

Psychotherapy Shows Promise for Fibromyalgia

BY BRUCE JANCIN
Denver Bureau

PARIS — Success rates for nonpharmacologic therapy in patients with fibromyalgia are climbing to previously unattainable levels by tailoring psychotherapy in accord with patient characteristics.

It is best to intervene before the physical and psychological impairments have hardened, and combining the tailored psychotherapy with an exercise training program seems to be important, mental health researchers said at the annual European Congress of Rheumatology.

Saskia van Koulil, Ph.D., summarized her recent comprehensive review of the published literature on nonpharmacologic therapies for fibromyalgia (*Ann. Rheum. Dis.* 2007;66:571-81) as showing modest and inconsistent benefits. In many studies, 30% or fewer of treated patients had at least a 50% improvement in symptoms and functioning, and the benefits typically faded over 6 months. But this poor showing is probably attributable to a past tendency to take a one-size-fits-all approach to psychotherapy for what is in reality a quite heterogeneous syndrome, said Dr. van Koulil of Radboud University, Nijmegen, the Netherlands.

She and her coworkers have developed a validated brief self-report screening instrument (*Int. J. Behav. Med.* 2008;15:211-20) to help differentiate the two major cognitive and behavioral patterns fibromyalgia patients exhibit: pain-avoidance behavior, which is an extension of the well-established psychological fear-avoidance model, and a pain-persistence pattern, in which patients ignore their

pain and persist in painful activities to their detriment.

Fibromyalgia patients with a pain-avoidance pattern are more likely to benefit from operant-behavioral therapy focused on changing observable pain behaviors, while those with a predominantly pain-persistence pattern tend to fare better with cognitive-behavioral therapy addressing maladaptive thoughts. For patients who have elements of both patterns, either form of therapy appears to be appropriate, according to Dr. van Koulil.

She presented a randomized trial in which 216 fibromyalgia patients were assigned either to a multimodal intervention—including tailored psychotherapy—or to a usual-care control group. All had high levels of psychological distress as an inclusion criterion.

The intervention consisted of small, 3-hour-long group sessions twice weekly for 8 weeks. Half of each session was devoted to tailored group psychotherapy, the other half to exercise training, which included pool exercise, aerobics, and relaxation therapy. The patient's significant other attended 3 sessions.

At the end of the intervention, patients rated its usefulness as 8.2 out of a possible 10. They also showed highly clinically relevant 80%-90% reductions on measures of pain, fatigue, functional disability, and anxiety.

At 6-month follow-up 57% of the multimodal intervention group maintained a clinically significant improvement as defined by at least a 0.5-standard deviation gain over baseline on physical functioning measures, compared with 29% of controls. And 49% in the intervention arm showed a similar improvement in psychological functioning, compared with 28% of controls.

Based upon these favorable results, the tailored nonpharmacologic intervention will be implemented nationally at the other Dutch university medical centers, Dr. van Koulil added.

Kati Thieme, Ph.D., reported on 125 fibromyalgia patients randomized to cognitive-behavioral therapy (CBT), operant-behavioral therapy (OBT), or a control group. Patients were followed for 12 months, at which point she and her colleagues looked retroactively at various pretreatment patient characteristics to see which ones separated subsequent responders from nonresponders.

The psychotherapy consisted of 15 once-weekly, 2-hour sessions conducted in small groups codirected by a psychologist and a rheumatologist. The control group met on the same schedule for therapist-guided general discussions of the medical and emotional problems of fibromyalgia, with no therapist recommendations. Spouses attended four sessions.

At 1 year follow-up, clinically meaningful improvements in pain intensity measures were documented in 54% of patients in the OBT group, a statistically similar 45% of the CBT group, and 5% of controls. In the OBT group, 58% had significant reductions in physical impairment, as did 38% in the CBT group and 7.5% of controls, according to Dr. Thieme of the University of Heidelberg (Germany).

"I think the central message is to find out which patients can profit from nonpharmacologic treatment," Dr. Thieme said. Her study was funded by the German Research Council. Dr. van Koulil's was supported by the Dutch Arthritis Association. ■

Foot Complications Found Common in Psoriatic Arthritis

BY BRUCE JANCIN
Denver Bureau

PARIS — When it comes to psoriatic arthritis, don't forget the feet.

