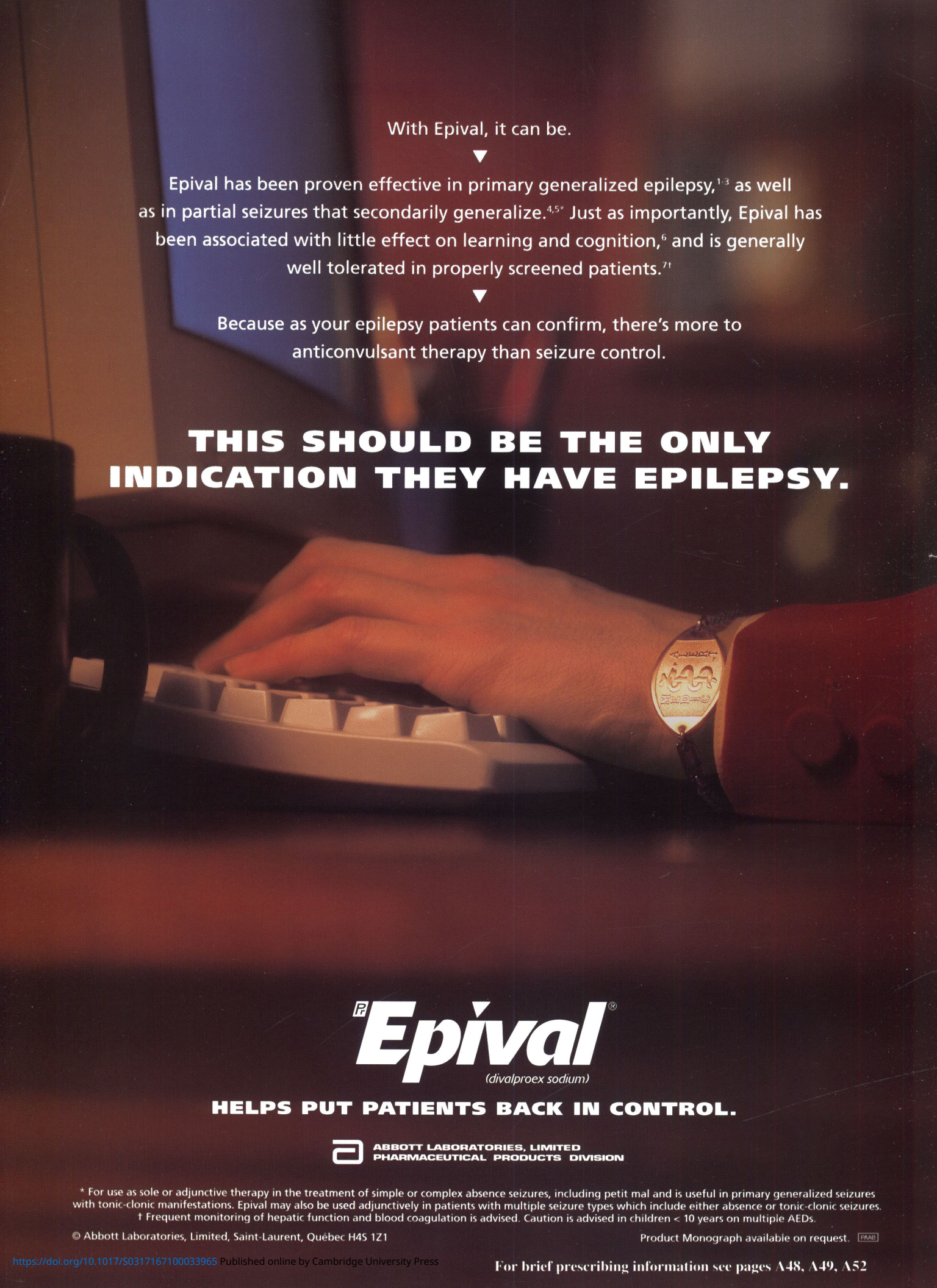
Volume 25 Number 3 August 1998

THE CANADIAN JOURNAL OF Neurological Sciences

LE JOURNAL CANADIEN DES Sciences Neurologiques

AN INTERNATIONAL JOURNAL / UN JOURNAL INTERNATIONAL

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



https://doi.org/10.1017/S0317167100033965 Published online by Cambridge University Press
For brief prescribing information see pages A48, A49, A52

Volume 25 Number 3 August 1998

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

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The official journal of: / La Revue officielle de:

The Canadian Neurological Society
La Société Canadienne de Neurologie

The Canadian Neurosurgical Society
La Société Canadienne de Neurochirurgie

The Canadian Society of Clinical Neurophysiologists
La Société Canadienne de Neurophysiologie Clinique

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L'Association Canadienne de Neurologie Pédiatrique

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The Canadian Journal of Neurological Sciences is published quarterly. The annual subscription rate is $70 for members; $77 for non-members in Canada; $88 for USA and elsewhere. Residents, Interns, Pre- and Post-Doctoral Students $35 per annum (members); $38.50 per annum (non-members). Single copies $22 each plus postage and handling. All manuscripts and communications should be sent to: Canadian Journal of Neurological Sciences, P.O. Box 4220, Station C, Calgary, AB Canada T2T 5N1. Courier to: 810, 906 - 12th Avenue S.W., Calgary, AB Canada T2R 1K7. Telephone (403) 229-9575; Fax (403) 229-1661. E-mail: cjns@canjneurolsci.org; Web Site: www.canjneurolsci.org
 Mailed under Publications Mail rAgreement number 1259563. Postage paid at Calgary, Alberta. This journal is indexed by *Index Medicus, EMBASE Excerpta Medica and Current Contents — Clinical Practice and Life Sciences, Elsevier Biobase/Current Awareness in Biological Sciences, Biological Abstracts, Chemical Abstracts, Current Advances in Ecological Sciences, Dent.index, Industrial Medicine, Industrial Science Reviews, INIS Automind, Nutrition Abstracts, Science Citation Index, Weed Abstract.*

Le Journal Canadien des Sciences Neurologiques est publié trimestriellement. L'abonnement annuel est de 70 $ pour les membres; 77 $ pour les non-membres au Canada; 88 $ pour les Etats Unis et ailleurs. Internes, résidents, fellows pré et post doctoral: 35 $ par année (membres); 38,50 $ par année (non-membres). Copie simple: 22 $ plus affranchissement et manutention. Toutes les communications et les manuscrits doivent être adressés à Journal Canadien des Sciences Neurologiques, P.O. Box 4220, Station C, Calgary, AB Canada T2T 5N1. Par courrier: 810, 906 - 12th Avenue S.W., Calgary, AB Canada T2R 1K7. Téléphone (403) 229-9575; Fax (403) 229-1661. E-mail cjns@canjneurolsci.org; Web Site: www.canjneurolsci.org
 Posté sous permis de poste-publications no 1259563. Port payé à Calgary, Alberta. Le Journal est cité et indexé dans *Index Medicus, EMBASE Excerpta Medica et Current Contents — Clinical Practice et Life Sciences, Elsevier Biobase/Current Awareness in Biological Sciences, Biological Abstracts, Chemical Abstracts, Elsevier Biobase/Current Advances in Ecological Sciences, Dent.index, Industrial Medicine, Industrial Science Reviews, INIS Automind, Nutrition Abstracts, Science Citation Index, Weed Abstract.*

Advertising representative/Représentant de publicité:
Sally Gregg, Canadian Journal of Neurological Sciences
810, 906 - 12 Ave. S.W., Calgary, AB Canada T2R 1K7
Tel (403) 229-9575 Fax (403) 229-1661
E-mail: cjns@canjneurolsci.org
Web Site: www.canjneurolsci.org

Printer/Imprimeur:
McAra Printing Limited, 105, 2507 - 12th Street N.E.,
Calgary, Alberta T2E 7L5

ISSN 0317 - 1671

Maîtrise efficace des crises

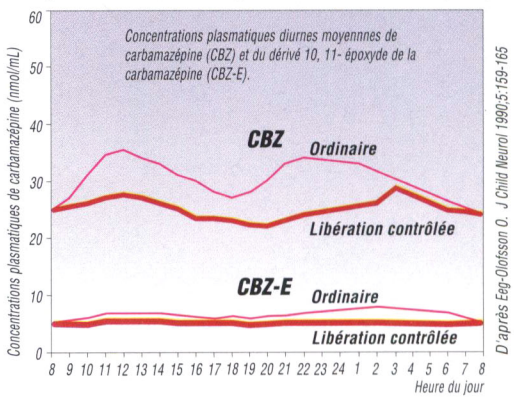
- **Bienfait clinique significatif et excellente maîtrise des crises épileptiques[1,2].**

Profil d'innocuité éloquent

- **Concentrations plasmatiques stables de carbamazépine pouvant mener à une incidence plus faible d'effets indésirables liés aux concentrations que Tegretol ordinaire[4].**
- **Niveau élevé de tolérabilité[2*].**

Permet d'atteindre et de maintenir une bonne maîtrise des crises tout en offrant une faible incidence d'effets indésirables liés aux concentrations[4].

Courbes des concentrations plasmatiques diurnes de Tegretol ordinaire et de Tegretol CR chez les enfants (n=25).[3]



Pr Tegretol® CR vs Pr Tegretol® ordinaire

- **Efficacité et tolérabilité équivalentes ou améliorées[6]**
- **Peut réduire considérablement la fréquence des crises[7]**
- **Entrave moins la fonction cognitive[5]**

L'un des effets secondaires les plus fréquents de la carbamazépine est la somnolence. Cette réaction ne survient généralement qu'en début de traitement[4] et peut être amenuisée par le recours à la carbamazépine à libération contrôlée (Tegretol® CR)[5].

