TIA / Nondisabling Stroke OBS

UC Emergency Med Quality Comm.

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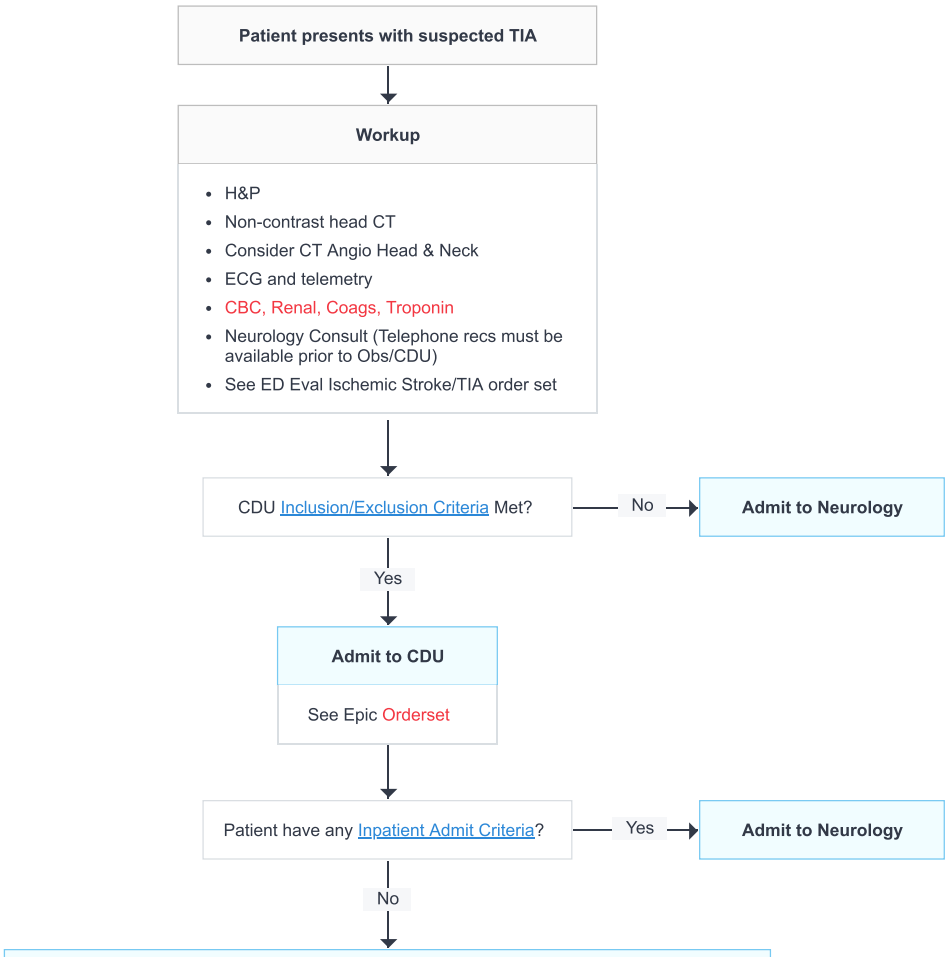

CDU Discharge Planning

- All patients with final diagnosis of TIA/minor stroke should be started on anti-platelet medication within 48 hours unless contraindicated:
  - ASA, clopidogrel, or aspirin/extended-release dipyridamole are acceptable
  - Short-term double anti-platelet therapy (i.e. ASA and plavix) may be indicated at discretion of treating neurologist or if indicated for other etiology (i.e. coronary stent).
    - Any delay in anti-platelet medication must have documentation.
    - Any patient not discharged on anti-platelet med must have documentation of why not.
- Statin should be considered in any patient with LDL>100. Document why one is not started (liver function, myopathy, etc.)
- Smoking cessation should be discussed and documented. (Document non-smokers)
- Blood pressure should be <160/90 prior to discharge.
- Follow up with primary care physician in 7-10 days for blood pressure check. Goal <120/80
- Follow up stroke clinic within 3 months per Neuro consult team or Contact Neuro stroke coordinator (584-2271)

Revised: 4/21/21
Department of Emergency Medicine

CDU Inclusion Exclusion Criteria:

Inclusion criteria

- Patient qualifies if they have symptoms concerning for possible TIA or non-disabling stroke
- Must document why the patient is not a tPA candidate
- Symptoms must be resolved or very mild/non-disabling:
  - No aphasia
  - No visual field deficit
  - No new Incontinence
  - No significant extremity weakness
  - Pass bedside swallow evaluation
  - Walk without assistance

Exclusion criteria

- Disabling symptoms of acute CVA present
- tPA administered
- Acute finding present on CT head WO (or CTA H&N if obtained)
- Unstable vital signs (SBP<90, HR>120 or <50) present
- Baseline significant cognitive deficit or baseline inability to ambulate
- ESRD/dialysis patient
- Young patient (age<55) may be admitted to facilitate TEE
- If MRI is reason for Obs, MRI slot in <6 hours (call 584-1095 to check)
- If echo is needed in Obs, cannot enter Friday 1600 to Sunday 1600 slot

Inpatient admit criteria:

- More than 2 TIAs in 24 hours
- Fluctuating symptomsIndication for acute anticoagulation.
- Abnormal TTE or recommendation for TEE {Ex. embolic source, wall motion abnormality)
- MRI shows pathology requiring further work-up or treatment (Mass, hemorrhage such as SAH)
- MRI shows DWI changes in embolic pattern (strokes of different ages and/or in different distributions)
- MRA/CTA Neck shows extracranial carotid stenosis >50% on the same side as the concerning lesion. If greater than 50% consider admit for urgent revascularization.
- MRA/CTA of the head shows any lesion >50%. May consider SAMMPRIS
- Significant lab abnormalities (Troponin elevation/increase)
- Any new arrhythmia on Telemetry
- Development of unstable/concerning vital signs ormental status changes
- Neurology consult may recommend admission based on clinical suspicion