

Lower Extremity Example

Report Writing
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California Orthopaedic Association

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Questions ?

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Case: "Ms. G"

- 26 year old female, involved in a **MVA**.
- Driving a full size pick up on-the-job.
- Struck from the rear by a Honda Civic traveling 5mph.
- **Wearing** a seat belt with shoulder restraint.
- Airbags did **not** deploy.
- Did **not** strike her head, chest, or any body part on steering wheel or any other component of the truck cab.

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Case: "Ms. G" (2)

- **No** loss of consciousness.
- In ER on Day of Injury, neck and back pain.
X-rays normal (including flexion and extension films of cervical and lumbar spines).
- **Exam:**
 - **No** radicular limb pain or numbness.
 - **Normal** neurologic exam.
 - Range of motion exam was not documented.
 - **No** documented swelling or ecchymosis.

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Case: "Ms. G" (3)

- 2 days after injury seen by **PCP**.
- Complains of neck and low back pain.
- Complains of pain in both lower limbs, and both posterior shoulders.
- **Treated** with NSAIDs, hydrocodone, **work absence**, and **advice to avoid any activity associated with the pain**.

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Case: "Ms. G" (4)

- Over time, **pain worsens**.
- Lower limb pain is symmetric, and **non-radicular**.
- **Seen by** orthopedist, neurologist, and neurosurgeon, but, **no objective findings**. Diagnosed with "sprains".
- **Normal tests** included Cervical and lumbar MRI, total spine myelogram/post-myelogram CT scan, EMG/NCV, and serologic screening for rheumatologic disease.

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Case: "Ms. G" (5)

- **Seen by PM&R.** Based on pain that was worst in her legs "trigger points" diagnosed with "myofascial pain".
- **Seen by rheumatologist.** Based on "tender points" diagnosed with "post-traumatic fibromyalgia"
- **Persisting pain** in neck, low back, and both lower limbs.
- She joins
 - a local [fibromyalgia support group](#)
 - a [fibromyalgia internet chat room](#)

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Case: "Ms. G" (6)

- **Exam:** Tender at 16 of 18 "tender points" described in "fibromyalgia" including **bilateral tenderness** near the **posterior superior iliac spines, medial knees**, and also the **gastronemius-soleus junctions**.
- **No** neurologic deficit.
- **Full** active range of motion of all joints.
- **No** swelling. **No** atrophy. **No** warmth. **No** effusion. **No** crepitus. **No** deformity.
- Other than "tender points",
Ms. G's exam is totally normal.

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Case: "Ms. G" (7)

- What is her *AMA Guides, 5th Edition* **impairment rating** for the lower limb pain she relates to the work related MVA ??
- What is her **diagnosis** ??
 - Fibromyalgia?
 - Myofascial pain?
 - Pain in limb? (ICD-9 729.5)
 - Pain disorder associated with psychological factors?
- What will you opine about **causation** ??
- What are her **work capacity/restrictions** ??

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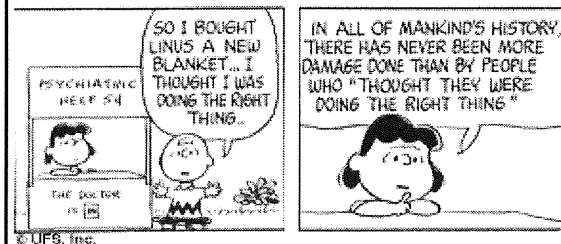
Case: Ms. G

- What is her **diagnosis** ??
 - Fibromyalgia?
 - Myofascial pain?
 - Pain in limb? (ICD-9 729.5)
 - Pain disorder associated with psychological factors?

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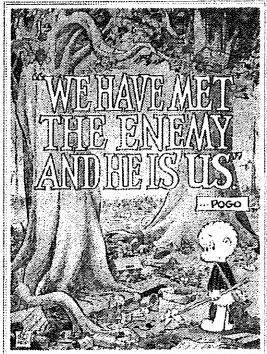
Doctors MEANT Well



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Doctors have ruined this lady's life



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Fibromyalgia (FM) Definition.

- Chronic pain in muscles and soft tissues surrounding the joints
- Form of non-articular rheumatism characterized by widespread musculoskeletal aching and stiffness, as well as tenderness on palpation at characteristics sites, called tender points.

