the fibromyalgia guidelines issued by EULAR represent a work in progress on a field “that is very much in evolution,” Dr. Philip J. Mease said in an interview.

The recommendations were formulated by a European working group that included specialists from various fields including rheumatology, pain medicine, and neurology, who reviewed all the available trials through 2005.

“They have done a good job with a difficult challenge, because the trials are so different, both in terms of the outcome measures used and the treatment approaches tried,” said Dr. Mease, a rheumatologist at the University of Washington, Seattle, and chief of clinical research at the Swedish Hospital Medical Center, Seattle.

“Moreover, they used a balanced way of looking at both pharmacologic and non-pharmacologic approaches, to give the managing physician a choice of therapeutic approaches,” he said.

Among the general recommendations were the concepts that fibromyalgia requires a comprehensive assessment of pain, function, and psychosocial context. Treatment should be multidisciplinary, combining various modalities tailored to pain intensity, function, and associated features such as depression and fatigue. While recommendations were evidence-based, possible, these general recommendations regarding the heterogeneity of fibromyalgia and the need for multidisciplinary treatment were based on expert opinion.

Among the recommendations for non-pharmacologic measures were the use of heat in pooled treatment, with or without exercise. This modality was found to be effective in improving pain and function in several “fairly high-quality” trials, according to the investigators.

They reported that tailored exercise programs including aerobic exercise and strength training can be useful for some patients, and noted that the evidence in the literature for this recommendation is poor, with many open trials and inadequate blinding. However, given the safety and overall health benefits associated with exercise, they felt this should be included in the recommendations.

“Amitriptyline and pramipexole are recommended, but if you look at the specific trials they are vastly different,” Dr. Mease said.

“It was a Herculean effort that was timely and appropriate, given the rising interest in fibromyalgia as a common condition that needs more attention,” he said.

Another fibromyalgia expert, Dr. Robert M. Bennett of Oregon Health and Science University, Portland, offered a caution about pharmacotherapy in fibromyalgia. “For instance, no mention is made of sleep medications or the adverse interactions of medications. ‘Tramadol has a dual action, as a weak opioid and a serotonin and norepinephrine reuptake inhibitor, and may interact with antidepressants, especially the monoamine oxidase inhibitors moclobemide and pirlindole, to induce a serotonin syndrome,’” Dr. Bennett explained in an interview.

The guidelines will be updated every 5 years, with the hope that good quality clinical trials will continue to add to the available evidence, wrote the investigators.

Singular Crystal Points the Way to a Pseudogout Diagnosis

BY DIANA MAHONEY
New England Bureau

BOSTON—To differentiate definitively between acute gout and pseudogout, look at the crystals.

On UV light microscopy, fluid aspirated from the inflamed joint of a patient with pseudogout will be teeming with rhomboid-shaped calcium pyrophosphate dihydrate (CPPD) crystals, which are morphologically different from the needle-shaped monosodium urate (MSU) crystals implicated in the pain and swelling of acute gout, Dr. Dwight R. Robinson said at a meeting on rheumatology sponsored by Harvard Medical School. “Calcium pyrophosphate dihydrate crystals are less well formed and show more variation in size and shape than monosodium urate crystals. In that regard, they are a little more difficult to identify.”

Like MSU crystals in the joints of gout patients, the deposition of CPPD crystals in pseudogout causes acute pain and swelling in one or multiple joints. The acute attacks can last anywhere from 1 day to 4 weeks and sometimes are accompanied by fever, leukocytosis, and elevated acute-phase reactants said Dr. Robinson, a rheumatologist and professor of medicine at Harvard Medical School, Boston.

Because the latter signs also may be indicative of septic arthritis, sepsis first must be excluded by gram stain and culture of synovial fluid.

In general, CPPD crystals have a predilection for depositing in articular and fibrocartilage, said Dr. Robinson. In pseudogout, the process commonly involves the knee or wrist joint but also may involve the first metatarsophalangeal joint, as occurs in gout, or almost any other joint, he said. Radiographically, the diagnosis of pseudogout often can be confirmed by evidence of chondrocalcinosis in the affected joint space.

In addition to mimicking the clinical patterns of gout, the symmetrical trials may overlap with other inflammatory conditions. “The disease may present as pseudorheumatoid arthritis, pseudo-osteoarthritis with or without pseudogout, or pseudoneuroarthropathies,” said Dr. Robinson. “In many patients, the condition is actually asymptomatic.”

CPPD disease develops idiosyncratically in individuals older than age 50. In younger patients, it’s more likely to be a complication of osteoarthritis, a late consequence of joint trauma or knee meniscectomy, or related to an underlying metabolic disease, such as hyperparathyroidism, diliary-dependent renal failure, hemochromatosis, and hypomagnesemia,” said Dr. Robinson, noting that there also may be a familial component.

Although the exact mechanism for the development of CPPD deposition disease is uncertain, an overactivity of enzymes that break down nucleoside triphosphates has been implicated, as have genetic defects, specifically mutations in the human homologue of the murine ANK gene. “Several mutations in the human homologue may be responsible for human diseases classified as CPPD arthropathies,” said Dr. Robinson.

There currently are no proven prophylactic therapies for pseudogout, but acute attacks can be treated effectively with colchicine, or intravenous colchicine should be considered only as a treatment of last resort because of the associated risks of gastrointestinal and renal toxicities as associated with NSAIDs, particularly in elderly patients, intra-articular corticosteroids, which infiltrated joint is a reasonable treatment option, he said, as is a short course of systemic corticosteroids for polyarticular pseudogout attacks. Oral or intravenous colchicine should be considered only as a treatment of last resort because of the associated risks of gastrointestinal and renal toxicities.