

A PATIENT WITH MEDICALLY UNEXPLAINED SYMPTOMS (MUS):

- Has unexplained symptoms after an appropriate assessment.
- May have been given one or more diagnoses that lack a well-defined disease explanation (e.g., idiopathic chronic fatigue, burning semen syndrome, diffuse pain syndrome, dysautonomia, hypoglycemia, multiple chemical sensitivities).

Definition for CFS (Chronic Fatigue Syndrome):

Clinically evaluated, unexplained, persistent or relapsing fatigue that is of new or definite onset; is not the result of ongoing exertion; is not alleviated by rest; and results in substantial reduction in previous levels of occupational, educational, social, or personal activities.

and

Four or more of the following symptoms that persist or reoccur during six or more consecutive months of illness and do not predate the fatigue:

- Self-reported impairment in short term memory or concentration
- Sore throat
- Tender cervical or axillary nodes
- Muscle pain
- Multi-joint pain without redness or swelling
- Headaches of a new pattern or severity
- Unrefreshing sleep (i.e., waking up feeling unrefreshed)
- Post-exertional malaise lasting >24 hours

Neurocognitive difficulties common in CFS/FM

- Forgetfulness
- Memory disturbance
- Problems with concentration

Sleep disturbances common in CFS

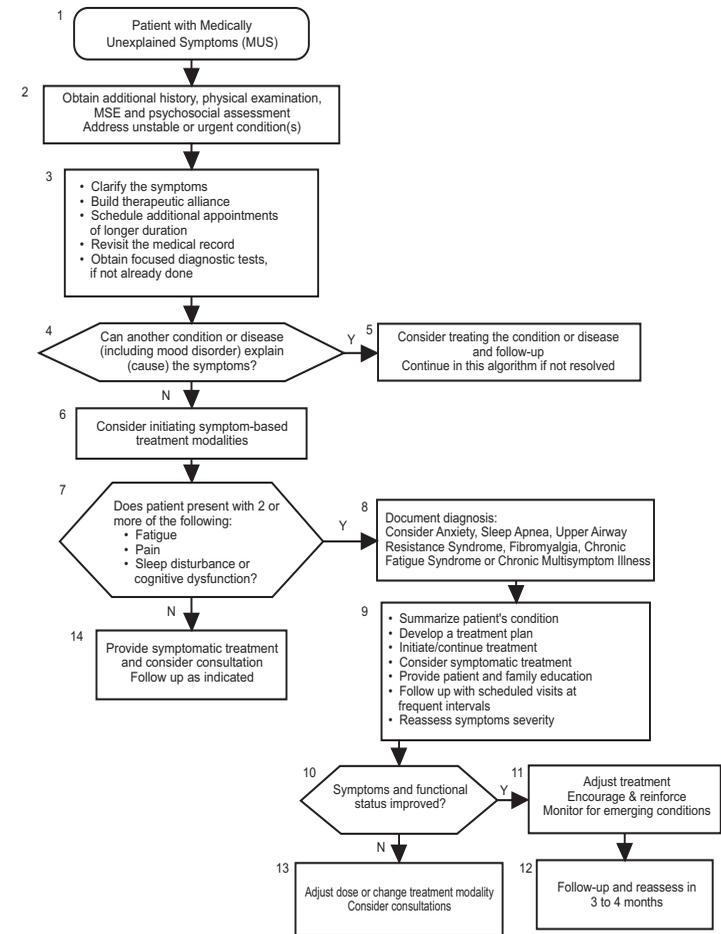
- Unrefreshing sleep that is characterized by:
 - Difficulty falling asleep
 - Frequent awakening
 - Abnormal limb movements (e.g., myoclonus)
 - Sleep Apnea (CFS present if sleep apnea treatment does not remedy fatigue)

