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PHYSIOTHERAPY MANAGEMENT OF FIBROMYALGIA SYNDROME: A SURVEY OF CURRENT PRACTICE IN NORTHERN IRELAND

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ABSTRACT

The aim of this study was to identify physiotherapeutic management of patients with FMS in Northern Ireland. A self-completed postal questionnaire was distributed physiotherapists working outpatient settings in Northern Ireland (n=106). A response rate of 71% (n=75) was achieved. FMS patients featured in the caseloads of all respondents. The most important reported goal of treatment was to 'increase daily function' (n=24; 32%). Exercise (n=44; 58.7%) and hydrotherapy (n=12; 16%) were the most common treatment approaches. It was noteworthy that 45.3% (n=34) of respondents stated they did not believe they could adequately assess patients with FMS and 41.3% (n=31) reported that they had no training in the management of FMS. Private practitioners were significantly (p=0.05) more likely to believe physiotherapy was beneficial for patients with FMS than their NHS counterparts. Physiotherapy treatments for FMS in Northern Ireland are consistent with current evidence. However practice varies and physiotherapists are uncomfortable with their level training in FMS.

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Introduction

Fibromyalgia Syndrome (FMS) is a chronic muscular pain syndrome that is often accompanied by systemic symptoms such as excessive fatigue, non-restorative sleep, anxiety and depression (1). More specifically, The American College of Rheumatology (1990) classification criteria states that FMS can be diagnosed when there is at least a three-month history of widespread pain in conjunction with tenderness at a minimum of 11 of 18 specific musculoskeletal tender points (1). Fibromyalgia is not rare and has an estimated prevalence in the general population of 2%, but is more common among women (3.4%) than men (0.5%) (2). The impact of FMS on patients' quality of life can be as great as that of chronic rheumatoid arthritis (3) with long-term follow-up studies reporting little symptom change with time (4).

While it is recognised that physiotherapy plays a major role in the management of FMS (5) and such patients often feature in physiotherapists' caseloads (6), the nature of physiotherapy interventions employed and the extent to which they reflect best evidence is unknown. In the only identified work in the field, Sim and Adams (7) surveyed occupational therapists and physiotherapists working in UK Rheumatology settings (n=201). These authors reported that the most common interventions were endurance-based exercises and energy conservation techniques. The primary therapeutic objectives among therapists were to increase exercise tolerance, general fitness and functional ability. However, this survey has several limitations that hinder extrapolation to therapy practice in general. First, the analysis was based on a relatively small sub-sample who reported treating patients with FMS in the previous 12 months

(occupational therapists n = 38 and physiotherapists n = 35) and second, this survey has only been published in abstract form.

Given the lack of awareness of physiotherapy treatment of FMS, the primary aim of this study was to identify the current physiotherapeutic management of patients with FMS in Northern Ireland. Secondary aims were to identify (i) aims of treatment, (ii) clinical experience and (iii) training in the management of patients with FMS. Information regarding number and source of FMS patient referral was also sought.

Method

In June 2001, after obtaining ethical approval from the University of Ulster's Research Ethics Committee, a self-administered postal questionnaire that comprised both open and closed responses was constructed after discussion with clinical specialists in this area (n=4; appendix1). The questionnaire consisted of 22 questions and was sub-divided into five sections: i.e. (1) background information; (2) numbers and sources of referral; (3) assessment; (4) treatment and outcome; and (5) therapist views and opinions.

Pilot Study

An initial pilot study was conducted which aimed to assess the questionnaire in terms of its structure and content. Seven physiotherapists (private practitioners n=2, and NHS-based therapists n=5) were requested to complete and critique the questionnaire, which was then modified to improve its clarity.

Main Study

Physiotherapists working in outpatient settings (hospital, community and private practice) in Northern Ireland were eligible to participate in this study. Letters of invitation to participate were sent to 14 of the 15 physiotherapy managers in NHS settings in Northern Ireland. Nine managers responded and agreed to their staff taking part in the study. Those managers who did not respond were followed-up by telephone to identify reasons for non-participation.

