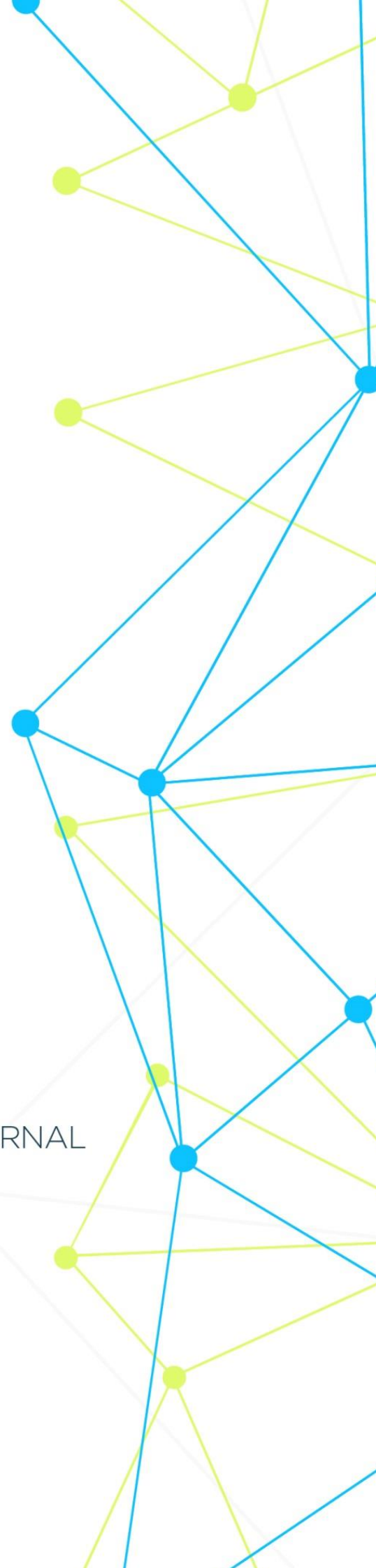


INTERNATIONAL MEDICAL SCIENTIFIC JOURNAL

ART OF MEDICINE



Art of Medicine International Medical Scientific journal

Founder and Publisher **Pascual Izquierdo-Egea**

Published science may 2021 year. Issued Quarterly.

Internet address: <http://artofmedicineimsj.us>

E-mail: info@artofmedicineimsj.us

11931 Barlow Pl Philadelphia, PA 19116, USA +1 (929) 266-0862

CHIEF EDITOR

Dr. Pascual Izquierdo-Egea

EDITORIAL BOARD

Prof. Dr. Francesco Albano

Prof. Dr. Tamam Bakchoul

Dr. Catherine J. Andersen

Prof. Dr. Pierre-Gregoire Guinot

Prof. Dr. Sandro Ardizzone

Prof. Dr. Rainer Haak

Dr. Dmitriy Atochin

Prof. Henner Hanssen

Prof. Dr. Antonio Aversa

Internal picture of the disease in patients with fibromyalgia syndrome.

Khodjiyeva Dilbar Todjiyevna

Egamov Dadajon Baxtiyor ugli

Bukhara State Medical Institute

Relevance. Primary fibromyalgia syndrome (PFS) is an extra-articular rheumatic disease characterized by generalized muscle pain, skeletal muscle fatigue, and decreased pain threshold on palpation at specific points [4].

The relevance of the problem under consideration is determined by the medical, social and economic significance of the issue. To date, SPF appears to be the most common form of chronic myalgic syndromes [11]. So epidemiological data show that about 4% of the total population of the USA, Great Britain, and Sweden suffer from SPF. Abroad, the diagnosis of SPF is from 6% to 10% of general clinical practice and 15% of rheumatology. At the same time, 80-90% of persons with SPF are women, whose predominant age is 30-45 years, i.e. the most able-bodied [7].

Attention to SPF is due to the high prevalence of this pathology, the steadily progressive nature of the course, and the difficulties of drug therapy. Meanwhile, there are many unresolved issues in the SPF problem [2, 12]. Despite a wide range of clinical, electrophysiological, biochemical studies in this area, characteristic clinical and pathophysiological criteria have not been defined. According to most authors, physiotherapeutic and pharmacological agents currently used in the treatment of patients with SPF (antidepressants, muscle relaxants, NSAIDs) are effective in no more than half of the patients and do not provide stable improvement or remission [1, 6].

