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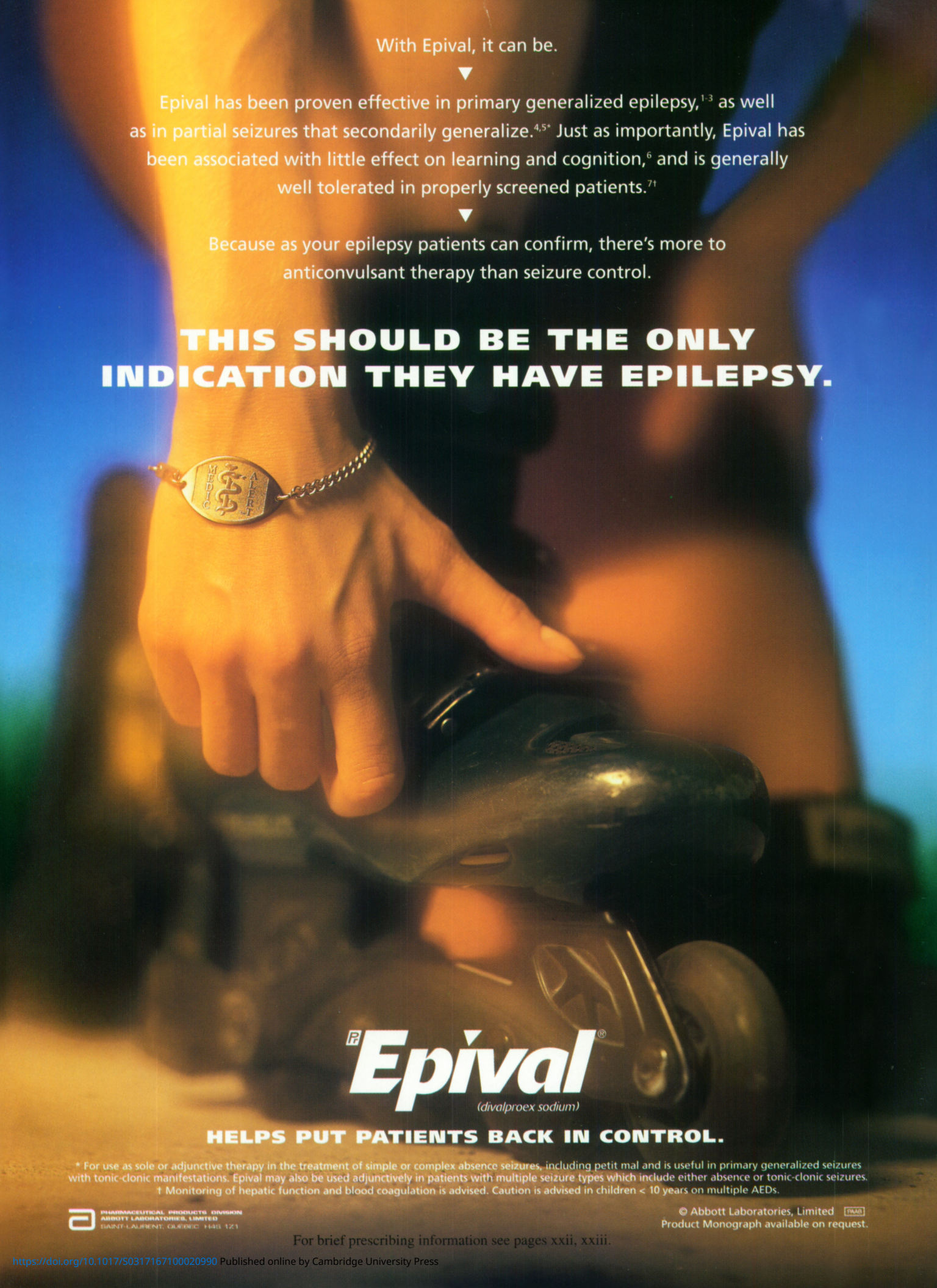

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La Société Canadienne de Neurologie

