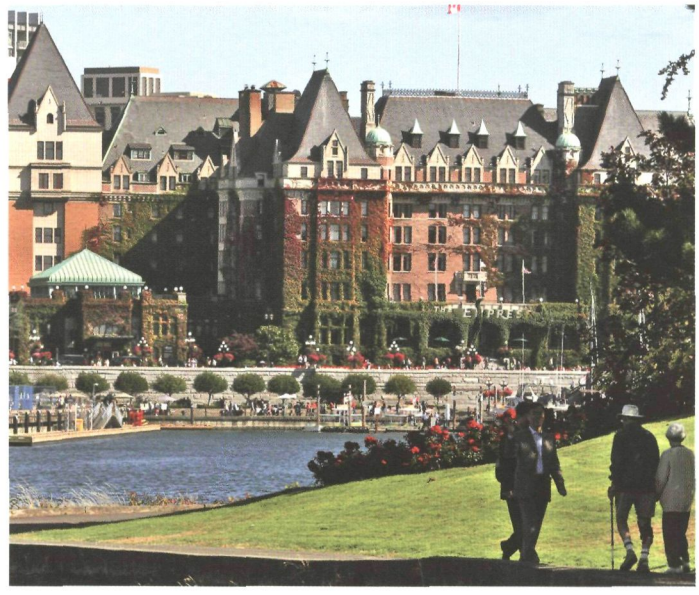
THE CANADIAN JOURNAL OF
# Neurological Sciences

LE JOURNAL CANADIEN DES
# Sciences Neurologiques

VOLUME 35 NUMBER 2 MAY 2008



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Annual Congress

Victoria, British Columbia
June 17-20, 2008

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https://doi.org/10.1017/S0317167100016093 Published online by Cambridge University Press

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## JOURNAL COVER

**We are investigating different options for the cover of the Journal and thought it might be appropriate to include pictures of major Canadian Cities and/or Universities as taken by our readers.**

**If you are interested in submitting pictures, please send them to maggie-mccallion@cnsfederation.org in high resolution format, (i.e. tif or jpeg). Please also indicate your willingness to provide these pictures free of charge. Picture 'acknowledgement' will be provided.**

https://doi.org/10.1017/S0317167100116993 Published online by Cambridge University Press

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**The official journal of: / La Revue officielle de:**

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**La Société Canadienne de Neurologie**
**The Canadian Neurosurgical Society**
**La Société Canadienne de Neurochirurgie**
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Le secrétariat des quatre associations et du Fédération des sciences neurologiques du Canada est situe en permanence à:
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Mailed under Publications Mail Agreement no: 40007777; PAP Registration no: 09824. Postage paid at Calgary, Alberta. This journal is indexed by *ASCA, ASFA, AbHyg, AgBio, BIOBASE, BIOSIS Prev, BiolAb, ChemAb, CurCont, Dentlnd, EMBASE, ExcerpMed, HelmAb, IABS, ISR, IndMed, Inpharma, JW-N, LHB, MEDLINE, MycolAb, NRN, NSCI, NutrAb, PE&ON, PN&I, ProtozoAb, PsycInfo, PsycholAb, RM&VM, RRTA, Reac, RefZh, SCI, SCOPUS, TDB, WeedAb, e-psyche, BLDSC (3033.300000), CASDDS, CISTI, GNLM, IDS, IE, Infotrieve, Ingenta, CCC.*

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Posté sous poste-publications: numéro de convention: 40007777; numéro d'enregistrement PAP 09824. Port payé à Calgary, Alberta. Le Journal est cité et indexé dans *ASCA, ASFA, AbHyg, AgBio, BIOBASE, BIOSIS Prev, BiolAb, ChemAb, CurCont, Dentlnd, EMBASE, ExcerpMed, HelmAb, IABS, ISR, IndMed, Inpharma, JW-N, LHB, MEDLINE, MycolAb, NRN, NSCI, NutrAb, PE&ON, PN&I, ProtozoAb, PsycInfo, PsycholAb, RM&VM, RRTA, Reac, RefZh, SCI, SCOPUS, TDB, WeedAb, e-psyche, BLDSC (3033.300000), CASDDS, CISTI, GNLM, IDS, IE, Infotrieve, Ingenta, CCC.*

