

Syncope / Transient Loss of Consciousness (TLoC) FPH Only

Key Points

- **Confirm true TLoC first** — distinguish syncope from mechanical falls, seizures, or other causes before applying the syncope pathway; history (patient and witness), examination, and ECG are mandatory for all.
- **Risk stratify using the RAG model** — Red (high risk) features such as exertional, seated or supine syncope, no prodrome, cardiac history, or high-risk ECG warrant admission; Amber warrants senior ED review; Green (typical reflex or orthostatic, normal ECG, full recovery) is suitable for discharge.
- **High-risk ECG findings mandate medical/ cardiology input** — this includes AV block, BBB, pre-excitation, NSVT, long/short QTc, Brugada, epsilon waves, HCM pattern, or ischaemic changes.
- **Orthostatic hypotension and neurological causes need specific action** — diagnose OH with lying/standing BP (≥ 20 mmHg systolic or ≥ 10 mmHg diastolic drop); refer to neurology (first fit clinic) if epilepsy is suspected based on lateral tongue bite, postictal confusion, or prolonged rhythmic movements.
- **Driving advice and safety-netting are mandatory on discharge** — document DVLA counselling, provide written follow-up instructions, and safety-net for exertional symptoms, chest pain, or recurrence; follow-up pathway is risk-stratified (cardiology for Red/Amber cardiac, GP for Green, neurology for suspected epilepsy).

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Abbreviations

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1.0 Immediate Assessment

Patients presenting with suspected syncope or TLoC should be stabilised (airway, breathing, circulation) and any trauma or acute medical issues addressed before syncope-specific evaluation. Confirm that true transient loss of consciousness occurred; if a mechanical fall is more likely, the appropriate Falls guidance should be followed.

2.0 History, Examination, and ECG

History (patient and witness):

Key elements include circumstances and triggers (pain, emotion, exertion, posture), prodromal symptoms (warmth, sweating, nausea, dizziness), witness account of the episode (pallor, eye position, motor activity), tongue biting (lateral suggests seizure vs tip), duration of loss of consciousness, post-event confusion, previous TLoC episodes, cardiac history including structural heart disease and arrhythmia, family history of sudden cardiac death <40, and medications predisposing to hypotension or arrhythmia.

Examination:

A full cardiovascular and neurological examination is recommended, including vital signs, lying and standing blood pressure (to assess for orthostatic hypotension), signs of heart failure (raised JVP, oedema, crackles), and auscultation for murmurs suggestive of aortic stenosis or hypertrophic cardiomyopathy (HCM).

ECG (recommended for all patients):

Any abnormal finding should be considered potentially cardiac in origin. Concerning features include:

- Bradycardia <40 bpm or pauses >3 s; Mobitz II or complete AV block.
- Bundle branch block, QRS prolongation, or pre-excitation (WPW pattern).
- Non-sustained VT; prolonged QTc (>440 ms men, >460 ms women) or short QTc (<350 ms).
- Brugada pattern; epsilon waves; LVH or HCM patterns.
- ST depression, pathological Q waves, or T-wave inversion (outside aVR and V1) suggesting ischaemia.

3.0 Investigations and Documentation

Targeted investigations should include capillary blood glucose, full blood count (anaemia or acute bleeding), and trauma-associated imaging as indicated. Pulmonary embolism or aortic dissection should be considered if supported by the clinical picture. A pregnancy test may be appropriate.

Detailed patient and witness accounts should be documented, ambulance observations incorporated, and the ECG attached to the record.

4.0 Risk Stratification (RAG System)

Integrating ESC 2018 and NICE CG109 criteria. See Figure 1.

