FIBROMYALGIA

DEFINITION:

IS A PAINFUL NON-ARTICULAR RHEUMATIC CONDITION OF AT LEAST THREE MONTHS' DURATION, CHARACTERIZED BY WIDESPREAD MUSCULAR ACHINESS AND SPECIFICALLY THE PALPATION OF TENDER POINTS AT 11 OF 18 PRESCRIBED LOCATIONS ON THE BODY

HISTORY OF FIBROMYALGIA

GENERALIZED MUSCULAR ACHES AND PAINS DESCRIBED AS MUSCULAR RHEUMATISM WERE DISCUSSED IN LITERATURE FROM THE SEVENTEENTH CENTURY.

IN 1904 “FIBROSITIS” WAS TERMED.

IN 1960/70s IT WAS USED INTERCHANGEABLY WITH FM TO DESCRIBE THE SYMPTOMS OF GENERALIZED MUSCULAR ACHING, MULTIPLE TENDER POINTS, POOR SLEEP, AND PAIN.

FIBROSITIS SUGGESTS INFLAMMATION OF MM TISSUE, FIBROMYALGIA INDICATES PAIN IN THE TISSUE.

IN 1980/90s FIBROMYALGIA BECAME ACCEPTED IN THE MEDICAL COMMUNITY AS A LEGITIMATE CONDITION.

HISTORY OF FIBROMYALGIA

FIBROMYALGIA IS A SYSTEMIC DISORDER THAT AFFECTS AN ESTIMATED 2-6% OF THE ADULT POPULATION.

⅔ OF THOSE STATE THEY “ HURT ALL OVER”

NO OBVIOUS ORIGIN OF PAIN

AREAS AFFECTED BY PAIN INCLUDE:

- ❑ LOW BACK
- ❑ SHOULDERS (TRAPS)
- ❑ NECK
- ❑ BACK OF HEAD
- ❑ UPPER CHEST
- ❑ ARMS
- ❑ HANDS
- ❑ THIGHS
- ❑ LEGS
- ❑ TMJ
- ❑ ANTERIOR CHEST

THERE ARE 18 SYMMETRICAL TENDER POINTS OF WHICH AT LEAST 11 NEED TO BE FOUND ON EXAMINATION TO CONFIRM FIBROMYALGIA

THIS DISTINGUISHES FIBROMYALGIA FROM OTHER CONDITIONS SUCH AS:

- CHRONIC FATIGUE SYNDROME
- MYOFASCIAL PAIN SYNDROME
- MYALGIC ENCEPHALOMYELITIS
- VARIOUS FORMS OF ARTHRITIS
- LUPUS

ABNORMALLY TENDER POINTS: POSTERIOR VIEW

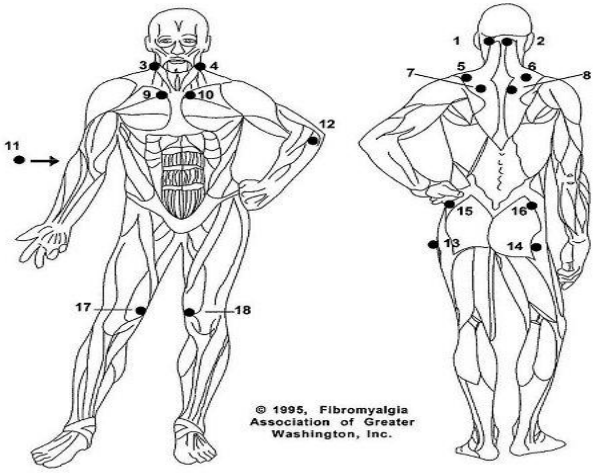
1-2: SUBOCCIPITAL MM INSERTION, JUST INF TO OCCIPUT

3-4: UPPER TRAPS, MIDPOINT ON UPPER BORDER OF THE MM

5-6: SUPRASPINATUS ORIGIN, MED BORDER NEAR THE SPINE OF SCAP

7-8: GLUTE MED, ANT PORTION OF MM

9-10: GREATER TROCHANTER, AT 2CM POST, SPECIFICALLY AT THE TROCHANTERIC PROMINENCE



Fibromyalgia Tender Points Identified By The American College Of Rheumatology In 1990

(at digital palpation with an approximate force of 4 kg)

1 & 2, Occiput: bilateral, at the suboccipital muscle insertions.

3 & 4, Low cervical: bilateral, at the anterior aspects of the intertransverse spaces at C5-C7.

5 & 6, Trapezius: bilateral, at the midpoint of the upper border.

7 & 8, Supraspinatus: bilateral, at origins, above the scapula spine near the medial border.

9 & 10, Second Rib: bilateral, at the second costochondral junctions, just lateral to the junctions on upper surfaces.

