

## EDITOR'S CHOICE

Pract Neurol 2009; 9: 253

If you want to confuse people then use one or more names for exactly the same thing. For example, as a medical student it took me a long time before I realised that the pyramidal and corticospinal tracts were essentially the same, and not much different—if at all—to the upper motor neurons. And yet 40 years on we still use these terms interchangeably when we talk of upper motor neuron/pyramidal/corticospinal tract signs. So no surprise that we are all confused by the host of names given to that increasingly recognised syndrome which is reviewed by Anne Ducros and Marie-Germaine Bousser from Paris ([page 256](#)); reversible cerebral vasoconstriction syndrome is a bit of a mouthful but that is probably what we should best call it. To make matters worse, the waters have been much muddled over the years by some authors assuming this syndrome is a benign form of isolated cerebral vasculitis—but without histological proof. In fact from the very few brain biopsies available it does not appear to be anything of the sort. Interestingly the two authors can look down both ends of the telescope at this syndrome because they run an acute stroke as well as an acute headache service at their hospital—the patients may present to either. Coincidentally, the test yourself case we are publishing ([page 294](#)) could have been seen by their headache service if he had lived in Paris rather than Oxfordshire (his diagnosis should be added to their list of causes of thunderclap headache).

John Craig and Stephen Hunt from Belfast take us through the tricky decision making process we have to make when selecting the best antiepileptic drug for young women with an idiopathic epilepsy syndrome on ([page 268](#)). Once again I am struck by how much practice-based research has to offer in sorting

out this kind of everyday problem, which is why I asked the people running one of the pregnancy registers to write the article. If only more epileptologists would do this kind of simple (but not simplistic) research rather than yet another small trial of the latest antiepileptic drug, we would know rather better how to advise the thousands and thousands of people with epilepsy. Which brings us nicely to NICE (the UK National Institute for health and Clinical Excellence) ([page 278](#)). We all need to understand how NICE works and David Chadwick, a "retired" neurologist, can tell us from the inside. As he says, it must be doing something right because it is being used as a model by other countries, and recently it has been under amazing attack by the US Republicans who don't care for Obama's healthcare reforms (they confuse civilised medicine with socialised medicine).

It may seem a bit perverse but I quite like publishing cases where the diagnosis is not completely clear ([page 284](#)), this after all reflects the reality of our practice, even in the best of centres such as the Santa Maria Hospital in Lisbon. Martin Shabet tells us about how he tolerated Miller Fisher syndrome ([page 289](#)) and Stefano Ricci how he tolerated the cultural trauma of arriving in Oxford from Perugia in the 1980s ([page 292](#)).

Finally Kevin Talbot gives us the bare essentials of motor neuron disease ([page 303](#)), the illness that I suspect most neurologists fear the most about getting, and which we all thought we had as medical students when we learned about fasciculations and then noticed them in our first dorsal interosseous muscle.

Charles Warlow