Bulletin 2
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ALTERNATIVE TO THE LOW DOSE METHYLPREDNISONE-KETOROLAC PROTOCOL

Eight years ago, when Arachnoiditis Hope was formed, we knew we needed a protocol specifically intended to suppress inflammation in the cauda equina and arachnoid membrane (inner lining of the spinal canal cover). After a good deal of trial and error the simultaneous use and protocol of low dose, intermittent methylprednisolone and ketorolac emerged as our best anti-inflammatory treatment and protocol for Adhesive arachnoiditis (AA).

Today's Problem: Unfortunately, methylprednisolone and ketorolac have well known side effects, malpractice concerns, and require extra physician time to monitor patients. Consequently, many physicians and medical institutions will not implement this protocol even though countless persons with AA have and currently benefit from low dose methylprednisolone and ketorolac.

Our Solution: Over the past two years we have vigorously experimented, studied, and reviewed AA cases to develop an alternative anti-inflammation protocol to low dose methylprednisolone and ketorolac. Both protocols are given here for patient and practitioner to have a choice.

Current Protocol	Alternative Protocol
Methylprednisolone, 4 mg and ketorolac 10-30 mg on 1 to 3 days a week	1. Pregnenolone 200 mg twice a day 2. Palmitoylethanolamide (PEA) with luteolin (Mirica™ or other) 600 to 1200 mg twice a day 3. Glutathione 500 mg twice a day

Other Protocol Components: Our recommendations remain the same.

1. Pain control: Short-acting opioid and neuropathic agent. Option: add low dose naltrexone.

2. Regeneration of Cauda Equina and Arachnoid: Dehydroepiandrosterone (DHEA) 200 mg twice a day. Option: add a colostrum or deer antler velvet supplement daily.

Can Protocols be Mixed? Yes, some persons with AA may wish to use the new protocol and reserve methylprednisolone and ketorolac for emergency or flare purposes. Elements of both protocols can be used.

Summary: The protocol of low dose methylprednisolone and ketorolac has some potential side effects and time-required monitoring. Consequently, some physicians will never incorporate it into AA treatment. The alternative now recommended is eminently safer, and we believe it may even prove to be more effective.

This educational information is provided as a public service by "Arachnoiditis Hope."
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