THE ROLE OF RIVAROXABAN IN PATIENTS WITH ATRIAL FIBRILLATION UNDERGOING PCI

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One of the most complex problems in coronary intervention is the use of dual antiplatelet therapy (DAPT) after stenting in patients on oral anticoagulation for stroke prevention in atrial fibrillation (AF). When DAPT is combined with warfarin, bleeding increased two- to threefold in recent studies[1,2] as well as in a large Danish registry[3,4], where especially early bleeding was enhanced.

Thus, the search is on to diminish this risk. There are two randomized studies available in this field. The WOEST trial showed that aspirin can be safely skipped.[5] And in the ISAR-TRIPLE trial 6 weeks of clopidogrel on top of aspirin and warfarin was not inferior to 6 months clopidogrel.[6]

Non vitamin-K oral anticoagulants (NOACs) for stroke prevention in AF may be useful in the setting of triple therapy, because they appear safer than vitamin K antagonists (VKA) , especially with respect to intracranial hemorrhage.[7] Specific data on NOACs in combination with antiplatelet agents so far, albeit post hoc and not randomized, come from the RE-LY trial and ARISTOTLE trials with dabigatran and apixaban, respectively.[1,8] Although antiplatelet therapy increased bleeding two- to threefold, the safety advantages of the NOACs over warfarin were maintained. Recently, rivaroxaban in this setting reduced significant bleeding compared to VKA without increasing ischemic complications.[9] Currently, three prospective trials are running to evaluate the safety and efficacy of a NOAC versus VKA in AF patients undergoing coronary intervention for either stable coronary disease or ACS (RE-DUAL, AUGUSTUS and ENTRUST.[10-12] In all three there is one arm where aspirin is withheld. Also the prasugrel and ticagrelor are allowed in these studies

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