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Neurological Sciences

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Sciences Neurologiques

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34th CANADIAN
CONGRESS OF
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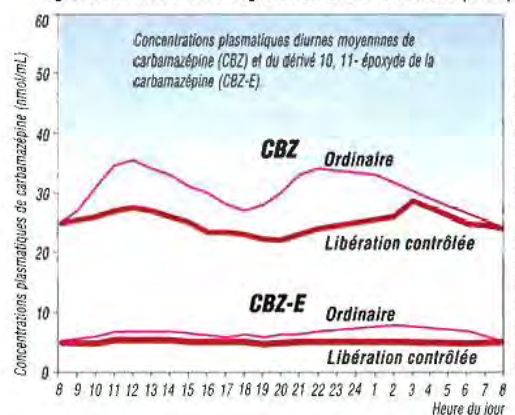
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* Consulter les mises en garde figurant à la monographie avant de prescrire.

Courbes des concentrations plasmatiques diurnes de Tegretol ordinaire et de Tegretol CR chez les enfants (n=25).³



D'après Eeg-Olafsson O. J Child Neurol 1990;5:159-165

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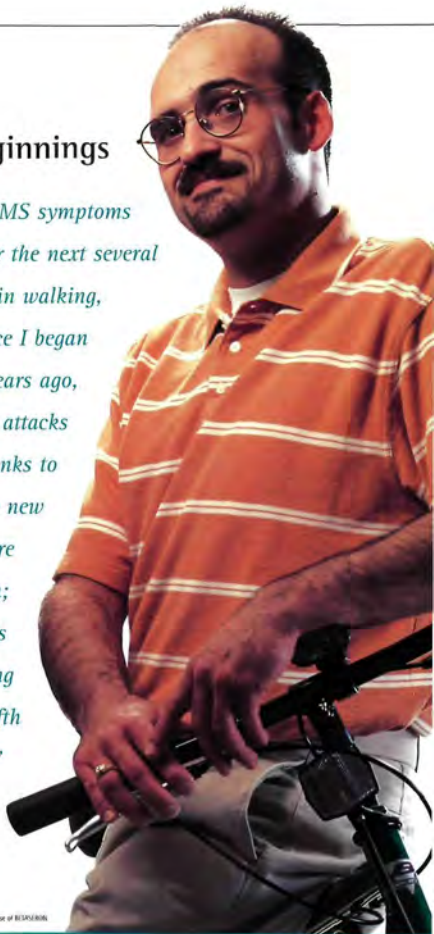
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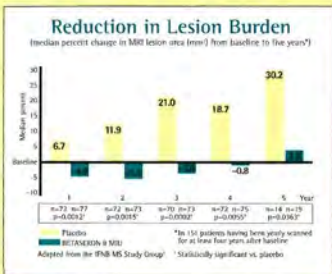
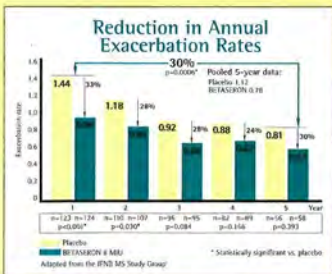
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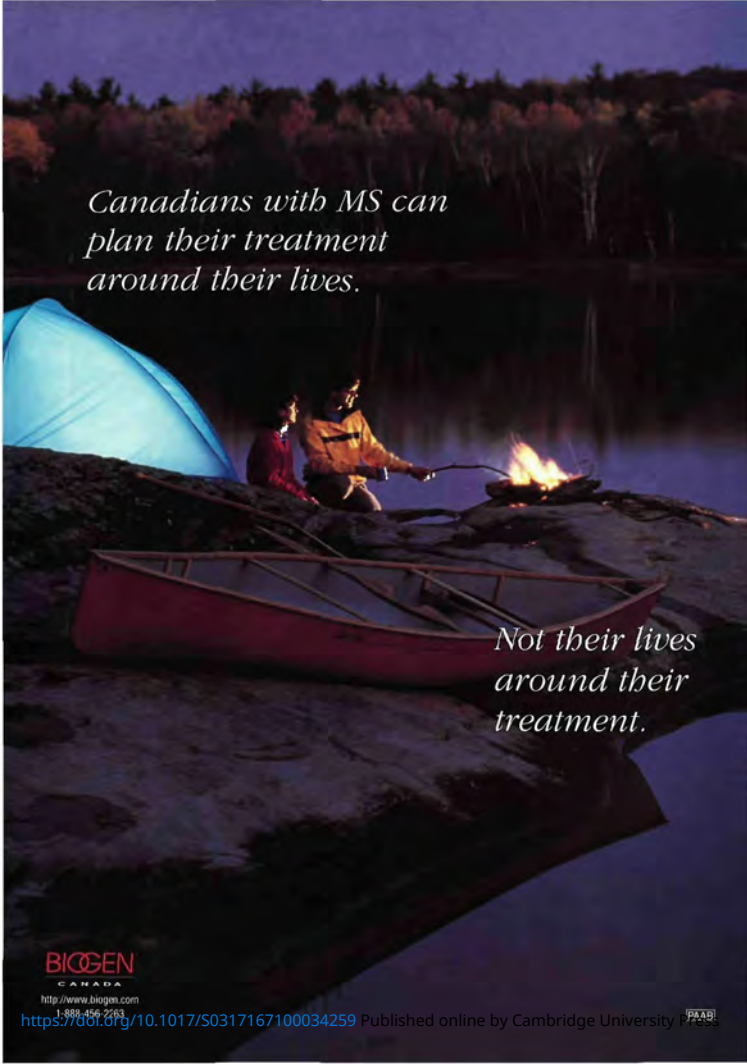
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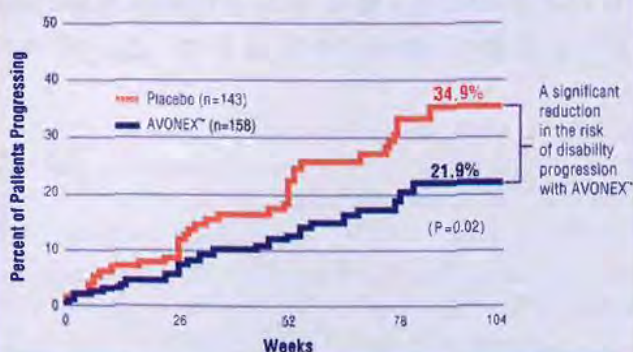
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(Interferon beta-1a)
IM Injection

