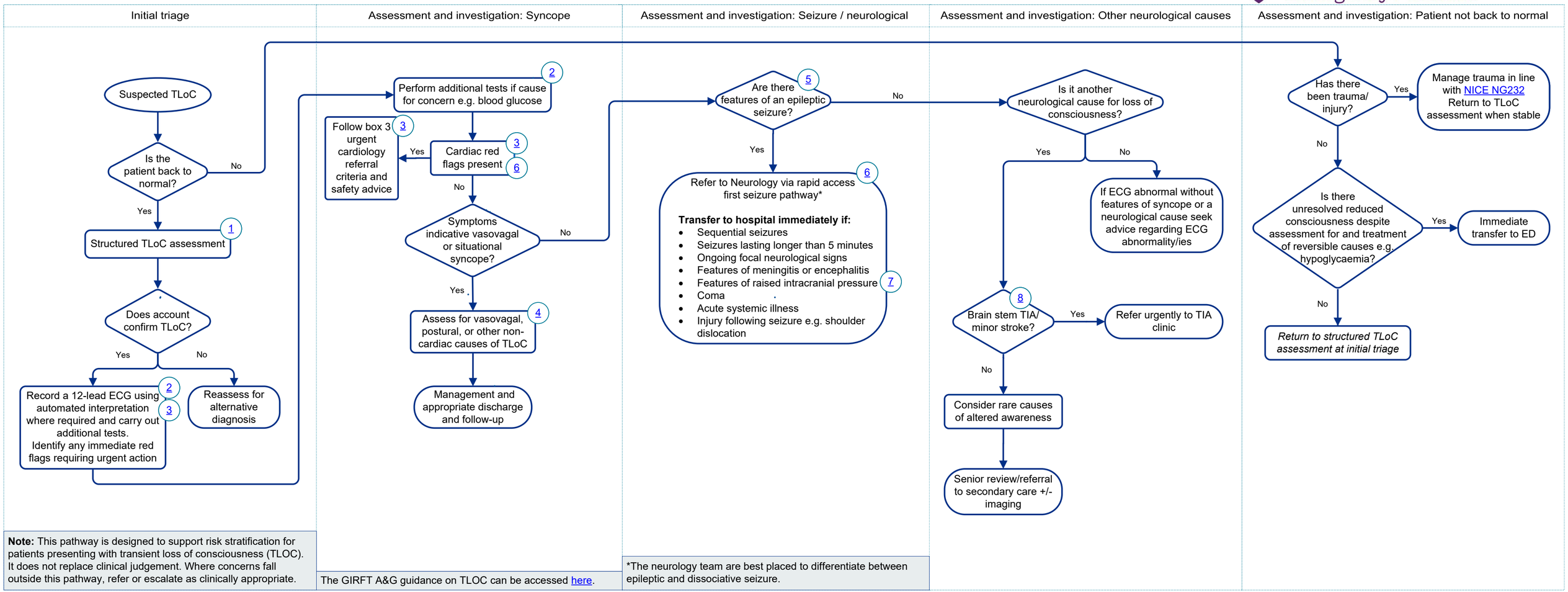
Transient loss of consciousness (16+)

Cardiology and Neurology, August 2026

See page two for further information



Note: This pathway is designed to support risk stratification for patients presenting with transient loss of consciousness (TLOC). It does not replace clinical judgement. Where concerns fall outside this pathway, refer or escalate as clinically appropriate.

The GIRFT A&G guidance on TLOC can be accessed here.

*The neurology team are best placed to differentiate between epileptic and dissociative seizure.

Back to page one

1 **Ask the person who experienced TLoC and any witnesses to describe what happened before, during and after event.**

Record details about:
- Circumstances of the event including potential precipitants e.g. pain
- Posture immediately prior to loss of consciousness
- Prodrome symptoms (e.g. sweating or feeling warm/hot before TLoC, nausea)
- Appearance (e.g. whether eyes were open or shut) and colour of the person during the event
- Presence or absence of movement during the event (e.g. limb-jerking) and its duration
- Any tongue-biting (record whether the side or the tip of the tongue was bitten)
- Injury occurring during the event (record site and severity)
- Duration of unconsciousness
- Weakness down one side during the recovery period
- Confusion during recovery, focal weakness, brain stem symptoms (diplopia, ataxia, dysarthria)
- In older adults due to confounding variables (cognitive or gait impairments) differentiating between falls and syncope can be challenging. Consider recurrent syncope as a cause of recurrent falls

Examination and investigations
- Cardiac examination, ECG, and routine bloods are typically normal

