



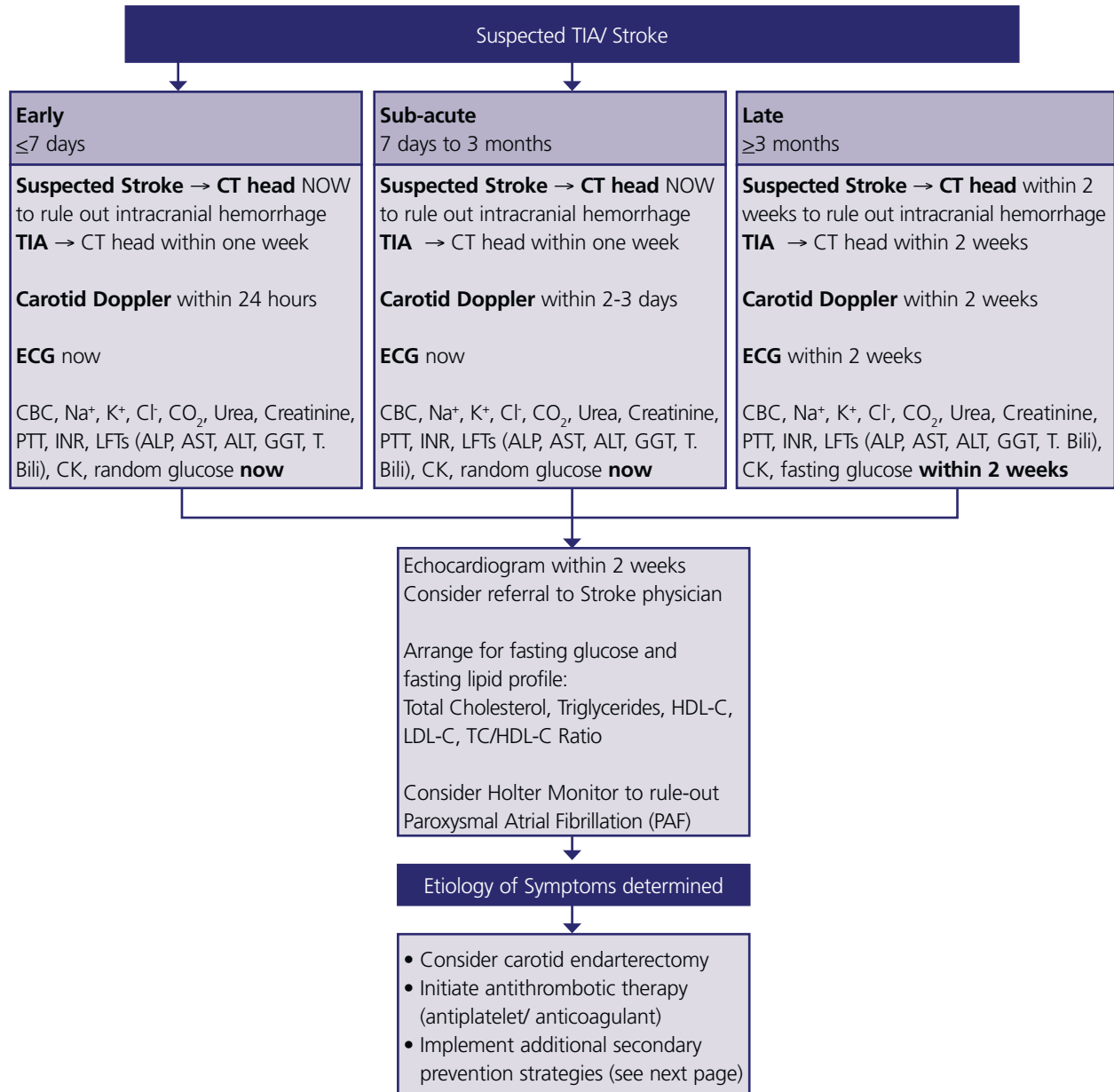
TIA & ISCHEMIC STROKE

Source: Adapted from The Canadian Stroke Strategy. Canadian best practice recommendations for Stroke Care 2006.²⁶

DIAGNOSIS OF TIA & ISCHEMIC STROKE

Major signs of TIA/ Stroke include but are not restricted to SUDDEN (may be temporary):

- **Focal weakness** (with or without numbness)
- **Speech impairment** (aphasia, dysarthria)
- **Vision impairment** (visual field defect, loss of vision particularly in one eye, double vision)
- **Loss of balance**, dizziness especially with any of the above signs
- **Headache** (severe and unusual)





