ARC (ARACHNOIDITIS) NEWSLETTER

Volume2, No.2 April-May-June 2002

As much as we and many others have worked in the last 12 years on this disease "ARACHNOIDITIS" we are still learning and there are many issues to deal with, information to distribute and skeptics to persuade. We thank the contributors of this third ARC Newsletter and would like to encourage others to send us material to include in our next issue. Lets be informative, objective and decisive to maintain our firm trajectory.
Editor.

PATIENT'S EXPERIENCES

ARACHNOIDITIS AND DEPRESSION by Sara Ann Conkling (part I)

In writing this article it is important for me to say what I am and what I am not. I am a person living with arachnoiditis, not a medical professional of any type. Everything I am about to say with the exception of explicitly referenced material attributable to qualified authors is the opinion of a lay person, me. Nothing said here should in any way be construed to be medical advice. All decisions regarding medical treatment should be discussed with appropriately trained medical professionals.

During my personal exposure it has become apparent that for every one thing, known about depression, about ten others are unknown, so it is impossible to offer a completely scholarly discussion on the topic of depression.

A friend of mine who is a physician cautioned me, "you better make this an upbeat article." While neither arachnoiditis nor depression are exactly upbeat topics, I do plan an upbeat conclusion, so stay tuned for a list of things that one can do which I feel may have a beneficial effect on depressive symptoms.

Depression is the mental health equivalent of the common cold. In and of itself, it should not be a life-altering or life-threatening illness to confront. However, in the context of arachnoiditis suffering, depression can be the monster that sneaks up from behind, potentially incapacitating our cognition to the point where life appears to lose its meaning. Kindly forgive the insult to vampires, but this monster is, in a way, like Dracula. If Dracula is on our necks, it is important to recognize Dracula and to know what to do to get free of him, and it is important to

be free of him before we are sucked dry. It would be even better to see Dracula coming from a distance and be able to elude him before he finds us. That is what this article is about.
Describing depression is a more or less formal exercise depending on who is defining it. There are those more or less strong and more or less transient moments of feeling sad or down, of grieving loss, of fatigue that are a part of just about everyone's existence from time to time. Those depressing feelings deserve recognition, respect and healing. If those feelings are strong enough or persist, we need to be able to ask for appropriate help to cope with them. This is irrespective of any clinical diagnosis of depression.

The clinical definition of major depressive episode is much more specific and includes: five (or more) of the following symptoms over the past two weeks, one of the first two mandatory:

1. Bad mood most of the day, nearly every day, observed in yourself or by others. Children and adolescents may display an irritable mood.
2. Markedly diminished interest or pleasure, nearly all the time, observed in yourself or by others.
3. Significant weight loss or gain, or decrease or increase in appetite.
4. Insomnia or hypersomnia nearly every day. Absence of desire to get out of bed.
5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt nearly every day (not merely self-reproach or guilt about being sick).
8. Diminished ability to think or concentrate, indecisiveness, nearly ever day.
9. Recurrent thoughts of death (not just fear of dying) or suicide as a mean of escaping. The Manual goes on to note that these symptoms should not be attributable to other mental causes, substance abuse, a general medical condition, or bereavement. (Source: DSM-IV).

In addition to major depressive disorder, mental health professionals recognize that there can be depressive components to a lot of other mental illnesses. It is the job of a competent mental health professional to determine in what clinical "box" does a given set of symptoms fit. From a consumer standpoint, any diagnostic "box" which fits gives legitimacy to mental health challenges in the eyes of mental health professionals and the third party payers of mental health services. Mental health professionals likewise know that the available boxes often do not fit, individual symptoms. Just because symptoms don't fit neatly into a box does not mean that a person is not suffering. What matters ultimately is what hurts.

I feel that depression can be triggered by the very event of having the diagnosis of arachnoiditis. We who have been diagnosed with ARC have likely suffered trauma: a failed procedure of some sort, a medical intervention which was supposed to be benign or therapeutic but instead became a mind-numbing, body-torturing event. In my personal scale of difficulty of life events, natural disasters and/or accidents are at the low end, followed by things that go wrong to which we can point out and say "I screwed up.". Getting arachnoiditis is often in a third (worse) category, a combination of unexpected bad result and betrayal - in this case, betrayal of a helping professional. To the extent that we arachnoiditis sufferers underwent medical procedures which carried a known risk of ARC that was not disclosed beforehand: this makes the disease even harder to bear. A valid analogy is when someone who was supposed to be helping instead gave me poison that will remain in my system and make me hurt for the rest of my life. That is depressing, to sat the least.

I also feel that dealing with this reality is extremely difficult. "Forgive and forget" is not often readily possible; it seems impossible to forget when one is in pain and has suffered irretrievable losses. I personally feel that we should also not be too quick to forgive. At the very least, we should not forgive until we can describe and adequately grieve our losses from Arachnoiditis. Then, maybe then, forgiveness is possible. Of course it helps immensely and probably speeds up the forgiveness process if the person who caused the Arachnoiditis is interested in taking some responsibility for her/his actions. In the absence of a volitionally responsible party(ies), it may be helpful to remember that forgiveness is something that is primarily for the benefit of the person doing the forgiving. Likewise, a failure to constructively deal with anger and loss can add spiritual disease to what we already are suffering. The anger and grief has to be constructively directed outward, or it will eat us up spiritually from within. Whatever it takes, however long it takes, whatever it costs to be able to turn the anger and grief constructively outward instead of inward is worthwhile in preventing depression.

to be continued…………………………………….

Sara Ann Conkling

My special thanks go to the Biomedical Library at the University of Pennsylvania for their generosity in allowing me access to many resources used for this article.

