MADISON NEUROLOGY · NEUROLOGY SYMPTOM GUIDE

A band-like sensation or sensory level across the trunk

Structured history, interpretation & clinical review

Symptom 28 of 94
Clinical educational workbook
Version 1.0 · October 2026

Not for clinical use. This guide cannot diagnose, triage, or exclude an emergency. Seek emergency care for severe, sudden, or worsening symptoms.

Contents

Scope and safe use 3

Section 1: Input form 4

- 1A. Immediate safety screen 4
- 1B. Timeline 4
- 1C. Discriminating features 5
- 1D. Associated findings 5
- 1E. Clinical context 5

Section 2: Interpreting the input form 7

Section 3: Clinical review 9

Selected references 11

> **Document purpose**
> A structured educational history and diagnostic-reasoning workbook. Treatment is outside its scope.

Scope and safe use

A band-like trunk sensation or discrete sensory level is a spinal-localizing symptom until carefully assessed, while allowing for functional and peripheral mimics.

Not for clinical use.
This educational workbook does not diagnose, triage, estimate probability, replace examination, or exclude an emergency. If a safety-screen answer is Yes or uncertain, follow the stated action rather than continuing routine interpretation.

How to complete the workbook

- Record the current episode and the person’s usual baseline; use a witness account for events with impaired awareness.
- Check one option per question unless a clinician documents a different combination. “Not sure” is unresolved information, not a negative answer.
- Complete the safety screen before all other sections. Record exact onset or last-known-well time for sudden deficits.
- Use Section 2 only after the form is complete. More than one pattern may be relevant; urgency takes precedence.
- Use Section 3 to plan focused examination and clinician-selected investigations. No test is automatic or universally required.

Specific escalation rule

New severe headache, new focal weakness or numbness, new speech/language difficulty, reduced consciousness, a prolonged seizure, severe breathing or swallowing difficulty, sudden visual loss, or rapidly progressive weakness requires emergency assessment. Call 911 in the United States.

Section 1: Input form

Checkbox history for A band-like sensation or sensory level across the trunk

1A. Immediate safety screen

Is there new urinary retention, loss of bladder or bowel control, saddle numbness, or new sexual dysfunction?

☐ No ☐ Yes ☐ Not sure

If Yes: Go to an emergency department now for cauda-equina assessment; do not wait for routine imaging.

Is there rapidly progressing weakness in one or more limbs, a sensory level, or new inability to walk?

☐ No ☐ Yes ☐ Not sure

If Yes: Seek emergency assessment now for possible spinal-cord compression or another acute cord process.

Is there fever, immune suppression, recent spinal procedure, injection-drug use, cancer, or severe unremitting night pain?

☐ No ☐ Yes ☐ Not sure

If Yes: Arrange same-day assessment; fever or progressive neurological deficits require emergency care.

Did significant trauma precede the pain, or is there new deformity or immediate neurological loss?

☐ No ☐ Yes ☐ Not sure

If Yes: Seek emergency assessment now and avoid unnecessary movement of the spine.

> **Stop rule:** Any Yes answer triggers the action printed under that question. Any Not sure answer requires prompt in-person clarification; do not treat it as No.

1B. Timeline

How did the symptom begin?

☐ Suddenly, over seconds or minutes ☐ Over hours to days ☐ Gradually over weeks or months ☐ Longstanding or since childhood ☐ Not sure

Use the first occurrence for recurrent episodes; use the current episode for a changing symptom.

What is the overall course?

☐ One persistent episode ☐ Separate recurrent episodes ☐ Steadily worsening ☐ Fluctuating or variable ☐ Currently resolved

Has this exact pattern been assessed before?

☐ Definitely new ☐ The same pattern occurred before ☐ Present and stable for a long time ☐ Not sure

1C. Discriminating features

Where is the band or upper border of altered sensation?

☐ Chest or upper abdomen ☐ Lower abdomen or pelvis ☐ Neck/shoulder region ☐ The level moves or is unclear

Are there leg weakness, stiffness, clumsiness, or walking difficulty?

☐ Yes ☐ No ☐ Not sure

Is there new urinary retention, urgency/incontinence, constipation, or sexual dysfunction?

☐ Yes ☐ No ☐ Not sure

Is there focal back/neck pain or tenderness?

☐ Yes ☐ No ☐ Not sure

1D. Associated findings

Are there other neurological symptoms—weakness, numbness, speech change, double vision, swallowing difficulty, or severe imbalance?

☐ Yes ☐ No ☐ Not sure

Are there systemic clues—fever, weight loss, cancer, infection risk, pregnancy/postpartum status, or a new medication?

☐ Yes ☐ No ☐ Not sure

How much does this affect daily activity?

☐ Noticeable but activities continue ☐ Some activities are limited ☐ Cannot perform usual activities ☐ Not sure

1E. Clinical context

Who is being assessed?

☐ Adult or adolescent ☐ Child under 12 ☐ Adult aged 65 or older

Could a medicine, substance, withdrawal, or recent dose change be relevant?

☐ No plausible contributor ☐ Yes or possibly ☐ Not reviewed

Include sedatives, dopamine-blocking drugs, stimulants, decongestants, anticholinergics, alcohol, and non-prescribed substances when relevant.

Is there a relevant neurological, muscular, metabolic, cardiovascular, autoimmune, or sleep disorder?

