

FIBROMYALGIA what it is and how it differs from ME

INTRODUCTION

Fibromyalgia (FM) is the name given to a fairly common condition that causes widespread pain and tenderness in the muscles (-my = muscle; -algia = pain), fibrous tissues (= tendons and ligaments) and sometimes the joints.

It commonly causes fatigue, sleep disturbance and a number of other symptoms that can also occur in ME/CFS – so it is sometimes referred to as a fibromyalgia syndrome.

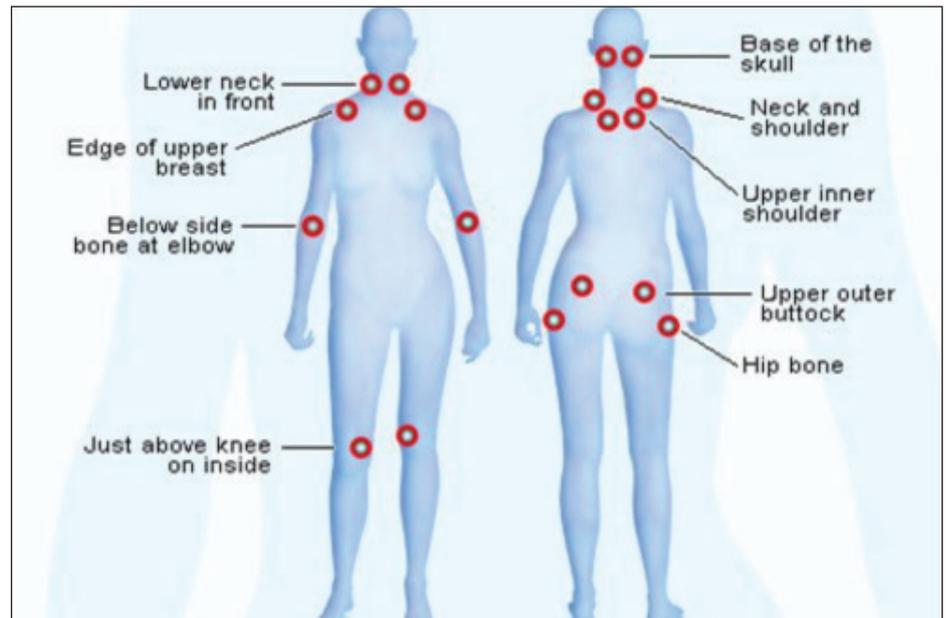
As with ME/CFS, there is no diagnostic test and no curative treatment. So management is largely based on the use of drugs to help with symptoms such as pain and activity management programmes.

FM is thought to affect about 4% of the population at some stage in their life.

As with ME/CFS, it is far more common in women than men (approx. 7:1 ratio). FM can affect more than one family member but no genetic links have been identified.

The first symptoms tend to occur between the ages of 25 and 55. FM is uncommon in children and adolescents.

The onset is often linked to some form of physical or mental stress such as an infection or injury; childbirth, surgical operation or bereavement. In other cases there is no obvious triggering event.



Diagnostic guidelines produced by the American College of Rheumatology have identified 18 specific sites around the body (nine on each side) where tenderness in fibromyalgia is likely to be found.

WHAT CAUSES FM?

Research into FM suggests that the problem lies in the nervous system and not in the muscles, fibrous tissues, or joints – even though this is where the pain is mainly felt. There are no pathological abnormalities in the joints so FM is not a degenerative joint disease like rheumatoid arthritis.

As with ME/CFS, there appear to be changes in the levels and activity of what are called neurotransmitters – the chemical messengers that help to transport messages between brain cells and between brain cells and nerves.

People with FM have an increased level of a specific brain chemical called

Substance P in the cerebrospinal fluid, the fluid that surrounds the brain and spinal cord.

Abnormalities in the hypothalamic-pituitary-adrenal axis, mitochondrial function and poor perfusion of the tissues have also been reported – as in ME/CFS.

As to how this causes pain in the muscles, fibrous tissues and joints – when normally there is no evidence of obvious damage to these parts of the body - the current theory is that people with FM develop an oversensitivity to pain signals that are entering the brain. This is called central sensitisation.

There is also some interesting but

limited evidence from neuroimaging studies (= brain scans) of structural and behavioural abnormalities in the brain.

WHAT ARE THE SYMPTOMS?

The main diagnostic symptom is pain, which can occur in any part of the body. Pain in the neck and back can be particularly disabling.

Pain is often more prominent in the morning and can be described as burning, throbbing, shooting or stabbing.

FM pain is commonly exacerbated by physical exertion, cold weather, stress and activity. Areas that are painful are often tender to touch.

Stiffness can also accompany the pain and may be more prominent in the morning after sleep.

Other symptoms that occur in FM include:

- **Fatigue:** This is very common and may be more disabling than the pain
- **Sleep disturbance and unrefreshing sleep:** People with FM often report feeling worse in the morning. This can be accompanied by what is called a restless legs syndrome – where there are unpleasant creeping or crawling sensations in the legs, often worse at night.
- **Cognitive dysfunction:** Problems with short-term memory, concentration and attention span (aka 'brain fog')
- **Headaches**
- **Irritable bowel symptoms:** Stomach pains, bloating, change in bowel habit
- **Irritable bladder symptoms:** Frequency, urgency
- **Painful periods (dysmenorrhoea)**
- **Sensory disturbances** – e.g. pins and needles sensations in fingers and toes. Some people also feel as though their fingers and toes are swollen.
- **Depression and anxiety**

The symptoms can range from mild to severe. As with ME/CFS, they tend to fluctuate throughout the day and from day to day.

