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A joint initiative of the Patient Services Section and the Drug and Therapeutics Information Service of the Pharmacy Department, Repatriation General Hospital, Daw Park, South Australia. The RGH Pharmacy E-Bulletin is distributed in electronic format on a weekly basis, and aims to present concise, factual information on issues of current interest in therapeutics, drug safety and cost-effective use of medications.
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Transient ischaemic attack– rapid assessment and treatment

TIA (Transient Ischaemic Attack) is a recognised emergency because the early risk of subsequent stroke is high. Australian guidelines recommend the three main models for TIA management – hospital admission, rapid-access TIA clinics, and primary care-centred models that aim to expedite assessment, investigation and treatment. The Australian National Health and Medical Research Council recommend the ABCD2 risk scoring tool be used for assessment of stroke risk. It is important that high risk patients should not have delay in thorough investigation and the development of treatment plans including antithrombotic choices, vascular risk factor reduction and lifestyle modification.

Recent evidence shows that the maximum risk is within the first few days after a TIA. One study has shown that for a period of 90 days after a TIA, the risk of stroke is 10.5%, with half of these patients suffering stroke within 48 hours. Rapid initiation of treatment leads to better outcomes. The EXPRESS observational study of specialist outpatient TIA management demonstrated that early pharmacotherapy (reducing the median delay to first prescription from 20 days to 1 day) as part of urgent assessment and treatment was associated with a significant lowering of the risk of recurrent stroke at 90 days from 10.3% to 2.1%. Patients with TIA and associated high-grade carotid stenoses receiving early surgical intervention within two weeks have better secondary stroke prevention outcomes than those receiving later surgery.

Anticoagulation therapy for long-term secondary prevention should be used in all people with TIAs who have atrial fibrillation, cardioembolic stroke from valvular heart disease, or recent myocardial infarction (unless contraindicated for other reasons).

For patients with TIA or ischaemic stroke due to arterial disease, long-term antiplatelet therapy reduces the relative risk of stroke, myocardial infarction or vascular death by 22% compared to no treatment. Choices for antiplatelet therapy include aspirin, aspirin plus dipyridamole, and clopidogrel. Comorbidities, tolerance and TIA/stroke recurrence while on an antiplatelet agent will influence selection of the treatment.

Antihypertensive medication is recommended within one week after a TIA. Commencing blood pressure lowering medication in hypertensive and normotensive patients following TIA is advocated unless contraindicated by symptomatic hypotension. Target blood pressure is not well defined, especially in the very elderly (> 80 years old), and should be individualised.

Patients suffering TIA with or without a history of established CHD should receive statins for cholesterol lowering. Benefits occur within 12 months of starting therapy. Diet should be modified.

Failure to take prescribed medication is a key barrier to optimal secondary prevention. Following TIA, smoking cessation and exercise to reduce CVS risk are important. Good diabetic management should be maintained in affected patients.

This E-Bulletin is based on work by Dr Brian Simmons, DATIS, RGH

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