EDITOR'S CHOICE

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What has subarachnoid haemorrhage (SAH) got to do with neurology? Not a lot in almost every UK centre, and nor in many non-UK centres either. It does not fit the slow stream don't-bother-to-phone-me-at-home style of neurologist who is wrestling with his bow tie while dressing for dinner. This is nonsense. Some years ago in Edinburgh it dawned on us that no-one was really looking after the SAH patients anymore. The neurosurgeons had lost interest because they almost never were doing any operations and yet the patients were in their beds, and being bossed around by neurointerventionists, who were after all only boys with toys, was a rather new experience. But the neurointerventionists were hardly trained to look after sick people and their communications skills—when on display at all—left something to be desired. Meanwhile we neurologists sat on the sidelines muttering (and thinking which is what we do best). Fortunately we all got on very well and already worked closely together, so that within a matter of weeks of deciding we moved over to a system of most patients being admitted under the neurologists for their general monitoring and care (and indeed follow-up which is a very neurological business). All patients are discussed with the interventionists who do most of the aneurysm occlusions, the neurosurgeons are involved where necessary, intensivists of course look after the sickest patients, and we work as a genuine multidisciplinary team seeing the patients together every day. Brilliant. But this was not new. Centres in Holland had provided this pattern of care for years, and because we had strong links with Utrecht (forged through research projects) we leaned a lot on them for training and their experience. So no surprise that we asked them to write in *Practical Neurology* about the medical and non-neurological complications after SAH. You can either ignore this article (***on page 195***) after giving a final tug on your bow tie, or roll up your sleeves, read it and start looking after sick patients for a change.

There is a nicely discussed clinicopathological conference (CPC) (***page 210***); I am afraid we continue to struggle getting postmortems despite the fact that we learn something from every one. I think exposing oneself as the discussant in a CPC is probably the most stressful experience for a neurologist, in front of both the juniors and one's peers, but they are always great learning occasions, and at the Edinburgh Course are followed by the necessary resuscitation of the discussant in a local pub. 'Presumably dry beriberi' features on ***page 221***, something to think about when you next see a case of what looks like Guillain-Barré syndrome—which it usually is—John Winer tells us what to do when the treatment is not producing the desired results (***page 227***). We continue Bare Essentials with a paper on dementia (***page 241***), another area which UK neurologists are in danger of ignoring. And I do like the Test yourself case—some diagnostic and even therapeutic use from the modern genetics, albeit in a rare situation. But when will genetics tell us something useful about the treatment of common neurological diseases like stroke and multiple sclerosis? One must be patient.

Charles Warlow