

These minors are victims



Jean — myoclonic seizures



Michael — akinetic seizures



Carol — Lennox-Gastaut syndrome

These children, victims of minor motor seizures, may benefit from the many advantages offered by 'Rivotril'.

- Effective in reducing the frequency and/or severity of a variety of epileptic seizures
 - akinetic seizures
 - myoclonic seizures
 - Lennox-Gastaut syndrome (petit mal variant)
 - absence seizures (where succinimide therapy has failed)
- flexible dosage regimen encourages patient compliance
- no reports of incompatibility with a ketogenic diet
- economical, for long-term therapy
- may be used concomitantly with most other anticonvulsants

'Rivotril' has not been associated with the severe side effects seen with some other anticonvulsant medications.

- No reports of serious side effects, such as hepatotoxicity.
- Very low incidence of nausea and G.I. upsets.¹
- No serious problems of drug interaction. (eg. ASA)
- Proven safety record in long-term administration.
- Drowsiness, which may occur, is generally dose-related and may be well controlled with proper dosage adjustment.^{2,3}



For Rx Summary, see page xii

Rivotril[®] for the victims of minor motor seizures

Brief Prescribing Information
Tegretol® 200 mg carbamazepine

Indications and Clinical Use

A. Trigeminal Neuralgia:

Tegretol is indicated for the symptomatic relief of pain of trigeminal neuralgia only during periods of exacerbation of true or primary trigeminal neuralgia (tic douloureux). It should not be used preventively during periods of remission. In some patients, Tegretol has relieved glossopharyngeal neuralgia. For patients who fail to respond to Tegretol, or who are sensitive to the drug, recourse to other accepted measures must be considered.

Tegretol is not a simple analgesic and should not be used to relieve trivial facial pains or headaches.

B. Tegretol has been found useful:

- 1) in the management of psychomotor (temporal lobe) epilepsy and,
- 2) as an adjunct, in some patients with secondary or partial epilepsy with complex symptomatology or secondarily generalized seizures, when administered in combination with other antiepileptic medication.
- 3) as an alternative medication in patients with generalized tonic-clonic seizures who are experiencing marked side effects or fail to respond to other anticonvulsant drugs.

Tegretol is essentially ineffective in controlling petit mal, minor motor, myoclonic and predominantly unilateral seizures, and does not prevent the generalization of epileptic discharge.

Contraindications
Tegretol should not be administered to patients with a history of hepatic disease or serious blood disorder. Tegretol should not be administered immediately before, in conjunction with, or immediately after a monoamine oxidase inhibitor. When it seems desirable to administer Tegretol to a patient who has been receiving a MAO inhibitor, there should be as long a drug-free interval as the clinical condition allows, but in no case should this be less than 14 days. Then the dosage of Tegretol should be low initially, and increased very gradually.

Tegretol should not be administered to patients presenting atrioventricular heart block.

Safe use in pregnancy has not been established. Therefore, Tegretol should not be administered during the first three months of pregnancy. Tegretol should not be given to women of childbearing potential unless, in the opinion of the physician, the expected benefits to the patient outweigh the possible risk to the foetus (See Reproductive Studies). Because of demonstrated toxicity in nursing animals, Tegretol should not be administered to nursing mothers.

Because of the similarity of chemical structure, Tegretol should not be administered to patients with known hypersensitivity to any of the tricyclic compounds, such as amitriptyline, trimipramine, imipramine, or their analogues or metabolites.

Warnings
Although reported infrequently, serious adverse effects have been observed during the use of Tegretol. Agranulocytosis and aplastic anemia have occurred in a few instances with a fatal outcome. Leucopenia, thrombocytopenia and hepatocellular and cholestatic jaundice have also been reported. It is, therefore, important that Tegretol should be used carefully and close clinical and frequent laboratory supervision should be maintained throughout treatment in order to detect as early as possible signs and symptoms of a possible blood dyscrasia.

Long-term toxicity studies in rats indicated a potential carcinogenic risk. Therefore, the possible risk of drug use must be weighed against the potential benefits before prescribing carbamazepine to individual patients.

