

EDITOR'S CHOICE

Pract Neurol 2008; 8: 207

"Patients should not be all that interested in their diagnosis—discuss". This would have been a nice written exam question in the (good) old days before the invention of the pernicious MCQs (Multiple Choice Questions) and the ever so boring OSCEs (Observed Structured Clinical Examinations). Why? Because the reflective (politically correct fashionable word for thoughtful) medical student and doctor realise that what patients really, really want to know is "what is going to happen next?" and then "what are you going to do about it?" In other words, prognosis and treatment. However clever the neurologist may feel in making the diagnosis (and some feel far too clever with or without justification), the "diagnosis" itself has not much meaning except in so far as it carries a threat of future catastrophe (for example, you have a had a mini-stroke and might have another which could carry you off) or not (for example, you just have migraine and can stop the aspirin, dipyridamole, water tablet, perindopril and the statin, and by the way I am not in the least interested in the white blobs which have been frighteningly called small vessel disease on your completely unnecessary MR brain scan). Diagnosis is a means to an end, and that end is prognosis and treatment. So how do we predict what is going to happen to our patients? Gaze into a crystal ball? Not very professional. Guess? The more experienced you are the more likely you are to get it right, but by no means always.

Better to read Peter Rothwell's article on page 242 where he explains our faltering steps towards providing individual patients with a prognosis, not on average for hundreds of patients rather like the one sitting in front of you, but for the one sitting in front of you.

Diagnosis meaning prognosis is everywhere. For example, the cause of vertigo has huge prognostic implications, as explained by Barry Seemungal and Adolfo Bronstein on page 211; too often the acutely dizzy patient is told he or she has had a stroke when in fact the diagnosis is the far more prognostically benign "vestibular neuronitis" (so learn all about the head impulse or thrust test). Again, on page 222, Bo Norrving reminds us that the prognosis for patients with small "black holes in the brain" is not as benign as we once thought, and on page 229 David Hutchinson and Ken Whyte highlight just which neuromuscular diseases are likely to be complicated by respiratory failure—diagnosis is all about prognosis, yet again. We continue our "What to do when ..." series with Werner Poewe's answer to that knotty problem of the Parkinson's patient who starts to hallucinate (page 238), and our "Image of the moment" series with venous infarction in the brainstem on page 254 which I have never seen but has convinced our rather severe referee. And at the end on page 263 we have number 2 of our "Bare Essentials" articles, this time on stroke from the Lille group—only another 22 to go!

Charles Warlow