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The New Criteria for Fibromyalgia: Evolution or Devolution?

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In a recent publication, Wolfe and colleagues provided a new definition of fibromyalgia, one that is ostensibly "more suitable for use in primary and specialty care and that do not require a tender point examination" [1]. Thus, a syndrome whose existence is still questioned by some, and which to date has been diagnosed solely through a good history and physical exam, now has its only objective finding (soft tissue tenderness) discounted.

A review of the history of fibromyalgia in the medical literature, notes that in 1904 Stockman was able to identify fibromyalgia (termed "fibrositis") by history and the accompanying presence of tender points [2]. It was not until the mid 70's when Smythe and Moldofsky defined the location of canonical tender points that the rheumatology community writ large began to develop an interest in the subject [3]. The landmark Wolfe study of 1990 published under the imprimatur of the ACR was the watershed moment for the syndrome but the study had a number of shortcomings [4]. Although tender points were used to assess patients, the study never addressed what their presence meant. Psychosocial issues were not taken into account and thus the study could not assess or define the role they may play in the syndrome.

Meanwhile, physicians in their offices began using 11 tender points as a hallmark of the illness (in the setting of widespread pain), although the authors of the study did not agree on the number of tender points as a cutoff when they themselves evaluated patients. After all, is there a major difference between a patient with 10 versus one with 11 tender points? Between 10 and 9? By 2000, however, some were suggesting to ignore tender points altogether and use the history as the sole marker of the illness. Thus, at the beginning of the century, what appeared to be an illness defined in part by physical markers was by the end of the century, deemed a syndrome requiring no findings at all.

Viewed with a critical eye, the newest criteria study raises more problems than it solves. It involves patients enrolled in the National Data Bank carrying a diagnosis of fibromyalgia according to the old criteria. Of these patients, however, only 60% satisfied the modified ACR2010 criteria. This unexpected and startling disconnect between the application of the old and new criteria is explained by Wolfe as follows: "Although the overall course of patients diagnosed with fibromyalgia is not clear, chronicity is often assumed, but considerable improvement may occur." The conclusion is questionable, particularly from an author who previously published an article indicating that at 10 year follow-up little change occurs in fibromyalgia patients' symptoms [5].

If this new scale identifies only 60% of patients as diagnosed by the 1990 criteria, we cannot be confident that the new criteria would have identified the NDB FM cohort at its time of entry into the NDB. Given the large number of physicians who participate in the NDB, the natural question that arises is whether the diagnosis of fibromyalgia was correctly made in any given patient. (Of 30 investigators, 9 used only the 1990 classification criteria while the rest either used only clinical diagnosis or a combination of "clinical methods and ACR methods").

Despite the sententious usage of statistical programs the new criteria may be defining a different process. There needs to be a better explanation by the authors than the one given as to whether the definition they are proposing is one of the same illness or of a different one altogether, or of a subset of those patients defined by the previous criteria.

When asked about the vagueness of the revised criteria questionnaire, the authors reply is that "we rely on the experience and judgment of the physician" [6]. For those who believe fibromyalgia is not a definable syndrome this will undoubtedly strengthen their case.

In a follow-up to the parent paper, an attempt to develop a fibromyalgia survey questionnaire for epidemiological studies was proposed [7]. Wolfe et al. have published a modification of their new proposed definition to be used for surveys with no need for physician evaluation. The choice of symptoms as well as how symptoms were weighted together with lack of requirement for muscle tenderness produced a scale with questionable content validity. The symptoms of fatigue, trouble thinking or remembering, awakening tired, abdominal pain, depression and headache represent depression as much as fibromyalgia and in fact 4 of the 6 symptoms are part of the Beck II Depression Inventory. The evolved instruments reflect symptom severity and correlate well with other measures of symptom severity, but do not appear to be syndrome -specific.

Perhaps the greatest problem with the new criteria is their tautological nature. To wit: a) new criteria have been created, b) there are patients who fulfill them, and c) those patients in turn prove the validity of the criteria. Such reasoning throws the already murky "science" of fibomyalgia into utter disarray. There is no better proof of this than the fact that almost half of the very population studied in order to develop the criteria – the FMS patients in the NDB – no longer meet the criteria for the syndrome they helped define.

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