MADISON NEUROLOGY · NEUROLOGY SYMPTOM GUIDE

Blank, staring, or unresponsive spells

Structured history, interpretation & clinical review

Symptom 63 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.

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

Scope and safe use

Blank, staring, or unresponsive spells are classified by duration, interruption, automatisms, triggers, awareness, recovery, and developmental or cognitive context.

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 Blank, staring, or unresponsive spells

1A. Immediate safety screen

Has shaking lasted five minutes or longer, have episodes repeated without recovery, or is the person still unresponsive?

☐ No ☐ Yes ☐ Not sure

If Yes: Call emergency services now. Time the episode and do not put anything in the person's mouth.

Did serious injury, breathing difficulty, blue lips, or pregnancy occur with the episode?

☐ No ☐ Yes ☐ Not sure

If Yes: Call emergency services now and follow dispatcher instructions.

Is there persistent new weakness, severe headache, confusion, double vision, or difficulty speaking after the episode?

☐ No ☐ Yes ☐ Not sure

If Yes: Seek emergency assessment now, even if the shaking or spell has stopped.

Was this the first convulsion, or did it occur in water, with diabetes, or with a known serious medical condition?

☐ No ☐ Yes ☐ Not sure

If Yes: Arrange emergency or same-day medical assessment; do not drive or swim alone.

> **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

How long does a typical spell last?

☐ A few seconds ☐ Thirty seconds to several minutes ☐ Longer than 10 minutes ☐ Highly variable

Can the person be interrupted by touch or a loud voice?

☐ No, unresponsive until it ends ☐ Yes, immediately ☐ Responds partially or slowly ☐ Not observed

Are there repetitive lip movements, hand fumbling, eye deviation, or brief jerks?

☐ Yes ☐ No ☐ Not sure

Is there confusion, headache, immediate normal recovery, or missed conversation?

☐ Confusion or sleepiness ☐ Immediate normal recovery ☐ Missed conversation but no visible change ☐ 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: Brief absence-like staring pattern

How long does a typical spell last? A few seconds
Can the person be interrupted by touch or a loud voice? No, unresponsive until it ends
Is there confusion, headache, immediate normal recovery, or missed conversation? Immediate normal recovery / Missed conversation but no visible change

Prompt clinical review pattern — Promptly

Brief uninterruptible staring with rapid recovery follows an absence-seizure assessment.

Differential to review:

- Absence seizure

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

Pattern 2: Focal impaired-awareness pattern

How long does a typical spell last? Thirty seconds to several minutes
Are there repetitive lip movements, hand fumbling, eye deviation, or brief jerks? Yes
Is there confusion, headache, immediate normal recovery, or missed conversation? Confusion or sleepiness

Urgent assessment pattern — Same day

Longer unresponsive spells with automatisms and confusion follow focal-seizure assessment.

Differential to review:

- Focal impaired-awareness seizure

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

Pattern 3: Interruptible attention-like episodes

Can the person be interrupted by touch or a loud voice? Yes, immediately
Are there repetitive lip movements, hand fumbling, eye deviation, or brief jerks? No

Structured clinical review pattern — Routine review

Immediately interruptible spells without automatisms support attention/daydreaming assessment, while persistent uncertainty may warrant event recording.

Differential to review:

- Attention lapse, daydreaming, sleep-related, or functional episode

Action: Arrange a routine in-person clinical review. New, severe, or worsening symptoms change this pathway.

Pattern 4: Prolonged variable altered-awareness episodes

How long does a typical spell last? Longer than 10 minutes / Highly variable

Prompt clinical review pattern — Promptly

Prolonged variable episodes need medical, sleep, seizure, and functional-event characterization.

Differential to review:

- Syncope, metabolic, or altered-awareness medical event
- Attention lapse, daydreaming, sleep-related, or functional episode

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.

Prompt clinical review pattern — Promptly

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

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 Absence seizure

Discriminating features: Brief frequent staring episodes with abrupt onset/termination, often immediate recovery and possible subtle automatisms.

Logical investigations: Neurological assessment and EEG; distinguish from focal seizures and attention lapses.

3.2 Focal impaired-awareness seizure

Discriminating features: Longer episodes with automatisms, eye deviation, aura, or postictal confusion.

Logical investigations: EEG and brain MRI as part of specialist seizure evaluation.

3.3 Syncope, metabolic, or altered-awareness medical event

Discriminating features: Collapse, prodrome, hypoglycemia, medication, or systemic clues.

Logical investigations: Event vitals, glucose/medication and cardiovascular assessment according to associated features.

3.4 Attention lapse, daydreaming, sleep-related, or functional episode

Discriminating features: Interruptible episodes, fatigue/attention context, or highly variable prolonged events.

Logical investigations: Witness/school/work and sleep history; EEG when events are frequent, injurious, or clinically uncertain rather than by default.

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. (2022, updated 2025). *Epilepsies in children, young people and adults (NG217)*. https://www.nice.org.uk/guidance/ng217
2. National Institute for Health and Care Excellence. (2010, updated 2023). *Transient loss of consciousness (“blackouts”) in over 16s (CG109)*. https://www.nice.org.uk/guidance/cg109