

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

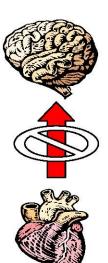
1 – Assess the patient

- 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 ≥ 20mmHg or systolic < 90mmHg

2 – Is it syncope? Features are:

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

<u>Reminder:</u> 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



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

Α	<u>Neurally Mediated Syncope:</u> Vasovagal faint due to heat, fear etc; Carotid sinus hypersensitivity; Situational eg cough, micturition		Refer Syncope and Falls Clinic If there is a clear cause this can be treated and advice given. Many patients can be discharged home. If the		
В	Postural Hypotension causing Syncope: May be due to: Drugs, Dehydration, Autonomic failure		cause is not clear or they need follow up then refer to syncope and falls clinic		
С	<u>Cardiac Syncope:</u> Consider if: Family history of sudden cardiac death, Murmurs / Valvular disease, Arrhythmia or suggestive ECG changes, Exertional symptoms, Palpitations, Chest pain.		Refer Cardiology: All patients with suspected cardiac syncope need to be discussed with the Medical Registrar on call – bleep 26006		
D	<u>Seizure:</u> Tonic phase, Limb jerking, Tongue biting, Post ictal phase, Headache		<u>Refer Neurology:</u> with advice not to drive ntil has seen neurologist (consider discuss /- CT Brain or MRI)		
Е	<u>Falls:</u> ** Consider falls and osteoporosis risk factors. Check visual acuity. Check hips, knees, ankles. Needs OT or PT? Dexa scan or Bone protection? ** see page 2		May need admission or home with letter to GP. Refer OT/ PT/ Osteoporosis service if equired. May benefit from Syncope and falls clinic		
4-1	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 <50bpm	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 LOCSimple vasovagal LOC with obviousprecipitant – continue to driveUnexplained LOC – stop untilmedical reviewSeizure – stop for 1 yearTIA – stop for 1 monthBased on European Society of Cardiologyguidelines for the management of syncope 2004
Pauses	See ap sioning mont supme	http://www.dvla.gov.uk/media/pdf/medical/aagv1.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

Intrinsic Medical problems; Acute/ Chronic Postural hypotension/ Syncope/ Dizziness Vision / Peripheral neuropathy Urinary urgency, Incontinence Foot problems/ Osteoarthritis and footwear	Extrinsic Hurrying Collisions in the dark Altered environmental conditions Home hazards				
Strength/Balance/Gait/ Physical functioning					
Mental health problems: • cognitive decline • poor mental status, • poor sleep • behavioural factors diet/ malnutrition • psychological - fear of falling					
Medicine use: Psychotropic/ Hypotensive/ Polypharmacy/ 4 or >/ Recent change of medication					
History of previous fall; Last year/3 or more/ Injury					

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. <u>http://www.dvla.gov.uk/media/pdf/medical/aagv1.pdf</u> for DVLA "medical standards of fitness to drive"