

TREATMENT AND FOLLOWUP GUIDELINES FOR THROMBOLYTIC THERAPY FOR ACUTE ISCHEMIC STROKE

TREATMENT

1. tPA 0.9 mg/kg total or max 90 mg.
2. Give 10% bolus.
3. Give remaining 90% with a constant infusion over 60 minutes without interruption.

FOLLOWUP

General patient management guidelines and other therapy

1. Admission to ICU for 36 hours
2. No IV heparin or antiplatelet drugs during the infusion or for 24 hours following onset of symptoms
3. Neuro checks with vital signs q 30 mins for 6 hours and q 1 hr for 18 hours
4. Cardiac monitoring
5. Appropriate measures to control blood pressure within acceptable limits
6. Avoid NG tube, blood draws and invasive lines of procedures for 24 hours if possible.
7. Inform Neurosurgery of events.

THROMBOLYTIC THERAPY FOR ACUTE ISCHEMIC STROKE: GUIDELINE

EMS

1. Alert hospital of possible stroke patient.
2. Rapid transport to hospital.

DOOR

Phase I - 10 minutes from arrival

1. Assess ABCs, vital signs.
2. Provide oxygen therapy.
3. Obtain IV access: obtain blood samples; order CBC, electrolytes, coagulation studies.
4. Check blood sugar; treat if indicated.
5. Perform general neurological screening assessment.
6. Alert members of the stroke team: Neurologist, Radiologist, CT technician.

Phase II - 25 minutes from arrival

1. Review patient history.
2. Review strict inclusion/exclusion criteria.
3. Perform quick head to toe physical examination.
4. Perform neurological examination.
5. Order an urgent, non-contrast CT scan (door to CT scan performed goal less than 25 minutes from arrival).

6. Read CT scan by a radiologist or neurologist (door to CT read goal less than 45 minutes from arrival).

REVIEW DATA

1. Review CT exclusions (stat reading by radiologist or neurologist)
2. Repeat neurological examination: are deficits variable or rapidly improving?
3. Re-review thrombolytic inclusion and exclusion criteria: are they all met?

DECISION - Patient remains candidate for Thrombolytic Therapy - yes or no?

DRUG

1. Obtain informed consent. Review risk and benefits with patient and/or family member.
2. Begin thrombolytic treatment (door to treatment goal less than 60 minutes).
3. Follow treatment plan as outlined on previous page.
4. Admit to ICU.

INTRACEREBRAL HEMORRHAGE MANAGEMENT: GUIDELINE

1. If clinical suspicion of ICH (example: neurological deterioration, new headache, acute hypertension, or nausea/vomiting) discontinue tPA.
2. Perform a stat CT Scan for any neurological deterioration.(notify neurosurgery if bleed present)
3. Order stat lab; PT/PTT, platelet count, fibrinogen, and Type and Cross for 4 units.
4. Prepare for administration of 6-8 units of cryoprecipitate and factor VIII.
5. Prepare for administration of 6-8 units of platelets.

Target times will not be achieved in all cases but represent goals (if time delays are predicted by waiting for the physical presence and evaluation of a Neurologist rTPA can be given if all other criteria are met)

Table NINDS - Recommended Stroke Evaluation Targets for Potential Thrombolytic Candidates*

	Time Target
Door to doctor	10 minutes
Door to CT ¹ completion	25 minutes
Door to CT read	45 minutes
Door to treatment	60 minutes
Access to neurological expertise [#]	15 minutes
Access to neurosurgical expertise [#]	2 hours
Admit to monitored bed	3 hours

*Target times will not be achieved in all cases, but they represent a reasonable goal.

¹CT indicates computed tomography. [#]By phone or in person.