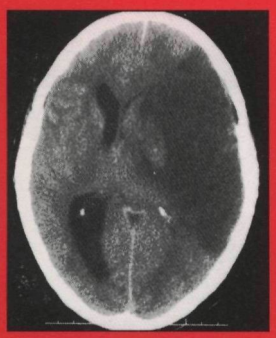
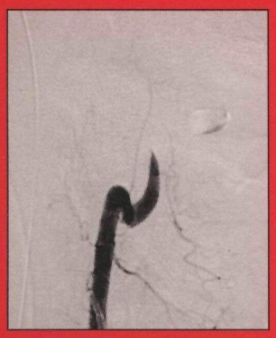
Volume 27 Number 4 November 2000

THE CANADIAN JOURNAL OF
Neurological Sciences
LE JOURNAL CANADIEN DES
Sciences Neurologiques

AN INTERNATIONAL JOURNAL / UN JOURNAL INTERNATIONAL

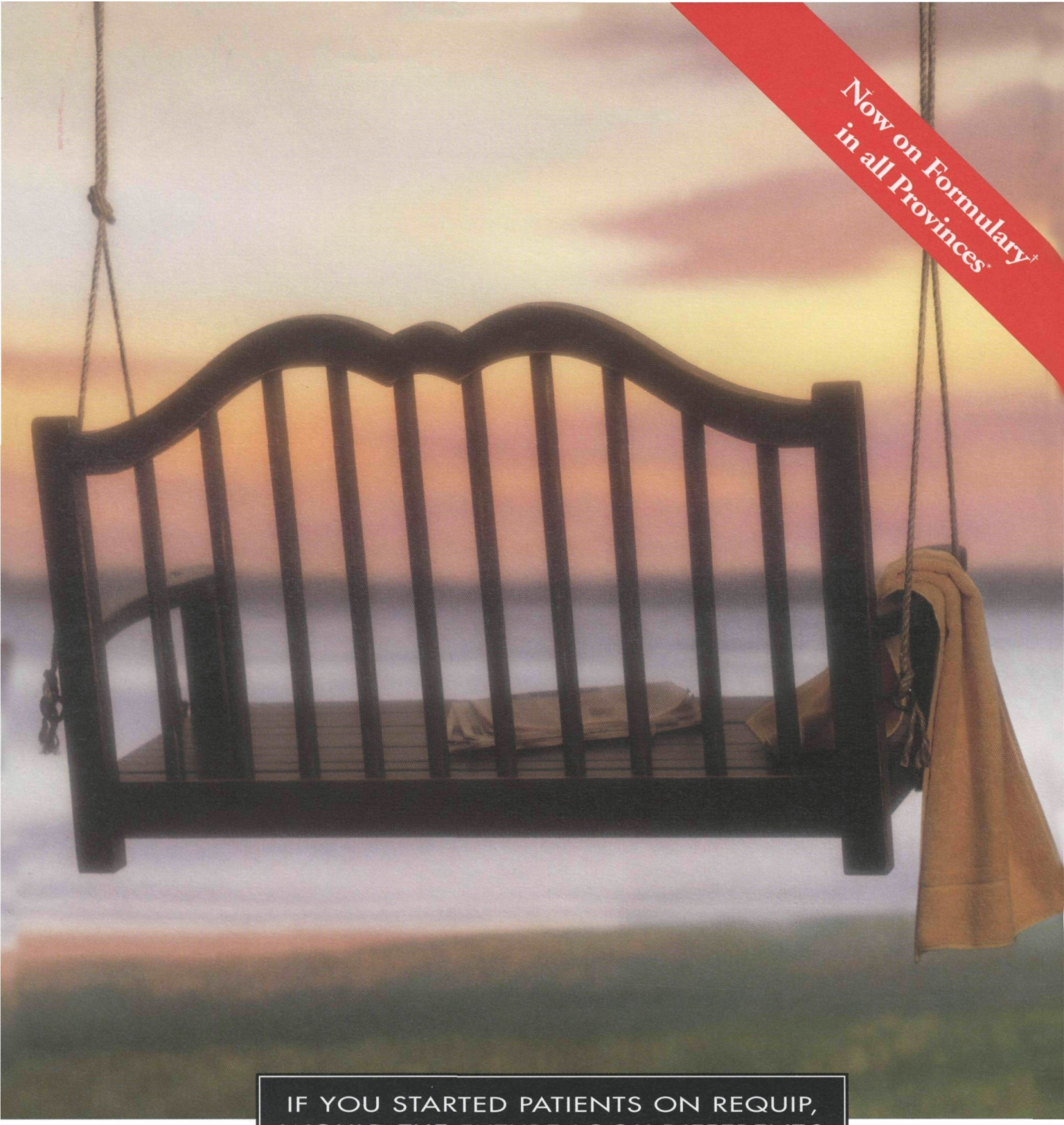


Hemicraniectomy for MCA infarction



Vertebral Artery Dissection

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



Interim 6-month results from a 5 year multicentre study show ReQuip demonstrated similar efficacy to L-dopa in the control of early† Parkinson's disease.[††] Yet ReQuip ropinirole REQUIP® Rethinking Parkinson's. has demonstrated a low propensity to produce dyskinesias.[2†††] Maybe it's time to rethink Parkinson's. And start early Parkinson's patients on ReQuip alone.

† Hoehn and Yahr stages III †† A 6 month interim analysis of a 5-year, double-blinded, randomized, multicenter study of patients with early Parkinson' disease. N = 268:179 patients received ropinirole and 89 received L-dopa. The mean daily dose was 9.7 mg and 464.0 mg respectively. There was no difference in Clinical Global Improvement scale in patients with Hoehn and Yahr stages I-II although L-dopa showed improvement in a greater proportion of patients with more severe disease. The proportion of responders was 58% in the L-dopa group and 48% in the ropinirole group: this was not of statistical significance. ††† In early therapy, the respective incidences of dyskinesia in early therapy of patients receiving ropinirole was 1.2%, and of patients receiving L-dopa was 11.2%. Meta analysis, n = 1364, 17 months. Nausea (39.1%), somnolence (12.3%) and insomnia (12.3%) were the most common side effects of ReQuip therapy. Six percent of ropinirole patients and nine percent of L-dopa patients had at least one psychiatric symptom (confusion, hallucinations, or delusions).

SB SmithKline Beecham Pharma PAAB CCPP Member R&D

† Except New Brunswick * Special Authority/Exceptional Status in B.C. and N.S.

https://doi.org/10.1017/S0317167100050125 Published online by Cambridge University Press

For brief prescribing information see page A-32

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For brief prescribing information see pages A-39, A-40, A-49

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.**[2]
¶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 increase incidence of serious dermatological reactions.

Product Monograph available to health care professionals upon request.

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Gastaut Syndrome

Lamotrigine

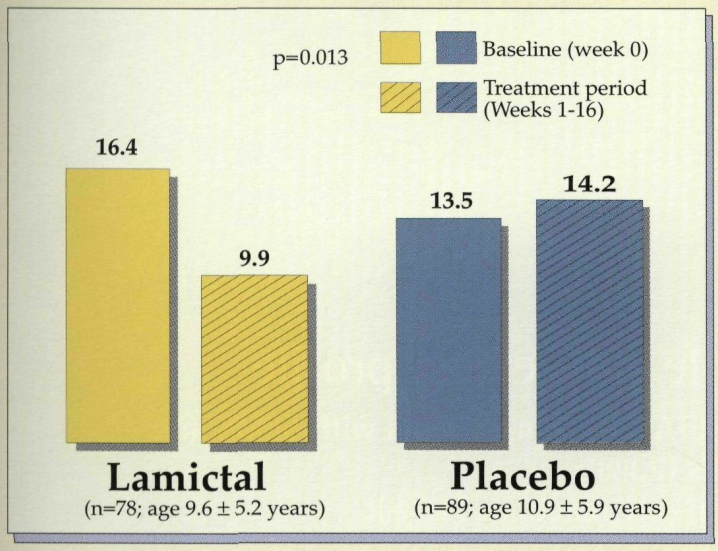
Lamictal®

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]

Lamotrigine

Lamictal®

For a Brighter Future

PMAC

PAAB CCPP

GlaxoWellcome

Glaxo Wellcome Inc.