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The American College of Rheumatology 1990 criteria for the classification of fibromyalgia:

A. Widespread pain in all four quadrants of the body for a minimum of three months (must have axial pain – neck, back, or chest)

And

B. at least 11 of the 18 specified tender points (in the neck, shoulder, chest, hip, knee and elbow regions).

Arthritis Rheum 1990; 33: 160-172

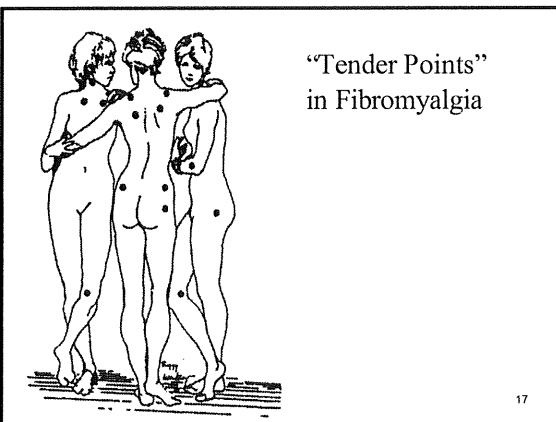
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Symptoms of fibromyalgia

Widespread pain and muscular tenderness.

- sleep disturbances,
- abnormal fatigue,
- anxiety, depressed mood,
- impaired concentration and memory,
- headaches,
- paresthesias in hands and legs,
- irritable bowel syndrome symptoms,
- frequent urination.

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SYNDROME

- "Syndrome": a set of symptoms that occur together; a symptom complex."
– *Dorland's Illustrated Medical Dictionary, 27th Edition* 1988 [ISBN 0-7216-3154-1]
- Used to describe symptoms commonly seen together for which medicine has No explanation.
- When science discovers a cause or etiology, the syndrome becomes a disease and is then renamed.
– Example: Down's Syndrome becomes Trisomy 21

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Definitions:

- **Disease:** a deviation from normal structure or function of any part, organ, or system of the body.
- **Illness:** the experience of feeling unwell or diseased.
 - The person's reaction to having or believing one has a disease.

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Fibromyalgia is a SYNDROME **NO KNOWN CAUSE**

- Subjective symptoms
- Subjective signs (tender points)
- No abnormal tests (No Objective findings)
 - Xrays
 - Laboratory Studies
 - MRI
 - EMG/NCV
 - Muscle biopsy by light and electron microscopy

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Fibromyalgia

The patient has a syndrome and frequently an illness, but **not a disease.**

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Myofascial Pain Syndrome MPS

DEFINITION

- Regional pain syndrome
 - Not pain all over like fibromyalgia
- “Trigger points”
 - Different from tender points
 - Unlike Fibromyalgia, MPS is Frequently diagnosed when unexplainable pain remains after trivial/minor injury.

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Trigger Points

- Characterized by:
 - Localized tenderness
 - Presence of a taut band
 - Unlike fibromyalgia the **doc** feels something
 - Twitch response on palpation or on needle insertion into trigger point
 - Referred pain on palpation
 - Pain somewhere else
 - Different from the “Tender Points” of Fibromyalgia Syndrome

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Laboratory Tests in Myofascial Pain Syndrome

- Muscle biopsy
 - no reliable abnormality demonstrated
- EMG studies
 - muscle trigger points are electrically silent (normal)
- Sleep studies
 - Usually Alpha wave intrusion in non-REM sleep as in Fibromyalgia
- Routine labs, x-rays
 - Normal

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Generalized Anxiety Disorder: SYMPTOMS

≥ 3 of the 6 Required for Diagnosis

- restlessness, or agitation
- easily **fatigued***
- difficulty concentrating
- **muscle tension (or muscle pain*)**
- **sleep disturbance***
- Irritability
- * Note: seen in Fibromyalgia Syndrome

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Generalized Anxiety Disorder ? as seen by various specialties ?

Fatigue, muscle tension (pain), sleep disturbance:
3 of 6 criteria needed
to Dx "Generalized Anxiety Disorder"

- Rheumatologist: "Fibromyalgia"
- PM&R: "Myofascial pain syndrome"
- Immunologist: "Chronic Fatigue Syndrome"
- Neurologist: "Tension Headache"
- Gynecologist: "Chronic Pelvic Pain"
- Gastroenterologist: "Irritable Bowel Syndrome"
- Ecologist: "Multiple Chemical Sensitivity"



Are all these doctors "seeing" the same patients (elephant), but blinded by their own biases and limited by their own anecdotal experience ??

Arch Intern Med 1994; 154: 2049-2053

Comparison of patients with FM, CFS, & MCS

- 30 Patients with each of these 3 illnesses recruited from a university medical center.
- Demographic factors, clinical factors, and health locus of control do NOT distinguish patients with these conditions.
- Symptoms typical of each disorder are prevalent in the other two conditions.

