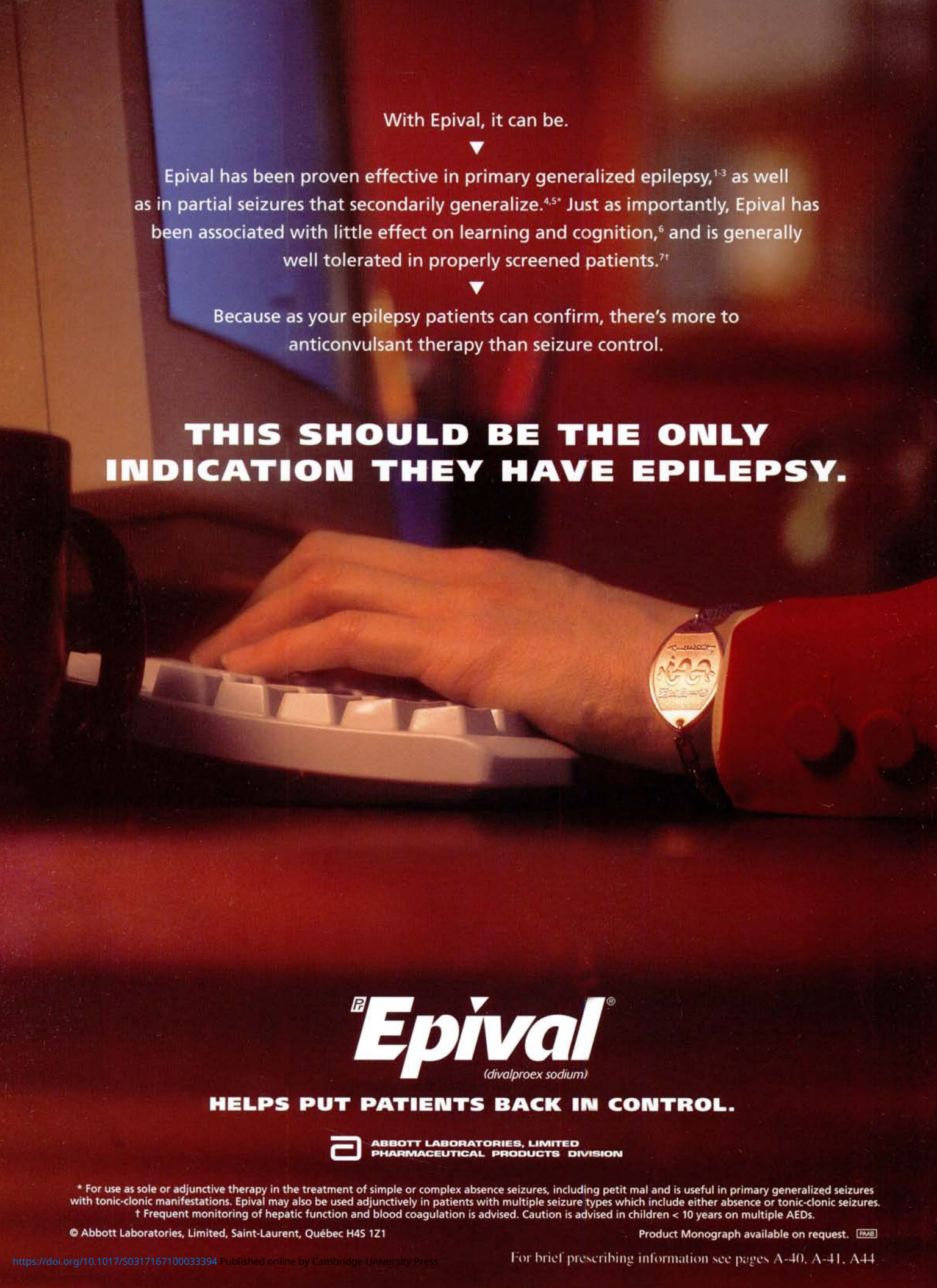
Volume 25 Number 1 February 1998

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



* For use as sole or adjunctive therapy in the treatment of simple or complex absence seizures, including petit mal and is useful in primary generalized seizures with tonic-clonic manifestations. Epival may also be used adjunctively in patients with multiple seizure types which include either absence or tonic-clonic seizures.
† Frequent monitoring of hepatic function and blood coagulation is advised. Caution is advised in children < 10 years on multiple AEDs.

Product Monograph available on request. PMAB

For brief prescribing information see pages A-40, A-41, A-44

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Volume 25 Number 1 February 1998

THE CANADIAN JOURNAL OF
Neurological Sciences
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Sciences Neurologiques

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La Société Canadienne de Neurologie

The Canadian Neurosurgical Society
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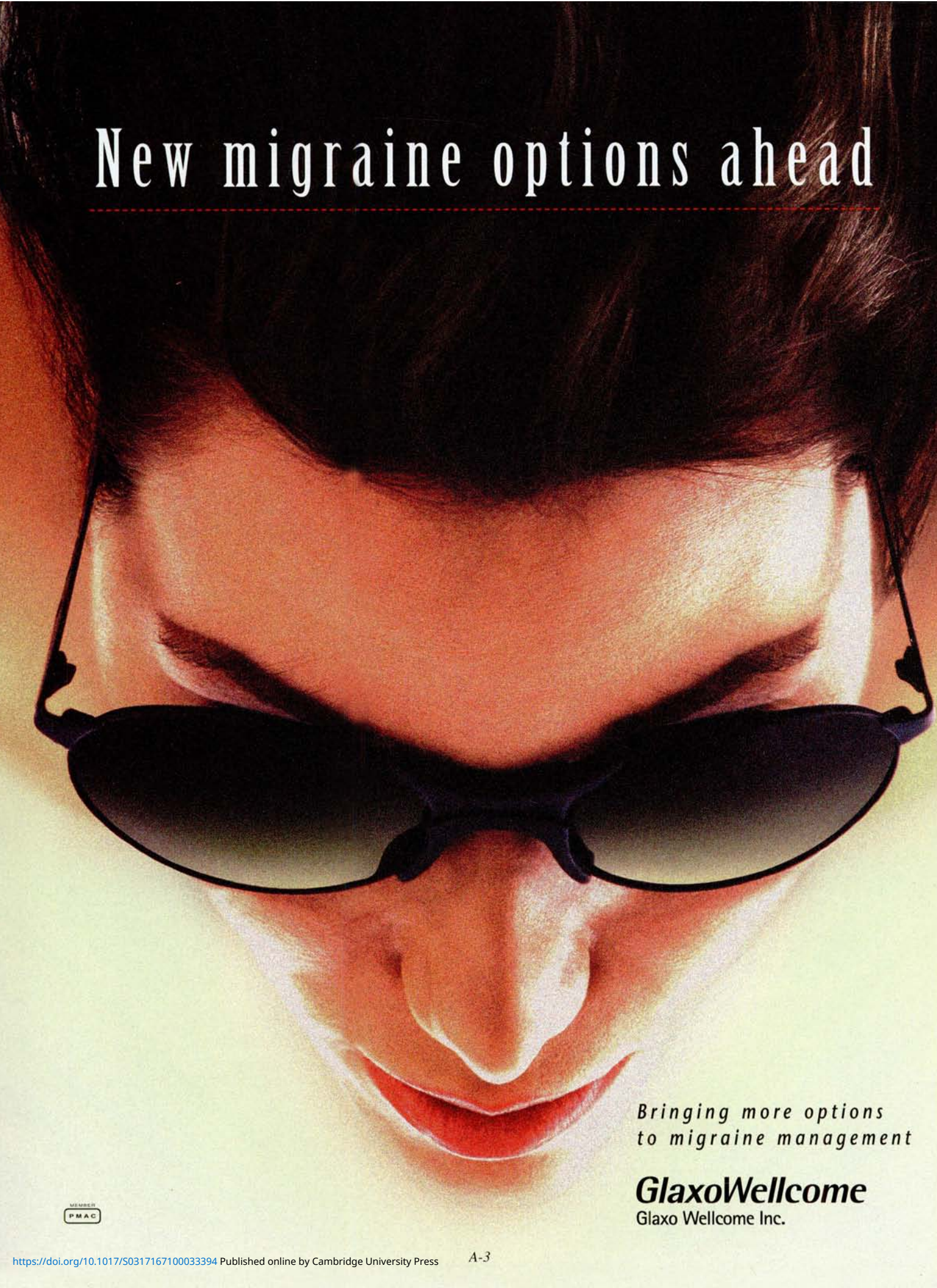

