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Guidelines on Treating Fibromyalgia With Nonpharmacological Therapies in China

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ABSTRACT

Fibromyalgia is a prevalent chronic condition marked by widespread pain, fatigue, and other debilitating symptoms. This guideline provides evidence-based recommendations for nonpharmacological treatments, developed by a multidisciplinary expert group, including specialists in rheumatology, rehabilitation, pain management, traditional Chinese medicine (TCM), and evidence-based medicine. The guideline follows the RIGHT checklist and is registered with the International Practice Guideline Registry Platform. The literature review incorporates systematic reviews, meta-analyses, and randomized controlled trials (RCTs) up to March 2023, focusing on the effects of nonpharmacological interventions on pain intensity, fatigue, sleep quality, mood, and quality of life. A total of 57 studies were included, with findings supporting acupuncture and health education as core therapies. These interventions significantly reduce pain, alleviate fatigue, and improve sleep quality, and are strongly recommended based on moderate-quality evidence. Additionally, aerobic exercise and resistance training are recommended for their proven effectiveness in reducing pain, enhancing physical function, and providing long-term benefits. Emerging therapies, such as transcranial magnetic stimulation (TMS) and nutritional supplements, show promise but require further research due to low-certainty evidence.

1 | Introduction

Fibromyalgia is a chronic syndrome of unknown origin, characterized by widespread pain, fatigue, sleep disturbances, cognitive dysfunction, and anxiety. Contributing factors may include genetic, neurological, psychological, sleep-related, and immunological influences [1]. Its prevalence ranges from 2% to 8%, with an annual incidence of 7–11 cases per 1000 individuals [2]. It is the

third most common musculoskeletal disorder, with prevalence increasing with age [3]. Studies show a general population prevalence of up to 5%, with fibromyalgia accounting for more than 10% of rheumatology clinic visits [4]. Prevalence estimates vary by diagnostic criteria, affecting 1.7% of individuals using the 1990 American College of Rheumatology (ACR) criteria, and 5.4% with the 2010 modified ACR criteria [2]. It is more common in women and can affect individuals of all ages.

Xuanlin Li, Hejing Pan, and Liaoyao Wang contributed equally to this work.

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Despite advances in diagnostic criteria, concerns remain regarding their ability to effectively alleviate pain and improve quality of life, even with widespread physician training. Pharmacological treatments have shown benefits in symptom management since 2019 [1]; however, many patients prefer nonpharmacological approaches due to concerns over side effects.

The primary goals of fibromyalgia treatment are symptom reduction, enhanced quality of life, and improved functional capacity. Due to its diverse etiology and clinical manifestations, a multidisciplinary approach is essential. Nonpharmacological interventions, including supervised exercise programs and cognitive-behavioral therapy (CBT), are foundational, while pharmacological treatments play an adjunctive role [5]. Integrating nonpharmacological approaches, such as traditional Chinese medicine (TCM) alongside Western therapies, may enhance treatment outcomes. The effectiveness of CBT, exercise, and resistance training in improving health outcomes is well established [6, 7], with tai chi also shown to enhance psychological well-being [8]. Personalized exercise prescriptions tailored to individual needs and limitations are critical for optimizing treatment outcomes and improving quality of life [9].

While several fibromyalgia guidelines have been published both domestically and internationally [1, 2, 10–12], none have incorporated TCM treatments, such as tai chi, acupuncture, and cupping, into management. This guideline, developed using the Grading of Recommendations, Assessment, Development, and Evaluations (GRADE) methodology [13], recommends nonpharmacological interventions, including TCM, to alleviate fibromyalgia symptoms and improve function and quality of life. It evaluates the evidence supporting both established nonpharmacological therapies and traditional Chinese treatments, offering corresponding recommendations for clinicians, patients, and healthcare providers.

2 | Methods

The development of this guideline was conducted following the methodology outlined in the World Health Organization's WHO Handbook for Guideline Development (2014 edition) [14] and the Guiding Principles for the Development/Revision of Clinical Practice Guidelines in China (2022 edition) published by the Chinese Medical Association [15]. This guideline is reported by the Reporting Items for Practice Guidelines in HealThacare (RIGHT) [16] checklist and registered on the Practice Guideline Registration for transPAREncy (PREPARA) platform (<http://www.guidelines-registry.cn/?lang=en-US>) with registration number PREPARA-2022CN695.

2.1 | Guideline Working Group

This guideline established a multidisciplinary expert group composed of specialists from fields such as rheumatology, rehabilitation, pain medicine, TCM, and evidence-based medicine (EBM). The working group consists of a Consensus Expert Group (CEG) and an Evidence Evaluation Group (EEG). The CEG members participated in the Delphi consensus survey and were primarily responsible for proposing modifications

to the recommendations and reviewing the final draft of the guideline. The EEG was primarily responsible for searching, selecting, and evaluating evidence, writing the summary of recommendations, and drafting the initial version of the guideline. All members of the working group have declared that there are no direct or indirect conflicts of interest related to this guideline.

2.2 | Guideline Users and Target Population

This guideline is intended for use by rheumatologists, general practitioners, rehabilitation physicians, pain specialists, psychiatrists, TCM practitioners, and other healthcare professionals involved in the diagnosis, treatment, and management of fibromyalgia. The target population for the application of the recommendations in this guideline is patients with fibromyalgia.

2.3 | Guideline Question

This guideline addresses a primary clinical question: What are nonpharmacological therapies recommended for treating fibromyalgia patients?

2.4 | Intervention Selection

This guideline focuses on nonpharmacological interventions for patients with fibromyalgia. The EEG first searched PubMed, Embase, Cochrane Library, CNKI, WANFANG DATA, and SinoMed to collect systematic reviews, meta-analyses, and randomized controlled clinical trials on nonpharmacological interventions for fibromyalgia. The detailed search strategy is provided in the Supporting Information 1. Based on this search, relevant literature was selected to summarize the current nonpharmacological treatments used for fibromyalgia patients. Subsequently, an online survey was sent to 15 clinicians from different specialties nationwide and 122 fibromyalgia patients. The final selection was based on nonpharmacological interventions that are easily accessible in frontline clinical practice and well-received by patients in terms of preference. The nonpharmacological interventions, categorized through database searches, are listed in Supporting Information Table 1. The characteristics of the surveyed clinicians and fibromyalgia patients are provided in Supporting Information Tables 2 and 3.

2.5 | Evidence Retrieval

The EEG deconstructed the final clinical questions and outcome indicators based on the Population, Intervention, Comparison, and Outcome (PICO) framework. Searches were then conducted according to the deconstructed questions. Systematic searches were performed in PubMed, The Cochrane Library, China National Knowledge Infrastructure (CNKI), and the China Biomedical Literature Database, using a combination of Medical Subject Headings (MeSH) and free-text terms. The search covered the period from the inception of each database to March 2023, with language limitations to Chinese and English.

2.6 | Inclusion and Exclusion Criteria for Evidence

Following the Population, Intervention, Comparison, Outcome, and Study design (PICOS) model, the inclusion criteria for this guideline are set as follows:

- Population: Fibromyalgia patients.
- Intervention: Nonpharmacological interventions (Supporting Information Table 1) may be used either as a standalone treatment or in combination with conventional Western medicine treatments (standard care).
- Comparison: Placebo interventions, sham interventions, wait-list control group, conventional Western medicine treatments, standard care, and so forth.
- Outcome: Pain intensity, symptom reduction or changes, psychological state (anxiety, depression), physical function (stiffness, range of motion, muscle strength), and quality of life (fatigue, sleep quality) were reported in the published systematic reviews, meta-analyses, and randomized controlled trials (RCTs) as primary outcomes.
- Study Design: Systematic reviews, meta-analyses, RCTs.

Exclusion Criteria: Conference abstracts not subsequently published in peer-reviewed journals; Editorials, reviews, letters, news articles, case reports, and narrative reviews; Publications in languages other than English or Chinese.

2.7 | Evidence Evaluation

The EEG assessed the risk of bias in the included systematic reviews and meta-analyses using the A Measurement Tool to Assess Systematic Reviews (AMSTAR) [17]. The Cochrane Risk of Bias tool was used to evaluate the risk of bias in RCTs [18]. Two authors conducted the assessment process independently, and any discrepancies were resolved through discussion or consulting a third party.

2.8 | Grading of Evidence

The evidence and recommendations were graded using the GRADE [19–21] methodology, as outlined in Supporting Information Table 4. The specific grading criteria used in GRADE rating are explained in Supporting Information Table 6 [22].

