Is Fibromyalgia a Variant of Sjö

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Abstract

Although fibromyalgia syndrome has previously been shown not to turn into an autoimmune disease the issue remains that such patients may be difficult to differentiate from those with mild and early connective tissue disease,

Interestingly, features of CTD are noticeable in patients FMS, possibly develop-ping latter on. For example, monitoring of 192 FMS patients and 80 pain-free healthy controls [7], supervised attributes of FMS, e.g. endless pain, and CTD, e.g. Raynaud's phenomenon (RP). ANA-positive patients were followed-up, on average, for 3.3 years. RP appeared in 9 % of the female patients, compared with 3% of the controls, whereas idiopathic subjective dryness of the mouth occurred in 12 % of the FMS patients and never in the controls. T e frequency of features of other CTD than SS was similar in ANA-positive and ANA-negative patients. No CTD could be diagnosed in the patients seen once referred, or followed-up. ANA and evidence of CTD were equally frequent in FMS patients and healthy controls, with the exception of subjective dry mouth more frequent in the patients. Unfortunately, the SG biopsy was not done in these patients, so that the cause of dryness in a proportion of patients is unknown. T at's the reason why we don't take the conclusion of Yunus that none of them su fered from SS. T e rationale of another study, on a three-year period of time, was to ask the question as to whether low-titer ANA-positive FMS patients (12/137) develop CTD, more o fen than 12 age- and sex-matched ANA-negative FMS patients and 225 patients with osteoarthritis (OA), of whom 20 displayed ANA [8]. Patients who developed at least three criteria of CTD were further investigated. Fourteen of 20 FMS and 17 of 30 OA patients presented with at least three symptoms of CTD a fterwards. On full assessment, one of the ANA-positive FMS patient met the criteria for SLE, one of the ANA-negative FMS patients met those for pSS, and one of the ANA-positive OA patients was next diagnosed as su fering from RA. T is study suggests that, even at low titer, ANA may be a good predictor for the development of various CTD, including pSS.

Psychiatric disorders are frequently recorded in patients giving a history of juvenile FMS, and, conversely, physical complications are more severe in FMS patients who complain of mood problems than in those who do not. In other words, these disorders warrant to be identi fed and treated as soon as possible in patients with juvenile FMS [9]. A blind control study has also established that neurologic signs and symptoms are more frequent than normally in FMS, although the correlation between symptoms and signs was marginal [10]. Notable di ferences concerned photophobia (70 versus 6%), poor balance (63 versus 4%), weakness (58 versus 2%) and tingling in the arms and legs (54 versus 4%).Poor balance or coordination, tingling or weakness in the arms or legs and numbness in any part of the body correlated with appropriate neurologic examination fndings in the FM group. Noteworthy is the work about evidence of Small-Fiber Polyneuropathy (SFPN) in unexplained juvenile-onset, widespread pain syndromes (5): 73% of these polyethnic patients were female and 68% of them chronically disabled. Some cases seemed to be immune-mediated to such an extent that immunotherapy proved to be e f cient [3].

A nationwide retrospective cohort of pSS patients enabled [11] to watch for psychiatric disorders developing. T ere appeared that depression, anxiety and insomnia, all disorders a fecting the quality of life, were more common in the patients than in the controls. In fact, such a variety of sleep disturbances have been described in pSS patients that there is a crucial need for polysomnography studies to con frm their night awakening and obstructive sleep apnea. T ese pSS

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