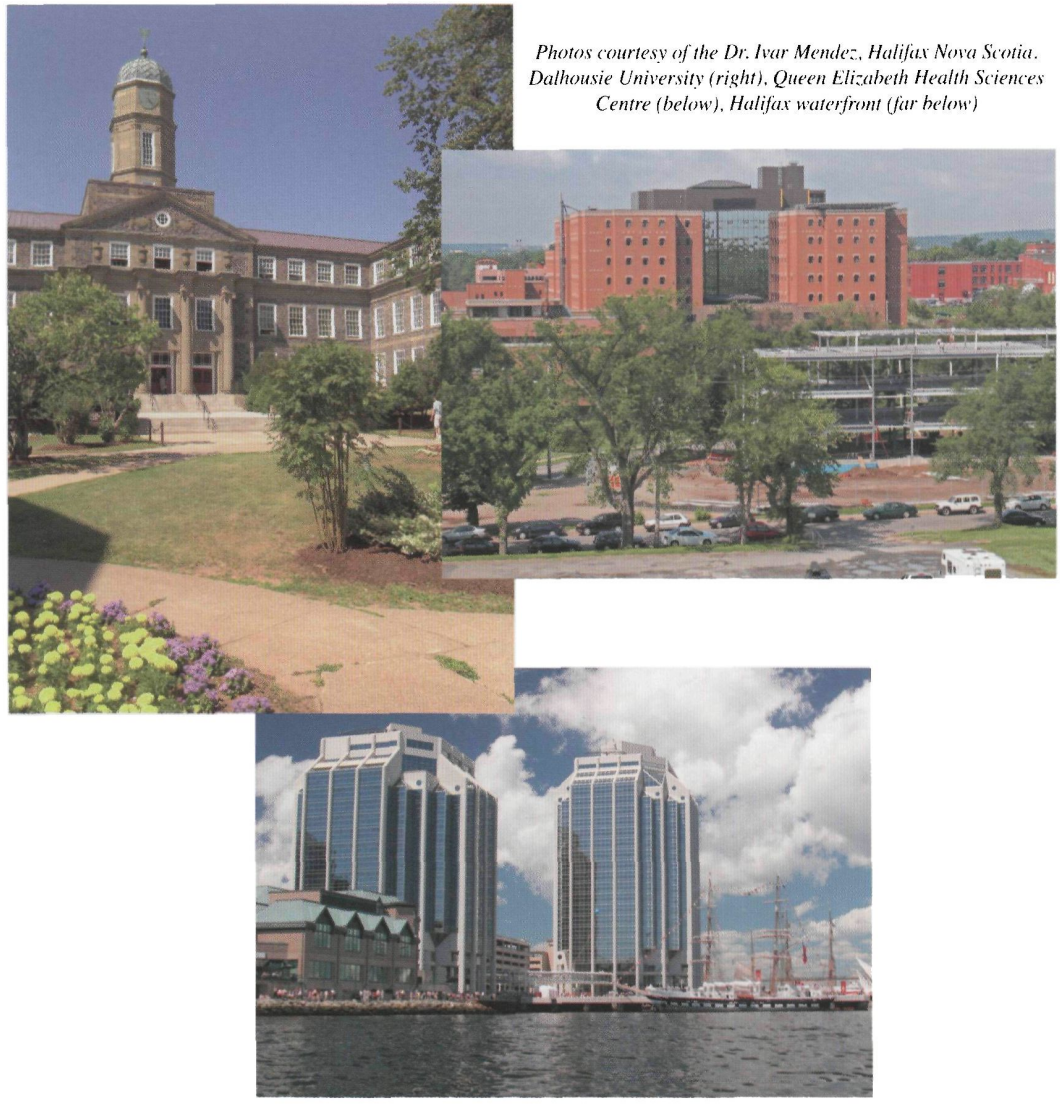
THE CANADIAN JOURNAL OF
Neurological Sciences

