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Sciences Neurologiques

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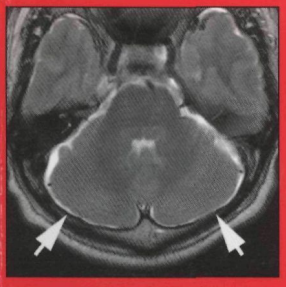

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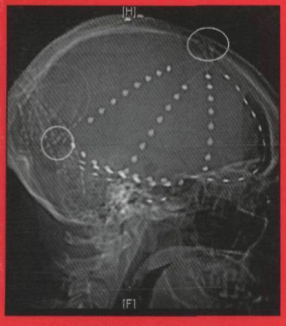

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41st CANADIAN CONGRESS OF NEUROLOGICAL SCIENCES
June 13-17, 2006
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The official Journal of: The Canadian Neurological Society, The Canadian Neurosurgical Society, The Canadian Society of Clinical Neurophysiologists, The Canadian Association of Child Neurology

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Volume 33 Number 2 May 2006

THE CANADIAN JOURNAL OF Neurological Sciences

LE JOURNAL CANADIEN DES Sciences Neurologiques

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THE CANADIAN JOURNAL OF Neurological Sciences

LE JOURNAL CANADIEN DES Sciences Neurologiques

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La Société Canadienne de Neurochirurgie

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Journals

Rose ME, Huerbin MB, Melick J, Marion DW, Palmer AM, Schiding JK, et al. Regulation of interstitial excitatory amino acid concentrations after cortical contusion injury. Brain Res. 2002;935(1-2):40-6.

Chapter in a book

Meltzer PS, Kallioniemi A, Trent JM. Chromosome alterations in human solid tumors. In: Vogelstein B, Kinzler KW, editors. The genetic basis of human cancer. New York: McGraw-Hill; 2002. p. 93-113.

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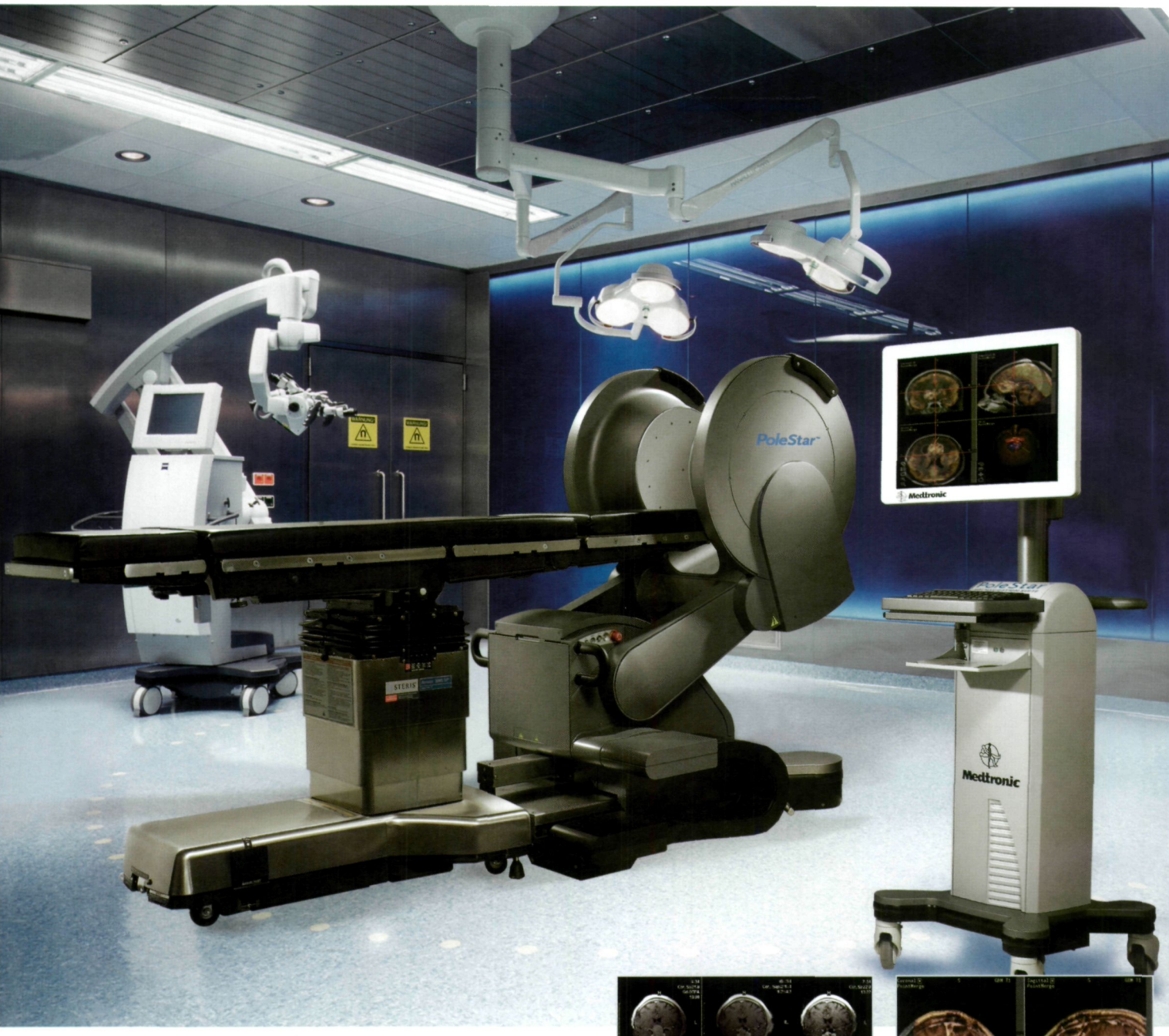

