Initial Management of Transient Ischaemic Attack (TIA)

Objective: To ensure appropriate initial medical management of TIA.

What is a TIA?
It is a transient (less than 24 hours) neurological dysfunction corresponding to a vascular territory, without evidence of acute infarction.

What to do if a TIA is suspected?
Referrals for suspected TIAs to be made via careflow connect (TIA high risk clinic).

On assessment and diagnosis of TIA:
Any person with a fully resolved acute onset neurological syndrome that might be due to cerebrovascular disease needs urgent specialist assessment to establish the diagnosis and to determine whether the cause is vascular.

- Patients with acute focal neurological symptoms that resolve completely within 24 hours of onset **(suspected TIA)** should be given **aspirin 300mg immediately** unless contraindicated and assessed urgently (ideally within 24 hours) by a stroke specialist clinician.
    - Referrals to be made via careflow connect (TIA high risk clinic) but to contact stroke specialist nurse via bleep 7337 if advice needed/urgent cases.
    - If patient cannot be reviewed in TIA clinic within 24 hours, continue aspirin 300mg daily until TIA clinic review.
- Recurrent hemispheric symptoms (limb weakness & speech) require urgent discussion with a stroke specialist nurse – contact via bleep 7337.
- Patients with suspected TIA that occurred more than a week previously should be assessed by a stroke specialist clinician as soon as possible within 7 days.
- For all suspected and confirmed TIA patients – inform patient not to drive until TIA clinic review.

Treatment and vascular prevention of confirmed TIA:
Patients who have short-lived symptoms due to cerebrovascular disease remain at high risk of further vascular events, and this risk is highest in the first few days. Consequently, their management is urgent.

- Patients with TIA should receive treatment for secondary prevention as soon as the diagnosis is **confirmed**, including:

Support to modify lifestyle factors:
- Stop smoking
- Reduce alcohol consumption to within recommended limits
- Healthy diet
- Exercise
- Signpost to Stroke Association information and support
  Managing risk | Stroke Association

Version 1 – July 2025 (DTG approved). Review July 2027.
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Antiplatelet/Anticoagulant therapy:

- Patients with a **confirmed** diagnosis of TIA should be given the below antiplatelet therapy provided there is neither a contraindication e.g atrial fibrillation (see below) nor a high risk of bleeding. The following regimens should be considered as soon as possible:
- **Start the treatment for confirmed TIA only if the patient has been seen or discussed by the stroke team.**

	STAT DOSE	**Initial Dual Antiplatelet Therapy (DAPT)** *(to be started the day following stat dose)*	**Maintenance Therapy** *(after DAPT)*
OPTION ONE – First choice			
	Aspirin po 300mg AND Clopidogrel po 300mg	Aspirin 75mg daily 21 days AND Clopidogrel 75mg daily	Clopidogrel 75mg daily
OPTION TWO – If clopidogrel allergy / intolerance / resistance is considered			
	Aspirin po 300mg AND Ticagrelor po 180mg	Aspirin 75mg daily for 30 days AND Ticagrelor 90mg twice daily	Ticagrelor 90mg twice daily
OPTION THREE – Where dual antiplatelet therapy is not appropriate e.g. high bleed risk or TIA > 7 days since onset			
	Clopidogrel po 300mg	-	Clopidogrel 75mg daily

- A proton pump inhibitor should be considered for concurrent use with dual antiplatelet therapy (DAPT) to reduce the risk of gastrointestinal haemorrhage. Primary choice to be lansoprazole - avoid use of omeprazole or esomeprazole if initiating clopidogrel.

- For patients with recurrent TIA whilst taking clopidogrel, consideration should be given to clopidogrel resistance.

- Patients with TIA in **atrial fibrillation** should be **anticoagulated immediately (do not wait for referral to TIA clinic)**, as soon as intracranial bleeding has been excluded, provided there are no other contraindications.

- If patient has a TIA whilst taking an anticoagulant, exclude intracranial haemorrhage or large ischaemic stroke with brain imaging and continue anticoagulant until TIA clinic review.

High intensity statin therapy:

- High intensity statin therapy (e.g. atorvastatin 20-80 mg daily) should be started immediately.

Blood pressure lowering therapy:

- Target systolic blood pressure (SBP) < 130
- If patient has severe bilateral carotid artery stenosis, then target SBP 140-150.
- Refer to National Clinical Guideline for Stroke (section 5.4 blood pressure) for therapy options Long-term management and secondary prevention - National Clinical Guideline for Stroke

References:

1. National Clinical Guideline for Stroke for the UK and Ireland (Section 3.2 and 3.3). London: Intercollegiate Stroke Working Party; 2023 May 4. Available at: www.strokeguideline.org. Accessed 4/7/2025
2. NICE Guideline. Stroke and transient ischaemic attack in over 16s: diagnosis and initial management. NG128. Last Updated 13 April 2022. Accessed 8/7/2025
3. Gov.UK. Transient ischaemic attack (TIA) or mini-stroke and driving. Transient ischaemic attack (TIA) or mini-stroke and driving - GOV.UK. Accessed 11/7/25.

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