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The latest physician jobs brought to you by the NEJM CareerCenter

Residents and Fellows Edition

Featured Employer Profile

Geisinger
Dear Physician:

As you near completion of your training, I'm sure that finding the right employment opportunity is a top priority for you. The New England Journal of Medicine (NEJM) is the leading source of information about job openings, especially practice opportunities, in the country. Because we want to assist you in this important search, a complimentary copy of the 2020 Career Guide: Residents and Fellows booklet is enclosed. This special booklet contains current physician job openings across the country. To further aid in your career advancement we've also included a couple of recent selections from our Career Resources section of the NEJM CareerCenter website (NEJMCareerCenter.org).

NEJMCareerCenter.org continues to receive positive feedback from physician users. Because the site was designed specifically based on advice from your colleagues, many physicians are comfortable using it for their job searches and welcome the confidentiality safeguards that keep personal information and job searches private. Physicians have the flexibility of looking for both permanent and locum tenens positions in their chosen specialties and desired geographic locations.

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- Email alerts that automatically notify you about new opportunities
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Our popular Clinical Practice articles are evidence-based reviews of topics relevant to practicing physicians. A reprint of the May 14, 2020, Clinical Practice article, “Transient Ischemic Attack,” is included.

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A career in medicine is challenging, and current practice leaves little time for keeping up with changes. With this in mind, we have developed these new features to bring you the best, most relevant information in a practical and clinically useful format each week.

On behalf of the entire New England Journal of Medicine staff, please accept my wishes for a rewarding career.

Sincerely,

Eric J. Rubin, MD, PhD

Knowing Your Worth in the Physician Job Market

By Nisha Mehta, MD, a physician leader whose work focuses on physician empowerment, community building, and career longevity in medicine

One thing physicians seldom do in the training setting is talk about money. Between daily clinical responsibilities and call, a never-ending amount of information to learn, and doing your best to keep up with the other aspects of your life, most of us would agree we're in survival mode for most of our residency and fellowship. Learning the business and financial aspects of a life in medicine doesn't usually make it to the priority list.

Consequently, as the end of training approaches, most physicians find themselves overwhelmed with the prospect of finding a job, and unprepared for negotiations. Many just feel grateful to have come to the conclusion of a long journey. After years of being paid a very low hourly rate and (on average) holding substantial six-figure debt, it's tempting to just be happy with the positive cash flow.

Not doing the requisite research before talking about numbers will almost always work against you. I routinely find myself encouraging physicians to know their worth — not just because I think physicians have the expertise to warrant earnings that reflect it, but because career longevity and job satisfaction are closely intertwined with feeling valued. When I counsel early-career physicians who are dissatisfied, this is often the reason they end up seeking other opportunities within the first five years out of practice.

As salary transparency is not commonplace in medicine, trainees (and their older counterparts as well, for that matter) often don't know how to evaluate offers or know what reasonable expectations are. This is a significant disadvantage at the negotiating table, and why physicians must put the research into figuring out their market value.

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Many mistakenly assume that knowing your worth means simply looking at widely cited compensation databases such as Medical Group Management Association (MGMA) and Association of American Medical Colleges (AAMC). These are available for purchase or may be available from your hospital libraries or your contract attorney. Although a great place to start, it's important to take this data into context. Compare not only the salary numbers, but the actual compensation per RVU. Know that this can range widely even within the same region of the United States depending on exact location, type of practice, stage of practice, how competitive the job market is, and

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Managing Medical-Education Loan Debt

Exploring repayment options, accessing all available resources are key

By Bonnie Darves

For many residents, their excitement about starting training is tempered by an economic reality: it’s time to reckon with the education debt they’ve incurred during medical school and start repaying those loans.

Although medical school remains a good investment and the associated loan debt is ultimately manageable — most physicians will earn incomes substantial enough to repay their loans, and loan-default rates are extremely low — looking at the loan tab can be unnerving. The median loan debt for graduation medical students is $200,000, and while that figure has changed little in recent years, it’s still a staggering sum.

