

# GP Resource Sheet



## What is POTS?

Postural orthostatic tachycardia syndrome (POTS) is a multisystem autonomic disorder causing orthostatic intolerance and excessive heart rate increase on standing. It affects mostly females (~85%) and often begins in adolescence or early adulthood. Diagnosis is often delayed due to symptom overlap with other conditions, but early recognition can reduce disruption to education, work, and social life.

## Common Symptoms

Light-headedness or dizziness on standing; palpitations, pre-syncope (syncope occurs in a small portion of POTS patients); fatigue and exercise intolerance; nausea, bloating, reflux, or constipation; heat or cold intolerance and sweating changes; brain fog, headache, anxiety, and poor concentration; urinary urgency or frequency, or retention; and dependent acrocyanosis (red/purple limbs on standing).

## Associated Conditions

Joint hypermobility (including hypermobile Ehlers-Danlos syndrome), migraine, fibromyalgia, endometriosis, menorrhagia, coeliac disease, irritable bowel syndrome, neurodiverse conditions such as ADHD and ASD, ME/CFS, mast cell activation syndrome, anxiety and mood disorders, thyroid disorders and long COVID.

## Assessment and Diagnosis

A thorough, well-structured medical history is the most valuable tool for diagnosing POTS. It should capture the onset and sequence of symptoms, factors that trigger or relieve them, current medications, and relevant past history. The Malmö POTS Survey can help identify the most significant autonomic symptoms and includes a validated diagnostic cut-off score for POTS. Please see QR below.

## Examination

Begin with a standard physical examination, followed by a 10 Minute Active Stand Test (also known as the NASA Lean Test). Tilt-table testing is generally not required unless the diagnosis remains unclear. Because POTS symptoms can fluctuate, a single negative test does not exclude the diagnosis, and repeating the test is advised if clinical suspicion remains high. For more information on performing and interpreting an Active Stand Test, please see QR below.

## Investigations

Investigations should aim to rule out alternative causes of orthostatic intolerance including malnutrition, anaemia, thyroid dysfunction, and acute illness. These may include an ECG, full blood count, urea and electrolytes, thyroid function tests, and iron studies, with further assessment using a Holter monitor, echocardiogram, or 24-hour ambulatory BP monitoring as clinically indicated.

## Management

Education is key to managing POTS. It's important to explain to patients that while there's no cure, symptoms can be well-managed. A supportive therapeutic relationship and access to clear information can prepare patients to engage with lifestyle adjustments that support symptom control.

### Diagnostic Criteria:

- HR  $\uparrow$   $\geq 30$  bpm within 10 min of standing ( $\geq 40$  bpm in adolescents or absolute HR  $> 120$  bpm in adults)
- No sustained orthostatic hypotension
- $\geq 3$  months of symptoms



New Patient  
Brochure



Active  
Stand Test



Malmö  
POTS Survey

more overleaf

## Lifestyle Measures

- **Fluids & Salt:** To increase plasma blood volume, aim for 2–3 litres of fluids daily and increase sodium intake to ~4000mg per day if there are no contraindications.
- **Compression Garments:** To reduce blood pooling in the lower body, use abdomen-to-ankle compression garments; well-fitted shapewear may be sufficient.
- **Diet:** To minimise post-meal symptom exacerbation, eat small, frequent, lower carbohydrate meals and ensure adequate nutrition to avoid weight loss.
- **Trigger Management:** To prevent symptom flares patients should avoid hot environments, prolonged standing, environmental allergic triggers, caffeine, alcohol, and stimulants.
- **Movement & Pacing:** To improve conditioning while avoiding symptom aggravation, refer to a POTS-aware exercise physiologist or physiotherapist for a tailored plan. Ensure plasma volume expansion and orthostatic intolerance are managed first; in cases of severe fatigue, prioritise maintenance of ADL's over formal exercise programs.

## Pharmacotherapy

Lifestyle measures are often insufficient to adequately control symptoms. Adjunctive pharmacological therapy should be individualised to the patient's presentation and primary symptoms, starting with treatment to manage orthostatic intolerance.

### To Support Blood Pressure

- **Midodrine:** Vasoconstrictor; monitor for urinary retention or hypertension; not PBS listed, short acting, and requires frequent dosing.
- **Fludrocortisone:** Expands plasma volume; relatively high side-effect profile including mood changes, acne, and weight gain.

### To Control / Reduce Heart Rate

- **Ivabradine:** Selectively lowers heart rate with minimal impact on blood pressure; not PBS listed.
- **Propranolol:** Low dose to reduce heart rate; use with caution as it may worsen hypotension.

Medications are symptom-focused and should be discontinued if ineffective.

## Multidisciplinary Support

POTS is multisystemic chronic condition. Consider early initiation of a GP Chronic Condition Management Plan (GPCCMP). Exercise physiologist – tailored movement/pacing plan; dietitian – salt, nutrition, GI symptoms; psychologist – mood and adjustment support; physiotherapist – hypermobility, deconditioning management.

The Australian POTS Foundation offers RACGP-approved CPD education and maintains a clinician registry to connect health professionals with POTS expertise.

For updates and event information, sign up to our newsletter.

[potsfoundation.org.au](https://potsfoundation.org.au)

