Impact of water therapy on pain management in patients with fibromyalgia: current perspectives

Abstract: Exercise-related interventions have been recommended as one of the main components in the management of fibromyalgia syndrome (FMS). Water therapy, which combines water's physical properties and exercise benefits, has proven effective in improving the clinical symptoms of FMS, especially pain, considered the hallmark of this syndrome. However, to our knowledge, the mechanisms underlying water therapy effects on pain are still scarcely explored in the literature. Therefore, this narrative review aimed to present the current perspectives on water therapy and the physiological basis for the mechanisms supporting its use for pain management in patients with FMS. Furthermore, the effects of water therapy on the musculoskeletal, neuromuscular, cardiovascular, respiratory, and neuroendocrine systems and inflammation are also addressed. Taking into account the aspects reviewed herein, water therapy is recommended as a nonpharmacologic therapeutic approach in the management of FMS patients, improving pain, fatigue, and quality of life. Future studies should focus on clarifying whether mechanisms and long-lasting effects are superior to other types of nonpharmacological interventions, as well as the economic and societal impacts that this intervention may present.

Keywords: hydrotherapy, exercise, pain management, chronic pain, physical therapy, aquatic therapy

Introduction

Fibromyalgia syndrome (FMS) is a chronic syndrome characterized by widespread musculoskeletal pain, chronic fatigue, and nonrestorative sleep, among other symptoms.\(^1\)\(^,\)\(^2\) It can be considered a clinical and pathological heterogeneous syndrome, thus requiring individualized and patient-tailored treatment.\(^3\) FMS is one of the most common conditions seen in the general population and outpatient rheumatology practice.\(^1\)

The burden of FMS is substantial and comparable to some other chronic disease such as osteoarthritis, rheumatoid arthritis, diabetes, and hypertension.\(^4\)\(^,\)\(^5\)\(^,\)\(^6\) FMS patients incur direct costs approximately equal to rheumatoid arthritis patients, but visit more emergency physicians, physicians, and physical therapists than rheumatoid arthritis patients.\(^7\) Several studies have evaluated the economic burden of FMS, including direct and indirect costs of the disease.\(^6\)\(^,\)\(^8\)\(^,\)\(^9\)\(^,\)\(^10\)\(^,\)\(^11\)\(^,\)\(^12\)\(^,\)\(^13\)\(^,\)\(^14\)\(^,\)\(^15\) These costs include the large number of medical consultations and medication, and the health system and societal expenses of disability from work, accounting for more than three-quarters of total FMS-related costs.\(^16\) Hence, a cost-effective treatment, or at least one that helps decrease the economic and societal burden, is more than welcome.\(^17\)

Recent recommendations for the management of FMS have suggested the use of pharmacological and nonpharmacological interventions,\(^18\) with exercise being...
recognized as one of the most important components of FMS treatment. Moreover, aerobic and strengthening exercises were the only therapeutic approach with a “strong for” recommendation by the European League Against Rheumatism, due to its positive effects on pain, physical function, and well-being, along with its availability, relatively low cost, and low risk.

Among different types and modalities of exercises for FMS, water therapy can be considered one of the most known and doctor-recommended interventions, as it combines water physical properties and exercise benefits. Indeed, several studies have investigated the effects of water therapy as a strategy in the management of FMS, reporting improvements in well-being, fitness, and symptoms, especially pain. However, to our knowledge, mechanisms underlying the water therapy effects on pain are still scarce. Therefore, the aim of this narrative review is to present the current perspectives of water therapy and the physiological basis for the mechanisms supporting its use for pain management in patients with FMS.

Clinical implication of water physics
Aquatic exercise describes an environment for structured activity rather than a type of exercise, as water’s physical properties and the physiological effects of immersion turn this environment into a unique one. According to the Chartered Society of Physiotherapists, water therapy or aquatic exercise refers to the use of water properties to design a therapy program aimed at improving function. Indeed, there is evidence that aquatic exercise is able to reduce the burden of musculoskeletal illnesses, which rely, basically, on the therapeutic effects achieved by the summation of physiological effects of immersion and principles of hydrodynamic exercises. The four most important water physics principles are buoyancy, resistance (drag forces), hydrostatic pressure, and thermal conduction. Definitions of the water physics principles, their properties, and implications for clinical use are summarized in Table 1.

Water therapy physiological effects and its relationship with pain
Several studies have reported beneficial effects of aquatic therapy on several conditions, among which stands FMS. Indeed, guidelines for the management of FMS have recommended water therapy mainly due to its analgesic effects and improvement in quality of life.

Although this narrative review does not intend to perform a systematic review on the theme, Table 2 summarizes the clinical trials assessing the effects of hydrotherapy on FMS symptoms, especially pain. We carried out a search of the following databases: MEDLINE/PubMed, Scopus, Web of Science, SciELO, CINAHL, LILACS, ScienceDirect, and Springer. The following keywords were used: “aquatic exercise”, “aquatic training”, “balneotherapy”, “fibromyalgia”, “fibromyalgia syndrome”, “fibromyalgic patients”, “hydrotherapy”, and “pool-based exercises”. Two authors independently extracted data from all of the trials and all discrepancies or disagreements were resolved by consensus.

Randomized clinical trials, nonrandomized clinical trials, and crossover design studies assessing the effects of any aquatic intervention on pain in FMS patients were considered eligible for inclusion. The methodological quality of the studies was analyzed using the PEDro scale. Thirty-five studies were included. Methodological quality varied between 1 and 9 according to the PEDro scale. Water temperature ranged between 28 and 37/38 ºC, and 7 studies did not report. Regarding the effectiveness of water therapy, only 2 studies reported no significant improvement compared to the baseline condition. However, one of these studies was composed of only 10 participants (5 in the Ai Chi group and 5 in a control group; PEDro score=1) and the other comprised 18 participants (9 in the sauna group and 9 in the hydrotherapy group; PEDro score=4). Thus, 94% of the included studies showed improvement in pain besides ameliorating other symptoms. In the following sections, we will discuss the possible mechanisms underlying the aquatic exercise effects.

Musculoskeletal and neuromuscular systems and the association with pain
The main symptom reported by FMS patients is pain. Pain is a dynamic and complex phenomenon that is the final result of several factors. The association between nociceptive activity and pain perception depends on several intrinsic and extrinsic influences. For the same nociceptive stimulus, pain perception and related brain activity will greatly differ between subjects. In the case of chronic rheumatic diseases that do not regress spontaneously, such as FMS, functional and structural central nervous system changes cause a generalized reduction in the pain threshold that is not limited to the anatomical structures involved, thus leading to the hyperalgesia and allodynia in many, if
Table 1 Summary of water physics principles

