

Arterial Stroke in Children and the 2026 AHA Guidelines for Early Management of Patients with Acute Ischemic Stroke



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Stroke in Children and the 2026 AHA Guidelines for Early Management of Patients with Acute Ischemic Stroke.

Michael J. Rivkin, M.D.

No financial relationships to disclose

Learning Objectives:

1. To learn the indications and treatments specified for *children* in the 2026 AHA Guideline for Early Management of Patients with Acute Ischemic Stroke (AIS).
2. To learn the major clinical settings in which AIS occurs in children 1 month of age through 18 years of age.
3. To recognize that neonates represent the pediatric age group in which AIS occurs most commonly and that it imparts life-long morbidity.
4. To become familiar with the evidence available that supports hyperacute treatment of AIS in children.

2026 American Heart Association Guidelines for Early Management of Patients with Acute Ischemic Stroke

Stroke

CLINICAL STATEMENTS AND GUIDELINES

2026 Guideline for the Early Management of Patients With Acute Ischemic Stroke: A Guideline From the American Heart Association/American Stroke Association

Endorsed by the American Association of Neurological Surgeons/Congress of Neurological Surgeons, Neurocritical Care Society, the Society for Academic Emergency Medicine, the Society of NeuroInterventional Surgery, and the Society of Vascular and Interventional Neurology.

The American Academy of Neurology affirms the value of this statement as an educational tool for neurologists.

- This guideline broke new ground: directly addressed treatment of children with acute arterial ischemic stroke.

Prabhakaran et al, Stroke;2026: 10.1161/STR.0000000000000513



Stroke

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Detection and Diagnosis

-In pediatric patients with suspected stroke transported by ambulance, the usefulness of common adult stroke screening tools is uncertain because they perform poorly for identification of stroke. Newer pediatric stroke screening tools demonstrate good interrater reliability; however, their sensitivity, specificity, and predictive value in the prehospital setting remain to be determined, and their usefulness is unknown.

-In pediatric patients with suspected AIS, emergent brain and vascular imaging with MRI/MRA of the cervical and intracranial vessels is reasonable to identify patients with large vessel occlusion and to differentiate arterial ischemic stroke from hemorrhagic stroke or stroke mimics.

-In pediatric patients with suspected AIS, emergent brain and vascular imaging with CT/CTA of the cervical and intracranial vessels is reasonable if MRI/MRA imaging is not available immediately (within 25 minutes) to identify patients with large vessel occlusion.



Stroke

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Treatment: Thrombolysis and Thrombectomy

-In pediatric patients aged 28 days to 18 years with confirmed AIS presenting within 4.5 hours of symptom onset and disabling deficits, IVT with alteplase may be considered as it is safe, but efficacy is uncertain.

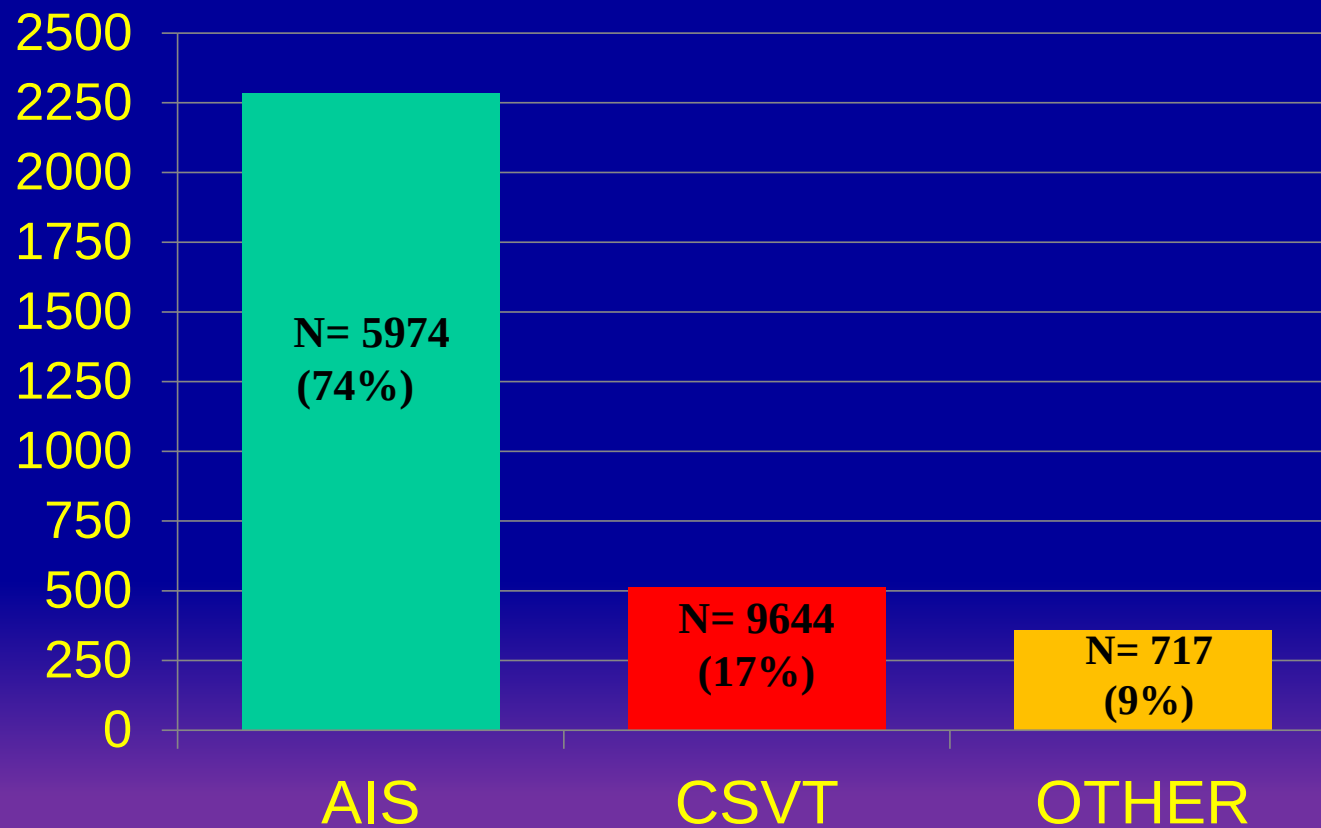
-In pediatric patients ≥ 6 years with acute neurological symptoms and ischemic stroke due to LVO and within 6 hours from symptom onset, EVT can be effective if performed by experienced neurointerventionalists to improve functional outcome .

-In pediatric patients ≥ 6 years with acute neurological symptoms and ischemic stroke due to LVO, 6 to 24 hours from symptom onset, and with potentially salvageable brain tissue, EVT can be effective to improve functional outcomes.

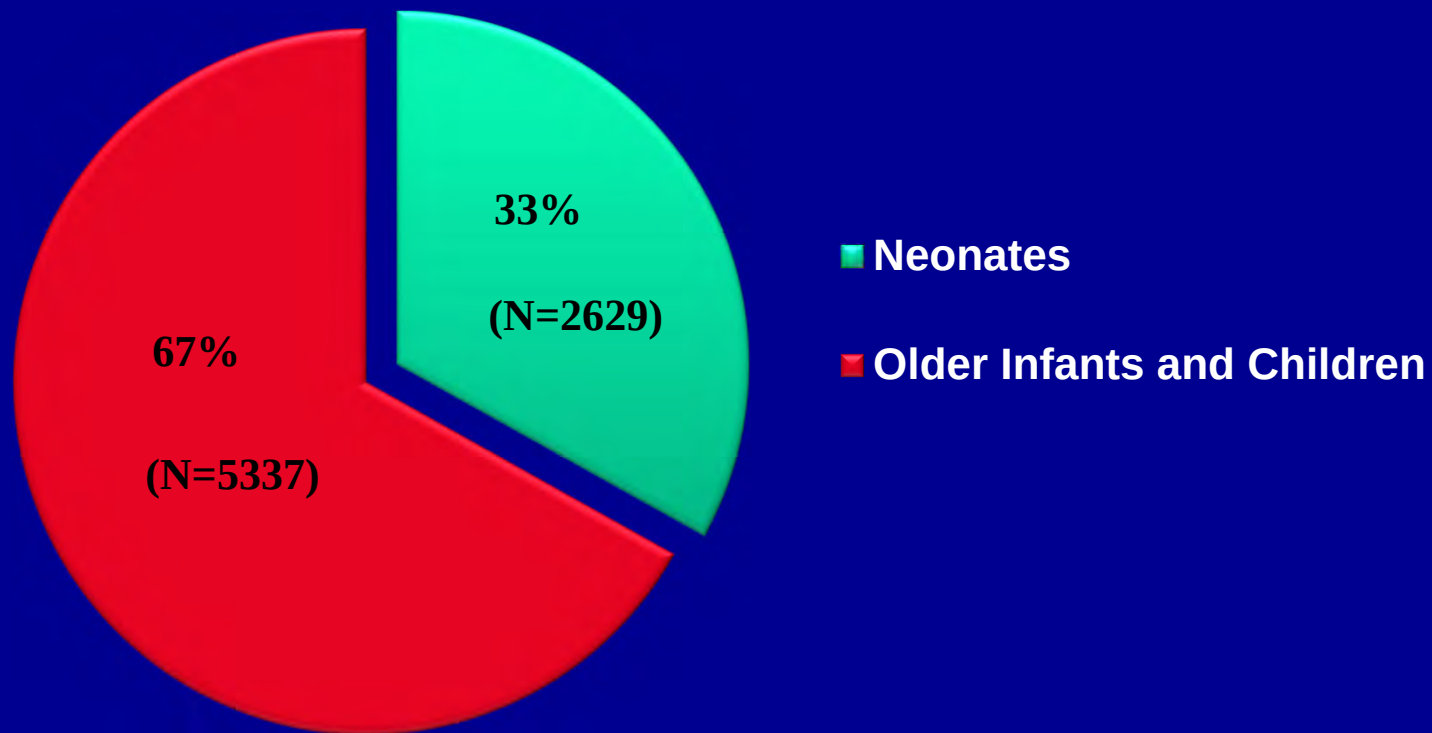
-In pediatric patients aged 28 days to 6 years with acute neurological symptoms, including first-time seizure and AIS due to LVO, within 24 hours from symptom onset, and with potentially salvageable brain tissue, EVT performed by neurointerventionalists with pediatric experience may be reasonable to improve functional outcome.



