

PAIN 2745

**'Fibromyalgia' — "What have we created?"
(Wolfe 1993)**

'Fibromyalgia' has recently become a popular diagnosis and many doctors now apply the American College of Rheumatology (ACR) 1990 criteria for the classification of fibromyalgia (Wolfe et al 1990). Regrettably this has brought hopeless despair to countless individuals. I have witnessed many patients who suffer from chronic musculoskeletal pain designated and treated as 'fibromyalgia'. However when their pain failed to respond to popular fibromyalgia treatment (such as tricyclic medications) they were abruptly abandoned as the condition is commonly viewed as a life-time disorder even worthy of life-long compensation (Wolfe 1993).

The ACR criteria have been promoted as highly sensitive and specific, but for what condition? Far from being a distinctive syndrome fibromyalgia merely describes the most extreme and extensive of the mundane aches pains and tender muscles that we all have in various degrees at one time or other. For example, mildly tender points are not unusual in asymptomatic individuals especially after strenuous physical activity and moderately tender points are not exceptional in those who have a history of a 'vulnerable' spine (Gunn and Milbrandt 1976 1978). These subjects although asymptomatic characteristically have minor degenerative changes visible on roentgenograms (Gunn and Milbrandt 1976)

Tender sites are almost consistently found in muscle at motor points or at muscle-tendon junctions (Gunn and Milbrandt 1976; Gunn 1989). (One ACR designated location is in a pad of fat although fatty tissue is not well endowed with pressure receptors). Patients with myofascial pain invariably have multiple tender points (Gunn and Milbrandt, 1978; Rosomoff et al. 1989) and even in localised conditions, such as lateral epicondylitis, examination will reveal numerous tender sites scattered throughout the body in a myotomal disposition (Gunn and Milbrandt 1976, 1978)—to practiced fingers, the number of tender sites in a fibromyalgic patient can be many times the stipulated number.

Many physicians who treat musculoskeletal pain disregard the term 'fibromyalgia' or 'fibrositis' preferring to use 'myofascial' pain and identifying the specific muscles and spinal level(s) that are involved. At a recent symposium on fibromyalgia (Physical Medicine Research Foundation, 1994) it was allowed that fibromyalgia cannot be distinguished from myofascial pain (and the putative association with sleep

disturbance not proven).

Patients with widespread myofascial pain should unflinchingly be given a competent and comprehensive examination of the musculoskeletal system (Gunn and Milbrandt 1976, 1978; Gunn 1989, 1990). This examination must include careful palpation of individual muscles for tenderness, increased tone and muscle shortening (eg taut muscle bands, enthesopathic tendons, restricted joint range) The examination is never complete without the evaluation of deep muscles especially the intrinsic muscles of the back (eg the semispinalis and multifidus muscles). These muscles, generally beyond the reach of a probing finger, can only be explored by using a dry-needling technique (Gunn and Milbrandt, 1980; Gunn and Sola, 1989).

Fibromyalgia has not been shown to be caused by ongoing nociception or inflammation, and psychologic factors have been ruled out. Its many features (such as widespread aching point tenderness, skin fold tenderness, articular pain, swelling of the hands or knees, numbness or coldness of the extremities, reticular skin discoloration, irritable bowel and trophedema) suggest a functional and/or structural alteration in the peripheral nervous system (Gunn 1980, 1989; Thomas 1984; Fields 1987; Chu-Andrews 1992). For instance, tenderness is usually escorted by other manifestations of radiculopathy (Gunn and Milbrandt 1978; Thomas 1984) and the most significant of these is muscle shortening (Gunn 1990). Shortened muscles are diffusely present in axial as well as in limb musculature; although they can produce muscle ache and pain by compressing intramuscular nociceptors, they can also produce pain by pulling upon tendons and ligaments. However, most significantly, shortening of paraspinal muscles can compress the intervertebral disc and irritate the nerve root to create a vicious circle that can perpetuate the problem.

It is naive and unkind to condemn a patient solely because of a few tender points. A patient with chronic musculoskeletal pain deserves a complete and competent physical examination. Whenever a physical examination is inconclusive, needle exploration of deeper muscles must be resorted to, because an unwarranted diagnosis that is based only on tender points can grievously delay or deter appropriate treatment. It is worth retelling that effective treatment for myofascial pain is available; patients with myofascial pain improve significantly when painful and shortened muscle bands are released by the dry-needle technique of Intramuscular Stimulation (IMS) (Gunn and Milbrandt 1980; Gunn 1989).

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