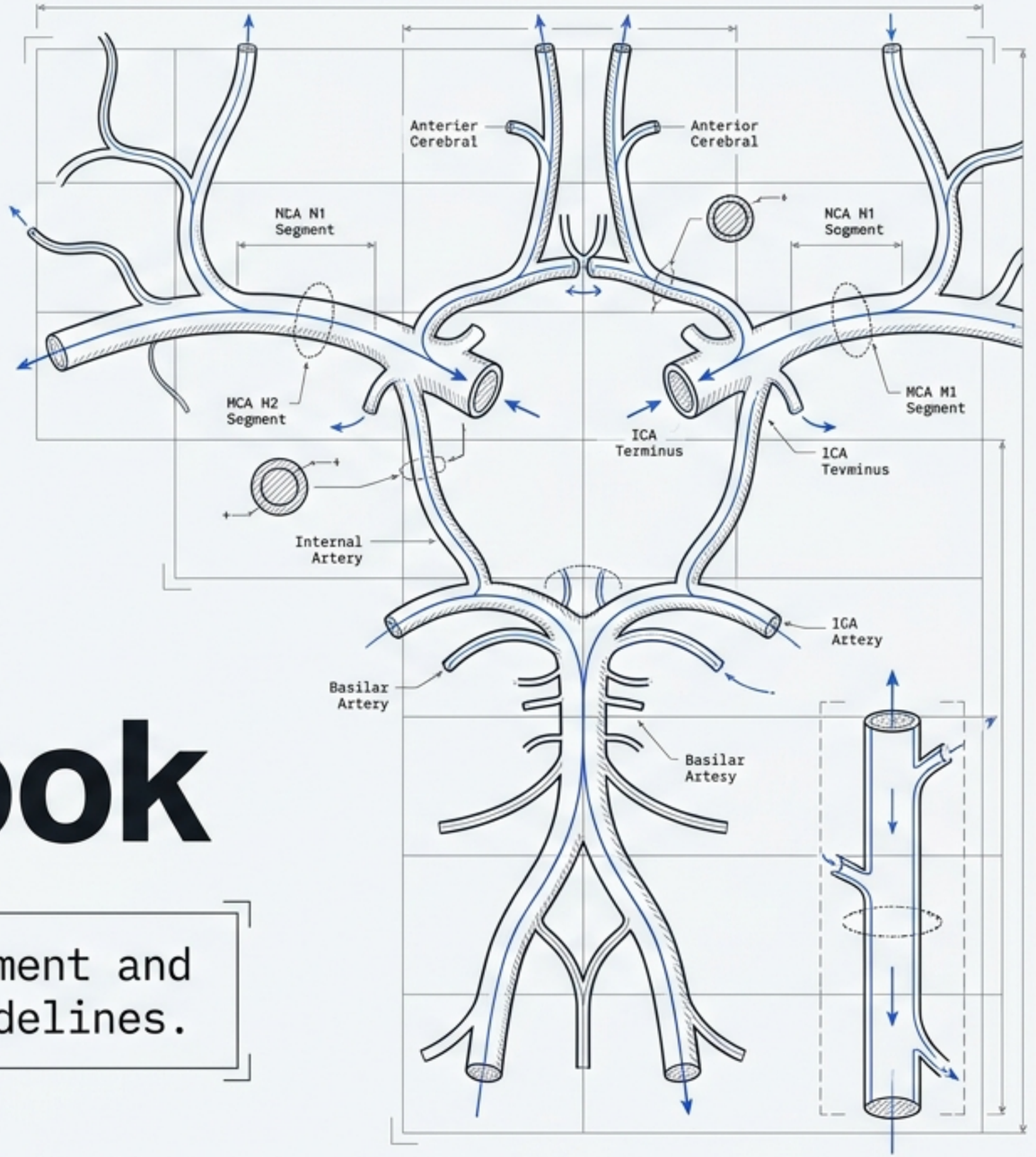
Stroke & TIA: The 2026 Clinical Playbook

A rapid-reference protocol for acute management and secondary prevention. Based on Med2Date Guidelines.



THE BURDEN

27,000 new strokes annually in Australia (1 every 19 minutes).

$6.2 billion system cost.

THE BENCHMARK

Door-to-Needle Time:

≤60 minutes.

1.9 Million Neurons Lost Per Minute of Large Vessel Occlusion.

THE PATIENT

Median age of first stroke:

73 (Male) / **78** (Female).

25% occur under age 65.