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Arch Intern Med 1994; 154: 2049-2053

Comparison of patients with FM, CFS, & MCS

- > 80 % of fibromyalgia (FM) and multiple chemical sensitivity (MCS) patients met criteria for chronic fatigue syndrome (CFS).
- 100% of MCS patients reported sensitivities to some chemical, while 53-67% of CFS and 47-67% of FM patients also reported such symptoms.
- MCS patients sought care more frequently from allergists or immunologists than did FM or CFS patients

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Arch Intern Med 1994; 154: 2049-2053

Symptoms	CFS %	FM %	MCS %
Fatigue > 6 months	100	90	83
Arthralgias	70	93	73
Myalgias	77	97	19
Headaches	83	67	63
Sleep disturbance	53	77	60
Memory loss	63	77	90
Confusion	64	73	90

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Other studies reporting that FM, CFS, & MCS may be one illness with different labels

- *Arthritis Rheum* 1987; 30: 1132-1136
- *Arthritis Rheum* 1990; 33: 381-387
- *Arch Intern Med* 1986; 146: 145-149
- *Am J Med* 1992; 92: 363-367
- Thus, what we discuss about any of these three may well apply to the other 2 as well.

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"Is Fibromyalgia a Distinct Entity? The Epidemiologist's Evidence"

- For FM to be an entity, epidemiologists can study it MUST have at least one of:
 - A characteristic feature(s) that clearly distinguishes it from the rest of the population
 - Identifiable risk factors
 - Characteristic natural course (prognosis)
 - Specific response to treatment
- FM has NONE of these.
- Epidemiologic evidence suggests key features are continuous, with **no clear population group identifiable**.
 - *Baillieres Best Pract Res Clin Rheumatol* 1999; 13 (3): 415-419 ³²

Fibromyalgia is a syndrome and an illness, BUT

Is Fibromyalgia a specific disease?

**NO,
not proven to be a disease**

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Fibromyalgia: Not a new illness

- 1700s German MD first distinguished "**muscular rheumatism**" from "articular rheumatism". Massage was part of the diagnosis and treatment.
- 1815 William Balfour (Edinburgh) described nodules in rheumatic muscles.
- 1904 Sir William Gowers coined the term "**fibrositis**" mistakenly believing inflammation was the pathologic process.
 - (sciatica was an inflammation that followed "lumbago" or "muscular rheumatism".)
- *Mayo Clin Proc* 1990; 65: 1237-1248

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Fibromyalgia: Not a new illness

- 1940s biopsy studies at Mayo clinic (and elsewhere) being normal (NO inflammation), Mayo chose to use the term "**Tension myalgia**"* for the spectrum of fibromyalgia to myofascial pain
- *Mayo Clin Proc* 1990; 65: 1237-1248
- * To emphasize the role of psychologic tension in the symptoms

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Not a New Syndrome

- Called "**Fibrositis**" or "**Neurasthenia**" in the 1800s and for most of the 1900s.
- Symthe and Moldofsky reported on tender points in specific anatomic locations.
 - *Bull Rheum Dis* 1978; 26: 928-931
- Term "**Fibromyalgia**" was substituted for "Fibrositis" in the **1980s**.
- Became a "popular" illness in the 1990s.

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Neurasthenia Well described in 1892

Symptoms:

- Debility
 - Low spirited and despondent
 - Inability to perform normal mental work
 - Headache
 - Sleeplessness
 - Weariness on the least exertion
 - **Pain in the back, neck, & legs**
 - Numbness and tingling
 - Nervous dyspepsia and dilation of the stomach
- William Osler MD, *The Principles and Practice of Medicine*, 1st Edition D. Appleton & Co. Publishers, New York, **1892**, Section VIII Diseases of the Nervous System, IV General and Functional Diseases, 12 Neurasthenia

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Fibromyalgia: Differential Diagnosis

- Systemic Lupus
- Polymyalgia rheumatica
- Hypothyroidism
- Bursitis, tendinitis, enthesopathies (eg tennis elbow)
- Osteoarthritis
- Prodrome of a connective tissue disease
- Polymyositis
- Metabolic myopathy
- Parkinson's disease
- Osteopenia, osteomalacia
- Sjögren's syndrome
- Chronic Lyme Disease

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Fibromyalgia Prevalence

Arch Intern Med 1999; 159(8): 777-785

- Females 10:1
- 10 – 12 % of population has chronic widespread pain
- **2% general population have FMS**
(by criteria of American College of Rheumatology)
- Second most common Dx
20% of Rheumatology Practice

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Compared to rheumatologic patients, FM patients were likely to have:

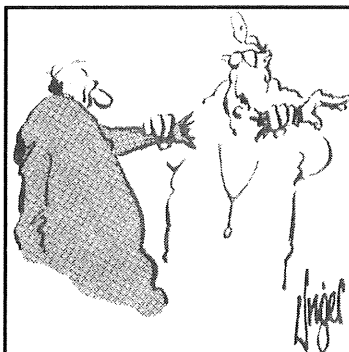
- More surgery (back, neck, carpal tunnel syndrome, appendectomy, T&A)
- More co-morbid or associated conditions (ulcer/stomach complaints, depression, allergies, hypertension)

Wolfe, F., et al. *A Prospective Longitudinal, Multicenter Study of*

Service Utilization and costs in Fibromyalgia.

