Why cant everyone with FMS see a rheumatologist ?

- Recommendation is a minimum of 1 rheumatologist per 80,000 population.
- Barnsley population 250,000 – 3.2 WTE consultants – Barnsley 2.1
- 12 % all consultant posts unfilled nationally
- 7 unfilled consultant posts in S Yorkshire alone

- Rheumatologists are now inflammationologists
- Explosion of biologic drugs (rosanolixizumab trial for FMS!)
- New conditions (IgG4 / VEXAS / auto-inflammatory disorders)

British Society for Rheumatology

Do not refer to rheumatology (this will depend on local services and pathways)	
Clinical Emergencies such as suspected cauda equina syndrome, metastatic cord compression, spinal infection, septic arthritis or GCA (unless rheumatology is the point of access for your local emergency referral pathway for this condition)	Must be dealt with on the day as an emergency. Please keep updated about local pathways to manage
Suspected cancers including bone malignancy	Urgent referral as per local 2WW rule pathways
Patients with positive antibody results in the absence of symptoms	Utilise advice and guidance with local rheumatology service to support decision making
Osteoarthritis	Refer to local pathways, making the best use of MSK expertise in Primary and Community Care. This will include use of clinical pharmacists, social prescribers, First Contact Practitioners, Advanced Practitioners as well as MSK interface services and local orthopaedic, spinal and pain management services. Consider the use of Specialist Advice (A&G) for any diagnostic/ management uncertainty
Non-inflammatory back pain	
Soft tissue disorders	
Fibromyalgia	
Chronic fatigue syndrome	
Hypermobility	

Caveat – REFER

Suspected fibromyalgia to confirm diagnosis where there is concern that other inflammatory conditions need to be excluded

Why is this the right decision?

- GPs see these patients all the time
- GPs are experts at managing uncertainty and conditions which cannot be cured with “a pill”
- Management needs to be holistic and therapy based
- Rheumatologists are not experts at managing chronic pain
- RCP Fibromyalgia guidelines are comprehensive and are not written by rheumatologists

2.2 Factors involved when making a diagnosis of FMS

Receiving a diagnosis of FMS can have a major impact on patients' lives. The following factors are therefore relevant:

i) Who can diagnose FMS?

The responsibility for the diagnosis of FMS has moved away from the domain of a medical subspecialist except in cases of uncertainty (see also 'diagnostic criteria' in Section 2.3).

Box 3: Timing and communication of the FMS diagnosis

Recommendation	Evidence
Diagnosis of FMS should be made as early as possible for those patients who meet the diagnostic criteria.	E2
The diagnosis of FMS should be made by any clinician adequately experienced to make this diagnosis.	E1+E2
The diagnosis should be communicated to the patient and supported by written information, and/or links to websites etc.	E1+E2

This diagnostic guideline aims to support clinicians when considering a diagnosis of fibromyalgia syndrome (FMS). In both highlighting potential symptoms that may indicate a diagnosis and guiding the clinician to interpret symptoms accurately, it is hoped this guideline will contribute to more timely diagnosis.

Be alert!

FMS symptoms are common and wide-ranging. When such symptoms are described, be curious and try to explore the presence of any other FMS-related symptoms.

*although only localised pain may be reported

Box 1. FMS alert factors

Recommendation	Evidence
Clinicians should be alert to the possible presence of fibromyalgia syndrome if the following factors occur either in isolation or in combination:	
Widespread pain (although only regional pain may be reported)[23,24,26,27]	E1+E2, RA
Poor refreshment from sleep[23,24,25]	E1+E2, RA
Hypersensitivities[24,28,29]	E1+E2, RB
Intrusive fatigue[23,24,25,26]	E1+E2, RA
Pain longevity[23,24,25]	E1+E2, RA
Ineffective treatments so far	E2
Feeling overwhelmed (patients)	E2
Feeling overwhelmed (clinicians)	E2
Poor concentration and poor short-term memory	E2

Key for evidence evaluation: E1=user or carer opinion; E2=professional or stakeholder opinion; RA/RB/RC=research grading based on published evidence. For details see Appendix 1.

