

# **MEDICAL SERVICES**

PROVIDED ON BEHALF OF THE DEPARTMENT FOR WORK AND PENSIONS

Training and Development

## **Continuing Medical Education Programme**

### **Fibromyalgia - Guidelines for the Disability Analyst**

**MED/S2/CMEP~0035**

Version 4 Final

**Module: 14**



# Medical Services

## Foreword

This document has been produced as part of the medical education programme for Health Care Professionals training for approval by the Department for Work and Pensions Chief Medical Adviser to carry out medical assessments.

All Health Care Professionals undertaking medical assessments must be registered medical or nursing practitioners who in addition, have undergone training in disability assessment medicine. The training includes theory training in a classroom setting, supervised practical training, and a demonstration of understanding as assessed by quality audit.

This guidance must be read with the understanding that, as experienced medical or nursing practitioners, the Health Care Professionals will have detailed knowledge of the principles and practice of relevant diagnostic techniques and therefore such information is not contained in this module.

In addition, the guidance is not a stand-alone document, and forms only a part of the training and written documentation that a Health Care Professional receives. As disability assessment is a practical occupation, much of the guidance also involves verbal information and coaching.

Thus, although the training module may be of interest to non-medical readers, it must be remembered that some of the information may not be readily understood without background medical knowledge and an awareness of the other training given to Health Care Professionals.

Office of the Chief Medical Adviser

July 2009



## Document control

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### Superseded documents

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# **1. Aims and Objectives**

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## **1.1 Aim**

The aim of this module is to present to Health Care Professionals an overview of fibromyalgia syndrome which will enable them to approach claimants with the illness in a structured and consistent way.

## **1.2 Objectives**

By the end of the module the reader will be able to:

- List the characteristics of fibromyalgia syndrome,
- List the areas where it overlaps with other, similar disorders,
- Describe an approach to the provision of medical advice which is pragmatic, medically logical and in keeping with the current consensus of medical opinion.

## 2. Introduction

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This short overview aims to refresh your awareness of fibromyalgia syndrome (FMS) and examines its implications in the disability analysis setting.

From your own study of the literature, you may hold different views on some facets of this condition to those expressed here. However, when advising the decision maker it would be preferable if we adopt a common approach to the uncertainties and conflicts inherent in the condition and as far as possible align our methods of evaluation and reporting.

The first part of the module invites you to explore your current view of the condition. The second presents a composite case which may help to refresh your recollection of its many facets.

A brief overview follows, and finally our proposals for a consistent approach to the disability assessment and the formulation of advice.

A short selection of the many references consulted is given at the end and we hope that the module will be informative and useful.

### 3. Fibromyalgia syndrome (FMS)

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Consider the following questions:

1. What are your current views on FMS?
2. Complete the table:

	YES	NO	DON'T KNOW
FMS is entirely psychological in origin			
FMS is wholly physical in origin			
FMS is partly physical, and partly psychological in origin			
There is always some evidence of a precipitating injury			
Most cases of FMS are attributable to abnormal illness behaviour			
Unlike CFS aerobic exercise has no beneficial effect in FMS			
As regards the outlook, each case is different: there are no clear prognostic indicators			

3. What are the characteristics of FMS? Write them down in the space below.

CHARACTERISTIC FEATURES OF FIBROMYALGIA SYNDROME

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### TRY TO RECALL WHEN YOU LAST SAW A CASE OF FMS

1. Who made the initial diagnosis:
  - A colleague?
  - You?
  - The patient?
2. What was the history, and what were the symptoms?
3. Was the assessment in connection with a disability examination?
4. If the person was seen in a clinical setting do you think the encounter would have been easier in the disability analysis context?
5. Give reasons.
6. What was the outcome of your examination?

### 4. Case example

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**Please read the following case example. It is based on an actual case but has been considerably amplified and altered to illustrate certain points and to encourage reflection.**

#### **Mrs C.**

Mrs C is a lady of 36 years. Symptoms began some 4 years ago. At that time she was employed as a sales manager in a small but thriving and growing company – a job which she describes as very responsible, hectically busy and challenging. She enjoyed the job, but had difficulties with her manager who she thought disapproved of a woman holding such a central position in the company.

She married at the age of 28 but her husband lost his job a few years later and he shouldered the household responsibilities while Mrs C became the sole breadwinner. They have one (disabled) boy of 6, and a daughter of 7.

In January 1999 she contracted a mild flu-like illness but did not stop work because of it. While driving in the city at this time her car was struck from behind by another vehicle. There was an altercation between herself and the other driver. She was upset and shaken and had sustained a few scratches from flying glass, but was otherwise unharmed. She attended the local A & E department, where she was “checked over” and given the all clear.

The (company) car was a write-off and relationships between her and her manager deteriorated further. Meanwhile her flu-like symptoms persisted and she began to experience pain in her lower cervical area. She thought it might be fibrositis or muscular rheumatism. Instead of improving, it became steadily worse, the pain extending over the left suprascapular area, then the right. Whiplash injury was retrospectively diagnosed by her GP, 5 months after the car accident.

Eventually she had to give up driving as she could not get in and out of the car without a great deal of pain, and reversing and parking were almost impossible.

Latterly the pain extended down to her waistline and her right leg was becoming involved. Her employer made it clear that she would have to be replaced as they were highly dependent on an efficient and committed sales manager, but offered her a desk job. This was quite a junior post and her salary was to be just over half of what it was as sales manager. She refused, and her employment was terminated. She is suing the owner of the vehicle involved in the accident for her injuries and her former employers for wrongful dismissal.

