Editorial

Fibromyalgia and the Physician

Fibromyalgia (FMS), a chronic disorder defined by widespread pain, often accompanied by fatigue and sleep disturbance, affects up to one in 20 patients in primary care (1). Although most patients with FMS are managed in primary care, diagnosis and treatment continue to present a challenge, and patients are often referred to specialists. Furthermore, the lack of a clear patient pathway often results in patients being passed from specialist to specialist, exhaustive investigations, prescription of multiple drugs to treat different symptoms, delays in diagnosis, increased disability and increased healthcare resource utilisation. Fibromyalgia continues to present a challenge for Healthcare Professionals (HCPs) (1). The extensive array of symptoms associated with, and gradual evolution of, FMS make it difficult to diagnose in primary care settings (1), and the condition is often under-diagnosed. One study has shown that diagnosis of FMS might take more than 2 years, with patients seeing an average of 3.7 different physicians during this time (2). Although the American College of Rheumatology (ACR) has published diagnostic criteria for FMS , these are not widely used in clinical practice, and there remains a knowledge gap among some HCPs, particularly in the primary care setting (1,2). In addition to diagnostic complexity, therapeutic management might be problematic, and there is a lack of prescribing consistency between physicians. Many patients might not receive treatment, and for those who do, repeated therapy switching, polypharmacy and discontinuation are common. Some patients may also have unrealistic treatment expectations and difficulty coping with their symptoms, which may contribute to struggles in managing their condition.

Are most physicians comfortable treating patients with FMS, especially in set ups where there is little or non-existent multi-disciplinary teams? Several surveys have been conducted amongst physicians about this topic. Very interesting and varied opinions about the disease have arisen. Some physicians have described FMS as a 'nightmare consultation' with some even questioning the existence of the condition as a disease entity! Many see FMS as a symptom description that is slowly evolving into a spurious diagnosis! With such a wide range of opinion, it is likely that patients with fibromyalgia are receiving different levels of support, advice and treatment!

The big question thus is "How can prejudice and skepticism regarding the validity of fibromyalgia be countered?" Knowledge that FMS is grounded in neurophysiological mechanisms will reduce skepticism regarding a syndrome of subjective complaints. Physicians comfort with a biomedical paradigm, which prioritizes diagnostics, adds to the insecurity in management of these patients, with some authors contending that the label of FMS promotes poor health (4,5). Patient preoccupation with physical symptoms rather than developing control over illness invokes frustration for the healthcare professional and erodes a good therapeutic relationship (5). The construct of somatization has however never been validated in situations involving pain, and particularly in FMS. In contrast, patients with FMS report frustration with healthcare professionals, dissatisfaction with the clinic visit and seek a concrete somatic diagnosis (6,7). Although discordance between patient and physician assessment of health perceptions has been reported, physicians have expressed the desire to comply with patients' wishes and avoid frustration (8). When physicians prejudge FMS patients in moralizing terms and believe them to be illness-focused, demanding and medicalized, the patient doctor alliance will be eroded with adverse effect on patient outcome (5). Both the individual patient's concept of illness as well as perceived attitudes of the healthcare team influences global well-being. Shared decision-making between patient and physician can improve the quality of interaction (8). An early diagnosis may have pharmacoeconomic implications with reduced healthcare costs as measured by fewer investigations, less referral to specialists and reduced healthcare visits (7,8).

Whereas opinion is highly divided amongst rheumalogists as to the approach of patients with FMS, it is my opinion that holistic management of FMS patients is a very useful concept, which allows the clinician to promote beneficial lifestyle changes to patients who appear to have lost their 'pain filter', and who would otherwise resist such initiatives. The complex and multifaceted nature of FMS lends itself better to a holistic (integrative medicine) or biopsychosocial approach than the more specific bio-scientific pathways typical for a pathologically defined disease. A person-centered approach to evaluation and care more effectively addresses and encompasses the biopsychosocial aspects of this disorder than traditional bio-scientific clinical methods. Physicians should not shy away from forming multi-disciplinary teams with other colleagues e.g. psychiatrists, counselors, neurologists, nurses and pain management specialists.

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