



Public Forum

Protecting Your Health

The Bureau of Health Professions

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Awareness of an Invisible Illness

Fibromyalgia is not technically a disease. A disease has known causes and the symptom process is understood. Fibromyalgia (FM) is instead a syndrome, which is a group of signs and symptoms that characterize a disorder. Fibromyalgia is often called "The Invisible Disease" because it is not perceptible to others. The face of Fibromyalgia is every face, and unless you were told the difference you could not tell who had it and who did not. The name Fibromyalgia comes from the Latin "Fibro", meaning fibrous tissues, "my" meaning muscles, and "algia", meaning pain. Therefore it affects the soft tissues (muscles, tendons, and ligaments), causing pain around the joints, skin, and organs. Commonly thought to be a "fad" syndrome of the 90's, Fibromyalgia symptoms have actually been cited since the early 1800's. In fact, Cleopatra seems to have suffered with this troublesome condition that today's medical professionals have only recently begun to understand and diagnose. Formerly, it was known as Rheumatism, Fibrositis, and Myalgia among other names.

Fibromyalgia is one of the most common widespread types of chronic pain in the U.S. In fact, it affects more than 6 million people. Its causes are still not fully known. Recent data suggest that changes in the central nervous system may contribute to the chronic pain of this condition. There is no cure for the disorder. The symptoms of FM can vary in severity, often waxing and waning, but most patients do tend to improve over time.

The term *fibromyalgia* refers to a complex syndrome characterized by pain amplification, musculoskeletal discomfort, and systemic symptoms. Dr. Daniel Clauw, Professor of Medicine in the Division of Rheumatology at the University of Michigan, explains that each of us has a "volume control" for the severity of pain, and that this controller is affected by both genetics and the environment (or experience). Studies have shown that persons with FM have a normal "detection threshold" for pain but a decreased "noxious threshold" to many stimuli, including pressure, heat, noise, and electrical stimulation. Thus, people with fibromyalgia sense the onset of pain the same as other individuals, but are much more sensitive to pain.

The chief complaint with fibromyalgia is pain. Nerve cells can become extra sensitive under certain conditions. This may lead to extra signals being sent to the brain and an increase in the pain that a person feels. A person whose central nervous system has become overly sensitive may feel the type of chronic widespread pain that is common in fibromyalgia.

The pain may be described as a constant ache, throbbing or burning. Painful spots are found in the muscles of the neck, head, shoulders (especially between the shoulder blades), lower back and hips. The pain may begin in one area, but over time it begins to involve more regions until it has spread throughout the body. Fibromyalgia pain is a wandering pain. One day it may be present in the back and the next day present in the shoulders.

Fibromyalgia is real, and the pain can affect any or all parts of the body with varying intensity. The pain can be overwhelming. The fatigue can be disabling. In spite of the fact that the cause of FM is not fully known, all the symptoms of fibromyalgia are very real, such as headaches, disturbed sleep, memory problems, and many other symptoms.

Living with fibromyalgia is a challenge. There is no cure, but there are ways to manage the pain. Patients must be motivated to take a proactive role in learning how to minimize the impact that this disorder can have on their life. Education is a very useful tool to empower a person with FM. Expanding one's knowledge of FM is now easy, thanks to support groups and numerous online resources.

The first step is to find a physician who is competent, knowledgeable about FM, and willing to invest the necessary time to work with the patient. No diagnostic test or x-ray can detect the syndrome. However, physicians can substantiate the diagnosis by checking established universal tender point sites throughout the body, which are more susceptible to pain from applied pressure than would be experienced by a person without the disease.

Prescribed medicines are an important part of FM treatment. Lyrica is the first drug approved by the FDA for the treatment of FM. Pain relief, improved sleep, more energy, and better mood are examples of goals that prescription medicines can help you reach. People with fibromyalgia tend to be more sensitive to medications and often experience side effects such as nausea, drowsiness, or lightheadedness. Therefore, lower doses of medicines need to be considered for FM. Prescribed medicines can provide great benefits to many, so it is worthwhile to work with the physician to find a successful medicine regimen.

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Regular exercise, stress management and alternative therapies such as reflexology, meditation, acupuncture and biofeedback can also be helpful. However, it is important to realize that a person's lifestyle up to the point that they develop FM has helped to set up the problem. After an individual is plagued by FM, unless that individual makes a commitment to changing their former lifestyle, they will be subjected to ever worsening exacerbations of the condition.

The prognosis of fibromyalgia is better than ever. The efforts of individuals, support groups, organizations and medical professionals have improved the quality of life for people with FM. Better ways to diagnose and treat FM are on the horizon. The symptoms of FM can vary in severity, and they often wax and wane, but most patients do tend to improve over time. By seeking new information, talking to others who have fibromyalgia, re-evaluating daily priorities, making lifestyle changes, and working hard to keep a hopeful attitude, patients can continue to live life to the fullest.

