Dr. Tebib replies

To the Editor:

I read with interest the fruitful comments of Dr. Pincus about the real-life experience of patients with rheumatoid arthritis (RA) also affected by fibromyalgia (FM). His most original point is to consider the patient's complaint as the primary endpoint to improve rather than to have a practical (economical) approach of the clinical state by an approved measure like the DAS28, as we discuss in our work[1]. Regarding our results, which clearly show that the RA patients with FM have less joint destruction than the regular RA population, it can be inferred either that FM abnormalities give some advantage to a patient with RA (maybe a biological protection, as proposed in the comment by St. Amand [below]) or that the physician follows more or less the patient distress, by increasing the treatment burden. Because I was this physician, I favor the Pincus hypothesis, noting, however, that no statistical difference was observed between the 2 populations in terms of prescription of disease-modifying antirheumatic drugs (DMARD) in our work; but we did not check the timing and amount of these prescriptions. Interestingly, biological therapies were not available at that time, and when we look for anti-tumor necrosis factor (anti-TNF) prescription in the followup of both populations, a relative increase of anti-TNF indication was seen in the RA patients with FM, indicating that physician prescription, even when well informed, tends to improve the patient's discomfort rather than follow rigid rules. The challenge at this time is to wonder if smart DMARD strategies including biotherapies are the base of the answer. For me, the response is complex. On the one hand, RA-FM patients who present the same RA profile as RA patients display a less severe progression of their disease, indicating that FM confers some advantage and probably, as implied, by triggering the physician's attention, which is rather good. On the other hand, this definite advantage has no influence on their clinical status, which remains rather bad. This suggests that the management of these patients, although tightly controlled, probably needs more particular attention to central pain control. Tools that allow us to suspect this association (and to measure its severity) are welcome, and I personally use the one-page MDHAQ self-report proposed by Pincus and colleagues[2]. I translated this to measure the status of FM patients in clinic; as well, the association of RA and FM can be easily suspected by the simple ratio of a count of painful joints to swollen joints, which is usually increased by more than 1.5 in my experience (as also observed in our report[1]).

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