

Original Research Article

Is fibromyalgia the most common diagnosis amongst female out-patients?

Adithya Kumar Jilumudi, Ganesan G. Ram*

Department of Orthopaedics, Sri Ramachandra Medical College, Chennai, Tamil Nadu, India

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***Correspondence:**

Dr. Ganesan G. Ram,

E-mail: ganesangram@yahoo.com

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ABSTRACT

Background: The objectives of this study were to determine the prevalence of fibromyalgia syndrome (FMS) among women coming to outpatient department.

Methods: A total of 68,625 female patients were evaluated out of which 47,901 were in the inclusion criteria. The screening protocol included interview items that have been defined as components of FMS using the 1990 American College of Rheumatology (ACR) classification criteria. Data was entered in MX excel sheet and results were analyzed. The socio-demographic data was expressed in proportions.

Results: Out of 47,901 female patients, about 40.7% of the patients were diagnosed to have fibromyalgia syndrome (FMS). Out of which the major group of patients belong to married, unskilled women aged between 40-60 years of age.

Conclusions: Fibromyalgia syndrome is the commonest diagnosis among the female patients coming to orthopedic outpatient department.

Keywords: Fibromyalgia, Poly arthralgia, Tender points, Dolorimeter

INTRODUCTION

There is a general belief that the most common diagnosis made in an orthopaedic female outpatient department is fibromyalgia. Though fibromyalgia is a common diagnosis, there are very few papers pertaining to that. Fibromyalgia is a syndrome characterised by chronic widespread pain at multiple tender points, joint stiffness, and systemic symptoms (e.g., mood disorders, fatigue, cognitive dysfunction, and insomnia) without a well-defined underlying organic disease. Associated with specific diseases such as rheumatic pathologies, psychiatric or neurological disorders, infections, and diabetes.¹⁻⁴

The aim of the study is to find the incidence of fibromyalgia in orthopaedic female outpatient department in a medical college hospital.

METHODS

This is a prospective study done in Sri Ramachandra Medical College Hospital between April 2017 to September 2017. Sri Ramachandra Medical College Hospital is a tertiary care hospital catering all socio-economic classes of patients. Orthopedic department gets an approximate case load of 600-650 patients per day out of which 60% will be female patients.

The inclusion criteria are the female patients coming to orthopedic outpatient department.

The exclusion criteria are pediatric female, fresh fracture cases, post-operative follow up cases. The assessment of fibromyalgia is based on the criteria for the classification of fibromyalgia by the American College of Rheumatology, (ACR) 1990.⁵⁻⁷

The criterion involves, history of widespread pain has been present for at least three months. Pain in both sides of the body pain above and below the waist. Pain is considered widespread when all of the following are present, pain in 11 of 18 tender point sites on digital palpation (both side of the body): occiput (2), low cervical (2), trapezius (2), supraspinatus (2), second rib (2), lateral epicondyle (2), gluteal (2), greater trochanter (2), knee (2). A tender point hurts only at the area where pressure (enough to cause the examiner's nail bed to blanch, or about 4 kg) is applied, and there is no referred pain. An instrument known as a colorimeter is used to apply exactly 4 kg of pressure over the tender points during the examination.⁶ During the study period, 68,625 patients were assessed out of which 20,724 patients were excluded as per our exclusion criteria. A total of 47,901 patients were studied. Data was entered in MX excel spread sheet and results were analyzed. The socio-demographic data was expressed in proportionals. Incidence of fibromyalgia was also expressed in same manner.

RESULTS

Table 1: Diagnosed conditions.

Condition	Number of patients	%
Fibromyalgia	19,496	40.70
Lumbar disc prolapse	8,287	17.30
Knee osteoarthritis	7,753	16.18
Plantar fasciitis/calcaneal spur	5,364	11.19
Cervical disc prolapse	3,497	7.30
Compressive nerve conditions	2,251	4.69
Fracture malunion/non-union	1,150	2.40
Osteomyelitis	92	0.19
Neoplasm	11	0.02

Table 2: Age distribution among patients diagnosed with FMS.

Age group	Number	%
18-40 years	3,509	18
40-50 years	5,654	29
50-60 years	6,044	31
Above 60	4,289	22

Table 3: Professional status among patients diagnosed with FMS.

Occupation type	Number	%
Unskilled	6,973	36
Clerical/shopkeepers	4,679	24
Unemployed	3,120	16
Semiskilled workers	2,923	15
Skilled workers	1,755	9
Semi-professional's	30	0
Professionals	16	0

Table 4: Marital status of the patients with FMS.

Marital status	Number	%
Married	17,352	89
Unmarried	2,144	11

- The result showed that about 40.7% patients diagnosed with fibromyalgia syndrome (FMS).
- With majority of them (36%) catering to unskilled labours followed by clerical work group (24%) accounting to about 60% together.
- The age group that is majorly affected by fibromyalgia is between 40-60 years of age.
- Married women accounts to the major group of 89%.

