

## **Fibromyalgia: The Rodney Dangerfield of Medical Diagnoses “I don’t get no respect.”**

### **Introduction**

---

If you are in the business of representing injured parties, whether those clients come to you through automobile collision cases, workers compensation claims, or medical malpractice claims, you have probably dealt with or will soon deal with the controversial diagnosis of fibromyalgia. Like Rodney Dangerfield, fibromyalgia for many years “got no respect.” Despite over a decade of investigation, research, and news reports, fibromyalgia continues to be a source of both medical and legal controversy. Since there are no apparent causes of the illness, as well as no objective or visible signs of the disease, many doctors either challenge its existence or dismiss the fibromyalgia sufferer’s symptoms as merely psychosomatic.<sup>1</sup>

The continuing debate over fibromyalgia syndrome’s existence in the medical community makes those claims difficult to litigate.<sup>2</sup> The essential missing link when dealing with fibromyalgia, whether as a physician trying to treat it or as an attorney trying to litigate a case, is a conclusive diagnostic test.<sup>3</sup> Currently there is no one such test and as with most injury cases, a successful claim depends largely upon a clear medical diagnosis. For this reason, fibromyalgia cases can be problematic since medical testing including blood tests, X-rays, endoscopic examinations, and biopsies result in negative or inconclusive results, leaving most doctors to make general assumptions about the sufferer’s psychiatric health, which only further disables the patient. In light of these difficulties, courts and juries are reluctant to provide favorable verdicts to plaintiffs who claim fibromyalgia symptoms as a result of accidents or injuries.<sup>4</sup>

Workers compensation and social security claims involving fibromyalgia are equally as difficult to prove, since documentation of the existence of the illness and the degree of disability are essential to a successful claim.<sup>5</sup> While some fibromyalgia workers compensation claims have been successfully litigated, the plaintiffs are often denied temporary disability or impairment awards due to the continual inconsistencies in medical testimony regarding the recognition and existence of the illness. For these reasons, it is essential that counsel representing this class of plaintiffs understands fibromyalgia.<sup>6</sup>

Formally recognized as an illness by the American College of Rheumatology in 1990<sup>7</sup> and as a disabling condition by Ruling 99-2p by the Social Security Administration in 1999<sup>8</sup>, fibromyalgia syndrome is a complex, puzzling medical condition that afflicts at least 5 million U.S. residents – approximately 2% of the population.<sup>9</sup> It has been suggested that fibromyalgia syndrome may be the third most common rheumatic illness in the U.S.<sup>10</sup>, occurring seven times more often in women than in men.<sup>11</sup> Fibromyalgia occurs most frequently in women between the ages of 24 and 35 but may afflict patients between the ages of 20 and 55 and does not appear to be related to ethnicity.<sup>12</sup> An increased incidence of fibromyalgia has been reported in people who have relatives with the disorder, indicating that a genetic component may cause certain people to be more susceptible.<sup>13</sup> Fibromyalgia syndrome is characterized by chronic widespread pain, fatigue, sleep disturbance, stiffness, impaired memory and concentration, gastrointestinal problems, anxiety, and depression all of which can severely impact a sufferer's interpersonal relationships, work performance, and ability to enjoy life.<sup>14</sup>

Counsel for an injured party must keep in mind that fibromyalgia syndrome is generally divided into two categories: primary and secondary. Primary fibromyalgia syndrome is idiopathic, whereas secondary fibromyalgia occurs in association with underlying disorders such as ankylosing spondylitis, trauma, or surgery.<sup>15</sup> Post-traumatic fibromyalgia syndrome (PTFS) is a special category of secondary fibromyalgia.<sup>16</sup> Once PTFS or other forms of secondary fibromyalgia have appeared, however, they are no different than primary fibromyalgia in symptoms and treatment.<sup>17</sup>

### **Causes of Fibromyalgia Syndrome**

---

There is now a considerable body of research explaining what makes up fibromyalgia syndrome; however, there is still no consensus on the cause. Because not all physicians keep up with the latest medical research, it is possible to have a client whose physician has dismissed her complaints without considering a diagnosis of fibromyalgia syndrome. It is also likely that the defense will engage a doctor as an expert witness who denies that fibromyalgia syndrome exists for a defense medical examination. A knowledgeable attorney can, however, portray this doctor's testimony as unreliable and not current with the latest scientific knowledge.<sup>18</sup>

While the etiology of fibromyalgia remains unknown, early research suggested that fibromyalgia was basically a muscular disorder. One study reported that fibromyalgia patients had lower levels of the muscle-cell enzyme phosphocreatine and adenosine triphosphate (ATP). Such enzymes regulate the ebb and flow of calcium in muscle cells, an important component in their ability to contract and relax. If ATP levels are low, calcium is not pushed back into the cells and the muscle remains contracted.

