

Primary care pathway: Fibromyalgia

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1. Diagnosing Fibromyalgia (FM) >

■ Diagnosis is based on clinical judgement; It is not a diagnosis of exclusion; There is no diagnostic 'gold standard' ■ Diagnosis is best made and managed in the Medical Home with the support of a multi-disciplinary team. ■ Earlier diagnosis and disclosure are likely associated with lower symptom severity, reduced healthcare costs and improved quality of life.

2. Confirmatory history >

Must be present for FM diagnosis. Core symptoms present for >3 months: ■ Widespread musculoskeletal pain (in four body quadrants plus axial region) ■ Fatigue – intrusive – physical, cognitive, emotional ■ Sleep disturbance/non-restorative sleep ■ Symptoms cannot be explained by any other condition



3. Differential/Co-existing diagnosis >

More than one may be present, and diagnosis of FM may still be made: ■ **Endocrinology:** Hypothyroidism, hyperparathyroidism/hypercalcemia, abnormalities in cortisol
■ **Rheumatology:** Hypermobility spectrum disorders, osteoarthritis, polymyalgia rheumatica, certain myopathic syndromes
■ **Neurology:** Myalgic encephalomyelitis/chronic fatigue syndrome, multiple sclerosis
■ **Respiratory:** Obstructive sleep apnea, post-COVID/long-COVID
■ **Psychiatry:** Depression
■ **Gastroenterology:** Celiac disease, irritable bowel syndrome
■ **Hematology:** Iron deficiency anemia, hemochromatosis



4. Commonly associated symptoms and diagnosis >

The more of these symptoms present, the more likely the diagnosis of FM is accurate. ■ Difficulty concentrating/cognitive disturbance
■ Depression +/- anxiety may commonly present at time of diagnosis
■ Sensitivity to temperature, weather change, light, sound, +/- significant sensitivity to medication ■ Migraine and muscular type headache ■ Sleep disorder ■ TMJ disorder ■ Painful bladder syndrome/pelvic pain syndrome ■ Irritable Bowel Syndrome

5. Review lifestyle and medications >

■ Medications – Rx and OTC ■ Sleep history
■ Movement/exercise history ■ Social history

6. Physical exam >

■ Should be entirely normal unless co-morbidities
■ Rule out differential diagnosis +/- associated symptoms

7. Investigations >

Consider existing co-morbid conditions and the potential for other co-morbidities to occur
■ Basic screening lab work is a CBC, CRP, TSH, electrolytes and calcium, celiac screen, liver function tests and glucose. ■ Other testing done based on clinical suspicion to exclude differential diagnosis and/or associated illness

8. Disclosing the diagnosis >

FM is a diagnosis of nervous system processing (known as nociplastic pain). Although it may exist with any of these conditions, FM is not:
■ a musculoskeletal condition; ■ a psychiatric disorder;
■ a maladaptive coping; mechanism; ■ or physical deconditioning

[RCP – FM information for patients >](#)

9. Management >

■ Movement/exercise (strongest evidence) ■ Sleep hygiene/management
■ Cognitive Behavioural Therapy for pain ■ Medication (limited evidence)
■ Follow up/Chronic disease management plan (in medical home w/team where available). ■ When/where to refer: Community resources: AHS Alberta Healthy Living Program (online patient education resources) Clinical resources: PCN Multidisciplinary Team/resources, Specialty Care (e.g. FibroFOCUS™ treatment program through the Calgary Chronic Pain Centre, Alberta Virtual Chronic Pain Program)

[Community resources >](#)

[Clinical resources >](#)

At any point along pathway, consider the following to support clinical decision making:

1. Non-urgent clinical advice:

■ Call Specialist Link (specialty specific), incl. chronic pain advice

[Specialist Link >](#)

■ Submit eReferral Advice Request (chronic pain, endocrinology, gastroenterology, neurology, or long COVID-19)

2. Relevant Specialist Link pathways

3. PCN/Multidisciplinary Team collaboration

PATHWAY PRIMER: FIBROMYALGIA (FM)

Fibromyalgia (FM) is a chronic disorder characterized by widespread musculoskeletal pain. In addition to widespread pain, the core symptoms of FM are fatigue (intrusive-physical, emotional, cognitive) and sleep disturbance in the form of non-restorative sleep. These symptoms must be present for greater than 3 months and cannot be explained by any other medical condition or disease process.

FM is caused by a disorder of nervous system pain processing, or chronic nociplastic pain. The nervous system is hypersensitive to external stimuli or environment, causing an individual to experience pain from what would be a non-threatening situation for someone else.

FM is a very common health issue, with a 2-4% prevalence in the general population.² Women are affected more than men, with a 9:1 prevalence. As FM symptoms can mimic other conditions and the symptoms often fluctuate or have periods of remission, it can be a difficult diagnosis to make. Optimal management, however, does require prompt diagnosis. This diagnosis is best made, and best managed, within the patient medical home with the support of the multidisciplinary team where available and appropriate. At any point along the pathway, consideration may also be given to Specialist Link (SL) advice, e-Advice or relevant SL pathways to support clinical decision making.

This pathway is meant for patients over the age of 16 years. It was developed to help guide diagnosis and provide both non-pharmacologic and pharmacologic management guidelines for use in the medical home. It is not indicated for suspected FM in pediatric/youth or pregnant/breastfeeding populations as these subpopulations may have unique considerations.

The content was reviewed and approved by family physicians, pain specialists, rheumatologists, pharmacy, and kinesiology working with the FM working group of the Calgary Zone Pathway Sub-group of Specialist Link.

EXPANDED DETAILS

1. Diagnosing FM

There is no diagnostic “gold standard” for FM. The diagnosis of FM is not a “diagnosis of exclusion”. It is based on identifying the core symptoms, commonly associated symptoms (often the more of these that are present, the more likely the diagnosis of FM is correct). Although a patient may have FM and any of the following conditions, FM itself is NOT: a musculoskeletal disorder, a psychiatric disorder, a maladaptive coping mechanism, or due to physical deconditioning. Earlier diagnosis and disclosure are likely associated with lower symptom severity, reduced healthcare costs and improved quality of life.¹

2. Confirmatory history

A comprehensive assessment of pain, function, and psychosocial environment is key. Symptoms must be present for > 3 months' time. Symptoms may fluctuate, and patients may only report their most concerning symptom at any given time, so careful additional questioning may reveal a more complete picture. The Widespread Pain Index (WPI) and/or Symptom Severity Score (SSS) are tools that may be helpful in establishing the degree of these symptoms, though they are not essential to making the diagnosis of FM.



