EMERGENCY MEDICINE LITIGATION

The Stroke That Looked Like Vertigo

Missed Stroke Cases Under the 2026 Treatment Guideline

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In late January 2026, the American Heart Association and American Stroke Association published a new guideline for the early management of acute ischemic stroke. If you handle diagnostic error cases, it's worth your time, because it changes the causation argument in a lot of missed-stroke claims.

The headlines: tenecteplase now sits alongside alteplase as an accepted clot-busting drug (0.25 mg/kg or 0.9 mg/kg respectively, within 4.5 hours). Thrombectomy, where a specialist pulls the clot out through a catheter, now has a strong recommendation from 6 to 24 hours for certain patients under 80 with a large anterior-circulation blockage even when imaging shows a fairly large area of damage (ASPECTS 3 to 5, without significant mass effect). There's a strong recommendation for thrombectomy within 24 hours for basilar artery blockages when symptoms are significant (NIHSS 10 or higher) and early damage is limited. Mobile stroke units got guideline support, and EMS protocols now contemplate taking some patients straight to thrombectomy-capable hospitals.

For years, defense experts in missed-stroke cases could often say, credibly, that the patient wouldn't have qualified for treatment anyway. For some patients that's still true. For others, the 2026 guideline makes it a much harder argument.

WHICH STROKES GET MISSED

The face-arm-speech stroke usually gets caught. The ones that get missed look like something else. Posterior circulation strokes, in the back of the brain, are the classic example: dizziness, vertigo, vomiting, trouble walking, double vision. Those symptoms overlap with inner ear disorders, migraine, and dehydration, which are all far more common. Research on emergency diagnostic error consistently finds that dizziness as the main complaint, younger age, and female sex are associated with a higher risk that a stroke gets missed.

Two clinical facts come up again and again in these cases. First, a plain head CT is poor at showing an early ischemic stroke, especially in the back of the brain. A normal CT doesn't rule out stroke. Second, a three-part bedside exam called HINTS (head impulse, nystagmus, test of skew), done by someone trained in it on a patient with continuous dizziness, can be more sensitive than an early CT for picking up a posterior stroke. It's often skipped, done incorrectly, or used on the wrong patients.

A FICTIONAL CASE

A 48-year-old man with high blood pressure comes to an emergency department at 7 p.m. He says the room has been spinning since about 4 o'clock. He's vomited twice and can barely stand. The note records nystagmus and says he's "unsteady." His head CT is normal. He gets anti-nausea and vertigo medication, feels a bit better, and goes home with "benign vertigo." The next morning his wife finds him confused and unable to move his left side. MRI shows a large stroke from a blocked basilar artery.

READING THE FIRST VISIT

Start with the history. Continuous dizziness that came on suddenly and hasn't let up is a different problem from brief spells brought on by turning the head. If the physician's note doesn't make that clear, the triage note, the nursing notes, and what the patient and his wife say may.

Then the exam. "Unsteady" is a loaded word. Plenty of people with inner ear vertigo can still walk, miserable as they are. A patient who can't stand or walk without help is a warning sign for a central cause. Was his gait actually tested? Was a HINTS exam done, and is there enough detail to tell whether it was done right? What kind of nystagmus was it? Certain patterns point to the brain, not the ear.

Look at the risk factors: hypertension, diabetes, smoking, recent neck trauma, atrial fibrillation. And look at what the physician did with the normal CT. If the note reads as though the CT ruled out stroke, that deserves attention, because it couldn't have. Was MRI or CT angiography considered? Whether MRI was actually available at that hospital at night is a practical question, and the answer affects what was reasonable.

Then look at how he left. "Return if symptoms worsen" is standard and not much use to a wife who doesn't know that new weakness, slurred speech, or confusion means call 911 right now. Was anyone told he shouldn't be alone overnight? Could he walk out on his own? Those details say a lot about how confident the team really was.

LAST KNOWN WELL

Stroke cases are clock cases, and the most important time in the chart is often "last known well," the last moment the patient was known to be normal. Treatment windows run from there.

Here, last known well might be 4 p.m., if the stroke started with the spinning. Or it might be much later, if the evening symptoms were a warning event and the major stroke happened overnight. That single fact can change the whole case. The wife's account of when he went to bed, how he seemed, and when she found him is critical, and it should be pinned down early.

Then build forward: arrival, first evaluation, CT ordered, CT read, discharge. And for the second visit: arrival, stroke recognized, imaging, stroke specialist contacted, transfer, treatment.

WOULD TREATMENT HAVE CHANGED THE OUTCOME?

Suppose the stroke had been recognized at 7 p.m. If he was within 4.5 hours of last known well and had a disabling deficit, he may have been a candidate for thrombolysis. If CT angiography had shown a basilar blockage, the 2026 guideline supports thrombectomy within 24 hours for patients who meet its severity and imaging criteria. Basilar strokes can be catastrophic, and for the right patient thrombectomy can change the outcome dramatically.

Every link needs support, though. Was the artery already blocked at the first visit, or did that happen later? Would his imaging and symptom severity have met the criteria? Could he have reached a thrombectomy-capable center in time? What does the evidence say about outcomes for someone like him with treatment versus without it? These are questions for a vascular neurologist or neurointerventionalist. Whether your state allows recovery for a lost chance of a better outcome is for counsel. The clinical reviewer's job is to lay out the treatment path that was probably available, step by step, and show which steps are solid and which rest on assumptions.

THE SYSTEM AROUND THE PHYSICIAN

Many emergency departments don't have a neurologist in the building overnight and rely on telestroke. Was it available? Was it used? Did the stroke protocol cover dizziness, or only classic face-arm-speech symptoms? Some screening tools largely miss posterior strokes. Certified stroke centers carry additional requirements for protocols, training, and data tracking, and those documents may be relevant. If the hospital couldn't do thrombectomy, what did its transfer agreements provide, and how long would a transfer realistically have taken?

RECORDS WORTH REQUESTING

- Complete ED records from every visit, including triage and nursing notes
- The imaging itself, not only the reports
- The hospital's stroke protocol and any stroke alert or code stroke records
- Telestroke consult records and call logs
- Transfer agreements and transfer records
- EMS run sheets
- A detailed, early statement from family about the timeline and last known well

SOURCES

- American Heart Association/American Stroke Association, *2026 Guideline for the Early Management of Patients With Acute Ischemic Stroke*, published online in *Stroke*, Jan. 29, 2026; AHA "Top Things to Know" summary
- TCTMD, "AHA/ASA Release New Comprehensive Acute Ischemic Stroke Guideline" (Jan. 2026)

This newsletter is for education only and isn't medical or legal advice. The case is fictional.

ABOUT LEXCURA CLINICAL INTELLIGENCE

Lexcura Clinical Intelligence provides integrated clinical and regulatory analysis for attorneys handling healthcare litigation. If you have a missed-stroke case and want the timeline anchored to last known well and the treatment pathway tested against the 2026 guideline, we'd welcome the conversation.

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