HAUTE AUTORITÉ DE SANTÉ

RECOMMENDING
BEST PRACTICES

GUIDELINE

Fibromyalgia in adults: diagnostic management and treatment strategy

Validated by the HAS Board on 19 June 2025

Description of the publication

Title	Fibromyalgia in adults: diagnostic management and treatment strategy
Working method	Clinical practice guidelines (CPG) Real-world data studies
Objective(s)	Define and improve the steps in the diagnostic process Define and scale the treatment strategy
Targets concerned	General practitioners, rheumatologists, internal medicine specialists, neurologists, physical medicine and rehabilitation specialists and multidisciplinary teams, chronic pain clinic resource physicians and nurses, preventive and occupational health service physicians and nurses, psychiatrists, orthopaedic surgeons, psychologists, advanced practice nurses, public health nurses (ASALÉE team-based community services), physiotherapists, adapted physical activity professionals, dieticians, pharmacists, occupational therapists, psychomotor therapists, social workers, patient associations in the field concerned
Requester	Patient associations in the field of fibromyalgia
Sponsor(s)	*Haute Autorité de santé* (French National Authority for Health - HAS)
Project management	Coordination: Ms Anne-Françoise Pauchet-Traversat, project manager, HAS Department for Good Clinical Practice (Head of Department: Dr Morgane Le Bail) Assistant: Marie-Catherine John
Literature search	Period from January 2016 to July 2022 with specific searches up until March 2025 and monitoring up until May 2025 (see literature search in the evidence report). Performed by Ms Sophie Nevière, assisted by Ms Sylvie Lascols (Head of Documentation and Monitoring Department: Ms Frédérique Pagès)
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Declaration of interests	The members of the working group have submitted their public declarations of interest to the HAS. They are available to view on the https://dpi.sante.gouv.fr website. They were reviewed according to the analysis grid of the HAS guidelines for the declaration of interests and management of conflicts of interest. For its analysis, the HAS also took into account the *"Transparence-Santé"* database, which requires companies operating in the health sector to publicise agreements, remuneration and benefits linking them to health sector professionals. The interests declared by the members of the working group and the information contained in the *"Transparence-Santé"* database were deemed to be compatible with their involvement as experts in the working group.
Validation	Version dated: 19 June 2025
Updating	
Other formats	Key-messages, evidence report

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Clinical practice guidelines (CPGs) are defined in the health field as systematically developed statements to assist practitioner and patient decisions about appropriate healthcare for specific clinical circumstances.

CPGs are rigorous summaries of the state-of-the-art and scientific data at a given time, described in the evidence report. They do not exempt healthcare professionals from exercising discretion in the patient's treatment; this must be the treatment considered to be most appropriate on the basis of their own findings and the patient's preferences.

These clinical practice guidelines were developed according to the method summarised in the evidence report and in the HAS methodological guide available online: Development of best practice guidelines – Clinical practice guidelines method.

The objectives of this guideline, plus the population and the professionals concerned by its implementation are summarised in the description of the publication and described in detail in the evidence report.

The latter and the guideline summary can be downloaded from www.has-sante.fr.

Grades of recommendations

A	**Established scientific evidence** Based on studies with a high level of evidence (level of evidence 1): randomised controlled trials with high power and without major bias or meta-analysis of randomised controlled trials, decision analysis based on well conducted studies.
B	**Scientific presumption** Based on scientific presumption provided by studies with an intermediate level of evidence (level of evidence 2) such as low power randomised controlled trials, well conducted non-randomised controlled studies, cohort studies.
C	**Low level of evidence** Based on studies with a lower level of evidence such as case-control studies (level of evidence 3), retrospective studies, case-series studies, comparative studies with major biases (level of evidence 4).
EC	**Expert consensus** In the absence of studies, the recommendations are based on agreement between experts in the working group after consultation of the review group. The absence of grading does not mean that the recommendations are not relevant and useful. However, it should prompt additional studies.

Concerning the "Fibromyalgia in adults: diagnostic management and treatment strategy" guideline

Due to the lack of studies or their inadequate methodological quality, it was not possible to grade the recommendations. Consequently, **all the recommendations are based on expert consensus (EC)** within the working group formed by the HAS, following consultation of the review group.

The HAS wishes to stress that the absence of evidence grading does not mean that the recommendations are not relevant and useful. However it should prompt additional studies, where possible.

This document and its bibliographic reference are available to download at www.has-sante.fr

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Foreword

Introduction

The HAS was consulted by several patient associations to draw up clinical practice guidelines on the theme of fibromyalgia.

This clinical practice guideline follows on from the Syndrome fibromyalgique de l'adulte – Rapport d'orientation (has-sante.fr) guidance report for fibromyalgia syndrome in adults published by the HAS in 2010.

For the organisational aspects, the work was based on the care pathway guide for patients with chronic pain https://www.has-sante.fr/jcms/p_3409569/fr/guide-parcours-de-sante-d-une-personne-presentant-une-douleur-chronique published by the HAS in 2023.

Objectives

The aim of these guidelines is to improve the diagnostic process for fibromyalgia and the treatment strategy offered to individuals with a diagnosis of fibromyalgia, in a personalised, scaled manner.

Grading of recommendations

Due to the lack of studies or their inadequate methodological quality, it was not possible to grade the recommendations concerning "Fibromyalgia in adults: diagnostic management and treatment strategy". Consequently, **all the recommendations are based on expert consensus (EC)** within the working group formed by the HAS, following consultation of the review group.

The HAS wishes to stress that the absence of evidence grading does not mean that the recommendations are not relevant and useful. However it should prompt additional studies, where possible.

Key messages

The World Health Organization's International Classification of Diseases (ICD 11) recognises and classes fibromyalgia under the chronic widespread pain grouping.

Fibromyalgia is linked to changes in pain detection and modulation processes in the central nervous system, manifesting as generalised hypersensitivity to pain. The pain is combined with other non-specific symptoms, such as fatigue, sleep disturbances, transit disturbances, and cognitive and psychological disorders.

Fibromyalgia impairs physical capacities, activities of daily living and quality of life.

The prevalence of fibromyalgia in the general population is around 1.5 to 2%, with the condition affecting almost three times more women than men.

- The diagnosis of fibromyalgia is a clinical one in the absence of specific biomarkers.
- A diagnosis of fibromyalgia recognises the suffering experienced by patients and legitimises their complaint. It is accompanied by in-depth, personalised explanations about the condition, its mechanisms and the treatment options, which facilitates patient engagement and the joint development of a care plan.
- The general practitioner coordinates care plan implementation, along with the professionals involved in the patient's care.
- The treatment strategy is scaled and personalised, with the first-line approach consisting of physical activity, including independent learning, personalised self-management strategies, retention in the workforce, and support for all forms of vulnerability.
- As a second-line approach, certain antidepressants and anticonvulsants, initiated at low doses in order to improve their tolerability and minimise side effects, may be prescribed for constant pain as background therapy, and the usual analgesics may be prescribed on an occasional basis for incident pain, but never as long-term treatment. Opioids should be used with caution and only occasionally for acute incident pain, and should be used only exceptionally as long-term therapy.
- Each time a medication prescription is issued or renewed: assess the safety and perceived efficacy, identify any misuse and associated risks.
- Throughout patient follow-up, assess and treat any psychological problems (anxiety, depression, suicidal ideation).
- Situations of overweight and obesity should be assessed and treated.
- Diets with specific restrictions (e.g. gluten-free, lactose-free, etc.) and nutritional supplements have no demonstrated benefit in fibromyalgia, except in cases of proven deficiencies.
- Other interventions with no adverse effects or health risks, such as hydrotherapy, relaxation therapy, hypnosis and meditation, may be discussed as part of the care plan subject to certain conditions and delivery methods, provided that practitioners are appropriately trained and treatment is discontinued if there is no response.
- As a third-line approach, neurostimulation techniques may be proposed following advice.
- Patient associations provide information, share their experiences, participate in patient education, and remind patients to be vigilant about certain practices.
- Referral to a specialised chronic pain clinic may be necessary for advice, guidance, multi-disciplinary and multi-professional assessment, and choice of treatment in cases of resistant pain or coordination difficulties.

1. Steps in the diagnostic process

Fibromyalgia in adults: diagnostic process in the primary care setting

1

Assess pain and its impact: bio-psycho-social approach

- Characteristics: conditions and circumstances of occurrence, topography, intensity, duration, variability, fluctuation over time, factors triggering, exacerbating, maintaining, relieving pain.
- Mechanisms: nociceptive, neuropathic, nociplastic pain.
- Impact on daily life, work, interpersonal relationships, mood.

2

Consider and clinically screen for fibromyalgia

Three guiding factors

- Pain ≥ 3 months, diffuse, often variable and fluctuating over time and in intensity and location, combined with other symptoms.
- Normal physical examination.
- Absence of diseases or medication use that could explain the pain.

A screening aid: self-administered FIRST[1]

- If FIRST positive: strong suspicion, but clinical judgement remains the primary factor.
- If FIRST negative or doubtful: **continue the diagnostic process**.

3

Investigate for other diseases causing chronic pain AND concomitant diseases*

- Minimal laboratory tests: CPK, CRP, CBC, TSH[2], transaminases.
- Additional investigations based on physical examination and clinical judgement.

→ **Repeat the physical examination before attributing any new symptom to fibromyalgia.**

* In particular, inflammatory or systemic rheumatological, neuromuscular, endocrine conditions, etc.

4

Clinically confirm the diagnosis of fibromyalgia and assess its impact

- American College of Rheumatology criteria [revised in 2016].
- Quality of life: self-administered fibromyalgia impact questionnaire (FIQ[3]).
- Anxiety and depressive disorders.

→ **If necessary, refer to another specialist for diagnostic assistance.**

5

Recognise the suffering and deliver the diagnosis

- Legitimise complaints.
- Inform, explain the condition, its mechanisms, the treatment options and provide a written document.
- Provide information about patient associations: experience-sharing, support.

Co-construct the care plan with the patient

- Formulate realistic and achievable goals to improve functional condition and learn to live with the condition, alleviate pain and other symptoms and improve quality of life.
- Define shared assessment criteria for monitoring the condition.

Fibromyalgia in adults
Diagnostic management and treatment strategy

1. FIRST: Fibromyalgia Rapid Screening Tool, self-administered questionnaire.
2. CPK: creatine phosphokinase; CRP: C-reactive protein; CBC: complete blood count; TSH: thyroid-stimulating hormone.
3. FIQ: Fibromyalgia Impact Questionnaire.

1.1. Listen to and acknowledge an individual's expression of chronic pain in the primary care setting

R.1. Any complaint of pain must be listened to carefully, acknowledged as the person feels and expresses it, and put into perspective in its biopsychosocial context, especially when the pain is persistent (≥ 3 months).

1.2. Implement favourable conditions for the initial assessment

R.2. Offer a face-to-face consultation, perform a physical examination combined with an interview with the person.

R.3. Establish and maintain a relationship of trust from the start of the diagnostic process, in order to:

- encourage the person to actively participate in analysing and understanding their situation;
- exchange information to prepare shared decisions on the care plan and its implementation.

1.3. Assess pain and its impact

R.4. It is recommended to use the assessment grid for patients with chronic pain and the self-administered questionnaire for patients with pain to:

- define the characteristics of the pain: conditions and circumstances of occurrence, topography, intensity, duration, variability, fluctuation over time;
- investigate for factors that trigger, exacerbate or maintain pain and/or those that alleviate it;
- identify nociceptive, neuropathic or nociplastic pain mechanisms.[1] Several of these mechanisms may coexist in the same patient;
- identify the impact of pain on daily life, work, interpersonal relationships, level of physical activity and sedentary behaviours that can lead to physical deconditioning, sleep or mood disorders, overweight or obesity;
- define a hierarchy for the difficulties experienced and the patient's expectations regarding treatment, in order to guide the care plan.

