Fibromyalgia Syndrome

A Mysterious Disease or a Psychological Curse?

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Confused?
What is Fibromyalgia?

Widespread pain in all 4 quadrants of the body, accompanied by sleep disturbance and multisystem symptoms ranging from headache, TMJ symptoms, fatigue to irritable bladder, irritable bowel, restless legs syndrome and mood disorder.
Clinical Presentation of Fibromyalgia

A multisymptom condition characterized by¹,²:

- Depressed mood
- Widespread chronic pain
- Severe fatigue
- Sleep dysfunction
- Stiffness
- Decreased well-being
- Headaches
- Cognitive impairment

Epidemiology

- 2-5% of population
- Women : Men = 9:1
- Peak incidence 40 – 60 years old
- Use 2.5 times more medical resources
- ~30% disability rate
Polypharmacy Is the Norm

~70% of fibromyalgia patients fill ≥2 relevant prescription drugs in a 3-month period

The only FDA-approved medications for FM are Lyrica®, Cymbalta®, and Savella®

Data on file, Forest Laboratories, Inc. SDI Longitudinal Patient Data, Ad hoc on patients with a diagnosis visit in May 2008 and related market drugs filled June to August 2008, n=8,344. Agent defined at the NDC code level of drug by form and strength.
Fibromyalgia in Perspective

For several centuries, muscle pains have been known as rheumatism.

1816 – Dr. William Balfour, surgeon at Univ of Edinburgh: first full description of fibromyalgia.
   1824 – Described tender points.
1904 – Sir William Gowers coined the term fibrositis, literally “inflammation of fibers”.

1972 – Dr. Hugh Smythe laid the foundation for the modern definition of fibromyalgia by describing widespread pain and tender points.

1987 – The American Medical Association recognized fibromyalgia as a real physical condition.

1990 – The American College of Rheumatology (ACR) developed diagnostic criteria for research purposes.
Earliest Recorded Case of Fibromyalgia?

Job's physical anguish described in the Bible was probably the earliest description of a fibromyalgia-like condition.

“I, too, have been assigned months of futility, long and weary nights of misery. When I go to bed, I think, 'When will it be morning?' But the night drags on, and I toss till dawn...And now my heart is broken. Depression haunts my days. My weary nights are filled with pain as though something were relentlessly gnawing at my bones.”

-Job 7:3-4 and 30:16-17 – NLT.
1990 American College of Rheumatology
Definition of Fibromyalgia Syndrome

1. History of widespread pain for more than 3 months.

*Definition.* Pain is considered widespread when all of the following are present: pain in the left side of the body, pain in the right side of the body, pain above the waist, and pain below the waist. In addition, axial skeletal pain (cervical spine or anterior chest or thoracic spine or low back) must be present. In this definition, shoulder and buttock pain is considered as pain for each involved side. "Low back" pain is considered lower segment pain.

2. Pain in 11 of 18 tender point sites on digital palpation.

Definition. Pain, on digital palpation, must be present in at least 11 of the following 18 sites:

- Occiput: Bilateral, at the suboccipital muscle insertions.
- Low cervical: bilateral, at the anterior aspects of the intertransverse spaces at C5-C7.
- Trapezius: bilateral, at the midpoint of the upper border.
- Supraspinatus: bilateral, at origins, above the scapula spine near the medial border.
- Second rib: bilateral, at the second costochondral junctions, just lateral to the junctions on upper surfaces.
- Lateral epicondyle: bilateral, 2 cm distal to the epicondyles.
- Gluteal: bilateral, in upper outer quadrants of buttocks in anterior fold of muscle.
- Greater trochanter: bilateral, posterior to the trochanteric prominence.
- Knee: bilateral, at the medial fat pad proximal to the joint line.

Digital palpation should be performed with an approximate force of 4 kg.

For a tender point to be considered "positive" the subject must state that the palpation was painful. "Tender is not to be considered "painful."
Tender point sites of the 1990 American College of Rheumatology criteria for fibromyalgia.
Objective. To develop simple, practical criteria for clinical diagnosis of fibromyalgia that are suitable for use in primary and specialty care and that do not require a tender point examination, and to provide a severity scale for characteristic fibromyalgia symptoms.

