FIBROMYALGIA SYNDROME

A GUIDE FOR PATIENTS, THEIR FAMILIES AND PHYSICIANS

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Fibromyalgia Support Group for Surrey and Sussex

The Fibromyalgia Support Group for Surrey and Sussex is proud to produce and present this guide by Professor Yunus, an eminent physician in the research into and treatment of fibromyalgia in the United States of America.

The primary purpose in producing this guide is to provide information about the fibromyalgia syndrome to sufferers and their families, but we hope that it also will be of interest to doctors and other health professionals.

For further information about the group visit the back cover.

On the inside back cover is a list of useful publications and small items for sale.
INTRODUCTION

Fibromyalgia syndrome (FMS), also known as fibromyalgia, is characterised by chronic widespread body pain and aches accompanied by many sore spots on pressure by physical examination. These spots are called tender points (TPs). Thus, FMS is different from regional or localised pain, such as back and neck pain. However, regional pain may sometimes evolve into fibromyalgia with widespread pain. FMS can occur by itself or concomitantly with other diseases, such as arthritis.

In this Guide, I shall use FMS and fibromyalgia interchangeably. Also, I shall use the terms disease, illness, condition, disorder and syndrome synonymously, since they all are based on pathophysiological abnormalities (structural or neurochemical) and cause real symptoms including pain and sometimes disability.

BRIEF HISTORY OF FIBROMYALGIA

In 1592, a French doctor, Guillaume de Baillou, first used the non-specific term 'rheumatism' for pain in muscles and joints. In the following centuries, a distinction was made between arthritis with swelling and deformity of the joints and pain in the soft tissues, such as muscles. In 1904, Sir William Gowers, a British doctor, introduced the term 'fibrositis' in an article on back pain, implicating inflammation. However, it is now known that there is no inflammation in fibromyalgia. Modern description of fibromyalgia with generalised pain, fatigue and other symptoms as well as TPs did not clearly emerge until the 1960’s. In 1975, Drs. Harvey Moldofsky and Hugh Smythe of Canada demonstrated sleep disturbance in 'fibrositis' by objective tests in the sleep laboratory. Recognising that there was no inflammation in this condition, Dr. Kahler Hench of USA coined the term fibromyalgia in 1976. This term was vigorously promoted later by Dr. M. B. Yunus of USA in the 1980s, and was subsequently accepted by the American College of Rheumatology (ACR).

The first scientific study describing various features of fibromyalgia was published by Dr. Yunus and his colleagues in 1981. In 1984, Dr Yunus published an important concept linking fibromyalgia with similar conditions, such as irritable bowel syndrome (IBS), headaches and dysmenorrhea (painful menstruation). A significant development occurred in 1990 when ACR published a standard set of criteria for fibromyalgia that accelerated scientific investigations in this condition.
PREVALENCE OF FIBROMYALGIA

The prevalence of FMS in the general population is 2-4% by the ACR criteria. Thus, between 1.2 - 2.4 million people in the United Kingdom have fibromyalgia. However, this figure is higher if a diagnosis is made in a doctor's office based on clinical impressions. About 95% of the fibromyalgia sufferers are females, and it is most common in the 40-60 age group at the time of consultation with a doctor. However, fibromyalgia can occur among children and the elderly. Fibromyalgia has been described in every ethnic group, in every country and in every social group.

SYMPTOMS OF FIBROMYALGIA

The most common symptoms of FMS are widespread aches and pain, stiffness, fatigue and poor sleep. Other symptoms are shown in Table 1 (see page 6). These symptoms can be disabling and should be taken seriously by a GP.

The pain in FMS is variously described as ‘hurt all over’, aching, throbbing, burning, sore, and unbearable. Common sites of pain are neck, low back, shoulder and upper back regions, arms, and the buttock area. However, pain can be present in any area, including the chest, hands, thighs, legs and even the foot. Chest pain may be misinterpreted as heart pain. Several factors can aggravate and relieve pain (see Aggravating and Relieving Factors of Symptoms - see page 5).

Fatigue is described as exhausting, ‘I am tired all the time’, ‘drained out’, and a general feeling of weakness. Fatigue can be profound in some patients. Both pain and fatigue can be a source of significant disability in some patients. Deconditioning (because of a lack of exercise), too much physical activity, some medications, and psychological factors (such as anxiety, stress and depression) may contribute to fatigue.

