TABLE 27-2 CAUSES OF SYNCOPE

A. Neurally Mediated Syncope

- Vasovagal syncope
  - Provoked fear, pain, anxiety, intense emotion, sight of blood, unpleasant sights and odors, orthostatic stress
- Situational reflex syncope
  - Pulmonary
    - Cough syncope, wind instrument player's syncope, weightlifter's syncope, "mess trick"[a] and "fainting lark,"[b] sneeze syncope, airway instrumentation
  - Urogenital
    - Postmicturition syncope, urogenital tract instrumentation, prostatic massage
  - Gastrointestinal
    - Swallow syncope, glossopharyngeal neuralgia, esophageal stimulation, gastrointestinal tract instrumentation, rectal examination, defecation syncope
  - Cardiac
    - Bezold-Jarisch reflex, cardiac outflow obstruction
  - Carotid sinus
    - Carotid sinus sensitivity, carotid sinus massage
  - Ocular
    - Ocular pressure, ocular examination, ocular surgery

B. Orthostatic Hypotension

- Primary autonomic failure due to idiopathic central and peripheral neurodegenerative diseases—the "synucleinopathies"
  - Lewy body diseases
    - Parkinson's disease
    - Lewy body dementia
    - Pure autonomic failure
  - Multiple system atrophy (the Shy-Drager syndrome)
- Secondary autonomic failure due to autonomic peripheral neuropathies
  - Diabetes
  - Hereditary amyloidosis (familial amyloid polyneuropathy)
  - Primary amyloidosis (AL amyloidosis; immunoglobulin light chain associated)
  - Hereditary sensory and autonomic neuropathies (HSAN) (especially type III—familial dysautonomia)
  - Idiopathic immune-mediated autonomic neuropathy
  - Autoimmune autonomic ganglionopathy
  - Sjögren's syndrome
  - Paraneoplastic autonomic neuropathy
  - HIV neuropathy
- Postprandial hypotension
- Iatrogenic (drug-induced)
- Volume depletion

C. Cardiac Syncope

- Arrhythmias
  - Sinus node dysfunction
  - Atrioventricular dysfunction
  - Supraventricular tachycardias
  - Ventricular tachycardias
  - Inherited channelopathies
- Cardiac structural disease
  - Valvular disease
  - Myocardial ischemia
  - Obstructive and other cardiomyopathies
  - Atrial myxoma
  - Pericardial effusions and tamponade

[a]Hyperventilation for ~1 minute, followed by sudden chest compression. [b]Hyperventilation (~20 breaths) in a squatting position, rapid rise to standing, then Valsalva.

to increased vagal outflow; and mixed syncope describes syncope in which there are both vagal and sympathetic reflex changes.

Features of Neurally Mediated Syncope In addition to symptoms of orthostatic intolerance such as dizziness, lightheadedness, and fatigue, premonitory features of autonomic activation may be present in patients with neurally mediated syncope. These include diaphoresis, pallor, palpitations, nausea, hyperventilation, and yawning. During the syncopal event, proximal and distal myoclonus (typically arrhythmic and multifocal) may occur, raising the possibility of epilepsy. The eyes typically remain open and usually deviate upward. Pupils are usually dilated. Roving eye movements may occur. Grunting, moaning, snorting, and stertorous breathing may be present. Urinary incontinence may occur. Fecal incontinence is very rare. Postictal confusion is also rare, although visual and auditory hallucinations and near death and out-of-body experiences are sometimes reported.

Although some predisposing factors and provocative stimuli are well established (for example, motionless upright posture, warm ambient temperature, intravascular volume depletion, alcohol ingestion, hypoxemia, anemia, pain, the sight of blood, venipuncture, and intense emotion), the underlying basis for the widely different thresholds for syncope among individuals exposed to the same provocative stimulus is not known. A genetic basis for neurally mediated syncope may exist; several studies have reported an increased incidence of syncope in first-degree relatives of fainters, but no gene or genetic marker has been identified, and environmental, social, and cultural factors have not been excluded by these studies.

TREATMENT NEURALLY MEDIATED SYNCOPE

Reassurance, avoidance of provocative stimuli, and plasma volume expansion with fluid and salt are the cornerstones of the management of neurally mediated syncope. Isometric counterpressure maneuvers of the limbs (leg crossing or handgrip and arm tensing) may raise blood pressure by increasing central blood volume and cardiac output. By maintaining pressure in the autoregulatory zone, these maneuvers avoid or delay the onset of syncope. Randomized controlled trials support this intervention.

Fludrocortisone, vasoconstricting agents, and beta-adrenoreceptor antagonists are widely used by experts to treat refractory patients, although there is no consistent evidence from randomized controlled trials for any pharmacotherapy to treat neurally mediated syncope. Because vasodilation is the dominant pathophysiologic syncopal mechanism in most patients, use of a cardiac pacemaker is rarely beneficial. Possible exceptions are older patients (>40 years) in whom syncope is associated with asystole or severe bradycardia and patients with prominent cardioinhibition due to carotid sinus syndrome. In these patients, dual-chamber pacing may be helpful.

ORTHOSTATIC HYPOTENSION

Orthostatic hypotension, defined as a reduction in systolic blood pressure of at least 20 mmHg or diastolic blood pressure of at least 10 mmHg within 3 min of standing or head-up tilt on a tilt table, is a manifestation of sympathetic vasoconstrictor (autonomic) failure (Fig. 27-4). In many (but not all) cases, there is no compensatory increase in heart rate despite hypotension; with partial autonomic failure, heart rate may increase to some degree but is insufficient to maintain cardiac output. A variant of orthostatic hypotension is "delayed" orthostatic hypotension, which occurs beyond 3 min of standing; this may reflect a mild or early form of sympathetic adrenergic dysfunction. In some cases, orthostatic hypotension occurs within 15 s of standing (so-called "initial" orthostatic hypotension), a finding that may reflect a transient mismatch between cardiac output and peripheral vascular resistance and does not represent autonomic failure.

Characteristic symptoms of orthostatic hypotension include lightheadedness, dizziness, and presyncope (near-faintness) occurring in response to sudden postural change. However, symptoms may be