trust clinical guideline

Guideline ID	CG23
Version	1.0
Title	Transient Loss of Consciousness
Approved by	Clinical Effectiveness Group
Date Issued	01/01/2013
Review Date	31/12/2016
Directorate	Clinical
Authorised Staff	☐ Ambulance Care Assistant ☒ Emergency Care Assistant ☒ Student Paramedic ☒ Advanced Technician ☒ Paramedic (non-ECP) ☒ Nurse (non-ECP) ☒ ECP ☒ Doctor
Clinical Publication Category	**Guidance (Green) - Deviation permissible; Apply clinical judgement**

1. Scope

1.1 This guideline details the assessment and management of patients who experience a transient loss of consciousness.

2. Background and Definitions

2.1 The presentation of patients with a transient loss of consciousness (TLoC) is relatively common, affecting up to half the population in the UK at some point in their lives. The episode is often described as a 'blackout' or 'collapse'.

2.2 TLoC may be defined as spontaneous loss of consciousness followed by a complete recovery with no residual neurological deficit.

2.3 There are various causes of TLoC, including cardiovascular disorders (which are the most common), neurological conditions such as epilepsy, and psychogenic attacks (Non-Epileptic Attack Disorders).

2.4 The National Institute for Health and Clinical Excellence (NICE) suggest that the diagnosis of the underlying cause of TLoC is often inaccurate, inefficient and delayed; there is huge variation in the management of TLoC. A substantial proportion of people initially diagnosed with, and treated for epilepsy, have a cardiovascular cause for their TLoC.

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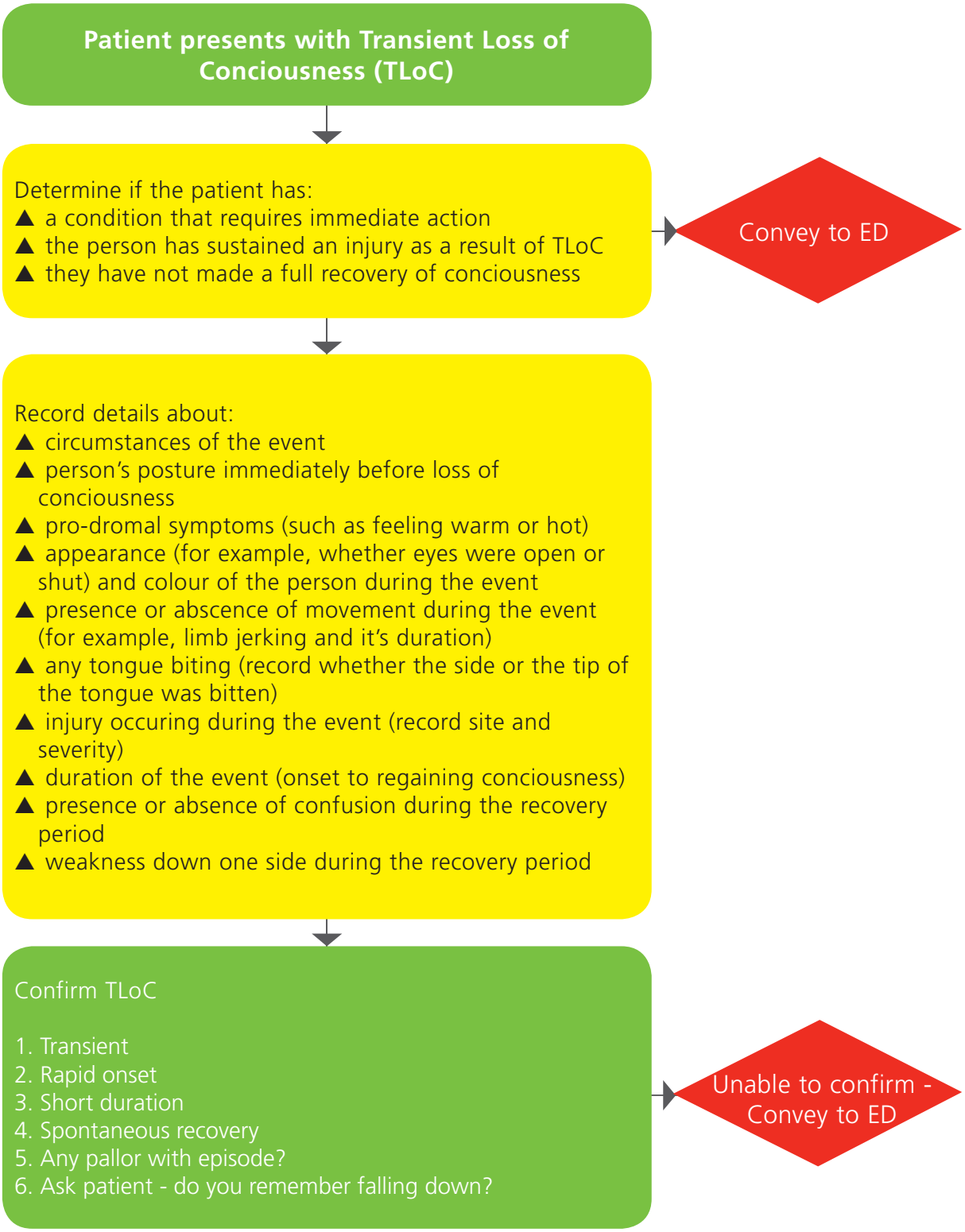
3. Guidance

