Antithrombotic treatment after stroke due to intracerebral haemorrhage

Citation for published version:

Digital Object Identifier (DOI):
10.1002/14651858.CD012144.pub2

Link:
Link to publication record in Edinburgh Research Explorer

Document Version:
Publisher's PDF, also known as Version of record

Published in:
Cochrane database of systematic reviews

General rights
Copyright for the publications made accessible via the Edinburgh Research Explorer is retained by the author(s) and / or other copyright owners and it is a condition of accessing these publications that users recognise and abide by the legal requirements associated with these rights.

Take down policy
The University of Edinburgh has made every reasonable effort to ensure that Edinburgh Research Explorer content complies with UK legislation. If you believe that the public display of this file breaches copyright please contact openaccess@ed.ac.uk providing details, and we will remove access to the work immediately and investigate your claim.
# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Header</td>
<td>1</td>
</tr>
<tr>
<td>Abstract</td>
<td>1</td>
</tr>
<tr>
<td>Plain Language Summary</td>
<td>2</td>
</tr>
<tr>
<td>Summary of Findings for the Main Comparison</td>
<td>3</td>
</tr>
<tr>
<td>Background</td>
<td>5</td>
</tr>
<tr>
<td>Objectives</td>
<td>5</td>
</tr>
<tr>
<td>Methods</td>
<td>6</td>
</tr>
<tr>
<td>Results</td>
<td>8</td>
</tr>
<tr>
<td>Figure 1</td>
<td>9</td>
</tr>
<tr>
<td>Figure 2</td>
<td>11</td>
</tr>
<tr>
<td>Figure 3</td>
<td>12</td>
</tr>
<tr>
<td>Discussion</td>
<td>14</td>
</tr>
<tr>
<td>Authors’ Conclusions</td>
<td>15</td>
</tr>
<tr>
<td>Acknowledgements</td>
<td>15</td>
</tr>
<tr>
<td>References</td>
<td>15</td>
</tr>
<tr>
<td>Characteristics of Studies</td>
<td>18</td>
</tr>
<tr>
<td>Data and Analyses</td>
<td>31</td>
</tr>
<tr>
<td>Analysis 1.2. Comparison 1 Short-term antithrombotic treatment, Outcome 2 Death</td>
<td>31</td>
</tr>
<tr>
<td>Analysis 1.6. Comparison 1 Short-term antithrombotic treatment, Outcome 6 Other major ischaemic event</td>
<td>32</td>
</tr>
<tr>
<td>Analysis 1.7. Comparison 1 Short-term antithrombotic treatment, Outcome 7 Intracerebral haemorrhage</td>
<td>32</td>
</tr>
<tr>
<td>Analysis 1.8. Comparison 1 Short-term antithrombotic treatment, Outcome 8 Major extracerebral haemorrhage</td>
<td>33</td>
</tr>
<tr>
<td>Analysis 1.9. Comparison 1 Short-term antithrombotic treatment, Outcome 9 Growth of intracerebral haematoma</td>
<td>33</td>
</tr>
<tr>
<td>Analysis 1.10. Comparison 1 Short-term antithrombotic treatment, Outcome 10 Deep vein thrombosis</td>
<td>34</td>
</tr>
<tr>
<td>Appendices</td>
<td>34</td>
</tr>
<tr>
<td>Contributions of Authors</td>
<td>42</td>
</tr>
<tr>
<td>Declarations of Interest</td>
<td>42</td>
</tr>
<tr>
<td>Sources of Support</td>
<td>42</td>
</tr>
<tr>
<td>Differences between Protocol and Review</td>
<td>43</td>
</tr>
</tbody>
</table>
Antithrombotic treatment after stroke due to intracerebral haemorrhage

Luke A Perry¹, Eivind Berge², Joshua Bowditch¹, Elisabeth Forfang³, Ole Morten Rønning¹, Graeme J Hankey⁴, Elmer Villanueva⁵, Rustam Al-Shahi Salman⁶

¹Monash University, Melbourne, Australia. ²Department of Internal Medicine, Oslo University Hospital, Oslo, Norway. ³Department of Neurology, Akershus University Hospital, Lørenskog, Norway. ⁴School of Medicine, Sir Charles Gairdner Hospital Unit, The University of Western Australia, Perth, Australia. ⁵Department of Public Health, Xi’an Jiaotong-Liverpool University, Suzhou, China. ⁶Centre for Clinical Brain Sciences, University of Edinburgh, Edinburgh, UK

Contact address: Luke A Perry, Monash University, Melbourne, Australia. laper4@student.monash.edu

Editorial group: Cochrane Stroke Group.


Copyright © 2017 The Cochrane Collaboration. Published by John Wiley & Sons, Ltd.

ABSTRACT

Background

Survivors of stroke due to intracerebral haemorrhage (ICH) are at risk of thromboembolism. Antithrombotic (antiplatelet or anticoagulant) treatments may lower the risk of thromboembolism after ICH, but they may increase the risks of bleeding.

Objectives

To determine the overall effectiveness and safety of antithrombotic drugs for people with ICH.

Search methods

We searched the Cochrane Stroke Group Trials Register (24 March 2017). We also searched the Cochrane Central Register of Controlled Trials (CENTRAL: the Cochrane Library 2017, Issue 3), MEDLINE Ovid (from 1948 to March 2017), Embase Ovid (from 1980 to March 2017), and online registries of clinical trials (8 March 2017). We also screened the reference lists of included trials for additional, potentially relevant studies.

Selection criteria

We selected all randomised controlled trials (RCTs) of any antithrombotic treatment after ICH.

Data collection and analysis

Three review authors independently extracted data. We converted categorical estimates of effect to the risk ratio (RR) or odds ratio (OR), as appropriate. We divided our analyses into short- and long-term treatment, and used fixed-effect modelling for meta-analyses. Three review authors independently assessed the included RCTs for risks of bias and we created a 'Summary of findings' table using GRADE.
Main results

We included two RCTs with a total of 121 participants. Both RCTs were of short-term parenteral anticoagulation early after ICH: one tested heparin and the other enoxaparin. The risk of bias in the included RCTs was generally unclear or low, with the exception of blinding of participants and personnel, which was not done. The included RCTs did not report our chosen primary outcome (a composite outcome of all serious vascular events including ischaemic stroke, myocardial infarction, other major ischaemic event, ICH, major extracerebral haemorrhage, and vascular death). Parenteral anticoagulation did not cause a statistically significant difference in case fatality (RR 1.25, 95% confidence interval (CI) 0.38 to 4.07 in one RCT involving 46 participants, low-quality evidence), ICH, or major extracerebral haemorrhage (no detected events in one RCT involving 75 participants, low-quality evidence), growth of ICH (RR 1.64, 95% CI 0.51 to 5.29 in two RCTs involving 121 participants, low-quality evidence), deep vein thrombosis (RR 0.99, 95% CI 0.49 to 1.96 in two RCTs involving 121 participants, low-quality evidence), or major ischaemic events (RR 0.54, 95% CI 0.23 to 1.28 in two RCTs involving 121 participants, low-quality evidence).

Authors’ conclusions

There is insufficient evidence from RCTs to support or discourage the use of antithrombotic treatment after ICH. RCTs comparing starting versus avoiding antiplatelet or anticoagulant drugs after ICH appear justified and are needed in clinical practice.

Plain Language Summary

Drugs to prevent clots after bleeding in the brain

Review question

What is the effectiveness and safety of medications used to prevent clots (antithrombotic treatments) both in the early stages and long-term in people who have had a bleed within their brain (intracerebral haemorrhage)?

Background

People with stroke due to bleeding in the brain (also known as intracerebral haemorrhage: ICH) are more likely to develop clots in their blood vessels due to immobility (in the early stages) and due to other medical conditions (in the long term). Blood clots in the lungs, brain, or other organs can cause serious illness or death. Drugs that prevent clots (also known as ‘antithrombotic drugs’) might be useful to stop clot formation in people with ICH. However, these drugs can also cause serious bleeding complications.

Study characteristics

From extensive searches conducted on 8 March 2017, we identified two relevant randomised controlled trials (RCTs), which are the fairest tests of treatment. There were 121 participants in these two trials, which compared blood-thinning ‘anticoagulant’ drugs (heparin in one and enoxaparin in the other) delivered by injections under the skin versus no anticoagulant drug soon after ICH.

Key results

The primary outcome of this review was the combined risk of several important clinical outcome events (such as another intracerebral haemorrhage, ischaemic stroke, or death from a cardiovascular cause). We were not able to calculate this outcome for the included studies. Neither RCT reported on recovery of independence or mental abilities. One RCT involving 46 participants reported on case fatality associated with short-term antithrombotic treatment, and did not find a statistically meaningful effect. For the consequences of treatment that could be analysed, the risk estimates were imprecise and uncertain. Therefore, the potential benefits and harms of antithrombotic drugs soon after a stroke due to bleeding in the brain remain unclear. New high-quality RCTs investigating the use of antithrombotic treatment after stroke due to ICH appear justified and are needed.

Quality of the evidence

The overall quality of the evidence was low. This is due to the way the included trials were conducted and reported, as well as the small number of participants, which may not have been high enough to detect small differences between the antithrombotic treatment and no antithrombotic treatment groups.
### SUMMARY OF FINDINGS FOR THE MAIN COMPARISON

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Anticipated absolute effects* (95% CI)</th>
<th>Relative effect (95% CI)</th>
<th>No of participants (studies)</th>
<th>Quality of the evidence (GRADE)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Risk with no antithrombotic treatment</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Composite vascular endpoint</td>
<td>Study population</td>
<td>not estimable</td>
<td>(0 studies)</td>
<td>-</td>
<td>We were unable to calculate the composite endpoint because no included study reported all component endpoints</td>
</tr>
<tr>
<td><strong>Death</strong></td>
<td></td>
<td>RR 1.25 (0.38 to 4.07)</td>
<td>46 (1 RCT)</td>
<td>⊕⊕⃝⃝ LOW 12</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>174 per 1,000 (66 to 708)</td>
<td>217 per 1,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Growth of ICH</strong></td>
<td></td>
<td>RR 1.64 (0.51 to 5.29)</td>
<td>121 (2 RCTs)</td>
<td>⊕⊕⃝⃝ LOW 12</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>51 per 1,000 (26 to 269)</td>
<td>83 per 1,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>ICH</strong></td>
<td></td>
<td>not estimable</td>
<td>75 (1 RCT)</td>
<td>⊕⊕⃝⃝ LOW 12</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0 per 1,000 (0 to 0)</td>
<td>0 per 1,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major extracerebral haemorrhage</td>
<td>Study population</td>
<td>not estimable</td>
<td>75</td>
<td>LOW 12</td>
<td>-</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>------------------</td>
<td>-------------</td>
<td>----</td>
<td>---------</td>
<td>---</td>
</tr>
<tr>
<td>0 per 1,000</td>
<td>0 per 1,000</td>
<td></td>
<td>(0 to 0)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Deep vein thrombosis</th>
<th>Study population</th>
<th>RR 0.99 (0.46 to 1.96)</th>
<th>121</th>
<th>LOW 12</th>
<th>-</th>
</tr>
</thead>
<tbody>
<tr>
<td>186 per 1,000</td>
<td>185 per 1,000</td>
<td></td>
<td>(86 to 365)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other major ischaemic events</th>
<th>Study population</th>
<th>RR 0.54 (0.23 to 1.28)</th>
<th>121</th>
<th>LOW 12</th>
<th>-</th>
</tr>
</thead>
<tbody>
<tr>
<td>186 per 1,000</td>
<td>101 per 1,000</td>
<td></td>
<td>(43 to 239)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*The risk in the intervention group (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; OR: Odds ratio;

**GRADE Working Group grades of evidence**

**High quality:** We are very confident that the true effect lies close to that of the estimate of the effect

**Moderate quality:** We are moderately confident in the effect estimate: The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different

**Low quality:** Our confidence in the effect estimate is limited: The true effect may be substantially different from the estimate of the effect

**Very low quality:** We have very little confidence in the effect estimate: The true effect is likely to be substantially different from the estimate of effect

1 This included RCT/s has serious risk of bias due to it not describing random sequence generation or allocation concealment, as well as lack of blinding.