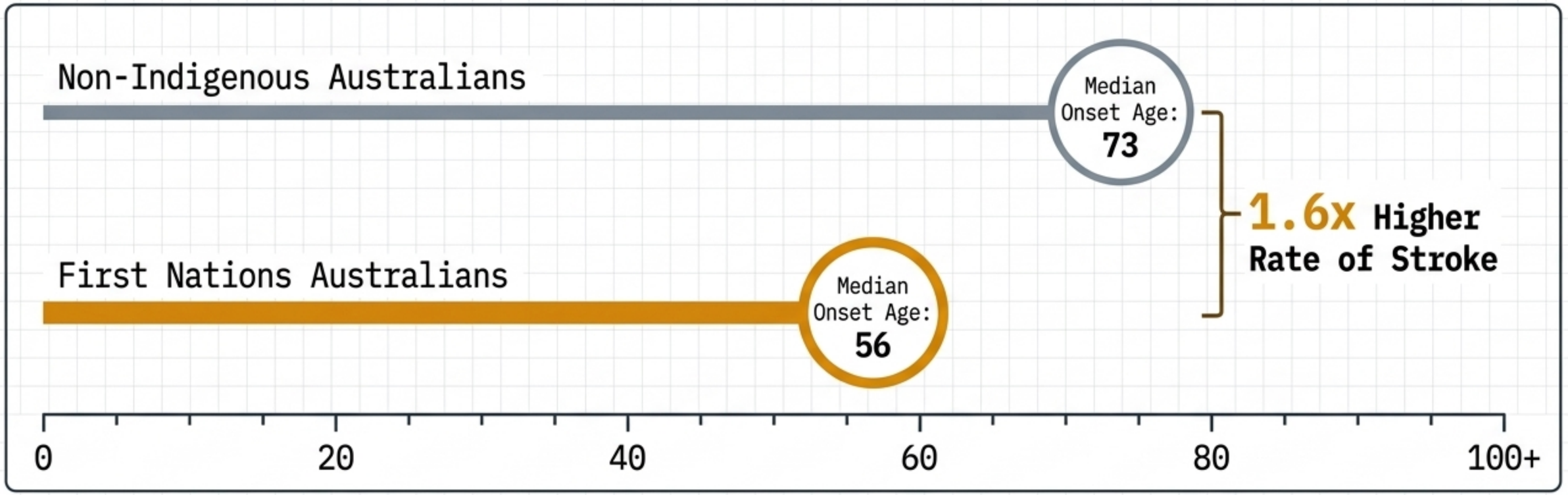
THE MANDATE

Prehospital notification

+

+ rapid transport

+ stroke unit care.



REMOTE ACCESS

<50% of remote stroke patients reach hospital within 4.5h. Telestroke networks are critical.

CULTURAL SAFETY

Mandates inclusion of Aboriginal Health Workers; emphasizes understanding of presence and Sorry Business.

PBS CLOSE THE GAP (CTG)

Reduces co-payments to ensure access to secondary prevention (statins, antihypertensives).

TIA: The 48-Hour Warning.

The Danger Zone:
50% of subsequent strokes occur within the first 48 hours.

The Threat:
10–15% risk of completed stroke within 90 days.

EXPRESS Study Data: Same-day or next-day evaluation reduces subsequent stroke risk by up to 80%.

The ABCD² Risk Speedometer

Score 0–3
~1% 2-day stroke risk

Urgent TIA Clinic within 7 days

Score 4–5
~4% 2-day stroke risk

Same-day/Next-day Specialist Assessment + Imaging

Score 6–7
~8% 2-day stroke risk

Immediate ED Assessment + Consider Admission

Override Warning: Do not use ABCD² to exclude evaluation. AF, carotid stenosis, or crescendo TIAs demand urgent escalation regardless of score.

The Urgent Workup Checklist

Essential - Immediate

- [x] **Non-contrast CT Brain:** Must occur <24h. Excludes **haemorrhage**, mass, **established infarct**.
- [x] **Antiplatelet Load:** Do not delay **once bleeding excluded.** **Aspirin** 300mg PO stat OR **Clopidogrel** 300mg PO stat.
- [x] **12-Lead ECG:** Screen for **atrial fibrillation**.

Advanced - Available/Targeted

- [ ] **MRI Brain with DWI:** Superior sensitivity. Reclassifies 30-50% of **TIAs** as minor strokes.
- [ ] **CTA Head & Neck / Carotid Duplex:** Identify **large-vessel stenosis** urgently for **anterior circulation symptoms**.
- [ ] **Extended Cardiac Monitoring:** Telemetry ≥24h or Holter (7-14 days) for **cryptogenic cases**.

Carotid Intervention Triggers

≥70% Stenosis.

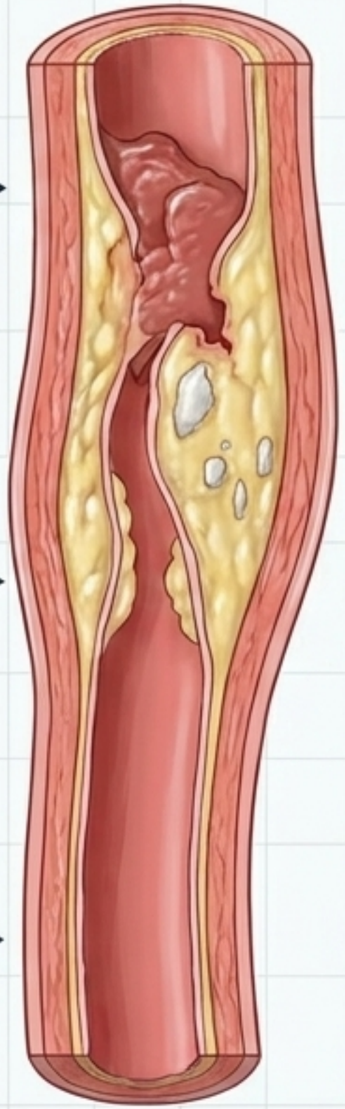
CEA recommended within 2 weeks (NNT ≈ 5 over 5 years).
Must be performed by surgeon with <6% complication rate.

