HOW TO REDUCE YOUR OPIOID DOSAGE TO 90MG OF MORPHINE EQUIVALENCE (90 MED)

>>> Chapters 1-10 <<<

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HOW TO REDUCE YOUR OPIOID DOSAGE TO 90MG OF MORPHINE EQUIVALENCE (90 MED)

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Chapter 1

If you wish to lower your opioid daily dosage to 90 MED, and we highly recommend you do so for your own well-being, we have the following recommendations. If you do not wish to lower your dosage to 90 MED, you must frankly, pursue your future pain care on your own volition as few physicians will now prescribe above this level. Thanks to some old withdrawal techniques, hormone therapies, and new opioid alternatives, the vast majority of intractable pain patients are now able to rapidly lower their opioid dosage to 90 MED and find easier access to care.

In your "March to 90" we recommend you follow the steps listed below. Our recommendations assume that the vast majority of pain patients who now take over 90 MED are patients with a severe underlying disease such as arachnoiditis or traumatic brain injury. All have centralized pain ("constant pain") with neuroinflammation and "descending" as well as "ascending" components to their pain. Consequently, our recommendations focus on centralized, intractable pain and its unique characteristics.

STEP 1 – SET YOUR GOAL:
Review the attached table and set your target opioid dosage. (See attached Table)

STEP 2 – FIND A LOCAL DOCTOR OR NURSE PRACTITIONER:
Ask any of your personal physicians as to which physicians, nurse practitioners, or clinic will prescribe opioids under 90 MED.

STEP 3 – LONG-ACTING OPIOIDS:
Stop or at least start cutting down on any long-acting opioid (e.g. fentanyl patch, Oxycontin®, MS Contin, methadone) you currently take. Be clearly advised: a long- acting opioid will block your opioid receptors and make you take a high dose of short-acting opioid to combat flare or breakthrough pain. See if your doctor can switch you to a short-acting opioid. If you are on methadone, consider dropping your dose to about 3 or 4 a day. It is extremely difficult to totally and abruptly stop methadone.

Special Note: It may be difficult to reduce to 90 MED if you are on a long-acting opioid. You may need a few months' time to stop a long-acting opioid.

STEP 4 – NATURAL PAIN RELIEVERS:
Find an effective non-prescription pain reliever such as: kratom, CBD oil, Palmitoylethanolamide (PEA). Take a natural pain reliever **before** you resort to a prescription drug or opioid.

STEP 5 – NATURAL ANTI-INFLAMMATORIES:
Curcumin, triphala. Find one that helps reduce your "baseline" or "constant" pain. Follow the dosage instructions on the label.

STEP 6 – DIET:
Try your best to follow a gluten-free diet (limit wheat & rye products). Gluten-free products are readily available. Start the day with high protein (eggs, cottage cheese, poultry, fish). Do not let yourself become too hungry. Eat on schedule.

STEP 7 – INTESTINE HEALTH:
Take a probiotic daily. They help you assimilate opioids to go from the intestine to the blood stream.

STEP 8 – SLEEP:
Take Tryptophan (1000 mg), melatonin (10 - 20 mg), or 5-hydroxytrytophan (5HTP) (500 mg) in addition to your regular sleeping medication. These natural compounds activate serotonin which will provide you with better pain relief during the following day.

STEP 9 – OPIOIDS:
Use opioid medication as a last resort after you have used your natural and non- opioid pain relievers. (Example: PEA followed by oxytocin followed by oxycodone.) Don't take an opioid unless your flare can't be controlled with a non-opioid.

STEP 10 – MAKE THE BEST USE OF YOUR CURRENT MEDICATION:
Use your current medication much wiser. The timing of intake of your medication is as important as what you take. Here are some common examples of timing to get the best use of your current medication.

1) Ketorolac – Mon., Wed., Fri., mid-morning.
2) Oxytocin or ketamine – Use for pain relief before resorting to an opioid.
3) Hormones:
   a) Methylprednisolone or dexamethasone – 3 – 4 PM on 3 to 5 days a week.
   b) Human chorionic gonadotropin – 3 – 6 PM on 3 to 5 days a week.
   c) Estradiol, nandrolone, testosterone, medroxyprogesterone, take in late afternoon.
   d) Pregnenolone, take in morning before 9:00 AM.
4) Stimulant, muscle relaxant, neuropathic agent, taurine, 7-9:00 am – Repeat mid-afternoon.

STEP 11 – DEVELOP AN EARLY MORNING PROGRAM:

Your morning program should be repeated in mid-afternoon and evening unless your pain is greatly suppressed.

Take your 1st dose of these drugs between 7 – 9:00 AM.

NEUROPATHIC ANTIDEPRESSANT ANTI-ANXIETY	**WITHDRAWAL SUPPRESSOR & GABA ENHANCER**	**STIMULANTS**	**TOPICAL CREAMS / RUB- ON PAINFUL AREAS**
Clonazepam, Diazepam	Taurine 2000 mg (2 grams)	Amphetamine Salt (Adderal®)	Carisoprodol
Carisoprodol (Soma®)		Methylphenidate (Ritalin®)	Morphine
Cymbalta®		Mormon Tea (Ephedra)	Determine where on your body pain first starts. Rub that area with a magnet or copper before applying cream.
Lyrica®			
Gabapentin (Neurontin®)			
Tizanidine (Zanaflex®)		Pseudoephedrine Phenylephrine (Sudafed®)	
Topirimate (Topamax®)			

STEP 12 – PREGNENOLONE:
Go to your local Health Food Store and purchase some. Take 25 to 50 mg each day. Why? It supports the N-methyl-D-asparate (NMDA) receptor, metabolizes to other hormones, and provides some of the same effect as Valium®, Soma®, or Neurontin® without sedation.

