Imipramine for the treatment of fibrositis: a therapeutic trial

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SUMMARY Twenty fibrositic patients were treated with imipramine 50-75 mg/day. Only two patients responded favourably. Nineteen patients stopped therapy during the initial three-month period: 14 of them due to lack of response, while two of these concomitantly disclosed side effects. The additional five patients stopped therapy mainly due to side effects, while only one of them improved with therapy. One patient, only, improved and adhered to therapy for more than three months.

Key word: tricyclic antidepressive agents

Fibrositis is a chronic disease characterised by muscular aches with local point tenderness, stiffness, disturbed sleep, and normal laboratory and radiological results.¹ Disturbance in non-REM (rapid eye movement) sleep pattern has been postulated as the aetiology of the disease.^{2,3}

Various therapies have been suggested for fibrositis, such as reassurance and explanation, local heat and massage, local injections, therapy with non-steroidal anti-inflammatory drugs (NSAIDs), and therapy with phenothiazines and tricyclic antidepressants.^{1,4-6} These psychotropic drugs are known to facilitate non-REM deep sleep pattern⁷ and thus were suggested as beneficial for the treatment of fibrositis.⁸ Moldofsky⁸ describes the use of chlorpromazine for treatment of fibrositis, and various other authors point out the use of tricyclic antidepressants for this disease.⁴⁻⁶ Yet we could not find a study detailing the efficacy of this therapy. Therefore, we decided to investigate the influence of imipramine, a tricyclic drug, on fibrositic patients.

Materials and methods

Patients were defined as having primary fibrositis according to the criteria described by Smythe.⁹ Patients had widespread aching and stiffness of

more than three-months' duration, skin roll tenderness over the upper scapular region, and disturbed sleep, with morning fatigue and stiffness. All patients had normal erythrocyte sedimentation rate, rheumatoid factor test, antinuclear antibodies, muscle enzymes, thyroid function tests, and sacroiliac films. No patient had symptoms or signs of additional rheumatic disease. All patients failed to respond to therapeutic trials of heat, massage, mild exercise, and NSAIDs.

The therapeutic trial consisted of imipramine at an initial dose of 25 mg twice a day. Fourteen days later when this dose was well tolerated it was raised to 25 mg three times a day.

Results

Twenty patients were examined: nineteen female and one male. The mean age of the patients was 46.9 ± 10.9 years, and the mean duration of the disease 7.2 ± 6.5 years: less than one year in three

Table 1 Response to treatment with imipramine

Duration of therapy	No of patients	Lack of response	Side effects
<1 week	5	1	4
1-4 weeks	7	7	1
1-3 months	7	6	1+1*
>3 months	1*	—	—

*Responded favourably to therapy.

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patients, one to five years in five patients, six to 10 years in eight patients, and more than 10 years in four patients. During the experiment only two patients described improvement with therapy. Fourteen of the patients (70%) stopped therapy due to lack of response. Of these, eight did not even complete one month of therapy. Seven patients (35%) described side effects (Table 1) consisting of: palpitations in two patients, abdominal discomfort in two patients, dryness of mouth, nervousness, and loss of balance, each in one patient. Of the two patients that reported improvement of symptoms with therapy, one omitted therapy due to adverse effects and one continued therapy for more than three months.

Discussion

Our study shows a lack of response of fibrositic patients to tricyclic therapy. Nineteen of our 20 patients stopped therapy due to either lack of response (70%), side effects (35%), or a combination of both. Actually only two patients described a favourable response, one of them stopped therapy due to side effects, and only one patient remained on therapy for more than three months.

Because of the open nature of our study it could be argued that some of the side effects are non-specific, secondary to a placebo effect. Yet, the fact that most patients did not improve with therapy is unrelated to the nature of our study.

Our results confirm previous impressions of poor compliance and response of fibrositic patients to therapy. A review of the literature shows that there is a discrepancy between the extensive evaluation of the presentation, symptoms, and signs of fibrositis^{4 6 10} and the relatively limited evaluation

of therapy. This discrepancy might be attributed to the disturbed psychological profile of these patients, with pronounced hypochondriasis and hysteria,¹¹ that could limit compliance in therapeutic trials. Future fibrositis investigation should focus on evaluating the efficacy of various therapeutic regimens.

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Book review

Combined Care of the Rheumatic Patient. By H A Bird, P le Gallez, J Hill. Pp. 303. £18.25. Springer-Verlag: Berlin. 1985.

The management of the rheumatic diseases may be the province of the rheumatologist, but he relies heavily on the skills of an increasing number of allied professions, including nurses, physiotherapists, occupational therapists, clinical metrologists, and medical social workers. This volume fulfils a clear need in that it reviews for the support specialist the whole field of rheumatic diseases and their management, covering all practical aspects and providing an integrated view of the work and specific skills of the various paramedical support specialists. The sections on

clinical diseases and their investigation is brief but adequate, although the quality of some of the x-ray illustrations is poor. The chapters on treatment, nursing, and clinical assessment are excellent, clearly written, balanced in view, and practical. It is refreshing to find a section devoted to patient education. There is a useful index which, together with a detailed contents list, makes information retrieval easy. I would thoroughly recommend this book to any non-medical specialist working in the field of rheumatic diseases.

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