Volume 27 Number 1 February 2000

THE CANADIAN JOURNAL OF Neurological Sciences

LE JOURNAL CANADIEN DES Sciences Neurologiques

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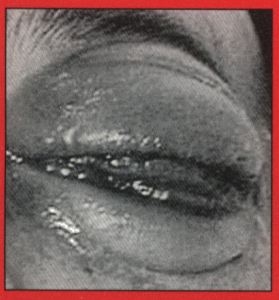

Neuroimaging Highlight

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

IF YOU STARTED PATIENTS ON REQUIP, WOULD THE FUTURE LOOK DIFFERENT?

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.[1††] Yet ReQuip 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.

ropinirole
REQUIP
Rethinking Parkinson's.

† Hoehn and Yahr stages HI †† 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 HI 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

For brief prescribing information see pages A-27

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La Société Canadienne de Neurologie

The Canadian Neurosurgical Society
La Société Canadienne de Neurochirurgie

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

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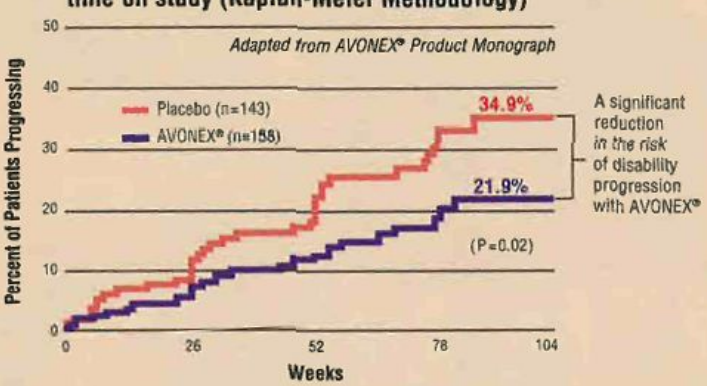
CALL 1-888-456-2263 for all the facts on AVONEX® therapy.

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.

BIOGEN CANADA

www.biogencanada.com

PAAB

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

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For brief prescribing information see pages A-45, A-46, A-49

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Gastaut Syndrome

Lamotrigine

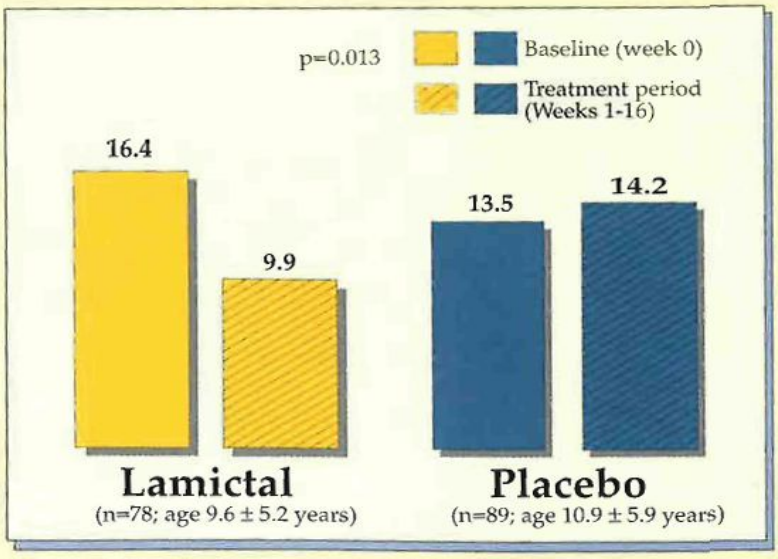
Lamictal®

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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Lamotrigine

Lamictal®

For a Brighter Future

PMAB

PAAB CCPP

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For brief prescribing information see pages A-42, A-43, A-44

INFORMATION FOR AUTHORS

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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.

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• 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.