Selected Bibliography

Ashburn, Michael A., MD, and Peter S. Staats. MD, "Management of Chronic Pain", The Lancet, vol. 353(9167), pp.1865-69.

Atkinson, J. Hampton, et.al., "Prevalence, onset, and risk of psychiatric disorders in men with chronic low back pain: a controlled study", Pain, vol 45(1991), pp. 111-21.

Burton, CV, MD, "Adhesive Arachnoiditis", in Neurological Surgery, Third edition, vol. 4, pp. 3856-63.

Carosella, Ann Marie, et.al., "Factors associated with early discharge form a multidisciplinary work rehabilitation program for chronic low back pain", Pain, vol 57 (1994), pp.69-76.

Cats-Baril, William L., Ph.D., et. al., "Identifying Patients at Risk of Becoming Disabled because of Low-Back Pain", Spine, vol. 16, number 6 (1991), pp. 605-7.

Crauford, D.I.O., MB, MRCPsych, et.al., "Life Events and Psychological Disturbance in Patients with Low-Back Pain", Spine, vol. 15, number 6 (1990), pp. 490-494.

DSM-IV, otherwise known as the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition

Florence, David W., MD, "The Chronic Pain Syndrome", Postgraduate Medicine, vol. 70, number 5 (November, 1981), pp. 217-9+.
Golden, Tom, LCSW, Crisis, Grief and Healing Web Page, http:\\www.webhealing.com
Guyer, David W., MD, et.al., "The Long-Range Prognosis of Arachnoiditis", Spine, vol. 14, number 12 (1989), pp.1332-41.
Heliovaara, Markku, MD, et.al., "Determinants of Sciatica and Low-Back Pain", Spine, vol. 16, number 6 (1991), pp. 608-14.
National Institute of Neurological Disorders and Stroke, Arachnoiditis Web Page, http://www.ninds.nih.gov/health_and_medical/disorders/arachnoi_doc.htm.
Polatin, Peter B., MD, et.al., "Psychiatric Illness and Low Back Pain", Spine, vol. 18, number 1 (1993), pp. 66-71.
Sanders, Steven H., et. al, "Relationship between Psychopathology and Graduated Spinal Block Findings in Chronic Pain Patients", Pain, vol. 19 (1984-), pp. 367-72.

LETTER FROM THE GOOD SIDE OF THE MINCH
by Mike Feehan

Firstly to explain the title. I have taken up residence, thanks to my great friend Jude, on the island of Lewis. This is one of the those islands which are collectively known as the Outer Hebrides or the Western Isles, they can be found off of the east coast of Scotland in the UK.

So grab the family atlas and follow the left-hand outline of the UK until you arrive at the Scottish border. Then keep going and you will find us parked in the sea off to the left, on the far side of that body of water known as “The Minch”, hence our title.

When I was asked to submit an article for this publication I was taken aback for just a second. What could I tell you all? I am still awaiting a definitive diagnosis of Arachnoiditis (ARC) some 2 years and 7 months after having discovered that it was the most probable cause of my pain and other symptoms, both of which have increased over that time. My medication has been increased with additional drugs to help ease the pain and improve the performance of other bodily functions. I am still unemployed. Well, who would employ a sufferer who cannot even guarantee one full day’s work a week?

This all sounds very negative and there is enough negativity regarding ARC to fill a few sick buckets. But, it does not sum up my life, I have a great deal more going on besides the above which all falls on the positive side of the coin. So it is this which will form the basis of this article. I also hope that it will inspire some folk to follow some of the ideas for themselves and gain the same amount of benefit.

I have spent a great deal of time researching the history of radiology and the origins of Chemically Induced Arachnoiditis. There are many sources of information on the Internet, which I have carried out from the comfort of my own home. Right now I am going through it all, verifying it, which partly why I have not loaded it yet. I must ensure that it is genuine. There are many Internet sites, which rant on hysterically, lambasting the medical profession with accusations, which cannot be supported. They can be instantly dismissed under close professional scrutiny and do our cause no good at all.

It is through this research that I came in contact with Professor Aldrete. I can recommend his excellent book as being a great place to start, if you know little or nothing about ARC. Sure it is full of medical terminology which, at first, appears daunting, but, feeding those terms into a Search Engine often brings up training material from teaching hospitals which explains it. After a while you will find that it begins to make sense and you feel comfortable with it.

Having worked very hard at gathering the facts regarding ARC I naturally, created a web-site to publish the results with Jude doing the building and me writing the text. I have not published a great deal yet because I have dedicated a lot of time to responding to sufferers from around the world who have emailed me for advice and information.

In addition I have been checking and double checking the results, assisting a documentary producer, helping my mate in Australia by acting as an unpaid Press Officer and working with a disabled sports group.

However, no matter how busy I am, I am always willing, ready and able to dispatch packages of information for sufferers of ARC. If you need information or advice I will certainly answer your e-mail with one of these packages which can be tailored to your situation.

Documentary on ARC

A small Manchester based Media Company, Snazzreality, is making a documentary about ARC. The boss is a young lady called Isabel Buckley whose mother is an ARC sufferer. After caring for her over an eight-year period, Isabel wanted some straight answers about her mum's conditions. Having discovered that her Mom's ARC may have had iotragenic causes she decided to do something about the appalling lack of recognition, knowledge and support for UK sufferers.

So she took herself off to college to learn how to make a documentary, despite being a busy mother of three. After that she purchased the required equipment, with the help of her partner Carl, and started to get material on film. She and Carl spent three days with us here going through the information I had acquired and filming interviews with Jude and myself. We became very close friends during their stay and this lead to us all taking a trip to London to interview Professor Aldrete. I was over the moon when they invited me along because the Professor had supported me through a very trying period after that first dismissive MRI report, the story of which is included in the article on my site. We spent about 3 or 4 hours with him in London and I got a chance to ask him many of the questions, which had puzzled me from the start. I am happy to report that his answers cleared up many of my doubts.

