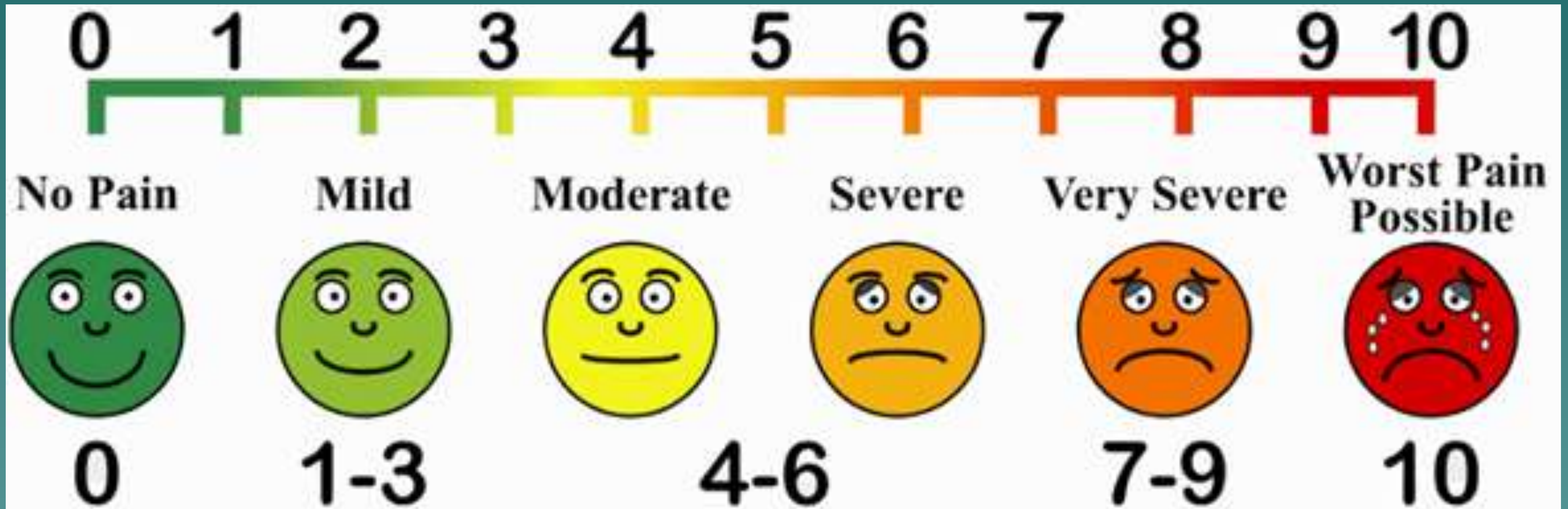
Everything Hurts!

Howard L. Feinberg, D.O. M.A.C.O.I., F.A.C.R.

Disclosures

- I am not a psychiatrist
- Nothing else to disclose

I'm a 30   I'm a 100



It's not a primary psychiatric disease until you exclude physical causes

- Depression
- Other psychiatric conditions
  - Borderline personality disorder
  - Psychosomatic disorders
  - Somatic Symptom Disorder (SSD)

Depression Diagnostic Criteria

- Must have 5 symptoms in a 2-week period
- Symptoms cannot be related to:
  - Substance abuse
  - Another medical condition
- Symptoms must cause clinically significant distress

Depression Diagnostic Criteria

1. Depressed mood most of the day, nearly every day.
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day.
3. Significant weight loss when not dieting or weight gain, or decrease or increase in appetite nearly every day.
4. A slowing down of thought and a reduction of physical movement (observable by others, not merely subjective feelings of restlessness or being slowed down).
5. Fatigue or loss of energy nearly every day.
6. Feelings of worthlessness or excessive or inappropriate guilt nearly every day. Diminished ability to think or concentrate, or indecisiveness, nearly every day.
7. Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

•.

Depression

- Incidence of diagnosable depression in chronic pain 10 -87% *
- Incidence of chronic pain in diagnosed depression 27-100% *
- WHO 22% of primary care patients suffer chronic pain**
- 50% of patients with depression who visit a primary care practitioner complain only of physical symptoms***

*Practical pain Management Volume 17 issue 1 2017

•**Lepine. Human Psychopharmacology. 2004 Oct;19 Suppl 1:s3-7.doi; 10.1002/hup.618.

