Quick Reference Guideline: TIA in adults

For the management of patients who present with symptoms and signs of a transient ischaemic attack. This quick reference guide has been adapted for local use and is based on the NICE Clinical Guideline 68: stroke and transient ischaemic attack in over 16s: diagnosis and initial management (2008) [http://www.nice.org.uk/CG68](http://www.nice.org.uk/CG68)

There are 4 key questions to ask in suspected TIA:

A) Was it sudden?
B) Was is a focal neurological deficit?
C) Has it resolved ... completely?
D) Was there impaired consciousness?

If the answer to 1-3 is YES, then follow this TIA guideline. If the answer to 1 and 2 is YES but the answer to 3 is NO then manage as a stroke. If the answer to 4 is YES then explore the possibility of another diagnosis e.g. syncope or seizure.

**SUSPECTED TIA**

Persistent symptoms at time of assessment?

YES

Treat as STROKE
Admit to hospital

NO

Mandatory triage questions:
1. Is the ABCD2 score 4 or more?
2. Is the patient in AF?
3. Has the patient had more than one TIA in the last week?
4. Is the patient anticoagulated?

YES to any of these questions

**HIGH RISK**
Start treatment
Send to hospital
Specialist assessment within 24 hours

NO to all 4 questions

**LOWER RISK**
Start treatment
Manage as an outpatient
Specialist assessment within 7 days

If a person presents after one week, they are considered lower risk

**MANAGEMENT**
Aspirin 300mg daily initiated immediately (for 2 weeks, then 75mg clopidogrel)
Cardiovascular examination, including BP
12-lead ECG
Bloods: FBC, U&E, lipid profile, LFTs, CRP, cholesterol, glucose
Start secondary prevention of vascular risk factors as soon as diagnosis confirmed
Brain imaging within 24 hours for high risk patients or 7 days for low risk patients only if a) CEA candidate and vascular territory uncertain; b) possible bleed/about to start urgent anticoagulation; c) alternative diagnosis likely; d) more than one TIA
Carotid Doppler USS in CEA candidates with a CAROTID ARTERY TERRITORY TIA
Quick Reference Guideline: TIA in adults - notes

1. Stroke is a leading cause of death and the major cause of long term adult disability. A TIA is defined as stroke symptoms and signs that resolve within 24 hours, and is a medical emergency. Recent evidence highlights that the risk of stroke following TIA can be high, especially in the first 48 hours. Strokes that follow a TIA are not minor; one in five are fatal and a further two thirds are disabling. Because stroke is such a burden in terms of death and disability, rapid assessment of people who have had a TIA is important in order to prevent a stroke.

2. TIA is a clinical diagnosis. Most TIAs last less than 1 hour and those of the eye last only a few minutes. Studies show around half of referrals to TIA clinic are for episodes that are not TIAs. Use the 4 key questions to establish whether a TIA is likely:
   A) Was it sudden? (symptoms usually maximal at onset)
   B) Was it a focal neurological deficit?
   C) Has it resolved ... completely? (within 24 hours)
   D) Was there impaired consciousness?
   If the answer to 1-3 is YES, then follow this TIA guideline. If the answer to 1 and 2 is YES but the answer to 3 is NO then manage as a stroke. If the answer to 4 is YES then explore the possibility of another diagnosis e.g. syncope or seizure. Common things that are NOT TIAs include: syncope/pre-syncope, vertigo, migraine, partial seizures.

3. Aspirin 300mg orally should be given immediately to a patient who presents with a TIA.

4. Specialist assessment focuses on answering the following questions: a) Was this a TIA? b) if YES, what arterial territory was it in? and c) what is the cause/underlying risk factors?

5. As soon as the diagnosis of TIA is confirmed treatment should be started for risk factors – e.g. anticoagulation for AF (after CT head), blood pressure treatment, smoking, diabetes, lifestyle etc. Note this is different to stroke when some treatments are delayed.

6. Brain imaging is not recommended for all patients following a single TIA. Brain imaging is recommended within 24 hours for high risk patients and 7 days for low risk patients ONLY if a) carotid endarterectomy candidate and vascular territory of the TIA uncertain; b) possible bleed/about to start urgent anticoagulation; c) alternative diagnosis likely; d) more than one TIA – when mimics e.g. SOLs are possible. If the vascular territory of the TIA is the issue then DWI-MRI should be used. For other reasons, CT of the head is recommended.

7. Carotid Doppler USS should be performed within 1 week in patients who are endarterectomy candidates and who have had a TIA in the carotid artery territory. The clinician should note which is the symptomatic carotid clinically, so that Doppler results can be interpreted correctly. Patients with 50%+ stenosis benefit from surgery if performed within 2 weeks of the event; after this time the benefit is only seen in 70%+ stenosis and the absolute risk reduction for stroke declines rapidly. Those with carotid occlusion require no vascular intervention. In retinal artery TIAS (monocular blindness) stroke risk is lower so surgery is considered only in 70%+ stenosis – note the relevant artery is on the same side in retinal artery TIAS.

8. Medical treatment of TIA is anti-platelet agents, control of blood pressure, cholesterol lowering through diet and drugs, lifestyle advice, and treatment of any underlying cause of the TIA – e.g. a vasculitis or embolic source.

9. All patients should be informed they may not drive for 4 weeks following a single TIA (need not inform DVLA), or 3 months if they have had more than one TIA (must inform DVLA) – NB rules are different for Group 2 licence holders.

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