

CME PSYCHCAST™

CLINICAL CASE UPDATE IN FIBROMYALGIA MANAGEMENT FIBROMYALGIA SYNDROME: CASE-BASED LEARNING

FACULTY

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CME .25

ABSTRACT

Fibromyalgia (FM) syndrome is a common clinical disorder characterized by severe widespread soft-tissue pain, chronicity, and allodynia. Diagnosed by chronic widespread body pain and unusual tenderness in response to digital pressure at anatomically identified soft tissue sites, FM is increasingly being recognized as a central nervous system disorder. FM patients commonly suffer from insomnia and depression, as well as other comorbidities that complicate the diagnosis, such as anxiety, fatigue, headaches, cognitive impairment, and stress intolerance. Important differential diagnoses include the various rheumatological disorders as well as sleep disorders. Because the presentation of FM is heterogeneous, the goal of treatment is an individualized approach that considers the severity of the patient's pain, the presence of other symptoms and comorbidities or stressors, and the degree of functional impairment. New pharmacologic treatments approved by the Food and Drug Administration offer important options to FM patients, and are expected to improve both diagnosis and treatment of FM. In most cases, the management of patients with FM involves both pharmacologic and nonpharmacologic treatments.

In this Expert Review PsychCast™, I. Jon Russell, MD, PhD, rheumatologist, provides a series of brief case studies to illustrate the range of possible clinical patterns in which FM can be identified.



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Activity Review Information

The activity content has been peer-reviewed and approved by **Stelian Serban, MD**.

Review Date: September 2, 2009.

Faculty Affiliation

I. Jon Russell, MD, PhD, is associate professor of medicine/rheumatology, and director of the University Clinical Research Center at the University of Texas Health Sciences Center in San Antonio, Texas.

Faculty Disclosure Policy Statement

It is the policy of the Mount Sinai School of Medicine to ensure objectivity, balance, independence, transparency, and scientific rigor in all CME-sponsored educational activities. All faculty participating in the planning or implementation of a sponsored activity are expected to disclose to the audience any relevant financial relationships and to assist in resolving any conflict of interest that may arise from the relationship. Presenters must also make a meaningful disclosure to the audience of their discussions of unlabeled or unapproved drugs or devices. This information will be available as part of the course material.

Faculty Disclosure

Dr. Russell is currently, or has been within the last 5 years, a consultant to Allergan, Eli Lilly, Forest, Grunenthal, Jazz, and Pfizer; on the speaker's bureaus of Eli Lilly, Forest, Grunenthal, Jazz, and Pfizer; on the advisory boards of Eli Lilly, Jazz, Pfizer, and Pierre Fabre; and lead investigator in clinical trials funded by Allergan, Autoimmune technologies, Eli Lilly, Grunenthal, Jazz, and Schwarz/UCB Pharma.

CME Course Director James C.-Y. Chou, MD, is associate professor of psychiatry at Mount Sinai School of Medicine in New York City. Dr. Chou has received honoraria from AstraZeneca, Bristol-Myers Squibb, Eli Lilly, GlaxoSmithKline, Janssen, and Pfizer.

Dr. Serban is assistant professor of anesthesiology and director of acute and chronic inpatient pain service in the Department of Anesthesiology at Mount Sinai School of Medicine in New York City. Dr. Serban reports no affiliation with or financial interest in any organization that may pose a conflict of interest.

Learning Objective

At the completion of this activity, participants should be better able to:

- Recognize the clinical presentations of fibromyalgia (FM) syndrome and identify key clinical domains impacted by FM.

Statement of Need and Purpose

Fibromyalgia (FM) syndrome is the most common chronic pain syndrome encountered in general medicine, estimated to affect 5 million adults in the United States. FM involves multiple clinical domains, including pain, fatigue, sleep disturbances, depression, and cognitive impairment. Patients with FM report significant negative impact of the illness on social and occupational function and overall quality of life. Much progress has been made in understanding FM, yet management of the condition continues to confound physicians and frustrate patients. Evaluating and treating the multiple domains of FM simultaneously presents a substantial challenge for clinicians. The complex interactions between neurobiological, psychological, and functional/behavioral components of FM, as well as the poor response of patients to conventional pain therapies, have proven particularly challenging. Patients report using an average of 3–4 medications to manage their FM. Research has shown that a multimodal management program yields the most benefit to patients. To implement this paradigm, physicians—including primary care physicians, neurologists, and psychiatrists—need direction regarding the diagnosis of FM, available pharmacologic and nonpharmacologic interventions, and clinical application. Using clinical case studies as an educational tool to discuss the clinical presentation, differential diagnosis, and treatment of FM, will help physicians to identify those patients with symptoms of FM and follow through with adequate treatment.

