

Other developments related to DRSI

Fibromyalgia is very strongly linked medically scientifically and legally to the subject of DRSI. These links were assessed in the LPC reports in September 2000 and continue to be highly controversial. The conference in Bristol gave an airing to many of the issues and provided an opportunity to assess the beliefs of experts.

Notes from the Fibromyalgia Conference Bristol 15th – 17th May 2001

Fibromyalgia is a diagnosis that is enjoying increasing popularity both among patients; who have a wide range of chronic pain, fatigue and other symptoms, and among those mainstream specialists and, "alternative therapists"; who manage them. Interest in the diagnosis is partly driven by medico-legal convenience, as the diagnosis becomes more widely used in reported cases. An interest also seems to arise out of the conviction that there really is a distinct condition at large and because of the appeal of having a new and fashionable label to give to patients. There remains considerable doubt as to the validity and clinical value of this diagnosis and there is no consensus on the most effective way to treat or case manage those so diagnosed.

Previous incarnations of chronic widespread pain syndromes include fibrositis and railway spine. Other current names for chronic widespread pain problems include chronic fatigue syndrome and ME, and chronic regional pain syndromes include low back pain and to some minds, RSI. It is not clear that these diagnostic labels really distinguish different pathologies or symptomatology.

LPC Centre for Risk Sciences produced a review of the science of Fibromyalgia (FM) in the year 2000. The report was intended to provide a context to repetitive strain injury with which it shares many of its scientifically, less satisfactory characteristics. Fibromyalgia is even occasionally suggested as an alternative label to the much maligned label; Diffuse RSI.

Much of the medico legal interest in FM arises in connection with mechanical injury events, in particular; whiplash events. So-called 'reactive' FM was the intended focus of this conference, though much of what could be learnt from the conference would also be applicable to those medical histories that include no trauma.

Apart from many interesting technical details (discussed below), the key messages that emerged from this conference were:

1. That FM is not a universally accepted diagnosis.
2. That there is no certainty about causation or pathogenesis of chronic widespread pain.
3. That our healthcare and insurance systems for preventing and managing chronic pain cases are inadequate, and
4. That our medical and legal systems both contribute to the creation of chronic pain conditions and aggravate them, a so-called iatrogenic effect.

As a nation we should consider improving the way we handle injury cases if we are to prevent unnecessary severity and chronicity of harm. Insurers could play a role in developing such changes, though this role should be approached with caution.

Causation

The key argument that is proposed by claimant lawyers in support of injury event causation of FM for a particular case, is based on temporality. Medical care utilisation, lifestyle, personal characteristics etc. are compared, for an undefined period, prior to and after the alleged injury accident. Anecdotal evidence is used to demonstrate a transformation of characteristics such as extroversion, sporting life, career progression and so on. By such argument, the claimant lawyer hopes to show that the injury event had far reaching consequences, out of proportion to the scale of the injury, and which can only be explained by the development of some chronic pain condition. It is apparently not essential that this condition is given a name, but the most fashionable name to attach is FM. It is apparently not essential to show that there were no other contributory causes to the development of FM, merely that the injury was the pivotal event in time.

Opposing this argument is the very strong doubt that can be generated by evidence of mental illness, pain condition or lifestyle instabilities prior to the alleged injury. Such histories are common place, 1% of the UK population (aged less than 65) has been diagnosed with serious mental ill health and 20% would be diagnosed with some form of mental ill health in any year, if assessed.

There is growing support for non-injury-event causation based on a biopsychosocial model of chronic pain conditions. A full description of this model has been provided previously in the LPC reports on

Diffuse RSI and FM (year 2000). In this model, biological, psychological and social factors interact, over a period of time, to produce a chronic pain condition that may, increasingly, attract the name FM. All three components (bio psycho and social) are often readily identifiable in the circumstances of an injury event and the care (or lack of appropriate care) of patients. The very least that is required for initiation of this process is psychological distress, though the interest of this conference focussed mostly on biological (physical injury) initiation. Social factors (and some medical care factors) act as barriers to the healthy resolution of biological or psychological healing processes.

Comment

Temporality argument

It is scientifically unsatisfactory in the case of a subjective condition for causation to be based solely on temporality. Although persuasive, temporality ought to be seen in the context of evidence as to strength of association, accuracy of diagnosis and biological plausibility. The basic science required to support this approach has not been done. Until it is done, temporality will surely be the main argument offered.

Biopsychosocial argument

This argument is scientifically well founded for low back pain, non-cardiac chest pain and PTSD. The interaction between biological, psychological and social factors (barriers to recovery) ought, by extrapolation, to apply to every type of injury or disease, but need not necessarily lead to the same end point. In fact extreme chronic pain reactions are not the majority.