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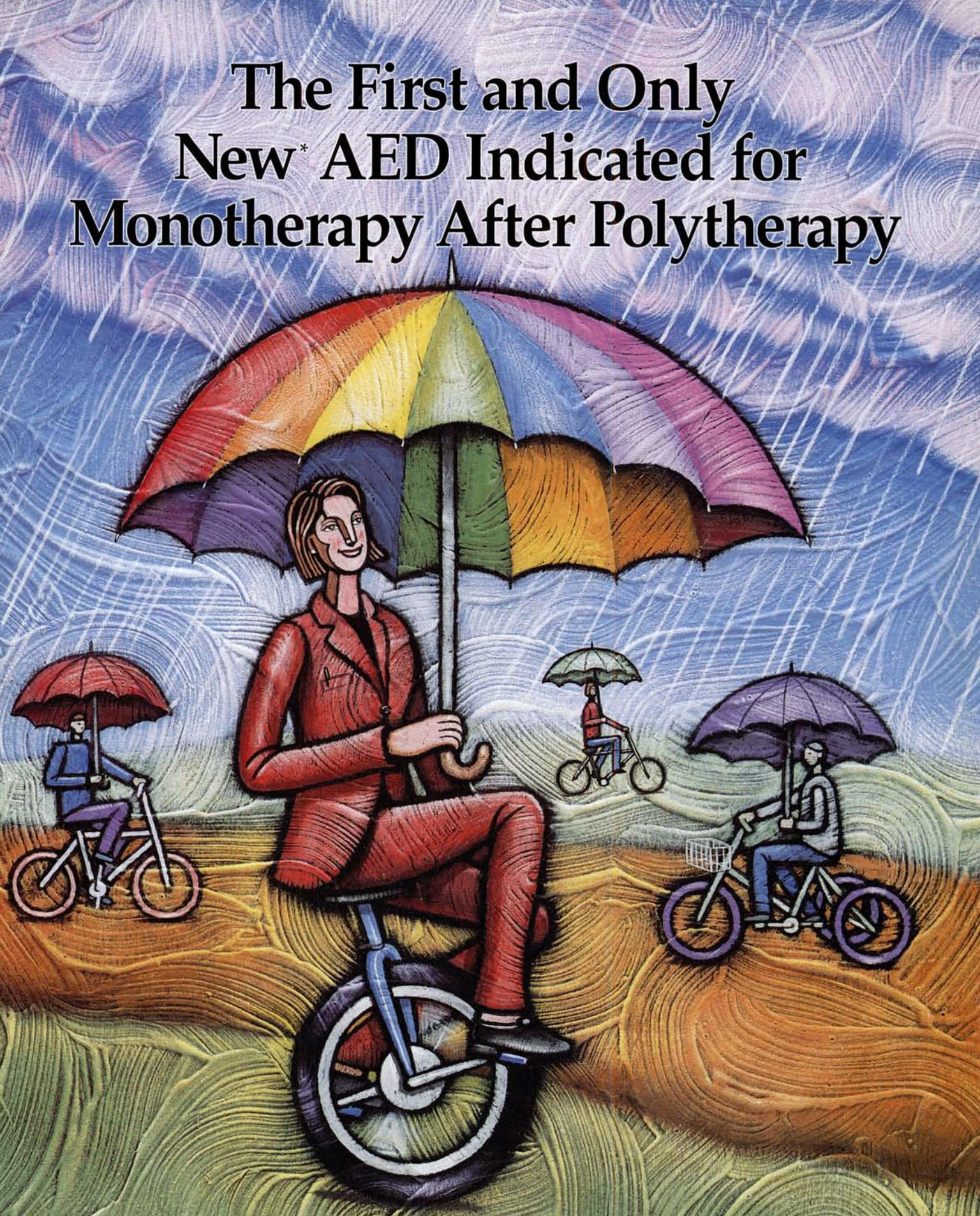
The First and Only New* AED Indicated for Monotherapy After Polytherapy



*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.

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

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PAAB CCPP

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

The first treatment for relapsing/remitting multiple sclerosis

T-2 weighted MRI scan (color added). Arrows indicate periventricular lesions.

