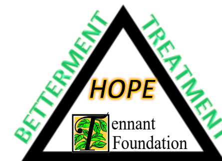
# THE CORE TREATMENT OF AA IS LOW DOSE, INTERMITTENT METHYLPREDNISOLONE AND KETOROLAC




Arachnoiditis Hope recommends that low dose, intermittent methylprednisolone and ketorolac (LDMK) be the core medical treatment for any person with MRI-confirmed adhesive arachnoiditis (AA). AA is a chronic inflammatory disease that has fused (glued) by adhesions some cauda equina nerve roots to the arachnoid membrane (inner lining of the spinal canal cover). We have not found other anti-inflammatory or corticosteroid medicinals that consistently and effectively suppress AA inflammation and relieve pain and other symptoms as well as LDMK.

**Core, Not Entire** Treatment: LDMK is the core of AA treatment, but there must be additional supporting treatment measures as indicated below to adequately treat the AA patient.

**Simple Administration:** LDMK can be easily prescribed by any MD, NP, or PA. Each drug is prescribed to be taken on 1 to 3 days a week. Each drug is taken on an alternate day. Our simple initiation of treatment is as follows:

1. Methylprednisolone, 4 mg PO on Monday and Thursday
Ketorolac, 10 mg oral with a meal or antacid on Tuesday and Saturday. Option: An injection each Monday, 15 to 30 mg.

**Safety:** Both methylprednisolone and ketorolac have well known side effects if used daily. The low doses and skipped days of administration minimize risks to the point that clinical benefits outweigh the risks.

**Supporting Measures to LDMK Core Treatment**

1. Pain flare control with a short-acting opioid or other medication (i.e., ketamine, oxytocin).
2. Add one or two anti-inflammatory/autoimmune medicinals. Give consideration to low dose naltrexone (LDN), palmitoylethanolamide (PEA), glutathione, resveratrol, quercetin, luteolin, and curcumin.
3. Daily protein, anti-inflammatory diet with vitamin C, B-12, D, and minerals selenium, magnesium, and zinc.
4. Spinal fluid flow (i.e., rocking, swinging) and physical exercises of arms and legs (i.e., stretching, flexing, light weightlifting, walking)

**Measures Following Initial Stabilization**: Once the patient is functioning with reasonable pain control, we highly recommend the following measures be added to the core treatment to possibly permanently reduce pain and neurologic symptoms (Information on request):

1. Electro current/electromagnetic therapy
2. Regenerative peptides and hormones
3. Epstein-Barr suppression if reactivation is present

References:

1. Strum B, et al. Parenteral ketorolac and risk of gastrointestinal and operative site bleeding. *JAMA* 1996;275:376-387.
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3. Sotgiu ML, et al. Central effect of ketorolac involving NMDA receptor activity. *Brain Res* 1998;813:223-226.
4. Takedo, et ala. Effect of methylprednisolone on neuropathic pain and spinal glial activation in rats. *Anesth* 2004;700:1249-1257.

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