

Vertigo and Transient Loss of Consciousness

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Description

I read with interest the article by Reuber et al. on the use of a comprehensive questionnaire to aid differentiation of epileptic seizures, syncope, and psychogenic nonepileptic seizures (PNES) in patients presenting with transient loss of consciousness (LOC) [1]. Previous research suggests that there is no single demographic, clinical, or semiologic feature that distinguishes clearly among epilepsy, syncope, and PNES [2]. In routine clinical practice, the diagnosis is usually based on a combination of facts derived from the patient's history and witness accounts (usually unavailable). The patient's history is crucial for the diagnosis, but the diagnostic value of individual semiologic features is limited. The diagnosis also takes account of interictal investigations like blood pressure recordings, ECG, EEG, and brain CT or MRI, although these investigations are of limited utility. However, in the absence of a clear pretest probability of one specific cause of TLOC, interictal test abnormalities may be misinterpreted, especially by nonexperts [3,4].

Syncope is a LOC secondary to global cerebral hypoperfusion, which is responsible for prodromal symptoms, such as dizziness and blurred vision. Symptoms caused by activation of the autonomic nervous system, such as nausea, vomiting, abdominal discomfort, pallor, sweating and urinary incontinence, may be present. The etiology of syncope includes cardioinhibitory carotid sinus syndrome (CSS), vasodepressor CSS, mixed CSS, orthostatic hypotension, vasodepressor vasovagal syncope, cardiac arrhythmia, and so on.

If syncope occurs in the upright position, LOC may lead to a fall. In older patients with presumed syncope, it is important to distinguish it from vertigo. Vertigo occurs in the context of temporary disorders, relatively harmless diseases associated with chronic impairment, as well as in acute life-threatening states. For patients with vertigo, some are able to remember the mechanism of the fall, how they lost their

balance, the moment when they hit the ground, and so on. However, there are no clear data on the percentage of patients suffering "vertigo" falls who are able to remember every part of the event. Often, the description of the event is incomplete or confused. Witnesses can be useful, and they should be asked whether the patient was unresponsive to external stimuli, particularly acoustic stimuli, during part of the incident, and how this unresponsiveness was established. Unfortunately, in 40% to 60% of patients, falls are not witnessed, thus rendering the differential diagnosis more difficult [5].

Despite the evident differences in the presentations of syncope and vertigo there will always be patients who present as diagnostic dilemmas.

Often the patient says he/she had a fall, a thorough, evidence-based history is essential, and bystander observations are important. Clinical investigations should include a differential examination of the oculomotor system with particular regard to nystagmus.

References

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