Such abnormal enzyme levels could derive from signals in the brain, although some researchers have observed overly thickened capillaries in the muscle tissue of fibromyalgia patients which could produce lower enzyme levels as well as reduce the flow of oxygen-rich blood in the muscle tissue.<sup>19</sup>

Nevertheless most current research is showing that the cause of fibromyalgia may be rooted in the central nervous system or neuroendocrine abnormalities.<sup>20</sup> Fibromyalgia sufferers tend to have low levels of the neurotransmitter serotonin and its precursor tryptophan, an amino acid. (Neurotransmitters serve as chemical messengers in the brain.) Low levels of both of these chemicals are associated with depression and other symptoms of fibromyalgia including gastrointestinal distress, migraine headaches, and anxiety. Some experts believe that migraine headaches and fibromyalgia are related because of possible defects in the systems that regulate serotonin and another neurotransmitter, epinephrine.<sup>21</sup>

A variety of other factors have also been attributed to causing fibromyalgia including genetics, infections, connective tissue diseases, and trauma. Since the symptoms of fibromyalgia mimic other diseases such as lupus and rheumatoid arthritis, patients are often misdiagnosed. Fibromyalgia resembles a number of rheumatic disorders that are known as autoimmune disorders including rheumatoid arthritis and systemic lupus erythematosus and commonly the result is misdiagnosis of the patient. These diseases occur when a defective immune system produces factors known as autoantibodies, which attack proteins in the body's own tissue, mistaking them as foreign proteins. Recently researchers have identified certain autoantibodies in many fibromyalgia patients that affect neurologic and hormonal systems. Researchers are

currently looking closely at the possible triggers and the overlap between fibromyalgia and these and other unexplained medical conditions such as chronic fatigue and irritable bowel syndrome.<sup>22</sup>

Other experts believe that disturbed sleep patterns may be the original precipitating factor for many cases of fibromyalgia pain. In one study, volunteers who did not have fibromyalgia reported fibromyalgia-like pain after they had been subjected to disrupted deep sleep. Disturbed sleep appears to trigger factors in the immune system that cause inflammation and pain.<sup>23</sup>

Studies of hormonal, metabolic, and brain chemical activity in fibromyalgia patients have also shown a number of abnormalities. Brain scans of fibromyalgia patients have revealed reduced blood flow to certain regions of the brain related to pain sensation. Of particular interest to researchers are possible abnormalities in the brain system known as the hypothalamus-pituitary-adrenal gland axis, which controls important functions including growth, sleep, response to stress, and depression. One research target is the hormone somatomedin C (also called insulin-like growth factor), which is produced by the pituitary gland in the brain during deep sleep and is responsible for communicating information about pain-producing stimuli to the brain. Very high levels of somatomedin C have been detected in spinal fluid of fibromyalgia patients. Such increased levels may cause a heightened sensitivity for pain in such patients, who can experience pain even after mild muscular activity. This causes patients to reduce their physical activity which results in muscle weakness and leads to a perpetual loop of muscle atrophy and increasing pain with less and less physical exertion. Excess

somatomedin C may be due to a genetic defect or may be derived from early unhealthy sleep habits that over time cause hormonal and brain chemical imbalances.<sup>24</sup>

### **Post-Traumatic Fibromyalgia Syndrome**

---

The most severe form of secondary fibromyalgia syndrome, PTFS appears after an acute injury such as an automobile accident or a fall and is of the most interest to counsel representing injured parties. There is no medical difference between PTFS and fibromyalgia syndrome.<sup>25</sup> It is essential for an attorney representing a personal injury client to understand that PTFS may not develop immediately following the injury but may appear after several months. Once this form of secondary fibromyalgia syndrome has developed, it has all of the pain and other symptoms characteristic of primary fibromyalgia syndrome and it can be permanent and debilitating. PTFS may be caused by minute cellular changes that cause tender points to develop during the healing process which are ultimately expressed in secondary fibromyalgia syndrome. The microscopic changes are suspected to be the same as those of primary fibromyalgia syndrome and are essentially set in motion by the injury.<sup>26</sup>