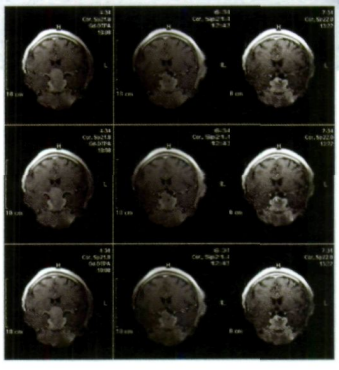

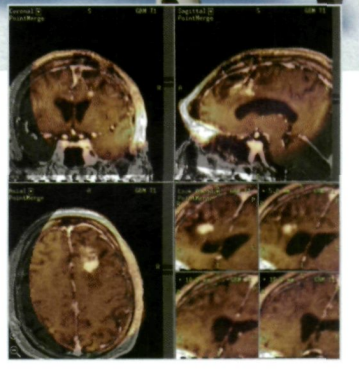

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Betaseron®: Demonstrated long-term efficacy*

In a major clinical trial, Betaseron® patients† experienced:

- 31% reduction in annual exacerbation rate vs. the placebo group (p=0.0001)[1,‡]
- Significant reduction in moderate or severe attacks per year vs. the placebo group (p=0.001)[1,§]
- Significantly fewer lesions on MRI (p=0.0001)[1,**]

16-year study ongoing[2]

The MS Pathways™ support program offers Betaseron® patients a caring and convenient approach to MS therapy – right from the start

- Multilingual nurse telephone support line for personalized assistance
- In-home Betaseron® injection training program
- Medical travel assistance and related services

*Double-blind, multi-clinic (11 site) randomized, parallel, placebo-controlled clinical investigation, two-year duration, subjects received 1.6 MIU Betaseron® (n=125), 8 MIU Betaseron® (n=124) or placebo (n=123).
†Treated with 8 MIU Betaseron®, self-administered, every other day.
‡0.9 vs. 1.31
§Mean of 19.5 moderate or severe exacerbation days per patient vs. 41.1 days
**0.9% decrease in MRI lesion area vs. 21.4% increase in placebo group

BETASERON®
INTERFERON BETA-1b
Act early. Act strong.

