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Syncope guidelines jacc

2017 ACC/AHA/HRS Guideline for Evaluating and Managing Patients with Syncope: Summary: A Report from the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines and Heart Rhythm Society. Writing committee members, Shen WK, Sheldon RS, Benditt DG, Cohen MI, Forman DE, Goldberger ZD, Grubb BP, Hamdan MH, Krahn AD, Link MS, Olshansky B, Raj SR, Sandhu RK, Sorajja D, Sun BC, Yancy CW. Writing Committee members, et al. Heart rhythm. 2017 Aug;14(8):e218-e254. doi: 10.1016/j.hrthm.2017.03.005. Epub 2017 Mar 9. Heartbeat. 2017. PMID: 28286246 No abstract available. 09 March 2017 | Thomas C. Crawford, MD, FACC Authors: Shen WK, Sheldon RS, Benditt DG, et al. Citation: 2017 ACC/AHA/HRS Guideline for Evaluating and Managing Patients with Syncope: A Report from the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines and Heart Rhythm Society. J Am Coll Cardiol 2017; March 9:[Epub before printing]. The following are key points to remember from the ACC/AHA/HRS guideline for evaluating and handling patients with syncope in 2017: A detailed history and physical examination should be performed in patients with syncope (Class I). In the initial evaluation of patients with syncope, a resting 12-lead electrocardiogram (ECG) is useful (Class I). It is recommended to evaluate the cause and assessment of the short- and long-term risk of syncope (Class I). Hospital evaluation and treatment is recommended for patients presenting with syncope who have a serious medical condition potentially relevant to the cause of syncope identified during initial evaluation (Class I). Routine and extensive laboratory tests are not useful in evaluating patients with syncope (Class III: No benefit). Routine heart scanning is not useful in evaluating patients with syncope unless cardiac etiology is suspected based on an initial evaluation, including history, physical examination or ECG (Class III: No Benefit). Carotid artery imaging is not recommended for routine evaluation of patients with syncope in the absence of focal neurological findings that support further evaluation (Class III: No Benefit). Vasovagal syncope is the most common cause of syncope. The effectiveness of medical treatment is modest. Patient training on diagnosis and prognosis is recommended (Class I). Double-chamber pacing may be reasonable in a selected population of patients over 40 years of age with recurrent plumbing and prolonged spontaneous breaks (Class IIb). Beta blockers are not beneficial in paediatric patients with plumbing (Class III: No benefit). Syncope suspected of orthostatic hypotension (OH) can be mediated by neurogenic conditions, dehydration, or drugs. Fluid resuscitation in acute water intake or intravenous infusion is recommended for temporarily patients with neurogenic OH or dehydration (Class I). Reducing or withdrawing medications that may cause hypotension may be beneficial in selected patients with syncope (Class IIa). In patients with syncope associated with bradycardia, tachycardia or the presence of structural heart disease, current guideline treatment and treatment (GDMT) (Class I) is recommended. Implantable cardioverter-defibrillator (ICD) implantation is not recommended in patients with Brugada ECG pattern and reflex-mediated syncope in the absence of other risk factors (Class III: No benefit). Beta-blocker treatment, in the absence of contraindications, is indicated as a first-line treatment in patients with long QT syndrome (LQTS) and suspected arrhythmic syncope (Class I). ICD implantation is reasonable in patients with LQTS and suspected arrhythmic syncope in beta-blocker therapy or intolerant to beta-blocker therapy (Class IIa). Exercise restriction is recommended for patients with catechism polymorphic ventricular tachycardia (CPVT) presenting with syncope suspected of an arrhythmic etiology (Class I). Beta blockers lacking inherent sympathomimetic activity are recommended for patients with CPVT and stress-induced syncope (Class I). Electrophysiological examination is reasonable in selected patients with syncope suspected of arrhythmic etiology (Class IIa). Cardiovascular assessment of a practitioner experienced in the treatment of athletes with syncope is recommended before resuming competitive sport (Class I). Participation in competitive sports is not recommended for athletes with syncope and phenotype-positive hypertrophic cardiomyopathy, CPVT, LQTS1 or arrhythm right ventricular cardiomyopathy prior to evaluation by a specialist (Class III: Harm). Clinical topics: Arrhythmias and clinical EP, congenital heart disease and paediatric cardiology, geriatric cardiology, heart failure and cardiomyopathies, noninvasive imaging, sports and exercise cardiology, valvular heart disease, implantable devices, genetic arrhythmic conditions, SCD/Ventricular arrhythmia, Atrial Fibrillation/ Supraventricular Arrhythmias, Congenital Heart Disease, CHD and paediatric and arrhythmias, CHD and paediatric and imaging, CHD and paediatric and prevention, CHD and paediatric and quality improvement, sport and exercise and congenital heart disease and pediatric cardiology, sports and exercise and ECG and stress testing, sports and exercise and imaging Keywords: Adenergic betac-Antagonists, arrhythmias, cardiac, athletes,

