London, June 13 2016.

New guidelines for the management of fibromyalgia presented at the EULAR Congress, London June 9 2016. After a period of 10 years working according the same guidelines EULAR decided to update these guidelines as more research and data is available to support the new guidelines.

The guidelines are bases on the following principles.

1. Optimal management requires prompt diagnosis
2. Full understanding of fibromyalgia requires comprehensive assessment of pain, function and psychosocial context.
3. It should be recognised as a heterogeneous condition where there is abnormal pain processing and other secondary features.
4. In general, the management of fibromyalgia should take the form of a graduated approach.
5. Management should aim on improving health-related quality of live balancing the benefit and risk which often requires a multidisciplinary approach with a combination of non-/pharmacological treatment modalities.
6. These should be tailored according to: pain intensity, function, associated features (e.g. depression), fatigue, sleep disturbance, patients co-morbidities: by shared decision making with the patient.
7. Initial management should focus on non-pharmacological therapies.

This all led to the following for the management of fibromyalgia made up by a working group of 11 clinical members, 5 methodologists and 2 patients representatives.

Recommendation; level of evidence grade agreement

*Non-Pharmacological Management;*

Aerobic and strengthening exercise Meta-analysis strong for 100%

Cognitive Behavioural Therapies Meta-analysis weak for 100%

Multicomponent therapies Meta-analysis weak for 93%

Defined physical therapies: Meta-analysis weak for 93%

Acupuncture or hydrotherapy

Meditative movement therapy; Meta-analysis weak for 71 / 73%

(Qigong, tai chi, yoga) and

Mindfulness bases stress reduction

*Pharmacological management;*

Amitrptyline ( in a low dose) Meta-analysis weak for 100%

Duloxetine or Milnacipran Meta-analysis weak for 100%

Tramadol Review weak for 100%

Pregabaline Meta-analysis weak for 94%

Cyclobenzaprine Meta-analysis weak for 75%

These recommendations and principles lead to the following flow chart:

History and physical exam.

diagnose of fibromyalgia. if needed to exclude treatable co-morbidities:

laboratory and / or radiological exams

Referral to other specialists

patient education and information sheet

*if insufficient effect*

physical therapy with individualised physical exercise

(can be combined with other non-pharmacological therapies

recommended, such as hydrotherapy, acupuncture)

*if insufficient effect*

reassessment of patient to tailor individualised treatment

additional individualised treatment

pain related depression

anxiety severe pain / severe disability

catastrophizing sleep disturbance sick-leave

overly passive

or active coping

pharmacotherapy

psychological therapies, mainly multimodal rehabilitation

CBT (for more severe depression programs

/anxiety consider

psychopharmacological treatment)

severe pain severe sleep problems

duloxetine low dose

pregabalin amitriptyline

tramadol (or in combination cyclobenzaprine or

with paracetamol) pregabalin at night

There were some medicines the project group didn’t recommend due to:

Lack of efficacy / high risk or side effects

* Growth Hormone
* Sodium Oxybate
* Strong Opioids
* Corticosteriods

There were some non-pharmacological therapies the project group didn’t recommend because of lack of effectiveness and / or low study quality:

* Biofeedback
* Capsaicin
* Hypnotherapy
* Massage
* SAMe
* Other complementary or alternative therapies

Compared with the old recommendations.

* Recommendations now evidence-based but there are no major changes to approach
* Non-pharmacological approaches should be first-line therapy
* If there is a lack of effect there should be individualised therapy according to patient need, which may include a pharmacological therapy

Comparison with recommendations from other bodies

* Recent guidelines from Canada, Israel and Germany
* The proposed EULAR guidelines agree on:
* Principles off approach to management
* The need for tailored therapy to the individual
* First-line role of non-pharmacological therapies
* There are differences
* In the strength of recommendations for some pharma (e.g. anticonvulsants, SNRIs) and non-pharma(e.g. meditative movement)

Overseeing all the omissions and the lack of solid clinical proof the working group formulated the following research priorities:

* Which type of exercise is most effective; strength and/or aerobic training?
* Is a combined pharma and non-pharma approach, more effective than single modality management?
* Are there characteristics of patients which predict response to specific therapies?
* How should FM be managed when it occurs as a co-morbidity to inflammatory arthritis?
* What aspects of healthcare system design optimise outcome for patients?

The working group was:

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