MBChB Year 2 Clinical contact in GP – Collapse – 28th May

Overview of the Collapse session in GP clinical contact

The Intended Learning Outcomes for this session are:

Undertake a clinical consultation & gather information relevant to the patient presentation
Describe & perform a clinical examination relevant to the patient presentation including vital signs
Practise formulating a differential diagnosis
Practise presenting the patient and be able to discuss the differential diagnosis and management options

The aims for this session are:

- To discuss how to assess collapse in clinical practice
- Practise consulting with and examining a patient (preferably with a history of collapse)
- Link university learning to Primary Care and share your clinical experience.

Common to all sessions:

- Refer to the Year 2 GP handbook, which covers the information common to all sessions.
- Please see Session plans for Clinical contact in GP year 2 (2025-26) attached to this email to help you structure time with your group.

Allow time for:

- introductions (reflecting on any learning/action points from the previous session)
- student-led interaction with patient(s), and
- debriefing the group (usually without the patient present) to ask questions and consolidate learning
- **Additionally for this session:** Please allow time for individual feedback. While you speak with individual students the other students should be completing their feedback form (see email information)

(Expert) patients **Suitable patients for the block are:**
• Patients with a history of syncope or transient loss of consciousness from any cause • Patients with a history of epilepsy • Patients with a previous TIA or stroke • Any patient with a neurological disorder such as Parkinson's disease • Any patient suitable for examination relevant to collapse

Context for the session

Students will have covered the following in the two-week collapse block:

In **Case-Based Learning**: a 76-year-old man was brought to the Emergency Department following a collapse at home; and his granddaughter who fainted/had vasovagal episode when she witnessed venesection.

In **Lectures, workshops and practicals**:

- Maintaining consciousness
- Neural networks
- Epilepsy
- Shock
- Aneurysms
- Suspected poisoning
- Stroke
- Applied anatomy and imaging
- Cardiac causes of collapse
- Transient loss of consciousness – syncope vs seizure

In their **clinical skills sessions** they will:

- Revise their clinical examination skills in preparation for the clinical and practical skills assessment (CAPA)

In their **Effective Consulting sessions** they will:

- Revise their consultation skills in preparation for the clinical and practical skills assessment (CAPA)
- Review and reflect on their learning in Effective Consulting

Specifics for Collapse in GP clinical contact

Introduction

As part of the "collapse" theme this fortnight, briefly discuss with your group how collapse presents in practice. What you focus on depends on the patient that you have invited to attend.

Brainstorm

Preparation – consider how patients who have had a collapse often present. If you are seeing a patient with collapse, how might you prepare? What would you look for in the electronic medical record to help you prepare for the consultation?

Discuss:

- What do students know about collapse?
- How do patients who have had a collapse present?
- What suggests a more serious cause? What are red flags?
- How do you assess a patient who has had an episode of collapse?

Student information

Notes on the clinical assessment of collapse

Causes of collapse

Causes of collapse can be classified into:

- Cardiovascular
  - Vasovagal syncope (faint)
  - Arrhythmia
  - Valvular disease
  - Shock
  - Postural / orthostatic hypotension
  - Myocardial infarction
  - Carotid sinus syndrome
- Neurological
  - Seizure
  - Stroke / TIA
  - Intracranial haemorrhage
  - Non-epileptic attack
- Other
  - Metabolic – Hypoglycaemia, hyperglycaemia, hyponatraemia, hypocalcaemia
  - Pulmonary embolism
  - Adrenal crisis
  - Drugs and alcohol, including withdrawal

Table: Features which help discriminate syncope from seizure (from Macleod's Clinical Examination)

	Syncope	**Seizure**
Triggers	Typically present (pain, illness, emotion)	Often none (sleep deprivation, alcohol, drugs)
Prodrome	Feeling faint, nausea, tinnitus, vision dimming	Focal onset (not always present)
Duration of unconsciousness	< 60 seconds	1-2 minutes
Convulsion	May occur but usually brief myotonic jerks	Usual, tonic-clonic 1-2 minutes
Colour	Pale	Red/blue, may be pale
Tongue biting	Very rare	Common
Recovery	Rapid, no confusion	Gradual, over 30 minutes, often confused, amnesic

Summary of the history in “collapse”

Introduction

The below notes are based on Chapter 24: Transient loss of consciousness, Macleod's Clinical Diagnosis.

Transient loss of consciousness can be diagnostically challenging because:

- the event has usually resolved by the time of assessment; and
- critical elements of the history are unknown to the patient

Therefore, witness or collateral accounts are crucial. Common causes of transient loss of consciousness include syncope, cardiac arrhythmias, epileptic seizure, non-epileptic attack disorders.

