MADISON NEUROLOGY · NEUROLOGY SYMPTOM GUIDE

Fluctuating or fatigable weakness

Structured history, interpretation & clinical review

Symptom 20 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

Fatigable weakness requires demonstration of task-specific decline, ocular and bulbar features, diurnal variation, and separation from generalized tiredness.

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 Fluctuating or fatigable weakness

1A. Immediate safety screen

Is there new face droop, one-sided weakness or numbness, difficulty speaking or understanding, double vision, or severe loss of coordination?

☐ No ☐ Yes ☐ Not sure

If Yes: Call emergency services now and record the exact time the person was last known well.

Is there new confusion, reduced consciousness, a seizure, or difficulty awakening?

☐ No ☐ Yes ☐ Not sure

If Yes: Call emergency services now. Do not leave the person alone or give food, drink, or medication by mouth.

Is there new severe breathlessness, inability to swallow saliva, blue lips, or rapidly worsening weakness?

☐ No ☐ Yes ☐ Not sure

If Yes: Call emergency services now; breathing and swallowing problems can become critical quickly.

Is there sudden loss of vision, a new missing visual field, or a painful red eye?

☐ No ☐ Yes ☐ Not sure

If Yes: Seek emergency eye or emergency-department assessment now.

> **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

Which functions fluctuate most?

☐ Drooping lids or double vision ☐ Chewing, speech, swallowing, or neck holding ☐ Arm or leg strength with repeated use ☐ General energy rather than specific strength

When is weakness worst?

☐ After repeated activity or later in the day ☐ On waking and improves later ☐ No meaningful fluctuation ☐ Not sure

Does brief rest produce noticeable recovery of the specific function?

☐ Yes ☐ No ☐ Not sure

Is there numbness, muscle pain, or sensory loss?

☐ None ☐ Muscle pain without sensory loss ☐ Sensory loss or numbness ☐ 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: Ocular or bulbar fatigability

Which functions fluctuate most? Drooping lids or double vision / Chewing, speech, swallowing, or neck holding
When is weakness worst? After repeated activity or later in the day
Does brief rest produce noticeable recovery of the specific function? Yes

Urgent assessment pattern — Same day

Activity-related ocular/bulbar weakness with rest recovery is a characteristic junction-disorder pattern.

Differential to review:

- Myasthenia gravis or another junction disorder

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

Contingency: Promptly assess swallowing, cough, neck strength, and breathing; breathlessness or inability to swallow saliva is an emergency.

Pattern 2: Fatigable limb weakness

Which functions fluctuate most? Arm or leg strength with repeated use
Does brief rest produce noticeable recovery of the specific function? Yes
Is there numbness, muscle pain, or sensory loss? None

Prompt clinical review pattern — Promptly

Reproducible limb fatigability without sensory symptoms warrants junction and myopathy assessment.

Differential to review:

- Myasthenia gravis or another junction disorder
- Myopathy or motor-unit disorder

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

Pattern 3: General fatigue rather than demonstrable weakness

Which functions fluctuate most? General energy rather than specific strength
When is weakness worst? No meaningful fluctuation

Structured clinical review pattern — Routine review

General low energy without a clear activity/rest strength pattern requires a systemic and sleep/mood evaluation.

Differential to review:

- Sleep, mood, systemic, or medication-related fatigue

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

Pattern 4: Weakness with sensory loss

Is there numbness, muscle pain, or sensory loss? Sensory loss or numbness

Urgent assessment pattern — Same day

Sensory loss moves the assessment toward peripheral, spinal, or central neurological disease.

Differential to review:

- Central, peripheral, or spinal neurological disorder

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

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 Myasthenia gravis or another junction disorder

Discriminating features: Fatigable ocular, bulbar, neck, or proximal weakness with rest recovery and preserved sensation.

Logical investigations: Neurological examination for fatigability; specialist antibody and repetitive-stimulation/single-fiber testing, with thymus imaging when indicated.

3.2 Myopathy or motor-unit disorder

Discriminating features: Fixed or activity-limited weakness, myalgia, atrophy, or CK abnormality may mimic fatigue.

Logical investigations: CK, metabolic/endocrine and medication review; electrodiagnostics and neuromuscular referral as indicated.

3.3 Central, peripheral, or spinal neurological disorder

Discriminating features: Sensory loss, upper/lower motor signs, or a fixed anatomical pattern argues against an isolated junction disorder.

Logical investigations: Focused central/peripheral examination and targeted imaging or electrodiagnostics.

3.4 Sleep, mood, systemic, or medication-related fatigue

Discriminating features: General low energy without reproducible task-specific force decline has a broader differential.

Logical investigations: Sleep, mood, medication, cardiopulmonary and targeted laboratory review; document objective task performance.

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

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