Naval Medical Center Portsmouth
Rheumatology Referral Guidelines

Diagnosis:	**Fibromyalgia Syndrome (FMS)**

Clinic Name	Rheumatology
Clinic Phone Number	757-953-2160 or 2161
On Call Numbers	Duty Pager: 757-860-5702

1. Indications for Specialty Care:

- Patient is **active duty** and is unable to perform their job in the US military due to fibromyalgia member should be considered for an MEB or is already undergoing a MEB. We will provide a onetime evaluation by a rheumatologist to confirm diagnosis if required by their branch of service for medical board purposes; however the NAVY no longer requires the patient to be seen by a Rheumatologist for diagnosis or medical board initiation. The diagnosis can be made and dictation completed by the primary care provided (per SECNAVVINST M-1850.1)

- When specific organic pathology is suspected (evidence of end organ damage or criteria present for systemic rheumatic illness such as SLE, RA, scleroderma, etc.).

- Referral should not be given to merely reaffirm a previous diagnosis, for chronic management, or for a prescription of non-formulary drugs (Lyrica, Savella) for this condition.

- Fibromyalgia can be diagnosed by a primary care provider based on chronic widespread pain and associated symptoms of fatigue, headaches, poor sleep and memory difficulty. Dependents with fibromyalgia will not be seen or followed in NMCP Rheumatology clinic and should be managed by the primary care physicians. These referrals will also not be deferred to the civilian network Rheumatology unless specific pathology is suspected.

2. Quality Consult Criteria

When referring a patient, please include as much of the following information as possible (OK to cut and paste this into consult request)

1. Provisional diagnosis
2. Duration of Problem
3. Prior treatments
4. Current treatments/medications
5. Diagnostic studies obtained (imaging, labs, other tests, etc.)
6. Primary reason for consult
7. Use of referral guidelines

3. Diagnosis Definitions

- **Fibromyalgia is a common neurologic health problem that causes widespread pain and tenderness,** affects 2-4% of people, and usually affects women more often than men. The pain and tenderness tend to come and go and move about the body. The causes of fibromyalgia are unclear.
- **Fibromyalgia is not from an autoimmune, inflammatory, joint or muscle disease**. Research suggests that the nervous system is involved. Brain chemicals, like serotonin and norepinephrine, may be off balance, changing reactions to painful stimuli. Fibromyalgia may cause severe fatigue, poor sleep (waking up unrefreshed), problems with memory or thinking clearly and mood problems, like anxiety or stress. It does not cause any signs on x-rays or blood tests.

4. Initial Diagnosis and Management

- **Fibromyalgia is an affirmative diagnosis made clinically.**
- FM can be diagnosed by any provider and **DOES NOT** require a Rheumatologist. Fibromyalgia is not a diagnosis of exclusion, thus laboratory tests and imaging studies play no role in establishing the diagnosis. **There is currently no cure for fibromyalgia. Medications may relieve symptoms for some people. The three things that have proven to help FM patients includes: exercise, good sleep routine and cognitive behavioral therapy.**
- Blood tests and x-rays may be used to rule out other inflammatory diseases like thyroid problems but should not be routinely ordered in patients with no inflammatory or systemic symptoms.
- **FM symptoms are different for each person.** The most common symptoms are widespread pain and tender places around the body. People may feel tenderness to even slight pressure on muscles or around joints. Severe fatigue and sleep problems are also common. Someone with fibromyalgia may not feel refreshed after sleeping all night.
- Other FM signs and symptoms include:
  - Problems with memory or clear thinking, known as “fibro fog”
  - Depression or anxiety
  - Migraines or tension headaches
  - Digestion problems like IBS or heartburn
  - Irritable or overactive bladder
  - Pelvic pain
  - Temporomandibular disorder (TMJ), or jaw pain or popping
- **Criteria for a FM Diagnosis**
  - Pain and symptoms over the past week, based on the total of number of painful areas out of 18 parts of the body plus severity of these symptoms:
    - Fatigue
    - Waking unrefreshed
    - Cognitive (memory or thought) problems
    - Symptoms lasting three months at similar level
    - No other health problem that would explain the pain and other symptoms.
- Chronic management is best summarized in: Clauw DJ. Fibromyalgia: A Clinical Review. *JAMA*. 2014; 311(15):1547-1555. doi:10.1001/jama.2014.3266
- The VA/DoD clinical practice guideline for the management of chronic multi-symptom illness may also be useful: https://www.guideline.gov/summaries/summary/48873/vadod-clinical-practice-guideline-for-the-management-of-chronic-multisymptom-illness?q=fibromyalgia
- Please see attached FM questionnaire to use for patients.