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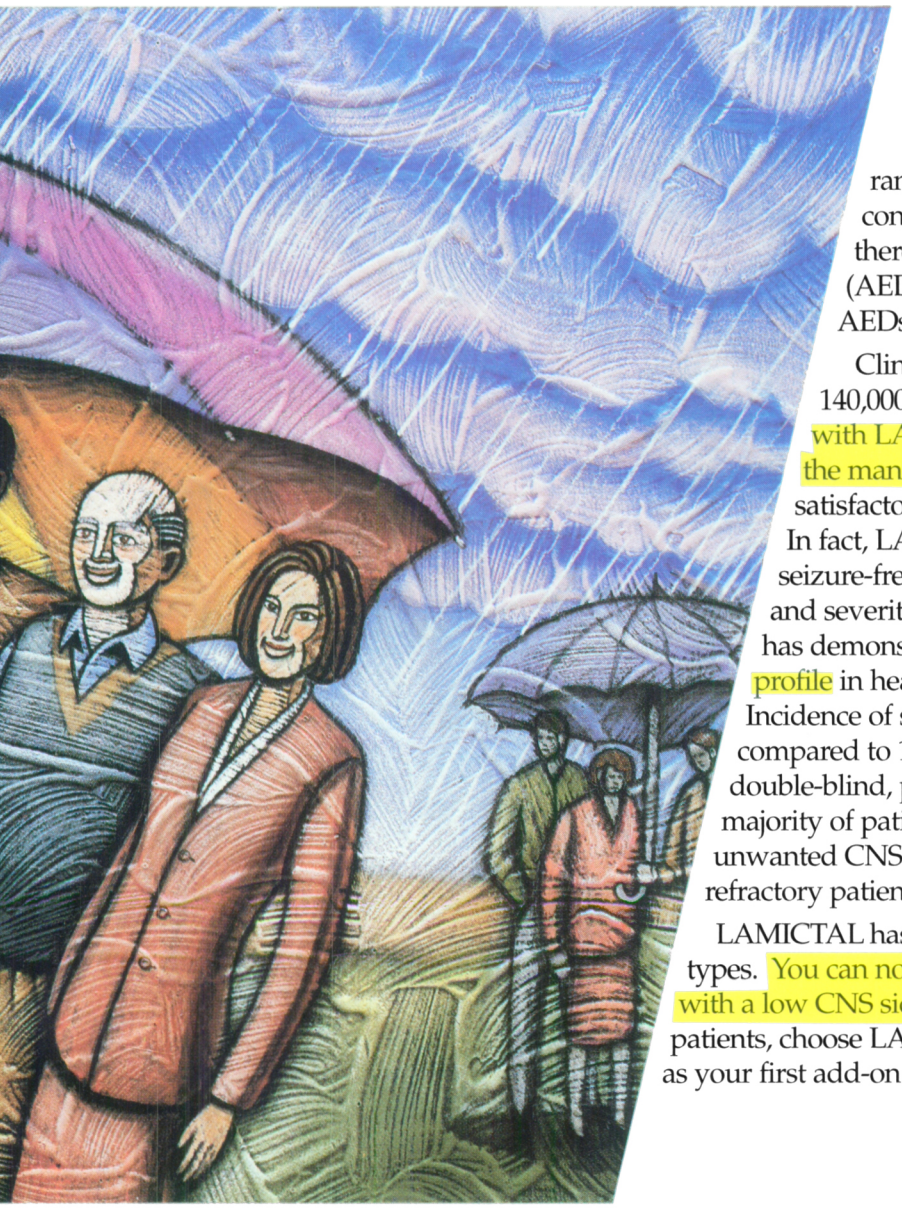
range of seizure types, side-effect profile



Many patients with epilepsy – across a wide range of seizure types – are unsatisfactorily controlled with conventional therapies.[1] Now there's LAMICTAL, a novel antiepileptic drug (AED) that is chemically unrelated to all other AEDs in current use.[1,2]

Clinical trials and worldwide experience in over 140,000 patients[3] have shown that adjunctive therapy with LAMICTAL offers a wide range of activity in the management of epilepsy for patients who are not satisfactorily controlled by conventional therapies.[1-24] In fact, LAMICTAL has been shown to render patients seizure-free[4-6,25] or to reduce seizure frequency[1,6,10,15-17,23,25] and severity in up to 65% of patients.[1,6,16,23,25] LAMICTAL has demonstrated a more favourable CNS side-effect profile in healthy volunteers compared to phenytoin.[26] Incidence of somnolence was 13% for LAMICTAL compared to 12% for placebo in pooled results of four double-blind, placebo-controlled studies.[7] Moreover, the majority of patients taking LAMICTAL will not experience unwanted CNS-related side effects.[5†] More of your refractory patients will feel better on LAMICTAL.[6,23]

LAMICTAL has activity across a wide range of seizure types. You can now offer your patients proven tolerability with a low CNS side-effect profile.[†] When faced with refractory patients, choose LAMICTAL – in 25- , 100- or 150-mg strengths – as your first add-on therapy.[‡]

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- *The frequency of exacerbations was reduced by approximately 30%*[1]
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• After a paper has been reviewed, the author will be requested to submit four copies of the revised manuscript, including illustrations and a computer diskette (3 1/2" or 5 1/4" size) containing the article. Identify clearly first author's name, file name, word processing program and version, and system (i.e. DOS 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. 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.

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• ***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.

