LOW DOSE KETOROLAC AND METHYLPREDNISOLONE (Medrol®) FOR ADHESIVE ARACHNOIDITIS

The most consistent, effective therapy to control adhesive arachnoiditis in our experience has been low dose ketorolac and methylprednisolone.

SIDE EFFECTS: Both ketorolac and methylprednisolone have unacceptable clinical complications if used on a high dose, daily schedule. Ketorolac can cause renal disease, and methylprednisolone may suppress adrenal activity, develop osteoporosis, and elevate glucose levels.

REASONS FOR SINGULAR EFFECTIVENESS: Ketorolac and methylprednisolone both cross the blood brain barrier and enter spinal fluid. Ketorolac suppresses neuroinflammation and simultaneously provides pain relief by activating the n-methyl-d-aspartate (NMDA) receptor. Methylprednisolone, in contrast to other corticosteroids such as prednisone, activates certain receptors in the spinal cord and brain to reduce neuroinflammation. (See references)

DOSAGE SCHEDULE: Ketorolac and methylprednisolone can be used once weekly or even just twice a month. The low dose schedule once a week: Ketorolac, 10 to 30 mg, Methylprednisolone, 4 to 8 mg

ALTERNATIVE LOW DOSE SCHEDULE: methylprednisolone can be an injection (10 to 20 mg) once or twice a month, ketorolac 30 to 60 mg injection once or twice a month.
Maximal dosage is 3 times a week. Days of no administration are essential for safety.

ACCEPTABLE FOR FLARE TREATMENT: Single injectable dosages of ketorolac (30 mg) or methylprednisolone (10-20 mg) are acceptable for flares.

SPECIAL NOTES:

1.We believe that one of the major attributes of low dose ketorolac and methylprednisolone is suppression of both autoimmunity and inflammation generated by the Epstein-Barr virus, other viral reactivations, or autoimmune diseases.
2. Low dose ketorolac and methylprednisolone can be used in persons with implanted stimulators, intrathecal pumps, low dose naltrexone, and systemic opioids.

SUMMARY: We have not identified a superior treatment to low dose ketorolac and methylprednisolone for adhesive arachnoiditis. No serious or lasting complications have been observed with the low dose schedule listed here.

References:

1. Takedo, et al. Effect of methylprednisolone on neuropathic pain and spinal glial activation in rats. *Anesthesiology* 2004;100:11249-1257.
2. Satkin, et al. Central effect of ketorolac involving NMDA receptor activity. *Brain Res* 1998;13:223-226.
3. Stubhaug, et al. Methylprednisolone and ketorolac rapidly reduces hyperalgesia around a skin burn injury and increase pressure pain thresholds. *Acta Anesthesiol Scand* 2007;57:1138-1146.

This educational information is provided as a public service by "Arachnoiditis Hope."
Tennant Foundation, 336 ½ S. Glendora Ave., West Covina, CA 91790.
Email: tennantfoundation92@gmail.com Fax: 626-919-7497 Website: www.arachnoiditishope.com