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LONG TERM FOLLOW-UP RESULTS OF FIBROMYALGIA PATIENTS

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ABSTRACT

Aims: Fibromyalgia is a chronic musculoskeletal syndrome of which the main symptoms are chronic widespread pain, debility and fatigue. This is an ailment that is seen 1-2% in general population, mostly in women. Most of the fibromyalgia patients are consulting to health care providers, have examinations made and getting chronic pain treatments. However, there is no sufficient data in the literature concerning long term follow-up of the fibromyalgia patients. Therefore in our study, we aimed to evaluate long term follow-up results of the patients formerly diagnosed as fibromyalgia. For this purpose, we aimed to evaluate our patients' latest status, to diagnose whether any pain to continue, to determine if there is any autoimmune inflammatory disease developing and to assess whether they have taken a treatment or not.

Methods: Seventy four female patients diagnosed fibromyalgia between the years 2003-2008 were taken to our study (Mean of age: 44.5+11.3). In the year of 2015, all of the patients are reached out and questioned about their complaints and treatments. In our study, chi-square test is used in the comparison of the categorical data (Fisher Exact test if necessary) and unpaired t test is used in the comparison of constant variables.

Results: Sixty one of the patients (82.4%) remarked that their widespread pain complaints continued. Only 12 patients (16.2%) remarked that they are under follow-up of a rheumatology or physiotherapy and rehabilitation clinic because of their widespread pain or a rheumatologic disease. The percentage of patients who get treatment regularly because of the widespread pain was found 21.6% (16 patients). During the period of follow-up none of the patients developed any autoimmune inflammatory disease.

Conclusion: In the group which the fibromyalgia complaints continue; scores of numbness, lassitude and somatization were found significantly high. Despite that regular treatment ratio was relatively low and the ratio of follow-through to treatment was higher in the smoker and well educated group.

Keywords: Fibromyalgia, chronic widespread pain, long-term follow-up

INTRODUCTION

Fibromyalgia (FM), is a musculoskeletal syndrome seen with sensitivity and fatigue in muscles that the main symptom is chronic, widespread pain (1,2). Psychiatric studies have shown that FM is in a close relationship with anxiety disorders. However, not all of the FM patients have clearly defined psychiatric diseases (1). Fatigue, headache, sleeping disorders, irritable bowel syndrome and depression can accompany FM. The frequency of FM changes among communities and the overall prevalence is 1-2%. Most of the FM patients are women (89%) (3).

Most of the fibromyalgia patients are consulting to health care providers, have examinations made and getting treatments because of the chronical pain. The major concern of some of the patients is whether they have a rheumatologic inflammatory disease or the possibility of development of a rheumatologic inflammatory disease. However, there is not enough data concerning long term follow-up of the FM patients providing to clarify this problem.

By the criteria of American College of Rheumatology (ACR), 3 conditions should be obtained in order to diagnose a patient;

1) To have similar stringency of the symptoms approximately for 3 months.

2) Not to have any other disease to explain the patient's complaints.

3) To have Widespread Pain Index ≥7 points and Symptom Severity Scale ≥5 points or Widespread Pain Index 3-6 points and Symptom Severity Scale ≥9 points (4).

In this study, we aimed to evaluate the final situation of patients who had received a FM diagnosis, to determine if their sores do continue, if they developed an autoimmune inflammatory disease and to specify whether they got any treatment or not. We also tried to determine which patients still had FM related symptoms by their first diagnosis findings.

