Diagnosis in general practice: Using probabilistic reasoning

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DIAGNOSIS IN GENERAL PRACTICE

Using probabilistic reasoning

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Having a sense of the accuracy of diagnostic tests will help general practitioners to interpret and use the tests appropriately and, as in the example of chest pain, avoid unnecessary testing general practitioner. The chance that such a woman has a urinary tract infection is approximately 55%, which is the proportion of patients without the disease who have a negative test result. Using this information, we can calculate the probability that the woman has a urinary tract infection after a urine dipstick result (table 1). This requires some mathematical manipulation and can be complex to follow, but is key to understanding the appropriate use and interpretation of diagnostic tests.

Of 1000 women, 55% or 550 will have a urinary tract infection and 450 will not (based on the prevalence of disease or pretest probability). Of the 550 women with disease, there are 495 true positives (550×90% sensitivity), and of the 450 women without disease, there are 270 true negatives (450×60% specificity); completing the table, the number of false negatives is 550−495=55 and the number of false positives is 450−270=180.

In clinical practice, we need to be able to calculate the chance that a patient does or does not have a disease when they have a positive or negative test result. Given a pretest probability of 55%, if either of the dipstick tests is positive, the probability that the woman has a urinary tract infection (the positive predictive value) is the proportion of true positives to all positive test results—that is, 495 divided by 675, or 73%. You may not think this conclusive enough to determine if an infection is present, and so may decide to send a urine specimen for microbiological confirmation. Conversely, if both tests

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are negative, the probability that the woman does not have a urinary tract infection (the negative predictive value) is the proportion of true negatives to all negative test results—that is, 270 divided by 325, or 83%. The probability that a woman has a urinary tract infection in this case is 17%. This may not be low enough to completely rule out infection, and further testing by microbiological culture may be necessary.

Although the positive and negative predictive values are the clinically useful measures, they are not generally reported in studies of the accuracy of diagnostic tests as predictive values vary greatly with changes in the pretest probability. To illustrate how the pretest probability affects the post-test probability, we can calculate post-test probabilities for the same test in an asymptomatic pregnant woman, using an estimate of the prevalence of asymptomatic urinary tract infection in pregnant women in Rochester, Minnesota (2.4%) (table 2). If we assume the same sensitivity and specificity as above but a pretest probability of 2.4%, and complete the table as before, the positive predictive value is now 22 divided by 413, or 5%; 95% of all positive results are false positives. The negative predictive value is, however, now 585/587, or close to 100%.

Women with recurrent urinary tract infection have a high pretest probability, about 84% (table 3). Assuming the same sensitivity and specificity but now using a pretest probability of 84%, a woman with a positive test result has a post-test probability of 756/820 or 92% (table 3). However, even if both tests are negative, the negative predictive value is 96/180 or 53%, so the probability that the woman has a urinary tract infection even with a negative test result is now 47%.

**When is probabilistic reasoning used?**

We use probabilistic reasoning intuitively whenever we consider the likelihood of a patient having a disease in the light of a new piece of information. In the diagnostic stages described previously, probabilistic reasoning occurs during the revision of the diagnosis (fig 1). In the accompanying article on the diagnosis of chest pain in general practice, Jelinek and Barraclough describe how different types of chest pain and the results of a stress electrocardiogram revise the probability that a patient has coronary artery disease.

Probabilistic reasoning is also used when deciding whether it is worthwhile to order further tests. For example, we might consider that the benefits outweigh the harms of treatment when the probability of a urinary tract infection is greater than about 60%. If a woman has a pretest probability of disease of 90%, even if the dipstick test is negative, her post-test probability of disease is above 60%. In this case, the dipstick test does not contribute to the decision on management and should not be ordered.

**How does probabilistic reasoning go wrong?**

We make errors by believing false positive and false negative test results and by ordering inappropriate diagnostic tests. To avoid these errors, we need to have a sense of both the pretest probability of disease and the diagnostic accuracy of test results. We do not need to be able to do these calculations exactly. Ultimately we need to decide whether it is worthwhile to treat a patient and whether it is worthwhile to order a diagnostic test.