IPSS Patients – Stroke Subtype (N=7965)



IPSS Patients – Age at Stroke (N=7965)



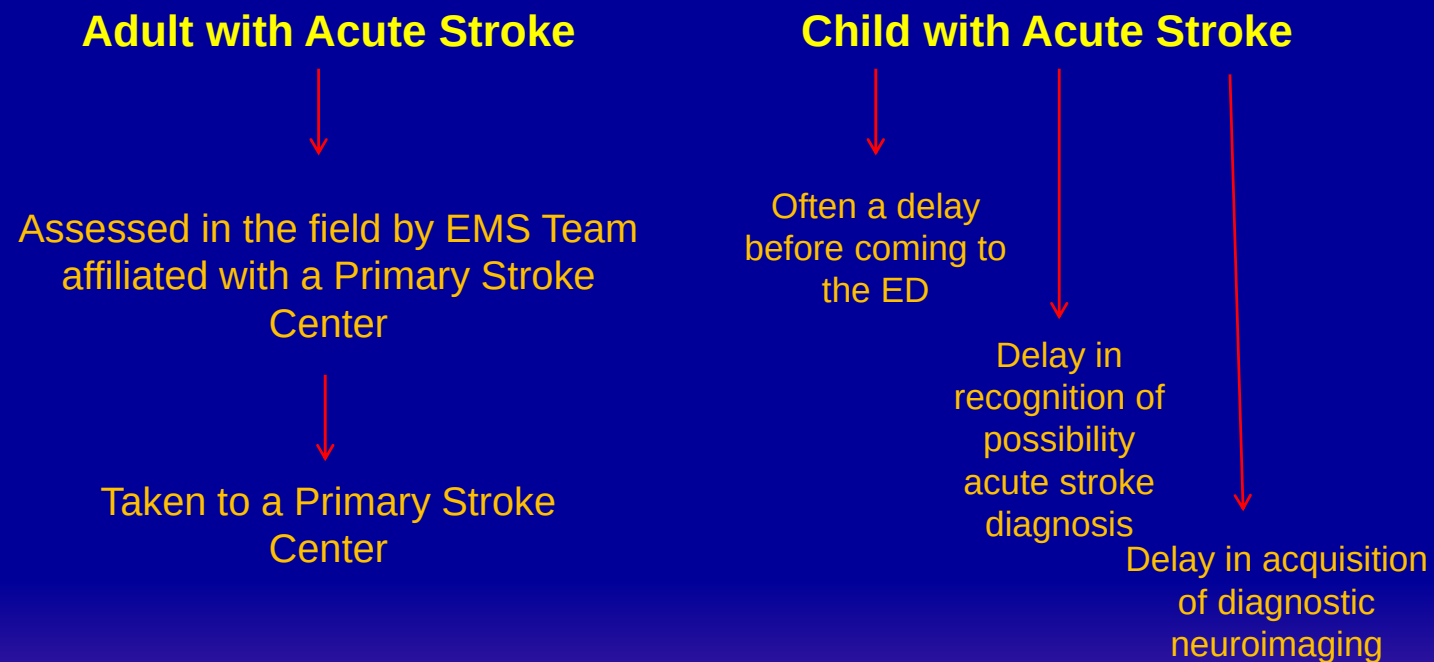
Stroke Detection in Children

In pediatric patients with suspected stroke transported by ambulance, the usefulness of common adult stroke screening tools is uncertain because they perform poorly for identification of stroke.

Newer pediatric stroke screening tools demonstrate good interrater reliability; however, their sensitivity, specificity, and predictive value in the prehospital setting remain to be determined, and their usefulness is unknown.



Adults and Children with Stroke Travel Different Paths during the Acute Phase of Their Illness.



Studied Time Intervals in Children With Out-of-Hospital and In-Hospital Arterial Ischemic Stroke

N=209

n_{out}=132

2017, Time to Dx
Mild – 13 hrs
All-20 hrs

Studied Time Intervals (in Hours)	N	Median	IQR‡
Out-of-hospital AIS			
Symptom onset to seek medical help	93	1.0	0.16–4.7
Symptom onset to initial assessment	85	1.6	0.4–6.4
Symptom onset to hospital arrival*	106	1.7	0.8–8.1
Symptom onset to initial neuroimaging	108	8.5	3.7–27.5
Symptom onset to diagnosis†	116	29	11.3–65.9
Hospital arrival to physician assessment	105	0.25	0.08–0.4
Hospital arrival to initial neuroimaging	95	3.1	1.5–7.4
Hospital arrival to diagnosis	95	12.9	5–31.1
Diagnosis to treatment, days	84	1	0–2
In-hospital AIS			
Symptom onset to initial assessment§	64	0.0	0.0–0.0§
Symptom onset to initial neuroimaging	75	10.5	3.8–25
Symptom onset to diagnosis	73	11.6	3.9–39.9
Diagnosis to treatment, days	25	2	0–5

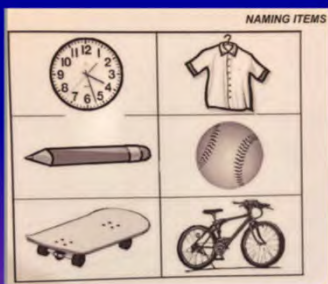
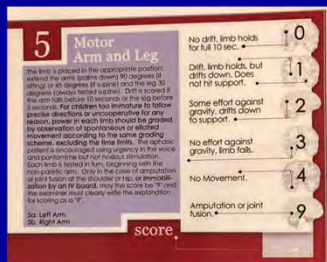
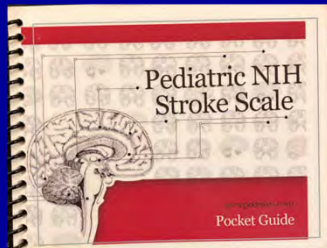
*Prehospital delay.
†Total delay.
‡Interquartile range defined by the 25th to 75th percentile.
§Majority of in-hospital AIS occurred in an intensive care setting (eg, postcardiac procedure) while under close observation.
N indicates number of patients with available data.

n_{in}=77

Rafay et al, Stroke.
2009;40:58-64;
Srinivasan et al,
Pediatrics. 2009; 124;
e227-e234; Gabis et al,
Pediatrics.2002;110;924-
928; Shack et al, DMCN.
2017;31-37; Pearson et
al, Front Stroke:2026



Development and Use of the Pediatric NIH Stroke Scale (PedsNIHSS)



- Scores across 11 domains, among them consciousness, gaze, visual fields, facial movement, arm/leg motor function, limb ataxia language.
- Validated for use in children with arterial ischemic stroke
- Possesses excellent interrater reliability
- Predicts functional outcome at 3 and 12 months *and* correlates with stroke severity

Ichord et al, Stroke; 2011;doi: 10.1161/STROKEAHA.110.607192; Beslow et al, Stroke; 2012;doi: 10.1161/STROKEAHA.111.633305



2026 AHA Acute AIS Guideline: Stroke Detection in Children

- In pediatric patients with suspected AIS, emergent brain and vascular imaging with MRI/MRA of the cervical and intracranial vessels is reasonable to identify patients with large vessel occlusion and to differentiate arterial ischemic stroke from hemorrhagic stroke or stroke mimics.

How does acute arterial stroke present in children

- Among adults 85% of acute stroke is ischemic acute stroke
- Among children, ~50% of acute stroke is ischemic and ~50% is hemorrhagic.
- Stroke mimicry by other disease more common in children than in adults
 - 80-90% of children with a clinical presentation of acute stroke will harbor a stroke mimic.
- Less severe mimics:
 - Migraine (esp. complex)
 - Bell's palsy
 - Post-ictal Todd's paralysis
 - Syncope
 - Psychogenic disorders
- More severe mimics:
 - Posterior reversible encephalopathy syndrome (PRES)
 - Demyelinating diseases (ADEM, MOGAD, NMOS, MS)
 - Cerebellitis
 - Encephalitis
 - Metabolic disorders.



- MRI discriminates among these possibilities much better than CT and identifies, *non-ischemic causes of stroke-like presentations* so that they may be correctly treated.
- Thus, MRI/ MRA is the first choice of imaging modality for evaluation of children with stroke like presentation.

Stroke in Children: Epidemiology

Neonates-

occurrence ~1 in 1,100-4,000 births

Males > Females

80% as arterial ischemic stroke (AIS)

20% as cerebral sino-venous thrombosis (CSVT) or other

Scope of the problem-

3.9 million live births/year in the United States

At estimated incidence of 1 in 2,500 term births/year

~ 1,600 newborns with neonatal stroke /year in U.S.



