TABLE 84-4 2010 AMERICAN COLLEGE OF RHEUMATOLOGY FIBROMYALGIA DIAGNOSTIC CRITERIA

CRITERIA

1. Widespread pain index (WPI) ≥7, symptom severity (SS) scale score ≥5, or WPI of 3-6 and SS scale score ≥9
2. Symptoms manifest at a similar level for at least 3 months
3. Exclusion of other explanation for the pain

ASCERTAINMENT

1. WPI score
   The number of areas where the patient has had pain over the past week is assessed from 19 possible sites: left shoulder girdle, right shoulder girdle, left upper arm, right upper arm, left lower arm, right lower arm, left hip, right hip, left upper leg, right upper leg, left lower leg, right lower leg, left jaw, right jaw, chest, abdomen, upper back, lower back, and neck.
2. SS scale score
   For fatigue, waking unrefreshed, cognitive symptoms, and somatic symptoms,* the level of severity during the past week is assessed as follows: 0 = no symptoms; 1 = few symptoms; 2 = moderate number of symptoms; 3 = many symptoms.
   The SS scale score is the sum of the severity of the first three symptoms plus the severity of somatic symptoms in general. The final score is between 0 and 12.

*Somatic symptoms may include muscle pain or weakness, irritable bowel syndrome, fatigue or tiredness, cognitive or memory problems, headache, numbness or tingling, dizziness, insomnia, depression, nervousness, seizures, abdominal pain or cramps (especially upper abdomen), constipation, diarrhea, nausea, vomiting, fever, dry mouth, itching, chest pain, wheezing, Raynaud's phenomenon, hives or welts, tinnitus, hearing difficulties, heartburn, oral ulcers, loss of or change in taste, dry eyes, blurred vision, shortness of breath, loss of appetite, rash, sun sensitivity, easy bruising, hair loss, frequent or painful urination, and bladder spasms.

The clinical presentation of fibromyalgia syndrome is an insidious onset of chronic, diffuse, poorly localized musculoskeletal pain, typically accompanied by fatigue and sleep disturbance. The physical examination reveals a normal musculoskeletal system, with no deformity or synovitis. However, widespread tenderness occurs, especially at tendon insertion sites, indicating a general reduction in the pain threshold.

Approximately one third of the patients identify antecedent trauma as a precipitant for their symptoms, one third of patients describe a viral prodrome, and one third have no clear precipitant. A variety of less typical presentations has been described, including a predominantly neuropathic presentation with paresthesias (i.e., numbness and tingling) in a nondermatomal distribution, an arthralgic rather than myalgic presentation, and an axial skeletal manifestation resembling degenerative disk disease. Many patients may have undergone invasive diagnostic tests and, in some cases, inappropriate procedures such as carpal tunnel release or cervical or lumbar laminectomies.

Conditions that should be considered in the differential diagnosis of fibromyalgia syndrome include polymyalgia rheumatica (in older patients), hypothyroidism, polymyositis, and early systemic lupus erythematosus or rheumatoid arthritis. However, symptoms are exhibited for many months or years without evidence of other signs or symptoms of an underlying connective tissue disease, making other possible diagnoses unlikely.

Results of laboratory and radiographic studies are usually normal for patients with fibromyalgia syndrome. Exclusion of other conditions, such as osteoarthritis, rheumatoid arthritis, and systemic lupus erythematosus, by radiography, erythrocyte sedimentation rate, assays for rheumatoid factor or antinuclear antibody, and other tests is no longer considered necessary for the diagnosis of fibromyalgia syndrome. Fibromyalgia should be diagnosed on the basis of positive criteria.

The treatment of fibromyalgia includes reassurance that the condition is not a progressive, crippling, or life-threatening entity. A combination of treatment options, including medication and physical measures, is helpful for most patients. Medications found to be helpful in short-term, double-blind, placebo-controlled trials include amitriptyline and cyclobenzaprine. Low doses of these medications (e.g., 10 to 30 mg of amitriptyline, 10 to 30 mg of cyclobenzaprine) are moderately effective and generally well tolerated. Studies have shown that newer antidepressants of the serotonin-norepinephrine reuptake inhibitor group (e.g., duloxetine, venlafaxine, bupropion) and $\alpha_2\delta$ ligands (e.g., gabapentin, pregabalin) are also effective, particularly in combination with low doses of tricyclic antidepressants.

Patients should be encouraged to take an active role in the management of their condition. If possible, they should begin a progressive, low-level aerobic exercise program to improve muscular fitness and provide a sense of well-being. A combination approach is effective for most patients in alleviating symptoms, although a small minority of patients requires more intensive treatment strategies, such as psychiatric treatment or referral to a pain center.

SUGGESTED READINGS

Goldenberg DL, Burkhardt C, Crofford L: Management of fibromyalgia syndrome, JAMA 292:2388–2395, 2004.

Littlejohn GO: Balanced treatments for fibromyalgia, Arthritis Rheum 50:2725–2729, 2004.