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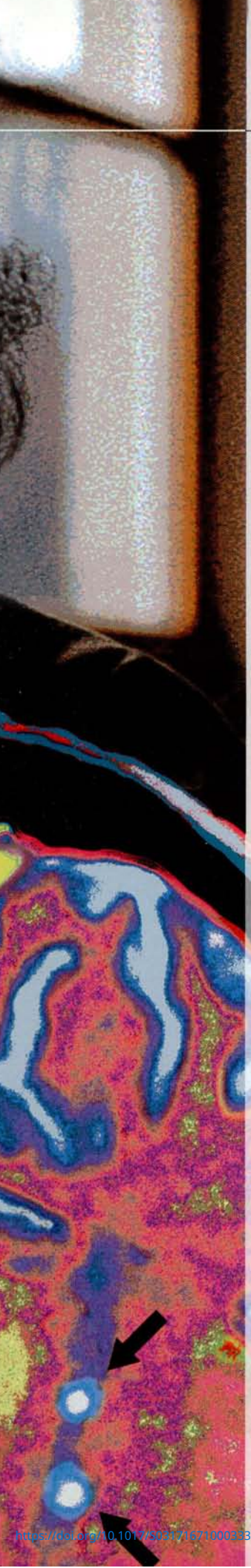


Clinical trials have shown that:

- *The frequency of exacerbations was reduced by approximately 30%*[1]
- *Moderate and severe exacerbations were reduced by 50%*[1]
- *Disease activity, as measured by MRI, was reduced significantly*[2]
- *There was a low incidence of serious side effects*[1]
- *Patient education about common side effects such as injection-site reactions and flu-like symptoms is key to compliance*

Over 55,000 patients treated to date worldwide[3]

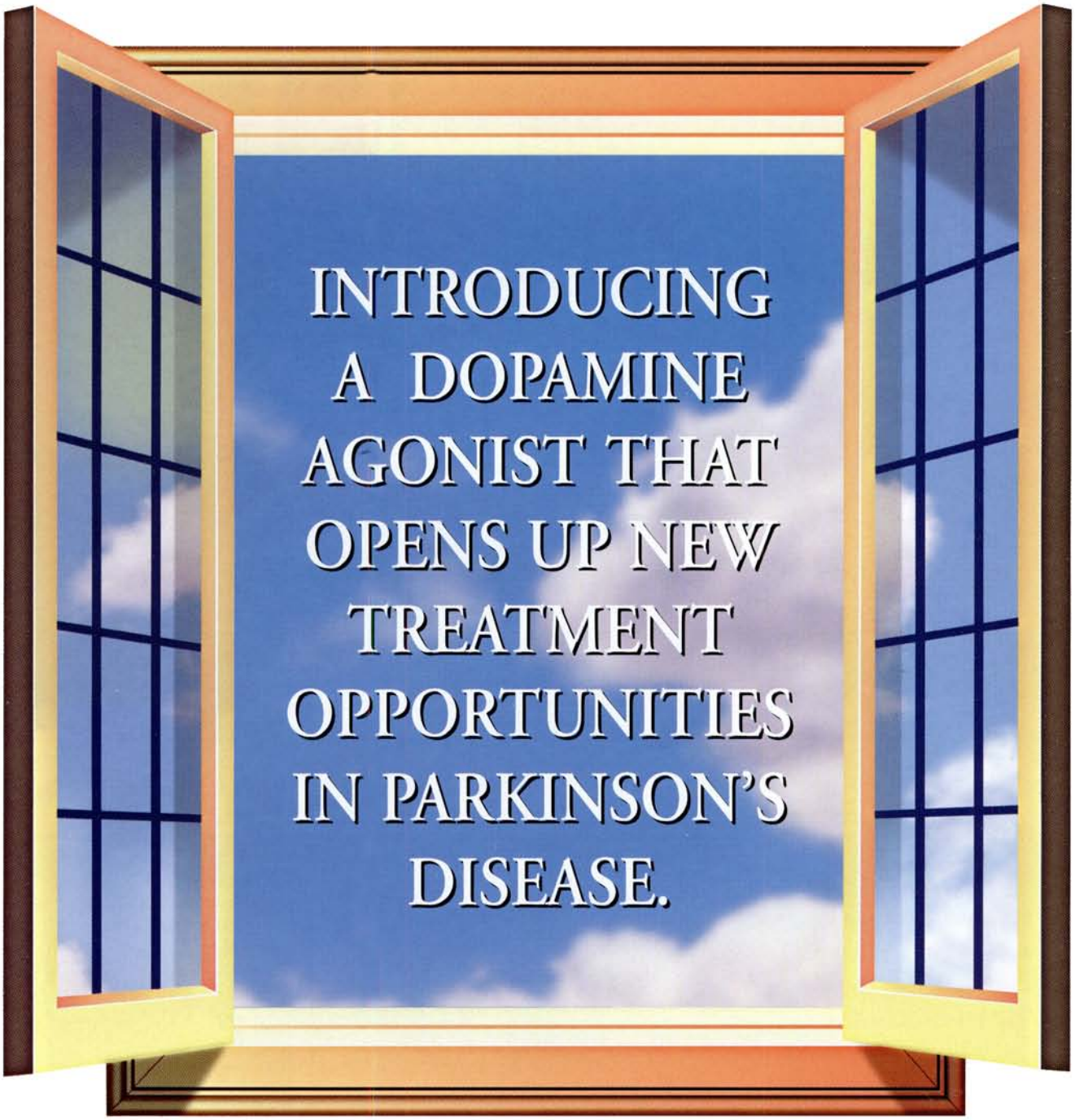
Pr BETASERON®

INTERFERON BETA-1b

Maintaining Independence

For an overview of Betaseron dial 1-800-422-1222, access code 400.

For brief prescribing information see pages A-32, A-33



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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.

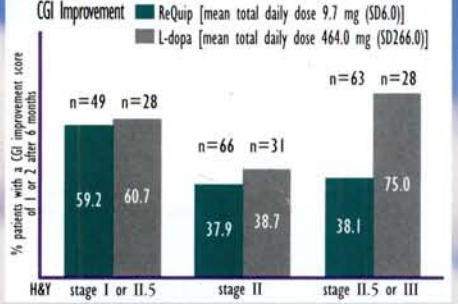
THE FIRST SELECTIVE, NON-ERGOLINE DOPAMINE AGONIST.