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PRESCRIBING INFORMATION

SABRIL®
VIGABATRIN
Tablets 500 mg
Antiepileptic

ACTION AND CLINICAL PHARMACOLOGY

SABRIL (vigabatrin) is an irreversible inhibitor of gamma-aminobutyric acid transaminase (GABA-T), the enzyme responsible for the catabolism of the inhibitory neurotransmitter gamma-aminobutyric acid (GABA) in the brain. The mechanism of action of vigabatrin is attributed to irreversible enzyme inhibition of GABA-T, and consequent increased levels of the inhibitory neurotransmitter, GABA.

Decreased serum levels of SGOT (ALT) and SGPT (AST) have been observed during treatment with vigabatrin and may be the result of inhibition of these transaminases by vigabatrin. The clinical significance of these findings is unknown.

The duration of effect of vigabatrin is thought to be dependent on the rate of GABA-T resynthesis rather than on the plasma concentration of vigabatrin.

Clinical Trials

In clinical trials, including double-blind, placebo-controlled studies involving 354 patients with drug-resistant complex partial seizures, vigabatrin reduced seizure frequency by 50% or more in approximately half of the patients studied.

In clinical trials involving children, the efficacy of vigabatrin was similar to that seen in adult patients with refractory partial seizures. In one study of 70 children with intractable infantile spasms, approximately 70% of the patients had a greater than 50% reduction in spasms. In this study, long-term response was observed in 75% of the children with symptomatic infantile spasms and 36% of the children with cryptogenic infantile spasms.

Pharmacokinetics

Vigabatrin is rapidly absorbed following oral administration and peak plasma concentrations are reached within two hours. Vigabatrin is widely distributed with an apparent volume of distribution slightly greater than total body water. The primary route of elimination is via the kidney, with little metabolic transformation occurring. Following a single dose, approximately 70% is excreted in the urine as unchanged drug within the first 24 hours post-dose. The plasma elimination half-life is approximately 5-8 hours in young adults and 12-13 hours in the elderly. In renal impairment the elimination is prolonged and the rate of renal clearance is directly related to creatinine clearance (see PRECAUTIONS and DOSAGE AND ADMINISTRATION). Vigabatrin does not induce the hepatic cytochrome P450 system nor is it extensively metabolized or plasma-protein bound. Administration of vigabatrin with food slightly reduces the rate, but not the extent of absorption.

INDICATIONS AND CLINICAL USE

SABRIL (vigabatrin) is indicated for the adjunctive management of epilepsy which is not satisfactorily controlled by conventional therapy.

There is insufficient data on the usefulness of vigabatrin in monotherapy at this time.

Vigabatrin should be used under close monitoring by a neurologist.

CONTRAINDICATIONS

SABRIL (vigabatrin) is contraindicated in pregnancy and lactation (see WARNINGS) and in patients with a known hypersensitivity to vigabatrin or to any components of the product.

WARNINGS

Neurotoxicity in Animals

Rat, Mouse and Dog: Safety studies carried out in the rat, mouse and dog at doses of 30 to 50 mg/kg/day and higher, caused dose-and time-dependent microvacuolation within certain white matter tracts of the brain (the cerebellum, reticular formation and thalamus in rodents and the columns of the fornix and optic tracts in dogs were most affected). The microvacuolation was caused by the separation of the outer lamellar sheath of myelinated fibres, a change characteristic of non-inflammatory intramyelinic edema.

In both the rat and dog (mouse was not tested), the intramyelinic edema was reversible after stopping the administration of vigabatrin; however, in the mouse and rat, residual changes consisting of swollen axons and mineralised microbodies were observed.

Monkey: In monkeys, the oral administration of 300 mg/ kg/day for 16 months produced minimal microvacuolation with equivocal differences between treated and control animals. Low oral absorption of vigabatrin in the monkey resulted in an actual absorbed dose of 75 mg/kg/day. In spite of the poor absorption, cerebrospinal fluid (CSF) levels of vigabatrin in the monkeys were comparable to those seen in rats treated with 300 mg/kg/day; however, GABA levels in the CSF and the brain cortex in treated monkeys were not significantly different from untreated monkeys. This finding may explain the reason for the equivocal effects, since the intramyelinic edema associated with vigabatrin treatment appears to be to increased brain GABA levels.

Evoked Potentials

Evoked potentials in animals: In the dog, studies indicate that intramyelinic edema is associated with increased latencies in somatosensory and visual evoked potentials. Magnetic resonance imaging (MRI) changes also correlated with intramyelinic edema in the fornix, thalamus and hypothalamus.

Evoked potentials in man: No increased evoked potential latencies have been observed in man. Two hundred and twenty-one patients treated for 4-5 months showed no significant evoked potential latency changes at the end of treatment as compared to baseline. MRI results in man did not show the changes observed in dogs who had intramyelinic edema.

Postmortem neuropathological changes seen in 11 patients who were treated with vigabatrin (mean duration of treatment was 28 months, and the longest treatment was 6 years) showed no myelin vacuolation in the white matter that was considered to be outside of the control range.