Mrs C. is in bed when you arrive to assess her for Disability Living Allowance (DLA). She looks quite well physically, with no signs of weight loss or muscle wasting. However she appears rather depressed and becomes quite emotional when describing her family problems and again later when explaining how she feels she was badly treated by her employer.

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All four limbs are generally painful; in fact she feels that most of her body is now affected by the pain. Her neck discomfort is still troublesome and she experiences tingling in both arms. She is quite dependent on her husband for help with a variety of self-care tasks, like hair-washing, dressing (some days), and getting in and out of bed. To make matters worse she has developed a bowel problem and this has added to her difficulties. She experiences diarrhoea at times, with cramping pain; at other times she has constipation accompanied by uncomfortable fullness and lower left-sided abdominal discomfort. This has been (negatively) investigated in hospital.

She sleeps poorly and in the morning is unrefreshed. Her back, shoulders and legs are particularly painful about this time and this adds to her feeling of lethargy and tiredness. Her joints, especially the wrists and elbows feel swollen, although there's nothing much to be seen, she says. To make things worse, she says she keeps getting (she thinks) bladder infections, and although specimens have been sent to the laboratory on repeated occasions they have failed to identify a cause. She says that she keeps having to pass urine, and it feels uncomfortable.

She has had acupuncture, aromatherapy etc. to no avail.

Her GP referred her to an orthopaedic consultant whom she saw privately in 1999, about three months after the accident. He confirmed the diagnosis of whiplash injury and since then she has seen a number of specialists of various kinds, including a psychologist.

She apologises for being in bed on the occasion of your visit explaining that she has a headache, which is a not infrequent event these days. A packet of paracetamol and a container of nasal decongestant drops sit on the bedside table. There is also a bottle containing amitriptyline tablets, 25mg.

She blames her condition partly on the virus she "caught" around the time of her accident and which she feels is still active, and on the whiplash injury she sustained. She describes a fairly restricted lifestyle; she no longer reads books, although she used to, because she often finds she has to read and re-read the pages and she cannot be bothered trying to follow the plot of films on the television.

Her mother arrives during the later stages of the assessment and she supplements her daughter's history. It emerges that Mrs C is one of a family of three girls. The youngest suffers from chronic fatigue syndrome. Her mother says that she helps Mrs C as much as she can but suffers a lot from fibrositis herself. Her husband, Mrs C's father, died 5 years ago; she explains that he was alcoholic and suffered from depression, and caused the family a great deal of worry and unhappiness.

Your examination is unremarkable, although on palpation a number of anatomically disparate areas are tender. On palpation of these she reacts by expressions of pain, with sighing, groaning, withdrawal and facial grimacing. You are extremely careful to explain that you are anxious to cause her the minimum of discomfort and will desist from further examination if she wishes. You find no muscle wasting.

Having taken her statement, completed the examination and made outline notes you leave, wondering how best to represent and explain the case to the decision maker.

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### PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. What is the differential diagnosis in this case? Give the likely diagnosis/diagnoses.
2. Are there features you would not expect to encounter in a case of FMS?
3. If so, what are they?
4. What difficulties would you encounter in describing her likely self-care problems to a decision maker?

### SUGGESTED RESPONSE TO QUESTIONS IN PRECEDING TABLE

1. Other diagnostic possibilities include:
  - Chronic fatigue syndrome
  - Rheumatoid arthritis
  - Ankylosing spondylitis
  - Other arthritides
  - Diffuse connective tissue diseases (e.g. SLE)
  - Diabetes mellitus and thyroid disorders may present in this way
  - Metabolic bone disease (other than osteoporosis).
  - Soft-tissue rheumatic disorders
2. & 3. See the table overleaf
4. This is one of the disability analyst's central problems in assessing claimants suffering from this group of illnesses. We suggest that the disparity between observed clinical findings and claimed functional impairment is one of the defining characteristics of these syndromes. The point is discussed later.

**Please complete the table overleaf.**

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**Table 1.**

	<b>TRUE</b>	<b>FALSE</b>
1. FMS may present with generalised muscle pains		
2. FMS may arise following trauma; often called “reactive fibromyalgia”		
3. Patients with reactive fibromyalgia have more perceived disability, self-reported pain and affective distress than those with idiopathic onset		
4. FMS may arise following a viral infection, e.g. influenza, coxsackie virus		
5. Patients with FMS often score highly on measures of anxiety and depression		
6. Most patients with FMS are female		
7. Aerobic exercise reduces pain and the number of tender points in fibromyalgia		
8. A family history of depression and alcoholism is more common in fibromyalgia		
Patients with FMS not uncommonly also suffer from the following:		
9. Irritable bowel syndrome		
10. Irritable bladder syndrome		
11. Migraine		
12. Rhinitis		
13. Sleep disorder		
14. Morning stiffness		
15. Impaired memory		
16. Impaired concentration		
17. Subjective sense of joint swelling		
18. Paraesthesiae		
19. Reduced aerobic fitness		



## 5. Overview

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All parameters in the table in the preceding section are **True**.

### 5.1 Clinical characteristics

Fibromyalgia syndrome is a common condition. It is one of the most frequently seen disorders in rheumatology outpatient clinics, and in most studies it accounts for about 2% of patients seen in a general practice setting and 5% of those attending a general medical outpatient clinic.

It is a chronic but non progressive disorder, characterised by a decreased ability to sustain repetitive activity or other forms of sustained work load as a result of pain, fatigue, global debility, and poor aerobic fitness, and an associated loss of concentration and attention span.

