Highlights from this issue

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Pattern recognition is an essential neurological skill. It depends on the neurologist being able to access a range of model conditions—mental index cards of neurological disorders—usually held internally, or perhaps from the literature or online, and then matching these up with the clinical presentation in front of them. It is extraordinary how difficult it can be to see the patterns in the first place, yet such patterns seem quite obvious once pointed out (once they become ‘threshold concepts’). Most experienced neurologists will have wondered how it was possible that it took till 1964 before Steele and Richardson described progressive supranuclear palsy¹ when it now appears to be such a characteristic and distinct syndrome. Neurologists at the end of the 19th century recognised the power of pattern recognition as a diagnostic tool when they filmed groups of patients with the same disorder to highlight the features common to a particular disorder,² something that still makes specialist clinics such useful learning aids for trainees.

More recently, the characteristic clinical syndromes associated with autoimmune limbic encephalitis have been described; when reading these first reports, many neurologists must have said to themselves, recalling often young patients with challenging illnesses, ‘So that is what it was’ And the spectrum of autoimmune encephalitis is still expanding. Angeliki Zarkali and colleagues describe a patient with a lymphocytic meningoencephalitis with delayed myelitis (page 315), an unusual sequence of events associated with antibodies to glial fibrillar acidic protein and responsiveness to immunosuppression: a new index card to remember. But surely a patient

on immunosuppression following organ transplant should be immune to autoimmune encephalitis? Yet surprisingly Andrew Larner and colleagues describe just such a case (page 320): a reminder to us all to keep an open mind.

Zika is another new disease widely reported in the lay press, particularly the dramatic and tragic microcephaly arising in babies born after intrauterine infection. However, Zika is also associated with neurological problems in adults, although mostly these are syndromes we will recognise in other contexts, for example, Guillain-Barré syndrome. Hugh Willison and colleagues tell us everything a neurologist needs to know about this new infection (page 271); more mental index cards.

The neurology of movement disorders relies on pattern recognition of clinical phenotypes perhaps more than other branches of the specialty. Intriguingly, Tourette’s syndrome was found on the streets of Paris when Charcot sent Giles de la Tourette out to find a disorder to rival the reported ‘jumping Frenchmen of Maine’. Jeremy Stern discusses this disorder and its borderlands on page 262. We encourage you to look at his videos online to help with your pattern recognition; our neurological ancestors would certainly expect you to.

Some patterns are more complicated than others. A multiorgan disorder with polyneuropathy, organomegaly, endocrinopathy, a monoclonal band and skin disease might be more difficult to remember if it did not have such a great acronym (POEMS syndrome). However, there is more to making this diagnosis than decoding the acronym, and Stephen Keddie and colleagues (page 278) draw upon

their considerable experience (they run a POEMS clinic!) to help you with your patients.

Our mimics and chameleons series is based on our use of pattern recognition in diagnosis and how it can go wrong. In the latest version, Michael Kinney and colleagues explore when you should think about non-convulsive status and when, having thought about it, you should think of something else (page 291). EEG reporting is also all about pattern recognition and depends not only on recognising patterns associated with abnormalities—particularly those suggesting epilepsy—but also in recognising benign patterns that are, well, benign. Ahmed Abbas and colleagues provide us with an illustration of one such pattern (page 331), which, once recognised, can be correctly interpreted and significant problems avoided.

Our Book Club book, *The Music Room*, is a moving memoir of family life and growing up with a brother with severe epilepsy (page 344). Your editors agree this is an excellent book to choose to start a Neurology Book Club—which we would encourage you to do.

However, neurology is much more than collecting mental index cards to help in diagnosis. This edition, with music, literature and POEMS, is a reminder that neurology is about the art of medicine.

Competing interests None declared.

REFERENCES

- 1 Steele JC, Richardson JC, Olszewski J. Progressive Supranuclear Palsy. *Arch Neurol* 1964;10:333–59.
- 2 Barboi AC, Goetz CG, Musetoiu R. The origins of scientific cinematography and early medical applications. *Neurology* 2004;62:2082–6.