

Keep it simple

Easing the care burden of fibromyalgia

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As you glance at your day sheet, you notice that the first patient of the day, 47-year-old Mrs J.B., has "TATT-NFW" as the reason for her visit. You silently groan. "Tired all the time." "Needs note for work." These are common problems in family medicine, but not ones you particularly enjoy dealing with.

Mrs J.B. has visited you 3 times in the past 3 months, complaining of terrible fatigue, as well as aches and pains. She has had no prior medical issues, just 3 normal pregnancies. She takes no medications, aside from ibuprofen or acetaminophen, which was suggested at her last visit. Mrs. J.B. works full time, is perimenopausal, and is happily married, but she also juggles care of elderly parents and occasionally fractious teenagers. She smokes cigarettes, drinks 2 large coffees a day, and enjoys wine with dinner. She has not led an active life. Last time you saw her she seemed glum and you wondered if she might be depressed; however, other than symptoms of fatigue and poor concentration, your review reveals that depression is not present.

During Mrs J.B.'s physical examination, you find the results are normal. She has no musculoskeletal abnormality or focal neurologic signs. Test results from her bloodwork (ie, complete blood count, erythrocyte sedimentation rate, and thyroid-stimulating hormone, creatinine, creatine phosphokinase, and C-reactive protein levels) are also normal. At her last visit Mrs J.B. said that her grandmother had been "crippled with arthritis." She is convinced that there is something wrong with her. You wonder if she might have fibromyalgia (FM) that is perhaps related to her hormonal status, disrupted sleep, and stress, but you recall that this is a diagnosis of exclusion. You perform a tender point count this time around. You decide that you will have to refer her to a specialist but know full well that the wait time is more than 6 months. Will it help Mrs J.B. to take time off from work? What should she try next?

For many primary care providers, this scenario is one they would rather avoid. Patients presenting with nonspecific problems can be challenging; it is a balance between investigating so as not to "miss anything" and becoming frustrated when a patient keeps returning to your office despite your reassurances that "all test results were normal." Many physicians also struggle to understand

conditions that lack any identifiable biomedical markers. Chronic pain depends primarily on patient self-report; hence, observers who lean more toward the biomedical issues and less toward the psychosocial-spiritual realms might have difficulty with subjective symptoms.¹

Guidelines

Fortunately, the 2012 Canadian FM guidelines² help clarify the diagnosis, workup, and management of patients with chronic widespread pain (ie, FM). The pathophysiology of FM is increasingly understood; changes in the hypothalamic-pituitary-adrenal axis stress-response system and maladaptive neuroplasticity have been well documented. At Laval University in Quebec city, Que, Marchand's elegant experiments point to defective central descending inhibitory pain control in FM.³

The 2012 guidelines stress the need for a biopsychosocial approach to treatment, and provide evidence for the influence of genetics, early childhood adversity, and stress on the development of FM. Family physicians have the privilege of providing continuing, comprehensive care and are best placed to know their patients' life trajectories, barriers, and strengths.

Physical examination in FM might reveal allodynia (ie, pain report when a non-painful stimulus, such as a light brush with a cotton swab, is administered).^{2,4} Patients might report unpleasantness or a painful or gritty feeling; lightly scraping a patient's back with the end of a paper clip might evoke a wince or an "ouch." Shading of a pain drawing might help the physician appreciate the extent of the pain, which might involve the torso and the limbs. The Brief Pain Inventory is another tool that can be completed by your patient at home or in the waiting room, and it can also be used to track changes in pain scores and pain interference.⁵

The guidelines list several FM screening and outcome assessment tools, including the Fibromyalgia Impact Questionnaire. However, even in its revised form, the Fibromyalgia Impact Questionnaire is cumbersome and time-consuming to score. The Fibromyalgia Rapid Screening Tool (FiRST) (**Table 1**) might be the simplest and most efficient screening tool in primary care.^{6,7} A copy of the FiRST tool is available for use at the Mapi Research Trust website,⁷ and it can be quickly completed by your patient in the waiting room.

Fibromyalgia treatment is covered in detail in the guidelines and should be based on symptoms. If sleep is the

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Cet article se trouve aussi en français à la page 605.

Table 1. The FiRST questionnaire: A FiRST score of 5 out of 6 for yes answers to the following statements has a 90% sensitivity and 86% specificity for FM.