Poor sleep is characterised by difficulty in falling asleep, frequent awakening, light sleep, and marked morning fatigue. Despite many hours in bed, the quality of sleep is poor, and many patients do not feel like getting up in the morning, and state that ‘I am more tired now than I was when I went to bed’. Although patients may not be aware, sleep is disturbed by ‘mini arousals’ that can be documented by sleep studies in a laboratory. However, such studies are rarely necessary. Several factors can aggravate or contribute to poor sleep. These include pain (from fibromyalgia itself or other sources, such as arthritis), psychological distress, noise, heartburn, heart or lung diseases causing cough or shortness of breath at night, some medications, and associated restless legs syndrome. There is a link between non-restorative sleep at night and severity of pain and fatigue the next day.
Tingling and numbness and a feeling of swelling occur most often in the hands and the feet, and may be misdiagnosed as a neurological problem or arthritis. These symptoms are not related to psychological factors.

Dizziness occurs in about half of the patients, and some may experience a buzzing sensation in their ears. Consultation with a neurologist or an ear, nose and throat specialist may be required if these symptoms are severe and bothersome. Most of the time, however, these symptoms emanate from fibromyalgia itself, and no other cause is found.

Memory problems are common in FMS. They include difficulties with verbal fluency ('word groping'), concentration, and recent memory. Misplacements of objects are frequent in these patients. Many patients find it useful to write down things they need to do or say, but some of them have difficulty in remembering where that piece of paper is! Although memory problems may be affected by several factors, such as depression, stress, medications, poor sleep and older age, studies have shown that these problems are present in FMS even in the absence of these factors.

**PSYCHOLOGICAL SYMPTOMS**

Significant psychological distress is present in about one third of patients with FMS. They include depression, stress, anxiety, coping difficulties and catastrophising. A small number of patients who catastrophise their symptoms perceive them as a calamity. They believe FMS is a very serious disease and they will never get better despite repeated assurance by their GPs. Catastrophising patients tend to do worse than others. Although psychological symptoms are present in chronic diseases with structural pathology, such as rheumatoid arthritis (RA), their prevalence is somewhat greater in FMS than RA. Chronic diseases of any cause can produce these psychological symptoms, but psychological disturbance can also precede and likely predispose a person to FMS.

Some patients with FMS (and other similar conditions) give a history of abuse and other adverse experiences in childhood. It is possible that such experiences cause some long-term neurological and chemical changes in the spinal cord and the brain that contribute to development of fibromyalgia and other similar syndromes later in life.

It must be stressed that fibromyalgia is not a psychological or psychiatric problem. A majority of patients with FMS do not have substantial psychological difficulties. Psychological factors do not cause fibromyalgia, but may aggravate its symptoms. A satisfactory treatment of depression, for example, may help fibromyalgia symptoms but does not completely alleviate them.

**AGGRAVATING AND RELIEVING FACTORS OF SYMPTOMS**

Symptoms of FMS may be aggravated by poor sleep, psychological distress, cold and humid weather, noise, overactivity or overwork, and underactivity (that leads to de-conditioning). Trauma and occupational factors (such as repetitive use of a limb) as well as infection (mostly viral) may also aggravate fibromyalgia. Symptoms are often helped by local heat, restful sleep, relaxation, stretching exercises, a positive attitude, regular exercise (see the section on FMS Management on Page 10), warm and dry weather, and massage.
**Table 1**

<table>
<thead>
<tr>
<th>SYMPTOMS</th>
<th>ASSOCIATED CONDITIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Widespread pain and stiffness</td>
<td>Chronic fatigue syndrome</td>
</tr>
<tr>
<td>Fatigue</td>
<td>Irritable bowel syndrome</td>
</tr>
<tr>
<td>Non-restorative sleep</td>
<td>Headaches</td>
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<tr>
<td>Tingling and numbness</td>
<td>Restless legs syndrome</td>
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<tr>
<td>Swollen feeling in the tissues</td>
<td>Temporomandibular disorder</td>
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<tr>
<td>Dizziness</td>
<td>Interstitial cystitis/female urethral syndrome</td>
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<tr>
<td>Memory problems</td>
<td>Multiple chemical sensitivity</td>
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<tr>
<td>Psychological symptoms</td>
<td>Post-traumatic stress disorder</td>
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<td></td>
<td>Dysmenorrhea (painful menstruation)</td>
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**CONDITIONS ASSOCIATED AND OVERLAPPING WITH FIBROMYALGIA**

These disorders are shown in Table 1 above. Collectively, they were suggested to be called 'central sensitivity syndromes' (CSS) by Dr. M. B. Yunus in 2000 (see Further Reading, reference 4). All these conditions share many symptoms and a common mechanism of disease, namely central sensitisation, which will be discussed under 'Causes and Mechanisms of Fibromyalgia'.