1.4. Consider and clinically screen for fibromyalgia

R.5. Fibromyalgia should be considered from the outset and screened for in the presence of the following suggestive clinical factors (Table 1):

- chronic pain and associated symptoms;
- normal physical examination;
- absence of diseases or medication use that could explain the pain.

R.6. The use of the self-administered FIRST (Fibromyalgia Rapid Screening Tool) questionnaire is recommended in the primary care setting to aid the diagnostic process.[2]

[1] Nociceptive pain: pain related to activation of nociceptors. In this case, the nociceptive system is intact but is activated abnormally intensely and for prolonged periods (“excessive nociception”), particularly when there are inflammatory processes that sensitise the nociceptors.
Neuropathic pain: pain caused by a lesion or disease affecting the somatosensory nervous system.
Nociplastic pain: pain associated with functional alterations of the nociceptive system, which differs from the other two types of pain in that there is no evidence of tissue damage that could activate nociceptors or damage to the somatosensory system.
Note: several of these mechanisms may coexist in the same patient.

[2] Perrot S, Bouhassira D, Fermanian J. Development and validation of the Fibromyalgia Rapid Screening Tool (FiRST). Pain 2010;150(2):250-6. https://dx.doi.org/10.1016/j.pain.2010.03.034

Table 1. Suggestive clinical factors and fibromyalgia screening aid

Pain	Persisting for more than 3 months, diffuse, often variable and fluctuating over time and in intensity and location.
Symptoms frequently associated with the pain	Chronic fatigue, excessive fatigability during exertion, cognitive disturbances (difficulty concentrating, memory loss, brain fog), sleep disorders, emotional distress, psychological disorders (anxiety, depression without necessarily implying a psychological cause for the pain), functional bowel disorders, functional limitations that interfere with activities of daily living, as well as professional, family and social activities.
Normal physical examination	No systematised motor or sensory deficits, no observable joint swelling. Possible hypersensitivity of muscles, joints and tendons to touch or pressure, either localised or widespread, sometimes associated with more general hypersensitivity to cold, heat, light, or noise.
Absence of situations that could explain the pain	No disease or medication use that could cause the pain (e.g. statins (muscle pain); opioids (diffuse pain); anti-cancer chemotherapies (neuropathic pain); aromatase inhibitors (joint pain and diffuse pain); bisphosphonates (bone pain).
Diagnostic aid using the self-administered FIRST questionnaire, in addition to physical examination	If FIRST is positive (at least 5 out of 6 criteria): fibromyalgia is strongly suspected, but clinical judgement remains the primary factor. If FIRST is negative or doubtful (fewer than 5 criteria out of 6): a diagnosis of fibromyalgia is unlikely and it is therefore important to continue the diagnostic process.

1.5. Continue the diagnostic process to identify the source of the pain

R.7. At each step in the diagnostic process, ensure personalised communication and information in order to maintain a relationship of trust.

1.5.1. Investigate for fibromyalgia, including in the presence of concomitant diseases

R.8. Underdiagnosis or overdiagnosis of fibromyalgia should be avoided.

Fibromyalgia should not be confused with diseases or conditions with persistent symptoms that may be similar to those of fibromyalgia. However, fibromyalgia may occur concomitantly with these diseases, which must be recognised, diagnosed, treated and monitored.

Such diseases include: inflammatory or systemic rheumatological conditions (rheumatoid arthritis, ankylosing spondylitis, osteoarthritis, psoriatic arthritis, lupus, Sjögren's disease), neuromuscular conditions (myositis, myopathy), endocrine conditions (hypothyroidism), myeloma, metabolic diseases (porphyria, Fabry disease, Ehlers Danlos syndrome), coeliac disease, infectious diseases (Lyme disease, post-treatment Lyme disease syndrome, prolonged symptoms following COVID-19), chronic fatigue syndrome, etc.

In addition, symptoms similar to those of fibromyalgia may be the initial manifestations of another disease (lupus, rheumatoid arthritis, etc.).

1.5.2. Prescribe minimal laboratory tests

R.9. Irrespective of the result of the self-administered FIRST questionnaire, prescribe minimal laboratory tests to screen for conditions, particularly inflammatory or endocrine diseases, with symptoms that can be similar to those of fibromyalgia: CBC, CRP, TSH, CPK, transaminases.[3]

R.10. Prescribe additional investigations based on the signs and symptoms identified during the physical examination and patient interview, and clinical judgement.

R.11. In the event of difficulties assessing or interpreting symptoms, and if the physical examination and/or laboratory tests reveal abnormalities that are difficult to interpret, and/or in the event of doubts about a diagnosis:

- avoid multiple additional tests that may lead to an excessive focus on symptoms and respond to an intolerance to uncertainty;
- refer the patient to another specialist (rheumatologist, neurologist, internal medicine specialist, psychiatrist, pain specialist, etc.);
- use teleconsultation or tele-expertise if required to facilitate access to specialist physicians.[4] However, these are not a substitute for a thorough physical examination if it proves necessary for the diagnostic process.

1.5.3. Schedule another medical consultation to further assess the situation

R.12. During the interval between consultations, encourage the individual to contribute to this assessment by recording their experiences in a diary or self-assessment notebook over a limited period of time (a few months), noting any changes in their pain and the other symptoms experienced:

- improvement, worsening, fluctuation, factors triggering or maintaining pain;
- impact on activities of daily living (continuation, difficulties, giving up)
- methods used to cope with pain, especially when it is difficult to control, and other symptoms;
- mood changes;
- changes in social and family or work context, if applicable.

When used properly, this self-assessment diary or notebook can help individuals gain a better understanding of themselves. However, self-monitoring can be stressful and add unnecessary and counterproductive mental strain. It is particularly inadvisable for people who have an obsessive tendency to work or keep themselves busy all the time, or who focus excessively on symptoms or catastrophise.

R.13. During the interval between consultations, advise the person to maintain as much daily physical exercise as possible (walking, breaking up periods of sitting), to engage in a physical activity according to their abilities, and to reduce sedentary behaviour (Annexe 1) and to continue working if possible.

R.14. At the scheduled consultation:

- analyse the results of laboratory tests;
- analyse the diary or self-assessment notebook with the person;
- repeat an appropriate physical examination in the event of any new symptoms and investigate their cause before attributing them to fibromyalgia;

[3] Complete blood count (CBC), C-reactive protein (CRP), creatine phosphokinase (CPK), thyroid-stimulating hormone (TSH).
[4] Teleconsultation and tele-expertise. Implementation. Memo sheet. Saint-Denis La Plaine: HAS; 2019.https://www.has-sante.fr/jcms/c_2971632/fr/teleconsultation-et-teleexpertise-guide-de-bonnes-pratiques

– identify any mood disorder (anxiety, depression) without necessarily implying a psychological cause for the pain.

1.6. Confirm the diagnosis of fibromyalgia, assess its impact on quality of life, prepare for any difficulties coping with the condition

1.6.1. Confirm the diagnosis of fibromyalgia

R.15. If the screening process results in a strong suspicion of fibromyalgia, it is recommended to use the revised [in 2016] diagnostic criteria of the American College of Rheumatology (ACR) to clinically confirm the fibromyalgia diagnosis.[5]

These criteria can be useful not only to make a diagnosis, but also to monitor the course of fibromyalgia over time.

The diagnosis of fibromyalgia is confirmed if the following three conditions are met:

– generalised pain, defined as pain in at least 4 of 5 regions of the body, is present (upper and lower body, left and right sides, head), with the exception of pain in the jaw, chest and abdomen;
– associated symptoms and their degree of severity: fatigue, waking unrefreshed, cognitive symptoms, headaches, pain or cramps in lower abdomen, depression;
– pain and symptoms present for at least three months.

Calculation of the scores (extent of pain, symptom severity, fibromyalgia severity), which initially appears complex, takes only 2 to 3 minutes routinely.

1.6.2. Assess the impact of fibromyalgia on quality of life

R.16. The initial assessment and the assessment of the impact of fibromyalgia on quality of life are complementary. To refine this assessment, the self-administered Fibromyalgia Impact Questionnaire (FIQ) may be used. This provides information on the ability to perform activities of daily living, difficulty working and days off work, well-being, pain and associated symptoms.[6]

1.6.3. Assess the psychological and social impact of fibromyalgia

R.17. It is recommended to identify early on any emotional impacts, anxiety or depression associated with the chronic pain that may make it difficult for the patient to engage in their care or cope with their condition:

– a psychological impact such as anxiety disorder or major depressive disorder if the patient presents at least two of the following three main symptoms: depressed mood; loss of interest or enjoyment in usually pleasurable activities; increased fatigability; AND at least two of the following seven other symptoms: decrease in attention span and concentration; loss of self-confidence; feelings of guilt and worthlessness; negative and pessimistic outlook on the future; sleep disturbances; loss of appetite; suicidal ideation. The diagnostic process is based on a

[5] American College of Rheumatology, Wolfe F, Clauw DJ, Fitzcharles MA, Goldenberg DL, Häuser W, et al. 2016 revisions to the 2010/2011 fibromyalgia diagnostic criteria. Semin Arthritis Rheum 2016;46(3):319-29. https://dx.doi.org/10.1016/j.semarthrit.2016.08.012
[6] Perrot S, Dumont D, Guillemin F, Pouchot J, Coste J. Quality of life in women with fibromyalgia syndrome: validation of the QIF, the French version of the fibromyalgia impact questionnaire. J Rheumatol 2003;30(5):1054-9.

clinical interview and the use of self-administered questionnaires, such as the Patient Heath Questionnaire-9 (PHQ-9);[7]

- any form of social vulnerability (material fragility, isolation, loneliness), professional vulnerability (sick leave, bullying, stigmatisation), any past or present situation of risk (ill-treatment, abuse, bullying, stigmatisation, domestic violence[8] or intra-family violence).

R.18. The involvement of other professionals (in particular, psychologists, psychiatrists, social workers, and occupational health and prevention service physicians) may be necessary for a thorough psychological, social, and professional assessment and in order to propose appropriate treatment and/or support in conjunction with the general practitioner (see chapters 2.4 Retention in the workforce and 2.6 Regularly investigate for mood disorders and treat them if appropriate).

1.7. Recognise the suffering and deliver the diagnosis

R.19. To deliver the diagnosis, it is necessary to propose sharing information with the patient (Annexe 2), and, if appropriate, with their family with the patient's consent, in an atmosphere of active listening, free from preconceptions, judgement and stigmatisation. This exchange can take place during a long consultation or through several dedicated consultations.

R.20. This diagnosis delivery phase acknowledges the patient's suffering and the legitimacy of their complaint. It is an opportunity to:

- provide explanations about the condition, its mechanisms and the symptoms that affect physical capacities, the performance of activities and quality of life, and be attentive to the patient's reactions to these personalised explanations;
- explain the available treatment options;
- make sure that the information is properly received and understood (reformulating phrases in other words, patient reactions) and to systematically supplement it with a written document[9] and/or reliable resources that the patient can refer to;
- inform the person that they can contact a patient association if they wish to do so.

1.8. Develop and implement a care plan and monitor its effects

1.8.1. Share decision-making and jointly put together a personalised care plan

R.21. It is recommended to involve patients in the co-construction of a personalised care plan, taking into account their experiences, what they already do that is useful or helpful in living with fibromyalgia, the improvements they have felt thanks to treatments they have already tried, their expectations regarding treatments and their preferences, needs, current priorities and plans, as well as the resources available to them in their environment.