Box 7: Diagnosis, multiple health conditions and differentials

Recommendation	
Diagnosing clinicians should consider conditions that may complicate the diagnosis of FMS because they may mimic some aspects of FMS and/or be experienced alongside it:	
Endocrine disease (hypothyroidism).[24,27]	E2
Rheumatic conditions (eg ankylosing spondylitis, SLE, RA, polymyalgia rheumatica) [24,27]	E2
Neurological disease (neuropathies, myopathies, multiple sclerosis) [24,27]	E2
Drug-induced conditions (lipid-lowering drugs, aromatase inhibitors, high-dose opioids causing opioid-induced hyperalgesia).[24,27]	E2
Sleep disorders such as sleep apnoea[24]	E2
Chronic fatigue syndrome	E1+E2
Depression	
To help differentiate and/or identify other possible diagnoses, the following screening tests should be arranged: †††	
Full blood count[24,27]	E2
Erythrocyte sedimentation rate (ESR) and C-reactive protein (CRP)[24,27]	E2
Creatine kinase (CK)[27]	E2
Liver function tests (LFT)[24]	E2
Thyroid stimulating hormone (TSH)[24,27]	E2
Blood glucose[24]	E2
U&Es[24]	E2

Fibromyalgia for GPs- What to do

DIAGNOSIS

1. Recognise the pattern
2. Consider the mimics
3. Organise screening blood tests
4. Refer to pain services or MSK if needed
5. Contact Rheumatology using advice and guidance if you have diagnostic doubt

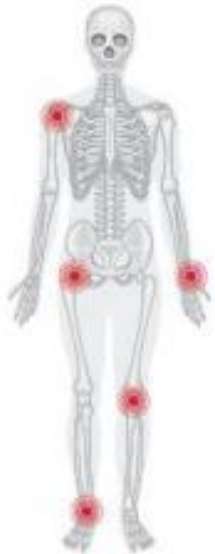
Fibromyalgia for GPs- Management

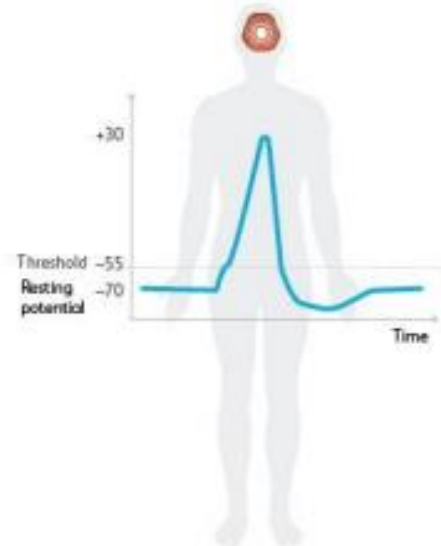
1. FOLLOW RCP GUIDELINES
2. Provide education
3. Manage expectations
4. Consider evidence based pharmacological intervention
5. Refer to MSK and /or Pain Management

*although only localised pain may be reported

Know pain types

All pains are painful! Not all pains mean damage or disease. Spending time understanding this can help choose the correct treatment or procedure. It may also prevent unnecessary treatments from taking place. FMS pain is 'nociplastic'.





Nociceptive pain*

- caused by harmful stimuli which activate pain receptors, eg osteoarthritis
- may be alleviated by conventional treatments, eg medicines, or surgery to repair the damage

Neuropathic pain*

- caused by a lesion or disease directly affecting the body's pain-sensing nerves, eg carpal tunnel syndrome, disc prolapse
- may sometimes be alleviated by medicines or surgery, eg nerve decompression

