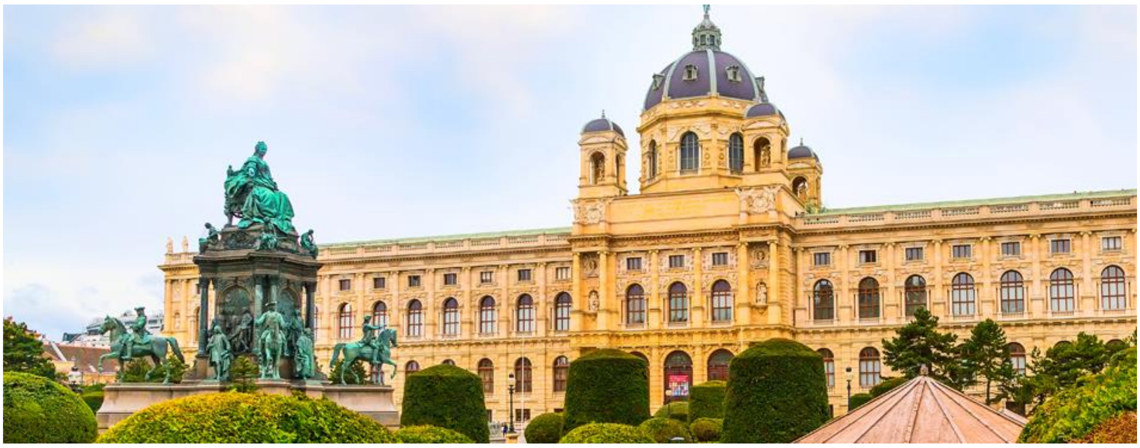
2019 欧州国際医学会研究旅行

詳細日程

第６日：３月４日（月）



行動目的：

The International Congress on Controversies in Fibromyalgia

線維筋痛症における争点に関する国際会議

重要な活動予定の詳細：

（オリジナルのプログラムを添付しました）

（学会発表の演題には和訳を加えました）

CONGRESS PROGRAM

Monday, 04 March

07:30-08:30	Registration
08:30-10:00	**Session 1** Opening Session Fibromyalgia in 2019: Where We Are and Where Are We Heading? Chairpersons: **Jacob Ablin**, *Israel* **Piercarlo Sarzi-Puttini**, *Italy*
	08:30-09:00 **Fibromyalgia State-of-the-Art Overview** **Ernest H. Choy,** *Cardiff University, UK*
	09:00-09:30 **A Longitudinal Perspective of Fibromyalgia - Past - Present - Future** **Jacob Ablin,** *Tel-Aviv Sourasky Medical Center, Israel*
	09:30-10:00 **A Sociological Perspective: Why are Doctors so Afraid of Fibromyalgia?** **Winfried Häuser,** *Klinikum Saarbrücken, Germany*
10:00-10:30	*Networking, Coffee Break, Poster Viewing and Visit the Exhibition*
10:30-12:00	**Session 2** "Fibromyalgia Wars" Chairperson: Piercarlo Sarzi-Puttini, *Italy*
	10:30-11:00 **The Good, the Bad and the Ugly Sides of "Psychosomatic"** **Riccardo Torta,** *University of Turin, Italy*
	11:00-11:30 **Transparent Pain. But you don't Look Sick at All...** **Cristina Iannuccelli,** *Sapienza University of Rome, Italy*
	11:30-12:00 **The Complexity and Difficulties of Handling Disability of Patients with Fibromyalgia** **Howard Amital,** *Sheba Medical Center, Israel*

12:00-13:00	*Lunch Break, Poster Viewing and Visit the Exhibition*
13:00-15:00	**Session 3** Classification and Diagnosis Chairperson: Winfried Häuser, *Germany*
	13:00-13:30 **Evolving Concepts in the Classification, Diagnosis and Epidemiology of Fibromyalgia** **Marco Di Carlo,** *Marche Polytechnic University, Italy*
	13:30-14:00 **Is Fibromyalgia really all that Different from other Rheumatological Disorders?** **Giuliana Guggino**, *University of Palermo, Italy*
	14:00-14:30 **Chronic Fatigue Syndrome and Fibromyalgia following Immunization: Another Angle of the 'Autoimmune (Auto-Inflammatory) Syndrome Induced by Adjuvants' (ASIA)** **Yehuda Shoenfeld,** *Sheba Medical Center, Israel*
14:30-15:00	*Networking, Coffee Break, Poster Viewing and Visit the Exhibition*
15:00-17:00	**Session 4** From Periphery to Central and Vice Versa; Where does Fibromyalgia Stand? Chairperson: Yehuda Shoenfeld, *Israel*
	15:00-15:20 **Mechanisms Underlying the Transition from Acute to Chronic Pain** **Daniel Clauw,** *University of Michigan, USA*
	15:20-15:40 **Mechanistic Similarities between Fibromyalgia and other Chronic Pain Conditions**

	Lars Arendt-Nielsen, *Aalborg University, Denmark*
	15:40-16:00 **The Role of Peripheral Nociceptors in Fibromyalgia Syndrome** **Nurcan Üçeyler,** *University of Wurzburg, Germany*
	16:00-16:20 **"More Brain than Muscle" the Fibromyalgia Paradigm** **Roberto Casale,** *Opusmedica, PC&R Patient, Care & Research Network, Italy*
16:20-17:20	Patients' Associations in Fibromyalgia: Do We Need Them?
	16:20-16:40 **ENFA: What is it for?** **Souzi Makri**, *The European Network of Fibromyalgia Associations (ENFA), Cyprus*
	16:40-17:00 **Role of Patients Associations on Dealing with Fibromyalgia Patients: The Italian Experience** **Egidio Riva**, Italian Association of Fibromyalgia (*AISF-ONLUS), Italy*
	17:00-17:20 **The Israeli Perspective - What's we've Learned Over the Last 2 Decades** **Sharon Gur**, *ASAF, Israel*
17:20	End of Day One

実際の活動成果：
（学会発表の演題をはじめ、要旨をできるだけ和訳しました）

07:30-08:30	Registration
08:30-10:00	**Session 1** Opening Session Fibromyalgia in 2019: 私たちはどこにいて、そして、どこに向かっているのか？ 共同座長: **Jacob Ablin**, *イスラエル*、 **Piercarlo Sarzi-Puttini**, *イタリア*

この学会は製薬会社の協賛を受けていないこと、

医療の専門家ばかりでなく患者会も参加して発表の機会が与えられていること

が注目されました。

08:30ー08:40

線維筋痛症：最先端の概要

Ernest H. Choy
CREATE Centre, Section of Rheumatology, Division of Infection and Immunity, Cardiff University, 英国

Fibromyalgia (FM) as a clinical diagnosis was brought about by the 1990 American College of Rheumatology (ACR) classification criteria [1]. Although these were developed initially to facilitate research, it gained widespread acceptance as a diagnostic tool. However, pain is a subjective symptom. The lack of specific pathology or diagnostic test, as well as the association with depression or anxiety, led many to question the legitimacy of FM as a medical illness. Over the last decade, there is a significant shift in the increasing acceptance of FM among Rheumatology community, driven by the recognition that improving the diagnosis and management of chronic pain in musculoskeletal diseases is a major unmet medical need.

First, FM is common. Prevalence of fibromyalgia in the general population is 2% [2]. A UK study found that the incidence of FM increased from 33.3 in 2001 to 38.2 per 100,000 people in 2013 [3]. The healthcare and societal burden associated with FM is high [4]. Delay in diagnosis led to inappropriate investigations and referrals to multiple specialties [5].

With functional neuroimaging, objective evidence of abnormal pain processing has been consistently demonstrated [6] removing the stigma of pain in FM being psychogenic.

Furthermore, whilst FM cannot be cured, systematic reviews based national and international guidelines such as European League Against Rheumatism (2016), Canadian Pain Society and Canadian Rheumatology Association (2012), as well as the Association of the Scientific Medical Societies in Germany (2012), agreed on the overall approach to FM should be multi-modal approach using non-pharmacological and with necessary pharmacological treatments to reduce pain and improve function [7-9]. Exercise and psychological/mind-body therapies are recommended by guidelines. If the response to non-pharmacological treatments is inadequate, low dose amitriptyline, serotonin-noradrenalin reuptake inhibitors (duloxetine, milnacipran) and the anti-convulsant, pregabalin may be added. The approval of duloxetine, milnacipran, and pregabalin by the Food and Drug Administration for the treatment of FM further emphasized FM being a treatable condition.

The ACR 2010 provisional criteria for FM [10], which has been updated in 2011 and 2016, allowed FM to be diagnosed by using questionnaire. One of the major advantages of these provisional criteria is that the diagnosis of FM can be made by primary care physician and the first-line treatment be initiated without referral to secondary care. Such an approach was recommended by the Canadian guidelines [8]. This may avoid delay in diagnosis and reduce unnecessary investigations and referral to secondary care.

More recently, comorbid FM is increasingly recognized in many chronic musculoskeletal diseases. Patients with comorbid FM have higher diseases activity score and more severe pain. Disease activity scores used in "treat-to-target" guidelines are higher in these patients. The management of these patients with comorbid FM poses an important challenge for Rheumatologists.

References

1.Wolfe F, Smythe HA, Yunus MB, Bennett RM, Bombardier C, Goldenberg DL, et al. The American College of Rheumatology 1990 Criteria for the Classification of Fibromyalgia. Report of the Multicenter Criteria Committee. Arthritis Rheum. 1990;33(2):160-72..

