Fibromyalgia in Male—Uncommon, but not Rare

1Arthy E Murthy, 2Gautam Das, 3Praneet Singh, 4Nagarajan Nagalingam

ABSTRACT

Fibromyalgia (FMG) is the most important cause of widespread pain. It is commonly missed out in male patients. We report a case of FMG in a male patient, which is a less common presentation as compared with female patients.

Keywords: Duloxetine, Fibromyalgia, Symptom severity scale score, Widespread pain index.

How to cite this article: Murthy AE, Das G, Singh P, Nagalingam N. Fibromyalgia in Male—Uncommon, but not Rare. J Recent Adv Pain 2017;3(3):145-146.

Source of support: Nil

Conflict of interest: None

INTRODUCTION

Fibromyalgia is one of the most important causes of widespread pain and is a common medical condition affecting the general population.1 The estimated prevalence ranges from 2 to 12%.2,3 The American College of Rheumatology (ACR) has helped in recognizing this disease better since the launch of their official FMG classification in 1990. Quality-of-life is significantly reduced for these sufferers.

The FMG is commonly missed out in the male population. This is probably due to milder severity of pain and it lasts for a shorter duration in comparison with women. Despite these features, the male symptoms can still be severe and debilitating. Thus, an early diagnosis and prompt treatment will definitely help these patients.

CASE REPORT

A 40-year-old male came to Daradia Pain Clinic with a history of chronic widespread pain, which was present in all four quadrants of the body. It started with low back ache, which gradually progressed to shoulder and neck pain. He has been having the pain since 15 years with recent aggravation for the past 1 to 2 years. The pain was described as a constant, dull pain that typically originated from the muscle and, occasionally, was associated with a burning sensation. It was often worse in the morning, which was associated with morning stiffness for about an hour. He often woke up tired, even though he seemed to get enough sleep. Apart from these, he complained of dryness of eyes, difficulty in breathing, constipation, chronic fatigue, memory impairment, and anxiety. The quality-of-life and psychosocial function were deteriorated due to the symptoms. The patient had visited multiple hospitals and received varied medications, but with no significant improvement of symptoms. He had a widespread pain index (WPI) of 14 and a symptom severity (SS) scale score of 6. Laboratory tests did not reveal anything significant and all potential diagnoses were ruled out. Ultimately, the diagnosis of FMG was made. He was started on Tab Duloxetine 20 mg O.D. and Tab Nortriptyline 25 mg B.D. with which his symptoms improved within 1 month and was advised to continue on the same medication.

DISCUSSION

The FMG had been initially termed “muscular rheumatism,” “tender points,” and “fibrositis.” The FMG is a chronic disorder, which is characterized by widespread musculoskeletal pain often accompanied by mood problems, headaches, sleep disturbances, and fatigue. Previously, the standard diagnostic criteria for FMG by the ACR criteria, proposed in 1990, require the presence of widespread pain for at least 3 months and at least 11 of 18 tender points. Using these criteria, FMG is estimated to affect 2 to 4% of the population4 with a much higher female-to-male ratio at 9:1.5 The 2010 ACR criteria require diagnosis of FMG to be made when following three conditions are met:

1. A WPI of 7 and SS scale score of 5 or WPI of 3 to 6 and SS scale score of 9.
2. Symptoms have to be present at a similar level for at least 3 months.
3. The patient does not have a disorder that would otherwise explain symptoms.

The prevalence of FMG is greater among first-degree relatives of individuals than in the general population, suggesting a genetic predisposition to the disease. Buskila and Neumann6 studied patients with FMG and found the prevalence among blood relatives to be 26% with prevalence in female relatives as 41% and in male relatives as 14%. Weir et al.7 in their study, found that females
were 1.64 times more likely than males to have FMG. The prevalence of FMG seen in specialty clinics is similar to that in the general population, with FMG being about six times more common in females than males.8

Although FMG is rare in male patients, that should not preclude a clinician to make a diagnosis of FMG in male counterparts. Yunus et al in their study found male patients with FMG having fewer symptoms and fewer Tender points, and less common “hurt all over,” morning fatigue, and irritable bowel syndrome (IBS) compared with female patients. Yunus et al10 in their study found that gender differences have also been observed in other related syndromes, e.g., chronic fatigue syndrome, IBS, and headaches. The mechanisms of gender differences in these illnesses are not fully understood, but are likely to involve an interaction between biology, psychology, and sociocultural factors. Arnson et al in their study related to physical activity in male patients with FMG found that physical exercise in male patients with combat-related posttraumatic stress disorder provides protection from the future development of FMG. Hendler12 mentioned why chronic pain patients are misdiagnosed and FMG may be one reason. Furthermore, physical activity is related in this group of patients to a better perception of their quality-of-life.

In conclusion, although diagnosis of FMG is rare in male patients, this should not mask a physician to rule out the disease solely based on gender differences.

REFERENCES


