Fibromyalgia: Open Access

Alegre and Trallero, Fibrom open 2015, 1:1

Editorial Open Access

Does "Multiple Labeling" Benefit or Harm in Fibromyalgia Patients?

Trallero E[1] **and Alegre C**[1,2 *]

[1]*Hospital Universitario Valle Hebron, Spain*

[2]*Hospital Universitario Dexeus, Barcelona, Spain*

[*]**Corresponding author:** Cayetano Alegre, Hospital Universitario Valle Hebron, Spain, Tel: 932 27 47 47, E-mail: 11120cam@comb.cat

Received date: September 15, 2015; **Accepted date**: September 17, 2015; **Published date**: September 24, 2015

Editorial

A systematic review showed that there is no evidence an accurate diagnosis of fibromyalgia per se could worsen prognosis in patients with this condition [1]. Indeed, it could be useful to reduce healthcare utilization by patients. Nevertheless, social and individual long-term benefits of fibromyalgia diagnosis are not clear as this condition can even eventually become a dramatic stigma for patients [2].

The term fibromyalgia helps clinicians to gather a subset of patients suffering from a syndrome with multiple and similar symptoms but without a clear etiology. Thus, under this concept, patients are grouped by a final similar phenotype that could be the end stage of multiple and different processes.

Interaction of several factors such as endocrinal disturbances, abnormalities in central monoaminergic transmission, dysfunction of small nerve fibers or neurovascular and psychological disorders have been involved in the development of fibromyalgia symptoms [3-6].

Patients with fibromyalgia usually experience other complaints such as irritable bowel syndrome, fatigue, depression, anxiety disorders or restless legs syndrome, among others, which are assumed as a constitutive part of this disorder.

Is it useful to add the label chronic fatigue syndrome to a patient with fibromyalgia?

According to Fukuda criteria the diagnosis of chronic fatigue syndrome requires the absence of other processes that can cause fatigue [7]. Under this assumption, the concomitant diagnosis of fibromyalgia and chronic fatigue in a sole patient appears to be incompatible.

Moreover, neither do clinicians seem to take any benefit from this double diagnosis, as both disorders have a similar clinical profile and share a similar prognosis and an analogous therapeutic symptomatic approach.

This reasoning can be extended to other central sensitivity syndromes such as multiple chemical sensitivity syndrome or electromagnetic hypersensitivity, diagnoses that are very often added to patients suffering from fibromyalgia.

If we want to maintain the benefit of classifying patients under certain clinical categories, we should try not to over-use them in our patients. Otherwise we will contribute to create undefined and very heterogenic groups of patients that would not help clinicians in management decision making. Moreover, it will also complicate the study of the underlying causes and mechanisms of chronic pain in fibromyalgia patients (Table 1).

Similarly, to group together all these syndromes under a unique label of central sensitivity syndromes will have similar consequences and will not help to clarify all these disorders.

Perhaps the only benefit to the patient could be economic or legal. The courts are more inclined to accept the disability if the patient has multiple diagnoses, regardless of the prognosis of each.

We suggest that each patient with a central sensitivity syndrome should only receive a sole label corresponding to the main disorder that dominates their clinical profile. Hence, in a patient with fibromyalgia with fatigue and chemical hypersensitivity in whom pain is the main complaint, we recommend considering fibromyalgia as their sole diagnosis. The addition of other diagnoses will not benefit the patient at all and can even increase the patient's feeling of malaise.

The diagnosis of fibromyalgia in patients with rheumatic or systemic autoimmune diseases with a decreased pain threshold or other general symptoms, such as fatigue or sleep disorders, has been supported as a useful tool to avoid unnecessary prescriptions of painkilling drugs. Nevertheless, the new fibromyalgia criteria published in 2010 also recommended [8], similarly to Fukuda criteria for chronic fatigue syndrome, to exclude from this condition patients suffering from other diseases that can intrinsically cause pain and fatigue, as do rheumatic diseases. We agree in considering these symptoms within the clinical profile of the rheumatic or autoimmune underlying disease itself and not as an independent condition. That does not mean that clinicians should not be aware of possible disturbances in pain tolerance in those patients when making treatment decisions.

