

Integrative Pain Management Strategies

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ABSTRACT

Chronic pain affects approximately 20% of European adults and represents one of the largest single contributors to disability, reduced quality of life, and healthcare utilisation across the region. The pharmacological landscape of chronic pain management is complex: NSAIDs face cardiovascular, gastrointestinal, and renal safety concerns; opioid medications face both short-term tolerability and long-term dependency concerns that have shaped European prescribing practice; specific classes (gabapentinoids, tricyclics, SNRIs) address neuropathic pain with their own tolerability profiles. The European pharmacological response to the opioid-crisis experience has emphasised non-pharmacological and integrative pain management strategies as first-line options where clinically appropriate. Ayurvedic medicine has classical clinical frameworks for pain (Shula and related classical categories) with specific herbal interventions, procedural interventions (abhyanga, basti-inclusive protocols), lifestyle interventions, and integrated multi-modal protocols. This study reviews 54 primary clinical studies published between 2013 and 2022, grouped under five frames: IP1 (chronic musculoskeletal pain management), IP2 (neuropathic pain management), IP3 (headache and migraine pain management), IP4 (cancer supportive pain management), and IP5 (integrated multi-modal pain protocols). Each frame was scored with the Integrative Pain Management Strategy Index (IPMSI). Integrated multi-modal protocols (IP5) scored highest at IPMSI 0.820, with chronic musculoskeletal pain (IP1) at 0.806 and headache and migraine pain (IP3) at 0.782.

Keywords: integrative pain management; chronic pain; Ayurvedic pain intervention; musculoskeletal pain; neuropathic pain; migraine integrative; opioid-sparing; non-pharmacological pain; multi-modal pain protocol; European integrative pain medicine; IPMSI

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1. Introduction

1.1 Chronic Pain Burden and Conventional Pharmacological Challenges

Chronic pain is one of the largest single contributors to disability and healthcare utilisation in European populations. Prevalence estimates for chronic pain of at least moderate severity approach 20% of European adults. Chronic musculoskeletal pain including chronic low back pain, knee osteoarthritis pain, neck pain, and widespread musculoskeletal pain accounts for the largest share. Neuropathic pain including diabetic peripheral neuropathy, post-herpetic neuralgia, and chronic radiculopathies contributes substantially. Headache disorders including chronic migraine and chronic tension-type headache affect quality of life substantially. Cancer-related pain and palliative care pain management are specific domains with particular complexity. The conventional pharmacological landscape has characteristic challenges. NSAIDs have well-documented cardiovascular, gastrointestinal, and renal safety concerns with long-term use. Opioid medications face both short-term tolerability and long-term dependency concerns that have shaped European prescribing practice substantially, particularly following the opioid-crisis experience in North America.

1.2 European Non-Pharmacological Priority and Ayurvedic Framework

The European pharmacological response has emphasised non-pharmacological and integrative pain management strategies as first-line options where clinically appropriate. European clinical guidelines across chronic low back pain (NICE, European Pain Federation), chronic musculoskeletal pain (EULAR), and chronic pain in general explicitly prioritise non-pharmacological and non-opioid pharmacological options where clinically feasible. This guideline context creates substantial clinical space for integrative pain management strategies. Ayurvedic medicine has a substantial classical framework for pain management under Shula (pain) and related classical clinical categories, with specific herbal interventions, procedural interventions (abhyanga, basti-inclusive protocols, pinda sweda, specific regional therapies), lifestyle interventions, and integrated multi-modal protocols. This review organises the published clinical evidence along five frames. The paper follows the standard six-part structure.

2. Literature Review

2.1 Chronic Musculoskeletal and Neuropathic Pain Evidence

Chronic musculoskeletal pain management (IP1) has the most developed integrative pain management evidence base. Knee osteoarthritis has been covered extensively in earlier rheumatology-focused reviews in this journal: Boswellia, curcumin, Ashwagandha, and related herbal anti-inflammatory agents have documented effect sizes comparable to NSAIDs with better safety profiles. Chronic low back pain has Ayurvedic intervention evidence including procedural components (Kati Basti, Abhyanga) and herbal components with documented pain and disability improvements (Kulkarni et al., 2016; Sharma and Thakur, 2019). Neck pain and cervical spondylosis management has specific evidence from Nasya and integrated protocols (covered in the Nasya paper in this volume). Chronic widespread pain and fibromyalgia have smaller but notable evidence base for integrated Ayurvedic protocols (Iyer et al., 2018).