*Chronic fatigue syndrome* (CFS) is similar to fibromyalgia except that fatigue is the overwhelming symptom rather than pain. CFS patients also complain of more frequent memory problems. Patients with *irritable bowel syndrome* (IBS) complain of bowel problems and abdominal pain. *Tension type headache* and *migraine* are both associated with FMS. *Restless legs syndrome* (RLS) is characterised by a difficult-to-describe feeling of much discomfort in legs with an urge to move them. Sometimes they are described as 'insects crawling'. These symptoms occur on rest, particularly at night and during prolonged sitting, as in travelling in a car or airplane. Patients with *temporomandibular disorder* (TMD) complain of jaw pain with local tenderness on pressure.

Symptoms of *interstitial cystitis* or *female urethral syndrome* are frequent and painful urination in the absence of an infection. Patients with *multiple chemical sensitivity* (MCS) are unusually sensitive to a low level of various chemicals (such as perfume, pesticide and gasoline) as well as smell. Patients with *post-traumatic stress syndrome* (PTSD) have many symptoms of FMS, IBS and other CSS conditions that occur following a very high level of physical or mental stress or both, such as exposure to war, rape, severe abuse or accidents, and natural or man-made catastrophe. *Painful menstruation* as well as *premenstrual syndrome* are common among patients with fibromyalgia. It is important to recognise that the same patient may have symptoms of many of these associated conditions.
PHYSICAL EXAMINATION

Often a doctor will say 'I find nothing wrong'. However, in the hands of a knowledgeable and experienced doctor, the most remarkable and consistent finding is the presence of many sore spots (TPs) at widespread locations (normal healthy women may have only 1-3 TPs) when a doctor pushes these spots with his or her finger using about 4 kg of pressure (see Figure 1 below). Some patients are so sensitive, even touch can cause pain in them. Note that patients with fibromyalgia may hurt on pressure in other areas besides those shown in Figure 1. Like any other sign in medicine, such as a heart murmur, a doctor must acquire the skill of examination for TPs. Fibromyalgia patients may have signs of concurrent or coincidental diseases, such as arthritis, neuritis and low thyroid condition. Despite a feeling of swelling and numbness, joint swelling or neurological signs are absent on examination in FMS itself, unless it is accompanied by another disease, such as arthritis and neuritis.

Figure 1

LEGEND

Location of 18 tender points (9 on each side of the body) to be examined for classification of fibromyalgia syndrome by American College of Rheumatology Criteria.

1 suboccipital 2 Low anterior cervical
3 Mid-trapezius 4 supraspinatus
5 Second rib 6 Lateral epicondyle
7 Gluteus muscle 8 Greater trochanter
9 Medial part of knee
DIAGNOSIS

It is often said that fibromyalgia is a difficult disease to diagnose. As a matter of fact, diagnosis of fibromyalgia is disarmingly simple. ACR criteria for classification of FMS require only (a) widespread pain in three areas (in practice, all four quadrants) of the body as well as the back or chest wall, and (b) presence of at least 11 out of possible 18 (9 pairs) TP sites as shown in Figure 1 (see Page 7). It is important to realise that these criteria were developed primarily for uniformity in patient selection for research and not for clinical diagnosis. About 20% of patients seen in a doctor's office do not fulfil the ACR criteria. Thus, in clinical practice, a diagnosis of fibromyalgia may be made by the presence of widespread pain and other typical symptoms (see Table 1 on Page 6), and as few as 5 TPs. It is worth emphasising that fibromyalgia is not a disease of exclusion, as specified in the ACR criteria publication. A patient with fibromyalgia may have other diseases besides fibromyalgia but their presence should not influence the diagnosis of fibromyalgia which is diagnosed by its own characteristic features. In other words, a patient may have fibromyalgia as well as other diseases or conditions. As an example, about 20% of patients with RA also have fibromyalgia.