The burden of foot pain and deformity is high and the level of foot care provision is low, Deborah E. Turner, Ph.D., reported at the annual European Congress of Rheumatology.

A big part of the reason the feet of psoriatic arthritis patients are under-assessed clinically is that the disease activity measures widely used in both clinical practice and research ignore the foot, according to Dr. Turner of Glasgow (Scotland) Caledonian University.

She reported on an unselected series of 88 consecutive psoriatic arthritis patients at Glasgow Royal Infirmary who underwent a clinical foot examination by a podiatrist. Two-thirds of the patients reported chronic foot pain; in most cases, the medical team was unaware of the problem because nobody had ever asked.

On clinical examination, 30% of the cohort had plantar fasciitis and 24% had Achilles tendonitis. These are probably marked underestimates of the true prevalence of pathology at these sites, as ultrasound studies have shown that roughly three-quarters of psoriatic arthritis patients are affected.

Interestingly, 40% of the psoriatic arthritis patients had inflammatory involvement of the posterior tibial tendon.

A striking finding in the study was the very high prevalence of flat feet in the pa-

tients with significant foot pain. The working hypothesis is that a combination of inflammation of tendons and in the joints around the ankle and rear foot leads to weakened foot ligaments, which then stretch under the stress of weight bearing, resulting in flattening of the arch, Dr. Turner said.

She added that foot problems are often one of the earliest features of psoriatic arthritis. A common scenario in young patients participating in sports is that months before they receive the diagnosis of psoriatic arthritis, they develop Achilles tendonitis and/or plantar fasciitis, which are misinterpreted solely as chronic overuse athletic injuries.

"A lot of attention is given to foot problems in rheumatoid arthritis, but we found the overall burden of foot problems in terms of how much they contribute to the patients' disability was as high for patients with psoriatic arthritis as for those with rheumatoid arthritis," Dr. Turner said in an interview.

Nevertheless, only one-quarter of study participants had received conservative foot care.

The standard podiatric treatment for painful flat foot deformities is the use of a rigid arch support.

As part of Dr. Turner's ongoing research project funded by the Arthritis Research Campaign, she plans to see whether correcting the abnormal foot mechanics in psoriatic arthritis patients improves their inflamed lower extremity joints and tendons. ■

Expert Gives the Lowdown on Diagnosing, Assessing Back Pain

BY DOUG BRUNK
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SAN DIEGO — The good news about low back pain is that it's often self-resolving. The bad news is it tends to reoccur.

"One in five people at any time will have low back pain," said Dr. Francis O'Connor, medical director of the Consortium for Health and Military Performance at the Uniformed Services University of the Health Sciences, Bethesda, Md.

About 40%-50% of patients improve within 1 week, regardless of the type of intervention. In injured workers, 85%-90% "are going to improve within 6-12 weeks.

So the natural history of acute low back pain is fairly favorable."

But overall, 40% of patients report a recurrence of low back pain within 6 months of follow-up and 44% are in a chronic phase within 2 years.

"In over 85% of cases of low back pain, no definitive diagnosis can be made. There are so many structures that cause back pain or referred pain that it's difficult to pin it on one particular structure," said Dr. O'Connor at the annual meeting of the American Academy of Family Physicians.

Clinical assessment of patients with low back pain should begin with an observation of posture. "We're looking for asym-

metry, atrophy, and function," he said. "You [also] want to look for skin lesions like café-au-lait spots, which may be a clue to underlying neurofibromatosis, or a hairy patch, which might be related to an underlying neurodegenerative process."

Lipomas may indicate spina bifida occulta; and asymmetry between the shoulders and pelvis might be a clue for an underlying muscular spasm or fixed deformity.

Making note of the patient's lordosis is also advised. "If it's exaggerated, that could be a characteristic of a weak abdominal wall or spondylolisthesis."

Other components of a clinical work-up should include palpation of the back, range-of-

motion testing, gait assessment, and a neurologic exam to evaluate motor and sensory function.

One should also evaluate for Waddell's signs—nonorganic signs indicating the presence of a functional component of back pain. The signs are superficial, nonanatomic tenderness; pain with simulated testing; inconsistent responses with distraction; nonorganic regional disturbances; and overreaction verbally or with exaggerated body language. Being positive for three of the five suggests a nonorganic etiology and a poor potential outcome with operative intervention, Dr. O'Connor said. ■

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DR. O'CONNOR