“What we’ve seen in the past few years is that indebtedness has remained relatively stable, if you control for inflation. It’s not increasing at the same high rate we were seeing in the past,” said Julie Fresne, senior director of student financial and career advisory services at the Association of American Medical Colleges (AAMC). Fully three-quarters of physicians enter training with loan debt, according to recent AAMC data, so those who fret about paying off their loans have plenty of company.

Ms. Fresne also noted that interest rates on federal direct loans have varied substantially enough to repay their loans, and loan-default rates are extremely low — looking at the loan tab can be unnerving. The median loan debt for graduation medical students is $200,000, and while that figure has changed little in recent years, it’s still a staggering sum.

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And while the 25-year plan is more manageable, such extended repayment is far more costly in terms of the interest charges. A third traditional option is the graduated 10-year repayment plan, in which payments are initially smaller and then increase after two years.

Because the traditional repayment options are somewhat rigid, many physicians today opt for income-driven repayment (IDR) plans. In those plans, available with 12- or 25-year terms, payments are set based on the physician’s income by using formulas that take into account discretionary income, adjusted gross income, and family size. Physicians must reapply annually to remain in the plans, which include the income-contingent repayment (ICR) plan and the newer income-based repayment (IBR) plan, introduced in 2014. For IBR, which has a 25-year repayment term, payments are capped at 15 percent of discretionary income.

The most popular income-based repayment plans introduced over the last decade include the Pay As You Earn (PAYE) and the new Revised Pay As You Earn (REPAYE) plans. Both are applicable only to federal Direct Loans, and REPAYE, the newest addition, is structured to accommodate long residencies.

Here is how the two plans compare:

- **PAYE.** The PAYE plan has a 20-year repayment term, and payments are based on 10 percent of discretionary income. Payments are capped at the 10-year Standard rate and cannot exceed 10 percent of the principal loan amount. Any debt remaining after 20 years is forgiven, but that sum is taxable.

- **REPAYE.** In the REPAYE plan, introduced in 2015, payments are also based on 10 percent of discretionary income. However, the repayment period is 25 years and there is no payment cap. Any debt remaining at 25 years is forgiven and, as with the PAYE plan, the remainder is taxable.

In all income-based plans, spousal income is taken into account if the couple files jointly. Spousal income is not factored into loan payment amounts if the couple files separate tax returns.

Paul Garrard, MBA, founder and president of PG Presents, LLC, which counsels medical professionals on education-loan management, notes that today, most graduating physicians are essentially channeled into income-based repayment plans. “Residents are pretty much pushed into one of these plans today,” said Mr. Garrard, who frequently makes presentations to medical students and residents.

Although IBR is inherently flexible and makes it easier to manage loan debt because payments are based on their income in any given year, residents with high debt loads should keep in mind that their lower payments might not cover the interest due. As such, unpaid interest will increase. “For residents who owe $200,000 and are using an income-based repayment plan, those lower payments, by the time they finish training, will not have covered the interest on that debt,” Mr. Garrard said.

Despite that downside, residents are increasingly choosing income-based repayment plans rather than traditional plans, according to Ms. Fresne. “Our data shows that physicians are showing more interest in income-driven plans today,” she said.

**Demystifying Public Service Loan Forgiveness**

Although the Public Service Loan Forgiveness (PSLF) program has been in place for many years, misconceptions about how it works and, more importantly, who is eligible for it, persist. The program is designed to help physicians and health professionals, and other qualified borrowers, have a portion pay of their education debt forgiven by working for qualified non-profit entities or government agencies. The other key benefit is that any loan amount forgiven is not taxable — a key difference between PSLF and many loan-repayment plans.

For physicians who have federal Direct Loans and who work (train and/or practice) in qualifying employer organizations, any education debt remaining after they have made 120 (10 years’ worth) of qualifying payments is forgiven. To be eligible for PSLF, physician borrowers must be enrolled in an income-driven repayment plan.

The requirements and eligibility criteria for PSLF are somewhat complex, but the option is worth exploring, and many physicians who think they might be ineligible may indeed qualify, Ms. Fresne points out. “It really affords any [qualifying] physician borrower to repay any level of debt, regardless of the specialty they’re in. And it can help borrowers make their payments more manageable from the tracking standpoint,” she said. That’s because once borrowers qualify for enrollment in the program, the government tracks their employment history and their payments.