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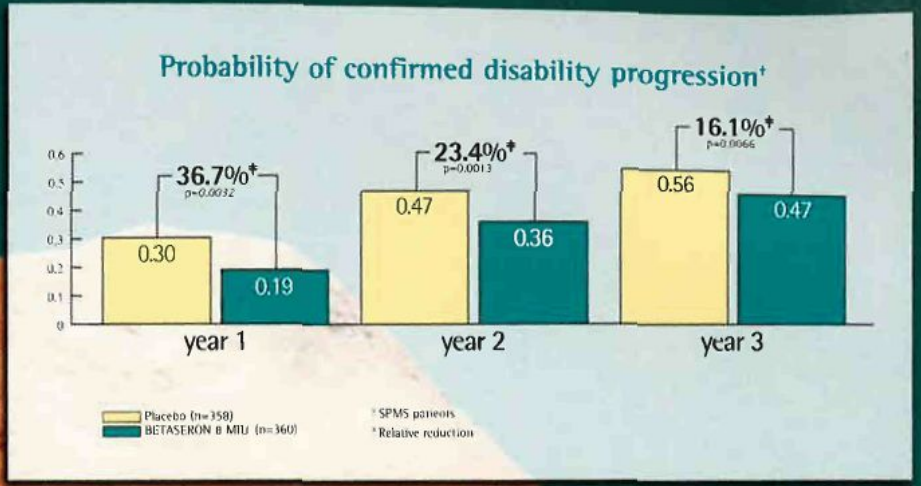
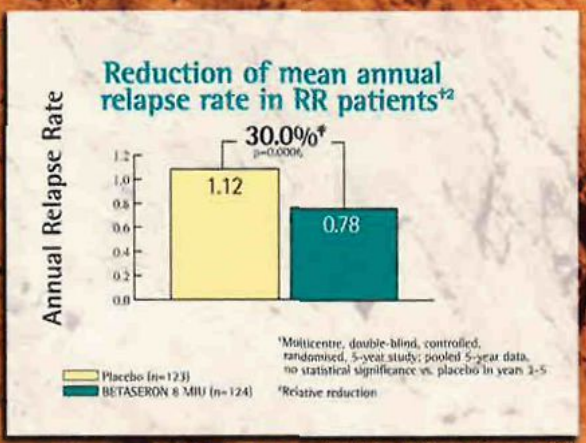
BETASERON delays disability progression*[1]

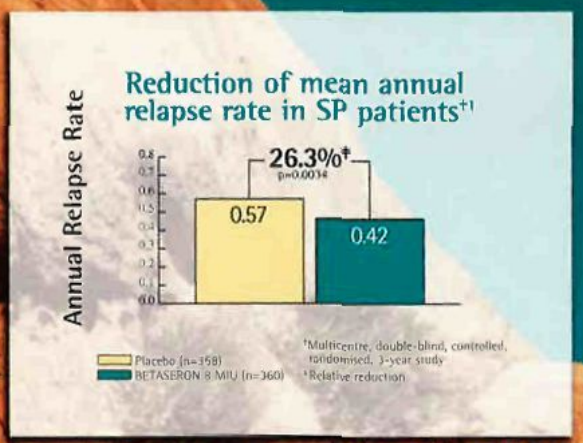


Adapted from BETASERON Product Monograph 1999

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



Adapted from the IFNB MS Study Group 1995



Adapted from BETASERON Product Monograph 1999

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.

