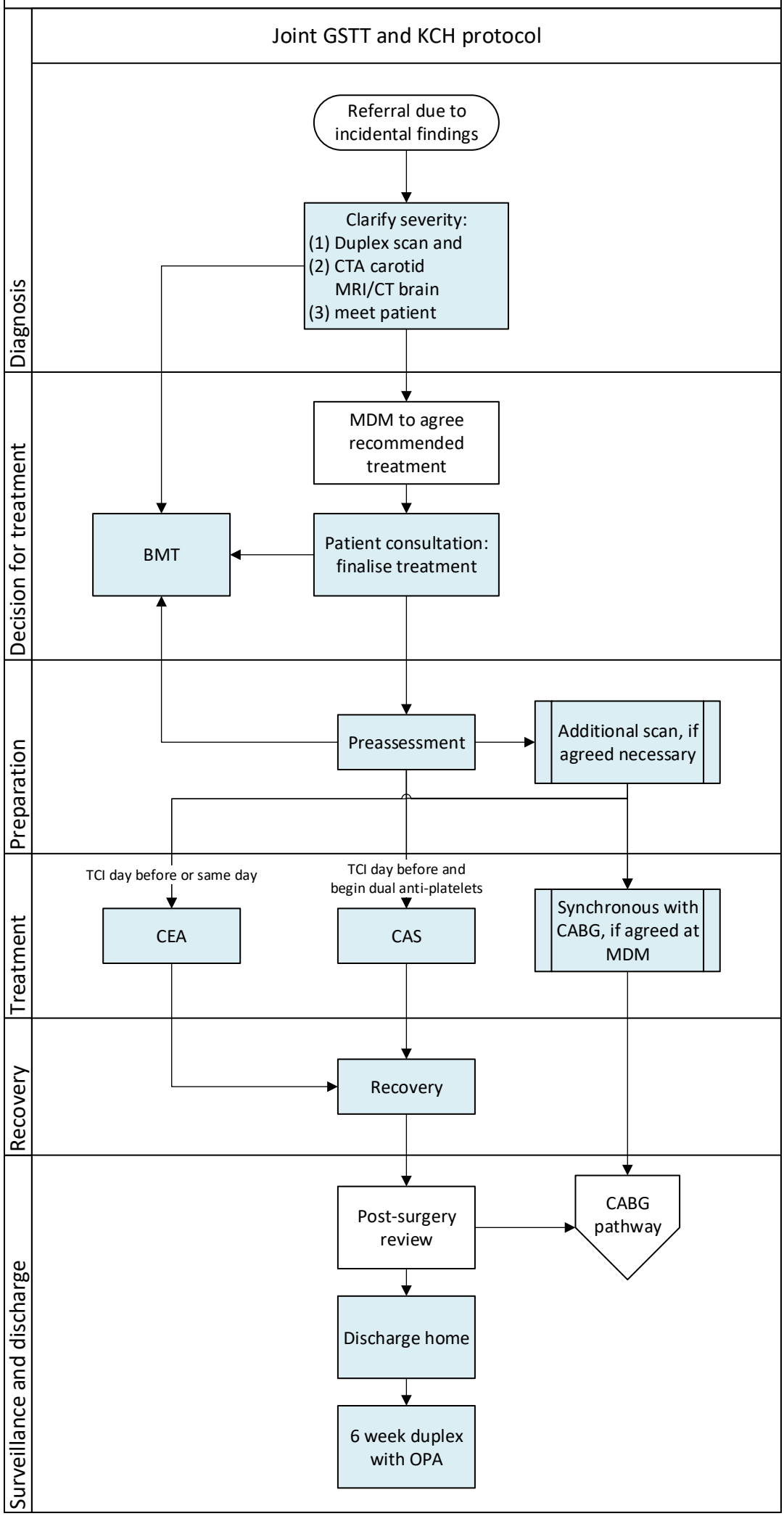
Asymptomatic carotid

Joint GSTT and KCH protocol



REFERRALS

General sources:

- National screening
- Cardiologist
- Neurologist
- CT surgeon
- GP

CLARIFY SEVERITY

(2) if surgery likely / if duplex unclear
(3) at clinician discretion

MDM

- Recommend all patients to be discussed at MDM where appropriate treatment is unclear
- Decided whether additional scan is needed before treatment

Consider:

- Average surgical risk? (Medical history/age /weight/fitness)
- Plaque morphology
- Thrombosis
- 60% < stenosis <99%
- Latest guidance and evidence (such as ESVS)

RECOVERY

- 24hrs neuro and BP monitoring in V-bay/HDU/equivalent
- Move to ward
- If clinical concerns, move back to HDU

POST-SURGERY REVIEW

- Complete and review (at MDM where relevant) any additional scans necessary
- Agree any additional surveillance required

SURVEILLANCE

- Minimum surveillance: completion duplex on table and/ or 6 week scan with OPA.
- A surveillance plan of additional scans can be created on a case by case basis
- Where possible, additional scans are to be undertaken locally, and reviewed centrally (St Thomas' or Kings'), if there is cause for concern
- The frequency and modality of surveillance should reflect recent guidance and evidence

IN CASE OF STROKE

- **Pre-TCI and post-surgery:** refer to stroke team, if cause for concern transfer to HASU
- **Perioperative stroke:** surgical team assessment, urgent imaging (CTA), contact HASU stroke team for image discussion, if no concern refer to local stroke team, if concern transfer to HASU for monitoring and neurosurgery
- Patients are **NOT** appropriate for thrombolysis shortly after surgery