FIBROMYALGIA

Raad Makadsi

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1. Introduction
2. Epidemiology
3. Pathogenesis
4. Clinical manifestation
5. Diagnosis and Differential diagnosis
6. Management

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Introduction

1. Fibromyalgia (FM) also called “Chronic Widespread Pain Syndrome”
2. Fatigue (ME), cognitive disturbance, psychiatric symptoms, and multiple somatic symptoms
3. Aetiology and pathophysiology – Unknown
4. No evidence of tissue inflammation
5. Organic illness, psychogenic or psychosomatic ?
6. **Disorder of pain regulation**

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EPIDEMIOLOGY

1. FM - most common cause of generalized, musculoskeletal pain in women between ages of 20 and 55 years
2. Prevalence is approximately 2-3%
3. More common in women than men 6:1

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PATHOGENESIS

1. **Altered pain processing** Patients perceive noxious stimuli, such as heat, electrical current, or pressure, as being painful at lower levels of physical stimulation than do healthy controls
2. **Sleep abnormalities** - majority of FM patients

- Phasic alpha sleep activity is most characteristic of FM
- An increase in cyclic alternating patterns of sleep has been noted in FM
- Sleep disturbances precede pain

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CLINICAL MANIFESTATIONS

1. Pain and fatigue, cognitive and psychiatric disturbances
2. Tenderness in multiple soft tissue
3. Normal lab tests
4. Cluster with FM- IBS, migraine, dyspepsia

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Symptoms

1. **Widespread pain**
2. **Fatigue**. A common quote is "No matter how much sleep I get, it feels like a truck ran me over in the morning."
3. **Cognitive disturbances** –" Patients typically describe problems with attention and difficulty doing tasks
4. **Psychiatric symptoms** – Depression and/or anxiety are present in 30-50%
5. **Headache** – 50 % migraine and tension
6. **Paresthesias** – including numbness, tingling, burning, or creeping or crawling sensations
7. **Other** poorly understood pain symptoms - abdominal - chest wall pain, IBS; pelvic pain and bladder symptoms

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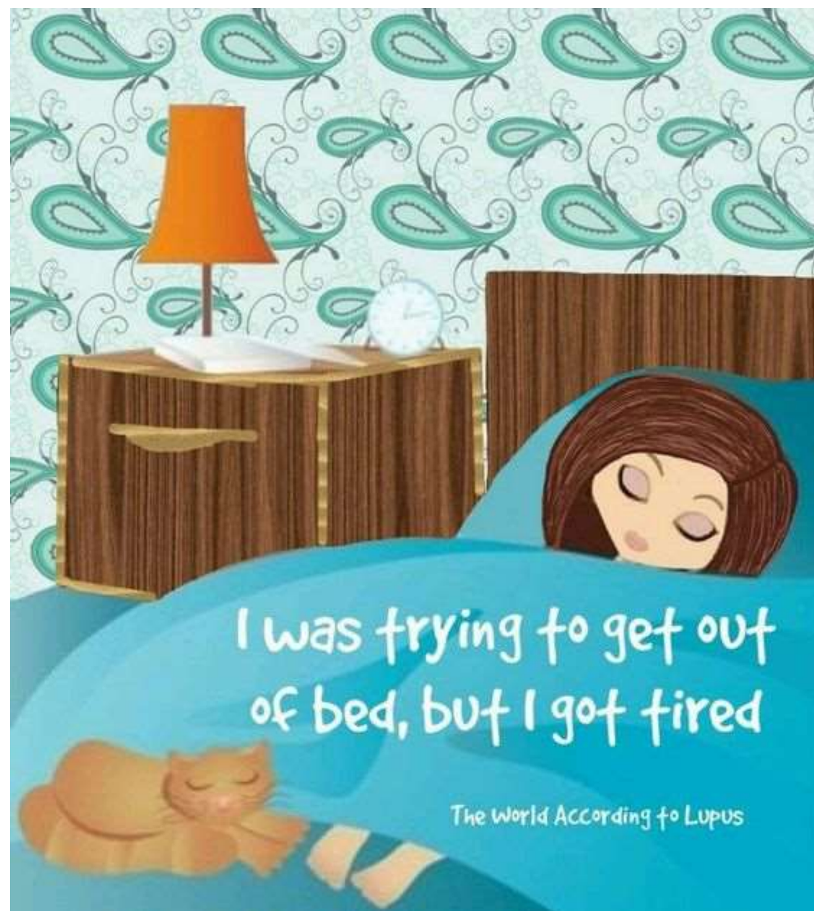

