FITS, FAINTS AND FUNNY TURNS

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SOME TERMS AND DEFINITIONS

- Transient Loss of consciousness (T-LOC)
  - An episode of sudden loss of consciousness then recovered
- Collapse
  - Abrupt loss of postural tone with or without T-LOC
- Syncope
  - T-LOC due to global impairment of cerebral perfusion causing collapse
- Epilepsy
  - A spontaneous inappropriate discharge of cortical neurones leading to a clinical event
- Psychogenic
  - A cause of apparent T-LOC without evidence of epilepsy or syncope
- TIA/CVA
  - Transient neurological deficit without T-LOC
FITS FAINTS AND FUNNY TURNS

- Symptoms vague and subjective
- Covers a number of possible diagnoses
  - Syncope
  - Epilepsy
  - Aura/prodrome without migraine
  - Epileptic aura without epileptiform activity
  - Sleep attacks/narcolepsy
  - Endocrine eg Hypoglycaemia
  - Vertigo and vestibular symptoms
WHAT HAPPENS NOW

- Lack of good examples of care pathways
  - Lack of clarity in primary care in assessment
  - Emergency presentations: ?admit
  - Appropriateness of investigations
  - Discharge back to GP
  - Lack of clarity for appropriate referrals
  - Clinics speciality (syncope or first seizure) not symptom (e..g. blackout) based

- Examples of good tertiary care
Syncope is the sixth most common cause for a medical emergency.

In a PCT with a resident population of 156,000, in 2003-2004 there were:
- 303 FCEs
- 2,323 bed days equating to an average of 7 beds/day
WHO IS AT HIGH RISK FOR SYNCOPE?

Syncope occurs in 50% of people at some time during their life

- History of heart disease:
  - Ischaemic/myocardial infarction
  - Cardiomyopathy
  - Valve disease
  - Left ventricular dysfunction
  - Left atrial myxoma
  - Congenital heart disease

- Family history of sudden cardiac death or unexplained death <40yrs
- Onset during exercise
WHO IS AT RISK OF NEUROLOGICAL CAUSES

- History of epilepsy
- History of head injury
- History of stroke
- History of brain surgery
OTHER CATEGORIES

- Falls in the elderly
  - Ageing process
  - Syncope common cause of recurrent falls including autonomic failure
  - Cardio inhibitory carotid sinus syndrome with associated retrograde amnesia

- Psychological
  - E.g. Hyperventilation associated with anxiety
  - Known psychological problems ?secondary gain
  - Over used when no physical cause identified …yet
DIAGNOSIS OF EPILEPSY

- Interim results from an audit of patients on the epilepsy register in one PCT showed that for 25% of patients the diagnosis was ‘dubious’
  - Mainly patients who had had a single seizure and not taking any medication
  - Problems with missing sections of medical records
- Studies have shown that the diagnosis of epilepsy may be incorrect in 20-30% of cases
  - Consider reviewing diagnosis in those who continue to have seizures despite medication
ASSESSMENT IN PRIMARY CARE (1)

- History
  - Diagnostic clues
  - Witness account
- Past medical history
  - High risk groups
- Medication
  - Cardiac drugs – hypotensive agents, anti arrhythmic
  - Interactions
  - Compliance
  - Starting treatment or change in dosage
ASSESSMENT IN PRIMARY CARE (2)

- Examination
  - Lying and standing blood pressure
  - Pulse – rate, rhythm, character
- Investigations
  - FBC, U&Es, glucose
- ECG
  - test and interpretation
- Echo if cardiac cause considered likely
  - Technique and interpretation of results
FURTHER INVESTIGATIONS

- Should EEG be directly available to primary care?
- Referring for MR or CT scan
  - Preferred investigation?
  - Reporting issues
- Prolonged ECG recording
  - 24 or 72 hour Holter monitoring (low detection rate)
  - Event recorder
  - Open access for ECG recording if symptomatic
  - Implantable loop recorders (18 month battery life, 90% diagnostic yield)
FROM THE PATIENTS POINT OF VIEW

- Getting a diagnosis for the patient quicker
- Manage those with psychological cause more efficiently
- Stigma of diagnosis
- Employment concerns
  - Driving, lone worker
- Insurance implications
- Lifelong medication
- Other family members who may be effected
SOME QUESTIONS

- Are there any clues in the history to help in the diagnosis; syncope v epilepsy? Any hallmarks?
- Which investigations should be available in primary care?
- Who can make a diagnosis of epilepsy: who is a specialist?
- Who can be reassured and who needs further investigations?
- Who should be referred urgently?
- Is there a place for symptom based clinics in primary care for triage and referrals to syncope or first seizure clinics?
- Are there wins for practice based commissioning?