Although clinical trials have not revealed the type of neurotoxicity seen in animal studies, because of increased CSF GABA levels observed in humans, it is recommended that patients treated with vigabatrin be closely observed for adverse effects on neurological function, with special attention to visual disturbance.

Use in Pregnancy and Lactation: In a teratology study in the rabbit a dose-related incidence, 2% and 9%, of cleft palate was observed at doses of 150 and 200 mg/kg/day, respectively.

In animal reproductive studies neurohistopathology was not performed on the fetuses, therefore it is not known whether micro-vacuolation occurred in utero. The possibility that microvacuolation or other neurotoxicity may occur in human fetuses cannot be discarded.

PRECAUTIONS

Use in Patients with a History of Psychosis Behavioural disturbances such as aggression and psychotic episodes have been reported following initiation of vigabatrin therapy. A history of abnormal behaviour or psychosis appears to be a predisposing factor for such reactions, therefore treatment in such patients should be initiated cautiously at low doses and with frequent monitoring.

Use in the Elderly and in Patients with Renal Impairment Vigabatrin is eliminated via the kidney and caution should be exercised when administering the drug to elderly patients and to patients with renal impairment (see DOSAGE AND ADMINISTRATION).

Use in Patients with Myoclonic Seizures As with other antiepileptic drugs, some patients may experience an increase in seizure frequency with vigabatrin. Patients with myocionic seizures may be particularly liable to this effect.

Discontinuation of Therapy As with other antiepileptic drugs, abrupt discontinuation may lead to rebound seizures. If a patient is to be withdrawn from vigabatrin treatment, it is recommended that this be done gradually by reducing the dose over a 2 to 4 week period if possible.

Drug Interactions A gradual reduction of about 20% in plasma phenytoin concentration has been observed following add-on therapy with vigabatrin. The mechanism whereby this occurs is unknown. Limited data from clinical trials suggest that increasing the phenytoin dose to compensate may not be necessary.

Occupational Hazards Patients with uncontrolled epilepsy should not drive or handle potentially dangerous machinery. During clinical trials, the most common adverse reactions observed were drowsiness and fatigue. Patients should be advised to refrain from activities requiring mental alertness or physical coordination until they are sure that vigabatrin does not affect them adversely.

ADVERSE REACTIONS

SABRIL (vigabatrin) is generally well tolerated in epileptic patients. Adverse events are mainly CNS-related and probably a secondary consequence of increased GABA levels caused by vigabatrin. The safety of vigabatrin was evaluated in 2081 epileptic patients treated in clinical trials. The relationship of adverse events to vigabatrin therapy was not clearly established as patients were taking other antiepileptic drugs concomitantly. The most frequently reported adverse events were somnolence (12.5%), fatigue (9.2%), and weight gain (5.0%).

The following adverse events were observed in more than 1% of patients:

Adverse Events Reported By More Than 1% of Patients

Body System/ Adverse Event	Number of Patients	Incidence n=2081
Nervous		
somnolence	261	12.5
headache	80	3.8
dizziness	79	3.8
nervousness	56	2.7
depression	52	2.5
memory disturbances	47	2.3
diplopia	46	2.2
aggression	42	2.0
ataxia	39	1.9
vertigo	39	1.9
hyperactivity	37	1.8
vision abnormal	34	1.6
confusion	29	1.4
insomnia	26	1.3
impaired concentration	25	1.2
personality disorder	23	1.1
agitation	21	1.0
Digestive		
abdominal pain	34	1.6
constipation	29	1.4
vomiting	28	1.4
nausea	28	1.4
Body as a Whole		
fatigue	192	9.2
weight gain	104	5.0
asthenia	23	1.1

Adverse events reported with a frequency of less than 1% include: anxiety, emotional lability, behavioural disturbances including psychosis, irritability, tremor, abnormal gait, speech disorder, increased appetite, and dyspepsia.

As with other antiepileptic drugs, some patients may experience an increase in seizure frequency with vigabatrin treatment (see PRECAUTIONS).

Laboratory data indicate that vigabatrin treatment does not lead to renal or hepatic toxicity. Chronic treatment with vigabatrin may be associated with a slight decrease in hemoglobin, which rarely attains clinical significance.

Pediatric Safety Safety data is available in 299 children, aged 2 months to 16 years (1 patient was 18 years of age), participating in clinical trials with vigabatrin. Relationship of adverse events to vigabatrin therapy was not clearly established as children were taking other antiepileptic drugs concomitantly.

The most frequent adverse event observed in children was "hyperactivity" (reported as hyperkinesia 7.7%, agitation 2.3%, excitation 0.3% or restlessness 0.7%), which was observed in 11.0% of children, an incidence higher than that seen in adults. Other commonly reported adverse events were somnolence (8.0%) and weight gain (3.0%).

