MADISON NEUROLOGY · NEUROLOGY SYMPTOM GUIDE

Other recurrent stereotyped “spells”

Structured history, interpretation & clinical review

Symptom 64 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

Recurrent stereotyped spells are reconstructed event by event using aura, triggers, motor/sensory features, awareness, duration, recovery, and witness or video evidence.

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 Other recurrent stereotyped “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

Which recurring feature dominates?

☐ The same focal sensory, motor, or speech symptom ☐ Altered awareness or lost time ☐ Fear, rising sensation, déjà vu, or autonomic surge ☐ Stereotyped movements or posturing

How long is a typical spell?

☐ Seconds ☐ Several minutes ☐ More than 30 minutes ☐ Highly variable

Are episodes nearly identical each time?

☐ Yes, strongly stereotyped ☐ They vary substantially ☐ Not sure

Is there post-episode confusion, focal weakness, headache, or immediate recovery?

☐ Confusion or focal weakness ☐ Headache or migraine features ☐ Immediate full recovery ☐ 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: Stereotyped focal-seizure pattern

Are episodes nearly identical each time? Yes, strongly stereotyped
How long is a typical spell? Seconds / Several minutes
Which recurring feature dominates? The same focal sensory, motor, or speech symptom / Altered awareness or lost time / Fear, rising sensation, déjà vu, or autonomic surge / Stereotyped movements or posturing

Urgent assessment pattern — Same day

Brief stereotyped recurrent episodes require focal-seizure and transient-neurological-event assessment.

Differential to review:

- Focal seizure or other epileptic event
- TIA or another transient vascular event

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

Pattern 2: Postictal or residual-deficit pattern

Is there post-episode confusion, focal weakness, headache, or immediate recovery? Confusion or focal weakness

Urgent assessment pattern — Same day

Post-episode confusion or focal weakness increases the need for prompt neurological assessment.

Differential to review:

- Focal seizure or other epileptic event
- TIA or another transient vascular event

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

Pattern 3: Migraine-like recurrent spell pattern

Is there post-episode confusion, focal weakness, headache, or immediate recovery? Headache or migraine features
How long is a typical spell? Several minutes

Prompt clinical review pattern — Promptly

Recurrent episodes evolving over minutes with migraine features follow an aura assessment.

Differential to review:

- Migraine aura or migraine-related episode
- Focal seizure or other epileptic event

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

Pattern 4: Variable prolonged spell pattern

Are episodes nearly identical each time? They vary substantially
How long is a typical spell? More than 30 minutes / Highly variable

Prompt clinical review pattern — Promptly

Variable prolonged episodes need careful event capture and a broad but structured differential.

Differential to review:

- Panic, functional/dissociative, movement, sleep, or metabolic 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.

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 Focal seizure or other epileptic event

Discriminating features: Strong stereotypy, brief duration, aura/automatisms, altered awareness, or postictal features.

Logical investigations: Neurological event assessment with EEG and MRI when supported; home video and exact timing improve classification.

3.2 TIA or another transient vascular event

Discriminating features: Sudden negative focal deficits, vascular risk, or new non-stereotyped neurological symptoms.

Logical investigations: Urgent vascular assessment, especially for first/new focal deficits; seizure-like positive phenomena do not exclude vascular disease.

3.3 Migraine aura or migraine-related episode

Discriminating features: Positive symptoms evolving over minutes with headache or established migraine phenotype.

Logical investigations: Headache/event diary and neurological examination; atypical brief or residual deficits require further evaluation.

3.4 Panic, functional/dissociative, movement, sleep, or metabolic episode

Discriminating features: Autonomic/emotional triggers, variable prolonged events, sleep relation, or glucose/medication clues.

Logical investigations: Witness/video history and targeted glucose/cardiac/sleep/neurological evaluation; functional episodes require positive diagnostic features.

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

Madison Neurology LLC — Neurology Symptom Guide
Other recurrent stereotyped “spells” — including unexplained episodes of altered awareness or focal neurological symptoms
Educational reference only. Not for clinical use. Treatment is outside the scope of this workbook.