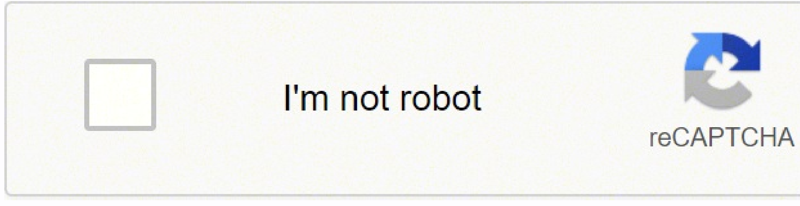
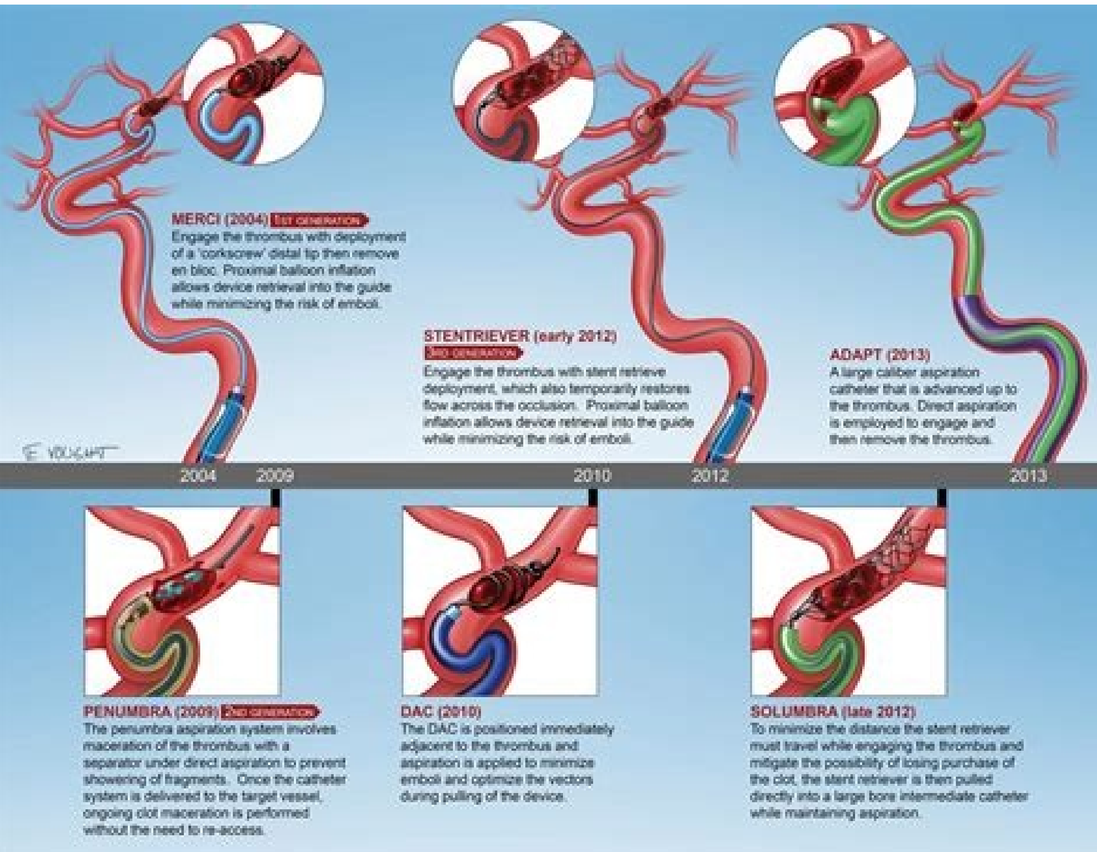



Open

# Aha guidelines for ischemic stroke




**INDICATIONS**

- Ischemic stroke onset within 3 hours of drug administration.
- Measurable deficit on the NIH stroke scale examination.
- Computed tomography (CT) scan does not show hemorrhage or nonstroke cause of deficit.
- Age >18 years.

