Volume 26 Number 3 August 1999

THE CANADIAN JOURNAL OF Neurological Sciences

LE JOURNAL CANADIEN DES Sciences Neurologiques

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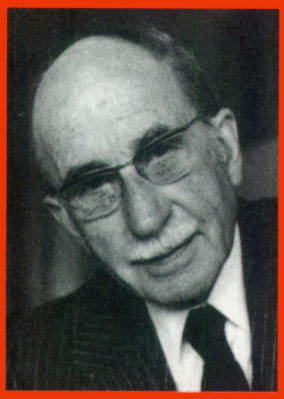

Herbert Jasper (1906-1999)

35th CANADIAN CONGRESS OF NEUROLOGICAL SCIENCES
June 13 - 17, 2000
Ottawa, Ontario

The official Journal of: The Canadian Neurological Society, The Canadian Neurosurgical Society, The Canadian Society of Clinical Neurophysiologists, The Canadian Association of Child Neurology

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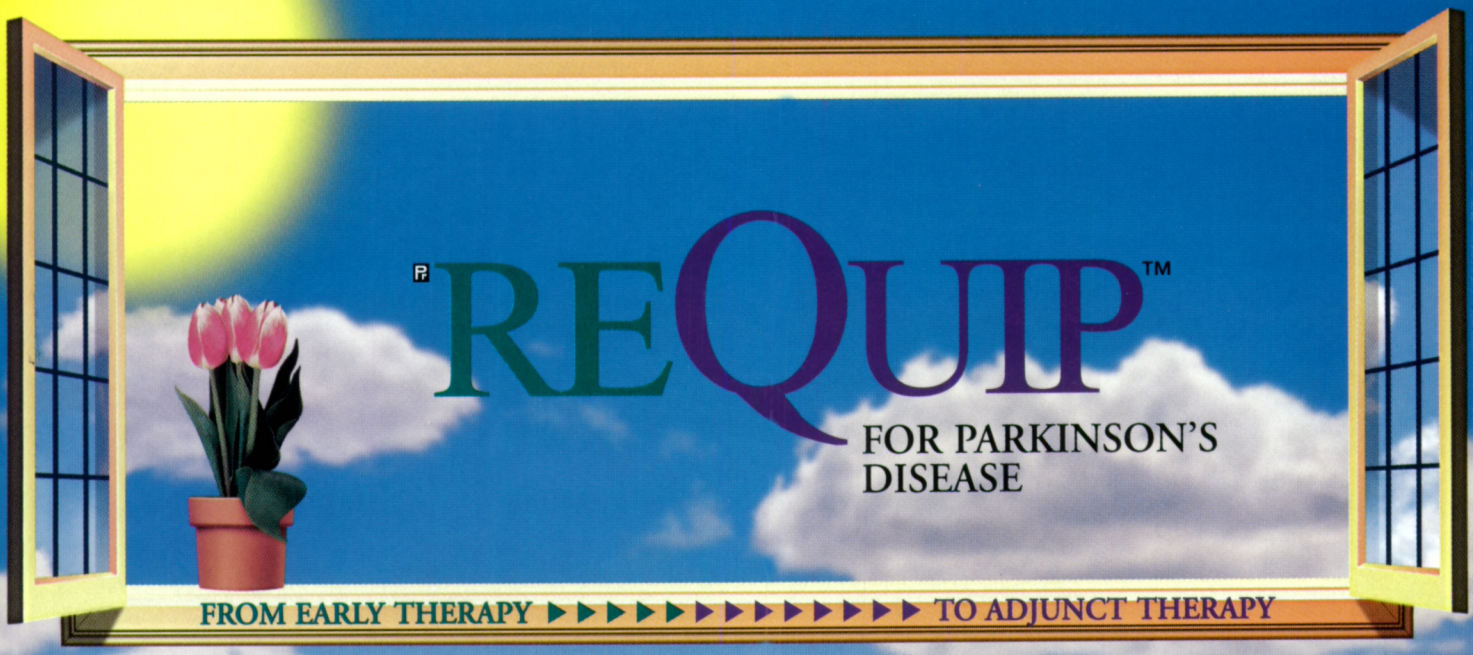
A DOPAMINE AGONIST YOU CAN START WITH AND STAY WITH.



REQUIP IS A NON-ERGOLINE DOPAMINE AGONIST THAT IS INDICATED FOR BOTH EARLY THERAPY WITHOUT LEVODOPA AND ADJUNCT THERAPY WITH LEVODOPA.

EQUALLY EFFECTIVE TO LEVODOPA IN EARLY DISEASE.[1]

After 6 months, ReQuip and levodopa showed no difference in Clinical Global Improvement in patients at Hoehn and Yahr stages I-II, although levodopa showed greater improvement in patients with more severe disease.[1+] As well, ReQuip monotherapy was shown to be significantly more effective than bromocriptine in early disease after 6 months.[2^]

CAN DELAY LEVODOPA FOR AT LEAST 3 YEARS.

Using ReQuip in early disease can sustain symptom control and has been shown to delay the need for levodopa in the majority of patients (61 of 102) who completed a full 3 year study.[3,4]

CONTINUED BENEFITS IN ADJUNCT THERAPY.

ReQuip allowed a 20% or greater reduction in levodopa dose and also increased patients' 'on' time by 20% or more after 6 months of combination therapy.[5*]

SPARING LEVODOPA CAN DELAY COMPLICATIONS.

Because ReQuip spares levodopa in both early and adjunct therapy, it can substantially reduce levodopa load for Parkinson's patients. As a result, ReQuip can delay and reduce long-term levodopa complications such as dyskinesias, 'on-off' effect and 'wearing off' effect.[1,6] So starting ReQuip today can give Parkinson's patients a brighter outlook for tomorrow.

+Mean dosage: 9.7 mg (SD 6.0) ReQuip (n=179), 464.0 mg (SD 266.0) l-dopa (n=89). 95% CI of 0.28, 2.26 Stage I or I.5; 0.43, 3.07 Stage II; 0.04, 0.35 Stage II.5 or III.
^Mean UPDRS improvement in the non-selegiline subgroup. Mean dosage: 9.0 mg (SD 5.2) ReQuip (n=109), 17.2 mg (SD 8.8) bromocriptine (n=101). 95% CI of 6.0%, 21.1%.
*Achieved by 28% of ropinirole (n=94) and 11% of placebo (n=54) treated patients. 95% CI of 1.533, 12.658.[5]
In early therapy[7], nausea (59.9%), dizziness (40.1%) and somnolence (40.1%) were the most common side effects of ReQuip. Postural hypotension occurred in 6.4% of patients.
In adjunct therapy with levodopa[7], dyskinesias (33.7%) and nausea (29.8%) were the most common side effects of ReQuip.

SmithKline Beecham Pharma

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℞ REQUIP™
Early Therapy → Adjunct Therapy

RIGHT FROM THE START.

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For brief prescribing information see pages A-29, A-30

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- Overall incidence of adverse events in controlled clinical trials similar to placebo[1-3†]
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- Chest and neck sensations characteristic of the 5-HT_1 agonist class reported in *only* 1.2 – 2.1% of patients[1‡]

Long-lasting Migraine Relief

- Significant migraine relief was sustained over 24 hours[2§]
- 93% of attacks per patient did not require a second dose for recurrence[4||]

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Highly tolerable, long-lasting migraine relief

Available in 2.5mg & 1mg tablets

AMERGE is a 5-HT_1 agonist indicated for the acute treatment of migraine attacks with or without aura. AMERGE is contraindicated in patients with hemiplegic, basilar, or ophthalmoplegic migraine. Safety and efficacy have not been established for cluster headache which is present in an older, predominantly male population.

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‡With 2.5 mg naratriptan. §Headache relief = reduction of moderate or severe pain to mild or no pain. ||Percentage does not represent recurrence rate. Headache recurrence equals a return of moderate or severe pain in 4 to 24 hours post-dose following initial relief.

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For brief prescribing information see pages A-33, A-34

New in Lennox-

*Refers to lamotrigine, gabapentin, vigabatrin, and topiramate, to be distinguished from standard AEDs.
†With the exception of atypical absence seizures.
‡Statistical significance not reported.
§**Rarely, serious skin rashes, including Stevens-Johnson syndrome and toxic epidermal necrolysis (Lyell syndrome), have been reported. Although the majority recover following drug withdrawal, some patients experience irreversible scarring and there have been rare cases of associated death.**[1]
¶Frequently reported adverse events were pharyngitis, fever, infection, and rash (p = not significant).[1]
**For detailed information about dosing in adult and pediatric patients with LGS, please refer to the full prescribing information for LAMICTAL.
Dosage of add-on LAMICTAL in Motte *et al.* and Mullens *et al.* studies ranged from 50 to 400 mg/day, after escalation.
DO NOT EXCEED the recommended initial dose and subsequent dose escalations of LAMICTAL. More rapid initial titration has been associated with an increased incidence of serious dermatological reactions.

Product Monograph available to health care professionals upon request.

