

Fibromyalgia (FM) is a chronic condition characterized by diffuse musculoskeletal pain and fatigue. In addition to widespread pain, the American College of Rheumatology (ACR) diagnostic criteria include pain in at least 11 of 18 specified “tender points” (See figure 2).

Prevalence and Prognosis: While adult and children are affected by FM, 80-90% of people with FM are female. Most develop the condition in middle-age. Over 3 million in U.S. have FM. Once affected, individuals with FM do not commonly experience complete remission. The condition waxes and wanes, so that symptoms vary over time. The likelihood of remission decreases the longer one has symptoms consistent with FM.

Diagnosis

Individuals often spend two or more years seeking an explanation for their symptoms before being diagnosed with FM. This delay occurs, in part, because many providers lack adequate knowledge of the symptoms associated with FM and because the symptoms do vary over time. Figure 1 summarizes the diagnostic sequence described in this document.

Subjective

The history of present illness should adequately assess the pain, including its nature, intensity, location, onset, duration, context, setting, and any aggravating/relieving factors.

Additionally ask about:

- Functionality
- Sleep disturbance
- Persistent fatigue
- History of trauma (emotional and/or physical)
- Comorbid conditions such as headaches, irritable bowel syndrome, restless leg syndrome, depression, anxiety, and/or interstitial cystitis

Review of systems should assess for symptoms:

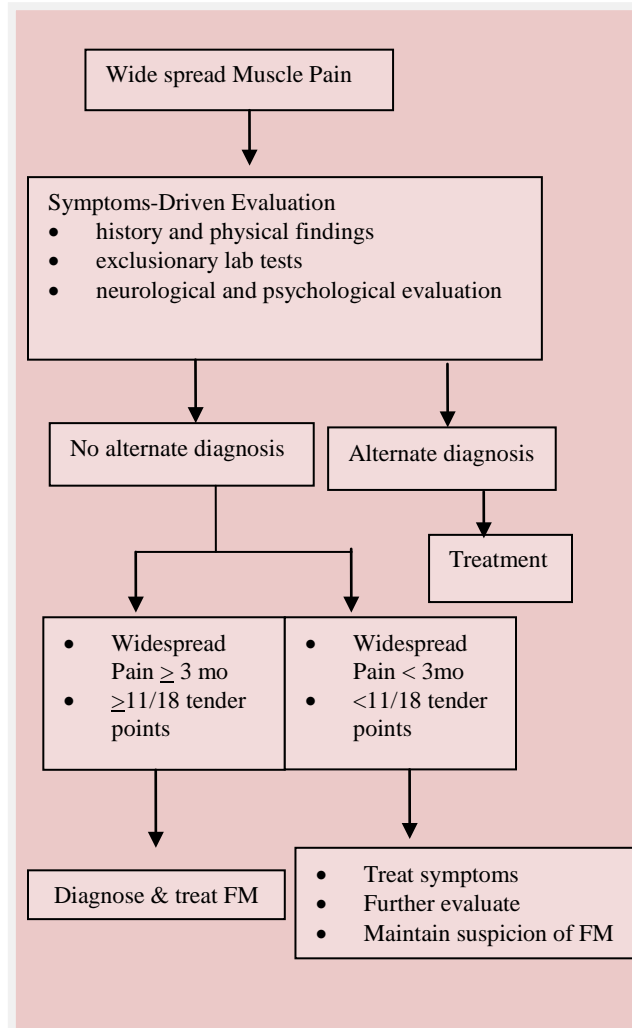
Musculoskeletal Symptoms

- widespread pain at multiple sites
- stiffness
- sensation of soft tissue swelling

Non-musculoskeletal Symptoms

- cognitive/ memory impairment (brain fog)
- fatigue
- sleep disturbance
- paresthesias

Figure 1. Diagnostic Steps



Past Medical History should include review of major illnesses, hospitalizations, current medications (including all OTC, herbs, etc) and family history