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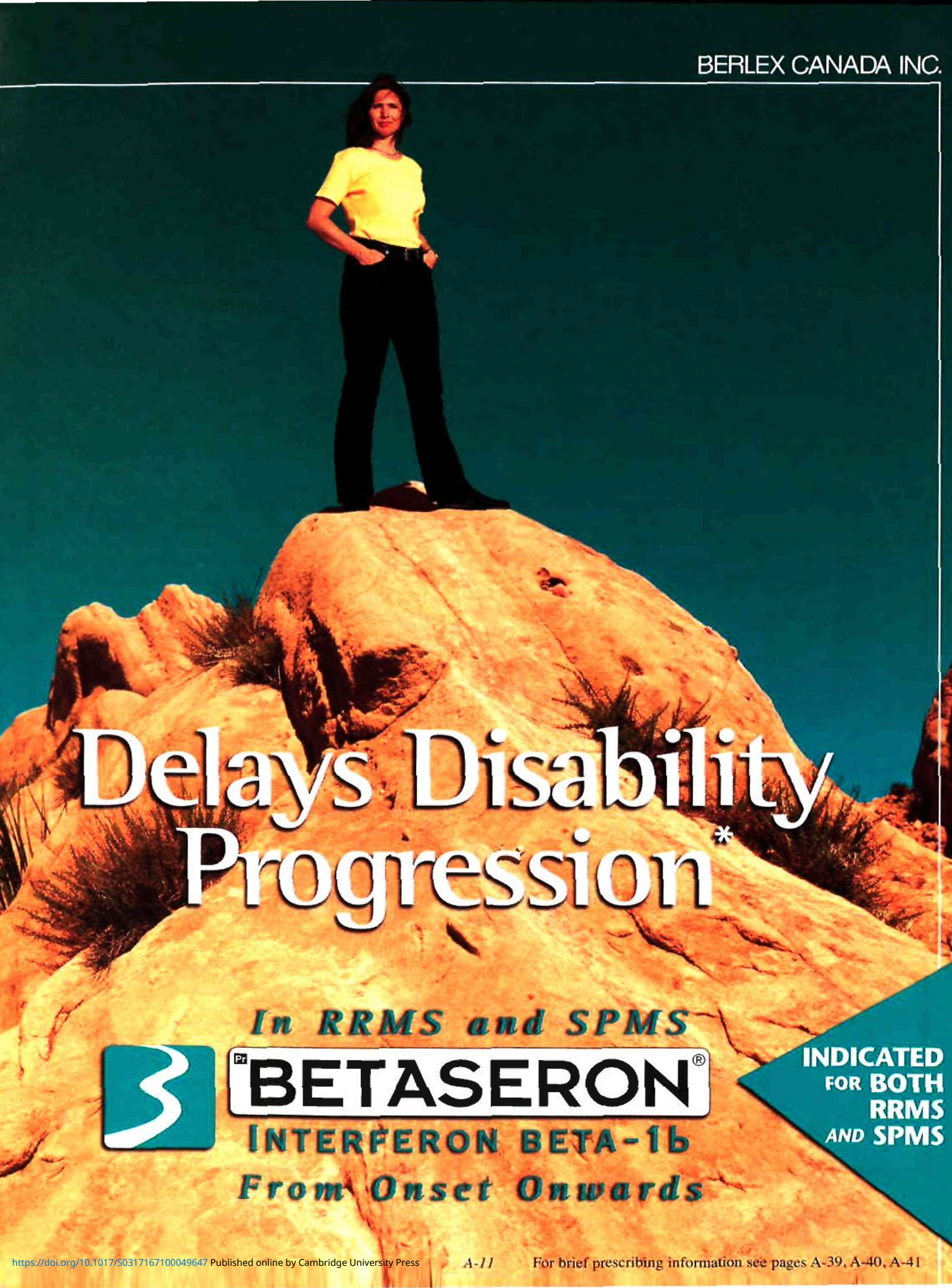

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25 Years Ago in the Canadian Journal of Neurological Sciences

The Brain, the Heart and Taurine

André Barbeau

Summary: This paper reviews some recent developments concerning the "non-essential" amino acid taurine. It is shown that taurine is important in metabolic regulations within the heart, muscle and brain. Particular attention is paid to the neuropharmacology of taurine, such as its possible role in epilepsy.

Can. J. Neurol. Sci. 1975;2:343

Patterns of Memory Performance in the Neurologically Impaired Aged

Francisco I. Perez, Joe R.A. Gay, Ronald L. Taylor and Victor M. Rivera

Summary: The specific behavioral manifestation associated with the different disorders producing the syndrome of dementia have remained poorly investigated. We examined the memory performance of three distinct groups of patients with dementia secondary to Alzheimer's disease (AD), multiple infarctions (MID) and vertebrobasilar insufficiency (VBI) on the ten subtests of the Wechsler Memory Scale (WMS). Statistical methods of analysis were used to maximise the differences between the groups. Univariate statistical procedures revealed that the AD group performed significantly and consistently lower that the two cerebrovascular groups. There were no significant differences between the two cerebrovascular disease groups, even though the MID group tended to perform consistently more poorly than the VBI group. For heuristic and conceptual purposes as well as to determine which combination of the ten WMS variables produced the "best" statistical model differentiating the groups the data was analyzed by multivariate techniques. A discriminate function analysis obtained a 100% valid positive hit rate in discriminating among the three groups. One hundred percent diagnostic accuracy was also obtained in discriminating between MID and AD as well as AD and VBI. The two cerebrovascular groups tended to overlap in their probability distributions with an 81% hit rate. Different predictive statistical models were identified to differentiate the various diagnostic groups. It was possible to discriminate the three diagnostic groups by different patterns of memory performance.

Can. J. Neurol. Sci. 1975;2:347

Congenital Displacement of Temporal Cortex into the Central Spinal Canal

David A. Silver and David M. Robertson

Summary: This is a report of the first recorded observation of displacement of temporal cortex into the central spinal canal in an infant with the Arnold Chiari malformation, platybasia, aqueductal atresia, hydrocephalus and meningomyelocele. The combination of an absent tentorium, absent right cerebellar hemisphere and malformed fourth ventricular roof provided the anatomical background for this unique event.

