

favor use of an oral anticoagulant while obtaining ambulatory 30-day electrocardiogram monitoring. If we identify significant internal carotid stenosis, we refer for carotid endarterectomy during the same hospitalization regardless of infarct size. For all else, we use the dual antiplatelet agents aspirin (81 mg) and ticagrelor (180-mg load, followed by 90 mg twice daily) daily for 30 days then discontinue ticagrelor and continue aspirin at 81 mg daily. We prefer ticagrelor to clopidogrel, which is also proven in these settings, because it is not affected by common polymorphisms of CYP2C19 that limit efficacy of clopidogrel in significant proportions of patients, particularly those of Asian descent. If the CTA revealed significant intracranial atherosclerosis or other precranial vessel stenosis within the vascular territory of the infarct (lumen caliber reduced by >50%) we continue dual antiplatelet agents for at least 3 months, then convert to a single agent. Unless contraindicated, all patients receive atorvastatin 80 mg, with goal low-density lipoprotein level of <70 mg/dL unless the stroke has a nonatherothrombotic cause. Patients who are statin intolerant can receive PSK9 inhibitors. Blood pressure control should target systolic blood pressure <120 mmHg long term, but we allow permissive hypertension for the first few weeks to help with collateral flow to the brain. BA, basilar artery; CTP, computed tomography perfusion; ICA, internal carotid artery; IV, intravenous; M1, middle cerebral artery first division; M2, middle cerebral artery second division; PA, plasminogen activator.

After the clinical diagnosis of stroke is made ([Chap. 426](#)), an orderly process of evaluation and treatment should follow. The first goal is to prevent or reverse brain injury. Attend to the patient's airway, breathing, and circulation (ABCs), and treat hypoglycemia or hyperglycemia if identified by finger stick testing. Perform an emergency noncontrast head CT scan to differentiate between ischemic stroke and hemorrhagic stroke ([Chap. 428](#)); there are no reliable clinical findings that conclusively separate ischemia from hemorrhage, although a more depressed level of consciousness, higher initial blood pressure, or worsening of symptoms after onset favor hemorrhage, and a deficit that is maximal at onset, or remits, suggests ischemia. Treatments designed to reverse or lessen the amount of tissue infarction and improve clinical outcome fall within six categories: (1) medical support, (2) IV thrombolysis, (3) endovascular revascularization, (4) antithrombotic treatment, (5) neuroprotection, and (6) stroke centers and rehabilitation.

MEDICAL SUPPORT