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Gastaut Syndrome

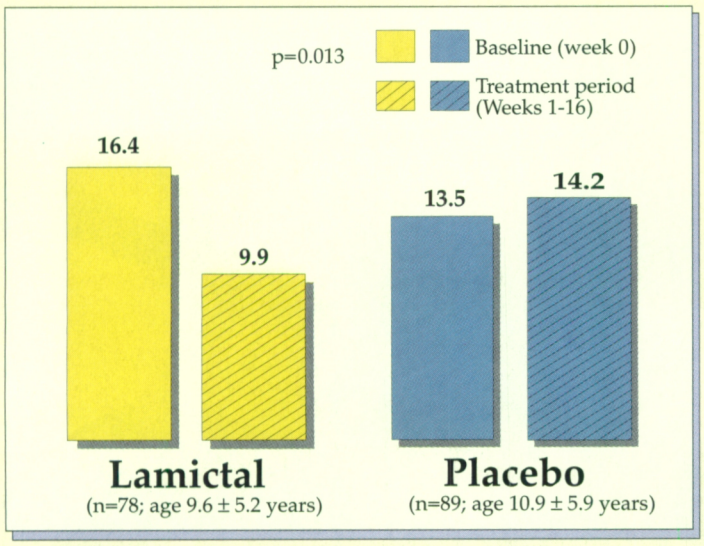
Lamotrigine
Lamictal®

LAMICTAL is the first and only of the newer* antiepileptic drugs (AED) indicated as adjunctive therapy for pediatric and adult patients with Lennox-Gastaut syndrome (LGS).[1] LAMICTAL is also the first and only of the newer* AEDs indicated for monotherapy after polytherapy in adults.

Significantly superior *control over the wide range of seizure types* associated with Lennox-Gastaut syndrome†

- Add-on LAMICTAL significantly reduced the number of all major seizures, all drop attacks, and all tonic-clonic seizures in patients with LGS.[1]

MEDIAN NUMBER OF
ALL MAJOR SEIZURES/WEEK



A double-blind, randomised, placebo-controlled trial in patients from 3 to 25 years of age

Low CNS side-effect profile maintained in patients with Lennox-Gastaut syndrome aged 3-25

- Low withdrawal rate compared to placebo:‡[1,2] group taking LAMICTAL 3.8% (mostly due to rash§) vs. placebo group 7.8% (mostly due to deterioration of seizure control).

- No significant difference in the incidence of adverse events between LAMICTAL and placebo except for cold or viral illness (LAMICTAL 5% vs placebo 0%; p=0.05).¶[1]

Improved neurological function and cognitive skills[2,3]

- A greater proportion of LGS patients (age 3 to 25 years) treated with add-on LAMICTAL (n=79) vs add-on placebo (n=90) had a **clinically significant improvement in neurological findings** across the 16 week treatment period for: behaviour (30.4% vs. 14.4%); speech (11.4% vs. 2.2%); and non-verbal communication (11.4% vs. 7.8%).‡[3]

LAMICTAL offers superior control over the seizure types associated with LGS and a low CNS side-effect profile. You may also improve the neurological function and cognitive skills of your patients.[2,3] Add LAMICTAL** as soon as the diagnosis of LGS is suspected.[4]

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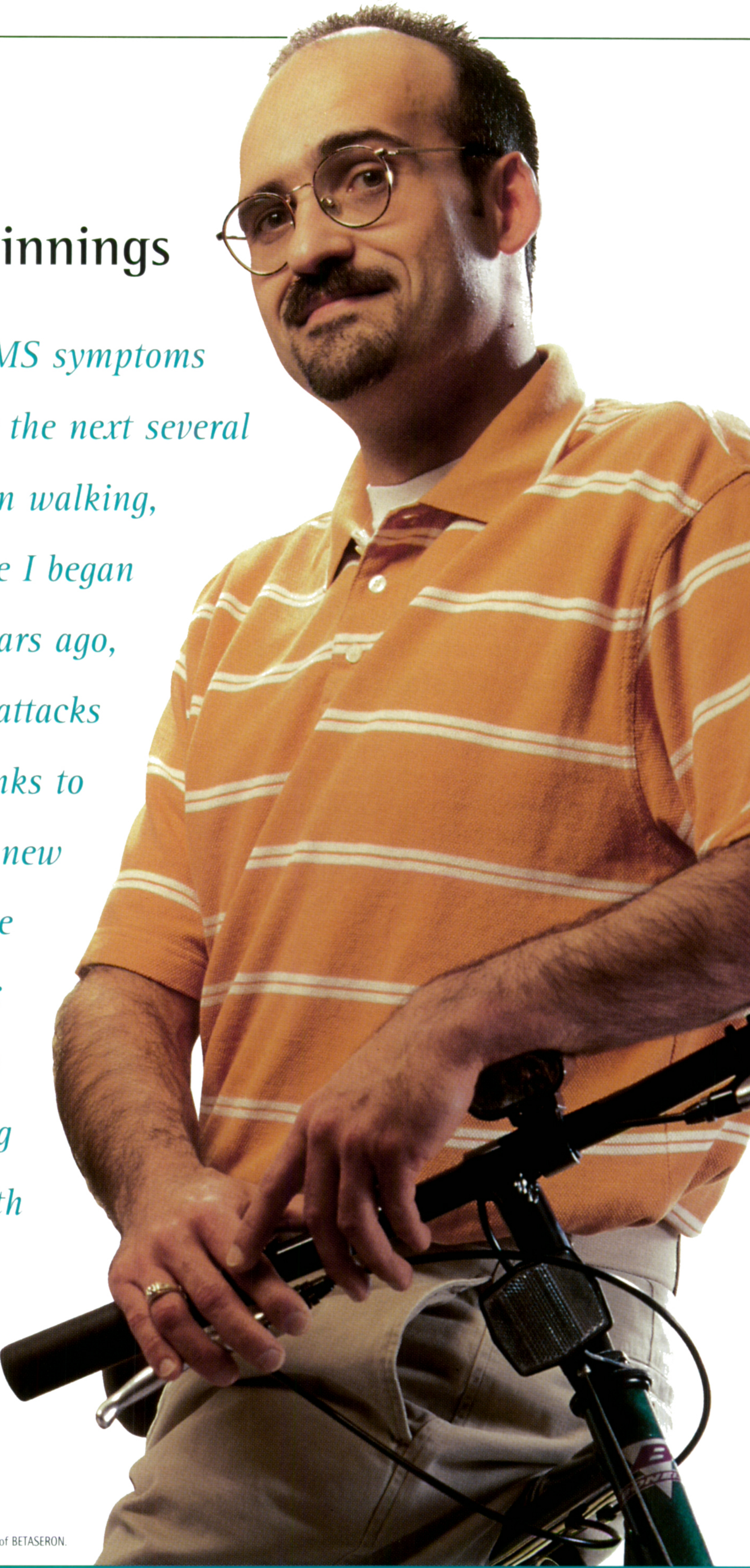
For brief prescribing information see pages A-45, A-46, A-47, A-48

Fred on New Beginnings

"I first experienced MS symptoms in 1985. Over the next several years, I had difficulties in walking, with speech ... But since I began BETASERON, *11 years ago, I have had no attacks whatsoever. Thanks to* BETASERON, *I now face new challenges. I can be there for my children; I'm preparing my master's degree; and I'm getting ready for my fifth MS bike-a-thon!"*



This real BETASERON patient testimonial may not be representative of all cases involving the use of BETASERON.

THE FIRST TREATMENT ALTERING MS NATURAL HISTORY,

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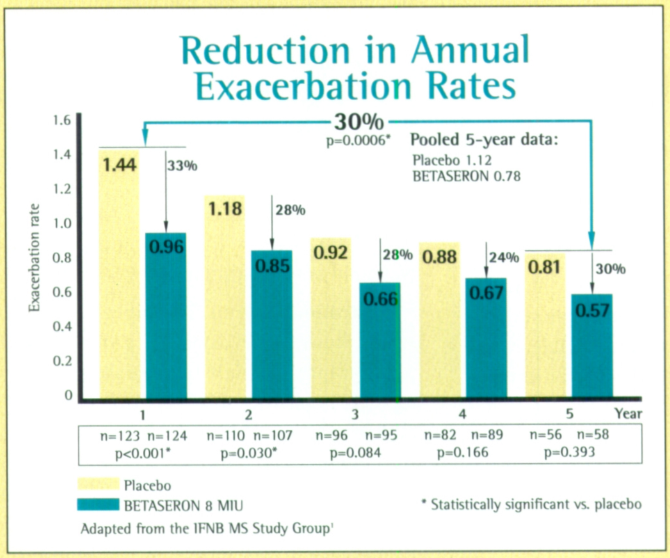

