Disorders of the musculoskeletal system are the leading causes of disability in
western societies. Musculoskeletal pain syndromes can be divided into two broad
categories: (1) myalgias, which include the major condition of myofascial pain
syndromes, as well as inflammatory and other myosites, and (2) articular disorders,
which include all of the arthritides. Fibromyalgia has long been considered a
chronic musculoskeletal pain syndrome, but recent research supports categorizing
fibromyalgia as a widespread chronic pain syndrome. Ergonomic and postural and
other structural dysfunctions, including pain associated with the hypermobility
syndromes, can bridge these two categories, although they tend to fall more into
the myalgic group of disorders.

A problem for the practitioner trying to understand a patient’s pain is that pain is
a subjective sensation that is colored by the patient’s personal life experience, and
ethnic and cultural background. Chronic pain is not simply a sensation, but a global
experience that involves suffering and a distortion of the patient’s role in all phases
of life, including family, work and social relationships, and can change the patient’s
self perception of him- or herself from being an independent, effective human
being, to being a dependent, ineffective person. Communication is particularly
difficult with chronic pain patients, because chronic pain is such a personal experi-
ence of global suffering, rather than a simple sensation like touch. There is a
definite effect of gender on pain perception. Therefore, when examining muscles
in patients for painful conditions, the greater sensitivity of women to painful stimuli
has to be taken into account.

Pain from muscle and skin is subjectively and objectively distinct. Muscle pain
is described as aching and cramping, diffuse and poorly localized, whereas cutane-
ous pain is described as sharp and pricking, and precisely localized. Cutaneous pain
is usually not referred to other body regions, while muscle pain is commonly
referred to other deep somatic structures like tendons and fascia or other muscles,
and viscera (viscerosomatic pain syndromes). Objective differences between
muscle and cutaneous pain exist in the processing of neuronal information at the
spinal and brainstem level and continue up to the brain, where nociceptive activity from skin and muscle terminates in different regions. Some of the established pain terms used in this book are defined in chapter 1 of the volume “Muscle Pain: Understanding the Mechanisms”.

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