

## UNEXPLAINED SYNCOPES: WHAT PLACE IS THERE FOR THE LIAISON PSYCHIATRY? Analysis of the first year of the Interdisciplinary Centre of Unexplained Faintness and Syncopes

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### SUMMARY

**Introduction:** The diagnostic process of syncopes remains an important and complex issue. In spite of everything, it is estimated that 20 to 30% of syncopes remain unexplained. The diagnosis of psychogenic syncope is estimated at 5.5% to 14% of syncopes. A systematic psychiatric evaluation of unexplained syncopes would be strongly recommended. We present here the original care by the "Centre Interdisciplinaire des Malaises Inexpliqués et des Syncopes (Interdisciplinary Centre of Unexplained Faintness and Syncopes.)" set up by the neurology and cardiology departments associated with the ENT department. We describe the place liaison psychiatry has been able to define and its field of action.

**Subject and methods:** After a year of operation, and on the basis of structured interviews with the "Mini International Neuropsychiatric Interview" and on a review of records, we assessed the recruitment in terms of psychiatric monitoring as well as the associated psychiatric diagnoses in patients who consulted for an unexplained syncope.

**Results:** Of the 91 patients who have consulted the Interdisciplinary Centre of Unexplained Faintness and Syncopes in 2009, 24% have been directed towards a psychiatric evaluation. Among these, 68% suffered from an anxiety disorder, 27% from a major depressive disorder and 22% from a substance-related disorder.

**Discussion:** We assess the interesting conditions that the Interdisciplinary Centre of Unexplained Faintness and Syncopes proposes for a liaison psychiatry activity. We note the interest in easier access to psychiatric care for a group that would not have spontaneously approached the Centre.

**Conclusion:** Other measures of quality of care indices are still to be developed.

**Key words:** unexplained syncopes - psychogenic syncopes - liaison psychiatry

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### INTRODUCTION

The diagnostic process of syncopes remains an important and complex issue. Syncopes represent 3% of visits to the emergency services in the United States (Day et al. 1982).

The syncope, defined as a sudden, brief and complete loss of consciousness linked to a global cerebral hypoperfusion, has often already taken place before arriving at the emergency room and is rarely observed directly by the doctor. Sometimes, the patient may have amnesia about the loss of consciousness and the history of present illness is also most of the time "witness-dependent".

The syncope may be or may not be accompanied, preceded or followed by a series of symptoms often non specific and often hard to interpret: feelings of dizziness, heart rhythm disorders, falling or convulsions. The patient sometimes reports the general term of feeling "unwell" without being able to further clarify the feelings experienced. A syncopal episode is too quickly equated with epilepsy with also an ignorance among caregivers of the different terminologies. Loss of consciousness has various well-documented etiologies and terminology and precise definitions are referenced (van Dijk et al. 2009).

Clear algorithms of care for syncopes are well established (Gauer 2011), the central issue is a priority diagnostic assessment of serious heart rhythm disorders.

In spite of everything, it is estimated that 20 to 30% of syncopes remain unexplained (Benbadis et al. 2006). Unexplained means that a clear neurological, cardiology or other diagnosis could not be identified. The temptation might often be strong to consider diagnosing a psychogenic syncope. The authors highlight the need for caution before confirming this diagnosis, to the extent where the highlighting of a serious organic diagnosis can take time and that sometimes its development reveals other symptoms (Kanjwal et al. 2009). Other rare diseases can mimic a psychogenic syncope and make the diagnostic process even more difficult (Caplan et al. 2011).

The diagnosis of a psychogenic syncope is estimated at between 5.5% (Petersen et al. 1995) and 14% (Iglesias et al. 2009) of all syncopes depending on the sequences. Induction methods with monitoring are necessary for differential diagnosis (Wilner 2010). The tilt-test is a valuable assessment tool (Grubb et al. 1992) associated in some cases with video-EEG (Laroche et al. 2011).

A systematic psychiatric evaluation of unexplained loss of consciousness would be strongly recommended (Diehl 2011). The anxiety and dissociative symptoms are intricate and can be the generators of psychogenic syncopes (Reuber et al. 2011). On the other hand, even if a organic diagnosis could be posed, secondary anxiety generating anxious expectations can become a factor that leads to syncope relapses. The famous and difficult question of the chicken or the egg?

It is the same with causal or associated hyperventilation (Moldavanu et al 1990).

It is with this questioning that the neurology and cardiology department of the university hospital center of Mont-Godinne founded the "Interdisciplinary Centre of Unexplained Faintness and Syncopes" (Centre Interdisciplinaire des Malaises Inexpliqués et des Syncopes C.I.M.I.S); which has been associated with the ENT (vestibulology) and psychiatry (psychosomatic) departments.

Patients with syncopes or unexplained blackouts are thus evaluated by these four specialities in consultation and a collegial discussion of records held every two weeks.

