

History and Physical Examination Elements for Neurocardiogenic Syncope

Category	Element	Notes
History	Detailed description of syncopal event(s)	Association with prolonged standing or increased adrenergic states (i.e., after exercise, marked pain or upset); brief loss of consciousness with rapid return and absence of injury may suggest neurocardiogenic syncope
History	Associated symptoms	Presyncopal lightheadedness, nausea, warmth, diaphoresis and blurred vision suggest neurocardiogenic syncope
History	Past medical history	Recurrent syncope throughout lifetime may suggest neurocardiogenic syncope
History	Medication history	Vasodilatory antihypertensive medications and preload reducing agents (i.e., diuretics, nitrates) decrease the intravascular volume, predisposing to orthostatic hypotension, and may increase the risk of neurocardiogenic syncope
History	Review of symptoms	Anorexia or poor oral intake of fluids may increase the risk of neurocardiogenic syncope
Physical exam	Vital signs (including supine and standing blood pressure and heart rate)	Bradycardia or tachycardia on physical exam may suggest a possible cause. Orthostatic changes reflecting intravascular volume depletion may predispose to neurocardiogenic syncope or may represent the sole cause of syncope. A pulsus paradoxus suggests pericardial tamponade as a likely cause
Physical exam	Cardiac exam	Systolic murmurs raise the question of valvular stenosis or hypertrophic cardiomyopathy. A diastolic murmur may suggest mitral stenosis. A parasternal lift may suggest pulmonary stenosis or pulmonary hypertension
Physical exam	Neurologic exam	New focal deficits (i.e., weakness, paralysis, dysarthria) may suggest a cerebrovascular accident as a rare possible cause
Physical exam	Carotid sinus massage	Should be considered in patients with unexplained syncope, particularly in patients age 60 or older, to determine susceptibility to carotid hypersensitivity. The incidence of an abnormal response was 46% in pooled data from five cohort studies of patients with syncope (1); however, an abnormal response does not exclude other causes of syncope because the positive predictive value of the maneuver has not been defined

Linzer M, Yang EH, Estes NA 3rd, Wang P, Vorperian VR, Kapoor WN. Diagnosing syncope. Part 1: Value of history, physical examination, and electrocardiography. Clinical Efficacy Assessment Project of the American College of Physicians. *Ann Intern Med.* 1997;126:989-96. (PMID: 9182479)