

Treatment: Is Your Plan Well-Rounded?

There is no “cookbook” way to treat a person with fibromyalgia (FM).

First, other “hidden” disorders need to be identified and treated. Then sleep needs to be targeted. Pain specialist **Steve Fanto, M.D.**, of Scottsdale, AZ, says, “The key is to be flexible when managing a patient with FM. Doctors can’t have one or two drugs in their bag of tricks, because they will probably fail with their treatment of FM patients.”

Reducing Pain

Lucinda Bateman, M.D., of Salt Lake City, UT, likes to approach different symptoms and treat them individually. Arthritis, headaches, bursitis, and irritable bowel are a few examples that can make your FM pain worse. Each one deserves its own specific treatment approach, she says (July 2009 *Fibromyalgia Network Journal*).

Once you have your aggravating pain conditions under better control, the generalized achiness of FM needs to be addressed. Bateman prefers anti-epileptic drugs thought to work by intercepting the pain signals going to your brain. Examples include Neurontin, Lyrica, Topamax, and Zonegran—but dosing up needs to be done carefully to minimize side effects.

Targeting the Muscles

Do you wonder why you are so tender to the touch? You are not alone, because 90 percent of your tender points are actually trigger points. Research by **Hong-You Ge, M.D., Ph.D.**, of Den-

mark (January 2010 *Journal*) explains how those tight, rope-like muscles with painful nodules not only hurt where you can feel them, but also they radiate pain throughout your body. The good news is there are many treatment options.

If you are looking for nondrug therapies to ease your muscle pain, **Ken Lamm, P.T.**, of Tucson, AZ, regularly offers photo-illustrated, self-help techniques in the *Fibromyalgia Network Journal*. Examples include relaxing chest tightness, reducing neck and shoulder tension, and easing back pain.

Getting Good Sleep?

If you spend eight hours in bed, but still wake up feeling as though you’ve just been run over by a Mack truck, your body isn’t getting the rest it needs to restore itself.

Better sleep can do more than improve your pain, it can benefit your cardiovascular system and help you lose weight, explains **Janet Mullington, Ph.D.**, of Harvard Medical School (April 2009 *Journal*). Poor sleep also affects optimism and mood.

A study by **Florian Chouchou, Ph.D.**, of France (July 2011 *Journal*) shows a tiny amount of pain arouses the brain and destroys sleep in healthy people. The situation is worse for unrelenting pain of FM, but strategies for minimizing sleep disruption can leave you feeling more refreshed.

You Have Medication Options

Don’t get stuck in a rut when your doctor only offers the three FDA-approved drugs to treat your fibromyalgia (Lyrica, Cymbalta, and

Savella). Actually, there are many different meds to address multiple symptoms. And don’t believe everything you see in the television ads (October 2011 *Journal*). **Alan Spanos, M.D.**, of Chapel Hill, NC, wants patients to know that “FDA-approval doesn’t mean ‘best in show’” (April 2010 *Journal*).

There are options. Know what the odds are that a drug will work and its most likely side effects before trying it. A specially assembled *Fibro Meds Resource Kit* offers you this most up-to-date information, including a comparison of the FDA-approved meds and hard facts about potential meds to help you make choices that best suit your symptoms. See the Special Issues section for details. **END**

Quick Facts

- Fibromyalgia (FM) is a widespread musculoskeletal disorder.
- Primary symptoms include pain, severe fatigue, disturbed sleep, and brain fog.
- FM means pain in the muscles, ligaments, and tendons—the soft fibrous tissues in the body.
- The severity of symptoms fluctuate and are commonly described as flu-like in nature.
- More women than men appear to be afflicted with FM (75% versus 25%).
- FM occurs in people of all ages, even children.
- FM affects 3-5% of the general population.

Articles are for informational purposes only.
You must consult your physician for treatment.

