Letter to the Editor: The Pundit Speaks

By Randolph M. Howes, M.D., Ph.D.
January 18, 2015

"Fibromyalgia: What is it and Can it be Treated ?"

Prior to 1980, fibromyalgia (FM) was called "fibrositis," which implied it was some form of inflammation in the connective tissue resulting in widespread pain. But, no such inflammation was verified so the name was changed to fibromyalgia. Patients experience pain, fatigue and sleep and memory problems. Currently, it is thought to be emblematic for a "centralized" pain state and it can occur alone or as a comorbidity with other "peripheral" pain states, such as osteoarthritis, rheumatoid arthritis, irritable bowel syndrome and lupus. It may be linked to some genetic factors or early life stressors. In the late 1800s, fibromyalgia-like conditions occurred primarily in women, who were considered to be weak, depressed, anxious and in need of psychotherapy. In the early 1900s, pathologists erroneously thought they saw evidence of inflammation in muscle tissue in FM patients. This led to a fad of removing organs such as the appendix or others, that were thought to be the source of some kind of infectious stimulus to inflammation in tissues. But, soon, they laid these incorrect notions to rest and started to look for biological evidence, as opposed to purely psychiatric causes. In the 1970s. it was discovered that FM patients have a fundamental abnormality in sleep physiology. In the 21st century, we are recognizing that FM is secondary to a complex interplay of neurochemical and genetic dysregulation. Experts recommend that physicians learn to recognize the pattern of widespread pain accompanied by fatigue, sleep, memory, and mood problems and then use the FM label when that is the most likely explanation of those symptoms. The "tender point" exam may be incorrectly applied in practice and be misleading in suggesting that FM is primarily a muscle or tendon problem as opposed to being primarily a problem with sensitization and dysregulation of the CNS. Doctors look for a constellation pattern of chronic widespread pain along with other characteristic features such as fatigue, sleep disturbance, cognitive dysfunction, and irritable bowel symptoms. FM diagnosis can be difficult and may require ruling out all other possibilities, such that FM is the only diagnosis left. Frequently, the primary care physician seeks the help of subspecialists, such as a rheumatologist or neurologist. Still, subspecialists may offer little beyond that of the primary care physician and at times, patients will get procedures that are not helpful or get put on classes of drugs (ie, opioids) that are not helpful. Sadly, there can be a stigma associated with the FM diagnosis.

In the America that I love, we empathize with FM patients because the diagnosis can be trying and treatment may be by trial and error. Only about one third respond favorably to current medications. Realistically, effective treatment is still in its infancy.

Randolph M. Howes, M.D., Ph.D.
Surgeon/Scientist/Patient Advocate
27439 Highway 441, Kentwood, LA 70444
985-229-6955 Home | 985-229-3760 – Fax | 985-514-0578 – Cell
rhowesmd@hughes.net | www.iwillfindthecure.org