Methods. We performed a multicenter study of 829 previously diagnosed fibromyalgia patients and controls using physician physical and interview examinations, including a widespread pain index (WPI), a measure of the number of painful body regions. Random forest and recursive partitioning analyses were used to guide the development of a case definition of fibromyalgia, to develop criteria, and to construct a symptom severity (SS) scale.

Results. Approximately 25% of fibromyalgia patients did not satisfy the American College of Rheumatology (ACR) 1990 classification criteria at the time of the study. The most important diagnostic variables were WPI and categorical scales for cognitive symptoms, unrefreshed sleep, fatigue, and number of somatic symptoms. The categorical scales were summed to create an SS scale. We combined the SS scale and the WPI to recommend a new case definition of fibromyalgia: (WPI >7 AND SS >5) OR (WPI 3–6 AND SS >9).

Conclusion. This simple clinical case definition of fibromyalgia correctly classifies 88.1% of cases classified by the ACR classification criteria, and does not require a physical or tender point examination. The SS scale enables assessment of fibromyalgia symptom severity in persons with current or previous fibromyalgia, and in those to whom the criteria have not been applied. It will be especially useful in the longitudinal evaluation of patients with marked symptom variability.
A patient satisfies diagnostic criteria for fibromyalgia if the following 3 conditions are met:

1) Widespread pain index (WPI) >7 and symptom severity (SS) scale score >5 or WPI 3–6 and SS scale score >9.
2) Symptoms have been present at a similar level for at least 3 months.
3) The patient does not have a disorder that would otherwise explain the pain.

Widespread Pain Index

1) WPI: note the number areas in which the patient has had pain over the last week. In how many areas has the patient had pain?

Score will be between 0 and 19.

<table>
<thead>
<tr>
<th>Shoulder girdle, left</th>
<th>Hip (buttock, trochanter), left</th>
<th>Jaw, left</th>
<th>Upper back</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shoulder girdle, right</td>
<td>Hip (buttock, trochanter), right</td>
<td>Jaw, right</td>
<td>Lower back</td>
</tr>
<tr>
<td>Upper arm, left</td>
<td>Upper leg, left</td>
<td>Chest</td>
<td>Neck</td>
</tr>
<tr>
<td>Upper arm, right</td>
<td>Upper leg, right</td>
<td>Abdomen</td>
<td></td>
</tr>
<tr>
<td>Lower arm, left</td>
<td>Lower leg, left</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lower arm, right</td>
<td>Lower leg, right</td>
<td></td>
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</tr>
</tbody>
</table>
Symptom Severity Scale

SS scale score:

- **Fatigue**
- **Waking unrefreshed**
- **Cognitive symptoms**

For each of the 3 symptoms above, indicate the level of severity over the past week using the following scale:

- 0  no problem
- 1  slight or mild problems, generally mild or intermittent
- 2  moderate, considerable problems, often present and/or at a moderate level
- 3  severe: pervasive, continuous, life-disturbing problems

Considering **somatic symptoms in general**, indicate whether the patient has:*

- 0  no symptoms
- 1  few symptoms
- 2  a moderate number of symptoms
- 3  a great deal of symptoms

The SS scale score is the sum of the severity of the 3 symptoms (fatigue, waking unrefreshed, cognitive symptoms) plus the extent (severity) of somatic symptoms in general. The final score is between 0 and 12.
Alternative Criteria

A. Generalized pain affecting the axial, plus upper and lower segments, plus left and right sides of the body.

Plus, Either B or C:

B. At least 11 of 18 reproducible tender points
C. At least 4 of the following symptoms:
   1. Generalized fatigue
   2. Generalized headache (of a type, severity, or pattern that is different from headaches the patient may have had in the premorbid state)
   3. Sleep disturbance (hypersomnia or insomnia)
   4. Neuropsychiatric complaints (1 or more of the following: forgetfulness, excessive irritability, confusion, difficulty thinking, inability to concentrate, depression)
   5. Numbness, tingling sensations
   6. Symptoms of irritable bowel syndrome (periodically altered bowel habits with lower abdominal pain or distension usually relieved or aggravated by bowel movements; no blood)

