



# Treatment of stroke and prevention of recurrent stroke

SIGN Treatment subgroup



# Background

- Since the last SIGN guideline
  - Thrombolysis
  - Organised stroke unit care
  - Many neuroprotectant studies
  - Interventional studies
  - Secondary prevention studies



# Evidence base

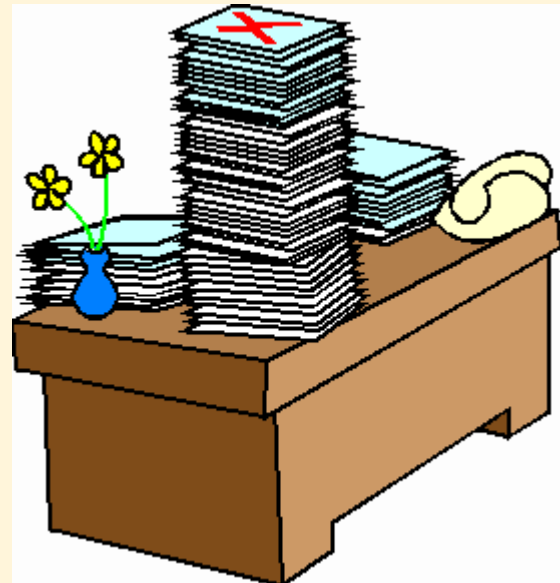
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What are the main messages?

# Thrombolysis

A

Patients admitted with stroke within four and a half hours of definite onset of symptoms, who are considered suitable, should be treated with 0.9 mg/kg (*up to a maximum 90 mg*) intravenous rt-PA.

A

- Onset to treatment time should be minimised.
- Systems should be optimised to allow the earliest possible delivery of intravenous rt-PA within the defined time window.

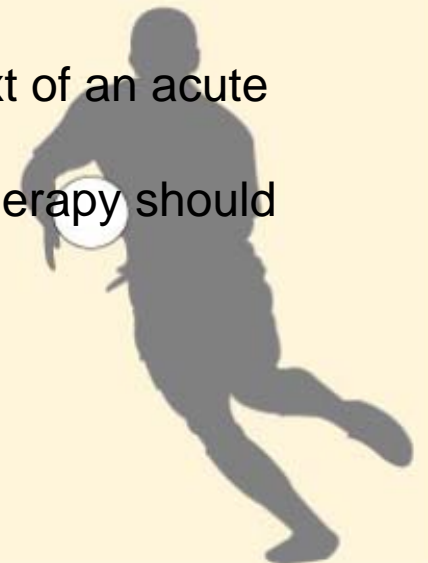
A

Streptokinase should not be used for treatment of patients in the acute phase of stroke.



Thrombolysis should be administered within the context of an acute stroke service.

Local protocols for the administration of thrombolytic therapy should be developed.



# Antiplatelet agents

## Acute stroke

**A** Aspirin 300 mg daily should be commenced within 48 hours of ischaemic stroke and continued for at least 14 days.



# Antiplatelet agents

## Secondary prevention

A

**Low-dose aspirin (*75 mg daily*) and dipyridamole (*200 mg modified release twice daily*) should be prescribed after ischaemic stroke or TIA for secondary prevention of vascular events.**

B

**Dose titration of dipyridamole may help to reduce the incidence of headache.**

A

**Clopidogrel (*75mg daily*) monotherapy should be considered as an alternative to combination aspirin and dipyridamole after ischaemic stroke or TIA for secondary prevention of vascular events.**



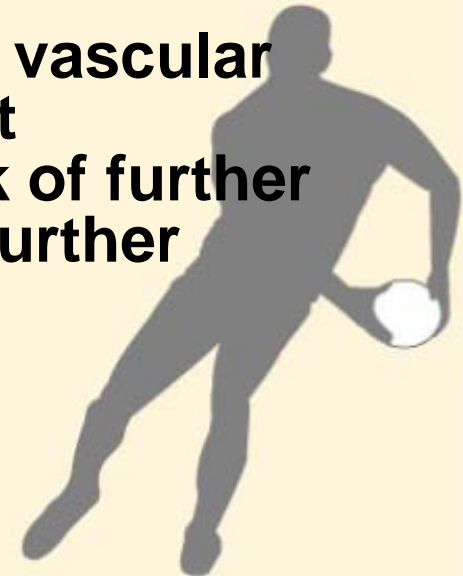
# Statins

**A** A statin should be prescribed to patients who have had an ischaemic stroke, irrespective of cholesterol level.

**A** Atorvastatin (*80 mg*) should be considered for patients with TIA or ischaemic stroke.

**A** Other statins (*such as simvastatin 40 mg*) may also be considered as they reduce the risk of major vascular events.

**A** Statin therapy for prevention of further vascular events post-haemorrhagic stroke is not recommended routinely unless the risk of further vascular events outweighs the risk of further haemorrhage.



# Hemicraniectomy

A

**For individuals aged up to 60 years who suffer an acute MCA territory ischaemic stroke complicated by massive cerebral oedema, surgical decompression by hemicraniectomy should be offered within 48 hours of stroke onset.**



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