

The Canadian Journal of Neurological Sciences

Le Journal Canadien des Sciences Neurologiques



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November 1992

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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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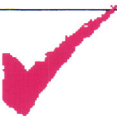
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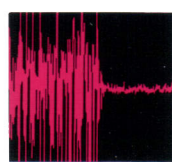
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As an adjunct to levodopa (with or without a decarboxylase inhibitor) in the management of the signs and symptoms of Parkinson's disease.

In newly diagnosed patients before symptoms begin to affect the patient's social or professional life, at which time more efficacious treatment becomes necessary.

Contraindications:

In patients with known hypersensitivity to Eldepryl, Eldepryl should not be used in patients with active peptic ulcer, extrapyramidal disorders such as excessive tremor or tardive dyskinesia, or patients with severe psychosis or profound dementia. Eldepryl should not be used with meperidine (Demerol or other trade names). This contraindication is often extended to other opioids.

Warnings (Selective vs non-selective inhibition of MAO-B):

Eldepryl should not be used at daily doses exceeding those recommended (10 mg/day) because of the risks associated with non-selective inhibition of MAO. It is prudent, in general, to avoid the concomitant use of Eldepryl and fluoxetine (Prozac).

Warnings to patients:

Patients should be advised of the possible need to reduce levodopa dosage after the initiation of Eldepryl therapy. The patients should be advised not to exceed the daily dose of 10 mg. The risk of using higher doses of Eldepryl should be explained, and a brief description of the "hypertensive crisis" ("cheese reaction") provided.

Precautions:

Some patients given Eldepryl may experience an exacerbation of levodopa associated side effects, presumably due to the increased amounts of dopamine reacting with supersensitive post-synaptic receptors. These effects may often be mitigated by reducing the dose of levodopa by 10-30%.

NURSING MOTHERS: It is not known whether Eldepryl is excreted in human milk. Because many drugs are excreted in human milk, consideration should be given to discontinuing the use of all but absolutely essential drug treatments in nursing women.

PEDIATRIC USE: The effects of Eldepryl in children under 18 have not been evaluated.

Laboratory Tests:

No specific laboratory tests are essential for management of patients on Eldepryl. Transient or continuing abnormalities with tendency for elevated values in liver function tests have been described in long term therapy. Although serious hepatic toxicity has not been observed, caution is recommended in patients with a history of hepatic dysfunction. Periodic routine evaluation of all patients is however appropriate.

Drug Interactions:

The occurrence of stupor, muscular rigidity, severe agitation and elevated temperature has been reported in a man receiving selegiline and meperidine, as well as other medications. These symptoms were resolved over days when the combination was discontinued. This case is typical of the interaction of meperidine and MAOis. Other than the possible exacerbation of side effects in patients receiving levodopa therapy, no interactions attributed to the combined use of ELDEPRYL and other drugs have been reported. It is also prudent to avoid the combination of ELDEPRYL and fluoxetine (Prozac).

Use during Pregnancy:

The use of Eldepryl during pregnancy has not been established. Therefore, Eldepryl should be given to a pregnant woman only if the potential benefits outweigh the potential risks.

Adverse reactions:

A) IN COMBINATION WITH LEVODOPA
THE SIDE EFFECTS OF ELDEPRYL ARE USUALLY THOSE ASSOCIATED WITH DOPAMINERGIC EXCESS. ELDEPRYL MAY POTENTIATE THE SIDE EFFECTS OF LEVODOPA, THEREFORE ADJUSTMENT OF THE DOSAGE OF LEVODOPA MAY BE REQUIRED. ONE OF THE MOST SERIOUS ADVERSE REACTIONS REPORTED WITH ELDEPRYL USED AS AN ADJUNCT TO LEVODOPA THERAPY ARE HALLUCINATIONS/CONFUSION, PARTICULARLY VISUAL HALLUCINATIONS.

Other reactions include nausea, dizziness, faintness, abdominal pain, dry mouth, vivid dreams, dyskinesias and headache.

B) IN MONOTHERAPY

The incidence of adverse reactions occurring in trials using Eldepryl as monotherapy has not been fully reported to date. Serious adverse reactions include depression, chest pain, myopathy and diarrhea. Other reported adverse reactions include insomnia, headache, nausea, dizziness and vertigo.

In prospective clinical trials, the following adverse effects (listed in decreasing order of frequency), led to the discontinuation of Eldepryl: Nausea, hallucinations, confusion, depression, loss of balance, insomnia, orthostatic hypotension, increased akinetic involuntary movements, agitation, arrhythmia, bradykinesia chorea, delusions, hypertension, new or increased angina pectoris and syncope. Events reported only rarely as a cause of discontinuation

of treatment include anxiety, drowsiness/lethargy, nervousness, dystonia, increased episodes of freezing, increased tremor, weakness, excessive perspiration, constipation, weight loss, burning lips/mouth, ankle edema, gastrointestinal bleeding and hair loss.

