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IMPA NEWS

THE OFFICIAL NEWS LETTER OF THE INDEPENDENT MEDICAL PRACTITIONERS ASSOCIATION

FROM THE PEN OF THE PRESIDENT. . .

Dear Colleagues,

First let me express my sincere and profound sorrow and sympathy for all those who died, injured and grieved by the April 21st bomb attacks at several churches and hotels on behalf of the IMPA.

As you are aware by now a few of our consultant family physicians have got together and forging ahead in the proposed project on the continuous morbidity registration of private primary care services in Sri Lanka. The project has been renamed to "Primary Care Morbidity Report System" (PCMRS). The background and the justification for the project has been discussed in the last newsletter. We are planning to implement the project in 2 phases for logistic reasons. In the first phase of the implementation of the project the emphasis will be on the research aspect with a view to establish the feasibility and to study the required information and communication technology (ICT) infrastructure. With the experience of the first phase we plan to execute the continuous morbidity registration of the private primary care services in Sri Lanka in the second stage of the project implementation.

We have identified the following organizations as stakeholders for this project. A project of this nature cannot be implemented without the support of this team. We plan to enlist the support of all these organizations and institutes for the recruitment of their membership who practice the private primary care level in Sri Lanka.

Recruitment of primary care physicians :

1. All IMPA members
2. All CGP members
3. SLMA members who are practicing at the primary care
4. GMOA members who are practicing at the primary care for any length of time
5. All the private hospital OPDs (get a list of emails of all the private hospitals
6. PGIM director
7. Board of Study of FM chairperson
8. PHSRC

I would continue the presentation of the project in next few newsletters as well. The whole purpose of this presentation is actually many-fold : First to make IMPA a vibrant research community (we have a pool of knowledge experts from various disciplines whose services and expertise cannot be allowed to wither in the course of time). Second to encourage more of our membership who can engage in similar exercises to do the same. Third the IMPA is invited and informed of many projects by many governmental and non governmental organizations with national interest and scope. It would be waste of resources and opportunity if we do not make use of these…….

INTELLECTUAL GROWTH SHOULD COMMENCE AT BIRTH AND CEASE ONLY AT DEATH - by Albert Einstein. Therefore let us not DIE….

Dr Ananda Perera

Editor - Dr A L P de S Seneviratne

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FIBROMYALGIA

A Case Study

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Mrs. HK 50 year old presented to the GP clinic with generalised body aches and pains in the last 4 months. She had pain over the neck, shoulders, upper arms, lower limbs, upper and lower back, chest, abdomen and lower limbs. There were no large or small joint involvement. The symptoms worsened towards evening. She also complained of awakening early in the morning and thereafter has difficulty in falling asleep. She felt tired. Her appetite was good and no change in weight. Though she had low mood, there was no other features to suggest a depressive illness. She had consulted several physicians and undergone number of tests.

No features to support thyroid dysfunction, Rheumatoid arthritis polymyalgia rheumatica. She was investigated with FBC, ESR, CRP, thyroid function tests which were normal. She had undergone a hysterectomy 3 years ago and has not been on HRT. She had been screened for CV risk factors.

She is married and has two grown up children. She has good family support and there were no relationship issues. One year ago her father-in-law for whom she had cared for about 18 years had committed suicide. He too had complained of similar symptoms for which the family had taken him to several doctors, however a diagnosis had not been made. This incident was a traumatic event in her life. This was the first time she had divulged this life event to a doctor. She had no features suggestive of Post Traumatic Stress Disorder.
She was unable to carry out her household chores due to her illness and the family members are very supportive. She is much concern about the illness and requests medicine to cure her symptoms.

Examination
She looked anxious. Not pale. No features suggestive of hypo/hyperthyroidism.
BMI - 29kg/m2
PR 80bpm, regular. BP 120/70mmHg
All joints were normal.
Tenderness over the arm and forearm.
Tender-points over the back of the chest and nape of neck.
A Diagnosis of Fibromyalgia was made.

Management
- Patient's illness and suffering was acknowledged and the likely diagnosis was explained.
- Offered to discuss with her family members.
- Both non-pharmacological management such as regular physical exercises, a healthy diet, relaxation techniques and pharmacological management options were discussed.
- She was prescribed simple analgesics, pregablin and Duloxetine 30mg DR daily. A review visit was fixed.

