

Tests, treatments and procedures at risk of inappropriateness in Italy
that Physicians and Patients should talk about.

**Five Recommendations from Cochrane Neurological Sciences Field (CNF) – 2nd List
Transient Loss of Consciousness**

1	<p>In gathering information on the history of a transient loss of consciousness, a clear description of a blackout and a list of all drugs in use cannot be omitted.</p> <p>The loss of consciousness must be proven by a reliable witness or the patient must be able to report a complete loss of environmental contact. Frequently the expression <i>loss of consciousness</i> is faultily used to define common discomfort.</p> <p>It is important to collect information about drugs currently or accidentally assumed which can induce hypotension or bradycardia. In this case a correct therapeutic indication (e.g. antihypertensive dose adjustment or beta-blockers replacement) can avoid new episodes.</p>
2	<p>In the clinical evaluation of a patient with a previous transient loss of consciousness, measurement of laying down and standing blood pressure cannot be omitted in order to exclude orthostatic hypotension.</p> <p>Orthostatic hypotension is defined as a decrease in systolic blood pressure ≥ 20 mmHg and in diastolic blood pressure ≥ 10 mmHg after 3 min of standing. Frequently the patients will tolerate this condition - as orthostatic intolerance is not constantly reported - therefore it must be investigated.</p> <p>If orthostatic hypotension is diagnosed and related to transient loss of consciousness, some other causes must be excluded: cardiological and neurological diseases or pharmacological treatments such as diuretics, alpha-blockers, beta-blockers, calcium channel blockers, tricyclic antidepressants, levodopa and antipsychotics.</p> <p>Orthostatic hypotension identification offers the opportunity of treatment and - if possible - of prevention measures.</p>
3	<p>In the evaluation of transient loss of consciousness and a normal neurological examination, don't perform an EEG.</p> <p>In this context it is unlikely that EEG adds anything to improve the diagnosis.</p> <p>On the contrary, this exam is indicated when signs/symptoms suggestive of epileptic seizures are reported, such as bitten tongue, head-turning to one side, unusual posturing, abnormal behaviour witnessed before, during or after the loss of consciousness, prolonged limb-jerking (note that brief seizure-like activity can occur during an uncomplicated faint and is not necessarily diagnostic of epilepsy), confusion after the event or prodromal déjà vu or déjà vécu. Epilepsy is the most common neurological cause of loss of consciousness.</p>
4	<p>Don't perform vertebral-carotid color-coded duplex ultrasound studies for transient loss of consciousness without other neurological symptoms. adapted from the American Academy of Neurology</p> <p>Vertebro-basilar TIA (transient ischemic attack) can cause transient loss of consciousness always associated with focal neurological signs such as limbs and/or facial weakness or numbness, ataxia, hemianopsia, balance and gait disturbances, drop attacks, diplopia, dysphagia, dysarthria or dizziness.</p> <p>Occlusive carotid artery disease does not cause fainting but rather causes focal neurologic deficits such as unilateral weakness. Carotid imaging will not identify the cause of the fainting and increases costs. Fainting is a frequent complaint, affecting 40% of people during their lifetime.</p>
5	<p>In the evaluation of transient loss of consciousness and a normal neurological examination, don't perform brain imaging studies (CT or MRI) adapted from the American College of Physicians</p> <p>In patients with witnessed loss of consciousness without any suspicion of seizure nor other neurological signs or symptoms, the likelihood of central nervous system damage is extremely low and patient outcome is not improved by brain imaging studies.</p>

Please note that these items are provided only for information and are not intended as a substitute for consultation with a clinician. Patients with any specific questions about the items on this list or their individual situation should consult their clinician.

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How this list was created

In 2014 the **Cochrane Neurological Sciences Field (CNF)** searched the list of recommendations published in Choosing Wisely for those of interest from a neurological point of view, dealing with transient loss of consciousness. Two recommendations have been included in the present list (number 4 adapted from the American Academy of Neurology and number 5 adapted from the American College of Physicians) but the term *transient loss of consciousness* has been preferred to the original *syncope* because the first means the symptom to be evaluated and the second the conclusion of a diagnostic process. *Transient loss of consciousness* is intended as in NICE 2010: "*transient loss of consciousness is the medical term for a blackout and can be defined as spontaneous loss of consciousness with complete recovery (full recovery of consciousness without any residual neurological deficit)*". Other three recommendations in this list are original, identified in the Italian medical practice (1, 2 and 3) and discussed in the CNF with the contribution of other clinicians on the behalf of AINAT, Italian Association of Out-Patient Department Neurologists.