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]



	stage I or II.5	stage II	stage II.5 or III
Odds ratio	0.80	1.15‡	0.11
95% CI	(0.28, 2.26)	(0.43, 3.07)	(0.04, 0.35)

† 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

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REQUIP™

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

▶▶▶▶▶▶▶ TO ADJUNCT THERAPY

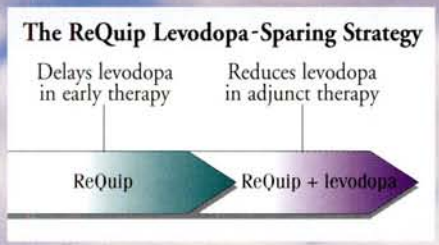
CAN DELAY THE INTRODUCTION OF LEVODOPA

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]

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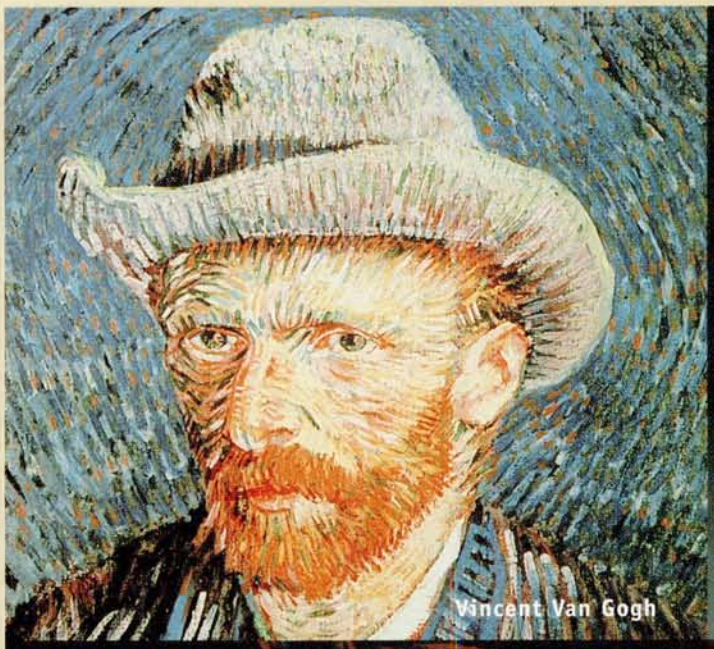
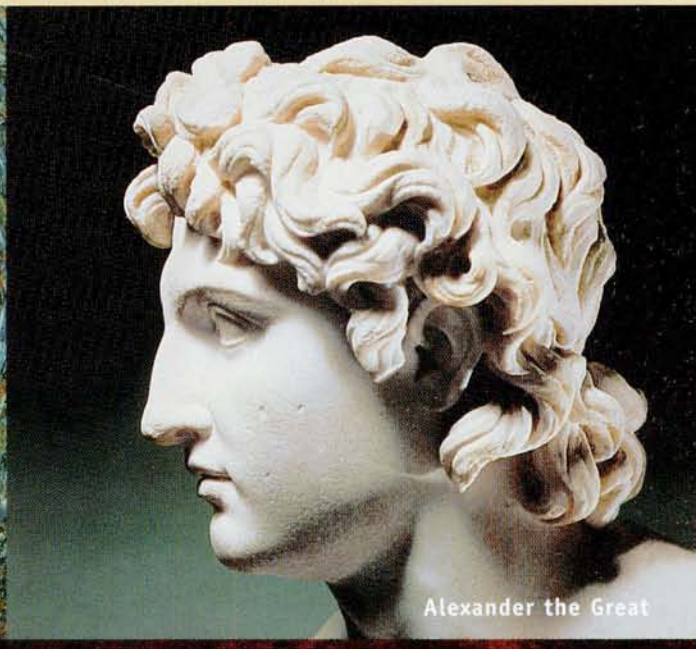
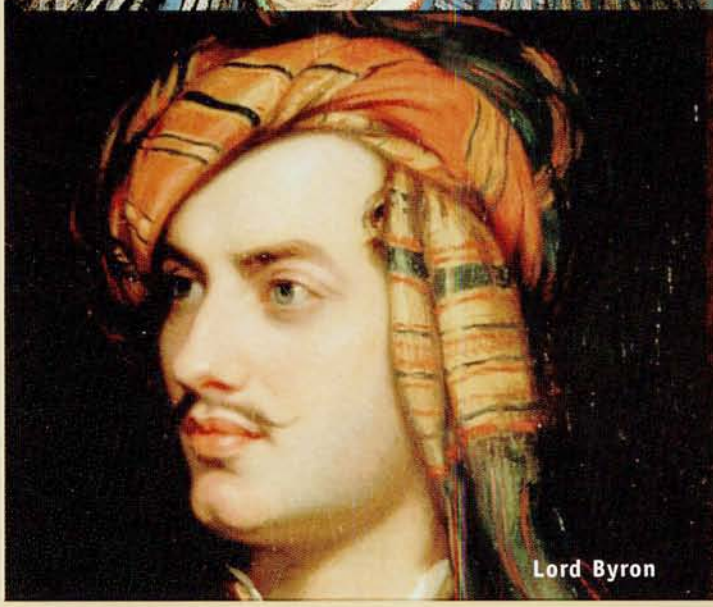
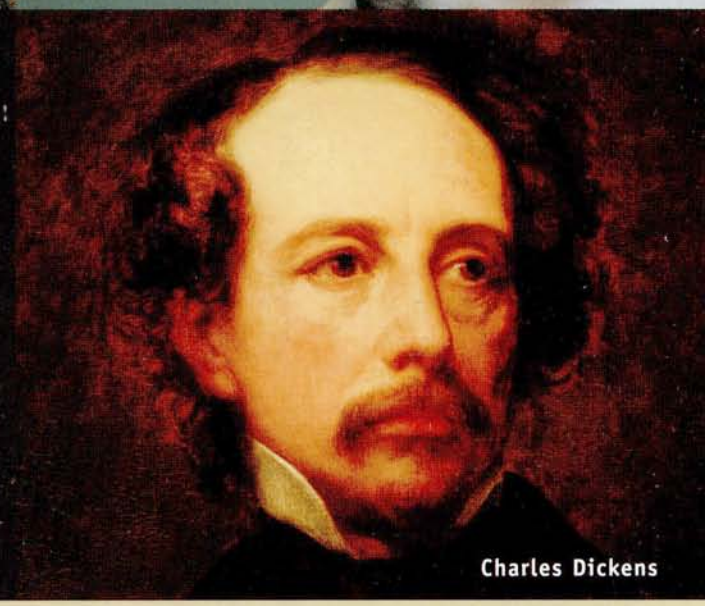
For brief prescribing information see pages A-36, A-37

NEW IN EPILEPSY. NOW ON B.C., ALBERTA, SASKATCHEWAN,

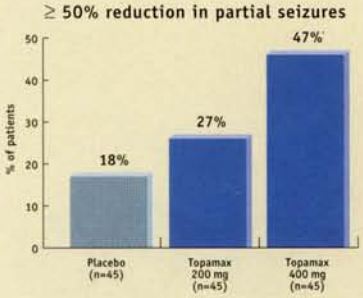








ONCE IT TOOK EXCEPTIONAL EFFORT OR EXTRAORDINARY
LUCKILY, YOUR PATIENTS CAN NOW



Adapted from reference 1. Double-blind trial of placebo vs. TOPAMAX b.i.d. as adjunctive therapy in 181 patients with refractory partial onset epilepsy receiving one or two other AEDs. *p=0.013.