La carbamazépine n'est pas efficace pour le traitement des absences, des crises myocloniques ou atoniques et ne prévient pas la généralisation de la décharge épileptique. En outre, une exacerbation des crises peut parfois survenir chez les patients ayant des absences atypiques[4].

**Consulter les mises en garde figurant à la monographie avant de prescrire.*

Pr Tegretol® CR
(carbamazépine à libération contrôlée)
et la suspension Pr Tegretol®
(carbamazépine)
POUR AIDER LES ÉPILEPTIQUES À S'ÉPANOUIR PLEINEMENT

Geigy
Spécialités pharmaceutiques
Dorval (Québec) H9S 1B1 ou Mississauga (Ontario) L5N 2W5

PAAB CCPP PMAC ACIM G-960710F

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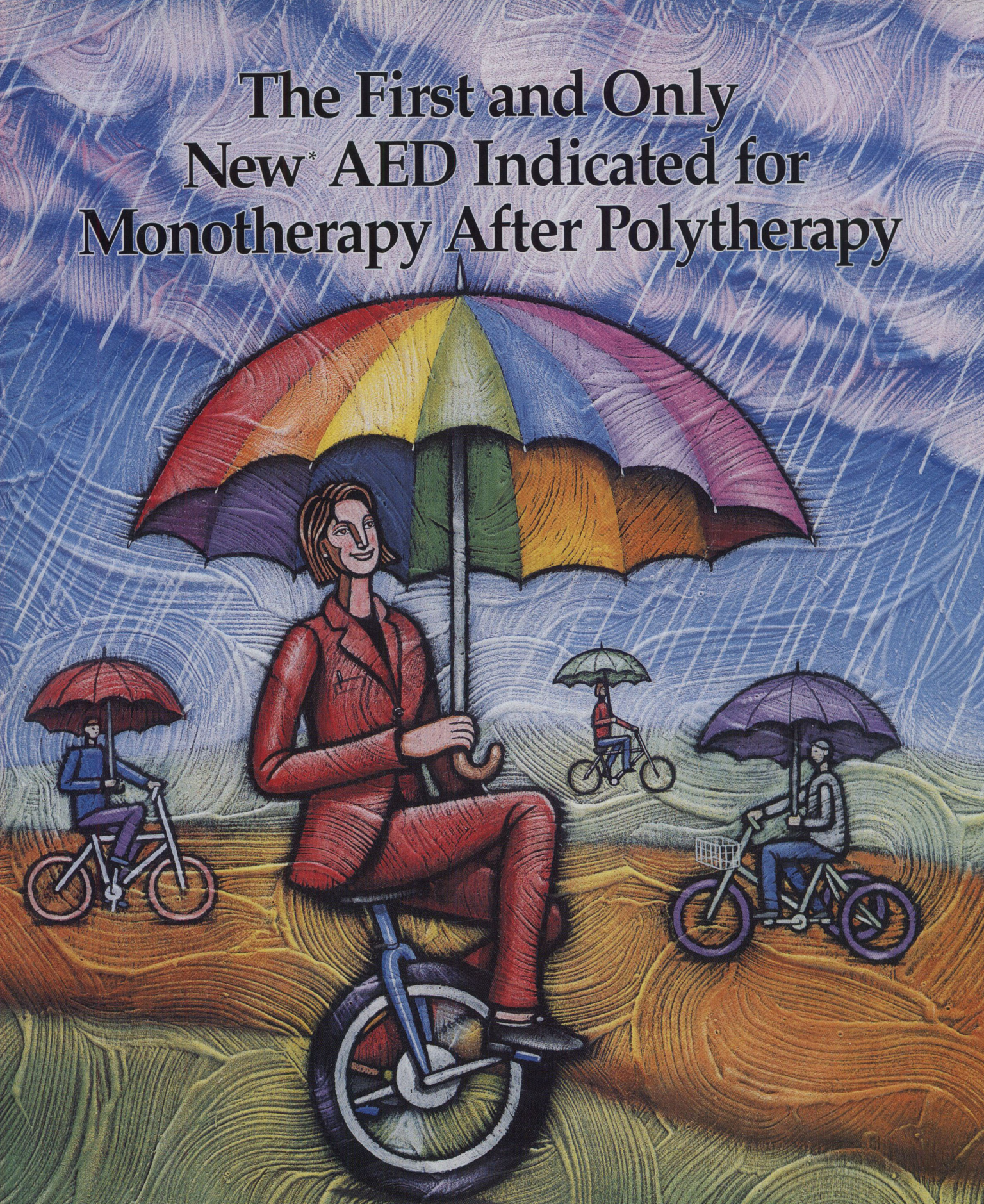
Pour documentation voir pages A-32, A-33

The First and Only New* AED Indicated for Monotherapy After Polytherapy



*Refers to lamotrigine, gabapentin, vigabatrin, and topiramate, to be distinguished from standard AEDs.
**A successful conversion to lamotrigine monotherapy was achieved in 50 of the 69 patients.
*** The three phases included add-on, withdrawal, and monotherapy. Should not be taken as an absolute measure of efficacy because patients with less satisfactory responses did not progress into all phases.
†The most common adverse experiences associated with discontinuation of LAMICTAL monotherapy were rash (6.1%), asthenia (1.1%), headache (1.1%), nausea (0.7%), and vomiting (0.7%).[3] See Product Monograph for further information.
††Please refer to Product Monograph for dose adjustment of LAMICTAL according to the concomitant AED withdrawn.

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For Control Over a Wide Range of Seizure Types, with a Low CNS Side-Effect Profile

Effective monotherapy has been largely accepted as the regimen of choice for achieving seizure control with minimal side effects in the management of patients with epilepsy.[1] Now, extending its proven success as adjunctive therapy,[2] LAMICTAL is indicated for monotherapy in adults following withdrawal of concomitant antiepileptic drugs (AEDs).[3]

HIGHLY EFFECTIVE MONOTHERAPY

In one add-on/withdrawal to monotherapy open-label trial, LAMICTAL monotherapy following withdrawal of concomitant AEDs kept 30% (n=50) of the successfully treated patients seizure-free.**[4] In a similarly designed trial, ≥ 40% of the patients were maintained with at least 50% reduction of seizure frequency across all phases of the trial.***[5]

GENERALLY BETTER TOLERATED†

Pooled data from three monotherapy trials show that withdrawals due to CNS-related side effects were 2.5% (n=443) with LAMICTAL monotherapy compared to phenytoin (7.4%; n=95) or carbamazepine (7.7%; n=246).[6] Incidence of somnolence, asthenia, and ataxia were reported less frequently with LAMICTAL compared to carbamazepine and phenytoin. There was no difference in the rate of withdrawal due to skin rash between LAMICTAL (6.1%) and phenytoin (5.3%) or carbamazepine (8.9%).[6] A higher incidence of skin rash has been associated with more rapid initial titration of LAMICTAL or use of concomitant valproic acid.[3]

CONTROL OVER A WIDE RANGE OF SEIZURE TYPES

LAMICTAL add-on polytherapy has been successfully used across a wide range of seizure types.[2] Now, opt to switch with confidence from LAMICTAL polytherapy to LAMICTAL monotherapy,†† particularly when you are concerned with CNS-related side-effects.

Lamotrigine

Lamictal®

FROM POLYTHERAPY TO MONOTHERAPY

GlaxoWellcome

Glaxo Wellcome Inc.