2.Heidari F, Afshari M, Moosazadeh M. **Prevalence of fibromyalgia in general population and patients, a systematic review and meta-analysis.** Rheumatol Int. 2017 Sep;37(9):1527-1539.

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syndrome. Systematic review, meta-analysis and guideline]. Schmerz (Berlin, Germany) 2012, 26, 297-310.15.
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＜コメント＞開会スピーチですが、線維筋痛症が抱えている現在までの課題について概要を説明していました。この学会のタイトルである論点をあらかじめ俯瞰して紹介されました。

＜メモ＞以下は、私の備忘録です。線維筋痛症は診断基準から治療まで、すべての段階で、時間経過とともに変化が大きい領域ですが、どの国でも医療問題が山積しているようです。線維筋痛症の治療の中心は、薬物療法ではないことは、線維筋痛症のエキスパートにとっては共通の認識のようです。またレディー・ガガの例が出されましたが、リアクションは乏しかったです。病名だけを公にして、その内容が明らかにされないのは、専門医にとってはあまり役に立たない、ということです。素人やマスコミの間で、根拠の乏しい情報が駆け巡るのは好ましいことではありません。

Bankrupt of the medical compensation
Lady Gaga
Points of Controversies
1) Diagnostic criteria,2010ACR,ACR2011patient self diagnosis、2016 confusing
ACR は分類だけして診断基準を示していない
２）pathodenessis(peripheral or central)
ACTTION=APS Pain Taxonomy:
Central Sensitisation に関連しない末梢神経障害
３）Management: concomitance
４）非薬物療法を第一選択に

09：10-09：40

線維筋痛症の時間軸経緯からの視点-過去-現在-将来

Jacob Ablin MD
Tel Aviv Sourasky Medical Center, イスラエル

The story of fibromyalgia (FM) brings to mind Paul McCartney's epic lyrics – "the long and winding road". While some may still consider FM to be a new entity, somehow contrived by various forces and incentives, when looking back into history it becomes obvious that patients suffering from the constellation of symptoms which we currently designate to title "fibromyalgia syndrome" have been around all the time, whether recognized or not. Indeed, when examining the description of patients suffering from "neurasthenia" in the Nineteenth century, or from "colitis" in Axel Menthe's "The Story of San Michele" it is obvious that no matter what misconceptions were abundant at the time regarding both the nature of the problem, it's pathogenensis and its treatment, many patients suffering from such diagnoses would currently be identified as suffering from FM.

Notably, eminent Nineteenth century scholars such as George Beard associated neurasthenia with malfunction of the central nervous system [1], a concept not so far from the way we look at "central sensitization" a century and a half later. Subsequently however, medical thinking about the problem shifted and gyred with the introduction of the "fibrositis" title by William Gower in 1904 [2]. While this term inherently implied the assumption of an underlying inflammatory etiology affecting connective tissue, a concept which subsequently fell out of favor, Gower did however direct attention at the possibility of fibrositis appearing as the results of physical trauma, such as the overturning of a tramcar, an etiological issue which continues to be discussed and debated to this very day.

Subsequently, over many decades, the fibrositis concept languished in a state of lack of interest. Despite the large numbers of individuals suffering from the clinical hallmarks of fibrositis/fibromyalgia, major medical textbooks paid little attention to the topic and students were usually instructed, either directly and/or by insinuation and innuendo, to regard the whole topic as somehow dubious, and definitely not very important.

The modern era of FM was ushered in at the last decade of the 20th Century, with the well – known ACR classification criteria published by Wolfe et al [3]. These criteria, formulating the concept of FM as a chronic widespread pain syndrome characterized by diffuse musculoskeletal tenderness, had tremendous impact. Once criteria were established and officially endorsed by the prestigious rheumatology body, FM suddenly started to gain in legitimacy. Studies were initiated, patients recruited based on criteria, and an onslaught of publications appeared. In parallel, public awareness regarding the syndrome rapidly increased. All this happened despite the fact that the 1990 criteria have subsequently been recognized as in fact missing out on important clinical aspects of the FM syndrome, e.g. chronic fatigue, disturbed sleep etc.

Intriguingly, while all this was happening, a gradual paradigm shift was evolving regarding the nature of FM. Initially, FM was regarded as a discrete illness, which one either had, based on criteira, or had not. Thus, a patient with 10 tender points did not have FM, despite suffering from chronic widespread pain, while one more tender point would establish the diagnosis. Moreover, based on this dichotomy, multiple studies examined the concept of comorbidity between FM and other "functional" disorders, reporting findings such as the frequent overlap between FM and Irritable Bowel Syndrome (IBS). However, over a relatively short period, FM came to considered more as a spectrum than as a yes-or-no condition and the concept of "central sensitization", denoting an increase in the gain of pain processing in the central nervous system [**4**] was first formulated and subsequently attributed to the pathogenesis of FM, as well as to other functional syndromes.

Current thinking regarding the FM concept has definitely come a long way. Over the last two decades, major progress has been made in the field of functional neuroimaging, allowing us for the first time to add objective meaning to the subjective heightened pain sensitivity classically described by patients. Starting with groundbreaking studies which showed that pain processing centers in the CNS of FM patients have a lower threshold for pain than in normal individuals [5] , subsequent research has delved into abnormal patterns of connectivity [6] and eventually led to an effort to develop a specific FM pain fingerprint with high specificity [**7**]. Simultaneously, multiple studies have shed light on the genetic (as well as epigenetic) underpinnings of FM[**8**].

So, where is FM going to be in 10-20 or 30 years from today? Although it's hard to tell, it seems safe to assume that a lot will change. Similar to other complex CNS conditions, the understanding of FM is likely to become ever more complicated and multi – leveled. In the future, a strive towards precision medicine is likely to include the creation of a matrix of novel parameters for each patient, profiling individuals on the basis of multiple parameters such as genetic mapping, functional connectivity, psychosocial factors etc. This is also likely to lead to novel sub classifications of the large group of patients currently collectively labeled as suffering from FM. Furthermore, the development of better and more objective diagnostic tools holds the promise to reduce the "transparent" nature of FM and to reduce the numbers of "fibro-skeptics". While it is hard to anticipate whether FM will remain strictly within the realm of rheumatology, what really matters is that FM continues to be treated and studied by those most interested in the subject, which may evolve into a more heterogeneous and multidisciplinary group. On the therapeutic side, huge interest regarding the role of cannabinoids in the management of chronic pain is likely to lead to a radically more extensive understanding of the cannabinoid system and its therapeutic potential. Other, non-pharmacological treatment modalities such as neurofeedback, hyperbaric oxygen, and magnetic stimulation are likely to gain a place in the therapeutic armamentarium. Thus, the story of FM will continue to evolve.

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＜コメント＞**線維筋痛症が抱えている現在までの課題について概要を説明していました。治療に関しては、非薬物療法が有望であり、神経フィードバック法，高圧酸素療法、磁気刺激法などが医療の現場に登場していることを紹介していました。これらの非薬物療法のエッセンスは水気道に通じるものがあります。**

＜メモ＞以下は、私の備忘録です。英語のスピーチを即座に理解することより、翻訳して、日本語で入力することは、誤変換を招きやすく、至難の業であることを実感しました。そこで、＜メモ＞ではスピーチやスライドの表現のまま、キーワードを乗せることにします。

The long and winding road///
Hipp:RA brain
Neurasthenia(1869)
Fibrositis(1904)
Colitis(1929)What is colitis
Tietze's syndrome and Fibrositis(1986)
ポオ rly でふぃね dsymp
P&D

1990ARC　2 criterias only
2010 WPI,Symptom severity scale(SS)
2016　genaralized pain

AAPI Diagnostic criteria AAPT 5 dimensions
Dichotomized abdomen head site の評価を加えるのは問題だ

Paradoxical　central pain
Primary pure fibromyalgia：typical symptoms
1983：Centarl sensitization
 ｆNRI,specific net pattern
FM as overlapping disorder

Genetics and epigenetics:13 folds incidence
Early life stress,
Differentially methylated of genes
Research Domain Criteria
Stepwise management
Distinct personality profile
Neuro-inflammations、biomarkers,brain glial activation

Question:diagnostic criterias
Gender difference:
Hormones serotonine,

09：40-10：10

社会学的視点:なぜ医師が線維筋痛症を恐れるのか？

Winfried Häuser

Professor of Psychosmatic Medicine, Technische Universität München, ドイツ Specialist in Internal Medicine and Pain Medicine. He is working with FMS patients since 25 years. He is head of the steering committee of the German guideline for FMS and member of the steering committee of the EULAR recommendations for the management of FMS. He is member of the medical board of the German Fibromyalgia Association.

