

Fibromyalgia and the Pain Services

Dr Richard Wassall

18th March 2026

GP BEST Event





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Overview

- **Stuff** you wanted to know about Fibromyalgia (but didn't know how to ask).

Neurological Pathways – how does it all work? DON'T

What Can We Do

Long-term Goals of Pain Clinic



What is Fibromyalgia?



What is Fibromyalgia?



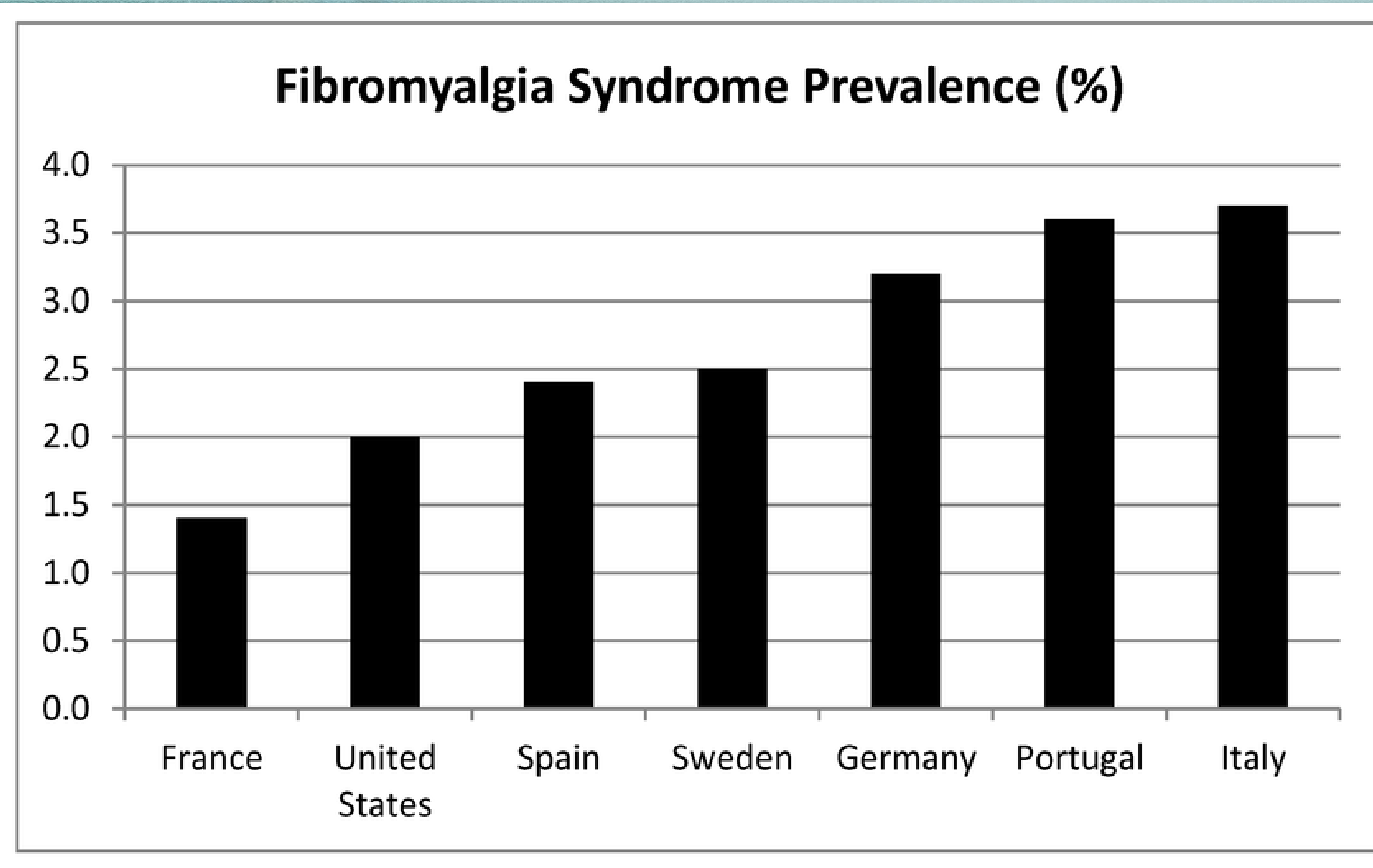
What is Fibromyalgia?

- Fibromyalgia is a chronic disorder characterized by **widespread musculoskeletal pain**, fatigue, sleep disturbances, and cognitive issues
- **Difficult to define**
- **ICD MG30** - "Chronic primary pain is chronic pain in one or more anatomical regions that is characterised by significant emotional distress (anxiety, anger/frustration or depressed mood) or functional disability (interference in daily life activities and reduced participation in social roles). Chronic primary pain is multifactorial: biological, psychological and social factors contribute to the pain syndrome. The diagnosis is appropriate independently of identified biological or psychological contributors unless another diagnosis would better account for the presenting symptoms."

What is Fibromyalgia?

- **Widespread Musculoskeletal Pain**
- **Vague, Multisystem Symptoms**
- **Distress**
- **(Usually associated with) Trauma**

What is Fibromyalgia?



- 3 - 6% of the population UK
- 2:1 Female:Male
- 98% says affects daily life
- Negative Profiling
- Similarities to CFS
- **Pain Overriding Aspect**

Definitions

- **Pain:** An unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage.

Six key notes and etymology:

- Pain is always a personal experience that is influenced to varying degrees by biological, psychological, and social factors.
- Pain and nociception are different phenomena. Pain cannot be inferred solely from activity in sensory neurones.
- Through their life experiences, individuals learn the concept of pain.
- A person's report of an experience as pain should be respected.
- Although pain usually serves an adaptive role, it may have adverse effects on function and social and psychological well-being.
- Verbal description is only one of several behaviours to express pain; inability to communicate does not negate the possibility that a human or a nonhuman animal experiences pain.

Definitions

- **Acute Pain** is pain that has lasted for **3 months or less**
- **Chronic Pain** is pain that has lasted for **3 months or more**
- Pain itself is (generally) ***not dangerous***, but it can alert us to something that may be dangerous

Definitions

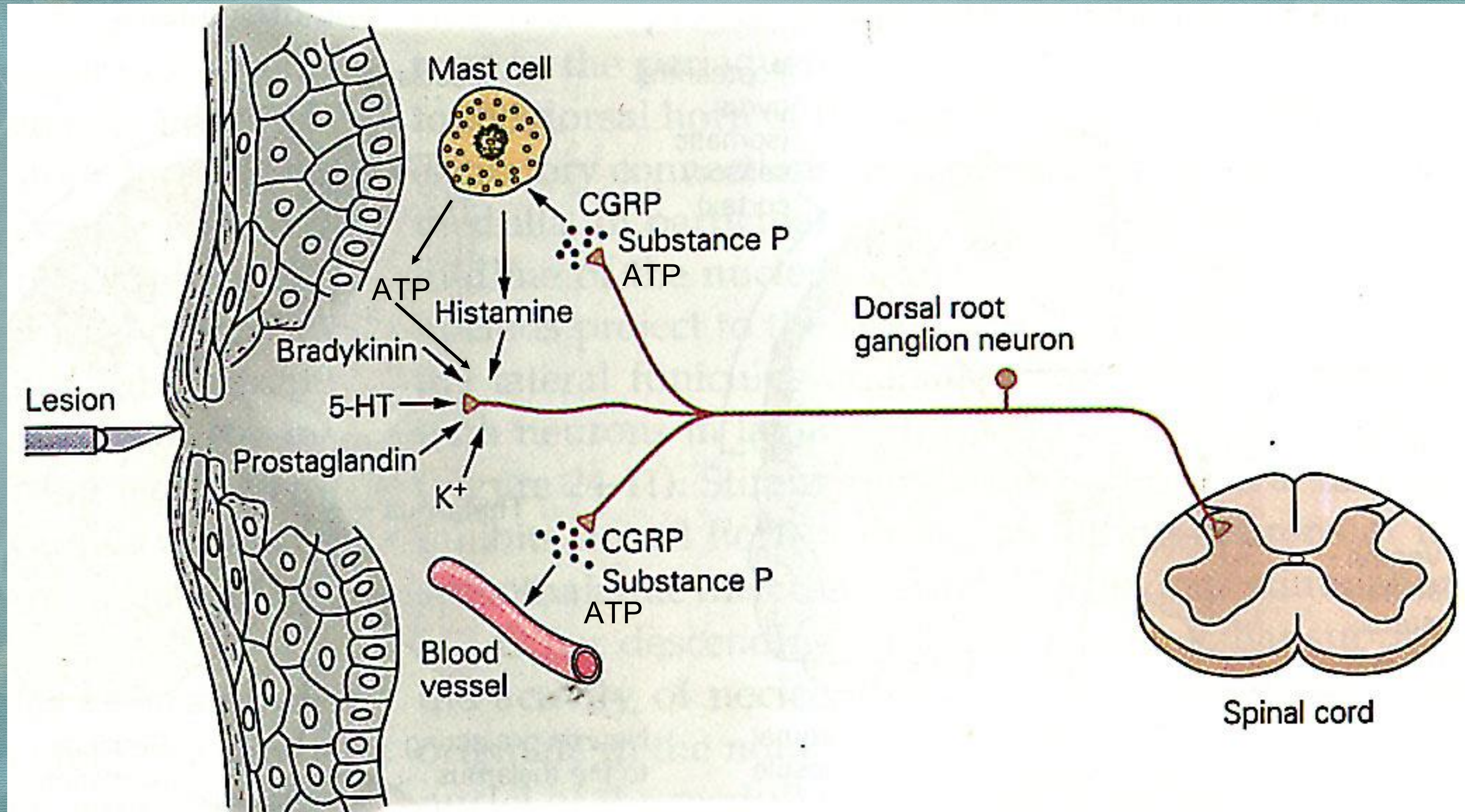


<https://www.tamethebeast.org/#tame-the-beast>

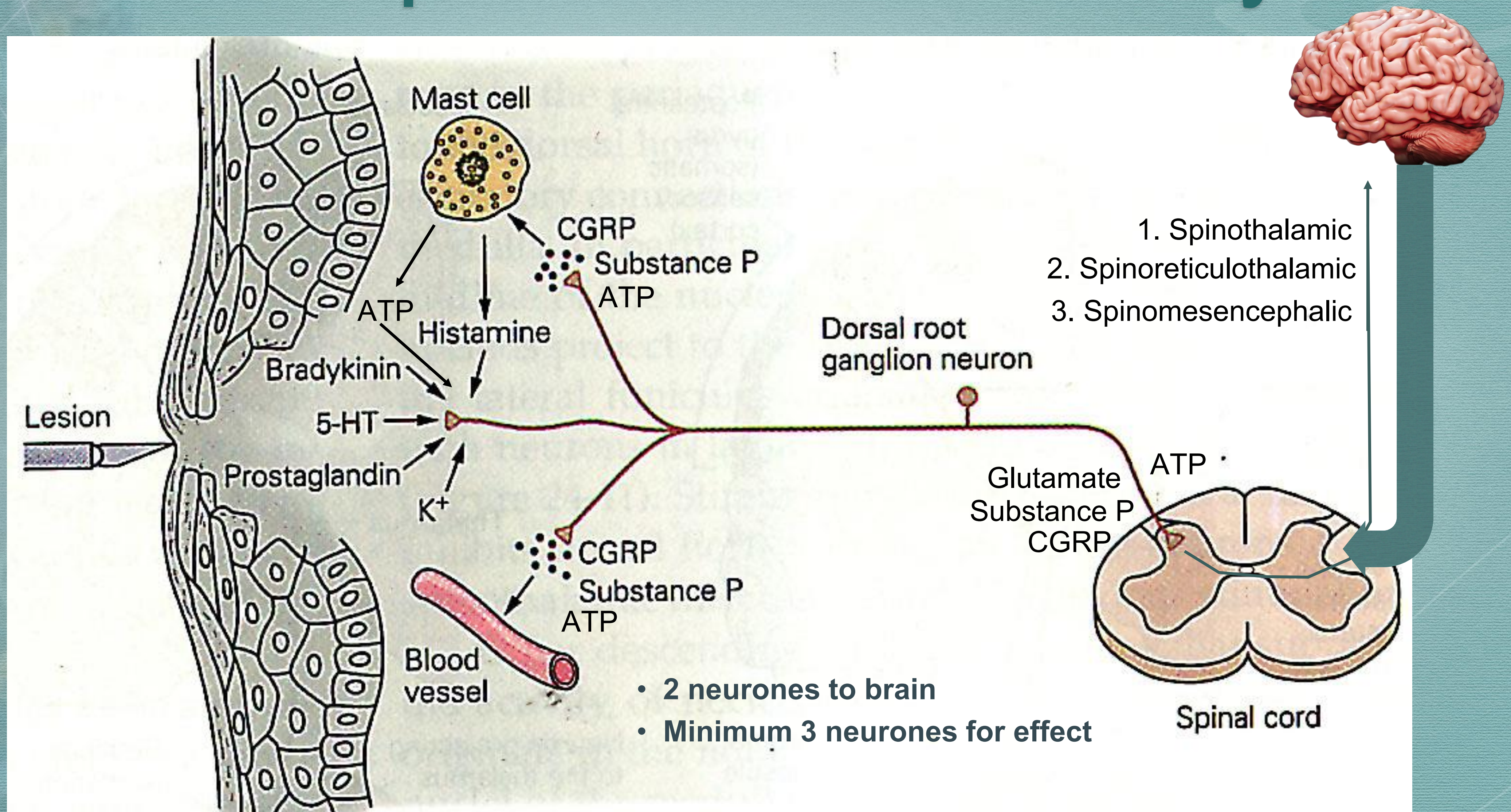
Definitions

- **Nociceptive Pain** - Pain that arises from actual or threatened damage to non-neural tissue and is due to the activation of nociceptors.
- **Neuropathic Pain** - Pain caused by a lesion or disease of the somatosensory nervous system.
- **Nociplastic Pain** - Pain that arises from altered nociception despite no clear evidence of actual or threatened tissue damage causing the activation of peripheral nociceptors or evidence for disease or lesion of the somatosensory system causing the pain.
- **Others?**

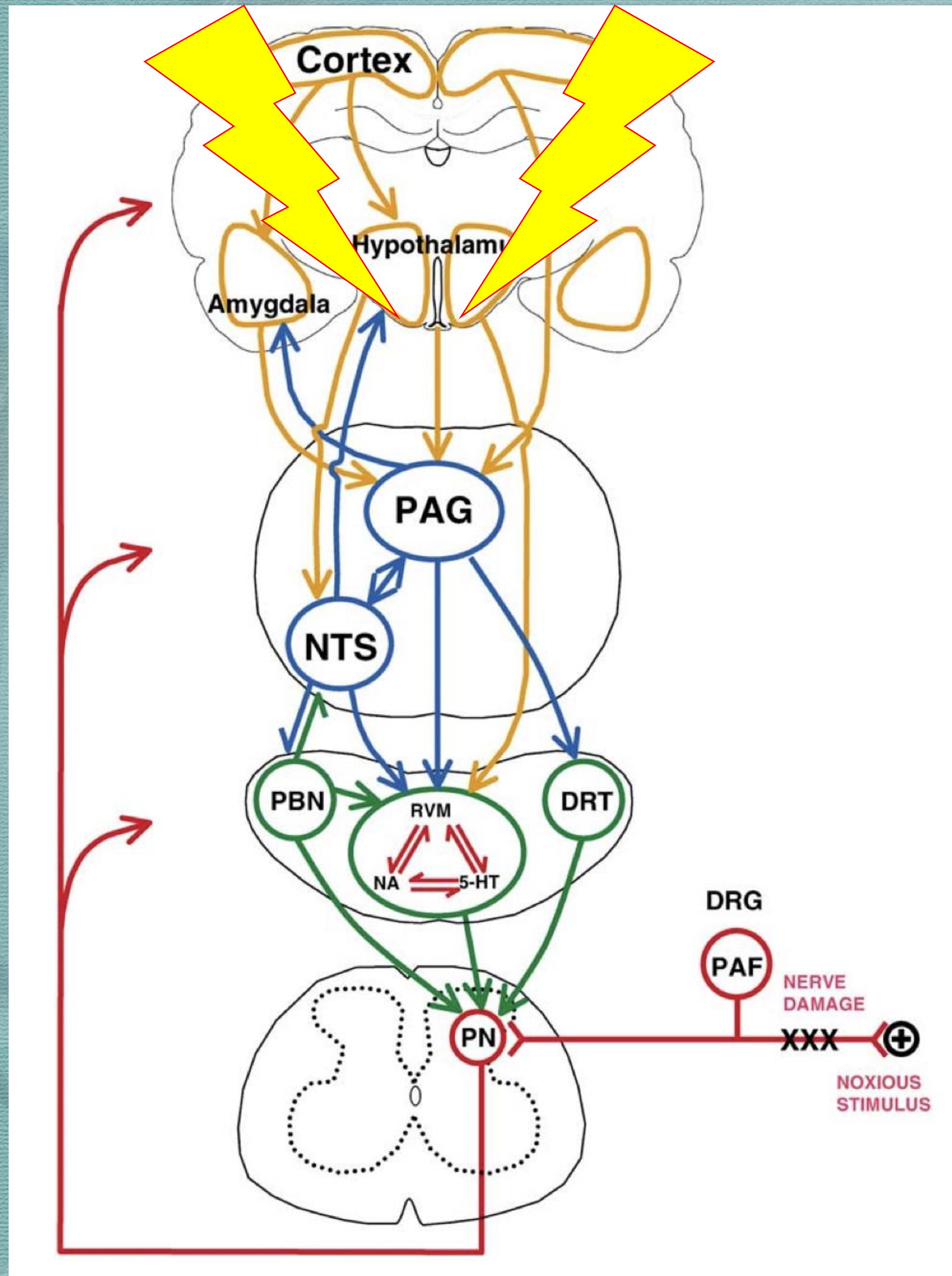
Nociceptive Pain Pathway



Nociceptive Pain Pathway



Descending Pain Pathways

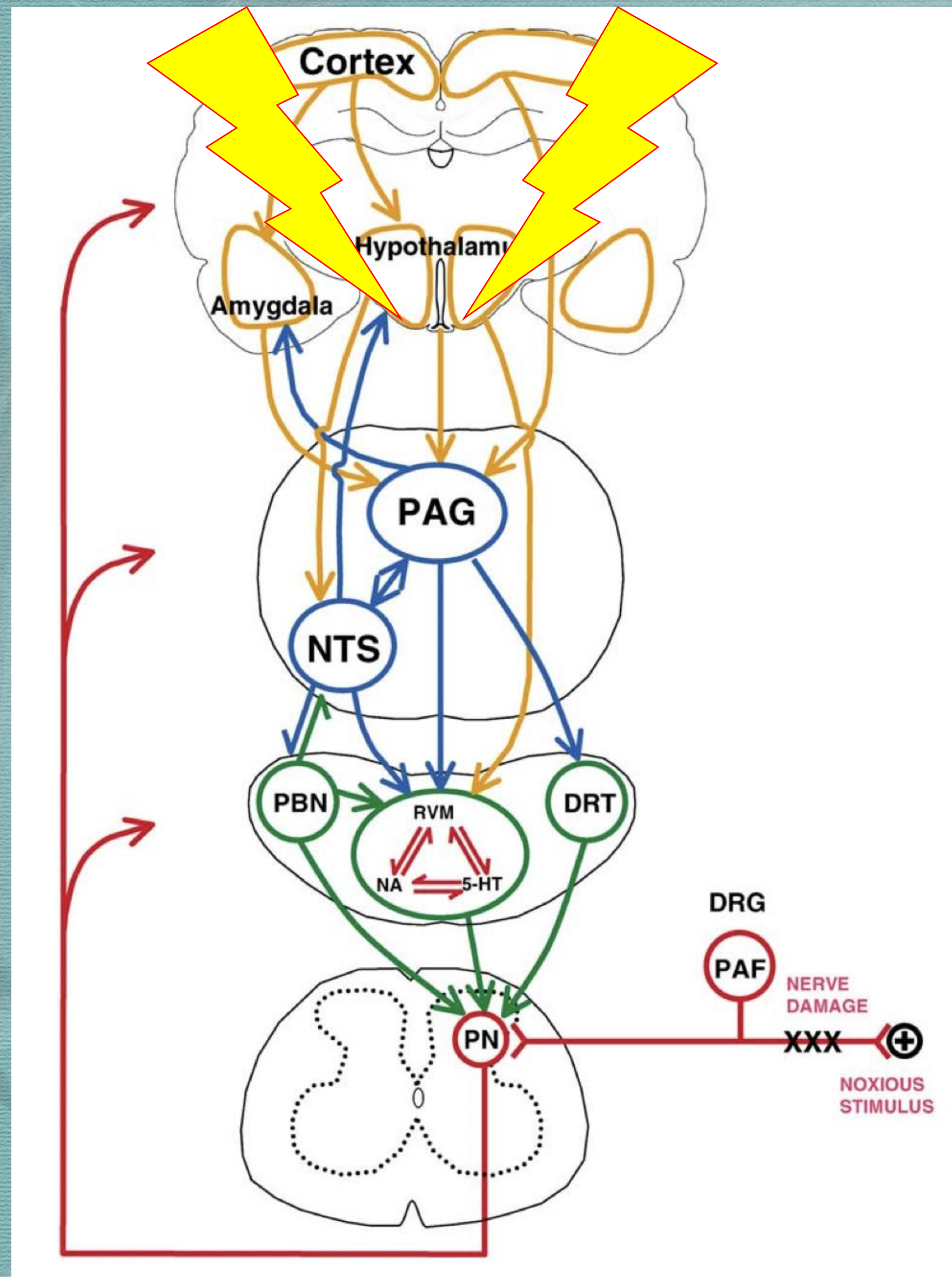


- **Nucleus Raphe Magnus:** 5-HT descending pathway
- **Locus Coeruleus:** NA descending pathway
- **PAG:** Releases endogenous opioids to activate LC and NRM as well as into CSF

Millan M (2002). Descending control of pain.

Progress in Neurobiology **66**: 355–474

Descending Pain Pathways



- **Nucleus Raphe Magnus: 5-HT** descending pathway
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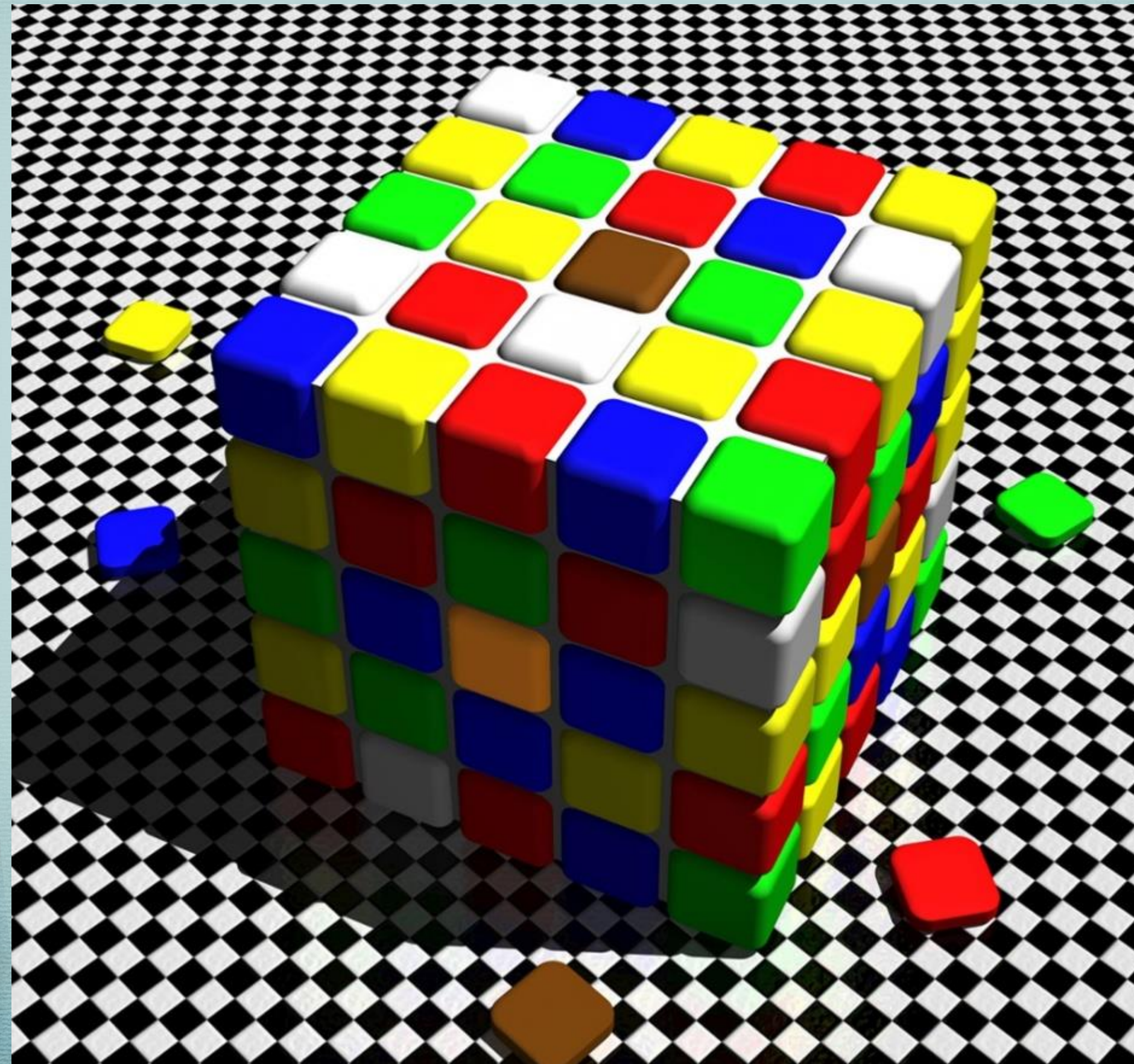
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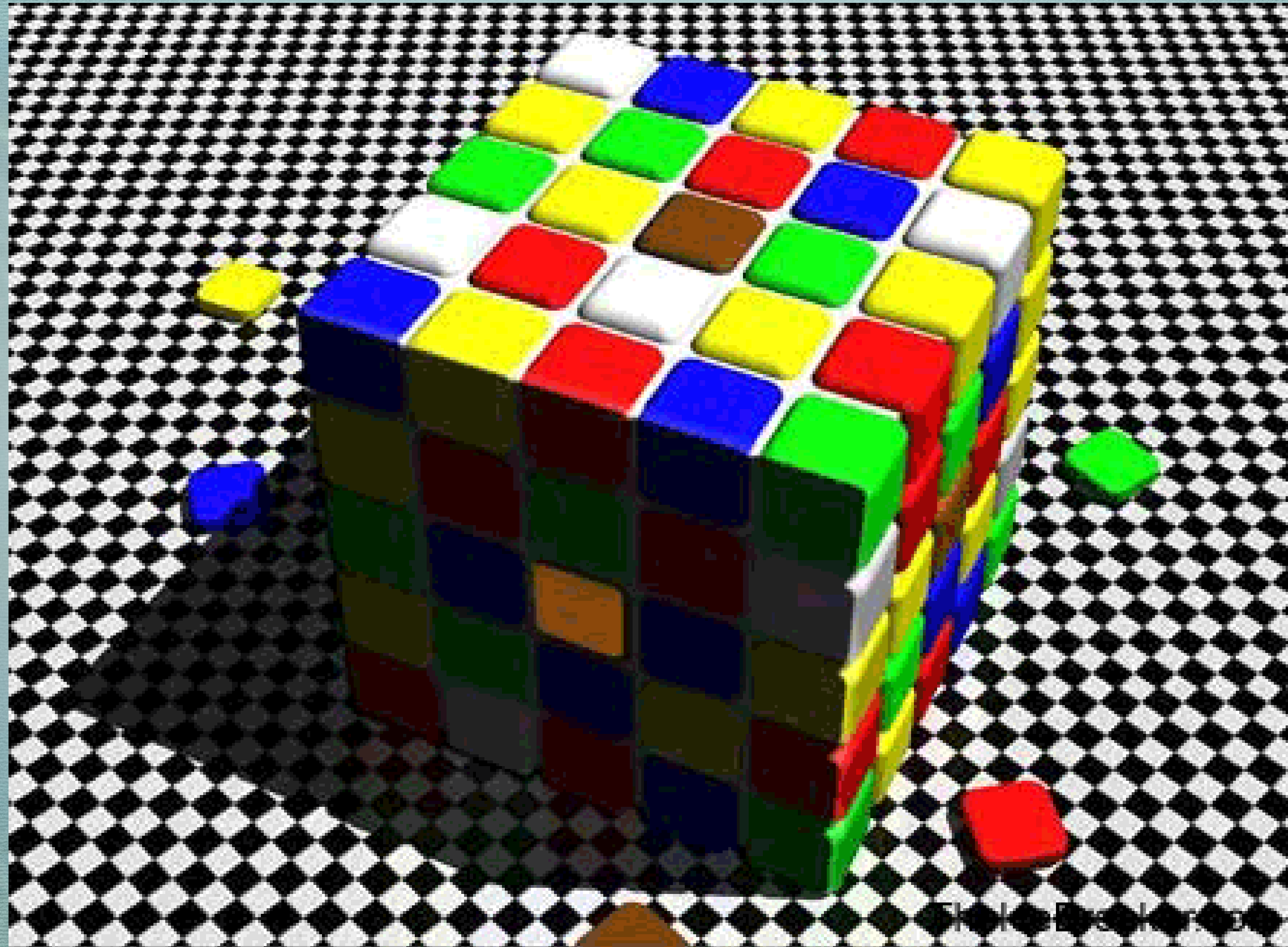
Would Your Brain Lie To You?



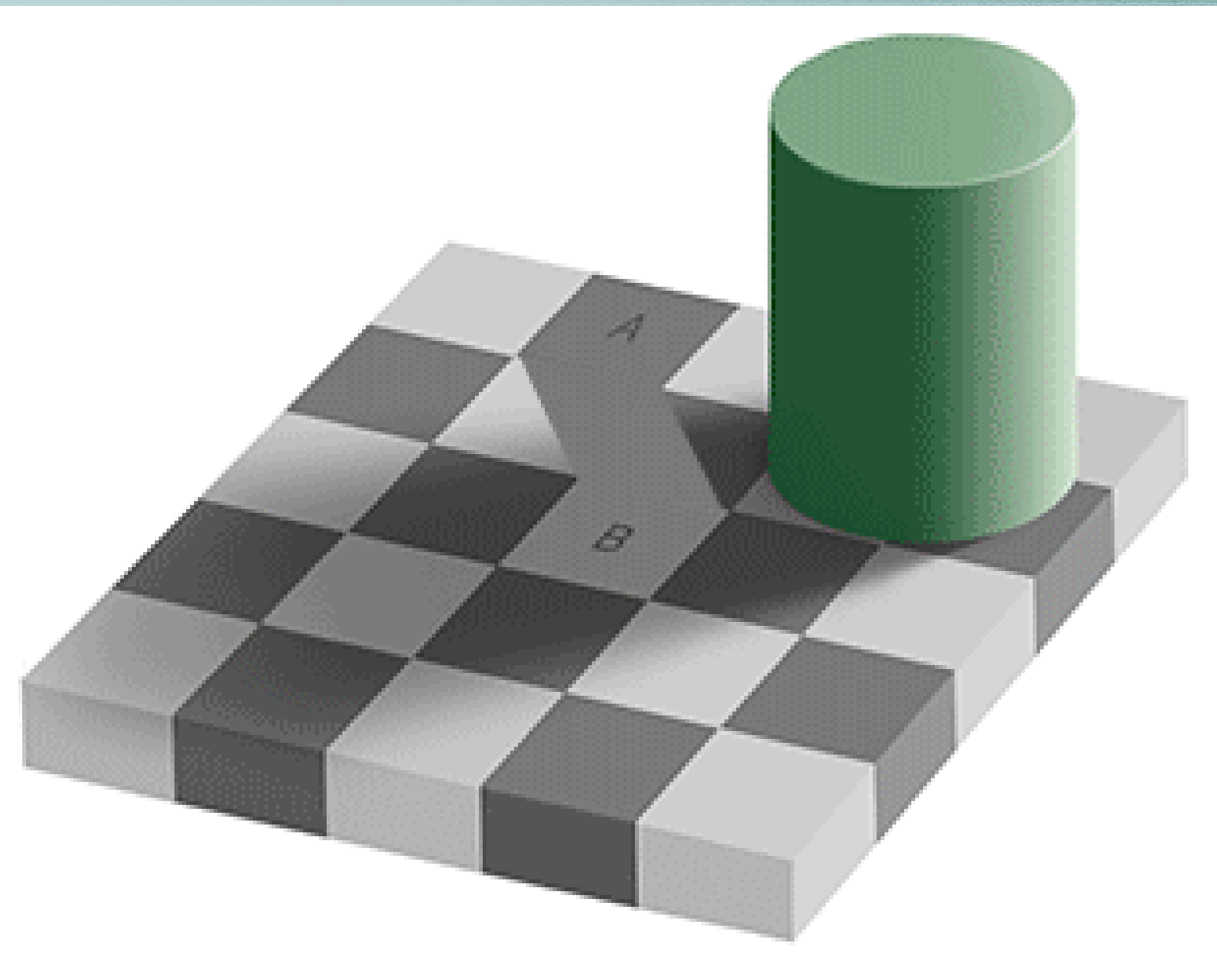
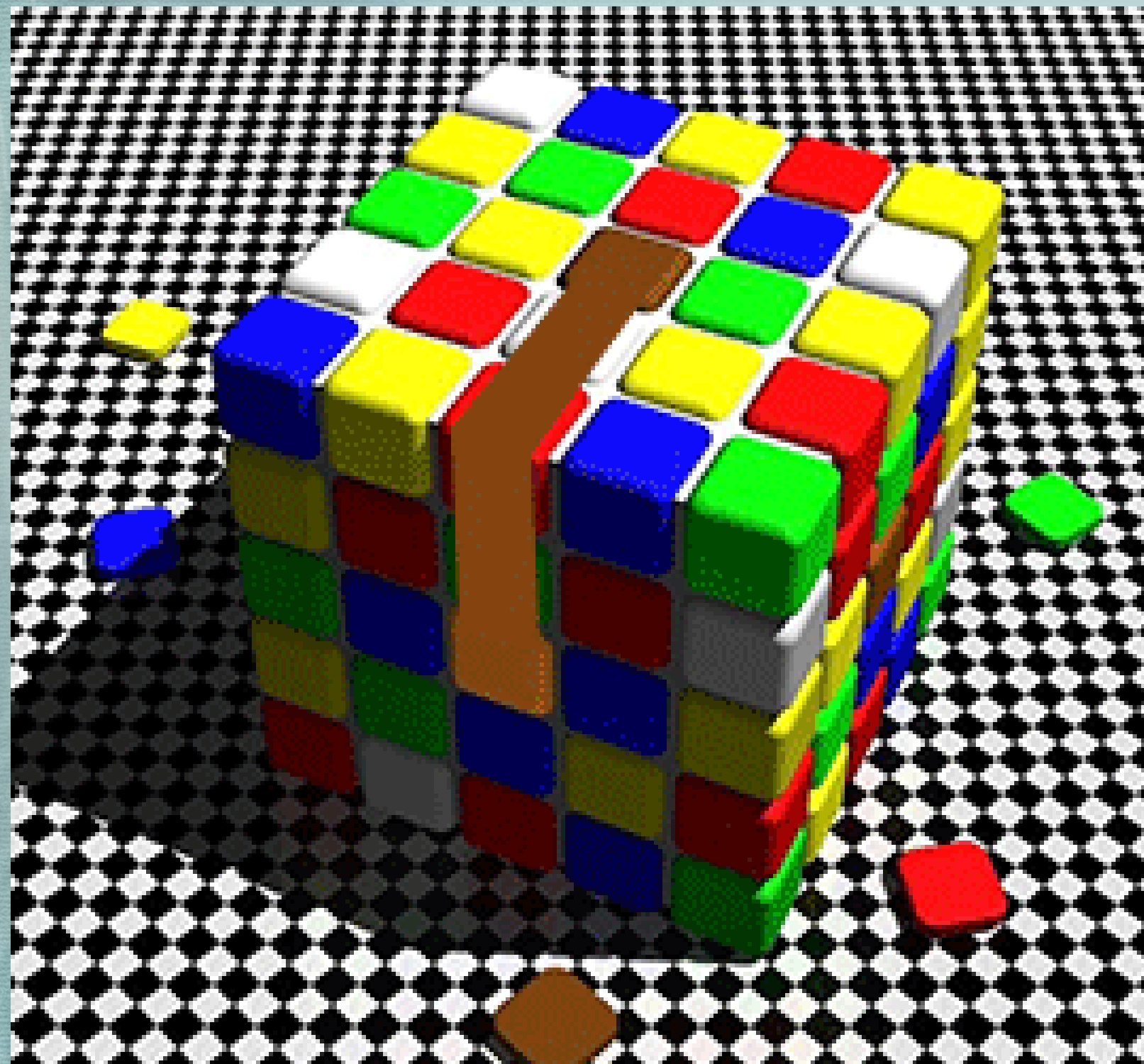
Optic Illusions – Would Your Eyes Lie To You?



