

In MIA, these tend to be more directly related to the pathological lesion, although there may be an element of central pain.

In CIA, there is a more florid, systemic picture, with a higher number of widespread autonomic features and often autoimmune type symptoms.

The predominant and most distressing symptom of arachnoiditis is chronic, persistent pain, which is primarily neurogenic and thus difficult to treat.

Pain tends to increase with activity. There is may be a delay after onset of activity, with a slow summation, to a point where the pain suddenly becomes unbearable and then persists once the activity has ceased.

This can make it difficult for patients and physicians or physiotherapists to assess what is the tolerable level of exercise.

Pain may be due to other factors besides nerve damage. These include musculoskeletal secondary to disuse, overuse or compensatory use of muscle groups, due to alteration of spine dynamics.

There may also be muscle tension due to being in pain, or spasticity caused by nerve damage. Joint pain may be due to similar factors, or may be part of the autoimmune picture (see below).

Deafferentation pain (causalgia/dysesthesia): Pain is generally described as burning, but often people are unable to describe it. It is specifically a feature of incomplete nerve damage.

Many patients suffer from burning feet, in particular.

Lancinating pain: The majority of patients experience transient shooting pains that may vary in intensity from an insect bite to an electric shock.

There is often an element of central pain, including feeling pain from normally painless stimuli especially from light touch such as clothing (allodynia).

Changes in temperature commonly trigger this type of pain, so that sufferers have a very narrow window of comfort as regards temperature. (See also under autonomic effects).

Hyperpathia: an enhanced response to painful stimuli, suggestive of a low pain threshold. In fact, there is not a lowered threshold, rather a raised one, but once it is reached the response is magnified. This is called "delay with overshoot".

This is particularly noticeable in "visceral hyperpathia" in which normal bladder and bowel sensation is diminished, but once the signals of fullness are perceived, there is burning pain and urgency.

This can lead to embarrassing accidents, especially if there is also nerve damage to bladder or bowel causing hyperactivity or sphincter dysfunction.

The areas commonly affected by pain are:

In most cases: lumbar, buttocks, legs (often both), feet, perineum, hip, abdomen.

In some cases: arms and hands, neck, head and face, chest.

However, it is important to remember that one of the aspects of central pain is that pain may be experienced over large areas of the body, rather than just in the lower part. This may lead the patient to fear that the disease has spread.

Parasthesiae and numbness are common features. Other sensory symptoms include loss of proprioception. This can result in tripping and falls.

Temperature perception is sometimes diminished.

There may also be bizarre sensations such as feeling as if walking on broken glass, water running down the legs, or insects crawling over the skin.

These can be very distressing and many patients are reluctant to admit them to their doctor. A minority of patients may suffer from tinnitus and/or vertigo.

Motor nerve damage may cause loss of muscle strength, especially in the lower back and legs, in some patients.

In most cases with weakness, it is mild, but it may progress sufficiently in some patients to necessitate use of walking aids or even a wheelchair.

There seems to be a phenomenon that some patients reach a plateau in their symptoms, but can then rapidly deteriorate after a minor accident, such as a fall.

The reason for this is unclear.

Also, many patients report that they fatigue quickly. There may be compensatory overuse of

some muscle groups to allow the patient to walk, but this leads to the muscle fatiguing more rapidly than normal. This is similar to the picture seen in PostPolio Syndrome (PPS).

Increase in muscle tone is quite a common feature and makes the legs stiff, which may have an effect on mobility.

Muscle spasms and cramps may be violent and painful. Muscle fasciculations are a common feature.

A number of patients complain of symptoms suggestive of Restless Legs Syndrome, with nocturnal unpleasant sensations in the legs, accompanied by motor restlessness.

Less commonly there may be trouble swallowing, sometimes due to oesophageal muscle spasms. (See also under autonomic problems).

A common component of the arachnoiditis syndrome is the effect on the autonomic nervous system.