ESOC26

ESOC 2026 — Summary of Large Clinical Trials and Late-Breaking Trials

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1 · PRE-HOSPITAL & SYSTEM OF CARE

STUDY	DESIGN / N	POPULATION	INTERVENTION VS CONTROL	KEY RESULT	PUBLICATION
ASPHALT	RCT · prehospital · ongoing · France · presented (preliminary, invited session)	Acute stroke eligible for recanalisation, prehospital setting	Standard in-hospital workflow vs mobile stroke unit (MSU) workflow (on-board CT to rule out haemorrhage, then IVT started pre-hospital in eligible patients)	**Preliminary results only, presented in an invited session — no full data/abstract available yet** Awaited.	*Pending* NCT05649670 Turc et al.
PRESTO-II	Diagnostic model (individual-patient-data: LPSS + PRESTO) · prehospital · N=3,321 (211 ICH, 6.4%) · Netherlands	Suspected stroke transported by ambulance	Clinical prediction model for prehospital ICH detection (4 variables)	**4-variable model (SBP, prior ICH, diabetes, RACE score): C-statistic 0.82 (95% CI 0.79–0.85)** **RACE ≥5 subgroup C-statistic 0.77 (95% CI 0.75–0.80)** Variable ORs: SBP 1.03, prior ICH 3.47, diabetes 0.47, RACE 1.45. External validation needed.	*Pending* Registry: NL (onderzoekmetmensen 51821) de Ruijter et al.

2 · HYPERACUTE PHASE — INTRAVENOUS THROMBOLYSIS (IVT)

STUDY	DESIGN / N	POPULATION	INTERVENTION VS CONTROL	KEY RESULT	PUBLICATION
TAPIS	RCT · double-blind · N=1,382 · 60 centres · China	Moderate acute ischaemic stroke (NIHSS 4–10) treated with IVT	Ticagrelor + aspirin (DAPT) within 6h of onset + IVT vs placebo + IVT	**mRS 0–1 at 90d: 68.7% vs 62.0% · RR 1.11 (95% CI 1.03–1.20) · p=0.009** **mRS 0–2 at 90d 79.7% vs 74.7% · RR 1.07 (95% CI 1.01–1.13) · p=0.027** **ordinal mRS common OR 1.24 (95% CI 1.02–1.50) · p=0.029** Early DAPT added to IVT improves excellent outcome; no significant increase in sICH.	10.1016/S0140-6736(26)00757-9 Lancet · 2026
INSTANT	RCT · double-blind · N=359 · 50 centres · China	acute ischaemic stroke without LVO/MVO, non-cardioembolic, inadequate response to tenecteplase	IV tirofiban after TNK vs placebo	**mRS 0–1 at 90d: 63.8% vs 52.2% · unadj p=0.03 · adj RR 1.17 (0.98–1.41), adj p=0.08** Promising signal not confirmed after adjustment; sICH <1%. Larger confirmatory trial needed.	10.1001/jama.2026.5245 JAMA · 2026
BEST-BAO	RCT · prospective · N=355 · China	BAO stroke, NIHSS≥6, eligible for IVT + EVT within 4.5h	EVT alone vs alteplase IVT + EVT (bridging)	**mRS 0–2 at 90d: 40.7% vs 41.6% · RR 1.02 (0.80–1.31) · non-inferiority met (intention-to-treat)** Direct EVT non-inferior to bridging for BAO (risk diff 0.90%, −9.34% to 11.13%, margin 15%, p=0.001); superiority not reached (p=0.432). Secondary outcomes similar: mRS 0–3 48.3% vs 49.7% (RR 1.03), successful reperfusion 93.0% vs 93.1% (RR 1.00).	NCT05631847 *Pending* Protocol: 10.1136/svn-2025-004144 Xiang et al.
Lacunar vs non-lacunar IVT	Observational registry (Swiss Stroke Registry) · 22 centres · Switzerland · 2015–2025 · retrospective	Non-LVO acute ischaemic stroke treated with IVT: lacunar vs non-lacunar	Outcome comparison by subtype (primary: 90-day mRS shift)	**Primary (90-day mRS shift): acOR 0.82 (0.71–0.95) · p=0.008 — worse in lacunar.** **mRS 0–1: 53% vs 58% (aOR 0.79, 0.66–0.94)** Lacunar: more disability (mRS 3–5 24% vs 18%, aOR 1.53, 1.25–1.88) but lower mortality (4% vs 8%, aOR 0.52, 0.33–0.81); sICH 1% vs 2% (ns). N not reported (slides show percentages only).	*Pending* Vabanesi et al.

PARENT TRIAL **OPTION** (ISC 2026 · JAMA 2026;335(13):1137–47, 10.1001/jama.2026.0210): IV tenecteplase 0.25 mg/kg 4.5–24 h after onset in non-LVO acute ischaemic stroke with salvageable tissue on perfusion (566 pts, 48 centres, China) improved excellent outcome — mRS 0–1 43.6% vs 34.2% (RR 1.28, 1.04–1.57; p=0.02; NNT 11) — with higher sICH (2.8% vs 0%; p=0.004). The ESOC 2026 DMVO subanalysis below extends this.

