Author, year	Type of article: primary study/ post hoc or pooled analysis	Aim or objective	Comparison(s)	Outcomes reported	Reason for non-inclusion of data
Randomised comparisons and supporting analyses					
Pérez-Gómez *et al.*, 2006[45]	Subanalysis of NASPEAF[39]	Subanalysis of high-risk group only according to presence or absence of mitral stenosis	Adjusted-dose acenocoumarol (INR 1.4–2.4) + triflusal (600 mg) vs adjusted-dose acenocoumarol (INR 2.0–3.0)	Same as NASPEAF study[39]	Data reported in the NASPEAF paper[39] includes this subpopulation
Pérez-Gómez *et al.*, 2007[44]	Subanalysis of NASPEAF[39]	Subanalysis of according to presence or absence of previous embolism in younger and older population (<75 years vs >75 years)	Acenocoumarol (any INR) + triflusal (600 mg) vs adjusted-dose acenocoumarol (INR 2.0–3.0)	Same as NASPEAF study[39]	Data reported in the NASPEAF paper[39] includes this subpopulation
Pérez-Gómez *et al.*, 2007[46]	Review of NASPEAF[39]	Difference in event rates for patients with valvular and non-valvular disease	Acenocoumarol (any INR) + triflusal (600 mg) vs adjusted-dose acenocoumarol (INR 2.0–3.0)	Composite of stroke + TE Bleeding (fatal ICH, GI)	Data reported in the NASPEAF paper[39] includes this subpopulation
Gullov *et al.*, 1999[47]	Primary	Analysis of AFASAK II[42]	Fixed-dose warfarin (1.25 mg) + aspirin (300 mg) vs fixed-dose warfarin (1.25 mg) or adjusted-dose warfarin (INR 2.0–3.0)	Same as AFASAK II study[42]	Duplicate data as the original AFASAK II[42] study
Blackshear *et al.*, 1999[49]	Subanalysis SPAF III[43]	Incidence of TEE and stroke rates according to plaque presence	Adjusted-dose warfarin (INR 1.2–1.5) + aspirin (325 mg) vs adjusted dose warfarin (INR 2.0–3.0)	Death, TE, bleeding (major)	No new data reported
Non-randomised comparisons and supporting analyses					
Lopes *et al.*, 2009 [50]	Primary	Difference in 90-day mortality rates between AF (baseline, new onset and discharge)	Warfarin + aspirin + clopidogrel vs warfarin	Stroke: 90-day rate	Follow-up 90 days Dose of warfarin or APT not specified No. of events not reported for either therapy group (outcomes reported as rate % per patient-year, but no information on patient-year data); no. of participants per therapy group (denominator) not clear
Abdelhafiz and Wheeldon, 2008[51]	Primary	Assess risk factors for bleeding during long-term anticoagulation of AF in older people (>75 years) in comparison to young people in clinical practice	Adjusted-dose warfarin (INR 2.0–3.0) + aspirin vs adjusted-dose warfarin (INR 2.0–3.0)	Bleeding (major, minor, major + minor)	Only 8 out of 504 patients on combined therapy Follow-up 19 months Dose of aspirin not specified

Author, year	Type of article: primary study/ post hoc or pooled analysis	Aim or objective	Comparison(s)	Outcomes reported	Reason for non-inclusion of data
Amadeus Investigators, 2008[72]	Primary	Idraparinux was non-inferior to VKA for primary outcomes	Idraparinux or VKA + aspirin or ticlopidine/clopidogrel vs idraparinux/VKA	Bleeding (any)	No. of events not reported for combined therapy group Dose of APT not specified; events not reported separately for idraparinux and VKA in combined therapy arms
Suzuki *et al.*, 2007[56]	Primary	Determine incidence and risk factors of major bleeding related to warfarin therapy in Japanese patients	Adjusted-dose warfarin (INR 1.6–2.6) + aspirin vs adjusted-dose warfarin (INR 1.6–2.6)	Bleeding (ICH, major)	Dose of aspirin not specified; no. of events in either therapy group not reported (outcomes reported as rate % per patient-year)