50–69% Stenosis.

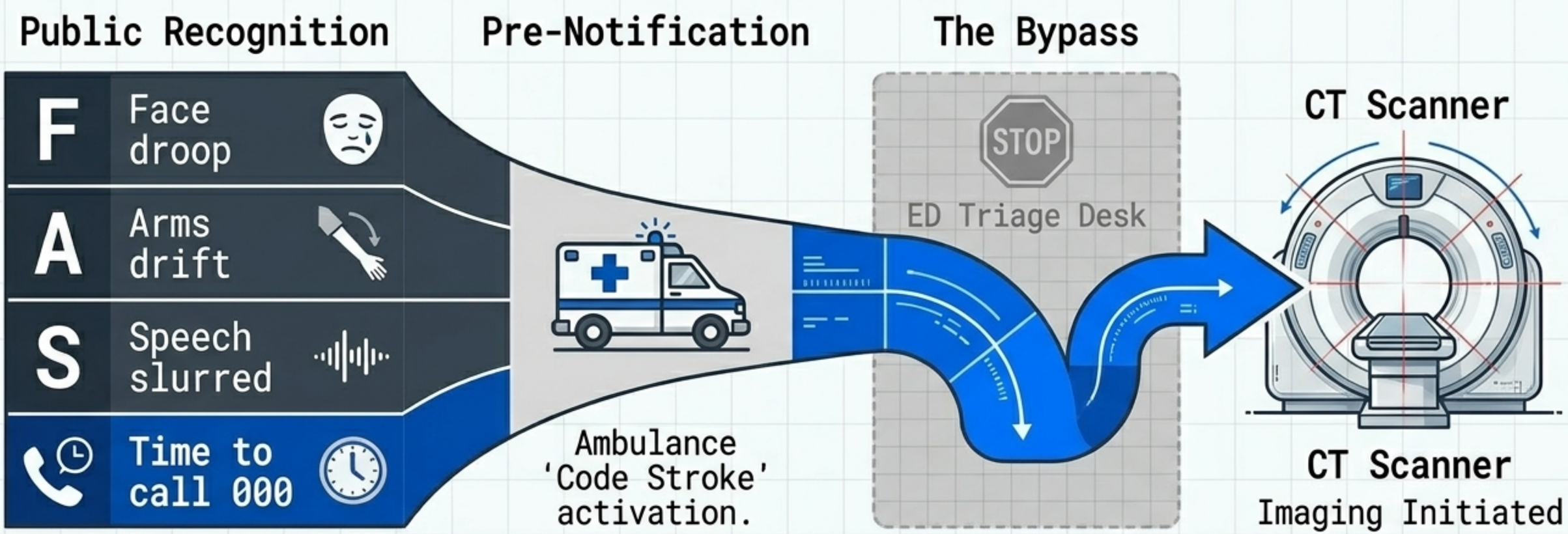
Moderate benefit from Carotid Endarterectomy (CEA).
Individualize decision (favour men, recent symptoms).

<50% Stenosis.

Best medical therapy alone.
Surgery not indicated.



The Prehospital Funnel (FAST to CT)



CT Standby + Stroke Team Ready = Drastic reduction in Door-to-Needle time.

‘Thrombolysis Protocol’

IV Alteplase (0.9 mg/kg max 90mg) OR Tenecteplase (0.25 mg/kg max 25mg).