NEW IN EPILEPSY. NOW ON B.C., ALBERTA, SASKATCHEWAN



Vincent Van Gogh



Alexander the Great

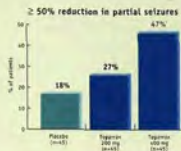


Lord Byron



Charles Dickens

ONCE IT TOOK EXCEPTIONAL EFFORT OR EXTRAORDINARY LUCKILY, YOUR PATIENTS CAN NOW



Adapted from reference 1. Double-blind trial of placebo vs. TOPAMAX (L.S.G.) as adjunctive therapy in 183 patients with intractable partial onset epilepsy receiving one or two other AEDs. $p < 0.001$.

Improved control over a wide range of seizure types

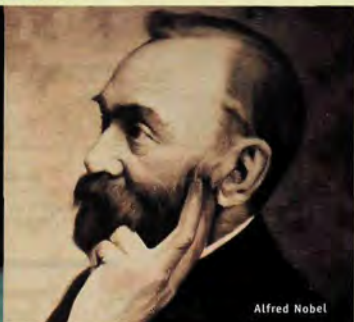
- TOPAMAX is indicated as adjunctive therapy for the management of patients with epilepsy who are not satisfactorily controlled with conventional therapy. There is limited information on the use of TOPAMAX in monotherapy at this time.
- High responder rate: 27% (200mg/day, n=45) and 47% (400mg/day, n=45) of patients experienced ≥ 50% reduction in partial seizures (16 week study)¹
- Effective control for patients with secondarily generalized tonic-clonic seizures: 36% of patients experienced a 100% reduction (200-600 mg, n=42, 16 week study)¹
- Unique three-way mechanism of action (Na⁺ channel blockade, GABA potentiation, glutamate antagonism)²

<https://doi.org/10.1017/S0317167100034259> Published online by Cambridge University Press

NOVA SCOTIA & QUEBEC FORMULARIES.



Joan of Arc



Alfred Nobel



George Frederick Handel



Fyodor Dostoyevsky

TALENT FOR PEOPLE WITH EPILEPSY TO SUCCEED. ENJOY LESS TAXING ALTERNATIVES.

