Ever since Hughlings Jackson’s pioneering work, neurologists have tried to localise a clinical presentation—or, more often, to localise in the nervous system affected. This approach is particularly important when trying to disentangle challenging clinical problems—such as the cauda equina syndrome; this prompts urgent action and reflex loss comprises a cauda equina syndrome (CANS), and a long-standing dry cough provides a further clue. Andrea Cortese and colleagues (page 14) provide a clear description of this disorder—the most common recessive cause of ataxia—which their team have recently genetically characterised.

CANS may in time appear as readily recognisable clinically as Huntington’s disease, a genetic condition also caused by a pathogenic repeat expansion. Thomas Stoker and colleagues provide an up-to-date review of the diagnosis and management of Huntington’s disease (page 32). One newer issue is deciding at what point to offer patients with a known mutation, for example, some with a known mutation, determined from predictive testing, has developed the condition. Frustratingly, recent trials of disease-modifying treatments have ceased but the team describe the range and application of currently available symptomatic treatments.

Some clinical signs can specifically pinpoint the level of the nervous system involved. Internuclear ophthalmoplegia reflects highly localised pathology in the medial longitudinal fasciculus that links the pons to the midbrain. Tylicho Chen reports a patient with wall-eyed bilateral internuclear ophthalmoplegia (WEBINO) following etanercept for psoriasis (page 71). We asked Luke Bennett and Christian Lueck to demystify the curious term ‘wall-eyed’ and to tell us what we need to know about WEBINO and how it differs from conventional internuclear ophthalmoplegia (page 4).

Charles Warlow, the founding editor of Practical Neurology, issued a challenge—and the prize of a copy of his book on stroke—to anyone who had diagnosed an intracranial vascular malformation using a stethoscope. Although Charles most likely had his tongue firmly in his cheek, Andrew Larner works through the likelihood of making the diagnosis this way. He demonstrates convincingly that cranial auscultation is not a sensible use of clinical time (page 79)—its only value being to impress an audience—and that we should think about performing and interpreting the clinical examination as we are with other investigations.

Hypnosis was one of the relatively few treatments available to Hughlings Jackson’s patients, though was perhaps of more interest to Charcot. Does hypnosis have anything to offer patients in the 21st century? Wendy Phillips and colleagues summarise the history of hypnosis, what it is, how it is done, the current neuroscience underpinning it (page 42), and Mark Edwards provides a commentary on what it may offer to practising clinicians (page 2). We have other cases relating to different levels of the nervous system: HTLV1-related encephalitis (page 60); longitudinally extensive myelopathy from syphilis (page 75) and spinal glioma causing limb myorhythmia (page 77); and chronic inflammatory sensory neuropathy (page 82)—David Grundy, a Professor of Biomedical Science and ironically an expert on brainstem control, provides a dramatic personal experience of being temporarily locked-in following a basilar artery stroke.

There are also podcasts on the journal website (pn.bmj.com) for those wishing to explore the journal’s best articles further. An editors’ fireside discussion (no actual fire is used) introduces each new issue (though we understand that this paragraph of commentary may be more than enough for most readers) and an editors’ choice podcast, with its lead author answering those questions that we might all like to ask. Might be worth a listen.

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