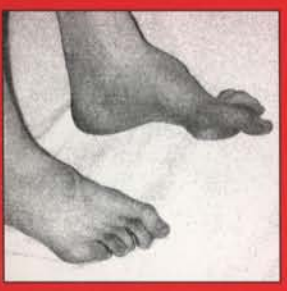
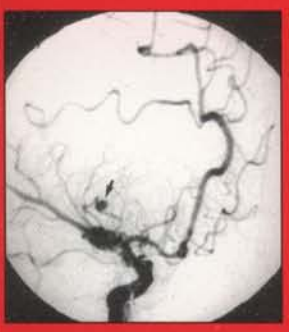
Volume 28 Number 3 August 2001

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

AN INTERNATIONAL JOURNAL / UN JOURNAL INTERNATIONAL



Charcot-Marie-Tooth Disease



Lenticulostriate Artery Aneurysm

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

Rebif®. Dose-dependent Efficacy in Relapsing MS[1]*.

Pr Rebif®

Interferon beta-1a

The most common reported adverse events are injection-site reactions and flu-like symptoms – e.g., asthenia, pyrexia, chills, arthralgia, myalgia, and headache. These tend to decrease in frequency and severity with continued treatment. Please see product monograph for full prescribing information. Evidence of safety and efficacy derived from 2-year data only.

* Rebif® is indicated for the treatment of relapsing-remitting multiple sclerosis in patients with an EDSS between 0 and 5.0, to reduce the number and severity of clinical exacerbations, slow the progression of physical disability, reduce the requirement for steroids, and reduce the number of hospitalizations for treatment of multiple sclerosis.

REFERENCES:

[1] PRISMS (Prevention of Relapses and Disability by Interferon ß-1a Subcutaneously in Multiple Sclerosis) Study Group (1998). Randomised double-blind placebo-controlled study of interferon ß-1a in relapsing/remitting multiple sclerosis. Lancet 352:1498-1504

PAAB

serono biotech & beyond

DO MORE WITH MORE

https://doi.org/10.1017/S0317167100049714 Published online by Cambridge University Press

For brief prescribing information see pages A-30, A-31

NOTE OUR NEW ADDRESS DETAILS ON A-2

Volume 28 Number 3 August 2001

THE CANADIAN JOURNAL OF Neurological Sciences

LE JOURNAL CANADIEN DES Sciences Neurologiques

https://doi.org/10.1017/S0317167100049714 Published online by Cambridge University Press

Volume 28 Number 3 August 2001

THE CANADIAN JOURNAL OF Neurological Sciences

LE JOURNAL CANADIEN DES Sciences Neurologiques

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

The Canadian Association of Child Neurology
L'Association Canadienne de Neurologie Pédiatrique

The permanent secretariat for the four societies and the Canadian Congress of Neurological Sciences is at/
Le secrétariat des quatre associations et du Congrès Canadien des Sciences Neurologiques est situe en permanence à:
709 - 7015 Macleod Trail SW, Calgary AB, Canada T2H 2K6,

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 5456, Station A, Calgary, AB Canada T2H 1X8. Courier to: 709 - 7015 Macleod Trail SW, Calgary, AB Canada T2H 2K6. Telephone (403) 229-9575; Fax (403) 229-1661. E-mail: journal@cjns.org; Web Site: www.cjns.org

Mailed under Publications Mail Registration number 09824. 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 5456, Station A, Calgary, AB Canada T2H 1X8. Par courrier: 709 - 7015 Macleod Trail SW, Calgary, AB Canada T2H 2K6. Téléphone (403) 229-9575; Fax (403) 229-1661. E-mail journal@cjns.org; Web Site: www.cjns.org

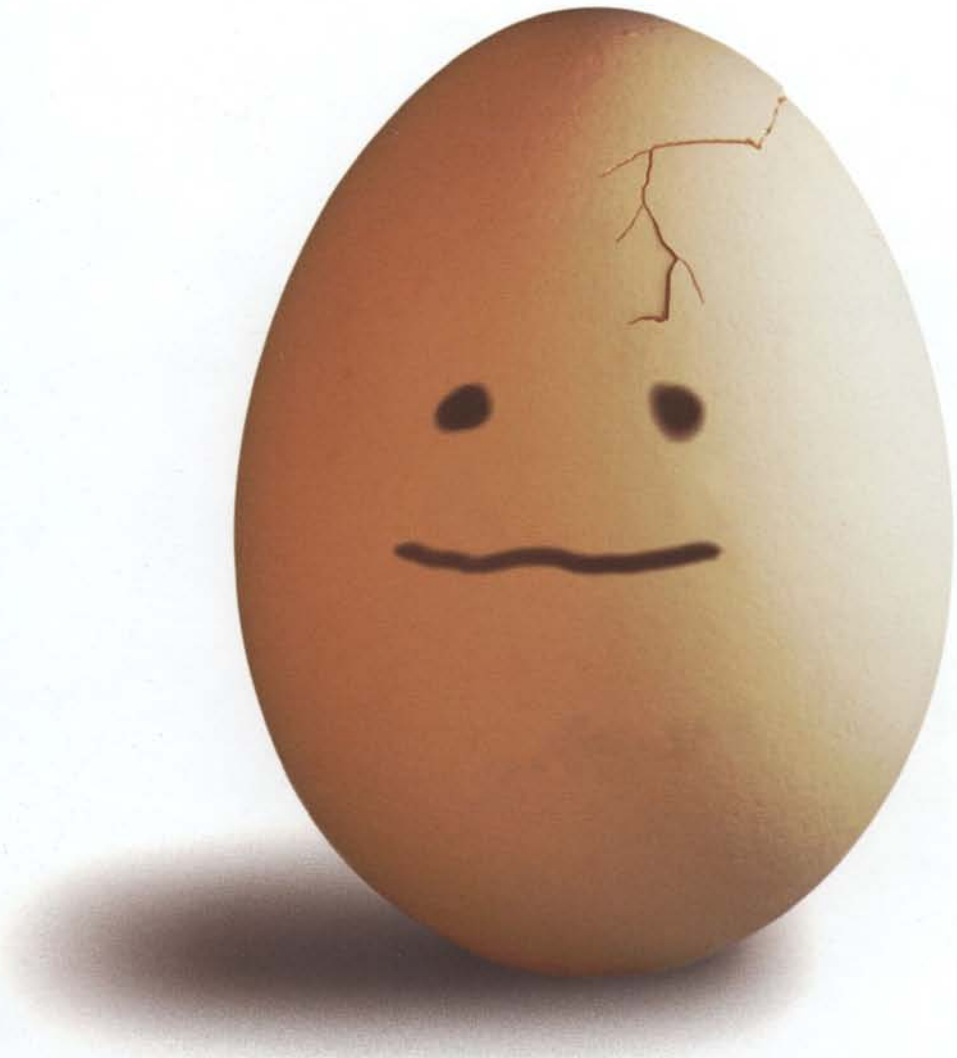
Posté sous registration de poste-publications no 09824. Port payé à Calgary, Alberta. Le Journal est cité et indexé dans *Index Medicus, EMBASE Excerpta Medica et Current Contents — Clinical Practice et Life Sciences, Elsevier Biobase/Current Awareness in Biological Sciences, Biological Abstracts, Chemical 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
709 - 7015 Macleod Trail SW, Calgary, AB Canada T2H 2K6
Tel (403) 229-9575 Fax (403) 229-1661
E-mail: journal@cjns.org
Web Site: www.cjns.org

Printer/Imprimeur:
Sundog Printing Limited, 1311 Ninth Avenue SW, Calgary, Alberta T3C 0H9

ISSN 0317 - 1671

Are you using ASA for the prevention of a second stroke?



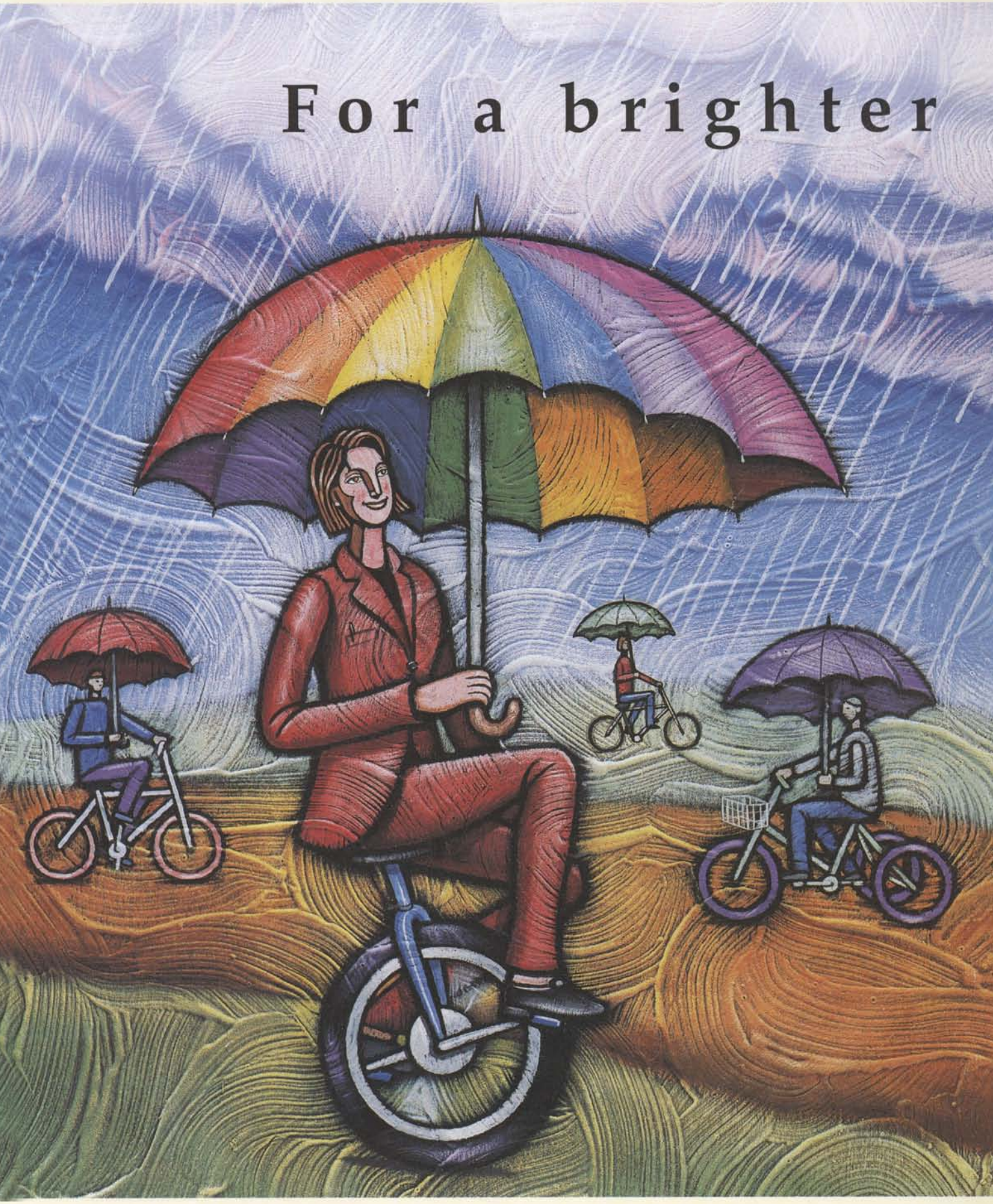
"Every patient who has experienced an atherothrombotic … stroke or TIA and has no contraindication should receive an antiplatelet agent regularly …"

