

A Brief Note on Fibromyalgia: A Chronic Pain Syndrome

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Description

Fibromyalgia Syndrome (FMS) is a chronic pain disorder with 4 to 7 percent prevalence in the general population, with a net female predominance. The syndrome is diagnosed if two major symptoms are met, according to the 1990 ACR criteria:

- The existence of widespread musculoskeletal pain for at least 3 months
- The presence of at least 11 of 18 specified body regions (9 symmetrical) known as tender points (TeP's), i.e. tenderness for an applied standard pressure of 4 kg-ft. administered either manually or using a pressure algometer.

These criteria were changed in 2010, with preliminary new criteria that no longer took the TeP count into consideration, while including further clinical requirements in addition to the diffuse muscular pain, such as the presence of sleep difficulties, emotional dysfunction, headache, or visceral aches. FMS may, in fact, have a high degree of comorbidity with a variety of other medical disorders, the most common of which is headache, particularly with an increased frequency of episodes or chronicity. Though tension-type headache is the most common form in FMS, migraine is also a common co-occurring condition.

Among fact, a recent large epidemiologic research found a 55.8 % frequency of migraine among fibromyalgia patients, whereas other studies found a 30 percent prevalence of fibromyalgia in migraine patients. Although the pathophysiology of FMS is still unknown, central mechanisms of sensitization, caused by an imbalance of neuromediators involved in nociceptive transmission/control in the Central Nervous System (CNS), are thought to play a critical role in the syndrome in genetically predisposed subjects. Clinical evidence of sensitization is provided by a generalised decrease in pain thresholds to many modalities of stimuli at the somatic level, not only in spontaneous painful locations but also in control,

nonpainful sites, as has been well reported in the condition. High frequency and chronic headache have also been linked to increased pain sensitivity in somatic regions outside the cephalic region, but to a lower extent than fibromyalgia.

These findings have prompted the issue of whether the link between FMS and headache is due to increased central sensitization in one condition exclusively. Clinical observations also show that FMS patients with concurrent headache, particularly migraine, frequently exhibit an aggravation of their characteristic FMS symptomatology during or immediately after a headache episode, implying that headache may be a triggering factor for fibromyalgia pain. Despite the significant degree of co-occurrence between headache and fibromyalgia, no comprehensive research appears to have been undertaken thus far to examine the significance of this co-morbidity not only for the spontaneous FMS symptoms but also for the patients' overall sensory sensitivity.

In the absence of an objective biomarker, FMS is diagnosed primarily on the primary complaint of pain and accompanying symptoms of exhaustion, sleep disruption, cognitive deterioration, and mood disturbances. Previously, diagnosis was mostly based on the presence of widespread pain in at least 11 of 18 "tender points" for at least 3 months. The American College of Rheumatology (ACR) developed preliminary diagnostic criteria for FMS in 2010, emphasizing patient complaints.

The absence of a reliable objective standard of disease activity has been the most difficult diagnostic challenge for FM. Over diagnosis and late diagnosis are issues that must be addressed in the absence of specialized diagnostic tests. Misdiagnosis also results in failed treatment regimens and a significant financial burden on the individual and the system. As a result, the future of FM diagnosis is dependent on the discovery of a reliable biomarker.