Presenting complaint

Consider what happened before, during and after the collapse:

Before: prodrome / triggers

Patient and collateral:

- Was there any warning? Feeling faint, blurring of vision, dizziness or nausea? Unusual smell? ‘rising’ sensation in the abdomen?
- Were there any associated symptoms? Palpitations or sensory symptoms? What were they doing at the time? For recurrent episodes, are there any precipitants, e.g. going from sitting to standing. How have you been in the last few weeks? Has this happened before?

During:

Patient:

- Was there any injury? e.g. from falling to the ground.

Collateral:

- Did they lose consciousness and if so, for how long?
- Were there any convulsions? Any tongue biting or urinary/faecal incontinence?

After:

Patient:

- What is the first thing you remember? How did you feel afterwards? What happened next?

Collateral:

- How long did it take them to come around (regain consciousness)?

History of presenting complaint

Sensory symptoms are common, and it is important to discern what the patient is describing. Clarify that, by ‘numbness’, the patient means lack of sensation rather than weakness or clumsiness.

Assessing a possible first seizure

An epileptic seizure is caused by paroxysmal electrical discharges from the brain – the whole brain (generalised), or part of the brain (focal). Symptoms can include: altered consciousness, behaviour, emotion, motor function, or sensation.
It is not possible to diagnose epilepsy after a single seizure. There are many other causes for a first seizure and patients will often be seen in a 'first seizure clinic'.

Epilepsy is a disease of the brain defined by at least two unprovoked seizures occurring more than 24 hours apart.
Risk factors that suggest epilepsy

- Triggers for seizure – on waking or in association with sleep deprivation or flashing lights, metabolic disturbances
- Family history of epilepsy
- Comorbid conditions (cerebrovascular disease, cerebral tumours)

Any symptoms of auras?

- Auras arising from the temporal lobe: unexpected tastes, smells, paraesthesia, or a 'rising' abdominal sensation

Specific features of generalised seizures

- **Tonic** seizures that cause impairment of consciousness and stiffening; the trunk may be either straight or flexed at the waist.
- **Clonic** seizures that cause rhythmical jerking and impairment of consciousness.
- **Tonic–clonic** seizures (convulsions) are the most common form of generalised seizure that cause stiffening and jerking and impairment of consciousness.
- **Atonic** seizures that cause sudden brief attacks of loss of tone, associated with falls and impairment of consciousness.
- **Post-ictal period**: residual symptoms after the attack, such as drowsiness, amnesia, headache, or focal neurological deficit that slowly recovers.
- Injuries may be sustained, including aching limbs and bites to the tongue.

Focal seizures are characterized by the area of the brain which is affected.

Functional dissociative attacks can be difficult to distinguish from epileptic seizures. They are sometimes referred to as pseudo seizures or psychogenic non-epileptic seizures.

Assessing a possible TIA or stroke
From Macleod's clinical examination: "A stroke is a focal neurological deficit of rapid onset due to a vascular cause. A transient ischaemic attack (TIA) is the same, but symptoms resolve within 24 hours. TIAs are an important risk factor for impending stroke and demand urgent assessment and treatment."

Suspect a TIA if:

- The person presents with sudden onset, focal neurological deficit e.g.
  - Unilateral weakness or sensory loss

- Dysphasia
- Ataxia, vertigo, or incoordination. (Isolated dizziness is not usually a symptom of TIA)
- Syncope
- Sudden transient loss of vision in one eye (amaurosis fugax), diplopia, or homonymous hemianopia
- Cranial nerve defects

- It resolves within 24 hours and can't be explained by an alternative cause e.g. hypoglycaemia
- Patients will normally be referred to TIA clinic for urgent assessment as they are at high risk of an impending stroke.

Suspect stroke if:

- The person presents with sudden onset, focal neurological deficit which is ongoing (or lasted more than 24 hours)
- The clinical features of stroke vary depending on causative mechanism and the area of the brain affected, but symptoms can include any of the above.

