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Original article

New guidelines for the diagnosis of fibromyalgia

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ABSTRACT

Objective: To establish guidelines based on scientific evidence for the diagnosis of fibromyalgia.

Material and methods: Evidence collection was performed based on 9 questions regarding the diagnosis of fibromyalgia, structured using the Patient, Intervention or Indicator, Comparison and Outcome (P.I.C.O.), with searches in the main, primary databases of scientific information. After defining the potential studies to support the recommendations, they were graded according to evidence and degree of recommendation.

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Novas diretrizes para o diagnóstico da fibromialgia

Palavras-chave:
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Dor
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Critérios diagnósticos
Diretrizes

RESUMO

Objetivo: Estabelecer diretrizes baseadas em evidências científicas para o diagnóstico da fibromialgia.
Material e métodos: A coleta de evidências foi elaborada a partir de nove questões sobre diagnóstico da fibromialgia, estruturadas por meio do PICO (Paciente, Intervenção ou Indicador, Comparação e *Outcome*), com busca nas principais bases primárias de informação científica. Após definir os estudos potenciais para sustentação das recomendações, esses foram graduados pela força da evidência e grau de recomendação.
Resultados e conclusões: As questões resultaram em nove recomendações para o diagnóstico da fibromialgia com base nas evidências de literatura e na opinião dos experts que participaram do trabalho.

Introduction

Considered one of the most common clinical rheumatologic conditions, fibromyalgia (FM) has variable epidemiological data. In studies performed in the USA and in Europe, the prevalence found was up to 5% in the general population,[1–5] surpassing 10% of visits in rheumatology clinics.[6] In Brazil, FM is present in up to 2.5% of the general population, predominantly among women, especially from 35 to 44 years of age.[7,8]

FM is certainly not a new syndrome, as corroborating reports have been published since 1592.[9] The term "fibromyalgia" was first used in a review by Hench[10] in 1976, although its recognition as a syndrome occurred after the publication of a study by Yunus et al. in 1981,[11] who described and characterized the clinical pattern of FM. However, its diagnosis in the daily routine and the choice of patients for clinical studies were challenging due to the lack of an objective clinical or laboratory marker. To minimize the subjectivity of clinical judgment, several diagnostic criteria were elaborated from 1980, though without unanimity, which generated more diagnostic confusion. In 1990, the American College of Rheumatology (ACR) prepared classification criteria that were accepted by the scientific community,[12] substantially helping to homogenize the diagnosis of FM and to promote studies on FM.

Despite advances in the use of these criteria, many criticisms have appeared over the years, especially regarding overvaluing widespread pain above symptoms such as fatigue, sleep disorders and morning stiffness, among others. Counting and searching for tender points became another reason for discussion because many physicians lacked adequate training to recognize them.

In response to these criticisms, in 2010, the ACR prepared new preliminary diagnostic criteria, which included several symptoms and excluded palpation of tender points. These criteria were subsequently changed and are still under analysis by the rheumatologic medical community.[13,14]

Given the variety in clinical patterns and the inexistence of laboratory markers or characteristic imaging examination, the diagnosis of FM is based on clinical judgment and varies with the experience of each physician.

Material and methods

This guideline followed a systematic review pattern, retrieving evidence based on the evidence-based medicine movement, in which clinical experience is integrated with the capacity to critically analyze and rationally apply scientific information, thus improving the quality of medical care.

Nine clinical questions relevant to the diagnosis of FM were elaborated, with the participation of all members of the Committee for Pain, Fibromyalgia, and Soft-Tissue Rheumatism of the Brazilian Society of Rheumatology (Sociedade Brasileira de Reumatologia). The formulation structure of each question is summarized by the P.I.C.O. acronym, wherein P corresponds to Patient – with Fibromyalgia; I to intervention – diagnostic criteria or ACR criteria, widespread pain, tender points, sleep disorders, fatigue, thermography; C to Comparison – clinical evaluation and other diagnostic criteria; and O to Outcome – diagnostic accuracy.[15] Thus, the descriptors to be used in the search strategies for scientific evidence were obtained. Searches were performed from August 2015 to September 2016 in the main primary databases of scientific information (Medline/PubMed, Embase, Lilacs/Scielo, Cochrane Library, Premedline via OVID), in addition to a manual search in the Brazilian Digital Library of Theses and Dissertations (Biblioteca Digital Brasileira de Teses e Dissertações – BDTD) of the Brazilian Institute for Information in Science and Technology (Instituto Brasileiro de Informação em Ciência e Tecnologia – IBICT; Table 1).

Initially, the studies were selected by title, then by abstract, and lastly by full text, which was subjected to critical evaluation and extraction of results on outcomes. The retrieved evidence was considered eligible if meeting the PICO method criteria. Observational studies (cross-sectional or cohort) or before-and-after studies were preferentially considered, without time or language restrictions and with available full text. The critical evaluations of the cohort studies were performed using the Newcastle-Ottawa Scale (NOS)[16] and the cross-sectional studies using Quadas.[17]

Studies that failed to address a population with FM or diagnosis; that used intermediate outcomes; that were narrative

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