Acute Management of Stroke

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Objectives
• To provide a comprehensive approach to acute stroke management.
• To provide guidelines for IV, IA, combined IA-IV rt-PA, and mechanical thrombectomy.
• To provide a review of telestroke.

Stroke Facts
• Third leading cause of death
• A stroke occurs every 40 s in the USA
• Every 3.3 min someone dies from stroke
• Leading cause of adult disability
• Over 4 million stroke survivors

Stroke Subtypes

Stroke Presentation

• Transient Ischemic Attack (TIA)
• Acute Ischemic Stroke

TIA

• Old definition: symptoms lasting <24 hr.
• New definition: Symptoms lasting < 1 hr.
• Majority of TIAs resolve within 60 minutes.
• Most TIA resolve within 30 minutes.

Transient Ischemic Attack

TIA and Stroke as Predictors of Secondary Stroke

<table>
<thead>
<tr>
<th></th>
<th>Post-TIA (%)</th>
<th>Post-Stroke (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 days</td>
<td>4 – 8</td>
<td>3 – 10</td>
</tr>
<tr>
<td>1 year</td>
<td>12 – 13</td>
<td>5 – 14</td>
</tr>
<tr>
<td>5 years</td>
<td>24 – 29</td>
<td>25 – 40</td>
</tr>
</tbody>
</table>

Short-term Prognosis after ED Diagnosis of TIA

<table>
<thead>
<tr>
<th>Outcome events</th>
<th>Inclusion criteria</th>
<th>Objective: Short-term risk of stroke after ED diagnosis</th>
<th>Risk of stroke and other events during the 90 days after index TIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>30.0%</td>
<td></td>
<td>TIA by ED physicians</td>
<td>25.1%</td>
</tr>
<tr>
<td>25.0%</td>
<td></td>
<td>TIA by ED physicians</td>
<td></td>
</tr>
<tr>
<td>20.0%</td>
<td></td>
<td>TIA by ED physicians</td>
<td></td>
</tr>
<tr>
<td>15.0%</td>
<td></td>
<td>TIA by ED physicians</td>
<td></td>
</tr>
<tr>
<td>10.0%</td>
<td></td>
<td>TIA by ED physicians</td>
<td></td>
</tr>
<tr>
<td>5.0%</td>
<td></td>
<td>TIA by ED physicians</td>
<td></td>
</tr>
<tr>
<td>0.0%</td>
<td></td>
<td>TIA by ED physicians</td>
<td></td>
</tr>
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</table>

Within 48 hr

0.0% Stroke Recurrent CV event Death TIA


ABCD2 Score

<table>
<thead>
<tr>
<th>Score</th>
<th>Stroke Risk 2 days</th>
<th>Stroke Risk 7 days</th>
<th>Stroke Risk 90 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>≤ 3</td>
<td>1%</td>
<td>1.2%</td>
<td>3.1%</td>
</tr>
<tr>
<td>4-5</td>
<td>4.1%</td>
<td>5.9%</td>
<td>9.8%</td>
</tr>
<tr>
<td>≥ 5</td>
<td>8.1%</td>
<td>11.7%</td>
<td>17.8%</td>
</tr>
</tbody>
</table>


TIA

- Do we need to admit all TIA’s?
- What work up is enough to D/C from ER

ABCD2 Risk stratification

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**ABCD2 and ED Management**

- **TIA**
  - **Score ≤ 3**
  - **Workup in ED**
  - **Score >3**
  - **Admitted**

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**Ischemic Stroke**

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**TIA Workup in ED**

- Initial evaluation
- NIH recommendations: 1209 and 2004/2008
- Diagnosis: Thrombolysis
- Intravenous rt-PA
- Intravenous rt-PA + intravenous heparin
- Intravenous rt-PA + intracoronary rt-PA
- Therapy: Recombinant tissue plasminogen activator (rt-PA) and aspirin
- Radiological imaging
- Magnetic resonance imaging
- Computed tomography angiography
- Duplex ultrasound
- Laboratory testing
- Full blood count, clotting screen, basic biochemistry
- CT chest, abdomen, and pelvis

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**Acute Stroke Treatment**

- IV rt-PA
- IA rt-PA
- Combined IV-IA rt-PA
- Mechanical Embolectomy

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**Acute Stroke Treatment**

- IV rt-PA
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### IV rt-PA

- 0-3 h last known well
- 3-4.5 h last known well

### Contraindications to rt-PA

### IV rt-PA Eligibility 0-3 h

- Diagnosis of ischemic stroke
- Onset of symptoms < 180 min

### Clinical

- Symptoms/signs only minor or rapidly improving
- Seizure at onset of stroke (not absolute)
- Symptoms suggestive of subarachnoid hemorrhage
- Persistent blood pressure elevation >185/110
- Active bleeding or acute trauma (fx)
### Historical
- Stroke or head trauma in prior 3 months
- Any history intracranial hemorrhage
- Major surgery in previous 14 days
- GI or GU tract bleeding in previous 21 d
- Arterial puncture at non-compressible site previous 7 days

### Other Relative Contraindications
- Seizure at onset of stroke
- Serum glucose <50 mg/dl or >400 mg/dl
- Hemorrhagic eye disorders
- Myocardial infarction in the prior six weeks
- Suspected septic embolism
- Infective endocarditis

### Laboratory
- Platelets less than 100K
- On oral anticoagulant with INR > 1.7
- On heparin with PTT higher than normal

### Radiological
- Evidence of hemorrhage
- Major early infarct signs
  - Diffuse swelling of affected hemisphere
  - Parenchymal hypodensity
  - Effacement of >33% of middle cerebral artery territory
NINDS rt-PA Stroke Study