Improved control over a wide range of seizure types

- TOPAMAX is indicated as adjunctive therapy for the management of patients with epilepsy who are not satisfactorily controlled with conventional therapy. There is limited information on the use of TOPAMAX in monotherapy at this time.
- High responder rate: 27%(200mg/day, n=45) and 47% (400mg/day, n=45) of patients experienced ≥ 50% reduction in partial seizures(16 week study)[1]
- Effective control for patients with secondarily generalized tonic-clonic seizures: 36% of patients experienced a 100% reduction (200-600 mg, n=42, 16 week study)[1]
- Unique three-way mechanism of action(Na+ channel blockade, GABA potentiation, glutamate antagonism)[2]

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NOVA SCOTIA & QUEBEC FORMULARIES.

TALENT FOR PEOPLE WITH EPILEPSY TO SUCCEED. ENJOY LESS TAXING ALTERNATIVES.

- Generally well tolerated: Discontinuations due to adverse events were 10.6% at 200-400 mg/day compared to 5.8% in the placebo group (this appeared to increase at dosages above 400 mg/day)[2]
- No evidence of serious rash or aplastic anemia[2]
- Dosage adjustments to primary therapy are generally not required; patients on phenytoin showing clinical signs or symptoms of toxicity should have phenytoin levels monitored†[2]
- **Convenient BID dosing**

Favourable side effect profile
(the most common are CNS related)

	TOPAMAX 200-400 mg (n=113)	PLACEBO (n=216)
Somnolence	30.1	9.7
Dizziness	28.3	15.3
Ataxia	21.2	6.9
Psychomotor slowing	16.8	2.3
Speech disorders	16.8	2.3
Nervousness	15.9	7.4
Nystagmus	15.0	9.3
Paresthesia	15.0	4.6

†As with other AEDs, please see prescribing information for complete information on drug interactions. A 1.5%(n=1715) incidence of kidney stones has been reported.[1] In one study(n=1200), 83%(15 of 18) of patients elected to continue therapy.[1] Ensure adequate hydration and avoid concomitant use with other carbonic anhydrase inhibitors.[2] *Trademark © Janssen-Ortho Inc. 1997

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19 Green Belt Drive
North York, Ontario M3C 1L9

PAAB

TOPAMAX®
topiramate

Helping patients make more of their lives

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At Biogen, we recognize that a promise takes commitment. And we're committed to helping minimize the devastating effects of diseases like Multiple Sclerosis. As a recognized leader in the field of MS research and treatment, our ongoing mandate is to develop new therapies such as Avonex® (Interferon beta-1a), currently available in the U.S.A. and EUROPE, and support programs to help better manage this disease. But our commitment doesn't end here. At Biogen, we continue to pioneer research in many other areas including inflammatory and auto-immune disease, virology, cardiology and nephrology. We do this while never losing sight of our commitment to being a full service, patient-oriented company. At Biogen, our mission is simple: we're committed to finding solutions today, to help maintain lifestyles for tomorrow.

And that's our promise.

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Now, you can help your patients escape the prison of Parkinson's.

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Tasmar

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gets more out of levodopa so patients get more out of life.

Tasmar The first COMT* inhibitor a new class of levodopa adjunctive therapy for Parkinson's patients.[6]

COMT inhibition increases levodopa bioavailability by limiting its metabolism.[6] This helps achieve steady and continuous dopaminergic stimulation in the brain.[6]

In clinical trials involving Tasmar, the results have been impressive. Fluctuating patients experienced a significant reduction of approximately 30-50% in OFF-time with Tasmar, and an improvement in motor function.[6]

In non-fluctuators, at a dose of 200 mg, there was a 20% improvement in the activities of daily living and an improvement in motor performance.[10]

Tasmar has a very reasonable side effect profile. The most frequent adverse event was diarrhea but only 5-6% of patients discontinued therapy as a result.[6] (Overall incidence was 16-18% as compared to 8% for placebo.[6]) And Tasmar patients experienced relatively low levels of psychiatric side effects.[12]

All of these benefits come with a rapid onset of action and a very convenient fixed dosing schedule. Patients take Tasmar three times a day with or without food.[6]**

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 6 weeks for the first 6 months.[6]

Pr TASMAR®
TOLCAPONE

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

Roche

* COMT (catechol-O-methyltransferase inhibitor)
** Please refer to prescribing information

PAAB CCPP MEMBER PMAC

For brief prescribing information see pages A-42, A-43, A44
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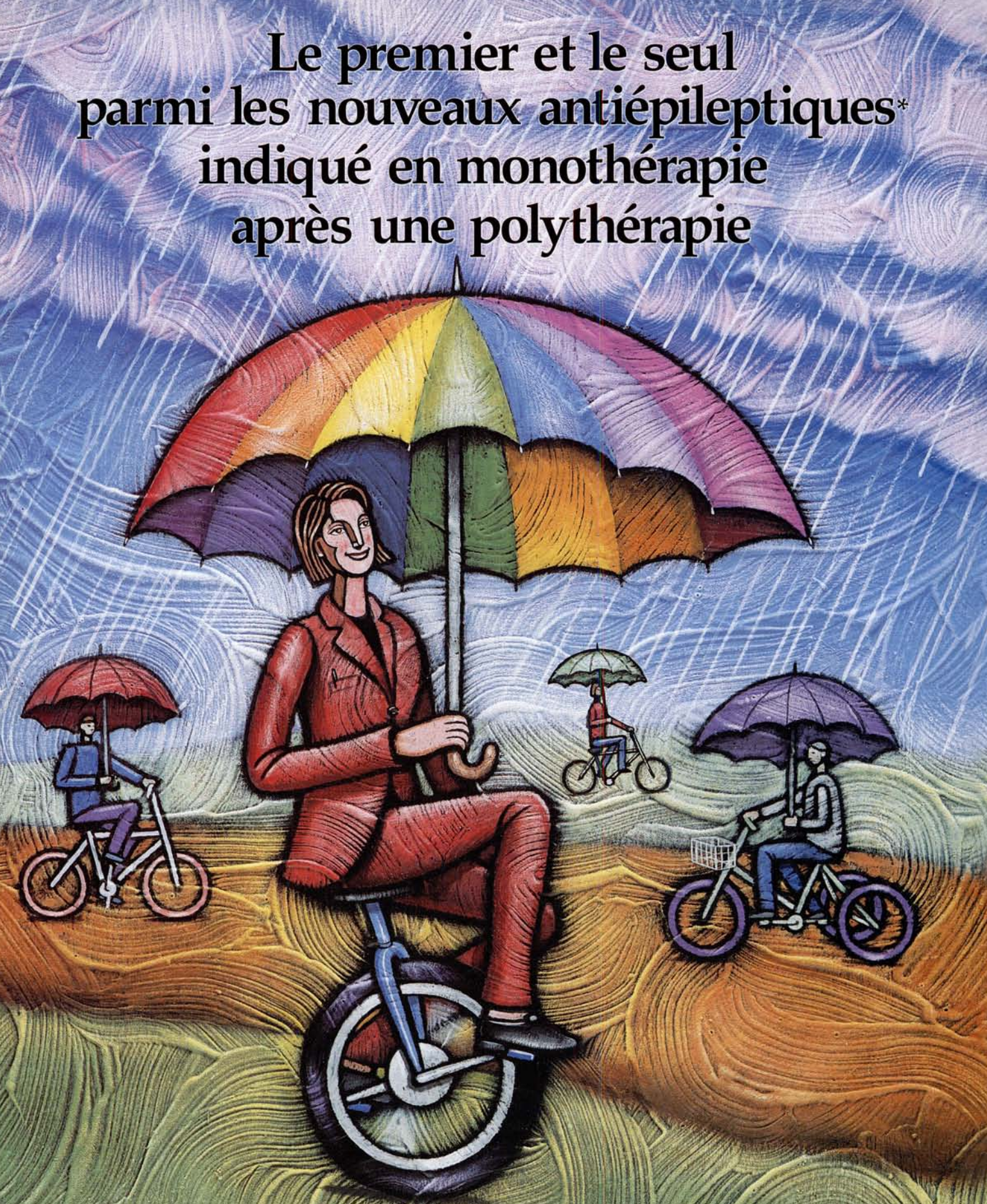
Le premier et le seul parmi les nouveaux antiépileptiques* indiqué en monothérapie après une polythérapie