Burton *et al.*, 2006[57]	Primary	Compare events in warfarin-treated patients with AF in primary care, with RCT data	Adjusted-dose warfarin (INR 2.0–3.0) + aspirin vs adjusted-dose warfarin (INR 2.0–3.0)	Bleeding (any)	Dose of aspirin not specified; very small number of participants on combined therapy (n= 18 approx.), no. of patients in either therapy group not clear
Stenestrand *et al.*, 2005[58]	Primary	Probability of receiving an OAC at discharge according to background characteristics and other treatments	OAC + aspirin vs OAC	Death (1-year mortality)	Name of OAC not reported Dose of aspirin not specified Some patients received combined OAC plus aspirin with or without thienopyridine, but numbers (participants) not clear
SPORTIF V investigators, 2005[65]	Primary	Whether or not ximelagatran was non-inferior to warfarin	Adjusted-dose warfarin (INR 2.0–3.0) + aspirin (100 mg) vs adjusted-dose warfarin (INR 2.0–3.0) ximelagatran 36 mg (b.i.d.) + aspirin (100 mg) vs ximelagatran 36 mg (b.i.d.)	Bleeding: major + minor	No. of patients on individual therapy (denominator) – unclear Only bleeding outcome reported duplicate in another included study[69]
SPORTIF III Investigators, 2003[64]	Primary	Whether or not ximelagatran was non-inferior to warfarin	Adjusted-dose warfarin (INR 2.0–3.0) + aspirin (100 mg) vs adjusted-dose warfarin (INR 2.0–3.0) ximelagatran 36 mg (b.i.d.) + aspirin (100 mg) vs ximelagatran 36 mg (b.i.d.)	Bleeding: major + minor	No. of patients on individual therapy (denominator) – unclear Only bleeding outcome reported duplicate in another included study[69]

Author, year	Type of article: primary study/ post hoc or pooled analysis	Aim or objective	Comparison(s)	Outcomes reported	Reason for non-inclusion of data
White *et al.*, 2007[68]	Pooled analysis SPORTIF III[64] and V[65]	Pooled analysis by anticoagulation (INR) control – only patients on warfarin reported	Adjusted-dose warfarin (INR 2.0–3.0) + aspirin (100 mg) vs adjusted-dose warfarin (INR 2.0–3.0)	Bleeding: major Death: all cause Stroke/SE: combined	No. of events not reported for any outcome; event rate % per patient-year reported with no information on either patient-year data or no. of patients (denominator); information on these outcomes also reported in other publication of same studies[69]
Halperin, 2005[71]	Review of SPORTIF III[64] and SPORTIF V[65]	Thromboembolic risk for patients receiving concomitant aspirin therapy in SPORTIF III[64] and V[65] with data on SPORTIF III[64] only	Adjusted-dose warfarin (INR 2.0–3.0) + aspirin (100 mg) vs adjusted-dose warfarin (INR 2.0–3.0) ximelagatran 36 mg (b.i.d.) + aspirin (100 mg) vs ximelagatran 36 mg (b.i.d.)	Stroke + SE	Data on patients enrolled in SPORTIF III trial[64] alone, also reported in another included publication[69] reporting pooled data for SPORTIF III and V[64,65]
Douketis *et al.*, 2006[70]	Pooled analysis of SPORTIF III[64] and V[65]	Annual incidence of any (major or minor), major, and intracerebral bleeding with ximelagatran and warfarin therapy during the study period, based on the time to first bleeding episode while patients were treated	Adjusted-dose warfarin (INR 2.0–3.0) + aspirin (100 mg) vs adjusted-dose warfarin (INR 2.0–3.0) ximelagatran 36 mg (b.i.d.) + aspirin (100 mg) vs ximelagatran 36 mg (b.i.d.)	Bleeding (major)	No. of events not reported for either therapy group; denominator not reported for combined therapy, outcomes reported as hazard ratios associated with aspirin use