- Generally well tolerated: Discontinuations due to adverse events were 10.6% at 200-400 mg/day compared to 5.8% in the placebo group (this appeared to increase at dosages above 400 mg/day)¹
- No evidence of serious rash or aplastic anemia²
- Dosage adjustments to primary therapy are generally not required; patients on phenytoin showing clinical signs or symptoms of toxicity should have phenytoin levels monitored^{1†}
- Convenient BID dosing

¹As with other AEDs, please see prescribing information for complete information on drug interactions. A 1.5% (n=1715) incidence of kidney stones has been reported.² In one study (n=1200), 83% (15 of 18) of patients elected to continue therapy.[†] Ensure adequate hydration and avoid concomitant use with other carbonic anhydrase inhibitors.[†] © Topamax (S) Janssen-Ortho Inc. 1997

Favourable side effect profile
(the most common are CNS related)

	TOPAMAX 200-400 mg (n=113)	PLACEBO (n=214)
Somnolence	30.1	9.7
Dizziness	28.9	15.3
Ataxia	21.2	6.0
Psychomotor slowing	16.8	2.3
Speech disorders	16.8	2.3
Nervousness	15.9	7.4
Nystagmus	15.0	9.3
Paresthesia	15.0	4.6



<https://doi.org/10.1017/S0317167100034259> Published online by Cambridge University Press

Helping patients make more of their lives

25 Years Ago in the Canadian Journal of Neurological Sciences

HL-A FREQUENCIES IN PATIENTS WITH MULTIPLE SCLEROSIS

D. W. Paty, H. Mervart, B. Campling, C. G. Rand, C. R. Stiller

SUMMARY: The histocompatibility antigens (HL-A) have been determined in 100 multiple sclerosis (M.S.) patients and 143 randomly selected controls. In the M.S. group there was a statistically significant increase in the frequency of HL-A 7 and W 18 with an insignificant increase in HL-A 3. The variance from normal HL-A patterns in the M.S. population may play some role in establishing the substrate for this disease. Studies in experimental animals have shown that susceptibility to autoimmune disease and to virus infection is linked to the major histocompatibility locus. This has interesting implications for both the "slow virus" and the "autoimmune" theories of the etiology of multiple sclerosis.

Can. J. Neurol. Sci. 1974; 4:211

SUPPRESSIVE EFFECTS OF VARIOUS AMINO ACIDS AGAINST OUABAIN-INDUCED SEIZURES IN RATS

Y. Tsukada, N. Inque, J. Donaldson A. Barbeau

SUMMARY: The suppressive effect of various amino acids against ouabain-induced seizures was investigated in young female rats. The amino acids were injected into the left lateral ventricle 10 minutes prior to the intraventricular administration of 5 μ g. of ouabain. Animals receiving 1.9×10^{-1} M solutions of hypotaurine and of B-alanine were almost completely protected from the ouabain seizures. Administration of L-alanine and of glycine was also effective, although running and leaping seizures still occurred to some extent. Betaine reduced only clonic-tonic and whole body flexion and extension seizures. In contrast, L-proline exclusively suppressed clonic-tonic and focal clonic seizures. Rats injected with isethionic acid showed increases in incidence of running and leaping seizures while L-arginine in high concentrations caused aggravation in clonic-tonic seizures. L-cysteine, even in low concentrations, also brought about an increase in the occurrence and incidence of clonic-tonic seizures. The ED₅₀ of hypotaurine was 10.11×10^{-2} M for running seizures and 4.63×10^{-2} M for clonic-tonic seizures; that of B-alanine was 14.01×10^{-2} M for running seizures and 5.5×10^{-2} M for clonic-tonic seizures. However, hypotaurine and B-alanine, the most effective compounds tested in the present studies, provided less protection than taurine previously examined by us under similar conditions (Izumi et al., 1973)

Can. J. Neurol. Sci. 1974; 4:214

ELECTRICAL STIMULATION OF THE HUMAN VISUAL CORTEX Preliminary Report

Andrew Talalla, Leo Bullara, Robert Pudenz

SUMMARY: A feasibility study for the development of a human visual prosthesis has led several workers to observe the effects of electrical stimulation of the human visual cortex. Experience with such stimulations of three normal-sighted patients is reported. The results confirm some of the findings of other workers, but do not show that multiple phosphenes were experienced by our patients, using strictly limited parameters of stimulation.

Can. J. Neurol. Sci. 1974; 4:236

IN THE TREATMENT OF ALZHEIMER'S DISEASE

Once-a-day Aricept[®]
improves patient function:

For a more *active* day,
a *brighter* tomorrow.



The loss of function that comes with Alzheimer's disease has a devastating effect on everyone involved: patient, caregiver and family.¹ Once-a-day Aricept[®] enhances cognition and improves patient function.^{2†} Once-a-day Aricept[®] (10 mg o.d.) has been shown to significantly improve complex Activities of Daily Living (ADL).³ A recent Canadian economic evaluation predicts that improvement in patient outcome will result in an overall healthcare cost saving.⁴ And once-a-day Aricept[®] has proven efficacy, dosing simplicity⁵ and tolerability⁶ in over 54 million patient days of therapy worldwide.⁷

Once-a-day Aricept[®]. To help your Alzheimer's patients enjoy more *active* days, and look forward to a *brighter* tomorrow.

