

Table 1 Vision, aphasia, neglect emergent large vessel occlusion screening tool

Stroke VAN

- How weak is the patient? Raise both arms
- Mild (minor drift)
 - Moderate (severe drift - touches or nearly touches ground)
 - Severe (flaccid or no antigravity)
 - Patient shows no weakness.
- Patient is VAN negative

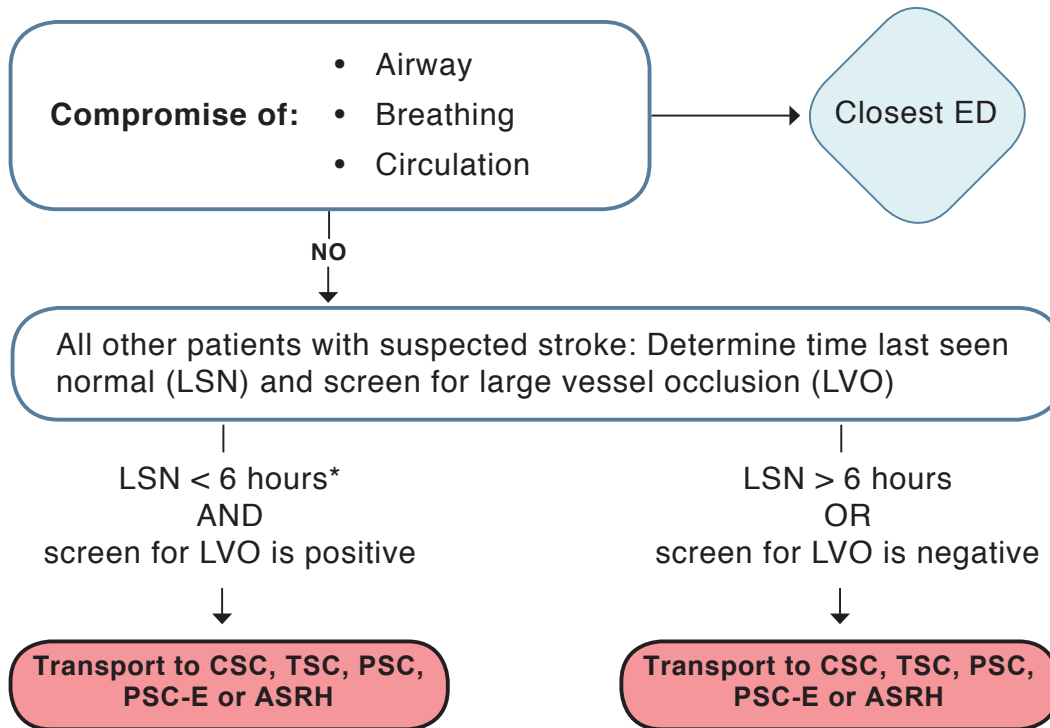
(exceptions are confused or comatose patients with dizziness, focal findings, or no reason for their altered mental status then basilar artery thrombus must be considered; CTA is warranted)

- Visual disturbance
- Field cut (which side) (4 quadrants)
 - Double vision (ask patient to look to right then left; evaluate for uneven eyes)
 - Blind new onset
 - None
- Aphasia
- Expressive (inability to speak or paraphasic errors); do not count slurring of words (repeat and name 2 objects)
 - Receptive (not understanding or following commands) (close eyes, make fist)
 - Mixed
 - None
- Neglect
- Forced gaze or inability to track to one side
 - Unable to feel both sides at the same time, or unable to identify own arm
 - Ignoring one side
 - None

Patient must have weakness plus one or all of the V, A, or N to be VAN positive. VAN positive patients had 100% sensitivity, 90% specificity, positive predictive value 74%, and negative predictive value 100% for detecting large vessel occlusion.
 CTA, CT angiography; VAN, vision, aphasia, and neglect.

STROKE DESTINATION PROTOCOL

The following protocol applies to patients with suspected stroke:



If < 15 minutes of additional transport time to reach CSC, TSC or endovascular capable Center (PSC-E), transfer to the CSC, TSC or endovascular capable Center (PSC-E)

If > 15 minutes of additional transport time to reach CSC, TSC, PSC-E, PSC or ASRH than to reach stroke capable Off Site ED, it is acceptable to transport to a stroke capable Off Site ED

* the LSN < 6 hours should include patients without a definite time of LSN, but who could reasonably be assumed to be within 6 hours of onset, including patients who wake-up with stroke symptoms

Guiding Principles:

- Time is the critical variable in acute stroke care
- Protocols that include pre-hospital notification while en route by EMS should be used for patients with suspected acute stroke to facilitate initial destination efficiency
- Treatment with intravenous tPA is the only FDA approved medication therapy for hyperacute stroke
- EMS should identify the geographically closest hospital capable of providing tPA treatment
- Transfer patient to the nearest hospital equipped to provide tPA treatment
- Secondary transfer to facilities equipped to provide tertiary care and interventional treatments should not prevent administration of tPA to appropriate patients

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