<table>
<thead>
<tr>
<th>Water property</th>
<th>Definition</th>
<th>Properties</th>
<th>Clinical significance</th>
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<tbody>
<tr>
<td>Buoyancy</td>
<td>Upward force that opposes gravity, and has a direct relationship with the immersion depth, movement speed, body composition, and gender[^36][^37]</td>
<td>Archimedes principle states that, as the body submerges, it displaces water, and this displacement creates a floating force (buoyancy) equivalent to the water volume that has been displaced[^18]</td>
<td>Buoyancy can be used to assist or to resist movements, to provide bodyweight offloading, and to help improve muscle activation and range of movement[^27][^35][^39] Also, buoyancy may assist in reduction of the perceived fatigue[^40]</td>
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<td>Hydrostatic pressure</td>
<td>Pressure exerted by the fluid on submersed objects</td>
<td>Pressure exerted by water on a submersed object is equal on all surfaces of the object, depending on the submersion depth[^40]</td>
<td>Fluids are driven from the extremities toward the central cavity[^36] compress the thorax, and increase respiratory load[^41] This property also provides support during movement performance underwater, improving static and dynamic balance[^32]-[^46] including in women with FMS[^31]</td>
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<tr>
<td>Hydrodynamic drag forces</td>
<td>Force that acts in an opposite direction to the line of the movement[^41] which is affected by the size and shape of the object[^31][^47]</td>
<td>Drag force is a function of the velocity squared, which means that doubling the speed quadruples the drag force[^41][^47]</td>
<td>As the movement speed through water increases, resistance to motion increases[^27] If a person stops movement, the resistance drops almost immediately to 0, allowing improved control of exercises considering the patient's comfort[^35][^47]</td>
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<tr>
<td>Thermal conduction</td>
<td>Water conducts temperature 2.5 times faster than air and exchanges heat with the submersed object</td>
<td>The aquatic environment is stable to retain cold or heat[^41] The rate of temperature change depends on the mass and specific heat of the object</td>
<td>A submerged body adapts to the aquatic environment, quickly exchanging heat and achieving thermal balance[^11] Temperatures of 26–28 °C (80–84 °F) are comfortably cool for exercising, while therapeutic pools are heated to between 30 and 32 °C (86 and 90 °F)[^27]</td>
</tr>
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Abbreviation: FMS, fibromyalgia syndrome.