•***Harvard Health March 21, 2017

Somatic Symptom Disorder

Other/Old Names

- Somatoform disorders
- Somatization disorder
- Pain Disorder
- Hypochondriasis
- Hysteria
- Atypical SSD

Subsets

- Factitious disorder
  - malingering
- Illness anxiety disorder
- Conversion Disorder
- Other Medical conditions affected by psychological factors
- Other SSD
- Unspecified SSD

SSD Diagnosis

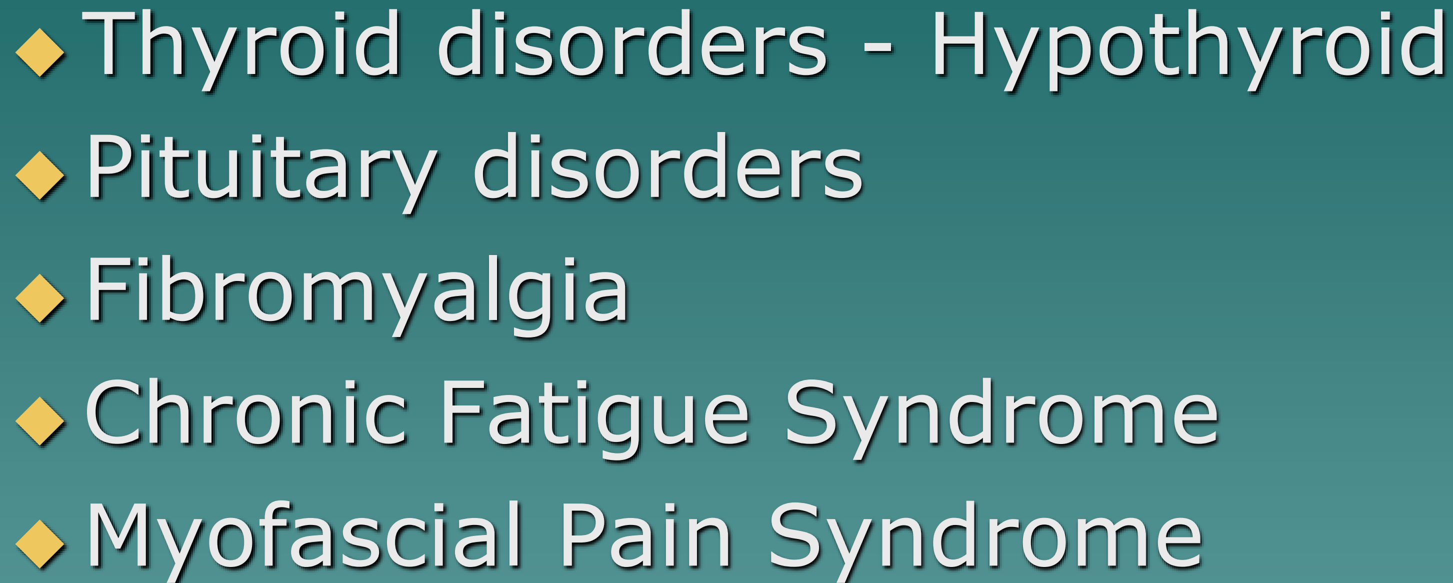
1. Disproportionate and persistent thoughts about the seriousness of one's symptoms.
2. Persistently high level of anxiety about health or symptoms.
3. Excessive time and energy devoted to these symptoms or health concerns.

- Onset before age 30
- Symptoms present for 6 months or more

Somatic Symptom Disorder

Excessive thoughts, feelings, or behaviors related to the somatic symptoms or associated health concerns as manifested by at least one of the following

- One or more physical symptoms that are distressing or cause disruption in daily life
- Excessive thoughts, feelings or behaviors related to the physical symptoms or health concerns with at least one of the following:
  - Ongoing thoughts that are out of proportion with the seriousness of symptoms
  - Ongoing high level of anxiety about health or symptoms
  - Excessive time and energy spent on the symptoms or health concerns
- At least one symptom is constantly present, although there may be different symptoms and symptoms may come and go


Thyroid disorders - Hypothyroid
Pituitary disorders
Fibromyalgia
Chronic Fatigue Syndrome
Myofascial Pain Syndrome

Sir William Osler

"When an arthritis patient walks in the front door, I feel like leaving by the back door."

Corollary

"When a patient with chronic pain walks in the front door I want to run for the back door."