A separate aspect of the problem is the role of mental disorders in the course and development of SPF. The literature provides indications of the involvement of neurotransmitter mechanisms of the brain in the formation of the corresponding symptom complex [10].

At the same time, there are obvious reasons to consider SPF within the framework of psychosomatic medicine, given its high degree of association with a number of mental phenomena (depression, anxiety, asthenia) [5]. It is emphasized that disorders such as anxiety, depression, and stress conditions are much more common in patients with SPF than in patients with other diseases, in particular, rheumatoid arthritis [3]. For practitioners, this often causes difficulties, primarily in the clinical assessment of existing disorders - a sharp discrepancy between the maladaptation of patients and the degree of damage to the muscular system in the absence of organic causes of pain [8]. However, works aimed at a detailed study of psychosomatic problems in fibromyalgia, according to the literature available to us, are clearly not enough [9]. The question of the significance of personality characteristics and their influence on the development of SPF remains unexplored.

The purpose of the study. Clarification of the role of neurotic disorders, psychological defense mechanisms, the level of subjective control and types of attitude towards the disease in the formation of the internal picture of the disease and

consideration of the features of clinical and psychological relationships in patients with SPF.

Materials and research methods . 100 patients with SPF were under observation. All patients were women, aged 21 to 54 years. The mean age was 43.85 ± 0.70 years. The average duration of the disease was 7.23 ± 0.47 years. The distribution by profession showed that the vast majority belonged to the engineering, technical and administrative staff - 76%, the non-working population amounted to 2%, and only 14% were in working professions. The control group consisted of 35 patients with insulin-dependent diabetes mellitus (IDDM), matched by sex and age, and participating in a medical and educational program. To determine the severity of the pathological process, the main clinical characteristics of the disease were used (Wolfe F., 1990). Clinical indicators were expressed in points (from 0 to 10) and ranked using a visual analogue scale. The following were determined: the intensity of pain, the degree of stiffness, the severity of fatigue and sleep disturbance, the intensity of the headache. The determination of specific diagnostic points was carried out by palpation. Palpation pressure on the point was carried out with a force of about 4 kg (at the same time, the disappearance of the vascular pattern and the staining of the nail plate of the thumb white when pressed is proportional to the diagnostic pressure with a dolorimeter with a force of 4 kg / 1.27 cm²) (Sterling J., 1999) . The investigated diagnostic point was considered as "positive" if the patient stated that palpation was accompanied by pain. "Sensitivity" was not seen as soreness. Mathematical and statistical analysis of data from clinical and experimental psychological studies was carried out using the "STATICTICA 5.0 for Windows " packages.

Research results . All patients complained of pain in 4 or more anatomical regions for at least 1 year. The main localization of pain was noted in the axial region (the area of the muscles of the neck and upper shoulder girdle), the muscles of the back, and also the lumbar spine. Significantly less often, the pain was localized in the areas of the hip joints and distal extremities. The pain was aggravated under the influence of stress, in a state of fatigue, after increased physical activity and the need to stay in an uncomfortable sitting position for a long time, in a period of damp, cold and windy weather. The distribution of the severity of the main clinical symptoms of SPF and their average values are shown in Table 1.

Table 1. Main clinical symptoms of fibromyalgia .

Key Clinical Characteristics	M±m	0-3 points	4-7 points	8-10 points
Pain syndrome	7.2 ± 0.14	-	53%	47%
Fatigue	7.14 ± 0.14	nine%	37%	54%
Headaches	6.82 ± 0.83	eleven%	44%	45%
stiffness	4.8 ± 0.23	24%	66%	10%
Sleep disturbance	6.66 ± 0.27	fourteen%	41%	45%

The combined combination of musculoskeletal pain, fatigue, sleep disturbances, stiffness, headaches and depression was determined in 51% of cases. The vast majority of patients (65%) had a history of acute or chronic traumatic effects that preceded the development of the disease or significantly aggravated the existing pain syndrome.

