EDITOR'S CHOICE

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In this issue we are starting something new; a series of 24 articles over four years covering all the core knowledge required for the practice of neurology. We are calling these the "Bare Essentials" because we are asking the authors to cut their ramblings down to the minimum one needs to know—anything less would be incompatible with safe neurological practice. We did consider restoring the title of "Neurology in Practice" remembering that *Practical Neurology* took over from the supplements of longer articles of that name published with JNNP, but we preferred a new title for a different and even more stripped-down style. For those are familiar with children's books, we even considered using the name "The Ladybird Book of Neurology", but that perhaps would have infringed copyright. So "Bare Essentials" it is, and our resident cartoonist Martin Zeidler (who has a day job seeing neurology patients in Fife) has risen to the occasion (see page 195).

Looking back to the 1960s, when I was a medical student, there was no such thing as secondary stroke prevention—although there were a few now outmoded and rather unpleasant drugs around for lowering blood pressure (reserpine, methyldopa and their like). Stroke survivors took their chances, perhaps cheered up by continuing to smoke cigarettes. Now, 40 years later these patients may be prescribed seven pills a day (one aspirin, two modified release dipyridamoles, one simvastatin, one diuretic and one ACE inhibitor). Two and half thousand pills a year! Reassuringly, all of these interventions are supported not just by one randomised controlled trial, but usually by several, as Cathie Sudlow sets out in her article on page 141; what progress, a triumph of what these days is called evidence-based medicine. And yet, as she points out, just dishing out all these pills according to a recipe (apologies, a guideline) is not necessarily in the patient's best interest; adverse effects have to be considered, when to start each intervention requires thought as well as when to stop, and the decreasing marginal gain as each intervention is added to the previous interventions and time passes since the stroke is another tricky issue (a cool and damp cloth applied to the forehead is required to follow the arithmetic in her table 3, but worth the effort!). By contrast, not a lot has changed in sorting out foot drop in the last 40 years, other than neurologists' decreasing interest in getting the basics right with good history taking and examination, at the expense of yet more and more tests (particularly imaging, and sometimes of the wrong bit of anatomy); but John Stewart, clinical researcher turned jobbing neurologist, keeps us right on page 158. No excuse for asking the York economists to explain QALYs to us on page 175; after all some neurologists are all too eager to attack NICE (the UK National Institute for Health and Clinical Excellence) decisions to recommend—or not—drugs like those for multiple sclerosis and Alzheimer's disease based not only on their effectiveness (if any), but also on their costs and the resource implications of letting them out of their bottles. Back to basics on page 170 where Frank Mastaglia continues our series on what to do when treatment does not seem to work, this time for polymyositis, and Jock Murray's lovely case report of the elderly farmer, his pain and the cow fence on page 183. Finally, the editorial on page 134 by the general practitioner on our editorial board will no doubt cause many conservative neurologists to splutter into their night time milky beverage, but no excuses there either—we need to think how better to care for our patients with epilepsy, even if we may not necessarily agree with what Greg Rogers suggests.

Charles Warlow

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