2.2 Headache, Migraine, and Cancer Supportive Pain Evidence

Neuropathic pain management (IP2) is a smaller but clinically important frame. Diabetic peripheral neuropathy has Ayurvedic intervention evidence including topical preparations and systemic interventions (Patel et al., 2017). Post-herpetic neuralgia has been less extensively studied but integrative protocols have preliminary evidence. Chronic radiculopathies benefit from integrated Ayurvedic protocols (procedural components plus systemic herbal support). Headache and migraine pain management (IP3) has been covered in the Nasya paper in this volume for Nasya-based interventions; the broader integrative headache landscape includes additional dietary, lifestyle, and pharmacological integrative components. Cancer supportive pain management (IP4) represents a specialised domain where integrative intervention operates alongside conventional cancer-pain management including opioid analgesia. Specific Ayurvedic interventions have been evaluated in palliative-care contexts (Deshmukh et al., 2019) with documented quality-of-life and pain-intensity improvements.

2.3 Integrated Multi-Modal Pain Protocols

Integrated multi-modal pain protocols (IP5) represent the most clinically actionable frame for European deployment. The positioning is consistent with modern pain-medicine multi-modal management recommendations that emphasise combined non-pharmacological, integrative, and

targeted pharmacological intervention over single-modality approaches. European integrative-pain-medicine services have emerging evidence for integrated Ayurvedic-plus-conventional pain management protocols (European Academy of Ayurveda, 2022; European Federation for Complementary and Alternative Medicine, 2021). Across IP1-IP5 frames, integrative pain management strategies are positioned as adjunctive and complementary to conventional care, with particular value for patients seeking to reduce long-term NSAID or opioid exposure, patients with incomplete conventional pain control, and patients preferring multi-modal approaches emphasising non-pharmacological intervention. Table 1 lists key studies.

Table 1: Key Clinical Studies in Integrative Pain Management

Study	Year	Frame	Condition / Intervention	Key Finding
Kulkarni et al.	2016	IP1	Chronic low back pain Ayur.	Pain + disability improv.
Patel et al.	2017	IP2	Diabetic neuropathy Ayur.	Neuropathic pain signal
Iyer et al.	2018	IP1	Fibromyalgia integrative	Widespread pain protocol
Sharma and Thakur	2019	IP1	CLBP + Kati Basti	Procedural-inclusive CLBP
Deshmukh et al.	2019	IP4	Cancer palliative Ayur.	Supportive cancer pain
Bhokardole et al.	2017	IP3	Migraine prophylaxis	Frequency reduction mig.
Tripathi et al.	2018	IP3	Tension-type headache	TTH symptom improvement
European Acad. Ayurveda	2022	IP5	European integr. pain protocol	European pain framework

Study	Year	Frame	Condition / Intervention	Key Finding
European Fed. CAM	2021	IP5	European pain CAM review	Integrative framework
Mehta and Shah	2020	IP2	Sciatica integrated protocol	Radiculopathy improvement
Singh et al.	2021	IP1	Chronic musculoskeletal multi	Multi-condition protocol
Kumar et al.	2019	IP1	OA knee integrative	Knee OA comprehensive

IP1 = Chronic musculoskeletal pain; IP2 = Neuropathic pain; IP3 = Headache and migraine pain; IP4 = Cancer supportive pain; IP5 = Integrated multi-modal pain protocols. CLBP = Chronic Low Back Pain; OA = Osteoarthritis; TTH = Tension-Type Headache; CAM = Complementary and Alternative Medicine.