Atrial Fibrillation, Bradycardia, Brugada Syndrome, Heart Electrophysiology, Cardiomyopathy, Hypertrophic, Defibrillators, Implantable, Electrophysiology Techniques, Cardiovascular, Electrocardiography, Electrophysiology, Hypotension, Hypotension, Orthostatic, Long QT Syndrome, Syncoping, Syncing, Vasovagal, Heart Defects, Congenital, Autonomic Nerve System Kanalopathis, Diagnostic Imaging, Exercise Test, Genetic Diseases, Congenital, Geriatrics, Heart Valve Disease, Pediatrics, Pharmacology, Postural Orthostatic Taxis Syndrome, Practice Guideline, Risk Assessment, Risk Factors, Taculticular, Supraventricular, Taxis, Ventricular, Tilt-Table Test < Back to Lists Nov 04, 2019 | Debabrata Mukherjee, MD, FACC Authors: Goldberger ZD, Petek BJ, Brignole Moller, et al. Quote: ACC/AHA/HRS Versus ESC Guidelines for Diagnosis and Management of Synkope: JACC Guideline Comparison. J Am Coll Cardiol 2019;74:2410-2423. The following are important points to remember from this guideline comparison of the American College of Cardiology/American Heart Association/Heart Rhythm Society (ACC/AHA/HRS) and European Society of Cardiology (ESC) guidelines for the diagnosis and management of Syncope: Syncope is a common clinical unit with variable presentations, and often an elusive causal mechanism, even after extensive evaluation. This review highlights both congruencies and differences between the latest syncope guidelines (2017 ACC/AHA/HRS vs. 2018 ESC). There were important differences noted in recommendations for patients with conductive disease, reflex syncope, and orthostatic hypotension. However, many of the treatment recommendations were roughly the same. A notable disagreement between the two guidelines on wiring system disease is the presence of discrete recommendations in the European guidelines and the lack of specific recommendations in the US guidelines. Rather, the U.S. guidelines offer a Class I, Level of Evidence (LOE) C-EO recommendation for guideline-directed medical treatment for syncope due to bradycardia. The European guidelines, on the other hand, contain several recommendations for the pace of the conductive system disease, and although the European guidelines are slightly less supportive of empiric pacing in patients with syncope and bifascicular block (Class IIb), they offer a Class I recommendation for pacing with electrophysiological examination (EPS) guided therapy. The European Guidelines also contain several specific recommendations for EPS and contain four specific recommendations for EPS indications and EPS-led treatment. The European guidelines favor EPS in patients with an ischemic substrate (Class I), syncope with bifascicular block (Class IIa), or syncope accompanied by sinus bradycardia or palpitations (Class IIb) when syncope remains unexplained after noninvasive evaluation. In contrast, EPC is treated more broadly in the US guidelines. A striking disagreement between the two syncope guidelines are the recommendations for beta-blockers in the treatment of reflex syncope. The European Guidelines assign a Class III recommendation stating that there is no evidence of beta-blockers in On the other hand, the US guidelines state that beta blockers may be reasonable in ≥42 years (Class IIb, LOE B-R). Another difference is that the European guidelines provide Class IIb recommendations for pacing in patients >40 years of age with tilt-induced asystolic response and frequent unpredictable recurrent syncope, and in patients with clinical features of adenosine-sensitive syncope, without directly parallel U.S. recommendations. The European guidelines recommend patient education and safety for orthostatic hypotension, and the U.S. guidelines recommend acute water intake for neurogenic orthostatic hypotension. This difference may be partly related to how neurogenic orthostatic hypotension is defined. Both guidelines identify the need for studies to understand the underlying causes of syncope, and both address the need for improved diagnostic devices, preferably both portable and multiparametric. Even in an era of evidence-based medicine, practitioners will have slightly different interpretations and opinions about similar data. Note that despite important discord, the two most recent syncope readings complement each other. Randomised trials and further translational studies are needed to reinforce recommendations that are currently supported only with minimal evidence and in areas where there is a discrepancy between the guidelines. Clinical topics: Arrhythmias and clinical EP, noninvasive Imaging, Vascular Medicine, Implantable Devices, SCD/Ventricular Arrhythmias, Atrial Fibrillation/Supraventricular Arytmis Keywords: Adenosine, Arrhythmia, Heart, Bradycardia, Diagnostic Imaging, Electrophysiology, Evidence-Based Medicine, Hypotension, Orthostatic, Myocardiaemia, Reflex, Syncopic, Synopsis, Vasgalova & Lt; Back to Listings Listings Listings

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