Rapid access blackout clinics: a priority for the elderly

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"Old age starts with the first fall and death comes with the second."[1]

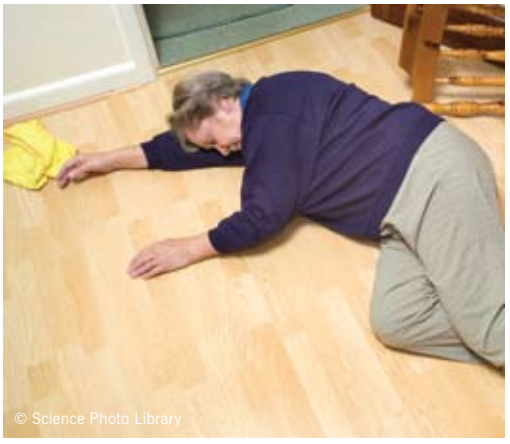
Syncopal events and falls are a major healthcare and cost burden for the National Health Service (NHS). Each year between 35% of community living adults over 65 years and 45% of adults over 80 years have such an event.[2] This common medical problem accounts for up to 6% of emergency medical admissions. We have previously shown the potential impact that a dedicated syncope and falls facility for older adults can have enabling an attributable diagnosis and on emergency bed usage.[3,4]

In this issue Ali *et al.* (see pages 22–8) further emphasise the need and benefits for the development of rapid access blackout clinics. They describe a comprehensive investigation pathway and highlight the importance of making a correct diagnosis and the implications of an incorrect one. It is still the case that a diagnosis is elusive in up to 40% of cases.[4,5]

They point out that even in those who do receive a diagnosis it may be incorrect. This is particularly so within the older age group. In relation to the diagnosis of 'epilepsy' the authors highlight that up to 100,000 people in the UK live with the moniker but without the condition. This has significant implications for public health including utilisation of inappropriate and expensive therapy.

Prognostic implications

There are profound prognostic implications for those suffering from syncope – Soteriades *et al.,* in their study, evaluated the incidence and prognosis of syncope in participants in the Framingham Heart Study.[5] They found the most frequently identified causes were vasovagal syncope, cardiac syncope and orthostatic hypotension: 36% still had no demonstrable cause. There was no increased risk of cardiovascular morbidity or mortality associated with vasovagal syncope, but persons in this study who fell into the diagnostic categories of cardiac syncope or syncope



of unknown cause, were at increased risk of death from any cause.

While respecting that blackouts can occur in all age categories, and accepting the clear bimodal age distribution, this area is particularly challenging in the elderly. Epidemiological data demonstrate an increasing prevalence of blackouts and falls with age. This, coupled with co-morbidities, dependency and dementia, as well as the observation that the incidence of injuries sustained in the fall increases dramatically with age,[6] make this a priority area in healthcare.

A public health priority

This public health priority has been captured by the Department of Health in the UK and incorporated into Standard 6 of the *National Service Framework for Older People*.[7] The development of rapid access blackout clinics is concordant with this standard.

The authors highlight and concur with the diagnostic approach suggested by the European Society of Cardiology and it is heartening to see that the fundamentals of clinical medicine – a good history and examination allied to judicious use of simple tests – remain the cornerstone of investigation.

A cautionary note needs to be struck when one considers patients with dementia. These are a

particularly frail group with an annual fall rate of 40–60%.[8] In addition, retrograde amnesia for loss of consciousness results in confusion between syncope and falls.[9] This adds to the complexity of the evaluation process and recourse to a strong, interested and focused multi-disciplinary team is invaluable in relation to optimising care. This multi-disciplinary team should be led by a cardiologist, neurologist or geriatrician, but most importantly by a motivated physician with a particular interest and specific training in the area.

The rapid access blackout clinic is a prudent, sensible and reasonable response to the increasing burden posed by loss of consciousness. It should certainly add value, diagnostic efficiency, improved patient outcome and cost-effectiveness to the patient journey

Conflict of interest

None declared.

Editors' note

The article on rapid access blackout clinics by Ali *et al*. can be found on pages 22–8 of this issue.

References

1. Garcia Marquez G. *Love in the time of cholera*. Penguin Books, 1994.

2. O'Shea D. Setting up a falls and syncope service for the elderly. *Clin Geriatr Med* 2002;**18**:269–78.

3. Kenny RA, O'Shea D, Walker HF. Impact of a dedicated syncope and falls facility for older adults on emergency beds. *Age Ageing* 2002;**31**:272–5.

4. Allcock LM, O'Shea D. Diagnostic yield and development of a neurocardiovascular investigation unit for older adults in a district hospital. *J Gerontol A Biol Sci Med Sci* 2000;**55**:M458–M462.

5. Soteriades ES, Evans JC, Larson MG *et al*. Incidence and prognosis of syncope. *N Engl J Med* 2002;**12**:878–85.

6. Kannus P, Parkkari J, Koskinnen S *et al*. Fall induced injuries and deaths amongst older adults. *JAMA* 1999;**281**:1895–9.

7. Department of Health. *National service framework for older people*. London: DoH, 2001.

8. Morris JC, Rubin EH, Morris EJ, Mandel SA. Senile dementia of the Alzheimer's type, an important risk factor for serious falls. *J Gerontol* 1987;**42**: 412–17.

9. McIntosh SJ, Lawson J, Kenny RA. Clinical characteristics of vasodepressor, cardioinhibitory and mixed carotid sinus syndrome in the elderly. *Am J Med* 1993;**95**:203–08.

Diary

2009

20th March:	ECG Pratical Workshop, London website: www.homerton.nhs.uk/gps/12234809154940.html
22nd–24th March:	2009 Annual Meeting and Cardiothoracic Forum of the Society for Cardiothoracic Surgery in Great Britian and Ireland, Bournemouth email: sctsadmin@scts.org website: www.scts.org
29th–31st March:	58th Annual Scientific Session of the American College of Cardiology, Orlando, USA website: www.acc.org
20th–22nd April:	Cardiology in the Young 2009, Great Ormond Street Hospital, London email: ash@ichevents.com website: www.ichevents.com
19th–22nd May:	EuroPCR 2009, Barcelona, Spain website: www.europcronline.com
1st–3rd June:	British Cardiovascular Society Annual Scientific Conference, Excel Exhibition Centre, London website: www.bcs.com
24th–26th June:	H.E.A.R.T UK 23rd Annual Conference 'THe Lipid Hypothesis on Trial', Liverpool Hope University website: www.heartuk.org.uk
29th August–2nd September:	European Society of Cardiology Congress 2009, (ESC) Barcelona, Spain website: www.escardio.org
27th September–1st October	EASD 2009 – 45th Annual Meeting of the European Association for the Study of Diabetes, Vienna, Austria website: www.easd.org
1st–3rd October:	12th Primary Care Cardiovascular Society Annual Scientific Meeting, Nottingham website: www.pccs.org.uk
7th–10th October:	2009 Cardiometabolic Health Congress Boston, USA email: jl@cardiometabolichealth.org website: www.cardiometabolichealth.org
14th–18th November:	Scientific Sessions 2009 of the American Heart Association, Orlando, USA website: www.americanheart.org