2 The optimal information size (OIS) criterion is not met. The sample size of this study is probably lower than the minimum number of participants required for a trial adequately powered to identify a statistically significant difference for this outcome.
BACKGROUND

Description of the condition

Stroke due to spontaneous (non-traumatic) intracerebral haemorrhage (ICH) is caused by the extravasation of blood into brain parenchyma following rupture of a cerebral artery or arteriole. The Global Burden of Disease (GBD) Study estimated that in the world in 2010 there were 5.32 million incident (first ever) haemorrhagic strokes (i.e. ICH and subarachnoid haemorrhage), resulting in an incidence of 82 (95% confidence interval (CI) 72 to 93) per 100,000 person-years (Krishnamurthi 2010). Hypertension is the strongest risk factor for ICH, with a population attributable risk of approximately 50% (O’Donnell 2016). Over recent decades, the prevalence of the use of antithrombotic (antiplatelet or anticoagulant) drug use at the time of ICH has increased to approximately 50% (Béjot 2013; Lovelock 2007). Population-based case-control studies report that, among people with ICH, about 20% were taking anticoagulants and 30% were taking antiplatelet agents at the onset of symptoms, whereas among populations free of ICH, about 6% were taking anticoagulants and about 23% were taking antiplatelet agents (Lauer 2013).

Survivors of ICH are at risk of recurrent ICH, particularly if the underlying cause of the incident ICH is not treated (e.g. hypertension, arteriovenous malformation). They are also at risk of ischaemic stroke, ischaemic heart disease, atrial fibrillation, and systemic embolism.

A review of observational studies found that the annual risk of recurrent ICH was between 1.8% and 7.4% (Poon 2014). Three studies compared outcomes after ICH in different locations within the brain, two of which found that the risk of recurrence after lobar ICH appeared higher than after deep ICH (Poon 2014). Most patients in the world have ICH diagnosis and location confirmed by computed tomography (CT). However, some patients have magnetic resonance imaging (MRI), on which brain microbleeds are biomarkers of a higher risk of both recurrent ischaemic stroke and ICH (Cordonnier 2007; Wilson 2016). In studies that quantified the risks of both recurrent ICH and ischaemic stroke after ICH, these risks appeared similar (Poon 2014).

Description of the intervention

Antithrombotic (antiplatelet or anticoagulant) drugs are effective for preventing thrombosis and embolism of clots in the brain, heart, limbs, and lungs. However, their effects are unknown in people who also have a past history of ICH, because they were excluded from the RCTs that demonstrated the benefits of antithrombotic drugs. There is uncertainty about whether to start these drugs after ICH (Al-Shahi Salman 2014; Falcone 2014; Molina 2011; Steiner 2011).

Consequently, there is variation in clinical practice: the proportion of patients starting antithrombotic drugs after ICH varies from 11% to 45% in different countries (Pasquini 2014).

The indications for restarting antithrombotic drugs after ICH may include the presence of prevalent risk factors for thromboembolism (e.g. atrial fibrillation, valvular heart disease, and atherosclerosis).

The indications for starting antithrombotic drugs for the first time after ICH may include new risk factors for thromboembolism (e.g. immobility, or new atrial fibrillation) or vaso-occlusive events (e.g. deep vein thrombosis and pulmonary embolism). Antithrombotic drugs after ICH can be given for prophylaxis over the short term (e.g. immobility during the period of hospitalisation following ICH) with low doses of low-molecular-weight heparin or unfractionated heparin, or over the long term (e.g. atrial fibrillation, previous vaso-occlusive disease) with oral antiplatelet or full-dose oral anticoagulant drugs.

Why it is important to do this review

A previous systematic review identified three RCTs that included a subset of people who received antithrombotic treatment after ICH, but it did not identify any clear benefits or harms of doing so (Keir 2002).

Some observational studies have addressed the use of antithrombotic drugs after ICH, but did not identify associations with beneficial or adverse outcomes that were large enough to preclude the need for RCTs (Chao 2016; Chong 2012; Claessen 2008; De Vleeschouwer 2005; Flynn 2010; Hawryluck 2010; Kuramatsu 2015; Nielsen 2015; Pennlert 2016; Poli 2014; Viswanathan 2006).

Whether and when to use antithrombotic drugs after ICH was identified as a dilemma in the European Stroke Organisation’s recent ICH guideline (Steiner 2014), which was unable to make any strong recommendations about the use of these drugs.

OBJECTIVES

Primary objective

To determine the overall effectiveness and safety of antithrombotic drugs for people with ICH.

Secondary objective

To determine whether the effectiveness and safety of antithrombotic treatment differs in prespecified subgroups (see Subgroup analysis and investigation of heterogeneity).
METHODS

Criteria for considering studies for this review

Types of studies
We sought all RCTs that made comparisons of starting versus avoiding antithrombotic drugs, or direct comparisons of different classes of antithrombotic drugs, for preventing thromboembolism after ICH. We included RCTs published in any language and planned to arrange translation where the language of publication was not English.

Types of participants
We sought RCTs whose participants survived a spontaneous ICH that had been diagnosed by CT or MRI. We included RCTs whether or not they had taken antithrombotic drugs at the time of ICH.

Types of interventions
We sought RCTs that compared the use of any antithrombotic drug against no antithrombotic treatment, as well as RCTs that compared different antithrombotic drugs. We placed no constraints on dosage, route of administration, or duration of administration. We separated RCTs investigating short-term treatment (for example, with low-molecular-weight heparin or unfractionated heparin in the acute post-stroke phase) and those investigating long-term treatment (for example, with oral anticoagulants or antiplatelets).

We excluded RCTs in which the effects of antithrombotic drugs might have been confounded by the administration of another active drug to participants (e.g. if allocation to this additional treatment was not evenly distributed between groups in an RCT, or was not randomly allocated).

Types of outcome measures

Primary outcomes
• Composite outcome of ‘all serious vascular events’ (ischaemic stroke, myocardial infarction, other major ischaemic event, ICH, major extracerebral haemorrhage, and vascular death) during the scheduled follow-up period.

Secondary outcomes
• Death during the scheduled follow-up period.
• The individual components of the composite vascular outcome: ischaemic stroke, myocardial infarction, other major ischaemic event, ICH, major extracerebral haemorrhage, and vascular death.
• Growth of ICH.
• Deep vein thrombosis.
• Functional status (where measured using validated scales) at the end of the scheduled follow-up period.
• Cognitive status (where measured using validated scales) at the end of the scheduled follow-up period.

Search methods for identification of studies

See the ‘Specialized register’ section in the Cochrane Stroke Group module. We searched for RCTs in any language and planned to arrange for the translation of relevant articles where necessary.

Electronic searches
We searched the Cochrane Stroke Group trials register in March 2017 and the following electronic databases, using search strategies that the Cochrane Stroke Group’s Information Specialist helped us design:
• Cochrane Central Register of Controlled Trials (CENTRAL; 2017, Issue 3) in the Cochrane Library (searched 8 March 2017) (Appendix 1);
• MEDLINE Ovid (1946 to 8 March 2017) (Appendix 2);
• Embase Ovid (1974 to 8 March 2017) (Appendix 3).

We also searched the following trials registers:
• US National Institutes of Health Ongoing Trials Register ClinicalTrials.gov (clinicaltrials.gov; searched 2 March 2017) (Appendix 4);
• World Health Organization (WHO) International Clinical Trials Registry Platform (ICTRP) (apps.who.int/trialsearch; searched 2 March 2017) (Appendix 4);
• ISRCTN Registry (www.isrctn.com; searched 2 March 2017) (Appendix 4);
• Stroke Trials Registry - the Internet Stroke Center (www.strokecenter.org/trials/; searched 2 March 2017) (Appendix 4).

Searching other resources
We screened the reference lists of relevant studies to identify further studies for potential inclusion in the review. We also used the Science Citation Index Cited Reference Search for forward tracking of relevant articles.

Data collection and analysis

Selection of studies
Three review authors (LAP, JB, EF) independently screened the titles and abstracts of the references obtained as a result of our searching activities, and excluded reports that were obviously irrelevant. We retrieved full-text articles for the remaining references, and the same three review authors independently screened these full-text articles to identify studies for inclusion, and identified and recorded reasons for the exclusion of ineligible studies. We resolved any disagreements through discussion or, if required, we planned on consulting a fourth review author (EB). We collated multiple reports of the same study so that each study, not each reference, is the unit of interest in the review. We recorded the selection process and completed a PRISMA flow diagram (See Figure 1 in the Results of the search section).

Data extraction and management
Three review authors (LAP, JB, EF) independently extracted data from included studies using a preformulated data collection form.

Assessment of risk of bias in included studies
Three review authors (LAP, JB, EF) independently assessed risks of bias for each study using the criteria outlined in the Cochrane Handbook for Systematic Reviews of Interventions (Higgins 2011). We resolved any disagreements by discussion or by involving another review author (EB). We assessed the risks of bias according to the following domains.

- Random sequence generation
- Allocation concealment
- Blinding of participants and personnel
- Blinding of outcome assessment
- Incomplete outcome data
- Selective outcome reporting
- Other potential bias

We graded the risk of bias for each domain as high, low or unclear and provide information from the study report, together with a justification for our judgement, in the 'Risk of bias' tables.

Measures of treatment effect
We intended to:

- convert categorical estimates of effect to the risk ratio (RR) or odds ratio (OR), if required;
- express measures of survival as a hazard ratio (HR); and
- use summary measures obtained from univariate or, where RCTs used the same covariates for adjustment, multivariable analyses.

Unit of analysis issues

Repeated observations on participants

We planned to analyse functional and cognitive status at end of follow-up, and not to use repeat observations during follow-up. If one RCT (or only a few RCTs) had a much longer period of follow-up than the majority of RCTs (for example, two years compared with six months in the majority of trials) we intended to perform a sensitivity analysis using the six-month observations from all RCTs.

Events that may recur
We analysed the first event in all participants, and not later events.

Multiple intervention groups
Where a RCT contained multiple treatment groups that were all compared with just one control group, we intended to ensure that the placebo group was shared between the multiple treatment groups by dividing it into the appropriate number of subgroups and conducting separate, independent comparisons.

Dealing with missing data
We contacted RCT authors for unpublished data if relevant data were missing. If only a minority (less than half) of data were missing, we planned to ignore the missing data and perform a 'complete set analysis'. If more substantial amounts of data were missing, and there was a chance that data were not missing at random, we planned to perform sensitivity analyses assuming both a best-case and a worst-case scenario, or apply statistical imputation or models, or both, to account for the missing data. A best-case scenario meant that we assumed that all missing data in the intervention group represent good outcomes and all missing data in the control group represent poor outcomes. A worst-case scenario meant that we assumed that all missing data in the intervention group represent poor outcomes and all missing data in the control group represent good outcomes.

Assessment of heterogeneity
We investigated inconsistency between included RCTs using the I² statistic. We interpreted this value using the guide provided in Chapter 9.5.2 of the Cochrane Handbook for Systematic Reviews of Interventions (Higgins 2011):

- 0% to 40%: might not be important
- 30% to 60%: may represent moderate heterogeneity
- 50% to 90%: may represent substantial heterogeneity
- 75% to 100%: represents considerable heterogeneity

If we observed substantial inconsistency in our data, we intended to use sensitivity analysis to elucidate which factors might explain the inconsistency.
Assessment of reporting biases
We included all published and unpublished data and secondary publications from RCTs. If we included a sufficient number of RCTs (more than 10), we planned to assess the likelihood of reporting biases through the use of a funnel plot.

Data synthesis
If RCTs were sufficiently similar, we planned to conduct a meta-analysis by pooling the appropriate data using Review Manager 5 (RevMan 2014). We planned to calculate the risk ratio (RR), odds ratio (OR), or hazard ratio (HR) for each outcome from data extracted from included RCTs using the Peto fixed-effect method, or a random-effects model if there was significant heterogeneity between RCTs. We defined significant heterogeneity as substantial clinical or methodological diversity between RCTs such that the true effect measure is no longer uniform.