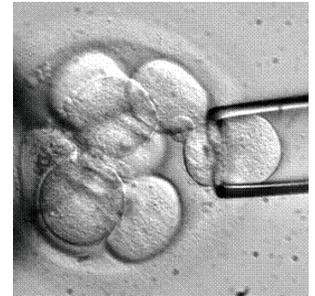
For more information about this widespread pain syndrome and other pain disorders, go to Michigan's pain management website at www.michigan.gov/pm.

Future of Healthcare, Part II

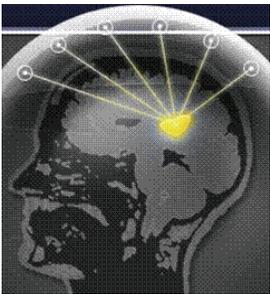
This article is Part II of the Future of Healthcare article found in the Fall 2008 issue of *Public Forum*. Part I described developments in computer technologies, E-Healthcare, E-Visits and the use of electronic medical records. Part II deals with emerging advances in treatments that are likely to change the face of health care in the 21st century.

One of the emerging medical advances impacting healthcare today is the use of *stem cells*. Stem cells are cells that can divide and grow into any type of cell in the body. There are two types of stem cells that can be used in the treatment of disease: embryonic stem cells found in early stage human embryos and adult stem cells found in umbilical cord blood and other adult tissue such as bone marrow, blood, and the brain.

Michigan's Dr. Jean Peduzzi-Nelson of Wayne State University School of Medicine, one of today's leading adult stem cell researchers, has dedicated over 15 years to researching ways to use adult stem cells. Her work has focused on using stem cells to treat patients that have severe chronic spinal cord injury and paralysis- one of the most promising areas of stem cell therapy. Dr. Peduzzi-Nelson indicates that "...so far this treatment has worked better than any other treatment we've tried and so I am very excited about the potential for this". Stem cells are currently being used or being researched for use in treating over 72 diseases, including stroke, heart disease, cancer, Alzheimer's and other brain disorders, spinal cord injury, and diabetes.



There are a number of other developments in medical technology that are also promising to change the way we treat disease. *Nanotechnology* is such a technology. This refers to the use of miniature medical equipment the size of molecules that can be programmed to target specific parts of the body to treat a disease, such as cancer. Another amazing technology is the Swallowable *PillCam™*, which is being used for non-invasive testing. The *PillCam™* is used to diagnose and treat patients with gastrointestinal (GI) disorders of the small intestine such as swelling, bleeding, tumors, and other diseases, which are normally tested through the less comfortable colonoscopy procedure. The physician can then view the pain-free images produced by the camera to make a diagnosis.



Another exciting development being researched and now being used is the *targeted delivery* of medication for various diseases, especially with antibiotics and chemotherapy. This treatment uses particles of drugs, which are placed inside microscopic bubbles, and then injected into a patient's bloodstream. The bubbles burst at the target sight allowing the particles to disperse. Doctors hope to use this treatment to

eliminate the many side-effects associated with normal therapies for infections and cancers, such as nausea, hair loss, and fatigue.

A number of other developments, such as customized drugs based on one's individual genes, high-powered lasers, miniature cameras, and advanced ways to get three dimensional pictures and movies of the human body through Magnetic Resonance Image (MRI) cameras and sonography are also among the "cutting edge" technologies likely to change the diagnosis and treatment of disease.

David Ellis, corporate director of planning and future studies at the Detroit Medical Center, believes that these new frontiers of medicine will not only eliminate many human diseases, but that this will happen within the next 10 or 15 years. In his book *Technology and the Future of Health Care*, David Ellis argues that advanced computers are making it possible to greatly increase the rate at which discoveries are made through research and the time it takes to put these discoveries into practice.

The famed British gerontologist [Aubrey de Grey](#) has suggested that the cutting edge technologies identified in this article, along with lifestyle improvements such as caloric intake reduction and enhanced nutritional supplements will result in a human lifespan extending to 120 years in our lifetime.

7 Myths Regarding Opioid Use in Pain Management

The National Center for Health Statistics estimates that chronic pain affects 76.5 million Americans, which is more than the combined total of diabetes, heart disease and cancer. The economic impact of untreated pain in the United States is difficult to measure, but is estimated at \$100 billion annually. While opioids remain the gold standard in managing pain today, there are many barriers and myths regarding their use and overall pain management that can result in negative patient outcomes. Although some myths are a part of the subculture of different medical disciplines, the following misconceptions are universal throughout the healthcare system.

Myth #1 - *Healthcare providers do an adequate job of providing adequate pain control.* Statistics say otherwise. When physicians prescribe a dose range for analgesia, most nurses tend to give lower doses. The under treatment of acute pain (oligoanalgesia) can have many negative effects on patient recovery and satisfaction. Continued under treatment of acute pain has been suggested to cause chronic pain because of subsequent alterations within the central nervous system. These changes may result in an overall decreased pain threshold, which could eventually lead to a patient's overuse of analgesia. Oligoanalgesia has been observed in emergency departments, intensive care units, medical-surgical units, and throughout the healthcare system. Nurses and physicians should be aware of their own beliefs regarding pain management in order to provide adequate relief for their patients. When a patient states they are in pain, the patient must always be believed and treated with adequate pain medication.