Symptom	Details	Tools for assessment
Widespread pain	Present in all four body quadrants plus axial region; rated for last week	Widespread Pain Index (WPI) https://www.rcp.ac.uk/improving-care/resources/the-diagnosis-of-fibromyalgia-syndrome/
Fatigue	Intrusive, includes physical, cognitive, and emotional	Symptom Severity Scale (SSS) https://www.rcp.ac.uk/media/yuhdz53b/fibromyalgia-syndrome-diagnostic-worksheet_1_0_0.pdf
Sleep disturbance	Non-restorative sleep	SSS, see above

- A WPI>6 and SSS>4 or WPI 4-6 and SSS>9 are considered a positive score, however there is no clear cut-off score to indicate the presence or absence of FM, as symptoms fluctuate from day to day. The higher the score, the more likely that the symptoms are explained by FM alone.
- **In older FM literature, a concept of tender points was included as a way of distinguishing FM from disorders that are more focal or affect only the joints. This was neither sensitive nor specific for FM and was removed from later diagnostic criteria.**

3. Differential/Co-existing diagnosis

Other diagnoses that should be ruled out as the sole cause for symptoms (although patients can concurrently be diagnosed with these conditions and FM):

- **Endocrinology:** Hypothyroidism, hyperparathyroidism/hypercalcemia, abnormalities in cortisol
- **Rheumatology:** Hypermobility spectrum disorders, osteoarthritis, polymyalgia rheumatica, certain myopathic syndromes
- **Neurology:** Myalgic encephalomyelitis/chronic fatigue syndrome (CFS), Multiple sclerosis
 - Where fatigue and/or excessive sleep is the predominant complaint, the patient should also be assessed for CFS.³ In CFS, fatigue is typically sudden, profound and does not improve with rest. It has a viral trigger and worsens with exercise.
- **Respiratory:** Obstructive sleep apnea (OSA) - [Respirology SleepApnea Pathway Survey.pdf \(specialistlink.ca\)](#), post-COVID/long-COVID - [Provincial Primary care COVID-19 Pathway \(albertahealthservices.ca\)](#)
- **Psychiatry:** Depression
- **Gastroenterology:** Celiac disease - [Celiac Disease Primary Care Pathway \(albertahealthservices.ca\)](#), Irritable bowel syndrome (IBS) - [Irritable Bowel Syndrome \(IBS\) Primary Care Pathway \(specialistlink.ca\)](#)
- **Hematology:** Iron deficiency anemia (IDA) - [Iron Deficiency Anemia Pathway \(specialistlink.ca\)](#), Hemochromatosis (typically can cause joint pain and compensatory muscle imbalances)
- **Neurology +/- Psychiatry:** Functional neurologic disorders and somatic symptom disorder are a consideration and one of the distinguishing features between these disorders and FM is the presence of weakness. Appropriate specialist consultation should be sought if these diagnoses are being considered.



4. Commonly associated symptoms and diagnosis

Other commonly associated symptoms with FM include the list below. The more of these symptoms that are present, the more likely the diagnosis of FM is accurate. These are symptoms that support the diagnosis but require assessment and management as well. See the links to other Specialist Link pathways/other tools to help assist.

Problem	Presentation	Assessment / Management
Cognitive changes	Difficulty concentrating/cognitive disturbance – “fibro fog”	SSS Pathophysiology and Clinical Implications of Cognitive Dysfunction in Fibromyalgia https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8614169/
Mood changes	Mood changes including depression and/or anxiety, is present in up to three quarters of patients with FM. ⁴ Anxiety commonly coexists with depression but is said to be independently increased in FM patients. ⁴	Patient is positive for mood changes if present in past 6 months. Use SSS, GAD-7 and PHQ-9. GAD-7, PHQ-9 tools and information on management found in Anxiety Primary Care Pathway: https://www.specialistlink.ca/assets/pdf/CZ_Anxiety_pathway.pdf
Nervous system hyperexcitability	Sensitivity to temperature, weather change, light, sound, +/- significant sensitivity to medication	Informed by patient history. <ul style="list-style-type: none"> • Pain science education: a hypervigilant nervous system will begin to react to non-painful stimuli as well, • consider desensitization strategies: https://library.sheffieldchildrens.nhs.uk/desensitization-techniques-for-pain-and-hypersensitivity/
Migraine/non-migraine headache	Migraine and tension-type headaches are common co-morbidities, typically associated with pericranial tenderness	Headache and Migraine Primary Care Pathway: https://www.specialistlink.ca/assets/pdf/CZ_Neurology_HeadacheMigraine_Pathway.pdf
Sleep disorder	Sleep latency, sleep disturbance, and fragmented sleep leading to impaired daytime function. Possible restless leg syndrome or sleep apnea.	See <i>Appendix B – Sleep</i> Uncomplicated Obstructive Sleep Apnea Primary Care Pathway https://www.specialistlink.ca/assets/pdf/Respirology_SleepApnea_Pathway_Survey.pdf
TMJ disorder	Can involve limited jaw movement; clicking, snapping, or popping sounds while opening or closing the mouth; pain within facial or jaw muscles (typically aggravated by eating or talking) in or around the ear; or headaches.	Provincial TMJ Dysfunction Primary Care Pathway: https://www.albertahealthservices.ca/assets/info/aph/if-aph-prov-tmj-dysfunction-primary-care-pathway.pdf
Painful bladder syndrome/pelvic pain syndrome	Pain with a full bladder and urinary urgency and frequency are typically present without an infection; and chronic, unexplained pelvic pain. Pelvic pain syndromes can include dysmenorrhea, dyspareunia, or vulvodynia.	Management of Bladder Pain Syndrome (BPS): A Practical Guide https://www.ncbi.nlm.nih.gov/books/NBK570588/
Irritable bowel syndrome (IBS) +/- Gastroesophageal reflux disease (GERD)	Frequent abdominal pain and episodes of diarrhea, constipation, or both	Irritable Bowel Syndrome (IBS) Primary Care Pathway: https://www.specialistlink.ca/assets/pdf/ahs-scn-dh-pathway-ibs.pdf



		GERD Primary Care Pathway: https://www.specialistlink.ca/assets/pdf/ahs-scn-dh-pathway-gerd.pdf
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5. Review lifestyle and medications

- Medications – Many prescription and OTC medications cause symptoms similar to FM. Specific examples include (but not limited to):
 - aromatase inhibitors – cause arthralgia in 15-30+% of patients
 - lipid lowering agents – cause arthralgia in 2-15% of patients
 - chronic opioids – arthralgia reported in 2-10% of patients
- Movement/exercise history (see Appendix A for more information)
- Sleep history (see Appendix B for more information)
- Social history: caffeine, alcohol, nicotine, cannabis, accidents, employment, support, living situation, diet, intimate partner violence.
- Other: coping, impact on work/life, disability.

