What is fibromyalgia?

Patients with fibromyalgia (FM) experience widespread body pain that fluctuates in intensity and location, and can have associated fatigue, sleep and mood disturbance, cognitive complaints, and other somatic symptoms.¹ FM affects 2 to 3% of the population — mostly middle-aged women — but can also occur in men, children, and the elderly.² There is no clinical or laboratory test to confirm the diagnosis.

The notion that FM is a rheumatic disorder of soft tissues is no longer tenable in light of neurophysiologic evidence pointing to dysregulation of pain processing pathways.³ Sensitization at the periphery and centrally, compounded with hypervigilance, alterations of grey matter volume and brain connectivity, and disordered descending pain modulation, all contribute to the clinical manifestation of pain and distress. The reason for these changes is still unknown, but contributing factors, such as genetic predisposition, previous pain experiences, a susceptible psychological status, or some triggering event, may play a selected role in the expression of FM.

There is currently no cure for FM, with symptoms persisting over time in a waxing and waning pattern. Treatments can generally reduce symptoms, with most patients able to identify strategies that can achieve reasonable symptom control or modulate a “flare.” Although patients have previously reported considerable functional impairment, current guidelines recommend encouraging participation in normal life activities, while discouraging sickness behaviour.⁴

Key points addressed in the 2012 Canadian Fibromyalgia Guidelines

Guidance pertinent to the diagnosis, management, and clinical trajectory for patients with FM may be found in the recently developed 2012 Canadian FM guidelines.⁴
FM is a clinical construct, which should be positively diagnosed in the primary care setting, without the requirement of confirmation by a specialist as often occurred in the past. The physical examination should be within normal limits for most patients, and the tender point count, a subjective assessment without scientific basis, should no longer be used to establish a diagnosis and may even be eliminated from the clinical evaluation. This finding simply represents a global reduction of pain threshold. Additionally, criteria for the diagnosis of FM, developed for the purpose of research, should not be used in the clinical setting. Furthermore, patients may move in and out of criteria at various times due to fluctuating symptoms.

Excessive investigation promotes uncertainty and illness behaviours and is strongly discouraged. Only exceptional circumstances should warrant a referral to a specialist for an opinion, such as when some other diagnosis is questioned, or for those presenting a treatment challenge. Following diagnosis, ideal patient care should, therefore, remain in the primary care setting.

The value of non-pharmacologic treatments is emphasized with a focus on self-management strategies and exercise activity; there should be a shift away from primarily pharmacological treatments, which are often associated with side effects similar to symptoms of FM. Drug categories that may be used include simple analgesics, pain modulators in the anticonvulsant or antidepressant class, but benzodiazepines, cannabinoids, or strong opioids should be used with caution. Drug combinations with cautious low dosing may be considered.

The culture of disablement surrounding FM is now questioned, calling for a societal change towards patient motivation and retention of normal life patterns, while acknowledging that symptoms will likely persist. A diagnosis of FM should not immediately equate with functional disability. Moreover, patients should be encouraged to remain in or return to the workforce, even with work modifications, as those working have more favourable outcomes.
**Patient management**

Management should be tailored to the individual patient with attention to weighting specific symptoms in a symptom-based approach. As there is no gold standard of treatment, with pharmacologic agents having only a modest effect, a multimodal strategy is ideal.

Self-management strategies that reinforce a strong internal locus of control emphasize good coping, positive attitude, pacing, and active patient participation. Regular physical activity, which can take any form, is vital.

There is no single drug treatment for FM, with no drug outperforming others. Most patients will, however, use some simple analgesics, mostly on demand. When using anticonvulsants or antidepressants, primarily as pain modulators, attention should be paid to subtle side effects, which can mimic symptoms of FM.

**Summary**

FM is a valid condition, without any confirmatory test that should be diagnosed in the clinical setting. Symptom control can be achieved for most patients with focus on self-management strategies, and cautious use of drug treatments, which provide only a modest effect. A societal change regarding the concept of FM is required with emphasis on maintaining function and discouraging disablement.

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**References**


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**Back to Linda**

Linda has FM. She should be reassured that regular exercise, although painful at times, is not harmful. She should set achievable goals at home and at work, which can be monitored at a follow-up visit and will help with returning to a normal life pattern. Pacing of work and home activities may attenuate fatigue. As pain and sleep are her most troublesome symptoms, a pharmacologic agent addressing both, such as a tricyclic antidepressant or an anticonvulsant, may be considered. Additionally, a gabapentinoid may help with anxiety. She should be encouraged to remain in the workforce.

**Take-home Message**

1. FM can be entirely managed in the primary care setting for most patients, without the need for specialist referral or confirmation of diagnosis.
2. A symptom-based approach combining non-pharmacologic and pharmacologic strategies with the goal of functional improvement or maintenance is the most appropriate avenue for the management of FM.
3. The outcome for most FM patients is not overly dismal, as motivated patients will identify strategies that modulate symptoms.

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