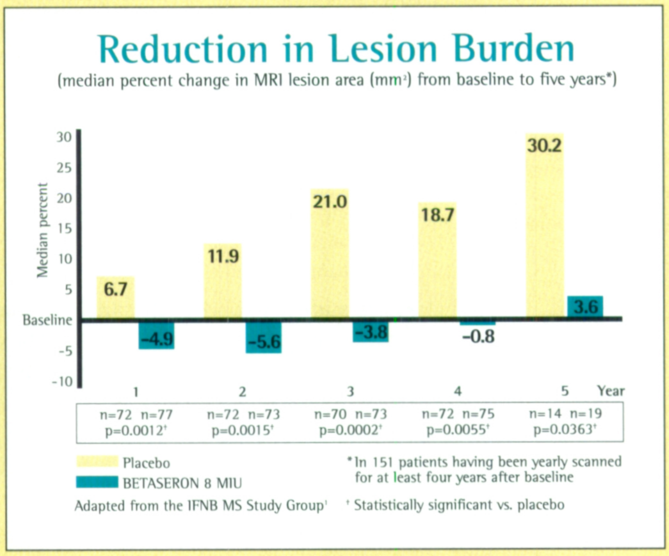

- **Proven long-term efficacy as first-line treatment in relapsing-remitting MS**
  - Over five years, exacerbation rate reduced by 30% (p=0.0006)[1]
  - At two years, moderate and severe exacerbations reduced by 49% (p=0.002);[2] significant annual reduction maintained over five years[1]
  - Median time to first exacerbation twice as long as in placebo patients (p=0.015)[2]
- **The only treatment studied for five years, both clinically and with MRI[1]**
  - MRI measured *lesion burden* significantly reduced over five years[1]
  - MRI measured *lesion activity* decreased (a median of 80% fewer active scans compared to placebo; p=0.0062; measured for two years)[3]
- **Trend toward slower disability progression demonstrated over a five year period[1]**
- **Low incidence of serious side effects:[1] injection-site reactions and flu-like symptoms are manageable and lessen markedly with time[4]**

More than 60,000 patients treated to date worldwide[5]

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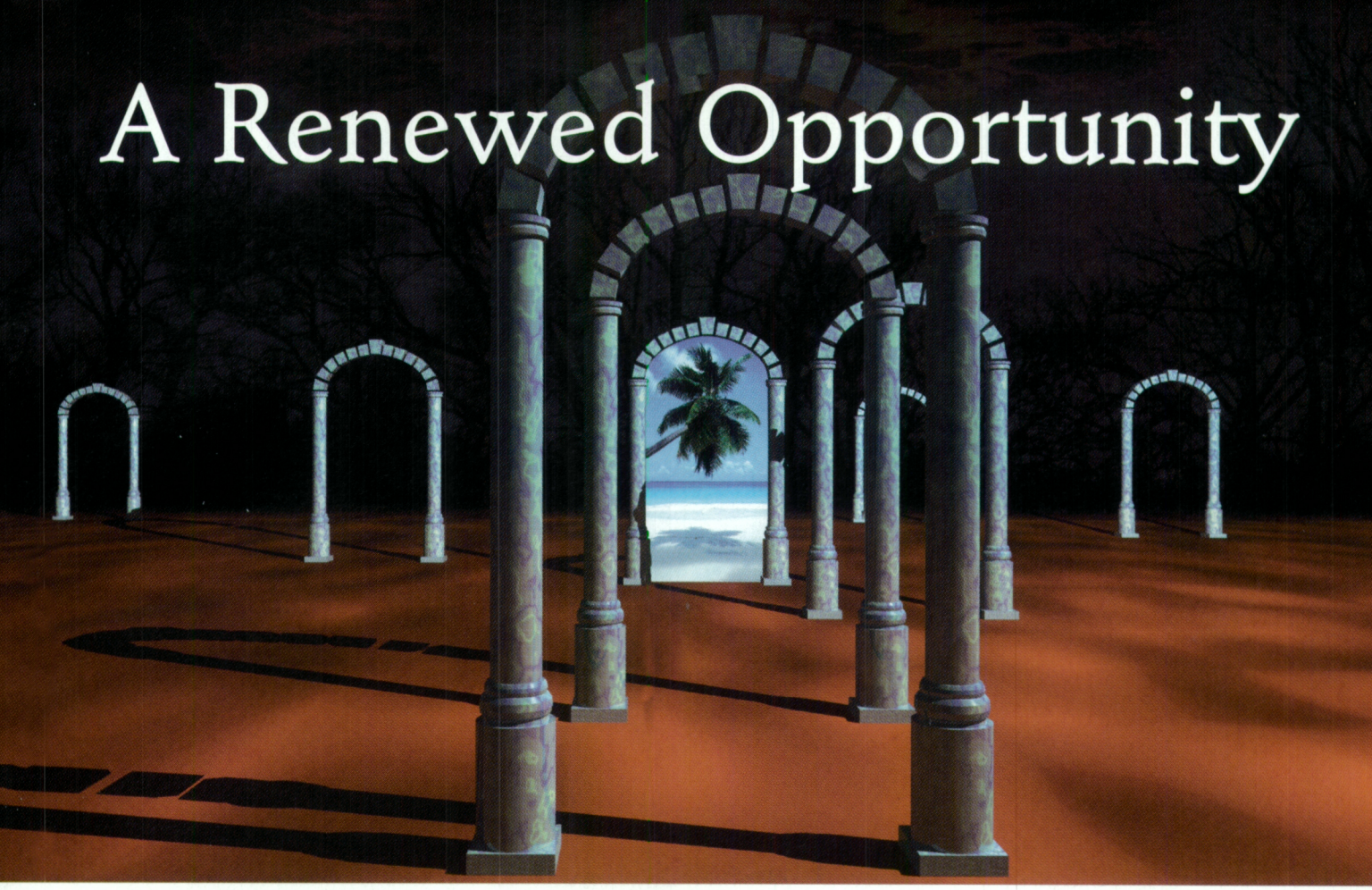

PARKINSON'S DISEASE

A world in which the therapeutic options are limited[1]

For those who have it, treat it, live with it; managing their Parkinson's disease can be quite frustrating. Yet there are moments that can be most rewarding. Motor function improves, the number of "off" hours decreases, rigidity subsides, gait improves. Their levodopa seems to be working... at least for today! Then there are times when nothing seems to help. Even their medication seems to be causing problems. It seems hopeless...

Today, however, there is another way to renew their hope. Even after its discovery more than fifteen years ago, Permax (pergolide mesylate) is still considered the most potent dopamine agonist available for the treatment of Parkinson's disease.[1-3] With its unique mode of action, i.e. stimulating both D_1 and D_2 dopamine receptors, Permax has demonstrated (n=376) statistically significant improvement in virtually all those numerous parameters of parkinsonian function, including bradykinesia, rigidity, gait, dexterity, etc. Equally important, these benefits were achieved with significantly less levodopa... 24.7% ($p < .001$), and by starting Permax at low doses "Adverse reactions were, for the most part, mild, reversible, and not of major clinical significance."[3]*

Successful treatment with Permax can last for up to 3-5 years[4,5] and renewed improvement has been demonstrated when Permax was given to patients (n=10) in whom the beneficial effect of bromocriptine had waned,[4] whereas the reverse was not true in a separate, non-comparable study (n=11) when bromocriptine was given to Parkinson's patients in whom Permax had waned.[6]

So, when given an opportunity to manage Parkinson's disease, there may be a way of renewing hope.

℞ PERMAX®
pergolide mesylate

DRAXIS

Draxis Health Inc.
Mississauga, Ontario

PAAB

* Rapid escalation of pergolide dosage may cause severe adverse reactions. Therefore a slow increase combined with a concomitant gradual and limited reduction of levodopa is recommended. See ADVERSE REACTIONS section in Prescribing Information

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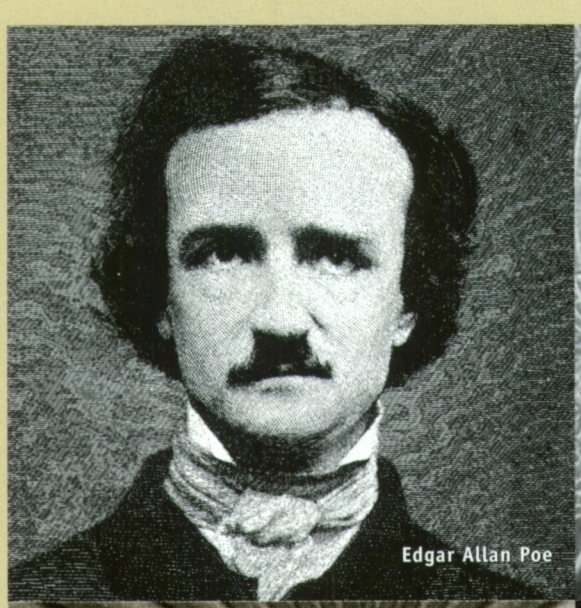