Thus, according to the results of the examination in the group of patients with SPF, the clinical level of neurotic manifestations was noted in 62.25% of cases, averaging 6.46 ± 0.15 points for depression scales, 6.72 ± 0.17 points for asthenia, anxiety - 6.8 ± 0.98 and hypochondria - 5.53 ± 0.18 points. When analyzing the correlations between neurotic disorders and the main clinical symptoms of the disease, it was found that depression directly correlated with the intensity of the pain syndrome ($r=0.35$, $p=0.011$), sleep disturbance ($r=0.30$, $p=0.002$) and the number of diagnostic tests. pain points ($r=0.41$, $p=0.038$). Asthenia and hypochondria directly correlated with pain syndrome in patients with SPF ($r=0.40$, $p=0.030$ and $r=0.320$, $p=0.001$), fatigue ($r=0.24$, $p=0.019$ and $r=0.30$, $p=0.002$), sleep disturbance ($r=0.31$, $p=0.04$ and $r=0.26$, $p=0.009$) and the number of diagnostic pain points ($r=0.30$, $p=0.038$ and $r=0.20$, $p=0.041$). The data obtained may indicate that the severity of clinical symptoms can be considered as one of the predisposing factors in the development of neurotic disorders in patients with SPF. It was also found that the intensity of anxiety directly correlated with the age ($r=0.570$, $p=0.019$) of patients with SPF and was significantly higher in groups of patients with a duration of up to 5 years ($p < 0.01$). Indicators of depression ($r=0.34$, $p=0.021$), asthenia ($r=0.38$, $p=0.017$) and hypochondria ($r=0.65$, $p=0.005$) were directly correlated with the duration of the disease. Such a high level of anxiety indicates subjectively experienced emotions of tension, which, perhaps, determine the dominant background of mood in the early stages of the disease in patients with SPF. A possible explanation for this may be that, as V.M. Astapov (1992), the state of anxiety is the result of a complex process that includes cognitive, affective and behavioral reactions at the level of a holistic personality to overcome it. At the same time, activity is formed, aimed at the possibility of a successful resolution of the situation and the removal of a real threat to the individual. Negatively colored emotional experiences of anxiety arise when an individual assesses the situation as dangerous and does not have ready-made and sufficiently reliable ways to resolve it. In cases of a subjective assessment of the impossibility of overcoming frustrating obstacles by an individual, a subsequent transformation of anxiety into a state of depression and depression occurs. A comparative study of the level of neuroticism in patients with SPF and the control group revealed that for patients with IDDM, all values of indicators of neurotic traits were significantly lower than in patients of the main group and were in the subclinical range (3-6 points). At the same time, the highest average values in patients with IDDM were obtained on the scales of asthenia (5.41 ± 0.36) and anxiety (5.3 ± 0.40). Of particular importance in the analysis of HKB is the experience of the fact of the disease by the patient himself, which often acts as the leading cause of subsequent changes in the socio-psychological status and can largely determine the rehabilitation potential. Based on the structural analysis of the

main types of attitudes towards the disease in patients with SPF, it was found that in almost half of the examined patients, mixed types of response prevailed (47%). Most of this structure was made up of types of relationships characterized by personal disadaptation to the disease: sensitive (33%) and anxious (17%). More adaptive response options, ergopathic and anosognosic, were determined in 17% and 13% of cases. Among the pure types of attitudes towards one's disease (42% of all cases) in patients with SPF, the most adaptive variants dominated (23%) with a predominance of the ergopathic radical (14%). Harmonious attitude to the disease was found in 3% of patients with SPF. The maladaptive part of the structure of pure types of attitudes towards the disease (19%) had more sensitive (9%) and anxious (4%) accents. Among the variants of diffuse distribution (11% of cases), the main structure-forming types of relationships were anxious-sensitive (10%), hypochondriacal (7%) and neurasthenic (6%) responses. Thus, in SPF patients, the main attitude to the disease is manifested by maladaptive mechanisms with a predominance of sensitive (51%) and anxious (31%) variants (defined in pure form and as part of mixed ones). To a lesser extent, hypochondriacal (19%), neurasthenic (12%), paranoid (8%) and egocentric (7%) variants are observed. Ergopathic (33%) and anosognosic (21%) types of attitude to the disease prevail in the structure of the most adaptive response block. Apathetic, melancholic and dysphoric types of attitude to the disease in patients with SPF were not registered.