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Brett Windle, *Corporate Development Coordinator*
Tel (403) 229-9575 Fax (403) 229-1661
E-mail: brett-windle@cnsfederation.org

***Printer/Imprimeur:***
Unicom Graphics, 4501 Manitoba Road SE
Calgary, Alberta T2G 4B9

ISSN 0317 - 1671

We acknowledge the assistance of the Government of Canada through the Publications Assistance Program towards our mailing costs. Canada

https://doi.org/10.1017/S0317167100116993 Published online by Cambridge University Press

# 2008 CNSF Congress Program Information

The Scientific Program Committee wishes to highlight a few of the features of the upcoming 43rd Annual Congress of the Canadian Neurological Sciences Federation.

We are pleased to announce that Dennis Choi, former Executive Vice-President for Neuroscience at Merck Research Labs and current Executive Director of Emory University's Neuroscience Initiative will be presenting as our Distinguished Guest Lecturer.

**Based on Congress feedback and the CNSF Member Survey conducted in 2007, we have a number of new educational offerings in the Congress this year.**

1. New Courses on Neuroradiology and Cerebrovascular Surgery.
2. The Grand Rounds session will this year incorporate the use of a touchpad response system.
3. Abstract submissions were the highest we've seen in years, so the Digital Poster stations will be quite busy. As well, the author standby tours have been re-conceptualized as "mini-platform sessions" so expect to see lively discussion in those sessions.
4. We have more Digital Poster stations, more Congress Course Notes printing stations and the same exciting Plenary Lectures that you've come to expect.

Check out our web site, www.cnsfederation.org to review our program and to reserve your hotel room at the Empress.

Please support the CNSF Congress by booking your accommodations at the official Congress hotel, the Fairmont Empress. Staying at the Empress means the CNSF receives benefits, such as complimentary meeting space for the Congress, for committee meetings and social activities. If we don't fill our block, the CNSF pays substantial penalty fees and ultimately these penalties result in a more expensive Congress next year.

*Your loyalty and cooperation is appreciated. Refer to the advertisement below.*



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# Rent vs. Buy – Time to Face Your Space

## Health Care Professionals Examine Both Options

Rent or buy? That's an age old question, whether you're talking about a home, a car, or equipment.

"Where you want to set up shop is always the first consideration, and after that it comes down to personal choice", says Michael Stoltz, Senior Account Manager, Healthcare Professionals, for RBC Royal Bank®.

One RBC Royal Bank client, Paul Arnold, who has a family practice in Edmonton has rented a series of spaces for 30 years: "For me," says Dr. Arnold, "leasing offers flexibility, and less headaches than if I owned."

This professional came to an easy conclusion about the rent vs. buy question – but what is right for your practice? The professionals at RBC Royal Bank weigh in.

### Weigh All the Costs

Leasing a location may be viewed as taking a lower risk, says Stoltz, as you need to borrow less.

Some doctors may only be comfortable with having a certain level of debt, and first want to meet certain performance measures before taking on more debt.

Others, comments Stoltz, are confident about their potential for success due to the demographics of the area and might wish to invest more in their practice by buying.

When you lease, the rent you pay is gone, and you're subject to your landlord's increases when its time to renew. "There is some insecurity there," admits Dr. Arnold.

Purchasing, while involving a higher initial cost, lets you build up equity. Plus, a fixed-rate mortgage will give you some measure of cost certainty.

"Clients only have a certain amount of capital to invest," says Dave Majeski, Vice-President, RBC Royal Bank. "Should you invest it in a property as equity? Or in equipment? What kind of cash flow do you generate to service your leasing costs and/or debt? You need to look at the return on your core business – your practice."

### Location Comes First

"Where you set up shop and establish your patient base is so important," says Stoltz.

Your preference may be to own, but what if you find the ideal spot for your practice, and your only option is leasing? Dr. Arnold, for instance, prefers to be in a shopping centre, so he has no choice but to lease.

Think also of your plans for your practice. With buying, you call the shots, so you can modify the office as needed. Also, it allows you to treat the space as an investment property and instead of selling, you could rent it to someone else if you eventually decide to move. However, if you outgrow your space, moving is easier to do with a lease.

"It just comes down to what you're comfortable with," says Stephanie Fitzgerald, Senior Account Manager, Healthcare Professionals, Calgary, RBC Royal Bank.