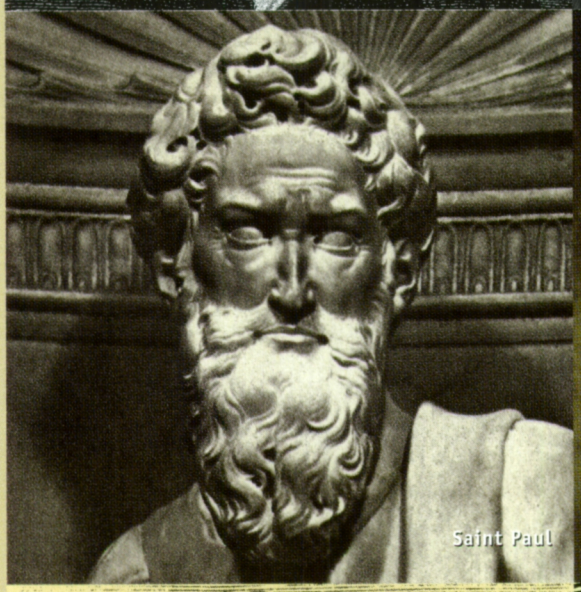

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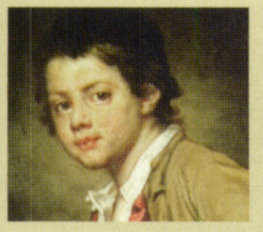


NOW INDICATED FOR CHILDREN

PrTOPAMAX* topiramate Tablets and Sprinkle Capsules: indicated as adjunctive therapy for the management of patients (adults and children two years and older) with epilepsy who are not satisfactorily controlled with conventional therapy. There is limited information on the use of topiramate in monotherapy at this time.[1]

Efficacy in Partial Onset Seizures:

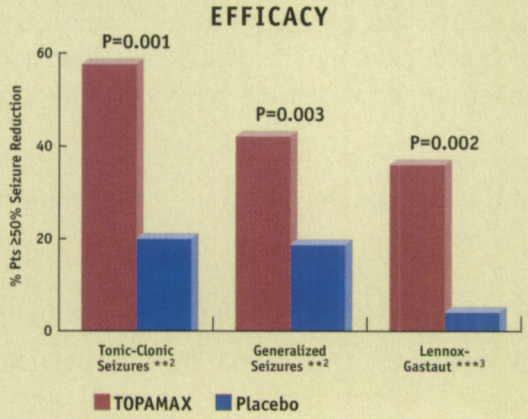
Dosage Individualized to Patient Response:[4,5]

	N	≥50% Seizure Reduction	Seizure Free
Adults[4,a]	450	59%	19%
Children[5,b]	41	73%	22%

Adapted from references 4 and 5
a Open label, 20 week trial in adults with partial onset seizures. TOPAMAX administered b.i.d. as adjunctive therapy, optimal dosage appeared to be 300-350 mg/day.
b Open label trial in children with partial-onset seizures following participation in a double-blind, placebo controlled trial. Reductions in seizure frequency were determined for children treated for at least 3 months. TOPAMAX administered b.i.d. as adjunctive therapy. Children received open label topiramate for a mean duration of 8 months at an average dose of 10 mg/kg/day (4-20 mg/kg/day).
For recommended dose refer to TOPAMAX* Prescribing Information.

Improved control over a wide range of seizure types:

- With additional data demonstrating efficacy as adjunctive therapy from randomized, double-blind, placebo-controlled trials in adults and a small number of children for:
- **Primary Generalized Tonic-Clonic Seizures**[1]
- **Seizures associated with Lennox-Gastaut syndrome**[1]



Adapted from references 2 and 3
**20 week double-blind treatment phase (8 week baseline and a 12 week treatment period) with either TOPAMAX (n=39, including 8 children ≤ 16 yrs) b.i.d. as adjunctive therapy or placebo (n=41). TOPAMAX was titrated to target doses of approximately 6 mg/kg/day.
***Drop attacks and tonic-clonic seizures: 11 week double blind treatment phase with either TOPAMAX (n=48) b.i.d. as adjunctive therapy or placebo (n=50); patient mean age 11.2 yrs. TOPAMAX was titrated to a target dose of approximately 6 mg/kg/day.

An appropriate first choice adjunctive therapy for many of your patients:

Favourable Side-effect Profile:

- Like most antiepileptic drugs, the most common side effects are CNS related††[1,6]:

- Usually mild to moderate occurring early in therapy and transient[1,6]
- If encountered:

Consider reducing the TOPAMAX dosage, rate of titration, and/or the concomitant AED dosage.[8]

- In children, there were no discontinuations due to adverse events at 5 to 9 mg/kg/day in the controlled clinical trials.[1]

Safety Considerations:

- No evidence to date of a proven association of TOPAMAX usage and the following: life threatening rash, permanent visual field constriction or polycystic ovary disease.[1,c]
- Weight loss

Adults: Modest weight loss may be sustained ≤ 12 months with the greatest weight loss occurring between 3 and 6 months and peaking at 9 months.[7]
Pediatrics: Of those pediatric subjects treated in clinical trials for at least a year who experienced weight loss, 96% showed a resumption of weight gain within the period tested.[1†]

Convenient BID dosing[1]

Now available in a convenient 15 mg and 25 mg Sprinkle Capsule formulation[1]:

Swallow whole or sprinkle on food
Bioequivalent to TOPAMAX Tablets

† The long term effects of weight loss in pediatric patients is not known.
†† CNS adverse events: Somnolence (30.1%), dizziness (28.3%), ataxia (21.2%), speech disorders (16.8%), psychomotor slowing (16.8%), nystagmus (15.0%), paresthesia (15.0%), nervousness (15.9%), difficulty with concentration/attention (8.0%), confusion (9.7%), depression (8.0%), anorexia (5.3%), language problems (6.2%), and mood problems (3.5%).[1] In an audit of 1446 adults and 303 children there appeared to be a similar pattern of adverse events.[1]

Please refer to the TOPAMAX Prescribing Information for complete prescribing details.
c Data on file JANSSEN-ORTHO Inc May 1999
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TABLETS NOW ON FORMULARY‡

‡ Limited use benefit–Ontario, Nova Scotia, New Brunswick, PEI.
Full Benefit–Quebec, Saskatchewan, British Columbia, Alberta, Manitoba.

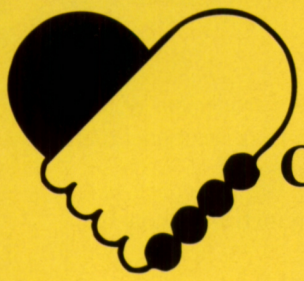
Pr TOPAMAX* topiramate

Helping patients with epilepsy make more of their lives

https://doi.org/10.1017/S0317167100049271 Published online by Cambridge University Press

For brief prescribing information see pages A-41, A-42, A-50

If you have an interest in Neurological Sciences – you should be a partner ...



CANADIAN CONGRESS OF NEUROLOGICAL SCIENCES PARTNERS PROGRAM

The CCNS PARTNERS PROGRAM is intended to provide a forum which will bring together all the professional societies, volunteer agencies, and commercial organizations in Canada which show a common interest in disorders affecting the nervous system. These include conditions such as Alzheimer's Disease, Stroke, Multiple Sclerosis, Epilepsy, ALS, Parkinson's Disease, Spinal Cord and Head Injuries.

Through a number of joint programs and initiatives, the goals will be to increase public awareness of neurologic disorders, to improve the well-being of people with these disorders, and to promote and encourage the development of new strategies for treatment and prevention of these conditions.

A website is being developed that will act as the core of communication for the PARTNERS PROGRAM. This site will act as a resource for information for the Partners, CCNS members, and individuals interested in gaining more information about neurological disorders.

A national Angus Reid telephone survey, aimed at the Canadian public to assess their general knowledge of neurological disorders, has recently been completed by the PARTNERS. The results strongly reinforce the need for a coalition of organizations involved in neurosciences. Details of the survey are available to the PARTNERS.

We are actively encouraging all those interested to join the PARTNERS PROGRAM and to develop this initiative.

THE PARTNERS ARE COMPRISED OF THE CCNS SOCIETIES AND AFFILIATE GROUPS, FOR-PROFIT AND NON-PROFIT ORGANIZATIONS WITH AN INTEREST IN CANADIAN NEUROSCIENCES.

Only by uniting Neurological Sciences in Canada will we achieve our goals.

FOR MORE INFORMATION REGARDING THE CCNS PARTNERSHIP PROGRAM

Mail: Suite 810, 906 12th Avenue SW,
Calgary, AB T2R 1K7
Phone: 403-229-9544
Fax: 403-229-1661
Email: brains@ccns.org

CANADIAN CONGRESS OF NEUROLOGICAL SCIENCES • CONGRÈS CANADIEN DES SCIENCES NEUROLOGIQUES
CCNS

https://doi.org/10.1017/S0317167100049271 Published online by Cambridge University Press

25 Years Ago in the Canadian Journal of Neurological Sciences

Supersensitivity of Central Neurons – A Brief Review of an Emerging Concept

G.G. Yarbrough and J.W. Phillis

Summary: The concept that "denervation" or "pharmacological disuse" supersensitivity develops in central neuronal systems subsequent to sustained attenuation of normal neurohumoral mechanisms is reviewed. Particular emphasis is placed on biochemical and electrophysiological parameters of supersensitivity in dopaminergic (striatal) neuronal systems. The possible applicability of theories to the phenomenon of narcotic tolerance and physical dependence and to psychoactive drug therapy is discussed.