Isabel and Carl are now working very hard at editing the results of our efforts into a cohesive and comprehensive documentary in their new offices in Isabel's hometown. Carl has also given up his position as a teacher in order to concentrate fully on the project. So far they have invested everything they could beg, steal or borrow. The finished product should be available around May this year, for full details, and a snippet of film, visit their site at: http://www.snazzreality.co.uk.

The amount of work still to be done came home to me when they told me that they had spent almost 8 hours yesterday producing an 8-second graphics clip showing what ARC looks like from the inside. Their dedication to bringing ARC to the attention of the public shines through everything they do.

In the meantime, Isabel"s Mom Bobby, the inspiration for the whole project, is coming to grips with computer technology and loves to hear from other sufferers. She is a very tough cookie with a great sense of humour and a firm grip on reality. I met her on my return from London to Manchester, where I awaiting my lift home with Jude. We had a great chat and it was good to be able to relate to another sufferer of ARC, we correspond regularly now and support each other through some of the tough times.

The Fight for Benefits

In the UK the Department of Health and Social Security have not been the most forthcoming organisation I have ever had to deal with. Since I was first deemed unfit to work by my doctors I have had a long uphill struggle to get the Benefits my working life has entitled me too. I know from the correspondence I receive that this experience is not limited to the UK and that many of you are fighting just as hard. To be continued……………..

Regards,
Mike Feehan

RESEARCH

Basic research on Arachnoiditis

Under the sponsorship of the Arachnoiditis Foundation, Inc, an ambitious project to study the mechanisms of how ARC is caused and what leads to the permanent lesions, noted in X-rays, that are responsible for the symptoms experienced by patients with this disease has began.
A grant request by Dr. Gabriel Guizar and his collaborators was funded by the Foundation to develop an experimental model for ARC. Dr. Guizar is the Medical Director of the Proyecto CAMINA, A.C., who includes a group of neuroscientists in Mexico City supported by private groups and governmental institutions dedicated to the "study of paralysis produced by lesions to the spinal cord (SC) and other neurological conditions.
Specifically their studies include investigations on the effects of direct contusion to the SC and all the sequelae that follows it (blood pressure, drug metabolism, endocrine gland response, partial recovery, etc), all of which are altered. In addition this group has studied SC and peripheral nerve transplantation and pioneered the treatment of Parkinson disease with adrenal gland implants to the brain.
The studies have promptly began and are progressing though it will take some time to bare fruits that we can apply to the clinical situation nevertheless this is

the beginning and we intent to go forward. All your donations and gifts to the Arachnoiditis Foundation will be used (without administrative expenses) to fund this and other forthcoming research projects.

In the meantime, in the clinical aspects, studies are being conducted to evaluate some already approved (and used for years) medications that have other indications to determine their effect tin the treatment of patients with ARC.

INFORMATION FRONT

We continue our information campaign on the risks and effects of invasive spinal procedures and operations at all levels and to all parties involved. Toward this goal in the last three months we have done the following:

a. On March 4th Dr. J.A. Aldrete presented a lecture on the "Causes and Diagnosis of Arachnoiditis from neuroaxial blocks" before the Colegio Mexicano of Anestesiology in Mexico City. Over 425 physicians attended and since then other invitations have been offered for more presentations and similar topics.
b. In the immediate future on April 26th Dr. J.A. Aldrete will present a poster on "Radiological diagnosis of arachnoiditis in relation to possible cause" at the Annual Meeting of the American Society of Regional Anesthesia in Chicago, IL.

REFLECTIONS:

What is next?
After the snow, the water melts,
After the storm, the calm reigns,
After the deluge
Drought supposedly sets.

Next comes the everafter.
Ever, because it is always there,
After, because it happens later on,
So, next is what follows afterever.

Nothing was before,
Then came everything as whole.
When everything appears as before

That means nothing is due to a whole.

So, what comes next?
May be leftovers
Of yesterday and today
That are over and left behind.
What will be next is for us to make
Turn it into happiness
Or, a real living hell.

J.A. Aldrete

CAUSES OF ARACHNOIDITIS

The following is an abstract from an article that appeared in Pain Digest (1999) 9:226-234.
<u>Current Guidelines in the Use of Epidural Steroids: Reports from Australia, Belgium, Norway, The Netherlands, the United Kingdom, and the United States of America</u>. By Prof. N. Bogduk, University of Newcastle, Newcastle Bone and Joint Institute and the National Directorate for the Musculoskeletal medicine Initiative. David Maddison Building, Royal Newcastle Hospital, Newcastle, NSW 2300,Australia.