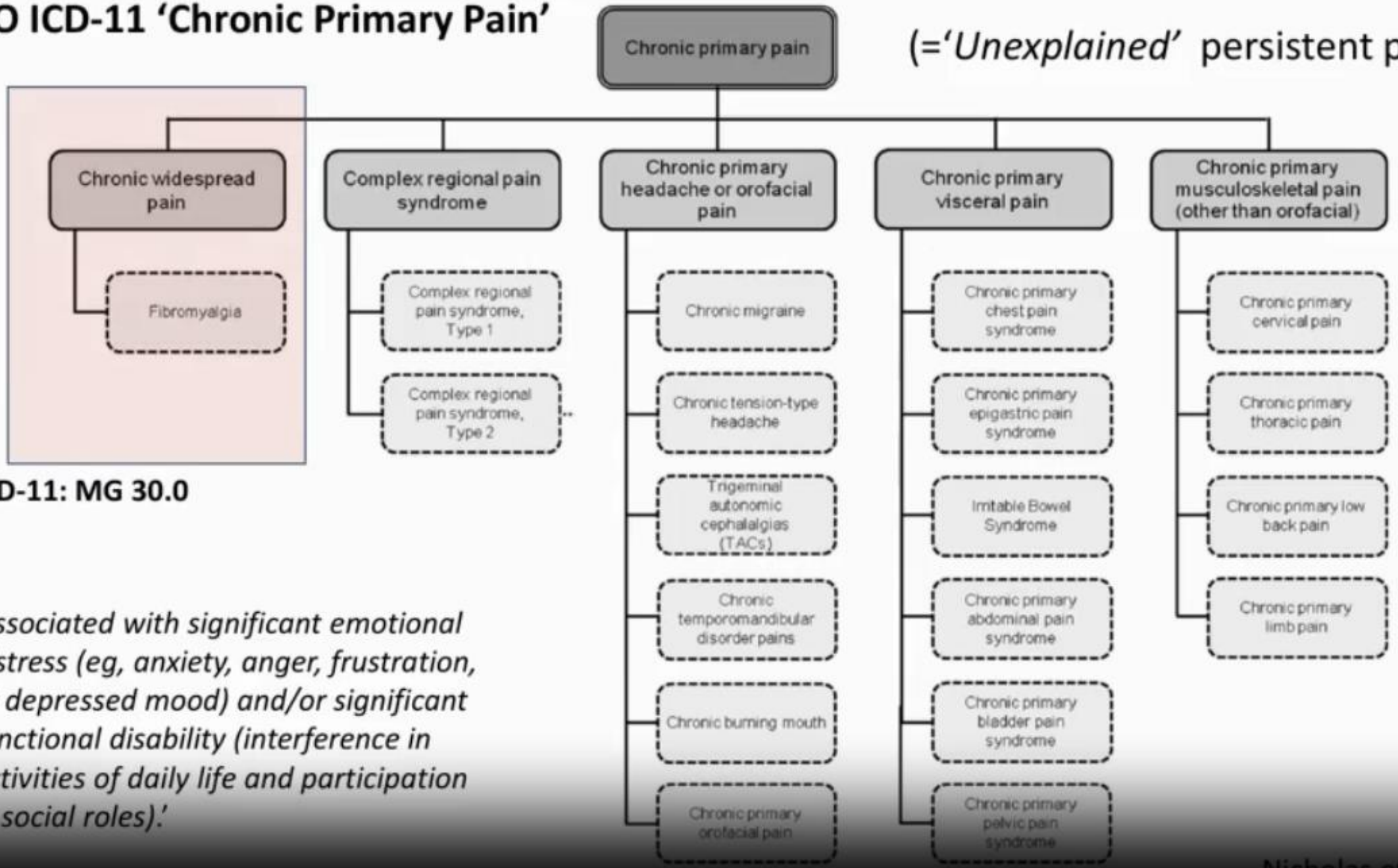
Nociplastic pain*

- caused by a disturbance in peripheral and/or central nervous system pain processing, eg fibromyalgia
- cannot be alleviated by surgery

* Note that in some patients experiencing more than one type of pain, it is unknown whether medical or surgical treatment of nociceptive or neuropathic pain associated with lesions has any effect on nociplastic pain. More research is needed, and MDT assessment will be useful in this situation.

WHO ICD-11 'Chronic Primary Pain'

(='*Unexplained*' persistent pain')



ICD-11: MG 30.0

'associated with significant emotional distress (eg, anxiety, anger, frustration, or depressed mood) and/or significant functional disability (interference in activities of daily life and participation in social roles).'