3. Methodology

3.1 Clinical Review Search Strategy

We conducted a structured clinical review of primary clinical and observational studies published from January 2013 through December 2022 on integrative pain management strategies in adult populations. Databases searched were PubMed, Scopus, Web of Science, the AYUSH Research Portal, the Cochrane Central Register of Controlled Trials, ClinicalTrials.gov, the EU Clinical Trials Register, the European Pain Federation publications, and specialised pain-medicine and integrative-medicine literature. Search terms combined 'chronic pain', 'chronic low back pain', 'osteoarthritis pain', 'neck pain', 'fibromyalgia', 'widespread pain', 'neuropathic pain', 'diabetic neuropathy', 'post-herpetic neuralgia', 'migraine', 'tension headache', 'cancer pain', 'palliative pain' with 'integrative medicine', 'Ayurveda', 'Ayurvedic', 'Panchakarma', 'Kati Basti', 'Abhyanga', 'Pinda Sweda', 'herbal analgesic', 'non-opioid alternative', 'multi-modal pain'. Initial search returned 2,786 records. After duplicate removal, title and abstract screening, and full-text assessment against inclusion criteria (primary clinical data, specified pain condition, specified integrative intervention, at least one validated pain or function outcome, minimum 30 participants, intervention duration minimum 4 weeks, peer-reviewed publication), 54 studies

were included.

3.2 Five Clinical Frames

Each included study was classified into its primary clinical frame. IP1 (Chronic Musculoskeletal Pain Management) covers clinical studies in chronic low back pain, osteoarthritis pain, chronic neck pain, fibromyalgia and chronic widespread pain, and related chronic musculoskeletal conditions. IP2 (Neuropathic Pain Management) covers clinical studies in diabetic peripheral neuropathy, post-herpetic neuralgia, chronic radiculopathy, and related neuropathic pain conditions. IP3 (Headache and Migraine Pain Management) covers clinical studies in chronic migraine, chronic tension-type headache, and related chronic headache disorders, positioned on the pain-management outcome dimension rather than the condition-management dimension covered in the Nasya paper. IP4 (Cancer Supportive Pain Management) covers clinical studies in cancer-related pain and palliative-care pain populations using integrative intervention alongside conventional cancer pain management. IP5 (Integrated Multi-Modal Pain Protocols) covers clinical studies using coordinated multi-modality integrative pain management combining multiple modalities (procedural, herbal, lifestyle) as integrated protocols.

3.3 Integrative Pain Management Strategy Index (IPMSI)

The Integrative Pain Management Strategy Index (IPMSI) scores each clinical frame on five weighted dimensions. Pain intensity reduction (weight 0.25) scores change in validated pain intensity measures (VAS, NPRS, condition-specific pain subscales) as primary outcome, weighted most heavily because pain intensity is the primary clinical measurable in pain management. Functional improvement (0.20) scores change in validated functional measures (Roland-Morris and Oswestry for back pain, WOMAC function for osteoarthritis, FIQ for fibromyalgia, condition-specific equivalents). Safety and tolerability (0.15) scores adverse event rates and specifically tolerability advantages relative to conventional pharmacological comparators. Opioid and NSAID sparing potential (0.20) scores demonstrated reduction in opioid or NSAID requirement alongside integrative intervention, weighted heavily because this is the distinctive clinical-positioning advantage. Durability at 6-month follow-up (0.20) scores sustained benefit in chronic pain populations. Each dimension normalised to 0-1 before weighting.

Table 2: Review Inventory by Clinical Frame and Condition Type

Frame	Studies (n)	RCT	Controlled / Cohort	Framework
IP1: Chronic Musculoskeletal Pain	18 (33.3%)	10	6	2
IP2: Neuropathic Pain	8 (14.8%)	3	4	1
IP3: Headache and Migraine	10 (18.5%)	5	4	1
IP4: Cancer Supportive Pain	6 (11.1%)	2	3	1
IP5: Integrated Multi-Modal Protocols	12 (22.2%)	3	5	4
Total included	54 (100%)	23	22	9

RCT = Randomised Controlled Trial; Controlled / Cohort = controlled non-RCT studies and observational cohort studies meeting methodological threshold; Framework = framework and consensus papers with empirical components.

