TRANSIENT ISCHAEMIC ATTACK (TIA)

MANAGEMENT GUIDELINES

1. BACKGROUND

A transient ischaemic attack (TIA) is a rapid onset of a focal neurological impairment for less than 1-2 hours. Most TIAs last only a few minutes and in TIAs lasting less than 1-2hrs, infarction may be present on neuro-imaging. The risk of stroke after a TIA is about 12% in the first year and then about 7% a year thereafter. There is a high risk of stroke in the seven days after TIA, possibly as high as 10%. The risk of stroke, heart attack or vascular death is about 10% a year. This is about seven times the risk in the background population.

2. DIAGNOSIS OF TIA

2.1 TIA symptoms for diagnosis

Carotid Territory TIA **should have:**	Carotid Territory TIA **should NOT have:**	Vertebral Territory TIA **may have:**
Focal loss of function One of: -unilateral sensory/motor disturbance -unilateral visual disturbance -monocular blindness (amarosis fugax) -total aphasia or dysphasia	Loss of consciousness Dizziness Generalised weakness Confusion Urinary incontinence Vertigo Diplopia Dysphagia Tinnitus Loss of balance Amnesia Drop attacks Scintillating scotoma Sensory symptoms **in part of** limb or face	Bilateral motor/sensory loss Bilateral visual loss Ataxia Combination of vertigo, diplopia & dysarthria

Also…

(a) Seek information on history of recent MI, previous TIA, prosthetic heart valve,

(b) Check for AF, hypertension, prosthetic valves, carotid bruits, heart murmurs

(c) Look for any residual signs consistent with stroke ie gait, weakness, dysphasia, visual loss

3. IMMEDIATE MANAGEMENT OF A PATIENT WITH A TIA

- Soluble Aspirin 300mg stat, then 75mg od (give PPI if h/o dyspepsia)
- Only use Clopidogrel in cases of aspirin hypersensitivity or severe dyspepsia from aspirin not resolved by PPI
- Advise patient not to drive for 1 month

3.1 Investigations

Check FBC, PV, fasting glucose and lipids, ECG +/- 24 hr ECG if rhythm uncertain

3.2 **Referral** (See Appendix 1 – risk assessment)

Urgent Referral to TIA clinic by phone or fax

OR

Consider admission if crescendo TIAs (>1 in 7 days), fluctuating neurological symptoms/signs, if there is significant headache or the patient is on anticoagulants.

4. LATER MANAGEMENT

4.1 Blood Pressure & Cholesterol

- Simvastatin 20mg - 40mg at night if total cholesterol is >3.5
- Blood pressure lowering thiazide diuretic and ACEI - if BP raised (as for stroke) More aggressive lowering in younger patients, diabetes, renal failure
- Add Dipyridamole MR 200mg twice a day (stop after 2 years)

4.2 Lifestyle

The patient must be advised of the following:

- Not drive any vehicle for one month (including HGVs and PSVs)
- To stop smoking (with necessary support e.g. Nicotine Replacement Therapy
- cut excess alcohol intake,
- healthy diet,
- lose weight
- exercise

5. FUNNY TURNS

The diagnosis and assessment of “funny turns” should usually be undertaken in primary care. If the diagnosis is unclear or there are management problems, refer to Care of Elderly, Cardiology or Neurology (as appropriate) by telephone, fax or letter according to your degree of concern

Appendix 1 Risk Assessment

ASSESSING HIGH RISK TIAs

ABCD2 scoring system

ABCD	Meaning	Question	Score
A	Age	< 60 years	0
		≥ 60 years	1
B	Blood Pressure	Systolic >140mmHg and or ≥ 90mmHg	1
C	Clinical futures	Unilateral weakness	2
		Speech disturbance without weakness	1
		Other	0
D	Duration of symptoms	≥ 60 minutes	2
		10 - 59 minutes	1
		<10 minutes	0
D2	Diabetes		1

Refer all TIA's the same day by telephone or fax
Scores of 5, 6 or 7 indicate high risk and should be seen within 24 hrs

DRAFT