STROKE IMAGING & THROMBECTOMY

Sarah Hancock BSN, RN, SCRN, ASC-BC
Stroke Coordinator
Covenant Medical Center
Lubbock, TX
Sarah Hancock is the stroke coordinator at Covenant Medical Center in Lubbock. Covenant is a Primary Stroke Center with thrombectomy capabilities. Sarah is a RN and has been working with stroke patients for the last six years.
DISCLOSURES

FINANCIAL DISCLOSURE:
No financial relationships to disclose

UNLABELED/UNAPPROVED USES DISCLOSURE:
None to disclose
## 2.2.3 MECHANICAL THROMBECTOMY ELIGIBILITY-VEssel IMAGING

<table>
<thead>
<tr>
<th>AHA Recommendation</th>
<th>COR</th>
<th>LOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>For patients who otherwise meet criteria for mechanical thrombectomy, noninvasive vessel imaging of the intracranial arteries is recommended during the initial imaging evaluation</td>
<td>I</td>
<td>A</td>
</tr>
<tr>
<td>For patients with suspected LVO who have not had noninvasive vessel imaging as part of their initial imaging assessment for stroke, noninvasive vessel imaging should be obtained as quickly as possible (eg, during alteplase infusion if feasible)</td>
<td>I</td>
<td>A</td>
</tr>
<tr>
<td>In patients with suspected intracranial LVO and no history of renal impairment, who otherwise meet criteria for mechanical thrombectomy, it is reasonable to proceed with CTA if indicated before obtaining a serum creatinine concentration</td>
<td>IIa</td>
<td>B-NR</td>
</tr>
<tr>
<td>In patients who are potential candidates for mechanical thrombectomy, imaging of the extracranial carotid and vertebbral arteries, in addition to the intracranial circulation, may by reasonable to provide useful information on patient eligibility and endovascular procedural planning</td>
<td>IIb</td>
<td>C-EO</td>
</tr>
</tbody>
</table>
2.2.4 MECHANICAL THROMBECTOMY ELIGIBILITY-MULTIMODAL IMAGING

<table>
<thead>
<tr>
<th>AHA Recommendation</th>
<th>COR</th>
<th>LOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>When selecting patients with AIS within 6 to 24 hours of last known normal who have LVO in the anterior circulation, obtaining CTP or DW-MRI, with or without MRI perfusion, is recommended to aid in patient selection for mechanical thrombectomy, but only when patients meet other eligibility criteria from one of the RCTs that showed benefit from mechanical thrombectomy in this extended time window.</td>
<td>I</td>
<td>A</td>
</tr>
<tr>
<td>When evaluating patients with AIS within 6 hours of last known normal with LVO and an Alberta Stroke Program EarlyComputed Tomography Score (ASPECTS) of &gt;6, selection for mechanical thrombectomy based on CT and CTA or MRI and MRA is recommended in preference to performance of additional imaging such as perfusion studies.</td>
<td>I</td>
<td>B-NR</td>
</tr>
</tbody>
</table>
3.7.1 MECHANICAL THROMBECTOMY CONCOMITANT WITH IV ALTEPLASE

<table>
<thead>
<tr>
<th>AHA Recommendation</th>
<th>COR</th>
<th>LOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients eligible for IV alteplase should receive IV alteplase even if mechanical</td>
<td>I</td>
<td>A</td>
</tr>
<tr>
<td>thrombectomy is being considered.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In patients under consideration for mechanical thrombectomy, observation after IV</td>
<td></td>
<td></td>
</tr>
<tr>
<td>alteplase to assess for clinical response should not be performed.</td>
<td>III: Harm</td>
<td>B-R</td>
</tr>
</tbody>
</table>
THROMBECTOMY TRANSFER TIPS

• MAINTAIN SBP > 150 IF POSSIBLE AND < 190 IF NO ALTEPLASE ADMINISTERED OR < 180 IF ALTEPLASE ADMINISTERED

• ACCESS TO IMAGING PRIOR TO ARRIVAL HELPS WITH DECISION MAKING

• ASPECTS SCORE IS IMPORTANT INFORMATION FOR NIR PHYSICIAN (RADIOLOGY OR NEUROLOGY)

• DURING TRANSIT KEEP STROKE CENTER APPRISED OF ANY CLINICAL CHANGES

• MAKE SURE IMAGING HAS BEEN SENT WITH THE PATIENT

• TRANSFER PATIENT TO THE STROKE CENTER ASAP

• CTA HEAD/NECK
QUESTIONS

American Heart Association
BE FAST
STROKE SYMPTOM ASSESSMENT

Presentation by Lisa Haley, BSN, RN, ASC-BC
Stroke Coordinator
Hendrick Medical Center
Lisa Haley is the Stroke Coordinator for Hendrick Medical Center in Abilene, Texas. She has been a registered nurse for 25 years with most of her experience in the Emergency Department. In 2018 she joined the Performance Improvement Department at Hendrick. Providing quality stroke care to patients and promoting the swift treatment of stroke is important to Lisa and is something she strives to improve on every day.
DISCLOSURES

FINANCIAL DISCLOSURE:
No financial relationships to disclose

UNLABELED/UNAPPROVED USES DISCLOSURE:
None to disclose
FAST VERSUS BE FAST

- 11% OF STROKES ARE POSTERIOR STROKES

- NATIONWIDE 37% OF POSTERIOR STROKES WERE MISSED WITH “FAST”

- ADDED “B” FOR BALANCE AND “E” FOR EYES OR VISION DISTURBANCE: BOTH ARE SPECIFIC SYMPTOMS FOR POSTERIOR STROKES
B: BALANCE LOSS

BALANCE
Loss of balance, headache or dizziness
E: EYES BLURRED

Or sudden onset of vision loss
F: FACE DROOPING

FACE
One side of the face is drooping
A: ARM WEAKNESS OR DRIFT

**ARMS**
Arm or leg weakness
S: SPEECH DIFFICULTY

Speech
difficulty

SPEECH DIFFICULTIES
T: TIME OF ONSET OF SYMPTOMS AND TIME TO CALL 911

TIME
Time to call for ambulance immediately

Don’t wait - Call 911
SUDDEN ONSET OF SEVERE HEADACHE: COULD BE HEAD BLEED DUE TO HYPERTENSION OR ANEURYRSM
TIPS AND TRICKS TO REDUCE DOOR IN AND DOOR OUT TIMES: DECREASE TIME TO TREATMENT
CALL TRANSFER LINE

- CALL TRANSFER LINE ASAP
- GIVE DIAGNOSIS OF STROKE
- LAST KNOWN WELL < 24 HOURS
- ? CT RESULT (WHAT KIND OF STROKE)
- WAS CLOT BUSTING MEDICATION GIVEN
- MUST BE WITHIN 3-4.5 HOURS OF LKW
- IF YES: TIME OF BOLUS & DOSE
- IF NO: WHAT MEDICATIONS & HISTORY
CALL TRANSFER LINE

- START TRANSFER ARRANGEMENTS ASAP
- WAS CTA DONE & RESULTS
- FAX CHART TO ER IF ABLE