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REPLY

The writing group of the “Scientific Statement on the Evaluation of Syncope” takes this opportunity to respond to the critique of this document (1) by Dr. Benditt and colleagues. The goal of this Scientific Statement, as set forth by the sponsoring organizations, was to provide a concise, practical approach to the initial evaluation of the patient with syncope within strict length limitations (2). The document approaches the evaluation of syncope as a clinician would when a patient presents to the office or hospital with such an event. The emphasis of this document is placed on the recognition of life-threatening clinical syndromes.

The criticisms of Dr. Benditt and colleagues can be grouped into three categories. First, the definition of syncope was inadequate. Second, the stated goal of preventing death is not adequate, and the goal for the evaluation of syncope should also be to establish a diagnosis and provide a prognosis. Third, the citations were incomplete.

The definition of syncope as “a transient loss of consciousness” fits into the category of a practical working definition. Although there is no uniform consensus on the ideal definition, the definition often includes reference to the loss of consciousness due to global cerebral hypoperfusion. Unfortunately, this definition can be strictly applied only when the mechanism of syncope is firmly established. The definition used in this document relates to the clinical presentation, as commonly used and understood, and does not require a specific mechanistic diagnosis. Academically, one might prefer a more detailed or thorough definition. However, one could also argue that any definition intended to be used universally should be developed by international consensus among appropriate medical societies. To date, this has not been achieved.

The specific etiology of syncope is identified in only about one-half of the patients who undergo an evaluation for syncope. Furthermore, many patients never have a recurrence after an episode of syncope, and only occasionally is syncope disabling. Ultimately, one can have many goals for a document of this type. We chose the identification of the patient at risk of death as the primary one.

Dr. Benditt and colleagues correctly state that many references relevant to syncope were not cited. Owing to space considerations and the document’s focus on the evaluation of syncope, many excellent papers could not be referenced. We agree that the “Guidelines on Management (Diagnosis and Treatment) of Syncope” developed by the European Society of Cardiology are particularly important documents, and we apologize for omitting them (3,4).

The “Scientific Statement on the Evaluation of Syncope” was reviewed and evaluated by >50 outside reviewers. The document was reviewed and approved by the American Heart Association

(AHA), American College of Cardiology Foundation, Heart Rhythm Society, and the American Autonomic Society. Criticisms and comments offered by these reviewers and organizations were responded to and incorporated into the final document. Although there are inherent limitations to any such document, the writing group believes that the “Scientific Statement on the Evaluation of Syncope” achieves the goals set forth by the AHA for this document, and it provides a concise and practical approach to the initial evaluation of syncope.

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Please note: this response is from the authors and is not approved or sanctioned by the sponsoring organizations.

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Examining the Concept of Preserved Systolic Function

Sophisticated analyses and the size of the Acute Decompensated Heart Failure National Registry (ADHERE) database strengthen the characterization of heart failure with preserved systolic function (PSF) made by Yancy et al. (1). Unfortunately, PSF includes