6. Physical exam

- Should be entirely normal unless due to co-morbidities
- In older FM literature, a concept of *tender points* was included as a way of distinguishing FM from disorders that are more focal or affect only the joints. This was neither sensitive nor specific for FM and was removed from later diagnostic criteria.⁵
- Rule out differential diagnosis +/- associated symptoms
- Exam to include the following:
 - **Vital signs:** specifically, heart rate and BP (including assessing for orthostatic hypotension)
 - **MSK/rheumatological exam:** specifically joint exam, range of motion/hypermobility, skin exam
 - **Neurological exam:** including looking for strength, sensation, deep tendon reflexes, Lhermitte's sign
 - **Endocrine:** signs of hypothyroidism, hyperparathyroidism/hypercalcemia, abnormalities in cortisol

7. Investigations

Consider existing co-morbid conditions, as well as the potential for other co-morbidities to occur:

- Basic screening lab work is: CBC, CRP, TSH, liver function tests, glucose, electrolytes and calcium, celiac screen.
- Other testing done based on clinical suspicion to exclude differential diagnosis and/or associated illness: iron studies (ferritin, TIBC, transferrin saturation and iron), creatine kinase (CK), urea, ALT, alk phos, random blood glucose, am cortisol, hep C (if not done previously) and serum protein electrophoresis.
- Additional tests and investigations may be indicated based on the results of the above investigations and clinical suspicion. If these investigations are normal, they do not need to be repeated unless symptoms change. If help or support is needed for interpretation of results consider a Specialist Link phone call, eReferral eConsult or referral as appropriate.
- Antinuclear antibody (ANA) reactivity is said to be present in many non-rheumatic conditions and should not be used to screen in the absence of specific signs or symptoms (e.g., photosensitivity, malar rash, symmetrical




polyarthritis, etc.) of systemic lupus erythematosus (SLE) or another connective tissue disease (CTD) when considering differentials. (See Choosing Wisely Canada recommendations for [Rheumatology](#)).

8. Disclosing the diagnosis

Early diagnosis and disclosure are associated with lower symptom severity and likely improved quality of life and reduced healthcare costs.¹ FM is a diagnosis of nervous system processing (known as nociplastic pain). Although it may exist with any of these conditions, FM is not:

- a musculoskeletal condition;
- a psychiatric disorder;
- a maladaptive coping; mechanism; or
- physical deconditioning

While it is acknowledged that there are challenges in making a diagnosis, there are key elements that support diagnosis. Establishing the diagnosis allows a patient to immediately engage with a management plan and hopefully see an improvement in symptoms and quality of life. Patients should be reassured that this diagnosis is best made and managed within the Patient Medical Home, with the support of MDT when and where available and appropriate. It is also important to share available information regarding FM – what it is and what it is not – with the patient.



Royal College of Physicians FM Information Sheet for Patients
Automatically download a printable copy by clicking the link below:
[Information Sheet for Patients](#)

Source: Berwick R, Barker C, Goebel A; guideline development group. The diagnosis of fibromyalgia syndrome. *Clin Med (Lond)*. 2022;22(6):570-574. (Appendix 4; Page 47)

9. Management


There is no treatment that has been shown to eliminate symptoms of FM. There are, however, many treatments which can improve pain and function. Pain education and active participation in care is key.

It is emphasized that all patients may benefit from graded incremental activity and pacing. Recommendations by the European League Against Rheumatism (EULAR) guidelines, established there is strong evidence for the use of movement/exercise in the management of FM given its effect on pain, physical function and well-being, availability, relatively low cost and lack of safety concerns.²

The summary table below details non-pharmacological and pharmacological approaches to management of FM, based on the most up-to-date information available.



Non-pharmacological management of FM

Management Approach	Intervention	Local resources
<p>MOVEMENT/EXERCISE (Graded incremental activity and pacing)</p> <p>All patients should participate in regular, planned & structured physical activity. Exercise improves global wellbeing, physical function, and pain.⁴</p> <p>Evidence does not point to a single exercise program that outperforms others.⁴ Patients should be encouraged to choose an activity according to their preferences/budget to improve adherence.</p>	<ol style="list-style-type: none"> 1) Establish patient's level in movement/exercise pathway. If patient is not participating in regular, planned & structured physical activity, assess their beliefs about movement & planned activity related to chronic pain. 2) Determine the goals/plan. 3) Prescribe movement approach. 4) Follow up after 3-4 weeks to re-assess progress & level in movement/exercise pathway. <p>See <i>Appendix A</i> for further information.</p>	<p>Alberta Healthy Living Program https://www.albertahealthservices.ca/info/page13984.aspx</p> <p>Prescription to Get Active https://www.prescriptiontogetactive.com/</p> <p>FIBROFocus™ https://www.fibrofocus.com/</p> <p>Power Over Pain (movement resources) https://portal.poweroverpain.ca/resources?region[]=42&topic[]=30</p>
<p>SLEEP (Sleep hygiene/ management)</p> <p>Sleep disturbance or non-restorative sleep is one of the core symptoms of FM. Other medical/lifestyle issues can impact sleep as well and may co-exist.</p> <p>There are numerous health effects correlated with poor sleep including increased neuroinflammatory response cardiovascular disease, obesity, increased pain response, increased substance misuse/overuse, and accidents causing bodily harm.</p> <p>When assisting a patient with sleep concerns, it is important to acknowledge that this is a not a "quick fix" issue and may take several months or longer.</p>	<ol style="list-style-type: none"> 1) Review current <u>sleep history</u> by having patient maintain a sleep diary, reviewing diary (this approach may take place over consecutive visits, 2-6 weeks apart). 2) Consider involving multidisciplinary team members for recurring appointments if available/where appropriate. 3) Provide <u>sleep hygiene</u> education that is tailored based on history. 4) Provide <u>sleep strategies</u> using cognitive behavioral therapy for insomnia. CBT-i is considered a first-line treatment that is more effective than medication with long lasting benefits. <p>See <i>Appendix B</i> for further information.</p>	<p>https://mysleepwell.ca</p> <p>Local PCN resources https://www.albertahealthservices.ca/info/Page15625.aspx</p>
<p>CBT (Cognitive behavioral therapy)</p> <p>CBT reframes concepts of danger and safety as they relate to pain processing, and therefore can reduce pain levels.</p> <p>CBT can also be helpful for mood disorders, poor coping mechanisms or fear of movement.</p>	<p>This can be accessed via mental health providers on the multidisciplinary team (MDT); there is also good evidence for asynchronous online CBT.</p> <p>Two 90-minute videos sharing basic skills in CBT for pain management and applying them to help patients better manage their pain, are available for learning by Dr. Lori Montgomery and Dr. Todd Hill. See https://www.specialistlink.ca/cognitive-behavioural-therapy</p> <p>See <i>Appendix C</i> for further information.</p>	<p>Tame the Beast https://www.tamethebeast.org/</p> <p>Affordable, barrier-free counselling in Calgary https://www.communityconnectyc.ca</p> <p>Local PCN resources https://www.albertahealthservices.ca/info/Page15625.aspx</p> <p>https://liveplanbeplus.ca</p> <p> pain cognitive patterns infographic</p>



