1. Transient LOC Excluding... Syncope Definition Coma / CVA **Transient** Global Cerebral hypoperfusion Rapid onset, short duration Spontaneous and Complete recovery Considering... **Routine ED Assessment** Continuous Cardiac Monitoring whilst in ED History: Age, Prodrome, Triggers, Associated Symptoms, Injuries, Previous Episodes, PMHx, FHx (see table to right) PEx: General exam and Postural & Bilateral BP, Carotid Sinus Massage (If not contraindicated) **ECG Special Cases Only bHCG** (Urine) in females Only if clinically suspect abnormality - EUC / Hb Only if Chest pain / ECG Changes – consider Troponin Considering... Benign cause suspected, or Cause unknown Cardiovascular: 3. Consideration of High Risk Criteria Severe Structural or Coronary Heart Disease Heart Failure; Low LVEF; Previous MI Clinical or ECG features suggesting Arrhythmia Syncope During Exertion or whilst Supine Palpitations at the time of Syncope Family History of Sudden (Cardiac) Death Other: Non-Sustained VT **Massive GI Bleed** Bifascicular Block (L/R BBB + Left ant/post Fascicular Block) OR Intraventricular Conduction abN with QRS duration >120ms Inadequate Sinus Brady or SA Block (without medications/ Physical Training) Pre-excited QRS Complex QT Interval short or long Brugada Pattern (RBBB with STE in V1-V3) Negative T Waves in Rt Precordial Leads, epsilon waves and Ventricular late potentials (suggestive of Rt Ventricular Cardiomyopathy) Important Co-morbidities Severe Anaemia Electrolyte Disturbance Elderly And Apply your Gestalt!!! No High Risk Factors -> Consider Discharge (after discussion with Senior Clinician) Education (Triggers, Prodrome, Physical Manoeuvres, Teds)

Review Medications (in consultation with GP)

Consider referral / further testing via GP or neurology / cardiology

Consider for Tilt Table Testing

Exclude Transient LOC due to:

- Seizure (i.e. Aura, Jerking pre-LOC/collapse, Tongue biting on lateral edge not tip, Post-ictal phase present) – if in doubt, it is safer to perform this Syncope assessment.
- Head Injury / Trauma (Causal)

Neurally Mediated	Orthostatic Hypotension	Cardiovascular
Absence of Heart Disease	Absence of Heart Disease	Structural Heart Disease
Long Hx of Recurrent Syncope	After standing	Family Hx of Sudden Death
Trigger Present – pain, shock, heat, standing	Temporal Relationship with change in meds	During Exertion/Supine
Associated with Nausea or vomiting	Prolonged standing in crowded / hot place	Sudden palpations immediately followed by syncope
During/Post Eating meal	Autonomic Neuropathy (e.g. Parkinson's, diabetes)	Abnormal ECG
Neck Pressure / Stimulation	Standing after exertion	
After exertion		

Dangerous Cause Confirmed / Suspected

Dangerous Causes Include

- Arrhythmia (Tachy or brady)
- **Ischaemic** (<3% of all presenations)
- Structural (AS / Cardiomyopathy/ Tamponade

Neurological: (nb need return of full neurological function):

- **Subarachnoid Haemorrhage**
- **TIA** (involving Vertebrobasilar territory -> RAS)
- Subclavian Steal (stenosis of Subclavian artery)
- Shock from other causes

Follow management guidelines of Specific Condition

4. Admit those with high risk criteria

High Risk Factors -> Admit

- Admission / Intensive Investigation
- Cardiology / Special review
- **Continued Telemetry**
- Consideration of ECHO / EPS / Angio / EEG / CTB / Dopplers