

Evaluation of Patients with Syncope

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Syncope is a sudden and short-lasting loss of consciousness accompanied by a loss of tonus, followed by spontaneous recovery. The pathophysiological explanation of all forms is a sudden decrease of cerebral blood supply. The first question we always have to answer in front of a patient, who fainted, is: Was it really syncope? Or was it an attack of dizziness, or a pre-syncope, or a drop attack? The differential diagnosis between syncope and epilepsy is not always easy. Epilepsy is probable, if the unconsciousness was preceded by an aura and if it lasted more than 5 minutes.

Syncope accounts for more than 3 percent of ER visits and for 6 percent of hospital admissions. The most frequent type of syncope is vagovagal syncope; it is followed in frequency by orthostatic hypotension. History, physical examination and ECG lead to the correct diagnosis in 45 percent of cases. It is of utmost importance to also carefully take the family history: Are there other cases with recurrent syncope in the family? Also take a careful drug history; look for drugs causing QT prolongation.

Laboratory tests only rarely are helpful in finding the cause of syncope. Patients with abnormal lab tests tend to have epilepsy!

The work-up of arrhythmia as a cause of syncope needs Holter-ECG or a continuous-loop event monitoring.

For the diagnosis of vasovagal syncope the test to do is the head-up tilt test, which has a sensitivity of 67 – 83 percent.

In elderly persons, who suffer from syncope during shaving or in turning their head a carotid sinus massage needs to be done.

The most important question to be answered is: Is the etiology of the syncope cardiac or non-cardiac? Patients with syncope of cardiac etiology have a 6-month-mortality of more than 10 percent. Syncope may herald ominous prognosis in patients with structural heart disease.