11 & 12, Lateral epicondyle: bilateral, 2 cm distal to the epicondyles.

13 & 14, Gluteal: bilateral, in upper outer quadrants of buttocks in anterior fold of muscle.

15 & 16, Greater trochanter: bilateral, posterior to the trochanteric prominence.

17 & 18, Knee: bilateral, at the medial fat pad proximal to the joint line.

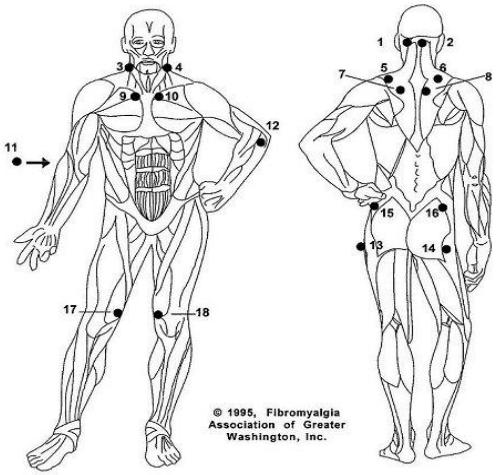
ANTERIOR VIEW

11-12: CERVICAL REGION, THE ANT ASPECT OF THE TVPs OF C5-7

13-14: SECOND RIB, COSTOCHONDRAL JUNCTION

15-16: EXTENSOR DIGITORUM, AT 2CM DISTAL TO LAT EPICONDYLE

17-18: KNEE, AT MCL PROXIMAL TO THE JOINT LINE



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CAUSES OF FIBROMYALGIA:

- UNCLEAR BUT RELATED TO:
  - IMMUNE ABNORMALITIES
  - GENETIC PREDISPOSITION
  - NEUROENDOCRINE DYSFUNCTION
- SEROTONIN DEFICIENCY DUE TO ABNORMALITIES OF SEROTONIN BINDING PLATELETS
  - RESULTS IN NEGATIVE EFFECT ON PAIN INHIBITORY PATHWAY OF NN SYSTEM

CAUSES OF FIBROMYALGIA

- SYMPTOMS TRIGGERED/AGGRAVATED BY:
  - OVEREXERTION
  - LACK OF EXERCISE
  - STRESS
  - ANXIETY
  - DEPRESSION
  - LACK OF/POOR QUALITY OF SLEEP
  - TRAUMA
  - EXTREMES OF TEMP/HUMIDITY
  - INFECTIOUS ILLNESS

TYPES OF FIBROMYALGIA

- POST-TRAUMATIC FIBROMYALGIA:
  - THOUGHT TO DEVELOP AFTER A FALL, WHIPLASH, OR BACK STRAIN
- PRIMARY FIBROMYALGIA:
  - UNCERTAIN ORIGIN

APPROXIMATELY 4 WOMEN TO EVERY MAN ARE AFFECTED

CAN OCCUR AT ANY AGE, EVEN CHILDREN/ELDERLY

SYMPTOMS OCCUR IN YOUNG ADULTHOOD, DEVELOPING SLOWLY, THEN PROGRESS IN INTENSITY BETWEEN AGES 30-50 YRS

COURSE OF SYNDROME UNPREDICTABLE

MAY BE CHRONIC, WITH BOUTS OF REMISSION/FLARE-UPS

IT IS NOT LIFE THREATENING/PROGRESSIVE, BUT CAN AFFECT QUALITY OF LIFE.

CAN BECOME DEBILITATING, DIFFICULTY KEEPING JOB, PARTICIPATING IN ACTIVITIES. MAY IMPROVE BY SEEKING TX AS SOON AS POSSIBLE

PSYCHOLOGICAL FACTORS

ANXIETY IS HIGHER,

INCREASE SEVERITY OF PAIN INCREASED IN THOSE WITH OTHER CHRONIC PAIN DISORDERS SUCH AS RA

USUALLY TREATED WITH DOUBT BY MEDICAL PROFESSIONALS REGARDING SYMPTOMS

OFTEN ACCUSED AS BEING A HYPOCHONDRIAC

MEDICALLY

3 MONTH HISTORY OF SYMMETRICAL PAIN IS DIAGNOSTIC

AFTER PALPATING 11 OF 18 TENDER POINTS, BLOOD WORK DONE TO RULE OUT OTHER PATHOLOGIES SUCH AS ARTHRITIS

THERE IS NO CURE FOR FIBROMYALGIA

TREATED WITH MEDICATIONS, PT, LIFESTYLE MANAGEMENT SKILLS

LOW DOSES OF ANTIDEPRESSANTS: TRICYCLIC/TETRACYCLIC, USED TO ASSIST WITH DEEP SLEEP, IMPROVE SEROTONIN LEVELS, DECREASE PAIN