Dr. Mark Pellegrino, a physician who also suffers from fibromyalgia syndrome, has stated injuries such as whiplash which are categorized by macroscopic trauma are often precursors to PTFS. There is usually no gross hemorrhage or swelling and there may not even be immediate pain if there is no major nerve damage. The injury, however, causes microscopic swelling or edema and hemorrhage due to disruption and tears of the muscle and ligament fibers. Then the microscopic damage causes irritation of the pain-mediating nerves and results in pain and spasms. At first, the patient's pain may be seen

only in tender points near the site of the injury; however, doctors who treat PTFS often observe that patients with regional PTFS may develop more generalization of their pain over time.<sup>27</sup>

The controlling study on secondary fibromyalgia, specifically PTFS, was conducted in 1997 at Ben Gurion University in Israel. In this study, Dr. Dan Buskila and his colleagues conducted a controlled study of 161 cases of traumatic injury to study the relationship between cervical spine injury and the development of secondary fibromyalgia syndrome. The study showed that secondary fibromyalgia syndrome was 13 times more frequent following neck injury than following lower extremity injury. One hundred and two patients with neck injury and 59 patients with leg fractures, the control group, were assessed for tenderness and the presence of fibromyalgia syndrome. Of the 102 patients with neck injuries, 74 were involved in traffic accidents and 67 of them fulfilled the classic “whiplash” criteria. A count of 18 tender points was conducted by palpation and tenderness thresholds were assessed by dolorimetry at 9 tender sites. All patients were interviewed about the presence and severity of neck and fibromyalgia related symptoms. Secondary fibromyalgia was diagnosed using the American College of Rheumatology 1990 criteria. Additional questions assessed measures of physical functioning and quality of life. Although no patient had chronic pain syndrome prior to the trauma, fibromyalgia syndrome was diagnosed following injury in almost 22% of the neck injury cases versus about 2% of the leg fracture cases. Almost all symptoms were more common and severe in the group with neck injury. Fibromyalgia was noted about 3 months after the trauma was sustained. Neck injury patients with fibromyalgia syndrome had more tenderness, more severe and prevalent symptom expression, and reported lower

quality of life and more impaired physical functioning than did those without fibromyalgia syndrome. In spite of the injury or the presence of fibromyalgia syndrome, all patients were employed at the time of examination.<sup>28</sup>

Dr. Buskila concluded that not only does trauma likely result in the onset of secondary fibromyalgia syndrome but also that injuries to some areas of the body are more likely to lead to the development of fibromyalgia syndrome than others. Trauma to the soft-tissue of the neck such as in whiplash injury may cause the development of secondary fibromyalgia syndrome more frequently than even a major trauma to the legs, such as fracture.

In another study conducted by Dr. Buskila and his colleagues at Ben Gurion University, 29 PTFS patients and 37 control subjects were assessed as to the diagnosis of fibromyalgia syndrome according to the American College of Rheumatology standards. As with the previous study mentioned, pain was measured with a dolorimeter. Fibromyalgia syndrome-related symptoms, quality of life, physical functioning, PTFS symptomatology, and psychiatric features were assessed by valid and reliable self-report inventories.

Results were similar to the previous study mentioned and showed that the prevalence of fibromyalgia syndrome in the PTFS group was 21% versus 0% in the control group. Furthermore, PTFS patients were more tender, reported more pain, lower quality of life, high functional impairment, and suffered more psychological distress than the control group.<sup>29</sup>

In a different study conducted between 1985 and 1989, Dr. Thomas Romano diagnosed PTFS in 14 patients, 11 women and 3 men, in his general rheumatology

practice. The average age for both sexes suffering from fibromyalgia was 37 and the vast majority of the patients seen in his clinic during this time were injured in automobile collisions. All the patients complained of fatigue, nonrestorative sleep, and an inability to work or perform activities of daily living. None of the patients had any symptoms of inflammatory arthritis and none of the symptoms they were suffering from were present prior to the collision. In addition, none of the 14 patients was thought to be suffering from any other active disease at the time of the collision and evaluation.

A careful tender point count was made on each patient and dolorimetry testing was conducted. In order to help distinguish between the malingerer and a patient who was truly in pain, and to avoid confusing fibromyalgia syndrome with other pain states such as psychogenic rheumatism, three control sites were tested in addition to the tender sites. All laboratory testing returned negative. Each of these patients was diagnosed as suffering from PTFS.