### Lean on the Experts

Whichever way you're leaning, it's vital to make an informed decision.

Fitzgerald notes that RBC® has account managers across Canada who are specifically devoted to doctors and have insight into their unique needs.

Many health care professionals aren't comfortable deciphering the intricacies of leasing agreements, the tax impacts of their mortgage or lease payments, an analysis of their cash flow, or a forecast of property appreciation and interest rates.

Health professionals, like any business professionals, need to rely on sound financial expertise, says RBC's Fitzgerald. The bank is a key partner in working with resources such as lawyers, accountants, or leasing or mortgage brokers – people who deal with questions of buying or leasing office space every day.

"All together," Fitzgerald says, "we'll provide the advice that helps you come to the right decision for you."

**For more information about how RBC can help you and your practice, speak with an RBC health care professional specialist today by calling 1-800-ROYAL® 2-0. Or visit www.rbcroyalbank.com/health-care to learn more.**





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The vision of the future is here. Now you can bring high-quality CT scanning directly to the bedside of your most critical patients. The CereTom® is an 8-slice portable CT scanner that provides the comparable image quality of a traditional scanner, but with a revolutionary design that gives you the freedom of portability. And the benefits are something to see...

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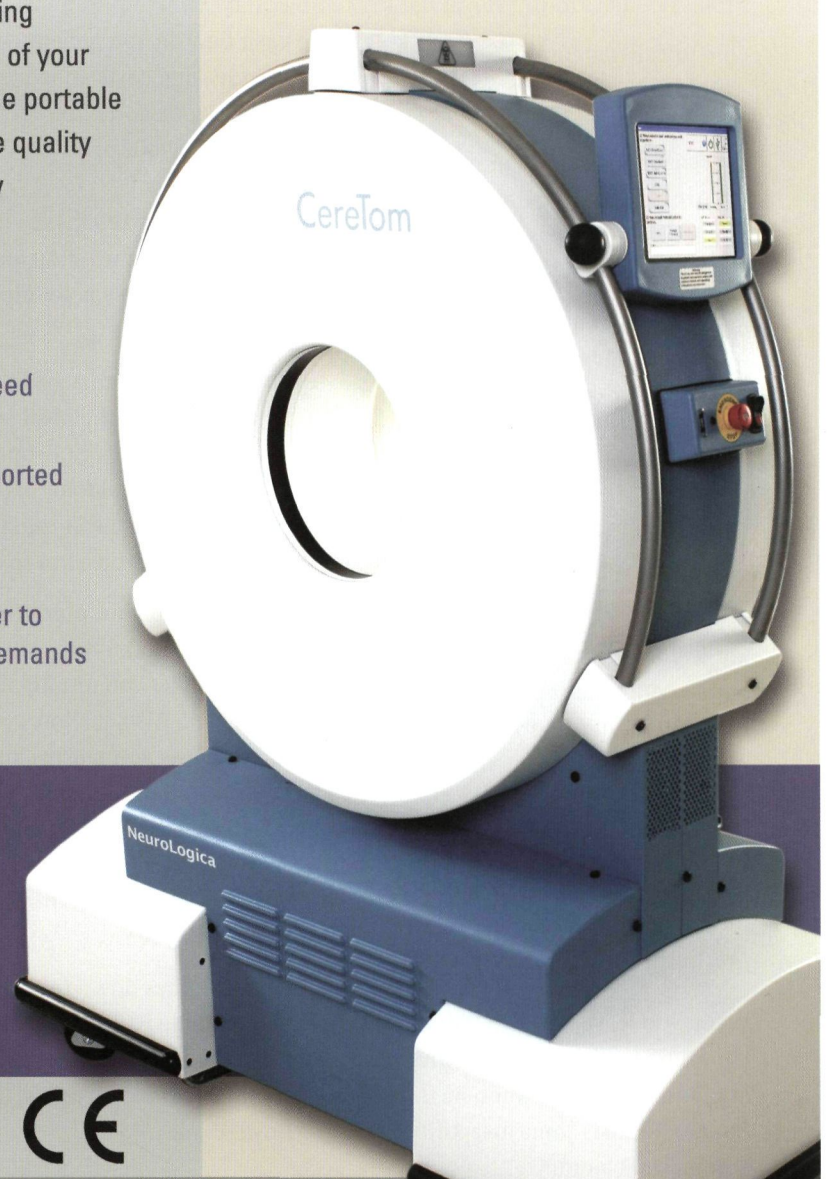
- Increases availability of the traditional scanner to enable a busy healthcare facility to meet its demands