☐ No known relevant condition ☐ Yes ☐ Not sure

What prior information is available?

☐ A previous examination or investigation ☐ Prior records but no clear explanation ☐ No useful prior assessment ☐ Not sure

Additional history and documentation

Record exact dates/times, witness details, relevant medication doses and changes, prior investigation reports, and the person’s baseline function.

Section 2: Interpreting the input form

Answer combinations generate a differential and an assessment pathway—not a diagnosis.

> **Precedence:** Emergency safety answers override every pattern below. Otherwise, the highest-urgency fully matched pattern takes precedence. If entries are incomplete, contradictory, or match no pattern, use the unresolved-information pathway.

Pattern 1: Reproducible sensory level

Where is the band or upper border of altered sensation? Chest or upper abdomen / Lower abdomen or pelvis / Neck/shoulder region

Urgent assessment pattern — Same day

A trunk sensory level requires prompt spinal-cord assessment.

Differential to review:

- Compressive or structural myelopathy
- Inflammatory, infectious, or vascular myelitis
- Multiple sclerosis or another central demyelinating process

Action: Arrange same-day medical assessment. If symptoms are rapidly worsening or severe, call 911.

Pattern 2: Sensory level with motor or sphincter signs

Are there leg weakness, stiffness, clumsiness, or walking difficulty? Yes

Emergency warning pattern — Now

A sensory level with leg weakness is an emergency cord-compression/myelitis pathway.

Differential to review:

- Compressive or structural myelopathy
- Inflammatory, infectious, or vascular myelitis

Action: Call 911 or go to the nearest emergency department now. Do not drive yourself.

Pattern 3: Sensory level with sphincter dysfunction

Is there new urinary retention, urgency/incontinence, constipation, or sexual dysfunction? Yes

Emergency warning pattern — Now

Autonomic dysfunction with a sensory level requires emergency spinal assessment.

Differential to review:

- Compressive or structural myelopathy
- Inflammatory, infectious, or vascular myelitis

Action: Call 911 or go to the nearest emergency department now. Do not drive yourself.

Pattern 4: Variable or unclear level

Where is the band or upper border of altered sensation? The level moves or is unclear
Are there leg weakness, stiffness, clumsiness, or walking difficulty? No
Is there new urinary retention, urgency/incontinence, constipation, or sexual dysfunction? No

Prompt clinical review pattern — Promptly

An unclear or shifting level needs careful sensory examination before assigning a cord localization.

Differential to review:

- Radicular, peripheral, or functional sensory pattern

Action: Arrange an in-person medical or neurological review promptly, usually within days. Seek sooner care if the pattern changes.

Unresolved-information pathway: The entries need structured in-person characterization.

Urgent assessment pattern — Same day

Do not guess missing answers or convert uncertainty into reassurance. Document what is unknown, perform an in-person examination, clarify the timeline with a witness or records when available, and reassess if any new feature appears.

Action: Arrange same-day medical assessment. If symptoms are rapidly worsening or severe, call 911.

Section 3: Clinical review

Diagnostic modules and focused investigation logic

The examination comes before a test list. Select investigations only after localization, urgency, comorbidity, pregnancy status, renal function, anticoagulation, and prior results have been considered.

3.1 Compressive or structural myelopathy

Discriminating features: A reproducible sensory level with corticospinal signs, sphincter dysfunction, or focal spinal pain.

Logical investigations: Urgent spinal MRI and neurological examination for acute/progressive findings.

3.2 Inflammatory, infectious, or vascular myelitis

Discriminating features: Subacute sensory level, motor/autonomic features, sometimes without pain.

Logical investigations: Emergency/urgent MRI and clinician-directed inflammatory, infectious, or vascular work-up.

3.3 Radicular, peripheral, or functional sensory pattern

Discriminating features: A band-like complaint may occasionally reflect radicular, neuropathic, or functional mechanisms; examination determines whether a true level exists.

Logical investigations: Map all sensory modalities and reflexes; imaging if the level is reproducible or other neurological signs occur.

3.4 Multiple sclerosis or another central demyelinating process

Discriminating features: A partial cord syndrome with prior neurological episodes or MRI/CSF clues.

Logical investigations: Neurological assessment with brain/spinal MRI and selected CSF testing when clinically indicated.

Reassessment and documentation

- If the symptom pattern changes, repeat the safety screen and timeline rather than carrying forward an earlier interpretation.
- If a test is unrevealing but the deficit persists or progresses, revisit localization and seek specialist review; a normal result does not automatically end assessment.
- If symptoms resolve, document duration, completeness of recovery, recurrence, and any residual deficit. Resolved sudden focal symptoms can still require urgent vascular assessment.
- If the history and examination conflict, obtain collateral information and in-person review rather than forcing a single diagnostic label.

Selected references

Sources provide background standards and do not replace local emergency pathways or current specialist guidance. Accessed October 2026.

1. National Institute for Health and Care Excellence. (2019, updated 2023). *Suspected neurological conditions: recognition and referral (NG127)*. https://www.nice.org.uk/guidance/ng127
2. National Institute for Health and Care Excellence. (2016, updated 2020). *Low back pain and sciatica in over 16s: assessment and management (NG59)*. https://www.nice.org.uk/guidance/ng59