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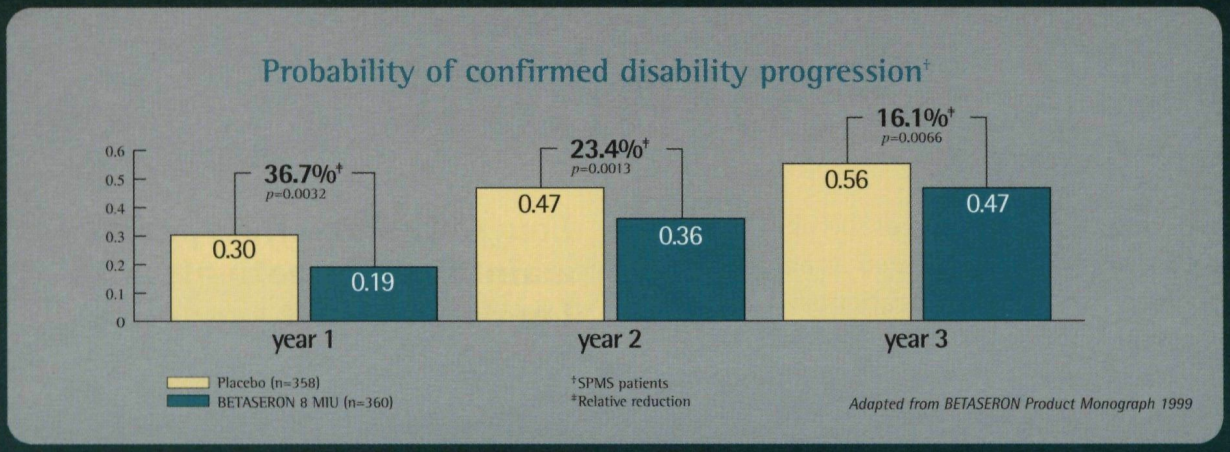
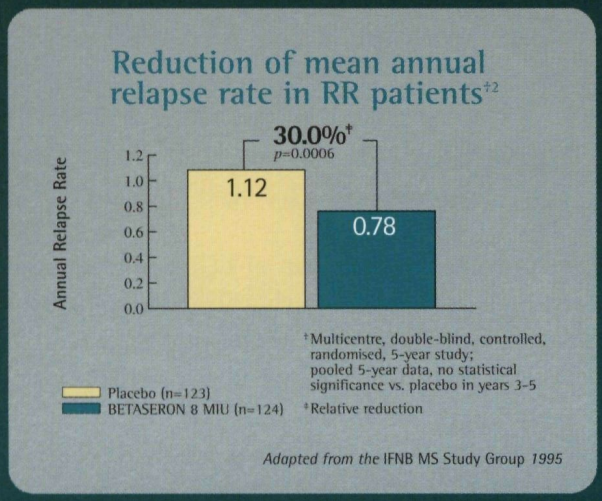
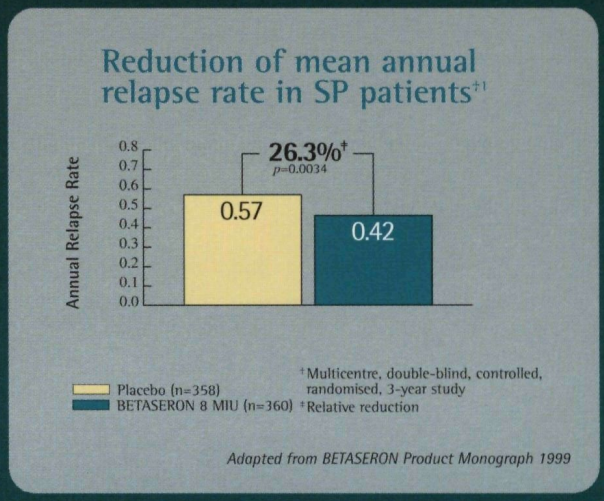
For brief prescribing information see pages A-36, A-37, A-38, A-44

BETASERON delays disability progression*[1]



BETASERON reduces relapse rate in both relapsing-remitting[2] and secondary progressive MS[1]





BETASERON has a manageable side-effect profile[1]

The most common side effects related to BETASERON in patients with SPMS are: flu-like syndrome (61%); fever (40%); chills (23%); injection-site inflammation (48%); injection-site reactions (46%); myalgia (23%); hypertonia (41%); rash (20%)[1]

Flu-like symptoms and injection-site reactions are manageable and lessen markedly with time[1]

*BETASERON has been demonstrated to delay the progression of disability in secondary progressive MS patients.[1] The safety and efficacy of BETASERON in primary progressive MS have not been evaluated. Efficacy of treatment for longer than 2 years has not been substantially demonstrated in relapsing-remitting MS. For secondary progressive MS, safety and efficacy data beyond 3 years are not available.

FOR COMPLETE WARNINGS AND PRECAUTIONS, PLEASE REFER TO THE PRODUCT MONOGRAPH. PRODUCT MONOGRAPH AVAILABLE TO HEALTH CARE PROFESSIONALS UPON REQUEST.

Member R&D PAAB

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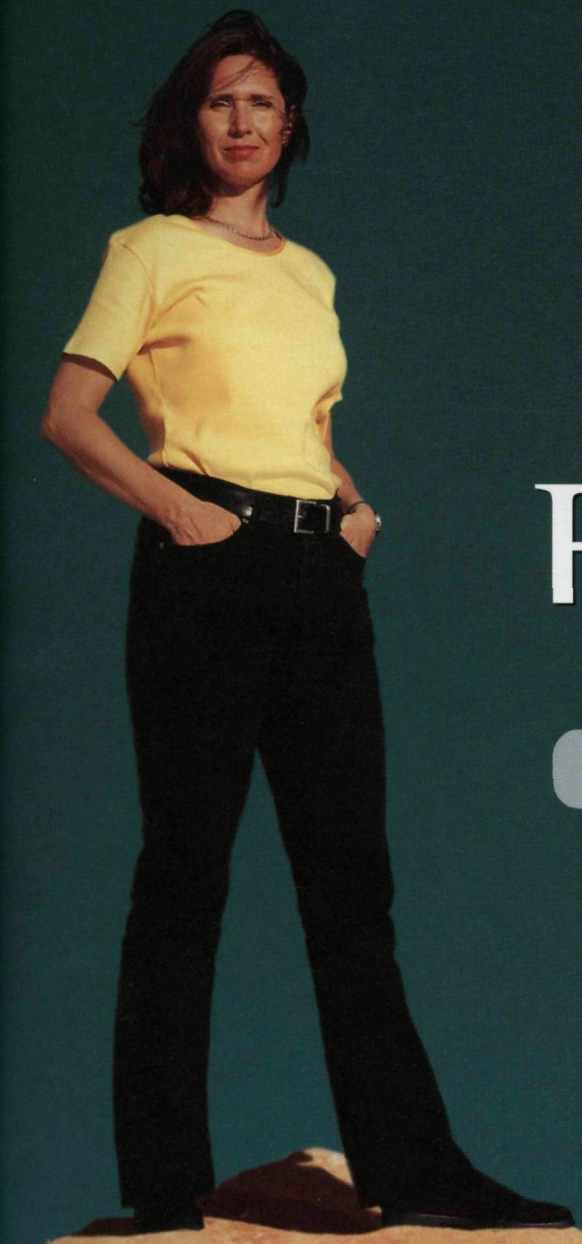