EXERCISE ENCOURAGED, INTRODUCED GRADUALLY

IMPROVE POSTURE

ENCOURAGE STRETCHING

INCREASE ENDURANCE

LEARN TO LISTEN TO BODY FOR PAIN/FATIGUE THEN REORGANIZE ACTIVITIES ACCORDINGLY

MASSAGE AND FIBROMYALGIA

HELPS TO REDUCE STRESS LEVELS

REDUCE PAIN

REDUCE MYOGLOBIN (OXYGEN CARRYING PROTEIN IN MM TISSUE) LEVELS IN BLOOD. PAIN MAY BE CAUSED FROM MYOGLOBIN LEAKING FROM MM.

REDUCE TENDER POINT PAIN

DECREASE ANXIETY

DECREASE DEPRESSION

DECREASE FATIGUE/STIFFNESS

FEWER NIGHTS OF INTERRUPTED SLEEP

SYMPTOMS

GENERALIZED PAIN OCCURRING IN 100% OF THOSE WITH FIBRO

STIFFNESS COMMON, AFFECTING 80%, WORSE IN AM AND EVENING

MODERATE/SEVERE LEVEL OF FATIGUE IN 85%, LEADING TO FEELING WEAK, AND AGGRAVATED BY PHYSICAL ACTIVITY, AFFECTING ADLs.

POOR SLEEP IN 80%. MORNING FATIGUE AGGRAVATES PAIN

ALPHA-EEG ANOMALY: LACK OF RESTORATIVE SLEEP, INTERRUPTS DEEP SLEEP WITH PERIODS OF WAKING-TYPE BRAIN ACTIVITY

CAN HAVE SLEEP APNEA

RESTLESS LEG SYNDROME

BRUXISM

SYMPTOMS

INTOLERANCE TO COLD

SWOLLEN FEELING IN TISSUE

DYSMENORRHEA

ANXIETY

PALPITATIONS

ALTERED SENSATIONS: NUMBNESS/TINGLING/PINS AND NEEDLES FEELING

DRY EYES/MOUTH

SKIN SENSITIVITIES

COGNITIVE DISORDERS: MEMORY/CONCENTRATION ISSUES

OTHER CONDITIONS

PREMENSTRUAL SYNDROME

DEPRESSION

CHRONIC HAs

MIGRAINES

INSOMNIA

TMJ DYSFUNCTION

MYOFASCIAL PAIN SYNDROME

IBS

IRRITABLE BLADDER SYNDROME

CHRONIC FATIGUE SYNDROME

CONTRAINDICATIONS

AVOID DEEP WORK/TECHNIQUES THAT OVERSTRETCH CLIENT'S MM

DEEP OR INVASIVE TECHNIQUES WILL RESULT INCREASED PAIN POST-TREATMENT

TREATMENT SHOULD NOT BE LONG/VIGOROUS TO FATIGUE CLIENT

OVER 60 MIN TREATMENT SHOULD BE AVOIDED

MODIFY TECHNIQUES IF CLIENT TAKING MM RELAXANTS, ANALGESICS, AND ANTIDEPRESSANTS TO COPE WITH SYMPTOMS

OBSERVATION/PALPATION

POSTURAL ASSESSMENT: ANTALGIC POSTURE, HYPERKYPHOSIS, HEAD-FORWARD POSTURE, IMBALANCE OF ANT TILT OF PELVIS

APICAL/PARADOXICAL BREATHING PATTERNS

PAIN PRESENT BILAT ON PALPATION, ABOVE/BELOW WAIST

TPs PALPATED, DO NOT BE CONFUSED WITH TENDER SPOTS

TESTING

AFROM: REDUCED RANGES IN AFFECTED AREAS DUE TO PAIN/WEAKNESS OF MM CROSSING JTS

AR STRENGTH TESTING: RESULT IN PAIN/WEAKNESS IN AFFECTED MM

PAIN IN 11 OF 18 TENDER SPOTS, MUST INCLUDE CONTROL AREA

4KG OF PRESSURE APPLIED TO EACH POINT

REFER TO DR FOR FURTHER TESTING. IT IS NOT IN OUR SCOPE OF PRACTICE TO DIAGNOSE CLIENTS

DIFFERENTIAL ASSESSMENT: PALPATING TENDER POINTS CAUSES LOCAL PAIN ONLY, MTPs HAVE REFERRAL PATTERNS AND TAUT BAND OF MM PRESENT