Can. J. Neurol. Sci. 1975;2:147

The Effects of Feedback on Focal Epileptic Discharges in Man A Preliminary Report

A.R.M. Upton and D. Longmire

Summary: The history of the control of epileptic disturbances by conditioning techniques is reviewed. The preliminary results of a three year trial of feedback techniques in 13 epileptic patients are presented.

Thirteen epileptic patients (age 2.5-39, mean 15.1 years) with lateralized focal discharges in the EEG were given repeated trials of feedback, the focal discharges being used to trigger auditory and somatosensory stimuli. Dosages and serum levels of medication were unchanged throughout the experimental period. The number of epileptic spikes per 15 seconds was assessed by automatic trend analysis during 20 to 30 minute control, biofeedback and post-feedback epochs. Ongoing EEG activity was quantified by 8 channel frequency analysis over 10 second epochs. The patients made efforts to increase and decrease the number of spike discharges with and without feedback and the results of both triggered and random auditory, somatosensory, photic and combined stimulation were compared at various intervals over a period of up to three years. A marked reduction in the number of focal discharges was noted in eight (61.5%) patients during and immediately following the sessions.

Intermittent biofeedback sessions were not associated with a serial reduction in the number of focal EEG discharges. There was a reduction in the number of clinical epileptic disturbances in six patients (46%) and possible reasons for this improvement are discussed.

One patient suffered an increase in focal temporal lobe discharges during triggered and random auditory stimulation whereas there was a marked reduction in the number of discharges during minimal electrical stimulation of the contralateral arm. The need for careful assessment of each patient to determine appropriate feedback stimulation is stressed.

One aim of this research has been to assess the feasibility of using miniature units for continuous feedback of focal discharges in epileptic patients.

Can. J. Neurol. Sci. 1975;2:153

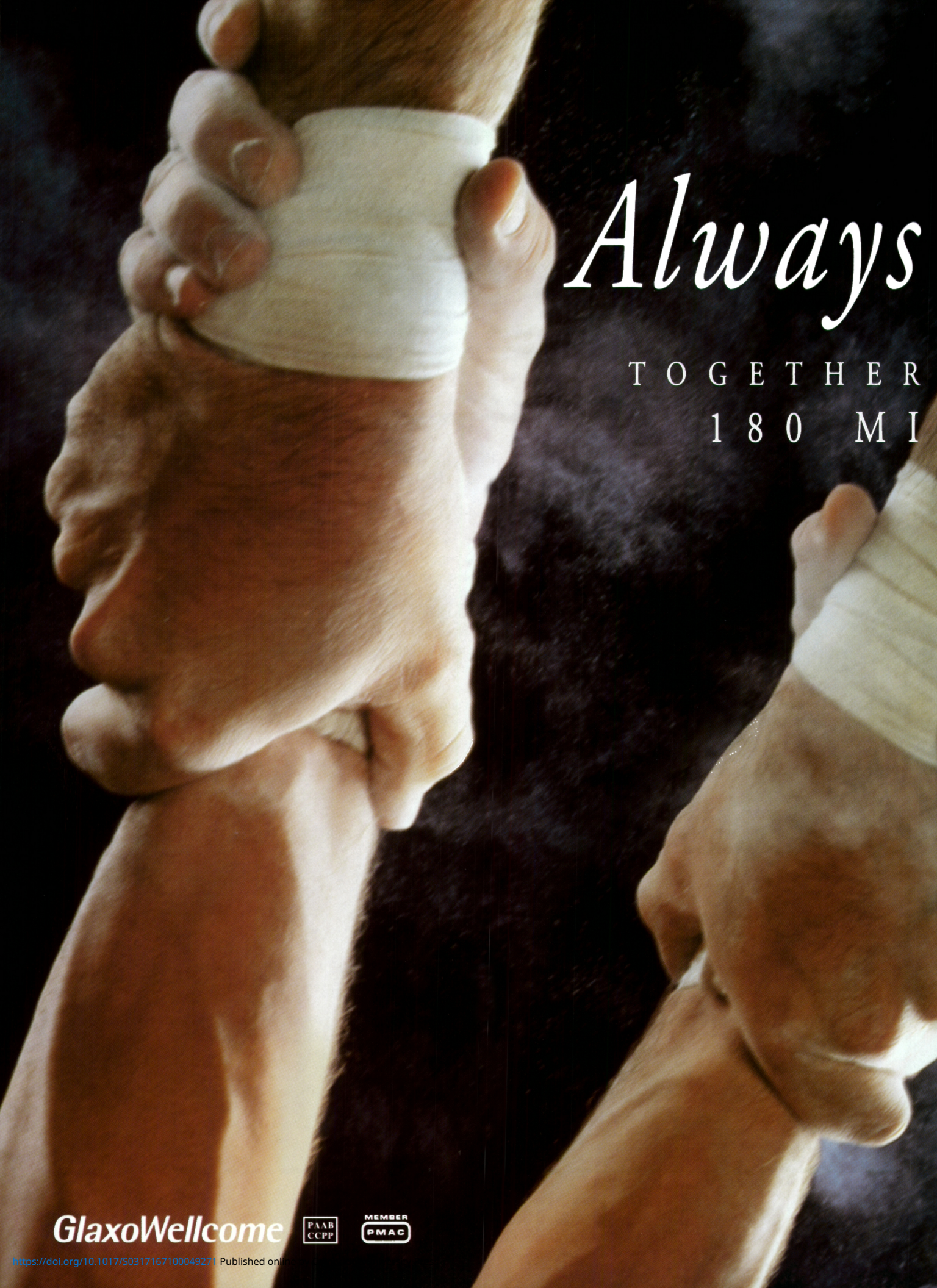
Alpha Methyldopahydrazine as an Adjunct to Levodopa Therapy in Parkinson's Disease

D.W. Paty, N. Jaatoul, A. Kertesz and W. McInnis

Summary: A double-blind, double-observer study was carried out in twenty-five patients with Parkinson's disease. Alpha methyldopahydrazine in combination with L-dopa was compared to placebo with L-dopa. Combination therapy resulted in a reduction in L-dopa dosage to ⅓ of the amount required during the baseline. There were no side effects attributed directly to the alpha methyldopahydrazine. The overall incidence of side effects in the two groups was similar but the combination therapy significantly reduced the incidence of nausea and vomiting. The limiting factor in the combination therapy was the presence of L-dopa induced dyskinesias.

Can. J. Neurol. Sci. 1975;2:169

https://doi.org/10.1017/S0317167100049271 Published online by Cambridge University Press



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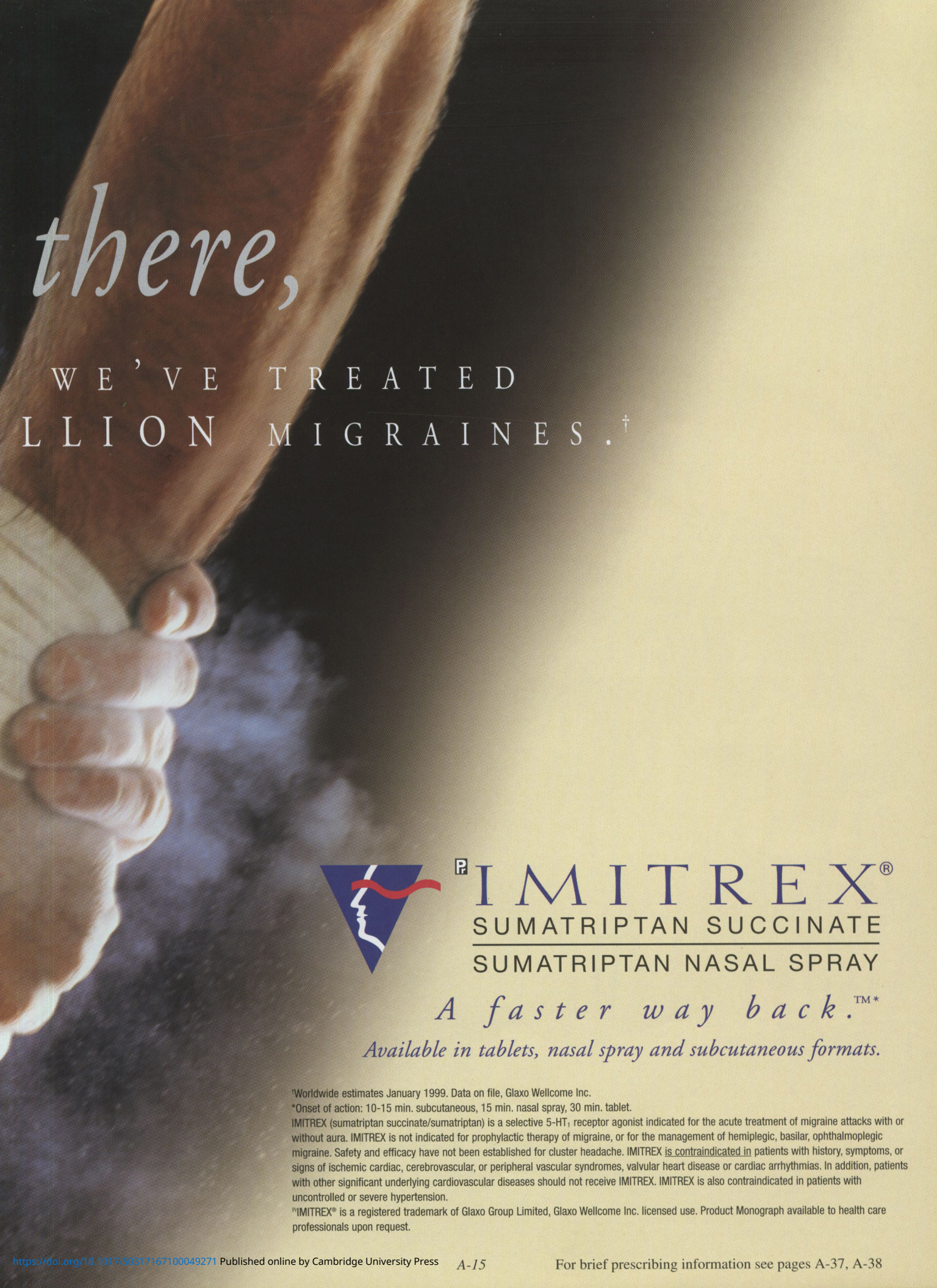