Do you Recognize These Symptoms? They are Common in Fibromyalgia

- ◆ Do you always seem to be cold, but have no energy to move around and warm up? If you feel run down and blame your recent weight gain on your fatigue, think again. An underperforming metabolic system could be at the heart of your fibro. And it's treatable, according to **John C. Lowe, D.C., M.A.**, director of the Fibromyalgia Research Foundation (January 2011 *Fibromyalgia Network Journal*).
 - ◆ Can't wake up in the morning, and feel like you are mentally dragging throughout the day? Research by **Roberto Riva, Ph.D.**, of Sweden, shows certain hormones may be at the root of this out-of-sync feeling and offers treatment solutions (October 2011 *Journal*).
 - ◆ Does it seem like your pain is migrating from one part of your body to another without any rhyme or reason? Research on those painful knots in your muscles show they are connected to your central nervous system like a dot-to-dot diagram. So signals from each painful knot can travel throughout your system causing the location of your pain to be unpredictable (April 2010 *Journal*).
 - ◆ Do your thoughts slip through your fingers like water? New research by **Bruce Dick, Ph.D.**, of the University of Alberta in Canada, verifies the fibro brain cannot juggle multiple tasks or distractions and offers suggestions to boost your memory. (July 2011 *Journal*).
 - ◆ Are you puzzled by chronic burning or irritable skin that isn't soothed by lotions or other topicals? **Claudio Torresani, M.D.**, at the University of Parma in Italy, says these common hive-like symptoms in fibromyalgia are caused by abnormalities in the central nervous system (January 2010 *Journal*).
 - ◆ More than half of fibromyalgia patients have clear signs of muscle weakness, according to a study by researchers in Denmark (October 2009 *Journal*). This same team is also showing that muscle pain tends to be the source of the weakness and can lead to alterations in the way you walk (October 2011 *Journal*).
 - ◆ Do you bump into walls or objects such as tables or chairs? Do you fall a lot but just get back up and go on your merry way? **Kim D. Jones, Ph.D.**, at Oregon Health and Sciences University in Portland, says that all the sensory perception systems, including concentration, are impaired in fibromyalgia patients and lead to balance difficulties (July 2010 *Journal*).
- If you are worried what to do about these symptoms, each one of these articles also discusses specific treatment strategies. **END**

Your Survival Tools for Coping

Having trouble getting family and friends to understand your fibromyalgia (FM) is a very common problem. There is no reason to feel guilty because you have to cancel out on attending an event, or you need to rest. Be up front and honest with family members about your FM. See our Special Issues section (next page) for help with Relationships. Here are a few survival tips:

- ◆ Learn to say "No" more often so you can spend your time doing what you want to do, rather than living up to other people's expectations.
- ◆ Talk to yourself in a positive manner and with conviction. Remember, our subconscious begins to believe the words we say in our head.
- ◆ Don't settle for a physician who doesn't believe or respect you.
- ◆ Lie down and zone out two to three times a day for 10 minutes to re-charge your fatigued batteries, mentally and physically.
- ◆ Don't let your pain get out of hand. Try to stay out of the "fight or flight" response.
- ◆ Allow "play time" or "fun time" with your significant other. Pain and fatigue can easily dry out any relationship. **END**

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Treating the Many Layers of Your Pain

“When approaching a pain patient, I try to think of what other conditions could be underlying their widespread symptoms,” says **Lucinda Bateman, M.D.**, who runs a clinic specifically for people with chronic fatigue syndrome (CFS) and fibromyalgia (FM) in Salt Lake City, UT. “For example, if a patient has osteoarthritis, that part of their pain will respond to anti-inflammatory medications, and you want to distinguish it from the FM.”

Speaking at the International Association for CFS in Reno, NV in March, Bateman spoke to her colleagues about pain and how to “peel away the layers of an onion” to identify the various sources and treat them.

Identifying the Pain Sources

Unlike the carefully selected patients who participate in research studies, Bateman says that the patients walking into her clinic have more symptoms and a variety of other medical conditions. When FM is present, all of the incoming pain signals going to the brain are magnified regardless of whether they are caused by tissue inflammation, a pinched or irritated nerve, an infection, or too much physical or mental stress (see diagram). To make matters worse, the brain’s pain inhibitory system that descends to the spinal cord to blunt incoming signals is defective, so incoming signals become amplified and even light touches can be painful.