Dietary considerations Nutrition plays an important role in pain management. ⁶ Although the effectiveness of dietary changes specifically in FM has not been widely researched ⁷ , there is evidence that anti-inflammatory diets improve pro-inflammatory conditions.	An anti-inflammatory and low-FODMAP diet has demonstrated promise in improving clinical features in patients with FM and may be considered as a complement to pharmacological therapy. ^{6,8} Implementation is typically done in three phases: 1) Elimination of high-FODMAP foods for 4-8 weeks 2) Slow and specific reintroduction of FODMAPS while monitoring for symptoms re-emerging. 3) Developing a long-term eating plan – include foods that are tolerated, avoid foods that cause negative symptoms.	Overview of a low-FODMAP diet https://supportfibromyalgia.org/wp-content/uploads/2022/08/Overview-of-the-Low-FODMAP-Diet_v2-1.pdf
Complementary therapies E.g. acupuncture, hydrotherapy, Tai Chi, yoga, mindfulness-based stress reduction (MBSR)	Evidence for these is less robust, particularly for long-term outcomes. ^{2,4} Overall, these are not recommended in guidelines, but may be combined with activity. Be aware that therapies like acupuncture can be helpful for baseline pain but may worsen pain if the patient is in a flare.	Pain BC Gentle Movement at Home https://painbc.ca/gentle-movement-at-home

Pharmacological management of FM

Medications are used for symptomatic management when non-pharmacologic treatments have failed or been insufficient. **Patients often show sensitivity to medication dose and side effects. It is prudent to start at the lowest recommended initial doses and increase dosing judiciously.** Health Canada have approved pregabalin and duloxetine for FM treatment; all other treatments are considered off-label.⁴ Medications are often not found by the patient to have a significant impact on their condition but may be worth trying.

Medication	Treatment Efficacy ^{4,9,10}	Dose	Effect
Tricyclic antidepressants (TCAs) Amitriptyline (largest body of evidence) Desipramine Nortriptyline	Pain, fatigue, sleep onset and overall quality of life.	10mg qhs x one week. If tolerated, weekly increments of 10mg to a target dose of 50-80mg qhs or minimum effective dose	Takes approximately 4-6 weeks to see full effect at any given dose. May assist with sleep initiation due to side effect of drowsiness. Therefore, can be useful for both conditions in patients with sleep issues. Take it 12 hours before planned wake up OR low dose is taken 30 mins before bed.
Cyclobenzaprine	Sleep (moderate improvement), pain (mild improvement, transiently).	10mg PO qhs for less than 6 weeks. Helpful in a flare.	



Gabapentinoids Pregabalin Gabapentin	Pain, sleep onset and overall quality of life. Less effective for fatigue and depressive symptoms.	Initial dose*: 25-75mg qhs. Increase by 25-75mg increments every 1-2 weeks. Target dose: 150-300mg bid Initial dose*: 100-300mg qhs. Increase by 100-300mg increments to a target dose of 300mg-600mg tid. Max dose 3600mg/d *In diminished renal function, the dose needs to be adjusted. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5291335/	Single daily dosing at bedtime can assist with sleep onset difficulties. Therefore, can be useful for both conditions in patients with sleep issues, especially with larger dose at bedtime. Many drug interactions are possible; these should be evaluated individually. One study has shown an increased risk of cardiovascular side effects in patients on gabapentinoids for diabetic neuropathy (who are at higher risk of CV events at baseline). This is a small magnitude of risk increase but should be part of your conversations with high-risk patients. Gabapentin is generally more cost effective than Pregabalin. Gabapentin in combination with opioids increases the risk of respiratory depression at doses higher than 900mg. ¹¹
	Pain (significant improvement), depressive symptoms (significant improvement) and anxiety. May be secondarily helpful for sleep. Consider other SNRIs as they become available or as evidence supports use in FM management	Initial dose 15-30mg qam x 1-2 weeks. If tolerated may increase by 15-30mg. Target dose: 60mg (max dose 120mg). 15mg can be obtained by opening the 30mg capsule and approximating half. Available as 30mg and 60mg capsules. All other doses require specialty compounding.	Takes approximately 4-6 weeks to see full effect at any given dose. May be useful for both conditions in patients with depression or anxiety.
Analgesic treatments	No direct support for use.	Acetaminophen and nonsteroidal anti-inflammatory drugs (NSAIDs) yield little benefit. As such, it is best not to start patients on such treatments.	
Avoid opioids	No evidence from clinical trials.	Opioid use is associated with increased harm and is to be avoided in FM, and tapering/deprescribing is recommended if the patient has already started on these medications. See AMA Toolkit for Opioid Prescribing and ISMP (Institute for Safe Medication Practices Canada) November 2016 Guidelines for Opioids .	



Monitoring

Optimal clinical follow up is largely patient-driven and requires clinical judgement. More frequent visits are likely during the initial management phase.⁴ Treatment goals should be realistic and follow-ups will be based on monitoring for changes in:

- Function – contributing factors should be considered such as treatment side-effects or patient motivation.⁴
- Symptoms – symptom flares will require intervention or change in management.
- Medication – consider duration of use and impact on symptoms. Acknowledge if/when side effects outweigh benefit. FM patients are often sensitive to drug effects, so start at the lowest recommended initial dose and increase dosing judiciously. When effective they can be used in combination.

When symptoms have stabilized, patient can drive their own timing for follow-up based on earliest change in symptoms. Periodic physical exams may be a part of the continued care plan. Where new symptoms occur, caution should be exercised before attribution to FM. Clinical evaluation and appropriate testing is needed, although additional investigations should be driven by sound clinical principals to avoid excessive testing.⁴

Specialist advice/Referrals

A diagnostic dilemma may be present if:

- the symptoms for FM are continually equivocal
- there is clear diagnostic uncertainty
- there are complex multiple health conditions clouding diagnostic certainty (consider general internal medicine)
- there are investigations that are abnormal, seek specialist advice/referral as appropriate/necessary

In such cases, consider a referral depending on the patient's symptom history and/or physical exam (i.e. neurology, rheumatology or rehab medicine).

If FM is the most likely diagnosis but the patient is not responsive to medical management, consider a Specialist Link phone call or eReferral eConsult to what you feel is the most appropriate resource below.