- Fifth ACCP Consensus Conference on Antithrombotic Therapy[1]

Reassess your options...

https://doi.org/10.1017/S0317167100049714 Published online by Cambridge University Press

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



https://doi.org/10.1017/S0317167100049714 Published online by Cambridge University Press

future in epilepsy

For monotherapy after polytherapy in a wide range of seizure types

Clinical trials have demonstrated that converting patients from polytherapy to monotherapy with LAMICTAL can maintain or even improve control over a wide range of seizure types.* And LAMICTAL monotherapy was generally well tolerated.[1] 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%).

For control of Lennox-Gastaut syndrome

LAMICTAL is the first and only of the newer antiepileptic drugs† (AED) indicated as adjunctive therapy for pediatric and adult patients with Lennox-Gastaut syndrome (LGS). LAMICTAL offers significantly improved control‡ over the wide range of seizure types associated with Lennox-Gastaut syndrome,§ including major seizures, drop attacks and tonic-clonic seizures. Yet LAMICTAL has demonstrated a low CNS side effect profile¶**†† and has been reported to improve neurological function and cognitive skills, such as behaviour, speech and non-verbal communication.‡

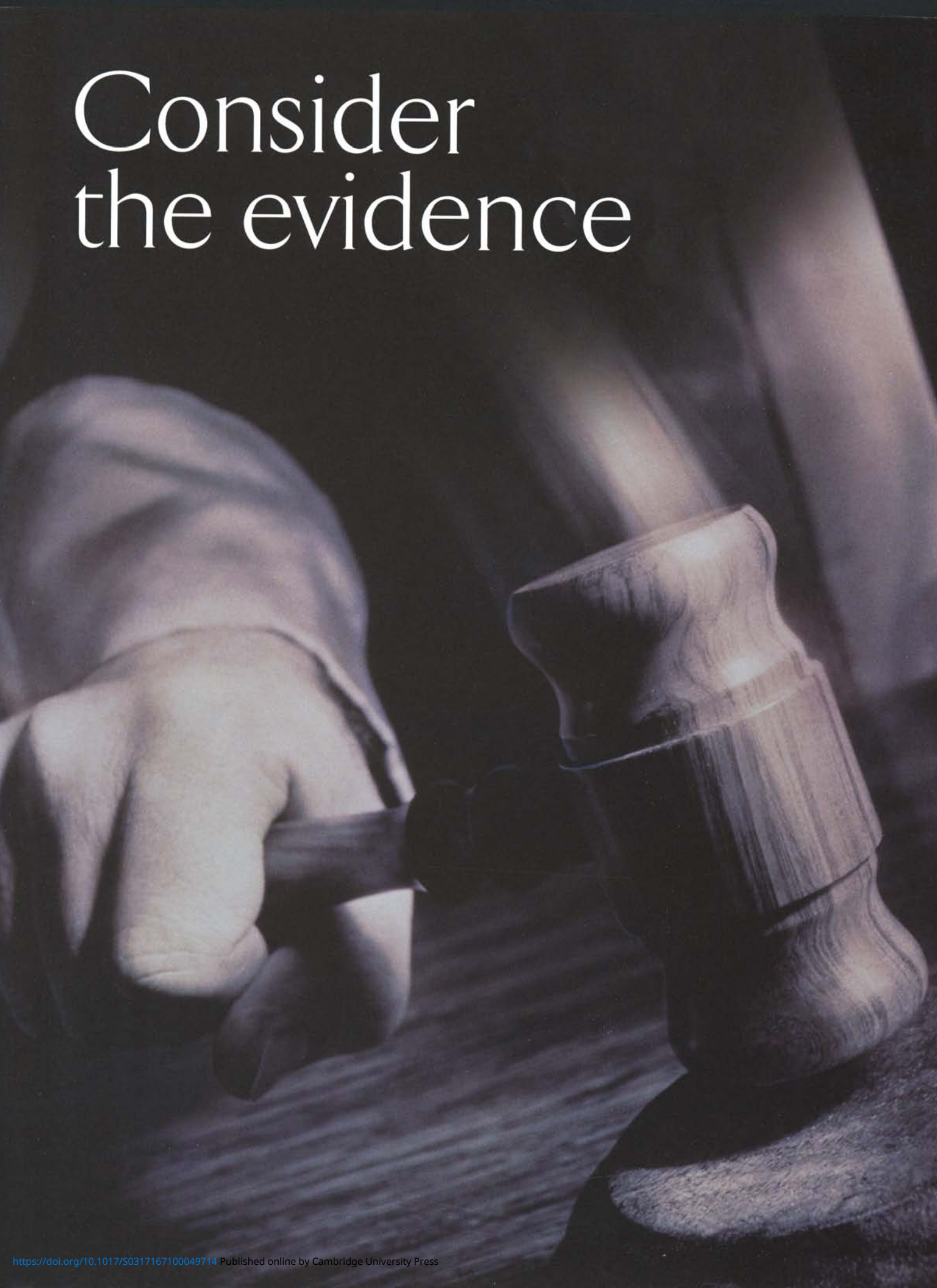
* Please refer to Product Monograph for dose adjustment of LAMICTAL according to the concomitant AED withdrawn.
† Refers to lamotrigine, gabapentin, vigabatrin and topiramate, to be distinguished from standard AEDs.
‡ Versus placebo.
§ With the exception of atypical absence seizures
¶ Frequently reported adverse events were pharyngitis (14%), infection (13%), vomiting (9%) and rash (9%).
** **Rarely, serious skin rashes, including Stevens-Johnson syndrome and toxic epidermal necrolysis (Lyell syndrome), have been reported. Although the majority recover following drug withdrawal, some patients experience irreversible scaring and there have been rare cases of associated death.**
†† **DO NOT EXCEED the recommended initial dose and subsequent dose escalations of LAMICTAL. More rapid initial titration has been associated with an increased incidence of serious dermatological reactions.**
® Lamictal is a registered trademark, used under license by GlaxoSmithKline Inc.

Lamotrigine
℗ Lamictal®
For a Brighter Future

Member R&D PAAB

gsk GlaxoSmithKline

https://doi.org/10.1017/S0317167100049714 Published online by Cambridge University Press



AVONEX® is proven effective in Relapsing Remitting MS

- 37% reduction in the probability of disability progression over two years (21.9% vs. 34.9%; p=0.02)¶[1,2]
- 32% reduction in the annual exacerbation rate over two years (0.61 vs. 0.90; p=0.002)*[1,2]
- 38% of patients remained relapse free at two years (p=0.03)@[1,2]
- 55% reduction in brain atrophy progression during the second year of therapy (-0.233 vs. -0.521; p=0.03)#[3]
- 89% reduction in gadolinium-enhanced lesions in patients with enhancement at baseline (0.11 vs. 0.50; p=0.041)†[4]
- AVONEX® is indicated for the treatment of relapsing forms of MS.[1]

AVONEX® is generally well tolerated. The most common side effects associated with treatment are flu-like symptoms (muscle ache [myalgia], fever, chills, and asthenia). Please see product monograph for important patient selection and monitoring information.[1] AVONEX® should be used with caution in patients with depression and in patients with seizure disorders. AVONEX® should not be used by pregnant women. Patients with cardiac disease should be closely monitored. Routine periodic blood chemistry and hematology tests are recommended during treatment with AVONEX®.[1]

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

BIOGEN
CANADA

¶ Kaplan-Meier methodology. AVONEX® n=158, placebo n=143.
* AVONEX® n=85, placebo n=87.
@ n=85.
# As measured by brain parenchymal fraction in the second year of treatment. AVONEX® n=68, placebo n=72.
† AVONEX® n=44, placebo n=44. The exact relationship between MRI findings and clinical status is unknown.

For brief prescribing information see pages A-52, A-53, A-54

INFORMATION FOR AUTHORS

The Canadian Journal of Neurological Sciences publishes original articles in neurology, neurosurgery and basic neurosciences. Manuscripts are considered for publication with the understanding that they, or the essence of their content, have not been published elsewhere except in abstract form and are not under simultaneous consideration by another journal. Articles undergo peer review. Manuscripts should be submitted to: Douglas Zochodne, M.D., Editor. Canadian Journal of Neurological Sciences, P.O. Box 5456, Station A, Calgary, AB, Canada T2H 1X8

Manuscript Preparation

• Submit five high quality copies of the manuscript and original illustrations. Papers will be accepted in English or French. Manuscripts must be double spaced throughout including references, tables and legends for illustrations. Margins of at least 25mm should be left on all sides.

• After a paper has been reviewed, the author will be requested to submit four copies of the revised manuscript, including illustrations. Supply a computer diskette (3 1/2" size) containing the article *saved in an RTF format*. Identify clearly first author's name, file name, word processing program and version, and system (i.e. PC or Mac). Clearly indicate the order and importance of headings.

