EDITOR'S CHOICE

Pract Neurol 2009; 9: 67

Once upon a time when I was young, some or maybe many patients with a neurological problem got a diagnosis, which was not necessarily correct, and that was all—no discussion of its effect on living or working. For example, I can't remember much discussion about driving. And even now, as some new research will be showing, doctors and other clinicians are apt to omit the all-important driving discussion with patients who have fixed or intermittent neurological problems that could affect their driving safety. I was therefore pleased when Rhys Thomas and Tom Hughes from Cardiff suggested they write a driving article for us, and after many months of honing you can read it in this issue (*page 71*). Of course one problem they and we all face is that the driving regulations are not the same in every country, hence the current attempts at European harmonisation which might, just might, lower the one-year ban after an epileptic fit to six months across the whole European Union; this would be helpful in many respects (including making driving articles written by UK authors in *Practical Neurology* more widely applicable than just to the UK). At least these days there is an attempt to actually quantify risk, specifically of a sudden event that might affect driving, against an acceptable benchmark which in the UK is set at no more than 20% in the next year for a car driver, and 2% for a bus or lorry driver. But back to "standard" neurology with the morning headache article by Andrew Larner (*page 80*), a subject we should all know about in our sleep, and to the paroxysmal dykinesias by Marina Tijssen and her colleagues (*page 102*), which are more likely to disturb my own sleep so difficult do I find it to get them straight in my mind—one reason of course is that they are rare, unlike morning headache. However, it would not do to misdiagnose them as epilepsy and, going back to the driving issue, ban the patients from the road. We continue to be keen to emphasise to the readers of *Practical Neurology* the crucial importance of postmortems, for how else will we properly learn about so many of the diseases we have to deal with, and how else can the bereaved know why their loved ones died when we don't during life? The patient described by Ursula Schulz and her colleagues (page 90) is yet another example of this truth. What to do about complaints of poor memory in a patient with epilepsy is a common challenge, faced as we are with not a lot of practice-based research—Adam Zeman takes us through this (*page 85*). Even older colleagues than me have a go at the history of the carpal tunnel syndrome (*page 96*), and at Chris Ward's December 2008 editorial (*page 117*). And for the Bare Essentials, Alasdair Coles encapsulates MS, and my how that has changed since I was a lad—there is so much to do nowadays that a whole team of people are there to do it, which has revolutionised the care these patients can now get, over and above the so-called disease-modifying treatments (*page 118*). Finally—a first for *Practical Neurology*—poetry (of a sort) from Northern Ireland (*page 114*).

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Correction

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Plug L, Reuber M. Making the diagnosis in patients with blackouts: it's all in the diagnosis. *Practical Neurology* 2009;**1**:4–15. In table 3, the first row, second column should read: "Pelvic thrusting, but no ictal injury, seizures from (apparent) sleep, incontinence or tongue biting"