RAG Risk Stratification — Visual Summary (Section 4)

Integrating ESC 2018 and NICE CG109 criteria

High Risk (Red)	Intermediate Risk (Amber)	Low Risk (Green)
Key features • Exertional or supine syncope • Palpitations immediately before TLoC • No prodrome (especially >65) • FHx sudden cardiac death <40 • Known structural heart disease or heart failure • Murmur suggestive of valve disease • High risk ECG (AV block, VT, Brugada, long/short QT, wide QRS, HCM changes, ST depression, TWI outside aVR and V1) • Consider PE: syncope on exertion, SOB, thrombo-embolic risk factors, hypoxia, ECG sinus tachycardia and/or right heart strain and/or AF Recommended action • Consider admission for monitoring and investigation • Inpatient cardiology assessment should be considered	Key features • >65 or multiple comorbidities • Cardiovascular disease not meeting high-risk thresholds • Minor / non-specific ECG changes • Some prodrome or unclear history • New hypotensive medications • Minor injury from event Recommended action • Outpatient cardiology clinic may be appropriate if suspected cardiac syncope (alternative causes excluded: vasovagal, orthostatic, situational) • Consider echo if history of MI, murmur suggestive of heart disease, FHx of cardiomyopathy or congenital heart disease • Ambulatory ECG may be indicated if suspected paroxysmal arrhythmia or intermittent heart block • ED senior review is advised before discharge • If ongoing concerns, consider referral to medics	Key features • Typical reflex or situational syncope • Rapid full recovery • Normal ECG and no cardiac history • Confirmed orthostatic hypotension Recommended action • May be suitable for discharge from ED with advice • GP follow-up (BP/meds review if orthostatic features)

Use alongside full criteria in clinical guideline. If unsure or any concerning ECG/history, treat as potentially cardiac and escalate appropriately.

Figure 1. RAG risk stratification summary.

High Risk (Red) — features suggesting a cardiac or life-threatening cause:

- Exertional, seated, or supine syncope; palpitations immediately before TLoC; no prodrome (especially >65 years).
- Family history of sudden cardiac death <40; known structural heart disease, heart failure, or coronary artery disease.
- High-risk ECG findings (Mobitz II or higher AV block, BBB, pre-excitation, NSVT, long/short QT, Brugada, epsilon waves, HCM pattern, ischaemic changes).
- Clinical suspicion of PE or aortic dissection; associated hypoxia, severe anaemia or hypotension, unexplained breathlessness, murmur suggestive of valve disease, or focal neurological deficit.
- **Recommended action:** Admission under the medical team for monitoring and investigation, with inpatient cardiology assessment, should be considered.

Intermediate Risk (Amber)

- Age >65 or multiple comorbidities; cardiovascular disease not meeting high-risk thresholds; minor ECG abnormalities (e.g. LVH without HCM features); unclear history or limited prodrome; new hypotensive medications; minor injuries.
- **Recommended action:** Senior ED review prior to discharge is advised. If ongoing concerns, referral to the medical team should be considered. Outpatient cardiology clinic may be appropriate if cardiac syncope is suspected and alternative causes (vasovagal, orthostatic, situational) have been excluded. Consider echocardiography if history of MI, significant murmur, or family history of cardiomyopathy; ambulatory ECG if paroxysmal arrhythmia is suspected.

Low Risk (Green)

- Typical reflex syncope (prodrome, pallor, nausea, sweating); situational trigger; full and rapid recovery; normal ECG; no cardiac history; confirmed orthostatic hypotension.
- **Recommended action:** Suitable for discharge from ED with advice and GP follow-up. Management of underlying cause (hydration, medication review) is recommended.

5.0 Referral to Neurology — First Fit Clinic

Referral should be considered if features suggest epileptic seizure: lateral tongue biting, head-turning during the event, prolonged rhythmic limb-jerking, complete amnesia, postictal confusion or prolonged drowsiness, or déjà vu / jamais vu aura. If there are ongoing concerns (e.g. the

patient has not returned to baseline or has had repeated episodes), inpatient assessment under the medical team may be warranted prior to discharge.

6.0 Orthostatic Hypotension

Diagnose via lying and standing blood pressure (measurements after standing for at least 1 minute, and again at 3 minutes where possible). A drop of ≥ 20 mmHg systolic or ≥ 10 mmHg diastolic at any point supports the diagnosis.

If confirmed: treat volume depletion, review and adjust hypotensive medications, and in patients with hypertension and symptomatic postural drop, titrate treatment to standing BP in line with NICE NG136. Consider Addison's disease if postural hypotension is accompanied by features such as hyperpigmentation, weight loss, fatigue, hyponatraemia, or known autoimmune disease.