Patients with FMS report problems with the activities of daily living (ADLs) that are as severe as those described by patients with rheumatoid arthritis (RA) and greater than individuals with osteoarthritis (OA). In addition they have rated their quality of life inferior to patients with either of these diseases, insulin dependent diabetes, COPD and colostomy. In a large survey of patients with RA, OA, systemic lupus erythematosus (SLE), scleroderma and FMS the latter reported the poorest global self-assessment of functional status, the highest visual analogue pain scale and the lowest global assessment of health status.

The typical patient is female, aged between 18 and 55, who complains of diffuse and chronic musculoskeletal pain which is aching, constant and concentrated in the axial regions of the body. Pain is often worse in the morning and exacerbated by changes in the weather, humidity, cold, stress and sleeplessness.

Physical findings are normal except for multiple, sometimes reproducible points of exaggerated tenderness to palpation.

A wide variety of somatic complaints may accompany these signs and symptoms.

### 5.2 Work implications

The disability which these patients exhibit is often considered sufficiently severe to prevent a significant proportion of them from seeking, continuing or resuming gainful employment and a US survey of 620 patients revealed that 15% were receiving disability payments. A British study of 72 patients over a mean interval of 4 years, found that 50% had stopped work as a result of their illness.

### 5.3 Aetiology

The aetiology is obscure, but the general theory is widely held that it is a disorder occurring in a genetically predisposed individual, triggered by environmental stressors.

Individuals developing the illness in mid life often have a history of antecedent injury, usually to the neck area or one side of the shoulder girdle; the symptoms are unrelieved by conventional treatment. Typically in these cases pain spreads to the contralateral side, then to one lower limb, followed by all four limbs, and finally the axial skeleton is involved. Such patients are usually more disabled by their FMS and have a worse prognosis.

Other patients describe an influenza-like illness which precedes the onset of fatigue and muscle pains.

There is general acceptance that patients who attribute their FMS to trauma are more disabled than those with “primary” FMS and have more perceived disability, self-reported pain, and interference with day to day living than those with a non-traumatic onset.

### 5.4 Prognosis

The prognosis for fibromyalgia is poor. In one UK study less than 1 in 10 patients diagnosed in hospital became symptom-free over five years. Identified risk factors for a poor prognosis include the duration of the illness at the time of presentation and the presence of a comorbid psychiatric disorder. The fixed belief that the illness is due solely to a physical cause e.g. a “chronic” viral infection, makes the prognosis much more uncertain.

Conversely, patients who take a broader perspective of their condition acknowledging that a combination of psychological and physical conditions have contributed to their illness have in general a much more favourable prognosis.

Despite the uncertain long-term outlook, a significant proportion of people with FMS continue to work even if experiencing symptoms. A number change their occupation to one that is less demanding.

### **6. Background**

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#### **6.1 18th century**

The condition now known as fibromyalgia has a long and distinguished pedigree. As long ago as 1750, Sir Richard Manningham described an illness with striking similarities to FMS, characterised by persistent fatigue and non-specific somatic symptoms. He called the condition *febricula*, or little fever, and noted that patients complained of profound “listlessness, with great lassitude and weariness all over the body...(and) little flying pains.” Interestingly, he noted an association between this condition and periods of emotional stress.

#### **6.2 19<sup>th</sup> century**

In the 1820's Balfour had remarked on the presence of tender points in some patients with rheumatic disease, and in 1841 Valliex observed that in many instances the tender points could only be elicited by means of palpation, the patients themselves often being unaware of the focal character of these locations.

#### **6.3 1900s**

The term “fibrositis” is attributed to Gowers in 1904 and he theorized that there was an underlying inflammatory process at work, localised to the “fibrous tissues of the muscles”. Other synonyms arose later in the century, such as tension rheumatism, muscular rheumatism and the like. However in the background was the constant suspicion that some other, psychogenic factor was at work.

#### **6.4 1950 - 80**

Graham, a Canadian rheumatologist, proposed in 1953 that fibrositis should be regarded not as a specific clinical entity but as a clinical syndrome of unexplained muscle pain. Many doctors were ill at ease with this concept. However in the 1970s Moldofsky in Canada found EEG abnormalities during sleep in patients with fibrositis. He attributed these to what he named ‘alpha EEG NREM sleep abnormality’ and formed the hypothesis that this phenomenon produced the pain and fatigue of these individuals.

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### 6.5 1980s

In the 1980s the term was gradually supplanted by fibromyalgia, or fibromyalgia syndrome. Although by now many professionals endorsed the condition the idea was rendered more palatable when Smyth, (also a Canadian rheumatologist) pointed out that there were indeed specific clinical markers for the disease in the form of discrete, reproducible tender points. In due course the “dolorimeter” was developed, a device which could deliver measured degrees of pressure over a specified area and this “objective” measurement overcame the reluctance of many to make the diagnosis.

