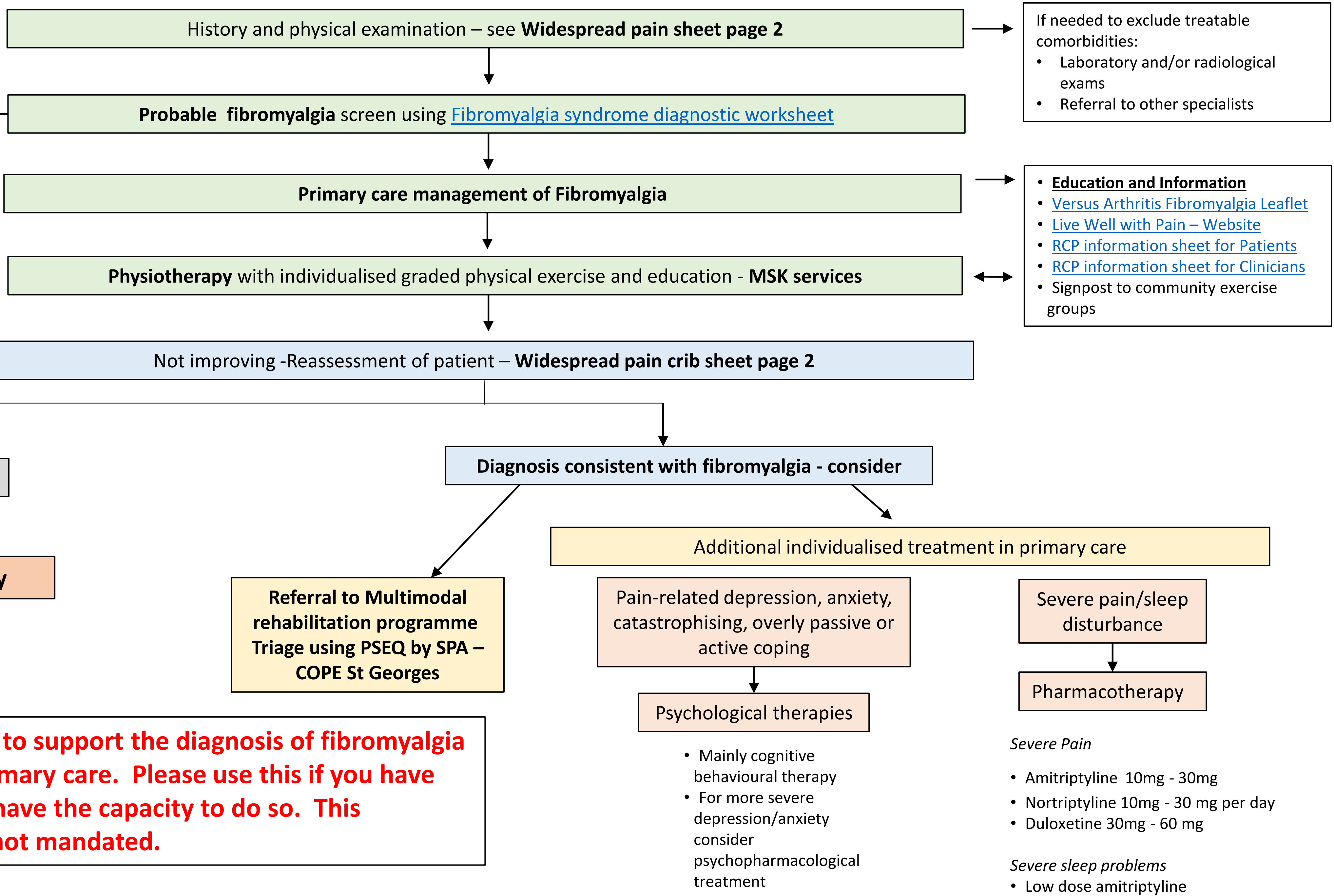
Fibromyalgia flow chart for Primary Care & Community Services

Adapted from: G J Macfarlane et al. Ann Rheum Dis 2017;76:318-328



This document is provided to support the diagnosis of fibromyalgia and decision-making in primary care. Please use this if you have the appropriate skills and have the capacity to do so. This diagnostic support tool is not mandated.

V7 May 2022 SL/JT/EC

Help sheet for generalised/widespread pain in primary care

Generalised/Widespread Pain

→ **Fibromyalgia diagnosis as per the** [Fibromyalgia syndrome diagnostic worksheet]

Any joint swelling?

- Consider diagnosis of **Rheumatoid arthritis** if:
- Swelling of 3 or more joints/small joints of hands or feet
- Positive MCPJ or MTPJ "Squeeze test"
- Early morning joint stiffness (EMS) >30mins.
- Request Bloods: FBC, LFT, U+E, CRP, ESR, Anti-CCP
- Consider X-ray of hands and feet

- **Refer to Rheumatology**
- **Refer to Early Inflammatory Arthritis pathway if symptoms > 6/52 and < 1 yr**

Personal or Family History of Psoriasis?

- Consider **Psoriatic arthritis**
- Can have normal ESR /CRP
- May have only spinal or tendon inflammation

- **Refer to Rheumatology**

morning spinal stiffness lasting > 30 mins improving with NSAIDs and exercise?

- Consider **Ankylosing spondylitis** especially if under 45 yrs of age
- Can have normal ESR/CRP
- In women may present with neck and thoracic pain only – easily confused with fibromyalgia.

- **Refer to Rheumatology**

Dry eyes, Dry eyes/mouth, Raynaud's, rash, fever?