The following adverse events were reported in children with a frequency greater than 1%:

Adverse Events Reported By More Than 1% of Pediatric Patients

Body System/ Adverse Event	Number of Patients	Incidence n=299
Nervous		
somnolence	24	8.0
hyperkinesia	23	7.7
aggression	8	2.7
insomnia	8	2.7
agitation	7	2.3
ataxia	7	2.3
emotional lability	3	1.0
headache	3	1.0
increased seizures	3	1.0
Digestive		
vomiting	6	2.0
nausea	3	1.0
increased saliva	3	1.0
Body as a Whole		
weight gain	9	3.0
fatigue	8	2.7
hypotonia	3	1.0

SYMPTOMS AND TREATMENT OF OVERDOSAGE

There is no specific antidote. The usual supportive measures should be employed.

Two cases of SABRIL (vigabatrin) overdose have been reported. In the first case, the patient accidentally took a dose of 14 g daily for 3 days and transient vertigo and tremor were reported. In the second case, an 18-year old female took 30 g of vigabatrin and 250 mg of chlorazepate in a suicide attempt. The patient was admitted to hospital in a state of coma which lasted four days; however, the coma was considered to be due to the chlorazepate rather than vigabatrin. The patient recovered without sequelae.

DOSAGE AND ADMINISTRATION

SABRIL (vigabatrin) is intended for oral administration once or twice daily and may be taken with or without food. Sabril should be added to the patient's current antiepileptic therapy.

Instructions to the patient on the use of SABRIL are provided in the INFORMATION FOR THE CONSUMER section.

Adults The recommended starting dose is 1 g/day, although patients with severe seizure manifestations may require a starting dose of up to 2 g/day. The daily dose may be increased or decreased in increments of 0.5 g depending on clinical response and tolerability. The optimal dose range is between 2-4 g/day. Increasing the dose beyond 4 g/day does not usually result in improved efficacy and may increase the occurrence of adverse reactions.

Children The recommended starting dose in children is 40 mg/kg/day, increasing to 80 - 100 mg/kg/day depending on response. Therapy may be started at 0.5 g/day, and raised by increments of 0.5 g/day weekly depending on clinical response and tolerability.

Elderly and Renally Impaired Patients Vigabatrin is almost exclusively eliminated via the kidney and, therefore, caution should be exercised when administering the drug to the elderly, and more particularly to patients with creatinine clearance less than 60 mL/min. It is recommended that such patients be started on a lower dose of vigabatrin and observed closely for adverse events such as sedation and confusion.

Bodyweight	Daily Dose	No. Tablets/Day
10 - 15 kg	0.5 – 1 g/day	1 – 2 tablets/day
16 - 30 kg	1 – 1.5 g/day	2 – 3 tablets/day
31 - 50 kg	1.5 – 3 g/day	3 – 6 tablets/day
> 50 kg	2 – 4 g/day	4 – 8 tablets/day

AVAILABILITY OF DOSAGE FORMS

Tablets

Each SABRIL (vigabatrin) 500 mg tablet is white to off-white film-coated, oval biconvex, and imprinted "SABRIL" on one side. SABRIL is available in HDPE bottles containing 100 tablets.

Product Monograph available on request.

References:

1 Grant SM, Heel RC, A Review of its Pharmacodynamic and Pharmacokinetic Properties, and Therapeutic Potential in Epilepsy and Disorders of Motor Control. Drugs. Adis International: June 1991, Vol. 41 No. 6, pg. 889-926.

2 Arzimanoglou AA, Dumas C, Chirardi L et al. Multicentre clinical evaluation of vigabatrin (Sabril) in mild to moderate partial epilepsies. Epilepsia 1995;36(S3)

3 Reynolds BH, Ring HA Farr IN et al. Open, double-blind and long term study of vigabatrin in long term epilepsy. Epilepsia 1991;32:(4):530-538.

4 Doddrill CB, Arnett JL, Sommerville KW, Sussman NM. Effects of differing dosages of vigabatrin (Sabril) on cognitive abilities and quality of life in epilepsy. Epilepsia 1995;36(2):164-173.

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Pour documentation voir page x.

