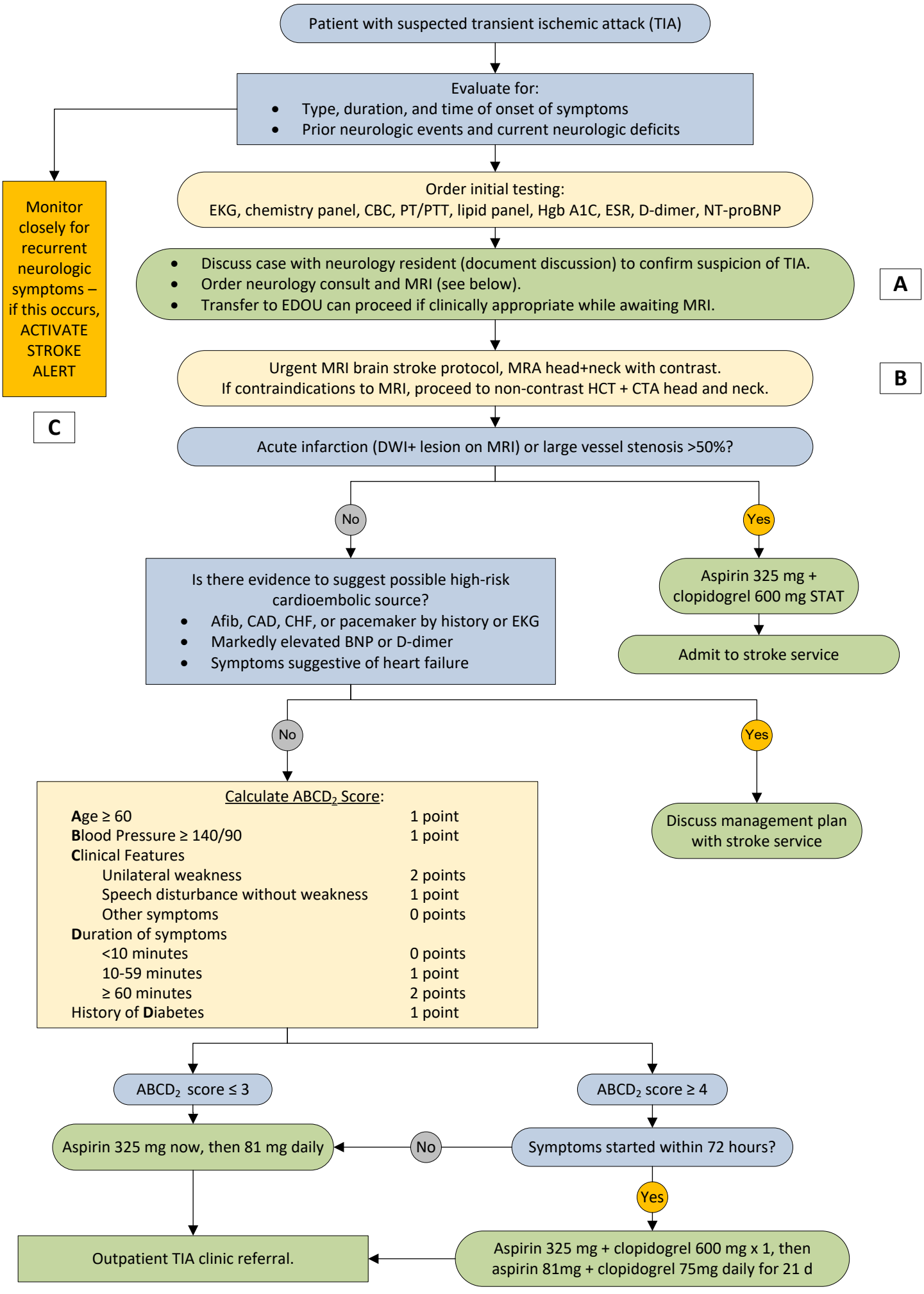
Patient with suspected transient ischemic attack (TIA)
Evaluate for:
• Type, duration, and time of onset of symptoms
• Prior neurologic events and current neurologic deficits
Monitor closely for recurrent neurologic symptoms – if this occurs, ACTIVATE STROKE ALERT
C
Order initial testing:
EKG, chemistry panel, CBC, PT/PTT, lipid panel, Hgb A1C, ESR, D-dimer, NT-proBNP
• Discuss case with neurology resident (document discussion) to confirm suspicion of TIA.
• Order neurology consult and MRI (see below).
• Transfer to EDOU can proceed if clinically appropriate while awaiting MRI.
A
Urgent MRI brain stroke protocol, MRA head+neck with contrast.
If contraindications to MRI, proceed to non-contrast HCT + CTA head and neck.
B
Acute infarction (DWI+ lesion on MRI) or large vessel stenosis >50%?
No
Yes
Is there evidence to suggest possible high-risk cardioembolic source?
• Afib, CAD, CHF, or pacemaker by history or EKG
• Markedly elevated BNP or D-dimer
• Symptoms suggestive of heart failure
Aspirin 325 mg + clopidogrel 600 mg STAT
Admit to stroke service
No
Yes
Calculate ABCD2 Score:
Age ≥ 60 1 point
Blood Pressure ≥ 140/90 1 point
Clinical Features
Unilateral weakness 2 points
Speech disturbance without weakness 1 point
Other symptoms 0 points
Duration of symptoms
<10 minutes 0 points
10-59 minutes 1 point
≥ 60 minutes 2 points
History of Diabetes 1 point
Discuss management plan with stroke service
ABCD2 score ≤ 3
ABCD2 score ≥ 4
Aspirin 325 mg now, then 81 mg daily
No
Symptoms started within 72 hours?
Yes
Outpatient TIA clinic referral.
Aspirin 325 mg + clopidogrel 600 mg x 1, then aspirin 81mg + clopidogrel 75mg daily for 21 d

Transient ischemic attack ED flowchart

A:

After initial evaluation by EM team, a brief phone discussion with neurology consult team to review the patient's presenting symptoms and examination should be conducted and documented. Many cases will be of obvious concern for TIA, and management can proceed along the pathway expeditiously. Neurology consultation should be ordered; the full consultation may take place after the MRI has been completed. Occasionally, the need for additional imaging may be uncertain; in such cases, neurology will assess the patient prior to deciding on the optimal imaging strategy.

EDOU transfer will be contingent on appropriate COVID screening.

B:

Brain MRI is highly sensitive for acute infarction, seen as restricted diffusion on diffusion weighted imaging (DWI) sequences. Note that sensitivity is greatest 3 or more hours after symptom onset; false negative DWI results may occur in patients imaged in the hyperacute period. A stroke protocol brain MRI is a compressed, rapid scan that provides the necessary sequences to evaluate for infarction, hemorrhage, or obvious large brain lesions. MRA head and neck performed with contrast provides good visualization of the extra- and intracranial circulations. If there are contraindications to MRI (e.g. pacemaker, severe claustrophobia, etc), CT head and CT angiography of the head and neck may be pursued as an alternative. CT perfusion is generally not needed for patients with suspected TIA.

C:

Patients with TIA are at high short-term risk of recurrent cerebral ischemia and should new stroke occur are generally eligible for IV tPA. Close neurological monitoring is very important – if neurologic symptoms recur, an acute stroke alert should be activated immediately.