MEMBER PMAC

PAAB CCPP

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

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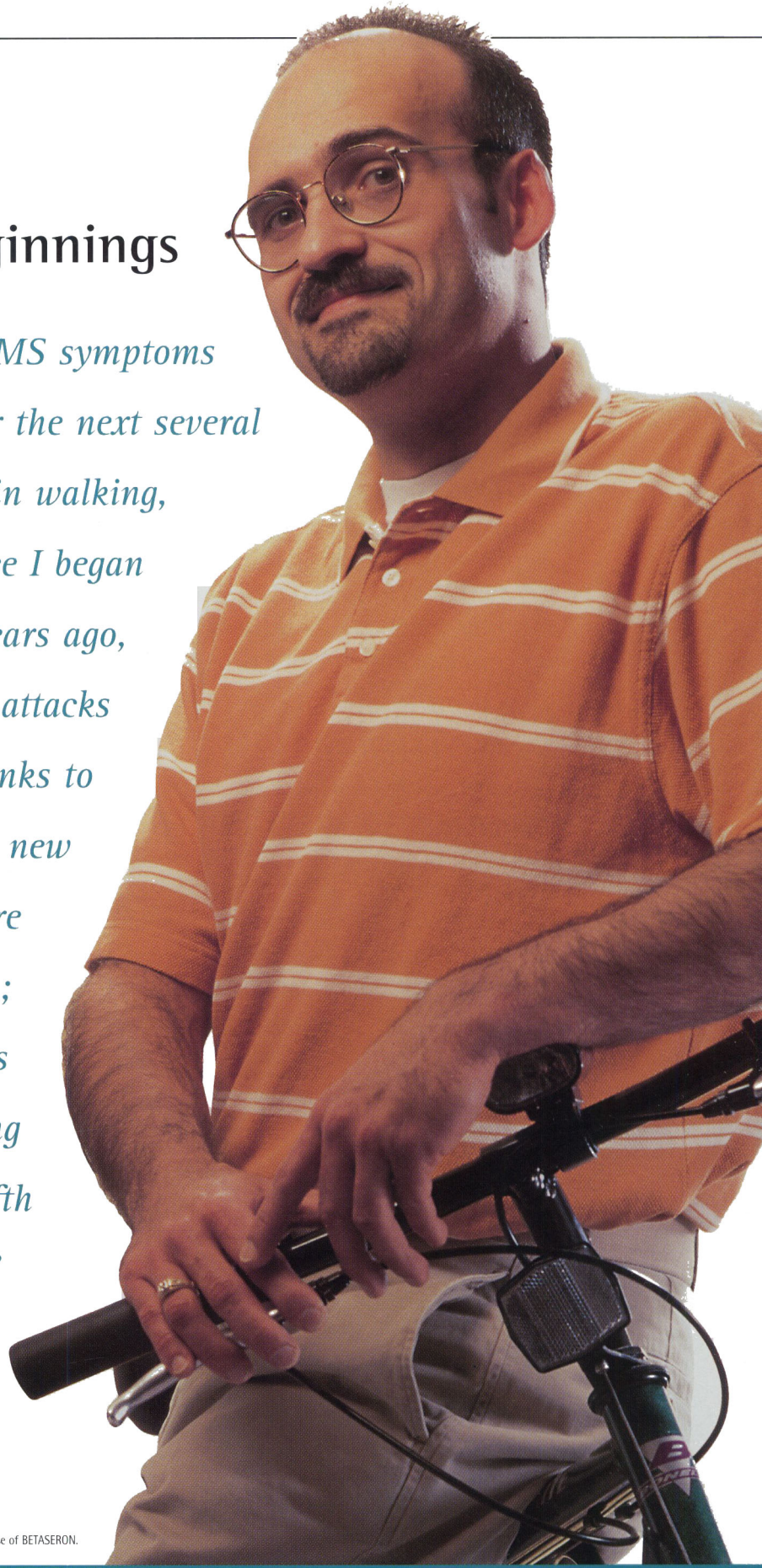
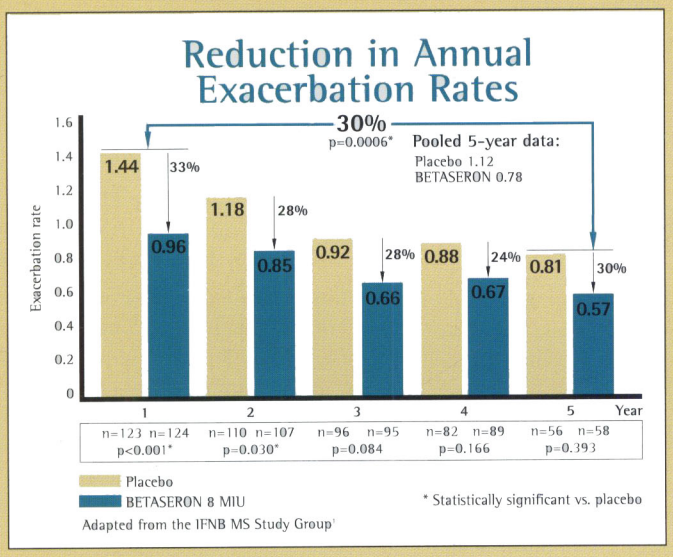
Fred on New Beginnings

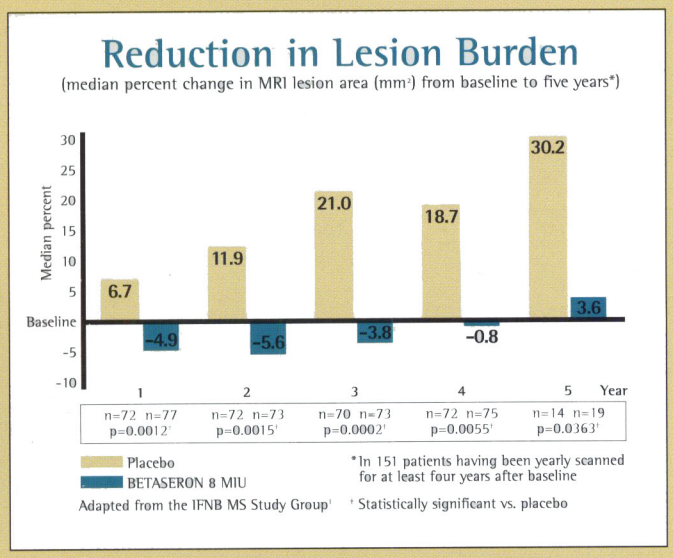
"I first experienced MS symptoms in 1985. Over the next several years, I had difficulties in walking, with speech ... But since I began BETASERON, *11 years ago, I have had no attacks whatsoever. Thanks to* BETASERON, *I now face new challenges. I can be there for my children; I'm preparing my master's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



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

THE FIRST TREATMENT ALTERING MS NATURAL HISTORY,





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

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

Pr BETASERON®

INTERFERON BETA-1b

Proven first-line treatment for MS

MULTIPLE SCLEROSIS PATHWAYS™ FOR CANADA

1 800 977-2770 CODE 4000

PAAB CCPP MEMBER PMAC

Provincial reimbursement available in British Columbia, Saskatchewan, Manitoba, Ontario and Quebec

WITH LONG-TERM BENEFICIAL EFFECTS FOR MS PATIENTS

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

Tasmar

gets more

out of

levodopa

so patients

get more

out of life.

And that means more living for your patients – day in and day out. Just look at the evidence.

Steady and continuous dopaminergic stimulation with Tasmar has shown that Parkinson's patients, in clinical trials, experienced;

- ✓ improved symptom control[6]
- ✓ reduced motor fluctuations[6]

In fluctuating patients, Tasmar has been shown to:

- ✓ reduce OFF-time by approximately 30-50%[6]
- ✓ significantly improve L-dopa "wearing off" effects[6]
- ✓ improve the severity of Parkinson's symptoms[12]

In non-fluctuating patients, Tasmar has demonstrated:

- ✓ significant improvements in the activities of daily living[10]
- ✓ improved motor performance[10]
- ✓ continued efficacy over time[10]

All these important benefits come with a very reasonable side effect profile. The most common adverse event was diarrhea (only 5-6% patients discontinued treatment as a result),[6] and psychiatric side effects were relatively low.[12]

With onset of action after the first dose, no titration and a simple dosing schedule (**just three times a day, with or without food**), Tasmar delivers even more to your patients.

Tasmar...so your Parkinson's patients can get more out of life.

Elevations in liver transaminases have been observed in 3% of patients, during the first six months of treatment with Tasmar. It is recommended that transaminases be monitored before starting Tasmar and approximately every six weeks for the first six months.[6]

Pr TASMAR® TOLCAPONE

COMT inhibition. A new frontier in Parkinson's therapy.

Roche

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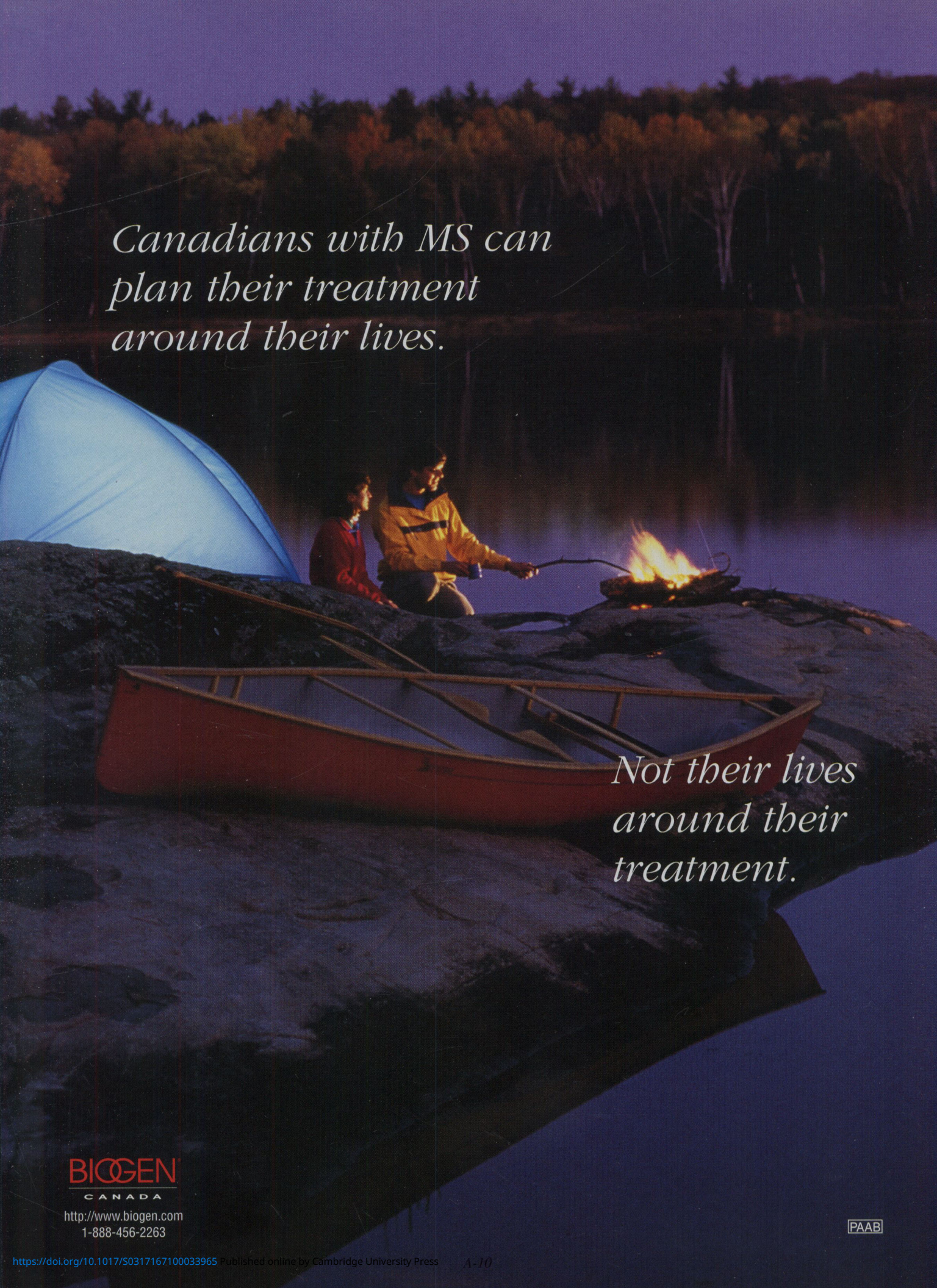
For brief prescribing information see pages A-55, A-56, A-57



