OPINION ARTICLE

Angiographic and Psychic Calcification of the Heart

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Two anatomies exist: the real and the psychic.
The science of the hour, medicine, accounts for the former; and the latter
is what is developed in the inner perception of the subject.

J.D. Nasio

I open the present opinion article with the story of a clinical case: 74 years old patient who was referred for the performance of a cinecoronariography, with a history of tobacco use and acute myocardial infarction 14 years ago. Reason for consultation: Grade II dypnea of evolution in the last months. The cinecoronariography was performed showing proximal occlusion of the Anterior Descendent Artery without collateral circulation and small size moderate to severe lesion in a postero-ventricular branch of the circumflex artery. No lesions were observed in the right coronary artery. The ventriculogram showed an extensively calcified anteroapical akinetic area and good motility in the remaining segments.

So far, just another case of coronary disease, with an extensive previous calcified sequelae, that we still see in patients with infarctions at the time where acute reperfusion was not as developed as today. During the 10 minutes of the study I had a conversation with the patient, of which I transcribe the most significant parts:

CS: What do you do for a living?

P: I am an accountant, but I have finished my Counseling career and I take care of patients with several problems.

CS: Would you relate your infarction 14 years ago with any event in your life?

P: One year before my wife died of colon cancer, and it caused me a deep depression.

CS: Have you reestablished your affective life?

P: No Dr., I have only casual relationships. It is as if my heart had been locked, masked.

Imagine what ran through me while I was listening to this patient and at the same time I was watching on the television screen the calcified, masked image of his heart.

The associations between depression and cardiovascular disease are multiple and I do not intend to discuss them in this work. (1, 2)

I will develop the concept of transference, its presence in the activity of interventional cardiology and its use as a therapeutic tool. The concept of transference is very wide and it does not belong exclusively to the psychoanalytic vocabulary.

According to the Dictionary of Psychoanalysis by Laplanche and Pontalis, transference is the process by which unconscious desires are updated on certain objects, within a certain type of established relation with them and, particularly, within the analytical relation. (3)

According to J.D. Nasio, the term has three meanings: first, that transference is the relation with the therapist; the second meaning, more vague, general, spontaneous, says that transference is formed by the affection and the allusive words, lived or not, in regards to the therapist; a third connotation, vague, refers to transference as the repetition in the present, with the therapist, of the lived sexual experiences of the past. (4)

Is there transference during the performance of a cinecoronariography? If yes, is it anecdotic or could it be instrumental?

In my opinion, *yes* there is transference during a diagnostic and/or therapeutic study performed by interventional cardiologists.

There is a short, but intense relation of the patient with the physician, the operator.

There is transference in this relation because there are many *affections and allusive words* that the patient and the interventional cardiologist exchange.

The patient, literally, exposes his heart for us to tell if he or she will have to undergo the experience of a major event in his/her life, an angioplasty or surgery, with the enormous impact that this has in his/her emotional life and relationships: social, familiar, working, etc.

We, physicians, not only must be alert to all the devices to ensure the success of our task, but with our words and actions, we become actors in critical

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situations of the life and sometimes of the death of the patients.

We can live this with increased or decreased intensity, more or less registry, but *yes*, in my opinion there is always transference, and a particular, acute, massive and extremely useful transference if we know how to capture it. In addition, the intensity or the type of registry of the patient's words will depend in turn on the set of the unconscious reactions of the physician in front of the patient and, specifically, in front of the patient's transference (counter-transference).

As I am explaining in this case, and as you will be able to see tomorrow, should you wish to do so, transference begins with questions, direct, short, intense, about the activity, the family, the civil status, the social or economic situation, etc.

The important thing is not the question; it is the *listening* which defines the transference bond.

If we exchange analyst by interventional cardiologist, and we are transported to the situation of our daily work, we can connect concepts.

For that reason, listening kindly, with interest in the patient, allows to pose new questions and a new listening, and to transform the moment of a diagnostic and/or therapeutic procedure into an excellent transference event extremely useful to the patient.

Why can this transference be instrumental?

This patient, clearly had calcified, covered his heart with an armor, in the anatomical, radiological and emotional sense.

The emotional deposit and anchorage in the body of different states and moments have been studied extensively by psychosomatic medicine, psychiatry, psychoanalysis, etc. (1)

This transference can be instrumental because it allows us to register the symptom (reason for the patient's consultation) in the history of the patient.

"Because somebody listens and wants to discover the enigma of the malaises of my body, these malaises will have a meaning in my history. Perhaps thus they will be able to disappear sometime".

We know that the coronary disease is chronic with different acute episodes.

Our intervention is a temporary participation in that history. There is a before and there is an after. The concept is that the symptom should be "an earth wire". (5)

We should take it and transmit it to the patient, not as a painful fact, but as an opportunity to review his past and modify it, to delay or slow down the progression of the disease.

Interventional cardiologists have an opportunity to start up this prevention mechanism.

We can step out of the dualism; it is not body on the one hand and soul or psyche on the other, the reason for the consultation is the whole.

To recognize and/or to generate "transference" during the doctor-patient meeting is utterly useful for the patients and also for the interventional cardiologist.

The multiple interrelations between the psychosocial factors and the ischemic heart disease, and cardiology in general lead us to believe that in the near future we will probably be attending the emergency in psycho-cardiology.

One first step in that direction is that cardiologists learn the meaning of habitual terminology in psychological-psychoanalytic language.

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