FIBROMYALGIA

- Depression
- Waking Unrefreshed
- Somatic symptoms
  - Pain
  - Fatigue
  - IBS
  - Nervousness
  - Bladder symptoms
  - etc

DEFINITION

A chronic widespread musculoskeletal pain syndrome with tender points at discrete sites

OLD DIAGNOSTIC CRITERIA

- History of Widespread Pain (>3 months)

Must have all of the following:

1) Pain in the left side of the body
2) Pain in the right side of the body
3) Pain above the waist
4) Pain below the waist
5) Axial skeletal pain

- Pain In 11 of 18 Trigger Points (4kg)

1) Occiput
2) Low Cervical (C5-C7)
3) Trapezius (midpoint of upper border)
4) Supraspinatus (border of scapula)
5) 2nd Costochondral junction
6) Lateral Epicondyle
7) Gluteal
8) Greater Trochanter
9) Knee (medial fat pad)

Occiput: suboccipital muscle insertions

Trapezius: midpoint of the upper border

Supraspinatus: above the medial border of the scapular spine

Gluteal: upper outer quadrants of buttocks

Greater trochanter: posterior to the trochanteric prominence

Low cervical: anterior aspects of the intertransverse spaces at C5–C7

Second rib: second costochondral junctions

Lateral epicondyle: 2 cm distal to the epicondyles

Knee: medial fat pad proximal to the joint line

CURRENT DIAGNOSTIC CRITERIA

- Widespread pain
- Symptoms present for at least 3 months
- No other condition that would explain pain/symptoms
- Severity scale
- Widespread pain index

Note the number of areas of pain during the past week
(WPI Score 0-19)

- Chest
- Back
- Neck
- Jaw
- Abdomen
- Shoulder girdle
- Upper arm
- Lower arm
- Upper leg
- Lower Leg
- Buttock or trochanter

Severity Scale Score

- Fatigue
- Cognitive Symptoms
- Somatic
- Waking Unrefreshed

- Severity Scale
  - 0 No problem
  - 1 slight or mild
  - 2 moderate
  - 3 severe

DIAGNOSTIC CRITERIA

- Severity Score >5 and
  Widespread Pain Index >7

OR

- Severity Score >9

MYTHS OF FIBROMYALGIA

- It is not a real disease
- It’s just a bunch of crazy women
- It’s just depression
- It’s all in their head
- It’s a wastebasket diagnosis for all chronic pain and chronic complainers
- It’s not a “real disease”

TRUTH BEHIND FIBROMYALGIA

- It has been described in medical literature for over 200 years
- There is research which shows that Fibromyalgia can and does exist in patients with no psychiatric illness
- It is a discrete disease with classification criteria established by the ACR in 1990

PSYCHIATRIC / PSYCHOLOGICAL FINDINGS IN FIBROMYALGIA

- Most patients report anxiety or depression. The incidence is the same in this disease as in other conditions with chronic pain
- 35% have a current psychiatric diagnosis – most often depression

EPIDEMIOLOGY

- 80-90% Female
- Peak Age 40-60
- 60-80% of patients with SLE
- Sleep apnea 13%
- Other medical conditions

EPIDEMIOLOGY

- 15% of rheumatology patients
  - 60 - 80% with SLE
  - 15.8% with OA
  - 2.1% with RA
- 5% of patients from a general medical practice
- 2% of the general population
- 3-6 million people

PATHOPHYSIOLOGY

Abnormal Sleep Architecture

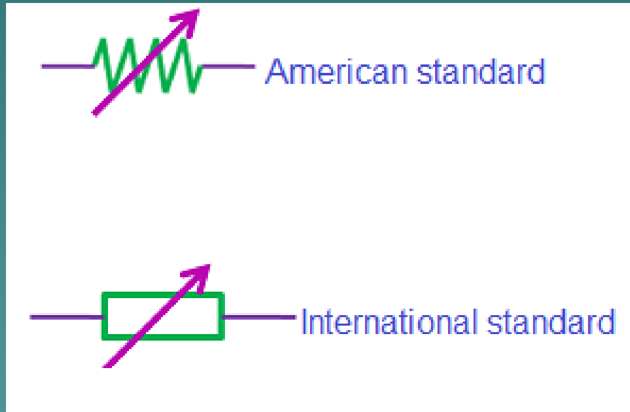
- Nonrestorative Sleep
- Alpha wave intrusion
- Decreased Stage 3-4 Sleep
- Moldofsky et al

PATHOPHYSIOLOGY

- Increased CSF Substance P
- Decreased Epinephrine
- Decreased Serotonin
- Altered Sleep
- Decreased Pain Threshold
- Decreased cerebral blood flow to caudate nucleus

