Highlights from this issue

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Neurologists are keen to remind their trainees that 'it's all in the history'. An illness's time course is a particularly important part of the history, providing the time signature for the underlying pathological process and thus significantly narrowing the differential diagnosis. However, sometimes the time course can be misleading. Erin Kelly and colleagues describe a patient with a relapsing encephalitis, a time course that suggests an inflammatory cause, but which turned out to have a genetic basis—a *RANBP2* mutation (***page 360***). In his editorial relating to this case, Rhys Thomas (***page*** 282) brings together a range of relapsing genetic disorders, a category that will hopefully provide a useful addition to the standard 'neurological sieve'.

Gaps in the history often causes difficulties with diagnosis and may sometimes prevent provision of optimal treatment, as occurs with wake-up stroke. However, there may be a way around this. Anthony Pereira's team (***page*** 326) describe how modern imaging techniques can complement the history to bring the option of thrombolysis to a new group of patients.

History (in the non-medical sense) can also inform current practice: 'Those who fail to learn from history are doomed to repeat it', to quote Winston Churchill (who was paraphrasing George Santayana). Grace Crotty and colleagues (***page 316***) revisit a case reported by Lord Brain alongside an historic case from their department in the light of current knowledge, to see what we can learn from this bit of neurological history. This long view, with historical context and contemporary follow-up, allows us to reflect on how to diagnose and manage patients with as yet undiagnosed encephalopathy, while awaiting results of antibodies—the situation Lord Brain worked in before the antibodies were discovered.

Antibodies are also increasingly available to help in the diagnosis and management of inflammatory myopathies. Anke Rietveld and colleagues (***page 284***) provide a practical summary of currently available antibodies, when to ask for them and how to interpret their results. Will these antibody studies help unpick the 'test yourself'—a case of proximal muscle weakness from Paloma Gonzalez-Perez and colleagues? Read on to find out (***page 321***).

Antibodies also feature as part of the diagnostic approach to the swollen optic nerve. Edward Margolin discusses his approach to this relatively common but challenging clinical presentation that can present either to neurologists or ophthalmologists (***page 302***). One uncommon cause of a swollen optic nerve is Vogt-Koyanagi-Harada disease, a granulomatous condition that combines uveitis with neurological and systemic manifestations. Ophthalmologists know it well but neurologists less so—Duncan Street and colleagues describe a case (***page 364***) and Christian Lueck overviews this unusual condition (***page 278***).

The diagnosis of multiple sclerosis used to be solely clinical but now depends on increasingly sophisticated investigations. With so many disease-modifying treatments, there is a clear need for a biomarker of disease activity. Emma Tallantyre and colleagues update us on biomarkers, either available now or in the pipeline (***page 342***). There has been a long-term interest in using cannabis-derived treatments for symptom treatment of MS, often prominently covered in the lay media. Gillian Ingram and Owen Pearson (***page 310***) provide a much-needed update of the evidence for using (or not using) these treatments.

We increasingly recognise that our method of explaining functional disorders to patients is an important part of their treatment. The discussion of dissociative (non-epileptic) seizures with patients is particularly important, and Markus Reuber explains how he does this and how he covers many of the issues that come up in those consultations (***page 332***). It is a privilege to peek behind the curtains and glimpse an expert colleague at work.

Bastiaan Bloem and colleagues provide an insight into their diagnostic process, which begins by observing patients outside of the consultation room (***page 295***). They describe how neurologists can make useful observations when going to fetch the patient, and particularly on patients with movement disorders. This is not entirely new—half the patients in the world's best known neurologist's[1] definitive six-patient case series were observed in the street rather than the consultation room.[2]

Many other movement disorders still rely on pattern recognition for diagnosis. Jane Alty and colleagues (***page 350***) present a patient with multiple pathologies mimicking multiple system atrophy, reminding us that Occam's razor is sometimes blunted.

'Me and my neurological illness' is a series that allows neurology colleagues to share insights gained from personally experiencing a neurological illness. Our associate editor Colin Mumford describes his post-traumatic benign positional vertigo (***page 354***).

In a letter from Malawi (***page 356***), Yahane Godama reminds us that many neurologists across the world do not have access to high tech tests and are still heavily dependent on their clinical skills; not so very different from James Parkinson and Lord Brain perhaps?

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REFERENCES

1 Stern G. The world's best known neurologist? *Pract Neurol* 2011;11:312–5.
2 Parkinson J. *An essay on the shaking palsy*. London, Sherwood: Neely and Jones, 1817.