Rapid Recap

Anticoagulation FORUM | ANTICOAGULATION Centers of Excellence

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Edoxaban Antithrombotic Therapy for Atrial Fibrillation and Stable Coronary Artery Disease

Background: This trial evaluated the efficacy and safety of edoxaban monotherapy compared to dual antithrombotic therapy (DAT, edoxaban plus ASA or clopidogrel) aiming to address the lack of robust data on long-term antithrombotic strategies in patients with atrial fibrillation (AF) and stable coronary artery disease (CAD).

Design: Multicenter, open-label, adjudicator-masked, randomized trial, included 1,040 patients with AF and stable CAD. Patients were randomized to receive edoxaban monotherapy or DAT. The primary outcome was a composite of death from any cause, myocardial infarction (MI), stroke, systemic embolism, unplanned urgent revascularization, and major bleeding or clinically relevant nonmajor bleeding at 12 months.

Results: At 12 months, the primary outcome occurred in 6.8% of patients in the edoxaban monotherapy group compared to 16.2% in the dual therapy group (hazard ratio, 0.44; 95% CI, 0.30 to 0.65; P<0.001). Major bleeding or clinically relevant nonmajor bleeding occurred in 4.7% of the edoxaban monotherapy group versus 14.2% in the dual therapy group (hazard ratio, 0.34; 95% CI, 0.22 to 0.53).

Rapid Takeaway: In this South Korean study, edoxaban monotherapy was associated with a lower risk of death from any cause, MI, stroke, systemic embolism, unplanned urgent revascularization, and major bleeding compared to DAT in patients with AF and stable CAD. *NEJM. 2024; 391:2075-2086.*

For an article summary by the Weekly Journal Scan, visit *Eur Heart J. 2025 Feb 14;46(7):669-671.*

Aspirin Plus Rivaroxaban Versus Rivaroxaban Alone for the Prevention of Venous Stent Thrombosis Among Patients With Post-Thrombotic Syndrome (PTS): ARIVA Trial

Background: Post-thrombotic syndrome (PTS) is a common complication of DVT. Venous stent placement can restore blood flow and improve functionality in patients with PTS but can be complicated by stent thrombosis. The optimal antithrombotic therapy strategy to prevent stent thrombosis is unknown. The ARIVA trial assessed rivaroxaban with or without aspirin for preventing venous stent thrombosis in patients with PTS.

Design: Randomized, open-label trial included patients with DVT > 3 months prior and with PTS, receiving or with planned treatment with rivaroxaban, and who had undergone caval or ileofemoral venous stent placement for stenosis or occlusion. Patients were randomized 1:1 to receive rivaroxaban 20 mg alone or combined with aspirin 100 mg daily. Primary efficacy outcome was composite of no occlusion in the treated segment or no re-intervention needed to maintain patency within 6 months.

Results: The trial was terminated early due to slow enrollment (n=80 for combination therapy, n=82 for rivaroxaban alone). There was no difference in the primary efficacy outcome for patency (94.8% for combination therapy and 92.4% for rivaroxaban alone, p=0.37). There were no significant differences in secondary outcomes, including the Villalta score, quality of life, or safety outcomes, between the two groups.

Rapid Takeaway: Primary patency rate was higher than expected and was comparable between the combination group and the rivaroxaban alone group.

Barco S. ARIVA Trial. Circulation. 2025 Jan 28: 39874026.

2024 ACC Expert Consensus Decision Pathway on Practical Approaches for Arrhythmia Monitoring After Stroke

These recommendations emphasize the importance of tailored arrhythmia monitoring strategies based on the stroke etiology and patient risk factors to optimize AF detection and subsequent management. *J Am Coll Cardiol. 2025 Feb 18;85(6):657-681.*

Arrhythmia Monitoring in Cardioembolic Stroke: In patients with stroke from presumed cardioembolic origin, need for rhythm monitoring is limited unless considering stopping anticoagulation or if needed for another treatment decision.

Arrhythmia Monitoring in Ischemic Stroke from Small- or Large-Vessel Disease:
- Reasonable to monitor for 2-4 weeks.
- Consider extended monitoring with implantable cardiac monitor in those with higher risk criteria for AF development.

