key points

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Fibromyalgia is a chronic condition characterised by regional pain at multiple sites, non-restorative sleep and fatigue. In the UK, it is a common cause of musculoskeletal pain and significant disability, affecting around 2% of the population. It has a strong female preponderance with a female to male ratio of 7:1. Both the prevalence and incidence of the condition increase with age, resulting in a maximum prevalence of around 8% in older women. However, fibromyalgia can occur at any age including adolescence.

Sleep studies have confirmed that patients with fibromyalgia have reduced delta wave sleep, which is predominantly deep, non-REM, non-dreaming sleep. Short-term deprivation of delta, but not REM, sleep in healthy controls induces fibromyalgia-like symptoms which strongly suggests that non-restorative sleep is a central problem in fibromyalgia. Altered physiology of pain processing manifests as a lowered pain threshold with both peripheral and central pain sensitisation.

Patients with fibromyalgia usually present with a history of musculoskeletal pain affecting all four quadrants of the body, and accompanied by difficulty getting off to sleep, waking up frequently during the night and waking up unrefreshed in the morning. They often experience fatigue, poor concentration and forgetfulness (fibromyalgia fog), early morning stiffness, subjective hand swelling, paraesthesia affecting all fingers, irritability and occasional weepiness.

Fibromyalgia is a clinical diagnosis and there are no required confirmatory tests. However, investigations are useful to identify or rule out comorbid conditions that may be difficult to diagnose clinically but which might contribute to one or more of the symptoms e.g. anaemia or hypothyroidism causing fatigue.

There often appears to be a disproportionate disability compared with the symptoms and it is associated with high levels of distress. It is important to acknowledge the reality of the symptoms and the distress caused to the patient, and to offer an explanation regarding sleep disturbance and altered pain physiology. Self-help strategies are important. There is strong evidence of benefit from a slow graded increase in daily aerobic exercise which can increase delta sleep and restore descending pain inhibition mechanisms. Sleep hygiene should also be considered to promote delta sleep.

Often standard analgesic medication is unhelpful. Amitriptyline is the only widely available drug that can increase delta sleep and 25-75 mg at night can improve sleep quality. Where there is intolerance, duloxetine or pregabalin may be tried. Where depression co-exists an SSRI may be useful e.g. fluoxetine 20 mg daily.