Delays Disability Progression*

Indicated for both RRMS and SPMS

In RRMS and SPMS

Pr BETASERON®

INTERFERON BETA-1b

From Onset Onwards

MULTIPLE SCLEROSIS PATHWAYS™ FOR CANADA

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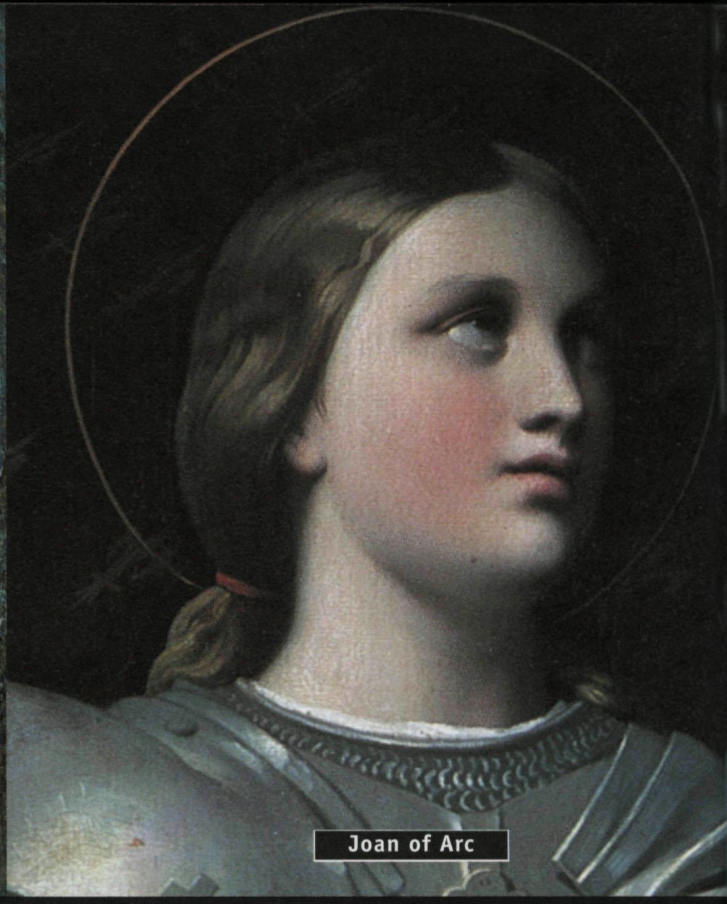
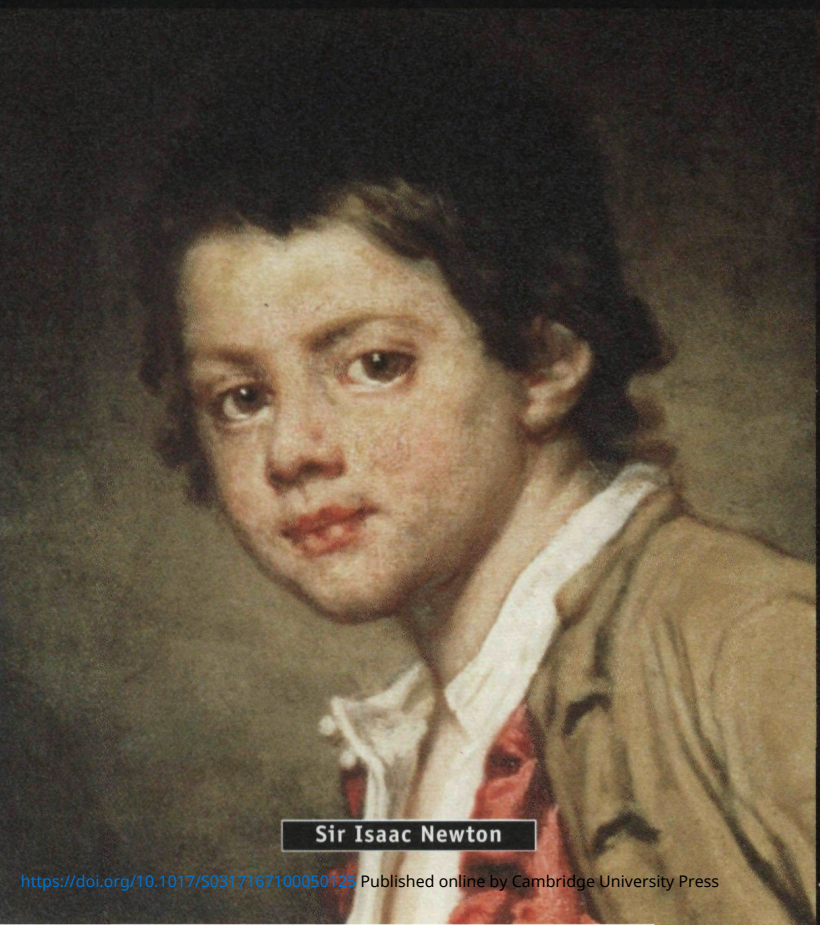
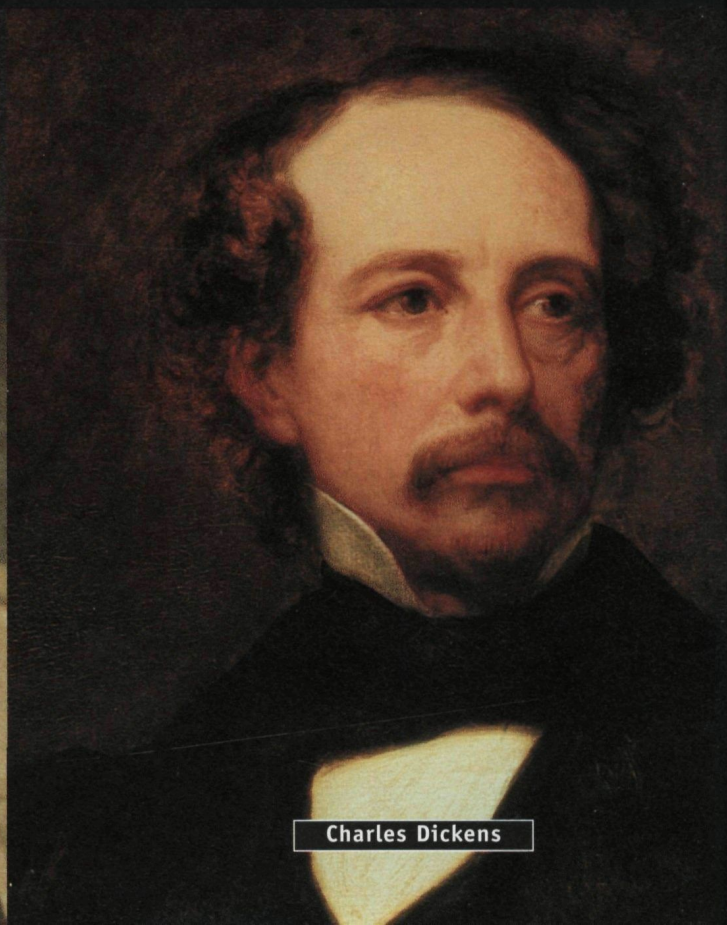


YESTERDAY, PEOPLE WITH EPILEPSY HAD TO BE EXTRAORDINARY TO SUCCEED.





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EFFICACY ACROSS A BROAD RANGE OF SEIZURES.

- TOPAMAX demonstrates efficacy in Partial Onset, Primary Generalized Tonic-Clonic, and Lennox-Gastaut Seizures[1]
- Desirable seizure-free results were shown in both Adults (19%)† and Children (22%)‡ with Partial Onset Seizures[2,3]

NO EVIDENCE OF LIFE-THREATENING SIDE EFFECTS.

- Like most antiepileptics, the most common side effects are CNS related, usually mild to moderate and transient§[1]

ADULT PATIENTS MAY EXPERIENCE WEIGHT LOSS.

- 73% of patients (n=52) showed a mean weight decrease of 5.97 lb (Interim analysis. Average duration 60 days)[4]
- 96% of children in clinical trials (≥ one year) who lost weight showed resumption of weight gain in test period**[1]

TODAY, THERE'S TOPAMAX.

B.I.D. DOSING WITH THE PATIENT IN MIND.

- TOPAMAX is initiated and titrated to clinical response regardless of existing anticonvulsant therapy
- Tablets available on formulary††

NOW AVAILABLE IN SPRINKLE CAPSULES

TOPAMAX* topiramate

NOW INDICATED FOR CHILDREN

HELPING PATIENTS MAKE MORE OF THEIR LIVES.

℞ *TOPAMAX* 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.*

† Open label, 20 week trial (n=450 Adults). Optimal dosing was 300-350 mg/day(Average 288 mg/day).
‡ Open label trial for children (n=72) treated for ≥ 3 months. Average dose of 10 mg/kg/day.
§ 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%). In an audit of 1446 adults and 303 children, there appeared to be a similar pattern of adverse events.
** The long-term effects of weight loss in pediatric patients are not known.
†† Limited use benefit: Ontario, Nova Scotia, New Brunswick, PEI. Full benefit: Quebec, Saskatchewan, British Columbia, Alberta, Manitoba.
Please refer to the TOPAMAX Prescribing Information for complete prescribing details.

REFERENCES: 1. TOPAMAX* topiramate Tablets and Sprinkle Capsules Product Monograph, May 11, 1999. 2. Kamin M, Kraut L, Olson W. Dose optimization of topiramate as add-on therapy in adults with treatment-resistant partial-onset seizures *Neurology* 1999;52 (Suppl 2):A525-526. 3. Glauser TA, Elterman R, Wyllie E et al. Open label topiramate in paediatric partial epilepsy *Epilepsia* 1997:38 (Suppl 3):94. 4. Rosenfeld WE et al.Topiramate and concomitant weight loss. *Epilepsia* 1997:38 (Suppl 8):98.

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For brief prescribing information see pages A-27, A-28

25 Years Ago in the Canadian Journal of Neurological Sciences

Progress in Understanding and Treating Parkinson's Disease

André Barbeau

SUMMARY: This review evaluates the long-term results of Levodopa therapy in Parkinson's disease upon quality of life, prolongation of survival and excess mortality. It also focuses on recent and new therapeutic approaches: Levodopa in combination with a Dopa-decarboxylase inhibitor or MAO-B inhibitor, dopamine agonists and an active tripeptide: L-prolyl-L-leucyl-glycine amide (MIF-I). It ends by looking at new avenues of etiological research in Parkinson's disease which may indicate specific accelerated ageing of catecholaminergic (pigmented) neuronal systems.

Can. J. Neurol. Sci. 1976;3:81

Integrative versus Delay Line Characteristics of Cerebellar Cortex

W.A. MacKay and J.T. Murphy

SUMMARY: In order to determine which of two general models ("tapped delay line" or "integrator") provides a more accurate description of mammalian Purkinje cell (P-cell) activation by natural stimulation, the spatial and temporal characteristics of a population of neurons in cerebellar cortex responsive to small controlled stretches of forelimb muscles were examined in awake, locally anesthetized cats. Stretch of a single wrist muscle excited P-cells over a distance of about 1 mm in the long axis of a folium, a span which is at most half the length of parallel fibers. Both granule cells and molecular layer interneurons were excited over a wider zone than P-cells.

Furthermore, P-cells across a response zone all fired on the average at the same time, as determined by computing peristimulus cross-interval histograms from pairs of simultaneously recorded neurons. Consistent delays could only be demonstrated in the *minimal* response latencies as measured from peristimulus time histograms. These delays, however, were longer than could be ascribed to parallel fiber conduction velocity.