Stroke in Neonates

Clinical Presentation

Signs

- Focal seizures— 77-95%, primary presenting sign
- Lethargy
- Apnea
- Encephalopathy

Billinghurst et al, Neurology:2017; Ferriero et al, Stroke:2019; Rivkin et al, Jour Pediatrics:2025

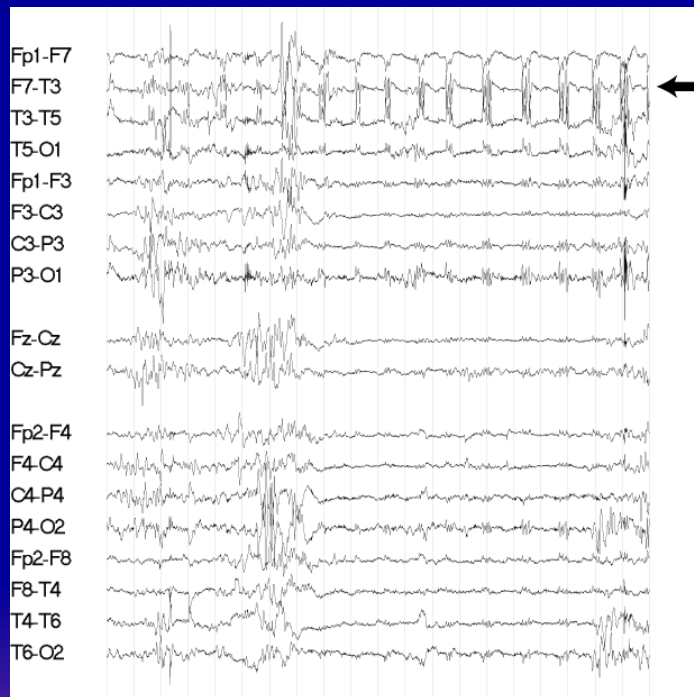
Stroke in Neonates

Clinical Presentation

Physical Examination

- Lateralized, diminished movement of one limb or one side
- Abnormal reflexes
- Hypotonia
- Hypertonia, rarely

Stroke in Neonates Diagnostic Studies

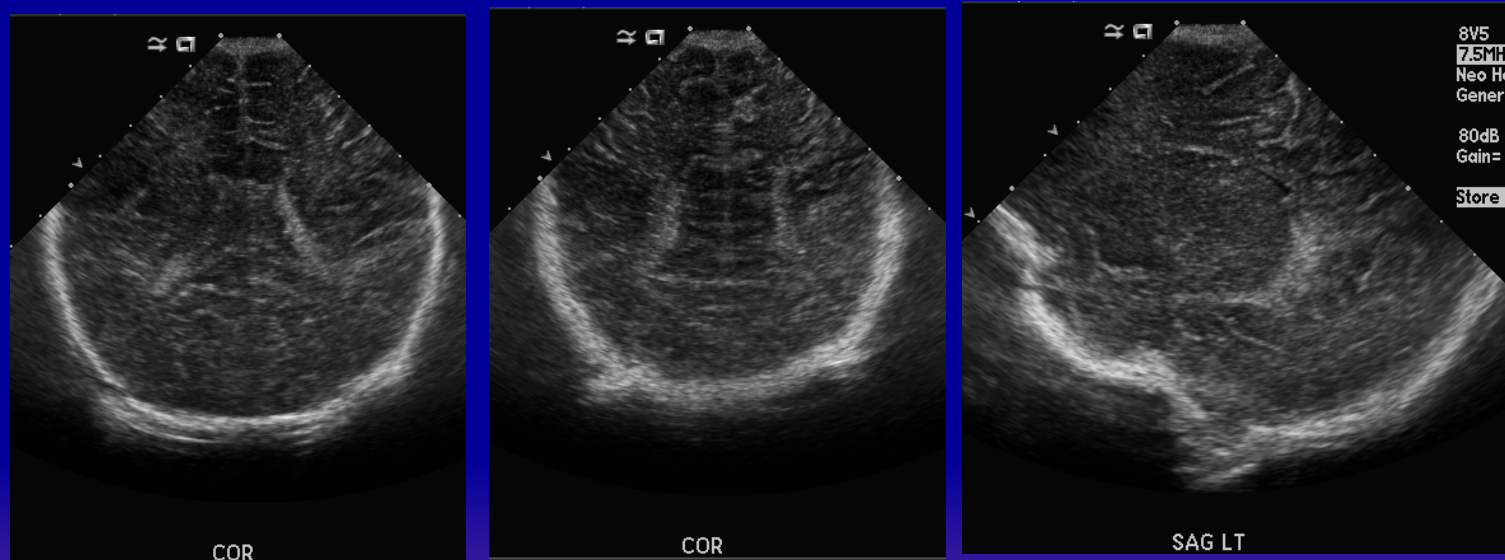


EEG

- Focal persistent voltage reduction
- Marked focal slowing and sharp wave activity
- Area of focal electrical abnormality should conform to the region of stroke

- In a neonate suspected of stroke, the occurrence of seizure or focal eeg findings should lead to MRI evaluation of brain

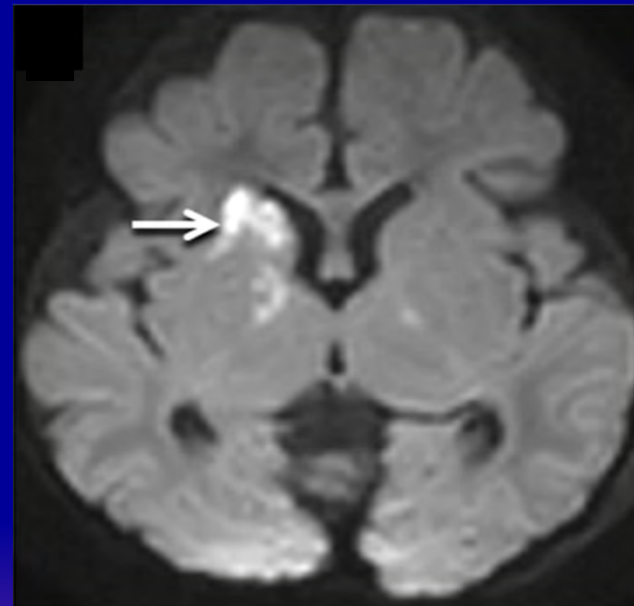
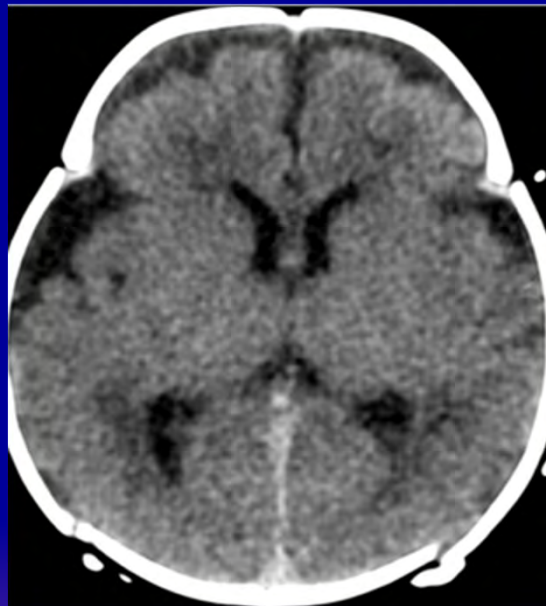
Term Neonate (1 day old) with Right Focal Seizures



Cranial Ultrasound

Sensitivity of Cranial CT as compared to MRI in Detection of AIS in Neonates and Infants

Cranial
CT scan



Cranial
MRI-DWI

Pai V, Shroff M, Pediatr Radiol:2026

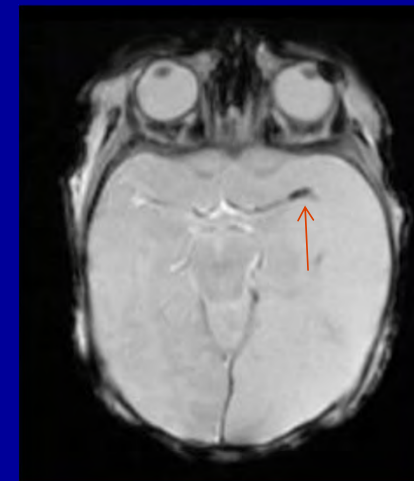
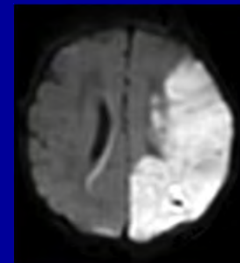
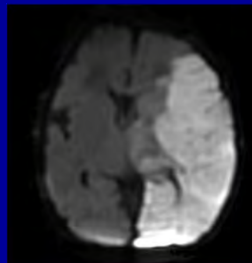
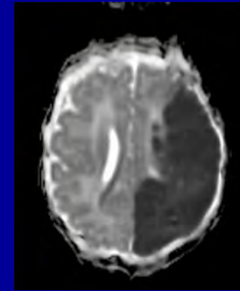
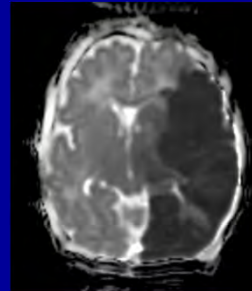
Stroke in Neonates-MRI Characteristics

Term Neonate

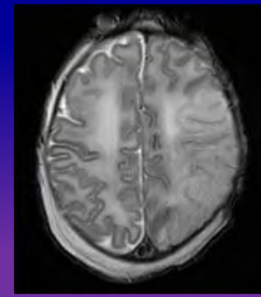
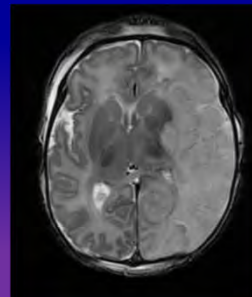
1 day old

**Refractory focal and
generalized seizures**

- Left hemisphere
- MCA territory
- PCA territory



Axial GRE



Axial T2FSE

2026 AHA Acute AIS Guideline: Stroke Detection in Children

- In pediatric patients with suspected AIS, emergent brain and vascular imaging with CT/CTA of the cervical and intracranial vessels is reasonable if MRI/MRA imaging is not available immediately (within 25 minutes) to identify patients with large vessel occlusion.
 - If MRI scanner not available in 25 minutes from patient's arrival, pivot to cranial CT
 - To document arterial vascular obstruction
 - To assess for intracranial hemorrhage
 - Parenchyma can be assessed for hypodensity to indicate AIS
 - Information can be used for decision about hyperacute therapy in real time
 - MRI/A can be obtained later in subsequent scan session.