HOW TO CHARACTERIZE SYMPTOMS

SYMPTOM ATTRIBUTES	QUESTIONS
Duration	<ul style="list-style-type: none"> • Has the symptom existed for days, weeks, or months? • Has the symptom occurred only intermittently? • Particularly with regard to pain and fatigue, can the patient define if these symptoms occurred only two or three days per month or constantly? • Is the symptom seasonal? • Are there times of the day when the symptom is worse?
Onset	<ul style="list-style-type: none"> • Can the patient recall exactly how the symptom began? • Were there triggering events, either physical or emotional? • Was the onset subtle and gradual, or dramatic and sudden? • Have the triggering events tended to be the same over time or are there changing patterns?
Location	<ul style="list-style-type: none"> • Is the symptom localized or diffuse? • Can the patient localize the symptom by pointing to it? • If the pain is diffuse, does it involve more than one body quadrant?
Co-morbidity	<ul style="list-style-type: none"> • Does the patient have any diagnosed co-existing illnesses? • What is the time relationship between the onset and severity of the co-existing illnesses and the symptoms of fatigue and/or pain? • What are the symptoms other than pain and/or fatigue? • Are there co-morbid diagnoses? • Are there changes in the patient's weight, mood, or diet?
Previous episodes	<ul style="list-style-type: none"> • If the symptoms are episodic, what is the pattern in regard to timing, intensity, triggering events, and response to any prior treatment?
Intensity and impact	<ul style="list-style-type: none"> • How severe are the symptoms (use the 1 to 10 Numerical Rating Scale [NRS])? • Ask the patient to describe any new limitations they have experienced compared to their usual life-style, including limitations in physical endurance or strength (e.g., climbing stairs, shopping, and amount or quality of their sleep).
Previous treatment and medications	<ul style="list-style-type: none"> • Exploring this aspect of the history may be complicated and require obtaining prior medical records, or having an authorized telephone conversation with the prior treating clinician. Ask the patient to bring in their medication bottles on a subsequent visit and document the exact names of the medications. Find out which medications have/have not been helpful.
Past medical, surgical and psychological history	<ul style="list-style-type: none"> • This area includes chronic and major acute illnesses and injuries, allergies, surgical procedures, and hospitalizations. The psychological history may take several visits to clarify, depending upon the ease with which the patient can articulate their emotional status and past and present issues. Explore stressors such as occupational and family issues.
Patient perception of symptoms	<ul style="list-style-type: none"> • Often omitted from the history-taking are questions designed to gain some understanding of what the patient believes is happening. Ask the patient about their hunches and fears.

VA/DoD Clinical Practice Guideline Management of Medically Unexplained Symptoms (MUS): Chronic Pain and Fatigue Pocket Guide

ASSESSMENT AND DIAGNOSIS



VA access to full guideline: <http://www.oqp.med.va.gov/cpg/cpg.htm>

DoD access to full guideline: <http://www.cs.amedd.army.mil/Qmc>

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Criteria for Fibromyalgia (ACR) Both criteria must be present for diagnosis:

- History of widespread pain of at least 3 months duration.

Definition. Pain is considered widespread when all of the following are present: pain in the left side of the body, pain in the right side of the body, pain above the waist, and pain below the waist. In addition, axial skeletal pain (cervical spine or anterior chest or thoracic spine or low back) must be present. In this definition, shoulder and buttock pain is considered as pain for each involved side. "Low back" pain is considered lower segment pain.
- Pain in 11 of 18 tender point sites on digital palpation (performed with an approximate force of 9 lb/4 kg).

Definition. Pain, on digital palpation, must be present in at least 11 of the following 18 sites:

- Occiput: Bilateral, at the suboccipital muscle insertions.
- Low cervical: bilateral, at the anterior aspects of the intertransverse spaces at C5-C7.
- Trapezius: bilateral, at the midpoint of the upper border.
- Supraspinatus: bilateral, at origins, above the scapula spine near the medial border.
- Second rib: bilateral, at the second costochondral junctions, just lateral to the junctions on upper surfaces.
- Lateral epicondyle: bilateral, 2 cm distal to the epicondyles.
- Gluteal: bilateral, in upper outer quadrants of buttocks in anterior fold of muscle.
- Greater trochanter: bilateral, posterior to the trochanteric prominence.
- Knee: bilateral, at the medial fat pad proximal to the joint line.