[^36]: Reference 36
[^37]: Reference 37
[^38]: Reference 38
[^39]: Reference 39
[^40]: Reference 40
[^41]: Reference 41
[^42]: Reference 42
[^43]: Reference 43
[^44]: Reference 44
[^45]: Reference 45
[^46]: Reference 46
[^47]: Reference 47
[^48]: Reference 48
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<td>Altan et al</td>
<td>8</td>
<td>RCT</td>
<td>Pain, tender points, fatigue, sleep, stiffness, health-related quality of life, muscle endurance, patient-rated disability, clinician-rated disability, depression</td>
<td>2 groups:</td>
<td>Aquatic exercise: not reported Balneotherapy: no exercise</td>
<td>Aquatic exercise: significant decrease in pain (VAS and 5-point scale), fatigue (VAS and 5-point scale), morning stiffness, number of tender points, myalgic score, FIQ, sleep disorder, patient's and physician's global evaluation, and BDI. Significant increase in algometric score. Balneotherapy: significant decrease in pain (VAS and 5-point scale), fatigue (VAS and 5-point scale), number of tender points, myalgic score, patient's and physician's global evaluation. Significant increase in algometric score. Significant difference between groups after 12 and 24 weeks for BDI favoring aquatic exercise group</td>
<td>35 min/session, 3×/week</td>
<td>37 ℃</td>
<td>Aquatic exercise after 12 weeks: pain (VAS)=1.06; pain (5-point scale)=0.99; number of tender points=2.11; myalgic score=1.62; FIQ=0.83; algometric score=0.62. Balneotherapy after 12 weeks: pain (VAS)=1.08; pain (5-point scale)=1.28; number of tender points=2.15; myalgic score=2.00; FIQ=0.62; algometric score=0.93.</td>
<td>NA</td>
<td>NA</td>
<td>Aquatic exercises and balneotherapy significantly decreased pain. Aquatic exercises proved longer-lasting effects. There was no superiority of aquatic exercises over balneotherapy</td>
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<td>Andrade et al (2018)</td>
<td>9</td>
<td>RCT</td>
<td>Peak oxygen uptake, PPT, pain (VAS)</td>
<td>2 groups: Aquatic exercise (n=27), No exercise control (n=27)</td>
<td>45 min/session 2×/week 16 weeks Protocol: warm-up, stretching, aerobic exercises (30 min), resistance exercises of upper limbs using floats (5 min), relaxation (5 min)</td>
<td>Aerobics: three HR percentages reached at VAT. Level 1: lower limb exercises sitting on floats (5 min) at 80% VAT HR; level 2: jumping on a trampoline (10 min) at 110% VAT HR; level 3: exercises in aquatic cycle with resistance adjustment at 100% VAT HR (10 min)</td>
<td>30 °C (±2°C)</td>
<td>Aquatic exercise: PPT=0.31; VAS pain=−0.20. No exercise control group: PPT=−0.33; VAS pain=0.43</td>
<td>NA</td>
<td>Not reported</td>
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<tr>
<td>Arcos-Carmona et al (2011)</td>
<td>8</td>
<td>RCT</td>
<td>Sleep, pain, fatigue, health-related quality of life, self-rated physical function, mental health, anxiety, depression</td>
<td>2 groups: Experimental (n=27) Placebo control (n=26)</td>
<td>60 min/session 2×/week 10 weeks Protocol: Experimental – 30 min of pool-based aerobic exercises and Jacobson relaxation Placebo control – 20 min of sham magnet therapy applied at cervical (10 min) and lumbar (10 min) spine.</td>
<td>Not reported</td>
<td>28 ºC</td>
<td>Experimental group: SF-36 scores were lower after intervention Placebo control group: no significant differences from baseline</td>
<td>Not reported</td>
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<td>Assis et al</td>
<td>9</td>
<td>RCT</td>
<td>Pain (VAS)</td>
<td>2 groups: DWR (n=26) land-based exercises (n=26)</td>
<td>60 min/session, 3×/week 15 weeks Protocol a) stretching warm-up (10 min), DWR aerobic training (40 min), relaxation (10 min); b) land-based exercises – stretching warm-up (10 min), aerobic training on a treadmill (40 min), relaxation (10 min)</td>
<td>DWR: first 2 weeks: low-intensity exercises for adaptation. Then, exercises performed at the anaerobic threshold level controlled by HR Land-based exercises: first 2 weeks: low-intensity exercises for adaptation. Then, exercises performed at the anaerobic threshold level controlled by HR</td>
<td>28–31 °C</td>
<td>DWR: significant improvement in pain (VAS) Land-based exercises: significant improvement in pain (VAS)</td>
<td>Not reported</td>
<td>Patient global assessment of response to therapy on a 5-point scale; SF-36, BDI, and FIQ</td>
<td>NA</td>
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<tr>
<td>Avila et al (2017)</td>
<td>5</td>
<td>Single-arm clinical trial</td>
<td>Scapular three-dimensional motion measured with electromagnetic tracking device (Flock of Birds)</td>
<td>1 group: (n = 20)</td>
<td>45 min/session, 2×/week, 16 weeks Protocol: stretching, warm-up, aero-bics, muscle activation exercises, stretching, relaxation</td>
<td>Patient determined</td>
<td>31 °C (±2 °C)</td>
<td>No significant changes in scapular kinematics</td>
<td>NA</td>
<td>Pain, quality of life, function</td>
<td>Pain significantly decreased (lower NPRS and PPT), function (lower FIQ scores), and quality of life (greater SF-36 scores for most domains) significantly improved</td>
<td>PPT: 0.41 to 1.61 NPRS: −1.41 to −1.93</td>
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<td>Biezus et al (2006)</td>
<td>5</td>
<td>RCT</td>
<td>Pain (VAS)</td>
<td>3 groups: GA – general aquatic exercises (n=5) GB – passive aquatic relaxation (n=5) GC – control (n=6)</td>
<td>60 min/session, 2×/week 8 weeks Protocol: GA – warm-up, strengthening, stretching, and relaxation. Number of exercises in each therapy was approximately 13 GB – passive aquatic relaxation. The exercises were done slowly and smoothly GC – no physical therapy intervention</td>
<td>Not reported</td>
<td>32 °C</td>
<td>Aquatic exercises and aquatic relaxation significantly decreased pain. However, aquatic exercises provided greater pain decrease than the aquatic relaxation program</td>
<td>GA – general aquatic exercises: d=0.55 GB – passive aquatic relaxation: d=1.26 GC – control group: d=0.20</td>
<td>NA</td>
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<tr>
<td>Bote et al  (2014)</td>
<td>7</td>
<td>RCT</td>
<td>Neutrophil function</td>
<td>2 groups: Aquatic exercise program (n=10) Control no exercise (n=10)</td>
<td>60 min/session, 2×/week 32 weeks Protocols: stretching out of the water (5 min), aerobic warm-up in the water (5 min), passive stretching of the main muscle groups in the water (5 min), aerobic aquatic choreography (25 min), strength exercises involving the main muscle groups of the upper limbs (15 min), and cool-down (10 min)</td>
<td>Parts (a), (b), (c), and (f) were performed at low exercise intensity (40–50% maximal HR). Part (d) was performed at low-to-moderate intensity (50–60% maximal HR) at the beginning of the program, and with increased intensity at the end of the program (65–75% maximal HR)</td>
<td>32 °C</td>
<td>Aquatic exercise group had lower concentrations of IL-8 and noradrenaline together with reduced chemotaxis of neutrophils compared with the values determined in the same month in the control group of non-exercised FMS women</td>
<td>Not reported</td>
<td>Weight, body mass index, waist-to-hip ratio, body fat, and FIQ</td>
<td>Significant decrease in body weight, body mass index, body fat and FIQ</td>
<td>Significant increase in grip strength</td>
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<td>Calandre et al (2009)</td>
<td>7</td>
<td>RCT</td>
<td>FIQ and PSQI</td>
<td>2 groups: Stretching in water (n=39) Ai Chi–water Tai Chi (n=42)</td>
<td>60 min/session, 3×/week 6 weeks Protocol stretching performed over muscles of main body areas: cervical, upper, and lower extremities and trunk Ai Chi: 16 movements which constitute the Tai Chi therapy</td>
<td>Adjusted according to the degree of pain and fatigue</td>
<td>36 °C</td>
<td>Significant reduction in the RQ and PSQI scores observed in Ai Chi but not in stretching group, with longer effect duration on sleep measures</td>
<td>Stretching in water: FIQ total score (d=0.35), FIQ-VAS (d=0.26), PSQI total scores (d=0.28)</td>
<td>AI Chi–water Tai Chi: FIQ total score (d=0.53), FIQ-VAS (d=0.53), PSQI total scores (d=0.72)</td>
<td>BD1 decreased in stretching but not in Ai Chi group. Trait-anxiety scores decreased in both groups</td>
<td>Stretching in water: FIQ difficulty at work (d=0.26), fatigue (d=0.21), morning tenderness (d=0.26), stiffness (d=0.17), anxiety (d=0.25), and depression (d=0.32)</td>
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<tr>
<td>Carbonel-Baeza et al (2010)</td>
<td>6</td>
<td>RCT</td>
<td>Tender points, blind flamingo test, chair stand test, body composition, chair sit and reach, back scratch, 8 feet up and go, handgrip strength, and 6MWT</td>
<td>2 groups: Intervention (n=27) Usual care (n=32)</td>
<td>120 min/session, 1×/week 12 weeks Protocol: a) verbal phase (3.5–45 min); b) moving/dancing according both to the suggestion given by the facilitator and the music played (75–80 min) Usual care: asked not to change their activity levels and medications during the 12-week intervention period</td>
<td>Adjusted according to the degree of pain and fatigue Intensity was controlled by the RPE based on Borg’s conventional (6–20-point) scale. The medium values of RPE were 11±1. These RPE values correspond to a subjective perceived exertion of “fairly light exertion,” that is, low intensity</td>
<td>Not reported</td>
<td>Biodanza intervention reduced pain and FM impact (measured by FIQ). There was significant decrease in body fat percentage. There was no significant improvement in physical fitness tests. The program was well tolerated and did not have any deleterious effects on the patients’ health</td>
<td>Not reported</td>
<td>NA</td>
<td>NA</td>
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<td>Cuesta-Vargas et al (2011)</td>
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<td>S</td>
<td>Non-randomised pilot clinical trial</td>
<td>FQ</td>
<td>2 groups: MMPP+DWR (n=22) Control (n=22)</td>
<td>40 min/session, 3×/week 8 weeks Protocol: land-based exercises (stretching of tonic muscle and strengthening of phasic muscles combined with advice and education – 30 min) and DWR (10 min) Control: waiting list (no intervention)</td>
<td>Exercise training at anaerobic threshold determined by a graded treadmill exercise test and DWR test with lactate and HR analyses</td>
<td>28–31 °C</td>
<td>Significant decrease in FIQ</td>
<td>Not reported</td>
<td>SF-12: physical component, mental component, EuroQoL-5D, EuroQoL-VAS</td>
<td>Significant improvement in pain, physical function, sleep, fatigue, morning stiffness, quality of life, and psychological symptoms (depression and anxiety)</td>
<td>Not reported</td>
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<th>Secondary outcomes</th>
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<tbody>
<tr>
<td>De Andrade et al (2008)[32]</td>
<td>9</td>
<td>RCT</td>
<td>Pain intensity, fatigue, number of tender points, physical functional capacity, general health status, sleep quality and depression</td>
<td>2 groups: Pool-based exercises (n=23) Thalassotherapy (n=23)</td>
<td>60 min/session, 3×/week 12 weeks The program was composed of 10-min stretching, 40 min of various forms of low-impact aerobic exercise according to the desired intensity, and then a 10-min relaxation period</td>
<td>Patients were monitored each for 10 min and were oriented to remain between levels 12 and 13 on BORG scale (from light to moderate). The first 2 weeks were used for familiarization, with light-intensity exercises only (between levels 10 and 11 on BORG scale) and learning the exercises. When pain occurred while they were exercising, patients were taught to decrease the intensity for a short time</td>
<td>Pool-based exercises (28–33 °C) Thalassotherapy (28–33 °C)</td>
<td>There was a statistically significant improvement in pain, fatigue, tender points, FIQ, PSQI, and BDI in both groups. Improvement in BDI was greater in the thalassotherapy group</td>
<td>Not reported</td>
<td>NA</td>
<td>NA</td>
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<tr>
<td>Evick et al (2008)</td>
<td>5</td>
<td>RCT</td>
<td>Number of tender points, pain, depression, and functional capacity</td>
<td>2 groups: Home-based exercise program (n=30) Aquatic exercise program (n=33)</td>
<td>60 min/session 3×/week 5 weeks Protocol: home-based exercise program: warm-up, ROM, relaxation, aerobic, stretching, and cool-down exercises. Aquatic exercise program: warm-up (20 min), aerobic exercises, active ROM, stretching, relaxation (35 min) and cool-down (5 min)</td>
<td>Not reported</td>
<td>33 °C</td>
<td>Both aquatic therapy and home-based aerobic exercise programs improved well-being, quality of life, and pain parameters in FMS. Aquatic therapy seems to have more advantage in long-term pain management</td>
<td>Not reported</td>
<td>NA</td>
<td>NA</td>
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<td>Author et al (year)</td>
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<tr>
<td>Fernandes et al (2016)</td>
<td>9</td>
<td>RCT</td>
<td>Pain (VAS)</td>
<td>2 groups: Swimming (n=39) Walking (n=36)</td>
<td>50 min/session 3×/week 12 weeks Protocol for both groups: warm-up (5 min), exercise (40 min), and cool-down (5 min) Swimming: freestyle swimming without floatation devices Walking: open-air walking</td>
<td>Not specified</td>
<td>Swimming group: HR was kept at 11 beats below the anaerobic threshold Walking group: HR was kept at the anaerobic threshold</td>
<td>Not reported</td>
<td>Swimming, like walking, is an effective method for reducing pain in patients with FM</td>
<td>Not reported for intragroup comparisons. Effect size=0.168 for between-group comparison</td>
<td>Not reported</td>
<td></td>
</tr>
<tr>
<td>Gowans et al (2001)</td>
<td>8</td>
<td>RCT</td>
<td>BDI and 6MWT</td>
<td>2 groups: Supervised exercise (n=15) Control (n=16)</td>
<td>30 min/session 3×/week 23 weeks Protocol: stretching (5 min before and 5 min after exercise) and aerobic exercise (20 min)</td>
<td>Not specified: “a warm therapeutic pool”</td>
<td>Not reported</td>
<td>There were significant improvements for exercise group subjects in 6MWT distances and BDI</td>
<td>Not reported</td>
<td>Anxiety, general mental health, number of tender points, isokinetic maximal voluntary strength, FIQ, and self-efficacy</td>
<td>Not reported</td>
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<tr>
<td>Gusi et al</td>
<td>6</td>
<td>RCT</td>
<td>Pain, isokinetic muscle strength, health-related quality of life, spare time and work activities</td>
<td>2 groups: Exercise (n=17) Control (n=17)</td>
<td>60 min/session 3×/week 12 weeks Protocol: exercise -- warm-up (10 min), aerobic exercises (10 min), over-all mobility and lower-limb strength exercises (20 min), another set of aerobics (10 min), and cool-down (10 min) Control -- follow normal daily activities, which did not include any form of exercise related to those in therapy</td>
<td>Aerobic exercises were performed at 65–75% of maximal HR</td>
<td>33 °C</td>
<td>Therapy relieved pain and improved HRQOL and muscle strength in the lower limbs at low velocity</td>
<td>Not reported</td>
<td>NA</td>
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<tr>
<td>Hecker et al (2011)</td>
<td>9</td>
<td>RCT</td>
<td>Quality of Life (SF-36)</td>
<td>2 groups: Kinesiotherapy (n=12) Hydrokinesiotherapy (n=12)</td>
<td>60 min/session 1×/week 23 weeks Protocol: muscle stretching exercises (15 min); passive and active movement of the lower limbs, upper limbs, trunk, and neck (30 min); and same stretching exercises performed at beginning of session (15 min)</td>
<td>Not reported objectively (low intensity during the entire protocol)</td>
<td>32–34 °C</td>
<td>No significant differences between groups after the intervention program. Both groups improved physical functioning, pain, social aspects, and mental health. Hydrokinesiotherapy group improved also emotional aspects, while the kinesiotherapy group improved physical aspects</td>
<td>Not reported</td>
<td>NA</td>
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<td>Ide et al (2008)</td>
<td>6</td>
<td>RCT</td>
<td>PAIN (VAS – 10 cm, number of tender points)</td>
<td>2 groups: ARG (n=18) CG (n=17)</td>
<td>Both groups: 60 min/session, 4×/week; 4 weeks: supervised recreational activities (involved no exercises or health-related issues) ARG: 60 min/session, 4×/week; 4 weeks: warm-up, general exercises targeting specific breath patterns (45 min), and relaxation exercises</td>
<td>Not specified</td>
<td>32 °C</td>
<td>Decrease in pain (lower VAS scores); no difference in tender points count</td>
<td>Not reported</td>
<td>Dyspnea, function, quality of life, anxiety, sleep</td>
<td>Improvement in dyspnea (lower VAS scores), sleep quality (lower PSQI scores), anxiety (lower HAS scores), function (lower FIQ scores), and quality of life (greater SF-36 values)</td>
<td>NA</td>
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<tr>
<td>Jentoft et al (2001)⁹⁹</td>
<td>5</td>
<td>RCT</td>
<td>Function (FIQ)</td>
<td>2 groups: PE (n=18) LE (n=16)</td>
<td>60 min/session, 2×/week, 20 weeks. Both groups: body awareness training, ergonomics, warm-up, stretching, strengthening exercises, relaxation. Pool-based exercise group performed adapted protocol in water</td>
<td>60-80% of maximum HR for age (during 40-50% of session)</td>
<td>34 °C</td>
<td>No differences between groups for function; function equally improved for both groups (lower FIQ scores)</td>
<td>NA</td>
<td>Pain (FIQ pain subscore and VAS for local pain), self-efficacy, cardiovascular capacity, grip strength, walking time and endurance time of shoulder muscles</td>
<td>Improved grip strength (hand-held dynamometry) in LE group; within-group improvements in cardiovascular capacity (maximum O₂ uptake), and walking time (s/100 m); within-group improvements in the PE group for several FIQ subscales including pain, anxiety, and depression</td>
<td>Not reported</td>
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<tr>
<td>Kesiktas et al (2011)</td>
<td>3</td>
<td>Quasi-randomized trial</td>
<td>Pain (tender points count, VAS – 10 cm, and total PPT on tender points)</td>
<td>2 groups: PTM+BT (n=16) PTM (n=20) PTM+HT (n=20)</td>
<td>PTM: 36 min/session, 5×/week, 3 weeks: conventional TENS (15 min), ultrasound (6 min), and infrared (15 min); PTM+BT: PTM added to 19 sessions of thermal pool bath (20 min of immersion/session); PTM+HT: PTM added to 20-min sessions of hydrotherapy (protocol not described)</td>
<td>Not specified</td>
<td>Thermal pool bath: 37–38 °C Hydrotherapy: 37 °C</td>
<td>Total PPT was lower for PTM+BT (compared to PTM+HT); improvement in pain symptoms (lower VAS total PPTs and tender point count) was observed for all groups after treatment and only for PTM+BT and PTM+HT in the follow-up (after 6 months)</td>
<td>Not reported</td>
<td>Depression, pulmonary function</td>
<td>Improvement in depressive symptoms (lower BDI and HDRS scores) for all groups after treatment; only PTM+BT maintained better scores at follow-up; pulmonary function only improved for PTM+HT and PTM+HT groups after treatment, but only PTM+BT maintained improved pulmonary function at follow-up</td>
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<tr>
<td>Latorre et al (2013)(^{39})</td>
<td>5</td>
<td>Nonrandomized clinical trial</td>
<td>Pain (tender point count, VAS – 10 cm, PPT over tender points)</td>
<td>2 groups: EG (n=48) CG (n=37)</td>
<td>Not specified (controlled by Borg scale)</td>
<td>Not specified</td>
<td>Not specified</td>
<td>EG significantly improved pain symptoms (lower VAS scores, greater PPT and reduced number of tender points)</td>
<td>Not reported</td>
<td>Functional capacity, body composition, and quality of life</td>
<td>EG improved functional capacity (greater hand-held grip dynamometry values, greater maximum $O_2$ uptake, greater agility and balance indexes, greater quality of life (greater FIQ scores), and body composition (reduced fat percentage)</td>
<td>NA</td>
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<td>Latorre Román et al (2015)</td>
<td>6</td>
<td>RCT</td>
<td>Pain (tender point count, VAS – 10 cm, PPT over tender points)</td>
<td>2 groups: EG (n=20) CG (n=16)</td>
<td>CG: no activities or exercises other than usual, and none similar to EG protocol EG: 60 min/session, 3 ×/week 2 ×/week pool exercises and 1 ×/week land exercises, 18 weeks Protocol: warm-up, exercises of muscular strengthening and balance, cool-down</td>
<td>Patient determined</td>
<td>30 °C</td>
<td>EG significantly improved pain symptoms (lower VAS scores, greater PPT and reduced number of tender points)</td>
<td>Not reported</td>
<td>Impact of fibromyalgia, strength, and balance</td>
<td>EG significantly improved: lower impact of fibromyalgia (lower FIQ scores), greater strength (leg and handgrip) and balance</td>
<td>NA</td>
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<tr>
<td>Letieri et al (2013)</td>
<td>6</td>
<td>RCT</td>
<td>Pain (VAS – 10 cm)</td>
<td>2 groups: HG (n=33) CG (n=33)</td>
<td>45 min/session, 2 ×/week, 15 weeks. Protocol: warm-up, strengthening, balance, coordination and agility exercises, stretching, and relaxation</td>
<td>Moderate according to the perceived effort modified scale</td>
<td>33 °C</td>
<td>Decrease in pain (lower VAS scores)</td>
<td>Not reported</td>
<td>Quality of life, depressive symptoms</td>
<td>Improved quality of life (lower FIQ scores) and depressive symptoms (lower BDI scores)</td>
<td>NA</td>
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<td>López-Rodríguez et al (2013)</td>
<td>6</td>
<td>RCT</td>
<td>Pain (VAS – 10 cm, MPQ, PPT)</td>
<td>2 groups: ABD (n=29) CG (n=30)</td>
<td>60 min/session, 2×/week; 12 weeks. Protocol: ABD – flexibility and breathing exercises, rhythmic dancing movements, and mild exercises; CG – stretching exercises for different body parts</td>
<td>Not specified</td>
<td>29 °C (preceded by a bath of 33–35 °C)</td>
<td>Decrease in pain (lower VAS and MPQ scores and lower number of active tender points for PPT)</td>
<td>Not reported</td>
<td>Sleep, anxiety, depression, function</td>
<td>Improvement in sleep quality (lower PSQI scores), anxiety (lower SAI scores), function (lower FIQ scores) for ABD</td>
<td></td>
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<tr>
<td>Mannerkorpi et al (2000)</td>
<td>4</td>
<td>Quasi-randomized clinical trial</td>
<td>Impact of fibromyalgia (FIQ – total score), physical capacity (6MWT)</td>
<td>2 groups: TG (n=37) CG (n=32)</td>
<td>35 min/session, 1×/week, 24 weeks. Protocol: exercises for endurance, flexibility, coordination, and relaxation along with education sessions (6 sessions, 1 h/session)</td>
<td>Patient determined</td>
<td>Not reported</td>
<td>Decreased fibromyalgia impact (lower FIQ total scores) and improved physical capacity (better scores in the 6MWT)</td>
<td>NA</td>
<td>FIQ subscores (including pain, quality of life, self-efficacy, functional limitations)</td>
<td>TG significantly improved physical functioning (lower FIQ subscores), anxiety (lower FIQ and AIMS subscores), depression (lower AIMS subscores), strength (greater grip strength), general health (greater SF-36 scores), social functioning (greater SF-36 scores), and pain (lower scores for pain severity and affective distress for the MPI-S)</td>
<td>Not reported</td>
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<tr>
<td>Mannerkorpi et al (2009) [7]</td>
<td>8</td>
<td>RCT</td>
<td>Impact of fibromyalgia (FIQ – total score), physical capacity (6MWT)</td>
<td>2 groups: Ex-Edu (n=81) Edu (n=85)</td>
<td>45 min/session, 1×/week, 20 weeks. Protocol: exercises for endurance, flexibility, coordination, and relaxation along with education sessions (6 sessions, 1 h/session)</td>
<td>48-65% of maximum HR (light to moderate intensity)</td>
<td>33 °C</td>
<td>Decreased fibromyalgia impact (lower FIQ total scores) and improved physical capacity (better scores in the 6MWT)</td>
<td>NA</td>
<td>FIQ subscores (including pain, pain, quality of life, anxiety and depression, leisure time physical activity, stress, fatigue)</td>
<td>Significant improvement for change in pain (lower FIQ pain subscores) and for leisure time (decreased LTPA-I scores)</td>
<td>0.69 (0.45 for the intention-to-treat analysis)</td>
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<tr>
<td>Munguia-Izquierdo and Legaz-Arrese (2007) [7]</td>
<td>7</td>
<td>RCT</td>
<td>Tender point count, PPT on the tender points, and FIQ pain subscore (VAS – 100 mm)</td>
<td>3 groups: Ex (n=35) CG (n=25) Healthy group (n=25)</td>
<td>60 min/session, 3×/week, 16 weeks. Protocol: warm-up with slow walks and mobility exercises, strength exercises, aerobic exercises, and cool-down</td>
<td>50-80% of predicted maximum HR according to age</td>
<td>32 °C</td>
<td>Decreased pain (reduced number of tender points, increased PPT over all tender points, and reduction in FIQ pain subscore) compared to control group</td>
<td>Not reported</td>
<td>Severity of FM and cognitive function</td>
<td>Improvement of FM severity (lower FIQ scores) and in cognitive function (improvement in neuropsychological tests)</td>
<td>NA</td>
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<td>Munguía-Izquierdo and Legaz-Arrese (2008)</td>
<td>8</td>
<td>RCT</td>
<td>Tender point count, PPT over tender points, health status (FIQ)</td>
<td>3 groups: Ex (n=35) CG (n=25) Healthy group (n=25)</td>
<td>60 min/session, 3×/week, 16 weeks Protocol: warm-up with slow walks and mobility exercises, strength exercises, aerobic exercises, and cool-down</td>
<td>50-80% of predicted maximum HR according to age</td>
<td>32 °C</td>
<td>Decreased pain (reduced number of tender points, increased PPT over all tender points) compared to control group, Improvement in health status (lower FIQ scores)</td>
<td>Not reported</td>
<td>Anxiety, sleep quality, cognitive function, physical function</td>
<td>Improvement in sleep quality (lower PSQI scores), cognitive function (greater PASAT scores) and physical function (increased muscle endurance for upper and lower limbs)</td>
<td>NA</td>
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<tr>
<td>Pérez de la Cruz and Lambeck (2016)</td>
<td>3</td>
<td>Pilot study</td>
<td>VAS (10 cm) for pain</td>
<td>1 group: FMS (n=20)</td>
<td>45 min/session, 2×/week, 10 weeks Protocol: warm-up, Ai Chi program, cool-down</td>
<td>Not reported</td>
<td>33 °C ±0.5 °C</td>
<td>Significant improvement in pain (lower VAS scores)</td>
<td>Not reported</td>
<td>Health-related quality of life</td>
<td>Improved quality of life (increased scores in all domains of SF-36 except role physical and role emotional)</td>
<td>NA</td>
</tr>
<tr>
<td>Piso et al (2001)</td>
<td>4</td>
<td>Case-control study</td>
<td>PPT over tender points</td>
<td>2 groups: Sauna (n=9) HT (n=9)</td>
<td>30 min/session, 2×/week, 6 weeks Protocol: bodily awareness exercises, low-impact strength exercises</td>
<td>Patient determined</td>
<td>Sauna: 90 °C HT: 35 °C</td>
<td>No significant differences comparing groups; significant improvement in PPT only for sauna group</td>
<td>Not reported</td>
<td>Previous treatment</td>
<td>Out of 18, 12 patients consider HT as first-choice treatment</td>
<td>NA</td>
</tr>
</tbody>
</table>
Table 2 (Continued)