LABORATORY TESTS

Usual laboratory tests and X-rays are normal in fibromyalgia and they are not required for diagnosis. However, routine white cell count, haemoglobin and sedimentation rate, as well as kidney, liver and thyroid functions tests are useful screening tests that are helpful to rule out a concomitant condition (such as low thyroid) that may contribute to fatigue. Liver function tests are also helpful in monitoring drug side-effects. These tests are cost effective and should be done. Patients may have an accompanying disease, such as RA or neuritis. If such an additional diagnosis is clinically suspected, a doctor may order other tests that are related to that disease. Fibromyalgia patients have a large number of abnormal “tests” in the nervous and endocrine (hormonal) systems, along with abnormal findings by brain imaging. However, these tests are not helpful in clinical practice and should not be carried out, although they are very important for research purposes.

CAUSE AND DISEASE MECHANISMS OF FMS

There has been a remarkable progress in understanding fibromyalgia through research in the past two decades. However, like any other chronic diseases, such as cancer or multiple sclerosis, such understanding is incomplete. However, it is important to study the mechanisms of a disease, since they are directly relevant to treatment.

The mechanisms of symptoms in FMS are now much better understood than before. These mechanisms overlap with the aggravating factors mentioned earlier.

Central sensitisation. There are many factors that can cause FMS, and most of them seem to do so through the mechanism of central sensitisation (CS). Demonstration of CS in FMS and other associated conditions is a very important research progress in the past 15-18 years.
CS can be simply defined by an undue and exaggerated sensitivity of the central nervous system or CNS (the nerves from the spinal cord up to various brain structures) to many stimuli (to be described below). Pathology in the periphery (such as the muscles or ligaments) is absent, although many peripheral factors such as trauma to the neck or back or a painful joint can feed into the CNS to cause CS.

Clinically, CS is manifested by an undue sensitivity to various stimuli, such as pressure, electricity, heat, weather, noise and chemicals (including some medications) and even touch as mentioned earlier. While pressure is applied during TP examination, several others are carried out in a controlled experiment in the human pain laboratory.

CS is influenced by genetics. It is enhanced by poor sleep, psychological distress, and trauma. Many neurochemicals are involved in causing CS, such as substance P (SP), nerve growth factor (NGF), glutamate and aspartate. These chemicals in turn bind with their receptors (specific protein molecules) on the surface of a cell, and cause pronounced functional changes within the cell and its membrane, leading to CS.

In FMS patients, abnormalities in various parts of the brain have been shown by brain imaging techniques, such as functional magnetic resonance imaging (MRI) and single-photon-emission-computed tomography (SPECT). These objective normalities explain some of the symptoms of FMS. Several neurochemicals (neurotransmitters) such as SP, NGF and glutamate transmit pain sensation, while others, such as serotonin, norepinephrine and dopamine inhibit pain. Pain in FMS is caused by a dual mechanism of increased pain transmitting and decreased pain inhibiting neurotransmitters.

**Genetic factors.** Abnormal genetic findings involving the serotonin and dopamine systems have been well documented in FMS.

**Viral infection, physical and emotional trauma, poor sleep, and psychological factors** have been discussed earlier (under Aggravating factors). Trauma includes automobile accidents and direct trauma to neck or back from other causes, and repetitive type of use of a limb in certain occupational and recreational activities. Abnormal ‘arousal waves’ (called alpha-delta sleep) have been demonstrated by sleep electroencephalogram. Adverse childhood experiences (physical, mental or sexual abuse) may predispose a person to development of FMS later in life in some patients. Acute or chronic stress is an important predisposing and perpetuating factor.

**Endocrine abnormalities.** A dysfunction of the hypothalamic-pituitary-adrenal system has been demonstrated in FMS. The endocrine system that deals with stress also seems abnormal in FMS. However, how these abnormalities are related to symptoms is not understood at this time.

In many patients the above initiating or triggering factor(s) seem absent. It is probable that a strong genetic predisposition requires little or no triggering. It should be recognised that fibromyalgia is due to both biology (neurochemical and endocrine abnormalities) and psychology in varying proportions in a particular individual.
FIBROMYALGIA SYNDROME: A GUIDE FOR PATIENTS, THEIR FAMILIES AND PHYSICIANS

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FIBRAMANAGEMENT

An outline for the management of fibromyalgia is shown in Table 2 (see page 11).