https://www.rheumatology.org/Portals/0/Files/2010_Preliminary_Diagnostic_Criteria.pdf

Table 4. Fibromyalgia diagnostic criteria

Criteria

A patient satisfies diagnostic criteria for fibromyalgia if the following 3 conditions are met:

1) Widespread pain index (WPI) ≥7 and symptom severity (SS) scale score ≥5 or WPI 3–6 and SS scale score ≥9.
2) Symptoms have been present at a similar level for at least 3 months.
3) The patient does not have a disorder that would otherwise explain the pain.

Ascertainment

1) WPI: note the number areas in which the patient has had pain over the last week. In how many areas has the patient had pain? Score will be between 0 and 19.

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

2) SS scale score:

Fatigue
Waking unrefreshed
Cognitive symptoms

For the each of the 3 symptoms above, indicate the level of severity over the past week using the following scale:

0 = no problem
1 = slight or mild problems, generally mild or intermittent
2 = moderate, considerable problems, often present and/or at a moderate level
3 = severe: pervasive, continuous, life-disturbing problems

Considering somatic symptoms in general, indicate whether the patient has:*

0 = no symptoms
1 = few symptoms
2 = a moderate number of symptoms
3 = a great deal of symptoms

The SS scale score is the sum of the severity of the 3 symptoms (fatigue, waking unrefreshed, cognitive symptoms) plus the extent (severity) of somatic symptoms in general. The final score is between 0 and 12.

* Somatic symptoms that might be considered: muscle pain, irritable bowel syndrome, fatigue/tiredness, thinking or remembering problem, muscle weakness, headache, pain/cramps in the abdomen, numbness/tingling, dizziness, insomnia, depression, constipation, pain in the upper abdomen, nausea, nervousness, chest pain, blurred vision, fever, diarrhea, dry mouth, itching, wheezing, Raynaud's phenomenon, hives/welts, ringing in ears, vomiting, heartburn, oral ulcers, loss of/change in taste, seizures, dry eyes, shortness of breath, loss of appetite, rash, sun sensitivity, hearing difficulties, easy bruising, hair loss, frequent urination, painful urination, and bladder spasms.

- Evaluating for tender points on physical examination is still helpful.

5. Ongoing Management and Objectives

- Optimize management of primary disease states and psychiatric illness if applicable. Rule out other disease process as clinically indicated (i.e., hypothyroidism). Fibromyalgia is not an inflammatory arthritis or a connective tissue disease. A primary care physician can provide all the other care and treatment of fibromyalgia.

- **Non-Medical Therapy:**
  - Educate the patient about FM, signs and symptoms, and treatment options. Only three things have proven to help fibromyalgia: good sleep, exercise and cognitive behavioral therapy. Provide handout: (http://www.rheumatology.org/Practice/Clinical/Patients/Diseases_And_Conditions/Fibromyalgia/) and direct to internet education resources for patients and family through the National FM Association (http://www.fmaware.org/) and the Fibromyalgia Network (http://www.fmnetnews.com/).
  - Validate the patient's symptoms.
  - Emphasize nondestructive nature of FM. It is not an inflammatory arthritis or a connective tissue disease.
  - Focus on improving function, not complete eradication of symptoms as there are no magic bullet medications that will alleviate pain. Emphasize this is a chronic condition with no cure.
  - Discuss importance of mind–body relationships. Teach meditation and relaxation techniques. Consultation for biofeedback training via cognitive behavioral therapy for motivated individuals.
  - Discuss drug and non-drug therapy options to include good sleep hygiene and exercise.
  - Inform about principles of sleep hygiene and how to get a good night's sleep.
  - Explain the importance of gentle life-long exercise/movement program. Moderately intense aerobic exercise has been shown to improve pain. Patients should gradually increase exercise to avoid an exacerbation of symptoms.
  - Recommend a gentle stretching program and low impact aerobic exercise/ progress movement. Instruct the patient in the principles and methods of gradual incremental cardiovascular fitness. Low impact aerobic exercises such as walking, swimming, and stationary bike are the most successful. Alternative forms of exercise include Tai Chi and

