Fibromyalgia for Rheumatologists or Psychiatrists? – The risks of a late psychiatry referral

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OBJECTIVES: To present a case of fibromyalgia with poorly controlled symptoms and how the diagnosis and accordant treatment of bipolar disorder affected their evolution.

BACKGROUND AND AIMS: Fibromyalgia is a clinical diagnosis. The American College of Rheumatology (ACR) diagnostic criteria solely require chronic widespread pain, fatigue and sleep disturbance in the absence of another explanation to the symptoms. Comorbid affective and anxiety disorders are highly prevalent and treatment includes antidepressants, cognitive-behavioural therapy and physical exercise. Clinical features, epidemiology, treatment and prognosis overlap tremendously with Somatic Symptom Disorder (SSD), leading us to argue if they are two different entities. ACR and DSM-5 differentiate the disorder based on the wording “excessive” behaviours related to the symptoms. This subjective preciousity only harms the patients.

ACR Revised (2016) Fibromyalgia Diagnostic Criteria
1) Widespread pain index* (WPI) ≥ 7 and symptom severity scale* (SSS) score ≥ 5 OR WPI 4–6 and SSS score ≥ 9 .
2) Generalized pain, defined as pain in at least 4 of 5 regions, is present.
3) Symptoms have been present at a similar level for at least 3 months.
4) A diagnosis of fibromyalgia is valid irrespective of other diagnoses. A diagnosis of fibromyalgia does not exclude the presence of other clinically important illnesses.

*The WPI scale defines generalized pain by evaluating its presence in different body regions (upper left, upper right, lower left, lower right and axial) for a total score of 19.

*The SSS scale evaluates the intensity of Fatigue, Cognitive Complaints and Sleep Disturbance, as well as the number of Somatic Symptoms in General for a total score of 12.

CONCLUSIONS: Patients’ psychiatry stigma allied with the acceptance of fibromyalgia as a distinct disorder from SSD only contribute to late diagnosis and incorrect treatment of comorbid mental disorders. An early psychiatry referral would have detected this patient’s bipolar disorder long ago and allowed for better mood and somatic symptom management, improving her quality of life through the years.

References:

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MATERIALS AND METHODS: Patient’s clinical files consultation and scientific bibliography search using the key-words *Fibromyalgia*, *Somatic Symptom Disorder*, *Bipolar Disorder*.

RESULTS: A 60 year-old woman with fibromyalgia and recurrent depressive disorder was referred for psychiatric evaluation. The mental state examination revealed hypomania. Over the follow-up, the diagnosis of Bipolar II Disorder was established. Mood stabilised and her pain and somatic symptoms, although ever present, became much better tolerated. She disagreed with a psychiatric management at first.

DSM-5 (2013) Somatic Symptom Disorder Diagnostic Criteria
A. One or more somatic symptoms that are distressing or result in significant disruption of daily life.
B. Excessive thoughts, feelings, or behaviors related to the somatic symptoms or associated health concerns as manifested by at least one of the following:
1. Disproportionate and persistent thoughts about the seriousness of one’s symptoms.
2. Persistently high level of anxiety about health or symptoms.
3. Excessive time and energy devoted to these symptoms or health concerns.
C. Although any one somatic symptom may not be continuously present, the state of being symptomatic is persistent (typically more than 6 months).
<u>Specify if:</u> With predominant pain (previously pain disorder) – this specifier is for individuals whose somatic symptoms predominantly involve pain.