• For detailed instructions regarding style and layout refer to *"Uniform requirements for manuscripts submitted to biomedical journals"*. Copies of this document may be obtained by writing to the Journal office, but the main points are summarized here. Articles should be submitted under conventional headings of *introduction, methods and materials, results, discussion,* but other headings will be considered if more suitable. Clinical trials must be reported in Consort format (JAMA 1996; 276: 637-639). Pages of text should be numbered consecutively.

• ***A title page*** should identify the title of the article which should be no more than 80 characters including spaces; name of institution(s) from which the work originated; and the name, address, telephone, and fax number of the corresponding author.

• ***Abstract*** Original Articles should be accompanied by an abstract of 250 words or less on a separate page, preferably in English and French, although the Journal will provide translation if required. Abstracts of original articles should consist of four paragraphs headed: *Background (or objective), Methods, Results and Conclusions.* Review articles should be accompanied by an abstract of 150 words or less.

• ***Acknowledgements*** including recognition of financial support should be typed on a separate page at the end of the text.

• The SI system (système international d'unités) should be used in reporting all laboratory data, even if originally reported in another system. Temperatures are reported in degrees celsius. English language text may use either British or American spelling, but should be consistent throughout.

• ***References*** should be numbered in the order of their citation in the text. Those cited only in tables and legends for illustrations are numbered according to the sequence established by the first identification in the text of a particular table or illustration. Titles of journals should be abbreviated according to the style used in Index Medicus. References should list the names of up to five authors; if there are more, cite the first three, then *et al.* Provide the full title, year of publication, volume number and inclusive pagination for journal articles. For any reference cited as "in press", five copies of the article must accompany the author's manuscript. Do not reference unpublished or "submitted" papers; these can be mentioned in the body of the text and authors must provide five copies of "submitted" manuscripts. Avoid "personal communications" and, if necessary, include them in the body of the text, not among the references. Reference citations should not include unpublished presentations or other non-accessible material. Books or chapter references should also include the place of publication and the name of the publisher. Examples of correct forms of reference follow:

Journals

Yang JF, Fung M, Edamura R, et al. H-Reflex modulation during walking in spastic paretic subjects. Can J Neurol Sci 1991; 18: 443-452.

Chapter in a book

McGeer PL, McGeer EG. Amino acid neurotransmitters. *In*: Siegel GJ, Albers RW, Agranoff BW, Katzman R, eds. Basic Neurochemistry. Boston: Little, Brown & Co., 1981: 233-254.

• ***Illustrations*** Submit five original sets of illustrations. We will not return illustrations; therefore, authors should keep negatives for all photographs. Submit high quality glossy black and white photographs preferable 127 x 173 mm (5" x 7"). This includes graphs and diagrams. Do NOT send photocopies of illustrations. Original artwork and radiographs should not be submitted. The additional cost of coloured illustrations must be borne by the author; quotations are available upon request from the Journal office. Identify each figure with a label at the back indicating top, figure number and first author. Letters and arrows applied to the figures to identify particular findings should be professional appliques suitable for publication. Photomicrographs should include a calibration bar with a scale indicated on the figure or in the legend. Legends for illustrations should be typed on a separate page from the illustrations.

• ***Tables*** Type tables double-spaced on pages separate from the text. Provide a table number and title for each. Particular care should be taken in the preparation of tables to ensure that the data are presented clearly and concisely. Each column should have a short or abbreviated heading. Place explanatory matter in footnotes, not in the heading. Do not submit tables as photographs.

• ***Review articles*** on selected topics are also published. They are usually invited, but unsolicited reviews will be considered. It is recommended that authors intending to submit review articles contact the Editor in advance.

• ***Letters to the Editor*** concerning matters arising in recent articles are welcome. Letters should be limited to two double-spaced pages and may include one illustration and a maximum of four references.

• ***Permissions and Releases*** Any non-original material (quotations, tables, figures) must be accompanied by written permission from the author and the copyright owner to reproduce the material in the Journal. Permission must be for **print** *and* **electronic** media. Photographs of recognizable persons must be accompanied by a signed release from the legal guardian or patient authorizing publication.

• ***Conflict of Interest*** Authors who have non-scientific or non-academic gain whether it be financial or other from publishing their article are responsible for delaring it to the Editor. Any financial interest, research grant, material support, or consulting fee associated with the contents of the manuscript must be declared to the Editor. These guidelines apply to each author and their immediate families. conflicts of interest are not necessarily wrong nor do they necessarily change the scientific validity of research or opinion, but the Journal and readers should be aware of the conflict. If the Editor considers the conflict to compromise the validity of the paper, it will not be accepted for publication. Authors, editorial staff and reviewers are asked to declare any relationship that would be considered as a conflict of interest whether or not they believe that a conflict actually exists. Information that the Journal receives about conflict or potential conflict will be kept confidential unless the Editor or Associate Editor considers it to be important to readers. Such conflicts will be published in the author credits or as a footnote to the paper, with knowledge of the authors.

Turn the agony of migraine into the beauty of relief.

Zomig® provides consistent relief.

- Rapid relief within one hour.[1]
- Significant headache response* after a single 2.5 mg dose.[1]
- Consistent efficacy across multiple attacks.[2-4]
- Effective in a wide variety of migraine subtypes.[1†]
- Effective when taken at any time during a migraine attack.[2]
- Treats associated symptoms of photophobia, phonophobia and nausea.[1]
- Proven safety profile in over 5,500 patients treating more than 89,000 attacks.[5,6††]

*Improvement from severe or moderate headache to mild or no pain at two hours.

† Zomig® is indicated for the acute treatment of migraine with or without aura.

Zomig® is not intended for use prophylactically or in hemiplegic, basilar, or ophthalmoplegic migraine. Safety and efficacy have not been established for cluster headache, which is present in an older, predominantly male population.

†† The most common side effects reported with Zomig® compared to placebo were nausea (9% vs. 3.7%), head/face sensations (8.6% vs. 1.7%), dizziness (8.4% vs. 4%) and neck/throat/jaw sensations (7% vs. 3%).

Zomig® is contraindicated in patients with history, symptoms, or signs of ischemic cardiac, cerebrovascular or peripheral vascular syndromes, valvular heart disease or cardiac arrhythmias (especially tachycardias). In addition, patients with other significant underlying cardiovascular disease should not receive Zomig®. Zomig® is also contraindicated in patients with uncontrolled or severe hypertension.

Please see Product Monograph.

For more information about Zomig® please contact AstraZeneca Customer Relations by phone at 1-800-668-6000 or fax at (905) 896-4745.

The AstraZeneca logo is a trademark of AstraZeneca PLC and is used under license by Astra Pharma Inc. and Zeneca Pharma Inc.
Zomig® (zolmitriptan) is a registered trademark of the AstraZeneca group of companies.

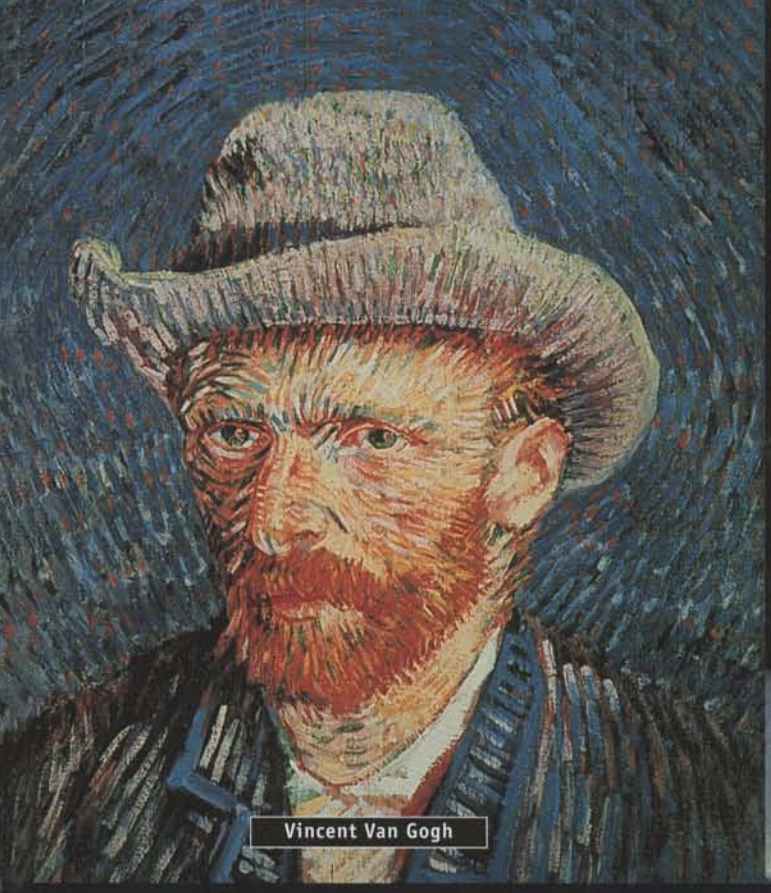
Zomig®
zolmitriptan tablets 2.5 mg

Consistent migraine relief.

