

Potsdam Fibromyalgia Support Group Newsletter

September, 2016

Research Update on Fibromyalgia

2010 Diagnostic Criteria for Fibromyalgia

Although this is no longer a 'recent' finding, the diagnostic criteria for FM were updated in 2010 (Wolfe, et al, 2010), and no longer include assessment of the '18 tender points.' People who were diagnosed before 2010 (or whose MDs are not familiar with the new criteria) might not be know the new diagnostic criteria. The exact criteria are a bit confusing – a simplified questionnaire that you can complete yourself is available on the Potsdam FM Support Group web site: <http://people.clarkson.edu/~lrussek/FMSG.html>.

Briefly, the criteria have 3 parts:

- Part 1: Widespread Pain Index: counts how many of 20 defined body regions have cause pain in the past week that are *not* due to other diagnosed conditions (e.g., OA, herniated discs, carpal tunnel, etc.)
- Part 2a: Symptom Severity Score, which assesses the severity of your fatigue, waking unrefreshed, and cognitive symptoms.
- Part 2b: Symptom Severity Score looking at other symptoms in the past week, such as irritable bowel, headaches, insomnia, numbness or tingling, etc.

The scoring is also a bit complicated, with different ways to meet the requirement for diagnosis of FM, and a requirement that there is no other diagnosis that could explain the pain.

- Wolfe F, Clauw DJ, et al. The American College of Rheumatology preliminary diagnostic criteria for fibromyalgia and measurement of symptom severity. *Arthritis Care Res.* 2010;62(5):600-610.

The following summary of research findings is based upon a systematic review published by Garcia, Nicholas & Hernandez in 2016. A 'systematic review' (SR) is a publication where researchers use a systematic approach to find and

evaluate the quality of all relevant research on a topic. A SR develops recommendations based on the quality and strength of research findings:

- Grade A: Rx recommended for all appropriate patients; benefit >> possible adverse effects.
- Grade B: Rx recommended for patients; benefit > possible adverse effects.
- Grade C: No recommendations against the Rx; benefits and risks offset each other; not recommended for typical patients.
- Grade D: The Rx is discouraged because adverse effects outweigh benefits
- Inconclusive: Research evidence is poor and does not support for or against the Rx.

Overall: Treatment is most effective when it is multimodal and multidisciplinary – that is, takes several approaches from several health care disciplines. (Grade A) Also, all treatment should emphasize patient education and self-care.

Medications: The best research support (grade A) is for amitriptyline (Elavil) to relieve pain and improves sleep, though it side effects that may be problems for some patients. Alternative medications, in order of the research support (grades A and B), include: serotonin-norepinephine re-uptake inhibitors (SNRI, especially duloxetine, i.e., Cymbalta), selective serotonin-reuptake inhibitors (SSRI, fluoxetine such as Prozac and generics, or paroxetine, e.g., Paxil) and antiepileptic drugs (pregabalin, such as

Lyrica). The evidence for benefit of mild opiates such as tramadol has been contradictory (grades A-C), but it can be tried if the previously listed medications are not adequately controlling pain. Cyclobenzaprine (e.g., Amrix) can be used at very low doses to enhance sleep (grades A-B). In all cases, use of these medications for FM should be short-term and discontinued as soon as possible. Research into other medications for



FM has been inconclusive: gabapentin (e.g., Neurontin), acetaminophen (e.g., Tylenol), and non-steroidal anti-inflammatory medications (grades B-D or I).

Physical Therapy: The best research support for managing FM exists for exercise. Exercise has the fewest adverse effects, and can benefit not only the physical effects of FM, but also psychological and hormonal symptoms. Mild to moderate aerobic exercise has the best evidence of benefit, starting gradually; aerobic exercise is best when it is something chosen by the patient and performed 2-3x/wk for at least 30 minutes each time (Grade A). Muscle strengthening can be added to aerobic exercise to improve function (Grade A). Relaxation after aerobic exercise helps decrease symptoms (Grade A). PT can also help educate patients in how to manage pain and symptoms independently (Grade A). Warm-water pool exercise and stretching can also be beneficial (Grade B). Other physical therapy approaches that can be beneficial include patient education and biofeedback (Grade B). Evidence is inconclusive for heat, ultrasound, laser, trigger point therapy, and transcutaneous electrical stimulation (Grade C or Inconclusive).

Psychological Approaches: Cognitive-behavioral therapy (CBT) has strong research support, both as a solitary treatment and along with other treatments such as PT or medication. CBT can also be helpful for decreasing fear of movement (Grade A). Education can improve self-efficacy and ability to manage pain and other symptoms (Grade A). Biofeedback, guided imagery, relaxation and hypnosis have been shown beneficial when used to complement other treatments (Grade B).

Alternative Therapies: Acupuncture, Qigong (or Chi Kung), yoga and Tai Chi have all been shown to be beneficial, though the research has not been as strong for these approaches (Grades B-C and Inconclusive). Evidence for mindfulness, massage therapy, chiropractic, magnetic therapy, homeopathy and relaxation is poor or inconclusive (Grade C or Inconclusive).

Overall, the Garcia, et al (2016) SR recommends that nonpharmacological approaches be given priority as they have the

best research evidence and the lowest risk of adverse effects. Medications, when used, should be combined with CBT and/or exercise. CBT and exercise require significant effort on the part of the patient, though, and many patients are not able to remain consistent in their efforts.

Note that the above discussion applied only to treatments for the FM, itself. Many people with FM have other conditions, as well, such as osteoarthritis, low back pain, pinched nerves, depression, anxiety, etc. Some of the treatments that are not proven beneficial for FM might be helpful for other conditions people have. Plus, much of the research is inconclusive, which is not the same as proving that a treatment does not work.

As always, this newsletter simply tries to present current research and cannot be used to make clinical decisions. Discuss treatment options with your health care providers.

Research used in this article:

- Garcia DA, Nicolas IM, Hernandez PJS. "Clinical approach to fibromyalgia: Synthesis of Evidence-based recommendations, a systematic review". *Reumatol Clin*. 2016;12(2):65-71.

Meeting Tuesday, September 6th

The Potsdam Fibromyalgia Support Group and the Parkinson's Support Group will have a joint meeting on **Tuesday, September 6th, 7-8 pm**. Dr. Russek will present some of the research discussed in this newsletter, and people can discuss what works for them. We can also discuss any recent topics, such as medications, medical marijuana, yoga, etc. The group meets at 59 Main St., Potsdam. Anyone with a chronic illness is welcome, as are friends and family.

This newsletter is a joint effort of Clarkson University and Canton-Potsdam Hospital. If you would like to receive these newsletters electronically, please send your email address to lrussek@clarkson.edu.

You can access current and previous Potsdam Fibromyalgia Support Group Newsletters on our web site:

www.people.clarkson.edu/~lrussek/FMSG. Or on the Potsdam Fibromyalgia Support Group on Facebook. To join this private Facebook group, contact Kris at:

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