Clinical Practice Guidelines: Other/Syncope

Policy code	CPG_OT_SYN_0221
Date	February, 2021
Purpose	To ensure a consistent appproach to patients with syncope.
Scope	Applies to Queensland Ambulance Service (QAS) clinical staff.
Health care setting	Pre-hospital assessment and treatment.
Population	Applies to all ages unless stated otherwise.
Source of funding	Internal – 100%
Author	Clinical Quality & Patient Safety Unit, QAS
Review date	February, 2024
Information security	UNCLASSIFIED – Queensland Government Information Security Classification Framework.
URL	https://ambulance.qld.gov.au/clinical.html

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Syncope

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Syncope is defined as a transient loss of consciousness (TLOC) due to global cerebral hypoperfusion.[1] In clinical practice, this is characterised by an abrupt loss of consciousness with associated postural collapse that is followed by a rapid spontaneous recovery without residual neurological deficit.[2-3]

Annually, there are 20,000 presentations made to emergency departments in Queensland where syncope is reported as the primary reason for attendance.[4] Syncope is not a diagnosis but a presenting symptom that is observed secondary to a myriad of medical conditions or disruption of hemodynamic processes.

There are three distinct classifications of syncope:[5]

Orthostatic Syncope:

Broadly, this classification describes syncope that occurs secondary to postural changes. Syncope of this nature may commonly occur following instances of volume depletion (haemorrhage, diarrhoea or vomiting), be induced by prescribed medications (vasodilators or diuretics) or result from cardiovascular autonomic dysfunction (typically seen in the elderly).

Reflex Syncope:

This form of syncope refers to the inappropriate response by autonomic sympathetic reflexes to a trigger or stimulus. Commonly, this occurs due to a vasovagal response to experiencing emotional stress and/or pain, the visualisation of blood or situationally after urination, defecation, coughing or straining.

Cardiac Syncope:

This category of syncope relates to instances where a reduction in cardiac output results in global cerebral hypoperfusion. Typically, this is secondary to either a structural cardiac abnormality (aortic stenosis, cardiomyopathy, aortic dissection) or a cardiac arrythmia that alters electrical conduction through the myocardium (sinus node dysfunction, atrioventricular block, tachycardia). Cardiac causes of syncope have a poorer prognosis than orthostatic or reflex syncope with a 20–30% mortality rate in the first year.

The initial evaluation of patients with syncope should be focused on the early identification and management of serious and life-threatening non-cardiac or cardiac causes, specifically:

Non-cardiac	Cardiac
Pulmonary Embolism (PE)	Cardiac disease
Subarachnoid Haemorrhage (SAH)	Cardiac arrhythmias
Abdominal Aortic Aneurysm (AAA)	
Gastrointestinal bleed (GI bleed)	
Ectopic pregnancy	
Stroke/TIA	
Seizure	

NOTE: Age is associated with an increase in risk for both non-cardiac and cardiac causes.

Clinical features

- Transient loss of consciousness
- Loss of postural tone
- Spontaneous recovery
- Prodromal symptoms (diaphoresis, warmth, nausea, pallor)

Risk Assessment

HIGH RISK PATIENTS

The identification of ANY of the following characteristics during physical examination or history taking indicates high risk patients:

- History of cardiac disease
- New or unexplained dyspnoea
- Syncope during physical exertion
- History or physical signs of cardiac failure
- History of anemia
- Family history of sudden cardiac death and/or history of an inherited cardiac condition
- Older age (> 50)
- Evidence of new ECG abnormalities

LOWER RISK PATIENTS

May be identified by the presence of ALL of the following:

- Younger age (< 50)
- No history of cardiac disease
- Normal 12-Lead ECG
- Symptoms consistent with neurally mediated or orthostatic syncope
- Haemodynamic stability

Additional information

- Defecation syncope (syncope while defecating) can be a sign of serious underlying illness. More than one third of patients with defecation syncope die within 2 years of complications of their underlying diseases.[6]
- The assessment of syncope is complex and requires multi-modal investigations. ALL high risk patients should be transported for further medical assessment.
- Determining the aetiology of a syncope can be difficult in some patients. Clinicians should therefore have a low threshold for referring patients for further medical assessment.
- The term syncope encompasses a nomenclature of terms such as fainting, blackout, collapse and passing out. Patients may use these terms interchangeably when describing syncope.
- A thorough history from the patient or witnesses (if available) should determine the circumstances prior, during and after the syncopal event. Pertinent questioning should detail:
  - The position of the patient immediately prior to the event
  - Details of previous syncopal episodes; including frequency and cause (if known)
  - Past medical history and family history
  - Current medications (identify if prescribed vasodilators or diuretics)
  - The presence of prodromal symptoms prior to the event
  - Evidence of limb movement or incontinence during the event
  - The presence or absence of acute confusion or neurological deficits during the recovery period.
- Non-lethal strangulation in domestic and family violence may be a cause of unexplained syncope.

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CPG: Standard cares

Serious/life-threatening cause of syncope identified?

N:

- Remove stimulus (if reflex syncope suspected)
- Positioning (if orthostatic syncope suspected)

Consider:

- IV access
- Sodium chloride 0.9%

Y:

Manage as per:

Relevant CPGs

Transport to hospital
Pre-notify as appropriate

Note: *Clinicians must only perform procedures for which they have received specific training and authorisation by the QAS.*

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