D. It cannot be established that the disturbance was caused by another systemic condition

Comorbidities Prevalent with Fibromyalgia

- Major depressive disorder: 19-25%
- Headache (tension and migraine): 10-80%
- Temporomandibular disorder: 75%
- Multiple chemical sensitivities: 33-55%
- Irritable bowel syndrome: 32-80%
- Interstitial cystitis: 13-21%
- Chronic pelvic pain: 18%

Fibromyalgia Pain Pathways

Processing Perception of Pain\textsuperscript{1,2}

GABA = \(\gamma\)-aminobutyric acid; NMDA = N-methyl-D-aspartic acid.
In general, “unknown,” although much more is known than previously.

- MUSCLES AND MICROTRAUMA
- PSYCHOSOCIAL FACTORS
- GENETIC AND FAMILIAL FACTORS
- SLEEP DISTURBANCE
- STRESS-RELATED NEUROENDOCRINE DYSFUNCTION
- PRIMARY NEUROENDOCRINE DYSREGULATION
- AUTONOMIC NERVOUS SYSTEM DYSFUNCTION
- ABNORMAL PAIN PROCESSING, POLYMODAL SENSITIVITY
- DECREASED PAIN INHIBITION
- PSYCHOLOGICAL ABNORMALITIES / SOMATOFROM DISORDER
- BRAINSTEM / CERVICAL CORD COMPRESSION
Abnormally Low Levels of Primary Metabolites of NE and 5-HT in CSF of Patients with FM

**Norepinephrine**

- Normal Control (n=12)
- Fibromyalgia (n=17)

![Graph showing CSF Concentration of Norepinephrine](image)

*P=0.028 for fibromyalgia patients vs controls.

**Serotonin**

![Graph showing CSF Concentration of Serotonin](image)

†P=NS.

Evidence of Altered Pain Processing in Fibromyalgia: Neuroimaging Findings

![Graph showing pain intensity vs. stimulus intensity.](Image)

- **N=32**

- **Stimulus Intensity (kg/cm²)**
  - 1.5
  - 2.5
  - 3.5
  - 4.5

- **Pain Intensity**
  - 0
  - 2
  - 4
  - 6
  - 8
  - 10
  - 12

- **Graph Legend**
  - **Δ FM**
  - **Green Subjective Pain Control**
  - **Purple Stimulus Pressure Control**

- **Brain Images**
  - **SI**
  - **SII**
  - **STG, Insula, Putamen**
  - **Cerebellum**

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STG = superior temporal gyri; SI = primary somatosensory cortex; SII = secondary somatosensory cortex; arrows indicate changes in fMRI signal.

Pain Scales:

Visual Analogue
Graphic
Numeric
Verbal
Picture
Digital
Inferential
Word Associative
MODERATE

UNIVERSAL PAIN ASSESSMENT TOOL

This pain assessment tool is intended to help patient care providers assess pain according to individual patient needs. Explain and use 0-10 Scale for patient self-assessment. Use the faces or behavioral observations to interpret expressed pain when patient cannot communicate his/her pain intensity.