2026 AHA Acute AIS Guideline: Thrombolysis and Endovascular Thrombectomy Treatment

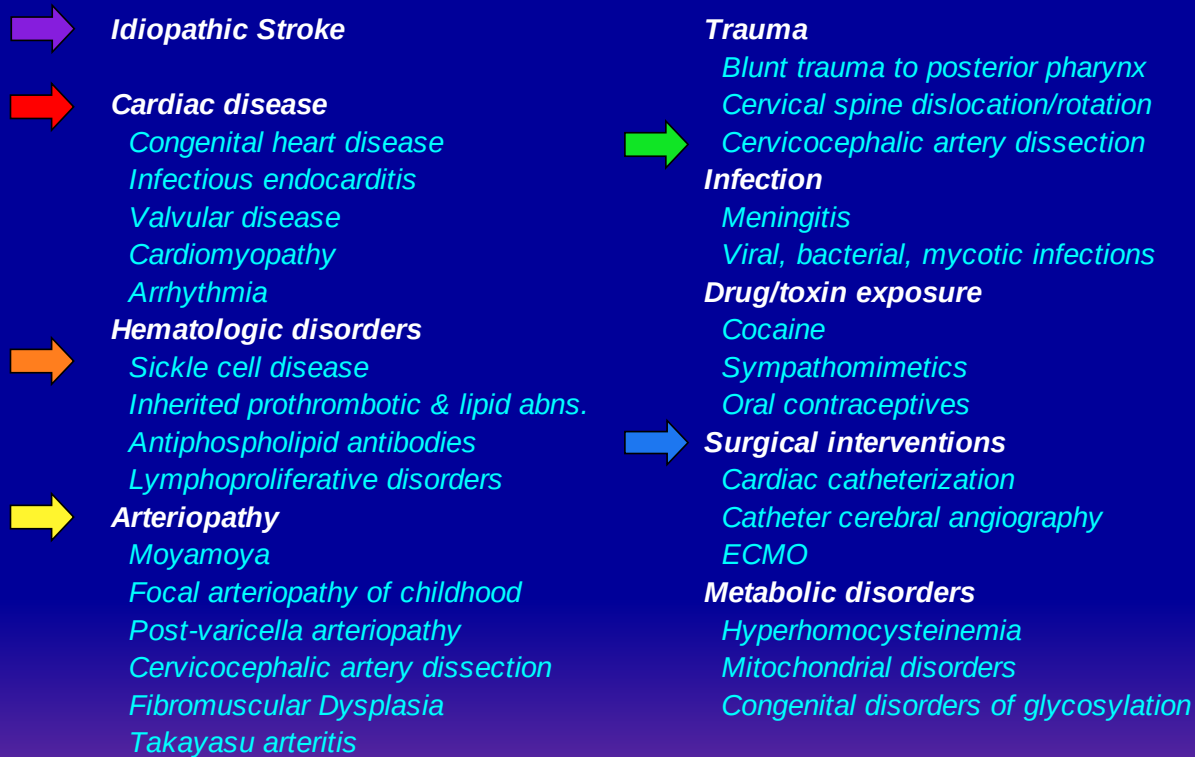
- -In pediatric patients aged 28 days to 18 years with confirmed AIS presenting within 4.5 hours of symptom onset and disabling deficits, IVT with alteplase may be considered as it is safe, but efficacy is uncertain.
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- -In pediatric patients aged 28 days to 6 years with acute neurological symptoms, including first-time seizure and AIS due to LVO, within 24 hours from symptom onset, and with potentially salvageable brain tissue, EVT performed by neurointerventionalists with pediatric experience may be reasonable to improve functional outcome.



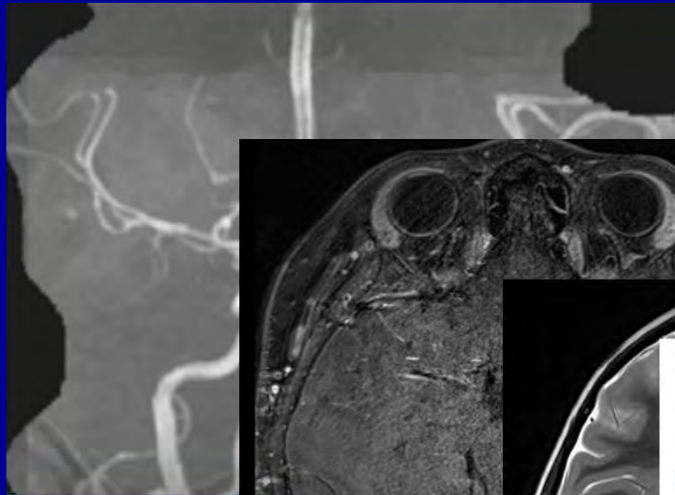
Stroke in Children: Comparative Frequency

- Brain tumor in children: $\sim 3/100,000$
- Inflammatory Bowel Disease in children:
 $\sim 2/100,000$
- Arterial Ischemic Stroke in all children:
 $3-13/100,000$ ($1/7,700$)
- Arterial Ischemic Stroke in Neonates
 $40/100,000$ ($1/2,500$)

Etiologies in Children



Focal Cerebral Arteriopathy



First, associated with VZV infection

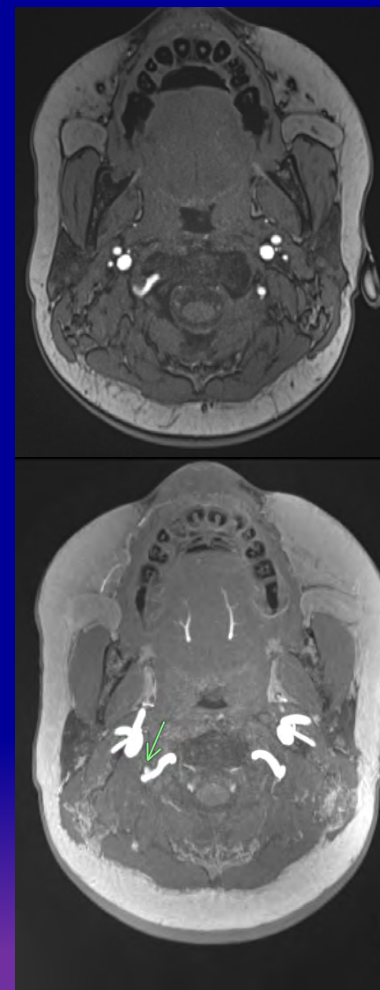
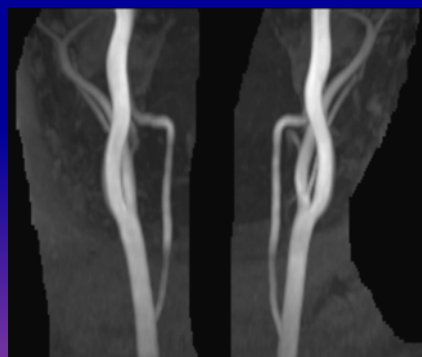
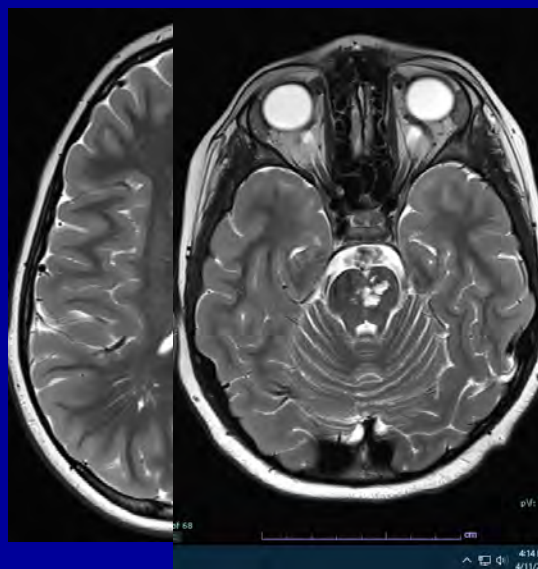
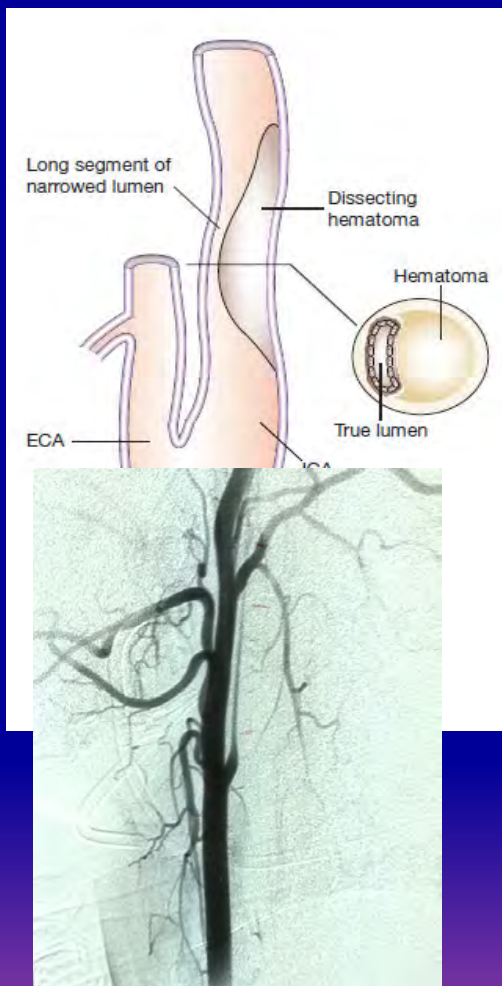
Evidence of Acute Herpesvirus Infection (IgM+ Ab Titers) in Childhood AIS Cases vs. Stroke-Free Trauma Controls



