

Fibromyalgia: A Mini Review

Teresa Pugliese*, Filippo Familiari, Olimpio Galasso and Giorgio Gasparini

Department of Orthopaedic and Trauma Surgery, "Magna Græcia" University of Catanzaro, Catanzaro, Italy

*Corresponding author: Teresa Pugliese, MD, Department of Orthopaedic and Trauma Surgery, "Magna Græcia" University of Catanzaro, Campus "S.Venuta", V.le Europa (Loc. Germaneto), 88100 Catanzaro, Italy, Tel: +39 0961/3647001, Fax: +39 0961/3647104; E-mail: dott.teresapugliese@libero.it

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Mini Review

Fibromyalgia (FM) is estimated to affect more than 5 million people in the United States of America (2-5% of the adult population) [1,2], making it one of the most common chronic widespread pain disorders [3,4]. Female patients are affected at least 6 times more often than male patients, and the prevalence of FM has been shown to increase with age [5]. Patients often have associated symptoms such as fatigue, nonrestorative sleep, cognitive dysfunction, and mood disorder, which are present to variable degrees in individual patients [6].

Although the pathogenesis of FM has not been totally defined, several authors consider it either a disorder of the pain modulation centre of or an altered central nervous system processing in response to nociceptive stimuli [7-11]. Recent evidence has suggested the contribution of environmental factors acting on genetically predisposed individuals [12]. Moreover, because FM is a chronic painful syndrome, it has a significant negative impact on patients' quality of life [3,13-15]. Chronic widespread pain remains the core symptom of FM, reported as diffuse, fluctuating and with neuropathic features among some patients.

Fatigue, which is tightly connected with sleep disorder, is present in more than 90% of patients with FM, whereas abnormal sleep with prolonged sleep latency, sleep disturbance and fragmented sleep occurs in up to 75% of patients [6,16]. Furthermore, FM is now recognized as a polysymptomatic distress syndrome; it is associated with pain and includes poor working memory, free recall and verbal fluency, spatial memory alterations, mood disorder, including depression and anxiety [17]. Other conditions causing pain can occur concomitantly, including irritable bowel syndrome, migraine and dysmenorrhea [18]. Patients may also experience lower urinary tract symptoms, myofascial pain involving the face and temporomandibular pain [18]. The 1990 American College of Rheumatology (ACR) classification criteria required 3 months or more of widespread pain and pain on palpation of at least 11 of 18 tender point sites. The 1990 ACR criteria have been used to identify patients for clinical trials and to diagnose FM in patients in clinical settings [19].

In 2010, these criteria have been updated to include a widespread pain index and a symptom severity scale and eliminate the tender point examination [20]. Consequently, due to its varied symptomatology and the multifactorial nature of its pathogenesis, treatment of FM requires a multidisciplinary approach and should include non-pharmacological treatment as well as pharmacological interventions [21]. The pharmacological therapy currently recommended for this disease includes antidepressants, calcium-channel modulators, muscle relaxants, and analgesics [22]. However, many patients fail to respond or they have side effects associated with the long-term use of these drugs. Therefore, there is growing interest towards non-pharmacological therapy and alternative and complementary therapy. Several non-pharmacological therapeutic

modalities are used in such patients: physiotherapy, whole body cryotherapy, complementary and alternative medicine, supervised aerobic physical activity and cognitive-behavioral therapy [23,24]. In conclusion, the treatment of this disorder is difficult and cannot be standardized because of the unknown etiology of FM. Furthermore, a multidisciplinary treatment approach including physical and medical therapeutic interventions should be individualized for FM patients based on their symptoms.

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