2.9 | Development of the Recommendation

The expert panel formulated the recommendations based on the evidence summary provided by the EEG, considering the preferences and values of fibromyalgia patients in China, the cost-effectiveness of interventions, and their benefits and harms. This process resulted in recommendations for nonpharmacological treatments for fibromyalgia in China. The guideline underwent two rounds of Delphi surveys to refine and finalize the recommendations.

2.10 | Delphi Consultation

The coordinating team conducted a systematic literature search, rigorously evaluated the quality of the included studies, and synthesized feedback from 15 clinicians and 122 fibromyalgia patients across the country. An evidence summary table was developed, which includes open-ended questions to allow Delphi experts to provide constructive feedback and suggest modifications to the interventions.

A total of 40 experts were invited to form the Delphi panel, with each expert independently completing the evidence summary table. These experts possess extensive experience and/or expertise in fields such as rheumatology, rehabilitation, pain medicine, and TCM.

To reach consensus on the inclusion of interventions, two rounds of Delphi consultation were conducted [23, 24]. In each round, experts were asked to indicate whether they agreed, disagreed, or were uncertain about the inclusion of each intervention, and to provide suggestions for modifications [25]. During the first round, experts were also encouraged to propose any additional interventions they deemed relevant. The second round addressed interventions for which consensus had not been reached in the first round, as well as any new interventions introduced by at least one respondent. After both rounds, the feedback from the Delphi experts was carefully reviewed, and certain interventions were revised. Detailed feedback was subsequently provided to the panel members.

The level of consensus for each intervention was determined by the percentage of panel members agreeing to include it. The inclusion of interventions was based on the following criteria: (1) Interventions with a consensus level below 70% were excluded; (2) Interventions with a consensus level of 70% or above, with no major disagreements, were considered for inclusion; (3) Interventions with a consensus level of 70% or above but with substantial disagreements in the first round were reviewed and revised by the coordinating team before proceeding to the second round of Delphi consultation; (4) In the second round, interventions that received 70% or more agreement and no disagreements were included.

3 | Results

3.1 | Characteristics of Studies Identified in the Literature Search

A total of 18,317 articles were identified through the literature search. After applying the eligibility criteria, 57 articles remained, forming the evidence base for the guideline recommendations.

The included studies were published between 2006 and 2023. These trials compared nonpharmacological interventions with placebo, sham, waiting list controls, conventional Western treatments, and standard care. The primary outcomes of most studies included pain intensity, symptom reduction or changes, psychological state (e.g., anxiety, depression), physical function (e.g., stiffness, range of motion, muscle strength), and quality of life (e.g., fatigue, sleep quality), measured using standardized tools

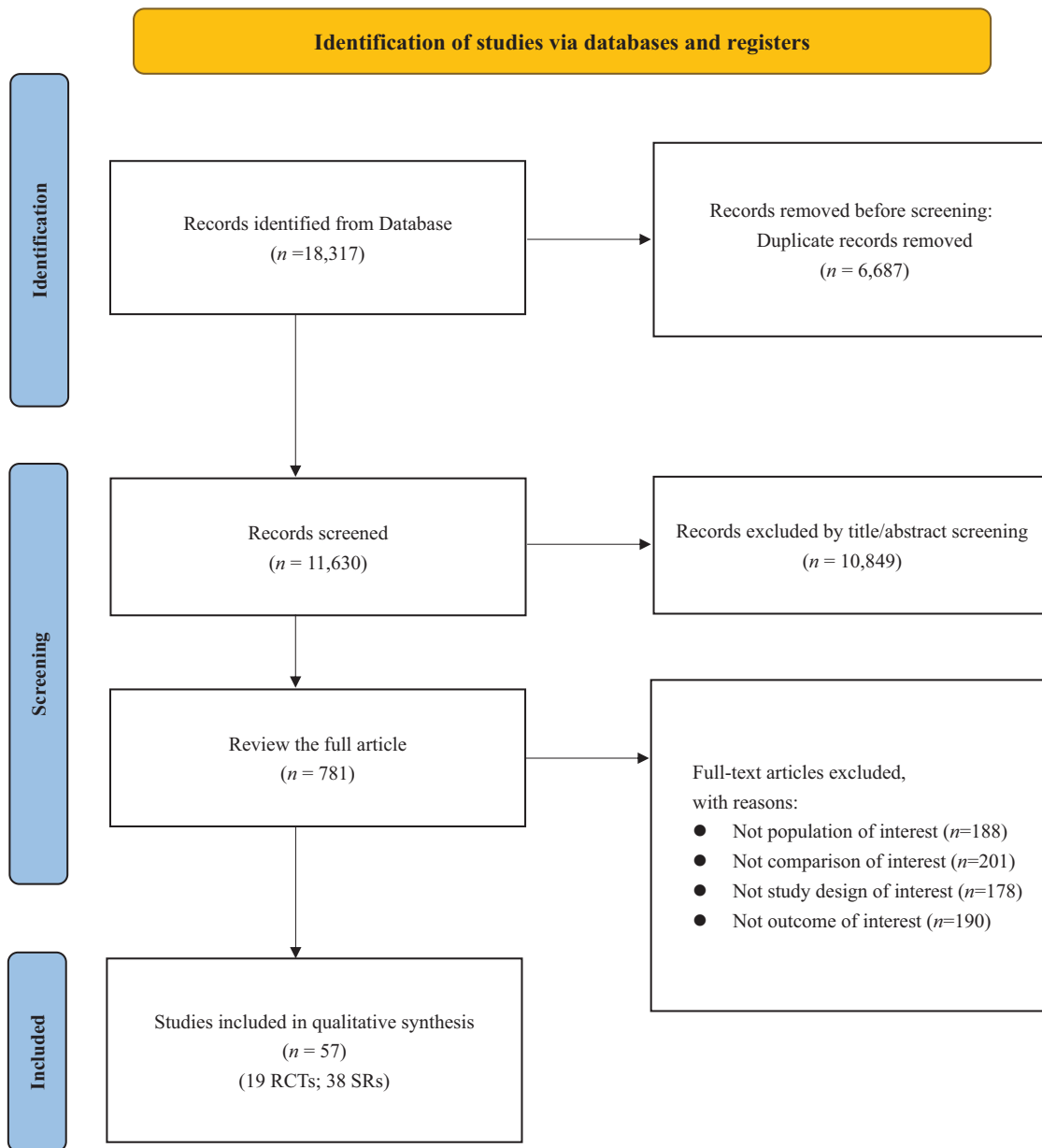


FIGURE 1 | Systematic review flow diagram. RCT, randomized controlled trial; SR, systematic review.

such as the Visual Analog Scale (VAS) and the Fibromyalgia Impact Questionnaire (FIQ). Figure 1 presents the flow diagram. Table 1 summarizes the specific recommendations for different nonpharmacological therapies along with the corresponding levels of evidence and recommendation strength.

3.2 | Recommendations

3.2.1 | Mind–Body Therapies

Traditional movement therapies such as tai chi, yoga, and qigong are categorized internationally as mind–body therapies. The European League Against Rheumatism (EULAR), the Italian Society of Rheumatology (SIR), and the Turkish Society of Physical Medicine and Rehabilitation (TSPMR) suggest med-

itation movement therapy as a supplementary treatment for fibromyalgia patients [10, 11, 26].

3.2.1.1 | Tai Chi.

- We suggest tai chi to patients with fibromyalgia over no exercise (conditional recommendation, moderate certainty of evidence).

The “Chinese recommendations for the management of fibromyalgia syndrome” [2] and the “The Fibromyalgia Rehabilitation Guidelines of China (2021)” [1] suggest tai chi as a rehabilitation intervention method for fibromyalgia patients.

We surveyed 122 patients diagnosed with fibromyalgia in China. The results revealed that over 80% of the patients expressed their

TABLE 1 | Summary of recommendations.

