Classical but not clinically oriented presentation

Although a catastrophic case in all terms, Abitbol and D'Urzo fail to use problem-based learning to propose useful pearls in their article on fatal aortic dissection.[1] In a condition where index of suspicion is key, aside from listing risk factors, the authors do not emphasize the importance of historical questions to identify high-risk populations including those with connective tissue disease, aortic valve disease, Turner syndrome, and family history of aneurysm or sudden cardiac death. Nor do they identify the nature of the pain: onset, quality, evolution, and signs of attendant limb ischemia and neurologic deficits are all critical to help differentiate this condition, yet none of these were detailed in their case description. The American Heart Association 2010 guidelines on thoracic aortic disease[2] guide the reader toward an approach that balances minimizing misdiagnosis with avoiding overinvestigation of every case of pneumonia, including reviewing the role of D-dimer testing. Perhaps this case also highlights the benefit of *Canadian Family Physician* providing comprehensive, up-to-date reviews on all such important diseases.

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Competing interests
None declared

References

1. Abitbol L, D'Urzo AD. Fatal aortic dissection in a 37-year-old man. Missed opportunity. *Can Fam Physician* 2014;60:1116-9.
2. Hiratzka LF, Bakris GL, Beckman JA, Bersin RM, Carr VF, Casey DE Jr, et al. 2010 ACCF/AHA/AATS/ACR/ASA/SCA/SCAI/SIR/STS/SVM guidelines for the diagnosis and management of patients with thoracic aortic disease. *Circulation* 2010;121(13):e266-369. Epub 2010 Mar 16.

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Response

We thank Dr Leung for commenting on our case report[1] and for highlighting the importance of identifying historical factors that might influence how we leverage our clinical decision making and how this, within the context of our case report, might have provided more clinically oriented management pearls. Given the word limitations for the case report, we limited the clinical presentation to pertinent positive accounts offered by the patient during the encounter with the family physician before the emergency department referral. We believed that it was important to present this case in this manner to highlight real-world conditions that often include patients with undifferentiated and "non-classical" presentations of aortic dissection. The reality is that patients often do not present in a classical fashion and, when they do, the differential diagnosis still can be quite lengthy and difficult to sort out without appropriate investigations. Given the spectrum of conditions presenting with chest pain, some potentially lethal as in this case, the process of delivering the best and most timely care might simply be to have a high index of suspicion with a view to arranging further appropriate management, including emergency department referral.

The objective of this case was to highlight the central role of primary care physicians in considering aortic dissection as a cause of chest pain even among patients who might not be considered at high risk and in making decisions around further care.

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Competing interests
None declared

Reference

1. Abitbol L, D'Urzo AD. Fatal aortic dissection in a 37-year-old man. Missed opportunity. *Can Fam Physician* 2014;60:1116-9.

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