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## When the correct Dx is elusive

**I**n this issue of *JFP*, Dr. Mendoza reminds us that “Parkinson’s disease can be a tough diagnosis to navigate.”<sup>1</sup> Classically, Parkinson’s disease (PD) is associated with a resting tremor, but bradykinesia is actually the hallmark of the disease. PD can also present with subtle movement disorders, as well as depression and early dementia. It is, indeed, a difficult clinical diagnosis, and consultation with an expert to confirm or deny its presence can be quite helpful.

**Other conundrums.** PD, however, is not the only illness whose signs and symptoms can present a challenge. Chronic and intermittent shortness of breath, for example, can be very difficult to sort out. Is the shortness of breath due to congestive heart failure, chronic obstructive pulmonary disease, asthma, or a neurologic condition such as myasthenia gravis? Or is it the result of several causes?

### Reevaluate your asthma patients to be sure they have the correct Dx, and keep Parkinson’s in the differential for patients with atypical symptoms.

tion such as myasthenia gravis? Or is it the result of several causes?

**When asthma isn’t asthma.** Because it is a common illness, physicians often diagnose asthma in patients with shortness of breath or wheezing. But a recent study suggests that as many as 30% of primary care patients with a current diagnosis of asthma do not have asthma at all.<sup>2</sup>

In the study, Canadian researchers recruited 701 adults with physician-diagnosed asthma, all of whom were taking asthma medications regularly. The researchers did baseline pulmonary function testing (including methacholine challenge testing, if needed) and monitored symptoms frequently. Then they gradually withdrew asthma medications from those who did not appear to have a definitive diagnosis of asthma. They followed these patients for one year. One-third (203 of 613) of the patients with complete follow-up data were no longer taking asthma medications one year later and had no symptoms of asthma. Twelve patients had serious alternative diagnoses such as coronary artery disease and bronchiectasis.

**Closer to home.** In my practice, I found 2 patients with long-standing diagnoses of asthma who didn’t, in fact, have the condition at all. In both cases, my suspicion was raised by lung examination. In one case, fine bibasilar rales suggested pulmonary fibrosis, which was the correct diagnosis, and the patient is now on the lung transplant list. In the other case, a loud venous hum suggested an arteriovenous malformation. Surgery corrected the patient’s “asthma.”

I urge you to reevaluate your asthma patients to be sure they have the correct diagnosis and to keep PD in your differential for patients who present with atypical symptoms. Primary care clinicians must be expert diagnosticians, willing to question prior diagnoses.

1. Young J, Mendoza M. Parkinson’s disease: a treatment guide. *J Fam Pract.* 2018;67:276-286.
2. Aaron SD, Vandemheen KL, FitzGerald JM, et al for the Canadian Respiratory Research Network. Reevaluation of diagnosis in adults with physician-diagnosed asthma. *JAMA.* 2017;317:269-279.

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