Psychosocial History should evaluate

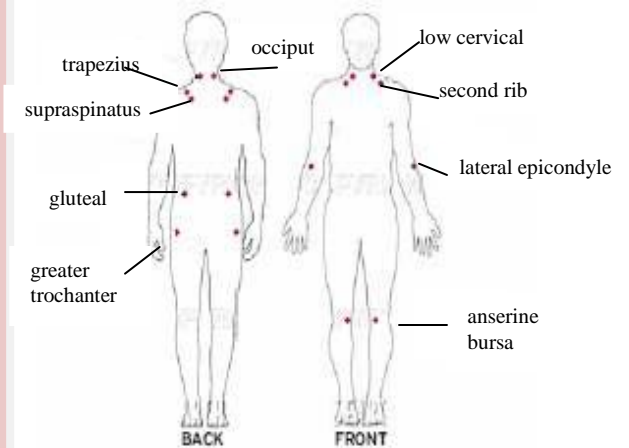
- Pain and coping skills using appropriate screening tools
- Impact of symptoms on the patient family, interpersonal relationships, work, school, and activities of daily living (ADL, IADL, AADL)

Objective

Physical examination should include:

- Bilateral digital palpitation using a force or until the nail bed just begins to blanch; to meet criteria of a positive tender pain. It is important to accurately palpate the specific tender points identified by ACR. (Figure 2)
- A complete musculoskeletal screening examination
- Mental status and neurological screening examination

Figure 2. Illustration of Tender Points



Basic Laboratory Studies include:

CMP, CRP, CBC, TSH, & ESR

- Expanded laboratory studies should be selected based on initial findings.
- Sleep study as indicated

Criteria for Diagnosis

- History of widespread pain present for at least 3 months: eg. Pain involving:
 - Both the left and right side of the body
 - Shoulder/buttock pain considered for the involved side
 - Both above and below the waist
 - LBP considered below the waist
 - Centrally/midline
 - Cervical spine, anterior chest, thoracic spine, or low back
- Presence of 11 out of 18 paired, bilateral tender points defined by ACR

Differential Diagnosis includes the following:

Rheumatologic disorders such as chronic fatigue syndrome, rheumatoid arthritis, Sjogren's syndrome, systemic lupus erythematosus, polymyalgia rheumatica, inflammatory myositis

Metabolic and Endocrine Disorders such as:

Metabolic myopathies, hypothyroidism, hyperparathyroidism, Cushing's syndrome

Infectious Disorders such as: Lyme disease, Epstein Barr

Treatment Modalities

Patient and Family Education is essential

- Validate the diagnosis. Patients need to understand their illness is real and treatable.
- Educate about prognosis, pathophysiology, and treatment principles

First Line Pharmacological Treatment

- FDA-approved treatment for FM include pregabalin, duloxetine, and milnacipran
- Other classifications are useful to:
 - Promote sleep (eg. Amitriptylline 10 mg starting dose before bedtime titrated to effective dose)
 - Treat fatigue and depression (eg. SSRI such as fluoxetine or SSNR such as venlafaxine)
 - Treat muscle spasms (eg. cyclobenzaprine)
 - Provide adequate pain control (eg. tramadol)
- **Avoid narcotics**

Non- Pharmacological Treatment Includes:

- Low intensity aerobic (walking)
- Sleep hygiene
- Muscle strengthening/stretching
- Therapeutic baths (balneotherapy)
- Massage
- Biofeedback
- Acupuncture
- Yoga

Monitoring Response to Therapy

Tender points may become more or less pain, but generally remain present with treatment. Depending on symptoms, consider monitoring response with rating schemes (scale 0-10) of pain, sleep, fatigue, stiffness, "brain fog", functionality, coping, etc. Can also monitor the impact of the symptoms by asking patient to rate (0-10) the degree to which their symptoms have impacted or interrupted their usual social, recreational, or occupational activities.

Referrals

To achieve goals or provide further evaluation, refer the patient to a rheumatology specialist, sleep center, mental health provider, pain management practice, physical therapist, or occupational therapist, as indicated..

More detailed information is available in the AANP Fibromyalgia Toolkit located at:

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Fibromyalgia: Recognition, Diagnosis, and Management