Dosage:

The recommended dosage of Eldepryl as monotherapy in newly diagnosed patients, or as adjunct to levodopa (usually with a decarboxylase inhibitor) is 10 mg per day administered as divided doses of 5 mg each taken at breakfast and lunch. When ELDEPRYL adjunctive therapy is added to the existing levodopa therapeutic regime, a reduction, usually of 10 to 30% in the dose of levodopa (in some instances a reduction in the dose of Eldepryl to 5 mg/day) may be required during the period of adjustment of therapy or in case of exacerbation of adverse effects. Doses higher than 10 mg per day should not be used. There is no evidence that additional benefit will be obtained from the administration of higher doses. Furthermore, higher doses will result in a loss of selectivity of Eldepryl towards MAO-B with an increase in the inhibition of type MAO-A.

There is an increased risk of adverse reactions with higher doses as well as an increased risk of hypertensive episode ("cheese reaction")

Supplied:

Eldepryl 5 mg tablets, available in bottles of 60 tablets.

References:

1. The Parkinson Study Group. Effect of Deprenyl on the Progression of Disability in Early Parkinson's Disease. *New Eng Journ* 321, 1364-1371, November 1989.
2. Eldepryl (selegiline hydrochloride) Product Monograph, December 1990.
3. Myllyla VV, Sotaniemi KA, Vuorinen JA, Heinonen EH. Selegiline as initial treatment in de novo parkinsonian patients. *Neurology* 1992; 42, 339-343.
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6. Langston JW in Lees A. Deprenyl in Parkinson's Disease: Guidelines for Clinicians. *North American Round Table Series, No. 1, 1988, 1-26.*
7. DuVoisin RC in Lees A. Deprenyl in Parkinson's Disease: Guidelines for Clinicians. *North American Round Table Series, No. 1, 1988, 1-26.*