The study of the features of the structure of ICD in the control group of patients with IDDM showed the predominance of pure types of attitudes towards their disease among this group of patients (70%). Moreover, half of them (41%) were types of relationships characterized by the absence of mental maladjustment to the disease (harmonious - 24%, ergopathic - 15% and anosognosic - 2.4%). Among the mixed types of relationships (26.6%), the anxiety-hypochondriac variant most often occurred (10%). Anxious-sensitive, ergopathically -sensitive and anosognosically -sensitive types of response were presented as single variants in this diagnostic distribution. The diffuse type, which included anxious -hypochondriac and egocentric-paranoid variants, was noted in 1 person (3.3%). An analysis was made of the distribution of credit responses for scales for certain groups of topics, arbitrarily combined in accordance with the objectives of the study. The first group included topics reflecting the emotional-affective component of the VKB ("Health", "Mood", "Sleep", "Appetite"). In general, by topic, there is a diffuse type of response of intersychic and intrapsychic orientation, the components of which are neurasthenic, sensitive, anxious, hypochondriacal and egocentric types of relationships. Note that the dominant type of relationship in the topic "Sleep" was a neurasthenic radical, in the topic "Mood" anxious, sensitive and egocentric accents dominated, and in the topic "Well-being" hypochondriacal and neurasthenic reactions prevailed.

Findings. The type of attitude to the disease in SPF depends on the severity of clinical symptoms: moderate manifestations of pain, fatigue, sleep disturbances are associated with an ergopathic type of attitude to the disease; severe musculoskeletal pains are associated with neurasthenic, sensitive and egocentric types of response. The neurasthenic type of attitude to the disease is associated with clinically

pronounced asthenia, the egocentric type with depression, a sensitive response with anxiety-depressive tendencies.

Bibliography:

1. Bennett RM Low level of somatomedin C in patients with the fibromyalgia syndrome / RM Bennett, SR Dark, SM Campbell // *Arthritis. Rheum.* . - 1992.- N. 10.-P. 113-116.
2. Bennett RM Muscle function and origin of pain in fibromyalgia / RM Bennett, S. Jacobsen// *Baillieres . Clinic . Rheumatol .* 1994.-N. 4. - P. 721-746.
3. Bennett RM Fibromyalgia : the commonest cause of widespread pain / RM Bennett // *Compr.Ther .* 1995.-N. 6. - P. 269-275.
4. Birnie DJ / DJ Birnie , AA Knipping , MH van Rijswijk // *J. Rheumatol .* -1991.-N. 18.-P. 1845-1848.
5. Boland EW Psychogenic rheumatism: the musculoskeletal expression of psychoneurosis IE. W. Boland // *An. Rheumatol . Dis.* 1947.-N. 6. - P. 195.
6. Branco I. Sleep cycles and alpha-delta sleep in fibromyalgia syndrome / I. Branco , A. Atalaia , T. Paiva // *J. Rheumatol .* 1994.-N. 6. - P. 1113-7.
7. Branco IC The diagnosis and treatment of fibromyalgia / IC Branco // *Act. Med. port.* 1995.-N. 4. - P. 233-238.
8. Bruckle W. The course and topography of pain in generalized tendomyopathies / W. Bruckle , I. Lautenschlager , W. Muller // *J. Rheumatol .* 1991. - N. 1. - P. 19-28.
9. Buskila D. Assessment of nonarticular tenderness and prevalence of fibromyalgia in children / D. Buskila , A. Press, M. Clein // *J. Rheumatol .* 1993. -N. 2.-P. 368-370.
10. Caidahi F. Difficulty in breath hinge in chronic primary fibromyalgia / F. Caidahi , M. Lurie, B. Bake // *J. Internal. Med.* 1989. - Vol. 226, N. 4. - P. 265-270.
11. Cambell SM Clinical characteristics of fibrositis , I: a "blinded", controlled study of symptoms and tender points / SM Cambell , S. Clark, EA Tindall // *Arthritis. Rheumatol .* 1983.-N. 26. - P. 817-824.
12. Cantini F. Fluoxetine combined with cyclobenzaprine in the treatment of fibromyalgia / F. Cantini , F. Bellandi , L. Niccoli // *Minerva. Med.* 1994. - N. 3.-P. 97-100.