[7] Haute Autorité de santé. *Épisode dépressif caractérisé de l'adulte : prise en charge en soins de premier recours.* [Major depressive disorder in adults: management in the primary care setting.] Clinical practice guideline. Saint-Denis La Plaine: HAS; 2017 https://www.has-sante.fr/jcms/c_1739917/fr/episode-depressif-caracterise-de-l-adulte-prise-en-charge-en-premier-recours

[8] Haute Autorité de santé. *Repérage des femmes victimes de violences au sein du couple.* [Identifying women who are victims of domestic violence.] Clinical practice guideline. Saint-Denis La Plaine: HAS; 2022 Haute Autorité de Santé – Repérage des femmes victimes de violences au sein du couple

[9] Haute Autorité de santé. *Comprendre la maladie pour mieux vivre avec les symptômes*. Information document aimed at patients [Fibromyalgia.Understanding the disease to better live with its symptoms.] Saint-Denis La Plaine: HAS; 2025 "Fibromyalgie : Comprendre la maladie pour mieux vivre avec ses symptômes"

R.22. The care plan is personalised and specifies realistic and achievable treatment goals, the most appropriate practitioners and locations for their implementation, and assessment elements that can be shared with the patient in order to reformulate the goals if necessary.

1.8.2. Coordinate the care plan

R.23. The general practitioner coordinates care plan implementation, along with the professionals involved in the care plan. Coordination can be shared with a healthcare professional (particularly advanced practice nurses or public health nurses trained in chronic pain management)[10] as part of a coordinated care process.

R.24. Referral to other specialist physicians or a specialised chronic pain clinic may be necessary:

- if advice or consultation is required (e.g. in the event of new symptoms appearing or a lack of response to the proposed treatments), the general practitioner will refer the patient to another specialist (rheumatologist, neurologist, internal medicine specialist, pain specialist, physical medicine and rehabilitation specialist, psychiatrist)[11] for an clinical opinion;
- in the event of difficulties, the physician may seek advice or request a consultation with a chronic pain clinic interface service, either via a dedicated hotline or using the request form for one-off support: advice, tele-expertise, teleconsultation, etc.;[12]-[13]
- when the situation is felt to be particularly complex, the general practitioner or chronic pain clinic physician has access to a coordination support system (DAC);[14]
- for resistant chronic pain, the general practitioner can refer the patient to a chronic pain clinic using the same form, if necessary on a priority basis via a fast-track system (to quickly see a patient who needs it outside of regular consultation slots or before the usual appointment delivery time by the pain clinic, within dedicated time slots), or to a specialised hospital department, with a referral letter.[15]

1.9. Regularly assess the situation with the patient

R.25. The frequency of follow-up consultations with the physician treating the patient is higher during the initial phase of the care plan and until the symptoms stabilise. The frequency is then reduced to every 3 to 6 months if the situation evolves favourably.

R.26. Ideally, patients should have a long consultation dedicated to follow-up of their fibromyalgia or several consultations focusing on a problem that is a priority for the patient.

Monitoring the situation of a person with chronic pain that affects their quality of life requires listening, an understanding attitude, empathy, support, reassurance, and the development of appropriate

[10] Assuming a future regulatory extension of their areas of competence to include chronic pain.

[11] French national registry of health and medico-social support resources – ROR https://esante.gouv.fr/produits-services/repertoire-ror

[12] Directory of specialised chronic pain clinics Les structures spécialisées douleur chronique – SDC – Ministère de la Santé et de l'Accès aux soins

[13] The care pathway of a person suffering from chronic pain, or pain in the process of becoming chronic, involves a three-tier organisation mobilised according to the degree of biopsychosocial complexity of the patient's situation fiche. parcours de sante dune personne presentant une douleur chronique.pdf

[14] A coordination support system (DAC) "provides a global response to requests for support from professionals, including, in particular, reception, analysis of the person's situation, guidance and referral, access to specialised resources, follow-up and enhanced support for situations, as well as care planning Chapter VII: Public and professional support mechanisms for complex care pathway coordination (articles L. 6327-1 to L. 6327-7)] – Légifrance

[15] The care pathway of a person suffering from chronic pain, or pain in the process of becoming chronic, involves a three-tier organisation mobilised according to the degree of biopsychosocial complexity of the patient's situation fiche. parcours de sante dune personne presentant une douleur chronique.pdf

solutions together, in coordination with other medical specialists and professionals involved in the care pathway if necessary.

R.27. Sharing follow-up information with the patient enables joint assessment of the effects of treatments on pain, functional capacities, quality of life, mood, activities of daily living and retention in the workplace, and to supplement the care plan based on improvements, difficulties expressed, expectations and requests from the patient (box 1).

Box 1. Follow-up information shared with patients for reassessment of their situation

- Relief of symptoms
- Improvement of physical activity levels and reduction of sedentary behaviour, improvement of functional capacities
- Performance of activities of daily living, maintenance of family, work and social activities
- Capacity to cope with the condition: evaluation of personal strategies developed to cope with fibromyalgia
- Perception of improvements and response to treatment concerning functioning, symptoms and quality of life
- Improvement of mood and effects of treatments if applicable
- Quality of life
- Assessment of medication use and any self-medication

R.28. In order to objectively assess changes in the situation, the use of several tools that can be shared with the patient and the professionals involved in the patient's care pathway is recommended:

- fibromyalgia symptoms and severity: American College of Rheumatology (ACR) criteria [revised in 2016];[16]
- impact of fibromyalgia: self-administered fibromyalgia impact questionnaire (FIQ);[17]
- self-administered PHQ-9 questionnaire: Patient Health Questionnaire 9, for follow-up of major depressive disorder;
- perception of change in clinical condition: Clinical Global Impression (CGI).[18]

R.29. Patients are informed that at any point during their care pathway:

- they may seek the advice of a doctor or healthcare professional if they have any concerns about the usefulness and safety of any treatment presented as being a miracle cure, or about any attitude on the part of a practitioner criticising conventional medicine and the care provided;
- they should be vigilant with regard to potential abuses and risks that products, practices and techniques may entail due to a lack of standardisation, regulation and training of those involved.

[16] American College of Rheumatology, Wolfe F, Clauw DJ, Fitzcharles MA, Goldenberg DL, Häuser W, et al. 2016 revisions to the 2010/2011 fibromyalgia diagnostic criteria. Semin Arthritis Rheum 2016;46(3):319-29. https://dx.doi.org/10.1016/j.semarthrit.2016.08.012

[17] Perrot S, Dumont D, Guillemin F, Pouchot J, Coste J. Quality of life in women with fibromyalgia syndrome: validation of the QIF, the French version of the fibromyalgia impact questionnaire. J Rheumatol 2003;30(5):1054-9.

[18] Guy W. Clinical Global Impressions (028-CGI). In: Guy W, ed. ECDEU assessment manual for psychopharmacology, revised 1976. Rockville: US Department of Health, Education, and Welfare; 1976. p. 218-22. https://ia800200.us.archive.org/19/items/ecdeuassessmentm1933guyw/ecdeuassessmentm1933guyw.pdf

2. Care pathway

Fibromyalgia in adults: scaled treatment strategy

Propose follow-up

- More frequent until symptoms stabilise.
- Then if favourable course: follow-up every 3 to 6 months.
- Referral to other specialist physicians, to a chronic pain clinic (SDC)[1] for an opinion, multidisciplinary and multi-professional assessment, choice of, or access to, appropriate treatment, recalcitrant pain.

Regularly assess the effects of treatments

- Functional status, activities of daily living, retention in workplace.
- Pain, other symptoms, mood.
- Quality of life.

Scale the treatment strategy

- Start with first-line interventions, then supplement with second-line interventions if required.
- Reconsider maintenance of one or more components of the treatment strategy.
- Supplement with third-line interventions following reassessment and opinion.

As a first-line approach: combine interventions

Physical activity

- **Advice** to maintain everyday physical activities, engage in PA[1] and reduce sedentary behaviours.
- **Supervised APA[1] programme with independent learning:** if PA levels are insufficient and difficulties exercising autonomously and safely.
- **Rehabilitative care programme to improve function (SMR)[1]:** if persistent difficulties or physical deconditioning.

Self-management of the condition

- **Advice** to simplify everyday activities. Co-construct coping strategies.
- **Group patient education sessions (ETP)[1]:** if need to develop autonomy in the management of the condition or difficulties coping.
- **Specialised and structured psychological interventions:** if inappropriate coping strategies or behaviours.

Retention in employment

- **Encourage** maintenance of work activities.
- **Support from occupational health and prevention service physician (SPST)[1]:** if significant impact on work.
- **Seek adaptations with the occupational health and prevention service physician and employer:** if significant difficulties or before sick leave.
- **Training, guidance, disabled worker status (RQTH)[1], temporary disability:** if the job cannot be adequately adapted.

Associated health problems or difficulties

- Identify, assess, treat, support:
  - **sleep** disorders;
  - psychological disorders (**anxiety**, **depression**, **suicidal ideation**);
  - **overweight** or **obesity**;
  - any form of **vulnerability, at-risk situation**.

As a second-line approach in addition to first-line interventions

Medicinal treatments: modest effect on pain

→ **Systematically identify any misuse and associated risks of medications.**
→ **Reassess tolerability, perceived efficacy, adverse effects.**

- **Constant pain:** background therapy with antidepressants and anticonvulsants, at low doses.
- **Incident pain:** occasional treatment, never long-term (paracetamol or NSAIDs)[1].
- **Cautious use of tramadol** as occasional treatment for acute incident pain.
- Long-term tramadol prescription in exceptional cases only, following an opinion (pain consultation).
- **Other opioids not recommended.**

Other non-medicinal interventions without adverse effects or health risks

- **Hydrotherapy always combined with physical exercise and continued independently:** in the event of moderate severity of fibromyalgia and in a stable phase.
- **Relaxation, hypnosis, meditation subject to delivery conditions:**
  - appropriate training of practitioners;
  - definition of content and practical arrangements;
  - self-learning by the patient;
  - discontinuation if no response.

As a third-line approach in addition to first-line and, if required, second-line interventions

Neurostimulation with effects on localised or locoregional pain

- **Following a multidisciplinary opinion:** TENS[1] on a temporary basis.

Subject to conditions and delivery methods, learning. Discontinuation if no response.

Neurostimulation with general effect on pain and quality of life

- **Following pain clinic opinion:** rTMS or tDCS[1].

Depending on availability of equipment and dedicated, trained personnel in the healthcare facility. Discontinuation if no response.

1. NSAIDs: nonsteroidal anti-inflammatory drugs; PA: physical activity; APA: adapted physical activity; ETP: *éducation thérapeutique du patient* [therapeutic patient education]; RQTH: *reconnaissance de qualité de travailleur handicapé* [recognition of disabled worker status]; rTMS: repetitive transcranial magnetic stimulation; SDC: *structure douleur chronique* [chronic pain clinic]; SMR: *soins médicaux et de réadaptation* [medical and rehabilitative care]; SPST: *service de prévention et de santé au travail* [preventive and occupational health service]; tDCS: transcranial direct current stimulation; TENS: Transcutaneous Electrical Nerve Stimulation.

Fibromyalgia in adults
Diagnostic management and treatment strategy

2.1. Scaling and personalisation

Scaling and personalising treatments involves providing appropriate and scalable responses over time, mobilising different professional skills and interventions depending on:

- the variability of the symptoms, the level of impairment of functional capacities, activities of daily living and quality of life, associated with the fibromyalgia and their evolution;
- the needs, requests, expectations and difficulties of each person;
- the shared assessment of improvements and response to treatments by patients and their care-givers.

R.30. The scaled and personalised treatment strategy offers several initial interventions that can then be supplemented depending on how the situation evolves.

