Antithrombotic Literature Updates

May 2026

Anticoagulation FORUM
Excellence in Thrombosis Care

Asundexian for Secondary Stroke Prevention (OCEANIC-STROKE)

Background: The risk of recurrent ischemic stroke or transient ischemic attack (TIA) remain despite standard secondary prevention therapies. This study explored the use of asundexian, a factor XI inhibitor, with standard of care to reduce risks of recurrent stroke.

Design: Phase 3, double-blind, RCT. Patients with noncardioembolic ischemic stroke or high-risk TIA (with imaging confirmed acute nonlacunar infarct, coronary artery or peripheral vascular disease, carotid stenosis ≥50%, or cerebrovascular atherosclerosis on imaging) were randomized within 72 hours of symptom onset to asundexian 50 mg once daily or placebo, with single or dual antiplatelet therapy. Patients with atrial fibrillation (or other indications for therapeutic anticoagulation) were excluded.

Results: Asundexian N = 6162, placebo N = 6165. Median follow-up: 567 days. Ischemic stroke (primary efficacy outcome): 6.2% of asundexian group vs 8.4% placebo (HR 0.74; 95% CI 0.65–0.84; P<0.001). ISTH major bleeding (primary safety outcome): 1.9% vs 1.7% (HR 1.10; 95% CI 0.85-1.44;P=0.46). Composite of CV death/MI/stroke (secondary efficacy outcome): 9.2% vs 11.1% (HR 0.83; 95% CI 0.74–0.92; P<0.001).

Rapid Takeaway: In patients with a history of noncardioembolic stroke or high-risk TIA treated within 72 hours of symptom onset, asundexian with antiplatelet therapy significantly reduced ischemic stroke without increased risk of major bleeding. This study demonstrated the potential benefit of combining a factor XI inhibitor with antiplatelet therapy to optimize secondary stroke prevention.

N Engl J Med. 2026 Apr 16

Antithrombotic Therapy for Noncardioembolic Ischemic Stroke: Current Evidence and Future Directions

Background: Several trials have evaluated secondary stroke prevention strategies. This review categorizes the current evidence supporting practice regimens and highlights the potential role of Factor XIa (FXIa) inhibitors in antithrombotic management.

Acute Short-Term: Dual antiplatelet therapy (DAPT; aspirin + clopidogrel or ticagrelor) for 21–90 days after minor stroke/TIA (CHANCE, POINT, THALES, INSPIRES, CHANCE-2) delivers 1–3% absolute RRR vs single antiplatelet therapy (SAPT) with ≤0.5% excess major bleeding. DAPT provides superior thrombosis reduction with low bleeding risk.

Long-Term Prevention: Antiplatelet monotherapy remains standard. Long-term DAPT increases bleeding without clear stroke benefit, except cilostazol-based DAPT in high-risk patients (CSPS.com).

Anticoagulation: Full dose provides no benefit over antiplatelet therapy in noncardioembolic stroke (WASID, NAVIGATE ESUS, RE-SPECT ESUS, ARCADIA). Dual pathway inhibition with rivaroxaban 2.5 mg BID + aspirin reduced vascular events in stable atherosclerosis but increased bleeding (COMPASS).

FXIa Inhibitors: OCEANIC-STROKE suggests asundexian + antiplatelet therapy reduces ischemic stroke without excess bleeding, representing a significant advance in secondary stroke prevention in decades. LIBREXIA-STROKE (milvexian) is ongoing.

Stroke. 2026 May

ASH ISTH 2026 Guidelines for Anticoagulant Prophylaxis of Pediatric Patients at Risk of Venous Thromboembolism

These guidelines present a shift from adult guidelines as pharmacologic VTE prophylaxis is reserved for select pediatric populations. This is attributed to lower baseline VTE incidence and developmental hemostatic differences in children, limiting the extrapolation of adult data. Summary of key recommendations includes:

- **Anticoagulant prophylaxis is suggested in only 2 subgroups:** Prophylaxis is conditionally recommended for (1) intestinal failure on long-term TPN (>60 days) using LMWH or VKA, and (2) secondary prophylaxis in pediatric antiphospholipid syndrome (APS). All other subgroups including solid cancers, trauma, and critically ill pediatric patients, received conditional recommendations *against* routine pharmacological prophylaxis.
- **ALL/Lymphoblastic Lymphoma:** The panel suggests either anticoagulant prophylaxis or no prophylaxis based on individual risk. High-risk features favoring prophylaxis include age ≥10 years, obesity, T-cell immunophenotype, high-risk ALL, and personal/family history of thrombosis. If initiated, pharmacologic VTE prophylaxis should be limited to asparaginase-containing cycles only.
- **"First do no harm" as the guiding principle: Guidance suggests withholding** anticoagulant prophylaxis in any pediatric patient at high-risk of major or clinically relevant non-major bleeding, even when VTE risk is high. The benefit-to-risk ratio must be reassessed regularly, and anticoagulant prophylaxis should be withheld during periods of thrombocytopenia and paused peri-procedurally.
- **Critical evidence and research gap:** Validated pediatric VTE risk stratification models are urgently needed across all subgroups. Emerging DOACs (apixaban in PREVAPIX-ALL) show promise but require further evaluation across subgroups before broader adoption.

