MADISON NEUROLOGY · NEUROLOGY SYMPTOM GUIDE

Proximal weakness

Structured history, interpretation & clinical review

Symptom 19 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

Proximal weakness is characterized through chair rise, stairs, overhead activity, pain, tempo, ocular/bulbar symptoms, and medication or endocrine exposures.

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 Proximal 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 group of tasks is most affected?

☐ Chair rise, stairs, or squatting ☐ Lifting arms, washing or combing hair ☐ Both shoulder and hip tasks ☐ Not sure

Is muscle pain prominent?

☐ Little or no muscle pain ☐ Muscle aching or tenderness ☐ Severe pain with dark urine or marked swelling ☐ Not sure

Does strength fluctuate or worsen with repeated activity?

☐ Yes, clear fatigability ☐ No, relatively fixed weakness ☐ Not sure

Is there steroid use, thyroid disease, statin or another new medicine, alcohol risk, or autoimmune disease?

☐ Yes ☐ No known exposure ☐ 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: Fixed proximal myopathic pattern

Which group of tasks is most affected? Both shoulder and hip tasks / Chair rise, stairs, or squatting / Lifting arms, washing or combing hair
Does strength fluctuate or worsen with repeated activity? No, relatively fixed weakness

Prompt clinical review pattern — Promptly

Fixed proximal weakness without sensory symptoms follows a myopathy and motor-unit evaluation pathway.

Differential to review:

- Inflammatory, toxic, endocrine, or necrotizing myopathy
- Muscular dystrophy or congenital/metabolic myopathy
- Proximal neuropathy, radiculopathy, or deconditioning

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

Pattern 2: Fatigable proximal weakness

Does strength fluctuate or worsen with repeated activity? Yes, clear fatigability

Urgent assessment pattern — Same day

Clear fatigability raises a neuromuscular-junction pathway and requires bulbar/respiratory screening.

Differential to review:

- Myasthenic or other neuromuscular-junction disorder

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

Pattern 3: Toxic or endocrine-associated pattern

Is there steroid use, thyroid disease, statin or another new medicine, alcohol risk, or autoimmune disease? Yes

Prompt clinical review pattern — Promptly

A relevant medication, endocrine, alcohol, or autoimmune clue targets initial myopathy testing.

Differential to review:

- Inflammatory, toxic, endocrine, or necrotizing myopathy

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

Pattern 4: Painful severe muscle presentation

Is muscle pain prominent? Severe pain with dark urine or marked swelling

Emergency warning pattern — Now

Severe muscle pain with dark urine or swelling requires emergency metabolic and renal assessment.

Differential to review:

- Inflammatory, toxic, endocrine, or necrotizing myopathy

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

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 Inflammatory, toxic, endocrine, or necrotizing myopathy

Discriminating features: Proximal weakness with or without pain; steroid, statin, thyroid, autoimmune, or systemic clues guide the subtype.

Logical investigations: CK and medication/endocrine review; specialist-directed EMG, MRI, antibody testing, or biopsy when indicated.

3.2 Muscular dystrophy or congenital/metabolic myopathy

Discriminating features: Longstanding or progressive proximal weakness, family history, calf change, or exercise-related episodes.

Logical investigations: CK, neuromuscular examination, genetic/metabolic evaluation, and selected electrodiagnostics.

3.3 Myasthenic or other neuromuscular-junction disorder

Discriminating features: Fatigable proximal, ocular, bulbar, neck, or respiratory weakness without sensory loss.

Logical investigations: Fatigability and reflex examination; specialist antibody and electrodiagnostic testing; respiratory assessment if bulbar symptoms occur.

3.4 Proximal neuropathy, radiculopathy, or deconditioning

Discriminating features: Painful lumbosacral/shoulder syndrome, root-level deficits, or reduced activity can mimic primary muscle disease.

Logical investigations: Distribution/reflex/sensory examination, glucose and medication review, electrodiagnostics when 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