SOCIETÀ ITALIANA
G.U.I.D.A.
PER LA GESTIONE UNIFICATA E INTERDISCIPLINARE
DEL DOLORE MUSCOLO-SCHELETRICO E DELL'ALGODISTROFIA

V CONGRESSO NAZIONALE

EVERYTHING
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BOLOGNA
ROYAL HOTEL CARLTON
27 Febbraio - 1 Marzo 2025

Chronic musculoskeletal pain

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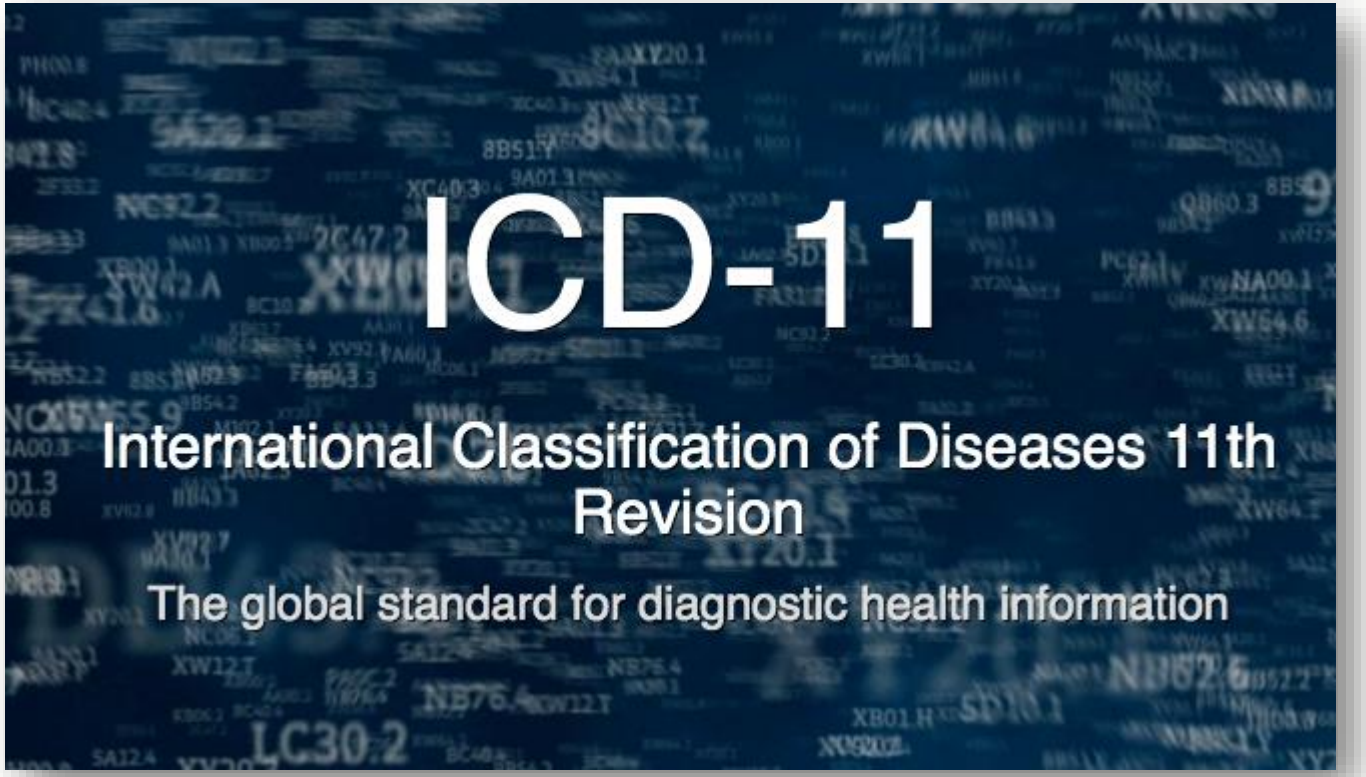
ASST Papa Giovanni XXIII

Quality improvement guidelines for the treatment of acute pain and cancer pain. American Pain Society Quality of Care Committee. JAMA. 1995 Dec 20;274(23):1874-80. doi: 10.1001/jama.1995.03530230060032. PMID: 7500539.



https://icd.who.int/en

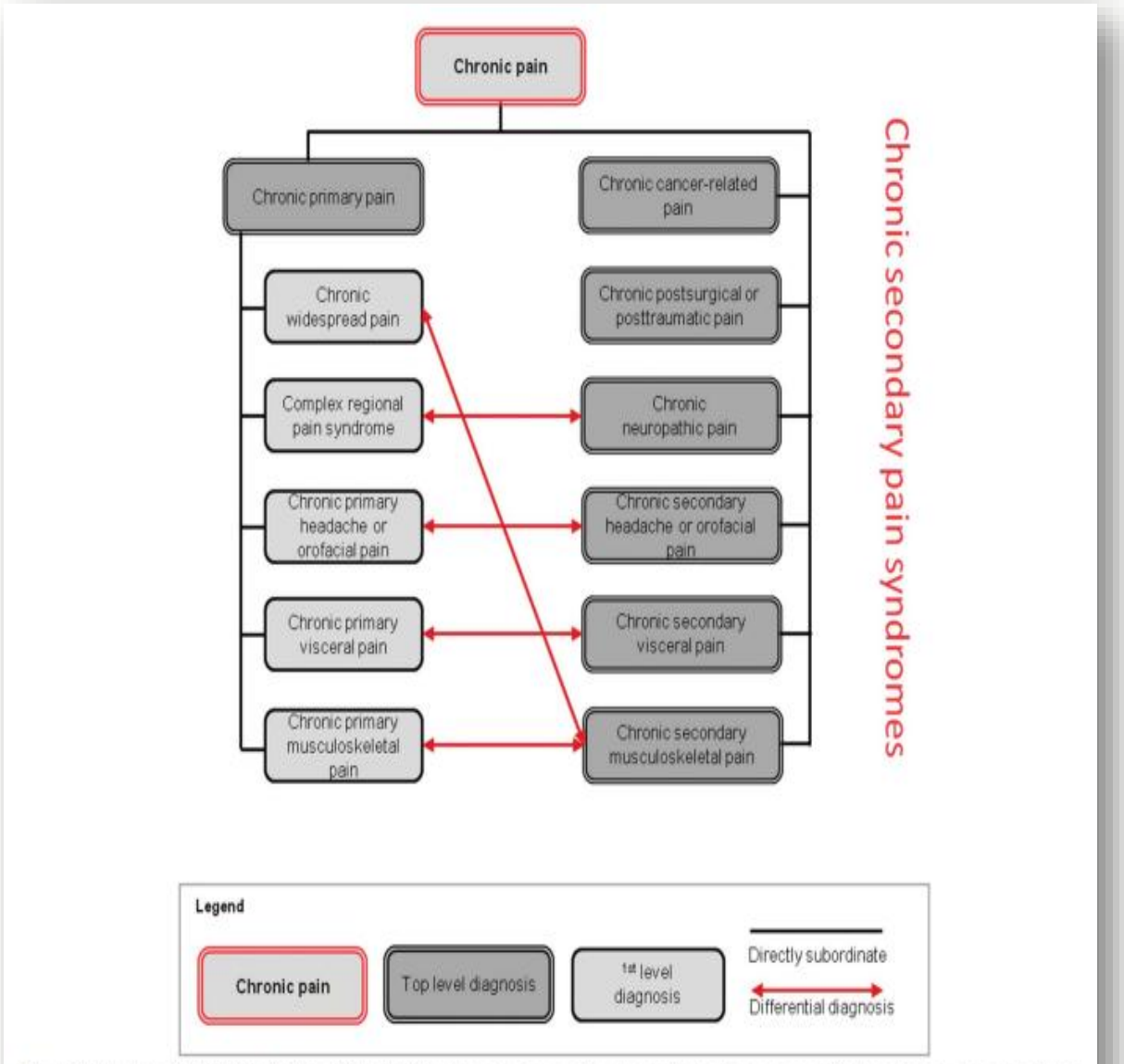


Figure 1. Structure of the IASP Classification of Chronic Pain. In chronic primary pain syndromes (left), pain can be conceived as a disease, whereas in chronic secondary pain syndromes (right), pain initially manifests itself as a symptom of another disease such as breast cancer, a work accident, diabetic neuropathy, chronic caries, inflammatory bowel disease, or rheumatoid arthritis. Differential diagnosis between primary and secondary pain conditions may sometimes be challenging (arrows), but in either case, the patient's pain needs special care when it is moderate or severe. After spontaneous healing or successful management of the underlying disease, chronic pain may sometimes continue and hence the chronic secondary pain diagnoses may remain and continue to guide treatment as well as health care statistics.