Akins *et al.*, 2007[67]	Pooled analysis of SPORTIF III[64] and SPORTIF V[65]	Comparison of warfarin and ximelagatran for the secondary prevention of stroke	Adjusted-dose warfarin (INR 2.0–3.0) + aspirin (100 mg) vs adjusted-dose warfarin (INR 2.0–3.0) ximelagatran 36 mg (b.i.d.) + aspirin (100 mg) vs ximelagatran 36 mg (b.i.d.)	Bleeding, stroke-ischaemic/ haemorrhagic and SE	No. of bleeds reported only for patients with previous embolism Data in another included study[69] envelopes this patient group
Teitelbaum *et al.*, 2008[66]	Pooled analysis of SPORTIF III[64] and SPORTIF V[65]	On-treatment analysis of SPORTIF studies to evaluate if treatment with warfarin vs ximelagatran was had a differential effect on cardioembolic vs non-cardioembolic stroke	Adjusted-dose warfarin (INR 2.0–3.0) + aspirin (100 mg) vs adjusted-dose warfarin (INR 2.0–3.0) ximelagatran 36 mg (b.i.d.) + aspirin (100 mg) vs ximelagatran 36 mg (b.i.d.)	Bleeding (primary brain haemorrhage) Stroke (all – clinical types: cardioembolic, non-cardioembolic, uncertain)	No. of patients on individual therapy (denominator) – unclear; stroke outcomes reported in another included study[69]

Author, year	Type of article: primary study/ post hoc or pooled analysis	Aim or objective	Comparison(s)	Outcomes reported	Reason for non-inclusion of data
Johnson *et al.*, 2005[59]	Primary	Annual rate of major haemorrhage in previously hospitalised patients on warfarin	Adjusted-dose warfarin (INR 2.0–3.0) + APT vs adjusted-dose warfarin (INR 2.0–3.0)	Bleeding: major	Name of APT not specified; no. of participants not reported for combined therapy group; $n = 228$
Blich and Gross, 2004[61]	Primary	Incidence of thromboembolic and bleeding events in patients with AF	Adjusted-dose warfarin (INR 2.0–3.0) + aspirin (100 mg) vs adjusted-dose warfarin (INR 2.0–3.0)	Bleeding: TE	No. of participants not reported for individual therapy arms, data reported as event rate % per patient-year
Shireman *et al.*, 2004[60]	Primary	Influence of patient-specific factors on concomitant warfarin–antiplatelet therapy and potential impact of combined therapy on bleeding risk	Warfarin + aspirin/clopidogrel/ticlopidine/ dual APT vs warfarin	Bleeding (ICH, major, GI)	Dose of warfarin or APT not specified, outcomes not reported for combination of warfarin with individual APT separately
Klein *et al.*, 2003[62]	Primary	To calculate cumulative major, minor and composite bleeding rates for the 56-day study period	Adjusted-dose warfarin (INR 2.0–3.0)/ heparin + aspirin vs adjusted-dose warfarin (INR 2.0–3.0)	Bleeding (major)	Follow-up 56 days; dose of aspirin not specified; no. of events in combined therapy group not clear; outcomes not reported separately for warfarin + aspirin and heparin + aspirin
Toda *et al.*, 1998[52]	Primary	Relationship between incidence of TE in patients with AF, and (1) underlying disease; (2) type of AF; and (3) antithrombotic therapy	Warfarin + APT vs warfarin	TE	$n = 257$; dose of warfarin or APT not specified; name of APT in combined therapy arm not reported; no. of participants in individual therapy groups not clear
Albers *et al* 1996[53]	Primary	Assess current status of antithrombotic therapy for patients with AF	Adjusted-dose warfarin (INR 2.0–3.0) + aspirin vs adjusted-dose warfarin (INR 2.0–3.0)	Bleeding (per rectum)	$n = 309$, follow-up period not reported; dose of aspirin in combined therapy group not reported; definition of bleeding possibly different in either therapy group

b.i.d., dose administered twice daily; GI, gastrointestinal; OT, on treatment; TEE, transoesophageal echocardiography.