Therapy name	Recommendations	Certainty of evidence	Strength of recommendation
Mind–body therapies			
Tai chi	We suggest tai chi to patients with fibromyalgia over no exercise.	Moderate	Conditional
Yoga	We suggest yoga to patients with fibromyalgia over no exercise.	Low	Conditional
Pilates	We suggest Pilates to patients with fibromyalgia over no exercise.	Very low	Conditional
Exercise therapies			
Aerobic exercise	We recommend aerobic exercise to fibromyalgia patients over no exercise.	Low	Strong
Resistance strength training	We recommend resistance strength training to patients with fibromyalgia over no exercise.	Low	Strong
Mixed exercise training	We suggest mixed exercise training to patients with fibromyalgia over no exercise.	Low	Conditional
Aquatic exercises	We suggest aquatic exercises to patients with fibromyalgia over no exercise.	Low	Conditional
TCM practices			
Acupuncture	We recommend acupuncture to patients with fibromyalgia over no interventions.	Moderate	Strong
Cupping	We suggest cupping to patients with fibromyalgia over no interventions.	Very low	Conditional
Massage	We suggest massage to patients with fibromyalgia over no interventions.	Low	Conditional
Device-based physical therapies			
Hyperbaric oxygen therapy	We suggest hyperbaric oxygen therapy to patients with fibromyalgia over no interventions.	Low	Conditional
Transcranial magnetic stimulation and transcranial direct current stimulation	We suggest transcranial magnetic stimulation (TMS) to patients with fibromyalgia over no interventions. We suggest transcranial direct current stimulation (TDCS) to patients with fibromyalgia over no interventions.	Low	Conditional
Low-level laser therapy	We suggest low-level laser therapy to patients with fibromyalgia over no interventions.	Low	Conditional

(Continues)

TABLE 1 | (Continued)

Therapy name	Recommendations	Certainty of evidence	Strength of recommendation
Hydrotherapy balneotherapy	We suggest hydrotherapy balneotherapy to patients with fibromyalgia over no interventions.	Low	Conditional
Virtual reality-based therapy or exergame training	We suggest virtual reality-based therapy (VRBT) to patients with fibromyalgia over no interventions. We suggest exergame training to patients with fibromyalgia over no interventions.	Moderate Moderate	Conditional Conditional
Psychological interventions			
Cognitive-behavioral therapy	We suggest cognitive-behavioral therapy to patients with fibromyalgia over no interventions.	Moderate	Conditional
Mindfulness therapy	We suggest mindfulness therapy to patients with fibromyalgia over no interventions.	Low	Conditional
Internet-delivered psychological therapies	We suggest internet-delivered psychological therapies to patients with fibromyalgia over no interventions.	Low	Conditional
Health education	We recommend health education as a fundamental nonpharmacological therapy for patients with fibromyalgia. We recommend health education to integrated throughout the entire treatment process for fibromyalgia patients, encompassing various forms and flexible methods. The educational content may include disease etiology, pathogenetic mechanisms, core symptoms, treatment plans, and prognosis, ultimately resulting in the development of suitable patient self-management strategies.	Moderate Low	Strong Strong
Creative arts therapies			
Music therapy	We suggest music therapy to patients with fibromyalgia over no interventions.	Low	Conditional
Dance therapy	We suggest dance therapy to patients with fibromyalgia over no interventions.	Low	Conditional
Complementary and alternative medicine			
Nutritional supplements and complementary medicine products	We suggest nutritional supplements and complementary medicine products to patients with fibromyalgia over no interventions.	Low	Conditional

support or willingness to engage in practicing tai chi to improve the symptoms of fibromyalgia. A meta-analysis [27], which involved six high-quality RCTs and 657 fibromyalgia patients, demonstrates that 12–16 weeks of tai chi practice yielded superior improvements in FIQ scores (SMD = −0.61; 95% CI, −0.90 to −0.31) and pain scores (SMD = −0.88; 95% CI, −1.58 to −0.18), as well as enhanced sleep quality (SMD = −0.57; 95% CI, −0.86 to −0.28), reduced fatigue (SMD = −0.192; 95% CI, −1.81 to −0.04), alleviated depression symptoms (SMD = −0.49; 95% CI, −0.97 to −0.01), and improved both physical (SMD = 6.21; 95% CI, 3.18–9.24) and psychological (SMD = 5.15; 95% CI, 1.50–8.81) aspects of quality of life compared to health education, stretching exercises, and relaxation therapy.

3.2.1.2 | Yoga.

- We suggest yoga to patients with fibromyalgia over no exercise (conditional recommendation, low certainty of evidence).

We conducted a questionnaire survey among 122 fibromyalgia patients in China. The results indicated that approximately 85% of female patients expressed support for or willingness to engage in yoga practice to alleviate fibromyalgia symptoms. A systematic review and meta-analysis published in 2022 assessed the impact of yoga therapy on depressive symptoms, anxiety, sleep quality, and mood in patients with rheumatic diseases [28]. This systematic review included 27 RCTs, among which seven studies focused on fibromyalgia patients, totaling 257 patients with fibromyalgia. The intervention measures included Hatha yoga, Iyengar yoga, chair yoga, and other forms of yoga. The duration of the treatment ranged from 8 to 12 weeks, with a frequency of one session per day or two sessions per week. The control group primarily received traditional exercise therapy or medication treatment. The results showed that yoga exercises were more effective in reducing depressive symptoms (SMD = −0.88; 95% CI, −1.42 to −0.34), anxiety (SMD = −0.51; 95% CI, −0.81 to −0.20), and improving sleep quality (SMD = −0.96; 95% CI, −1.36 to −0.56).

3.2.1.3 | Pilates.

- We suggest Pilates to patients with fibromyalgia over no exercise (conditional recommendation, very low certainty of evidence).

We conducted a systematic review of Pilates therapy for fibromyalgia [29–34] (including six RCTs and quasi-RCTs with a total of 303 fibromyalgia patients). The typical duration of treatment was 60 min per session, with a frequency of two to three times per week, for 6–8 weeks. The results showed that Pilates exercise significantly reduced pain (MD = −9.29; 95% CI, −14.17 to −4.41). The Pilates group had better quality of life dimensions, including vitality (MD = −9.14; 95% CI, 0.06–18.2), function (MD = −9.5; 95% CI, −18.2 to −0.06), and pain (MD = −11.5; 95% CI, −21.0 to −2.0), compared to the control group. The combination of Pilates therapy and aquatic aerobic exercise improved the sleep quality (MD = 2.7; 95% CI, 1.0–4.3) and alleviated pain (MD = 0.74; 95% CI, 0.3–1.1) of fibromyalgia patients after 12 weeks of treatment. Due to the limited sample size and duration of therapy, a larger sample size and longer duration trials are necessary. No studies reported adverse events related to Pilates therapy, the results indicated that the quality of the evidence was very low.

3.2.2 | Exercise Therapies

3.2.2.1 | Aerobic Exercise.

- We recommend aerobic exercise to fibromyalgia patients over no exercise (strong recommendation, low certainty of evidence).

Exercise plays a significant role in the treatment of fibromyalgia and has received attention and recommendations in multiple fibromyalgia guidelines [1, 10, 11, 26]. The “Fibromyalgia Rehabilitation Guidelines of China (2021)” [1] independently evaluated and recommended different exercise modalities based on the available evidence. Long-term regular aerobic exercises, such as moderate walking, stretching, jogging, and cycling, are exercise forms that fibromyalgia patients are more likely to accept and adhere to in the long run. The Cochrane systematic review [35] included 13 RCTs with 839 participants, demonstrates that aerobic exercises significantly improve the quality of life (MD = −7.89; 95% CI, −13.23 to −2.55), pain intensity (MD = −11.06; 95% CI, −18.34 to −3.77), stiffness (MD = −7.96; 95% CI, −14.95 to −0.97), physical function (MD = −10.16; 95% CI, −15.39 to −4.94), and fatigue (MD = −6.48; 95% CI, −14.33 to −1.38) of fibromyalgia patients compared to the control group (conventional treatments such as medication, low-intensity walking, education, and self-management interventions without exercise). Moreover, aerobic exercises have been shown to have a favorable long-term effect on pain and physical function improvement, lasting up to 24–208 weeks. In 2022, a systematic review and meta-analysis [36] was conducted to assess the clinical efficacy of different exercise modalities on adult fibromyalgia patients. The results indicated that aerobic exercise alleviated pain intensity (MD = −7.89; 95% CI, −13.23 to −2.55), stiffness (MD = −7.96; 95% CI, −14.95 to −0.97), FIQ scores (MD = −11.06; 95% CI, −18.34 to −3.77), psychological quality of life (MD = −7.96; 95% CI, −14.95 to −0.97), and physical quality of life (MD = −10.16; 95% CI, −15.39 to −4.94) in fibromyalgia patients.

3.2.2.2 | Resistance Strength Training.

- We recommend resistance strength training to patients with fibromyalgia over no exercise (strong recommendation, low certainty of evidence).

