Transcript Details
This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: https://reachmd.com/programs/living-rheum/differentiating-fibromyalgia-and-axial-spondyloarthritis-can-these-conditions-co-occur/13362/

ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Differentiating Fibromyalgia and Axial Spondyloarthritis: Can These Conditions Co-occur?

Announcer:

You're listening to ReachMD.

This episode of Living Rheum, titled "Differentiating Fibromyalgia and Axial Spondyloarthritis: Can These Conditions Co-occur?" is sponsored by Novartis US Clinical Development and Medical Affairs. The host and speaker have been compensated for their time. This program is intended for health care professionals.

Here's your host, Dr Ethan Craig.

Dr Craig:

Many patients with fibromyalgia may present with symptoms that look consistent with axial spondyloarthritis. These patients with overlapping symptoms can make reaching an accurate diagnosis of spondyloarthritis or, for that matter, fibromyalgia, challenging, especially in cases with borderline features. So how can we improve the diagnosis of these patients?

This is ReachMD, and I'm Dr Ethan Craig. Joining me to take a look at this challenging scenario and discuss how to work through it as Dr Lianne Gensler. Dr Gensler is a rheumatologist and the Director of the UCSF Spondyloarthritis Clinic at the University of California San Francisco Medical Center. Dr Gensler, thank you for being here today.

Dr Gensler:

Thanks for inviting me.

Dr Craig:

So, let's start with some background. Dr Gensler, how often do we see fibromyalgia co-occurring with axial spondyloarthritis?

Dr Gensler:

Yeah, so of course I guess that first depends on how are both the diagnosis of axial spondyloarthritis and fibromyalgia being made? And it's really a challenge to make both of these diagnoses in the same patient because it requires that we have said the patient with axial spondyloarthritis does not have disease activity that's driving the pain.

And the reason why there is overlap in some of these presentations is that we know patients with axial spondyloarthritis may have enthesitis and many of the areas that would be tender at entheseal insertion points, could be also tender in the setting of fibromyalgia. So, it's a challenging entity to disentangle. Based on literature out there, the range of fibromyalgia co-occurrence in patients with axial spondyloarthritis is probably somewhere between 16 and 30%. But many of the studies that have assessed this have not necessarily excluded patients with true active axial spondyloarthritis.

Dr Craig:

And one of the areas, as you mentioned, that can be particularly challenging in diagnosing these conditions is differentiating those fibromyalgia tender points, as it were, from enthesitis. Is there a reliable way to distinguish these 2 entities?

Dr Gensler:

In some areas. So, for example, the Achilles tendon insertion or the plantar fascia insertion on the calcaneus isn't really a fibromyalgia tender point. In addition, areas like the patella tendon insertion on the tibial tuberosity, that's a fairly bony structure. And so, in the setting of true inflammation, sometimes that area is warm and swollen. That should not be a fibromyalgia tender point or an area of tenderness. Even in a patient with axial spondyloarthritis, I think when there are many entheseal tender points, that should be a red flag to you that it is probably less likely coming from active enthesitis than possibly being driven by more of a widespread pain syndrome. So, I think part of it is the location of the tender points and thinking, and if there's objective inflammation that's obviously not fibromyalgia, and then part of it is how many areas are tender. And the more tender areas there are, polyentheseal tenderness is less likely driven by spondyloarthritis.

So those are some of the clinical ways for us to think about differences. Of course, you can use objective imaging studies to look for entheseal inflammation. And an easy point-of-care study, if you do ultrasound in your clinic could be to look at inflammation by ultrasound. You can certainly send a patient to get a musculoskeletal ultrasound in radiology. And then I sometimes, if I'm not sure, will actually go on to MRI because in the patients with true enthesitis, they will also have bone marrow edema of the bony area where the entheses inserts. So, I do think when you're not sure, even despite these clinical features, using objective measures to look for inflammation can be helpful.