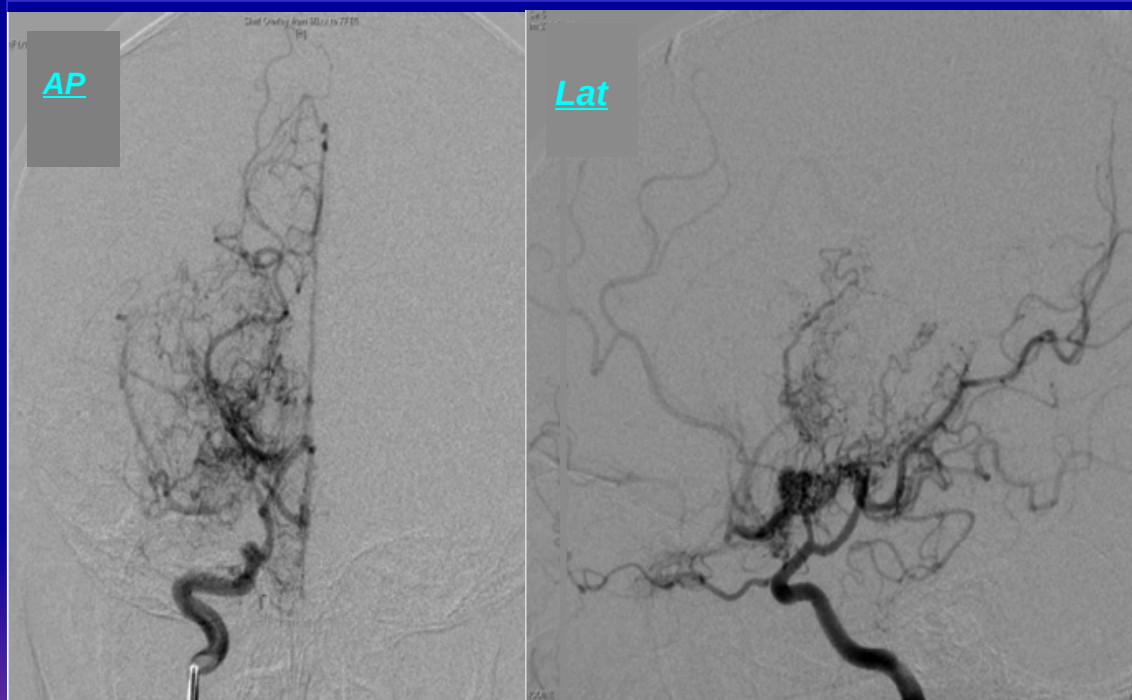
Herpesvirus	Cases n=326		Controls n=115		OR†	(95% CI)	P Value
	n	(%)	n	(%)			
HSV 1 or 2	80	(24.5)	19	(16.5)	1.68	(0.98–3.00)	0.07
HSV 1	32	(9.8)	4	(3.5)	3.42	(1.31–11.8)	0.04
HSV 2	0	(0.0)	0	(0.0)	–	–	–
HSV, indeterminate	48	(14.7)	15	(13.0)	1.23	(0.67–2.37)	0.31
VZV	37	(11.3)	3	(2.6)	4.43	(1.55–18.7)	0.02
CMV	18	(5.5)	2	(1.7)	2.85	(0.79–18.2)	0.17
EBV	4	(1.2)	1	(0.9)	1.44	(0.21–28.4)	0.75
Any herpesvirus	98	(30.1)	21	(18.3)	1.91	(1.14–3.31)	0.02



Cervicocephalic Arterial Dissection



Moyamoya Disease



Scott and Smith, NEJM, 2009;
Munot et al, Lancet Neurol, 2011

Primary Moyamoya

assoc. w 3p and 7q;
ACTA2; YAPP1;
RFN 213; GUCY1A3

Secondary Moyamoya

neurofibromatosis

tuberous sclerosis

homocystinuria

sickle cell anemia

trisomy 21

Williams syndrome

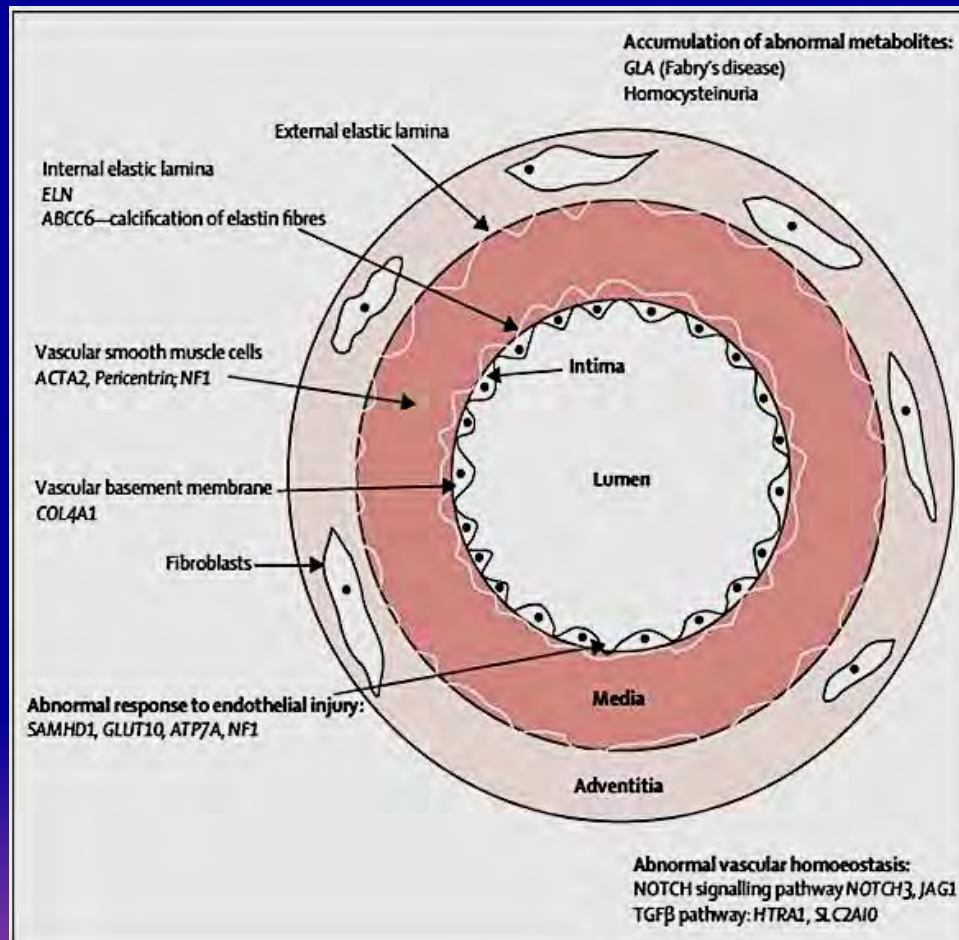
Alagille syndrome

cranial irradiation

Vascular Pathology:
Smooth muscle hyperplasia;
Luminal thrombosis



Genes Associated with Pediatric Cervicocephalic Arteriopathy



	Disease mechanism or pathway implicated
COL4A1	Abnormal vessel-wall integrity
ABCC6	Abnormal vascular homeostasis
ACTA2; NF1; ELN	Smooth-muscle proliferation
NOTCH3; JAG1	Notch signalling
HTRA1	TGFβ pathway
SAMHD1	Possibly immune response or vascular homeostasis
PONT	Undefined
ATP7A; SL C2A10 (GLUT10)	Abnormal response to vascular or endothelial injury (infection, trauma, oxidative stress)
Homocysteinuria; GLA	Vascular injury due to accumulation of abnormal metabolites

TGFβ=transforming growth-factor β.

Table 1: Genes and disorders associated with childhood cerebral arteriopathy with disease pathogenesis related to vascular development, homeostasis, or response to injury

Arteriopathy in Pediatric Stroke

	Focal Cerebral Arteriopathy	Cerebral Arterial Dissection	Moyamoya Disease
Clinical Features	Hemiparesis; aphasia Stuttering onset; Hx viral infection, wks to months; esp., HSV family	Hemiparesis, aphasia; Often with headache; Preceding head/neck trauma Or spontaneous	Hx of headache, TIA sxs including hemiparesis, aphasia; Sx provoked by exercise, stress, fever
Findings in Brain on MRI	Subcortical infarcts, typically in basal ganglia	Cortical/subcortical mixed pattern of infarction; can be isolated to either anterior or posterior circulation.	Cortically based infarcts; Evidence of old white matter injury; "ivy sign" on FLAIR imaging
Cerebral Angiography	Irregular vascular wall, stenosis in distal ICA, MCA, ACA	Tapered occlusion or stenosis ICA, proximal MCA, ACA or of vertebrobasilar tree.	Stenosis or occlusion distal ICAMCA and ACA. Basal lenticulostriate 'puff of smoke' collateral vessels
Vessel Wall Imaging	Wall thickening & concentric enhancement with contrast administration	Intramural, eccentric enhancement	Wall thickening; usually no enhancement
Treatment	Can consider thrombolytic; Steroid Immunosuppression	Anticoagulation/antiplatelet treatment,	Antiplatelet agent; revascularization surgery.