STEP 13 – DON'T LET YOURSELF GET HUNGRY:
Keep your blood sugar regulated. Start the day with protein. (Eggs, cottage cheese, turkey, chicken, sea food.)

STEP14:
If you can't honestly reduce to 90 MED with the above recommendations you will need medical assistance to reduce to 90 MED.

SPECIAL NOTICE:
The National pain movement is to limit opioids, emphasize non-opioid therapies, and have treatment provided in local communities by primary care providers. At this time, however, primary care physicians (internists, family physicians, nurse practitioners) are limited to prescribing 90 MED.

MAXIMAL DAILY OPIOID DOSAGES FOR 90 MG MORPHINE EQUIVALENCE

MAXIMAL DAILY OPIOID DOSAGES ALLOWED	
Approx. Oral Doses a Day	**OPIOID (Oral or Patch)**
8-9	Morphine – 10 mg
3-4	Methadone – 10 mg
8-9	Hydrocodone/APAP – 10/325 mg (Vicodin®, Norco®)
3	Morphine – 30 mg
6	Oxycodone/APAP – 10/325 mg (Percocet®)
5	Hydromorphone – 4 mg (Dilaudid®)
2-3	Hydromorphone – 8 mg (Dilaudid®)
6	Oxycodone Plain – 10 mg
2-3	Oxycodone Plain – 20 mg
2	Oxycodone Plain – 30 mg
16-20	Codeine 30 mg
8-10	Codeine 60 mg
16-18	Tramadol 50 mg
8-9	Tramadol 100 mg
1	Fentanyl Patch – 25 mcg per hour
1	Fentanyl Patch – 50 mcg per hour is 120 mg of morphine equivalence
	OPIOID INJECTIONS
2-4	Hydromorphone 50 mg/ml, .05 to .1 ml (2.5 to 5 mg)
3-4	Fentanyl 1000 mcg/ml, 0.1 ml (100 mcg) sub cu per injection
8-9	Morphine 10 mg per injection
3-4	Meperidine (Demerol®) 50-100 mg per injection
• **This table is based on recommendations of the Federal Centers for Medicare and Medicaid.**	
• **If a patient wishes, they can take 2 opioids, each at half the maximal number a day which is listed above.**	

SUPPLIES TO HELP YOU LOWER YOUR DOSAGE TO 90 MED (MORPHINE EQUIVALENCE)

Below are resources that we or some patients use to obtain supplies. Please share this information with your physicians and nurse practitioners.

ANAZAO HEALTH
5710 Hoover Blvd
Tampa, FL 33634
Ph: 1-800-995-4363
Fax: 1-800-985-4363

1. Human chorionic gonadotropin (HCG) 500 units as troche or sublingual tablet. Take 3 to 5 times a week.
2. Oxytocin, 40 units as sublingual tablet or troche. Take 1 to 2 every 4 to 6 hours for a pain flare.
3. Ketamine, 25 mg as a troche. Take 1 to 2 every 4 to 6 hours for a pain flare.
4. Hydromorphone, 50mg/ml - #20ml. Use .05 to .1 ml subcutaneous every 4 to 6 hours for a severe pain flare.

LIFE EXTENSION
P.O. Box 407198
Ft. Lauderdale, FL 33340-7198 Ph:
1 866-542-9857

1. PEA – Palmltoylethanolamide (Trade name is "Comfort Max")
2. Probiotics
3. Taurine
4. Pregnenolone
5. Tryptophan
6. Curcumin

KRATOMCRAZY.COM: Various brands of Kratom.

YOUR LOCAL HEALTH FOOD STORE

1. CBD oil products
2. Triphala
3. Probiotics
4. Tryptophan
5. Taurine
6. Melatonin
7. Pregnenolone
8. Curcumin
9. 5-Hydroxytryphan

YOUR LOCAL COMPOUNDING PHARMACY

1. Ketorolac Troches (30 mg)
2. Ketamine Troches (25 to 50 mg)
3. Oxytocin sublingual tablets or troches (40 units)
4. Nandrolone Troches (25 to 50 mg)

Chapter 2

TERRIFIC TROCHES - ESSENTIAL ON YOUR "MARCH TO 90"

Troche technology is saving the day. With their proper use, intractable pain patients can almost always drop their opioid dosage to about 90 milligrams of morphine equivalence.

- What is a troche? It is a small gelatin-like substance in which a drug is placed.
- How is it taken? Hold it between your tongue and cheek and it will dissolve.
- Is it better than a pill or shot? Sometimes. Pills have to dissolve in the stomach and intestine and be metabolized by the cytochrome system and/or liver. Consequently, usually no more that about 50% gets into the nervous system to reduce pain, suppress neuroinflammation, and promote healing. Injections are simply painful and somewhat unpredictable. Furthermore, most physicians will not prescribe injectables.

THE TERRIFIC TROCHES (For pain and neuroinflammation):

1. Ketorolac (30 mg) (Toradol®) (Pain and neuroinflammation reduction)
2. Human Chorionic Gonadotropin (500 units) (For tissue regeneration)
3. Nandrolone (25 to 50 mg) (For pain relief and tissue healing)
4. Ketamine (25 to 50) (Pain relief)
5. Oxytocin (40-80 units) (Pain relief)

Note: Oxytocin can also be made as an effective sublingual (under-the-tongue) tablet.

TAKE ACTION NOW:

1. See your local compounding pharmacy today and see which of the above troches they can make for you. We can supply a source if your local pharmacy can't make them.

2. Show this list of troches to your physicians and nurse practitioners and find out which of them they will be willing to prescribe. We can supply prescribing instructions.

JUST IN: A patient just reported she was able to stop high dose fentanyl (Oral "breakthrough" lozenges) by switching to ketorolac troches (30 mg) and nandrolone (50 mg) on 3 days a week.