No evidence, therefore, was found in cat cerebellum to support the "tapped delay line" model, which postulates the successive activation of P-cells as an excitatory volley travels along a parallel fiber beam. Instead, an integrative mode of operation seems to predominate: a relatively wide substratum of activated granule cells simultaneously activates a narrower focus of P-cells centrally situated with respect to the granule cell population. The role of inhibitory interneurons in promoting the "integrator" model is discussed.

Can. J. Neurol. Sci. 1976;3:85

Studies of Human Papovavirus Tumor Antigen in Experimental and Human Cerebral Neoplasms

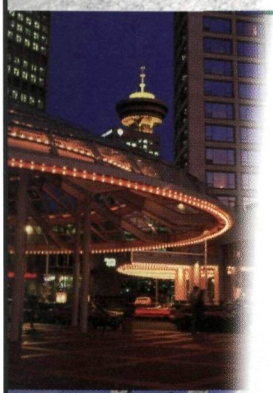
L.E. Becker, O. Narayan and R.T. Johnson

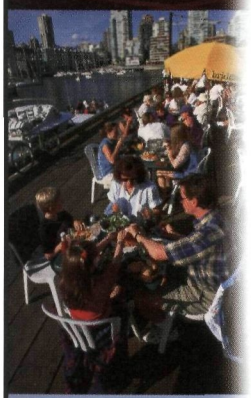
SUMMARY: Three types of papovaviruses (JC, BK and SV40) have been isolated from man. All three are oncogenic in hamsters, cause frequent infection of man, and share a common T antigen. Augmentation of the expression of T antigen by *in vitro* cultivation of SV40-induced tumors of hamsters suggested that growing human brain tumors *in vitro* might provide an effective screening technique for the SV40 virus. In a series of human brain tumors examined in cryostat sections and in tissue culture, T antigen could not be demonstrated, suggesting that by this immunofluorescent technique SV40 was not implicated in the etiology of these tumors.

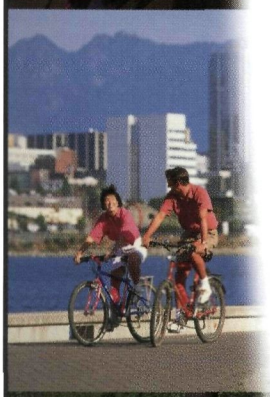
Can. J. Neurol. Sci. 1976;3:105

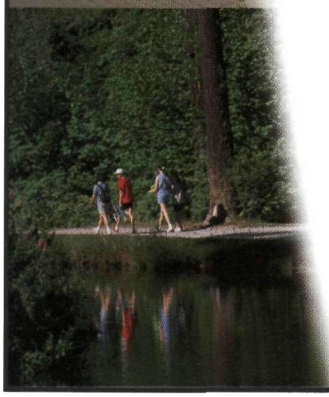
Vancouver

Voted Best City in North America to Live...









Acute & Critical Care Nurses

Become clinical experts providing the highest standard of care as part of our dynamic and motivated Neuroscience Patient Care Team...

And we'll provide the training!

A wide variety of challenging clinical opportunities are available within Neuroscience – ranging from critical and specialized acute care to early rehabilitation.

The Neuroscience Department at Vancouver General Hospital combines Neurology and Neurosurgery services and delivers both tertiary and quarternary care. With excellence and leadership, the Neuroscience program provides the only Seizure Investigation Unit in British Columbia; a 5-bed Step-down Unit; a 10-bed Neuroscience Intensive Care Unit and a 56-bed Neuroscience Ward.

Patient-focused care is inherent in our philosophy: patient/family input critical to the functioning of our teams. The Neuroscience Patient Care team provides hospital-wide service for Neuroscience patients/families and acts as a provincial clinical resource.

Full-time and casual opportunities are offered to Nurses wishing to join our dedicated group of professionals. Dependent upon your current qualifications and experience in either acute or critical care Neuroscience, you may be offered an initial 5-week Neuroscience Training Program, or an Advanced Specialty Training in Neuroscience through the 5-week Neuroscience Intensive Care Unit course. (This specialty training prepares staff to care for critically-ill patients and provides the foundation for a Neuroscience clinical expert.) The Neuroscience Patient Care Unit is also delighted to offer an annual structured in-service schedule as well as support for staff with self-directed learning interests.

Assistance with relocation expenses is available.

If you are interested in being considered for employment with this dynamic team, please forward your résumé in confidence to: Human Resources, Vancouver Hospital & Health Sciences Centre, Vancouver General Hospital, 855 West 12th Avenue, Vancouver, BC V5Z 1M9. Fax: 604.875.4761; job-line: 604.875.5123; email: careers@vanhosp.bc.ca.

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AS IN MS, SOME THINGS ARE NOT ALWAYS OBVIOUS.

Danger can lurk behind the face of an apparently healthy MS patient.

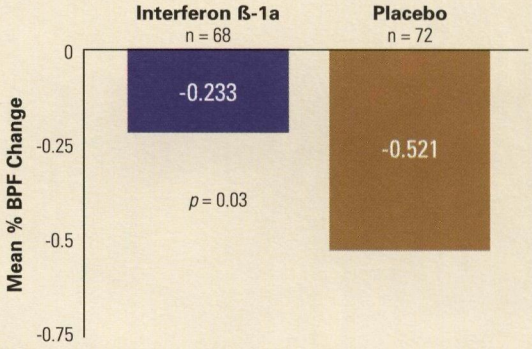
Progressive brain atrophy begins early in the course of MS and is likely irreversible.[1] Cognitive disturbances begin early in the MS process, but are often subtle and easily overlooked by patient and clinician alike.[2-4]

AVONEX® has shown a 55% reduction in brain atrophy progression.[5]

The use of AVONEX® can help patients with relapsing forms of MS maintain both physical AND mental function longer. In a clinical trial, patients treated with AVONEX® showed a 55% reduction in brain atrophy progression versus placebo, during the second year of treatment.*[5] AVONEX® is proven to slow the progression of physical disability - patients treated with AVONEX® showed a 37% reduction in the risk of disability progression and a 32% reduction in annual exacerbation rate over two years.†[6] AVONEX® also demonstrated a significant MRI effect showing an 89% reduction in gadolinium-enhanced lesions in patients with enhancement at baseline.◊[7]

Change in Brain Parenchymal Fraction[5]

(Adapted from Rudick et al.)



Change in brain parenchymal fraction (BPF) according to treatment arm in the interferon ß-1a clinical trial. Significantly less brain atrophy in interferon ß-1a patients during the second year.

Once-a-Week AVONEX® is generally well tolerated.[6]

The once-a-week intramuscular dosing regimen with AVONEX®, means few opportunities for injection-related side effects to disrupt patient's lifestyle.[6] The most common side effects associated with treatment are flu-like symptoms and usually resolve within 24 hours after injection.[6,8] Incidence of side effects decrease over time with continued treatment for most people.[8] Please see product monograph for important patient selection and monitoring information.

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

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

* It remains to be determined whether brain atrophy during the relapsing-remitting stage of MS will predict long-term disability progression better than clinical features in the majority of patients. Additional prospective studies are needed to determine the biologic factors associated with atrophy progression, the clinical significance of BPF change during the relapsing-remitting disease stage, and the impact and time course of therapeutic intervention.

† Kaplan-Meier estimate of percentage progressing at two years for placebo patients: 34.9% (n=143); AVONEX®-treated patients: 21.9% (n=158);(p=0.02). Placebo annual exacerbation rate: 0.90 (n=87); AVONEX® annual exacerbation rate: 0.61(n=85);(p=0.002).

◊ The exact relationship between MRI findings and clinical status is unknown (n=44).

AVONEX® is indicated for the treatment of relapsing forms of MS.