BETASERON® (interferon beta-1b) is indicated for the reduction of the frequency of clinical exacerbations in ambulatory patients with relapsing-remitting multiple sclerosis (RRMS) and for the slowing of the progression in disability and the reduction of the frequency of clinical exacerbations in patients with secondary-progressive multiple sclerosis (SPMS). The safety and efficacy of BETASERON® in primary-progressive MS (PPMS) have not been evaluated. Efficacy of treatment for longer than two years has not been substantially demonstrated in RRMS. The most common side effects related to BETASERON® in patients with RRMS are: flu-like symptom complex (76%); fever (59%); chills (46%); injection site reactions (85%); myalgia (44%); asthenia (49%) and malaise (15%).

For complete warnings and precautions, please refer to the product monograph available to healthcare professionals upon request.

References: 1. Betaseron® Product Monograph, June 2004. 2. Data on file. Berlex Canada Inc.

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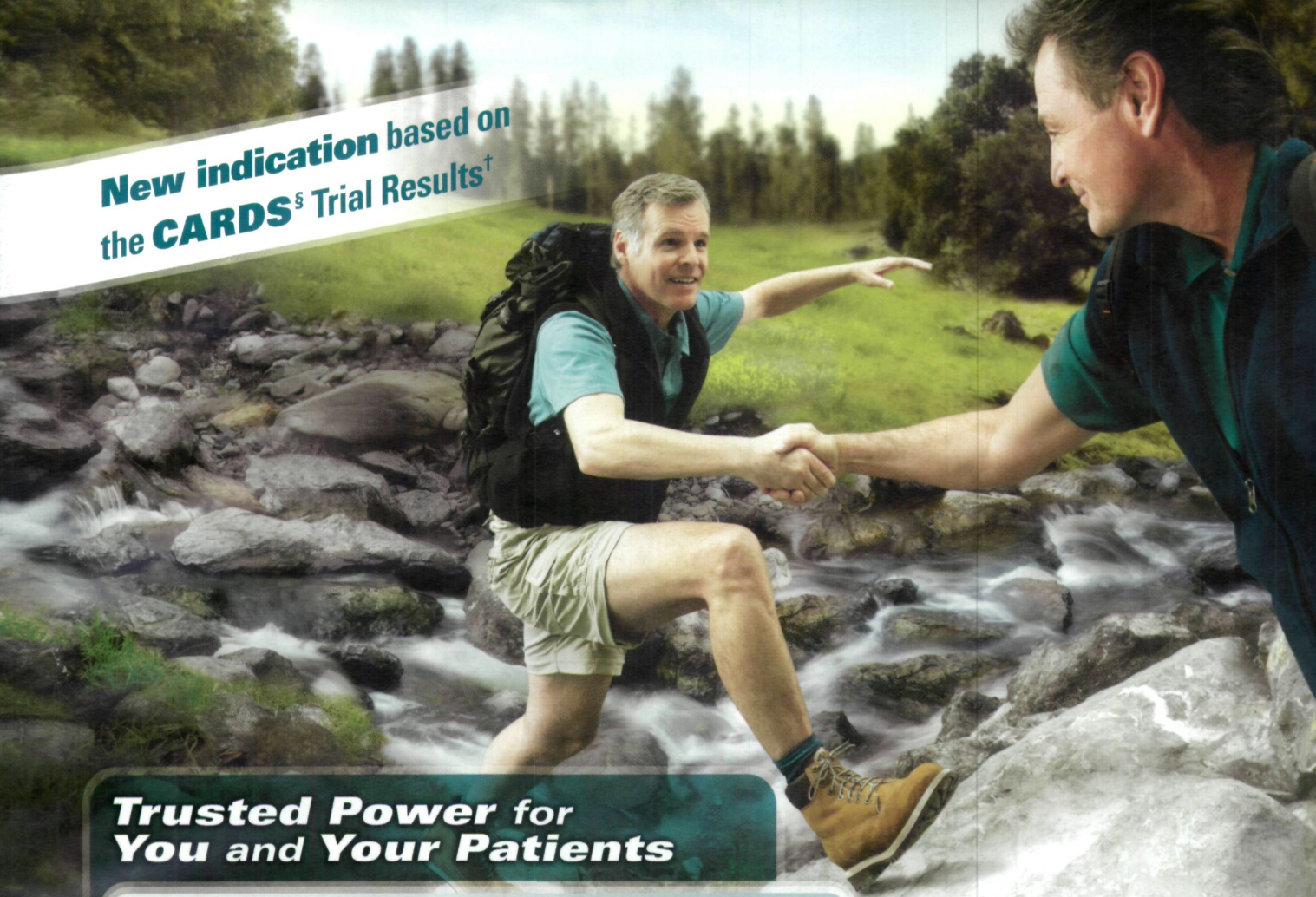

