Int. j. adv. multidisc. res. stud. 2026; 6(6):1233-1234

Received: 07-11-2026
Accepted: 17-11-2026

International Journal of Advanced Multidisciplinary Research and Studies

ISSN: 2583-049X

Letter to the Editor

Before Fibromyalgia Symptoms are attributed to Cervical Myelopathy, All Alternative Explanations for Tetraspasticity and Tetraparesis must be Ruled Out

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Letter to the Editor

We read with interest the article by Lowe *et al*. on a case series of three patients with fibromyalgia symptoms who met the diagnostic criteria of the 2016 American College of Rheumatology diagnostic criteria and survey score (ACRDCSS) criteria [1]. Since all three patients also presented with neurological symptoms and findings (paresthesia, numbness, muscle weakness, signs of upper motor neuron damage), they underwent a comprehensive neurological examination and were reclassified with cervical myelopathy [1]. The study is noteworthy, but some aspects warrant discussion.

First, the ACRDCSS has several limitations: Ambiguities in the Generalized Pain Index (WPI) and the disproportionate influence of the Symptom Severity Scale (SSS) can lead to false-positive results, particularly in patients with high overall psychological distress or regional pain syndromes. The ACRDCSS may not capture the full clinical complexity and leads to underdiagnosis of fibromyalgia in individuals with multiple comorbidities or overlapping inflammatory conditions. The WPI counts the number of pain locations without assessing their spatial distribution, pain type, anatomical specificity, or intensity; the ACRDCSS struggles to differentiate between generalized fibromyalgia and localized functional pain disorders such as myofascial pain syndrome; the SSS relies on subjective patient interpretation and only captures symptoms within a limited one-week period [2].

Secondly, we disagree with the statement that Patient 1 had cervical myelopathy between C5 and C7 [1]. The T2-weighted images in Fig 1 show no spinal cord hyperintensity at this level, neither in the axial nor the sagittal plane. The axial plane even suggests that the stenosis is relative rather than absolute. The MRI scans of patient 2 also showed no evidence of cervical myelopathy. The T2-weighted images of the cervical spinal cord did not show convincing hyperintensity in the C5-7 region, as depicted in Fig 3. Similarly, Fig 6 of patient 3 is not convincing in suggestive of cervical myelopathy. Therefore, it is unlikely that the tetraspasticity and tetraparesis are attributable to the findings of the cervical MRI. Was the masseter reflex elevated in any of the three patients? Did any of the three patients undergo cerebral MRI to detect a cerebral lesion that could explain the clinical presentation?

Third, a cerebrospinal fluid (CSF) analysis was not performed in any of the three patients to rule out inflammation of the central nervous system (CNS) [1]. In patients with tetraspasticity and tetraparesis, it is essential to rule out a cerebral cause of these symptoms not only by imaging but also by CSF analysis [3]. Were lupus encephalopathy and lupus myelopathy ruled out in patient 1 with an elevated ANA level?

Fourth, the discrepancy between the patient's 3 symptoms (increasing weakness and heaviness in the upper and lower extremities) and the clinical neurological findings (strength grade 4/5 only in the biceps bilaterally) was not explained. It should be clearly stated whether the patient had tetraparesis or paraparesis of the upper extremities.

Finally, some inconsistencies require clarification. Which fingers were numb in patient 1, and which nerve root was responsible for the radicular leg pain? Cervical myelopathy does not explain radicular pain in the legs. It is equally incomprehensible why patients still require painkillers despite surgery for spinal stenosis. This discrepancy requires clarification.

Declarations
Ethical approval: Not applicable.

Consent to participation: Not applicable.

Consent for publication: Not applicable.

Funding: None received.

Availability of data and material: All data are available from the corresponding author.

Completing interests: The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

Author contribution: JF was responsible for the design and conception, discussed available data with coauthors, wrote the first draft, and gave final approval. xx: Contributed to literature search, discussion, correction, and final approval.

Acknowledgements: None.

AI tools: Were not used.

Keywords: Lower Back Pain, Muscle Relaxants, Acute Disease, Nonsteroidal Anti-inflammatory Drugs, Pain Scales

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