HOW TO TAME
FIBROMYALGIA

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PROLOGUE

AUTHOR'S BACKGROUND AND INTEREST

My initial training/certification was in Internal Medicine and Anesthesiology interrupted by a stint in the Army with an obligated tour in Viet Nam. This was followed by 17 years of clinical anesthesia and pain medicine practice. After Desert Storm (Army Reserves), I gradually shifted my practice to Medicine, occupational medicine and disability evaluation.

In 1995/6 I was struck by the recurring symptom patterns in chronic pain and disability patients. Many of these individuals, as well as a number of friends/associates with pain complaints, met criterion for the "recently defined" fibromyalgia syndrome.

Two thirds of my practice is in contract to the VA, performing comprehensive disability evaluations. Of the 1000+ new patients per year, 100 +/- fully meet the criterion for fibromyalgia.

The other third of my practice is treatment of work injuries. I see 350 +/- new injuries per year, among these are 25 +/- active fibromyalgics. In about half of these, the fibromyalgia is intertwined with the work injury and needs to be addressed for a timely resolution of the work injury.

Over the past three years I have evaluated over three hundred people who meet the ACR criterion of fibromyalgia. The more fibromyalgics I see, the less complicated the picture has become.

Fibromyalgics have a number of things in common besides widespread pain:

1. Most can identify heralding trauma(s) and/or a history of cumulative traumas.
2. All have identifiable on-going daily cumulative traumas that exceed their short-term recovery powers. These traumas are seemingly-innocuous, common physical and mental insults of daily living.
3. All have amplified pain perception to any and all noxious stimuli along with a decreased capacity to physiologically cope with ongoing traumas.

THE PURPOSE OF THIS PRESENTATION

It is the purpose of this presentation to demystify and simplify fibromyalgia.

Viewed as a cumulative trauma disorder, fibromyalgia can be understood and broken into key elements permitting formulation of successful management and control strategies.

A treatment approach based upon this cumulative trauma premise has rendered excellent results in this presenter's experience. However, I have no long-term tracking and no hard numbers.

This is a clinical presentation based upon my experience over the past five years. There is no research or clinical budget. For this premise and treatment approach to meet the scientific burden of proof will require a properly financed, prospective eighteen month study.

WHAT IS FIBROMYALGIA?

DEFINITION

Fibromyalgia is an idiopathic chronic pain disorder which is marked by disabling muscle pains, associated sleep dysfunction and multiple systemic symptoms. It is neither a specific disease, nor a diagnosis of exclusion. It is a clinical syndrome with similar physical and constitutional manifestations in its sufferers. There is no specific blood test, scan or purely objective measurement to confirm the diagnosis.

In 1990, a group of courageous and forward-looking Rheumatologists collaborated to establish criterion for the diagnosis and research of the muscle-pain syndrome previously called fibrositis, neuro-myasthenia, myofascitis, etc. They adopted the name, Fibromyalgia Syndrome.

The official American College of Rheumatology (ACR) diagnosis requires:

1. Chronic widespread myalgia (>3-6 months);
2. Demonstrable pain in at least 11 of 18 ACR designated tender areas, including axial, above and below the waist, and right and left sides; and,
3. Accompaniment of systemic manifestations which might include sleep dysfunction, cold intolerance, morning stiffness, chronic headaches, etc.

HISTORY

The syndrome or condition that is currently been given the name. Fibromyalgia has been present throughout the ages and across all cultures.

Year	Practitioner	Symptoms
440 BC	Hippocrates	regional and diffuse muscle pain
1783	Ramizziniz	muscle pain and fatigue with repetitive motion
1816	Balfour	British surgeon described widespread muscle/joint pains
1841	Velliex	muscular rheumatism and widespread tender points
1869	Beard	myelasthenia, neurasthenia
1904	Glowers	fibrositis, lumbago; "ladies of blameless habits and abstemious clergymen"
1915	Llewellyn & Jones	fibrositis, myofibrositis
1927	Albee	myofascitis, mimicry of other disorders
1942	Travell	myofascial trigger points, idiopathic myalgia
1977	Smythe and Modofsky	fibrositis syndrome
1981	Yunis	fibromyalgia
1990	American College of Rheumatology	defined disease (Wolfe, et al.)
1993	World Health Organization	recognition (#2 Rheumatology disorder)

WHO GETS FIBROMAYALGIA?

