Emergency Department/ AMU RIE

▶ Collapse & Syncope Service

NHS Lothian

Assessment: History (FH sudden cardiac death, driving status, and collateral)
Examination (esp. Cardiovascular and Neurological)
CSM in monitored environment (avoid if carotid bruit or CVA/TIA/MI in past 6/12)

At Triage
Baseline observations, Lying and Standing BPs at 1 and 3 minutes, ECG, Blood sugar, FBC/U&Es if anaemia/electrolyte disturbance suspected. Imaging – CT brain only if trauma/SAH suspected

Suggested approach to TLOC/syncope:

(1) Is it syncope?

- TLOC =Transient Loss of Consciousness includes neurological seizure and syncope
- Syncope = TLOC due to cerebral hypoperfusion
- Take a focussed but thorough history of the event
- Neurological seizure more likely if patient does not recover fully within several minutes
- Document all presenting symptoms fully – this will be vital for future expert review
- Get any available history from witnesses or paramedics
- Examine the ambulance notes for initial observations and review any pre-hospital ECG

(2) Is there an obvious diagnosis – if so, manage the underlying condition

(3) Is the patient at high risk of a cardiac cause?

Hospital admission is not routinely indicated unless there is injury, or specific high-risk features are present, and the patient is not suitable for urgent outpatient follow-up.

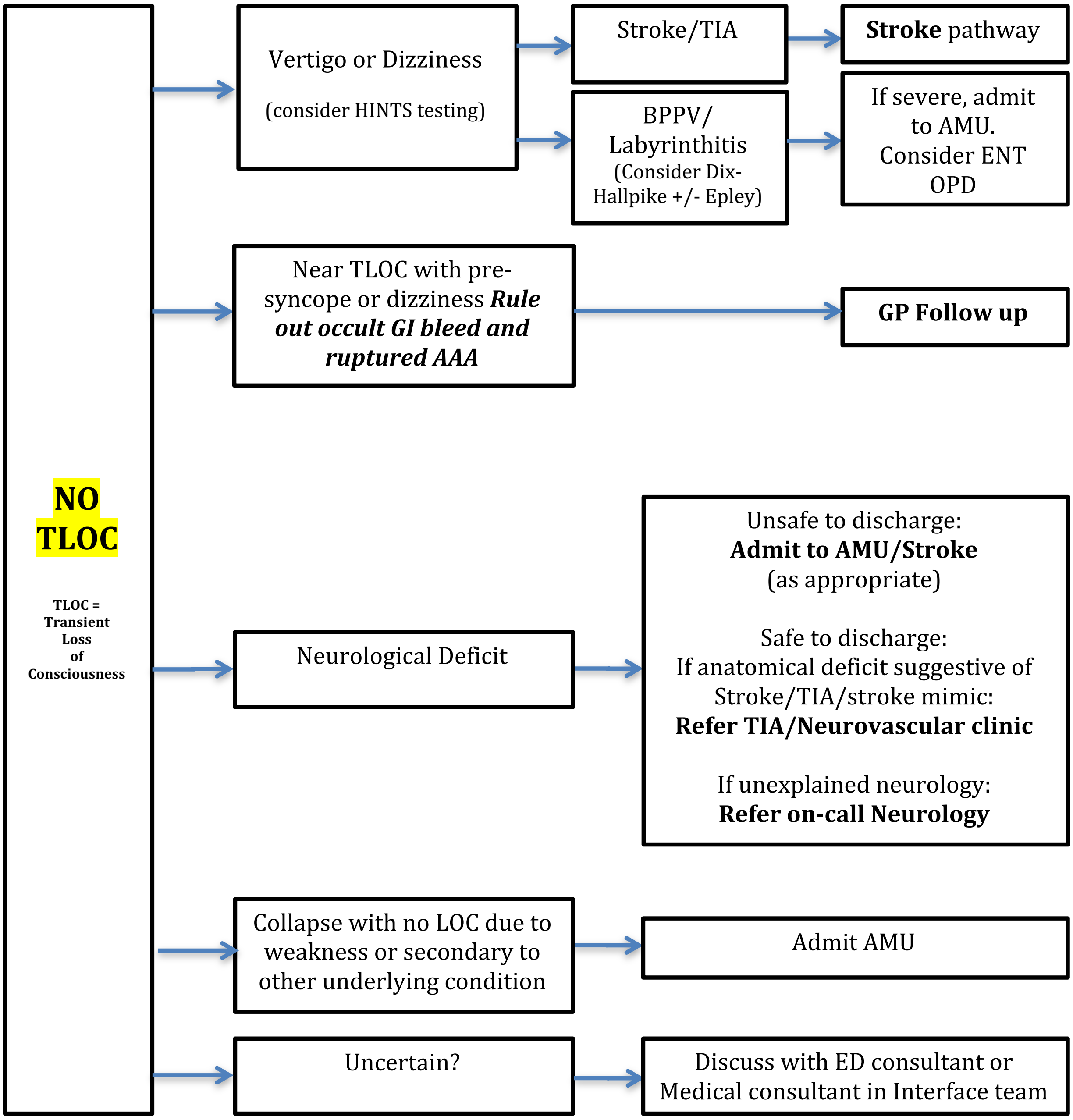
Patients who may require immediate admission to hospital
- Causative arrhythmia identified
- Injury requiring hospitalisation
- High risk cardiac syncope not suitable for urgent outpatient follow-up
- Other factors may influence the need for admission e.g. frailty, co-morbidities