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New Once-A-Week AVONEX™

(Interferon beta-1a)

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

The therapy prescribed in 18 countries is now available in Canada

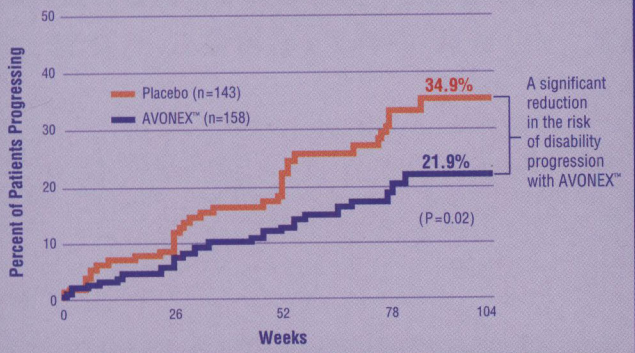
Treatment with once-a-week AVONEX™ results in minimal disruption of patients' lives and mild side effects that decrease over time for most patients.[1,2]

Our easy to plan, once-a-week IM injections may promote patient compliance.

AVONEX™ is proven to slow the progression of disability in relapsing forms of MS[1]

Prophylactic use of AVONEX™ can help patients maintain function longer. In a clinical trial, patients treated with AVONEX™ showed a significant reduction in risk of disability progression and a 32% reduction in annual exacerbation rate over two years.[3†]

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



AVONEX™ also demonstrated a significant MRI effect, showing an 89% reduction in gadolinium-enhanced lesions in patients with enhancement at baseline.[2◊]

The Avonex Support Line™: 1-888-456-2263

Biogen Canada is committed to providing healthcare professionals and their patients with the information and support they require. Our toll-free Avonex Support Line™ provides patients with information on injection training, delivery options and reimbursement counseling. Healthcare professionals are also available to answer your questions about AVONEX™.

Once-a-week AVONEX™ is generally well tolerated[1]

The unique once-weekly dosing regimen with AVONEX™, means fewer opportunities for injection-related side effects to disrupt patient's lifestyle.*

- The most common side effects associated with AVONEX™ treatment are flu-like side effects and usually resolve within 24 hours after injection.[1,2]
- Incidence of side effects decrease over time with continued treatment for most people.[2]
- Compared to subcutaneous injections, intramuscular injections result in far fewer site reactions.[2]
- No cases of injection site necrosis have been reported for patients on AVONEX™ therapy.[4]
- Please see product monograph for important patient selection and monitoring information.

P ONCE-A-WEEK AVONEX™ (Interferon beta-1a) IM Injection

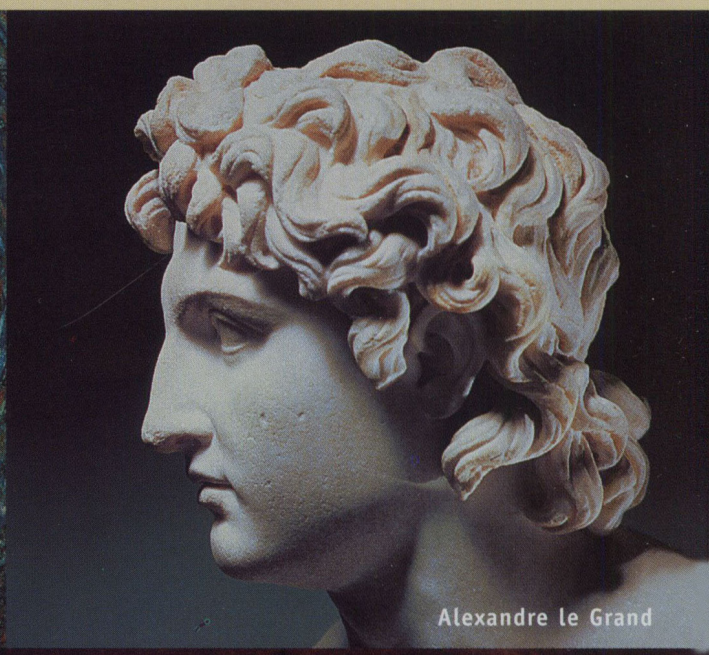
*Versus a more frequent dosing regimen.

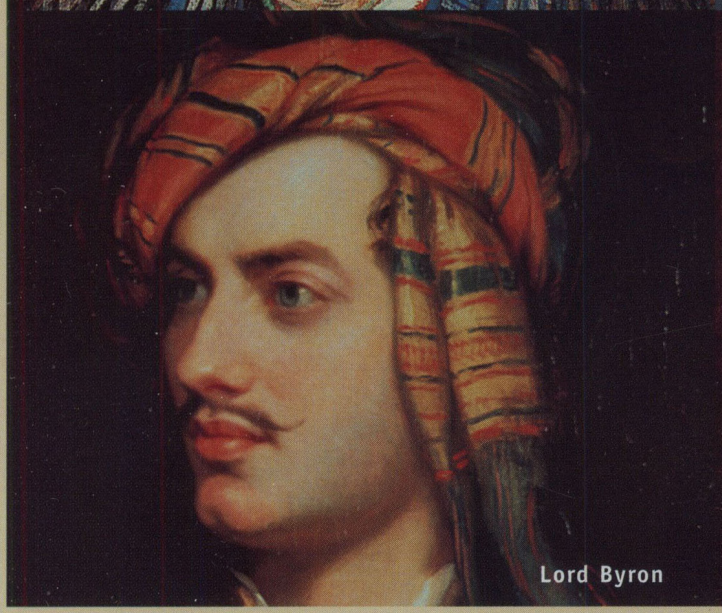
† P= 0.002; Placebo annual exacerbation rate 0.90, N:87; Avonex annual exacerbation rate 0.61, N:85.

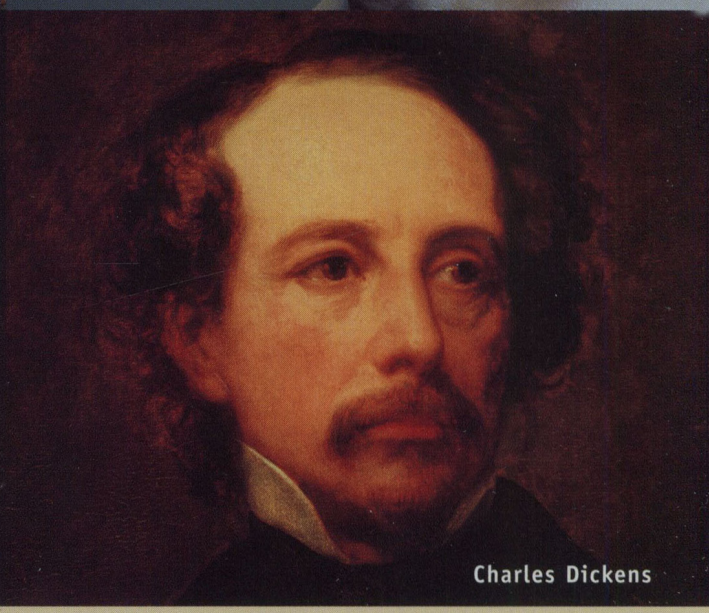
◊ P=0.041; Placebo median ratio 0.50, N=44; Avonex median ratio 0.11, N=44. The exact relationship between MRI findings and clinical status is unknown.

For brief prescribing information see pages A-50, A-51, A-52

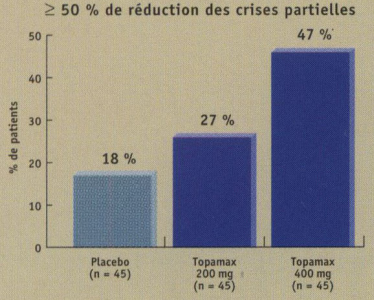
DU NOUVEAU EN ÉPILEPSIE. MAINTENANT REMBOURSÉ PAR LES FORMULAIRES







NAGUÈRE ENCORE, LA RÉUSSITE EXIGEAIT D'UN ÉPILEPTIQUE HEUREUSEMENT POUR VOS PATIENTS, IL EXISTE



Extrait de référence N° 1. Étude en double aveugle avec placebo contre TOPAMAX b.i.d. comme traitement d'appoint, portant sur 181 patients atteints d'épilepsie partielle réfractaire et recevant une ou deux autres médications antiépileptiques. *p = 0,013.