Chabrier et al, Stroke, 2016, doi:10.1161/STROKEAHA.116.014606;
 Amlie-Lefond et al, Circulation, 2009, doi: 10.1161/CIRCULATIONAHA.108.806307;
 Rafay et al, Neurology, 2020, doi: 10.1212/WNL.00000000000009557



Presentation of AIS in Children

- Sudden-onset, focal neurologic deficits in 85% of non-neonates
 - Hemiparesis 60-80%
 - Speech difficulty 10-35%
 - Visual field defects 5-20%
 - Other 18%

Thrombolysis



Use of tissue plasminogen activator to treat acute arterial ischemic stroke in children

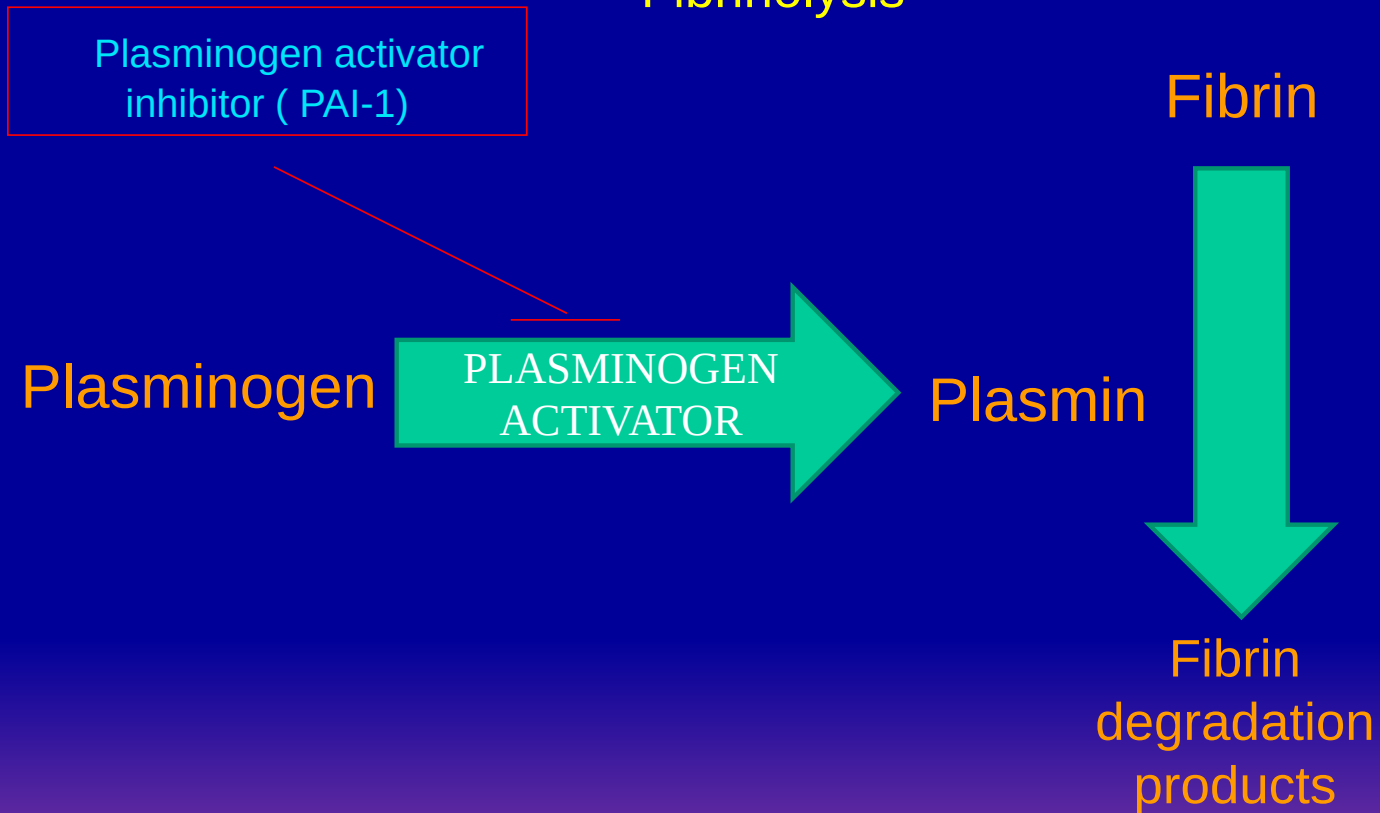


Goals of TIPS:

- To determine safety,
- To determine best dose of tPA
- To determine treatment feasibility

→ IV tPA when used to treat children who present with arterial ischemic stroke (AIS), within 4.5 hours of onset of symptoms

Tissue Plasminogen Activator and Fibrinolysis



TIPS



TIPStER

Age, y/Sex (Year Treated)	Site of Treatment	Known Risk Factors for AIS	PedNIHSS Before tPA	Hours From Stroke Onset to tPA	Dose of tPA, mg/kg	CASCADE Subtype, Primary (Secondary)
1 M (2014)	Site	CHD	15	3.52	0.9	Cardioembolic
3 F (2010)	Site	Rheumatic heart disease	24	3	0.9	Cardioembolic (dehydration)
3 M (2016)	Site	CHD, history of previous stroke	NA	3	0.9	Cardioembolic
4 F (2015)	Site	CHD, anticoagulation on hold	12	2	0.9	Cardioembolic (lipoprotein a)
6 M (2016)	OSH	Sinusitis, neck trauma	7	3.5	0.9	Focal cerebral arteriopathy
8 F (2014)	OSH	None	9	4.08	0.9	Cryptogenic
9 F (2016)	Site	None	19	2.53	0.9	Focal cerebral arteriopathy
9 F (2017)	Site	None	13	3.80	0.9	Cryptogenic
10 F (2009)	OSH	None	19	2.45	0.99	Cryptogenic
11 M (2015)	Site	None	19	2.68	0.9	Cryptogenic
13 F (2007)	Site	Carotid ligation 24 h earlier	20	2.5	0.9	Aortic/cervical arteriopathy
14 M (2016)	Site	None	25	3.33	0.9	Cryptogenic (PFO*)
14 M (2017)	OSH	Duchenne cardiomyopathy, head/neck trauma	14	3.18	0.9	Cryptogenic
14 F (2018)	OSH	Hypertension, reflux nephropathy	2	3.25	0.9	Bilateral cerebral arteriopathy of childhood/Moyamoya
15 F (2016)	OSH	Myocarditis	11	2	0.9	Cardioembolic
15 M (2016)	OSH	IgA nephropathy	15	3.37	0.9	Multifactorial/IgA nephropathy, lipoprotein a (PFO*)
15 M (2017)	OSH	None	NA	3	0.9	Cryptogenic
15 F (2018)	Site	None	17	3.5	0.9	Cryptogenic (PFO*)
15 M (2018)	OSH	None	10	2.3	0.54	Other/CNS vasculitis (PFO)
16 M (2010)	OSH	Head trauma	NA	4.5	0.9	Aortic/cervical arteriopathy/dissection (connective tissue disorder)
16 M (2015)	Site	CHD	5	3.37	0.9	Cardioembolic
16 F (2016)	OSH	Respiratory infection	10	2.12	0.9	Multifactorial (birth control, lipoprotein a; PFO*)
17 F (2010)	OSH	Smoking	4	3	0.9	Cryptogenic
17 F (2014)	OSH	None	NA	3	0.9	Cryptogenic (lipoprotein a)
17 M (2014)	Site	Dilated cardiomyopathy	21	4.45	0.9	Cardioembolic
17 F (2015)	OSH	None	NA	2	0.9	Cryptogenic



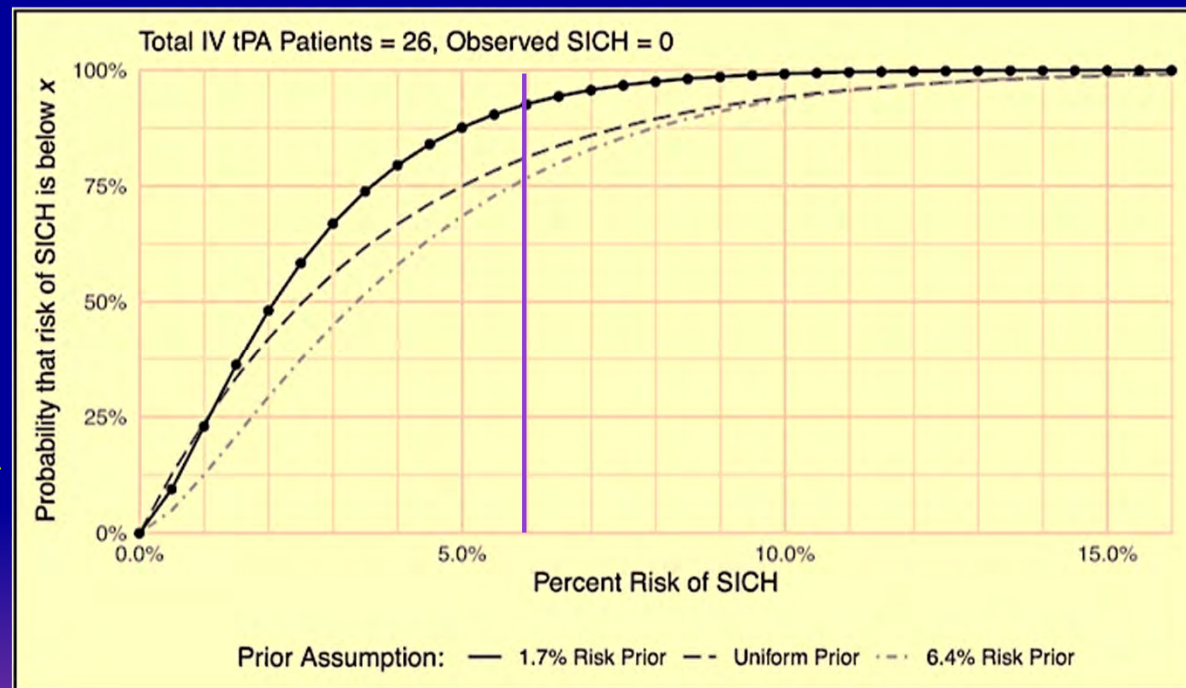
Used a Bayesian beta-binomial model for risk of SICH following intravenous tPA

Risk of Intracranial Hemorrhage Following Intravenous tPA (Tissue-Type Plasminogen Activator) for Acute Stroke Is Low in Children

Catherine Amlie-Lefond, MD; Dennis W.W. Shaw, MD; Andrew Cooper, PhD; Mark S. Wainwright, MD, PhD; Adam Kirton, MD, MSc; Ryan J. Felling, MD, PhD; Michael G. Abraham, MD; Mark T. Mackay, MBBS, PhD; Michael M. Dowling, MD, PhD; Marcela Torres, MD; Michael J. Rivkin, MD; Eric F. Grabowski, MD, DSci; Sarah Lee, MD; Jonathan E. Kurz, MD, PhD; Hugh J. McMillan, MD, MSc; Dwight Barry, PhD; Jacqueline Lee-Eng, BS; Rebecca N. Ichord, MD

