

# **SEVEN WAYS TO TREAT INTRACTABLE PAIN SYNDROME**

**By Forest Tennant, PNN Columnist**

Intractable Pain Syndrome (IPS) requires a care program custom-made for each individual person, depending on their underlying painful condition and clinical severity. There are therapeutic, pharmacologic, dietary and physical measures you can take that specifically target the cause of IPS. Step One in finding relief and recovery is to target the cause of the pain, and not just take the “shotgun” approach with only symptomatic pain relievers. A multi-faceted approach is needed.

The 7-component treatment outlined here is to aid patients, families and medical practitioners in formulating an individualized IPS care program

## **1) Suppression of Inflammation**

**Underlying Cause:** The injury or disease that originally produced the pain may continuously generate inflammation that requires suppression by a variety of means. Common measures to reduce inflammation include anti-inflammatory agents, electromagnetic therapies, local injections or topical agents.

**Central Nerve Inflammation:** IPS is caused by central nervous system (CNS) inflammation (neuroinflammation) that destroys or damages neurotransmitter systems. Only some treatment agents cross the blood brain barrier and suppress neuroinflammation. Some common agents: naltrexone, ketorolac, indomethacin, methylprednisolone, acetazolamide and dexamethasone.

## **2) Sleep Restoration**

It is during sleep that the CNS regenerates the neurotransmitters you need for pain control. Adequate sleep is necessary for this to occur. Some common agents: Ambien, trazadone, temazepam (Restoril), amitriptyline, melatonin and Benadryl.

## **3) Control of Electric Currents**

Some drugs now called “neuropathic” normalize electric current conduction, which is erratic due to nerve damage. Some common agents: gabapentin (Neurontin), pregabalin (Lyrica) and benzodiazepines (Klonopin and Valium).

## **4) Pain Control**

The constant pain of IPS is composed of two types of pain: ascending and descending. IPS control requires agents for both types.

**Ascending Pain:** Some common agents: cannabinoids, opioids, ketamine, clonidine, kratom and naltrexone (if not already on opioids).

**Descending Pain:** Some common agents: amphetamine salts (Adderall), phentermine, modafinil, methylphenidate, mucuna.

## **5) Hormone and Neurotransmitter Supplementation**

Groups of hormones now known as neurosteroids, and biochemical molecules known as neurotransmitters, are made in the brain and spinal cord. Their function includes suppressing inflammation, rebuilding damaged tissue and to provide pain control. Analgesic/pain-relieving drugs will not be effective if any neurosteroid or neurotransmitter is deficient. Neurotransmitter testing is now available.

Hormones: DHEA, pregnenolone, testosterone, progesterone.  
Neurotransmitters: dopamine-noradrenaline, serotonin, GABA.

## **6) Anabolic Measures (Tissue Building)**

In IPS, tissue degeneration is constantly present due to inflammation. Some genetic connective tissue/collagen diseases such as Ehlers-Danlos Syndrome (EDS) have a built-in, constant tissue degenerating component (catabolic).

Tissue building (“anabolic”) measures are essential to counteract tissue degeneration, and several agents have been identified that do this: nandrolone, human chorionic gonadotropin (HCG), colostrum, deer antler velvet, and amino acid/collagen supplements are recommended.

## **7) Disease Specific Exercise**

Spinal fluid circulates in and around the brain and spine. It washes out biologic waste products such as inflammation. It also brings nutrients to the inflamed and/or damaged nerves for healing.

Exercises that enhance spinal fluid flow include walking, rocking in a chair, and gently bouncing. Practice exercises and stretches that will prevent tissue shrinkage, paralysis and dysfunction of your extremities or other organs that are specific for your underlying condition. All seven of these components should be considered for inclusion in an IPS care program.

Forest Tennant is retired from clinical practice but continues his groundbreaking research on intractable pain and arachnoiditis. This column is adapted from newsletters recently issued by the IPS Research and Education Project of the Tennant Foundation.

The Tennant Foundation has given financial support to Pain News Network and sponsors PNN's Patient Resources section.