R.-D. Treede et al. • 156 (2015) 1003–1007

MG30.02 Chronic primary musculoskeletal pain

Foundation URI: http://id.who.int/icd/entity/1236923870

Code: **MG30.02**

Description

Chronic primary musculoskeletal pain is chronic pain in the muscles, bones, joints or tendons that is characterised by significant emotional distress (anxiety, anger/frustration or depressed mood) or functional disability (interference in daily life activities and reduced participation in social roles). Chronic primary musculoskeletal pain is multifactorial: biological, psychological and social factors contribute to the pain syndrome. The diagnosis is appropriate independently of identified biological or psychological contributors unless another diagnosis would better account for the presenting symptoms. Other chronic musculoskeletal pain diagnoses to be considered are those listed under chronic secondary musculoskeletal pain.

Inclusions

Chronic primary low back pain
Chronic primary cervical pain
Chronic primary thoracic pain
Chronic primary limb pain

Exclusions

Acute pain (MG31)

https://icd.who.int/browse/2025-01/mms/en#1236923870

MG30.3 Chronic secondary musculoskeletal pain

Foundation URI: http://id.who.int/icd/entity/1968541653

Code: **MG30.3**

Description

Chronic secondary musculoskeletal pain is chronic pain arising from bone(s), joint(s), muscle(s), vertebral column, tendon(s) or related soft tissue(s). It is a heterogeneous group of chronic pain conditions originating in persistent nociception in joint, bone, muscle, vertebral column, tendons and related soft tissues, with local and systemic aetiologies, but also related to deep somatic lesions. The pain may be spontaneous or movement-induced.

Exclusions

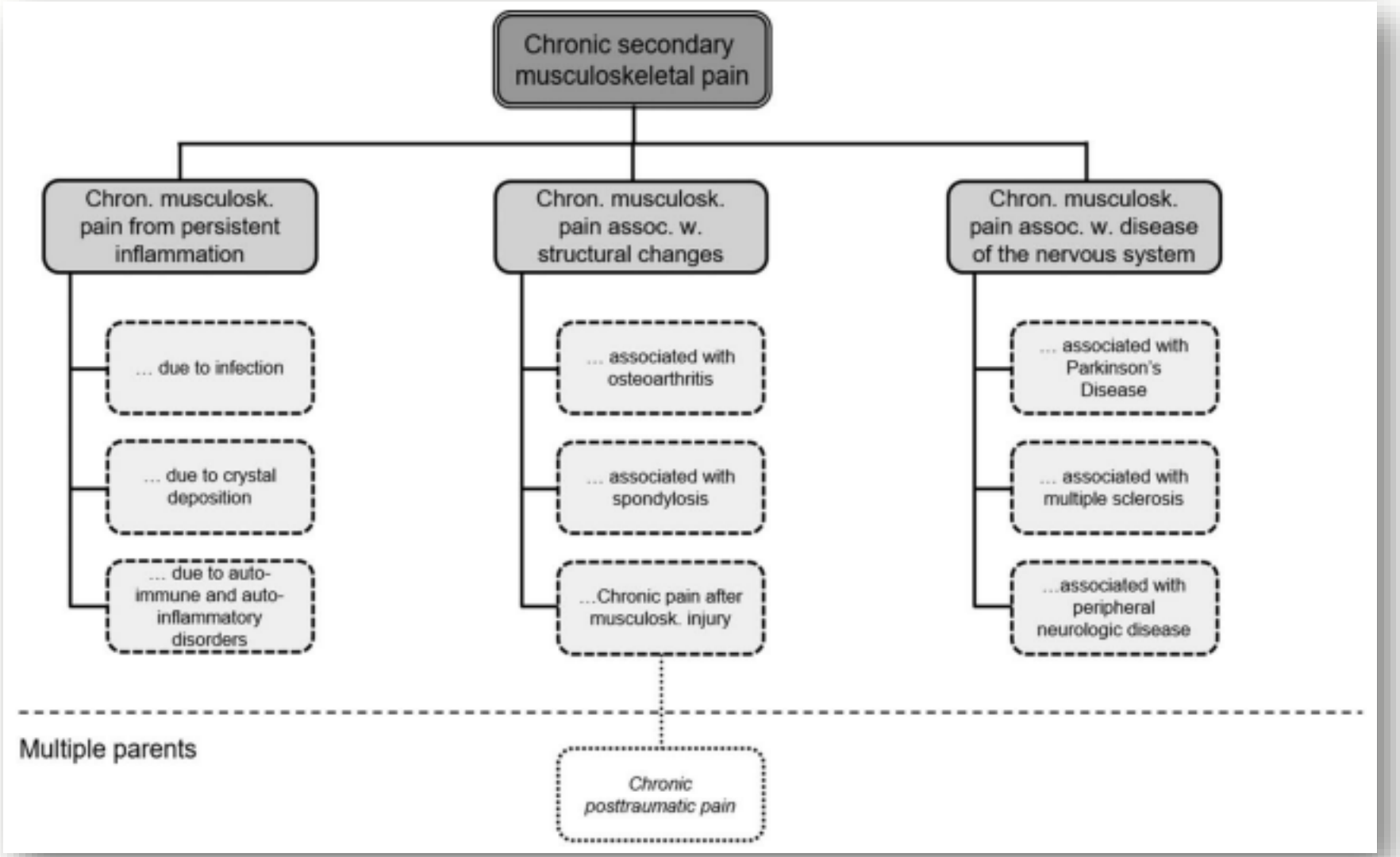
Acute pain (MG31)
Chronic neuropathic pain (MG30.5)
Chronic primary pain (MG30.0)
Chronic secondary visceral pain (MG30.4)

Exclusions from above levels Show all [18] ▾

Coding Note

If the pain is related to visceral lesions, it should be considered whether a diagnosis of chronic visceral pain is appropriate; if it is related to neuropathic mechanisms, it should be coded under chronic neuropathic pain; and if the pain mechanisms are non-specific, chronic musculoskeletal pain should be coded under chronic primary pain.

https://icd.who.int/browse/2025-01/mms/en#1968541653



Perrot S, Cohen M, Barke A, Korwisi B, Rief W, Treede RD; IASP Taskforce for the Classification of Chronic Pain. The IASP classification of chronic pain for ICD-11: chronic secondary musculoskeletal pain. Pain. 2019 Jan;160(1):77-82.

Chronic secondary MS pain 1. PERSISTENT INFLAMMATION

1. **Infection** may be due to persistent bacterial, viral (hepatis C e B, HIV, Herpes virus, EBV HTLV1 parvovirus, chikungunya) or fungal infection and it's characterized by the clinical features of inflammation;
2. **Crystal deposition**: the mechanism of the pain is mainly nociceptive;
3. **Autoimmune and autoinflammatory disorders**: secondary to inflammation but not necessarily correlate with clinical or biological activity of the underlying disease;

Perrot S, Cohen M, Barke A, Korwisi B, Rief W, Treede RD; IASP Taskforce for the Classification of Chronic Pain. The IASP classification of chronic pain for ICD-11: chronic secondary musculoskeletal pain. Pain. 2019 Jan;160(1):77-82.