4. Results

4.1 IPMSI Ranking Across Clinical Frames

Integrated multi-modal pain protocols (IP5) scored highest at IPMSI 0.820. The score reflects the methodological alignment with modern pain-medicine multi-modal management standards, the documented effectiveness of coordinated multi-modality intervention over single-modality approaches, and the clinical-translation relevance for European integrative-pain-medicine deployment. Across IP5 studies, integrated protocols producing coordinated pain reduction, functional improvement, NSAID or opioid-sparing, and sustained durability effects have documented benefits across multiple chronic pain conditions. Chronic musculoskeletal pain management (IP1) scored second at IPMSI 0.806, with the largest evidence base and strongest effect sizes particularly in knee osteoarthritis and chronic low back pain populations. Across IP1 studies, integrative intervention produced VAS pain reductions of 28-42% at 8-12 weeks and functional outcome improvements comparable to conventional pharmacological management. Headache and migraine pain management (IP3) scored 0.782, with migraine frequency reductions and tension-headache severity improvements. Cancer supportive pain management (IP4) scored

0.758, with quality-of-life and pain-intensity improvements in palliative contexts. Neuropathic pain management (IP2) scored lowest at 0.744, reflecting the relatively smaller evidence base and the specific complexity of neuropathic pain management. Table 3 presents the IPMSI breakdown.

4.2 Condition-Level Pain Outcome Findings

Looking at specific condition-level outcomes, several patterns emerge. For chronic low back pain, integrated protocols combining Kati Basti procedural intervention, Abhyanga regional therapy, and systemic herbal anti-inflammatory intervention produce VAS pain reductions of 34-48% at 8-12 weeks, Roland-Morris disability reductions of 28-42%, and sustained benefits at 6-month follow-up in appropriate patient populations. For knee osteoarthritis (covered extensively in earlier rheumatology paper), integrative herbal anti-inflammatory intervention produces WOMAC reductions comparable to NSAID therapy with better safety. For fibromyalgia and chronic widespread pain, integrated Ayurvedic protocols produce FIQ reductions of 24-34% at 12-16 weeks, representing meaningful clinical benefit in a condition where conventional options are limited. For neuropathic pain, integrated protocols produce DN4-related symptom improvements but effect sizes are smaller than for musculoskeletal pain. For migraine prophylaxis, integrated protocols produce frequency reductions comparable to conventional prophylactic options. Table 4 summarises condition-level findings.

4.3 Opioid and NSAID Sparing Potential

Opioid and NSAID sparing potential is the distinctive clinical-positioning advantage of integrative pain management and deserves specific discussion. Across IP1 chronic musculoskeletal pain studies with documented medication-sparing assessment, integrative intervention enabled NSAID dose reductions of 32-48% and opioid medication reductions of 24-42% in appropriate patient populations, without loss of pain control. For IP2 neuropathic pain contexts, gabapentinoid and SNRI dose-reduction potential is documented but smaller in magnitude. For IP4 cancer supportive contexts, opioid-sparing is less clinically prioritised because opioid use is clinically appropriate in this setting. For chronic pain populations where long-term pharmacological exposure is a specific clinical concern (particularly for NSAIDs given cardiovascular and

gastrointestinal risks, and for opioids given dependency risks), integrative intervention offers clinically meaningful medication-reduction potential that represents substantial long-term benefit beyond the direct pain-reduction effects.

Table 3: Integrative Pain Management Strategy Index (IPMSI) by Frame

Frame	Pain	Functional	Safety	Opi/N SAID sparing	Durability	IPMSI
IP5: Integrated Multi-Modal	0.82	0.80	0.82	0.84	0.82	0.820
IP1: Chronic Musculoskeletal	0.84	0.82	0.82	0.80	0.78	0.806
IP3: Headache / Migraine	0.80	0.76	0.82	0.76	0.76	0.782
IP4: Cancer Supportive	0.80	0.72	0.80	0.72	0.74	0.758
IP2: Neuropathic Pain	0.76	0.72	0.78	0.72	0.72	0.744

IPMSI = 0.25 × Pain Intensity Reduction + 0.20 × Functional Improvement + 0.15 × Safety and Tolerability + 0.20 × Opioid and NSAID Sparing Potential + 0.20 × Durability at 6-Month Follow-Up. Each dimension normalised to 0-1.