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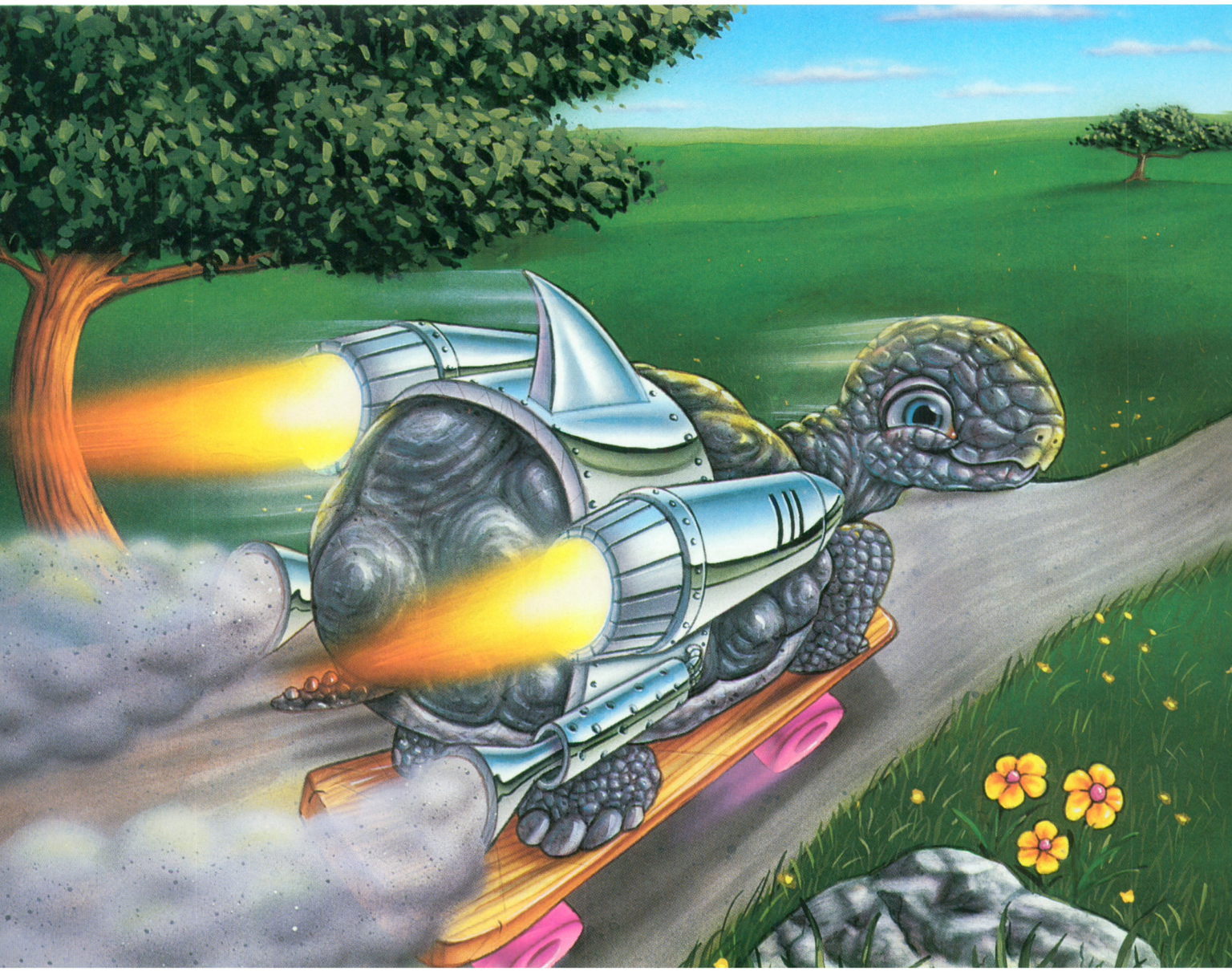
Introducing MIGRANAL

A 5-HT$_1$ agonist that starts fast and offers



5-HT$_1$ agonist therapy

- MIGRANAL relieves migraine headaches and associated symptoms[1]
- Nasal administration bypasses the GI tract

Fast onset of relief

- Can be taken at any stage of the migraine[1,◊]
- Clinical response begins within 30 minutes[1]
- MIGRANAL relieved up to 70% of migraines at 4 hours (n=105)[2,†]

Long-lasting relief††

- Long half-life: 10 hours[1]
- 85% of responders had no return of migraine within 24 hours after taking MIGRANAL (n=73)[2]
- Therefore, MIGRANAL may help avoid the need for repeated dosing, rescue medication, and the associated costs

◊ For best results, treatment should be initiated at the first sign/symptom of a migraine attack.

