Fibromyalgia

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Potential issues when dealing with fibromyalgia in primary care

- Number of people who present with compatible picture or openly ask about this diagnosis.
- Need for the person to feel validated in their symptoms and their impact.
- Level of confidence when diagnosing or advising on management of fibromyalgia.
- Traditional vs current concept of where fibromyalgia should be diagnosed and treated.

What is FM?

- Chronic widespread pain.
- Sleep disturbance.
- Mood disturbance.
- Often multitude of non-specific symptoms.

- NICE 2021. Chronic primary pain is suspected when there is no clear underlying (secondary) cause or the pain or its impact is out of proportion to any observable injury or disease, particularly when the pain is causing significant distress and disability.

The size of the problem

- Arthritis Research UK: 1 in 25 people.
- Meta-analysis (Fayaz et al, BMJ, 2016): UK population-based, including chronic pain (43%, disabling 12%), chronic widespread pain (14%), FM (5%), neuropathic pain (8%).

Does FM exist?

- Neuroimaging abnormalities: cause or consequence?
- Small, heterogeneous studies.
- Heterogeneous syndrome.

The extent of the disease

- HRQoL.
- Function.
- Family and relationships.
- Contribution to society.
- Work ability.

Diagnosis

- RCP 2022. Any diagnostician (eg a GP or physiotherapist) is well-placed to consider a diagnosis of FM.

FM ACR 2016 classification and clinical criteria

- Generalised pain (4 of 5 regions).
- At least 3 months duration of similar level symptoms.
- Widespread pain index >/=7 (0-19) and symptom severity score >/=5 (0-12).
- A diagnosis of FM is valid irrespective of (and does not exclude) other clinically important illnesses.

- RCP guidelines supports the use of these criteria.

Fibromyalgia diagnostic worksheet

Symptom severity scale (SSS)

Have your problems with the symptoms below been present for 3 months or more? ☐ Yes ☐ No

If yes, using the following scale, indicate the severity of each symptom over the past week by circling the appropriate number.

	No problem	Mild	Moderate	Severe
Fatigue	0	1	2	3
Trouble thinking or remembering	0	1	2	3
Waking up tired (unrefreshed)	0	1	2	3

During the past 6 months, have you had any of the following symptoms?

Pain or cramps in lower abdomen	☐ Yes	☐ No
Depression	☐ Yes	☐ No
Headache	☐ Yes	☐ No

Total score* for the SSS _____

*The sum of the three scaled symptoms plus one point each for the other symptoms (pain or cramps, depression, headache). The total will be between 0 and 12.

Body map

Use the figures to record where pain occurs in detail. Shade the areas of your body where you have felt persistent or recurrent pain for the past 3 months or longer (chronic pain).

Calculating the WPI score

Use this checklist to calculate the widespread pain index (WPI) score. Tick the areas where you have had chronic pain for 3 months or longer.

Region 1: left upper
- ☐ L jaw
- ☐ L shoulder girdle
- ☐ L upper arm
- ☐ L lower arm and/or L wrist/hand, L elbow

Region 2: right upper
- ☐ R jaw
- ☐ R shoulder girdle
- ☐ R upper arm
- ☐ R lower arm and/or R wrist/hand, R elbow

Region 3: left lower
- ☐ L hip and/or L buttock
- ☐ L upper leg and/or L groin
- ☐ L lower leg and/or L ankle/foot, L knee

Region 4: right lower
- ☐ R hip and/or R buttock
- ☐ R upper leg and/or R groin
- ☐ R lower leg and/or R ankle/foot, R knee

Region 5: axial
- ☐ Neck
- ☐ Upper back
- ☐ Lower back
- ☐ Chest (L and/or R)
- ☐ Abdomen

Total score† for the WPI _____

†The total will be between 0 and 19.

L=left; R=right

A diagnosis requires widespread pain >3 months duration with currently either i) widespread pain index (WPI) ≥7 and symptom severity scale (SSS) score ≥5, or ii) WPI 4–6 and SSS score ≥9, with pain in 4/5 body regions (see text).

Acknowledgements
> ACR 2016 criteria reprinted from: Wolfe F *et al.* 2016 Revisions to the 2010/2011 fibromyalgia diagnostic criteria. *Semin Arthritis Rheum* 2016;46:319–329 with permission from Elsevier.
> The design of this worksheet was inspired by the Michigan body map: https://medicine.umich.edu/dept/pain-research/clinical-research/michigan-body-map-mbm

Royal College of Physicians

Fibromyalgia syndrome: the essentials

For clinicians

What is fibromyalgia syndrome (FMS)?