New indication based on the CARDS§ Trial Results†

Trusted Power for You and Your Patients

LIPITOR® offers up to 50% LDL-C reduction at starting doses of 10, 20 and 40 mg[1¥]

¥ When a >45% LDL-C reduction is required, patients may be started at 40 mg o.d.

Power

AND is indicated to reduce the risk of MI and stroke in patients with type 2 diabetes and hypertension without CHD but with other risk factors[1]

Evidence

ONLY LIPITOR® is supported by 5 million patient-years of therapy in Canada[2£]

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LIPITOR®
atorvastatin calcium
tablets

***power** you can **trust**™*

10 mg 20 mg 40 mg 80 mg

LIPITOR is an HMG-CoA reductase inhibitor (statin). LIPITOR is indicated as an adjunct to lifestyle changes, including diet, for the reduction of elevated total cholesterol (total-C), LDL-C, TG and apolipoprotein B (apo B) in hyperlipidemic and dyslipidemic conditions (including primary hypercholesterolemia, combined [mixed] hyperlipidemia, dysbetalipoproteinemia, hypertriglyceridemia and familial hypercholesterolemia) when response to diet and other non-pharmacological measures alone has been inadequate.

LIPITOR also raises HDL-cholesterol and therefore lowers the LDL-C/HDL-C and total-C/HDL-C ratios (Fredrickson Type IIa and IIb dyslipidemia).

LIPITOR is indicated to reduce the risk of myocardial infarction in adult hypertensive patients without clinically evident coronary heart disease, but with at least three additional risk factors for coronary heart disease such as age ≥55 years, male sex, smoking, type 2 diabetes, left ventricular hypertrophy, other specified abnormalities on ECG, microalbuminuria or proteinuria, ratio of plasma total cholesterol to HDL-cholesterol ≥6 or premature family history of coronary heart disease.

† LIPITOR is also indicated to reduce the risk of myocardial infarction and stroke in adult patients with type 2 diabetes mellitus and hypertension without clinically evident coronary heart disease, but with other risk factors such as age ≥55 years, retinopathy, albuminuria or smoking.

Very rare cases of rhabdomyolysis with acute renal failure secondary to myoglobinuria have been reported with LIPITOR and with other HMG-CoA reductase inhibitors.

Patients who develop any signs or symptoms suggestive of myopathy should have their CK levels measured. LIPITOR therapy should be discontinued if markedly elevated CK levels are measured or myopathy is diagnosed or suspected.

See Prescribing Information for complete warnings, precautions, dosing and administration.

Less than 2% of patients discontinued therapy due to adverse experiences. Most common adverse effects vs. placebo occurring in patients at an incidence ≥1% were constipation (1% vs. 1%), diarrhea (1% vs. 1%), dyspepsia (1% vs. 2%), flatulence (1% vs. 2%), nausea (1% vs. 0%), headache (1% vs. 2%), pain (1% vs. <1%), myalgia (1% vs. 1%) and asthenia (1% vs. <1%). The adverse events reported in ≥1% of boys and postmenarchal girls (10-17 years of age) were abdominal pain, depression and headache.

LIPITOR is contraindicated: During pregnancy and lactation; active liver disease or unexplained persistent elevations of serum transaminases exceeding 3 times the upper limit of normal; hypersensitivity to any component of this medication.