Arthritis Rheum 1997, September, 40(9): 1560-1570

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"Does that hurt?"

Examination for Tenderness

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Tender Points

- Accepted as criteria for fibromyalgia, based on original study which lead the American College of Rheumatology to adopt diagnostic criteria.
- 293 FM patients and 265 controls (with Possible Rheumatoid Arthritis, or Neck and Back pain syndromes). Examined by "experts".
- **11 of 18 tender points:**
 - Sensitivity 88%, Specificity 81%
 - Fail to diagnosis **12 %** of FM patients (**false negatives**)
 - Incorrectly label **19 %** of non-FM patients as FM (**false positives**)

Arthritis Rheum 1990; 33: 160-172

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Reproducibility of Examination

- ? = Kappa
 - Estimates degree of agreement corrected for “agreement” occurring by chance
 - With high % of negative tests, or positive tests, there is a good chance for “agreement” by chance, so an extremely high degree of agreement is then necessary to get a high Kappa value.

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Reproducibility of Examination

? = Kappa	Agreement
> 0.20	fair
> 0.40	moderate
> 0.60	good
> 0.80	excellent
1.00	perfect

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Trigger Points & Low Back Pain

Arch Phys Med Rehabil 1992; 73: 893-898

- 50 LBP patients, examined for 197 trigger points by random pairs of physical therapists
- ? (Kappa) = 0.29 – 0.38
- “The low Kappa and Ppos values suggest different therapists are **unable to reliably determine when a trigger point is present** in a patient with LBP.”

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Reliability of Trigger Points in Trunk and Lower Limb Muscles

Arch Phys Med Rehabil 2000; 81 (3): 258-264

- Chiropractic and Physiatric expert, non-expert, and untrained examiners.
- 26 patients with low back pain and 26 normal controls
- “Among non-expert physicians, physiatric or chiropractic, **trigger point palpation is NOT reliable** for detecting taut bands and local twitch response, and only marginally reliable for referred pain after training.”

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Arch Phys Med Rehabil 2000; 81 (3): 258-264

? (Kappa) scores

Examiners	Taut Bands	Twitch Response	Referred Pain
Expert vs. Trained	0.215	0.123	0.342
Expert vs. Untrained	0.050	0.118	0.326
Trained Non-experts	0.108	-0.001	0.435
Untrained Non-experts	-0.019	0.022	0.320

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Reliability of Trigger Points in Trunk and Lower Limb Muscles

Arch Phys Med Rehabil 2000; 81 (3): 258-264

- Note: the “expert” in myofascial pain authors tell us how unreliable “non-expert” docs are at examining myofascial pain patients, BUT they DO NOT TELL US how reliable (?unreliable?) the “experts” themselves are in doing these examinations.

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Tender Points & Trigger Points

Fibromyalgia, Myofascial Pain & No Disease
J Rheumatology 1992; 19 (6): 944-951

- 4 experts on MFP examined for trigger points
- 4 experts on FM examined for tender points
- "We had planned for both the rheumatologists and the MFP experts to perform the same examinations... The MTP examinations were very complicated, and during the training sessions for the study it became clear that the **rheumatologists were unable to become proficient enough in the MTP examinations.** We therefore restricted the rheumatologist examinations to FM tender points."

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Tender Points & Trigger Points

Fibromyalgia, Myofascial Pain & No Disease
J Rheumatology 1992; 19 (6): 944-951

- Latent trigger points were rare, but found in equal frequency in the 3 groups
- Taut bands and muscle twitch (requirements for trigger points) also found in **equal frequency** in controls, FM, and MFP patients
- Frequency of taut bands **varied 2-fold, muscle twitch 3-fold, and active trigger points 5-fold** among expert MTP examiners.