Driving advice can be found at: http://intranet.lothian.scot.nhs.uk/Directory/emergencydepartment-rie/DepartmentalProtocols/NEW%20EM%20Guidelines/Driving%20-%20Fitness%20to%20Drive%20(Edinburgh%20EM%20Guidance).pdf

NO TLOC (Transient Loss of Consciousness) – go to page 2

TLOC (Transient Loss of Consciousness) – go to page 3

Professor Matt Reed/Dr Ishwinder Thethy v1.7; 7 Oct 2025. For revision October 2027



If discharged, ensure letter sent to GP, **Driving** & Occupational Advice given if required.

3 main categories of syncope:

(1) Reflex
Diagnose if:
- Features suggestive of ***Vasovagal Syncope e.g.*** posture, provoking factors, prodromal symptoms
- Features suggestive of ***Situational Syncope e.g.*** syncope provoked by a specific action (e.g. micturition, coughing, swallowing)
- No high-risk ECG abnormalities

(2) Orthostatic Hypotension (OH)
Diagnose if:
- The history is suggestive.
- Evidence of OH during lying and standing BP assessment
- No high-risk ECG abnormalities

(3) Cardiac/Cardiogenic Syncope
Suspect if:
- Syncope on exercise (NB syncope after exercise often vasovagal)
- Syncope without prodrome (esp. >65 yrs)
- Family history sudden cardiac death <40 yrs
- Syncope preceded by palpitations
- ECG abnormality
- Structural or ischaemic heart disease, heart failure

If discharged, ensure letter sent to GP, **Driving** & Occupational Advice given if required.

TLOC

TLOC = Transient Loss of Consciousness

Suspected Seizure
Post ictal period>10 mins, Prolonged recovery, Previous history, Lactate raised, Psychogenic nonepileptic seizures

→
- Follow seizure pathway
- First Seizure Clinic referral if appropriate

Obvious underlying cause
Acute ischaemia, Hypoglycaemia, Obvious arrhythmia, GI bleed, Ruptured AAA, Ruptured ectopic, PE, SAH

→ Manage appropriately
Treat underlying cause

Orthostatic Hypotension
History – when standing from supine/sitting position
Postural drop on ES BP (clinician to perform)
No high-risk ECG abnormalities

Situational Syncope
Provoked by specific action (e.g. cough/ defecation/ micturition/ postprandial/ after unpleasant sight/ sound/ smell/ pain). No high-risk ECG abnormalities

Vasovagal Syncope
Provoking factors (prolonged standing/hot places)
Prodromal symptoms (warmth, lightheaded, nausea)
No high-risk ECG abnormalities

→ Uncomplicated & infrequent = low risk. **Discharge to GP with Syncope Discharge Advice (VV or OH)**

→ Only if multiple life affecting episodes, then **Refer Rapid Access Syncope Clinic (RASCL) – Routine**
(see p7 for referral form)

Possible High Risk Cardiac Syncope

Palpitation followed by syncope, VT
Symptomatic heart block: Mobitz type II 2nd degree/Complete/3rd degree, Tri/ Bifascicular
Symptomatic bradycardia (<40) or Pause>6 seconds
Symptomatic AF> 100bpm

→
- Will require admission
- Monitored bed
- **In hours:** D/W cardiology
- **Out of hours:** Medicine, next day cardiology r/v

