

EDITOR'S CHOICE

Pract Neurol 2010; 10: 187

I don't like the fashion for theme issues of journals. In fact I hate them. Either the theme is of no interest to me (and I assume many other readers) and so I dump the issue in the bin, or it is right up my street in which case I get irritated that I have to spend a lot more time than anticipated with the issue of the journal in question. Surely journals are about having a bit of this and a bit of that to entice, entertain, instruct and generally amuse—particularly journals like *Practical Neurology* (or are we a magazine in which case we definitely should not be doing theme issues?). So why so much epilepsy, or at least possible epilepsy, in this issue—three articles indeed? Pure chance, plus the usual difficulties of getting authors to write stuff on time which mucks up my beautifully planned schedules. But no excuses, epilepsy is important to almost all neurologists unless they only look after the (relatively) dull bit of the nervous system below the foramen magnum.

When I began my neurology training in the 1970s hardly anyone in the UK took a lot of interest in epilepsy. I don't recall there being any epileptologists. Now every centre has one. For anticonvulsants (these days more sensibly called antiepileptic drugs) we had just phenobarbitone, phenytoin, carbamazepine and maybe a benzodiazepine or two (plus the wonderfully effective paraldehyde for status, such an evocative smell when arriving on the ward in the morning). Now we are spoilt for choice with antiepileptic drugs and so Andrew Nicolson and Tony Marson take us through their plan of action when the first one fails in patients with juvenile myoclonic epilepsy (page 208) (noting the lamentable lack of decent randomised trials to answer the questions that are important to patients rather than regulators). And there was a lot of stigma, which is much less now as reflected in the way Rhys Thomas and his colleagues from Wales recruited

artists with epilepsy to help us understand the patient point of view (page 219), and in passing noting that if it can be difficult to diagnose epilepsy with a patient in front of you how much harder it is to sort out if figures from history had epilepsy or not. Finally, the 'test yourself' has something of an epileptic feel to it (page 233).

Biomarkers are the fashionable term for what I call tests, usually blood tests (the blood urea is now a biomarker for renal failure) but also images (white blobs on MR scans are biomarkers for multiple sclerosis). Alex Mitchell and his colleagues usefully explain how tests on the CSF (aka biomarkers) may or may not help predict dementia in those who may or may not be on the way there (page 202). Are they better than a clinical opinion? More importantly, what do they add to a clinical opinion?

Thomas Miller and Mira Farquharson tell us what to think and do when the platelet count (another biomarker I suppose) comes back too high in a neurological patient (page 195), and Adrian Wills and Guy Sawle tell us about the causes of the rather rare problem of accessory nerve palsy (page 191). For a really rare problem, read about the Andersen-Tawil syndrome in an article from—not surprisingly—that centre of rare syndromes and of the expertise to deal with them, the National Hospital for Neurology and Neurosurgery in London (page 227).

Bare Essentials carries on, this time with Parkinson's disease by Andrew Lees (page 240), the wise physician who like me I suspect can remember when levodopa came in very large white tablets that made the patients vomit, and also made them a lot better—the first definitely useful drug for a so-called 'neuro-degenerative' condition, and still I would argue probably the only one.

Charles Warlow