Norwegian physicians ranked FMS on two separate occasions in 2002 and 2014 as the disease with the lowest prestige of 38 „low ranking“ conditions. In my lecture, I will give some very personal explanations for the bad reputation of FMS among doctors.

a)GPs: Physicians may be poorly knowledgeable in the recognition and diagnosis of FMS. Physicians are attuned to using objective abnormalities on examination or biomarkers on laboratory testing to confirm clinical diagnoses, a scenario completely lacking in the diagnosis of FMS. Outside of psychosocial and pain medicine, there are uncertainties and reluctance to use symptom-based diagnosis.

b)Rheumatologists: They prefer patients with inflammatory rheumatic diseases for which a broad spectrum of effective drug therapies is avaliable – in contrast to FMS. Rheumatologists are (better) paid for technical investigations than for educating and reassuring FMS-patients.

c)Mental health care specialists: There are still some health care professionals with a narrow psychiatric view on these patients which claim that FMS is an unhelpful diagnosis for the patient and that (masked) depression is the appropriate diagnosis.

d)The FMS community: The rapid change of FMS diagnostic criteria (ACR 2010, 2011, 2016, ACTTION) criteria leave specialists and GPs helpless which criteria to use for the diagnosis of FMS. Scientific controversies in a field can be very stimulating. However, some controversies between the protagonists of a neurobiological and sociological perspective in the FMS community were not helpful at all.

e)Patients: a) A substantial part of FMS patients have experienced childhood adversities and traumatic life events.FMS patients show a higher frequency ofn insecure attachment styles and lower frequencies of secure attachment styles in comparison with healthy women. Insecure attachment styles increase the risk of interpersonal problems including the doctor-patient relationship. Analyses of facial expressions of interviews with FMS patients demonstrated that elements which stabilize relationships were lacking and that dissociative elements were implanted in the interaction. Doctors (without psychiatric knowledge) experience (some patients) with FMS to be time-consuming and stressful. Some FMS patients provoke a negative counter-transference of the doctors. b) The powerful actions of some FMS self-help organisations (partially supported by pharmaceutical companies) claiming that FMS is a somatic disease deserving disability pensions has raised resentments by insurances, pension providers and physicians providing medical expertise.

＜コメント＞　医師の多くが線維筋痛症という病気に対してばかりでなく、線維筋痛症患者に対してまで苦手意識や嫌悪感をもっていて、しばしば、いらつきや怒りすら抱いている、という患者さんにとってはおそらくショックな本音トークが展開されました。それは患者-医師の関係性の構築がしばしば難しいこと以前に、線維筋痛症の患者さんは、しばしば、最も身近な家族との間での関係性が不良であるという問題点も指摘されました。精神医学の知識をもたず、線維筋痛症患者の治療経験に乏しいいほとんどの非専門医にとって、

それは現実の問題です。

＜メモ＞　日本の事例が紹介されていました。新たな線維筋痛症の患者の受け入れを望む医師の比率は44%という数字が示されました。これは、おそらく日本の線維筋痛症学会からのデータを根拠にしているのだと推測されますが、この数字自体がデタラメです。疼痛を専門とするペインクリニック専門医や整形外科医で線維筋痛症を積極的に受け入れている医療機関は１割にも満たないはずですが、日本人は体裁の良い回答をしたがるせいか、数字が現実と甚だしく乖離していることは、このスピーチの後の質疑応答で指摘しておくべきだったかもしれません。

Dr have negative feelings toeard FM patients.

Financial
Academic
Doctors:Uncertainses fears Rejection Anger
Patients:
D and P relationships:
Medicolegal pharmaceutical problems

Uncertainties about diagnosis
Criteria,confusing
AAPT2018Diagnostic Criteria

Differences
Terminology concerning to pains
Pain areas
Importance and scaling of non-painful symptoms
Exclusion of a somatic disorder

To be clarified
Type of pain,Clinical diagnosis self report physicains assessment

Underscore

Journal of Psychosomatic Research80
Patient-related PCP DPIrelated

Doctors afraid of misdiagnosing
Feeling
FMS=masked depression/ affective spectrum disorder

Rejection-malingering

Frustration and helplessness

Not trainesd to treat distress and suffering
233 Japanese physicans wanto to accept additional FM
Patients 44%

Defeats,humilitations and unpleasant experiences

Attachment styles snd docto-patient relationship
FMS expresind attachment style
Emotional expression:non congruence
Emotional abuse and neglect in childhood:expects to accepted
Doctor:annoyed and cool
Patient:Annoyed more
Lyrica
Fibromyalsia’s status as a real disease
Legitimacy
www.fibronetz-saar.de
doctor-patient seminer, collaboration[

10:00-10:30	*Networking, Coffee Break and visit the Exhibition*

朝食抜きでしたが、コーヒーのほかにパンやフルーツが用意してあり、ちょうど良かったです。

10:30-12:00	**Session 2** "線維筋痛症戦争" 座長: Piercarlo Sarzi-Puttini, イタリア

１０：４０－１１：１０

"心身医学"の良い側面、悪い側面、醜い側面

Riccardo Torta MD, & Rossana Botto PsyD
Clinical Psychology and Psycho-Oncology Unit, Department of Neuroscience, University of Turin, Turin, イタリア

The presentation proposes to summarize the evolution of the concept of "Psychosomatic" and the approach to it. The Mind-body problem is a philosophical matter of concern to science since its inception.

In ancient Greece, ***Hippocrates***, proposing the humoral theory, tried to provide a unitary conception of human being, in which the body, the mind and the environment were strictly interconnected. According to his theory, four humors, blood, yellow bile, black bile, and phlegm combine in the human body, and manifest in the form of temperaments.

A few centuries later, in the modern age, ***Descartes*** replaced this perspective with his reflections on **res extensa** versus **res cogitans**. It distinguished between psychic and physic reality, contemplating the existence of two distinct domains, i.e. that of thinking (cogito) and that of the material world (sum). The introduction of such dichotomy, known as **Cartesian dualism**, had a protracted harmful impact on science.

The term "**Psychosomatic**" has been introduced at the beginning of the 19th century, and the first phase of development of the modern psychosomatic medicine started in the early 1900s. Originally, due to the strong influence of psychoanalysis, the nucleus of psychosomatic diseases were the individual intrapsychic conflicts. It was thought that such unconscious instincts and drives generated emotional states that could determine pathological modifications in tissues and organs, and had a direct causal relationship with somatic diseases.

For example, in the hysterical conversion, neurological deficits, such as paralysis or somatosensory alterations, were considered as caused by psychogenic stressors. In this way, the physical symptoms that could not be explained by organic reasons, were the resulting effects of psychic issues.

Subsequently, thanks to the scientific advances especially in genetics and neurobiology, these first theories were questioned, and the mind and the body started to be considered as interconnected and exerting reciprocal influences. **Multi-factorial circular models** replaced the causal-linear ones, and the study of other individual aspects, such as attachment, subjective development and cognitive domain became salient. Furthermore, Psychosomatic received a fundamental support from **the bio-psycho-social model** and **the concept of heterogeneity of diseases**, according to which psychosomatic diseases do not exist, but psychosomatic factors could be central in some diseases.

Therefore, the actual hypothesis is that multiple aspects, such as bio-chemical, psycho-social and environmental contribute to the manifestation of a certain clinical condition. This is sustained also by neuroscientific evidences, that are demonstrating how neurobiological processes can impact on both soma and psyche. For example, it has been shown the double role of oxytocin that, on the one hand, stimulates uterine contractions during delivery and milk secretion and, on the other, promotes maternal care and attachment. Also the function of proinflammatory cytokines both on mood and physical disease well represents this new actual psychosomatic perspective.

Paradigmatic in this context is the problem of fibromyalgia syndrome (FMS) in which both biological and psychosocial factors play significant roles in his pathogenesis. In FMS there is a greater presence of psychological distress and psychosomatic syndromes than in rheumatoid arthritis (RA) patients (Ghiggia et al., 2017). A better understanding of the psychosomatic manifestations of FM syndrome could allow clinicians to structure tailored interventions that take more account of the emotional distress associated with the physical complaints. Also the current evidence strengthens the relevance about the management of FMS from a psychosomatic perspective (Sancassiani et al., 2017). In agreement with these considerations an integrated model of Psychosomatic Medicine could help the approach to FMS in clinical practice (Deter, 2018).

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＜コメント＞ヒポクラテスからはじまり、心身二元論のデカルトを経て、精神分析の創始者フロイトや心身医学という言葉を初めて用いたハインロートまでの医学のコンセプトの沿革が説明されました。そして、最後に他因子円環モデルが紹介され、心身症は存在せず、ただ、心身相関が存在するという論調のようでした。サイトカインというたんぱく質のうちで炎症性サイトカインに属するものは気分と体調の両面に影響を与えることを紹介しました。

＜メモ＞この演者だけでなく、発表者によっては、線維筋痛症（fibromyalgia:FM）という用語の代わりに、線維筋痛症候群（fibromyalgia syndrome:FMS）という表現を用いています。私も後者がより望ましい医学的表記だと考えます。この演者が結論しているように、線維筋痛症候群に対しては心身医学的理解を基礎とする統合的なモデルにしたがって診療に臨むことが不可欠だと思います。

Medical,philosophical and religious history

Heinroth : the first concept of “Psychosomatic”
Freud
Roy Grinker:biopsychosocial
Geoge Engel(1977)
The change of concept of disease
From biomedical reductionism
But BPSM shouws some limitation im the clinical practice:
Biomedical semplifivation or biopsychosocial complexity?I
Karl Jaspers:vs William Osler
Engel(1977)psychobiosocial model

BSP Medicine
Relevant progress(genetic,epigenetic///¥
Rosetta stone of PS aspect
Interconnection influence :indrecrt activity
Stress and diseasea
Microbiota and autism
Depression and NK
Low grade inflammation

Apsycho-and somatid alterations share the same mechanisims
Cytokines
Chronic pain :inadequate drug ,dosages,resistance
Emotional,cognitive, social

FDCPR(Diagnostic Criteria dor
ibromyalgia and psychosomatic

Conclusions
Evidenceifferent clusters
in the clinical practice
The spectrum of therapeutic stratetegies in PS must be enlarged
PS education

Nosography

Attitude toward to patients with FM patients
Multidiciplinary approach
Patiants proactive
FM patients

Pain clinic practitioner tive manner
Holistic approach
Psychoeducation integrxationative
Psychodynamic
Relaxation
Group therapy

11：10－11：40

明白な痛み。しかし、だれの目から見てもまったく病んでいるようには見えない…

Manuela Di Franco**, Cristina Iannuccelli**
Reumatologia, Dipartimento di Medicina Interna e Specialità Mediche, Sapienza – University of Rome, Rome, イタリア

The IASP (International Association for the Study of Pain) defines pain as an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage.