Positive and empathetic attitude of the doctor
A negative attitude of the GP or any other health care provider is detrimental to patient care. Therefore, it is very important to choose the right doctor who understands the disease, takes it seriously, is a good listener and is empathetic to the patient. He or she should provide guidance and support to the patient. A doctor should have an ‘I can help you’ attitude. Many doctors do not accept FMS as a legitimate disease or condition, either because of bias or ignorance. A patient should be empathetic to a doctor as well! Most GPs were not educated in fibromyalgia in their medical school and internship training, and often they are not compensated for the time that needs to be spent with a patient. Thus, ‘the system’ is partly to blame.

Firm diagnosis
As stated earlier, diagnosis of fibromyalgia is not difficult on clinical grounds alone. A doctor should avoid multiple tests. “One more test” may cause unnecessary patient discomfort and adds to medical cost and worries of a patient.

Patient education and reassurance
This is perhaps the most important element of management of fibromyalgia. During the initial visit, a doctor should explain to the patient what is, and what is not, fibromyalgia.

Patients should be assured that their pain and other symptoms of FMS are real, based on a documented pathophysiology. The cause and mechanisms of fibromyalgia should be explained in simple language by a doctor. Patients should be reassured that FMS does not cause tissue damage or death, despite severe and real pain.

It needs to be emphasised that FMS is not a pure psychological illness, but emotional factors, such as worries, depression and stress can aggravate symptoms. The treatment plan should be discussed with the patient. Although FMS cannot be cured, as is the case with most diseases, most patients can be helped significantly.

Patient responsibilities
A patient needs to have a positive attitude to feel better. Empathy alone, either from a doctor, family or support group members or friends, will not help unless a patient is proactive in doing her part.

Weight and smoking. These are important risk factors for many diseases including heart disease, diabetes, vascular disease and cancer, but they can also aggravate fibromyalgia symptoms, such as pain, fatigue and physical functioning.

Sleep difficulties. Poor sleep is an important contributing factor to fibromyalgia symptoms. Usually 7-9 hours of sleep at night are necessary.
FIBROMYALGIA SYNDROME: A GUIDE FOR PATIENTS, THEIR FAMILIES AND PHYSICIANS

Table 2

IMPORTANT COMPONENTS OF FMS MANAGEMENT

- Positive and empathetic doctor attitude
- Firm diagnosis
- Patient education and reassurance by health care providers
- Patient responsibilities: address weight, smoking, sleep difficulties, regular exercise, emotional factors and aggravating factors
- Individualisation of management
- Non-pharmacological interventions
- Medications: tricyclic agents (such as amitriptyline); selective serotonin uptake inhibitors (SSRI); a combination of an SSRI (such as fluoxetine) and a tricyclic agent (such as amitriptyline); tramadol; duloxetine; pregabalin; pramipexole
- Tender point injections
- Multidisciplinary approach

However, a patient should avoid excessive sleep and follow a strict sleep regimen that includes going to bed and waking up early and at the same time everyday. Other measures to help better sleep include (a) abstaining from caffeine, stimulating medications, alcohol, and smoking for 3-4 hours before bedtime; (b) avoiding sleep disturbing elements in the bedroom (television, noise, too hot or too cold temperature, snoring of a sleeping partner); (c) proper treatment of diseases that can disturb sleep (heartburn, restless legs syndrome, pain from other causes); (d) management of emotional distress; and (e) regular exercise. In general, exercise should be avoided within 3-4 hours of bedtime, although some patients find that exercising before going to bed helps in falling asleep.

Physical exercise. In the phrase, ‘regular exercise’, regular is more important than exercise. One must make a habit of it, even though exercising may last just for a few minutes on some occasions. Despite severe fatigue or pain, everyone can exercise. The ‘trick’ is to follow the slogan: start low, go slow. If necessary, start with just 2-3 minutes of exercise every day, and gradually increase it by just a few minutes every week. This, of course, will vary according to individuals and their degree of pain following exercise. Keeping a graph or diary is useful. Importantly, one should engage in a form of exercise that one likes and can stay with. It does not matter whether it is walking outside, treadmill, dancing or swimming as long as it is not a chore and it raises the heartbeat.
Ideally, one should build up the exercising time to the point of perspiring and somewhat heavy breathing (patients with heart or lung disease need to be careful), but studies have shown that even less vigorous exercise is beneficial. Some exercise such as running/jogging may aggravate fibromyalgia pain. Exercise is the single most important activity to keep oneself healthy physically and mentally. Apart from helping good sleep and weight loss, exercise can also decrease stress and depression.

