

Guideline for the Diagnosis and Management of Syncope

**POLICY:** Guideline for the Diagnosis and Management of Syncope follows.

Evidence Base Guidelines are intended to serve as a general statement regarding appropriate patient care practices based upon the available medical literature and clinical expertise at the time of development. They should not be considered to be accepted protocol or policy, nor are intended to replace clinical judgment or dictate care of individual patients.

## **SUPPORTIVE DATA:**

- Syncope is a transient loss of consciousness (LOC) due to transient global cerebral hypoperfusion characterized by rapid onset, short duration, and spontaneous complete recovery.
- The differentiation between syncope and non-syncopal conditions with real or apparent LOC can be achieved in most cases with a detailed clinical history, but sometimes can be extremely difficult

## **REFERENCES:**

- 1. Wieling W, Ganzeboom KS, Krediet CT, Grundmeijer HG, Wilde AA, van Dijk JG. Initial diagnostic strategy in the case of transient losses of consciousness: the importance of the medical history. Ned Tijdschr Geneeskd 2003;147:849–854.
- 2. Sheldon R, Rose S, Ritchie D, Connolly SJ, Koshman ML, Lee MA, Frenneaux M, Fisher M, Murphy W. Historical criteria that distinguish syncope from seizures. J Am Coll Cardiol 2002;40:142–148.
- 3. Alboni P, Brignole M, Menozzi C, Raviele A, Del Rosso A, Dinelli M, Solano A, Bottoni N. Diagnostic value of history in patients with syncope with or without heart disease. J Am Coll Cardiol 2001;37:1921–1928

## Geriatric "G-60" Trauma Syncope Protocol Trauma Care Pathway **Syncope Evaluation** Trauma Surgeon Order: 1. History/ Physical routine orders based 2. 12 Lead ECG upon PMH, Mechanism of injury 3. Orthostatic blood pressure checks and assessment 4. Labs: CBC and BMP Syncope Non-Syncope Non-Cardiac/ Low Risk: Non-Syncopal Event: Per assessment likely non-cardiac High Cardiac: Per assessment likely cardiac source No history of heart disease Intoxication Abnormal ECG (see #1) Related to nausea, emesis, meals/hypoglycemia Seizure Family history of sudden cardiac death Positive Orthostatics (BP) Transient alerted level of Syncope with exertion or when supine consciousness Stress or Known recurrent syncope Syncope with palpitations TIA/ CVA Common Medication side effect: Mechanical Fall Presence of Pacemaker ex: alpha blocker, BB, CCB, diuretics History of CAD and/or CHF Psychiatric Associated with Parkinson's/autonomic dysreflexia STOP- syncope evaluation 1.Admit to observation—telemetry status (unless trauma status dictates full admission) 2.Consultation to cardiology 3.Echocardiogram (see #2) 4.If applicable: interrogate pacemaker If above testing normal: STOP---Transition to outpatient evaluation options Follow up with cardiologist: Holter Monitor, Loop Recorder, Event Monitor, Tilt table test Neurological evaluation (1) ECG -- 2 or 3rd degree HB, MI, previous MI, Q waves present, QT prolonged, LBBB, RBBB, HR < 50, VTach, non-sustained VT. (2) Diagnostic = Psychiatric evaluation severe aortic stenosis, HOCM, tumor, tamponade, dissection AHA/ ACCG Scientific Statement of Evaluation of Syncope (2006), AHRQ Guidelines for the diagnosis and management of syncope (2009 version).