



Title	Collapse and Syncope Protocol
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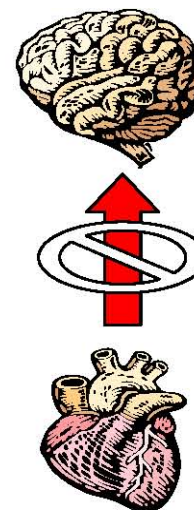
Collapse and Syncope Protocol

Assessment, Investigation and Referral of Patients with Loss of Consciousness / Collapse For use in Borders General Hospital, A+E and GP practices

1 – Assess the patient

- History, including witness account
 - Full examination including blood sugar
 - 12 lead ECG
 - Active stand: Lie down for 10mins, take BP, stand up, take BP every 30 seconds for 3 minutes
- Postural Hypotension = systolic drop ≥ 20 mmHg or systolic < 90 mmHg

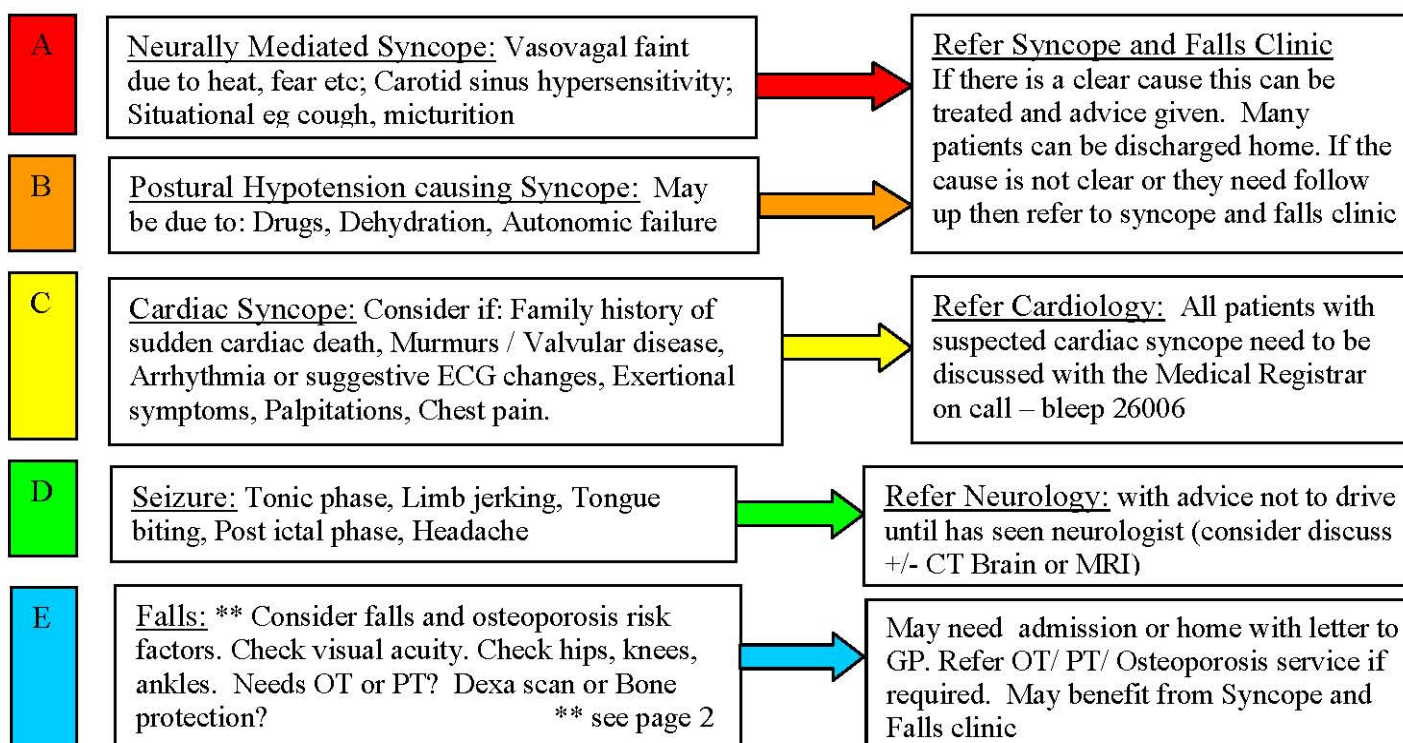
Reminder:
Syncope is due to a temporary decrease in cerebral perfusion and common causes include: postural hypotension, Vasovagal syncope and cardiac causes. Non syncopal causes of collapse include seizures and simple falls