Can. J. Neurol. Sci. 1975;2:3357

25 Years Ago in the Canadian Journal of Neurological Sciences

A Model for the Future Care of Acute Spinal Cord Injuries

E.H. Botterell, A.T. Jousse, A.S. Kraus, M.G. Thompson, M. Wynne-Jones and W.O. Geisler

Summary: This is a review of the total care of those acute spinal cord injury patients in Ontario during the years 1969 and 1970, from extrication and transportation following the accident to death, or the completion of primary definitive rehabilitation.

Information was extracted from the available ambulance records, the patients and many of the responsible physicians were interviewed personally. The study was detailed and intensive and included a review of each patient's hospital records in each hospital up to discharge from the rehabilitation programme into the community, or to a chronic care unit. The data was compiled in accordance with a detailed and lengthy questionnaire developed for this study.

The incidence of acute cord injuries in Ontario in 1969 and 1970 amounted to 244; in 1969, 15.9 per million population and in 1970, 13.6 per million. As in other studies road accidents took first place, followed by falls from a height; sports injuries ranked third and 65.7% of these were caused by diving into shallow water. Age incidence, and incidence by month, day of week and time of day were identified. Fridays and Saturday afternoons in July and August are particularly hazardous.

The study continued to the end of 1974 by which time 34 deaths had been recorded. Peak incidence of death occurred within fourteen days of injury. The most common cause of death was respiratory in origin.

Geographical distribution was identified and the type of hospital treating the acutely injured patient.

Fourteen percent of persons with spinal column injury suffered progressive or sequential spinal cord damage both prior to and following medical contact. The incidence of pressure sores and genitourinary sepsis and calculosis was high in all types of hospitals. The effect of operative treatment was noted in the cases of complete quadriplegia and paraplegia.

Of the 133 survivors who undertook a rehabilitation program, 84% returned to their homes and 59% achieved gainful employment or ongoing education.

The cost was determined of general hospital services and rehabilitation programmes.

A new model for the care of the spinal cord injury patients in Ontario was proposed.

Can. J. Neurol. Sci. 1975;2:361

Technical Report: Method of Fixation of Subluxed or Dislocated Cervical Spine below C1-C2

H.H. Tucker

Summary: A method of internal fixation of adjacent vertebrae that have been dislocated or subluxed has been presented. In the author's hands and in the hands of associates this has proven to be a satisfactory method of fixation of this type of injury. It has the advantage over many other posterior techniques that only two vertebrae are fixed together.

Can. J. Neurol. Sci. 1975;2:381

ONCE IT TOOK EXCEPTIONAL EFFORT OR EXTRAORDINARY TALENT FOR PEOPLE WITH EPILEPSY TO SUCCEED. LUCKILY, BOTH YOUR ADULT AND PEDIATRIC PATIENTS CAN NOW ENJOY LESS TAXING ALTERNATIVES.

https://doi.org/10.1017/S0317167100049647 Published online by Cambridge University Press

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:

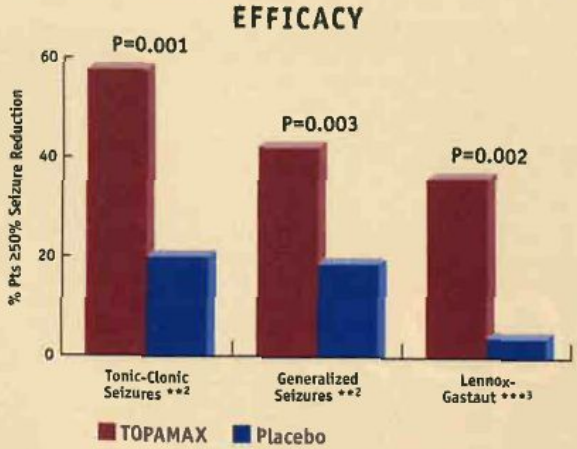
Dosage Individualized to Patient Response:[4,5]

	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.[1]
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%)! 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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 PAAS JATX991005A

TABLETS NOW ON FORMULARY‡

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

TOPAMAX* topiramate

Helping patients with epilepsy make more of their lives

https://doi.org/10.1017/S0317167100049647 Published online by Cambridge University Press

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

25 Years Ago in the Canadian Journal of Neurological Sciences

KINDLING
A SYMPOSIUM ON BASIC RESEARCH IN NEUROSCIENCE

May 16-17 1975

Health Sciences Centre Hospital

University of British Columbia, Vancouver, Canada

DOES THE ENGRAM OF KINDLING MODEL THE ENGRAM OF NORMAL LONG TERM MEMORY?