FAST warning signs: Stroke signs and symptoms | Stroke Association

FAST (Face, Arms, Speech, Time) is an acronym to help people identify the most common signs of a stroke, and emphasises the importance of acting quickly by calling 999

- F = Face Drooping – Does one side of the face droop or is it numb? Ask the person to smile. Is the person's smile uneven?
- A = Arm Weakness – Is one arm weak or numb? Ask the person to raise both arms. Does one arm drift downward?
- S = Speech Difficulty – Is speech slurred?
- T = Time to call 999

Other stroke symptoms – sudden onset of:

- NUMBNESS or weakness of face, arm, or leg, especially on one side of the body
- CONFUSION, trouble speaking or understanding speech
- TROUBLE SEEING in one or both eyes
- TROUBLE WALKING, dizziness, loss of balance or coordination
- SEVERE HEADACHE with no known cause

Systems review

Systemic: Fever, weight loss, pain.
Cardiovascular & Respiratory: Chest pain, breathlessness (including PND & orthopnoea) palpitations, ankle swelling, cough, wheeze, exercise tolerance normally and any recent change.
Gastrointestinal: Appetite, weight, abdominal pain, swallowing, nausea, changes in bowel habit, jaundice, stool appearance/blood.
Genitourinary: Urinary symptoms (hesitancy, terminal dribbling, dysuria, haematuria, nocturia, incontinence, discharge), menstrual history, pregnancy.
Neurological: Memory, vision, hearing, headaches, fits, faints, funny turns, mood changes, unsteadiness, weakness.
Musculoskeletal: Injuries, joint pain/swelling, muscle pain.

Dermatological: Rash, skin lesions, ulcers

Past medical and surgical history

- Risk factors for stroke such as AF, hypertension, diabetes, smoking, high cholesterol

Medication

- Are they on anti-coagulants? – risk of bleeding into the brain and risk of bleed if they injure themselves during the collapse
- Any medications increasing their risk of PE? Eg exogenous oestrogens
- Check medication concordance – have they missed any essential medications including anticonvulsants?
- Any recent changes to medications? e.g. increased insulin dose causing hypoglycaemia.

Family history

- Family history of stroke at an early age?
- Family history of epilepsy?

Social, lifestyle and wellbeing

- Occupation/hobbies – they may need time off work while awaiting assessment. Do they operate heavy machinery?
- Housing/ living situation – do they live alone? Is someone able to support them?
- Connectedness: Social support/ family/ relationships and network
- Health: How do you look after your general health? (listen, then explore specific areas)
- Do they drive? This is important and if referring to TIA clinic or you suspect a neurological cause you may need to advise the patient not to drive until fully investigated. The DVLA has guidance on driving with medical conditions: Assessing fitness to drive: a guide for medical professionals - GOV.UK

- **Exercise**:
  - Do you get a chance to be physically active during the week?
  - What kinds of movement or exercise do you enjoy, if any?
  - Are there any barriers that make it hard to stay active?
  - Physical inactivity is a risk factor for stroke

- **Nutrition**
  - Can you tell me about your usual eating habits or meals? Do you follow a specific diet?
  - Do you ever find it hard to access or afford healthy food?
  - Poor diet is a risk factor for stroke

- **Sleep**
  - How have you been sleeping lately?
  - Do you feel rested when you wake up?
  - Are there any issues like trouble falling asleep, waking during the night, or feeling tired during the day?
  - Is there anything affecting your sleep, like stress, noise, or caring responsibilities?

- **Stressors**
  - Have you been feeling under pressure or stressed lately?
  - Are there particular things in your life that are causing you worry or anxiety?
  - How do you usually cope when things feel overwhelming?

- **Alcohol**
  - Do you drink alcohol? If so, how often and how much?
  - Have you ever felt your drinking was affecting your health or daily life?
  - Are there times when you've felt you should cut down?
  - Don't forget alcohol intoxication can cause collapse, and withdrawal can also cause collapse.

- **Smoking**
  - Do you currently smoke or use any tobacco products?
  - Have you ever tried to stop smoking? What helped or made it difficult?
  - Would you be open to talking about support for cutting down or quitting?
  - Smoking is a risk factor for stroke

- **Recreational drugs**
  - Do you use any recreational drugs, including cannabis or others?
  - Have you ever felt your use of substances affected your health or relationships?
  - Is there anything you'd like to share about how you manage or feel about your use?
  - Recreational drugs can also cause collapse.

PATIENT PERSPECTIVE (IDEAS, CONCERNS, EXPECTATIONS, IMPACT & EMOTIONS)

It's important to ensure you fully appreciate the ideas the patient has about what's going on, the underlying fears and worries they may have, whether they want reassurance, diagnosis, medication, or referral, what impact their symptoms are having on their life, and how it is making them feel (ICEIE).

Ideas. What do they think is going on? Possible causes? What have they tried already? Sources of info e.g. What does your partner/ family think?
Concerns. What are they worried is going on or will happen[4]?
Expectations. What are they hoping for?
Impact. How is the problem affecting them?
Emotions. What are the predominant emotions around the problem? Psychological impact.