MADISON NEUROLOGY · NEUROLOGY SYMPTOM GUIDE

Recurrent sleep paralysis or sudden emotion-triggered loss of muscle tone

Structured history, interpretation & clinical review

Symptom 92 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 sleep paralysis and emotion-triggered loss of muscle tone are separated by timing, consciousness, trigger, breathing, sleepiness, hallucinations, and seizure or syncope mimics.

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 Recurrent sleep paralysis or sudden emotion-triggered loss of muscle tone

1A. Immediate safety screen

Is there current severe breathlessness, blue lips, chest pain, or inability to awaken?

☐ No ☐ Yes ☐ Not sure

If Yes: Call emergency services now.

Is the person falling asleep while driving, operating machinery, or doing another safety-critical activity?

☐ No ☐ Yes ☐ Not sure

If Yes: Stop the activity now and arrange prompt assessment; do not drive until the safety issue has been evaluated.

Is there new focal weakness, sudden severe headache, confusion, or a prolonged seizure?

☐ No ☐ Yes ☐ Not sure

If Yes: Call emergency services now.

Has a sleep behavior caused serious injury, or is there a new prolonged unresponsive episode?

☐ No ☐ Yes ☐ Not sure

If Yes: Seek emergency or same-day assessment depending on current responsiveness and injury severity.

> **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 triggers the episode?

☐ Laughter, surprise, anger, or excitement ☐ Falling asleep or waking ☐ No consistent trigger ☐ Standing or exertion

Is awareness preserved during the episode?

☐ Yes, fully aware ☐ No, awareness is lost ☐ Not sure

Which associated features occur?

☐ Cannot move but can breathe, at sleep-wake transition ☐ Dream-like sights/sounds around sleep ☐ Irresistible daytime sleep attacks ☐ None

How long is the episode and recovery?

☐ Seconds to two minutes with immediate recovery ☐ Longer or followed by confusion ☐ Highly variable ☐ 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: Emotion-triggered cataplexy pattern

What triggers the episode? Laughter, surprise, anger, or excitement
Is awareness preserved during the episode? Yes, fully aware
How long is the episode and recovery? Seconds to two minutes with immediate recovery

Prompt clinical review pattern — Promptly

Brief emotion-triggered weakness with preserved awareness is a characteristic cataplexy pattern requiring sleep assessment.

Differential to review:

- Cataplexy associated with narcolepsy

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

Pattern 2: Sleep-paralysis pattern

What triggers the episode? Falling asleep or waking
Which associated features occur? Cannot move but can breathe, at sleep-wake transition / Dream-like sights/sounds around sleep
Is awareness preserved during the episode? Yes, fully aware

Prompt clinical review pattern — Promptly

Sleep-wake paralysis with preserved awareness follows a sleep-paralysis and narcolepsy-feature assessment.

Differential to review:

- Recurrent isolated sleep paralysis
- Cataplexy associated with narcolepsy

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

Pattern 3: Event with impaired awareness or delayed recovery

Is awareness preserved during the episode? No, awareness is lost
How long is the episode and recovery? Longer or followed by confusion

Urgent assessment pattern — Same day

Loss of awareness or prolonged recovery requires seizure, syncope, and other urgent event mimics to be assessed.

Differential to review:

- Focal/generalized seizure, syncope, or atonic event

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

Pattern 4: Standing or exertional weakness episode

What triggers the episode? Standing or exertion

Urgent assessment pattern — Same day

Standing or exertional episodes require orthostatic, cardiac, and metabolic assessment rather than assuming cataplexy.

Differential to review:

- Focal/generalized seizure, syncope, or atonic event
- Medication, metabolic, functional, or other motor episode

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 Cataplexy associated with narcolepsy

Discriminating features: Brief emotion-triggered bilateral tone loss with preserved awareness, often alongside excessive daytime sleepiness.

Logical investigations: Sleep-specialist assessment and targeted narcolepsy testing; evaluate driving and safety risks.

3.2 Recurrent isolated sleep paralysis

Discriminating features: Sleep-wake transition paralysis with preserved breathing/awareness, sometimes with hallucinations and sleep disruption.

Logical investigations: Sleep schedule and narcolepsy-feature review; specialist assessment if frequent or associated with marked sleepiness.

3.3 Focal/generalized seizure, syncope, or atonic event

Discriminating features: Loss of awareness, postictal confusion, standing/exertion trigger, injury, or prolonged recovery suggests a mimic.

Logical investigations: Neurological/cardiovascular event assessment with ECG, EEG, or imaging as indicated.

3.4 Medication, metabolic, functional, or other motor episode

Discriminating features: Drug, electrolyte, neuromuscular, or functional causes can produce transient weakness without classic triggers.

Logical investigations: Medication, metabolic, and neurological examination guided by the witnessed pattern.

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. (2021, updated 2024). *Obstructive sleep apnoea/hypopnoea syndrome and obesity hypoventilation syndrome in over 16s (NG202)*. https://www.nice.org.uk/guidance/ng202
2. Winkelman JW, Berkowski JA, DelRosso LM, et al.. (2025). *Treatment of restless legs syndrome and periodic limb movement disorder: an American Academy of Sleep Medicine clinical practice guideline*. https://pubmed.ncbi.nlm.nih.gov/39324694/

Madison Neurology LLC — Neurology Symptom Guide
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Educational reference only. Not for clinical use. Treatment is outside the scope of this workbook.