G.V. Goddard and R.M. Douglas

Summary: The kindling effect is a relatively permanent alteration in brain function which results from repeated electrical or chemical stimulation and culminates in the appearance of electrographic and behavioral convulsions whenever the original stimulus is re-applied. The effect results from tetanic activation in the anterior cortex, limbic system or associated areas of the adult mammalian brain, and the lasting alterations are transynaptic and quite widespread. They are based in part on synaptic facilitation, and they are accompanied by specific alterations in normal behavior. In these and other respects, kindling is analogous to normal learning. It is possible that the stored component (engram) of kindling involves the same physiological mechanism as the engram of normal long term memory. Morphological study of identified synapses has not provided conclusive evidence for an anatomical substrate of kindling, but physiological experiments demonstrate a lasting potentiation of the excitatory post-synaptic potential.

Can. J. Neurol. Sci. 1975;2:(Suppl 2):385

KINDLING, UNIT DISCHARGE PATTERNS AND NEURAL PLASTICITY

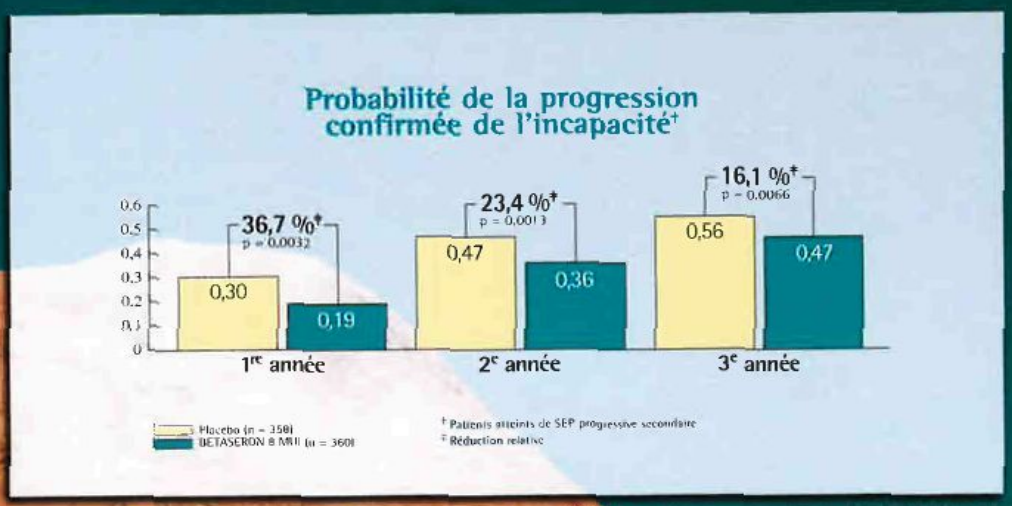
Ronald Racine, Larry Tuff and Josef Zaide

Summary: Two approaches to the study of the kindling phenomenon were discussed: 1) an attempt to identify the pattern of neural activity required to produce the changes underlying kindling and 2) an investigation into the nature of those changes. Three experiments were reported that used the neocortical transcallosal system as a monosynaptic model system in which to study possible synaptic mechanisms of the kindling effect. Experiment I showed an increase in the transcallosal evoked potential following neocortical kindling. Experiment II showed an increase in the strength of the transcallosal evoked cell discharge following neocortical kindling. Experiment III reported the results of an histological examination of neocortical tissue in kindled and non-kindled animals using the Golgi-Cox technique. Spine density, spine dimension and branching were measured for pyramidal cell apical dendrites. No differences were found between primary and secondary (contralateral) foci or between kindled and non-kindled animals.

Can. J. Neurol. Sci. 1975;2:(Suppl 2):395

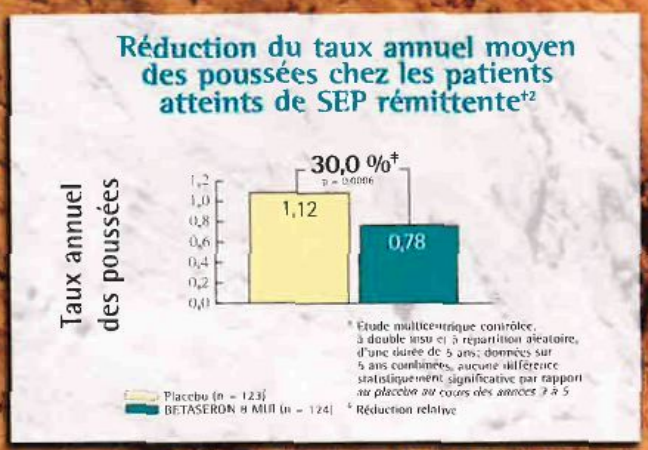
https://doi.org/10.1017/S0317167100049647 Published online by Cambridge University Press