Regarding the supply of psychiatric care, two care options are proposed: either an individual consultation, participation in a "stress management and relaxation" group.

The orientation is based on the clinic, demand but also depending on the patient's choice.

The "stress management" groups are run over three sessions per group with a maximum of 8 people.

The first meeting: information on the definition of stress and its various causes, inventory of sources of stress, illustration of the psychosomatic dimension and learning relaxation techniques (preparation)

The second meeting: relaxation (performed during meeting) and scheduling of self-managed relaxation sessions at home

The third meeting: information on other stress management methods and points of reference in relation to medicines and various therapeutic follow-ups

## SUBJECTS AND METHODS

After the first year of operation of the Interdisciplinary Centre of Unexplained Faintness and Syncopes, to assess the work of liaison psychiatry carried out, on the basis of a review of records, we quantified the number of patients evaluated in psychiatry for unexplained syncopes. On the basis of the Mini International Neuropsychiatric Interview used in consultation, we completed the inventory of associated psychiatric co-morbidities. We also quantified the proportion of patients who have set up a regular psychiatric follow-up.

The evaluation focuses on the patients followed up between 1 January 2009 and 1 October 2009.

## RESULTS

Of the 91 patients who consulted the Interdisciplinary Centre of Unexplained Faintness and Syncopes in 2009, 22 were referred to the consultation of psychosomatic medicine which is 24%.

Of these 22 patients, 9 had never visited psychologists or psychiatrists before (40%). None of the 22 patients were undergoing regular psychiatric or psychotherapeutic follow-ups.

### Diagnosics

- 68% met the criteria of ANXIETY DISORDERS (n=15)
  - Panic disorder (n=9)
  - Obsessive Compulsive Disorder (n=1)
  - Post-Traumatic Stress (n=4)
  - Hypochondria (n=1)
- 27% met the criteria of a MAJOR DEPRESSIVE DISORDER (n=6)
- 22% met the criteria of a DISORDER LINKED TO A SUBSTANCE (n=5)
  - Tobacco (n=4)
  - Alcohol (n=3)
  - Benzodiazepines (n=1)
  - Cannabis (n=1)

After a year, 13 of 22 patients (63%) continued to have a regular psychiatric follow-up: 6 patients had a follow-up with a psychiatrist or psychologist external to the centre and 7 patients continued to be followed up at the centre.

## DISCUSSION

The diagnosis of psychogenic syncope is not simply a diagnosis of exclusion. It requires a close collaboration between the various stakeholders. Sometimes it is helpful for syncope to remain "unexplained" to keep the differential diagnosis open and the analysis of the any development of symptoms. Rushing towards a diagnosis of psychogenic syncope may lead to neglecting the analysis of the symptoms presented.

The originality of the Interdisciplinary Centre of Unexplained Faintness and Syncopes is the possibility of a multiple follow-up and it enables an integrative discussion from the start of the care without falling into the trap of "pure" diagnosis, whether it is organic or it is psychiatric.

Our experience has led us to see that the two dimensions can coexist.

In addition, even if an organic etiology is highlighted, stress and anxiety continue to play a negative part and can become the factors precipitating relapses. The coordination and the centralisation of the follow-up by the different specialities allow you to avoid a rupture in the follow-up or a repetition of complementary examinations. The fact of being able to address the "affective", "emotional" or "stress" dimension from the start then facilitates the possibility of introducing a "shrink" in the care more easily if it is associated with organic physicians who have initiated the development.

In our preliminary results, we obtained results concerning the proportion of anxiety disorders (panic disorder) which correspond to what is mentioned in the literature. We highlighted the issue of substance consumption that may not have been analysed systematically enough and which could also play a role in psychogenic syncopes.

After a year, the rate of maintaining psychiatric care (n=13 or 63% of patients evaluated) leads us to believe that this model of care offers an interesting recruitment of patients requiring psychiatric care but who would not otherwise have had access.

We now have to define evaluation measures for the quality of care for the follow-up focus on the impact of diagnosis and treatment's effects.

## CONCLUSION

The Interdisciplinary Centre of Unexplained Faintness and Syncopes model fully enables liaison psychiatry work to be conducted. The interest in multiple follow-up offers the physician the possibility of focussing on assessing the organic symptoms and the psychiatrist of having an organic assessment in real-time, which enables the analysis of anxious phenomena to be carried out with more precision.

The proportion of anxiety disorders in patients with unexplained syncopes is significant. We also note the

problem of substance abuse that also seems linked to syncopes.

After a year of operation, we have a good recruitment of patients requiring psychiatric care who would probably not have consulted without the care at the Interdisciplinary Centre of Unexplained Blackouts and Syncopes.

We must define indices for follow-up quality and development to be able to support the interest in this type of care.

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