Contrôle amélioré d'une plus grande variété de types de crises.

- TOPAMAX est indiqué comme traitement d'appoint pour toutes les épilepsies réfractaires aux traitements conventionnels. À l'heure actuelle, les données sur l'utilisation de TOPAMAX comme traitement unique demeurent limitées.
- Taux élevé de répondants : 27 % (200 mg/jour, n = 45) et 47 % (400 mg/jour, n = 45) des patients ont manifesté une réduction des crises d'épilepsie partielle ≥ 50 % (étude d'une durée de 16 semaines)[1]
- Contrôle efficace pour les patients souffrant de cirses toniques-cloniques secondaires généralisées : 36 % des patients ont manifesté une réduction de 100 % (200-600 mg, n = 42, étude portant sur 16 semaines)[1]
- Triple mécanisme d'action unique : blocage des canaux sodiques, activation de l'acide gamma-aminobutyrique, antagonisme du glutamate)[2]

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DE LA C.-B., L'ALBERTA, LA SASKATCHEWAN, LA NOUVELLE-ÉCOSSE ET DU QUÉBEC.

DES EFFORTS EXCEPTIONNELS OU UN TALENT EXTRAORDINAIRE. MAINTENANT DES SOLUTIONS PLUS ACCESSIBLES.

- Généralement bien toléré : les interruptions entraînées par des réactions adverses étaient de 10,6 % pour les doses journalières de 200 à 400 mg, comparé à 5,8 % pour le groupe placebo (cela semblerait augmenter pour les doses journalières supérieures à 400 mg)[2]
- Aucune preuve d'éruption cutanée sérieuse ni d'anémie aplasique[2]
- Il n'est généralement pas nécessaire de changer le dosage des médications principales; les patients prenant de la phénytoïne et manifestant des signes ou symptômes de toxicité devraient faire contrôler leurs niveaux de phénytoïne†[2]
- **Dosage commode BID**

Profil favorable des effets secondaires
(les plus courants affectent le SNC)

	TOPAMAX 200-400 mg (n = 113)	PLACEBO (n = 216)
Somnolence	30,1	9,7
Étourdissements	28,3	15,3
Ataxie	21,2	6,9
Ralentissement psychomoteur	16,8	2,3
Troubles de la parole	16,8	2,3
Nervosité	15,9	7,4
Nystagmus	15,0	9,3
Paresthésie	15,0	4,6

†Comme pour les autres traitements antiépileptiques, veuillez vous reporter aux renseignements thérapeutiques pour plus de détails concernant les interactions médicamenteuses. On a rapporté l'occurence de 1,5 % (n = 1715) de calculs rénaux[2]. Dans une étude (n = 1200), 83 % des patients (15 sur 18) ont choisi de continuer le traitement[4]. Assurer un taux d'hydratation adéquat et éviter l'utilisation parallèle d'autres inhibiteurs de l'anhydrase carbonique[2].

TOPAMAX®
topiramate

Aide vos patients à mieux tirer parti de leur vie

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For brief prescribing information see pages A-50, A-51, A-52

IN THE TREATMENT OF ALZHEIMER'S DISEASE

Once-a-day Aricept* improves patient function:

For a more *active* day, a *brighter* tomorrow.

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 54 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.

Once-a-day Aricept*

donepezil HCl 5 & 10 mg tablets

Hope for a brighter tomorrow

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

Pfizer
We're part of the cure

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

If only the severity of migraines could be measured...

PAAB CCPP

MEMBER PMAC

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New Amerge® naratriptan hydrochloride from Glaxo Wellcome

A highly selective 5-HT$_1$ receptor agonist for moderate to severe migraines*

Highly Tolerable

- Overall incidence of adverse events in controlled clinical trials after treatment with AMERGE was similar to placebo[1-3]
  (31% AMERGE 2.5 mg vs. 32% placebo)[2]
- Chest and neck sensations characteristic of the 5-HT$_1$ agonist class reported in 1.2 - 2.1% of patients[1†‡]
- Tolerability maintained regardless of number of attacks treated[4]

5-HT$_1$ Efficacy with Long-lasting Migraine Relief

- Significant relief was sustained over 24 hours[2‖]
- 93% of attacks per patient did not require a second dose for recurrence[4#]
- Efficacy of AMERGE is unaffected by use with beta-blockers, calcium channel blockers, or tricyclic antidepressants[1§]

*AMERGE is indicated for the acute treatment of migraine attacks with or without aura. AMERGE is contraindicated in patients with hemiplegic, basilar, or ophthalmoplegic migraine. Safety and efficacy have not been established for cluster headache which is present in an older predominantly male population.[1]

†**AMERGE 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 (e.g., atherosclerotic disease, congenital heart disease) should not receive AMERGE. AMERGE is also contraindicated in patients with uncontrolled or severe hypertension.**

‡With 2.5 mg naratriptan.
‖Headache relief = reduction of moderate or severe pain to mild or no pain.
#Percentage does not represent recurrence rate. Headache recurrence equals a return of moderate or severe pain in 4 to 24 hours post dose following initial relief.
§Appropriate observation of the patient for acute and long term adverse events is advised.
®AMERGE® is a registered trademark of Glaxo Group Ltd., Glaxo Wellcome Inc. licensed use.

Consult Product Monograph for complete prescribing information, patient selection, screening and monitoring criteria.
Product monograph available to health care professionals upon request.

New Amerge® naratriptan hydrochloride

Highly tolerable, long-lasting migraine relief
Also available in 1 mg tablets

GlaxoWellcome

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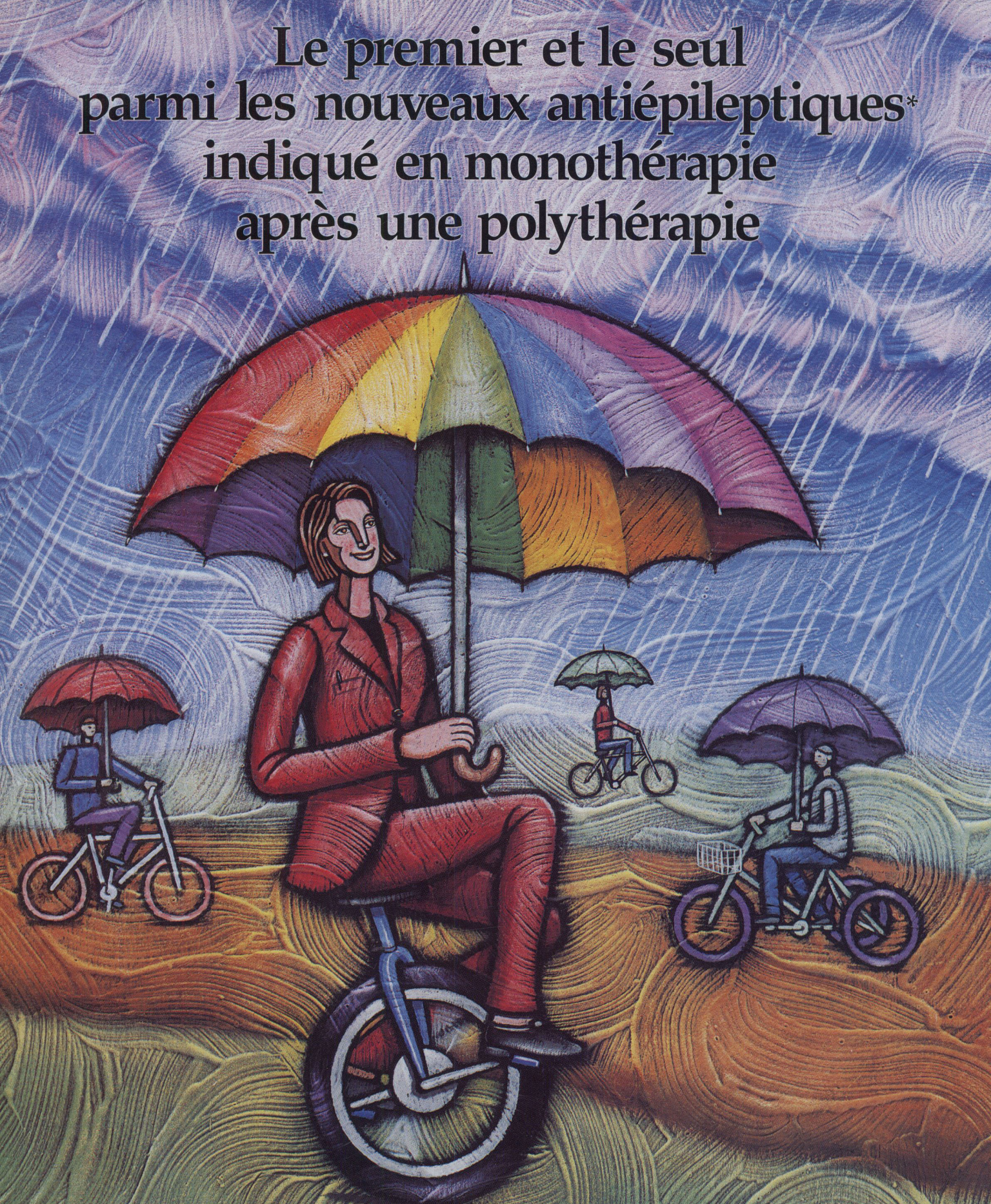
For brief prescribing information see pages A-39, A-40

Le premier et le seul parmi les nouveaux antiépileptiques* indiqué en monothérapie après une polythérapie



*C'est-à-dire la lamotrigine, la gabapentine, la vigabatrine et le topiramate, qui se distinguent des antiépileptiques traditionnels.
**Un passage réussi à la lamotrigine en monothérapie a été obtenu chez 50 patients sur 69.
*** L'essai comprenait trois phases : traitement d'appoint, retrait des autres antiépileptiques et monothérapie. Ne doit pas être considéré comme une mesure absolue de l'efficacité parce que les patients n'ont pas terminé toutes les phases de l'essai lorsque leur réponse n'était pas satisfaisante.
† Les effets indésirables le plus fréquemment associés à un arrêt de la monothérapie à LAMICTAL ont été les éruptions cutanées (6,1 %), l'asthénie (1,1 %), la céphalée (1,1 %), la nausée (0,7 %) et les vomissements (0,7 %)[3]. Pour de plus amples renseignements, consulter la monographie de LAMICTAL.
†† Veuillez consulter la monographie pour ce qui est de l'ajustement posologique de LAMICTAL lors du retrait des antiépileptiques administrés en concomitance.

