PROTOCOL FOR ONGOING PAIN RELIEF

1. Continue any current pain relief medications and measures that the patient reports to be effective.

2. Patients Not on Opioid Medication: Low dose naltrexone. Starting dose is 1.0 mg BID. Can be raised up over time to 7.0 mg BID.

3. Acute Flares – Non-Opioid Medication Options:

   a. Journavx® (suzetrigine), 50 mg every 12 hours as needed.
   b. Palmitoylethanolamide (PEA) with luteolin (Mirica™ or other), 600 to 1200 mg g 4-6 hrs
   c. Ketamine troche or buccal tablet, 5 to 20 mg g 4-6 hrs

4. Low Dose Opioids – Options: Use for flares and/or baseline pain.

   a. Tramadol
   b. Codeine
   c. Hydrocodone with acetaminophen (Norco®, Vicodin®)
   d. Oxycodone with acetaminophen (Percocet®).

5. Neuropathic agent: choice of gabapentin, baclofen, diazepam, alprazolam, carisoprodol.

6. Central Pain: If pain is constant with periodic episodes of tachycardia, hypertension, sweating, and vasoconstriction (cold hands/feet) (i.e., central pain or centralization) add a descending pain medicinal: choice of tizanidine, clonidine, methylphenidate, amphetamine salts (Adderall®). Option: Palmitoylethanolamide (PEA) for specific amelioration of central pain, 600 mg BID 1st month, 1200 mg BID 2nd month.

Special Situation:

1. Failure of LDN or Low Dose Opioid to control Pain: Switch to a potent long-acting opioid. Options: fentanyl patch or a morphine or oxycodone long-acting preparation.

2. Severe Pain Flares: Short acting hydromorphone, oral 2.0 to 8.0 mg. For optimal relief, use ultra potent hydromorphone injectable (50 mg/ml). Five (5.0) mg is only 0.1 cc which is injected subcutaneously under the skin (Source: Anazao Laboratories, Tampa, Florida).

3. Medical Failure to Relieve Pain: If potent opioid therapy fails to relieve pain, consider intrathecal opioids or implanted electrical spinal stimulator.

Special Note: Pain control in persons with AA may fail or be inadequate unless the following measures are instituted, if necessary:

1. Suppression of spinal canal inflammation with a corticosteroid (methylprednisolone) and ketorolac or equivalent.
2. Replacement of deficient serum hormones such as testosterone, pregnenolone, and DHEA.
3. Suppression of a reactivated Epstein-Barr virus with specific antiviral medicinals.

This educational information is provided as a public service by "Arachnoiditis Hope" a project of the Tennant Foundation, 336 ½ S. Glendora Ave., West Covina, CA 91790.
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