Fibromyalgia (FM) is one of the most severe and disabling chronic pain syndromes characterized by the absence of structural pathology (so-called "organic cause") and accompanied by fatigue, sleep, memory and mood issues.

FM patients complain of strange and variable pain described from time to time as burning, aching, sharping, stabbing, exhausting, cramping, gnawing, tingling, etc

This description of the pain changes during the hours, the days, the months, the years often with different and capricious characteristics.
Because of that the patients are not taken into consideration by relatives and sometimes also by physicians. Their inexplicable pain is transparent and consequently the patients result "transparent": they are not considered sick at all.

The problem is that FM etiopathogenesis is still a matter of debate and consequently validated biological biomarkers have not yet been identified. Currently, according to 2016 ACR criteria, FM diagnosis is based exclusively on a comprehensive clinical assessment.

A recent study showed as a patient-centered care and an empathetic behavior towards the patient are significantly higher for patients who have visible signs of pain (rheumatoid arthritis and complex regional pain syndrome) than for those who have no visible signs (Ehler–Danlos syndrome and fibromyalgia).

How this disease can be made non-transparent? How those patients can be made "non-transparent"?

During the years there have been numerous attempts to find some markers for the disease but no one was conclusive. Recent attempts to make the pain objective included studies with functional magnetic resonance imaging that showed an abnormal resting state functional connectivity of the periaqueductal gray suggesting that patients with FM have an endogenous pain modulatory system dysfunction, possibly causing an impaired descending pain inhibition. Moreover some authors described a high prevalence of small fiber pathology in FM.

Unfortunately those data are not so strong to be used in the clinical practice. Likely it is necessary to look not only for biological or instrumental markers, but also for other possible markers such as psychological and anthropological findings.

From a psychological point of view, various subgroups based on distinct characteristics have been identified (essential pain, concurrent distress, particularly depression and anxiety) suggesting the existence of heterogeneous and interacting etiopathogenetic processes. Clusters of patients have been also described using psychological measures but findings are not univocal. FM patients have been found to show a dysfunctional representation of their illness and to adopt coping strategies that are ineffective and focused on a catastrophic view. Conversely, one of the few protective factors that has been investigated in the context of chronic pain is pain acceptance, which seems to reduce negative emotions in response to pain and to favor effective pain coping strategies.

From an anthropological point of view, chronic pain is a phenomenon determined by the interaction of several factors, which include cultural and social determinants. Specifically, experiences such as isolation and marginalization, sense of abandonment, lack of support, or complications in family, social, and work relationships can aggravate the level of psychological distress, which in turn adversely affects pain perception. At the same time, personal and social factors, such as lived trauma, subordination status, social suffering, or forced identity redefinition, can be considered as illness' determinants in themselves.

The development of clinimetric assessment tools and/or patient-centered questionnaires tested on large population could be useful to evaluate FM pain and consequently to bring out the transparent pain.

To conclude pain invisibility can be a barrier to quality of care. It is necessary to educate caregivers to look to the transparent FM pain and to “transparent” FM patients in order not to underestimate this frequent condition.

＜コメント＞線維筋痛症候群の患者さんが主観的に経験する痛みは明白に存在します。しかし、他人に説明することが難しい痛みなので、周囲の人々にとっては明白な痛みどころか、理解不能な痛みなので、共感を得ることが難しくなります。そのため、患者の精神的なストレスが昂じて痛み知覚に対して好ましくない影響を及ぼします。そのため、痛みを＜見える化＞することで、十分なケアを受けることができないでいる患者を救うことができる旨を述べていました。

＜メモ＞　スピーチの後の質疑応答で、患者はまず両親や家族に対して痛みを明確に伝えることが治療の第一歩であることでの合意がありました。家族にはどうせ理解してもらえないという思いがあると、そうした患者さんは、医師の前では執拗に痛みを訴える傾向があります。こうした患者さんには、まず家族や職場の同僚に打ち明けることをお勧めする場合がありますが、それだけで痛みの大半が解消されることも珍しいことではありません。

Pain definition

Pain is transparent
FM is different from ordinary pain
Difficult to explain:untransparant

Inexplicable oain the importance of being visible
From disease centered to patient centerd care

Double action
Chronic primary pain
Attempt to objectifys
Treatment and management implication

Genetic contribution

The role of epigenetics
miRNA
Inflammation;Cytokines
NMDA receptors
Neuroendocrinal abnormalities:NPY
Nociceptive system
Environmental influencds
Influence gene
Ling-lasting change of genes
A healthy invalid?

A person-centered care
Poor illness perception,dysfunctional representation

FM may be better way with multiple 7tailored imtervention

Education,psychological and anthropological perspectives

Question:
Family understanding
Speak and explain to parents and other family members

１１:４０－１２:１０

線維筋痛症患者の障害を取り扱うことの複雑性と困難性

Howard Amital
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Associate Professor and former Chair of Internal Medicine, Sackler Faculty of Medicine, Tel-Aviv University, イスラエル

Chronic pain conditions are the most common cause for disability leave from work. In addition, these conditions account for the highest indirect costs for society and also accounts for an individual economic, social, educational and vocational burden.

The leading symptoms limiting vocational tasks in patients with fibromyalgia were found to be pain (87%), tiredness (80%), muscle weakness (73%) and memory and concentration problems (51%).

Many of these disabled subjects are dependent on the government health care systems. Given the complexity of the medical community toward patients with fibromyalgia they are often regarded as malingers and in many cases their appeals are denied.

The following presentation will shed light on the current situation that patients with fibromyalgia face and suggest ways to solve this issue.

＜コメント＞線維筋痛症候群をはじめとする慢性疼痛性疾患は労働力を削ぐことになり、患者さんの生活水準を厳しいものにしがちです。社会福祉財源にとっても大きな負担になっています。そのため、しばしば仮病扱いを受け、病気悪化の悪循環を招きます。

＜メモ＞ このスピーチ自体は、特別に画期的な内容ではありませんでしたが、その後の質疑応答がドラマチックでした。質問者は線維筋痛症候群の患者さんの治療を担当する作業療法士の女性でしたが、彼女自身が職務上の支援が得にくく、治療には大きな困難が付きまとっていて途方にくれていることを涙を交えながら切々と述べていました。線維筋痛症候群の患者さんはもちろんのことですが、そうした患者さんを真剣にサポートしようと日夜苦闘している医療従事者に対して政府や自治体が冷淡であるのは、日本だけでなく各国に共通の社会問題であることを痛感しました。

What is Disability?

Disability

Cause;disease related symptoms,patient7s perspectives

Work related therapeutic, secondary gains, malingering

Work disability of FM

Women overload,occupational

Unemployment

A rapid process within the first year after being diagnosed with FM

Absenteeism/Presenteeism

Conclusions-the role of stressors

Assessing working capacity is difficult
Question:from an occupation therapist
Answers
Work place bullying
Do not stigmatize the patients with FMS

12:00-13:00	*Lunch Break, Poster Viewing and Visit the Exhibition*

この立食の席で、ポーランドのリウマチ専門医の Dr.Robert Rupiñski と話が合いました。ポーランドでの線維筋痛症候群の医療状況と日本の状況は類似点が多いこと。リウマチ専門医でも線維筋痛症候群の患者さんを歓迎しないことがほとんどであること。手間暇がかかり、ストレスを被るのにもかかわらず、保険医療で給付される対価には到底見合わないのが最大の理由であること。それでも線維筋痛症の患者さんを診ようとする医師は強靭な精神力を要するので、信仰の力の支えが必要であること。ポーランドは経済的にはかつてより豊かになってきたが、カトリック国であるにもかかわらず教会離れが顕著であるとのこと。その理由は経済的な豊かさを精神的な豊かさより優先する人が増えてきたためとのご意見でした。信仰を持つ人と持たない人が二極化する傾向にあり、名目だけのカトリック信者の比率が大きくなる一方で、敬虔な信仰をもつ人々の熱心さの質はかつてより高まっているとのことでした。教皇ヨハネ・パウロ二世の出身地のほど近い土地のご出身だとか、「ポーランドには是非足を運んで欲しい、あなたを案内したいところがたくさんあるので」とのことで名刺をいただきました。私は線維筋痛症候群の患者さんに対する非薬物療法として水中有酸素運動（水気道）を続けていて、他の方法に引けを取らない成績を上げている話をしたところ、とても興味をもっていただけました。

13:00-15:00	**Session 3** 分類と診断 座長: Winfried Häuser，ドイツ

13：10－13：40

線維筋痛症の分類、診断および疫学における概念の進化

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Different studies, coming from different countries and settings estimated the prevalence of fibromyalgia (FM). The worldwide prevalence of FM is around the 2.7%, ranging from values of 0.4% (Greece) to 12% (Tunisia). Across the various continents, the prevalence of FM is of the 3.1 % in the Americas, 2.5 %in Europe, and 1.7 % in Asia. Globally, FM mean prevalence is 4.2 % in females and 1.4 % in men, with a female-to-male ratio of 3:1. The prevalence of the disease is also influenced by the diagnostic criteria adopted: applying the 2010 criteria of the American College of Rheumatology (ACR) seems to be higher than the 1990 criteria that required the objective examination of the tender points.

