

Editorial

Comments on the 2018 ESC Guidelines for the Diagnosis and Management of Syncope



Comentarios a la guía ESC 2018 sobre el diagnóstico y el tratamiento del síncope

SEC Working Group for the 2018 ESC Guidelines for Syncope, Expert Reviewers for the 2018 ESC Guidelines for Syncope, and the SEC Guidelines Committee*[◇]

INTRODUCTION

The new syncope guidelines significantly increase the volume of information on how to diagnose and manage this entity, which is of considerable importance not only to cardiologists, but also to all physicians involved. A welcome addition is the incorporation of emergency specialists, neurologists, and geriatricians into the working group.

The new document¹ comprises 69 pages and 440 references vs the 41 pages and 213 references of the previous guidelines.² The increase is even greater if one considers the new online section of additional material called “Practical Instructions”. This material includes an extensive glossary that establishes a general vocabulary, a definition of criteria, and a description of techniques and management instructions. This hugely valuable supplement comprises 38 pages and 192 references.

The recommendations continue to operate in an environment of pervasive uncertainty. Quantitatively, the number of recommendations has increased by 7%; however, 40% are level I (49% in 2009) and only 3% are level III (14% in 2009). Neither has the level of evidence changed substantially: only 5% of recommendations are level A (3% in 2009) and most—50%—are level C (52% in 2009).

In addition to specific novel aspects, which are addressed in each section, the role of syncope units (SUs) is emphasized in a commitment to improved patient-focused safety and efficiency. This same commitment is reflected in the definition of the initial evaluation and risk stratification in the emergency department.

Beyond the specific novelties (Figure 1), we also highlight the conceptual aspects that have been updated and describe them in the same order as the headings of the original document (Figure 2).

DEFINITIONS, CLASSIFICATION, AND PATHOPHYSIOLOGY

The definition of syncope is unchanged, although the new document emphasizes the pathophysiological differences from other transient losses of consciousness.

The pathophysiological classification of syncope shows no significant differences from the 2009 guidelines. The guidelines reiterate that reduced cardiac output or peripheral resistance

mechanistically underlie the drop in global cerebral blood flow, the defining characteristic of syncope.

The differentiation between reflex syncope, syncope due to orthostatic hypotension, and cardiac syncope is maintained, and the authors of the guidelines stress that several mechanisms can participate in the genesis of a single syncopal episode. The presence of vasodepression, cardioinhibition, or both, bears no relationship to the cause of reflex syncope.

Nonsyncopal forms of loss of consciousness (real or apparent). The types of epileptic seizures involving loss of motor control, as well as psychogenic loss of consciousness and other rare triggers, are briefly described to distinguish them from true syncopal episodes.

DIAGNOSTIC EVALUATION AND MANAGEMENT ACCORDING TO RISK STRATIFICATION

Initial Evaluation

Emphasis is placed on a detailed clinical history obtained from patients or eyewitnesses. The history taking has multiple aims: to establish whether loss of consciousness occurred, to determine whether the loss of consciousness was of syncopal origin, to identify its etiology, and to stratify the risk. A novel inclusion is the additional material in the “Practical Instructions”. The recommended diagnostic criteria of reflex syncope, orthostatic hypotension, and cardiac syncope have not undergone substantial changes from the previous guidelines. Helpfully, the guidelines offer practical solutions based on the extensive experience of the members of the ESC working group.

Management of syncope in the emergency department according to risk stratification. One of the most novel aspects of the guidelines is the recommendations for the management of syncope in the emergency department. The main objective of this approach is to reduce the hospital admission rate without compromising patient safety. The guidelines clearly detail the low- and high-risk factors that can be obtained from the clinical history, physical examination, and electrocardiogram. The indications for other complementary examinations are established (hospital monitoring for suspected arrhythmic syncope, echocardiography if there is evidence of structural heart disease, carotid sinus massage in patients older than 40 years of age, tilt-table (TT) testing when there is a suspicion of reflex or orthostatic syncope, and laboratory