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Tender Points & Trigger Points

Fibromyalgia, Myofascial Pain & No Disease
J Rheumatology 1992; 19 (6): 944-951

- 80.8 % of subjects reported the exam caused pain that they had NOT had previously
- 84.6 % reported the exam caused pain in areas they previously thought were pain free
- Pre-exam VAS = 3.7, Post-exam VAS = 6.4

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Tender Points & Trigger Points

Fibromyalgia, Myofascial Pain & No Disease
J Rheumatology 1992; 19 (6): 944-951

- **Conclusion: Trigger point exam is not reliable (reproducible) and thus is not valid.**
- Authors felt tender point exam was but didn't report data on reliability other than "mean tender point count" for all patients.

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Tender Points

- 177 adults examined for tender points
 - 45 had chronic widespread pain.
 - 93 had regional pain, and
 - 39 NO pain.
- Tender point count was highest in "widespread" pain, lower in regional pain, and lowest in No pain group.
- Mean symptom scores for depression, fatigue, and sleep problems increased as the tender point count rose ($p < 0.001$), independent of pain complaints.
- **Conclusion: Tender points are a measure of general distress.**
- Fibromyalgia does not seem to be a distinct entity.

BMJ 1994; 309: 696-699

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BMJ 1994; 309: 696-699

Tender point count	No. (%) women	No. (%) Widespread Pain	No. (%) Regional Pain	No. (%) NO pain
0	9 (35%)	2 (4%)	14 (15%)	10 (26%)
1-4	40 (64%)	11 (24%)	33 (36%)	19 (49%)
5-10	37 (74%)	14 (31%)	28 (30%)	8 (21%)
11 or more	34 (90%)	18 (40%)	18 (19%)	2 (5%)

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Reliability Study *J Rheumatology* 1995; 22: 944-952

- 3 blinded examiners, 24 patients, 6 with FM, 6 with MFP, 6 with chronic pain, and 6 normal, pain free controls.
 - All without a psychiatric diagnosis
- Examined with “dolorimeter*” and by palpation.
- * device that simulates finger palpation, but measures how much pressure is being applied when pain occurs

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Reliability Study *J Rheumatology* 1995; 22: 944-952

- Intra-rater and Inter-rater reliability “good” with dolorimeter. Consistent differences between examiners due to differences in technique used.
- Gradual change in tenderness threshold at tender points and at control points from normals, to chronic pain patients, to MFP & FM patients.
 - Suggests tender points reflect lowering of pain perception threshold.
- More variation in results by palpation.

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Reliability Study *J Rheumatology* 1995; 22: 944-952

- Variation in tender point counts.
 - “one examiner might find 9 tender points localized mostly on the right body side, and call it myofascial pain, while a 2nd might find 8 on one side and 3 on the other, and call it FM because of its diffuseness and bilaterality.”
 - “The ACR criteria for FM, based as they are mainly on tender point counts, may be appropriate for distinguishing FM from other rheumatic disease and from normals, but may be inadequate for distinguishing patients with myofascial pain from those with FM.”

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Tender Point Reliability Study *Scand J Rheumatol* 1995; 24: 243-247

- **30 FM patients** examined by 2 MDs
- 14 tender points examined, with exam repeated 1 week later.
 - 12 of the points were those used in the definition of Fibromyalgia
 - Total tender point counts were fairly reliable

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Tender Point Reliability Study *Scand J Rheumatol* 1995; 24: 243-247

Test – retest reliability (Intra-rater reliability) on 420 total tender points (14 points measured on 30 patients)

- Examiner #1
 - 75 negative points, 35 were positive 1 week later, 47 %
 - 345 positive points, 23 were negative 1 week later, 7 %
- Examiner #2
 - 69 negative points, 32 were positive 1 week later, 46 %
 - 351 positive points, 21 were negative 1 week later, 6 %

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Tender Point Reliability Study *Scand J Rheumatol* 1995; 24: 243-247

Inter-observer reliability on 420 total tender points (14 points times 30 patients)

- 1st Assessment
 - 75 negative points by MD #1, 30 were positive by MD #2, **40 %**
 - 345 positive points by MD #1, 24 were negative by MD #2, **7 %**
- 2nd Assessment 1 week later
 - 63 negative points by MD #1, 29 were positive by MD #2, **46 %**
 - 357 positive points by MD #1, 24 were negative by MD #2, **7 %**

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Fibromyalgia:
Can One Distinguish it from **Simulation?**
J Rheumatol 2000; 27: 2671-2676

- 2 experienced MDs examined 24 female "patients"
 - 8 with fibromyalgia behaving honestly
 - 8 normals behaving honestly
 - 8 normals given an article on fibromyalgia and told to simulate (with a reward if they fooled the examiners)

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Fibromyalgia:
Can One Distinguish it from Simulation?
J Rheumatol 2000; 27: 2671-2676

- When examiners rated tender points for degree of tenderness (5 point scale), **agreement was poor**
 - ? = 0.38
- When examiners rated just "non-tender" or "tender", agreement was "better", but ? was not stated.

