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background of other diseases occurring with muscle damage (endocrine pathology, rheumatological diseases, etc.) [5].

Fibromyalgia has taken a firm place among the most pressing and complex problems of medicine in recent years. There is no doubt about the practical importance of its study, since fibromyalgia is the most common form of chronic myalgic syndromes. Meanwhile, there are many unresolved issues in the problem; fibromyalgia syndrome it is called a myth, questioning its reality as an independent disease [2].

Despite certain advances in this area, due to a wide range of clinical, functional and experimental studies, characteristic clinical and pathophysiological patterns have not been identified. In particular, there is not clear data on the localization, frequency and severity of myofascial pain syndrome in fibromyalgia. Indeed, both terms are often found in the special literature, however, the criteria for classifying them as independent diseases, or arguments in favor of considering them as a single pathological process, remain controversial [4].

Some authors believe that fibromyalgia syndrome is a syndrome of muscle pain without trigger zones, according to others, it is generalized myofascial pain syndrome [6].

The leading question for understanding the essence of fibromyalgia syndrome remains the question of the nature of the pain syndrome. At the same time, mechanisms of both nociceptive pain with the presence of receptor insufficiency and neuropathic pain are revealed, as a reflection of violations of the physiological process of pain modulation, which results in a decrease in pain tolerance and hyperalgesia [7]. In this regard, it seems relevant to study the functional state of the spinal and supraspinal links of the neuromotor system in patients with fibromyalgia syndrome. These data, perhaps, will help to bring closer understanding of the pathogenesis of pain and movement disorders in patients with fibromyalgia.

Along with the general neurological and vertebro-neurological examination, all patients underwent manual testing of the musculo-articular and fascial-ligamentous structures of the locomotor system [2]. Taking into account the subject of the study, the myofascial system was assessed in detail (the degree of pain, its duration, irradiation, tone, the presence of TT, as well as fascial restrictions [3]. For subjective pain assessment, a visual analogue pain scale (VAS) was used, as well as a 4-level visual analogue pain scale, which makes it possible to detail the severity of pain in different time periods of the disease. points of subjective and objective signs [7] $IMS = VBS + T + HT + KU + B + PB + SI$. (VVS) - the severity of spontaneous pain (three point scale); (T) - muscle tone (three-point scale); (HT) - muscle wasting (three-point scale); (CU) - number of myofibrosis nodules (three-point scale); (B) - muscle soreness (three-point scale); (PB) - duration of pain (three-point scale); (SI) - the degree of irradiation (three-point scale). For a detailed analysis of TT in muscle, the clinical criteria proposed by Trevell and Simons (1989) were used [7], MRI, CT and ENMG studies were performed.

Common muscle pain is a common problem that faced by doctors of various specialties - therapists, neurologists, rheumatologists, etc. Very often these pains are of a functional nature and coincide in clinical features with pain in other diseases (functional disorders of the gastrointestinal and biliary tract, headache). tension pain, neurocirculatory dystonia, etc.). Fibromyalgia syndrome is a symptom complex, manifested by chronic widespread muscle pain and the presence of painful points located in certain anatomical zones. In the ICD-10, it is classified under the "Unspecified rheumatism" section [6].

The frequency of fibromyalgia syndrome in the population is about 4% (according to various sources, from 1 to 13%), among patients of a general practitioner - from 6 to 10%, and among those who have consulted a rheumatologist - more than 15%. It is believed that in rheumatoid arthritis (RA) fibromyalgia syndrome occurs in 14% of

cases, in systemic lupus erythematosus (SLE) - in 22%, in systemic scleroderma (DM) - in 55%. Mostly women suffer from fibromyalgia syndrome (the ratio of women to men is 2-10: 1. There are no significant differences in the prevalence of fibromyalgia syndrome in different ethnic groups. Different data are given on the age at which the disease occurs. Some authors indicate the age from 25 to 45 years, others note an increase in the incidence of fibromyalgia syndrome symptoms with age. Thus, in women 20-40 years of age fibromyalgia syndrome is noted in 3.9% of cases, 40-60 years - in 5.8%, 55-64 years - in 8%, 60-79 years - in 7%. Patients with fibromyalgia syndrome are a high risk of social maladjustment and frustration - about 70% lose their ability to work, and more than 90% have a significantly reduced quality of life.

From a practical point of view, very important for clinical verification of fibromyalgia syndrome is the study of specific sensitive points, which are designated as "tender points" (TP) [8]. One of the most characteristic features of these pain points is the reproducibility in their palpation of the pain that the patient usually experiences. However, today it has been convincingly shown that, as well as a violation of the descending (noradrenergic and serotonergic) inhibitory control of pain, occur in fibromyalgia not as a result of peripheral changes in muscles, fascia, ligaments or connective tissue, but as a result of neurodynamic disorders in the central nervous system in individuals with a genetic predisposition to exposure to a large number of stressful (physical and mental) events [7].