### 6.6 1990s

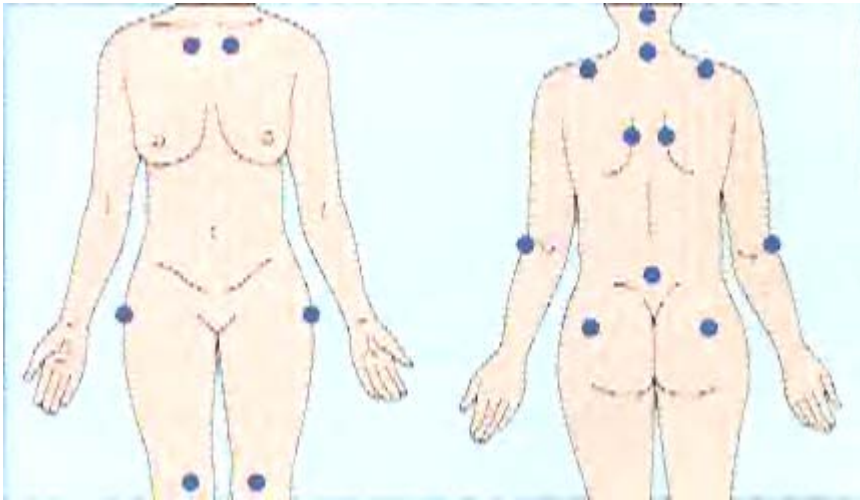
In 1990 the American College of Rheumatology (ACR) attempted to define the condition in light of the apparently reproducible nature of the tender points found on clinical examination (Table 2. overleaf). While the definition was appealing and appeared to introduce a degree of objectivity into the debate it is still viewed with a degree of scepticism. In 1995 the “Copenhagen Declaration” recognised the existence of the syndrome and so ensured that the condition is now established as a distinct clinical entity.

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**Table 2**

From: Wolfe F, Smyth HA, Yunus MB et al. The American College of Rheumatology 1990 criteria for the classification of fibromyalgia: the Multicenter Criteria Committee. *Arthritis Rheum* 1990;33:160.

<p><b>1. History of widespread pain for more than three months</b></p> <p><b><u>Definition</u></b></p> <p>Pain is considered widespread when all of the following are present:</p> <ul style="list-style-type: none"><li>• Pain in the left side of the body,</li><li>• Pain in the right side of the body,</li><li>• Pain above the waist, and</li><li>• Pain below the waist.</li></ul> <p>In addition, axial skeleton pain (cervical spine or anterior chest or thoracic spine or low back) must be present. In this definition, shoulder and buttock pain is considered as pain for each involved side. Low back pain is considered lower segment pain.</p>
<p><b>2. Pain in 11 of 18 tender point sites on digital palpation</b></p> <p><b><u>Definition</u></b></p> <p>Pain, on digital palpation, must be present in at least 11 of the following 18 tender point sites:</p> <p><u>Occiput</u>: bilateral, at the suboccipital muscle insertions.</p> <p><u>Low cervical</u>: bilateral, at the anterior aspects of the intertransverse spaces at C1-C7</p> <p><u>Trapezius</u>: bilateral, at the midpoint of the upper border</p> <p><u>Supraspinatus</u>: bilateral, at its origins, above the scapular spine near the medial border</p> <p><u>Second rib</u>: bilateral, at the second costochondral junctions, just lateral to the junctions on upper surfaces.</p> <p><u>Lateral epicondyle</u>: bilateral, 2cm distal to the epicondyles.</p> <p><u>Gluteal</u>: bilateral, in upper outer quadrants of buttock in anterior fold of muscle.</p> <p><u>Greater trochanter</u>: bilateral, posterior to the trochanteric prominence.</p> <p><u>Knee</u>: bilateral, at the medial fat pad proximal to the joint line.</p> <p><b><u>Digital palpation</u></b> performed with an approximate force of 4kg (<b>not</b> appropriate in disability analysis setting). For a tender point to be considered “positive” the subject must state that the palpation was painful. “Tender” is not to be considered “painful”.</p>



**Figure 1 - Tender point sites of fibromyalgia syndrome**

The intention was not to employ these criteria as strict requirements for diagnosis, and many patients who could undoubtedly be regarded as suffering from FMS fail to meet them fully.

**It is widely felt that this classification, although initially useful, is an oversimplification of a condition which is complex, multifactorial and not in the strict sense a discrete entity.**

# 7. Pain and stress

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The aetiology is unclear. The various components of the syndrome have been considered in detail but no unifying common cause for the condition has been found.

## 7.1 Pain

Pain in FMS can be regarded as attributable partly to a generalised decrease in the pain perception threshold i.e. the ability to discriminate between nociceptive and non-nociceptive (i.e. warmth, cold, touch) quality. It is also partly due to diminished pain tolerance (reflecting an unwillingness to receive more intense stimulation).

In the 1990's particularly, much research focused on the pain elicited by pressure algometry (dolorimetry) in which incremental pressure is applied to the "classical" tender points as defined by the ACR, or control sites, and the degree of reported pain documented. Unfortunately of course this process relies heavily on subjective communication between subject and examiner, and in addition it is not clear whether perception or tolerance levels are being assessed.

Nevertheless there is a significant amount of evidence that patients with FMS have reduced thresholds for the perception and tolerance of pressure both at tender points and in other areas of the body.

Pain research in animals has suggested a variety of mechanisms for central sensitisation to pain, including activation of certain neurons which react both to nociceptive and nonnociceptive stimuli, and the effects of cytokines. These mechanisms are theoretically possible but their relevance to FMS must remain purely conjectural.

Some investigators propose a "hypervigilance" model of pain; that is a heightened sensitivity to pain due to a maladaptive increased attentiveness to external stimuli and an increased preoccupation with sensations of pain. Sufferers from FMS are said to have an intrinsic perceptual style of amplification of pain.

## 7.2 Stressors

In addition there is evidence that psychological distress is central to the pain experience and overall morbidity of fibromyalgia, and patients with the condition report more stress in their lives than do healthy control subjects or sufferers from, for example, rheumatoid arthritis.

