Yoga Alleviates Fibromyalgia Pain in Small Study

BY MIRIAM E. TUCKER
Senior Writer

VANCOUVER, B.C. — Yoga may be an effective adjunct to medical treatment for patients with fibromyalgia, Malinda L. Breda, Ph.D., reported at the annual meeting of the American Psychosomatic Society.

There are many reasons why yoga is an attractive treatment for fibromyalgia, which affects about 6 million Americans. Current therapies provide inadequate symptom relief, and a recent meta-analysis concluded that optimal treatment regimens should include nonpharmacologic interventions such as exercise (Ann Behav Med. 1999;21:180-91).

But although conventional exercise can alleviate symptoms for some fibromyalgia patients, it actually worsens them in others. Yoga, with its meditative, low-impact approach, may be better for these patients than conventional exercise. Moreover, data suggest that yoga may be beneficial in other medical conditions, including obsessive-compulsive disorder, osteoarthritis, carpal tunnel syndrome, chronic fatigue syndrome, and other pain conditions, noted Dr. Breda of the California School of Professional Psychology, San Diego.

Of 38 adults who met the 1990 American College of Rheumatology criteria for fibromyalgia, 19 were randomized to an experimental yoga group, and 19 controls were put on a waiting list.

Conventional exercise can actually worsen fibromyalgia symptoms in some patients.

DR. BREDA

The yoga intervention consisted of 8 weeks of classical hatha yoga, taught by a certified instructor who had experience with fibromyalgia patients, she said.

The 90-minute sessions emphasized gentle poses and breath work designed to match individual ability and were followed by relaxation/meditation exercises. Classes were conducted twice weekly, and subjects practiced at home with a video the other 5 days of each week. Class attendance was consistently high, with patients averaging 14 of 16 sessions. At-home practice adherence was slightly less impressive, with a mean of 3 of 5 days with yoga practice.

COURTESY DR. MALINDA L. BREDA

Gentle poses and breath work were emphasized during the 8-week interventional program on classical hatha yoga.

Instructor visual analog scale ratings, used to check manipulation, revealed significant improvement across sessions in patients' ability to perform the postures, Dr. Breda reported.

Patients completed a variety of assessments of pain, fatigue, sleep quality, and disability at baseline, 4 weeks, and 8 weeks.

Compared with controls, significant improvements were seen in the yoga group on the visual analog scale and the Pain Rating Index on ranked values, both for pain; the Multidimensional Assessment of Fatigue scale; the Pittsburgh Sleep Quality Index; and the Fibromyalgia Health Assessment Questionnaire.

The yoga group did not show significant improvements over time in disability, depression, or active coping scores. The control group showed no significant differences over time, except for worsening anxiety. ■

Coping Skills Can Prevent Or Relieve Headache Pain

BY NANCY A. MELVILLE
Contributing Writer

SCOTTSDALE, ARIZ. — Medications have their rightful place in headache treatment, but a strong dose of some key coping and behavioral tools can go a long way toward helping patients manage their own headaches, Alvin E. Lake III, Ph.D., said at a symposium sponsored by the American Headache Society.

The placebo effect has long shown how powerful an influence perception can be in how patients experience pain, and research shows that effect to be particularly important in headaches, he said.

In fact, nearly every published headache study comparing drugs alone with a combination of drugs and behavior therapy has shown the combined treatment to be superior, said Dr. Lake, who is director of the division of behavioral medicine at the Michigan Head-Pain & Neurological Institute in Ann Arbor, Mich.

"We can emphasize the power of drugs in our interventions, or we can emphasize the coping skills, but it doesn't have to be either/or because there are ways to think of them together," he said.

An important starting point in teaching patients self-efficacy in headache control is to convey the sense of confidence that they can indeed prevent and control headaches, and that they can remain calm and continue to function, Dr. Lake said.

Establishing those core beliefs gives patients a critical sense of control over pain; research has shown that people's beliefs that they can accomplish something are better predictors of their actually accomplishing it than are most other factors, including past performance, he said.

Clinicians can help build up those beliefs by presenting examples of people who had similar obstacles and overcame them. "What often inspires us the most and changes our behavior is seeing someone else who overcame it," Dr. Lake said.

In addition to noting others' experiences, clinicians can suggest that patients look to their own experiences and think of an obstacle that they overcame. "Urge patients to consider how they overcame it and think about how they could use those same skills in managing or preventing their pain," Dr. Lake said.

Patients should, however, also work to try to raise their level of pain tolerance. This effort is especially important among patients who are trying to decrease excessive use of analgesics and who will likely have to deal with some pain in the process. "These patients need to learn to tolerate some level of pain without reaching for a painkiller," Dr. Lake said.

Deep breathing skills and other relaxation methods can be useful tools in pain tolerance, and optimal health behavior, including nutrition and sleep regulation, should be encouraged to further control headaches.

Finally, Dr. Lake emphasized that a clinician's enthusiastic reinforcement of adaptive behavior can make a bigger difference to patients than some doctors may realize. "Reinforcement is a huge factor in our relationships with patients," he said. "I think we sometimes don't recognize how important our relationship is with patients." ■

As Obesity Rates Rise, so Should Awareness of Pseudotumor Cerebri

BY NANCY A. MELVILLE
Contributing Writer

SCOTTSDALE, ARIZ. — The incidence of pseudotumor cerebri is rising among the obese, so physicians should keep this relatively uncommon condition in mind when obese patients present with symptoms resembling brain tumor or intracranial pressure, said Deborah Friedman, M.D., at the American Headache Society's 2004 Headache Symposium.

Pseudotumor cerebri is primarily seen in obese women of childbearing age, and although the condition affects only 1 in 100,000 people in the United States, the rate for obese women between the ages of 20 and 44 is about 19 per 100,000.

In areas with higher levels of obesity, however, pseudotumor cerebri is being seen more frequently.

In Mississippi, called the most overweight state in the nation because a quarter of its population is considered obese by BMI criteria, the incidence of pseudotumor cerebri in the overall population is double, at 2 per 100,000, and among obese women aged 20-44, the rate is about 25 per 100,000. Large increases in pseudotumor cerebri incidence rates have also been noted in men in the region, said Dr. Friedman of the University of Rochester (N.Y.).

The most common symptom, headache, occurs in about 90% of patients. Descriptions of the pain range from headache behind the eyes that feels like pressure to headache in the morning, said Dr. Friedman.

Visual symptoms, seen in about three-quarters of patients, are the second most common symptom, and papilledema is also very common.

"Patients will often describe blurriness or say that if they bend over, their vision goes out for a few seconds when they straighten up again," Dr. Friedman said. "It's usually a sign that the optic nerve is swollen."

About 60% of patients also experience the third most common symptom of intracranial noises, usually described as a whooshing in the ear or the sound of their heartbeat in the ear.

In diagnosing the disease, imaging and mental status are typically normal, and a lumbar puncture should show increased cranial pressure with otherwise normal spinal fluid content.

Dr. Friedman underscored the need for a lumbar puncture. "You have to do a spinal tap to make a diagnosis," she stressed. "It's disheartening how many people I see who come in without having an LP."

There are no evidence-based guidelines for treating pseudotumor cerebri, and not all patients even require treatment. But with the possibility of vision loss, the most important goal of treatment should be to preserve a patient's vision, she said.

An ophthalmologist needs to be brought in for such cases, but it's essential that the physicians collaborate on care, Dr. Friedman noted.

"Most of the time, there's no captain of the ship in management, and the doctors aren't working as a team," she said. "It's crucial to have an ophthalmologist and a neurologist who are both following the patient and talking to each other about how to manage the patient." ■