Specialist Link Non-urgent tele-advice for family doctors	https://www.specialistlink.ca/ <ul style="list-style-type: none">• Call 403-910-2551 or 1-844-962-5465; M-F 0800-1600h (callback within two hours)
Alberta Netcare eReferral eConsult Non-urgent medical questions answered by a specialist within five calendar days.	https://www.albertanetcare.ca/learningcentre/eReferral.htm <ul style="list-style-type: none">• An eReferral eConsult may be made through the Alberta Netcare portal
Alberta Virtual Chronic Pain Program Virtual group education treatment program over Zoom for people in Alberta experiencing persistent pain longer than 3 months.	<ul style="list-style-type: none">• Patients may call 1-877-719-7707 to register.• Clinicians may refer through Connect Care: Use the Ambulatory Referral Order to AHS PROV PAIN PROGRAM or• Alberta Referral Directory
FibroFOCUS™ Distance learning (Zoom) for adults with FM. Weekday/weekend programs. Covered by Alberta Health Care by healthcare provider referral.	https://www.fibrofocus.com/ Referral fax: 1-403-209-2954
Primary Care Network (PCN) chronic pain programs Services vary between PCNs.	Local PCN resources: https://www.albertahealthservices.ca/info/Page15625.aspx



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BACKGROUND

About this pathway

The pathway is designed for adult patients with suspected FM. It is not indicated for suspected FM in pediatric/youth or pregnant/breastfeeding populations as these subpopulations may have unique considerations – consider a Specialist Link call for advice on these populations.

Authors and conflict of interest declaration

This pathway was developed by leveraging the collective knowledge, experience and expertise of several individuals. See a full list below. For more information, please email info@calgaryareapcns.ca. For more information, contact info@calgaryareapcns.ca.

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Pathway review process, timelines

Primary care pathways undergo scheduled review every three years, or earlier if there is a clinically significant change in knowledge or practice. The next scheduled review is June, 2027. If you have any questions or concerns about this pathway, please email info@calgaryareapcns.ca with “FM Pathway” in the subject line.

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DISCLAIMER

This pathway represents evidence-based best practice but does not override the individual responsibility of health care professionals to make decisions appropriate to their patients using their own clinical judgment given their patients' specific clinical conditions, in consultation with patients/alternate decision makers. The pathway is not a substitute for clinical judgment or advice of a qualified health care professional. It is expected that all users will seek advice of other appropriately qualified and regulated health care providers with any issues transcending their specific knowledge, scope of regulated practice or professional competence.



PROVIDER RESOURCES

Advice options

- Non-urgent telephone advice connects family physicians, nurse practitioners and specialists in real time via a tele-advice line. Family physicians, nurse practitioners and specialists can request non-urgent advice (specialty specific) including chronic pain advice at specialistlink.ca or by calling 403-910-2551. This service is available from 8 a.m. to 5 p.m. Monday to Friday (excluding statutory holidays). Calls are returned within two (2) hours.
- Non-urgent electronic advice is available for chronic pain, endocrinology, gastroenterology, neurology or long COVID-19 across the province via Alberta Netcare eReferral eConsult (responses are received within five calendar days). View the [eReferral Learning Centre](#) for more information.

Resource	Location
FM diagnostic worksheet	https://www.rcp.ac.uk/media/yuhdz53b/fibromyalgia-syndrome-diagnostic-worksheet_1_0_0.pdf
Information sheet on FM (for clinicians)	https://www.rcp.ac.uk/media/41sf1sz0/information-sheet-for-clinicians_0.pdf
Screening Tools	
Widespread pain index (WPI)	Page 22 https://www.rcp.ac.uk/media/udlhnt1b/the-diagnosis-of-fibromyalgia-syndrome-guidelines_1_2_0.pdf
Symptom Severity Score (SSS)	https://www.rcp.ac.uk/media/yuhdz53b/fibromyalgia-syndrome-diagnostic-worksheet_1_0_0.pdf
Articles/References	
PEER pain guideline	https://www.cfp.ca/content/68/3/179
Diagnostic and therapeutic care pathway for FM	https://orca.cardiff.ac.uk/id/eprint/150536/1/Diagnostic%20and%20therapeutic%20care%20pathway%20.pdf
Royal College of Physicians. The diagnosis of fibromyalgia syndrome. UK clinical guidelines.	https://www.rcp.ac.uk/improving-care/resources/the-diagnosis-of-fibromyalgia-syndrome/
Canadian Fibromyalgia Guidelines (2012)	https://fmguidelines.ca/
Framework for FM management for Primary Care Providers	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3498162/
Management strategies for primary care providers.	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6093261/
European League Against Rheumatism (EULAR) Fibromyalgia Guidelines (2017)	https://ard.bmj.com/content/76/2/318
UpToDate fibromyalgia recommendations (2023)	https://www.uptodate.com/contents/initial-treatment-of-fibromyalgia-in-adults
Living Systematic Review on Cannabis and Other Plant-Based Treatments for Chronic Pain	https://effectivehealthcare.ahrq.gov/products/plant-based-chronic-pain-treatment/living-review
Anti-Inflammatory Diet and outcomes in FM	https://www.frontiersin.org/articles/10.3389/fnut.2022.856216/full
Diet and Chronic Non-Cancer Pain: The State of the Art and Future Directions	https://www.mdpi.com/2077-0383/10/21/5203



PATIENT RESOURCES

Information – Online and in the Community

Resource	Location
Information sheet on FM (for patients)	https://www.rcp.ac.uk/media/mfmpij5t/fibromyalgia-information-sheet-for-patients.pdf
Fibromyalgia: Fact and Function Zoom class	https://www.albertahealthservices.ca/assets/info/phc/if-phc-cdm-ahlp-cal-ffaf.pdf
Activity	https://painbc.ca/gentle-movement-at-home https://www.prescriptiontogetactive.com Movement/Exercise videos: https://www.youtube.com/playlist?list=PLHgoco7_bPro08rXXVZOm9fPhKNpxH9Pp
Sleep (general information, sleep diary, calculator, hygiene checklist, CBTi)	https://mysleepwell.ca Alberta Healthy Living: Sleep Habits Zoom class: https://www.albertahealthservices.ca/info/Page16878.aspx
Cognitive behavioral therapy (CBT)	https://liveplanbeplus.ca
Fibro Fog	https://myhealth.alberta.ca/health/pages/conditions.aspx?Hwid=zt1337
Flare-up planning	https://www.oregonpainguidance.org/paineducationtoolkit/flareups
General pain education	https://poweroverpain.ca/ https://www.tamethebeast.org https://www.retrainpain.org/ https://www.paincanada.ca/ https://www.paintoolkit.org/ https://www.paintrainer.org/ https://www.thepaintruth.org https://www.ecentreclinic.org/chronic-pain https://www.painscience.com/articles/sensitization.php https://cumming.ucalgary.ca/centres/anesthesiology/chronic-pain-centre
UpToDate patient education	Fibromyalgia (Beyond the Basics) https://www.uptodate.com/contents/fibromyalgia-beyond-the-basics
AHS Chronic Pain Management Lecture Series	https://www.albertahealthservices.ca/services/Page2790.aspx

