

Rethinking the Diagnosis of Fibromyalgia: A Narrative Review and Proposed Framework for the Evaluation of Chronic Widespread Pain

Louis Vilotti, MBA, OMS-IV^{1,2}, Stephen Soloway, MD², Nicholas Depace, MD^{1,3}, Joseph Colombo, PhD^{1,2}

¹Franklin Cardiovascular Associates, United States of America

²Rowan University School of Osteopathic Medicine, United States of America

³Thomas Jefferson University Hospital, United States of America

*Corresponding author:

Louis Vilotti,
MBA, OMS-IV, Franklin Cardiovascular
Associates, United States of America and
Rowan University School of Osteopathic
Medicine, United States of America

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1. Abstract

Fibromyalgia (FM) is characterized by chronic widespread pain, fatigue, sleep disturbance, and cognitive dysfunction, with overlap across rheumatologic, neurologic, connective-tissue, and autonomic disorders. Current diagnostic criteria identify an FM phenotype but do not require a standardized evaluation for alternative causes of chronic widespread pain.

A focused narrative review of PubMed was conducted through August 26, 2026. Literature addressing FM diagnostic criteria, diagnostic overlap and misclassification, joint hypermobility and hypermobile Ehlers-Danlos syndrome/hypermobility spectrum disorders (hEDS/HSD), autonomic dysfunction, orthostatic intolerance, small-fiber pathology, inflammatory rheumatic disease, and other causes of chronic widespread pain was evaluated. Priority was given to diagnostic studies, guidelines, reviews, and studies providing objective evidence of overlap.

Substantial overlap was identified between FM and alternative disorders. Joint hypermobility and hEDS/HSD are frequently reported among patients with FM, while autonomic abnormalities, orthostatic intolerance, and small-fiber pathology have been demonstrated across multiple cohorts. Patients referred with presumed FM have also been subsequently diagnosed with inflammatory rheumatic diseases. Studies comparing physician-assigned FM diagnoses with established criteria demonstrate diagnostic inconsistency and potential misclassification. Meeting FM criteria does not establish that alternative causes of chronic widespread pain have been adequately evaluated. We propose that FM be approached after a directed evaluation has failed to identify a more specific disorder that explains the pre-

sentation. Comprehensive history and physical examination, followed by targeted testing when indicated, may reduce premature diagnosis and improve identification of alternative conditions. Prospective validation is needed to determine whether this approach improves diagnostic accuracy, treatment selection, and clinical outcomes.

2. Introduction

Fibromyalgia (FM) is a chronic pain disorder characterized by widespread musculoskeletal pain accompanied by symptoms that commonly include fatigue, sleep disturbance, cognitive dysfunction, and mood-related complaints [1,2]. Despite the substantial impact on quality of life, diagnosing FM is challenging as there are no laboratory tests, imaging studies, or other objective biomarkers that confirm this diagnosis. Furthermore, the diagnostic criteria for FM have changed considerably over time [3,4]. The 1990 American College of Rheumatology (ACR) classification criteria emphasize widespread pain and the presence of pain at 11 out of 18 defined “tender-points” [5]. Continued revisions have shifted away from the tender-point examination criteria and moved toward patient-reported symptom severity, leading to the revised 2016 criteria that remain in-place today [4,6,17]. These changes have further advanced the ability to recognize the clinical presentation of FM, but have also contributed to discussion surrounding the diagnosis itself and how it should be applied in clinical practice [3,7].

A major challenge with diagnosing FM exists in the nonspecific nature of its many characteristic symptoms. Widespread pain, fatigue, brain fog, cognitive issues, sleep disturbances, paresthesia, headaches, and exercise intolerance are not unique to FM

and may occur in different conditions. These symptoms are present in a variety of rheumatologic, neurologic, connective-tissue, musculoskeletal, metabolic, and autonomic disorders [8,9]. Additionally, several studies have demonstrated significant overlap between FM and generalized joint hypermobility, hypermobile Ehlers-Danlos syndrome (hEDS), and hypermobility spectrum disorders (HSD) [10,11]. Autonomic dysfunction, orthostatic intolerance (OI), postural orthostatic tachycardia (POTS), and small-fiber neuropathy have also been reported in subsets of patients that are diagnosed with FM [12,13,15,16]. Several of these conditions are diagnosed using objective measures, including the Beighton Score, orthostatic vital signs, tilt-table testing, other forms of autonomic testing, rheumatologic testing, and skin biopsies for small-fiber neuropathy [14-16,28]. Though there seems to be overlap in these conditions, current FM criteria do not prescribe a standardized evaluation for these alternative or coexisting conditions [4].