SUMMARY: The 5 troches listed above represent the new technology and treatment approach to such terrible intractable pain problems as arachnoiditis, RSD, Ehlers-Danlos, TBI, and post-viral autoimmune disorder. To lower your opioid dosage to about 90 mg, you will likely need at least 2 of the 5 troches listed above. If you are currently a patient in our clinic we can supply prescriptions with instructions. Send your request to the clinic by e-mail, fax, or postal service.

MY POSITION ON PRIMARY CARE PRACTITIONERS AND THE 90 MG OF MORPHINE LIMIT

I support the position that internists, family practitioners, nurse practitioners, and other primary care providers who don't have a special government authorization to prescribe high dose opioids, follow the CDC Guidelines of milligrams of daily morphine equivalence (90 MED). I have changed my position in this regard, because, in the past year, we have identified multiple opioid alternatives as well as therapies for the major underlying causes of intractable pain. Current chronic pain patients who have well-maintained on high dose opioids for a considerable time-period should be given some leeway, in time, to reduce their daily opioid dosage to 90 MED.

DISCLAIMER: The recommendations presented here are strictly those of the authors, and they do not guarantee safety or efficacy. These recommendations and opinions are purely private ones that are not endorsed or sanctioned by any governmental agency or professional organization.

Stay on the "March to 90" by following our updates on these websites:

www.familiesforiprelief.com
www.arachnoiditishope.com
www.foresttennant.com
www.hormonesandpaincare.com

Chapter 3

SOURCES FOR NATURAL PAIN RELIEVERS AND REDUCERS ON THE MARCH TO 90

In order to reduce your daily opioid dosage to 90 mg, you may need to take one or more natural pain relievers and reducers. Attached is a bibliography of agents we recommend.

WHEN TO TAKE A NATURAL PAIN RELIEVER: Always try a natural pain reliever to either avoid or at least reduce the amount of opioid you take.

WHEN TO TAKE A NEUROINFLAMMATORY AGENT: Take one between 6:00 – 9:00 AM and one between 6:00 – 9:00 PM.

SOURCES:

Taurine and Inflammatory Diseases:

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3894431/

Taurine-Neuropathic pain -rat models:

https://www.ncbi.nlm.nih.gov/pubmed/21512835

Taurine Helps Regenerate Brain Cells:

http://www.lifeextension.com/magazine/2015/9/grow-new-brain-cells/page-01

PAIN RELIEVERS
PEA
CBD OIL
KRATOM

NEUROINFLAMMATORIES
SERRAPEPTASE
TUMERIC/CURCUMIN
TRIPHALA

OPIOID WITHDRAWAL
TAURINE

Amino Acids and Diet in Chronic Pain Management:

https://www.practicalpainmanagement.com/treatments/nutraceutical/amino-acids-diet-chronic-pain-management

Triphala -NIH Study Report:

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5567597/

Gastroprotective Qualities of Triphala:

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3480757/

Tumeric/Curcumin- NIH report:

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5664031/

Turmeric-Arthritis-NIH:

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5003001/

Kratom-American Kratom Society-Science:

https://www.americankratom.org/science

Kratom-NIH-The Roots of Kratom:

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4657101/

Kratom-Pharmacology of Kratom

http://jaoa.org/article.aspx?articleid=2094342

Kratom-NIDA Publication:

https://www.drugabuse.gov/publications/drugfacts/kratom

Cannabinoid Receptors:

https://www.sciencedirect.com/topics/neuroscience/cannabinoid-receptor

CBD Oil:

https://www.medicalnewstoday.com/articles/317221.php

CBD-***Primer-Cannabidiol and CBD:***

https://www.huffingtonpost.com/entry/cannabidiol-cbd-a-primer_us_58b7129ee4b0ddf654246290

Serrapeptase:

http://www.lifeextension.com/Magazine/2003/9/report_aas/Page-01

PEA

(palmitoylethanolamide):

http://www.lifeextension.com/Magazine/2017/SS/Break-the-Cycle-of-Chronic-Pain/Page-01

PEA ***(palmitoylethanolamide) NIH Research Study on Pain:***

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5094513/

PEA (palmitoylethanolamide) NIH Study on Neuropathic Pain:

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3500919/

PEA (palmitoyletanolamide) in Pain of various pathologies -neuroinflammation,

etc: https://academic.oup.com/painmedicine/article/13/9/1121/1864240

Have you asked your local physician or nurse practitioner how much opioid they will prescribe to you after June 30, 2018?

Chapter 4

LONG-ACTING OPIOIDS - BIGGEST BARRIER TO REDUCING TO 90*
"MARCH TO 90"
(* 90 milligrams of daily morphine equivalence)

HISTORY
In the past 20 years long-acting opioids have been standard pain practice to lower or suppress baseline pain. Why? There were no real alternatives. The belief has been that an opioid that stays in the blood a long time will provide the best pain relief. Long-acting opioids include formulations of morphine (MS Contin®), Oxycodone (Oxycontin®), hydromorphone (Exalgo®) methadone, and fentanyl patch (Duragesic®).

PROBLEM WITH LONG-LASTING OPIOIDS
Long-acting opioids constantly coat the opioid receptors in the "brain and spinal cord." This causes the receptors to undergo biologic changes resulting in physical dependency. When a long-acting opioid is stopped, withdrawal symptoms start, and the patient craves another dose. Long-acting medications, fill up all the opioid receptors. This causes suppression of the body's own natural endorphin system of natural painkillers and mood elevators. Another major problem with filling up all the opioid receptors is that it blocks out or neutralizes other drugs that need this receptor to function. The best example is "breakthrough" or "flare pain." A patient may need increasingly higher and higher dosages of a short-acting opioid to "breakthrough" the blockage caused by a long-acting opioid. Long-acting opioids also cause multiple hormone deficiencies over time, which in turn makes the opioid medication less effective.