PrIMITREX®
SUMATRIPTAN SUCCINATE
SUMATRIPTAN NASAL SPRAY

A faster way back.™*

Available in tablets, nasal spray and subcutaneous formats.

†Worldwide estimates January 1999. Data on file, Glaxo Wellcome Inc.

*Onset of action: 10-15 min. subcutaneous, 15 min. nasal spray, 30 min. tablet.

IMITREX (sumatriptan succinate/sumatriptan) is a selective 5-HT_1 receptor agonist indicated for the acute treatment of migraine attacks with or without aura. IMITREX is not indicated for prophylactic therapy of migraine, or for the management of hemiplegic, basilar, ophthalmoplegic migraine. Safety and efficacy have not been established for cluster headache. IMITREX is contraindicated in patients with history, symptoms, or signs of ischemic cardiac, cerebrovascular, or peripheral vascular syndromes, valvular heart disease or cardiac arrhythmias. In addition, patients with other significant underlying cardiovascular diseases should not receive IMITREX. IMITREX is also contraindicated in patients with uncontrolled or severe hypertension.

PrIMITREX® is a registered trademark of Glaxo Group Limited, Glaxo Wellcome Inc. licensed use. Product Monograph available to health care professionals upon request.

https://doi.org/10.1017/S0317167100049271 Published online by Cambridge University Press

For brief prescribing information see pages A-37, A-38

Nouveau dans le syndro

*Lamotrigine, gabapentine, vigabatrine et topiramate (à distinguer des antiépileptiques standards).
†À l'exception des absences épileptiques atypiques.
‡Signification statistique non indiquée.
§**Dans de rares cas, des éruptions cutanées graves, y compris le syndrome de Stevens-Johnson et l'épidermolyse nécrosante suraiguë (syndrome de Lyell), ont été signalées. Bien que la plupart des patients se soient rétablis après le retrait du médicament, certains patients ont éprouvé des séquelles irréversibles et il y a eu de rares cas de décès associés**[2].
¶Les effets indésirables fréquemment signalés sont la pharyngite, la fièvre, les infections et les éruptions cutanées (p = non significatif)[1].
Pour obtenir des précisions sur la posologie de LAMICTAL chez l'adulte ou chez l'enfant atteints du syndrome de Lennox-Gastaut, consulter les renseignements thérapeutiques détaillés sur ce produit. La posologie de LAMICTAL comme traitement d'appoint qui a été utilisée dans les études de Motte et al. et de Mullens et al. était de 50 à 400 mg par jour, après augmentation graduelle de la dose initiale. **NE PAS DÉPASSER la dose initiale de LAMICTAL ni l'augmentation posologique graduelle qui sont recommandées. Un ajustement plus rapide de la dose initiale a été associé à une fréquence accrue de réactions dermatologiques graves.

Monographie du produit fournie sur demande aux professionnels de la santé.

https://doi.org/10.1017/S0317167100049271 Published online by Cambridge University Press

me de Lennox-Gastaut

lamotrigine

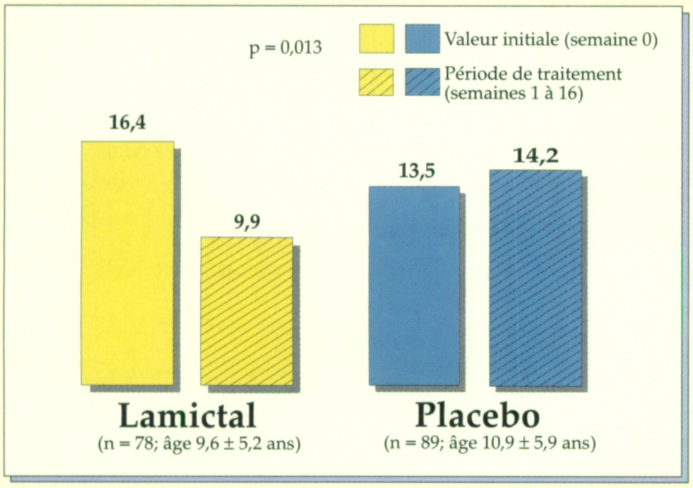
Lamictal®

LAMICTAL est le premier et le seul parmi les nouveaux antiépileptiques* qui soit indiqué comme traitement d'appoint chez les enfants et les adultes atteints du syndrome de Lennox-Gastaut (SLG)[1]. LAMICTAL est également le premier et le seul parmi les antiépileptiques récents* qui soit indiqué comme monothérapie après polythérapie chez l'adulte.

Une supériorité significative pour *maîtriser les divers types de crises* liées au syndrome de Lennox-Gastaut†

- L'adjonction de LAMICTAL réduit, de façon significative, le nombre de crises majeures, les effondrements épileptiques et les crises tonico-cloniques chez les patients atteints de SLG[1].

NOMBRE MÉDIAN
DES CRISES MAJEURES/SEMAINE



Essai à double insu, à répartition aléatoire et à contrôle placebo chez des patients de 3 à 25 ans

Maintien d'un *faible profil d'effets indésirables touchant le SNC* chez les patients de 3 à 25 ans atteints du syndrome de Lennox-Gastaut

- Faible taux d'abandons comparativement au placebo‡[1,2] : 3,8 % pour le groupe LAMICTAL (principalement reliés aux éruptions cutanées§) contre 7,8 % pour le groupe placebo (principalement reliés à une détérioration de la maîtrise des crises).
- Aucune différence significative dans la fréquence des effets indésirables entre LAMICTAL et le placebo, sauf pour le rhume ou des maladies virales (LAMICTAL, 5 % contre placebo, 0 %; p = 0,05)¶[1].

Amélioration de la fonction neurologique et des facultés cognitives[2,3]

- Une plus forte proportion de patients (de 3 à 25 ans) atteints de SLG, traités à l'aide de LAMICTAL comme traitement d'appoint (n = 79) c. un placebo d'appoint (n = 90), ont connu une **amélioration cliniquement significative des symptômes neurologiques** durant la période de traitement de 16 semaines : comportement (30,4 % c. 14,4 %), parole (11,4 % c. 2,2 %) et communication non verbale (11,4 % c. 7,8 %)‡[3]

LAMICTAL offre une plus grand maîtrise des divers types de crises liées au SLG, avec faible profil d'effets indésirables touchant le SNC. Vous pouvez aussi améliorer la fonction neurologique et les facultés cognitives de vos patients[2,3]. Ajoutez LAMICTAL** dès que l'on soupçonne un SLG[4].

GlaxoWellcome
Glaxo Wellcome Inc.

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lamotrigine

Lamictal®

L'avenir en tête

ACIM
CCPP PAAB

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For brief prescribing information see pages A-45, A-46, A-47, A-48

25 Years Ago in the Canadian Journal of Neurological Sciences

Morphological Responses of Cerebral Tissues to Temporary Ischemia

Ronald F. Dodson, Yukio Tagashira, Yasuo Kawamura and Lena Wai-Fong Chu

Summary: The ultrastructural responses of cerebral tissue following temporary periods (½, 1, 2, 3, or 4 hour) of right, middle cerebral artery (MCA) occlusion were studied acutely after a three day or seven day interval following the removal of the MCA clip. Cortical and basal ganglia tissues for each ischemic duration were compared at three post-occlusive periods (acute, 3-days, 7-days). With the short periods of ischemic insult (½, 1, 2, 3, and 4 hour), the temporal and insular cortex contained no greater changes in the 7-day group than in the 3-day group.The basal ganglia were more susceptible to MCA occlusion as indicated by more marked cytological changes and/or necrosis in all intervals of ischemia.

