

STROKE CODE

Practice mode: example case. Nothing you tap is saved.

Lytic dose

Doses for 82 kg. Change weight here or on the Tracker tab.

82 kg

TENECTEPLASE
(TNK)

22.5 mg

4.5 mL at 5
mg/mL · IV bolus
over 5 s

ALTEPLASE
(TPA) TOTAL

73.8 mg

Bolus 7.4 mg
over 1 min, then
66.4 mg over 60
min

LABETALOL IV
PUSH

20 mg

10–20 mg over
1–2 min (max 20
mg/dose)

TNK is preferred. Do not use the 0.4 mg/kg (cardiac) dose. Window: ≤ 4.5 h from last known well with a disabling deficit.

TNK / tPA contraindications

Tick anything present. One tick means no lytic.

- ☐ Intracranial hemorrhage on CT, or prior ICH
- ☐ BP can't be lowered to $<185/110$ before treatment
- ☐ Glucose <50 and the deficit resolves with correction
- ☐ Platelets $<100k$, INR >1.7 , PT >15 s, or elevated aPTT (heparin <48 h)
- ☐ DOAC or thrombin / factor Xa inhibitor within 48 h, unless labs confirm it's cleared
- ☐ Ischemic stroke, serious head trauma, or intracranial / spinal surgery within 3 months
- ☐ Bleeding diathesis, active internal bleeding, or GI malignancy / GI bleed within 21 days
- ☐ Infective endocarditis, aortic dissection, or intra-axial neoplasm

No absolute contraindication ticked

BP targets

ISCHEMIC

Before lytic or EVT

<185/110

During and 24 h after lytic

<180/105

- **No reperfusion therapy:** treat only if >220/120, then lower about 15% over 24 h.
- **After EVT with reperfusion:** keep <180/105. Don't target SBP below 140.

HEMORRHAGE (ICH)

Target SBP

~140

range 130–150

- Start within 2 h of arrival and reach target within 1 h.
- Avoid SBP <130 and large swings.
- SBP >220: lower cautiously toward 160–180.
- Reverse any anticoagulant now.

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) for 21 days, then one agent. Start within 24 h. Not after a lytic.
- **AF or cardioembolic:** start anticoagulation after the acute phase. Early DOAC (≤4 d) is reasonable if bleed risk is low.

IV antihypertensives

Labetalol

10–20 mg IV over 1–2 min (about 0.15–0.3 mg/kg, max 20 mg per dose). Repeat every 10 min. Infusion 2–8 mg/min. Max 300 mg in 24 h.

Avoid with asthma or COPD, HR <60, 2nd/3rd-degree block, decompensated HF.

Nicardipine

Start 5 mg/h. Increase 2.5 mg/h every 5–15 min, max 15 mg/h. Drop to 3 mg/h at goal.

Clevidipine

Start 1–2 mg/h. Double every 2–5 min, max 21 mg/h.

Avoid with soy or egg allergy.

Hydralazine

10–20 mg IV every 4–6 h. Second line.

Nitroprusside

Only for refractory DBP >140 when nothing else works.

NIHSS bands

- 0 no deficit · 1–4 minor · 5–15 moderate · 16–20 moderate–severe · 21–42 severe
- NIHSS ≥6: think large-vessel occlusion. Get CTA and call the EVT team.
- A change of 2 or more points is clinically significant.

Verify all doses against institutional protocol.