Most recent figures indicate that there are approximately 160 physiotherapists working in NHS outpatient settings in Northern Ireland (Gracey et al. 8), therefore a total of 81

questionnaires were posted to participating departments with stamped addressed envelopes for return. Managers were asked to distribute the questionnaires among their physiotherapy outpatient staff. Twenty-five questionnaires were also distributed at a private practitioner's meeting in Northern Ireland in June 2001. Again, the questionnaires were distributed with stamped addressed envelops for ease of return. There are currently 80 private practitioners registered with the Organisation of Chartered Physiotherapists in Private Practice in Northern Ireland (OCPPP, the professional group that represents physiotherapists in private practice).

Data Analysis

Questionnaires were coded and entered into spreadsheets for analysis using Statistical Package for Social Sciences (SPSS version 9.0), data were analysed using descriptive statistics.

Results

Of the 106 questionnaires distributed, 75 were returned, yielding a response rate of 71%. Respondents represented therapists from a variety of outpatient settings; i.e. hospital 48% (n=36); community 34.7% (n=26); and private practice 17.3% (n=13). In follow-up telephone contact with non-participating units, a variety of reasons for non-participation were cited. Some managers indicated they had no recollection of receiving the questionnaire while some delegated responsibility to other staff where issues such as pressure of waiting lists and staff availability mitigated against participation in the survey.

Background Information

Table 1 demonstrates that respondents reported a range of experience and clinical grade. It can be seen that more than 85% (n=65) of respondents reported having at least 4 years physiotherapy experience, and that the majority (83%; n=52) of NHS therapists were either Senior II or I grade therapists. It is also noted that 41.3% (n=31) of respondents reported having no training (either undergraduate or postgraduate) in the management of FMS or chronic pain. Therapists who stated they had postgraduate training in FMS management reported either receiving this through in-service training (48.5%; n=17) or specific postgraduate courses (42.8%; n=15). A small number of therapists (8.6%; n=3) indicated that self-study constituted their postgraduate training in the management of FMS.

Insert Table 1 and Figure 1.

Patient referral

All respondents reported receiving at least one new referral per week for a patient with FMS, with 10.7% (n=8) of therapists receiving between two to five new FMS patient referrals per week. As illustrated in Figure 1 there was some variation in referral source according to practice setting; for community-based physiotherapists general practitioners (GPs) were the most common source of referral; hospital outpatient therapists, on the other hand, found that their patients were referred in roughly equal numbers by rheumatologists and GPs. Most private practitioners reported "self referral" to be the main source of referral (76.9%; n=10).

Assessment

Almost half, (45.3%; n=34), of respondents reported that they could not adequately assess patients with FMS. In an open response, 81.8% (n=27) of these respondents indicated reasons associated with the 'complexity of the condition' as the main barrier to adequate assessment.

Treatment and Outcome

Figure 2 illustrates that most therapists (68%; n=51) provided between five and eight treatment sessions for patients with FMS. Respondents identified a variety of "most important treatment goals " (figure 3) most commonly 'increasing daily function' or 'improving patient education'.

Insert Figures 2 and 3.

Respondents indicated that a range of treatment interventions were utilised with exercise-based interventions (exercise programmes and hydrotherapy) receiving most support among NHS-based therapists (Table 2). Additionally, passive treatment interventions such as massage and electrotherapy were utilised particularly by private practitioners compared to NHS-based therapists. However, there was no statistically significant between group differences with respect to the most common treatment intervention reported by therapists ($\chi^2 = 13.479$,df =12, p = 0.34).

Insert Table 2.

When questioned as to the perceived benefits of physiotherapy for patients suffering from FMS, 92.3% (n=11) of private practitioners deemed physiotherapy to be of benefit compared to 66.6% (n=24) of hospital outpatient physiotherapists and 46.1% (n=12) of community outpatient physiotherapists. This difference was significant at the 0.05 level ($\chi^2 = 5.953$,df = 2, p = 0.05).

Discussion

The principal aim of this study was to investigate the current physiotherapeutic management of patients with FMS in Northern Ireland. The results demonstrate that FMS commonly features on physiotherapists' caseloads and a range of treatment interventions are employed. A variety of treatment goals were identified and many physiotherapists were not comfortable in the assessment of patients with this complex condition.