BARRIER TO REDUCING OPIOID DOSAGE
In order to significantly lower one's opioid dosage, one must stop long acting opioids. Why? Opioid receptors must be free of opioids to recover. They actually begin to recover if uncoated for just a few hours during a 24- hour day. This allows alternatives such as Oxytocin/Ketamine troches and hormones to get in and work.

TIPS ON STOPPING LONG-ACTING OPIOIDS
There is no easy way to stop long-acting opioids. Here are some tips:

1. See if your doctor can switch you to a short acting opioid medication.
2. Reduce your long-acting opioids dosage by 5 to 10% a week;
3. Increase your short-acting opioids when reducing your long-acting;
4. If on a fentanyl patch, lengthen the time you keep it on before you reduce to a

lower dose;

5. If withdrawal symptoms occur, take taurine, 2000 mg (obtain at a health food store) about every 4 to 6 hours; plus make sure to take a daily B-Complex supplement.
6. Increase your protein intake (poultry, fish, eggs, meat).
7. 5-HTP (5-hydroxytyptophan) - helps with pain, mood and sleep. Take 500 – 2000 mg a day.
8. If you are currently taking Methadone, consider dropping your dose to about 3 or 4 -10 mg doses per day. It is extremely difficult to totally and abruptly stop Methadone.

SUCCESS

Once off long-acting and only on short-acting opioids, you can start to substitute the short acting opioids with oxytocin, ketamine, ketorolac, nandrolone, kratom, CBD oil, or taurine among other non-opioid alternatives.

By changing to a short acting opioid medication, it allows your own natural endorphin and endocrine system to recover its own natural balance, leading to less pain.

Resource: The clinical protocol we use to reduce opioid dosages is now available to any physician or nurse practitioner upon request.

Recommendations: Do you have naloxone nasal spray in case of an overdose?

If you are depressed or uncertain about your future, have you considered seeing a psychiatrist or psychologist?

Your primary doctor can refer you.

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www.familiesforiprelief.com
www.arachnoiditishope.com
www.foresttennant.com
www.hormonesandpaincare.com

Chapter 5

CENTRALIZED PAIN AND NEUROINFLAMMATION TREATMENT IS CRITICAL TO REACH 90* "MARCH TO 90"

(* 90 milligrams of daily morphine equivalence)

WHAT IS CENTRALIZED PAIN?

Severe chronic pain may develop a focus or "hot spot" inside the brain and/or spinal cord. This "hot spot" is caused by cells called "microglia" and they form neuroinflammation. Once you develop centralized pain within a "hot spot" or "spots" of neuroinflammation, the usual treatments for acute and chronic pain don't work very well.

HOW DO YOU KNOW IF YOU HAVE CENTRALIZED PAIN?

The hallmark is "constant" pain ("24/7"). It may lessen, but it never totally goes away. Why? The "hot spots" of neuroinflammation form a "battery" which never shuts off unless medically treated.

Here are the characteristics of centralized pain. Review this list and make your own determination.

- ✓ Constant pain, with stabbing, shooting, jerking, or burning pain
- ✓ Sudden flares of extreme pain
- ✓ Fatigue
- ✓ Electric build-up-often "shocking "or experiencing "static electricity" when touching items.
- ✓ Insomnia
- ✓ Episodes of heat or sweating
- ✓ Cold hands/feet, redness of hands, feet and pain sites
- ✓ Burning hands, feet or buttocks
- ✓ Blood pressure and pulse periodically elevate
- ✓ Ringing in the ears

FALLACY OF OPIOIDS AND OTHER TREATMENTS

Before centralized pain and neuroinflammation were recognized, it was assumed that opioids, epidural injections, electrical stimulators, high dosages of gabapentin, buprenorphine, Suboxone®, and other drugs would control pain. This has been a widespread misconception and error. It has led to prescribing of high dose opioids and unnecessary procedures as the first line of treatment to control the devastating pain from this condition. Why? It was not understood that centralized pain and neuroinflammation produce a physiologic condition known as "descending pain". With this new knowledge, we now have better options!

FAILURE TO TREAT DESCENDING PAIN AND NEUROINFLAMMATION WILL RESULT IN NOT ONLY INADEQUATE AND INCONSISTENT PAIN CONTROL, BUT NEUROINFLAMMATION MAY SPREAD AND LEAD TO NEUROLOGIC IMPAIRMENTS SUCH AS MEMORY LOSS, TREMORS, AND LOSS OF FUNCTION.

DESCENDING PAIN – JUST WHAT IS IT?

Normally pain signals (electricity) travel from the injury or disease site such as the knee, hip, shoulder, or cauda equina, and ASCEND up the spinal cord to the pain control centers in the brain. Descending pain is the
pain signals (electricity) that originate in the "hot spot" or "battery" of neuroinflammation and DESCEND downward in not only through the spinal cord but also down through the vagus nerve and sympathetic nervous system, which is outside the spinal cord. Key Point: DESCENDING PAIN is not well controlled by opioids, anti-inflammatory agents, or antidepressants. Only a few agents will control descending pain. Most pain control agents work primarily on ascending pain.

AGENTS TO CONTROL DESCENDING PAIN

We have identified these agents which appear to help control neuroinflammation and descending pain. Some are listed here, and, in our protocol, which is available to medical practitioners on request.

- ✓ Stimulants (e/g/ amphetamine derivatives)
- ✓ Clonidine
- ✓ 5-Hydroxytrytophen (5-HTP) (Health Food Store)
- ✓ Taurine (Health Food Store)
- ✓ Ketorolac
- ✓ Nandrolone
- ✓ Tizanidine

TREATMENT TIP: DISCHARGING EXCESS ELECTRICITY FROM CENTRALIZED PAIN THAT BUILDS UP OVERNIGHT

Patients should identify the area where the pain first starts in the morning and apply a topical pain reliever there. Also, rub that area with a magnet or copper- it will release the excess electricity (descending pain) that builds up overnight. Repeat daily each morning.

