



## *ARC (ARACHNOIDITIS) NEWSLETTER*

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A Non-Profit Organization created for the Study of the Causes, the Diagnosis and the Treatment of ARACHNOIDITIS.

### ***FROM THE EDITOR'S DESK***

Just when I thought that I have identified every single cause of arachnoiditis (ARC) another patient walks in through the door of my office with a story I have not heard before. In the last year, we have examined three patients that had methylmethacrylate injected into the compartment that contains the spinal cord and the nerve roots. This material is the same cement used to fix the hip prosthesis into the femur a material strong enough to tolerate the patients' weight.

This cement is being injected into the body of vertebrae to relieve the pain from the collapsed fracture, indeed a noble and effective treatment, most of the time. Except for the fact that when the material injected into the dural sac, hardens while liberating heat that may reach 80 degrees centigrade.

Needless to say, injecting it, by mistake, into a compartment, containing the most delicate neural structures produces the most severe pain as patients, only partially sedated have screamed immediately, requiring large doses of opiates. The injury resembles the Cauda Equina syndrome and is permanent. There are multiple similar cases after epidural injections, transforaminal nerve root injections, etc.

The procedures may or may not be indicated, they may be or may not be helpful, but when erroneously executed, they turn harmful.

## **PUBLICATIONS THAT MAY BE OF INTEREST TO THE ARACHNOIDITIS READERSHIP**

### ***“I AM NOT GOING TO TAKE IT ANY LONGER”***

*This unusual title in a well read Neurosurgical journal called my attention.*

*Essentially, it lists the multiple difficulties that the medical profession is facing these days. Including*

- *Increased difficulties with Hospitals*
- *Unfair and delayed reimbursement for services*
- *Unfair and unbalanced media representation*
- *Higher operating costs*
- *Frequent hospital reviews*
- *Facing a myriad of government regulations*
- *An ever growing malpractice crisis.*

*The author also mentioned that the combined effect of the general public's perception that physicians appear arrogant and aloof about the maladies of their patients together with a general divisiveness imposed by regulatory agencies and implemented by themselves.*

*The author called for unity, action and revolution against the Epidemic of apathy. We hope that such direction will help us to reconcile with our patients and allows both to better comply with the regulatory agencies.*

*Another author in the same section remarked “The system of medical reimbursement that has evolved in this country is the descendent of the Medicare that went into effect in the mid 1960's. Prior to 1965, physicians were not reimbursed for the care of the elderly and the poor, therefore, they did that as a gratis service. Following the advent of Medicare and Medicaid, it became possible for physicians to become wealthy, while doing sometimes questionable thousands of procedures in the infirm, old and poor, such as cataracts and coronary bypasses that produced M.D. millionaires spawned. As the cost for this government*

*sponsored bonanza became prohibitive, some one decided to get even. Hence, the current difficulties in the finances of medicine, which are at least in part, of the physicians own making.*

*The expansion of HMO's over the last 10 years, has failed to save any money, but it has gone into someone else's pockets (Insurance companies, drug and device manufacturers and lawyers). Government has not helped; by insisting with its effort to keep us all "in compliance", it has created another perverse system that has been spawned. We have to buy books, posters, brochures and attend meetings where we are indoctrinated on what we have to do to keep us all "in compliance". After all the expense and the threats, now there are different regulations, HIPAA.  
(From Surg Neurol 2003:59:244-9).*

#### **WHAT APPEARS BEST, MAY BE WORSE**

Lately we have been bombarded by all-media propaganda (brochures, tapes, diskettes, CD's, movies, conferences, telephone calls, offers of free meals, weekend trips to learn about the legitimate use of opioids in the treatment of Chronic Moderate to Severe Noncancer Pain".

This is not a new concept, opioid therapy is accepted around the world as an important therapy for severe pain, but this particular application remains controversial, not because patients need and should have their pain relieved, but because only properly prescribed it leads to mismanagement by the doctors and abuse by the patients.

There is no question that by reducing the pain, suffering is alleviated, physical activities are increased and the quality of life as a whole is improved, all of these goals that algologists should aim for. The most frequently used drugs are morphine\*, meperidine\*, codeine\*, oxycodone\*, hydrocodone\*\*, hydromorphone\*, fentanyl\*, sufentanyl\*, alfentanyl\* and propoxyphene\*\*, all of them relatively with short duration of action. One other medication with slightly longer duration is methadone\*.