This raises a fundamental clinical question: what constitutes an adequate evaluation of chronic widespread pain before a diagnosis of fibromyalgia should be made? The purpose of this narrative review is to examine the evolution and limitations of the existing FM diagnostic criteria, review the evidence linking the various overlapping conditions, and evaluate what the optimal clinical assessment for these conditions should be to improve diagnostic accuracy. Attention is given to hEDS/HSD and joint hypermobility, autonomic dysfunction, OI, POTS, small-fiber neuropathy, and other disorders that have been shown to be associated with FM presentations. Based on the available literature, we propose that a structured, clinically directed framework for evaluating patients with chronic widespread pain, and targeted objective testing when indicated should be performed before FM is assigned as the primary diagnosis for a patient's symptoms.

3. Methods

3.1. Literature Search Strategy

A focused narrative review of the literature was conducted using PubMed through August 26th, 2026. This search was done to identify literature relevant to the diagnosis of fibromyalgia (FM), diagnostic overlap and misclassification, and alternative or coexisting conditions that contribute to widespread chronic pain. Search terms combined "fibromyalgia" with "diagnosis", "misdiagnosis", "differential diagnosis", "joint hypermobility", "hypermobility spectrum disorder", "Ehlers Danlos Syndrome", "autonomic dysfunction", "dysautonomia", "postural orthostatic tachycardia syndrome", "small-fiber neuropathy", and "connective tissue disorders".

Given the narrative scope of this review, and the large number of publications identified with the several searched domains, formal systematic screening of every search was not performed. Articles were selected based on clinical relevance to the clinical question of how chronic widespread pain should be evaluated before FM is determined to be the primary diagnosis. Priority was given to foundational studies that established or revised

FM diagnostic criteria. Studies that provide objective evidence relevant to diagnostic overlap or misdiagnosis were included. Emphasis was placed on studies that incorporated clinical diagnostic testing of joint hypermobility (via Beighton/Brighton scoring), orthostatic vital signs, tilt-table testing and autonomic function testing. Skin biopsies for small-fiber pathology were also evaluated.

For diagnostic literature with particularly large search yields, foundational studies were identified based on their roles in establishing or modifying accepted diagnostic criteria. Studies were also identified based on their influence on subsequent clinical practice regarding FM and their continued inclusion of or discussion in contemporary guidelines and authoritative reviews. The reference lists of other relevant manuscripts, clinical guidelines, and foundational publications were also examined. Case reports and treatment focused reviews were excluded, as well as other articles that were redundant, or if they did not materially inform the diagnosis or differential diagnoses.

Since this was performed as a narrative review rather than a systematic review, no formal risk-of-bias assessment or quantitative evidence synthesis was performed. Additional articles that were not published in PubMed by the authors were considered when directly relevant to the review question. These sources were included alongside, rather than as substitutes for the independently identified literature. The selected literature was organized according to diagnostic domains, including FM diagnostic criteria and misclassification, hypermobility and connective-tissue disorders, autonomic dysfunction, orthostatic intolerance (OI), neurologic and small-fiber disorders, and other alternative or contributing conditions.

Additional targeted searches were performed to evaluate potential metabolic/genetic mimics, inflammatory and seronegative spondyloarthropathies, and outcomes associated with the evaluation or treatment of small-fiber and autonomic abnormalities. Additional included search words of "fibromyalgia" with "Fabry disease", "Gaucher disease", "Pompe disease" or "acid maltase deficiency", "spondyloarthritis", "seronegative spondyloarthritis", "non-radiographic axial spondyloarthritis", "small fiber neuropathy", "dysautonomia", "autonomic testing", "mast cell", and "treatment outcomes" were included in our review.

4. Results

4.1. Evolution and Diagnostic Uncertainty

Fibromyalgia (FM) diagnostic criteria have evolved significantly over the past several decades [4-6]. The 1990 American College of Rheumatology (ACR) criteria first defined FM using widespread pain and tenderness at ≥ 11 of 18 designated tender-points [5]. This approach prioritized standardized physical examination into FM classification. The 2010 criteria then removed the mandatory tender-point examination and replaced it with the Widespread Pain Index (WPI) and Symptom Severity Scale (SSS). This shifted the criteria for diagnosing FM toward subjective assessment of pain and associated pain symptoms

[17]. In 2016, revisions further introduced a generalized pain requirement and clarified that FM may be diagnosed with other existing conditions [4].

These revisions increased the number of patients being diagnosed with FM; however, they also moved the diagnosis away from examination-based findings and from the exclusion of alternative disorders. Now, contemporary criteria determine whether a patient “satisfies the clinical presentation” of FM but they fail to provide a standardized evaluation to identify other potential inflammatory rheumatologic, neurologic, connective-tissue, autonomic and metabolic disorders that may present alongside those usually seen in patients with FM [3,7].