To help doctors identify the various sources of your pain, Bateman suggests that at each visit, patients mark a body diagram pinpointing pain. “It saves a lot of time and conversation.” If there is radiating pain from a nerve on one side (single nerve compression or injury), or in the nerve endings of the feet (a

peripheral neuropathy), a regional muscle pain, a joint problem, or enhancement of the widespread pain of FM, the diagram will look different. “Every potential area that can have pain may show up for a person with FM, and clinicians must be prepared. So you can look at a pain diagram and make a few quick decisions on what questions to ask about your patient’s pain.” The Brief Pain Inventory diagram can be downloaded from the Internet.

Treating Different Pains

“Each pain condition has its own specific set of effective or partially effective therapies that might reduce the impact of FM,” says Bateman. “Don’t just lump all of these pains with the FM. Patients can become over-medicated when pain is just viewed as a single package instead of being teased apart into its contributing components.”

Cervical or lumbar disc disease with nerve compression may respond to anti-epileptic drugs (AEDs) like Lyrica, but physical therapy, local procedures, or surgical interventions might rectify a situation. Carpal tunnel syndrome (wrist pain), bursitis, tendinitis, plantar fasciitis, and bone spurs may all be irritated by repetitive motion that is eased by anti-inflammatory drugs, which are not effective for FM. There are other options as well, says Bateman. “The patient can wear a brace, get a steroid injection, or there could be a surgical solution.”

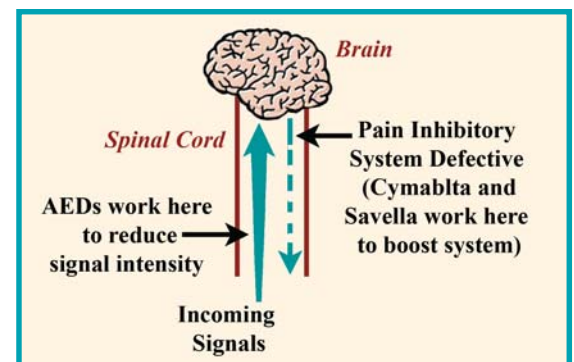
Irritable bowel syndrome, interstitial cystitis and endometriosis are just a few abdominal or pelvic pains that may be present in people with FM. “Each of these conditions has its own specific set of

treatments that might eliminate or reduce that pain,” says Bateman.

“Daily headaches and migraines deserve a very focused approach and special treatment.” Myofascial trigger point therapies can ease tension headaches (see the April 2007 *Journal*), and there are preventive medications for migraines. If your FM patient has frequent migraines, Bateman says, “You might want to prescribe Topamax (topiramate). It must be dosed very carefully to avoid common debilitating side effects (e.g., fatigue, nausea, diarrhea, trouble concentrating). Start low (12.5 mg) and build very gradually (12.5 mg every one to two weeks), with the largest dose at night and little or none in the morning. Topamax may control the migraines, get your patient sleeping, and work as a mild pain modulator to minimize the FM during the day.” Trileptal (oxcarbazepine) and Neurontin (gabapentin) and other AEDs may also help with migraines.

Generalized FM Pain

So far, the focus has been on identifying and treating the regional pains that become amplified by the FM. But what can doctors do specifically to treat the generalized FM pain? There are anti-epileptic drugs (AEDs) that work to reduce the intensity of pain signals going to the brain, such as Lyrica, Neurontin, Zonegran (zonisamide), and



Topamax. Although Lyrica gets the most publicity, it is expensive and may also cause weight gain. What about the other AEDs that are available as less costly generics?

“In terms of effective pain modulation,” says Bateman, “I would list Lyrica and Neurontin well ahead of the others. Although a clinically important group of patients do gain weight on Lyrica, I find that the majority of patients don’t. However, I do counsel all patients at the onset to avoid dietary sugar and fat, and to not ‘give in’ to the increased appetite.

“Many other AEDs modulate pain somewhat and can be effective tools,” says Bateman. “I use Topamax and Zonegran in some patients because they aid in weight loss, and are much less likely to cause brain fog. Zonegran is a sulfa-drug relative, so patients must be screened for sulfa allergy. I start with 25 mg, then 50 mg, and have the patient slowly build up to 100 mg twice daily. Topamax may be a good choice for FM with migraines.”

