

Supplemental Table 2. Results of Delphi consensus

Recommendations	Delphi round achieving consensus	Agreement (score 7-9), (%)	Uncertainty (score 4-6), (%)	Disagreement (score 1-3), (%)
Endovascular Recanalization Therapy				
1. In patients with major ischemic stroke due to an acute large artery occlusion in the anterior circulation (internal carotid artery, M1, and possibly large M2 branch) within 6 hours, endovascular recanalization therapy (ERT) is recommended to improve clinical outcomes (LOE Ia, GOR A).	First round	91.2	5.9	2.9
2. In patients eligible for intravenous tissue plasminogen activator (IV-TPA), administration of IV-TPA is recommended before the initiation of ERT (LOE Ia, GOR A). Since IV-TPA should not significantly delay ERT, it is recommended to simultaneously proceed ERT during IV-TPA treatment without waiting for clinical response to IV-TPA.	First round	94.1	2.9	2.9
3. In patients who are contraindicated for IV-TPA, ERT is recommended as a first-line therapy in patients with major ischemic stroke due to an acute large artery occlusion in the anterior circulation within 6 hours (LOE IIa, GOR B).	First round	97.1	2.9	0
4. In patients with major ischemic stroke due to acute large artery occlusion in the posterior circulation (basilar artery, P1, and vertebral artery) within 6 hours, ERT can be considered (LOE III, GOR B).	First round	91.2	8.8	0
5. For patients with acute large artery occlusion in the anterior or posterior circulation presenting after 6 hours, ERT can be considered for patients having favorable multimodal imaging profiles regarding expected benefit and safety. Each center is encouraged to define own selection criteria (LOE IV, GOR C).	First round	88.2	8.8	2.9
6. If indicated, ERT should be initiated as fast as possible (LOE IIa, GOR B).	First round	91.2	5.9	2.9
7. Stent-retriever thrombectomy is recommended as a first-line ERT (LOE Ia, GOR A).	First round	76.5	20.6	2.9
8. If recanalization is not achieved with stent-retriever thrombectomy, the addition of other ERT modalities can be considered after taking into account the expected efficacy and safety (LOE IV, GOR C).	First round	91.2	8.8	0
9. Other mechanical thrombectomy or thrombus aspiration devices may be considered as a first-line modality at the discretion of responsible interventionists after taking into account technical aspects (LOE IV, GOR C).	First round	85.3	11.8	2.9
10. During ERT, conscious sedation is generally preferred to general anesthesia. However, the decision should be made after consideration of patient's condition and center's experience (LOE III, GOR B).	First round	91.2	8.8	0
Neuroimaging evaluation				
1. Noncontrast CT or MRI should be conducted to exclude hemorrhagic stroke or other non-stroke etiologies (GPP).	First round	91.2	5.9	2.9
2. Non-invasive vascular imaging (CT angiography or MR angiography) is recommended to confirm acute large artery occlusion for patients with major ischemic stroke (GPP).	First round	91.2	5.9	2.9
3. For patients who are not able to perform non-invasive vascular imaging, stroke severity or clot sign on noncontrast CT can guide decision for ERT (GPP).	First round	91.2	5.9	2.9
4. For selecting patients, neuroimaging evaluation for extensive early ischemic injury can guide decision for ERT (GPP).	Second round	100	0	0
5. Advanced multimodal imaging to assess collaterals, extent of ischemic core, or perfusion-diffusion mismatch can be considered to identify patients who are likely to benefit from ERT (GPP). However, the multimodal imaging should not significantly delay ERT.	First round	82.4	11.8	5.9
System organization				
1. For centers capable of providing ERT, the organization and implementation of critical pathway and formal protocol is recommended to accelerate the delivery of ERT (GPP).	First round	91.2	8.8	0
2. For centers which are not adequately staffed for ERT, it is encouraged to have a referral plan to a center capable of ERT for patients eligible for ERT. If indicated, initiating IV-TPA before referral is encouraged (GPP).	First round	88.2	11.8	0
3. Each center is encouraged to define own criteria for the multidisciplinary ERT team that is responsible for initial evaluation, decision making, and ERT procedure (GPP).	Second round	96	4	0
4. To assess and improve the quality of ERT, each center is encouraged to monitor key time metrics of door-to-neuroimaging and door-to-groin puncture (GPP).	First round	91.2	8.8	0
5. It is encouraged to assess functional outcome, recanalization rate, and complication rate after ERT (GPP).	First round	91.2	8.8	0