Modeled as:

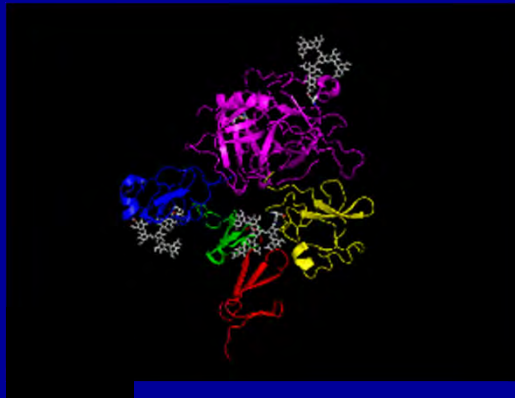
1. *B* with a mode of 1.7% (young adult risk of SICH after tPA)
2. *B* where all values of risk equally likely
3. *B* where values of risk had a mode similar to older adult risk of 6%



Amlie-Lefond et al, Stroke, 2020



Tenecteplase

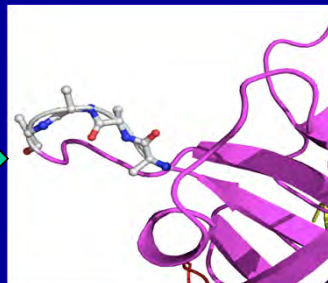
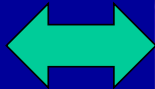


Tenecteplase vs. Alteplase:

- 14 fold greater fibrin affinity
- 80 fold greater resistance to PAI-1
- More rapid thrombolysis
- Bolus dosing
- Single dosing



tPA-alteplase: Lys, His, 2Arg



tPA-tenecteplase: 4Arg

In Phase 3 trials comparing tenecteplase with alteplase for outcome:

- 30% complete reperfusion v. 15%
- Significantly better 3 month mRS scores
- sICH rate either same or better than alteplase

Developmental hemostasis and trajectory of [tPA]/[PAI-1] ratios in development

- From 1 to 16 years of age, baseline tPA concentrations in blood are about 50% lower than in adults
- Plasminogen activator inhibitor-1 (PAI-1) concentrations overall are increased in children compared to adults
- Neonates have ~2x adult levels of tPA and PAI-1; yet fibrinolytic activity impaired
- Protein C low at birth and matures latest remaining low throughout most of childhood.
- Antithrombin 3 (AT3) ~30% of adult at birth and matures over the next 3 months.
- Protein S is 35% of adult level at birth and rises over the first 3-4 months of life.

Child, < 18 y.o.

tPA↓/PAI-1↑

Adult

tPA↑/PAI-1↓



tPA administration to Children with Acute AIS

- Safety data for use of alteplase in children greater than 3 years of age exists.
- Tenecteplase likely to be safe and very useful in treatment of children who meet treatment criteria for thrombolytic treatment
- There exists a developmental trajectory of hemostasis in children.
- There is no report on the use of intravenous tPA in infants 28 days to 1 year of age, and only one child with outcome data under the age of 3 years.

Summary of Literature on tPA administration in Children with Acute AIS

Author	Type of study	# patients treated with tPA	# patients under the age of 1 year	# patients age > 1 and < 3 years	Youngest patient (years)
Amlie-Lefond et al, Stroke, 2020.	Retrospective	26	0	1	1 yrs
Kossorotoff et al, JAMA Network, 2022.	Retrospective	44 total (28 IV tPA alone, 16 IV tPA prior to EVT)	?*	?*	2 yrs*
Bigi et al, Ann Neurol, 2018	Retrospective	5	0	0	5 yrs
Tabone et al, Stroke, 2017	Retrospective	11	0	0	3 yrs

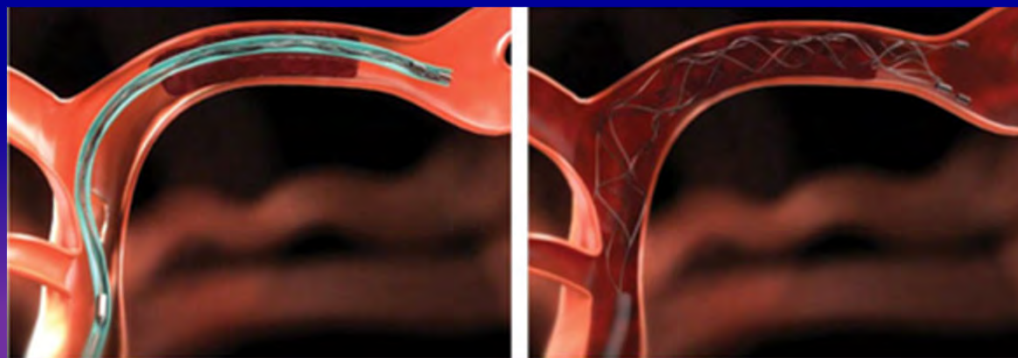
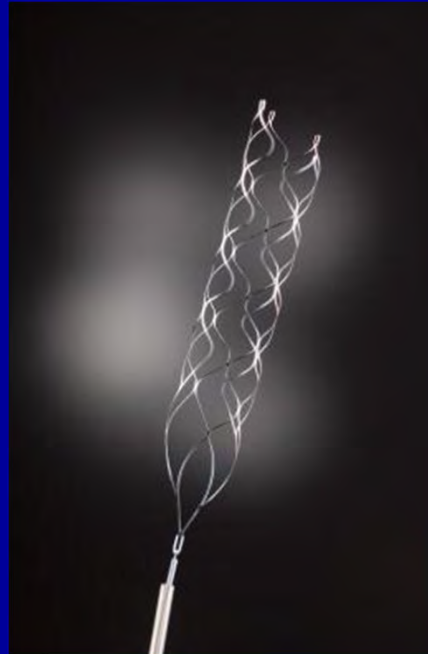
Tenecteplase safety in children: submitted IPSS data-symptomatic ICH not reported in any of 44 children who received IV TNK→under review



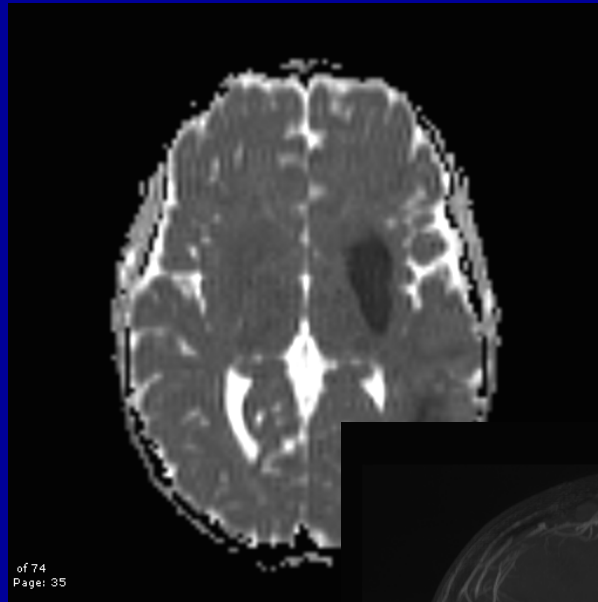
2026 AHA Acute AIS Guideline: Endovascular Thrombectomy in Children with Acute Arterial Ischemic Stroke

In pediatric patients aged 28 days to 6 years with acute neurological symptoms, including first-time seizure and AIS due to LVO, within 24 hours from symptom onset, and with potentially salvageable brain tissue, EVT performed by neurointerventionalists with pediatric experience may be reasonable to improve functional outcome