Some studies have also evaluated the incidence of the disease. A Norwegian study shows an incidence of 5.83 cases/1000 people in women between 20 and 49 years of age, while Weir and coworkers detected an age-adjusted incidence rate of 6.88 cases/1000 person-years for males and 11.28 cases/1000 person-years for females.

Over the last decades, numerous efforts have been made to establish valid diagnostic/classification criteria for FM, and this area of research is still extremely dynamic. FM is still a complex disease to diagnose, and the diagnostic delay is about two years.

As a result, FM is still an under-diagnosed and under-treated disease. The 1990 ACR criteria were extremely focused on chronic widespread pain (CWP) (defined as pain in the left side of the body, pain in the right side of the body, pain above the waist, pain below the waist, and axial skeletal pain) and tenderness (defined as pain on palpation of 11 or more of 18 specific tender point sites on the body), with little relevance to symptoms for diagnostic purposes.

Therefore, for over 20 years, a history of CWP and the presence of tender points have been the cornerstones for the diagnosis of FM. However, over the years a number of critical issues have emerged with regard to this diagnostic/classification approach.

First of all, it has been revealed that in primary care many physicians do not know how to evaluate tender points and, refusing to do so, in practice the diagnosis is based on symptoms.

Secondly, the literature has increasingly valued the presence of symptoms, such as fatigue, unrefreshing sleep, and cognitive symptoms, as key elements for the diagnosis of FM.

A third important objection was that a complex pathology such as FM is that characterized by manifestations that are a continuum, whose diagnosis is difficult to interpret in a simple cut-off point.

Consequently, the 2010/2011 criteria have been developed with the intention of enhancing the non-tender point symptoms by translating them into a symptom severity (SS) scale.

In addition, the formal count of tender points was replaced by the widespread pain index (WPI), avoiding the objective examination.

Recently, one of the criticisms levelled against the 2010/2011 ACR criteria, is that they have allegedly moved away from chronic pain.

The latest development of diagnostic criteria for FM has been provided by the FM Working Group of the AAPT (Analgesic, Anesthetic, and Addiction Clinical Trial Translations Innovations Opportunities and Networks [ACTTION] - American Pain Society [APS] – Pain Taxonomy).

In these criteria, FM has again been classified as a disease characterised predominantly by chronic pain (a self-reported of the multi-site pain [MSP], defined by the presence of at least six of nine pain sites throughout the body), along with fatigue and sleep problems as two key associated symptoms.

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＜コメント＞線維筋痛症の診療の促進をさまたげているのは、外ならぬ診断法、それも数度にわたって改訂される診断基準にあることを指摘していました。

その理由として1）多くの医師は圧痛点の確認法を知らず、苦手意識があり、自覚症状のみを頼りに診療していること、2）文献上、疲労、疲れの取れない睡眠、認知障害などが、診断の要素に含まれるので、身体各科の医師はこれを苦手とすること、3）正常と異常の間が連続的なので、どのあたりで両者をふるい分けるかが難しいこと、の3点を挙げていました。ただし、最近の診断基準では、より単純化された疼痛の評価を軸として、疲労及び睡眠障害の２点を不可欠な項目としていることを紹介しました。

＜メモ＞　様々な診断基準が出現しましたが、新しいもののほうが優れているといのではありません。最近の診断基準は、実際の医療現場で非専門医でも実施しやすくした妥協の産物のように思われました。

Evolving of the classification
Diagnostic entity:ICD 11th code chronic pain MG30.0 chronic primary pain
Widespread,musculoskeletal,complex

Nociplastic from nociceptic plasticity

Exclusion criteria
2011criteria
ACTTION
FDA
APS
AAPT:ACTTION and APS

APTT diagnostic criteria for fibromyalgia

MSP:simple count
CWP
Body manikin ≧points

.Fatigue,Sleeplessness

Tenderness Dyscognition Musculocutaneous ,Environmental

Falls positive patients

Cumple t-off 5
SIFIS questionnaire :Simple Fibromyalgia Questionnaires

DAS28-P
DAPSA
PSDscale= WPI +SSS
Trget Approach
Potential targets

FIQ <30　remission

１３：４０－１４：１０

線維筋痛症は他のリウマチ性疾患とは実際上まったく異なっているのか？

Guggino G
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There is still a great debate on the definition of fibromyalgia (FM) and how to deal with patients affected by this condition. Although FM has been considered a musculoskeletal disorder rather than a central sensitization syndrome, its classification is not easy since it is a systemic disease.

The complexity of the symptoms reflects an intriguing pathogenesis in which the neuroimmuno axis seems to be widely involved. It is for such complexity that, in reality, we should ask whether FM is really so different from other rheumatic diseases.

The crucial points is to understand which pathogenetic factors are at the base of FM, where patients report severe pain. The experience of pain is the cardinal element of the disease, making it the first element of treatment.

Nowadays, the treatment of chronic pain is widely debated and new therapeutic approaches have been borrowed and made available also for FM. One of these approaches is based on the hyperbaric oxygen therapy (HBOT), which has been found able to modulate immune system response.

Recent findings, in this stream of research, have demonstrated that FM patients show a significant increase in inflammatory mediators such as TNF-alpha, an activation of T helper 1 lymphocytes and a reduction of central nervous mediators such as serotonin. These alterations are correlated with widespread pain, fatigue, sleeping disorders and the quality of life.

After HBOT the modulation of immune system is rapidly obtained restoring the balance of CD4+ T cell subsets and relative cytokines. CD4+ T cell subsets have significant cross-talk, with the ability to “differentiate” given appropriate environmental signals, suggesting that environmental factor could participate to the activation of immune system. These findings suggest a great involvement of immune systems in the pathogenesis of FM.

The proinflammatory status detected in FM patients makes FM not so different from other rheumatic diseases in pathogenetic terms.

On the contrary, the conventional treatments used for rheumatic disease appear ineffective for FM making it different in regards to therapy.

The end of the pattern towards the definition of FM is still open and many other studies will be necessary to put together the pieces of a still incomplete puzzle.

＜コメント＞線維筋痛症を神経免疫軸でとらえると治療に結び付けやすくなること。一般の慢性疼痛性疾患に応用されている非薬物療法を線維筋痛症に応用して効果を上げることができること。最近の知見では、線維筋痛症の患者では炎症性サイトカインの著増やヘルパー1Tリンパ球の活性化が生じていて、セロトニンをはじめとする中枢神経系媒体が減少している報告があること。こうした事実を踏まえて、線維筋痛症も他の慢性疼痛性疾患と同様に炎症性機序が明かになりつつあることを指摘しています。しかしながら、関節リウマチとの共通性は乏しく、まだまだ研究の余地が残されています。

＜メモ＞　**サイトカインの異常が観察されるとしたら、種類の違いこそあれ、それ自体が関節リウマチとの共通性であると考えることもできたはずです。そして、これらの炎症性マーカーが示唆されれば、線維筋痛症の診断と治療が促進されることは十分に期待できると思います。既出の論点ですが、炎症性サイトカインは患者の気分と体調の両側面に同時に影響を及ぼすことについて質疑応答がありました。**

FM without signs of synovitis and tendinitis
Increased fragments of muscle

Flu-like viral illness
Physical trauma
Emotional trauma
Medication,esp. steroid withdrawal

Etiopathogenesis
Neuroimmmunoendocrinological axis

Hypersensitive to all kind of stimuli
Chemokines,cytokines
From physiological state to neuropathic pain state

Astrocyte
Inflammation and depression:cytokines
Systemic inflammation and neuroinflammation
proflammatory cytokines
anti-TNF in cytokine’ therapy
differences in cytokines
HBOT effects
Antidepressants inhibit interferone-gamma
IL-6,TNF,IL-1beta

Question:
Mood and Pain relationship by certain cytokines
IL-6

Question:anti-inflammatory diet
Optimize life style
Mitochondria

14:10－14:40

予防接種を受けた後の慢性疲労症候群と線維筋痛症：

‘アジュヴァント誘発性自己免疫（自己炎症）症候群’

(ASIA)

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The Mosaic of Autoimmunity Project of Saint Petersburg University

The objectives of this study were to gather information regarding demographic and clinical characteristics of patients diagnosed with either fibromyalgia (FM) or chronic fatigue (CFS) following hepatitis B vaccination (HBVv) and furthermore to apply the recently suggested criteria of autoimmune (auto-inflammatory) syndromes induced by adjuvants (ASIA), in the aim of identifying common characteristics that may suggest an association between fibromyalgia, chronic fatigue and HBV vaccination.

Medical records of 19 patients with CFS and/or fibromyalgia following HBVv immunization were analyzed. All of which were immunized during 1990–2008 in different centers in the USA. All medical records were evaluated for demographics, medical history, the number of vaccine doses, as well as immediate and long term post-immunization adverse events and clinical manifestations.

In addition, available blood tests, imaging results, treatments and outcomes were analyzed. ASIA criteria were applied to all patients. This study suggests that in some cases CFS and FM can be temporally related to immunization, as part of ASIA syndrome. The appearance of adverse event during immunization, the presence of autoimmune susceptibility and higher titers of autoantibodies all can be suggested as risk factors. ASIA criteria were fulfilled in all patients eluding the plausible link between ASIA and CFS/FM.

Keywords: Autoimmune (auto-inflammatory) syndromes induced by adjuvants (ASIA) . Vaccines. Autoimmunity. Fibromyalgia. Chronic fatigue syndrome.

