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Stroke Algorithm Review

The most important point to the stroke algorithm is to provide fast evaluation, increased clinical suspicion and faster transport for the suspected stroke patient.

The correct time of onset is essential, if it cannot be determined, then the patient is not a candidate for thrombolytic therapy. Alteplase, tPA, is currently the only approved drug for stroke therapy.

Emergency management system activation (911), with evaluation and transport will enable more patients to meet the 3 hour deadline criteria for the consideration of thrombolytic therapy.

The recommendations for the three hour deadline criteria may be extended soon.

The patient needs to present to an emergency facility, be stabilized for glucose and blood pressure control, receive a quick evaluation, and obtain a complete, *interpreted* non-contrast CT brain scan, all within the 3 hour time window. Any hemorrhage, or a *large volume ischemic stroke*, will prevent the patient from receiving thrombolytic therapy.

The evidence is accumulating for extended periods of thrombolytic therapy, perhaps as long as 6 hours. Previous studies showed that there was benefit for the thrombolytic therapy beyond three hours, but that the risks of bleeding complications were unacceptable. This may change.

Consultations with a stroke team, neurologist (and perhaps neurosurgeon) are essential after or concurrently with the CT brain scan.

Glucose evaluation management is increasingly important in stroke care. Intravenous bolus administration of glucose *only for hypoglycemia* and insulin for glucose elevations above 140-185 are currently recommended. This should be discussed with a neurologist.

Hypertension must be addressed, but care must be taken not to lower the blood pressure too far.

1. DO NOT TRY TO ACHIEVE A NORMAL BLOOD PRESSURE. The recommendations still allow for high blood pressures. The current recommendation is only to treat blood pressures above 220/120 (mean arterial pressure > 120 mmHg).
2. *However*, if the patient turns out to otherwise be a candidate for fibrinolytic therapy, then they need to have a blood pressure of less than 185/110.
This is an odd discrepancy, but has existed for a long time.
3. Use Labetalol, Nicardipine or Nitroprusside for treatment.

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