

**JOHN HUNTER HOSPITAL  
DIVISION OF EMERGENCY MEDICINE**

**TIA MANAGEMENT**

Presentation Date

Presentation Time

/  /    :

Q230 - JOHN HUNTER HOSPITAL  
MRN \_\_\_\_\_ Surname \_\_\_\_\_ Name \_\_\_\_\_  
Address \_\_\_\_\_  
DOB \_\_\_\_\_ Sex \_\_\_\_\_

Antithrombotic therapy to be considered in all cases

*Antiplatelet therapy commenced in ED following CT head scan*

**YES**  **NO**

**HIGH RISK TIAS**

**(Consider admission in patients with the following clinical features)**

**Atrial Fibrillation**

*If persistent or paroxysmal AF - not anticoagulated*

**YES** Discuss commencement of full anticoagulation with stroke/general medical team

*If on warfarin - INR <1.8*

**YES** Discuss use of heparin or warfarin dosage adjustment with stroke/general medical team

**Crescendo pattern**

*If two or more TIAs within 1 week*

**YES** Discuss need for urgent vascular imaging with stroke team

**Aspirin Failure**

*If antiplatelet therapy failure*

**YES** Discuss use of combination antiplatelet therapy and need for urgent vascular imaging with stroke team

**Neck bruit**

*If neck bruit relevant to the ischaemic event*

**YES** Consider possible high grade carotid artery stenosis - discuss with stroke team

**Recent MI**

*If Acute myocardial infarction <= 4 weeks*

**YES** Discuss need for anticoagulation and urgent cardiac imaging

**Comorbidities**

*Examples = Fever/sepsis, unstable diabetes, decompensated cardiac failure, prosthetic heart valve*

**YES** Discuss need for overall medical review

*If inability to function safely at home due to neurological or other impairments*

**YES** Discuss need for nursing care and/or rehabilitation process

**Social**

*If inadequate social supports*

**YES** Discuss need for nursing care and/or rehabilitation process

If Patient with TIA for admission with: AF  **YES** Crescendo pattern  **YES** Other  **YES** Not Admitted  **YES**

**LOW RISK TIAS**

**(Consider outpatient management in patients with the following clinical features)**

**Clinical features**

*If Single event + Sinus rhythm + Full resolution of neurological deficit (all 3 present)*

**YES** Communication with GP and outpatient clinic  **YES**  
Referral to outpatient clinic with planned review within 2 weeks  **YES**  
Commencement of antithrombotic therapies (see guidelines below)

**Choice of outpatient antiplatelet therapies**

*If NO aspirin within 1 week prior to ischaemic event*

Prescribe Aspirin 300 mg daily for 3 days then 100-150 mg daily

*If Patient receiving aspirin within 1 week prior to the ischaemic event*

OPTIONS

1. Addition of Dipyridamole SR to aspirin (appropriate for patients who are aspirin tolerant)

2. Change from aspirin to clopidogrel 75 mg BD for 3 days then 75 mg daily (appropriate for patients with aspirin intolerance)

*If Patient on "enhanced" antiplatelet therapy at time of event*

Discuss options with stroke team - in general - pathophysiology of event needs to be determined in order to guide further adjustments in antithrombotic therapy

If outpatient management is appropriate either arrange:

Neurovascular Clinic appointment via Stroke Case Manager page 5538 (0800 -1700) or call13481 all hours

Arrange GP review

Medical Officer Signature: \_\_\_\_\_

(Please Print)

Designation: \_\_\_\_\_

Name: \_\_\_\_\_