† Relief = from moderate/severe pain to mild/no pain

†† Up to 24 hours with a single 2 mg dose

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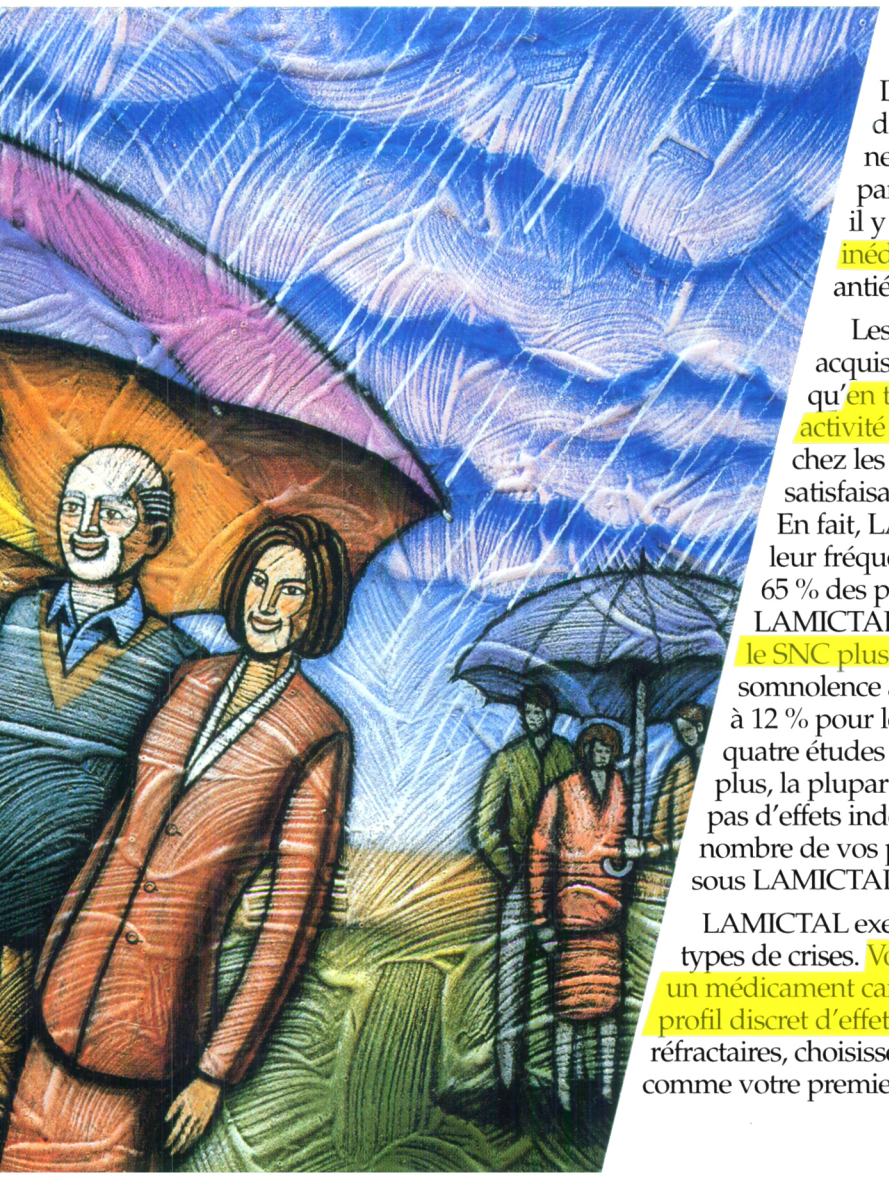
tail de types de crises avec secondaires sur le SNC



De nombreux patients souffrant d'épilepsie – dans un vaste éventail de types de crises – ne sont pas contrôlés de façon satisfaisante par les traitements conventionnels[1]. Maintenant, il y a LAMICTAL, un nouvel antiépileptique inédit sans parenté chimique avec aucun autre antiépileptique actuel[1,2].

Les essais cliniques et l'expérience mondiale acquise chez plus de 140 000 patients[3] ont montré qu'en traitement d'appoint, LAMICTAL offre une activité étendue dans le traitement de l'épilepsie chez les patients qui ne sont pas contrôlés de façon satisfaisante avec les traitements conventionnels[1-24]. En fait, LAMICTAL a supprimé les crises[4-6,25] ou diminué leur fréquence[1,6,10,15-17,23,25] et leur gravité chez jusqu'à 65 % des patients[1,6,16,23,25]. Chez des volontaires en santé, LAMICTAL a présenté un profil d'effets secondaires sur le SNC plus favorable que la phénytoïne[26]. L'incidence de somnolence a été de 13 % pour LAMICTAL par rapport à 12 % pour le placebo dans les résultats combinés de quatre études à double insu contrôlées par placebo[7]. De plus, la plupart des patients sous LAMICTAL n'éprouveront pas d'effets indésirables qui affectent le SNC[5†]. Un plus grand nombre de vos patients réfractaires se sentiront donc mieux sous LAMICTAL[6,23].

LAMICTAL exerce une activité dans un vaste éventail de types de crises. Vous pouvez maintenant offrir à vos patients un médicament caractérisé par une tolérabilité éprouvée et un profil discret d'effets indésirables sur le SNC[†]. Pour vos patients réfractaires, choisissez LAMICTAL – en 25, 100 ou 150 mg – comme votre premier traitement d'appoint[‡].

lamotrigine

Lamictal®

Pour documentation voir pages xxviii, xxix.

