REPORT

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MEDICATIONS FOR TREATMENT OF THE INFLAMMATION OF ARACHNOIDITIS

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Adhesive arachnoiditis (AA) is a very serious inflammatory disease in which cauda equina nerve roots are attached by adhesions to the arachnoid membrane, which is the inner lining of the spinal canal cover. AA is characterized by severe intractable pain and neurologic impairments of the bladder, bowel, sex organs, and lower extremities. Unless treated, the disease ends in a debilitated, bed bound state, and early death. The basic treatment of AA is to suppress the inflammation that is present in the arachnoid membrane and cauda equina. Unless inflammation is controlled, pain and neurologic complications will progressively occur. This report gives our up-to-date list of medications to control the inflammation of arachnoiditis.

Corticosteroids

At this time, we consider that one of these two corticosteroids are essential to control and suppress arachnoiditis inflammation: (1) methylprednisolone, (2) dexamethasone. These corticosteroids are well known to have potential complications, so they are used on a low-dose, intermittent basis, except when used intravenously for emergency use. For example, our starting dosage recommendation is methylprednisolone 4 mg or dexamethasone 0.5 mg given on 2 days a week (example, Monday-Thursday).

If there is concern over a 2-day-a-week schedule, we recommend at 1-2 times a month injection (methylprednisolone 10-20 mg, or dexamethasone 2-5 mg). To prevent corticosteroid complications, skip days between dosages. Do not take daily to avoid corticosteroid complications.

Below are non-corticosteroid medicinals that we recommend. They are to be used in addition to methylprednisolone or dexamethasone as there are no known substitutes for corticosteroids.

Ketorolac

Other than the corticosteroids described above, we have found that ketorolac is the most effective and consistent suppressor of inflammation and pain in AA. It, like corticosteroids, has complications (especially renal and gastrointestinal) if used on a daily basis. It should never be used for over 5 consecutive days. Our starting recommendation is 10, 30, or 60 mg on two days a week. Example: Tuesday and Saturday. We suggest it be used on days that a corticosteroid is not taken. Ketorolac can be taken as an oral tablet or injection. If a clinician is opposed to twice a week dosing, it can be given as 30 or 60 mg injection on 1 to 2 days a month. In summary, our best recommendation to control arachnoiditis inflammation is a low-dose, intermittent corticosteroid and ketorolac.

Other Anti-Inflammatory Agents

In order for an anti-inflammatory medication to be effective in arachnoiditis, it must cross the blood brain barrier, enter spinal fluid, and have receptors on the cauda equina nerve roots and arachnoid membrane. Few medicinals will suffice. We have identified three that have clinically, in our hands, proven effective in some cases:

1. Pentoxifylline, 400 mg, twice a day
2. Diclofenac, 25 mg, 3 times a day
3. Acetazolamide, 250 mg, 1 or 2 times a day

The three agents above can be added to a regimen of corticosteroids, and ketorolac, or they can substitute for ketorolac, if necessary.

Low Dose Naltrexone

This agent may boost or enhance the effectiveness of methylprednisolone or ketorolac, but, by itself, does not have enough anti-inflammatory capability to suppress the inflammation of AA. To be effective in reducing pain and inflammation, low dose naltrexone will have to be accompanied by other medications such as hormone and peptide therapy.

Ivermectin

This antiparasitic drug may not only to eliminate and prevent Epstein-Barr virus complications, it is a potent anti-inflammatory and pai-relieving drug. Maintenance dosage is 3.0 to 6.0 mg on 2 days a week.

Herbal Medicinals

There are a few herbal dietary supplements that are popular with persons with AA. We recommend that one or two be taken daily to enhance the effectiveness of the medications listed above. They are curcumin, serrapeptase, quercetin, astragalus, or ashwagandha. While helpful, herbal agents, by themselves, are not effective enough to suppress the inflammation of AA.

Summary

Every person with arachnoiditis must develop a treatment plan that targets the inflammation of arachnoiditis. A failure to develop a treatment plan to suppress inflammation will likely allow it to produce nerve root degeneration and destruction so as to result in increased pain and debilitation.