Yoga. The goal should be 30 minutes of aerobic activity, 5 days per week. Physical therapy or exercise physiology consultations can be utilized if necessary.
  - Consider a trial of acupuncture which has been shown to moderately reduce pain in patients with FM.
  - Emphasize patient's active role in any treatment.

- **Medical therapy:** CNS active medications such as amitriptyline, nortriptyline, and cyclobenzaprine and gabapentin should be tried. Chronic management is best summarized in: Clauw DJ. Fibromyalgia: A Clinical Review. *JAMA*. 2014; 311(15):1547-1555. doi:10.1001/jama.2014.3266. PMID: 24737367.

  - Lowest effective dose should be used; medications should be titrated upwards to effect. An adequate trial (at least 4 weeks) should be attempted before considering the medication ineffective. If the patient fails a clinical trial of one medication or cannot tolerate the medication due to side effects, another trial with a similar medication should be attempted.
  - NSAIDs are not effective alone; they may have a synergistic effect with CNS active medications. They may also be effective in musculoskeletal pain exacerbated by exercise.
  - If the tricyclic class is unsuccessful alone, a morning dose of an SSRI (fluoxetine or paroxetine) with non-sedating properties should be added. Dual reuptake inhibitors such as duloxetine or milnacipran (both FDA approved for the treatment of FM) may also be considered if TCA/SSRI therapy is ineffective. These medications may require a non-formulary Drug Request through pharmacy. As noted above, an adequate trial should be attempted.
  - Narcotic medications should be **avoided** in the treatment of FM. Tramadol may be an effective pain medication (especially as an evening dose), but should be used with caution in patients on SSRIs, tricyclic antidepressants, or other cyclic compounds (such as cyclobenzaprine) due to increased risk of seizure and it is now a schedule IV narcotic. Tramadol should be avoided in patients with a prior history of seizures.
  - Antiepileptic medications such as gabapentin may be tried with gradual titration of dose to effect.
  - If the patient fails TCAs, SSRIs, SNRIs and/or gabapentin, consideration should be given for a trial of pre-gabalin (Lyrica). A non-formulary drug request must be completed for approval of this medication through the pharmacy. Any provider in the military system is capable of prescribing a non-formulary medication.

6. Criteria for Return to Primary Care

- Diagnosis of FM established in the absence of autoimmune disease.
- If a provider has management questions this does not require another referral. These questions would be handled as a conversation between referring provider and the consulting Rheumatologist.

Date Adopted or Last Reviewed:	14 July 2020	By	CDR Shauna O'Sullivan LCDR Jeffrey Eickhoff CDR Terrence Kilfoil LCDR Jason Weiner
Referral Guidelines require review every three years.			

7. Resources/References

- American College of Rheumatology: http://www.rheumatology.org/Practice/Clinical/Patients/Diseases_And_Conditions/Fibromyalgia/
- National FM Association: http://www.fmaware.org/
- Fibromyalgia Network: http://www.fmnetnews.com/
- Chronic Management of FM: Chronic management is best summarized in: Clauw DJ. Fibromyalgia: A Clinical Review. *JAMA*. 2014; 311(15):1547-1555. doi:10.1001/jama.2014.3266. PMID: 24737367.
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