Can. J. Neurol. Sci. 1975;2:173

The Effect of Diazepam on Presynaptic Inhibition in Patients with Complete and Incomplete Spinal Cord Lesions

M. Verrier, S. MacLeod and P. Ashby

Summary: The effect of diazepam on presynaptic inhibition in man has been examined in 5 patients with complete spinal transections and 7 patients with incomplete lesions. The inhibition of the H reflex by vibration applied to the tendo Achilles was used to assess presynaptic inhibition of the Ia monosynaptic pathway. Diazepam increased this inhibition in the patients with incomplete lesions, but had no significant effect on the inhibition in the patients with complete spinal transections. Evidently diazepam can enhance presynaptic inhibition in man. The effect, however, cannot be demonstrated in patients with longstanding complete spinal lesions possibly because of some alteration in the segmental presynaptic inhibitory mechanism in this group.

Can. J. Neurol. Sci. 1975;2:179

Analysis of 128 Patients with Angiogram in Acute Head Trauma

M.P. Cinesi, J.D.R. Miller, M. Grace and T.N. Ayers

Summary: A computerized analysis of 128 patients admitted with acute head injury and who underwent angiography is shown, Patients were divided into groups according to: age, sex, type of accident, state of consciousness and presence of localizing signs on admission, types of cerebral lesions on angiography, and discharge condition.

There is a preponderance of young males in this series of patients, related mainly to MVA. A total of 71% of the patients had abnormal angiograms, but the incidence of normal and abnormal results did not correlate significantly with any of the chosen parameters.

The same parameters were also analysed to assess their value as a prognostic index for the patient. The conclusion was drawn that the angiogram per se has no significant value as a prognostic tool and that state of consciousness on admission is the best single index for prognosis.

Can. J. Neurol. Sci. 1975;2:185

https://doi.org/10.1017/S0317167100049271 Published online by Cambridge University Press

25 Years Ago in the Canadian Journal of Neurological Sciences

Memory and Growth in the Superior Temporal Gyri

E.J. Akesson, W.J. Dahlgren and J.B. Hyde

Summary: The superior temporal gyri were measured in 33 infants and in 33 adults. In the adults, most right superior temporal gyri were larger. This asymmetry was not found in infants, a difference which suggest greater growth of the right superior temporal gyri in the population from which our sample was taken. The asymmetry may be related to the functional asymmetry found by Penfield: some of his patients reported re-experiencing of past sensory experiences with electrical stimulation of the temporal lobe. This response was more frequently evoked from the right hemisphere.

Can. J. Neurol. Sci. 1975;2:191

The Nature of Primary Vocal tremor

V.C. Hachinski, I.V. Thomsen and N.H. Buch

Summary: Three elderly women with marked progressive voice tremor, without other neurological symptoms, and negative family histories were investigated.

All had a 4-5Hz respiratory tremor in expiration and, to a lesser degree, in inspiration; and all had vocal tremulousness synchronous with their respiratory irregularity. Articulation of phonemes was normal. In two cases the neurological examination was otherwise normal; in the third case there was a minimal 7½Hz tremor in the left thumb and index finger.

Simultaneous speech and vocal air pressure recordings, as well as cinematographic studies of the vocal apparatus and diaphragm were carried out.

It is suggested that these cases represent primarily an action tremor of respiration, that they belong in the spectrum of essential tremor, and hence may be amenable to treatment with propranolol.

Can. J. Neurol. Sci. 1975;2:195

Pituitary Melanocorticotrophinoma with Amyloid Deposition

Juan M. Bilbao, Kalman Kovacs, Eva Horvath, Hubert P. Higgins and William J. Horse

Summary: The light and electron microscopic features of a pituitary adenoma composed of adrenocorticotrophic hormone (ACTH) and melanocyte stimulating hormone (MSH) cells with perivascular amyloid deposition is reported. Histochemical and fine structural data indicate that this material is APUD amyloid and is present in the extra-cellular perivascular spaces. It is suggested that the differences in fine structure and of distribution of the amyloid in pituitary adenomas is dependent upon the cell of origin.

Can. J. Neurol. Sci. 1975;2:199

Cucumber-shaped and 35nm Particles in Creutzfeldt-Jakob Disease

Dikran S. Horoupian and R.T. Ross

Summary: A 63-year-old female with the ataxic form of Creutzfeldt-Jakob disease (CJD) is presented. In addition to amyloid plaques, which were not associated with Alzheimer's neurofibrillary tangles, rare profiles similar to those reported in Scrapie were also seen. To our knowledge, these profiles have never been observed in CJD and their presence in this condition adds a further morphologic similarity between the human and animal forms of subacute spongiform "viral" encephalopathies.

Can. J. Neurol. Sci. 1975;2:203

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Turn the agony of migraine into the beauty of relief.

Introducing Pr Zomig®.

Consistent migraine relief that patients can depend on time after time.

ZOMIG® is a new oral 5-HT_1 agonist indicated for the acute treatment of migraine.[1]

ZOMIG® offers consistent efficacy with significant headache response* rates at 2 hours following a single 2.5 mg dose.[2,3] In addition, efficacy is maintained across multiple migraine attacks and within different migraine subtypes.[1,4,5]

ZOMIG® has a proven safety and tolerability profile with studies in over 3,000 patients treating more than 34,000 attacks.[6†]

For consistent migraine relief, prescribe ZOMIG® 2.5 mg.

*Improvement from severe or moderate headache to mild or no pain.
† The most common side effects reported with ZOMIG® compared to placebo were nausea (9% vs. 3.7%), head/face sensations (8.6% vs. 1.7%), dizziness (8.4% vs. 4%) and neck/throat/jaw sensations (7% vs. 3%).[1]

ZOMIG® is not intended for use prophylactically or in hemiplegic, basilar, or ophthalmoplegic migraine. Safety and efficacy have not been established for cluster headache, which is present in an older, predominantly male population.

ZOMIG® is contraindicated in patients with history, symptoms, or signs of ischemic, cardiac, cerebrovascular or peripheral vascular syndromes, valvular heart disease or cardiac arrhythmias (especially tachycardias). In addition, patients with other significant underlying cardiovascular disease should not receive ZOMIG®. Please see Product Monograph.

For more information about ZOMIG®, please contact Zeneca Pharma Medical Information by phone at 1-888-325-0555, fax (905) 821-8882 or e-mail at canada.medinfo@cams.zeneca.com

Pr Zomig®

https://doi.org/10.1017/S0317167100049271

IL FUT UN TEMPS OÙ LES PERSONNES ÉPILEPTIQUES DEVAIENT DÉPLOYER DES EFFORTS CONSIDÉRABLES OU FAIRE PREUVE DE TALENTS EXTRAORDINAIRES POUR RÉUSSIR DANS LA VIE. HEUREUSEMENT, LES ENFANTS ET LES ADULTES ÉPILEPTIQUES QUE VOUS TRAITEZ PEUVENT MAINTENANT BÉNÉFICIER D'OPTIONS MOINS ÉPROUVANTES QUE PAR LE PASSÉ.

https://doi.org/10.1017/S0317167100049271 Published online by Cambridge University Press

MAINTENANT INDIQUÉ CHEZ L'ENFANT

Comprimés et capsules à saupoudrer PrTOPAMAX* (topiramate) : indiqués en tant que traitement d'appoint dans la prise en charge des patients (adultes et enfants de deux ans ou plus) épileptiques dont l'état n'est pas maîtrisé de façon satisfaisante par le traitement traditionnel. Les renseignements sur l'emploi du topiramate en monothérapie sont encore limités[1].

Efficacité en cas de crises partielles initiales :

Posologie ajustée en fonction de la réponse de chaque patient[4,5] :

	N	Réduction ≥ 50 % du nombre de crises	Absence de crises
Adultes[4,a]	450	59 %	19 %
Enfants[5,b]	41	73 %	22 %

D'après les références 4 et 5

[a] Étude ouverte d'une durée de 20 semaines portant sur des adultes atteints de crises partielles initiales. Administration biquotidienne de TOPAMAX en tant que traitement d'appoint. La posologie optimale semblait comprise entre 300 et 350 mg/jour.

