# Health Care Use Dips After Fibromyalgia Diagnosis

BY BRUCE JANCIN
*Denver Bureau*

AMSTERDAM — Many physicians mistakenly believe there is no effective treatment for fibromyalgia, and some even argue that the diagnosis should not be made at all, but they are wrong on all accounts according to Dr. Ernest H.S. Choy.

"If we want to change the prognosis of fibromyalgia, both the patient and the doctor need to change their attitude. We need to be far more positive in managing this condition. It's no good putting our heads in the sand and hoping the condition will just go away. It won't," he said at the annual European Congress of Rheumatology.

Many physicians believe that it is not a distinct entity, but rather a label that turns symptoms into a disease having no signs, no objective imaging abnormalities, and no effective therapy, according to Dr. Choy, of King's College London. They also claim that making the diagnosis encourages illness behavior and could potentially bankrupt health care systems.

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A recent study using data from the U.K. General Practice Research Database, led by Dr. Simon Wessely, a King's College psychiatrist, compared health care use from 10 years before through 4 years after diagnosis of fibromyalgia in 2,260 patients and a group of age- and gender-matched controls.

The investigators found that the rates of office visits, prescriptions, and medical tests were markedly higher and rising in the years prior to diagnosis in fibromyalgia patients, compared with control patients.

In the year prior to diagnosis, patients averaged 25 office visits and received 11 prescriptions, compared with 12 office visits and 4.5 prescriptions during the same year for controls. The most common reason for prediagnosis office visits by fibromyalgia patients was depression, followed by fatigue, chest pain, headache, and disrupted sleep.

Diagnosis of fibromyalgia was not followed by a surge in illness behavior and health care utilization. In fact, utilization declined for 2-3 years following the diagnosis before climbing back up, probably because the patients were not getting effective treatment, according to the investigators (Arthritis Rheum. 2006;54:177-83).

"This shows that, overall, U.K. physicians are quite good at using the diagnosis to reassure the patient. Patients demand less tests and have less consultations after the diagnosis is made. So the diagnosis can be used in a positive manner. It doesn't always have to be negative," Dr. Choy commented.

This is not to say that fibromyalgia is not a high-cost medical condition, he noted. A classic University of Kansas 7-year prospective study determined that the mean annual per-patient cost was $2,274 in 1996 dollars. "That is a phenomenal cost. It's comparable to inflammatory arthritis. These patients are consuming a vast amount of health care resources. It's an issue we've got to tackle," he said at the congress sponsored by the European League Against Rheumatism (EULAR).

According to Dr. Choy, another recent large observational study undercuts claims that fibromyalgia is simply part of a single larger, ill-defined somatization disorder that also includes conditions like chronic fatigue syndrome, irritable bowel syndrome, and regional pain disorders. This study involved 18,122 U.K. patients diagnosed by their primary care physician as having a fatigue syndrome during 1988-2001.

The key finding was that outcomes differed significantly for patients with various diagnostic labels, being best for those with postviral fatigue syndrome, worst for myalgic encephalomyelitis and chronic fatigue syndrome, and intermediate for those with fibromyalgia (Fam. Pract. 2005;22:383-8).

As for treatment options, Dr. Choy presented new EULAR evidence-based recommendations for fibromyalgia management. The recommendations, to be published later this year, identified a number of interventions with what he termed "moderate to good" effectiveness, including drugs, exercise, and cognitive-behavioral therapy. ■