Small fibers, large impact

We're all aware that our Internet use is closely tracked and analyzed. Search once for a turtle aquarium light and then dodge the e-mails and Amazon shopping suggestions for amphibian heaters, gourmet dried shrimp turtle treats, and waterfall-shaped water filters.

The details about an individual's search for information tell us a lot about healthcare concerns and uncertainty across the medical universe. For nearly a decade, one of the most "clicked on" papers we have published in the *Journal* has been a review of small fiber neuropathy—a clinical entity with a prevalence of perhaps 1 in 1,000 to 2,000 people and, to my knowledge, no associated walkathons or arm bracelets. Yet it certainly piques the interest of clinicians from many specialties far broader than neurology. In this issue of the *Journal,* Dr. Jinny Tavee updates her 2009 review and provides us with a clinical overview of the disorder and the opportunity to assess how much further we need to more fully understand its management and associated comorbid conditions (page 801).

The wide interest in this disorder plugs into our current seeming epidemic of patients with chronic pain. It seems that almost half of my new patients have issues related to chronic pain that are not directly explained by active inflammation or anatomic damage. Many of these patients have diffuse body pains with associated fatigue and sleep disorders and are diagnosed with fibromyalgia. But others describe pain with a burning and tingling quality that seems of neurologic origin, yet their neurologic examination is normal. A few describe a predominantly distal symmetric stocking-and-glove distribution, but most do not. In some patients these pains are spatially random and evanescent, which to me are usually the hardest to fathom. Nerve conduction studies, when performed, are unrevealing.

A number of systemic autoimmune disorders, as discussed by Dr. Tavee in her article, are suggested to have an association with these symptoms. Given the chronicity and the frustrating nature of the symptoms, it is no surprise that a panoply of immune serologies are frequently ordered. Invariably, since serologies (eg, ANA, SSA, SSB, rheumatoid factor) are not specific for any single entity, some will return as positive. The strength of many of these associations is weak; even when the clinical diagnosis of lupus, for example, is definite, treatment of the underlying disease does not necessarily improve the dysesthetic pain. In an alternative scenario, the small fiber neuropathy is ascribed to a systemic autoimmune disorder that has been diagnosed because an autoantibody has been detected, but this rarely helps the patient and may in fact worsen symptoms by increasing anxiety and concern over having a systemic disease such as Sjögren syndrome or lupus (both of which sound terrible when reviewed on the Internet).

Some patients describe autonomic symptoms. Given the biologic basis that has been defined for this entity, it is no surprise that some patients have marked symptoms of decreased exocrine gland function, gastrointestinal dysmotility, and orthostasis. These symptoms may not be recognized unless specifically sought out when interviewing the patient.

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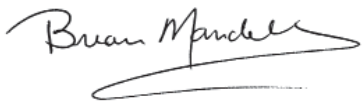
Given the chronicity and sometimes the vagaries of symptoms, it is often comforting for patients to get an actual diagnosis. Dr. Tavee notes the relative simplicity of diagnostic procedures. But determining the clinical implications of the results may not be straightforward, and devising a fully and uniformly effective therapeutic approach eludes us still. As she points out, a multidisciplinary approach to therapy and diagnosis can be quite helpful.



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