STUDY	DESIGN / N	POPULATION	INTERVENTION VS CONTROL	KEY RESULT	PUBLICATION
OPTION (DMVO subanalysis)	Subgroup of OPTION (DMVO) · ESOC 2026 · N=415 (213 vs 202) · China	Distal/medium vessel occlusion (OPTION DMVO definition) with evidence of salvageable tissue (perfusion)	IV tenecteplase 4.5–24 h vs standard care (DMVO)	**mRS 0–1: 43.2% vs 33.7% · adj RR 1.29 (1.02–1.64) · p=0.04** Benefit consistent with the overall trial; also favourable on ordinal mRS (cOR 1.52, p=0.02) and mRS 0–2 (RR 1.17, p=0.04). Significance is sensitive to the DMVO definition: under the stricter ESCAPE-MeVO/DISTAL definition (N=386, excluding 29 cerebellar occlusions) the primary attenuates to p=0.054.	*Pending* Mo et al. · DMVO subanalysis presented at ESOC 2026

3 · HYPERACUTE PHASE — ENDOVASCULAR TREATMENT (EVT)

3A · IMAGING & WORKFLOW

STUDY	DESIGN / N	POPULATION	INTERVENTION VS CONTROL	KEY RESULT	PUBLICATION
DIRECT ANGIO	RCT · N=115 (57 vs 58) · 10 centres · France · stopped early (safety)	Deficit suggestive of LVO (NIHSS ≥5 with ≥1 cortical sign) admitted <5h to an EVT-capable centre	Direct transfer to angiography suite (DTAS) vs conventional pathway (imaging first)	**Stopped early for safety; no functional benefit despite faster workflow** mRS 0–2 at 90d 36% vs 42% · aOR 0.73 (0.32–1.69) — NS; mortality 18% vs 11% (NS); workflow faster (−38 min admission-to-puncture, −37 min onset-to-reperfusion). Higher symptomatic ICH (15% vs 0%, small numbers) prompted early stopping.	10.1016/S1474-4422(26)00056-6 Lancet Neurol 2026;25:346–56
SPINNERS	Multicentre non-inferiority study · N=252 · 13 centres · International	Suspected stroke requiring ICH exclusion before reperfusion	Flat-detector CT (DynaCT Sine Spin) vs standard multidetector CT for ICH detection	**Overall non-inferiority not met: sensitivity 92.6% (88.9–95.7), specificity 92.3% (90.8–96.1)** Best subgroup NIHSS≥10: sensitivity 96.3% (93.6–98.8), specificity 93.2% (89.6–96.1) — favourable point estimates, but CI lower bounds still cross 95% (not formal non-inferiority). Sensitivity and specificity varied with centre experience and image quality (both >95% in experienced centres; per-centre data not reported). Potential role in one-stop / direct-to-angio workflows in selected patients.	*Pending* NCT05458908 Psychogios et al.

3B · EXPANDING THE EVT INDICATION

STUDY	DESIGN / N	POPULATION	INTERVENTION VS CONTROL	KEY RESULT	PUBLICATION
LARGE CORE · LATE WINDOW · MILD STROKE					
ATLAS	Individual-patient-data meta-analysis · 6 RCTs · N=1,886	Large ischaemic core LVO stroke (ASPECTS ≤5 or core ≥50 mL) within 24h	EVT vs best medical care	**aGenOR 1.63 (1.42–1.88) · p<0.0001 · NNT 4.2 (3.3–5.8) (≥1-pt mRS)** Benefit across the full large-core spectrum, maintained in ASPECTS 0–2 and core volumes up to 150 mL; no effect modification by age, severity, occlusion site or perfusion mismatch. **Mortality reduced 31.1% vs 37.3% (aRR 0.82, 0.70–0.97; p=0.022), with no significant increase in symptomatic ICH (1.1% vs 1.0%)** or early neurological deterioration.	10.1016/S0140-6736(26)00876-7 Lancet · 2026
LATE-MT	RCT · N=336 · China · 24–72h window	LVO stroke, NIHSS≥6, perfusion-selected (core <50 mL, mismatch ratio ≥1.8, vol ≥15 mL), ASPECTS median 8, 24–72h from onset	EVT vs standard medical care in the extended 24–72h window	**Primary (90-day mRS shift): acOR 0.47 (0.32–0.70), favouring thrombectomy (OR<1 = benefit)** Recanalisation at 48h 82.4% vs 18.0%. But safety worse: mortality 6.0% vs 1.8% (ns), any ICH 28.3% vs 5.5%, sICH 4.8% vs 0%, serious adverse event 22% vs 13.1% — more selective targeting needed in the very late window.	*Pending* NCT05326932 Liu et al.
MILD-MT	RCT · N=300 · 26 centres · China	Mild anterior LVO stroke (NIHSS<6, median 4), ASPECTS≥6, perfusion mismatch ≥50 mL, within 24h; **58% intracranial atherosclerosis**	EVT + best medical treatment (BMT) vs BMT alone	**mRS 0–1 at 90d: 69.4% vs 50.0% · RR 1.39 (1.14–1.70)** mRS 0–2 82.6% vs 66.0% (RR 1.28, 1.11–1.48); early neurological deterioration at 7d 13.9% vs 31.4% (RR 0.48, 0.29–0.78); any ICH 18.9% vs 6.8%, sICH 2.1% vs 1.9% (ns), 1 death. Perfusion-based selection (mismatch ≥50 mL) validated.	*Pending* Protocol: 10.1136/svn-2025-004832 NCT06464731 Chen et al. · ESOC LB73
MEDIUM & DISTAL VESSEL OCCLUSIONS (MEVO / DMVO)					