Optic Illusions



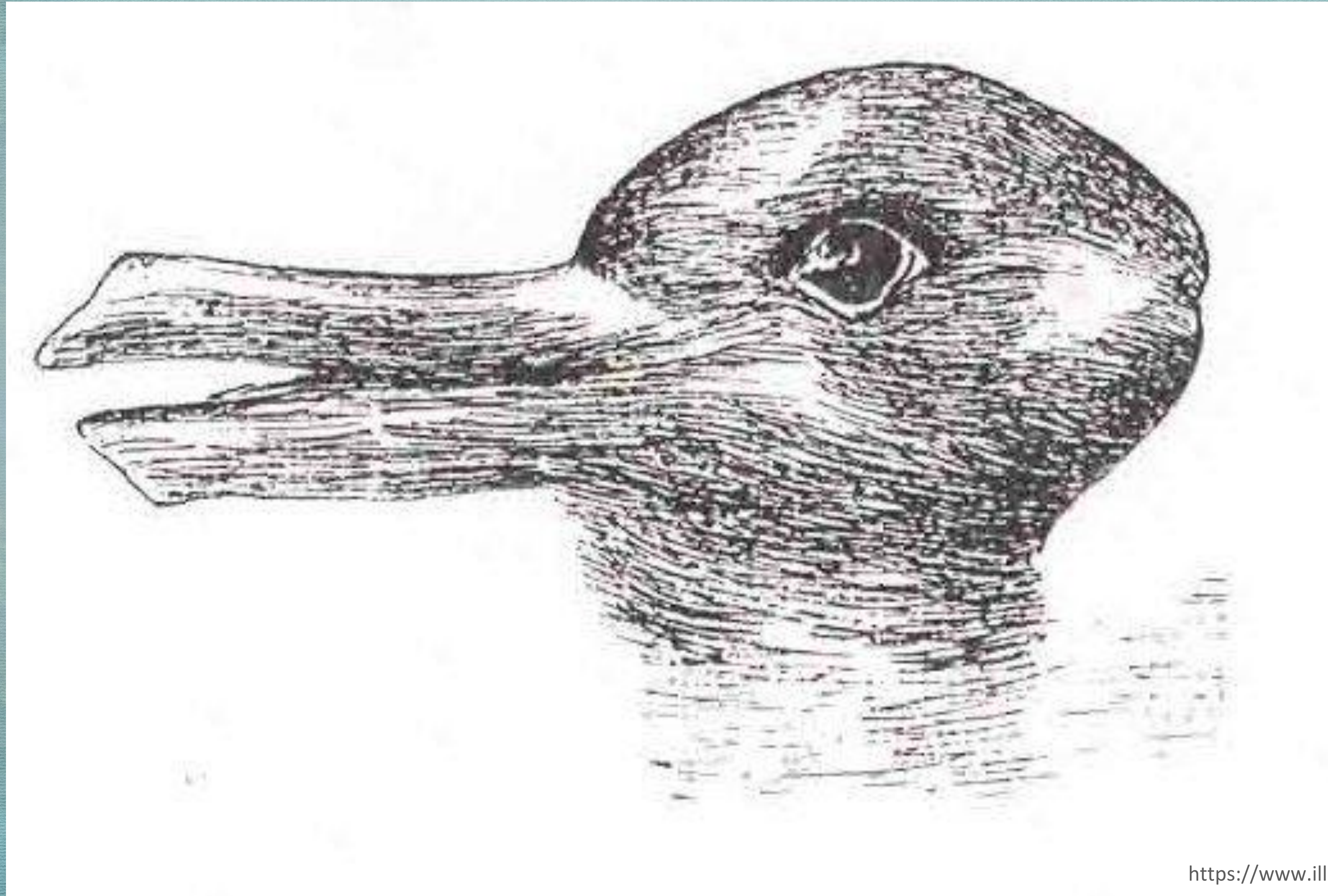
Optic Illusions



Optic Illusions



Optic Illusions

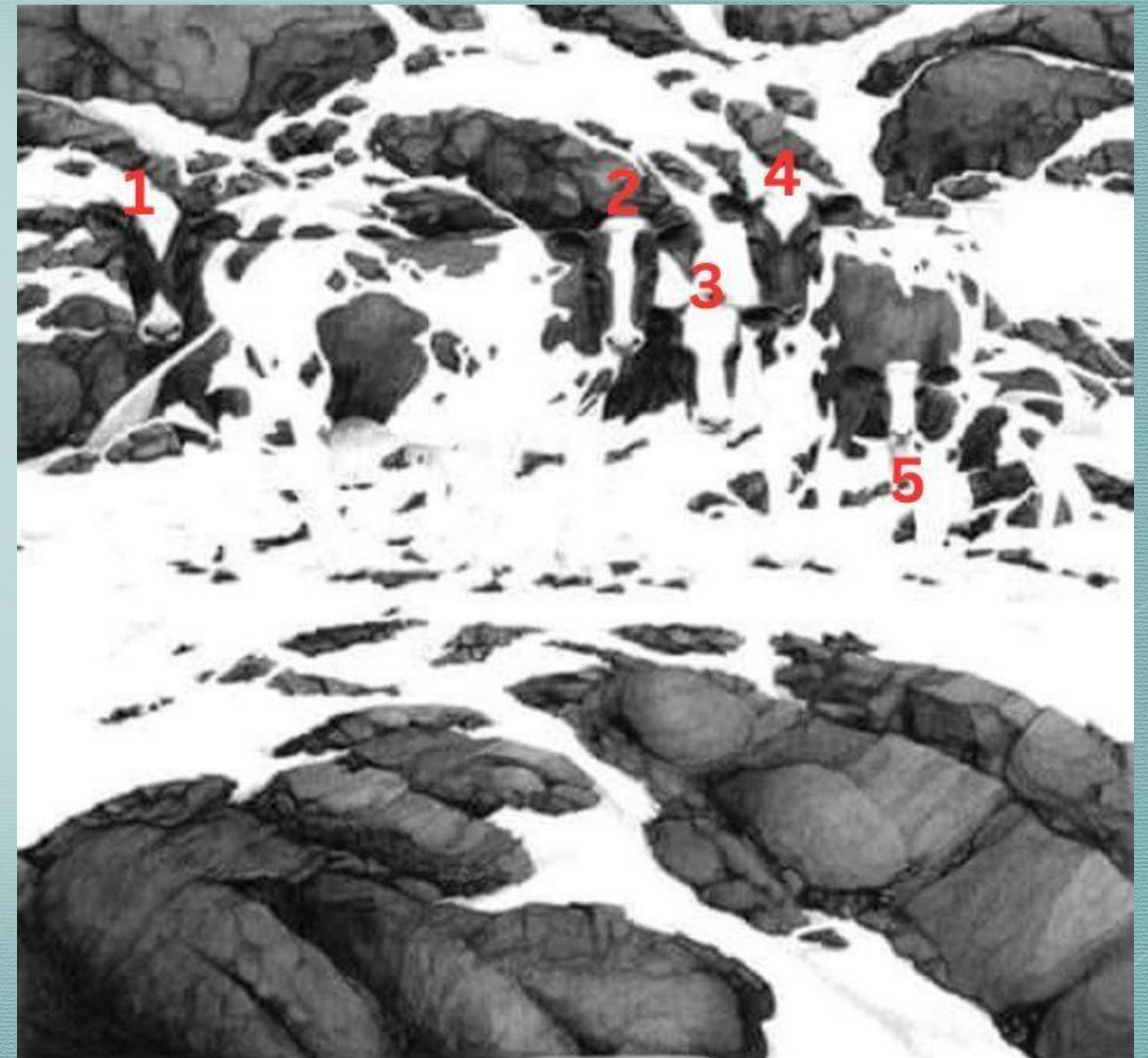


Optic Illusions

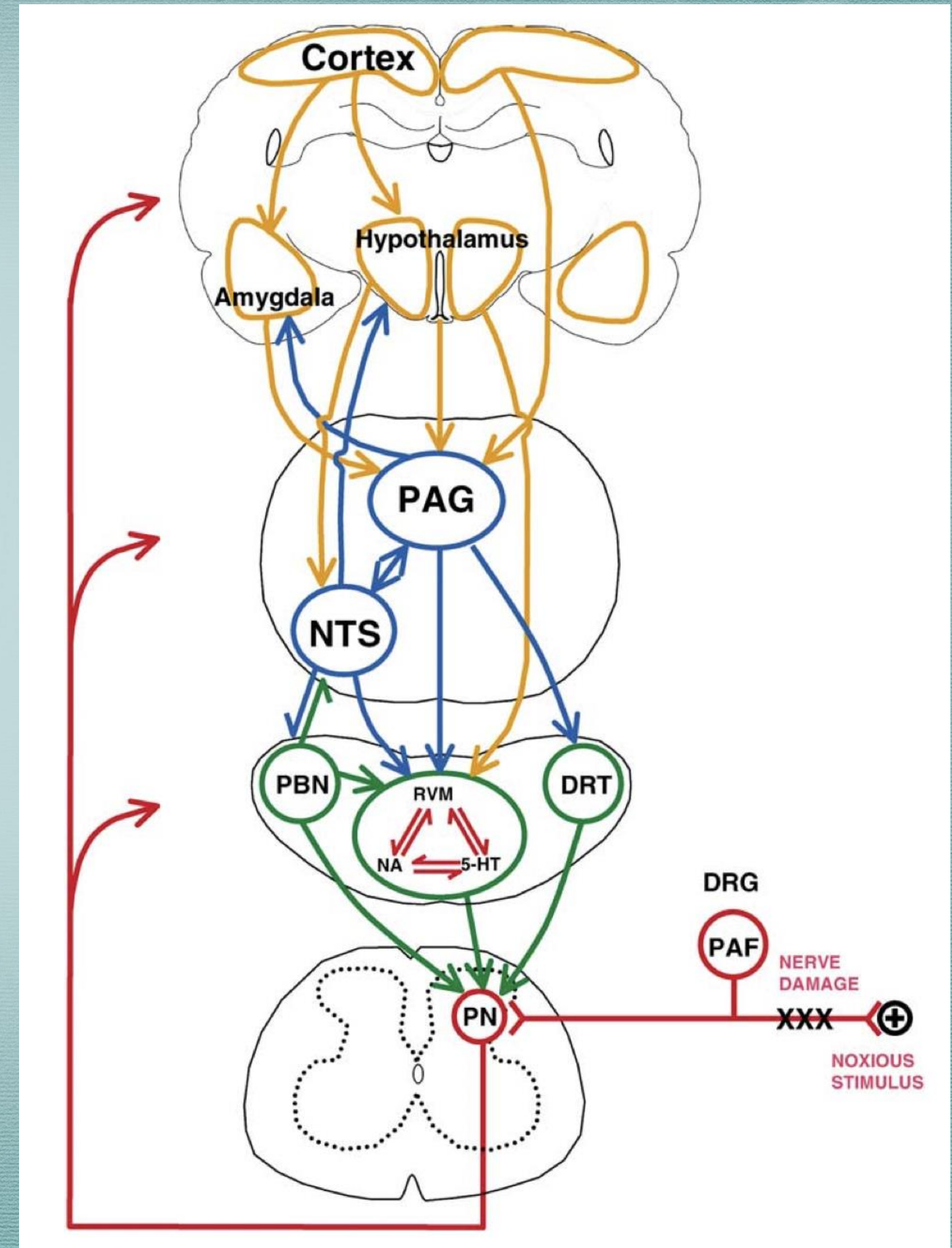


Optic Illusions

How many cows?



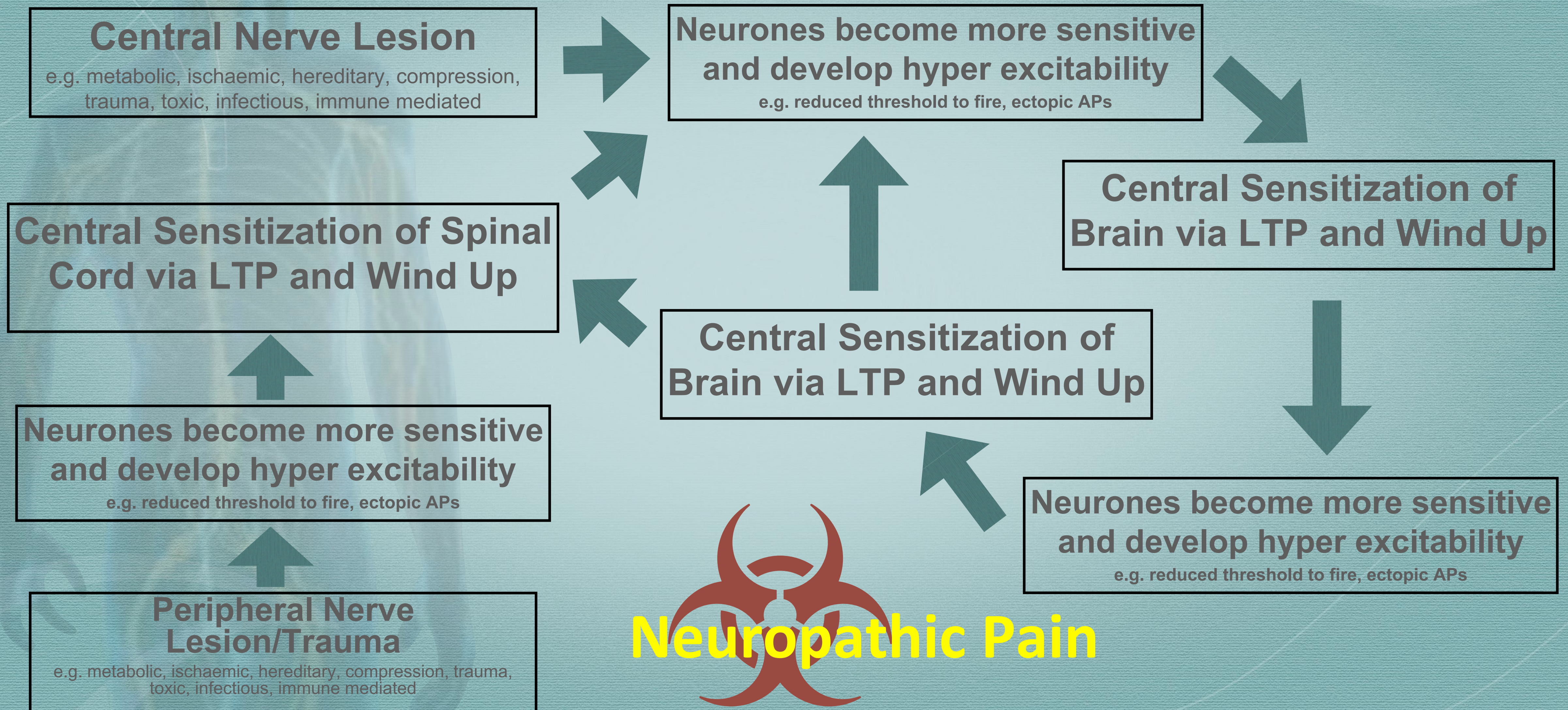
Pain Is Similar



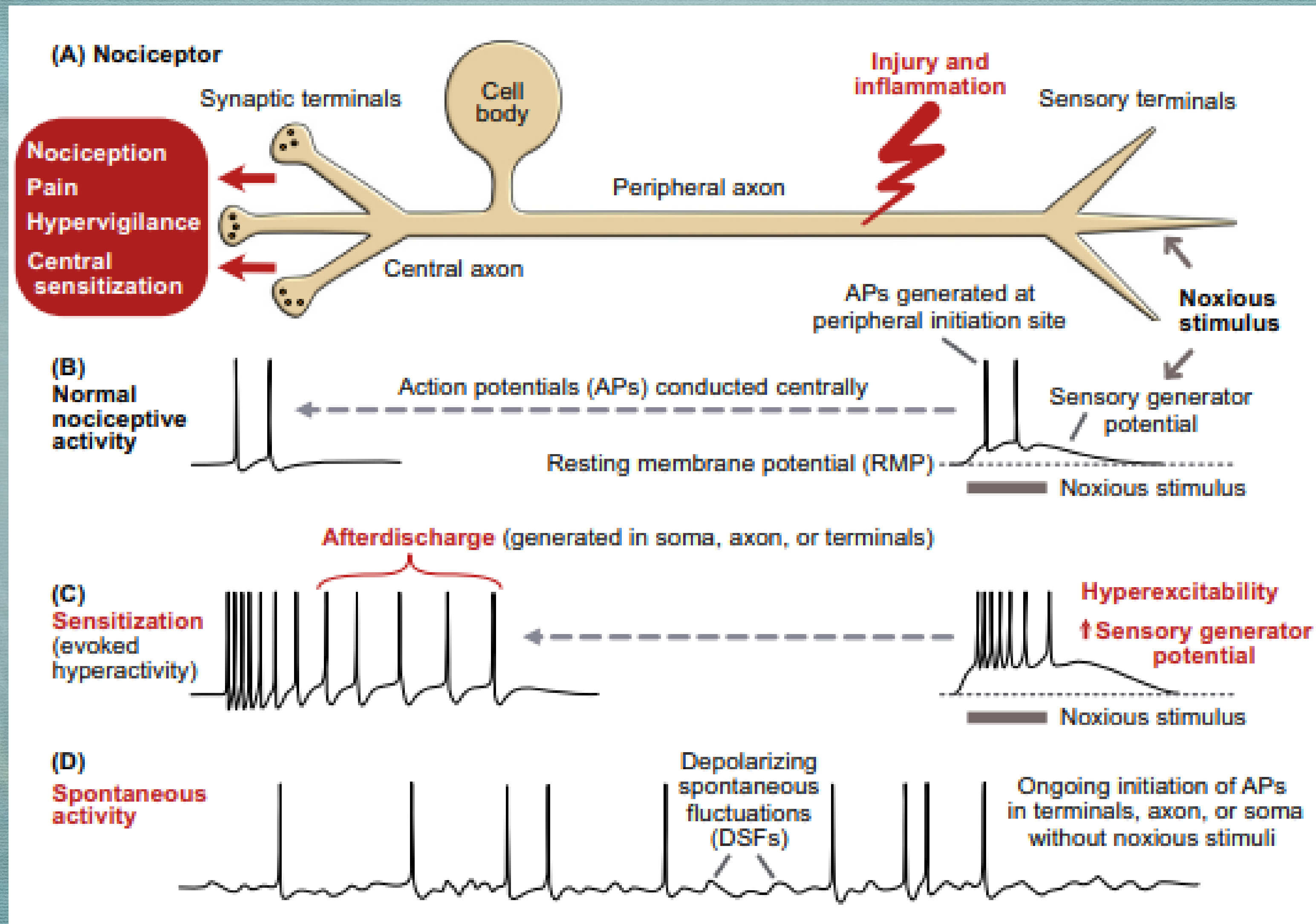
<https://deepai.org/machine-learning-model/text2img>

Millan M (2002). Descending control of pain. *Progress in Neurobiology* 66: 355–474

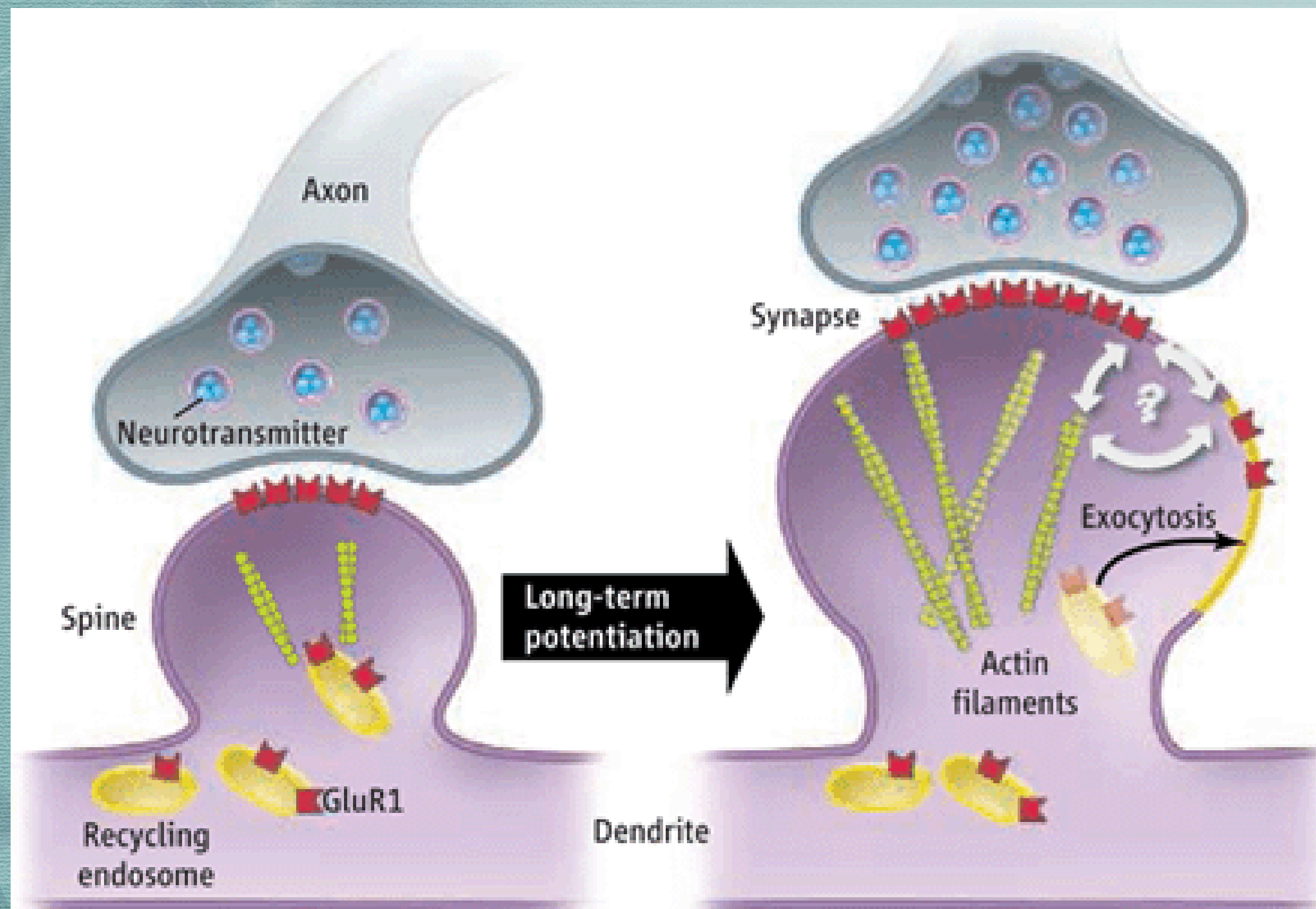
Mechanisms of Neuropathic Pain



Neuropathic Pain Pathway Problems



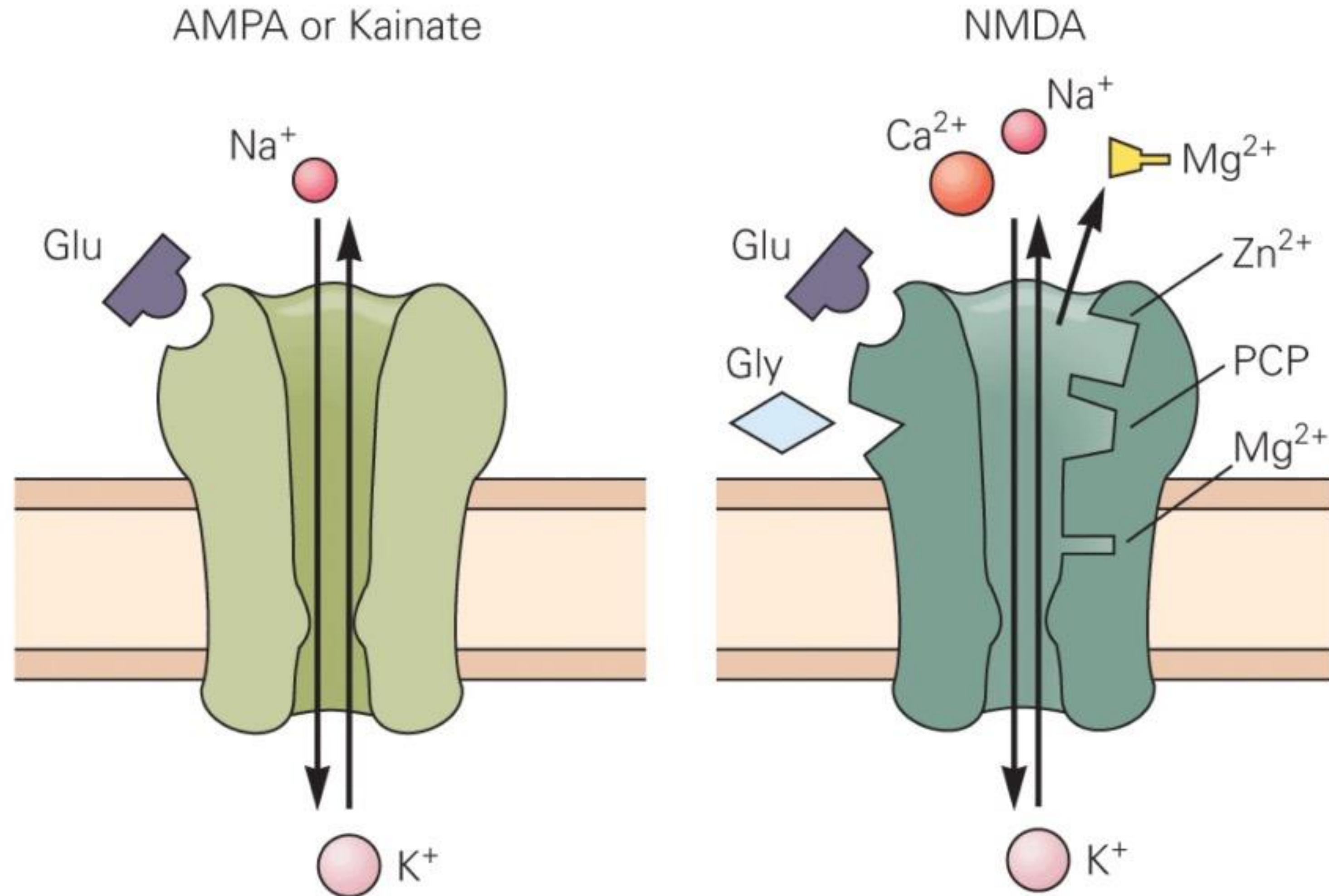
Long-Term Potentiation



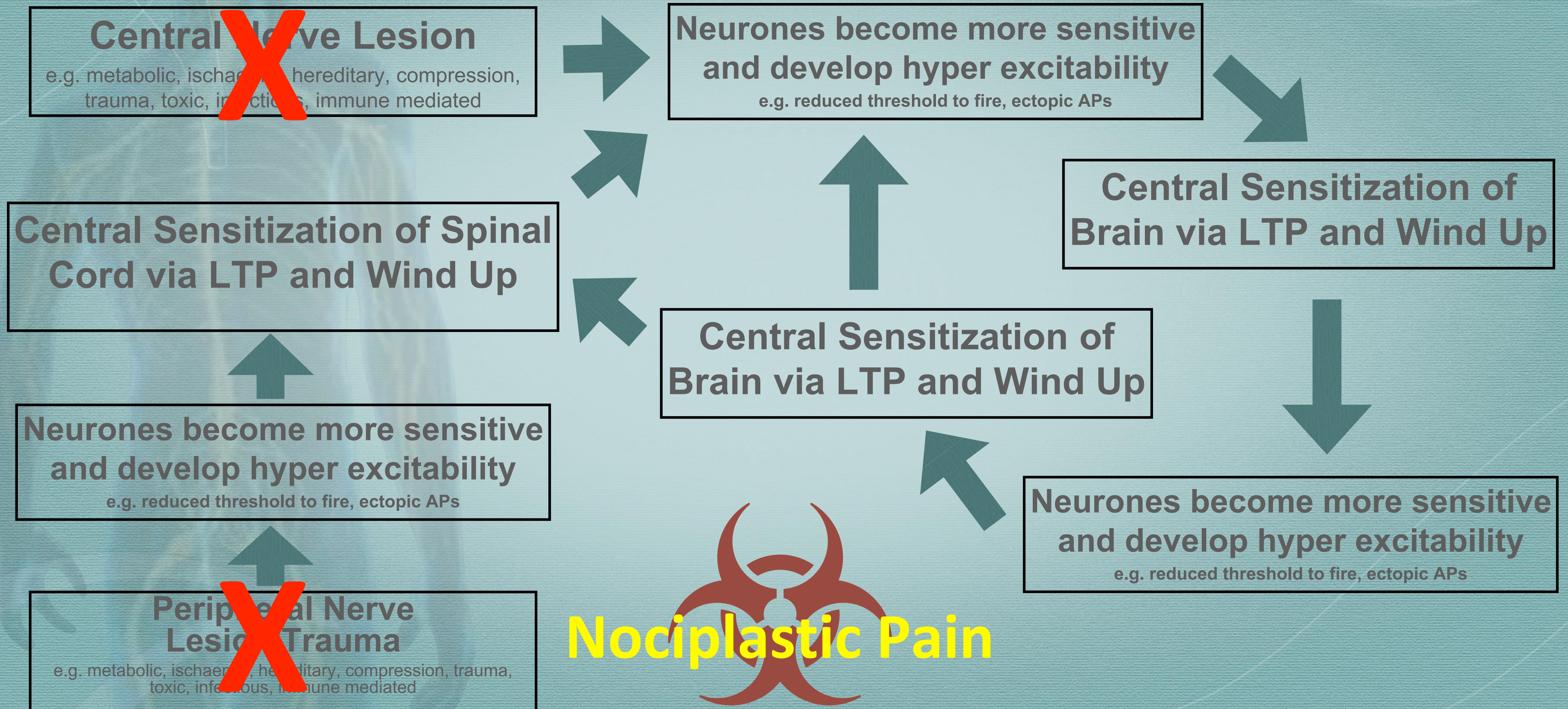
- **Presynaptically:**
 - More vesicles
 - More exocytosis
 - More stimulatory channels
 - More neurotransmitter per vesicle
 - More transporters
 - Excitatory receptor expression
- **Postsynaptically:**
 - More receptors
 - Less breakdown
 - nNOS?
- **Synapse Changes:**
 - Grows closer - cf. electrical synapse
 - May divide and multiply