Despite these benefits, some physicians fail to investigate their PSLF eligibility precisely because of the myths that have persisted. The key one is that physicians’ income will be too high to qualify. That’s not the case,
at least during training. According to the Medscape 2019 Residents Salary and Debt Report, the mean salary for residents in 2019 was $61,200. As such, many physicians who have long residencies will likely qualify for PSLF throughout training at least, and possibly longer. That’s because PSLF eligibility is predicated on income relative to the balance of education loans, not just on income alone. “Some physicians have the impression that it’s very difficult to qualify for PSLF, but that’s not the case,” Mr. Garrard said.

Two other misconceptions about PSLF:

1. **My employer or institution won’t qualify for PSLF.** That might be the case, but the odds are somewhat against it, particularly for physicians in training who do their residencies at hospitals or health systems. Of the approximately 5,000 U.S. hospitals, more than 2,800 are nonprofit community hospitals and nearly 1,000 are state or local government community hospitals. In addition, there are also 209 federal government hospitals. All three types of institutions meet the PSLF qualifications, which means that approximately three-quarters of those facilities would be eligible employers.

2. **The program will be discontinued.** That’s possible, based on statements coming out of the current administration, but no decisions have been made and for now it’s still operating. Further, any status change is unlikely to affect borrowers who are already enrolled in the PSLF program.

There’s yet another myth that continues to circulate, according to Mr. Garrard: Many physicians think that by enrolling in PSLF, they must continue working in public service for a long time. “If borrowers enroll in PSLF, they’re not committing to anything. Basically, they’re just having the government track their payments,” he said. “And if they’re training or working in a qualifying 501(c)(3) hospital, the qualified loan payments they make go toward PLSF.” The benefit of the arrangement is that, regardless of where enrollees work, the government will track whether the loan payments being made qualify toward PSLF, saving physicians considerable paperwork and possible guesswork.

To apply for the program, borrowers must complete the PSLF Employment Certification Form to start the process. The form must be completed annually or whenever borrowers change employers.

“The point is that by enrolling in PSLF, physicians preserve the option to use public service to require their debt tax free,” Mr. Garrard said. “There’s really no downside to enrolling.” He cited the example of a pediatrics resident in a teaching hospital who decides to subspecialize, thereby spending an additional three years in training and accruing six years toward possible loan forgiveness. If that physician were to work at a qualifying entity after training, she or he might be able to obtain loan forgiveness after four more years.

It’s important to keep in mind, Ms. Fresne and Mr. Garrard advised, that to have loan debt ultimately forgiven under the PSLF program, borrowers must have met all requirements during the period when they made their 120 payments. For example, to have payments qualify toward loan forgiveness, borrowers must work full time (at least 30 hours a week), make the full scheduled payment on time, and remain in a qualified repayment plan (PAYE, REPAYE, IBR, and ICR) during the period before they request forgiveness. However, neither the qualifying payments nor the employer need to be consecutive, so a physician who worked in the private sector and returned to a qualifying public-sector employer might still be eligible for loan forgiveness.

Numerous individual agencies and entities also offer special loan-forgiveness service options for physicians, including the National Institutes of Health (NIH), the National Health Service Corps (NHSC), the Indian Health Service (IHS), and all branches of the U.S. military.

Consolidation and refinancing: understand the risks

Physicians who hold numerous loans, including some private loans, might want to consider consolidating or refinancing their debt — if they’re in a solid financial position and it makes economic sense to do so. However, it’s worth noting that consolidation is unnecessary for borrowers who hold only federal loans; government-contracted loan servicers manage the individual loans as a package and borrowers make a single payment. That payment is apportioned among the loans.

Refinancing is a different matter. Physicians who hold private loans with high interest rates or whose solid financial circumstances permit them to exit an income-based repayment program, and the relative safety that confers, might be good candidates for refinancing. And that option may be especially appealing in a low-interest-rate environment, for physicians who are working in the private sector. The primary caveat is that in leaving the federal loan program, physician borrowers may lose the ability to overpay on their loans and thereby reduce total interest costs over the life of those
loans. Such loans also don’t qualify for loan federal loan forgiveness through PSLF.

