Air-contrast barium enema

A barium enema with a good air-contrast technique can be used in conjunction with sigmoidoscopy to evaluate the entire colon. A single-contrast barium enema has a 40% false-negative rate and is not acceptable as a screening tool.

Colonoscopy

Colonoscopy in experienced hands is the screening method of choice, but until recently its cost and manpower requirements have limited its use to populations at high risk. One proposal is to perform a colonoscopy in all persons between the ages of 50 and 60. Patients found to have adenomas would have them removed and then undergo colonoscopic surveillance; patients without adenomas could wait 10 years before undergoing colonoscopy again.

FOLLOW-UP AFTER POLYPECTOMY

The National Polyp Study published results of a randomized evaluation of the appropriate surveillance interval after adenomas have been removed. It appears safe for most patients to wait 3 years before the next examination. Once no adenomas are found, the interval can be extended to 5 years. Longer intervals may even be appropriate for persons with only one small adenoma. Patients at higher risk include those with four or more adenomas, an incompletely removed polyp, a polyp with invasive cancer, or a poorly prepared colon. These patients may be better served by an examination in 1 year and then 3 years.

CAN POLYPS BE PREVENTED?

Epidemiologic studies suggest a relationship between high-fat, low-fiber diets and colorectal cancer and adenomas. Genetic studies have elucidated loss of several tumor suppressor genes and activation of the *ras* oncogene in a stepwise progression from normal colonic mucosa to adenoma to cancer. Despite these advances, we are still not able to exert primary prevention for colon cancer.

Several large trials are investigating various supplements and medicines to prevent polyps. Supplements of vitamins A, C, and E showed no effect on polyp recurrence in a randomized, prospective, double-blind study of patients with adenomas. Calcium is currently under study, as is a metabolite of sulindac, a nonsteroidal anti-inflammatory drug. The most exciting agent under current study is aspirin; several epidemiologic and cohort studies have shown a protective association between regular aspirin use and a reduced incidence of colon cancer.

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IS FIBROMYALGIA A USEFUL DIAGNOSTIC LABEL?

FIBROMYALGIA is a hypothesis. It is a descriptor that serves many masters: it facilitates research, offers the comfort of the laying on of diagnostic labels, and serves the intellectual and administrative mandate to categorize.

See Editorial, page 87

However, on close inspection, it can be seen that the label "fibromyalgia" is a contrivance that harms the patient. The diagnosis of fibromyalgia results from the reductionistic way of thinking that has dominated Western medicine for most of this century. It describes physical complaints that all humans associate with being "out of sorts" and magnifies these complaints into a full-blown syndrome. The labeling process itself is iatrogenic; it cues patients on how to perceive their problems and prompts them to change how they view themselves.

THE SYNDROME OF OUT-OF-SORTS

Everyone has bad days. Most of us realize that simply being alive means we will have some days when we feel a little indisposed. I have identified the components of a bad day, which I call the syndrome of out-of-sorts (SOOS). SOOS is characterized by at least four of the following: loss of the sense of well-being, decrease in energy, easy fatigue, heaviness in the head, stiffness and achiness, and awareness of one's bowels (*Table*). Usually, people can identify the stressors that contribute to their SOOS, and most

TABLE
COMPONENTS OF THE SYNDROME OF OUT-OF-SORTS (SOOS)*

At least four required for diagnosis
Loss of the sense of well-being
Decreased energy
Easy fatiguability
Bitemporal heaviness or achiness
Inexplicable anxiousness
Perception of a sleep debt
Vigilance as to unusual symptoms
Musculoskeletal symptoms
Diffuse achiness
Disconcerting stiffness, often in the morning
Sense of swelling, particularly about small joints
Tenderness, often about the neck, shoulders, and low back
Intermittent numbness of the hands or feet or both
Gastrointestinal symptoms
Increased or decreased stool frequency
Keen awareness of bowel function
Peculiar associations of well-being with external events
Improvement with exercise
Exacerbation with stress
Exacerbation on gloomy, damp, and cold days

*From Hadler NM. Occupational musculoskeletal disorders. New York: Raven Press, 1993

bad days are quickly forgotten. But sometimes they are not forgotten. If people have a number of bad days consecutively, they speak to family and friends about their symptoms and seek out articles about their complaints in the popular media.

When these coping mechanisms no longer work, they go to the doctor, who will do the most dangerous thing in all medicine—take a history. The history-taking is an extraordinarily instructional moment for the patient, and it can never be undone. By asking certain questions (and not others) and by focusing on specific issues (and not others), the doctor creates a participant in the diagnostic event, who interacts with the doctor's predisposition to focus on certain problems.