Muscular strength training, recommended by multiple fibromyalgia management guidelines [1, 10, 11], is an exercise modality that enhances muscle strength, improves muscle endurance, and modifies muscle morphology. The Fibromyalgia Rehabilitation Guidelines of China (2021) [1] indicate that resistance strength training, in combination with aerobic exercise, forms the foundation of nonpharmacological management for fibromyalgia.

Several meta-analyses focus on the effectiveness of resistance strength exercises in treating fibromyalgia [37–39]. One systematic review and meta-analysis included 13 RCTs, which demonstrated that resistance muscle training improved pain (MD = −10.22; 95% CI, −18.86 to −1.58), fatigue (MD = −0.39; 95% CI, −0.61 to −0.17), and muscle strength (MD = 0.94; 95% CI, 0.02–1.85) in fibromyalgia patients. Additionally, it improved physical functional ability (MD = 18.75%; 95% CI, 4.27–33.22) [39]. Furthermore, a dose–response meta-analysis on resistance

muscle training [38] showed that compared to the control group, pain in fibromyalgia patients could be effectively alleviated when performing one to two set of 4–20 repetitions at moderate to high intensity, twice a week, for 8–12 weeks. Moreover, a network meta-analysis involving 45 RCTs [37] reveals that a combination of aerobic and resistance exercise may be the best exercise type for improving the quality of life, relieving pain, and enhancing physical function in fibromyalgia patients.

3.2.2.3 | Mixed Exercise Training.

- We suggest mixed exercise training to patients with fibromyalgia over no exercise (conditional recommendation, low certainty of evidence).

Mixed exercise training modalities have been used in the treatment of fibromyalgia patients, but the recommended intensities differ among different guidelines [1, 2]. A systematic review conducted on 29 RCTs, including 2088 patients with fibromyalgia, from The Cochrane Library [40], reveals that mixed exercise training (aerobic or cardiorespiratory exercise, resistance or strength training, and flexibility exercises, either two or more combined) compared to control groups (waitlist, usual care, or no treatment) improved quality of life (MD = -6.95; 95% CI, -10.51 to -3.38), pain intensity (MD = -5.2; 95% CI, -8.85 to -1.48), fatigue (MD = -12.93; 95% CI, -17.79 to -8.07), stiffness (MD = -6.95; 95% CI, -8.85 to -1.48), physical function (MD = -10.99; 95% CI, -14.80 to -7.18), and 6-min walking distance (MD = 52.77 m; 95% CI, 34.11–71.43) in fibromyalgia patients. The improvements in health-related quality of life, fatigue, and physical function in the mixed exercise training group were sustained up to 6–52 weeks or longer after treatment without any dropouts or adverse events. However, compared to single exercise training (aerobic exercise, resistance training) or nonexercise interventions (biofeedback), only studies with small sample sizes and significant heterogeneity obtained very low-quality evidence supporting the effectiveness of different types of mixed exercise training (aerobics, flexibility exercises, resistance training, flexibility exercises, and postural exercises) in improving patient quality of life, physical function, or symptom reduction. Therefore, it is currently uncertain if the effects of multiple exercises are superior to those of a single exercise.

3.2.2.4 | Aquatic Exercises.

- We suggest aquatic exercises to patients with fibromyalgia over no exercise (conditional recommendation, low certainty of evidence).

Previous guidelines [1, 10, 11] recommends a combination of aquatic exercise and hydrotherapy. In order to clarify the respective efficacy of aquatic exercise therapy, the current guideline conducts separate evidence evaluations and provides independent recommendations.

A systematic review and meta-analysis published in 2021 [41] demonstrates that patients with fibromyalgia who underwent aquatic exercises (based on 10 RCTs and 508 participants) had significantly lower VAS scores compared to the control group (SMD = -0.27; 95% CI, -0.45 to -0.09), as well as reduced FIQ scores (SMD = -0.29; 95% CI, -0.49 to -0.09). However, the low

quality of evidence was due to small sample sizes and moderate dropout rates in clinical trials. The treatment duration ranged from 12 to 32 weeks, with two to three sessions per week and exercise duration of 30–70 min each time. Another systematic review and meta-analysis published in 2022 [41], which included 14 RCTs with 762 fibromyalgia patients, showed that aquatic exercise therapy improved pain (MD = -0.98; 95% CI, -1.36 to -0.60), 6-min walk test (MD = 38.12; 95% CI, 13.65–62.59), FIQ scores (MD = -7.35; 95% CI, -13.05 to -1.65), Short Form 36 (SF-36) questionnaire scores (MD = 9.53; 95% CI, 0.62–18.43), and Brief Health Status questionnaire scores (MD = 10.39; 95% CI, 1.42–19.36) compared to other forms of exercise or no exercise. The treatment duration ranged from 12 to 32 weeks, with one to three sessions per week and exercise duration of 30–90 min each time. Considering the factors of safety and accessibility, it is recommended that fibromyalgia patients with appropriate conditions engage in exercise under the guidance of professionals.

3.2.3 | TCM Practices

3.2.3.1 | Acupuncture.

- We recommend acupuncture to patients with fibromyalgia over no interventions (strong recommendation, moderate certainty of evidence).

The guidelines from the EULAR, the SIR, and the TSPMR [10, 11, 26] provide strong evidence supporting the use of acupuncture in the treatment of fibromyalgia. However, due to factors such as accessibility, these guidelines only provide Conditional recommendations. Several systematic reviews and meta-analyses have investigated the effectiveness and safety of acupuncture in the treatment of fibromyalgia [40, 42–45]. In 2022, a systematic review and meta-analysis on acupuncture therapy for fibromyalgia [43] evaluated the efficacy and safety of acupuncture (both manual and electrical) compared to sham acupuncture, simulation or placebo acupuncture. The results showed that acupuncture treatment can reduce pain in fibromyalgia patients (MD = -0.42; 95% CI, -0.66, -0.17) and improve their overall well-being (MD = -0.86; 95% CI, -1.49 to 0.24). Furthermore, acupuncture therapy demonstrated long-term effects in reducing pain (MD = -0.40; 95% CI, -0.77 to -0.03) and improving well-being (MD = -0.58; 95% CI, -0.82 to -0.35) when followed up for 3 months or longer. There is no evidence to show that acupuncture is effective in relieving fatigue, improving sleep quality, physical function, or stiffness. No serious adverse events were reported during acupuncture treatment. The “Chinese recommendations for the management of fibromyalgia syndrome” [2] recommend that the depth of acupuncture should be determined by specific acupoints, and the needles should be retained for 20 min after de qi. The recommended treatment frequency is one to three times per week, with a treatment duration of 4–12 weeks. Adjunctive electroacupuncture may be utilized as appropriate. In 2023, a multidimensional evidence-based systematic review on acupuncture treatment for fibromyalgia [46] included 29 clinical trials, identifying the commonly used high-frequency acupoints such as Zusanli (ST36), Hegu (LI4), Sanyinjiao (SP6), Baihui (DU20), Taichong (LR3), Yanglingquan (GB34), Yintang (EX-HN3), Quchi (LI11), Shenmen (HT7), and Qihai (RN6). Based on

studies conducted in fibromyalgia patients and animal models, it was summarized that acupuncture may improve the symptoms of fibromyalgia patients by modulating various molecular pathways involved in both pain transmission and pain inhibition, such as ASIC3, Nav1.7, Nav1.8, TRPV1, as well as peripheral inflammation and the autonomic nervous system.

3.2.3.2 | Cupping.

- We suggest cupping to patients with fibromyalgia over no interventions (conditional recommendation, very low certainty of evidence).

We conducted a systematic review of cupping therapy for the treatment of fibromyalgia [47–50] (four clinical trials involving 519 fibromyalgia patients). The treatment frequency was three to six times per week, with a median duration of 23 days (ranging from 18 to 28 days). The results showed that cupping therapy significantly reduced pain (MD = −2.32; 95% CI, −3.36 to −1.28). In terms of quality of life, cupping therapy improved scores on the bodily pain scale (MD = 4.7; 95% CI, 0.9–8.6), vitality (MD = 6.3; 95% CI, 0.9–11.7), and mental health (MD = 4.5; 95% CI, 0.0–8.9), while reducing scores on the fatigue motivation scale (MD = −1.2; 95% CI, −2.1 to −0.2). Cupping therapy demonstrated efficacy in reducing pressure pain sensitivity in the left rhomboid muscle, left gluteus maximus muscle, and the site of maximal pain. One study showed that patient preference had little impact on the effectiveness of cupping therapy, and there was no significant difference in dropout rates between randomized and nonrandomized allocation groups. No study reported any treatment-related adverse events.

3.2.3.3 | Massage.