Pour la maîtrise d'un vaste éventail de crises, associée à un profil discret d'effets indésirables liés au SNC

D'une manière générale, une monothérapie efficace a été reconnue comme le traitement de choix pour obtenir la maîtrise des crises avec le minimum d'effets indésirables chez les patients souffrant d'épilepsie[1]. Maintenant, renforçant son succès éprouvé comme traitement d'appoint[2], LAMICTAL est indiqué comme monothérapie chez l'adulte après le retrait d'antiépileptiques administrés en concomitance[3].

MONOTHÉRAPIE HAUTEMENT EFFICACE

Dans le cadre d'un essai ouvert sur le passage d'un traitement d'appoint à la monothérapie incluant le retrait des antiépileptiques administrés en concomitance, la monothérapie à LAMICTAL a permis à 30 % (n = 50) des patients traités avec succès de rester exempts de crises**[4]. Dans un autre essai du même type, ≥ 40 % des patients ont obtenu une réduction de la fréquence de leurs crises d'au moins 50 % pendant toutes les étapes successives de l'essai***[5].

GÉNÉRALEMENT MIEUX TOLÉRÉ†

Selon les données regroupées de trois essais sur la monothérapie, la fréquence des retraits dus aux effets indésirables sur le SNC était de 2,5 % (n = 443) avec la monothérapie à LAMICTAL, par rapport à 7,4 % pour la phénytoïne (n = 95) ou à 7,7 % pour la carbamazépine (n = 246)[6]. La fréquence de somnolence, d'asthénie et d'ataxie a été moins élevée pour LAMICTAL que pour la carbamazépine et la phénytoïne. On n'a noté aucune différence quant à la fréquence des retraits dus aux éruptions cutanées entre LAMICTAL (6,1 %) et la phénytoïne (5,3 %) ou la carbamazépine (8,9 %)[6]. Une fréquence plus élevée d'éruptions cutanées a été associée à une augmentation posologique plus rapide de la dose initiale de LAMICTAL ou à l'utilisation concomitante d'acide valproïque[3].

MAÎTRISE SUR UN VASTE ÉVENTAIL DE CRISES

LAMICTAL a été utilisé avec succès pour un vaste éventail de crises comme traitement d'appoint dans une polythérapie[2]. Vous pouvez passer avec confiance de LAMICTAL comme traitement d'appoint en polythérapie à LAMICTAL en monothérapie††, en particulier lorsque les effets indésirables liés au SNC sont une considération importante.

lamotrigine

PrLamictal®

DE LA POLYTHÉRAPIE À LA MONOTHÉRAPIE

GlaxoWellcome

Glaxo Wellcome Inc.
Bureau d'affaires du Québec

MEMBRE ACIM

PAAB CCPP

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

https://doi.org/10.1017/S0317167100033965 Published online by Cambridge University Press

Pour documentation voir pages A-42, A-43

ReQuip is a new dopamine agonist you can use continuously right from the start of Parkinson's therapy. It is indicated for early therapy without concomitant levodopa, and subsequent adjunct therapy with levodopa. And, as a result, ReQuip brings specific benefits to both early and late Parkinson's therapy.

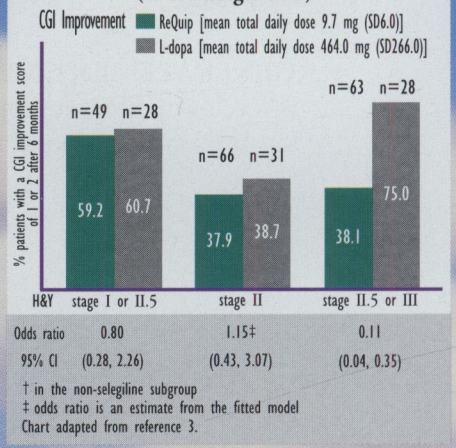
THE FIRST SELECTIVE, NON-ERGOLINE DOPAMINE AGONIST.

ReQuip has high affinity for dopamine receptors and binds selectively to dopamine D_2-type receptors[1] - the key receptors for antiparkinsonian activity.

EFFECTIVE THERAPY IN EARLY DISEASE.

ReQuip therapy is highly effective in early Parkinson's disease.[1,2,3] In fact, ReQuip and levodopa showed no difference in Clinical Global Improvement (CGI) in patients at Hoehn and Yahr stages I-II; however levodopa showed greater improvement in patients with more severe disease.[1,3]

ReQuip vs. L-dopa in early stage disease (H & Y stages I-III)†[3]



† in the non-selegiline subgroup
‡ odds ratio is an estimate from the fitted model
Chart adapted from reference 3.

As is expected of peripheral dopaminergic drugs, in early therapy, nausea (59.9%), dizziness (40.1%), and somnolence (40.1%) were the most common side effects of ReQuip. All dopamine agonists appear to impair the systemic regulation of blood pressure with resulting orthostatic symptoms of dizziness or lightheadedness. Patients should be monitored and informed of this risk. ReQuip should be titrated to optimal effect.[1]

SB SmithKline Beecham Pharma

https://doi.org/10.1017/S0317167100033965 Published online by Cambridge University Press

REQUIP™

THE NEW DOPAMINE AGONIST YOU CAN START WITH AND STAY WITH.

▶▶▶▶▶▶ TO ADJUNCT THERAPY

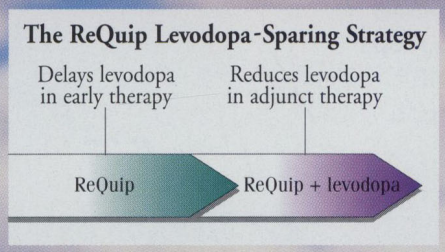
CAN DELAY THE INTRODUCTION OF LEVODOPA

ReQuip has also shown that it can successfully maintain its efficacy in early therapy. In clinical trials, it has sustained symptom control and thereby delayed the need to initiate levodopa therapy.[3,4]

OFFERS BENEFITS IN ADJUNCT THERAPY.

When it is necessary to add levodopa, ReQuip continues to offer important clinical benefits. In combination with levodopa, ReQuip was shown to allow a 20% reduction in levodopa dose[1] and increase patients' 'on' time by 20% after 6 months.*[1]

*Achieved by 28% of ropinirole (n=94) and 11% of placebo (n=54) treated patients. 95% CI of 1.533, 12.658[1]



MINIMIZES LEVODOPA LOAD TO HELP DELAY COMPLICATIONS.

Because ReQuip spares levodopa in early and adjunct therapy, it can substantially reduce the patient's overall levodopa load. Using ReQuip in early therapy can help delay the onset and reduce the risk of long-term levodopa complications such as dyskinesias, 'on-off' effect and 'wearing off' effect.[3]

HELPS EXTEND THERAPY AND PROLONG FUNCTION.

By sparing levodopa right from the start, ReQuip can extend and enhance the response to levodopa therapy. And that can help patients function better longer. So consider ReQuip for your Parkinson's patients. Because starting ReQuip today can mean a brighter outlook for tomorrow.

ropinirole
℞ REQUIP™
Early Therapy → Adjunct Therapy

RIGHT FROM THE START.

In adjunct therapy with levodopa, dyskinesias (33.7%) and nausea (29.8%) were the most common side effects of ReQuip.[1] And unlike other dopamine agonists, no ergot-related adverse experiences have been reported with ReQuip.[1]

PAAB MEMBER PMAC

https://doi.org/10.1017/S0317167100033965 Published online by Cambridge University Press

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

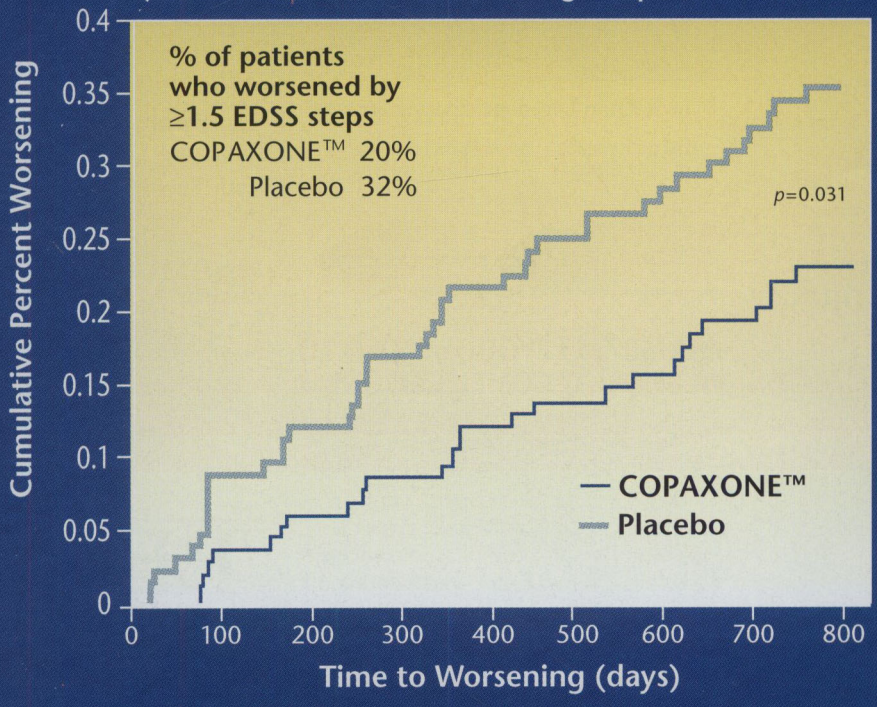
In relapsing-remitting multiple sclerosis:

Why are neurologists choosing Pr COPAXONE™?