STUDY	DESIGN / N	POPULATION	INTERVENTION VS CONTROL	KEY RESULT	PUBLICATION
DISTAL (1y)	RCT · N=543 (271 vs 272) · 55 centres · International · 1-year follow-up	MeVO/DMVO within 12h · M2 44% + M3 27% (~71% MCA-branch), P2 13%, P1 6% · median NIHSS 6 · 65% IVT	EVT + BMT vs BMT alone (1-year outcomes)	**mRS 0–1 at 1 year: 39% vs 40% · OR 0.90 (0.60–1.36)** **mRS 0–2 at 1 year: 55% vs 57% · OR 0.91 (0.60–1.37)** **Ordinal mRS at 1 year: acOR 0.81 (0.59–1.12) · p=0.20 — no difference** 1-year all-cause mortality 20% vs 16% (HR 1.46, 0.93–2.30; p=0.10) — numerically higher with EVT, not significant. Consistent with the 90-day results; routine EVT not supported for mild–moderate MeVO/DMVO.	10.1016/S1474-4422(26)00169-9 Lancet Neurol · 2026
ESCAPE-MeVO (1y)	RCT secondary · 530 enrolled / 506 at 1y · International · 1-year follow-up	MeVO stroke (M2/M3, A1–A3, P1–P3) · ~85% MCA-branch occlusions	EVT + BMT vs BMT alone (1-year outcomes)	**mRS 0–1 at 1 year: 44% vs 48% · adjRR 0.90 (0.75–1.07)** **mRS 0–2 at 1 year: 59% vs 62% · adjRR 0.93 (0.82–1.07)** **Ordinal mRS at 1 year: NS — no difference** 1-year all-cause mortality significantly higher with EVT: 20% vs 12% (adjHR 1.99, 1.26–3.15) — safety concern for routine MeVO EVT.	*Pending* Abstract: 10.1093/esj/aakag023.1127 Ospel et al. · Eur Stroke J 2026;11(S1):i634
DISTALS	RCT · device (Tigertriever 13) · N=118 · International	Primary distal/medium vessel occlusion with disabling deficits, <24h, IVT-ineligible	Tigertriever 13 stent-retriever + medical management vs medical management	**Reperfusion (mTICI ≥2b) at 24h without sICH: 86.3% vs 27.7% · p<0.001** **0% sICH (primary, ISC 2026)** Positive proof-of-concept for a distal-specific adjustable device. ESOC 2026 90-day data (manufacturer press release, no p/CI reported): mRS 0–1 41.2% vs 38.2%. Not powered to demonstrate functional benefit.	NCT05152524 *Pending* Saver et al.
TANDEM LESIONS & CAROTID STENTING					
CASES	Non-inferiority RCT · PROBE · 633 recruited / 597 analysed (297 vs 300) · 26 centres · Netherlands + Belgium · mean age 72	Tandem lesion acute ischaemic stroke (ICA stenosis/occlusion + intracranial LVO) · median NIHSS 14	Immediate carotid stenting (CAS) during EVT vs deferred treatment	**non-inferiority not met in full-analysis set (acOR 1.06, 0.79–1.43; non-inferiority margin 0.8)** **met in per-protocol (acOR 1.10, 0.81–1.5)** sICH 2.1% vs 3.8% (OR 0.55, 0.29–1.4), mortality 21% vs 25% (acOR 0.79, 0.54–1.14) — immediate CAS during thrombectomy appears safe.	*Pending* Protocol: 10.1177/23969873251319941 Uyttenboogaart et al.

STUDY	DESIGN / N	POPULATION	INTERVENTION VS CONTROL	KEY RESULT	PUBLICATION
ATILA	RCT · N=240 (aspirin 121 vs tirofiban 119) · 13 centres · Spain	Tandem-lesion acute ischaemic stroke with carotid stenting during EVT (in-stent reocclusion risk)	Low-dose IV tirofiban (500 µg bolus + 200 µg/h × 20±2 h) vs IV aspirin (500 mg single dose)	**In-stent reocclusion at 24h: tirofiban 7.2% vs 16.8% · aOR 0.345 (95% CI 0.135–0.815) · p=0.015 · NNT 10.4** Clinical outcome numerically worse with tirofiban (mRS 0–2 at 90d 59.6% vs 70.8%), the trial was not powered for clinical outcomes and the difference was not significant (p=0.111; mRS shift aOR 1.49, 95% CI 0.9–2.49). sICH at 24h tirofiban 7.9% vs aspirin 3.6% (aOR 2.20, 95% CI 0.72–7.82; p=0.171), also non-significant.	NCT05225961 *Pending* Protocol: 10.1177/23969873221146383 Zapata-Arriaza et al.

