



Kath O'Connor

Incidentally...

Sometimes I wonder what medical secrets my body holds. Do I have gallstones just waiting for the next meal of fish and chips to erupt into biliary colic? What degree of osteoarthritis is accumulating unseen in my spine? How much atherosclerosis is silently mounting up in my arteries? Then again, knowing the answers to these questions is unlikely to enhance my life. Unless these abnormalities become symptomatic, I am probably better off not knowing. Better to carry some secrets with me to the grave.

The World Health Organization's (WHO) principles of screening provide some guidance on which asymptomatic abnormalities are worth detecting in a population screening program.¹ Cervical cancer screening clearly fulfils these principles; prostate cancer screening is more controversial.² However, these guiding principles are of no help for abnormal investigation findings detected incidentally while testing for another condition. Incidental findings are a common problem in general practice with the ever increasing availability and sensitivity of pathology testing and imaging studies. The more we look, the more we see.

Last year, in the clinic, I saw a 68-year-old woman (Mrs AS) with persistent cough and crackles at the right lung base. On her chest X-ray, the lung fields were clear, but the lateral view showed a mass lesion in the apex of the lung, adjacent to the spine. A few days of anxiety followed until we could get a CT scan, which showed that the lesion was simply a large osteophyte, projecting into the thorax from the spine. Luckily, my patient didn't have to undergo any further painful or prolonged testing, as sometimes happens, before finding out that the lesion was benign.

I remember some advice I received from an emergency physician, early on in my intern year:

'Don't order a test if you don't want a result'. We were discussing a positive D-Dimer. I had ordered the test in a patient with a suspected deep vein thrombosis and I was scratching my head over what to do with the positive result. Unfortunately, the patient concerned had to wait around for hours for an ultrasound that might not have been necessary if I had assessed their pre-test probability of having a deep vein thrombosis. This was the first in the thousands of lessons in the rational use of medical investigations that have followed over the years.

Rational ordering can avoid the release of some of the worms from the can, but not all. Incidental abnormalities or 'incidentalomas' are common. In some cases, the significance of these incidental findings may be clear; an isolated elevated bilirubin on liver function testing can safely be ignored, as can mild osteoarthritis on an X-ray performed to exclude a fracture. By contrast, the anxiety and further testing that occurred in the case of Mrs AS was unfortunately necessary.

In this issue of *Australian Family Physician*, Kantha Rao and Peter Royce provide us with some guidance on what to do when imaging done for another purpose incidentally reveals a small renal mass or cyst.³ This is important because, as they explain, 50% of renal cancers are detected incidentally.³ Also in this issue, Finlay McNeil and Simon Bariol discuss the management of renal stones. Importantly, while stones may cause excruciating pain, they are also sometimes found on imaging performed for other reasons.⁴

In this issue of *AFP* we also look at management issues in urology. In particular, Gillian Duchesne outlines the management of localised prostate cancer⁵ and Mohan Arianayagam, et al look at lower urinary tract symptoms in older men.⁶

Incidental abnormalities found on pathology testing or medical imaging can sometimes open a can of worms, resulting in patients being

subjected to painful or inconvenient further testing. In some cases this further testing reveals a diagnosis that is both sinister and treatable. In others, we are simply documenting an abnormality that could have gone with the patient to the grave (or to a footnote on an autopsy report). When incidental findings occur, general practitioners play a vital role in helping patients negotiate a safe and practical course through any further tests that are necessary and toward a meaningful explanation.

Author

Kath O'Connor MBBS, FRACGP, is Medical Editor, Australian Family Physician and a general practitioner, Castlemaine, Victoria.

References

1. Wilson JMG, Jungner G. Principles and practice of screening for disease. World Health Organization Public Health Papers, No. 34; 1968. Available at http://whqlibdoc.who.int/php/WHO_PHP_34.pdf [Accessed 8 September 2011].
2. Australian Health Ministers' Advisory Council. Available at [www.cancerscreening.gov.au/inter-net/screening/publishing.nsf/Content/449D837448F6BA03CA25752700062313/\\$File/joint%20prostate%20screening%20statement.pdf?](http://www.cancerscreening.gov.au/inter-net/screening/publishing.nsf/Content/449D837448F6BA03CA25752700062313/$File/joint%20prostate%20screening%20statement.pdf?) [Accessed 8 September 2011].
3. Rao K, Royce P. Incidentally detected small renal masses: Investigation and management. *Aust Fam Physician* 2011;40:776–82.
4. McNeil F, Bariol S. Assessment and management of urinary stone disease. *Aust Fam Physician* 2011;40:772–5.
5. Duchesne G. The grading, staging and management of localised prostate cancer: an overview for GPs. *Aust Fam Physician* 2011;40:768–71.
6. Arianayagam M, Arianayagam R, Rashid P. Lower urinary tract symptoms: current management in older men. *Aust Fam Physician* 2011;40:758–67.

correspondence afp@racgp.org.au