FIBROMYALGIA SYNDROME

***F**ibromyalgia* has proven to be rather a mystery for the medical and paramedical fields to come to grips with. It is often misdiagnosed and generally misunderstood from the point of view of causality, etiology and therapeutic resolution.

The median age for onset of *fibromyalgia* is 34 to 53 years, and it is far more likely to afflict women than men at a ratio of 9:1. The *Fibromyalgia Syndrome* is commonly defined as a chronic pain disorder of unknown etiology, characterized by widespread musculoskeletal aches and pains, stiffness, and general fatigue. Additional symptoms may include weakness, excessive fatigue, nonrestorative sleep with morning fatigue, chronic tension and migraine headaches, bowel and bladder irritability, dysmenorrhea, paresthesia, chest pains, generalized anxiety, depression, swelling and numbness of the extremities, mitral valve prolapse, tachycardia, hyper mobility syndrome, confusion, lack of concentration, short term memory loss, vertigo, tinnitus, tendonitis, bursitis, reticular skin discoloration (skin mottling), temporomandibular joint dysfunction, sciatica, swelling of articular and periarticular tissue, dry skin, dry eyes, and dry mouth. However, these same symptoms may also characterize the myofascial pain syndrome, chronic fatigue syndrome, polymyalgia, polymyositis, hypothyroidism, rheumatoid arthritis, or systemic lupus erythematous. Because of the medical confusion involved, objective medical diagnosis is appears to be quite difficult. As a result this condition is often referred to as *nonarthritical or psychogenic rheumatism*.

In 1990, the American College of Rheumatology declared that *fibromyalgia* can be differentially diagnosed based on a history of widespread pain occurring for longer than three months. The pain involved arising from at least 11 out of 18 specified, bilateral ***tender points*** in muscular tissue distributed throughout the neck, shoulders, upper chest wall, and lower back. A tender point is described as "a discrete area tissue, tender to the touch (to varying degrees), and without the characteristic referred pain pattern characterizing the ***trigger point"***. To establish its existence, a suspected tender point area and its contralateral counterpart should be palpated using the thumb or first two fingers to apply steady uniform pressure firmly enough to blanch the examiner's thumbnail. The examiner should apply increasing pressure until the patient reacts to the pain. The site should form an erythemic response from the probed skin. One hesitates to be overly critical, but basing a diagnosis on this rather subjective technique seems to be rather foolish.

It is known that depression and sleeplessness are almost hallmarks of *fibromyalgia.* Both of these conditions can be caused or exacerbated by decreased levels of serotonin in the blood, and a drop in serotonin levels in the blood is one of the few biochemical changes specifically noted to be present in those suffering from *fibromyalgia.* Consequently, a better choice as a test for *fibromyalgia* would seem to be a blood test for a severe drop in serotonin levels. To date, no standardized test for the measurement of serotonin levels in the blood, relative to *fibromyalgia,* has been officially recognized, but it is only a matter of time. In the meantime, pragmatic assessment and evaluation will have to do (for an in-depth overview of *fibromyalgia* the best reference is an article written by Susan Krsnich-Shriwise, *Fibromyalgia Syndrome: An Overview*).

Clinical observation and experience has demonstrated *fibromyalgia* to start when the patient has a fairly high level of physical stress almost simultaneously with a high stress psychological event (a car accident coupled with a job loss, for example). In fact, causality seems to mirror the conditions that seem to trigger an episode of *shingles.* The result seems to be depression, sleeplessness, and a pain syndrome that does not respond normally to ordinarily effective physical therapy treatment techniques. Early on, it was demonstrated that the patient's overall "well-being" was improved with the administration of an effective anti-depressant, as was the response to standard physical therapy techniques. It was even thought the condition would prove untreatable without an anti-depressant and that *no treatment* would ultimately be successful.

Fibromyalgia did prove to be treatable, however, even without an anti-depressant, when it was discovered that ***fibromyalgia*** **sufferers have the odd distinction of producing adhesions before they produce the inflammation process** (the opposite of what is normally seen). In fact, it was the search for a means of inhibiting the formation of adhesions that led us to a successful treatment for *fibromyalgia*.

A DSR survey should be performed in any areas the patient identifies as being painful to identify any inflamed zones.

Treatment

Treatment is centered on establishing the presence of any overt inflammation, the presence of any adhesions that may have formed (with or without inflammation), the elimination of both inflammation and adhesions, and the inhibition of the production of spontaneously occurring adhesion formations.

Application:

- Having identified zones of inflammation preset an ultrasound unit to deliver a 1 MHz pulsed waveform, at 1.8 W/cm². Ultrasound the zones, utilizing an effective anti-inflammatory as the coupling agent. Ultrasound for six minutes (fibromyalgic patients only seem to positively respond to ultrasound applied at 1.8 W/cm²).

- Manipulate the soft tissues in and around the inflamed zones. Also manipulate in any areas that the patient can identify as being painful to establish the presence of adhesions and to eliminate them. This includes the tissues in and around any trigger points that might be responsible for producing the patient's pain.

- Preset an electrical stimulation unit to deliver a 7 Hz, wide-pulsed galvanic current. Place negative electrodes over areas having held the greatest concentration of adhesions, and positive electrodes over less involved areas. Stimulate for 20 minutes at an amplitude level strong enough to produce visible rhythmic contractions. This technique has proven to be the key to the treatment of *fibromyalgia.* If performed consistently enough (once or twice a week for several weeks), it may throw the condition into remission.

A general decrease in pain levels should occur in just a few sessions, but prolonged relief may occur only after a considerable number of sessions, combined with the ability of the patient to avoid physical trauma and to eliminate any identified sources of extreme stress.

Post Treatment Suggestions:

The patient should be advised to decrease high-level emotional stress and to curtail alcohol consumption, at all costs. This is difficult since depressed individuals generally tend to either seek emotional stress or to resort to central nervous system depressants to dampen the perception of hopelessness.

The patient should also be advised that carbohydrates enhance the production of serotonin naturally, when they are not taken with a protein, and that although processed sugar also increases serotonin, the insulin reaction to it may result in a rebound deepening of depression.