*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

Lamictal®

DE LA POLYTHÉRAPIE À LA

MONOTHÉRAPIE

GlaxoWellcome

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PAAB CCPP

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Pour documentation voir pages A-34, A-35

Memory loss is often the beginning of functional decline in patients with Alzheimer's disease.[1] Now you can bring light back into the lives of your Alzheimer's patients and their families with new once-a-day ARICEPT – a cholinesterase inhibitor for the symptomatic treatment of mild to moderate Alzheimer's disease.†

Enhances cognition: ***80% of patients on ARICEPT improved or did not deteriorate (vs 58% on placebo)***

- In a 30-week study, patients showed significant cognitive improvement vs placebo, including memory, reasoning, orientation, and language[2] (ADAS-cog, $p \leq 0.0001$)

Improves patient function

- In a 30-week study, clinician's global assessment with caregiver input demonstrated significant improvement vs placebo in patient function across these major areas: general function, cognition, behaviour, and activities of daily living[2] (CIBIC plus, $p \leq 0.0001$)

† *ARICEPT has not been studied in patients with moderately severe or severe Alzheimer's disease. ARICEPT has not been studied in controlled clinical trials for longer than 6 months.*

‡ *It is recommended that patients with renal or hepatic disease be monitored for adverse effects. Caution is also advised when using ARICEPT in low body-weight elderly patients, especially in those ≥ 85 years old.*

§ *When used as recommended. For patients not responding after 4-6 weeks of therapy at 5 mg/day, a 10 mg once-daily dose may be considered.*

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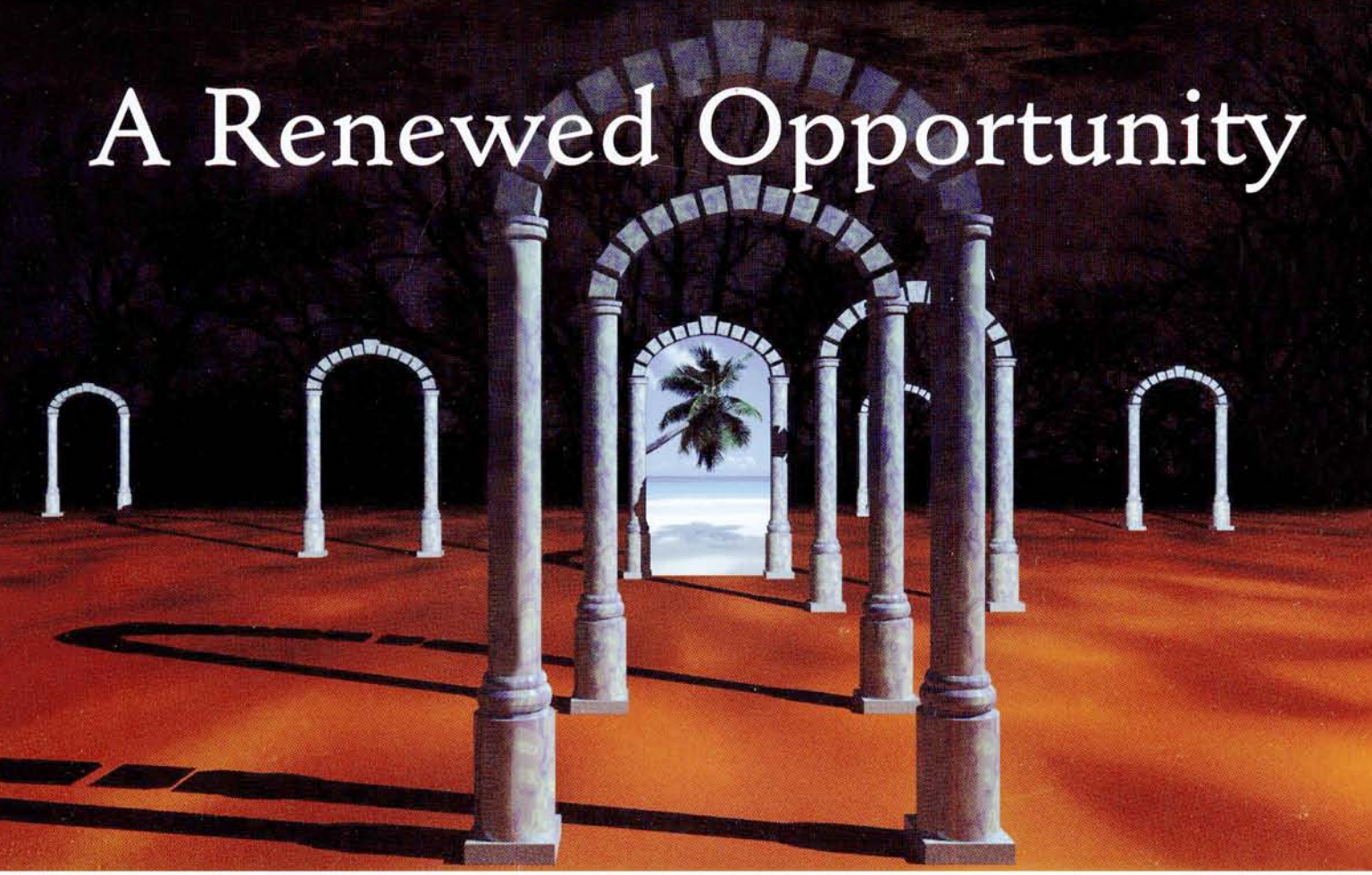
For brief prescribing information see pages A-38, A-39



