in line with national guidance. Please see the AAC summary: <https://www.england.nhs.uk/aac/wp-content/uploads/sites/50/2020/04/lipid-management-pathway-v6.pdf>^[7]

4. REFERENCES

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