

risk stratification factors are being incorporated into clinical practice and affecting the incidence of PML.

P-RH, NC, and IC are employees of and hold stock or stock options, or both, in Biogen.

\**Pei-Ran Ho, Nolan Campbell, Ih Chang peiran.ho@biogen.com*

Biogen, Cambridge, MA 02142, USA

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## Optimal stroke prevention in patients with PFO

We read with interest Bernhard Meier's Comment<sup>1</sup> on the Article by Scott E Kasner and colleagues,<sup>2</sup> suggesting that current recommendations on the treatment of patients with stroke patients and patent foramen ovale (PFO) should be reconsidered. Meier states that "in patients with a stroke and PFO as the presumed cause, PFO closure with a device should be considered first, oral anticoagulation (eg, with rivaroxaban) second (due to the accumulating bleeding risk), and aspirin should not be considered at all".<sup>1</sup>

As members of the editorial committee of the Italian National Guidelines on Stroke, in December 2018, we summarised the available evidence for PFO closure compared with medical treatment, that shows the very low risk of events in the medical group that included patients treated with anticoagulation or antiplatelet therapy (1% per year), and published our rapid recommendations.<sup>3</sup> We recommend

percutaneous closure of PFO in highly selected patients with cryptogenic ischaemic stroke or transient ischaemic attack, defined after accurate diagnostic screening. That is, when uncontrolled vascular risk factors are absent, in patients aged younger than 61 years, and in patients with particular anatomical features of PFO (large size or association with aneurysm of the interatrial septum), also taking into account patient preferences. We also published a comment in the same report, to document the risk of atrial fibrillation and draw attention to the need to inform patients of this risk. Atrial fibrillation or flutter after PFO closure occurred in 4.4% of patients in the RESPECT trial, 4.6% of patients in the CLOSE trial, and 6% in the GORE-REDUCE trial.<sup>4</sup>

When considering the strengths and limitations of existing clinical trials to inform the selection of patients for PFO closure, the importance of actively involving patients in the treatment decision and of informing them of the potential risks and benefits of treatment should not be overlooked.

Based on current evidence, we disagree with Meier's statement that aspirin should not be considered.<sup>1</sup> In agreement with the 2018 European consensus paper on the management of patients with PFO,<sup>5</sup> we believe that, when a medical therapy is chosen, the individual risk of bleeding should be weighed against the risk of PFO-related stroke recurrence, in close collaboration with the patient. When the patient has a high haemorrhagic risk, is poorly compliant, or when proper anticoagulant monitoring cannot be guaranteed, or the risk of stroke recurrence is deemed to be low, an antiplatelet therapy should be prescribed.

We declare no competing interests.

\**Maurizio Melis, Stefano Ricci, Danilo Toni, on behalf of the editorial committee of the Italian National Guidelines on Stroke mauriziomelis@aob.it*

Neurology and Stroke Unit, Neuroscience and Rehabilitation Department, Azienda Ospedaliera G Brotzu, Cagliari 09134, Italy (MM); Neurology Unit, USL Umbria 1, Città di Castello, Italy (SR); and Neurovascular Treatment Unit, Department of Human Neurosciences, Sapienza University, Rome, Italy (DT)

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## Primum non nocere: a call for balance when reporting on CTE

As clinicians and researchers in traumatic brain injury and neurodegeneration, we are concerned by the tone of reporting on chronic traumatic encephalopathy (CTE) that has developed over the past decade, highlighted in an article in *The New York Times*.<sup>1</sup> Misleading reporting can have unintended, negative consequences and we call for balance from the medical and scientific communities and the media when communicating on issues related to CTE.

Contrary to common perception, the clinical syndrome of CTE has not yet been fully defined,<sup>2</sup> its prevalence is unknown, and the neuropathological diagnostic criteria are no more than preliminary.<sup>3</sup> We have an incomplete understanding of the extent or distribution of pathology required to