- We suggest massage to patients with fibromyalgia over no interventions (conditional recommendation, low certainty of evidence).

Previous guidelines have provided inconsistent recommendations regarding the use of massage, massage and myofascial release therapy. The EULAR guidelines [26] conditionally discourage the use of massage, while the TSPMR guidelines [10] do not offer a recommendation regarding this therapy. The “Chinese recommendations for the management of fibromyalgia syndrome” [2] and the “Rehabilitation Guidelines for Fibromyalgia in China (2021)” [1], based on low-quality evidence, suggest the use of massage for the treatment of fibromyalgia patients. A systematic review and meta-analysis of one RCT and six non-RCTs involving 279 fibromyalgia patients, the effectiveness of myofascial release therapy in combination with conventional treatment was evaluated [51]. The results indicate that this massage therapy reduced pain scores (MD = −0.81; 95% CI, −1.15 to −0.47) and continued to alleviate pain after 6 months of treatment (MD = −0.61; 95% CI, −0.95 to −0.28). Furthermore, this therapy was found to improve sleep quality and overall quality of life compared to placebo and no treatment.

In the systematic review and meta-analysis on nonpharmacological interventions for the treatment of fibromyalgia in 2022 [4], two RCTs with a total of 115 fibromyalgia patients were included to evaluate the effectiveness of massage therapy. The results of

this analysis indicated that massage therapy led to improvements in the FIQ scores (MD = −1.51; 95% CI, −2.19 to −0.83), pain reduction (MD = −1.05; 95% CI, −1.69 to −0.41), alleviation of fatigue (MD = −0.95; 95% CI, −1.58, −0.31), and improvement in sleep quality (MD = −0.73; 95% CI, −1.35 to −0.11). However, no significant difference was observed in relieving depressive symptoms (MD = −0.73; 95% CI, −1.83 to 0.37).

Massage Types: It is recommended to primarily use light to moderate myofascial release or Swedish massage, with a focus on pain trigger points and tense muscle groups, such as the shoulders and neck.

Frequency and Duration: Connective tissue massage (CTM) is advised twice a week, with each session lasting 5–20 min, for a minimum of 6 weeks. Self-myofascial release (SMFR) should be performed five to six times per week, with each session lasting 50 min, including 10 min of warm-up, 30 min of active practice, and 10 min of static stretching. Swedish massage is recommended one to two times per week, with each session lasting 60–90 min, for at least 4 weeks [52–54].

Contraindications and Precautions: Deep tissue pressure should be avoided to prevent exacerbating pain. Caution is required for patients with osteoporosis or sensitive skin, and clinical interventions should be tailored to the patient’s individual tolerance levels.

We conducted a survey among 122 patients with fibromyalgia. The results revealed that approximately 80% of the patients expressed their support or willingness to practice massage and acupressure treatments to alleviate fibromyalgia symptoms.

3.2.4 | Device-Based Physical Therapies

3.2.4.1 | Hyperbaric Oxygen Therapy.

- We suggest hyperbaric oxygen therapy to patients with fibromyalgia over no interventions (conditional recommendation, low certainty of evidence).

In 2023, a systematic review and meta-analysis on the effect of hyperbaric oxygen therapy in patients with fibromyalgia was conducted [55]. This review included a total of nine open-label randomized or clinical controlled trials involving 288 fibromyalgia patients. Compared to the control group (conventional treatment or health guidance), hyperbaric oxygen therapy significantly reduced pain in fibromyalgia patients (MD = −1.56; 95% CI, −2.18 to −0.93). The systematic review also indicated that hyperbaric oxygen therapy improved tender points, fatigue, multidimensional functioning, overall patient well-being, and sleep disturbances in fibromyalgia patients. Among the included patients, 44 cases reported adverse events and 12 patients dropped out due to adverse reactions, but no severe adverse events or complications were observed.

We investigated 122 cases of fibromyalgia patients, a small number of whom were knowledgeable about or expressed a willingness to undergo hyperbaric oxygen therapy.

3.2.4.2 | Transcranial Magnetic Stimulation and Transcranial Direct Current Stimulation.

- We suggest transcranial magnetic stimulation (TMS) to patients with fibromyalgia over no interventions (conditional recommendation, low certainty of evidence).
- We suggest transcranial direct current stimulation (TDCS) to patients with fibromyalgia over no interventions (conditional recommendation, low certainty of evidence).

The TSPMR guidelines [10] TMS and TDCS as potential treatment options for eligible fibromyalgia patients. The Chinese Fibromyalgia Rehabilitation Guidelines (2021) [1] propose TMS and TDCS as therapeutic approaches for fibromyalgia patients with severe symptoms. Noninvasive neuromodulation techniques, namely, TMS and TDCS, involve the application of pulse magnetic or direct current stimulation to specific brain regions to achieve a therapeutic effect. “Chinese recommendations for the management of fibromyalgia syndrome” [2] suggest that fibromyalgia patients with predominant pain symptoms may consider treatment with TMS or TDCS. The unique central sensitization in fibromyalgia involves sensory processing dysfunction and cortical adaptive neuroplasticity changes. Neurophysiological techniques based on cortical electrical currents aim to enhance cortical excitability and promote changes in pain-modulating brain regions to alleviate symptoms.

Meta-analysis and systematic reviews [56–58] have investigated the efficacy and safety of repetitive transcranial magnetic stimulation (rTMS) in the treatment of fibromyalgia. The meta-analysis conducted in 2022 included 14 RCTs with 433 fibromyalgia patients [58]. The results showed that rTMS treatment led to a reduction in pain (SMD = -0.49 ; 95% CI, -0.86 to -0.13) and the FIQ scores (SMD = -0.50 ; 95% CI, -0.75 to -0.25) compared to sham rTMS. However, there were no statistically significant differences in the Beck Depression Inventory (BDI), Hospital Anxiety and Depression Scale (HADS) anxiety scores, Pain Catastrophizing Scale (PCS), Fatigue Severity Scale (FSS), and Short Form Health Survey (SF-36) psychological scores when compared to sham rTMS.

Additionally, another meta-analysis including 11 RCTs with 303 fibromyalgia patients found that rTMS significantly improved pain (SMD = -0.35 ; 95% CI, -0.62 to -0.08) and quality of life (SMD = -0.51 ; 95% CI, -0.78 to -0.23) compared to sham rTMS, but it was not more effective than sham rTMS for depression and anxiety.

Furthermore, a meta-analysis of high-frequency (10 Hz) rTMS for fibromyalgia conducted in 2023 showed that 10 Hz rTMS significantly reduced pain (SMD = -0.72 ; 95% CI, -1.12 to -0.33) and improved quality of life (SMD = -0.70 ; 95% CI, -1.00 to -0.40) compared to sham rTMS. However, it did not significantly improve depression (SMD = -0.23 ; 95% CI, -0.50 to -0.05) when compared to sham rTMS.

Multiple systematic reviews and meta-analyses [59–61] have investigated the efficacy and safety of TDCS for the treatment of fibromyalgia. One meta-analysis [61], which included 16 RCTs, showed that TDCS significantly improved pain in fibromyalgia

patients compared to sham TDCS (SMD = 1.22 ; 95% CI, 0.68 – 1.65). Meta-regression analyses indicated that longer treatment durations of at least 4 weeks had greater effectiveness compared to shorter durations. In 2023, another systematic review and meta-analysis [59] of neuroelectric modulation for fibromyalgia included 25 clinical trials and 1061 fibromyalgia patients. Both active electrical nerve stimulation and active TDCS demonstrated significant improvements in subjective pain (MD = 0.53 ; 95% CI, 0.28 – 0.78), depression (MD = 0.36 ; 95% CI, 0.16 – 0.56), and physical function (MD = 0.47 ; 95% CI, 0.30 – 0.64) in fibromyalgia patients. Regarding different anode TDCS electrode positions, only F3–F4 showed significant improvement in depression (MD = 0.49 ; 95% CI, 0.18 – 0.79).

3.2.4.3 | Low-Level Laser Therapy.

- We suggest low-level laser therapy to patients with fibromyalgia over no interventions (conditional recommendation, low certainty of evidence).

