key points

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In the UK, at least 100,000 people have an acute stroke each year and there are more than 1.2 million stroke survivors. A first ever transient ischaemic attack (TIA) affects approximately 50 people per 100,000 per year in the UK and around 15% of people who have a first stroke have had a preceding TIA. Assessing patients and instituting treatment quickly represents a golden opportunity to prevent a potentially disabling stroke. TIAs are brief episodes of neurological dysfunction resulting from focal cerebral ischaemia not associated with permanent cerebral infarction.

A validated tool, such as the FAST (Face Arm Speech Time to call 999) test may be used to screen people with sudden onset of neurological symptoms. However, the FAST test may miss some patients with a TIA/stroke, particularly when it occurs in the posterior circulation. If TIA/stroke is suspected even if the FAST test is negative, urgent action is required with referral to, and review by, specialist services.

Patients with a suspected TIA should be referred immediately for specialist assessment and investigation, to be seen within 24 hours of onset of symptoms. Patients with a suspected stroke should be admitted immediately to hospital, ideally to an acute stroke unit. Patients with a suspected TIA who have a bleeding disorder or are taking an anticoagulant should also be admitted to an acute stroke unit as haemorrhage must be excluded.

For those with a clinically definite TIA, the use of diffusion weighted MRI is debatable. However, where there is diagnostic uncertainty, imaging (either MRI or CT) may be helpful, mainly to exclude an alternative diagnosis such as a space occupying lesion. For those with a suspected stroke, an urgent CT scan is required to exclude a bleed if the patient is eligible for thrombolysis within 4.5 hours of symptom onset. Other investigations for patients presenting with TIA or stroke should include: full blood count, blood glucose, lipid profile and a coagulation screen. An ECG is done routinely to assess cardiac rhythm.

Aspirin (300 mg daily) should be offered to all patients who are suspected of having had a TIA in the emergency department or community, and started immediately, provided there are no contraindications. Once the diagnosis of TIA has been confirmed, clopidogrel (75 mg daily) should be substituted for aspirin as long-term secondary prevention. Unless contraindicated, high-dose statin therapy is recommended in all patients for long-term secondary prevention. Patients presenting with an ischaemic stroke within 4.5 hours of symptom onset should be considered for intravenous thrombolysis and this should be delivered as quickly as possible, aiming for a door to needle time < 30 minutes. Aspirin (300 mg daily) is used following ischaemic stroke, switching to clopidogrel after 2 weeks or on hospital discharge.