To make them more effective they have been added acetaminophen, ibuprofen and aspirin. Long acting forms have been manufactured for morphine, oxycodone and fentanyl. Longer action may result in less frequent dosing and a greater adherence to the manner of how they are prescribed. Although the above listed drugs do not appear to have a "ceiling effect" described as a limit on their pain relieving effect when increasing dosages are given, repeated increases in the dosages lead to toxicity, overdose and tachyphylaxis.

This latter effect is not well understood, although is real and found in every animal species. A considerable danger is the fact that as patients are given any of these medications, they gradually developed tolerance to them, in other words, they do not get the same pain relief effect that they noticed at the beginning. Without knowing this pharmacological phenomenon, patients believe that their disease is getting worse, but what in fact is happening is that they have developed tolerance to the drug, increasing the dosage only results in a gradual increase to tolerance to the higher dosage, and it goes on and on and on...Until the doctors realize that patients are receiving considerable, enormous and dangerous dosages, then they stop giving into the patients request and patients begin to take their prescribed pills more often or in greater quantities and then they are accused of “abusing their medications” and the relationship ends.

Of all the studies that I have reviewed including Schedule II drugs, none have lasted more than six months in which the patients did not get a higher dosage; in other words the researchers were not able to keep the patient’s pain relieved, unless they increased the dose. Just what I said. Where do we stop? In reality the only winners are the manufacturers of these medications. Eventually, the patients can not afford the ever growing cost of these medications, nor should the insurance companies be obligated to pay for this overload.

In reality, prescribing opioid medications to patients with long lasting (non cancerous) diseases is a serious matter; it should not be taken lightly by the doctor, nor the patients. However, it behooves the former to inform the latter of the risks and possible development of dependency and the ultimate withdrawal. These events have to be explained to the patients so they know what it is expected.

In all its wisdom, the Drug Enforcement Administration classified these controlled substances in schedule II \* more controlled, no refills, can not be called because they are more prone to produce dependency than schedule III\*\*, which are less likely to result in tolerance, can be called over the phone and refills can be written. There is no free ride, though schedule II are more potent analgesics, they are not the type of medicines that ought to be prescribed lightly.

The finally word, remains to be said on this issue.

Promoting pain relief and preventing abuse of pain medications: A critical balancing act. A joint Statement from 21 Health Organizations and the Drug Enforcement Administration. [Http://ampainsoc.org/advocacy/pdf/concensus\\_1.pdf](http://ampainsoc.org/advocacy/pdf/concensus_1.pdf). Accessed August11:2004.

**House of Delegates of the Federation of State Medical Boards of the United States, Inc. Model Policy for the use in control substance for the treatment of pain. May 2004.**

## **MEDICAL ERRORS IN THE OPERATING ROOM**

Seldom are mistakes that happen during surgery discussed in the open; as the author opens his article “It happened a very long time ago”, just like a fairy tale.

After discussing a case of a technical error made by a medical student who was ordered to finish an operation started by the Staff surgeon, recognizes that patients trust us assuming that every thing we do have been error and fool tested. In the majority of the cases, either errors do not happen or they are recognized before harm is produced. Occasionally such errors are not recognized ensuing in a catastrophe or death.

Surgeons assume that others (nurses, technicians, hospital administrators, etc.) have done what is expected of them, to their best of their abilities. That is a wishful thought as the system can break down at any point. Mishaps can happen in spite of every precaution, essentially each health care worker and professionals who participate in the care of the sick is beholden to others who rely on others, and others in a long chain of trust with links loosely intertwined. Not long ago (February 2005) the London tabloids pick up on the high rate of “Methicillin Resistant Staph Infections (MRSI)” occurring in the National Health System (NHS) of the UK that involved MP’s, the Health Minister and even Tony Blair. A lot of investigations followed with many promises made.

Some errors occur because the system is overtly violated; others from human fallibility. The author admits that there are problems in the system of medical care such as faulty design of equipment, overworked personnel, inadequate methods of drug delivery, protocols ignored, lack of verification, information transmission, equipment maintenance and many others, but most importantly the failure to fulfill expectations of the patients. This can be addressed by giving them a real informed consent, that is telling them what they have, what can be done and whatever complication or intangible event that can occur.

The famous phrase “ **DON’T WORRY, EVERYTHING IS GOING TO BE ALLRIGHT**” should be out of the informed consent vocabulary.