For a tender point to be considered "positive" the subject must state that the palpation was painful. "Tender is not to be considered 'painful'."

The presence of a second clinical disorder does not exclude the diagnosis of fibromyalgia.

Concurrent symptomatology is nearly universal and includes fatigue, headaches (both migraine and musculoskeletal), paresthesia, hearing /ocular/ vestibular complaints, cognitive difficulties (memory and concentration), "allergic" and chemical/photo sensitivity symptoms, non-cardiac chest pain, palpitations, dyspepsia, irritable bowel syndrome, chronic sinusitis, heartburn, irritable bladder, and affective /somatoform disorders..

ASSOCIATED SOMATIC SYMPTOMS	
Cardiovascular System <ul style="list-style-type: none"> Palpitations Raynaud's phenomenon 	Endocrine System <ul style="list-style-type: none"> Generalized fatigue Excessive sweating, localized or generalized Hypoglycemia (e.g., sudden severe hunger, headache, sudden anxiety, tremulousness/shakiness, sweating, confusion, and unconsciousness/coma) Dry skin Hair loss
Eyes, Ears, Nose & Throat <ul style="list-style-type: none"> Dry eyes Dry mouth Sore throat Sinusitis Rhinorrhea 	Musculoskeletal System <ul style="list-style-type: none"> Costochondritis Temporo-mandibular dysfunction Muscle spasms (including nocturnal myoclonia) Coccydynia
Respiratory System <ul style="list-style-type: none"> Asthma Dyspnea Cough 	Central Nervous System <ul style="list-style-type: none"> Disturbance of mood Chronic headaches, migraines Generalized dysesthesia (e.g., burning sensation, heat, numbness, chills, pins and needles, subjective sensation of swelling) Hypersensitivity to noise, odors and air conditioning Insomnia Tendency to drop things Tinnitus Double vision Balance problems and dizziness Dry eyes or excessive tearing
Digestive System <ul style="list-style-type: none"> Dry mouth Dysphagia (e.g., "lump" in the throat, difficulty swallowing, and sore throat) Dyspepsia Irritable bowel (diarrhea or constipation) 	
Genitourinary System <ul style="list-style-type: none"> Irregular menstrual cycles Dysmenorrhea Irritable bladder (urgency of urination) 	

BATHE TECHNIQUE
Provides a time-efficient way to address the impact of patients' symptoms on their level of function. <ul style="list-style-type: none"> Background: "What is going on in your life?" Affect: "How do you feel about it?" Trouble: "What troubles you the most about the situation?" Handle: "What helps you handle that?" Empathy: "This is a tough situation to be in. Anybody would feel (down, stressed, etc.). Your reaction makes sense to me."

For management of MUS, see Treatment Options Pocket Guide

Standardized Assessment and Reassessment of Symptoms

Track the patient's response to treatment using the following standardized assessments. Patients are asked to rate the intensity of their pain using the 0 to 10 Numeric Rating Scale (NRS) on which 0 equals no pain and 10 represents the worst possible pain. THE PROVIDER WOULD ASK:

- For pain:** "On a scale of zero to ten, where zero means no pain and ten equals the worst possible pain, what is your current pain level?"
- For symptoms other than pain:** "On a 0 to 10 scale, 0 being no (insert SYMPTOM) and 10 being (insert SYMPTOM) as bad as you can imagine, what number would you say your (insert SYMPTOM) has been over the past week?"
- For symptom impact:** "During the past week, how much have your symptoms interfered with your usual work, school or social activities, 0 being does not interfere at all and 10 being completely interferes?"