3C · PHARMACOLOGICAL ADJUNCTS TO REPERFUSION

STUDY	DESIGN / N	POPULATION	INTERVENTION VS CONTROL	KEY RESULT	PUBLICATION
EXTEND-IA DNase	Umbrella Bayesian optimal phase 2 · dose-finding · N=330 (233 TNK, 97 alteplase) · 17 centres · Australia	LVO ischaemic stroke, ≤4.5h, on standard IV thrombolysis + EVT; median NIHSS 16	Adjuvant IV dornase alfa (DNase1) 0.125–1 mg/kg; single-arm vs objective performance criterion (20% substantial reperfusion pre-EVT without sICH, EXTEND-IA TNK)	**Did not meet the pre-specified promise-of-efficacy criterion (primary negative). Dose-dependent reperfusion signal: day-90 mRS 0–1 41% overall vs 50% benchmark, but 52% at 1 mg/kg** Safety excellent — sICH 1.3% overall, 0% at 1 mg/kg — though 2 anaphylaxis serious adverse events. Bayesian optimal phase 2 eliminated non-promising doses; further investigation of DNase1 warranted.	10.1093/esj/aakag023.1851 Eur Stroke J 2026;11(S1):i986 Campbell et al. · Pending
TECNO	RCT · PROBE · N=156 · 20 centres · Europe	Incomplete reperfusion (TICI 2a/2c, residual occlusions) after MT	IA tenecteplase 3 mg + BMT vs BMT alone, post-EVT	**Co-primary reperfusion negative: early 39% vs 36% (adj RD 3.4%, p=0.68), late 51% vs 40% (adj RD 15.4%, p=0.069)** Safe on sICH (5.2% vs 8.6%), but a non-significant trend toward worse outcomes: mRS 0–2 28% vs 38% (acOR 0.60, 95% CI 0.34–1.06), mortality adj RD +13.2% (95% CI −0.5 to 27.0%). Powered for reperfusion, not clinical outcomes; does not support routine IA TNK.	Protocol: 10.1093/esj/23969873251381974 NCT05499832 Kaesmacher et al. · Pending

STUDY	DESIGN / N	POPULATION	INTERVENTION VS CONTROL	KEY RESULT	PUBLICATION
ATTRACTION	RCT · N=1,380 (689 vs 691) · 82 centres · China	Anterior LVO stroke after successful recanalisation (mTICI 2b/3)	IV tirofiban after successful EVT vs standard care	**Functional independence (mRS 0–2) at 90d: 49.3% vs 43.3% · adj RR 1.15 (1.03–1.27) · p=0.0092** IV tirofiban after successful EVT. sICH numerically higher but not significant (11.9% vs 9.4%; RR 1.24, p=0.17); 90-day mortality similar (18.3% vs 19.0%, HR 0.96). China-only — external validation warranted.	10.1016/S0140-6736(26)00983-9 Lancet 2026 Luo et al.
GREEN	Phase 2/3 RCT · double-blind · N=102 (glenzocimab 50 vs placebo 52) · France · stopped early (futility); final 90-day analysis, futility on interim of 78	LVO stroke, 0–24h, clinico-radiological mismatch (ASPECTS) or perfusion (DEFUSE-3 criteria), EVT-eligible	IV glenzocimab (anti-GPVI mAb fragment) adjunct to EVT vs placebo	**Stopped early for futility. mRS ordinal shift cOR 0.58 (95% CI 0.28–1.19) p=0.14 — trend toward harm** Trend toward harm driven by excess mortality 17% vs 8% and more total ICH (28% vs 17%), despite lower sICH (2% vs 4%); mRS 0–2 numerically lower with glenzocimab. The mortality signal was unexpected and unexplained; does not support glenzocimab as an adjunct to thrombectomy.	*Pending (results)* Protocol: 10.1136/jnis-2025-023606 Mazighi et al.
GALLOP-2	Phase 3 RCT · PROBE · N=388 (semaglutide 193 vs control 195; both arms received EVT) · 19 centres · China · preprint	Anterior LVO (terminal ICA/M1/dominant M2), NIHSS ≥6, no IVT; <6h with ASPECTS≥6, or 6–24h perfusion mismatch-selected	SC semaglutide 0.5 mg pre-EVT + 0.5 mg at day 7 vs EVT alone	**Positive primary — 90-day mRS shift cOR 1.46 (95% CI 1.03–2.09) p=0.035, driven by mRS 0–1 40.9% vs 25.6% (RR 1.60)** Attenuates after adjustment (adj cOR 1.34, 95% CI 0.95–1.95, ns). Safety: sICH numerically higher 10.9% vs 5.7% (RR 1.92, 95% CI 0.97–4.03); death 18.1% vs 14.9% (ns). First phase-3 GLP-1 receptor agonist cytoprotection signal in EVT.	*Preprint · Pending peer review* NCT06788626 Wang et al.

