The only causative therapy for acute stroke now available is thrombolysis with rtPA, both intravenous and intraarterial. But not all patients with stroke are suitable and not all patients have the same beneficial results. This is because acute stroke patients have the same clinical features although several different patterns of vessel occlusion. The identification of the presence and site of vascular lesion in the acute phase can help to choose the best strategy of treatment for each patient. We visited a 53 years old healthy man, who in the first night of 2007 had abruptly right hemiplegia, aphasia and agitation. We performed at two hours from the onset Color Doppler sonography of Supra Aortic trunks and TCCD and we found total occlusion of left internal carotid artery from its origin and occlusion of the left MCA and ACA. This thrombotic burden, soon identified by non-invasive ultrasound tools, gave him a worse prognosis quoad vitam and obiously it was not thinkable a successful reperfusion by intravenous thrombolysis. Then we choose the intravascular approach in order to restore patency at least of MCA for the rescue of penumbra. Therefore our neuroradiologist performed a selective arteriography of left internal carotid artery and crossed the clot by a guide toward M2 MCA, that was demonstrated patent at locale contrast injection. This diagnostic phase confirmed neurosonological report and then therapeutic phase was begun with microboli of urokinase directly into MCA clot. Early we achieved reperfusion of A1 ACA and no effect on M1 middle cerebral artery although multiple microboli of urokinase into M1 thrombus. TC of the head one hour after the end of the procedure was significant only for a mild blood-contrast collection into the basal ganglia of the left hemisphere. Neurosonological control at ten hours revealed persistent occlusion of the left ICA and MCA but control at 24 hours shown patent left MCA with persistent occlusion of ICA.