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Physical findings

1. Tenderness in soft-tissue
2. The tender point - Pressure - whiten the nail bed of the finger tip
3. 9 pairs of tender points used for the 1990 American College of Rheumatology Classification Criteria
4. upper mid-trapezius muscle, the lateral epicondyle, the second costochondral junction, the greater trochanter,
5. Rarely minor sensory and motor abnormalities

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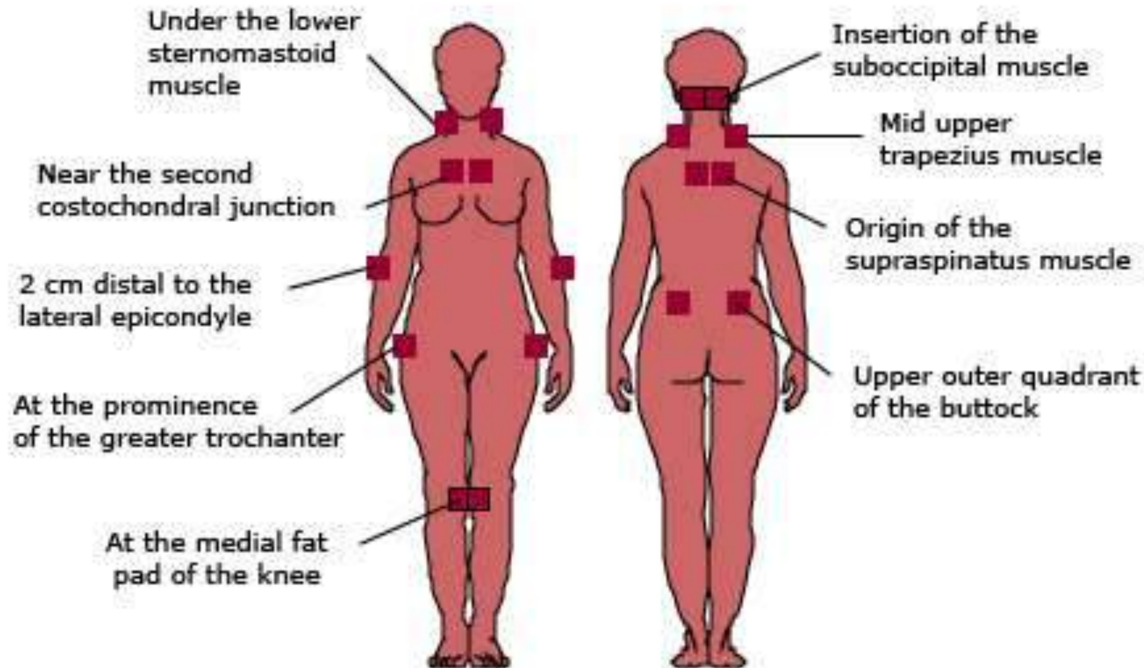
Tender points in fibromyalgia



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1990 ACR FM classification criteria included:

1. Symptoms of widespread pain, occurring both above and below the waist and affecting both the right and left sides of the body
2. Physical findings of at least 11 of 18 defined tender points

A specific number of tender points is not required to make the diagnosis in clinical practice

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ACR preliminary diagnostic criteria for fibromyalgia 2010

A patient satisfies diagnostic criteria for fibromyalgia if the following three conditions are met:
1) Widespread pain index (WPI) ≥7 and symptom severity (SS) scale score ≥5 or WPI 3 to 6 and SS scale score ≥9. (fatigue, waking unrefreshed, and cognitive symptoms, and the number of somatic symptoms in general)
2) Symptoms have been present at a similar level for at least three months.
3) The patient does not have a disorder that would otherwise explain the pain.