7.0 Discharge, Advice, Driving, and Follow-Up

Discharge and Follow-Up — Quick Visual Guide (Sections 7–8)

After ABC stabilisation + history/exam + ECG, apply RAG risk stratification	
RED (high risk)	- Consider admission under medical team - Continuous monitoring and inpatient work-up - Inpatient cardiology input should be considered
AMBER (intermediate risk)	- ED senior review is advised before discharge. If ongoing concerns, consider referral to medics - Outpatient cardiology clinic may be appropriate if suspected cardiac syncope (alternative causes excluded: vasovagal, orthostatic, situational) - Consider echo if history of MI, murmur suggestive of heart disease, FHx of cardiomyopathy or congenital heart disease - Ambulatory ECG may be indicated if suspected paroxysmal arrhythmia or intermittent heart block
GREEN (low risk)	- May be suitable for discharge from ED/AMU if criteria met - GP follow-up where relevant (esp. postural BP/medication review)
For anyone discharged: - Advise on hydration, trigger avoidance, slow postural change - Consider providing written safety-net: return for recurrence, exertional syncope, chest pain, breathlessness, injury - Encourage event documentation (diary/smartphone video where appropriate) - Driving advice: no driving until medically assessed; signpost DVLA 'Assessing Fitness to Drive'	

Figure 2. Discharge and follow-up summary.

Discharge criteria:

Patients may be discharged if presentation meets Green (low-risk) criteria, ECG and examination are normal, no high-risk markers are present (if Amber, ED senior review should be completed), and there is full return to baseline.

Patient advice:

- Reflex syncope: maintain hydration, avoid triggers, recognise prodrome.
- Orthostatic hypotension: slow postural change, hydration, medication review with GP.
- Uncertain diagnosis: safety-net regarding recurrence, exertional symptoms, chest pain, breathlessness, or injury.
- Encourage documentation of future events (diary or smartphone video).
- Advise that driving may be restricted after TLoC and will be guided by DVLA rules.

Driving:

Anyone with unexplained loss of consciousness should not drive until medically assessed. Clinicians and patients should refer to DVLA "Assessing Fitness to Drive" guidance. Document advice given, including any requirement to inform DVLA. Advise occupational health review for safety-critical roles.

Follow-up

- High risk: immediate cardiology involvement / inpatient work-up.
- Intermediate risk: ED senior review; outpatient cardiology if cardiac syncope suspected.
- Low risk: GP review (including BP review for orthostatic hypotension where relevant).

- Suspected epilepsy: neurology within two weeks.
- Written follow-up instructions should be provided on discharge.

8.0 Governance

This guideline aligns with NICE CG109 (TLoC), NICE NG136 (Hypertension in adults), ESC 2018 Syncope Guidelines, NICE CKS Syncope, and Frimley Health pathways. It supports consistent implementation across ED, AMU, and SDEC.

