Management:

The goal of the management programme is to decrease pain and to improve function, while patients develop a self-management programme to improve self-efficacy. The primary care doctor is in the most favourable position to manage patients with FM, utilising a biopsychosocial, patient-centred approach.[17,18]

> "FM is a real and complex pain disorder which is probably caused by inappropriate augmentation of pain transmission in the spinal cord"

Patients should be encouraged to take an active role in the management, to focus on appropriate self-management and accept that there is no "instant cure" for the disorder. Patients must take personal responsibility for effecting change ("internal locus of control"), develop optimistic attitudes and engage in pain-distracting activities. Cognitive strategies also include restructuring of negative and catastrophic thinking patterns (cognitive behavioural therapy).[19,20]

It is rare for patients to improve if they don't engage in a programme of low-impact aerobic and stretching exercises. Most components of a fitness programme (hydrotherapy, aerobics, stretching and strengthening, etc.) are beneficial if individually adjusted to avoid muscle micro-trauma and "over-training".[21]

The majority of FM patients have disturbed sleep with a "non-restorative" character. FM patients may have a primary sleep disorder (e.g. restless legs syndrome or sleep apnoea syndrome) requiring specific treatment, however, in most patients, no obvious "cause" will be found for the sleep disruption and all aspects of sleep hygiene should be discussed with the patient.[22,23] Low-dose tricyclic antidepressants (TCAs) e.g. amitriptyline have been the best studied and most commonly prescribed drugs for the FM-associated sleep disturbances. The key is to use a low dosage (e.g. 10-20mg two hours before retiring) and to gradually increase the dose if necessary.[24]

Selective serotonin re-uptake inhibitors (SSRIs) are less effective than TCAs for treating the pain in FM patients, but are valuable adjuncts to therapy in FM patients with depression.[25,26] Dual re-uptake inhibitors (SSNRI's) e.g. duloxetine are better tolerated than TCA's and clinical data has so far demonstrated a benefit compared to placebo when used for the pain in FM patients.[27,28]

Once the central nervous system has become sensitised, peripheral pain generators will be perceived as more painful and will amplify the central sensitisation. The management of peripheral pain generators is therefore of great importance in the management of FM patients - these include conditions such as visceral pain (e.g. irritable bowel syndrome and endometriosis), tendonitis and bursitis, neuropathic pain, degenerative joint disease and co-morbid myofascial pain syndrome.[29,30,31]

Pharmacological therapies for the pain of FM include central acting analgesics such as paracetamol and tramadol. A tramadol/ paracetamol combination has been shown to be safe and effective in the treatment of FM pain and anti-inflammatory medications are regarded as useful adjuncts for some of the peripheral pain generators.[32,33] Pregabalin, an alpha-2 delta ligand, which is also used for neuropathic pain, has shown effectivity in reducing the pain and improving sleep in FM patients and has recently been approved by the US Food and Drug Administration for treatment of FM.[34]

Agents that have recently shown promising results in controlled studies include 5-HT3 antagonists (e.g. odansetron), NMDA-antagonists (e.g. dextromethorphan) and pramipexole, a dopamine-3-receptor agonist.[35,36]

Conclusion:

FM is a real and complex pain disorder which is probably caused by inappropriate augmentation of pain transmission in the spinal cord. It has been accepted as a distinct clinical disorder by the World Health Organisation and various other scientific bodies.[37] Prompt recognition and a patient-centred approach which integrates biomedical and behavioural aspects is mostly a successful management strategy. Current genetic discoveries may in future be useful to optimise the pharmacological treatment of FM.

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