- **As a first-line approach:** physical activity, including independent learning; the development of personalised self-management strategies; support to remain in work; assessment, treatment and support for all health problems or associated difficulties: sleep disturbances, psychological disorders, overweight or obesity, all forms of vulnerability and at-risk situations.
- Medications are a **second-line approach**.
- **As a third-line approach**, neurostimulation techniques offered following reassessment and a multidisciplinary or chronic pain clinic opinion, depending on the method envisaged.
- **From the time of diagnosis and throughout the overall follow-up process**, the detection of any psychological disorders, not necessarily implying a psychological cause of the fibromyalgia, and their prompt treatment. These disorders can make it difficult for patients to engage in their treatment and cope with their condition if they are not assessed and treated.

2.2. Proposing personalised physical activity is essential in the treatment of fibromyalgia

2.2.1. Encourage physical activity

R.31. It is recommended to encourage the maintenance of everyday physical activities, along with regular exercise and a reduction in sedentary behaviour.

Physical activity is beneficial for all patients, provided that the goals are realistic and that it is progressive, chosen by the patient, enjoyable, well tolerated, and adjusted in terms of frequency, duration, progression, and intensity.

Physical activity improves functional capacities, fatigue, activities of daily living, and may have a protective effect against stress and anxiety, as well as sleep and mood disorders. Physical activity is recommended as a treatment for mild to moderate depression.

2.2.2. Propose and prescribe an adapted physical exercise programme

R.32. If levels of physical activity, including muscle strengthening activities, do not reach the levels recommended by WHO,[19] and if patients have difficulties being physically active autonomously and safely, it is recommended that an adapted physical activity (APA) programme be prescribed.

[19] At least 150 to 300 minutes of moderate-intensity aerobic physical activity or at least 75 to 150 minutes of vigorous-intensity aerobic physical activity, or an equivalent combination of moderate- and vigorous-intensity physical activity per week, supplemented by moderate- or vigorous-intensity muscle-strengthening activities twice a week. World Health Organization. Global action plan on physical activity 2018–2030: more active people for a healthier world. Geneva: WHO; 2018. http://apps.who.int/iris/bitstream/handle/10665/272722/9789241 514187-eng.pdf

R.33. An assessment should be performed by the prescribing physician prior to issuing any prescription for adapted physical activity (Annexe 3). If necessary, a diagnostic assessment performed by a physiotherapist,[20] systematically transmitted to the prescribing physician, may be prescribed by the general practitioner or another specialist in order to:

- conduct an in-depth assessment of the various components of the individual's physical condition: mobility, strength, flexibility, balance, aerobic capacity, fatigability, possible kinesiophobia, symptoms experienced during and at the end of the assessment;
- identify the patient's daily physical activity in the context of leisure, work and family activities;
- identify the patient's preferences, expectations and motivation with respect to physical activity;
- in the absence of contraindications, propose an APA programme including realistic treatment goals in terms of expected effects, duration and implementation methods;
- avoid passive approaches, which are of no benefit for getting patients moving again in the event of fibromyalgia.

R.34. The APA programme is primarily implemented and supervised by an APA trainer or physiotherapist,[21] taking into account the specificities related to fibromyalgia (fatigability, exercise tolerance, recovery and potential persistence of pain between sessions).

R.35. The APA programme should be structured and correspond to FITT-VP principles[22] (Annexe 3), include varied and educational active strategies, incorporating independent practice learning into each session to meet the expected goals set out in the care plan (Box 2).

Box 2. Types of physical exercises and implementation methods in fibromyalgia

Progressive, **low- to moderate-intensity** exercises that are land- or water-based are proposed based on local provision and the patient's preferences. In particular, the exercises proposed may include **aerobic endurance*** and **muscle-strengthening**** exercises, along with exercises promoting **muscle and joint flexibility and balance**.

➔ Aquatic activities have the benefit of being better tolerated due to the relative reduction in weight bearing in water, and of facilitating movement and reducing kinesiophobia.

Sessions take the form of **group or individual sessions, delivered 1 to 3 times per week, over a period of 3 months**.

➔ The duration of the sessions, along with their methods, should be adapted based on the patient's tolerance to exercise, the persistence of pain between sessions and the patient's availability.

Exercises should be varied and fun to prevent them becoming monotonous and patients giving up during the programme, and to support motivation and effort.

Support for resuming physical activity and continuing it independently with follow-on support **is an integral part of the APA programme**.

When patients already engage in significant physical activity, the objective is to **support them in regulating its intensity** to prevent worsening of symptoms.

* Aerobic endurance physical activity: exercise bike, treadmill. ** Muscle-strengthening physical activity: weight machine with guided weights, weights and dumbbells, elastic bands.

[20] Diagnostic assessment by a physiotherapist https://www.ameli.fr/masseur-kinesitherapeute/exercice-liberal/facturation-remuneration/tarifs-conventionnels/bilan-diagnostic-kinesitherapique

[21] Adapted physical activity professionals: physiotherapist, APA trainer, occupational therapist, psychomotor therapist.

[22] FITT-VP: F for frequency, I for intensity, T for type of physical activity, T for session time, V for volume or amount of physical activity, P for progression.

2.2.3. Support independent learning to perform physical activities

R.36. To maintain the benefits of the physical activity programme, it is essential that APA professionals incorporate learning from the very first PA sessions and throughout the programme. This learning helps individuals understand the benefits of physical activity, encourages regular participation in sessions, promotes their awareness of their physical capacities and limitations and their own internal resources, helps them adapt their efforts, and guides them towards independent practice of physical activities.

R.37. At the end of the APA programme, if pain and fatigue, functional capacities, performance of activities of daily living and learning to engage independently in APA have not improved sufficiently, it is recommended that APA sessions be continued for a further period of 3 months and/or that the therapeutic strategy be supplemented.

R.38. Once symptoms have stabilised, follow-on support, within a sport for health facility,[23-24] for example, is provided to encourage the continuation of personalised physical activity and independent learning: the patient's capacity to engage in regular physical activity that suits their preferences, either alone or with the help of social support, family or friends, and to adapt the progression, duration and intensity of the physical activity, even once symptoms have stabilised.

2.2.4. Propose medical and rehabilitative care in the event of persistent difficulties or physical deconditioning

R.39. If the difficulties persist, or if physical deconditioning develops, it is recommended to refer the patient to a physical medicine and rehabilitation specialist or a specialised chronic pain clinic[25] for a multidimensional and multidisciplinary assessment of the situation and proposal of a medical and rehabilitative care programme.

R.40. This multi-component medical and rehabilitative care programme may be prescribed if the patient requires the services of a multi-professional team in the community setting, provided that local resources are available and sufficient, or in a healthcare facility (general medical and rehabilitative care unit or one specialising in locomotor care) on a partial or full inpatient basis.[26]

R.41. Continuation of the care plan after the stay in a medical and rehabilitative care facility, in particular independent learning in the practice of physical activity, and coping with their condition are essential in order to maintain the benefits of the stay.

[23] *"Maisons sport-santé"* ("sport for health centres") can be found throughout metropolitan France and in almost all French overseas regions Découvrez les maisons sport-santé les plus proches de chez vous | sports.gouv.fr [Find your nearest "sport for health centre"]; *Société française des professionnels en activité physique adaptée* [French Society of Adapted Physical Activity Professionals], L'Annuaire des Enseignant·e·s en APA | SFP-APA [Directory of APA trainers]

[24] MédicoSport-santé®, updated directory of sports federations in the field of sport for health, and their indications, published by the French National Olympics and Sports Committee website: Sport Santé | CNOSF

[25] French national registry of health and medico-social support resources – ROR https://esante.gouv.fr/produits-services/repertoire-ror

[26] Depending on the patient's clinical condition and needs: nurse, APA trainer, physiotherapist, occupational therapist, psychomotor therapist, psychologist, dietician/nutritionist, social worker, coordinated by a medical and rehabilitative care specialist (French decree No. 2022-25 of 11 January 2022 relating to the technical terms of practice applicable to medical and rehabilitative care activities. French Official Journal; 13 January 2022. http://dx.doi.org/https://www.legifrance.gouv.fr/jorf/id/JORFTEXT000044947234)

2.3. Accompany learning with strategies for the self-management of fibromyalgia

2.3.1. Help the patient gradually adapt to management of the condition

R.42. From the time fibromyalgia is diagnosed, it is recommended to help patients to:

- understand their condition, its mechanisms, its symptoms and its impact on quality of life by providing personalised explanations;
- express their feelings and emotions, and acknowledge their difficulties and resources;
- consider ways of simplifying activities of daily living, breaking them down into smaller tasks if necessary, alternating periods of activity and rest, then work together to develop ways of coping with the condition, leading to personal coping strategies.

R.43. Encourage the maintenance of health-promoting lifestyle habits and the continuation of activities as much as possible (Annexe 1):

- continue everyday physical activities and reduce sedentary behaviour, engage in physical exercise: choose an enjoyable physical activity, adjust the intensity, and practise it with other people (family, friends, clubs, etc.);
- preserve the quality of sleep;
- adjust dietary balance and variety if necessary, and maintain a regular meal schedule;
- remain in employment, advising patients to consult their occupational health and safety physician (SPST) if required, even during a period of sick leave if this proves necessary (see chapter 2.4).

2.3.2. Offer patient education to foster independent self-management of the condition

R.44. If the healthcare professional identifies, or the patient expresses, a need to develop autonomy in the management of the condition or difficulties coping with the situation during follow-up consultations, it is recommended that patient education sessions be offered after assessing the patient's needs (Annexe 4).

These sessions, which are ideally group sessions, are delivered by healthcare professionals with the participation of patients trained in patient education. They enable patients to become more independent in managing their condition, to feel less isolated and to share experiences and work together to find solutions.

R.45. Depending on the patient's situation, patient education sessions are organised:

- ideally locally, as part of a coordinated approach between healthcare professionals[27] trained in patient education and chronic pain, in particular with the participation of public health nurses,[28] or advanced practice nurses, and patients trained in patient education;

[27] Multiprofessional healthcare centre: groups together, on a single site or otherwise, healthcare professionals – general practitioners and other specialists, midwives, dentists, nurses, physiotherapists, occupational therapists, dieticians, etc., and, where applicable, pharmacists, who share patient information using certified digital solutions. Coordinated primary care practice . Local healthcare professional communities (CPTS): bring together primary and secondary healthcare professionals working in private practice or as employees; health and medico-social services and facilities, and, depending on the projects, other social and medico-social professionals from the same area who wish to organise themselves – on their own initiative – around a health plan to address common issues.

[28] ASALÉE system (team-based community health action).

- or in the context of a stay in a medical and rehabilitative care unit, on a partial or full inpatient basis with the participation of a multi-professional team;[29]
- or in the context of a specialist chronic pain clinic with the participation of a pain resource nurse, a pain specialist or a psychologist.

2.3.3. Propose a specialised and structured approach in the event of difficulties with self-management of the condition

R.46. In the event of difficulties with self-management and coping strategies or inappropriate behaviours such as catastrophising, an obsessive tendency to work or keep busy all the time, or avoidance behaviours such as kinesiophobia, it is recommended to offer a personalised approach for structured psychological treatment based on:

- an assessment and identification of the psychological processes relevant to achieving specific goals for improving daily functioning and well-being;
- a choice of interventions and methods left to the assessment of the practitioner;
- implementation under the conditions and methods specified (description of the techniques used, the number of sessions, their frequency and duration, and the methods: face-to-face, in a group or individually) and by a clinical psychologist or an experienced psychiatrist trained in psychopathology.

R.47. A broad variety of structured psychological interventions are proposed in the context of chronic pain, reflecting the diversity of approaches and techniques used. One of these interventions - cognitive behavioural therapy (CBT) - can be considered in fibromyalgia to develop mechanisms for coping with pain.

