

Further studies on the treatment of fibromyalgia

To the editor:

I wish to comment upon the POEM "Useful treatments for fibromyalgia syndrome" (*J Fam Pract* 2005; 54:105, citing *JAMA* 2004; 292:2388–2395).¹ Drs Goldenberg, Burckhardt, and Crofford did only a partial job of covering the readily accessible literature. Unfortunately, a useful set of randomized controlled trials²⁻⁴ escaped their search strategy. Furthermore, there is a major error in their conclusions that is inconsistent with the body of the discussion.

In 1997 the cause of the symptoms of fibromyalgia was strongly linked to partial peripheral resistance to thyroid hormone in 3 studies published in an off-Medline journal, the *Clinical Bulletin of Myofascial Therapy*. This choice of journals, a regrettable decision, consigned the studies to obscurity.

Barnes⁵ first suggested, because of observed high rates of hypometabolism, that resistance to thyroid hormone must be fairly common. That same year, the famous Albright⁶ guessed the same thing for the same reason given by Barnes. In 1981 Kaplan⁷ finally reported the biological parameters of a prototypical case. Since then, textbooks in endocrinology and thyroid disease in particular⁸ make routine reference to thyroid hormone resistance. While the emphasis in these texts is upon genetic lesions, acquired lesions are also suggested.

Our research group⁹ has given doses far in excess of those given to the Kaplan patient, ranging up to 1350 µg of liothyro-

nine (T3) (T4 equivalence 5400 µg) on multiple occasions without thyrotoxic effects. This is prima facie evidence that we have learned to accurately recognize partial peripheral resistance to thyroid hormone, for the consequences of this dosing would otherwise be catastrophic. The 3 studies cited above²⁻⁴ exhaustively document our initial experience with subjects in doses up to 150 µg of liothyronine (T3) (T4 equivalence 600 µg). Symptomatic responses of these patients were dramatically clinically significant as well as statistically significant to tiny values of *P*.

This establishes thyroid hormone resistance as the most evidence-based proposed cause of fibromyalgia. I know of no evidence refuting this. Also, this information is available from Cochrane, so the authors' search strategy failed. Lastly, our group has had personal communication with the authors, and still they do not acknowledge it.

Since 1997 our group has concentrated upon refinement of the use of suprathreshold doses of thyroid hormone for the ablation of fibromyalgia symptoms. We have also worked out much of the biological bases of the acquired causes of thyroid resistance. This latter work¹⁰ is summarized in a recent review. Thus the state of the art has moved beyond establishing the etiology of fibromyalgia as T3 resistance, to the causes and successful treatments of that resistance.

As for the error in the conclusions of this review, the paper states that there is strong evidence for efficacy of tricyclic antidepressants (TCAs). In the discussion, however, it is correctly noted that there is no evidence for such efficacy except in the first 12 weeks of treatment; even then only a tiny percentage respond. After that, there is no difference between TCA and placebo.

Thyroid hormone resistance is the most evidence-based proposed cause of fibromyalgia

I wish the myth of TCA effectiveness would go away, but this paper perpetuates it.

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Screening for prostate cancer

To the editor:

Prostate cancer (unless in cases of urinary tract obstruction, metastases, and related disorders which occur in advanced disease) is usually asymptomatic. In Greece, a non-symptomatic patient would never visit an urologist, unless consulted by another physician. As a result, in several patients

the diagnosis of prostate cancer is attained at a stage when surgical therapy is not an option. Thus, the contribution of the general practitioner on prostate cancer screening is substantial. We agree with Schwartz et al ("Screening for prostate cancer: Who and how often?," *J Fam Pract* 2005; 54:586–596) that prostate-specific antigen (PSA) as a screening test performed alone can be misleading, resulting in a possible overdiagnosis and treatment of clinically insignificant cancers.

However, based on our experience in prostate cancer screening in our daily practice (from the prospective of the general practitioner in primary health care settings), we observed that in a series of males screened for prostate cancer in the Urban Health Center of Vyronas (in the period September 2004 to February 2005), the accuracy of PSA for prostate cancer screening was greatly improved when performed after a positive digital rectal examination (DRE).¹ Among patients with positive DRE and a PSA value over the age-specific limit, 94% had clinically significant prostate cancer and most of them underwent surgery. Although positive prognostic value of DRE is respectively low, it remains a major tool in presymptomatic control for prostate cancer and can contribute as a useful screening method in the hands of general practitioners. Moreover, the implication of health education programmes concerning the importance of DRE in men aged >50 years is imperative, as shown by the percentage of DRE denial in our study (86.6%).

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