Fibromyalgia/Myofascial Pain Syndrome Medications

Often, you may have to try many medications before you find the optimum ones for you. We react differently to each medication, and there is no "cookbook recipe" for FMS or MPS. What works well for one of us can be ineffective for another. A medication which puts one person to sleep may keep another awake. Each of us has our unique combination of neurotransmitter disruption and connective tissue disturbance. We need doctors who are willing to stick with us until an acceptable symptom relief level is reached.

Medications which affect the central nervous system are appropriate for FMS/MPS. They target symptoms of sleep lack, muscle rigidity, pain and fatigue. Pain sensations are amplified by FMS, and so the pain of MPS pain is multiplied. FMS/MPS patients often react oddly to medications.

It is the rule rather than the exception that a FMS/MPS patient will save strong pain meds from surgery or injury for when they REALLY need it-for an FMS/MPS "flare". This is a sign that your needs aren't being met. I give you the following quotes. I hope you will pass them on to your doctor. They are from "PAIN A Clinical Manual for Nursing Practice".

Health professionals "often are unaware of their lack of knowledge about pain control."

"The health team's reaction to a patient with chronic nonmalignant pain may present an impossible dilemma for the patient. If the patient expresses his depression, the health team may believe the pain is psychogenic or is largely an emotional problem. If the patient tries to hide the depression by being cheerful, the health team may not believe that pain is a significant problem."

"Research shows that, unfortunately, as pain continues through the years, the patient's own internal narcotics, endorphins, decrease and the patient perceives even greater pain from the same stimuli."

''The person with pain is the only authority about the existence and nature of that pain, since the sensation of pain can be felt only by the person who has it."

"Having an emotional reaction to pain does not mean that pain is caused by 9n emotional problem.

"Pain tolerance is the individual's unique response, varying between patients and varying in the same patient from one situation to another."

"Respect for the patient's pain tolerance is crucial for adequate pain control."

"THERE IS NOT A SHRED OF EVIDENCE ANYWHERE TO JUSTIFY USING A PLACEBO TO DIAGNOSE MALINGERING OR PSYCHOGENIC PAIN."

"No evidence supports fear of addiction as a reason for withholding narcotics when they are indicated for pain relief. All studies show that regardless of doses or length of time on narcotics, the incidence of addiction is less than 1%."

This book, is so clear in its facts, and so well documented, I suggested that my local library buy it. They did. I wanted everyone in the area to have access to the information within. Once you read this book, you get a greater understanding of pain and pain medications, as well as coping mechanisms. Many non-pharmaceutical methods of pain control are also described thoroughly in this reference.

It's normal to be depressed with chronic pain, but that doesn't mean depression is causing the pain. Maintenance with mild narcotics (Darvocet, Tylenol #3, Vicodin-Lorcet-Lortab) for nonmalignant (non-cancerous) chronic pain conditions may be a humane alternative if other reasonable attempts at pain control have failed. The main problem with raised dosages of these medications is not with the narcotic components, per se, but with the aspirin or acetaminophen that is often compounded with them.

Narcotic analgesics are sometimes more easily tolerated than NSAIDs, the Non-Steroidal Anti-Inflammatory Drugs. Neither FMS nor MPS is inflammatory. Prolonged use of narcotics may result in physiological changes of tolerance or physical dependence (withdrawal), but these are not the same as psychological dependence (addiction). Under-treatment of chronic pain of MPS/FMS results in a worsening contraction which results in even more pain. "Anti-anxiety" medications are not an

indication that your symptoms are "all in the head". These medications don't stop the alpha-wave intrusion into delta-level sleep, but they extend quantity of sleep, and may ease daytime symptom "flares".

This is only a partial list. Stay tuned to the FM Network for news of more medications of possible use in FMS/MPS.

Relafen (nambumetone): this is a NSAID that is often well tolerated because it is absorbed in the intestine, sparing the stomach.

Benedryl:(dyphenhydramine): a helpful sleep aid/antihistamine which is safe in pregnancy. The starting dose is 50 mg 1 hr. before bed. Increase as tolerated until symptoms are controlled or 300 mgs. About 20% of patients react with excitation rather than sedation when taking benadryl (non-prescription)

Desyrel (Trazadone): an antidepressant that helps with sleep problems. It must be taken with food.

Atarax (hydroxyzine HCl): suppresses activity in some areas of Central Nervous System to produce an anti-anxiety effect. This antihistamine may be useful when itching is a problem.

Elavil (amitriptyline): a tricyclic antidepressant (TCA) is cheap and useful. It generates a deep stage four sleep. Most patients will adapt to this med after a few weeks. It can cause photosensitivity and morning grogginess. It often causes weight gain, dry mouth, as well as stopping the normal movements of the intestine. It may cause Restless Leg Syndrome.

Wellbutrin (bupropion HCl): is a weak Specific Serotonin Reuptake Inhibitor (SSRI) and antidepressant that is sometimes used in FMS/MPS in place of Elavil. It can promote seizures.