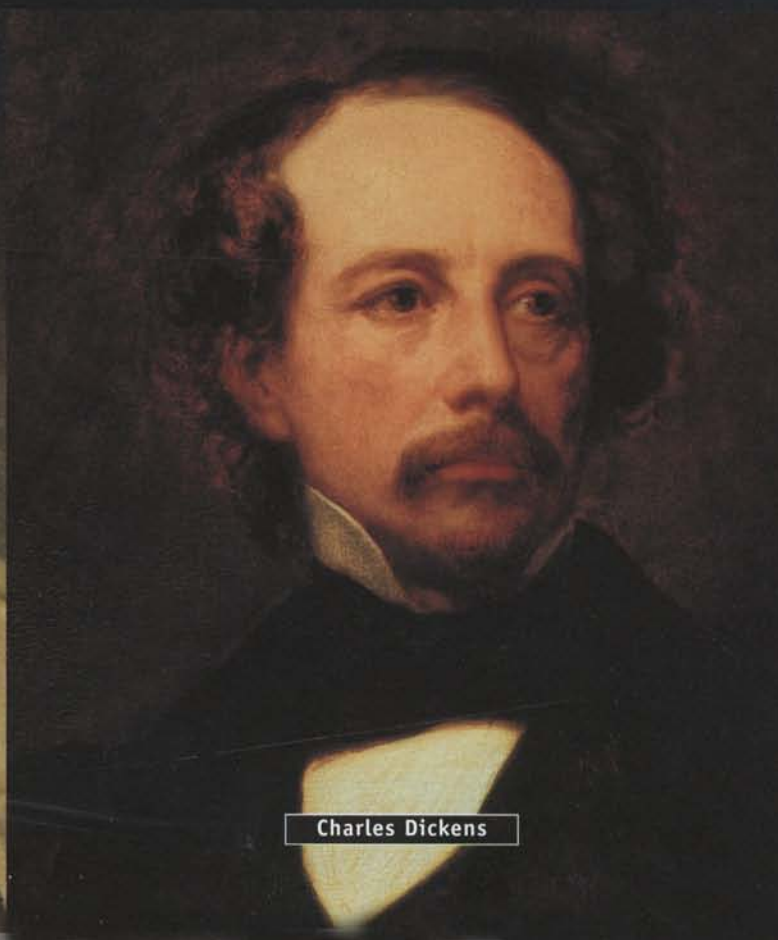
AstraZeneca PMS

https://doi.org/10.1017/S0317167100049714 Published online by Cambridge University Press

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



YESTERDAY, PEOPLE WITH EPILEPSY HAD TO BE EXTRAORDINARY TO SUCCEED.



https://doi.org/10.1017/S0317167100049714 Published online by Cambridge University Press

EFFICACY ACROSS A BROAD RANGE OF SEIZURES.

- TOPAMAX demonstrates efficacy in Partial Onset, Primary Generalized Tonic-Clonic, and Lennox-Gastaut Seizures[1]
- Desirable seizure-free results were shown in both Adults (19%)† and Children (22%)‡ with Partial Onset Seizures[2,3]

NO EVIDENCE OF LIFE-THREATENING SIDE EFFECTS.

- Like most antiepileptics, the most common side effects are CNS related, usually mild to moderate and transient§[1]

ADULT PATIENTS MAY EXPERIENCE WEIGHT LOSS.

- 73% of patients (n=52) showed a mean weight decrease of 5.97 lb (Interim analysis. Average duration 60 days)[4]
- 96% of children in clinical trials (≥ one year) who lost weight showed resumption of weight gain in test period**[1]

TODAY, THERE'S TOPAMAX.

B.I.D. DOSING WITH THE PATIENT IN MIND.

- TOPAMAX is initiated and titrated to clinical response regardless of existing anticonvulsant therapy
- Tablets available on formulary††

NOW AVAILABLE IN SPRINKLE CAPSULES

TOPAMAX* topiramate

NOW INDICATED FOR CHILDREN

HELPING PATIENTS MAKE MORE OF THEIR LIVES.

**TOPAMAX* topiramate Tablets and Sprinkle Capsules: indicated as adjunctive therapy for the management of patients (adults and children two years and older) with epilepsy who are not satisfactorily controlled with conventional therapy. There is limited information on the use of topiramate in monotherapy at this time.*

† Open label, 20 week trial (n=450 Adults). Optimal dosing was 300-350 mg/day(Average 288 mg/day).
‡ Open label trial for children (n=72) treated for ≥ 3 months. Average dose of 10 mg/kg/day.
§ CNS adverse events: Somnolence (30.1%), dizziness (28.3%), ataxia (21.2%), speech disorders (16.8%), psychomotor slowing (16.8%), nystagmus (15.0%), paresthesia (15.0%), nervousness (15.9%), difficulty with concentration/attention (8.0%), confusion (9.7%), depression (8.0%), anorexia (5.3%), language problems (6.2%) and mood problems (3.5%). In an audit of 1446 adults and 303 children, there appeared to be a similar pattern of adverse events.
** The long-term effects of weight loss in pediatric patients are not known.
†† Limited use benefit: Ontario, Nova Scotia, New Brunswick, PEI. Full benefit: Quebec, Saskatchewan, British Columbia, Alberta, Manitoba.
Please refer to the TOPAMAX Prescribing Information for complete prescribing details.

REFERENCES: 1. TOPAMAX* topiramate Tablets and Sprinkle Capsules Product Monograph, May 11, 1999. 2. Kamin M, Kraut L, Olson W. Dose optimization of topiramate as add-on therapy in adults with treatment-resistant partial-onset seizures *Neurology* 1999;52 (Suppl 2):A525-526. 3. Glauser TA, Elterman R, Wyllie E et al. Open label topiramate in paediatric partial epilepsy *Epilepsia* 1997:38 (Suppl 3):94. 4. Rosenfeld WE et al.Topiramate and concomitant weight loss. *Epilepsia* 1997:38 (Suppl 8):98.

JANSSEN-ORTHO Inc.
19 Green Belt Drive, Toronto
Ontario, Canada M3C 1L9

TXJA001001A

https://doi.org/10.1017/S0317167100049714 Published online by Cambridge University Press

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

In Canada, IVIG is approved for 5 indications.[1,2,3*] Why are Doctors using it for approximately 100?[4]

* Idiopathic thrombocytopenic purpura,[A,B] primary humoral immune deficiency[A,B,C] and secondary immune deficiency,[C] allogeneic bone marrow transplant,[A] pediatric AIDS[A] and B-cell chronic lymphocytic leukemia.[B] A Gamimune® B Gammagard® C Iveegam Immuno®

®Gammagard and Iveegam Immuno are registered trademarks of Baxter Healthcare Corporation.
®Gamimune, Bayer and Bayer Cross are trademarks of Bayer AG, used under license by Bayer Inc. ©2001 Bayer Inc.

39052/05-2002

https://doi.org/10.1017/S0317167100048714 Published online by Cambridge University Press

Bayer Canada is looking for answers.

This is what we found.

In making the decision to use IVIG (Intravenous Immune Globulin) in specific indications, Canadian physicians rely on tools such as the published literature and/or available guidelines. The development of guidelines for the appropriate use of IVIG was sponsored by Bayer, who provided an unrestricted educational grant, including extensive literature review and specialist consultation.[4,5]

A recent survey found that over 80% of IVIG use in Canadian hospitals is in keeping with these consensus guidelines for appropriate use.[6] But 80% is not 100%.

We're still looking.

We spend $8M in Research & Development, which includes IVIG use as a priority, and we are committed to sponsoring Canadian clinical trials to investigate possible new indications.

And because physicians are the key, we also sponsor two Immunology Fellowships (one in co-operation with CIHR) worth $250,000, and we develop and offer CME promoting appropriate use through Canadian hospitals. For more information about the Appropriate Use of IVIG, contact Bayer at gamimune.canada@bayer.com

Appropriate Use.

Bayer

maker of Gamimune®N, 10%
Immune Globulin Intravenous (Human), 10%

Member R&D PAAB

1. Gamimune Prescribing Information, 2001. **2.** Gammagard Prescribing Information, 2001. **3.** Iveegam Prescribing Information, 2001. **4.** The Consensus Working Group. Present and Future Uses of IVIG: A Canadian Multidisciplinary Consensus-Building Initiative. Canadian Journal of Allergy & Clinical Immunology 1997; 2(5): 176-208. **5.** Brill V, Allenby K, Midroni G, O'Connor PW, Vajsar J. IVIG in Neurology – Evidence and Recommendations. Can J Neurol Sci 1999:26(2): 139-152. **6.** Hanna K, Poulin-Costello M, Preston M, Maresky N. Intravenous Immune Globulin (IVIG) Utilization in Canada. Submitted.

BP080-0601E

https://doi.org/10.1017/S0317167100049714 Published online by Cambridge University Press

25 Years Ago in the Canadian Journal of Neurological Sciences

Quebec Cooperative Study of Friedreich's Ataxia
Phase One: A Prospective Survey of 50 Cases

Organized and Edited by André Barbeau

Design of the Investigation

A. Barbeau

SUMMARY: The general outline of the complete prospective study of 50 cases of spinocerebellar degeneration is given. The general protocol followed, the criteria for inclusion and the mode of analysis are described. The aim of this study was to establish a base of clinical, physiological and biochemical facts upon which a logical and systematic approach to pathogenesis and treatment of Friedreich's ataxia could be attempted.

Can. J. Neurol. Sci. 1976;4:271

Nicolaus Friedreich and Degenerative Atrophy of the Posterior Columns of the Spinal Cord

F. Andermann

SUMMARY: A short outline is given of the pioneer efforts of Nicolaus Friedreich in the description of the spinocerebellar degeneration which now bears his name.

Can. J. Neurol. Sci. 1976;4:275

Clinical Description and Roentgenologic Evaluation of Patients with Friedreich's Ataxia

G. Geoffroy, A. Barbeau, G. Breton, B. Lemieux, M. Aube, C. Leger and J.P. Bouchard

SUMMARY: The 50 patients in this survey were classified by a panel of neurologists into four clinical subgroups; Group Ia ("typical" Friedreich's ataxia, complete picture), Group Ib ("typical" Friedreich's ataxia, incomplete picture), Group IIa ("atypical" Friedreich's ataxia, possible recessive Roussy-Levy syndrome), Group IIb (heterogeneous ataxias). The clinical symptoms and signs were analyzed for each of these groups. A constellation of signs constantly present in Friedreich's ataxia and obligatory for diagnosis was described. Other important symptoms, such as the Babinski sign, kyphoscoliosis and pes cavus were found to be progressive, but not essential for the diagnosis at any given time. Finally, a host of other symptoms can only be called accessory. The progression of scoliosis was found to be an important tool in the differential diagnosis of ataxias. Our study also indicates, in contrast to the opinion of some authors, that absent deep tendon reflexes in the lower limbs and early dysarthria are essential in "typical" Friedreich's ataxia.