 **Once-a-day**
Aricept[®]
donepezil HCl 5 & 10 mg tablets

Hope for a brighter tomorrow

Aricept[®] is indicated for the symptomatic treatment of patients with mild to moderate Alzheimer's disease. Aricept[®] has not been studied in controlled clinical trials for longer than 6 months.
† Cognition measured by ADAS-cog and MMSE; Function measured by CIBIC plus.
‡ The most common side effects observed with Aricept[®] include diarrhea, muscle cramps, nausea and insomnia; these effects are usually mild and transient, resolving with continued use.
§ For patients not responding to donepezil, a switch to another medication may be considered.
¶ For full prescribing information, please refer to the package insert or visit www.pfizer.com.

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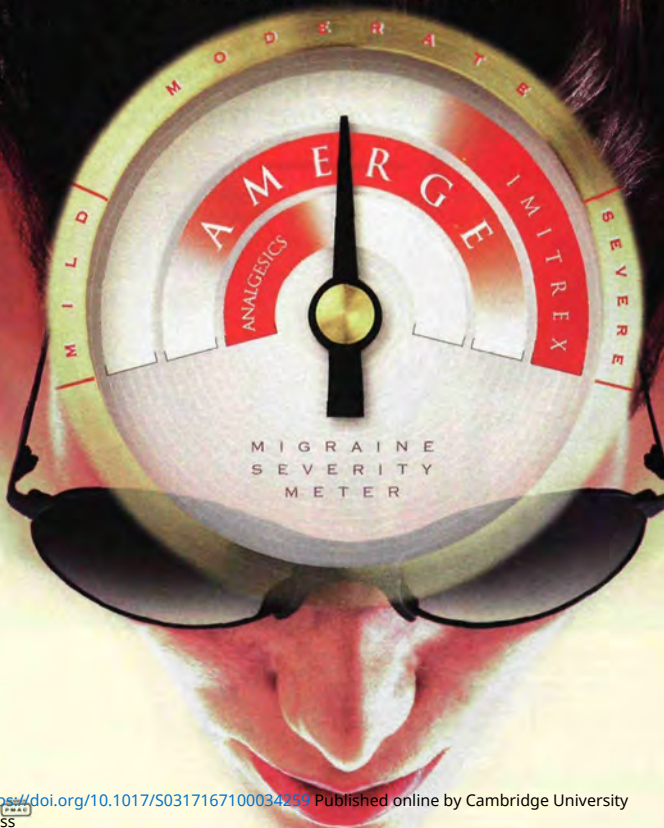
PAAB



We're part of the cure

For brief prescribing information see pages A-35, A-36

If only the severity of migraines
could be measured...



MIGRAINE
SEVERITY
METER

New from Glaxo Wellcome

*A highly selective 5-HT₁ receptor agonist for moderate to severe migraines**

Highly Tolerable

- Overall incidence of adverse events in controlled clinical trials after treatment with AMERGE was similar to placebo¹⁻³
(31% AMERGE 2.5 mg vs. 32% placebo)²
- Chest and neck sensations characteristic of the 5-HT₁ agonist class reported in 1.2 - 2.1% of patients^{1†‡}
- Tolerability maintained regardless of number of attacks treated⁴

5-HT₁ Efficacy with Long-lasting Migraine Relief

- Significant relief was sustained over 24 hours^{2||}
- 93% of attacks per patient did not require a second dose for recurrence^{4#}
- Efficacy of AMERGE is unaffected by use with beta-blockers, calcium channel blockers, or tricyclic antidepressants^{1§}

*AMERGE is indicated for the acute treatment of migraine attacks with or without aura. AMERGE is contraindicated in patients with hemiplegic, basilar, or ophthalmoplegic migraine. Safety and efficacy have not been established for cluster headache which is present in an older predominantly male population.¹

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

‡With 2.5 mg naratriptan.

§Headache relief = reduction of moderate or severe pain to mild or no pain.

#Percentage does not represent recurrence rate. Headache recurrence equals a return of moderate or severe pain in 4 to 24 hours post dose following initial relief.

||Appropriate observation of the patient for acute and long term adverse events is advised.

§AMERGE® is a registered trademark of Glaxo Group Ltd., Glaxo Wellcome Inc. licensed use.

