Why Did Rheumatologists Have Ownership of Fibromyalgia (FM)?
The health community, patients, and third-party payers have traditionally turned to the rheumatologist for the diagnosis, and often continued care, of FM patients for a variety of reasons. In the olden days, it was believed that FM stemmed from an abnormality of soft tissues; thus, it was rheumatologists’ territory. Indeed, textbooks of that era included FM under the heading of soft-tissue problems, as does the American College of Rheumatology (ACR) even to this day. This explanation was even more plausible when it was demonstrated that patients were sensitive to touch on examination of those specific areas of the body termed “the tender points”, a finding that reinforced the notion of some soft-tissue pathology. So it has been for the past two decades, with rheumatologists bearing the responsibility to lay on the hands, or rather the thumbs, with exactly 4 kg pressure, and pronounce a diagnosis of FM.

Secondly, in the setting of a somewhat nebulous condition without any defining abnormality, reassurance was sought by having the diagnosis confirmed by an “expert”. With the understanding that the pathogenesis of FM is principally located in the nervous system, with evidence of dysregulation of pain-processing pathways extending from the periphery to spinal cord and also involving the brain, it is perhaps time for rheumatologists to abrogate their responsibility for the diagnosis and clinical care of these patients.

Finally, a frequent question posed to rheumatologists is the significance of a weakly positive antinuclear antibody or rheumatoid factor (RF) in the setting of a patient with ill-defined symptoms of body pain and fatigue. It has therefore been the rheumatologist’s responsibility to pronounce on the absence of a smoldering connective tissue disease in favor of a diagnosis of FM.

Time for a Paradigm Change?
There are a number of reasons why the medical community and society should embrace a paradigm change regarding FM; concerns of limited manpower and large rheumatic disease patient loads are paramount. Given that population studies estimate that FM affects, by conservative estimates, at least 2% of persons, it is inconceivable that all, or even a portion of, FM patients can be seen by a specialist or a rheumatologist in particular. Rheumatologists are experts in caring for patients with inflammatory arthritis (IA) and should be allowed to build on this strength, but without attributing lesser importance to a patient with FM compared to one with inflammatory arthritis. Patients with FM do suffer and therefore the best setting for care should be sought.

FM is a polysymptomatic distress syndrome with symptoms of pain, mood, and sleep disorder, symptoms that are clearly outside the usual rheumatic disease domain. Rheumatologists are not expert in diagnosing or treating the nuances of mood disorder, or spending time explaining the principles of sleep hygiene or initiating sleep-promoting drugs. In that ideal care for most FM patients incorporates a multimodal approach by a healthcare team, a one-on-one visit with a single rheumatologist is also less helpful. Management in a multidisciplinary setting, with access to a nurse and other health care professionals, has been shown to be optimal, but that too is not available for most patients. Therefore, the role of the primary-care physician in FM management is increasingly logical and should be strongly encouraged. New multidisciplinary primary-care models, such as integrated Family Health Teams in Ontario, and similar models in other provinces, could potentially provide the type of care FM patients need.

Societal concepts of health and disease also require a paradigm change as patients have come to expect specialist
diagnosis and often management to be the norm. Finally, there remains the mindset that symptoms should be explained by some physical abnormality, which has driven the high healthcare costs recorded for these patients.

The Essence of the Guidelines
With these concepts in mind, a multidisciplinary group of health care professionals have drafted guidelines for the rational management of FM patients in Canada, incorporating recommendations for diagnosis, management, and patient trajectory. Endorsed by both the CRA and the Canadian Pain Society, it is hoped that the medical community will be more confident regarding various aspects of FM. Some of the key concepts incorporated into the guidelines are further described, and the entire guidelines and recommendations can be accessed freely on the CRA website (www.rheum.ca/en/publications/cra_fm_guidelines).

FM is a clinical construct, which should be positively diagnosed in the primary-care setting without requirement for specialist confirmation or follow up, and with only the exceptional patient referred for specialist opinion. The diagnosis is clinical without need for extensive investigation; the tender point count, a subjective assessment without scientific basis, may be eliminated from the clinical evaluation. As the primary-care physician is best placed to have a composite knowledge of the patient, both from the health and psychosocial aspect, ideal care should remain in the primary care setting, and excessive healthcare contact and investigations, which will augment the sickness role, should be avoided.

Regarding treatments, non-pharmacologic strategies should be incorporated into the management of every patient, with a focus towards development of a strong internal locus of control by means of self-management strategies. There should be a shift away from nurturing passivity by simply prescribing medications, which generally provide only modest effect, and with side effects that may mimic symptoms of FM. Drug combinations, although not supported by the evidence in the literature but commonly used in clinical practice, may allow lower doses of each agent to be used with reduction of side effects. The culture of disablement surrounding FM is now questioned, with a call for a societal change to focus on patient motivation and retention of normal life pattern, with the acknowledgement that symptoms will likely persist and fluctuate.

Will this Proposed Paradigm Change Occur or Will FM Patients Remain the Cinderellas’ of Rheumatology Practice?
Rheumatologists will be required to play a critical role in effecting this paradigm change by contributing to the education of the primary-care community regarding confident diagnosis and management of FM. FM remains ensconced in many myths that will need to be dispelled with knowledge and empathy. The perception that FM patients are particularly “needy” or challenging must be superseded by firm empathy. They have recognized needs, but we now require a societal paradigm change to move these persons out of the passive sickness role, and encourage their participation in normal society with acceptance of societal responsibilities. Social marketing, which has likely contributed to the prevalent impression of disablement, should now be used to project a positive concept of FM.

Mary-Ann Fitzcharles, MB, ChB
Associate Professor, Division of Rheumatology,
Alan Edwards Pain Management Unit,
McGill University Health Centre
Montreal, Quebec

Peter A. Ste-Marie, BA
Faculty of Law, Université de Montréal
Alan Edwards Pain Management Unit,
McGill University Health Centre
Montreal, Quebec

It is with great sadness that we share the news of the passing of Dr. Hugh Smythe, 1927-2012; and Dr. Duncan Gordon, 1930-2012. Full tributes will be featured in the Spring 2013 issue of the CRAJ.