It is entirely plausible, though not yet satisfactorily proven, that if continuous deterioration is detected within 4 to 6 weeks of initiation (either by biological damage or psychological trauma) interventions can be made, such that chronic pain states can be prevented.

It is a common feature of court proceedings to attempt to assess the credibility of the claimant by reference to their diligence at work and other commitments. However, it may well be argued in defence that excessive commitment may have led to a state of exhaustion, which may have been a contributory or even a principal causal factor.

Diagnosis

The debate about the medical validity or utility of this diagnosis continues. Proponents and detractors agree that it is a "diagnosis" of exclusion, sometimes referred to as a dustbin diagnosis, and that there are a very wide range of symptoms that form a characteristic set among the FM population. There is no gold standard.

Proponents and researchers tend to use a diagnostic system devised by the American College of Rheumatology (ACR). The system was originally devised to identify extreme cases of chronic pain and allodynia and was intended to be used in research rather than in the clinic. Detractors point out that the system really only applies to finding a distinction between rheumatoid arthritis and allodynia of unknown origin. Other methodological problems with the system were proposed at the meeting. Both pain and allodynia are subjective. The prevalence of self-reported neck pain is 4%.

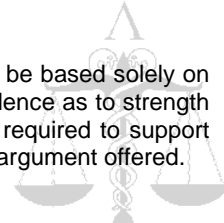
Detractors point to a lack of objective specific signs, or pathology that could explain the symptoms and that, few of the myriad symptoms are either necessary nor sufficient in common diagnostic practice. Proponents and others will continue to endeavour to identify such objective signs and specific pathology but also argue that having a universal name for a set of inexplicable bodily symptoms and sleep disturbance is helpful in terms of communication. One leading proponent conceded that FM is more a description of a process than an end point, i.e. it is not a diagnosis. Having provided a diagnosis to a patient has one beneficial effect in that it deters endless Dr shopping and wasted investigation. However, this then leads to an endless search for a cure thereby detracting from efforts to re-normalise life.

One of the most persuasive papers at the conference described the discovery of anomalously high levels of pain transmission chemicals (substance P) in the central nervous system of FM cases. The correlation with the subjective determination of allodynia was 90% accurate. However specificity was not reported. In a prospective study it was found that FM cases evolve from normal levels of substance P to high. Once a high level is reached there was no remission for the subjects under study.

Other objective signs were proposed such as, abnormal brain blood flow (determined by brain scans), raised concentrations of nerve growth factor, abnormal EEG during sleep... but in general many of the so-called signs were rather more subjective than advertised. Of the objective signs (above) no work was reported on whether they were associated with cause or effect or whether they were specific to FM.

Comment

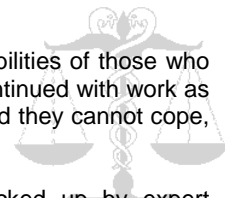
Symptom syndromes have not been adequately suited to medical models since the early 1700's when it began to be considered that symptoms should be explicable by reference to underlying pathology. Our



current medical model relies on such an association and, as in the case of FM, is evidenced by years of failed testing and ineffectual treatment, often at the behest of the client/patient. The record demonstrates the extreme lengths that are gone to to maintain this assumption of pathology. Symptom syndromes do not easily fit with the pathology based medical model. A great deal of heated debate surrounds the distinctions between pathology and non-pathology models.

There is no obvious end in sight for this argument, but it would seem that further research is inevitable. The argument is of course one sided as it will always be impossible to show that something that does not exist, does not exist. However, if a more attractive alternative label for this symptom syndrome emerges, the debate may continue under a different name.

Diagnosis is not the same as disability. That is, there is a very wide spectrum of abilities of those who have been given a label on FM. Some studies show that 60% of FM cases have continued with work as normal. It was suggested that those who seek medical assistance are those who find they cannot cope, their level of diagnosis does not correlate with the level of dysfunction.



The discovery of promising candidates as objective signs will probably be picked up by expert epidemiologists, who will then be able to provide much more meaningful insight into the sensitivity and specificity of these signs. Further research seems inevitable.

Malingering

Symptom syndromes do not fit with our culturally accepted models of disease and ill health. Without objective signs of ill health there remains the possibility that the patients veracity will be doubted. There are no proven methods of detection of malingering. Many commentators thought it important to emphasize that there was a genuine distinction (established in law) to be made between exaggeration to deceive and exaggeration to convince.

One speaker suggested that symptom magnification was a habit that could be established over a whole lifetime. Evidence of overreaction to illness in childhood could be used to cast doubt on the interpretation of self-reported symptoms. Symptom magnifiers may be unaware of the normal levels of pain and discomfort that are experienced by an uncomplaining majority.

Comment

Diligence and long – term maintenance of commitments (occupational and social) have in the past proved persuasive of the honesty of the claimant. It is likely that such evidence will continue to be advanced to this end.

