SYMPTOMS AND EXAM
Sudden onset of transient neurological dysfunction, usually lasting several minutes to a few hours, including weakness or numbness on half of the face/body, difficulty speaking or understanding speech, partial loss of vision or double vision, dizziness, imbalance, difficulty walking.

The neurological exam should be normal or have no new findings following the episode. Signs and symptoms that improved > 24 hours from onset are more likely to be associated with stroke on imaging.

SUGGESTED PREVISIT WORKUP
Patients should be referred to the ED if symptoms occurred within the last 72 hours, or have not completely resolved.

Imaging: MRI brain, CT head if unable to do MRI; CTA or MRA head and neck preferred, carotid ultrasound only if unable to do either CTA/MRA

Cardiac Evaluation as indicated: TTE with bubble study and EKG; Troponin and Telemetry while hospitalized

LABS:
Fasting lipid panel, fasting blood glucose or HbA1c, CBC, CMP, and consider PT/INR, aPTT, and urinalysis in appropriate cases

CLINICAL PEARLS
- Transient neurological symptoms that last only seconds are unlikely to be TIA.
- Paresthesia isolated to the face or part of a limb, slurred speech without facial droop or other deficits and vertigo without any other deficits, are unlikely to be TIA and alterative explanations should be considered.
- Actual reports of diagnostic testing (imaging, cardiac evaluation, labs) are strongly preferred over second hand reports of results.
- Please make sure actual images are available for review on IMPAX or disc prior to the patient’s appointment.

Reviewed by Christopher Cummings, MD

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.