PAAB

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For brief prescribing information see pages A-47, A-48, A-49

Nouveau dans le syndr

*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[1].**
¶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.

ne de Lennox-Gastaut

lamotrigine

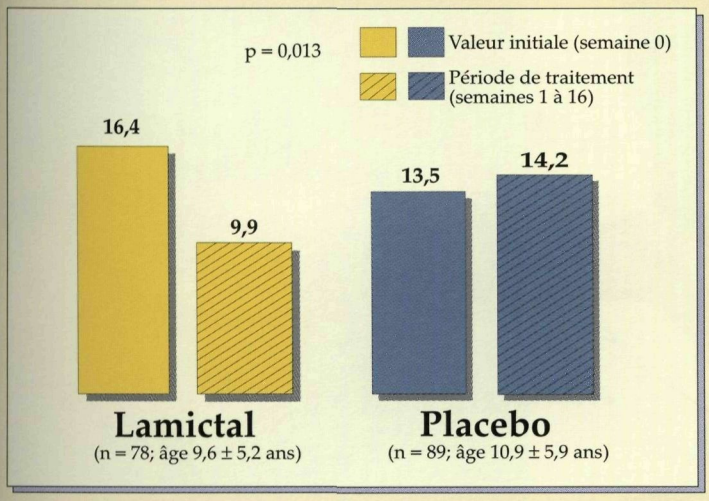
Lamictal®

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.

lamotrigine

Lamictal®

L'avenir en tête

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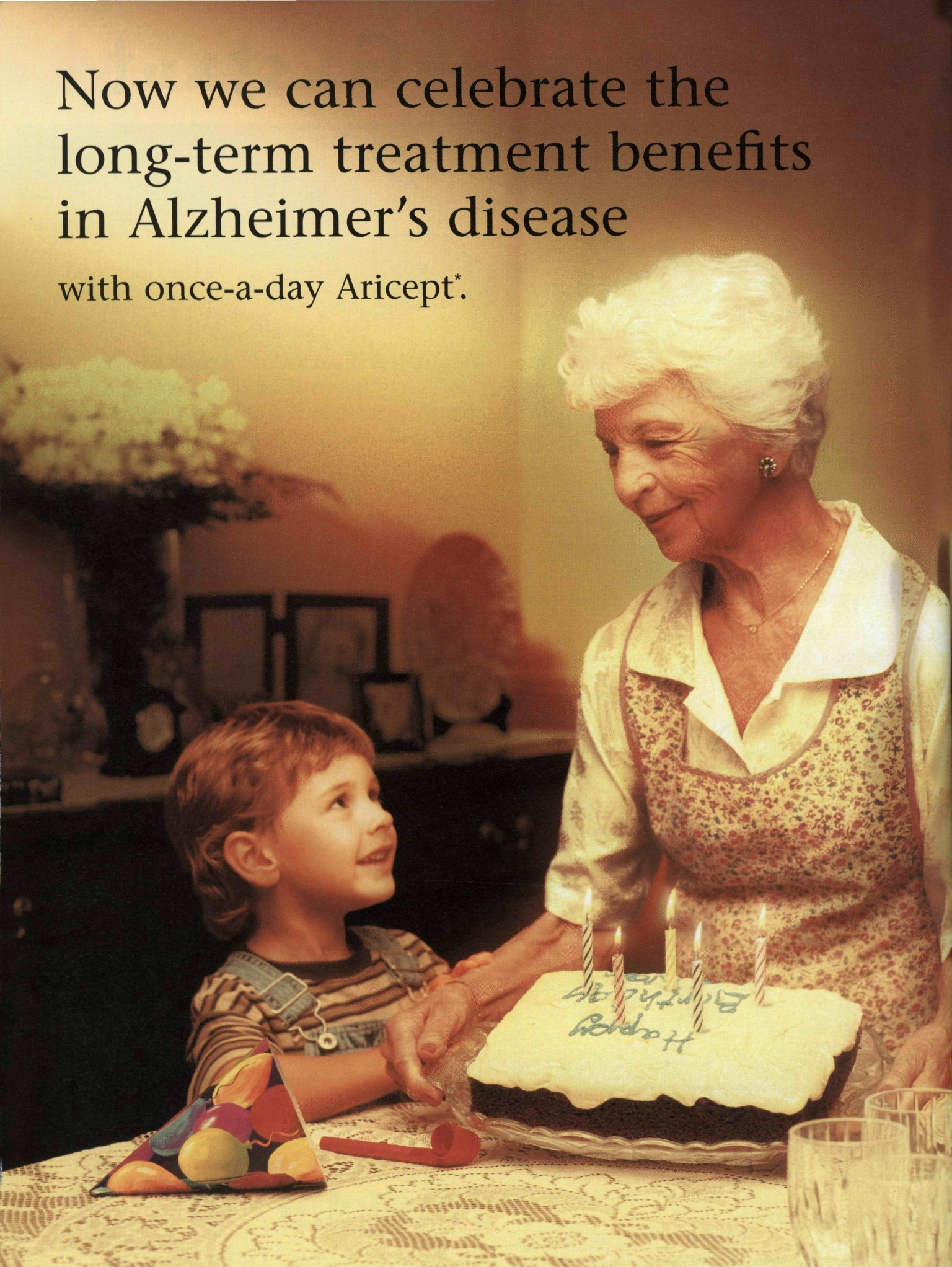
Pour documentation voir pages A-36, A-37, A-38, A-44



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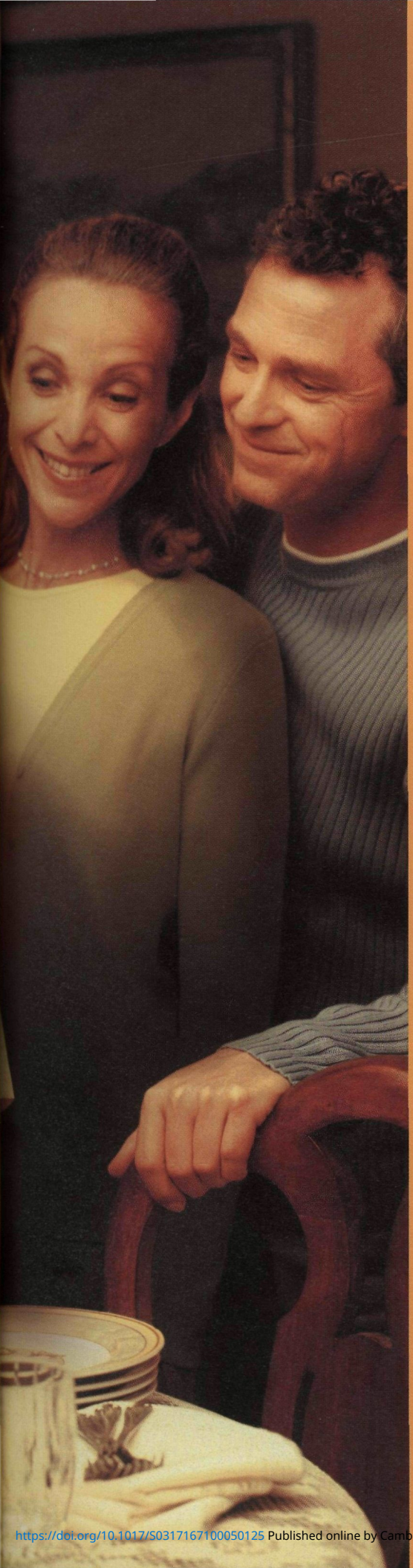
For brief prescribing information see pages A-



Celebrate another birthday, another holiday, another family gathering. Because Aricept* has been shown to result in improvement or stabilization in 80% of Alzheimer's disease patients over six months of treatment[1‡] and our new long-term data is even more cause for making Aricept* your standard of care.[2]

After one year, placebo-controlled studies demonstrated that Aricept*-treated patients showed significantly less decline in their cognition, global functioning and Activities of Daily Living.[3,4§¶]

After almost 2 years, Aricept*-treated patients showed significantly less decline in their cognition and global functioning in comparison to data expected from untreated patients.[5††]

After 3 years, Aricept*-treated patients continued to show treatment benefits on cognition and global functioning compared to data expected from untreated patients.[6‡‡]

Aricept* has demonstrated long term safety and tolerability profiles.[3-6] With appropriate dose escalation, 10 mg/d dose, 5 mg/d dose and placebo were shown to have comparable adverse events.[1†]

With Aricept*, patients may now be able to maintain their autonomy—for a longer time. Now that's cause for celebration.

Aricept* does not change the underlying course of the disease. Aricept* is indicated for the symptomatic treatment of patients with mild-to-moderate Alzheimer's disease.

† The most common adverse clinical events with Aricept* include: diarrhea, nausea, insomnia, fatigue, vomiting, muscle cramps and anorexia. These events are usually mild and transient, resolving with continued Aricept* treatment without need for dose modification.

‡ As demonstrated in a 30-week, placebo-controlled, parallel group study in which 473 patients were randomized to receive Aricept* 5 mg, 10 mg, or placebo. The mean difference for Aricept*-treated patients (10mg/d) vs. placebo was –2.87±0.63 (p<0.0001) units in ADAS-cog scores, 0.47±0.11 (p<0.0001) units in CIBIC-plus scores, and 0.59±0.17 (p=0.0007) units in CDR-SB scores.

§ In a 1-year, multicentre study, in which 286 mild-to-moderate AD patients were randomized to receive either Aricept* 5 mg/d for 28 days, followed by 10 mg/d, as per clinician's judgement, or placebo. At study endpoint, significant treatment differences were observed in MMSE scores in Aricept*-treated patients with mild AD (1.50; p=0.049) and moderate AD (2.11; p=0.002).

¶ In a 54-week, double-blind, multicentre study, 431 mild-to-moderate AD patients were randomized to receive either Aricept* 5 mg/d for 28 days, followed by 10 mg/d, as per clinician's judgement, or placebo. Significant differences were observed in favour of Aricept* in IADL and ADL scores (p=0.001 and 0.007), and MMSE scores (1.21; p=0.0005). CDR-SB scores were also improved.