<table>
<thead>
<tr>
<th>Author</th>
<th>PEDro score</th>
<th>Design</th>
<th>Primary outcome</th>
<th>Groups (number in each group)</th>
<th>Water therapy protocol</th>
<th>Exercise Intensity</th>
<th>Water temperature</th>
<th>Main results</th>
<th>Effect sizes (reported for pain)</th>
<th>Secondary outcomes</th>
<th>Main results of Secondary outcomes</th>
<th>Effect sizes (reported for pain)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Santana et al (2010)</td>
<td>1</td>
<td>Analytical clinical trial</td>
<td>FM impact and pain over tender points</td>
<td>2 groups: Ai Chi (n=5) CG (n=5)</td>
<td>40 min/session, 10 sessions (number of weeks not specified) Protocol: Ai Chi program (sequence of slow and wide movements with upper limbs, lower limbs, and trunk, emphasizing deep breathing during the exercises)</td>
<td>Not reported</td>
<td>34–36 °C</td>
<td>No significant improvement was observed for intervention group compared to CG</td>
<td>Not reported</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Segura-Jiménez et al (2013)</td>
<td>2</td>
<td>Uncontrolled clinical trial</td>
<td>Tender point count and immediate pain (VAS – 10 cm)</td>
<td>1 group: FMS (n=33)</td>
<td>45 min/session, 2×/week, 12 weeks Protocol: warm-up, general exercises (on Mondays: strength; on Wednesdays: balance), stretching, and relaxation</td>
<td>RPE (Borg): 12 ±2 points</td>
<td>34 °C</td>
<td>Improvement in immediate pain (decreased VAS scores)</td>
<td>Not reported</td>
<td>Body composition</td>
<td>No differences were observed in body composition</td>
<td>NA</td>
</tr>
<tr>
<td>Author (year)</td>
<td>PEDro score</td>
<td>Design</td>
<td>Primary outcome</td>
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<tr>
<td>Sevimli et al (2015)</td>
<td>5</td>
<td>RCT</td>
<td>Pain (VAS – 100 mm)</td>
<td>3 groups: ISSEP (n=25) AEP (n=25) AAEP (n=25)</td>
<td>ISSEP: 15 min/day (3 months) of home-based stretching and strength exercises AEP and AAEP: 40–50 min/session, 2 x/week, 12 weeks Protocol not described for AEP and AAEP</td>
<td>60–80% maximal HR</td>
<td>Not reported</td>
<td>Pain improved for AEP and AAEP (lower VAS after treatment)</td>
<td>Not reported</td>
<td>Health status, endurance, quality of life, depression</td>
<td>Improvement in quality of life (greater SF-36 scores), depression (lower BDI scores), health status (lower FIQ scores) and endurance (greater scores for 6MWT) for AAEP and AEP</td>
<td></td>
</tr>
<tr>
<td>Tomas-Carus et al (2007)</td>
<td>7</td>
<td>RCT</td>
<td>FM impact (FIQ total score)</td>
<td>2 groups: EG (n=17) CG (n=17)</td>
<td>60 min/session, 3×/week, 12 weeks Protocol: warm-up, mobility exercises, aerobic exercises, lower limb exercises, cool-down exercises, and relaxation</td>
<td>60–65% maximal hear rate</td>
<td>33 °C</td>
<td>Improvement of FM impact (lower FIQ scores)</td>
<td>NA</td>
<td>FIQ subscores (including pain)</td>
<td>Improvement of all FIQ subscores (lower scores for all, including pain)</td>
<td>Not reported</td>
</tr>
</tbody>
</table>

