
What's New in ACP Medicine

Fibromyalgia

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Defining Fibromyalgia

Fibromyalgia is a chronic syndrome that occurs predominantly in women and is marked by generalized pain, multiple defined tender points, fatigue, disturbed or nonrestorative sleep, and numerous other somatic complaints. It is not a discrete disease; rather, it lies at the far end of a continuum of psychological distress and chronic pain in the population. Currently, fibromyalgia is best classified as one of a series of disorders that are variously termed symptom-based conditions, functional somatic syndromes, or affective spectrum disorders.[1] Advances in our understanding of the psychophysiologic dysregulation[2] in these illnesses undoubtedly will lead to revision of such classification in the future. There appear to be discrete subgroups of patients with respect to pain sensitivity and psychological factors,[3] and these subgroups vary in response to therapy and in prognosis.

Fibromyalgia largely overlaps with other syndromes with unexplained symptoms, such as chronic fatigue syndrome and irritable bowel syndrome, all of which are related to, but not fully dependent on, depression and anxiety.[4] Fibromyalgia frequently coexists with organically defined disease, such as systemic lupus erythematosus (SLE) or rheumatoid arthritis. On a typical day, primary care physicians should expect to interact with several patients with fibromyalgia, many of whom will be seeking care for illness other than fibromyalgia. For example, more than 25% of patients with SLE exhibit painful tender points and other clinical and psychological features of fibromyalgia.

Drugs for Pain Relief in Fibromyalgia

A well-established conventional approach to initial therapy of diffuse pain in fibromyalgia is the use of a tricyclic antidepressant (TCA) at bedtime. Amitriptyline, starting at 10 mg and escalating slowly to 50 mg, is a common choice. In approximately one third of fibromyalgia patients, low doses of amitriptyline produce moderate short-term improvements in pain, disturbed sleep, patient and physician global assessments, physical status, psychological status, and capacity for activities of daily living. Improvements in fatigue, tenderness, and stiffness are more modest. With regard to long-term improvement, TCAs have not been shown to be superior to placebo, however; in addition, patient acceptance of these agents is poor because of their anticholinergic and sedative effects and their tendency to cause weight gain. The selective serotonin reuptake inhibitors (SSRIs) fluoxetine[5] and citalopram have proved effective in randomized, controlled trials, and the combination of a TCA with an SSRI typically produces greater improvement in pain, sleep, and overall well-being than either drug used alone. Dual-action (serotonin/noradrenaline) reuptake inhibitors, such as venlafaxine and the investigational agents duloxetine and milnacipran, also show promise.

Centrally acting skeletal muscle relaxants (e.g., cyclobenzaprine, baclofen, tizanidine) generally are not effective as single agents for the diffuse pain of fibromyalgia, although such usage is common practice and is supported by a few clinical trials. However, muscle relaxants given at low doses and in combination with a TCA or an SSRI may provide some benefit, at least over the short term. Topical capsaicin is useful when gently massaged into painful areas twice a day. The patient should be informed that the initial discomfort often encountered with capsaicin will subside with time and that beneficial effects may not be apparent until after 3 to 4 weeks of therapy.

The addition of an antiepileptic drug (AED) is indicated in patients with marked allodynia and hyperalgesia. AEDs have efficacy for pain sensitivity and as adjunctive medications for disturbed sleep and depression. Many choices are available, including gabapentin, topiramate, and tiagabine (see Table 1); the experimental AED pregabalin has also shown promise for this purpose.

Prognosis in Fibromyalgia

Although improved treatment provides optimism for better outcomes in fibromyalgia, prospective long-term longitudinal studies in academic medical centers have found little improvement in health status, disease severity, health service utilization, and costs, with approximately 25% of patients with fibromyalgia receiving disability or other compensation payments. Persons with fibromyalgia suffer much more than those with other chronic rheumatologic diseases, such as rheumatoid arthritis.

Even though hyperalgesia and allodynia cannot be reversed entirely, most patients can expect substantial improvement in symptoms and in overall quality of life. Resolution of ongoing stress and promotion of the patient's self-efficacy for control of pain are of pivotal importance. Prognosis varies among three fairly distinct subsets of patients, who have been termed adaptive copers, interpersonally distressed, and dysfunctional. Adaptive copers, many of whom do not seek care for fibromyalgia, do well with respect to self-reported pain, disturbed sleep, and fatigue. Interpersonally distressed patients also respond to a comprehensive interdisciplinary therapeutic approach. Dysfunctional patients with high levels of pain, anxiety, and opioid dependence do poorly, as do patients with pending litigation. The treatment goal that responds least to therapy is improvement in daily functioning.

Tables

Table 1. Selected Antiepileptic Drugs for Treatment of Fibromyalgia Pain

Agent (Trade Name)	Dosage
Gabapentin (Neurontin)	300 mg h.s. to 600 mg t.i.d.; escalate over several weeks
Topiramate (Topamax)	25-50 mg h.s. to 200 mg b.i.d.; escalate by 25-50 mg at weekly intervals
Tiagabine (Gabitril)	2-4 mg h.s. to 56 mg q.d. in two to four divided doses; escalate by 4-8 mg at weekly intervals

References

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