Target Audience

This activity is designed to meet the educational needs of psychiatrists and neurologists.

Accreditation Statement

This activity has been planned and implemented in accordance with the Essential Areas and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint sponsorship of the Mount Sinai School of Medicine and MBL Communications, Inc. The Mount Sinai School of Medicine is accredited by the ACCME to provide continuing medical education for physicians.



Credit Designation

The Mount Sinai School of Medicine designates this educational activity for a maximum of 0.25 *AMA PRA Category 1 Credits™*. Physicians should only claim credit commensurate with the extent of their participation in the activity.

To Receive Credit for this Activity

Listen to this Expert Panel PsychCast™, reflect on the information presented, and complete the CME posttest and evaluation. To obtain credit, you should score 70% or better. Early submission of this posttest is encouraged. Please submit this posttest by February 1, 2012 to be eligible for credit.



FIBROMYALGIA SYNDROME: CASE-BASED LEARNING

By I. Jon Russell, MD, PhD — CHAIR

SLIDE LIBRARY

SLIDE 1
Key Clinical Manifestations of Fibromyalgia¹

SLIDE 3
Tender Points Associated with Fibromyalgia³

Chronic widespread pain

Plus Comorbids

Allodynia at $\geq 11/18$ tender points

Plus Comorbids

Reprinted from: Wolfe F, Smythe HA, Yunus MB. *Arthritis Rheum.* 1990;33:160-172.

SLIDE 2
OMERACT Domains by Delphi Method²

<u>Expert Round 3</u>	<u>Patient Round 2</u>
1. Pain	1. Pain or physical discomfort
2. Fatigue	2. Joint aching or pain
3. Patient global improvement	3. Lack of energy or fatigue
4. Sleep quality poor	4. Impact on sleep
5. Physical functioning	5. Poor attention, "fibro-fog"
6. Health-related quality of life	6. Stiffness*
7. Depression, now or before	7. Disorganized thinking
8. Treatment side effects*	8. Difficulty moving, walking
9. Tender point intensity*	9. Impact on ability to accomplish
10. Dyscognition	10. Having to push yourself
	11. Depression, sad, resigned
	12. Impact on normal activities

* Not shared by patients and physicians.

Adapted from: Mease PS, Arnold LM, Crofford L. *Arthritis Rheum.* 2008;59(7):952.

Case #1

- 56-year-old Caucasian female; homemaker
- Solid marriage; three adult children
- 3-year history of insomnia and widespread pain; no trauma or other medical conditions
- Needs assistance at home; Visual Analog Scale pain rating=7.5/10
- Mother had chronic pain; sister with FM
- Exam: 16/18 tender points; neuro-negative
- Diagnosis: primary FM

Case #2

- 47-year-old Caucasian male; manufacturer
- Physically inactive; private yacht on weekends
- Developed extensive pain, insomnia, fatigue with no diagnosis
- Eventually lost his business due to symptoms; lost his yacht, wife divorced him, and he became depressed
- Exam: 14/18 tender points
- Diagnosis: primary FM

Case #3

- 58-year-old widow; socially active; golfer
- Typical chest wall pain, subtle exercise pain involving left arm and left side of neck
- Exam: slender, fit, tan, 18/18 tender points
- EKG-normal sinus rhythm, >1 mm ST depression, anterior precordial ETT positive, narrow LADCA, CABG
- Follow-up: 3 months, 16/16 tender points
- Diagnosis: primary fibromyalgia syndrome (persisted after CABG)

EKG=electrocardiogram; ETT=exercise tolerance test; LADCA=left anterior descending coronary artery; CABG=coronary artery bypass graft.

Case #4

- 38-year-old married female
- Worked 12 years as embassy staff member in Norway
- Three years ago, fell at work; ankle fracture
- Uneventful healing in 6 weeks; developed insomnia
- Additive spreading pain within 3 months
- Exam: Slender, ankle painless, 18/18 tender points
- Diagnosis: FM secondary to trauma

Case #5

- 36-year-old African-American female
- Sero+ RA for 5 years
- Complains bitterly of severe joint pain
- Exam: mild synovitis at wrists, elbows, knees, ankles; insomnia is so severe that she is always tired
- Exam: very obese, well healed, non-tender chest scar, tender points=18/18
- Diagnosis: FM secondary to RA

Case #6

- 52-year-old Caucasian female
- 4-month history of body aches, fatigue
- Exam: puffy hands, oral ulcer, rash, tender points=18/18
- Lab: antinuclear antibody + homo2560, absolute lymphocyte count low
- Diagnosis: SLE and FM
- Follow-up: 3 months, severe central nervous system SLE; 12 months, died