When the prevalence or pretest probability of disease is low, the probability that a positive test result is a false positive becomes quite high. This is often the case in general practice, and it is always the case in screening tests. For example, only about 1 in 7 women with a positive screening mammogram will have breast cancer, and only 1 in 88 patients with a positive fecal occult blood test will have colorectal cancer—most patients with a positive test result will be false positives.

One of the specific skills of a general practitioner is to understand the pretest probabilities of disease in his or her clinical setting and to interpret the test results and order appropriate diagnostic tests. The difference in pretest probabilities between primary care and secondary care is one reason why clinicians find it difficult to move between these settings.

We also need to have better evidence about the diagnostic accuracy of tests, and particularly in the clinical setting in which they are going to be used.

**How can we improve?**

In clinical practice, we need to be aware of false positive and false negative test results in our clinical decision
making. The information in the three case scenarios can be shown on a graph that plots the post-test probabilities for positive and negative results against each possible pretest probability from 0 to 100%, using the sensitivity and specificity of the test (fig 2). The woman in the first case scenario moves from the pretest probability of 55% (table 1) to a post-test probability of 73% if the dipstick test is positive and to a post-test probability of 17% if the dipstick test is negative. An asymptomatic pregnant woman moves from a pretest probability of 2.4% (table 2) to a post-test probability of 5% if the dipstick test is positive and to a post-test probability of about 0% if the dipstick test is negative. A woman with recurrent urinary tract infection moves from a pretest probability of 84% (table 3) to a post-test probability of 92% if the test is positive and to a post-test probability of 47% if the test is negative.

Using this graph, which is based on the sensitivity and specificity of the test, means we do not have to recalculate a 2×2 table for each case and shows graphically how well a test rules in or rules out the diagnosis. The further the curve above the diagonal is away from the diagonal, the greater the ability of the test to rule the disease in, and the further the curve below the diagonal is away from the diagonal the greater the ability of the test to rule the disease out. A useful mnemonic is Ŝppin (when a specific test is positive, it rules the diagnosis in) and Snnot (when a sensitive test is negative, it rules the diagnosis out).7

**Likelihood ratios**

Another method for describing the diagnostic accuracy of tests is likelihood ratios. The positive likelihood ratio is the probability of a positive test result in patients with the disease divided by the probability of a positive test result in patients without the disease, or sensitivity/(1−specificity).8 In the example above, the positive likelihood ratio is 90%/40%, or 2.25. A test is moderately good at ruling in disease if the positive likelihood ratio is >2 and very good at ruling in disease if the positive likelihood ratio is >10, so the urine dipstick test is moderately good at ruling in the diagnosis.

Conversely, the negative likelihood ratio is the probability of a negative test result in patients with the disease divided by the probability of a negative test result in patients without the disease, or (1−sensitivity)/specificity. The negative likelihood ratio in the example above is 10%/60%, or 0.17. A test is moderately good at ruling out disease if the negative likelihood ratio is <0.5 and is very good at ruling out disease if the negative likelihood ratio is <0.1, so this test is moderately good at ruling out the diagnosis.

Likelihood ratios can be used to convert pretest to post-test probabilities using the formula:

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\text{Post-test odds of disease} = \text{pretest odds of disease} \times \text{likelihood ratio}
\]

where the odds of disease are (probability of disease)/(1−probability of disease).

Likelihood ratios can be used to describe more than two test outcomes. For example, we can calculate the likelihood ratio for both urine dipstick tests being positive, for each test being positive and the other negative, and for both tests being negative. The combination of likelihood ratios is the basis of clinical prediction rules, as described earlier in this series.9

We need to be able to recognize the potential for diagnostic test results to be wrong, particularly the probability of false positive test results in low prevalence settings and false negative test results when the pretest probability of disease is high. We also need to have better evidence about the diagnostic accuracy of tests, and particularly in the clinical setting in which they are going to be used. The publication in the Cochrane Library of systematic reviews of the accuracy of diagnostic tests will allow more of this information to be available to general practitioners.

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