For information purposes, the most representative interventions implemented in the context of chronic pain include:

- cognitive behavioural therapies (CBT), which generally focus on maladaptive cognitions (cognitive restructuring) and the activation of behaviours at an appropriate pace. By acting on thoughts, it is possible to act on emotions and behaviours. CBT also uses relaxation techniques, particularly during exposure, to alleviate anxiety. These also help treat disorders associated with chronic pain, such as depression, anxiety, catastrophising and insomnia;
- mindfulness-based stress reduction (MBSR), which focuses on the acceptance of present experiences and mindfulness. MBSR can be incorporated into CBT. Individuals learn to develop greater awareness of their thoughts and emotions, helping them to better manage stress and anxiety on a daily basis;
- acceptance and commitment therapy (ACT) is based on techniques exposing patients to their “lived experience”. It encourages people to accept painful internal experiences, to detach themselves from negative thoughts motivated by fear of pain, and to re-engage in rewarding activities despite pain. It uses both CBT tools and mindfulness. ACT tools are still in the process of being developed and their validation and practice is still too recent to be used.

[29] Depending on the patient’s clinical condition and needs: nurse, APA trainer, physiotherapist, occupational therapist, psychomotor therapist, psychologist, dietician/nutritionist, social worker, coordinated by a medical and rehabilitative care specialist (French decree No. 2022-25 of 11 January 2022 relating to the technical terms of practice applicable to medical and rehabilitative care activities. French Official Journal; 13 January 2022. http://dx.doi.org/https://www.legifrance.gouv.fr/jorf/id/JORFTEXT000044947234)

2.4. Help people remain in employment and adapt their job

R.48. The retention in the workplace of a person diagnosed with fibromyalgia should be encouraged as far as possible in order to prevent professional exclusion along with its psychological, social and financial consequences.

It should be highlighted that repeated and/or prolonged sick leave can lead to isolation, feelings of worthlessness and a loss of bearings and regularity in daily activities, which can cause anxiety when returning to work, or a potential symptom avoidance strategy, which need to be understood and prevented.

R.49. From the fibromyalgia diagnosis stage, if the condition has a significant impact on the patient's work, whether functional, psychological or socioprofessional, or vice versa, the patient should be referred to an occupational health and safety physician.

R.50. Both the occupational health and safety physician and the physician treating the patient remind the worker that they can request a consultation with the occupational health and safety physician at any time (including during sick leave).

R.51. In the event of significant difficulties, and ideally before considering sick leave, it is recommended that adaptations be sought in coordination with the occupational health and safety physician.

These adaptations are personalised, scalable and tailored to the patient's symptoms, taking into account the individual's capacities and the company's constraints, and ensuring a balance between adaptation and maintaining professional momentum. Adaptations may include: adapted or flexible working hours (possibly as part of a therapeutic part-time work arrangement); adaptation of activities in terms of quantity and frequency, task order and productivity requirements; alternating between more demanding and lighter tasks; adaptation of the environment or workstation, allowing the employee to sit down when necessary; sharing responsibilities with colleagues; teleworking, while taking care to avoid isolation, which can be counterproductive, etc.

R.52. Once all pertinent adaptations have been made, and in the event that the job cannot be adequately adapted, training and career guidance measures may be offered with a view to professional redeployment. Multidisciplinary management by the players involved in the process of maintaining people in work is encouraged [occupational health and safety physician, regional centre for people with disabilities (MDPH), the “CAP emploi” employment service for people with disabilities, the French National Health Insurance system’s social and medical service, centre for career guidance (CEP)].

R.53. An application for recognition as a disabled worker (RQTH) submitted to the MDPH, or even an application for first-category disability submitted to the French National Health Insurance system’s medical service, may be necessary, sometimes on a temporary basis.

2.5. Investigate for any sleep disorders and treat if required

R.54. For all patients, advise them to maintain good sleep quality and keep to a regular sleep-wake cycle:[30] maintain regular activities, engage in physical activity or movement from the start of the day, make dietary changes if necessary in terms of variety and balance, maintain a regular meal schedule, engage in physical activity during the day and avoid it for a few hours before bedtime, reduce screen time, especially before bedtime, and reduce smoking, coffee and alcohol, if applicable.

[30] Réseau Morphée: http://www.reseau-morphee.fr/; Institut national du sommeil et de la vigilance: http://www.institut-sommeil-vigilance.org/

R.55. If the patient complains about the quality and/or quantity of sleep, waking up feeling unrefreshed, and in the event of sleep disorders:

- systematically investigate for signs suggestive of restless leg syndrome and/or sleep apnoea syndrome, confirm the diagnosis, propose specific treatment and evaluate its benefits;
- propose investigation of sleep habits,[31] any insomnia[32] that could be an indication for the prescription of medication for a limited period and/or referral to a sleep specialist;
- if signs of anxiety are detected or in the event of known depression, treatment is proposed based on current recommendations (chapter 2.6);
- identify any self-medication, since prescribed medications can sometimes cause sleep disorders, and find the medications or dosages best suited to the patient.

R.56. No hypnotics, benzodiazepines or related substances are indicated in the treatment of chronic insomnia. Their indication is limited to short-term treatment (4 weeks including the dose tapering phase) of severe sleep disorders in adults: occasional and temporary insomnia.[33]

Such medications should not be widely prescribed, because although they facilitate sleep, they do not resolve the causes of insomnia, which must be investigated. They can cause numerous side effects, with sometimes serious consequences. The use of these medicinal products requires compliance with specific rules: minimum effective dose, prescription limited to 28 days, patient information. The end-of-treatment arrangements must be anticipated from the time the medication is first prescribed.

2.6. Early and regular screening for any mood disorders and their treatment

Chronic pain, insomnia and functional limitations can lead to anxiety or depression. Treating these disorders provides relief for patients, makes it easier for them to engage in their treatment, particularly physical activity, and helps them cope with their condition.

R.57. From the initial phase of fibromyalgia treatment until symptoms stabilise, it is recommended to identify any major depressive disorder and to assess its severity in order to choose a treatment (supportive psychotherapy, [34] antidepressant treatment, structured psychotherapy, in particular cognitive behavioural therapy).[35]

R.58. During the follow-up phase, it is recommended to carefully look out for the onset or recurrence of mood disorders at each medical consultation, and to offer appropriate treatment. In the event of suicidal ideation, refer the patient to a psychiatrist without delay.

[31] Pittsburgh sleep quality index (PSQI).

[32] Haute Autorité de santé. *Prise en charge du patient adulte se plaignant d'insomnie en médecine générale.* [Management of adults complaining of insomnia in general medicine.] Saint-Denis La Plaine: HAS; 2006 RPC SFTG Insomnie - Synthèse Version finale MEL 1ère relec…

[33] Haute Autorité de santé. *Quelle place pour les benzodiazépines dans l'insomnie ?* [What role for benzodiazepines in insomnia?] Saint-Denis La Plaine: HAS; 2024 Microsoft Word - BUM_BZD_INSOMNIE_11_07_24_VF.docx

[34] Referral to the *"Mon soutien psy"* ["My psychological support] programme: 12 sessions partially reimbursed by the French national health insurance system.[34] Patients can enrol in the *"Mon soutien psy"* programme themselves by making an appointment directly with a partner psychologist who has signed an agreement with the French national health insurance system.

[35] Haute Autorité de santé. *Épisode dépressif caractérisé de l'adulte : prise en charge en soins de premier recours.* [Major depressive disorder in adults: management in the primary care setting.] Clinical practice guideline. Saint-Denis La Plaine: HAS; 2017 https://www.has-sante.fr/jcms/c_1739917/fr/episode-depressif-caracterise-de-l-adulte-prise-en-charge-en-premier-recours

2.7. Role of nutrition in the treatment of fibromyalgia

R.59. Overweight and obesity are more common in people diagnosed with fibromyalgia, linked, in particular, to inadequate levels of physical activity and sedentary behaviour, and in some cases exacerbated by the use of medications the promote weight gain. In these situations, based on a multi-dimensional assessment, involving a dietitian or nutritionist as part of the care plan if necessary,[36] recommend:

- support enabling them to adopt health-promoting lifestyle habits and maintain them over time: improving their diet (sensations, balance, quality, environment, portion sizes) and systematically combining this with regular physical activity and a reduction in sedentary behaviour, improved sleep and life rhythms (Annexe 1);
- weight stabilisation followed by personalisation of the weight target in cases where health is affected;
- treatment of comorbidities and eating disorders if applicable;
- reassessment with a proposal for complementary treatments while maintaining lifestyle changes.

R.60. If patients request nutritional advice, it is necessary to:

- record their past experiences, perceived effects and specific avoidance strategies;
- explain that a balanced and varied diet generally covers real needs;
- inform them that there are no arguments for or against a vegetarian, vegan, Mediterranean, high-fibre, high-olive oil, low-FODMAP[37] or other specific diet in fibromyalgia;
- inform them that there is no evidence of a benefit of a specific diet for fibromyalgia, except in cases of proven deficiencies or gastrointestinal disorders, due to the lack of high-quality studies. This includes, in particular:
  - diets with specific restrictions, such as gluten- or lactose-free diets,
  - probiotics (live microorganisms) or prebiotics (selectively fermented non-digestible food ingredients),
  - vitamin D or other vitamins and minerals, in the absence of deficiencies linked to an identified disease or condition. Low vitamin D levels are common in the general population; the usual supplementation rules apply in the event of vitamin D deficiency,
  - nutritional supplements (herbal, vitamins and minerals, or other concentrated substances for nutritional or physiological purposes, used alone or in combination) with potential adverse effects (allergies, exceeding safety limits, interactions with medications taken by the patient).

When healthcare professionals or patients have questions about the expected properties and safety of nutritional supplements, it may be useful to consult the European Commission's register of authorised health claims. Information on nutritional and health claims is available on the website of the French Ministry of Economy, Finance, and Industrial and Digital Sovereignty.[38]

[36] Haute Autorité de santé. *Parcours de soins. Surpoids et obésité de l'adulte.* [Care pathway: Overweight and obesity in adults.] Saint-Denis La Plaine: HAS; 2024. Haute Autorité de Santé - Care pathway guide: overweight and obesity in adults

[37] FODMAP (Fermentescible Oligosaccharides, Disaccharides Monosaccharides And Polyols): naturally poorly digested sugars that ferment when they come into contact with bacteria in the bowel and, when eaten in excess or by sensitive individuals, cause intestinal bloating, leading to pain and gas.

[38] Allégations nutritionnelles et de santé : ne vous faites pas avoir ! | Ministère de l'Économie des Finances et de la Souveraineté industrielle et numérique

2.8. Role of medicinal treatments to alleviate symptoms

Preliminary point

It should be highlighted that no marketing authorisations (MA) for a pharmaceutical product have been granted in France in the “Fibromyalgia” indication.

2.8.1. General principles for the prescription of medicinal products in fibromyalgia

R.61. The expected benefit of medicinal treatments in fibromyalgia is modest.

- Medicinal products are a second-line treatment following the implementation and assessment of the effects of physical activity, learning of self-management strategies for fibromyalgia, and support to remain in work.
- The potential role of medication in the overall management strategy should be discussed with the patient.

R.62. In the event of concomitant painful conditions (osteoarthritis, migraine, etc.), the recommendations specific to these other painful conditions or symptoms apply.

R.63. It is necessary to differentiate between pharmacological treatment for constant pain and that for incident pain, associated with exertion, for example. In the first case, treatments with a pain-modulating effect are probably more appropriate, while conventional analgesics are likely to be considered in the second case, for intermittent use (see Paracetamol and NSAIDs).

2.8.2. Choice of medication

R.64. Since studies have not revealed any differences between the various drugs in terms of their effects on pain, the choice of medication may be based on other symptoms (sleep, depression, anxiety) depending on their predominance. The adverse effects and contraindications of each drug should be taken into consideration.