Chronic secondary MS pain 2. STRUCTURAL CHANGES

1. **Osteoarthritis**;
2. **Spondylosis**;
3. **Muscoloskeletal injury** , after bone fractures;

- Structural changes, inferred from clinical exanimation or demostrable on imaging (origin of the nociception);
- Allodinia, swelling, loss of movement
- Diagnosi: clinical examination or imaging

Perrot S, Cohen M, Barke A, Korwisi B, Rief W, Treede RD; IASP Taskforce for the Classification of Chronic Pain. The IASP classification of chronic pain for ICD-11: chronic secondary musculoskeletal pain. Pain. 2019 Jan;160(1):77-82.

Chronic secondary MS pain 3.

- Disease of nervous system : altered motor function due to neurological disease for activation of nociceptors (upper and lower motoneuron disease, extrapyramidal disease);
- Pain is one of most common non-motor symptom of **Parkinson**'s disease (nociceptive origin);
- **Multiple sclerosis** nociceptive and neuropatic pain (inflammatory myelitis);
- **Peripheral neurologic disease** (Charcot joint disease, nerve entrapment);

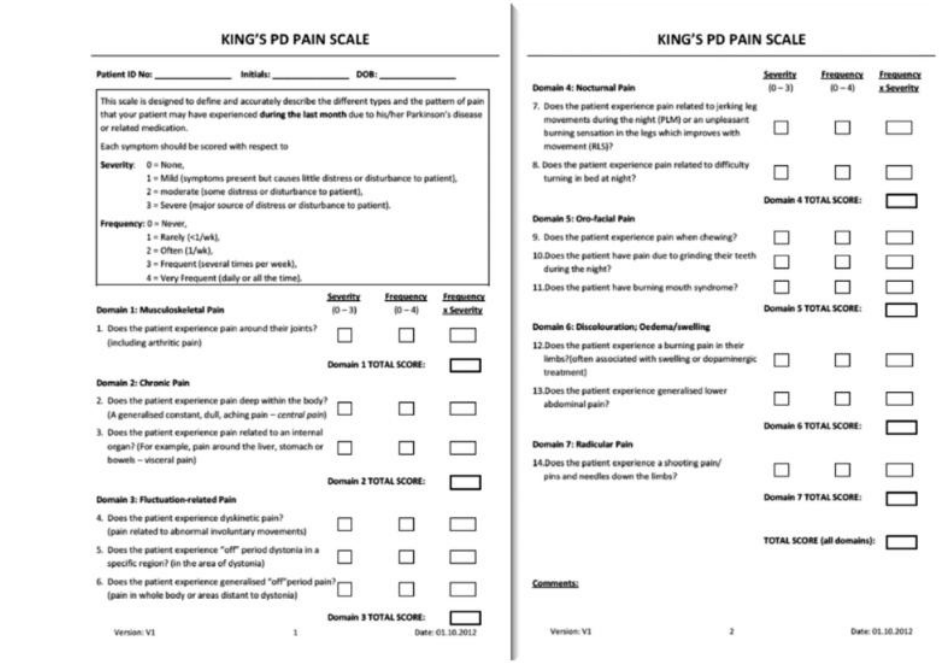
- Other chronic secondary MS pain ...associated with work-related MS disorders;

Perrot S, Cohen M, Barke A, Korwisi B, Rief W, Treede RD; IASP Taskforce for the Classification of Chronic Pain. The IASP classification of chronic pain for ICD-11: chronic secondary musculoskeletal pain. Pain. 2019 Jan;160(1):77-82.

RESEARCH ARTICLE

King's Parkinson's Disease Pain Scale, The First Scale for Pain in PD: An International Validation

K. Ray Chaudhuri, MD, DSc,[1,2,3] A. Rizos, MSc,[1*] C. Trenkwalder, MD, PhD,[4] O. Rascol, MD, PhD,[5] S. Pal, MD,[6] D. Martino, MD,[7] C. Carroll, MD,[8] D. Paviour, MD,[9] C. Falup-Pecurariu, MD,[10] B. Kessel, MD,[11] M. Silverdale, MD,[12] A. Todorova, MD,[1] A. Sauerbier, MD,[1] P. Odin, MD, PhD,[13,14] A. Antonini, MD, PhD,[15] and P. Martinez-Martin, MD, PhD,[16] on behalf of EUROPAR and the IPMDS Non Motor PD Study Group



KING'S PD PAIN SCALE

Patient ID No: _____ Initials: _____ DOB: _____

This scale is designed to define and accurately describe the different types and the pattern of pain that your patient may have experienced **during the last month** due to his/her Parkinson's disease or related medication.

Each symptom should be scored with respect to

Severity: 0 = None,
1 = Mild (symptoms present but causes little distress or disturbance to patient),
2 = moderate (some distress or disturbance to patient),
3 = Severe (major source of distress or disturbance to patient).

Frequency: 0 = Never,
1 = Rarely (<1/wk),
2 = Often (1/wk),
3 = Frequent (several times per week),
4 = Very Frequent (daily or all the time).

	Severity (0 – 3)	Frequency (0 – 4)	Frequency x Severity
Domain 1: Musculoskeletal Pain			
1. Does the patient experience pain around their joints? (including arthritic pain)	☐	☐	☐
Domain 1 TOTAL SCORE:			☐
Domain 2: Chronic Pain			
2. Does the patient experience pain deep within the body? (A generalised constant, dull, aching pain – *central pain*)	☐	☐	☐
3. Does the patient experience pain related to an internal organ? (For example, pain around the liver, stomach or bowels – visceral pain)	☐	☐	☐
Domain 2 TOTAL SCORE:			☐
Domain 3: Fluctuation-related Pain			
4. Does the patient experience dyskinetic pain? (pain related to abnormal involuntary movements)	☐	☐	☐
5. Does the patient experience "off" period dystonia in a specific region? (in the area of dystonia)	☐	☐	☐
6. Does the patient experience generalised "off" period pain? (pain in whole body or areas distant to dystonia)	☐	☐	☐
Domain 3 TOTAL SCORE:			☐

Version: V1 1 Date: 01.10.2012

KING'S PD PAIN SCALE

	Severity (0 – 3)	Frequency (0 – 4)	Frequency x Severity
Domain 4: Nocturnal Pain			
7. Does the patient experience pain related to jerking leg movements during the night (PLM) or an unpleasant burning sensation in the legs which improves with movement (RLS)?	☐	☐	☐
8. Does the patient experience pain related to difficulty turning in bed at night?	☐	☐	☐
Domain 4 TOTAL SCORE:			☐
Domain 5: Oro-facial Pain			
9. Does the patient experience pain when chewing?	☐	☐	☐
10. Does the patient have pain due to grinding their teeth during the night?	☐	☐	☐
11. Does the patient have burning mouth syndrome?	☐	☐	☐
Domain 5 TOTAL SCORE:			☐
Domain 6: Discolouration; Oedema/swelling			
12. Does the patient experience a burning pain in their limbs? (often associated with swelling or dopaminergic treatment)	☐	☐	☐
13. Does the patient experience generalised lower abdominal pain?	☐	☐	☐
Domain 6 TOTAL SCORE:			☐
Domain 7: Radicular Pain			
14. Does the patient experience a shooting pain/ pins and needles down the limbs?	☐	☐	☐
Domain 7 TOTAL SCORE:			☐
TOTAL SCORE (all domains):			☐

Comments:

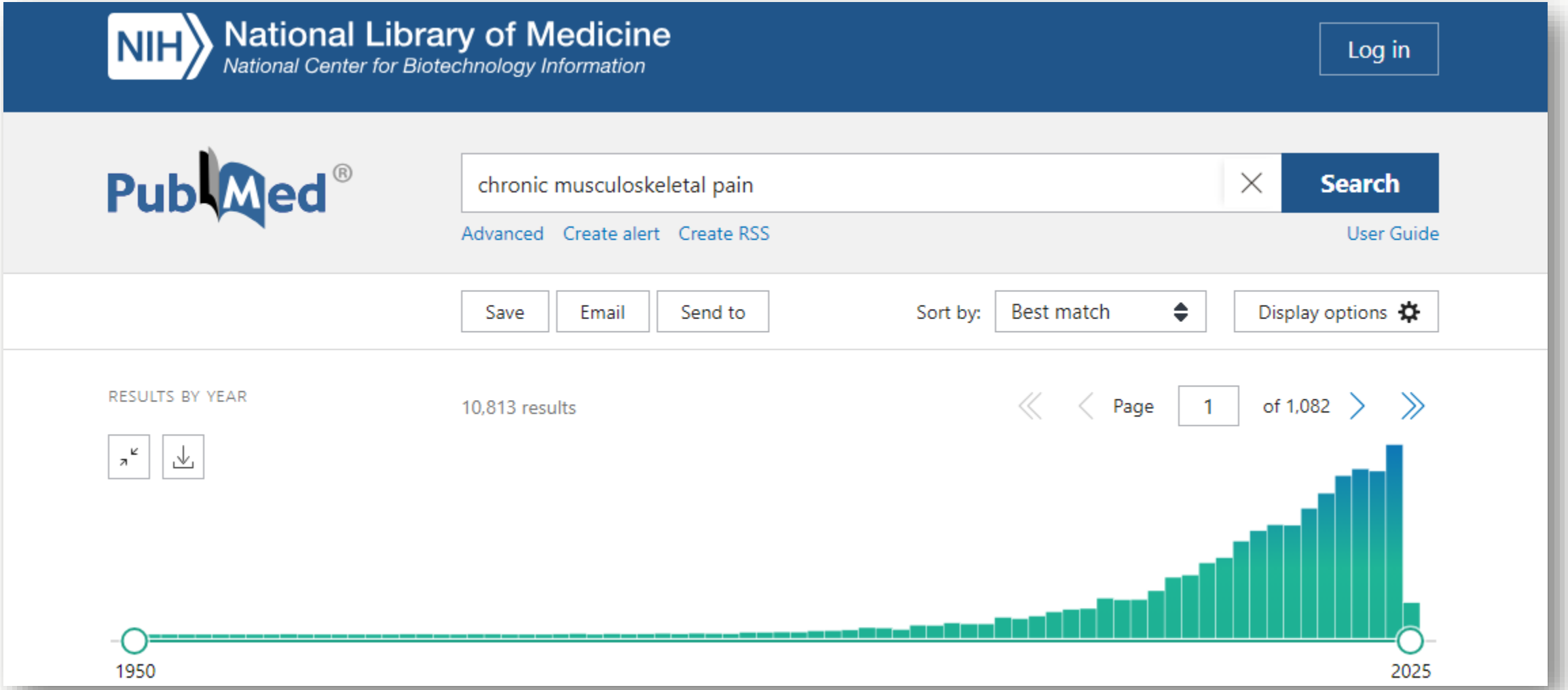
Version: V1 2 Date: 01.10.2012

FIG. 1. The King's Parkinson's Disease Pain Scale (KPPS).

TABLE 5a. Convergent validity of the King's Parkinson's Disease Pain Scale

Domains	VAS Total	NMSS Item 27	PDQ-8 Item 8	PDSS-2 Item 10	PDSS-2 Item 11	PDSS-2 Item 12
1. Musculoskeletal pain	0.45	0.22	0.16	0.24	0.19	0.22
2. Chronic pain	0.34	−0.04*	0.17	0.27	0.25	0.34
3. Fluctuation-related pain	0.24	0.08*	0.41	0.38	0.36	0.39
4. Nocturnal pain	0.32	0.10*	0.36	0.44	0.36	0.47
5. Oro-facial pain	0.21	−0.08*	0.09*	0.22	0.17	0.29
6. Discoloration, edema/swelling	0.24	−0.07*	0.25	0.34	0.38	0.37
7. Radicular pain	0.23	−0.04*	0.26	0.32	0.32	0.37
Total score	0.55	0.21	0.45	0.50	0.47	0.58

*Nonsignificant Spearman rank correlation coefficients. All others, $P < 0.05$ or lower.
VAS, visual analog scale; NMSS, non-motor symptom scale; PDQ-8, Parkinson's disease questionnaire - 8 items; PDSS-2, Parkinson's disease sleep scale—version 2.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RESULTS BY YEAR
10,813 results
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Review > Pain. 2019 Jan;160(1):19-27. doi: 10.1097/j.pain.0000000000001384.

Chronic pain as a symptom or a disease: the IASP Classification of Chronic Pain for the International Classification of Diseases (ICD-11)

Rolf-Detlef Treede [1], Winfried Rief [2], Antonia Barke [2], Qasim Aziz [3], Michael I Bennett [4], Rafael Benoliel [5], Milton Cohen [6], Stefan Evers [7], Nanna B Finnerup [8] [9], Michael B First [10], Maria Adele Giamberardino [11], Stein Kaasa [12] [13] [14], Beatrice Korwisi [2], Eva Kosek [15], Patricia Lavand'homme [16], Michael Nicholas [17], Serge Perrot [18], Joachim Scholz [19], Stephan Schug [20] [21], Blair H Smith [22], Peter Svensson [23] [24], Johan W S Vlaeyen [25] [26] [27], Shuu-Jiun Wang [28] [29]

