

Fibromyalgia

In fibromyalgia the nervous system turns the 'pain volume' up, so pain is felt widely across the body.

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What you're feeling

Fibromyalgia is **widespread, long-term pain**: an ache, burning or soreness that can move around the body and seems to be felt almost everywhere rather than in one joint. Alongside the pain, most people are deeply tired, and sleep doesn't fix it: you can spend a full night in bed and still wake up feeling unrefreshed, as though you never really rested.

Many people also notice their thinking feels foggy: trouble concentrating, finding words, or remembering things. This is so common it has a name: "fibro fog". On top of this, the body often becomes more sensitive in general: touch, pressure, light, sound or temperature can feel like too much, and a knock that wouldn't bother most people can really hurt. It is exhausting, and it is easy to feel that no one quite believes how much you are dealing with.

What's actually happening

Here is the important part: fibromyalgia is **not damage to your joints or muscles, and it is not inflammation**. That's why scans, X-rays and blood tests usually come back normal. There's nothing being "missed", and a normal result does not mean the pain isn't real.

What's happening is in the way your nervous system processes pain. In fibromyalgia the system that carries pain signals becomes turned up too high: the volume is set louder than it should be. Normal sensations get amplified into pain, and real pain feels more intense. Doctors call this **central sensitisation**. It is a genuine, physical change in how the nerves and brain handle signals: **not something that is "in your head", and not a sign of weakness**. Fibromyalgia is common, it is real, and it is recognised.

It also often travels with other conditions (things like irritable bowel, headaches, low mood or other long-term pain), and it can **amplify pain after an operation**. That last point is worth telling your surgical team about,

because knowing you have fibromyalgia helps them plan your pain relief and recovery so you are better looked after.

What we can do about it

There is **no cure, but fibromyalgia is manageable**, and many people get their symptoms to a much more liveable level. The strongest, most reliable help doesn't come from a tablet; it comes from a few steady habits:

- **Gentle, graded movement.** Exercise is the single best-supported treatment. The trick is to start *very* small and build up slowly: walking, stretching, or water-based exercise are good starting points. Pushing too hard too soon flares the pain, so slow and steady wins.
- **Better sleep.** Because unrefreshing sleep feeds the pain and the fog, a regular routine and good sleep habits make a real difference.
- **Pacing.** Spreading activity through the day and week (rather than doing everything on a good day and crashing afterwards) keeps you steadier.
- **Stress management and psychological approaches.** Stress turns the volume up further. Techniques such as **CBT** (cognitive behavioural therapy), relaxation and mindfulness help calm an over-sensitive system.

Medicines can help some people, but the useful ones aren't painkillers in the ordinary sense: they calm the nervous system rather than blocking pain signals. These include **amitriptyline, duloxetine and pregabalin**; you can read more on our [nerve-pain medicines](#) page. By contrast, ordinary **anti-inflammatories don't work** for fibromyalgia (because there's no inflammation to settle), and **opioids do not help and can cause real harm**: they tend to make things worse over time, not better. Our page on [managing pain after surgery](#) explains why we steer away from them.

What to expect

Fibromyalgia tends to be a long-term condition that goes up and down: better spells and flares, often triggered by stress, poor sleep, illness or overdoing it. That can feel discouraging, but the trajectory for most people who stick with the movement, sleep and pacing approach is genuinely hopeful. Symptoms settle, flares become easier to ride out, and life opens back up.

The work is yours to lead, but you are not meant to do it alone. A supportive team (your GP, sometimes a physiotherapist or pain service) can help you build a plan, adjust it over time, and keep you moving in the right direction. Self-management is powerful precisely because *you* are the one who can turn the volume back down, day by day.