3.1 The Flow chart in Figure 1 provides support to the decision making process and the development of an appropriate care plan.

3.2 Figure 1 - Transient Loss of Consciousness Flowchart



12 Lead ECG

Treat as a red flag if any of the following abnormalities are recorded on the ECG:

- conduction abnormality e.g. complete right or left bundle branch block or any degree of heart block;
- a long or short QT interval;
- any ST segment or T wave abnormalities

Red Flag present
Convey to ED

Red Flag?

ECG abnormality

- Heart failure (history or physical signs)
- TLoC during exertion
- Family history of sudden cardiac death under 40 years and/or inherited cardiac condition
- New or unexplained breathlessness
- Heart murmur
- Anyone aged older than 65 years who has experienced TLoC without prodromal symptoms (such as sweating or feeling warm/hot before TLoC)

Can a diagnosis of uncomplicated faint or situational syncope be made?

Make a diagnosis of uncomplicated faint when:

- There are no features that suggest an alternative diagnosis AND there are features suggestive of uncomplicated faint such as (Three P's):
- Posture - prolonged standing or similar episodes which have been prevented by lying down
- Provoking factors (such as pain or a medical procedure)
- Prodromal symptoms (such as sweating or feeling warm/hot before TLoC)

Make a diagnosis of situational syncope when:

- There are no features from the intial assessment that suggest an alternative diagnosis AND syncope is clearly and consistently provoked, for example, by straining during micturition usually while standing, coughing or swallowing.

Red Flag present
Convey to ED

3.3 Patient Assessment

3.3.1 Assess the patient using a CABCD approach. Ask the person who has had the suspected TLoC, and any witnesses, to describe what happened before, during and after the event. Review past medical history, current medication, any recent changes and any issues in relation to medicines compliance.

3.3.2 Record the following details:

- Circumstances of the event;
- Person's posture immediately before loss of consciousness;
- Prodromal symptoms such as sweating or feeling hot. A prodrome is an early symptom, or set of symptoms, that might indicate the start of the episode before specific symptoms occur;
- Appearance (for example, whether eyes were open or shut) and colour of the person during the event;
- Presence or absence of movement during the event (for example, limb-jerking and its duration);
- Tongue-biting (record whether the side or the tip of the tongue was bitten);
- Injury occurring during the event (record site and severity);
- Duration of the event (onset to regaining consciousness);
- Presence or absence of confusion during the recovery period;
- Weakness down one side during the recovery period.

3.3.3 Record a 12-lead electrocardiogram (ECG). Treat as a red flag if any of the following abnormalities are found on the ECG:

- Conduction abnormality (for example, complete right or left bundle branch block or any degree of heart block);
- Evidence of a long or short QT interval (see additional information sheet);
- ST segment or T wave abnormalities.

3.3.4 Patients should be conveyed to an Emergency Department for specialist cardiovascular assessment following TLoC when any of the following are present:

- ECG abnormality;
- Heart failure (physical signs, where this is not a pre-existing diagnosed condition);
- TLoC during exertion;
- Family history of sudden cardiac death in people aged younger than 40 years and/or an inherited cardiac condition;
- New or unexplained breathlessness;
- A heart murmur (where this is not a pre-existing diagnosed condition).