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＜コメント＞感染症が原因で発症する様々な病気が知られています。特に、慢性疲労症候群では以前から指摘されていました。この病気と類縁関係にあるとされる線維筋痛症も例外ではないことを述べていました。とくにショッキングなのはB型肝炎予防ワクチンなどのワクチンが線維筋痛症発症の引き金になっているという主張です。豊胸術で用いられるシリコンも予防接種ワクチンとどうようにアジュヴァントして、これが慢性炎症を引き起こ

し、長期にわたって炎症が持続することによって自己免疫疾患を引き起こすことをスピーチしました。演者は自身を自己免疫性疾患専門医としての立場からの発表である旨を明らかにしていました。

＜メモ＞　線維筋痛症や慢性疲労症候群に何らかの免疫学的異常が関与しているのではないか、という印象はもっていましたが、これほど明確に自説を展開する論者は初めてでした。特に予防接種が発病の引き金になるので予防接種は受けないように勧めているという見解には馴染めませんでした。やはり、この点について疑問視する参加者が少なくないようにみえました。実際に複数の参加者から質問がありました。ワクチン接種の恩恵は大きいので、せめて、どういうタイプが自己免疫疾患を誘発されやすいのかの目安はないのか、という至極当然の質問があがりました。

Autoimmunologist
Autoimmunology

Vaccines could induce autoimmune disorders.

ASIA syndromes
Lipid replacement therapy

Toward personalized treatement
Environmental factors
Polymorphism in HLA=DRB1 the notorious
Is assiociated with resistance to bacteria

Hyperstimulated by adjuvants
Chronic idifferencescytokines

Esrogens and Baff
More aggressive immune system
Autoimmune auto-inflammmatory adjuvant syndrome(ASIA)
ASIA-a new syndromes

Adjuvant breast diseaseSilicone implant rupture,chronic inflammation,cytokines

Adjuvants come from vaccines

Mrchanisms:activate the innate immunity
Narcolepsy ;An autoimmune diseases?

1) Infection
2) HBV vaccine
3) HPV vaccine

FM:Vaccine-maintained chronic inflammation
hyperstimulation

14:30-15:00	*Networking, Coffee Break, Poster Viewing and Visit the Exhibition*

この時間に、会場の後方に衝立が設置されポスターが掲示されていることに気づきました。プログラムに紹介されていたポスター数は 28 で、いずれも興味深い内容でした。日本からの発表は口演、ポスターともに皆無なのが残念に思えました。たまたま、ディスカッションしたのが米国からの唯一のポスターで、メイヨー・クリニックの若手医師のものでした。メイヨー・クリニックは米国でも超一流の病院の一つですが、線維筋痛症に対しては集学的な様々なアプローチをしていることが分かりました。リラクゼーション・プログラム、認知行動療法、鍼灸療法なども積極的に行われ効果を上げていることを知りました。ただし、水中エクササイズの設備はないため、有効性は認めているが行っていないとのことでした。杉並国際クリニックはメイヨー・クリニックのプログラムと共通点も多いですが、さらにその先を行っていることを自負しています。

15:00-17:00	**Session 4** 末梢から中枢へと進展するのか、それともそれとは逆なのか; 線維筋痛症はどこに立脚するのか? 座長: Yehuda Shoenfeld, イスラエル

１５：１０ー１５：３０

急性から慢性の疼痛への移行を裏付けるメカニズム

Daniel Clauw
University of Michigan, 米国

We are beginning to better understand the mechanisms that underlie the transition from acute to chronic pain. As with many other complex chronic diseases, although chronic pain runs strongly in families, there are no single genes that confer strong effects, so at present this risk is thought to be polygenic with likely epigenetic factors playing a significant role.

Other risk factors for developing chronic pain include female sex, previous chronic pain elsewhere, a history of trauma or stress, a history of mood or sleep problems, and cognitions such as catastrophizing.

Biological mechanisms that may contribute include altered pain and sensory processing on quantitative sensory testing, changes in brain connectivity patterns, structure, or neurochemistry on functional neuroimaging, and a primed immune system.

＜コメント＞

急性の痛みと慢性の痛みの性質は大きく異なります。ただし、すべての慢性疼痛も急性疼痛から始まるので、その移行のメカニズムが盛んに議論されています。急性疼痛は一般に末梢性で局所に生じますが、慢性疼痛の中には線維筋痛症のように広範で持続的な痛みとなるものがあります。この痛みが末梢性由来なのか中枢性由来なのかは議論されています。原因として特定の遺伝子の明かな関与は見出されていないので、エピジェネティック因子のような多数の遺伝子が関与している可能性があります。その他の因子としては、女性、慢性疼痛の既往、心的外傷やストレスの既往、気分や睡眠障害の病歴、破滅的な思考などが挙げられます。

＜メモ＞

演者はどうやら、慢性疼痛の原因は末梢性よりも中枢性の関与を示唆しているようでした。ただし、古典的な心理因子ではなく、過去の症状（痛み、疲労、記憶障害、身体症状）とくに睡眠障害が予測因子であると述べました。しかし、これは心身症の特徴をもつ患者さんにとってはごく当たり前のことであり、身体症状には敏感である反面、自分自身の心の状態の気づきには疎いというアレキシサイミアの特徴を示したものです。この演者が述べたことは、慢性疼痛患者にありがちなのは、心理的症状を切々と訴える神経症タイプではなく、心身症タイプであるということを示唆していると考えます。

Predicting transition from acute to chronic pain
OPPERA studies : insident of temporomandibular disorders
The role of QST in predicting pain: complicatedging studies

Chronic post-surgical pain
Australian studies of chronic fatigue syndrome
Relatively uniform post-infective fatigue syndrome: pathophysiological pathway
Genetics of pain :complicated

previous symptoms are always the best predictor
(pain,fatigue,memory problems,somatic symptoms)
rather than classic psychological factors,
Poor sleep is a potent and very stronger predictor of new onset pain
Only a few functional imaging studies have been performed and these suffer from methodological issues

15:30－15:50

線維筋痛症と他の慢性疼痛状態とのメカニズム上の類似性

Lars Arendt-Nielsen, *Sensory-Motor Interaction (SMI) Center, School of Medicine, Aalborg University, Aalborg,* デンマーク

It is generally accepted that pain diagnosis and therapy should be mechanism based and hence pain assessment tools (pain biomarkers) should be sufficiently sensitive and advanced to provide such mechanistic information. Translating clinical observations to mechanisms and vice versa is not trivial, and tools to assess quantitatively the different phenomena are mandatory. This approach has provided new insight into how reorganization of the pain system is manifested in fibromyalgia and other chronic pain conditions. Common features across different pain patient populations have been identified utilizing this approach. Peripheral and central sensitization are important mechanisms for fibromyalgia (FM) and musculoskeletal pain conditions in general. Many similarities exist between different chronic musculoskeletal pain conditions. Musculoskeletal pain may transit from a localized pain problem through a regional representation to a widespread pain condition such as FM. As the pain condition transit from one to the other, more and more sensory abnormalities occur with many sensory abnormalities in FM. There is evidence that as well the intensity of ongoing pain as the duration of pain determine the degree of generalized hyperalgesia. This is important to realize as it underpins the importance of the ongoing nociception for the chronification process in conditions (e.g. osteoarthrosis) where the peripheral nociceptive drivers are known, whereas it is more complicated in, e.g. FM where the drivers are less obvious.

Such techniques for assessing the peripheral/central pain sensitization mechanisms in patients with FM and other patients with musculoskeletal pain have been developed and provide the opportunity to quantify pain mechanisms such as temporal summation, descending inhibition, spreading sensitization, and additional modality-specific hyperalgesic reactions. Such tools can help to phenotype patients with FM based on the role of the various pain sensitization mechanisms involved and have recently been used as tools to predict pain outcomes after pharmacological or surgical interventions in various groups of musculoskeletal pain conditions.

Relating clinical benefit of a given therapy with quantitative assessment of the pain sensitization mechanisms involved provides new opportunities for better diagnostics and hence for tailored and individualized management regimes. Although assessed differently in specific tissues for various musculoskeletal pain conditions, the underlying mechanisms share common underlying features An example of similar mechanisms across chronic pain conditions could be cutaneous allodynia in neuropathic pain assessed by brush, which corresponds to pain evoked by weak muscle pressure in musculoskeletal pain and to pain provoked by a weak colonic distension in visceral pain. Another example can be facilitated temporal summation and impaired descending modulation across many different chronic pain conditions including fibromyalgia. This mechanistic understanding is of importance for developing better diagnostics and for implementing tailored pain management programs. The understanding that FM and other musculoskeletal conditions share common fundamental features has positioned FM as the one extreme end as opposed to, e.g. a myofascial pain problem at the other end. This has provided some new insight into the development of the sensitization processes from one extreme to the other. Some of the current available mechanistic human pain biomarkers translate back to animals, providing new possibilities for bridging findings between pre-clinical and clinical studies. Data on the clinical applicability are increasingly available.