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J Rheumatol 2000; 27: 2671-2676
Note: Examiners were "looking for" simulators

	Diagnosis made by blinded examiners			
Actual Group	FM	Simulator	Normal	Total
FM	13	3	0	16
Simulator	6	11	1	18
Normal	0	1	19	20
Total	19	15	20	54

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J Rheumatol 2000; 27: 2671-2676
Note: Examiners were "looking for" simulators

- Normal people acting normally should be easy to diagnose.
- Leave these out of analysis, and EXPERTS LOOKING FOR SIMULATORS were WRONG in 10 of 34 "patients" or **30 % error rate.**
- "Volunteers who simulate a condition and who have financial rewards for doing so are not necessarily similar to people who fake illness to obtain unfair advantages such as pensions or special treatment."
 - "Professional patients who really study the disease should be better at "simulating".

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Prevalence of Malingering

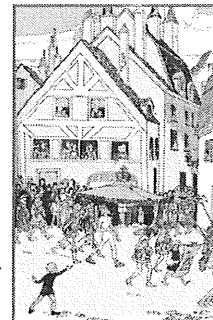
131 members of American Board of Clinical Neuropsychology review of 33,000 cases:
Malingering recognized in

- Personal Injury 29 %
- Disability/Workers' Comp 30 %
- Mild traumatic brain injury 39 %
- **Fibromyalgia/CFS 35 %**
- Chronic pain 31 %
- Mittenberg, et al, "Base Rates Of Malingering and Symptom Exaggeration", *J of Clin and Exper Neuropsych* 2002; 24: 1094-1102

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Conclusion on Trigger Points and Tender Points

- "When I use a word," Humpty-Dumpty said, "It means just what I choose it to mean – neither more nor less."
- Lewis Carroll,
Alice's Adventures in Wonderland, Chapter 6
- "The Emperor's New Clothes"
– Hans Christian Andersen



Does Trauma Cause Fibromyalgia ?

- 25 % of Fibromyalgia patients attribute their illness onset to an injury, often minor.
- Minor injury occurs very frequently.
- **Temporal association is NOT causation**
- American College of Rheumatology **does not recognize** the term "Secondary Fibromyalgia"
- *J Rheum* 1996; 23 (3): 534-539

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Temporal Correlation is NOT Causation

- Every day on the farm, the rooster crows, and then the sun rises.
- In western Europe for centuries, as the stork population increased, so did the human population. (storks built nests on roofs)
- In the last 50 years the human birth rate and the stork population have both fallen dramatically. (human birth control, stork habitat less suitable)
- Perfect temporal correlation between human birth rate and stork population.

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Hill's Criteria for Causation *Proc R Soc Med* 1965; 58: 295-300

1. Strength of the association
2. **Temporality**
 - Only criterion present to support Ms G's contention
3. Consistency among studies
4. Biologic Gradient
5. Experimental evidence
6. Plausibility of a biologic mechanism
7. Coherence of evidence
8. Analogy to a similar effect, from a similar agent
9. Specificity of outcome.

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Does Trauma Causes FMS ?

- "Evidence to determine whether there is a causal relationship between trauma and FM is currently inadequate."
- "Until such a relationship is established, the terms "post traumatic" or "secondary" FM should not be used."

– *Arch Intern Med* 1999; 159 (8): 777-785

– *J Rheumatol* 1996; 23 (3): 534-539

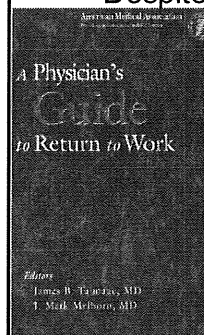
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Is FM Work Related ?

- Washington State Dept. of Labor and Industries. Fibromyalgia. Olympia 1999 Jun. 5 p.
- "Based on a lack of scientific evidence, the Washington Department of Labor and Industries does not generally recognize fibromyalgia as an industrial injury, or occupational disease, or an **aggravation** to a pre-existing condition."

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Can I Work Despite MY Fibromyalgia?



Disclaimer: Mark and I will be paid royalties

AMA Press
www.amapress.com
800-621-8335

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Can I Work, Despite my Fibromyalgia?

- Does it require restrictions because of documented **risk**?
 - “NO”
- Does it affect **capacity**?
 - “Perhaps, as many choose a sedentary lifestyle and become deconditioned. However, exercise, or work, can improve conditioning/capacity.”
- Fibromyalgia patients complain of **pain** when they do what they don't like doing. Thus, work ability is a **question of tolerance**, and **NOT** a matter of risk or capacity.