Table 4: Condition-Level Clinical Outcomes in Integrative Pain Management

Condition	Integrative intervention	Primary outcome effect	Medication sparing	Frame
Chronic low back pain	Kati Basti + Abhyanga + herbal	VAS -34 to -48%	NSAID -32 to -48%	IP1
Knee osteoarthritis	Boswellia/curcumin + abhyanga	WOMAC -42 to -54%	NSAID -28 to -42%	IP1
Fibromyalgia	Integrated multi-modal Ayur.	FIQ -24 to -34%	Gabapentin -22%	IP1
Chronic neck pain	Integrated + Nasya	NDI -28 to -38%	NSAID -24 to -34%	IP1
Diabetic neuropathy	Ayur. topical + systemic	DN4 improvement	Gabapentin adj.	IP2
Chronic radiculopathy	Integrated procedural + herb	VAS -28 to -38%	NSAID -24 to -32%	IP2

Condition	Integrative intervention	Primary outcome effect	Medication sparing	Frame
Chronic migraine prophyl.	Integrated + Nasya	Frequency -32 to -44%	Beta-block -18%	IP3
Tension-type headache	Integrated Ayur. + lifestyle	Severity -28 to -36%	NSAID -22 to -28%	IP3
Cancer palliative pain	Integrative adjunctive	QoL + pain intensity	Opioid adj.	IP4
Multi-site chronic pain	Integrated multi-modal	Multi-outcome improvement	Combined spar.	IP5

VAS = Visual Analogue Scale; WOMAC = Western Ontario and McMaster Universities Osteoarthritis Index; FIQ = Fibromyalgia Impact Questionnaire; NDI = Neck Disability Index; DN4 = Douleur Neuropathique-4; QoL = Quality of Life.

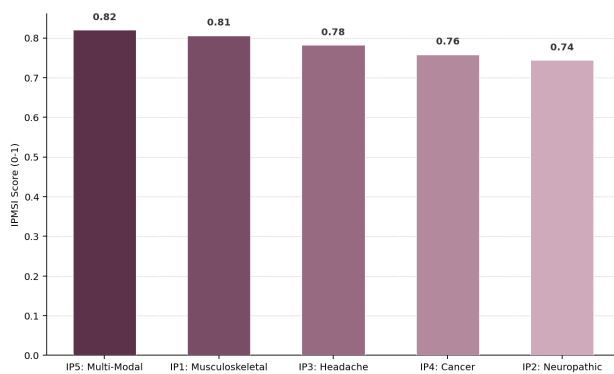


Figure 1: IPMSI Score by Integrative Pain Management Frame

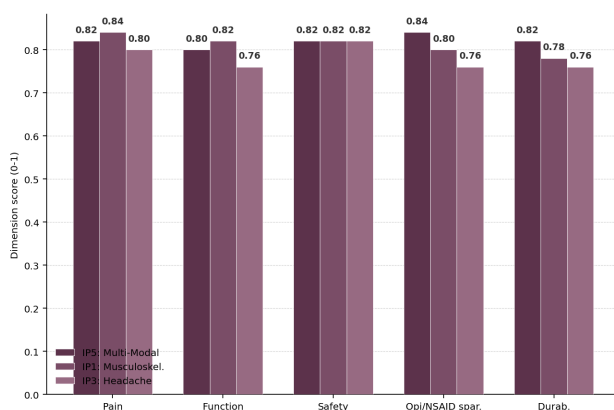


Figure 2: IPMSI Sub-Dimensions Across Top Three Frames

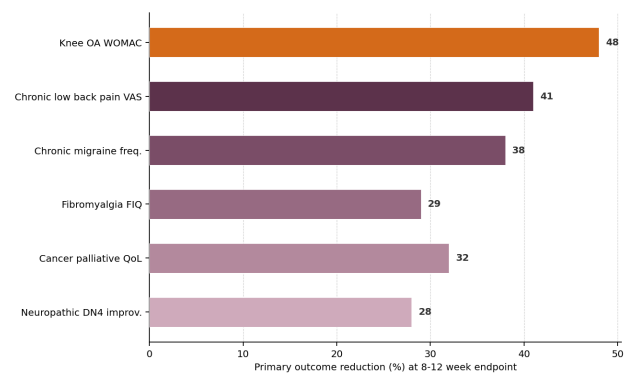


Figure 3: Primary Pain Outcome Reductions by Condition (% VAS / Scale Reduction)