Precautions

Monitoring of Haematological and Other Adverse Reactions: Complete blood studies, including platelet counts, and evaluation of hepatic and renal function and urinalysis should be carried out before treatment is instituted. Careful clinical and laboratory supervision should be maintained throughout treatment, including frequent performance of complete blood counts, in order to detect any early signs or symptoms of blood dyscrasia. Should any signs or symptoms or abnormal laboratory findings suggestive of blood dyscrasia or liver disorder occur, Tegretol should be immediately discontinued until the case is carefully reassessed.

Urinary Retention and Increased Intraocular Pressure: Because of its anticholinergic action, Tegretol should be given cautiously, if at all, to patients with increased intraocular pressure or urinary retention. Such patients should be followed closely while taking the drug.

Occurrence of Behavioural Disorders: Because it is closely related to the other tricyclic drugs, there is some possibility that Tegretol might activate a latent psychosis, or, in elderly patients, produce agitation or confusion, especially when combined with other drugs. Caution should also be exercised in alcoholics.

Use in Patients with Cardiovascular Disorders: Tegretol should be used cautiously in patients with a history of coronary artery disease, organic heart disease, or congestive failure. If a defective conductive system is suspected, an E.K.G. should be performed before administering Tegretol, in order to exclude patients with atrioventricular block.

Use in Patients taking Oral Contraceptives: In women under treatment with Tegretol, the reliability of oral contraceptives may be adversely affected; such patients should accordingly be advised to use some alternative, non-hormonal method of contraception.

Driving and operating Hazardous Machinery: Because dizziness and drowsiness are possible side effects of Tegretol, patients should be warned about the possible hazards of operating machinery or driving automobiles.

Adverse Reactions
The reactions which have been most frequently reported with Tegretol are drowsiness, unsteadiness on the feet, vertigo, dizziness, gastrointestinal disturbances, and nausea. These reactions usually occur only

during the initial phase of therapy. They have rarely necessitated discontinuing Tegretol therapy, and can be minimized by initiating treatment at a low dosage. The more serious adverse reactions observed are the haematologic, hepatic, cardiovascular and dermatologic reactions, which require discontinuation of therapy.

The following adverse reactions have been reported:
Haematological reactions: Transitory leucopenia, eosinophilia, leucocytosis, thrombocytopenic purpura, agranulocytosis, macrocytic anemia and aplastic anemia. In a few instances, deaths have occurred.

Hepatic disturbances: During the long-term administration of Tegretol, abnormalities in liver function tests and cholestatic or hepatocellular jaundice have been observed.

Dermatological reactions: The following reactions occurred during treatment with Tegretol: skin sensitivity reactions and rashes, erythematous rashes, pruritic eruptions, urticaria, photosensitivity, pigmentary changes, neurodermatitis and in rare cases Stevens-Johnson syndrome, exfoliative dermatitis, alopecia, diaphoresis, erythema multiforme, erythema nodosum, and aggravation of disseminated lupus erythematosus.

Neurological reactions: The reactions reported as occurring during treatment with Tegretol include vertigo, somnolence, disturbances of coordination, confusion, headache, fatigue, blurred vision, transient diplopia and oculomotor disturbances, speech disturbances, abnormal involuntary movements and increase in motor seizures. In addition, peripheral neuritis and paresthesia, depression with agitation, talkativeness, nystagmus, and tinnitus have been reported but only very rarely. There have been some reports of paralysis and other symptoms of cerebral arterial insufficiency but no conclusive relationship to the administration of Tegretol could be established.

Cardiovascular systems: Recurrence of thrombophlebitis in patients with a prior history of thrombophlebitis, congestive heart failure, aggravation of hypertension, Stokes-Adams in patients with AV block, hypotension, syncope and collapse, edema, aggravation of coronary artery disease. Some of these complications (including myocardial infarction and arrhythmia) have been associated with other tricyclic compounds.

Genitourinary reactions: Urinary frequency, acute urinary retention, oliguria with elevated blood pressure, and impotence. Elevation of BUN, albuminuria and glycosuria also have been observed.

Digestive tract: Disturbances associated with Tegretol therapy have included nausea, vomiting, gastric or abdominal discomfort, diarrhoea, anorexia and dryness of the mouth and throat, glossitis and stomatitis.

Eyes: There is no conclusive evidence that Tegretol produces pathological changes in the cornea, lens or retina. However, it should be recognized that many phenothiazines and related drugs have been shown to cause eye changes. By analogy, periodic eye examinations, including slitlamp funduscopy and tonometry, are recommended.