Despite these revisions, the literature shows that diagnostic inconsistency remains. In a community study of 3,276 patients, only 32.2% of those reporting a physician diagnosis of FM satisfied the 2016 criteria, while only 35.4% of criteria-positive individuals reported a physician diagnosis [18].

4.2. Hypermobility, HSD, and hEDS

Substantial overlap has been reported between FM and joint hypermobility disorders. In a controlled study, joint hypermobility was identified in 46.6% of patients with FM compared with 28.8% of controls [14]. A systematic review subsequently reported high rates of concomitant FM among hEDS/HSD populations, although estimates varied considerably between studies. In these studies, estimates ranged from 68-88.9%¹⁰. Similarly, among 733 patients evaluated within an EDS clinic, 56.5% carried both hEDS/HSD and FM diagnoses¹¹. In another cohort of patients with FM and/or chronic fatigue syndrome (CFS), 81% met criteria for generalized joint hypermobility and 18% met 2017 hEDS criteria¹⁹. Earlier studies identified joint hypermobility in patients who had initially been labeled with FM that did not satisfy formal FM criteria, raising the possibility of diagnostic misclassification in some patients [20].

4.3. Autonomic Dysfunction and Orthostatic Intolerance

Autonomic abnormalities have also been shown to be commonly seen in patients with FM. In a controlled study performed in 1997, 60% of patients with FM demonstrated an abnormal blood-pressure response during upright tilt compared with 0% of the controls [21]. A subsequent study found positive head-up tilt testing (HUTT) in 64.7% of patients with FM compared with 21.3% of controls and additionally demonstrated reduced heart rate variability [22]. More recently, a 2026 systematic review and meta-analysis reported a pooled dysautonomia prevalence of 60% among 13 studies of patients with FM, while the pooled prevalence across all musculoskeletal pain conditions was 64%¹². However, autonomic symptom burden may exceed objectively demonstrated autonomic dysfunction in some patients with FM [15,23].

4.4. Small-Fiber Neuropathy and Neurologic Disease

Small-fiber abnormalities have been identified in a substantial subset of patients diagnosed with FM. Oaklander et al. examined skin-biopsies and found small-fiber polyneuropathy evi-

dence in 41% of patients with FM compared with 3% of controls [16]. Similarly, Giannoccaro et al. identified reduced epidermal nerve-fiber density in 30% of patients referred with FM despite normal nerve-conduction studies [24]. Another systematic review and a meta-analysis estimated that the prevalence of small-fiber pathology in FM is approximately 49%¹³. It is important that small-fiber pathology in FM is not automatically considered to be equivalent to clinical small-fiber neuropathy, as recent literature emphasizes that the two remain distinguishable entities [25,26].

4.5. Inflammatory and Seronegative Rheumatologic Disease

Inflammatory rheumatologic disease represents another important source of disease that overlaps with FM diagnoses. Fitzcharles and Esdaile described patients who were referred to their practice with presumed FM who were subsequently found to have unrecognized spondyloarthropathy, with clinical features including spinal pain, prolonged morning stiffness, nocturnal pain, and enthesopathy [27]. Ablin et al. [28], also evaluated patients diagnosed with FM and used inflammatory markers such as HLA-B27 as well as diagnostic sacroiliac imaging and identified sacroiliitis in 8.1% of included patients, while 10.2% fulfilled Assessment of Spondyloarthritis International Society (ASAS) criteria for axial spondyloarthritis [28]. Another systematic review and meta-analysis showed the coexistence of FM with axial spondyloarthritis, reporting an FM prevalence of among 16.4% among patients with axial spondyloarthritis [29].

4.6. Metabolic and Genetic Mimics

Select metabolic and genetic disorders may also exist in patients with chronic pain syndromes that overlap with features attributed to FM. Marchesoni et al. reported diagnostic delay among patients with Fabry disease, with neuropathic pain representing the most common initial symptom, along with hypohidrosis and recurrent abdominal pain providing additional clinical clues³⁰. Üçeyler et al. also highlighted recognition of a characteristic small-fiber neuropathy phenotype when evaluating patients with otherwise unexplained neuropathic pain for Fabry disease [31].

4.7. Diagnostic Overlap and Misclassification

FM and “FM-like” presentations may occur across a wide range of rheumatologic, neurologic, endocrine, metabolic, and musculoskeletal conditions [8,9]. Misdiagnoses have also been well documented and published, including patients referred with prior diagnoses of FM who were subsequently found to have other inflammatory rheumatologic disease [27]. Prior published work from our group has similarly identified frequent autonomic dysfunction and hEDS/HSD among patients referred with an existing FM diagnosis. Among these patients have also been commonly identified parasympathetic and/or sympathetic dysfunction. 69.1% of patients seen with prior FM diagnoses were reported to have EDS/HSD [33].

