An Approach to Geography of Landscape of Pain in General Medicine: From Life to Pathology

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Abstract

Chronic pain is one of the most prevalent health problems in general medicine, and patients with chronic unexplained pain are frequent. In these patients are common to find alterations at an emotional level. In addition, they can have a generalized increase in pain sensitivity. These concepts can be difficult to understand and teach. However, the GP must understand patient’s biography, as if it were the “geography of a landscape”, and the variations of its context as chapters in the history of each patient’s life - the landscape and its colors in each season. In this article, a brief fable is used as a method for intuitively understand these abstract concepts by relating them to specific situations. In consequence, the approach to chronic pain in family medicine should include: consider the diagnosis of somatoform pain disorder in patients with chronic benign pain; do not hurt; eliminate the dependence produced by drugs; focusing treatment in the functioning, not in pain; having greater empathy or communication of positive messages towards patients, which can have benefits for a range of clinical conditions, especially pain; and, an excessive biomedical closeness to a problem is dangerous for decision making; so we must try to see patients from a broad perspective, like a landscape: seeing not only pathology but experience; starting from the patient and its context, not from pathology.

Keywords

General Practice; Family Medicine; Metaphors; Communication; Framework; Teaching; Chronic Pain/Diagnosis; Chronic Pain/Therapy; Pain Management/Methods

“The pain had actually colored the landscape in a peculiar way”

Lars Gustafsson, Death of a Beekeeper

Introduction

Some fundamental concepts of general medicine are difficult to understand and explain. But it is important to know them to systematize and apply them in practice. The general practitioner (GP) usually starts by learning biochemistry, and then physiopathology, to later go to the clinical data, and finally reach the sick person. However, each of these entities must be approached with different methods for their understanding, and the methods to understand the biochemical level, for example, are not useful to understand the level of the whole person. The opposite, trying to understand the person based on their biochemical reality, that is, trying to understand a living being as a laboratory object, is the essence of reductionism [1-4].

On the other hand, the GPs show a great disagreement between the diagnostic categories considered less serious, as well as judgments that are dimensional (that is, they exist along a continuum instead of being discrete categories) versus the categorical ones. This has important
implications on the biopsychosocial model used by GPs and on pain and emotional problems. Thus, the physician usually relegates to a second position the biopsychosocial vision, the disorders that do not allow a quantitative approach, and the emotional problems, and leave as the most important the biological and quantitative.

However, the GP must understand the different positions and problems of each patient within their life cycle and contextual situation. Using this methodology the GP begins to understand the patient’s biography, as if it were the geography of a landscape, and can use the phases of the life cycle, and the variations of its context as chapters in the history of each patient’s life (the landscape and its colors in each season). This helps the GP to make connections between the data presented by the patient and the observed behaviors and feelings [5-8].

There has been a great development in understanding the experience of pain in recent years. But, this has also produced a complexity and abstraction of the subject, which can make it difficult to understand and address, since it involves aspects of physiology and biochemistry, which influence psychological processes, how people feel, and in social relationships. When pain is experienced, the whole human being may be affected. In addition, the experience of pain is an individual, personal experience that is known only to the sufferer, and that affects the body and the mind [9].

The fable is a method of adult education that is useful to intuitively understand abstract concepts by relating them to specific situations, to facilitate its teaching, its understanding, its reflection and its assimilation. In the fable there is a part that is the story, and another, finally, that is the moral, where we can see the conclusion, with the educational consequence, that is, with the systematization and conceptualization of the related topic [10-13].

In this way, a fable is presented to illustrate the concept of approaching pain in general medicine.

Short Communication: The Fable of Elk and the Spray [10]

Once, a long time ago, an Elk consulted the family doctor, again, for his ache of the antlers.

“Puffff!” snorted the family doctor as soon as he saw his name on the patients list. “Again here! What will have badly now? He was there 3 days ago!! “

Mr. Elk was a huge 400 kg animal with a relatively short and thick body, tall, broad chest, tall and firm legs, bulging and strong neck, large elongated head that narrowed toward the eyes and ended in a long muzzle in the front. Beside, he had very large, wide and webbed antlers.

“It is the pain of the antlers, Doctor..., I continue with pain...” said Mr. Elk.

“But, Mr. Elk, we have already talked about that... We already did the x-ray that was normal, you was visited by the traumatologist and he found no pathology, you went to rehabilitation and you was discharged because there were no bone alterations... What more do you want? ... “, said the family doctor in an excessively loud voice.

Mr. Elk was silent.

“... We have studied your antlers completely! Your pain is not real. You have nothing!”’, concluded the family doctor, with another exclamation, already convinced that Mr. Elk was a somatizing patient and a problem for him.