Executive Summary of the paper

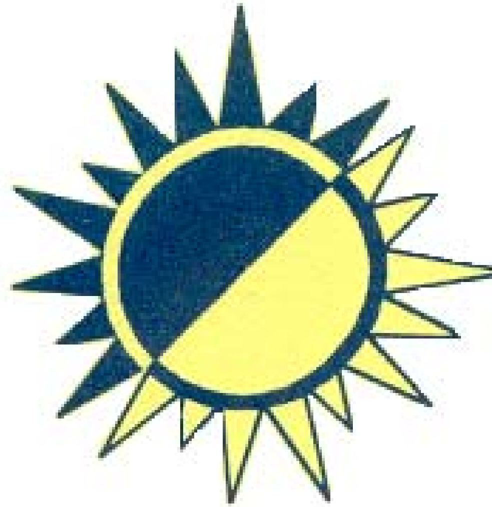
1. The term epidural steroids refers to the injection of corticosteroids into the epidural space of the vertebral column as a means of treating pain of spinal origin.
2. Steroids can be injected into the lumbar epidural space by way of an interlaminar route (lumbar epidural steroids) or a transsacral route (caudal epidural steroids). In the cervical spine epidural steroids can be delivered by an interlaminar route. Less commonly used is the transforaminal route at lumbar and sacral levels.
3. There is no indication in the literature as to what constitutes a "standard" epidural injection. Different authors have reported the use of different steroids in different doses and with a variety of different adjunct agents such as normal saline and local anesthetics different concentrations and in different volumes.
4. Over the past 40 years the use of epidural steroids has enjoyed endorsement in the medial literature throughout the world; however,
   --the endorsement of epidural steroids pertains only to the use of caudal and lumbar epidural injection for radicular pain described as sciatica or in similar term.
   --There is only a small body of literature eon the of cervical epidural steroids, which is mixed with respect to favor, enthusiasm, and results;

and

--There is a minimal body of literature pertaining to the use of epidural steroids for the treatment of any form of spinal pain other than radicular pain.

5. The rationale for the use of lumbar and caudal epidural steroids is the belief that lumbar radicular pain involves and inflammatory process of the affected nerve or its dural sleeve; but the evidence for this belief is, at best, circumstantial.
6. A competing theory is that the apparent therapeutic effect of epidural steroids does not arise because of the anti-inflammatory action of the drug but because of its capacity (like a local anesthetic) to block conduction in the spinal nerve, its roots or the nerves that supply the nerve-root sleeve.
7. The chief apparent effect of epidural steroids is to reduce pain but this effect is limited in duration. Although more lasting remissions have been reported, the proportion of patients obtaining relief of pain following a circumstantial.
8. A competing theory is that the apparent therapeutic effect of epidural steroids does not arise because of the anti-inflammatory action of the drug but because of its capacity (like a local anesthetic) to block conduction in the spinal nerve, its roots or the nerves that supply the nerve-root sleeve.
9. The chief apparent effect of epidural steroids is to reduce pain but this effect is limited in duration. Although more lasting remissions have been reported, the proportion of patients obtaining relief of pain following a single injection attenuates rapidly, with most receiving good relief for a matter of weeks or for up to 3 months after the injection, and only a small proportion obtaining longer-lasting relief.
10. Despite its widespread endorsement in the literature, the use of epidural steroids has not been vindicated by double-blind, controlled trials with:
    Two controlled studies of caudal epidural steroids that approach, but do not achieve, statistical significance;
    --One acceptable study of lumbar epidural steroids that denies any benefit in patients with myelographically confirmed nerve-root compression;
    --One controlled study of lumbar epidural steroids that demonstrated a statistically and clinically significant superiority of steroid mixed with local anesthetic over sham therapy but did not demonstrate whether the steroid, the local anesthetic, or the combination of both was the active ingredient; and
    --One controlled study of lumbar epidural steroids that showed no superiority of steroid over normal saline alone, local anesthetic alone, or sham needling of an interspinous space.
11. Epidural steroids are associated with a number of side effects and complications. Of these, only very rare problems such as fluid retention, hypercorticocism, and allergy can be attributed to the steroid agent injected.

12. The most common side effects and complications of lumbar and caudal epidural steroid injections relate not to the steroid injected but to the technical aspects of the procedure.
13. The most common technical side effect is temporary exacerbation of pain, which occurs in about 1% of lumbar epidural steroid injections and appears to be related ot the volume of substance injected into the epidural space.
14. Dural puncture is a potential complication of any epidural injection, regardless of what might or might not be injected. It is a rare complication of caudal epidural injection, but in the context of lumbar epidural injections it has a mean incidence of about 5%.
15. the foremost side effect of dural puncture is headache, which arises either as a result of leakage of CSF or as a result of inadvertent injection of air into the subarachnoid space.
16. The prevalence of headache following lumbar epidural steroids is about 1%. The prevalence of long-term headache following epidural steroids is unknown, but following epidural anesthesia the prevalence of headaches lasting many months is about 0.1%.
17. There is no experimental evidence or reliable clinical evidence that any steroid preparations have a deleterious effect on neural tissue, provided they are injected into the epidural space.
18. Experimental studies in animals have shown explicitly that neither triamcinolone nor methylprednisolone exerts any deleterious effect when injected into the epidural space. However, many of the constituents of commercially available preparations that might be used for epidural steroids contain ingredients that have been shown directly or by inference to exert deleterious effects on nerve tissue or the meninges if injected into the subarachnoid space, e.g., local anesthetics.
19. In the conduct of lumbar epidural steroid injections, there is a risk, albeit small, that if dural puncture is not recognized, the inadvertent intrathecal injection of a steroid preparation could be associated with deleterious complications ascribable, not so much to the steroid agent, but its accompanying ingredients.
20. Multiple injections of corticosteroid preparations into the subarachnoid space appear to be associated with increased risk of complications.



PAIN CONTROL DIET

J. Antonio Aldrete, MD, MS
With the assistance of Sonya C. Johnson, LPN
and Fréderika H. Montpetit, NP
P.O. Box 4627
Seaside, FL 32459-4627
Phone: (850)622-0653
Website: www.arachnoiditis.com
E-mail: taldrete@arachnoiditis.com

ANSWERS ABOUT YOUR HEALTH AND NUTRITION

HOW HEALTHY IS THE TYPICAL AMERICAN DIET?

Two out of three Americans eat high-fat, high-sugar foods that may increase the risk of heart disease, cancer, diabetes and high blood pressure. However, a growing number of Americans are becoming more health-conscious eaters and are consuming fewer calories, but more fruits, vegetables, whole grains, beans, low-fat dairy foods, chicken, turkey and fish.

