

# Observation Unit Admissions:

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## SYNCOPE/ NEAR SYNCOPE

All patients presenting to the ED with a chief complaint of syncope/ near syncope should have a detailed history and physical performed to help ascertain potential etiologies.

This should include but is not limited to the following:

- Duration of event
- Presence of prodromal symptoms
- Associated symptoms during event (ex. Tongue biting, bladder or bowel incontinence, tremors, chest pain)
- Post-event condition (ie. presence or absence of post-ictal state)
- Witness accounts if available
- Prior hx syncopal events with timing if known
- History of prior neurologic or cardiac testing including but not limited to: cardiac monitoring, stress testing/ CCTA, TTE, brain imaging, EEG
- Presence of serious medical conditions<sup>1</sup>

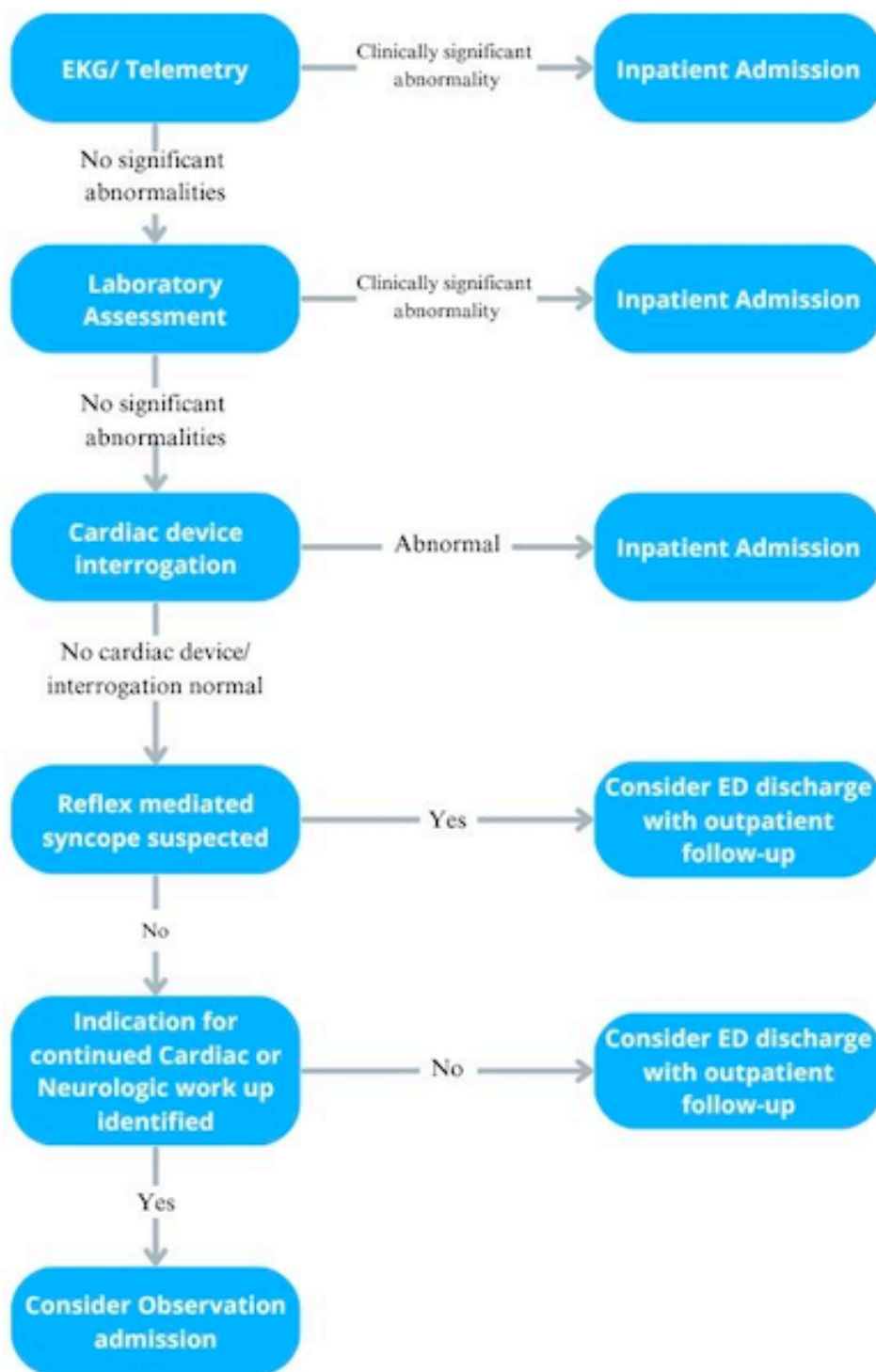
Recommended tests/ assessments before admission decision:

1. EKG
2. Cardiac device interrogation if present
3. Hemoglobin, BMP/ electrolytes, D-dimer, Troponin, Prolactin as clinically indicated based on history and physical
4. Orthostatic vitals if clinically indicated (optimally should be done prior to IVF challenge)

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<sup>1</sup> See Supplements Table 7 for a list of serious medical conditions

Syncope admission algorithm<sup>23</sup>:



<sup>2</sup> Shen, Win-Kuang, et al. "2017 ACC/AHA/HRS Guideline for the Evaluation and Management of Patients with Syncope." *Journal of the American College of Cardiology*, vol. 70, no. 5, Aug. 2017, pp. e39–e110, <https://doi.org/10.1016/j.jacc.2017.03.003>.

<sup>3</sup> Reflex mediated syncope includes the following: vasovagal syncope, carotid sinus syncope, situational syncope from activities such as coughing, laughing, swallowing, micturition, or defecation

Relative exclusion criteria for Observation unit admission:

- Acute encephalopathy
- Acute intoxication or overdose
- EKG/ Telemetry changes that may be related to syncope/ near syncope: new bifascicular block, significant arrhythmia (Mobitz II 2nd degree block or 3rd degree block, significant or prolonged brady or tachycardia), new BBB, daytime pause > 3 secs, prolonged corrected QT interval
- Significantly abnormal labs that may be related to syncope/ near syncope
- Hemodynamic instability (SBP < 90 or > 220 that requires continuous IV drip for correction, sustained HR < 50 or > 150 while awake)
- Presence of cardiac device with acute dysfunction
- Confirmed or highly suspected serious cause of syncope/ near syncope: acute/ subacute CVA with NIH > 2, acute MI, PE, acute GI bleed, intracranial bleed
- Significant injury as complication of syncopal event that warrants inpatient admission

While being evaluated on the Observation unit, consider the following:

- Toxicology screen as clinically indicated
- Review of home medications with any recent changes<sup>4</sup>
- Continuous telemetry monitoring during stay if concern for cardiogenic syncope
- Echocardiogram only if suspicion for structural heart disease
- Consider NST for patients who experienced symptoms during or shortly after exertion
- Neurology or Cardiology consultation as clinically indicated

NOTE: Head imaging in the absence of head trauma, carotid US, EEG are not recommended tests as routine part of the syncope evaluation in absence of focal neurologic findings

For patients cleared for discharge after completion of evaluation:

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<sup>4</sup> Elevated risk home medications include: antiarrhythmics, antihypertensives, diuretics

