Fibromyalgia (FMS) is a condition that is thought to affect around 5% of patients in a general medical practice, with women being affected more often than men.

The chief complaint tends to be all-over ache, with other symptoms such as fatigue, morning stiffness, sleep disturbance, tingling and headaches.

FMS was first described in 1904 and when no medical evidence of physical abnormality was found and it was noted that patients were often depressed, it was labelled as a ?psychogenic rheumatism'.

Some of the negative connotations still exist, despite the work of experts such as Yunus.

Nowadays, it is known that FMS patients have, for instance, the same sort of central sensitisation to sensory input that arachnoiditis patients experience, which renders the lightest touch unbearable and heightens perceptions including sight, to an uncomfortable level. (hence intolerance of bright light and loud noise).

It is thought that FMS is linked to abnormal sleep patterns. Of course, in conditions such as arachnoiditis, pain and other symptoms such as muscle cramps often severely impact adversely on sleep.

This may be part of the reason why arachnoiditis patients so often have FMS type symptoms in addition to the many neurological symptoms.

Diagnosis relies on presence of tender points, and requires 11 out of 18 to be elicited during examination.

Note that 70% of patients with FMS meet the CDC criteria for CFS *(Buchwald 1987)* and two thirds of patients with CFS meet the ACR criteria for FMS (
Goldenberg 1990b)
.

FMS and myofascial pain syndrome (MPS), while probably separate entities, often coexist *(Gra nges 1993)*
. It seems unlikely that these patients have three separate disease processes. There is obviously a considerable degree of overlap between these conditions.

Associated signs and symptoms *(Wolfe 1990).*

widespread pain	97.6% of patients
tenderness in > 11/18 tender points	90.1
fatigue	81.4
morning stiffness	77.0
sleep disturbance	74.6
paraesthesias (pins and needles)	62.8
headache	52.8

anxiety	47.8
dysmenorrhea (painful periods)	40.6
sicca symptoms (dry eyes/mouth)	35.8
prior depression	31.5
irritable bowel syndrome	29.6
urinary urgency	26.3
Raynaud's phenomenon	16.7

Other commonly reported symptoms include dizziness, trouble with memory and concentration, rashes, and chronic itching

(unpublished observations).

You will note that these are remarkably similar to the sort of problems arachnoiditis patients experience.

Treatment

Medications effective in the treatment of FMS appear to work mainly through an effect on deep sleep *(Goldenberg 1986)*.

They should be started at the lowest possible dose and increased every few days to a week to maximum relief of daytime FMS symptoms without unacceptable side effects.

These include: trazodone (50mg starting dose); cyclobenzaprine (10-60mg taken an hour before bedtime); alprazolam (0.5-4mg taken half to one hour before bedtime) and diphenhydramine (50-300mg half to one hour before bedtime); amitriptyline (10-150mg taken 2 hours before bedtime).

American expert Dr. Devin Starlanyl, herself a sufferer with FMS, has written extensively about the condition.

She notes that in FMS, exercise can cause problems because of reduced growth hormone secretion, which is important in muscle tissue repair.

She remarks:

"Inappropriate exercise can often make the symptoms much worse."

Furthermore, she states that in MPS (see below),

"repetitive exercise can be destructive."

Dr. Starlanyl maintains that in FMS patients,

"exercise causes a reduction in temperature and cerebral blood flow"

which interferes with the patient's ability to think clearly enough to set reasonable limits; this can be overcome by using a written protocol, a timer and/or exercising in a group or with a friend.

Other measures include gentle daily aerobic exercise(e.g. in water, and best in afternoon/evening) a consistent bed time with adequate amounts of sleep.

Patients who are unaccustomed to exercise are best advised to start out with just 3-5 minutes of exercise every day and gradually increase as tolerated, usually up to 20-30 minutes a day.

Exercise tends to be more beneficial if exercise of the most painful muscles is avoided.

After habitual daily exercise, missing even a day may result in feeling worse for 2-3 days afterward.

Overdoing physical activity may trigger a relapse that can last for several days. It is better to plan to spend a smaller amount of time every day at activities of daily living (such as housework) until they are completed.

Gentle massage and application of heat may also be helpful.