Episode 12

This week's episode of the CPSers, guest Dr. Stephanie Sherman discusses her approach to syncope.

Problem Representation
A 58-year-old man with a history of non-ischemic cardiomyopathy & hypertension presented after an acute episode of unheralded syncope and was found to have arrhythmias on ECG and telemetry.

Schemas
Dr. Sherman's schema divides the causes of syncope into three broad categories - neurocardiogenic/reflex, orthostasis, and cardiac syncope.

Diagnosis
ECG and telemetry demonstrated slow atrial fibrillation with prolonged pauses as well as non-sustained VT, suggesting cardiac syncope. He was recommended to undergo implantation of a cardioverter-defibrillator.

Teaching points

- Syncope is a syndrome of global cerebral hypoperfusion that leads to a transient loss of consciousness.
- A number of conditions can mimic syncope - including seizures, brainstem stroke, hypoglycemia, and conditions that make people unexpectedly fall to the ground (falls, drop attacks, cataplexy).
- Distinguishing between seizures and syncope can be difficult. Jerking movements occur in both seizure and syncope. In contrast, tongue biting is specific but not sensitive for a preceding seizure.

Clinical Reasoning Pearl

Dr. Sherman highlights the importance of the directed patient history.

Constructing the history is an active exercise, focusing on symptom-specific details that can be translated into "semantic qualifiers" in our problem representations. These help us navigate down the different branches of our schemas.

For example:
Carefully exploring the moments prior to the syncopal event helps distinguish between "heralded" and "unheralded" syncope - a useful diagnostic branch point.

References