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Highlights from this issue

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How should we best manage a patient with myasthenia gravis? This issue includes a guideline prepared by Jon Sussman and colleagues from the Association of British Neurologists (ABN) myasthenia section (*see page 199*). For most guidelines, a development group's biggest task is to sift through multiple clinical trials and meta-analyses to grade evidence and to arrive at the best advice, based on the best data, while highlighting conflicts of interest. The very few randomised clinical trials in myasthenia left this group with a different task—to provide the best pragmatic guidance on the information available. Their objective was, in effect, to bring the myasthenia section members into clinic with you. What would the experts do for your patient? This should tell you, in a format that hopefully you find useful. AGREE II criteria¹ are used to assess the quality of clinical guidelines—particularly their development process—and our website has just such an assessment of these guidelines.

Clinical guidelines are most useful when the patient fits in. But what should you do when the evidence does not apply to your patient's problem and there is no trial to put your patient in? Daniel Korya managed such a patient (*see page 216*), with a carotid dissection and progressive symptoms despite conventional treatment (albeit with limited evidence even for that) who recovered after carotid stenting. David Werring (*see page 158*) discusses how to approach this quandary and proposes how we might capture data to make better sense of it in the future. Stroke is an area of neurology where the many clinical trials have significantly influenced our management. Joe Anderson reviews new developments for

preventing venous thromboembolism following stroke (*see page 160*)—with advice that may surprise you.

Hereditary peripheral nerve disease is unusual in neurology in that the huge expansion of our genetic knowledge of them has informed, rather than blurred, our understanding of its clinical presentation. Mary Reilly and her team bring welcome clarity and have chosen to describe their review as providing a practical approach to the problem (*see page 187*). Perhaps we should consider developing 'practical approaches' to other similar clinical situations where we would like distilled advice but the evidence is insufficient to provide guidelines?

Many of our medical terms have evolved from everyday usage: sometimes they acquire more particular technical meanings, which causes confusion; indeed, the term 'confusion' illustrates this problem beautifully. David Sharp (*see page 172*) argues that 'concussion' is too loose a term and that its false reassurance risks inappropriate management and argues that we need to think differently about patients with traumatic brain injuries.

Many patients presenting to neurology pose diagnostic challenges. Myoclonic epilepsies are rare but important to recognise, characterise and address the underlying causes: Naveed Malek reviews this group of conditions (*see page 164*).

We have reports of unusual strokes from Edward Littleton (*see page 218*) and Roberto López-Blanco (*see page 224*), and we have tumours that proved difficult to diagnose from Nancy Colchester (*see page 210*) and Romain Deschamps (*see page 228*). Jose Velasquez (*see page 221*) uses another tumour case to highlight the phenomenon of Kernohan's notch.

We have several striking images—an aneurysmal cause of internuclear ophthalmoplegia from Saad Khan (*see page 230*), a lump on the head with a rare cause from Tayyib Hayat (*see page 227*) and a striking but reversible shunt complication from Bhavini Patel (*see page 222*).

Superficially neurotoxicology would seem pretty straightforward—you identify the toxin, remove it, and so facilitate neurological recovery. But sometimes the toxin is concealed, as in Alexander Thompson's case of recreational nitrous oxide use (*see page 207*), hidden in plain sight, as in Olga Kinzel's case of methotrexate toxicity that occurred after years of treatment (*see page 214*), or is hard to identify because the effects are hidden, as in Phil Duffey's case of occult impulse control disorder (*see page 226*). Wouter van Balloogij calls for a more precise interpretation of the menace reflex (*see page 233*) and Ben Wakerley provides a challenging case for to test us all (*see page 236*).

We hope that UK neurology registrars will savour Christopher Carswell's 'Neurological letter from down under' (*see page 231*), recalling his time as an ABN/ANZAN Australasian fellow. We are optimistic that this will stimulate many others to take these opportunities.

We have the report of a neurology book club's discussion of the *Diving Bell and the Butterfly* (*see page 241*) and A Fo Ben's final word with views from other journals (*see page 242*).

REFERENCE

- 1 Brouwers M, Kho ME, Browman GP, *et al.* for the AGREE Next Steps Consortium. AGREE II: Advancing guideline development, reporting and evaluation in healthcare. *Can Med Assoc J* 2010;182:E839–42.