Patient presents with suspected TIA

### Workup
- H&P
- Non-contrast head CT
- ECG and telemetry
- CBC, Renal, Coags, Troponin
- Neurology Consult
- Calculate ABCD² Score
- See ED Eval Ischemic Stroke/TIA order set

### Patient meets inclusion criteria?
- Yes
  - Admit to CDU
  - See EPIC Orderset
- No
  - Admit to Neurology

### Patient has any inpatient admission criteria?
- Yes
  - Admit to Neurology
- No

#### CDU 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
  - ABCD² score 0-2 for TIA
    - Age >60 = 1
    - Blood pressure: SBP >=140 OR DBP >= 90 on initial evaluation = 1
    - Either:
      - Unilateral Weakness = 2
      - OR
      - Speech Disturbance without weakness = 1
    - Either:
      - Duration 10-59 min = 1
      - OR
      - Duration >60 min = 2
    - Diabetes = 1
    - Patient does not meet any exclusion criteria

#### CDU Exclusion Criteria
- Disabling symptoms of acute CVA
- tPA administration
- Young patient with TIA/Minor stroke may be considered for admission (Age<55) to facilitate TEE
- Unstable vital signs
- Cannot enter protocol between Thursday from 1600 to Sunday at 1600

#### Inpatient Admission Criteria from CDU
- More than 2 TIAs in 24 hours
- Fluctuating symptoms
- Indication 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 protocol
- Significant lab abnormalities (Troponin elevation/increase)
- Any new arrhythmia on Telemetry
- Development of unstable/concerning vital signs or mental status changes
- Neurology consult may recommend admission based on clinical suspicion

#### Discharge
- 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 (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.
    - Contact Alicia, RN from Neuro (584-2271)

8/3/15