A systematic review and meta-analysis conducted in 2019 [62] evaluated the therapeutic effects of low-level laser therapy on fibromyalgia. The results revealed that compared to placebo laser, low-intensity laser treatment (wavelength range of 640–950 nm, power approximately 0.9–1000 MW) administered for 2–12 weeks effectively alleviated pain (SMD = 1.18 ; 95% CI, 0.82 – 1.54), reduced fatigue (SMD = 1.4 ; 95% CI, 0.96 – 1.84), relieved stiffness (SMD = 0.92 ; 95% CI, 0.36 – 1.48), and mitigated symptoms of depression (SMD = 1.46 ; 95% CI, 0.93 – 2.00) and anxiety (SMD = 1.46 ; 95% CI, 0.45 to -2.47) in patients with fibromyalgia. Furthermore, this analysis included four studies that reported no adverse effects associated with low-dose laser treatment.

Another systematic review and meta-analysis published in 2019 [63] evaluated the efficacy of low-level laser therapy for myofascial neck pain in an indirect population comprising 13 studies and 556 patients. The findings revealed that low-level laser treatment significantly reduced pain (MD = -1.29 ; 95% CI, -2.36 to -0.23), improved pressure pain threshold (SMD = 2.63 ; 95% CI, 0.96 – 4.30), and enhanced range of motion on the right side (SMD = 3.44 ; 95% CI, 0.64 – 6.24).

The Chinese Guidelines for Fibromyalgia Rehabilitation (2021) [1] suggest that fibromyalgia patients who express a willingness to explore nonpharmacological interventions can consider trying low-level laser therapy.

A survey conducted by the research team involving 122 fibromyalgia patients revealed that a minority of patients had knowledge of or exhibited a willingness to undergo low-level laser irradiation.

3.2.4.4 | Hydrotherapy Balneotherapy.

- We suggest hydrotherapy balneotherapy to patients with fibromyalgia over no interventions (conditional recommendation, low certainty of evidence).

The TSPMR recommend that patients with fibromyalgia consider hydrotherapy balneotherapy on their personal preferences, environmental factors, and adherence to exercise [10]. The “Chinese Fibromyalgia Rehabilitation Guidelines (2021)” suggest that

fibromyalgia patients who have the opportunity should engage in water-based exercise or hydrotherapy [1]. The “Chinese recommendations for the management of fibromyalgia syndrome” recommend that fibromyalgia patients who are willing to receive more nonpharmacological interventions may consider trying immersion therapy [2].

A meta-analysis in 2021 investigated various forms of hydrotherapy (including mineral or hot water baths, hot spring therapy, seawater therapy, hot tubs, mineral baths, and mud packs) in the treatment of fibromyalgia. The study included 11 RCTs with a total of 672 fibromyalgia patients [64]. The original studies had a treatment duration of 2–4 weeks, with sessions lasting 15–30 min each, and an average water temperature of 36.5°C (ranging from 34.8°C to 38°C). The meta-analysis results showed that compared to the control group, hydrotherapy resulted in reduced pain after 2 weeks of treatment (MD = −0.92; 95% CI, −1.31 to −0.53), reduced pain after 3 months of treatment (MD = 0.45; 95% CI, −0.73 to −0.16), and reduced pain after 6 months of treatment (MD = −0.70; 95% CI, −1.34 to −0.05). Additionally, hydrotherapy led to lower scores on the FIQ after 2 weeks (SMD = −1.04; 95% CI, −1.51 to −0.57), after 3 months (SMD = −0.69; 95% CI, −0.88, −0.49), and after 6 months (SMD = −0.94; 95% CI, −1.55 to −0.34). However, there was no significant improvement in depressive symptoms after 2 weeks of treatment (SMD = −0.35; 95% CI, −0.73 to 0.04) and after 3 months of treatment (SMD = −0.23; 95% CI, −0.64 to 0.17), but there was improvement in depressive symptoms after 6 months of treatment (SMD = −0.45; 95% CI, −0.73 to −0.17).

In 2023, a systematic review and meta-analysis [65] included seven RCTs involving 311 fibromyalgia patients. The results reveal that hydrotherapy balneotherapy significantly improved the sleep quality of fibromyalgia patients (MD = −2.05; 95% CI, −4.35 to 0.25) compared to the control group. The study concluded that hydrotherapy balneotherapy promise for alleviating sleep disorders in fibromyalgia patients.

3.2.4.5 | Virtual Reality-Based Therapy or Exergame Training.

- We suggest virtual reality-based therapy (VRBT) to patients with fibromyalgia over no interventions (conditional recommendation, moderate certainty of evidence).
- We suggest exergame training to patients with fibromyalgia over no interventions (conditional recommendation, moderate certainty of evidence).

VRBT and exergame training are novel treatment methods for fibromyalgia syndrome in women, which have not been evaluated and recommended in previous fibromyalgia guidelines or consensus. A meta-analysis conducted in 2021, including 11 RCTs involving 535 female fibromyalgia patients, demonstrated significant improvements in various outcome measures with VRBT therapy [66]. These improvements included FIQ scores (MD = −0.62; 95% CI, −0.93 to −0.31), pain (MD = −0.45; 95% CI, −0.69 to −0.21), dynamic balance (MD = −0.76; 95% CI, −1.12 to −0.39), aerobic capacity (SMD = 0.32; 95% CI, 0.004–0.63), fatigue (SMD = −0.58; 95% CI, −1.02 to −0.14), quality of life (SMD = 0.55; 95% CI, 0.30–0.81), anxiety (SMD = −0.47; 95% CI,

−0.91 to −0.03), and depression (SMD = −0.46; 95% CI, −0.76 to −0.16). Furthermore, VRBT combined with cognitive therapy demonstrated significant efficacy in reducing FIQ scores, fatigue, and improving the quality of life in female fibromyalgia patients.

In 2022, a systematic review and meta-analysis [67] including nine RCTs and 466 women with fibromyalgia showed that exercise video game training improved overall function (SMD = −0.52; 95% CI, −0.77 to −0.27), pain perception (SMD = −0.49; 95% CI, −0.97 to −0.02), quality of life (SMD = 0.77; 95% CI, 0.44–1.10), physical ability (SMD = 0.58; 95% CI, 0.32–0.84), and health perception (SMD = 0.69; 95% CI, 0.38–1.01) among female fibromyalgia patients. Furthermore, it was found that exercise video game training had no significant impact on exercise phobia (SMD = −1.13; 95% CI, −2.88 to −0.38). The intervention duration ranged from 3 weeks to 3 months. The game devices used in the studies included Xbox 360 Kinect, Nintendo Wii, and virtual Ex-FM.

3.2.5 | Psychological Interventions

3.2.5.1 | Cognitive–Behavioral Therapy.

- We suggest CBT to patients with fibromyalgia over no interventions (conditional recommendation, moderate certainty of evidence).

CBT is recommended by multiple clinical practice guidelines [1, 2, 10, 11, 26] for improving symptoms in patients with fibromyalgia. A meta-analysis in 2018, which included 29 RCTs with 2509 fibromyalgia patients [68], revealed that CBT significantly improved pain (RD = 0.05; 95% CI, 0.02–0.07), quality of life (RD = −0.13; 95% CI, 0.00–0.26), mood (SMD = −0.43; 95% CI, −0.62 to −0.24), disability (SMD = −0.30; 95% CI, −0.52 to −0.08), and fatigue symptoms (SMD = 0.27; 95% CI, −0.50 to −0.03) compared to control groups (waitlist, attention control training, standard treatment, other active nonpharmacological interventions). The 6-month follow-up results indicate long-term efficacy for all outcomes except for quality of life.

A meta-analysis conducted in 2023 examined the effects of CBT on fibromyalgia patients with prominent symptoms of insomnia [69]. The results demonstrated that compared to other nonpharmacological treatments, CBT significantly improved the quality of sleep (MD = −0.53; 95% CI, −0.93 to −0.13), alleviated pain (MD = −0.41; 95% CI, −0.67 to −0.16), reduced anxiety (MD = −0.46; 95% CI, −0.74 to −0.18), and mitigated depression (MD = −0.33; 95% CI, −0.61 to −0.05) in fibromyalgia patients.

3.2.5.2 | Mindfulness Therapy.

- We suggest mindfulness therapy to patients with fibromyalgia over no interventions (conditional recommendation, low certainty of evidence).

Mindfulness-based therapy has been recommended for the treatment of fibromyalgia patients by multiple clinical practice guidelines both domestically and internationally [1, 2, 11, 26]. A meta-analysis conducted in 2019, including nine RCTs involving 750 fibromyalgia patients, revealed that compared to the control group, mindfulness and acceptance-based treatment methods

resulted in improvements in pain (SMD = -0.46; 95% CI, -0.75 to -0.17), depression (SMD = -0.49; 95% CI, -0.85 to -0.12), anxiety (SMD = -0.37; 95% CI, -0.71 to -0.02), mindfulness (SMD = -0.40; 95% CI, -0.69 to -0.11), sleep quality (SMD = -0.33; 95% CI, -0.70 to -0.04), and quality of life (SMD = -0.74; 95% CI, -2.02 to -0.54) in fibromyalgia patients [70].

