

Child with Sickle Cell Disease (SCD) with Suspected Stroke (ED/Inpatient)

Initiate Sickle Cell Suspected Stroke EDP Powerplan or Inpatient Powerplan

Provide immediate stabilization management:

- Supplemental oxygen to keep saturations > 96%
- Place on monitors obtain vital signs (including BP) every 15 minutes for first hour
- Place at least one antecubital 22G intravenous catheter
- Treat seizures and increased intracranial pressure if indicated
- Provide adequate pain control
- Consult: Hematology / Oncology, PICU, Apheresis Team
- Make patient NPO
- Obtain the following labs:
 - Type & crossmatch for sickle-negative PRBCs (Order 1 unit for pts < 30 kg and 1 to 2 units for patients > 30 kg), hold blood as per blood bank for extended phenotype
 - CBCD, reticulocyte count, Hemoglobin S, BMP, Mg, iCa, Phos, PT, INR, aPTT, LFT, Fibrinogen, D Dimer, Urine hCG (female > 10 years) or serum beta hCG, POC Glucose
- If patient has fever: obtain blood culture then treat with acetaminophen and antibiotics

Do NOT delay imaging to obtain labs or IV access

If patient is known to CM:

- Review Critical Information note

Obtain history of:

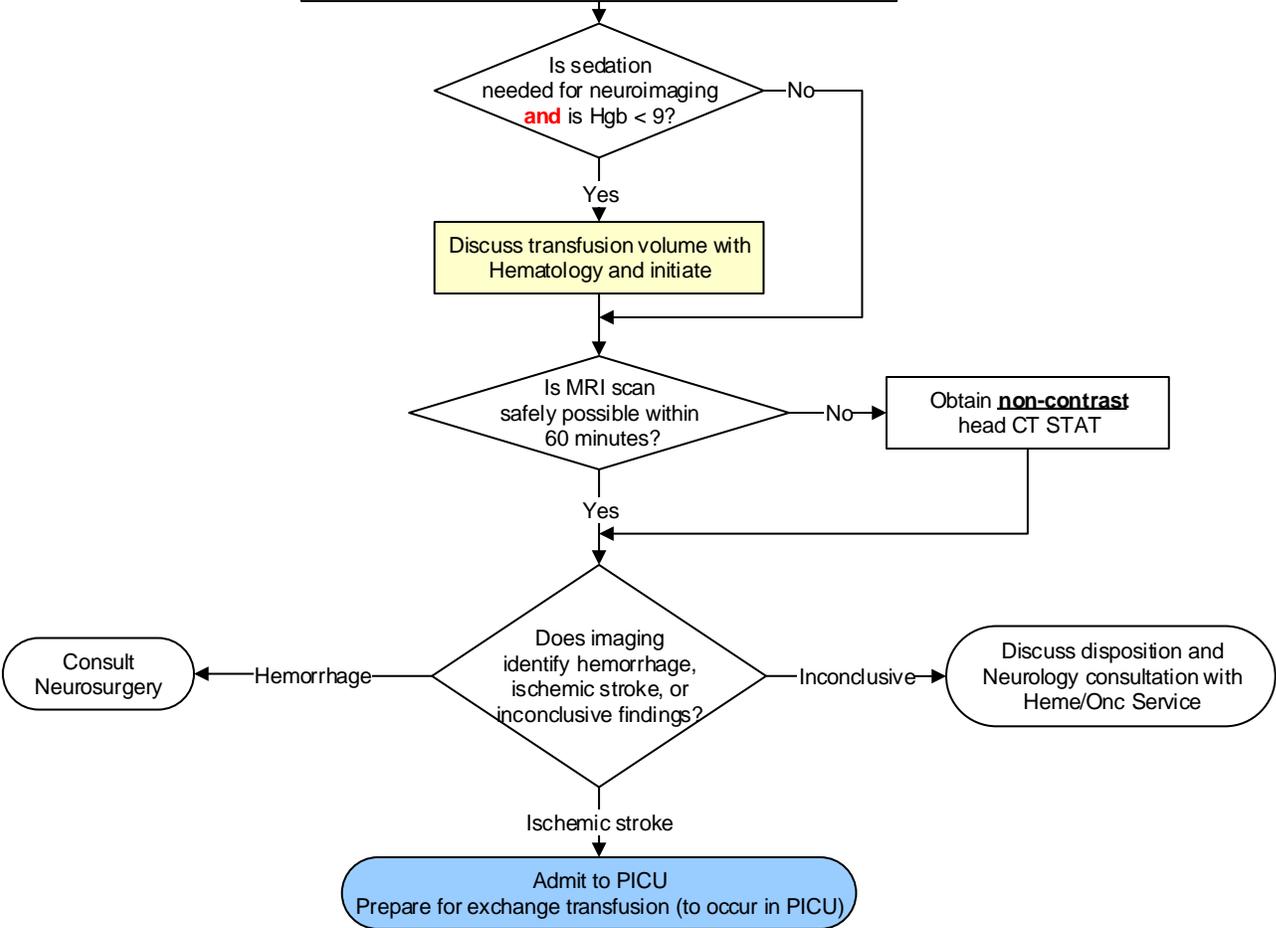
- Stroke, Moya Moya
- Headaches (H/A)
- Nausea or vomiting
- Visual changes
- Weakness
- Loss of coordination
- Numbness and tingling
- Fever
- Syncope
- Seizures
- Recreational or prescribed drug use

Physical exam:

- Baseline mental status with detailed neurologic exam
- Hydration status
- Signs of infection

Acute Sickle Stroke Neuroprotective Care

- Head of bed flat: if tolerated and no signs of increased ICP
- Avoid hypotension: bolus PRN with NS 10-20 ml/kg
- Normovolemia: 1/2NS at maintenance or D5 1/2 NS if glucose < 100
- Saturations > 96%
- Normothermia: Treat T > 38°C with antipyretics, +/- cooling
- Seizure control: ASAP with any suspected seizure activity. Consider cEEG to monitor subclinical seizures.



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