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Diagnosis – from gold to shades of grey

Diagnosis started as the elusive gold. At medical school, the goal of history, examination and investigations was diagnosis. You may remember the differential diagnosis, but the diagnosis was the gold. With the naïveté of enthusiastic inexperience, diagnosis was the golden key that unlocked the knowledge of what to do to make the patient better.

Diagnosis is something I now view very differently. It is often far more complicated. Sometimes the child falls, cries, the x-ray tells you the diagnosis is a fracture and plaster follows. It can be simple. However, mostly it is not. An older person falls and breaks a bone, is there a reason for the fall? Were there palpitations? Did they trip over the cat? Is it a pathological fracture?

Problems without a diagnosis are a challenge. There are often consultations when a patient is concerned about a symptom, a problem. After assessment, I may not be able to label, but I can reassure it is unlikely to be serious and is likely to resolve. Explaining this takes time. However, if you can name the condition, even if the treatment is still 'expect to improve and review if not', it seems to take less time to achieve a shared understanding. The diagnostic label can be a time saver.

There are the times when the aim is to exclude a diagnosis, like the colonoscopy to exclude bowel cancer in a patient with a positive screening faecal occult blood test. The art in these consultations is different. Getting the patient to understand the potential seriousness and why further investigation is important; while at the same time not being overwhelmed with concern about a possible diagnosis with a low pre-test probability.

A wrong diagnosis can be as problematic as no diagnosis. We all have a level of trust in a diagnosis, so you manage. At times something is not quite right, or you instinctively have concerns, so you go back and look for the evidence for the diagnosis. Sometimes it was correct, sometimes you realise it was not. Wrong diagnosis means you have unlocked the wrong management door. Hopefully only delaying the correct treatment with no harm done; less good scenarios include giving toxic treatments or further deterioration in the condition leading to poorer prognosis.

We all like the certainty of a label. In casual conversations, people volunteer, or are asked, their diagnosis. The 'right' diagnosis can be the key to accessing a treatment or a service. One of the tasks of a GP in helping a patient with medically unexplained symptoms is to move from the diagnostic search and be able to hold the uncertainty of no label and move to managing ongoing symptoms.[1]

Diagnostic goal posts can shift. This year, DSM-V changed the criteria for some mental health diagnoses.[2] Then there are diagnoses where there are questions being raised about the criteria expansion labelling more people with a diagnosis, for example the expansion of chronic kidney disease criteria and what the diagnosis means in an asymptomatic older patient.[3]

Now I view diagnosis as having many shades of grey. My haste for the golden answer of the diagnosis is less, and my consideration about labels and their significance greater.

This month in *AFP* we look at diagnostic challenges. These are some conditions that hide in plain sight. Multiple myeloma is the focus of Eslick and Talaulikar's article,[4] a challenge is to consider the potential diagnosis with subtle presentations. Fibromyalgia, the focus of Guymer and Littlejohn's article,[5] is common but has varied and fluctuating clinical spectrum, which affects the challenge of diagnosis. Systemic lupus erythematosus is the focus of Apostolopoulos and Hoi's article.[6] It is the first autoimmune disease that you learnt and the range of systems it can affect is a challenge. We hope this issue will help you manage some of the diagnostic challenges that you see every day in your clinic.

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This issue is my last at AFP. *It has been a privilege to contribute to the journal. Thank you to all the readers who make comment, provide feedback and talk to us about* AFP. *Thank you particularly to the reviewers whose expertise and time are central to a peer-reviewed journal, and the authors who offer their findings and ideas to the readers. Thank you to all the enthusiastic committed people, far too many to list, that I have been fortunate to work with. As an ongoing reader, I look forward to continuing to turn to* AFP *for useful clinical information, to stimulate reflection on practice and to read research that can impact on general practice.*

References

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