BETASERON retarde la progression de l'incapacité

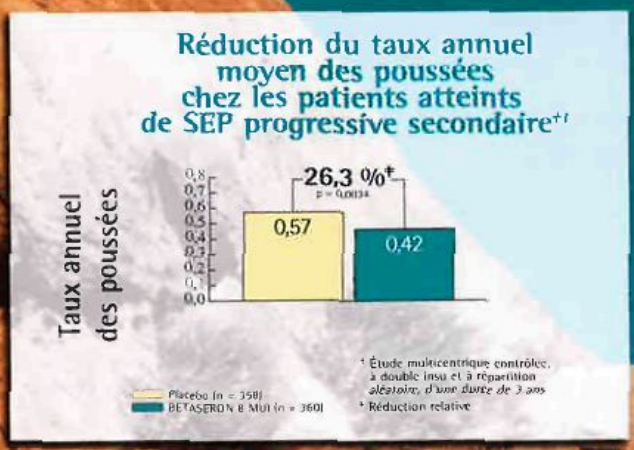


Adapté de la monographie de BETASERON, 1999

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



Adapté des résultats de l'étude menée par le IFNB MS Study Group, 1995



Adapté de la monographie de BETASERON, 1999

Effets indésirables pouvant être pris en charge[1]

Chez les patients atteints de la 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 %)*.

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. 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.
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Membre R&D CCPP PAAB

https://doi.org/10.1017/S0317167100049647 Published online by Cambridge University Press

https://doi.org/10.1017/S0317167100049647 Published online by Cambridge University Press

Pour documentation voir pages A-39, A-40, A-41

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 rares cas de décès associés.
¶Les effets indésirables fréquemment signalés sont la pharyngite, la fièvre, les infections et les éruptions cutanées (p = non significatif).
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.

me de Lennox-Gastaut

lamotrigine

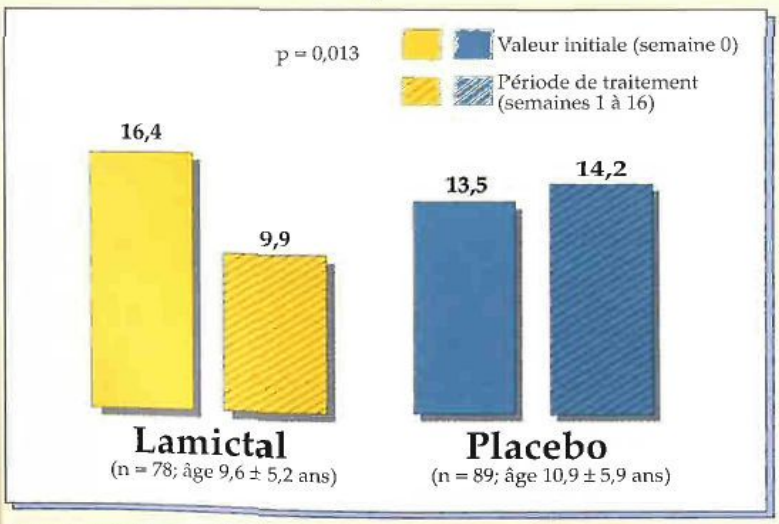
Lamictal®

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

https://doi.org/10.1017/S0317167100049647 Published online by Cambridge University Press

Pour documentation voir pages A-42, A-43, A-44

35th Meeting of the

Canadian Congress of Neurological Sciences

Ottawa, June 13-17, 2000

PRELIMINARY PROGRAM

See www.ccns.org for full program details

Mark your calendar for Ottawa in June!