(glatiramer acetate for injection)

Effect of COPAXONE™ on neurologic function in randomized, placebo-controlled trial. (n=251)

(EDSS Measurements Taken During Relapse are Excluded)



Adapted from Johnson, KP et al.[1,2]

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SUSTAINED EFFICACY

Kate's physician chose COPAXONE™ because it keeps working.†[1,2] Kate isn't giving in to MS.*

Kate H.
Burlington, Ontario

PROVEN COMPLIANCE

Claire's physician chose COPAXONE™ because it's generally well-tolerated.[1,2,3] It's one she could start on and stay with.*

Claire S.
La Salle, Québec

For information on **Shared Solutions,™** a free patient support program for healthcare professionals and their patients:
1-800-283-0034
info@tevamarion.com

SHARED SOLUTIONS
1-800-283-0034

TEVA MARION PARTNERS™
www.tevamarion.com

℗ COPAXONE™
(glatiramer acetate for injection)

† mean number relapses (24 mos) COPAXONE™ 1.19: Placebo 1.68 (p=0.007)[2]
*Not actual patient case study.

COPAXONE™ (immunomodulator) is indicated for reduction of the frequency of relapses in ambulatory patients with relapsing-remitting multiple sclerosis. A correlation between reduction in attack frequency alone and decreased risk of future disabilities remains to be established. Safety and efficacy beyond 2 years have not been adequately studied in placebo-controlled trials. Safety and efficacy in chronic progressive MS have not been evaluated. The most commonly observed adverse events (>20%) include (not all adverse events were related to treatment): injection site reactions (2.4%-66.4% depending on reaction), vasodilation (27.2%), chest pain (26.4%), hypertonia (35.2%), asthenia (64.8%), flu syndrome (30.4%), back pain (26.4%), nausea (23.2%), arthralgia (24.8%), rhinitis (23.2%).

PAAB CCPP

https://doi.org/10.1017/S0317167100033965 Published online by Cambridge University Press

For brief prescribing information see pages A-38, A-39

PARKINSON'S DISEASE

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

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

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

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

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

PERMAX®
pergolide mesylate

DRAXIS

Draxis Health Inc.
Mississauga, Ontario

PAAB

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

For brief prescribing information see page A-58

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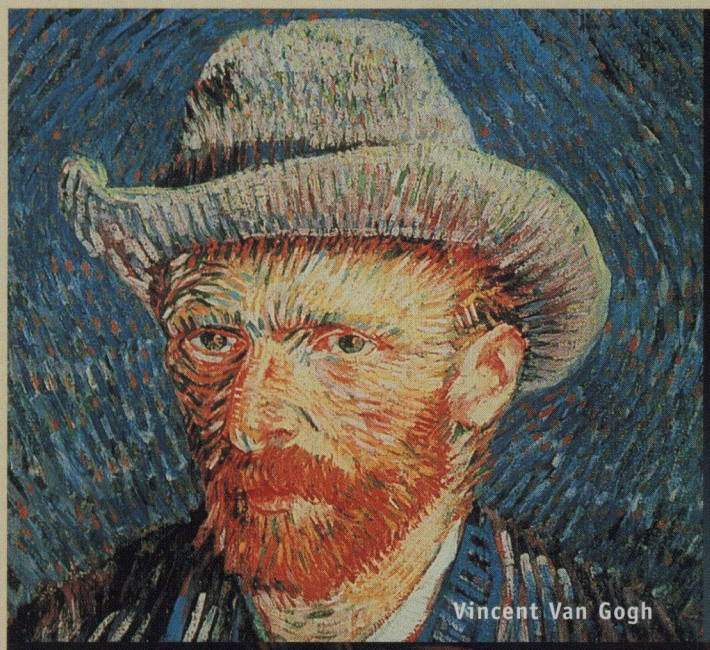
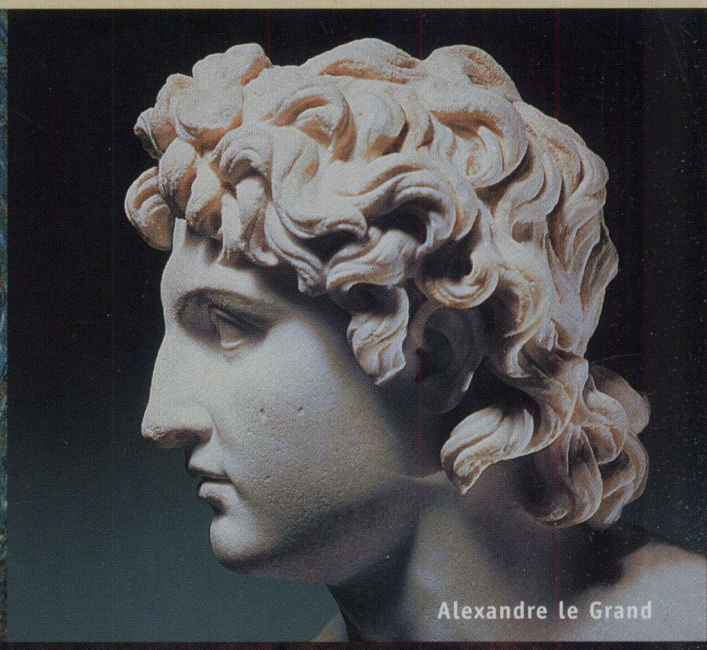
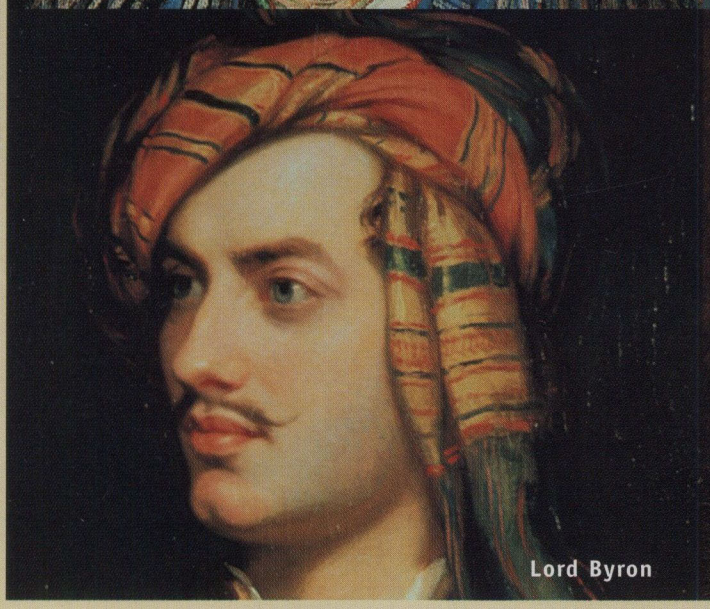
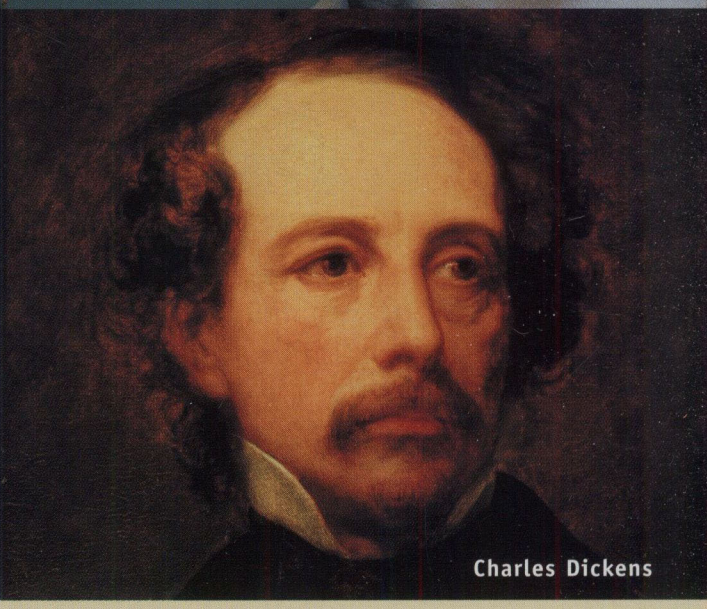
DU NOUVEAU EN ÉPILEPSIE. MAINTENANT REMBOURSÉ PAR LES FORMULAIRES

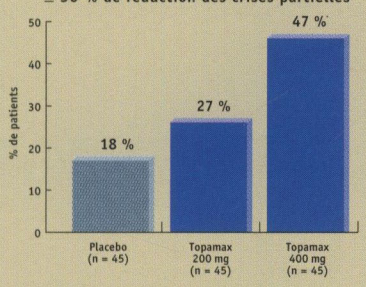








NAGUÈRE ENCORE, LA RÉUSSITE EXIGEAIT D'UN ÉPILEPTIQUE HEUREUSEMENT POUR VOS PATIENTS, IL EXISTE



Extrait de référence N° 1. Étude en double aveugle avec placebo contre TOPAMAX b.i.d. comme traitement d'appoint, portant sur 181 patients atteints d'épilepsie partielle réfractaire et recevant une ou deux autres médications antiépileptiques. *p = 0,013.