2 **Assess and record in line with NICE CG109: Transient loss of consciousness ('blackouts') in over 16s:**
- Details of any previous TLoC (including number and frequency)
- The person's medical history and any family history of cardiac disease (for example, personal history of heart disease and family history of sudden cardiac death)
- Current medication that may have contributed to TLoC (e.g. insulin, hypoglycaemic agents or antiarrhythmic drugs)
- Vital signs (for example, pulse rate, respiratory rate and temperature) - repeat if clinically indicated
- Lying and standing blood pressure if clinically appropriate
- Other cardiovascular and neurological signs

12 lead ECG
Record a 12-lead ECG using automated interpretation where required. 12-lead ECG - treat as a red flag if any of the following abnormalities are reported on the ECG printout, **unless such abnormalities are known to pre-exist and have already been assessed:**
- Conduction abnormality (for example, complete right or left bundle branch block or any degree of heart block)
- Evidence of a long or short QT interval
- Any ST segment or T wave abnormalities

If a 12-lead ECG with automated interpretation is not available, take a manual 12-lead ECG reading and have this reviewed by a healthcare professional trained and competent in identifying the following abnormalities:

- Inappropriate persistent bradycardia
- Any ventricular arrhythmia (including ventricular ectopic beats)
- Possible long QT (QTc >450 ms) and short QT (corrected QT <350 ms) intervals
- Brugada syndrome
- Ventricular pre-excitation (part of Wolff-Parkinson-White syndrome)
- Left or right ventricular hypertrophy
- Abnormal T wave inversion
- Pathological Q waves
- Atrial arrhythmia (sustained)
- Paced rhythm

Additional tests:
Relevant examinations and investigations (for example, check blood glucose levels if diabetic hypoglycaemia is suspected, or haemoglobin levels if anaemia or bleeding is suspected)
Do not routinely use electroencephalogram (EEG) in the investigation of TLoC

3 **Cardiac red flags**

If patient presents with any of the following, refer via ED, SDEC, rapid access or TLoC service according to local arrangements and level of clinical concern:

- ECG abnormality (see box 2) and history indicative of cardiac syncope
- Heart disease e.g. angina or failure (history or physical signs)
- TLoC during exertion
- Family history of sudden cardiac death under 40 years and/or inherited cardiac condition
- New or unexplained breathlessness
- Heart murmur

Note: Anyone aged older than 65 years who has experienced TLoC without prodromal symptoms should be referred to cardiology via single point of access, where available, or A&G. Consider referral to Falls Team

Urgent transfer to hospital if:
- Current concerning disturbance of heart rhythm e.g. major sinus bradycardia, second or third degree heart block, complete heart block, on-going tachyarrhythmia, decompensated heart failure, clinical features of severe aortic stenosis, chest pain, major QT prolongation

Interim safety advice:
- Advise people waiting for specialist cardiovascular assessment what they should do if they have another event. If appropriate, how they should modify their activity (for example, by avoiding physical exertion). Consider driving implications, clinician to refer to DVLA guidance before counselling patient about driving

4 **Are there features of:**

Vasovagal / situational syncope:
Are features suggestive of uncomplicated faint (the 3 'P's) such as:
- Posture – prolonged standing, or similar episodes that have been prevented by lying down
- Provoking factors (e.g. pain or a medical procedure, micturition, cough, swallowing)
- Prodromal symptoms (e.g. sweating or feeling warm/hot before TLoC, nausea)

Management:
- Hydration
- Lie down/elevate legs
- Review medications
- Treat underlying cause

Or

Postural hypotension syndromes (including POTS). Typical symptoms include feeling faint or fainting and/or rapid palpitations on standing

RCP Measurement of lying and standing blood pressure

Use stand test to assess for POTS
Tilt-table testing is not required to make a diagnosis
Cardiac exam, ECG, and routine bloods are typically normal

Management:
- Review medications
- Offer lifestyle advice
- Consider possibility of systemic autonomic dysfunction
- Does not normally require specialist assessment

Or

Syncope induced by head turning – consider carotid sinus hypersensitivity
Consider referral to cardiology or TLoC service

5 Following a seizure and recovery of consciousness neurological examination is usually normal

Features of:
- Tongue biting (especially lateral)
- Prolonged jerking duration >30 seconds
- Prolonged postictal confusion (> 5 mins)
- Prodromal déjà vu or jamais vu
- Recurrent vacant or blank spells

6 **Offer advice to patients waiting for cardiological / neurological assessment:**
- **Do not drive (see DVLA guidance):** Assessing fitness to drive: a guide for medical professionals - GOV.UK)
- Do not operate heavy machinery
- Avoid high risk heights
- Do not participate in extreme sports
- Shower rather than bathe
- Do not swim unaccompanied
- Consider advising patient to obtain video recording of episode prior to appointment

7 **Features include:**
- Papilloedema
- Raised pressure headaches
- Unsteadiness
- Imaging may include CT and/or MRI. Potential causes include colloid cyst of the fourth ventricle

8 **Symptoms include:**
- Dysarthria
- Double vision
- Focal weakness