Tuesday, June 13

- Neurobiology Review Course 2000
- ALS Symposium
- Clinical Epilepsy Video Session (evening)
- Vascular Dementia (evening)

Wednesday, June 14

- Meet the Expert Breakfast - Pediatric Neurology
- Courses
  1. Evidence-based Neurology (am)
  2. Management of Disorders of the Craniocervical Junction (full day)
  3. Current Educational Issues in the Clinical Neurosciences (am)
  4. Medical Legal Issues in Child Neurology (am)
  5. Molecular Mechanisms of Epileptic Syndromes (am)
  6. Medical Ethics in Neurology (pm)
  7. Molecular Mechanisms of Neuromuscular Disease (pm)
  8. Case Studies in Neurocritical Care (Neurocritical Care Group) (pm)
  9. Epilepsy (pm)
- Welcome Reception

For additional information contact:
The Canadian Congress of Neurological Sciences
P.O. Box 5456, Station A,
Calgary, AB Canada T2H 1X8
Tel: (403) 229-9544 Fax: (403) 229-1661
Email: brains@ccns.org

Thursday, June 15

- Meet the Expert Breakfast - Neurosurgery and Neurology
- Breakfast/posters/exhibits
- Plenary Session I:

  The Millenium and the Future of Clinical Neuroscience
- Oral Platform Sessions
- Lunch/posters/exhibits
- Plenary Session II:

  Endovascular Horizons in Cerebrovascular Disease
- Social evening

Friday, June 16

- Breakfast/posters/exhibits
- Plenary Session III: Molecular Genetics and Clinical Neuroscience
- Oral Platform Sessions
- Lunch/posters/exhibits
- Debates: Neurosurgery; Neurology

Saturday, June 17

- Child Neurology Day: Neurobehavioural Disorders
- Courses
  1. Emergent Therapies in Acute Stroke (full day)
  2. Multiple Sclerosis (am)
  3. Migraine 2000: A New Era in Migraine Therapy (pm)
- Child Neurology Dinner

https://doi.org/10.1017/S0317167100049647 Published online by Cambridge University Press

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.
‡ 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.
§ 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.

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

Once-a-day
℞ Aricept*
donepezil HCl 5 & 10 mg tablets

Hope for a brighter tomorrow

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

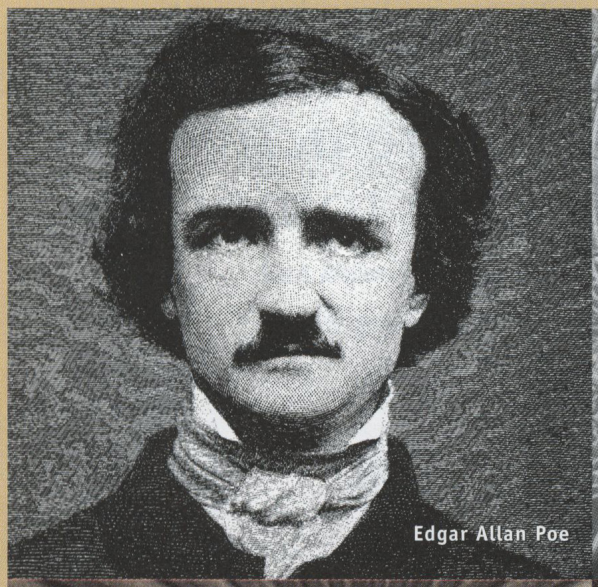
PAAB Member R&D

Pfizer
Life is our life's work

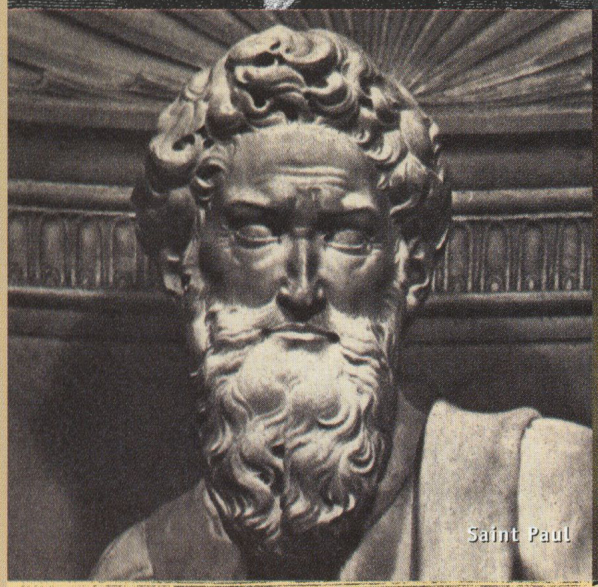
https://doi.org/10.1017/S0317167100049647 Published online by Cambridge University Press

