



Ten key messages from the 2018 ESC Guidelines for Diagnosis and Management of Syncope

From the Editorial desk

The following are key points to remember from the 2018 European Society of Cardiology (ESC) Guidelines for the Diagnosis and Management of Syncope[1].

1. Syncope is defined as transient loss of consciousness (TLOC) due to cerebral hypoperfusion, characterized by a rapid onset, short duration, and spontaneous complete recovery.
2. At the time of initial evaluation, clinicians should answer the following key questions:
 - Was the event TLOC?
 - In cases of TLOC, are they of syncopal or nonsyncopal origin?
 - In cases of suspected syncope, is there a clear etiological diagnosis?
 - Is there evidence to suggest a high risk of cardiovascular events or death?
 - Is there a serious underlying cause that can be identified?
 - If the cause is uncertain, what is the risk of a serious outcome?
 - Should the patient be admitted to the hospital?
3. Prolonged ECG monitoring (external or implantable) should be performed in patients with recurrent severe unexplained syncope who have all of the following three features:
 - Clinical or ECG features suggesting arrhythmic syncope.
 - A high probability of recurrence of syncope in a reasonable time.
 - Who may benefit from a specific therapy if a cause for syncope is found.
4. Electrophysiological study should be performed in patients with unexplained syncope and bifascicular bundle branch block (impending high-degree atrioventricular [AV] block) or suspected tachycardia, and an exercise stress test performed in patients who experience syncope during or shortly after exertion.
5. All patients should undergo a complete history, physical examination (including standing blood pressure measurement), and standard electrocardiogram (ECG). ECG monitoring (in bed or telemetry) should be performed in high-risk patients when there is a suspicion of arrhythmic syncope.
6. An echocardiogram should be performed when there is previous known heart disease, or data suggestive of structural heart disease or syncope secondary to cardiovascular cause. Carotid sinus massage should be performed in patients >40 years of age with syncope of unknown origin compatible with a reflex mechanism. In addition, tilt testing should be performed in cases where there is suspicion of syncope due to reflex or an orthostatic cause.
7. All patients with reflex syncope and orthostatic hypotension should have the diagnosis explained, reassured, explained the risk of recurrence, and given advice on how to avoid triggers and situations. These measures are the cornerstone of treatment and have a high impact in reducing the recurrence of syncope.
8. In patients with severe forms of reflex syncope, one or more of the following additional specific treatments according to the clinical features may be selected:
 - Midodrine or fludrocortisone in young patients with low blood pressure phenotype.



- Counter-pressure maneuvers (including tilt training if needed) in young patients with prodromes.
 - Implantable loop recorder guided management strategy in selected patients without or with short prodromes.
 - Discontinuation/reduction of hypotensive therapy targeting a systolic blood pressure of 140 mm Hg in older hypertensive patients.
 - Pacemaker implantation in older patients with dominant cardioinhibitory forms.
9. In patients with orthostatic hypotension, one or more of the following additional specific treatments may be selected according to clinical severity.
- Education regarding lifestyle maneuvers.
 - Adequate hydration and salt intake.
 - Discontinuation/reduction of hypotensive therapy.
 - Counter-pressure maneuvers.
 - Abdominal binders and/or support stockings.
 - Head-up tilt sleeping.
 - Midodrine or fludrocortisone.
10. The diagnostic process should be re-evaluated and alternative therapies considered if the above rules fail or are not applicable to an individual patient. Even though guidelines are based on the best available scientific evidence, treatment should always be tailored to an individual patient's need and be patient centered

Reference

1. Brignole, M., et al., *2018 ESC Guidelines for the diagnosis and management of syncope*. Eur Heart J, 2018.