

# Endovascular Therapy for Acute Ischemic Stroke

(All EVTs 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**

**YES**

Proceed with preferred institutional techniques for EVT

Consider General Anesthesia (GA)

Monitored Anesthesia Care

General Anesthesia

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

**No**

**YES**

Induce GA in IR suite

Induce GA in ED

Emergency Conversion to GA

### General Anesthesia

### Monitored Anesthesia Care

- Patient should wear surgical mask
- Avoid high flow nasal cannula oxygen
- Careful titration of sedation to avoid oropharyngeal or nasopharyngeal airway insertion or chin lift/jaw thrust.
- Consider use of expiratory viral filter on oxygen masks.

- 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, SpO<sub>2</sub> >94%, normocarbica
- HEPA filter on ETT and CO<sub>2</sub> sampling line
- Avoid circuit disconnections
- Extubate preferably in a negative pressure location avoiding coughing

\*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.