INITIAL ASSESSMENT

- GCS <= 13
- SBP <90
- P< 50 or > 120
- any ventricular or supraventricular arrhythmia except AF <120
- CHB
- Wenkebach or Mobitz II
- Bifascicular or trifacicular block
- Suspected sick sinus syndrome
- Acute dyspnoea

→ Resus and Admission

INITIAL ASSESSMENT IN STREAMING

- Focussed Hx from patient and witness
- Examination
- 12 lead ECG
- VBG
- BHCG
- If ?postural syncope then postural BP/pulse after 5 mins lying flat, recorded at 1 and 5 mins.

→

- HEARSE +ve?
- Chest pain suggestive of ACS?
- Carotid sinus hypersensitivity?
- Unclear diagnosis?

→ Yes → Monitored Cubicle
Full evaluation including full history from witness of event

→ No →

If diagnosis = vasovagal (posture, provoking event, prodrome, pallor, post event symptoms) and full recovery and age < 50 then discharge with advice on trigger avoidance, (evasive action, physical counter manoeuvres, hydration)

→ Yes → Home

→ No → Majors

HEARSE

- **H**eart – CCF, IHD, Structural Heart Disease, Ejection Fraction <45%
- **E**CG – Any pathological Q waves, any BBB, any 2nd or 3rd degree heart block, unexplained sinus bradycardia
- **A**ge >60 or f**a**mily history
- Exe**r**cise – during exercise likely cardiac, post exercise likely vasovagal
- **S**upine or **s**itting at onset, **s**udden onset without prodrome,
- **E**xternal significant injury

ED EVALUATION

Investigation as above

→ BRACES +ve OR HEARSE +ve

Yes → **High risk of serious outcome** Consider admission for further investigation as indicated by relevant diagnosis pathway

No → **Lower Risk** Management as indicated by relevant diagnosis pathway

PATIENT LABEL HERE

Diagnosis

- Neurally mediated syncope - vasovagal, situational syncope or neuralgic syncope
- Orthostatic Hypotension (Fall of >20mmHg in SPB or systolic to <90
- History s/o carotid sinus hypersensitivity
- Cardiac syncope
- If history, exam, VBG, ECG and BHCG are all unremakable

Investigation and Disposal

Neurally mediated syncope - vasovagal, situational syncope or neuralgic syncope → Normal exam and normal ECG → Remaining symptomatic? → Yes → CDU / OP / IP (As required)

No → Home

Driving advice required for cough syncope

Orthostatic Hypotension (Fall of >20mmHg in SPB or systolic to <90 → Identify cause → CDU / OP / IP (As required)

History s/o carotid sinus hypersensitivity → Provocative testing

No change → Home

> 3 second ventricular pause or fall in SBP>50mmHg → D/W Electrophysiology at Bart's (post senior review) and arrange admission

Cardiac syncope → **ECG**

- CHB
- trifascicular block
- Bifasicular Block
- Ventricular arrythmia
- WPW
- Brugada
- Evidence of new RV dysplasia
- Abnormal QTc (<350 >450)
- ?pacemaker dysfunction

Yes → D/W Electrophysiology at Bart's (post senior review) and arrange admission

No → BRACES +ve OR HEARSE +ve

Yes → **High Risk** D/W Senior re: either Medical team for monitored bed or OP Holter with either OP or CDU echo

No → **Moderate Risk** OP Holter and echo

If history, exam, VBG, ECG and BHCG are all unremakable → Likely Dx is vasovagal so discharge → If recurrent syncope, significant external injury, high risk profession (professional driver, pilot, doctor)

- **Do not request CT head or troponin** without clearly suggestive history of intra-cerebral event or myocardial ischaemia – both very rare in this group. Headache and palpitations are very common symptoms with simple syncope
- **Discharge only if:** Normal mentition, able to eat, drink, walk safely and free of symptoms and either firm diagnosis or plan for further evaluation in place. Many patients feel unwell post syncope and may require time of CDU for symptom resolution.

Outcome
BRACES: +ve ☐ -ve ☐
HEARSE: +ve ☐ -ve ☐
Disposal: Home ☐ CDU ☐ Admitted ☐

Diagnosis……

BRACES

- **B**radycardia < 50 bpm with no obvious cause
- **R**ectal bleeding
- **A**naemia Hb < 9
- **C**hest pain
- **E**CG - Q in any lead but III
- **S**pO2 < 94% air