Other reactions reported during treatment with Tegretol include fever and chills, lymphadenopathy, aching joints and muscles, leg cramps and conjunctivitis.

Dosage and Administration

Use in Epilepsy (see Indications): A low initial daily dosage with a gradual increase in dosage is advised. Dosage should be adjusted to the needs of the individual patient.

Adults and Children over 12 years of age: Initially, 100 to 200 mg once or twice a day depending on the severity of the case and previous therapeutic history. The initial dosage is progressively increased, until the best response is obtained, up to 600 mg daily. The usual optimal dosage is 600 mg daily, but occasionally dosages up to 800 to 1000 mg have been used for short periods. As soon as disappearance of seizures has been obtained and maintained, dosage should be reduced very gradually until a minimum effective dose is reached.

Use in trigeminal neuralgia: The initial daily dosage should be small; 200 mg, taken in two doses of 100 mg each is recommended. The total daily dosage can be increased by 200 mg per day until relief of pain is obtained. This is usually achieved at a dosage between 200 and 800 mg daily, but occasionally up to 1200 mg per day may be necessary. As soon as relief of pain has been obtained and maintained, progressive reduction in dosage should be attempted until a minimum effective dosage is reached. Because trigeminal neuralgia is characterized by periods of remission, attempts should be made to reduce or discontinue the use of Tegretol at intervals of not more than 3 months, depending upon the individual clinical course.

Prophylactic use of the drug in trigeminal neuralgia is not recommended.

Tegretol should be taken in two or three divided doses daily, with meals whenever possible.

Dosage Forms

Tegretol is available as a 200 mg white, round, flat, bevelled-edged, double-scored tablet, imprinted with the GEIGY monogram.

Availability
Bottles of 50 and 500 tablets. Protect from heat and humidity.

Full information available on request.

See outside back cover.



Geigy
Dorval, Qué. H9S 1B1

G-9091

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.

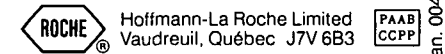
White, cylindrical, biplane tablets with RIVOTRIL 2 engraved on one face, and single scored on the other with ROCHE above and C below the score, each containing 2 mg clonazepam.

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.
*Reg. Trade Mark



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The Sir Mortimer B. Davis-Jewish General Hospital, a 600-bed teaching hospital currently has a position available for a general neurosurgeon. The successful candidate will also receive an appointment as Assistant Professor in the Department of Neurology and Neurosurgery at McGill University. Interested candidates should direct their inquiries and curriculum vitae to:

Sir Mortimer B. Davis-Jewish General Hospital,
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H3T 1E2

Attention: P.L. Heilpern, M.D.,
F.R.C.P. (C).
Director of Profes-
sional Services.

EEG COURSE SELECTED TOPICS IN ELECTROENCEPHALOGRAPHY

AT: Canadian Congress of Neurological Sciences
Calgary, Alberta, Canada

ON: June 24, 1981

- Pierre Gloor "Physiology of the E.E.G."
Pierre Gloor "Principles of polarity and potential fields."
Gordon Blair "I.C.U. recordings."
Jean Reiher "Recognition of some difficult to recognize E.E.G. patterns."
Adrian Upton "Artefactual pitfalls."
Don McLean "Clinical significance of some major E.E.G. patterns."
Morton Low "Introduction to evoked potentials."
Andrew Eisen "Somatosensory Evoked Potentials."
Sherrill Purves "Visual and Auditory Evoked Potentials."

Designed for neurologists, resident neurologists and technologists with some knowledge of EEG who wish to further their grasp in several vital areas.

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Write: Congress Office: Nurses' Residence, Calgary General Hospital, 841 Centre Avenue East, Calgary, Alberta T2E 0A1

FIORINAL[®]

(ASA U.S.P. 330 mg, Sandoptal[®] (butalbital) 50 mg, caffeine U.S.P. 40 mg.)

Contraindications

Porphyria, hypersensitivity to any of the components.

Precautions

Due to the presence of butalbital Fiorinal may be habit-forming. Excessive or prolonged use should be avoided.

Activities requiring mental alertness should not be undertaken until the patient's response and sensitivity to the medication have been established.

Fiorinal should be used with caution in the presence of peptic ulcer.