Although Lyrica was approved by the U.S. Food and Drug Administration to treat FM pain, the clinical trials also showed a significant improvement in sleep. This is another reason for doctors to prescribe Lyrica and other AEDs with similar properties.

While Lyrica and other AEDs work on incoming pain processing problems in FM, there are also antidepressant medications that help the faulty pain inhibitory system work better, such as Cymbalta (duloxetine) and Savella (milnacipran). Tricyclics fall into this latter group (e.g., amitriptyline and cyclobenzaprine), but they may produce many more undesirable side effects. However, if cost is an issue, a small dose of one of these medications taken at night may help with pain and sleep.

Bateman says the clinical trials on Cymbalta show the drug takes effect within about a week. The change in pain is not huge, but it can be used for the

Easing Off Opioids

“In my experience, opioids are less effective for the widespread pain of FM,” says **Lucinda Bateman, M.D.** “You don’t get as much bang for your buck as you would for other painful conditions.” Her greatest concern about opioids involves the difficulties patients face on the higher doses often required to relieve FM pain and when going off of them.

“When you try to take FM patients off opioids, everything about their disease gets worse. They can’t sleep, they have more restless legs, and their pain amplifies. Taking FM patients off opioids is a much bigger challenge than it is for people with other illnesses on long-term opioids.

“With the advent of pain modulating drugs, we have been successful at doing this, but we must do it very, very slowly.” Bateman says they often stretch the process out one or two years to make it less miserable.

A study by **Jarred Younger, Ph.D.**, of Stanford University, showed that chronic pain patients who were taken off their opioids in a hospital-controlled setting had a significant increase in pain even after 14 days.¹ “The inhibitory (i.e., pain-relieving) systems change faster than the excitatory (pain-increasing) systems,” says Younger. “So, when we withdraw the opioids, the patients are going to get temporarily worse.”

In the latest study by Younger, six out of ten FM patients treated with low-dose naltrexone (4.5 mg nightly) obtained more than a 30 percent reduction in pain.² Although naltrexone blocks opioids, in low doses it is believed to work by settling down the microglial cells that could be ramping up the excitatory pain system in FM patients. It took 28 days for the drug to reach maximum effectiveness. The details of this promising yet inexpensive new therapy are posted on the *Latest News* section of our website (April 29, 2009).³

central pain of FM. Savella may be even more effective overall, but Bateman says doctors have to work with their patients so they slowly adapt to the side effects. Obviously, one should get better pain relief by combining a drug that reduces the pain signals to the brain (e.g., AEDs) with one that boosts the effectiveness of the pain inhibitory system (e.g., antidepressants). Although there are no studies to show that this is the way to go, Bateman says that clinically, many doctors are using this method.

“It’s good to remember that anything that helps reduce mood or anxiety symptoms, or that aids with sleep, may also help pain indirectly,” says Bateman. “I like Lamictal (lamotrigine) as a mood stabilizer and mild antidepressant, but I don’t find it does much for pain.”

Lamictal is available as a generic and does not have the potential to interfere with sleep like antidepressants that modulate serotonin and/or norepinephrine.

“We use a lot of medications to modulate the symptoms of FM/CFS,” says Bateman. “You want to be frugal and pick the drugs carefully.” Bateman also strongly endorses non-drug therapies because they can be effective and enable patients to reduce their doses of medications. **END**

**Medically reviewed and edited by
Lucinda Bateman, M.D.**

1. Younger J, et al. *Pain Med* 9:1158-1163, 2008.
2. Younger J, et al. *Pain Med* April 22 [Epub ahead of print] 2009.
3. www.fmnetnews.com/latest-news

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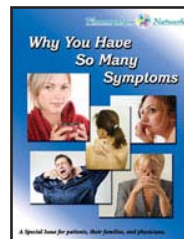
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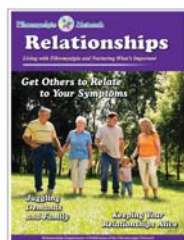
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