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Triflusal

A Viewpoint by Wilbert S. Aronow

Mount Sinai School of Medicine, New York, New York, USA

Randomised trials involving 19 791 patients have demonstrated that aspirin and other antiplatelet drugs, when administered to patients after myocardial infarction (MI), reduced the incidence of recurrent MI, stroke or vascular death by 25% during a 27-month follow-up period.[1] The benefit of aspirin in reducing MI, stroke or vascular death in patients after MI was not related to age, sex, blood pressure or the presence of diabetes mellitus. This commentary discusses some of the clinical trials comparing the platelet antiaggregant triflusal with aspirin or placebo that are discussed in the paper by McNeely and Goa.[2]

In a study of 281 patients with unstable angina pectoris, triflusal compared with placebo reduced the incidence of nonfatal MI but did not reduce cardiac or vascular mortality when administered for 6 months. In 217 patients with atherothrombotic stroke, the cumulative event rate for stroke, ischaemic cardiomyopathy and vascular death was lower (not significant) in patients treated with triflusal than with aspirin. In a retrospective study of 197 patients who underwent percutaneous transluminal coronary angioplasty, the number of postoperative complications (acute MI, death or emergency surgery) was similar in patients treated with triflusal or aspirin but lower in these groups than in patients who did not receive antiplatelet therapy.

Further long term studies comparing triflusal and aspirin that involve larger patient numbers and include elderly patients and women with coronary artery disease, atherothrombotic brain infarction, transient cerebral ischemic attack, extracranial carotid arterial disease and peripheral arterial disease are required before we can accurately determine the place of triflusal in the therapy of vascular disease. Currently, unless the patient is unable to tolerate aspirin or is at high risk of bleeding, the author considers aspirin to be the initial antiplatelet drug of choice.

References

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