LE JOURNAL CANADIEN DES
Sciences Neurologiques

VOLUME 36 NUMBER 3 MAY 2009



Photos courtesy of the Dr. Ivar Mendez, Halifax Nova Scotia. Dalhousie University (right), Queen Elizabeth Health Sciences Centre (below), Halifax waterfront (far below)

Welcome all delegates to the 44th Annual Congress of The Canadian Neurological Sciences Federation June 9-12, 2009 - Halifax, Nova Scotia

AN INTERNATIONAL JOURNAL PUBLISHED BY THE CANADIAN NEUROLOGICAL SCIENCES FEDERATION

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

PM 40007777 R 9824

https://doi.org/10.1017/S0317167100117585 Published online by Cambridge University Press

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JOURNAL COVER

We are investigating different options for the cover of the Journal and thought it might be appropriate to include pictures of major Canadian Cities and/or Universities as taken by our readers.

If you are interested in submitting pictures, please send them to maggie-mccallion@cnsfederation.org in high resolution format, (i.e. tif or jpeg). Please also indicate your willingness to provide these pictures free of charge. Picture 'acknowledgement' will be provided.

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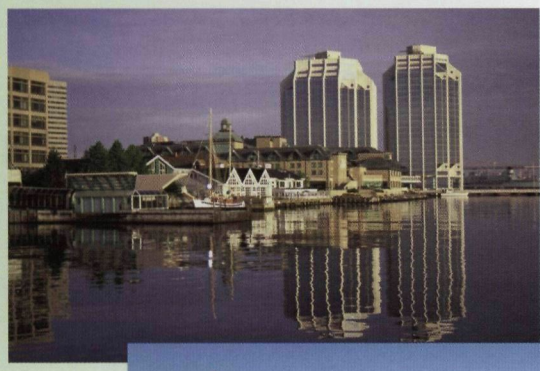
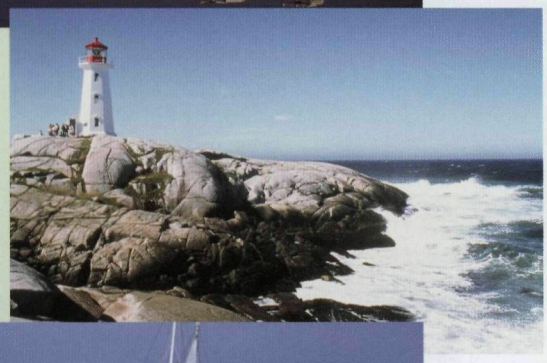
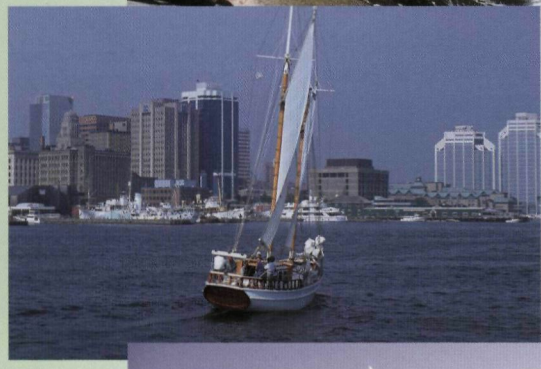
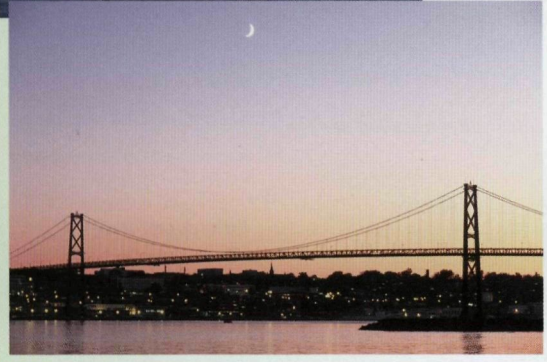
FÉDÉRATION DES SCIENCES NEUROLOGIQUES DU CANADA









Join us in Halifax, Nova Scotia for the

44th Annual Congress of the

Canadian Neurological Sciences Federation

June 9-12, 2009

Halifax Nova Scotia

Photos Courtesy Destination Halifax / Nova Scotia Tourism and Culture / W. Hayes

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Neurological Sciences

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Sciences Neurologiques

VOLUME 36 NUMBER 2 MARCH 2009

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 Neurological Sciences Federation is at:
Le secrétariat des quatre associations et du Fédération des sciences neurologiques du Canada est situe en permanence à:
7015 Macleod Trail SW, Suite 709, Calgary AB, Canada T2H 2K6.