Mr. Garrard reminds physicians considering refinancing to keep in mind that refinancing eligibility requirements vary, sometimes significantly, from lender to lender. However, all lenders will look at key factors that indicate the borrower’s ability to repay.

“Physicians who are doing well financially and decide they don’t like the 6.5% interest rate on their loans might start exploring refinancing options,” he said. “But they must have good credit, a solid employment history, and a favorable debt-to-income ratio.” The latter simply means the amount of debt compared to their current income. It’s also worth noting that refinancing is usually available only to U.S. citizens or permanent residents. International medical graduates might, however, be able to secure new financing if they have a creditworthy cosigner who is a U.S. citizen or permanent resident.

Mr. Garrard suggested that physicians evaluating refinancing options — for all or part of their loan portfolio debt — should ask the following questions:

• What fixed and variable interest rates would I qualify for? Some lenders might offer a hybrid.

• With variable rates, what are the maximum and minimum rates that can be charged? Variable rates are usually based on an index, such as the Prime Rate or the London Inter-bank Offered Rate (LIBOR) that changes over time.

• How often can the interest rate change, and how much notice would I receive before that happens? Mr. Garrard said that this can occur as frequently as monthly or quarterly, so it’s key information for borrowers for budgeting purposes, especially if they’re paying via automatic debit.

Finally, borrowers should be fully aware of how long they have to repay the loan. The range might be five years to 15 years or longer.

Regardless of whether physicians keep their federal loans or seek refinancing, the main thing to remember is that because physicians can expect to earn good income, they’ll find a workable way to repay their loans. “Physician borrowers have options — even if their debt load is high. That’s the important thing,” Mr. Garrard said.

Resources
Association of American Medical Colleges. The AAMC offers numerous resources about education loans on its website, www.aamc.org. In addition, the AAMC FIRST program provides a wide range of overall guidance on personal finance matters such as budgeting and goal setting. It’s accessible at https://aamcfiscalwellness.com/index.cfm.

PG Presents. The company focuses primarily on counseling physicians and medical students, and its website includes numerous up-to-date resources on loan-debt management. The website is www.pgprents.com.

Public Service Loan Forgiveness (PSLF). For a basic overview of how this option works and the types of loans and employer organizations that qualify, go to the federal Student Aid web page at https://studentaid.gov/app/pslFlow.action#!/pslf/launch.
Transient Ischemic Attack

Pierre Amarenco, M.D.

This Journal feature begins with a case vignette highlighting a common clinical problem. Evidence supporting various strategies is then presented, followed by a review of formal guidelines, when they exist. The article ends with the author’s clinical recommendations.

A 54-year-old man presents 2 hours after sudden weakness in his left arm prevented him from turning the steering wheel while driving. His symptoms lasted for 30 minutes. He has hypertension and hyperlipidemia, for which he takes an angiotensin-receptor blocker and a statin, and he is a smoker with a 30-pack-year history. On examination, the blood pressure is 156/96 mm Hg. How should this patient be further evaluated and treated?

The Clinical Problem

Approximately 20 to 25% of ischemic strokes are heralded by transient ischemic symptoms1 (Table 1). These symptoms usually last for seconds or minutes and typically last less than 1 hour.2 An older, time-based definition of transient ischemic attack (TIA) (based on symptoms lasting <24 hours) has been revised owing to the identification of an infarct on brain imaging in many patients with symptoms that last more than 10 minutes and given that many patients who arrive at the hospital within 6 hours after the onset of symptoms are considered for urgent revascularization. The new definition of TIA is now “tissue-based.” An ischemic lesion is not visible on brain imaging in a patient with TIA,3 and a patient with transient symptoms who has even a tiny ischemic brain lesion on imaging is considered to have had a minor ischemic stroke.4 Since TIA and minor ischemic stroke generally have the same clinical manifestations (except for neuroimaging findings) and management, they are clinically considered together.4,4

Symptoms of a TIA, if recognized as such, provide a critical opportunity to quick treat and find the cause in order to prevent a devastating stroke.5 Without treatment, the risk of stroke is as high as 20% at 3 months, and most of this risk occurs within the first 10 days, particularly within the first 2 days.6,40 Observational data indicate that prompt clinical diagnosis and immediate preventive measures are associated with a decrease of up to 80% in the 3-month risk of stroke.5,40,7 The multinational TIAregistry.org project5,13 collected data from TIA clinics in Europe, Asia, and Latin America, where patients with suspected TIA or minor stroke were rapidly triaged, evaluated, and treated. This project reported a 3-month risk of stroke of approximately 5%, but the risk was front-loaded during the early days after the TIA. Urgent evaluation of these patients5,13 is best performed in a TIA clinic5 with round-the-clock access or in an emergency department, depending on local practices.

