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Highlights from this issue

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Neurological diagnosis is based upon the clinical assessment, the history and examination. How can we make an appropriate diagnosis without an adequate clinical assessment? “Fundoscopy—discs not seen”, “ophthalmoscope not available”, or simply a blank space where the ophthalmoscopy findings should appear, are commonly seen in the notes of patients admitted with neurological problems across the world. One recent study found that only 30% of such patients recalled being examined with an ophthalmoscope.¹ This unsatisfactory situation must be putting patients at risk. A ‘what if’ game brings out the critical importance of ophthalmoscopy: consider the differential diagnosis and management (and urgency of investigations) if the same patient had bilateral papilloedema, unilateral optic atrophy, etc. Despite its readily demonstrable importance in clinical assessment, ophthalmoscopy risks being dropped—along with many a departmental ophthalmoscope—as a routine part of examination. All doctors own a stethoscope—and most an expensive mobile phone—but only neurologists seem to own an ophthalmoscope. Ophthalmoscopy used to be mandatory in undergraduate and postgraduate exams but no longer; now only a minority of candidates for Membership of the Royal College of Physicians’ (UK) clinical examination are actually specifically assessed on this. With less practice and reduced incentive to learn, it is perhaps no surprise that many doctors do not feel confident in their ophthalmoscopy skills. What can be done? In this issue, Beau Bruce and colleagues (*see page 343*) describe their experience and give advice on introducing non-mydriatic fundus photography into acute medical care. This technology is so simple to use and the images of such high quality, that it seems to provide a solution to the falling rates of fundoscopy—at least providing

high quality images to look at and learn from. Certainly this technology merits further exploration.

Devices are increasingly viewed as potential alternatives to drug treatments. Alex Sinclair and colleagues (*see page 362*) review neurostimulation for primary headache disorders, and explore the difficulties in interpreting the studies that underlie their use—what is an appropriate control for an electric shock?—and how to make sense of them.

Enteral feeding has become an increasingly important and widespread intervention for many neurological disorders, and particularly motor neurone disease. It is being used earlier in the course of the disease, not just to provide nutritional support and to avoid weight loss, but also to provide the patient with control: people who can be fed and watered and have their medication can choose where they are looked after. Chris McDermott and colleagues review this developing topic for us (*see page 352*) and remind us how to distinguish a PEG from a RIG and a PIG.

We now have potent and effective treatments for multiple sclerosis but at the cost of potential complications, notably progressive multifocal leukoencephalopathy in people taking natalizumab. Our increased understanding of which patients are at highest risk allows us to consider switching from this drug to another—but should we? This is not straightforward decision and Gavin Giovannoni and colleagues discuss this and outline their strategy (*see page 389*).

Some diagnoses stare you in the face: one such is hereditary haemorrhagic telangiectasia. But when patients with this disorder presents with ischaemic stroke, due to pulmonary arterio-venous fistula, should you give thrombolysis? Ingrid Kane and colleagues discuss

this issue and what they did (*see page 381*).

The kind of clinical challenge posed in our Test Yourself (*see page 394* from David Bourke) suggests that machines will not replace all the functions that clinical neurologists currently perform in the near future. Migraine is common and typically diagnosed on clinical assessment, often with exclusion of alternative pathologies. Despite our imperfect understanding of its pathogenesis, it comprises a model for several transient neurological phenomena. We have two reports of unusual migraine; one with stroke-like presentation after cranial radiotherapy (‘SMART syndrome’, described on *see page 406*), the other with recurrent hypersomnia (*see page 389*).

A significant mythology has built up around the neurological examination: some parts are treated with particular reverence, but should they be? Is the Babinski sign, the extensor plantar response, actually a myth (ie, a widely held but false belief)? Matthew Kiernan takes on this issue as he offers us the next instalment of neuromythology (*see page 419*). The aspects of clinical examination discussed in Neuromythology are clearly dear to our readers’ hearts, and we publish two ripostes to Martin Turner’s dismantling of Romberg’s test. We expect these debates to continue and invite further discussion of neuromythology online. If you have myths (or rather neuromyths) you wish to debunk, we should be very interested to hear of them.

Competing interests None declared.

REFERENCE

- 1 Appleton PH, Ilinca A, Lindgren A, *et al*. Improving the likelihood of neurology patients being examined using patient feedback. *BMJ Qual Improv Report* 2015;4. pii:u209610.w4063.