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32ND MEETING OF THE CANADIAN CONGRESS OF NEUROLOGICAL SCIENCES

June 24 - 28, 1997 Saskatoon, SK, Canada

PRELIMINARY PROGRAM

Guest Lecturers

Dr. Peter Dyck, Rochester, MN
Dr. Patrick Kelly, New York, NY
Dr. Ali Rajput, Saskatoon, SK
Dr. Robert C. Vannucci, Hershey, PA
Dr. Anne Young, Boston, MA
Dr. Kevin Foley, Memphis, TN
Dr. Fred Andermann, Montreal, QC

Topics

- Cerebrovascular Disease in Infants and Children
- Neurobiology - DNA
- Peripheral Neuropathies
- Movement Disorders
- Malignant Gliomas
- Lumbar Spine
- Dementia
- Trauma
- Cerebrovascular Disease
- Multiple Sclerosis
- Headache

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Calgary, Alberta, Canada T2R 1K7
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E-mail: brains@ccns.org

1997 NORTH AMERICAN STROKE MEETING

Clinical Aspects of Stroke Diagnosis and Treatment
October 16-18, 1997 Montreal, Quebec, Canada

The focus of this conference is to educate physicians, surgeons and other health professionals in clinical aspects of stroke, and the enhancement of their skills in diagnosing, treating and managing patients with stroke.

Topics

- Clinical Trials
- Cerebral Angioplasty
- Acute Cerebral Ischemia
- Hemorrhagic Stroke
- Organized Stroke Care
- Long Term Stroke Prevention
- Nutrition and Swallowing
- Thrombolysis in Acute Stroke
- Ultrasound in Cerebrovascular Disease

For meeting information please contact Ms. Kimberly Anderson at the CCNS (as above) or Ms. Thelma Edwards, R.N., National Stroke Association at (303) 649-9299 ext. 919 for additional information.

Pour documentation voir pages xxvi, xxvii.

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Voici MIGRANAL en

Un agoniste des récepteurs 5-HT$_1$ qui agit rapidement et

Agoniste des récepteurs 5-HT$_1$

- MIGRANAL soulage la migraine et les symptômes connexes[1].
- L'administration par voie nasale permet de contourner le tractus gastro-intestinal.

Pour un soulagement rapide

- On peut prendre MIGRANAL à n'importe quel stade de la migraine[1,◊].
- La réponse clinique commence à se manifester en moins de 30 minutes[1].
- Jusqu'à 70 % des migraines sont soulagées 4 heures après l'administration de MIGRANAL (n = 105)[2,†].

Pour un soulagement durable††

- Longue demi-vie : 10 heures[1]
- Pas de réapparition de la migraine chez 85 % des répondeurs au cours des 24 heures suivant l'administration de MIGRANAL (n = 73)[2]
- Par conséquent, MIGRANAL peut permettre d'éviter le renouvellement fréquent de la dose, la prise de médicaments d'urgence, ainsi que les coûts qui s'y rattachent.

◊ Pour de meilleurs résultats, entreprendre le traitement dès les premiers signes ou symptômes d'une crise migraineuse.

† Soulagement = disparition complète ou atténuation de la douleur modérée ou grave

†† Jusqu'à 24 heures avec une seule dose de 2 mg

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vaporisateur nasal

qui offre un soulagement durable de la migraine

Généralement bien toléré lors des essais cliniques[1]

- Les effets indésirables les plus courants étaient transitoires, spontanément résolutifs et peut-être imputables à la voie d'administration[2,3]. La rhinite (incidence de 25 %) comprend : rhinite, rhinorrhée, congestion nasale, sécheresse et oedème de la muqueuse nasale et éternuements en rafale. Parmi les autres effets secondaires observés, mentionnons les nausées (9 %), les perturbations gustatives (7 %) et les vomissements (4 %).

MIGRANAL*

(mésylate de dihydroergotamine en vaporisateur nasal)

Soulagement rapide et durable de la migraine

MIGRANAL est contre-indiqué chez les patients prédisposés aux réactions angiospastiques. Veuillez consulter les renseignements posologiques pour obtenir plus de détails.

*Marque déposée

SANDOZ

SANDOZ CANADA INC.
Dorval (Québec) H9R 4P5

MIG-96-10-3501F

CCPP MEMBRE ACIM

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in

EPILEPSY

treatment goal is complete control

Impressive degree of complete seizure control[1]

Frisium is a "remarkably effective and [generally] safe add-on anti-epileptic drug"[1]

Effective in all seizure types, in adults and children alike[2]

Once-daily dosage, preferably at bedtime†

WIDE-RANGE

℞ Frisium (clobazam)

Once a Day†

† Daily dose can be divided for some patients

Frisium is indicated as adjunctive therapy in epileptic patients not adequately stabilized with their current anticonvulsant therapy. As with all benzodiazepines, patients (particularly geriatrics) should be cautioned accordingly. Most frequent adverse effects (> 1%) include drowsiness, dizziness, fatigue, ataxia, weight gain, nervousness, behaviour disorder, hostility and blurred vision.

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For brief prescribing information see page xxxii.

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