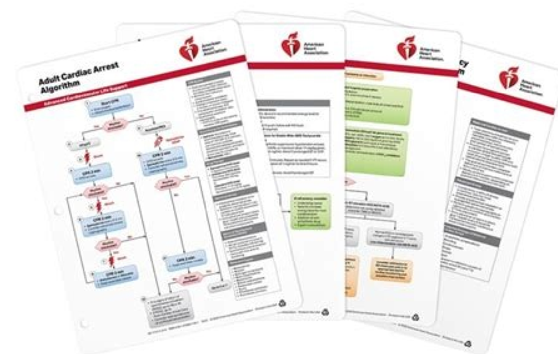
**CONTRAINDICATIONS**

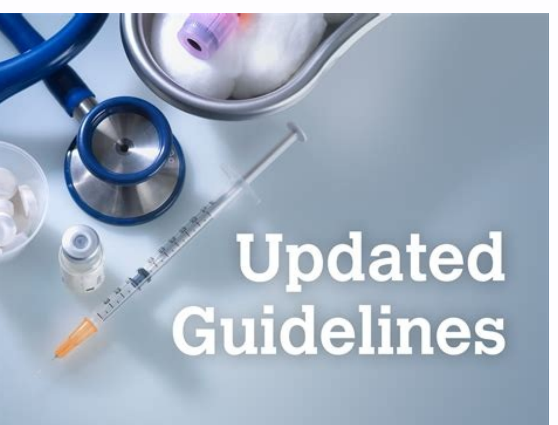
- Symptoms are minor or improving rapidly.
- Patient had seizure at onset of stroke.
- Patient had another stroke or serious head trauma within the past 3 months.
- Patient had major surgery within the past 14 days.
- Patient has a known history of intracranial hemorrhage.
- Patient has sustained systolic blood pressure >185 mmHg.
- Patient has sustained diastolic blood pressure >110 mmHg.
- Aggressive treatment is necessary to lower the patient's blood pressure.
- Patient has symptoms suggestive of subarachnoid hemorrhage.
- Patient had gastrointestinal or urinary tract hemorrhage within the past 21 days.
- Patient had arterial puncture at a noncompressible site within the past 7 days.
- Patient received heparin within the past 48 hours and has elevated partial thromboplastin time (PTT).
- Prothrombin time (PT) is >15 seconds.
- Platelet count is < 100,000 mL.
- Patient's serum glucose is < 50 mg/dL or > 400 mg/dL.

**RELATIVE CONTRAINDICATIONS**

- Patient has a large stroke with NIH Stroke Scale score > 22.
- CT scan shows evidence of large middle cerebral artery territory infarction (sulcal effacement or blurring of gray-white junction in more than one-third of MCA territory).

Reprinted with permission from: American College of Emergency Physicians. Policy Resource and Education Paper: Use of intravenous tPA for the management of acute stroke in the emergency department. ACEP web site www.acep.org/1,5005,0.html, February 2002. Accessed 2/12/2004.






2013 aha/asa guidelines for acute ischemic stroke. Aha guidelines for acute ischemic stroke 2018. Aha guidelines for acute ischemic stroke.

