What Doesn’t Fit?

How to recognize when “almost right” becomes dangerous

Thank you to everyone who joined us in Bunbury for **Danger Close: Respiratory Conditions Hiding in Plain Sight**.

Before the session, I had an interesting conversation with one of the GPs attending. We talked about how medicine has changed. There was a time when general physicians commonly looked across multiple organ systems and tried to put the whole patient together. Today, medicine is increasingly subspecialised.

In many ways, that integrative role now falls heavily on the GP.

A patient may see a cardiologist for one problem, a respiratory physician for another and an endocrinologist for another—but the GP is often the person who sees **the whole picture**.

At the same time, general practice is getting busier. More complexity. More information. Less time.

So we do what experienced clinicians naturally do:
We recognise patterns.
Breathlessness + wheeze → asthma.
Fever + infiltrate → pneumonia.
Fatigue + hypertension + poor sleep → several common problems.

And most of the time, we are right.
Pattern recognition isn’t bad medicine. **It is what makes efficient medicine possible.**

The danger is the patient who is *almost* the pattern.
Close enough to make us comfortable.
Wrong enough to matter.

That was the premise of *Danger Close*. It wasn’t about memorising rare respiratory diseases. It was about recognising the moment when we need to stop and ask:

What doesn’t fit?

Four traps that catch all of us

Diagnostic errors are often not failures of knowledge. They arise from normal human decision-making—particularly when we are busy.

In *Danger Close*, we discussed four situations where I think we need to be particularly careful:

1. Treatment failure — the familiar mistake

We anchor to the original diagnosis. When treatment doesn't work, our instinct is often to treat harder rather than rethink.

2. Normal tests — the subtle mistake

A normal result reassures us. But a test only tells us about what it actually measured.

3. Wrong system — the conceptual mistake

We divide symptoms into respiratory, cardiac, psychological or other systems when sometimes one diagnosis links them together.

4. False reassurance — the dangerous mistake

Once we have a diagnosis, confirmation bias makes it easier to notice evidence supporting it and discount evidence that doesn't.

The solution isn't to stop using pattern recognition.
It's to recognise **when the pattern is starting to break.**

When asthma isn't behaving like asthma

Consider the patient labelled with severe asthma who remains breathless despite escalating inhalers, repeated steroids or even consideration of biologic therapy.

The instinct is:
What else can I add for the asthma?

Sometimes the better question is:
Is this actually asthma?

Excessive dynamic airway collapse or tracheomalacia can cause cough, wheeze and breathlessness but represents a structural problem—the central airway collapses excessively during expiration. Standard inspiratory computed tomography may not demonstrate the dynamic abnormality.

Inducible laryngeal obstruction can also masquerade as asthma. A useful clue is predominantly inspiratory difficulty, often localised by the patient to the throat, with poor response to inhalers.

These diagnoses are not the point.
The point is the **treatment failure**.
If the patient isn't responding the way your diagnosis predicts, don't just escalate.
Question the diagnosis.

Then question the test
One of the most discussed parts of our Bunbury session was **Forced Oscillation Technique (FOT)**, including a live demonstration.

Spirometry and FOT are not competing tests. **They ask different physiological questions.**

Spirometry measures airflow during a forced manoeuvre and is particularly useful for detecting obstruction involving the larger and medium-sized conducting airways. FOT measures respiratory system mechanics—including resistance and reactance—during quiet breathing and can provide additional information about peripheral or small-airway dysfunction.

One case from the session illustrated this particularly well.
The patient had symptoms strongly suggestive of asthma.
Baseline spirometry: normal.
Baseline FOT: normal.

We therefore proceeded to a mannitol bronchial challenge.
Using the conventional spirometric criteria, **the mannitol challenge was also normal**.

At this point, it would have been very easy to conclude:
"We have investigated for asthma. The tests are normal. This isn't asthma."

But FOT had also been performed during the mannitol challenge. It demonstrated a significant change in airway mechanics during provocation, revealing airway dysfunction that was not detected by spirometry.

So the sequence was:
Normal baseline spirometry → Normal baseline FOT → Normal mannitol challenge by spirometry → Abnormal response detected by FOT during mannitol provocation.

This is not an argument that FOT is “better” than spirometry.
It is an argument for understanding **what your test is actually testing before allowing a normal result to close the diagnosis.**

Spirometry is an excellent test, but it is weighted towards airflow changes in the larger and medium-sized airways and can be less sensitive to abnormalities confined predominantly to the small airways. FOT interrogates airway mechanics differently and may provide additional information about peripheral airway dysfunction.

A normal spirometry result therefore doesn’t necessarily mean:
“The airways are normal.”

It means something more specific:
“This test has not demonstrated the airflow abnormality it is designed to detect.”

That distinction matters. Because premature closure doesn’t only happen when we choose the wrong diagnosis.

It can also happen when we ask a test a question it isn’t well designed to answer—and then interpret a normal result too broadly.

The test is only as good as the question it is testing.

Sometimes spirometry and FOT agree.
Sometimes they don’t.
And when the clinical story and the test result disagree:
The mismatch is the message.

When should you stop and reconsider?
You don’t need to remember every respiratory mimic from *Danger Close*.
Instead, recognise the situations that should make you pause:

- Treatment isn’t working as expected.

- Tests are normal, but significant symptoms persist.
- The same diagnosis keeps recurring.
- Imaging isn't resolving as expected.
- The symptoms and objective findings don't match.
- Multiple apparently separate problems might have one unifying explanation.

When these occur, ask four questions:

1. Question the diagnosis

What is my working diagnosis—and what doesn't fit?

2. Question the test

What did this test actually measure, and what could it have missed?

3. Question the response

Is the patient behaving the way they should if my diagnosis is correct?

4. Look again

Reconsider the diagnosis, investigate differently, or escalate the case when appropriate.

Good medicine isn't about avoiding pattern recognition. We couldn't function without it.

It is about recognising the moment when the pattern stops making sense.
So when something feels *almost right*, ask:

What doesn't fit?

Because sometimes the clue isn't the abnormal result.

It's the mismatch.

If you have a patient with persistent or unexplained respiratory symptoms where the clinical picture doesn't quite fit, our team at Western Respiratory & Sleep is always happy to assist with further assessment.

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