3D · ADJUNCT NEUROPROTECTION — INTRA-ARTERIAL HYPOTHERMIA

STUDY	DESIGN / N	POPULATION	INTERVENTION VS CONTROL	KEY RESULT	PUBLICATION
CHILL-ART	RCT · open-label · N=262 · 26 centres · China	Anterior LVO stroke, age 18–85, treated within 24h	IA selective hypothermia (cold saline infusion) during EVT vs EVT + room-temperature saline (22–25°C)	**mRS 0–1 at 90d: 38.3% vs 26.3% · aRR 1.44 (1.01–2.06)** **mRS 0–2 at 90d: 54.7% vs 39.8% · aRR 1.36 (1.05–1.76)** **Ordinal mRS shift: acOR 1.72 (1.12–2.65) — favours hypothermia** 90-day mortality 13.3% vs 18.0% (aRR 0.74, 0.42–1.30), NS. any-ICH 21.7% vs 29.3% (aRR 0.74, 0.49–1.12), NS; sICH 7.0% vs 9.0% (aRR 0.77, 0.34–1.75), NS. No significant excess of adverse events with hypothermia.	*Pending* Huang et al. Protocol: 10.1161/SVIN.125.002058
SI-AC (FOCUS)	RCT · subject/assessor-blind · N=258 · 12 centres · China	Anterior LVO stroke, NIHSS 6–25, thrombectomy within 24h	Selective intra-arterial cooling (SI-AC, cold saline) during EVT vs EVT + best medical management (no sham)	**mRS 0–2 at 90d: 50.8% vs 46.9% · adjRR 1.07 (0.84–1.37; p=0.57)** **Ordinal mRS shift: acOR 1.16 (0.75–1.79; p=0.51) — no difference** 90-day mortality 12.2% vs 13.3%, NS. any-ICH at 24h 26.9% vs 45.3% (adj risk difference −0.174, −0.288 to −0.059; p=0.003) — significantly lower with cooling; sICH 3.1% vs 6.2%, NS.	*Pending* NCT06485427 Li et al.

3E · PERI-PROCEDURAL HEMODYNAMIC MANAGEMENT

STUDY	DESIGN / N	POPULATION	INTERVENTION VS CONTROL	KEY RESULT	PUBLICATION
MASTERSTROKE	RCT · double-blind · N=562 (170 mmHg n=282 vs 140 mmHg n=280) · Australia + New Zealand	Anterior LVO stroke undergoing EVT under general anaesthesia (median NIHSS 15)	Intra-procedural systolic BP target 170±10 vs 140±10 mmHg	**Day-90 mRS shift: no difference — median mRS 2 both groups (p=0.49).** **mRS 0–2 51.2% (SBP 170) vs 54.7% (SBP 140) (OR 0.87, 95% CI 0.62–1.21)** sICH 2.1% vs 2.1% (OR 0.99, 95% CI 0.32–3.12); mortality 15.2% (SBP 170) vs 12.1% (SBP 140) (OR 1.30, 95% CI 0.80–2.10, p=0.23). Class-1 evidence: no signal of benefit or harm across the 140–180 mmHg intra-procedural SBP range.	*Pending* ACTRN12619001274167 Campbell et al.

STUDY	DESIGN / N	POPULATION	INTERVENTION VS CONTROL	KEY RESULT	PUBLICATION
HOPE	RCT · N=440 (215 vs 225) · 11 centres · Spain	acute ischaemic stroke after successful EVT (complete/near-complete recanalisation)	Post-EVT BP target tailored to final mTICI (2b→140–160; 2c–3→100–140) vs guideline care	**mRS 0–2 at 90d: 60.0% vs 46.7% · aOR 1.71 (1.11–2.63) · p=0.02 · ARD 13.3%** any-ICH 22.3% vs 31.6% (OR 0.62, 0.41–0.95) — significantly lower with treatment; sICH 3.5% vs 3.9%, NS; 90-day mortality 15.4% vs 15.6%, NS. First RCT to stratify post-thrombectomy BP targets by reperfusion grade; consistent across subgroups.	JAMA Neurol 2026 · 10.1001/jamaneurol.2026.1706 NCT04892511

4 · INTRACEREBRAL HAEMORRHAGE (ICH)