'Summary of findings' table
We created a 'Summary of findings' table using the GRADEpro Guideline Development Tool (GRADEpro GDT), and included the following outcomes for short-term antithrombotic treatment: the composite outcome of all serious vascular events, death, growth of ICH, ICH, major extracerebral haemorrhage, deep vein thrombosis, other major ischaemic events, functional status, and cognitive status. We planned a 'Summary of findings' table for long-term antithrombotic treatment which included the following outcomes: the composite outcome of all serious vascular events, death, functional status, and cognitive status. Two review authors (LAP, JB) independently classified the quality of the evidence as being 'high', 'moderate', 'low', or 'very low', based on the presence and extent of the following five criteria outlined in the Cochrane Handbook for Systematic Reviews of Interventions (Higgins 2011):

- Limitations in the design and implementation of the contributing trials
- Indirectness of evidence
- Unexplained heterogeneity or inconsistency of results
- Imprecision of results
- High probability of publication bias

We provided justification in the footnotes when we downgraded the quality from 'high'.

Subgroup analysis and investigation of heterogeneity
We planned to perform the following subgroup analyses, if possible:

- Participants with different age, sex, and stroke severity
- Different classes of antithrombotic drugs
- Different intensities of antithrombotic treatment
- Different times of starting treatment (e.g. within one month of ICH versus later, or within 10 to 30 weeks or later)
- Participants who were on antithrombotic treatment before ICH (re-starters) versus participants who were not receiving these treatments (starters)
- Different levels of risk for future ischaemic events (for example, because of differences in age, sex, history of hypertension, history of atrial fibrillation (with further stratification by the CHA2DS2-Vasc score))
- Different levels of risk for future ICH
- Biomarkers of bleeding or clotting risk on brain CT or MRI (e.g. brain microbleeds on MRI)

Sensitivity analysis
If the results were heterogeneous, we planned to use sensitivity analysis to investigate how the results differed when we excluded RCTs that were found to have a high risk of bias. We planned to perform other sensitivity analyses to explore reasons for heterogeneity, for example, where there is an active therapy other than an antithrombotic drug that is not balanced by the randomisation process.

RESULTS
Description of studies
We included two RCTs (see Included studies), excluded seven RCTs (see Excluded studies), and identified seven ongoing RCTs (see Ongoing studies). For comprehensive tabulated descriptions of included, excluded, and ongoing studies please refer to Characteristics of included studies, Characteristics of excluded studies, and Characteristics of ongoing studies.

Results of the search
Our searches of CENTRAL, Embase, and OVID MEDLINE identified 331, 2557, and 850 potentially relevant records, respectively. Automated de-duplication identified 904 redundant records, leaving 2834 unique and potentially relevant records. We screened the titles and abstracts of these 2834 records and assessed the full texts of nine relevant records for inclusion (Boeer 1991; CAST 1997; Dickmann 1988; Frontera 2014; IST 1997; Li 2013; Orken 2009; Venturelli 2014; Yan 2014). We included two RCTs in our review (Dickmann 1988; Orken 2009). A reference search of included RCTs yielded no further relevant records. See Figure 1 for a graphical representation of our search.
Figure 1. Study flow diagram.

3738 records identified through database searching

0 additional records identified through other sources

2834 records after duplicates removed

2834 records screened

2825 records excluded

9 full-text articles assessed for eligibility

7 full-text articles excluded, with reasons

2 studies included in qualitative synthesis

2 studies included in quantitative synthesis (meta-analysis)
The search of trials registries for ongoing RCTs identified three relevant RCTs: APACHE-AF; PICASSO; RESTART, and we were aware of four additional RCTs from personal communication with investigators (NASPAF-ICH; RESTART Nord de France; SoSTART; STATICH).

**Included studies**

Dickmann 1988 was a German single-centre study that excluded patients if they had a bleeding diathesis, a sustained diastolic blood pressure higher than 120 mmHg or were in deep coma with signs of brain herniation, and retained 46 participants for inclusion.

Orken 2009 was a Turkish single-centre study that started with 110 ICH patients and applied the following exclusion criteria: early death before heparin treatment (n = 13), death before day 7 investigations (n = 4), secondary ICH due to aneurysm, arteriovenous malformations, trauma, or tumour (n = 11), excessive anticoagulation (International normalised ratio (INR) > 2.0) (n = 5), and contraindication to contrast media (n = 2). This left 75 participants for inclusion.

Both of the included RCTs included participants with ICH diagnosed by CT. Orken 2009 specified that these were primary ICH, whereas Dickmann 1988 did not specify the type of ICH included. Dickmann 1988 used 5000 units of heparin (Liquemin-Roche) delivered subcutaneously every eight hours starting at day four after ICH. Orken 2009 used 40 mg/day of enoxaparin sodium delivered subcutaneously after the first 48 hours from ICH onset. The intervention and comparator groups of both RCTs received graduated compression stockings. Dickmann 1988 reported on other major ischaemic events, and vascular death from other causes, although did not specifically define these outcomes. Orken 2009 reported on other major ischaemic events, ICH, and major extracerebral haemorrhage. Both of the included RCTs provided short-term outcome data only. Dickmann 1988 had a follow-up period of 10 days and Orken 2009 had a follow-up period of 21 days.

**Excluded studies**

We excluded seven studies for not meeting the inclusion criteria of this review after having screened their full texts. Boeer 1991 was an extension phase of Dickmann 1988 and randomisation was not described, leading to its exclusion from this review. CAST 1997 and IST 1997 were two RCTs investigating the use of antplatelet treatment after acute ischaemic stroke, and included several hundred participants with ICH who were randomised before CT had been performed to establish the pathological sub-type of stroke. Data on the ICH sub-population of these studies were reported in a systematic review (Keir 2002) and the individual patient data from IST 1997 (Sandercock 2011). These sources reported that this population included primary ICH (52%) and haemorrhagic transformation of ischaemic stroke (48%), but unfortunately the chief investigator informed us that it would be impossible to isolate the participants with primary ICH (IST 1997). Frontera 2014 was excluded because it was not randomised. Li 2013 assessed transfusion of frozen apheresis platelets in patients with ICH and on aspirin. Venturelli 2014 was a post hoc analysis of a RCT in which antithrombotic treatment was not randomly assigned, making this analysis observational in nature. Yan 2014 included a population of patients with and without cerebral microbleeds after acute ischaemic stroke.

**Risk of bias in included studies**

We assessed risks of bias for both included RCTs (Dickmann 1988; Orken 2009). Please refer to Figure 2 and Figure 3 for graphical depictions of this analysis.
Figure 2. Risk of bias graph: review authors’ judgements about each risk of bias item presented as percentages across all included studies.
Figure 3. Risk of bias summary: review authors’ judgements about each risk of bias item for each included study.

<table>
<thead>
<tr>
<th></th>
<th>Dickmann 1988</th>
<th>Orken 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allocation</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>Both</td>
<td>Dickmann 1988 and Orken 2009 were reported to be randomised but neither RCT described the method of randomisation, and neither RCT described the method of allocation concealment. We therefore determined both RCTs to be at unclear risk of selection bias.</td>
<td></td>
</tr>
<tr>
<td>Blinding</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>Due to the nature of the intervention (subcutaneous injection), and lack of placebo, blinding of participants and the personnel delivering the intervention was not possible. Both Dickmann 1988 and Orken 2009 were therefore at high risk of performance bias. Dickmann 1988 explicitly mentioned blinding of outcome raters and was at low risk of detection bias. Orken 2009 reported that radiologists were blinded to the clinical baseline radiological findings, but did not explicitly mention blinding of treatment allocation and was therefore at unclear risk of detection bias.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incomplete outcome data</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Selective reporting (reporting bias)</td>
<td>?</td>
<td>?</td>
</tr>
</tbody>
</table>
Outcome data were complete in both included RCTs, which were both rated at low risk of attrition bias.

**Selective reporting**
Both Dickmann 1988 and Orken 2009 reported all outcomes planned in their respective Methods sections, and each reported most expected outcomes of interest. Both included RCTs were therefore at low risk of reporting bias.

**Other potential sources of bias**
Neither Dickmann 1988 nor Orken 2009 described conflicts of interest or sources of funding. Neither study was prospectively registered. Both were therefore at an unclear risk of other potential sources of bias.

**Effects of interventions**
See: Summary of findings for the main comparison Antithrombotic treatment compared to no antithrombotic treatment for intracerebral haemorrhage

**Short-term antithrombotic treatment**
We included two RCTs for this comparison (Dickmann 1988; Orken 2009). We were able to extract numerical data on some of the relevant outcomes.

**Composite outcome of all serious vascular events**
We were unable to calculate the composite vascular endpoint for either Dickmann 1988 or Orken 2009 (Analysis 1.1).

**Death**
Only one RCT reported death from all causes (Dickmann 1988). The causes of death in this RCT were rebleeding (4), bronchopneumonia (4), and heart failure (1). There was no statistically significant difference between the intervention and control groups for this outcome (risk ratio (RR) 1.25, 95% confidence interval (CI) 0.38 to 4.07; Analysis 1.2; 46 participants).

**Vascular death**
Only one RCT reported deaths, but it did not adequately report in which group (control/intervention) instances of death from bronchopneumonia (4) and heart failure (1) occurred (Dickmann 1988). Because death from heart failure constitutes a vascular death and it was unclear in which group this death occurred, we were unable to include data for this outcome. However, it was reported that three deaths from expansion of the haematoma occurred in the control group and one such death occurred in the intervention group.

**Ischaemic stroke**
This outcome was not reported by either Dickmann 1988 or Orken 2009.

**Myocardial infarction**
This outcome was not reported by either Dickmann 1988 or Orken 2009.

**Other major ischaemic event**
Both included RCTs reported other major ischaemic events (Dickmann 1988; Orken 2009). All events for this outcome were pulmonary embolism detected by CT pulmonary angiogram (Orken 2009) or lung perfusion scintigraphy (Dickmann 1988). We combined results in a meta-analysis (Analysis 1.6), and detected no statistically significant difference between groups (RR 0.54, 95% CI 0.23 to 1.28; 121 participants). The results of this analysis are limited by the different methods of detecting pulmonary emboli used by each study group.

**Intracerebral haemorrhage**
One RCT involving 75 participants reported this outcome (Orken 2009). There were no recorded events in either group.

**Major extracerebral haemorrhage**
One RCT involving 75 participants reported this outcome (Orken 2009). There were no recorded events in either group.

**Growth of ICH**
Both of the included studies reported on ICH growth. Dickmann 1988 had an ambiguous definition for this outcome, ‘rebleeding’, which we considered to refer to ICH growth (whether this was due to continued bleeding, or recurrent ICH after cessation of the first ICH). This study did not describe a threshold of increased volume above which ICH growth was deemed to occur, and conducted brain CTs on days 1, 6, and 10 after ICH. Orken 2009 defined ICH growth as an increase in volume on CT of more than 33% or more than 12.5 mL using the ABC/2 method (Kothari 1996), and checked for this outcome on follow-up brain CTs at 24 hours, 72 hours, day 7, and day 21 after ICH. We combined the results from these two RCTs in a meta-analysis (Analysis 1.9), and observed no statistically significant differences between groups (RR 1.64, 95% CI 0.51 to 5.29; 121 participants).
Deep vein thrombosis
Both included studies reported on the outcome of deep vein thrombosis (DVT). All events for this outcome were DVT detected by phleboscintigraphy at days 2 and 10 (Dickmann 1988) or by venous doppler ultrasound examination on day 7 (Orken 2009). All events reported in Orken 2009 were asymptomatic, whereas Dickmann 1988 did not specify whether events were symptomatic or not. We detected no statistically significant difference between groups for this outcome (RR 0.99, 95% CI 0.49 to 1.96; Analysis 1.10; 121 participants).

Functional status
This outcome was not reported by either Dickmann 1988 or Orken 2009.

Cognitive status
This outcome was not reported by either Dickmann 1988 or Orken 2009.

Long-term antithrombotic treatment
We did not find any completed RCTs that investigated long-term antithrombotic treatment.