PATHOPHYSIOLOGY

- The Bodies Pain Rheostat

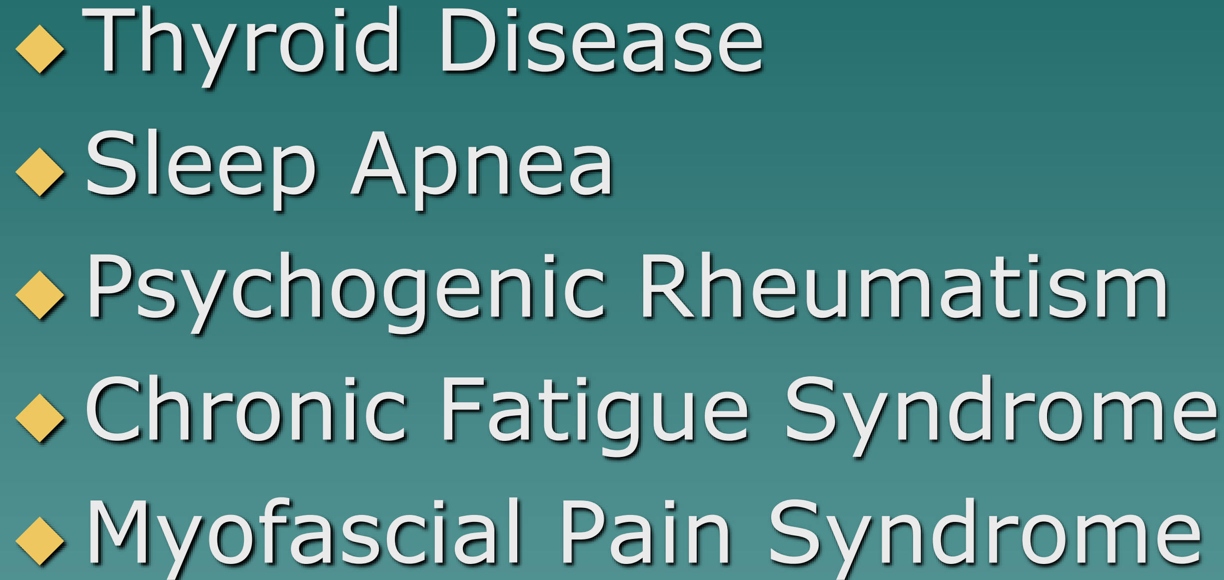


PATHOPHYSIOLOGY

- Aberrant Salience*
  - 33 FM patients
  - 15 healthy controls
  - Pain onset -higher BOLD signal response in FM compared with controls
    - Dorsolateral and ventrolateral cortices
    - Orbitofrontal cortices
    - Frontal pole
    - Precentral gyrus
  - Pain offset - higher BOLD signal response in frontal region previously hyper activated

*Arthritis and Rheumatology vol 72, July 2020 pp 1203-1217

DIFFERENTIAL DIAGNOSIS



FIBROMYALGIA VS MYOFASCIAL PAIN SYNDROME*

Feature	Fibromyalgia	Myofascial
Pain	Diffuse	Local
Fatigue	Common	Uncommon
AM Stiffness	Common	Uncommon
Tender points	Diffuse	Localized
Prognosis	Chronic	Resolves/ Relapses
Treatment	Exercise/ Medication	Local Measures

*Adapted from Primer on Rheumatic Disease

FIBROMYALGIA VS CHRONIC FATIGUE SYNDROME

Feature	Fibromyalgia	CFS
Cause	Unknown	Viral
Myalgias	Chronic	Chronic
Fatigue	Chronic	Chronic
Sleep	Poor	Poor
Depression	Common	Common

FIBROMYALGIA VS CHRONIC FATIGUE SYNDROME

- Chronic Fatigue
  - Acute onset
  - Low-grade fever
  - Pharyngitis
  - Adenopathy
  - Associated with viral illness
- Fibromyalgia
  - Gradual or acute onset
  - No fever
  - No pharyngitis
  - No adenopathy
  - No infectious association

ECONOMIC IMPACT

- 18% Work Disabled
- 8 Separate physician evaluations
- Cost of repeated tests over 5+ years prior to diagnosis

HISTORY IN FIBROMYALGIA

- Persistent Generalized Pain
- Poor Sleep
- Non-restorative Sleep
- Fatigue
- Mood Disturbance
- Headache
- Abdominal Pain
- Sense of Numbness
- Temperature sensitivity
- Sense of Swelling

DIAGNOSTIC TESTING

- Laboratory – normal
- X-ray – normal
- Muscle biopsy - normal
- Sleep study - ?
- CSF - ?
- Always check TSH