＜コメント＞この演者は線維筋痛症の特徴として末梢性及び中枢性の感作をあげています。強い痛みが持続すると全身の痛みに発展します。様々な実験が現在進行中であり、疼痛感作過程が基礎研究で明かになれば、その知見が臨床現場にも応用できるようになるだろうとの予測でした。

＜メモ＞アロデニアという極度に痛みに過敏になった状態は、しばしば中枢感作との関連で議論されています。中枢感作とは脳の過敏性ですから中枢抑制剤である抗てんかん薬が線維筋痛症の治療に用いられています。また下降性中枢抑制のメカニズムにも触れ、それに作用する抗うつ薬の有効性についても触れられていましたが、いずれも症状を緩和するのみで、治癒を目指せる本格的な治療法ではありません。線維筋痛症に対する本格的治療としては、ますます非薬物療法が見直されなければならいことでしょう。

FM common translational features pain mechanisms

Localized sensitization
Spreading of pain:
Time: from tissue injury to
Pain intensity and duration
Musculoskeletal pain
Muscle hyperalgia

Allodenia
Pressure pain sensitivity Maps in OA

Generalized pain and spreading sensitization
Contralateral sensory aabnormalities

Pressure pain
Impaired descending inhibition system

Temporal syinhibition system
summation and after-sensation

Facilitated integration of pain
Central integration
Gabapentin,Gabapentin
Descending pain moduration

Antidepressants and anticonvalsnts are widely used
Tourniquet induced DNIC-effects

Specific epigenetic modification

１５：５０－１５：１０

線維筋痛症候群における末梢性侵害受容器の役割

Prof. Dr. Nurcan Üçeyler, Department of Neurology, University of Würzburg, **ドイツ**

The pathophysiology of pain in fibromyalgia syndrome (FMS) is unknown. Patients mostly describe deeply localized pain in muscles and tendons with high variance in intensity and spatial distribution. Pain mostly starts at circumscribed regions and spreads over the entire body. Patients regularly report of typical additional core symptoms such as sleep disturbance, gastrointestinal problems, subjective cognitive impairment, and depressed mood, which in turn may increase pain.

Analgesic treatment is challenging and often leads to side effects rather than being efficient. Hence, most FMS patients stop pharmacological treatment and turn to non-pharmacological therapies with better outcome.

In the last years FMS research has increasingly focused on small nerve fibers (thinly-myelinated A-delta and unmyelinated C fibers), which terminate in the epidermis and mainly conduct pain, thermal sensations, itch, and pleasant touch.

Since the first description in 2013, several studies from different laboratories worldwide have been published describing hints for small fiber impairment in FMS patient subgroups. These alterations cover a reduction in fiber quantity as assessed in the skin and the cornea, an increase in small fiber sensory function thresholds, and a reduction in electrical conduction.

In parallel, microneurography revealed spontaneously active nociceptors in FMS patients. The underlying mechanisms that lead to small fiber impairment in FMS patients are not understood and it is also unclear, if and how small fiber abnormalities may contribute to FMS pain. Also, these findings are not specific for FMS and do not prove or disprove the diagnosis.

Currently, small fiber assessment does not have a diagnostic impact in FMS patients. Lacking a validated objective biomarker, the diagnosis of FMS is still made following internationally accepted criteria that are based on the clinical presentation and symptom load. However, research on the pattern and underlying pathophysiology of small fiber pathology in FMS has intensified and more studies investigating well characterized large patient cohorts are needed to decipher the underlying pathomechanisms.

In this presentation, current data on small fiber pathology in FMS will be summarized and critically discussed with the audience mainly focusing on methodology, data interpretation, and potential diagnostic and therapeutic implications.

＜コメント＞ここでも線維筋痛症候群に対する通常の鎮痛剤の効果あまり期待できないことが述べられました。そのため患者の多くは鎮痛剤の内服を中断して、非薬物療法にシフトする傾向がドイツでもみられるようです。また、ここでは線維筋痛症候群の病態として末梢の細い神経線維の異常についての知見の集積を紹介しています。

＜メモ＞　線維筋痛症は細い末梢性感覚神経の障害であるという結論につながるのかと予測してスピーチを聞いていましたが、実際にはそれを否定する見解でした。日本では通常の鎮痛剤ではなく、オピオイド（モルヒネのような阿片類似物質）さえ無抵抗に処方されているので、本格的な非薬物療法にシフトできずに病気を長引かせたり、障碍者の認定のための診断書を

切望したりする患者が増えていることを実感します。これは、即刻解決すべき大きな社会問題だと考えています。

peripheral
peripheral nervous system-the small nerve fibers
small fiber neuropathy(SFN)
special test:quantitative sensory testing (GST)
non invasing method
nociceptor
in vivo test
A- delta,C
mechanoinsenssitive 1B nociceptive

generalized skin denervation
role of miRNA
FMS is not SFN

16:10−16:30

“筋肉よりむしろ脳"線維筋痛症のパラダイム

Roberto Casale[1] & Alberto Rainoldi[2]
[1] *Opusmedica, PC&R Patient, Care & Research Network, Piacenza, Italy*
[2] *Motor Sciences Research Center, Interfaculty School of Motor Sciences, University of Turin,　イタリア*

　Using PubMed to go back in time, at the beginning of the publications of what at that time was called fibrositis and now defined as fibromyalgia, the muscle was always indicated as the pivot of the myriad of symptoms reported by fibromyalgic patients. Even sleep disturbances were referred to a lack of rest because of muscle pain, anxiety because of continuous pain in the muscle and even easier, fatigue was considered as the perfect condition that may follow continuous muscle pain. And when fibrositis was dropped out and myositis took its place, followed by muscle rheumatism and non-articular rheumatism, muscle remained the bad guy. In this period that we can define the “muscle era”, the pivotal point was to find out possible presence of alterations in the fibromyalgic muscle.

All bioptic studies agreed on the presence of atrophy of type II fibers and of a phlogistic aspect. However, these features can be found regularly in the elderly, as well as in different pathologies and etiology: disuse and corticosteroids induced atrophy, corticospinal tract alterations and other diseases. Neither optical nor electronic microscopy revealed any inflammatory or pathognomonic pattern. Both techniques have in fact shown how, from this point of view, the fibromyalgic muscle may appear "normal" or show borderline characteristics as discrete and non-specific alterations.

The use of ultrastructural electron microscopy techniques didn’t substantially change the idea that what can be found, were only secondary non-specific alterations. On this cul de sac are also modern non-invasive techniques such as fMR, failed to provide proof and sound diagnostic markers, again showing in one of the most recent papers only unspecific alterations in intramuscular ATP, PCr and fat content reflecting a combination of inactivity/atrophy-related to pain and dysfunction of muscle mitochondria i.e. a lack of function in oxidative muscle fibers [Gerdle et al 2013]. In more recent years and once again starting from the muscle we have succeeded in identifying patterns of muscular activation typical of fibromyalgia and not referred to a disorder of the muscle itself but to a wrong or better to say, non-appropriate or disfunctional motor command. This puts attention not on the effector organ rather that on the ability of the nervous system to match sensory information and to generate congruous motor output.

These researches agreed with other lines of research where instead of looking at the periphery, researchers were looking into the CNS functioning with the more sophisticated technologies such as fMR. Indeed, this is the “brain era” in which the muscle doesn’t miss its important role but simply changes its role from the major and main actor to an important part of the interplay between sensory inputs and motor output in a continuous interplay. Moreover there are experimental evidences that indicate that when the bioelectrical phenomena known as localized muscular fatigue develop in the muscle, also in the central nervous system there are neuro-hormonal and excitability changes of the cerebral cortex, which suggest central factors that act upstream of the motoneuronal drive (Taylor JL, Gandevia 2008).

In a simplistic and schematic representation: an incongruous motor output, triggered by a wide range of bio-psycho-social and person-related factors, generates an incongruous motor activation which generates incongruous sensory inputs to the brain which misinterpret the information and generates incongruous motor response (Casale & Rainoldi 2011).

It turns that this abnormal sensory-motor coupling, if reiterated, can steadily modify the brain response to any motor task. This opens new questions on which type of rehabilitation is needed in fibromyalgia.

＜コメント＞この発表は、疲労をに大別して、末梢性の疲労と中枢性の疲労の鑑別法について言及したすぐれた発表です。

＜メモ＞疲労の本質について正しく理解することができれば、線維筋痛症の患者さんの治療効果を上げるうえで大きな助けになります。たとえば、水気道は非言語的な身体活動によって適度な末梢性疲労（筋肉と末梢神経の疲労）をもたらし、逆に中枢性疲労（脳をはじめとする中枢神経の疲労）を軽減させる目的も持っています。この話題については、別の機会にお話ししたいと思います。

Central fatigue and peripferal fatigue(muscle fatigue)
TypeI fibers
Type　Ⅱfibers

Time/fatigue vs frequency an’s principleHennem
FM

Minor/non-efficient

Central reorganization of motor system
Abnormal sensory-motor system systems
Non-congruent output to muscles
Altered descending control
NOXA;overload,

Maladaptaion of muscles

16:20-17:20 線維筋痛症患者団体: 我々はそれくぉ必要とするのか?

１６：３０－１６：５０

ENFA:それは何のため?

ENFA (The European Network of Fibromyalgia Associations) was officially inaugurated as an Organization in September 2004 and was supported by the United Kingdom, Scotland, The Netherlands, Switzerland, Denmark, Norway and France.

Fibromyalgia affects an estimated 14 million people in Europe. It has a devastating impact on those who suffer from the disease and also for those careers and families who are trying to support them. Also it imposes a large economic burdens on society and individuals. The mission of ENFA is to promote Fibromyalgia awareness to politicians, physicians, scientists and the general public on a European level.

As Fibromyalgia was adopted by the European politicians by way of accepting the written declaration 69/2008, ENFA’s efforts aim to achieve implementation of the declaration with the primary goal of placing Fibromyalgia as a key topic in the European Health Programme.

ENFA, has Organized some various events to raise awareness of this invisible disease among the general public and the patients. These include a lunch meeting hosted by the Cypriot Member of the European Parliament, Mr.Takis Hadjigeorgiou on 12th 2017 under the topic: “The position of the fibromyalgia patients in the society".

