Health Services
LOS ANGELES COUNTY

Expected Practices

Specialty: Rheumatology

Subject: Fibromyalgia

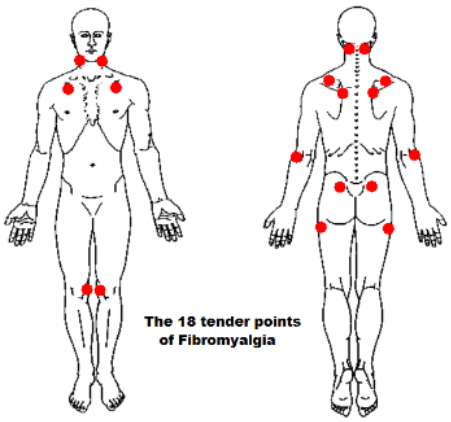
Date: April 15, 2014

Purpose: Evaluation and Management of Fibromyalgia

Target Audience: Primary Care Providers

Expected Practice:

Diagnosis:
Fibromyalgia is a disorder of chronic widespread pain generally accompanied by one or more concomitant symptoms including fatigue, sleep disturbances, cognitive dysfunction, anxiety, and/or depressive episodes. On exam, patients have tenderness in multiple soft tissue locations present for at least three months. Specifically, patients with fibromyalgia have moderate pain and tenderness at a minimum of 11 of the 18 specified tender points.



This *Expected Practice* was developed by a DHS Specialty-Primary Care Work Group to fulfill the DHS mission to ensure access to high-quality, patient-centered, and cost-effective health care. SPC Work Groups, composed of specialist and primary care provider representatives from across LA County DHS, are guided by 1) real-life practice conditions at our facilities, 2) available clinical evidence, and 3) the principle that we must provide equitable care for the entire population that LA County DHS is responsible for, not just those that appear in front of us. It is recognized that in individual situations a provider's clinical judgment may vary from this *Expected Practice*, but in such cases compelling documentation for the exception should be provided in the medical record.

A limited serological work-up including a CBC, ESR, CRP, TSH, chemistry, and CK may be undertaken to evaluate for the presence of underlying disease. If there are any abnormalities in the above tests, please submit eConsult and discuss with rheumatologist. Avoid routine ordering of ANA or RF unless the exam suggests features of lupus or other inflammatory arthritis. A screen for depression and underlying sleep disorders should be considered and a referral to sleep study or psychiatry may be indicated.

Management:

Rheumatology services in the LA County DHS system do not accept consults for fibromyalgia. Patients with this diagnosis can be well managed by primary care.

1) **Education** of the patient is critical. Explain to the patient that this is not a deforming or disfiguring disease and it is not cancer. Explain the rationale of medical therapy, especially the use of anti-depressant medications as they help manage central CNS pain processing. Emphasize the importance of exercise and performing good sleep hygiene.

2) **Medications** should be targeted to the patient's symptoms. Gabapentin can be trialed for generalized pain. The best PRN pain medicines are tramadol or cyclobenzaprine. Antidepressant medicines can help with pain, mood, and insomnia and include TCA's (e.g., amitriptyline), SNRI's (e.g., venlafaxine), or higher dose SSRI's (e.g., fluoxetine, paroxetine, fluvoxamine, citalopram). NSAIDS, steroids, and opioids are not the recommended treatment as this is not an inflammatory disorder and opioids are not effective.

3) **Exercise**: Referral to physical therapy for a graded exercise program is the cornerstone of management and will potentiate the efficacy of medicines used. In addition, consider referral to a local YMCA with enrollment in an aqua-aerobics class if possible. Referral to a Fibromyalgia support group through the Southern California Arthritis Foundation can help to provide psychosocial support. Patient should be cautioned that a temporary increase in myalgias may occur upon initiating an exercise program.

4) **Prognosis**: Most patients do not achieve cure but do have reduced symptoms in response to a multidisciplinary approach to therapy. This should include a regular aerobic exercise program, medical therapy targeted to symptoms, and education/support groups.

References:

Wolfe, et al. Arthritis and Rheumatism. Vol. 33, No. 2 (1990).
Busch, et al. J Rheumatol. 35, 1130-1144 (2008).
Schmidt-Wilcke, T. & Clauw, D. J. Nat. Rev. Rheumatol. 7, 518–527 (2011).
Häuser et al. Pain. 145, 69–81 (2009).
Häuser et al. Rheumatology. 50, 532–543 (2011).
Häuser et al. JAMA. 301(2), 198-209 (2009).
Fitzcharles et al. J Rheumatol. 30, 154-159 (2003).