1. Almost anyone can get fibromyalgia. However, it is 5 to 10 times more frequent in women than men. It is usually presents in high-functioning, hard-driving, and over-achieving regular people. There is probably a hereditary vulnerability.
2. Population prevalence across cultures is reported between 2 and 8 percent. The US admits to about 2.5%.

VIEWS OF FIBROMYALGIA

THE GENERAL MEDICAL COMMUNITY'S VIEW OF FIBROMYALGIA

There is great variety of response: skepticism, disbelief, compassion, suspicion, frustration, irritation, avoidance, detachment, and even disdain.

Mainline explanations include: Growing pains, hysteria, or somatization. There is no specific treatment, but there are remedies that may help some. Fibromyalgia management usually centers on pain alleviation. Pain relievers and physical therapy are the predominant prescriptions.

Practitioners (who see this condition infrequently, who refuse to deal with it, or who don't get to know their patient's with the condition) often label fibromyalgia as a psychiatric condition and label those who treat it as "quacks."

"If we don't understand it and if we can't measure it or cure it with surgery or a pill, it doesn't exist in reality. Therefore the condition is in the mind, a mental disorder or the person is faking it."

THE LAY COMMUNITY'S VIEW

The lay community looks upon the disease with curiosity and fear. They may feel the sufferers must be exaggerating, or they are faking the pain.

THE FIBROMYALGIC'S VIEW

When the condition is active or hyper-active, the fibromyalgics hurt all over, all the time, without relief - 24 hours a day 7 days a week. They always have a smoldering pain which exacerbates and calms. They are afraid to talk about it. They are tired, don't get decent sleep, have diarrhea, lose social contact, are snowed by pain meds that don't work, don't want to go anywhere, can only accomplish tasks with the greatest concentration, try to mask their feelings, and wonder if they are crazy. They just "want to be normal." When the

condition calms a little, they proceed in fear until the next weather change or stress that exacerbates the condition again.

They usually don't look for help until they are totally "spent." By then, they are isolated, filled with fear, anger, blame, defense, denial, and masking. They are afraid to say anything because theirs is a condition shrouded in debate and confusion and people call them crazy. There is great frustration with the mainline health specialists and alternative medicine approaches are the only avenues to them.

HOW I VIEW IT

There're a lot of people out there with a diffuse muscle pain condition that is intense and persistent enough to compromise their daily lives. These are real and believable people who deserve to be heard and helped beyond just temporary pain alleviation.

These people have a real condition that can be generally understood and can be controlled by the individual, with education, guidance, behavioral modification and selected medical adjutants (selected individualized drugs, procedures, etc.) such that the condition has limited impact on the activities of daily living.

When the tools and necessary behaviors for the fibromyalgic to gain and maintain control can be identified, recommended and facilitated by an experienced, knowledgeable *healer*, only then, can the fibromyalgic secure and consistently apply the tools, knowledge and behavioral modifications that allow full control of the condition.

UNDERSTANDING FIBROMYALGIA

FIVE CONCEPTS

To understand fibromyalgia (FM), it is necessary to understand these five concepts:

I. Vulnerability

II. Cushion and Overload

III. Trigger and Enabler

IV. Active Fibromyalgia

V. Ownership

I. VULNERABILITY

There is an apparent increased vulnerability among certain persons toward development of fibromyalgia. Others, exposed to the same triggers, show no signs of the condition. Vulnerability (predisposition) appears to be familial with women more vulnerable than men. However, with enough trauma, virtually anyone can develop fibromyalgia. There are not significant cultural, ethnic, geographic, or generational predisposes or protectors.

II. COPING, CUSHION, OVERLOAD, OVERWHELM

People have varying capacities to cope with or cushion ongoing stress and trauma. An intact, healthy capacity allows multi-task coping without exhaustion. Each individual has a limited capacity for trauma which can be overwhelmed. When the coping mechanism is strained or maladaptive (e.g., during illness, severe mental or stress), marked sleep deprivation – capability (buffering, cushioning) is decreased and an individual can become chronically overwhelmed. Uninjured individuals, with normally resilient and untaxed restorative powers, continue to readily cope with the ongoing large and small traumas of daily life.

While some people can endure prolonged torture without "breaking," others are more easily overwhelmed. When the micro-traumas of daily tasks cumulate and neuro-muscular restoration (coping) cannot keep pace, even tiny traumas become noxious and cause pain. There is hypersensitivity to the slightest noxious (“hyperalgesia”) with normally non-noxious stimuli perceived as pain ("allodynia"). This is pain amplification. With coping mechanisms overwhelmed, “pain-begets-pain.”

