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Q&A

Managing fibromyalgia

In this issue, EDI Journal is launching a new section featuring practical answers to clinical questions received by the BDIZ EDI office via email or phone. This first case concerns the treatment planning of an implant for a patient who has recently been diagnosed with fibromyalgia.

Question

One of my patients is scheduled to have tooth 36 replaced with a dental implant. The bone quality is good. However, she has recently been diagnosed with fibromyalgia by her internist. She is receiving low-dose corticosteroid therapy, which she says has led to an improvement in symptoms. Are there any medical or expert concerns regarding implant placement in this context? Should any adjustments be made to the procedure, such as temporarily increasing the corticosteroid dosage in consultation with the treating internist?

Answer

Thank you for your detailed enquiry.

Fibromyalgia is primarily considered a chronic pain disorder rather than a classical autoimmune disease. This diagnosis does not represent a direct contraindication for implant placement. More relevant are the patient's concomitant medications and individual risk factors.

1. **Medication:** The use of low-dose corticosteroids should definitely be taken into account. Even at low doses, infection prophylaxis must be ensured, and careful soft-tissue management (flap handling) is essential. A perioperative corticosteroid adjustment or stress dose is generally not required, but if one is considered, it must be closely coordinated with the internist and depend on the dosage, the duration of the treatment and the patient's overall health. Please also ask about other commonly prescribed medications in this context, such as proton pump inhibitors or antidepressants.
2. **Comorbidities:** Additional potential risk factors—such as osteoporosis, diabetes mellitus, or other systemic metabolic disorders – should be evaluated in advance, as these may affect bone healing and implant integration.
3. **General approach:** If the patient's bone conditions are favourable, her oral hygiene is good and interdisciplinary coordination is ensured (particularly regarding corticosteroid use), implant placement appears feasible in the case described.

Conclusion: In summary, there are no general objections to implant treatment, provided that the patient's individual risks are considered and treatment planning is carried out in consultation with her physicians.