Highlights from this issue

Philip E M Smith, Geraint N Fuller

'Rules are for the obedience of fools and the guidance of wise men'. Douglas Bader

Group Captain Sir Douglas Bader was a fighter pilot who returned to flying despite having lost both legs in a crash. He was famously determined and iconoclastic and later in life campaigned vigorously for people with disabilities. His pithy advice on using rules is perhaps at odds with the medical establishment's view on how the aviation industry uses rules (although rather more in tune with our own views). Safety in aviation and medicine differs on many levels (or on many planes): the aircraft does not set out with multiple comorbidities, individual preferences, anxieties and beliefs; if the plane develops a potentially disabling problem then the flight is aborted, and if the plane goes down the pilot goes down with it. Nevertheless, commercial flying is now very safe and medicine can undoubtedly improve patient care by taking on board some of civil aviation's safety strategies. Assessing a patient with a suspected stroke and starting appropriate treatment is a complicated and time-sensitive intervention that requires a coordinated approach and team work; an ideal setting for the 'crew resource management' used in aviation. Laurent Willems and the team from Frankfurt describe how they do it and how we can apply it to our patients (page 36).

Rules in medicine are often disguised; diagnostic criteria are 'rules' for diagnosis. What happens when diagnostic criteria change, as they have for multiple sclerosis? Anand Trip and colleagues bring their experience to explore the impact of these changes (page 64). Diagnostic criteria are rules to allow a clinician to come to a diagnosis without having access to the gold standard diagnostic test, often a pathological diagnosis. Alison Green from the Edinburgh prion group introduces us to

cerebrospinal fluid real-time quaking induced conversion (RT-QuIC), which is 92% sensitive and 100% specific for the diagnosis of sporadic Creutzfeldt-Jakob disease (CJD) (page 49). This is getting very close to a gold standard; it is likely to transform the CJD diagnostic process and important step towards treatment trials, which depend on an early and secure diagnosis.

Our 'How to do it' articles are often a long way from 'rules' or even guidelines, ending up providing advice rather than something more concrete. Peter Fernandes and Richard Davenport discuss what, if anything, to do when we see a patient with exertional rhabdomyolysis (page 43).

As a rule, *Practical Neurology* does not consider drugs in isolation but only as part of a set of guidelines or treatment strategies. However, in this edition, we have set aside that 'rule'. Rituximab has been available since 1997 and is now prescribed as 'biosimilar' rather than simply as a branded formulation. It has been used to treat many immune-mediated neurological disorders, often as a last resort. As with many rare diseases, especially those that can respond to other agents, reports of rituximab use usually come as case series or individual reports rather than as randomised controlled trials. The main alternative treatments for many of these indications are corticosteroids or intravenous immunoglobulin and even for these there is only limited randomised controlled trial support. The current order for treatment generally follows the order of discovery: corticosteroids (significant adverse effects) followed by intravenous immunoglobulin (costly, scarce and with infection potential) and then rituximab (generally well tolerated and getting cheaper). Is it time for a rethink? Or for some clever trials? Daniel Whittam and colleagues discuss what we know now about rituximab and what we will need to know when considering using it (page 5).

Cataplexy is rare but dramatic and is likely to be referred to neurology for assessment, sometimes masquerading as epilepsy and sometimes as syncope. Paul Reading (page 21) discusses how to make the diagnosis and manage patients with cataplexy. It is well worth looking at the video of a typical attack on our website. Hearing loss is common but is rarely the reason for a neurology clinic referral. However, the auditory nerve is undoubtedly part of the nervous system and neurologists should know how our ENT colleagues approach hearing loss. Manohar Bance discusses his approach to hearing loss on page 28.

We have our usual range of cases, each with a practical message: a thoracic cord lesion that breaks the rules by presenting with a purely lower motor neurone syndrome (page 72); a dramatic disseminated infection in someone with only minimal immunosuppression (page 80) and an unusually shaped compound action potential—something most neurologists may not look at in everyday practice—that helps to diagnose a rare condition (page 77).

And finally, do our patients have Parkinson's disease or just Parkinson's? We had thought the answer was clear: after all we use PD for short. However, in our recently published review on Parkinson's and exercise,¹ the authors preferred to avoid the term 'Parkinson's disease', preferring simply 'Parkinson's'. We were unaware of this patient-led change, and so asked Paul Worth to tell us more (page 2)—wise guidance about a new rule.

Competing interests None declared.

Patient consent Not required.

REFERENCE

- 1 Ramaswamy B, Jones J, Carroll C. Exercise for people with Parkinson's: a practical approach. *Pract Neurol* 2018;18:399–406.