R.65. It is recommended to set treatment goals with the patient to reduce pain intensity, improve function, or improve quality of life. These objectives should be realistic. For example, a 30% reduction in pain intensity appears to be a realistic and clinically relevant objective.

R.66. Pharmacological treatments should be started at low doses with a gradual and cautious increase in dosage in order to improve tolerability and reduce the occurrence of adverse effects.

R.67. The decision to continue or stop a pharmacological treatment should be based on a reassessment at each consultation, evaluating both safety and perceived efficacy.

2.8.3. Role of analgesics to alleviate pain in fibromyalgia

Paracetamol and NSAIDs

R.68. There are not currently enough data to recommend the use of paracetamol as a background therapy for continuous pain.

R.69. The prescription of nonsteroidal anti-inflammatory drugs (NSAIDs) as background therapy to alleviate continuous pain is not recommended.

R.70. In the event of acute incident pain, paracetamol or NSAIDs may be considered as occasional treatment, at the lowest effective dose and in accordance with the usual contraindications for these medicinal products.

Opioids

R.71. Tramadol should be prescribed with caution in fibromyalgia, taking into account the recommendations of the HAS' good practice guidelines for opioid medicines[39] (procedures for initiating treatment, monitoring adverse effects or signs of misuse, improvement of pain intensity, function, quality of life, and discontinuation).

Due to an international signal relating to the misuse of opioids, particular attention should be paid to identifying any misuse following the initial prescription and at each prescription renewal. The French National Agency for Medicines and Health Products Safety (ANSM) indicates that prescriptions should be as short as possible and that the maximum prescription duration for tramadol cannot exceed 3 months (< 12 weeks) and requires a secure prescription (News – Tramadol and codeine must be prescribed using a secure prescription process – ANSM).

R.72. In the event of acute incident pain, tramadol may be considered as an **occasional** treatment.

R.73. **Long-term** treatment with tramadol in fibromyalgia patients should be exceptional and may only be considered after obtaining specialist advice (pain consultation at a chronic pain clinic).

R.74. Other opioid analgesics (codeine, opium, morphine sulfate, oxycodone, fentanyl, buprenorphine, methadone, hydromorphone, nalbuphine) are not recommended in fibromyalgia.

Other drugs

R.75. The prescription of corticosteroids and muscle relaxants is not recommended in fibromyalgia.

2.8.4. Role of psychotropic drugs to alleviate pain and other symptoms

Tricyclic antidepressants

R.76. Amitriptyline can be used as a background therapy to improve the symptoms of fibromyalgia, particularly pain and sleep (at small doses in these indications). The effective doses to alleviate pain appear to be between 10 and 75 mg/day, and primarily around 25 mg/day. Given its potential adverse effects, amitriptyline should be prescribed with caution in the elderly.

In the event of discontinuation of treatment, gradually reduce the doses to prevent any withdrawal symptoms.

R.77. The prescription of topical amitriptyline as a pharmacy-compounded preparation is not recommended to alleviate fibromyalgia pain.

Serotonin and noradrenaline reuptake inhibitors

R.78. Serotonin and noradrenaline reuptake inhibitors (SNRIs) can be used to improve fibromyalgia symptoms, particularly pain. The most studied drugs for which robust data are available are duloxetine and milnacipran. The data are modest but positive for venlafaxine.

The effective doses are around 60 to 120 mg/day for duloxetine,100 mg/day for milnacipran, 75 mg to 150 mg/d for venlafaxine.

R.79. There are not currently enough data to recommend the use of mirtazapine.

[39] Haute Autorité de santé. *Traitement antalgique opioïde de la douleur chronique non cancéreuse. Bon usage des médicaments opioïdes : antalgie, prévention et prise en charge du trouble de l'usage et des surdoses.* [Opioid analgesia for non-cancerous chronic pain. Good practice guidelines for opioid medicines: analgesia, prevention and management of misuse and overdoses.] 2022.

Other psychotropic agents

R.80. Selective serotonin reuptake inhibitors (SSRIs) are not recommended for the treatment of fibromyalgia pain but may be considered in the event of concomitant anxiety or depressive disorders.

R.81. There are not currently enough data to recommend the use of monoamine oxidase inhibitors (MAOIs) or quetiapine to alleviate pain or improve sleep disorders, depression and anxiety in fibromyalgia.

2.8.5. Role of anticonvulsants and gabapentinoids to alleviate pain

R.82. Anticonvulsants and gabapentinoids may be used as background therapy to improve fibromyalgia symptoms, in particular pain. The working group's opinion is that gabapentin should be favoured as a first-line approach due to the risk of misuse associated with pregabalin. The effective doses are between 1,200 and 3,600 mg/day for gabapentin and 150 and 600 mg/day for pregabalin.

In the event of discontinuation of treatment, gradually reduce the doses to prevent any withdrawal symptoms.

Due to an international signal relating to the misuse of pregabalin and the associated risks (confusion, disorientation, altered consciousness, coma), particular attention should be paid to identifying any misuse when prescribing and at each prescription renewal. The prescription should be as short as possible and limited to a maximum of 6 months. A secure prescription is required.

R.83. The prescription of the following medicinal products is not recommended: carbamazepine, lamotrigine, topiramate, clonazepam or other anticonvulsant drugs in the absence of efficacy and considering the risk of adverse effects.

2.8.6. Role of cannabinoids and products containing cannabidiol

R.84. There are not enough data to recommend the use of cannabinoids in fibromyalgia.

The ongoing ANSM trial in France concerns refractory neuropathic pain, not fibromyalgia.

Products containing cannabidiol (CBD) are available without prescription. Their quality, composition and harmfulness have not been assessed, and these products do not have the status of medicinal products.

2.8.7. Role of other drugs to alleviate pain and other symptoms

R.85. Low-dose oral naltrexone appears to have a beneficial effect to alleviate fibromyalgia pain according to some international studies. However, the < 5 mg strength is not available in France. Consequently, the working group has no experience in the use of this medicinal product.

R.86. The prescription of the non-competitive NMDA (N-methyl-D-aspartate) receptor antagonist ketamine, which is a narcotic drug, is not recommended for the treatment of fibromyalgia.

Its use outside the context of anaesthesia, particularly when repeated, carries serious risks: psycho-dysleptic effects, damage to the kidneys, liver and urinary tract, dependence and acquired tolerance.

The ANSM points out the risks concerning the use of ketamine and the precautions to be taken, particularly in the event of prolonged use to treat recalcitrant or chronic pain.[40]

[40] News – The ANSM highlights good practices for the use of ketamine – ANSM (updated in September 2023).

R.87. There are not enough data to recommend the use of memantine [moderate-affinity noncompetitive NMDA (N-methyl-D-aspartate) receptor antagonist] for the treatment of fibromyalgia.

R.88. The prescription of intravenous lidocaine is not recommended for the treatment of fibromyalgia.

R.89. There are not enough data to recommend the use of topical lidocaine.

R.90. The prescription of L-carnitine (100 mg/ml, oral solution) is not recommended in the absence of systemic or muscular primary carnitine deficiency, which is very rare.

R.91. The use of melatonin is not recommended in the treatment of fibromyalgia. Melatonin is used in nutritional supplements, medicines and pharmacy-compounded preparations for its effects on sleep, and on mood and immune system modulation, body temperature regulation and intestinal motility. Adverse effects have been reported, particularly for use at a dose of 3 mg in fibromyalgia to relieve sleep disorders, fatigue and pain.

2.8.8. Role of homeopathy to alleviate pain

R.92. Homeopathy is not recommended in the treatment of fibromyalgia. The low number of studies and the insufficient data do not enable any conclusions to be drawn about the benefits of homeopathic medicines for pain in fibromyalgia.

2.8.9. Role of mesotherapy to alleviate local pain

R.93. Mesotherapy (subcutaneous or intradermal injection of low doses of medication as close as possible to the area to be treated, either manually or with the aid of an electronic injection gun) has not been clinically demonstrated to be effective and involves numerous local reactions, sometimes severe allergic reactions, as well as exposure to a risk of infection due to skin penetration. The effects of product mixtures in terms of their efficacy or safety are difficult to predict. Mesotherapy is not recommended in the treatment of fibromyalgia pain.

2.9. Role of other non-medicinal interventions

R.94. Several non-medicinal interventions, both invasive and non-invasive, demonstrate modest short and medium-term effects in other chronic pain syndromes. Their effects have not yet been clearly demonstrated for fibromyalgia.

Pending new, better-quality studies including the perspective of patients in addition to quantitative data, confirming the benefit of these interventions in the future, the working group makes the following proposals.

- The physician treating the patient must be vigilant with regard to practices, techniques and approaches proposed for fibromyalgia due to their lack of standardisation, regulation and reliable studies concerning their efficacy and safety. If in doubt, the benefits of these interventions as part of the care plan should be discussed with a physician trained in chronic pain management.
- If patients are willing, their past experiences, expectations and motivations should be gathered, and they should be informed about any demonstrated effects of the intervention, the absence of adverse effects and health risks, and the practical conditions and procedures of the intervention, including delivery or supervision by a trained professional, the number of sessions, the frequency, the duration, the need for a prior test and patient training, and the cost.
- If implemented, regular assessments of the benefits of the intervention should be scheduled with the patient, as well as discontinuation if the intervention, when delivered as planned, does not have the expected effects in terms of providing relief.

2.9.1. Hydrotherapy

R.95. Hydrotherapy, systematically combined with supervised physical exercise in a swimming pool, provides moderate analgesic and/or functional benefits, but these do not last beyond the short to medium term. This treatment may be offered, in particular, to patients whose condition severity is moderate and in a stable phase.

Patients who have undergone a hydrotherapy facility programme emphasise its benefits in terms of helping them get moving again in a structured and safe environment. The conditions are conducive to this renewed movement thanks to a group emulation process and the fact that patients get to take a break from their usual living environment and obligations of everyday life, but a significant level of personal commitment is also required (motivation, family organisation, intensity of treatments that can be a source of fatigue, continuation of activities after the stay, transport and accommodation costs, etc.).

R.96. Patient education incorporated into the hydrotherapy programme may be useful to help maintain benefits.

R.97. It is the responsibility of the prescriber, physician and hydrotherapy team to inform the patient of the importance of continuing their care plan after their stay at the hydrotherapy centre, particularly independent physical activity.

2.9.2. Neurostimulation techniques

R.98. Transcutaneous Electrical Nerve Stimulation (TENS) can be useful to temporarily relieve flare-ups of localised or locoregional pain. Its long-term efficacy on physical function or quality of life has not been demonstrated.

As with prescriptions in other types of pain, this non-invasive treatment, which can be used independently, may be considered with specific prescribing conditions (multidisciplinary opinion), administration methods (number of sessions, frequency, duration, placement of electrodes on the skin surface, intensity of pulsed electrical currents), prior testing to identify responsive patients, and patient training in the use of the medical device.[41]

R.99. Repetitive Transcranial Magnetic Stimulation (rTMS) of the motor cortex is effective in the short to medium term to obtain a general effect, both on chronic pain and quality of life in fibromyalgia. Offering this non-invasive technique can be considered. However, the performance of stimulation sessions in a healthcare facility requires dedicated and trained personnel.

R.100. Transcranial Direct Current Stimulation (tDCS) promotes a general, moderate short- and medium-term effect on chronic pain associated with an improvement in quality of life. Offering this non-invasive technique can be considered. However, the performance of stimulation sessions in a healthcare facility requires dedicated and trained personnel.

R.101. In the absence of high-quality studies, it is not yet possible to reach a conclusion with respect to the efficacy and use of stimulation of the auricular or cervical branch of the vagus nerve to relieve pain in fibromyalgia, even though studies have shown positive effects in other chronic pain conditions.