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Fibromyalgia: Treatment

- Exercise:
 - Aerobic training is **more effective** than stretching
 - Aerobic training improves fitness, tender point counts, and patient & MD global assessment.
 - Many patients had immediate post exercise worsening in symptoms, and **most stopped exercise** following conclusion of research study, even though they were improved.
- *Arthritis Care and Research* 1996; 9 (6): 315-328

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Fibromyalgia:

NORWAY

(Very liberal system of disability benefits)

- **Most frequent single diagnosis for disability**
- Varies by county (social insurance scheme)
- **11%** of Norwegian females meet ACR criteria.

Brussgaard: Fibromyalgia-A New Cause for Disability Pension.

Scand J Soc Med 1993; 21: 116

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Fibromyalgia: Health Status

Arthritis & Rheumatism 1997; 40 (9): 1571-1579

- **538 FM patients** followed at 6 academic centers
 - Illness for average of 7.8 years at first assessment, followed for 7 years
 - Functional disability worsened slightly, and health satisfaction improved slightly.
 - Pain, severity, fatigue, sleep disturbance, anxiety, & depression were markedly abnormal at first assessment and did NOT CHANGE over time.
 - Marked differences in illness severity among the various centers

Worst Cases

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Fibromyalgia: Work and Disability Status

J Rheumatol 1997; 24: 1171-1178

- **1604 FM patients** followed at 6 academic centers
 - 16 % were on SS Disability versus 2 % of US population
 - Highest center rate = 36 % versus 6 % at the center with the lowest rate
 - Center variability may reflect clinic referral patterns, **physician beliefs**, or socioeconomic status
 - 27 % reported at least one source of disability payment

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Fibromyalgia and Disability

Disability Medicine 2001; 1(1): 14-15

- Iceland in 1990s labeling widespread pain as fibromyalgia became popular.
- Social security claims began to be filed with MDs listing just FM as the disabling diagnosis.
- Claims were rejected by Iceland's SS system.
- In many cases the MDs re-filed listing a **psychiatric second diagnosis**.
- Today claims usually accompanied by some psychiatric diagnosis.

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Recovery from Fibromyalgia *Disabil Rehabil* 2004; 26 (1): 46-53

- First study of FM "victims" who later recovered to NORMAL
- 5 women ages 37-49
- Recovered irrespective of specific treatment
- Motivated to recover by unpleasantness of the "sick role"
- Instead of adapting activities to pain, they used **pain as a warning signal** (like a barometer) of too much stress in life. They developed their ability to alter their life goals and everyday obligations

79

Fibromyalgia: Work Ability?

- No evidence of disease.
- Decreased capacity of exercise/work is expected based on deconditioning.
- No study reports risk of serious harm or consequences with exercise or work.
- Exercise (work) may be therapeutic.
- **TOLERANCE** for pain, fatigue, etc. is NOT scientifically measurable, and is best left to the patient's judgment.
- Patients are usually better off if working
 - (different lecture).
- Thus MD should say "I can not honestly say you're disabled. You can work despite your pain if you wish. The decision of whether the rewards of work are worth the increase in your symptoms is one only you can make."

Ms G

What is her
AMA Guides, 5th Edition
Impairment rating
for the lower limb pain
she relates
to the work related MVA ??

81

Fibromyalgia: Impairment Rating

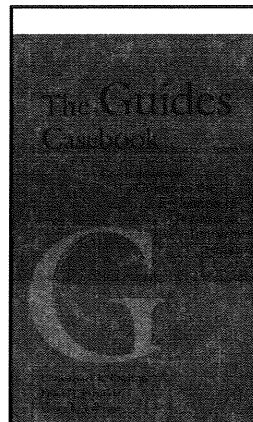
- *AMA Guides, 5th Edition*
 - Chapters 15, 16, & 17: Musculoskeletal
 - NOT mentioned, NO objective finding, **NO method**
 - Chapter 18: Pain
 - **Do NOT USE** if condition does not have a widely accepted well-defined pathophysiology (p 572)
 - "...medical community has **not** achieved consensus about how to construe such conditions as myofascial pain, **fibromyalgia**, ..." (p 569)
 - Thus, text clearly says **DO NOT USE** chapter 18, Pain, to rate fibromyalgia.

82

Fibromyalgia: Impairment Rating

- *AMA Guides, 5th Edition*
 - Chapter 13: Central Nervous System
 - NOT mentioned, NO objective findings, NO method
 - Section 13.8 & Table 13-22, "Criteria for Rating Impairment Related to Chronic Pain in One Extremity" INSTRUCTIONS CLEARLY STATE "Chronic pain in this section covers the diagnoses of causalgia, post traumatic neuralgia, and reflex sympathetic dystrophy."
 - Clearly **DOES NOT APPLY** to fibromyalgia.