5. Discussion

5.1. Principal Findings and Interpretation

This narrative review highlights that many of the symptoms

used to diagnose fibromyalgia (FM) substantially overlap with other clinically identifiable disorders. The diagnostic criteria for FM currently present a recognizable clinical presentation, however, they do not establish the underlying cause of a patient's widespread pain or require a thorough analysis of alternative disorders. Furthermore, the literature demonstrates strong associations between FM and many other pain related disorders that could more adequately explain a patients' presentation. Joint hypermobility, hEDS/HSD, autonomic dysfunction, orthostatic intolerance (OI), and small-fiber pathology and inflammatory rheumatic diseases commonly show significant overlap with FM [10,12,13,28,29]. Furthermore, there has been reported inconsistency between FM diagnoses and established diagnostic criteria, suggesting that both misdiagnosis and overdiagnosis of FM exist in clinical practice [7,18]. These findings raise concern that FM may be assigned prematurely in some patients before an identifiable cause of chronic widespread pain has been ruled out or properly tested for.

The continual evolution of FM diagnostic criteria illustrates this concern [4-6-17]. The 1990 ACR criteria established a standardized tender-point examination for FM, and subsequent revisions replaced this requirement with subjective, patient-reported pain symptoms. Although these revisions addressed important limitations of the earlier tender-point criteria, they also reduced the examination-based component of the FM diagnosis. The 2016 criteria, which is currently in-place, have established that FM may be diagnosed in addition to other existing conditions that are oftentimes present. This ability to diagnose FM in the presence of another disorder makes appropriate investigation of these disorders more important, especially when clinical findings warrant further investigation.

In our clinical experience within specialized autonomic and rheumatologic referral practices, patients referred with FM frequently demonstrate various clinically relevant diagnoses, and improvement may occur when these conditions are specifically addressed [33]. The resolution of their symptoms after treating these specific causes separate from FM reinforces the need to have these patients undergo thorough evaluation for the exact diagnosis that is causing their pain. Resolution of symptoms after treating a patient for a condition distinct from FM, may indicate that the prior FM diagnosis was improperly assigned or was made prematurely, before a thorough diagnostic workup was completed.

5.2. Proposed Diagnostic Framework for Chronic Widespread Pain

Due to the diagnostic overlap that exists in the literature, we propose a structured clinical framework when evaluating patients that present with diffuse or widespread pain (Figure 1). This framework serves to provide a standardized approach and to ensure that all commonly overlapping conditions and alternative diagnoses are considered and screened for, followed by targeted testing when clinically relevant. The purpose of this schematic is not to suggest that extensive laboratory diagnostics, imaging, or autonomic testing be performed for every patient, but to systematically consider major alternative conditions before a fibromyalgia (FM) diagnosis is made.

Evaluation should always begin with a comprehensive history and physical exam³⁴. Clinicians should assess associated symptoms including fatigue, sleep disturbances, cognitive dysfunction, neurologic symptoms, gastrointestinal distress, exercise intolerance, and orthostatic or autonomic symptoms in addition to characterizing the distribution, duration, and severity of pain. A thorough history including medication use, comorbidities, family history, and other relevant psychosocial factors should also be obtained. Physical examination should include a general, musculoskeletal, neurologic, and a systems-based evaluation depending on the patient's presentation. This initial assessment is key in identifying the features that warrant deeper investigation rather than using a uniform battery of diagnostic testing for each patient.

After initial assessment, the framework organizes the differential diagnosis into six categories: (1): inflammatory / rheumatologic, (2): connective-tissue / hypermobility, (3): neurologic / neuropathic, (4): autonomic / orthostatic. (5): structural / musculoskeletal, (6): metabolic / endocrine and other systemic contributors. These categories represent the recognized differential diagnoses of widespread chronic pain and the areas of potential diagnostic overlap that was identified throughout this review [8,9]. Evaluation within each domain should be guided by findings from the history and physical exam.

This framework distinguishes patients who meet the diagnostic criteria for FM from completing an appropriate evaluation for widespread chronic pain. Meeting the diagnostic criteria for FM should not keep clinicians from investigating findings suggestive of another condition, as many of these conditions have shown to overlap and present similarly. The overall goal is to provide a thorough yet practical approach that improves the diagnostic workup for FM, while considering alternative and oftentimes coexisting disorders. We believe that this may improve diagnostic accuracy of FM and inform the management of these patients.

