HIGH RISK
SUGGESTED EMERGENT CONSULTATION

SIGNS & SYMPTOMS
Signs of Stroke or TIA:
- Transient monocular blindness
- Expressive or receptive aphasia
- Unilateral weakness or numbness

SUGGESTED PREVISIT WORKUP
Immediate transfer to ED for persistent symptoms suggestive of stroke
For TIA, carotid duplex
If symptoms have resolved, urgent office visit for any carotid stenosis > 50%, these patients warrant surgical intervention within 1-2 weeks
Start aspirin, statin

MODERATE RISK
SUGGESTED CONSULTATION OR CO-MANAGEMENT

SIGNS & SYMPTOMS
High-grade Carotid Stenosis:
- Asymptomatic
- Identification of > 70% stenosis on carotid duplex, CTA, or MRA

SUGGESTED WORKUP
Start aspirin/statin (even if patients have normal cholesterol)
Office visit with vascular surgeon to discuss surgical options (2-4 weeks)

LOW RISK
SUGGESTED ROUTINE CARE

SIGNS & SYMPTOMS
Low-grade Carotid Stenosis:
- Asymptomatic
- Identified on carotid duplex, CTA, or MRA
- Identification of < 70% stenosis on imaging study

SUGGESTED MANAGEMENT
Start aspirin/statin (even if patients have normal cholesterol)
Confirm asymptomatic status
Office visit with vascular surgeon vs. yearly carotid duplex studies with PCP for > 50% stenosis.
Smoking cessation

CLINICAL PEARLS

- Patients with signs of a TIA are likely to have a recurrent event or a stroke if carotid revascularization is not done, with the highest risk being in the first 2 weeks.
- Asymptomatic patients with > 80% stenosis still warrant revascularizations based on current guidelines. There are ongoing trials to study the benefits of medical management alone which can be discussed at the time of consultation.

For more information or referral questions, contact your local vascular practice. For a complete listing, visit mainehealth.org/services/cardiovascular/service-locations

These clinical practice guidelines describe generally recommended evidence-based interventions for the evaluation, diagnosis and treatment of specific diseases or conditions. The guidelines are: (i) not considered to be entirely inclusive or exclusive of all methods of reasonable care that can obtain or produce the same results, and are not a statement of the standard of medical care; (ii) based on information available at the time and may not reflect the most current evidenced-based literature available at subsequent times; and (iii) not intended to substitute for the independent professional judgment of the responsible clinician(s). No set of guidelines can address the individual variation among patients or their unique needs, nor the combination of resources available to a particular community, provider or healthcare professional. Deviations from clinical practice guidelines thus may be appropriate based upon the specific patient circumstances.