**Eligibility criteria to be applied by stroke physicians for referral for Thrombectomy**

Each patient presenting to medical services with an ischaemic stroke needs to be assessed clinically by a competent clinician to determine if they are likely to benefit from Thrombectomy. The following eligibility criteria should be applied in discussion with a stroke physician. Our knowledge regarding the balance of benefits and risks of thrombectomy is evolving rapidly and these criteria will be reviewed at least annually.

At this time it is probably best to put patients into three categories

1. **Would definitely be eligible for Thrombectomy if ALL of the following apply:**
2. Patient is normally completely independent in everyday activities – *the RCTs demonstrating that Thrombectomy was effective only recruited patients with a modified Rankin scale of less than 3.*
3. Has a clinical diagnosis of acute stroke which is very likely to result in long term disability or dependency on others *– i.e. not a stroke which is unlikely to cause long-term deficits which will disable the patient*
4. Brain imaging has excluded an acute intracranial haemorrhage or stroke mimic
5. CT angiography has shown an occluded distal internal carotid artery (ICA) or proximal or M1 segment of the middle cerebral artery (MCA)
6. The Thrombectomy can be started within 6 hours of the patient known to be free of focal stroke symptoms – *based on a realistic estimate of transfer time*
7. **Might be still eligible for Thrombectomy if any of the following apply:**
* Patient is not completely independent in everyday activities but they would significantly benefit if the new stroke deficits could be reduced
* Has a clinical diagnosis of acute stroke which might cause long term disability *– for instance sometimes patients deficits are fluctuating or concern the patient will worsen*
* CT angiography has shown an occluded M2 branch of the MCA, anterior cerebral artery, posterior cerebral artery or basilar artery
* The patient has a wake-up stroke or an onset time which may be more than 6 hr ago but a stroke physicians considers that imaging (e.g. with CT or MR perfusion) may demonstrate a volume of potentially salvageable brain tissue which is likely to be causing the patient’s deficits. *Advanced imaging should not be requested without prior discussion with a stroke physician.*
1. **Would definitely not be suitable for Thrombectomy if any of the following apply:**
* Patient has little scope for benefit *– for example, severe frailty*
* Has a clinical diagnosis of acute stroke which is unlikely to result in disability or dependency on others *– Thrombectomy has little to offer those with non-disabling stroke*
* Brain imaging has shown a large volume of infarction in keeping with the patient’s stroke deficits *– there is unlikely to be a significant volume of salvageable brain tissue*
* CT angiography has not shown an occluded intracranial artery amenable to thrombectomy
* The patient has had no new stroke symptoms within 24 hours *– none of the RCTs have demonstrated benefit from thrombectomy beyond 24 hours even those selecting patients based on advanced imaging.*