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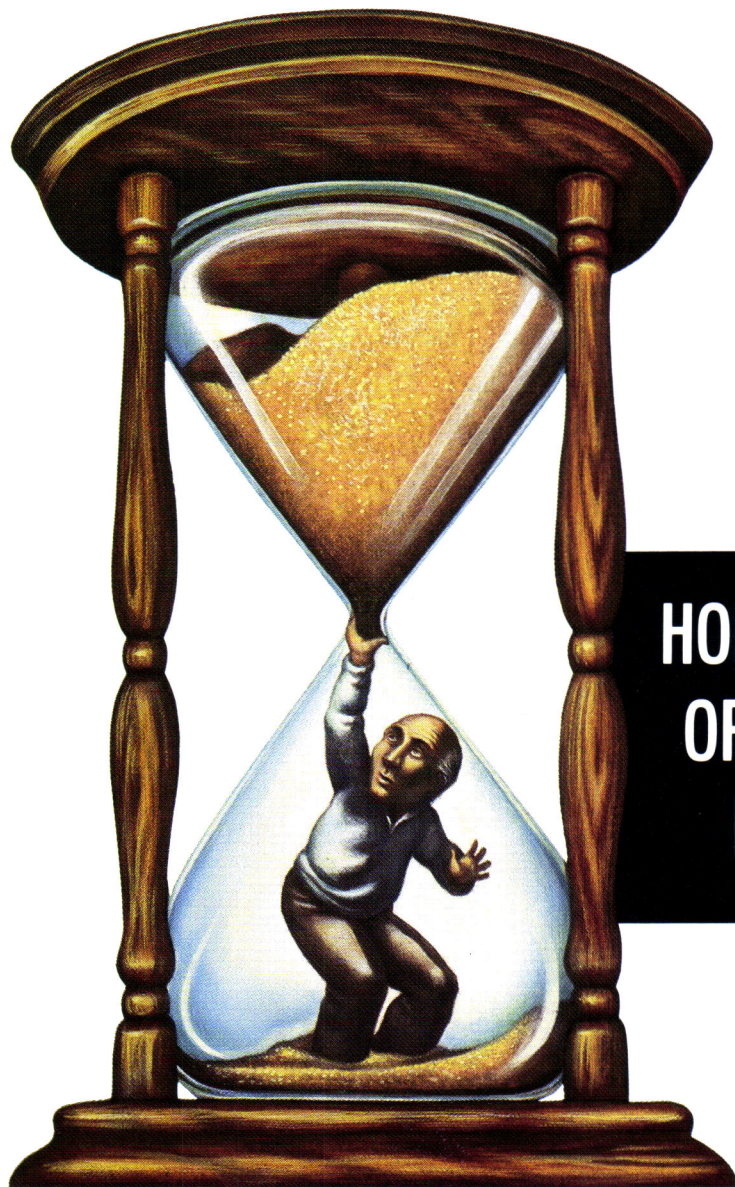
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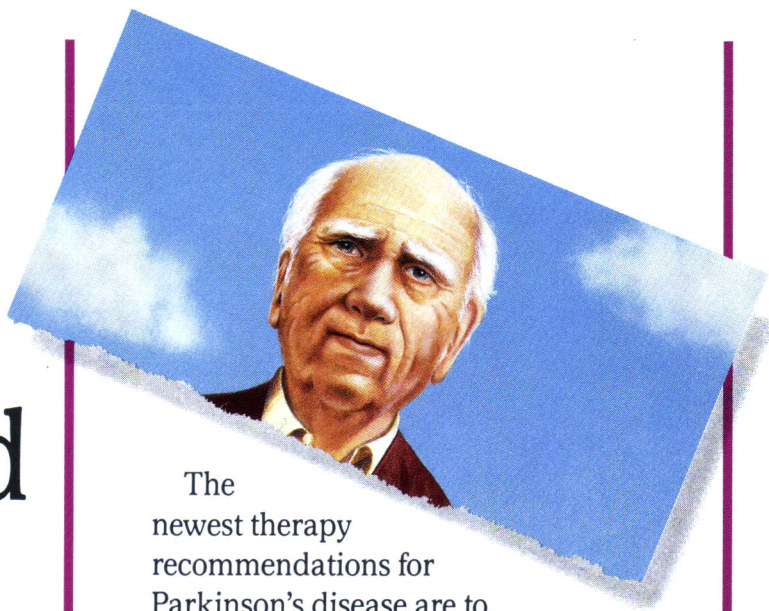
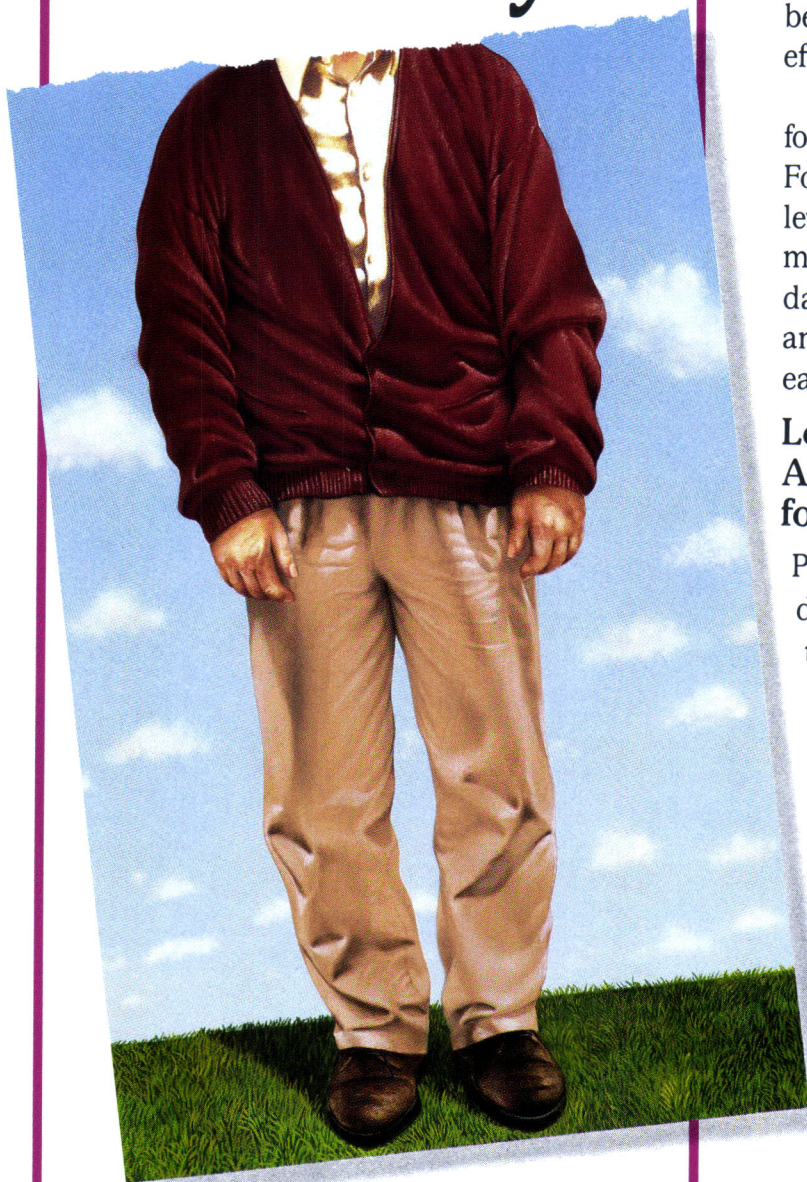


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On peut facilement reconnaître le jeune patient épileptique traité au Tegretol® CR.