Case #7

- 44-year-old Caucasian female, complex regional pain syndrome
- History of C-spine surgery for a canal cyst
- Developed widespread pain, insomnia, fatigue, stiffness
- Exam: 17/18 tender points
- Neuro: abnormal Hoffman +/-, hyperreflexia
- Neck extension: dizzy, diaphoresis
- Magnetic resonance imaging: C stenosis, cord compression at 3 levels
- Diagnosis: FM secondary to spinal stenosis

Case #8

- 54-year-old Caucasian female
- Insomnia, widespread pain, stiff, fatigue for 15 years
- Very active prior to these symptoms
- Exam: 16/18 tender points; neuro exam abnormal
- Neck extension: dizzy, hyper-reflexic, clonus, left ankle, Hoffman +/-; pinprick test abnormal,
- Magnetic resonance imaging: Chiari-1; surgery; 70% better; active
- Diagnosis: FM secondary to spinal stenosis

Case #9

- 52-year-old Caucasian female
- Well until rear ended in motor vehicle accident; suffered acute whiplash
- Over time, local neck pain generalized all over her body
- Developed insomnia which she considered to be as bad or worse than the pain
- Exam: 16/18 tender points
- Diagnosis: FM secondary to cervical cord trauma

Case #10

- 42-year-old female
- In good health until flu-like illness resolved, leaving achy pain, fatigue, and cognitive concerns; persisted >5 months
- Unable to maintain work schedule; missed 1–2 days per week; became depressed
- Exam: 15/18 tender points
- Diagnosis: FM secondary to febrile illness

Case #11

- 49-year-old Caucasian female with FM for 5 years
- CC: new buttocks pain, leg pain, pain getting in/out of car (abducting thigh)
- Exam: 13/18 tender points, duck walk, pain with internal rotation of hip, sciatic notch area painful to pressure
- Magnetic resonance imaging: pelvis negative
- Diagnosis: FM with piriformis syndrome
- Treatment: Injected both piriformis muscles; 90% relief

References

1. Russell IJ. Fibromyalgia syndrome: approach to management. *Primary Psychiatry*. 2006;13(9):76-84.
2. Mease PJ, Arnold LM, Crofford L. Identifying the clinical domains of FM: contributions from clinician and patient Delphi exercises. *Arthritis Rheum*. 2008;59(7):952-160.
3. Wolfe F, Smythe HA, Yunus MB. The American College of Rheumatology 1990 Criteria for the Classification of FM. Report of the Multicenter Criteria Committee. *Arthritis Rheum*. 1990;33(2):160-172.

SLIDE 4**Summary****Common complaints**

- Pain – usually widespread
- Pain – regional (back pain), tender all over

Common backgrounds

- Familial, trauma to C spine, inflammatory diagnosis

Common comorbidities

- Insomnia, fatigue, headache, cognitive insecurity, anxiety, depression, feeling stressed

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CME QUESTIONS

- 1. Which of the following is the most common and most characteristic symptom of fibromyalgia (FM) syndrome ?**
 - A. Migraine headaches that recur on a weekly basis
 - B. Painful piriformis muscle myofascial pain syndrome
 - C. Widespread body pain
 - D. Depression
- 2. The finding of spinal stenosis in patients with FM is believed to mean which of the following?**
 - A. FM causes the spinal cord to expand, taking up more space
 - B. Compression of the spinal cord is capable of causing widespread pain
 - C. The pain of FM is bone pain resulting from expansion of bone into the canal
 - D. The spinal fascia tethered to the sacrum is stretching the spinal cord during flexion
- 3. FM is frequently comorbid with many conditions, including:**
 - A. ADHD
 - B. Anxiety
 - C. Personality disorder
 - D. Schizophrenia
- 4. Which of the following has been shown to initiate the pain process that may lead to FM?**
 - A. Trauma to the cervical spine
 - B. Back pain
 - C. Inflammatory disease
 - D. Schizophrenia

REGISTRATION

FEBRUARY 2010 CME POSTTEST



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ANSWER FORM

Expert Panel PsychCast™ – Clinical Case Update in Fibromyalgia Management
Fibromyalgia Syndrome: *Case-Based Learning*

TERMINATION DATE: February 19, 2012

To receive credit, you should score 70% or better (participants will receive certification for their records in approximately 4–6 weeks). Early submission of this posttest is encouraged. Please submit this test by February 1, 2012, to be eligible for credit. If you have any questions about this, or any of our other CME materials, please e-mail CME@mblcommunications.com

Please circle your answers

1. A B C D 2. A B C D 3. A B C D 4. A B C D

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