The Canadian Journal of Neurological Sciences is published bi-monthly. The annual subscription rate for Individuals are: C$120 (Canada), C$140 (Foreign including USA). Subscription rates for Institutions are: C$150 (Canada), C$170 (Foreign including USA). See www.cjns.org for details. Single copies C$30 each plus postage and handling. Communications should be sent to: Canadian Journal of Neurological Sciences, 709 - 7015 Macleod Trail SW, Calgary, AB Canada T2H 2K6. Telephone (403) 229-9575; Fax (403) 229-1661. E-mail: journal@cjns.org; Web: www.cjns.org
 Mailed under Publications Mail Agreement no: 40007777; PAP Registration no: 09824. Postage paid at Calgary, Alberta. This journal is indexed by *ASCA, ASFA, AbHyg, AgBio, BIOBASE, BIOSIS Prev, BiolAb, ChemAb, CurCont, Dentlnd, EMBASE, ExcerpMed, HelmAb, IABS, ISR, IndMed, Inpharma, JW-N, LHB, MEDLINE, MycolAb, NRN, NSCI, NutrAb, PE&ON, PN&I, ProtozoAb, PsycInfo, PsycholAb, RM&VM, RRTA, Reac, RefZh, SCI, SCOPUS, TDB, WeedAb, e-psyche, BLDSC (3033.300000), CASDDS, CISTI, GNLM, IDS, IE, Infotrieve, Ingenta, CCC.*

Le Journal Canadien des Sciences Neurologiques est publié 6 fois par an. L'abonnement annuel est de 120 $C (non-membres au Canada); 140 $C (Etats Unis et ailleurs); l'abonnement annuel for pour les institutions est de 150 $C (non-membres au Canada); 170 $C (Etats Unis et ailleurs); Voir www.cjns.org pour détails. Copie simple: 30 $C plus affranchissement et manutention. Toutes les communications doivent être adressés à Journal Canadien des Sciences Neurologiques, 709 - 7015 Macleod Trail SW, Calgary, AB Canada T2H 2K6. Téléphone (403) 229-9575; Fax (403) 229-1661. E-mail journal@cjns.org; Web:www.cjns.org.
 Posté sous poste-publications: numéro de convention: 40007777; numéro d'enregistrement PAP 09824. Port payé à Calgary, Alberta. Le Journal est cité et indexé dans *ASCA, ASFA, AbHyg, AgBio, BIOBASE, BIOSIS Prev, BiolAb, ChemAb, CurCont, Dentlnd, EMBASE, ExcerpMed, HelmAb, IABS, ISR, IndMed, Inpharma, JW-N, LHB, MEDLINE, MycolAb, NRN, NSCI, NutrAb, PE&ON, PN&I, ProtozoAb, PsycInfo, PsycholAb, RM&VM, RRTA, Reac, RefZh, SCI, SCOPUS, TDB, WeedAb, e-psyche, BLDSC (3033.300000), CASDDS, CISTI, GNLM, IDS, IE, Infotrieve, Ingenta, CCC.*

Printer/Imprimeur:
Unicom Graphics, 4501 Manitoba Road SE
Calgary, Alberta T2G 4B9

We acknowledge the assistance of the Government of Canada through the Publications Assistance Program towards our mailing costs. Canada