Discussion
Fibromyalgia (FM) is a complex chronic condition and is characterized by widespread pain (100%), fatigue (90%), sleep disturbances (90%), stiffness, cognitive disturbances, anxiety and depressive episodes. It may coexist and/or overlap with other conditions that involve central sensitivity such as chronic fatigue syndrome, irritable bowel syndrome, tension headache, irritable bladder syndrome or interstitial cystitis, and temporo-mandibular joint disorder. Age at presentation varies from 30-55 years and 80% of those diagnosed are women. This disorder negatively impacts physical and social functioning, quality of life, emotional well-being, relationships, daily activities and work life. FM is considered a central sensitivity syndrome resulting in a disordered processing of endogenous pain inhibitory system. This abnormal processing, transmission and modulation of the experience of pain produces augmented responses to noxious stimuli causing mechanical hyperalgesia. FM is a clinical diagnosis and is diagnosis of exclusion. Therefore physical conditions which could give a similar clinical picture should be included in the hypothesis and red flags should be actively searched for, to exclude serious diseases.

The diagnostic criteria have changed from requiring 11 or more out of 18 tender points to confirm the presence

Cont. on page 04

of chronic widespread pain, fatigue, unrefreshed sleep, and other somatic complaints.

Often the onset of symptoms to diagnosis can be long and frustrating for a patient.

2010 Acr Fibromyalgia Diagnostic Criteria

Criteria

A patient satisfies the diagnostic criteria for FMS if the following 3 conditions are met:

1. WPI ≥ 7 and 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.

Ascertainment

WPI:

Note the number of areas in which the patient has had pain over the past week (score will be between 0 and 19): left shoulder girdle, right shoulder girdle, left hip (buttock, trochanter), right hip (buttock, trochanter), left jaw, right jaw, upper back, lower back, left upper arm, right upper arm, left lower arm, right lower arm, left upper leg, right upper leg, left lower leg, right lower leg, neck, chest, abdomen.

SS scale score:

A. 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 or at a moderate level or both; 3, severe, pervasive, continuous, life-disturbing problems.

B. Considering somatic symptoms in general, indicate whether the patient has 0, no symptoms; 1, few symptoms; 2, a moderate number of symptoms; or 3, many symptoms.

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

FMS, fibromyalgia syndrome; WPI, widespread pain index; SS, symptom severity.

There is no definitive treatment for FM. However it is important to address the illness and the related co morbidities. Treatment plan in general practice should be a multidisciplinary, patient-centered, individualised and multimodal approach. These include disease education for the patient and family, life style changes, aerobic exercise, healthy diet, sleep hygiene, relaxation techniques, cognitive behavioral therapy, pharmacological therapies(eg, pregabalin, duloxetine, milnacipran) and alternative medicine based therapies. A stepwise treatment plan and a symptom based approach is recommended.

It is therefore important to assess the impact of fibromyalgia across multiple domains at diagnosis and then to work collaboratively in a patient-centered approach during follow-up sessions to develop and prioritize treatment goals with a focus on the areas most affected. Establishing treatment goals early will help to give structure for follow-up visits, enabling goals to be achieved. Validated assessment tools could be used to assess baseline health status and progress could be monitored over time.

As in other chronic diseases which require continuity of care, patient education and explanation is an important role in the management. Acknowledging the symptoms, confirming the diagnosis and describing the clinical symptoms has a positive impact on patients with FM. This alone may improve patient's symptoms and satisfaction. Patients feel reassured that their symptom have a cause. Patient education should include a brief explanation about FM, symptoms, treatment, prognosis and self-management options. Patients should be allowed to ask questions and clarify their doubts as this would help in understanding and acceptance of the disease. Time for patient education is limited in a busy GP clinic. Therefore use of patient education material - paper based and electronic forms would be helpful.

At the outset basic expectations of how the GP and patient will work together can help to establish efficient partnership and minimise frustration. Therefore details such as frequency of clinic visits, time allocation for each visit, prioritization of treatment goals, expected outcomes from treatment and long-term prognosis should be included in the consultation.

Multimodal Treatment Approach

No single treatment options targets all of the symptoms therefore a multimodal approach is recommended. Patient education, pharmacotherapy, and non-pharmacological therapies need to be integrated in the management plan. Multidisciplinary involvement as well as patient taking responsibility for self-management is needed. A proactive, patient-centered approach is required for effective management of FM and to achieve this GP should know their patients, available community resources and have a supportive network.

Pharmacological Therapies

The FDA has approved 3 medications for fibromyalgia namely pregabalin, duloxetine, and milnacipran. These drugs act on the central pain pathway and their mode of action differs. Other medications, such as tricyclic medications (eg, amitriptyline), gabapentin, tramadol, fluoxetine are also used for symptomatic management. Nonsteroidal anti-inflammatory agents and opioids may be used for pain management.

