Understanding the Diagnosis and Treatment of Fibromyalgia: A New Approach

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Purpose

Fibromyalgia (FM) is a complex, multifaceted disorder currently affecting between 2% and 4% of the United States (U.S.) population. While some practitioners view FM as a distinct chronic pain condition, other clinicians have difficulty accepting FM as a valid medical disorder. Although the American College of Rheumatology (ACR) guidelines provide researchers with a standardized diagnostic approach, not all physicians apply the ACR criteria uniformly. Therapeutic recommendations from the American Pain Society (APS) and the European League against Rheumatism (EULAR) are contradictory, and there is evidence to suggest that some physicians utilize clinical experience rather than practice guidelines when developing treatment regimens for the FM patients. The condition's complexity and clinical ambiguity impacts how primary care physicians (PCPs) diagnose, treat, and manage their FM patients. Thus, many PCPs may feel uncomfortable with their ability to accurately assess, treat, and manage FM patients. Through the primary research, we wanted to understand how physicians diagnose, treat and manage FM patients.

Given these therapeutic expectations, the lack of diagnostic and treatment consensus, the diversity of patient symptoms, and the variability of practice environments, there may be significant differences in how PCPs diagnose, treat, and manage FM patients that could be deemed more "efficient". Thus, another objective was to identify segments of physicians who are more "efficient" in their approach to FM care compared to others.

Method

The research design utilized a mixed-methods approach with the goals of both quantifying and exploring physician perceptions, beliefs, and real-world practice patterns. 14 semi-structured focus groups were conducted among 94 private practice PCPs in seven U.S. cities. In addition, physicians were asked to complete a 15 to 25 minutes survey while they wait for the focus group to begin. Participating physicians were recruited by a central agency, based within a single chain of focus group facilities (Fieldwork, Inc.) that also hosted the group discussions. The survey included a set of closed-ended questions on practice and patient characteristics and office visits as they related to (1) confirming a diagnosis of FM; (2) differential diagnoses; (3) treatment; and (4) outcomes. Survey data was entered and analyzed using SPSS version 15.0.

In this study, we combined the concepts of resource use and quality in our definition of PCP efficiency. A PCP was deemed "efficient" based on their reported ability to find the "right" FM treatment plan for 50% or more of their FM patients in < four office visits post FM diagnosis, with the "right" treatment defined as that resulting in patients achieving a quality of life they deem as acceptable, and post-hoc, yielding two PCP sub-groups: FM-Efficient (FME) PCPs (n=40) and FM-Usual Care (FMUC) PCPs (n=54), based on the number of office visits needed to diagnose FM and patients' clinical outcomes as reported by physicians.

Results

Analysis revealed that there were two distinct sub-groups of PCPs in terms of their reported ability to achieve an acceptable quality of life for their FM patients in a relatively short number of office visits post-
FM diagnosis (FME-PCPs, 68% of patients; FMUC-PCPs, 28% of patients, p<0.01). Compared to FMUC-PCPs, FME-PCPs reported fewer visits to identify the “right” treatment (FME, 3.8 visits; FMUC-PCPs, 4.6 visits (p<0.05)), converting into quicker treatment initiation (FME, 65 minutes; FMUC, 89 minutes, p<0.05). Qualitative analysis also supported these numerical findings and revealed differing PCP approaches and attitudes between segments.

No statistically significant differences were observed between the two PCP sub-groups for specific physician or practice characteristics measured in the survey. Physician cohorts’ years of practice, percentage of direct patient care time (FME, 18 years, 97%; FMUC-PCP, 20 years, 96%), and monthly FM patient caseload, 5.1% (FME) and 4.7% (FMUC) were similar.

Conclusions

Our hybrid research design permitted data capture that suggests that “efficient” practices exist in the care of FM patients. “Efficient” PCPs report being able to confirm FM diagnosis and identify the “right” treatment faster, and consistently improve clinical outcomes for a significantly higher proportion of their patients. Fewer office visits required for diagnosis and treatment planning has direct and indirect financial implications for physician practices and managed care organizations. PCPs can also maximize their opportunity costs, defined by their ability to spend more time with additional patients or on necessary administrative tasks instead of conducting lengthy FM visits.