Consider **CTD/ Vasculitis:**
- Perform urine dip for protein(not UTI)
- Bloods - Abnormal ESR/CRP
- Autoantibodies

- **Refer to Rheumatology**

Jaw Claudication, proximal muscle tenderness, visual disturbance

- Consider **Giant Cell Arteritis / Polymyalgia Rheumatica.**
- Bloods : ESR/CRP

- **Same day emergency referral**

Early morning stiffness shoulders and/or pelvic girdle?

- Consider **Polymyalgia Rheumatica** if:
- Raised ESR/CRP
- No symptoms of GCA

- **Primary care management unless complex or resistant**

Muscle weakness/ myositis?

- Consider diagnosis of **myopathy/ myositis**
- Weakness, raised CK, remember Vitamin D deficiency

- **Refer to Rheumatology**

History of Gout?

- Can be polyarticular **gout** especially after years – can involve upper limb joints.
- Raised uric acid/tophi

- **Manage in primary care unless complex or resistant (see BSR gout guidelines**

Hypermobility?

- Beighton Score >4
- Additional features GAPE - Gut, Allergy, Postural problems, Exhaustion

- **Consult RCGP EDS syndromes toolkit for referral and management guidance**

History of Osteoarthritis of multiple joints?

- **Polyarticular osteoarthritis** - especially hands/knees/ hips/spine.

- **Refer to physiotherapy and treat with analgesia**

Consider Alternative Diagnoses:

- **Thyroid/parathyroid/diabetes**
- **MS/myasthenia gravis/motor neurone disease**
- **Lymphoma/myeloma/leukaemia** (weight loss, fever, lymphadenopathy)

Useful documents:
Royal College of Physicians – The diagnosis of fibromyalgia syndrome (March 2022)
www.rcplondon.ac.uk/fibromyalgia-guidelines

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PRESCRIBING INFORMATION SHEET

NHS

Primary Care Management of Fibromyalgia

- **Drug Treatments: Amitriptyline, nortriptyline and duloxetine**

Fibromyalgia

Fibromyalgia diagnosis as per the New Fibromyalgia Diagnostic Criteria

Management

- Once diagnosed, the patient should be given information about the condition and management:
  - Versus Arthritis Fibromyalgia Leaflet
  - Live Well with Pain – Website
- Exercise has the strongest evidence base and should be first line This should include graded aerobic and resistance training. Patients should be encouraged to choose exercises they can gradually increase in frequency and duration. NHS resources where patients can access guidance:
  - Signpost to community exercise
  - Fitness exercise videos – 24 instructor-led videos for use at home: NHS Fitness Studio
  - Fitness guides https://www.nhs.uk/live-well/exercise/get-active-your-way/
  - 12 week fitness plan provides an example of graded exercise and can be adapted to suit the patient's needs and exercise preferences https://www.nhs.uk/live-well/exercise/12-week-fitness-plan/#week-1
  - Referral to physiotherapy / COPE St Georges Hospital for refractory non-inflammatory pain
- Cognitive behavioural therapy has proven to be effective in people with mood disorders or poor coping strategies e.g. pain related depression, anxiety, catastrophising, overly passive or active coping.
- There is limited evidence to support use of analgesia, anti-inflammatory drugs or stronger pharmacological interventions.

Pharmacological Management * – REASSESS TREATMENT EVERY 3 MONTHS

Consider any of the following treatment options individualised to the patient:

Amitriptyline 10 - 30mg once daily (at night) - for Fibromyalgia pain and to help sleep (unlicensed indication).

Start with Amitriptyline 10mg 2-3 hours before bedtime, increase at 10mg increments as tolerated up to every third night and continue on lowest effective dose

- Take two hours before bedtime. If still drowsy in the morning after taking, then take an hour earlier.
- Sleep benefit can occur after a few days but may take 6 weeks to help pain. Consider trialling amitriptyline for 6–8 weeks, with at least 2 weeks at the maximum tolerated dose, before deciding it is not effective.
- Little evidence that increasing dose over 30mg increases benefit.
- If amitriptyline is not effective or not tolerated, discontinue treatment gradually over a minimum of 1-2 weeks to prevent discontinuation symptoms (such as dizziness, nausea, paraesthesiae, anxiety, diarrhoea, flu-like symptoms, and headaches).

Nortriptyline 10 - 30 mg once daily (at night) - for Fibromyalgia pain (unlicensed indication). Less sedating than amitriptyline can be used if sleepiness is not desired or is excessive with amitriptyline.

Start with nortriptyline 10mg 2-3 hours before bedtime, increase at 10mg increments as tolerated up to every third night and continue on lowest effective dose

- Take two hours before bedtime. If still drowsy in the morning after taking, then take an hour earlier.
- May take 6 weeks to help pain. Consider trialling nortriptyline for 6–8 weeks, with at least 2 weeks at the maximum tolerated dose, before deciding it is not effective.
- Little evidence that increasing dose over 30mg increases benefit.
- If nortriptyline is not effective or not tolerated, discontinue treatment gradually over a minimum of 1-2 weeks to prevent discontinuation symptoms (including insomnia, irritability and excessive perspiration)

Duloxetine 30mg - 60 mg once daily - for Fibromyalgia pain (unlicensed indication).

- Take in the morning or evening.
- May take 4-6 weeks to help pain.
- Drug with best evidence base for Fibromyalgia pain with maximal benefit at 60mg per day and no increased benefit at higher doses.
- If duloxetine is not effective or not tolerated, discontinue treatment gradually over a minimum of 1–2 weeks in order to reduce the risk of withdrawal reactions.

**Pregabalin is a treatment option for patients but has not been included as this information sheet supports the Primary Care Widespread Pain Pathway. There is no intention to switch patients from pregabalin or gabapentin.*

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Date final document written: 29th September 2021
Approval Date: 20th October 2021
Review date: October 2023