TRANSIENT ISCHAEMIC ATTACK (TIA) / STROKE CLINICAL PATHWAY

ROSIER Score (Recognition Of Stroke In Emergency Room)
If the patient has had acute onset of symptoms, calculate the following score:

- (+1) Asymmetric face weakness
- (+1) Asymmetric arm weakness
- (+1) Asymmetric leg weakness
- (+1) Speech disturbance
- (+1) Visual field defect
- (-1) Seizure activity
- (-1) Loss of consciousness or syncope

Total (if the total score is +1 or more, or stroke is suspected on other clinical grounds then triage Category 2. Possible score of -2 to +5.)

Assessment
Completed Initial Time Date
Primary and secondary survey
Perform BGL on arrival (notify MO and treat if BGL < 3.5 mmol/L)
RMO to follow flowchart overleaf, and use as a guide to make clinical decisions based upon the recommendations

Initial assessment

- Time of onset of acute neurological deficit
  - Time unknown

- Persistent neurology more than 4.5 hours since onset
- Persistent Neurology less than 4.5 hours since onset
- Neurological deficit resolved

- Non-contrast CT Brain (or MRI brain)
- ECG (esp. re: ?AF)
- Send FBC / ELFT / ESR and request fasting lipids
- Admit / refer Stroke Unit
- See local or national stroke management guidelines for further details

- ?Thrombolysis Candidate
  - Contact Stroke, Medical or ED consultant urgently re: acute imaging
  - See Statewide or local Thrombolysis protocol for further details

- If CT: Ischaemia / NAD, Risk Stratify the TIA (see over)
- If CT: bleed, refer as appropriate

Signature log (every person documenting in this clinical pathway must supply a sample of their initials and signature below)

<table>
<thead>
<tr>
<th>Initials</th>
<th>Signature</th>
<th>Print name</th>
<th>Role</th>
</tr>
</thead>
</table>
**Risk stratification of TIA**

**ABCD² Score for Risk Stratification.** Maximum score of 7.

- **Age**
  - 60 or more years: (1)
- **Blood pressure**
  - Systolic greater than or equal to 140
  - Diastolic greater than or equal to 90: (1)
- **Clinical signs**
  - Unilateral Weakness; OR: (2)
  - Speech disturbance without weakness: (1)
- **Other**
  - Duration of symptoms: (0)
  - Less than 10 minutes: (0)
  - 10 minutes – 1 hour: (1)
  - More than 1 hour: (2)
- **Diabetes**: (1)

**Total:** □

**High Risk TIA** □ 4–7 points

- Admit to hospital
  - See local or national stroke management guidelines
  - If last symptoms were more than one week ago then treat as low risk

- □ 1 or more complicating factors

- □ Complicating factors
  - New / untreated atrial fibrillation
  - Recurrent / crescendo TIAs
  - Carotid territory symptoms or known carotid artery disease
  - Other (if in doubt, discuss with stroke specialist or admit for assessment)

**Low Risk TIA** □ 0–3 points

- □ No complicating factors

- □ Discharge from Emergency Department
  - Anti-platelet agent (unless contraindicated)
  - Arrange outpatient appointment within 1 week (include this page with referral; tick when referral has been made)

Further imaging studies and consideration of antihypertensive and lipid-lowering therapy will be addressed at the outpatient appointment.

- Advise not to drive or enter other risk situations until review
- Advise smoking cessation if relevant
- Notify LMO (include this page with letter)

Medical Officer’s initials: ________________

**Medication recommendations for patients discharged from ED** (all to be given orally)

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspirin</td>
<td>300 mg stat</td>
<td>All patients in whom haemorrhage has been excluded with CT or MRI brain (unless contraindicated)</td>
</tr>
</tbody>
</table>
| Aspirin / Dipyridamole (Asasantin SR) | 25/200 mg bd     | To reduce the risk of side effects (e.g. headache):
  - Week 1: Asasantin SR 25/200mg and Aspirin 75–150mg, each once daily
  - Week 2: Increase to Asasantin SR 25/200mg bd and CEASE Aspirin |

- For patients intolerant of Dipyridamole SR: Clopidogrel or Aspirin is recommended.
- If currently taking Aspirin / Dipyridamole SR 25/200mg or Clopidogrel: recommend that this be continued.
- If the patient is in Atrial Fibrillation: Admission for anticoagulation is recommended.

| Clopidogrel                  | 75 mg daily     | Only if aspirin contraindication or intolerance                          |

**Comments**

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This document serves as a guide and is not intended to replace clinical judgement. Further information can be found in the National Stroke Foundation Clinical Guidelines for Stroke Management 2010