EDITOR'S CHOICE

Practical Neurology 2006; 6: 270

For UK medical schools at least, a higher level of chemistry compared with physics is required for student entry. This is very odd when you think about how much we depend on applied physics—for imaging with anything from x rays to ultrasound, for endoscopes to poke into every orifice, for monitoring bodily functions from the brain to the fetus, and for all the clever coils, stents, and balloons so beloved of our interventional colleagues. Of course, as with cars, TVs, and boiling the kettle we don't have to know the physics of how they work—we just have to know which buttons to press and not to let the kettle boil dry. But what about MR imaging? It seems to me rather useful to understand just a little of the physics behind the images, and you will if you work carefully through Andrew Farrall's article on page 318 (interestingly he had a physics degree before he went into medicine). Neurocysticercosis is endemic in most countries of the world, so no excuse for publishing the article on page 288, even though in developed countries we seldom (yet) see any cases. Focal hand dystonia continues to intrigue (page 278), a problem that neurologists themselves do not seem to get—has any reader a case of tendon hammer dystonia to report? Neuralgic amyotrophy (page 298) is a condition I first saw when I was a student in a general practice where it was pointed out to me that fancy London Medical Schools seldom—then—taught students in the outpatient clinic, where we all know most neurology is seen. So, as usual, we have a bit of this and that in this issue of *Practical Neurology,* reflecting I hope our as ever fascinating speciality with so many more interesting symptoms than any other speciality, other than psychiatry perhaps—from shakiness (page 314), to whatever each of us means by "dissociation" (page 308).

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