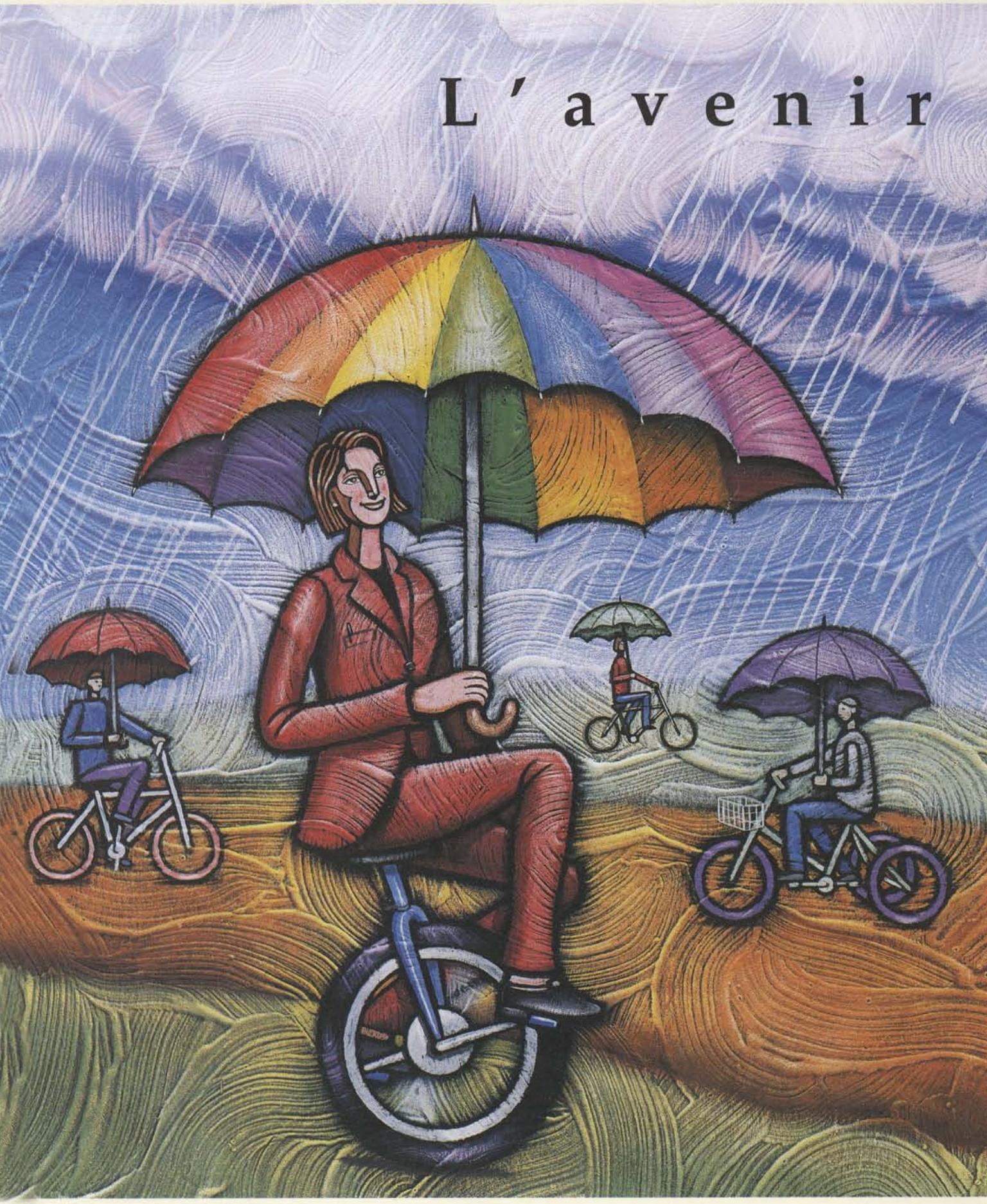
Can. J. Neurol. Sci. 1976;4:279

Continued on page A-22

For brief prescribing information see pages A-44, A-45, A-54

https://doi.org/10.1017/S0317167100049714 Published online by Cambridge University Press

L'avenir



https://doi.org/10.1017/S0317167100049714 Published online by Cambridge University Press

en tête

Pour passer à la monothérapie après une polythérapie, dans le traitement de diverses crises épileptiques.

Lors d'essais cliniques, on a pu constater que le passage de la polythérapie à la monothérapie par LAMICTAL peut maintenir ou même améliorer la maîtrise d'un vaste éventail de crises épileptiques*. La monothérapie par LAMICTAL a été généralement bien tolérée[1]. Les effets indésirables les plus souvent associés à l'abandon de la monothérapie par LAMICTAL ont été l'éruption cutanée (6,1 %), l'asthénie (1,1 %), la céphalée (1,1 %), la nausée (0,7 %) et les vomissements (0,7 %).

Pour maîtriser le syndrome de Lennox-Gastaut

LAMICTAL est le premier et le seul parmi les nouveaux antiépileptiques† qui est indiqué comme traitement d'appoint chez les enfants et les adultes atteints du syndrome de Lennox-Gastaut. LAMICTAL offre une maîtrise significativement supérieure‡ d'un vaste éventail de crises épileptiques associées au syndrome de Lennox-Gastaut§, y compris les crises majeures, les effondrements épileptiques et les crises tonico-cloniques. LAMICTAL a démontré peu d'effets indésirables¶**†† sur le SNC. Il a été associé à une amélioration de la fonction neurologique et des facultés cognitives, comme le comportement, la parole et la communication non verbale‡ .

* Veuillez consulter la monographie du produit afin d'ajuster les doses de LAMICTAL selon l'antiépileptique concomitant faisant l'objet du retrait.
† Lamotrigine, gabapentine, vigabatrine et topiramate (à distinguer des antiépileptiques standards).
‡ Comparativement au placebo.
§ À l'exception des absences épileptiques atypiques.
¶ Les effets indésirables fréquemment signalés étaient : pharyngite (14 %), infection (13 %), vomissements (9 %) et éruptions cutanées (9 %).
** **Dans de rares cas, des éruptions cutanées graves, y compris le syndrome de Stevens-Johnson et l'épidermolyse nécrosante suraiguë (syndrome de Lyell), ont été signalées. Bien que la majorité des patients se soient rétablis après le retrait du médicament, certains ont présenté des séquelles irréversibles et il y a eu de rares cas de décès associés.**
†† **NE PAS DÉPASSER la dose initiale de lamotrigine ni l'augmentation posologique graduelle qui sont recommandées. Une augmentation plus rapide de la dose initiale a été associée à une fréquence accrue de réactions dermatologiques graves.**
® Lamictal est une marque déposée, utilisée sous licence par GlaxoSmithKline Inc.

Lamotrigine
PrLamictal®
L'avenir en tête

Membre R&D CCPP

gsk GlaxoSmithKline
Bureau d'affaires du Québec

https://doi.org/10.1017/S0317167100049714 Published online by Cambridge University Press

Pour documentation voir pages A-49, A-50, A-51, A-55

SINCE 1997, COPAXONE® HAS BEEN AVAILABLE TO HELP MEET YOUR NEEDS AND THOSE OF YOUR RRMS PATIENTS.

For the reduction of relapse frequency in ambulatory patients with relapsing-remitting multiple sclerosis...

COPAXONE® is an excellent choice for early treatment.

COPAXONE® has a side effect profile that compares to placebo and is an excellent choice to start with.

In clinical trials, only 8% of 844 patients discontinued treatment due to an adverse event.[1] The most commonly observed adverse events associated with the use of COPAXONE® in controlled clinical trials which occurred at a higher frequency than placebo were[1]:

Adverse Event	Non-interferon COPAXONE®[1]	Placebo
Injection Site Reactions†	2.4% - 66.4%	0.0% - 36.5%
Asthenia	64.8%	61.9%
Hypertonia	35.2%	29.4%
Vasodilatation	27.2%	11.1%
Back Pain	26.4%	22.2%
Chest Pain	26.4%	10.3%
Arthralgia	24.8%	17.5%
Nausea	23.2%	17.5%
Pain (Neck)	12.8%	7.1%
Infection (Vaginal Moniliasis)	12.8%	7.1%
Agitation (Anxiety)	5.6%	3.2%

† Depending on reaction.

https://doi.org/10.1017/S0317167100049714 Published online by Cambridge University Press

COPAXONE® is an excellent choice for the long-term (2 years), too.

COPAXONE® is supported by long-term evidence of up to 2 years and efficacy that's been demonstrated in 6 clinical studies.[2-7] A correlation between a reduction in attack frequency and a decreased risk of future disability remains to be established. The safety and efficacy of COPAXONE® beyond two years have not been adequately studied in placebo-controlled trials.

COPAXONE® is an antigenic substance and thus, it is possible detrimental host responses can occur with its use.

Only COPAXONE® has Shared Solutions™.

Shared Solutions™ helps support patients through early treatment and in the long-term (January 1999-March 2000 data).[††] With Shared Solutions™, 93% of COPAXONE® patients stayed on therapy.[8]

††n=1377

COPAXONE® (glatiramer acetate for injection) + SHARED SOLUTIONS™

1 800 283-0034

COPAXONE®
(glatiramer acetate for injection)

EFFICACY BACKED BY EVIDENCE

Product Monograph available on request. PAAB

TEVA MARION™
Dedicated to enhancing the management of multiple sclerosis.

https://doi.org/10.1017/S0317167100049714 Published online by Cambridge University Press