Long-Term Potentiation

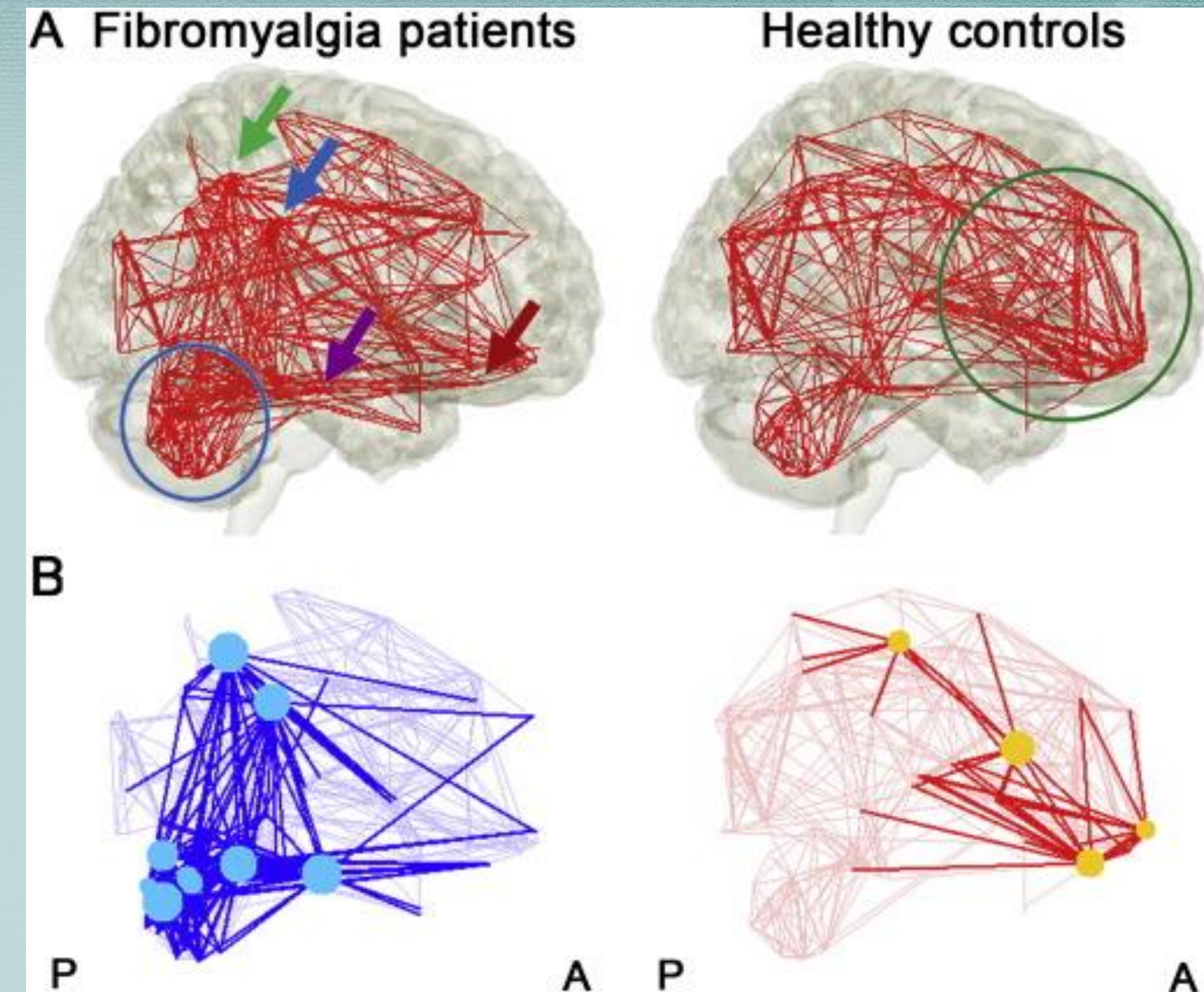
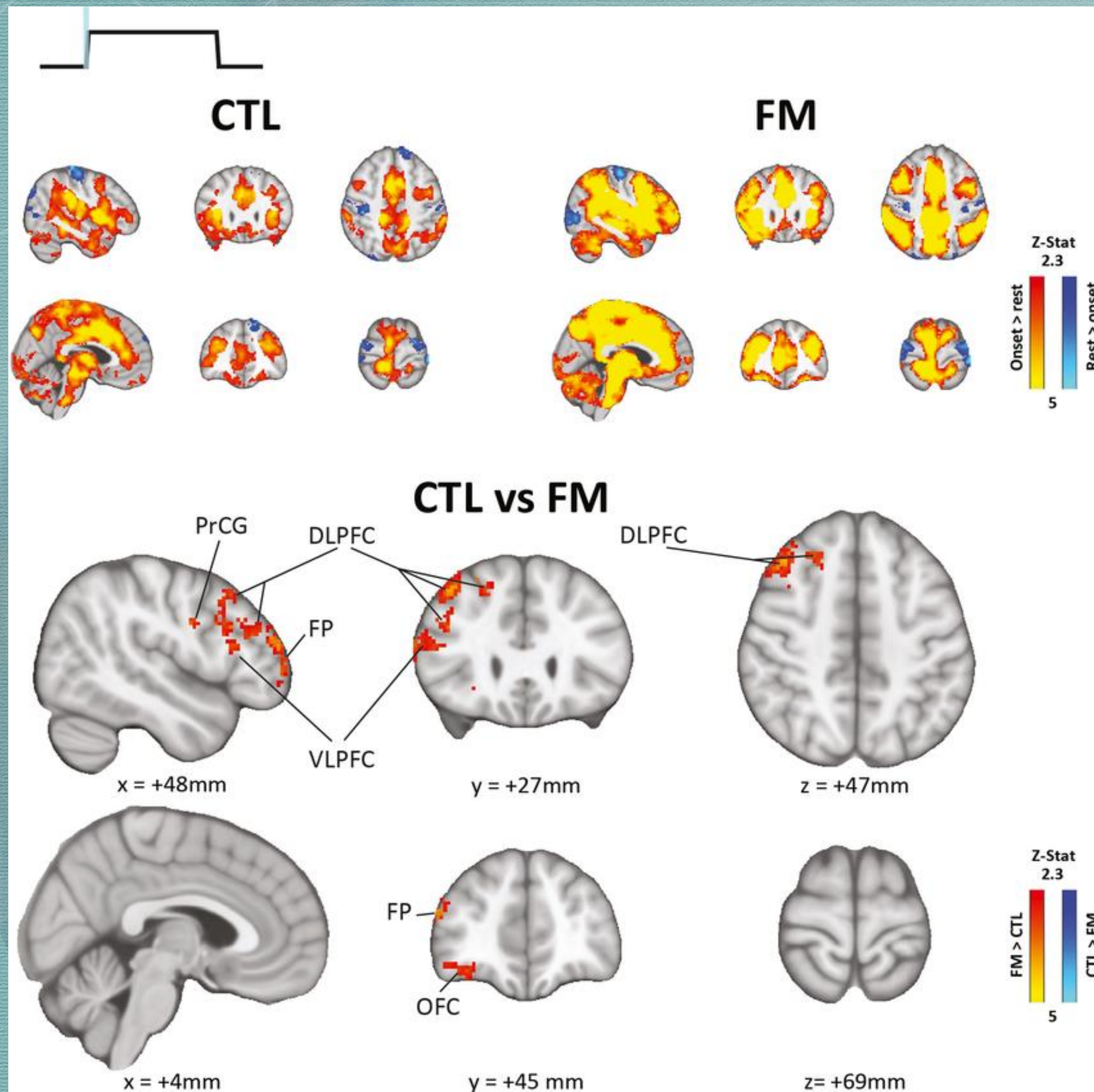
A Ionotropic glutamate receptor



Mechanisms of Nociceptive Pain



Brain Changes in FMS



Hubbard, C *et al.* (2020). Aberrant Saliency? Brain Hyperactivation in Response to Pain Onset and Offset in Fibromyalgia. *Arthritis & Rheumatology*. 72. 10.1002/art.41220.

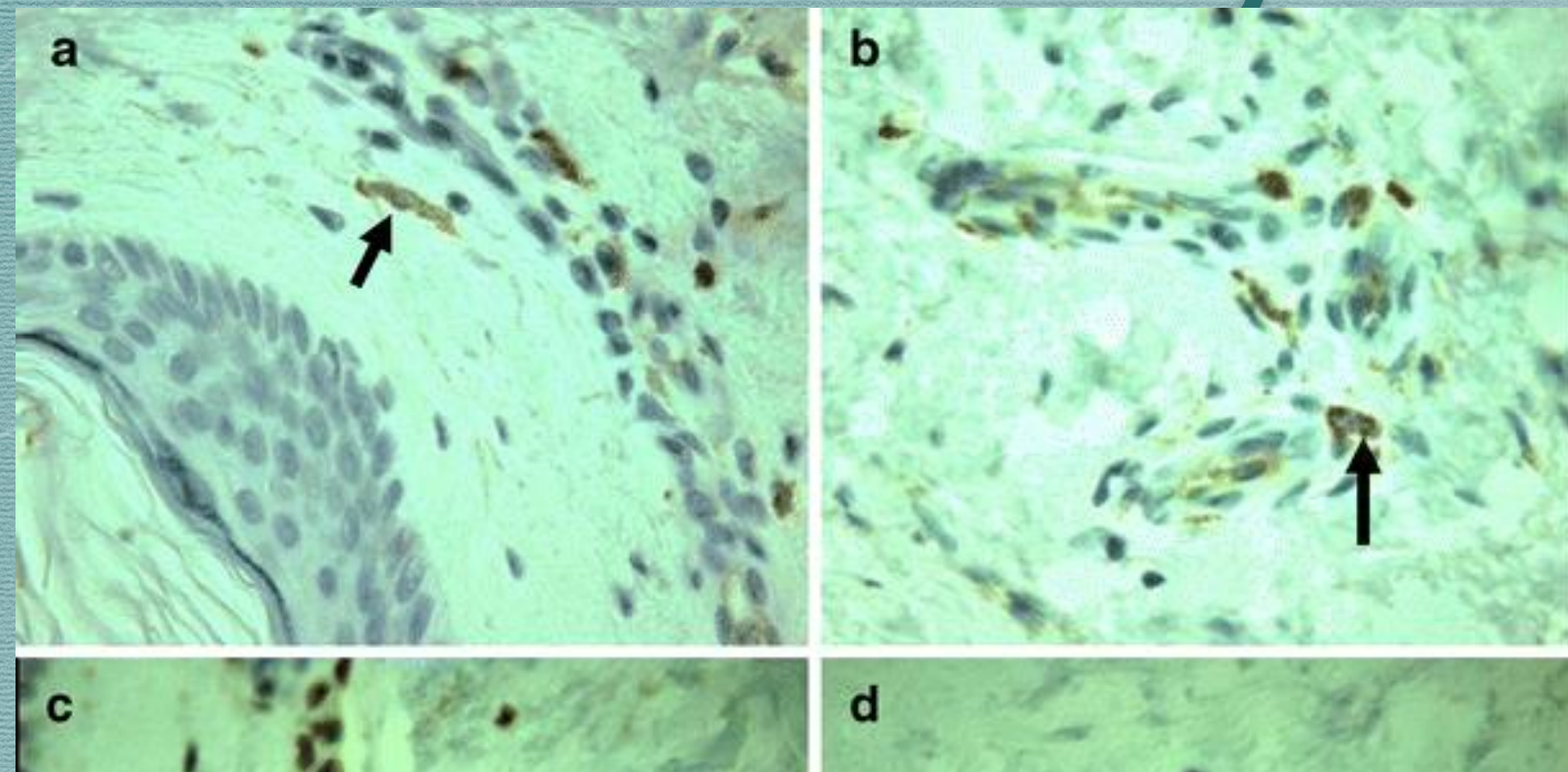
Kim H *et al.* (2015). Fibromyalgia is characterized by altered frontal and cerebellar structural covariance brain networks *NeuroImage: Clinical*, Volume 7, Pages 667-677,

Brain Changes in FMS

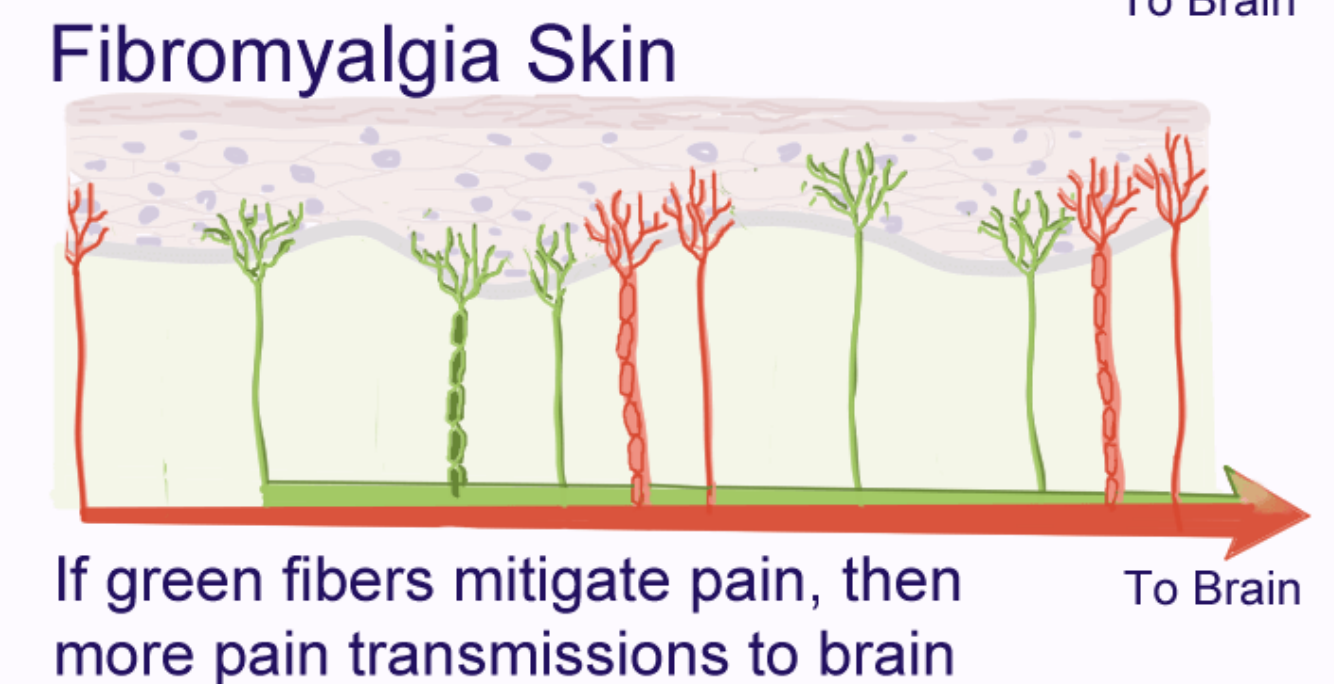
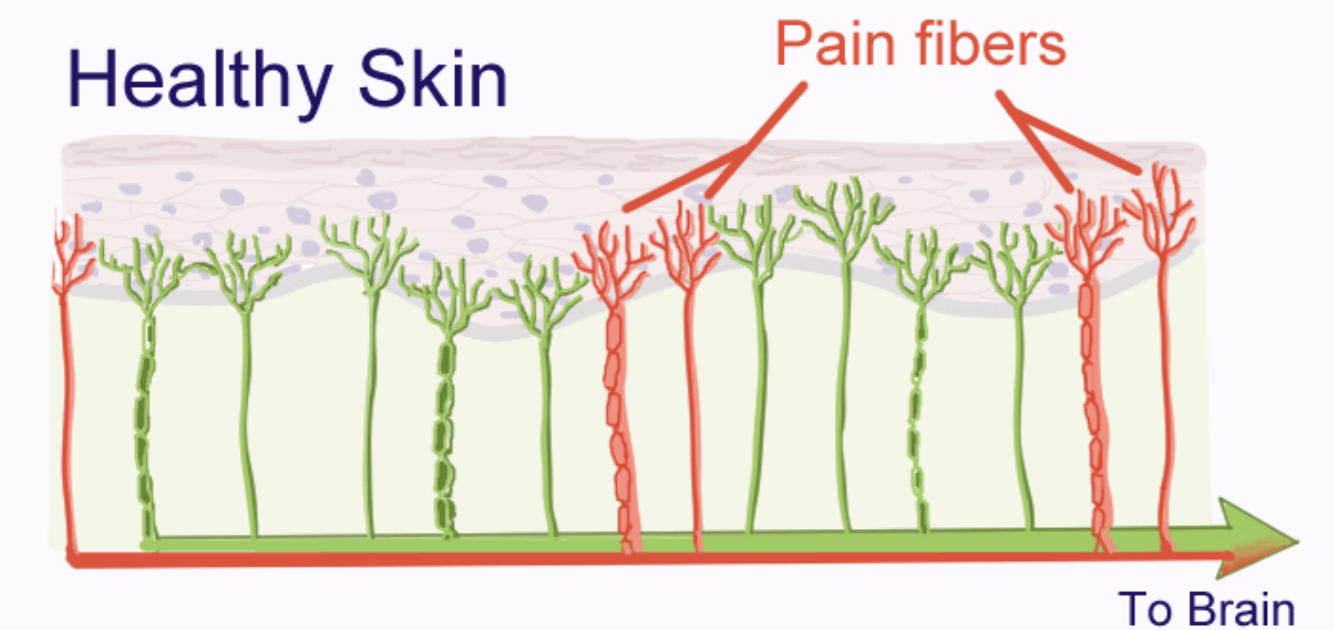
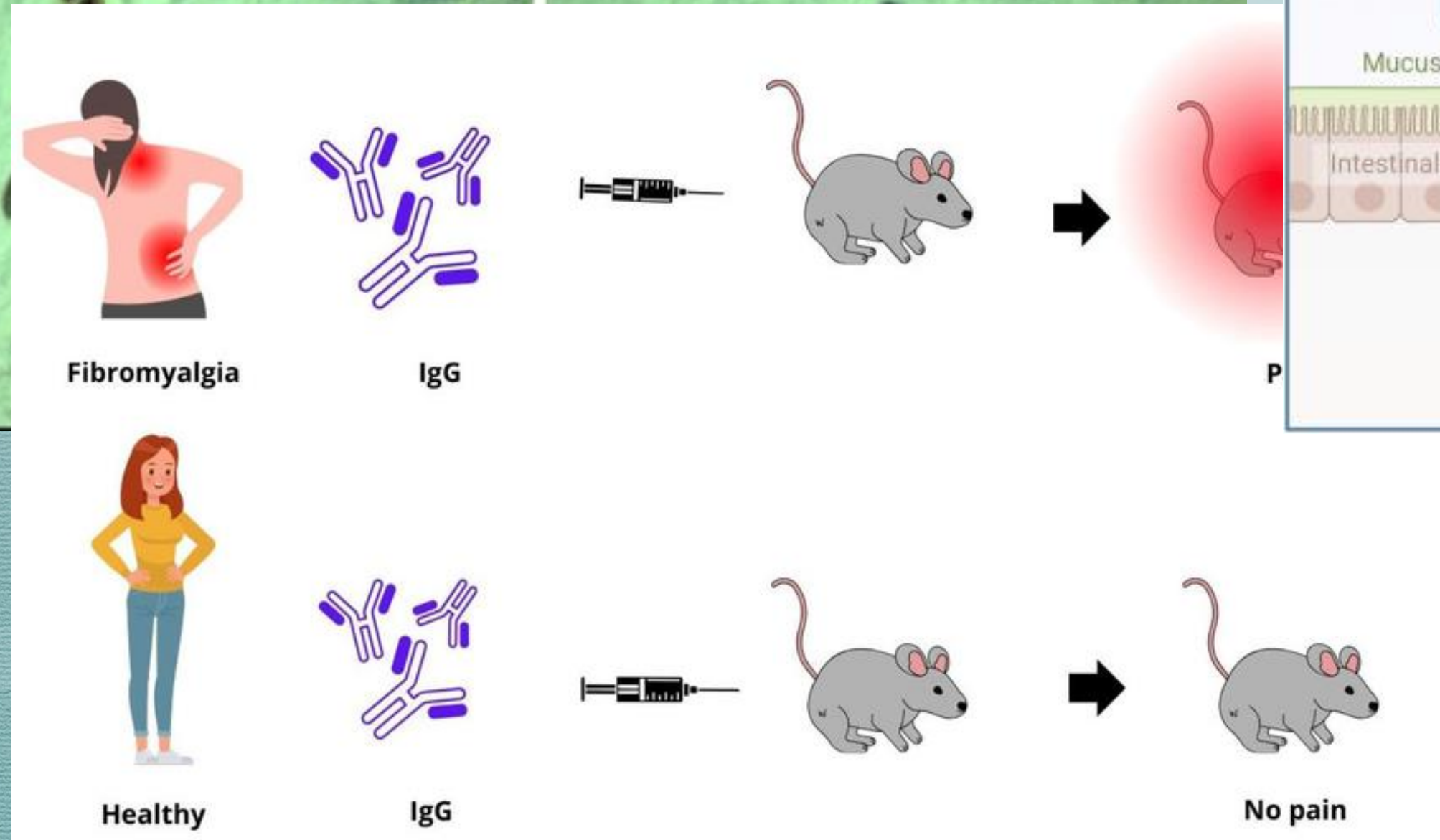
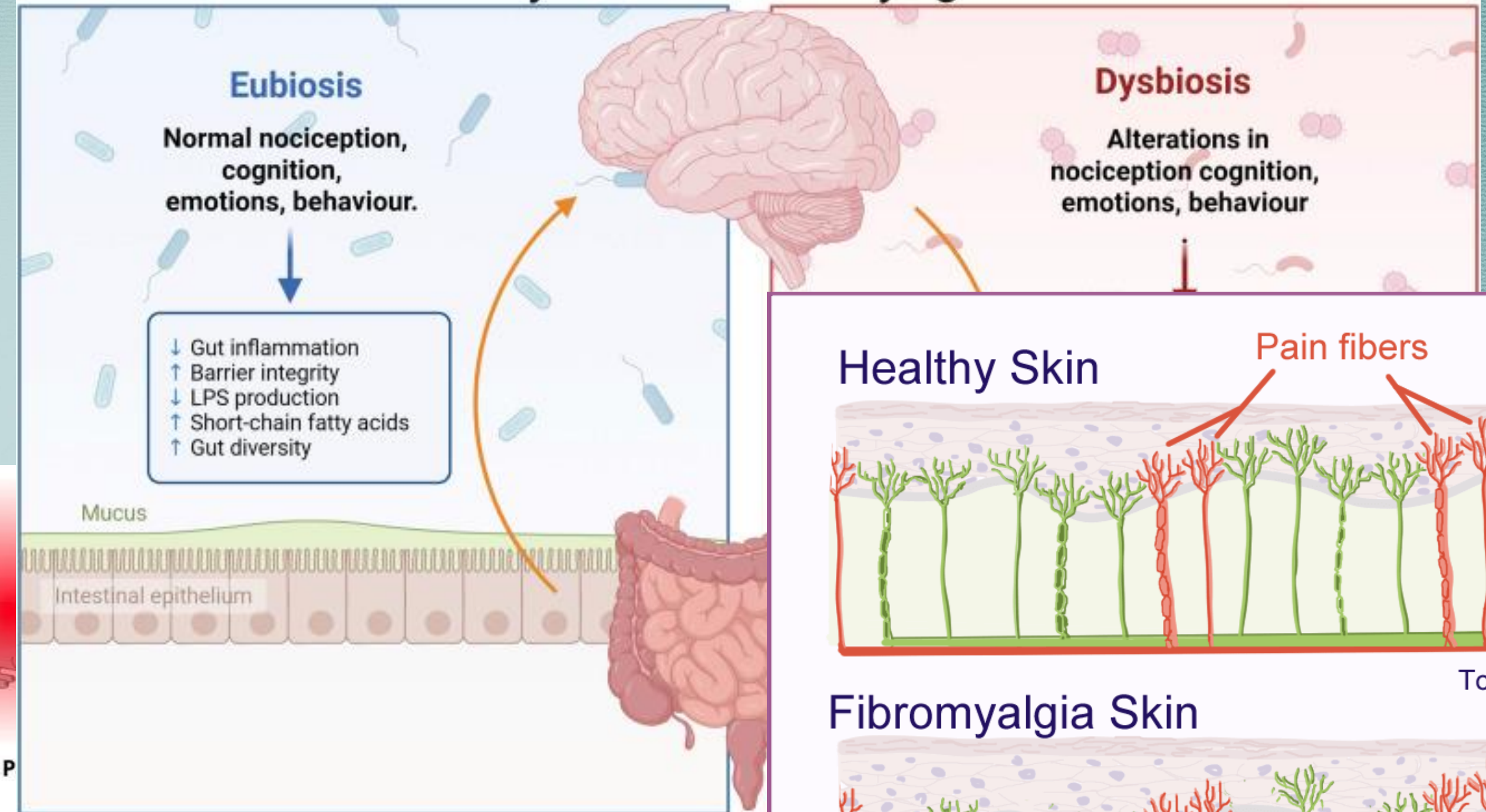


Albrecht DS *et al.* (2018). Brain glial activation in fibromyalgia - A multi-site positron emission tomography investigation. *Brain Behav Immun.* 2019 Jan;75:72-83. doi: 10.1016/j.bbi.2018.09.018. Epub 2018 Sep 14. PMID: 30223011; PMCID: PMC6541932.

Body Changes in FMS



Function of the gut-microbiota brain axis under conditions of eubiosis and dysbiosis in fibromyalgia

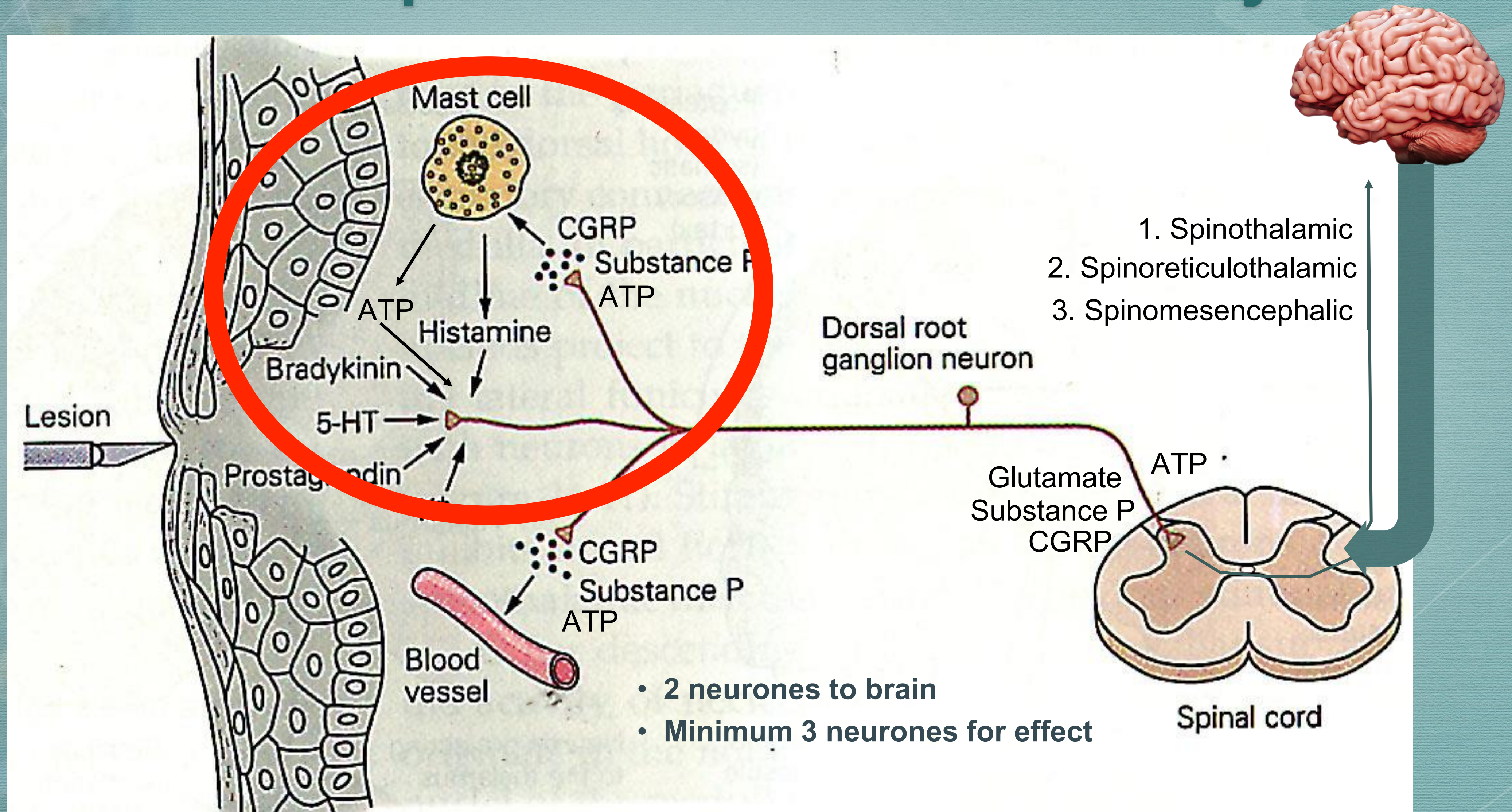


Blanco, I., Bérizte, N., Argüelles, M. *et al.* Abnormal overexpression of mastocytes in skin biopsies of fibromyalgia patients. *Clin Rheumatol* **29**, 1403–1412 (2010). <https://doi.org/10.1007/s10067-010-1474-7>

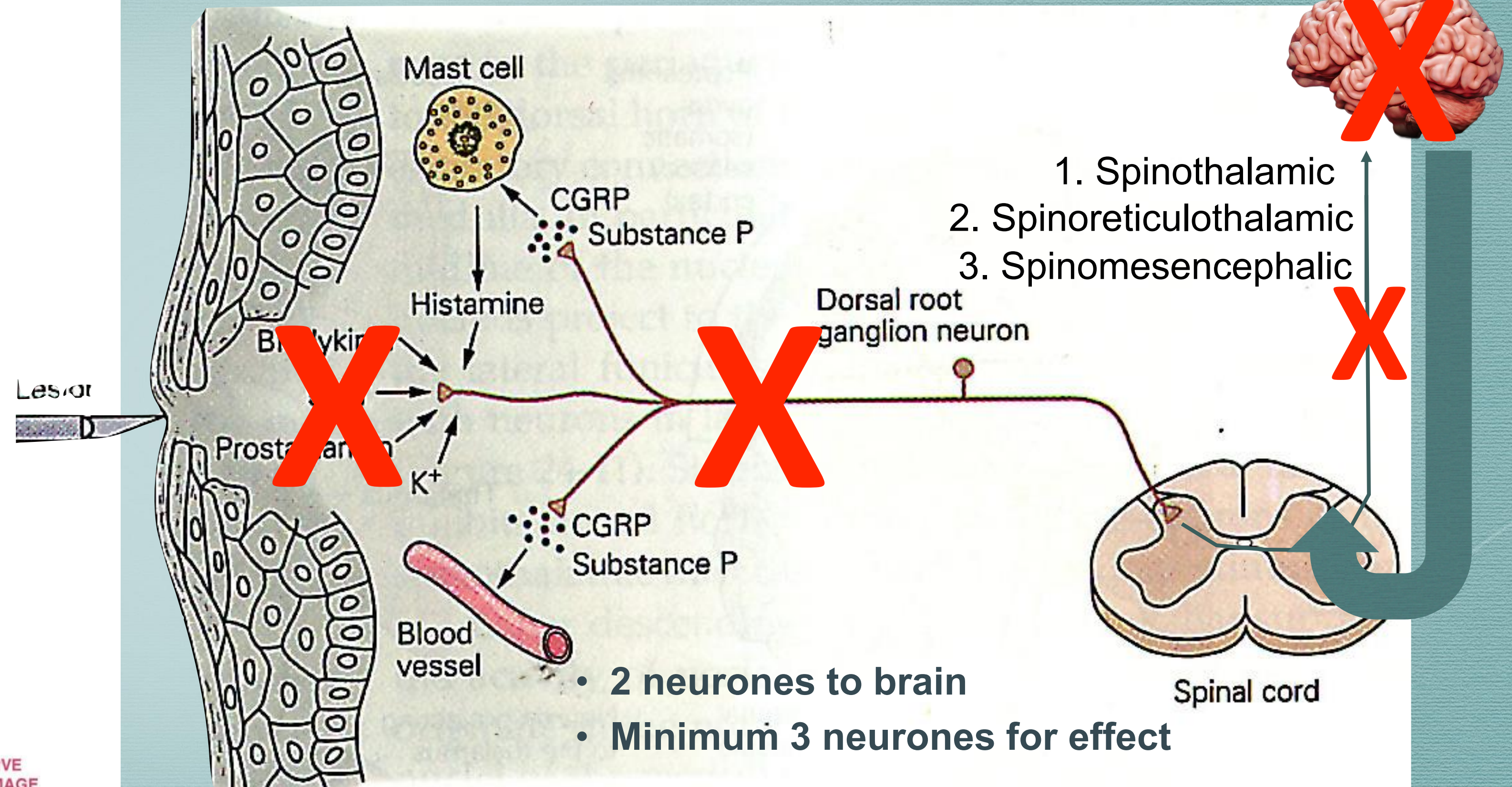
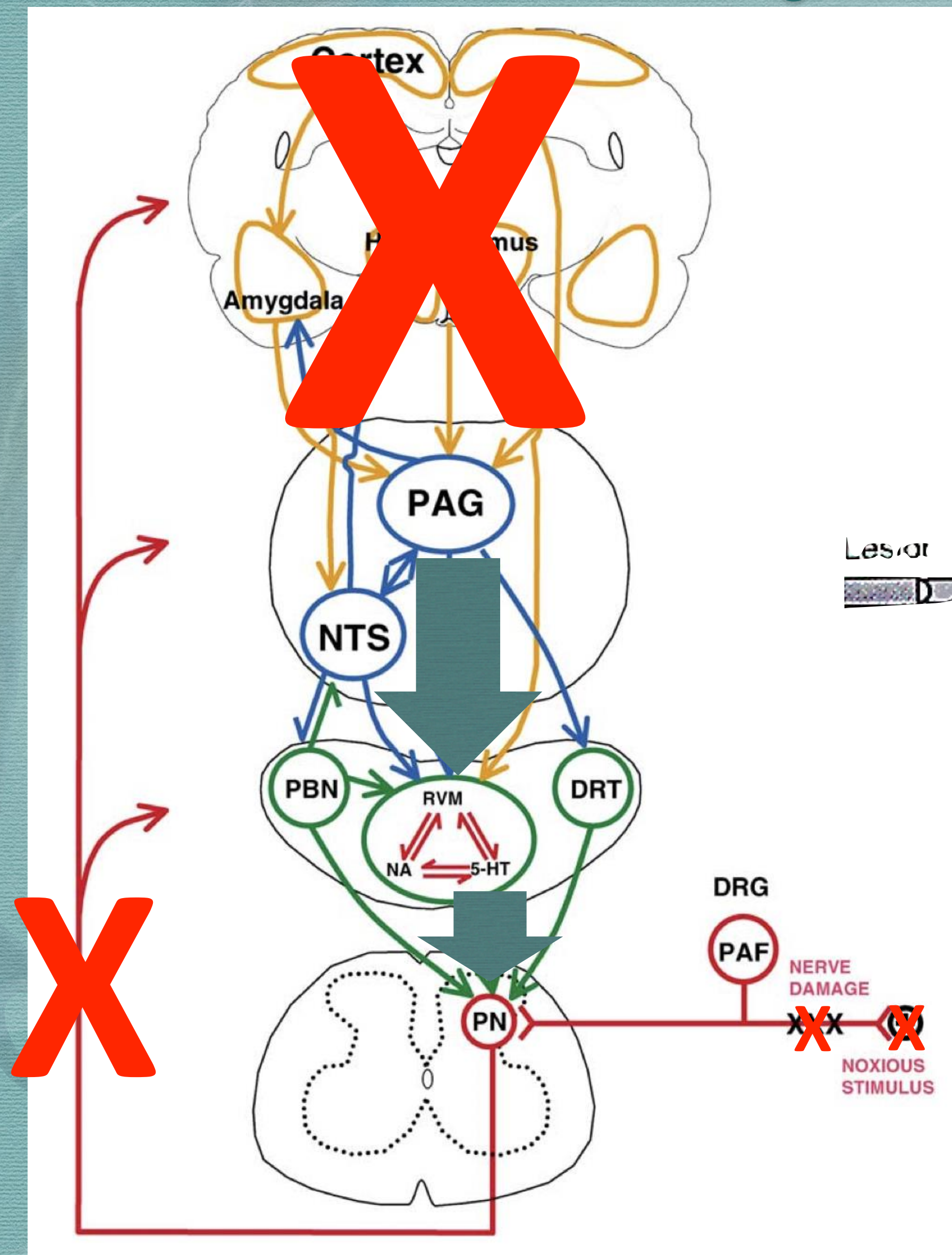
Goebel A *et al.* (2021). Passive transfer of fibromyalgia symptoms from patients to mice. *J Clin Invest.* 131(13):e144201. <https://doi.org/10.1172/JCI144201>.

www.fibromyalgiafund.org/small-nerve-fiber-damage-in-fibromyalgia/ <https://www.sciencedirect.com/science/article/pii/S2590097826000029>

Nociceptive Pain Pathway



Everything in Disarray!



