



# Highlights from this issue

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To make a decision is to answer a question. Clinical neurology involves a sequence of questions relevant to most patients—what is the clinical syndrome? what investigations are needed? what is the probable diagnosis? what is the best treatment? what is the likely prognosis? This is how students and trainee doctors are taught to structure their clinical questioning, and how clinical case vignettes are presented in final or post-graduate exams. Though these exam vignettes are slightly deceptive as the case summary is designed to include all the appropriate information that can lead to a decision—a diagnosis or treatment.

A primary care physician's letter often reads like such a vignette, typically providing enough information to make a diagnosis or to plan the next steps in investigation. 'Advice and Guidance' is a system that recognises that this occurs quite often; it is designed to allow neurologists to provide advice on diagnosis, investigation or management in collaboration with primary care. This allows patients to start their investigations or receive appropriate treatment sooner. Kirstie Anderson and colleagues use their experiences to discuss the approach to Advice and Guidance, what works and what doesn't (page 209). Additional questions come into play—is the information sufficient (there are mechanisms to ask for more)? Is it reliable? Is it safe to give advice? Victor Patterson, a neurologist in Northern Ireland, builds on his long experience of enhancing neurology provision by techniques such as teleneurology (long before the pandemic made such approaches fashionable) to set this new initiative into context. He also provides a helpful thought experiment to use at the start of clinic, for neurologists who are uncertain if Advice and Guidance is possible for them (try it; page 179).

Some patients need their neurologist to ask a different question. Most

patients with optic neuritis will make a good recovery and are usually managed conservatively. However, a small number do not—such as those with antibodies to myelin oligodendrocyte glycoprotein or aquaporin—yet have potentially treatment-responsive conditions. The specific antibody results often arrive well after the treatment decisions have been made. So the question for someone with optic neuritis becomes 'is this patient at high risk of poor recovery?' Sarah Cooper and colleagues discuss how to identify and treat such patients (page 190).

Transient global amnesia is the most common acute-onset amnesia and usually presents in a sufficiently characteristic way that neurologists can usually make a confident diagnosis on reading the referral. However, acute amnesic syndromes may have other causes. Tom Miller and Chris Butler explore the various causes and advise how to assess and manage such patients (page 201).

Posterior reversible encephalopathy syndrome is another dramatic disorder, with seizures, confusion and headache and marked changes on MRI. It has many associations and a wide range of differentials to consider. However, the changes are not necessarily posterior in site nor are they always reversible. James Triplett and colleagues discuss this challenging condition on page 183 to help our decisions on diagnosis and management.

In neurology, we usually make diagnoses without histological proof—indeed we rarely request a brain biopsy. But sometimes this is essential to make a diagnosis that may be treated. Such conditions include cerebral amyloid angiopathy with inflammation and amyloid-beta-related angiitis. This edition includes reports of both—from Duncan Maddox and colleagues (page 216) and Memoona Nasir and colleagues (page 228)—and Neil Scolding (page 181) provides an overview of the developing understanding

of amyloid cerebrovasculopathies, their pathophysiology and potential treatments, and addresses the additional question, does this patient need a brain biopsy?

Consensus diagnostic criteria often help in making a diagnosis, especially where there is no histology or diagnostic laboratory test (often the case in neurology). Such criteria may initially be developed as a research tool to standardise the diagnosis but then, unsurprisingly, are repurposed for clinical practice. Martin Turner and the UK motor neurone disease studies group provide an overview of the new Gold Coast criteria for the diagnosis of amyotrophic lateral sclerosis (page 176). These provide a clinically based approach to diagnosis, and remove the 'definite', 'probable' and 'possible' categories that had featured in the 1990 El Escorial criteria, which were unhelpful in the clinic.

Baclofen pumps are increasingly used to treat severe spasticity. Neurologists need a working knowledge of them for when a patient with such a pump presents neurologically; Michelle Balaratnam and Valerie Stevenson provide this for us on page 241. One important question is whether the pump is contributing to the presentation (too much or too little baclofen), or whether it relates to the underlying neurological disorder or to some other cause.

This issue of *Practical Neurology* also contains a diverse range of clinical cases—from genetic to vascular—and opportunities again to 'test yourself'. Our neurology book club report aims to stimulate broader reading (and group discussion) and A Fo Ben updates us with neurological news that we may have missed.

There is only one decision to make now; which article to read first?

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