During pregnancy and lactation, Fiorinal should be taken only upon medical advice.

Adverse reactions

Drowsiness, dizziness, nausea, constipation and skin rash may occur in rare instances.

Dosage

Adults, 2 tablets or capsules at once, followed if necessary, by 1 tablet or capsule every 3 to 4 hours, or as directed by the physician. Maximum daily dose: 6 tablets or capsules.

Children, 1 to 3 tablets or capsules a day, according to age.

Supply

Capsules or Tablets, bottles of 100 and 500.

1. Federal Register, Vol. 42, No. 220:
59115. Tuesday, November 15, 1977.

Complete prescribing information available on request.

Sandoz (Canada) Limited
P.O. Box 385, Dorval, Quebec H9R 4P5



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.

® Reg. Trade Mark

'Prolopa' is listed in provincial formularies.

PAAB
CCPP



Hoffmann-La Roche Limited
® Vaudreuil, Québec J7V 6B3

XVI Canadian Congress of Neurological Sciences,

June 24th — 27th, 1981,
Calgary Alberta

Information: Dr. Peter Seland, Rm. M3-016,
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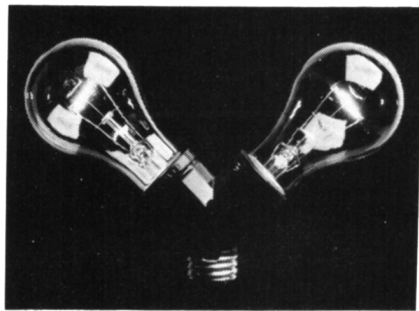
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DILANTIN/ZARONTIN

BRIEF PRESCRIBING INFORMATION



New

Sandomigran DS

Specific, Double Strength headache prophylaxis.

PRESCRIBING INFORMATION

SANDOMIGRAN (pizotyline) SANDOMIGRAN D.S.

Dosage - The average maintenance dosage is 0.5 mg 1 t i d. A progressive dosage is recommended until the fifth day of therapy. The dosage range is 1 to 6 mg per day.

Since vascular headache is a paroxysmal but basically chronic disorder, treatment must extend over an adequate period of time in order to obtain maximal benefit. While some patients have responded rather quickly, most investigators agree that a four-week trial period should be instituted to determine the true efficacy of pizotyline in specific cases. The periodic nature of the disorder will have to be considered in determining when and for how long therapy should be maintained. Since some investigators have observed a change in headache pattern after several months of therapy, a drug free interval is advisable to reassess the necessity of continuing treatment. The dosage should be reduced gradually during the last two weeks of each treatment course to avoid a headache rebound.

Composition - Each ivory sugar coated tablet contains 0.5 mg of pizotyline as the hydrogen malate. Each single scored white tablet contains 1 mg of pizotyline as the hydrogen malate.

Contraindications - Anticholinergic agents including pizotyline are contraindicated in patients taking monoamine oxidase inhibitors and in patients with pyloroduodenal obstruction and stenosing pyloric ulcer. Pizotyline is also contraindicated for patients who have a known sensitivity to the drug. Until further studies are completed the drug is not recommended for children under the age of twelve.

Warnings and precautions - Since drowsiness may occur with pizotyline, sensitive patients should be cautioned against activities requiring rapid and precise response (i.e. driving an automobile or operating dangerous machinery) until their response to the drug has been determined. Since the effects of antihistamines can potentiate those of other drugs affecting the central nervous system, patients should be cautioned against drinking alcoholic beverages or taking hypnotics, sedatives, psychotherapeutic agents or other drugs with CNS depressant effects during pizotyline therapy. Administer pizotyline with caution to patients with narrow angle glaucoma or with urinary retention (e.g. prostatic hypertrophy).

Since it is desirable to keep drug administration to a minimum during pregnancy, pizotyline should be given only when the benefits derived from treatment exceed the possible risks to mother and fetus. Some patients developed tolerance to pizotyline with prolonged use of the drug. An increase in dosage may overcome this tolerance.

After prolonged use, hepatotoxic effects might occur and patients should be advised to report for adequate laboratory evaluation. Patients with diabetes, cardiovascular disease and known or suspected impaired renal or hepatic function should be given pizotyline with caution and appropriate laboratory tests should be done at regular intervals.