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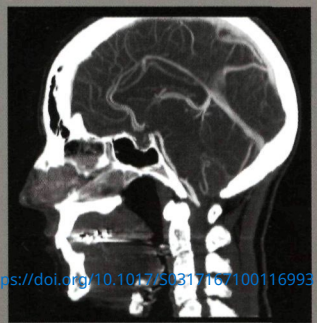

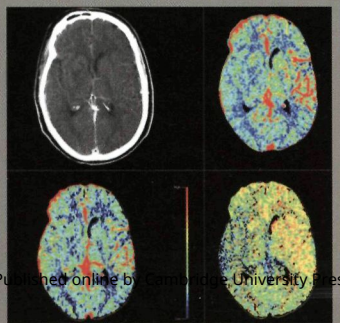

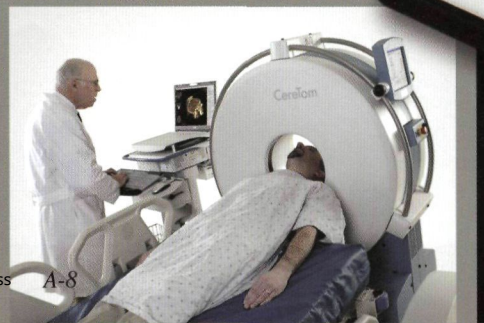


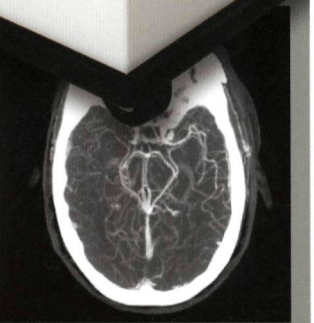

LYRICA may be useful in the management of central neuropathic pain (NeP) in adult patients for which it has been issued marketing authorization with conditions to reflect the promising nature of the clinical evidence and the need for a confirmatory study to verify its clinical benefit. Patients should be advised of the nature of the authorization.

# NEW

## Pregabalin: First and only first-line analgesic with a conditional indication in central neuropathic pain

Pr LYRICA®

## Powerful Pain Relief

**Powerful. Fast onset. Sustained relief.**

- Pain relief shown in postherpetic neuralgia (PHN) and central NeP as early as week 1 and demonstrated over 3 months[1-3*†]
- Improvement shown in pain-related sleep interference in PHN and central NeP as early as week 1 and demonstrated over 3 months[1-4*†]

**Significant improvement in overall status.**

- Significant improvement demonstrated in patient-reported overall status (Patient Global Impression of Change [PGIC]) in patients with peripheral NeP [diabetic peripheral neuropathy (DPN) or PHN] and central NeP[1-3,5*†‡]

LYRICA (pregabalin) is an analgesic indicated for the management of neuropathic pain (NeP) associated with DPN and PHN.

LYRICA is contraindicated in patients who are hypersensitive to pregabalin or to any ingredient in the formulation or component of the container.

The most commonly observed adverse events (≥5% and twice the rate as that seen with placebo) were dose related for PHN and DPN patients in the recommended dose range of 150 mg/day to 600 mg/day: dizziness (9.0-37.0%), somnolence (6.1-24.7%), peripheral edema (6.1-16.2%), and dry mouth (1.9-14.9%). The most commonly observed adverse events seen in central NeP patients (≥5% and twice the rate as that seen with placebo) in the recommended dose range of 150 mg/day to 600 mg/day were: somnolence (41.4%), dizziness (24.3%), asthenia (15.7%), dry mouth (15.7%), edema (12.9%), constipation (12.9%), amnesia (10.0%), myasthenia (8.6%), amblyopia (8.6%), and thinking abnormal (8.6%). The most commonly observed adverse events in the PHN, DPN, and central NeP patients were usually mild to moderate in intensity. Discontinuation rates due to adverse events for LYRICA and placebo, respectively, were 9% and 4% in DPN, 14% and 7% in PHN and 21% and 13% in central NeP.