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

4TH ANNUAL NEUROLOGY RESIDENTS HEADACHE COURSE

CHS

CANADIAN CONGRESS OF NEUROLOGICAL SCIENCES
CCNS
CONGRÈS CANADIEN DES SCIENCES NEUROLOGIQUES

REGISTER NOW

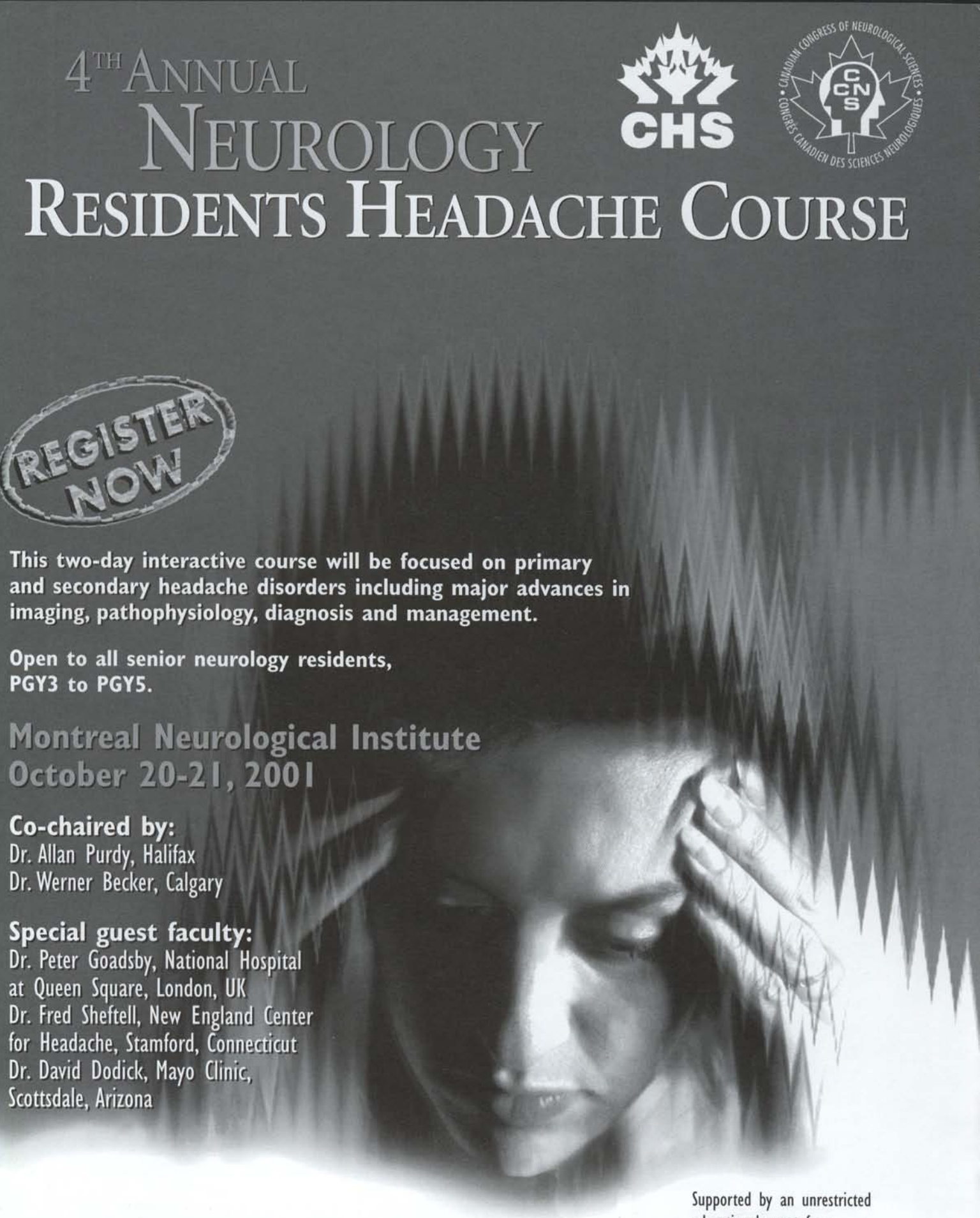
This two-day interactive course will be focused on primary and secondary headache disorders including major advances in imaging, pathophysiology, diagnosis and management.

Open to all senior neurology residents, PGY3 to PGY5.

Montreal Neurological Institute
October 20-21, 2001

Co-chaired by:
Dr. Allan Purdy, Halifax
Dr. Werner Becker, Calgary

Special guest faculty:
Dr. Peter Goadsby, National Hospital at Queen Square, London, UK
Dr. Fred Sheftell, New England Center for Headache, Stamford, Connecticut
Dr. David Dodick, Mayo Clinic, Scottsdale, Arizona



Supported by an unrestricted educational grant from

gsk GlaxoSmithKline

Arrangements for this course, including travel and lodgings, can be made through the CCNS Secretariat. Tel: (403) 229-9544 Fax: (403) 229-1661 E-mail: brains@ccns.org

https://doi.org/10.1017/S0317167100049714 Published online by Cambridge University Press

4TH ANNUAL NEUROLOGY RESIDENTS HEADACHE COURSE

Friday October 19, 2001

19:30-22:00 Welcome Reception

Saturday October 20, 2001

07:00 Breakfast

07:30-08:00 Pretest

08:00-08:30 Headache Classification and Epidemiology

08:30-08:40 Questions

08:40-09:25 Imaging Headache – State of the Art 2001

09:25-09:40 Questions

09:40-10:00 Coffee Break

10:00-10:45 Headache History Taking – Patient Based

10:45-12:15 Case-Based Session (Migraine)

12:15-12:45 Resident Summaries of Case Discussions

12:45-13:45 Lunch

13:45-15:45 Chronic Daily Headache and Medication Induced Headache

15:45-16:00 Break

16:00-17:30 Case-Based Session (Secondary Headaches)

17:30-17:55 Resident Summaries of Case Discussions

18:00 Adjourn

19:00 Reception and Dinner

Sunday October 21, 2001

08:00-08:20 Diagnosis/Investigation

08:20-08:30 Questions

08:30-09:15 Migraine Therapy – Acute and Preventative

09:15-09:35 Tension Type Headache Therapy

09:35-09:45 Questions

09:45-10:00 Break

10:00-10:40 Case-Based Session (Trigeminal Autonomic Cephalalgias)

10:40-11:00 Therapy of Trigeminal Autonomic Cephalalgia

11:00-11:30 Posttest

11:30-12:00 Burning Issues

12:00 Certificate Ceremony

Notes:

- This course will combine primary and secondary headaches in one year.
- We will emphasize imaging this time but this of course will include some neurobiology.
- The headache history will be new and could a case on video or a live patient.
- There will be more case based sessions, and feedback from the residents.
- There will be a pretest and a posttest again.

For more information please contact the Canadian Congress of Neurological Sciences
Tel: (403) 229-9544; Fax: (403) 229-1661; E-mail: brains@ccns.org

https://doi.org/10.1017/S0317167100049714 Published online by Cambridge University Press

25 Years Ago in the Canadian Journal of Neurological Sciences

Genetic and Family Studies in Friedreich's Ataxia

E. Andermann, G.M. Remillard, C. Goyer, L. Blitzer, F. Andermann and A. Barbeau

SUMMARY: This study consists of two parts: 1. A detailed genetic analysis of 35 sibships in which 58 individuals were affected with Friedreich's ataxia; and 2. Clinical and laboratory examinations of parents and siblings, in an attempt at carrier detection and diagnosis of the preclinical state.

The increased parental consanguinity, the lack of affected individuals in other generations, and the lack of significance of extrinsic etiological variables, all suggested an autosomal recessive mode of inheritance, and this was confirmed by formal genetic analyses, employing several different methods.

Associated abnormalities in our series of 58 patients included cardiomyopathy (51.7%), diabetes mellitus (19.0%), optic atrophy (5.2%), nerve deafness (5.2%) and congenital malformations (6.9%). The incidence of diabetes mellitus, congenital malformations, and epilepsy and/or febrile convulsions was elevated in first degree relatives of patients with Friedreich's ataxia.

Examinations in first degree relatives revealed an increased frequency of neurological and skeletal abnormalities (26.3%), but no abnormalities on neuro-ophthalmological examination. Frequent EMG abnormalities were noted in parents (56.3%), but not in siblings; and these could usually be attributed to extrinsic causes. There was an increased incidence of ECG abnormalities in both parents (50.0%) and siblings (25.0%) and some of these abnormalities may represent cardiomyopathy. An increased frequency of EEG abnormalities was also recorded in parents (14.3%) and siblings (27.2%), but these were not specific. None of these examinations resulted in a practicable method of carrier detection or preclinical diagnosis.

Since carrier detection is still not feasible, genetic counselling remains the only possible means of prevention of Friedreich's ataxia.

Can. J. Neurol. Sci. 1976;4:287

Friedreich's Ataxia: Preliminary Results of some Genealogical Research

A. Barbeau, M. Le Siege, G. Breton, R. Coallier and J.P. Bouchard

SUMMARY: A preliminary genealogical investigation of all the known ancestors from the year 1608 of four apparently unrelated French Canadian kindreds with Friedreich's ataxia reveals that the original ataxia gene in the province of Quebec was present within a core of no more than 10 families living in Quebec City in the mid-1600s.