Dr. Romano counseled and treated each of these patients throughout the course of their respective injuries. The significant finding to his study in addition to the diagnosis of PTFS is the fact that 9 of the 14 (77%) patients diagnosed continued treatment in his office after receiving a cash settlement or cash award from a civil court. Only half of the patients were able to return to work.<sup>30</sup>

Similar results were found in a study completed by Drs. George Waylonis and Robert Perkins. They studied 176 individuals who had been diagnosed with PTFS between 1980 and 1990 and found through their study that the symptoms of PTFS do not disappear after litigation is complete. In fact, 85% of patients with fibromyalgia syndrome still have symptoms and physical evidence of their condition ten years later.<sup>31</sup>

The results of these studies are strong evidence of the existence of fibromyalgia syndrome and prove that the illness is real and can be permanently debilitating. What is also important to counsel for an injured party is the fact that the majority of patients will continue to need treatment for fibromyalgia into the future and many individuals will not be able to resume employment. These costs should be considered carefully and fully when litigating a fibromyalgia claim.

### **Effects of Fibromyalgia**

---

Fibromyalgia pain is severe and may cause chronic sometimes debilitating permanent muscle pain and fatigue.<sup>32</sup> The pain occurs in muscles as well as tendons, ligaments, and other soft tissue areas and is similar to the pain of arthritis; however, unlike arthritis, the joints themselves are not affected so they are not deformed nor do they deteriorate as they may in arthritic conditions.<sup>33</sup>

Fibromyalgia can affect the whole body or specific areas of the body. The pain typically originates in one area, usually the neck and shoulders, and then radiates out.<sup>34</sup> Most fibromyalgia patients report feeling some pain all the time and many describe it as “exhausting.” The pain can vary depending on the time of day, weather changes, physical activity, or the presence of stressful situations. It has been described as stiffness, burning, radiating, and aching. The pain is often more intense after disturbed sleep. Another major complaint is fatigue, which some patients report as being more debilitating than the pain. Fatigue and sleep disturbances are almost universal in patients with fibromyalgia and if these symptoms are not present then some experts believe that physicians should seek a diagnosis other than fibromyalgia.<sup>35</sup>

Between a quarter and a third of patients experience depression and disturbances in mood and concentration are very common. Significantly, Dr. Pellegrino determined that when fibromyalgia patients suffer from depression, it is more often found to be the result of fibromyalgia syndrome than the cause.<sup>36</sup> Fibromyalgia patients are also prone to tension and/or migraine headaches. Other symptoms include dizziness, tingling or numbness in the hands and feet, and gastrointestinal problems including irritable bowel syndrome with gas and alternating diarrhea and constipation. Some patients complain of urinary frequency caused by bladder spasms.<sup>37</sup>

A study conducted in 1994 by Chris Henriksson examined 56 patients with fibromyalgia who had been seen and treated for the disease 5 years earlier. A questionnaire was completed by each patient regarding their level of pain and what activities they participated in on a daily basis. Fifty percent of patients reported that their pain, fatigue, and sleep problems had increased over the five-year period. Less than 20% reported improvements and it is suspected in these cases that improvements were accomplished through adaptation to the limitations of the disease as opposed to lessening of the disease.

The study also reported that patients' leisure activities were extremely impacted by the disease and the patients reported higher scores than even sufferers of rheumatoid arthritis or chronic tension headaches. Patients were less active and spent more time in their homes than they had before developing fibromyalgia. Approximately 27% of patients used leisure time for rest and about 70% reported that they could not participate in the types of leisure activities that they wanted to. Eighty percent of patients also reported that the disease had adversely affected their relationships with friends and family

and over half the patients spent less time with friends than they had when they were well. More than 90% of fibromyalgia patients studied reported that household tasks took longer or they had to have help from other family members in performing the tasks or they had to adjust their demands by doing things such as buying prepared foods.<sup>38</sup>

## **Diagnosing Fibromyalgia**

---

In spite of increasing evidence that fibromyalgia is a physical disorder, there is no unequivocal objective method for diagnosing the problem. The American College of Rheumatology specifies that fibromyalgia's diagnosis is characterized by widespread, musculoskeletal pain for longer than three months in all four quadrants of the body, by an absence of other systemic disease that could be the cause of the pain, and by the presence of 11 of 18 designated tender points or points of extreme tenderness at characteristic locations on the body.<sup>39</sup> To be more specific, if applying 9 pounds of pressure causes severe pain in 11 of these spots, fibromyalgia is diagnosed according to the Fibromyalgia Association of Greater Washington, D.C.<sup>40</sup> These trigger points can be found in the following areas:

- **On the left or right side of the back of the neck, directly below the hairline;**
- **On the left or right side of the front of the neck, above the collar bone;**
- **On the left or right side of the chest, right below the collar bone;**
- **On the left or right side of the upper back, near where the neck and shoulder join;**
- **On the left or right side of the spine, in the upper back between the shoulder blades**

- **On the inside of either arm, where it bends at the elbow;**
- **On the left or right side of the lower back, right below the waist;**
- **On either side of the buttocks, right under the hip bones;**
- **On either knee cap.**<sup>41</sup>

Using such criteria is helpful in making a diagnosis of fibromyalgia, but is not completely reliable and misses about 10% of patients. Because the sensitivity of tender points may vary depending on the circumstances, a physician may re-check pressure points that did not respond the first time in patients who have other significant symptoms. Some experts believe that fibromyalgia can be diagnosed if as few as 8 to 10 tender points are identified but the patient also has at least three other relevant symptoms, including morning stiffness, fatigue, sleep disturbance, numbness or tingling in the hands and feet, or headache.<sup>42</sup>

A physician should always take a careful personal and family medical history, which would include a psychological profile and a history of any factors that might be indicative of disorders other than fibromyalgia, including recent weight change, physical injuries, infectious diseases, muscle weakness, rashes, and any instances of sexual, physical, or substance or alcohol abuse. The patient should report any drugs being taken, including vitamins and over-the-counter or herbal medications.

Any physical examination for fibromyalgia requires that the physician press firmly on all potential trigger points. It also includes scrutiny of nails, skin, mucous membranes, joints, spine, muscles, and bones to help rule out arthritis, thyroid disease, and other disorders.<sup>43</sup>

In most cases of fibromyalgia, laboratory tests tend to be normal. If they are abnormal, then other disorders should be suspected. Tests for specific diseases may be given if a family history or symptoms of other disorders are present. Sometimes blood tests, such as thyroid and liver function tests, blood count, tests of certain antibodies, and sedimentation rate, are recommended.<sup>44</sup> Follow-up psychological profile testing may be suggested if laboratory results do not indicate a specific disease.<sup>45</sup>

### **Treating Fibromyalgia**

---

There is treatment that can lessen the symptoms of fibromyalgia, but there is no cure. Most treatment is aimed at curing the sleep disorder that fibromyalgia syndrome causes. Most patients are also treated with a low-dose antidepressant to help them sleep and with some type of pain medication as well as an exercise program.<sup>46</sup>

Experts recommend a multi-faced approach for treating fibromyalgia patients that involves exercise to reduce pain and strengthen muscles, regular sleep routines, drug therapies to improve sleep and other symptoms, and psychological tools for coping with emotional disorders caused by the disease and for reducing stress that can exacerbate pain.<sup>47</sup>

One study compared three treatment options, biofeedback and relaxation techniques, exercise, and a combination of the two, with a passive educational approach used as a control. After two years, the combination approach proved to be the most effective and the passive control approach was the least effective.<sup>48</sup>

Another study found that interdisciplinary treatment programs were effective in significantly improving pain in 42% of patients. Improvements in pain and other

symptoms, including depression and sense of physical capability, persisted for at least six months although patients tended to become fatigued.<sup>49</sup>

Many studies have indicated that exercise is the most effective component in managing fibromyalgia. Patients must expect to undergo a long-term exercise program. Some patients of fibromyalgia avoid exercise for fear it will exacerbate pain. According to studies, however, any pain caused by exercising subsides within 30 minutes. Physical activity prevents muscle atrophy, increases the sense of well-being, and over time reduces fatigue and pain itself. Regular low-impact aerobic exercises are the most helpful for raising the pain threshold, although it may take months to perceive benefits. A very gradual incremental program of activity, beginning with mild exercise and building over time is important. Patients who attempt strenuous exercise too early actually experience an increase in pain and are likely to become discouraged and quit.<sup>50</sup>

Stretching techniques are another important pain reduction tool for your client. Much of the pain experienced by fibromyalgia patients occurs when muscles join tendons or bones, particularly when the muscles are stretched. Stretching, or flexibility exercises, are part of the warm-up and cool-down routines of any regular exercise program, but the stretching technique used for muscle relaxation and pain reduction must be performed by a person other than the patient, usually a family member or close friend.<sup>51</sup>

Other techniques for managing the pain and symptoms of fibromyalgia syndrome are cognitive therapy, maintaining a healthy lifestyle through diet and regular sleep patterns, stress reduction techniques such as deep breathing and meditation, and massage therapy.

