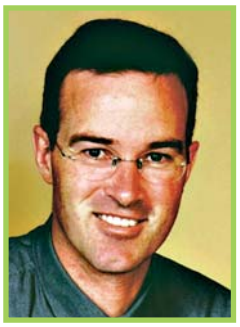

Fits, faints and funny turns

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A chill wind blows through rural Victoria in winter and it was tending toward the sub-Arctic on the night I saw my first patient in the hospital's emergency department. 'FFFT' was scrawled across the front of the history card, which I presumed to be some sort of poetic reference to flatulence.

'Fit, faint or funny turn' drawled the triage nurse, with that particular tone she reserved for interns doing their first shift. I hurried off to the cubicle with a sense of trepidation and began examining the unconscious patient, a middle aged woman of rather disheveled appearance.

I had absolutely no idea what was going on and was just about to start poking needles into her unresponsive form when the Admitting Officer swept aside the curtain, grabbed the trolley and, with an almighty shove, sent it banging out through the double doors into the ambulance bay. The trolley coasted gently to a stop while a light snow dusted the huddled shape. Then the shape stirred, sat up and wandered off into the night. Apparently, Marg was well known around the hospital for her various attempts at getting a bed for the night.

Apart from reminding me of the importance of compassion in medical practice, Marg also taught me that fits, faints and funny turns can present in many challenging ways; diagnosis is not easy. Poorly differentiated patient presentations can be a source of stress for the general practitioner, and the symptoms commonly described as 'fits, faints and funny turns' clearly fit this category.

This issue of Australian Family Physician presents a comprehensive overview of the diagnosis and management of patients who present following an episode of collapse. Importantly, the major emphasis is on diagnosis. As our authors point out: fits, faints and funny turns are merely symptoms and a firm diagnosis is required before treatment can commence.

Three major causes of fits, faints and funny turns are presented: cardiovascular, neurological and psychological. In describing the cardiovascular causes, Wright and Arnolda remind us that, although rhythm disturbances and outflow obstruction can cause syncope, simple vasovagal faints are much more common. As explained, the seminal Framingham Heart Study describes the cause of first reports of syncope as being due to vasovagal activity in 21.2% of cases, and orthostatic hypotension in a further 5–10% of cases.[1]

King's article on neurological causes of collapse is purposely limited to epilepsy. General practitioners are commonly called upon to determine whether a patient's 'fit' was actually an epileptic seizure or something else. It is at this time that the GP's skill in gathering information from a variety of sources (such as family, friends and workmates) comes to the fore. A carefully collected history from the patient and others may well play a larger part in diagnosis than any number of expensive investigations. Nevertheless, King reminds us that investigations such as electroencephalography are important in the diagnosis of people following their first seizure, especially when performed early.

Morgan and Blashki write on the assessment of people with fits, faints and funny turns from a mental health point of view. They make the important statement that the search for psychological causes of an episode of collapse should be made with the same vigour and thoroughness that is applied to presumed physical causes, rather than it being a diagnosis of exclusion. They demonstrate how screening instruments can assist the GP to identify the presence of psychopathology that may have caused the episode.

Finally, Australia's most respected GP returns to AFP to apply his Diagnostic Strategy Model to the clinical dilemma of patients presenting with fits, faints or funny turns. Professor John Murtagh's article brings together the theme articles into his simple and relevant diagnostic framework that actually works in today's general practice.

I hope you find this issue of AFP helpful in your diagnosis and management of patients with fits, faints and funny turns. Although probability rests on the side of the faint, we must always be alert for the more serious cause.

Reference

1. Soteriades E S, Evans J C, Carson M G, et al. Incidence and prognosis of syncope. N Engl J Med 2002; 347:878–885.

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