Well-known examples of diagnoses of exclusion (*per exclusionem*) include IBS, "fever of unknown origin," chronic fatigue syndrome, and fibromyalgia. Although these conditions have well-researched questionnaires and assessment tools (eg, for bowel dysfunction),[2] there is a fundamental lack of understanding of both the underlying pathophysiology and the mechanism of action of their treatments. We do not imply that these conditions are without a pathologic process, nor do we suggest that they are fictitious or "psychological" (an anecdotal opinion of some physicians); rather, we believe that they represent heterogeneous clusters of unknown pathologic processes, grouped by symptoms. Forming these diagnoses occurs without objective verification, often after a crude process of elimination. In reality, we think this highlights an intrinsic desire of doctors to provide a diagnosis for patients. This diagnosis then acts as a basis on which to initiate treatment and provide, to the extent of the abilities of a modern physician, a form of reassurance to both doctor and patient. However, the use of a diagnosis of exclusion unfortunately can be tantamount to saying that a true diagnosis is not known. Herein lies the problem with modern medicine—we can image the functioning brain and examine the deepest recesses of the human body, but we remain uncomfortable uttering 3 words: "I don't know."

To progress as a profession, we need to understand that a diagnosis of exclusion should be seen as a target for research. Individual pathologic processes must be elucidated carefully if we are to understand the myriad conditions that contribute to the aforementioned umbrella terms. Sunderji et al[3] utilized electrocardiography in an attempt to elevate tako-tsubo cardiomyopathy from a diagnosis of exclusion. Ultimately, they failed, further highlighting the difficulty of these diagnoses. We must not be discouraged, but rather, continue the quest to find the best methods of discerning the constituent parts of these diagnoses. After identifying these problems we will be in a position to generate diagnoses of *inclusion* rather than exclusion. We will then be better able to diagnose and treat our patients, which, ultimately, is the *raison d'être* of a doctor.

Joseph M. Norris, BSc (Hons)
David R. McGowan, BSc (Hons)
Department of Medical Education
Brighton and Sussex Medical School
Brighton, East Sussex, UK
J.Norris1@uni.bsms.ac.uk

References

1. Barnes MG. Irritable bowel syndrome: a "mesh" of a situation. J Am Board Fam Med 2012;25(1):120–3.
2. Leung L, Riutta T, Kotecha J, Rosser W. Chronic constipation: an evidence-based review. J Am Board Fam Med 2011;24(4):436–51.
3. Sunderji S, Ariyarajah V, Solodum V, Shaikh N, Tam JW. Electrocardiographic criteria in tako-tsubo cardiomyopathy-is there added certainty in a diagnosis per exclusionem? Am Heart Hosp J 2009;7(2):130–5.

doi: 10.3122/jabfm.2012.03.120030

The above letter was referred to the author of the article in question, who offers the following reply.

Response: Re: Irritable Bowel Syndrome: A "Mesh" of a Situation

To the Editor: I greatly appreciate Drs. Norris and McGowan's correspondence and I share their many concerns. I certainly agree that, as physicians, we should be monitoring constantly those patients with diagnoses of exclusion or we may easily miss the true cause of illness. As providers, I'm sure that we all have seen a similar case of misdiagnosis. Whether it be an autoimmune disease masquerading as a fibromyalgia or pericarditis masquerading as costochondritis, we should never place our complete faith behind a single diagnosis.

The law of clinical inertia often amplifies a diagnostic label. In a busy clinic, the path of least resistance is often the path involving the previous diagnosis as opposed to creating a "fresh look." Neither the provider nor the patient (nor the insurance company) look forward to a brand new work-up with every visit. As such, Newton's corrupted second law seems to reign supreme, unless providers make that herculean effort.

Do I have the energy and patience to revisit a differential with every patient I see? No. But sometimes we all have to break the laws of physics. I challenge all providers to look at their difficult patients with diagnoses of desperation (especially when their treatments just are not working) to take that second look, revisit the work-up, and see if that diagnosis of exclusion has just excluded the diagnosis.

Matthew Barnes, MD
United States Air Force
Matgbarnes@gmail.com

doi: 10.3122/jabfm.2012.03.120040