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

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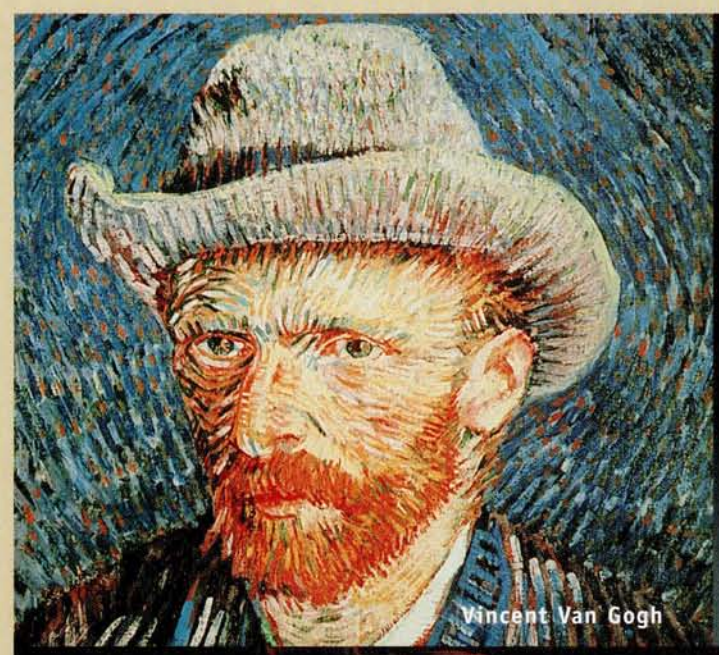
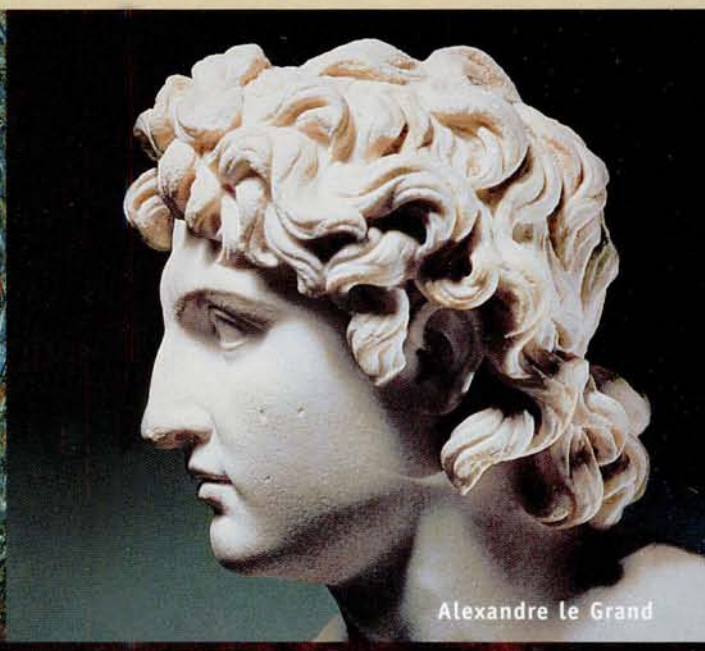
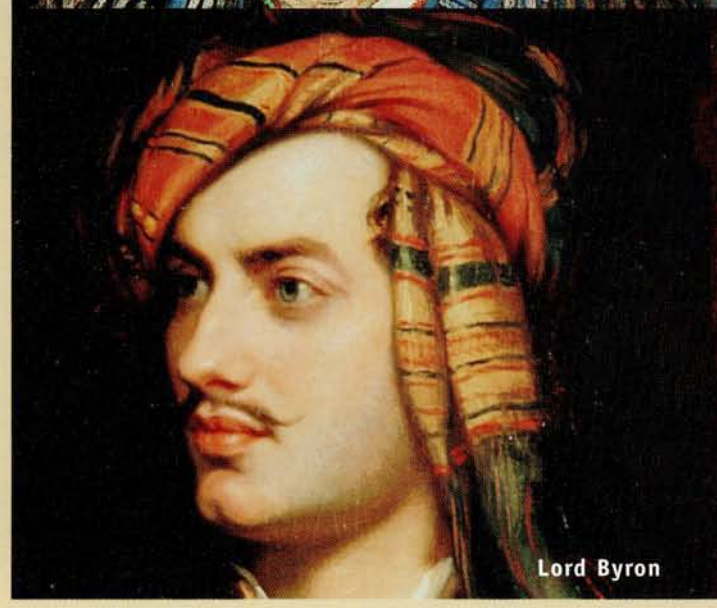
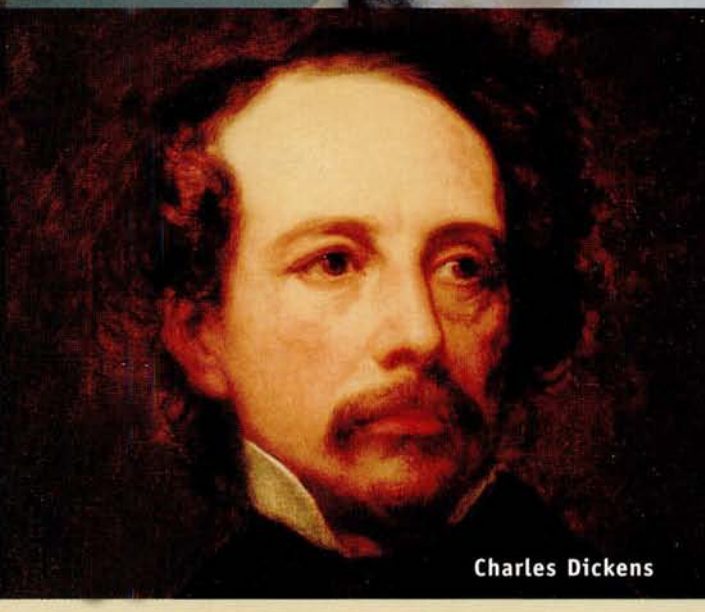
For brief prescribing information see page A-45