MATERIAL AND METHODS

Seventy four patients who were diagnosed with FM between the years of 2003-2008 at Trakya University Department of Rheumatology were taken to this study. FM diagnosis of the patients' were given according to the criteria of ACR 1990. Latest clinical and demographic features and sociodemographic and clinical findings of the first diagnosis were found from the records. Beside marital status, smoking history, education status and psychiatric disease history; dry eyes, dry mouth, migraine, oral symptoms, Reynaud phenomenon and photosensitivity symptoms were enquired from the patients' files. Furthermore, duration of the disease (in years) was determined and severity of pain (in a scale of 100), sleeping disorder (in a scale of 5), waking up tired (in a scale of 5), numbness in the body (in a scale of 5), severity of languor (in a scale of 100) were questioned. Beside these scales, all of the patients answered the Fibromyalgia Impact Questionnaire (FIQ), Duke Depression Scale, Somatization Symptom Scale and LANNS Neuropathic Pain Scale.

Anxiety and depression are the diseases which are undiagnosed in the first step. Duke Depression Scale aims to pre-diagnose the diseases with 7 questions in the first step (5).

Classifying the pain and distinguishing it from the other pain models are necessary in order to determine the right treatment. LANSS pain scale was firstly used clinically for this purpose by Bennett to distinguish neuropathic pain from nociceptive pain. The advantage of this scale is ease in evaluation and shortness in application time (6).

Fibromyalgia Impact Questionnaire score is developed to evaluate the current status of female fibromyalgia patients and it is formed from questions which the patient can answer herself about physical function, working status, depression, anxiety, sleep patterns, pain, morning stiffness, fatigue and well being (7).

Somatization symptom scale provides a measure how the patient feels. It queries if are there any stomach or intestine problems; backache; arm, leg and joint pain; headache; chest pain or short of breath; dizziness; fatigue; sleeping disorders (8).

The patients who have been taken to evaluation were checked out if they were attending their polyclinic controls. Patients who did not attend were called by phone. The patients were asked if they had any widespread pain, if they had any rheumatologic disease and whether they take any treatment or not. The patients who had inflammatory rheumatologic disease findings and who had taken any kind of treatment were called in and they were evaluated by a diagnostic angle.

In this study, Chi-square test was used to compare categorical data (Fisher exact test if necessary) and unpaired t test was used in the comparison of the constant variables. P-value <0,05 was considered significant.

RESULTS

Seventy four patients who had FM diagnosis between the years of 2003-2008 at Trakya University Department of Rheumatology were taken to this study (74 women, mean of age: 44.5±11.3). The general demographic features of the patients can be seen in Table 1.

Table 1: Demographic features of the patients

	Number of patients (%)
N	74 (100%)
Smokers	19 (26%)
Marritial status: Married	63 (85%)
Minimum 9 Years of Education	23 (31%)
Dry Eyes	22 (30%)
Dry Mouth	22 (30%)
Migraine	10 (14%)
Oral Symptoms	22 (30%)
Raynaud Phenomenon	15 (20%)
Psychiatric Treatment History	31 (42%)

In the year of 2016, the patients' symptoms were questioned again after they have had FM diagnosis (7-12 years). Sixty one (82.4%) of the patients pointed out that they had widespread pain. Only 12 (16.2%) patients pointed out that they were under watch of a rheumatologist or physiotherapist because of a widespread pain or a rheumatologic disease. The ratio of the patients who got regular treatment because of widespread pain was found to be 21.6%. There were no patients who had inflammatory rheumatologic disease.

Table 2: The comparison between the patients who still have FM related pain and who does not

	The patients who still have FM related pain		The patients who does not have FM related pain		P
	Number of Patients (n)		Number of Patients (n)		
Age	60	42.2±15.6	11	40.9±9.3	>0,05
Pain Duration (in Years)	55	6.36±5.94	9	3.22±3.39	>0,05
Severity of the Pain	57	64.45±19.26	11	58±22.22	>0,05
Sleeping Disorders	58	2.67±1.53	13	2.3±1.7	>0,05
Waking up Exhausted	58	3.98±5.47	13	2.15±1.28	>0,05
Numbness in body	57	2.67±1.44	13	1.38±1.45	p=0,005
Fatigue	58	3.4±1.83	13	2.3±1.32	>0,05
Severity of the Fatigue	54	61.63±26.82	11	46.81±24.73	p=0,004
Total FIQ Score	53	9.55±6.03	12	7.5±6.27	>0,05
Duke Score	37	7.43±3.18	7	5.71±2.93	>0,05
Total Somatization	31	3.32±1.74	8	1.37±1.06	p=0,004
Lans Score	32	3.90±2.97	6	4.16±6.01	>0,05

When the patients who have widespread pain are compared with the ones who do not, numbness in the body after first diagnosis, severity of fatigue and total somatization scores were found significantly higher in the first group (p<0.05).

