Patients with fibromyalgia suffer from widespread pain and fatigue; their sleep is nonrefreshing (1-3); most experience headaches; and 48% may have migraine (4). Cognitive disturbances are common; other distressing and painful symptoms occur frequently and include irritable bladder, irritable bowel and vulvodynia (1-3). In one study of community cases of fibromyalgia (5), approximately one-half of the individuals examined were found to have high state and trait anxiety scores, and high scores for depression. Many patients with fibromyalgia are unable to engage in gainful employment; in one study in the United States, 26% received disability payments, as did the same percentage in a study conducted in Canada (6). Kleinman et al (7) reported data obtained from approximately 700,000 employees from various large self-insured employers in the United States; employees with fibromyalgia incurred significantly higher total health benefit costs, and had a much higher number of days absent from work than employees without fibromyalgia; employees with fibromyalgia also had “significantly lower per-employee annual objective productivity” than employees without fibromyalgia.

In addition, patients with fibromyalgia have to shoulder a burden seldom borne by individuals with other medical conditions. Fibromyalgia sufferers are frequently not perceived as having a distressing condition. Their families, their friends and their coworkers are often skeptical of their symptoms or their functional impairment. Kool et al (8) used the term ‘invalidation’, which includes social rejection; they pointed out that invalidation includes not only a lack of understanding and denial, but also “lecturing and over protecting”. A recent study reported on embitterment in 64 fibromyalgia patients who were employed; embitterment was the apparent result of a combination of invalidation and helplessness (9). Rodero et al (10) studied 250 patients with fibromyalgia using the Injustice Experience Questionnaire (IEQ), a measure of perceived injustice. They found that 47.2% of patients had high IEQ scores (>30), which translated to a clinically relevant level of perceived injustice. IEQ scores were significantly associated with global function and pain catastrophizing (10).

Briones-Vozmediano et al (11) further explored the relationships between patients with fibromyalgia and their professional health care providers using a qualitative research approach; their report was published in the January/February 2013 issue of Pain Research and Management. Interviews were conducted with 12 patients and nine health professionals, of whom seven were physicians, one was a physiotherapist and one a psychologist. There were nine female and three male patients, ranging in age between 29 and 61 years; five of the 12 were inactive, unfit for work or on sick leave. A feeling of invalidation and therapeutic nihilism. The experiences and attitudes described by Briones-Vozmediano et al (11) are not unique to one region of Spain.

It is, therefore, not surprising that patients with fibromyalgia seeking help from their physicians may encounter hostility, skepticism, confusion and therapeutic nihilism. The experiences and attitudes described by Briones-Vozmediano et al (11) are not unique to one region of Spain. They exist in many countries. The situation, however, is not entirely bleak. First, much has become known about fibromyalgia. It is a disorder...
of unknown etiology, but its pathogenesis has become significantly clearer. Patients with fibromyalgia have a central pain-processing disorder, aggravated by an abnormally functioning descending pain inhibitory pathway; this has been demonstrated by a number of sophisticated neuroimaging and other techniques. Abnormally high concentrations of neurotransmitters, such as substance P and nerve growth factor, in the cerebrospinal fluid have been documented; genetic factors predisposing to this condition are being identified. All of this has been well outlined in several recent reviews (16-18). The statement that ignorance of the etiology of a condition precludes its treatment is incorrect. Conditions of unknown etiology are often treated successfully. Rheumatologists need only consider rheumatoid arthritis, ankylosing spondylitis and systemic lupus erythematosus. The diagnosis of fibromyalgia should not be a difficult one. The American College of Rheumatology Classification Criteria were published more than 20 years ago (19); some physicians have had difficulty in eliciting fibromyalgia trigger points on examination, thus presumably deterring them from making a diagnosis (20). The introduction of the American College of Rheumatology Preliminary Diagnostic Criteria, which avoid examination of trigger points, should now overcome that objection (21). The complaints voiced by several professionals in the study by Briones-Vosmediano (11) reflect a common, but readily remediable, lack of confidence in their clinical skills. The symptoms of fibromyalgia can be easily elicited on history. The absence of confirmatory laboratory tests need not unduly intimidate physicians. Laboratory tests are not necessary in diagnosis of other well-recognized painful conditions such as migraine and trigeminal neuralgia (22,23).

Both patients and professionals in this study complained about the length of time that it took to confirm the diagnosis. Until recently, rheumatologists were believed to be the specialists most qualified to diagnose and treat fibromyalgia. This, however, is changing. Many rheumatologists now doubt that they should be responsible for the treatment of fibromyalgia (24,25). A recent survey of Ontario rheumatologists shows that 71% believe that they should not retain ownership of fibromyalgia; only 60% were accepting new referrals for fibromyalgia in their practices and were managing patients with fibromyalgia; the great majority (89%) believed that family physicians should be the main care providers for these patients (26). Family physicians can certainly learn how to diagnose fibromyalgia. In a study conducted in Israel (27), there was significant agreement between the diagnosis of fibromyalgia made by the referring family physician and the consultant rheumatologist.

In the Spanish study published in the January/February 2013 issue of Pain Research and Management (11), both patients and professionals were dissatisfied with the efficacy of treatment. A recent review of the

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longitudinal outcome of fibromyalgia showed that patients generally experienced continuous high levels of self-reported symptoms and distress, but that there was a slight trend toward improvement, especially with regard to pain (28); that study, however, may not reflect some recent changes in treatment. It has become clear that exercise (low impact aerobic and strengthening) can have significant beneficial effects (16). One patient interviewed in Briones-Vosmediano et al (11) complained about gymnasiums being expensive, but exercise can be pursued outside of a gymnasium. Cognitive behavioural therapy is also effective, although access to it may not be readily available. There is an increasing number of pharmacological agents, such as tricyclic antidepressants, certain serotonin and norepinephrine reuptake inhibitors, gamma-aminobutyric acid analogues, anti-epileptic agents (gabapentin and pregabalin) and analgesics such as tramadol, that have shown statistically significant efficacy in clinical trials, although, admittedly, such efficacy has only a modest effect size (16,29). The various pharmacological agents and the various nonpharmacological interventions have been studied in isolation. However, it has been reported that the efficacy of monotherapy is limited, and that many patients require a combination of treatments (30); in practice, nonpharmacological interventions are often used with pharmacological interventions.

Fibromyalgia has been, and continues to be, a challenging problem. If family physicians are to be the primary diagnosticians and care providers, then it is important that they be well educated in the pathogenesis and diagnosis of fibromyalgia. Clearly, rheumatologists are becoming less willing to be the main caregivers, but if they do not want to retain ownership of fibromyalgia, they must participate actively and extensively in the educational efforts necessary to transfer its care to family physicians. It has been suggested that special multidisciplinary clinics be established to treat patients with fibromyalgia. Such clinics would be useful, but their objectives should be mainly those of performing research, assessing and assisting with difficult cases and participating in effective educational programs for both patients and health care professionals. It is unrealistic to believe that such clinics could be responsible for the care of the great majority of the fibromyalgia population.

Progress in fibromyalgia has been painfully slow, but there has been and there continues to be progress. We may sympathize with those who curse the darkness, but we must keep in mind that lighting more candles is a much better strategy.

DISCLOSURES: Dr Harth has received a stipend from Pfizer Canada for acting as regional director for the Patient Partners program at the University of Western Ontario, London, Ontario, and is on the Medical Advisory Board for Pfizer Canada for Lyrica.