Can. J. Neurol. Sci. 1976;4:303

Friedreich's Ataxia: Observations with Q and G banding of Human Chromosomes

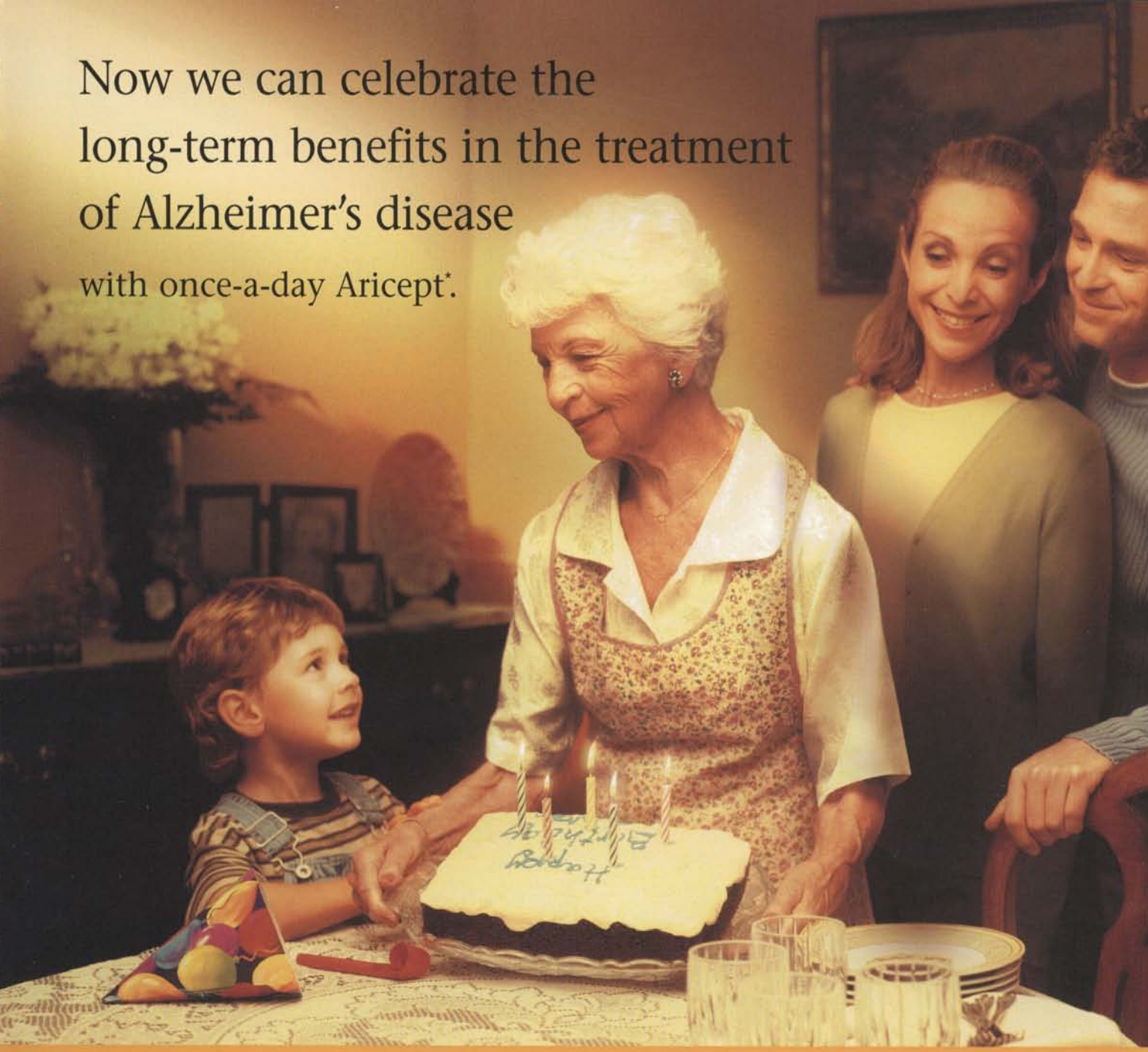
M. Cadotte, A. Barbeau and G. Breton

SUMMARY: No chromosomal anomaly was found in 15 cases of typical Friedreich's ataxia and three cases of atypical recessive ataxia studied with Q and G banding techniques. No difference between frequency of chromosomes gaps or breakages was noted amongst patients with Friedreich's ataxia and controls.

Can. J. Neurol. Sci. 1976;4:307

Now we can celebrate the long-term benefits in the treatment of Alzheimer's disease

with once-a-day Aricept*.



There's cause for celebration—because Aricept* has been shown to result in improvement or stabilization in 80% of Alzheimer's disease patients over 6 months of treatment.[‡§] And long-term data shows that Aricept*-treated patients continued to show treatment benefits up to 3 years on cognition and global functioning compared to data expected from untreated patients.[2§] What's more, Aricept* has demonstrated long-term safety and tolerability profiles.[2†] All of which means there's even more reason to make Aricept* your standard of care.[3]

Aricept* does not change the underlying course of the disease. Aricept* is indicated for the symptomatic treatment of patients with mild-to-moderate dementia of the Alzheimer's type.

† With appropriate dose escalation 5 mg/day dose, 10 mg/day dose and placebo were shown to have comparable adverse events. Most common adverse clinical events with Aricept*: diarrhea, nausea, insomnia, fatigue, vomiting, muscle cramps and anorexia. These events are usually mild and transient, resolving with continued Aricept* treatment without need for dose modification.

‡ In a 24-week, double-blind, placebo-controlled study, 473 mild-to-moderate AD patients were randomized to receive Aricept* 5 mg/day, 10 mg/day or placebo. The mean difference for Aricept*-treated patients (10 mg/day) vs. placebo was –2.87 ± 0.63 ($p<0.0001$) units in ADAS-cog, 0.47 ± 0.11 ($p<0.0001$) units in CIBIC-plus, and 0.59 ± 0.17 ($p=0.0007$) units in CDR-SB.

§ In a 162-week, multicentre, open-label extension study, 579 patients who had previously completed a randomized, double-blind, placebo-controlled study with Aricept* were treated with Aricept* 5 mg which could be increased to 10 mg between weeks 6 and 24, as per clinician's judgement. At study endpoint, ADAS-cog declined 15.57 points (95% CI,12,19.2) vs. the estimated decline of 6-12 points per year in untreated patients.

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

Now on several provincial formularies.[¶]

Once-a-day

℞ *Aricept**

donepezil HCl 5 & 10 mg tablets

Hope for a brighter tomorrow

Product Monograph available upon request.

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

PAAB R&D

Pfizer CNS
Life is our life's work

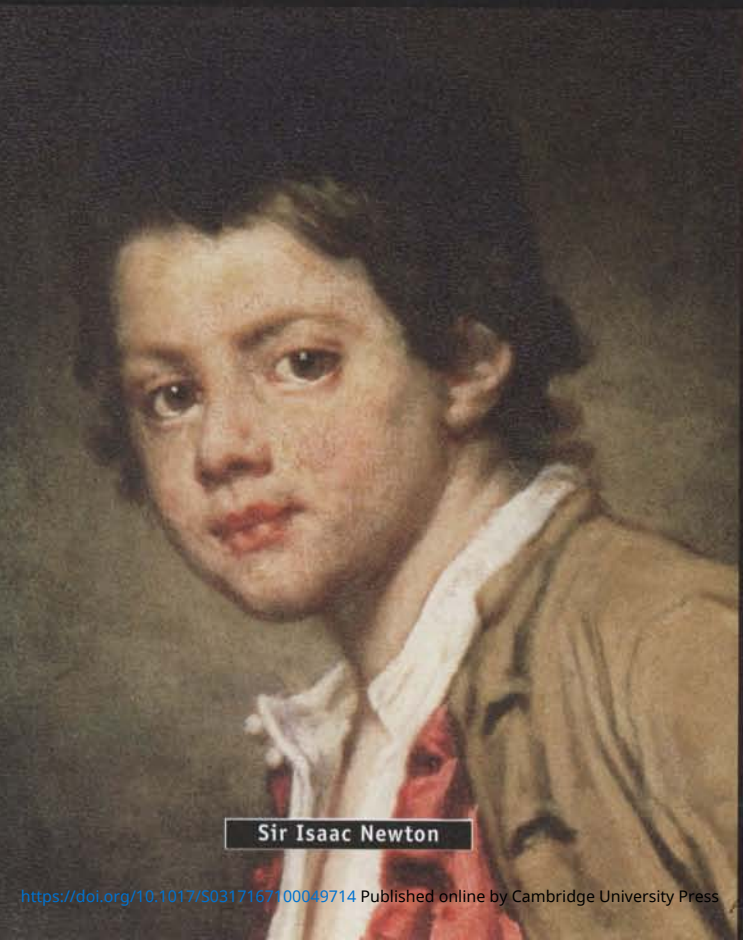
https://doi.org/10.1017/S0317167100049714 Published online by Cambridge University Press

For brief prescribing information see page A-29

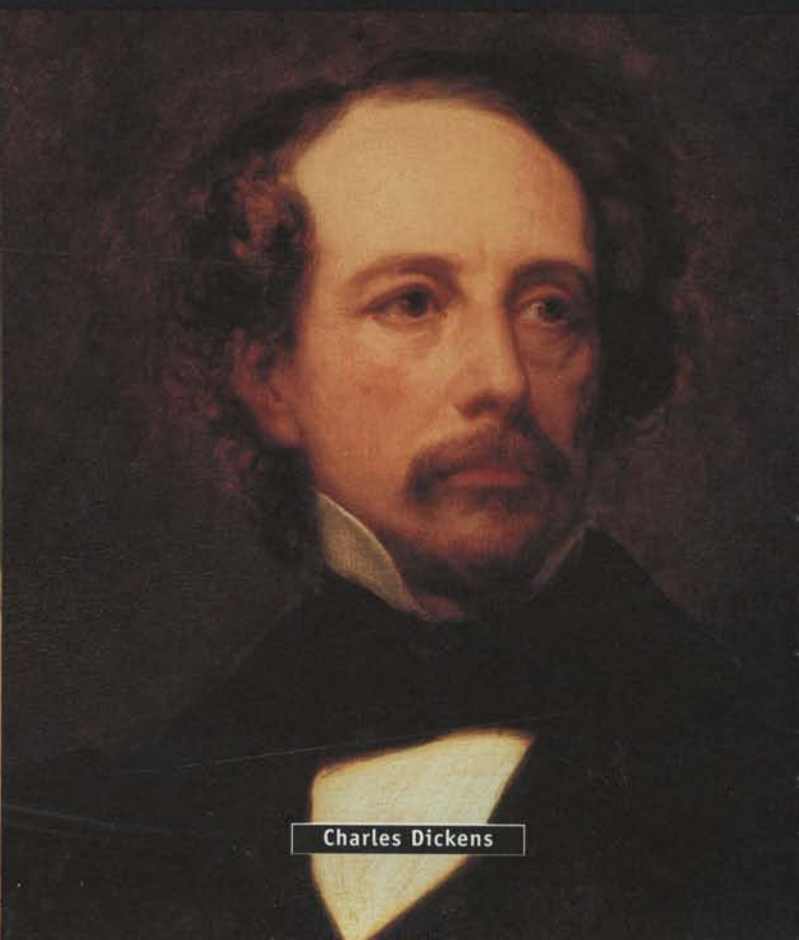
Vincent Van Gogh

Jeanne d'Arc

AUPARAVANT, LES PERSONNES ÉPILEPTIQUES DEVAIENT SE MONTRER EXCEPTIONNELLES POUR RÉUSSIR.



Sir Isaac Newton



Charles Dickens

https://doi.org/10.1017/S0317167100049714 Published online by Cambridge University Press

EFFICACE CONTRE UN GRAND NOMBRE DE TYPES DE CRISES.

- TOPAMAX est efficace contre les crises partielles initiales, les crises tonico-cloniques primaires généralisées et les crises associées au syndrome de Lennox-Gastaut[1]
- Des résultats souhaitables avec absence totale de crises chez 19 % des adultes† et 22 % des enfants‡ atteints de crises partielles initiales[2,3]

AUCUN SIGNE D'EFFETS SECONDAIRES CAPABLES DE MENACER LE PRONOSTIC VITAL.

- Comme pour la plupart des antiépileptiques, les effets secondaires le plus fréquemment signalés relèvent du SNC et sont généralement légers à modérés et de nature passagère§[1]

IL EST POSSIBLE QUE LES PATIENTS ADULTES SUBISSENT UNE PERTE DE POIDS.