Evidence of emotional insecurity, continuing grievance and illness behavior post accident will undermine any case for permanent incapacity. It may well be that an award in these circumstances would be made for past loss only.

It would seem unlikely in these circumstances that joint experts will be appointed for FM cases. Litigation involving FM is rare and precedents are few.

Treatment

The biopsychosocial model of chronic pain conditions very strongly suggests that ill advised care which has the effect of maintaining a disease (pathology) model can have the effect of unnecessarily perpetuating or aggravating the condition. The same model suggests a cognitive behavioral therapy (CBT) approach to treatment of disability associated with the syndrome. This approach has proved successful in returning people to normal function, while being less successful at eliminating pain.

CBT treatment for chronic back pain has proved highly successful in re-activating cases and getting people back to work or full time education. The cost may be as little as £1000 per case. In these cases it is found essential to assure patients that pain is not the same as evidence of harm or danger of aggravation.

The pathology model of chronic pain conditions requires (or at least implies a need for) biological interventions. Those biological therapies that are currently on the market include physical therapies, detoxification, sleep restoration (using strong medications), electrical nerve therapy and analgesia. Clinicians sometimes believe that selection of treatment should correlate with a diagnosed cause. It was widely agreed that whatever the treatment regime; treatments should be for a defined course only, before review. Endless therapy with no improvement would increase patient anxiety, and dependency.

Variability of symptoms is a major problem for re-employment of FM cases.

Comment

Proponents of biological therapies tend to be certain that the problem is pathological.

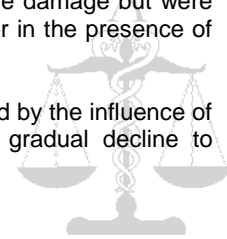
In the absence of a cure, the sensible option would seem to be to aim for symptom relief and restoration of function.

There should be an onus put onto case managers to show that continued treatment is justified.

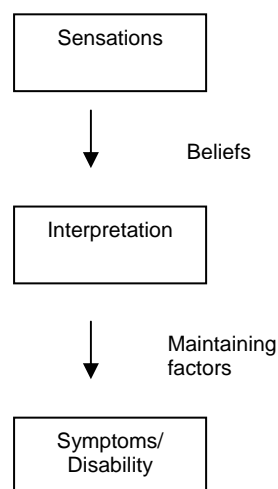
Pathogenesis

Evidence of neurological mechanisms for the generation of chronic pain states was argued. The argument allowed that such states could originate with or without any form of tissue damage but were more likely to occur if tissues (especially nerve tissues) were physically damaged or in the presence of psychological distress, acting through the central nervous system.

The biopsychosocial model allows physical or purely psychological initiation, followed by the influence of internal and external contextual factors, which both aggravate and maintain a gradual decline to chronicity.



Both mechanisms allow interaction between mind and body.



Comment

It is claimed that CNS sensitisation or “wind-up” should occur within hours or days of the initiating event. Proponents of this model of pathogenesis find it difficult to explain delayed FM (i.e. FM that manifests months after the alleged causative event). They allow the possibility that wind-up could be a more gradual process than is observed in the laboratory but would prefer to find that a second event must have occurred in the interim. Some would suggest that the stress of bringing a claim may be sufficient to count as a second event, others would suggest ongoing anxiety was sufficient. It may be easy to show a lack of proximity if manifestation is delayed by more than a few weeks. Delayed FM is more difficult for those who believe in an underlying pathology as the cause of FM.

Predisposition

There are few pre-event factors that can be strongly argued to indicate higher risk of developing an extreme reaction to a normally self-limiting injury or trauma. For whiplash related events, proposed factors include female gender, previous whiplash experience, previous neck pain, back pain and psychological illness.

In the biopsychosocial model, it would be the meaning of the event to the individual that would be important. To some extent personality type and social circumstances could predict this. For example, it would be unsurprising if high flying and dedicated employees were more affected by a perceived threat to career progression than someone in a steady job.

Predisposition to chronicity is perhaps better assessed a few weeks after the event in question. At this point, meaning can be more readily identified, as can the psychosocial indicators of chronicity. Anyone, who appears to be deteriorating at this point, should be thoroughly biopsychosocially assessed and treated. Such an intervention may even be economically viable even though a high rate of false positives would be encountered.

Comment

Predisposition to chronicity is much better understood in terms of factors that can be assessed immediately after an injury (or distressing) event. Psychosocial factors are referred to as yellow flags. These factors have been successfully deployed in the management of low back pain.

Social Comment

The conference largely concurred with the suggestion that our medical, legal and insurance systems have been effective in amplifying otherwise self-limiting injuries and shock. Suggested remedies to the systems included, proactive involvement of insurers, more personal interaction with legal advisors and improved training for all those involved in care giving.

Comment

A great deal of care is needed before embarking on such changes.