SELF CARE

WARM/HOT HYDROTHERAPY, EPSOM BATH, WHIRLPOOL, HEATING PADS OFFER TEMPORARY RELIEF

ESSENTIAL OILS: CHAMOMILE (GERMAN/ROMAN), LAVENDER, MARJORAM, ROSEMARY HAVE ANALGESIC/RELAXATION PROPERTIES

MASSAGE TO ABDOMEN WITH ESSENTIAL OILS

REFERRAL TO NATUROPATH: STRENGTHEN IMMUNE SYSTEM

RELAXATION STRATEGIES: DDB, MEDITATION, TAI CHI, AND YOGA

DAILY EXERCISE: WHEN FEELING MOST ENERGETIC: SHOULD INCLUDE STRETCH/STRENGTHENING, MODERATE AEROBIC ACTIVITY, SUCH AS SWIMMING/WALKING

SELF CARE

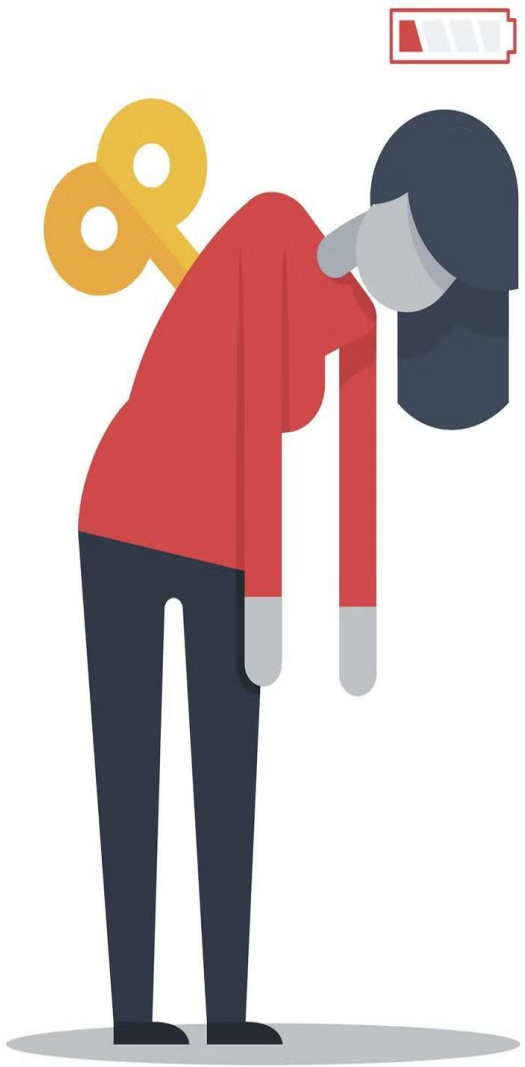
MILD EXERCISE RECOMMENDED: AFTER 6-8WKS PAIN WILL DECREASE WHEN EXERCISING. IF PAIN SEVERE AND LASTING MORE THAN 48 HRS, EXERCISE SHOULD BE REEVALUATED FOR APPROPRIATENESS

REFERRING TO GROUPS OFFERING SUPPORT AND INFORMATION SUCH AS ONTARIO FIBROMYALGIA ASSOCIATION

REFERRAL FOR MOVEMENT THERAPY: MITZVAH, FELDENKRAIS, ALEXANDER TECHNIQUE TO HELP IMPROVE BODY AWARENESS

OPTIMAL POSTURAL PATTERNS NEED TO BE LEARNED, DEVELOP PROGRAM TO ENCOURAGE

CHRONIC FATIGUE SYNDROME



DEFINITION

CONDITION DISTINGUISHED BY PERSISTENT FATIGUE THAT DOES NOT RESOLVE AND SEVERELY REDUCES ACTIVITY LEVELS FOR AT LEAST 6 MONTHS

WIDESPREAD IN NORTH AMERICA, BUT OFTEN MISDIAGNOSED AS A FLU/VIRAL INFECTION, HYPOCHONDRIA, OR DEPRESSION

REPORTS DOCUMENTED OUTBREAKS OF FLU-LIKE SYMPTOMS ASSOCIATED WITH FATIGUE OVER THE PAST 50 YRS.

CAUSES

NOT WELL UNDERSTOOD

WAS LINKED TO THE EPSTEIN-BARR VIRUS (PART OF HERPES VIRUS GROUP THAT CAUSES MONONUCLEOSIS), NOW THOUGHT TO BE RELATED TO SOME OTHER VIRAL OR INFECTIVE SOURCE.

DEFICIENCY OF T-LYMPHOCYTES, OR NATURAL KILLER CELLS

LINK TO FIBROMYALGIA, BUT UNCLEAR HOW THEY ARE CONNECTED

SYMPTOMS

CHRONIC OR RECURRENT

PRIMARY SYMPTOM: DISABLING FATIGUE THAT DOES NOT RESOLVE WITH REST

ACHING MM AND JTS

SPASM