Pacemaker or ICD

→ **In hours:** D/W cardiology
Out of hours: Admit medicine for next day cardiology review

No preceding warning or syncope during exertion or syncope when supine **AND ONE OF:**
1. FH sudden death< 60 or FH unexplained syncope
2. Syncope with head rotation or carotid sinus pressure
3. CSM: ventricular pause> 3s or fall in SBP> 50mmHg
4. Severe structural or coronary artery disease
5. Systolic heart murmur
6. ECG showing sinus pause> 3s
7. ECG showing BBB or interventricular block,
8. ECG showing ventricular hypertrophy,
9. ECG showing Q waves consistent with IHD/cardiomyopathy,
10. ECG showing Prolonged or short QT interval

→ **Refer to general cardiology as outpatient:** Send EPR with referral at bottom to Cardiology, OPD3, RIE)
If previous cardiologist then refer back

- RBBB with ST elevation V1-V3 (?Brugadas)
- Negative T waves in R precordial leads, epsilon waves and ventricular late potentials (?ARVC)
- Pre-excited QRS and short PR (?WPW)
- SVT> 100bpm

with no above criteria for admission

→ **Refer to electrophysiology service** (Cardiology) as outpatient. Send copy of EPR with ECG to Dr Neil Grubb/ Dr Chris Lang/ Dr Colin Stirrat or Dr Steve Williams)

Possible High Risk Syncope
No preceding warning, syncope during exertion or supine, history unclear with no above criteria for cardiology / EPS referral

→ **Refer Rapid Access Syncope Clinic (RASCL) - Urgent**
(see p7 for referral form)

If discharged, ensure letter sent to GP, **Driving** & Occupational Advice given if required.

Emergency Department and Acute Medicine, RIE

► Discharge Information Sheet for patients attending with a Blackout

You have had a blackout. The doctor you saw today has decided that you are fit to go home, BUT you need to attend an Outpatient clinic in General Medicine or Cardiology to review why you had a black out and to see if you need any further tests to find this out.

Between now and your clinic appointment you may not be able to do the following activities

1. Drive a vehicle
2. Operate heavy machinery for work, work up scaffolding or heights, or drive for work. Some examples of jobs that may be affected include Fire-fighting, Heavy Goods Vehicle driver, Pilot, and Taxi/Train/Bus Driver.
3. Go to the gym and exercise, e.g. lifting heavy weights and strenuous cardio work outs

The doctor who saw you today will speak to you about this and advise

Driving Advice:

If the doctor has told you **NOT to drive until you are seen in clinic:**

You should **NOT drive** any vehicle **until** further advice is given at clinic **or until** you have received further advice from a specialist that you are able to restart driving.

If you drive when you should NOT your insurance will not cover you if you are in an accident

Preparing for the Outpatient Clinic:

1. Write down what happens before, during and after a blackout, and how you feel
2. Try to take a witness, who has seen your blackout, with you to your appointment. If they cannot come to your appointment with you, ask them to write down exactly what they saw, or ask them if the doctor could contact them if necessary
3. A video of your black out can be helpful. This lets the doctor see what is happening and gives them more information
4. Ask family if anyone else has had blackouts, faints, epilepsy or conditions affecting the heart
5. Make a note of any questions you may want to ask at the clinic
6. **If you have any queries before your outpatient clinic, please contact the Emergency Department on 0131 242 1300 and ask to speak to a consultant or registrar.**

Syncope Discharge Advice (Orthostatic/postural)

Your Care Provider in the Emergency Department today has diagnosed your symptoms as postural, or orthostatic, syncope. They are happy that you are safe to be discharged home. You may have also been referred for further investigations.

What is Syncope?

Syncope (also known as fainting or passing out) is a sudden, temporary, loss of consciousness followed by a rapid and complete recovery. Feeling lightheaded or dizzy without loss of consciousness is known as presyncope.