Consult Product Monograph for complete prescribing information, patient selection, screening and monitoring criteria.

Product monograph available to health care professionals upon request.

New



Highly tolerable, long-lasting migraine relief

Also available in 1 mg tablets

GlaxoWellcome

Le premier et le seul parmi les nouveaux antiépileptiques* indiqué en monothérapie après une polythérapie



* C'est à-dire la lamotrigine, la gabapentine, la vigabatrine, et le topiramate, qui se distinguent des antiépileptiques traditionnels.

** Un passage réussi à la lamotrigine en monothérapie a été observé chez 50 patients sur 60.

*** L'essai comprenait trois phases de traitement d'appoint, séparées des autres. Elles ont été réalisées en double aveugle. Néanmoins, il n'y a pas été considéré comme une mesure

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Press Les effets indésirables le plus fréquemment associés à son utilisation en monothérapie à LAMICTAL sont les éruptions cutanées (6,1%), l'asthénie (1,1%),
le vertige (1,1%), la nausée (0,7%) et les vomissements (0,7%). Pour de plus amples renseignements, consultez la monographie de LAMICTAL.

†† Veuillez consulter la monographie pour ce qui est de l'ajustement posologique de LAMICTAL lors du retrait des antiépileptiques administrés en concomitance.

Pour la maîtrise d'un vaste éventail de crises, associée à un profil discret d'effets indésirables liés au SNC

D'une manière générale, une monothérapie efficace a été reconnue comme le traitement de choix pour obtenir la maîtrise des crises avec le minimum d'effets indésirables chez les patients souffrant d'épilepsie¹. Maintenant, renforçant son succès éprouvé comme traitement d'appoint², LAMICTAL est indiqué comme monothérapie chez l'adulte après le retrait d'antéépileptiques administrés en concomitance³.

MONOTHÉRAPIE HAUTEMENT EFFICACE

Dans le cadre d'un essai ouvert sur le passage d'un traitement d'appoint à la monothérapie incluant le retrait des antéépileptiques administrés en concomitance, la monothérapie à LAMICTAL a permis à 30 % (n = 50) des patients traités avec succès de rester exempts de crises⁴. Dans un autre essai du même type, ≥ 40 % des patients ont obtenu une réduction de la fréquence de leurs crises d'au moins 50 % pendant toutes les étapes successives de l'essai⁵.

GÉNÉRALEMENT MIEUX TOLÉRÉ⁶

Selon les données regroupées de trois essais sur la monothérapie, la fréquence des retraits

dus aux effets indésirables sur le SNC était de 2,5 % (n = 443) avec la monothérapie à LAMICTAL, par rapport à 7,4 % pour la phénytoïne (n = 95) ou à 7,7 % pour la carbamazépine (n = 246)⁷. La fréquence de somnolence, d'asthénie et d'ataxie a été moins élevée pour LAMICTAL que pour la carbamazépine et la phénytoïne. On n'a noté aucune différence quant à la fréquence des retraits dus aux éruptions cutanées entre LAMICTAL (6,1 %) et la phénytoïne (5,3 %) ou la carbamazépine (8,9 %)⁸. Une fréquence plus élevée d'éruptions cutanées a été associée à une augmentation posologique plus rapide de la dose initiale de LAMICTAL ou à l'utilisation concomitante d'acide valproïque⁹.

MAÎTRISE SUR UN VASTE ÉVENTAIL DE CRISES

LAMICTAL a été utilisé avec succès pour un vaste éventail de crises comme traitement d'appoint dans une polythérapie¹. Vous pouvez passer avec confiance de LAMICTAL comme traitement d'appoint en polythérapie à LAMICTAL en monothérapie², en particulier lorsque les effets indésirables liés au SNC sont une considération importante.

lamotrigine
Lamictal[®]
DE LA POLYTHÉRAPIE À LA
MONOTHÉRAPIE

GlaxoWellcome

Glaxo Wellcome Inc.
Borley d'Aunay, France

1000

PSAR
1000

25 Years Ago in the Canadian Journal of Neurological Sciences

SEX-LINKED HEREDITARY ATAXIC DIPLEGIA, THE BORDERLAND BETWEEN CEREBRAL PALSY AND PELIZSAEUS-MERZBACHER DISEASE

H. G. Dunn, Margaret W. Thompson, Elizabeth Bandler, L. G. Andrews

SUMMARY: After a review of the literature concerning hereditary cases of cerebral palsy, a family is reported in which ataxic diplegia appears to be inherited as a sex-linked and probably recessive condition occurring in 3 males in successive generations. This ataxic diplegia, occurring after an unremarkable perinatal course, is associated with mild to moderate mental retardation, congenital nystagmus and significantly small stature and prevents the acquisition of free walking. Associated extrapyramidal features may gradually become more marked, while the nystagmus may subside. The condition is similar to that described in three previous reports in the literature. No evidence of linkage with other sex-linked disorders has been found. Xga typing showed that recombination between the Xg locus and the locus for hereditary ataxic diplegia has occurred once out of three possible opportunities. In the absence of neuropathological findings or specific biochemical tests, the differential diagnosis from Pelizaeus-Merzbacher disease cannot be made with certainty. The differentiation from other progressive sex-linked neurological disorders is discussed.