Services available

Resource	Location
Alberta Virtual Chronic Pain Program	<ul style="list-style-type: none"> Patients may call 1-877-719-7707 to register. Clinicians may refer through Connect Care: Use the Ambulatory Referral Order to AHS PROV PAIN PROGRAM or Alberta Referral Directory
FibroFOCUS™	https://www.fibrofocus.com/ - Referral fax: 1-403-209-2954
Primary Care Network (PCN) chronic pain programs	Local PCN resources: Multidisciplinary teams (kinesiology, physiotherapy, pharmacy, chronic disease management nurses, behavioural health consultants, social workers, etc.), classes/courses, etc. Services vary between PCNs. https://www.albertahealthservices.ca/info/Page15625.aspx
Alberta Rehabilitation Advice Line	Telephone service open Mon-Fri. Provides rehabilitation advice and general health information for Albertans of any age. https://www.albertahealthservices.ca/findhealth/Service.aspx?serviceAtFacilityID=1126573 Tollfree: 1-833-379-0563



APPENDIX A – Movement/Exercise

Considering the complexity of chronic pain and the variety of individualization that accompanies activity prescription, there should be a nuanced and methodical approach to discussing and prescribing physical activity with patients suffering from chronic pain. A stepped pyramid approach to movement for chronic pain is a resource to equip health professionals to be able to discuss movement/exercise for chronic pain by meeting the patient where they are at and focusing on appropriate barrier reduction and pacing before progressing to more advanced recommendations.

Movement/exercise pathways can support clinicians in their management of patients experiencing persistent pain lasting more than 3 months. The pathway determines the degree to which the patient is participating in **regular, planned & structured physical activity**, to characterize them according to level of activity and provide detailed guidance for intervention. Click on the following PDF to view the Movement/Exercise Pathway in flowchart format.



CPFM_ExercisePathway_Final_June2024.pdf

This resource was created by Evan Ward BScHK, Manager, Mosaic Primary Care Network with contributions from: Elizabeth Hitt, BKin, CSEP-CEP, ACSM-CCEP, ACSM-EIM III, Kinesiologist, Mosaic Primary Care Network; Patrick Bernat, MSc, CSEP-CEP, Kinesiologist, Mosaic Primary Care Network; Rachel Webb, BKin, CSEP-CEP, Kinesiologist, Mosaic Primary Care Network; Megan Roach, BKin, CSEP-CEP, Supervisor, Mosaic Primary Care Network; Stephanie Brown HBKin, CSEP-CEP, Kinesiologist, Calgary Foothills Primary Care Network; Faun Lusty, BScPharm, APA, Clinical Pharmacist, Calgary Foothills Primary Care Network.

Movement/Exercise pathway

Patient is **not** currently participating in planned & structured physical activity

Step 1: ASSESS – Beliefs about movement & planned activity related to chronic pain.

FEAR & RESISTANCE to discussions about activity. ISSUES performing activities of daily living (ADLs). LOW awareness of benefits of activity, pacing, & triggers.	OPENNESS to setting daily physical activity goals. READINESS to utilize activity as a self-management tool. AWARENESS of the benefits of activity & pacing on pain.
Level 0-1	Level 2-3

Step 2: CHARACTERIZE – Level of activity between 0-3

Level 0 High sedentary time & avoidance of movement due to fear of increasing pain.	Level 1 Low awareness of the movement, sedentary time & pain relationship.	Level 2 Interest in activity as a self-management tool & increasing daily movement.	Level 3 Increased confidence, buy-in, & ready to start planned activity.
Patient description <ul style="list-style-type: none">Avoidance of movement due to fear of increasing pain (Kinesiophobia) & belief that exercise does more harm than good.High perceived barriers to increasing movement.	Patient description <ul style="list-style-type: none">Some hesitancy about starting structured exercise.May only associate planned exercise as having benefits.Does not associate non-exercise activity	Patient description <ul style="list-style-type: none">Understands importance & benefits of movement for chronic pain.Increased interest of activity as a self-management tool.	Patient description <ul style="list-style-type: none">Confidence in self-monitoring, increasing, & pacing daily activity.Realizes the benefits & importance of increasing NEAT & reducing sedentary time.



<ul style="list-style-type: none"> • No knowledge of benefits of movement for chronic pain. • May be avoiding or having assistance with activities of daily living (ADLs). • No awareness of the concepts of flare ups, pacing, or pain triggers. 	<p>time (NEAT) + reducing sedentary time as having benefits.</p> <ul style="list-style-type: none"> • May not recognize relationship between sedentary time & pain. • Low awareness of patterns related to flare ups, pushing through pain. 	<ul style="list-style-type: none"> • Confident in creating steps goal to increase activity. • Making conscious decisions to reduce sedentary time, increase NEAT. • Recognizing patterns between flare ups, stress, activity level. 	<ul style="list-style-type: none"> • Has ideas for types of planned activities they would like to try. • Increased confidence in preventing & managing flare ups
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Step 3: PLAN – Goals for movement/exercise

Level 0	Level 1	Level 2	Level 3
Goal/Plan <ul style="list-style-type: none"> • Address fears & assumptions related to movement & pain. • Increase body awareness, benefits of exercise for chronic pain. 	Goal/Plan <ul style="list-style-type: none"> • Establish baseline activity level & tolerance (steps). • Educating on benefits of activity on pain & mood. • Increase awareness of patterns between activity levels & chronic pain. • Introduce concept of breaking up sedentary time with short periods of activity (walking around the house). 	Goal/Plan <ul style="list-style-type: none"> • Review current/baseline activity level. • Setting daily activity goal above established baseline increasing tolerance in a safe manner. 	Goal/Plan <ul style="list-style-type: none"> • Introduction of planned, structured activity. Consider involving a support person for increased feelings of safety. • Focus on an activity that: <ul style="list-style-type: none"> ○ Patient enjoys ○ Patient has done before ○ Patient feels safe doing ○ Is aligned with functional goals • Is accessible & easy to integrate into their schedule • Focus is on habit building & celebrating “just showing up”. • A 1-2/10 point increase in discomfort is normal as long as it is transient & doesn't lead to a flare up.
Prescription <ul style="list-style-type: none"> • Explain safe vs. unsafe pain. • Explain deconditioning cycle, how avoiding movement contributes to weaker muscles & cardiovascular system. May cause higher pain when movement required. • Introduction of 360 breathing technique. 	Prescription <ul style="list-style-type: none"> • Monitoring & tracking of activity for 14 days, consider step tracking. • Work with patient to set up activity tracker on their phone or activity diary. 	Prescription <ul style="list-style-type: none"> • Set goal of increasing amount of activity by 5-10% each week. (For example, if the patient's average is 2000 steps per day, try for 2100-2200 steps per day over the next week). • Encourage pt to reflect on relationship between activity & overall daily function, “good” pain days, flare ups. 	Prescription <ul style="list-style-type: none"> • Start low, go slow: Set goal of 1-3 bouts of planned low intensity exercise, 8-10 minute intervals per day to start. • Duration can be gradually increased based on patient comfort & confidence. • Consistency is key.