The effectiveness of the treatments tends to depend on how depressed the patients are, the sense of their own disability, and personal support networks. The severity of the pain at the start of treatment has little to do with outcome. Patients must realize that such therapies are prolonged and in some cases lifelong. They should not be discouraged by relapses. Enlisting family, partners, and close friends, particularly with exercise and stretching programs, and becoming involved with support groups of fellow patients are very helpful. Patients must have realistic expectations about the long-term outlook and their own individual capabilities. Improvement is subjective, and some patients are pleased with only a 10% reduction in pain and other symptoms.<sup>52</sup>

### **Determining Disability**

---

The American Medical Association (AMA) Guides to Permanent Impairment are used as a tool for rating permanent impairment in patients suffering from work-related or personal injuries.<sup>53</sup> They are the general standard by which physical impairment and disability is measured. When representing a party with fibromyalgia syndrome, counsel should make sure that the treating physician has kept careful records of the patient's illness so that an accurate disability diagnosis can be made according to the guidelines. The majority of fibromyalgia sufferers are permanently injured and many never return to work or enjoy the same quality of life as before their injury.

The AMA Guides provide physicians in all specialties with guidelines for evaluating a patient's qualification for disability benefits by converting medical information into numerical values.<sup>54</sup> Chapters of the AMA Guides focus on individual organs and systems and provide a description of the evaluative and diagnostic methods

for assessing certain impairments.<sup>55</sup> The impairments are assigned a rating as a percentage of loss of function for that organ or system and are later translated into impairment ratings for the whole person. Since the AMA Guides are used in over forty state workers compensation programs and provide a medically standardized and objective method for evaluating impairment, the presumption is that the ratings are unbiased, reliable, and highly scientific.<sup>56</sup>

When representing an injured client, counsel will want to stress to the treating physician that the standards of the AMA Guides may not completely reflect the patient's disability and that perceived and actual loss of function and quality of life should be considered in making the disability determination.<sup>57</sup> This way the physician will be more likely to provide a comprehensive, valid, reliable, unbiased and evidence-based determination of impairment which will more accurately reflect the fibromyalgia sufferer's true disability.

In a study concerning physical disability and quality of life in fibromyalgia sufferers, Dr. Robert Bennett and his colleagues had patients complete a Quality of Life Scale. The answers given by fibromyalgia patients were significantly lower than the control group who had no chronic illnesses. In fact, the fibromyalgia patients had lower scores than all other groups with the exception of those with diabetes and chronic obstructive pulmonary disease. These scores show that fibromyalgia patients are severely impacted by their disease and this should be stressed to the physician completing the impairment rating.<sup>58</sup>

### **Winning the Fibromyalgia Case**

---

Because fibromyalgia syndrome can take months or years to develop fully, counsel must be careful not to settle the matter too quickly in case the client begins to exhibit signs of fibromyalgia. Dr. Pellegrino has conducted research showing that often six months or more elapse between the onset of the trauma and a diagnosis of fibromyalgia syndrome. By the end of six months the major healing of soft-tissues, sprains, and other injuries will have occurred.<sup>59</sup> Clients diagnosed with fibromyalgia syndrome may also develop other conditions such as anxiety disorder, sleep disorder, irritable bowel syndrome, fatigue, and/or depression.

The primary obstacle to any claim for fibromyalgia is that unlike a broken bone or other objective injuries, pain cannot be seen.<sup>60</sup> To win a fibromyalgia claim, counsel must make sure that there is extensive medical documentation of the client's condition and records linking the plaintiff's symptoms to the American College of Rheumatology diagnostic guidelines.<sup>61</sup> Objective, clinical information is the best hope of a successful claim because without substantial objective evidence, a plaintiff's claim, and often a doctor's diagnosis, is viewed as one of speculation and conjecture.<sup>62</sup>

In the case of Cook v. Liberty Life Assurance Co. of Boston<sup>63</sup>, the court recognized the impossibility of the claimant presenting radiologic or laboratory proof of fibromyalgia. The court held that the plaintiff cannot be required to present laboratory proof as a condition of receiving benefits.

