

# **Clinical Guidelines for Stroke Management 2017**

10 things to know about the Clinical  
Guidelines

A plain English summary for consumers

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The Stroke Foundation's *Clinical Guidelines for Stroke Management 2017* cover all aspects of stroke care, from initial acute treatment through to rehabilitation, discharge from hospital and rejoining the community. They are an update of the previous version of the guidelines, which was released in 2010.

The Clinical Guidelines were updated following standards issued by the Australian government's National Health and Medical Research Council (NHMRC). These standards involve considering research evidence with input from clinical experts and patients, and making recommendations that balance benefits and harms, values of patients and their families, access to specialist services, and costs to patients and the healthcare system.

## Key points:

- › A suspected stroke or transient ischaemic attack (TIA) is a medical emergency. Patients should be medically assessed urgently and treated as soon as possible.
- › Patients whose stroke has been caused by a blood clot should be assessed to determine if they are eligible for, and would benefit from, thrombolysis treatment (the process of giving a clot-busting drug to try to dissolve the clot and return blood supply to the brain), or endovascular thrombectomy (also known as “clot retrieval” surgery), which is a minimally invasive procedure where a small tube is inserted in the leg artery and fed into the brain artery to physically remove the clot causing the stroke. Thrombolysis must be administered within 4.5 hours of stroke onset but is more effective the earlier it can be given. Endovascular thrombectomy is generally performed within 6 hours of stroke onset, depending on patient-specific factors, but is also much more effective when performed as early as possible.
- › While in hospital, stroke patients should be treated in a stroke unit by an interdisciplinary team of healthcare professionals with expertise covering all areas of stroke care. Attention should be given to patients' body temperature, blood sugar levels and ability to swallow.
- › Investigations to identify the underlying cause of the stroke should be undertaken early so that measures to prevent another stroke can be commenced.

- › Any problems caused by the stroke, including difficulties with movement, sensation, thinking, perception and communication, should be assessed quickly so that rehabilitation can start straight away.
- › Other complications, such as fatigue, pain, incontinence and mood, should be addressed early while the patient is in hospital, and then reviewed on an ongoing basis (in and out of hospital) to try and prevent the impact of these issues.
- › Planning for discharge from hospital must include the stroke survivor, their family and carers, members of the stroke care team and community service providers. A written plan with information and resources specific to the individual patient should be provided. The need for home assessment and training of carers should also be considered.
- › To help stroke survivors return to living in the community, the stroke care team should also talk about driving, returning to work, leisure activities, getting around, sexual intimacy, self-care and self-management techniques, and the need for ongoing support.
- › This version of the Clinical Guidelines covers 3 new topics: cardiac investigations (testing for heart problems that may have caused the stroke); cervical artery dissection (stroke due to tears in arteries in the neck); and venous sinus thrombosis (clots in the veins that drain blood from the brain). Topics that have not been included in these Clinical Guidelines include: physiological monitoring, seizure management, central post stroke pain, agnosia, behavioural change, pressure care, sleep apnoea and complementary and alternative therapy. Topics about how stroke services are organised can be found in the Stroke Foundation's [National Stroke Services Frameworks](#).
- › Some recommendations have changed significantly since the 2010 version due to new research:
  - › The use of the ABCD<sup>2</sup> risk score, a tool for predicting stroke risk, should be avoided in isolation because it can potentially delay recognition of other high risk warning signs.
  - › Endovascular thrombectomy, or 'clot retrieval', has been shown to be the best stroke treatment for patients with blockage of a large brain artery and, when appropriate, should be commenced within 6 hours of stroke onset.
  - › Intensive out-of-bed activity within 24 hours of the stroke is not recommended; however, all stroke patients should start out of bed activity within 48 hours of stroke onset, when able.
  - › Blood pressure should not be lowered significantly below a systolic pressure of 140 mmHg in the first few days after the stroke.
  - › Rehabilitation therapy should be provided to stroke survivors for a minimum of 3 hours per day, with at least 2 hours of active task practice.