

# Stroke

American Stroke  
Association<sup>SM</sup>

JOURNAL OF THE AMERICAN HEART ASSOCIATION

A Division of American  
Heart Association



## Correction

*Stroke* 2005;36;1352; originally published online May 5, 2005;

DOI: 10.1161/01.STR.0000169645.38361.a1

Stroke is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75214  
Copyright © 2005 American Heart Association. All rights reserved. Print ISSN: 0039-2499. Online  
ISSN: 1524-4628

The online version of this article, along with updated information and services, is  
located on the World Wide Web at:

<http://stroke.ahajournals.org/cgi/content/full/36/6/1352>

Subscriptions: Information about subscribing to *Stroke* is online at  
<http://stroke.ahajournals.org/subscriptions/>

Permissions: Permissions & Rights Desk, Lippincott Williams & Wilkins, a division of Wolters  
Kluwer Health, 351 West Camden Street, Baltimore, MD 21202-2436. Phone: 410-528-4050. Fax:  
410-528-8550. E-mail:  
[journalpermissions@lww.com](mailto:journalpermissions@lww.com)

Reprints: Information about reprints can be found online at  
<http://www.lww.com/reprints>

# Correction

In the April 2005 issue of *Stroke*, the AHA/ASA Scientific Statement, “Guidelines for the Early Management of Patients With Ischemic Stroke” by Adams et al,<sup>1</sup> contained two dosing errors in Table 6 on page 920. In the table, there are 2 rows labeled “Diastolic >140.” Because of an error in production, in each of these rows the dose for nitroprusside was given as 0.5 mg·kg<sup>-1</sup>·min<sup>-1</sup>.

Please note that the correct dose in both cases should be 0.5 μg·kg<sup>-1</sup>·min<sup>-1</sup>. The corrected Table 6 appears below.

**TABLE 6. Approach to Elevated Blood Pressure in Acute Ischemic Stroke**

Blood Pressure Level, mm Hg	Treatment
<b>A. Not eligible for thrombolytic therapy</b>	
Systolic ≤220 OR diastolic ≤120	Observe unless other end-organ involvement (eg, aortic dissection, acute myocardial infarction, pulmonary edema, hypertensive encephalopathy) Treat other symptoms of stroke (eg, headache, pain, agitation, nausea, vomiting) Treat other acute complications of stroke, including hypoxia, increased intracranial pressure, seizures, or hypoglycemia
Systolic ≤220 OR diastolic 121–140	Labetalol 10–20 mg IV for 1–2 min May repeat or double every 10 min (max dose 300 mg) OR Nicardipine 5 mg/h IV infusion as initial dose; titrate to desired effect by increasing 2.5 mg/h every 5 min to max of 15 mg/h Aim for a 10%–15% reduction in blood pressure
Diastolic >140	Nitroprusside 0.5 μg·kg <sup>-1</sup> ·min <sup>-1</sup> IV infusion as initial dose with continuous blood pressure monitoring Aim for a 10%–15% reduction in blood pressure
<b>B. Eligible for thrombolytic therapy</b>	
<b>Pretreatment</b>	
Systolic >185 OR diastolic >110	Labetalol 10–20 mg IV for 1–2 min May repeat 1 time or nitropaste 1–2 in
<b>During/after treatment</b>	
1. Monitor blood pressure	Check blood pressure every 15 min for 2 h, then every 30 min for 6 h, and finally every hour for 16 h
2. Diastolic >140	Sodium nitroprusside 0.5 μg·kg <sup>-1</sup> ·min <sup>-1</sup> IV infusion as initial dose and titrate to desired blood pressure
3. Systolic >230 OR diastolic 121–140	Labetalol 10 mg IV for 1–2 min May repeat or double labetalol every 10 min to maximum dose of 300 mg, or give initial labetalol dose, then start labetalol drip at 2–8 mg/min OR Nicardipine 5 mg/h IV infusion as initial dose and titrate to desired effect by increasing 2.5 mg/h every 5 min to maximum of 15 mg/h; if blood pressure is not controlled by labetalol, consider sodium nitroprusside
4. Systolic 180–230 OR diastolic 105–120	Labetalol 10 mg IV for 1–2 min May repeat or double labetalol every 10–20 min to maximum dose of 300 mg or give initial labetalol dose, then start labetalol drip at 2–8 mg/min

<sup>1</sup>[Correction for Vol 36, Number 4. Pages 916–923.]

© 2005 American Heart Association, Inc.