- FMS is a medical condition that causes widespread pain, fatigue and difficulty concentrating
- It is multifactorial with neurophysiological, immunological and cognitive elements
- It responds poorly to conventional treatments, including medicines and injections
- It is best managed with an individualised multi-element support plan

What to look for

- Pain treatment is ineffective – 'nothing works'
- Significant distress
- Multiple symptoms over time
- Other conditions such as IBS, headache, abdominal or pelvic pain
- Pain out of proportion to what would usually be expected

Screen for other pathologies

- History and examination:
  - rheumatological, endocrine or neurological conditions
  - obstructive sleep apnoea
  - chronic fatigue syndrome/ME
  - depression
- Review and examine medication
- Lab tests based on clinical suspicion, but should include:
  - full blood count
  - ESR/C-reactive protein
  - urea and electrolytes (U&Es)
  - liver and bone profile
  - creatinine kinase
  - blood glucose
  - thyroid stimulating hormone
- Remember: FMS is not a diagnosis of exclusion; it can also coexist with other conditions

How to diagnose

- Ideally, carry out a face-to-face assessment
- Symptoms should be present for >3 months
- Use ACR (American College of Rheumatology) criteria to aid diagnosis
- Use symptom severity index (SSI)* to score fatigue, concentration, refreshment from rest and presence of abdominal pain, depression and headache
- Use widespread pain index (WPI)* to score pain in four body quadrants plus axial region
- Does it sound right? ie not unilateral or upper/lower body pain only
- Symptoms cannot be explained by any other conditions

What to say

- First of all, listen, supportively
- Share information and signpost to links
- Share decisions on management and support planning
- Help coordinate an individualised support plan based on goals and skills

*FMS diagnosis requires a WPI score ≥7 and SSI score ≥5 or WPI 4–6 and SSIS ≥9, with pain in 4/5 body regions

www.rcp.ac.uk/fibromyalgia-guidelines

What not to miss

- Short duration of symptoms.
- Joint swelling, particularly a short history.
- Seronegative illness: Ps, IBD, uveitis.
- CTD symptoms: Raynaud's, sicca, mouth ulcers, rash.
- Systemic upset.
- Sinister symptoms.
- PMH cancer.

Battery of tests

- UE, FBC, LFT, CRP.
- CK, TSH, diabetes screen.
- Vitamin D, bone profile.
- ANA if symptoms suggestive of CTD.
- (RF required for MSK referral).

FM management

- Patient education.
- Validation of their pain/effect in life.
- Management of expectations.
- Mood management.
- Sleep management.
- Fitness maintenance.

2021 NICE guidance for management of primary chronic pain in over 16s

- Person-centred.
- Advice on self-management.
- Exercise: remain active, group setting.
- Psychological support: acceptance and commitment therapy (ACT) or cognitive behavioural therapy (CBT).
- Acupunture up to 5 hours.

NICE recommended

- For over 18s, antidepressant (amitriptyline, citalopram, duloxetine, fluoxetine, paroxetine or sertraline) to manage chronic primary pain, after a full discussion of the benefits and harms, for quality of life, pain, sleep and psychological distress, even in the absence of a diagnosis of depression.

Not recommended by NICE

- Gabapentinoids.
- Antipsychotic drugs.
- Benzodiazepines.
- Steroid +/- local anaesthetic trigger point injections.
- Ketamine.
- Local anaesthetics (topical or intravenous).
- NSAIDs.
- Opioids.
- Paracetamol.

Drug withdrawal

- If a particular medication has not been beneficial after a fair trial period (approx. 6 months), consider withdrawal.
- Particularly if psychotropics and opiates.

My routine

- History and examination.
- Exclusion of relevant illnesses.
- Education. Versus Arthritis leaflet.
- Physiotherapy.
- Occupational therapy (pacing/CBT).
- Analgesia (worse days/targeted).
- Amitriptyline or nortriptyline.
- Mood/sleep optimisation.

Who to refer

- Another diagnosis is suspected.
- Diagnosis is in doubt.

- Rheumatology review is not required for those with classical presentation of FM.
- Rheumatology does not address chronic fatigue syndrome without pain.

What a person with FM can expect from rheumatology

- Exclusion of other illnesses.
- Guidance on education/self-management.
- Management of expectations.
- Referral to allied health professionals.
- Discharge after usually a single visit.

Case 1

- 23 y.o. woman with 6/12 of widespread pain and tiredness.
- Psoriasis.
- Toe swelling.

Case 2

- 45 y.o. woman with 5 year history of pain and morning stiffness that are progressively deteriorating over 2 years.
- Unrefreshing sleep.
- Previous depression and IBS.
- Tiredness.
- Painkillers and physio don't work.

Case 3

- 57 y.o. woman with 10 year history of FM.
- Deterioration of pain over 3/12 and report of wrist swelling.
- No clinical evidence of synovitis or deformity.

Conclusion

- FM is very common.
- Symptoms can be very heterogeneous.
- Education and management of expectations leading to self-management are key.
- Multidisciplinary/holistic approach is essential.
- People with FM can have clinically important illnesses, before or after the diagnosis.

Any questions?