Cont. on page 05

Drugs	LoE	Dose	Comments
Amitriptyline	1A	10-50 mg	Frequent side effects
PREGABALIN	1A	150-450 mg	FDA-approved, Long-term efficacy
Duloxetine	1A	30-60 mg	FDA-approved, Long-term efficacy
Milnacipran	1A	25-200 mg	FDA-approved
Gabapentin	1B	1200-2400 mg	One large RCT
Fluoxetine	2A	20-60 mg	Three small RCT
Paroxetine	2B	20 mg	One large RCT
Tramadol	2B	50-300 mg	Two RCT Tramadol 150 mg + Paracetamol 1300 mg

IASP Pain: Clinical Updates Vol XVIII Issue 4 June 2010

Nonpharmacological Therapies

Regular aerobic exercises and strength training, sleep hygiene; CBT (problem solving, stress management, and self-control) heated pool therapy, relaxation , rehabilitation, physical therapy and ongoing patient education are some of the non-pharmacological therapies that are recommended.

Progress

The progress needs to be monitored as the pain and symptoms of FM fluctuates over time and this will help in focusing on self-management and motivate patients to adhere to the management plan. Questionnaires and assessment tools are available online and these could be used to monitor the progress.

Summary

Patient's illness and suffering was acknowledged and was not dismissed. Diagnosis was explained to the patient. Patient was educated about the condition, the prognosis. Patient was reassured that the condition would not lead to invalidism or shorten life span. However complete cure was also not possible. Goal of management was adaptation and that regular physical activity leads to adaptation was explained. GP offered to explain to the patient's husband as well. She was prescribed simple analgesics, pregablin and duloxetine. The GP assured of his availability and advised about doctor shopping and the importance of regular review. An appointment was given for review.

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Physical Activity Guidelines

Physical Activity Guidelines Advisory Committee of the US Dept. of Health and Human Services

The guidelines on physical activity were released in November 2018 by the Physical Activity Guidelines Advisory Committee of the USDHHS.

Age - and Condition - Related Recommendations

- Children aged 3-5 years: Should be physically active throughout the day to enhance growth and development.
- Children aged 6-17 years: Sixty minutes or more of moderate-to-vigorous physical activity per day.
- Adults: At least 150-300 minutes per week of moderate-intensity aerobic physical activity, OR 75-150 minutes per week of vigorous-intensity aerobic physical activity, OR an equivalent combination of moderate- and vigorous-intensity aerobic activity; muscle-strengthening activities should be performed on two or more days per week.
- Older adults: Multicomponent physical

Cont. on page 06

activity to include balance training, aerobic activity, and muscle-strengthening activity.

- Pregnant and postpartum women: At least 150 minutes of moderate-intensity aerobic activity weekly.

- Adults with chronic conditions or disabilities who are able: Follow key guidelines and perform both aerobic and muscle-strengthening activities.

- Sleep, Daily Functioning, and Mental Health

- Strong evidence demonstrates that moderate-to-vigorous physical activity improves sleep quality by decreasing the time it takes to fall asleep; it can also increase deep-sleep time and decrease daytime sleepiness.

- Single episodes of physical activity promote improvements in executive function, to include organization of daily activities and future planning. Cognition (ie, memory, processing speed, attention, academic performance) also can be improved with physical exercise.

- Regular physical activity reduces the risk of clinical depression, as well as reducing depressive symptoms and symptoms of anxiety.

- Strong evidence demonstrates regular physical activity improves perceived quality of life.

Risk of Diseases and Conditions

- Regular physical activity minimizes excessive weight gain, helps maintain weight within a healthy range, improves bone health, and prevents obesity, even in children as young as 3-5 years.

- In pregnant women, physical activity helps reduce excessive weight gain in pregnancy and helps reduce the risk of developing gestational diabetes and postpartum depression.

- Regular physical activity has been shown to improve cognitive function and to reduce the risk of dementia; falls and fall-related injuries; and cancers of the breast, esophagus, colon, bladder, lung, endometrium, kidney, and stomach. It also helps retard the progression of osteoarthritis, type 2 diabetes, and hypertension.

Promotion of Physical Activity

- School- and community-based programs can be effective.

- Environmental and policy changes should improve access to physical activity and support of physical activity behavior.

- Information and technology should be used to promote physical activity, to include activity monitors (eg, wearable devices), smartphone apps, computer-tailored printed material, and Internet-based programs for self-monitoring, message delivery, and support.

For more information, please go to Therapeutic Exercise.

Editor
Dr A L P de S Seneviratne

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