While in this survey a high response rate of 71% (n=75) was obtained, it is important to note that this is the response rate from nine of 14 NHS physiotherapy departments in Northern Ireland and from 13 of the 25 private practitioners that agreed to participate. This might have resulted in an unrepresentative biased sample. However in a census type survey Gracey et al (8) reported that there were approximately 160 physiotherapists working in outpatient settings in Northern Ireland in 1996/7, and while this number may have increased slightly our sample represents approximately half of the physiotherapists working in NHS departments in Northern Ireland. Gracey et al (8) also reported that in their sample 71.8% of therapists described themselves as a senior physiotherapist, 80% of respondents had 3 or more years clinical experience, with 36% reporting more than 10 years experience. In our sample 57% were senior grade therapists, 86.7% had more than 4 years clinical experience and 65.3% reported more than 8 years clinical experience. It would appear that our sample is broadly similar to Gracey et al (8) in terms of clinical experience and seniority.

While there are 80 private practitioners registered with OCPPP in Northern Ireland, not all private practitioners are registered with this group. The total number of physiotherapists working in private practice in Northern Ireland is therefore unknown.

All therapists in this survey reported receiving at least one new FMS patient per week with 10% receiving up to five new patients per week. This represents a higher referral rate than suggested by Sim and Adams (7) where 90% of respondents reported receiving between one and five new FMS patient referrals per month. The higher referral rate reflected by our results may indicate an increased awareness of the condition among doctors in Northern Ireland or perhaps an increased awareness of the benefits of physiotherapy for these patients.

In this survey, the majority of therapists working in the NHS provided FMS patients with between five and eight treatments (68%). This finding is supported by Gracey et al (8) who reported that the median number of physiotherapy treatments for patients with low back pain in Northern Ireland was five.

One of the most striking findings of this study is that even though the vast majority of therapists had more than four years clinical experience, almost half did not believe that they could adequately assess patients with FMS. While 80% of therapists who reported difficulty with assessment cited reasons associated with the complexity of the condition, it should also be noted that more than 40% of all therapists reported having received no undergraduate or postgraduate training in the management of FMS. It is possible therefore, that limited training in FMS management also contributed to therapists' perceived difficulties in patient assessment. There is a clear need for

comprehensive evidence-based continuing professional development for therapists working in this area.

Another possible reason for therapist's perceived difficulties in assessing patients with FMS is that the physical and biomedical emphasis (9) of the physiotherapy assessment is inappropriate for this condition. A complex condition such as FMS may not easily fit into this biomedical model. Given that psychological problems such as distress, anxiety and depression are often associated with FMS (10) it would seem appropriate that patients with FMS are assessed within a bio-psycho-social paradigm (11). Indeed Watson[9] has highlighted the need for physiotherapists to address musculoskeletal pain within a bio-psycho-social framework, however the difficulties in achieving this cultural and philosophical shift should not be underestimated. Jones et al (12) have highlighted that physiotherapists have historically learned psychosocial assessment and patient management skills through personal experience. Whilst psychosocial influences and their effect on patients' problems are increasingly being made more explicit in manual therapy curricula (12), there is ongoing debate as to whether physiotherapists have adequate training to assess the psychological aspects of disease and illness (13). The difficulty in assessing patients with FMS is possibly an expression of that debate.

A number of recent systematic reviews (Adams & Sim, 14); Hadhazy et al.11) reported that there was little evidence for the effectiveness of commonly used physiotherapy interventions for FMS such as manual therapy or electrotherapy. However, these authors found that there was some evidence to support the use of aerobic exercise and patient education in FMS. For example Mannerkorpi et al (15) in comparing a combined education and pool based aerobic exercise programme (n=28)

with a control group (n=30) found that the intervention group improved significantly more than the control group as measured by, the Fibromyalgia Impact Questionnaire (FIQ) and the Six Minute Walk Test. However, the poor methodological quality of much of the fibromyalgia research has been highlighted and there is a need for appropriately powered and methodologically sound randomised controlled trials (RCTs) in this area.

Notwithstanding the need for further research it is noteworthy that an active management strategy (exercise programmes or hydrotherapy) was cited as the most commonly used treatment intervention by 80% of NHS-based therapists, and 46% of private practitioners. This is in agreement with the earlier work of Sim and Adams (7) who reported that an endurance-based exercise programme and energy conservation techniques were the most frequent intervention used by physiotherapists and occupational therapists in their survey.