Contrôle amélioré d'une plus grande variété de types de crises.

- TOPAMAX est indiqué comme traitement d'appoint pour toutes les épilepsies réfractaires aux traitements conventionnels. À l'heure actuelle, les données sur l'utilisation de TOPAMAX comme traitement unique demeurent limitées.
- Taux élevé de répondants : 27 % (200 mg/jour, n = 45) et 47 % (400 mg/jour, n = 45) des patients ont manifesté une réduction des crises d'épilepsie partielle ≥ 50 % (étude d'une durée de 16 semaines)[1]
- Contrôle efficace pour les patients souffrant de cirses toniques-cloniques secondaires généralisées : 36 % des patients ont manifesté une réduction de 100 % (200-600 mg, n = 42, étude portant sur 16 semaines)[1]
- Triple mécanisme d'action unique : blocage des canaux sodiques, activation de l'acide gamma-aminobutyrique, antagonisme du glutamate)[2]

JANSSEN-ORTHO Inc. 19 Green Belt Drive, North York, Ontario M3C 1L9 *Marque déposée ©Janssen-Ortho Inc. 1997

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DE LA C.-B., L'ALBERTA, LA SASKATCHEWAN, LA NOUVELLE-ÉCOSSE ET DU QUÉBEC.

DES EFFORTS EXCEPTIONNELS OU UN TALENT EXTRAORDINAIRE. MAINTENANT DES SOLUTIONS PLUS ACCESSIBLES.

- Généralement bien toléré : les interruptions entraînées par des réactions adverses étaient de 10,6 % pour les doses journalières de 200 à 400 mg, comparé à 5,8 % pour le groupe placebo (cela semblerait augmenter pour les doses journalières supérieures à 400 mg)[2]
- Aucune preuve d'éruption cutanée sérieuse ni d'anémie aplasique[2]
- Il n'est généralement pas nécessaire de changer le dosage des médications principales; les patients prenant de la phénytoïne et manifestant des signes ou symptômes de toxicité devraient faire contrôler leurs niveaux de phénytoïne†[2]
- **Dosage commode BID**

Profil favorable des effets secondaires
(les plus courants affectent le SNC)

	TOPAMAX 200-400 mg (n = 113)	PLACEBO (n = 216)
Somnolence	30,1	9,7
Étourdissements	28,3	15,3
Ataxie	21,2	6,9
Ralentissement psychomoteur	16,8	2,3
Troubles de la parole	16,8	2,3
Nervosité	15,9	7,4
Nystagmus	15,0	9,3
Paresthésie	15,0	4,6

†Comme pour les autres traitements antiépileptiques, veuillez vous reporter aux renseignements thérapeutiques pour plus de détails concernant les interactions médicamenteuses. On a rapporté l'occurence de 1,5 % (n = 1715) de calculs rénaux[2]. Dans une étude (n = 1200), 83 % des patients (15 sur 18) ont choisi de continuer le traitement[4]. Assurer un taux d'hydratation adéquat et éviter l'utilisation parallèle d'autres inhibiteurs de l'anhydrase carbonique[5].

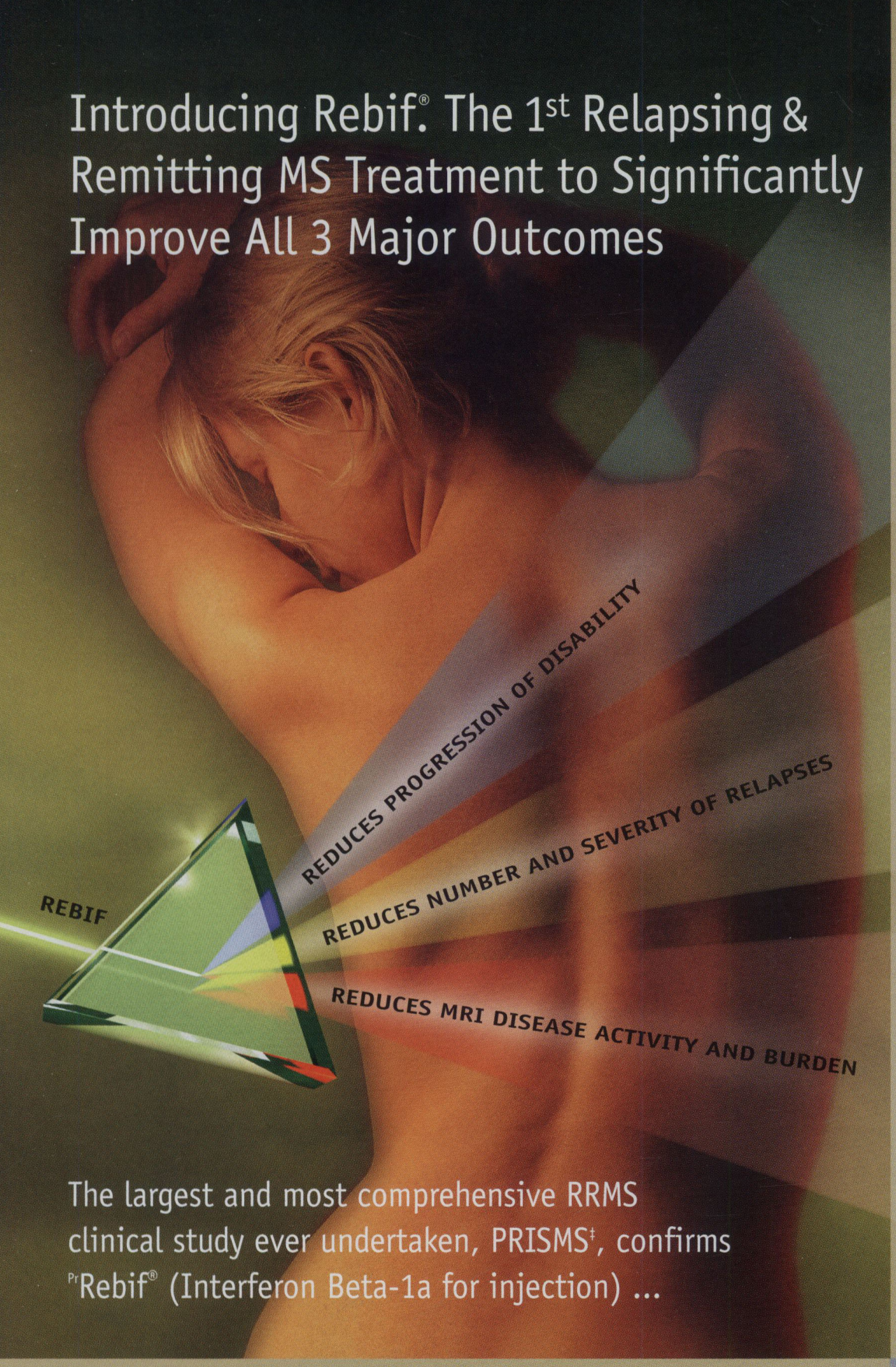
TOPAMAX®
topiramate

Aide vos patients à mieux tirer parti de leur vie

https://doi.org/10.1017/S0317167100033965 Published online by Cambridge University Press

Pour documentation voir pages A-53, A-54, A-55

Introducing Rebif®. The 1st Relapsing & Remitting MS Treatment to Significantly Improve All 3 Major Outcomes



Reduces progression of disability

The time to confirmed progression was significantly increased by 78% and 54% at both the 44 mcg and 22 mcg doses respectively versus placebo.[††]

Reduces the number and severity of relapses

The likelihood of remaining relapse-free at 2 years increased by 75% with the 22 mcg dose and by 119% with the 44 mcg dose.[††]

Reduces MRI disease activity and burden

Compared to placebo, Rebif® significantly reduced the number of active lesions per patient per MRI scan by 78% and 67% (at the 44 and 22 mcg doses respectively) in 560 patients. This reduction was seen early and persisted throughout the 2 year study period.[††]

Flexible dosing for optimal response

Available in ready-to-use liquid pre-filled syringes for subcutaneous injection.

The largest and most comprehensive RRMS clinical study ever undertaken, PRISMS[‡], confirms PrRebif® (Interferon Beta-1a for injection) ...

The most commonly reported adverse events are injection-site reactions and flu-like symptoms - e.g., asthenia, pyrexia, chills, myalgia, headache and arthralgia. These tend to decrease in frequency and severity with continued treatment. Please see Product Monograph for further information on patient selection.

[‡]2-year clinical trial involving 560 patients given 44 mcg and 22 mcg doses of Rebif® three times per week.

[†]Evidence of efficacy is derived from 2-year trials only.

Serono For more information contact our website at http://www.ms-network.com PAAB

Recombinant human interferon beta-1a

REBIF®

MULTIPLE EFFICACY. MULTIPLE SUPPORT.

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For brief prescribing information see pages A-34, A-35