

## EDITOR'S CHOICE

Pract Neurol 2008; 8: 277

**M**y first post after qualification as a doctor was with the late Tony Dornhorst, the first Professor of Medicine at St George's Hospital Medical School—nowadays rebranded as St George's University of London. He had a huge influence on me and many other St George's students, and one reason was his ability to produce—apparently spontaneously—brilliantly pithy phrases to express rather important thoughts. One such, just when intensive care units were being set up in the late 1960s was "Humph, intensive care units—more intense than careful!" How true then, and still true I fear in many units today, which is a good reason to read the review on weakness in ICUs by Robin Howard and his colleagues on page 280. Even if a patient appears moribund, is attached to a bewildering array of monitors, has lines and tubes sprouting from every part of their body, and is surrounded by eager nurses measuring everything there is to measure, you—the neurologist—must not forget your special skills in history taking and examination (so complementing those of the intensivist). In the rush to the ICU, and the drama in the ICU, you may be the first person to enquire about abdominal pain, a family history of weakness, or street drugs. You may even be the first person to realise the patient is conscious and "locked in". Keep the article tucked in your bag to have a quick peep at on your way to the ICU, and do not be intimidated when you get there.

Sadly, and I believe quite wrongly, neuropathology is hardly touched on in UK neurology training, and yet gross and microscopic anatomy is how we can "visualise" what is going on in the diseased nervous

system. CT and MR imaging is far too crude to reveal not just the beauty of central nervous system structure seen with tinctorial stains, but nowadays with immunohistochemistry the very proteins that make up that structure, as described by Alexander Jeans and Margaret Esiri on page 303. Postmortem examination of the brain remains, therefore, a crucial tool in our efforts to understand diseases of the nervous system. And likewise, even if the clinician gets it wrong or at least not quite right like our visiting Australian colleague Geoff Donnan on page 296, the well constructed clinicopathological conference is one of the best educational tools in teaching neurology; asking an excellent clinician to think through how he or she unravels a difficult case is always a delight, and in fact the highlight of the neurology course we have run in Edinburgh for the last couple of decades.

I have never myself diagnosed—correctly—a case of Whipple's disease of the brain but we all worry about it, and so the article by Peter Panegyres on page 311 comes as a useful reminder. The team at the Walton Centre in Liverpool come up with a bright idea on page 318 and Jon Stone suggests another one (even though it came from a neurosurgeon) in his editorial on page 278.

We continue our Bare Essentials series with headache (page 335), the commonest symptom we have to deal with in general neurology clinics, indeed the commonest neurological symptom and one which almost all of us have experienced—so even if you don't like it, and might even find it boring, you have to know about headache.

**Charles Warlow**