**Dosage reduction is required in patients with renal impairment (creatinine clearance <60 mL/min) as LYRICA is primarily eliminated by renal excretion.**

Please see Prescribing Information for complete Warnings and Precautions, Adverse Reactions, Dosage and Administration and patient selection criteria.

* A 13-week, multicentre, double-blind, placebo-controlled trial in 368 patients with PHN. A significant difference in pain reduction was shown over placebo for all doses: 150 mg/day, 300 mg/day, and 600 mg/day ($p \leq 0.01$, weeks 1-13). Sleep interference was improved at all time points (weeks 1 to 13 and endpoint) for the three doses evaluated ($p \leq 0.01$ vs. placebo). PGIC was reported as (at least minimally) improved by 51.2%, 47.9% and 67.1% of patients treated with LYRICA doses of 150, 300, and 600 mg/day vs. 35.5% of patients in the placebo group. At study termination, patients in the 150 mg/day ($p=0.02$) and 600 mg/day group ($p=0.003$) were more likely to report global improvement than those in the placebo group.

† Data based on a 12-week, parallel-group, double-blind, flexible-dose, placebo-controlled study. 137 patients with spinal cord injury for ≥1 year and who had a pain score ≥60 mm on the 100-mm visual analog scale (VAS) of the Short-Form-McGill Pain Questionnaire (SF-MPQ) were randomized to LYRICA 150 to 600 mg/day (n=70) or placebo (n=67) BID. Pain scores rated on 11-point numerical scale from 0 (no pain) to 10 (worst possible pain) during the past 24 hours averaged over the last seven days. Pain-related sleep interference scores rated on 11-point numerical scale from 0 (did not interfere) to 10 (completely interferes) during the past 24 hours averaged over the last seven days. A significant difference in pain reduction was demonstrated for the LYRICA group vs. placebo at all time points evaluated ($p \leq 0.001$, weeks 1-7 and endpoint and $p \leq 0.01$, weeks 8-12). Sleep interference was significantly improved at all time points (weeks 1 to 12 and endpoint) vs. placebo ($p \leq 0.01$, weeks 4, 10 and 12 and $p \leq 0.001$ for all other time points evaluated and endpoint). PGIC was reported as (at least minimally) improved by 56.5% and 21.5% of patients in the LYRICA and placebo treatment groups, respectively ($p<0.001$ for overall LYRICA comparison vs. placebo across "improved", "unchanged" and "worse" subgroups).

‡ A 12-week, multicentre, randomized, double-blind, placebo-controlled study in 338 patients with neuropathic pain (DPN [n=249] or PHN [n=89]), resulting in a significant difference from placebo in the flexible dose range 150-600 mg/day ($p \leq 0.05$, week 2-3 and $p \leq 0.01$, weeks 4-12), and the fixed dose of 600 mg/day ($p \leq 0.05$, week 1 and $p \leq 0.01$, weeks 2-12). PGIC was reported as very much improved or much improved by 52.0% of the flexible-dose group, 53.6% of the fixed-dose group and 30.5% of the placebo group ($p<0.01$ for overall comparison of both LYRICA treatment groups vs. placebo across "improved", "unchanged" and "worse" subgroups).

**References: 1.** Data on file, Pfizer Canada Inc., Study 1008-196. **2.** van Seventer R, Feister HA, Young JP *et al.* Efficacy and tolerability of twice-daily pregabalin for treating pain and related sleep interference in postherpetic neuralgia: a 13-week, randomized trial. *Curr Med Res Opin* 2006; 22(2):375-84. **3.** Siddall PJ *et al.* Pregabalin in central neuropathic pain associated with spinal cord injury: a placebo-controlled trial. *Neurology* 2006; 67:1792-800. **4.** LYRICA Product Monograph, Pfizer Canada Inc., November 8, 2007. **5.** Freynhagen R, Strojek K, Griesing T *et al.* Efficacy of pregabalin in neuropathic pain evaluated in a 12-week, randomised, double-blind, multicentre, placebo-controlled trial of flexible- and fixed-dose regimens. *Pain* 2005; 115:254-63.

