

STROKE CODE

LYTICS · CONTRAINDICATIONS

THROMBOLYTICS

LKW ≤ 4.5 h · disabling deficit

TNK 0.25 mg/kg IV bolus over 5 s, max 25 mg (preferred). Do NOT use 0.4 mg/kg.

Wt kg	<60	60–69	70–79	80–89	≥90
TNK mg	15	17.5	20	22.5	25
mL @5 mg/mL	3	3.5	4	4.5	5

tPA 0.9 mg/kg, max 90 mg: 10% bolus over 1 min, remaining 90% over 60 min.

Wt kg	50	60	70	80	90	≥100
Total mg	45	54	63	72	81	90
Bolus mg	4.5	5.4	6.3	7.2	8.1	9

Before lytic: BP **<185/110**. Glucose is the only lab required unless coagulopathy is suspected.

ABSOLUTE CONTRAINDICATIONS

- ICH on CT, or prior ICH
- BP can't be lowered to <185/110
- Glucose <50 and deficit resolves with correction
- Plt <100k · INR >1.7 · PT >15 s · elevated aPTT (heparin <48 h)
- DOAC / thrombin or Xa inhibitor <48 h, unless labs confirm clear
- Ischemic stroke, serious head trauma, intracranial or spinal surgery <3 mo
- Bleeding diathesis · active internal bleeding · GI malignancy or bleed <21 d
- Infective endocarditis · aortic dissection · intra-axial neoplasm



**SCAN FOR TRACKER
+ NIHSS CALCULATOR**

Timestamps, door-to-needle clock, NIHSS and lytic dosing.
timetotreat.org/stroke/tracker

BP TARGETS

ISCHEMIC

Pre-lytic / EVT

<185/110

During & 24 h after lytic

<180/105

No reperfusion: treat only if $>220/120$, lower ~15% over 24 h.

After EVT, reperfused: keep $<180/105$; don't push SBP below 140.

HEMORRHAGE (ICH)

Target SBP

~140 (range 130–150)

Start within 2 h, reach target within 1 h. Avoid SBP <130 and large swings.

SBP >220 : lower cautiously toward 160–180.

Reverse any anticoagulant now.

IV ANTIHYPERTENSIVES

Labetalol	10–20 mg IV over 1–2 min (≈ 0.15 – 0.3 mg/kg, max 20 mg/dose), repeat q10 min. Infusion 2–8 mg/min. Max 300 mg/24 h. Avoid: asthma/COPD, HR <60 , 2°/3° block, decompensated HF.
Nicardipine	5 mg/h , +2.5 mg/h q5–15 min, max 15 mg/h. Drop to 3 mg/h at goal.
Clevidipine	1–2 mg/h , double q2–5 min, max 21 mg/h. Avoid: soy or egg allergy.
Hydralazine	10–20 mg IV q4–6 h. Second line.
Nitroprusside	Only for refractory DBP >140 when nothing else works.

EARLY ANTITHROMBOTICS

- Aspirin 160–325 mg** within 24–48 h. After a lytic, wait 24 h and confirm no ICH on repeat imaging.
- Minor stroke (NIHSS ≤ 3) or high-risk TIA (ABCD² ≥ 4):** aspirin + clopidogrel 300–600 mg load, then 75 mg daily $\times$ 21 d, then one agent. Start within 24 h. Not after a lytic.
- AF / cardioembolic:** start anticoagulation after the acute phase. Early DOAC (≤ 4 d) is reasonable if bleed risk is low.