Sources

1	<ol style="list-style-type: none"> 1. NICE National Institute for Health and Clinical Excellence. Transient loss of consciousness ('Blackouts') Management in adults and young people. London: Royal College of Physicians (UK); 2010:8, 14. 2. The Task Force for the Diagnosis and Management of Syncope of the European Society of Cardiology. Guidelines for the diagnosis and management of syncope (version 2009). Eur Heart J. 2009; 30(21):2644, 2645. 3. AHA/ACCF scientific statement on the evaluation of Syncope: From the American Heart Association councils on clinical cardiology, cardiovascular nursing, cardiovascular disease in the young, and stroke, and the quality of care and outcomes research interdisciplinary working group; and the American College of Cardiology Foundation in collaboration with the Heart Rhythm Society. J Am Coll Cardiol. 2006; 47(2):317, 323.
2	<ol style="list-style-type: none"> 1. NICE National Institute for Health and Clinical Excellence. Transient loss of consciousness ('Blackouts') Management in adults and young people. London: Royal College of Physicians (UK); 2010:11, 18, 20, 24. 2. The Task Force for the Diagnosis and Management of Syncope of the European Society of Cardiology. Guidelines for the diagnosis and management of syncope (version 2009). Eur Heart J. 2009; 30(21):2647.
3	<ol style="list-style-type: none"> 1. The Task Force for the Diagnosis and Management of Syncope of the European Society of Cardiology. Guidelines for the diagnosis and management of syncope (version 2009). Eur Heart J. 2009; 30(21):2655. 2. NICE National Institute for Health and Clinical Excellence. Transient loss of consciousness ('Blackouts') Management in adults and young people. London: Royal College of Physicians (UK); 2010:11. 3. AHA/ACCF scientific statement on the evaluation of Syncope: From the American Heart Association councils on clinical cardiology, cardiovascular nursing, cardiovascular disease in the young, and stroke, and the quality of care and outcomes research interdisciplinary working group; and the American College of Cardiology Foundation in collaboration with the Heart Rhythm Society. J Am Coll Cardiol. 2006; 47(2):323.
4	<ol style="list-style-type: none"> 1. The Task Force for the Diagnosis and Management of Syncope of the European Society of Cardiology. Guidelines for the diagnosis and management of syncope (version 2009). Eur Heart J. 2009; 30(21):2656.
5	<ol style="list-style-type: none"> 1. The Task Force for the Diagnosis and Management of Syncope of the European Society of Cardiology. Guidelines for the diagnosis and management of syncope (version 2009). Eur Heart J. 2009; 30(21):2656.

Slow Medicine, an Italian movement of health professionals, patients and citizens promoting a Measured, Respectful and Equitable Medicine, launched the campaign "**Doing more does not mean doing better-Choosing Wisely Italy**" in Italy at the end of 2012, similar to Choosing Wisely in the USA. The campaign aims to help physicians, other health professionals, patients and citizens engage in conversations about tests, treatments and procedures at risk of inappropriateness in Italy, for informed and shared choices. The campaign is part of the Choosing Wisely International movement. Partners of the campaign are the National Federation of Medical Doctors' and Dentists' Orders (FNOMCeO), that of Registered Nurses' Orders (FNOPI), the Academy of Nursing Sciences (ASI), National Union of Radiologists (SNR), Tuscany regional health agency, PartecipaSalute, Altroconsumo, the Federation for Social Services and Healthcare of Aut. Prov. of Bolzano, Zadig. www.choosingwiselyitaly.org; www.slowmedicine.it

The Cochrane Neurosciences Field (CNF) is an entity of the Cochrane Collaboration; It was formally registered in 2000. Headquarters were in Milan, at the University Department of Neurological Sciences, until 2006, since 2007 it has been based in Perugia at the Region Umbria Health Authority. The main objective of the CNF is to disseminate Cochrane reviews of neurological interest, promoting evidence-based medicine, building links between review authors, clinicians, patients, their families and administrators to contribute to the health information of citizens and provide scientific support to health professionals and decision makers. The team is made up of the director of the field, the coordinator, clinical neurologists, administrative staff, and archive management.

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