

**Supplementary Table 2.** Recommendations on ERT in patients with acute ischemic stroke (as recommended by the Korean Stroke Society)

Endovascular recanalization therapy	
1.	In patients with major ischemic stroke due to an acute large artery occlusion in anterior circulation (internal carotid artery, M1, and possibly large M2 branch) within 6 hours, ERT is recommended to improve clinical outcomes (LOE Ia, GOR A).
2.	In patients eligible for 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.
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).
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).
5.	In selected patients with acute ischemic stroke due to large vessel occlusion in the anterior circulation presenting within 6 to 24 hours from last seen normal, endovascular recanalization therapy can be recommended when the patients have target mismatch assessed by multimodal imaging and/or clinical deficit AND when reperfusion by ERT is expected to improve the outcome of the patients. For patient selection, each institution is recommended to have its own criteria, which can timely and reasonably identify patients with target mismatch in the late time window (LOE III, GOR C).
6.	In selected patients with acute ischemic stroke due to large vessel occlusion in the posterior circulation presenting after 6 hours, ERT can be considered for patients having favorable multimodal imaging profiles in consideration of risks and benefits. Each center is encouraged to define its own patient selection criteria (LOE IV, GOR C).
7.	If indicated, ERT should be initiated as fast as possible (LOE IIa, GOR B).
8.	Stent-retriever thrombectomy is recommended as a first-line ERT (LOE Ia, GOR A).
9.	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).
10.	Other mechanical thrombectomy or thrombus aspiration devices may be Recommendations considered as a first-line modality at the discretion of responsible interventionists after taking into account technical aspects (LOE IV, GOR C).
11.	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).
Neuroimaging evaluation	
1.	Noncontrast CT or MRI should be conducted to exclude hemorrhagic stroke or other non-stroke etiologies (LOE III, GOR C)
2.	Non-invasive vascular imaging (CT angiography or MR angiography) is recommended to confirm acute large artery occlusion for patients with major ischemic stroke (LOE III, GOR C).
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).
4.	For selecting patients, neuroimaging evaluation for extensive early ischemic injury Can guide decision for ERT (GPP).
5.	In selected patients who present within 6 to 24 hours from last seen normal, multimodal imaging for assessing collaterals, infarct core, or perfusion (or clinical)-diffusion mismatch is recommended to select eligible patients for ERT. Each center is encouraged to define its own imaging modality to timely identify target mismatch (LOE III, GOR C).
System organization	
1.	For centers capable of providing ERT, the organization and implementation of critical pathway and formal protocol are recommended to accelerate the delivery of ERT (GPP).
2.	For centers that 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).
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).
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).
5.	It is encouraged to assess functional outcome, recanalization rate, and complication rate after ERT (GPP).

ERT: endovascular recanalization therapy; LOE: level of evidence; GOR: grade of recommendation; IV-TPA: intravenous tissue plasminogen activator; CT: computed tomography; MRI: magnetic resonance imaging; GPP: good practice point.