Cardiovascular:
Syncope and Presyncope

Goals: Stabilization and resuscitation, when necessary; initiation of monitoring and diagnostic procedures; transfer for further evaluation
Inclusion Criteria: Patients of all ages with confirmed or suspected sudden loss of consciousness and loss of postural tone(syncope) or prodromal syncope symptoms (presyncope or pre-arrest)
Exclusion Criteria: Trauma (refer to Trauma and Head Injury CPGs); Coma (refer to AMS CPG)
Refer to: Altered Mental Status (AMS), Bradycardia, Cardiac Arrest, Chest Pain, Diabetic Emergencies, OB-Gyn, Shock, Seizure, Stroke, Tachycardia-Stable, Tachycardia-Unstable, and other, symptom-specific CPGs

NOTES:
- Syncope is heralded by both abrupt loss of consciousness AND loss of postural tone.
- It resolves spontaneously without medical intervention - EMS Providers may find the patient awake and alert.
- Presyncope consists of prodromal syncope symptoms, lasting seconds to minutes; it may be described by the patient as “nearly blacking out” or “nearly fainting”.

Basic Level

1. Assess and support ABCs according to UNIVERSAL CARE – ADULT or UNIVERSAL CARE – PEDIATRIC, as clinically indicated:
    a. A (Airway): Ensure airway patency, with positioning, suctioning and OPA or NPA, as needed
    b. B (Breathing): Provide supplemental oxygen to maintain SpO_2 of at least 94% (continuous monitoring)
    c. C (Circulation): Evaluate, document and treat signs/symptoms of shock according to the Shock CPG; initiate continuous ECG monitoring
        i. Orthostatic vital signs are generally not necessary and may be dangerous
    d. D (Disability): Assess and document GCS; assess pupillary size and reactivity; refer to the Altered Mental Status CPG
    e. E (Exposure/Environmental): Consider trauma (especially in the elderly); treat per the Trauma CPG
2. Positioning:
    a. If trauma is not suspected, position the patient supine or in the left lateral decubitus position, facing EMS Providers, in order to monitor and manage the airway
    b. If trauma is suspected, refer to the Spinal Motion Restriction Policy and Trauma CPG
3. Perform and document a POC Glucose analysis and treat according to the Diabetic Emergencies CPG
4. Perform and document results of initial evaluation and screening according to the Stroke CPG
5. Obtain SAMPLE history from patient/bystanders, with attention to cardiovascular and neurologic illness/injury:
    a. NOTE: Consider ruptured ectopic pregnancy in any woman of childbearing age with syncope, lightheadedness or fainting (refer to the OB-Gyn CPG)
    b. NOTE: Obtain a complete medication/drug history and signs/symptoms leading up to the event:
        i. Example: Syncope that occurs during exercise suggests an ominous cardiac cause
        ii. Example: Obtain history of fluid losses (vomiting, diarrhea, blood loss) and fluid intake
6. Once advanced level care arrives on scene, give report and transfer care

Advanced Level

7. Maintain continuous SpO_2 and ECG monitoring until patient care has been transferred to hospital staff
8. Initiate continuous $PetCO_2$ monitoring if signs/symptoms of shock, hypoperfusion or respiratory distress
9. Obtain and transmit a 12-Lead ECG, preferably before initiating transport
10. Treat hemodynamically significant dysrhythmias according to the relevant CPG:
    a. Examples: Bradycardia CPG, Tachycardia-Stable CPG, or Tachycardia-Unstable CPG
11. Treat chest pain/discomfort or anginal equivalents according to the Chest Pain CPG
12. Establish IV/IO access at TKO rate or with a saline lock:
    a. Treat shock/hypotension with fluid resuscitation according to the Shock CPG
13. All patients with syncope shall be encouraged to accept ambulance transport to a hospital E.D. for evaluation
14. For additional patient care considerations not covered under standing orders, consult BioTel