Stroke CPG Medication Recommendations

Northeast Rehabilitation Hospital has adopted these Stroke Clinical Practice Guidelines to guide the clinical care that is provided by our Rehab Team.

Prevention of DVT

Ischemic stroke: prophylactic –dose subcutaneous heparin (UFH or LMWH) should be used for the duration of the acute and rehabilitation stay or until the stroke survivor regains mobility

Ischemic stroke: it is reasonable to use prophylactic-dose LMWH over prophylactic dose UFH for prevention of DVT

Ischemic stroke: it may be reasonable to use intermittent pneumatic compression over no prophylaxis during the acute hospitalization

Ischemic stroke: it is NOT useful to use elastic compression stockings

ICH: it may be reasonable to use prophylactic-dose subcutaneous heparin (UFH or LMWH) started between days 2 and 4 over no prophylaxis

ICH: it may be reasonable to use prophylactic dose LMWH over prophylactic –dose UFH

ICH: it may be reasonable to use intermittent pneumatic compression devices over no prophylaxis

ICH: it is NOT useful to use elastic compression stockings

Assessment, Prevention, and Treatment of Hemiplegic Shoulder Pain

Botulinum toxin injection can be useful to reduce severe hypertonicity in hemiplegic shoulder muscles

A trial of neuromodulating pain medications is reasonable for patients who have clinical signs and symptoms of neuropathic pain manifested as sensory change in the shoulder region, allodynia, or hyperpathia

Usefulness of subacromial or glenohumeral corticosteroid injection for patients with inflammation in these locations is NOT well established

Suprascapular nerve block may be considered as an adjunctive treatment for hemiplegic shoulder pain

Central Pain after Stroke

The choice of pharmacological agent for the treatment of central poststroke pain should be individualized to the patient's needs and response to therapy and any side effects

Reasonable first line pharmacological treatments: amitriptyline and lamotrigine

Second line pharmacological treatments: pregabalin, gabapentin, carbamazepine, phenytoin

Seizures

Any patient who develops seizures should be treated with standard management approaches, including a search for reversible causes of seizure in addition to potential use of antiepileptic drugs

Please refer to the full CPG for details of each recommendation: Guidelines for Adult Stroke Rehabilitation and Recovery. American Heart Association/American Stroke Association. Stroke. 2016;47:e98-e169. www.stroke.ahajournals.org

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Poststroke Depression, including Emotional and Behavioral State

A therapeutic trial of an SSRI or dextromethorphan/quinidine is reasonable for patients with emotional lability or pseudobulbar affect causing emotional distress

No recommendation for the use of any particular class of antidepressants is made. SSRIs are commonly used and generally well tolerated in this population.

Use of Drugs to Improve Cognitive Impairments, including Attention

The usefulness of the following drugs in the treatment of poststroke cognitive deficits is not well established: Donepezil, Rivastigmine, antidepressants, dextroamphetamine, methylphenidate, modafinil, atomextine.

Spasticity

Targeted injection of botulinum toxin into localized upper limb muscles is recommended to reduce spasticity, improve passive or active range of motion and to improve dressing, hygiene, and limb positioning

Targeted injection of botulinum toxin into lower limb muscles is recommended to reduce spasticity that interferes with gait function

Oral antispasticity agents can be useful for generalized spastic dystonia but may result in dose-limiting sedation or other side effects

Intrathecal baclofen may be useful for severe spastic hypertonia that does not respond to other interventions

Mobility

The effectiveness of fluoxetine or other SSRIs to enhance motor recovery is not well established

The effectiveness of levodopa to enhance motor recovery is not well established

The use of dextroamphetamine or methylphenidate to facilitate motor recovery is NOT recommended

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