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The point of view of the patient about disease

The challenge of the diagnosis resurfaces at each appointment. Physicians fight a constant battle to define a diagnosis that explains the complaints that led the patient to seek medical care. In situations of conflict of interests, even the question of whether a disease really exists arises. With the advance in health care technology, besides the facilities, in this daily exercise in the life of a physician arise. If new technologies show us new details, their meaning is frequently uncertain; as a rule, an increase in sensitivity is associated with a reduction in specificity. This is especially true in imaging exams of the locomotor apparatus. "Changes" in asymptomatic patients and "normality" in symptomatic patients are constant in daily practice, but a symptomatic patient with an "abnormal" imaging exam is one of the most difficult situations. What can guarantee they are interrelated? Where is the disease when a low clinical-radiological correlation is present?

Studies and conduct directives have been stimulating physicians not to request too many tests. In the financial view of health care they are not cost effective; in the point of view of the patient, they do not solve the problem, and, often, lead to more unnecessary tests and to iatrogenic disorders. Unfortunately, requesting a test and saying that the diagnosis depends on it is the fastest way of finishing an appointment without making the patient unhappy and to hide a poor history and physical exam.

In a study published in *Radiology* in 2005,[1] MRIs were randomLy done in the first appointment of patients with acute lumbosciatalgia without red flags; half of the MRIs were showed to the physician and the other half were not. The evolution of patients in both groups did not differ, showing that this exam should not be requested in the first medical appointment in those cases. Despite that, we see the opposite in well-equipped emergency rooms; requesting an exam is so easy that it seems that the requests are aimed at reducing the cost of the equipment and insecurities of the physician, and not the interest of the patient.

The study by Professor Feldman *et al.*[2] published here corroborates the impression that we are walking in a swamp full of traps.

An exam that is positive in only 20% of the patients with shoulder pain is predictive of a disease? An exam that can be altered in 5% of asymptomatic patients is predictive of disease? Despite the statistical difference, those numbers demonstrate little clinical difference.

In this scenario, care should be exercised when requesting an exam. Its results can only be valued along with a good history and physical exam. We should not treat the exam, but the patient.

Since health is the physical, mental, and social wellbeing of an individual, someone who seeks medical care for a shoulder pain is sick, even though his/her ultrasound is normal, and an asymptomatic individual is not sick, even with an abnormal ultrasound of the shoulder. We could argue about the individual with shoulder pain, who never went to a physician or complained about it before being asked, and continued to work at the factory Professor Feldman selected his study population, but this is another story.

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