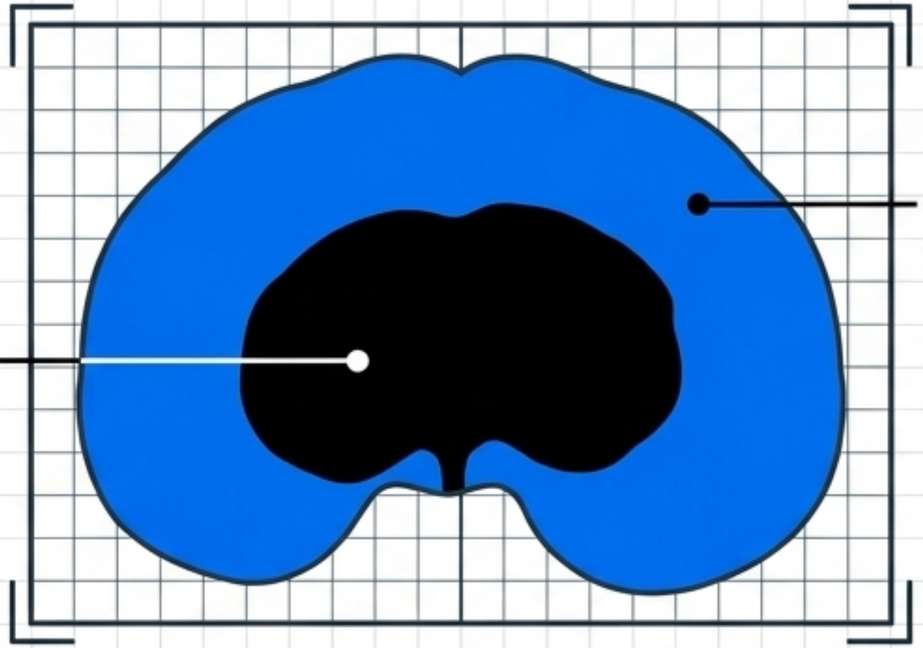
GO

- ≤4.5 hours from symptom onset/last known well
- Measurable deficit
- CT shows no blood
- Age ≥18

ABORT (Absolute Exclusions)

- ICH on CT
- BP stubbornly >185/110 mmHg
- Platelets <100 × 10^9/L
- DOAC use <48 hours (normal renal function)
- INR >1.7
- Recent major surgery/trauma (<14 days)

Endovascular Thrombectomy (EVT) Windows



Ischaemic Core
(Irreversibly infarcted tissue)

The Penumbra
(Salvageable Tissue - Flow required)

0–6 Hours (Standard)

Standard CTA/MRA showing occlusion (ASPECTS ≥6). EVT indicated.

6–24 Hours (Extended)

Requires CTP/MRI mismatch (DAWN/DEFUSE 3 criteria). Core must be <70 mL with mismatch ratio ≥1.8.

COMPARISON MATRIX: Acute BP Management (Ischaemic Stroke)

	Pre-Thrombolysis	Post-Thrombolysis (First 24h)	Non-Thrombolysed Ischaemic
Target	<185/110 mmHg	<180/105 mmHg	Permissive Hypertension up to 220/120 mmHg
Rationale	To safely administer Alteplase.	Prevent haemorrhagic transformation.	Maintain collateral perfusion to the penumbra.
Agents	IV Labetalol 10-20mg boluses OR IV GTN infusion.	IV Labetalol or IV GTN infusion.	Treat only if >220/120 or end-organ damage.

Intracerebral Haemorrhage: The Bleed (30–50% 30-day mortality).

Assessment Sequence

Airway

GCS ≤8 typically requires intubation.

Imaging

Urgent non-contrast CT. Look for the ‘Spot Sign’ on CTA (active contrast extravasation = high expansion risk).

ICH Score

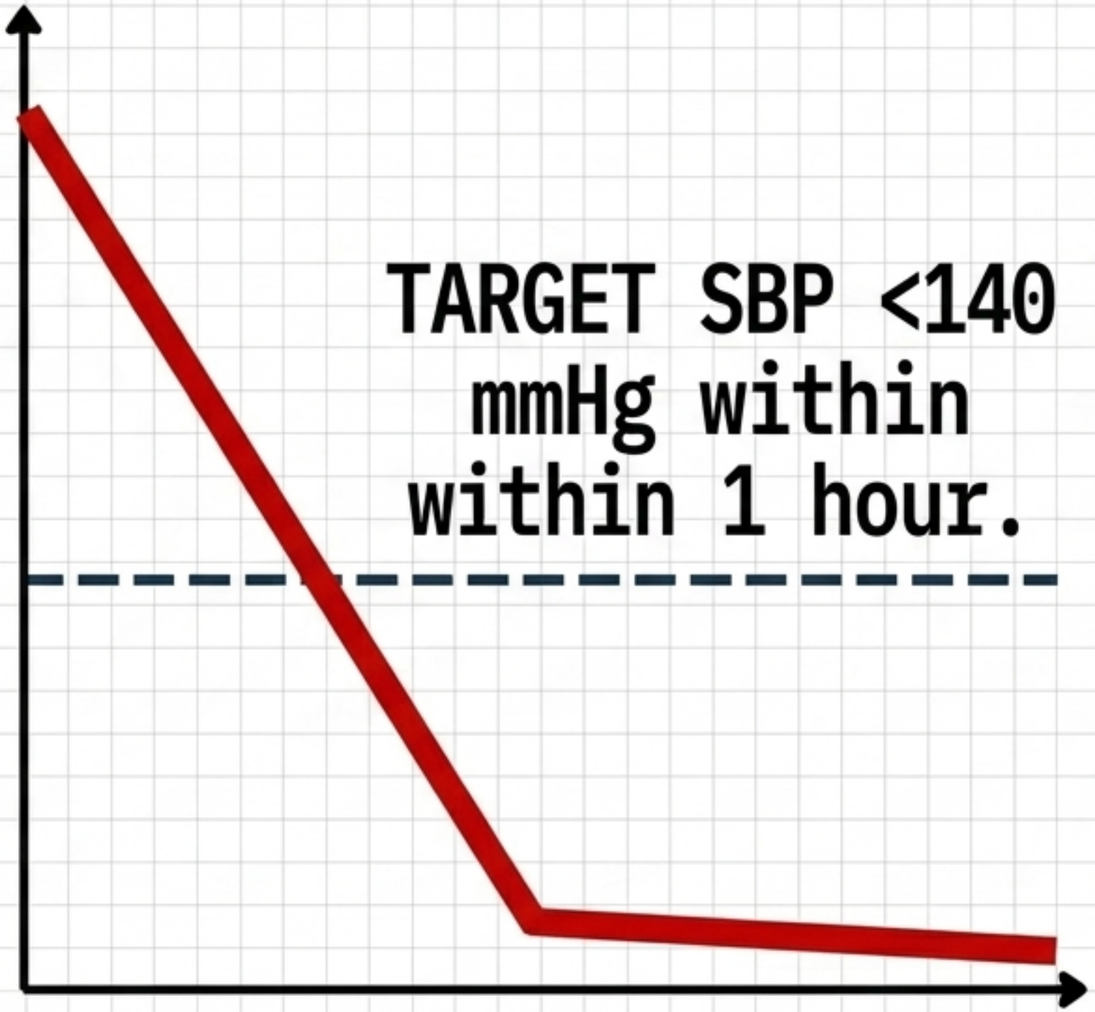
Prognostication based on GCS, Age, ICH Volume (ABC/2), Intraventricular Extension, Infratentorial Origin. (Score ≥5 = >95% mortality).