WHY SHOULD I BE CONCERNED ABOUT MY BLOOD CHOLESTEROL LEVEL?

Too much cholesterol increases your risk of heart disease. Although cholesterol is manufactured in the body, eating foods containing high levels of cholesterol or saturated fat raises the level of blood cholesterol. Evidence shows that the higher your blood cholesterol level, the higher your risk of heart disease. The recommended level of blood cholesterol for adults is 30 years and older is under 200 mg ldl.

WHAT IS THE CONNECTION BETWEEN DIET AND BLOOD CHOLESTEROL?

Cholesterol is obtained directly from foods of animal origin. However, an even more important factor in elevated blood cholesterol is the saturated fat in the diet, some of which is converted into cholesterol in the body. Most saturated fat is also obtained from food of animal origin. Several vegetable fats that are saturated are coconut, palm-kernel oil, and hydrogenated oils.

IS FASTING, SKIPPING MEALS AND EATING LESS THAN 750 CALORIES A DAY A GOOD WAY TO LOSE WEIGHT?

No. The above methods produce temporary weight loss at best, and will probably produce weight gain in the long run. The pounds lost are mainly from water and protein. It is better for your health and figure not to set yourself up for “starvation,” thus lowering your basal metabolic rate. Instead, increase your energy expenditure through exercise and eat a healthy balance of nutrients controlled in calories.

WHY SHOULD I BE CONCERNED ABOUT CALCIUM IN MY DIET?

More than 15 million Americans have some degree of osteoporosis, much of which could be prevented. Two out of three women over seventeen do not get enough calcium in their diets. Since your body cannot manufacture calcium, it depends on you to supply it. If you do not eat calcium-rich foods every day, your body takes the calcium it needs out of your bones and puts it into the blood system for its use. Calcium taken from your bones is not replaced and causes bones to become weak and brittle.

If you are having difficulty getting enough calcium from your diet, check with your physician regarding calcium supplementation. Calcium carbonate is the best form of supplemental calcium. Be sure to accompany your calcium supplement intake with lots of water. Good sources of calcium include low-fat, skim dairy products, salmon, sardines and dark, leafy green vegetables. If you have difficulty getting enough calcium from your diet, check with your physician regarding calcium supplementation. Calcium carbonate is the best form of supplemental calcium. Be sure to accompany your calcium supplement intake with lots of water.

WHY DO I HAVE THE URGE TO EAT WHEN I FEEL NERVOUS, DEPRESSED, LONELY OR BORED? ANY SUGGESTIONS?

- Do something that takes concentration, such as playing cards, working a puzzle, doing needlework, or exercising.
- Do something that cannot be done while eating, such as singing, jogging, painting or taking a shower.
- Remove yourself from where the food is located. Exercise, go shopping, read a book or clean a closet.
- To control eating, restrict the areas where you allow yourself to eat such as your car, the TV room, your bedroom, etc.
- Take up a hobby.

WHAT CAN YOU EAT TO REDUCE YOUR PAIN?

OBJECTIVES OF NUTRITIONAL COUNSELING

Long-term objectives: Patient or significant other verbalizes knowledge of the principle of dietary treatment, the ability to plan purchase for, prepare and select a prescribed pain control diet. The patient or significant other can verbalize an understanding of the relationship between diet, serotonin levels, the role of tryptophan, weight loss and physical activities.

Element: Patient or significant other demonstrates the ability to execute the prescribed pain control, weight-reducing diet, and a knowledge of the role of the diet in the management of pain.

1. Selecting food choices selected from the food exchange, required to include within the prescribed levels of calories.
2. Writing menu for one day using the food exchange list and the prescribed meal pattern for level of calories.
3. Retains knowledge of the purchasing and preparation practices needed for executing the prescribed diet.
4. Verbalizing the relationship between diet, serotonin and tryptophan level, weight and level of physical activity.

Plan of action:

1. Upon receipt of a physician's order, the designated Aldrete Pain Care Center personnel will give instructions in:
    a. Proper interpretations of the rationale for a Pro restricted diet and High Complex diet for needed tryptophan and serotonin level.
    b. Concept of controlling calories to achieve or maintain ideal body weight.
    c. The use of the diet exchange as a working reference to plan the diet (meal plan) and provide options for food selection.
    d. Understanding of the need to increase fluid intakes, from 8 to 10 cups per day.
2. Patient or significant other is given a written copy of the diet and the exchange list and their prescribed meal plan and calorie diet.
3. Instructions on food and drug interaction as necessary.

4. Counseling activities are to be documented on the Medical Progress Note of the patient's chart.

YOU ARE WHAT YOU EAT—WHY NOT THINK ABOUT IT?
PAIN CONTROL DIET

High Carbohydrate, Reduced Protein and Fat, No Caffeine

INDICATION: This diet is recommended in conjunction with pain management programs. This diet is adequate in the specified nutrients from the 1989 Recommended Dietary Allowances except for protein at very low calorie levels of 1,000 calories or below.

RATIONALE: Tryptophan, an amino acid, is the precursor for Serotonin, one of the body's own pain killers. A carbohydrate-rich meal can increase the level of Tryptophan and Serotonin in the brain. Studies have shown that increased Serotonin in the brain decreases pain levels and seems to do so by increasing pain tolerance. A balanced diet is essential in order to replete the body stores and to avoid deficiencies. Weight loss, if necessary, is beneficial in that the strain on the body is reduced.