STUDY	DESIGN / N	POPULATION	INTERVENTION VS CONTROL	KEY RESULT	PUBLICATION
PARENT TRIAL **TRIDENT** (WSC 2025 · NEJM 23 Apr 2026, 10.1056/NEJMoa2515043): triple low-dose pill (telmisartan 20 + amlodipine 2.5 + indapamide 1.25) reduced recurrent stroke ~39% (4.6% vs 7.4%; HR 0.61; p=0.02) with better BP control. The ESOC 2026 substudy and pooled analysis below extend this.					
TRIDENT — cognitive substudy	Secondary cognitive & imaging substudy of TRIDENT · ESOC 2026 · International	ICH survivors (TRIDENT participants)	Triple Pill (telmisartan 20 / indapamide 1.25 / amlodipine 2.5 mg) vs placebo	**Over mean 3-year follow-up, no significant difference vs placebo in cognitive outcomes or in MRI markers of cerebral small vessel disease** Longer follow-up or larger dedicated studies may be needed.	*Pending* Anderson et al. · Design (Brazilian sub-cohort): Alzheimer's Dement 2024;20(S3):e088874 · NCT03785067
TRIDENT — pooled analysis	Individual-patient-data meta-analysis of 4 RCTs · ESOC 2026 · N=2,944 (1,487 treatment vs 1,457 control)	ICH survivors — BP-lowering for secondary prevention	Intensive BP lowering vs control (pooled)	**First recurrent stroke HR 0.62 (95% CI 0.48–0.80) p=0.00021 (~40% reduction)** **recurrent ICH HR 0.39 (95% CI 0.26–0.59) p<0.001** **major adverse cardiovascular events HR 0.67 (95% CI 0.54–0.84) p=0.00045** TRIDENT directionally consistent with the pooled estimate.	*Pending* Wang et al.
PARENT TRIAL **ANNEXA-I** (WSC 2023 · NEJM 2024, 10.1056/NEJMoa2313040; NCT03661528): in factor-Xa-inhibitor–associated ICH, andexanet alfa gave better haemostatic control than usual care (haematoma expansion controlled 67% vs 53%) but with more thrombotic events (10.3% vs 5.6%). International, 530 patients from >20 countries. The ESOC 2026 blood-pressure sub-analysis below extends this.					

STUDY	DESIGN / N	POPULATION	INTERVENTION VS CONTROL	KEY RESULT	PUBLICATION
ANNEXA-I (BP sub)	Secondary analysis of ANNEXA-I · ESOC 2026 · N=530 · International	factor Xa inhibitor–associated ICH (ANNEXA-I participants)	Andexanet alfa vs usual care — effect modification by baseline & post-randomisation BP	**No treatment interaction between baseline SBP or DBP and effective haemostasis (primary) or any pre-specified secondary endpoint — andexanet effect not modified by baseline BP** Hematoma expansion associated with higher baseline DBP (88.1 vs 83.1 mmHg, p=0.004). Baseline mean SBP 158.5 (SD 26.4), DBP 84.6 (SD 18.1) mmHg. Post-randomisation BP analyses ongoing.	*Pending* Tsivgoulis et al.

5 · SECONDARY PREVENTION

STUDY	DESIGN / N	POPULATION	INTERVENTION VS CONTROL	KEY RESULT	PUBLICATION
PARENT TRIAL **OCEANIC-STROKE** (ISC 2026 · NEJM 15 Apr 2026, 10.1056/NEJMoa2513880): asundexian 50 mg (oral factor XIa inhibitor) added to antiplatelets reduced recurrent ischaemic stroke 6.2% vs 8.4% (csHR 0.74, 0.65–0.84; p<0.001) with no increase in ISTH major bleeding. The ESOC 2026 sub-analyses below extend this.					
OCEANIC-STROKE LB157	OCEANIC-STROKE sub-analysis · ESOC 2026 · N=12,327 · International	Substudy topic: severity, acute treatment and outcomes of the incident (breakthrough) ischaemic strokes that still occurred · Non-cardioembolic ischaemic stroke or high-risk TIA ≤72h	Asundexian 50 mg od + antiplatelet vs placebo	**Fewer incident ischaemic strokes with asundexian 6.2% vs 8.4%; NIHSS ≥8 less likely 22.9% vs 30.3% (p=0.045); disabling stroke reduced csHR 0.69 (95% CI 0.55–0.87)** Of incident ischaemic strokes, 13.5% received IVT/EVT (asundexian 10.4% vs placebo 15.8%), EVT less likely csHR 0.61 (95% CI 0.38–0.99); haemorrhagic transformation similar 0.3% vs 0.3% (csHR 0.96, 95% CI 0.52–1.76); 90-day mRS after acute treatment similar.	*Pending* Sharma et al.
OCEANIC-STROKE LB158	OCEANIC-STROKE sub-analysis · ESOC 2026 · N=12,327 · International	Substudy topic: net clinical benefit and time-course of benefit (efficacy vs bleeding over time) · Non-cardioembolic ischaemic stroke or high-risk TIA ≤72h	Asundexian 50 mg od + antiplatelet vs placebo	**Composite ischaemic stroke or ISTH major bleeding 7.0% vs 8.6%, csHR 0.82 (95% CI 0.72–0.93)** **CV death/all stroke/MI/major bleeding 8.5% vs 10.0%, csHR 0.85 (95% CI 0.76–0.96)** **all-cause mortality/disabling stroke/fatal bleeding/ sICH 3.1% vs 3.8%, csHR 0.81 (95% CI 0.67–0.99)** Benefit consistent over time (initial ischaemic stroke csHR 0.84, 95% CI 0.69–1.02, decreasing). Net benefit favours asundexian.	*Pending* Sharma et al.