Clinical Practice

Caren G. Solomon, M.D., M.P.H., Editor

Transient Ischemic Attack

Caren G. Solomon, M.D., M.P.H., F.A.C.C.

Key Clinical Points

Strategies and Evidence

Clinical Presentation and Differential Diagnosis

Transient symptoms can be motor (in the frontal lobe or pyramidal tract), sensory (in the parietal area), or visual (monocular [transient monocular blindness] with retinal ischemia or binocular [e.g., hemianopia due to intracerebral visual tract or parietal, temporal, or occipital involve- ment]), or they can involve speech disturbance (aphasia or dysarthria). Other types of transient symptoms (e.g., vertigo, diplopia, dizziness, unsteady gait, or amnesia) can also occur with transient ischemic brain injury, although uncommonly. The occurrence of these symptoms or signs in isolation is explained by ischemia (Table 1).4,4

Several other conditions (termed “TIA mimics”) may alternatively explain transient neurologic symptoms. Most common among these are migraine aura, peripheral vertigo, epilepsy (e.g., parietal-lobe epilepsy), hypoglycemia, transient global amnesia, and postural hypotension. Transient neurologic symptoms may also occur in patients who have myasthenia, cerebral arthros- is, peripheral-nerve injury, multiple sclerosis, or hypocalcemia, and, rarely, in those who have cerebral amyloid angiopathy, subdural hematoma, or subarachnoid or brain hemorrhage.

Neuroimaging

Immediate diffusion-weighted imaging assessed with magnetic resonance imaging (MRI) is the current preferred test for patients with a suspected TIA,4,8 since its sensitivity in detecting brain ischemia is much higher than that with computed tomography (CT). In up to 50% of patients with suspected TIA, a bright spot on diffusion-weighted imaging14 indicates ischemia (Fig. 1); this finding is particularly useful when the transient symptoms are of borderline significance or when the symptoms are atypical (Table 1).4,4,15 Although CT of the head generally cannot be used to diagnose ischemia, when diffusion-weighted imaging is not available, CT should be performed to rule out another cause of the symptoms.14

If diffusion-weighted imaging is negative and there is a strong clinical suspicion of TIA, perfusion-weighted imaging may be performed during the same MR exam; in 30% of cases, a focal perfusion deficit is identified in the brain area corresponding to the symptoms.16,17 Several other sequences (e.g., susceptibility-weighted imaging, diffusion-weighted imaging, perfusion-weighted imaging, or susceptibility-weighted imaging) may add to the yield of perfusion-weighted imaging for the detection of acute ischemic lesions.18

Other Evaluations

The causes of TIA or minor ischemic stroke are similar to those of all ischemic strokes. If the knowledge of intracranial steno-occlusive disease would alter management, the extracranial and intracranial arteries should be routinely assessed with the use of noninvasive imaging (carotid-artery ultrasonography, CT angiography, or magnetic resonance angiography) of the cervical vessels and of the intracranial vasculature to diagnose a proximal intracranial stenosis, occlusion, or both.4,8 Additional evaluations should include electrocardiography (ECG), inpatient
Table 1. Common Symptoms Suggestive of TIA.*