The dosage of LIPITOR should be individualized according to the baseline LDL-C, total-C/HDL-C ratio and/or TG levels to achieve the recommended target lipid values at the lowest dose needed to achieve LDL-C target.

Caution should be exercised in severely hypercholesterolemic patients who are also renally impaired, elderly or are concomitantly being administered digoxin or CYP 3A4 inhibitors.

Liver function tests should be performed before the initiation of treatment, and periodically thereafter.

If increases in alanine aminotransferase (ALT) or aspartate aminotransferase (AST) show evidence of progression, particularly if they rise to greater than 3 times the upper limit of normal and are persistent, the dosage should be reduced or the drug discontinued.

LIPITOR, as well as other HMG-CoA reductase inhibitors, should be used with caution in patients who consume substantial quantities of alcohol and/or have a past history of liver disease.

§ CARDS = Collaborative Atorvastatin Diabetes Study.

£ A patient-year represents the total time of exposure to LIPITOR as defined by the sum of each patient's time on LIPITOR.[3]

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Life is our life's work

References: 1. LIPITOR (atorvastatin calcium) Product Monograph, Pfizer Canada Inc., November 2005. **2.** IMS Health, IMS MIDAS™ (Standard Units: Year 1997 through to April 2005). **3.** Simon Day. *Dictionary for Clinical Trials*, 1999, John Wiley & Sons Ltd. 137-38.

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For brief prescribing information see pages A-24, A-25

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BERLEX
et la médecine avance

Betaseron®
Efficacité à long terme éprouvée*

Durant une étude clinique d'importance, les patients† prenant Betaseron ont présenté :

- une réduction de 31 % de leur taux annuel de poussées par rapport aux patients du groupe placebo (p = 0,0001)[1,‡]
- une diminution significative du nombre annuel de leurs poussées modérées ou graves par rapport aux patients du groupe placebo (p = 0,0001)[1,§]
- un nombre significativement moindre de lésions observables à l'IRM (p = 0,0001)[1,**]

Étude en cours depuis 16 ans[2]

SEP LeParcours offre aux patients atteints de SEP prenant Betaseron un programme de soutien à visage humain et une démarche thérapeutique pratique – dès le début

- Ligne d'aide où du personnel infirmier multilingue offre un service personnalisé
- Programme de formation à domicile sur l'injection de Betaseron
- Assistance médicale en voyage et services associés

* Étude clinique multicentrique (11 centres) parallèle, randomisée, à double insu et contrôlée par placebo, d'une durée de deux ans, menée auprès de patients recevant 1,6 MUI de Betaseron (n = 125), 8 MUI de Betaseron (n = 124) ou un placebo (n = 123).
† Traités par 8 MUI de Betaseron auto-administrés tous les deux jours
‡ 0,9 vs 1,31
§ Moyenne de 19,5 jours de poussées modérées ou graves par patient vs 41,1 jours
** Diminution de 0,9 % de l'étendue des lésions observables à l'IRM vs une augmentation de 21,4 % dans le groupe placebo

BETASERON®
INTERFÉRON BÊTA-1b

Agir tôt. Agir en force.

BETASERON (interféron bêta-1b) est indiqué pour réduire la fréquence des poussées cliniques chez les patients ambulatoires atteints de sclérose en plaques rémittente (SEP) et pour ralentir la progression de l'incapacité et réduire la fréquence des poussées cliniques 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 de la SEP rémittente au-delà de deux ans. Chez les patients atteints de SEP rémittente, les effets indésirables les plus courants liés à l'utilisation de BETASERON sont : syndrome pseudo-grippal (76 %) ; fièvre (59 %) ; frissons (46 %) ; réactions au point d'injection (85 %) ; myalgie (44 %) ; asthénie (49 %) et malaise (15 %).

Pour plus de renseignments sur les mises en garde et les précautions, veuillez consulter la monographie du produit fournie sur demande aux professionnels de la santé.
Références : 1. Monographie de Betaseron, juin 2004. 2. Données internes. Berlex Canada inc.