Discussion
Summary of main results
We found some evidence on the short-term effects of antithrombotic drugs after ICH in two RCTs (Dickmann 1988; Orken 2009), but no evidence on the effects of long-term antithrombotic treatment. We were unable to calculate the composite primary outcome of all serious vascular events due to incompleteness of reporting of the component outcomes in the included RCTs (Dickmann 1988; Orken 2009). None of the outcomes reported showed a statistically significant difference between groups, possibly because the two included RCTs were inadequately powered to detect significant differences for our outcomes. Neither included RCT reported outcomes for ischaemic stroke, myocardial infarction, functional status, or cognitive status. We were unable to extract data on any prespecified subgroups.

Overall completeness and applicability of evidence
The evidence available from completed RCTs of short-term antithrombotic drug treatment after ICH is sparse. Data from the two included RCTs contribute moderately applicable evidence to this field; their inclusion criteria and settings are representative of typical ICH patients. The applicability of Dickmann 1988 is somewhat limited by waiting to start treatment until after day four following ICH onset; one implication might be that some of the potential effects of subcutaneous heparin, for example those on ICH growth, never manifested. There is no comparative evidence on the differences between distinct types of anticoagulants used in this setting. Dickmann 1988 investigated the effects of heparin, whereas Orken 2009 used enoxaparin sodium, a low-molecular-weight heparin.

However, we were encouraged to find that there are seven ongoing RCTs investigating long-term antithrombotic treatment after ICH (APACHE-AF; PICASSO; NASPAF-ICH; RESTART; RESTART Nord de France; SoSTART; STATICH).

Quality of the evidence
The methodological quality of the included RCTs was limited by randomisation and allocation concealment not being described, failure to blind participants, and the optimal information size criterion not being met. The overall quality of evidence was therefore low. Both studies, despite investigating different drugs and starting treatment at different times, found no statistically significant difference between groups for outcomes relevant to this review. It is possible that this is due to these RCTs being inadequately powered to detect statistically meaningful differences, rather than there being no effect of the interventions.

Potential biases in the review process
None identified.

Agreements and disagreements with other studies or reviews
We identified two systematic reviews on short-term antithrombotic treatment (Keir 2002; Paciaroni 2011). Keir 2002 included data from three RCTs (CAST 1997; Dickmann 1988; IST 1997) and included individual patient data from IST 1997 and CAST 1997 on participants with both primary ICH (52%) as well as haemorrhagic transformation of ischaemic infarcts (48%), but did not describe results for these groups separately. Keir 2002 preceded Orken 2009, a study which we included in this review. The second systematic review we identified included non-randomised controlled studies (Paciaroni 2011). The non-randomised studies included in this review were Wasay 2008 and Tetri 2008. This review concluded that early antithrombotic treatment was associated with a significant reduction in pulmonary embolism, a non-significant reduction in mortality, and a non-significant increase in haemorrhagic expansion (Paciaroni 2011). We identified one
systematic review on long-term antithrombotic use after ICH, but it could not draw any conclusions from the two epidemiological studies and several case series that it included (Flynn 2010b).

A U T H O R S ’ C O N C L U S I O N S

Implications for practice
The available evidence from two RCTs of short-term parenteral anticoagulation after ICH neither support nor discourage the use of short-term antithrombotic treatment after ICH.

There are no published RCTs on long-term antithrombotic treatment after ICH, but seven RCTs are ongoing at the time of this review.

At the present time, clinicians will have to use other sources of information to support clinical judgements.

Implications for research
Research on the use of antithrombotic drugs after ICH represents an area of unmet need for patients, clinicians, and other consumers. These data suggest that further high-quality RCTs are needed. For short-term antithrombotic use, future studies should consider functional outcome and quality of life in addition to clinical outcomes, such as ischaemic events, haemorrhagic events, or death. For long-term antithrombotic use, future RCTs should consider investigating the relative effectiveness and safety of different antithrombotic drugs, for example warfarin, aspirin, and the direct oral anticoagulants.

A C K N O W L E D G E M E N T S

We thank the Cochrane Stroke Group’s Editorial Board for facilitating this review and providing editorial feedback.

We acknowledge and thank the Cochrane Stroke Group’s Information Specialists Joshua Cheyne and his predecessor Brenda Thomas for their assistance in developing the search strategies for this review.

A special thanks to our two consumer reviewers, Odie Geiger and U Hla Htay, for generously providing their feedback on this review.

R E F E R E N C E S

References to studies included in this review
Dickmann 1988 {published data only}

Orken 2009 {published data only}

References to studies excluded from this review
Boeer 1991 {published data only}

CAST 1997 {published data only}

Frontera 2014 {published data only}

IST 1997 {published data only}

Li 2013 {published data only}

Venturelli 2014 {published data only}
Antithrombotic treatment after stroke due to intracerebral haemorrhage (Review)

Copyright © 2017 The Cochrane Collaboration. Published by John Wiley & Sons, Ltd.

References to ongoing studies

APACHE-AF [published data only]

NASP-AF-ICH [published data only]
NCT02998905. NOACs for stroke prevention in patients with atrial fibrillation and previous ICH (NASP-AF-ICH). ClinicalTrials.gov/NCT02998905 (first received: 25 November 2016). NCT02998905

PICASSO [published data only]

RESTART [published data only]

RESTART Nord de France [published data only]
Cordonnier C, RESTART Nord de France [personal communication]. Email to: LA Perry. 26 September 2016.

SoStART [unpublished data only]
Start or ST op Anticoagulants Randomised Trial. Ongoing study 2017.

STATICH [published data only]
Berge E. STATICH [personal communication]. Email to: LA Perry. 7 September 2016.

Additional references

Al-Shahi Salman 2014

Béjot 2013

Chao 2016

Chong 2012

Claassen 2008

De Vleeschouwer 2005

Falcone 2014

Flynn 2010a

Flynn 2010b

GRADEpro GDT [Computer program]
McMaster University. GRADEpro Guideline Development Tool. McMaster University, 2015.

Hawryluk 2010
Hawryluk GW, Austin JW, Furlan JC, Lee JB, O’Kelly C, Fehlings MG. Management of anticoagulation
Antithrombotic treatment after stroke due to intracerebral haemorrhage (Review)

Copyright © 2017 The Cochrane Collaboration. Published by John Wiley & Sons, Ltd.


Higgins 2011

Keir 2002

Kothari 1996

Krishnamurthi 2010

Kuramatsu 2015

Lauer 2013

Lovelock 2007

Molina 2011
Molina CA, Selim MH. The dilemma of resuming anticoagulation after intracranial hemorrhage. *Stroke* 2011;42(12):3656–6. [DOI: dx.doi.org/10.1161/STROKEAHA.111.631689]

Nielsen 2015

O’Donnell 2016

Paciaroni 2011

Pasquini 2014

Pennlert 2016

Poli 2014

Poon 2014

RevMan 2014 [Computer program]

Sandercock 2011
Steiner 2011

Steiner 2014

Tetri 2008

Viswanathan 2006

Wasay 2008

Wilson 2016

References to other published versions of this review

Perry 2016

* Indicates the major publication for the study
**CHARACTERISTICS OF STUDIES**

**Characteristics of included studies  [ordered by study ID]**

**Dickmann 1988**

| Methods | RCT  
|---------|------|
|         | Duration: 10 days  
|         | Design: parallel  
|         | Setting: inpatient unit in Germany  
|         | Dates: not described  

| Participants | 46 participants  
|             | Diagnosis: intracerebral haemorrhage  
|             | Diagnosis model: cranial CT  
|             | Eligibility criteria: diagnosis of ICH in the previous 24 hours before admission  
|             | Exclusion criteria: bleeding diathesis, diastolic blood pressure higher than 120 mmHg, and deep coma with clinical signs of brain herniation  
|             | Age (years, mean (SD)): 62 (SD not described) (intervention group), 60 (SD not described) (control group)  
|             | Sex: 52% female (intervention group), 48% female (control group)  

| Interventions | 1. 5000 units of heparin administered subcutaneously 8-hourly starting at day 4 (n = 23)  
|              | 2. 5000 units of heparin subcutaneously 8-hourly starting at day 10 (n = 23)  
|              | Both groups had the same treatment otherwise, with compression stockings and physical treatment  

| Outcomes | Rebleeding occurring during the trial period  
|         | Thrombosis of abdomen or legs at day 2 and day 10  
|         | Pulmonary embolism at day 10  
|         | Death during the trial period  

| Notes | Rebleeding is not defined by the authors of this study and could mean multiple things. Conflicts of interest and sources of funding were not described  

### Risk of bias

| Bias | Authors’ judgement | Support for judgement  
|------|--------------------|-----------------------|
| Random sequence generation (selection bias) | Unclear risk | The method of randomisation was not described  
| Allocation concealment (selection bias) | Unclear risk | Allocation concealment was not described  
| Blining of participants and personnel (performance bias) | High risk | Blinding was not possible due to the control group not receiving a placebo injection  
| All outcomes | | |
### Dickmann 1988 (Continued)

<table>
<thead>
<tr>
<th>Bias</th>
<th>Risk</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blinding of outcome assessment (detection bias)</td>
<td>Low risk</td>
<td>“All scintigrams were read by the same blinded investigators”</td>
</tr>
<tr>
<td>Incomplete outcome data (attrition bias)</td>
<td>Low risk</td>
<td>Outcome data were complete</td>
</tr>
<tr>
<td>Selective reporting (reporting bias)</td>
<td>Low risk</td>
<td>All outcomes planned in the Methods section were reported in full in the Results section. Additionally, most expected outcomes of interest were reported in this study</td>
</tr>
<tr>
<td>Other bias</td>
<td>Unclear risk</td>
<td>To our knowledge this study was not prospectively registered</td>
</tr>
</tbody>
</table>

### Orken 2009

<table>
<thead>
<tr>
<th>Methods</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>RCT</td>
<td></td>
</tr>
<tr>
<td>Duration: 21 days</td>
<td></td>
</tr>
<tr>
<td>Design: parallel</td>
<td></td>
</tr>
<tr>
<td>Setting: inpatient unit in Turkey</td>
<td></td>
</tr>
<tr>
<td>Dates: between January 2006 and March 2008</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Participants</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>75 participants</td>
<td></td>
</tr>
<tr>
<td>Diagnosis: intracerebral haemorrhage</td>
<td></td>
</tr>
<tr>
<td>Diagnosis model: cranial CT</td>
<td></td>
</tr>
<tr>
<td>Eligibility criteria: diagnosis of primary ICH</td>
<td></td>
</tr>
<tr>
<td>Exclusion criteria: early death before heparin treatment, death before 7th day investigations, secondary ICH due to aneurysm, arteriovenous malformations, traumas and tumours. Excessive anticoagulation (INR &gt; 2.0). Contraindication to contrast agents</td>
<td></td>
</tr>
<tr>
<td>Age (years, mean (SD)): 68.1 (11.98) (intervention group) 66.08 (9.55) (control group)</td>
<td></td>
</tr>
<tr>
<td>Sex: 56% female (intervention group), 22% female (control group)</td>
<td></td>
</tr>
<tr>
<td>Additional details: mean National Institutes of Health Stroke Scale scores on admission for the LMWH group was 9.74 ± 6.06 and for the compression stocking group was 8.61 ± 6.87. 32/39 participants in the LMWH group and 29/36 participants in the compression stocking group had hypertension identified as a risk factor for ICH. 11 participants from the LMWH group and 6 from the compression stocking group had had a prior cerebrovascular accident</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Interventions</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Enoxaparin sodium 48 mg/day (n = 39)</td>
<td></td>
</tr>
<tr>
<td>2. Compression stocking control (n = 36)</td>
<td></td>
</tr>
<tr>
<td>Treatment began after the first 48 hours from hospital admission</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcomes</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Haematoma enlargement at 72 hours, 7 days and 21 days. Haematoma enlargement was defined as an increase in volume of &gt; 33% or 12.5 mL</td>
<td></td>
</tr>
<tr>
<td>Systemic bleeding complications</td>
<td></td>
</tr>
<tr>
<td>DVT or PE based on CTPA and bilateral venous Doppler at 7 days</td>
<td></td>
</tr>
</tbody>
</table>
Notes
Conflicts of interest and sources of funding were not described

