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,

severe, chronic expressions are rare and *do* characterize a homogenous group of patients, as shown in population studies.[4–6] These patients can expect some improvement in symptoms with education, aerobic exercise, and tricyclic antidepressant drugs.[7] The severity and outcome can be predicted on the basis of demonstrated prognostic factors.[8–10]

The role of sleep disorders and stress

I agree that the sleep anomaly described in fibromyalgia is not unique to this condition. However, Hadler's selection of the mildly pejorative noun "myth" is a poor choice to describe the role of disordered sleep in fibromyalgia. That delta sleep is abnormal or deficient in fibromyalgia has been shown in nearly all appropriately conducted series.[11,12] Because altered delta sleep is also seen in patients with depression, this "myth" has helped us understand one of Dr. Hadler's valid conjectures, that patients with fibromyalgia may well have "distress" as an underlying condition. Useful theories of the pathophysiology of fibromyalgia rely heavily on information derived from sleep research.[13,14] Furthermore, recognition that disordered sleep and psychological distress might be important in the etiology of fibromyalgia has led to positive therapeutic trials of tricyclic antidepressant drugs.

Given that distress is an important etiologic factor, clinical overlap with other conditions that may also be mediated by response to stress should not invalidate the definition. For instance, rheumatoid arthritis shares physiologic mechanisms with Sjögren's syndrome and vasculitis, both of which can occur in patients with rheumatoid arthritis. Signs and symptoms of Sjögren's syndrome and vasculitis do not invalidate the diagnosis of rheumatoid arthritis in a patient whose chief complaint is symmetrical arthropathy. Neither should the co-occurrence of fatigue, alternating constipation and diarrhea, or other symptoms invalidate the diagnosis of fibromyalgia in a patient whose chief complaint is diffuse pain. In fact, overlap should be expected.[15]

I agree with Dr. Hadler that the tender-point concept as a major component of the diagnosis may be simplistic. Tender points may be nothing more than normally tender anatomic structures that become more tender when pain thresholds fall.[16] The combination of widespread pain, sleep disturbance, fatigue, and depressed feelings may better define fibromyalgia than does sole reliance on a prescribed number of tender points.[4,5]

Treatments for fibromyalgia work

If fibromyalgia were not effectively treatable, applying the label would not be pragmatic. In fact, a number of treatments provide significant improvement compared with placebo.[7] Felson[9] reported modest long-term clinical improvement in patients with difficult-to-treat fibromyalgia treated at a tertiary care center. Reports from community-based practices in Europe have been more optimistic. In one study, of 44 patients, nearly half no longer fulfilled the criteria for fibromyalgia after 2 years of treatment, and 20% were asymptomatic.[17] The diagnosis should be made because effective treatment is available.

THE DANGER OF ABOLISHING FIBROMYALGIA

Dr. Hadler argues that the label of fibromyalgia harms patients, rendering the well sick. Let us imagine that labels such as fibromyalgia were officially banned. What might happen? Arguments that stress-related syndromes do not exist are particularly seductive for third-party payers. A nonexistent condition can neither cause disability nor require medical care. However, doing away with such labels could have the opposite, unintended effect of increasing costs. Without these labels, the physician may feel compelled to investigate each separate symptom thoroughly (and expensively), and then, in the absence of obvious physiologic causation, apply the "one-symptom, one-drug" dictum and treat each symptom individually. These outcomes—the squandering of diagnostic medical resources and knee-jerk polypharmacy—are worst-case scenarios that can result from the medicalization of somatic symptoms.

Patients with these symptoms have been with us in the past and will continue to be with us.[18,19] Without unifying labels, after exhaustive tests reveal nothing, moderately distressed people may be labeled with overly enthusiastic psychiatric diagnoses to allow them to qualify for medical care or disability benefits or both. Such inaccurate psychiatric labeling carries social stigma and may be more destructive than a descriptive physiologic label such as fibromyalgia.

Barsky[20] predicts that as capitation produces greater incentives to reduce medical utilization, innovative strategies will be needed to meet the needs of patients with somatic symptoms without obvious pathologic basis or target-organ damage. He suggests

that distinct subtypes be defined. These already exist as fibromyalgia, chronic fatigue, and other designations. Rather than discard these labels, I would argue for better definition and characterization of each of these syndromes to identify similarities, differences, and important prognostic features. These well-defined populations then would be available for meaningful therapeutic trials.

THE PROPER ROLE OF FIBROMYALGIA

The diagnostic label fibromyalgia identifies a population with a homogenous pattern of somatic complaints. When physicians recognize the characteristic pattern of symptoms and find no end-organ damage after a careful history and physical examination, exhaustive testing is not necessary. Treatment and education can then be promptly initiated with expectation of some improvement. As research and education continue, more physicians will become aware of the pathophysiologic factors in fibromyalgia, including anxiety and depression. Rather than obscuring psychiatric diagnoses, the label will facilitate recognition and provide further impetus for treatment.

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