†† Interim analysis (at 98 weeks of treatment) of a 192-week, multicentre, non-randomized, open-label extension study in which 133 mild-to-moderate Alzheimer's patients continued to receive Aricept* (up to 10 mg/d) after a 14-week, double-blind, placebo-controlled study. Improvements were observed in cognitive and global functioning as measured by the ADAS-cog and CDR-SB.

‡‡ In a 162-week, multicentre, open-label extension study held at 82 sites internationally (including 8 Canadian sites), 579 patients were initially treated with Aricept* 5 mg/d, increased to 10 mg/d between Weeks 6 and 24, as per clinician's judgement. At study endpoint, ADAS-cog scores declined 15.57 points (95% CI, 12,19.2) vs. the estimated decline of 6-12 points per year in untreated patients. Significant improvements were observed in CDR-SB scores for Aricept*-treated patients vs. placebo (p<0.05) at Week 24 but were lost when treatment was interrupted for the 6-week placebo washout.

Product Monograph available upon request.

Now on several provincial formularies.[§§]

Once-a-day

P *Aricept**

donepezil HCl 5 & 10 mg tablets

Hope for a brighter tomorrow

* TM Eisai Co. Ltd., Tokyo, Japan
Pfizer Canada Inc., licensee

PAAB Member R&D

Pfizer CNS
Life is our life's work

§§ In Quebec, Alberta, Manitoba and Ontario. Please see individual formularies for special-, exceptional-, or limited-use drug status. For more information on coverage criteria, please call 1-800-510-6141.

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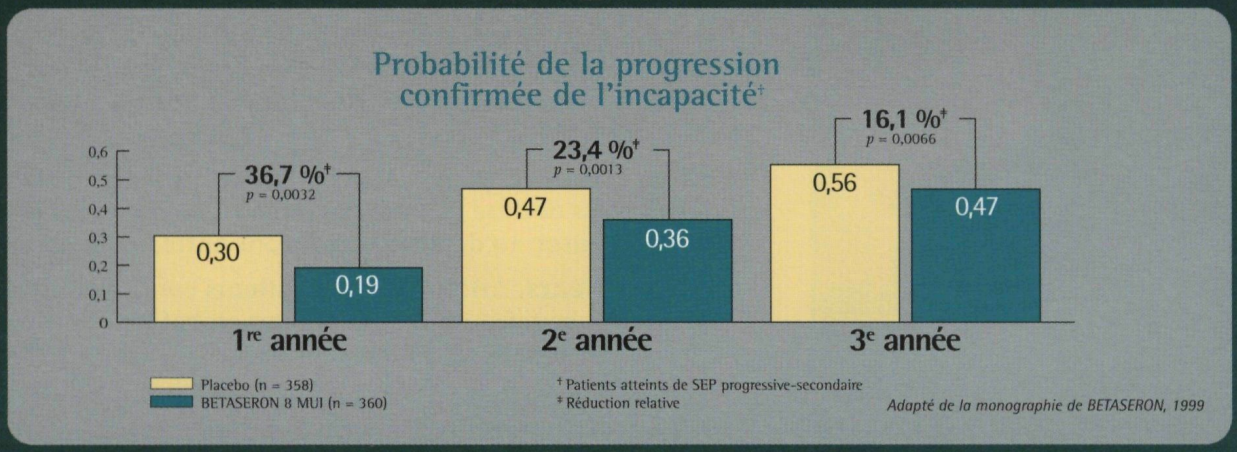
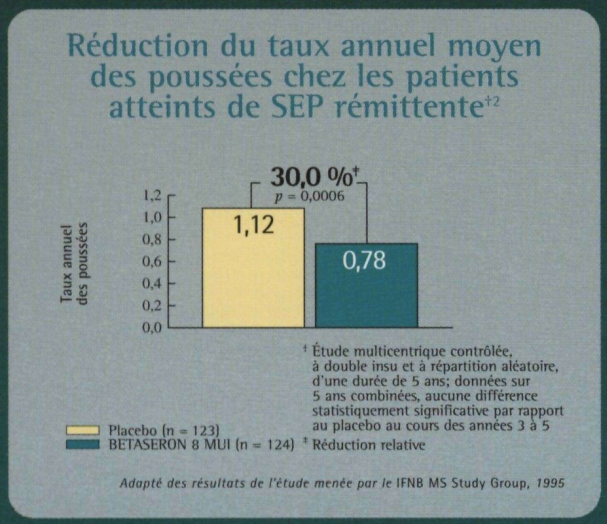
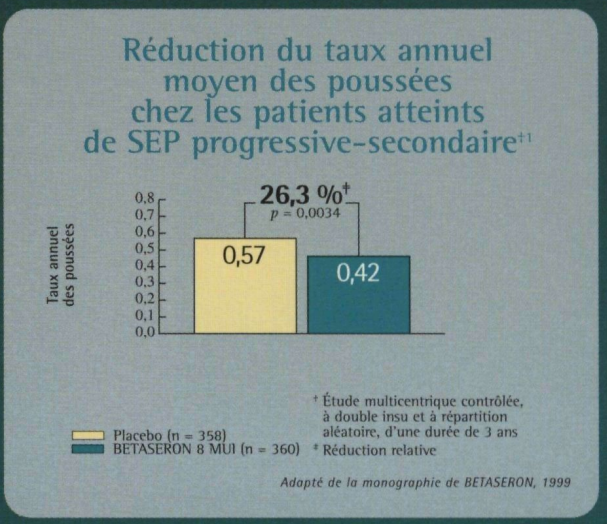
For brief prescribing information see page A-31

BETASERON retarde la progression de l'incapacité*[1]



BETASERON réduit le taux de poussées dans la SEP rémittente[2] et dans la SEP progressive-secondaire[1]

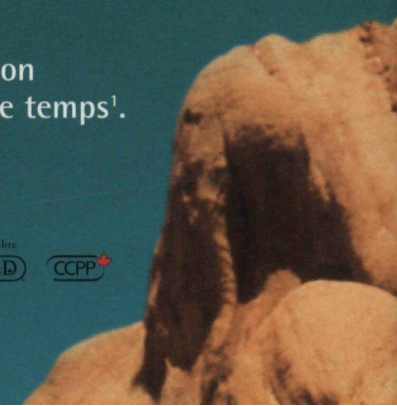




Effets indésirables pouvant être pris en charge[1]

Chez les patients atteints de SEP progressive-secondaire, les effets indésirables les plus fréquents de BETASERON sont : syndrome pseudo-grippal (61 %), fièvre (40 %), frissons (23 %), inflammation au point d'injection (48 %), réactions au point d'injection (46 %), myalgie (23 %), hypertonie (41 %) et éruption cutanée (20 %)[1].

Les symptômes pseudo-grippaux et les réactions au point d'injection peuvent être pris en charge et diminuent de façon marquée avec le temps[1].



*Il a été démontré que BETASERON retarde la progression de l'incapacité chez les patients atteints de SEP progressive-secondaire[1].
L'efficacité et l'innocuité de BETASERON dans la SEP progressive-primaire n'ont pas été évaluées.
On ne dispose pas de données probantes sur l'efficacité du traitement dans la SEP rémittente au-delà de deux ans, ni de données sur l'efficacité et l'innocuité du traitement dans la SEP progressive-secondaire au-delà de trois ans.

VEUILLEZ CONSULTER LA MONOGRAPHIE DE PRODUIT POUR OBTENIR LA LISTE COMPLÈTE DES MISES EN GARDE ET DES PRÉCAUTIONS.
MONOGRAPHIE DE PRODUIT OFFERTE SUR DEMANDE AUX PROFESSIONNELS DE LA SANTÉ.

Membre R&D CCPP

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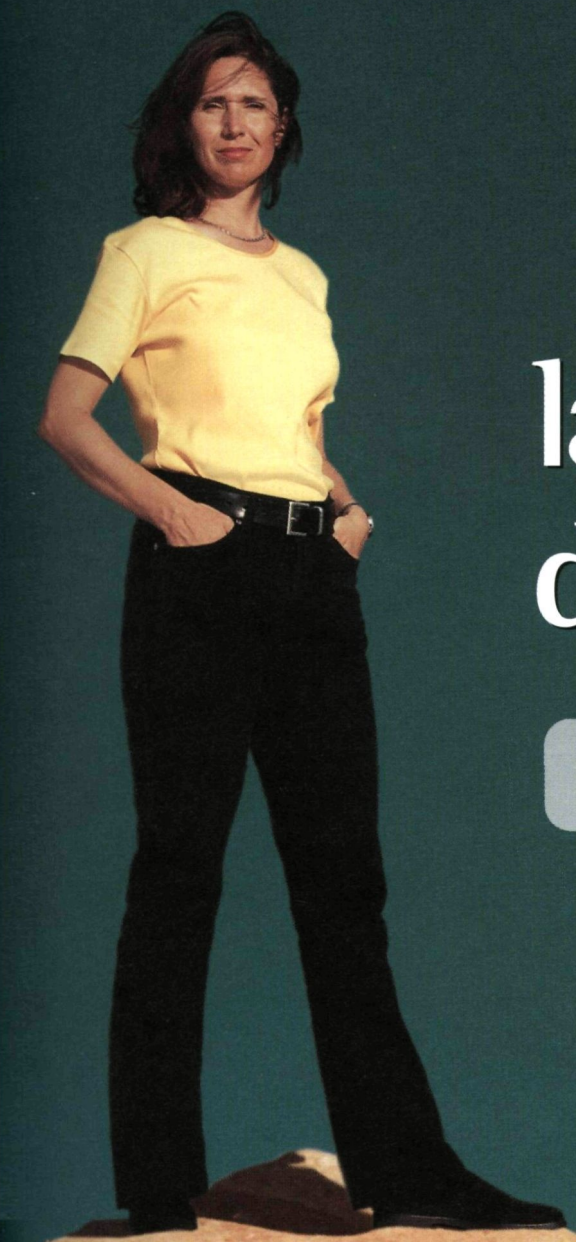