DESCRIPTION: This is a regular diet based on the Dietary Guidelines along with the following restrictions:

1. High complex carbohydrates (60% of total calories). With emphasis on fiber-rich fruits, vegetables, whole grain breads and cereals. A high carbohydrate bedtime snack is recommended.
2. Restricted protein (15% of calories).
3. Moderate fat (25% of calories).
4. Controlled calories to achieve or maintain ideal body weight. Foods need to be chosen carefully to insure adequate nutrition without consumption of excess calories.
5. Diet exchanges are used as a reference base and to provide options for food selection.
6. Increased fluid intake. Eight to ten cups per day. However, caffeine is restricted.

Reference:
Bonica, J.J., Febiger, Lea
The Management of Pain.
1990

CALORIE-RESTRICTED PAIN CONTROL DIET

INTRODUCTION:
Your doctor has ordered a ____________ calorie diet for you. For lasting results, it is best to lose weight gradually while changing your eating habits so that you are able to maintain your ideal weight when you reach it. At all times, it is important that the food you eat meets your nutritional requirements for good health.

BASIC PRINCIPLES OF YOUR DIET
To plan your meals, a method called the **Exchange System** is used. Foods are divided into six groups (called **Exchange Lists**), according to the nutrients they furnish. Portion sizes are fixed so that within each Exchange List, each choice has about the same calories and nutritional value. Your plan allows a specific number of choices from each group. You will be using measuring spoons and cups to measure the portion (**exchange**) size.

Food preparation is important. Anything you eat must come from your meal plan. Fats, butter, oils, etc. add calories and may be used only in the amounts allowed from the Fat Exchanges. Broiling, baking, steaming, simmering in water, charcoaling, or using a nonstick finish skillet are all good ways to prepare meat without adding fat. Watch out for "empty calories." These are foods that furnish very little nutritional value for their calories. They include sugar (any kind), jam, jelly, honey, syrup, rich desserts, candy, regular soft drinks, etc. **THESE ARE FOODS TO AVOID!!**

To season your food, you may use many things. Spices and herbs are not limited…be creative in adding them to your food flavor. Also, try lemon juice or vinegar to tenderize meat. See **Food Exchange Lists** for a guide to how many food exchanges you can have at each meal.

FREE FOODS
The following may be used without measuring unless otherwise instructed:

- Broth, consommé, bouillon cubes
- Club Soda
- Coffee, hot/iced tea, decaffeinated
- Cranberries or rhubarb (unsweetened)
- Flavoring essence (butter, rum, lemon, maple, vanilla)
- Gelatin, unflavored or diet
- Herbs and spices
- Vegetables (See List 6)
- Lemon-lime
- Low-calorie salad dressings
- Pickles, dill or sour
- Prepared or dry mustard
- Soy sauce
- Sugar-free soft drinks, decaffeinated
- Sugar substitutes
- Vinegar, Worcestershire sauce

MEAL PLAN

The following is a guide to how many food exchanges you can have for each meal:

BREAKFAST:

2 Fruit or Juice Exchange *(List 1)*
1 Meat (Eggs or Cheese) Exchange *(List 3)*
2 Bread or Cereal Exchange *(List 2)*
1 Fat Exchange *(List 4)*
1 Milk (Whole, Low-Fat, Skim) *(List 5)*

LUNCH:

1 Meat Exchange *(List 3)*
2 Bread or Cereal Exchange *(List 2)*
2 Vegetable Exchange *(List 6)*
___ Free Vegetables as desired *(List 6)* **AS MUCH AS YOU WANT**
2 Fruit Exchange *(List 1)*
2 Fat Exchange *(List 4)*
0 Milk (Whole, Low Fat, Skim) *(List 5)*

DINNER:

2 Meat Exchange *(List 3)*
2 Bread or Cereal Exchange *(List 2)*
2 Vegetable Exchange *(List 6)*
___ Free Vegetables as desired *(List 6)*
2 Fruit Exchange *(List 1)*
0 Fat Exchange *(List 4)*
2 Mild (Whole, Low Fat, Skim) *(List 5)*

BEDTIME SNACK:

1 Starch
2 Fruit Exchange *(List 1)*
1 Skim Milk

CALORIE-RESTRICTED DIET

LIST 1 – FRUIT EXCHANGES

(Unsweetened, no sugar added)
(60 calories)
(Fresh whenever possible)

***Apple*……………………………………**	1 small (2” diameter)
Apple Juice……………………………..	½ cup
Applesauce……………………………..	½ cup
Apricots, Fresh…………………………	4 medium
Apricots, Dried…………………………	7 halves
Banana………………………………….	½ small
Berries (Black, Blue)…………………..	¾ cup
Cantaloupe……………………………..	7” diameter
Cherries………………………………..	10 large, ½ cup
Raspberries…………………………….	1 cup
Dates…………………………………..	2 ½ medium
Figs, Fresh…………………………….	2
Figs, Dried…………………………….	1 ½
Fruit Cocktail…………………………	½ cup
Grapefruit…………………………….	½ small
Grapefruit Juice………………………	½ cup
Grapes………………………………..	15 small
Grape Juice…………………………..	1/3 cup
Honeydew Melon……………………	1/8 (7” diameter)
Mango……………………………….	½ small
Nectarine…………………………….	1 small
Orange……………………………….	1small
Orange Juice…………………………	½ cup
Papaya……………………………….	1 cup medium
Peach…………………………………	1 medium, ½ cup
Pear………………………………….	1 small, ½ cup
Persimmon, Native………………….	2 medium
Pineapple……………………………	½ cup
Pineapple Juice……………………..	½ cup
Plums………………………………	2 medium
Prunes, Dried……………………….	3 medium
Raisins………………………………	2 Tbsp.
Strawberries………………………..	1 ¼ cup
Tangerine…………………………..	2 medium
Watermelon………………………..	1 ¼ cup