KEY TO 90

The successful clinical treatment of a patient with centralized pain is a combination of low dose opioids and the treatment of neuroinflammation and descending pain using some of the agents listed above to control descending pain.

SPECIAL NOTE TO PATIENTS

Please show the above list of drugs to your local physicians, pharmacists, and nurse practitioners. You must plan on getting your future pain care in your local community with a low dose of opioids and alternatives. You MUST NOT plan on crossing state lines to obtain drugs very long after June 30, 2018.

Chapter 6

EARLY MORNING PROGRAM IS CRITICAL TO REACH 90 MME "MARCH TO 90" *

(* 90 milligrams of daily morphine equivalence)

PREPARING FOR THE DAY

New research shows that a centralized pain patient must prepare or "prime" their body between 6:00 – 9:00 AM EACH DAY. A failure to do this will result in excess pain later in the day.

BRAIN CENTERS FOR PAIN CONTROL

There are 7 known pain centers in the brain (attached). Each one needs to be energized throughout the day or your pain will not be controlled.

STORAGE OF ELECTRICITY DURING SLEEP

When you are sleeping, electricity will build up in the brain and spinal cord. Therefore, when you first awaken electricity may need to be discharged (descending pain). You must be ready for this each morning and be ready to prevent early morning pain.

EARLY MORNING MEDICAL MASSAGE

Even before you get out of bed, you should massage with one of the following medicated, topical creams onto the area where pain first begins: (1) morphine topical cream; (2) lidocaine topical gel; or (3) carisoprodol topical cream. Rub the area with copper or a magnet before massaging the area with topical cream.

Keep your medicated massage cream at your bedside.

FIRST MEDICATION TO TAKE

Between 6:00 and 9:00 AM you must take a stimulant and a neuropathic ("electrical blocker") agent:

	AGENT	**CHOICES**
1.	Stimulant (activates Dopamine receptors)	Amphetamine salts (Adderall®), dextroamphetamine, methylphenidate (Ritalin®), phentermine
2.	Neuropathic ("electricity blockers") (activates GABA receptors)	Gabapentin, topiramate (Topamax®), carisoprodol, tizanidine, clonazepam (Klonopin®)

MORNING HORMONE- 6:00 AM-9:00 AM

Pregnenolone: The "parent" of other hormones, and acts on the NMDA and GABA receptors -50-100mg.

OPTIONS

You may get extra pain relief if you take one or two of these between 6:00 AM & 9:00 AM.

1.	Taurine (Activates GABA receptors)	2000 mg
2.	5-hydroxytryptophan (Activates Serotonin receptors)	50 – 100 mg
3.	Clonidine (Activates Opioid receptors)	0.1 – 0.2 mg (Stops descending pain)

INTESTINAL HEALTH AND ABSORPTION

Take your Probiotic and Triphala herbal blend in the morning between 6:00 AM – 9:00 AM. Both help with intestinal absorption and/or promote gut-health.

START YOUR DAY RIGHT

Make sure to have a high protein breakfast-eggs, chicken, turkey, red meat, low-fat cheese, cottage cheese.

WHEN TO TAKE A PAIN RELIEVER?

Not until at least 30 minutes after the above 6:00 – 9:00 AM medications are taken. Do not take an opioid until your early morning medications have had time to start working (15 to 30 minutes). Also, do not take an opioid until you have tried oxytocin, ketamine, and/or clonidine. To get to 90 MME, your opioid must be a last resort, not the first thing you grab.

REPEAT OF YOUR MORNING PROGRAM

If your pain is not well controlled, repeat your morning program at these times:

2:00 PM-4:00 PM and/or 7:00 PM-9:00 PM
(If sleep is affected by stimulant don't take it after 2:00PM)

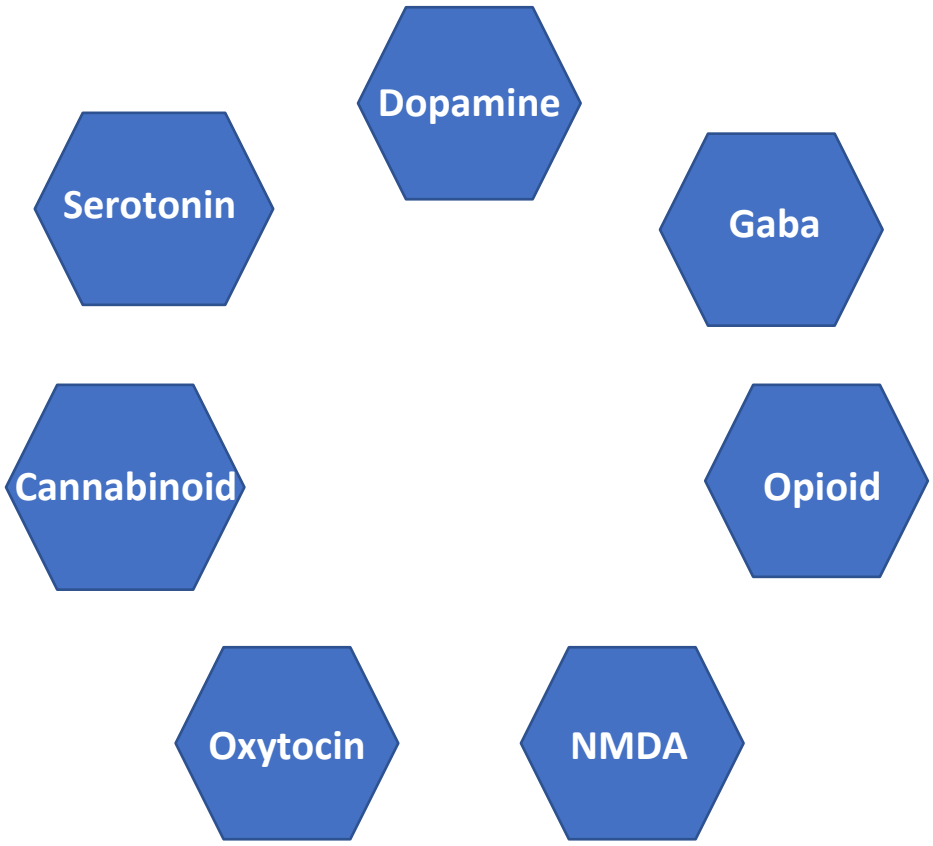
SPECIAL NOTICE – TIME TO REACH 90 MME IS RUNNING OUT