But, as he spoke, the doctor felt that something in his head told him to be careful ... He did not know why he remembered that this morning when he went to the office in his car while it was raining, he got too close to the vehicle in front of him, and the spray and dirty water came to his windshield, and for a moment he saw nothing ... That morning his head told him “watch out for the spray effect”, and now, facing Mr. Elk, something told him “be careful, do not get so close that you can not see the situation well ...”

And the family doctor mused: “Why I self-convinced myself that he is a somatizing patient, and his pain has no organic basis. The patient has probably felt de-legitimized. I have to do better: I will avoid the rush to label. Although we have little time and it is inevitable to go fast, it is not a good method of work, because actions little planned give rise to more mistakes. To make good decisions it is important to devote sufficient time to thinking about the problem. And I should avoid excessive biomedical closeness... that blinds us or puts us at risk in case of abrupt braking, as it happened to me this morning with the dirty water sprayed in my windshield. Actually, what I know about Mr. Elk?”

So the family doctor asked Mr. Elk:
“... Well... I live in thick, lonely woods, with marshes... I spend the summer in the humid and low plains and in winter I move to higher places... To rest I simply lie on the muddy ground or on the snow, in the thickest area of the forests... I live with my flock, composed of males and females not yet suitable for reproduction, as the females that have given birth... Actually... I think I am an un sociable animal and not very peaceful, and it is true that I have a history of quarrels with my companions... but when I was younger...”

“And what do you think about that pain... tell me what you was happening...?” asked the family doctor.

“... Doctors tell me that my webbed antlers pains do not give any alterations in the tests and tell me, like you before, that my pain may not be ‘real’. When you say that I have nothing, my symptoms increase, I do not know if whether consciously or unconsciously. Some doctors tell me it’s to draw attention to the seriousness of my complaints... but the truth is that those pains make me suffer”, explained Mr. Elk.

“So, they send me to multiple specialists, they prescribe me narcotic painkillers or benzodiazepines but that say then that I should not take, fill me with many medications, I have a lot of appointments for tests, and even one of these medical specialists wanted to operate me ... And then Doctors say no I take the medicine, and I am difficult, that I am every day in the consultation, and that I do nothing more than protest ... But my pains and the treatments fill my life, and there are other problems: my flock can get separated, I can not work, there may be different social pressures from the community, etc.”, specified Mr. Elk.

The doctor thought: “The 'panoramic view' allows the individual to gain a better understanding of what he is looking at. From a single perspective there are always parts of an object that are hidden or are obscure: the vision of a forest or the mind of a person need panoramic views to know them better and avoid distortions and illusions inherent in a single perspective. Having this panoramic view allows us to understand how people can interpret the same event differently. That is, if that person, group, family, community, can be fully understood, everything finds its right place and can be perceived”.

Discussion

Pain can be broadly divided into 3 classes, including nociceptive or inflammatory pain (protective), neuropathic (pathological, occurring after damage to the nervous system), or centralized (pathological, due to abnormal function but with no damage or inflammation to the nervous system). Patients with chronic unexplained or chronic / recurrent pain without a clear organic base have been reported and commented for many years, although the terms used to describe these sets of symptoms have changed frequently in the literature, including that of “functional somatic syndromes”, or “symptoms for which no organic cause is found”. Although these conditions are often characterized by symptoms such as pain, they are usually complex conditions with a multiplicity of symptoms [14].

Chronic pain is one of the most prevalent health problems in general medicine, especially among patients older than 65 years. Pain is associated with a moderate or severe degree of disability due to reduced mobility, limitations of activities, frequency or risk of falls, depression and anxiety, deterioration of sleep and social isolation. Its negative effects go beyond the patient, reaching their family, work and community context, in a way that disrupts family and social relationships. In addition, chronic pain is a recurrent reason for medical visits and a significant economic cost to the health system and society as a whole. Even, it is foreseeable that chronic pain prevalence rates increase as populations continue to age: By 2035 it is estimated that a quarter of the population of the European Union will be 65 or older, which will increase the impact of pain on the public health [15].

It is common to find alterations at an emotional level in patients with chronic pain. In many cases, the symptoms are of sufficient importance to classify them within the manual of classification of mental disorders DSM-IV as a psychiatric disease. Numerous studies have documented a strong association between chronic pain and psychopathology. The presence of a psychiatric disorder can increase the intensity and perception of pain. Chronic pain is associated with the presence of depressive episodes, anxiety disorders, somatoform disorders, personality disorders and substance abuse. Chronic pain is a factor that influences the production of psychopathology. Reciprocally, psychopathology intensifies painful perception. However, the majority of patients with chronic pain (such as chronic low back pain, etc.) do not meet the criteria for depressive disorder or anxiety. The
most frequent psychiatric disorder in these patients is the adaptive disorder [16]. It has been reported that near 80% of patients with anxiety and depression feel some physical pain. Pain is a frequent symptom that affects the performance of patients with clinical depression and may persist for a prolonged period. Both the severity of the pain and the performance impairment caused by it are systematically associated with the level of non-painful somatic symptoms. Therefore, there are a close relationship between both types of symptoms that should be considered when rethinking the criteria for the diagnosis of depression/anxiety and pain. Painful symptoms can mask the diagnosis of depression/anxiety, and symptoms of depression/anxiety can mask the diagnosis of pain, especially in the field of general medicine; that is, the symptoms of pain are an equivalent of anxiety or depression [17].