3.3.5 Consideration should also be given to conveying anyone aged older than 65 years who has experienced TLoC without prodromal symptoms.

3.3.6 In the absence of any factors listed in Para 3.3.3, patients with any of the following should be referred for further cardiovascular assessment via their General Practitioner, where they are pre-existing diagnosed conditions and the patient is not currently compromised:

- Heart failure;
- Heart murmur.

3.4 Uncomplicated Vasovagal Syncope

3.4.1 Diagnose an uncomplicated vasovagal syncope (faint) on the basis of the initial assessment when there are no features that suggest an alternative diagnosis (note that brief seizure activity can occur during uncomplicated faints and is not necessarily diagnostic of epilepsy) and there are features suggestive of uncomplicated faint, such as the 3 P's:

- Posture - Prolonged standing, or similar episodes that have been prevented by lying down;
- Provoking factors, such as pain or a medical procedure;
- Prodromal symptoms, such as sweating or feeling warm/hot before TLoC.

3.4.2 Situational syncope is a temporary loss of consciousness that is triggered by a specific situation. These situational triggers are diverse, and include having blood samples taken, straining while urinating or defecating and coughing. They can also be caused by heightened emotional stress, fear, or pain. When experiencing the trigger condition, the person often becomes pale and feels nauseated, sweaty, and weak just before losing consciousness.

3.4.3 Situational syncope is caused by a reflex of the involuntary nervous system called the vasovagal reaction. The vasovagal reaction causes bradycardia and at the same time leads the nerves that serve the blood vessels in the legs to cause dilatation. The result is that the heart pumps out less blood, the blood pressure drops, and circulating fluid is drawn by gravitational forces into the legs rather than to the head. The brain is deprived of oxygen, and the fainting episode occurs. Situational syncope is also known as vasovagal syncope.

3.4.4 If a diagnosis of uncomplicated faint or situational syncope is made, the patient does not have the red flags detailed in Para 3.3.4 and there is nothing in the initial assessment to raise clinical or social concern, no further clinical management is required.

3.5 Epilepsy

3.5.1 The presence of one or more of the following features is strongly suggestive of an epileptic seizure:

- Bitten tongue;
- Head-turning to one side during TLoC;
- No memory of abnormal behaviour that was witnessed before, during or after TLoC by someone else;
- Unusual posturing;
- Prolonged limb-jerking (brief seizure-like activity can often occur during uncomplicated faints);
- Confusion following the event;
- Prodromal deja vu, or jamais vu (the opposite to deja vu where a person momentarily does not recognise a word, person, or place that he or she already knows.

3.5.2 The episode may not be related to epilepsy if any of the following features are present:

- Prodromal symptoms that on other occasions have been abolished by sitting or lying down;
- Sweating before the episode;
- Prolonged standing that appeared to precipitate the TLoC;
- Pallor during the episode.

3.5.3 All patients suffering from their first seizure must be conveyed to an Emergency Department. The conveyance of confirmed epileptic patients following seizure must be based on the clinical presentation, the patients recent medical history and seizure pattern, their level of social support and consideration of capacity. The decision must be made in conjunction with the patient where they have capacity.

4. Incident Closure

4.1 Patients who are not conveyed must be provided with a copy of the PCR and a patient information leaflet. The following information should be explained:

- Explain the mechanisms causing their syncope.
- Advise on possible trigger events, and strategies for avoiding them. If the trigger events are unclear, advise people to keep a record of their symptoms, when they occur and what they were doing at the time, in order to understand what causes them to faint;
- Advise the person to take a copy of the patient clinical record, and the ECG where this can be printed, to their GP;
- Advise them to consult their GP if they experience further TLoC, particularly if this differs from their recent episode;

4.2 The ambulance clinician should inform the patient's GP about the episode using local mechanisms to do so.

5. Documentation

5.1 In line with Trust Policy, a Patient Clinical Record must be completed and annotated appropriately to include the information detailed in Section 3. Any deviation from this guideline must be recorded, with any potential or actual adverse event reported through the incident reporting system.

6. References

1. National Institute for Health and Clinical Excellent (2011) Clinical Guideline CG109: Transient loss of consciousness in adults and young people. NICE.