Ambien (zolpidem tartate): hypnotic-sleeping pill, for short-term use for insomnia. There have been reports of serious depression.

Soma (carisoprodol): acts on Central Nervous System to relax muscles, not on the muscles themselves. It works rapidly and lasts from 4 to 6 hrs. It helps detach from pain, and modulates erratic neurotransmitter traffic, damping the sensory overload of FMS.

Flexeril (cyclobensaprine): this medication can sometimes stop spasms, twitches and some tightness of the muscle. It is related chemically to Elavil. It generates stage four sleep, but it may cause gastric upset and a feeling of detachment from life.

Sinequan (doxepin): tricyclic antidepressant and antihistamine. It can produce marked sedation. This medication may enhance Klonopin, but can reduce muscle twitching by itself.

Prozac (fluoxetine hydrochloride): anti-depressant that increases the availability of serotonin, useful for those patients who sleep excessively, have severe depression and overwhelming fatigue.

Ultram (tramadol): non-narcotic, Central Nervous System medication for moderate to severe pain, in a new class of analgesics called CABAs-Centrally Acting Binary Agents. It has a "low-abuse potential". Doctors may prescribe it more liberally than other strong pain-killers. One Internet doctor reported that 70 % FMS patients had pain control well enough that they could resume a more active life. Reports say you have to take it regularly for best benefits. Many people said it brought more alertness for longer times, and less ''fibrofumble" of the fingers. It can lower the seizure threshold. Side-effects reported are grogginess, insomnia (may not be able to take at night), headache or loss of sex drive.

Xanax: (alprazolam): an anti-anxiety medication, that may be enhanced by ibuprofen. It must not be used in pregnancy. It enhances the formation of blood platelets, which store serotonin, and also raises the seizure threshold. When stopping this medication, you must taper it very gradually.

EMLA: a prescription only topical cream, that may help cutaneous TrPs. It is a mixture of topical anesthetics.

Pamelor (nortriptyline): this is used to help sleep. Some people find it stimulating, and must take it in the morning. Others use it before bed to help sleep. Some reports of depression with use.

Klonopin (klonazepam): anti-anxiety medication and anticonvulsive/ antispasmodic. It is useful in dealing with muscle twitching, Restless Leg Syndrome and nighttime grinding of teeth.

Buspar (buspirone HCl): may improve memory, reduce anxiety, helps regulate body temperature, and is not as sedating as many other anti-anxiety drugs.

Zoloft (sertraline): this is an SSRI and antidepressant, and is commonly used to help sleep.

Tagamet, Zantac, Prilosec, Axid: often used to counter esophageal reflux. Tagamet may increase stage 4 sleep, and enhance Elavil.

Paxil (paroxetine HCl}: serotonin and norepinephrine reuptake inhibitor, and may reduce pain. It should not be used with other meds that also incr-ease brain serotonin. Suggested dosage is 10 mgs (half a scored tablet) may cause insomnia or drowsiness.

Effexor (venlafaxine HCl): antidepressant and serotonin and norepinephrine reuptake inhibitor. Suggested trial dosage is 25 mg, taken in the morning. Food has no effect on its absorption. When discontinuing this medication, taper off slowly.

Inderal (propranolol HCl): sometimes helps in the prevention of migraine headaches, although blood pressure may drop with its use. Antacids will block its effect, and should not be used.

Hismanol (astemizole): this is a potent antihistamine often given for allergies. Do not take at the same time as ketaconazole.

Librax: for Irritable Bowel Syndrome. It is a combination of antispasmotic plus tranquilizer, that helps modulate bowel action.

Diflucan (fluconazole): this antifungal penetrates all of the body's tissues, even the central nervous system. Very short term use can be considered if cognitive problems and/or depression is present, and yeast is suspected. Yeast may also be at the root of irritable bowel, sleep dysfunction (muramyl dipeptides from bowel bacteria induce sleep), and other common FMS problems.

Potaba (aminobenzoate potassium): used to diminish fibrotic tissue. Travell and Simons recommend it for stubborn cases of myofascial pain syndrome. Do not use with sulfa. The suggested dosage 500 mg tid for 5 months. It will counteract guaifenesin.

Guaifenesin: see handout "Guaifenesin" December 1995

Quotane: this topical prescription ointment is helpful for TrP relief in close-to-the-surface areas not reachable by stretching. TrPs that refer burning, prickling or lightning-like jabs of pain are likely to be found in cutaneous scars.

Imitrex (sumatriptan): this is available as an injectable solution or pill that will not prevent migraines, but it is effective for migraine pain in many cases. Works on serotonin release instead of blood vessel spasm, and may provide relief in less than 20 minutes. It should not be used within 24 hours of ergot (a common migraine drug) medications. It can increase blood pressure. It may cause spasm of muscles in jaw, neck, shoulders and arms. Also reported were tingling sensations, rapid heartbeat and the "shakes".