In a systematic review and meta-analysis conducted in 2022 on nonpharmacological therapy for fibromyalgia [71], a total of eight RCTs with a sample size of 630 fibromyalgia patients were included to investigate the effectiveness of mindfulness-based therapy. The results revealed that mindfulness-based therapy has favorable effects in alleviating depression (MD = -0.46; 95% CI, -0.75 to -0.17) and fatigue symptoms (MD = -0.49; 95% CI, -0.91 to -0.07) among fibromyalgia patients. However, no significant differences were found in pain reduction, sleep quality, and efficacy compared to the control group.

3.2.5.3 | Internet-Delivered Psychological Therapies.

- We suggest internet-delivered psychological therapies to patients with fibromyalgia over no interventions (conditional recommendation, low certainty of evidence).

In 2019, a meta-analysis of six RCTs involving 493 fibromyalgia patients [72] revealed that internet-delivered psychological therapies showed superiority over control groups (waitlist, attention control, and usual care) in reducing negative emotions (SD = -0.51; 95% CI, -0.87 to -0.15) and disability (SMD = -0.56; 95% CI, -1.00 to -0.13) among fibromyalgia patients. However, no significant differences were found in terms of safety data and long-term follow-up outcomes in comparison to the control group. Additionally, no conclusive evidence was found regarding a pain relief rate of 50% or higher (RD = 0.09; 95% CI, -0.02 to 0.20).

In addition, a RCT evaluated the effects of online nursing consultation through an internet platform on improving the perceived quality of life in patients with fibromyalgia [73]. A total of 80 patients with fibromyalgia were randomly assigned to an intervention group ($n = 40$) and a control group ($n = 40$). The intervention group received monitoring from nursing experts through the online platform, while the control group received standard follow-up at the clinic. After 12 months, the intervention group showed a 65% improvement in overall health perception, compared to a 5.6% improvement in the control group ($p < 0.001$). Furthermore, the intervention group achieved better results in terms of emotional status. Throughout the study, the anxiety variable in the intervention group improved by more than two points (from 7.64 to 5.36), while it remained unchanged in the control group. After 12 months, the intervention group also demonstrated continued improvement in the depression variable, with a mean of 7.72 (SD 2.05) decreasing to 5.33, whereas a slight worsening was observed in the control group.

3.2.5.4 | Health Education.

- We recommend health education as a fundamental non-pharmacological intervention for patients with fibromyalgia (strong recommendation, moderate certainty of evidence).

- We recommend health education to integrated throughout the entire treatment process for fibromyalgia patients, encompassing various forms and flexible methods. The educational content may include disease etiology, pathogenetic mechanisms, core symptoms, treatment plans, and prognosis, ultimately resulting in the development of suitable patient self-management strategies (strong recommendation, low certainty of evidence).

The guidelines for the diagnosis and treatment of fibromyalgia from various countries and organizations recommend health education as an important nonpharmacological intervention for fibromyalgia patients [1, 2, 4, 10–12]. We should attach importance to the education of fibromyalgia patients, emphasize the integration of health education throughout the entire treatment process, and diversify the forms and methods of education. The content of education could include disease etiology, pathological mechanisms, common symptoms, treatment plans, and prognosis, and can also guide fibromyalgia patients in establishing a good self-management plan. A systematic review [13] demonstrates that interdisciplinary health education in the form of lectures, and group activities could enhance awareness of the disease, exercise, and treatment methods, thereby alleviating pain and enhancing the quality of life for fibromyalgia patients, but with low-quality evidence. Another systematic review and meta-analysis, which included nine RCTs involving a total of 1004 fibromyalgia patients, showed that combined conventional treatment with health education could enhance pain relief (MD = -1.05; 95% CI, -1.69 to -0.41), fatigue (MD = -0.95; 95% CI, -1.58 to -0.31), and sleep disorders (MD = -0.73; 95% CI, -1.35 to -0.11) in fibromyalgia patients [71]. However, the efficacy of health education alone showed no statistical difference compared to conventional treatment.

An additional meta-analysis [74] reveals that adding Pain Neuroscience Education (PNE) to multimodal therapy provides additional benefits for fibromyalgia patients. The PNE group showed significant improvements compared to the control group in terms of severity of fibromyalgia (SMD = -1.051; 95% CI, -1.309 to -0.793), pain intensity (SMD = -1.049; 95% CI, -1.400 to -0.698), and depression (SMD = -0.686; 95% CI, -0.849 to -0.523).

In addition, a meta-analysis [70] reveals that self-management interventions (including psychological counseling, physical activity, health education, mind-body therapies, and lifestyle modifications) improved physical functioning in the short-term and up to 3 months post-treatment (SMD = 0.42; 95% CI, 0.20–0.64), as well as in the long-term and up to 6 months post-treatment (SMD = 0.36; 95% CI, 0.20–0.53), compared to the control group receiving no treatment or standard care. Furthermore, self-management interventions reduced pain in fibromyalgia patients in the short-term (SMD = -0.49; 95% CI, -0.70 to -0.27) and long-term (SMD = -0.58; 95% CI, -0.58 to -0.19) when compared to no treatment or standard care.

3.2.6 | Creative Arts Therapies

3.2.6.1 | Music Therapy.

- We suggest music therapy to patients with fibromyalgia over no interventions (conditional recommendation, low certainty of evidence).

A systematic review and meta-analysis on nonpharmacological therapies for fibromyalgia conducted in 2022 [4], music therapy was assessed in six RCTs with a total of 297 fibromyalgia patients. The results revealed that music therapy alleviated depressive symptoms in fibromyalgia patients (MD = −0.54; 95% CI, −0.92 to −0.15). However, no significant differences were observed in pain reduction, fatigue relief, and improvement in sleep quality compared to the control group. Another systematic review and meta-analysis on music therapy for fibromyalgia conducted in 2020 [52] included seven RCTs with a total of 334 fibromyalgia patients. Patients receiving music therapy showed significant reductions in pain VAS scores (MD = −1.70; 95% CI, −2.22 to −1.18), alleviation of depressive symptoms (MD = −0.34; 95% CI, −0.65 to −0.03), and decreased FIQ scores (MD = −0.51; 95% CI, −0.82 to −0.20) compared to the control group. The duration of treatment ranged from 2 to 12 weeks. We conducted a survey among 122 patients with fibromyalgia. The results revealed that approximately 80% of the patients expressed their support or willingness to undergo music therapy as a means to alleviate fibromyalgia symptoms.

3.2.6.2 | Dance Therapy.

- We suggest dance therapy to patients with fibromyalgia over no interventions (conditional recommendation, low certainty of evidence).

In 2022, a systematic review and meta-analysis [75] of dance therapy for the treatment of fibromyalgia (including 15 clinical trials and RCTs with a total of 713 patients) demonstrated that dance therapy significantly reduced the FIQ scores (MD = −0.69; 95% CI, −0.88 to −0.49), pain scores (MD = −0.79; 95% CI, −0.98 to −0.60), and improved the quality of life (MD = 0.43; 95% CI, −0.09 to −0.70) among fibromyalgia patients. When incorporating creative elements such as aquatic dance, belly dance, therapeutic dance, and dance movement therapy, the effectiveness of creative dance further increased, leading to better improvement in pain, FIQ scores, and quality of life among fibromyalgia patients. The treatment duration varied from 8 to 24 weeks, with a total treatment time ranging from 16 to 48 h.

In 2018, a systematic review and meta-analysis on the use of dance therapy for the treatment of fibromyalgia was conducted [76]. The review included seven RCTs, with dance therapy interventions lasting between 12 and 24 weeks, with exercise durations of 60–120 min per session, one to two times per week. The results demonstrated that dance therapy significantly improved pain in fibromyalgia patients (MD = −1.64; 95% CI, −2.69 to −0.59). Additionally, dance therapy showed significant improvements in the patients' quality of life, depression levels, FIQ scores, anxiety levels, and physical functioning. We conducted a survey among 122 patients with fibromyalgia. The results revealed that approximately 90% of the patients expressed their support or willingness to undergo dance therapy as a means to alleviate fibromyalgia symptoms.

3.2.7 | Complementary and Alternative Medicine

3.2.7.1 | Nutritional Supplements and Complementary Medicine Products.

