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EDITORIAL

Clinical listening of painful patients and its importance in the daily life of pysicians

A escuta clinica do paciente com dor e sua importância no cotidiano do médico

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Pain and pleasure pathways might entwine all the time, even when they are lost in tone, quantity or quality, even knowing that for a healthy life the ideal would be pleasure. Pain imposes limits, cutoff points, signaling that not everything is possible. This is also the role of the adult monitoring the child in the attempt to prevent disagreeable events and memories. Otherwise, if some stimulus has induced pain, the body understands that this is not good. For such, there is a memory, a record that such trauma should be promptly identified. The more severe the trauma, the larger is the record[1].

Some authors have observed that animals exposed to repeated painful stimuli in the neonatal period present, in adulthood, stronger anxiety and defensive behavior, associated to increased painful transmission. Neonates' circumcision without anesthesia is associated to increased response (weeping duration and facial mimic change) to needle prick during vaccination between four and six months after circumcision as compared to non-circumcised infants[2]. These results suggest that, although early painful records are not accessible to conscious memory, they may be coded in the memory and lead to abnormal behavioral patterns and changed sensory processing in future life, possible throughout the life of the individual[3-5].

In addition, other authors correlated diffuse chronic pain in the adult with previous history of hospitalization by traffic accident in childhood, loss of the mother, living in public institutions and financial difficulties. This was regardless of social class or the presence of psychiatric comorbidity. Risk, for these subjects has increased 1, 2 and 5 times, showing that psychic trauma is also a predictive factor for physical pain[6].

Acute pain means learning not to repeat it, to survive, and has beginning and end related to injured tissue healing. But in chronic pain, considered a non-adaptive phenomenon, what is seen are excessive stimuli mobilizing different sites of central and peripheral nervous system with neuronal hyperexcitability. Maybe when these mnemonic records are translated into a different language such as that of allodynia (non-aggressive stimulus causing pain) or of hyperalgesia (aggressive stimulus generating response intensity beyond what was expected), pain and chronicity pathways are installed[1].

So, based on the idea that all traumatic stimuli generate a mnemonic record, our first traumatic experiences related to losses, separation, frustration and physical aggression might be the basis for a complex tangle of neurons to show cause and effect inter-relations. So, for every pain there is a physiological and emotional component of neuronal excitation or excessive load. Pain is registered in the unconsciousness and may be transfigured in a different feeling[7]. It is common the high prevalence of psychiatric disorders, such as anxiety or depression, in chronic pain patients[8]. It is possible to theorize, in a simplistic way, that the emotional body presents with positive (excess) or negative (lack) symptoms.

Anxiety (positive symptom) with fear of the future, and depression (negative symptom) with the expression of anguish and incapacity to deal with some issues. On the other hand, neurons, in the course of peripheral neuropathy, for example, may present negative (analgesia) or positive (allodynia, hyperalgesia) sensory signals or, in a frightening way, in chronic pain pathway, may choose, from a behavioral point of view, their own death. Because, how to direct excessive excitability if not planning its own end (cell apoptosis)? There are reports that fibromyalgia, chronic low back pain and tension headache patients lose cortical neurons[9]: - would this be a body defense? Would it be better to lose cognitive and evaluative capacity? Would it be necessary to suffer in the melancholic immobility? Would this be counterpoint to the principle of pleasure? Would this be the place of impossible knowledge?

So, we are faced to a history full of mysteries, connections and expressions of symptoms which are different from the reality causing them, from mental representation (symbolic) and from unconscious repressions, so present in Nelson Rodrigues' stories[10]. Imagine a typical 21st Century patient, now implanting teeth and developing post-trauma chronic pain (post-traumatic neuralgia), remembering that diagnosis is clinical and there are no additional exams to identify this disease. This is a typical painful emotion; it is the development of a different image, not only linked to surgical circumstances. His so desired and immortal teeth now would be reason for suffering. And his possible old pains may reappear in a different way, in another place and another affection[7].

This is the major challenge of the clinician: to deal with what is beyond names, with things that leave the nervous injury sphere and its symbolic representation. Maybe there is excessive affective investment in the image of the injured body region (mouth) or in the image of the lost object (teeth). So, there will be intersection between body pain (nervous injury) and psychic pain. So, it is possible to say that symbolic body representation of the mouth is integrated to an already built fantasy of unconscious desires and records which will never correspond to reality[7]. This is probably why pain has not clear metrics and presents a descriptive and always very subjective character.

The fact is that, thinking initially in pain neurobiology, neurons, neurotransmitters, receptors and synapses, also means understanding that people are connected by their own history and social relations. Let's talk, then, about soul allodynia and hyperalgesia, about impressions rich in meanings, about small stimuli which lead us to panic or isolation, or about the absolute conviction of irreparable pain. It is common to receive patients with musculoskeletal pain or autoimmune diseases after losing beloved ones, separation or loss of social position.

Another way to persist in pain is to destitute the physician from his qualification, position and image, creating an offensive speech, based on research about the disease in the internet or previous consultations. Patients do not adequately listen to orientations and fantasize that procedures or drugs worsen their pain, when in fact there are no evidences for such.

This structure reflects the self-organizational structure of psychomotor development produced by the interaction between neurobiological events, sensory-motor, neurovegetative, immune and load connections which are beyond individual's control. Painful body presents to the physician like this, full of unending mysteries. This way, it is up to the physician to resist to the process of sickening the individual, based on his behavior, or to monitor or neglect the subject due to his deviations, but rather try to provide a care and safety environment regardless of moral[11]. Taking the patient to psychotherapy is also a task requiring ability.

The discussion around treatment adherence in pain clinics to prevent chronic pain patients of circulating in search of solution for their pain, preventing iatrogenia and inadequate concepts, is raising complex and multiprofessional discussions. In addition to the possibility of drugs or interventions, it is necessary to emphasize that psychic body balance is ruptured. In chronic pain, there might be increased dopamine concentration in the central nervous system extracellular space (orbitofrontal cortex, nucleus accumbens, amygdala and pallidum ventral) with decreased effect of this substance in specific receptors, as well as loss of immediate release (peak), extremely necessary for rewarding-related tasks[12]. There is also decreased efficacy of spinal cord opioid system, with decreased β-endorphins in the brain and spinal cord and consequent decrease of morphine analgesic effect, both by systemic and spinal routes[13].

It is possible to infer that mental system work is directed to the sense of maintaining the amount of excitation low, so that anything calculated to increase this pattern is destined to be felt as adverse to the adequate functioning. The interesting is that any repressed or replaced instinct, or the effort to get pleasure, may become an unpleasant experience, especially if crossed by the principle of reality. It is observed that tolerance to repetition of what is unpleasant is sustained in the hope of a progressive decrease of the unpleasant[14,15].

I close this report stating how necessary it is to unveil numerous theoretical paradigms involving chronic pain patients, making clear that the most important, in any clinical hearing, is the subject.

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