Affiliations + expand

PMID: 30586067 DOI: 10.1097/j.pain.0000000000001384

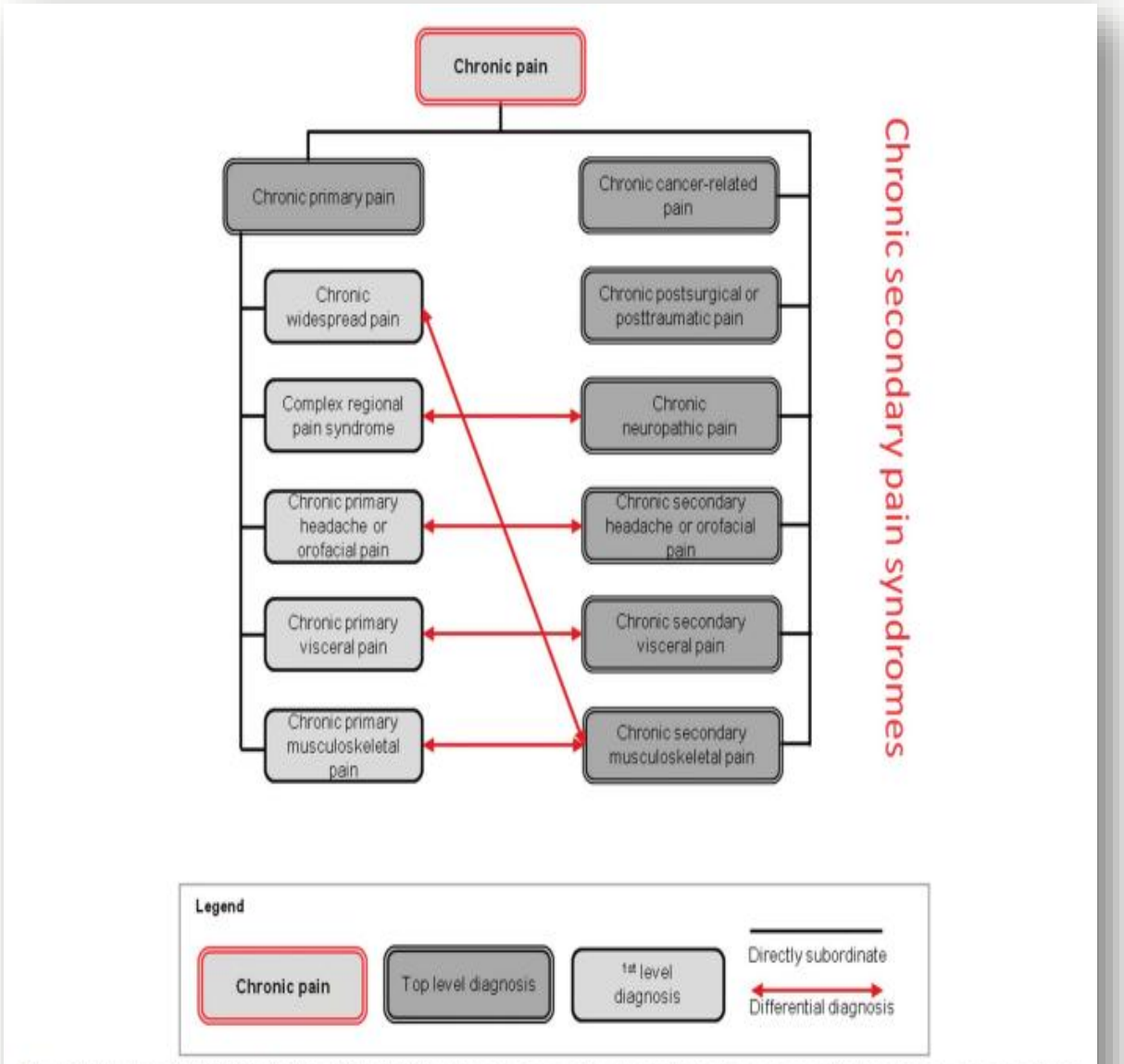


Figure 1. Structure of the IASP Classification of Chronic Pain. In chronic primary pain syndromes (left), pain can be conceived as a disease, whereas in chronic secondary pain syndromes (right), pain initially manifests itself as a symptom of another disease such as breast cancer, a work accident, diabetic neuropathy, chronic caries, inflammatory bowel disease, or rheumatoid arthritis. Differential diagnosis between primary and secondary pain conditions may sometimes be challenging (arrows), but in either case, the patient's pain needs special care when it is moderate or severe. After spontaneous healing or successful management of the underlying disease, chronic pain may sometimes continue and hence the chronic secondary pain diagnoses may remain and continue to guide treatment as well as health care statistics.

R.-D. Treede et al. • 156 (2015) 1003–1007

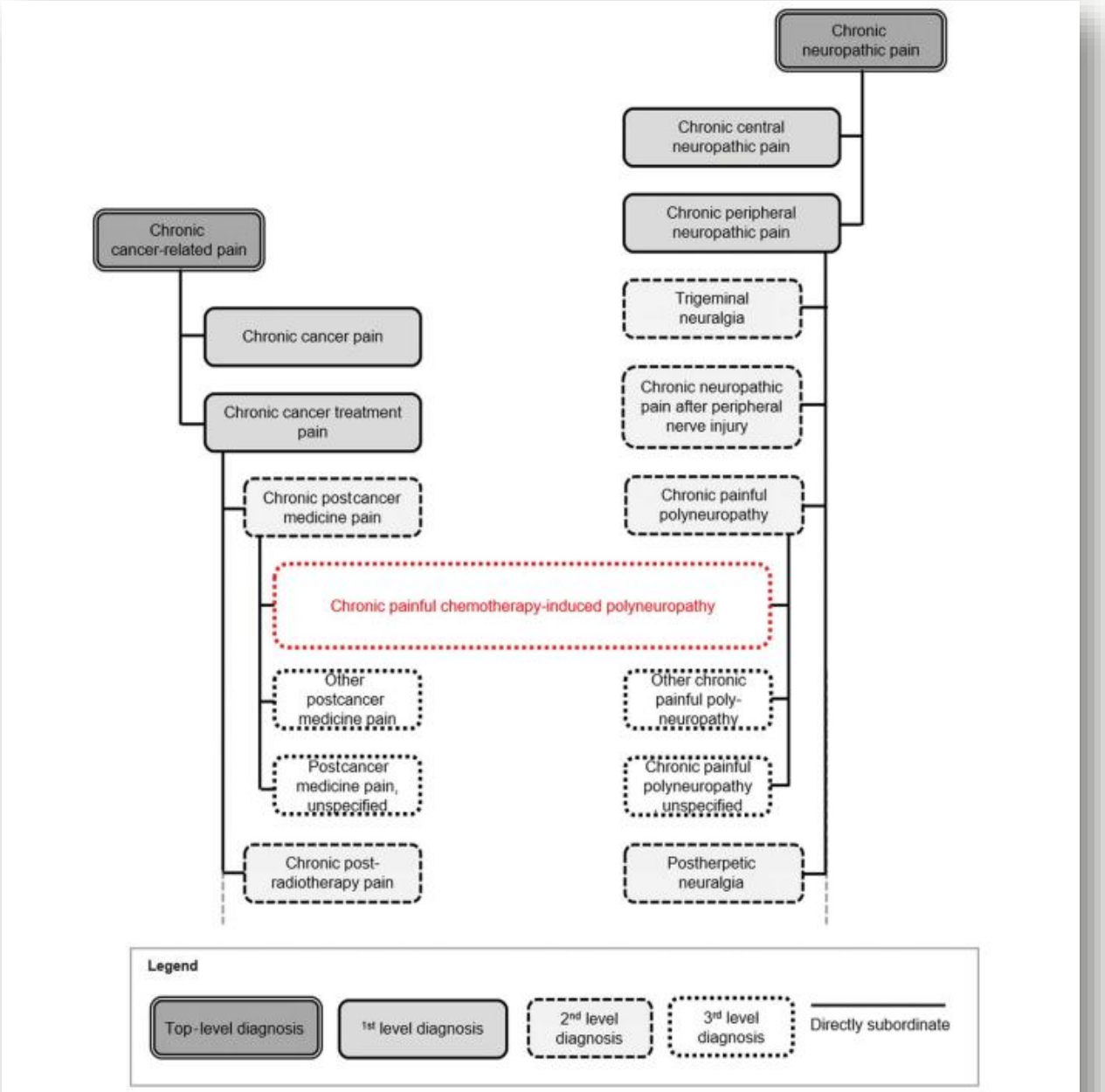


Figure 2. Multiple parenting concept of WHO for *ICD-11*. In contrast to the strictly linear structure of all previous versions of *ICD*, *ICD-11* allows for any given disease ("child") to belong to more than one section ("parent"). This is called "multiple parenting." "Chronic painful chemotherapy-induced polyneuropathy" is illustrated here as one example. *ICD*, *International Classification of Diseases*.

R.-D. Treede et al. • 156 (2015) 1003–1007

Box 1. Specifiers or "extension codes" in ICD-11

Pain severity

Pain intensity may be assessed verbally or on a numerical or visual rating scale. For the severity coding, the patient should be asked to rate the average pain intensity for the last week on an 11-point numerical rating scale (NRS) (ranging from from 0 "no pain" to 10 "worst pain imaginable") or a 100-mm visual analogue scale (VAS):

mild pain	NRS: 1-3; VAS: <31 mm
moderate pain	NRS: 4-6; VAS: 31-54 mm
severe pain	NRS: 7-10; VAS: 55-100 mm

Pain-related distress may be assessed by asking the person to rate the pain-related distress they experienced in the last week (multifactorial unpleasant emotional experience of a cognitive, behavioral, emotional, social, or spiritual nature due to the persistent or recurrent experience of paint) on an 11-point numerical rating scale or a VAS from "no pain-related distress" to "extreme pain-related distress" ("distress thermometer").

mild distress	NRS: 1-3; VAS: <31 mm
moderate distress	NRS: 4-6; VAS: 31-54 mm
severe distress	NRS: 7-10; VAS: 55-100 mm

Pain-related interference last week as rated by the patient on an 11-point NRS (from 0 "no interference" to 10 "unable to carry on activities") or VAS (0 mm "no interference" to 100 mm "unable to carry on activities").