Perhaps we have over-rated ourselves and made appear that operations, anesthetics, endoscopies, and other procedures are overtly safe. Instead we should give the real odds, informing them of the true risk/benefit ratio which had been represented as safer than what they really are. Maybe then, patients will not have higher than real expectations and we all can rejoice of how good we are by doing a great job that resulted in a GOOD OUTCOME.

*Nuland AB: Mistakes in the Operating Room- Error and responsibility. N Eng J Med 2004;351:1281-3.*

*Ferguson DD, Gershman K, Jensen B, et al: Mycobacterium good infections associated with surgical implants at Colorado Hospital. Emerg Infect Dis 2004;10:1868-70.*

*Carson LA, Bland LA, Cusick LB et al: Prevalence of nontuberculous mycobacteria in water supplies of hemodialysis centers. Appl Environ Microbiol 1988;54:3122-5.*

*Wenger PN, Brown JM, McNeil MM et al: Neocardia facinica sternotomy site infections in patients following open heart surgery. J Infect Dis 1998; 178:1539-43.*

### **Who can we trust in evaluating the intensity of the PAIN?**

This frequently debated topic was investigated by formulating and agreement among the PATIENTS, the SPOUSES and the DOCTORS conducted in 114 older women with osteoarthritis with their husbands and their rheumatologists. It was found that patients' spouses tended to underestimate their wife's pain and the agreement among patients and their physicians did not evaluate patients' well-being that resulted in less efficacy and positive affect when compared to physicians' underestimation of patients' pain.

*Cremins-Smith JK, Stephens MA, Franks MM, Martire LM, Druley JA, Wojno WC: Spouses' and physicians' perception of pain severity in older women with osteoarthritis: dyadic agreement and patients' well being. Pain 2003;106:27-34.*

## **INQUIRIES**

I need to state that to protect patient's confidentiality under HIPAA, I do not offer medical opinions over the Internet.

However, not uncommonly our web site receives inquiries about certain issues and if they are related to arachnoiditis.

### **AM I GETTING BETTER OR WORSE?**

A good idea has been proposed by other authors to define whether the patients pain originating disease.

Essentially they had the patients keep count of the free-pain days, days with their Pain under control and days with Pain-related functional interference, then given a numerical scale to compare the patients' disease from one month to another. This scale seems a good idea as it provides a quantitative assessment for the evolution of the patients' disease.

*Zelman DC, Hoffman DL, Seifeldin R, Dukes EM: Development of a metric for a day of manageable pain control: derivation of pain severity cut-points for low back pain and osteoarthritis. Pain 2003;106:35-42.*

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## NEW MEDICATION TO TREAT PAIN

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A drug that was obtained from a snail (*Conus magus*) from the South Pacific has shown definite pain relief properties. A N-type calcium channel blocker, ziconitide interrupts the transmission of pain by interrupting the nociceptive electrical signals. Research has been conducted for the last 7 years in numerous animal and human studies. Early observations suggested some neurotoxicity, however larger series in patients (1200 patients) in three clinical studies, apparently showed limited reasons for concern and so the FDA has approved its use.

The Director of the FDA's Office of Drug Evaluation stated that "the benefits outweigh the risks".

The trade name is "Prialt" and has been used mostly in patients with implanted infusion pumps with catheters in the dural sac. Side effects include dizziness, drowsiness, and altered mental status. Contraindications are history of psychosis and every patient that receives this drug should be monitored for signs of cognitive impairment.

*We would like to see the articles in print and a larger clinical experience before expressing an opinion. For information, patients are referred to ELAN the manufacturer. <http://www.elan.com>*

### **CALL FOR WRITTEN CONTRIBUTIONS**

As in the past, we invite contributions by physicians, patients, relatives of patients, therapists on subject related to ARACHNOIDITIS, specially their impressions, experiences and sacrifices as they help or care for this patients.

### **CALL FOR LETTERS, ARTICLES, CONFESSIONS POEMS, DEBATES, etc.**

Readers are invited to write short, but meaningful, articles on any subject related to Arachnoiditis. They may be submitted with the author's name or anonymously, however, with the understanding that:

- a. The Editorial Board reserves the right to modify them or alter them to conform with the style and the "Objectives" of the ARC Newsletter.
- b. The copyrights will be waived with the assurances that the Editorial Board will not derive any profit from any of these publications.
- c. They are simple, constructive and civil.

Thank you.  
The Editorial Board

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**Arachnoiditis Foundation, Inc.**

P.O. Box 4627, Seaside, FL 32459-4627

E-mail: [taldrete@arachnoiditis.com](mailto:taldrete@arachnoiditis.com)

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