or rheumatoid arthritis, is that patient automatically excluded from a diagnosis of fibromyalgia? Patients with rheumatoid arthritis alone who meet the new criteria and patients with combined rheumatoid arthritis and fibromyalgia cannot be distinguished based on the new criteria.

Second, based on the new criteria, psychogenic pain or somatoform disorder may exclude a diagnosis of fibromyalgia. In Japan, few physicians administer treatment for fibromyalgia and many physicians do not believe in fibromyalgia. Patients with fibromyalgia are frequently left untreated, treated with nonsteroidal antiinflammatory drugs, or diagnosed with psychogenic pain or somatoform disorder. Therefore, in Japan psychogenic pain or somatoform disorder will exclude a diagnosis of fibromyalgia based on the new criteria.

Third, survey studies will become almost impossible if the new criteria are used from the viewpoint of cost. Blood tests are needed to confirm that the patient does not have a disorder that would otherwise explain the pain. It is almost impossible to perform blood tests in survey studies from the viewpoint of cost.

The number of somatic symptoms in the new criteria is ambiguous. How many symptoms are "few symptoms," "a moderate number of symptoms," and "a great deal of symptoms," respectively? Who decides the number of somatic symptoms in the new criteria? Do physicians decide it? Do patients decide it?

Further consideration of these issues is warranted before the new criteria are implemented.

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Reply

To the Editors:

We are grateful to Dr. Toda for raising several important points. He is concerned that the 2010 preliminary criteria exclude patients with other disorders from the diagnosis of fibromyalgia. The 1990 criteria state that ". . . a diagnosis of fibromyalgia remains a valid construct irrespective of other diagnoses; 'exclusionary tests' such as radiographs, antinuclear antibody titers, T4 levels, etc. are not a requisite for diagnosis" (Wolfe F, Smythe HA, Yunus MB, Bennett RM, Bombardier C, Goldenberg DL, et al. The American College of Rheumatology 1990 criteria for the classification of fibromyalgia: report of the Multicenter Criteria Committee. Arthritis Rheum 1990;33:160–72).

The 2010 criteria do not change that position—fibromyalgia is not an exclusionary illness, and exclusionary tests are not needed. However, there are certain circumstances where exclusions (and tests) would make sense. As an example, we would want to exclude from a diagnosis of fibromyalgia patients with multiple bone metastases and anemia or with extreme hyperparathyroidism, and such patients might have generalized pain and fatigue. Every patient should have a diagnostic interview and examination. If the history and the clinical examination do not lead to suspicion of a somatic disease, no additional tests are needed. Only if there is another disease present that could explain the patient's pain that would ordinarily be attributed to fibromyalgia (as in metastatic cancer described above), should the diagnosis of fibromyalgia not be made. Although we used different wording in the 2010 criteria, the intent was exactly the same as in the 1990 criteria.

Dr. Toda also inquires about the problem of somatic symptoms: "How many symptoms are 'few symptoms,' 'a moderate number of symptoms,' and 'a great deal of symptoms,' respectively? Who decides the number of somatic symptoms in the new criteria? Do physicians decide it? Do patients decide it?"

The criteria ask physicians to interview patients to assess the extent of somatic symptoms. Based on the interview, the physician determines how to classify the number of symptoms. When physicians evaluate symptoms such as fatigue, cognitive problems, unrefreshed sleep (the other symptom items), and the extent of somatic symptoms, the physician brings to the evaluation experience with patients of all sorts, and expected norms for the various categories. The physician should use these skills and make the best judgment. In making these criteria, we recognized that there were many, often complex, evaluation questionnaires that could be used to provide more precise answers. But we also recognized that such questionnaires would never be used in primary care practice. So we chose questions that were suitable for clinical use, even though there were more exact questions that could have been used.

There is no specific number of symptoms for each category. It may be possible to determine the degree of somatic symptoms with a few questions in some patients and with many questions in other patients. The type and nature of the symptoms might be important. We rely on the experience and judgment of the physician.

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Submissions Invited for Themed Issue of *Arthritis Care & Research*: Muscle and Bone in the Rheumatic Diseases

Arthritis Care & Research is soliciting manuscripts for a themed issue addressing muscle and bone issues and outcomes in the rheumatic diseases. Manuscripts covering a broad range of topics related to the major theme are invited, for example: risk factors for the onset of sarcopenia or bone loss among persons with rheumatic conditions; the epidemiology and consequences of deconditioning or muscle loss in rheumatic diseases (osteoarthritis, rheumatoid arthritis, lupus, osteoporosis, and others); inflammation and muscle; muscle fat infiltration and sarcopenia; muscle power and mobility limitations; and exercise interventions and sarcopenia. Submissions are encouraged from a range of disciplines relevant to muscle and bone issues and outcomes in rheumatic diseases, and we will entertain both original research articles and review articles.

The issue will include regular submissions as well, but a certain number of pages will be reserved for manuscripts accepted in response to this solicitation. All manuscripts will be peer-reviewed.

The deadline for submission is April 1, 2011. For further information, contact the editors of *Arthritis Care & Research*, Edward H. Yelin, PhD (Ed.Yelin@ucsf.edu) or Patricia P. Katz, PhD (Patti.Katz@ucsf.edu) or Marian T. Hannan, DSc, MPH (Hannan@hsl.harvard.edu).