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SUBSCRIPTION DETAILS

235,279
Diagnostic accuracy and specialist consultation patterns upon transient loss of consciousness in primary health care

Sir,

Surveys both in the developed[1] and developing countries[2] suggest that patterns of referral, diagnosis and treatment of patients with transient loss of consciousness (LOC) in primary healthcare (PHC) are highly variable. We evaluated the present patterns of specialist consultation in the diagnostic LOC in PHC of an urban community in Finland.

In a two-year prospective study we examined 166 consecutive patients (77 male, 89 female, median age 55 years, range 17-91 years) with transient loss of consciousness, who were referred for consultation in the PHC specialist consultation service of neurology and an outpatient clinic of internal medicine in the City Hospital. Patients who already had a prior confirmed diagnosis for their symptoms were excluded. Before the beginning of the study, general practitioners (GP) (n=86) of the community health center were informed of its purposes and they were given written diagnostic criteria for syncope, seizure and transient ischemic attack. The physicians were advised to refer patients with suspected seizure to a neurologist and those with recurrent syncope to an internist. In all cases, the consultant took a detailed history and the patients underwent a physical examination. Ancillary tests, such as ECG, EEG and clinical chemistry analyses, were done at the discretion of the specialist. A diagnosis of a seizure required a history of repetitive tonic and/or clonic movements or automatisms and the diagnosis was supported by blue face, frothing at the mouth and disorientation or sleepiness after the event. Syncope was diagnosed when the patient had premonitory sweating or nausea, short duration of the attack and the subject was oriented after the event. A written informed consent was obtained from all patients and the study was approved by the research ethics committee of the Social and Health Services of the city. In almost half of the referrals (79/166, 48%), GPs were uncertain of the cause of the attack. In 37 (22%) of the cases they had suspected syncope and in 50 (30%) seizure. After the specialist evaluation syncope was diagnosed in 71 (43%) of 166 cases, seizure in 52 (31%) and in 18 (11%) cases the cause remained unknown. No loss/altered consciousness could be confirmed in 25 cases. The most common etiologies of syncope were vasovagal (28%), orthostatic (21%) and cardiogenic (18%) syncope. The ECG and EEG findings were mostly nonspecific including only two cases with epileptiform EEG changes (n=2/63 recordings) and one sick sinus syndrome revealed in 37 ambulatory ECG recordings. Most of the total patient population (138/166, 85%) and more than half of those with suspected syncope (20/37, 54%) were referred to
a neurologist. The referral diagnosis was correct in 38 (73%) patients with the final diagnosis of seizure but only in 31 (44%) patients with syncope.

In agreement with previous studies\[2,3\] we conclude that GPs need training in the diagnosis of syncope. Diagnostic difficulties in turn may lead to inappropriate referral to specialists. The identification and referral pattern of seizures in PHC seem to be well recognized.

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