Endovascular Therapy for Acute Ischemic Stroke
(All EVT's Should Proceed With Airborne Precautions)

Discussion between anesthesiologist and interventionalist regarding optimal anesthetic technique to occur prior to the patient entering IR suite (ideally in the ED)

Do any of the following apply?
- Acute respiratory distress / hypoxemia / requiring high flow oxygen
- Active cough
- Inability to protect airway
- Active vomiting
- Posterior circulation / dominant cerebral hemisphere occlusions
- High NIHSS (>15) or low GCS (<9)
- Agitated / uncooperative / aphasic patients

No

Proceed with preferred institutional techniques for EVT

Yes

Consider General Anesthesia (GA)

Can anesthesia be induced safely in a negative-pressure location in ED?*

No

Emergency Conversion to GA

Yes

Induce GA in IR suite

General Anesthesia
- Only essential personnel
- Avoid high flow pre-oxygenation
- Rapid sequence induction using video-laryngoscopy (most experienced person available to intubate)
- Vasopressors immediately available.
- Maintain SBP >140mmHg, SpO₂ >94%, normocarbia
- HEPA filter on ETT and CO₂ sampling line
- Avoid circuit disconnections
- Extubate preferably in a negative pressure location avoiding coughing

Induce GA in ED

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*It is recognized that patients in acute respiratory distress / hypoxemia may require emergent intubation in ED. Patients suffering from AIS while already in hospital and requiring GA for EVT should be intubated safely in a suitable negative pressure location while minimizing delays in reperfusion.