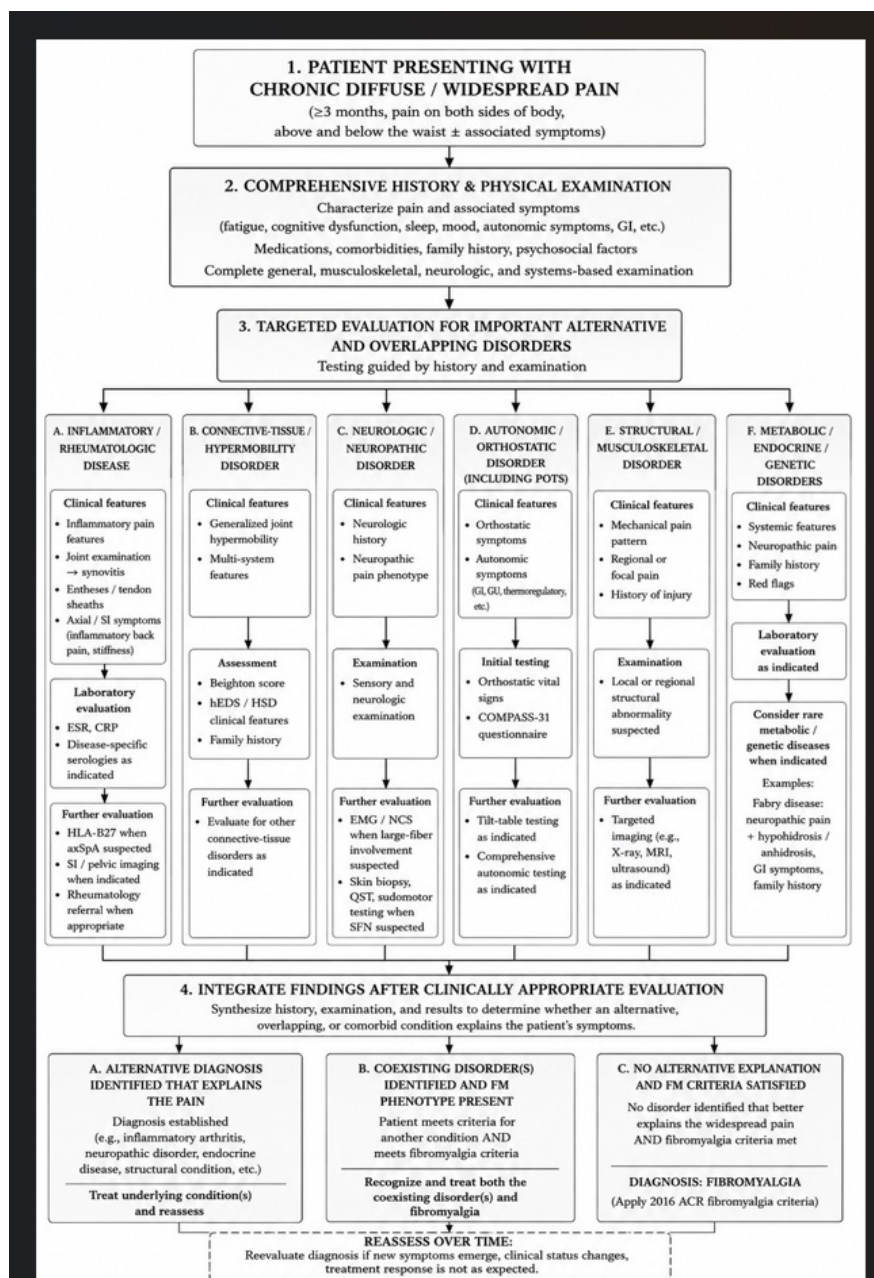


Figure 1: Diagnostic Framework for Chronic Widespread Pain.

5.3. Clinical Implications

This framework is proposed to provide a systematic approach to this diagnostic problem while obtaining more accurate diagnoses. We do not propose that every patient with widespread pain undergoes rheumatologic testing, autonomic testing, skin biopsy, electrodiagnostic studies, or advanced imaging. Rather, we suggest that a comprehensive history and physical exam should identify potential conditions that warrant further evaluation and propose a schematic for how to thoroughly assess a complex presentation. This approach allows testing to remain clinically guided while ensuring that various conditions with significant overlap in presentation are actively considered.

Inflammatory rheumatologic disease deserves important consideration in this evaluation as chronic widespread pain, fatigue, stiffness, and functional impairment commonly occur in both FM and inflammatory rheumatic diseases [2,27,29]. Additionally, seronegative and non-radiographic inflammatory diseases have also shown associations with FM [28,29], but these dis-

eases may be increasingly difficult to identify without a trained board-certified rheumatologist. The literature showed that patients referred with presumed FM have subsequently been found to have unrecognized spondyloarthropathy, sacroiliitis, and axial spondyloarthritis [27,28]. A directed physical exam should assess for synovitis, joint swelling, enthesitis, tendon involvement, inflammatory back pain, and sacroiliac disease. Further diagnostics and laboratory tests of HLA-B27, imaging, or another rheumatologic workup should be done when clinically indicated [27,28,34].

