

**Table 3. Guideline or Consensus Statement Management Recommendations for Primary Prevention of Ischemic Stroke**

Factor	Goal	Recommendations
Hypertension	SBP <140 mm Hg  DBP <90 mm Hg	Measure BP in all adults at least every 2 years and more frequently in minority and elderly populations.  Promote lifestyle modification: weight control, physical activity, moderate alcohol intake, moderate sodium intake, adoption of the Dietary Approaches to Stop Hypertension (DASH) eating plan. If BP >140/90 mm Hg after 3 months of life-habit modification or if initial BP >180/100 mm Hg: add antihypertensive medication; individualize therapy to patient's other requirements and characteristics.
Smoking	Cessation	Strongly encourage patient and family to stop smoking. Provide counseling, nicotine replacement, and formal programs as available.
Diabetes	Improved glucose control; treatment of hypertension; consider statin	Diet, oral hypoglycemics, insulin. See guidelines and policy statements. <sup>1, 2</sup>
Asymptomatic carotid stenosis	...	Endarterectomy may be considered in selected patients with >60% and <100% carotid stenosis, performed by surgeon with <3% morbidity/mortality. Careful patient selection guided by comorbid conditions, life expectancy, patient preference, and other individual factors. Patients with asymptomatic stenosis should be fully evaluated for other treatable causes of stroke.
Atrial fibrillation Age <65 y, no risk factors <sup>†</sup> Age <65 y, with risk factors Age 65–75 y, no risk factors Age 65–75 y, with risk factors Age >75 y, with or without risk factors	...	Aspirin. Warfarin (target INR 2.5; range 2.0–3.0). Aspirin or warfarin. Warfarin (target INR 2.5; range 2.0–3.0). Warfarin (target INR 2.5; range 2.0–3.0).
LDL-C  0–1 CHD risk factor <sup>†</sup>  ≥2 CHD risk factors and 10-y CHD risk <20%  ≥2 CHD risk factors and 10-y CHD risk 10% to 20%  CHD or CHD risk equivalent <sup>‡</sup> (10-y risk >20%)  Non-HDL-C in persons with triglycerides ≥200 mg/dL  Low HDL-C	LDL-C <160 mg/dL  LDL-C <130 mg/dL  LDL-C <130 mg/dL, or optionally LDL-C <100 mg/dL  LDL-C <100 mg/dL, or optionally LDL-C <70 mg/dL  Goals are 30 mg/dL higher than LDL-C goal  No consensus goal	Diet, weight management, physical activity. Drug therapy recommended if LDL-C remains ≥190 mg/dL. Drug therapy optional for LDL-C 160–189 mg/dL.  Diet, weight management, physical activity. Drug therapy recommended if LDL-C remains ≥160 mg/dL.  Diet, weight management, physical activity. Drug therapy recommended if LDL-C remains ≥130 mg/dL (optionally ≥100 mg/dL).  Diet, weight management, physical activity. Drug therapy recommended if LDL-C is ≥130 mg/dL Drug therapy optional for LDL-C 70–129 mg/dL.  Same as LDL-C with goals 30 mg/dL higher.  Weight management, physical activity. Consider niacin (nicotinic acid) or a fibrate in high-risk individuals with HDL-C <40 mg/dL.

**Table 3. Guideline or Consensus Statement Management Recommendations for Primary Prevention of Ischemic Stroke\* (cont'd)**

Lp(a)	No consensus goal	Treat other atherosclerotic risk factors in subjects with high Lp(a). Consider niacin (immediate- or extended-release formulation) up to 2000 mg/d for reduction of Lp(a) levels, optimally in conjunction with glycemic control and LDL control.
Sickle cell disease (SCD)	Monitor children with SCD with transcranial Doppler for development of vasculopathy	Institute transfusion therapy for children who develop evidence of sickle cell vasculopathy.
Oral contraceptive use	Avoid in those at high risk	Inform patients about stroke risk and encourage alternative forms of birth control among women who smoke cigarettes, have migraines (especially with older age or smoking), are ≥35 years of age, or have had prior thromboembolic events.
Sleep-disordered breathing	Successful treatment of sleep-disordered breathing	Consider sleep laboratory evaluation in patients with snoring, excessive sleepiness, and vascular risk factors, particularly if body mass index is >30 and drug-resistant hypertension is present.
Obesity and body fat distribution	Maintain ideal body weight (BMI 18.5–24.9 kg/m <sup>2</sup> ) and waist circumference men <40 inches and women <35 inches	Achieve and maintain healthy weight throughout life with an increased effort aimed at avoiding inappropriate weight gain in the first place.
Physical inactivity	≥30 min of moderate-intensity activity daily	Moderate exercise (eg brisk walking, jogging, cycling, or other aerobic activity). Medically supervised programs for high-risk patients (eg cardiac disease) and adaptive programs depending on physical/neurological deficits.
Poor diet/nutrition	Well-balanced diet	A diet containing at least 5 servings of fruits and vegetables per day may reduce the risk of stroke.
Alcohol	Moderation	No more than 2 drinks/d for men and 1 drink/d for nonpregnant women.
Drug Abuse	Cessation	An in-depth history of substance abuse would be included as part of a complete health evaluation for all patients.

BP = blood pressure; CHD = coronary heart disease; DBP = diastolic blood pressure; HDL-C = high-density lipoprotein cholesterol; INR = International Normalized Ratio; LDL-C = low-density lipoprotein cholesterol; Lp(a) = lipoprotein a; SBP = systolic blood pressure; TC = total cholesterol

\* Atrial fibrillation risk factors: hypertension, type 2 diabetes, poor left ventricular function, rheumatic mitral valve disease, prior TIA/stroke, systemic embolism or stroke, prosthetic heart valve (may require higher target INR).

† To screen for dyslipidemia, a fasting lipoprotein profile (cholesterol, triglycerides, HDL-C, and LDL-C) should be obtained every 5 years in adults. It should be obtained more often if ≥ 2 CHD risk factors are present (risk factors include cigarette smoking, hypertension, HDL-C <40 mg/dL, CHD in a male first-degree relative <55 years of age or in a female first-degree relative <65 years of age, or age ≥ 45 years for men or ≥ 65 years for women) or if LDL-C levels are borderline or high. Screening for Lp(a) is not recommended for primary prevention unless (1) unexplained early cardiovascular events have occurred in first-degree relatives or (2) high Lp(a) is known to be present in first-degree relatives.

‡ CHD risk equivalents include diabetes or other forms of atherosclerotic disease (peripheral arterial disease, abdominal aortic aneurysm, symptomatic carotid artery disease).

<sup>1</sup> *Guide to Clinical Preventive Services: Report of the US Preventive Services Task Force*. 2nd ed. Baltimore, Md: Williams & Wilkins; 1996.

<sup>2</sup> American Diabetes Association. Clinical practice recommendations 1998. *Diabetes Care*. 1998;21(suppl 1):S1-S89.

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