



## Fibromyalgia validated as a diagnosis

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Fibromyalgia has occupied an uncomfortable position in general practice for as long as it has had a name. Chronic widespread pain, fatigue and cognitive fog, disproportionately affecting women in mid-life, with nothing to find on examination and nothing to find on investigation. The result is a condition some clinicians treat as a syndrome to be managed and others quietly treat as a diagnosis of exclusion that never quite excludes anything. The largest genetic study ever run on it has now been published, and it settles at least one of the long-running arguments.

The uncertainty has had costs that show up in the notes. People with fibromyalgia accumulate referrals, repeat imaging and normal bloods, and somewhere along the way absorb the message that because nothing has been found, there is nothing there. The competing explanations have not helped. A muscle disorder points the workup one way, an autoimmune process points it another, and the overlap with depression and myalgic encephalomyelitis has left the label looking less like a diagnosis than a holding pattern.

There is now a defensible answer to the question that gets asked in the room, which is whether this is real. It is, and the evidence locates it in the nervous system rather than in the tissues where the pain is felt. That reframe does clinical work as well as conversational work. If the mechanism is central rather than peripheral, further peripheral investigation is unlikely to be productive, and treatments aimed at central pain processing have a rationale behind them rather than just a track record.

The study, published in *Nature Medicine*, pooled genetic data from 2,563,755 people across 11 cohorts in the US, UK, Finland, Estonia, Denmark and Iceland, including 54,629 with a fibromyalgia diagnosis. It identified 26 independent genome-wide significant risk loci. Heritability was enriched exclusively within brain tissue and neural cell types, with the strongest signals in hippocampal dentate gyrus neurons and enteric neurons. There was no enrichment in muscle. The strongest single association sat within HTT, the gene implicated in Huntington's disease, carrying roughly 9% increased odds, though the variant involved is separate from the mutation that causes Huntington's. A second locus implicated GPR52, which regulates HTT levels and is already being pursued as a drug target in Huntington's disease.

The genetic correlations are arguably the more immediately useful finding. Fibromyalgia correlated strongly with post-traumatic stress disorder, low back pain and irritable bowel syndrome, moderately with depression, and shared risk loci with chronic fatigue syndrome. On the genetics, fibromyalgia sits closer to post-traumatic stress disorder than to depression. None of this delivers a test or a treatment yet. What it delivers is a mechanism, and a mechanism changes what a diagnosis feels like both to give and to receive. The comorbidities that once made fibromyalgia look like a diagnosis of last resort now look like part of the same picture.

### References

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## COVID vaccination is changing

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From 1 October, COVID-19 vaccination in Australia stops being an emergency response and becomes an item on the schedule. The National COVID-19 Vaccine Program ends and COVID vaccines move onto the National Immunisation Program, bringing them into line with influenza, pneumococcal and everything else that runs on an age and risk-based eligibility table. The practical consequence is the one worth leading with. Funded COVID vaccination is no longer universal.

Five years of a universal program have set an expectation that the vaccine is simply free, and that expectation will walk into consulting rooms and pharmacies from October onwards. The eligibility rules are not complicated, but they are new, and the people most likely to ask about them are the ones who have been having a booster every six months without needing to check anything first.

The funded groups from 1 October are:

- Adults aged 75 and over, one dose every six months
- Adults aged 65 to 74, one dose every 12 months
- Aboriginal and Torres Strait Islander people aged 50 to 74, one dose every 12 months
- Adults aged 18 and over with severe immunocompromise, as defined in the Australian Immunisation Handbook, one dose every 12 months

Everyone outside those groups can still be vaccinated. The vaccine remains available, it is simply no longer government funded, and the Department frames this as a private purchase following a risk-benefit discussion with the treating clinician. Two details are worth being clear on before that conversation rather than during it. The funded entitlement for severely immunocompromised adults is one dose per year, so additional doses may well be clinically appropriate but the funding does not automatically follow the recommendation. And NIP funding requires Medicare eligibility, where the current program covers anyone physically present in Australia including temporary visa holders. That is a cohort which has been vaccinated free for five years and now moves to private purchase regardless of age or risk.

There is a supply-side change too. Ordering through the Commonwealth Vaccination Administration System closed on 28 August, and COVID vaccines now move to routine ordering through state and territory immunisation programs alongside the rest of the NIP stock. Practices that have not yet moved their ordering process across will want to check what is on the shelf before the changeover rather than after it. The full provider update, including the Handbook definition of severe immunocompromise, is available from the Department of Health, Disability and Ageing.

### References

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