
Fibromyalgia – a challenge for health care systems or: Don't leave the physician out in the cold

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Background

The health care system within a socio-political system is one of its mainstays and is as important as the education system or the economic system. Moreover, The sub-systems interact and need to be balanced, and this balance, in turn, is one of the indispensable stabilising factors for the whole system.

If there is agreement on the basic rule, that no sub-system suffers loss of function due to excessive use of system resources by another sub-system, then balance is guaranteed. The overall efficiency of the system should increase and the sub-systems should benefit from the total profit. In this context, a political society reacts most sensitively if costs are produced somewhere in the system and the impression predominates that these costs are not conducive to the efficacy of the whole system but, on the contrary, may be lost.

Within health care systems which are already failing economically, diseases in particular become a target which burden our understanding and empathy by not presenting with a clear definition, but with a much greater complexity than suggested by the still favoured model of disease as a simple cause and effect relationship.

Fibromyalgia

Against this background, for more than twenty years, we have had to deal with fibromyalgia as a disease, for which an ICD code exists, and to which one of the largest worldwide scientific societies has dedicated classification criteria (1, 2), but which we struggle to achieve recognition and acceptance for. Why is this?

First of all, the lack of ability to objectify the main symptom pain, at least on the level of daily clinical use, presents a simple explanation. Moreover, fre-

quent comorbidities such as unrefreshing sleep, fatigue and tiredness, depression, irritable bowel syndrome, cognitive dysfunction, and others cannot be objectified. Attempts to define the respective causes of these comorbidities end up with mainly disappointing results. However, this is also true for many other diseases, supposedly better defined, but, in fact, without any known single and exclusive cause. As it is true for fibromyalgia, we know about plausible models of pathophysiology for the conditions just mentioned. These models may explain pain to a certain degree and may even support the understanding of some of the comorbidities, but they do not automatically improve diagnostic capabilities and tools. The inability to objectify pain is often experienced as a special deficiency. But, again, we ignore our approach to other diseases, which we have learned to accept as “entities”, without a single objective finding, but for which we need a “construct” of criteria to make the diagnosis. And it is worth thinking about history of diseases: We must remember that some physicians once considered rheumatoid arthritis as one of the classic psychosomatic conditions (3).

The fibromyalgia patient and the physician

The lack of an objective pain parameter burdens the patient-physician relationship. Many patients do not understand, why such an objectification cannot be achieved. The patients' desire for explanation and reasons corresponds with the physician's predilection, preferring a talk about findings, which can be presented to patients and their families as facts. This procedure saves time and does not need a great deal of explanation. The system is inclined to reward rapid approaches and punish time con-

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suming and detailed statements about the disease and its treatment.

Another problem remarkably burdens the therapeutic relationship: in contrast with the US, where three compounds have now been approved for the treatment of fibromyalgia, the European physician has to practice off-label use if she/he wants to treat fibromyalgia patients in the best possible way, in accordance with the most recent data from clinical trials.

Epidemiology and costs

Meanwhile, fibromyalgia has to be considered one of the most common rheumatic diseases. Unfortunately, comparable data from different countries is not available. The most recent data from the US describes fibromyalgia as being the third most prevalent rheumatic disease, after low back pain and osteoarthritis, ahead of all inflammatory autoimmune rheumatic diseases (4). Finally, and almost inevitably, we have reached the problem of costs. There are no comparable cost analyses from different countries, however, two facts can be emphasised:

Fibromyalgia patients, even on a primary care level, obviously produce significantly more costs for the social system, compared with other patient-users of primary care support. A Spanish survey calculated incremental costs of approximately 5,000 euros per fibromyalgia patient per year, of which approximately 600 euros were only direct costs (5, 6).

In some analyses, fibromyalgia is still considered to be one among several so-called “medically unexplained illnesses” such as chronic back pain, irritable bowel syndrome, chronic fatigue syndrome. Compared with these conditions it can be concluded that fibromyalgia does not produce incremental costs, despite the small amount of data from one study (7).

Treating and reducing costs

A multimodal approach is essential, but pharmacological treatment seems to be a *conditio sine qua non* for most of the patients.

With all this data in mind, it does not make any sense at all, and is even counterproductive and unethical, to ignore the disease, which diminishes patients' quality of life, and to leave the physician, who is willing to treat such patients, out in the cold. Presumably, treating these patients will decrease costs for the social system remarkably. Chronic pain and its comorbidities in fibromyalgia patients are facts. Of course, we have to discuss definition, diagnostic criteria and data from clinical trials on a scientific level, and we must continue our research. But, at the same time, we have to try to treat the patients according to the best of our knowledge. To this end, we have the means necessary to do it, yet we still need – in terms of drug approval, among others – acceptance and authorisation.

References

1. WOLFE F, SMYTHE HA, YUNUS MB *et al.*: The American College of Rheumatology 1990 Criteria for the Classification of Fibromyalgia. Report of the Multicenter Criteria Committee. *Arthritis Rheum* 1990; 33: 160-72.
2. WOLFE F, CLAUW DJ, FITZCHARLES MA *et al.*: The American College of Rheumatology preliminary diagnostic criteria for fibromyalgia and measurement of symptom severity. *Arthritis Care Res* (Hoboken) 2010; 62: 600-10.
3. VON UEXKÜLL T: *Lehrbuch der Psychosomatischen Medizin*. 1st ed. München, Wien, Baltimore: Urban und Schwarzenberg; 1979.
4. LAWRENCE RC, FELSON DT, HELMICK CG *et al.*: Estimates of the prevalence of arthritis and other rheumatic conditions in the United States. Part II. *Arthritis Rheum* 2008; 58: 26-35.
5. SICRAS-MAINAR A, REJAS J, NAVARRO R *et al.*: Treating patients with fibromyalgia in primary care settings under routine medical practice: a claim database cost and burden of illness study. *Arthritis Res Ther* 2009; 11: R54.
6. SPAETH M: Epidemiology, costs, and the economic burden of fibromyalgia. *Arthritis Res Ther* 2009; 11: 117.
7. CHANDLER HK, CICCONE D, MACBRIDE RJ, NATELSON B: Medically unexplained illness in short- and long-term disability applicants: prevalence and cost of salary reimbursement. *Disabil Rehabil* 2008; 30: 1185-91.