Retarde la progression de l'incapacité*

Indiqué dans la SEP rémittente et la SEP progressive-secondaire

Dans la SEP rémittente et la SEP progressive-secondaire

Pr BETASERON®

INTERFÉRON BÊTA-1b

Dès le tout début

SCLÉROSE EN PLAQUES
ACCÈS MC
POUR LE CANADA

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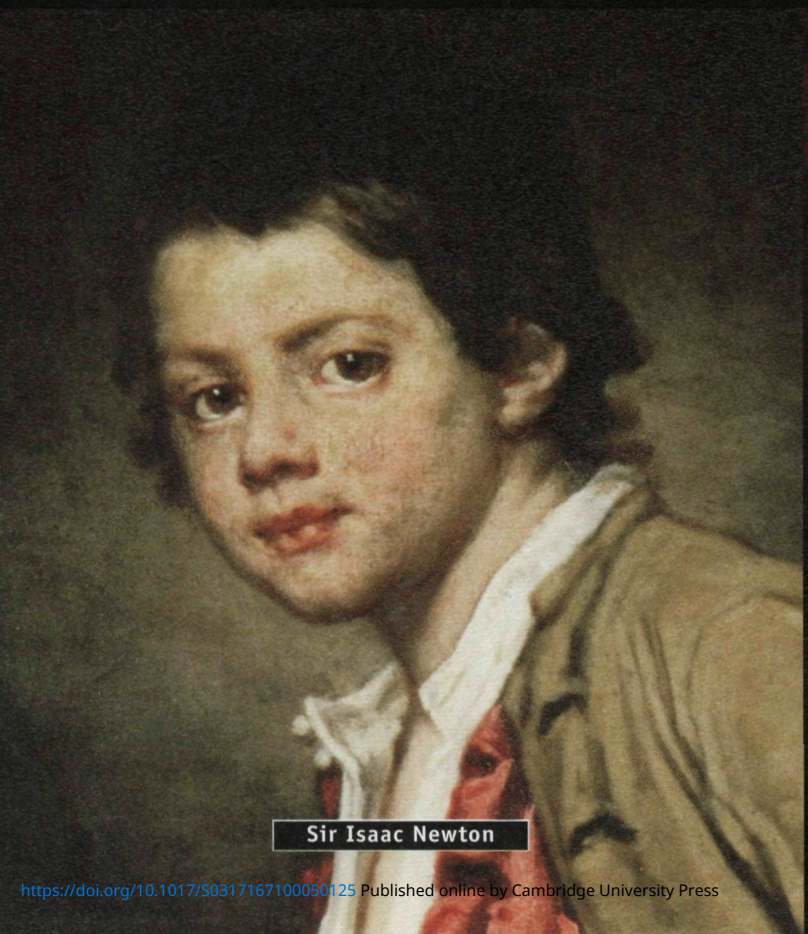
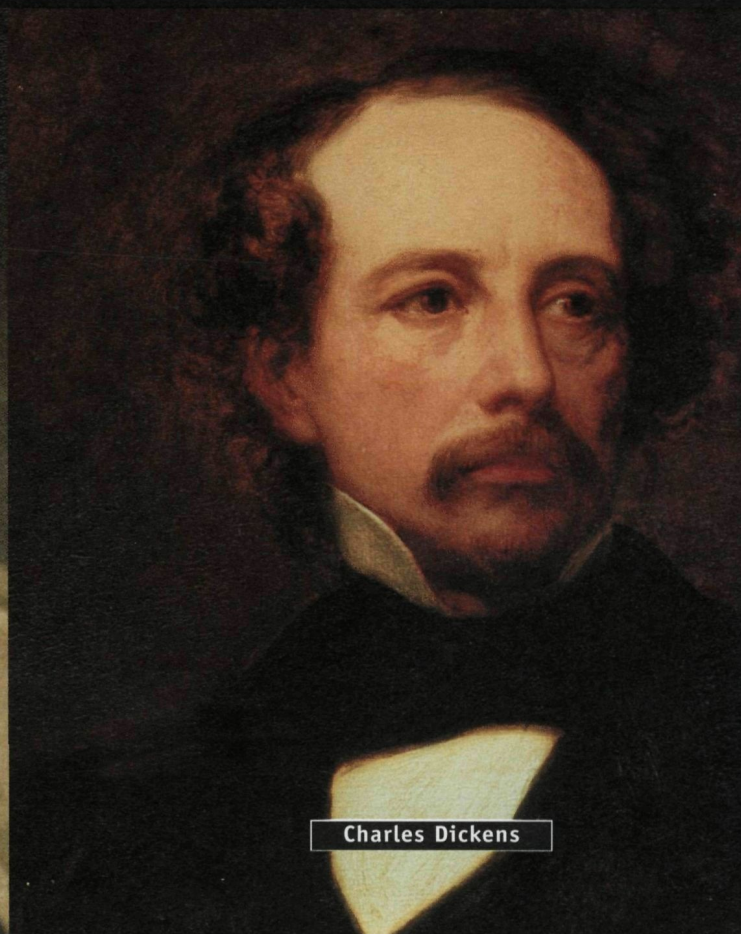
AUPARAVANT, LES PERSONNES ÉPILEPTIQUES DEVAIENT SE MONTRER EXCEPTIONNELLES POUR RÉUSSIR.





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EFFICACE CONTRE UN GRAND NOMBRE DE TYPES DE CRISES.

- TOPAMAX est efficace contre les crises partielles initiales, les crises tonico-cloniques primaires généralisées et les crises associées au syndrome de Lennox-Gastaut[1]
- Des résultats souhaitables avec absence totale de crises chez 19 % des adultes† et 22 % des enfants‡ atteints de crises partielles initiales[2,3]

AUCUN SIGNE D'EFFETS SECONDAIRES CAPABLES DE MENACER LE PRONOSTIC VITAL.

- Comme pour la plupart des antiépileptiques, les effets secondaires le plus fréquemment signalés relèvent du SNC et sont généralement légers à modérés et de nature passagère§[1]

IL EST POSSIBLE QUE LES PATIENTS ADULTES SUBISSENT UNE PERTE DE POIDS.

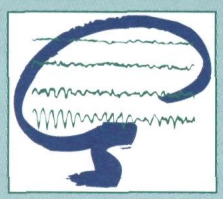
- 73 % (n = 52) des patients ont subi une perte de poids de 5,97 lb en moyenne (Analyse provisoire. Durée moyenne de 60 jours)[4]
- 96 % des enfants traités dans le cadre des essais cliniques pendant au moins un an et ayant subi une perte de poids ont repris du poids au cours de la période d'exécution des essais**[1]

AUJOURD'HUI, IL Y A TOPAMAX.

UNE POSOLOGIE BIQUOTIDIENNE POUR TENIR COMPTE DU PATIENT.

- Le traitement par TOPAMAX peut être commencé et ajusté selon la réponse clinique quel que soit le traitement anticonvulsivant en cours
- Les comprimés sont inscrits au formulaire††

MAINTENANT OFFERT EN CAPSULES À SAUPOUDRER



TOPAMAX* topiramate

MAINTENANT INDIQUÉ CHEZ L'ENFANT

POUR AIDER LES PATIENTS À MIEUX PROFITER DE LA VIE

Comprimés et capsules à saupoudrer TOPAMAX (topiramate) : indiqués comme traitement adjuvant chez les patients (adultes et enfants âgés de deux ans ou plus) atteints d'épilepsie dont l'état n'est pas maîtrisé de façon satisfaisante avec le traitement traditionnel. Les renseignements sur l'emploi du topiramate en monothérapie sont encore limités‡.*

†Une étude ouverte d'une durée de 20 semaines (n = 450 adultes). Posologie optimale : 300 à 350 mg/jour (moyenne : 288 mg/jour).
‡Étude ouverte portant sur des enfants (n = 72) traités pendant au moins 3 mois. Posologie moyenne : 10 mg/kg/jour.
§Manifestations indésirables liées au SNC : Somnolence (30,1 %), étourdissements (28,3 %), ataxie (21,2 %), troubles de la parole (16,8 %), ralentissement psychomoteur (16,8 %), nystagmus (15 %), paresthésie (15 %), nervosité (15,9 %), difficulté à se concentrer/troubles de l'attention (8 %), confusion (9,7 %), dépression (8 %), anorexie (5,3 %), problèmes de langage (6,2 %) et troubles de l'humeur (3,5 %). Une évaluation de 1 446 adultes et 303 enfants a indiqué que ces deux groupes semblent présenter des profils de manifestations indésirables similaires.
**Les effets à long terme d'une perte de poids chez les enfants ne sont pas connus.
††Médicament à usage limité : Ontario, Nouvelle-Écosse, Nouveau-Brunswick, Î.-P.-É. Remboursement intégral : Québec, Saskatchewan, Colombie-Britannique, Alberta, Manitoba.
Veuillez vous reporter aux Renseignements thérapeutiques sur TOPAMAX pour les détails thérapeutiques complets.

