Combined Aspirin Plus Warfarin
Recent Evidence and Residual Questions

Geoffrey A. Donnan, MD, FRACP; Stephen M. Davis, MD, FRACP

There are several key issues in this debate, and substantial recent evidence has been accrued to guide clinical practice. The first and largest problem is the frequent coexistence of pathologies of atrial fibrillation and coronary artery disease, where there appears to be a real difference in the approach of stroke clinicians and cardiologists to the use of combined anticoagulation and antiplatelet therapy. In our experience, cardiologists often use combined therapy for atrial fibrillation with evident coronary artery disease. Stroke clinicians, frequently confronted with intracerebral hemorrhage (ICH) in the setting of anticoagulant therapy, are particularly concerned given the increased risk of ICH with combination therapy. We believe that this issue has been resolved. The evidence is strong that in fact monotherapy is as effective as combination therapy, with less risk of major bleeding.1 We consider that our role as stroke physicians is to convince our cardiology colleagues that this is the case and use warfarin monotherapy for this indication.

The second issue, where again the evidence is clear, is the choice of antithrombotic therapy in patients with mechanical heart valves. Both protagonists agree, and clearly the evidence supports the use of combined therapy for these patients.1

The third important area of controversy is the optimal regimen for patients with atrial fibrillation and either coronary artery or cerebrovascular stents. Here, the evidence supports the need for antiplatelet therapy for the arterial component.2 Clearly, antiplatelet therapy is inferior to warfarin for atrial fibrillation.3 The indication for dual therapy is stronger for at least several months after stent insertion. However, we agree with Fisher that the optimal combination remains uncertain.

Finally, Furlan has raised the potential role of combination therapy for a number of high-risk patient scenarios, such as “antiplatelet failures”, refractory high-grade intracranial stenosis, and recent large vessel occlusion. Although longer term warfarin is clearly not indicated in such patients, based on the WASID,4 WARRS,5 and ESPRIT6 trials, the role of short-term anticoagulants or combination therapy is less clear. We suspect that other approaches such as urgent intervention with angioplasty and stenting, or newer anti-thrombotic agents, may be a more compelling indication for new trials.

Disclosures

None.

References


Key Words: aspirin ■ warfarin

Received September 18, 2008; accepted October 1, 2008.
From the Royal Melbourne Hospital, University of Melbourne, Parkville, Victoria, Australia.
Correspondence to Stephen Davis and Geoffrey Donnan, Controversies Editors, Stroke, Royal Melbourne Hospital, University of Melbourne, Parkville Vic Australia 3050. E-mail stephen.davis@mh.org.au, or gdonnan@unimelb.edu.au

Stroke is available at http://stroke.ahajournals.org

DOI: 10.1161/STROKEAHA.108.537696