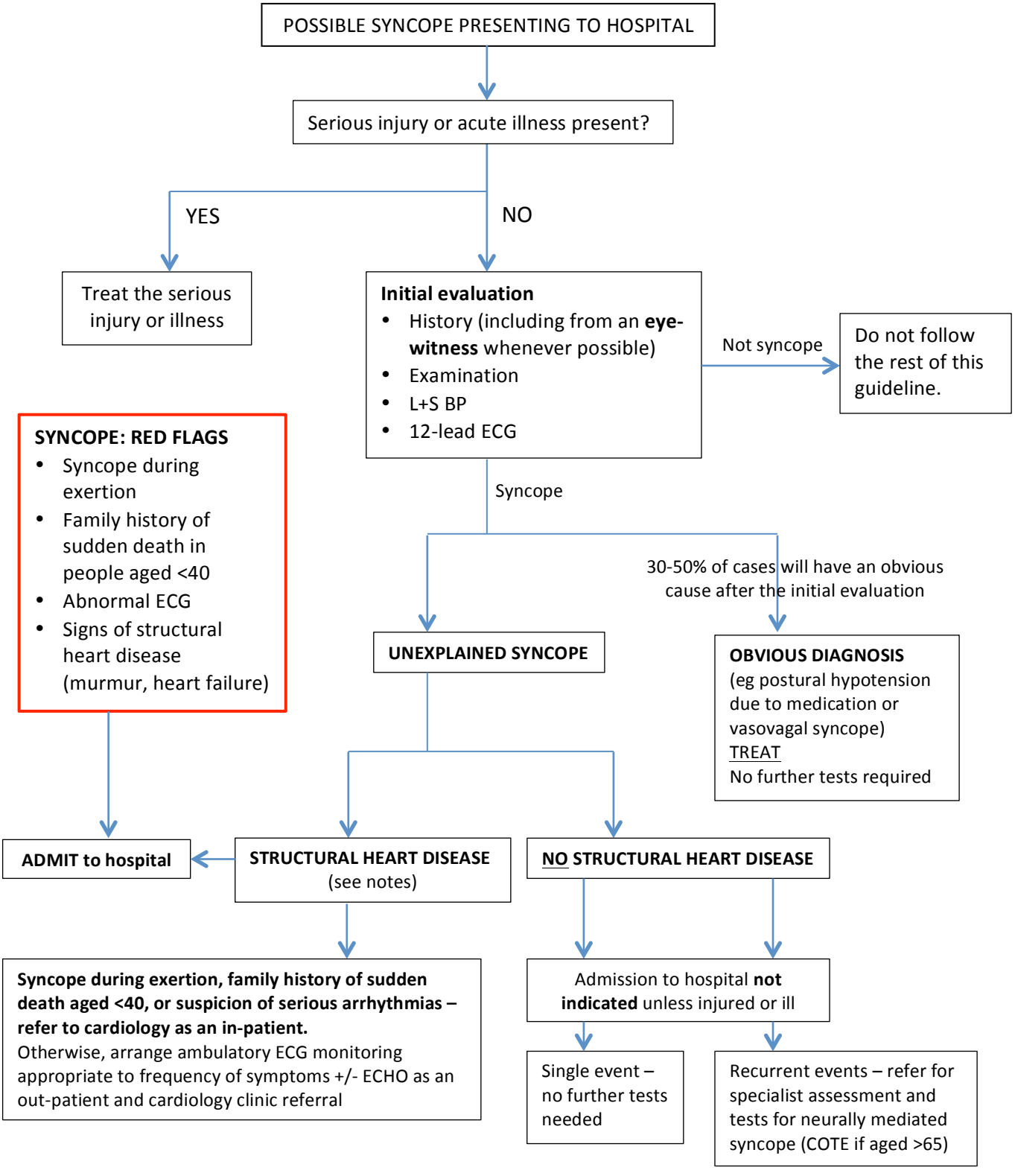
Quick Reference Guideline: Syncope in adults

For the management of patients in ED or EAU who present to hospital with syncope.
This quick reference guide has been adapted for local use and is based on the NICE Clinical Guideline 109: transient loss of consciousness in adults http://www.nice.org.uk/CG109

Syncope is a symptom, not a diagnosis. It is caused by **transient global cerebral hypoperfusion** leading to transient loss of consciousness. Syncope is usually the result of either a transient fall in blood pressure or a cardiac arrhythmia. Cardiac arrhythmias account for around 20% of cases.



GIVE DRIVING ADVICE TO ALL PATIENTS. Go to www.gov.uk/government/publications/at-a-glance

Quick Reference Guideline: Syncope in adults – notes

1. This is a syncope guideline – not a guideline for 'blackouts' or 'found lying on the floor'. Only an eye-witness account can confirm syncope. Use the paramedic sheet or the telephone to obtain one if necessary.

2. In syncope, the patient usually goes pale/grey, loses muscle tone (usually leading to a fall, and sometimes loss of bladder control), and spontaneously recovers – unless they are propped upright. Recovery is usually prompt and complete. Feeling 'washed out' afterwards is common, and some patients vomit. Older people may not experience a prodrome (feeling dizzy, hot, nauseated, vision going black etc) before any kind of syncope. The presence of absence of a prodrome does not indicate whether or not the syncope was caused by a cardiac arrhythmia.

3. Syncope can be caused by an acute illness (eg sepsis, bleeding, dissection, PE). If syncope is the result of an acute illness, do not follow this guideline.

4. The initial evaluation is very important in syncope. The history – including from any available eye-witness – is key (covering before, during and after), followed by the examination (especially of the heart), lying and standing BP and a 12-lead ECG. You must do a lying and standing BP as part of the initial evaluation – do not leave this for later.

5. There are 4 main causes of syncope: **1)** neurally mediated (vasovagal, situational, carotid sinus hypersensitivity); **2)** postural hypotension; **3)** cardiac arrhythmias; and **4)** structural (eg aortic stenosis) – only 3%.

6. After the initial evaluation, 30-50% of cases will have an obvious cause. Vasovagal syncope is characterised by the 3 P's: posture (standing), precipitating factors, and prodrome. Situational syncope may be obvious (eg fainting after a coughing fit). Postural hypotension (a fall in SBP of more than 20mmHg immediately after standing) is a common incidental finding in older people, but when accompanied by a typical history, can also be an obvious cause of the syncope.

7. Unexplained syncope is when the cause is not obvious after the initial evaluation. Patients are then divided in to two groups: those with structural heart disease, and those without. People without structural heart disease have a good prognosis and do not require admission to hospital unless they are injured or ill or there are other concerns. **A normal 12-lead ECG, a normal cardiovascular examination and no red flags virtually excludes a cardiac cause of syncope.**

8. Structural heart disease means: **a) abnormal ECG** (eg long or short QT interval, conduction abnormalities, AF, abnormal bradycardia, ST/T wave abnormalities, signs of WPW syndrome, old MI); **b) a clinically significant murmur**; **c) a history of structural heart disease** eg previous MI, congenital heart disease. Structural heart disease should also be suspected if syncope occurred during exertion, and when there is a family history of sudden death in people aged <40 years.

9. All suspected cardiac syncope should be investigated, even after a single event. Syncope in people with normal hearts only needs to be investigated if it is unexplained and recurrent. Do not request cardiac investigations in people with normal hearts.

10. A CT head is not indicated in syncope. A troponin is not indicated in syncope unless there was chest pain and there are possible new ECG changes.

Authors:
Dr Nicola Cooper, consultant in acute medicine
Dr

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Signed off by the Salford Healthcare Divisional Governance Committee on: [date]