EDITOR'S CHOICE

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The greatest diagnostic challenge for a neurologist is spotting an unusual or rare disorder, particularly if it is treatable, and the greatest pleasure is in doing this quickly and efficiently where others have failed. My own highlight came when I diagnosed my first and only case of Wilson's disease which caused the extraordinary elation that this was just what I had been trained to do over all those years of unrelenting toil as a junior hospital doctor! It is this diagnostic ability which can make neurologists seem like magicians in the eyes of some, at least those who don't realise that it is mostly a matter of rigorous clinical training rather than superior brain power and the ability to solve crosswords in minutes. We are still – I hope - trained to think rather than just meander down algorithms, ticking boxes as we go. And, apart from the psychiatrists, we are of course the final guardians of taking a proper history.

As Katie Murray tells us (*page 19*) it is all too easy to diagnose CJD, but you do have to think – and think again – could this patient with 'CJD' have something else, and something else treatable? Read her article for tips from someone who had to do this for a couple of years all round the UK when she was a research fellow at the National Creutzfeldt-Jakob Disease Surveillance Unit. The test yourself piece (*page 44*) also shows how you have to think to spot the unusual. But this pleasurable (and maybe for some elitist) part of being a neurologist must absolutely not excuse us from sorting out the headaches and dizziness in general neurology clinics, or the many challenges of managing acute and sometimes long term conditions.

And thinking acute, being called to the Intensive Care Unit is a worrying moment for many neurologists, particularly for those who have abdicated from acute medicine and have no idea what each beep on the monitor means, or which fluids are coming and going through which tube. Because we have to grapple with the causes and consequences of hypoxic-ischaemic brain injury, read Robin Howard and his colleagues' guide (*page 4*) and have no fear.

Stem cells are trendy, and patients want to know about them, so bear in mind the rather sober messages in the Cambridge and Edinburgh article (*page 29*). And if you prefer the comfort of looking backwards rather than forwards, we have some thoughts on Hughlings Jackson (*page 37*); even better than diagnosing Wilson's disease must be having a disease – or in this case a seizure - named after you.

Bare Essentials (*page 50*) this time is about head injury. I deliberately asked a Dutch neurologist because in Holland they do things properly – neurologists are seriously engaged in looking after head injury. Astonishingly in the UK we leave it to orthopaedic and general surgeons, with occasional help from the neurosurgeons.

Finally, for those that are wondering, the new editors of Practical Neurology will be Geraint Fuller in Gloucester and Phil Smith in Cardiff, a well known UK double act. They take over from the October 2011 issue.

Charles Warlow