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Definite TIA</th>
<th>Possible TIA</th>
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<tbody>
<tr>
<td>Focal cerebral or retinal symptoms lasting for seconds or minutes</td>
<td>Focal</td>
<td>Nonfocal</td>
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<tr>
<td>and typically lasting &lt;1 hr</td>
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<tr>
<td>Motor weakness in two limbs or in one limb and the face</td>
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<tr>
<td>Sensory deficit in two limbs or in one limb and the face</td>
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<tr>
<td>Visual-field deficit (homonymous hemianopia) or monocular blindness</td>
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<tr>
<td>Aphasia or dysarthria</td>
<td></td>
<td></td>
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<tr>
<td>Possible TIA†</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unsteady gait</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diplopia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vertigo, dizziness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dysphagia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Usually not a TIA</td>
<td>Ambulosis</td>
<td>Possible TIA</td>
</tr>
<tr>
<td>Confusion</td>
<td></td>
<td></td>
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<tr>
<td>Incoordination of limbs</td>
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<tr>
<td>Partial sensory deficit (abnormal sensation or deficit in one limb or in the face)</td>
<td></td>
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<tr>
<td>Unusual cortical visual symptoms (lone bilateral blindness and bilateral positive visual phenomena)§</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transient loss of consciousness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Headache</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phosphens, photopias, complex visual hallucinations, and palinopsia</td>
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</tr>
</tbody>
</table>

* TIA denotes transient ischemic attack.
† When combined, at least two of these symptoms suggest definite TIA, when isolated, they suggest possible TIA.
‡ “Bizarre spells” or isolated atypical symptoms are nonfocal or not clearly focal transient neurologic events for which the type of onset, topography, and course of symptoms do not fulfill the criteria for definite or possible TIA or another definite or possible neurologic syndrome (e.g., epilepsy or migraine).
§ Sudden positive visual phenomena affecting one or both eyes in one hemifield are often described as flashes of light, stars, colored spots, or swirls of light. Transient positive visual phenomena involving both eyes include a variety of symptoms such as distortion, tilt of images, trails of images, and formed or unformed visual hallucinations.

Figure 1. Neuroimaging Evaluation.

An axial section of a diffusion-weighted image of the brain shows multiple bright spots in the cortical territory of the right middle cerebral artery. Panel A shows two small brain infarctions (arrows), Panel B shows one small infarct (arrow), and Panel C shows one small infarct (arrow).

The ABCD² score was previously recommended for use in triage. For example, previous National Institute for Health and Care Excellence (NICE) guidelines called for immediate hospitalization of patients with an ABCD² score of 4 or higher but allowed up to 8 days for evaluation in patients with scores lower than 4, provided that aspirin was immediately initiated. However, subsequent data have called this strategy into question. In some studies involving large cohorts of patients presenting with TIA, serious findings on diffusion-weighted imaging (e.g., clinically significant extracranial-artery stenosis, intracranial-artery stenosis, or atrial fibrillation) were detected in 20% of those with an ABCD² score lower than 4, and the 3-month risk of stroke among these patients was similar to that among
TREATMENT

ANTIPLATELET THERAPY

In patients with noncardioembolic ischemic stroke, aspirin is the most effective treatment to reduce the risk of recurrent stroke during the first 90 days, and it is the only antipatelet treatment that has been shown to reduce the risk of recurrent disabling ischemic stroke (i.e., ischemic stroke in patients with a score on the modified Rankin scale of 2 or more (scores range from 0 [no symptoms] to 6 [death]) during that period). However, beyond 3 months, the efficacy of aspirin has been less clear. On the basis of clinical trials that have patients effective, a loading dose of aspirin (300 mg orally) should be administered as soon as possible after symptoms, a loading dose of aspirin (300 mg orally) plus a maintenance dose of 75 to 100 mg per day for 90 days. However, beyond 3 months, the efficacy of aspirin has been less clear.

In patients with TIA, long-term treatment involves blood pressure–lowering and lipid-lowering therapy and control of diabetes. Smoking cessation and lifestyle changes are also recommended. It is reasonable to target blood pressure to less than 140/90 mm Hg; a target below 130/80 mm Hg is appropriate for patients with lacunar stroke or diabetes and is appropriate more generally if the patient can achieve these levels without adverse effects. Randomized trials involving patients with recent ischemic stroke or TIA have shown significant decreases in the risk of stroke and overall cardiovascular events with high-dose statins or those specifically targeting a low-density lipoprotein (LDL) cholesterol level of less than 70 mg per deciliter (1.8 mmol per liter). Thus, intensive statin therapy is recommended when an atherosclerotic origin of the TIA is presumed, regardless of the baseline LDL cholesterol level.