It should be noted that the treatment frequency and intensity of exercise programmes reported in published RCTs are greater than the exercise interventions reported by therapists in this survey. For example, Martin et al (16) demonstrated a significant decrease in the number of tender points and the myalgic score of an exercise group compared to a control group using an exercise programme that consisted of six-weeks aerobic exercise for one hour three times per week; while Mannerkorpi et al's (15) pool-based exercise programme continued for six months. More recently Richards & Scott (17) demonstrated significant improvement in tender point count and self assessment of improvement in patients with FMS who undertook a 12 week graded aerobic exercise programme over a control group. These changes were maintained at

one-year follow up. The extent to which the shorter duration treatment interventions used in current clinical practice in Northern Ireland are as effective as those cited in previous studies needs further investigation in a pragmatic randomised controlled trail.

There is some evidence to support the use of shorter intervention programmes in the management of FMS. Worrel et al (18) reported a significant reduction of the impact of FMS on patients (n=100) and a reduction in pain severity scores (as measured by the Fibromyalgia Impact Questionnaire and the Multidimensional Pain Inventory) with a brief interdisciplinary programme (1.5 days) at the Mayo Clinic Rochester, USA. Unfortunately, the lack of a control group and a short 1-month follow-up period prevent definitive conclusions from being drawn.

White et al (19) have identified functional impairment as a major feature of FMS and improving patient function is an accepted primary treatment objective (20). Therefore, it is surprising that less than one third of respondents identified improving patient function as the most important treatment objective. The lack of consensus among therapists on the 'most important' treatment objective in FMS further highlights the fragmented nature of the physiotherapy approach to the management of this condition, which emphasises the need for further research in this field.

Physiotherapists working in private practice were significantly more likely ($p=0.05$) to report physiotherapy to be of benefit to patients with FMS compared to their colleagues based in either hospital or community physiotherapy departments. The different perceptions held by therapists may reflect different patient populations attending private or NHS physiotherapy. Patients attending private physiotherapy may

be more affluent or more motivated towards therapy than those patients attending NHS facilities (21). Alternatively the stronger belief in the benefits of physiotherapy for FMS patients held by private practitioners might reflect their own professional enthusiasm.

This survey had some shortcomings that may limit the extent to which the results can be generalised to the broader physiotherapy population. First, our sample is a sample of convenience that could have resulted in an unrepresentative biased sample of therapists being recruited for this survey. Also a limited number of private practitioners were included in the survey. It cannot be claimed that the group of private practitioners included in this survey is representative of the group generally in Northern Ireland.

Conclusions

This study represents the largest evaluation of the beliefs and practices of UK physiotherapists treating patients with FMS. Although the study is limited to Northern Ireland, it does give an indication of the current physiotherapy management of patients with FMS in the UK. FMS patients can present with complex and varied symptoms and it is not surprising that many therapists have difficulty with this condition, despite extensive clinical experience. This study highlights the need for more comprehensive training in the management of FMS and emphasises the need for further quality RCTs to identify the most effective treatment for patients with this challenging condition.

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Clinical Message.

- Patients with FMS commonly feature on physiotherapists caseloads.
- Physiotherapists commonly utilise exercise in the management of FMS but practice varies.
- Many physiotherapists are not confident in the assessment of patients with FMS.
- Private practitioners are more satisfied than their NHS colleagues with treatment outcomes in patients with FMS.
- There is a need for further research to identify effective management strategies for patients with FMS.

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Summary of Results

Table 1. Demographics of Sample (n=75)

1. Number of years clinical experience		
Years	n	Valid Percent
0-1	4	5.3
2-3	6	8.0
4-5	8	10.7
6-7	8	10.7
>8	49	65.3
2. Grade		
Junior	5	6.7
Senior II	22	29.3
Senior I	30	40
Superintendent	5	6.7
Private Practitioners	13	17.3
3. Training in FMS management		
Undergraduate	8	10.7
Postgraduate	36	48.0
No Training	31	41.3
	n = 75	100%

Table 2. Most Common Treatment Modality Used By Physiotherapists.

