PATIENT ARRIVAL VIA EMS/TRIAGE WITH S/S STROKE

EMERGENCY DEPARTMENT ASSESSMENT:
If time last known well <8 hours, unknown, or wake-up stroke
- Expedite to CT
- EMS/RN/MD confirm S/S
- Confirm Time Last Known Well (TLKW) using clock time
- Confirm stability
- Confirm glucose check >50 mg/dl
- MD order: Non-contrast head CT
  (Goal <10 min)

STROKE NEUROLOGY CONSULT
ONE CALL TRANSFER CENTER: 612-863-1000

(Goal <10 min)

Non-Contrast Head CT Review tPA Eligibility

NEGATIVE HEAD CT/tPA CANDIDATE?
ADMINISTER FULL DOSE IV tPA
(Goal <40 min D2N)

DO NOT delay tPA while proceeding with
Intra- Arterial (IA) workup

NIHSS ≥6 or global aphasia

NO

YES

Abbott Northwestern Hospital stroke neurologist
will contact NIR for consideration of IA Treatment,
if deemed appropriate

ASPECTS ≥6

NO

YES

Age ≤85 and TLKW ≤6 hours

Age ≤85 and TLKW >6 hours

Age >85

CTA ASPECTS ≥6

CTA ASPECTS <6

Obtain emergent CTA head/neck
(if possible and readily available–do not delay
transport) NIR calculates CTA ASPECTS

Transfer for emergent thrombectomy

Not optimal candidate for thrombectomy,
may consider on an individual basis or plan for
urgent transfer to Abbott Northwestern Hospital

CT Results = Bleed?
Consult Neurosurgery or Neuro
Interventional Radiologist (NIR) as appropriate

To contact the Stroke Neurology Service:
One Call Transfer Center
Any patient. Any time.
612-863-1000

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Alteplase (IV-tPA) Acute Ischemic Stroke
Treatment Recommendations

Inclusions

- Diagnosis of ischemic stroke causing measureable neurological deficit
- Time last know well <4.5 hrs. before treatment begins
- Age ≥18 years (equally recommended for ages 18-80 and >80)

Exclusions

- Acute evidence of intracranial hemorrhage on non-contrast CT
- Severe head trauma within 3 months
- Acute post-traumatic infarction
- Patients presenting with symptoms and signs most consistent with a Subarachnoid Hemorrhage
- Recent history of intracranial hemorrhage (excluding cerebral microbleeds)
- Intracranial/spinal surgery within 3 months
- Elevated blood pressure despite aggressive treatment (systolic >185 mmHg or diastolic >110 mmHg)
- Acute bleeding diathesis or coagulopathy history
- Platelets <100,000/mm³, INR > 1.7, PT >15 sec, or aPTT >40 sec (do not delay treatment for test results if no reason to suspect an abnormal test)
- LMWH used within 24 hours or direct thrombin Inhibitors or Direct Factor Xa Inhibitors (NOAC) used within 48 hours
- Early extensive ischemic changes: severe hypo-attenuation or obvious hypodensity on CT
- Wake up stroke or unclear time last known well (should only be treated under a clinical study protocol)
- Infectious endocarditis
- Stroke associated with aortic arch dissection

Relative Exclusions

(Risks/Benefits)

The potential risks should be discussed during eligibility deliberation and weighed against the anticipated benefits during decision making

- Prior ischemic stroke within 3 months
- Arterial puncture at non-compressible site
- Intr-axial intracranial neoplasm – consider histology, location and bleeding risk
- Intracranial vascular malformation - unruptured and untreated, consider stroke severity
- Active Internal bleeding
- Severe stroke with acute pericarditis (Consult cardiology)
- Left atrial or ventricular thrombus , consider stroke severity
- Pregnancy (Consult OB/GYN)
- Early postpartum (<14 days)
- Active or recent vaginal bleeding with clinically significant anemia, consult gynecology and consider stroke severity
- Major surgery or serious trauma within previous 14 days
- GI bleeding within 21 days (limited data >7 days may be acceptable)

If patient cannot receive IV-tPA, consider intra-arterial intervention if acute large vessel occlusion is present