Myth #2 - *Pain medications always lead to addiction.* When prescribed appropriately in a dose sufficient to relieve pain, there is no indication that opioids lead to addiction. Recent studies have indicated that the incidence of addiction is less than 1% for those patients using opioids for short-term acute pain management. When clinicians believe that appropriate use of narcotics leads to addiction, their reluctance to prescribe these medications may result in chronic pain, which may lead to a long-term reliance on analgesics. Early use of narcotics, with tapering of the doses as pain is relieved, should be encouraged in managing acute pain.

Myth #3 - *Pain medications always cause heavy sedation.* Because chronic pain can cause sleep deprivation, most opioids will cause initial sedation. However, once the patient catches up on lost sleep, continuing treatment with adequate narcotic doses will allow them to resume normal mental alertness and orientation. Sedation is often caused by other drugs, such as anti-anxiety agents and/or tranquilizers, which are prescribed for other reasons.

Myth #4 - *Some kinds of pain cannot be relieved.* Because all pain is not the same, all pain medications do not have the same effect. Some pain may require a multi-modality approach, such as combining opioids with nonsteroidal anti-inflammatory agents. A thorough pain assessment and history can help a provider prescribe a medication regimen that will allow the patient to keep pain at a manageable level.

Myth #5 - *Pain and suffering are character-building.* Although some cultural and religious communities view stoicism with pain as a sign of strength, the impact of pain on quality of life is serious. With acute or chronic pain, the patient is affected holistically. Pain causes stress on the cardiovascular system through increased blood pressure and heart rate, and increased risk for blood clots and heart attack.

Myth #6 - *Effective pain management can be achieved on an "as needed" basis.* Medications provided "around the clock" have a much better impact on pain management with fewer side effects.

Myth #7 - *Narcotic analgesics in older patients should be avoided.* Pain has no age limit. Difficulty in completing a thorough pain assessment for a patient with dementia adds to the misconception that these patients have decreased sensitivity to pain. Because the elderly patient may be more susceptible to the negative effects of opioid analgesics, these patients may be prescribed doses of narcotics that are ineffective. Clinicians frequently express concern regarding the possibility of confusion or delirium as a result of these medications. Continuing patient and staff education and acceptance can have a positive impact on treating pain in the geriatric population.

These are seven of the most often cited myths in the literature regarding pain management. Other myths include:

- Morphine hastens death in a terminally ill patient.
- Injectable morphine works better than morphine by other routes.
- Heavy-duty analgesics should be withheld until death is imminent.
- A patient who is sleeping is not in pain.
- A patient who is watching television or laughing with visitors is not in pain.
- Infants and children don't experience pain as adults experience pain.
- Once you start pain medications you always have to increase the dose.
- Alterations in vital signs are reliable indicators of pain in a patient.

Clinicians are obligated to determine the most effective means of relieving pain in their patients. Understanding the clinician's own biases regarding pain management is the first step in creating a pain-free environment for their clients. Adequately and consistently addressing pain within the health care system will ultimately lead to an increase in patient trust, shorter lengths of stay, and better patient outcomes.

To view the full document on this subject, along with references used to prepare it, select the following link: [7 Myths Regarding Opioid Use in Pain Management](#). More information on pain management topics can be found on Michigan's pain management website at www.michigan.gov/pm.

Michigan Medical Marijuana Program

On November 4, 2008, Michigan voters approved Proposal 1, which became [Initiated Law 1 of 2008](#). This law legalizes the use of marijuana in Michigan for patients with serious medical conditions. The Bureau of Health Professions will be administering the program and launched a website with information about the program on December 5, 2008. For more information about the program, who is eligible to participate, proposed administrative rules, and more, visit www.michigan.gov/mmp.

Q & A

QUESTION & ANSWER

Question: Can a physician assistant (PA) see patients while the physician is out of the office on vacation?

Answer: PAs work under the delegation and supervision of a physician. They are allowed to see patients of record while the doctor is out of the office.

Delegation is defined in §333.16104 of the Michigan Public Health Code as an authorization granted by a licensee to a licensed or unlicensed individual to perform selected acts, tasks, or functions that fall within the scope of practice of the delegator and that are not within the scope of practice of the delegatee and that, in the absence of the authorization, would constitute illegal practice of a licensed profession.

Supervision is defined in §333.16109 of the code as meaning the overseeing of or participation in the work of another individual by a health professional licensed under this article in circumstances where at least all of the following conditions exist:

- (a) The continuous availability of direct communication in person or by radio, telephone, or telecommunication between the supervised individual and a licensed health professional.
- (b) The availability of a licensed health professional on a regularly scheduled basis to review the practice of the supervised individual, to provide consultation to the supervised individual, to review records, and to further educate the supervised individual in the performance of the individual's functions.
- (c) The provision by the licensed supervising health professional of predetermined procedures and drug protocol.

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