Modality	Hospital % (n=36)		Community % (n=26)		Private Practice % (n=13)	
		<rank order>		<rank order>		<rank order>
Exercise Programme	66.7	<1>	65.3	<1>	23	<1>
Hydrotherapy	13.9	<2>	15.4	<2>	23	<1>
Pain Management Programme	5.6	<3>	7.7	<3>	7.7	<3>
Heat/Manual Therapy	2.8		3.8		15.4	<2>
Massage	5.5		0		15.4	<2>
Electrotherapy	5.6	<3>	3.8		7.7	<3>
Acupuncture	0		3.8		7.7	<3>

Figure 1. Source of Patient Referral

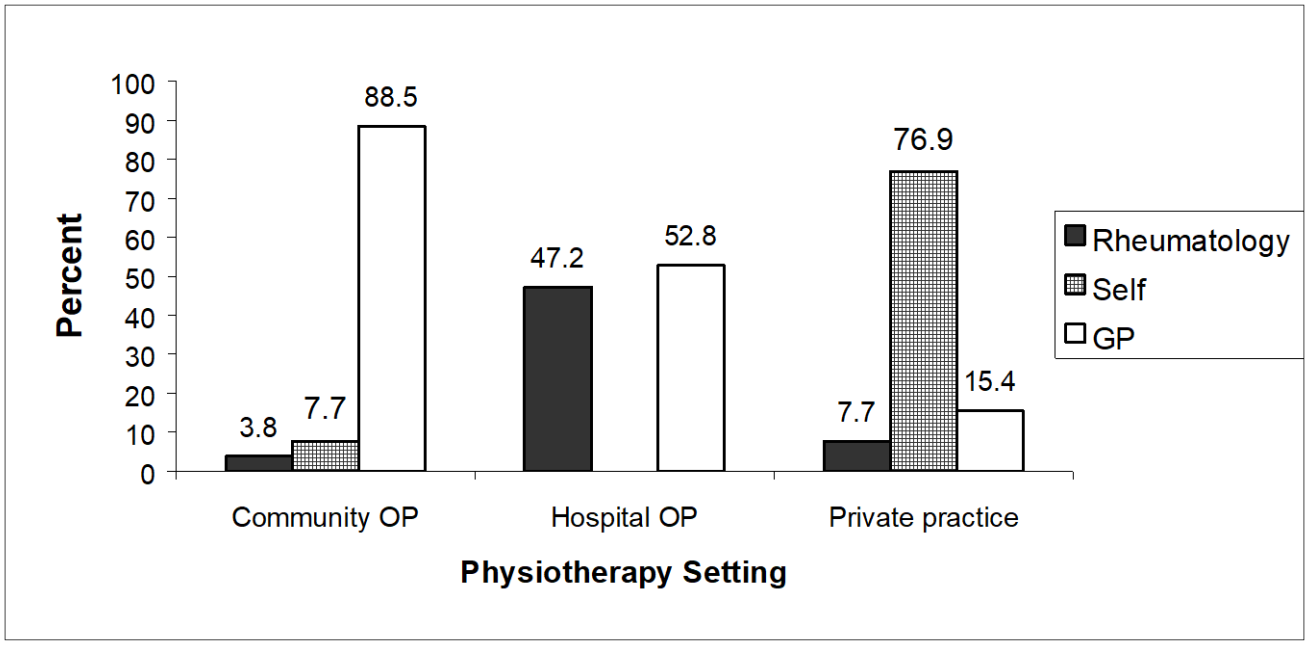


Figure 2. Number of Physiotherapy Sessions

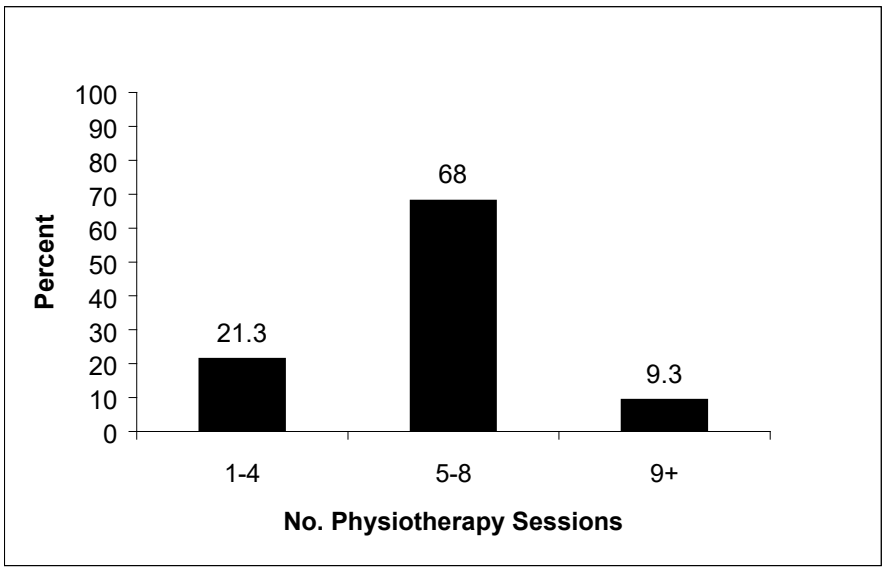
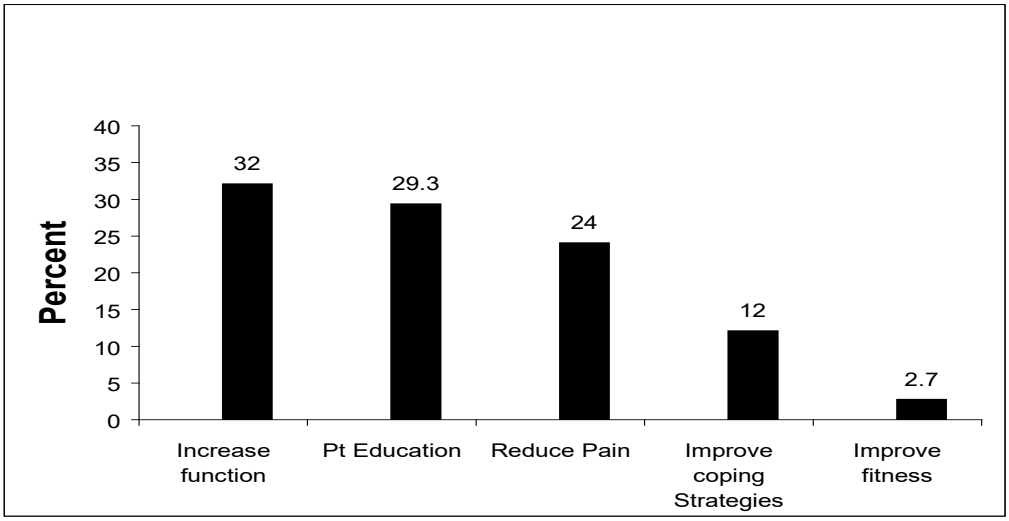


Figure 3. 'Most Important' Treatment Goal



Appendix 1.

FIBROMYALGIA QUESTIONNAIRE

The following questionnaire concerns the current outpatient physiotherapy management of fibromyalgia patients in Northern Ireland. It is entirely confidential and therefore it is requested that you do not use your name on any part of the questionnaire. **Thank you for taking the time to complete this questionnaire, your time is greatly appreciated.**

BACKGROUND INFORMATION

1. Sex:
   - MALE ☐
   - FEMALE ☐

2. If you work in a setting where you are clinically graded, please indicate your grade.

   (Please tick)
   - Basic Grade ☐
   - Senior II ☐
   - Senior I ☐
   - Superintendent ☐
   - Other (please state)_____

3. Number of years qualified –

   (Please tick)
   - 0 – 1 year ☐
   - 2 – 3 years ☐
   - 4 – 5 years ☐
   - 6 – 7 years ☐
   - 8+ years ☐

4. Number of years of outpatients experience –

   (Please tick)
   - 0 – 2 years ☐
   - 2 – 4 years ☐
   - 4 – 6 years ☐
   - 6 – 8 years ☐
   - 8+ years ☐

5. Please state any specific training you have had regarding the management of fibromyalgia or chronic pain training.

NONE ☐

UNDERGRADUAUTE ☐

POSTGRAGUATE ☐

If Postgraduate, please specify
(e.g. in-service or other) _____

NUMBERS AND SOURCES OF REFERRAL

6. On average, what percentage of your total caseload do you estimate is accounted for by patients with fibromyalgia.

(Please tick)

