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# Highlights of the issue

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'Heuristic' is the kind of word we generally avoid in *Practical Neurology*. It's not that the word is not useful, rather it is a bit recherché. And one of the coeditors is forever forgetting exactly what it means and thinks some readers may share this blind spot. A (or 'an?') heuristic is an approach to problem solving (from the Greek for 'discover'), a short cut in thinking to help you reach the answer, or at least get close to a good answer. There are lots of subtypes—our word blind coeditor says in his defence—and are all prone to failure at times.

One heuristic helps to diagnose neuromuscular disorders: muscle weakness with muscle atrophy is caused by a neuromuscular disorder. Jon Walters turns this rule of thumb on its head and focuses on how muscle hypertrophy in patients with suspected muscle disease can provide a diagnostic lever to the genetic diagnosis (*see page 369*). Rather than destroy one heuristic, he generates another perhaps a more sophisticated one.

Our neuromythology series prompts more correspondence than almost anything else and most such letters go on the website. However, we were so impressed by Jon Stone's response to Mark Wiles' piece on pyramidal weakness that we included it in the paper journal (*see page 422*). Jon argues that pyramidal weakness (or normal weakness) is useful—to distinguish it from weakness, that is proximal, distal or global—and that 'global weakness' (or even inverse pyramidal weakness) suggests functional weakness. A useful clinical tip (or heuristic).

Clinicians who see patients with acute stroke are under considerable time pressure to make decisions. One important element of that assessment is interpretation of the imaging. While they depend on radiological colleagues for advice, the time pressure means that the greater their own understanding of what imaging can tell them—and what it cannot—the better. James Caldwell and colleagues provide insights into some radiological heuristics in discussing the pearls and pitfalls of imaging in acute stroke (*see page 349*).

It is instructive to wonder why clinicians choose to write up and submit case reports on some patients and not others. Sometimes, this is because the case is rare—particularly if it is treatable or gives genetic information to the family. We have one example of this: adult onset Tay–Sachs disease (*see page 396*). However, often it is because: the clinicians were surprised in some way; their usual approach did not work; a common presentation turned out to be caused by an unusual disorder or a common disorder presented in an unusual way. You could characterise all of these surprises as failures of their usual diagnostic approach, their everyday heuristics. We have several such cases—a case of Eastern equine encephalitis whose virological tests were negative in life but confirmed at postmortem (*see page 387*), or a patient with pain as the presentation for their non-convulsive status (*see page 400*). Case reports also arise where colleagues wish to share difficult and challenging management problems.

We rarely use tracheostomy and tracheal ventilation in patients with motor neurone disease (MND) in the UK. We received two separate MND case reports where tracheostomy was used to manage different symptoms (*see page 383 and 403*). The perception is that tracheostomy helped in these, albeit unusual patients. The use of tracheal ventilation led to challenging management decisions as the patient's ability to communicate faded. Chris McDermott provides a commentary on this difficult issue (*see page 341*).

While we would all like to provide curative treatments for our patients, neurological interventions more often focus on symptom management. Thomas Brown discusses the diagnosis and management of patients with pure autonomic failure, where the focus is on the reversing the physiological consequences of the condition (*see page 341*). Depression in Parkinson's disease is common and often a significant cause of morbidity and frequently unrecognised; Monique Timmer and colleagues review this difficult comorbidity (*see page 359*).

Catch up with Carphology (*see page 420*) and find out about a philosophically impossible turnip (*see page 417*)—not to be missed.

The truth is that jobbing neurologists use lots of diagnostic strategies and rules of thumbs to get them through the day and lots of what appears in this journal relates to this. However, we still think 'Practical Neurology' is a better journal title than 'Useful Neurological Heuristics'.

**Competing interests** None declared.