**Risk of bias**

<table>
<thead>
<tr>
<th>Bias</th>
<th>Authors’ judgement</th>
<th>Support for judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Random sequence generation (selection bias)</td>
<td>Unclear risk</td>
<td>The method of randomisation not described</td>
</tr>
<tr>
<td>Allocation concealment (selection bias)</td>
<td>Unclear risk</td>
<td>Allocation concealment not described</td>
</tr>
<tr>
<td>Blinding of participants and personnel (performance bias) All outcomes</td>
<td>High risk</td>
<td>Blinding not possible due to 1 group receiving a subcutaneous injection and the other group receiving compression stockings</td>
</tr>
<tr>
<td>Blinding of outcome assessment (detection bias) All outcomes</td>
<td>Unclear risk</td>
<td>“All radiologic material was prospectively evaluated by 2 radiologists ... who were blinded to the clinical findings and cranial CTs of the patients”. The methods did not explicitly state that the radiologists were also blinded to treatment allocation</td>
</tr>
<tr>
<td>Incomplete outcome data (attrition bias) All outcomes</td>
<td>Low risk</td>
<td>Outcome data were complete</td>
</tr>
<tr>
<td>Selective reporting (reporting bias)</td>
<td>Low risk</td>
<td>All outcomes planned in the Methods section were reported in full in the Results section. Additionally, most expected outcomes of interest were reported in this study</td>
</tr>
<tr>
<td>Other bias</td>
<td>Unclear risk</td>
<td>To our knowledge this study was not prospectively registered</td>
</tr>
</tbody>
</table>

CT: computed tomography
CTPA: CT pulmonary angiography
DVT: deep vein thrombosis
ICH: intracerebral haemorrhage
INR: International normalised ratio
LMWH: low-molecular-weight heparin
PE: pulmonary embolism
RCT: randomised controlled trial
SD: standard deviation
### Characteristics of excluded studies  [ordered by study ID]

<table>
<thead>
<tr>
<th>Study</th>
<th>Reason for exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boeer 1991</td>
<td>This is an extension phase of Dickmann 1988 that introduces non-randomised data to the previously published data</td>
</tr>
<tr>
<td>CAST 1997</td>
<td>This trial included some people with ICH who were randomised prior to CT. These data were not available in the original manuscript. We had hoped that there would be useable data published in the Keir 2002 systematic review, but this did not separate primary ICH from haemorrhagic transformations of acute ischaemic stroke and we were therefore unable to include data from CAST 1997 in this review.</td>
</tr>
<tr>
<td>Frontera 2014</td>
<td>This is a controlled clinical trial that was not randomised.</td>
</tr>
<tr>
<td>IST 1997</td>
<td>This trial included several hundred participants with ICH who were randomised prior to CT. These data were not available in the original manuscript. We had hoped that data from the Keir 2002 systematic review or the published individual data forms (Sandercock 2011) would yield useable data for this review, but Keir 2002 did not report primary ICH separately from haemorrhagic expansion of an acute ischaemic stroke, and after contacting the chief investigator of IST 1997 we discovered that it was not possible to extract data on primary ICH separately</td>
</tr>
<tr>
<td>Li 2013</td>
<td>The intervention randomised in this study is transfusion of frozen apheresis platelets in participants on aspirin and with ICH</td>
</tr>
<tr>
<td>Venturelli 2014</td>
<td>This is a post hoc analysis of the INTERACT2 trial. The intervention that is the subject of this analysis, prophylactic subcutaneous heparin after ICH, was not randomly assigned in INTERACT2. Therefore, this analysis is observational in nature</td>
</tr>
</tbody>
</table>
| Yan 2014  | The participant group did not have primary ICH; it was a cohort of people with and without cerebral microbleeds and haemorrhagic transformation, with acute ischaemic stroke following rtPA treatment | CT: computed tomography  
ICH: intracerebral haemorrhage  
rtPA: Recombinant tissue plasminogen activator |

### Characteristics of ongoing studies  [ordered by study ID]

#### APACHE-AF

<table>
<thead>
<tr>
<th>Trial name or title</th>
<th>Apixaban versus antiplatelet drugs or no antithrombotic drugs after anticoagulation-associated intracerebral haemorrhage in patients with atrial fibrillation (APACHE-AF)</th>
</tr>
</thead>
</table>
| Methods             | Allocation: randomised  
Blinding: open-label (none)  
Duration: 12 to 30 months  
Setting: multicentre trial across the Netherlands  
Dates: September 2014 and currently recruiting |
Participants

<table>
<thead>
<tr>
<th>Inclusion criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>• ICH (including isolated spontaneous intraventricular haemorrhage), documented</td>
</tr>
<tr>
<td>with CT or MRI, during treatment with anticoagulation (VKA, any direct</td>
</tr>
<tr>
<td>thrombin inhibitor, any factor Xa inhibitor, or (low- molecular-weight)</td>
</tr>
<tr>
<td>heparin at a therapeutic dose)</td>
</tr>
<tr>
<td>• Haemorrhage occurred between 7 and 90 days before randomisation</td>
</tr>
<tr>
<td>• Diagnosis of (paroxysmal) non-valvular AF, documented on electrocardiography</td>
</tr>
<tr>
<td>• A CHA2DS2-VASc score ≥ 3</td>
</tr>
<tr>
<td>• Score on the mRS ≤ 4</td>
</tr>
<tr>
<td>• Equipoise regarding the optimal medical treatment for the prevention of stroke</td>
</tr>
<tr>
<td>• Age ≥ 18 years</td>
</tr>
<tr>
<td>• Written informed consent by the participant or by a legal representative</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Exclusion criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Conditions other than AF for which the participant requires long-term</td>
</tr>
<tr>
<td>anticoagulation</td>
</tr>
<tr>
<td>• A different clinical indication for the use of an antiplatelet drug even if</td>
</tr>
<tr>
<td>treated with apixaban, such as clopidogrel for recent coronary stenting</td>
</tr>
<tr>
<td>• Mechanical prosthetic heart valve (biological prosthetic heart valves are</td>
</tr>
<tr>
<td>allowed) or rheumatic mitral valve disease</td>
</tr>
<tr>
<td>• Serious bleeding event in the previous 6 months, except for ICH</td>
</tr>
<tr>
<td>• High risk of bleeding (e.g. active peptic ulcer disease, a platelet count of</td>
</tr>
<tr>
<td>&lt; 100,000 mL-1 or haemoglobin level of &lt; 6.2 mMol.L-1, ischaemic stroke in the</td>
</tr>
<tr>
<td>previous 7 days (participants are eligible thereafter), documented</td>
</tr>
<tr>
<td>haemorrhagic tendencies, or blood dyscrasias</td>
</tr>
<tr>
<td>• Current alcohol or drug abuse</td>
</tr>
<tr>
<td>• Life expectancy of &lt; 1 year</td>
</tr>
<tr>
<td>• Severe renal insufficiency (a serum creatinine level of more than 221 µmol</td>
</tr>
<tr>
<td>per litre or a calculated creatinine clearance of &lt; 15 ml per minute)</td>
</tr>
<tr>
<td>• Alanine aminotransferase or aspartate aminotransferase level &gt; 2 times the</td>
</tr>
<tr>
<td>upper limit of the normal range or a total bilirubin &gt; 1.5 times the upper</td>
</tr>
<tr>
<td>limit of the normal range, unless a benign causative factor (e.g. Gilbert's</td>
</tr>
<tr>
<td>syndrome) is known or identified</td>
</tr>
<tr>
<td>• Allergy to apixaban</td>
</tr>
<tr>
<td>• Use of strong cytochrome P450 3A4 (CYP3A4) and P-glycoprotein (P-gp)</td>
</tr>
<tr>
<td>inhibitors (e.g. systemic azole-antimycotics as ketoconazole or HIV protease</td>
</tr>
<tr>
<td>inhibitors such as ritonavir)</td>
</tr>
<tr>
<td>• Pregnant or breastfeeding</td>
</tr>
<tr>
<td>• Women of childbearing potential: any woman who has begun menstruation and is</td>
</tr>
<tr>
<td>not postmenopausal or otherwise permanently unable to conceive. A postmenopausal</td>
</tr>
<tr>
<td>woman is defined as a woman who is over the age of 45 and has not had a</td>
</tr>
<tr>
<td>menstrual period for at least 12 months</td>
</tr>
</tbody>
</table>

Interventions

<table>
<thead>
<tr>
<th>Participants will be randomised into 6 groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>• apixaban</td>
</tr>
<tr>
<td>• aspirin</td>
</tr>
<tr>
<td>• carbasalate calcium</td>
</tr>
<tr>
<td>• clopidogrel</td>
</tr>
<tr>
<td>• dipyridamole</td>
</tr>
<tr>
<td>• no antithrombotic treatment</td>
</tr>
<tr>
<td>Each of the groups will run in parallel</td>
</tr>
</tbody>
</table>

Outcomes

<table>
<thead>
<tr>
<th>Primary outcome measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Number of participants who experience the combination of vascular death or non-</td>
</tr>
<tr>
<td>fatal stroke (cerebral infarction, intracerebral haemorrhage, or subarachnoid</td>
</tr>
<tr>
<td>haemorrhage)</td>
</tr>
</tbody>
</table>

Secondary outcome measures: number of participants who experience:
**APACHE-AF** *(Continued)*

- vascular death
- death from any cause
- all stroke
- ischaemic stroke
- intracerebral haemorrhage
- other major extracranial haemorrhage
- any intracranial haemorrhage other than ICH
- systemic embolism
- myocardial infarction
- a good functional outcome as assessed with the score on the mRS

### Starting date

September 2014

### Contact information

Contact: Koen M van Nieuwenhuizen, MD. Tel: +31 88 757 4097; email: k.m.vannieuwenhuizen-3@umcutrecht.nl

Contact: H Bart van der Worp, MD PhD. Tel: +31 88 755 98 99; email: h.b.vanderworp@umcutrecht.nl

### Notes

**NASP-AF-ICH**

<table>
<thead>
<tr>
<th>Trial name or title</th>
<th>Non-VKA Anticoagulants for Stroke Prevention in Patients with Atrial Fibrillation and Previous IntraCerebral Hemorrhage Study (NASP-ICH)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methods</td>
<td>Allocation: randomised 2:1 (non-vitamin K oral antagonist (agent at the discretion of the local investigator) vs aspirin)</td>
</tr>
<tr>
<td></td>
<td>Blinding: open-label, blinded adjudication of outcomes</td>
</tr>
<tr>
<td></td>
<td>Duration: recruitment 24 months, participants will be followed to a common terminate date designated at 6 months following the end of recruitment. Average follow-up per participant approximately 12 months (range: 12 to 30 months)</td>
</tr>
<tr>
<td></td>
<td>Design (parallel, other): phase II, open-label randomised controlled trial</td>
</tr>
<tr>
<td></td>
<td>Setting: 10 high-volume stroke centres across Canada</td>
</tr>
<tr>
<td></td>
<td>Dates: January 2017 to June 2019</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Participants</th>
<th>Inclusion criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- 45 years of age or older</td>
</tr>
<tr>
<td></td>
<td>- prior spontaneous intraparenchymal or intraventricular haemorrhage</td>
</tr>
<tr>
<td></td>
<td>- High risk AF (CHADS² ≥ 2)</td>
</tr>
<tr>
<td>Exclusion criteria</td>
<td>- Non-stroke indication for antiplatelet or anticoagulant therapy</td>
</tr>
<tr>
<td></td>
<td>- Estimated creatinine clearance of &lt; 30 ml per minute</td>
</tr>
<tr>
<td></td>
<td>- Platelet count less than 100,000/mm³ at enrolment or other bleeding diathesis</td>
</tr>
<tr>
<td></td>
<td>- Uncontrollable hypertension with SBP/DBP consistently above 160/100 mmHg</td>
</tr>
<tr>
<td></td>
<td>- Prior symptomatic lobar ICH other than the qualifying event (i.e. ≥ 2 symptomatic lobar ICH)</td>
</tr>
<tr>
<td></td>
<td>- Known hypersensitivity to either aspirin or NOACs</td>
</tr>
<tr>
<td></td>
<td>- Pregnant or breastfeeding</td>
</tr>
</tbody>
</table>
### NASP AF-ICH