(Continued)
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<tr>
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<th>Groups (number in each group)</th>
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<tr>
<td>Tomas-Carus et al (2009)</td>
<td>7</td>
<td>RCT</td>
<td>FM impact (FIQ total score and subscores), including pain and anxiety state (STAI)</td>
<td>2 groups: EG (n=15), CG (n=15)</td>
<td>60 min/session, 3×/week, 24 weeks</td>
<td>Protocol: warm-up, mobility exercises, aerobic exercises, lower limb exercises, cool-down exercises</td>
<td>60-65% maximal heart rate</td>
<td>33 °C</td>
<td>Significant reduction of FM impact (lower FIQ total scores, and FIQ pain subscores)</td>
<td>Treatment effect of −0.5 (−1.8 to 0.7) for the FIQ pain subscore</td>
<td>Physical fitness</td>
</tr>
<tr>
<td>Trevian et al, (2015)</td>
<td>1</td>
<td>Single-arm study</td>
<td>Postural control (center of pressure sway)</td>
<td>1 group: FMS (n=17)</td>
<td>45 min/session, 2×/week, 16 weeks. Protocol: familiarization, warm-up, exercises (aerobic and strength exercises for upper and lower limbs and trunk), cool-down stretching and relaxation</td>
<td>Patient determined</td>
<td>30 °C ±2 °C</td>
<td>Improvement in postural sway (lower center of pressure sway in different situations)</td>
<td>NA</td>
<td>Pain (VAS – 100 mm during rest and movement); function (lower FIQ scores)</td>
<td>Improvement in pain (lower VAS scores) and function (lower FIQ scores)</td>
</tr>
</tbody>
</table>