ISSN 0317 - 1671

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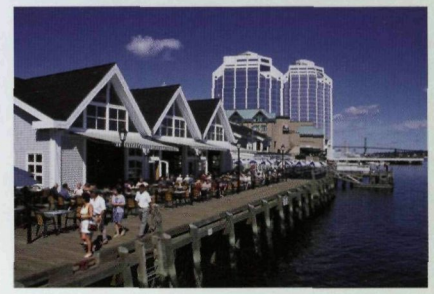
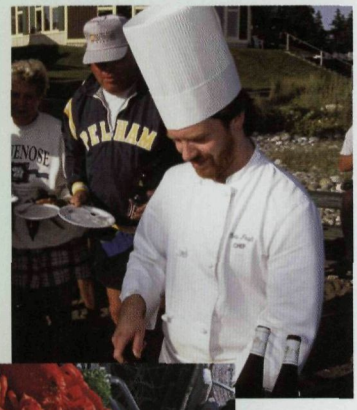


It will come as no surprise to long time Congress participants that the annual social event this year in Halifax will feature a lobster feast!



MARITIME LOBSTER SUPPER AND KITCHEN PARTY

Thursday June 11, 2009
at the Cunard Centre on historic Pier 23
along the Halifax harbour front.
After cracking your way through dinner, kick up your feet to live music, dancing and possibly a game or two. Tickets are $85 per person. Don't delay in purchasing your ticket as this event has sold out quickly every time the Congress has visited Halifax.
Reception: 18:00, Dinner and Dancing 19:00

Halifax Nova Scotia

Photos Courtesy Destination Halifax / Nova Scotia Tourism and Culture / W. Hayes

https://doi.org/10.1017/S0317167100117585 Published online by Cambridge University Press

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See prescribing summary on pages A-25-28

PrMAXALT RPD®
(rizatriptan benzoate):
The Most Dispensed Non-tablet Migraine Formulation in Canada[1]

Fast dissolving
RPD wafer can be taken
anytime, anywhere[2,*]

MAXALT® 10 mg and
MAXALT RPD® 10 mg
ALSO AVAILABLE IN
12 PACK

ALSO AVAILABLE IN TABLET FORMULATION.

MAXALT® (rizatriptan benzoate) is indicated for the acute treatment of migraine attacks with or without aura in adults. MAXALT® is not intended for the prophylactic therapy of migraine or for use in the management of hemiplegic, ophthalmoplegic or basilar migraine. Safety and effectiveness of MAXALT® have not been established for cluster headache, which is present in an older, predominantly male population.

MAXALT® 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 diseases should not receive MAXALT®.

MAXALT® is also contraindicated in patients with uncontrolled or severe hypertension.

MAXALT® is contraindicated in co-administration with monoamine oxidase (MAO) inhibitors within 2 weeks after discontinuation of treatment, and within 24 hours of administration of 5-HT_1 agonists or ergot-type medications. For a complete list of contraindications, please consult the Product Monograph.

The recommended single adult dose is 5 mg. The maximum recommended single dose is 10 mg.

The most common adverse events during treatment with MAXALT® (rizatriptan benzoate) tablets 10 mg were dizziness (8.9%), somnolence (8.4%), asthenia/fatigue (6.9%), nausea (5.7%) and pain/pressure sensation (chest, 3.1%; neck/throat/jaw, 2.5%; upper limb, 1.8%).

The most common adverse events during treatment with PrMAXALT RPD® (rizatriptan benzoate) wafers 10 mg were dizziness (8.6%), nausea (7.0%), dry mouth (6.0%), somnolence (5.3%), asthenia/fatigue (3.6%), and pain/pressure sensation (chest, 1.7%; neck/throat/jaw, 2.0%; upper limb, 2.0%).

MAXALT RPD® wafers contain phenylalanine (a component of aspartame).

*The wafer will dissolve rapidly and be swallowed with saliva. No liquid is needed to take the wafer.[2]
RPD = Rapidly dissolving

References:
1. Brogan Inc. Geographic Prescription Monitor (GPM®) October 2007 to September 2008.
2. Data on file, Merck Frosst Canada Ltd.: Product Monograph, MAXALT®, 2008.

