Pharmacological management of fibromyalgia

- Fibromyalgia can co-exist with other conditions that may also be associated with pain e.g., rheumatoid arthritis, osteoarthritis, chronic non-specific low back pain. Treatment for those conditions should be reviewed and optimised where necessary.
- All new **medicines** should be assessed for suitability in the person, considering all other diagnoses and any medicines prescribed for any condition.

There is limited evidence to support the use of any medication for the management of fibromyalgia. However, some people may derive limited benefit, so a trial of medication may be considered but only continued where evidence of functional benefit is demonstrated.

Fibromyalgia can have significant impact on a person's ability to function and take an active part in daily activities, relationships, employment etc.

The medicines suggested to trial for fibromyalgia can also impact functioning due to e.g., sedation, cognitive impairment, weight gain.

This should be considered before initiating a medication trial.

Self-care, maintaining activity and improving function are key outcomes for living with fibromyalgia. Support to self-manage should be offered at every opportunity, regardless of how long the symptoms have been present.

Fibromyalgia is strongly associated with trauma and difficulty maintaining psychological wellbeing. Anxiety, depression, post-traumatic stress disorder, and previous emotional trauma or other mental health diagnoses will make the pain feel worse and make it more difficult to treat.

Managing distress should be a priority but is not helped by the use of opioids, which are only recommended for flare-up.

Medicines that may be trialled for fibromyalgia

1. Antidepressants	**Amitriptyline 10 mg increasing to 50 mg between 6–8 pm** initially but effectiveness for pain is dose related so may need **50–125 mg** (dosed between 6–8 pm). • Amitriptyline is particularly useful if sleep is affected. • Dose should be increased by 10 mg weekly, fortnightly or longer as tolerated by the patient and dependent on effect. • Taking the dose in the evening (6–8 pm) helps to reduce the 'hangover' effect the following morning. **Duloxetine 30 mg increasing to a maximum 120 mg per day** Initiate at 30 mg once daily for 1–2 weeks then increase to 60 mg daily (maximum 120 mg in divided doses). **Selective-serotonin-reuptake-inhibitors** – may be used in place of amitriptyline or duloxetine if either are not tolerated. **Citalopram 20 mg increasing to a maximum of 40 mg** once daily. **Fluoxetine 20 mg increasing to a maximum of 60 mg** once daily. **Paroxetine 20 mg increasing to a maximum of 50 mg** once daily. **Sertraline 50 mg increasing to a maximum of 200 mg** once daily. Check BNF for dose adjustments, e.g. in renal failure.

If the patient is already prescribed an antidepressant, consider optimising the dose, within recommended limits, before changing to an alternative.

If patient has co-diagnosed depression or anxiety, then treatment may need to continue long-term with six-monthly reviews. If antidepressant use is for lone diagnosis of fibromyalgia, then review at 3 months and consider switch or taper and stop if functional improvement and pain reduction are not demonstrated.

Do not co-prescribe antidepressants of any class unless recommended by a mental health professional.

Prescribers are reminded of MHRA advice relating to the use of antidepressants in patients at risk of harming themselves, including those aged less than 25 years.

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2. Gabapentinoids	**Gabapentin 900–1200 mg daily in three divided doses** • Start with 300 mg daily in divided doses for one week, 600 mg daily in divided doses for one week then 900 mg daily in divided doses thereafter. Further increase to a maximum of 600 mg three times a day may be indicated depending on response to lower doses. • Doses greater than 600 mg three times a day should be prescribed only when some benefit has been demonstrated at lower doses. **Or** where anxiety is a significant presenting symptom despite optimised Step 1 treatment with an antidepressant, pregabalin may be considered as an option. **Pregabalin 100–400 mg daily in two divided doses** • Doses greater than 200 mg twice a day should only be prescribed where some benefit has been demonstrated at lower doses. Gabapentin and pregabalin need to be prescribed with appropriate dose reductions for patients with impaired renal function and in the elderly. See BNF for further advice on gabapentin and pregabalin.

Gabapentinoids are associated with misuse, especially pregabalin. Caution prescribing for people with a history of substance misuse. If indicated, consider a trial using limited quantities of medication.

Gabapentin has less evidence to support its use in fibromyalgia than pregabalin, but less association with misuse.

3. Flare-up management	**Tramadol starting dose 50 mg up to four times a day increased to maximum 100 mg four times a day for maximum of 2 weeks** • Caution in elderly patients (poor tolerance of side effects). • Caution with alcohol use. • Avoid in epilepsy and head injury (lowers seizure threshold). • Avoid in pregnancy. • Can cause psychiatric side effects. Where tramadol is contraindicated consider the following options (despite lack of supporting evidence): **Codeine starting dose 30 mg up to four times a day increased to maximum 60 mg four times a day for a maximum of 2 weeks** **Or** **Dihydrocodeine 30 mg up to four times a day, increased to 60 mg three times a day for a maximum of 2 weeks** Caution with both codeine and dihydrocodeine in: • obstructive airways disease; • respiratory depression; • acute alcohol intake.

Tramadol should be very cautiously co-prescribed with antidepressants or gabapentinoids due to increased risks of serotonin syndrome, lowered seizure threshold and misuse.

If an opioid is genuinely indicated, consider codeine or dihydrocodeine for maximum 2 weeks as safer alternatives.