The BP Crush (INTERACT2 Paradigm)

The Evidence Data Card

INTERACT2 / ATACH-2 trials.

Early intensive lowering reduces haematoma expansion and improves functional outcomes.



The Arsenal (Medication Panel)

- IV Labetalol (10-20mg boluses, max 300mg)
- IV Nicardipine (5mg/hr)
- IV GTN infusion

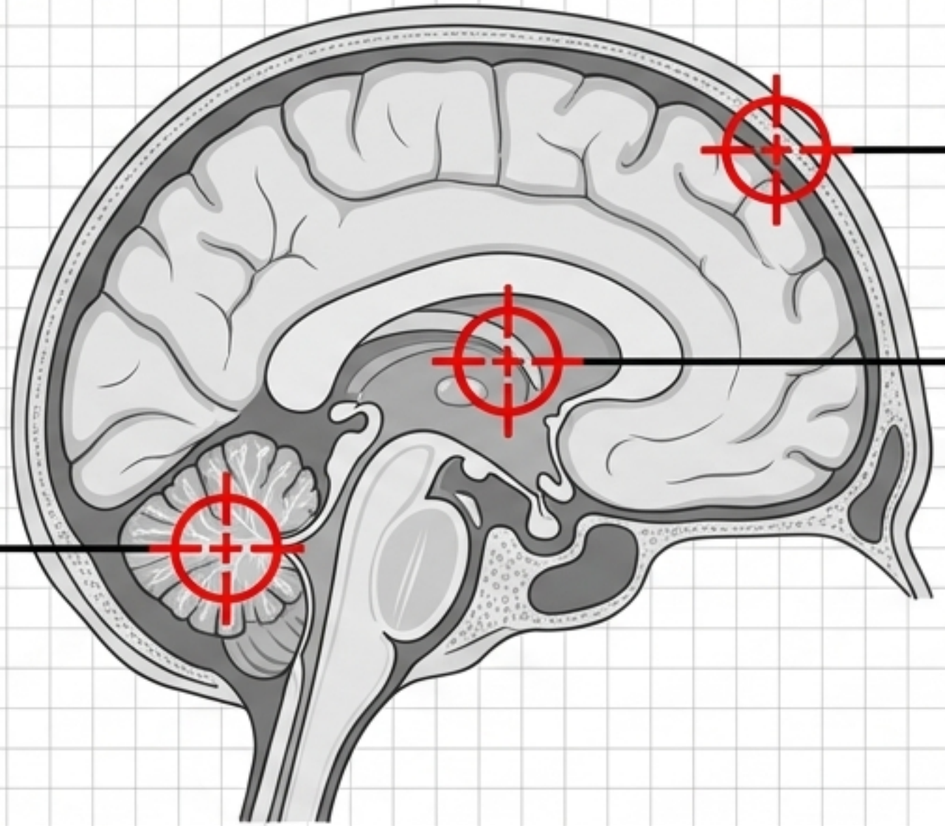
Transition to oral agents once stable.

COMPARISON MATRIX: Anticoagulation Reversal

The Lock (Offending Drug)	The Key (Antidote & Dosage)
Warfarin	Vitamin K (5-10mg IV) + 4-Factor PCC (25-50 IU/kg based on INR).
Dabigatran (Pradaxa)	Idarucizumab (Praxbind) 5g IV.
Apixaban / Rivaroxaban	Andexanet Alfa (Ondexxya) Low/High dose IV OR 4-Factor PCC 50 IU/kg (if Andexanet unavailable).

