



Evening Medical Update: Blackout/Collapse **Tuesday 28 April 2020**

Assessment of Syncope in the Elderly – Dr Jane Rimer

The use of two alpha blockers (Dox and Tamsulosin) is a curious one in your first case. Were they started for two different conditions? Was it an oversight by a doctor?

We frequently encounter elderly patients on multiple medications which can contribute to postural hypotension. The scenario was taken from a real patient example, with prescriptions for two different conditions – and highlights all too common prescribing practises which can be suboptimal. This underlines the importance of reviewing all medications and their indication during every clinical encounter.

What is the role of the tilt-table test in the investigation of syncope? It seems this mode of investigation lately is on the decline.

I agree this mode of investigation is being used less often – but can be helpful, in a select patient group. It is labour intensive and required patient co-operation, which in the frail elderly can be a limiting factor. Generally, it can help to differentiate syncope subtypes, particularly in repeated unexplained syncope where reflex syncope is suspected. It can also be helpful to diagnose carotid sinus syndrome.

Many elderly patients are coming to A&E with syncope and they get blanket blood testing, including troponins. What are your thoughts on this?

I think it is helpful to have a routine blood profile to exclude anaemia / AKI etc. Troponin measurement, however, should be reserved if there is clinical suspicion of myocardial ischaemia, PE etc. It should be used to help support clinical decision making but not as a blanket test.

Are there any exercises to recommend for postural hypotension? What is the starting dose of fludrocortisone and how to up titrate the dose?

If I use this in the elderly, I would start a low dose – 50 micrograms – and titrate up according to effect. In practice, I would likely bring the patient back for review after a few weeks to assess baseline BP, repeat E&S BP, check renal function and assess for fluid retention. Generally, the aim is to reduce symptomatic postural hypotension at the lowest tolerated dose.

With orthostatic hypotension – should standing BP be checked 30 seconds after standing or three minutes?

Check BP when lying down (if possible) for 5 minutes, then immediately on standing, 30 seconds, 1 minute, 2 minutes, and 3 minutes – essentially looking for delayed orthostatic hypotension.