- We suggest nutritional supplements and complementary medicine products to patients with fibromyalgia over no interventions (conditional recommendation, low certainty of evidence).

According to the guidelines of the TSPMR [10], along with supporting a healthy diet and achieving target body weight, it is not recommended for fibromyalgia patients to use special nutrition, supplements, and medications. “Chinese recommendations for the management of fibromyalgia syndrome” [2] suggest that fibromyalgia patients should control their body weight and consume a variety of nutrient-rich diets, following a healthy dietary pattern. If a decrease in serum vitamin D levels is detected in the patients, supplementation could be considered.

Multiple systematic reviews [77–80] have focused on the efficacy and safety of different dietary patterns and nutritional supplements for patients with fibromyalgia. One systematic review [77], including 12 studies (11 intervention studies and one observational study) with 546 fibromyalgia patients, investigated the beneficial effects of plant-based diets, anti-inflammatory diets, gluten-free diets, and elimination/restrictive diets on pain, Fibromyalgia Impact Questionnaire/Revised Fibromyalgia Impact Questionnaire scores, tender point count, pain pressure threshold, and/or overall pain scores in fibromyalgia patients. However, due to small sample sizes and short intervention periods in the included studies, no specific diet can be recommended to fibromyalgia patients. In addition, two systematic reviews examined the efficacy of vitamin D supplementation in improving clinical conditions and alleviating symptoms in fibromyalgia patients and found that vitamin D supplementation may have some efficacy in reducing pain and other symptoms in fibromyalgia patients.

Supporting Information Table 5 shows a summary of recommendations. The clinical outcomes of fibromyalgia are broken down by the recommended nonpharmacological therapies.

4 | Discussion

This guideline incorporates feedback from 122 patients, including clinical doctors and members of the Chinese Fibromyalgia Association. The recommendations are relevant, clinically significant, and aligned with patient needs. A review of 19 randomized trials, five systematic reviews, and 33 meta-analyses made different recommendations for various nonpharmacological therapies. Among traditional therapies, acupuncture is effective in relieving pain, sleep disturbances, and fatigue. Tai chi helps improve function and reduce depression. Aerobic exercise and resistance training are strongly recommended for pain reduction, functional improvement, and long-term benefits. CBT and mindfulness-based therapies can help with pain, emotions, and sleep issues, although their effects vary. Emerging therapies like TMS, VRBT, and nutritional supplements show promise but need further validation. Massage, once recommended cautiously due to limited evidence and cultural differences, has been upgraded in the 2023 Chinese guideline to a “strongly recommended core therapy,” supported by localized research. However, our study found limited evidence, so it is recommended conditionally. Acupuncture is strongly recommended due to its ease of use,

despite moderate evidence. TMS is conditionally recommended due to its high cost and complexity. Although the evidence for aerobic exercise and resistance training is not strong, exercise therapy has achieved consensus in chronic disease management and shows a good risk–benefit ratio in practice [81]. Tai chi, which requires professional guidance and varies across regions, has limited data on long-term adherence. Therefore, it is conditionally recommended [8]. The Delphi expert consensus survey also supports this conclusion.

4.1 | Health Disparities

This guideline provides expert recommendations on nonpharmacological treatments for fibromyalgia. However, many patients face barriers to accessing healthcare, influenced by factors such as race, ethnicity, age, socioeconomic status, geographic location, and insurance coverage, particularly in resource-limited settings [82–84]. In areas without universal healthcare, insufficient or lack of insurance is a major barrier to receiving care, and non-pharmacological treatments are often not reimbursed, limiting access for low-income patients [85, 86]. Healthcare professionals should strive to provide high-quality care to all populations, particularly underserved or marginalized groups. Future clinical trials should include patients with comorbidities, especially those from minority groups, to enhance the diversity and representativeness of the research. Policymakers should prioritize ensuring equitable access to high-quality care and eliminating barriers that contribute to health disparities.

4.2 | Guideline Implementation and Potential Barriers

We plan to promote the guideline to the public after its release. The specific content will be presented and discussed at relevant academic conferences and shared with clinicians and fibromyalgia patients through WeChat (a major social networking platform in China). There are several challenges in implementing this guideline. Although nonpharmacological treatments (such as CBT and mindfulness therapy) are effective, ensuring patient participation remains a key issue. Fibromyalgia symptoms fluctuate, and about 25% of patients experience moderate symptom improvement within 10 years, which makes participation difficult. Pain exacerbation is a common side effect of physical activity and treatment, which may affect patient compliance [87]. While the availability of nonpharmacological treatments has improved, patients still face access limitations, especially in community hospitals. Low-income or minority groups may encounter additional barriers in accessing interdisciplinary care, such as clinical psychologists, nutritionists, and physical therapists [85]. Moreover, delays in fibromyalgia diagnosis and inadequate knowledge among healthcare providers may impact the optimal implementation of treatments. Patients' difficulties in expressing symptoms or understanding the benefits of nonpharmacological therapies may also lead to suboptimal treatment decisions [87, 88].

4.3 | Strengths and Limitations

This guideline innovatively incorporates TCM therapies, such as acupuncture, cupping, and tai chi, which have high accessibility

and potential for promotion due to their cultural foundation and ease of practice. The survey conducted with 122 patients from different regions of China makes the interventions more representative and widely applicable, reducing disparities in health equity. The recommendations in this guideline are for clinicians' reference, and patients should seek guidance from professional doctors when considering different treatment options.

However, our guideline did not establish a dedicated guideline steering committee, and some studies included in the evidence base have methodological limitations. For example, mind–body interventions such as tai chi and yoga are difficult to blind properly, and differences in intervention dose and form may introduce heterogeneity. Furthermore, there is inconsistency in monitoring intervention fidelity. Many treatments, such as cupping and music therapy, rely on small-scale studies, and some lack rigorous blinding or show high heterogeneity, which impacts the robustness of conclusions [50, 89]. As a result, the recommendations in the guideline are often based on lower level evidence, leading to uncertainty about their effectiveness in widespread application. Additionally, inconsistent assessment methods for fibromyalgia-specific symptoms may introduce bias, and many studies did not report related adverse events.

4.4 | Future Directions

Future research should prioritize addressing the following issues: increasing sample size and extending follow-up time to enhance the reliability of results and the assessment of long-term effects; employing rigorous double-blind, randomized controlled designs and introducing standardized placebo treatments to reduce the interference of placebo effects; standardizing intervention protocols and outcome measures to reduce heterogeneity; and strengthening research on the combined use of multiple interventions, exploring the best integration of therapies such as acupuncture, health education, and tai chi.

At the same time, attention should be paid to personalized treatment for fibromyalgia, combining biomarkers, genetic factors, and psychosocial influences to develop precise medical strategies that improve treatment outcomes and quality of life. Given the broad impact of this disease on patients, multidisciplinary collaboration is crucial. Future guidelines should encourage cooperation among experts from various fields to create a comprehensive treatment framework. Psychosocial interventions combined with physical therapy have shown potential in alleviating symptoms and improving quality of life. Innovative therapies such as mindfulness meditation, emotional regulation training, and neurofeedback may improve mental health, reduce pain, and enhance coping abilities. Lifestyle interventions, such as nutrition, sleep, and stress management, should also be an important part of nonpharmacological treatment. Future research should evaluate the impact of specific diets on fibromyalgia and comprehensively assess the long-term effects of interventions.

Although some nonpharmacological therapies show potential, they have not yet been recommended due to insufficient or low-quality evidence. Studies indicate that multidisciplinary treatments, including occupational therapy, may help alleviate depression and anxiety in fibromyalgia patients, but their direct

effect on pain remains limited, and the evidence is inconsistent. Vibration therapy shows some potential, but small sample sizes and inadequate control designs make it difficult to determine its long-term efficacy. Research on traditional therapies, such as gua sha and Ba Duan Jin, is limited by challenges related to international recognition, quantification of efficacy, and scientific validation, with insufficient clinical data hindering their widespread use. Future high-quality research is needed to assess the effectiveness of these therapies and provide feasible recommendations.

Conflicts of Interest

The authors declare no conflicts of interest.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section.

Table S1: The non-pharmacological therapies selected for inclusion in **Table S2** The characteristics of the surveyed clinicians **Table S3** Basic Characteristics of 122 Fibromyalgia Patients **Table S5** Summary of Recommendations. **Table S6** The specific grading criteria used in GRADE rating. **Appendix Table 4** Grading of Evidence Quality and Recommendation Strength **Supporting File 2:** jebm70044-sup-0002-SuppMat1.xlsx