

Naval Medical Center Portsmouth Referral Guidelines

Fibromyalgia

Diagnosis/Definition

Chronic syndrome characterized mainly by widespread pain, non-restorative sleep, disturbed mood, and fatigue.^{1,2}

Initial Diagnosis and Management

- Laboratory Testing. FM is not a diagnosis of exclusion, and thus laboratory tests and imaging studies play no role in establishing the diagnosis according to the 1990 ACR criteria and the 2010 preliminary ACR diagnostic criteria.
- Basic laboratory studies, however, should be obtained to evaluate for potential underlying disease process.
 1. CBC, Chem 7, LFTs and TSH.
 2. Laboratory and/or radiological tests for concomitant conditions, if clinically indicated by history and/or examination.
 3. Routine testing for rheumatoid factor (RF) or antinuclear antibodies (ANA) is not recommended.
 4. Extra evaluations should be reserved for a history suggestive of specific problems (i.e., sleep study for obstructive sleep apnea, testing for suspected infectious etiology, referral for primary psychiatric illness, etc.).

Ongoing Management and Objectives

- Optimize management of primary disease states and psychiatric illness if applicable. Rule out other disease process as clinically indicated (i.e., hypothyroidism). Fibromyalgia is not an inflammatory arthritis or a connective tissue disease. A primary care physician can provide all the other care and treatment of fibromyalgia.
 1. Educate the patient about FM, signs and symptoms, and treatment options. Provide handout: (http://www.rheumatology.org/Practice/Clinical/Patients/Diseases_And_Conditions/Fibromyalgia/) and direct to internet education resources for patients and family through the National FM Association (www.fmaware.org) and the Fibromyalgia Network (www.fmnetnews.com).
 2. Validate the patient's symptoms.
 3. Emphasize nondestructive nature of FM. It is not an inflammatory arthritis or a connective tissue disease.
 4. Focus on improving function, not complete eradication of symptoms as there are no magic bullet medications that will alleviate pain. Emphasize this is a chronic condition with no cure.
 5. Discuss importance of mind–body relationships. Teach meditation and relaxation techniques. Consultation for biofeedback training via cognitive behavioral therapy for motivated individuals.
 6. Discuss drug and non-drug therapy options to include good sleep hygiene and exercise.

7. Inform about principles of sleep hygiene and how to get a good night's sleep.
 8. Explain the importance of gentle life-long exercise/movement program. Moderately intense aerobic exercise has been shown to improve pain. Patients should gradually increase exercise to avoid an exacerbation of symptoms.
 9. Recommend a gentle stretching program and low impact aerobic exercise/ progress movement. Instruct the patient in the principles and methods of gradual incremental cardiovascular fitness. Low impact aerobic exercises such as walking, swimming, and stationary bike are the most successful. Alternative forms of exercise include Tai Chi and Yoga. The goal should be 30 minutes of aerobic activity, 5 days per week. Physical therapy or exercise physiology consultations can be utilized if necessary.
 10. Consider a trial of acupuncture which has been shown to moderately reduce pain in patients with FM.
 11. Emphasize patient's active role in any treatment.
- Institute medical therapy: CNS active medications such as amitriptyline, nortriptyline, and cyclobenzaprine and gabapentin should be tried.
1. Lowest effective dose should be used; medications should be titrated upwards to effect. An adequate trial (at least 4 weeks) should be attempted before considering the medication ineffective. If the patient fails a clinical trial of one medication or cannot tolerate the medication due to side effects, another trial with a similar medication should be attempted.
 2. NSAIDs are not effective alone; they may have a synergistic effect with CNS active medications. They may also be effective in musculoskeletal pain exacerbated by exercise.
 3. If the tricyclic class is unsuccessful alone, a morning dose of an SSRI (fluoxetine or paroxetine) with non-sedating properties should be added. Dual reuptake inhibitors such as duloxetine or milnacipran (both FDA approved for the treatment of FM) may also be considered if TCA/SSRI therapy is ineffective. These medications may require a Non-formulary Drug Request through pharmacy. As noted above, an adequate trial should be attempted.
 4. Narcotic medications should be avoided in the treatment of FM. Tramadol may be an effective pain medication (especially as an evening dose), but should be used with caution in patients on SSRIs, tricyclic antidepressants, or other cyclic compounds (such as cyclobenzaprine) due to increased risk of seizure. Tramadol should be avoided in patients with a prior history of seizures.
 5. Antiepileptic medications such as gabapentin may be tried with gradual titration of dose to effect.
 6. If the patient fails TCAs, SSRIs, SNRIs and/or gabapentin, consideration should be given for a trial of pre-gabalin (Lyrica). A Non-formulary Drug Request must be completed for approval of this medication through the pharmacy. Any provider in the military system is capable of prescribing a non-formulary medication.

Indications for Specialty Care Referral

- Patient is active duty and is unable to perform their jobs in the US military due to fibromyalgia and member should be considered for an MEB. A initial evaluation by a rheumatologist will confirm diagnosis and assess need for MEB. Patient will be sent back to primary care manager for ongoing treatment.
- When specific organic pathology is suspected (evidence of end organ damage or criteria present for systemic rheumatic illness such as SLE, RA, scleroderma, etc.).

- Referral should not be given to merely confirm the diagnosis, if a positive diagnosis has been made. Dependents with fibromyalgia will not be seen or followed in NMCP Rheumatology clinic.
1. American College of Rheumatology (ACR) 1990 criteria for the **classification of Fibromyalgia**.
 2. American College of Rheumatology (ACR) 2010 preliminary criteria for the **diagnosis of Fibromyalgia**.

Last Review for this Guideline: **Feb 2014**

Referral Guidelines require review every three years.

Maintained by the Naval Medical Center Portsmouth - Quality Services Division
Clinical Practice and Referral Guidelines Administrator