Highlights from this issue

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Some conditions fall between specialties: optic neuritis is a very good example. It presents with visual disturbance, sometimes with eye pain, and a patient is likely to be referred to an ophthalmologist—from optician, emergency department or primary care. Many of the important differential diagnoses are ophthalmological, though not all, and the ophthalmologist is usually concerned about the neurological implications of the diagnosis—a concern that the patient often shares after only a brief internet search. Thus, patients with optic neuritis often attend a neurologist, particularly if there are atypical features. In this edition of *Practical Neurology*, Dinushi Weerasinghe and Christian Lueck (***see page 96***) explore the mimics and chameleons of optic neuritis, a paper that should help us in making the diagnosis more secure and to increase awareness of the ophthalmological differentials.

Another clinical area of overlap occurs when children with neurological disorders grow up and move to adult services. A clinical approach to some disorders that is familiar to paediatric neurologists but rather less to adult neurologists is recognising and identifying patterns of dysmorphology. Abhijit Dixit and Mohnish Suri explore patterns of facial dysmorphology that can help in syndromic diagnosis of epilepsy (***see page 111***).

The diagnosis of brainstem death in the intensive care unit is not the sole province of the neurologist; despite this being a formalised neurological examination, it is intensivists who usually perform it in the UK. David Breen and colleagues provide a clear exposition of how this is done, while emphasising the very important caveats in place (***see page 129***). There is some international variation around the definition and diagnosis of brain and brainstem death. Panayiotis Varelas provides a North American perspective, exploring the difference between brain (US) and brainstem (UK) death that seems to exist in theory but not in clinical practice (***see page 85***).

Sometimes it is our patients who fall between specialties, for example those with Parkinson's disease who are undergoing gastroenterological procedures or surgery and cannot take their medications. This a relatively common problem and Jane Alty and colleagues provide a very practical guide—one to cut out and keep (***see page 122***).

We are increasingly diagnosing spontaneous intracranial hypotension, presumably due to wider awareness of the diagnosis and improved non-invasive diagnosis with MRI. For many patients, the condition is self-limiting or it resolves following simple interventions such as blind blood patching. But what should we do if these do not work? Christopher Stephen describes an intervention that appears to have been successful (***see page 146***) and Alok Tyagi discusses more generally the range of available treatment options (***see page 87***). Caffeine is one agent that might provide short-term benefit in intracranial hypotension (on very limited evidence). Patients with other neurological problems sometimes ask if they should stop drinking coffee—but overall the evidence (again limited) suggests the opposite—a topic that Astrid Nehlig discusses on page 89.

In managing patients with infectious disease we often depend upon advice from our microbiological colleagues, valuing their expertise in identifying the underlying infectious organism. Tim Beernink and colleagues describe a patient with meningitis where the organism was found using an RNA PCR technique you may not have come across before, but which may be informative in culture-negative infections (***see page 136***).

We also have overlaps with neurological services in different countries and in this issue we have a neurological letter from Italy (***see page 166***). We report on a further fortuitous overlap when two neurology book clubs discussed the same book, with each coming to rather different conclusions (***see page 170***). Carphology, as always, harvests the most interesting overlaps with neurology from other journals (***see page 172***).

In this edition we have a wide range of articles exploring situations where neurology overlaps with other specialties, the borderlands of neurology. 'Me and my neurological illness' articles provide the ultimate overlap, particularly when the illness is the patient's (neurologist's) area of expertise. Many UK neurologists and epileptologists around the world know Jim Morrow, not least for his work on the UK epilepsy and pregnancy register. On page 162 Jim describes his own neurological illness, providing a moving insight into his autoimmune encephalopathy and seizures and his recovery. This provides not only privileged insights for fellow neurologists but also a helpful framework for patients and their families still within the throes of the illness.