Like many illnesses, fibromyalgia may be the result of one or more stressors acting on a person who is genetically predisposed, triggering the expression of symptoms. Examples of such stressors include trauma, infections (e.g. parvovirus, coxsackie, influenza virus) acute or longstanding emotional distress, and immune challenge such as occurs in certain autoimmune diseases and other situations.

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In a similar way, a proportion of the population at large are ill-equipped to cope with the day to day stressors of life. With a background of negative experiences in childhood and poorly developed cognitive, emotional and behavioural skills as adults they display maladaptive coping strategies when faced with the inevitable challenges of their environment. If exposed to certain stressors, whether chemical, physical, emotional or infective they may develop a spectrum of symptoms, both somatic and psychological.



## 8. Links with other conditions

Medically unexplained physical symptoms represent by far the most frequent cause of referral to specialist outpatient clinics, and it is not surprising that each specialty has its own compartment in which such patients can comfortably be accommodated. Rheumatologists have their fibromyalgia, cardiologists their non-cardiac chest pain and gastroenterologists, irritable bowel syndrome.

It is not surprising therefore that FMS shares common features with a number of other conditions.

### 8.1 Chronic fatigue syndrome

The clearest overlap is with chronic fatigue syndrome (CFS). Some of the shared characteristics are illustrated below.

<b>Pain</b>
About 70% of subjects with CFS also experience persistent diffuse muscle pain
<b>Fatigue</b>
85% to 95% of patients diagnosed with fibromyalgia also complain of general fatigue
<b>Myalgia*</b>
"Myalgia" is enshrined in the term myalgic encephalomyelitis
<b>Tender points</b>
Tender points are commonly encountered in CFS
<b>Sleep disorder</b>
Sleep disorder is common to both
<b>Infectious links</b>
These are also found in fibromyalgia, and in one series 55% of fibromyalgia patients volunteered that their illness had started with a viral illness
<b>Prevalence</b>
As in CFS most fibromyalgia sufferers are female and between the ages of 18 and 55; depression is common and in general the prognosis is poor.

**\*Myalgia.** The complaint of painful muscles is a common one and it has been pointed out that the sensation of painful weariness is one expression of fatigue. It is not surprising therefore that it can also be also an indicator of general distress. Indeed it has been said that the tender point count is a 'sedimentation rate' (ESR) for distress.

A number of studies confirm the overlap between FMS and CFS and in one, 42% of patients with primary fibromyalgia met the full criteria for CFS and 27% were only one item short.

## 8.2 Major depressive disorder

Large number of studies have assessed the possible association between FMS and major depressive disorder [as defined in the *Diagnostic and Statistical manual of Mental Disorders 4<sup>th</sup> ed. (DSM IV)*].

In one study<sup>1</sup> where the authors attempt to identify and clarify any association between fibromyalgia and major depressive disorder they make the following points:

<b>Shared features</b> High rates of symptoms of major depressive disorder are reported in fibromyalgia; high rates of myalgia, musculoskeletal pain and other symptoms of fibromyalgia are reported in major depressive disorder.
<b>Psychological tests and rating scales</b> High rates of psychiatric symptomatology similar to that found in major depressive disorder are reported in fibromyalgia
<b>Lifetime prevalence of major depressive disorder</b> High rates of major depressive disorder are found in individuals with fibromyalgia in a majority of studies, though not in all.
<b>Patterns of comorbidity</b> High lifetime rates of migraine, irritable bowel syndrome, chronic fatigue syndrome and atypical facial pain are found in patients with fibromyalgia; high rates of major depressive disorder are found in patients with migraine, irritable bowel syndrome, chronic fatigue syndrome and atypical facial pain.
<b>Family history</b> High rates of major depressive disorder are found in the relatives of individuals with fibromyalgia.

They conclude:

- That fibromyalgia and major depressive disorder share a common underlying abnormality, and
- That they may be perceived as part of a wider spectrum of related disorders.

The authors propose that major depressive disorder and fibromyalgia share a common ancestor which has been variously named “dysfunctional spectrum disorder” or “affective spectrum disorder”.

<sup>1</sup> Hudson JI, Pope HG. The relationship between fibromyalgia and major depressive disorder. *Rheumatic Diseases Clinics of North America* 22(2);1996:285-303.

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They conclude that the siblings of fibromyalgia include chronic fatigue syndrome, migraine, irritable bowel syndrome, mood disorders and anxiety disorders.

### 8.3 Other medically unexplained syndromes

Similarities and overlaps between many other unexplained syndromes have been pointed out; e.g. tension headache, gynaecological syndromes and temporomandibular disorders. Do these disorders too represent other expressions of the somatisation of distress?

### 8.4 The biopsychosocial model

From our own viewpoint as disability analysts it is essential to examine this condition in terms of the biopsychosocial model (Fig 2.)

