

Australian Association of Musculoskeletal Medicine

Fibromyalgia – enigma or epidemic?

The term “fibromyalgia” has come into common usage to describe chronic soft tissue pain experienced by some patients. It has been called the commonest cause of widespread musculoskeletal pain.

What is fibromyalgia?

Pathology: not identified

No distinctive tissue pathology, pathophysiology or psychopathology has been found for fibromyalgia and there is no defining blood or imaging test. Extensive muscle studies have shown changes only of disuse.¹

It has been postulated that fibromyalgia is due to sensitisation in the dorsal horn of the spinal cord. However, this is an untested hypothesis arising from clinical observation and psychophysical studies, informed by current pain theory.²

We are left with a no-pathology model for a pain syndrome. This is not really acceptable but we are in good company with other common disorders such as classic migraine, tension headache and irritable bowel syndrome.

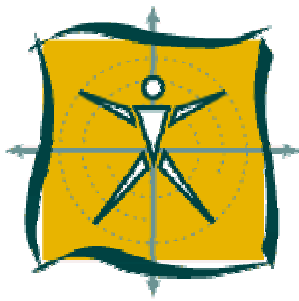
Diagnosis:

Since there is no identifiable pathology, one would expect a unique set of symptoms and signs for diagnosis.

The American College of Rheumatology (ACR) initial criterion for fibromyalgia was widespread pain of at least 3 months duration and tenderness at any of 11 of 18 defined musculoskeletal sites (tender points).³ When this criterion was tested for reliability, investigators obtained a kappa score of only 0.7;³ this means independent observers could agree about which patients have fibromyalgia 70% of the time. Further, the false positive rate for the tender point criterion was 20%, that is, 20% of those with 11 or more tender points were considered not to have fibromyalgia. These figures illustrate the difficulty in grouping these patients into a homogenous group and thus having a reliable diagnosis.

To allow for regional fibromyalgia, the ACR relaxed on the number of tender points required for diagnosis.⁴ If the 11 point-requirement isn't met, the diagnosis of fibromyalgia can still be made in the presence of associated symptoms, such as non-restorative sleep, mood disturbance, headache, fatigue, and irritable bowel.

While this construct is broad, most doctors can probably relate to the type of patient thus described, albeit imperfectly.



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Differential Diagnosis

Many other conditions can cause widespread pain, fatigue and general unwellness. The primary practitioner needs to exclude:

- metabolic disorders
- endocrine disorders
- occult cancer
- viral and other infections
- inflammatory joint and muscle disease
- early neurodegenerative disease

Investigations will depend on the nature of the presenting complaints but useful tests include; FBS & diff., ESR, TSH, E & LFT's, Rh factor, ANA & CK.

How common is it?

American community surveys indicate a prevalence of 3%-5% for fibromyalgia as per the American College of Rheumatology (ACR) classification criteria. The female to male ratio is 6:1.⁵

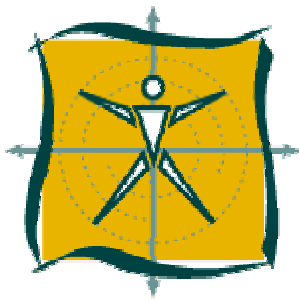
Although Australian prevalence is unknown, a recent survey by Sydney researchers found that 20% of women and 15% of men suffer chronic pain.⁶

Is treatment effective?

The key to managing ill-defined syndromes, including fibromyalgia, and chronic fatigue, seems to lie in taking a biopsychosocial approach. This is best done in primary care. General practitioners are ideally placed to manage fibromyalgia as they generally are well versed in the nature of the patient's psychosocial milieu eg family and social supports, personality type, cultural background etc.

Just giving the patient a diagnosis is somewhat healing in itself. It results in decreased utilisation of health services as it retrieves them from the "wheel of misfortune"(repeated investigation and referral that reinforces the sick role). Cognitive-behavioural techniques are very useful. Improved coping strategies and less anxiety are the ensuing outcome.

Also, graded exercise, sleep normalisation with tricyclics and a focus on self-management have all been shown to improve symptoms.⁷ Education is vital for fibromyalgia sufferers. Reinforcement of the generally favourable prognosis is important for the patient. Simple cheap and safe techniques to achieve this goal can then be elucidated, such as:



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- gentle exercise (this can include hydrotherapy, tai chi, yoga)
- good sleep hygiene
- pacing activities; regular short breaks
- sensible nutrition; many diets are on offer for fibromyalgics. If patients are going to make dietary change, here is a chance for the GP to ensure they are sensible changes.
- addressing soft tissue imbalances; stretches, needling techniques and stability exercises can all be useful. A musculoskeletal physician, physiotherapist or personal trainer may all be useful.
- cerebral care; this is an opportune time for patients to reassess matters such as spirituality, relationship and sexual issues and long-term goals. Patients can use fibromyalgia to refocus on the big issues in life.

Vulnerability

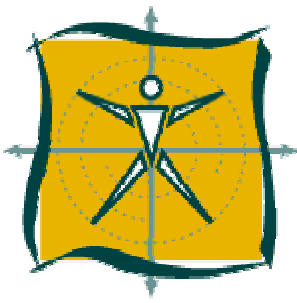
Another key component in managing these patients is the need to be cognisant of their vulnerability. They are perfect prey for the supplement-pushing, multilevel marketing pariah who targets such vulnerable people.

Recognising the need for hope is also paramount and telling these patients there is nothing to offer them is counterproductive. Gently guiding them through the maze of alternatives is crucial while making sure they are paying attention to the simple but effective management goals listed above.

Finally, it is vital not to become complacent about patients' complaints. Keep vigilant for any change in symptoms. As it is not uncommon for patients with fibromyalgia to be harbouring undeclared rheumatic or endocrine abnormalities. A recent UK study suggests that people with widespread pain have an increased risk of cancer.⁸ Follow-up of these patients is paramount.

What of the future?

Meaningful research into fibromyalgia will be problematic when the only evidence for the presence of disease is subjective. Compensation cases have already proved a minefield with decisions often appearing arbitrary. The limitations in this diagnosis have to be acknowledged before we can move forward. Further research into spinal cord sensitisation may deliver better ways of documenting and treating this illness.



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References

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