83



Ms G is "plagiarized" from
The Guides Casebook, 2nd Edition
Case 18-1,
pages 367-371

Disclaimer:

I was paid a fixed fee for writing and editing. I will NOT receive any more money if you buy this book.

84

The Guides Casebook, 2nd Edition

- Page 368. "The Fifth Edition states in Section 1.5, that "subjective concerns, including fatigue, difficulty in concentrating, and pain, when not accompanied by demonstrable clinical signs or other independent, measurable abnormalities, are generally not given separate impairment ratings." (5th Ed, p 10)

85

The Guides Casebook, 2nd Edition

- Page 369. Points out the pain chapter "3 question test" as to whether it is appropriate to rate impairment from the pain chapter.
- Question "3. Is the condition one that is widely accepted by physicians as having a well-defined pathophysiologic basis?" (5th ed, p 572)
 - If the answer is "no", do NOT use the pain chapter to rate impairment.

86

The Guides Casebook, 2nd Edition

Page 369. states

- "Impairment: 0 % impairment of the whole person per the Fifth Edition."

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AMA Press American Medical Association Physicians dedicated to the health of America

The Guides Newsletter

Expert advice, practical information, and current trends on impairment evaluation

July/August 2001

Also in this issue
Lower Extremity Impairment Evaluation: Fifth Edition

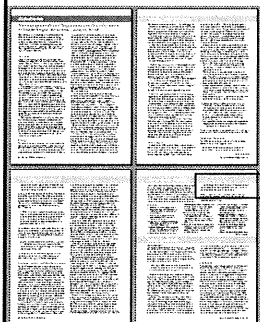
Revisions
Clinical Update: Fibromyalgia Syndrome: Impairment and Disability Issues

Fifth Edition: Causalgia, RSD, CRPS Impairment Evaluation
by Leon H. Ensalada, MD, MPH

The *Guides* Fifth Edition methods for rating impairment due to causalgia, reflex sympathetic dystrophy (RSD), and complex regional pain syndrome: 4 RPS differ from the approach found in previous editions of the *Guides*. The Fifth Edition methods for rating these conditions are found in four chapters: Chapter 13, The Central and Peripheral Nervous System; Chapter 16, The Upper Extremities; Chapter 17, The Lower Extremities; and Chapter 18, Pain. Table 3 (page 3) summarizes the relevant chapters, sections, tables, and examples, and will serve to facilitate the

In this month's issues:

The Guides Newsletter July/August 2001



- "Fibromyalgia is a classic example of a syndrome that may be associated with significant disability, yet not be associated with any ratable impairment."
– Christopher R. Brigham MD and Norma J. Leclair RN, PhD, LCPC

89

Important concept

- Many conditions exist, cause symptoms, and cause patients logically to seek treatment, BUT do NOT rise to the level of an impairment.
- Examples:
 - Tension headache
 - Irritable bowel syndrome
 - Dysmenorrhea
 - Abdominal pain without objective findings
 - Backache without objective findings

90

Fibromyalgia: Impairment Rating

- *AMA Guides, 5th Edition*
 - Chapters 14: Mental and Behavioral Disorders
 - NO percentages
 - Not mentioned
 - Not generally accepted as a psychiatric disorder
- AADEP (American Academy of Disability Evaluating Physicians) Position Paper 1999
 - Use “ADL” limitations Table from Mental Disorder chapter to describe the consequences, leaving a rating (number) to the trier of fact.

91

Mental Impairment “NO percentages”

- “...there are no precise measures of impairment in mental disorders. The use of percentages implies a certainty that does not exist, and the percentages are likely to be used inflexibly by adjudicators... no data exist that show the reliability of the impairment percentages... difficult for *The Guides* users to defend... in hearings”
 - page 301, 4th Edition
 - page 361, 5th Edition

92

Classes of Impairment

Table 14-1 Classes of Impairment Due to Mental and Behavioral Disorders

Area or Aspect of Functioning	Class 1 No Impairment	Class 2 Mild Impairment	Class 3 Moderate Impairment	Class 4 Marked Impairment	Class 5 Extreme Impairment
Activities of daily living	No impairment noted	Impairment levels are compatible with mild social functioning	Impairment levels are compatible with moderate social functioning	Impairment levels are compatible with marked social functioning	Impairment levels are compatible with extreme social functioning
Social functioning					
Communication					
Relationships					

NO percentages listed

93

Ms G

What is her impairment rating?

- **Zero (0%) percent whole person**
- **Zero (0%) percent lower extremity**

94

