



*Dynamic Chiropractic* – July 5, 1991, Vol. 09, Issue 14

## **Fibromyalgia Syndrome or Myofascial Pain Syndrome?**

By Donald Murphy

There appears to be much confusion among many physicians of all types regarding the differential diagnosis of myofascial pain syndromes (MPS) and fibromyalgia syndrome (FS). There is also a great deal of misdiagnosis occurring, especially a tendency to use FS as a "wastebasket diagnosis." Anyone with widespread and/or poorly localized musculoskeletal pain without signs of overt pathology are just lumped into the general category of FS.<sup>1,2</sup> This is very unfortunate, and also very avoidable.

Each of these syndromes has clinical features which distinguishes it from the other. A patient with FS will experience widespread pain in all four body quadrants for at least three months duration.<sup>1,3</sup> They will also have tender points (TePs) in at least eleven of the following eighteen locations: two cm below the lateral epicondyle at the elbow; the occiput; intertransverse ligaments of C5-C7; midpoint of the upper trapezius; medial aspect of the supraspinatus; pectoralis major at the level of the second rib two cm from the sternum; the upper gluteal area; the greater trochanter; and the medial condyle of the femur two cm above the joint line (these, of course, are bilateral locations).<sup>2,3</sup>

Palpation of the TePs will cause local tenderness but no referred pain, and the patient's muscles in general will feel boggy or "mushy." Approximately 75 percent experience sleep disturbance which can range from insomnia to wakefulness to non-restorative sleep.<sup>1,2,3</sup> The discomfort will be aggravated by extremes in temperature as well as humidity. The patient will often experience chronic fatigue, tiring easily, and will often have poor aerobic fitness. FS patients often suffer from irritable bowel syndrome, morning stiffness, urinary urgency, anxiety, paresthesias, dysmenorrhea, and Raynaud's phenomenon.

In patients with MPS, the pain will more likely be localized to one region of the body and can be acute or chronic, the chronic cases frequently having active and latent stages, as opposed to the mostly constant pain for a prolonged period as seen in FS. MPS features trigger points (TrPs), which are primarily found in myofascial tissues as opposed to the TePs of FS, some of which are found at non-myofascial sites.<sup>4</sup> TrPs,

like TePs, will be locally tender but also characteristically produce referred pain and/or automatic symptoms upon palpation. They will be located along a palpable taut band of skeletal muscle.

This taut band is easily distinguished from the boggy feel of the FS patient by an experienced palpator. The MPS patient may experience some difficulty sleeping, and the pain can awaken them at night, but sleep disturbance is not a typical finding in MPS. Cold will tend to aggravate a MPS, but heat and humidity will not, in fact, these may be soothing to the patient. Although weakness and fatigueability of the muscle or muscles involved in the MPS is very commonly seen, generalized chronic fatigue is not characteristic, and MPS can affect the aerobically fit or unfit. Irritable bowel syndrome and dysmenorrhea are not typical of MPS in general, unless they involve specific areas in the rectus or oblique abdominis muscles. Anxiety is frequently seen in MPS,<sup>5</sup> as is parasthesias. Raynaud's phenomenon is not typical.

FS must also be differentially diagnosed from, among other disorders, limbic system dysfunction<sup>6,7</sup> which features painful and tender muscles in the shoulder-neck, lower back, and pelvic floor. These patients may also experience dysmenorrhea and urinary urgency.

Understanding the differential diagnosis of these disorders is essential for the chiropractic physician, for most medical physicians are not trained to diagnose or treat them, even though most of the patients suffering from them are currently attending medical offices. The well-trained DCs, because of their superior palpatory skills and understanding of the integrated workings of the body, play an extremely important role in the evaluation and care of any individual suffering from pain in the locomotor system. It is our job to educate the scientific community and the public in this regard, to end some of the needless suffering that goes on, and take our rightful place as experts in locomotor system function/dysfunction and their relationship to health.

1. Wolfe F. Diagnosis of fibromyalgia. *J Musculoskel Med* 1990; 7 (7):53-69.
2. Bennett RM. Myofascial pain syndromes and fibromyalgia syndrome: a comparative analysis. *Man Med* 1991; 6(1):34-45.

3. Duarte M. Primary fibromyalgia syndrome and myofascial pain syndrome: clinical features and criteria for diagnosis. *Chiro Tech* 1989; 1(3):97-100.
  
4. Simons DG. Muscle pain syndromes. *Man Med* 1991; 6(1):3-23.
  
5. Lowe JC. The purpose and practice of myofascial therapy. (Audio Cassette Album). 1989 McDowell, Houston.
  
6. Janda V Manipulation, Pain, and Locomotor System. Conference. New York Chiropractic College, May, 1990.
  
7. Murphy DM. The neglected muscular system: its role in the pathogenesis of the subluxation complex. *J Chiro* 1990;26(12):36-40.

*Donald R. Murphy, D.C.*

*Westerly, Rhode Island*

Dr. Murphy will be conducting his next Myofascial Pain seminar in --city--, --state-- on ----date----. You may register by dialing 1-800-327-2289.



Page printed from:

[http://www.chiroweb.com/mpacms/dc/article.php?id=44417&no\\_paginate=true&p\\_friendly=true&no\\_b=true](http://www.chiroweb.com/mpacms/dc/article.php?id=44417&no_paginate=true&p_friendly=true&no_b=true)