The potential for missed diagnoses is particularly relevant under the current FM criteria because these criteria do not require the exclusion of another disorder to diagnose FM4. Simply satisfying FM criteria should not be considered sufficient for establishing FM as the primary cause of chronic widespread pain until thorough evaluation of inflammatory rheumatic disease and other overlapping conditions has been performed. When a more specific disease is diagnosed and treated in a patient with

overlapping FM, the continued designation of FM as the primary diagnosis should be reconsidered. Especially when treatment of the more specific condition yields resolution of a patients' symptoms.

This principle should also extend beyond inflammatory rheumatic diseases. The literature showed a high prevalence of joint hypermobility, autonomic abnormalities, and small-fiber pathology that was reported among patients diagnosed with FM10,12-16. This supports that a directed evaluation of these conditions should be performed when clinical suspicion exists. Hypermobility can be assessed through physical examination, while orthostatic symptoms, exercise intolerance, palpitations, presyncope, or other autonomic complaints should prompt more comprehensive testing, and autonomic evaluation when appropriate. Additionally, neuropathic pain, sensory abnormalities, or autonomic features may warrant further evaluation for small-fiber neuropathy when indicated. Identification of an objective abnormality should then question whether a more specific disorder is contributing to or better explains the patient's symptoms rather than automatically attributing these findings to FM.

Mast-cell activation has also been proposed as a potential contributor to pain and other symptoms associated with FM35,36. Studies have reported and proposed interactions between mast cells, neuroinflammation, and nociceptive pathways [35,36]. Mast-cell-related disease, therefore, may be most appropriately considered when supported by characteristic clinical features rather than as a routine component of the standard workup.

Many components of this proposed evaluation may be incorporated into the routine clinical assessment with relatively small additional burden. For example, joint hypermobility can be assessed and screened during a physical examination using Beighton and/or Brighton tests14. Similarly, neuropathic symptoms or sensory abnormalities may identify patients that require evaluation for small-fiber or other neurologic disorders [25,26]. These initial screening measures may help elucidate which patients require more specialized diagnostics, which may improve the accuracy of the final diagnosis.

Clinicians should attempt to determine which identified condition most adequately explains the patient's presentation and whether treatment of that condition resolves the symptoms that have previously been attributed to FM. When another, more specific rheumatologic, neurologic, autonomic, connective-tissue, or other disorder provides a more accurate explanation for a patient's presentation, it would make sense for that diagnosis to supplant FM. FM should remain the main diagnosis when a thorough evaluation does not identify a more specific explanation for the patient's persistent widespread pain.

6. Limitations

Several limitations should be considered when evaluating this review. First, this was a narrative review, and formal risk-of-bias assessment and quantitative evidence synthesis were not performed. The literature demonstrates substantial heterogeneity in patient populations, diagnostic criteria, testing, and definitions

of the conditions studied. Many studies were performed in specialty or referral populations, which may limit generalizability to the broader FM population. Additionally, the presence of an association or objective abnormality does not establish that the abnormality is responsible for a patient's widespread pain or that the original FM diagnosis was incorrect. Small-fiber pathology, autonomic abnormalities, and hypermobility may represent comorbid conditions, contributors to symptoms, or overlapping clinical phenotypes rather than alternative diagnoses in every patient [10,15,26]. Prior work from our group was also derived from specialized autonomic clinics and should be interpreted within that context33. Finally, the proposed diagnostic framework has not been prospectively validated, and future studies are needed to determine whether its implementation improves diagnostic accuracy, treatment selection, or patient outcomes.

The diagnostic approach proposed in this review represents a suggested clinical framework rather than an established recommendation. Current FM criteria does not require exclusion of other disorders, and our proposal that FM should be assigned as the primary diagnosis only after an appropriate clinically directed evaluation represents a departure from the prevailing consensus. Our group's work was also derived from specialized rheumatologic and autonomic referral populations and should be interpreted in the context of potential referral and selection bias33. Future studies should prospectively evaluate whether implementation of this approach changes diagnoses, identifies clinically relevant disease, alters treatment, or improves outcomes.

