

Stroke Prevention in Symptomatic Intracranial Atherosclerosis

Diagnosis, antithrombotic therapy, vascular risk factor modification, and endovascular/surgical options for symptomatic large artery intracranial atherosclerosis (sICAS).

2022 AAN Practice Advisory
Stroke Prevention in Symptomatic Large Artery Intracranial
Atherosclerosis
AAN Guideline Subcommittee • Neurology 2022;98:486–498

LEVEL

● A • Must (Highest Confidence)

● B • Should (Moderate)

● C • May (Lower Confidence)

1 Diagnosis

B

Workup: use diagnostic modalities to diagnose sICAS and distinguish it from other intracranial vasculopathies when results would change management or add prognostic value.

2 Antithrombotic Therapy

B

Aspirin 325 mg/day, preferred over warfarin, for long-term stroke/death prevention.

B

Dual therapy: add clopidogrel 75 mg/day to aspirin for up to 90 days in severe (70%–99%) sICAS with low hemorrhage risk.

C

Alternative: may add cilostazol 200 mg/day instead of clopidogrel, or in Asian patients, with low hemorrhage risk.

3 Vascular Risk Factor Modification

B

Statin: high-intensity therapy to achieve goal LDL < 70 mg/dL.

B

Blood pressure: long-term target < 140/90 mm Hg in clinically stable patients.

B

Physical activity: at least moderate activity in patients safely capable of exercise.

A

Other risk factors: must treat other modifiable vascular risk factors.

4 Investigational — Ischemic Preconditioning

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BAIPC: no consensus reached; evidence limited to 2 small, unblinded Chinese trials — insufficient to recommend for or against.

5 Endovascular Therapy — PTAS

B

Severe sICAS: should not recommend PTAS as initial treatment for 70%–99% stenosis.

B

Moderate sICAS: should not recommend PTAS for 50%–69% stenosis.

B

Angioplasty alone: should not routinely recommend outside clinical trials.

B

Counsel: discuss PTAS risks and alternative treatments if a procedure is being contemplated.

6 Surgical Therapy

B

Direct bypass: should not recommend for stroke prevention in sICAS.

A

Indirect revascularization: must not routinely recommend outside clinical trials.