LIST 2 – BREAD EXCHANGES

(Without added sugar or fat)
(80 calories)

- Biscuit (omit 2 fat)……………………………………………. 1
- Bread………………………………………………………….. 1 slice
- Bagel, small…………………………………………………… ½
- English Muffin……………………………………………….. ½
- Plain Roll…………………………………………………….. 1
- Bun, Hamburger………………………………………………. ½
- Bun, Hotdog………………………………………………….. ½
- Bread Crumbs………………………………………………… 3 Tbsp.
- Tortillas, 6"…………………………………………………… 1
- Cereal
  - Dry unsweetened………………………………… ¾ cup
  - Cooked……………………………………………. ½ cup
- Grits, rice, spaghetti, barley, noodles, and macaroni………. ½ cup (cooked)
- Popcorn (no fat)………………………………………………. 3 cups
- Cornmeal……………………………………………………… 2 ½ Tbsp.
- Cornbread…………………………………………………….. 2" cube
- Flour………………………………………………………….. 2 ½ Tbsp.
- Crackers
  - Graham (2 ½" sq.)……………………………….. 3
  - Oysterettes……………………………………….. 24
  - Saltines…………………………………………… 6
  - Soda (2 ½" sq.)…………………………………… 4
- Beans, peas, lentils (dried and cooked)…………………….. 1/3 cup
- Baked beans, no pork………………………………………. ¼ cup
- Corn…………………………………………………………… ½ cup
- Corn on cob…………………………………………………… 1 small
- Lima beans……………………………………………………. ½ cup
- Mixed vegetables…………………………………………….. ½ cup
- Parsnips………………………………………………………. 2/3 cup
- Peas, green……………………………………………………. ½ cup
- Potato, white…………………………………………………. 1 small
- Potato mashed………………………………………………… ½ cup
- Potato, sweet or yam…………………………………………. 1/3 cup
- Wheat germ…………………………………………………… 3 Tbsp.
- Winter squash, acorn or butternut………………………….. 1 cup

MISCELLANEOUS

- Cake, without icing
  - Angel or sponge………………………………….. 1 ½" cube
- Gelatin dessert, sweetened…………………………………. ½ cup

- Ice Cream (omit 2 fats)…………………………………….. ½ cup
- ***Sherbet*****………………………………………………...** ¼ cup

LIST 3 – MEAT EXCHANGES

(Prepare without additional fat or sugar)
(75 calories)

- Lean Meat and Poultry…………………………………….. 1 oz.
  (Beef, lamb, liver, pork, veal, chicken, turkey, etc.)
- Cold cuts – low fat………………………………………… 1 ½ oz.
  (4 ½" sq. 1/8" thick)
- Frankfurter (limit 1/day)………………………………….. 1 small
- Fish
  - Any fresh or frozen………………………….. 1 oz.
  - Canned tuna, salmon, mackerel, lobster, crab…. ¼ cup
  - Oysters, shrimp, clams, scallops………………. 5 small or 2 oz.
  - Sardines…………………………………….. 2 medium
- Cheese
  - ***American*****……………………………………..** 1 oz.
  - Cottage……………………………………… ¼ cup
- Egg…………………………………………………. 1
- Peanut Butter (omit 2 fat exchanges)…………………… 2 Tbsp.

LIST 4 – FAT EXCHANGES

(45 calories)

- Avocado………………………. 1/8 (4" diameter)
- Butter or Margarine…………… 1 tsp.
- Diet Margarine………………... 1 Tbsp.
- Bacon, crisp…………………… 1 slice
- Cream, light, 20%…………….. 2 Tbsp.
- Cream, heavy, 40%…………… 1 Tbsp.
- Cream cheese…………………. 1 Tbsp.
- Dressing, French or Italian……. 1 Tbsp.
- Dressing, Salad………………... 2 tsp.
- Reduced Calorie Dressing…….. 1 Tbsp.
- Mayonnaise…………………… 1 tsp.
- Diet Mayonnaise……………… 1 Tbsp.
- Nuts…………………………… 6 small
- Oil or Cooking Fat……………. 1 tsp.
- Olives…………………………. 10 small
- Sour Cream…………………… 2 Tbsp.

LIST 5 – MILK EXCHANGES

- Whole (150 Calories)…………… 1 cup
- Low Fat (120 Calories)…………. 1 cup
- Skim (90 Calories)……………… 1 cup
- Yogurt, Plain (90 Calories)…….. 1 cup

LIST 6 – VEGETABLE EXCHANGES

(Prepare without additional fat or sugar)
(25 calories)
One Vegetable Exchange is ½ cup cooked (boiled)

- Asparagus
- Bean Sprouts
- Beets
- Broccoli
- Brussel Sprouts
- Cabbage
- Carrots
- Cauliflower
- Celery
- Cucumbers
- Mushrooms
- Okra
- Onions
- Pepper
- Rhubarb
- Rutabaga
- Sauerkraut
- String Beans
- Eggplant
- Greens
    - Beet
    - Chard
    - Collard
    - Dandelion
    - Kale
    - Mustard
    - Spinach
    - Turnip
- Squash
- Jicama
- Tomatoes
- Tomato Juice
- Turnips
- Vegetable
    - Juice
    - Cocktail
- Zucchini

FREE VEGETABLES

The following raw vegetables may be used as desired. Other raw vegetables, limit to 1 cup.