STUDY	DESIGN / N	POPULATION	INTERVENTION VS CONTROL	KEY RESULT	PUBLICATION
CRAFT	RCT · open-label · blinded outcome · N=1,676 (of 2,109 run-in) · 157 centres · China + Japan	High-risk AF (≥65y or prior stroke/TIA/embolism/ diabetes/coronary/PAD/ CKD), SBP 140–179 mmHg on ≤3 drugs	Intensive (home SBP <120) vs standard (home SBP <135) BP control	**Primary hierarchical composite (CV death, stroke, MI, HF hospitalisation): win ratio 1.02 (95% CI 0.90–1.15) over ~4 years — no difference between intensive and standard BP control** Achieved between-group SBP difference 8 mmHg (121 vs 129 mmHg). Treatment effect heterogeneous across subgroups (intensive appeared beneficial in men, age <75, and those on OAC).	*Pending* NCT04347330 Anderson et al.
PATHSTROKE	RCT · open-label · blinded endpoint · N=1,224 (611 guided vs 613 standard) · 26 centres · China	First-ever non-cardiogenic ischaemic stroke, 1–3 months, on aspirin	Platelet-function-testing-guided antiplatelet switching (switch if high on-treatment platelet reactivity, maximal aggregation ≥35%) vs standard aspirin	**Primary — high on-treatment platelet reactivity at 30±5 days: 15.2% vs 21.0% · adj RR 0.72 (95% CI 0.57–0.92) · p=0.008** Primary is a surrogate (biomarker) endpoint — the same high on-treatment platelet reactivity measure that triggered the switch; the clinical endpoint (major ischaemic events) was a 180-day secondary. Major bleeding 0.8% vs 0.7% (p=0.778); serious adverse events not increased (p=0.132).	*Pending* Preprint: rs-10150945 Yang et al.
ASA + Cil/ GBE	RCT · double-blind · active-controlled · N=444 (of 475 screened) · 18 centres · Korea · exploratory analysis	Non-cardioembolic acute ischaemic stroke ≤72h	Cilostazol 200 mg + Ginkgo biloba extract 160 mg + aspirin vs clopidogrel 75 mg + aspirin (both DAPT × 90 days)	**Primary composite (in-hospital neurological deterioration or recurrent stroke ≤90d): 7.8% vs 3.5% · HR 2.28 (95% CI 0.98–5.28) · p=0.055 — no difference** In-hospital neurological deterioration higher with cilostazol/Ginkgo biloba extract: 5.5% vs 0.9%, HR 6.35 (95% CI 1.42–28.35) p=0.016. Recurrent ischaemic stroke 2.8% vs 2.2% and mRS 0–2 at 90d 90.5% vs 90.2% — no difference.	*Pending* NCT05445895 (RENEW) Yang et al.
SAFFO	RCT · PROBE · N=317 (mean age 71.2, 25.6% women) · Italy (multicentre)	First-ever atherothrombotic (large-artery) or lacunar (small-vessel) ischaemic stroke, ≥60y, no prior AF	Implantable loop recorder (ILR) + standard care vs standard care alone	**AF detection at 12 months (primary): 13.3% vs 3.5% · HR 4.27 (95% CI 1.59–11.51) · p=0.002** **at 36 months 22.2% vs 8.2% (p=0.0006)** Most AF asymptomatic/paroxysmal; 30-day monitoring would miss most episodes. Anticoagulation initiated more often with ILR; recurrent stroke no difference.	*Pending* NCT02684825 Lorenzano et al.

STUDY	DESIGN / N	POPULATION	INTERVENTION VS CONTROL	KEY RESULT	PUBLICATION
ODEA-TIA	RCT (1:1:1) · N=516 enrolled (504 monitored; 158 ICM / 176 Holter / 170 patch), mean age 69 · ~27 centres · Europe	TIA patients without known AF, enrolled ≤30d of index TIA	Implantable cardiac monitor (ICM, REVEAL-LINQ) vs 24h Holter-ECG vs 28d non-invasive ECG	**AF detection at 6 months (primary): ICM superior — 14.6% (ICM) vs 3.4% (24h) vs 3.5% (28d) [interim 15.6% vs 1.5% vs 1.4%]** First RCT on AF detection specifically in TIA; ICM superior to both short-term and prolonged non-invasive ECG. Clinical-endpoint impact to be presented.	*Pending* Protocol: 10.1055/a-2833-7974 Veltkamp et al.
TAILSWITCH	Prospective comparative (feasibility) · DOAC-dosage n=114 vs standard of care n=502 · 9 centres · Italy	AF patients with breakthrough ischaemic stroke (within 1 month) restarting anticoagulation · mRS ≤4 · no warfarin indication	Tailored DOAC choice by plasma trough levels (switch if out of therapeutic window) vs standard (DOAC without monitoring)	**major adverse cardiovascular events at 1y (Kaplan–Meier): 9.6% (DOAC-dosage) vs 13.7% (standard) · adj HR 0.64 (95% CI 0.34–1.23) · p=0.181** Numerically fewer cardioembolic recurrences (1.8% vs 4.8%) and recurrent strokes (4.4% vs 6.2%); major bleeding 1.8% both. 20.2% of DOAC-dosage patients needed a DOAC switch for subtherapeutic levels; no increase in length of stay. Non-randomised feasibility study.	*Pending* Abstract: 10.1093/esj/aakag023.1883 Romoli et al. · feasibility study
SLAAO	Observational · N=694 patients / 895 CTs · Canada	Segmental LAA opacification (SLAAO) on CT across AF and stroke phenotypes. Principal hypothesis: SLAAO is a radiological biomarker of LAA dysfunction — type 1 (hypoattenuation) or type 2 (hyperattenuation) — identifying a dysfunctional appendage independently of thrombus.	Three analyses: one case-control (breakthrough stroke vs anticoagulated AF without stroke) + two cross-sectional (by AF phenotype; embolic stroke of undetermined source vs known AF).	**All three pre-specified hypotheses significant after correction — SLAAO tracks LAA dysfunction across phenotypes.** Breakthrough stroke vs anticoagulated AF without stroke: OR 3.71, p=0.0043. Steep gradient across AF phenotypes: known AF > ECG-detected AF > AF detected after stroke. Known AF vs embolic stroke of undetermined source: OR 0.048 (case-control, n=195) / 0.043 (multiple imputation, n=283), p<0.0001. SLAAO is rare in anticoagulated AF without stroke.	*Pending* Sposato et al.
EXCOA-CVT	Cluster-RCT · N=448 · 43 centres · International · 24-month follow-up	Cerebral venous thrombosis survivors, <1 month from diagnosis (anticoagulation duration)	3–6 months vs 12 months of anticoagulation after CVT	**No additional benefit from prolonging anticoagulation beyond 3–6 months at 24 months** Consistent with the 12-month results; supports an individualised anticoagulation duration after CVT.	*Pending* Protocol: 10.1177/17474930187778137 Aguiar de Sousa et al.

