



Revista Colombiana de REUMATOLOGÍA

www.elsevier.es/rcreuma



Editorial

Fibromyalgia, a call for multidisciplinary management[☆]



Fibromialgia, una llamada al manejo multidisciplinario

Unlike what happens with other medical specialties, pain is the main reason for consultation in rheumatology. Rheumatoid arthritis, gout, spondyloarthritis and osteoarthritis, are nosological entities in which pain is the central axis of the symptoms reported by the patient, with individual characteristics that allow the rheumatologist to do the exercise of differential diagnosis, but among all the entities that cause osteomuscular pain, fibromyalgia stands out for being one of the most complex in its diagnostic approach. Fibromyalgia is a chronic disease characterized by the presence of widespread and persistent musculoskeletal pain, associated with a diverse range of symptoms that can, in conjunction with the pain, alter the quality of life of the patients who suffer from this disorder.¹ It is estimated that fibromyalgia affects 0.5–5% of the general population, with a clear predominance of involvement in women (female:male ratio of 11:1), and it can appear in any age group, with a higher prevalence between 40 and 49 years.² It is estimated that patients with fibromyalgia account for 10–25% of the rheumatologic consultation and between 2% and 6% of the general practice consultation.³ The diagnosis implies to rule out, in the first instance, other entities that cause osteomuscular pain, representing a challenge for the clinician, since these patients have usually consulted on average 5 different physicians before reaching the rheumatologist,⁴ with a clinical picture that goes beyond the high-intensity diffuse osteomuscular pain and is also accompanied by a wide range of symptoms including sleep disorders, cognitive alterations, neurovegetative symptoms, and anxiety, among others, and may be associated in some cases with other entities such as irritable bowel syndrome, depression and migraine.⁵ The complexity of fibromyalgia is easy to understand when evaluating the evolution of the criteria for classification over 20 years, passing from a few initial

criteria in 1990, which included the presence of generalized pain for at least three months associated with pain of at least 11 out of 18 trigger points,⁶ to reach in 2010 much more complex classification criteria that seek to integrate the symptoms associated with pain, using a regional pain scale, and also to develop a severity scale that allows to assess the evolution of the patient and his response to treatment through the index of severity of symptoms part one and part two.⁷ This issue of the Colombian Journal of Rheumatology presents an interesting research work carried out in the Principality of Asturias, Spain, in which is evidenced that patients with fibromyalgia show a degree of anxiety and catastrophization in the presence of moderate pain, which becomes severe in some cases; both levels are strongly associated with each other and generate an increase in the consumption of medications. The results shown by the researchers are consistent with what is found in the daily clinical practice and make us return to the key aspect in the treatment of fibromyalgia: the multidisciplinary approach. Being a condition that is characterized by a wide range of symptoms, not only at the onset of the disease but also during its evolution, it should be clear that the rheumatologist is only a part within the comprehensive care scheme for the patient with fibromyalgia. The rheumatologist is a key element at the beginning of the process, establishing a judicious differential diagnosis, since fibromyalgia is a diagnosis by exclusion, even more taking into account the frequent involvement of young women, as it occurs with autoimmune diseases such as rheumatoid arthritis and systemic lupus erythematosus. Once other entities have been ruled out and fibromyalgia has been diagnosed, the physiatrist comes to play a very important role, as stated by the majority of doctors who participated in a study conducted by our research group at the Pontificia Universidad Javeriana, presented in the last

[☆] Please cite this article as: Fernández Ávila DG. Fibromialgia, una llamada al manejo multidisciplinario. Rev Colomb Reumatol. 2016;23:1–2.

Colombian Congress of Rheumatology and that will be published soon in the pages of this Journal,⁸ the specialists in Colombia consider that the medical specialty that should lead the multidisciplinary team in fibromyalgia should be Physical Medicine and Rehabilitation, specialty that not only can provide non-pharmacological treatment, but it also can prescribe drugs for the treatment of the disease. In this order of ideas, the physiatrist is the physician called to lead the multidisciplinary team that provides treatment to the patient with fibromyalgia, with the support of other specialties such as Rheumatology, Neurology, Psychiatry, and Gastroenterology, among others, according to the predominant symptoms in each particular case, but always under the guidelines of a comprehensive treatment that ultimately will benefit the patient and will be reflected in a better control of the disease and improvement in key aspects for the patient such as his well-being, functionality and quality of life.

REFERENCES

1. Fernández-Ávila DG, Arbeláez AM, Mercado B, Valle O. Fibromialgia. In: Daza JS, Iglesias A, editors. *Dolor musculoesquelético*. 1st ed. Bogotá: Editoria Guadalupe SA; 2010. p. 185–98.
2. White KP, Harth KM. Classification, epidemiology and natural history of fibromyalgia. *Curr Pain Headache Rep*. 2001;5:320–9.
3. White KP, Speechley M, Harth M, Nielson W, Speechley M, Teasell R, et al. Fibromyalgia in rheumatology practice: a survey of Canadian rheumatologists. *J Rheumatol*. 1995;22:722–6.
4. Ubago MC, Ruíz I, Bermejo MJ, Olry de Labry A, Plazaola J. Clinical and psychosocial characteristics of subjects with fibromyalgia. Impact of the diagnosis on patients' activities. *Rev Esp Salud Pública*. 2005;79:683–95.
5. Rahman A, Underwood M, Carnes D. Fibromyalgia. *BMJ*. 2014;348:g1224.
6. Wolfe F, Smythe HA, Yunus MB, Bennett RM, Bombardier C, Goldenberg DL, et al. The American College of Rheumatology 1990 Criteria for the Classification of Fibromyalgia: report of the Multicenter Criteria Committee. *Arthritis Rheum*. 1990;33:160–72.
7. Wolfe F, Clauw DJ, Fitzcharles MA, Goldenberg DL, Katz RS, Mease P, et al. The American College of Rheumatology preliminary diagnostic criteria for fibromyalgia and measurement of symptom severity. *Arthritis Care Res*. 2010;62:600–10.
8. Fernández-Ávila DG, Ronderos DM, Ruíz AJ, Gómez C, Gutiérrez JM, Díaz MC. Conceptos y percepciones acerca del diagnóstico y tratamiento de la fibromialgia entre un grupo de médicos especialistas colombianos. *Rev Colomb Reumatol*. 2015;22:31.

Daniel G. Fernández Ávila^{a,b,c}

^a Hospital Universitario San Ignacio, Bogotá, Colombia

^b Facultad de Medicina, Pontificia Universidad Javeriana, Bogotá, Colombia

^c Grupo de Investigación en Enfermedades Crónicas del Adulto, Pontificia Universidad Javeriana – Hospital Universitario San Ignacio, Bogotá, Colombia

E-mail address: daniel.fernandez@javeriana.edu.co

2444-4405/© 2016 Asociación Colombiana de Reumatología.

Published by Elsevier España, S.L.U. All rights reserved.

<http://dx.doi.org/10.1016/j.rcreue.2016.04.005>