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COEXISTING DISORDERS

1. **Functional somatic syndromes** Chronic fatigue syndrome, Tension headache and migraine, IBS, chronic bladder and Pelvic pain, Temporomandibular disorders
2. **Psychiatric disorders** Depression, anxiety, PTSD
3. **Sleep disorders** sleep abnormalities correlate with severity of FM symptoms and quality of life
4. **Inflammatory rheumatic diseases** chronic inflammatory arthritis and systemic autoimmune rheumatic diseases
5. **Post-coronavirus disease 2019 (long COVID)** 10 % of acute respiratory syndrome have persistent widespread myalgias and arthralgias, fatigue, and cognitive disturbances Many of these patients meet diagnostic criteria for FM. COVID-19 infection may trigger FM or exacerbate preexisting FM

Differential diagnosis of fibromyalgia

1. Inflammatory arthritis –RA, CTD, Spondyloarthropathy
2. Polymyalgia Rheumatica
3. Myositis/myopathies
4. Hypothyroidism
5. Hyperparathyroidism
6. Neuropathy

Benefits of establishing the diagnosis

Although concerns that diagnostic labels such as FM would promote illness behaviour and drive up health care costs, establishing the diagnosis help to reduce testing, reduce health visits and overall health care costs

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1. Patient education, including cognitive behavioral therapy (CBT)
2. Addressing comorbidities
3. An exercise program
4. Drug monotherapy

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Patient Education include:

1. Reassurance that fibromyalgia is a real illness
2. Explain centralized pain.
3. Lack of evidence of persistent infection
4. Stress and mood disorders
5. Cognitive behavioural therapy
6. Role of exercise

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Addressing comorbidities

1. Sleep disturbances
2. Psychiatric symptoms and disorders
3. Other painful conditions

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Choice of exercise program

1. Land- versus water-based exercise
2. preferences or interest in self-directed versus therapist-directed stretching and strengthening exercise
3. Yoga and tai chi.
4. Optimal cardiovascular

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Tricyclic antidepressants and related drugs

1. Amitriptyline 10 mg at nighttime
2. Duloxetine 30-60mg/day or Venlafaxine
3. Anticonvulsants pregabalin and gabapentin

Combination Drug Therapy

1. Co-codamol, tramadol, NSAIDs
2. Amitriptyline
3. Pregabalin
4. Fluoxetine, Duloxetine
5. Can combine Fluoxetine am Plus Amitriptyline at night
6. Duloxetine am Plus Pregabalin at night

FACTORS LIMITING TREATMENT EFFICACY

1. Nonadherence to treatment interventions is very common (50%)
2. Comorbidities that cause peripheral pain and that require additional interventions to those used for treatment of the fibromyalgia

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Refer to Rheumatology - indications:

1. Need of combination drug therapies or in coordinating multidisciplinary management
2. Confirmation of the diagnosis
3. Re evaluation of the treatment - unresponsive to initial therapies and combination drug therapy
4. For evaluation and assistance in management of comorbid musculoskeletal conditions

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1. Early Arthritis Clinic
2. Referral Form

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Surrey and Sussex Healthcare NHS Trust

Early Inflammatory Arthritis Clinic (EAC) Referral Form

Please refer patients by completing this form and sending it via ERS

Patient Information	**Practice Information**
Full Name:	Referring GP
Address:	Practice Address
NHS Number:	Practice Phone number:
Hospital number:	Practice Email address:
DOB: Gender:	
Contact Phone Number:	

- Please **only** use this referral form if the patient **clinically has inflammatory arthritis affecting more than one joint**
- **Please send all other referrals to a general Rheumatology clinic in the usual way**
- Please refer patient for appropriate blood tests +/- x-rays prior to sending referral

Please answer each statement below with an X in either Yes or No. **MUST have Yes for 1 AND any TWO of 2-5 to make a referral to the Early Inflammatory Arthritis Service.**

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Please answer each statement below with an X in either Yes or No. **<u>MUST</u> have Yes for 1 AND any TWO of 2-5 to make a referral to the Early Inflammatory Arthritis Service.**

		Yes	No
1	Synovitis – Inflammation (Hot, tender & swelling) of the MCPs, PIPs and MTPs or 2 or more large joints		
2	Joint pain for more than 4 weeks and less than 6 months?		
3	Involvement of the hands, wrists and feet		
4	Positive RF and or Anti CCP		
5	Raised ESR and CRP		

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Please include relevant blood tests, either by filling in below table or attaching relevant practice summary. Please request these **PRIOR** to referring patients to EAC.

Test	**Result**
FBC	
U&Es	
LFTs	
CRP	
ESR	
Urate	
Immunology if known	

Please document relevant past medical history, drug history and family & social history in this space or please attach relevant practice summary:

Incomplete information will result in the referral being rejected and returned for completion of required fields.

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