BEFORE PRESCRIBING **MAXALT®**, PLEASE CONSULT THE ENCLOSED PRESCRIBING INFORMATION.

PRODUCT MONOGRAPH AVAILABLE FOR DOWNLOAD AT www.merckfrosst.com

Please visit our website at: **www.merckfrosst.com**

PrMaxalt® (rizatriptan benzoate)

MERCK FROSST
Discovering today for a better tomorrow.
Merck Frosst Canada Ltd., Kirkland, Quebec

PAAB

MXT-08-CDN-34381016-JA

https://doi.org/10.1017/S0317167100117585 Published online by Cambridge University Press

See prescribing summary on pages A-13-16

The ongoing, large-scale, international RE-LY™ study of **stroke prevention in atrial fibrillation (AF)*** is just part of our comprehensive RE-VOLUTION™ clinical program.

RELY™
Study of stroke prevention in atrial fibrillation

RE-LY: To demonstrate the efficacy and safety of dabigatran etexilate ([Pr]PRADAX™) in patients with non-valvular atrial fibrillation for the prevention of stroke (including hemorrhagic) and systemic embolism.*

Study design:

18,000 patients with AF†
at moderate to high risk of stroke or systemic embolism

R

- **Oral PRADAX** (dabigatran etexilate) **110 mg b.i.d.** (blinded)
- **Oral PRADAX** (dabigatran etexilate) **150 mg b.i.d.** (blinded)
- **Warfarin** (dosed to INR control: 2.0-3.0) (open-label)

Primary outcomes:
- Incidence of stroke (including hemorrhagic) and systemic embolism

Secondary outcomes:
- Incidence of stroke (including hemorrhagic)
- Systemic embolism
- Pulmonary embolism
- All death incidence of stroke (including hemorrhagic)
- Acute myocardial infarction, or vascular deaths (including deaths from bleeding)

42 months

†Patients aged 18+ with non-valvular atrial fibrillation (AF), at moderate to high risk of stroke or systemic embolism with at least one additional risk factor (i.e. previous ischemic stroke, TIA, or systemic embolism, left ventricular dysfunction, ≥ 75 years of age, ≥ 65 years of age with either diabetes mellitus, history of coronary artery disease, or hypertension.

R = Randomization

*PRADAX is not indicated for the prevention of stroke and systemic embolism in patients with atrial fibrillation.

PRADAX (dabigatran etexilate) is indicated for the prevention of venous thromboembolic events (VTE) in patients who have undergone elective total hip replacement or total knee replacement surgery. As with all anticoagulants, bleeding may occur. Should severe bleeding occur, treatment with PRADAX must be discontinued and the source of bleeding investigated promptly. Treatment that should NOT be administered concomitantly with PRADAX due to increased bleeding risk includes: unfractionated heparin and heparin derivatives, low molecular weight heparins (LMWH), fondaparinux, bivalirudin, thromboembolic agents, GPIIb/IIIa receptor antagonists, clopidogrel, ticlopidine, sulfinpyrazone, and vitamin K antagonists, such as warfarin. Unfractionated heparin can be administered at doses necessary to maintain a patent central venous or arterial catheter. Co-administration of ASA (81-325 mg daily) has been shown to increase risk of bleeding when given with PRADAX at doses above those currently recommended, i.e. above 220 mg daily. Co-administration of low-dose ASA, i.e. ≤160 mg daily, with PRADAX has not been adequately studied and is not recommended.

The most common adverse events (those observed in ≥ 2% of patients), were wound secretion [4.7% (150 mg), 4.8% (220 mg), 3.0% (enox.)], anemia [4.0% (150 mg), 4.4% (220 mg), 4.5% (enox.)], ALT ≥3x ULN [2.5% (150 mg), 2.2% (220 mg), 3.5% (enox.)], post-procedural hematoma [2.4% (150 mg), 1.7% (220 mg), 2.5% (enox.)], hemoglobin decreased [1.6% (150 mg), 1.3% (220 mg), 2.4% (enox.)], post-procedural hemorrhage [1.5% (150 mg), 2.4% (220 mg), 1.7% (enox.)], anemia post-operative [1.4% (150 mg), 2.0% (220 mg), 1.8% (enox.)].

