ANESTHETIC MANAGEMENT FOR ENDOVASCULAR TREATMENT OF ACUTE ISCHEMIC STROKE

1) **STAT CASE (EO)** - Avoid any delays

2) Monitoring:
    a. Standard monitors with NIBP q3 minutes
    b. Arterial line if does not delay procedure, insert pre-induction if GA
    c. If arterial line not possible consider T-ing off IR femoral artery sheath
3) Anesthesia:
    a. Most patients will require minimal to mild sedation;
    b. A minority of patients will require a GA (e.g. posterior circulation or severe stroke; airway compromise or vomiting, uncooperative)
    c. If GA, aim for early extubation if possible
4) Blood pressure management
    a. Target Blood Pressure
        i. SBP 140 - 180 mmHg if received IV TPA
        ii. Permissive HTN up to SBP 220 if no IV TPA
    b. ***Avoid hypotension (**SBP<140**) prior to revascularization***
    c. Consider lowering BP target after successful recanalization due to risk of hyperperfusion and hemorrhagic conversion, ideally discuss BP target with stroke neurologist/radiologist
5) End-tidal CO2 management
    a. Aim for normocapnea
6) Glucose management
    a. Avoid hypoglycemia
    b. Treat blood glucose >10 mmol/L
7) Disposition from IR:
    a. GA with immediate extubation will go PACU → NICU
    b. MAC/uncomplicated patients will go directly to NICU
    c. Intubated/unstable patients will go to the regular ICU