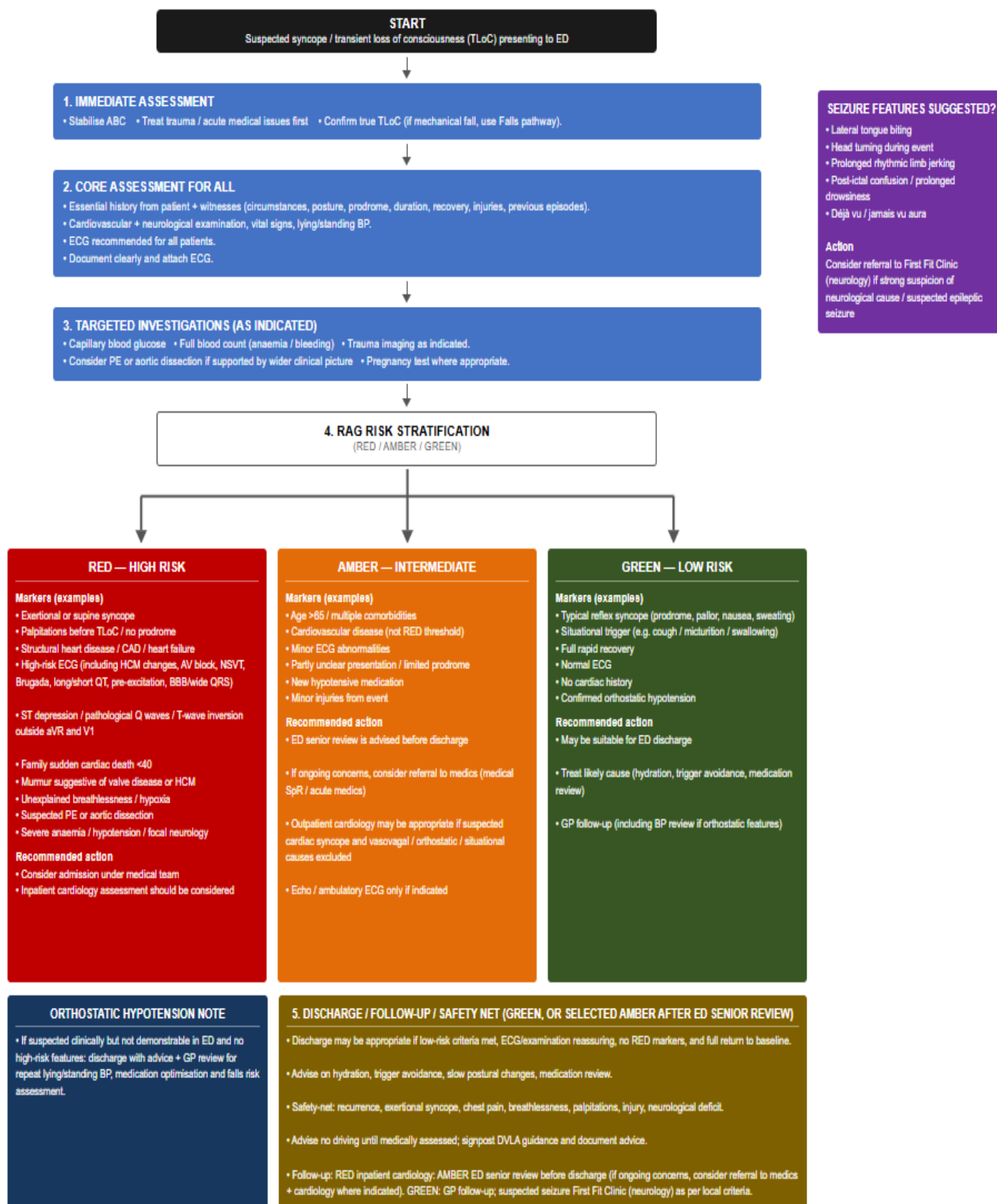
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Appendix — Syncope / TLoC ED Flow Diagram Quick-reference pathway (RAG risk stratification and key actions) for ease of use in *clinical practice*.

Appendix: Syncope / TLoC ED Flow Diagram

Rapid-use pathway for ED / AMU / SDEC



Use alongside the full Primley syncope/TLoC clinical guideline (appendix quick reference only; not a substitute for senior clinical judgement).

Full version control record

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Contributor(s):	Doctor Lydia Sturridge, Doctor Sitara Khan, Doctor Amna Azad
Lead Director / Chief of Service:	Doctor Christopher Orchard
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This guideline has been registered with the Trust. However, clinical guidelines are guidelines only. The interpretation and application of clinical guidelines will remain the responsibility of the individual clinician. If in doubt, contact a senior colleague or expert. Caution is advised when using guidelines after the review date.

This guideline is for use in Frimley Health NHS Foundation Trust hospitals only. Any use outside this location will not be supported by the Trust and will be at the risk of the individual using it.

Version History

Version	Date	Guideline Lead(s)	Status	Comment
1	28 th March 2026	Dr Ryan Wilson	Final	For Frimley Park use only Ratified at: Frimley Park Hospital Emergency Department Clinical Governance – 19th March 2026 X-Site Acute Medicine Clinical Governance – 26th March 2026 Cardiology Clinical Governance 28 th April 2026
1.1	16 th July 2026	Dr Ryan Wilson	Interim	As above, with confirmation of change from Dr Sitara Khan - the word 'seated' has been added into the risk stratification model under the red category

Related Documents

Document Type	Document Name
None	