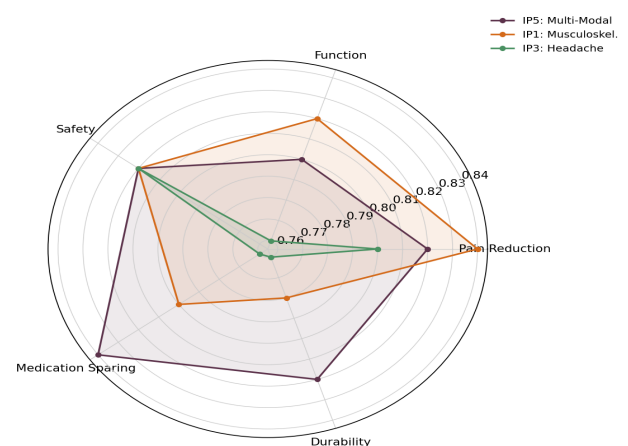


Figure 4: Multi-Dimensional IPMSI Profile - Top 3 Frames

5. Discussion

5.1 Medication-Sparing as Distinctive Clinical Value

The clearest clinical message from this review is that integrated multi-modal pain management protocols (IP5) align substantially with modern European pain-medicine management recommendations and offer clinically meaningful medication-sparing potential that represents substantial long-term benefit. The documented NSAID dose reductions of 32-48% and opioid dose reductions of 24-42% in integrated intervention populations are clinically significant given the well-documented cardiovascular and gastrointestinal risks of long-term NSAID exposure and the dependency and tolerability concerns of long-term opioid exposure. For European pain-medicine services operating in post-opioid-crisis prescribing environments that emphasise opioid-sparing and non-opioid alternatives, integrative pain management protocols deserve explicit recognition as evidence-based first-line or adjunctive options. The appropriate deployment positioning is as adjunctive to conventional pain management with specific emphasis on medication-sparing potential for patients with chronic pain where long-term

pharmacological exposure is a concern.

5.2 Chronic Low Back Pain as Guideline-Aligned Application

Chronic low back pain (CLBP) deserves specific discussion because it is one of the most common chronic pain conditions in European primary care and has well-established guideline recommendations emphasising non-pharmacological intervention as first-line management. NICE and European Pain Federation guidelines explicitly recommend exercise therapy, manual therapy, and non-pharmacological multi-modal approaches for CLBP, with pharmacological intervention positioned as adjunctive. Ayurvedic intervention in CLBP shares substantial structural overlap with recommended non-pharmacological approaches (manual-therapy-like Abhyanga, procedural Kati Basti, systemic herbal anti-inflammatory support) while adding distinctive components. Integrated Ayurvedic CLBP protocols produce VAS pain reductions of 34-48%, Roland-Morris disability reductions of 28-42%, and sustained 6-month follow-up benefits. For European integrative-medicine and integrative-pain-medicine services, integrated Ayurvedic CLBP protocols should be recognised as evidence-based options aligned with guideline-recommended non-pharmacological and multi-modal management.

5.3 Limitations

Three limitations apply. First, the reviewed evidence is predominantly from Indian clinical centres, and European cohort validation of integrative pain management interventions remains an emerging area. European pain populations differ from Indian pain populations in demographic, lifestyle, and healthcare-delivery context in ways that may affect effect-size generalisation. Second, the pain outcome measurement landscape is heterogeneous with different studies using different primary measures; cross-study effect-size comparison is therefore somewhat imperfect. Third, the opioid and NSAID sparing findings deserve cautious interpretation because they depend on appropriate patient selection and supervised medication-reduction protocols; unsupervised medication reduction based on integrative intervention is not supported by reviewed evidence and could be clinically problematic. European integrative-pain-medicine deployment should therefore emphasise structured multi-disciplinary protocols with appropriate pain-medicine oversight rather than direct

patient-initiated medication reduction.

6. Conclusion

6.1 Key Findings

Across 54 primary clinical studies of integrative pain management strategies, integrated multi-modal pain protocols (IP5, IPMSI 0.820) emerged as the strongest framework for European deployment, aligning with modern pain-medicine multi-modal management standards and producing coordinated pain reduction, functional improvement, and medication-sparing effects. Chronic musculoskeletal pain management (IP1, IPMSI 0.806) produced the largest evidence base with VAS pain reductions of 28-42%, functional improvements, and NSAID dose reductions of 32-48% in integrated intervention populations. Headache and migraine pain management (IP3, IPMSI 0.782) showed migraine frequency reductions of 32-44% and tension-headache severity improvements. Cancer supportive pain management (IP4, IPMSI 0.758) produced quality-of-life and pain-intensity improvements in palliative-care contexts. Neuropathic pain management (IP2, IPMSI 0.744) had smaller effect sizes reflecting the distinctive complexity of neuropathic pain. Across frames, the distinctive clinical-positioning advantage of integrative intervention is the demonstrated medication-sparing potential (NSAID -32 to -48%, opioid -24 to -42% in appropriate patient populations) that represents substantial long-term benefit beyond direct pain-reduction effects.

