Editorial Comment: Primary Care and Psychosocial Issues in Pain

June 01, 2007
By AIDS Reader [1]

On a daily basis, both patients and providers are confronted with the complicated problem of pain. Unfortunately, pain is prevalent among persons infected with HIV-1 and is undertreated.2 Metaphorically, pain can be likened to sound. At the same decibel level, different persons will perceive the same level of sound as pleasant or unpleasant. At either end of the spectrum (ie, no sound and extreme noise), all who are not hearing-impaired will agree on how the sound is perceived. Likewise, in pain, at the extremes (no pain and excruciating pain), everyone will agree on how the level of pain is perceived. Like sound, what complicates our assessment of pain is that pain typically falls in the middle range, where many different variables affect both the physiology of the pain and the psychosocial perception of that pain.

It is the multifactorial nature of pain and the perception of pain which make it difficult for clinicians to ascertain the etiology so as to prescribe appropriate therapy. Take, for example, an HIV-infected person who has underlying anxiety with depression and is injecting opioids. If this person were to present with chronic back pain, the cause could be one of any number of things or a combination of everything all at once. A few possible causes of this person’s back pain could include an infection (eg, osteomyelitis), musculoskeletal injury (eg, trauma), or symptoms of opioid withdrawal, or it could be related to anxiety or depression or both. Each source of pain would result in different treatment.

Typically, clinicians reach for the diagnoses with which they are most familiar and therefore often begin by ruling out an infection or ascribing the pain to injury. However, Douaihy and colleagues3 have challenged clinicians to properly equip themselves to consider, evaluate, and respond to the psychosocial issues of HIV/AIDS-related pain. This is of particular importance because HIV primary care clinicians need to understand how psychosocial issues, such as anxiety/depression and chemical dependency, may change an HIV-infected person’s perception of painful stimuli. Understanding this will allow clinicians to respond proactively in their treatment of pain and will help them to consider psychosocial issues as either the primary etiology of pain or, more commonly, a complicating factor that will need to be addressed for treatment to succeed. Simply put, clinicians must learn to assess the psychosocial stressors that may exacerbate or mask pain and be prepared to begin treatment when identified.4

Douaihy and colleagues rightly advocate for a multidisciplinary, comprehensive approach to the evaluation and treatment of this multifactorial problem. This broad approach is of particular importance in clinical areas where there is a high prevalence of chemical dependency. Although the article by Douaihy and colleagues is on pain assessment, the authors do briefly address some of the principles of treatment in this population, focusing on the psychosocial issues. For additional information on treatment, the reader is referred to a recent review of the medical management of pain in HIV-infected patients with drug dependence.5 With complaints of pain being so prevalent in HIV clinical settings, providers will need to equip themselves for the appropriate evaluation of pain itself and the psychosocial issues that may underlie it.

The author would like to thank the National Institute on Drug Abuse (RDB– K23 DA 022143) for
funding this work.

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No potential conflict of interest relevant to this commentary was reported by Dr Bruce.

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