In patients with pain disorders, emotions modulate the perception of discomfort and pain. In turn, the pain is especially intense in the presence of pain-related stimuli. The psychological characteristics of patients with somatizing patients and a large group of patients with pain in which there is an organic base of a type that does not seem to be able to justify the intensity and duration of pain symptoms, as in patients with dervicalgia, lumbo -ciatica, epicondylitis, syndrome of the carpal tunnel, painful shoulder, gonalgia, coxalgia, headaches, abdominal pains, etc., are related to the perception of pain. Patients with somatoform pain disorder have a generalized increase in pain sensitivity, which may cause a condition [18].

In consequence of all the above, the approach to chronic pain in family medicine should include:
1. Consider the diagnosis of somatoform pain disorder in patients with chronic benign pain. There are usually multiple sites of pain, irradiation or extension of pain from the initial site, and lack of response to treatments. The presence of medication dependence is a strong indicator of pain disorder. These patients usually interpret common findings, such as the presence of a disc protusion, as indicators of serious pathology. They tend not to remain calm when there are negative results from diagnostic studies, and they seem to be more satisfied with positive results.

2. Do not hurt. Surgical procedures do not cure somatoform pain disorders. The lack of response to conservative treatments is not an indication of surgery in these patients.

In fact, the repetition of diagnostic procedures and surgery, supports their idea of invalidating chronic disease, and encourages the patient to adopt a permanent role as sick and invalid.

3. Eliminate the dependence produced by drugs. This includes the detoxification of narcotics and benzodiazepines. In any case you may need pain medication.

4. Focusing treatment in the functioning, not in pain. Show the patient that the tests are negative, or that their symptoms are not explained by their pathophysiology, does not cause the patient to stop presenting them. For one reason or another, the patient seems to need pain. On the other hand, the functioning can vary a lot from one patient to another, and favoring their activity, work, social and family activities can be useful. Including the couple in the treatment sessions can be especially useful in this aspect [19-21].

Conclusion
In the film “Lawrence of Arabia” there is a scene in which T.E. Lawrence holds his hand over the flame of a candle until the flesh begins to burn. When his partner tries to do the same, he retreats in pain, and screams. “Does not it hurt?” While caressing the burned hand. “Yes,” Lawrence responds coldly. “Where is the trick?” Asks the other. “The trick,” says Lawrence, “is to not give importance.”

One of the great enigmas of biology is why the experience of pain is so subjective. Being able to withstand pain depends, to a considerable extent, on culture and tradition. Most people who go to a hospital for surgery focus completely on the pain and suffering they experience, while the soldiers, in war, with horrible wounds, or the saints or other martyrs can think of something nobler and more important for them, and that can modify their perception of pain. Frequently, our fear of pain contributes to it appearing. Our culture expects birth to be a deeply painful event, and then it is. Women from other cultures interrupt their work in the fields to give birth, and return immediately to work afterwards. What we call “happiness” can only be the absence of pain. But it is difficult to define pain, which can be acute, dull, explosive, intermittent, imaginary or referred. We have many pains that arise from within, such as headaches or cramps. And we also call pain to emotional misery. The pains usually combine, the emotional with the physical, and the physical with another physical.
The continuous use of any analgesic can neutralize its beneficial effect, but twenty minutes of aerobic exercise are enough to stimulate the body to produce more endorphins, than natural analgesics. Shifting attention to something else will distract us from the pain. Pain requires full attention. Relaxation techniques, hypnosis, acupuncture and placebos can induce the body to produce endorphins and prevent the pain message from being sent. Pain it is an emotional, psychological and physical affliction. So, we must not forget that greater empathy or communication of positive messages towards patients, from GP, can have small patient benefits for a range of clinical conditions, especially pain.

In short, excessive biomedical closeness to a problem is dangerous for decision making; in fact it is one of the most common mistakes. We must try to see patients from a broad perspective: seeing not only pathology but experience. Consequently, the initial approach to pain in general medicine is how to achieve a broad vision of the geography of the pain landscape starting from the patient and its context, not from pathology. The pain had actually colored the landscape in a peculiar way; the GP works from the particular to general: from the patient’s life to pathology.

References


