

Correspondance

Diagnosis of fibromyalgia

Michael Puttick noted that a diagnosis of fibromyalgia can be made if multiple tender points are present.¹ According to the American College of Rheumatology, this condition can be diagnosed even if only 6 tender points are present, provided there is "moderate or greater tenderness."² I wish to point out that even if there is only one tender point in one of the typical areas for fibromyalgia, the pain in the tender point can be relieved by massage so dramatically as to confirm the diagnosis.

For example, there may be occipital pain, perhaps radiating over the skull to the frontal area, giving the patient the impression that she or he suffers from migraine. One feels a fibrous band in the muscle attachment in the occipital area, which softens on being massaged. Likewise, there may be only one painful point in the supraspinatus, but when one massages the area one senses a sort of bubbling or crackling under the thumb or palm, and with this the patient's pain begins to subside. The relief may be complete if the treatment begins soon after the onset of the pain but only gradual if the pain has been present for several days. The plasma myoglobin concentration has been shown to increase after massage for myofascial pain,^{3,4} and the degree of tension and pain in the muscle is positively correlated with the plasma myoglobin level after the muscle is massaged.⁴

However, physician be warned. Treatment by massage is extremely painful; patients find it difficult not to shrink away from the pressure. Yet because the relief is so dramatic, they withstand the pain for the few minutes necessary and usually return when the pain recurs, perhaps after several weeks or months, to receive the treatment again.

Ronald Bayne

Emeritus Professor of Medicine
McMaster University
Hamilton, Ont.

References

1. Puttick MPE. Rheumatology: 11. Evaluation of the patient with pain all over. *CMAJ* 2001;164(2):223-7.
2. Wolfe F, Smythe HA, Yunus MB, Bennett RM, Bombardier C, Goldenberg DL, et al. The American College of Rheumatology 1990 criteria for the classification of fibromyalgia. Report of the Multicenter Criteria Committee. *Arthritis Rheum* 1990;33(2):160-72.
3. Danneskiold-Samsøe B, Christiansen E, Lund B, Andersen RB. Regional muscle tension and pain ("fibrositis"). Effect of massage on myoglobin in plasma. *Scand J Rehab Med* 1983;15(1):17-20.
4. Danneskiold-Samsøe B, Christiansen E, Lund B, Andersen RB. Myofascial pain and the role of myoglobin. *Scand J Rheumatol* 1986;15(2):174-8.

The community's voice in research

We congratulate *CMAJ* for inviting representatives from an Aboriginal community to put forward the community's reflections and recommendations on the basis of their experiences with a previous research project.¹ The Special Working Group of the Cree Regional Child and Family Services Committee wrote an eloquent commentary outlining how research can be strengthened through knowledge of community history and traditions and by incorporating local expertise and previous experience; they also stressed the importance of the local language and family or group decision-making. They proposed that researchers undertake intensive community consultations with health and social service personnel before undertaking research projects. In return, health care workers would need to recognize that their responsibilities include such consultations.

As a group with expertise in community-based research whose members include both Aboriginal representatives and researchers, we encourage the use of community-based participatory research. We developed a document that was accepted as a policy statement by the North American Primary Care Research Group to promote this method of research.^{2,3} Community-based participatory research promotes the development of researcher-community

partnerships. As a team the researchers and community representatives design the research (i.e., identify the nature of the problem, develop the most appropriate intervention and identify the best ways to assess the impact of the intervention), implement the intervention and evaluation, analyze and interpret the data and disseminate the results. In addition, it is our experience that these partnerships are greatly strengthened by jointly negotiated written ethical guidelines that outline the obligations of all team members and that promote sharing of decision-making and power. These guidelines help to maximize community knowledge and capacity building and to sustain programs after the funding for the project ends, which are the ultimate goals of all community-based health research.

Ann C. Macaulay

Associate Professor
Department of Family Medicine
McGill University
Montreal, Que.

Nancy Gibson

Chair
Department of Human Ecology
University of Alberta
Edmonton, Alta.

William L. Freeman

Director
IHS Research Program
Rockville, Md.

Laura E. Commanda

Community advocate
Serpent River First Nation
Cutler, Ont.

Melvina L. McCabe

Associate Professor
Department of Family and Community
Medicine
University of New Mexico
Albuquerque, NM

Carolyn M. Robbins

Community advocate
Bellingham, Wash.

Peter L. Twohig

Assistant Professor
Department of Family Medicine
Dalhousie University
Halifax, NS