Neuro-physiological and pharmacological equivalent for diminished "coping."

Chronic pain researchers have shown reproducible neuro-anatomical and biochemical changes from induced chronic pain in the nervous systems of animal-model experimentation.

With chronic pain, there is on-going hyper-stimulation of the nociceptors, anti-nociceptors, and dorsal horn cells, resulting in dendritic nerve remodeling with inhibition of the normal thalamic down regulation of pain stimulus transmission. The anti-nociceptive system is not allowed to recover, the inter-relationship between dorsal horn dendrites and the nociceptive and anti-nociceptive receptors doesn't recover.

There is nerve remodeling with dendritic new growth toward the thalamus. There is sympathetic nerve sprouting as well as crossing over of fibers between lamina in the spinal cord. Experimental over stimulation in animals can produce retrograde activation of nociceptors, nerve remodeling, dorsal horn hyper-excitability with the allodynia and hyperalgesia that is common to the chronic pain syndromes. This process can be halted and may be partially reversible.

III. TRIGGERS AND ENABLERS (T&E's)

Triggers. Fibromyalgia is started (triggered) by painful stimuli (traumas) which overwhelm an individual's physical and mental defenses or coping mechanisms.

In my view, fibromyalgia (FM) can be categorized by how it starts.

"Secondary" FM (10-30%) has a rapid (within three months) onset associated with a specific traumatic episode or event (macro trauma).

"Delayed-secondary" FM: (20-30%) onsets six months to several years after a traumatic episode or disease that leaves an ongoing, chronic measurable residual (i.e., whiplash, chronic inter-vertebral disc syndrome, rotator cuff injury, etc.).

"Primary" FM: (50% +/-) - also called "idiopathic" -- has a gradual onset without immediately obvious trigger(s). My experience suggests that multiple, chronic, cumulative micro-traumas are its usual trigger(s).

Enablers. Once activated, the global condition of active FM is kept active by ongoing irritations or traumas, which I dub enablers. Enablers are usually multiple. They may be ongoing residuals of macro-trauma triggers (i.e., whiplash, coccydynea, systemic diseases) or ongoing (micro) traumas (i.e., chronic sinusitis, repeated impact trauma, musculoskeletal dysfunction in the upper or lower extremities, positional sleep traumas, etc.).

IV. THE FIBROMYALGIA SYNDROME (FMS)

THE ULTIMATE CUMULATIVE TRAUMA OVERLOAD SYNDROME

Active fibromyalgia is manifest or hypersensitive (“hyperalgesia”) widespread myalgia with extreme sensitivity to the slightest noxious stimulus ("allodynia"). The FMS persists as a widespread neuro-muscular-spasm condition with "pain-begetting-pain." Living with fibromyalgia is like living in a “pain-amplification-chamber.”

I prefer to use "pain amplification" to express hyperalgesia and allodynia.

Fibromyalgia continues because of uninterrupted daily activity trauma amplification (DATA). Amplification of daily activities traumas continues to further injure and prevent recovery of the individual's normal coping responses. The fibromyalgic is unable to adequately blunt or cope with even small daily traumas. Until the enablers and the triggers are corralled, the fibromyalgic's diminished physical and/or mental coping mechanism (thalamic down-regulation) is overwhelmed.

V. OWNERSHIP - RESPONSIBILITY

Control of fibromyalgia is dependent upon the individual, not the health professional. Fibromyalgia cannot be turned off by some doctor, some special treatment, pill, diet or supplement from the outside. Tools for control are education (understanding), behavior modifications with removal of the T&E's, adjunctive medications, physical modalities, and emotional support. These tools can be made available to the fibromyalgic, however only the fibromyalgic can elect whether to employ them.

Fibromyalgia **can control** the individual when it is hyper-active. It becomes a dominant factor that limits home and employment activities, etc.

Fibromyalgia **may co-exist** within the individual when the individual has some *ownership* of the condition and can temporarily "shut-down" the condition (the echo or amplification effect) by willpower and concentration.

The fibromyalgic ***owns*** **the condition** when the individual can “turn-down," then "turn-off” the condition by removing the triggers and the DATA (daily activity trauma amplifiers) that keep it active.

