The referral of patients with fibromyalgia to a rheumatological specialist care unit. Is it necessary?

Sirs,

Fibromyalgia (FM) is a prevalent disease which afflicts approximately 4% of the population, most frequently women (1). Chronic widespread pain (CWP) is the central symptom of FM, but the patients commonly experience a wealth of symptoms, such as depression, fatigue, sleep disturbances, abdominal pain and anxiety (2, 3). A recent study found that the diagnostic delay in FM was more than six years (4).

Although national guidelines frequently recommend that it is the general practitioner (GP) who should diagnose FM (5), patients typically consult several physicians in the years prior to diagnosis (1), and are frequently referred to a rheumatologist. In this letter we present a study which examined how frequently patients with suspected fibromyalgia are diagnosed with an alternative diagnosis after referral from a GP to a specialist rheumatology clinic.

A randomised controlled trial evaluating the effects of a community-based multicomponent rehabilitation programme for patients with FM recruited potential participants from general practitioners (6).

Participants were eligible for inclusion if they had suspected FM, were aged between 20 and 50 years, and had not been out of work or other full-time occupation for more than two years. All eligible participants were invited to an examination by a specialist rheumatologist (authors SAP or IJB). The 45-minute consultation consisted of a medical interview, followed by a clinical examination and a clinical ultrasonographic examination of selected joints and entheses. The patients were diagnosed with FM according to the 1990 and 2011 FM criteria (2, 7, 8). Patients were referred on to supplementary blood tests or radiological examinations when deemed necessary by the examining rheumatologist, and were also taken back for a follow-up examination when deemed necessary.

The study was approved by the Data Protection Officer at Diakonhjemmet Hospital and the Regional Ethical Committee of the South-Eastern Health Authority.

One hundred and eighty-eight patients were referred by their GP, the median age was 41.3, (IQR 34.2 to 46.7). 177 (94.2%) were female. Table I presents key findings from the referral letters and clinical examinations.

This letter presents a study showing a large level of agreement between GP and rheumatologist diagnosis of FM. None of the patients referred to the rheumatology outpatients clinic were diagnosed with an inflammatory joint disease (IJD), but there were two cases of arthritis/joint effusions that later resolved spontaneously. An MRI-scan of the iliosacral joints and/or axial skeleton was performed in 20 (11%) of patients, but no patients were subsequently diagnosed with spondyloarthritis.

Table I. Key-findings from the referral letters and clinical examinations.

Information in referral letter	Number **(%)**
Diagnosis of FM mentioned in letter	135 (71.8)
Mentions 1990 criteria in referral letter	21 (11.8)
Mentions 2011/6 criteria in referral letter	15 (8.0)
Results of consultation with rheumatologist number (%)	
Duration of symptoms (years, IQR)	5, 2.5 to 10.0
Patients diagnosed with FM according to 1990-criteria	149 (79.3)
Patients diagnosed with FM according to 2011-criteria	176 (93.6)
Eligible for study inclusion	147 (78.2)
Referred to additional conventional MRI scan of iliosacral joints or axial skeleton	22 (11.7)
Patient diagnosed with severe osteoarthritis	1 (0.5)
Patient diagnosed with joint effusion/ arthritis, but not given IJD diagnosis	2 (1.1)
Referred to other medical specialist	8 (4.3)
Referred to new check-up at clinic	8 (4.3)
Eligible but not willing/able to participate	33 (17.6)
Not qualified to participated (%), too old (4)/other medical condition (2)/did not fulfil FM-criteria (6)	27 (14.4)

FM: fibromyalgia; IQR: inter quartile range; MRI: magnetic resonance imaging; IJD: inflammatory joint disease.

There is general agreement that FM should be diagnosed by the GP (5,9). A large number of patients are however still referred to the rheumatologist specialist clinics to verify a diagnosis of FM (10,11). In this study the GPs were specifically invited to refer patients with suspected FM to the rheumatologist clinic, and in 135 (72%) of cases FM was mentioned as a possible or definite diagnosis in the referral letter. A study from 2003 reported FM in just 29% (18 out of 63) of patients referred to a rheumatologist with suspected FM (12). This figure had improved significantly by 2009 when a Canadian group reported that FM was confirmed in 70.9% (139 out of 196) of patients referred to a rheumatologist (13).

In contrast to the 1990-criteria (2), the 2011-criteria bases the diagnosis on self-reported number of painful areas in addition to the severity of key symptoms such as sleep disturbances and depression, and the FM diagnosis can thus be made without any specific rheumatological skills (7). It is important to consider rheumatological differential diagnosis, but our study confirms that the GPs are well qualified to make such considerations and this may contribute to reduce diagnostic delay.

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