A similar case controlling in the Fourth Circuit is Westberry v. Gislaved Gummi.<sup>64</sup> Here the court states that a differential diagnosis, or differential etiology, is a standard scientific technique of identifying the cause of a medical problem by eliminating the likely causes until the most probable one is isolated. A reliable differential diagnosis is

typically performed after physical examinations, the taking of medical histories, and the review of clinical tests, including laboratory tests. It generally is accomplished by determining the cause for the patient's symptoms and then eliminating each of these potential causes until reaching one that cannot be ruled out and determining which of those that cannot be ruled out is most likely.

When considering future costs of living and future medical costs, counsel will want to keep in mind that the fibromyalgia client often faces a future of continuous medical treatment. In a study of 538 patients suffering who were observed for seven consecutive years, fibromyalgia patients averaged ten outpatient medical visits per year and used an average of three fibromyalgia related drugs.<sup>65</sup> The study found the average cost per patient in 1996 was \$2,274.00 with the major contributing costs associated with hospital admissions and drug treatments.<sup>66</sup> Often the combination of chronic pain and drugs such as anti-inflammatory medications, muscle relaxants, and anti-depressants cause additional symptoms such as irritable bladder and bowel syndrome to name a few.<sup>67</sup>

### **Author Biography**

---

John C. Shea has been in practice since 1977, focusing his practice exclusively in representation of the injured. Graduating from Wake Forest University in 1974 (Cum Laude), he received his J.D. in 1977 from the University of Richmond School of Law. He has been with Marks & Harrison since that time.

He is a member of:

- Virginia Trial Lawyers Association  
(President 2001-2002)
- American Board of Trial Advocates
- Voted one of the 2005-2006 *Best Lawyers in America*
- Virginia Bar Association
- Faculty of Virginia College of Trial Advocacy
- Southern Trial Lawyers Association  
(Board Member)
- Boyd-Graves Conference
- Fellow of the Roscoe Pound Institute
- Member of Arbitration Associates, Inc.
- Association of Trial Lawyers of America  
(Member of Advertising and Small Firm Committees)

### **Endnotes:**

---

<sup>1</sup> Salt, William B., II, M.D., et.al, *Fibromyalgia and the MindBodySpirit Connection*, note 1, at xvi (Parkview Publishing 2000).

<sup>2</sup> Id. at 246.

<sup>3</sup> Kelly, Earl, *Fibromyalgia*, The Daily Record (Baltimore, MD. Sept. 2, 2000).

<sup>4</sup> Connolly, Gene, *Hidden Illness, Chronic Pain: The Problems of Treatment and Recognition of Fibromyalgia in the Medical Community*, 5 DePaul J. Health Care L. 111 (Summer 2002).

<sup>5</sup> Salt, et.al., *supra*, note 1, at 249.

<sup>6</sup> Connolly, *supra*, at 112.

<sup>7</sup> Id. at 115.

---

<sup>8</sup> Skelly, Mari, et.al., *Alternative Treatments for Fibromyalgia and Chronic Fatigue Syndrome*, 219 (Hunter House Publishers 1999)

<sup>9</sup> Afram, Ruby, *NOTE: New Diagnoses and the ADA: A Case Study of Fibromyalgia and Multiple Chemical Sensitivity*, 4 Yale J. Health Pol'y L. & Ethics 85, 94 (Winter 2004).

<sup>10</sup> Romano, Thomas J., *Valid Complaints or Malingering? Clinical Experience with Post-Traumatic Fibromyalgia Syndrome* (7 March 2000). [www.immunesupport.com/fms\\_research/fma005txt.htm](http://www.immunesupport.com/fms_research/fma005txt.htm).

<sup>11</sup> American College of Rheumatology (2000). *Fibromyalgia*. [www.arthritis.org](http://www.arthritis.org).

<sup>12</sup> Salt, et.al., *supra*, note 1, at xiii.

<sup>13</sup> Buskila, Dan, et.al., *Familial Aggregation in the Fibromyalgia Syndrome*, 26 Seminars in Arthritis and Rheumatism 605-611 n.3 (1996).

<sup>14</sup> Salt, et.al., *supra*, note 1 at xv.

<sup>15</sup> Center for Physical Medicine & Pain Management, [www.treatingpain.com/pages/int\\_pain/fibromyalgia.html](http://www.treatingpain.com/pages/int_pain/fibromyalgia.html).

<sup>16</sup> Pellegrino, Mark J., M.D., *Understanding Post-Traumatic Fibromyalgia: A Medical Perspective*, Columbus, Ohio: Anadem Publishing, 1997.

<sup>17</sup> Center for Physical Medicine & Pain Management, *supra*.

