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**Reply***To the Editor:*

We couldn't agree more with Dr. Ehrlich's final comment that suggests we eliminate this unnecessary banter about the fibromyalgia label and "worry about the pains." In fact, we also agree that those patients meeting American College of Rheumatology classification criteria for fibromyalgia (1) may not have a discrete disease but are at the extreme end of a continuum of patients with chronic musculoskeletal pain. Our concern is that most who advocate abandoning the fibromyalgia construct also would like to abandon this group of patients. We would reiterate that regardless of whether a label is attached to these individuals, research into the physiology of chronic musculoskeletal pain is a critically important endeavor in the field of rheumatology.

As with many critics of the fibromyalgia construct, Dr. Ehrlich veils his discomfort regarding patients with the fibromyalgia symptom complex by posing a legitimate concern surrounding societal or legal issues. In this case the issue raised is that assigning labels such as fibromyalgia may have an adverse impact on patient outcome. Unfortunately, there are few data that directly address whether this is the case or not. In direct opposition to Dr. Ehrlich's view, recent data reported by White et al show that assigning a label of fibromyalgia to individuals with chronic widespread pain has no meaningful adverse affect on clinical outcome over the long term (2). There are also data, however, suggesting that *any* disease label may have a detrimental impact on patient behavior. In a study of workers in an occupational setting, Haynes et al demonstrated more than two decades ago that detecting and labeling even an asymptomatic disease (hypertension) markedly increased absenteeism from work (3).

Dr. Ehrlich seems to suggest that labels may be more harmful in cases in which the etiology of the symptoms reported by the patient has yet to be clearly understood. Stated another way, he proposes that syndromes characterized by subjective symptoms should not be given a label that implies those who have the symptoms are abnormal, perhaps in contradistinction to syndromes characterized by alterations of easily measured variables. It is not clear to us why this should be the case, unless one questions the veracity of self-reported symptoms. Furthermore, even when a variable is objective, the definition of what constitutes abnormal may change over time (e.g., hypertension, hypercholesterolemia, obesity) as new research changes our understanding of human physiology.

The implications of Dr. Ehrlich's proposition to eliminate semantic terms from our clinical vernacular would be enormous. As he himself notes, the symptoms do not go away; the label only changes. If we discard the fibromyalgia label, then we should logically reject other labels such as migraine headache, dyslexia, all psychiatric disorders, etc. This would require a tremendous paradigm shift in how we practice clinical medicine, since the aggregate data suggest that approximately half of the visits to primary care physicians are for symptoms and syndromes that fall into the category of not being easily measurable in a purely objective manner (4).

Labels are like any intervention, and can lead to both positive and negative effects. The potential positive effects of labels include eliminating unnecessary diagnostic testing, alle-

viating concerns about life-threatening illnesses, and providing an improved understanding of the most appropriate course of management by both physicians and patients. As with any intervention, we should use a label only when our judgment is that the likelihood of benefit outweighs possible negative effects.

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**Pyridostigmine for fibromyalgia: comment on the article by Paiva and a historical vignette***To the Editor:*

Rob Bennett's group is to be congratulated, as usual, for an important extension of their ongoing outstanding work investigating the role of growth hormone in fibromyalgia (1). Their recently published insight that pyridostigmine reverses the impaired growth hormone response to exercise suggests a possible therapeutic role for this agent, one that was first propounded 50 years ago.

Long before there were rheumatologists, neurologists managed a group of patients with "neurasthenia and myasthenic states." Dr. J.E. Tether headed the myasthenia gravis clinic at Indiana University School of Medicine for more than 30 years. In 1961, a textbook on myasthenia gravis included a chapter he wrote entitled, "Mild myasthenic state" (2). Of the 2,327 patients he followed, 775 were diagnosed with mild myasthenic state, in that they had clinical symptoms but a negative tensilon test. The patients were almost all women who were diagnosed between the ages of 20 and 40. The onset of symptoms was usually gradual, but sometimes occurred after a traumatic event and was exacerbated by exertion, infection, menstruation, and emotion. The principal clinical features of this group included fatigue, tightness or stiffness and aching in the back of the neck, chest heaviness, aching in the interscapular and lumbar areas, and "sad, tired expressions." Dr. Tether noted that these patients also responded to pyridostigmine, and could not explain why they "flared" when the medication was withdrawn. Similar studies from myasthenia clinics at