RÉFÉRENCES : **1.** Monographie des comprimés et capsules à saupoudrer TOPAMAX* (topiramate), 11 mai 1999. **2.** Kamin M, Kraut L, Olson W. Dose optimization of topiramate as add-on therapy in adults with treatment-resistant partial-onset seizures *Neurology* 1999;52 (Suppl 2):A525-526. **3.** Glauser TA, Elterman R, Wyllie E *et al.* Open label topiramate in paediatric partial epilepsy *Epilepsia* 1997:38 (Suppl. 3):94. **4.** Rosenfeld WE *et al.* Topiramate and concomitant weight loss. *Epilepsia* 1997:38 (Suppl 8):98.

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Pour documentation voir pages A-27, A-28

INFORMATION FOR AUTHORS

The Canadian Journal of Neurological Sciences publishes original articles in neurology, neurosurgery and basic neurosciences. Manuscripts are considered for publication with the understanding that they, or the essence of their content, have not been published elsewhere except in abstract form and are not under simultaneous consideration by another journal. Articles undergo peer review. Manuscripts should be submitted to: Douglas Zochodne, M.D., Editor. Canadian Journal of Neurological Sciences, P.O. Box 5456, Station A, Calgary, AB, Canada T2H 1X8

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• Submit five high quality copies of the manuscript and original illustrations. Papers will be accepted in English or French. Manuscripts must be double spaced throughout including references, tables and legends for illustrations. Margins of at least 25mm should be left on all sides.

• After a paper has been reviewed, the author will be requested to submit four copies of the revised manuscript, including illustrations. Supply a computer diskette (3 1/2" size) containing the article *saved in an RTF format*. Identify clearly first author's name, file name, word processing program and version, and system (i.e. PC or Mac). Clearly indicate the order and importance of headings.

• For detailed instructions regarding style and layout refer to *"Uniform requirements for manuscripts submitted to biomedical journals"*. Copies of this document may be obtained by writing to the Journal office, but the main points are summarized here. Articles should be submitted under conventional headings of *introduction, methods and materials, results, discussion,* but other headings will be considered if more suitable. Clinical trials must be reported in Consort format (JAMA 1996; 276: 637-639). Pages of text should be numbered consecutively.

• ***A title page*** should identify the title of the article which should be no more than 80 characters including spaces; name of institution(s) from which the work originated; and the name, address, telephone, and fax number of the corresponding author.

• ***Abstract*** Original Articles should be accompanied by an abstract of 250 words or less on a separate page, preferably in English and French, although the Journal will provide translation if required. Abstracts of original articles should consist of four paragraphs headed: *Background (or objective), Methods, Results and Conclusions*. Review articles should be accompanied by an abstract of 150 words or less.

• ***Acknowledgements*** including recognition of financial support should be typed on a separate page at the end of the text.

• The SI system (système international d'unités) should be used in reporting all laboratory data, even if originally reported in another system. Temperatures are reported in degrees celsius. English language text may use either British or American spelling, but should be consistent throughout.

• ***References*** should be numbered in the order of their citation in the text. Those cited only in tables and legends for illustrations are numbered according to the sequence established by the first identification in the text of a particular table or illustration. Titles of journals should be abbreviated according to the style used in Index Medicus. References should list the names of up to five authors; if there are more, cite the first three, then *et al*. Provide the full title, year of publication, volume number and inclusive pagination for journal articles. For any reference cited as "in press", five copies of the article must accompany the author's manuscript. Do not reference unpublished or "submitted" papers; these can be mentioned in the body of the text and authors must provide five copies of "submitted" manuscripts. Avoid "personal communications" and, if necessary, include them in the body of the text, not among the references. Reference citations should not include unpublished presentations or other non-accessible material. Books or chapter references should also include the place of publication and the name of the publisher. Examples of correct forms of reference follow:

Journals

Yang JF, Fung M, Edamura R, et al. H-Reflex modulation during walking in spastic paretic subjects. Can J Neurol Sci 1991; 18: 443-452.

Chapter in a book

McGeer PL, McGeer EG. Amino acid neurotransmitters. *In*: Siegel GJ, Albers RW, Agranoff BW, Katzman R, eds. Basic Neurochemistry. Boston: Little, Brown & Co., 1981: 233-254.

• ***Illustrations*** Submit five original sets of illustrations. We will not return illustrations; therefore, authors should keep negatives for all photographs. Submit high quality glossy black and white photographs preferable 127 x 173 mm (5" x 7"). This includes graphs and diagrams. Do NOT send photocopies of illustrations. Original artwork and radiographs should not be submitted. The additional cost of coloured illustrations must be borne by the author; quotations are available upon request from the Journal office. Identify each figure with a label at the back indicating top, figure number and first author. Letters and arrows applied to the figures to identify particular findings should be professional appliques suitable for publication. Photomicrographs should include a calibration bar with a scale indicated on the figure or in the legend. Legends for illustrations should be typed on a separate page from the illustrations.

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Turn the agony of migraine into the beauty of relief.

Zomig® provides consistent relief.

- Rapid relief within one hour.[1]
- Significant headache response* after a single 2.5 mg dose.[1]
- Consistent efficacy across multiple attacks.[2-4]
- Effective in a wide variety of migraine subtypes.[1†]
- Effective when taken at any time during a migraine attack.[2]
- Treats associated symptoms of photophobia, phonophobia and nausea.[1]
- Proven safety profile in over 5,500 patients treating more than 89,000 attacks.[5,6††]

*Improvement from severe or moderate headache to mild or no pain at two hours.

† Zomig® is indicated for the acute treatment of migraine with or without aura.

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.

†† 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%).

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®. Zomig® is also contraindicated in patients with uncontrolled or severe hypertension.

Please see Product Monograph.

For more information about Zomig® please contact AstraZeneca Customer Relations by phone at 1-800-668-6000 or fax at (905) 896-4745.

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Zomig®
zolmitriptan tablets 2.5 mg

Consistent migraine relief.

AstraZeneca PAAB

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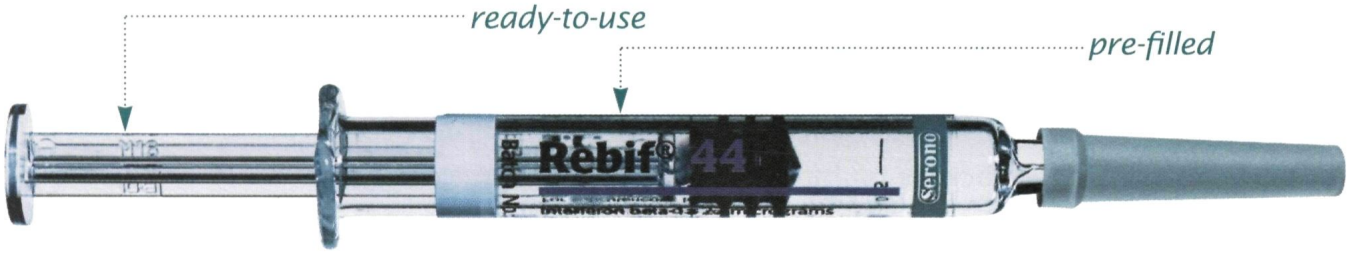
For brief prescribing information see pages A-25, A-26

Rebif®. Dose-dependent Efficacy in Relapsing MS[1]*.

Rebif®

Interferon beta-1a



The most common reported adverse events are injection-site reactions and flu-like symptoms – e.g., asthenia, pyrexia, chills, arthralgia, myalgia, and headache. These tend to decrease in frequency and severity with continued treatment. Please see product monograph for full prescribing information. Evidence of safety and efficacy derived from 2-year data only.

* Rebif® is indicated for the treatment of relapsing-remitting multiple sclerosis in patients with an EDSS between 0 and 5.0, to reduce the number and severity of clinical exacerbations, slow the progression of physical disability, reduce the requirement for steroids, and reduce the number of hospitalizations for treatment of multiple sclerosis.

REFERENCES:

[1] PRISMS (Prevention of Relapses and Disability by Interferon ß-1a Subcutaneously in Multiple Sclerosis) Study Group (1998). Randomised double-blind placebo-controlled study of interferon ß-1a in relapsing/remitting multiple sclerosis. Lancet 352:1498-1504

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