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See prescribing summary on page A-16

# Start early with BETASERON®

## Prolonged time to CDMS by 363 days

From 255 days in the placebo group to 618 days in the BETASERON® group (based on the 25th percentiles)[1]

## An early start with BETASERON® was demonstrated to significantly delay the progression from the first clinical event to clinically definite MS (CDMS) in patients with a first clinical demyelinating event suggestive of MS (CIS)[1,†]

- a **47% risk reduction** (hazard ratio – 0.53; 95% CI [0.39, 0.73], p<0.0001) in progression to CDMS[1,‡]

†A two-year, multicenter, randomized, double-blind, placebo-controlled, phase III clinical trial evaluated the effect of 8 MIU subcutaneous BETASERON® every other day on time to onset of MS in patients with a single clinical demyelinating event suggestive of MS (Patients were 18 to 45 years of age with an EDSS of ≤5.0, BETASERON® group n=292 and placebo group n=176).

‡CDMS occurred in 45% of the placebo group compared to 28% of the BETASERON® group (Kaplan-Meier estimates)

BETASERON® (interferon beta-1b) is indicated for the treatment of patients with a single demyelinating event accompanied by at least two clinically silent lesions typical of multiple sclerosis (MS) on magnetic resonance imaging, to delay progression to definite MS. Before initiating treatment with BETASERON®, alternate diagnoses should first be excluded. BETASERON® is also indicated for the reduction of the frequency of clinical exacerbations in ambulatory patients with relapsing-remitting (RR) MS, characterized by recurrent attacks of neurologic dysfunction followed by complete or incomplete recovery. In addition, BETASERON® is indicated for the slowing of the progression in disability and the reduction of the frequency of clinical exacerbations in patients with secondary-progressive (SP) MS.

In patients with a single clinical event suggestive of MS, efficacy has been demonstrated over a period of two years. Efficacy of treatment for longer than two years has not been substantially demonstrated in RRMS. For SPMS, safety and efficacy data beyond three years are not available. The safety and efficacy of BETASERON® in primary-progressive (PP) MS have not been evaluated.

BETASERON® is contraindicated in patients with a history of hypersensitivity to natural or recombinant interferon beta, albumin human or to any other ingredient in the formulation and in pregnant women.

The most common side effects (regardless of causality) in patients treated with BETASERON® are: abnormal gait (34% in SPMS); asthenia (21.6% in CIS), (49% in RRMS) and (63% in SPMS); chills (46% in RRMS); fever (59% in RRMS) and (40% in SPMS); flu-like symptom complex (76% in RRMS); flu-like syndrome (44.2% in CIS); flu syndrome (61% in SPMS); headache (26.7% in CIS), (84% in RRMS) and (47% in SPMS); hypertonia (41% in SPMS); injection site inflammation (48% in SPMS); injection site reactions (48.3% in CIS), (85% in RRMS) and (46% in SPMS); lymphocyte count <1500/mm$^3$ (79.1% in CIS), (82% in RRMS) and (90.9% in SPMS); myasthenia (39% in SPMS); neuropathy (38% in SPMS); pain (52% in RRMS) and (31% in SPMS); paresthesia (35% in SPMS).

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

**Reference: 1.** Bayer Inc. BETASERON Product Monograph. Dec 21, 2007.



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See prescribing summary on page A-25-28


# INTRODUCING THE NEW BETAJECT® LITE AUTOINJECTOR, WITH OUR THINNEST NEEDLE EVER – 30 GAUGE.

## Same demonstrated BETASERON® efficacy:

- Shown to significantly delay the progression to clinically definite MS (CDMS) by one year (363 days; from 255 days in the placebo group to 618 days in the BETASERON® group based on the 25th percentiles)‡ in patients with a first clinical demyelinating event suggestive of MS (CIS)[1,†]

  – a **47% risk reduction** (hazard ratio – 0.53; 95% CI [0.39, 0.73], p<0.0001) in progression to CDMS[1,‡]

BETASERON® (interferon beta-1b) is indicated for the treatment of patients with a single demyelinating event (CIS) accompanied by at least two clinically silent lesions typical of multiple sclerosis (MS) on magnetic resonance imaging, to delay progression to definite MS. Before initiating treatment with BETASERON®, alternate diagnoses should first be excluded. BETASERON® is also indicated for the reduction of the frequency of clinical exacerbations in ambulatory patients with relapsing-remitting (RR) MS, characterized by recurrent attacks of neurologic dysfunction followed by complete or incomplete recovery. In addition, BETASERON® is indicated for the slowing of the progression in disability and the reduction of the frequency of clinical exacerbations in patients with secondary-progressive (SP) MS.

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