

Common 'Other' mimics	48.2%
Bell's palsy	5.7%
Syncope	5.3%
Delirium	4.1%
Fall	3.8%
Decompensation of old stroke	3.7%
Headache	2.1%
Peripheral nerve / neuropathy/neuropraxia	1.8%

Method of assessment by stroke clinician



The majority of patients assessed by a stroke clinician were reviewed in person. The median time for evaluating a patient varied depending on the evaluation method: 45 minutes for assessment in person; and 15 minutes for telephone assessments. Although a minority of patients were assessed by telemedicine, the median review time was 60 minutes, highlighting the complexity of making such assessments remotely. There are a wide range of medical and neurological conditions presenting as stroke mimics with neurological mimics making up the biggest group. 19.1% of stroke calls resulted in a diagnosis of TIA. Migraine, functional disorders ('nonorganic'), vestibular syndromes and seizure activity are the next commonest stroke mimics. An important number of mimics included decompensation of a previous stroke which may occur in the setting of infection or metabolic insult. In many of these circumstances of diagnostic uncertainty, urgent access to MRI is important (see the National Optimal Stroke Imaging Pathway here).

Thrombolysis

The benefits of intravenous thrombolysis are time dependant and as such, attempts to reduce the door to needle time and increase the proportion of patients receiving reperfusion therapies may lead to **stroke mimics receiving such treatment inadvertently**. The proportion of stroke mimics receiving thrombolysis ranged between sites from **0 to 10.7%**. Stroke mimics were younger (58 years) compared with stroke patients (74 years).