7. Conclusion

Due to the nonspecific nature of its symptoms and overlap with other conditions associated with chronic widespread pain, fibromyalgia (FM) remains a challenging clinical diagnosis. Substantial evidence has demonstrated frequent associations with joint hypermobility, hEDS/HSD, autonomic dysfunction, orthostatic intolerance, small-fiber neuropathy, and inflammatory rheumatologic disease. Selected metabolic and genetic disorders may also produce symptomatic overlap. This highlights the importance of considering alternative and coexisting conditions when performing a diagnostic workup for a patient with chronic widespread pain. Meeting the established criteria for FM may not indicate that alternative or contributing conditions in a patient's presentation have been adequately evaluated.

Therefore, we propose a structured systematic approach for clinical investigation, following up with targeted testing if indicated. Additionally, we believe that FM should be approached as a diagnosis reached only when appropriate clinical evaluation has failed to identify a more specific disorder that adequately explains a patient's widespread pain. Future prospective studies are needed to validate this approach and determine whether a standardized diagnostic evaluation will improve clinical outcomes.

8. Conflicts of Interest

There are no authors with conflicts of interest in this study.

References

- Williams DA, Clauw DJ. Fibromyalgia. *N Engl J Med*. 2026; 395(3): 267-277.
- Winslow BT, Vandal C, Dang L. Fibromyalgia: Diagnosis and management. *Am Fam Physician*. 2023; 107(2): 137-144.
- Galvez-Sánchez CM, Reyes Del Paso GA. Diagnostic criteria for fibromyalgia: Critical review and future perspectives. *J Clin Med*. 2020; 9(4): 1219.
- Wolfe F, Clauw DJ, Fitzcharles MA. 2016 revisions to the 2010/2011 fibromyalgia diagnostic criteria. *Semin Arthritis Rheum*. 2016; 46(3): 319-329.
- Wolfe F, Smythe HA, Yunus MB. The American College of Rheumatology 1990 criteria for the classification of fibromyalgia. Report of the Multicenter Criteria Committee. *Arthritis Rheum*. 1990; 33(2): 160-172.
- Wolfe F, Clauw DJ, Fitzcharles MA. The American College of Rheumatology preliminary diagnostic criteria for fibromyalgia and measurement of symptom severity. *Arthritis Care Res (Hoboken)*. 2010; 62(5): 600-610.
- Gür A. Why fibromyalgia criteria keep changing: A systematic review of misclassification, measurement, and diagnostic spillover. *Arch Rheumatol*. 2026; 41(3): 155-167.
- Häuser W, Perrot S, Sommer C, Shir Y, Fitzcharles MA. Diagnostic confounders of chronic widespread pain: not always fibromyalgia. *Pain Rep*. 2017; 2(3): e598.
- D'Amuri A, Greco S, Pagani M, Presciuttini B, Ciaffi J, Ursini F. Common non-rheumatic medical conditions mimicking fibromyalgia: A simple framework for differential diagnosis. *Diagnostics (Basel)*. 2024; 14(16): 1758.
- Alsiri N, Alhadhoud M, Alkatefi T, Palmer S. The concomitant diagnosis of fibromyalgia and connective tissue disorders: A systematic review. *Semin Arthritis Rheum*. 2023; 58: 152127.
- Fairweather D, Bruno KA, Darakjian AA. High overlap in patients diagnosed with hypermobile Ehlers-Danlos syndrome or hypermobility spectrum disorders with fibromyalgia and 40 self-reported symptoms and comorbidities. *Front Med (Lausanne)*. 2023; 10: 1096180.
- Almutairi NA, Greenwood DC, Sivan M. The prevalence of dysautonomia in chronic musculoskeletal pain: a systematic review and meta-analysis. *Rheumatol Adv Pract*. 2026 Mar 18; 10(2): rkag034.
- Grayston R, Czanner G, Elhadd K. A systematic review and meta-analysis of the prevalence of small fiber pathology in fibromyalgia: Implications for a new paradigm in fibromyalgia etiopathogenesis. *Semin Arthritis Rheum*. 2019; 48(5): 933-940.
- Sendur OF, Gurer G, Bozbas GT. The frequency of hypermobility and its relationship with clinical findings of fibromyalgia patients. *Clin Rheumatol*. 2007; 26(4): 485-487.
- Vincent A, Whipple MO, Low PA, Joyner M, Hoskin TL. Patients with fibromyalgia have significant autonomic symptoms but modest autonomic dysfunction. *PM R*. 2016; 8(5): 425-435.