QUESTIONS	YES	NO
I have pain all over my body		
My pain is accompanied by a continuous and very unpleasant general fatigue		
My pain feels like burns, electric shocks, or cramps		
My pain is accompanied by other unusual sensations throughout my body, such as pins and needles, tingling, or numbness		
My pain is accompanied by other health problems, such as digestive problems, urinary problems, headaches, or restless legs		
My pain has a significant impact on my life, particularly on my sleep and my ability to concentrate, making me feel generally slower		
FiRST—Fibromyalgia Rapid Screening Tool, FM—fibromyalgia. Reproduced with permission from Mapi Research Trust. ⁷		

patient's main issue, inquire about restless leg syndrome or sleep apnea and treat accordingly. If mood is an issue, an antidepressant such as the serotonin-norepinephrine reuptake inhibitor duloxetine might affect pain as well as mood. This agent has been approved in Canada for use in FM. Remember that patients with FM report sensitivity to medications, so "start low, go slow" with all medications. For example, duloxetine might be started at a tiny dose; during the main meal of the day, a 30-mg capsule can be opened and one-quarter to one-third of its contents can be sprinkled on applesauce and swallowed whole without chewing. This "off-label" mode of administration avoids the nausea that is the most common limiting side effect. Tricyclic antidepressants have a long track record in treating FM: sedation can be avoided by taking the dose 12 hours before the usual rising time. For pain, pregabalin or tramadol have supporting evidence in FM.² Stronger opioids are discouraged, but if used, physicians should refer to the Canadian guidelines for opioid prescribing.⁸ There is some evidence for a synthetic cannabinoid (nabilone) for sleep and possibly pain relief.² In contrast, there is currently no evidence for the use of smoked or ingested marijuana for management of FM symptoms. (For more information on medical marijuana, contact the Canadian Consortium for the Investigation of Cannabinoids, www.ccic.net, or the Medical Cannabis Access Society, www.medcannaccess.ca.)

The FM guidelines also discuss psychological and movement-rehabilitative treatments,^{9,10} as well as


self-management^{11,12} strategies and complementary and alternative medicine treatments.

Fibromyalgia, like diabetes, is a chronic condition, and the relationship with a supportive, caring, and non-judgmental primary care provider is the cornerstone of the continuing comprehensive care that family physicians offer.

After reviewing the FM guidelines, you ask your secretary to book a longer appointment with Mrs J.B. and request that Mrs J.B. complete the FiRST questionnaire while in the waiting room. Her FiRST score is a 6 out of 6. You enter the examination room without the usual sinking feeling. You discuss the normal test results, confirm the presence of allodynia, and explain the underlying pathophysiology of and contributors to FM, including stress and excess people-pleasing behaviour. You show Mrs J.B. the video Understanding pain. What to do about it in less than 5 minutes?¹³

You explain to Mrs J.B. that removal from the workplace can adversely affect outcomes, and rarely leads to functional improvements. She agrees to speak to her boss about modifying her workload, and you are happy to provide a letter to that effect. She will also speak to her spouse and siblings about helping with family responsibilities. She is interested in trying nonmedical therapy for starters, so you provide her with the information about the Stanford-based Chronic Pain Self Management Program¹⁴ and the Mindfulness-based Chronic Pain Program,¹⁵ both of which are available in your community. You set some SMART (Specific, Measurable, Achievable, Realistic, Time-limited) goals. She enjoys walking the dog, so she agrees to try to do this for 15 minutes every day. You explain the effects of caffeine on sleep, as well as of cigarettes on pain levels, and book a follow-up appointment in 6 weeks. You make a note in the file to use the Brief Pain Inventory at the next visit to gauge her symptoms, ask her how the dog walking is going, and provide strong advice about the value of smoking cessation.

Conclusion

The 2012 Canadian FM guidelines are a useful tool for primary care providers. The guidelines emphasize that we can investigate, educate, and treat FM without the need for expensive tests and specialist referrals. New symptoms developing in a patient with FM need to be reviewed with the same care we use for all patients. Functional outcomes and a biopsychosocial approach that uses medications, movement, mind-based treatments, complementary and alternative medicine, and self-management in a recipe that is tailored to the individual patient can lead to satisfying results for both the patient and the provider. 

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