- 73 % (n = 52) des patients ont subi une perte de poids de 5,97 lb en moyenne (Analyse provisoire. Durée moyenne de 60 jours)[4]
- 96 % des enfants traités dans le cadre des essais cliniques pendant au moins un an et ayant subi une perte de poids ont repris du poids au cours de la période d'exécution des essais**[1]

AUJOURD'HUI, IL Y A TOPAMAX.

UNE POSOLOGIE BIQUOTIDIENNE POUR TENIR COMPTE DU PATIENT.

- Le traitement par TOPAMAX peut être commencé et ajusté selon la réponse clinique quel que soit le traitement anticonvulsivant en cours
- Les comprimés sont inscrits au formulaire††

MAINTENANT OFFERT EN CAPSULES À SAUPOUDRER

TOPAMAX*
topiramate

MAINTENANT INDIQUÉ CHEZ L'ENFANT

POUR AIDER LES PATIENTS À MIEUX PROFITER DE LA VIE

Comprimés et capsules à saupoudrer TOPAMAX (topiramate) : indiqués comme traitement adjuvant chez les patients (adultes et enfants âgés de deux ans ou plus) atteints d'épilepsie dont l'état n'est pas maîtrisé de façon satisfaisante avec le traitement traditionnel. Les renseignements sur l'emploi du topiramate en monothérapie sont encore limités[2].*

†Une étude ouverte d'une durée de 20 semaines (n = 450 adultes). Posologie optimale : 300 à 350 mg/jour (moyenne : 288 mg/jour).
‡Étude ouverte portant sur des enfants (n = 72) traités pendant au moins 3 mois. Posologie moyenne : 10 mg/kg/jour.
§Manifestations indésirables liées au SNC : Somnolence (30,1 %), étourdissements (28,3 %), ataxie (21,2 %), troubles de la parole (16,8 %), ralentissement psychomoteur (16,8 %), nystagmus (15 %), paresthésie (15 %), nervosité (15,9 %), difficulté à se concentrer/troubles de l'attention (8 %), confusion (9,7 %), dépression (8 %), anorexie (5,3 %), problèmes de langage (6,2 %) et troubles de l'humeur (3,5 %). Une évaluation de 1 446 adultes et 303 enfants a indiqué que ces deux groupes semblent présenter des profils de manifestations indésirables similaires.
**Les effets à long terme d'une perte de poids chez les enfants ne sont pas connus.
††Médicament à usage limité : Ontario, Nouvelle-Écosse, Nouveau-Brunswick, Î.-P.-É. Remboursement intégral : Québec, Saskatchewan, Colombie-Britannique, Alberta, Manitoba.
Veuillez vous reporter aux Renseignements thérapeutiques sur TOPAMAX pour les détails thérapeutiques complets.

RÉFÉRENCES : **1.** Monographie des comprimés et capsules à saupoudrer TOPAMAX* (topiramate), 11 mai 1999. **2.** Kamin M, Kraut L, Olson W. Dose optimization of topiramate as add-on therapy in adults with treatment-resistant partial-onset seizures *Neurology* 1999;52 (Suppl 2):A525-526. **3.** Glauser TA, Elterman R, Wyllie E *et al.* Open label topiramate in paediatric partial epilepsy *Epilepsia* 1997:38 (Suppl. 3):94. **4.** Rosenfeld WE *et al.* Topiramate and concomitant weight loss. *Epilepsia* 1997:38 (Suppl 8):98.

JANSSEN-ORTHO Inc.
19 Green Belt Drive, Toronto
Ontario, Canada M3C 1L9

https://doi.org/10.1017/S0317167100049714 Published online by Cambridge University Press

Pour documentation voir pages A-38, A-39

37th Meeting of the Canadian Congress of Neurological Sciences

VANCOUVER, BRITISH COLUMBIA

with the Australian Association of Neurologists

Scientific Themes in Vancouver

June 18-22, 2002

Tentative Scientific Program

TUESDAY JUNE 18, 2002

Pre-Congress Courses

Neurobiology Review Course
ALS Strategies for Quality of Life and Quality of Care
Movement Disorder Video Session
Epilepsy Video Session

WEDNESDAY JUNE 19, 2002

Course Day

Spinal Surgery Course
Evidence Based Neurology
CSCN EMG
Update on Radiosurgery
Introduction of Design and Analysis of Clinical Research
CSCN EEG
Imaging in Neurocritical Care
Welcome Reception

THURSDAY JUNE 20, 2002

Plenary Session I

Platform Sessions
Lunch, Poster Viewing, Exhibit viewing
Interactive/CPC Neurology/Neurosurgery
Wine and cheese/Poster viewing

FRIDAY JUNE 21, 2002

Meet the Expert Breakfast: Neurosurgery

Plenary Session II

Platform Sessions
Lunch, Poster Viewing, Exhibit viewing
CLAE/CEC Epilepsy
Update on peripheral nerve surgery
Neurosonology or Ultrasound in Neurology/Neurosurgery
Neuroscience Challenge and Social Night

SATURDAY JUNE 22, 2002

Plenary Session III

Child Neurology Day
Stroke Course: Neurovascular Endovascular Surgery
MS Course

https://doi.org/10.1017/S0317167100049714 Published online by Cambridge University Press

Rebif®. Efficacité dépendante de la dose dans la SEP rémittente[1]*.

Pas encore

Pr **Rebif®**

Interféron bêta-1a

Les effets secondaires les plus fréquemment observés sont les réactions au point d'injection et les symptômes pseudo-grippaux (asthénie, pyrexie, frissons, arthralgie, myalgie et céphalées). Leur fréquence et leur intensité tend à diminuer avec la poursuite du traitement. Veuillez consulter la monographie du produit pour les renseignements posologiques complets. Les données portant sur l'innocuité et l'efficacité proviennent d'observations sur 2 ans seulement.

* Rebif® est indiqué pour le traitement de la sclérose en plaques rémittente chez des patients dont la cote EDSS se situe entre 0 et 5,0, afin de réduire le nombre et la gravité des poussées cliniques, de ralentir la progression de l'invalidité physique, et de réduire les besoins de corticothérapie et le nombre de séjours à l'hôpital pour le traitement de la sclérose en plaques.

RÉFÉRENCE :

[1] Groupe d'étude PRISMS (Prevention of Relapses and Disability by Interferon ß-1a Subcutaneously in Multiple Sclerosis), 1998. Randomised double-blind placebo-controlled study of Interferon ß-1a in relapsing/remitting multiple sclerosis. *Lancet*, 352:1498-1504

CCPP

serono biotech & beyond

FAIRE PLUS AVEC PLUS

https://doi.org/10.1017/S0317167100049714 Published online by Cambridge University Press

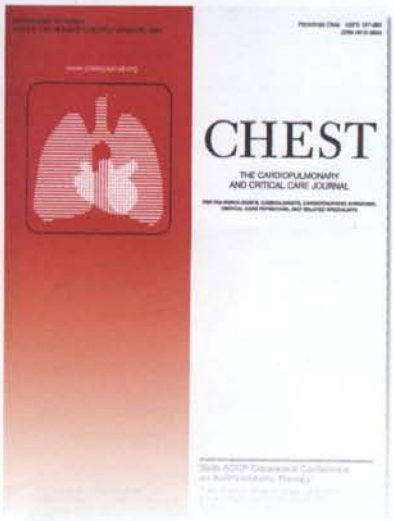
Pour documentation voir pages A-32, A-33

Introducing...

New Aggrenox®

Prevented twice as many strokes vs. ASA[2,3,4]*

New American College of Chest Physician Stroke Guidelines state[1]:



"Aggrenox is more effective than ASA alone for the prevention of [secondary] stroke" (grade 1A evidence)

Consider switching your ASA patients to Aggrenox:

- 22.1% additional stroke protection over ASA (p=0.008)[3†§]
- 36.8% additional stroke protection over placebo (p<0.001)[3]
- Proven safety and tolerability profile[3††] (Most common adverse events vs. ASA alone and vs. placebo: headache 39.2%, 33.8%, 32.9%; nausea 16.0%, 12.7%, 14.1%.)
- One capsule B.I.D.[3]

The overall discontinuation rate for Aggrenox was 27.8%, 23.2% for ASA and 23.7% for placebo.[3]
Aggrenox is indicated for the prevention of stroke in patients who have had a previous stroke or transient ischemic attack (TIA).[3]
Aggrenox is contraindicated in patients with hypersensitivity to dipyridamole, ASA, or any of the other product components. Due to the ASA content, Aggrenox is also contraindicated in patients with known allergy to nonsteroidal anti-inflammatory drug products and in patients with the syndrome of asthma, rhinitis and nasal polyps.[3]
Due to the ASA component, Aggrenox should be avoided in patients with severe hepatic insufficiency or severe renal failure, used with caution in patients with inherited/acquired bleeding disorders or who consume three or more alcoholic drinks every day, and avoided in patients with a history of active peptic ulcer disease.
Aggrenox should not be used in pediatric patients or during the third trimester of pregnancy.[3]
Aggrenox has a vasodilatory effect and should be used with caution in patients with severe coronary artery disease (e.g., unstable angina or recently sustained myocardial infarction).[3]

* For every 1,000 patients treated for two years, Aggrenox prevented 58 strokes vs. only 29 for ASA, compared to placebo.[2,3]

† Percentage of patients experiencing a stroke within two years: Aggrenox 9.5%, ASA 12.5%, placebo 15.2%.[3]

§ Randomised, double-blind, placebo-controlled trial, 6602 patients with history of TIA or ischemic stroke, mean age 66.7 years, 58% male, 42% female.[3]

†† When headache occurred, it was particularly evident in the first month of therapy. 8.9% of patients discontinued due to headache, 66% of these discontinued within the first month.[3]

Full Product Monograph is available upon request.
®Aggrenox is a registered trademark of Boehringer Ingelheim (Canada) Ltd.

Boehringer Ingelheim

Member R&D PAAB

Aggrenox®
ASA/Extended Release Dipyridamole
Helping to maximize stroke protection

https://doi.org/10.1017/S0317167100049714 Published online by Cambridge University Press

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