<sup>18</sup> Pellegrino, *supra*, at 9.

<sup>19</sup> Center for Physical Medicine & Pain Management, *supra*.

<sup>20</sup> James, Melissa, *Fibromyalgia Research: Growing by Leaps and Bounds*, Arthritis Today, May 1989, 54.

<sup>21</sup> Center for Physical Medicine & Pain Management, *supra*.

<sup>22</sup> Id.

<sup>23</sup> Id.

<sup>24</sup> Id.

<sup>25</sup> Pellegrino, *supra*, at 9.

<sup>26</sup> Id. at 14.

<sup>27</sup> Id.

<sup>28</sup> Buskila, Dan, et.al., *Increased Rate of Fibromyalgia Following Cervical Spine Injury*, 40 Arthritis and Rheumatism 446-452 n.3 (March 1997).

<sup>29</sup> Buskila, Dan, et.al., *Posttraumatic Stress Disorder, Tenderness, and Fibromyalgia*, 42 J. Psychosom Res. 607-613 n.6 (June 1997).

<sup>30</sup> Romano, *supra*.

- 
- <sup>31</sup> Waylonis, George W., et.al., *Post-Traumatic Fibromyalgia*, American J. of Physical Medicine and Rehabilitation 408 (1994).
- <sup>32</sup> Connolley, *supra*, at 111.
- <sup>33</sup> Center for Physical Medicine & Pain Management, *supra*.
- <sup>34</sup> Pellegrino, *supra*.
- <sup>35</sup> Center for Physical Medicine & Pain Management, *supra*.
- <sup>36</sup> Pellegrino, *supra*, at 5.
- <sup>37</sup> Center for Physical Medicine & Pain Management, *supra*.
- <sup>38</sup> Henriksson, Chris, *Longterm Effects of Fibromyalgia on Everyday Life – A Study of 56 Patients*, 23 Scandinavian J. of Rheumatology 36-41 (1994).
- <sup>39</sup> *Carson v. Canada Life Assur.*, 28 Fed. Appx. 262, 263 (4th Cir. 2002).
- <sup>40</sup> Kelly, *supra*.
- <sup>41</sup> Wolfe, F., et.al., *The American College of Rheumatology 1990 Criteria for the Classification of Fibromyalgia: Report of the Multicenter Criteria Committee*, 33 Arthritis and Rheumatism 160-172 n.2 (1990).
- <sup>42</sup> Center for Physical Medicine & Pain Management, *supra*.
- <sup>43</sup> Center for Physical Medicine & Pain Management, *supra*.
- <sup>44</sup> Pellegrino, *supra*.
- <sup>45</sup> Center for Physical Medicine & Pain Management, *supra*.
- <sup>46</sup> Pellegrino, *supra*, at 82.
- <sup>47</sup> Center for Physical Medicine & Pain Management, *supra*.
- <sup>48</sup> Id.
- <sup>49</sup> Id.
- <sup>50</sup> Id.
- <sup>51</sup> Id.
- <sup>52</sup> Pellegrino, *supra*, at 82.
- <sup>53</sup> Spieler, Emily, et.al., *Recommendations to Guide Revision of the Guides to the Evaluation of Permanent Impairment*, 283 JAMA 519, 519-523 n.4 (2000).
- <sup>54</sup> Id.
- <sup>55</sup> Id. at 519.

---

<sup>56</sup> Id.

<sup>57</sup> Id. at 520.

<sup>58</sup> Bennett, Robert, *A Multidisciplinary Approach to Treating Fibromyalgia*, 393-410.

<sup>59</sup> Pellegrino, *supra*, at 14.

<sup>60</sup> Fisk, Margaret, *Six New Ways to Win*, National Law Journal (Dec. 3, 2001).

<sup>61</sup> Id.

<sup>62</sup> Connolly, *supra*, at 123; *see also Whaley v. Hardee's*, 912 S.W.2d 14, 16 (Ark. Ct. App. 1995).

<sup>63</sup> *Cook v. Liberty Life Assurance Co. of Boston*, 320 F.3d 11 (1st Cir. 2003).

<sup>64</sup> *Westberry v. Gislaved Gummi*, 178 F.3d 257 (4th Cir. 1999)

<sup>65</sup> Goldenberg, Don, *Fibromyalgia Syndrome a Decade Later: What Have We Learned?*, 159 Arch. Intern. Med. 777, 781 (1999).

<sup>66</sup> Id.

<sup>67</sup> Skelly, *supra*, at 17.