(Continued)

| Interventions | Non-vitamin K oral antagonist (agent at the discretion of the local investigator) vs aspirin 81 mg  
|               | Strict long-term blood pressure control to target of < 130/80 mmHg for all participants |
| Outcomes      | Primary outcome measure: the primary feasibility outcome will be recruitment rates  
|               | Secondary outcomes will be refusal rates and retention rates |
| Starting date | January 2017 |

#### Contact information

Co-Principal Investigator:  
Ashkan Shoamanesh, MD, FRCPC  
Assistant Professor of Medicine (Neurology)  
Director, Stroke Fellowship Program  
Marta and Owen Boris Chair in Stroke Research and Care  
McMaster University / Population Health Research Institute  
237 Barton Street East  
HGH-DBCVSRI C4-118  
Hamilton, Ontario, L8L 2X2, Canada  
Email: ashkan.shoamanesh@phri.ca  
Telephone: (905) 521-2100 ext 41277  
Fax: (905) 577-1427

### PICASSO

#### Trial name or title

Prevention of Cardiovascular Events in Ischemic Stroke patients with high risk of cerebral hemorrhage (PICASSO)

#### Methods

- Allocation: randomisation  
- Blinding: double-blinding (participant, caregiver, investigator, outcome assessor)  
- Duration: 1 to 5.5 years  
- Setting: multicentre trial across China, South Korea and the Philippines  
- Dates: June 2009 and ongoing

#### Participants

- **Inclusion criteria**  
  - People with TIA or ischaemic stroke within 180 days prior to screening - adult aged 20 years or older  
  - High risk of haemorrhagic stroke (history of intracranial haemorrhage or imaging evidence of previous intracranial haemorrhage)  
  - Informed consent  
- **Exclusion criteria**  
  - Clinical diagnosis of myocardial infarction or coronary intervention within 4 weeks  
  - Bleeding tendency  
  - Pregnant or breastfeeding woman  
  - Haemorrhagic stroke within 6 months  
  - Person taking antithrombotic medication other than aspirin and not agreeing to change the previous medication  
  - Severe cardiovascular disease such as cardiomyopathy or congestive heart failure  
  - Life expectancy < 1 year
### PICASSO (Continued)

- Contraindication to long-term aspirin use
- Enrolled in other clinical trial within 30 days

<table>
<thead>
<tr>
<th>Interventions</th>
<th>A factorial design across the following groups:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• cilostazol</td>
</tr>
<tr>
<td></td>
<td>• probucol</td>
</tr>
<tr>
<td></td>
<td>• aspirin</td>
</tr>
<tr>
<td></td>
<td>• placebo of cilostazol</td>
</tr>
<tr>
<td></td>
<td>• placebo of aspirin</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Primary outcome measures: time to first occurrence of:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• cerebral haemorrhage</td>
</tr>
<tr>
<td></td>
<td>• composite cardiovascular events</td>
</tr>
<tr>
<td></td>
<td>Secondary outcome measures: time to first occurrence of:</td>
</tr>
<tr>
<td></td>
<td>• stroke</td>
</tr>
<tr>
<td></td>
<td>• ischaemic stroke</td>
</tr>
<tr>
<td></td>
<td>• myocardial infarction</td>
</tr>
<tr>
<td></td>
<td>• other designated vascular events</td>
</tr>
<tr>
<td></td>
<td>Other outcome measures</td>
</tr>
<tr>
<td></td>
<td>• Incidence rate of major and non-major haemorrhagic event</td>
</tr>
<tr>
<td></td>
<td>• Rate of asymptomatic haemorrhage in GRE (microhaemorrhage or macrohaemorrhage)</td>
</tr>
<tr>
<td></td>
<td>• Rate of new asymptomatic cerebral infarction lesion in FLAIR</td>
</tr>
<tr>
<td></td>
<td>• Change of ankle-brachial index</td>
</tr>
<tr>
<td></td>
<td>• The effect of the size of CCA including plaque on the occurrence of cardiovascular events</td>
</tr>
<tr>
<td></td>
<td>• Time to all deaths including vascular and non-vascular death</td>
</tr>
<tr>
<td></td>
<td>• Incidence rate of dementia diagnosed after initiation of the trial</td>
</tr>
</tbody>
</table>

| Starting date | June 2009 |

Contact information

Principal Investigator: Sun U Kwon, MD, PhD
Departement of Neurology, Asan Medical Center

Notes

### RESTART

<table>
<thead>
<tr>
<th>Trial name or title</th>
<th>REstart or STop Antithrombotics Randomised Trial (RESTART)</th>
</tr>
</thead>
</table>

Methods

- Allocation: randomised
- Blinding: treatment is open-label, but outcome assessors are blinded
- Duration: at least 6 months
- Design: parallel
- Setting: UK National Health Service (NHS) secondary care (inpatient and outpatient services in stroke, neurology and neurosurgery) and primary care
- Dates: May 2013 to May 2018 (recruitment), November 2018

Participants

- Inclusion criteria:  
  - Patient age ≥ 18 years.
### Inclusion criteria:
- Spontaneous primary or secondary ICH.
- Patient had taken antithrombotic drug(s) for the prevention of vaso-occlusive disease before ICH onset. Randomisation > 24 hours after ICH onset.
- Patient and their doctor are uncertain about whether to start or avoid antiplatelet drugs.
- Patient is registered with a general practitioner (GP).
- Brain imaging that first diagnosed the ICH is available.
- Participant or representative consent.

### Exclusion criteria:
- ICH due to preceding trauma or haemorrhagic transformation of ischaemic stroke.
- Patient is taking an anticoagulant drug following ICH.
- Patient is pregnant, breastfeeding, or of childbearing age and not taking contraception.
- Patient is being treated or followed up in another CTIMP.
- Patient and carer unable to understand spoken or written English.
- Brain magnetic resonance imaging (MRI) sub-study: MRI done after ICH but before randomisation. No claustrophobia. MRI not contraindicated.

### Interventions
Participants will be randomised to either ‘start antiplatelet medication’ (restricted to the use of 1 or more of aspirin, dipyridamole or clopidogrel at the investigator’s discretion) or “avoid antiplatelet medication”.

### Outcomes
- **Primary outcome measure:** recurrent symptomatic ICH
- **Secondary outcome measures:**
  - possible recurrent ICH;
  - symptomatic non-fatal extracerebral haemorrhage, extracranial haemorrhage, and vaso-occlusive events; death;
  - modified Rankin Scale score;
  - adherence to antiplatelet drug(s)

### Starting date
April 2013

### Contact information
UK Chief Investigator: Rustam Al-Shahi Salman; Trial Manager: Karen Innes
RESTART.trial@ed.ac.uk.

### Notes
- **RESTART Nord de France**

#### Trial name or title
RESTART Nord de France

#### Methods
- **Allocation:** randomisation 1:1 - restart vs no antiplatelet
- **Blinding:** PROBE design
- **Duration:** each participant will be followed up during year 2
- **Design (parallel, other):** RCT 1:1
- **Setting:** region North of France
- **Dates:** start October 2016, recruitment 3 years, overall: 5 years

#### Participants
- **Inclusion criteria:**
  - Adult, no upper age limit
  - Spontaneous ICH
  - Randomisation at least 24 hours following the index ICH
• The participant and the doctor are uncertain about the net clinical benefit of restarting or not antiplatelet agents

Exclusion criteria
• Traumatic ICH
• Secondary ICH
• MRI contra-indications

Interventions
Restart antiplatelet agent vs no antiplatelet agent

Outcomes
Primary outcome measure: recurrent ICH (fatal and non fatal)
Secondary outcome measures:
• Serious vascular events fatal (followed by death within 30 days) and non-fatal
• Symptomatic haemorrhagic events (excluding cerebrovascular)
• Symptomatic ischaemic events (cerebral and extracerebral)
• Stroke of undetermined nature
• Other fatal events
• Functional outcome at 2 years
• Incident brain microhaemorrhages on follow-up MRI at 1 year

Starting date
October 2016

Contact information
Contact information: Professor Charlotte Cordonnier
charlotte.cordonnier@chru-lille.fr

Notes

SoSTART

Trial name or title
Start or STop Anticoagulants Randomised Trial

Methods
Investigator-led, multicentre, randomised, open, assessor-masked, parallel group, clinical trial of investigational medicinal product (CTIMP) prescribing strategies. We plan for a pilot phase, followed by a main phase

Participants
Inclusion criteria: spontaneous intracranial haemorrhage, AF and a CHA₂DS₂-VASc score ≥ 2
Exclusion criteria:
• Patient age < 18 years
• Intracranial haemorrhage within the last 24 hours
• Brain imaging that first diagnosed the intracranial haemorrhage is not available
• Intracranial haemorrhage is exclusively due to trauma or haemorrhagic transformation of ischaemic stroke. Patient or their doctor is certain about whether to start or avoid full oral anticoagulation
• Patient is not registered with a general practitioner
• Patient is pregnant, breastfeeding, or of childbearing age and not taking contraception
• Patient and carer unable to understand spoken or written English
• Previously randomised in SoSTART

Brain MRI substudy: MRI must be done after intracranial haemorrhage but before randomisation. Substudy participants must not have contraindications to MRI
**Interventions**
- Start full OAC: (either a non-vitamin K antagonist DOAC or warfarin if a DOAC cannot be used), chosen by the participant's physician before randomisation.
- Start antiplatelet drug(s) (if the participant has an indication for antiplatelet drugs) or avoid all antithrombotic drugs (if the participant does not have an indication for antiplatelet drugs), specified by the participant’s doctor before randomisation.

**Outcomes**
- Primary outcome: all symptomatic serious vascular events (i.e. major adverse cardiac or cerebrovascular events: MACCE) including non-fatal stroke, non-fatal acute coronary syndrome, vascular death, sudden death, or death of unknown cause.
- Secondary outcomes:
  - individual symptomatic vascular events;
  - individual types of fatal events;
  - dependence according to the mRS.

**Starting date**
- 2017

**Contact information**
- Professor Rustam Al-Shahi Salman, University of Edinburgh, UK (Rustam.Al-Shahi@ed.ac.uk)

**Notes**
- Funded by Chest Heart and Stroke Scotland

---

**STATICCH**

**Trial name or title**
- Study of Antithrombotic Treatment after Intracerebral Haemorrhage (STATICCH)

**Methods**
- Allocation: randomised
- Blinding: open, blinded endpoint
- Duration: 2 years
- Design: parallel
- Setting: multicenter in Norway, Denmark, and Sweden
- Dates: start up 2017

**Participants**
- Inclusion criteria:
  - Spontaneous, primary ICH
  - No preceding traumatic injury, no structural secondary underlying structural cause
  - Indication for antithrombotic drug
  - Uncertainty about whether to start or avoid antithrombotic drugs after ICH
  - Patient age $\geq$ 18 years
  - Patient is at least 24 hours after symptom onset
  - Consent from patient or representative
- Exclusion criteria:
  - Absolute indication for anticoagulant treatment
  - Patient is pregnant, breastfeeding or of childbearing age and not taking contraception
  - Patient is being treated or followed up in another CTIMP
  - For MRI substudy: contraindication for MRI

**Interventions**
- Interventions for each group: the intervention is starting antithrombotic drug. The comparator is avoiding antithrombotic drugs.
### STATICH (Continued)

| Outcomes | Primary outcome measure: recurrent symptomatic ICH  
Secondary outcome measures:  
• complication of qualifying ICH;  
• symptomatic extradural haemorrhage, subdural haemorrhage, subarachnoid haemorrhage;  
• symptomatic major extracranial haemorrhage;  
• symptomatic ischaemic events;  
• cardiovascular death; death from any other cause;  
• mRS |
|---|---|

| Starting date |  
|---|---|

| Contact information | Trial co-ordinating investigator: Eivind Berge, MD, PhD, email: eivind.berge@medisin.uio.no  
Trial manager: Elisabeth Forfang, MD, email: elisabeth.forfang@medisin.uio.no |
|---|---|

| Notes | AF: atrial fibrillation  
CCA: common carotid artery  
CT: computed tomography  
DBP: diastolic blood pressure  
DOAC: direct oral anticoagulant  
ICH: intracerebral haemorrhage  
MRI: magnetic resonance imaging  
mRS: modified Rankin Scale  
NOAC: novel oral anticoagulant  
OAC: oral anticoagulation  
SBP: systolic blood pressure  
TIA: transient ischaemic stroke  
VKA: vitamin K antagonist |
|---|---|
Comparison 1. Short-term antithrombotic treatment