Stenting should be screened and treated for diabetes mellitus and should receive counseling regarding lifestyle (e.g., diet, weight loss, smoking cessation, and the importance of three to four exercise sessions per week). Screening for sleep apnea is also recommended.

Carotid endarterectomy or stenting should be considered in patients in whom the underlying cause of TIA is ipsilateral internal-carotid-artery stenosis of 50% or more. Stenting of intracranial stenosis is not usually recommended.

TIA EVALUATION

TIA can be a challenging diagnosis even for experienced vascular neurologists, and careful and rapid evaluation is needed even for atypical symptoms, given the potentially catastrophic risks of a missed diagnosis. On the basis of observational data showing associated decreases in hemorrhage in the two trials, respectively. Post hoc analyses of these trials showed that the benefit of the combination treatment was seen during the first 21 days, without a significant increase in major hemorrhage complications.

Previous trials have shown that anticoagulant treatment was not superior to aspirin in patients with noncardioembolic TIA or stroke. If atrial fibrillation is detected after the TIA, oral anti-coagulant treatment should be initiated without delay.
the 3-month risk of stroke and length of stay and cost, as well as improved patient satisfaction.10,11,24 TIA clinics with round-the-clock eva-
uluation have been promoted and developed as an ed in addition to many comprehensive stroke centers (particularly in Europe, Australia, and Cana-
24,12,13) Alternatively, urgent evaluation can be performed in emergency departments where stroke expertise and imaging are readily available.

AREAS OF UNCERTAINTY

Without findings on neuroimaging, the diagno-
sis of TIA is often uncertain, particularly in pa-
tients with isolated, “bizarre,” or nonfocal symp-
toms (Table 1). “Bizarre spells” or isolated atypical symptoms are nonfocal or not clearly focal transient neurologic events for which the type of onset, topography, and course of symptoms do not fulfill the criteria for definite or possible TIA or another definite or possible neurologic syn-
drome such as epilepsy or migraines. Research is needed to identify blood biomarkers or new neuroimaging techniques that might improve the diagnosis.

Minor ischemic stroke are both char-
acted by the absence of disability (score on the modified Rankin scale, 0 or 1). Many ische-
ic events that were previously considered to be TIsAs (according to the time-bound definition), are now considered to be “minor strokes” on the basis of the presence of a bright spot or spots on diffusion-weighted imaging (Fig. 1). This defini-
tion is consistent with the results of clinical trials in which stroke outcomes in-
clude these events along with major strokes that cause disability. Increased analysis of individual patient data39 from trials of antplatelet therapy for secondary prevention of TIA and minor ischemic stroke showed a considerable early benefit (in the first 2 weeks) of aspirin (99% relative reduction in the risk of early recurrent stroke). This finding sup-
ports a benefit of a loading dose (300 mg) of oral aspirin as soon as possible after the first TIA symptoms occur. If possible, patients should take antplatelet therapy as soon as possible after the first TIA symptoms (Fig. 2), but this strategy has not been formally evaluated.

Randomized trials are needed to determine the best antihypertensive strategy for patients with TIA (or minor ischemic stroke). Dual antiplatelet therapy of aspirin and clopidogrel for 21 days is considered by many experts to be the standard of care,46 yet clopidogrel is less effec-
tive or not effective in patients who are carriers of certain CYP2C19 low-activity alleles (in 20 to 40% of the population, depending on eth-
nic group),32,49,50 and screening for clopidogrel resis-
tance has not been validated for clinical use. Ongoing randomized trials investigating treat-
ment of patients with previous TIA or stroke are assessing the benefits and risks of ticagrelor, an alternative, direct-acting antplatelet agent that does not need to be activated, in combination with as-
pirin, as compared with aspirin alone (Clinical-
Trials.gov number, NCT03354429), triple anti-
thrombotic strategies (a dual antplatelet agent plus a short-term oral anticoagulant) (NCT07266981), and an intravenous tissue plasminogen activator in patients with intracranial large-vessel occlu-
sion (NCT02989656). Randomized trials have shown a benefit of antiinflammatory agents in decreasing the incidence of recurrent events among patients with previous myocardial infarc-
tion47; clofichine is currently under study in pa-
tients who have had a TIA or stroke (NCT02898610).

