MADISON NEUROLOGY · NEUROLOGY SYMPTOM GUIDE

Persistent drowsiness, reduced responsiveness, or coma

Structured history, interpretation & clinical review

Symptom 66 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

Persistent drowsiness, reduced responsiveness, or coma is an emergency presentation; documentation supports—but must not delay—airway, medical, neurological, toxic, and structural assessment.

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 Persistent drowsiness, reduced responsiveness, or coma

1A. Immediate safety screen

Is the person acutely confused, struggling to breathe, having a seizure, or difficult to awaken?

☐ No ☐ Yes ☐ Not sure

If Yes: Call emergency services now.

Is there new one-sided weakness, facial droop, severe imbalance, or speech/language difficulty?

☐ No ☐ Yes ☐ Not sure

If Yes: Call emergency services now and record the onset time.

Is there sudden visual loss or a new painful red eye?

☐ No ☐ Yes ☐ Not sure

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

Is there fever with rapidly worsening illness, a new rash, severe dehydration, or an inability to keep fluids down?

☐ No ☐ Yes ☐ Not sure

If Yes: Arrange same-day or emergency assessment depending on severity and current consciousness.

> **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

What is the current response?

☐ Opens eyes or responds to voice ☐ Responds only to physical stimulation ☐ No meaningful response ☐ Fluctuates between these

Is breathing normal and is the person easy to keep awake?

☐ Breathing appears normal but drowsy ☐ Slow, irregular, noisy, or labored breathing ☐ Cannot remain awake ☐ Not sure

Is there overdose, diabetes, seizure, trauma, infection, or stroke risk?

☐ Yes or possibly ☐ No known factor ☐ Not sure

When was the person last known at their usual responsiveness?

☐ Within the last hour ☐ Several hours ago ☐ More than a day ago ☐ Not known

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: Persistent reduced responsiveness emergency

What is the current response? Opens eyes or responds to voice / Responds only to physical stimulation / No meaningful response / Fluctuates between these

Emergency warning pattern — Now

Any persistent reduction in responsiveness requires emergency assessment now.

Differential to review:

- Toxic, metabolic, hypoxic, or systemic cause
- Stroke, hemorrhage, seizure, or structural brain disorder
- Encephalitis, meningitis, or inflammatory central process

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

Contingency: Call emergency services now. Do not give food, drink, or oral medication; follow dispatcher positioning and airway instructions.

Pattern 2: Abnormal breathing or inability to stay awake

Is breathing normal and is the person easy to keep awake? Slow, irregular, noisy, or labored breathing / Cannot remain awake

Emergency warning pattern — Now

Abnormal breathing or inability to remain awake is immediately life-threatening.

Differential to review:

- Toxic, metabolic, hypoxic, or systemic cause
- Stroke, hemorrhage, seizure, or structural brain disorder

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

Pattern 3: Possible toxic or metabolic cause

Is there overdose, diabetes, seizure, trauma, infection, or stroke risk? Yes or possibly

Emergency warning pattern — Now

A possible overdose, diabetes, trauma, seizure, infection, or stroke context reinforces emergency assessment.

Differential to review:

- Toxic, metabolic, hypoxic, or systemic cause
- Stroke, hemorrhage, seizure, or structural brain disorder
- Encephalitis, meningitis, or inflammatory central process

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

Unresolved-information pathway: Reduced responsiveness is an emergency.

Emergency warning pattern — Now

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

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 Toxic, metabolic, hypoxic, or systemic cause

Discriminating features: Overdose, glucose/electrolyte disturbance, hypoxia, infection, organ failure, or withdrawal.

Logical investigations: Emergency vital-sign/airway assessment and targeted bedside glucose, laboratory, toxicology, oxygenation and infection testing.

3.2 Stroke, hemorrhage, seizure, or structural brain disorder

Discriminating features: Focal signs, trauma, abrupt onset, postictal state, or brainstem findings.

Logical investigations: Emergency brain/vascular imaging and neurological assessment; EEG for suspected nonconvulsive seizure when indicated.

3.3 Encephalitis, meningitis, or inflammatory central process

Discriminating features: Fever, headache, meningism, behavioral change, seizures, or immune context.

Logical investigations: Emergency infection/inflammation evaluation with imaging, LP and EEG as clinically appropriate.

3.4 Severe sleep-related, psychiatric, or functional unresponsiveness

Discriminating features: A diagnosis only after medical and neurological emergencies are assessed.

Logical investigations: Continuous observation and objective examination; do not assume a behavioral cause from normal initial tests alone.

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