- CHICORY
- CHINESE CABBAGE
- ENDIVE
- ESCAROLE
- LETTUCE
- PARSLEY
- RADISHES
- WATERCRESS

TIPS FOR STREAMLINING CALORIES

- Reduce or eliminate the amount of fat in the recipe. Cook onion and green pepper in a little broth instead of browning in fat. Enhance flavor by adding garlic or onion powder or flavored salts. In quick breads such as muffins and fruit loaves, the fat can frequently be reduced to just a few tablespoons. It is usually not necessary to brown meat in oil. Instead, cook meat in its own fat and pour off the drippings. Eliminate the dabs of butter (unnecessary calories) from casserole and sauce toppings.
- When recipes call for milk, cut calories and cost by using reconstituted non-fat dry milk. In recipes using evaporated milk or coffee cream, substitute evaporated skim milk.
- Refrigerate stews, soup and roasts before service so fat will harden and can be removed before reheating dish. Chill meat drippings and remove fat; serve the roast au jus instead of gravy. Make gravy from skimmed fat-free broth, skim milk and minimum cornstarch or flour.
- Serve foods more simply. Instead of Heavenly Hash, make a fresh fruit compote. Serve vegetables and meats with natural juices instead of heavy sauces saving time and money as well as calories.
- Reduce sugar in quick breads, muffins and cookie recipes by using natural sweeteners such as bananas, raisins, shredded carrots or chopped apple. Extracts such as vanilla, almond cherry, also enhance sweetness. Experiment using one chopped apple or banana in with your favorite recipes and cutting back on sugar.
- Substitute low-fat cheese and skim milk for whole milk and regular cheese in cheese sauce and other cooking. Laughing Cow cheese (green label reduced calorie variety from Fromageries Bel) melts well and is good on potatoes and bread. Danalette is another good low-fat cheese. So is NuTrend cholesterol-controlled cheese.
- Use lean bits of ham, Canadian bacon, ham bone, herbs, spices, garlic, onions and beef or chicken broth to season vegetables instead of butter, bacon, ham hocks or salt pork.
- Be alert to hidden fat. Fat supplies more than twice the calories of carbohydrates or protein. One gram of pure fat equals nine calories. By comparison, one gram of protein or carbohydrate supplies only four calories. Many foods contain significant amounts of hidden fat. Among these are nuts, avocados, olives, bacon, cheese and cream. Remove every bit of visible fat possible from meats before cooking. Estimate one teaspoon of fat for each small muffin, biscuit or pancake, and that's before you add butter!
- For fatty luncheon meats, substitute wafer-thin sliced packaged sandwich meats, turkey pastrami, Canadian bacon, boiled ham and honey loaf. These are lower in fat and calories, about 55 per ounce (but are high in salt). Some suggestions by brand name: Eckrich pressed luncheon loaf, chopped ham, breast of chicken, gourmet loaf, peppered loaf, jellied corn beef and barbecue loaf; Oscar Mayer jellied beef loaf, jelled corn beef, luncheon roll sausage, luxury loaf and New England sausage; Wilson's pepper loaf, jellied cooked roast beef, canned pork loin and canned roast beef.
- Controlling what you eat when you dine out is not easy, but it can be done with a little extra effort and planning. Do not starve yourself all day if you are going out to dinner. You will be too hungry to eat with control. Have a light breakfast and lunch and make a special effort to avoid foods high in fat. Eat only what you order. Do not fill up on tortilla chips, crackers, bread or cheese placed on the table before the meal. Have the waiter serve them with the meal or remove them from the table. Eat slowly and enjoy the meal, knowing that you are not overindulging.
- Prepare vegetables with imagination and fill up on them. Steam colorful combinations together just until tender. Season with spices and herbs. Try stir-frying in a wok or electric fry pan; you will only need one tablespoon of oil or less.

SAMPLE DAY – MENU

Meal	Item	Category
BREAKFAST:	• 2 Hard-Boiled Eggs	✓ Protein
	• 2 Slices Whole Wheat Toast	✓ Complex Carbohydrate
	• 1 Tbsp. Margarine	✓ Condiment
	• 1 Cup Skim Milk	✓ Low-Fat Dairy
	• 1 Medium Orange	✓ Fruit
LUNCH:	• 1 Turkey (4 oz.) Sandwich on whole wheat bread w/ lettuce and tomato	✓ Protein ✓ Complex Carbohydrate
	• 1 Tbsp. Margarine	✓ Condiment
	• ¾ Cup Plain Low-Fat Yogurt	✓ Low-Fat Dairy
	• 1 Glass Iced Tea	✓ Unlimited Extra Fruit
	• 1 Cup Strawberries	✓ Fruit
DINNER:	• 6 oz. Fish	✓ Protein
	• 1 Large Baked Potato	✓ Complex Carbohydrate
	• 1 Cup Skim Milk	✓ Low-Fat Dairy
	• Steamed Broccoli	✓ Vegetable
	• Lettuce Salad w/ vinegar	✓ Vegetable (unlimited)
	• Cucumber or Cauliflower	✓ Vegetable
SNACK:	• 1 Apple	✓ Fruit

Nancy L. Fong, R.D., L.D., the registered and licensed dietician for The Houstonian Preventive Medicine Center and Phoenix Spa. Nancy has been with The Houstonian since 1981 and has over ten years of nutrition assessment and individual tailoring of your diet to achieve the maximum results of improved fitness and weight loss.

Questions, Comments or Suggestions?

CALL FOR LETTERS, ARTICLES, 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

DISCLAIMER

Personal data (E-mail, location, etc) on the authors of reports will be made available upon request, as long as the authors authorize it. The editors are entitled to modify the material so it can comply with the objectives of the Newsletter. Neither the Arachnoiditis Foundation, Inc, nor the Editors of the Newsletter are responsible for the opinions or concepts herein expressed. They represent the author's point of view.

Arachnoiditis Foundation, Inc.
P.O. Box 4627, Seaside, FL 32459-4627
Tel: (850) 622-0653 Fax: (850)622-1950
E-mail: taldrete@arachnoiditis.com