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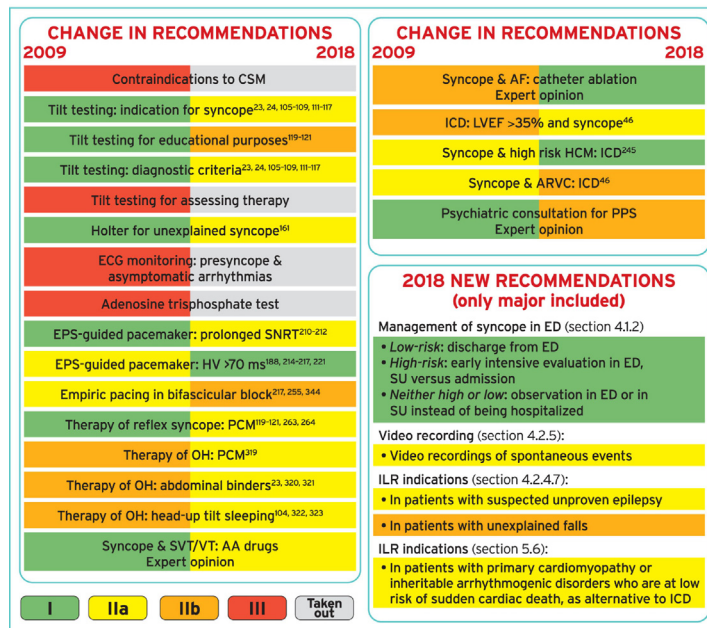


Figure 1. What is new in the 2018 syncope guidelines? AA, antiarrhythmic; AF, atrial fibrillation; ARVC, arrhythmogenic right ventricular cardiomyopathy; CSM, carotid sinus massage; ECG, electrocardiogram; ED, emergency department; EPS, electrophysiological study; HCM, hypertrophic cardiomyopathy; ICD, implantable cardioverter defibrillator; ILR, implantable loop recorder; LVEF, left ventricular ejection fraction; OH, orthostatic hypotension; PCM, physical counter-pressure maneuvers; POTS, postural orthostatic tachycardia syndrome; PPS, psychogenic pseudosyncope; SNRT, sinus node recovery time; SU, syncope unit; SVT, supraventricular tachycardia; VT, ventricular tachycardia. Reproduced with permission of Brignole et al.,¹ courtesy of the European Society of Cardiology and *European Heart Journal*, through OUP.

analyses to rule out secondary causes when required). The authors note that high-risk patients are more likely to have cardiac syncope and, therefore, have a higher risk of sudden death than low-risk patients who, in contrast, are more likely to have reflex syncope and good prognosis.

Not all high-risk patients require hospitalization. The document stresses that SUs are a safe and effective alternative. The guidelines recommend (class I B) that low-risk patients without recurrence be discharged from emergency departments, that high-risk patients be admitted or exhaustively evaluated in emergency departments or SUs, and that patients without high- or low-risk criteria be studied in emergency department observation units or referred to SUs instead of being admitted. Low-risk patients requiring specific treatment (eg, due to multiple recurrences) can be referred to SUs. Risk stratification algorithms are noted to not be superior to clinical judgment in predicting severe short-term events: their use is a class IIb recommendation. A novelty is the equal consideration of presyncope and syncope, introduced because evidence indicates that they have the same prognosis.

The published experience on the implementation of SUs in Spain is scarce,³ although the SEC-EXCELENTE project provides a unique opportunity for the creation of units with specific and homogeneous quality standards.

Diagnostic Tests

There are no changes to diagnostic tests, but a change in “philosophy” is seen with the promotion of the study of

dysautonomia as a possible cause of neuromediated syncope. A reasoned step is the incorporation of the neurologist’s viewpoint and of neurological tests into the diagnosis and, although to a lesser extent, into the treatment.

Carotid sinus massage. Because it is one of the most cost-effective tests, the guidelines insist that carotid sinus massage be performed in the initial evaluation of patients older than 40 years. There are no changes in the level of indication or in the positive diagnostic criteria (presence of syncope together with ventricular pause > 3 seconds or a systolic blood pressure fall > 50 mmHg). There is another major consideration: the guidelines no longer deem the test contraindicated in patients with stroke in the previous 3 months or with carotid murmurs. Other considerations deserving comment are as follows:

- Carotid sinus massage must be performed first in decubitus and then in orthostatism (usually in the TT, unless the test was already positive).
- A somewhat confusing comment is added: carotid sinus massage is indicated for syncope of unknown origin “compatible with a reflex mechanism”. It appears that this statement has been added so that a more serious form of syncope is not diagnosed in a patient with a positive test result.
- Greater emphasis could have been placed on the diagnosis of carotid hypersensitivity because its value is supported in the literature.⁴ The guidelines do mention that asymptomatic pauses exceeding 3 seconds (carotid sinus hypersensitivity) have little value in the diagnosis of syncope etiology.

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