**Abbreviations:** 6MWT, 6-min walking test; AAEP, pool-based aquatic aerobic exercise program; ABD, aquatic biodance; AEP, gymnastic-based aerobic exercise program; AIMS, Arthritis Impact Measurement Scales; ARG, aquatic respiratory exercise-based program; BDI, Beck Depression Inventory; CG, control group; DWR, deep water running; Edu, education group; EG, exercise group; EuroQol-5D, EuroQol Research Foundation Quality of Life Questionnaire; EuroQol-VAS, EuroQol Research Foundation Quality of Life Questionnaire Visual Analog Scale; Ex, exercise group; Ex-Edu, exercise and education group; FIQ, Fibromyalgia Impact Questionnaire; FMS, fibromyalgia syndrome; HAS, Hamilton Anxiety Scale; HDRS, Hamilton Depression Rank Scale; HG, hydrotherapy group; HR, heart rate; HRQOL, health-related quality of life; HT, hydrotherapy; ISSEP, home-based isometric strength and stretching exercise program; LE, land-based exercise group; LTPAI, leisure-time physical activity instrument; MMPP+DWR, multimodal physiotherapy program+deep water running; MPI-5, Multidimensional Pain Inventory – Swedish Version; MPQ, McGill Pain Questionnaire; NA, not applicable; NPRS, numerical pain rating scale; PSQI, Pittsburgh Sleep Quality Index; PFM, physical therapy modalities; PFM+BT, photobiomodulation +balneotherapy; PFM+HT, photobiomodulation+hydrotherapy; RCT, randomized controlled trial; ROM, range of motion; RPE, rate of perceived exertion; SAI, State Anxiety Inventory; SF-36, Medical Outcomes Study 36-item Short Form Health Survey; STAI, State-Trait Anxiety Inventory; TENS, transcutaneous electrical nerve stimulation; TG, training group; VAS, visual analog scale; VAT, ventilatory anaerobic threshold; VO2, oxygen uptake.
not all, body regions. FMS is associated with changes in the central nervous system that affect sensory information processing, amplifying peripheral input and/or generating pain perception in the absence of a noxious stimulus. People with FMS are reported to present hyperactivity of the hypothalamic–pituitary–adrenal axis, and this may be linked to the initiation or worsening of FMS symptoms. Moreover, dopamine dysfunctions have been linked to the pathophysiology of FMS, which are associated with hyperalgesia and deficient pain inhibition.