<table>
<thead>
<tr>
<th>Outcome or subgroup title</th>
<th>No. of studies</th>
<th>No. of participants</th>
<th>Statistical method</th>
<th>Effect size</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 Death</td>
<td>1</td>
<td></td>
<td>Risk Ratio (M-H, Fixed, 95% CI)</td>
<td>Totals not selected</td>
</tr>
<tr>
<td>6 Other major ischaemic event</td>
<td>2</td>
<td>121</td>
<td>Risk Ratio (M-H, Fixed, 95% CI)</td>
<td>0.54 [0.23, 1.28]</td>
</tr>
<tr>
<td>7 Intracerebral haemorrhage</td>
<td>1</td>
<td></td>
<td>Risk Ratio (M-H, Fixed, 95% CI)</td>
<td>Totals not selected</td>
</tr>
<tr>
<td>8 Major extracerebral haemorrhage</td>
<td>1</td>
<td></td>
<td>Risk Ratio (M-H, Fixed, 95% CI)</td>
<td>Totals not selected</td>
</tr>
<tr>
<td>9 Growth of intracerebral haematoma</td>
<td>2</td>
<td>121</td>
<td>Risk Ratio (M-H, Fixed, 95% CI)</td>
<td>1.64 [0.51, 5.29]</td>
</tr>
<tr>
<td>10 Deep vein thrombosis</td>
<td>2</td>
<td>121</td>
<td>Risk Ratio (M-H, Fixed, 95% CI)</td>
<td>0.99 [0.49, 1.96]</td>
</tr>
</tbody>
</table>

Analysis 1.2. Comparison 1 Short-term antithrombotic treatment, Outcome 2 Death.

Review: Antithrombotic treatment after stroke due to intracerebral haemorrhage

Comparison: 1 Short-term antithrombotic treatment

Outcome: 2 Death

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Experimental</th>
<th>Control</th>
<th>Risk Ratio M-H,Fixed,95% CI</th>
<th>Risk Ratio M-H,Fixed,95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dickmann 1988</td>
<td>5/23</td>
<td>4/23</td>
<td>1.25 [0.38, 4.07]</td>
<td></td>
</tr>
</tbody>
</table>
Analysis 1.6. Comparison 1 Short-term antithrombotic treatment, Outcome 6 Other major ischaemic event.

Review: Antithrombotic treatment after stroke due to intracerebral haemorrhage

Comparison: 1 Short-term antithrombotic treatment

Outcome: 6 Other major ischaemic event

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Experimental</th>
<th>Control</th>
<th>Risk Ratio</th>
<th>Weight</th>
<th>Risk Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n/N</td>
<td>n/N</td>
<td>M-H,Fixed,95% CI</td>
<td></td>
<td>M-H,Fixed,95% CI</td>
</tr>
<tr>
<td>Dickmann 1988</td>
<td>5/23</td>
<td>9/23</td>
<td>0.56 [0.22, 1.41]</td>
<td>81.2 %</td>
<td></td>
</tr>
<tr>
<td>Orken 2009</td>
<td>1/39</td>
<td>2/36</td>
<td>0.46 [0.04, 4.88]</td>
<td>18.8 %</td>
<td></td>
</tr>
<tr>
<td><strong>Total (95% CI)</strong></td>
<td><strong>62</strong></td>
<td><strong>59</strong></td>
<td><strong>0.54 [0.23, 1.28]</strong></td>
<td><strong>100.0 %</strong></td>
<td></td>
</tr>
</tbody>
</table>

Total events: 6 (Experimental), 11 (Control)
Heterogeneity: Chi² = 0.02, df = 1 (P = 0.89); I² = 0.0%
Test for overall effect: Z = 1.40 (P = 0.16)
Test for subgroup differences: Not applicable

Analysis 1.7. Comparison 1 Short-term antithrombotic treatment, Outcome 7 Intracerebral haemorrhage.

Review: Antithrombotic treatment after stroke due to intracerebral haemorrhage

Comparison: 1 Short-term antithrombotic treatment

Outcome: 7 Intracerebral haemorrhage

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Experimental</th>
<th>Control</th>
<th>Risk Ratio</th>
<th>Risk Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n/N</td>
<td>n/N</td>
<td>M-H,Fixed,95% CI</td>
<td>M-H,Fixed,95% CI</td>
</tr>
<tr>
<td>Orken 2009</td>
<td>0/39</td>
<td>0/36</td>
<td>Not estimable</td>
<td></td>
</tr>
</tbody>
</table>

Test for overall effect: Not applicable
### Analysis 1.8. Comparison 1 Short-term antithrombotic treatment, Outcome 8 Major extracerebral haemorrhage.

**Review:** Antithrombotic treatment after stroke due to intracerebral haemorrhage

**Comparison:** 1 Short-term antithrombotic treatment

**Outcome:** 8 Major extracerebral haemorrhage

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Experimental</th>
<th>Control</th>
<th>Risk Ratio</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n/N</td>
<td>n/N</td>
<td>M-H,Fixed 95% CI</td>
<td>M-H,Fixed 95% CI</td>
</tr>
<tr>
<td>Orken 2009</td>
<td>0/39</td>
<td>0/36</td>
<td>Not estimable</td>
<td></td>
</tr>
</tbody>
</table>

### Analysis 1.9. Comparison 1 Short-term antithrombotic treatment, Outcome 9 Growth of intracerebral haematoma.

**Review:** Antithrombotic treatment after stroke due to intracerebral haemorrhage

**Comparison:** 1 Short-term antithrombotic treatment

**Outcome:** 9 Growth of intracerebral haematoma

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Experimental</th>
<th>Control</th>
<th>Risk Ratio</th>
<th>Weight</th>
<th>Risk Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n/N</td>
<td>n/N</td>
<td>M-H,Fixed 95% CI</td>
<td>M-H,Fixed 95% CI</td>
<td></td>
</tr>
<tr>
<td>Dickmann 1988</td>
<td>1/23</td>
<td>1/23</td>
<td>24.3 %</td>
<td>1.00 [ 0.07, 15.04 ]</td>
<td></td>
</tr>
<tr>
<td>Orken 2009</td>
<td>6/39</td>
<td>3/36</td>
<td>75.7 %</td>
<td>1.85 [ 0.50, 6.84 ]</td>
<td></td>
</tr>
<tr>
<td><strong>Total (95% CI)</strong></td>
<td><strong>62</strong></td>
<td><strong>59</strong></td>
<td><strong>100.0 %</strong></td>
<td><strong>1.64 [ 0.51, 5.29 ]</strong></td>
<td></td>
</tr>
</tbody>
</table>
## Analysis 1.10. Comparison 1 Short-term antithrombotic treatment, Outcome 10 Deep vein thrombosis.

Review: Antithrombotic treatment after stroke due to intracerebral haemorrhage

Comparison: 1 Short-term antithrombotic treatment

Outcome: 10 Deep vein thrombosis

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Experimental n/N</th>
<th>Control n/N</th>
<th>Risk Ratio M-H,Fixed,95% CI</th>
<th>Weight</th>
<th>Risk Ratio M-H,Fixed,95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dickmann 1988</td>
<td>8/23</td>
<td>10/23</td>
<td></td>
<td>90.6 %</td>
<td>0.80 [0.39, 1.66]</td>
</tr>
<tr>
<td>Orken 2009</td>
<td>3/39</td>
<td>1/36</td>
<td></td>
<td>9.4 %</td>
<td>2.77 [0.30, 25.43]</td>
</tr>
<tr>
<td><strong>Total (95% CI)</strong></td>
<td><strong>62</strong></td>
<td><strong>59</strong></td>
<td></td>
<td><strong>100.0 %</strong></td>
<td><strong>0.99 [0.49, 1.96]</strong></td>
</tr>
</tbody>
</table>

Total events: 11 (Experimental), 11 (Control)

Heterogeneity: $\chi^2 = 1.15, df = 1 (P = 0.28); I^2 = 13%$

Test for overall effect: $Z = 0.04 (P = 0.97)$

Test for subgroup differences: Not applicable

### APPENDICES

#### Appendix 1. CENTRAL search strategy

#1 MESH DESCRIPTOR Basal Ganglia Hemorrhage EXPLODE ALL TREES

#2 MESH DESCRIPTOR Intracranial Hemorrhages

#3 MESH DESCRIPTOR Intracranial Hemorrhage, Hypertensive

#4 MESH DESCRIPTOR Cerebral Hemorrhage

#5 (brain* or cerebr* or cerebell* or intracerebral or intracran* or parenchymal or intraparenchymal or intraventricular or infratentorial or supratentorial or putaminal or putamen or hemispher* or stroke or apoplex*):TI

#6 (basal and gangli*):TI

#7 (posterior and fossa):TLAB,KY

#8 (haemorrhag* or hemorrhag* or haematoma* or hematoma* or bleed*):TI
Antithrombotic treatment after stroke due to intracerebral haemorrhage (Review)
Copyright © 2017 The Cochrane Collaboration. Published by John Wiley & Sons, Ltd.
polyester* or phenindione* or protein next c or protein next s or tedaparin*):TL,AB,KY
#33 (tinzaparin or pardaparin or dalteparin or reviparin or danaparoid or lomoparan or org next 10172 or mesoglycan or polysaccharide next sulphate* or sp54 or sp-54 or md805 or md-805 or cy222 or cy-222 or cy216 or cy-216):TL,AB,KY
#34 (Marevan or Fragmin* or Fraxiparin* or Klexane):TL,AB,KY
#35 (argatroban or MD805 or MD-805 or dabigatran or ximelagatran or melagatran or efegatran or flouagatran or inogatran or napsagatran or bivalirudin or lepirudin or hirudin* or desirudin or desulfatohirudin or hirugen or hirulog or AZD0837 or bothrojaracin or odiparcil):TL,AB,KY
#36 (xabans or antistasin or apixaban or betrixaban or du next 176b or erixaban or fondaparinux or idraparinux or otamixaban or razaxaban or rivaroxaban or yagin or ym next 150 or ym150 or LY517717):TL,AB,KY
#37 #25 or #26 or #27 or #28 or #29 or #30 or #31 or #32 or #33 or #34 or #35 or #36
#38 MESH DESCRIPTOR Platelet Glycoprotein GPIIb-IIIa Complex EXPLODE ALL TREES WITH QUALIFIERS AI,DE
#39 MESH DESCRIPTOR Platelet Activation EXPLODE ALL TREES WITH QUALIFIERS DE
#40 MESH DESCRIPTOR Blood Platelets EXPLODE ALL TREES WITH QUALIFIERS DE
#41 (antiplatelet* or anti-platelet* or antiaggreg* or anti-aggreg* or (platelet* NEAR5 inhibit*) or (thrombocyt* NEAR5 inhibit*)):TL,AB,KY
#42 (alprostadil* or aspirin* or acetylsalicylic next acid or (acetyl ADJ salicylic and acid*) or (acetyl-salicylic and acid or epoprostenol* or ketanserin* or ketorolac next tromethamine* or milrinone* or mopenadomol* or procainamide* or thiophen* or trapidil* or picotamide* or ligustrazine* or levamisol* or suloctidil* or ozagrel* or oky046 or oky-046 or defibrotide* or cilostazol or satirgel or sarpolgrelate or kbt3022 or kbt-3022 or isbogrel or cv4151 or cv-4151)):TL,AB,KY
#43 ((glycoprotein next ii* near/5 inhibit*) or (glycoprotein next ii* near/5 antag*) or (gp next ii* near/5 inhibit*) or (gp next ii* near/5 antag*) or GR144053 or GR-144053 or triflusal):TL,AB,KY
#44 (Argatroban or Beraprost or Cicaprost or Cilostazol or Clopidogrel or Dipyridamole or Iloprost or Indobufen or Lepirudin or Pentosan next Polysulfate or Pentoxifylline or Piracetam or...
Appendix 2. MEDLINE search strategy