- Prospective, randomized, double-blind trial
- 624 patients: half treated within 90 minutes, half treated within 91 to 180 minutes
- rt-PA dose: 0.9 mg/kg, maximum dose: 90 mg, 10% as IV bolus, remainder via 1-hour infusion
- Careful attention to Bp: <185/110
- No anticoagulant or antiplatelet agents for 24 hours

Baseline symptoms and outcome

![Graph showing effect of baseline NIHSS score on outcome at 1 year](image)


IV rt-PA and Outcome

<table>
<thead>
<tr>
<th>Discharge dispositions from initial hospitalization in the NINDS study</th>
<th>t-PA (n=312)</th>
<th>Placebo (n=312)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home</td>
<td>48%</td>
<td>36%</td>
</tr>
<tr>
<td>Inpatient rehabilitation unit</td>
<td>29%</td>
<td>37%</td>
</tr>
<tr>
<td>Nursing Home</td>
<td>7%</td>
<td>13%</td>
</tr>
<tr>
<td>Other facility</td>
<td>4%</td>
<td>2%</td>
</tr>
<tr>
<td>Dead</td>
<td>11%</td>
<td>13%</td>
</tr>
</tbody>
</table>


rt-PA Complications

- In a meta-analysis of 15 published studies, rate of ICH was 5.2% in 3 month
- Increase rate of hemorrhage was associated with protocol deviations.

### 3 TO 4 ½ HOURS

- 821 patients
- 18 to 80 years old randomized to tPA vs placebo
  - 52% no disability with tPA vs 45% placebo
  - No mortality difference (7.7% tPA vs 8.4%)
  - Symptomatic hemorrhage 7.9% tPA vs 3.5%

ECASS III: NEJM 2008;359:1317-29

### Contraindications to tPA 3 - 4.5 hours

- Patients older than 80 years
- Patients taking oral anticoagulants regardless of INR
- Patients with baseline NIHSS >25
- Patients with history of diabetes and stroke

*IV t-PA should be administered to eligible patients who can be treated in the time period of 3 to 4.5 hours after stroke (Class I Recommendation, Level of Evidence B).*

Science Advisory from AHA. Stroke 2003;40:2056
78 y.o. female with sudden onset of left hemiparesis and aphasia. Acute left MCA occlusion. IV t-PA thrombolysis resulted in immediate improvement. Deterioration 12 hours later. IA reperfusion and L ICA stenting. Good clinical outcome.
Thrombectomy for Stroke

Recanalization (restoring flow) rates by intervention

- Spontaneous: 24.1%
- Intravenous thrombolysis: 46.2%
- Intra-arterial thrombolysis: 63.2%
- Combined IV and IA thrombolysis: 67.5%
- Mechanical: 83.6%


Stroke: Every Minute Counts

Early Rx was better in the NINDS tPA Trial

Goal treatment timeline
door-to-needle

- Evaluation by physician: 10 min
- Stroke expertise contacted: 15 min
- Head CT or MRI performed: 25 min
- Interpretation of CT/MRI: 45 min
- Start of treatment: 60 min

Limitations

- 21% of the US population lives in rural areas
- Significant shortage of physicians with expertise in acute stroke treatment
- Four neurologists per 100,000 persons
- Many neurologists have discontinued hospital privileges

Is the Golden Hour Achievable?
rt-PA Experience

- A review of medicare data for 4750 hospitals showed that only 2.4% of patients are treated with t-PA.
- 60% of hospitals reported no t-PA treatment.
  - Smaller hospitals <100 beds
  - Rural areas

Treatment of Stroke in rural area

- Ship and drip
- Drip and ship

Primary Stroke Centers

- More than 600 PSC across the US.
- Most located in metropolitan areas
- <25% of US population lives within 30 min of PSC
- Only half able to reach a PSC within 1 h if state boundaries respected by ground ambulance

Ship and Drip Concept

- Patients initially assessed in rural hospital
- Transfer patients who are able to get to a PSC within 3 h
- This is feasible probably within 80 miles radius
- Not a desirable solution

Hess DC et al. Cerebrovascular Disease and Stroke. 2011, 13:215
Drip and Ship Concept

- Initial assessment in rural hospital
- Consultation with stroke expert through phone consultation or telestroke
- t-pa started then patient is transferred

Telestroke

How can we do a neuro exam on camera?

- NIHSS done through video connection by as a stroke specialist is as good as bedside evaluation. (Class I, Level of Evidence A).
**Telemedicine and telephone consultation**

- Several successful demonstrations published
- 234 patients assessed prospectively and randomised to telemedicine vs telephone consultation
- Correct treatment decisions were made more often in the telemedicine group than in the telephone group [98%] vs [82%]
- IV thrombolytics were used at an overall rate of 25% ([28%] telemedicine vs [23%] telephone,

**AHA Recommendations Telephone Consultation**

- Compared with traditional bedside evaluation and use of IV tPA, the safety and efficacy of IV tPA administration based solely on telephone consultation without CT interpretation via teleradiology is not well established (Class Iib, Level of Evidence C).

**Telestroke in practice**

![Cartoon of a person in a hospital setting]

**AHA Recommendations Telestroke**

- It is recommended that a stroke specialist using video conferencing provide medical opinion in favor of or against the use of IV tPA in patients with suspected acute ischemic stroke when on-site expertise is not immediately available (Class I, Level of Evidence B)

"Your advice highly, Dr. Neurologist"
Conclusion

- Acute stroke is analogous to trauma:
  - Patients should be quickly assessed and screened for t-PA
  - Stroke expertise should be at the bedside either physically or through telemedicine approach