Lens opacities occurred in two cases but did not appear to be drug related. However, it is recommended that any impairment in vision be reported to the attending physician for further investigation.

Side effects - Increased appetite, weight gain and drowsiness are the most frequent side effects. An appropriate diet should be recommended by the physician for patients benefiting from the drug but gaining excessive weight. A gradual increase in the dosage of pizotyline is recommended to minimize or reduce the incidence of drowsiness. The following adverse effects have been observed less frequently in relation to the aforementioned reactions: fatigue, nausea, dizziness, headache, confusion, edema, hypotension, depression, weakness, epigastric distress, dry mouth, nervousness, impotence and muscle pain.

Supply - 0.5 mg tablets in bottles of 100 and 500. 1 mg scored tablets in bottles of 100.

Complete prescribing information available on request.

PAAB

PMAC

SANDOZ®

Sandoz (Canada) Limited, Dorval, Quebec

INDICATIONS (DILANTIN):

DILANTIN is indicated for the control of grand mal epilepsy, psychomotor seizures, and certain other convulsive disorders. Parenteral DILANTIN is indicated for the treatment of status epilepticus and the prophylactic control of seizures in neurosurgery.

PRECAUTIONS AND CONTRAINDICATIONS (DILANTIN):

Periodic examination of the blood is advisable since hematologic disorders in association with DILANTIN administration have been reported. Nystagmus in combination with diplopia and ataxia indicates dosage should be reduced. When DILANTIN with PHENOBARBITAL or PHELANANTIN are used, it should be borne in mind that phenobarbital may cause drowsiness, and may be habit-forming. PHELANANTIN, because of the methamphetamine content, should be given cautiously to patients with hypertension.

PHELANANTIN is contraindicated in patients hypersensitive to ephedrine-like compounds; in those showing anxiety or undue excitability; and in patients with cardiac or coronary disease not likely to tolerate vasoconstrictors. The possibility of toxic effects of DILANTIN during pregnancy has not been explored.

ADVERSE REACTIONS (DILANTIN):

Once proper dosage has been determined, toxic effects of DILANTIN are infrequent. Minor side effects which may occur during the initial stages of therapy include gastric distress, nausea, weight loss, transient nervousness, sleeplessness, and a feeling of unsteadiness, all of which usually subside with continued use. Allergic phenomena such as polyarthralgia, fever, and skin eruptions may occur. Acute generalised morbilliform eruptions with or without a temperature elevation, may occur about two weeks after treatment is begun. The dermatitis may in some instances go on to exfoliation and hepatitis may occur, contraindicating further therapy with DILANTIN. Eruptions usually subside when therapy is discontinued.

Gingival hypertrophy, hirsutism, and excessive motor activity are occasionally encountered, especially in children, adolescents, and young adults. Only occasionally is it necessary to discontinue DILANTIN because of these manifestations. Gingival hypertrophy can be greatly minimized by scrupulous daily care of gums and prophylactic dental care.

Megaloblastic anemia and macrocytosis have been reported but have responded to antianemic therapy. Leukopenia, granulocytopenia, thrombocytopenia, pancytopenia, aplastic anemia, and agranulocytosis have also been reported. Usually these patients were simultaneously receiving other drugs. Lupus erythematosus and erythema multiforme have occurred in patients receiving DILANTIN.

DOSAGE AND ADMINISTRATION (DILANTIN):

In all cases, optimal dosage of DILANTIN must be determined by trial. Dosage in excess of the minimum required to prevent convulsions is not recommended. For most patients, DILANTIN CAPSULES, 100 mg or DILANTIN CAPSULES, 30 mg are suitable for administration.

FORMS AVAILABLE:

In order to provide versatile therapy, DILANTIN is supplied in the following convenient product forms: DILANTIN® CAPSULES, 100 mg (Cap 362). Each white capsule with orange cap contains phenytoin sodium 100 mg.

DILANTIN® CAPSULES, 30 mg (Cap 365). Each white capsule with pale pink cap contains phenytoin sodium 30 mg.

DILANTIN® INFATABS, 50 mg. Each triangular shaped, grooved tablet, contains 50 mg phenytoin.

INFATABS are palatably flavoured tablets, intended primarily for pediatric use.

DILANTIN-125 SUSPENSION. Each 5 ml contains 125 mg phenytoin. DILANTIN-30 SUSPENSION. Each 5 ml contains 30 mg phenytoin.

These are pleasantly flavoured suspensions of DILANTIN, especially adapted for pediatric use, but suitable for adolescents and adults who prefer liquid medication.

⊕ DILANTIN® with 15 mg PHENOBARBITAL CAPSULES, (Cap. 375). Each white capsule with garnet cap contains 100 mg phenytoin sodium and 15 mg phenobarbital.

⊕ DILANTIN with 30 mg PHENOBARBITAL CAPSULES (Cap. 531). Each white capsule with black cap contains 100 mg phenytoin sodium and 30 mg phenobarbital.

These combinations of DILANTIN with PHENOBARBITAL are supplied for the convenient and economical use of those patients who require combined DILANTIN and PHENOBARBITAL therapy.

⊕ PHELANANTIN CAPSULES®, (Cap. 394). Each yellow capsule contains phenytoin sodium, 100 mg; phenobarbital, 30 mg; and methamphetamine hydrochloride, 2.5 mg.

Combining these agents takes advantage of the clinically proved anticonvulsant actions of DILANTIN and phenobarbital, while the methamphetamine counteracts the sedative effects of phenobarbital.

DILANTIN® AMPOULES, 100 mg (Amp. 1488). Each 2 ml ampoule contains 100 mg (50 mg/ml) phenytoin sodium ready-mixed.

DILANTIN® AMPOULES, 250 mg (Amp. 1475). Each 5 ml ampoule contains 250 mg (50 mg/ml) of phenytoin sodium ready-mixed.

INDICATIONS (ZARONTIN):

ZARONTIN is indicated for the control of petit mal epilepsy.

PRECAUTIONS (ZARONTIN):

The physician should be alert to any symptoms indicative of the following conditions which have been reported in association with the use of ZARONTIN: aplastic anemia, agranulocytosis, dermatitis, leukopenia. Periodic blood counts should be performed. The drug should be used with caution in patients with known liver or renal disease or dysfunction. Routine urinalyses and frequent liver function tests are advised. Safe use of this drug in pregnancy has not been established.

Because of the possibility of drug-induced drowsiness, operation of motor vehicles or other machinery by patients on ethosuximide therapy is not advised. ZARONTIN when used alone in mixed types of epilepsy may increase the frequency of grand mal attacks in some patients.

ADVERSE REACTIONS (ZARONTIN):

In 727 patients gastrointestinal side effects occurred in 12.5%, central nervous system symptoms in 6.7%, blood changes in 0.4%, and miscellaneous side effects in 1.2%. Side effects are usually mild and transient and usually subside with continued therapy. Anorexia, gastric distress, nausea, emesis, drowsiness, headache, dizziness, euphoria, and singultus have been reported. Psychiatric or psychologic aberrations, including insomnia, night terrors, inability to concentrate, motor unrest, agitation, and aggressiveness thought to be drug-induced or exacerbated by anticonvulsant medication, were noted in a few patients who had previously shown emotional instability. Leukopenia, agranulocytosis, and severe pancytopenia with fatal outcome, have been reported in association with ethosuximide. In most cases of leukopenia, the condition cleared either on reduction of dosage or discontinuation of the drug. Other reactions in which the extent of ethosuximide implication is not yet determined include myopia, rash, vaginal bleeding, swelling of the tongue, and hirsutism. One instance of temporarily elevated (3-plus) cephalin flocculation test has been reported; patient showed normal values as medication continued.

DOSAGE AND ADMINISTRATION (ZARONTIN):

The initial dose for children under six years of age is 250 mg (1 capsule or 5 ml of syrup) per day; for patients six years of age and older, 500 mg (2 capsules or 10 ml of syrup) per day. The dose thereafter must be individualized according to the patient's response.

FORMS AVAILABLE:

ZARONTIN® CAPSULES, 250 mg (Cap. 237). Each soluble gelatin capsule contains 250 mg ethosuximide.

ZARONTIN® SYRUP: Each 5 ml contains 250 mg ethosuximide.

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References:

1) Rinne UK, Mölsä P. Neurology, 1979; 29:1584-1589.

2) Pakkenberg H et al, Acta Neurol. Scand 1976; 53:376-385.

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See page for brief prescribing information.



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