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What is Fibromyalgia Syndrome?

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Fibromyalgia Syndrome (FMS) is a syndrome characterized by chronic, generalized, musculoskeletal pain. While there is controversy in the medical community surrounding diagnosis and treatment of FMS it is very debilitating to the persons who suffer from it. In the following short article I will attempt to give an overview of the epidemiology, clinical findings and treatment options of this chronic pain syndrome. Hopefully, this will be helpful to my healthcare colleagues confronted with the challenge of the FMS patient.

In terms of Epidemiology, FMS is primarily seen in middle-aged women, but the age range is broad and includes those from 20 - 60 years old. It appears to be fairly gender specific in that women make up as much as 73% to 90% of patients diagnosed with FMS. In the general population, widespread pain is considered to affect 7.3% to 12.9%. FMS by comparison is considered to be 0.5% to 5%.

There is an association of FMS with other conditions, such as rheumatologic disorders, certain systemic illness, and a broad spectrum of syndromes involving chronic fatigue known as Chronic Fatigue Syndrome (CFS) or Chronic Fatigue Immune Dysfunction Syndrome (CFIDS). Patients with certain rheumatologic conditions such as Systemic Lupus Erythematosus (SLE) present symptoms that also meet the FMS criteria. In fact, up to 65% of patients with SLE may meet the FMS diagnostic criteria.

In addition there is a family of conditions known as Functional Somatic Syndromes and some or all of these may also be present in the FMS patient. Included are Irritable Bowel Syndrome (IBS), Temporomandibular Joint Disorder (TMJ), and various subsets of chronic low back pain and/or chronic headache. The American College of Rheumatology has formulated the following diagnostic criteria to help clinicians in defining and diagnosing FMS:

1. Diffuse and generalized pain with aches, stiffness and generalized fatigue.
2. Tender points in specific areas that are palpated with application of approximately 4kg of pressure (done properly with a dolorimeter).
3. Pain in at least 11 of 18 tender point sights upon digital palpation presenting on both the left and right side of the body, above and below the waist with the lower back being considered as below the waist.
4. Areas where multiple tender points may be present include:
    - Occiput

- Low cervical area
- Trapezius muscle
- Supraspinatus muscle
- Second rib
- Lateral epicondyle
- Gluteal muscle
- Greater trochanter
- Knee

The Treatment for FMS demands a multi-focal approach. Start simply by eliminating contributing factors such as underlying vitamin deficiencies and stress the importance of a well balanced diet. Approach and correct any biomechanical problems that may be contributing to pain such as anatomic leg length discrepancies and/or poor body posture. The assistance of a physical and/or occupational therapist may help in addressing any motor dysfunction with the overall goal of decreasing pain, restoring functional range of motion, improving cardiovascular and aerobic fitness and restoring normal neuro-muscular conditioning. Tender points may be treated locally with cold spray and the use of a Transcutaneous Electrical Nerve Stimulation (TENS) unit. Many tender points, upon examination, are actually trigger points in the muscles which can cause referred pain to other parts of the body. Treatment of trigger points may include injection with a dry needle alone, with saline, with a local anesthetic or a combination of anesthetic and a corticosteroid.

When considering medications for treatment of pain associated with Fibromyalgia the only FDA approved medication is Lyrica (pregabalin). However, Cymbalta (duloxetine) is in the process of receiving FDA approval and several new drugs are in development for FMS pain. The daily treatment dose of Lyrica is 300mg/day in divided doses. When I prescribe Lyrica, I usually start at 50mg at bedtime for two to four weeks. If toleration is achieved at that dose with manageable side-effects (i.e. somnolence, visual changes, dizziness) I will increase to 50mg three times a day for two to four weeks. Then I titrate up to 75mg three times a day again assuming no symptoms. Finally I will increase to 100mg three times a day, which is the suggested daily therapeutic dosage (300mg/day) for the treatment of pain associated with FMS.

There are situations where a narcotic opioid medication may be necessary in the treatment of FMS pain. When considering use of an opioid narcotic therapy always try to choose medications that allow for a pattern of decreased dosage. A controlled release opioid narcotic should be used whenever possible for long term pain control and an immediate release opioid for break-through pain. Also there are other drugs, such as Ultram (tramadol), which is a weak opioid agonist, and some NSAID's like Celebrex (celecoxib) that have excellent analgesic properties. These medications can be tried before using narcotic opioid medications. However if a patient presents to you and has been on narcotic opioid medications for an extended period try to wean them from the immediate release narcotics (Lortab, Vicodin, Percocet) and replace with a small dose of long acting opioid medication which can be titrated up as necessary as long as side effects are minimal. Then if the patient requires something for break-through pain try

Ultram and/or an NSAID like Celebrex in place of an immediate release opioid. You are more likely to encounter difficulties with misuse and abuse with the immediate release opioids more-so than any other class of medications. Therefore the immediate release opioids should be substituted for and/or used as infrequently as possible. Other medications such a Neurontin (gabapentin), which is an anticonvulsant and Tricyclic Antidepressants (TCA's) can be used effectively for the neuropathic symptoms that many FMS patients have in their extremities such as aesthesia, dysesthesias, allodynia, and parathesias. The TCA's can also be helpful because several of them have a sedative effect, which can be beneficial in treating sleep disturbances. TCA's may also be effective with underlying psychiatric disorders, such as depression, which is also common in the FMS patient. However, due to potential side effects such as cardiotoxiticity, you may want to consider other agents for use in helping with the sleep disturbances such as Ambien (zolpidem tartrate) or Lunesta (eszopiclone). For the comorbid psychiatric disorders you should consider Paxil (paroxetine) Lexapro (escitalopram), or Prozac (fluoxetine).

Despite the controversy surrounding the FMS diagnosis for the patient suffering with FMS the pain is very real. We must use every tool at our disposal to provide pain relief and help them return to their optimum level of function.

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