CORRESPONDENCE

Fibromyalgia Syndrome—Classification, Diagnosis, and Treatment
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Definition Should Be Changed
The abolishment of the infamous “tender points” as the most important criterion of fibromyalgia syndrome (FMS) is a very welcome move. However, with regard to a definition of FMS, this brings with it further problems: the pathology of FMS used to be inadequately defined; now it is hardly defined at all. I find it rather dubious if epidemiological scientific efforts and the resultant therapeutic recommendations (current German S3 guideline FMS) relate to a group of patients with inclusion criteria that are as vague as “pain in the axial skeleton (cervical spine or frontal thorax or thoracic spine or lumbal spine), pain in the right and left half of the body, pain above and below the waist, sensation of stiffness/swelling in hands, feet, or face, or other physical or mental fatigue or sleep disturbances.” As a doctor having 20 years’ clinical experience with FMS patients I would change the definition as follows: FMS is a pathology that is characterized by a long term, generalized, vertebrogenic, functional disorder that manifests with multiple sensorimotor, particularly painful local symptoms, which are transmitted by reflex action, in the upper and lower extremities, the head, the trunk, and the inner organs; generalized trophic inflammatory soft tissue disorders; and psychovegetative exhaustion as a result of pain. The patient group with these or further specified inclusion criteria should become the subject of scientific research. By this, I do not only mean statistical-epidemiological but primarily clinical-physiological basic research. From the positions of traditional segment anatomy (metameric structure of the body [1]) and modern pain physiology (neurogenic inflammation, central and peripheral pain sensitization [2]), I do not believe that the pathology of fibromyalgia syndrome is etiopathogenetically unexplained but very clearly vertebrogenic, related to the metameric structure, and mediated in a trophic-vegetative way (3).

REFERENCES

Complex and Heterogeneous
Recommendations are an extraordinarily labor intensive achievement, especially as—in tune with the trend of the times—evidence based, rather than rationally guided, studies were favored. When studying the deluge of information it is easy to lose sight of the wood for the trees.

According to the pioneering studies by Wolfgang Müller and colleagues, the “generalized tendomyopathy” (a synonym for fibromyalgia; the term was coined by Müller in 1976) is diverse in its pathogenesis (mostly from primary monolocular pain syndromes) and its course (1). My personal observations of about 1000 patients certainly support this knowledgeable statement; the complexity with impairments and complications seems to increase during the course of the disease. These facts restrict the value of general, so called nomothetical, statements and require the particular observation of individual, sometimes unique, idiosyncrasies. Taking a thorough medical history and biography is the ideal way to approach subjective experiences.

Klaus Mainzer’s request for “thinking in complexity” (2), which has already been introduced into many other disciplines outside medicine, is, in this context, more instructive for explaining and understanding the condition than any attempts to identify the “cause and effect relation,” especially because different physiological changes and psychopathological findings have been confirmed. I think that, all that has been detected relates to merely probable relations following a circular causality principle, and not linear, determined correlations between stimulus and reaction (3).

A simple, further pointer for treatment: affected patients almost always describe the influence of heat as positive and that of cold temperatures and moisture as negative. This does not necessarily mean a “spa treatment” but a hot shower or bath; not prescribed Fango packs but using hot packs from the microwave. Heat is evidently more beneficial than the significantly—but rarely convincingly effective—amitryptiline with its associated weight gain.

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Conflict of interest statement
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Meager Result

The unsatisfactory result of two decades’ research and 8000 reviewed literature citations is that fibromyalgia is a functional disorder, whose right to exist is simply due to the fact that it is not identical with a somatoform disorder.

The guideline committee, in evaluating the literature, decided to declare the “tender points” that were previously required for defining a diagnosis of fibromyalgia as optional. This echoes the spectacular 2003 editorial by Wolfe (1), among others, which concludes that tender points are inappropriate for the definition of the disorder. If the definition was soft before it has now liquefied completely, and it seems even less likely than before that any attempts to formulate criteria for the distinction from a somatoform disorder will be unsuccessful. The fact that all the medications that are known to be effective are all psychotropic substances fits in with this scenario. This postulate does obviously not require any further proof from its champions, and the demand for “empirical testing” of the identity of both disorders is at its core nothing other than an elegant reversal of the burden of proof.

Unconventional treatment methods that have failed in the individual test are now recommended as part of the “multimodal complex treatment.” This is the consensus of experts who rely on proofs whose methodology—for this result—would be worth questioning. The guidelines contain many further ambiguities (2). The concept of fibromyalgia, whether as a syndrome or not, has proved to be fruitless and should be abandoned. This would not be the first time in medical history: —vegetative dystonia is another entity that no one ever mentions any more.

References


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In Reply:

We welcome the correspondence from readers and wish to take this opportunity to clarify and correct possible misunderstandings of the recommendations of the S3 guideline on fibromyalgia syndrome (FMS).

– The symptom complex “chronic pain in several regions of the body” without any explanatory organic disorder is a clinical reality. The unsolved problems of its classification and definition in the World Health Organization’s classification of diseases, which Mindach rightly points out, were dealt with extensively in the guideline.

– The “tender points” have not been abolished by the guideline (Judin) nor are they fundamentally unsuitable for the definition of FMS (Mindach). To make a clinical diagnosis of FMS, the guideline recommends using either the criteria of the ACR classification, which provide for the testing of the tender points, or the symptom based criteria defined by the guideline group (chronic widespread pain, and sensation of stiffness/swelling in hands, feet, or face, and physical or mental fatigue or sleep disturbances without tender point examination). These diagnostic criteria can be validly captured by means of a pain sketch and symptom questionnaire completed by the patients; they are therefore hardly “vague” (Judin). The selection of criteria was supported by expert consensus and by a survey of a large group of FMS patients about the key symptoms of FMS (1).

Studies from Canada (2) as well as a current German multicenter study (Häuser et al, in preparation) point at a high rate of concordance of the diagnosis according to the ACR and symptom based (without tender point examination) criteria.

Judin’s statement, that FMS is undoubtedly vertebrogenic, was not confirmed by our systematic literature search.

The observation of “partly individual, partly unique idiosyncrasies” (Wörz)—namely, comorbidities, patients’ preferences regarding the availability and side effects of different therapeutic options—in the therapy of FMS was emphasized in the guideline in several places. Systematic review articles have confirmed Wörz’s clinical experience, that, in contrast to antidepressants, heat therapy for the entire body has no side effects. However, controlled studies are available only for mud baths and spa therapy. The differences in effect size between spa therapies and antidepressants with regard to pain reduction do not reach significance, however (3, 4).

The guideline has a dedicated chapter on complementary and alternative approaches. Mindach rightly comments that some of these methods—such as acupuncture and tai-chi, which were not recommended as monotherapy because of negative study results—might be considered in the context of a multicomponent approach (obligatory are activating approaches such as...