The following Key Points to Remember are not impacted by these changes. In selected acute stroke patients within 6-24 hours of last known normal who have large vessel occlusion in the anterior circulation and meet other DAWN eligibility criteria, mechanical thrombectomy with a stent retriever is reasonable. May 09, 2018 | Mollie McDermott, MD, MS Authors: Powers WJ, Rabinstein AA, Ackerson T, et al., on behalf of the American Heart Association Stroke Council. The use of stroke units that incorporate rehabilitation is recommended for all acute stroke patients. No perfusion imaging (CT-P or MR-P) is required in these patients. Urgent anticoagulation (e.g., heparin drip) for most stroke patients is not indicated. Editor's Note: The American Heart Association and the American Stroke Association released several clarifications, updates, and/or modifications to the 2018 Guidelines for the Early Management of Patients With Acute Ischemic Stroke on April 18, 2018. It remains unknown whether it would be beneficial for emergency medical services to bypass a closer IV tPA-capable hospital for a thrombectomy-capable hospital. An international normalized ratio, partial thromboplastin time, and platelet count do not need to have resulted prior to IV tPA initiation if there is no suspicion for underlying coagulopathy. Stroke 2018;49:e46-e110. As with IV tPA, treatment with mechanical thrombectomy should be initiated as quickly as possible. For patients treated with IV tPA, aspirin administration is generally delayed for 24 hours. For patients who may be candidates for mechanical thrombectomy, an urgent CT angiogram or magnetic resonance (MR) angiogram (to look for large vessel occlusion) is recommended, but this study should not delay treatment with IV tPA if indicated. Citation: 2018 Guidelines for the Early Management of Patients With Acute Ischemic Stroke: A Guideline for Healthcare Professionals From the American Heart Association/American Stroke Association. Centers should attempt to achieve door-to-needle times of Prior to initiation of IV tPA in most patients, a noncontrast head computed tomography (CT) and glucose are the only required tests. Patients ≥18 years should undergo mechanical thrombectomy with a stent retriever if they have minimal prestroke disability, have a causative occlusion of the internal carotid artery or proximal middle cerebral artery, have a National Institutes of Health stroke scale score of ≥6, have a reassuring noncontrast head CT (ASPECT score of ≥6), and if they can be treated within 6 hours of last known normal. IV tPA should be administered to all eligible acute stroke patients within 3 hours of last known normal and to a more selective group of eligible acute stroke patients (based on ECASS III exclusion criteria) within 4.5 hours of last known normal. While such an approach may delay IV tPA administration for patients who are and who are not mechanical thrombectomy candidates, this approach would expedite thrombectomy for those who are mechanical thrombectomy candidates. The benefits of intravenous (IV) tissue plasminogen activator (tPA) are time-dependent, and treatment for eligible patients should be initiated as quickly as possible (even for patients who may also be candidates for mechanical thrombectomy). In selected acute stroke patients within 6-24 hours of last known normal who have evidence of a large vessel occlusion in the anterior circulation and would have been eligible for DAWN or DEFUSE 3, obtaining perfusion imaging (CT-P or MR-P) or an MRI with diffusion-weighted imaging (DWI) sequence is recommended to help determine whether the patient is a candidate for mechanical thrombectomy. In selected acute stroke patients within 6-16 hours of last known normal who have a large vessel occlusion in the anterior circulation and meet other DAWN or DEFUSE 3 eligibility criteria, mechanical thrombectomy is recommended. In addition, in the last 3 months, two trials (DAWN and DEFUSE 3) showed a clear benefit of "extended window" mechanical thrombectomy for certain patients with large vessel occlusion who could be treated out to 16-24 hours. Administration of aspirin is recommended in acute stroke patients within 24-48 hours after stroke onset. The following are key points to remember from the American Heart Association (AHA)/American Stroke Association (ASA) 2018 Guidelines for the Early Management of Patients With Acute Ischemic Stroke: These 2018 guidelines are an update to the 2013 guidelines, which were published prior to the six positive "early window" mechanical thrombectomy trials (MR CLEAN, ESCAPE, EXTEND-IA, REVASCAT, SWIFT PRIME, THRACE) that emerged in 2015 and 2016. Centers should attempt to obtain a noncontrast head CT within 20 minutes of arrival in ≥50% of stroke patients who may be candidates for IV tPA or mechanical thrombectomy. Clinical Topics: Anticoagulation Management, Cardiac Surgery, Cardiovascular Care Team, Dyslipidemia, Invasive Cardiovascular Angiography and Intervention, Noninvasive Imaging, Prevention, Cardiac Surgery and Arrhythmias, Lipid Metabolism, Interventions and Imaging, Angiography, Magnetic Resonance Imaging, Nuclear Imaging Keywords: Angiography, Aspirin, Diffusion Magnetic Resonance Imaging, Emergency Medical Services, Glucose Tolerance Test, Heparin, Magnetic Resonance Imaging, Perfusion Imaging, Primary Prevention, Rehabilitation, Secondary Prevention, Stents, Stroke, Therapeutics, Thrombectomy, Tissue Plasminogen Activator, Vascular Diseases < Back to Listings

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