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PORTRAIT OF A FAMILY HISTORY

HISTORY DOESN'T HAVE TO REPEAT ITSELF

Roger, History of angina.

Died age 57 of MI.

Alice, History of diabetes and hypercholesterolemia.

Died age 62 of complications related to stroke.

Help Reduce the Risk of CV Death by 26%[1]

($p<0.001$; 6.1% vs. 8.1%)

ALTACE® 10 mg
ramipril

GUARDING AGAINST CV DEATH

ALTACE is indicated in the treatment of essential hypertension, normally when beta-blockers and diuretics are inappropriate. It may be used alone or in association with thiazide diuretics. ALTACE is indicated following acute myocardial infarction in clinically stable patients with signs of left ventricular dysfunction to improve survival and reduce hospitalizations for heart failure.

Results from the HOPE study showed that ALTACE improved survival in patients by reducing the risk of CV death by 26% ($p<0.001$; 6.1% vs. 8.1%). ALTACE may be used to reduce the risk of MI, stroke, or CV death in patients over age 55 who are at high risk of CV events because of a history of CAD, stroke, peripheral artery disease, or diabetes accompanied by at least 1 other CV risk factor such as hypertension, elevated total cholesterol levels, low HDL levels, cigarette smoking, or documented microalbuminuria.

Like other ACE inhibitors, ALTACE is not recommended for pregnant or lactating women and should be used with caution in patients with renal insufficiency. The most frequent adverse events occurring in clinical trials with ALTACE monotherapy in hypertensive patients who were treated for at least 1 year (n=651) were: headache (15.1%); dizziness (3.7%); asthenia (3.7%); chest pain (2.0%). Discontinuation of therapy due to clinical adverse events was required in 5 patients (0.8%).

The reasons for stopping treatment were cough (ramipril 7.3% vs. placebo 1.8%); hypotension/dizziness (1.9% vs. 1.5%) and edema (0.4% vs. 0.2%).

ALTACE is the most prescribed ACEI in Canada and the ACEI most prescribed by cardiologists.*

*IMS Health Canada: Canadian CompuScript Audit, Moving Annual Total ending March 2005, Total Dispensed Prescriptions.

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NOW AVAILABLE on the Quebec formulary

New

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- Diabetic peripheral neuropathy
- Postherpetic neuralgia

Demonstrated fast, sustained neuropathic pain relief

- Rapid neuropathic pain relief shown in patients with PHN as early as Week 1[2†]
- Sustained neuropathic pain relief demonstrated over 3 months[3‡]
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- No clinically significant pharmacokinetic drug interactions reported[1¥]
- Simple dosing regimen[1]

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

The most commonly observed adverse events (twice the rate as that seen with placebo) were dose related for PHN and DPN patients in the recommended dose range of 150 mg/day to 600 mg/day: dizziness (9-37%), somnolence (6.1-24.7%), peripheral edema (6.1-16.2%) and dry mouth (1.9-14.9%).

Dosage reduction is required in patients with renal impairment as pregabalin is primarily eliminated by renal excretion.

¥ Pharmacodynamic interactions were reported with oxycodone, lorazepam, ethanol and thiazolidinedione antidiabetic agents. Please consult Prescribing Information for complete interaction information.

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

† A 13-week, multicentre, double-blind, placebo-controlled trial in 368 patients with PHN. A significant difference was shown over placebo for all doses: 150 mg/day, 300 mg/day, and 600 mg/day at week 1, $p<0.001$ for pain and $p<0.01$ for sleep.

‡ A 12-week, multicentre, randomised, double-blind, placebo-controlled study in 338 patients with neuropathic pain (DPN [n=249] or PHN [n=89]), resulting in a significant difference from placebo in the flexible dose range 150-600 mg/day ($p\leq0.05$, week 2 and $p\leq0.01$, weeks 3-12), and the fixed dose of 600 mg/day ($p\leq0.05$, week 1 and $p\leq0.01$, weeks 2-12).

For brief prescribing information see pages A-18, A-19, A-20, A-21

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