Arrhythmia Monitoring in Embolic Stroke of Undetermined Source (ESUS):
- Reasonable to offer monitoring for 2-4 weeks if candidate for long-term anticoagulation should AF be identified.
- Can consider implantable monitor in select patients with higher risk of post-stroke AF with recent ESUS and no identified cause during external monitoring.

Anticoagulation Recommendations:
- Reasonable to consider anticoagulation in patients with AF events ≥5 minutes with a CHA2DS2-VASc score ≥3 or equivalent stroke risk.
- Use of anticoagulation for patients with a very low burden of AF (<5 minutes) is not recommended without other indications.

2021 AHA/ASA Guideline for the Prevention of Stroke in Patients with Stroke and TIA and 2023 ACC/AHA/ACCP/HRS Guideline of the Dx and Management of AF: Class 2a

Abelacimab versus Rivaroxaban in Patients with Atrial Fibrillation

Background: Abelacimab is a monoclonal antibody that inhibits both inactive and active factor XI. Available evidence suggests factor XI is needed for thrombosis but is nonessential in hemostasis making factor XI a potential target for clot prevention with suspected lower risks for bleeding.

Design: Phase 2, multi-center, randomized, open-label trial with blinded outcome assessment, included 1,287 patients with AF and a moderate-to-high risk of stroke (CHA_2DS_2-VASc ≥4, or score of 3 if on antiplatelet therapy or CrCl ≤50 ml/min). Patients were randomized to abelacimab (90 mg or 150 mg) monthly subcutaneous injections or standard-dose rivaroxaban. The primary endpoint was the time to first occurrence of major or clinically relevant non-major bleeding (ISTH criteria).

Results: The trial was terminated early due to a favorable benefit-to-risk ratio for abelacimab. Both doses of abelacimab significantly reduced the primary endpoint compared to rivaroxaban (HR for 150-mg abelacimab vs. rivaroxaban, 0.33 [95% confidence interval {CI}, 0.19 to 0.55]; HR for 90-mg abelacimab vs. rivaroxaban, 0.23 [95% CI, 0.13 to 0.42]; P<0.001 for both comparisons).

Rapid Takeaway: This phase 2 study demonstrated a reduction in bleeding events with abelacimab compared to rivaroxaban in patients with atrial fibrillation. As the authors mention, larger trials are needed to address the clinical efficacy of abelacimab.

N Engl J Med. 2025 Jan 23;392(4):361-371.

Asundexian versus Apixaban in Patients with Atrial Fibrillation

Background: DOACs are recommended as first-line treatment for stroke prevention in atrial fibrillation (AF), but their risk of bleeding may curtail use in certain patients. A new class of anticoagulants, activated factor XI (XIa) inhibitors, may have a lower risk of bleeding. This trial compared the efficacy and safety of asundexian with apixaban for the prevention of stroke or systemic embolism in patients with AF.

Design: Phase 3, international, randomized, double-blind, double-dummy, active comparator-controlled trial that included 14,810 patients. Patients with AF were assigned to receive asundexian 50mg once daily or standard-dose apixaban in a 1:1 ratio. Primary efficacy objective was to determine if asundexian was, at a minimum, noninferior for stroke or systemic embolism prevention.

Results: The mean age was 73.9 years and the mean CHA2DS2-VASc score was 4.3. The trial was terminated early due to a higher incidence of stroke or systemic embolism in the asundexian group (1.3%) compared to the apixaban group (0.4%), (HR 3.79; 95% CI 2.46 - 5.83). Major bleeding occurred at a rate of 0.2% in the asundexian group vs. 0.7% in the apixaban group, (HR 0.32, 95% CI 0.18 - 1.55).

Rapid Takeaway: In this Phase 3 study, the Factor XIa inhibitor asundexian was associated with a higher risk of stroke or systemic embolism compared to apixaban in AF patients. Additional research is needed to determine if factor XIa inhibition will be a viable mechanism for stroke prevention in this patient population.

N Engl J Med. 2025 Jan 2;392(1):23-32.

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