TREATMENT (MANAGEMENT vs. TREATMENT)

THREE APPROACHES TO FIBROMYALGIA MANAGEMENT/TREATMENT

1. Remove factors of VULNERABILITY = ideal
2. Alleviation of pain and symptoms PAIN MANAGEMENT = the most common
3. Control and eliminate TRIGGERS and ENABLERS (T&E APPROACH) = most effective

REASONABLE GOALS FOR THE T&E APPROACH

A reasonable treatment goal is for eighty percent of fibromyalgics to attain and sustain eighty percent improvement within six months:

- Most can be calmed in a month, controlled in two months, and "owned" within four months.
- This is true provided there is:
    - A fibromyalgic whose primary agenda is to get rid of the condition;
    - A knowledgeable healer as a guide;
    - An individualized plan that is focused, comprehensive and coordinated;
    - An educable, fully-committed, co-operative, persistent patient (fibromyalgic);
    - The availability of modest and appropriate pharmacologic tools, orthotic devices, work-home modifications and physical medicine resources;
    - Cooperation and co-ordination of health care resources.

T&E APPROACH (CONTROL OF TRIGGERS AND ENABLERS)

For the *healer* to help tame fibromyalgia the following steps are necessary:

1. **Diagnosis**
2. **Patient selection**
3. **Education-based plan of attack: start with the 'Five Concepts'**
4. **Identify triggers and enablers**
5. **Draft solutions**
6. **Apply solutions to neutralize T&E's**
7. **Prevent reactivation**

1. DIAGNOSIS

According to the ACR: Strict diagnosis of fibromyalgia requires: (1) chronic, widespread myalgia (2) with pain in 11 of the 18 specified tender areas, including axial, right and left sides and above and below the waist, (3) and systemic manifestations, such as: sleep dysfunction, chronic headaches, IBS, numbness and tingling, etc.

Also, screening physical and labs should not suggest the presence of another organic condition with similar manifestations [must differentiate from inflammatory myositis, polymyalgia rheumatica and polymyositis, collagen vascular diseases, endcocrinopathies (esp. hyper-thyroid and hyper-parathyroid), malignancy with hypercalcemia, etc.]. If so, that condition must be addressed from the start.

Lab studies: Screening labs: CBC, ESR and CRP and CPK. Chemistries, to include: glucose, BUN, creatinine, electrolytes, calcium and phosphate, alkaline phosphatase, ALT, AST, thyroid function screen, ANA, and Rheumatoid Factor.

2. PATIENT SELECTION

Agenda, Attitude, Attention

A candidate for improvement:

- Doesn't *need* the condition or diagnosis for income, disability or other secondary gain;
- Is committed to self-control of the condition; ready to make behavioral change;
- Has realistic expectations, does not expect a magic pill or surgical or diet cure;
- Does not have a set, fixed agenda;
- Will use and continue successful adjunctive treatments, give up problem behaviors, and terminate overload activities.

3. EDUCATION

The patient and the healer must clearly understand that:

- It is the *healer's* role to diagnose, guide and assist, while
- It is the *patient's* role is to:
    - make the necessary behavioral modifications;
    - review and maintain the necessary treatment remedies;
    - discover other helpful/harmful factors and seek aid for remedies; and
    - secure/pay for necessary ancillary services, medicines and devices.

4. IDENTIFY TRIGGERS & ENABLERS (T&E's)

History: Review the common T&E's

Fully list the symptoms: uncover medical problems, orthopedic problems, underlying sinus or breathing problems, occupational and environmental conditions, foot problems, sleep behaviors, and other physical or psychological stressors.

Fully review home, work, sleep & recreational ergonomics.

Common discrete triggers are: Difficult pregnancy; whiplash; shoulder trauma; unstable back injury; non-healing fractures; arthropathies (i.e., osteoarthritis); and, acute psych stress (i.e., PTSD).

Common enablers and enabler-triggers are associated with: uncontrolled chronic sinusitis/rhinitis; injurious sleep position (stomach, flat-back, twisted); foot and shoe dysfunction impacting the lower body; repetitive impact loading at work, home or play; driving (stick-shift, stiff seat, pedal position); and, sitting (chair type, posture/equipment).

Physical: "Fibro-thorough" physical examination and observation.