Excellent contrôle des crises

Tegretol CR (carbamazépine à libération contrôlée) maîtrise les crises chez de nombreux patients, causant peu d'impact sur la fonction cognitive^{1,2,3,4}. Contrairement aux médicaments tels la phénytoïne, Tegretol CR permet à de nombreux patients de penser clairement et de donner le meilleur d'eux-mêmes^{1,2,3,4}.

Taux sanguins uniformes

Tegretol CR cause moins de "hauts et de bas" dans les taux sanguins que le Tegretol conventionnel. Les effets secondaires sont ainsi réduits et le modèle de fonction cognitive est plus stable^{5,6}.

Posologie b.i.d. commode

Lorsque vous instituez ou remplacez un traitement, pensez au Tegretol CR. Il est présenté en comprimés à 200 mg et 400 mg facilement divisibles pour une plus grande souplesse d'administration et améliorer l'observance du patient.



TEGRETOL® CR.
Aide les épileptiques à réaliser leur plein potentiel.

Gelgy Mississauga, Ontario L5N 2W5

MEMBRE
FAAD
CCPP
ADMA
G-92111F

Pour documentation voir pages xxi

(xiii)



*There's only one thing
your TIA patients want from a
stroke prevention therapy.*

Tomorrow.

What patients at risk want most is the reassurance everything possible is being done to prevent another event.

By making Ticlid a part of your patients' treatment, you can give them that reassurance.

Because for non-cardiogenic thromboembolic stroke – the most common form of the disease¹ – there is no therapy proven more effective than Ticlid.

In two landmark studies, Ticlid has been shown to significantly reduce the risk of both initial and recurrent stroke.^{2,3}

During the critical first year after a TIA, Ticlid reduced the incidence of stroke by nearly half relative to ASA. And its superiority was maintained over a 5 year term, in women as well as men.^{2,4}

Ticlid also performed significantly better than placebo in

recurrent stroke, and remains the only therapy indicated for the prevention of initial and recurrent stroke in both men and women.^{3,5}

With Ticlid, side effects have been shown to be manageable, transient and to occur early in therapy, with most common side effects being relieved by a temporary dose reduction.^{2,6}

In clinical trials, there was a 2.4% incidence of neutropenia (0.8% severe). Upon immediate discontinuation of therapy, the neutrophil count usually returned to normal within one to three weeks.^{2,3}

To manage the condition requires regular WBC monitoring every two weeks for the first three months of therapy.⁶

Ticlid. After you tell your patients about the risk of stroke, tell them about Ticlid.

And let them get on with their lives.

Ticlid Information Hotline
1-800-263-8918
Dosage: 250 mg BID with meals

Ticlid[®]

ticlopidine hydrochloride 250 mg tablets

*Nothing protects patients
from stroke more effectively.*



SYNTEX[®] PARS
DCPP

For brief prescribing information see page xvii



VALPROATE: THE GROWTH OF EXPERIENCE IN PRIMARY GENERALIZED EPILEPSY

For years, valproate has been regarded as an excellent choice for the control of absence seizures.^{1,2}

In addition to its proven efficacy in simple and complex absence seizures,^{2,3} valproate has been shown to be as effective as previous standards in controlling primary generalized seizures with tonic-clonic manifestations.⁴ Epival* tablets have a special enteric-coating designed to reduce GI upset⁵ and are bioequivalent to Depakene*.⁶

Compared to most antiepileptics, Epival has been shown to have minimal effects on behaviour and cognition⁷ and relatively less interactions with commonly-prescribed medications.^{8,9}

Today's consensus favours monotherapy wherever possible. And no other single agent can provide this spectrum of efficacy in the management of primary generalized seizures.¹



 **Epival***
divalproex sodium

HELPING TO MEET TODAY'S THERAPEUTIC GOALS



PHARMACEUTICAL PRODUCTS DIVISION
ABBOTT LABORATORIES, LIMITED
MONTREAL, CANADA

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