What causes Syncope

Syncope is caused by a reduction in blood supply to the brain. This can be because of a drop in blood pressure or a slow heart rate

In many patients syncope is triggered by simple things such as standing for long periods, or emotional stress, such as the sight of blood or needles. Occasionally people can have syncope shortly after eating. Some medications can predispose you to postural syncope, as can some medical conditions such as Parkinson's Disease or diabetes

What Can I Do:

- Blood pressure can be low in the mornings and can cause dizziness when getting out of bed or standing. Always sit for 1-2 minutes and exercise your calves by moving your feet up and down before standing in the mornings, or getting out of a chair.
- Try and lie down as soon as warning symptoms are detected
- Keep up a good intake of fluids, especially in warm weather as dehydration can make syncope more likely. Current recommendations suggest a fluid intake of 2 to 3 litres of fluid daily.
- Consider using compression stockings during the day, or for as long as possible. Your GP can advise which stockings may be most beneficial for you
- If your syncope is triggered by eating, try to avoid meals with lots of carbohydrate (e.g. bread, pasta or potatoes)

When Should I return to the Emergency Department?

It is important to return to the Emergency Department if you experience collapse or syncope associated with any of the following:

- Exertion or effort
- When lying down
- Headache, chest pain, palpitations or shortness of breath

Further Information

www.stars.org.uk

Syncope Discharge Advice (Vasovagal/Relfex Syncope)

Your Care Provider in the Emergency Department today has diagnosed your symptoms as vasovagal or reflex syncope. They are happy that you are safe to be discharged home. You may have also been referred for further investigations.

What is Syncope?

Syncope (also known as fainting or passing out) is a sudden, temporary, loss of consciousness followed by a rapid and complete recovery. Occasionally people may have some brief shaking or be incontinent of urine. Feeling lightheaded or dizzy without loss of consciousness is known as presyncope.

What causes Syncope

Syncope is caused by a reduction in blood supply to the brain. This can be because of a drop in blood pressure or a slow heart rate.

In many patients syncope is triggered by simple things such as standing for long periods, or emotional stress such as the sight of blood or needles.

Syncope is very common. Approximately 1 in 3 people will have a syncopal episode at some time in their lives.

What Can I Do if I Feel Symptoms Coming On:

- Immediately you feel symptoms coming on, sit down, squat, or better still, lie down flat and put your legs in the air (against a wall or chair, or propped up on a pillow)
- Cross your ankles and tense your calf muscles and buttocks tightly.
- Once your symptoms have passed, slowly sit up and then gradually get up
- Keep up a good intake of fluids, especially in warm weather as dehydration can make syncope more likely. Current recommendations suggest a fluid intake of 2 to 3 litres daily.

When Should I return to the Emergency Department?

The type of syncope you have been diagnosed with is not serious or life threatening and it is unlikely that you will need immediate medical attention following an episode. However, it is important to return to the Emergency Department if you experience collapse or syncope associated with any of the following:

- Exertion or effort
- When lying down
- Headache, chest pain, palpitations or shortness of breath

Further Information

www.stars.org.uk

Rapid Access Syncope Clinic (RASCL) RIE

► Referral Form

- **Email Completed Referral Form to General Medical Outpatient Clinic, for review loth.GM@nhs.scot**

Date of referral	
Referring Doctor	
Grade	
Department	
Consultant Name *	
All ED referrals should be discussed with a senior EM clinician (consultant/registrar)	

Patient Name:
Chi Number:
DOB:

Appointment Type: **Routine** ☐ **Urgent** ☐

- **Reason for referral:** (Syncope with diagnostic uncertainty and concern about significant underlying cause)

NB:

- Episodes of TLOC of likely Vagal/Situational/Orthostatic - please provide syncope leaflet and advise primary care management unless significant problematic symptoms despite compliance with conservative management advice.

- Possible cardiac syncope - please refer to cardiology

- **Complete /syncope notes on TRAK** ☐
- **1 and 3 minutes L/S BPs performed?** ☐
- **ECG findings?** ☐
- **Working Differential Diagnosis:** ☐
- **DRIVING and occupation advice given as required and documented?** ☐

Investigations (✓ if completed)			
FBC	☐	**ECG**	☐
U&E's	☐	**CXR**	☐
LFT's	☐	**USS**	☐
Ca/Alb	☐	**CT**	☐
Glucose	☐		
Coagulation	☐		
Other:			

Investigations requested✓ *Please ensure forms have been completed and submitted*	
24-Hour Tape	☐
Echocardiogram	☐
Exercise Tolerance Test	☐
CT Brain Scan	☐
Carotid Doppler	☐
Ultrasound	☐
MRI Scan	☐
Other:	

English as the first language: ☐ **Yes** ☐ **No**

If no, Specify Language and if translator required ______________________________

Vulnerable Adult: **(Please specify type)** ☐ **Yes** ☐ **No**