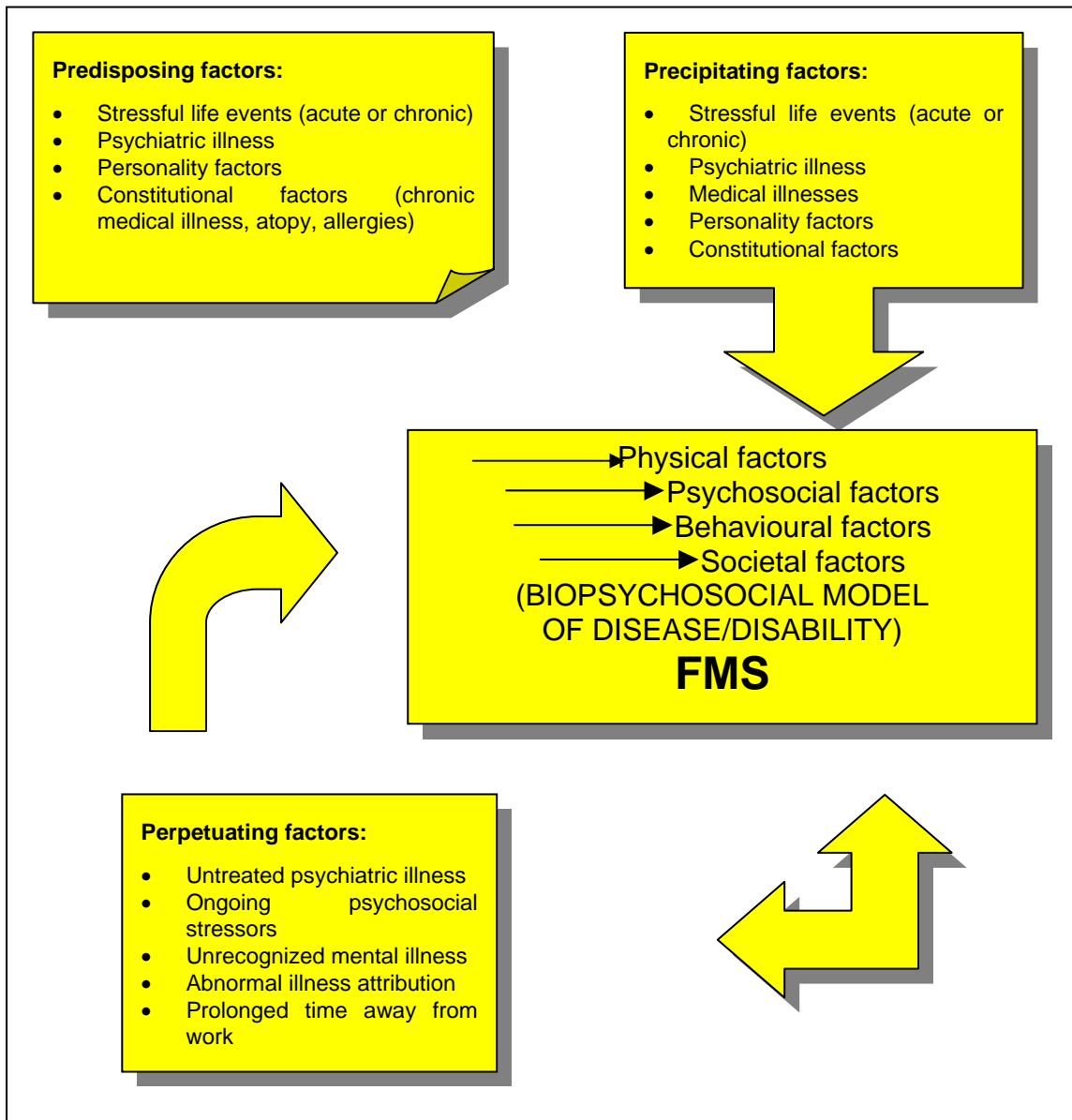
Until recently, research has focused on a mechanical perception of the disease; muscles are painful, therefore there must be some underlying pathological condition affecting the muscles; sleep is disturbed, therefore lack of sleep causes painful muscles. However, contributions from a number of different disciplines have encouraged a broader perspective and Engel's model of a complex interaction between physical, psychosocial, behavioural and societal elements, the biopsychosocial model of disease/disability, is particularly apt in FMS.

FMS is of course like all illnesses, particularly chronic conditions, a composite of physical and psychological elements which will affect the reaction of the patient to pain and illness.

However many other factors are at play, and support from family and community alter disease expression and prognosis. The activities of the medical profession in investigating and treating the illness are not without impact. The demands of the person's job and the influences brought to bear by the social security system and other insurance schemes (including, it has to be said the disability assessment) will also produce an effect on the overall effects of the condition and its outcome.

The biopsychosocial construct is relevant in the disability analysis setting and clinically in the formulation of treatment plans. It should be used so that the decision makers are given informed advice regarding the level of function of the claimant.

