EDITOR'S CHOICE

Pract Neurol 2007; 7: 279

Back in the very old days, a bag of potato crisps contained a small blue packet from which salt could be sprinkled onto the crisps. No longer. The wicked purveyors of salt now realise that if they sprinkle their product onto the crisps *before* they go into the bag we, the eaters, will have no choice but to consume their blood-pressure raising product with the crisps. Neat. Why then do so many medical schools teach some traditionally unpopular and yet important subjects—such as ethics, public health and epidemiology—so often in classrooms while the bees gently buzz and the students gently doze? It is all too easy for the students to throw out the little blue bag containing the boring subject; better surely to sprinkle it—like salt—on to the drama of real patients with real problems, at the bedside. A very good example, is the "difficult case" described on page 336. Here there was a real diagnostic and ethical issue, the one cannot possibly be discussed without the other, and both must be taught at the bedside to engage the students—not in a sterile classroom by an ethicist who has no idea of the clinical issue (or at the bedside by a clinician with no interest in the ethical issue). Tropical medicine is another topic which students, in the UK anyway, are seldom interested in (all those life cycles to remember, at least for exams) while travel to the tropics for electives is hugely popular. So rather than letting them just sit on a beach listening to their iPods and acquiring a tan, someone should sprinkle them with useful medical knowledge so they, and the readers of *Practical Neurology*, don't come back with Ciguatera poisoning (page 316) or Japanese encephalitis (page 288). Not much chance of either in Paris according to Anna Williams's letter on page 346 describing her experiences as an English neurologist having to upgrade her French rather fast. Do the students anywhere go to autopsies any more? Mostly they don't, perhaps because the autopsy has more or less disappeared, more is the pity. And yet the correlation between the clinical with the postmortem findings lies at the heart of understanding neurological diagnosis, as we see—yet again—in a clinicopathological conference, this time from Cardiff, on page 306. Of course history is a real turn off for medical students but how interesting it is, at least for the older person like me, to read about who thought what and when about the mechanism of neuronal transmission on page 331. Finally, a well aimed warning to us all about over-cooking EEG reports on page 323, and a step-by-step exposition of how to examine eye movements properly on page 326 (I suspect most of us don't do this properly at all). A potpourri, as ever—to be read, on the beach, or more likely on the train or in front of the fire as some of us shiver our way into a northern hemisphere winter.

Charles Warlow

A REQUEST

Every day of every week all around the world cases are being presented at local neurology meetings by neurology trainees. So let the trainees write some up, in the format we are developing for the "Test yourself" section (page 342) and send them to us for consideration for publication. The cases must be interesting, educational and maybe sometimes a little quirky, drawing the reader in and along the twisting diagnostic pathway via a series of questions to the final solution, exploiting the ever growing fascination that we all have with neurology (so much more interesting than cardiology, for example). Write the cases up well, as a story—active tense, short well chosen words and all that—and email them to Myles Connor (mconnor@staffmail.ed.ac.uk). If we like what you send we will help you improve it and get it into print.

CORRECTION

Please note that in the paper "Essential tremor, deceptively simple ...", published in the last issue (*Pract Neurol* 2007;**7**:222–33), F B Nahab and E Peckham should have been listed as joint first authors.

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