Millan M (2002). Descending control of pain.

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Widespread Pain Index

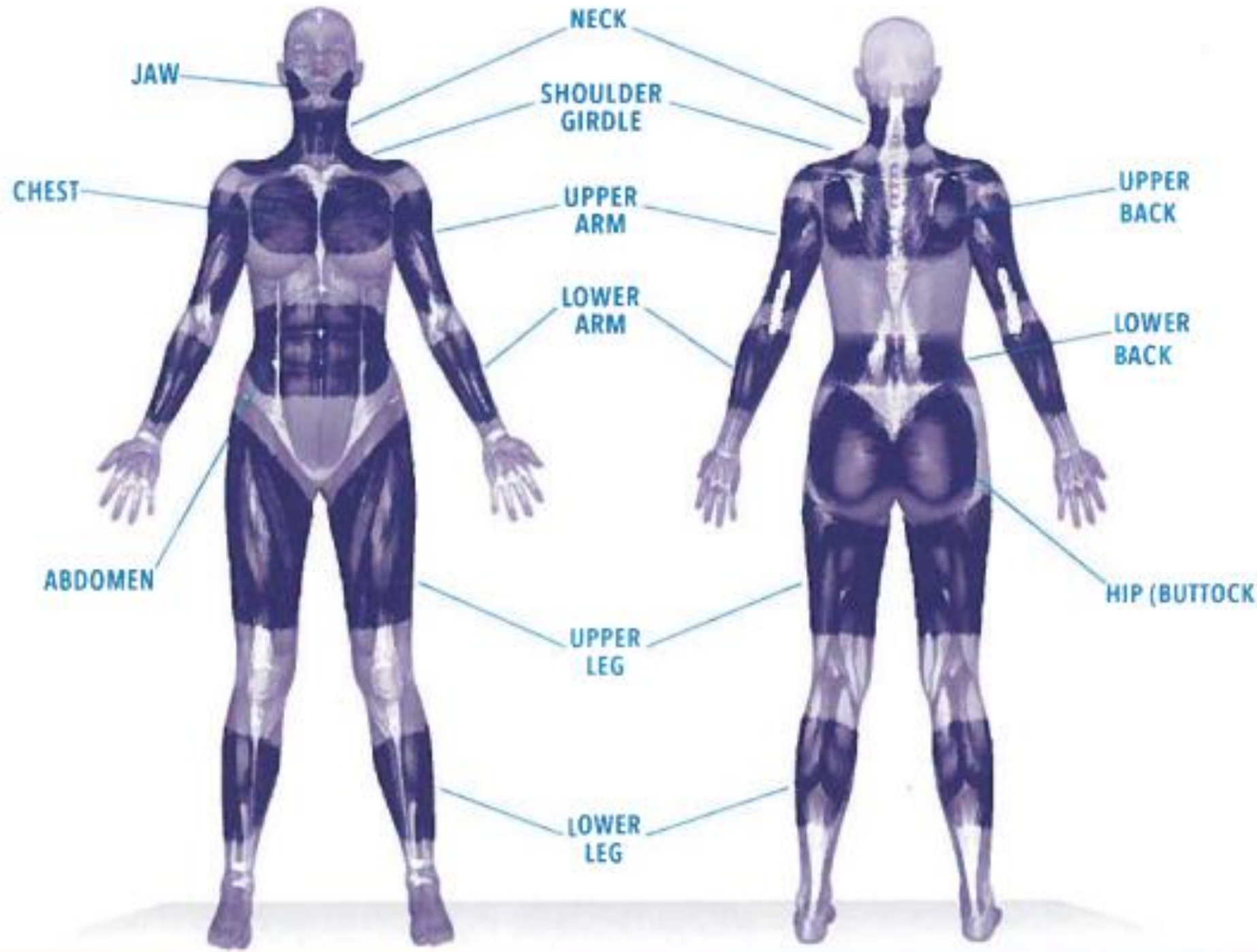
Diagnosis

Symptom Severity Score

Identify the areas where the patient felt pain over the **past week**

☐ Shoulder girdle, left	☐ Lower arm, right	☐ Lower leg, left	☐ Abdomen
☐ Shoulder girdle, right	☐ Hip (buttock), left	☐ Lower leg, right	☐ Neck
☐ Upper arm, left	☐ Hip (buttock), right	☐ Jaw, left	☐ Upper back
☐ Upper arm, right	☐ Upper leg, left	☐ Jaw, right	☐ Lower back
☐ Lower arm, left	☐ Upper leg, right	☐ Chest	

- Waking Unrefreshed?
- Cognitive Symptoms?
- Fatigue?



Other somatic symptoms

☐ Muscle pain	☐ Depression	☐ Itching	☐ Dry eyes
☐ Irritable bowel syndrome	☐ Constipation	☐ Wheezing	☐ Shortness of breath
☐ Fatigue/tiredness	☐ Pain in upper abdomen	☐ Raynaud's	☐ Loss of appetite
☐ Thinking or memory problem	☐ Nausea	☐ Hives/welts	☐ Rash
☐ Muscle weakness	☐ Nervousness	☐ Ringing in ears	☐ Sun sensitivity
☐ Headache	☐ Chest pain	☐ Vomiting	☐ Hearing difficulties
☐ Pain/cramps in abdomen	☐ Blurred vision	☐ Heartburn	☐ Easy bruising
☐ Numbness/tingling	☐ Fever	☐ Oral ulcers	☐ Hair loss
☐ Dizziness	☐ Diarrhea	☐ Loss/change in taste	☐ Frequent urination
☐ Insomnia	☐ Dry mouth	☐ Seizures	☐ Bladder spasms

Based on the quantity of symptoms, the patient's score is:

☐ 0 = No symptoms	☐ 2 = A moderate number of symptoms
☐ 1 = Few symptoms	☐ 3 = A great deal of symptoms

Diagnosis

- **No** blood test (yet).....
- **Exclude other things** that mimic i.e. arthritides, muscle wasting disorders, lupus, kidney failure, thyroid disorder, liver disease, drugs, diabetes etc.
- FBC, LFTs, TFTs, CK, CRP, ESR, Clotting, HbA1C, U+Es, Ca²⁺, Mg²⁺, (Vit D), Cortisol, RhF, (ANCA) ----> B12, Folate, Iron Saturations, Pituitary Screens, Lupus Anticoagulant, Gamma GT

Questions?



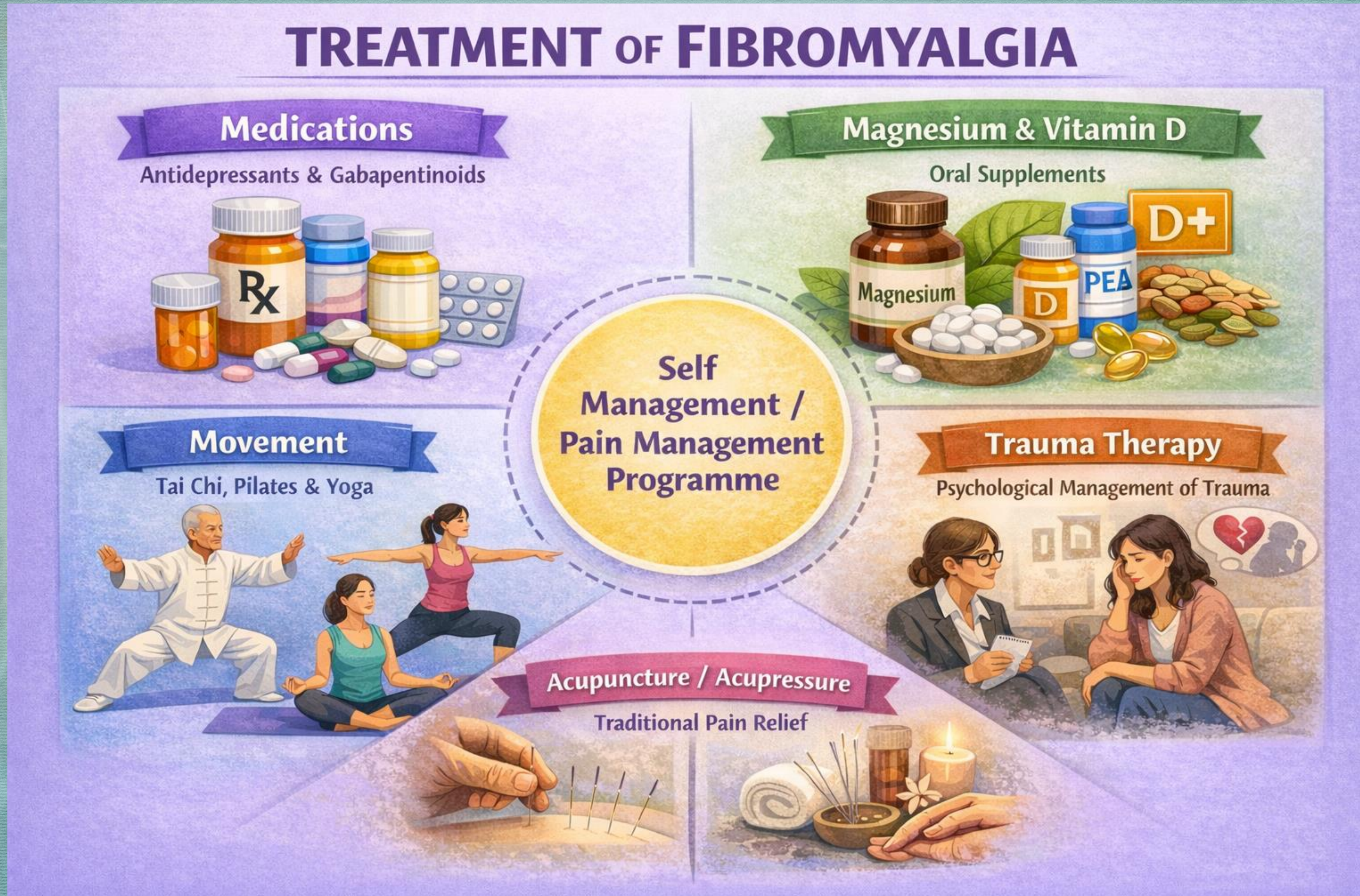
Treatment



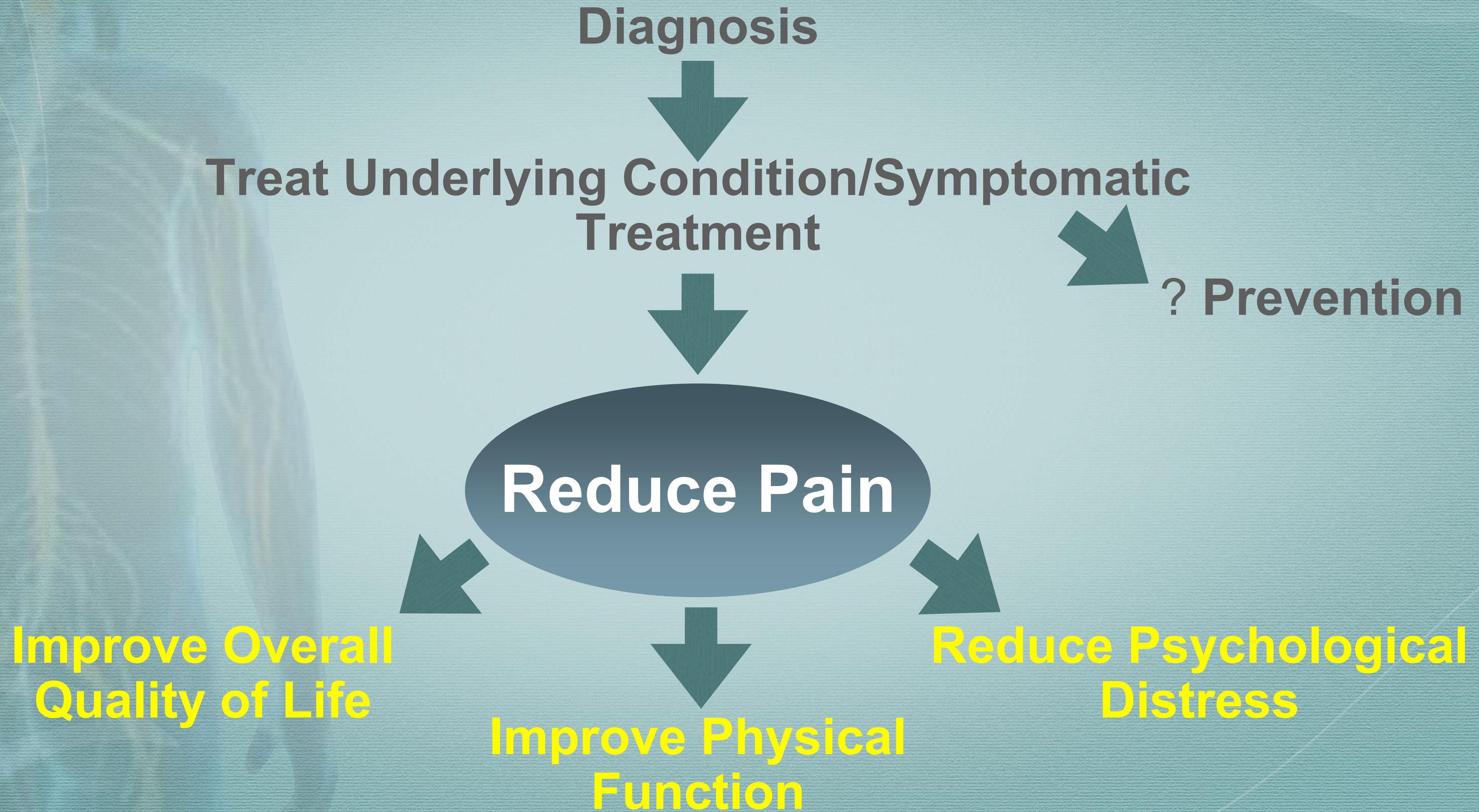
“Tame the Beast”

<https://www.tamethebeast.org/#tame-the-beast>

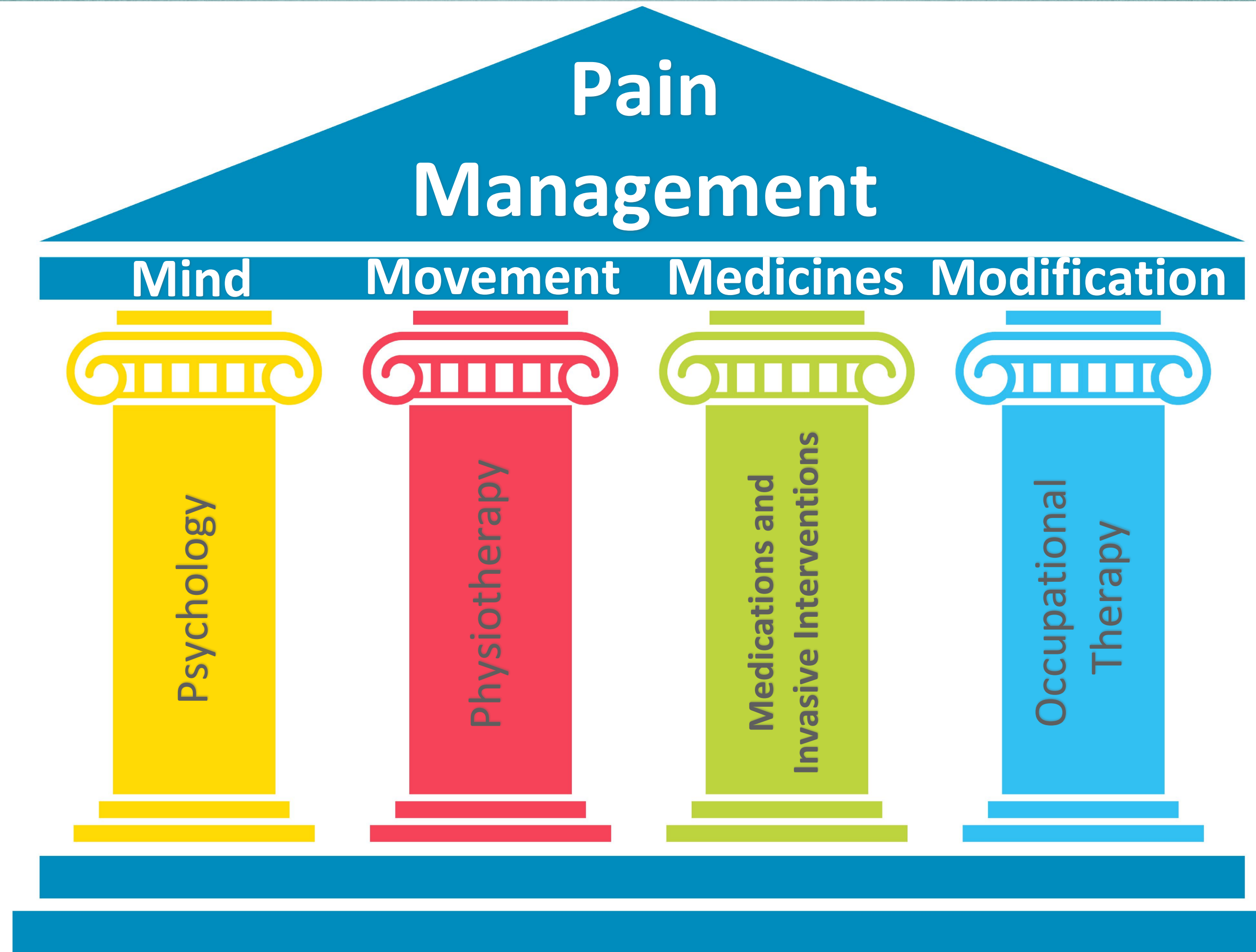
Treating Fibromyalgia: Goals



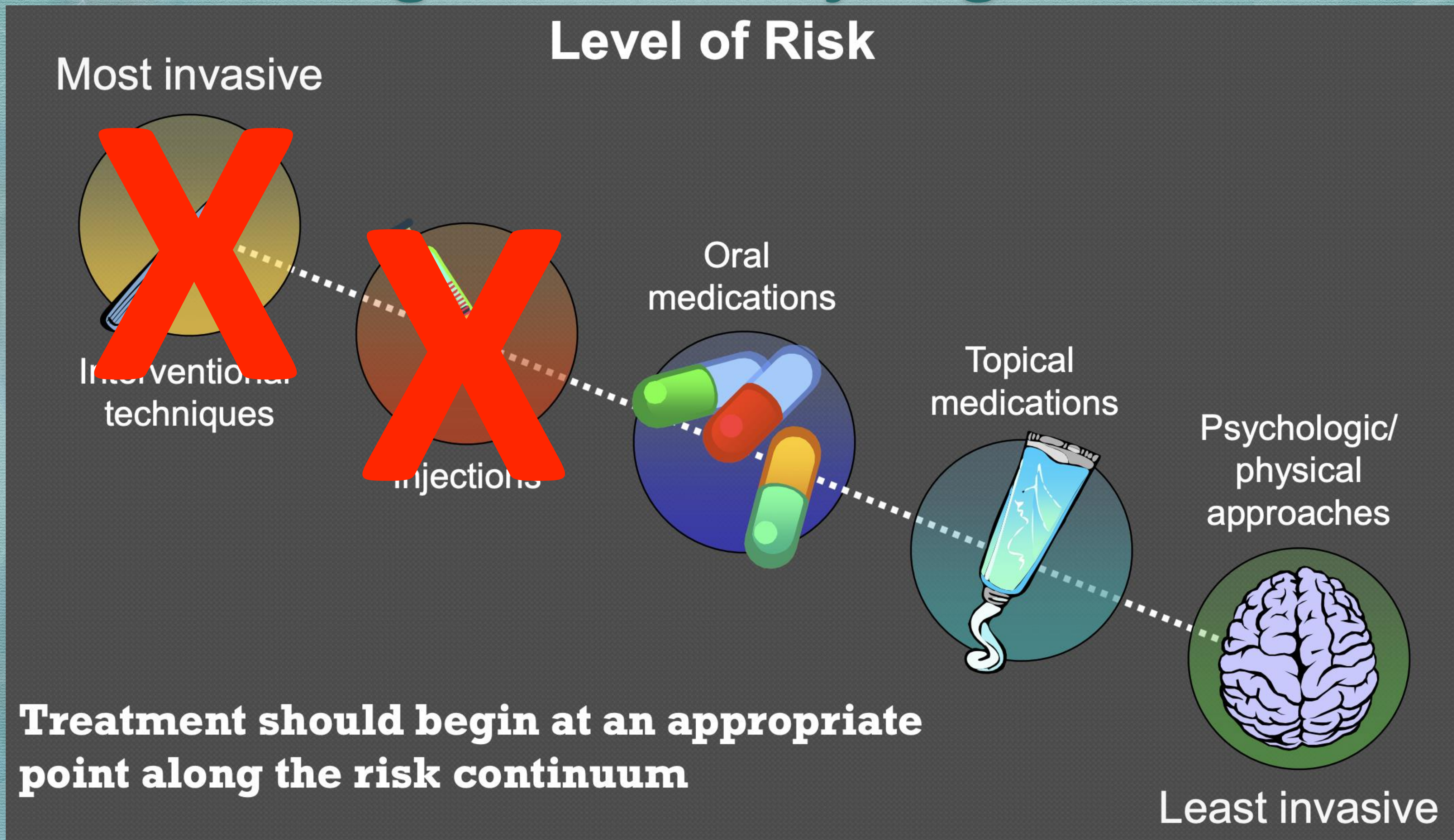
Treating Fibromyalgia: Goals



Treating Fibromyalgia: 4 Ms & 4 Pillars



Treating Fibromyalgia: Risks



Treating Chronic Pain: What We Do

- Chronic pain costs the UK £10-12 billion per year
- 20-40% GP appointments are related to chronic pain

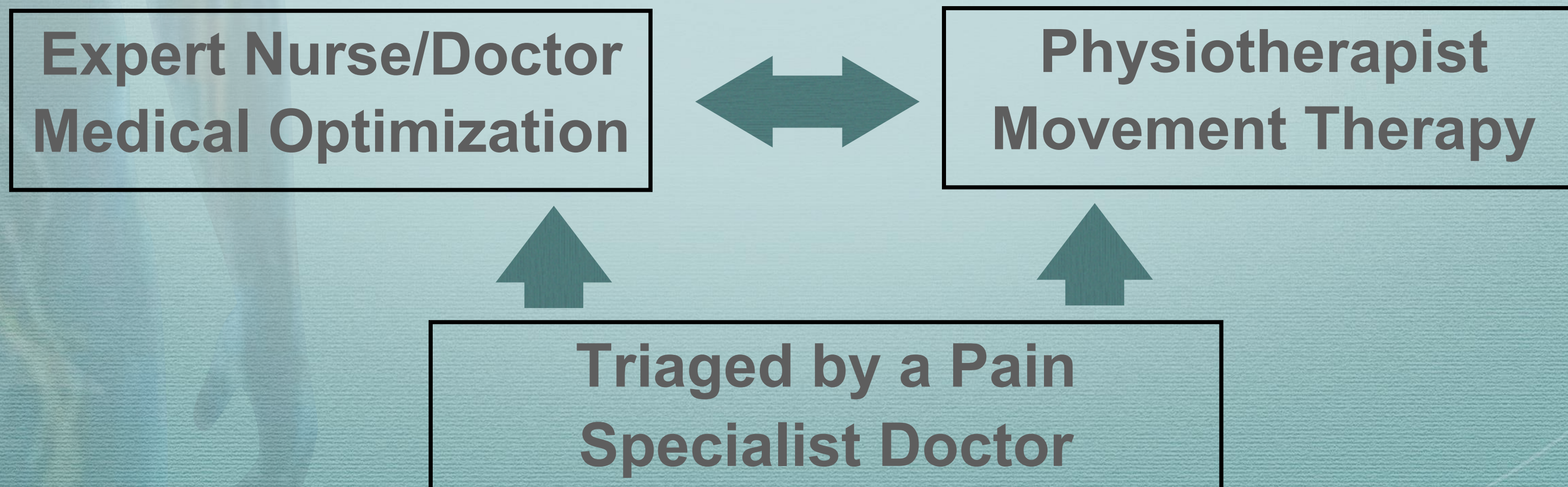
- Sheffield Teaching Hospitals Pain Service:

- 4 consultants
- 7 clinical nurse specialists
- 2 physiotherapists
- 2 occupational therapists
- 2 psychologist/psychiatrist

- 10,000 appointments per year
- Waiting time 1 year and growing

• Commissioned 2000 new patients
• 6000+ /year referrals
• 4000 acceptances
• ?!?!?!?!?!?
• 52 week wait

Treating Chronic Pain: What We Do

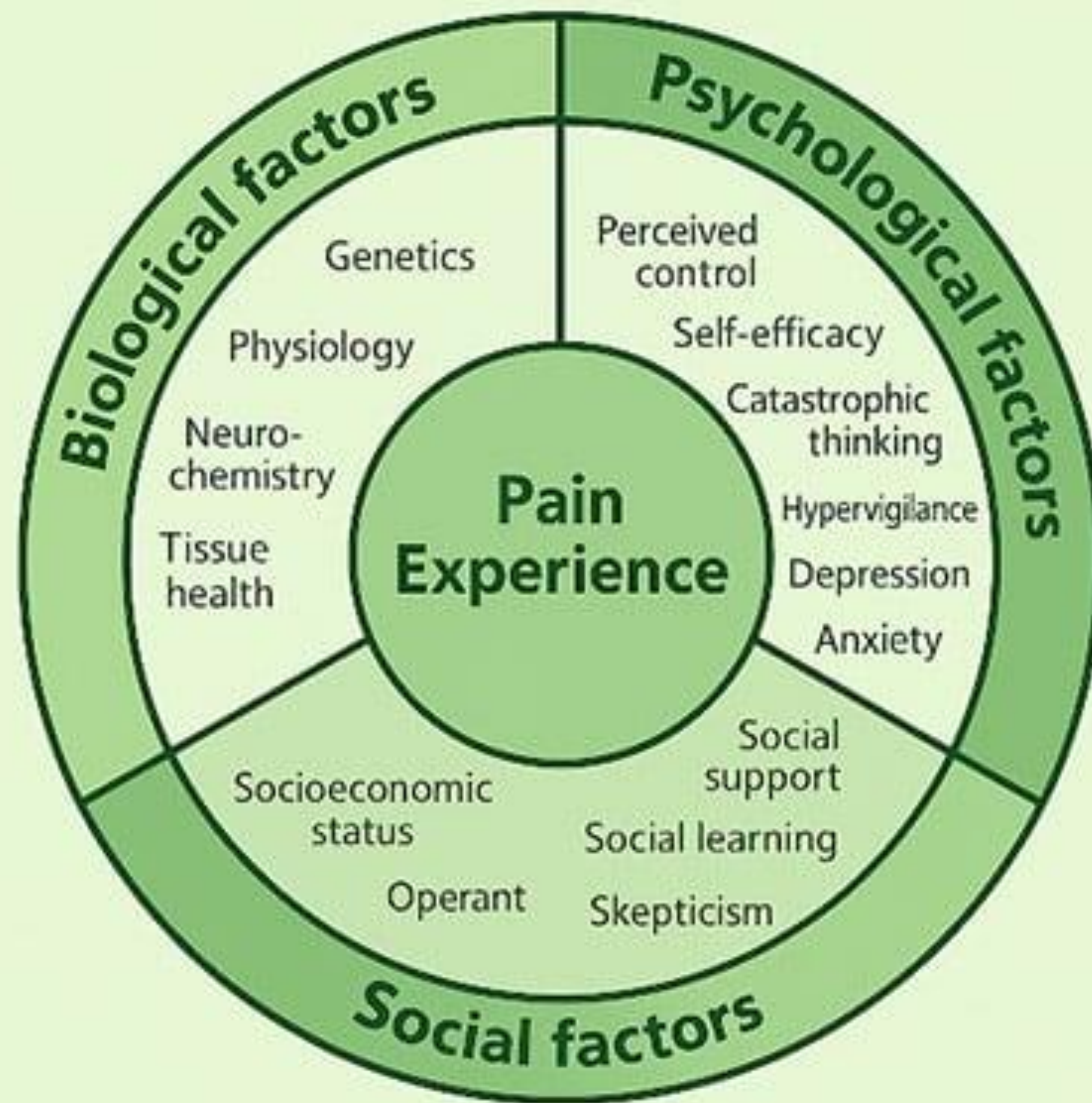


Treating Chronic Pain: What We Do

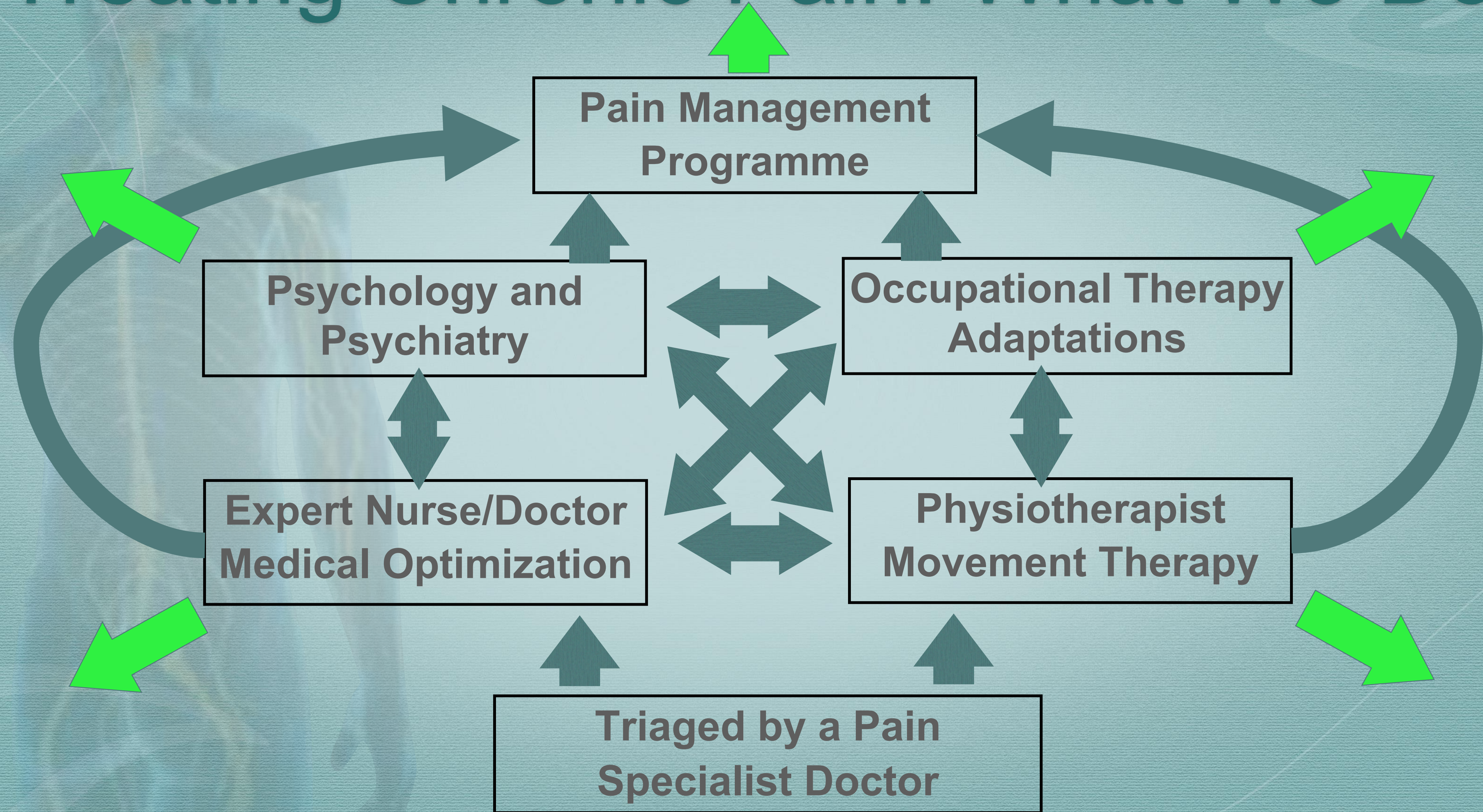
The first appointment will be an assessment with a Pain Consultant/ Nurse/ Physio which will include:

- Discussion about current pain
- Your current medication
- Past medical history
- Ways you have tried to manage your pain
- Impact on day-to-day living
- Expectations of pain management
- Individualized agreed plan to manage pain

Treating Chronic Pain: What We Do

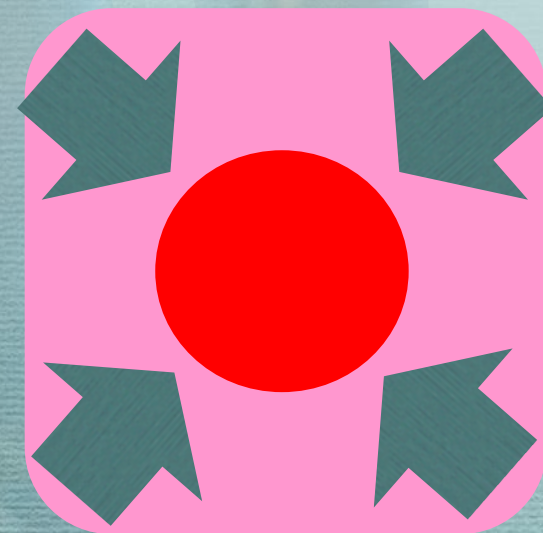


Treating Chronic Pain: What We Do



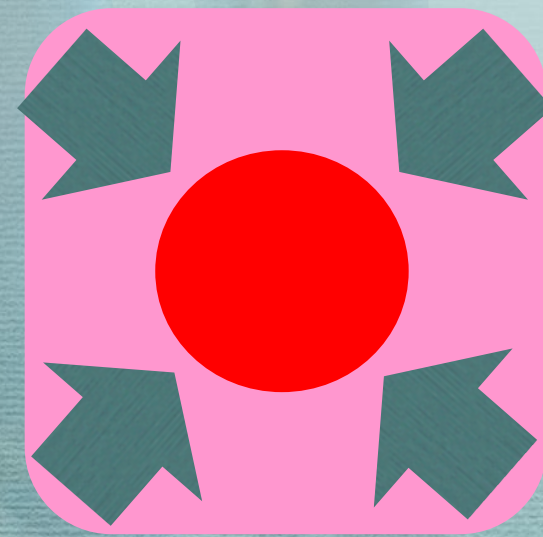
Treating Chronic Pain: What We Do

- Focus **more** on **living**, and **less** on **existing**
- Diagnosis less important – it becomes about the **symptoms** that are **important to patients**



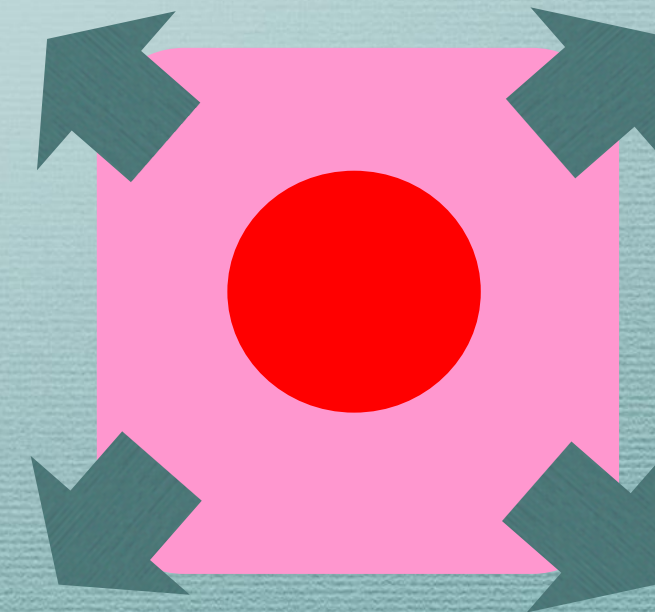
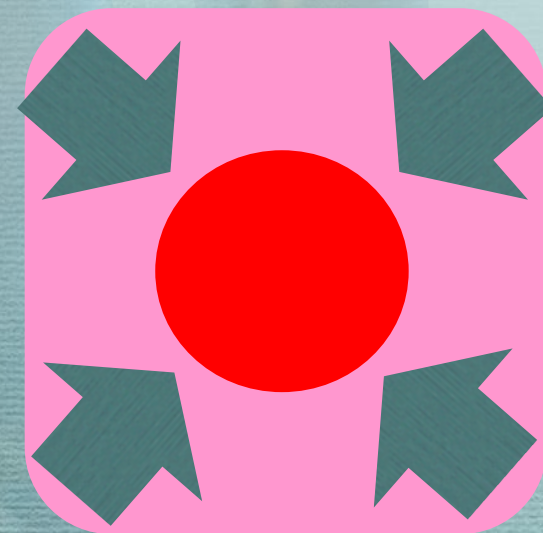
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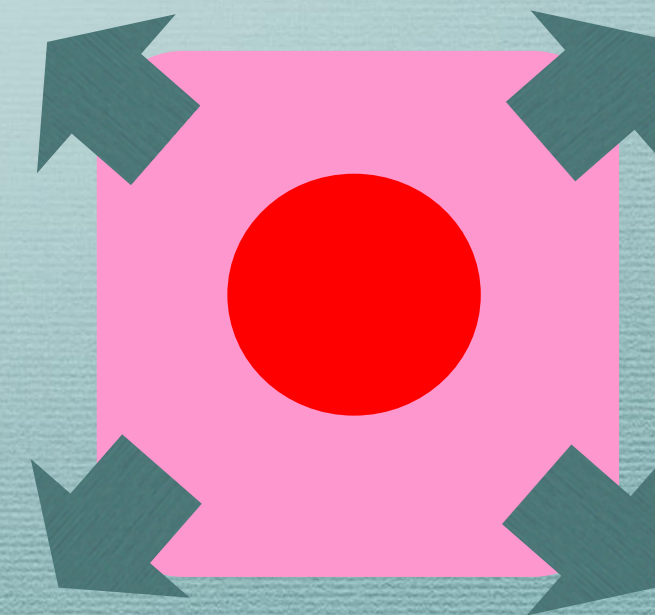
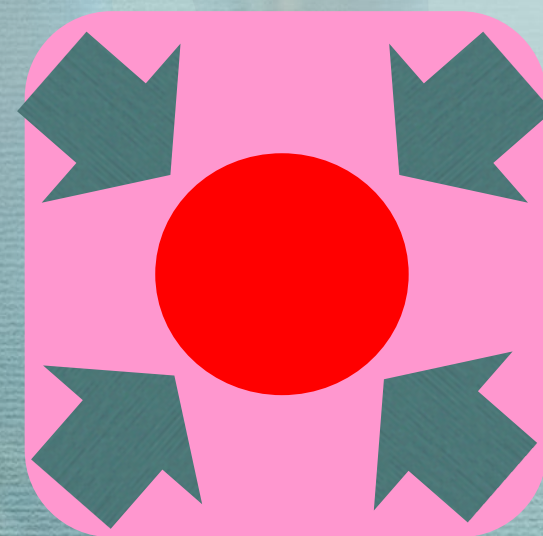
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Treating Chronic Pain: What We Do

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Treating Chronic Pain: What We Do

- Focus **more** on **living**, and **less** on **existing**
- Diagnosis less important – it becomes about the **symptoms** that are **important to patients**
- **Range of techniques** – TENS, Breathing, Relaxation, Movement, Mirrors, Adaptation, Pacing, Education, Medication, Injections, Mindfulness, Patches, Sleep, CBT etc.
- **Everyone is different**, and **not everything works for everyone**

Treating Chronic Pain: What We Do

- Providing a space to share experience of living with pain
- Improving understanding of chronic pain and why it can't be fixed
- Reduce overall impact of pain on life, moving towards improved quality of life
- Explore ways to manage stress caused by pain
- Increase confidence in gentle movement
- Helping people manage setbacks and flare-ups
- Exploring ways of communicating effectively with others about pain
- Provide a range of practical strategies to manage pain

Treating Chronic Pain: What We Do

- We cannot promise to reduce your pain
- ***But we do promise to try our best to work with you to help you manage your pain better***
- We cannot promise you will like everything we advise you
- ***But we do promise to be open and honest with you about what is achievable, even if this is hard or frightening for you, and we will be there to support you through the difficult steps***

Treating Chronic Pain: What We Don't Do

- **We do not prescribe**
- *Medication changes come through your GP*
- **We are not a diagnostic service**
- *Ideally your scans and investigations are complete so we can concentrate on your symptom management. We may need to send you for further investigations if your diagnosis is uncertain*
- **We do not offer cures**
- *We concentrate on symptom management to help you live more and get back into work where possible. Often there is no cure for pain. If you still feel like you need further investigation to help you find a “cause or cure” then Chronic Pain Management is not for you, and you should seek further input from your GP*

Treating Chronic Pain: What We Don't Do

- **We do not give you what you may think you want**
- *But we do give you what you need*



Who To Refer?: What We Don't Do

Hydrotherapy

Repeat referrals

Cure Pain

Acupuncture

Standalone
Psychology
Service

“EDS Pain
Management
Programme”

“Fibromyalgia
Clinic”

Who To Refer?: What We Don't Do Those Who Don't Do So Well.....

- Looking for a cure
- Seeking further assessment/opinion
- Those who investigations aren't complete (e.g. dual referral to Pain Clinic and spinal orthopaedic team)
- Those who have a passive approach to Pain Management
- “I'll do anything...but I won't do that”
- Lots of social/psychological/medical competing factors whereby they can't devote time to investing in the process

Who To Refer?: What We Do

Who to refer?

More emphasis
on the
biopsychosocial
approach

Curious about
trying a different
way

Those who have
already engaged
in some form of
appropriate
rehabilitation

Likely to benefit
from a
multidisciplinary
approach

Stuck
Despite actively
engaging in
rehabilitation

Treating Chronic Pain: What We Do

- **Is there a focal pain that we can inject to help?**
- **Risks:** infection, bleeding, bruising, failure, failure to help, worsening of pain, unmasking new pain, allergic reaction, temporary or permanent nerve damage, organ damage, damage to surrounding structures, COVID-19, (Steroid)
- **NOT A CURE**
- **Aims:** 3-6 months of reduced pain to help you engage with physiotherapy
- **Radiofrequency? Up to 2 years – NOT A CURE**
- (Even if injections work, 30-40% of radiofrequency procedures fail).



Treating Fibromyalgia

- Is there a focal pain that we can inject to help?

- **Risks:** infection, bleeding, bruising, numbness, failure to help, worsening of pain, unmasking new pain, allergic reaction to temporary or permanent nerve damage, organ damage, damage to surrounding structures, COVID-19, (Steroid)

- **NOT A CURE**

- **Aims:** 3-6 months of reduced pain to help you engage with physiotherapy

- **Radiofrequency:** Up to 2 years – **NOT A CURE**

- (Even if no prior work, 30-40% of radiofrequency procedures will help)



Treating Chronic Pain: What We Do

- **Is there a Medication that can help?**
- **4 Main Types: Antidepressants, Gabapentinoids, Opioids, Relaxants**
- **NOT A CURE**
- **Aims: 10-30% reduction in pain to help you engage with physiotherapy**
- **All come with side effects: addiction, sedation, stop working eventually**
- **Everyone is different: Bespoke Regimes**



Treating Fibromyalgia

- Is there a Medication that can help?

- 4 Main Types: Antidepressants, Gabapentinoids, Opioids, Muscle Relaxants

- NOT A CURE

- Aims: 10-30% reduction in pain to help you engage with physiotherapy

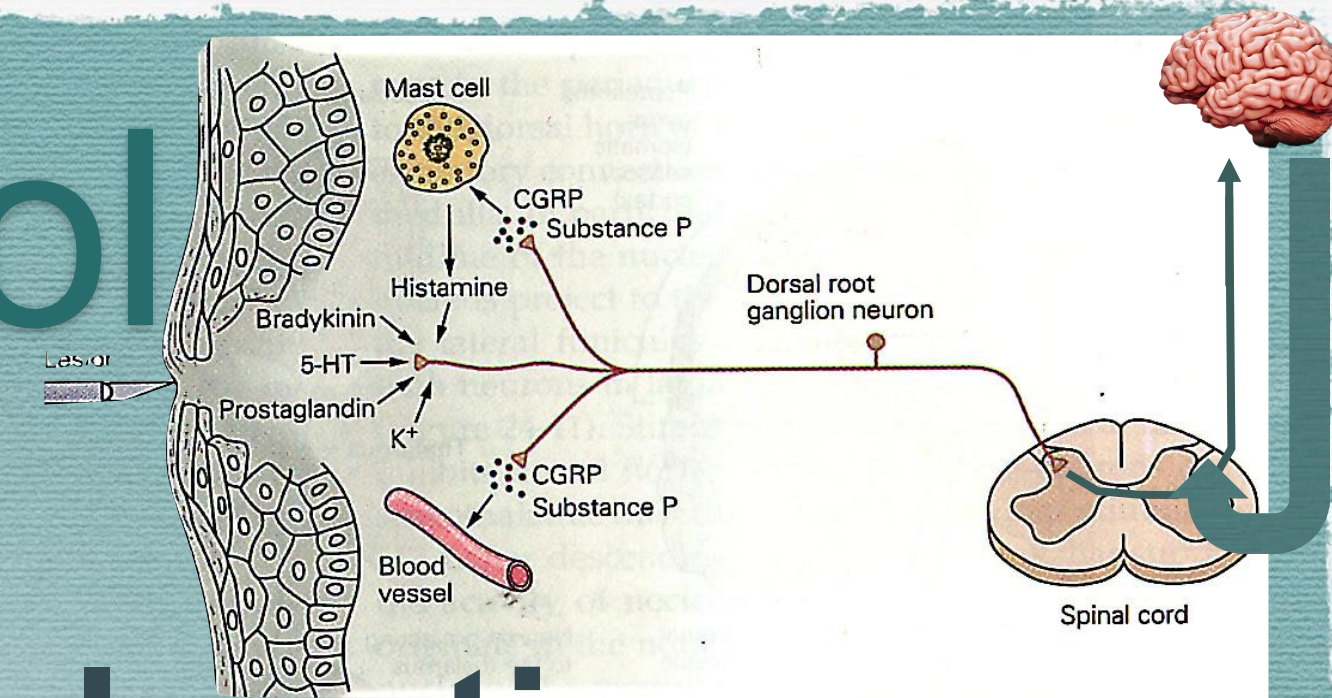
- All come with side effects: drowsiness, sedation, constipation, etc. eventually

- Everyone is different. Be open to Recommendations



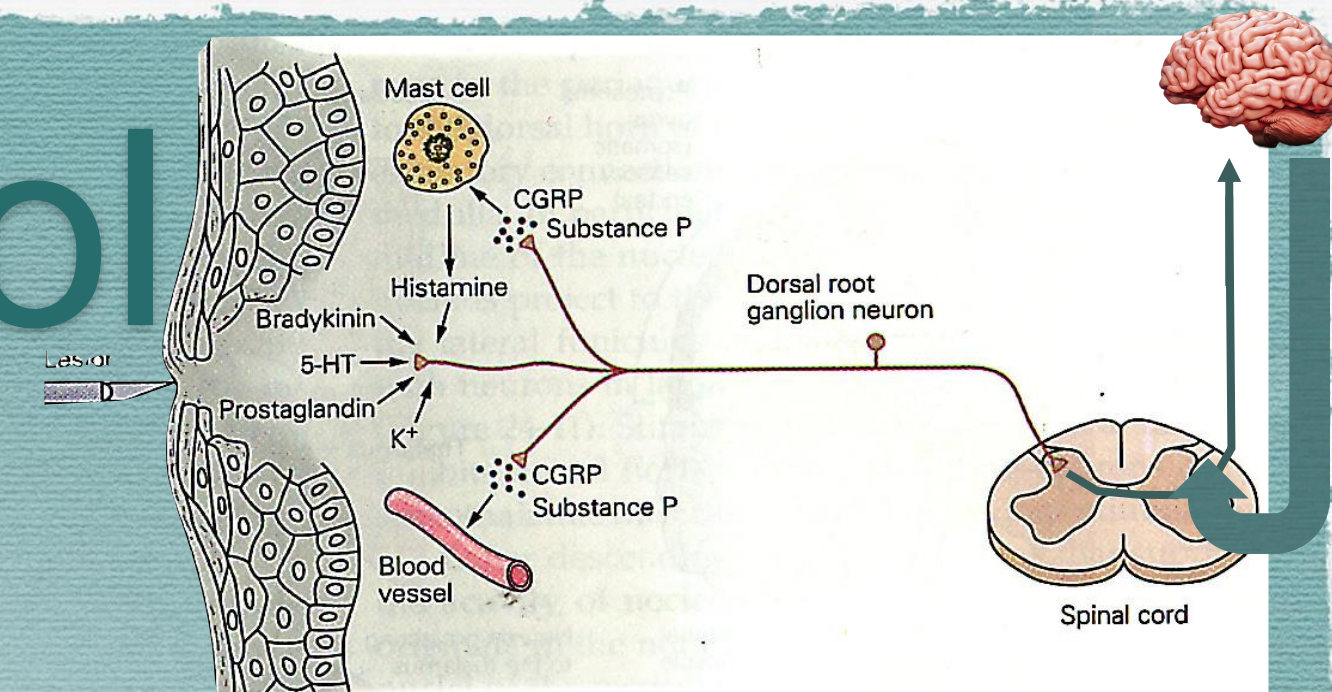
WORK

1. Descending Control



- **Antidepressants – amitriptyline, duloxetine, venlafaxine (tramadol, tapentadol, fentanyl)**
- Help neuropathic/nociplastic pain by increasing 5HT and/or noradrenaline availability, enhancing descending pathways
- Most are reuptake inhibitors
- Take weeks to have full effect, but secondary effects e.g. sedation, opioid effects are often useful in acute setting
- **Careful in:**
 - **Glaucoma:** worsens
 - **Elderly:** use reduced dose – anticholinergic effects (memory and bowels)
 - **Renal Failure:** use amitriptyline
 - **Liver Failure**
 - **Heart Failure** (worsens) and **Recent MI**
 - **Bowel Obstruction:** worsens
 - **Do not mix** – can worsen QT prolongation
 - **Do not mix** – can cause SSRI Syndrome

1. Descending Control



- All patients with fibromyalgia or complex widespread pain should be considered for a trial of antidepressants
 - I tend to use **Duloxetine** as can be titrated quickly, more easily absorbed, and twice daily dosing, antidepressant
 - Does some things the others don't
 - Really bad sickness

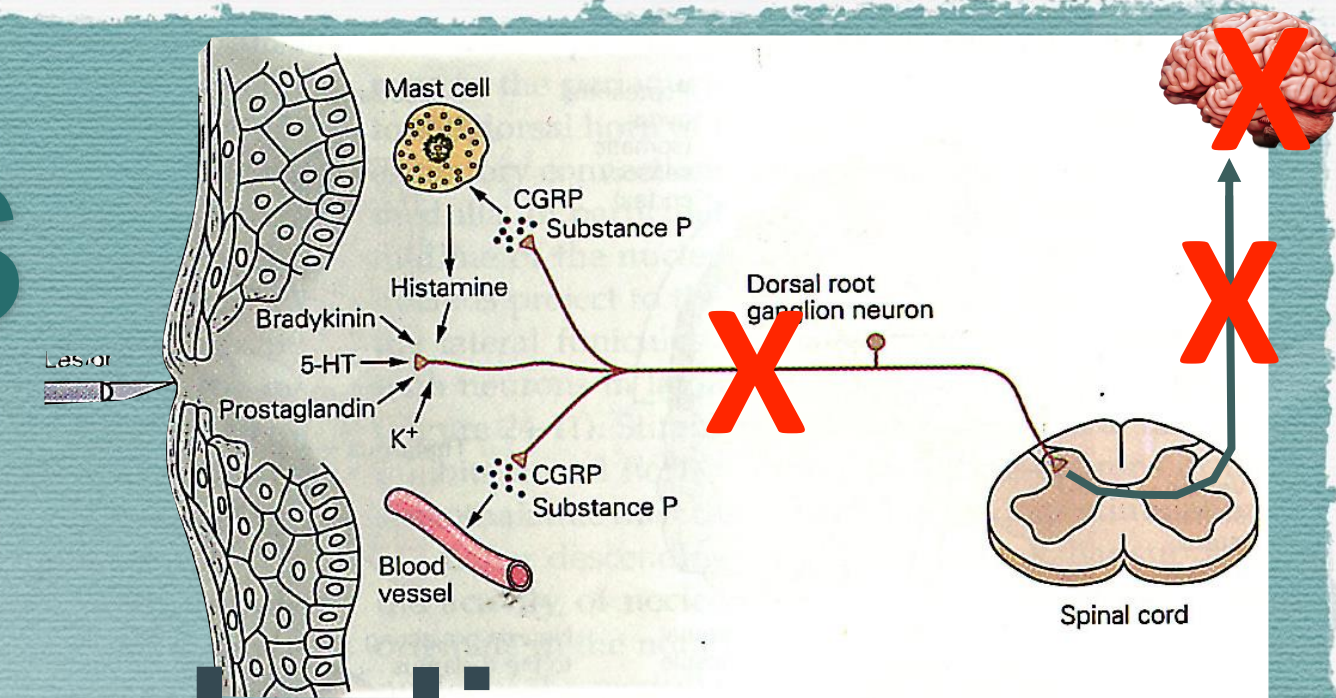


<https://vastoversdrugsandalliedproducts.com/product/teva-amitriptyline-amitriptyline-hydrochloride-10mg-x-10-film-coated-tablets/>



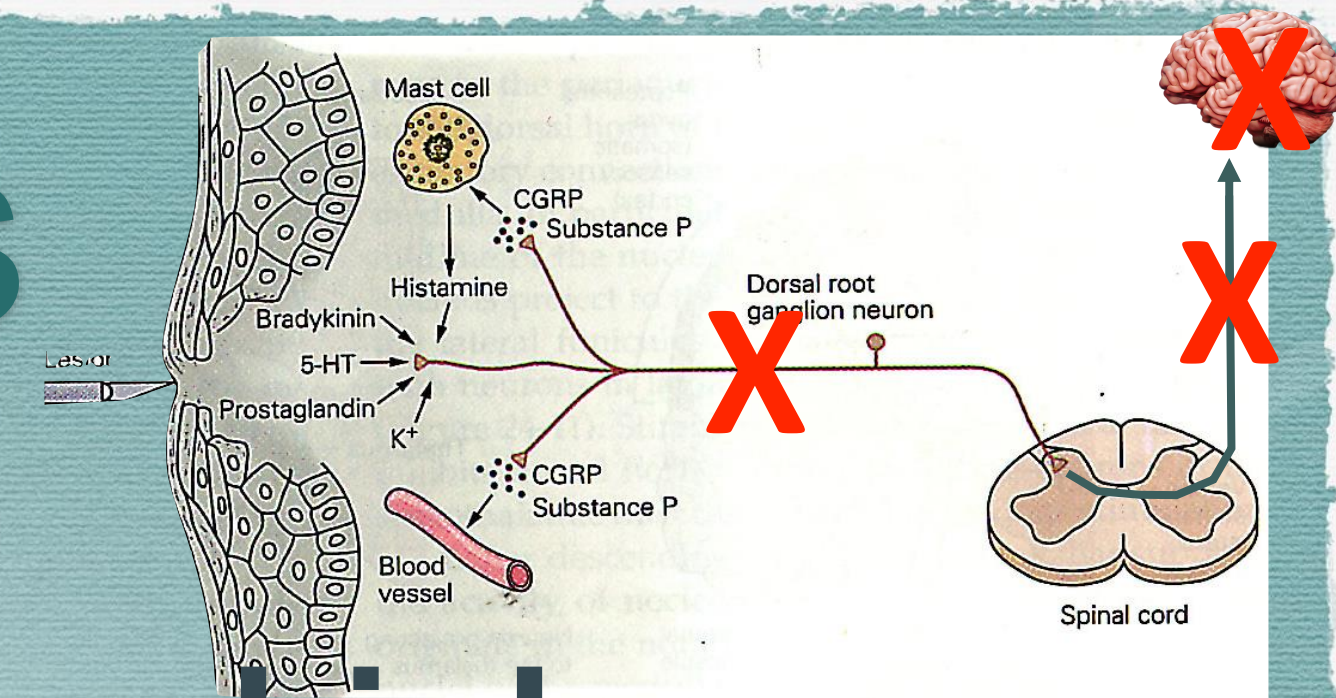
<https://www.medpagetoday.com/rheumatology/arthritis/96520>

2. Along the Nerves



- **Gabapentinoids – gabapentin, pregabalin**
 - Block Calcium Currents in nerves
 - Tend to work on overactive channels
 - Really work for neuropathic and nociplastic pain
- **Careful in:**
 - **Opioid Use:** have naloxone ready (worsens sedation and respiratory depression)
 - **Renal Failure:** use reduced dose
 - **Absorption Difficulties:** use Pregabalin
 - **Elderly**
 - **Heart Failure** (worsens) and **Ankle Swelling** (worsens)

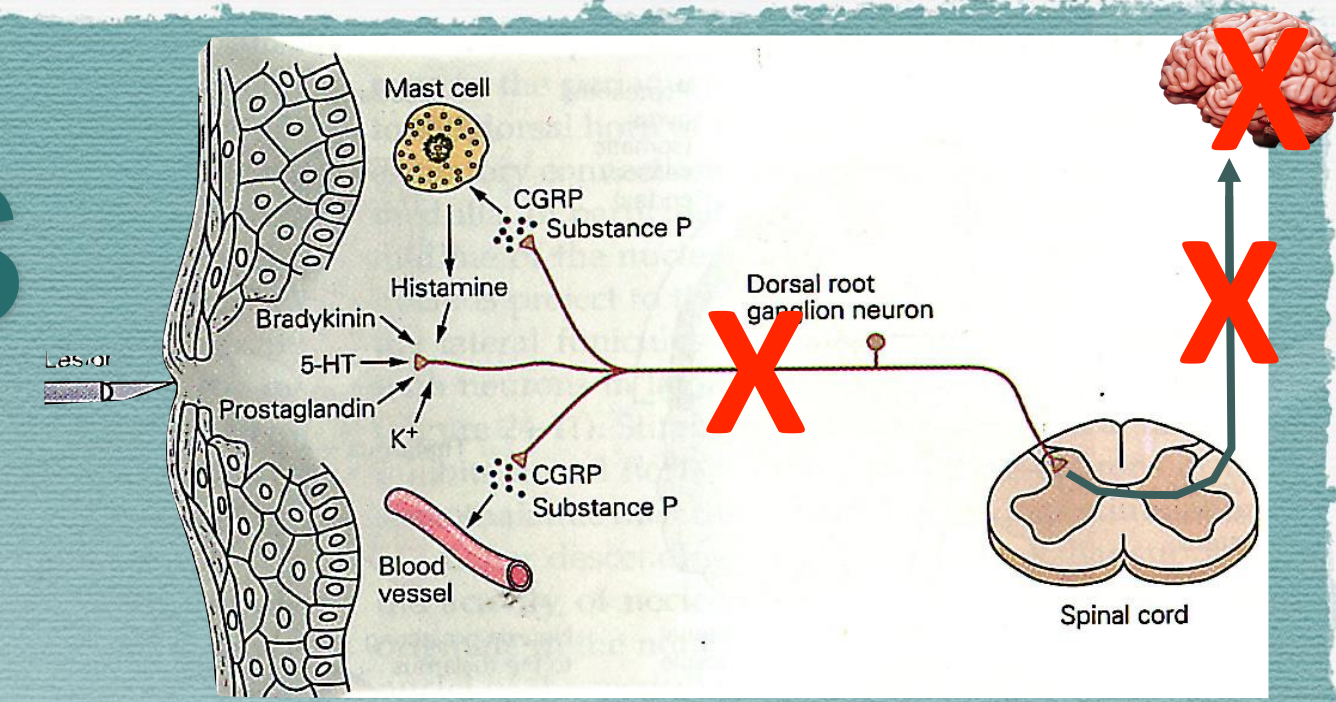
2. Along the Nerves



- All patients with neuropathic pain or high levels of anxiety can be considered for gabapentinoids
 - We tend to use pregabalin as can be titrated quickly, more easily absorbed, and twice daily dosing
 - Gabapentin may be more useful for spasm
 - Tend to **reduce need for opioids**

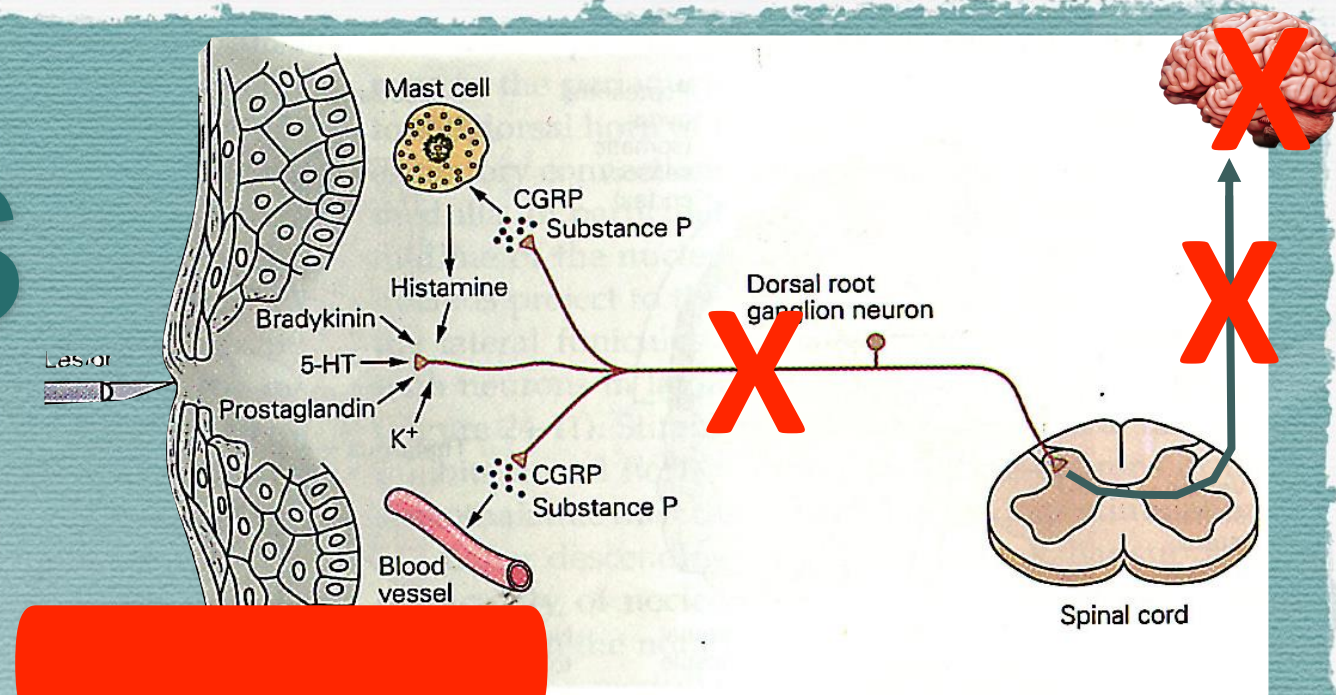


2. Along the Nerves



- **IV lidocaine**
 - Works well for neuropathic pain
 - Dangerous – risk of arrhythmia
 - Can give up to 3 months of pain relief
 - Can use in anaesthetics – need monitoring
 - Useful for when there is no regional anaesthetic, or when opioid use is high

