“FSS are characterised by patterns of persistent bodily complaints for which adequate examination does not reveal sufficiently explanatory structural or other specified pathology.”
How do we help...?

Occupational MD
Academic Resources for FSS
• BMJ FSS 2002
• NEJM FSS 2004
• Lancet FSS 2007
• Canadian FM guides 2012
• Cochrane Review FSS 2013
• JAMA FM review 2014

FSS Tool Box!
• Approach
• Pearls
• Communication
• Treatment review
• Focus on function

Is FSS a Psychiatric Dx?
“While many patients with FSS meet criteria for co-morbid anxiety or depressive disorders, these are not invariably present and the concept that FSS might simply represent somatised psychiatric illness is not tenable.”
NEJM The Psychopathology of FSS

• “... previously argued that these syndromes are probably manifestations of a primary affective disorder...... concludes otherwise. ”
• “...a substantial portion of patients with these disorders do not have a mood disorder.”

2012 Canadian Guidelines for FM

• Polygenetic effect affecting serotonergic, catecholaminergic and dopaminergic systems
• Dysfunctional stress response via the hypothalamo-pituitary axis
• Psychosocial distress, as well as early life adversity can predict onset of chronic widespread pain

Central Sensitivity?

• FM is a centralized pain state.
• “Centralized” refers to CNS origins of or amplification of pain.
• Feel more pain than normally expected.
• These central factors may also result in fatigue, poor memory & sleep & mood disturbance.
  – JAMA April 16, 2014 Volume 311, Number 15
Group Exercise

• Take a minute to remember an FSS case and jot down a note.

• Group in 2 or 3s and one of you quickly discuss your case.

What are some clinical issues noted?

• Beyond Myalgic Encephalomyelitis/Chronic Fatigue Syndrome An IOM Report on Redefining an Illness
  • Ellen Wright Clayton, MD, JD
  • JAMA. 2015;313(11):1101-02
Prototypical FSS is FM

Barsky’s 6-Step Approach to FSS

1. Search for a medical disorder
2. Search for a psychiatric disorder
3. Collaborative therapeutic alliance
4. Restoration of Fx is goal of Tx
5. Provide limited reassurance
6. Cognitive Behavioral Therapy if no response to steps 1-5

Barsky, Borus 1999 Ann Int Med 130; 11
“My macrophages are hemosiderin laden!”

1990 ACR FM Criteria
Wolfe et al.
• Rheumatological & physical emphasis
• Hx of widespread pain for at least 3 months
• In combination with at least 11/18 tender points being painful

FP Screening for FMS 2010
• Does not require a physical or tender point examination
• Correctly classifies 88.1% of cases
• Combines 2 brief questionnaire scales
  —Symptom Severity (SS) scale
  —Widespread Pain Index (WPI)
2011 Modification of ACR Preliminary Dx Criteria

- Eliminating extent of somatic symptoms
- Substituting the sum of 3 self-reported Sx
  - Abdominal pain/cramps, depression & HA
- A score ≥ 13 best separated criteria + and criteria – pts
  - Sensitivity of 96.6%
  - Specificity of 91.8%

JAMA Clinical Review 2014

Fibromyalgia
A Clinical Review 2014
Uses 2012 Canadian Guidelines for the diagnosis and management of fibromyalgia syndrome.

2012 Canadian Guidelines for FM

“...biopsychosocial model in which predisposition, triggering and other factors, such as depression, maladaptive coping or fear avoidance behaviour, contribute to chronicity”

Barsky’s 6-Step Approach

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Barsky, Borus 1999 Ann Int Med 130; 11

Don’t miss pathology!
FM History

- Caution with AIDS, SLE, TB
- Careful with pts age >50 & “red flags”
  - Change in headache?
  - History of cancer?
  - Nocturnal back pain?
  - Unexplained weight change?

2012 Canadian Guidelines for FM

Rule out conditions:
- Hypothyroid
- Early inflammatory arthritis
- Polymyalgia rheumatica
- Myopathy
- MS
- Drug-induced conditions (lipid-lowering agents)

When to stop investigations for FM?

- Reasonable workup for common conditions
- No “red flags”
- +/- specialist consultation
- Patient is counselled & educated
- You are comfortable
- Workup is well documented
FM Family History

- 1st degree relatives of patients with FM are more likely (OR 8.5) to have FM and other chronic pain conditions.
- Twin studies suggest that approximately 50% of risk of developing FM & related conditions such as IBS is genetic.
  - JAMA April 16, 2014 Volume 311, Number 15

FM Physical Examination

- Full physical exam
- Functional physical exam
  - Sit, arise, stand, walk, bend, squat...
- MSE:
  - Depressed or anxious
  - Cognitive screen

Exam Screening for FM

BP Cuff invoked allodynia
- Inflate 10 mmHg/sec to 180 mmHg or to pain
- “Tell me if the cuff’s pressure brings forth pain”
- 69% FMS report pain vs. 2% normals
  - 70% sensitive & 96% specific for FMS
  - J Clin Rheum 2006;6
Barsky’s 6-Step Approach
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   Barsky, Borus 1999 Ann Int Med 130; 11

Global Sx Pain & Fatigue
• Most frequent worldwide somatized Sxs of depression & anxiety are MSK pain & fatigue
• Globally 45-95% of pts with depression initially report somatic Sx
  – 11% deny psychological Sx of depression on direct questioning