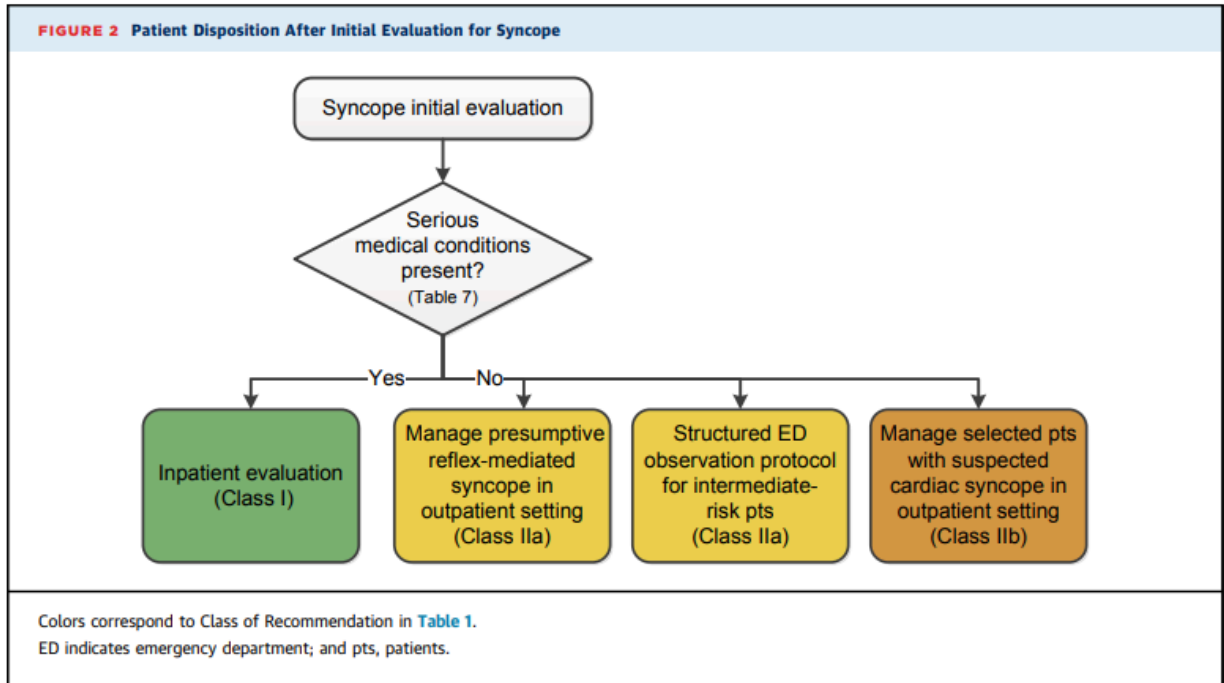
- Consider referral to neurology outpatient for assessment of neurogenic orthostatic hypotension
- Consider referral to cardiology outpatient for ambulatory cardiac monitoring devices
- Consider referral for tilt-table testing for the following indications: cause of syncope remains unknown, suspected delayed orthostatic hypotension, to distinguish convulsive syncope from epilepsy, to establish a diagnosis of pseudosyncope
- Provide instructions for return to the ED if recurrent symptoms

Indications for upgrade from Observation to Inpatient admission:

- Recurrent episode syncope/ near syncope
- New EKG/ Telemetry changes
- Structural cardiac condition identified as likely cause
- Serious arrhythmia identified
- Serious cause of syncope/ near syncope identified

# SUPPLEMENTS

## JACC Disposition Recommendations:



## Serious medical conditions to illicit in history:

**TABLE 7** Examples of Serious Medical Conditions That Might Warrant Consideration of Further Evaluation and Therapy in a Hospital Setting

Cardiac Arrhythmic Conditions	Cardiac or Vascular Nonarrhythmic Conditions	Noncardiac Conditions
<ul style="list-style-type: none"> <li>■ Sustained or symptomatic VT</li> <li>■ Symptomatic conduction system disease or Mobitz II or third-degree heart block</li> <li>■ Symptomatic bradycardia or sinus pauses not related to neurally mediated syncope</li> <li>■ Symptomatic SVT</li> <li>■ Pacemaker/ICD malfunction</li> <li>■ Inheritable cardiovascular conditions predisposing to arrhythmias</li> </ul>	<ul style="list-style-type: none"> <li>■ Cardiac ischemia</li> <li>■ Severe aortic stenosis</li> <li>■ Cardiac tamponade</li> <li>■ HCM</li> <li>■ Severe prosthetic valve dysfunction</li> <li>■ Pulmonary embolism</li> <li>■ Aortic dissection</li> <li>■ Acute HF</li> <li>■ Moderate-to-severe LV dysfunction</li> </ul>	<ul style="list-style-type: none"> <li>■ Severe anemia/gastrointestinal bleeding</li> <li>■ Major traumatic injury due to syncope</li> <li>■ Persistent vital sign abnormalities</li> </ul>

HCM indicates hypertrophic cardiomyopathy; HF, heart failure; ICD, implantable cardioverter-defibrillator; LV, left ventricular; SVT, supraventricular tachycardia; and VT, ventricular tachycardia.

JACC Additional evaluation:

