

12th WORLD CONGRESS OF NEUROLOGY

Dates: Sunday, September 20 - Friday, September 25, 1981

Congress Site: Kyoto International Conference Hall
Takaraike, Sakyo-ku, Kyoto 606, Japan

A. Main Themes:

1. Hemispheric Specialization in Man
2. Cerebral Vascular Diseases
3. Neurotransmitter and Neuropeptide Dysfunction in Relation to Neurological Disease
4. Viral Infections of the Nervous System

B. Free Communications

C. Scientific Exhibition and Technical Exhibition of Medical Equipment, Books and Pharmaceuticals

D. Symposia related to Neurology

Official Languages: English, French, German and Spanish

Provisional Registration: To reach Secretariat by June 30, 1980

Any further information can be obtained from:

Secretariat
12th World Congress of Neurology
c/o Simul International, Inc.
Kowa Bldg. No. 9
1-8-10, Akasaka, Minato-ku
Tokyo 107, Japan
Telephone: (03) 582-4224

First Announcement

The Brain in Health and Disease

An international congress to bring together neuroscientists and clinical neurologists from all countries to discuss the latest aspects of brain research and its clinical applications.

Organized by the International Brain Research Organization (IBRO).

Scientific programme:

Each morning there will be two lectures by distinguished neuroscientists, with ample opportunity for discussion.

The afternoons will be devoted to symposia, oral presentations and posters.

Scope: All nine of the IBRO panels will be represented:

1. Neuroanatomy
2. Neurochemistry
3. Neuroendocrinology
4. Neuropharmacology
5. Neurophysiology
6. Behavioural Sciences
7. Neurocommunications and Biophysics
8. Brain Pathology
9. Clinical and Health-related Brain Science

We hope to be able to offer limited financial support for travel and accommodation.

April 1 to 6, 1982, Lusanne, Switzerland.

Further information from

Dr. L.J. Garey
Institute of Anatomy
Rue du Bugnon 9
1011 Lausanne, Switzerland

RESIDENT POST IN NEUROLOGY

(Unexpected immediate vacancy)

University of Ottawa training program in Neurology fully accredited by the Royal College of Physicians and Surgeons of Canada, has immediate opening for resident at any level.

Applicant must be Canadian graduate or have landed immigrant status and be eligible for Ontario Educational License.

Apply to: R.F. Nelson, M.D.,
Program Director
Postgraduate Training Program,
in Neurology,
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THE SOUTHERN CLINICAL NEUROLOGICAL SOCIETY

8th Annual Meeting

- DATES — January 25 - 31, 1981
- PLACE — Colony Beach and Tennis Club,
Longboat Key, Sarasota, Florida
- CONTACT — Millie F. Walden, Executive Secretary
SOUTHERN CLINICAL
NEUROLOGICAL SOCIETY
3425 S.W. 2nd Avenue, #153
Gainesville, Florida 32607

Rivotril®

Rx Summary

Indications

Alone or adjunctively in the management of myoclonic, akinetic and petit mal variant seizures. In petit mal (absence spells) when response to succinimides unsatisfactory.

Contraindications

Hypersensitivity to benzodiazepines. Clinical or biochemical evidence of significant liver disease. Narrow angle glaucoma.

Warnings

Use in pregnancy: in women who are or who may become pregnant when potential benefits warrant possible risks to mother and fetus. Mothers receiving 'Rivotril' should not breastfeed infants. Consider the risk/benefit of long-term use, particularly in children.

Precautions

Use of multiple anticonvulsants may increase CNS depression and dosage of each may need adjustment downward. Avoid abrupt withdrawal and consider substitution with another anticonvulsant during withdrawal.

May cause paradoxical increase in seizure activity or new seizure types. Concomitant use with valproic acid may produce absence status.

Caution patients against engaging in hazardous activities requiring complete mental alertness or physical coordination. Warn against concomitant use of alcohol or other CNS depressant drugs.

Monitor patients who may be prone to increasing the dosage on their own accord.

Administer with caution to patients with impaired renal function. Periodic liver function tests and blood counts may be advisable during long-term therapy.

Institute therapy with caution in patients with chronic respiratory disease because of possible hypersecretion in upper respiratory tract.

Adverse Reactions

Drowsiness has occurred in 50% and ataxia in 30% of patients but these effects have diminished with time. Behavioural problems have been noted in approximately 25% and increased salivation in 7% of patients.

Consult monograph for complete list of reported adverse reactions.

Dosage

Depends upon age and must be determined according to clinical response and tolerance.

Daily requirements should be given in 2 or 3 divided doses and if not equal, the larger dose should be given before retiring.

Children up to 10 years (30 kg): Initial dose should be 0.01 to 0.03 mg/kg/day and should not exceed 0.05 mg/kg/day. Increase dose by 0.25 to 0.5 mg every third day to maintenance dose of 0.1 to 0.2 mg/kg/day providing optimum response.

Adults: Initial dose should not exceed 1.5 mg/day. Increase dose by 0.5 to 1.0 mg every third day to maintenance dose of 8 to 10 mg/day with optimum response. Dosage in excess of 20 mg/day should be administered with caution.

Bear in mind possible increased depressant effects whenever 'Rivotril' is added to an existing anticonvulsant regimen.

Supply

Orange, cylindrical, biplane tablets with RIVOTRIL 0.5 engraved on one face, and single scored on the other with ROCHE above and C below the score, each containing 0.5 mg clonazepam.

White, cylindrical, biplane tablets with RIVOTRIL 2 engraved on one face, and single scored on the other with ROCHE above and C below the score, each containing 2 mg clonazepam.

Bottles of 100.

References

1. Shakir, R.A. et al: *Arch. Neurol.* 36:302, May 1979.
2. Bruni, J.: *CMAJ* 120:819, April 7, 1979.
3. Browne, T.R.: *New Eng. J. Med.* (Ed.), 299:812-816, Oct. 1978.

Product Monograph available on request.

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Can. 0048

Original Research in Medicine and Chemistry

(xviii)

CHIEF OF NEUROSURGERY

A 650-bed McGill University teaching hospital is accepting applications for the position of Neurosurgeon in Chief and Co-Director of Neurosciences Department.

Direct inquiries and C.V. to the chairman of the Search Committee:

C. Lachance, M.D.
The Sir Mortimer B. Davis
Jewish General Hospital
3755 Côte St. Catherine Rd.
Montreal, Quebec
H3T 1E2

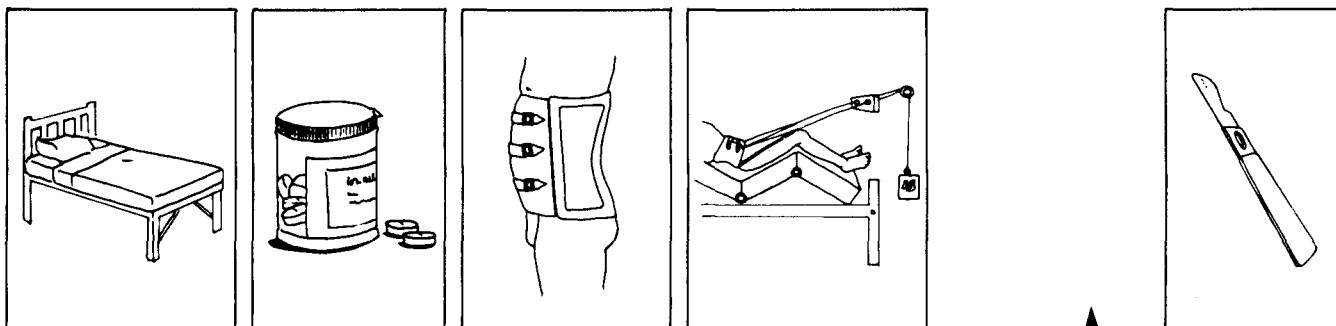
Research In Huntington's Disease

Up to two predoctoral scholarships and three postdoctoral fellowships available in 1981 in research relevant to Huntington's disease. Stipends identical to 1981 MRC rates except that both Ph.D and M.D. fellowship recipients will be paid at the prevailing rate for fellows with the M.D. degree. Deadline is December 31st, 1980. To be announced by March 15th, 1981. Awards to begin July 1st, 1981 and are to be held for one year with renewal for a second year, dependent on progress.

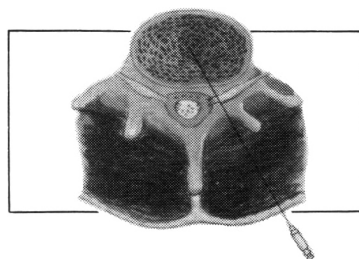
Write: Huntington's Society of Canada, Box 333, Cambridge, Ontario, Canada N1R 5T8 for application. Preference given to Canadians, or landed immigrants to Canada.

UPDATE: DISCASE®

-chymopapain intradiscal injection

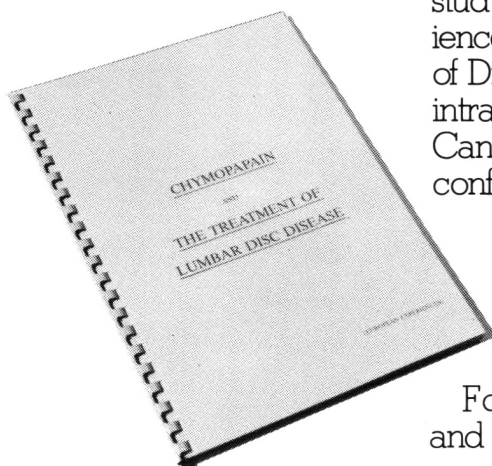


The role for Chemonucleolysis



In 1971, Dr. Ian Macnab published the first major study of his clinical experiences and defined the role of Discase® -chymopapain intradiscal injection. Other Canadian clinicians have confirmed his results.

A symposium sponsored by Travenol International Services was held in Albufeira, Portugal in September 1978. Gathered at the symposium were clinicians from various parts of Europe who had personal experience in the use of chymopapain in the treatment of patients with lumbar intervertebral disc disease. Their experiences are presented in a complimentary reprint of the symposium, "Chymopapain and The Treatment of Lumbar Disc Disease."



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(xix)

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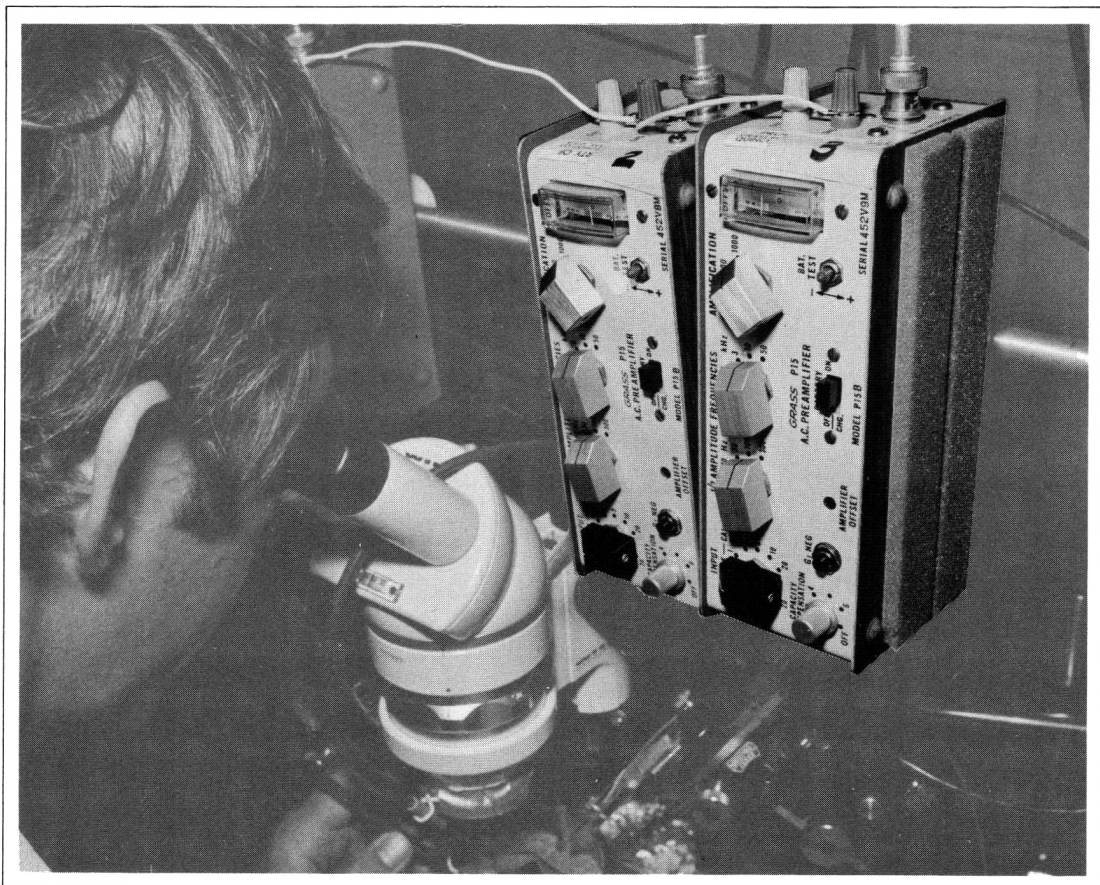
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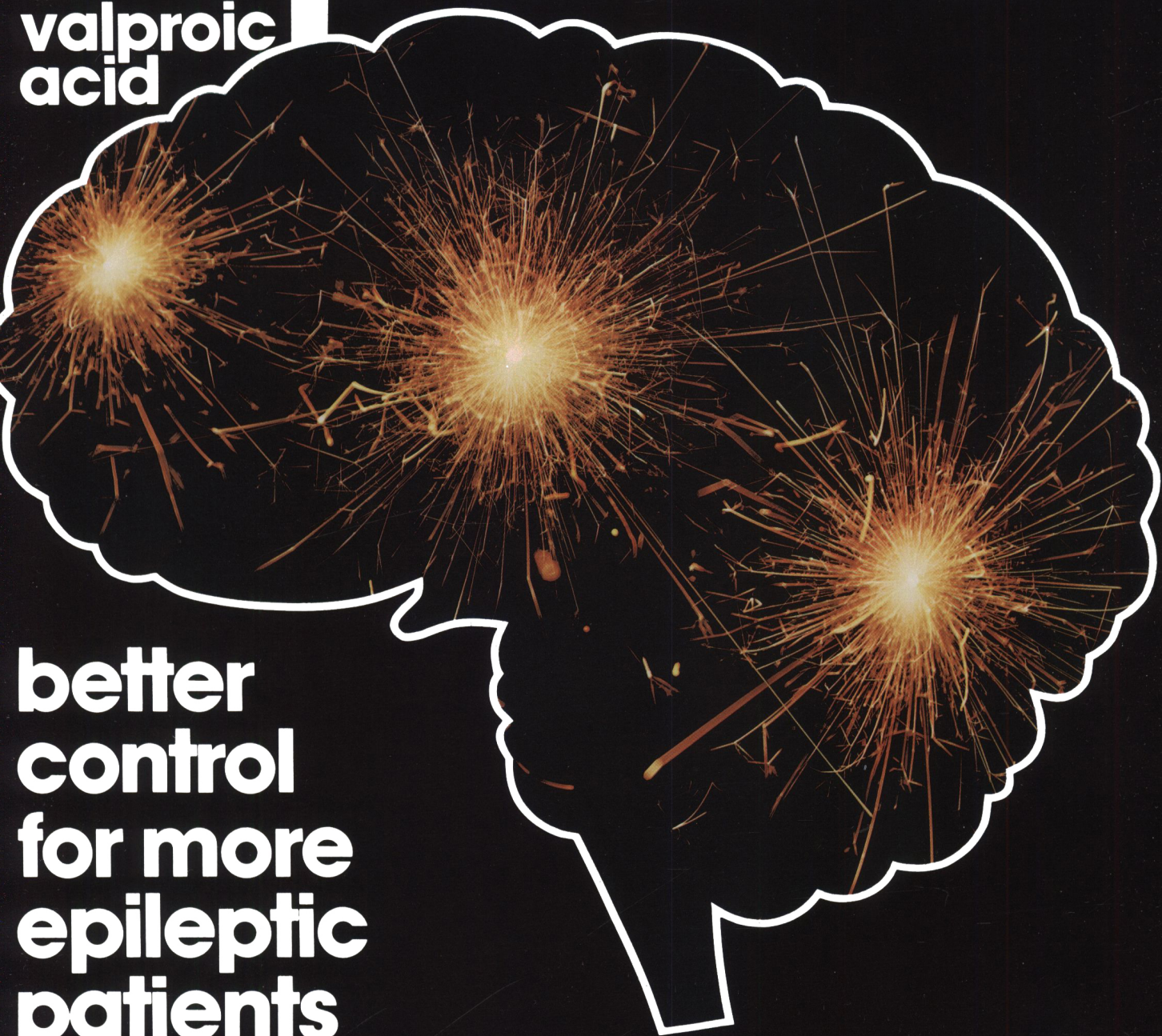
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Depakene*

valproic
acid



**better
control
for more
epileptic
patients**

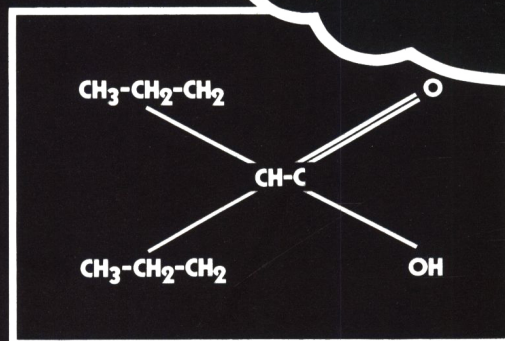
Depo

valproic acid

A major advance in anti-convulsant therapy that could bring more epileptic patients closer to normal.
as sole and adjunctive treatment of simple or complex absence seizures, including petit mal.
as adjunctive therapy of multiple seizures that include absence attacks.

a unique chemical structure

DEPAKENE is a simple fatty acid, chemically unrelated to other anticonvulsants.



a physiological mode of action

DEPAKENE appears to increase GABA (γ -aminobutyric acid) levels in the brain and cerebellum. GABA is known to inhibit neuronal excitability.¹

Depakene extends the range

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**“remarkably free
of side effects in the
general context of
antiepileptics”³**

Patients taking DEPAKENE have been reported to be more lively and alert and better able to carry out their daily tasks.³

DEPAKENE has not been associated with cosmetically undesirable side effects such as hirsutism, acne and gum hyperplasia. Although inhibition of platelet aggregation and leukopenia have been occasionally reported, it has not been associated with aplastic anemia or agranulocytosis. And DEPAKENE has no record of tolerance in long-term use.²

**world-wide documentation
of effectiveness**

Numerous publications and clinical trials involving more than 4000 patients whose ages ranged from 5 months to 71 years, have demonstrated the antiepileptic efficacy of DEPAKENE.

An overview of clinical studies² involving valproic acid in 1020 patients demonstrates an excellent (75-100%) reduction in seizure frequency in 45.7% of patients, and satisfactory results (33-74% reduction of seizures) in 25.4% more.

of anticonvulsant therapy.

Prescribing Information

CLINICAL PHARMACOLOGY

Depakene (valproic acid) has anticonvulsant properties. Although its mechanism of action has not yet been established, it has been suggested that its activity is related to increased brain levels of gamma-aminobutyric acid (GABA).

Valproic acid is rapidly absorbed after oral administration. Peak serum levels occur approximately one to four hours after a single oral dose. The serum half-life (1/2) of valproic acid is approximately 8 to 12 hours. Valproic acid is rapidly distributed throughout the body and the drug is strongly bound (90%) to human plasma proteins. The therapeutic plasma concentration range is believed to be from 50 to 100 µg/mL.

Excretion of valproic acid and its metabolites occurs principally in the urine, with minor amounts in the feces and expired air. Very little unmetabolized parent drug is excreted in the urine. The principal metabolite formed in the liver is the glucuronide conjugate.

INDICATIONS AND CLINICAL USE

Depakene (valproic acid) is indicated for use as sole and adjunctive therapy in the treatment of simple and complex absence seizures, including petit mal. Valproic acid may also be used adjunctively in patients with multiple seizure types which include absence.

In accordance with the International Classification of Seizures, simple absence is defined as a very brief clouding of the sensorium or loss of consciousness (lasting usually 2-15 seconds), accompanied by certain generalized epileptic discharges without other detectable clinical signs. Complex absence is the term used when other signs are also present.

CONTRAINDICATIONS

Depakene (valproic acid) is contraindicated in patients with known hypersensitivity to the drug.

WARNINGS

Hepatic failure resulting in fatalities, has occurred in patients receiving Depakene (valproic acid). These events have occurred during the first six months of treatment with valproic acid. Caution should be observed when administering Depakene to patients with pre-existing liver disease. Liver function tests should be performed prior to therapy and every two months thereafter. The drug should be discontinued immediately in the presence of significant hepatic dysfunction, suspected or apparent.

The frequency of adverse effects (particularly elevated liver enzymes) may increase with increasing doses. Therefore, the benefit gained by increased seizure control must be weighed against the increasing incidence of adverse effects.

Use in pregnancy

The safety of Depakene (valproic acid) during pregnancy has not been established, however, animal studies have demonstrated teratogenicity. Therefore, the physician should weigh the potential benefits against the possible risks in treating or counselling women of childbearing age who have epilepsy.

Recent reports indicate an association between the use of anticonvulsant drugs and an elevated incidence of birth defects in children born to epileptic women taking such medication during pregnancy. The incidence of congenital malformations in the general population is regarded to be approximately 2% in children of treated epileptic women this incidence may be increased two to threefold. The increase is largely due to specific defects, e.g. congenital malformations of the heart, and cleft lip and/or palate. Nevertheless, the great majority of mothers receiving anticonvulsant medications deliver normal infants.

Data are more extensive with respect to diphenylhydantoin and phenobarbital, but these drugs are also the most commonly prescribed anticonvulsants. Some reports indicate a possible similar association with the use of other anticonvulsant drugs, including trimethadione and paramethadione. However, the possibility also exists that other factors, e.g. genetic predisposition or the epileptic condition itself may contribute to or may be mainly responsible for the higher incidence of birth defects.

Anticonvulsant drugs should not be discontinued in patients in whom the drug is administered to prevent major seizures, because of the strong possibility of precipitating status epilepticus with attendant hypoxia and risk to both the mother and the unborn child. With regard to drugs given for minor seizures, the risks of discontinuing medication prior to or during pregnancy should be weighed against the risk of congenital defects in the particular case and with the particular family history.

Epileptic women of child-bearing age should be encouraged to seek the counsel of their physician and should report the onset of pregnancy promptly to him. Where the necessity for continued use of antiepileptic medication is in doubt, appropriate consultation might be indicated.

Nursing Mothers

Depakene is secreted in breast milk. As a general rule, nursing should not be undertaken while a patient is receiving valproic acid.

Fertility

Chronic toxicity studies in juvenile and adult rats and dogs demonstrated reduced spermatogenesis and testicular atrophy at doses greater than 200 mg/kg/day in rats and 90 mg/kg/day in dogs. Segment I fertility studies in rats have shown that doses up to 350 mg/kg/day for 60 days have no effect on fertility. The effect of Depakene (valproic acid) on the development of the testis and on sperm production and fertility in humans is unknown.

PRECAUTIONS

General

Because of reports of thrombocytopenia and platelet aggregation dysfunction, platelet counts and bleeding-time determination are recommended before instituting therapy and at periodic intervals. It is recommended that patients receiving Depakene (valproic acid) be monitored for platelet count prior to planned surgery. Clinical evidence of hemorrhage, bruising or a disorder of hemostasis/coagulation is an indication for reduction of Depakene (valproic acid) dosage or withdrawal of therapy pending investigation.

Because valproic acid may interact with other anticonvulsant drugs, periodic serum level determinations of such other anticonvulsants are recommended during the early part of therapy (see Drug Interactions).

Valproic acid is partially eliminated in the urine as a ketone-containing metabolite which may lead to a false interpretation of the urine ketone test.

Driving and Hazardous Occupations

Valproic acid may produce CNS depression, especially when combined with another CNS depressant, such as alcohol. Therefore, patients should be advised not to engage in hazardous occupations, such as driving a car or operating dangerous machinery, until it is known that they do not become drowsy from the drug.

Drug Interactions

Depakene (valproic acid) may potentiate the CNS depressant action of alcohol.

There is evidence that valproic acid may cause an increase in serum phenobarbital levels, although the mechanism is unknown. Patients receiving concomitant barbiturate therapy should be closely monitored for neurological toxicity. Serum barbiturate drug levels should be obtained, if possible, and the barbiturate dosage decreased, if indicated.

Primidone is metabolized into a barbiturate, and therefore, may also be involved in a similar or identical interaction.

There is conflicting evidence regarding the interaction of valproic acid with phenytoin. It is not known if there is a change in unbound (free) phenytoin serum levels. The dose of phenytoin should be adjusted as required by the clinical situation.

The concomitant use of valproic acid and clonazepam may produce absence status.

Caution is recommended when valproic acid is administered with drugs affecting coagulation, e.g. acetylsalicylic acid and warfarin (see Adverse Reactions).

ADVERSE REACTIONS

The most commonly reported adverse reactions are nausea, vomiting and indigestion. Since Depakene

(valproic acid) has usually been used with other anticonvulsants, it is not possible in most cases to determine whether the adverse reactions mentioned in this section are due to valproic acid alone or to the combination of drugs.

Gastrointestinal

Nausea, vomiting and indigestion are the most commonly reported side effects at the initiation of therapy. These effects are usually transient and rarely require discontinuation of therapy. Diarrhea, abdominal cramps and constipation have also been reported. Anorexia with some weight loss and increased appetite with some weight gain have also been seen.

CNS Effects

Sedative effects have been noted in patients receiving valproic acid alone but are found most often in patients on combination therapy. Sedation usually disappears upon reduction of other anticonvulsant medication. Ataxia, headache, nystagmus, diplopia, asterixis, "spots before the eyes", tremor, dysarthria, dizziness, and incoordination have rarely been noted. Rare cases of coma have been reported in patients who were also on phenobarbital.

Dermatologic

Transient increases in hair loss have been observed. Skin rash and petechiae have rarely been noted.

Psychiatric

Emotional upset, depression, psychosis, aggression, hyperactivity and behavioural deterioration have been reported.

Musculoskeletal

Weakness has been reported.

Hematopoietic

Thrombocytopenia has been reported. Valproic acid inhibits the secondary phase of platelet aggregation. (see Drug Interactions). This may be reflected in altered bleeding time. Bruising, hematoma formation and frank hemorrhage have been reported. Relative lymphocytosis and hypofibrinogenemia have been noted. Leukopenia and eosinophilia have also been reported.

Hepatic

Increases in serum alkaline phosphatase and elevation of serum glutamic oxaloacetic transaminase (SGOT) have been noted. Elevation of SGOT may be dose-related. Elevations of SGPT and LDH have been noted less frequently. Isolated cases of severe hepatotoxicity have been reported, but do not appear to be dose-related (see Warnings).

SYMPTOMS AND TREATMENT OF OVERDOSAGE

In a reported case of overdose with Depakene (valproic acid) after ingesting 36 g in combination with phenobarbital and phenytoin, the patient presented in deep coma. An EEG recorded diffuse slowing, compatible with the state of consciousness. The patient made an uneventful recovery.

As valproic acid is absorbed very rapidly, gastric lavage may be of limited value. General supportive measures should be applied with particular attention to the prevention of hypovolemia and the maintenance of adequate urinary output.

DOSE AND ADMINISTRATION

Depakene (valproic acid) is administered orally. The recommended initial dose is 15 mg/kg/day, increasing at one week intervals by 5 to 10 mg/kg/day until seizures are controlled or side effects preclude further increases. The maximum recommended dose is 60 mg/kg/day. When the total daily dose exceeds 250 mg, it is given in a divided regimen.

The frequency of adverse effects (particularly elevated liver enzymes) may increase with increasing dose. Therefore, the benefit gained by increased seizure control must be weighed against the increased incidence of adverse effects.

Table of Initial Doses by Weight
(based on 15 mg/kg/day)

Weight	Total Daily Dose (mg)	Number of Capsules or Teaspoonful of Syrup		
		Dose 1	Dose 2	Dose 3
kg	lb			
10-24.9	22-54.9	0	0	1
25-39.9	55-87.9	1	0	1
40-59.9	88-131.9	1	1	1
60-74.9	132-164.9	1	1	2
75-89.9	165-197.9	2	1	2

As the dosage of valproic acid is raised, blood levels of phenobarbital and/or phenytoin may be affected (see Precautions).

Patients who experience G.I. irritation may benefit from administration of the drug with food or by a progressive increase of the dose from an initial low level. The capsules should be swallowed without chewing to avoid local irritation of the mouth and throat.

1. Roberts, E.: Formation and utilization of gamma-aminobutyric acid in brain. In: S.R. Korey & J.I. Nurnberger (Eds), *Progress in Neurobiology*, J. Neurochemistry, Hoeber-Harper, New York 1956, pp. 11-25.
2. Simon, D., Penry, K.J.: Sodium Di-N-Propylacetate (DPA)

AVAILABILITY

Depakene (valproic acid) is available as orange-coloured soft-gelatin capsules of 250 mg in bottles of 100 (Number 5681, DIN 443840), and as a red syrup containing the equivalent of 250 mg valproic acid, as the sodium salt, per 5 mL in bottles of 450 mL (Number 5682, DIN 443832). Depakene is a prescription drug (Schedule F).

in the Treatment of Epilepsy, *Epilepsia* 16, 549-573, 1975.
3. Pinder, R.M. et al. Sodium valproate: A Review of its Pharmacological Properties and Therapeutic Efficacy in Epilepsy, *Drugs* 13, 81-123, 1977.

Prolopa[®] Roche[®]



Prolopa[®] Roche[®]
(benserazide/levodopa)

**an
antiparkinson
agent
whose time
has come**

- at recommended maintenance dosages, contains less levodopa yet provides therapeutic results equivalent to levodopa/carbidopa.^{1,2}
- associated with significantly fewer peripheral side effects than levodopa/carbidopa.¹
‘However, nausea and vomiting occurred *significantly more often* during 12 weeks’ treatment periods *with levodopa and carbidopa* (maximal dose 4 x 250/25) *than with levodopa and benserazide* (‘Prolopa’) (maximal dose 4 x 200/50) but the occurrence of involuntary movements was similar’.¹
- may be of greater benefit to some patients than the carbidopa/levodopa combination.²
- may provide a more optimal therapeutic response than levodopa alone.²

References:

1. Rinne, U.K., Recent Advances in Research on Parkinsonism, *Acta Neurologica Scand., Suppl. 67, 57, 77-113, 1978.*
2. Pakkenberg, H., et al, Parkinson’s Disease Treated with Sinemet or Madopar (‘Prolopa’), *Acta Neurologica Scand., 53, 376-385, 1976.*

See page xxii for brief prescribing information.

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Original Research in Medicine and Chemistry

(xxi)

Can. 9025

Rx Summary

Indications

Treatment of Parkinson's syndrome with the exception of drug-induced parkinsonism.

Contraindications

Known hypersensitivity to levodopa and/or benserazide. In patients in whom sympathomimetic amines are contraindicated; in conjunction with monoamine oxidase inhibitors or within two weeks of their withdrawal. Clinical or laboratory evidence of uncompensated cardiovascular, endocrine, renal, hepatic, hematologic or pulmonary disease; narrow-angle glaucoma (may be used in wide-angle glaucoma provided intraocular pressure remains under control). History of melanoma or suspicious undiagnosed skin lesions.

Warnings

Discontinue levodopa therapy at least 12 hours before initiating 'Prolopa' therapy. Increase dosage of 'Prolopa' 100-25 gradually to avoid inducing CNS side effects (abnormal movements). Observe patients for signs of depression with suicidal tendencies or other serious behavioural changes. Caution in patients with history of psychotic disorders or those receiving reserpine, phenothiazines or tricyclic antidepressants.

Administer with care to patients with history of myocardial infarction or who have atrial, nodal or ventricular arrhythmias.

Safety in patients under 18 years has not been established. In women who are or may become pregnant benefits should be weighed against possible hazards to mother and fetus. Should not be given to nursing mothers.

Precautions

Caution in patients with history of convulsive disorders. Upper gastrointestinal hemorrhage possible in patients with history of peptic ulcer.

Normal activity should be resumed gradually to avoid risk of injury.

Administer with caution to patients on antihypertensive medication; discontinue 12 hours before anesthesia. Monitor intraocular pressure in patients with chronic wide-angle glaucoma.

Adverse reactions

Most common are abnormal involuntary movements, usually dose dependent, and may disappear or become tolerable after dosage reduction.

Most serious after prolonged therapy are periodic oscillations in performance (end of dose akinesia, on-off phenomenon and akinesia paradoxa).

Nausea, vomiting, arrhythmias and orthostatic hypotension occur less frequently than with levodopa alone.

Psychiatric disturbances, including mild elation, depression, anxiety, agitation, aggression, hallucinations and delusions have been encountered.

Consult monograph for complete list of reported adverse effects.

Dosage

Recommended initial dose is one capsule 'Prolopa' 100-25 once or twice daily, increased carefully by one capsule every third or fourth day until an optimum therapeutic effect is obtained without dyskinesias. At upper limits of dosage increments should be made slowly at 2 to 4-week intervals.

Optimal dosage for most patients is 4 to 8 capsules of 'Prolopa' 100-25 daily (400-800 mg levodopa) divided into 4 to 6 doses. Most patients require no more than 6 capsules 'Prolopa' 100-25 (600 mg levodopa) per day. 'Prolopa' 200-50 capsules are intended only for maintenance therapy once the optimal dosage has been determined using 'Prolopa' 100-25 capsules. No patients should receive more than 5 to 6 capsules 'Prolopa' 200-50 daily (1000 to 1200 mg levodopa) during the first year of treatment.

For patients previously treated with levodopa discontinue for 12 hours and initiate with 'Prolopa' 100-25 to provide approximately 15% of previous levodopa dosage. The initial daily dose, however, should not exceed 6 capsules 'Prolopa' 100-25 divided into 4 to 6 doses.

Supply

Blue, flesh-coloured capsules imprinted ROCHE C and PROLOPA 100-25 (black ink) alternating between body and cap each containing 100 mg levodopa and 25 mg benserazide.

Blue, caramel-coloured capsules imprinted ROCHE C and PROLOPA 200-50 (black ink) alternating between body and cap, each containing 200 mg levodopa and 50 mg benserazide.

Bottles of 100.

Product monograph available on request.

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'Prolopa' is listed in provincial formularies.



Hoffmann-La Roche Limited
Vaudreuil, Québec J7V 6B3

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inside back cover

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The University of Toronto and The Wellesley Hospital are seeking a Chief for the Division of Neurosurgery of The Wellesley Hospital.

Qualifications required include leadership ability in clinical neurosurgery, teaching and research. The Wellesley Hospital is a major teaching hospital of the University of Toronto.

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- Reduces number and severity of vertigo attacks^{2,3}
- Well-tolerated... suitable for longterm management^{1,2,4}
- Non-sedative... acts on micro-circulation of inner ear^{5,6}

REFERENCES:

1. Bertrand, R.A.: Acta Oto-Laryng. Supp. 305:48, 1972. 2. Guay, R.M.: Applied Thera. 12:25 (Aug.) 1970. 3. Frew, I.J.C. et al: Postgrad. Med. J. 52:501-503, 1976. 4. Wilmot, T.J. et al: J. Laryng. Otol. 9:833-840, 1976. 5. Snow, J.B. Jr. & Suga, F.: A.M.A. Arch. Otolaryng. 97:365, 1973. 6. Martinez, D.M.: Acta. Oto-Laryng. Supp. 305:29, 1970.

PRESCRIBING INFORMATION:

DESCRIPTION AND CHEMISTRY: SERC is the proprietary name for a histamine-like drug generically designated as betahistine hydrochloride.

INDICATIONS: SERC may be of value in reducing the episodes of vertigo in Meniere's disease. No claim is made for the effectiveness of SERC in the symptomatic treatment of any form of vertigo other than that associated with Meniere's disease.

DOSAGE AND ADMINISTRATION: The usual adult dosage has been one to two tablets (4 mg. each) administered orally three times a day.

