## **Echocardiology Utilization**

Guidelines for utilization of cardiac echo in MGH inpatients with stroke/TIA.

Prior to making any medical decisions, please view our disclaimer.

Echo Not Needed	Outpatient Echo Justified if	Inpatient Echo Necessary
	Performed Within 7-10 Days After Discharge	
Established atrial fibrillation, with previous cardiac workup	Patient in whom stroke treatment will not changeregardless of the echo result, however, echo still needed for assessing recurrent stroke risk	Multiple arterial territory stroke on brain imaging
determine the need	(Note: Date and time of echo appointment must be clearly indicated in the discharge summary. Echo should be performed before the scheduled appt. in the outpatient stroke clinic. If the patient is being discharged to another facility, the resident and primary care physician should arrange to be notified of echo results by telephone or E-mail.)	
Typical lacunar stroke, without concern for other mechanism		Evidence for systemic venous clots or emboli
Documented severe parent vessel stenosis (e.g. severe ipsilateral ICA stenosis; vertebral artery stenosis and PICA infarct)		Stroke within 3 months after myocardial infarction, or new EKG changes
Stroke clearly associated with a non- cardiac interventional procedure		Suspicion for cardiomyopathy or congestive heart failure
Carotid or vertebral artery dissection		Suspicion for infective endocarditis (fever, risk factors such as IVDA) or non- infective endocarditis (cancer, DIC, elevated ESR, positive antiphospholipid antibodies)
Stroke from CNS vasculitis		High suspicion for ASA/PFO, e.g. embolic appearing stroke in a patient with DVT/PE, high risk for DVT, known hypercoagulable state, age < 55, or migraine- associated stroke ( <b>Bubble study</b> should be performed for these indications)