Highlights from this issue

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Most patients referred to the neurology service are seen only once or twice. For these patients a diagnosis can be made at the first consultation and treatment and advice provided. This can be characterised as a 'type A' strategy, when you know what is wrong and what to do about it. However, often we do not know what it is and have no specific treatment—but we do know what to do next: usually what tests to do, and what part of the nervous system to image, what symptomatic treatment might help. This is a 'type B strategy'. Having an appropriate array of type B strategies is essential for successful follow-up clinics. Hopefully, with the benefit of the investigations (often helped by the passage of time), you may get into a position to switch back to a 'type A' solution. CT perfusion scanning in acute stroke is a type B strategy (described on page 136 by Stevan Wing and Hugh Markus) that can rapidly redirect management towards specific intervention (thrombectomy). But when the type B strategy does not provide an answer and we remain uncertain, what should we do? What is our 'type C' strategy? One colleague's 'type C' strategy is to consider a second opinion if there has been no progress after three consultations—something to think about.

Teenagers who transfer to adult care are simultaneously new patients (to adult services) and follow-ups (to paediatric services). Transition provides the opportunity for a rethink. Investigations may have been undertaken many years before and an imperfect but acceptable treatment regimen may already be in place. Should we reinvestigate? And given the different spectrum of disorders that begins in the paediatric age range, what tests should we do? Can treatment be improved? Lina Nashef and colleagues address these questions for patients with epilepsy and physical or learning disability (page 115).

Patients with multiple sclerosis (MS) on disease-modifying drugs require long-term monitoring and follow-up. In addition to issues around drugs' effectiveness and adverse effects and symptom management, young women with MS will be concerned about how their treatment might affect pregnancy or potential pregnancy. Ruth Dobson and colleagues (page 106) provide the Association of British Neurologists consensus guidelines to help us in these consultations. Pregnancy also features in one of our difficult cases—Sabrina Kalam and colleagues describe how they managed a pregnant woman with anti-NMDAR encephalitis (page 131).

Long-term follow-up often provides neurologists with their best learning experiences. The clinicopathological conference (CPC), linking as it does a full clinical story to pathology, remains a challenging and very effective (and thus popular) format of case presentation. The patient's problem has usually been very complicated and the treating team has typically used strategies from 'type A' to 'type Z'. So what is the best way to present a CPC, and how can we derive the best learning from it? Richard Davenport draws on his long experience of running the Edinburgh Neurology Course (including an annual CPC) to provide guidance for discussants (page 143) and illustrates this with a CPC of his own (page 147). A few rare disorders crop up disproportionally frequently in CPCs, partly because of the difficulty they pose in diagnosis: Whipple's disease is a prime example—the condition *Whipplophilia neurologica* being the overwhelming desire among neurologists to diagnose the condition at meetings.[1] Neurocysticercosis would be another unusual condition for UK neurologists despite its relative frequency elsewhere in the world; Guillermo Delgado-García and colleagues discuss the mimics and chameleons of this condition on page 88. Cerebral hydatid, a rare condition that would be a challenging diagnosis anywhere in the world, is discussed by Patricia Svrckova and colleagues on page 156. Diabetic amyotrophy is uncommon, although diagnosis is usually clinical rather than pathological; D and G Llewelyn give us their type A to type C strategies relating to this condition (page 164).

The Birmingham team's infographic that distilled their proposed management of idiopathic intracranial hypertension prompted a letter suggesting we use cutting needles both to diagnose and treat the condition; the infographic's authors disagreed and we thought you might like to read their discussion (page 178).

Deception by patients is considered rare in clinical practice, although much more common in medicolegal practice. Malingering and factitious disorders can be difficult to prove, since this involves determining that there is conscious deception which in turn depends on either admission by the patient or by surveillance. Chris Bass and Derick Wade discuss this complicated and difficult area on page 96.

We have our usual left field contributions from Carphology and a Neurology Book Club report of a book that describes a deeply personal experience of NMDAR encephalitis. One final strategy that might help if you have used your type A, type B and type C strategies and are stuck; type 'Practical Neurology' into Google…

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Patient consent for publication Not required.

REFERENCE

1 Williams A, Fuller G, Bell JE, *et al*. Confusion and ataxia in a middle age woman: a case with four diagnoses discussed at the Edinburgh advanced clinical neurology course in 2001. *Pract Neurol* 2003;3:282–91.