Highlights from this issue

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We aim not to repeat ourselves in *Practical Neurology*. Well, that is not strictly true, we do repeat ourselves deliberately and quite a lot—it is all in the history'; 'think'; 'thank you to our authors and reviewers', etc.—rather we aim to avoid covering the same topics repeatedly. This creates a problem for our trainees who have only just started reading *Practical Neurology*. Obviously, they read it as it comes out but they will have missed important topics covered before they started training. An enthusiastic *Practical Neurology* reader, Dilraj Sokhi, spotted this problem when he was a trainee and has provided a solution that he describes on ***page 2***.

If you visit our website you will find the UK Neurology Curriculum with relevant *Practical Neurology* papers, dating back to its inception in 2001, linked (and hyperlinked) to each element within it. This will certainly help trainees to ensure they have wide curriculum coverage. It will help anyone giving a talk to find relevant papers readily. It also allows us as editors to identify gaps and to know what we should commission. While this has been built specifically on the UK curriculum, it also fits well with the European curriculum (hosted by the Union Européenne des Médecins Spécialistes),[1] which was developed along similar principles. We hope trainees and their trainers will find this a useful resource.

The topics that are easiest to cover within a curriculum are those based on diagnosis and those where management is underpinned by evidence derived from clinical trials. More challenging are those topics that deal with clinical presentations. One challenging clinical presentation is the patient with a myelopathy, especially when the diagnosis is not forthcoming on initial investigation. Lionel Ginsberg provides a magisterial guide to the mimics and chameleons of myelopathy on ***page 6*** to help you with these patients.

Sleep apnoea is a diagnosis that can lead to effective treatment but when it presents to the neurologist sleep disruption is not normally mentioned at all and a diagnostic opportunity is missed. Richard Stark discusses when the neurologist should think about sleep apnoea and what to do when you have thought it might be relevant (***see page 21***).

Infective endocarditis is a famously difficult diagnosis. But even when thought of and diagnosed, it continues to provide challenging decisions for the neurologist. It causes both cardioembolic and haemorrhagic strokes; so should you anticoagulate, use antiplatelet drugs or do neither? This knotty question is discussed by David Werring and colleagues on ***page 28***.

'There is nothing so tragic as a life needlessly lost'. Sudden unexpected death in epilepsy (SUDEP) is by definition both sudden and unexpected; but could it be avoidable? While there are no perfect solutions, Brendan McLean and colleagues discuss (***see page 13***) strategies to reduce the risks of SUDEP and hopefully the numbers of lives lost.

Epilepsy is so common that patients admitted to hospital with other medical and surgical problems are often taking antiepileptic medications. Sometimes they are 'nil by mouth', prompting a call to the neurologist, but then what should be done? Despite the dearth of evidence in this area, Anna Bank and colleagues provide us with the approach they use in Boston, Massachusetts, USA (***see page 66***). There are some differences in the drugs available in the UK and Sanjay Sisodiya has provided a commentary and a UK perspective (***see page 4***).

Developments in technology often take time to be adopted. Lumbar puncture is a time-honoured procedure that is done mainly by trainees. Using ultrasound scanning seems to make the procedure easier and more successful. The case for adopting it will probably need to be made by senior doctors yet they usually do not do the procedure. Stefan Williams provides a 'How to do it' on ***page 47*** that may get that ball rolling.

Our recent readers' survey reassured us that *Practical Neurology* is widely read, even though most articles do not trigger a response from our readers. However, *Neuromythology* does seem to provoke a response (which can be read online), perhaps reflecting the august and revered myths that these articles have tackled. The latest, a robust critique of the Mini-Mental State Examination, might not hit a nerve in the same way.

On top of all this, we have our usual mix of cases, a challenging Test Yourself, a clinicopathological conference, Book Club and Carphology to keep you thinking.

Competing interests None declared.

REFERENCE

1 Union Européenne des Médecins Spécialistes. Core curriculum for a specialist training program in adult neurology. http://www.uems-neuroboard.org/html/docs/Core-curriculum_nov2014.pdf (accessed 11 Dec 2016).

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