Contraindications include: severe renal impairment (CrCL <30 mL/min); hemorrhagic manifestations; bleeding diathesis, or patients with spontaneous or pharmacologic impairments of hemostasis; lesions at risk of clinically significant bleeding, eg. cerebral infarction (hemorrhagic or ischemic) within the last 6 months; concomitant treatment with strong P-glycoprotein inhibitors, eg. quinidine; known hypersensitivity to dabigatran or dabigatran etexilate or to any ingredient in the formulation or component of the container.

PRADAX is not recommended in patients with moderate or severe hepatic impairment (Child-Pugh classification B and C), elevated liver enzymes (>2x ULN) or in patients undergoing anesthesia with post-operative indwelling epidural catheters.

Women of child-bearing potential should avoid pregnancy during treatment. Breast-feeding during treatment is not recommended. The safety and efficacy of PRADAX has not been established in children younger than 18 years of age, so PRADAX is not recommended in this patient population. Limited data are available in patients of low body weight (<50 kg), so in these patients, PRADAX should be used with caution.

For complete prescribing information, please refer to the Product Monograph for further information on PRADAX including warnings and precautions, dosing guidelines and patient selection.

Boehringer Ingelheim

References: 1. Randomized Evaluation of Long Term Anticoagulant Therapy (RE-LY) With Dabigatran Etexilate [Online]. 2005 Dec 6 [cited 2008 Oct 8]; Available from: URL: http://www.clinicaltrials.gov/ct2/show/NCT00262600?term=NCT00262600&rank=1.
2. PRADAX™ Product Monograph, Boehringer Ingelheim (Canada) Ltd. June 10, 2008.

https://doi.org/10.1017/S0317167100117585 Published online by Cambridge University Press

LYRICA may be useful in the management of central neuropathic pain (NeP) in adult patients for which it has been issued marketing authorization with conditions to reflect the promising nature of the clinical evidence and the need for a confirmatory study to verify its clinical benefit. Patients should be advised of the nature of the authorization.

NEW

Pregabalin: First and only first-line analgesic with a conditional indication in central neuropathic pain

Pr LYRICA®

Powerful Pain Relief

Powerful. Fast onset. Sustained relief.

- Pain relief shown in postherpetic neuralgia (PHN) and central NeP as early as week 1 and demonstrated over 3 months[1-3*†]
- Improvement shown in pain-related sleep interference in PHN and central NeP as early as week 1 and demonstrated over 3 months[1-4*†]

Significant improvement in overall status.

- Significant improvement demonstrated in patient-reported overall status (Patient Global Impression of Change [PGIC]) in patients with peripheral NeP [diabetic peripheral neuropathy (DPN) or PHN] and central NeP[1-3,5*†‡]

LYRICA (pregabalin) is an analgesic indicated for the management of neuropathic pain (NeP) associated with DPN and PHN.

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 (≥5% and 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 (9.0-37.0%), somnolence (6.1-24.7%), peripheral edema (6.1-16.2%), and dry mouth (1.9-14.9%). The most commonly observed adverse events seen in central NeP patients (≥5% and twice the rate as that seen with placebo) in the recommended dose range of 150 mg/day to 600 mg/day were: somnolence (41.4%), dizziness (24.3%), asthenia (15.7%), dry mouth (15.7%), edema (12.9%), constipation (12.9%), amnesia (10.0%), myasthenia (8.6%), amblyopia (8.6%), and thinking abnormal (8.6%). The most commonly observed adverse events in the PHN, DPN, and central NeP patients were usually mild to moderate in intensity. Discontinuation rates due to adverse events for LYRICA and placebo, respectively, were 9% and 4% in DPN, 14% and 7% in PHN and 21% and 13% in central NeP.