6 · REHABILITATION & POST-STROKE CARE

STUDY	DESIGN / N	POPULATION	INTERVENTION VS CONTROL	KEY RESULT	PUBLICATION
AVERT-DOSE	Multiarm phase 3 adaptive RCT · N≈1,000 (not confirmed in source) · 50 centres · International · stopped early (funding)	Mild–moderate acute ischaemic stroke within 48h of onset	Higher-dose early-mobility regimens vs 1 × 10 min/day (lowest-dose reference arm), initiated <48h	**mRS 0–2 at 90 days: no differences between higher and lower dose regimens** In moderate stroke, a clinically meaningful benefit. Regimens are safe and can be easily delivered. Stopped early (funding); largest dose-ranging dataset on early mobilisation.	*Pending* ACTRN12619000557134 Bernhardt et al.
COMMITS	RCT · 3-arm · N=1,246 · 18 centres · UK	Mild acute ischaemic stroke, within 12 weeks of onset	Motivational-Interviewing-Based Intervention (MIBI) + usual care vs attention control vs usual care	**Small but consistent reduction in depressive symptoms at 3 months with MIBI vs usual care** No significant functional, QoL, or economic benefit; predominantly mild population. Scalable remote delivery.	*Pending* Lightbody et al.

Abbreviations: aGenOR = adjusted generalised odds ratio · aOR/acOR = adjusted (common) odds ratio · ARD = absolute risk difference · ASPECTS = Alberta Stroke Program Early CT Score · BAO = basilar artery occlusion · BMT = best medical treatment · BP = blood pressure · CAS = carotid artery stenting · CI = confidence interval · csHR = cause-specific hazard ratio · CSVD = cerebral small vessel disease · CT = computed tomography · CTA = CT angiography · CVT = cerebral venous thrombosis · DAPT = dual antiplatelet therapy · DMVO/MeVO = distal/medium vessel occlusion · DOAC = direct oral anticoagulant · DTAS = direct transfer to angiography suite · EVT = endovascular thrombectomy · HR = hazard ratio · ICH = intracerebral haemorrhage · ICM = insertable cardiac monitor · ILR = implantable loop recorder · IVT = intravenous thrombolysis · LAA = left atrial appendage · LVO = large vessel occlusion · mRS = modified Rankin Scale · mTICI = modified Thrombolysis In Cerebral Infarction · MSU = mobile stroke unit · NETs = neutrophil extracellular traps · NIHSS = National Institutes of Health Stroke Scale · NNT = number needed to treat · OAC = oral anticoagulant · OR = odds ratio · RR = risk ratio · SBP/DBP = systolic/diastolic blood pressure · sICH = symptomatic intracranial haemorrhage · SLAAO = segmental LAA opacification · TNK = tenecteplase.

Notes & sources: ESOC 2026 press releases and ESO session reports (6–8 May 2026), presenter slides, and peer-reviewed papers (TAPIS: *Lancet* 2026; INSTANT: *JAMA* 2026; ATLAS individual-patient-data & DISTAL: *Lancet / Lancet Neurol* 2026; DIRECT ANGIO: *Lancet Neurol* 2026). Parent trials shown for context — **OCEANIC-STROKE** (ISC 2026; *NEJM* 2026) and **TRIDENT** (WSC 2025; *NEJM* 2026) — were not first presented at ESOC 2026; only their sub-analyses were. **DISTALS** primary endpoint was first presented at ISC 2026 (90-day data at ESOC 2026). Publication status verified as of **27 June 2026**; "Pending" entries were presented at ESOC 2026 with no full paper available at that date.