



CrossMark

# Highlights from this issue

Geraint N Fuller, Phillip E M Smith

*Primum non nocere*; 'First, do no harm' is a fundamental principle in medicine. Neurologists' thinking is often led by this principle when considering referring a patient for neurosurgery. Consider a 35-year-old man who presents with a single seizure and his scan shows what looks like a low-grade glioma. Such patients could easily be followed for many years with repeated scans and little progression, but with the knowledge that they would, at some stage, deteriorate as the tumour transforms. Against this, there is no such thing as a minor neurosurgical operation and the patient may be left with post-operative deficits. Should he have surgery? Do the risks outweigh the benefits? Is an operation not just feasible but also desirable? Caroline Hayhurst updates us (*see page 183*) with the information needed to inform this difficult decision in people with low-grade gliomas. She concludes that we should move to early resection, where feasible: a significant paradigm shift. Less *primum non nocere* but more a caricature neurosurgical approach: 'Have a good plan; execute it violently; and do it today' (General Douglas McArthur, 1880–1964).

Such step changes are unusual in medicine; most are gradual. One change we do all encounter (both professionally and personally) is the effect of ageing. Our thoughts undoubtedly differ on finding absent ankle reflexes and lost vibration sense in an 81-year-old compared with in a 21-year-old. We all make allowances in what we consider normal as patients get older—as indeed do patients

themselves—but what is the neurology of normal ageing? Jonathan Schott (*see page 172*) takes us through the evidence, using the prescient Macdonald Critchley (1900–1997) as his guide. (In case you were wondering, 34% of normal 80+ year-olds have lost their ankle reflexes and 41% have lost vibration sense in their big toes).

Driving eligibility can change abruptly or gradually in people with neurological disorders. Neurologists often are the bearers of bad news, informing patients of the driving regulations that relate to their situation. However, this need not all be negative. Joel Handley and colleagues (*see page 203*) discuss how driving ability can be assessed and how adaptations can be made to allow patients still to drive; maybe this will help to shift some awkward discussions about driving to being rather more positive.

Perhaps the greatest paradigm shift in recent years has been the internet, a change so pervasive that after only 25 years or so, we now take it for granted and can hardly imagine a pre-web world. The internet has dramatically changed how we access information and communicate—and indeed with whom we communicate. Alison Thomson and colleagues (*see page 224*) provide the neurological guide on 'how to start a blog', built on their experiences developing and running a research blog for patients with multiple sclerosis. Hopefully, those of us who still remember life before this transformation as well as the current

generation of 'digital natives' will find it helpful (along with their patients).

A change that adult neurologists must handle carefully is the transition of people with learning difficulties and epilepsy from paediatric to adult care. The transition provides an opportunity to think about their problems anew. Andrew Barritt and colleagues provide an example (*see page 214*) and remind us to look at the serum creatinine result. If it has always been low, the patient could have guanidinoacetate methyltransferase deficiency, and the uncontrolled epilepsy can respond to dietary treatment.

The neuromythology series continues, this time with a critical take on 'pyramidal weakness' (*see page 241*). Does it exist? Is it a useful concept? Mark Wiles suggests not—though we anticipate that not all our readers will agree.

We have a challenging Test Yourself from Graham Mackay and colleagues (*see page 237*), a thought provoking Carphology (*see page 247*), and an assortment of images and cases.

We are grateful to the *BMJ* for allowing us to reprint their infographic for managing back pain (*see page 243*). We feel this conveys a lot of information in an effective and efficient way and would be interested in developing *Practical Neurology* infographics. If you have ideas, do get in touch. A shift to infographic from the purely printed word...

**Competing interests** None declared.

**Provenance and peer review** Commissioned; internally peer reviewed.