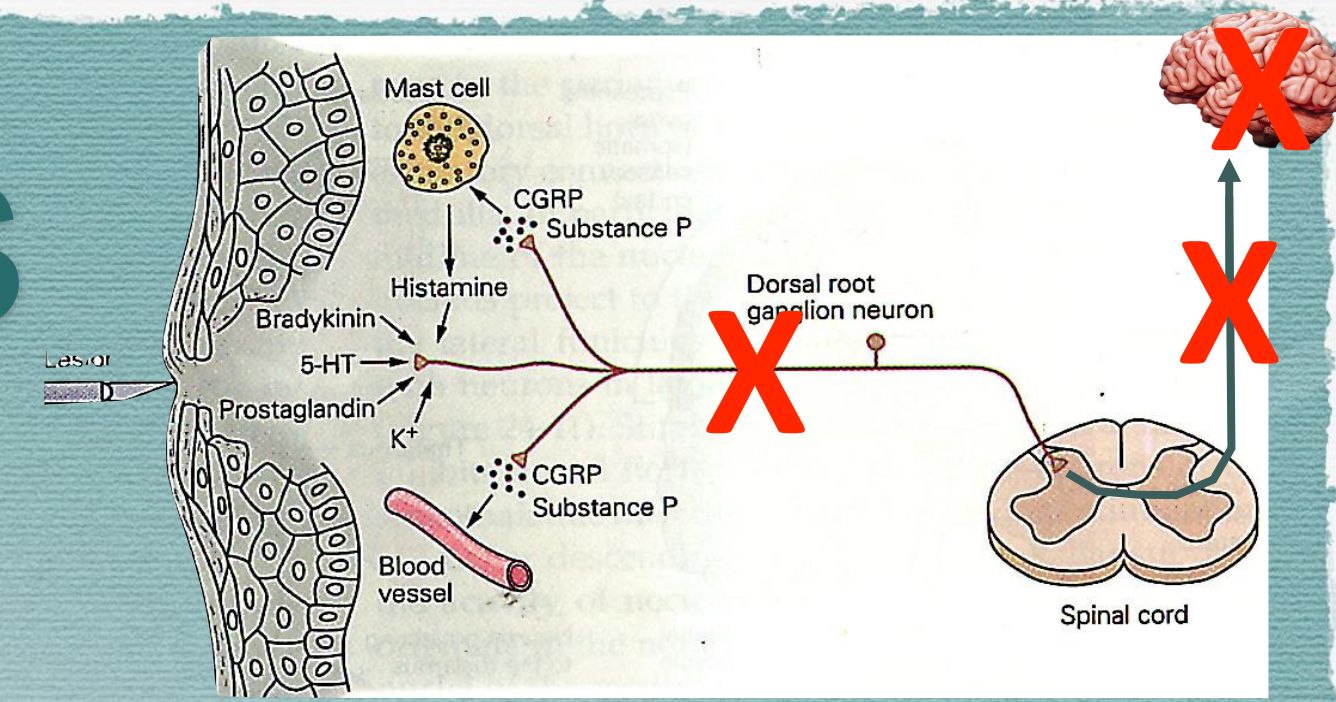
2. Along the Nerves



- **DO NOT** use in local anesthetic
- Works well for neuropathic pain
- Dangerous – risk of arrhythmia
- Can give up to 3 months of pain relief
- Can use in anaesthetics – need monitoring
- Useful for when there is no regional anaesthetic, or when opioid use is high

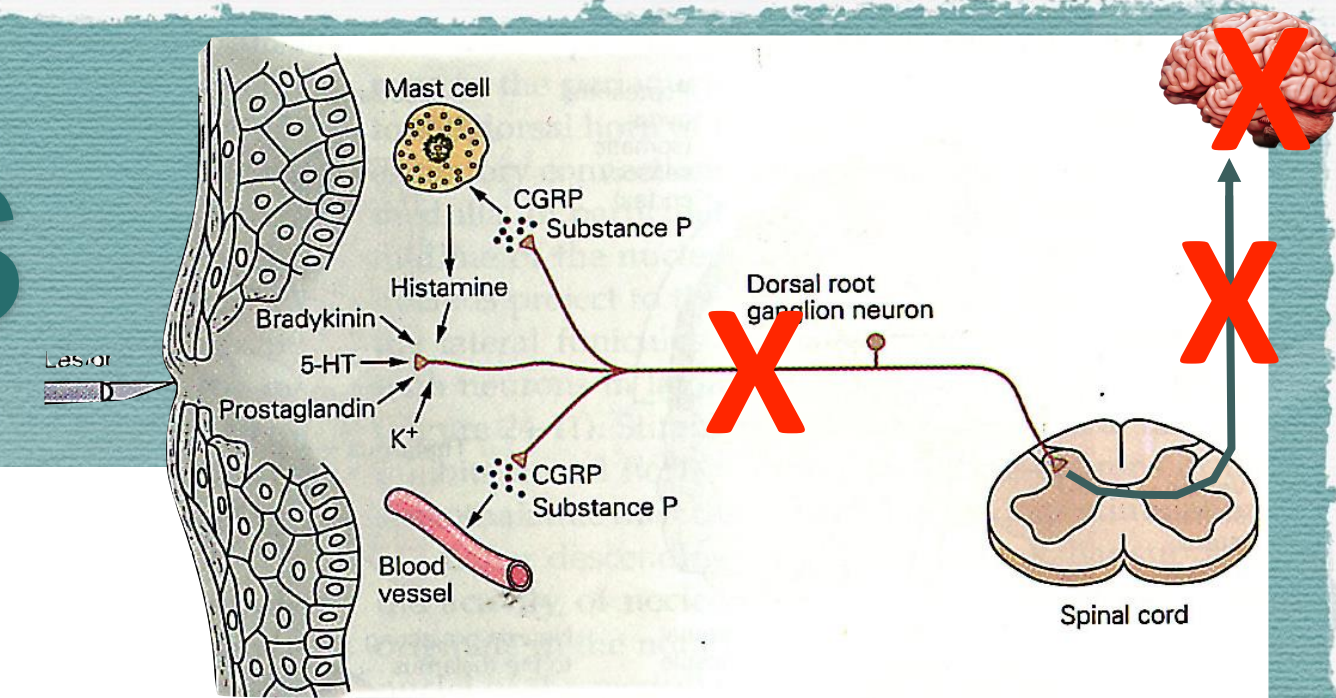
OFFER

2. Along the Nerves

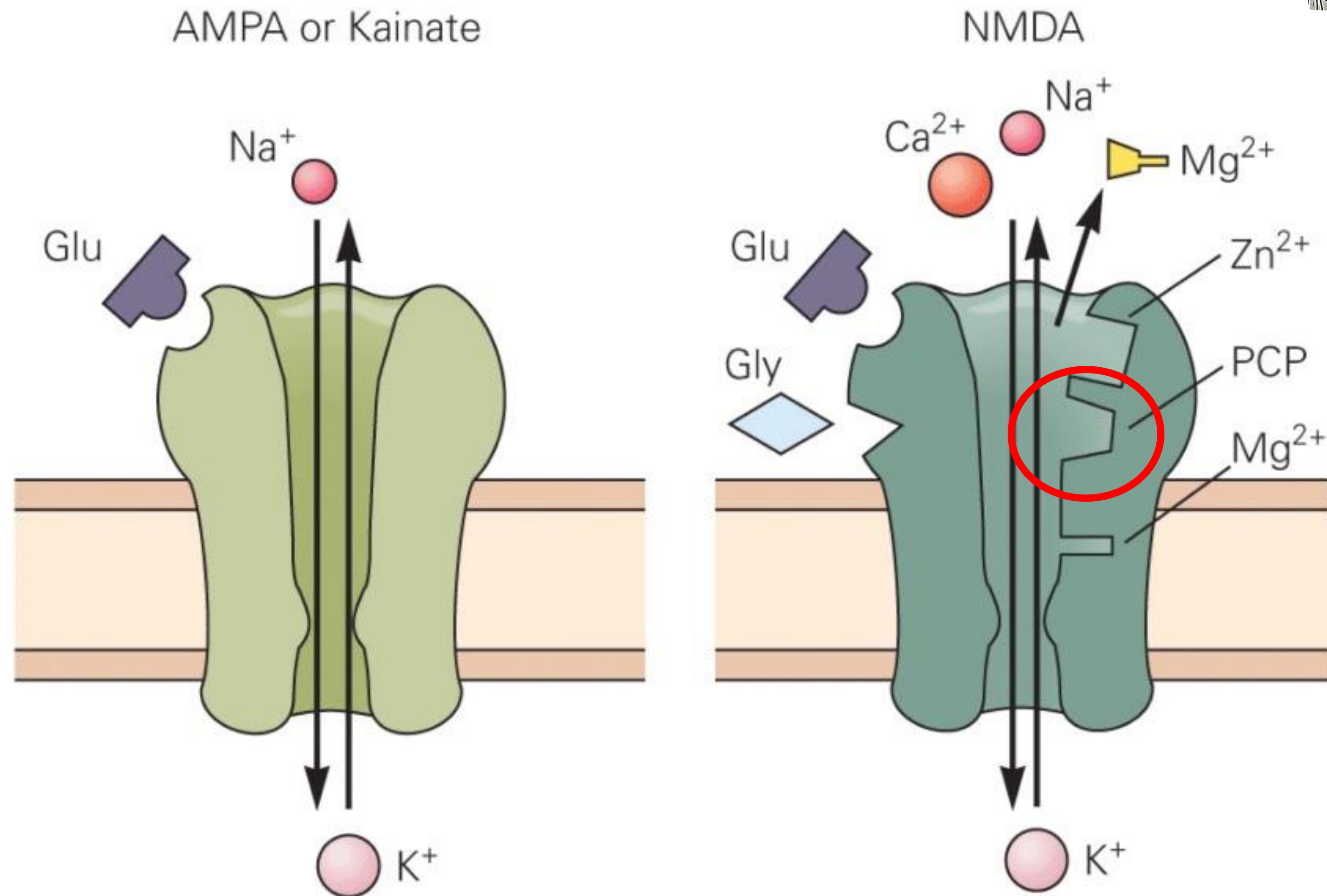


- **NMDA Blocker – Ketamine**
 - Dirty Drug – blocks lots of reuptake inhibitors, channels and receptors
 - Really works for neuropathic and nociplastic pain
 - Risk of Addiction
 - Risk of OD
 - Risk of Ketamine Bladder
 - Risk of Liver Failure
 - Tend to **reduce need for opioids**

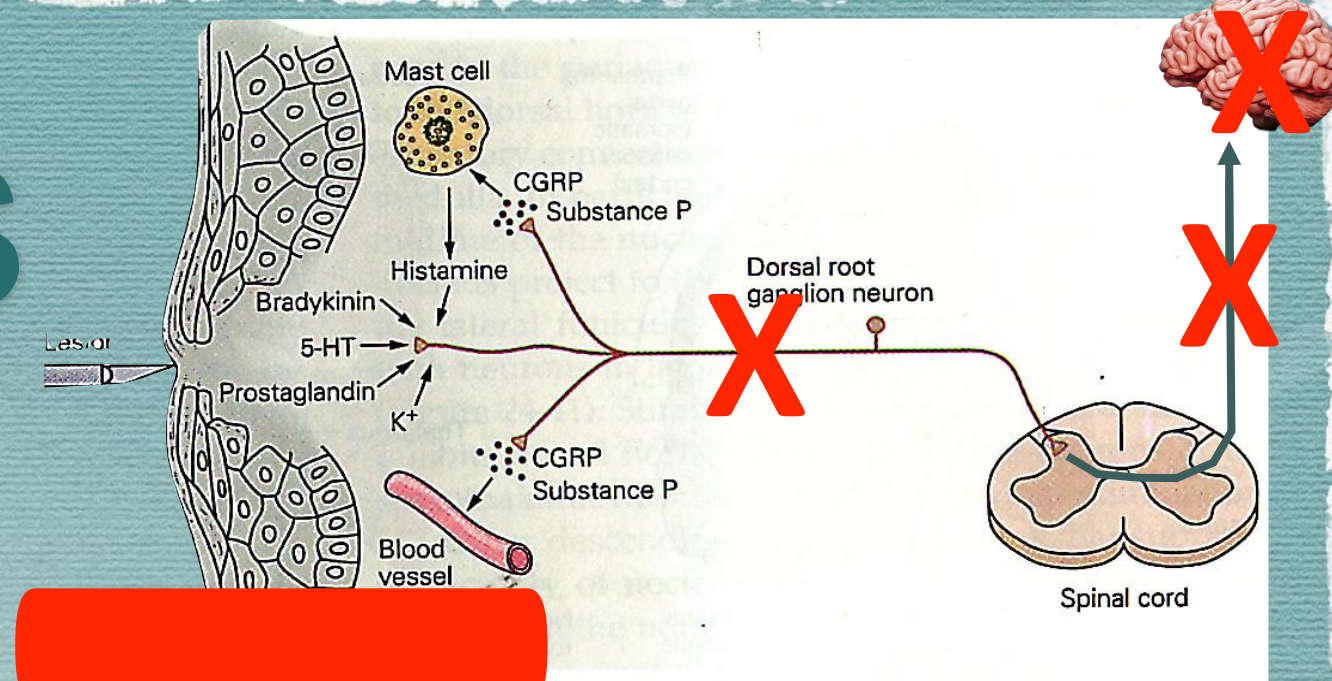
2. Along the Nerves



A Ionotropic glutamate receptor



2. Along the Nerves

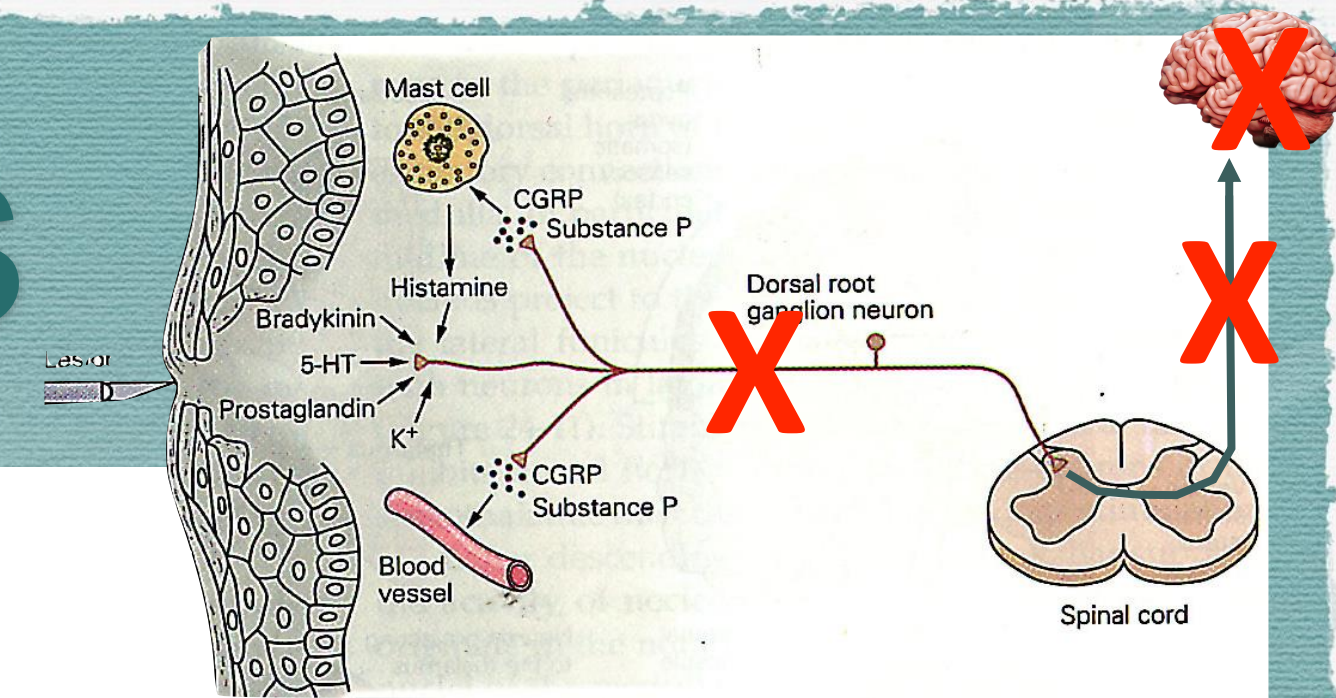


- **NM2A Flocur – Ketamine**
 - Dirty Drug – blocks lots of receptors like inhibitory, channels and receptors
 - Really works for neuropathic and nociceptive pain

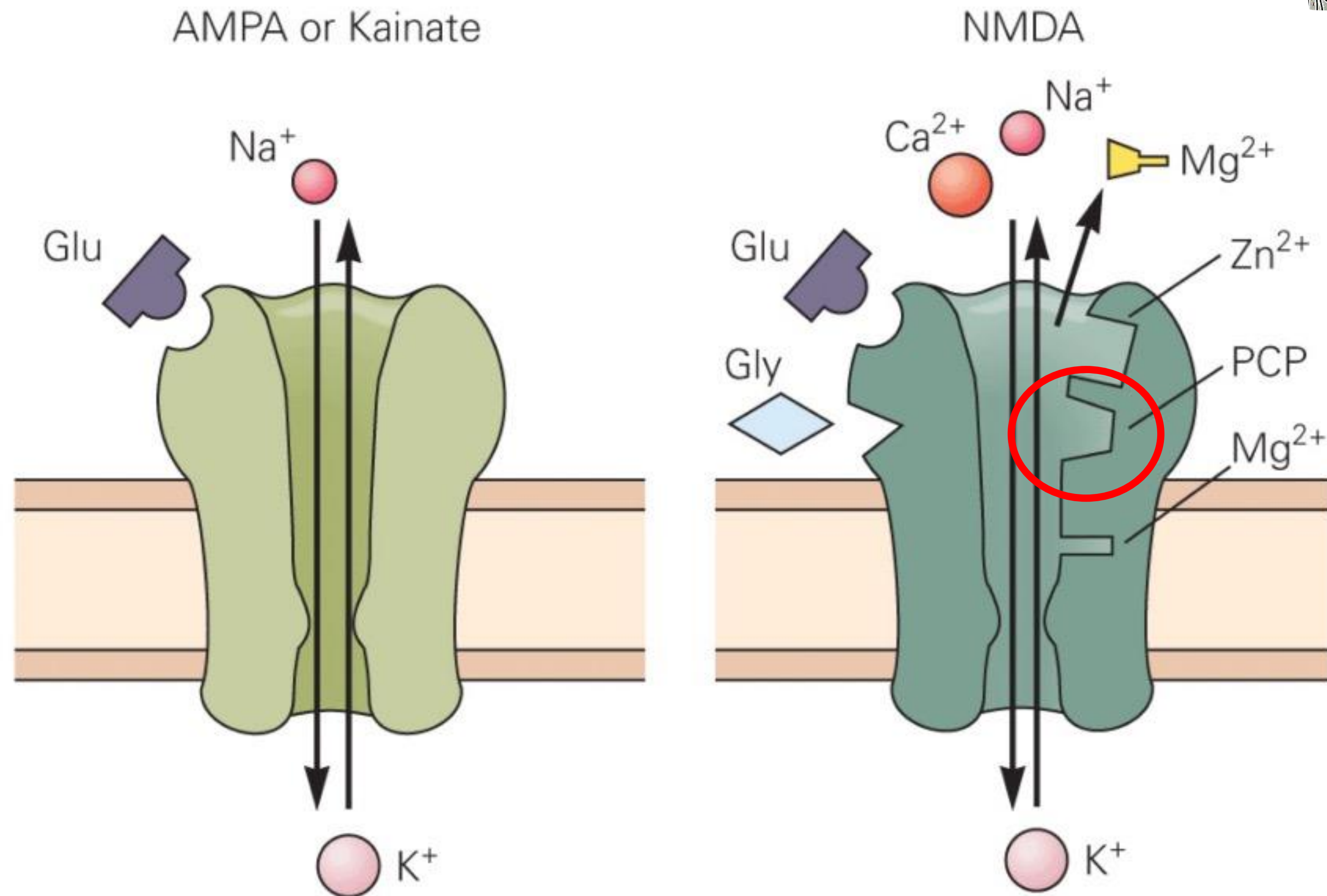
- Risk of Addiction
- Risk of OD
- Risk of Ketamine Bladder
- Risk of Liver Failure
- Tend to be neoplastic

DO NOT OFFER

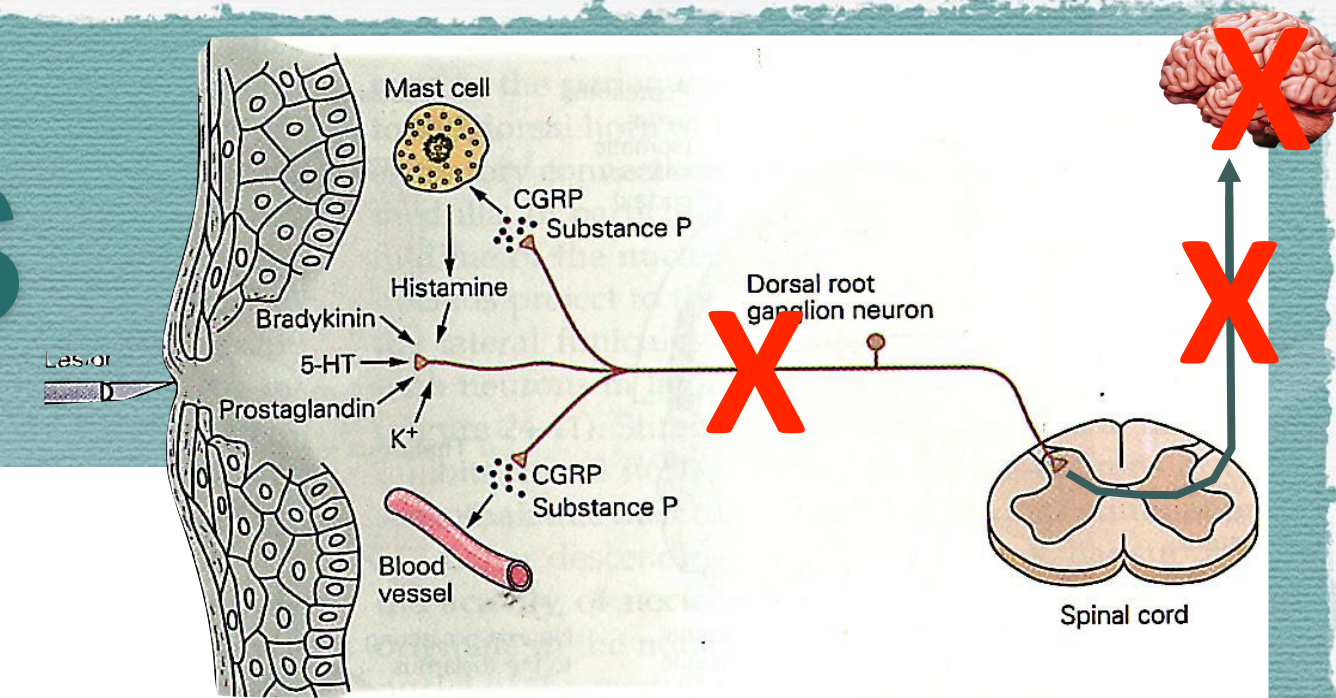
2. Along the Nerves



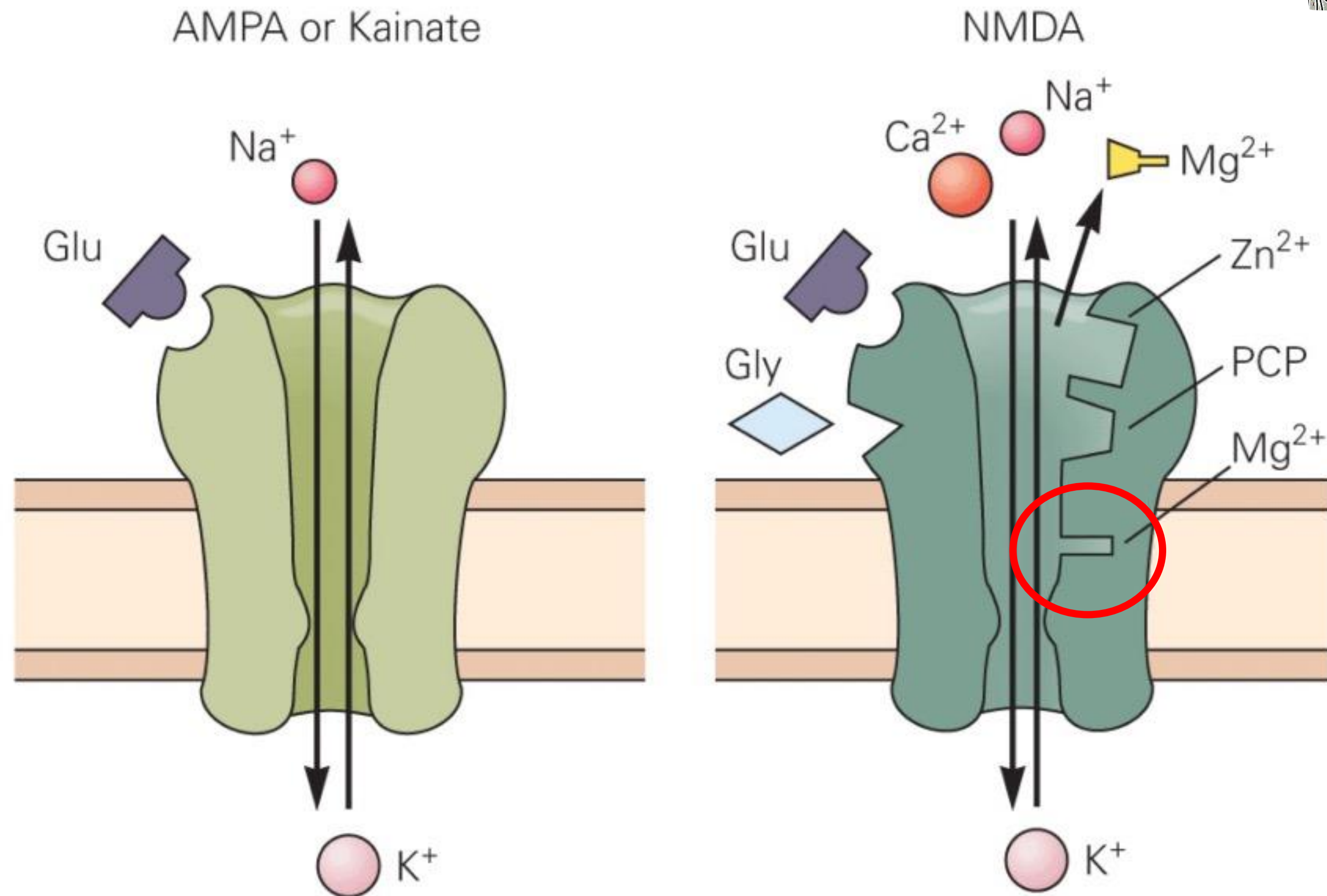
A Ionotropic glutamate receptor



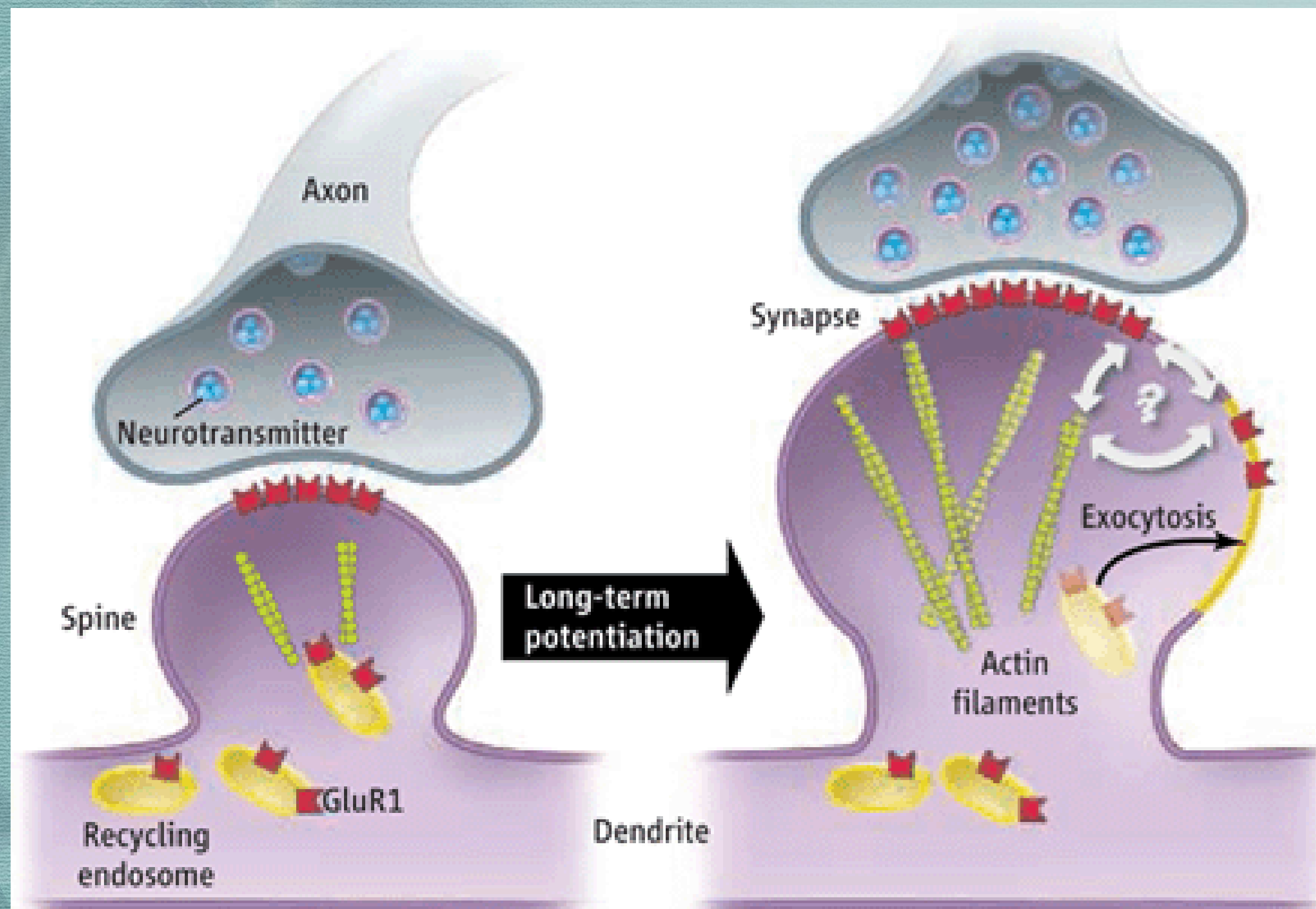
2. Along the Nerves



A Ionotropic glutamate receptor

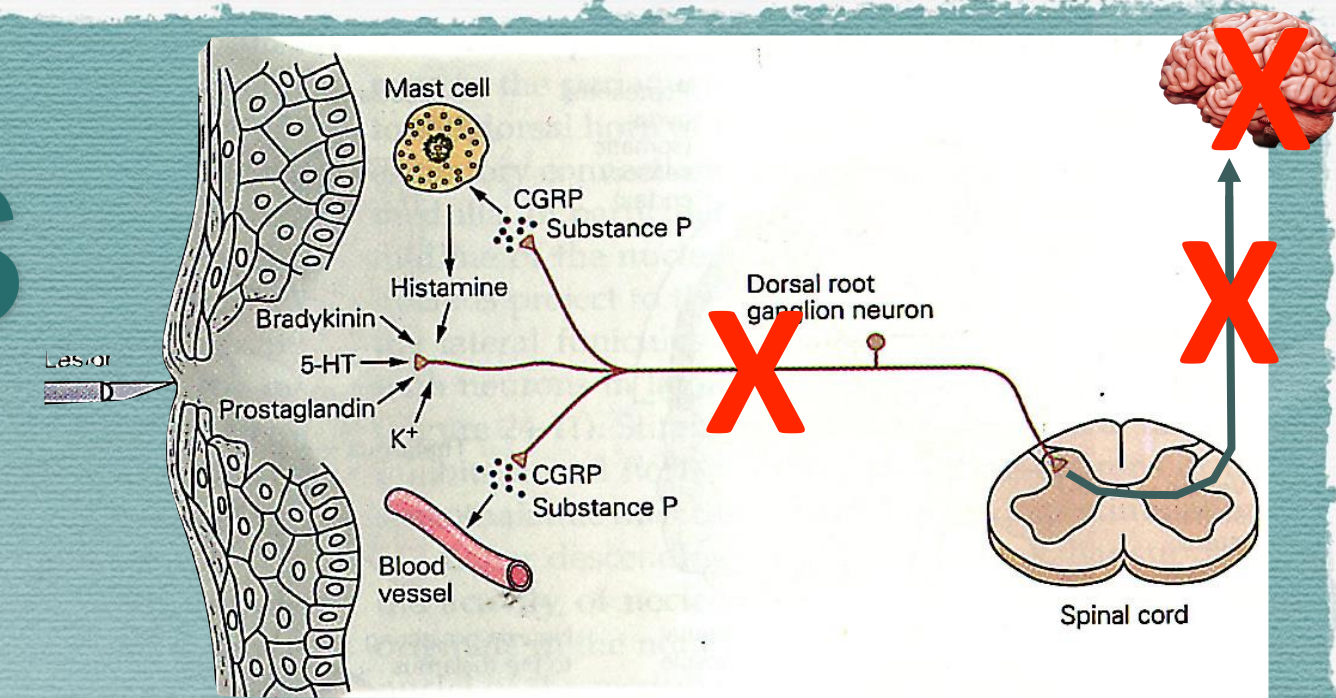


Long-Term Potentiation



- **Presynaptically:**
 - More vesicles
 - More exocytosis
 - More stimulatory channels
 - More neurotransmitter per vesicle
 - More transporters
 - Excitatory receptor expression
- **Postsynaptically:**
 - More receptors
 - Less breakdown
 - nNOS?
- **Synapse Changes:**
 - Grows closer - cf. electrical synapse
 - May divide and multiply