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verbal Descriptor Scale</td>
<td>NO PAIN</td>
<td>MILD PAIN</td>
<td>MODERATE PAIN</td>
<td>MODERATE PAIN</td>
<td>SEVERE PAIN</td>
<td>WORST PAIN</td>
<td></td>
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</tr>
<tr>
<td>WONG-BAKER FACIAL GRIMACE SCALE</td>
<td>Alert Smiling</td>
<td>No humor serious flat</td>
<td>Furrowed brow pursed lips breath holding</td>
<td>Wrinkled nose raised upper lips rapid breathing</td>
<td>Interferes with concentration</td>
<td>Interferes with basic needs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACTIVITY TOLERANCE SCALE</td>
<td>NO PAIN</td>
<td>CAN BE IGNORED</td>
<td>INTERFERES WITH TASKS</td>
<td>INTERFERES WITH CONCENTRATION</td>
<td>INTERFERES WITH BASIC NEEDS</td>
<td>BEDREST REQUIRED</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SPANISH</td>
<td>NADA DE DOLOR</td>
<td>UNPOQUITO DE DOLOR</td>
<td>UN DOLOR LEVE</td>
<td>DOLOR FUERTE</td>
<td>DOLOR DEMASIADO FUERTE</td>
<td>UN DOLOR INSOPORTABLE</td>
<td></td>
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<tr>
<td>TAGALOG</td>
<td>Walang Sakit</td>
<td>Konting Sakit</td>
<td>Katamangam Sakit</td>
<td>Matinding Sakit</td>
<td>Pinaka-Matinding Sakit</td>
<td>Pinaka-Malang Sakit</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>CHINESE</td>
<td>不痛</td>
<td>輕微</td>
<td>中度</td>
<td>嚴重</td>
<td>非常嚴重</td>
<td>最嚴重</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>KOREAN</td>
<td>통증 없음</td>
<td>약한 통증</td>
<td>보통 통증</td>
<td>심한 통증</td>
<td>아주 심한 통증</td>
<td>최악의 통증</td>
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<td></td>
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<tr>
<td>PERSIAN (FARSİ)</td>
<td>بدون درد</td>
<td>درد ملایم</td>
<td>درد معتدل</td>
<td>درد شدید</td>
<td>درد بسیار شدید</td>
<td>درد بسیار شدید</td>
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</tr>
<tr>
<td>VIETNAMESE</td>
<td>Không Đau</td>
<td>Dau Nhợp</td>
<td>Dau Vưa Phải</td>
<td>Dau Nắng</td>
<td>Dau Thịt Nắng</td>
<td>Dau Đón Tấn Công</td>
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</tr>
<tr>
<td>JAPANESE</td>
<td>痛みがない</td>
<td>少し痛い</td>
<td>いくらか痛い</td>
<td>かなり痛い</td>
<td>ひどく痛い</td>
<td>ものすごく痛い</td>
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</tbody>
</table>
The Biopsychosocial Model

- Biological
- Psychological
- Sociological

FMS/CFIDS
FIQ-R

Last Name:          First Name:          Age:

Duration of FM symptoms (years):          Time since FM was first diagnosed (years):

**Directions:** For each of the following 9 questions check the box that best indicates how much your fibromyalgia made it difficult to perform each of the following activities during the past 7 days. If you did not perform a particular activity in the last 7 days, rate the difficulty for the last time you performed the activity. If you can’t perform an activity, check the last box.

<table>
<thead>
<tr>
<th>Activity</th>
<th>No difficulty</th>
<th>Very difficult</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brush or comb your hair</td>
<td></td>
<td></td>
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<tr>
<td>Walk continuously for 20 minutes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prepare a homemade meal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vacuum, scrub or sweep floors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lift and carry a bag full of groceries</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Climb one flight of stairs</td>
<td></td>
<td></td>
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<tr>
<td>Change bed sheets</td>
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<td></td>
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<tr>
<td>Sit in a chair for 45 minutes</td>
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<td></td>
</tr>
<tr>
<td>Go shopping for groceries</td>
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<td></td>
</tr>
</tbody>
</table>

**Sub-total (for internal use only)**

[ ]
There are just 3 steps:

Step 1. Sum the scores for each of the three domains (function, overall, and symptoms).

Step 2. Divide domain 1 score by three, divide domain 2 score by one (that is, it is unchanged), and divide domain score 3 by two.

Step 3. Add the three resulting domain scores to obtain the total Revised Fibromyalgia Impact Questionnaire (FIQR) score.

Scoring Total: It is scored from 0 to 100 with the latter number being the worst case. The average score for fibromyalgia patients seen in tertiary care settings is about 55. The lower the score, the better the case.
Please mark your pain on the following diagram:
Aching ■■■■■■■ Burning XXXXXXX Stabbing ///////// Pins & Needles 00000 Numbness =========

191.0 130/84 98% 78

Hydromorphone 2mg 5/9/10 10-21-10
Methadone 10mg 10/7/10 10-21-10
Show main pain areas, use arrows to show spread.