ALERT: Haematoma expansion risk is highest in the first hours. Reversal must not be delayed for any reason.

Neurosurgical Triggers



Superficial Lobar

≤1cm from cortical surface with progressive deterioration (STICH II trial data).

Action: Consider evacuation.

Ventricles

Intraventricular haemorrhage causing Hydrocephalus.

Action: External Ventricular Drain (EVD) insertion.

Posterior Fossa/Cerebellum

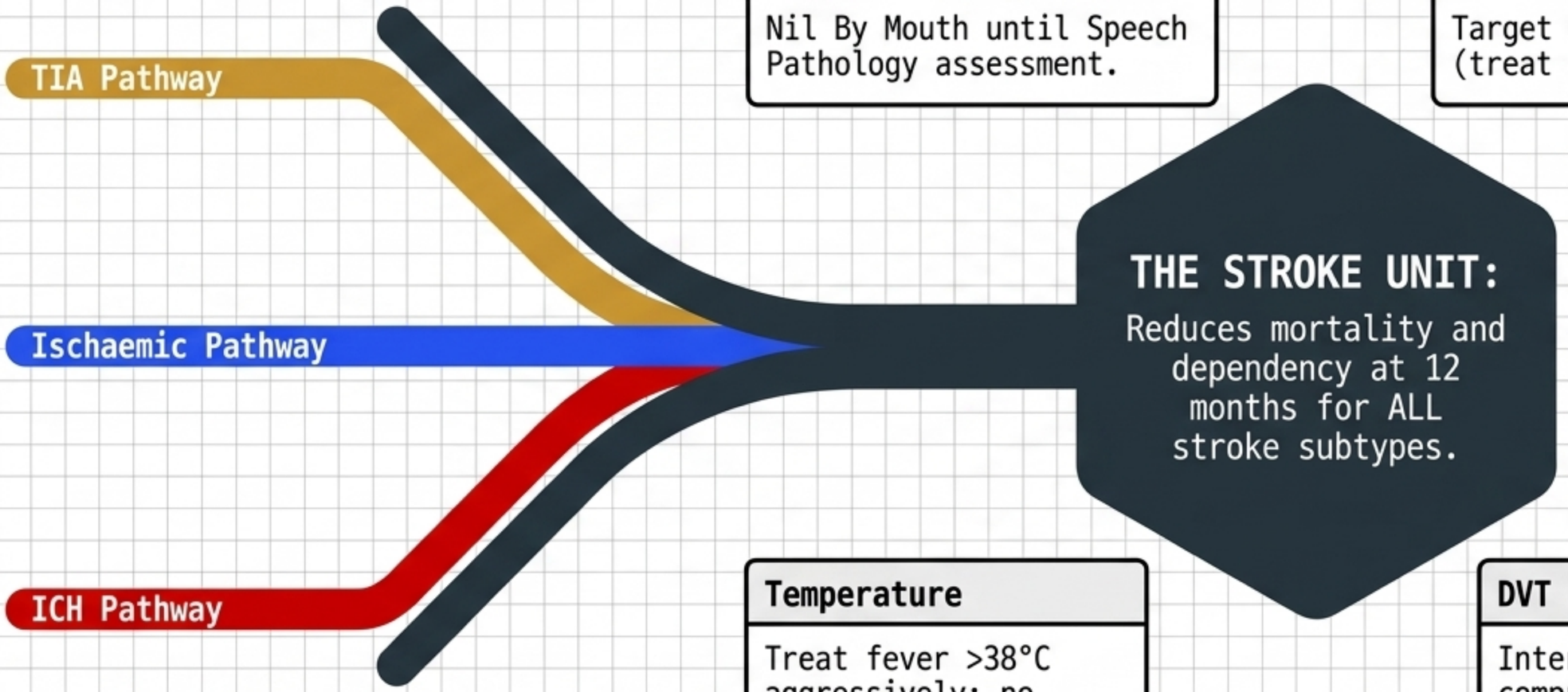
Haemorrhage ≥3cm or brainstem compression.

Action: Urgent surgical evacuation (lifesaving).

Context Note

Deep-seated (basal ganglia/thalamic) ICH generally does not benefit from surgery (STICH I).

SYNTHESIS ARC: The Stroke Unit Ecosystem



Swallow Protection

Nil By Mouth until Speech Pathology assessment.

Glycaemic Control

Target BSL 5–15 mmol/L (treat >10 with insulin).

THE STROKE UNIT:

Reduces mortality and dependency at 12 months for ALL stroke subtypes.