2 – Is it syncope? Features are:

- Brief, Transient LOC
- Rapid Onset
- Usually results in fall
- Prompt, complete recovery

3 – Decide likely diagnosis. From list below and make referral +/- admission



4 – Does the patient need to be admitted?* see page 2

A suspicion of cardiac syncope warrants discussion with the medical registrar on bleep 26006. For other causes consider any injuries, home circumstances etc. Use common sense, if in doubt discuss with medics

ECG changes suggestive of arrhythmic syncope
Bundle Branch Block
Trifasicular Block
QRS > 0.12
Long QT
Q waves
AV blocks
Tachy / Bradyarrhythmias
Sinus bradycardia < 50 bpm
Pauses

Advice for vasovagal / postural syncope
Ask about caffeine intake, aim for no more than 5 cups of coffee / tea a day
2.5L / day fluid intake
Review medications
antihypertensives?
Avoid prolonged standing
get up slowly from supine

Driving advice after LOC
Simple vasovagal LOC with obvious precipitant – continue to drive
Unexplained LOC – stop until medical review
Seizure – stop for 1 year
TIA – stop for 1 month

Based on European Society of Cardiology guidelines for the management of syncope 2004
<http://www.dvla.gov.uk/media/pdf/medical/aagy1.pdf>
for DVI.A “medical standards of fitness to drive”

*** When to hospitalise a patient with syncope for diagnostic evaluation**

Strongly recommended for diagnosis:

- Suspected or known significant heart disease
- ECG abnormalities suggestive of arrhythmic syncope
- Syncope occurring during exercise
- Syncope causing severe injury
- Strong family h/o sudden death

Occasionally may need to be admitted:

- Patients with or without heart disease but with:
 - sudden onset of palpitations shortly before syncope
 - syncope in supine position
 - worrisome family history
 - significant physical injury
- Patients with minimal or mild heart disease when there is high suspicion for cardiac syncope
- Suspected pacemaker or ICD problem

**** Falls Risk factors**

<p>Intrinsic</p> <p>Medical problems;</p> <ul style="list-style-type: none">• Acute/ Chronic• Postural hypotension/ Syncope/ Dizziness• Vision / Peripheral neuropathy• Urinary urgency, Incontinence• Foot problems/ Osteoarthritis and footwear <p>Strength/Balance/Gait/ Physical functioning</p> <p>Mental health problems:</p> <ul style="list-style-type: none">• cognitive decline• poor mental status,• poor sleep• behavioural factors diet/ malnutrition• psychological - fear of falling <p>Medicine use:</p> <p>Psychotropic/ Hypotensive/ Polypharmacy/ 4 or >/ Recent change of medication</p> <p>History of previous fall;</p> <p>Last year/3 or more/ Injury</p>	<p>Extrinsic</p> <p>Hurrying</p> <p>Collisions in the dark</p> <p>Altered environmental conditions</p> <p>Home hazards</p>
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References:

1. European Society of Cardiology Guidelines for the management of Syncope – 2009
2. Assessment and Prevention of Falls in Older people NICE Guideline 21- 2004
3. American Geriatric society and British Geriatric society Clinical practice Guidelines; Prevention of Falls in Older people - 2010
4. <http://www.dvla.gov.uk/media/pdf/medical/aagv1.pdf> for DVLA "medical standards of fitness to drive"