Dosage reduction is required in patients with renal impairment (creatinine clearance <60 mL/min) as LYRICA is primarily eliminated by renal excretion.

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

* A 13-week, multicentre, double-blind, placebo-controlled trial in 368 patients with PHN. A significant difference in pain reduction was shown over placebo for all doses: 150 mg/day, 300 mg/day, and 600 mg/day ($p \leq 0.01$, weeks 1-13). Sleep interference was improved at all time points (weeks 1 to 13 and endpoint) for the three doses evaluated ($p \leq 0.01$ vs. placebo). PGIC was reported as (at least minimally) improved by 51.2%, 47.9% and 67.1% of patients treated with LYRICA doses of 150, 300, and 600 mg/day vs. 35.5% of patients in the placebo group. At study termination, patients in the 150 mg/day ($p=0.02$) and 600 mg/day group ($p=0.003$) were more likely to report global improvement than those in the placebo group.

† Data based on a 12-week, parallel-group, double-blind, flexible-dose, placebo-controlled study. 137 patients with spinal cord injury for ≥1 year and who had a pain score ≥40 mm on the 100-mm visual analog scale (VAS) of the Short-Form-McGill Pain Questionnaire (SF-MPQ) were randomized to LYRICA 150 to 600 mg/day (n=70) or placebo (n=67) BID. Pain scores rated on 11-point numerical scale from 0 (no pain) to 10 (worst possible pain) during the past 24 hours averaged over the last seven days. Pain-related sleep interference scores rated on 11-point numerical scale from 0 (did not interfere) to 10 (completely interferes) during the past 24 hours averaged over the last seven days. A significant difference in pain reduction was demonstrated for the LYRICA group vs. placebo at all time points evaluated ($p \leq 0.001$, weeks 1-7 and endpoint and $p \leq 0.01$, weeks 8-12). Sleep interference was significantly improved at all time points (weeks 1 to 12 and endpoint) vs. placebo ($p \leq 0.01$, weeks 4, 10 and 12 and $p \leq 0.001$ for all other time points evaluated and endpoint). PGIC was reported as (at least minimally) improved by 56.5% and 21.5% of patients in the LYRICA and placebo treatment groups, respectively ($p<0.001$ for overall LYRICA comparison vs. placebo across "improved", "unchanged" and "worse" subgroups).

‡ A 12-week, multicentre, randomized, 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 ($p \leq 0.05$, week 2-3 and $p \leq 0.01$, weeks 4-12), and the fixed dose of 600 mg/day ($p \leq 0.05$, week 1 and $p \leq 0.01$, weeks 2-12). PGIC was reported as very much improved or much improved by 52.0% of the flexible-dose group, 53.6% of the fixed-dose group and 30.5% of the placebo group ($p<0.01$ for overall comparison of both LYRICA treatment groups vs. placebo across "improved", "unchanged" and "worse" subgroups).

References: 1. Data on file, Pfizer Canada Inc., Study 1008-196. **2.** van Seventer R, Feister HA, Young JP *et al*. Efficacy and tolerability of twice-daily pregabalin for treating pain and related sleep interference in postherpetic neuralgia: a 13-week, randomized trial. *Curr Med Res Opin* 2006; 22(2):375-84. **3.** Siddall PJ *et al*. Pregabalin in central neuropathic pain associated with spinal cord injury: a placebo-controlled trial. *Neurology* 2006; 67:1792-800. **4.** LYRICA Product Monograph, Pfizer Canada Inc., November 8, 2007. **5.** Freynhagen R, Strojek K, Griesing T *et al*. Efficacy of pregabalin in neuropathic pain evaluated in a 12-week, randomised, double-blind, multicentre, placebo-controlled trial of flexible- and fixed-dose regimens. *Pain* 2005; 115:254-63.

Pfizer

Working for a healthier world™

PAAB Member R&D

Pr LYRICA® PREGABALIN

Fast onset. Sustained relief.