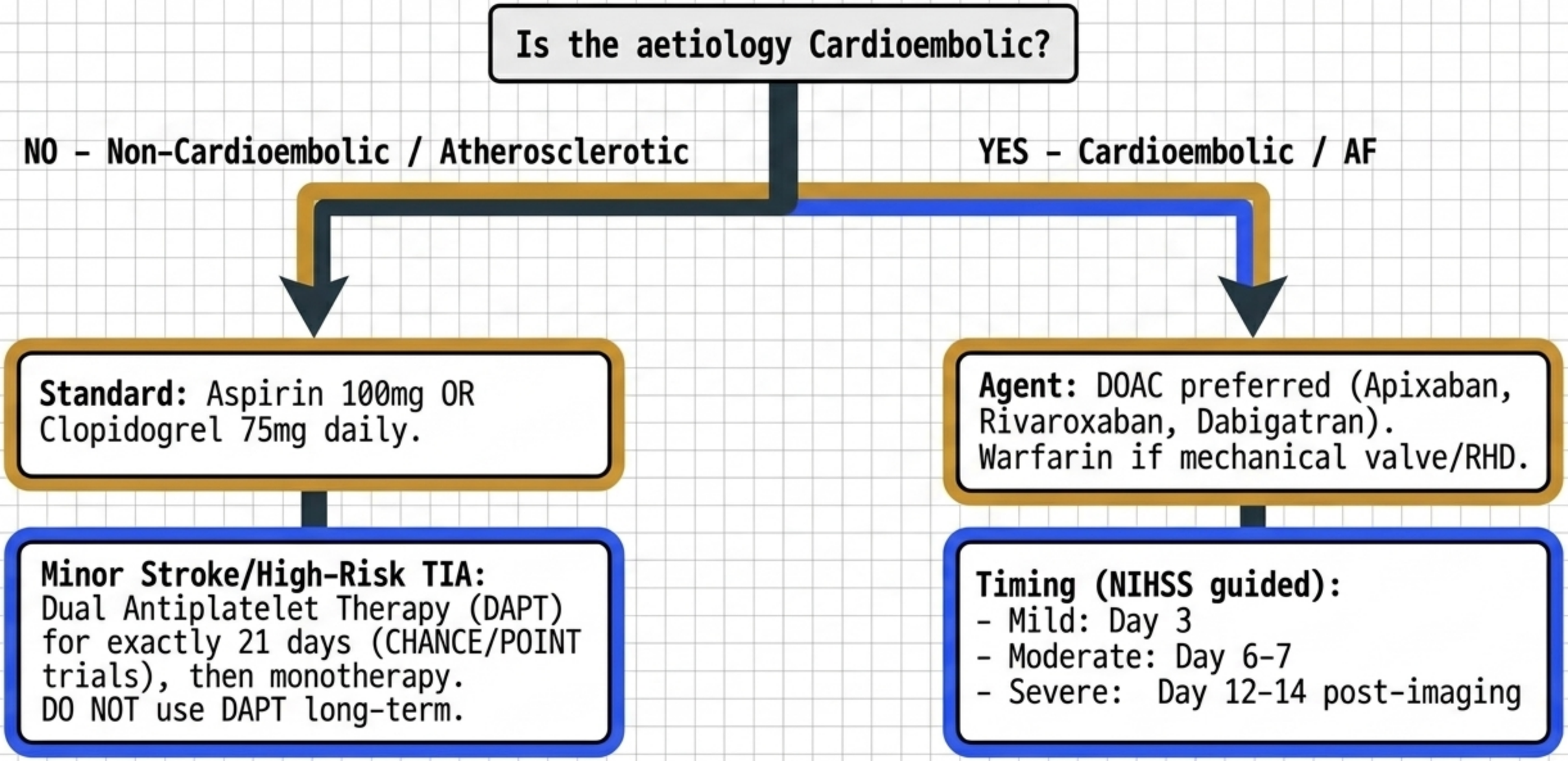
Temperature

Treat fever >38°C aggressively; no routine hypothermia.

DVT Prophylaxis

Intermittent pneumatic compression devices (LMWH after 24–48h if bleed excluded).

Antiplatelet vs. Anticoagulant Decision Tree



The Secondary Prevention Pillars

Lipids (The Statin Mandate)

High-intensity therapy for ALL ischaemic stroke/TIA regardless of baseline LDL. Atorvastatin 80mg or Rosuvastatin 40mg.

Target LDL <1.8 mmol/L.

Blood Pressure

Restart 24-48h post-ischaemic (7 days post-ICH). Target <130/80 mmHg.

First line: ACEi (Perindopril) ± Indapamide (PROGRESS trial) or Calcium Channel Blocker.

Glycaemic/Metabolic

HbA1c target ≤7.0%.
SGLT2 inhibitors or GLP-1
SGLT2 inhibitors or GLP-1 agonists preferred for proven cardiovascular benefit.

Lifestyle/Structural

Smoking cessation (single best intervention).
OSA screening (STOP-BANG).
PFO closure consideration (<60 years, cryptogenic).

Special Populations Modifier Grid (Part 1)

Pregnancy & Puerperium 

- **Risk:** Elevated 2–3x (especially 3rd trimester to 6w postpartum).
- **Thrombolysis:** Alteplase is Cat B3; use only if life-threatening.
- **Meds:** Warfarin/Statins contraindicated. Use LMWH. Low-dose aspirin is safe.
- **Differentials:** Consider PRES and CVST.