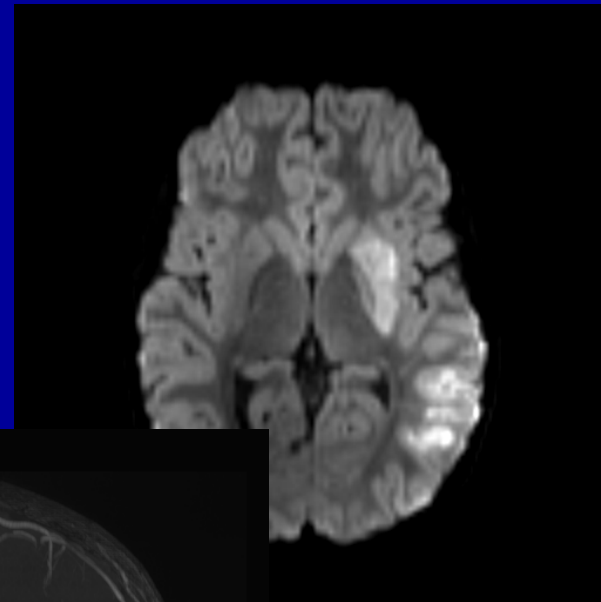
Invasive Endovascular Treatment



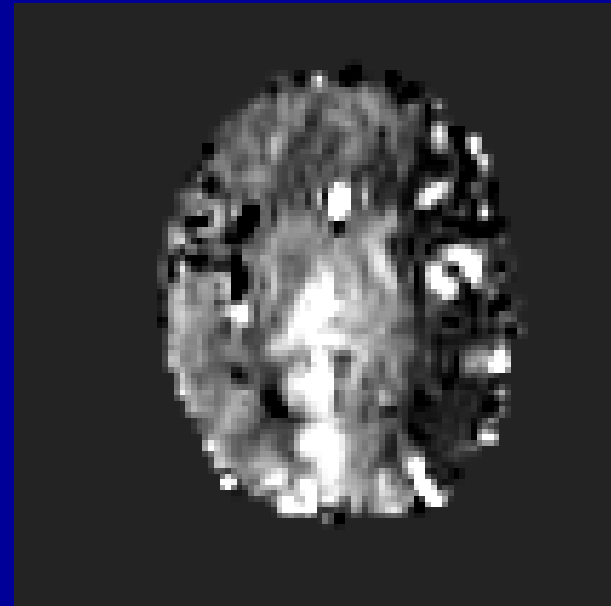
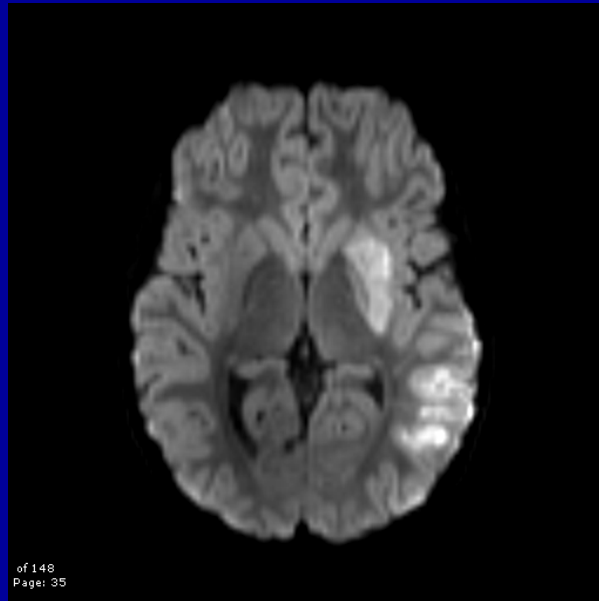
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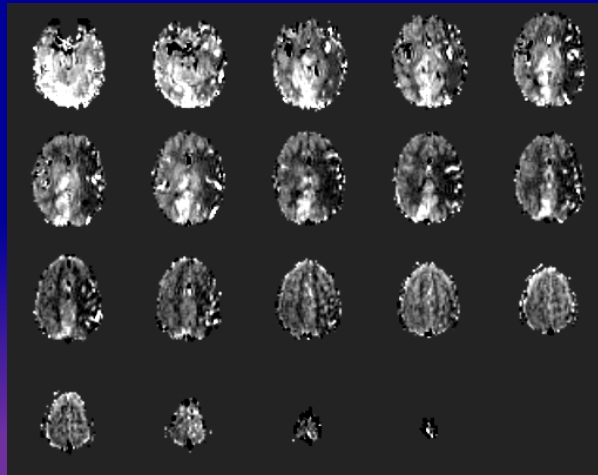
DWI trace

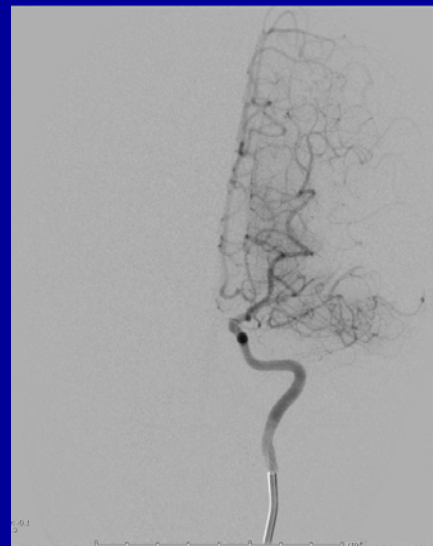
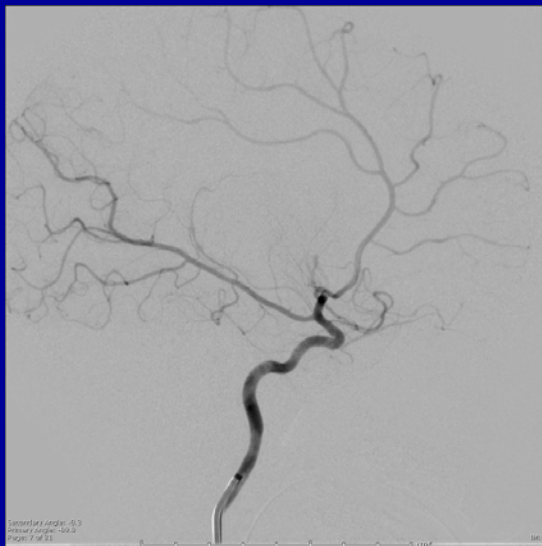


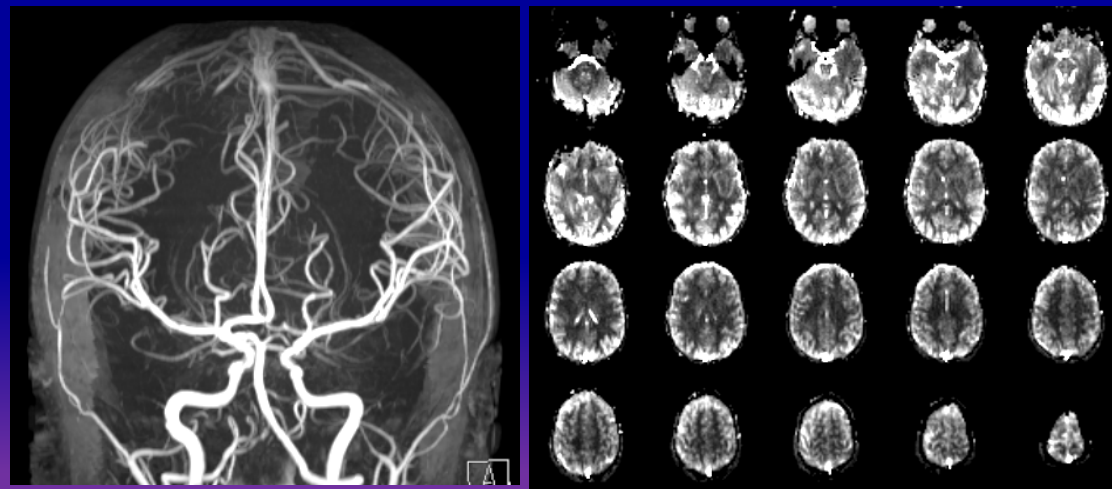
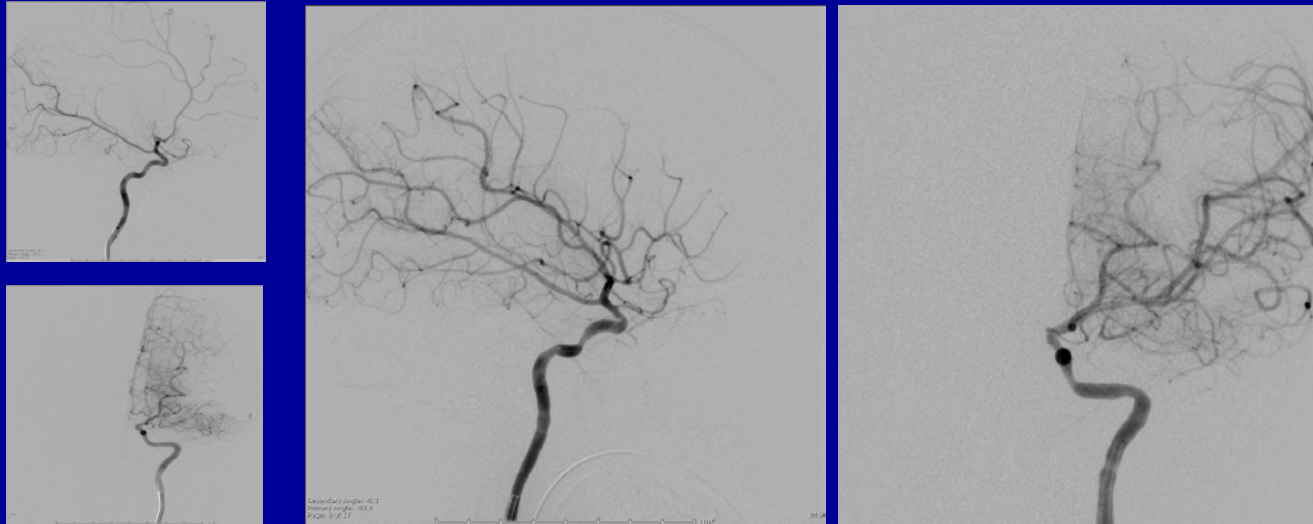
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PWI







PWI



Endovascular Thrombectomy in Children with Acute AIS

- Endovascular thrombectomy can be effective in reperfusion after stroke and in improvement of 30-day functional outcome as compared to medical (nonthrombolytic medical therapy)
- Save CHILDS Pro study : Intercontinental, 45 centers, registry design, is ongoing
- Experience reported with very young children is limited; little published data exist regarding the age floor for this procedure.
- Concern exists for cannulated arterial size, age-related endovascular differences, age related difference in hemostasis.

<i>Author</i>	<i>Type of study</i>	<i># patients treated with EVT</i>	<i># patients under the age of 1</i>	<i># patients age > 1 and < 3 years</i>	<i>Youngest patient*</i>
<i>Sporns et al, Lancet Child Adolesc Health, 2024</i>	Prospective	117 Per table Median 11 years (IQR 6-14)	At least 1, otherwise not specified	Not specified	0.25 yrs (3 mos)
<i>Sporns et al, JAMA Neurol. 2019**</i>	Retrospective	Median 11.3 years (range 0.7-18 years), 11 patients age 0-6 years	At least 1, otherwise not specified	Not specified	0.7 yrs*** (8 mos)
<i>Bhatia et al, JAMA Neurol, 2023</i>	Retrospective	32	0	0	3 yrs
<i>Kossorotoff et al, JAMA Network, 2022.</i>	Retrospective	40	?*	?*	2 yrs*
<i>Bigi et al, Ann Neurol, 2018</i>	Retrospective	11	0	1	2 yrs



Conclusions

1. The 2026 AHA Guidelines for Early Management of Patients with Acute Ischemic Stroke recognizes and recommends specific therapies for children with acute arterial ischemic stroke.
2. Both thrombolysis and endovascular therapies are indicated for qualifying children with acute arterial ischemic stroke.
3. The age floor for thrombolytic therapy and for endovascular thrombectomy is not yet clear. Continuing research is needed. Current limits of 2 years of age for thrombolysis and of 3 years for thrombectomy are suggested.



Thanks for your attention!