2012 Canadian Guidelines for FM
Depression can present with pain, although local tenderness is more common in FM patients compared to those with depression
Psychological Trauma & FSS
Systematic Review & Meta-Analysis

• 71 studies with control/comparison grp
• Association with emotional, sexual, or physical abuse, combat exposure, or PTSD?
• Reported trauma has OR 2.7 for FSS
  – *Psychosom Med*. 2014 January

Fibromyalgia Comorbidity

• FMS n=108  no FMS n=288
  – MDD          OR 2.7
  – Panic disorder OR 5.0
  – PTSD         OR 12
  – Etoh abuse/depend OR 2.0
  – Drug abuse/depend OR 2.4

An FM & PTSD case....
2012 Canadian Guidelines for FM

- A Dx of FM should be made in primary care.
- Referral to specialist is reserved for pts who have failed management or have more complex co-morbidities.

Barsky’s 6-Step Approach

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Barsky, Borus 1999 Ann Int Med 130; 11

2012 Canadian Guidelines for FM

- When MDs believe FM pts to be illness-focused & medicalized, the pt doctor alliance is eroded
- Shared decision-making between patient & physician improves quality of care
- Promote self efficacy
**FM Structure & Support**

- Provide structure
- Schedule regular visits
- Office review of Rx
- Assess measurable goals
- “Homework” diary
Barsky’s 6-Step Approach

1. Search for a medical disorder
2. Search for psychiatric disorder
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Barsky, Borus 1999 Ann Int Med 130; 11

2012 Canadian Guidelines for FM

Individuals with FM should participate in a graduated exercise program of their choosing to obtain global health benefits and probable effects on FM symptoms (level 1, grade A)

FM & Lifestyle Physical Activity

• Recorded daily steps
• Diarized the types of LPAs
• LPA group increased daily steps from 3,788 to 5,837 over 12/52
• LPA group reported less perceived functional deficits & pain

Clinical Database for Function
• Stated activity tolerances
• Current roles
• House and yard chores
• Hobbies & recreational activities
• Functional physical examination

Focus on Function!

FM Employment Status
• 54 Vancouver FMS pts 94% female
  – Employed full time 26%
  – Employed part time 17%
  – Unemployed 7%
  – Retired 15%
  – Disability insurance 35%
2012 Canadian Guidelines for FM

• Explain the pain-modulating effects of antidepressant meds to pts to dispel the concept of a primarily psychological complaint
• All categories of antidepressant medications including TCAs, SSRIs and SNRIs used for treatment of pain and other symptoms in patients with FM (level 1, grade A)

2012 Canadian Guidelines for FM

• Pregabalin improved pain, global function, and sleep at doses of 450 mg/day
• Associated with reduced use of other medications such as NSAIDs

2012 Canadian Guidelines for FM

• Opioids considered in pts with mod to severe pain unresponsive to other Tx (level 2, grade D)
• Begin with tramadol
• Strong opioid use is discouraged
• Pts should show improved pain & function
• Monitor for efficacy, side effects or aberrant drug behaviours (level 5, grade D)
Barsky’s 6-Step Approach

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Barsky, Borus 1999 Ann Int Med 130; 11

Provide Limited Reassurance

1. Hurt vs. harm
2. Care rather than cure
   — “You do not have any life-threatening illness. You do, however, have a medical condition that is incompletely understood. Though no treatment is available that can cure it completely, there are a number of interventions that can help you deal with the symptoms better than you have so far.”

Provide Limited Reassurance for FSS

• The symptoms are real and familiar to doctor
• Provide a positive explanation, including how behavioural, psychological, & emotional factors may exacerbate physiological somatic symptoms
• Discussion of patient’s and family’s worries
• Give practical advice on coping with symptoms
• Encourage return to normal activity and work
  — BMJ VOLUME 325 3 AUGUST 2002
Barsky’s 6-Step Approach

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Barsky, Borus 1999 Ann Int Med 130; 11

CBT if Required

CBT is indicated in
• Fibromyalgia
• CFS
• IBS
• Major depressive disorder
• Panic disorder
• Insomnia

2012 Canadian Guidelines for FM

CBT, even for a short time, is useful and can help reduce fear of pain and fear of activity (level 1 grade A)
CBT & Stress Management Resources

• Vancouver CBT clinics
  – www.vancouvercbt.ca
  – www.changeways.com
• Relaxation response instructions
  – www.relaxationresponse.org/steps/
• CBT treatment for insomnia
  – www.cbtforinsomnia.com

Summary
1. Search for a medical disorder
2. Search for psychiatric disorder
3. Therapeutic alliance
4. Restoration of Fx is goal of Tx
5. Provide limited reassurance
6. CBT if no response to steps 1-5

Discuss your case...
1. Search for a medical disorder
2. Search for psychiatric disorder
3. Collaborative therapeutic alliance
4. Restoration of Fx is goal of Tx
5. Provide limited reassurance
6. CBT if no response to steps 1-5
FPs Best for Restoration of Function!

- Excellence in lifestyle counselling
- Graded gradual activity
  - Lifestyle physical activity
  - Activity RX
- Weight management
- Sleep management
- Mood & anxiety disorders
- Cognitive behavioral therapy