DISCUSSION

Fibromyalgia is the most common chronic widespread pain condition, it is often under diagnosed. The diagnosis of fibromyalgia has been shown to increase patient satisfaction and reduce healthcare utilisation. In 1904, Gowers coined the term “fibrositis” which was used until the seventies and eighties of the last century when an aetiology involving the central nervous system was discovered.⁵ In 1950 Graham introduced the modern concept of fibromyalgia as “pain syndrome” in the absence of a specific organic disease. Smythe and Moldofsky in mid-1970’s coined “fibromyalgia” and identified the tender points. However, it is still a poorly understood condition that is difficult to diagnose.⁸ Different hypotheses on the aetiology of fibromyalgia have been suggested.⁹⁻¹³ It has also been argued that fibromyalgia is too heterogeneous a condition to consider only one single aetiology, and it has been questioned whether it is a disease entity or one end of a continuous spectrum of pain.¹⁴⁻¹⁶

The result of this study indicates high prevalence of fibromyalgia about 40.7%. From the interpretation of all the data collected, married unskilled women between the ages of 40-60 years are the ones with highest incidence. The advantage of my study is large study group. The disadvantage is that the study group population is confined to patients coming to single institute and not that of generalised population. Majority of patients visiting the study institute are south Indian population. Since it is medical college outpatient department, medicines are given at a subsidised cost to the patient. Most of the patients coming for diabetic, hypertension and other illness tend to come to orthopaedic outpatient department for analgesics. Hence there is a little risk of malingering which may affect the result.

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Conflict of interest: None declared

Ethical approval: The study was approved by the institutional ethics committee

REFERENCES

1. Bigatti SM, Hernandez AM, Cronan TA, Rand KL. Sleep disturbances in fibromyalgia syndrome: relationship to pain and depression. *Arthritis Care Res.* 2008;59(7):961-7.
2. Clauw DJ. Fibromyalgia: an overview. *American J Med.* 2009;122(12):3-13.
3. Giesecke T, Williams DA, Harris RE, Cupps TR, Tian X, Tian TX, et al. Subgrouping of fibromyalgia patients on the basis of pressure-pain thresholds and psychological factors. *Arthritis Rheumatism.* 2003;48(10):2916-22.
4. Mease P. Fibromyalgia syndrome: review of clinical presentation, pathogenesis, outcome measures, and treatment. *J Rheumatol.* 2005;75(6):21.
5. Woolf AD. The bone and joint decade 2000-2010. *Ann Rheum Dis.* 2000;59(2):81-2.
6. Katz RS, Wolfe F, Michaud K. Fibromyalgia diagnosis: a comparison of clinical, survey, and American College of Rheumatology criteria. *Arthritis Rheum.* 2006;54(1):169-76.
7. Wolfe F, Smythe HA, Yunus MB, Bennett RM, Bombardier C, Goldenberg DL, et al. Report of the Multicenter Criteria Committee The American College of Rheumatology 1990 criteria for the classification of fibromyalgia. Report of the multicenter criteria committee. *Arthritis Rheum.* 1990;33(2):160-72.
8. Gowers WR. A lecture on lumbago: its lessons and analogues: delivered at the national hospital for the paralysed and epileptic. *Br Med J.* 1904;1:117-21.
9. Bengtsson A, Henriksson K. Fibromyalgins orsaker ba°de perifer och centrala (The cause of fibromyalgia both peripheral and central). *La`kartidningen.* 1996;193:161-5.
10. Yunus M. Towards a model of pathophysiology of fibromyalgia: aberrant central pain mechanisms with peripheral modulation. *J Rheumatol.* 1992;19:846-50.
11. Pillemer S, Bradley L, Crofford L, Moldofsky H, Chrousos G. The neuroscience and endocrinology of fibromyalgia. *Arthritis Rheum.* 1997;40:1928-39.
12. Goldenberg D. Psychological symptoms and psychiatric diagnoses in patients with fibromyalgia. *J Rheumatol.* 1989;16:127-30.
13. Kellner R. Psychosomatic syndromes, somatization and somatoform disorder. *Psychother Psychosom.* 1994;61:4-24.
14. Schochat T, Croft P, Raspe H. The epidemiology of fibromyalgia. *Br J Rheumatol.* 1994;33:783-6.
15. Croft P, Burt J, Schollum J, Thomas E, Macfarlane G, Silman A. More pain more tender points: Is fibromyalgia just the end of a continuous spectrum? *Ann Rheum Dis.* 1996;55:482-5.
16. Wolfe F. The relation between tender points and fibromyalgia symptom variables: Evidence that fibromyalgia is not a discrete disorder in the clinic. *Ann Rheum Dis.* 1997;56:268-71.

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