

# Angry patient with fibromyalgia: Diagnosis and management in primary care

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## SUMMARY

I report a case of 40-year-old lady who presented with symptoms and signs suggestive of fibromyalgia but was disregarded by attending doctor. She was infuriated and lodged a complaint to Family Medicine Specialist (FMS) whereby further assessment confirmed the diagnosis of fibromyalgia and subsequently treated in primary care setting.

## KEY WORDS:

*Fibromyalgia; de-escalation; primary care*

## INTRODUCTION

Fibromyalgia is a chronic pain condition characterised by allodynia and hyperesthesia due to abnormal central and peripheral pain perception resulting in physical and social dysfunction. Globally, prevalence of fibromyalgia is estimated at 2.7%, and affect one in 20 patients in primary care.<sup>1</sup> From Malaysia's Community Oriented Program for the Control of Rheumatic Diseases (COPCORD) survey, up to 7% of those with musculoskeletal pain fulfilled the criteria for fibromyalgia and visits to primary care facilities were the commonest for all causes of musculoskeletal pain.<sup>2</sup>

## CASE REPORT

A 40-year-old Malay homemaker barged into Family Medicine Specialist's (FMS) room angrily after completed consultation in Medical Officer's (MO) room. De-escalation technique was employed and she was successfully calmed down.

She presented two months earlier with history of multiple joints and body pain for one year. They were located at bilateral medial side of knees, lower back, sternum, neck, hip and small joints of both hands. However, there was no joint swelling, hair loss and photosensitivity. For past medical history, she was diagnosed to have chronic low back pain three years ago but defaulted Orthopaedic follow up.

In view of her problems, she had frequent absence from work and decided that resignation from her job as a clerk was the best option. Despite that, being a fulltime homemaker proved to be troublesome too as she felt fatigue most of the time and insomnia thinking about her problem. However, there were no symptoms of depression.

On the eventful day, she came to review her investigations results and was told that renal profile, liver function test, urine examination and electrocardiogram were normal. Anti-nuclear antibody and rheumatoid factor were normal too. Despite that, her worries were not alleviated and perceived to be disregarded by attending MO causing her to lodge a complaint.

On FMS review, the above history obtained and from physical examination, she appeared calm after de-escalation and vitals were normal. Pain points described were palpated and tenderness elicited at the locations marked in Figure 1. There were no joint deformity, swelling and tenderness of hands and feet. Urgent erythrocyte sedimentation rate (ESR) was ordered and reported to be 25mm/hour.

She was diagnosed to have fibromyalgia and educated about it. Tablet Fluvoxamine 50mg ON was started and she reported only slight improvement two weeks later. Her medication was increased to 75mg ON and she was referred to Psychologist for cognitive behavioural therapy (CBT).

## DISCUSSION

Diagnosing fibromyalgia is difficult because symptoms are vague and solely dependent on clinical acumen. The differential diagnoses for patients presenting with chronic body pain are vast; ranging from both rheumatology and psychiatry disorders. Thus, a high index of suspicion is required to diagnose fibromyalgia. The role of primary care in diagnosing and treating fibromyalgia has been emphasised but primary care providers' lack of knowledge in this disease made this a farfetched task.<sup>1</sup>

In this case, the patient fulfilled all year 1990 American College of Rheumatology (ACR) criteria but only partially fulfilled the latest one as ratings were not asked during assessment. In comparison to the former criteria, this new criterion reduce dependence on tender point examination and included cognitive, mood and general somatic symptoms as illustrated in Table I.<sup>1</sup>

The first 'treatment' should be educating the patient about the diagnosis, nature of disease, prognosis and available treatment options. By doing this, patient will be reassured that the disease is real and that help is available. In addition to that, aerobic exercises such as swimming, cycling and

