Highlights from this issue

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The idea of evolution took time to become established and recognised. Increasingly, technology and business are embracing evolution by recognising that repeated design failures provide the essential selection process that ultimately leads to success. Those who never make a mistake never make anything. Entrepreneurs are encouraged to 'fail fast and fail often', to allow better things to take over and so lead to improvement.[1]

Discussion of failure in medicine lags behind that in business, with physicians preferring to avoid the term 'failure' unless applying it to a organ system, such as the heart, kidney or brain. However, failure does happen, in diagnosis or management of individual patients and in the way that we think. It is useful to remember that the current understanding within medicine (disease classification, diagnostic test, treatment or whatever) is temporary, just the best we have at the moment: the latest link in a chain of gradually improving failures. We might recall the (probably apocryphal) introductory talk at medical school that included something like, 'Half of what we will teach you will be wrong. Unfortunately, we don't know which half…'. All knowledge is provisional.

The understanding of disease evolves with newer understanding in pathophysiology or improved investigations. This shift can be slow—young doctors now find it hard to believe that patients with postural vertigo could have been thought to have vertebrobasilar insufficiency rather than benign paroxysmal positioning vertigo. But they need to imagine a previous world that had infrequent and difficult access to potentially dangerous imaging (eg, catheter angiography), high rates of smoking and hence large vessel atheroma and no concept of canalolithiasis. In such a world, vertebrobasilar insufficiency seemed plausible. Although the indications evolve, we still have patients who need cerebral catheter angiography for other reasons; Vafa Alakbarzade and colleagues advise us on its current practice and its complications, based on their extensive experience: is it really that dangerous? (*see page 393*).

As practice evolves, so does terminology, though never without controversy. Bhanu Ramaswamy and colleagues (*see page 399*) give us helpful and practical advice on exercise for people with Parkinson's, and in doing so highlight their preference to omit the word 'disease' from this most famous of eponyms. Christian Lueck argues that another familiar although rare syndrome, the Tolosa–Hunt syndrome (on *page 350*), should be retired altogether. What was a useful idea in a time of limited imaging is helpful no longer. Indeed, keeping the syndrome risks us missing treatable diagnoses, such as cavernous sinus actinomycosis (*see page 373*). Terminology sometimes evolves to obscure the original intended meaning. Timothy Counihan's 'Treating by Numbers' (*see page 421*) takes a sideways look at how scales and scores—and particularly their abbreviations—may even hinder clinical communication. An idea ready for 'fast failure' perhaps?

Our editors choice is 'Neurological Disorders in the Returning Traveller' (*see page 359*), a case-based discussion from a team with wide experience of patients returning to the UK. We recognise that the idea of a returning traveller is inherently parochial, as neurologists caring for patients in the area from which they return would simply regard them as patients. However, increased travel does pose problems for neurologists, as patients move from areas with radically different disease profiles, requiring us to think in different ways (as you will see in the cases).

Neurologists know very well that there are some conditions that we often fail to diagnose: conditions that are rare and protean. Among these—and step aside syphilis and lupus—porphyria stands out; it is hard to remember to include in the differential and the diagnosis is messy and involves keeping urine and faeces in the dark. Ronan O'Malley and colleagues (page 352) provide an up-to-date 'how to do it' approach to diagnosis that should make this easier and help neurologists to interpret results in a suspected case.

Neurologists are often keen on the small print. The superior oblique muscle may be small print in anatomical and clinical terms but it punches above its weight in having idiosyncratic anatomy that can lead to some interesting and challenging clinical problems, including ocular neuromyotonia (*see page 389*) or superior oblique myokymia (*see page 415*). Mark Lawden's overview of this small but important muscle (*see page 348*) covers probably all that we need to know about it.

We have Carphology, never failing to pique readers' interest. Our Book Club discussion of the much-lauded novel 'Saturday' identified failures on several levels. And as always, we have a series of challenging cases for testing yourself—as well as an official and challenging 'Test Yourself'—remembering that failing allows and encourages learning. Fail fast, fail often and you cannot fail to improve.

Competing interests None declared.

REFERENCE

1 Donohue J. 2015. Fail fast, fail often, fail everywhere, New Yorker. https://www.newyorker.com/business/currency/fail-fast-fail-often-fail-everywhere (accessed Jul 2018).