



# Highlights from this issue

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Despite wide ranging advances in neurological therapeutics for many neurological conditions, there are frustratingly few interventions that can reverse a neurological deficit or prevent deterioration. Patients are faced with the consequences—some of which we can help. One such is loss of function at the ankle, for example, from foot drop, with its associated impact on walking. Sometimes this is temporary, for example, after a stroke, but in others is permanent. Ankle orthoses can significantly improve function but the choice of orthosis depends on several factors, including whether the problem affects the swing phase or the stance phase of walking. Stephen Kirker discusses the range of orthoses available, from simple to highly sophisticated, illustrated with 15 examples (page 311). This practical intervention—barely a footnote in most neurological textbooks—will often substantially help patients.

When a patient has had a seizure, or presents with epilepsy, they are prevented from driving. For many people, their loss of driving privileges can seem of greater consequence than their seizure, especially if they were barely aware of the seizure itself, for example, if it occurred during sleep. Jeremy Rees *et al* (page 268) explore the UK's driving regulations for medical conditions and the reasoning behind the rules and how they differ internationally. In a linked editorial, Tony Marson discusses the challenges of developing and implementing these rules, balancing the rights of a driver against the risks to the public, the heterogeneity of drivers and their diagnoses, and the uncertainties and limitations in the evidence, particularly for neurodegenerative disorders (page 266).

Classical infratentorial superficial siderosis is usually the late consequence of a previous neurological

insult, either neurosurgical or traumatic, often from many years before. Natallia Kharytaniuk *et al* discuss the presentation of this condition (page 274)—usually with deafness and progressive imbalance but often myelopathy or polyradiculopathy. They describe its diagnosis using particular MRI sequences and explore the as yet limited treatment options from the perspective of a specialist unit.

When there is limited evidence and uncertainty about management, we can often be helped by advice from a specialist unit. The understanding of CSF biomarkers for dementia is advancing quickly, though their role in everyday diagnoses remains unclear. Ashvini Keshavan *et al* update us (page 285) on how CSF biomarkers are used in their unit, ranging from how best to take the samples to their interpretation, including a discussion of the current limitations. Similarly, Mark Thaller *et al* run a specialist idiopathic intracranial hypertension (IIH) service. Given the condition mainly affects young women, they see many patients with IIH becoming pregnant; the team share their experience and provide practical advice on managing IIH before and during pregnancy (page 295).

Giulia Navarro and Khalid Hamandi provide a further specialist unit update, discussing lessons from their video EEG telemetry unit (page 301). A general neurologist might understandably feel that something so highly specialised is not really relevant to their practice. However, patients and their relatives will often bring recordings of events made on their phones to clinic, and interpretation of these videos requires a similar approach and skills as those in the video EEG unit. Their videos available online are worth watching.

Tom den Heijer describes his personal experience of sustaining

a spinal cord stroke in 'Me and my neurological illness' that was most likely from fibrocartilaginous embolism (page 328). Sai Adithya Nagaratnam *et al* report a patient that they argue has the same condition (page 324). Fibrocartilaginous embolism arises from degenerative spinal disc material embolising to the spinal arteries. It can be diagnosed definitively pathologically but making the diagnosis in life is rather harder. The paper discusses its pathogenesis and constructs an approach to making the diagnosis.

We have two reflective editorials from retired colleagues. Graham Flint, a neurosurgeon, asks 'Of what value is experience?' (page 262): experience helps in deciding when to intervene, and more significantly when not to intervene—to avoid unintended consequences. Ian Bone, a neurologist, describes 'The art of doing nothing' (page 264). In the past there were certainly more opportunities to do nothing in neurology and medicine in general, but we must still avoid being drawn to activity without benefit. He suggests we should reframe 'doing nothing' as a different way of 'doing something' with masterly inactivity.

In addition to our usual case reports, Test Yourself and Carphology we have a Book Club report about an alternative approach to coping with selected unwanted consequences that people face in life. The prescriptions offered by 'Poetry Pharmacy' are, unsurprisingly poems, with choices matched to problems. This unusual proposition is well argued and entertaining, but no randomised poetic trials were reported. Was the Gloucester Book Club persuaded? Find out on page 338.

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