Comment on "Fibromyalgia and Physical Trauma: The Concepts We Invent"

To the Editor:

It was with great interest that we read the review by Wolfe, *et al*[1] dealing with the issue of fibromyalgia (FM) and physical trauma.

The authors of the paper consider and discuss FM and chronic widespread pain (CWP) as if they are identical. In fact, the authors claim that the 1990 American College of Rheumatology (ACR) FM criteria[2] are obstacles to performing clinical and epidemiological research. We believe that in trained hands the performance of tender point count takes less time than it takes to complete the 2010 ACR FM preliminary criteria questionnaires[3]. This notion was expressed years ago: "All patients have multiple areas of local tenderness called 'tender points' that are easily identified during physical examination…"[4]. It is also true that by the 2010 criteria, the responsibility to diagnose the patient shifts from the physician to a research assistant or a nurse. The authors consider CWP as a surrogate for FM, allowing an unbiased diagnosis. Why use a surrogate instead of the real thing? A diagnosis that is based solely on the patient's description and interview, without physical examination and at least some objective or semiobjective signs, is often extremely biased. Quantity is not a substitute for quality.

It is true that some patients can be diagnosed without meeting the required 11 tender points. Good clinical judgment is of invaluable importance in daily clinical work and this applies not only to FM. Those of us who meet these patients over time know that the likelihood of improvement over time is poor[5].

Dr. Wolfe should be commended for the criticism of the paper in which he was a co-author (Buskila, *et al*[6]), and he disclosed that information in the review. He also disclosed that he has testified in US courts but he ignored a minor piece of information: whether he represented the claimant or the insurer in his court testimony.

In their review of Tishler, *et al*[7,8], the authors forgot to mention that the majority of the patients were male, in contrast to the expected sex distribution in FM. Only 0.6% of the study group developed FM, far below the expected prevalence of FM in the general population, suggesting a protective role for neck injury in FM. As for the methodology of the study, Tishler and co-workers examined only 12 patients out of their initial study group, and the rest of the data were derived from questionnaires and phone calls.

Spinal injury as a possible cause for the development of FM is not devoid of logic. The spine as a possible etiologic factor was introduced by Smythe[9] and reiterated by a magnetic resonance imaging study of the C-spine in FM[10].

The absence of good-quality data perhaps does not prove the concept of trauma as a pathogenetic factor in FM, as stated in the Vancouver FM consensus conference: "… the data from the literature are insufficient to indicate whether causal relationships exist between trauma and fibromyalgia." This "… does not mean that causality does not exist, rather that appropriate studies have not been performed."

As in many medical conditions, we have to use the available data and our clinical skills as best we can and not just express a feeling, or a belief, that the association does not exist.

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Disclosures: Dr. Mader testified in courts in favor of claimants or has been nominated as a specialist by the court; Dr. Ehrenfeld testified in courts as a specialist nominated by the court or by the Israeli Ministry of Defense; Dr. Buskila testified in courts in favor of claimants.

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