THE OVERLAP WITH ME/CFS

As can be seen, there is a considerable degree of overlap, especially in relation to symptoms, between ME/CFS and FM.

So it's quite possible for someone with exactly the same symptoms to go to a neurologist (who don't tend to see FM patients) and be diagnosed with ME/CFS and be diagnosed with FM by a rheumatologist (who don't tend to see ME/CFS patients but do see plenty of patients with muscle and joint pains).

My personal view is that these two conditions are separate clinical entities with similarities and differences and that it should normally be possible to separate the two.

However, there are people with ME/CFS who have the sort of widespread pain and tenderness seen in FM. So it may be helpful to refer to ME/CFS with a fibromyalgic component in such cases.

DIAGNOSING FM

As with ME/CFS, the diagnosis of FM has to be made on the patient's clinical history. In particular, the widespread pain should involve both sides of the body, be above and below the waist, as well as neck, back and pelvic area. Symptoms should have been present for three or more months.

Any 'red flag' or uncharacteristic symptoms – e.g. bone pain, weight loss – should prompt further investigations to rule out other explanations for the symptoms.

There is no diagnostic blood test for FM – so investigations are arranged to make sure other conditions that can cause joint and muscle pain (e.g. rheumatoid arthritis, hypothyroidism, vitamin D deficiency) are excluded.

Where there are any indications from the clinical history or family history (e.g. a family member has rheumatoid arthritis) that the joint pain component

could be due to an actual joint disease, an autoimmune screen is advisable.

This is to check for the presence of various antibodies and autoantibodies – e.g. anti-nuclear antibodies (ANA), anti-extractable nuclear antigen (ENA), rheumatoid factor, anti-cyclic citrullinated peptide (anti-CCP) – that are indicative or diagnostic of an inflammatory joint disease.

Unlike ME/CFS, finding what are called tender spots in characteristic sites on physical examination is very important in relation to making a firm diagnosis. This is done by the doctor pressing firmly with the thumb on specific sites, where pressure can cause a significant exacerbation of pain.

Diagnostic guidelines produced by the American College of Rheumatology have identified 18 specific sites around the body (nine on each side) where tenderness is likely to be found – see diagram on page 1.

Diagnosis is highly likely where there are 11 or more tender points. The skin, joints and muscles should also be checked for any signs of underlying inflammation.

HOW IS FM TREATED?

Management tends to concentrate on activity programmes and the use of drugs to reduce pain.

Activity management

The emphasis here tends to be on a gradual but progressive increase in activity levels. This is very similar to the type of graded exercise therapy that causes so much controversy in ME/CFS and which many people with ME/CFS find makes their condition worse.

People with FM are often therefore recommended to carry out aerobic (oxygen requiring) exercise such as walking on a treadmill, using an exercise bicycle, or swimming - but not to the point where this exacerbates the pain. Stretching exercises and yoga may also be recommended.

Heated pool treatment (balneotherapy)

A programme that involves 20 minutes bathing in a warm pool on a regular basis five days per week for three weeks has been reported to be helpful in a clinical trial. This will obviously depend on whether a GP or physiotherapist has access to a suitable local heated hydrotherapy pool.

Cognitive behavior therapy (CBT)

As with ME/CFS, CBT may be recommended. In relation to FM, CBT aims to deal with the here and now and how thoughts and behaviours are affecting symptoms.

Painkillers

Over the counter painkillers such as aspirin, paracetamol and ibuprofen (Brufen) tend to be of limited value in treating FM pain – as also happens with ME/CFS.

If these drugs do not help, prescription-only painkillers such as a low dose of amitriptyline (e.g. 10mg at night) or tramadol may be worth trying. Pregabalin and gabapention can also be helpful for more severe pain in

FM. Strong opiate/morphine painkillers are not normally recommended. Although sleep is often disturbed and is unrefreshing, sleeping tablets are not normally prescribed.

Antidepressants

The use of an antidepressant drug known as an SSRI (selective serotonin uptake reinhibitor) is another treatment option that can be considered.

Alternative and Complementary treatments (ACMs)

There is very little evidence to show that ACMs such as aromatherapy are effective. However, some people find them helpful to reduce stress and cope better with their illness.

WHAT IS THE OUTCOME/ PROGNOSIS?

Outcome is very variable and not easy to predict. In some cases the symptoms

ease off and gradually disappear over a period of months or years. However, as with ME/CFS, this condition often turns into a chronic illness which varies in severity over a long period of time. FM does not affect life expectancy,

FURTHER SUPPORT AND INFORMATION

Fibromyalgia Action UK is a charity that offers information and support to people with fibromyalgia.

If you have any questions about fibromyalgia, you can call the charity's helpline on 0300 999 3333. The charity also has a network of local support groups you may find helpful and an online community, where you can find out about news, events and ongoing research into the condition.

Another support group you may find useful is **UK Fibromyalgia**.

Medical information contained in this leaflet is not intended to be a substitute for medical advice or treatment from your doctor. The ME Association recommends that you always consult your doctor or healthcare professional about any specific problem. We also recommend that any medical information provided by The MEA is, where appropriate, shown to and discussed with your doctor.



Our quarterly **ME Essential** magazine.

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