Management of Associated Rheumatoid Arthritis and Fibromyalgia

To the Editor:

The interesting report of Coury and colleagues[1], and thoughtful accompanying editorial by Mäkinen and Hannonen[2], call attention to the important problem of fibromyalgia (FM) in patients with rheumatoid arthritis (RA).

Patient self-report questionnaire data for pain, fatigue, or patient global estimate, the patient measure that is included in the DAS28[3], are usually high in patients with FM or FM and RA. The self-report scores often appear to health professionals disproportionately high in patients with FM and RA relative to "objective" data from a joint examination or laboratory tests. For example, Coury, *et al*[1] suggest that "DAS28 overestimates the *true* status of patients with RA who also have FM" (emphasis added by this author).

An alternative approach is to regard anything written or reported by a patient as "true," although the response may suggest higher levels of inflammatory activity than might be present. Apparently disproportionately high scores, as interpreted by the clinician, in patients who might have FM or FM and RA or another rheumatic disease might be regarded as a clue in diagnosis. This approach is reflected in the January 2009 issue in an article by Wolfe, *et al* on complexities in evaluation of systemic lupus erythematosus (SLE) activity in patients with both FM and SLE[4].

We have reported 3 phenomena regarding self-report responses on a multidimensional health assessment questionnaire (MDHAQ)[5] in patients with FM: a high ratio of pain to functional disability scores[6], a high ratio of fatigue to functional disability scores[7], and a high number of symptoms on a review of systems[7]. These measures appear as effective as a sedimentation rate to distinguish patients with RA from patients with FM[6,7]. We did not report on patients with RA and FM, but subsequent clinical experience has indicated particular value in patients with FM who meet criteria for RA or another rheumatic disease.

The reported "clues" certainly are not 100% diagnostic, as is the case with all rheumatology measures. For example, a substantial rise in erythrocyte sedimentation rate in a patient with RA may indicate an infection or lymphoma, rather than a disease flare. All rheumatology measures, including laboratory tests and patient questionnaire responses, require interpretation by a thoughtful and caring clinician.

All the measures reported as "clues" to FM are included on the simple one-page MDHAQ[5]. FM is primarily a patient-reported syndrome, and patient self-report appears a most effective way to identify patients, particularly patients who meet criteria for concomitant inflammatory diseases, such as RA and SLE. We continue to advocate routine use of the MDHAQ[8] at all visits of all patients seen by a rheumatologist.

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