Dr Craig:

Okay. So, another factor that can be really challenging is considering disease activity in patients that you think have axial spondyloarthritis, but also a component of fibromyalgia. So how do you approach disease activity monitoring in patients with comorbid fibromyalgia? And what do you use to monitor these patients?

Dr Gensler:

Yeah, it's a great question. So, I do measure disease activity at every visit by using a specific PRO, patient-reported outcome. I use the BASDAI, and then I also calculate the ASDAS, which adds in the patient global and typically the CRP. And so, in a patient with fibromyalgia and axial spondyloarthritis, these may be high. But by following them over time, as I tell patients, they are their own control, and so when I see improvement, even if it still persists as being high, that is helpful to me. And stability is helpful to me, as opposed to not knowing where a patient was before and just reporting a higher degree of pain and symptoms or fatigue.

I also, from a PRO standpoint with the BASDAI, certain of the questions if you look at the components is really helpful. So, I'll see a patient with high disease activity. And then I'll look back at the components and I'll see that actually, the thing that is really high today is fatigue. And fatigue, obviously, is nonspecific, it certainly could be a manifestation of active inflammation. But if that's the only thing that's up and actually the patient's axial symptoms are better or stable, that suggests maybe something else is driving the overall disease activity.

Dr Craig:

Dr Gensler, what do we know about the impact of having fibromyalgia on outcomes for patients with axial spondyloarthritis in the long term?

Dr Gensler:

Yeah, so in the setting of both conditions you can imagine that if we're measuring response to treatment by symptoms of pain, and fatigue, and patient global, then those may be less responsive to immunomodulatory treatment then thinking about the patient more holistically and approaching all of the ways pain manifests. So, I think we just need to be realistic in a patient that has both axial spondyloarthritis and fibromyalgia. It doesn't mean that they don't warrant the same treatment, but in terms of expecting them to reach remission or responding as well as a patient that only has axial spondyloarthritis, there may be a difference.

I think it's typically our female patients that are diagnosed with fibromyalgia more and, in fact, misdiagnosed with fibromyalgia over axial spondyloarthritis. And so, we do need to be careful as clinicians not biasing our approach to patient's treatment recommendations based on the presence of fibromyalgia or considering fibromyalgia as the primary driver of their pain. Every patient with axial spondyloarthritis deserves treatment if they have symptoms that would warrant that, or could improve. And I think it's sometimes only after we've treated those patients that we are left with saying, well, what's residual may be driven by fibromyalgia. So, this comorbid condition could actually hurt patients if we're really focused on the fibromyalgia.

Dr Craig:

Based on what we know then, how often do you think we might be misclassifying in the other direction, and misclassifying patients with fibromyalgia as having axial spondyloarthritis both clinically and in the research environment?

Dr Gensler:

Yeah, so I think that definitely happens, this is the overdiagnosis as opposed to the underdiagnosis. It more typically happens in patients with non-radiographic disease because the MRI findings, we're still learning about MRI as a biomarker and understanding what the implications of bone marrow edema are, for example. And so, in the setting of radiographic disease, if you truly have damage to the sacroiliac joints, in particular with extensive damage, ie, large erosions or pseudo-widening of the joint or joint space narrowing or partial ankylosis or full ankylosis, there is no question that's a patient with radiographic axial spondyloarthritis or ankylosing spondylitis. But it's the other group, the patients that don't have a lot of damage that may be diagnosed with axial spondyloarthritis who may actually have fibromyalgia.

Dr Craig:

Great. You know, well, with those final thoughts in mind I want to thank my guest for helping us in thinking about differentiation of axSpA from fibromyalgia and how we approach those difficult patients that do have both conditions. And Dr Gensler, it was great speaking with you today. Thank you.

Dr Gensler:

Thank you.

Announcer:

This industry podcast was sponsored by Novartis US Clinical Development and Medical Affairs. If you missed any part of this discussion or to find others in this series, visit reach-M-D-dot-com-slash-living-rheum.

This is ReachMD. Be Part of the Knowledge.