Can. J. Neurol. Sci. 1974; 4:226

SPINAL MYOCLONUS IN ASSOCIATION WITH HERPES ZOSTER INFECTION: Two Case Reports

G. S. Dhaliwal, D. A. McGreal

SUMMARY: Two cases of segmental spinal myoclonus, attributed to herpes zoster infection, are presented. The findings support the suggestion made by Campbell and Garland (1956) that "subacute myoclonic spinal neuronitis" is of viral origin. Both patients were receiving immuno-suppressive treatment when the myoclonus developed. The value of carbamazepine in therapy is mentioned.

Can. J. Neurol. Sci. 1974; 4:239

LARGE ELECTROENCEPHALOGRAPHIC RESPONSES AND THEIR RELATIONSHIP TO CLEIDO-CRANIAL DYSPLASIA

Adrian Upton, Sarah Bunday, Susan Sanders

SUMMARY: We have reported six individuals (five certain heterozygotes for cleido-cranial-dysostosis and one possible heterozygote) who have unusual EEG findings, consisting of very large responses to photic flash stimulation at very low stimulus rates.

Such visual responses are extremely rare and have not been seen before in the experience of an EEG department over 12 years and they were not seen in 98 control subjects. It is likely that these responses are an irregular manifestation of the gene for cleido-cranial-dysplasia, and that the responses are independent of skull deformity. One importance of these responses is their demonstration in neurologically normal individuals for previously such large responses have only been reported in association with neurolipidosis. They may have neurophysiological significance in that they may reflect an unusual balance between inhibitory and excitatory mechanisms in the nervous system.

Can. J. Neurol. Sci. 1974; 4: 242

POLYARTERITIS NODOSA COMPLICATED BY A MULTIPLE SCLEROSIS LIKE SYNDROME

H. Waisburg, K. L. Meloff, R. Buncic

SUMMARY: A case is presented of a 16-year-old boy with angiographically proven polyarteritis nodosa who developed a multiple sclerosis like syndrome affecting the brain stem and cerebrum. His serum demyelinated nerve in tissue culture. The case is reviewed in detail and the mechanism of myelotoxicity is discussed.

Can. J. Neurol. Sci. 1974; 4:250

A Renewed Opportunity



PARKINSON'S DISEASE

A world in which the therapeutic options are limited¹

For those who have it, treat it, live with it, managing their Parkinson's disease can be quite frustrating. Yet there are moments that can be most rewarding. Motor function improves, the number of "off" hours decreases, rigidity subsides, gait improves. Their levodopa seems to be working... at least for today! Then there are times when nothing seems to help. Even their medication seems to be causing problems. It seems hopeless...

Today, however, there is another way to renew their hope. Even after its discovery more than fifteen years ago, Permax (pergolide mesylate) is still considered the most potent dopamine agonist available for the treatment of Parkinson's disease.^{1,4} With its unique mode of action, i.e. stimulating both D₁ and D₂ dopamine receptors, Permax has demonstrated (n=376) statistically significant improvement in virtually all those numerous parameters of parkinsonian function, including bradykinesia, rigidity, gait, dexterity, etc. Equally important, these benefits were achieved with significantly less levodopa... 24.7% (p < .001), and by starting Permax at low doses. "Adverse reactions were, for the most part, mild, reversible, and not of major clinical significance."^{2,3*}

Successful treatment with Permax can last for up to 3-5 years^{1,3} and renewed improvement has been demonstrated when Permax was given to patients (n=10) in whom the beneficial effect of bromocriptine had waned,⁴ whereas the reverse was not true in a separate, non-comparable study (n=11) when bromocriptine was given to Parkinson's patients in whom Permax had waned.⁴

So, when given an opportunity to manage Parkinson's disease, there may be a way of renewing hope.