[41] Haute Autorité de santé – Appareils de neurostimulation électrique transcutanée (TENS): the initial prescription of TENS is subject to a multidisciplinary medical opinion from physicians chosen according to the type of condition being treated (involving at least one physical and rehabilitative medicine specialist or rheumatologist, neurologist or psychiatrist); a prior test (testing the efficacy of the technique using a pain assessment scale); training for the patient in the use of the medical device; follow-up at 1, 2, 3 and 6 months after the initial prescription and follow-up at least every 6 months after purchase of the device.

The stimulation parameters, duration and the most appropriate route for stimulation need to be better defined in order to establish with certainty the efficacy of vagus nerve stimulation in fibromyalgia.

2.9.3. Relaxation, hypnosis, meditation

R.102. Relaxation therapy may be considered for fibromyalgia given its positive effects on other chronic pain conditions (state of relaxation, calmness and well-being) and its ability to be practised independently after learning, provided that it is delivered in accordance with the specified conditions and procedures (description of the technique used, practitioner with appropriate training, number of sessions, frequency, duration, patient learning).

In the absence of sufficient studies, it is not possible to reach any conclusion in terms of the choice of one relaxation method over another (in particular, Schultz's autogenic training, Jacobson's progressive muscle relaxation, visualisation with guided imagery, biofeedback, Caycedo sophrology, cardiac coherence).

R.103. Hypnosis may be considered for fibromyalgia if performed by a healthcare professional or psychologist trained in this approach, given its benefits for other chronic pain conditions (providing patients with resources to learn how to change their relationship with pain and cope with it) and the implementation of self-hypnosis independently after training.

R.104. Before considering hypnosis, the physician treating the patient must make sure that there is no known psychiatric condition, which requires assessment by a psychiatrist, who can indicate or contra-indicate hypnosis and propose appropriate treatment.

R.105. Meditation involves a variety of practices, the most common being mindfulness meditation. This may be considered for fibromyalgia given its encouraging results in other painful conditions, provided that it is delivered in accordance with the specified conditions and procedures (description of the technique used, practitioner with appropriate training, number of sessions, frequency, duration, patient learning).

2.9.4. Acupuncture

R.106. The efficacy of acupuncture on chronic pain is low and temporary. The mechanisms of action of acupuncture in fibromyalgia have not been adequately elucidated, and its benefits in terms of pain relief are contradictory. In the absence of high-quality studies describing the techniques used, the frequency and duration of sessions, and the training of practitioners, it is not possible to recommend acupuncture in fibromyalgia.

2.9.5. Other interventions

R.107. "Body and mind" techniques (such as tai chi, yoga or qigong) or movement-based methods such as Pilates, dance, Nordic walking, etc. can lead to a moderate short-term improvement in pain and functional capacities in fibromyalgia. These approaches require patient learning in order to be practised independently. They may be recommended if supervised by appropriately trained professionals and in accordance with the specified conditions and methods (number, frequency, duration of sessions, precision of techniques, exercises).

R.108. In the absence of high-quality studies and given risks to patients, it is not possible to determine the efficacy of whole-body or partial-body cryotherapy (head not exposed) in the treatment of fibromyalgia.

R.109. Hyperbaric oxygen therapy is not indicated for fibromyalgia according to the European guidelines for hyperbaric medicine. Its mechanisms of action are poorly defined and its benefits for the

treatment of fibromyalgia are not established and are contradictory. In addition, the treatment protocols are demanding for the individual, and this therapy causes adverse effects.

R.110. In the absence of high-quality studies, it is not possible to determine the efficacy of chiropractic treatment, osteopathy, massage and fasciatherapy in the treatment of fibromyalgia.

In addition, the working group highlights that some manual methods may be poorly tolerated due to the allodynia present in some patients with fibromyalgia.

R.111. Eye Movement Desensitization and Reprocessing (EMDR) has no role in fibromyalgia, except in the event of associated post-traumatic stress disorder, which should be investigated.

R.112. The HAS returned an unfavourable opinion for reimbursement of a millimetre-wave emission neuromodulation bracelet along with its mobile application for symptom relief in adult patients with moderate to severe fibromyalgia (Fibromyalgia Impact Questionnaire score ≥ 39).[42]

[42] *Commission nationale d'évaluation des dispositifs médicaux et des technologies de santé* [National Committee for the Assessment of Healthcare Devices and Technologies]. Opinion of 11 March 2025. Haute Autorité de santé – FIBROREM

3. Role of patient associations

R.113. If the patient wishes, suggesting that they meet other patients within an association[43] can be beneficial in order to:

- share reliable information about fibromyalgia, its mechanisms, treatments that may be beneficial or that have side effects or health risks;
- share experiences and insights into managing the condition and receive reassurance and support;
- highlight the criteria for vigilance with regard to certain practices and techniques due to their lack of standardisation, regulation and reliable studies on their efficacy and safety.

Advice on protecting people from cult-based abuses, as well as criteria for recognising a charlatan or pseudothherapist belonging to a cult,[44] proposed by the Interministerial Mission for Vigilance and Combating Cult-Based Abuses (Miviludes),[45] may be useful to patients and their families, as well as to healthcare professionals and user associations.

R.114. Wherever possible, the design and co-facilitation of patient education sessions with a healthcare professional should be enriched by feedback and experience-sharing from people affected by fibromyalgia. Prior training in patient education is required in order to conduct or co-facilitate educational sessions alongside healthcare professionals.

[43] Associations d'usagers du système de santé agréées – Ministère de la Santé et de la Prévention (solidarites-sante.gouv.fr); France Assos Santé – La voix des usagers (france-assos-sante.org)

[44] Information sheet 4-1 Ten tips to protect yourself from cult-based abuses and Information sheet 4-2 How to recognise a charlatan or pseudotherapist belonging to a cult. *Guide Santé et dérives sectaires.* 2018. *Mission interministérielle de vigilance et de lutte contre les dérives sectaires*. Paris. MIVILUDES_Santé et dérives sectaires(148x210).indd

[45] Bienvenue sur le site de la Miviludes | MIVILUDES

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Annexe 1. Lifestyle: tips for better habits

Start with an assessment of lifestyle practices, encourage health-promoting behaviours and provide support to make changes if necessary

Increase physical activity

Encourage the person to be as active as their functional capacity allows, adapting their level of exercise to their own physical fitness. Start with small amounts of physical activity (PA), then gradually and moderately increase the frequency, intensity and duration to reach the recommended levels in addition to everyday physical activities. The daily duration of moderate-intensity cardiovascular activities (getting slightly out of breath during exercise) combined with muscle strengthening (e.g. climbing stairs) and stretching several times a week can be divided up into sequences of 10 minutes or less.

Reduce sedentary behaviour

Reduce the amount of time spent sitting or lying down as far as possible. Break up sedentary periods every 90 to 120 minutes with short sequences (4/5 min) of movement (walking, simple muscle relaxing movements, etc.), make a few movements to activate muscles and mobilise joints (rotation of shoulders, pelvis, ankles, wrists, hands, head).

Improve diet: meal quality and environment, dietary balance

- Make sure each meal contains nutrients that promote satiety, particularly wholegrain or semi-wholegrain products. Add fresh produce: fruit and vegetables, pulses: lentils, beans, chickpeas, nuts: walnuts, hazelnuts, almonds and unsalted pistachios, etc.
- Encourage home cooking and meal preparation, eating at regular times, allowing enough time to eat (at least 20 minutes), paying attention to the food being eaten, chewing slowly and savouring each mouthful. At the table, avoid screens, films or television programmes, and listening to the news.
- Promote access to dietary assistance if necessary (social worker).

Favour wholemeal or multigrain bread, wholemeal pasta and rice, wholemeal semolina, alternating consumption of oily and lean fish, rapeseed oil, walnut and olive oil, sufficient consumption of dairy products (excluding sweetened milk desserts), limited to 2 servings per day for young adults and 3 to 4 per day for adults over 70 years of age, seasonal foods and locally produced foods. Recommend a Mediterranean-style diet (rich in fruit, vegetables, legumes, whole grains, olive oil and oily fish) due to its health benefits. It should be noted that the effect on weight loss is increased if the Mediterranean diet is combined with a reduction in dietary energy intake, an increase in physical activity, and implementation for more than six months.

Limit the amount and frequency of alcohol, sugary products and drinks, salty products, cured meats, red meat (pork, beef, veal, mutton, lamb, offal), and ultra-processed products. Avoid snacking between meals.

Get enough sleep, maintain good sleep quality and keep to a regular sleep-wake cycle

In the morning, get your biological clock working properly: get up at regular times, expose yourself to sunlight or light, and engage in regular physical activity, which also increases sleep pressure (accumulation of fatigue during the waking period and the need to sleep at the end of the day).

- In the evening, prepare for sleep: learn to limit screen time, go to bed at regular times, prevent night-time food cravings: do not skip dinner, eat foods that make you feel full.
- At night, keep your bedroom quiet, cool and dark to promote sleep.
- Engage in physical activity or movement from the morning.
- If necessary, re-establish a regular sleep-wake cycle during the week.

Promote physical, mental and social well-being

- Social activities in all their forms, regular family contact that is experienced as positive, feeling respected, and having a positive self-image.
- Fulfilling emotional and sex life.
- Good quality of work life: respect, atmosphere, recognition and appreciation of work done, good working conditions, sense of involvement, absence of psychosocial risks (stress, bullying, stigmatisation)

Annexe 2. Fibromyalgia. Information to be shared with the patient

What fibromyalgia is and is not

Fibromyalgia is multifactorial and is a chronic pain syndrome. The pain is usually associated with other symptoms and impairs physical capacities, the performance of everyday activities and quality of life. It is not a degenerative disease. It is not dangerous and does not affect vital organs or life expectancy.

Its frequency and the population concerned

The prevalence of fibromyalgia is approximately 1.5 to 2%. It affects more women than men.

Its causes, its origin

Fibromyalgia is linked to changes in the pain detection and modulation processes in the central nervous system, leading to hypersensitivity to pain.

Its main signs and symptoms

- Diffuse pain persisting for more than 3 months, but often variable and fluctuating over time and in intensity and location.
- Symptoms often associated with the pain, in particular chronic physical fatigue, excessive fatigability on exertion, cognitive disturbances (attention and concentration difficulties, memory loss, brain fog), sleep disturbances, emotional distress, psychological disorders (anxiety, depression without necessarily implying a psychological cause for the pain), functional bowel disorders, functional limitations that interfere with activities of daily living, as well as professional, family and social activities.
- Hypersensitivity of muscles, joints and tendons to touch or pressure, either localised or widespread, that may be associated with more general hypersensitivity to cold, heat, light, or noise.

Its diagnosis

The diagnosis is clinical, based on the disease history, a physical examination and an in-depth interview with the patient. A process is implemented to investigate for other diseases or conditions with similar symptoms. The existence of fibromyalgia does not exclude the concomitant presence of other diseases.

A small number of laboratory tests are prescribed to screen for diseases, particularly inflammatory or endocrine diseases, which can be treated. Other tests may be required to eliminate other diagnoses.

Its impact on quality of life

Symptoms can interfere with activities of daily living, their planning and their performance, as well as work and interpersonal relationships. The difficulties experienced may vary from person to person and change over time.

The objectives of treatment

In fibromyalgia, the treatment strategy primarily focuses on physical activity, including independent learning so that it can be continued and incorporated into the person's lifestyle, the development of personalised strategies for self-managing pain and coping with the condition; support to remain in work; support for all forms of vulnerability, treatment and support for other health problems (sleep disturbances, obesity).

Medication has modest effects in terms of alleviating pain. A risk of misuse may exist.

If mood disorders (anxiety, depression, suicidal ideation) are identified, they need to be assessed in order to offer appropriate treatment. These disorders can make it difficult for patients to engage in their treatment and cope with their condition.

