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Psychiatric bridges- finding a linkage between fibromyalgia and the premenstrual syndrome

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Background: Fibromyalgia syndrome (FMS) is associated with depressive disorders.

Aim: to investigate characteristics of FMS in a cohort of young women with premenstrual syndrome (PMS).

Methods: 30 young patients with PMS were included and compared with 26 women who attended a gynecological outpatient clinic. Assessment included demographics, clinical health assessment questionnaire (CLINHAQ), fibromyalgia impact questionnaire (FIQ), sleep and fatigue questionnaires, Sheehan disability scales, SF-36 assessment for QoL, visual analogue scale (VAS) and MINI questionnaires were completed. Each patient underwent a physical examination.

Results: The FIQ score of the PMS group was 33.09±18.48 vs. 8.6±12.62 ($p<0.001$).. The global pain scale was 3.92±2.96 vs. 1.29±2.2 ($p<0.005$). A sleep questionnaire scored in the PMS group compared to 12.6±7.8 vs. 7.46±5.3 ($p<0.01$) in the controls. The tenderness was measured by the number of tender point as defined in the ACR criteria of the FMS 3.13±4.36 v. 0.46±1.1 in the PMS groups compared to the controls ($p<0.005$), five PMS patients and none in the controls had clinical established FMS. Psychiatric comorbidity was significantly more common in the PMS group affecting 16 of the 30 PMS patients compared to only 3 of the 26 controls ($\chi 2(1)=10.85$) ($p<0.005$).

Conclusion: In this study group of patients PMS we detected higher levels of tenderness, higher psychiatric comorbidity, higher disabilities and lower QoL. All of these correlated with have a lower pain threshold.

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Fibromyalgia among major depression disorder females compared to males

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Background: Fibromyalgia syndrome (FMS) is characterized by widespread pain and diffuse tenderness. FMS is more prevalent in females rather than males, and among patients with major depression disorder (MDD).

Aim: to obtain better conception of linkage between depression, gender and FMS.

Methods: 42 male and 42 age matched females, and age matched male and female healthy controls were evaluated for coexisting FMS. Each patient completed a questionnaire characterizing sleep quality, Sheehan Disability Scale (SDS) and SF-36 scale, Hamilton Depression rating scales (HDRS) and the CGI-S.

Results: Disease parameters were worse for men as compared to women;

CGI-S: 5.4±1, vs. 4.0±1 ($t=6.634$, $p<0.001$), HDRS: 23.9±6 vs. 20.8±6 ($t=2.304$, $p=0.024$), respectively. Yet, FMS was more prevalent among depressed females. The SF-36, SDS and sleep quality scores were similar between males and females. A one way analysis of variance with gender and MDD revealed that both gender and disease were found to be significant contributing factors for the number of tender points ($F=21.131$, $p<.0001$; $F=65.232$, $p<.0001$, respectively). A one way analysis of covariance for tender points with CGI-S and HDRS as covariates revealed that gender was a significant factor regardless of depression severity. CGI-S and Hamilton scores correlated with tender points count in females but not in males.

Conclusion: Female gender is a risk factor for FMS in depressed population. Depression is associated with FMS among women but not among men. Among females, depression severity is significantly correlated to FMS severity. FMS is correlated to sleep quality and to QoL among depressed patients.

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Urgent questions of treatment of patient with organ somatization and somatoform disorders

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Object: The frequency of organ somatization in multimedical network

Materials: The results of clinical and epidemiological study of 2181 patients (average age-54 ± 0.8)

Methods: List of clinical and anamnestic behavior sign of adaptative form of disease of patients with comorbidity

Standard scales for evaluation of anxiety and depression.

Results: Patients with somatoform pain had more complicated pharmacological treatment, complex diagnostic procedures, sometimes surgical interventions, and they more often had analgesic dependence 5,8 ($P<0,05$).

Patient with idiopathic pain (response to antidepressant therapy 4,2 ($P<0,05$) and cognitive therapy 2,8($P<0,05$)) and organ somatizations (analgesic dependence 3,5 ($P<0,05$), effect of antidepressant therapy 4,3 ($P<0,05$) response to cognitive therapy 3,4($P<0,05$)) almost never had an idea about the mental nature of agonizing somatic sensations, seldom collaborated with psychiatrists. The choice of group of antidepressants is preferable and is formed with the specter of secondary effects and the individual characteristics.

Conclusion: Nowadays there is no coordinated medical viewpoint of treatment of patients with clinical somatic symptoms.

As rule, recommendations for treatment of somatoform disorder are preliminary and have not correct psychopharmacologic studies.

Cloth and truthful contact between physician and psychiatrist particularly important in this case.

Prolongation of this problem studying will lead to creating of correct therapeutic recommendations for medicine treatment of patients with somatoform disorders in comorbid conditions.

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The effectiveness of psychoanalysis and long- and short-term psychotherapy on psychiatric symptoms during a 5-year follow-up; A quasi-experimental study

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