See prescribing summary on pages A-23-24

Choose RELPAX ONE migraine therapy that has demonstrated rapid, reliable relief.[1-4†‡§]

- Demonstrated headache response as quickly as **30 minutes postdose vs. placebo** (RELPAX 40 mg: 9%; placebo: 4%, $p<0.05$)[1,2†]
- Provided **greater relief of associated symptoms vs. sumatriptan 100 mg at 2 hours** (absence of nausea: 74% vs. 67%, $p<0.01$; absence of photophobia: 71% vs. 63%, $p<0.01$; absence of phonophobia: 74% vs. 67%, $p<0.01$)[3‡]
- Demonstrated **superior functional response at 2 hours vs. sumatriptan 100 mg** (68% vs. 61%, $p<0.01$; 63% vs. 46%, $p<0.005$)[3,4‡§]

RELPAX tablets are indicated for the acute treatment of migraine with or without aura in adults. RELPAX tablets are not intended for the prophylactic therapy of migraine or for use in the management of hemiplegic, ophthalmoplegic or basilar migraine. Safety and effectiveness of RELPAX tablets have not been established for cluster headache, which is present in an older, predominantly male population.

Among 5984 patients who treated a single migraine headache with RELPAX 20 mg, 40 mg or 80 mg tablets in short-term, placebo-controlled trials, the most common and dose-related adverse events reported with treatment with RELPAX were asthenia (7.2%), nausea (7.8%), dizziness (5.7%) and somnolence (5.2%). RELPAX 80 mg is not an available dose. The maximum daily dose is 40 mg.

RELPAX 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 diseases (e.g., atherosclerotic disease, congenital heart disease) or uncontrolled or severe hypertension should not receive RELPAX. Serious cardiac events, including acute myocardial infarction, life-threatening disturbances of cardiac rhythm and death, have occurred within a few hours following the use of other 5-HT_1 agonists. These events are extremely rare and have been commonly reported in patients with CAD risk factors or a family history of CAD. RELPAX is contraindicated within 72 hours of treatment with potent CYP3A4 inhibitors (i.e., ketoconazole, itraconazole, nefazodone, troleandomycin, clarithromycin, ritonavir and nelfinavir). RELPAX is contraindicated within 72 hours with drugs that have demonstrated potent CYP3A4 inhibition and have this potent effect described in the CONTRAINDICATIONS, or WARNINGS AND PRECAUTIONS sections of their labeling. RELPAX is contraindicated within 24 hours of treatment with another 5-HT_1 agonist, an ergotamine-containing or ergot-type medication such as dihydroergotamine (DHE) or methysergide. RELPAX is contraindicated in patients with hemiplegic, ophthalmoplegic or basilar migraine, patients with severe hepatic impairment, and those with known hypersensitivity to eletriptan or any of its inactive ingredients.

† In a multicentre, double-blind, placebo-controlled, parallel-group clinical trial, 1334 outpatients with a diagnosis of migraine were randomized to receive RELPAX 20 mg, 40 mg, or 80 mg, or placebo for the treatment of up to 3 migraine attacks. The efficacy, consistency, tolerability and safety of RELPAX were evaluated.

‡ In a randomized, double-blind, double-dummy, parallel-group study conducted in 2113 patients with a diagnosis of migraine. Subjects were randomized to receive RELPAX 40 mg, sumatriptan 100 mg or placebo for the treatment of a single migraine attack.

§ In a randomized, double-blind, double-dummy, placebo-controlled study conducted in 1008 patients with a history of migraine. Subjects were randomized to receive RELPAX 40 mg or 80 mg, sumatriptan 50 mg or 100 mg, or placebo to treat up to 3 migraine attacks.

For complete prescribing information, please refer to the Product Monograph. The Product Monograph is available upon request.

℞ RELPAX®
eletriptan HBr 40 mg

https://doi.org/10.1017/S0317167100117585 Published online by Cambridge University Press

See prescribing summary on pages A-31-34