Recommended starting dose is two tablets three times daily. Therapy is then adjusted as needed to maintain patient response. The dosage has ranged from two tablets per day to eight tablets per day. No more than eight tablets are recommended to be taken in any one day.

SERC (betahistine hydrochloride) is not recommended for use in children. As with all drugs, SERC should be kept out of reach of children.

CONTRAINDICATIONS: Several patients with a history of peptic ulcer have experienced an exacerbation of symptoms while using SERC. Although no causal relation has been established SERC is contraindicated in the presence of peptic ulcer and in patients with a history of this condition. SERC is also contraindicated in patients with pheochromocytoma.

PRECAUTIONS: Although clinical intolerance to SERC by patients with bronchial asthma has not been demonstrated, caution should be exercised if the drug is used in these patients.

USE IN PREGNANCY: The safety of SERC in pregnancy has not been established. Therefore, its use in pregnancy or lactation, or in women of childbearing age requires that its potential benefits be weighed against the possible risks.

ADVERSE REACTIONS: Occasional patients have experienced gastric upset, nausea and headache.

HOW SUPPLIED: Scored tablets of 4 mg each in bottles of 100 tablets.

Full prescribing information available on request.

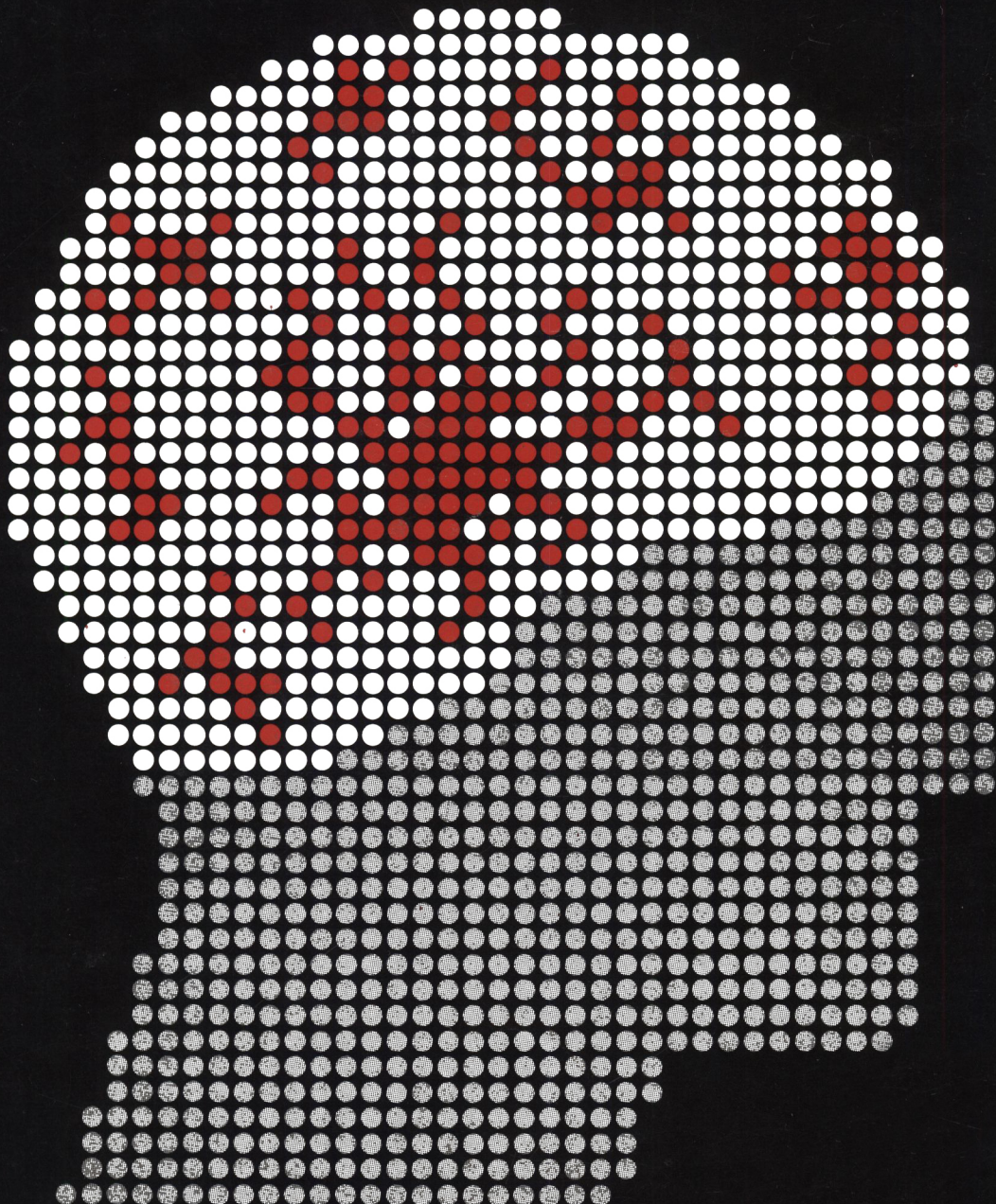
UNIMED Pharmaceuticals Limited
Dorval, Quebec H9P 2P4



Tegretol[®]

carbamazepine

To help control
refractory generalized
tonic-clonic seizures
without excessive sedation



Geigy

For Brief Prescribing
Information see Page (V)