Step 4: FOLLOW-UP – 3-4 weeks to re-assess progress & level in exercise pathway.



Patient is currently participating in planned & structured physical activity

Step 1: CHARACTERIZE – Level of activity between 4-5

Engaging in one type/modality of exercise (ie. Walking, Biking, Stretching, Swimming only).	Engaging in multiple types/modalities of physical activity as part of a well-rounded physical activity plan.
Level 4 Established movement routine, ready for progression & modalities.	Level 5 Optimization, progression, & individualization of exercise routine.
Patient description <ul style="list-style-type: none"> Confidence with current structured activity routine Ready for introduction of new exercise/movement to integrate all aspects of physical activity (strength, stretching, cardio, etc). Would like to improve their ability to extend/enhance their enjoyed planned activity (ie. stretch/strengthen so they can walk longer durations). Confident in ability to self-manage flare ups, pace activity, & try new activity modalities. 	<ul style="list-style-type: none"> Has established a consistent exercise routine incorporating various exercise modalities. Is desiring more challenge or variety with regards to their exercise/activity routine. Interested in individualized exercise plan with prescribed frequency, intensity, time, type. Highly confident in ability to self-manage flare ups, pace activity, & incorporate new activity modalities.

Step 2: PLAN – Goals for movement/exercise

Level 4	Level 5
Goal/Plan <ul style="list-style-type: none"> Addition of variety of exercise modalities that could benefit function & address all aspects of physical activity. For example, an established walking routine could have a flexibility or resistance training component added. Focus on quality over quantity. If incorporating flexibility or resistance components, find 2-3 movements the patient would like to try. Continue to build confidence & consistency with the new exercise or activity. 	Goal/Plan <ul style="list-style-type: none"> Optimize & progress exercise routine based on functional goals & occupational needs. Ensure patient has a flare up plan & understands to adapt activity during these times. <p>Flare Up Plan</p>
Prescription <ul style="list-style-type: none"> Addition of 1 x 10 minute bout of new exercise modality, 2-3 times per week. 	Prescription <ul style="list-style-type: none"> Encourage continued consistency. Suggest a variety of activities that build in all areas of physical activity: strength, balance, cardio, & flexibility.

Step 3: FOLLOW-UP – 3-4 weeks to re-assess progress & level in exercise pathway.

Guiding principles, conversation enablers and resources

CONSIDERATIONS FOR ALL CONVERSATIONS:

- Provider buy-in & belief in effect of treatment improves outcomes.
- Focus on quality of life & function-related goals.
 - What activities of life are important to the patient? Center conversations about movement around improving their ability to perform occupational tasks, enjoyable tasks.
- Reframe passive therapies/interventions as tools to aid in increasing activity & movement vs. silver bullet solutions independent of activity.



CONTRAINDICATIONS

- Discussing Canada's or other health organization physical activity guidelines not specifically developed for individuals suffering from chronic pain - can create unrealistic or seemingly unattainable standard for "normal" or what is expected of the patient.
- Placing emphasis on diagnostic imaging to determine appropriate exercises.
- Unfounded restrictions on certain movements/ exercise modalities.
- Focus on passive therapies (massage, physiotherapy) & interventions (joint injections) as replacements to increasing activity levels.
- Refrain from "wait to start until" messaging (for example: patients waiting for total knee/total hip replacement). Better strength, conditioning, higher activity levels, and "prehabilitation" within pain tolerance prior to surgery may enhance post-surgical outcomes.

Level of activity and description	Guiding principles	Patient resources/Referrals
<p>0 - High sedentary time and avoidance of movement due to fear of increasing pain.</p> <p>1 - Low awareness of the movement, sedentary time and pain relationship.</p> <p>2 - Interest in activity as a self-management tool and increasing daily movement.</p> <p>3 - Increased confidence, buy-in, and ready to start planned activity.</p>	<ul style="list-style-type: none"> • Focus on language using terms such as movement or activity vs. "Exercise". • Focus on increasing feelings of safety around movement & planned activity. • Emphasize the positive effects of increasing NEAT (non-exercise activity time) & planned, structured activity. • Modification of prescribed movement to improve convenience or align with patients "pain pattern". • Enjoyment (or lack thereof) for certain activities may play a role in what is or is not possible for the patient - may not be aligned with traditional clinical assessment especially in the presence of mental health issues. • Pacing is important – start with low intensity and duration and follow-up to gradually increase based on patient comfort and confidence. 	<ul style="list-style-type: none"> • Retrain the brain: Andrea Furlan YouTube video https://www.youtube.com/watch?v=DaLSRag7uCE • Pain BC: Self Management BC Online Classes https://www.selfmanagementbc.ca/chronicpainprogram • Pain Diary https://myhealth.alberta.ca/Health/Pages/conditions.aspx?hwid=abg7017 • Flare up Plan https://tapmipain.ca/patient/managing-my-pain/pain-u-online/triggers-management.html • Alberta Virtual Chronic Pain Program https://www.albertahealthservices.ca/findhealth/service.aspx?source=mha&Id=1085140&facilityid=1011654 • Alberta Healthy Living Program (AHLP) https://www.albertahealthservices.ca/info/Page18355.aspx • AHS Calgary Chronic Pain Centre https://www.albertahealthservices.ca/services/Page11132.aspx • FibroFOCUS https://www.fibrofocus.com/ • Community-based Chronic Pain support groups • PCN Resources*: Pain Programs, Kinesiologists *Contact your local PCN representative for more information
<p>4 - Established movement routine, ready for progression and modalities.</p> <p>5 - Optimization, progression, and individualization of exercise routine</p>	<ul style="list-style-type: none"> • Tailor exercise prescription based on occupational goals/realities 	<ul style="list-style-type: none"> • 23 ½ Hours: Dr. Mike Evans YouTube video https://www.youtube.com/watch?v=3F5Sly9JQao • Pain BC: Self Management BC Online Classes https://www.selfmanagementbc.ca/chronicpainprogram • Prescription to Get Active https://www.prescriptiontogetactive.com/ • Alberta Healthy Living Program (AHLP) https://www.albertahealthservices.ca/info/Page18355.aspx • FibroFOCUS https://www.fibrofocus.com/



		<ul style="list-style-type: none"> • Community-based Chronic Pain support groups • PCN Resources*: Pain Programs, Kinesiologists <p>*Contact your local PCN representative for more information</p>
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Appendix B – Sleep