0 – 25% ☐

25 – 50% ☐

50 – 75% ☐

75%+ ☐

7. On average, how many **new** fibromyalgia patients do you assess per week?

(Please tick)

0 – 1 ☐

2 – 3 ☐

4 – 5 ☐

6 – 7 ☐

8+ ☐

8. Place in rank order the following sources of referral.
1 = the most common source of referral, 3 = the least common.

SOURCE OF REFERRAL	RANK
GENERAL PRACTITIONER	
RHEUMATOLOGY	
SELF	

ASSESSMENT

9. Do you use a specific assessment for patients with fibromyalgia?
   (Please tick)

   YES ☐

   NO ☐

10. If you answered NO to the question above, what do you use in the assessment of patients with fibromyalgia?
    (Please tick)

    McKenzie ☐

    Maitland ☐

    Cyriax ☐

    Other
    (please state)_____

11. On average, what amount of time is spent on assessment of each fibromyalgia patient?

    (please tick)

    < 15 mins ☐

    15 – 30 mins ☐

    30 – 45 mins ☐

    45 – 60 mins ☐

    > 60 mins ☐

12. Do you feel you are able to adequately assess fibromyalgia patients?

    (Please tick) YES ☐

    NO ☐

    If NO, please specify why?

    _____
    _____

TREATMENT AND OUTCOME MEASURES

13. Please rank in order what you consider the main **physiotherapy** treatment goals for patients with fibromyalgia to be.
(1 = most important, 8 = least important)

GOAL	RANK
REDUCTION OF PAIN	
DECREASE FATIGUE	
INCREASE DAILY FUNCTION	
PSYCHOLOGICAL SUPPORT	
PATIENT EDUCATION	
IMPROVE FITNESS	
PREVENT DECONDITIONING	
IMPROVE COPING STRATEGIES	

14. In the table below, please tick the modalities you use in the management of fibromyalgia. (Please tick as many as you want)
Then rank the modalities you use in order, 1 = most often and 12 = least often (do not rank modalities you do not use)

	TICK	RANK
MASSAGE		
EXERCISE PROGRAMME		
McKENZIE		
MAITLAND		
CYRIAX		
MANUAL THERAPY		
LOCAL HEAT		
PAIN PROGRAMME		
RELAXATION		
ELECTROTHERAPY		
ACUPUNCTURE		
HYDROTHERAPY		

15. Please state any other techniques you commonly use in the treatment of fibromyalgia.

_____

_____

16. Are there any techniques which you would like to use but do not use?

_____
_____

Please state why you do not use these techniques.

_____
_____

17. In the table below please rank in order the outcome measures you use with patients with fibromyalgia. 1 = most common, 7 = least common.

OUTCOME MEASURE	RANK
ROM	
PAIN DISTRIBUTION	
PAIN RATING SCALE	
FUNCTIONAL ACTIVITY	
SLEEP PATTERN	
OCCUPATIONAL STATUS	
FITNESS ASSESSMENT	

18. On average, how often do your patients with fibromyalgia attend appointments?

(Please tick)

TWICE A WEEK ☐
ONCE A WEEK ☐
FORTNIGHTLY ☐
MONTHLY ☐
OTHER
(Please state) _____

19. On average, for how many sessions does each patient attend?

(Please tick)

1 – 2 ☐
3 – 4 ☐
5 – 6 ☐
7 – 8 ☐
9+ ☐

THERAPIST VIEWS AND OPINIONS

20. Would you be prepared to carry out research into fibromyalgia?

(Please tick) YES ☐

NO ☐

If NO, please state why not.

_____

_____

21. Do you feel that physiotherapy is beneficial for patients with fibromyalgia?

(Please tick) YES ☐

NO ☐

If NO, please state why not.

_____

_____

22. Do you feel there is a need for more training for physiotherapists on the condition of fibromyalgia and its management?

(Please tick) YES ☐

NO ☐

If YES, do you feel this training should be part of undergraduate training, or specific postgraduate training?

(Please tick) UNDERGRADUATE ☐

POSTGRADUATE ☐

THANK YOU FOR YOUR TIME.

Official Use Only

Centre Code ☐☐

Therapist Code ☐☐