We do not believe you have more than 4 to 6 months to reduce to 90MME. You can find yourself forced to 90MME any day. The major drug store chains (e.g. CVS, WALMART, drug wholesalers/suppliers) are cutting back, and some are refusing to fill Rx's over 90MME. The DEA has reduced the national quota of opioid medications. Medicare is now threatening physicians with audits and monetary payback if they exceed 90MME due to new data analytic programs being used to monitor prescribing practices.

BOTTOM LINE: Your physician may still be willing to prescribe over 90MME, but you may not be able to obtain the amount prescribed. Keep "Marching to 90"!!

SAD REALITY: No pain patient is exempt, even if you are palliative, pregnant, have cancer, or genetic abnormalities you are not protected or assured you can get over 90 MME.

THE SEVEN PAIN CENTERS IN THE CNS



All seven must activate for maximal pain relief.

Analogue: Pistons in your car's engine.

Chapter 7

HOW TO DEAL WITH YOUR BASELINE ("ALWAYS THERE-24/7") PAIN IN YOUR "MARCH TO 90"

WHAT IS BASELINE PAIN?

A good argument can be made that the attempt to treat baseline or constant (24/7) pain resulted in millions of people taking high dose opioids. It has long been recognized that some chronic pain patients only have intermittent episodes of pain while some unfortunate individuals develop pain which is constantly present. In the late 1990's there was a movement to relabel baseline pain and call it "persistent" pain and to label pain flares "breakthrough" pain. Regardless of terminology, in the 1990's it was clear: constant, never-ending pain (even while asleep) occurs in some severe chronic pain patients for unknown reasons.

THE ORIGINAL ANSWER TO CONSTANT PAIN – LONG ACTING OPIOIDS

Since no one at the time knew why constant pain occurs, the simple answer was to symptomatically treat it with a long-acting opioid. Hence, we had the birth of manufactured, extended release (ER) formulations which remain in the blood for longer periods than immediate release (IR) opioids. These formulations include the fentanyl patch (e.g. Duragesic®), oxycodone (Oxycontin®), morphine (MS Contin®), hydromorphone (Exalgo®), and hydrocodone (Zohydro®). The clinical approach was simple and universal. Start treating baseline, constant pain with a low dose of a long-acting opioid. Raise the dose at intervals until the pain is suppressed enough for the patient to physically and mentally function. If there were pain flares, they were labeled "breakthrough pain" and symptomatically control and suppress it with a short-acting opioid. Unfortunately, this approach often force patients into the high and ultra-high opioid dosage range.

WHAT CAUSES BASELINE PAIN?

One of the great scientific discoveries of the past decade is the cause of baseline pain. Of great benefit, is that this discovery has led to measures that almost eliminate the need for long-acting opioids.

The cause of baseline pain is pockets or centers of neuroinflammation inside the brain and/or spinal cord (the Central Nervous System-CNS). This occurs when an injury, disease or chemical agent is introduced to nerves, nerve roots, brain, or spinal cord. This activates cells inside the CNS called microglial cells. These cells are the innate "immune system" of the CNS, and when overly active due to injury, disease, or chemical agent, they can over fire and cause auto-immune reactions and resulting in neuroinflammation and damage to the CNS.

After the discovery of microglial activation and neuroinflammation, scientists and clinical researchers went to work and have now identified some therapeutic, non-opioid agents that will greatly suppress and control neuroinflammation in the CNS.

BIGGEST SCIENTIFIC BREAKTHROUGH

After the discovery that neuroinflammation is the basic cause of baseline pain, it was discovered that the CNS makes and uses specific hormones to control and suppress neuroinflammation and the over-

active microglial cells that produce it. Some of the hormones made inside the CNS are also made and used outside the CNS and include the w ell-known hormones estradiol (estrogen), progesterone, testosterone, and cortisone. Other hormones that the CNS makes and uses to control neuroinflammation are lesser known and include pregnenolone, human chorionic gonadotropin (HCG), and nandrolone.

HORMONE NECESSITY

Be clearly advised. We believe the informed use of some hormones is a critical measure to not only reduce opioid dosage but to possibly attain some permanent healing-neurogenisis.

NEUROINFLAMMATORY AGENTS

Research to find agents that suppress and control neuroinflammation has been an arduous process, but it has paid off. Unfortunately, most common anti-inflammatory agents such as Celebrex®, aspirin, ibuprofen, and hydrocortisone are either too weak or don't cross the blood-brain barrier. Here are the major agents that we have identified that appear clinically effective in suppressing neuroinflammation and reducing opioid dosages:

	WORKS	**EXAMPLES THAT DON'T WORK**
1.	Ketorolac	Celexcoxib, ibuprofen, diclofenac
2.	Methylprednisolone	Hydrocortisone, Triamcinolone, Prednisone
3.	Dexamethasone	" " "

A few other agents have been identified that will suppress neuroinflammation in some patients: (1) acetazolamide; (2) minocycline, clarithromycin; (3) metformin; and (4) pentoxifylline.