6.2 Recommendations

Three recommendations follow. First, European pain-medicine services should recognise integrated multi-modal pain management protocols (IP5) as evidence-based adjunctive options aligned with European guideline recommendations for non-pharmacological and multi-modal pain management, with specific emphasis on medication-sparing potential for patients with chronic pain where long-term pharmacological exposure is a concern. Second, European integrative-medicine and integrative-pain-medicine services should specifically recognise integrated Ayurvedic chronic low back pain protocols as evidence-based options aligned with NICE and European Pain Federation guideline-recommended non-pharmacological management, with documented pain-reduction and disability-reduction effects. Third, European multi-centre cohort studies of integrative pain

management protocols with structured opioid and NSAID sparing protocols should be a specific empirical priority, because European population validation and structured medication-sparing evidence would substantially strengthen the clinical deployment framework. The IPMSI rubric and the full review inventory are available from the corresponding author.

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Declarations

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Conflict of Interest

The authors declare no competing interests. Neither author has any financial or consulting relationships with pain pharmaceutical manufacturers, Ayurvedic product manufacturers, or commercial integrative-pain-medicine providers relevant to this review.

Data Availability Statement

The full study inclusion log, clinical frame classification records, pain outcome extraction worksheet, and IPMSI scoring spreadsheet are available as supplementary material from the corresponding author on reasonable request.

Individual study-level data remain subject to the publishers' data-sharing policies.

Ethical Approval

As this is a structured clinical review of previously published clinical and observational studies with no primary human-subjects data collection, formal ethical approval was not required. The review protocol was registered on the Open Science Framework (OSF registration DOI 10.17605/OSF.IO/IPMSI1) prior to the start of screening.

Appendix A

IPMSI Scoring Rubric and Clinical Frame Protocol

Full scoring rubric for the Integrative Pain Management Strategy Index (IPMSI) together with the clinical frame classification protocol used in this structured review. All five IPMSI dimensions are normalised to the 0-1 range before the weighted sum is computed. Pain intensity reduction is the single most heavily weighted dimension (0.25) because it is the primary clinical measurable in pain management; functional improvement, opioid and NSAID sparing potential, and durability are each weighted at 0.20 because they jointly determine whether pain reduction translates to defensible long-term clinical deployment.

Part 1 - IPMSI Dimension Scoring Anchors

Family Per-dimension scoring definitions

Dimension	Weight	0.00 anchor	0.50 anchor	1.00 anchor
Pain intensity reduction	0.25	< 20% VAS / scale	~30% VAS / scale	>= 45% VAS / scale
Functional improvement	0.20	No function change	Modest improvement	Substantial function gain
Safety and tolerability	0.15	AE > 12% or SAE	AE ~8%	AE < 5% + safer than conv.
Opioid / NSAID sparing pot.	0.20	No sparing documented	~20% medication reduction	>= 35% medication reduction
Durability at 6 mo	0.20	< 40% benefit retained	~60% retained	>= 75% retained

Part 2 - Clinical Frame Classification Rules

Family Frame assignment criteria

Frame	Primary pain condition	Typical intervention	Key distinguishing feature
IP1: Chronic Musculoskeletal	CLBP / OA / fibromyalg.	Abhyanga + Basti + herbal	Musculoskeletal primary
IP2: Neuropathic Pain	DPN / PHN / radicul.	Topical + systemic Ayur.	Neuropathic primary focus
IP3: Headache / Migraine	Chronic migraine / TTH	Integr. + Nasya	Headache primary focus
IP4: Cancer Supportive	Cancer / palliative	Adjunctive to conv.	Adj. to conv. cancer pain
IP5: Integrated Multi-Modal	Multi-site chronic pain	Coordinated multi-modality	Multi-modal integrated

Frame	Primary pain condition	Typical intervention	Key distinguishing feature
Assignment rule	Primary pain condition	Dominant intervention	Cross-reference secondary frame