Code 0	no interference
Code 1	mild interference; NRS: 1-3; VAS: <31 mm
Code 2	moderate interference; NRS: 4-6; VAS: 31-54 mm
Code 3	severe interference; NRS: 7-10; VAS: 55-100 mm

Overall severity combines the ratings of intensity, distress, and disability using a 3-digit code: Example: A patient with a moderate pain intensity, severe distress, and mild disability will receive the code "231." The severity code is optional.

Temporal characteristics of the pain

The temporal course of the pain can be coded as "continuous" (the pain is always present), "episodic recurrent" (there are recurrent pain attacks with pain-free intervals) and "continuous with pain attacks" (there are recurrent pain attacks as exacerbations of underlying continuous pain).

Presence of psychosocial factors

This extension code permits coding problematic cognitive (eg, catastrophizing, excessive worry), emotional (eg, fear, anger), behavioral (eg, avoidance) and/or social factors (eg, work, relationships) that accompany the chronic pain. The extension code is appropriate if there is positive evidence that psychosocial factors contribute to the cause, the maintenance and/or the exacerbation of the pain and/or associated disability and/or when the chronic pain results in negative psychobehavioral consequences (eg, demoralisation, hopelessness, avoidance, withdrawal).

R.-D. Treede et al. • 156 (2015) 1003–1007

Pain. 2021 Nov 1;162(11):2629-2634. doi: 10.1097/j.pain.0000000000002324.

Chronic nociplastic pain affecting the musculoskeletal system: clinical criteria and grading system

Eva Kosek [1] [2], Daniel Clauw [3], Jo Nijs [4] [5] [6], Ralf Baron [7], Ian Gilron [8], Richard E Harris [3], Juan-Antonio Mico [9], Andrew S C Rice [10], Michele Sterling [11]

Affiliations + expand

PMID: 33974577 DOI: 10.1097/j.pain.0000000000002324

Table 2

Clinical criteria and grading for nociplastic pain affecting the musculoskeletal system.

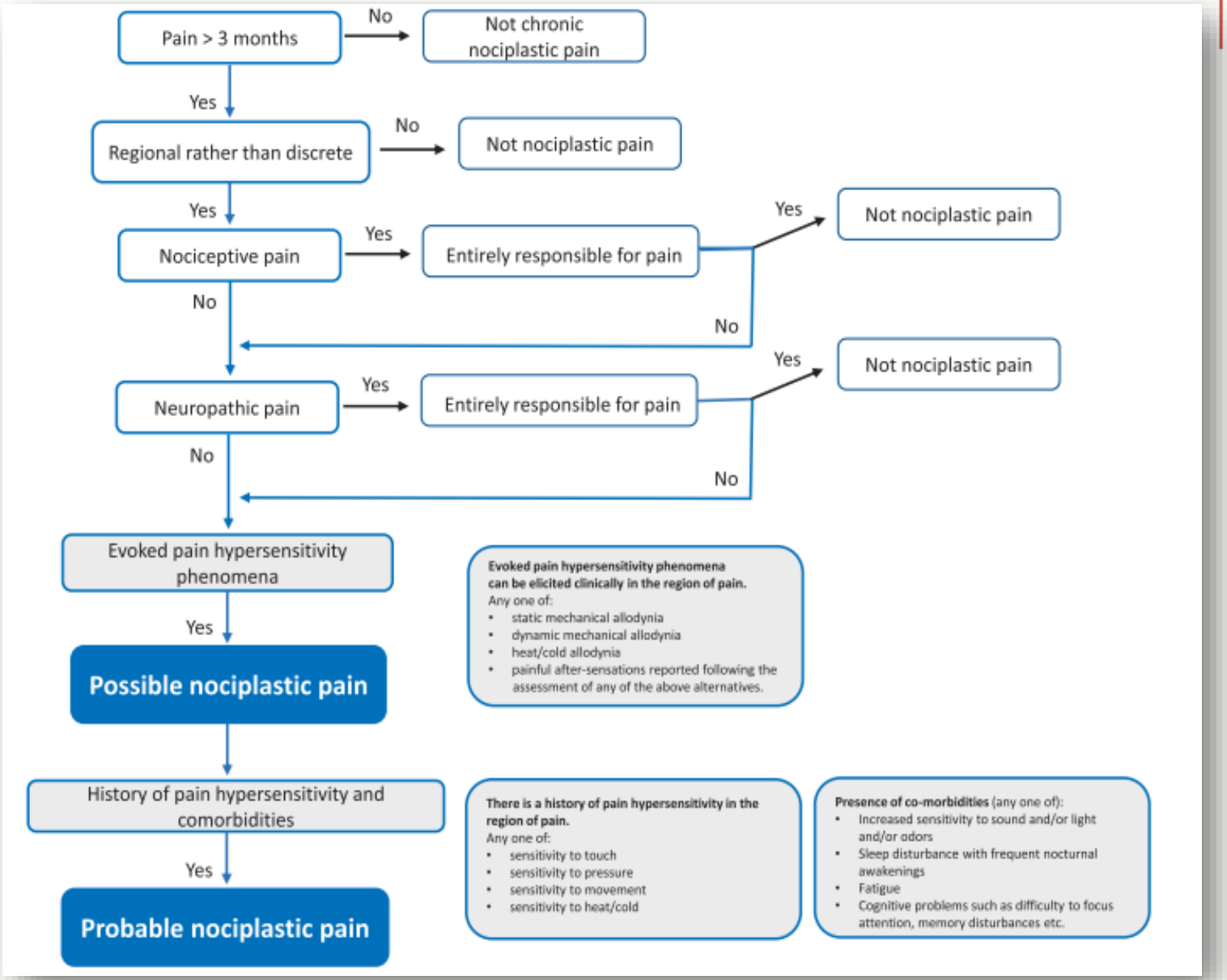
1. The pain is 1a. Chronic (>3 mo); 1b. Regional (rather than discrete) in distribution*; 1c. There is no evidence that nociceptive pain (a) is present or (b) if present, is entirely responsible for the pain; and 1d. There is no evidence that neuropathic pain (a) is present or (b) if present, is entirely responsible for the pain.†
2. There is a history of pain hypersensitivity in the region of pain. Any one of the following: Sensitivity to touch Sensitivity to pressure Sensitivity to movement Sensitivity to heat or cold
3. Presence of comorbidities: Any one of the following: Increased sensitivity to sound and/or light and/or odors Sleep disturbance with frequent nocturnal awakenings Fatigue Cognitive problems such as difficulty to focus attention, memory disturbances, etc.
4. Evoked pain hypersensitivity phenomena can be elicited clinically in the region of pain. Any one of the following: Static mechanical allodynia Dynamic mechanical allodynia Heat or cold allodynia Painful after-sensations reported following the assessment of any of the above alternatives.
Possible nociplastic pain: 1 and 4.
Probable nociplastic pain: all the above (1, 2, 3, and 4)‡

* Musculoskeletal pain is deep, rather than cutaneous and regional, multifocal, or widespread in distribution (rather than discrete). In case of multifocal pain states that can be caused by different chronic pain conditions (eg, shoulder myalgia and knee osteoarthritis), each chronic pain condition or pain region must be assessed separately.

† The presence of a source of nociceptive pain, such as osteoarthritis, or of neuropathic pain, such as a peripheral nerve lesion, does not exclude the concurrence of nociplastic pain, but the region of pain must be more widespread than that which can be explained by the identifiable pathology.

‡ The purpose of the grading system is to indicate the level of certainty that a patient has nociplastic pain and, as mentioned above, was inspired by the current grading system for neuropathic pain.[7] However, because of the lack of clinically useful, reliable diagnostic tests to confirm the presence of altered nociception, currently nociplastic pain is graded as possible or probable but not definite. If future diagnostic tests are developed and validated, the introduction of the term "definite nociplastic pain" should be considered.