- Oaklander AL, Herzog ZD, Downs HM, Klein MM. Objective evidence that small-fiber polyneuropathy underlies some illnesses currently labeled as fibromyalgia. *Pain*. 2013; 154(11): 2310-2316.
- Wolfe F, Clauw DJ, Fitzcharles MA. Fibromyalgia criteria and severity scales for clinical and epidemiological studies: A modification of the ACR preliminary diagnostic criteria for fibromyalgia. *J Rheumatol*. 2011; 38(6): 1113-1122.
- Srinivasan S, Maloney E, Wright B. The problematic nature of fibromyalgia diagnosis in the community. *ACR Open Rheumatol*. 2019.
- Eccles JA, Thompson B, Themelis K. Beyond bones: The relevance of variants of connective tissue (hypermobility) to fibromyalgia, ME/CFS and controversies surrounding diagnostic classification: An observational study. *Clin Med (Lond)*. 2021; 21(1): 53-58.
- Karaaslan Y, Haznedaroglu S, Oztürk M. Joint hypermobility and primary fibromyalgia: A clinical enigma. *J Rheumatol*. 2000; 27(7): 1774-1776.
- Bou-Holaigah I, Calkins H, Flynn JA. Provocation of hypotension and pain during upright tilt table testing in adults with fibromyalgia. *Clin Exp Rheumatol*. 1997; 15(3): 239-246.
- Raj SR, Brouillard D, Simpson CS, Hopman WM, Abdollah H. Dysautonomia among patients with fibromyalgia: A noninvasive assessment. *J Rheumatol*. 2000; 27(11): 2660-2665.
- Bay-Smidt CN, Bruun KD, Gaist LM. Structured symptom assessment to identify patients with small fiber or autonomic neuropathy in fibromyalgia. *Eur J Neurol*. 2025; 32(9): e70349.
- Giannoccaro MP, Donadio V, Incensi A, Avoni P, Liguori R. Small nerve fiber involvement in patients referred for fibromyalgia. *Muscle Nerve*. 2014; 49(5): 757-759.
- Jänsch S, Evdokimov D, Egenolf N. Distinguishing fibromyalgia syndrome from small fiber neuropathy: A clinical guide. *Pain Rep*. 2024; 9(1): e1136.
- Sommer C, Üçeyler N. Small-Fiber-Neuropathien. *Fortschr Neurol Psychiatr*. 2018; 86(8): 509-518.
- Fitzcharles MA, Esdaile JM. The overdiagnosis of fibromyalgia syndrome. *Am J Med*. 1997; 103(1): 44-50.
- Ablin JN, Eshed I, Berman M. Prevalence of axial spondyloarthritis among patients with fibromyalgia: A magnetic resonance imaging study with application of the Assessment of SpondyloArthritis International Society classification criteria. *Arthritis Care Res (Hoboken)*. 2017; 69(5): 724-729.
- Jones GT, Mallawaarachchi B, Shim J, Lock J, Macfarlane GJ. The prevalence of fibromyalgia in axial spondyloarthritis. *Rheumatol Int*. 2020; 40(10): 1581-1591.
- Marchesoni CL, Roa N, Pardal AM. Misdiagnosis in Fabry disease. *J Pediatr*. 2010; 156(5): 828-831.
- Üçeyler N, Kahn AK, Kramer D, Zeller D, Casanova-Molla J, Wanner C, Weidemann F, Katsarava Z, Sommer C. Impaired small fiber conduction in patients with Fabry disease: a neurophysiological case-control study. *BMC Neurol*. 2013; 13: 47.
- van der Tol L, Cassiman D, Houge G. Uncertain diagnosis of Fabry disease in patients with neuropathic pain, angiokeratoma or cornea verticillata: consensus on the approach to diagnosis and follow-up. *Fabry disease in patients with neuropathic pain, angiokeratoma or cornea verticillata JIMD Rep*. 2014; 17: 83-90.

33. Soloway S, DePace NL, Colombo J, Weksel JK. Fibromyalgia review: Remembering what it is and differentiating what it is not. *J Clin Med Images Case Rep.* 2024; 4(4): 1725.
34. Fitzcharles MA, Ste-Marie PA, Goldenberg DL. National Fibromyalgia Guideline Advisory Panel. 2012 Canadian Guidelines for the diagnosis and management of fibromyalgia syndrome: Executive summary. *Fibromyalgia Guideline Advisory Panel. Pain Res Manag.* 2013; 18(3): 119-126.
35. Tsilioni I, Russell IJ, Stewart JM, Gleason RM, Theoharides TC. Neuropeptides CRH, SP, HK-1, and Inflammatory Cytokines IL-6 and TNF Are Increased in Serum of Patients with Fibromyalgia Syndrome, Implicating Mast Cells. *J Pharmacol Exp Ther.* 2016; 356(3): 664-672.
36. Theoharides TC, Tsilioni I, Bawazeer M. Mast Cells, Neuroinflammation and Pain in Fibromyalgia Syndrome. *Front Cell Neurosci.* 2019; 13: 353.