NHS

Hambleton, Richmondshire and Whitby
Clinical Commissioning Group

Transient Loss of Consciousness (TLoC) in Adults
(FINAL VERSION 24th September 2012)

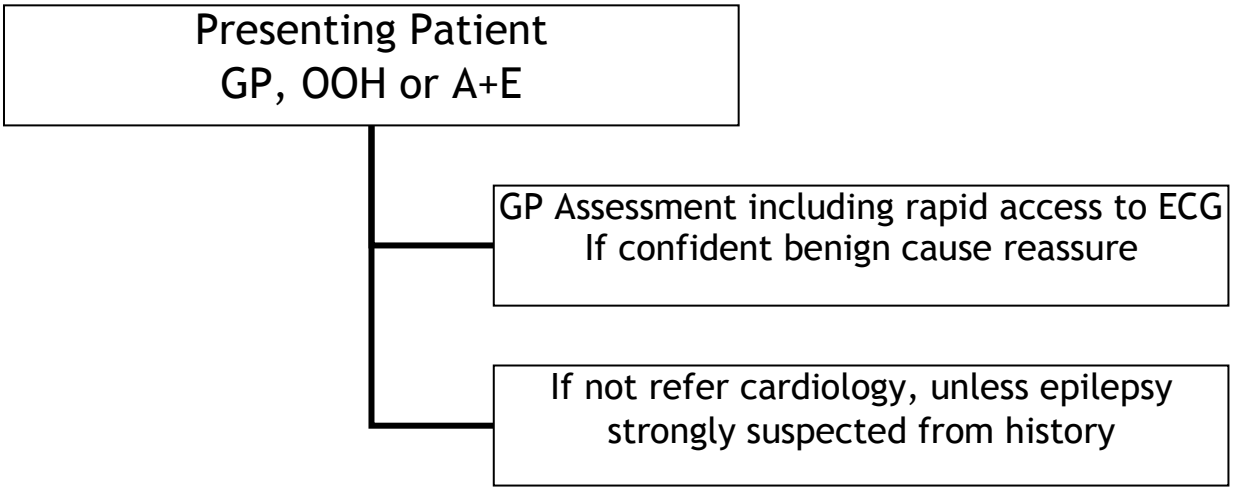
The design of this care pathway for adults follows the NICE guidance CG109. The aim if the guidance is to design a pathway for use throughout primary care and unscheduled care. The aim is to prevent premature deaths, unnecessary admissions and to ensure the patient sees the right speciality should they need to be referred.

The plan is to provide education for the practices and urgent care services on the assessment of an episode of TLoC including ECG. This will include the differential diagnoses of epilepsy, uncomplicated faint, situational syncope – ie micturition syncope, orthostatic hypotension, or cardiovascular causes.

The aim of this guidance is to increase the confidence of primary care and other front line services to deal with this topic and to confidently reassure those who have experienced uncomplicated faint, situational syncope or orthostatic hypotension without the need of referral.

The effective working of the pathway relies on the discrimination between true loss of consciousness and a "dizzy-do", or there will be a rise in unnecessary outpatient referrals. Where orthostatic hypotension in the elderly cannot be ruled out in the practice, then a referral to the falls team can be considered.

All other cases can be referred appropriately. If it is not clear whether it is cardiological or neurological, then refer to cardiology will assess in a "Black-out" clinic to decide outcome.



The guidance includes heart failure as a red flag referral. This is correct where there has been a true loss of consciousness and there is no previous history of faint that hasn't already been investigated.

End of year-audit

Practices will be expected to adopt the new pathway. Events should be coded, along with the recording of an ECG. An audit of cases should be carried out to evaluate the care of patients according to the pathway at the year end. The audit should include all patients who have had a collapse, discrimination as to whether or not the collapse was a true LoC, evaluation of the recorded history, ECG/other investigations, diagnosis, referral and advice about driving.

Codes	5 byte (EMIS / iSOFT)	SystmOne (CTV3)
Had a collapse	1B65	XE2ah
- No consciousness disturbance (will include dizzy do's)	1B61	
- Consciousness disturbance NOS (not otherwise specified) (for those that need an ECG and/or referral)	1B6z	
- Syncope/vasovagal faint (which does not need investigating)	1B62	
ECG -normal -abnormal	 3216 3217	 X77At Xa86L
Falls Assessment	38A	XaJL7
Referral to Neurology	8H46	8H46
Advised not to drive	8CA8	8CA8
Referral to Cardiology	8H44	8H44

<u>For information</u> – changes made to final version

Following feedback from practices on the draft guidance, the following changes have been included within the final version of the guidance:

- Emphasising the importance of discriminating between true loss of consciousness and a "dizzy do" in the elderly in order to prevent inappropriately referrals
- Raising the profile of the role of the Falls prevention service as an option for assessing orthostatic hypotension
- Removing syncope from the title of the pathway to emphasise this is a diagnostic pathway
- Adding code for "had a collapse" to audit
- Confirming that referral for heart failure is a red flag referral where there is true loss of consciousness
- Corrected codes for ECG normal and abnormal – please note these were incorrect on previous version
- Note additional codes for collapse

Pathway implementation for Management of Transient Loss of Consciousness

Step 1

Disseminate and discuss the pathway in the practice.