RECOMMENDATIONS TO REDUCE OR ELIMINATE OPIOIDS

Below is our recommended program to significantly reduce neuroinflammation and opioid dosage:

- Ketorolac – 30 mg as a troche on 3 days a week (cannot take 5 consecutive days)
- Pregnenolone – 25 to 100 mg on 5 to 7 days a week, oral tablet or capsule
- Methylprednisolone – 4 mg oral on 3 to 5 days a week in the afternoon, oral tablet or capsule
- Nandrolone – 25 to 50 mg, taken as a troche on 2-3 days a week, or human chorionic gonadotropin- HCG- (500 units), as a troche or injections on 2-3 days a week

WHAT TO EXPECT

When neuroinflammatory agents are started, do not expect to see immediate pain relief like you get with a potent, symptomatic opioid pain reliever. After about a week you will feel more energized with a better feeling of well-being, and you will feel less need to take opioids. After a week, you should start cutting down on your opioids. We have observed patients who have cut down on their long-acting opioid by as much as 50% after the first week. Many patients totally eliminate their long-acting opioid and some of their short-acting opioid within 4-8 weeks.

Remember, neuroinflammation in your CNS may have been there for years, so it may take a few weeks for your CNS to wipe out enough neuroinflammation and create enough healing to reduce baseline pain. Be patient with the process.

Patient Testimonial:

“Thanks to working together with Dr. Tennant, treating neuroinflammation, and tweaking his protocol, with his continued help that I was able to successfully reduce my own opioid dosage by well more than half of where I started when I began with Dr. Tennant in 2015.” Denise M. - Arachnoiditis

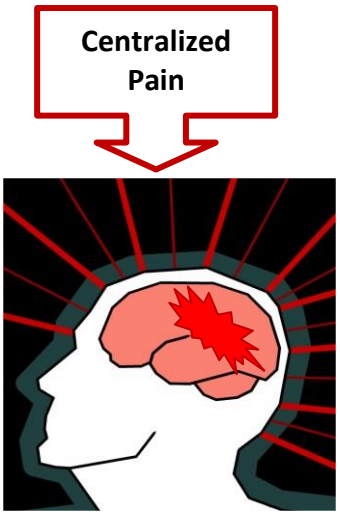
Chapter 8

THREE KINDS OF PAIN YOU MUST TACKLE TO REACH 90

If you are an intractable pain patient with constant pain, you have "centralized" your pain. A small cell in your brain called "microglial" has been activated and is producing hot spots that are painful balls of electricity and neuroinflammation that operate 24/7.

Here's the issue. If you have centralized, constant pain you will have to take steps to combat 3 different kinds of pain:

	PAIN TYPE	EXPLANATION OF THE 3 TYPES
1.	Baseline	Always present in the hot spot of electricity and neuroinflammation
2.	Brain Discharge or Descending	The hot spot will periodically discharge electricity down your vagus and other nerves to give you such symptoms as jerking, burning, stabbing, water dripping, bugs crawling,
3.	Flare	Episodes of severe, unexpected pain.



3 KINDS OF TREATMENT

#1. BASELINE PAIN		
NEUROINFLAMMATION	**SLEEP**	**NEUROGENESIS (NEURON RE-GROWTH)**
Ketorolac	Tryptophan	Pregnenolone
Methylprednisolone or dexamethasone	5-Hydroxytrytophan (5-HTP)	Human Chorionic Gonadotropin
Curcumin/Turmeric	Melatonin	Nandrolone
Serrapeptase		

#2. BRAIN DISCHARGE OR DESCENDING PAIN
Amphetamine Salts or Methylphenidate
Tizanidine or Clonidine
Taurine

#3. PAIN FLARES
Oxytocin
Ketamine
Opioids – Last Resort

OTHER MEDICATIONS TO TRY:

While the drugs listed above are usually our 1st choices, there are some others that we, at times, recommend:

- **NEUROINFLAMMATION:** acetazolamide, metformin, pentoxifylline, clarythromycin
- **BASELINE:** Low dose naltrexone (not an opioid); can't take if on opioids
- **NEUROGENESIS:** Medroxyprogesterone, estradiol, DHEA, testosterone
- **SLEEP**: Zolpidem (Ambien®), Temazepam, amitriptyline – if severe insomnia
- **BRAIN DISCHARGE/DESCENDING**: Dextroamphetamine, phentermine, carisoprodol, gabapentin, topiramate, baclofen, diazepam, valerian root, St. John's wort
- **PAIN FLARES**: Fioricet®, palmetoylethanolamine (PEA), kratom, CBD oils

TAKE ACTION TODAY!

Carefully look over this bulletin.

- **Do you understand the 3 different types of pain?**
- **Are you taking medical agents for all three pain types?**
- **Are you sharing this information with your fellow pain sufferers and physicians?**

Chapter 9

NATURAL and OTC PAIN RELIEF: FACT OR FANTASY?

NATURAL DEFINITION: A substance that exists in nature that can be used whole or extracted and purified from natural substances or used whole without chemical alteration. Some mimic and stimulate the hormones the body naturally produces. Pregnenolone is made from yams, curcumin is extracted from turmeric.

FACT: Almost every person with a Usual or common chronic pain condition such as arthritis and fibromyalgia can easily find natural or non-prescription, over-the-counter (OTC) agents to control their pain. Self-care works!

FANTASY: The major uncertainty is whether patients with centralized, intractable pain can satisfactorily control their pain without resorting to opioids and other controlled drugs. The fact is that we have recently been identifying more natural and OTC agents that are allowing centralized intractable pain patients to entirely stop or markedly reduce their opioids.

DO YOU HAVE CENTRALIZED, INTRACTABLE PAIN? (CIP)
HALLMARKS:
(1) constant pain;
(2) intermittent cold hands and feet, and
(3) intermittent heat and excess sweating.

