

Fibromyalgia and breast cancer

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Dear Editor,

The article entitled “Frequency of fibromyalgia syndrome in breast cancer patients” by Akkaya et al. [1], published online in 2012 in your journal, was quite interesting. We perceived the article as an important topic while screening the literature for our own study in which we are researching the frequency of fibromyalgia (FM) in patients with non-metastatic colorectal cancer. According to the title, we thought that the article defining the prevalence of FM in breast cancer was considerable. Therefore, we wanted to emphasize some points.

In this article by Akkaya et al. [1], we first want to point to the missing “adjuvant” terminology. Tamoxifen and aromatase inhibitors (AIs) are part of adjuvant “endocrine” treatment in patients with early-stage breast cancer (ESBC). We would like to draw your attention to the fact that the adjuvant terms for chemotherapy and radiation treatment given to the patients were not expressed clearly. For this reason when the article was first read, we thought that adjuvant treatment was only

given with hormone therapy to the patients included in the study. According to the article we understood that 10 patients out of 101 patients with ESBC were diagnosed with FM syndrome according to the 1990 ACR criteria [2]. After further analysis, we now understand that seven of the 10 patients were followed up with hormonotherapy after adjuvant chemo-radiotherapy. We know that AIs cause musculoskeletal menopausal symptoms by lowering estrogen levels in postmenopausal women. In previous studies, when tamoxifen and placebo were compared with AIs, the women using AIs had more musculoskeletal side-effects. In these studies, arthralgia and myalgia were reported as the most common musculoskeletal side-effects [3]. Therefore, the design of the study group is statistically poor as the frequency of FM is analyzed and, in fact, this situation removes the study from the topic it describes. Because most of the 10 patients ($n = 7$) diagnosed with FM were taking hormonotherapy, this significantly limited the study which already only had a few patients.

If the study’s title was “the effect of regional and widespread pain on the quality of life in breast cancer patients” then perhaps it would more appropriately reflect the contents of the article. Again, in the patients with FM who have widespread pain, by using the tender points diagnosed according to the 1990 ACR criteria, the tender points indicated the radiation and mastectomy areas in the 10 patients. Therefore, the study could only be meaningful if it was performed in a large series, taking the effects of hormonotherapy into account according to the ACR 2010 criteria [4].

In our project, we will research the frequency of FM according to the 2010 ACR criteria in patients with ESBC which we have divided into two groups—those taking hormonotherapy and those not taking it.

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Additionally, previous studies have reported that FM occurs more frequently in women. Thus, in the American Society Survey Study which includes 3006 individuals as determined by the 1990 ACR criteria, the rate of chronic widespread pain was 11 %. In other survey studies, the prevalence of FM is reported as 2 % in the general population; 3 % in women, and 0.5 % in men [5–7]. In the study by Akkaya et al. [1], the frequency of FM in breast cancer patients is above the rate of the normal population. Unfortunately, statistical power achieving this outcome is absent in this study.

In conclusion, when a cancer patient's psycho-oncological situation is taken into account, we thank Akkaya et al. [1] because their study takes into account the pain symptoms which reduce a patient's quality of life. We believe that if cancer patients have pain symptoms, then FM syndrome must not be ignored.

We will be waiting the reply of authors in great interest.

Best regards.

Conflict of interest The authors declare that they have no conflict of interest.

References

1. Akkaya N, Simsir-Atalay N, Taflan-Selcuk S et al (2012) Frequency of fibromyalgia syndrome in breast cancer patients. *Int J Clin Oncol* (Epub ahead of print)
2. Wolfe F, Smythe HA, Yunus MA et al (1990) The American College of Rheumatology 1990 criteria for classification of fibromyalgia: report of the Multicenter Criteria Committee. *Arthr Rheum* 33:160–172
3. Gaillard S, Stearns V (2011) Aromatase inhibitor-associated bone and musculoskeletal effects: new evidence defining etiology and strategies for management. *Breast Cancer Res* 13:205–211
4. Wolfe F, Clauw DJ, Fitzcharles MA et al (2010) The American College of Rheumatology preliminary diagnostic criteria for fibromyalgia and measurement of symptom severity. *Arthr Care Res* 62:600–610
5. White KP, Speechley M, Harth M et al (1999) The London fibromyalgia study: the prevalence of fibromyalgia syndrome in London, Ontario. *J Rheumatol* 26:1570–1576
6. Carmona L, Ballina J, Gabriel R et al (2001) The burden of musculoskeletal diseases in the general population in Spain: results of a national survey. *Ann Rheum Dis* 2001:1040–1045
7. Hauser W, Schmutzer G, Glaesmer H et al (2009) Prevalence and predictors of pain in several body regions: results of a representative German population survey. *Schmerz* 2009(23):461–470