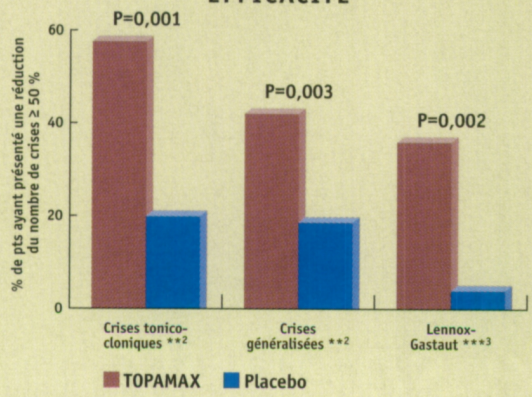
[b] Étude ouverte portant sur des enfants atteints de crises partielles initiales ayant participé à un essai à double insu contrôlé par placebo. Les réductions de la fréquence des crises ont été déterminées chez les enfants qui avaient été traités pendant au moins 3 mois. Administration biquotidienne de TOPAMAX en tant que traitement d'appoint. Les sujets ont reçu un traitement par topiramate pendant une période moyenne de 8 mois, selon une posologie moyenne de 10 mg/kg/jour (4-20 mg/kg/jour).

Pour connaître les posologies recommandées, reportez-vous aux Renseignements thérapeutiques concernant TOPAMAX*.

Meilleure maîtrise d'un grand nombre de types de crises :

- Des données complémentaires recueillies dans le cadre d'études randomisées, à double insu et contrôlées par placebo portant sur des adultes et un nombre restreint d'enfants ont en outre montré que ce médicament était efficace en tant que traitement d'appoint en cas de :
- **crise tonico-clonique primaire généralisée**[1]
- **crise associée au syndrome de Lennox-Gastaut**[1]

EFFICACITÉ



D'après les références 2 et 3

**Phase de traitement à double insu d'une durée de 20 semaines (données de départ recueillies pendant une période initiale de 8 semaines, et période de traitement de 12 semaines) consistant en l'administration de TOPAMAX (n = 39, y compris 8 enfants ≤ 16 ans) en tant que traitement d'appoint à raison de 2x/j, ou d'un placebo (n = 41). La posologie de TOPAMAX était ajustée jusqu'à ce qu'une dose cible d'environ 6 mg/kg/jour soit atteinte.

***Chutes brusques par dérobement des jambes et crises tonico-cloniques : phase de traitement à double insu d'une durée de 11 semaines consistant en l'administration de TOPAMAX (n = 48) à raison de 2x/j en tant que traitement d'appoint, ou d'un placebo (n = 50); âge moyen des patients : 11,2 ans. La posologie de TOPAMAX était ajustée jusqu'à ce qu'une dose cible d'environ 6 mg/kg/jour soit atteinte.

COMPRIMÉS DÉSORMAIS INSCRITS AU FORMULAIRE‡

‡Indemnité partielle – Ontario, Nouvelle-Écosse, Nouveau-Brunswick, Î.-P.-É.
Indemnité intégrale – Québec, Saskatchewan, Colombie-Britannique, Alberta, Manitoba

Un traitement d'appoint approprié en première intention pour nombre de vos patients :

Profil d'effets secondaires favorable :

- Comme pour la plupart des antiépileptiques, les effets secondaires le plus fréquemment signalés relèvent du SNC††[1,6] :

- Généralement légers à modérés, ils surviennent à un stade précoce du traitement et sont passagers[1,6]
- En cas de survenue d'effets secondaires :

Envisagez de réduire la posologie de TOPAMAX, le taux d'augmentation de la posologie, et/ou la posologie de l'antiépileptique administré de façon concomitante[8].

- Chez les enfants traités dans le cadre des essais contrôlés, on n'a signalé aucun abandon du traitement attribuable à des manifestations indésirables lorsque la posologie était de 5 à 9 mg/kg/jour[1].

Profil d'innocuité :

- Aucune donnée n'a montré, jusqu'à présent, qu'il existait un lien entre l'emploi de TOPAMAX et les affections suivantes : éruption cutanée potentiellement mortelle, rétrécissement permanent du champ visuel ou syndrome des ovaires polykystiques[1,c].
- Perte de poids

Adultes : une perte de poids modérée peut se produire au cours des 12 premiers mois, les pertes pondérales les plus importantes survenant entre le 3e et le 6e mois, avec un pic au 9e mois[7].

Enfants : 96 % des enfants traités dans le cadre des essais cliniques pendant au moins un an et ayant subi une perte pondérale ont repris du poids au cours de la période d'exécution des essais[11].

Posologie BID commode[1]

Maintenant offert sous forme de capsules à saupoudrer à 15 et 25 mg, une présentation encore plus commode[1] :

La capsule peut être avalée entière ou on peut en saupoudrer le contenu sur de la nourriture
Les capsules sont bioéquivalentes aux comprimés TOPAMAX

† Les effets à long terme d'une perte pondérale n'ont pas été établis chez l'enfant.
†† Manifestations indésirables associées au SNC : Somnolence (30,1 %), étourdissements (28,3 %), ataxie (21,2 %), troubles de la parole (16,8 %), ralentissement psychomoteur (16,8 %), nystagmus (15,0 %), paresthésie (15,0 %), nervosité (15,9 %), problèmes de concentration/d'attention (8,0 %), confusion (9,7 %), dépression (8,0 %), anorexie (5,3 %), troubles du langage (6,2 %) et troubles de l'humeur (3,5 %)[1]. Une analyse portant sur 1 446 adultes et 303 enfants indique que ces deux groupes semblent présenter des profils de manifestations indésirables similaires[1].

Pour obtenir des renseignements complets sur les modalités de prescription de TOPAMAX, veuillez vous reporter aux Renseignements thérapeutiques concernant ce produit.
c Données internes. JANSSEN-ORTHO Inc. Mai 1999
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TOPAMAX* topiramate

Pour aider les patients épileptiques à mieux profiter de la vie

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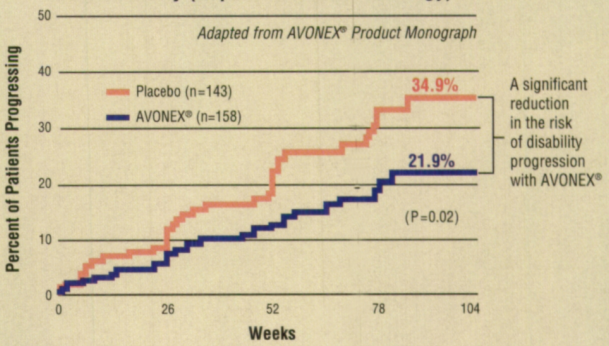
for all the facts on AVONEX® therapy.

Proven to slow the progression of disability in relapsing forms of MS.[1]

- Patients treated with AVONEX® showed a significant reduction in risk of disability progression and a 32% reduction in annual exacerbation rate over two years.[2]
- AVONEX® also demonstrated a significant MRI effect, showing an 89% reduction in gadolinium-enhanced lesions in patients with enhancement at baseline.[3]
- Prescribed for more than 50,000 patients worldwide, now available in Canada.[4]

Onset of sustained disability progression by time on study (Kaplan-Meier Methodology)[1]



Compliance-enhancing once-a-week dosing.

- Treatment with Once-a-Week AVONEX® results in minimal disruption of lives and mild side effects that decrease over time for most patients.[1,3]
- The most common side effects associated with AVONEX® treatment are flu-like symptoms and usually resolve within 24 hours after injection.[1,3] No cases of injection site necrosis have been reported for patients on AVONEX® therapy.[1,5]

Superior Support Services

- Extensive patient program including a 24 hour, 7 days a week 1-888 support line, injection training, delivery options and reimbursement counseling.

Pr ONCE-A-WEEK AVONEX® (Interferon beta-1a) IM Injection

Helping people with relapsing forms of MS get on with their lives.

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PAAB

Please see product monograph for important patient selection and monitoring information.

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For brief prescribing information see pages A-43, A-44, A-48

The loss of function that comes with Alzheimer's disease has a devastating effect on everyone involved: patient, caregiver and family.[1] Once-a-day Aricept* **enhances cognition and improves patient function.**[2†] Once-a-day Aricept* (10 mg o.d.) has been shown to significantly improve complex Activities of Daily Living (ADL).[3] A recent Canadian economic evaluation predicts that improvement in patient outcome will result in an overall healthcare cost saving.[4] And once-a-day Aricept* has proven efficacy, dosing simplicity[§] and tolerability[‡] in over 129 million patient days of therapy worldwide.[5]

Once-a-day Aricept*. To help your Alzheimer's patients enjoy more *active* days, and look forward to a *brighter* tomorrow.

Aricept* is indicated for the symptomatic treatment of patients with mild-to-moderate Alzheimer's disease. Aricept* has not been studied in controlled clinical trials for longer than 6 months.
† Cognition measured by ADAS-cog and MMSE; function measured by CIBIC plus.
‡ The most common side effects observed with Aricept* include diarrhea, muscle cramps, nausea and insomnia; these effects are usually mild and transient, resolving with continued use.
§ For patients not responding after 4-6 weeks of therapy at 5 mg/d, a 10 mg/d dose may be considered.
Please see enclosed Prescribing Information before prescribing.

¶ For more information on Limited Use criteria, please call 1-800-510-6141.

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donepezil HCl 5 & 10 mg tablets

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For brief prescribing information see pages A-35, A-36