There is uncertainty as to whether a 90-
day, lifelong treatment with aspirin is useful in low-risk patients with TIA (i.e., those in whom brain-tissue damage has not been detected on diffusion-weighted imaging, with no documen-
ted stenosis in the ipsilateral cerebral artery, no major cardiac source of embolism, no small-
vessel disease, and an ABCD score of <4). Simi-
larly, investigation is needed of the benefit of aspirin beyond 90 days relative to bleeding risk among patients with isolated diplopia, amnesia, visual defect, vertigo, dizziness or gait instability, dysphasia, or isolated aphasia in the leg, arm, or both lasting less than 10 minutes.

Aggressive lowering of LDL cholesterol levels (e.g., to <5 mg per deciliter [1.4 mmol per liter]) has shown to reduce cardiovascular events after the acute coronary syndrome and ischemic stroke.45,46 Studies to determine the role of this strategy in patients with TIA are warranted.

The length of hospitalization for low-risk pa-
tients (e.g., those with an ABCD score of 0) is uncertain. Whether these patients should be ad-
mitted for evaluation and treatment for less than 1 day, as reported by the SOS-TIA researchers,8 or whether longer hospitalization for in-hospital cardiac monitoring is required is unclear.

GUIDELINES

The American Heart Association and the Ameri-
Can Stroke Association (AHA–ASA),51,52 and the European Stroke Organization53 have pub-
lished guidelines for the evaluation and treat-
ment of patients with TIA or minor ischemic stroke. All the guidelines recommend that pa-
tients should be evaluated and receive treatment with previous TIA or stroke are assessing the benefits and risks of ticagrelor, an alternative, direct-acting antplatelet agent that does not need to be activated, in combination with as-
pirin, as compared with aspirin alone (Clinical-
Trials.gov number, NCT03354429), triple anti-
thrombotic strategies (a dual antplatelet agent plus a short-term oral anticoagulant) (NCT07266981), and an intravenous tissue plasminogen activator in patients with intracranial large-vessel occlu-
sion (NCT02989656). Randomized trials have shown a benefit of antiinflammatory agents in decreasing the incidence of recurrent events among patients with previous myocardial infarc-
tion47; clofichine is currently under study in pa-
tients who have had a TIA or stroke (NCT02898610).

The patient described in the vignette presented with symptoms consistent with a motor TIA. Had I spoken with him by telephone before he presented, I would have recommended that he take 300 mg of aspirin if possible. In this case, when he arrived at the TIA clinic without having received self-administered aspirin, I would have adminis-
tered the aspirin as well as 300 mg of clopido-
grel. In a prompt assessment of diffusion-
weighted imaging on brain MRI, the finding of a bright spot in the right hemisphere would confirm ischemia. I would then prescribe clopi-
dogrel at a dose of 75 mg per day, followed by long-term as-
pirin monotherapy (75 mg). If ipsilateral carotid stenosis were detected on imaging of the extracranial and intracranial vasculature, I would recommend prompt carotid endarterectomy. I would also perform a cardiac evaluation includ-
ing 3-week ECG monitoring to detect paroxys-
amal atrial fibrillation that would warrant long-
term oral anticoagulation instead of antplatelet therapy, particularly in the absence of severe carotid stenosis or another potential direct cause of TIA. I would review with the patient his in-
creased risk of stroke and provide guidance re-
garding control of risk factors, including smoking cessation and lifestyle changes.

Dr. Amarenco reports receiving grant support from Pfizer, Merck, and Boston Scientific, grant and support fees for serving on executive committees from Antithrom, fees for serving on an executive committee and fees for serving on a steering committee from Bristol-Myers Squibb, fees for serving on an executive committee from GlaxoSmithKline, fees for serving on a safety monitoring board from Fosgenex, fees for serving on an end-point commit-
tee from Glimakra-Valneva, and fees for serving on a safety monitoring board from Shinpoong Pharma, advisory board fees and lecture fees from Janssen, fees for serving on an executive committee from Kowa, grant support and advisory board fees from Sanofi, and grant support and fees for serving on a steering committee from Bristol-Myers Squibb. No other potential conflict of interest relevant to this article was reported.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

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