Accordingly, exercise has been one of the most recommended nonpharmacological interventions for FMS. It has been shown that exercise is able to influence gene expression and structural complexity in the limbic structures that regulate the hypothalamic–pituitary–adrenal axis and can improve conditioned pain modulation due to increased endogenous opioids, stimulation of brain structures involved in the inhibitory descending pathways that regulate painful response. Geytenbeek has examined over 500 articles that were available on the theme and has concluded, after examining randomized controlled trials, case–control studies, and cohort studies, that high to moderate quality evidence supports the use of hydrotherapy for pain, function, joint mobility strength, and balance. Moreover, exercise seems to be the most effective component of a hydrotherapy program for FMS.

Hence, exercising in an aquatic environment is advantageous. The pain-relieving effect of water-based exercises is suggested to be due to the joint effect of exercise, warm water, and buoyancy on thermal receptors and mechanoreceptors. Sensory-motor hyperstimulation exerted by the hydrostatic pressure, viscosity, and water temperature increases the triggers of thermal receptors and mechanoreceptors while blocking nociceptors. The viscosity of the water provides an environment with three-dimensional resistance, which facilitates proprioceptive feedback through functional patterns of movement and increases the synchronization of the motor units due to slowed movement. Also, immersion in warm water helps to increase blood flow and oxygen supply, improving nutrition and removal of catabolites, and thereby reducing signal molecules, such as IL-8 and noradrenaline, responsible for activation of nociceptors. In addition, regular exercise has been shown to improve overall health, as shown in other chronic conditions. This prominent effect on pain could be previously observed in several studies.

It is noteworthy to mention that patients with FMS present abnormalities regarding pain modulation, including central sensitization and other pathophysiological mechanisms, such as the accumulation of cytotoxic substances in the extracellular space (glutamate, lactate, bradykinin, prostaglandins, etc.) generated by muscle activity, which exert algogenic effects by sensitizing and exciting nociceptors. Glutamate is a major cortical excitatory neurotransmitter that acts in pain neurotransmission. Increased levels of insular glutamate have been reported to be present in FMS. In addition, the concentration of this molecule is correlated with pain report. Enhanced glutamatergic neurotransmission resulting from higher concentrations of glutamate within the posterior insula may play a role in the pathophysiology of FMS and other central pain augmentation syndromes. Moreover, the sympathetic nervous system, which is already in a condition of hyperactivity (see section “Cardiovascular and respiratory systems and the association with pain”), under the action of bradykinin stimulates the release of noradrenaline and prostaglandins that further potentiate sympathetic hyperactivity and sensitize the nociceptors.

Therefore, another mechanism explaining the pain improvement may rely on the combination of hydrostatic pressure and temperature on nerve endings, which would lead to competing stimuli that would diminish the peripheral nociceptive input. Aquatic therapy also leads to muscle relaxation, which would in turn lead to less pain. Buoyancy decreases compressive weight-bearing stresses on joints and allows functional exercise with lessened gravitational load, making the movements easier, and even facilitating the improvement of both strength and range of motion. Furthermore, drag forces can be used as a resource to assist movements or to impose resistance favoring muscle strengthening. Nonetheless, quantifying the resistance training intensity and planning a progressive overload program in aquatic environments is challenging due to several factors (eg, speed of movements, range of motion, shape and size of floats, etc.). Therefore, it is still not clear whether aquatic exercises can really induce strength gains, since controversial results have been reported.

Regarding chronic fatigue, another core feature of FMS, its perception may be reduced after water therapy due to the buoyancy effects. Buoyancy helps reduce the musculoskeletal system’s gravitational forces due to gravitational muscle relaxation and energy conservation, which seems to reduce perceived fatigue. Water immersion may also reduce neuromuscular responses or trigger inhibitory
mechanisms, with an overall reduction in neural transmis-
sions, which would impact not only on the perceived
fatigue but also on the nociceptive input, reducing pain
perception.

**Cardiovascular and respiratory systems
and the association with pain**

FMS patients present cardiorespiratory dysfunction char-
acterized by reduced respiratory muscle endurance,
inspiratory muscle strength, and thoracic mobility. Moreover, cardiovascular autonomic control and barore-
flex sensitivity have been also shown to be altered in this population. In addition, although it is not possible
to identify a causal relationship, several studies have shown that these cardiorespiratory abnormalities are
related to the pain in these subjects. Forti et al showed that inspiratory muscle strength is associated with
the number of active tender points. In addition, Zamuner et al found that FMS show reduced respiratory sinus
arrhythmia magnitude as compared to healthy women. Also, the indices obtained during the deep breathing test,
a vagal maneuver, had an important association with pain
in FMS. In another study, Zamuner et al also showed that sympathetic activity, as assessed by muscle sympa-
thetic nerve activity, was related to pain in this population.

Several studies have described the interaction between
autonomic and nociceptive pathways occurring at multiple
levels with the nucleus tractus solitarius playing an
important role. The nucleus tractus solitarius, located in
the brainstem, receives visceral information through the
primary afferents of the vagus nerve and receives the
spinal pathways involved in pain processing, functioning
as an interface between the autonomic and sensory
systems. Therefore, improving cardiovascular and
respiratory outcomes in FMS patients should be consid-
ered one of the aims in the management of FMS.

