Whiplash and Fibromyalgia

To the Editor:

Littlejohn and Guymer\(^1\) attempt to reestablish the nexus between injury and the fibromyalgia syndrome (FMS). Their editorial recommends that “the most important thing is to get the diagnosis right”. However, their suggestion that the diagnosis of whiplash is an “emotionally charged” term holds no credibility if they suggest that “fibromyalgia” should be preferred.

Central sensitization has become the first explanatory resort of those seeking to describe virtually any issue relating to chronic pain and the alleged behavioral consequences of mood disturbance and disability. Absent from this discourse is the fact that central sensitization is a reversible phenomenon in virtually all experimental models where an injury occurs as a discrete event. There is no need for epidemiological series to demonstrate this. In competitive contact sports, the full spectrum of physical injuries is seen. Occasionally, serious and permanent disability occurs — almost invariably because of major neurological injury. Despite this, the FM signal remains entirely absent from this domain.

The authors assert that a high proportion of patients with FMS identify a traumatic life event as the trigger for their illness. However, this relies on retrospective data, plagued by recall bias. Prospective population-based studies do not demonstrate the “traumatic” etiology, and baseline psychological distress remains the only recurring predictive factor.

The authors postulate that the paper by Hours, \( et \ al \)^2 demonstrates a link between posttraumatic stress disorder (PTSD) and FMS that sustains central sensitization. Hours’ paper makes a “diagnosis” of PTSD at 1 year on questionnaire responses alone. Yet the authors acknowledge an association between those contemplating litigation and the later diagnosis of PTSD. This is not a trivial issue. PTSD is overdiagnosed in litigation, and the ability of lay persons to inflate symptoms of psychological distress (including PTSD) has been well described\(^3,4\). Further, it seems bold to suggest that the circumstances in which these individuals sustained their minor injuries represent the severely traumatic psychological environment that would yield a high prevalence of chronic PTSD.

Hours, \( et \ al \) recorded the intention to proceed with legal redress at an extremely early stage (apparently with the patients still in hospital) while recording only minimal details of psychological status without assessment of preexisting psychological traits. PTSD symptoms were then recorded at 12 months, but no assessment of the patients’ legal status was made, ignoring those patients who later decided to open legal proceedings after discharge from hospital.

Littlejohn and Guymer mention issues of legal causality and dispute, asserting that the secondary consequences of this “may continue to feed the mechanisms of central sensitisation”. This may suit the zeitgeist of the FM lobby, but ignores even the possibility that the substantial awards made by medicolegal advisors succeed in characterizing the phenomenon as an irrecoverable disease of the central nervous system with its attendant assertions of disability and demands for financial compensation. Do Littlejohn and Guymer genuinely believe that the “bad and costly outcomes” they lament elsewhere will improve in this setting?

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