The research on fibromyalgia over the past two decades has shown that pain threshold is related to the degree of distress [8]. Many psychological factors, such as hypervigilance, suspiciousness, catastrophization, and the external locus of pain control, can play an important role in the severity of fibromyalgia symptoms. Special studies have shown that patients with fibromyalgia have decreased serotonergic and noradrenergic activity. It was also found that in patients with fibromyalgia, there is a decrease in the level of serum serotonin and its precursor L-tryptophan and a decrease in the main metabolite of serotonin in the cerebrospinal fluid, 5-hydroxyindole acetate [9,4]. Supporting these findings is the fact that drugs that simultaneously increase serotonin and norepinephrine levels (tricyclic antidepressants, duloxetine, milnacipram, and tramadol) are effective in treating fibromyalgia. Neurobiological evidence that fibromyalgia is a condition with increased pain sensitivity and impaired perception processes is confirmed by the results of hardware diagnostic methods: single-photon emission computed tomography and functional magnetic resonance imaging.

In this regard, it is important to thoroughly analyze the clinical picture and assess the information content of individual signs of this syndrome for the correct diagnosis and differentiation of fibromyalgia syndrome from a number of other diseases accompanied by widespread musculoskeletal pain [9,10].

The main symptom of fibromyalgia is chronic diffuse pain, not caused by any pathology of the musculoskeletal system, which bothers the patient for at least three months. The pain is diffuse, spreading throughout the body above and below the waist. Typically, patients describe their condition as "I feel like I have pain everywhere" or "I feel constantly cold". Patients usually describe pain that spreads to all muscles, but sometimes they also report pain and swelling in the joints. In addition, patients often complain of paresthesias, numbness, tingling, burning, and crawling on the skin, especially in the legs and arms.

In patients with fibromyalgia, physical examination reveals only tenderness or tenderness at specific points in the body. Exploring painful spots requires experience. The doctor should know exactly where to palpate and with what force. According to the ACR criteria, 9 pairs of painful points in fibromyalgia were identified (Figure 1).

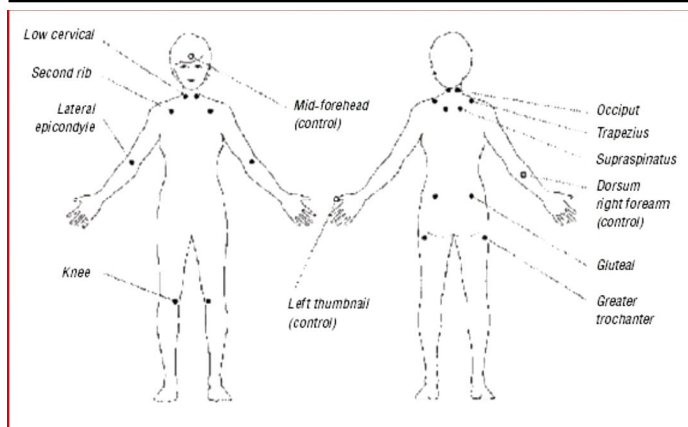


Figure 1. The examination of painful points with fibromyalgia syndrome

The pressure produced at these points should be 4 kg / cm - the pressure at which the researcher's nail beds turn white. When performing palpation of 18 painful points, it is recommended to apply uniform pressure on the paired points and, with the same effort, palpate other parts of the body to compare sensitivity. In patients with fibromyalgia, tender points have increased sensitivity compared to other parts of the body. Painful points reflect areas of increased sensitivity to pain stimuli, and are not the result of local inflammation or tissue damage [11].

The presence of a positive reaction in more than 11 of 18 painful points was determined by the diagnostic criterion based on the analysis of statistical data from large populations of patients. However, not all

patients with fibromyalgia will necessarily have increased sensitivity at more than 11 points. Again, the criteria for fibromyalgia are intended for research purposes and not for specific patient diagnoses [12]. Nevertheless, the examination of painful points is considered an important part of the study of the functioning of the musculoskeletal system in patients with generalized pain syndrome. Palpation of soft tissues and joints allows you to identify areas of increased sensitivity. This examination excludes synovitis or myositis and is very important in the diagnosis of fibromyalgia.

Today there are four main directions in the treatment of fibromyalgia:

1. reduction of peripheral pain, in particular, muscle pain;
2. prevention of central sensitization;
3. normalization of sleep disorders;
4. treatment of concomitant pathology, in particular depression.

The first approach is more focused on the management of acute pain in fibromyalgia and includes the use of physiotherapy, muscle relaxants, muscle injections, and analgesics. Central sensitization is successfully controlled by cognitive behavioral therapy, sleep correction, antidepressants and anticonvulsants. Sleep disturbances are corrected by stress reduction, aerobic exercise, and gamma-aminobutyric acid (GABA) agonists. Medication and behavioral therapy for secondary pain affect (anxiety, depression, fear) are among the most promising treatment strategies for fibromyalgia. Although any combination of these approaches can be very beneficial for patients with fibromyalgia, only comparative studies can provide reliable data on the effectiveness of a particular treatment. All specialists emphasize the need for an integrated multimodal approach in the treatment of fibromyalgia, including both pharmacological and non-drug methods.

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