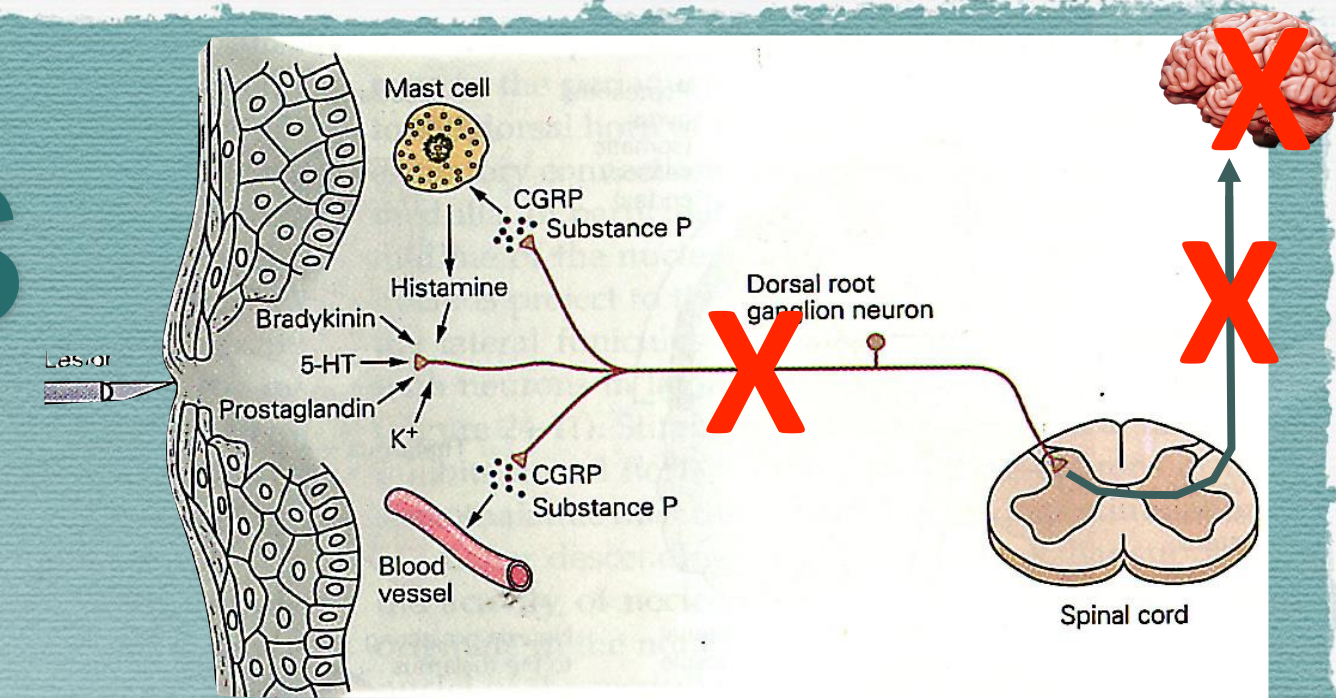
2. Along the Nerves



Magnesium

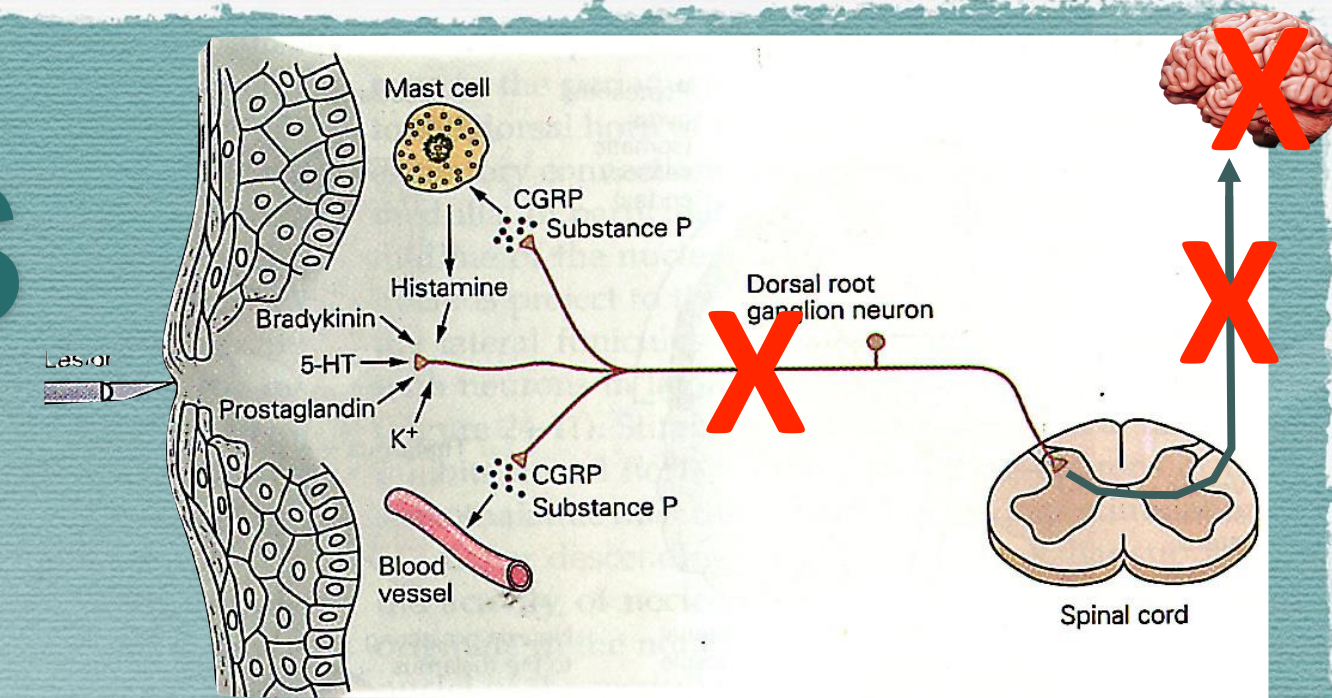
- Blocks NMDA receptors – analgesia and prevents chronic pain
- Prevents Withdrawals
- Prevents Arrhythmia
- Helps Asthma
- Improves Migraines and Headaches
- Prevents Epilepsy
- Protects against Eclampsia and Protects Foetal Brain
- Lowers blood pressure and improves microcirculation
- Helps Wound Healing (Ulcers)
- Anti-inflammatory
- Relaxes Muscles
- Prevents Acid Build Up
- Prevents Constipation (especially opioid-associated)
- Improves Cellular Metabolism
- etc. etc. etc.....

2. Along the Nerves



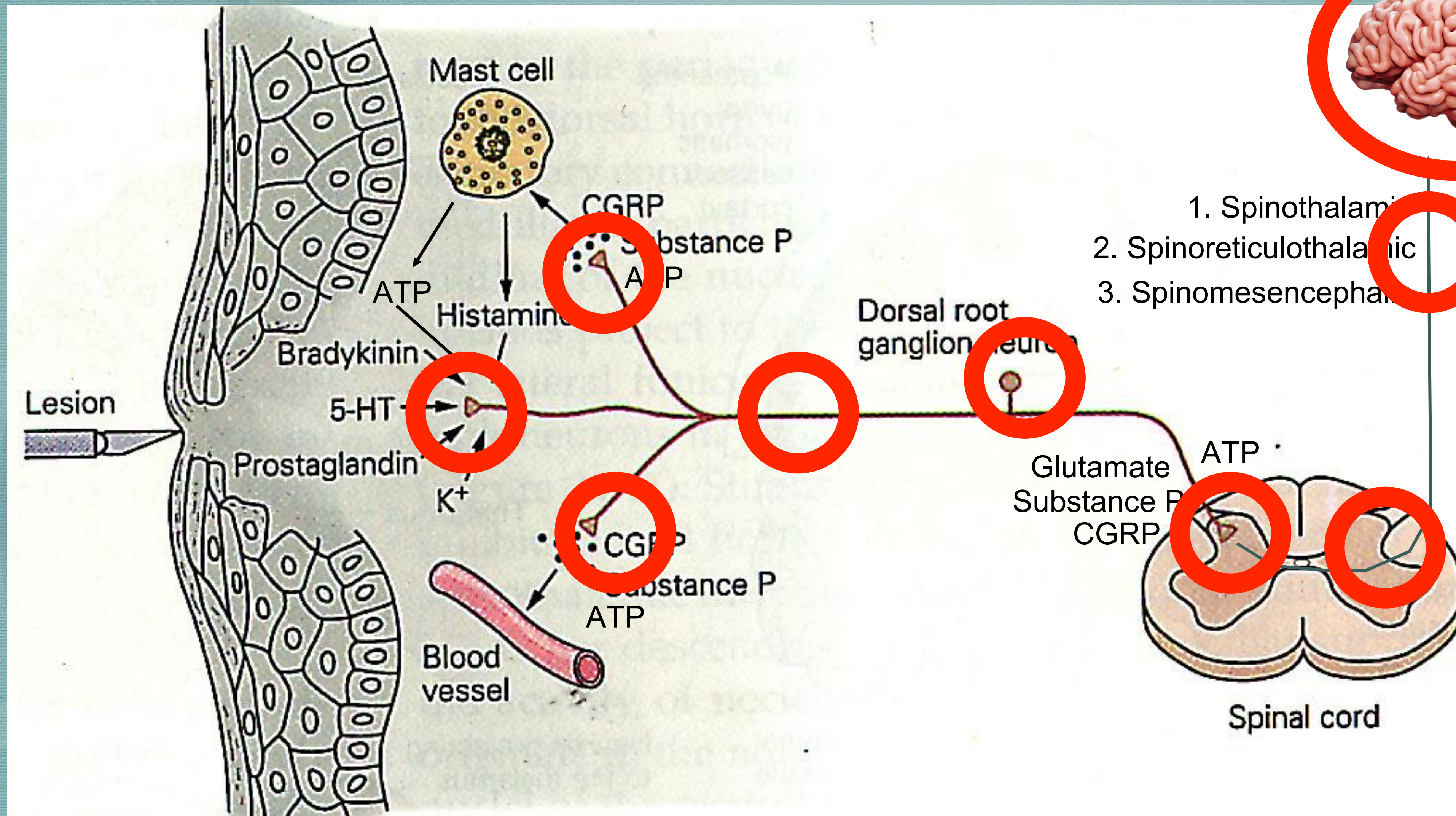
- **Why don't we give it?**
 - Only licenced for hypomagnesaemia
 - 50% of people are hypomagnesaemic despite normal plasma levels
 - 75% of people with chronic pain are hypomagnesaemic
 - Already using in Anaesthetics – can cut opioid use by 60-70% intraoperatively, and postoperatively
 - Applying for off licence use for wards (oral and IV) – watch this space!
 - Watch BP

2. Along the Nerves



- Why don't we give it?
 - Only licensed for hypomagnesaemia
 - 50% of people are hypomagnesaemic despite normal plasma levels
 - 75% of people with chronic pain are hypomagnesaemic
 - Already using in Anaesthetics – can cut opioid use by 60-70% intraoperatively, and postoperatively
 - Applying for licence for use (oral and IV) – watch this space
 - Watch B...

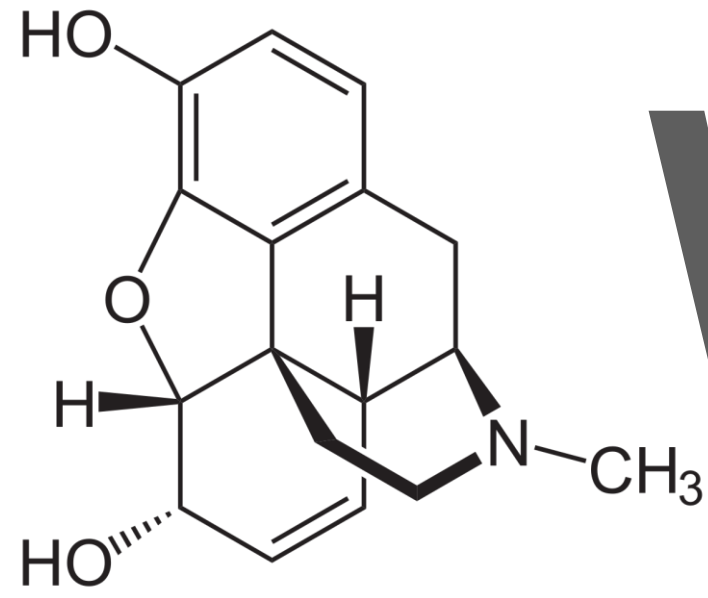
3. What About Opioids?



Opioids for Treating Pain?

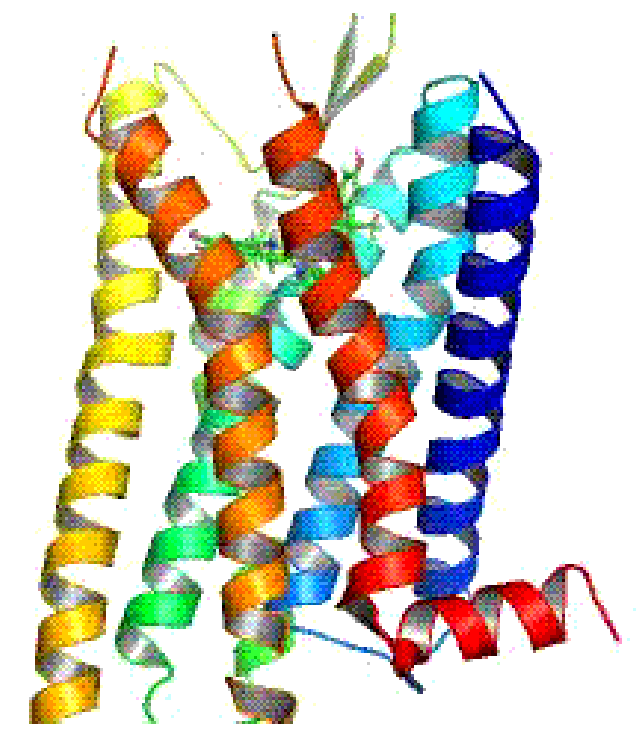
Drug	Dose	Approximate Oral Morphine Dose
Oral		
Codeine	100 mg	10 mg
Dihydrocodeine	100 mg	10 mg
Tramadol	50 mg	5-10 mg
Oxycodone (PO, SC, IV)	6.6 mg	10-15 mg, 20-30 mg, 20-40 mg
Pethidine	50 mg	5-6.25 mg
Tapentadol (Palexia SR)	100 mg	40 mg
Patches		
BuTrans 10 Patch	10 mcg/hr	20 mg /24 hours
Fentanyl 50 Patch	50 mcg/hr	120-224 mg /24 hours
Transtec 52.5 Patch	52.5 mcg/hr	94-145 mg /24 hours
Subcutaneous		
Diamorphine	10 mg	30 mg

- Lowest Dose for Shortest Period
- MAX 90 MG OME/DAY
- No MR Opioids
- No longer than 12 weeks



WHY DO WE CARE?

SIDE EFFECTS OF OPIOIDS



- **Acute use:**
 - drowsiness
 - confusion
 - nausea
 - constipation
 - euphoria and analgesia
 - respiratory depression
- **Chronic use:**
 - fractures
 - breathing difficulties
 - hyperalgesia
 - immunosuppression
 - myocardial infarction
 - chronic constipation and bowel obstruction
 - tooth decay secondary to xerostomia
 - hormonal disruption (HPA effects)
 - depression/anxiety/personality changes
 - sexual dysfunction
 - obesity
 - increased risk of cancer/mets
 - withdrawal reactions
 - dependence, addiction, tolerance

Etc.

Opioids for Treating Pain?

- If prescribing an Opioid for Pain:
- Immediate Release Weak Opioid + Adjuncts
- Lowest Dose for Shortest Time e.g. 5 days Dihydrocodeine
- Consider “Opioid Contract”
 - When we will be reviewing
 - When we will be increasing/stopping
- Max 3 weeks then follow up if wants repeat – offer earlier for reassurance
- Max 12 weeks before becomes Chronic – Opioids stopped/reduced/stabilized for Chronic (follow up every 6 months)

Opioids for Treating Pain?

CRISIS

- If prescribed for acute pain
- Immediate Release Weak Opioid Adjuvants
- Lowest Dose for Shortest Time e.g. Day Dihydrocodeine
- Consider "Opioid Contract"
 - When we will be reviewing
 - When we will be increasing/stopping
- Max 3 weeks for set up if war repeated – off earlier for reassurance
- Max 12 weeks before we make Chronic – Opioids stopped/reduced/stabilized for Chronic (follow up every 4 months)

ONLY

Having the Conversation is Key for Opioid Reduction

“ASKING THE QUESTION”



- Barriers:
 - Patients are:
 - *Frightened*
 - *Dependent* on their “opioid crutch” - ? Placebo ? Addiction
 - Concerned “left with nothing” - *unable to cope*
 - Clinicians:
 - Lack of *Time*
 - Lack of *Awareness*
 - Lack of *Empowerment*
 - Lack of *Knowledge*

**“HAVE YOU THOUGHT
ABOUT REDUCING YOUR
OPIOIDS?”**

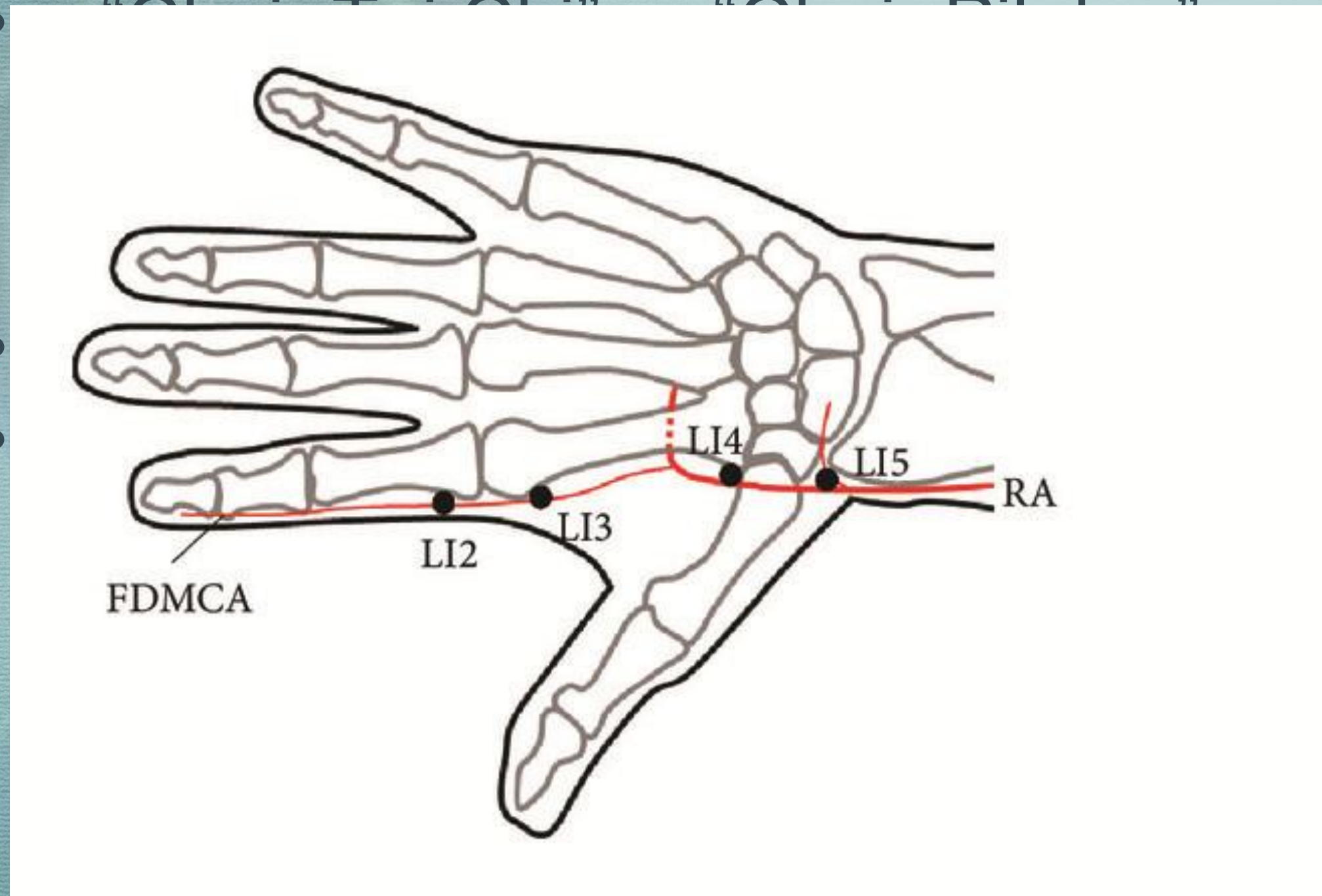


Non Pharmacological – What You Can Do

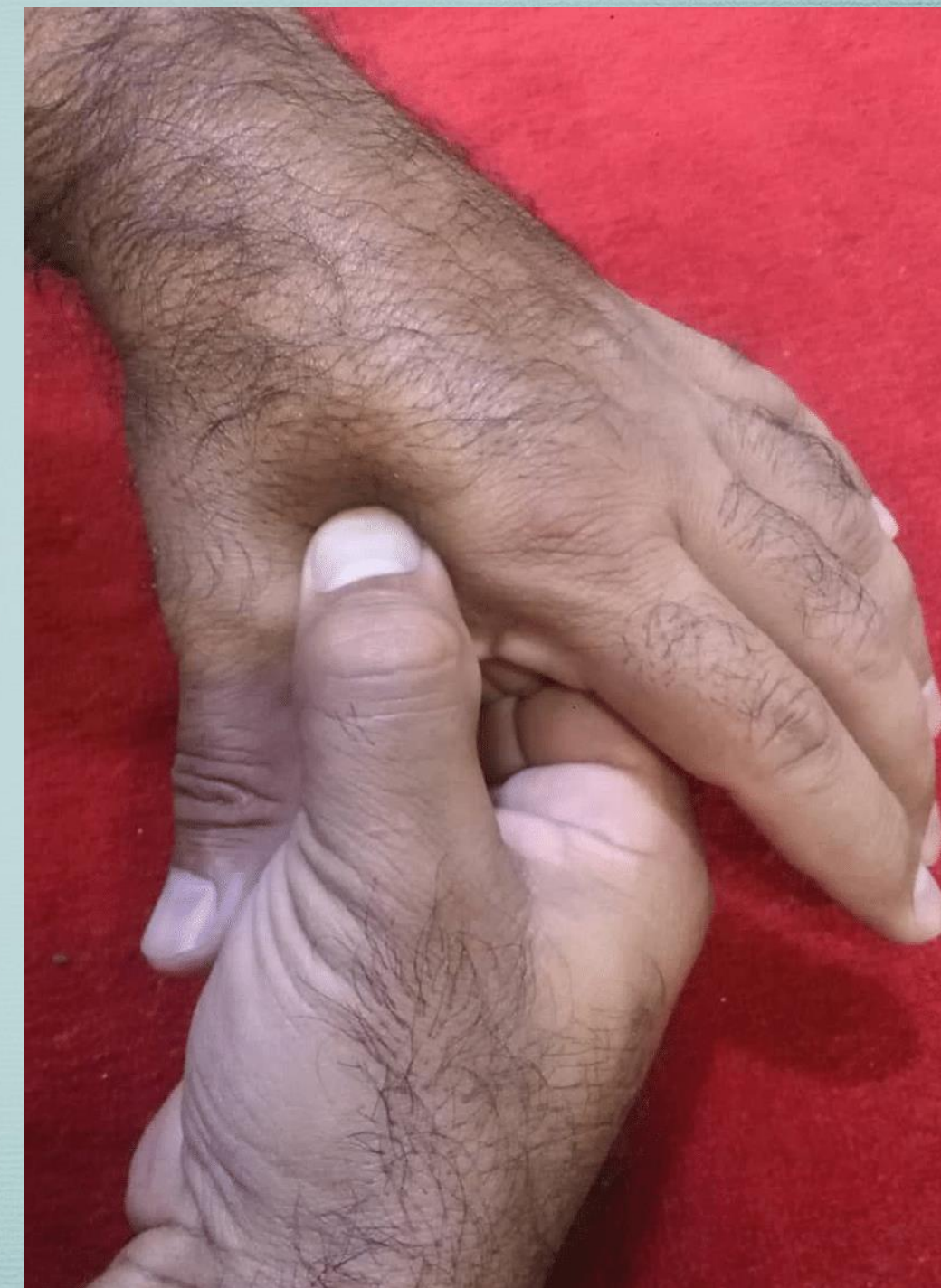
- **Tai Chi/Pilates/Yoga**

- “Bed Tai Chi”

- “Chair Tai Chi” “Chair Pilates” “Chair Yoga” encourage,



Li4



- **Meditation**

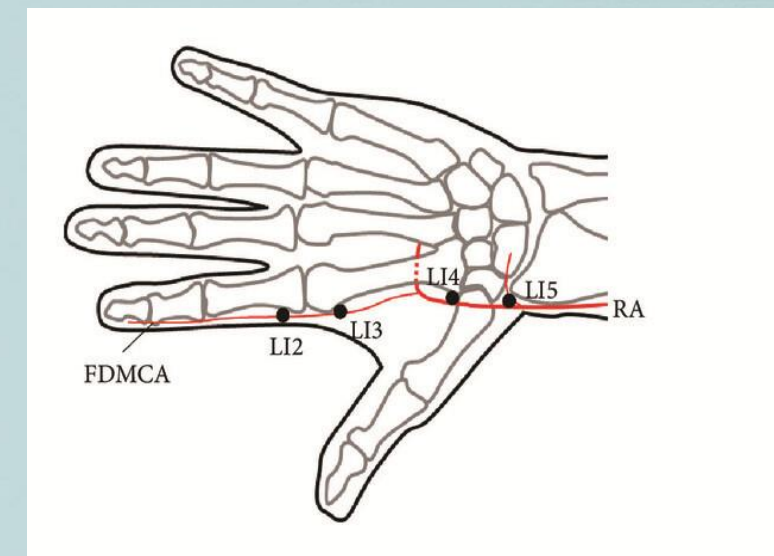
- **Mirror Therapy**

<https://onlinelibrary.wiley.com/doi/10.1155/2019/6879076>

https://www.researchgate.net/figure/LI4-acupressure-point_fig1_328409298

Non Pharmacological – What You Can Do

- **Tai Chi/Pilates/Yoga**
 - “Bed Tai Chi”
 - “Chair Tai Chi” or “Chair Pilates” – encourage, no excuses!
- **Distraction**
- **Virtual Reality**
 - “Trail of 10 falls 360 degree view”
 - Any 360 degree view on Youtube
- **Acupuncture/Acupressure – Li4**
- **Magnesium**
- **TENS**
- **Pain Gone Pen**
- **Meditation**
- **Mirror Therapy**



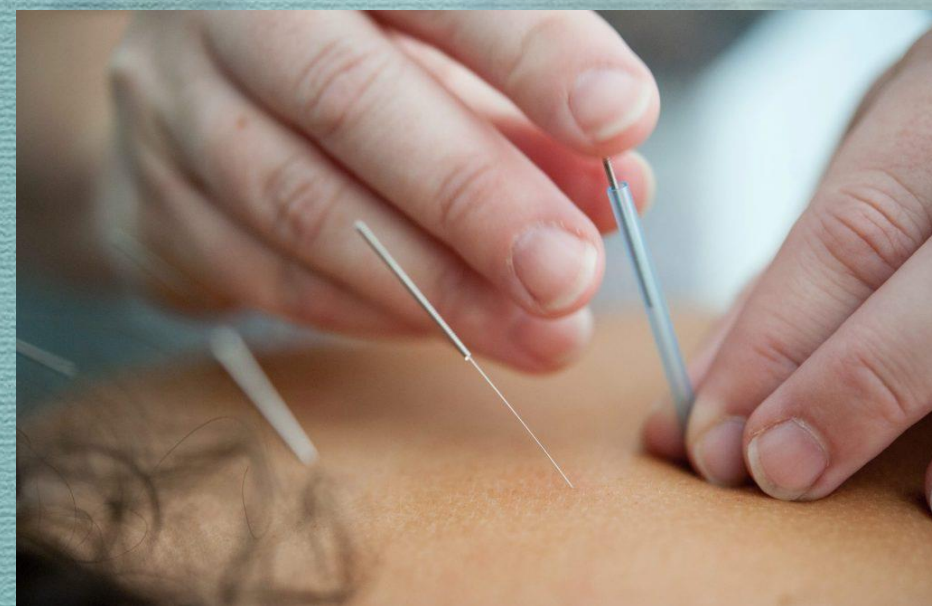
- **Sometimes just listening and validating someone's pain is enough, but you should also encourage them to MOVE**



<https://onlinelibrary.wiley.com/doi/10.1155/2019/6879076>

https://www.researchgate.net/figure/LI4-acupressure-point_fig1_328409298

Non Pharmacological



<https://www.tesco.com/groceries/en-GB/products/312092741>

<https://www.acesportsclinic.com.au/blog/the-most-common-physiotherapy-treatments-for-healing-wellbeing/>

<https://www.fit4-physio.co.uk/acupuncture-in-sheffield/>

<https://www.istockphoto.com/search/2/image-film?phrase=psychological+therapy>

<https://www.visitgreenwich.org.uk/whats-on/tai-chi-in-the-park-p1747661>

<https://thecalmostone.com/?srsltid=AfmBOoqM7f32vJH9umGFCEwyGu6p7qZqSiS5fqX2atSXN0CNSDm4fx4K>

<https://www.intelligentliving.co/anxiety-disorder-neurofeedback-therapy/>

Non Pharmacological

PLEASE

OFFER



<https://www.tesco.com/groceries/products/31741>

<https://www.acesportsclinic.co.uk/the-most-common-physiotherapy-treatments-for-ligament-injuries/>

<https://www.fit4-physio.co.uk/acupuncture-in-sheffield/>

<https://www.istockphoto.com/search/2/image-film?phrase=psychological+therapy>

<https://www.greenwich.org.uk/whats-on/tai-chi-in-the-park-p1747661>

<https://thecalmstone.com/?srsltid=AfmBOoqM7f32vJH9umGFCEwyGu6p7qZqSI55fqX2atSXN0CNSDm4fx4K>