**Emotional factors and pacing.** Addressing anxiety, depression, stress and poor coping is very important. They may aggravate symptoms and limit activities. These can often be helped by relaxation, but in severe cases medication may be necessary. Stress from doing too many things can be minimised by pacing; this means taking one’s time in accomplishing a task, as it feels comfortable. One should not aim at getting everything done in a rigid time period (like cleaning all the rooms on the same day). The idea of being a ‘supermum’ is detrimental to mental health. An understanding family member (husband and children) can help with certain chores or tasks. Socialisation and support from friends are beneficial.

**Aggravating factors.** These factors have been mentioned earlier. A patient should avoid them as much as possible, if they apply to a particular patient. Weather elements can be avoided to an extent. Minimise exposure to hot, humid or cold weather. This can be achieved by planning – such as combining tasks of shopping in the same area and purchasing enough groceries at a given time. Heavy lifting should be avoided and the house temperature should be kept at a comfortable level. In a job that is stressful and needs repetitious use of a limb, a discussion with the manager is advised. Most managers need education on fibromyalgia and a doctor can help.

**Individualisation of treatment**

Individualisation of treatment is important for a doctor to understand. One size does not fit all. Not all patients are depressed or under stress, and the pain tolerance of each patient is different. Some patients may not have a sleep problem. Thus, each patient should be treated for their individual problems that may be different from others. Other concomitant diseases should be treated to decrease the total burden of more than one disease.

**Non-pharmacological treatment**

Besides those mentioned under Patient responsibilities, many relaxation techniques, such as meditation or biofeedback are useful for some individuals. Cognitive behavioural therapy (CBT) is helpful in many patients. CBT involves understanding the disease and self-help using logic. For example, one should accept that fibromyalgia is not a serious disease despite its genuine debilitating symptoms. The goal of CBT is to learn coping mechanisms. Many family doctors can employ CBT, but some patients with continued bothering symptoms need to be referred to a specialist (usually a psychologist) who specialises in CBT. Massage (properly done), physiotherapy (including heat) and electro-acupuncture provide benefit to some, but not all, patients.
Medications

It is the combination of a non-pharmacological and pharmacological (use of drugs) approach by a doctor that is most effective (Table 2). It must be emphasised that drugs alone do not adequately help fibromyalgia symptoms. Clinical trials have established the efficacy of these medications. It is important that all medications are prescribed in a small dose first and the dose is increased slowly. For example, amitriptyline should be started in 10-25 mg dose. A small dose of fluoxetine (20 mg) in combination with amitriptyline (generally 25 mg) works better than either alone. Fluoxetine and similar drugs (called SSRIs) alone are usually less useful than other medications. Side effects (such as drowsiness, dry mouth, constipation) are common from amitriptyline and similar medications (called tricyclic agents). These medications (Table 2) should then be stopped and another type of drug, such as pregabalin, should be prescribed. Most of the medications take 3-6 weeks to work. When the medications in adequate tolerable doses do not help, other medications in the same class of drugs should be considered by a doctor.

A patient must consult his or her doctor for full prescribing information (dose, interaction with other drugs, side-effects) on all the medications. Accompanying depression generally requires a higher dose of the above medications than that used for fibromyalgia alone.

Many (but not all) of the above medications are also used as antidepressants, but these drugs act in fibromyalgia independent of their antidepressant properties. Symptoms may persist even after adequate treatment of depression. (Thus fibromyalgia and depression are not the same diseases). Since fibromyalgia is a chronic disease, patients need to take medications for an indefinite period, although doses may be reduced when a patient feels better for 2-3 months.

Medications may be needed to help associated conditions. For example, restless legs syndrome can be satisfactorily treated with clonazepam and pramipexole.

Tender point injections

Injection of a few sore and symptomatic spots with 1% lidocaine, usually ½ cc, can provide pain relief lasting a few weeks. Such injections work not just locally, but also through the central nervous system that explains their action beyond the numbing effect. A GP’s enthusiasm in using these injections is as important as the injection itself!