PLEASE USE ANY OTHER MARKINGS FOR OTHER TYPES OF PAIN.
269.6 140/88 96.2 87

Methadone
10mg
1/4
5.3.10

Please List your present providers: Physicians, Physical Therapists, Psychologists, LMT, Chiropractors, Etc.
Cognitive Domains Related to FMS/CFIDS

- **Executive Functioning** (planning, organizing, inhibition of behavior, error detection, insight)
- **Attention** (focus on specific stimuli to the relative exclusion of others)
- **Memory** (encoding, recall, recognition)
- **Working Memory** (temporary storage and management of information)
- **Processing Speed** (rate of processing stimuli and making use of it in thought and action)
Neurocognitive complaints

- Memory impairment
- "Fibro Fog"
- Coordination
- Balance
- Concentration
- Word substitution
- Executive function
Qualitative Studies in FMS

• Greatest impact on quality of life included pain, sleep disturbance, fatigue, depression, anxiety, and **cognitive impairment**

• Primary reported cognitive effects were on memory, thought processes, planning/organization, response time, word-finding and concentration

• These impairments have collectively been referred to by patients as “fibro fog”

• “Fibro fog” is reported to affect a wide range of activities including driving, social interactions, and work-related tasks

Possible Biological Explanations

- cortisol levels
- hippocampus is responsible for memory function
- FMS patients have lower salivary-free cortisol levels
- very low and very high cortisol levels affect hippocampal function
- selective effects on verbal declarative memory, selective attention, and divided attention

Perspectives from people who have it...
O Tender Brain, my complaints were undue!

I didn't realize you were suffering too.
We'll work together to win this fight with every weapon available in sight.
Botox, Savella, PT and nerve blocks,
The solution to fibro -- you and I will unlock.

-- Written by Dot and Fibro Mom (representing Dot's Brain)
CLIP 'N COPY!
A handy response to all those unsolicited “helpful suggestions”

Dear __________:
(circle one)
a) Friend of a friend
b) Random stranger I met on the subway
c) Second cousin by marriage of my mother's uncle
d) Primary care physician,

Thank you so much for your brilliant insight that:
(circle all that apply)
a) Exercise
b) Blue-green algae
c) Positive thinking
d) Developing a personal relationship with Jesus Christ
e) Risky experimental surgery not covered by insurance
f) Other ________________

could cure me of my long-term (circle one) illness/disability.

My life has been transformed. I feel better already.
If only I had met you _____ years ago. Please (circle one) publish/post on the internet your suggestion(s) so that others may benefit.

And to think that all these years I have been:
(circle all that apply)
a) Sitting on my butt
b) Twiddling my thumbs
c) Paying expensive specialists to tell me there's nothing they can do for me
d) Lying awake nights in needless pain.

You have given me the will to heal. See you on the slopes!

Gratefully,
(Your Name Here)
(circle one) Ex-crip/Ex-sickie
Fibromyalgia

You look fine to me
Developing and implementing compensatory strategies should increase function and not simply provide “symptom relief.”
Perpetuating Factors

**Chemicals:** Caffeine, amphetamine, stimulants including OTC decongestants, nicotine, opiate addiction, depressants including benzodiazepines and alcohol and some muscle relaxers.

**Sleep** disorder: Insomnia, sleep apnea, abnormal circadian cycles (work shifts vary), sleep deprivation, anxiety, panic attacks, psychiatric disturbances.

**Nutritional** deficiency: B12, B6, ascorbic acid, folate, magnesium, etc.

**Pacing** difficulty: Waxing and waning symptoms lead to spurts of activity, the need to “catch up” on things that have been put off, resulting in “over-doing” or doing incorrectly.

**Repetitive** use: Microtrauma associated with repetitive use activities, leading to muscular shortening, trigger point formation, pain, etc. Carpal tunnel syndrome, etc. often initial presenting symptom.

