HAUTE AUTORITÉ DE SANTÉ

RECOMMENDING BEST PRACTICES

SUMMARY

Fibromyalgia in adults: diagnostic management and treatment strategy

Validated by the HAS Board on 19 June 2025

Key messages

Fibromyalgia is a disease recognised by the World Health Organization, which classes it under the chronic widespread pain grouping (international classification of diseases – ICD 11).

It is linked to changes in pain detection and modulation processes in the central nervous system, manifesting as generalised hypersensitivity to pain. It impairs physical capacities, the performance of 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 is a clinical one in the absence of specific biomarkers

- Consider fibromyalgia in the event of diffuse pain persisting for more than 3 months, often variable and fluctuating over time and in intensity and location. The pain is combined with other non-specific symptoms, such as fatigue, sleep disturbances, transit disturbances, and cognitive and psychological disorders (anxiety, depression).
- Use the self-administered FIRST (Fibromyalgia Rapid Screening Tool) questionnaire in the primary care setting to aid the diagnostic process, but clinical judgement remains the primary factor.
- Investigate for other diseases causing chronic pain and concomitant diseases: minimal laboratory tests supplemented on the basis of the physical examination and clinical judgement.
- Confirm the diagnosis of fibromyalgia, assess its severity using the American College of Rheumatology (ACR) criteria [revised in 2016].
- Repeat the physical examination before attributing any new symptom to fibromyalgia.

Recognising the person's suffering and delivering the diagnosis are essential

- Legitimise their complaints. Deliver in-depth, personalised explanations about the condition, its mechanisms and the treatment options, supported by a written document[1].
- Co-construct the care plan taking into account the patient's experiences, expectations and preferences: realistic and achievable treatment goals, the most appropriate practitioners and locations for their implementation, and assessment elements defined with the patient.

[1] « Fibromyalgie : Comprendre la maladie pour mieux vivre avec ses symptômes"

The treatment strategy is personalised, scaled, coordinated and scalable

- Fibromyalgia treatment focuses on getting patients moving again, finding personalised strategies for the self-management of pain and other symptoms, and continuation of everyday activities and work.
- The general practitioner coordinates the care plan, along with the professionals involved in its implementation, with, if necessary, an advanced practice nurse or public health nurse[2] trained in chronic pain, and as part of a coordinated care process.
- Referral to other specialist physicians in the community or healthcare facility setting, or to a chronic pain clinic (SDC)[3] may be necessary for an opinion, advice, multidisciplinary and multi-professional assessment, the choice of, or access to, a treatment, recalcitrant pain, and to a coordination support system (DAC)[2] in the event of coordination difficulties.

As a first-line approach

Physical activity and independent, safe exercising

- First encourage the maintenance of everyday physical activities, along with regular exercise and a reduction in sedentary behaviour.
- If physical activity levels are insufficient and the patient has difficulties exercising autonomously and safely by themselves: propose an adapted physical activity programme including independent learning, supervised by an APA professional[4].
- In the event of persistent difficulties or physical deconditioning: refer to a rehabilitation programme based on multidisciplinary, multi-professional assessment.

The development of coping strategies and self-management strategies for the condition

- Improve daily functioning and jointly develop coping strategies: simplify daily activities, break them down into smaller tasks, alternate periods of activity with rest periods.
- To encourage greater autonomy in managing the condition or in the event of self-management difficulties: collective therapeutic patient education sessions.
- In the event of inappropriate behaviours such as catastrophising, an obsessive tendency to work or keep busy all the time, avoidance behaviours: act on cognition (erroneous thoughts, beliefs), emotions and behaviours with specialised and structured psychological interventions.

Retention in employment

- Seek the support of an occupational health and prevention service physician in the event of a significant impact of the condition on the patient's work, or of the patient's work on the condition.
- In the event of significant difficulties, and ideally before considering sick leave: seek adaptations in coordination with the occupational health and safety physician.
- In the event that the job cannot be adequately adapted: consider training and career guidance measures, recognition as a disabled worker, or an application for disability, sometimes temporarily.

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

[3] SDC: *structure spécialisée douleur chronique* [specialised chronic pain clinic]; DAC: *dispositif d'appui à la coordination* [coordination support system].

[4] APA : adapted physical activity professionals (in particular adapted physical activity trainers, physiotherapists)

Assessment and treatment of any associated health problems

- Situations of overweight and obesity, which are more common in fibromyalgia, linked to inadequate levels of physical activity and sedentary behaviours, must be assessed and treated.
- Dietary restrictions (e.g. gluten-free, lactose-free, etc.) and the use of nutritional supplements (vitamins, minerals, herbal, etc.) have no demonstrated benefit in fibromyalgia, in the absence of diagnosed gastrointestinal disorders or proven deficiencies.
- A balanced and varied diet covers the real needs of the individual. There are no arguments for or against a Mediterranean, vegetarian or vegan diet.
- Sleep disturbances should be investigated and treated.
- Psychological disorders (anxiety, depression, suicidal ideation) should be regularly assessed and treated, without necessarily implying a psychological cause for the pain.
- Any form of vulnerability should be identified and support provided.

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

The expected benefit of some medicinal treatments is modest, and opioids should only be used in exceptional circumstances

- Start treatments at low doses with a gradual and cautious increase in dosage in order to improve tolerability and reduce the occurrence of adverse effects.
- For constant pain and as background therapy: certain antidepressants and anticonvulsants, at low doses.
- For incident pain, associated with exertion, for example: the usual analgesics (paracetamol or NSAIDs) on an occasional basis, never as long-term treatment.
- For acute incident pain: cautious and occasional use of tramadol (opioid) and as long-term treatment in exceptional cases only, following a specialist opinion in a chronic pain clinic.
- Each time a medication prescription is issued or renewed: assess the safety and perceived efficacy, identify any misuse and associated risks.

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

- Hydrotherapy if combined with physical exercise and continued independently: in the event of moderate severity of the condition and in a stable phase.
- Relaxation, hypnosis, meditation: 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 following assessment and in addition to first- and second-line interventions

Proposal of neurostimulation techniques subject to certain conditions

- In the event of flare-ups of localised or locoregional pain following a multidisciplinary opinion: transcutaneous electrical nerve stimulation (TENS)[5] on a temporary basis.

[5] TENS: Transcutaneous Electrical Nerve Stimulation; rTMS: Repetitive Transcranial Magnetic Stimulation (tDCS: Transcranial Direct Current Stimulation)

- If seeking a general effect on pain and quality of life, following the opinion of a chronic pain clinic: repetitive transcranial magnetic stimulation (rTMS),[5] transcranial direct current stimulation (tDCS),[5] depending on the availability of the technique.

Throughout the care pathway

Support from patient associations

- Sharing of reliable information on fibromyalgia, sharing of experiences of living and coping with the condition, support for patients.
- Highlighting of the criteria for vigilance to prevent certain abusive practices.
- Participation in the design of patient education sessions, co-facilitation with a healthcare professional following prior training.

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.

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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.

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

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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