1. exp basal ganglia haemorrhage/ or intracranial hemorrhages/ or cerebral haemorrhage/ or intracranial haemorrhage, hypertensive/
2. ((brain$ or cerebr$ or cerebell$ or intracerebral or intracran$ or parenchymal or intraparenchymal or intraventricular or infratentorial or supratentorial or basal gangli$ or putaminal or putamen or posterior fossa or hemispher$) adj5 (h?emorrhag$ or h?ematoma$ or bleed$)).tw.
3. ((h?emorrhag$ or bleed$) adj5 (stroke or apopleкс$)).tw.
4. (ICH or ICHs).tw.
5. 1 or 2 or 3 or 4
6. exp anticoagulants/
7. exp Vitamin K/ai or thrombin/ai or factor Xa/ai or exp Blood coagulation factors/ai
8. exp antithrombins/ or hirudin therapy/
9. (anticoagul$ or antithromb$).tw.
10. (Vitamin K antagonist$ or VKA or VKAs).tw.
11. (direct$ adj3 thrombin adj3 inhibit$).tw.
12. DTI$.tw.
13. (((factor Xa or factor 10a or Xa or autoprorhombin c or thrombokinesis) adj3 inhibit$)).tw.
14. (activated adj3 (factor X or factor 10) adj3 inhibit$).tw.
15. ((acenocoumarol$ or dicoumarol$ or ethyl biscoacetaet$ or phenprocoumon$ or warfarin$ or ancred$ or citric acid$ or coumarin$ or chromonar$ or coumestro$ or esculi$ or ocratroxin$ or umbelliferone$ or dermatan sulfate$ or dextran$ or edetic acid$ or enoxaparin$ or gabexate$ or heparin$ or lnwh$ or nadroparin$ or pentosan sulfatic polyesten$ or phenindione$ or protein c or protein s or tedelpafur$).tw, nm.
16. (tinzaparin or parnaparin or dalteparin or reviparin or danaparoid or lomoparan or argatroban or MD805 or MD-805 or dabigatran or ximelagatran or fondaparinux or idraparinux or rivaroxaban or yagin or ym 150 or ym150 or LY517717).tw, nm.
17. (Marevan or Fragmin$ or Fraxiparin$ or Klexane$).tw, nm.
18. (argatroban or MD805 or MD-805 or dabigatran or ximelagatran or fondaparinux or idraparinux or rivaroxaban or yagin or ym 150 or ym150 or LY517717).tw, nm.
19. (xigans or antistasin or apixaban or betrixaban or du 176b or eribaxaban or fondaparinux or idraparinux or otamixaban or razaxaban or rivaroxaban or yagin or ym 150 or ym150 or LY517717).tw, nm.
20. (alprostadil$ or aspirin$ or acetylsalicylic acid or acetyl salicylic acid$ or acetylsalicylic acid or epoprostenol$ or ketanserin$ or ketorolac tromethamine$ or milrinone$ or mepipamole$ or propranolim$ or thyoprost$ or thriphen$ or trapidil$ or picotamid$ or liquestrin$ or levamisol$ or sulocitidil$ or ozagrel$ or oky046 or oky-046 or defibrotide$ or citostal $ or satigel$ or serpolrelate or kbt3022 or

Antithrombotic treatment after stroke due to intracerebral haemorrhage (Review)

Copyright © 2017 The Cochrane Collaboration. Published by John Wiley & Sons, Ltd.
Antithrombotic treatment after stroke due to intracerebral haemorrhage (Review)

Appendix 3. EMBASE (Ovid) search strategy

1. anticoagulant agent/ or antivitamin k/ or exp blood clotting inhibitor/ or exp coumarin anticoagulant/ or defibrotide/ or dextran sulfate/ or fluindione/ or

glycosaminoglycan polysulfate/ or exp heparin derivative/ or lupus anticoagulant/ or phenindione/

2. (anticoagul$ or antithromb$).tw.

3. (Vitamin K antagonist$ or VKA or VKAs).tw.

4. (direct$ adj5 thrombin adj5 inhib$).tw.

5. DTI$1.ti.
6. ((factor Xa or factor 10a or fXa or autoprothrombin c or thrombokinase) adj5 inhib$).tw.

7. (activated adj5 (factor X or factor 10) adj5 inhib$).tw.

8. (acenocoumarol$ or dicoumarol$ or ethyl biscoumacetate$ or phenprocoumon$ or warfarin$ or ancrod$ or citric acid$ or coumarin$ or chromonar$ or coumestrol$ or esculin$ or ochratoxin$ or umbelliferone$ or dermatan sulfate$ or dextran$ or edetic acid$ or enoxaparin$ or gabexate$ or heparin$ or lmwh$ or nadroparin$ or pentosan sulfuric polyester$ or phenindione$ or protein c or protein s or tedelparin$).tw.

9. (tinzaparin or parnaparin or dalteparin or reviparin or danaparoid or lomopar or org 10172 or mesoglycan or polysaccharide sulphate$ or sp54 or sp-54 or md805 or md-805 or cy222 or cy-222 or cy216 or cy-216).tw.

10. (Marevan or Fragmin$ or Fraxiparin$ or Klexane).tw.

11. (argatroban or MD805 or MD-805 or dabigatran or ximelagatran or melagatran or efeogatran or flavogatran or inogatran or napsagatran or bivalirudin or lepirudin or hirudin$ or desirudin or desulfatohirudin or hisirugen or hirulog or AZD0837 or bothrojaracin or odiparcil).tw.

12. (xabans or antistasin or apixaban or betrixaban or du 176b or eribaxaban or fondaparinux or idraparinux or otamixaban or razaxaban or rivaroxaban or yagin or ym 150 or ym150 or LY517717).tw.

13. or/1-12

14. exp antithrombocytic agent/

15. fibrinogen receptor/dt [Drug Therapy]

16. (antiplatelet$ or anti-platelet$ or antiaggreg$ or anti-aggreg$ or (platelet$ adj5 inhibit$) or (thrombocyt$ adj5 inhibit$)).tw.

17. (alprostadil$ or aspirin$ or acetylsalicylic acid or acetyl salicylic acid$ or acetyl?salicylic acid or eprostenol$ or ketanserin$ or ketorolac tromethamine$ or milrinone$ or m odpamol$ or procainamide$ or thiophen$ or trapidil$ or picotamide$
or ligustrazine or levamisole or sulcotidil or ozagrel or oky046 or oky-046 or defibrotide or cilostazol or satigrel or sarpolgrelate or kbt3022 or kbt-3022 or isbogrel or cv4151 or cv-4151 or ((glycoprotein iib or gp iib) adj5 (antagonist or inhibitor)) or GR144053 or GR-144053 or triflusal).tw.

18. (Argatroban or Beraprost or Cicaprost or Cilostazol or Clopidogrel or Dipyramidole or Iloprost or Indobufen or Lepirudin or Pentosan Polysulfate or Pentoxifylline or Piracetam or Prostacyclin or Sulfinpyrazone or Sulphinpyrazone or Ticlopidine or Triflusal or Abciximab or Disintegrin or Echistatin or Eptifibatide or Lamifiban or Orbofibran or Roxifiban or Sibrafiban or Tirofiban or Xemilofiban or terutroban or picotamide or prasugrel).tw.

19. (Dispril or Albyl or Ticlid or Persantin or Plavix or ReoPro or Integrilin or Aggrastat).tw.

20. or/14-19

21. 13 or 20

22. *basal ganglion hemorrhage/ or *brain hemorrhage/ or *brain ventricle hemorrhage/ or *cerebellum hemorrhage/

23. ((brain or cerebr or cerebell or intracerebral or intracran or parenchymal or intraparenchymal or intraventricular or infratentorial or supratentorial or basal gangli or putaminal or putamen or posterior fossa or hemispher or stroke or apoplex) adj5 (h?emorrhag or h?ematoma or bleed)).ti.

24. 22 or 23 or (ICH or ICHs).ti.

25. randomized controlled trial/ or "randomized controlled trial (topic)"/

26. Randomization/

27. Controlled Study/

28. control group/

29. clinical trial/ or phase 1 clinical trial/ or phase 2 clinical trial/ or phase 3 clinical
trial/ or phase 4 clinical trial/ or controlled clinical trial/
30. Double Blind Procedure/
31. Single Blind Procedure/ or triple blind procedure/
32. placebo/
33. drug comparison/ or drug dose comparison/
34. "types of study"/
35. random$.tw.
36. (controlled adj5 (trial$ or stud$)).tw.
37. (clinical$ adj5 trial$).tw.
38. ((control or treatment or experiment$ or intervention or surgical) adj5 (group$ or subject$ or patient$)).tw.
39. (quasi-random$ or quasi random$ or pseudo-random$ or pseudo random$).tw.
40. ((singl$ or doubl$ or tripl$ or trebl$) adj5 (blind$ or mask$)).tw.
41. placebo$.tw.
42. controls.tw.
43. or/25-42
44. meta analysis/ or "meta analysis (topic)"/ or "systematic review"/ or "systematic review (topic)"/
45. meta analy$.tw.
46. metaanaly$.tw.
47. (systematic adj (review$1 or overview$1)).tw.
48. literature/
49. (cochrane or embase or psychlit or psyclit or psychinfo or psycinfo or cinahl or cinhal or science citation index or bids or medline or pubmed).ab.
50. (reference list$ or bibliography$ or hand-search$ or relevant journals or manual search).ab.
51. (selection criteria or data extraction).ab.
Appendix 4. Trials register search strategies

1. US National Institutes of Health Ongoing Trials Register (ClinicalTrials.gov)
   'Randomised' AND 'intracerebral haemorrhage'
2. World Health Organization (WHO) International Clinical Trials Registry Platform (ICTRP) (apps.who.int/trialsearch)
   'Intracerebral haemorrhage' OR 'Intracerebral hemorrhage' OR 'ICH'
3. ISRCTN Registry (www.isrctn.com)
   'Intracerebral haemorrhage' OR 'Intracerebral hemorrhage' OR 'ICH'
4. Stroke Trials Registry - the Internet Stroke Center (www.strokecenter.org/trials/)
   'Intracerebral haemorrhage' OR 'Intracerebral hemorrhage' OR 'ICH'

CONTRIBUTIONS OF AUTHORS
All authors, Luke A Perry, Eivind Berge, Joshua Bowditch, Elisabeth Forfang, Ole Morten Rønning, Graeme J Hankey, Elmer Villanueva, Rustam Al-Shahi Salman, contributed to planning, writing, and editing the review.

DECLARATIONS OF INTEREST
Luke A Perry: none known
Eivind Berge: co-ordinating investigator of the ongoing STATICH trial.
Joshua Bowditch: none known
Elisabeth Forfang: managing investigator of the ongoing STATICH trial.
Ole Morten Ronning: none known
Graeme J Hankey: in the past three years, GJH has received honoraria from AC Immune for chairing the data safety monitoring committee of two clinical trials of vaccines for Alzheimer’s disease, from Bayer for lecturing about stroke prevention in atrial fibrillation at sponsored scientific symposia, and from Medscape, Web MD for participating in a discussion about stroke prevention in atrial fibrillation at theheart.org.
Elmer Villanueva: none known
Rustam Al-Shahi Salman: Chief investigator of the UK REstart or STop Antithrombotics Randomised Trial (RESTART, www.RESTARTtrial.org, ISRCTN71907627), which is funded by a special project grant from the British Heart Foundation.
Sources of Support

Internal sources
- No sources of support supplied

External sources
- Medical Research Council, UK.
  Senior clinical fellowship to RA-SS

Differences Between Protocol and Review

We separately grouped RCTs investigating short-term and long-term treatment, instead of performing subgroup analyses as our protocol had specified.

We added two new outcomes: deep vein thrombosis and ICH growth, as we believe that they are of potential interest to consumers of this review. The addition of the outcome deep vein thrombosis allowed us to include it as a secondary outcome in this review without including it in another category (e.g. major ischaemic events). The addition of the ICH growth outcome is relevant to short-term antithrombotic treatment and was considered after we decided to divide our analysis into two groups according to the duration of antithrombotic drug use. The addition of these new outcomes did not result in any additional RCTs being included in this review.

We optimised the ‘Summary of findings’ tables to better reflect the outcomes of interest related to short- and long-term treatment.