It is well established that aerobic exercise improves
cardiorespiratory function in patients with FMS. In
addition, an aquatic environment can allow higher-intensity
exercises to be undertaken, with lower cardiovascular stress
than is possible on land. In this sense, some studies have
assessed the effects of water therapy on the cardior-
respiratory system. Zamuner et al found that a 16-week
aquatic therapy program proved to be effective in amelior-
ating symptoms, aerobic functional capacity, and cardiac
autonomic control in FMS patients. Surprisingly, improve-
ments in cardiac autonomic control were related to the
improvements in pain and the impact of FMS on quality
of life, thus suggesting an important role of autonomic
control mediating symptoms. Regarding the improvement
of functional aerobic capacity, aquatic therapy has also been
proven to be effective. However, studies have shown
no association between cardiorespiratory fitness improve-
ments and FMS symptom improvements.

In summary, cardiorespiratory function and cardiac
autonomic control should be routinely monitored in the
management of FMS patients since they seem to be related
to the symptoms; and water therapy might be seen as a
strategic method to improve these outcomes in this popu-
lation. However, improving cardiorespiratory fitness
should not be the main goal in the therapy, but instead a
tailored approach directed to the key FMS symptoms
(pain, sleep disorders, fatigue, depression, disability) with
exercise assignment that does not exacerbate post-exercise
pain should take place.

**Neuroendocrine system and inflammation**

Growing interest has been shown in the study of the benefits
of aquatic therapy on the neuroendocrine system and
inflammation. However, little is known about these in FMS
patients. This is of interest since neurohormonal abnormal-
ities have been reported in this population, such as low
levels of serotonin, hypothalamic–pituitary–adrenal axis
dysfunction, and low levels of growth hormone, which
is associated with poor sleep quality. Moreover, although there are no specific biomarkers for FMS, some studies have suggested the involvement of inflammatory
disorders on its etiology. Those disorders involve cyto-
kines, proteins responsible for mediating the inflammatory
reaction in the immune system. Studies have shown that
FMS patients have increased levels of serum IL-8, IL-6,
IL-10, and IL-1β. Ortega et al found that FMS patients
present a higher circulation concentration of C-reactive
protein and that their monocytes release more IL-1β, tumor
necrosis factor alpha, IL-6, and IL-10 than those from an
age-matched healthy control group. Additionally, FMS
patients present a greater concentration of IL-8 in cerebro-
vascular fluid. IL-8 release is stimulated by substance
P secretion and promotes sympathetic pain, and thus is
considered an inflammatory marker of FMS, which is
indicative of underlying low-grade systemic inflammation.
There is evidence showing the participation of chemokines
(signaling molecules present in inflammatory and immune
responses) in FMS, with higher concentrations of inflammatory chemokines (TARC/CCL17, MIG/CXCL9, MDC/CCL22, I-TAC/CXCL11, and eotaxin/CCL11).134

Aquatic therapy has been shown to reduce plasma levels of norepinephrine,135–137 epinephrine,135,138 β-endorphin, and cortisol139 in healthy men. In this context, we may suggest that aquatic therapy may contribute to a reduction of stress, improvement of sleep quality, and reduction of pain sensitivity.26,137 Regarding FMS patients, to our knowledge, no studies have assessed the effects of aquatic therapy on the neuroendocrine system. However, Bote et al140 found that a single session of moderate cycling improved the inflammatory and stress status of FMS patients. Moreover, their results also suggest that the neuroendocrine mechanism seems to be an exercise-induced decrease in the stress response of these patients, since they observed a reduction in the systemic concentration of cortisol, noradrenaline, and extracellular heatshock protein 72. In agreement with these findings, Ortega et al130 studied the effects of an aquatic fitness program performed for 8 months twice a week. After the program, monocytes from FMS patients presented similar spontaneous release of IL-1β and IL-6 to that of healthy controls and a reduction in C-reactive protein, showing that aquatic exercise might exert anti-inflammatory effects.

Current perspectives

A considerable amount of evidence27 has shown that water therapy improves pain, fatigue, and quality of life. However, current recommendations for the management of fibromyalgia elaborated by the European League Against Rheumatism18 suggest a “weak for” recommendation, implying that most therapists would, although a substantial minority would not, recommend water therapy for FMS patients. This recommendation underlies the small amount of evidence suggesting superiority of water therapy over land-based therapies.141

Therefore, future studies should focus on the possible mechanisms explaining the beneficial effects of water therapy in order to elucidate whether they are similar or not to the mechanisms leading to the improvement of symptoms and quality of life promoted by land-based exercises. Moreover, studies should also compare the detraining effects or long-lasting effects promoted by water therapy and land-based exercises since these have been addressed only by a few studies and the results are controversial. A recent study24 showed that 16 weeks of aquatic exercise therapy was effective in improving aerobic capacity and symptomatology such as pain, quality of life, and fatigue in FMS patients. However, after 16 weeks of detraining, all variables returned to near baseline. Thus, elucidating whether this is comparable to land-based exercises would assist FMS patients and therapists on the proper therapeutic approach recommendation and selection.

Another noteworthy point to be mentioned regards the FMS patient’s adherence to treatment and engagement aftercare tasks in the long term.86 Coupled with the fact that pharmacological interventions seem to be ineffective, as they seldom induce minimally important clinical differences in pain after 3 months of therapy,142,143 this makes the development of treatments that benefit patients over their lifetime extremely challenging. Hence, a multidisciplinary approach and educational strategies may be helpful additions to physical treatment, in this case, water therapy; these strategies show the importance of continuing with treatment, that the disease may vary in intensity over the time, and, more importantly, that they have to take responsibility for their healthcare and habits that influence on FMS symptoms, giving them tools to help with daily FMS management. Water therapy, in this context, comes as an alternative that makes movement easier and may increase compliance with the treatment.

Another topic to be discussed is the cost-effectiveness of water therapy for FMS. One previous study11 has shown that adding water therapy to the usual care for FMS patients is cost-effective for both healthcare and societal costs. The authors also concluded that the characteristics of facilities (distance from patients’ homes and the number of patients who can participate per session) are major determinants that have to be considered before a health manager decides to invest in such a program. Therefore, this point should be addressed in future studies that aim to elucidate whether the cost-effectiveness differs among other kinds of interventions. Studies involving cost-effectiveness may also be helpful in guiding the development of public policies for the healthcare of FMS patients, and, as such, are much needed.

The present study has some limitations, as it is not a systematic review. As such, performance of a metaanalysis was not possible. As a narrative review, the scope of the present study was to highlight and discuss the possible mechanisms involved in the improvement of pain for FMS patients who undergo water therapy. Nonetheless, this discussion is still difficult as the protocols described vary in duration, session length, and techniques used into the swimming pool, as well as the outcomes chosen; also, several outcomes are not sufficiently described.
Conclusion
Water therapy may be recommended as a nonpharmacologic therapeutic approach for the management of FMS patients, improving pain, fatigue, and quality of life; these therapeutic effects are achieved by the physiological changes caused by in-water exercising. However, future studies should be conducted in order to clarify the action mechanisms and whether long-lasting effects are superior to other types of intervention, especially land-based exercises.

Disclosure
The authors declare no conflicts of interest in this work.

References