PERMAX[®]
pergolide mesylate

DRAXIS

Draxis Health Inc.
Mississauga, Ontario

PKAB

* Rapid escalation of pergolide dosage may cause severe adverse reactions. Therefore a slow increase combined with a concomitant gradual and limited reduction of levodopa is recommended. See ADVERSE REACTIONS section in Prescribing Information.

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Turn the agony
of migraine into
the beauty of relief.

Introducing [®]Zomig[®].

Consistent migraine
relief that patients can
depend on time after time.

ZOMIG[®] is a new oral 5-HT₁ agonist
indicated for the acute treatment
of migraine.¹

ZOMIG[®] offers consistent efficacy
with significant headache
response² rates at 2 hours
following a single 2.5 mg dose.^{2,3}
In addition, efficacy is maintained
across multiple migraine attacks and
within different migraine subtypes.^{1,4,5}

ZOMIG[®] has a proven
safety and tolerability profile
with studies in over
3,000 patients treating
more than 34,000 attacks.^{4,6}

For consistent migraine relief,
prescribe ZOMIG[®] 2.5 mg.

¹Improvement from severe or moderate headache to mild or no pain.
²The most common side effects reported with ZOMIG[®]
compared to placebo were nausea (9% vs 3%),
headache sensations (6.6% vs 1.7%), dizziness (5.4% vs 2%)
and vertigo/circular sensations (7% vs 3%).

ZOMIG[®] is not intended for use prophylactically by
or in hemiplegic, basilar or ophthalmoplegic migraines.
Safety and efficacy have not been established for "cluster headache"
which is present in an acute predominantly male population.

ZOMIG[®] is contraindicated in patients with history
symptoms or signs of ischemic, cardiac, cerebrovascular
or peripheral vascular syndromes, severe heart failure
or cardiac arrhythmias (especially tachycardia).
In addition, patients with other significant underlying
cardiovascular disease should not receive ZOMIG[®].
Please see Product Monography.

For more information about ZOMIG[®], please contact
Zenecca Pharma Medical Information by phone at 1-888-551-0055
(7:00 AM - 4:00 PM), or e-mail at info@zomig.com.

Zomig[®]
zolmitriptan tablets 2.5 mg

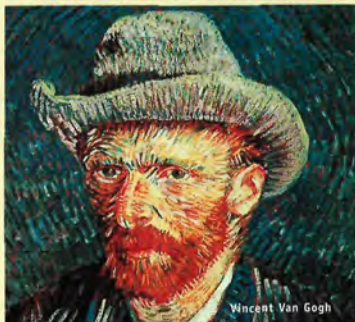
Consistent migraine relief.

<https://doi.org/10.1017/S0317167100034259> Published online by Cambridge University Press

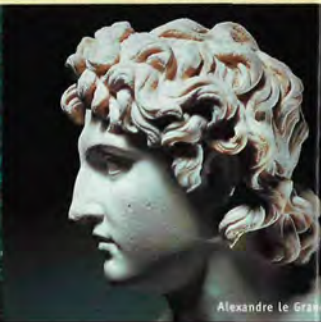
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DU NOUVEAU EN ÉPILEPSIE. MAINTENANT REMBOURSE PAR LES FORMULAIRES



Vincent Van Gogh



Alexandre le Grand



Lord Byron



Charles Dickens

NAGUÈRE ENCORE, LA RÉUSSITE EXIGEAIT D'UN ÉPILEPTIQUE HEUREUSEMENT POUR VOS PATIENTS, IL EXISTE



Extrait de référence N° 1. Étude en double aveugle avec placebo contre TOPAMAX 500 mg comme traitement d'appoint, portant sur 183 patients atteints d'épilepsie partielle réfractaire et recevant une ou deux autres médicaments antiepileptiques. *p < 0,05.

Contrôle amélioré d'une plus grande variété de types de crises.

- TOPAMAX est indiqué comme traitement d'appoint pour toutes les épilepsies réfractaires aux traitements conventionnels. À l'heure actuelle, les données sur l'utilisation de TOPAMAX comme traitement unique demeurent limitées.
- Taux élevé de répondants : 27 % (200 mg/jour, n = 45) et 47 % (400 mg/jour, n = 45) des patients ont manifesté une réduction des crises d'épilepsie partielle ≥ 50 % (étude d'une durée de 16 semaines)¹
- Contrôle efficace pour les patients souffrant de crises toniques-cloniques secondaires généralisées : 36 % des patients ont manifesté une réduction de 100 % (200-600 mg, n = 42, étude portant sur 16 semaines)¹
- Triple mécanisme d'action unique : blocage des canaux sodiques, activation de l'acide gamma-aminobutyrique, antagonisme du glutamate)²