The ENFA Conference 2018, was Organized in partnership with ME, CFS & Fibromyalgia Alliance Malta – VO/818 and took place in May 2018 in Valetta, Malta. Titled ‘In every disability, there is an ability’, the conference was held under the distinguished patronage of Her Excellency Marie-Louise Coleiro Preca, President of Malta.

＜コメント＞

欧州には、国境を越えた線維筋痛症の患者会が組織されています。

日本の線維筋痛症友の会も国際的ネットワークに参画するのが望ましいですが、

それ以前に、自称線維筋痛症指導医が誰一人としてこの学会に参加していない現状こそを

厳しく見据えなければならないと思います。

16：50－17：10

線維筋痛症患者を扱うことに関すうる患者会の役割:

イタリアでの経験

Egidio Riva, Giuseppina Fabio, Piercarlo Sarzi-Puttini
Associazione Italiana Sindrome Fibromialgica (AISF-onlus), イタリア

Background

The need of patients associations is quite relevant when you deal with chronicity; there are a variety of unmet needs that patients associations can take care of starting from patients proper information, visibility, political issues and funding among the others.

Clinicians face a rather difficult task in fibromyalgia: to guide patients on what may be a syndrome which will be present and influence in a relevant way the journey of their lives. Clinicians must preserve their patients' hope and resilience while at the same time giving them accurate information.

And patients with fibromyalgia face a difficult task: navigating a route while confronting a chronic and treatment-resistant disease. Communication between patients with fibromyalgia, their familial and social environment, and the treating clinicians may present many challenges.

Comunications between physicians and patients may improve; patients need easier access to information about their medical condition and their health care; patients associations can help to deliver patient-centered care, reflecting to what is important to them, and how to endorse relationships between health care professionals and patients that should be stronger, more trusting, and empathic.

Education and Information

AISF (Italian Association of Fibromyalgia Syndrome) was founded nearly 15 years ago with the mission of obtaining the recognition of Fibromyalgia as a discrete entity and with the willingness of educating both the clinicians and the patients on recognising this diagnosis and treating properly the patients affected by this syndrome.

One of our main activities is concentrated on spreading out the knowledge of the existence of this syndrome. Patients need to know the upcoming news and AISF takes care of an yearly National Congress where professionals open their knowledge in the various subjects of their specialities and answer to general and personal questions. A dedicated booklet “**Manuale pratico per il paziente affetto da sindrome fibromialgica**”, which is regularly updated and which probably will have this year an English edition as well, explains the main contents of symptoms, diagnosis, pharmacological and non-pharmacological treatments; 28 authors develop topics on Fibromyalgia on 13 chapters addressed to patients and to health care professionals.

AISF takes care and issues complete scientific and information literature addressed to patients and professionals. A six-monthly paper, called “Caleidoscopio”, reports recent studies and specific informations on the activities organized by the local sections and an Internet account gives general information on all activities.

General practitioners who take care of family based public health need to be updated about diagnostic procedures and appropriate therapies to be prescribed according to their personal knowledge and the informations derived by the specialists and by the evidence-based literature.

AISF organizes Regional Courses for health care professionals to let them expand their knowledge on this topic.

Self Help Groups

AISF has 20 Sections spread out in the majority Italian Regions; their mission and action is supported by the main head office based in Milan. Sections are managed by voluntary referees: two patients and one Doctor mostly often specialized in Rheumatology or in Pain medicine. Sections take care of organization of periodical events dedicated to associated and non associated patients. Some of the conferences and meetings are organized for clinicians with different specializations but interested in chronic pain. AISF promotes the idea of self-management and creates self-help group among patients where it's possible. Our main office and the local sections provide continous personal informations through telephone calls and mail assistance to all patients who need for practical and psychological support. It is helpful when we may suggest where dedicated and specialised hospitals departments are located on the nearby for quick and easy assistance.

Experianced patients are supporting other newly-diagnosed patients with suggestions and advices on how to do and how to manage their day by day life, to survive to their pain and to handle frequent misunderstandings by families and sometimes by clinicians that do not recognize this syndrome as a clinical entity or do not have enough scientific knowledge to deal with.

Political Issues

One of the main controversies in Italy is to have Fibromyalgia recognised by Public Health Assistance Institutions; this will help scientific and pharmaceutical researches and will reduce the costs for the patients.

AISF political activity is continuously and deeply dedicated to contacts with National and Regional Institutions looking for having the opportunity to request and to obtain the syndrome to be included by law into chronic diseases sponsored by the Italian Public Health System.

＜コメント＞

この発表は良くまとまっていて、我々医師も大いに感心させられました。

患者が医師に望むことは、患者の希望や病気に負けない力が維持できるように支援するこ

と、そのために、患者に正確な情報を提供すること、病気中心でなく患者中心の立場で患者-医師関係の大切さを保証すること、などが必要であることの背景をわかりやすく語ってくれました。その上に立って、患者自らが受け身の立場にとどまっているのではなく、むしろ教育と情報、自助グループ、政府や自治体との密接なコンタクトなどを患者会として積極的に取り組んでいく姿勢を紹介してくれました。私もイタリアの患者会を応援したい気持ちです。

１７：１０－１７：３０

イスラエル人からの視点 - 過去20年間にわたって私たちは何を学んできたのか

Sharon Gur
Asaf, Fibromyalgia and CFS Nonprofit Organization, イスラエル

ASAF association for fibromyalgia, (FM) and CFS, was founded 20 years ago by a small group of young women with common background - all had Fibromyalgia. Back then, there was no information, no known cure and no support. We felt lost, and seeking support, we decided to work together in order to raise awareness to FM among doctors, medical teams and patients alike. Only few rheumatologists knew about FM and recognized it as illness. Family physicians were not aware of FM, there was no medical treatment offered, no research. We felt that no one cared.

Our foremost task was and still is, getting appropriate recognition, acceptance from the medical, state authorities and the society.

From this modest start and with hard work ASAF became the voice of the patients

It is a Sisyphean process we call: From transparency to Visibility. Approaching rheumatologists, pain physicians and family physicians in various occasions, arranging dedicated meetings, joining medical professional conferences and adamantly lecturing in order to explain and convince. We approached medical teams, nurses, and alternative medicine practitioners etc. trying to educate and gain support.

The journey was, and still is, a long one. Although specific medicines were finally introduced worldwide, but, at the beginning, they were not approved in Israel as part of the national healthcare insurance funded drugs. Therefore, we advocated and eventually succeeded to make it possible for FM patients to purchase these medicines at a considerable discount.

A decade ago we encouraged a research aimed to explore the benefits of Cannabis use for FM patients and later approached the Ministry of Health, appealing to include FM patients among those who are given prescription to legally use Cannabis for pain relief.

We also realized that without recognition the patients had no rights under social security law. Insurance companies refused to cover claims of income protection insurance for FM patients.

10 years ago, ASAF approached the Social Security Institute in order to create a dedicated deficiency article in the disabilities list, so patients will get proper recognition and fair entitlement.

We had to appeal to the Supreme Court twice. Eventually it ruled in our favor. We are finally approaching an agreement with SSI. That will be a major change for the patients.We approached the media numerous times, got articles in newspapers, interviews on the radio and on television shows and social media - Facebook etc.

ASAF is a safe haven for patients – our message to them is: "you are not alone; we understand your suffering and wishes, we want and can help".

Our mission is to empower the patients and encourage them to take full responsibility on their life. Our support groups enable patients and their families to be part of a larger group of people that suffer similar symptoms.

An important tool is our phone help line, open to all patients and their families even before they were diagnosed.

ASAF reaches out to reclusive populations in Israel, such the orthodox Jews, share knowledge and offer assistance and comfort.

We encourage patients to follow up with doctors’ recommendation on physical activity, which is most effective for FM patients. We suggest trying hydrotherapy, CBT and T'ai Chi. Part of our responsibility is to alert patients from treatments offered by charlatans.

Our yearly conference is dedicated to familiarizing patients and families with the newest innovations and allowing them to meet people with similar interest and struggle. Membership is open to all.

ASAF cooperates with other patients’ organizations that complete our activities for the mutual benefit of all.

It is our life mission; all of us are volunteers and dedicate our time to our goals. In the past 20 years ASAF helped thousands of patients. Let’s do more, much more.

＜コメント＞

イスラエルの患者会も国際的ネットワークに参画しているとのことです。

ASAF という彼らの患者団体は線維筋痛症および慢性疼痛症候群の連合患者会です。これは、すぐれたコンセプトです。どうしても、個別化して連帯することが苦手な日本の閉鎖的団体と大いに異なる点です。もっとも印象に残ったメッセージは、

"*you are not alone; we understand your suffering and wishes, we want and can help".* （あなたは孤独ではありません；私たちはあなたの苦悩も望みも理解しています、私たちはあなたの力になりたいし、それができるのです。）これが ASAF というイスラエルの患者会のメッセージです。何か深い親交のような響きのあるメッセージに思えました。

それから、彼らの具体的な活動について

We encourage patients to follow up with doctors’ recommendation on physical activity, which is most effective for FM patients. We suggest trying hydrotherapy, CBT and T'ai Chi. Part of our responsibility is to alert patients from treatments offered by charlatans.

興味のある方は、上記の短い英文をご自分の力で読み解いてみましょう。患者中心の医療の実現のためには、自らが積極的に課題に取り組むことが必要です。

学会終了後、ホテルに戻り、予定通りフォルクスオーパーでオペレッタ「こうもり」を観劇しました。その内容については、いずれ VIVA 聖楽院に掲載する予定です。