



Highlights from this issue

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When neurologists of a certain age get together, they often end up discussing the vexed but unresolvable question of 'What has been the greatest development in neurology in our lifetime?' (oh yes, you know you do). Clearly this depends on the age of the neurologist but the same candidates generally line up. Those of us who remember when you could pick out with ease the pixels in the CT scan argue for imaging. The astonishing detail available in everyday MR imaging surely is the biggest leap? John Duncan illustrates how the very latest imaging can help to manage patients with epilepsy (*page 438*) and Christopher Doppler and colleagues illustrate how rapidly-changing MR images can point to the diagnosis of a mitochondrial cytopathy (*page 447*).

Modern imaging is all very well, some argue, but it reveals only what we already knew from the classical approach to localisation. The big leaps in understanding have come from basic science. We can now understand the genetic basis for neurological disorders, aiding diagnosis and providing novel treatments, as Luis Braz and colleagues tell us in their review of Brody disease (*page 417*) and Meher Lad and colleagues in their update on Niemann-Pick disease type C (*page 420*). Emanuela Molinari and colleagues describe how genetic understanding and molecular markers have revised the classification of gliomas with important implications for treatment and prognosis (*page 412*).

No, the biggest change (says our next neurologist) is the availability of treatments. Neurologists have moved from being diagnosticians and prognosticators to doctors who

treat their patients and manage treatments. These can include very common disorders such as medication-overuse headache (discussed by Ben Wakerley on *page 399*), very challenging conditions such as gliomas (with management led by the molecular markers) and issues relating to the increasingly commonplace use of a wide range of immunological treatments (Puja Mehta and colleagues discuss the special case of myositis in pregnancy *page 444*).

'Of course you are all correct. Everything you say is true. These are remarkable things', says our last neurologist. 'But none of these great developments can benefit our patients without careful application of the clinical method. Imaging requires you to know where to look and what to ignore. The basic science approach and therapeutic interventions depend on careful identification of clinical phenotypes. The continued integration of all these things using the clinical method: that is the greatest development'. And in this issue we have papers that illustrate such clinical method in action: Elan Louis carefully dissects the clinical phenotype of essential tremor—a common though not yet fully elucidated disorder (*page 389*). Wladimir Pinto and colleagues report a recently described motor neurone disease (MND) variant with the acronym of FEWDON (*page 424*) and Martin Turner discussed the importance of 'splitting' and analysing these MND subtypes (*page 376*). Michael O'Sullivan and colleagues explore how the current neuroscience of language links up with clinical practice (*page 380*). A key feature of neurology clinical

method is observation. Recognising patterns is difficult but nevertheless forms the basis of much of neurology; seeing new patterns is more difficult and can be the foundation for research. Andrew Lees draws on his long experience to discuss noticing in neurology (*page 427*).

After another drink our neurologists turn to their next favourite topic: training. Most doctors seem to end up thinking that their own training would be a good blueprint for future generations, almost regardless of what they thought about it at the time. Sam Shribman and colleagues (*page 431*) have tried to capture what current UK trainees think by seeking opinions from those in well-regarded and less well-regarded training programmes; their work should improve training for future generations.

Our neurologists might like to consider introducing some new topics into these familiar conversations. For example, what to put in (or to omit from) our clinic letters (*page 457*); what neurological books to read (our Book Club report discusses Helen Keller's life (*page 456*)); how to thrive in challenging working environments (Marieke Dekker and colleagues discuss mountain neurology on *page 404*); and how would we personally face up to a neurological illness (who can fail to be moved by Eric Seacrest's account of 'clinically isolating syndrome' (*page 449*)).

Or, maybe they could just agree to discuss topics that they read about recently in *Practical Neurology*....

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