Kosek E et al.
162(2021):2629:2634



Kosek E et al.
162(2021):2629:2634

Global estimates of the need for rehabilitation based on the Global Burden of Disease study 2019: a systematic analysis for the Global Burden of Disease Study 2019

Alarcos Cieza, Kate Causey, Kaloyan Kamenov, Sarah Wulf Hanson, Somnath Chatterji, Theo Vos

	Prevalence				Years of life lived with disability				Average disability weight
	All age (millions)		Age-standardised rate (per 1000)		All age (millions)		Age-standardised rate (per 1000)		
	2019	Percentage change*	2019	Percentage change*	2019	Percentage change*	2019	Percentage change*	2019
Overall total	**2412·0 (2338·0 to 2501·0)**	**63% (61 to 64)†**	**298·0 (289·0 to 309·0)**	**–5·6% (–6·1 to –5·1)†**	**310·0 (235·0 to 392·0)**	**69% (67 to 72)†**	**38·0 (29·0 to 49·0)**	**–5% (–6 to –3·9)†**	**0·13 (0·10 to 0·16)**
Musculoskeletal disorders									
Musculoskeletal disorders (total)	**1714·0 (1632·0 to 1800·0)**	**62% (60 to 64)†**	**210·0 (200·0 to 221·0)**	**–8·8% (–10 to –8·2)†**	**149·0 (108·0 to 199·0)**	**59% (55 to 64)†**	**18·0 (13·0 to 24·0)**	**–11% (–13 to –10)†**	**0·08 (0·06 to 0·11)**
Low back pain	568·0 (505·0 to 641·0)	47% (44 to 51)†	70·0 (62·0 to 79·0)	–16% (–17 to –16)†	64·0 (45·0 to 85·0)	47% (43 to 51)†	7·8 (5·5 to 10·0)	–16% (–17 to –16)†	0·11 (0·08 to 0·15)
Neck pain	223·0 (179·0 to 281·0)	79% (70 to 87)†	27·0 (22·0 to 34·0)	–0·45 % (–2·6 to 1·7)	22·0 (15·0 to 32·0)	78% (69 to 87)†	2·7 (1·8 to 3·8)	–0·31% (–2·5 to 1·8)	0·10 (0·07 to 0·14)
Fractures	436·0 (411·0 to 465·0)	69% (67 to 71)†	54·0 (51·0 to 57·0)	–6·9% (–7·8 to –6·0)†	26·0 (18·0 to 36·0)	66% (63 to 68)†	3·2 (2·2 to 4·4)	–8·3% (9·5 to –7·2)†	0·06 (0·04 to 0·08)
Other injuries	305·0 (282·0 to 336·0)	43% (40 to 46)†	38·0 (35·0 to 41·0)	–17% (–18 to –15)†	11·0 (7·5 to 15·0)	25% (19 to 31)†	1·3 (0·9 to 1·8)	–24% (–27 to –21)†	0·03 (0·02 to 0·05)
Osteoarthritis	344·0 (275·0 to 414·0)	114% (112 to 117)†	41·0 (33·0 to 50·0)	3·1 % (1·8 to 4·2)†	19·0 (10·0 to 38·0)	115% (112 to 117)†	2·3 (1·2 to 4·5)	3·3% (2 to 4·6)†	0·05 (0·03 to 0·1)
Amputation	176·0 (164·0 to 190·0)	52% (50 to 55)†	22·0 (20·0 to 23·0)	–13% (–14 to –12)†	5·5 (3·8 to 7·7)	36% (29 to 44)†	0·7 (0·5to 1·0)	–23% (–27 to –18)†	0·03 (0·02 to 0·04)
Rheumatoid arthritis	13·0 (12·0 to 15·0)	106% (104 to 109)†	1·6 (1·5 to 1·8)	8·1% (7·5 to 8·6)†	2·4 (1·7 to 3·3)	105% (102 to 108)†	0·3 (0·2 to 0·4)	8·3% (7·3 to 9·3)†	0·18 (0·13 to 0·24)
Neurological disorders									

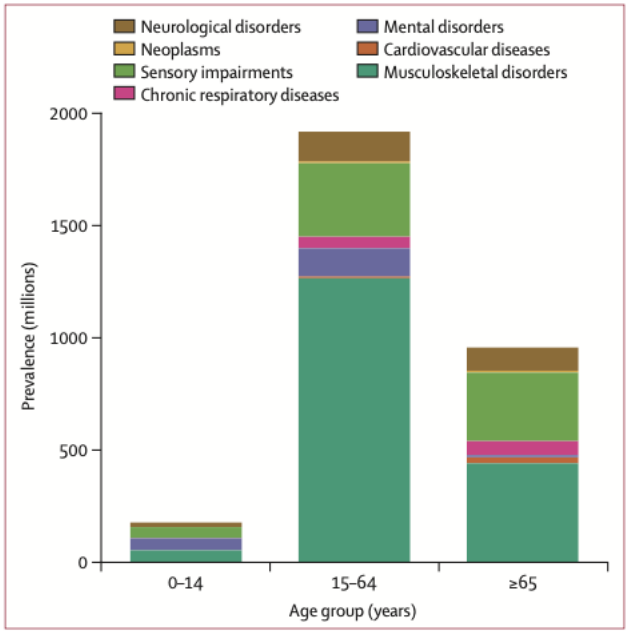


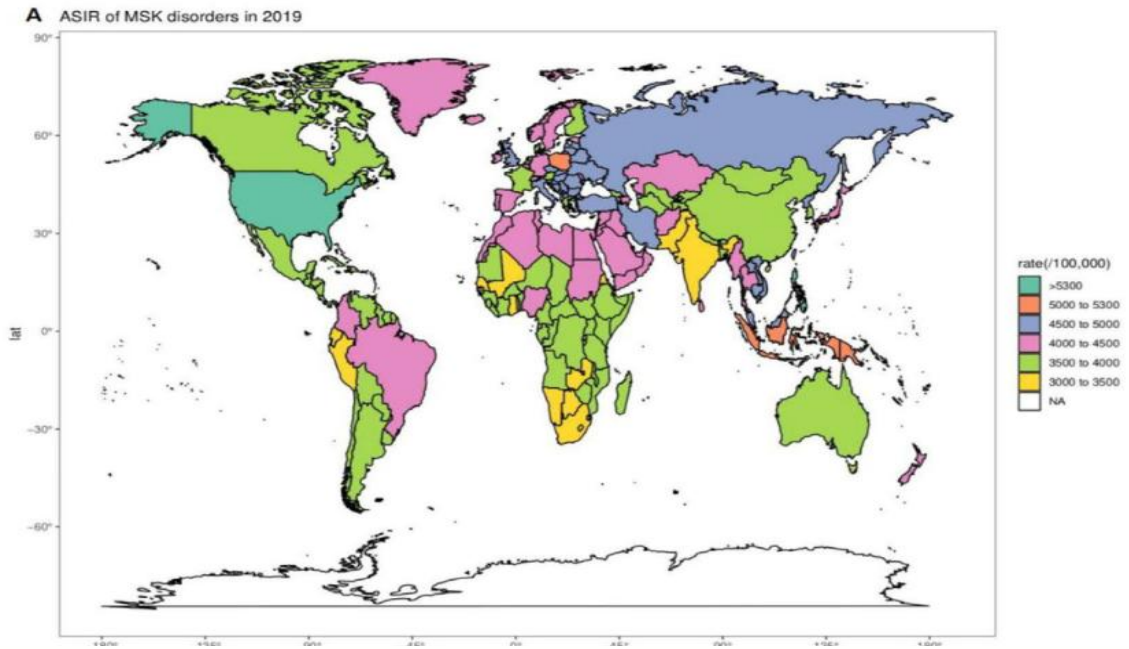
Figure 2: **Disease categories of prevalent conditions that would benefit from rehabilitation globally, by three age groups, 2019**