Paediatrics 

- **Aetiology Shift:** Cardiac, moyamoya, sickle cell, prothrombotic (not atherosclerosis).
- **Protocol:** Use adapted FAST. Thrombolysis/EVT not routine; case-by-case at specialist centres.
- **Treatment:** Anticoagulate for dissection/CVST.

Special Populations Modifier Grid (Part 2)

Elderly (≥80 years)

- Age is no longer an absolute EVT/ Alteplase exclusion.
- **DOAC dose reduction critical** (e.g., Apixaban 2.5mg if Wt≤60kg or Cr≥133).
- **Falls alone do not** justify withholding anticoagulation.

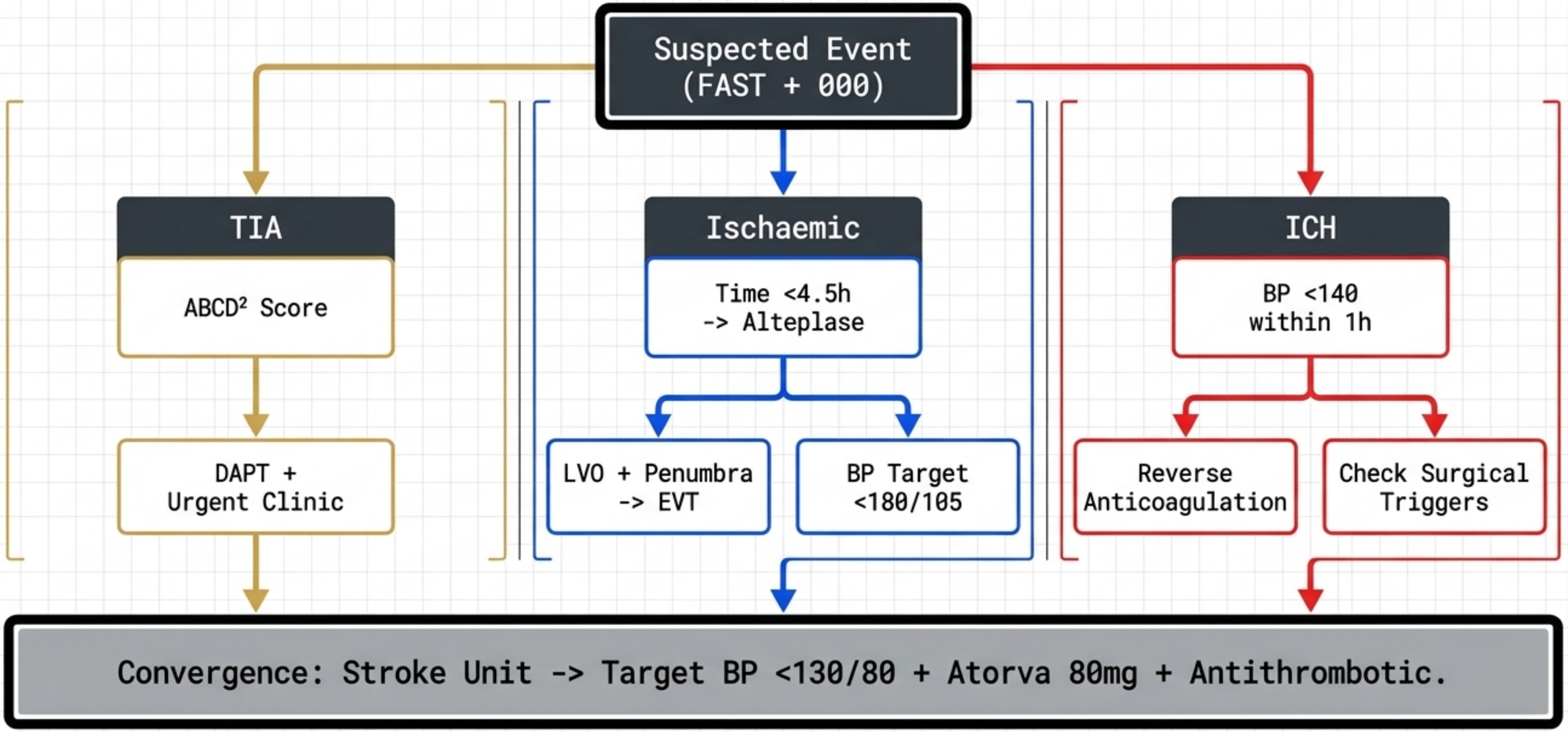
Renal Impairment (eGFR <60)

- **Avoid Dabigatran** if eGFR <30.
- **Enoxaparin** reduced to 20mg SC daily if eGFR <30.
- **Caution** with contrast CTA.

Hepatic Impairment

- **Rivaroxaban** contraindicated in Child-Pugh B/C.
- **Statins** contrandicated in active liver disease.
- **Prefer LMWH** in severe disease over unpredictable Warfarin.

The Playbook in One Page: The Med2Date Protocol



Always cross-reference with current Therapeutic Guidelines.