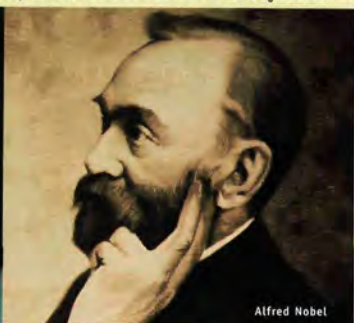
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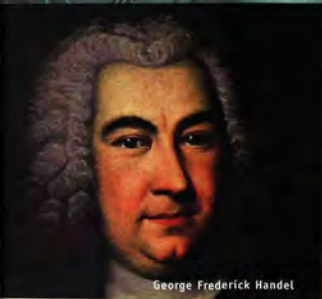
DE LA C.-B., L'ALBERTA, LA SASKATCHEWAN, LA NOUVELLE-ÉCOSSE ET DU QUÉBEC.



Jeanne d'Arc



Alfred Nobel



George Frederick Handel



Fyodor Dostoyevsky

**DES EFFORTS EXCEPTIONNELS OU UN TALENT EXTRAORDINAIRE.
MAINTENANT DES SOLUTIONS PLUS ACCESSIBLES.**

- Généralement bien toléré: les interruptions entraînées par des réactions adverses étaient de 10,6 % pour les doses journalières de 200 à 400 mg, comparé à 5,8 % pour le groupe placebo (cela semblerait augmenter pour les doses journalières supérieures à 400 mg)¹
- Aucune preuve d'éruption cutanée sérieuse ni d'anémie aplasique²
- Il n'est généralement pas nécessaire de changer le dosage des médicaments principaux; les patients prenant de la phénytoïne et manifestant des signes ou symptômes de toxicité devraient faire contrôler leurs niveaux de phénytoïne³
- Dosage commode BID

Profil favorable des effets secondaires
(les plus courants affectent le SNC)

	TOPAMAX 200-400 mg (n = 113)	PLACEBO (n = 218)
Somnolence	30,1	9,7
Troubles cognitifs	28,3	15,1
Ataxie	22,2	8,9
Baillonnement psychomoteur	19,5	2,3
Troubles de la parole	18,6	2,3
Nausée	11,9	7,4
Nystagmus	11,0	6,3
Paresthésie	10,0	4,6



Aide vos patients à mieux tirer parti de leur vie

¹Cette étude a été menée sur des patients atteints d'épilepsie. Les données de tolérance présentées ici sont basées sur une étude (n = 200), 83 % des patients (15 sur 18) ont choisi de continuer le traitement.
²Assurez-vous d'une hydratation adéquate et évitez l'utilisation prolongée d'autres inhibiteurs de l'anhydrase carbonique.

<https://doi.org/10.1017/S0317167100034259> Published online by Cambridge University Press

Introducing Rebif®. The 1st Relapsing & Remitting MS Treatment to Significantly Improve All 3 Major Outcomes

REBIF

REDUCES PROGRESSION OF DISABILITY

REDUCES NUMBER AND SEVERITY OF RELAPSES

REDUCES MRI DISEASE ACTIVITY AND BURDEN

The largest and most comprehensive RRMS clinical study ever undertaken, PRISMS¹, confirms Rebif® (Interferon Beta-1a for injection) ...

Reduces progression of disability

The time to confirmed progression was significantly increased by 78% and 54% at both the 44 mcg and 22 mcg doses respectively versus placebo.²

Reduces the number and severity of relapses

The likelihood of remaining relapse-free at 2 years increased by 75% with the 22 mcg dose and by 119% with the 44 mcg dose.²

Reduces MRI disease activity and burden

Compared to placebo, Rebif significantly reduced the number of active lesions per patient per MRI scan by 78% and 67% (at the 44 and 22 mcg doses respectively) in 560 patients. This reduction was seen early and persisted throughout the 2 year study period.²

Flexible dosing for optimal response

Available in ready-to-use liquid pre-filled syringes for subcutaneous injection.

The most commonly reported adverse events are injection-site reactions and flu-like symptoms - e.g., asthenia, pyrexia, chills, myalgia, headache and arthralgia. These tend to decrease in frequency and severity with continued treatment. Please see Product Monograph for further information on patient selection.
¹ 2-year clinical trial involving 560 patients given 44 mcg and 22 mcg doses of Rebif three times per week.
² Evidence of efficacy is derived from 2-year trials only.

Rebif® (Interferon Beta-1a)
Injection 0.5 mL x 30

REBIF®

MULTIPLE EFFICACY.
MULTIPLE SUPPORT.

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