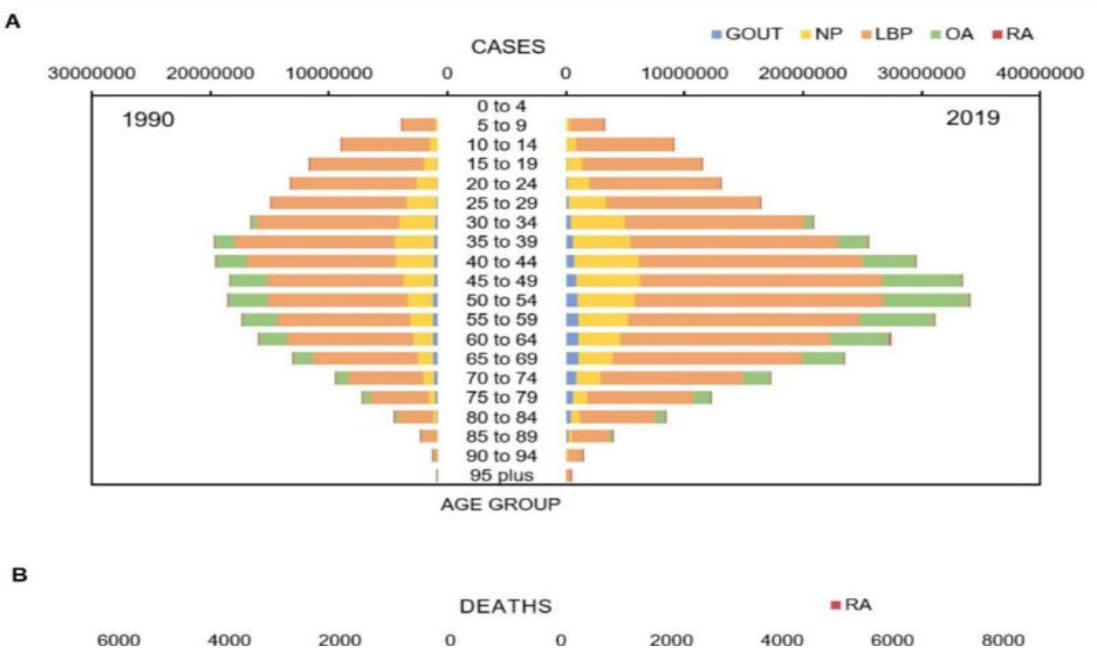
Open access Original research

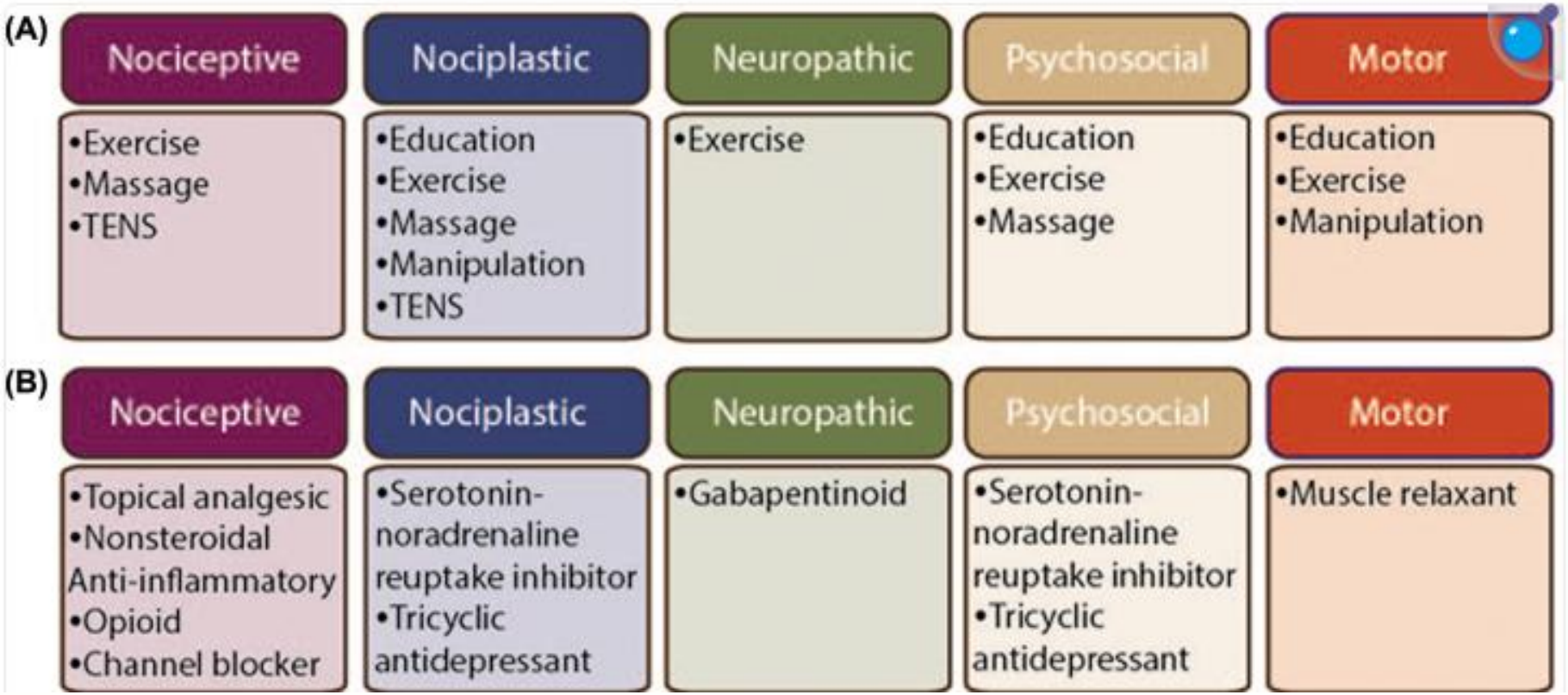
BMJ Open

Global burden of musculoskeletal disorders and attributable factors in 204 countries and territories: a secondary analysis of the Global Burden of Disease 2019 study

Shiwen Liu, Binyan Wang, Shuzhen Fan, Yaxuan Wang, Yuxuan Zhan, Ding Ye







Chimenti RL et al. 1;98(2018):302-314

DOI: 10.1002/msc.1191

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CLINICAL UPDATE

Exercise for chronic musculoskeletal pain: A biopsychosocial approach

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Abstract

Chronic musculoskeletal pain (CMP) refers to ongoing pain felt in the bones, joints and tissues of the body that persists longer than 3 months. For these conditions, it is widely accepted that secondary pathologies or the consequences of persistent pain, including fear of movement, pain catastrophizing, anxiety and nervous system sensitization appear to be the main contributors to pain and disability. While exercise is a primary treatment modality for CMP, the intent is often to improve physical function with less attention to secondary pathologies. Exercise interventions for CMP which address secondary pathologies align with contemporary pain rehabilitation practices and have greater potential to improve patient outcomes above exercise alone. Biopsychosocial treatment which acknowledges and addresses the biological, psychological and social contributions to pain and disability is currently seen as the most efficacious approach to chronic pain. This clinical update discusses key aspects of a biopsychosocial approach concerning exercise prescription for CMP and considers both patient needs and clinician competencies. There is consensus for individualized, supervised exercise based on patient presentation, goals and preference that is perceived as safe and non-threatening to avoid fostering unhelpful associations between physical activity and pain. The weight of evidence supporting exercise for CMP has been provided by aerobic and resistance exercise studies, although there is considerable uncertainty on how to best apply the findings to exercise prescription. In this clinical update, we also provide evidence-based guidance on exercise prescription for CMP through a synthesis of published work within the field of exercise and CMP rehabilitation.

KEYWORDS

biopsychosocial, chronic pain, exercise, musculoskeletal pain

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CHRONIC PAIN: WHERE THE BODY MEETS THE BRAIN

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