

## Should secondary stroke prevention include NOACs in addition to antithrombotics?

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Recently, the efficacy of rivaroxaban plus aspirin combination was investigated for secondary vascular prevention (1). More than 27 000 patients with stable atherosclerotic vascular disease were randomized for rivaroxaban (2.5 mg twice daily) plus aspirin (100 mg once daily), or lonely rivaroxaban (5 mg twice daily), or lonely aspirin (100 mg once daily). The composite of cardiovascular death, stroke, or myocardial infarction were the primary outcome. The study was stopped for superiority of the rivaroxaban-plus-aspirin group. The rivaroxaban-plus-aspirin group had only 4.1% primary outcome event while the lonely aspirin group experienced 5.4% ( $P<0.001$ ). The major bleeding events occurred in more patients in the rivaroxaban-plus-aspirin group (3.1%) vs. 1.9% in the aspirin group ( $P<0.001$ ). There were fewer deaths (3.4%) in the rivaroxaban-plus-aspirin group as compared with 4.1% in the aspirin-alone group. The lonely rivaroxaban therapy resulted in more major bleeding events without significant decrease of composite of cardiovascular death, stroke, or myocardial infarction. The benefit was consistent in the post-stroke subgroup (more than 1000 patients). The benefit was also present in patients with baseline blood pressure below or above the mean and in patients with baseline cholesterol levels below or above the median, confirming the conclusion that the benefits of combination therapy are additive to standard secondary preventive interventions. On contrary, the lonely rivaroxaban (5 mg twice daily) alone did not result in better outcome but more major bleeding events. Should secondary stroke prevention include NOACs in addition to aspirin? My answer: yes. Eikelboom JW, et al *N Engl J Med.* 2017 Oct 5;377(14):1319-1330.