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2018 ESC/EHRA Guideline for diagnosis and management of Syncope

https://www.escardio.org/Guidelines/Clinical-Practice-Guidelines/Syncope-Guidelines-on-Diagnosis-and-Management-of

Introduction

The European Society of Cardiology has published a new version of syncope management guideline in collaboration with European Heart rhythm association. Supplementary Data were released, for the first time, to bridge the gap between evidence-based recommendations and their adoption in day to day clinical practice. Furthermore, Web Practical Instructions were published to evaluate patients with syncope and to interpret relevant test results. The guideline covers diagnostic evaluation, management according to risk stratification and treatment of syncope. It covers various conditions like reflex syncope, orthostatic hypotension, and cardiac arrhythmias including unexplained syncope with high risk of Sudden Cardiac death. As new evidence has emerged over the last nine years, the new guidelines make changes pertaining to investigations, but mainly to risk stratification and to management in Emergency department and outpatient clinic.

New recommendations

Risk stratification in Emergency department (ED) receives a Class I recommendation. It provides a clear guide regarding admission, discharge and observation in ED / Syncope unit. Video recording during spontaneous events receives a Class IIa recommendation. Implantable loop recorder (ILR) use is recommended (Class IIa) in patients with suspected unproven epilepsy and (Class IIb) in patients with unexplained falls. ILR implantation is recommended (Class IIa) in patients with a low risk of sudden cardiac death due to primary cardiomyopathy or inheritable arrhythmogenic disorders, as an alternative to ICDs.

There are important upgrades of recommendations in relation to pacemaker indication, AF ablation, ICD implantation and orthostatic hypotension therapy. Electrophysiology study-guided pacemaker implantation with HV interval >70 ms is now a Class I (from Class IIa) recommendation. Patients with AF developing syncope can benefit from expert guided catheter ablation (Class I from Class IIa recommendation). There are two upgraded guidelines for ICD indication. Firstly, high risk for sudden cardiac death in HCM patients ICD recommendation is now a Class I recommendation (from Class IIa). Secondly, in patients with unexplained syncope and LV impairment, even with left ventricular ejection fraction >35%, ICD use is recommended Class IIa (Class IIb in 2009). Recommendations for orthostatic hypotension therapies like physical counter-pressure manoeuvres, abdominal binder support and head-up tilt sleeping are upgraded from IIb to IIa.

Downgrades

Tilt testing indication and diagnostic criteria are now downgraded to Class IIa from Class I. Tilt testing is not that well supported anymore for patient educational purpose (from Class I to IIb). Holter monitoring for unexplained syncope is downgraded from Class I to IIa. Pacemaker therapy for sick sinus syndrome guided by prolonged sinus node recovery time on electrophysiology study is now a class IIa rather than class I recommendation. Physical counter pressure manoeuvres in reflex syncope is less well supported (IIa rather than I). Anti-arrhythmic drug therapy in patients with syncope secondary to ventricular tachycardia or supraventricular tachycardia guided by expert is downgraded from class I recommendation to Class IIa. Psychiatric consultation in patients with psychogenic pseudo-syncope is no longer mandated (class I to class IIb).

Some recommendations are no longer part of the guideline. Tilt testing for assessing response to therapy is no longer recommended. ECG monitoring for presyncope or asymptomatic arrhythmias is also excluded. Adenosine triphosphate testing is similarly not part of the guideline.

Empiric pacing therapy for bifascicular block is downgraded (recommendation downgraded from Class IIa to Class IIB). Implantable cardioverter defibrillator implantation in patients with syncope and arrhythmogenic right ventricular cardiomyopathy is downgraded from Class IIa to Class IIb.

Transient loss of Consciousness (TLOC) / Syncope: NICE 2009 (CG109)

The NICE guidance gives an approach to patient management in a more descriptive manner. However, it does not include risk stratification, guidance on in-patient or out-patient management. Moreover, there are recommendations but no specific class of recommendation. There are no recommendations about inherited cardiac conditions, cardiomyopathy or risk stratification for sudden cardiac death which are covered in the new ESC guidance.

Bradycardia devices: NICE 2005 (TA88)

The current ESC update describes electrophysiology study guided pacemaker therapy, which was not mentioned in the NICE technology appraisal. Moreover, there was no clear comment about pacemaker therapy with bi-fascicular and tri-fascicular block. However NICE provides cost effectiveness analysis of pacemaker therapy.

Implantable Cardioverter defibrillator (ICD) and Cardiac resynchronisation therapy (CRT) for arrhythmias and heart failure: NICE 2014 (TA344)

This separate technology appraisal recommends ICD only for LVEF <35%. However, there is no clear recommendation about patients with syncope with left ventricular ejection fraction >35%. NICE highlights cost-effectiveness of these devices, which is not a focus of the ESC 2018 guidance.

Conclusion

Syncope guidance by ESC in 2018, has provided multidisciplinary guidance by taking current practice into consideration, and overall is similar to current UK medical practice. Moreover, it has also included updates from relevant specialities; including neurology and cardiac electrophysiology. Moreover, the supplementary data and Web based instruction provide practical guidance. However, cost-effectiveness is not assessed, but a fundamental focus of NICE guidance. The Syncope unit organisational guidance is very useful for optimising care pathways.

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