<https://www.intelligentliving.co/anxiety-disorder-neurofeedback-therapy/>

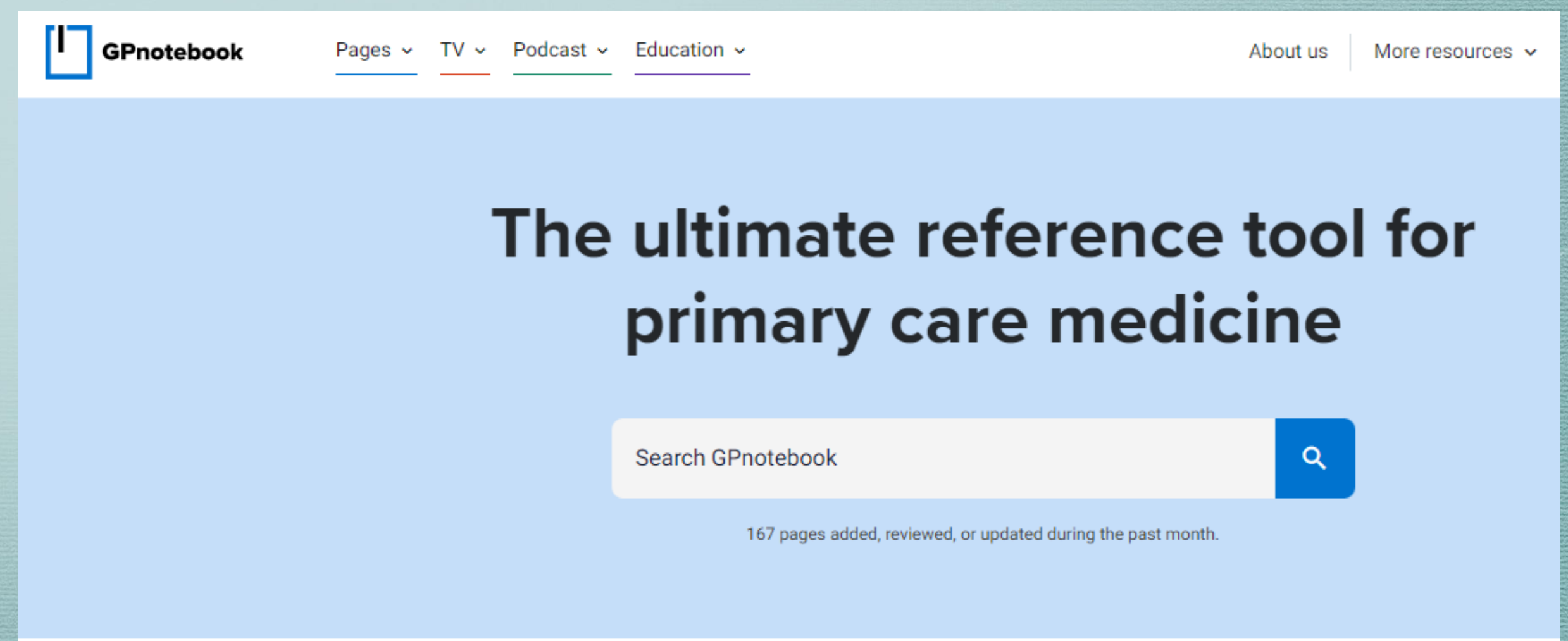
My Big 5 Tips for FMS



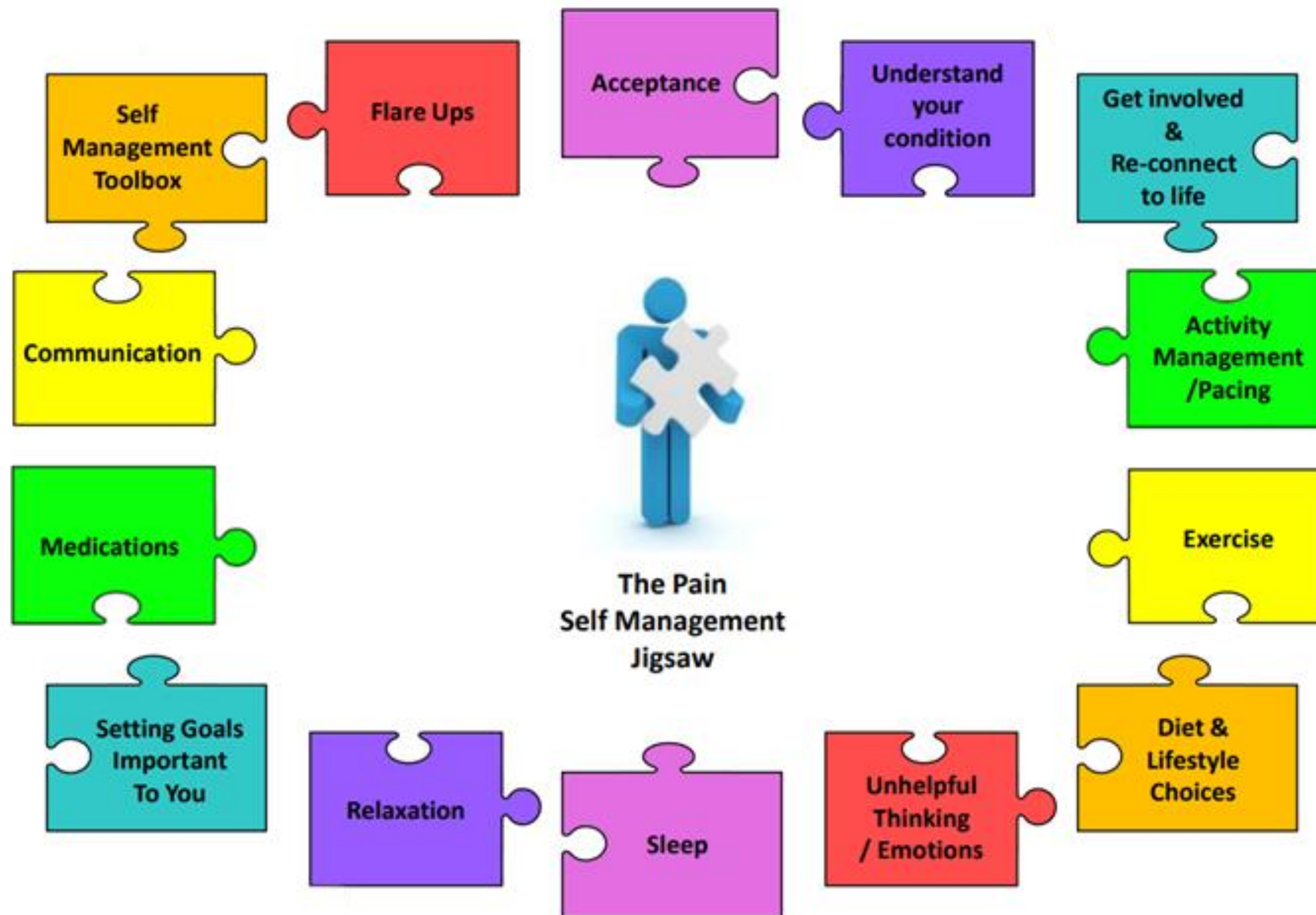
- Get them on **Magnesium (375-750 mg ON)** and Vit D
- Get them **Moving** (Tai Chi/Pilates/Yoga/Walking)
 - Be **Creative**
- **Suggest** acupuncture/acupressure with breathing and body scan exercise
- **Trial** of medication if everything else fails - 6 monthly trials of **reduction. Reduce and stop** all opioids/gabapentinoids
- Remind them that Pain itself is (generally) ***not dangerous***, but it can alert us to something that may be dangerous. **Develop self-management strategies** to work with body rather than against – "**new normal**". **Keep looking if it's new.**

Resources To Help You

- Your COLLEAGUES!!!!!!
 - (You are never alone)
- Your Patients!
- Medical School Notes
- BNF
- Renal Handbook
- GP Notebook
- Local Guidance
- Local Resources
 - E-learning healthcare
 - Internet



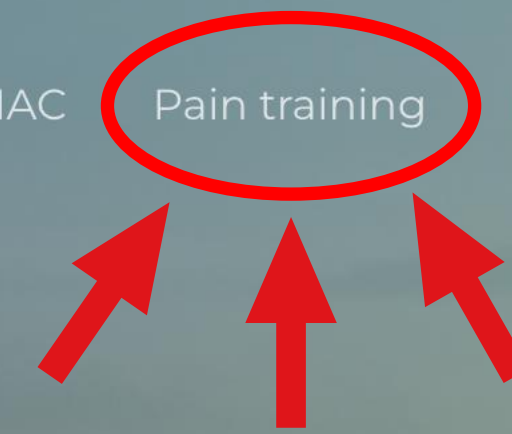
PAIN MANAGEMENT



<https://www.nhsfife.org/services/all-services/pain-management-service/>

► Search for
“NHS FIFE PAIN
MANAGEMENT
Jigsaw”

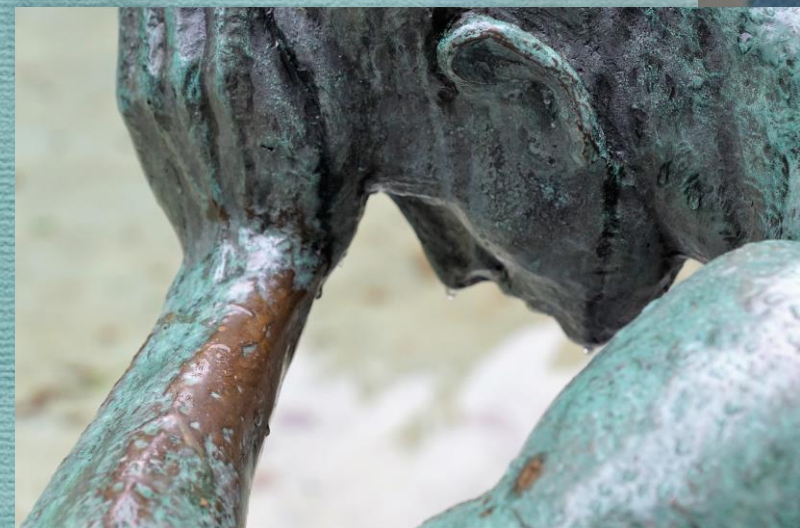
Shameful Plug

[Home](#)[About](#)[IAC](#)[Pain training](#)[FAQ](#)[Trainers area](#)[Contact](#)

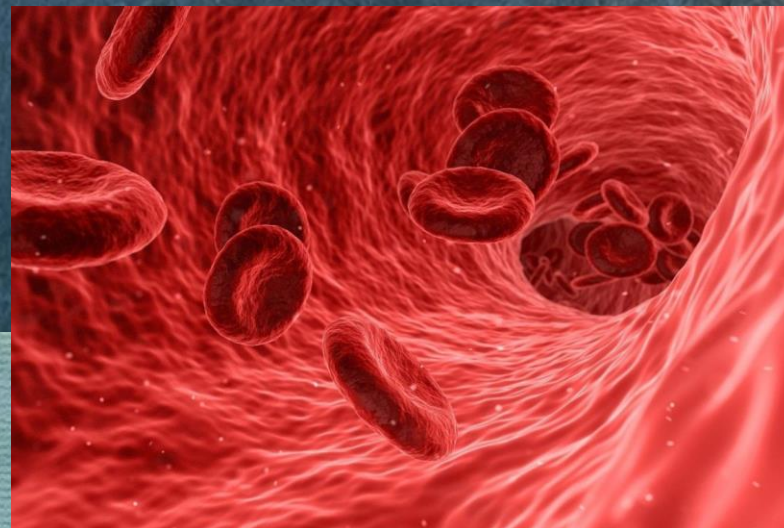
Where training happens

Virtual Anaesthetics

Welcome to Virtual Anaesthetics the home of interactive learning

[GET STARTED](#)[CONTACT US](#)

Intro to PMP
LBP



Acute Pain WR
Sickle Cell
Rib #



CRPS



Fibromyalgia
Biopsychosocial



Opioid Overuse



Cancer Pain
Coeliac Plexus

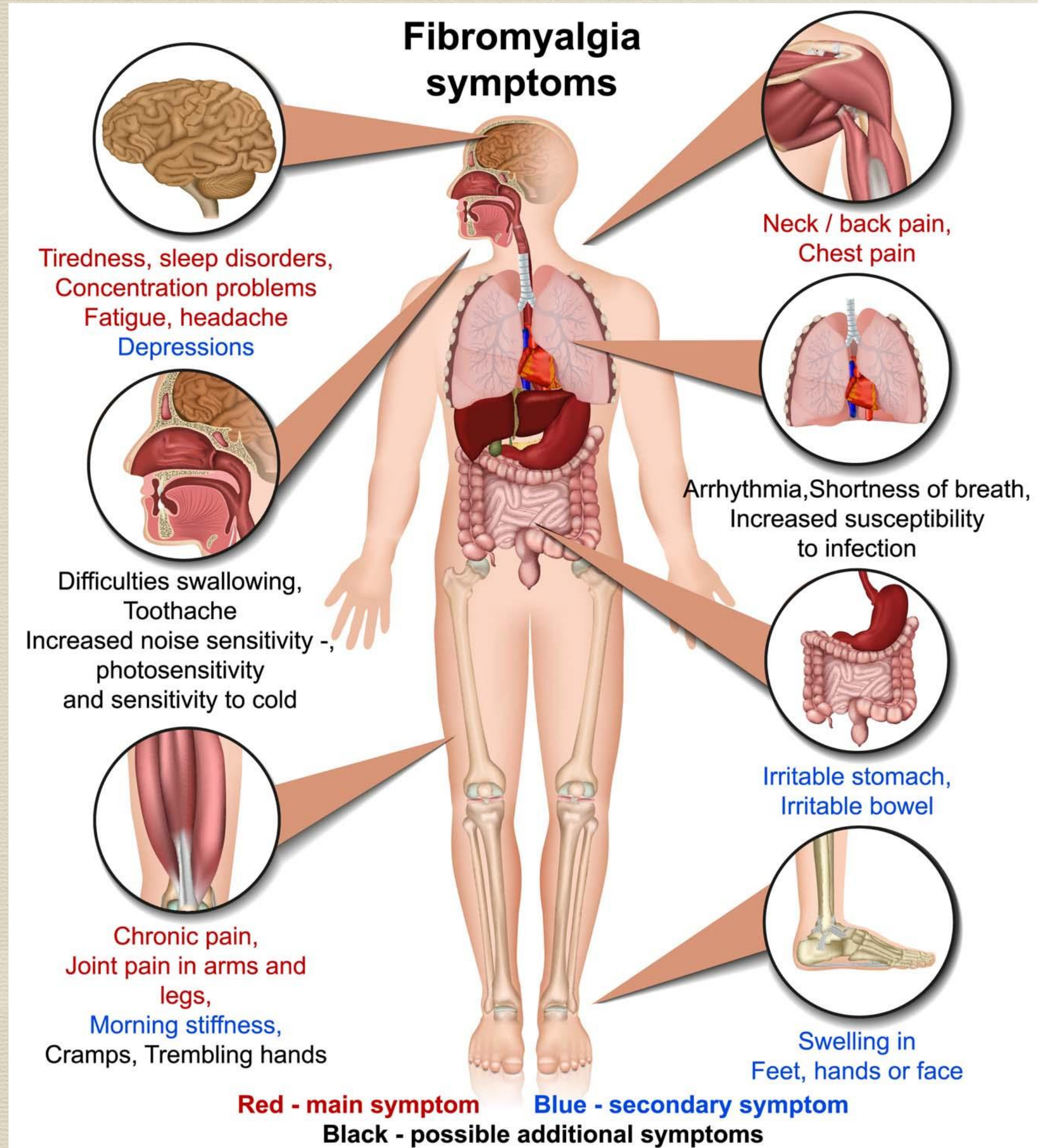
LOTS OF OTHER THINGS

- Acute Pain Team were Finalists for Team of the Year (2 years in a row!)
- Dragon's Den Finalists
- Big Congrats to the new prescribers
- Lots happening:
 - Increasing Study Days
 - Acute Pain Lecture Series
 - Pain Bites
- Audits/Projects
 - Epidurals
 - Fractured Ribs
 - Patient Expectations
 - Patient Satisfaction
 - Online Learning
 - DHC
 - Better Prescribing
 - Opioid Reduction
 - Virtual Reality
 - Artificial Intelligence
 - Hypnosis
 - Neurolinguistic Programming
 - Biofeedback
 - Neurofeedback
- *And Much Much More!.....*



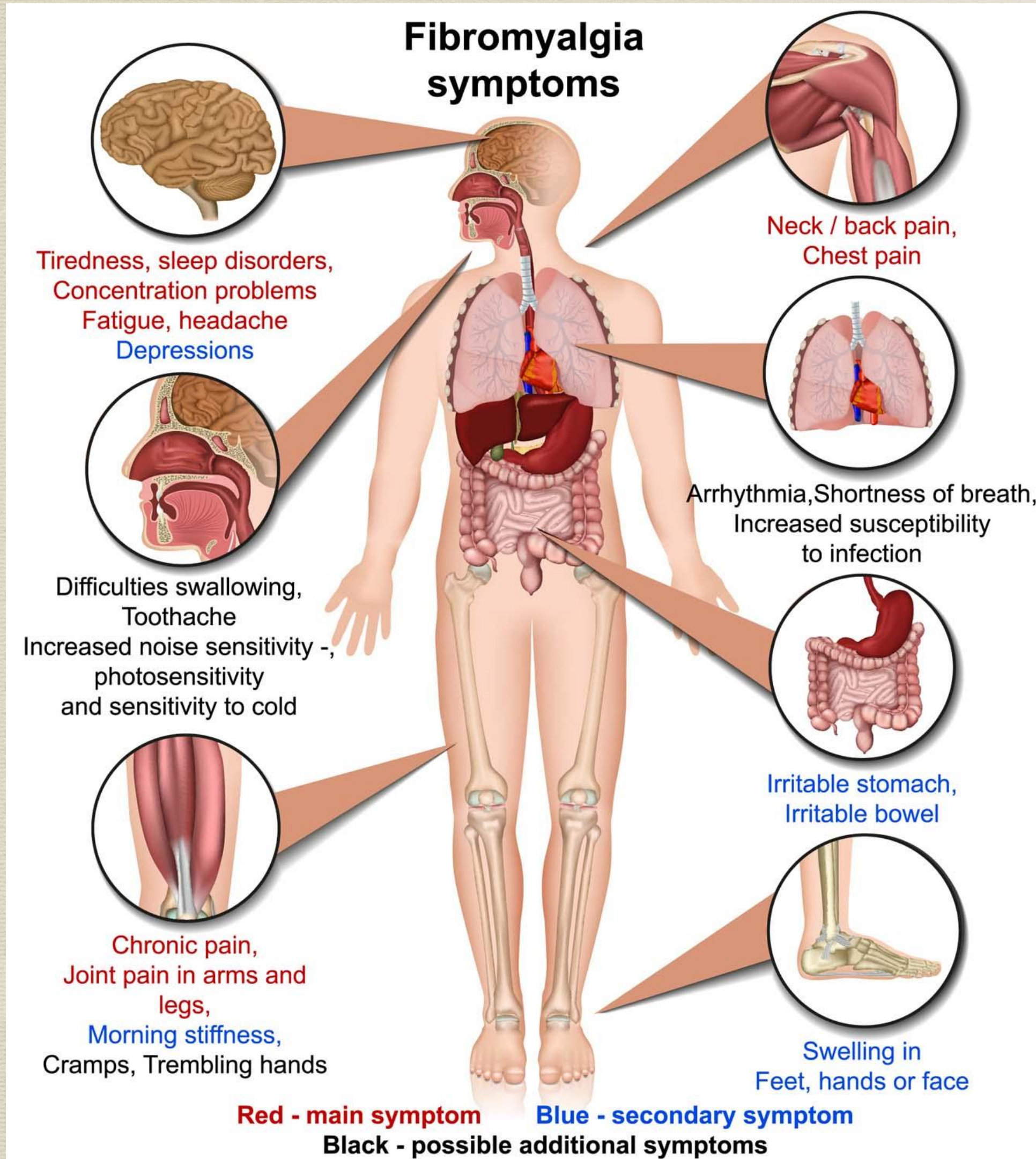
Come See Us In The Office (Above Daycase in NGH, or in the Anaesthetic Department next to the toilets in RHH).

SUMMARY FIBROMYALGIA



- Primary Pain Syndrome
- Nociplastic Pain

SUMMARY FIBROMYALGIA



Other somatic symptoms

- | | | | |
|---|--|---|---|
| ☐ Muscle pain | ☐ Depression | ☐ Itching | ☐ Dry eyes |
| ☐ Irritable bowel syndrome | ☐ Constipation | ☐ Wheezing | ☐ Shortness of breath |
| ☐ Fatigue/tiredness | ☐ Pain in upper abdomen | ☐ Raynaud's | ☐ Loss of appetite |
| ☐ Thinking or memory problem | ☐ Nausea | ☐ Hives/welts | ☐ Rash |
| ☐ Muscle weakness | ☐ Nervousness | ☐ Ringing in ears | ☐ Sun sensitivity |
| ☐ Headache | ☐ Chest pain | ☐ Vomiting | ☐ Hearing difficulties |
| ☐ Pain/cramps in abdomen | ☐ Blurred vision | ☐ Heartburn | ☐ Easy bruising |
| ☐ Numbness/tingling | ☐ Fever | ☐ Oral ulcers | ☐ Hair loss |
| ☐ Dizziness | ☐ Diarrhea | ☐ Loss/change in taste | ☐ Frequent urination |
| ☐ Insomnia | ☐ Dry mouth | ☐ Seizures | ☐ Bladder spasms |

Based on the quantity of symptoms, the patient's score is:

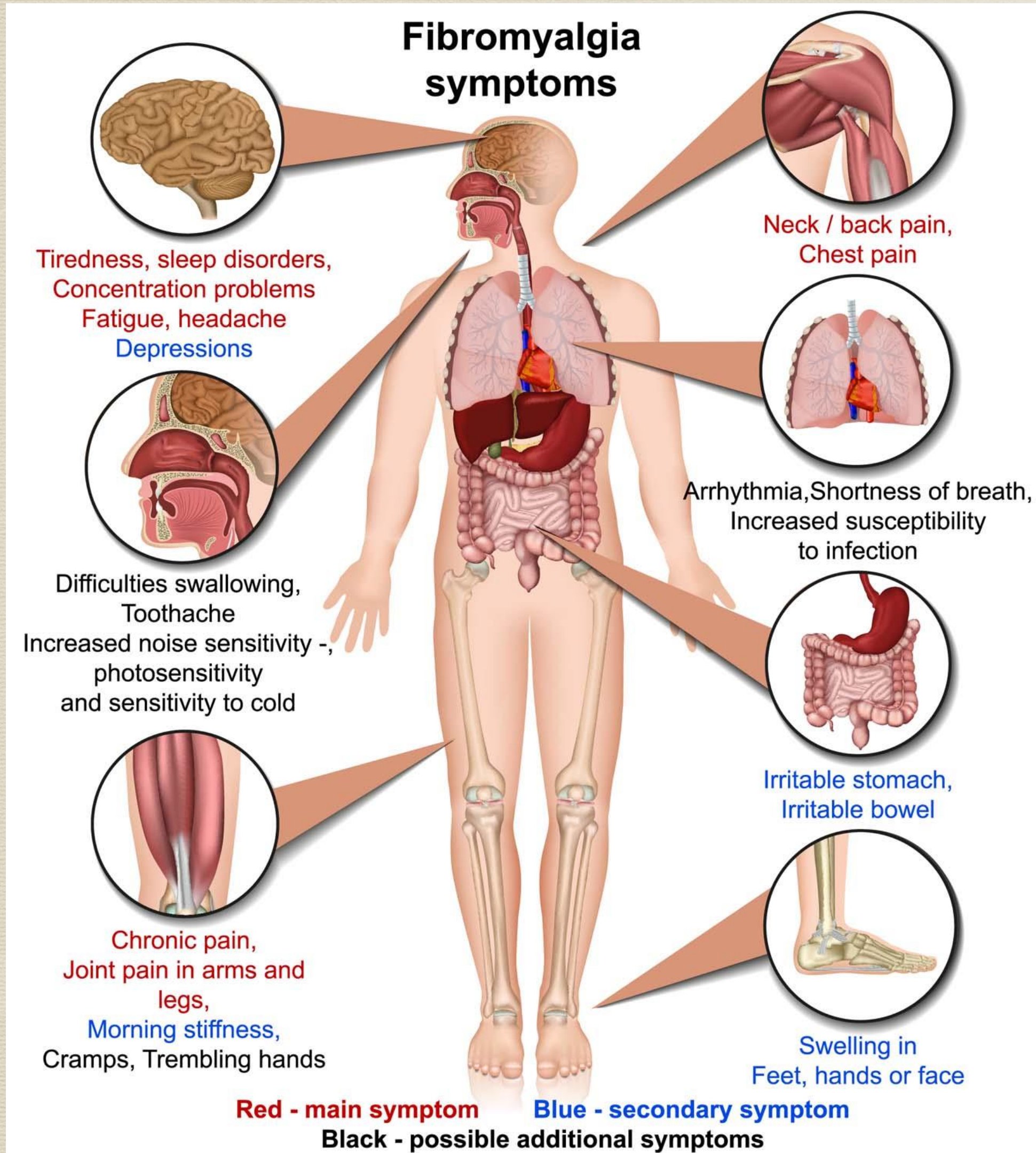
- | | |
|---|--|
| ☐ 0 = No symptoms | ☐ 2 = A moderate number of symptoms |
| ☐ 1 = Few symptoms | ☐ 3 = A great deal of symptoms |

López-Solà M, Woo CW, Pujol J, et al. [Towards a neurophysiological signature for fibromyalgia](#). Pain. [2016 Aug 31, Epub ahead of print] 2017 Jan;158(1):34–47.

Harte SE, Ichesco E, Hampson JP, et al. [Pharmacologic attenuation of cross-modal sensory augmentation within the chronic pain insula](#). Pain. 2016 Sep;157(9):1933–1945.

Geobel A, Krock E et al. 2021. Passive transfer of fibromyalgia symptoms from patients to mice. J Clin Invest. 2021;131(13):e144201. <https://doi.org/10.1172/JCI144201>.

SUMMARY FIBROMYALGIA



- Primary Pain Syndrome
 - Nociceptive Pain
 - fMRI changes
 - Blood Changes
- Reduced Skin small fibres and Immunological changes
- Widespread Pain Index of ≥ 7 + Symptom Severity of ≥ 5
 - OR WPI 3-6 and SS ≥ 9
- <https://www.umassmed.edu/globalassets/office-of-continuing-medical-education/pdfs/cme-primary-care-days/c1-handout-fibromyalgia.pdf>

López-Solà M, Woo CW, Pujol J, et al. [Towards a neurophysiological signature for fibromyalgia](#). Pain. [2016 Aug 31, Epub ahead of print] 2017 Jan;158(1):34–47.

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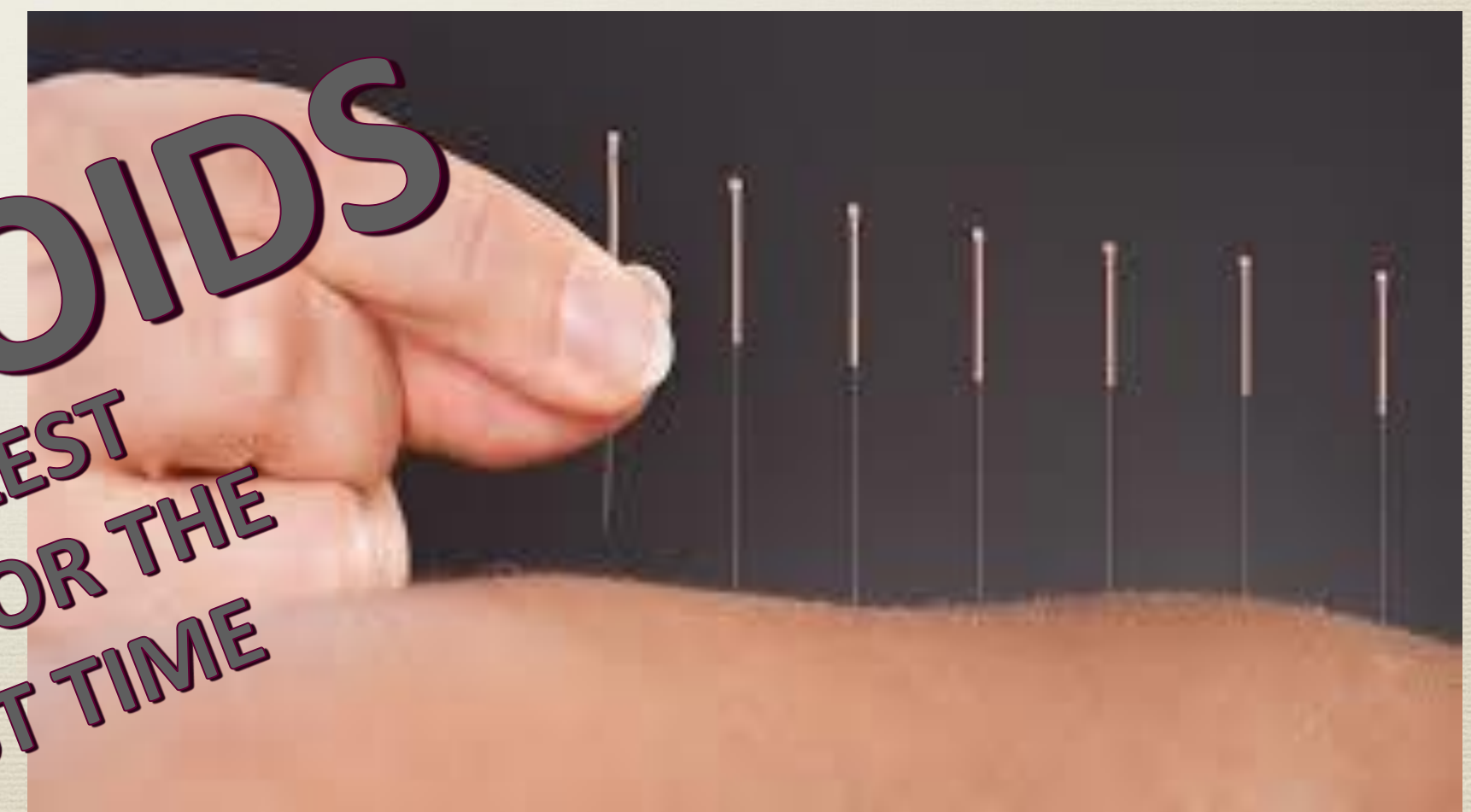
Geobel A, Krock E et al. 2021. Passive transfer of fibromyalgia symptoms from patients to mice. J Clin Invest. 2021;131(13):e144201. <https://doi.org/10.1172/JCI144201>.

SUMMARY FIBROMYALGIA

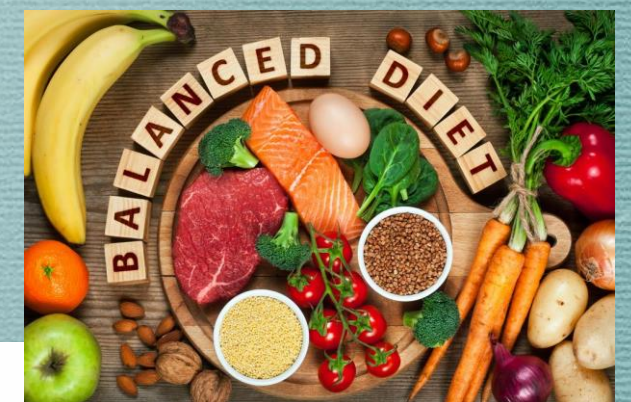
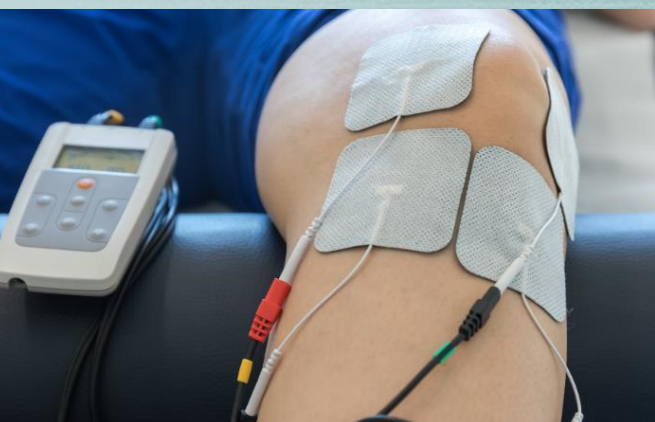
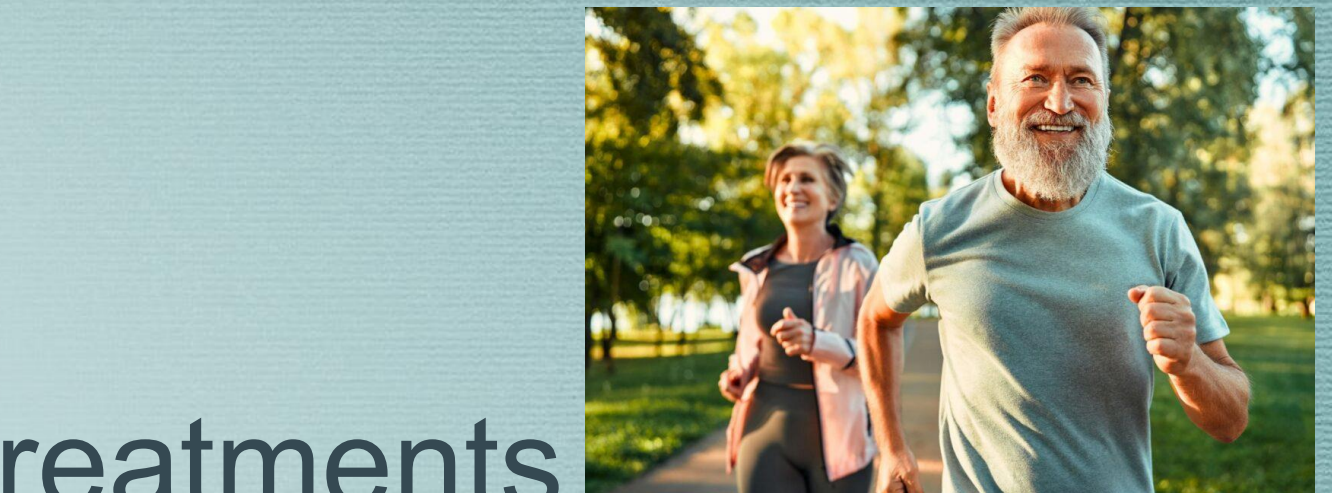
- Blood Tests: Anaesthetics Fibromyalgia (Order Set)
- FBC, CRP, ESR, U+Es, TFTs, LFTs, HbA1c, Creatine Kinase, Magnesium, Calcium, (Vitamin D), Rheumatoid Factor, (Lupus Screen), Clotting.
- Reassurance – do they want the label? Psychology Support?
 - Reduce CNS stimulation:
 - Duloxetine and OTC Magnesium
 - Relearn how to MOVE:
 - Graded Exercise Program
 - Tai Chi
 - Acupuncture
 - Relearn how to LIVE:
 - PMP



NO OPIOIDS
OR SMALLEST
AMOUNT FOR THE
SHORTEST TIME



Summary



- Pain is individual and subjective
- Pharmacology is not always the answer, but it helps
- Various pharmacological and non-pharmacological treatments
- Aim is to improve function
- Avoid Opioids
- When in doubt, phone a friend (refer to specialists!)



- **Ask the Patient if they have thought about reducing their opioids?**

References

Further Reading

- Song F, Bachmann M, Howe A (2023). Factors associated with the consultation of GPs among adults aged ≥ 16 years: an analysis of data from the Health Survey for England 2019. *BJGP Open*. Jul 26;7(3):BJGPO.2022.0177.
- Kang Y *et al.* (2023). Chronic Pain: Definitions and Diagnosis. *BMJ* 381:e076036
- Aaron M *et al.* (2020). Postoperative administration of non-steroidal anti-inflammatory drugs in colorectal cancer surgery does not increase anastomotic leak rate; A systematic review and meta-analysis. *EJSO* Volume 46, Issue 12 p 2167-2173
- Murphy P *et al.* (2023). Efficacy and safety of non-steroidal anti-inflammatory drugs (NSAIDs) for the treatment of acute pain after orthopedic trauma: a practice management guideline from the Eastern Association for the Surgery of Trauma and the Orthopedic Trauma Association. *BMJ Trauma Surgery and Acute Care Open* (8)1,
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- Smith J (2018). Advances in understanding nociception and neuropathic pain. *J Neurol*; 265(2):231-238.
- Bouhassira D (2018). Neuropathic pain: Definition, assessment and epidemiology. *Neurol (Paris)*;175(1-2):16-25
- Finnerup N, Kuner R, Jensen T (2021). Neuropathic Pain: From Mechanisms to Treatment. *Physiol Rev*. 1;101(1):259-301
- Didangelos T, Doupis J, Veves A (2014). Painful diabetic neuropathy: clinical aspects. *Handb Clin Neurol* 126:53-61
- NICE guidance on neuropathic pain

www.virtualanaesthetics.com

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Pictures

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Questions?



Tame the Beast

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It's time to rethink persistent pain