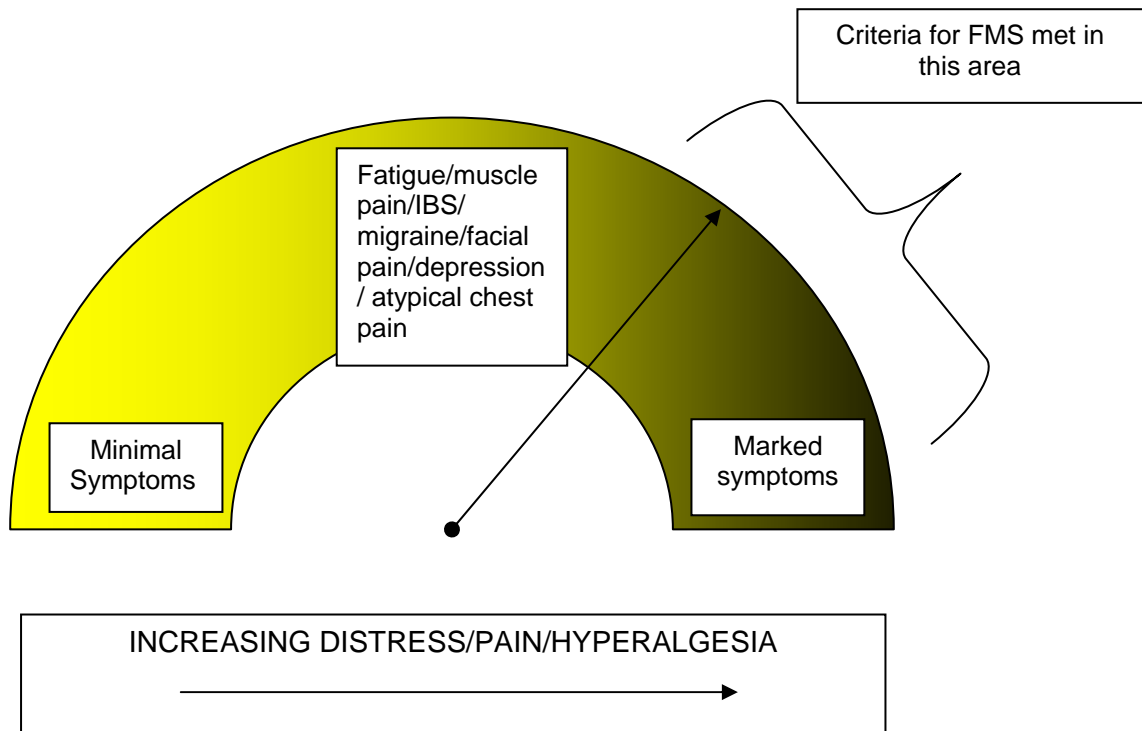
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**Figure 2 - A multidimensional perspective which may be applied to FMS or chronic fatigue syndrome**

Consider how this applies to the case example (Mrs. C)

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**Figure 3 - The distress/pain/hyperalgesia continuum**

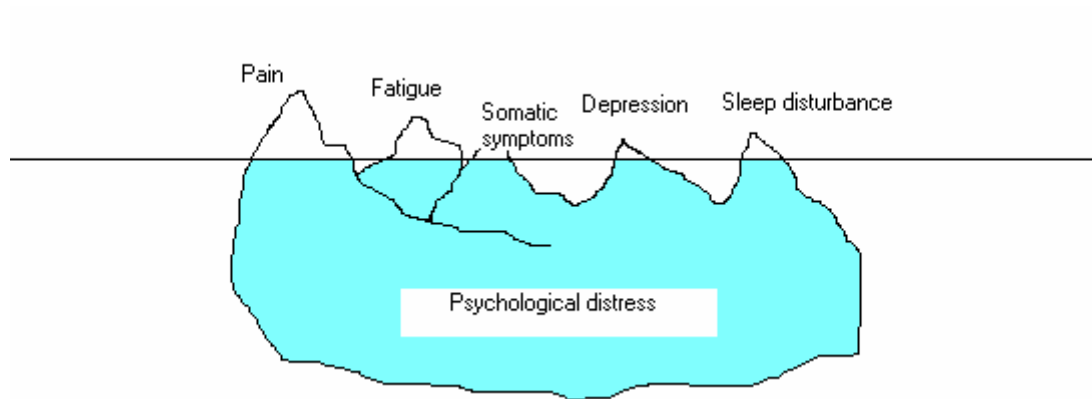
It perhaps oversimplifies the issue to represent the tender point count as a meter for polysymptomatic distress (fig 3.) but it may be helpful if the analogy is widened to include the various somatic and psychological expressions of this group of conditions. It does seem likely that vulnerable people who can be classified by the ACR criteria as having fibromyalgia do not have a discrete disease. They are simply the most ill in a continuum of distress, chronic pain, and painful tender points in the population.

### 8.5 What's in a name?

Some may take the view that by giving the resulting disorder a medically respectable title it will contribute to illness behaviour and learned helplessness. It must be recognised that unless a condition is labelled there will be difficulties for physicians, the legal profession, insurers and benefits decision makers in dealing with these patients.

Few if any insurance or social security systems will permit compensation for general aches, pain and misery. However, when we as a Health Care Professional encounter an individual who is clearly distressed and debilitated most of us will be content to apply a label like fibromyalgia, if the clinical evidence generally supports it, so ensuring that the person can be classified and handled within the system. The term fibromyalgia syndrome is a clinical construct that allows physicians and others to describe and communicate to themselves a definition of one expression of chronic distress (Figure 4).

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**Figure 4 - The Iceberg Model**

## **9. The role of the disability analyst in FMS**

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### **9.1 The clinical setting**

There is no doubt that for the clinician, patients suffering from this illness pose diverse and complex problems relating to diagnosis and management. However, the mainstay of clinical management centres around a collaborative, patient, pragmatic, step by step approach involving the treatment of any comorbid conditions (including psychiatric disorders), the graded resumption of physical activity, and a cognitive behavioural approach by the physician.

### **9.2 The disability analysis setting**

For the disability analyst, building up a clear picture of disability and disablement can also be difficult and complex; the uncertain area between psychological medicine and general medicine is an unnerving place for non-medical decision makers and a challenge to us as medical advisers, particularly as our analysis and advice is based on a single encounter with the claimant.

### **9.3 Proposed approach**

What is certain is that we cannot continually engage in the “FMS/CFS exists/does not exist” debate on each occasion we encounter a claimant with these or allied syndromes. There is ample evidence that these troublesome, complex illnesses are common and genuinely disabling but we cannot shield the decision maker from the uncertainties and problems which surround them.