A personalised care plan and the essential engagement of the patient

The care plan is developed jointly with the patient based on a shared decision-making approach: information-sharing, supported by a written document [Fibromyalgia.Understanding the disease to better live with its symptoms.] "Fibromyalgie : Comprendre la maladie pour mieux vivre avec ses symptômes" , explanations about the condition and treatment options, consideration of the patient's expectations and preferences, regular assessment of the effects of treatment, and reformulation of the care plan if necessary.

To start with: offer support in coping with the condition and finding personalised pain management strategies, continuing daily physical activity, choosing an enjoyable physical activity to practise with others (family, friends, clubs, etc.), reducing sedentary behaviour; maintaining good sleep quality; adjusting dietary balance and variety if necessary; and maintaining a regular meal schedule. Encourage continued employment and usual activities as far as possible.

The joint assessment by the physician and the patient identifies clinical improvements and those perceived by the patient, as well as difficulties. It makes it possible to propose complementary treatments or approaches.

In the event of difficulties engaging in physical activities independently, supervised adapted physical activity is proposed, to then be continued independently. To help patients become more independent in the management of their condition, patient education sessions are proposed. A specialised and structured psychotherapeutic approach may be proposed in the event of difficulties coping with the condition.

Working with fibromyalgia is possible

Keeping a person with a diagnosis of fibromyalgia in work should be promoted early on and, if applicable, adaptations should be sought with occupational health and prevention service physicians.

Medication has a modest effect

Only certain antidepressants or anticonvulsants are prescribed as background therapy for their analgesic action, even in the absence of a diagnosis of depression or epilepsy. The usual analgesics may be prescribed for incident pain but never as long-term treatment. Opioids should be used with caution and only occasionally for acute incident pain, and should be used only exceptionally as long-term therapy following advice.

Medicinal products are started at low doses to improve their tolerability and reduce the occurrence of adverse effects. Their continuation or discontinuation is assessed in terms of the tolerability and efficacy as perceived by the patient. Misuse is possible and should be identified, along with the associated risks requiring support.

Nutrition

A balanced and varied diet covers the real needs of the individual. Diets with specific restrictions (e.g. gluten-free, lactose-free, low-calorie, low in FODMAP),[46] the use of nutritional supplements (vitamins, minerals, herbal, etc.), probiotics and prebiotics have no demonstrated benefit in fibromyalgia in the absence of proven deficiencies or diagnosed gastro-intestinal disorders. There are no arguments for or against a Mediterranean, vegetarian or vegan diet.

Other interventions without adverse effects or health risks may be discussed in the context of the care plan

Hydrotherapy combined with physical exercise has moderate analgesic and/or functional benefits, to be consolidated by independent physical activity.

Transcutaneous Electrical Nerve Stimulation (TENS) can be useful to temporarily alleviate flare-ups of localised or locoregional pain following multidisciplinary advice and in specific prescribing conditions, with patient training, regular monitoring of the effects and discontinuation in the event of inefficacy.

Repetitive Transcranial Magnetic Stimulation (rTMS) and Transcranial Direct Current Stimulation (tDCS) have a general effect on chronic pain and quality of life. These techniques may be offered in a healthcare facility, following the advice of a chronic pain clinic and depending on their availability.

Relaxation therapy, hypnosis and meditation may have positive effects (state of relaxation, calmness and well-being), provided that they are delivered in accordance with certain conditions, in particular appropriate training of the practitioner, self-learning by the patient.

User associations: experience-sharing, support

User associations share information about fibromyalgia and experiences of living and coping with the condition, provide support to patients, highlight the criteria for vigilance to prevent certain abusive practices, and participate in the design of patient education sessions, co-facilitating them with a healthcare professional following prior training.

[46] FODMAP (Fermentescible Oligosaccharides, Disacchararides Monosaccharides And Polyols): naturally poorly digested sugars that ferment when they come into contact with bacteria in the bowel and, when eaten in excess or by sensitive individuals, cause intestinal bloating, leading to pain and gas.

Annexe 3. Fibromyalgia. Prescription and implementation of adapted physical activity

➔ Any prescription for adapted physical activity must be preceded by an assessment [47]

Box 1. Content of the medical consultation prior to prescription of adapted physical activity (APA) (HAS. *La prescription d'activité physique adaptée.* [Prescribing adapted physical activity] July 2022)

- Full physical examination: cardiovascular, respiratory, cutaneous and locomotor.
- Assessment of the various components of the patient's physical condition, which may be performed by an APA professional.
- Motivational interview to identify obstacles and levers for physical activity and a more physically active, less sedentary lifestyle.
- Prescription of additional tests and/or a specialised opinion if applicable.
- Scheduling of medical follow-up to assess progress, adjust the prescription, boost patient motivation, and gradually guide patients towards a more physically active, less sedentary lifestyle, independently and safely.

➔ In particular, the exercises proposed may include aerobic endurance and muscle-strengthening exercises, along with exercises promoting muscle and joint flexibility and balance

Box 2. Types of physical exercises and implementation methods in fibromyalgia

Progressive, **low- to moderate-intensity** exercises that are land- or water-based are proposed based on local provision and the patient's preferences.

In particular, the exercises proposed may include **aerobic endurance*** and **muscle-strengthening**** exercises, along with exercises promoting **muscle and joint flexibility and balance**.

➔ Aquatic activities have the benefit of being better tolerated due to the relative reduction in weight bearing in water, and of facilitating movement and reducing kinesiophobia.

Sessions take the form of **group or individual sessions, delivered 1 to 3 times per week, over a period of 3 months**.

➔ The duration of the sessions, along with their methods, should be adapted based on the patient's tolerance to exercise, the persistence of pain between sessions and the patient's availability.

Exercises should be varied and fun to prevent them becoming monotonous and patients giving up during the programme, and to support motivation and effort.

Support for resuming physical activity and continuing it independently with follow-on support **is an integral part of the APA programme**.

When patients already engage in significant physical activity, the objective is to **support them in regulating its intensity** to prevent worsening of symptoms.

* Aerobic endurance physical activity: exercise bike, treadmill.

** Muscle-strengthening physical activity: weight machine with guided weights, weights and dumbbells, elastic bands.

[47] Haute Autorité de santé. *Guide. Consultation et prescription médicale d'activité physique à des fins de santé chez l'adulte.* [Physical activity consultation and medical prescription on health grounds in adults]. 2022. Saint-Denis La Plaine Haute Autorité de Santé - Consultation et prescription médicale d'activité physique à des fins de santé

➔ The prescription is based on “FITT-VP” principles adapted to fibromyalgia

Box 3. FITT-VP characteristics of the physical activity (HAS) [48]

- **F for frequency**: 1 to 3 times per week (for fibromyalgia) over a period of 3 months, potentially renewable following assessment of functional capacities after the programme
- **I for intensity**, low to start with, then gradually progressing to moderate intensity (patients moderately out of breath and moderate perspiration, conversation possible)
- **T for type of physical activity** chosen based on the expected physiological effects in terms of improvement: endurance exercises combined with muscle strengthening exercises and, if necessary, flexibility and balance exercises
- **T for session time**, progressive, intermittent if necessary and without repetition of movements, including a warm-up phase and a recovery phase in addition to the physical activity itself
- **V for volume or amount of physical activity**: start with small amounts of physical activity and gradually increase the frequency, intensity and duration, paying attention to exercise tolerance, assessment of pain and fatigue before and after each session, and any persistence between sessions
- **P for progression**, low-intensity physical activity at the start, with slow, controlled progression

➔ Physical activity is proposed in the form of a programme

Box 4. Characteristics of an adapted physical exercise programme (APA)

- Structured and supervised by an adapted physical activity professional
- Delivered as a group or individual session
- Personalised and therefore appropriate to the patient’s capacities, expectations and preferences
- Well tolerated in terms of fatigability, exercise tolerance (working on endurance rather than strength), recovery and possible persistence of pain between sessions, and patient availability
- Progressive, with fun, varied exercises to prevent them becoming monotonous and stop patients giving up during the programme, and to support motivation and effort

➔ The APA professional transmits the programme and a regular report to the prescribing physician

Box 5. Implementation of adapted physical exercise: content of interim assessments

- FITT-VP characteristics of the physical activities: intensity, frequency, progressivity, any flare-ups of pain and/or fatigue, patient perception
- Process, effects on physical condition and functional capacities, ability to perform activities of daily living, including professional activity
- Degree of autonomy in physical activity
- Need to renew the APA prescription or change physical activities if necessary, or continue independently and safely, or refer to a suitable facility

[48] Haute Autorité de santé. *Guide. Consultation et prescription médicale d’activité physique à des fins de santé chez l’adulte.* [Physical activity consultation and medical prescription on health grounds in adults]. 2022. Saint-Denis La Plaine Haute Autorité de Santé - Consultation et prescription médicale d’activité physique à des fins de santé

Annexe 4. Fibromyalgia. Patient education: skills to be developed

Self-care skills

- Learn about fibromyalgia.
- Recognise and know how to assess symptoms, their fluctuations, life situations or events, factors that aggravate, trigger or maintain pain, and what provides relief based on experience.
- Identify and understand the repercussions of fibromyalgia on activities of daily living and quality of life.
- Recognise own emotions and warning signs (worsening of pain, mood disorder, reduced motivation, etc.).
- Understand the benefits of treatment options, the uncertainties and risks of certain practices, products and methods.
- Recognise own physical capacities and limitations.
- Know how to organise everyday life, simplify activities of daily living, breaking them down into smaller tasks, find a balance between periods of activity and rest, then work together to develop ways of adapting to the condition and then moving towards personal coping strategies.
- Regularly participate in adapted physical exercise sessions, know how to continue these independently.
- Implement lifestyle changes: daily physical activity, reducing sedentary behaviour, engage in enjoyable physical exercise at an appropriate intensity, sleep and life rhythms, diet.

Coping or pyschosocial skills

- Know yourself and accept your limits, rebuild confidence in own abilities.
- Put your feelings and emotions into words, express your fatigue from the daily effort of taking care of yourself.
- Express your needs, expectations, beliefs, perceptions, fears and understanding of your pain.
- Seek help from those around you and involve them in the adjustments made necessary by the condition.
- Identify a feasible plan that takes into account the condition and treatment requirements, set achievable goals and make choices, proceed in stages.
- Based on your experience and discussions with other patients, develop creative reasoning and critical thinking in the search for personalised solutions to alleviate symptoms and cope with flare-ups of pain.
- Take decisions and solve problems: adapt your environment, simplify activities of daily living, continue working.
- Develop communication and interpersonal skills, seek support from family, friends and social circles to maintain motivation and facilitate daily life.
- Observe yourself, assess yourself and build your strength.

Educational resources for skills learning [49]

Resources	Examples
Patient-centred communication techniques	Active listening, empathy, encouraging attitude, motivational interviewing to be used when developing the educational diagnosis, during educational and medical follow-up, to initiate change in the patient and to support their motivation over time
Teaching techniques	Interactive presentation, case study, round table discussion, brainstorming, critical analysis of documentary or technological resources, analysis of a situation, experience or follow-up diary, workshop, physical activities, role playing, documentary testimony, photolanguage technique®
Tools	Posters, picture books, brochures, technological resources for transmitting, sharing or exchanging information

[49] HAS. *Éducation thérapeutique du patient. Comment la proposer et la réaliser ?* [Patient education. Offering and providing Therapeutic Patient Education (TPE)] June 2007 Haute Autorité de santé_Therapeutic_patient_education_tpe_-_offering_and_providing_tpe_-_quick_reference_guide.pdf

This document presents the main points of the publication: **Fibromyalgia in adults: diagnostic management and treatment strategy,** Clinical practice guideline, June 2025

All our documents are available to download at www.has-sante.fr

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