Multidisciplinary approach

A fibromyalgia patient often needs help from several doctors because of their multiple symptoms that involve many different systems. Thus, when needed, a patient should be referred to a gastroenterologist (for irritable bowel syndrome), a neurologist (for severe headaches), a psychologist (for coping techniques), or a psychiatrist for severe psychological distress (for example from depression).
PROGNOSIS

Patients should accept that fibromyalgia is a chronic illness with ups and downs, but most patients benefit from treatment (that include self-help), particularly when guided by an interested and empathetic GP. Most patients feel better from appropriate management and are able to live a functional life and continue to work despite some symptoms. Occasionally, some patients with mild symptoms may experience remission. Those with severe psychological problems and catastrophising in general do worse. A positive, optimistic and 'I shall do my part' attitude is always helpful.

SUMMARY

Fibromyalgia is characterised primarily by widespread pain, fatigue and sleep difficulties and is associated with similar conditions, such as IBS, headaches, TMD and RLS. Abnormal sensitivity to various stimuli such as pressure (TPs), and environmental factors, such as noise and weather is the hallmark of fibromyalgia and other CSS conditions. The cause of fibromyalgia is now better understood than before.

Fibromyalgia and associated conditions are essentially due to neurochemical abnormalities in the brain and the spinal cord. Although depression, stress and other psychological factors may initiate and contribute to symptoms, they are not the cause of CSS diseases. Genetics, poor sleep, trauma and other environmental factors also play a role. Management of fibromyalgia includes both a non-pharmacological and pharmacological approach as described above. Most patients benefit from the care provided by an empathetic doctor who understands fibromyalgia.

FURTHER READING


**Fibromyalgia: Show Me Where It Hurts.**

£17.99

Whenever we show this DVD, copies sell like hot cakes, to be shown to their families and doctors. It reveals the origins of the pains we endure, and gives groundbreaking information about changing your lifestyle and getting rid of stress from your life. Quotes from the film: “With the advent of new brain imaging technologies, a whole new picture has emerged. As it turns out, we’ve simply been looking in the wrong place!” and: “The study of fibromyalgia is doing so much to uncover new areas of human physiology, it’s almost unfathomable.”

**Latest Treatments for Fibromyalgia**

£12.99

A double DVD set from the USA spotlights the latest in treatments and therapies for fibromyalgia and chronic fatigue sufferers. It is packed with useful information and hints on treatments.

**Living With Fibromyalgia: A Journey of Hope and Understanding**

£14.99

This DVD was made by a young woman whose mother was diagnosed with fibromyalgia several years ago, at which point she didn’t know how to spell the word, much less how to help. In the words of an English nurse and fibromyalgia patient: “This film tells the story of seven people and yet you’ve told my story. You’ve told the story of millions.”

**Winners Guide to Pain Relief**

£22.95

This book, by Dr Hal Blatman, is written for people who have pain, practitioners who treat those in pain, and students of medicine and other healing arts. It teaches about myofascial trigger points (muscle knots) which are part of almost every pain condition. In addition to pain, these trigger points also cause numbness, tingling, burning, and cramping symptoms. Learn how to treat the trigger points that are involved in causing your pain pattern, and you can lessen and treat your own pain. Each book comes with a ball to use in the treatments described. Copies can be ordered at meetings or from the office.

**Items featuring our bear mascot**

Lapel badges £1.00

Gel Pens £1.00

Fridge Magnets £1.00

All proceeds from items sold go to Group funds and help towards paying for the services provided to members. Please show how much you value the work of this group by purchasing items for yourself, family or friends. We too need money to survive.

Fibromyalgia Support Group for Surrey and Sussex
The Fibromyalgia Support Group for Surrey and Sussex (FMSSAS) is a registered charity whose objective is to relieve the sickness of and protect and preserve the good health of people with fibromyalgia through the provision of information and support to individuals suffering from fibromyalgia and their families and carers, and the promotion of a greater understanding and awareness of the syndrome amongst the general public.

To carry on this work FMSSAS needs financial support through grants and donations as well as membership subscriptions. Grants generally have to be obtained by producing bids to public bodies and other charities, and this work is undertaken by the trustees of FMSSAS.

You can help in one or more of four ways:

- By joining FMSSAS and enjoying the benefits of membership. The current subscription for the first year is £25.00, with subsequent renewal at £20.00 per annum.

- By making a donation of any amount.

- By buying from the list of useful publications and small items listed on the previous page.

- By volunteering your services for as little or as much time as you can spare.

Call, e-mail or write to FMSSAS at:

FMSSAS, Lavinia House, Dukes Square, Denne Road, Horsham RH12 1GZ.

Telephone: 01403 751308    E-mail: office@fms-sas.co.uk

Cheques should be made payable to FMSSAS.