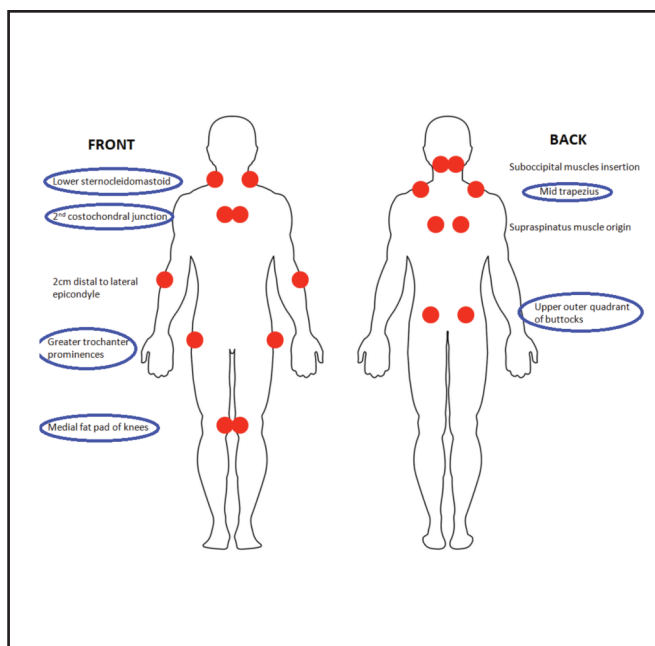
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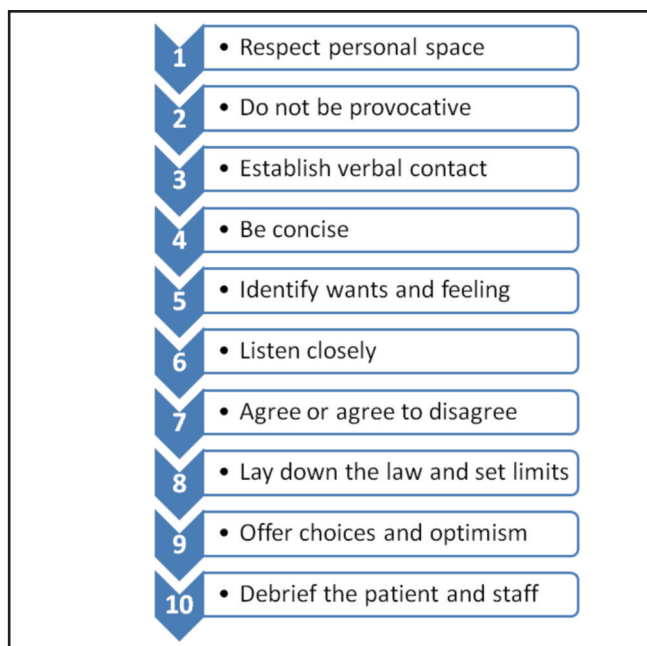
**Table I: Differences between the American College of Rheumatology (ACR) 1990 and the revised ACR 2010 criteria for fibromyalgia<sup>1</sup>**

1990	2010
History of widespread pain	WPI $\geq 7$ and SS $\geq 5$ OR WPI 3-6 and SS $\geq 9$
Pain $\geq 3$ months duration	Symptoms have been present at a similar level for $\geq 3$ months
Pain in 11 of 18 tender points on digital palpation	Patient does not have a disorder that would otherwise explain the pain
Definitions	
Widespread pain	WPI score
<ul style="list-style-type: none"> <li>Pain on left side of body, right side of body, above waist, below waist and axial skeletal pain</li> </ul>	<ul style="list-style-type: none"> <li>The number of areas in which patient has had pain over the last week (six lower extremities, six upper extremities, seven axial skeleton)</li> <li>Final score: between 0 and 19</li> </ul>
Tender points (all bilateral)	SS score
<ul style="list-style-type: none"> <li>Occiput, low cervical, trapezius, supraspinatus, 2nd rib, lateral epicondyle, gluteal, knee, greater trochanter</li> </ul>	<ul style="list-style-type: none"> <li>The sum of severity of fatigue, waking unrefreshed and cognitive symptoms, plus the severity of general somatic symptoms</li> <li>Each symptom is rated on a scale of 0-3, where 0 = no symptoms/problem and 3 = severe symptoms/problems</li> <li>Final score: between 0 and 12</li> </ul>

ACR, American College of Rheumatology; SS, symptom severity; WPI, widespread pain index  
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**Fig. 1:** Tender points for diagnosis of fibromyalgia. Points circled in blue are those experienced by this patient.<sup>1</sup>



**Fig. 2:** Ten domains in de-escalation.<sup>5</sup>

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jogging should be recommended to improve pain symptoms and general wellness.<sup>3</sup>

First line pharmacological treatments are amitriptyline and cyclobenzaprine. However, only amitriptyline is available in primary care. It should be started at a low dose (10mg ON) and titrated to desirable symptoms control.<sup>3</sup> Fluvoxamine was chosen for this case in view of lesser anti-cholinergic adverse effect, physician preference and availability in primary care. A small study from Japan showed that fluvoxamine might be as useful as amitriptyline in treating fibromyalgia.<sup>4</sup> If no improvement, multidisciplinary

approach should be considered by referral to psychologist, psychiatrist, rehabilitation services, rheumatologist and other services as the primary care physician deem fit.<sup>4</sup>

It is possible that patients may present with anger in clinical practice. Therefore, skills in handling angry patient are important for primary care providers at all levels. Pre-emptive measures should be taken by ensuring safe working space with clear exits and placing moveable and non-moveable furniture at appropriate location to avoid agitated patients throwing them. Next is the training to deal with such situation which should be taught to all staff as angry patients

can present at any stage of a clinic visit. The person attending to such situation must approach calmly and safety should be prioritised. Lastly, 10 domains of de-escalation as outlined in Figure 2 should be used and empathy shown at each phase.<sup>5</sup>

### CONCLUSION

Diagnosis of fibromyalgia should be considered by primary care doctors whenever patients presented with unresolved body ache. Without prompt diagnosis and empathy toward patients, they might opt for doctors shopping, traditional remedies or as in this case presented angrily. Treatment modalities include pharmacological, non-pharmacological and sometimes multidisciplinary approaches are required.

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