DU NOUVEAU EN ÉPILEPSIE. MAINTENANT REMBOURSÉ PAR LES FORMULAIRES

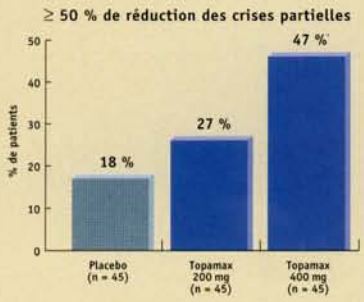








NAGUÈRE ENCORE, LA RÉUSSITE EXIGEAIT D'UN ÉPILEPTIQUE
HEUREUSEMENT POUR VOS PATIENTS, IL EXISTE



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 CCPP

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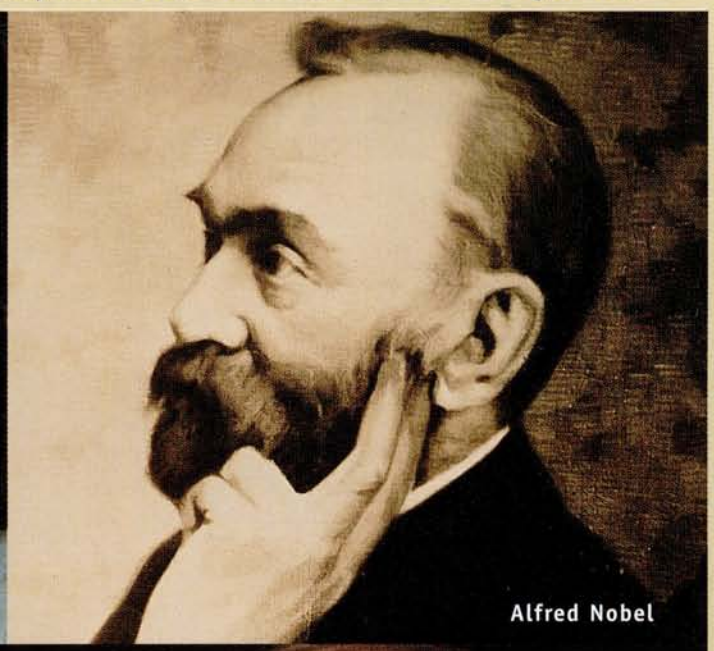
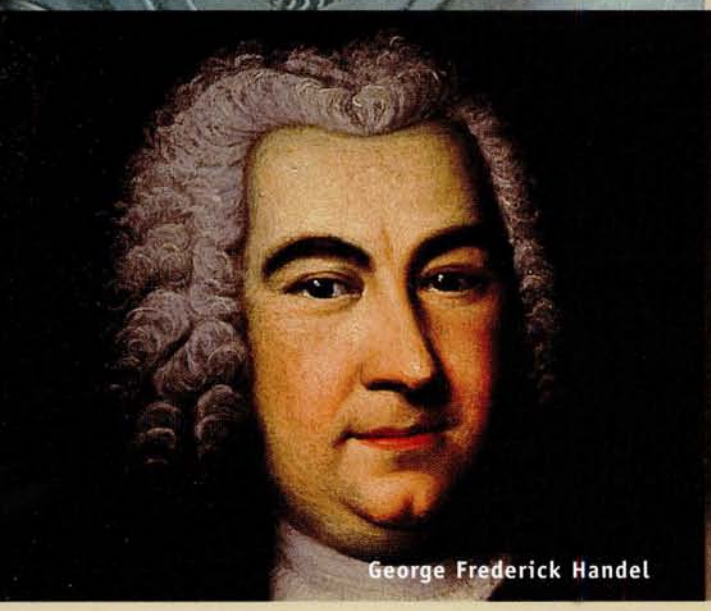
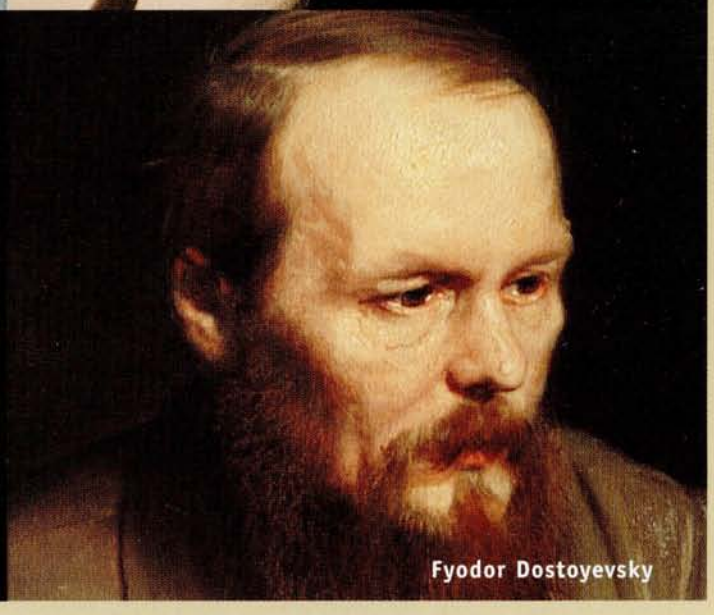
DE LA C.-B., L'ALBERTA, LA SASKATCHEWAN, LA NOUVELLE-ÉCOSSE ET DU QUÉBEC.







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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Pour documentation voir pages A-46, A-47, A-49

Maîtrise efficace des crises

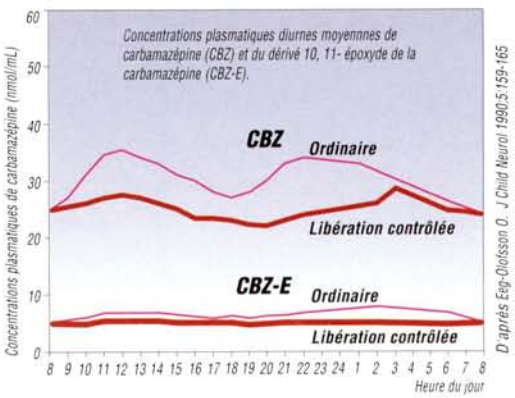
- **Bienfait clinique significatif et excellente maîtrise des crises épileptiques[1,2].**

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 ACTM

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Pour documentation voir pages A-30, A-31