

SJMH Department of Emergency Services Policy

SJMH Emergency Observation Center Transfer Guidelines: Transient Ischemic Attack (TIA)

Department of Emergency Services
Policy Number P- 4.0

Effective Date: May 2, 2007
Revised Date:
Reviewed Date:

Approved by:

Christopher Newton MD
Margaret Gillis MD
Susan Hickenbottom MD
Kimberly Gray RN

Policy

This policy is intended for patients with a TIA that have resolved neurological symptoms and meet inclusion and exclusion criteria for admission to the Emergency Observation Center.

Initial ED Assessment:

- Patients presenting with signs or symptoms consistent with a TIA may be eligible for transfer to the EOC for further diagnostic testing after an initial emergency department evaluation.
- TIA is defined by sudden onset of focal neurologic symptoms and/or signs that last less than 24 hours, with no apparent non vascular causes. **Neurologic findings will have resolved**, and there is no evidence of acute infarction on head CT.
- The emergency department evaluation will include:
 1. History
 2. Physical examination
 3. CBC with platelets, serum electrolytes, BUN, Creatinine, Glucose, PT and PTT
 4. ECG
 5. Head CT without contrast
- Based on the results of this emergency department examination, several determinations should be made before considering the patient for transfer to the EOC
 1. Which circulation is involved?
 - Anterior circulation TIAs** are characterized by any of the following:
 - Unilateral numbness or weakness involving the face, arm, or leg.
 - Aphasia
 - Neglect
 - Amaurosis fugax
 - Hemianopia
 - Posterior circulation TIAs** are characterized by any of the following:
 - Diplopia
 - Dysarthria
 - Dysphagia
 - Bilateral (crossed) weakness or numbness
 - Vertigo, nausea or vomiting
 - Ataxia
 - Hemianopia
 2. Is the TIA likely due to embolism from a cardiac source? TIA of probable cardio-embolic origin should be considered if the patient has any of the following:
 - Atrial fibrillation
 - Dilated cardiomyopathy with EF less than 20%

- Myocardial infarction within six months prior to the episode
 - Mechanical heart valve
 - Mitral annular calcification
 - Septal abnormalities
3. Has the patient had a recent TIA evaluation? Patients with TIA evaluation (i.e. vascular and cardiac imaging) within the previous 6 months do not require EOC admission. In these cases, the ED physician may discuss the case with the neurologist on call – statin agents or adjustment of anti platelet agents may be recommended. Most of these patients may be discharged if follow up is assured.

**Emergency Department
Disposition of TIA:**

1. Hospital admission if any of the following:
 - Positive CT scan which explains the acute episode
 - Suspected cardioembolic episode in patients not already anticoagulated or with subtherapeutic INR (INR less than 2.0)
 - Patients with uncontrolled hypertension
 - Any other medical condition or symptom complex which would require inpatient admission.
2. Consider discharge home with outpatient follow up if any of the following:
 - A. TIA evaluation within the previous 6 months - consider discussing with the neurologist on call
 - B. TIA episode greater than 4 weeks prior to their presentation
 - C. Migraine equivalent
3. All other patients may be considered for the EOC

Exclusion Criteria

1. A positive CT scan which explains the acute episode. These patients are not appropriate for the EOC
2. Non-focal symptoms (e.g. altered consciousness, generalized weakness, confusion, incontinence, syncope, or seizure). These indicate probable diagnosis other than TIA and are not appropriate for the EOC
3. Fever. This suggests alternate diagnosis, requiring infectious disease evaluation and treatment, and is not appropriate for the EOC.
4. Severe Headache. This suggests alternate diagnosis, and pain management will be difficult in the EOC.
5. Suspected carotid or vertebral artery dissection. Horner’s syndrome or symptoms that are preceded by neck or facial pain, recent neck trauma.
6. Suspected cardio-embolic episode in a patient not already anticoagulated, or with sub therapeutic INR.
7. Hypertension (greater than 185/110) uncontrolled by one or two doses of an anti hypertensive medication in the emergency department.
8. Greater than 4 weeks since the episode. The risk of stroke in this group is lower, and early outpatient follow-up is appropriate.
9. Chronic alcoholism with high likelihood of withdrawal
10. Prisoners or moderately to severely demented patients
11. Patients with a clear history of migraine equivalent.

**EOC Transfer
Procedure:**

1. Patients with TIA who meet the inclusion and exclusion criteria above are candidates for transfer to the EOC
2. The necessity for further evaluation will be explained to the patient by the emergency physician.
3. The emergency physician will complete the A4 chart prior to transfer to the EOC.
4. The emergency physician will complete the EOC standing order sheet for TIA prior to transfer to the EOC.
5. The patient will be transported to the EOC along with the standing order sheet, ECG, laboratory data, CT scan report, and an up-to-date copy of the emergency department chart.

Responsibility

Emergency Observation Center / Emergency Department/ Stroke Collaborative Practice Team

<u>Approval</u>	<u>Consultation</u>	<u>Committee/Person</u>	<u>Date</u>
		Stroke Collaborative Practice	4.10.2007