Avoiding Incorrect Diagnosis of Fibromyalgia Syndrome

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Misdiagnosis of fibromyalgia syndrome (FMS) occurs frequently in the clinic. In our case report, a 27-year-old woman with recurring neck pain and stiffness had received a diagnosis of cervical spondylosis, but later a definitive diagnosis of FMS was made. Misdiagnosis of FMS has occurred with various other diseases.

ABSTRACT: Misdiagnosis of fibromyalgia syndrome (FMS) occurs frequently in the clinic. In our case report, a 27-year-old woman with recurring neck pain and stiffness had received a diagnosis of cervical spondylosis, but later a definitive diagnosis of FMS was made. Misdiagnosis of FMS has occurred with various other diseases. Some patients had other diseases but received a diagnosis of FMS. Diagnostic errors are not only the result of the similarity in symptoms. Many physicians do not recognize how prevalent FMS is and are not totally comfortable with using the history and physical examination to make the diagnosis. We suggest that clinicians study FMS carefully, become well-versed in the nuances of this condition, and always keep in mind the possibility of FMS while conducting the examination. (J Musculoskel Med. 2011;28:213-215)

Fibromyalgia syndrome (FMS) is a relatively new diagnostic entity that surfaced in the rheumatology literature in the late 20th century. After detailed discussion of FMS at a rheumatology consensus conference in 1989, the American College of Rheumatology published criteria for the classification of FMS in 1990—widespread pain in combination with tenderness at 11 or more of 18 specific tender point sites. However, misdiagnosis occurs frequently in the clinic. Patients with FMS may receive a diagnosis of various disorders, including Lyme disease, depression, spondyloarthropathy and, in particular, other rheumatologic diseases. In addition, patients with other diseases have received a diagnosis of FMS. In this article, we describe the case of a patient with FMS who received a diagnosis of cervical spondylosis. We also provide a review of the literature on misdiagnosis of FMS. Our objective is to suggest that clinicians study FMS carefully and become well-versed in the nuances of this condition to avoid misdiagnosis.

Case report
A 27-year-old woman presented with recurring neck pain and stiffness of 3 years' duration. She had received a diagnosis of cervical spondylosis and had been treated several times with needle-knife therapy, but she still experienced neck pain and stiffness. She became depressed and experienced anxiety.
Physical examination revealed tension in the sternocleidomastoid and trapezius muscles on both sides. Tender points included the midpoint of the upper edge of the trapezius muscles bilaterally; the gaps in front of C5-7 bilaterally; the beginning part of the supraspinatus muscle; the inner, upper corner of the scapula bilaterally; the point at 2 cm distal to the humeral epicondyle; the junctions of the second rib and cartilage bilaterally; and the upper quadrant of the hips bilaterally.
Results of the brachial plexus traction test (Eaten test), which often are positive with nerve root-type cervical spondylosis, and the Hoffmann sign, which indicates pyramidal tract pathology of the upper extremity, were both normal. The result of an antinuclear antibody test was normal.
On the basis of the patient's symptoms and a detailed physical examination, a definitive diagnosis of FMS was made. After 2 weeks of treatment with Chinese herbs taken orally, acupuncture, massage, and transcutaneous electrical nerve stimulation, the patient's symptoms were obviously relieved.

Discussion
FMS was once considered a rare clinical disease. More recently, the prevalence of FMS in the general population was reported to range from 0.5% to 5% and up to 15.7% in the clinic.2
Misdiagnosis of FMS has occurred with various other diseases (Table 1). Calabozo Raluy and associates\(^3\) evaluated the prevalence of FMS in the 673 patients seen as first consultations in a hospital rheumatologic outpatient clinic during 1 year; they found 70 patients with FMS (10.4%), none of whom had been referred to the hospital with this diagnosis. FMS has been found to be the correct diagnosis in many patients who were referred for suspected tertiary or refractory Lyme disease.\(^4,5\)

Zhou Lei and colleagues\(^6\) reported that within a 3-year period, a 60-year-old patient with constitutional FMS received, in succession, diagnoses of rheumatoid arthritis, gout, depression, multiple myositis, Raynaud disease, and arteriosclerosis obliterans. In a summary of 21 patients with FMS who received erroneous diagnoses, Zou Ming\(^7\) reported 14, 4, 2, and 1 cases with diagnoses of depression, chronic fatigue syndrome, myofascial pain syndrome, and polymyalgia rheumatica, respectively.

Cheng-Pei Li and coworkers\(^8\) reported on 6 patients with FMS who received a diagnosis of ankylosing spondylitis. Deng and associates\(^9\) analyzed the cases of 24 patients who received a misdiagnosis of spondyloarthropathy within a 3-year period; 3 of the patients had FMS. Tan Jun and colleagues\(^10\) described 5 patients with juvenile primary FMS who received a diagnosis of appendicitis.

In contrast, some patients had other diseases but received a diagnosis of FMS (Table 2). Auvinen and associates\(^11\) found that 2 of 63 patients who received a diagnosis of FMS had myotonic dystrophy type 2. Alnwick\(^12\) reported on a 42-year-old woman with a diagnosis of FMS who was referred for physical therapy. The physical therapist recognized that the patient's symptoms did not resemble those of FMS and recommended referral to a neurologist for further diagnostic testing. The new diagnosis was serotonin syndrome related to the use of citalopram. Fitzcharles and Esdaile\(^13\) reported the diagnosis of FMS in 11 women in whom the primary cause of musculoskeletal symptoms was spondyloarthritis rather than only FMS.

**Summary**

Such diagnostic errors are not only the result of the similarity in symptoms. Many physicians do not recognize how prevalent FMS is and are not totally comfortable with using the history and physical examination to make the diagnosis.

We suggest that clinicians study FMS carefully, become well-versed in the nuances of this condition, and always keep in mind the possibility of FMS while conducting the examination. All of the symptoms, signs, and laboratory examination results—particularly widespread pain—should be considered to confirm the diagnosis.

**References:**

References


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