ASSOCIATED CONDITIONS

- Irritable Bowel Syndrome
- Interstitial Cystitis
- Irritable Bladder
- Migraine
- Tension Headaches
- “Fibro Fog”
- Paresthesias
- “Swollen Hands”
- Depression
- Mood Disturbances

Rx

TREATMENT

- Validate Diagnosis
- Educate Patient
- Discuss Treatment Goals
- Discuss Sleep Habits
- Nonpharmacologic intervention
- Pharmacologic intervention

TREATMENT

- Fibromyalgia Network
- Support Groups
- ACR
- Arthritis Foundation
- Local Programs

TREATMENT

Consultation With Other Professionals

- Rheumatologist
- Physical Medicine and Rehabilitation
- Clinical Psychologist
- Psychiatrist
- Counselors
- Physical Therapy

TREATMENT

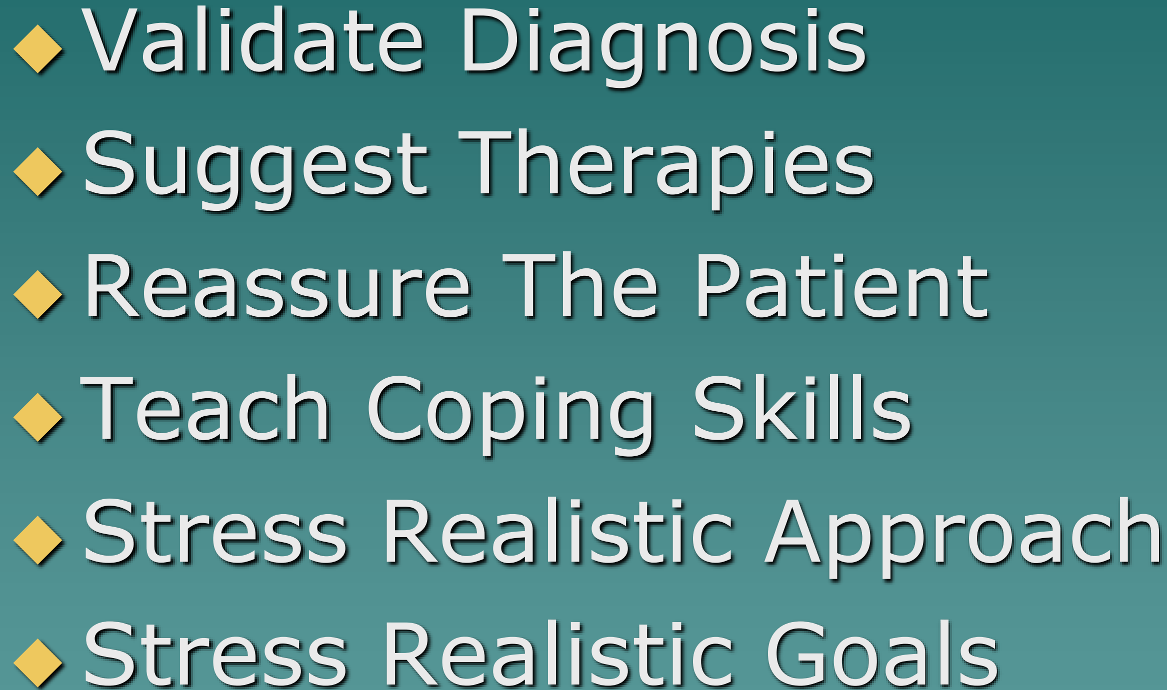
- Medications
  - Amitriptyline
  - Cyclobenzaprine
  - Nortriptyline
  - Alprazolam
  - Doxepin
  - Trazadone
  - Tizanidine
  - Clonazepam
  - Duloxetine
  - Milnacipran
  - Pregabalin

- Exercise
  - Aerobic conditioning exercise
  - 30 minutes
  - Daily
  - No excuses

OTHER TREATMENTS

- Injections
- NSAID's
- Analgesics
- Hypnotics
  - flurazepam
  - temazepam
  - triazolam
  - zolpidem
- Steroids
- Biofeedback
- Meditation
- Acupuncture
- Massage
- Ultrasound
- Antidepressant

YOUR ROLE AS PHYSICIAN



- Validate Diagnosis
- Suggest Therapies
- Reassure The Patient
- Teach Coping Skills
- Stress Realistic Approach
- Stress Realistic Goals

OUTCOME IN FIBROMYALGIA

- Most patients have persistent symptoms 75%
- Most patients continue to work (10 – 15% disabled)
- Most patients experience an adverse affect in their work
- Most patients experience an adverse effect in leisure activities
- Duration of time without a diagnosis directly affects outcome