If feeling tired is what the patient displays, and what the physician is prepared to hear, the taking of the history will lead into the diagnostic algorithm for chronic fatigue syndrome. If the patient wants to talk about his or her bowels and the doctor is prepared to hear about bowels, the result will be a diagnosis of irritable bowel syndrome. Or if the patient displays musculoskeletal symptoms and the doctor is prepared to focus on those, a diagnosis of fibromyalgia is the likely result.

The diagnosis of any of these three conditions involves exclusion of any other known causes. To reach these diagnoses, patients are subjected to months of expensive and sometimes unpleasant tests. At the end of this time, the patients' feelings of invincibility are gone forever, and the language in which they describe their SOOS will be totally different from any language they ever used before the initiation of the diagnostic algorithm. We teach them to be sick.

FIBROMYALGIA CRITERIA: UNSPECIFIC AND SUBJECTIVE

Despite contentions that these labels help physicians diagnose and quantify a constellation of problems, these labels are not specific. Up to 70 percent of people labeled as having fibromyalgia can also be labeled as having irritable bowel syndrome or chronic fatigue syndrome, and vice versa. The criteria (generalized aching for at least 5 months, 11 or more "tender points" in 18 specific locations, symptom modulation by weather, symptom modulation by physical activity, symptom aggravation by anxiety, unrestful sleep, morning fatigue, generalized chronic fatigue, anxiety, chronic headaches, irritable bowel symptoms) can also be found in normal, healthy people.

The concept of tender points is especially preposterous. Everyone has tender points because nobody likes to be poked. Because so many people have tender points, attempts were made to define fibromyalgia patients as having tender points that are somehow "more tender," or as having more of them. A substantial portion of the general population, as many as 12% by some estimates, meet the criteria of "widespread pain."

The myth that sleep disturbances are at the root of fibromyalgia is based on the mistaken impression that we all sleep soundly. In fact, occasional sleep disturbances are the normal response to SOOS, to the stresses of a bad day. There is nothing pathological about it. The studies that have found something amiss in the sleep architecture of fibromyalgia patients cannot be replicated.

THE FIBROMYALGIA DIAGNOSIS DOES HARM

The diagnosis of fibromyalgia (or irritable bowel syndrome or chronic fatigue syndrome) actually does harm. It labels people as sick and changes their own perceptions of themselves. It may also miss the point. For example, one study found that patients referred

to a center for irritable bowel syndrome tended to be young women with histories of abusive relationships.

The diagnosis of any of these conditions does little good. The available therapies (mood elevators, exercise, and counseling) provide minimal demonstrable benefit. Direct discussion of psychological issues is often avoided, because of the stigma associated with mental problems.

When patients present with SOOS symptoms, physicians usually can quickly exclude serious underlying disease. The doctor's approach should then be, "I hear what you are telling me. Clearly this is unpleasant, but the reason you are here is you are having trouble coping with something that you could cope with in the past. Why?" Otherwise, the physician creates illness and does harm.

Fibromyalgia illustrates the perils of medicalization. Here is a population of patients who have no end-organ damage but who are forced to live a life that is the lot of only the most impaired. The discordance is heart-breaking. It is also a lesson.

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Fibromyalgia: more than a label

STEPHEN JAY GOULD bemoans a common tactic employed by scholars in academic debate, the "...ripping apart [of] nonexistent caricatures of each other's ideas."[1] By using this sophist technique, the intellectual substance and empiric reality of a theory or argument is mischaracterized to advance a competing idea.

See Hadler, page 85.

In many ways, Nortin Hadler's critique of fibromyalgia in this issue of the *Cleveland Clinic Journal of Medicine* is a case in point.[2] Hadler makes a number of statements that are true—in part. But in presenting each of his points, he fails to go far enough and presents an incomplete picture of fibromyalgia.

Although my disagreements with Dr. Hadler on many of his individual points are quantitative, not qualitative, on his central thesis—that labeling a patient as having fibromyalgia is destructive—I disagree entirely.

FIBROMYALGIA: A 'CONDITION,' NOT A DISEASE

Dr. Hadler argues that fibromyalgia is a contrived hypothesis, not a distinct clinical disease. I agree and have always thought that fibromyalgia might best be considered a "condition" rather than a disease, but a distinct condition nevertheless.[3] To be valid and useful, the definition of a condition or syndrome should satisfy certain criteria: patients with the condition should present with the same characteristic clinical symptoms, should respond in like manner to treatment, and should share a predictable outcome. Although symptoms such as myalgia, fatigue, tender points, irritable bowel, and headache regularly occur in the general population,