Profile of Patients With Fibromyalgia Being Treated in Primary Care Centers in Terrassa, a City in Northeastern Spain

Teresa Mur Martí, Montse Llordés Llordés, Mercè Custal Jordà, Gemma López Juan, Silvia Martínez Pardo

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A B S T R A C T

Objective: To perform an extensive clinical and epidemiological characterization of our fibromyalgia patients.

Patients, material, and method: Two-year observational study in 3 primary care centers in Terrassa, Spain. We recruited a sample of 235 individuals diagnosed with fibromyalgia being treated in primary care or rheumatology clinics who, when offered inclusion in a multidisciplinary program, agreed to provide the initial data we requested. The main measures were sociodemographic data, unhealthy habits and physical activity, comorbidities, treatment for fibromyalgia, Fibromyalgia Impact Questionnaire (FIQ), Hospital Anxiety and Depression Scale (HADS), and a family functioning scale (family APGAR).

Main results: In all, 97.8% were women and the average age was 54.6 years. Most of the patients had a primary school education and the majority was on sick leave. Ninety-four percent had associated comorbidity and only 3% were not taking any medication for their disease. Many were taking drugs with no proven efficacy in fibromyalgia. The majority had intermediate scores on the FIQ, the HADS showed that 63% and 53% had an anxious and/or probable depressive disorder, respectively, and, according to the family APGAR score, 62% received proper family support.

Conclusions: In agreement with the literature, the major findings in our fibromyalgia patients were a marked predominance of women, a high incidence of comorbidities—mainly psychiatric disorders—a moderate impact of the disease and widespread use of drugs with no demonstrated efficacy.

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Perfil de pacientes con fibromialgia que acuden a los centros de atención primaria en Terrassa

R E S U M E N

Objetivo: Realizar una amplia caracterización clínica y epidemiológica de nuestra población afectada de fibromialgia.

Pacientes, material y método: Estudio observacional a lo largo de 2 años realizado en 3 centros de atención primaria de Terrassa. Muestra de 235 personas diagnosticadas de fibromialgia visitadas en consultas de atención primaria o de reumatología a las que se ofrece la asistencia al programa multidisciplinar y aceptan completar los datos iniciales del programa. Las mediciones principales fueron: datos sociodemográficos; hábitos tóxicos y ejercicio físico; comorbilidades; tratamientos para la fibromialgia; cuestionario de impacto de la fibromialgia (FIQ); escala hospitalaria de ansiedad-depresión (HADS), y cuestionario de funcionalidad familiar (APGAR familiar).

Palabras clave:
Fibromialgia
Atención primaria
Comorbilidad

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* Corresponding author.
E-mail addresses: tmme37@gmail.com, tmm@mutuaterrassa.es (T. Mur Martí).

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Introduction

Fibromyalgia (FM) is a disorder characterized by chronic widespread pain and the presence of tenderness in defined anatomic locations. Incorporated in 1991 into the tenth revision of the international classification of diseases of the World Health Organization (WHO) as a nonarticular rheumatism, it is the third most common rheumatic disease and one of the most frequent causes of pain. It affects 2.4% of the population (1.5–3.2), with a maximum prevalence between 40 and 49 years of age (4.9%), and is 6–8 times more frequent among women. It is the reason for 10–20% of visits to a rheumatologist and for 5–8% of those to primary care clinics. The main symptoms are chronic pain and extreme fatigue or exhaustion. There can be many other symptoms, such as sleep problems, muscle stiffness, headache, irritable bowel syndrome, cold extremities, intolerance to drugs and chemical substances, dry mouth and eyes, frequent and/or painful urination, paresthesias, dizziness and impaired concentration and memory, which are increasingly important for the diagnosis of FM, as is shown by the new preliminary criteria drawn up in 2010 by the American College of Rheumatology (ACR) and subsequently modified in 2011. Fibromyalgia is a significant cause of disability for patients and involves high expenses, both directly, with medical visits and medication, and indirectly, with time off from work or disabilities. The major change in FM seems to be a central sensitization of the system for transmitting and producing pain of an unknown etiology. The recognized risk factors for its development would include sex (a great number of women), familial aggregation (first-degree relatives have an 8-fold higher likelihood of developing FM than the general population) and the previous presence of chronic regional pain such as headache, low back pain, myofascial pain or irritable bowel disease, with which, moreover, there is familial coaggregation. Other risk factors could be stress, hepatitis C virus (HCV) or a history of physical or psychological trauma. Patients with FM usually have considerable comorbidity, and the presence of psychiatric or psychological disorders is stressed, with an open debate on whether their presence is equivalent to that which develops in any process with chronic pain, or whether FM is a psychiatric condition. This comorbidity could also be influenced by the perception of limited general social support provided to these patients, who perceive greater support from their families and partners.

The objective of our study was to characterize from the epidemiological and clinical points of view a series of FM patients in our area of reference, especially emphasizing the comorbidities, treatments and the impact of the disease.

Material and Methods

We conducted a cross-sectional descriptive study in 3 primary care clinics (PCC) in Terrassa. The population studied included all the persons who attended the welcome visit that introduced them to the multidisciplinary Fibromyalgia Care Program over a period of a little more than 2 years (2011–2013). All had been seen in the rheumatology department of Hospital Mútua of Terrassa, where the diagnosis of FM had been confirmed on the basis of the 1990 ACR criteria. Attendance was totally voluntary, and the participants were asked to provide verbal consent to employ their data. In turn, the researchers involved in the study ensured complete anonymity and confidentiality in their utilization. The information collected consisted of sociodemographic data (age, sex, marital status, number of children, ethnicity, level of education, current employment, professional standing and disability); data on lifestyle (tobacco use, alcohol consumption and regular physical activity); data on their disease (time since onset of pain and fatigue, years since diagnosis, use of drugs for FM, alternative therapies, treatment at the time of the interview and familial history of FM); and comorbidity (chronic physical or psychological disorders). The information was obtained in an interview with each participant and a review of the electronic medical record. The questionnaires used were: the Fibromyalgia Impact Questionnaire (FIQ), which evaluates the impact of the disease on the activities of daily living of the patients, with a score of 0–100, the higher the score reflects a greater impact; Family Appgar (Adaptation, Partnership, Growth, Affection and Resolve), which assesses the perception of family support, considering the family to be functionally normal if the score was 7 or more, over a maximum of 10 points; and the Hospital Anxiety and Depression Scale (HADS), which deals with the possible coexistence of psychiatric disorders like anxiety and/or depression, which is very probable when the score is greater than 10 and not very probable when it is under 8. The logbook could be self-completed, but patients had the constant support of the organizers of the program to resolve doubts, and it could be done jointly if the level of education was very low.

Definitions

Smoker: person who had had at least 1 cigarette a day over the previous year.

Habitual alcohol consumption: person who consumed at least 1 standard drink per day.

Regular physical activity: at least 1 hour of physical activity (not job-related) per day at least 3 days a week.

Concomitant or associated chronic disease: any condition reported in the patient history as an active process with a duration of over 3 months. Those considered were physical disease, whether symptomatic (osteoarthritis, hypothryroidism or disc herniation) or asymptomatic (diabetes mellitus, hypertension or dyslipidemia), and psychiatric/psychological disorders (depression, anxiety or phobias).
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