Rapid Takeaway: The 2026 ASH ISTH Guidelines for Anticoagulant Prophylaxis in Pediatric Patients at risk for VTE are conservative on the use of pharmacologic VTE prophylaxis. This area represents a key opportunity for shared decision-making and Antithrombotic Stewardship, as individualized, subgroup-specific risk assessment is essential.

Blood Adv. 2026 Apr 8

Perioperative Management of Antithrombotic Therapy in Patients with Thrombotic Antiphospholipid Syndrome

Background: Due to high thrombotic risk, guidance for the perioperative interruption of anticoagulation in patients with APS is limited.

Methods: Single-center, retrospective cohort study of 172 adults with thrombotic APS who underwent planned anticoagulation interruptions. The primary outcomes were 30-day risks of arterial thromboembolism (ATE), VTE, and major bleeding.

Results: A total of 172 patients who underwent 282 interruptions were included. 84.9% of patients were on warfarin and 25% were triple-positive (aCL + aβ2GPI + LA). Preoperative LMWH bridging was used in 84.7% of warfarin interruptions (42.9% therapeutic dose and 36.7% prophylactic dose, respectively). The 30-day risk of ATE was 0.7% (95% CI 0.2–2.6). Major bleeding was 0.7% (95% CI 0.2–2.6) and occurred in the setting of high bleed risk procedures. Therapeutic LMWH bridging was more common in patients with triple-positive APS (OR 7.6; 95% CI 3.2–18.2) and prior ATE (OR 3.4; 95% CI 1.5–7.8).

Rapid Takeaway: This study shows a low 30-day risk of postoperative ATE, VTE, and major bleeding and supports individualized management of perioperative anticoagulation interruption in patients with APS. More studies are needed to confirm optimal bridging strategies in this patient population.

Blood Adv. 2026 May 12

Ultrasound-Facilitated, Catheter-Directed Fibrinolysis for Acute Pulmonary Embolism (HI-PEITHO)

Background: For patients with acute, high-risk pulmonary embolism (PE), thrombus removal, including via catheter-directed thrombolysis (also known as fibrinolysis; CDT), is indicated. However, there is limited high-quality evidence for CDT in patients with acute, intermediate-risk PE.

Methods: HI-PEITHO was a multinational, adaptive-design, open label randomized controlled trial of adult patients with intermediate-risk PE (RV:LV ≥1.0 and elevated troponin with ≥2 signs of cardiorespiratory distress: SBP ≤110, HR ≥100, RR >20) randomized to ultrasound-facilitated CDT (USCDT) with alteplase and anticoagulation (AC) vs. AC alone. Primary outcome was a composite of PE-related death, cardiorespiratory decompensation/collapse, or symptomatic PE recurrence at 7 days.

Results: Patients who underwent USCDT with AC had a lower risk of the primary outcome (4.0%) compared to those treated with AC alone (10.3%; RR 0.39; 95% CI 0.20–0.77; p=0.005), driven by reduced cardiorespiratory decompensation (3.7% vs 10.3%). There was no difference in major bleeding 30 days (4.1% vs 3.0%, p=0.64). No intracranial hemorrhage occurred in either group.

Rapid Takeaway: USCDT plus AC led to a lower composite rate of PE-related adverse outcomes compared to AC alone in patients with intermediate-risk PE, primarily with reduced cardiorespiratory decompensation/collapse, and without increased bleeding risk.

See also 2026 AHA Acute Management of PE Guidelines. N Engl J Med. 2026 Mar 28

Eager to deepen your anticoagulation expertise? Register for our upcoming free webinars!

Comprehensive summaries of the most impactful articles from our biweekly literature updates. Includes a short overview and pub med link along with important takeaways from the article. Antithrombotic Literature Updates are published monthly.

Antithrombotic Literature Updates

Author: Hamza Sinan, PharmD

Editorial Team: Candace Bryant, PharmD; Cecilia Gollaher, PharmD; Greg Hadlock, PharmD; Yamel Herrera, PharmD; Carlee O'Connor, DNP; Bishoy Ragheb, PharmD; Kelly Rudd, PharmD