Nicholas et al., 2019

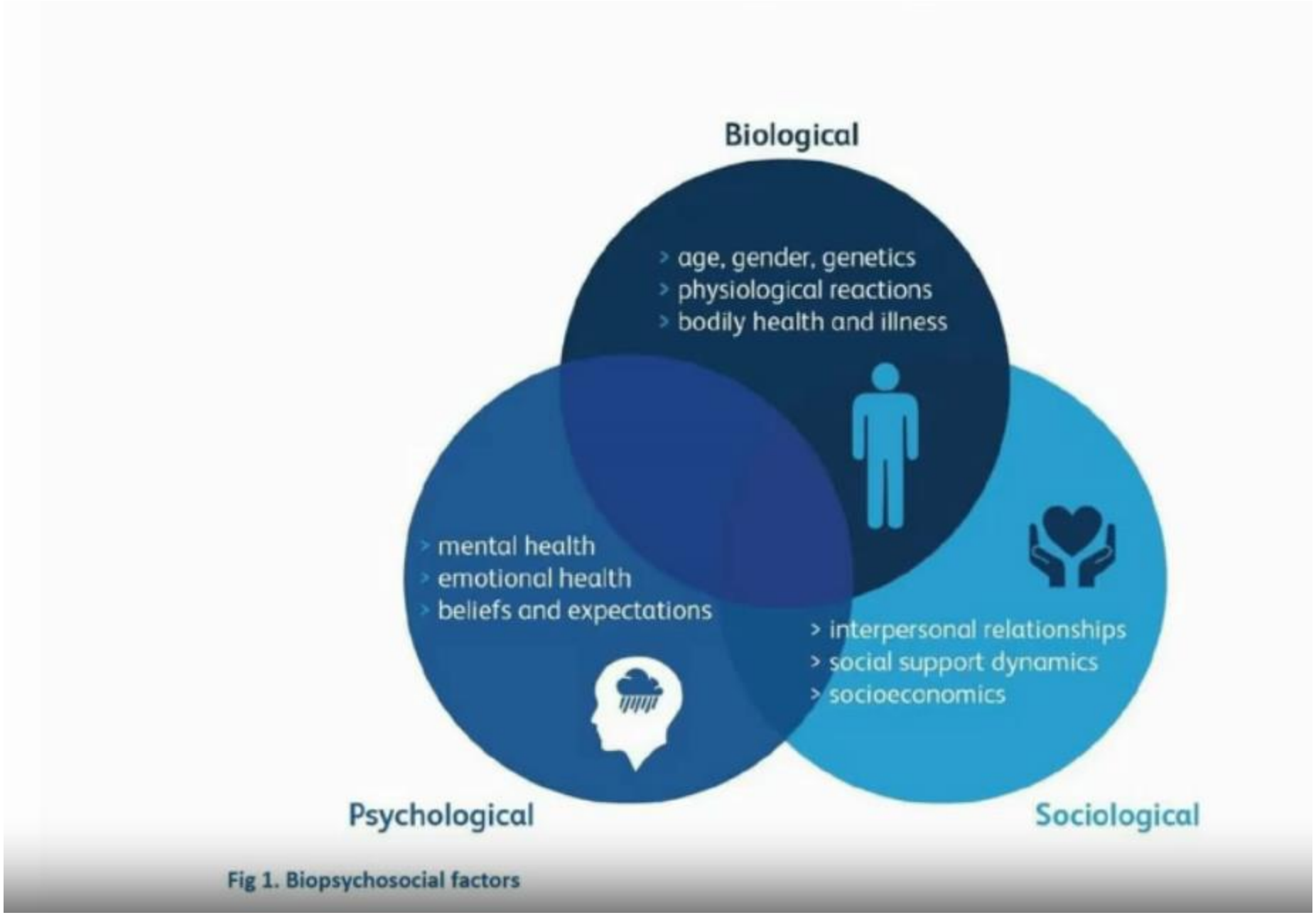
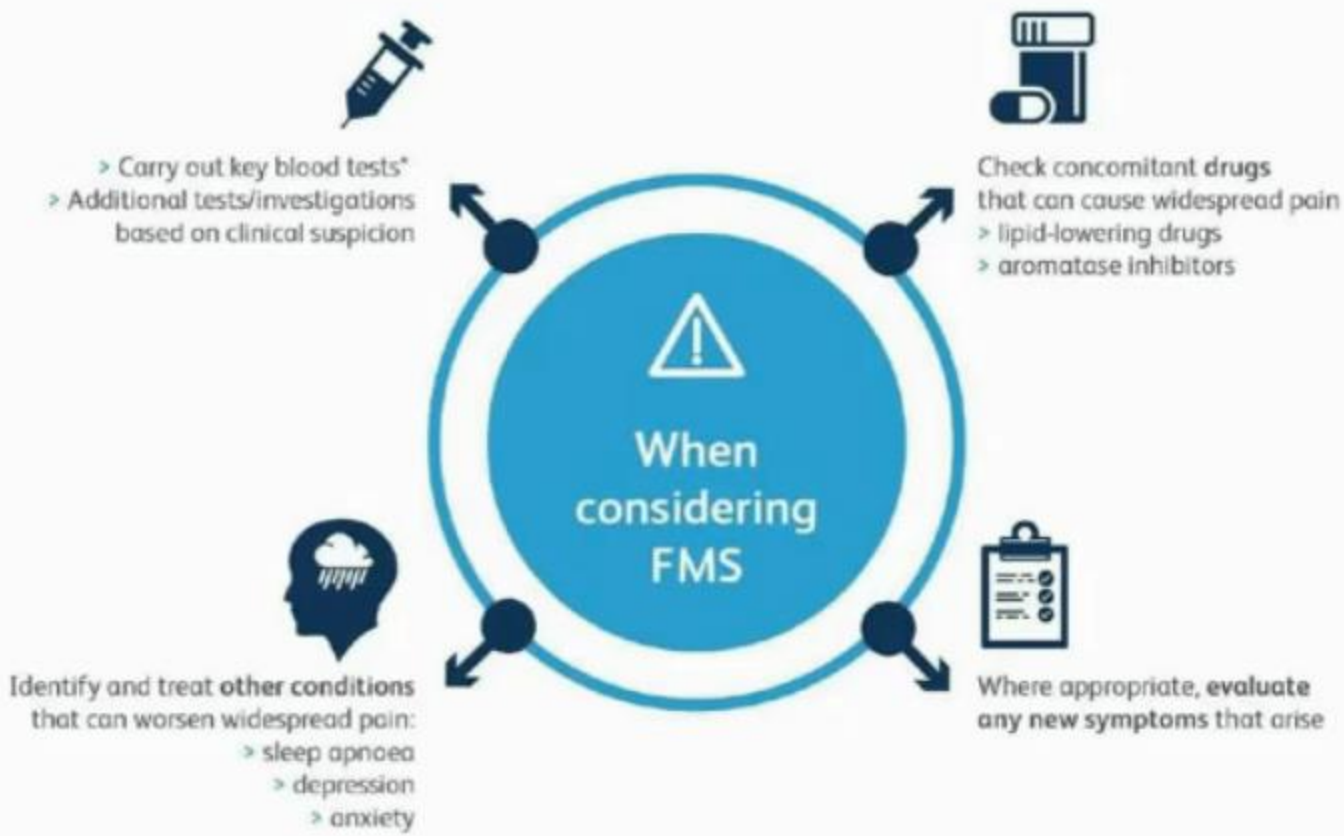


Fig 1. Biopsychosocial factors

Box 6: Validity of the FMS diagnosis when associated with other disorders

Recommendation	Evidence
A diagnosis of FMS is valid irrespective of other diagnoses. A diagnosis of FMS does not exclude the presence of other clinically important illnesses.[23,24,26,27]	E2, RB

See Appendix 1 for description of evidence evaluation.



* Blood tests should include: full blood count, erythrocyte sedimentation rate (ESR) and C-reactive protein (CRP), creatine kinase (CK), liver function tests (LFT), thyroid stimulating hormone (TSH), glucose, urea and electrolytes (U&Es).

Patient messages

- “I have severe fibromyalgia that has effectively cost me my life - my work, relationships, and ability to care for my family”
- “I was told over 50 years ago that it was all in my head”
- “I am also a cancer survivor and by comparison to fibromyalgia, that was easy”
- “I have tried every drug possible and none of them have even touched the pain”
- “if it were not for the support of my wife I would have ended my life”
- “I had to finish work/…./ not been able to get my pension”

Very low health-related QoL

Small fibre pathology in FMS

- Intraepidermal Nerve Fibre (IENF) density is reduced in 40-50% of FMS patients
- Loss of IENFs in mice within 14 days
- Anatomical sign