If we thoroughly follow these diagnostic recommendations we would increase homogeneity within patients with fibromyalgia, an essential aspect to guarantee a better assessment of this condition and increase the quality of our medical research.

Clinical assays in fibromyalgia usually use strict criteria for patient selection, excluding all patients with other possible misleading diseases or conditions. This could explain why efficacy of certain drugs used to treat fibromyalgia symptoms is normally higher in these assays than in clinical practice, where they are used in a more heterogeneous population.

Conversely, epidemiologic studies and assays comprising alternative treatments are not usually so strict in patient inclusion criteria, leading to uncertain and confusing results.

We have been suggesting for years the great utility of Gieseke classification in the assessment of patients with fibromyalgia [9]. In a previous study, we identified in our cohort that 68.5% of our patients with fibromyalgia suffered from a functional somatamorphic disorder, 20.6% from depression and only 10.9% had no major psychological

disorder [10]. If we consider the first two groups together our results are similar to those reported by Gieseke [11] in a different population.

If we consider that the prevalence of fibromyalgia in our country is around 2.4% [12], we can estimate that the prevalence of patients with fibromyalgia without psychopathology in our population will only represent around 0.3%.

The latter figure draws a different and more rational scene for fibromyalgia in our sanitary health systems. Rheumatologists should attempt to identify this subset of patients in which pain, but not psychological disorders, is the most relevant clinical feature. This group deserves, in our opinion, special attention and is the main group on which research has to be focused.

Benefits	Harm
Provides a diagnosis	High heterogeneity
Possible economic profits/disability	Detrimental for clinical assays
	A high number of patients referred to a non-appropriate specialist
	Increased feeling of malaise
	Over-treatment

Table 1: Benefits and harm of multiple labeling of patients with fibromyalgia.

References

1. Carmona L (2006) Systematic review: does a diagnosis of fibromyalgia per se have a harmful effect on prognosis? Reumatol Clin 2: 52-57.
2. Rivera J, Alegre C, Ballina FJ, Carbonell J, Carmona L, et al. (2006). Documento de consenso de la Sociedad Española de Reumatología sobre la fibromialgia. Reumatol Clin 2: S55-S66.
3. Geenen R, Jacobs JW, Bijlsma JW (2002) Evaluation and management of endocrine dysfunction in fibromyalgia. Rheum Dis Clin North Am 28: 389-404.
4. Martinez-Lavin M, Hermosillo AG (2000) Autonomic nervous system dysfunction may explain the multisystem features of fibromyalgia. Semin Arthritis Rheum 29: 197-199.
5. Caro XJ, Winter EF (2014) Evidence of abnormal epidermal nerve fiber density in fibromyalgia: clinical and immunologic implications. Arthritis Rheumatol 66: 1945-1954.
6. Arnold LM, Hudson JI, Keck PE, Auchenbach MB, Javaras KN, et al. (2006) Comorbidity of fibromyalgia and psychiatric disorders. J Clin Psychiatry 67: 1219-1225.
7. Fukuda K, Straus SE, Hickie I, Sharpe MC, Dobbins JG, et al. (1994) The chronic fatigue syndrome: a comprehensive approach to its definition and study. International Chronic Fatigue Syndrome Study Group. Ann Intern Med 121: 953-959.
8. Wolfe F, Clauw DJ, Fitzcharles MA (2010) The American College of Rheumatology preliminary diagnostic criteria for fibromyalgia and measurement of symptom severity. Arthritis Care Res (Hoboken); 62: 600-610.
9. de Miquel CA, Campayo J, Florez MT (2010). Interdisciplinary consensus document for the treatment of fibromyalgia. Actas Esp Psiquiatr 38: 108-120.
10. Moyano S, Kilstein JG, Alegre de MC (2015). New diagnostic criteria for fibromyalgia: Here to stay? Reumatol Clin 11: 210-214.
11. Giesecke T, Williams DA, Harris RE (2003). Subgrouping of fibromyalgia patients on the basis of pressure-pain thresholds and psychological factors. Arthritis Rheum 48: 2916-2922.
12. Carmona L, Ballina J, Gabriel R, Laffon A (2001) The burden of musculoskeletal diseases in the general population of Spain: results from a national survey. Ann Rheum Dis 60: 1040-1045.