Complete by end August 2012

Step 2

From 1st September, use pathway to aid in management of pathway, including rapid access to ECG and triage into:

- Practice management for vasovagal/uncomplicated faints, funny do's (exclusion of UTI and orthostatic hypotension in elderly) or
- Urgent cardiological referral for TLoC with "Red Flags"
- Routine cardiological ("Blackout Clinic")
- Neurological referral only in suspected epilepsy
- Record advice to drivers

Complete by end March 2013

Step 3

Peer review meeting to discuss any initial findings and further develop plans (as part of wider peer review discussion on emergency admissions)

Complete by end November 2012

The Report

In April a report is to be completed to include the following details

- The number of new cases presenting with a collapse between 1.10.12 and 31.3.13 (include with this the split against the three sub-categories: No Consciousness disturbance, Consciousness disturbance NOS, Syncope/vasovagal faint)
- The number with Consciousness disturbance NOS who also had an ECG within 24 hours between 1.10.12 and 31.3.13
- The numbers with Consciousness disturbance NOS and "Red Flags" referred urgently within 24 hours between 1.10.12 and 31.3.13
- The numbers with Consciousness disturbance NOS referred to cardiology routinely between 1.10.12 and 31.3.13
- The numbers with Consciousness disturbance NOS referred to neurology routinely between 1.10.12 and 31.3.13
- The numbers with No Consciousness disturbance or Syncope/vasovagal faint managed within the practice between 1.10.12 and 31.3.13

Complete by end April 2013

Guidance to help support the diagnosis of transient loss of consciousness

The History

Record circumstances, posture immediately prior, prodromal symptoms, appearance (eyes open/shut and colour of person), presence or absence of movement, tongue biting, injury occurred during event – inc severity, duration till regained consciousness, confusion after event, unilateral weakness. Use witness accounts and paramedic reports.

Remember to record PMH, FH (inc sudden cardiac death), medication, vital signs, lying/standing BP, other CV/neuro signs.

In the case of TLoC or "funny-do" in the elderly, remember **UTI** and **orthostatic hypotension**. To rule out latter the patient should lie horizontal for **10 mins** and then have BP checked. On standing perform repeated BP measurements over **3 minutes.** (If this is difficult to do in practice, consider referral to Falls team).

If true loss of consciousness, then evaluate further.

True LoC?

Yes – Investigate (ECG, Gluc, FBC, MSU) and continue **No – consider Falls Team**

History compatible with uncomplicated faint?

Yes
Advise and reassure

No – Continue

History compatible with uncomplicated faint?

there are no features that suggest an alternative diagnosis
And there are features suggestive of uncomplicated faint (the 3 'P's) such as:
- **P**osture (prolonged standing, or similar episodes that have been prevented by lying down)
- **P**rovoking factors (such as pain or a medical procedure)
- **P**rodromal symptoms (such as sweating or feeling warm/hot before TLoC)

Remember **Situational Syncope** – clearly and consistently provoked micturition, cough and swallowing

Cardiology Red Flags?

Yes – refer urgently

No – Continue

Red flags – for cardiology referral
Refer within 24 hours for specialist cardiovascular assessment (by the most appropriate local service) anyone with TLoC who also has any of the following:
– an ECG abnormality – heart failure (history or physical signs) – 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

Consider referring within 24 hours anyone aged older than 65 years who has experienced TLoC without prodromal symptoms

Epilepsy suspected?

Yes – refer

No – refer Cardiology "Blackout"Clinic

Suspect epilepsy in a person who presents with one of more of the following features suggestive of epileptic seizures:
- a bitten tongue - head-turning to one side during TLoC- unusual posturing
- prolonged limb-jerking - confusion after the event - prodromal déjà vu or jamais vu
- no memory of abnormal behaviour that was witnessed before, during or after TLoC by someone else

Advice for people waiting for a specialist assessment
-**Driving**: Advise all people who have experienced TLoC that they must not drive while waiting for specialist assessment. After specialist assessment, the healthcare professional should advise the person of their obligations regarding reporting the TLoC to the DVLA
-**Advise people waiting for a specialist cardiovascular assessment**:
- what they should do if they have another event
- if appropriate, how they should modify their activity (for example, by avoiding physical exertion) and not to drive
-**Offer advice to people waiting for a specialist neurological assessment** as recommended in 'The epilepsies: the diagnosis and management of the epilepsies in adults and children in primary and secondary care' (NICE CG 20)
-**Health and safety at work** Advise people of the implications of their episode for health and safety at work and any action they must take to ensure the safety of themselves and other people