When to see someone

- A **new symptom, or a clear change in an old one**: don't assume everything new is "just the fibromyalgia". Sudden or severe pain in one spot, swelling, fever, unexplained weight loss, or new weakness or numbness deserve a proper look, because they may be something separate.
- **Low mood, anxiety, or losing interest in things** you usually enjoy: these often go hand in hand with fibromyalgia, they are treatable, and help makes the pain easier to manage too. If you ever feel hopeless or unsafe, reach out promptly.
- **Symptoms taking over your daily life** despite your best efforts: that is the moment to ask your GP about more support, including a referral to a pain or rheumatology service.

In more depth

This section goes further than you need for your own treatment decisions. Fibromyalgia is worth the extra reading because the single most useful idea about it is also the least intuitive: despite presenting as a muscle and joint problem, the evidence points away from the muscles and joints entirely.

THE CLUE THAT HAS NOTHING TO DO WITH JOINTS

If fibromyalgia were a disease of muscle or connective tissue, it should confine itself to those tissues. It does not.

In a population study of **44,494** people, those with fibromyalgia or other musculoskeletal pain were more likely to report **hearing loss**. The authors' interpretation is the important part: the finding is consistent with fibromyalgia being related to a **general dysregulation of the central nervous system**, and the same may be true of other widespread musculoskeletal pain [1].

Hearing has no mechanical relationship to sore shoulders. When a condition defined by musculoskeletal pain also tracks with how the ear and brain process signal, the common factor is the processing, not the tissue. This is the central-sensitisation model in one unexpected observation: the volume control on sensory input is turned up, and pain is the most obvious consequence rather than the only one.

WHY YOUR TESTS ARE NORMAL, AND WHY THAT IS NOT DISMISSAL

Patients are frequently told that everything has come back normal, and hear it as disbelief. The research explains why the tests are normal without implying the pain is not.

A meta-analysis of cytokines – the inflammatory signalling molecules that would be abnormal in an inflammatory arthritis – pooled **1,255** participants and concluded that their pathophysiological role in fibromyalgia is **still unclear**, with better and larger studies needed [2]. Investigation of the gut microbiome as a contributor reached a similar verdict: a plausible direction within the emerging gut–musculoskeletal axis, and a paucity of quality research so far [3].

So there is no blood test to find, because the abnormality is in signal processing rather than in tissue damage or inflammation. A normal inflammatory screen and a normal scan are the expected findings, and they rule out other conditions rather than ruling out this one.

WHAT HAS ACTUALLY BEEN SHOWN TO HELP

Movement-based treatment has the strongest supporting data, and the form matters less than the fact of it. A meta-analysis of **936** patients found that traditional Chinese exercise – tai chi, qigong and similar low-intensity, movement-and-breathing practices – produced significant improvement in **pain, sleep quality** and symptoms of **anxiety and depression** [4].

Note what that trial set is measuring. The gains are across pain, sleep and mood together, which is what you would expect if the target is a sensitised nervous system rather than a painful structure. Sleep is not a side issue here; poor sleep lowers pain thresholds, and the two reinforce each other.

THE OVERLAP WITH MENOPAUSE

Fibromyalgia symptoms often begin around menopause, tend to be more severe afterwards, and can worsen after hysterectomy with or without removal of the ovaries [5]. The symptom lists overlap substantially with the musculoskeletal syndrome of menopause.

The review's conclusion is a caution against collapsing the two: fibromyalgia also occurs in women who are not menopausal and in men, so sex hormones are not the whole mechanism, and the two should be recognised and treated as separate problems that may coexist [5]. See our [musculoskeletal syndrome of menopause](#) page.

WHAT THIS MEANS IF SURGERY IS BEING DISCUSSED

This is where the central-sensitisation model becomes practical. An operation corrects a structural problem. If part of your pain is generated by altered central processing, that part of it will still be there afterwards, because the operation never addressed it.

That is not an argument against having surgery when there is a genuine structural problem to fix. It is an argument for being precise beforehand about which portion of your pain the operation is expected to remove, and for treating the fibromyalgia in its own right rather than hoping the operation will resolve everything. Going into surgery with sleep, activity and mood as well managed as they can be is doing real work on the outcome, not preparation around the edges.

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CQ HAND + UPPER LIMB

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