Thus; the patients who have numbness, fatigue and a high somatization score also still have FM widespread pain (Table 2).

Table 3: Comparison of the patients who still take drugs and the ones who don't after follow-up results

	Who Continue Taking Drugs		Who do not Continue taking drugs		P
	Number of Patients (n)		Number of Patients (n)		
Age	16	43.5±11.24	55	44.84±11.43	>0.05
Pain Duration (As in Years)	16	9.07±8.5	48	4.87±4.07	p=0.01
Severity of the Pain	16	70.81±18.85	52	61.13±19.63	>0.05
Sleeping Disorders	16	2.38±1.31	55	2.67±1.63	>0.05
Waking up Exhausted	16	3.06±1.24	55	3.81±5.66	>0.05
Numbness in Body	15	3.06±1.03	55	2.25±1.59	p=0.023
Fatigue	16	3.31±1.2	55	3.16±1.03	>0.05
Severity of the Fatigue	15	63.33±25.04	50	57.86±27.52	>0.05
Total FIQ Score	15	9.2±6.37	50	9.16±6.06	>0.05
Duke Score	11	8.18±3.28	33	6.82±3.12	>0.05
Total Somatization	8	4.38±1.6	31	2.55±1.67	p=0.008
Lans Score	8	4.13±2.23	30	3.9±3.8	>0.05
Minimum 9 Years of Education	%38.2		%12.5		p=0.05
Smoking	%31.5		%10		p=0.05

After a re-query, it was seen that only 16 of the patients were continuing to take their drug treatment. After comparing these two groups; the first group had longer pain durations, higher scores of numbness in body and significantly higher somatization scores (p<0.05). Furthermore, consumption of cigarettes was higher and educational status was better than the second group (Table 3).

DISCUSSION

We did not find any case of inflammatory rheumatologic diseases in FM patients which we have queried a long time. In addition, remarkably, FM symptoms like pain or fatigue continued in the most of the patients. As well as there are no studies who queries symptoms of FM cases in such time, the general impression is that these patients will continue to have complaints relevant to FM.

A small portion of the patients were continuing their medicaments and polyclinic follow-ups despite most of the patients had complaints. This situation is a sign of patients' clear divergence to drugs and treatment. Still having pain and low response rates to the treatment is an important factor which creates this result.

After comparing the group which had symptoms like pain with the other group; it was found that the group which had symptoms like pain had significantly higher symptom scores of fatigue and numbness in body. Moreover, somatization score was higher in this group. Eventually, we can foresee that; whoever have this kind of personality structure would possibly have disease findings.

Consumption of cigarettes was higher and educational status was better in the group which the patients get a drug treatment. This points out the sociocultural factors between the educational status and drug use. Besides that, numbness and somatization scores were higher in the group which continued to the treatment.

As a conclusion, we have determined that most of the FM patients had continuing symptoms at the long term follow-up and it was higher in the group which the somatization symptoms were evident. Despite of having continuing symptoms we have observed that long term drug use and regular medical control follow-up was insufficient and there is an incompliance. Furthermore, we determined that development of an inflammatory rheumatologic disease would be highly exceptional in this kind of patients.

Ethics Committee Approval: This study was approved by Scientific Researches Ethics Committee of Trakya University Medical Faculty.

Informed Consent: Written informed consent was obtained from the participants of this study.

Conflict of Interest: The authors declared no conflict of interest.

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