It is necessary therefore for us to adopt an approach which is practical and pragmatic, and provide advice which is in keeping with the balance of current medical opinion.

### **9.4 Our role**

In our role as disability analysts:

- Investigation and formulating the diagnosis are not part of our remit
- We are not responsible for any aspect of treatment
- We have no part to play in the alleviation of symptoms or in counselling
- We are free of any requirement to decide on benefit entitlement

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Our task is to:

- Assess the history, presenting signs and symptoms
- Confirm the diagnosis in order to support our expectations of the effects of the condition
- Give an objective description of the:
  - Claimant
  - Disease
  - Extent of disablement

and

- On this basis provide clear, reasoned, up-to-date advice to the decision maker

### 9.5 Scope of the examination

The physical examination should follow traditional lines, focusing on evidence of functional restriction in the musculoskeletal system, evidence of muscle wasting and general deconditioning, and any signs suggesting a comorbid condition or alternative diagnosis.

#### 9.5.1 Mental health examination

All claimants in whom the diagnosis of FMS or CFS has been made should undergo a mental health evaluation, in keeping with the current requirements of the relevant work strand. Normally, of course, the Mental Health Test (PCA) and mental state evaluation form part of the flow of the normal “history”, but occasionally a claimant will protest that “There’s nothing *mentally* wrong with me, doctor”.

This should be answered by the explanation that although you accept that this is the case; in fairness to the claimant it has to be demonstrated in the report that all possible conditions have been addressed. In addition, you should point out that the mental health assessment undertaken in disability analysis seeks to test cognitive function as well as the effects of defined mental health disorders; therefore it is also useful in the assessment of symptoms such as fatigue and lack of concentration.

### 9.6 Disparity between findings and claimed disability

In undertaking our task, the central problem in assessing patients with FMS, CFS and related disorders arises when we try to evaluate and describe a person whose claimed degree of disability appears to fall well outside the expected range suggested by the diagnosis, the clinical findings and/or the history.

However, the disparity is a universal finding in this group of conditions; indeed it is one of their key characteristics. It is well documented and has been thoroughly investigated; it is, as near as we can judge a consistent finding. In many cases we cannot provide decision makers with the unequivocal answers or solutions they would find most palatable and the apparent anomaly must be accepted as part and parcel of the condition.



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### 9.6.1 Malingering

Although apparent inconsistencies between the clinical findings and the claimed degree of disability are an intrinsic feature of these disorders, we must be alert for any areas where such inconsistencies are so unusual or conflicting as to suggest that the claimant is making an intentional attempt to simulate disability in the pursuit of gain. The use of “malingering” and other pejorative terms should not be used but it is possible to describe outstanding contradictions in a way that is fair, overt and yet non-judgemental.

### 9.7 The disability analyst’s task

Decision makers cannot be immune from the uncertainties that assail us as Health Care Professionals in evaluating claimants with disorders of this kind and we would suggest that our approach should be to:

- Confirm whether the results of our assessment support the diagnosis,
- Provide an accurate, objective account of the nature and severity of any abnormal clinical findings,
- Describe and comment upon any disparity between our findings and the claims made by the individual,
- Describe and comment upon any disparity between the assembled medical evidence and the characteristics of FMS or other allied syndromes,
- Identify and comment upon any tendency of the claimant to deliberately exaggerate their symptoms or over-state their difficulties,
- Give a pragmatic account of the intrinsic nature of the condition as it relates to this particular claimant,
- Provide a prognosis.

If we provide this service thoughtfully and in keeping with current, up to date medical practice we will be more than adequately fulfilling our role.

### 9.8 Other sources

Finally, your attention is drawn to earlier modules in the CME programme relevant to this topic; in particular those dealing with Chronic Fatigue Syndrome and Effective Report Writing, and the training material relating to the biopsychosocial model and disability assessment.

## 10. Summary

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Fibromyalgia syndrome is common, complex and chronic in nature.

Individuals suffering from the syndrome complain of diffuse pain, fatigue and abnormal sleep pattern. They also frequently complain of impaired concentration and a wide variety of somatic symptoms.

It overlaps in its characteristics with a number of other conditions, including chronic fatigue syndrome and major depressive disorder.

The disability analyst's approach should be accurate, consistent and pragmatic. It should include a clear factual description of the characteristics of the claimant's disorder, and the way in which the condition affects the claimant's functional abilities. Any inconsistencies which are outwith those characteristic of the illness should be clearly expressed.

## 11. References

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## 12. Evaluation

### Fibromyalgia syndrome: guidelines for the disability analyst

In order to evaluate your understanding of this module, please answer the following questions, referring to the reference material when required.

If the objectives have been achieved you should have no difficulty in responding correctly.

		Correct	Incorrect
1.	Cases in which there is a clear history of precipitating trauma have a worse prognosis		
2.	Patients with FMS have reduced thresholds for the perception and tolerance of pressure, localised to specific tender points.		
3.	A patient's belief that a physical,(e.g. viral) rather than a psychological cause underlies FMS is to be encouraged as it will improve the prognosis		
4.	Unlike CFS, sleep disorder is uncommon in FMS		
5.	Individuals with FMS have rated their quality of life inferior to patients with insulin dependent diabetes, COPD and colostomy.		
6.	Aerobic exercise reduces pain and the number of tender points in FMS		
7.	Pain in FMS is often least severe in the morning, becoming worse as the day progresses		
8.	In the 1900s particularly, much research by Gowers and others focused on the pain elicited by pressure algometry.		

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