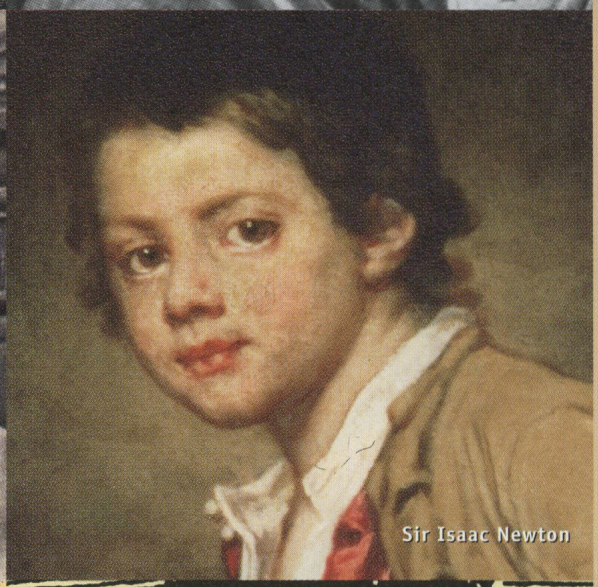
For brief prescribing information see pages A-31, A-32

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.

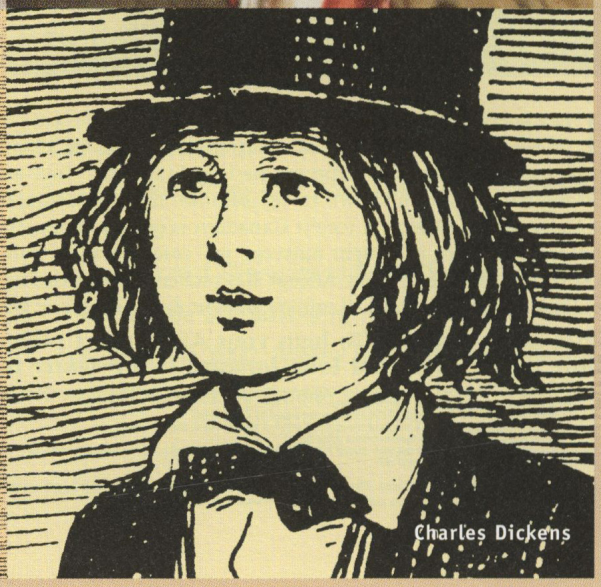

Edgar Allan Poe


Jeanne d'Arc


Saint Paul


Sir Isaac Newton


Pythagore


Charles Dickens

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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

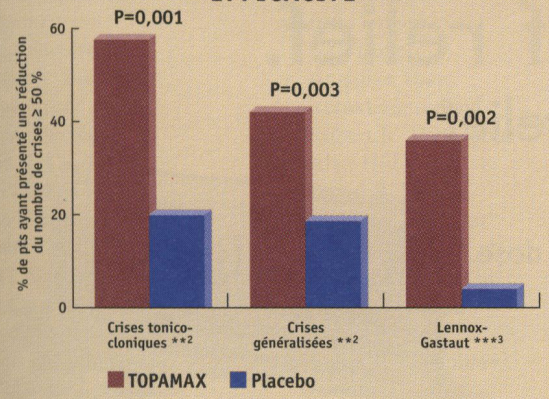
[a] Étude ouverte d'une durée de 20 semaines portant sur des adultes atteints de crises partielles initiales. Administration biquotidienne de TOPAMAX en tant que traitement d'appoint. La posologie optimale semblait comprise entre 300 et 350 mg/jour.

[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]



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[1†].

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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 JATX991005FA

PrTOPAMAX*
topiramate

Pour aider les patients épileptiques à mieux profiter de la vie

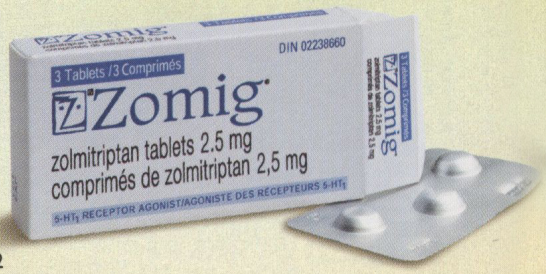
https://doi.org/10.1017/S0317167100049647 Published online by Cambridge University Press

Pour documentation voir pages A-47, A-48, A-49

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) is a registered trademark of the AstraZeneca group of companies.

AstraZeneca PAAB

Zomig®
zolmitriptan tablets 2.5 mg
Consistent migraine relief.

https://doi.org/10.1017/S0317167100049647 Published online by Cambridge University Press

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