This is of utmost importance. It requires different attentions, skills and understandings than those of the standard classical "physical exam." It is an exam of observation and listening. It should start and finish with the patient clothed in usual attire. It requires understanding and familiarity with ergonomics of daily living, myofascial triggers and systemic impacts of both.

i.e., Must observe the breathing style, watch for sniffles, and observe sitting postures, gait, shoes, clothing, worn areas on clothes, make-up, hair style, hands, fingernails and mannerisms. Must thoroughly examine the sinuses, the neck and shoulder muscles, the major body joints, the interscalenes, costo-vertebrals, myofascial areas of the shoulder

and, pectoral and forearm areas, the abdominal muscles, the hip and gluteal muscles, the knees, ankles and feet. Must subtly test 20 to 30 trigger areas and non-trigger areas.

5. DRAFT SOLUTIONS

To deal with the identified triggers and enablers (T&E's):

Behavioral Modifications - VERY, VERY IMPORTANT

- Alter approach to the task, habits, and culture.
- Give insight and suggest solutions. There is never only one answer.
- Exercise clinical skills, insert brain, and assign ownership.
- Examine sleep time and position, driving, travel, breathing, exercise, clothing, footwear, diet, music, makeup, and fashion.

Permanent Mechanical (Ergonomic) Changes

- Provide engineering and ergonomic solutions
- Give insight and suggest solutions. There is never only one answer.
- Look at shoes, orthoses, tools, automobile, chair, bedding, clothing, and exercise equipment.

Adjunctive/Supportive Therapy

Understand the role of each:

PERSONAL EQUIPMENT (Appendix iii)

Shoes, orthotics, CPAP, allergen control, squared pillows, bed pillow-tops, warm nightwear, recliner chair, vehicle selection, TheraCane, Jacuzzi, knee pads, ear plugs, home and personal office, equipment and tools.

PHARMACOLOGY- DRUGS (Appendix iv)

Allergy meds, nasal steroids, non-sedating antihistamines, tricyclics (Elavil), neuraleptics, nerve muffling/calming (Neurontin, baclofen), anxiolytics, SSRI's, analgesics.

PHYSICAL MEDICINE MODALITIES (Appendix v)

Selective and appropriate: physical therapy, chiropractic, massage, aqua-therapy, yoga, careful self-workout, daily loosening activities.

Physical Exercise Programs

This also is adjunctive, yet key in recovery and preventing recurrence.

Type and frequency (e.g., seven days per week, and at a certain time) are patient-related.

Utilize appropriate Specialists

Key to treat/resolve some triggers and important adjuncts to control/eliminate some enablers: Orthopedics, Chiropractic, ENT, Neurology, Rheumatology, Psychiatry, Allergy, Podiatry, GI, Neurosurgery, etc.

6. APPLY SOLUTIONS

- Behavioral modifications
- Mechanical changes
- Adjuncts (personal equipment, medicines, and physical medicine)
- Exercise
- Specialists

7. PREVENT RECURRENCE

- Guard against over-tasking: Fibromyalgia is a condition of “burn-out"
  - Identify and remove multi-stressors, cut activities, despite desire.
  - Ensure adequate sleep. Rest and sleep is the most important weapon.
- Keep using needed medicines, read early warning signs
- Repeatedly review the T&E solutions: adherence, adequacy, simplicity, and alternatives.
- Stay educated: learn from others, support groups, share solutions, and utilize on-line information.
- Build on strong points, especially concentration and enforced breaks.
- Don’t expect the magic pill or cure.
- Maintain routine daily fitness and mobility.

SUMMARY

Fibromyalgia is a chronic pain syndrome characterized by widespread muscle pain accompanied by various systemic dysfunctions. The fibromyalgic's coping mechanism for pain (thalamic down-regulation?) is severely compromised. It is a systemic condition of hyperalgesia and allodynia. Input is pain-amplified. Micro-traumas (tiny impacts or disruptions) encountered during the simplest activities of daily living are amplified and often overwhelm the fibromyalgic's capacity to cope.

The Fibromyalgia Syndrome's onset and continuance is profoundly dependent upon the daily living ergonomics, to include: breathing, sleeping, standing, walking, sitting, driving, etc.

To calm fibromyalgia remaining triggers and all the enabling daily micro-traumas must be identified and, then, eliminated or severely diminished. When the triggers and enablers are effectively neutralized, the fibromyalgic's coping capacity will replenish. When the coping mechanism is restored, pain amplification and the Fibromyalgia Syndrome will go dormant.

Control of fibromyalgia requires co-ordination of consultants and resources as well as the full commitment of the patient and resources. Activity management, with adherence to behavioral modifications, ergonomic improvements and medical treatment for underlying conditions are crucial to recovery and maintenance of recovery.