Sleep history	Sleep hygiene	Other medical/lifestyle issues	Medications for sleep
<p>Establish patient's current sleep/quality/length/rule out and/or address above medical issues that may be impacting sleep.</p> <p>Determine what is insomnia? Trouble falling asleep, staying asleep or waking up early.</p> <ul style="list-style-type: none"> What isn't insomnia: Sleep apnea, circadian sleep-wake disorders, narcolepsy, other medical issues listed above (which may co-exist). <p>A sleep diary can document individual sleep patterns. Have patient keep a sleep diary for at least 2 weeks' time of usual routine (not vacation/holidays).</p> <p>Consider including the following:</p> <ul style="list-style-type: none"> Time to bed Time to get up Time to fall asleep Number/time of awakenings Length of awakenings Total hours of sleep Alcohol/caffeine/tobacco (amount and time of use). These three are likely to interfere with sleep. Sleep aids used and time of use <p>Resources: https://mysleepwell.ca/insomnia/</p> <p>Patient sleep diary https://mysleepwell.ca/cbti/sleep-diary/</p>	<p>Review sleep diary. What did the patient learn? Continue to use this over the next few weeks.</p> <p><u>Concepts of sleep hygiene</u></p> <p>During the day:</p> <ul style="list-style-type: none"> Get up around same time each day (*key concept – work back to determine time in bed, aiming for 8-9 hours of sleep) Movement/exercise is helpful (increased sleep drive) Avoid naps or keep to 30 minutes before 3pm Avoid using stimulants (caffeine, nicotine, stimulating medications), but if using, use early in the day <p>At bedtime:</p> <ul style="list-style-type: none"> Go to bed when sleepy Avoid screentime for at least one hour prior to bed Avoid being full or hungry (small snack with protein) Avoid bright lights, loud noises Consider a warm shower or bath Avoid alcohol <p>In bed:</p> <ul style="list-style-type: none"> Phone in night mode or out of bedroom Use bed for sleeping and sex only No TV in bedroom Keep room dark, quiet, cool Get out of bed if awake longer than 20 minutes. Go to another room and do a quiet activity like reading. <p>Resources: https://mysleepwell.ca/cbti/hygiene-of-sleep/</p>	<p>Other medical/lifestyle issues can impact sleep as well and may co-exist including:</p> <ul style="list-style-type: none"> Obstructive Sleep Apnea (OSA) Restless Leg Syndrome Anxiety Pain Menopausal symptoms GERD Cough Urinary frequency Nightmares/PTSD Shift work <p>Resources: Uncomplicated Obstructive Sleep Apnea Primary Care Pathway https://www.specialistlink.ca/assets/pdf/Respirology_SleepApnea_Pathway_Survey.pdf</p> <p>Anxiety Primary Care Pathway https://www.specialistlink.ca/assets/pdf/CZ_Anxiety_pathway.pdf</p> <p>GERD Primary Care Pathway https://www.specialistlink.ca/assets/pdf/ahs-scn-dh-pathway-gerd.pdf</p> <p>All other conditions manage as appropriate.</p>	<p>Sleep medications are not generally recommended except for those previously listed.</p> <p>Problems to be considered with medications for sleep:</p> <ul style="list-style-type: none"> Ineffective Reduces deep restorative sleep Tolerance develops quickly Significant side effects can occur: <ul style="list-style-type: none"> Memory issues Injuries from falls Impaired driving, even the next morning Dependence, overuse, withdrawal Daytime hangover Impaired breathing (especially when combined with other medications or alcohol) <p>If patient is taking sedative-hypnotic medication, safely and slowly taper their dose by reducing the dose on the same day of the week, and adding in another day of reduction every 1-2 weeks. This may take months to complete.</p> <p>Resources: https://mysleepwell.ca/sleeping-pills/the-dangers-of-sleeping-pills/</p> <p>https://mysleepwell.ca/wp-content/uploads/2021/05/Stop-Sleeping-Pills-Guide-and-Planner-FILLABLE.pdf</p>

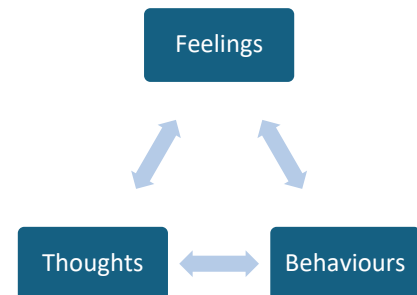


Appendix C – Cognitive behavioural therapy: a primer

Cognitive behavioural therapy (CBT) is a psychological treatment that involves identifying, understanding, and modifying the relationship between thoughts, feelings, and behaviours. Typically, people present for care because they are feeling something they don't want to feel; sadness, anxiety, pain, shortness of breath, and nausea are some examples of feelings that might respond to CBT.

HOW DOES CBT WORK?

We can't directly treat feelings, but we can change thoughts, and change behaviours, both of which can change what we feel. CBT is an umbrella term that includes several different strategies. In many cases, formal CBT is a structured, time-limited intervention that is delivered according to certain protocols, but you can use the principles of CBT in most of your conversations with a patient.



HOW DO I USE CBT PRINCIPLES IN TREATMENT?

We have thousands of thoughts during our day. These are sometimes positive and sometimes negative thoughts. If our automatic thoughts are consistently negative, we might feel depressed, anxious, or in pain. We often attribute our mood or feelings to a particular situation or event, but the reality is that our feelings about that situation are mediated by our perceptions or interpretations of the event. For example, when our best friend fails to “like” something we’ve posted on social media, our feelings will depend on whether our belief is that a) they are very busy, or b) they are mad at us. These assumptions and automatic thoughts often affect our behaviour. We might choose to do (or not do) certain things because of our beliefs, but choosing to do (or not do) these things anyway can challenge and alter our previous assumptions. Depending on the patient, you may choose to focus on:

- **cognitive** aspects — encouraging awareness of automatic thoughts and deliberately changing them.
- **behavioural** aspects — encouraging a patient to go for a walk, go to bed later, or do a relaxation exercise, even if they don't feel entirely confident they can.

See link for short articles on using CBT principles in clinics: <https://www.cfp.ca/search/greg%2Bdubord>

PROBLEMATIC PAIN BELIEFS

There is evidence that CBT is consistently helpful for chronic pain.¹ It can reduce pain levels and improve quality of life and function. For example, if you are convinced that pain = tissue damage (thoughts/beliefs), your pain levels will be higher (feelings), and you will limit your activity to avoid pain (behaviour). One of the most important CBT interventions in pain is to help patients understand that 1) pain is protective; it is never an accurate measure of tissue health, 2) persistent pain is overprotective; this is a learned response that can be retrained, and 3) pain is complex, and therefore there are many windows into retraining the system.

¹ Williams, A.C. de C., Fisher, E., Hearn, L., & Eccleston, C. (2020) Psychological therapies for the management of chronic pain (excluding headache) in adults. *Cochrane Database of Systematic Reviews*. 8. Art. No.: CD007407. DOI: 10.1002/14651858.CD007407.pub4. Accessed 17 January 2023.