**Physical** deconditioning: Sedentary lifestyle as a result of pain, obesity, etc.

**Stress:** Family conflict, poverty, abuse, work-a-holic, etc. Sustained alarm reactions.

Untreated underlying physical **ailment:** Diabetes, ulcer, colitis, anemia, etc.
Barriers to Treatment: Patient Perspective

1. Medical treatment and medical providers are ineffective and uncaring, respectively.

2. Pain pills are the only allopathic option that works. Give me my Vicodin!


4. I read about a cure on the internet....

5. Psychologists, psychiatrists and counselors are for crazy people. Your referral means you think I'm crazy and it's all in my head. I'm not depressed. I'm insulted.

6. Exercise hurts and I'm not going to do it.

7. I can't sleep unless I have the TV on.
Ranking Fibromyalgia Pharmacotherapies

Strong evidence of benefit
- Tricyclics (amitriptyline, cyclobenzaprine)
- Dual reuptake inhibitors (venlafaxine, duloxetine, milnacipran)
- α2-δ ligands (pregabalin, gabapentin)

Modest evidence of benefit
- Tramadol
- Selective serotonin reuptake inhibitors
- Dopamine agonists
- γ-Hydroxybutyrate

Weak evidence of benefit
- Growth hormone
- 5-Hydroxytryptamine
- Tropisetron
- S-adenosyl-l-methionine

Not shown to be effective
- Opioids
- NSAIDs
- Corticosteroids
- Benzodiazepine and nonbenzodiazepine hypnotics
- Melatonin
- Guanifenesin
- Dehydroepiandrosterone
Ranking Nonpharmacologic Therapies

Strong evidence of benefit
• Cardiovascular exercise
• Cognitive behavioral therapy
• Patient education
• Multidisciplinary therapy

Modest evidence of benefit
• Strength training
• Hypnotherapy
• Biofeedback
• Balneotherapy

Weak evidence of benefit
• Acupuncture
• Chiropractic, manual, and massage therapy
• Electrotherapy
• Ultrasound

No evidence of benefit
• Tender (trigger) point injections
• Flexibility exercise
Psychotherapeutic Techniques

- CBT
- Hypnotherapy
- Psychodynamic therapy
- Group therapy
- Family therapy
- Interpersonal therapy
- Reverse Therapy™
- Cell Phone Therapy
- Interpersonal Social Rhythm Therapy
- Mindfulness-Based Stress Reduction

"Are you not thinking what I'm not thinking?"
Compensating Through Lifestyle Change

- diet/nutritional changes (avoid aspartame, MSG, caffeine, simple carbohydrates, yeast, gluten, dairy, nightshade plants)
- regular exercise (low to moderate intensity aerobic exercise at least 2x/week with strength training)
- maintain a regular, consistent, paced routine (sleep/wake, meals, rest breaks)
- stress reduction (relaxation, prayer/meditation, diaphragmatic breathing)
Compensating Through Environmental Change

- avoid cold and/or damp environments
- avoid exposure to strong odors
- create rest environments void of distractions (e.g. silence cell phone, turn off computer etc.)
- follow principles of sleep hygiene (e.g. bedtime rituals, bed for sleep/sex only, get up after 20 min. of unsuccessful sleep, etc.)
- avoid overheating
- reduce exposure to fluorescent lighting
Compensating Through Use of Technology

- computer-assisted cognitive rehabilitation using computer games (e.g. BrainAge™ and HAPPYneuron™) to address processing speed, memory, and attention
- PDAs and Smartphones to address memory and executive function/organizational skills
- Pulse Smartpens™ to assist with memory and executive functioning
- Speech recognition software (e.g. Dragon™) to address fatigue related to writing and note taking
Novel Therapies

I've heard that magnetic therapy is great for pain.

I've also heard that my FMS is all in my head.

So my solution is ...

Refrigerator Magnets!

Steve Thorson '00
Questions & Answers

“Mr. Osborne, may I be excused? My brain is full.”
References

- Dr. John Eaton, http://www.reverse-therapy.com/
References (cont.)

- The FIQ-R is found at:

- Scoring the FIQ-R at: http://www.myalgia.com/FIQR/Scoring.htm