HERE ARE OUR RECOMMENDATIONS FOR THE 3 TYPES OF PAIN THAT ARE PRESENT IN CIP:

1. BASELINE PAIN

SUPPLEMENT	DOSAGE
NEUROINFLAMMATION	
Turmeric/Curcumin Herb	400-500 mg AM and PM
Pregnenolone	50mg twice a day
Serrapeptase	As directed on bottle
SLEEP	
Benadryl ®	25-50 mg at bedtime 10-
Melatonin	20mg at bedtime
Tryptophan	500-1000mg at bedtime
NEUROGENESIS	
Pregnenolone	50mg twice a day
Ashwagandha Herb	As directed on bottle
Suma Herb	500mg-2-4 x daily

2. BRAIN DISCHARGE/DESCENDING PAIN

Taurine Coffee Green Tea	2000mg – every 4-6 hrs 2-4 cups in AM 2-4 cups in AM
Mormon Tea-(Ephedra)	1 cup as needed

3. PAIN FLARES

ORAL Pain Relief

- Taurine-2000mg – every 4 to 6 hours
- PEA-600mg 2 x day
- Valerian Root-400-900mg – every 4 to 6 hours
- Muscle Relax® (valerian root, skullcap blend) - 2 as needed
- Kratom
- Cannabidol CBD 25mg 2x day
- Hydroxytryptophan (5-HTP)-100mg as needed
- Turmeric/Curcumin-500mg

TOPICAL Pain Relief

- Zeel ® Homeopathic Ointment
- Traumeel® Homeopathic Ointment
- Topricin ® Pain Relieving Ointment
- Blue Emu ® Topical Cream
- Arnica Ointment
- Lidocaine patches
- Castor oil packs

REMEMBER YOUR ABC'S:

Vitamin B-Complex w/Folate
B-12
Vitamin C
Co-Q-10
Vitamin D
Probiotic

The recommendations given here are those of the authors. No guarantee is given as to their effectiveness. We want to identify as many natural compounds for pain care as possible. If you know of one we have missed, please tell us. Thanks!!

Chapter 10

STEP DOWN DOSAGE REDUCTION AND SELF-TREATMENT OF OPIOID WITHDRAWAL SYMPTOMS

GET STARTED TODAY:

Any pain patient who is taking a dosage of opioids over 90 MME a day (milligrams of morphine equivalence) should be on a progressive step-down, dosage reduction plan if not an aggressive effort to rapidly reduce to 90 MME.

5% PLAN:

We recommend 5% a month. You simply calculate 5% of your current dosage and reduce by this amount each month.

EXAMPLES:

MONTH	DAILY DOSAGE	5% REDUCTION	NEW DOSAGE
1	500 MG	25 MG	475 MG
2	475 MG	24 MG	451 MG
3	451	23 MG	428 MG

GOAL OF 5% PLAN:

The "5% Plan" will help you reduce our baseline opioid dose by 30-50%. To reduce further, you will need to develop a new baseline treatment plan and vigorously treat all 3 kinds of centralized intractable pain: (1) baseline; (2) brain discharge/descending; and (3) flares. A 30-50% reduction is doable by everyone. If a pain patient says they can't reduce this amount, expect your physician to believe you are addicted and not worthy of being treated.

STEPS AND HOW TO TREAT WITHDRAWAL SYMPTOMS:

When on the "5% Plan" you won't initially need much help to treat withdrawal symptoms, but you will when you reduce about 20-30%.

REAL PROBLEM TODAY!

Lots of chronic pain patients are literally being thrown out of pain treatment and sometimes, without warning, opioid dosages are slashed or eliminated. Pain patients and their advocates must know how to self-treat withdrawal symptoms.

In this political, anti-opioid climate, taurine can be your "best friend". WHY? At high dosages, it suppresses opioid withdrawal symptoms.

STEP NO. 1:
Go to your local health food store and purchase their highest dosage of taurine.

STEP NO. 2:
While at the Health Food store also purchase a bottle of tryptophan or 5- hydroxytryptophan (5-HTP). Buy the cheapest.

STEP NO. 3:
Take these dosages:

- Taurine 2000 mg every 4-6 hours
- Take tryptophan 500-1000 mg and/or 5-HTP (50-100 mg) and valerian root (400-800 mg) with the taurine to better eliminate or suppress opioid withdrawal symptoms.

PRESCRIPTION DRUGS FOR OPIOID WITHDRAWAL SYMPTOMS:
Your physician may be willing to prescribe one of the following which will boost the effects of taurine:

a. Clonidine, .1-.2 mg b. Tizanidine, 4 mg

LONG-TERM USE OF OPIOID WITHDRAWAL DRUGS:
You can use (1) taurine, (2) 5-HTP, (3) tryptophan, (4) clonidine, (5) tizanidine; and (6) valerian root for long-term to keep your opioid dosage down and to keep from getting withdrawal sickness.
If coming off methadone, you will have withdrawal symptoms up to 10-12 weeks.

DON'T KID YOURSELF!

Lots of pain patients think that the political, anti-opioid, anti-patient, anti-doctor climate will change and again allow high and ultra-high opioid dosages. While there are now regulatory, supply, and insurance issues that restrict opioids, what is being overlooked, sadly, is that doctors everywhere are rejecting pain patients due to malpractice restrictions and the extraordinary amount of time and loss of money necessary to service a chronic pain patient (pharmacy calls, insurance hassles, paper work, forms, complaints, reviews, etc.).

BOTTOM LINE!

Be prepared to help yourself along with whatever help you can get from your local physician, nurse practitioner, and pain clinic.

DISCLAIMER: The recommendations presented here are strictly those of the authors, and they do not guarantee safety or efficacy. These recommendations and opinions are purely private ones that are not endorsed or sanctioned by any governmental agency or professional organization.

Stay on the "March to 90" by following our updates on these websites:

www.familiesforiprelief.com

www.arachnoiditishope.com

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