MANAGEMENT OF TIA & ISCHEMIC STROKE

Risk Factor	Target	Intervention
Education	Recognize warning signs of Stroke	<ul style="list-style-type: none"> Educate patients to recognize the warning signs of Stroke and to call 911 immediately if symptoms occur. Major signs of TIA/ Stroke include but not restricted to SUDDEN (may be temporary): <ul style="list-style-type: none"> Focal weakness (with or without numbness); Speech impairment (aphasia, dysarthria); Vision impairment (visual field defect, loss of vision particularly in one eye, double vision); Loss of balance, dizziness especially with any of the above signs; and/ or, Headache (severe and unusual) characteristic of an hemorrhagic Stroke. Call 911 immediately if symptoms occur.
Smoking	Smoke-free	<p>See Smoking Cessation Guideline (page 29)</p> <ul style="list-style-type: none"> Ask about tobacco use at every visit. Advise every tobacco user to quit. Advise of risks of continued smoking to Stroke patients. Assess the tobacco user's readiness to quit. Assist by counselling and pharmacotherapy - see smoking cessation recommendations. Arrange follow-up, referral to specialized programs or community programs. Urge avoidance of exposure to environmental tobacco smoke at work and home.
Physical Activity	30-60 minutes, 4-7 days/ week	<ul style="list-style-type: none"> Encourage 30 to 60 minutes of moderate-intensity aerobic activity such as brisk walking on most days of the week, supplemented by an increase in daily lifestyle activities. Identify problems/ barriers to starting and maintaining exercise program and discuss possible solutions. Refer to suitable community program as indicated.
Weight Management	<p>Target Weight: BMI 18.5 to 24.9 kg/m²</p> <p>Waist circumference: ≤88 cm (35") for women and ≤102 cm (40") for men</p> <p>Start with targeting weight loss of 5 – 10% of body weight.</p>	<ul style="list-style-type: none"> Assess BMI and/ or waist circumference (see Appendix B for instructions on proper waist line measurement). Discuss weight issues with patients who are outside of the BMI and waist circumference limits. Encourage weight maintenance or reduction through appropriate balance of physical activity, caloric intake. Refer to behavioural programs as necessary. See specific obesity/ overweight recommendations (page 43).
Alcohol Consumption	<2 drinks/ day	<ul style="list-style-type: none"> No alcohol to moderate <2 drinks/ day (<9/ week for women; <14/ week for men).
Hypertension	<140/90 mmHg or <130/80 mmHg if patient has Diabetes or CKD	<ul style="list-style-type: none"> Assess BP every 3 to 6 months. For patients who have had a Stroke, BP lowering is recommended even if BP <140/90 mmHg. Ensure patient knows his/ her BP values and targets. Initiate or maintain lifestyle modification (page 12). Add BP medication as needed to achieve targets.
Dyslipidemia	LDL-C <2.0 mmol/L or a 50% decrease in LDL-C; TC/ HDL-C Ratio <4.0	<ul style="list-style-type: none"> Conduct fasting lipid profile in all patients every 12 months. Ensure patient knows his/ her lipid values and targets. If required, initiate LDL-lowering drug therapy (page 21). Ensure adequate titration to achieve targets. Start recommended dietary therapy (page 21). Promote daily physical activity and weight management. After obtaining required target, recheck annually.
Glycemic Control/ Diabetes	If diabetic: HbA1c <7% (<6% if possible without hypoglycemia)	<ul style="list-style-type: none"> Screen for Diabetes annually or as clinically indicated (page 65). If diabetic: <ul style="list-style-type: none"> Initiate lifestyle and pharmacotherapy to achieve near normal HbA1c. Initiate pharmacotherapy as per recommendations from Canadian Diabetes Association.²⁹
eGFR/ ACR	If proteinuria or CKD: Target ACR <40	<ul style="list-style-type: none"> Screen with eGFR/ ACR according to guideline (page 27). If target exceeded: <ul style="list-style-type: none"> ACEI or ARB to maximum tolerated dose and modify CV risk factors to target ACR <40; and, If ACR >60, refer to nephrology.
Antiplatelet	All patients with Ischemic Stroke or TIA to be started on antiplatelet therapy and continue indefinitely unless there is an indication for anticoagulation or a contraindication to the antiplatelet.	<ul style="list-style-type: none"> Evidence suggests that treating patients with: (1) ASA + ER Dipyridamole; or (2) clopidogrel is more effective than treating with ASA for secondary prevention. Long-term combinations of ASA and clopidogrel are not recommended. If ASA alone is used, the usual maintenance dosage is 80 – 325 mg/day. For secondary prevention in Ischemic Stroke or TIA, antiplatelet therapy is used life-long.
Antithrombotic	Warfarin	<ul style="list-style-type: none"> Stroke patients with atrial fibrillation should be treated with warfarin at a target INR of 2.5, range 2.0 to 3.0 target INR of 3.0 for mechanical cardiac valves, range 2.5 to 3.5, if they are likely to be compliant with the required monitoring and are not at high-risk for bleeding complications.
Influenza Vaccination	Annually	<ul style="list-style-type: none"> Patients with CVD should have an influenza vaccination on an annual basis.
Referral	Stroke Physician Carotid Endarterectomy	<ul style="list-style-type: none"> Stroke physician referral may be helpful in confirming diagnosis and cause of the event in addition to comprehensive management. Patients with symptomatic carotid artery disease of 70–99% stenosis measured at angiography or by two concordant non-invasive imaging modalities should be offered carotid intervention (carotid endarterectomy) within 2 weeks of the incident Stroke or TIA.