If fibromyalgia is approached and viewed as multi-sourced cumulative trauma disorder, it can be broken into its parts, simplified, understood and controlled.

The core of the Fibromyalgia Syndrome is daily-activity-trauma-amplification (DATA). The key to fibromyalgia treatment is down-regulation of DATA through behavioral modification and ergonomic re-adaptation in the basic activities of daily living. Appropriate application of selective pharmacologic agents, physical medicine and mobility enhancement are important adjuncts in treatment, but will not fix the condition in themselves.

RATE THE SEVERITY OF THE FIBROMYALGIA

Scores are based upon FUNCTIONAL condition 3-5 days/week, or 15-20 days/month

Global Score (Rate) is the overall condition. Separate ratings go with separate conditions.

(Function Level) SCORE: **A** through **F.**

Measurements of Useful Function	
Personal hygiene **Self-grooming** **Self-dressing** **Sleep, effectiveness** **Get out of bed** **Sexual function** **Self-feeding** **Cook and clean** **Communication, use of telephone** **Writing, computer usage** **Ambulation, walking several blocks** **Travel, ability to ride, use bus** **Operation of motor vehicle**	**Sitting one half hour** **Standing one half hour** **Climb flight of stairs** **Bending, stooping** **Lifting 10 pounds** **Tolerate outside weather** **Entertain, keep friendships** **Tolerate outside weather** **Age-related sports** **Ten hours of being awake** **Ability to successfully do work** **Ability to successfully recreate**

Fibromyalgia Activity Level	Level of Function	Impairment Classification	Pain Level
0 =A	No impairment is noted	No impairment = class 0	Global pain level 1-2
1+=B	Compatible with most useful functioning	Mild impairment = class 1	Global pain level 3-4
2+=C	Compatible with some, not all, useful functioning	Moderate impairment = class 2	Global pain level 5-6
3+=D	Significantly impedes useful functioning	Marked impairment = class 3	Global pain level 7-8
4+=E	Between D and F up only in seeking care	Housebound impairment = class 4	Global pain level 9-10
5+=F	Bedridden. Precludes useful functioning	Extreme impairment = class 5	Global pain level 11-12

Summary: Pain Level and Activity Level in Fibromyalgia						
1- Pain Level:	1 - 2	3 - 4	5 - 6	7 - 8	8 - 9	9 -10
Zero is absence of any pain, ten is the worst pain imaginable; it allows no function.						
2. FM Activity	0	(1+)	(2+)	(3+0)	(4+)	(5+)
Zero or "A" is without problems or impairment; (+) 5 or"F" means incapable of function or self-care.						
Score / Rate	**A**	**B**	**C**	**D**	**E**	**F**

Rating systems based upon the classic 1-10 pain scale and the Functional Impairment Classification due to Pain Disorders, Table 18-3, *AMA Guides to the Evaluation of Permanent Impairment*, Fifth Edition p. 575.

POINTS OF NOTE

- Ergonomics of the most basic activities in daily living play a pivotal role in fibromyalgia, and behavioral modification is vitally necessary to control fibromyalgia.
- Pain relief is pain alleviation, not treatment.
- It's not crazy people who get fibromyalgia. It is fibromyalgia that makes people crazy.
- One needs a clear airway; restorative sleep position; comfortable standing, sitting & driving positions; and unstressed neck-shoulder-arm usage to get rid of fibromyalgia.
- Fibromyalgia is a post-traumatic, ongoing cumulative-trauma disorder in persons who develop a diminished ability to cope with even the least obvious daily traumas. It can be successfully calmed or made dormant if:
    - The patient is a willing/motivated participant;
    - The physical traumas of daily living are identified and neutralized (by whatever means: behavior modification, orthoses, ergonomics, medications)
    - Any underlying major organic injury is repaired or controlled; and,
    - Supportive medical adjuncts are available and used (meds, physical medicine).
- People with work injuries and fibromyalgia get better. However, for the quickest, surest return to "pre-injury status," the underlying fibromyalgia triggers and enablers (T&A DATA) must be addressed and quieted along with treatment of the work injury component.
- The greatest aggravators that I see delay the fibromyalgic's recovery in the occupational medicine arena are:
    - Chronic allergic sinusitis/rhinitis;
    - Sleep position problems;
    - Stick-shift vehicle;
    - Uncorrected flexible pes planus;
    - Delayed or inadequate provision of ergonomic changes; and
    - Adversarial employer or co-worker attitude.

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