Volume 25 Number 4 November 1998

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For brief prescribing information see pages A45, A46, A47, A53

Volume 25 Number 4 November 1998

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La Société Canadienne de Neurologie

The Canadian Neurosurgical Society
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L'épilepsie n'effleure même pas ces esprits vifs… Tegretol CR au boulot !

Maîtrise efficace des crises

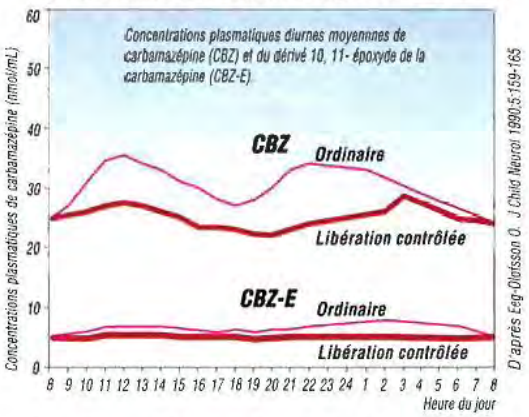
- **Bienfait clinique significatif et excellente maîtrise des crises épileptiques[1,2].**

Profil d'innocuité éloquent

- **Concentrations plasmatiques stables de carbamazépine pouvant mener à une incidence plus faible d'effets indésirables liés aux concentrations que Tegretol ordinaire[4].**
- **Niveau élevé de tolérabilité[2*].**

Permet d'atteindre et de maintenir une bonne maîtrise des crises tout en offrant une faible incidence d'effets indésirables liés aux concentrations[4].

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



Pr Tegretol® CR vs Pr Tegretol® ordinaire

- **Efficacité et tolérabilité équivalentes ou améliorées[6]**
- **Peut réduire considérablement la fréquence des crises[7]**
- **Entrave moins la fonction cognitive[5]**

L'un des effets secondaires les plus fréquents de la carbamazépine est la somnolence. Cette réaction ne survient généralement qu'en début de traitement[4] et peut être amenuisée par le recours à la carbamazépine à libération contrôlée (Tegretol® CR)[5].

La carbamazépine n'est pas efficace pour le traitement des absences, des crises myocloniques ou atoniques et ne prévient pas la généralisation de la décharge épileptique. En outre, une exacerbation des crises peut parfois survenir chez les patients ayant des absences atypiques[4].

**Consulter les mises en garde figurant à la monographie avant de prescrire.*

Pr Tegretol® CR
(carbamazépine à libération contrôlée)
et la suspension Pr Tegretol®
(carbamazépine)
POUR AIDER LES ÉPILEPTIQUES À S'ÉPANOUIR PLEINEMENT

Geigy
Spécialités pharmaceutiques
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PAAB CCPP PMAC ACIM

G-960170F

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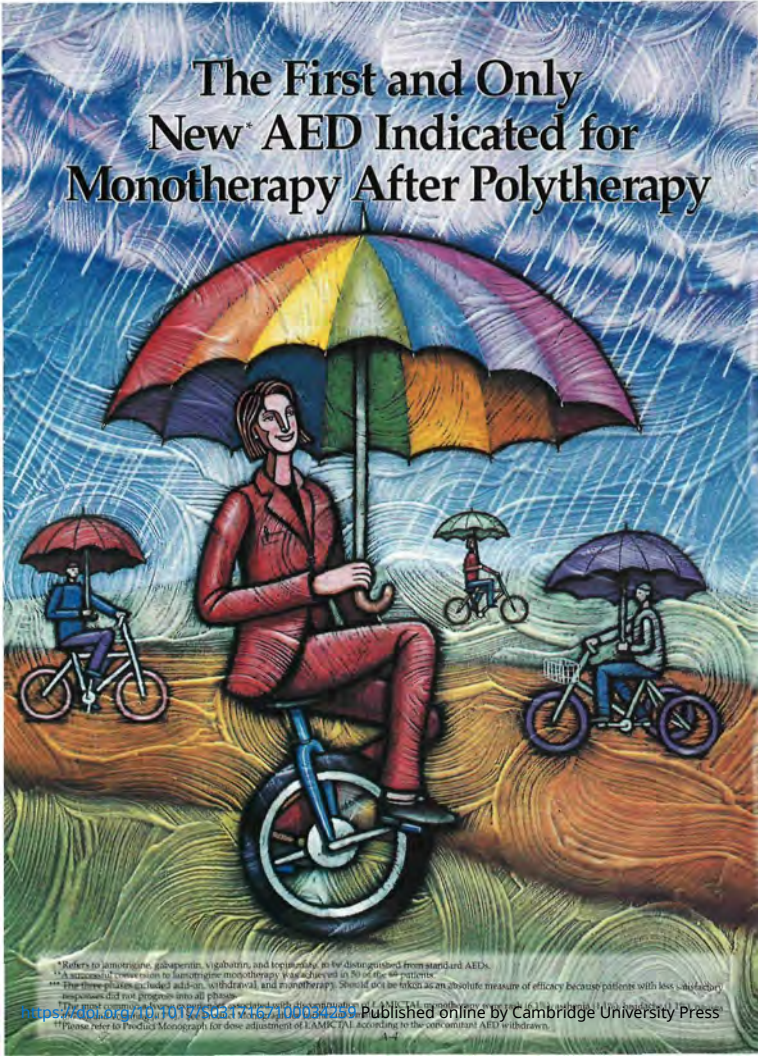
Pour documentation voir pages A-29, A-30



*Refers to lamotrigine, gabapentin, vigabatrin, and topiramate, so far distinguished from standard AEDs.
**A successful conversion to lamotrigine monotherapy was achieved in 50 of the 80 patients.
***The three phases excluded add-on, withdrawal, and monotherapy. Should not be taken as an absolute measure of efficacy because patients with less satisfactory responses did not progress into all phases.
†The most common adverse events associated with discontinuation of LAMICTAL monotherapy were rash (6.1%), headache (1.0%), nausea (1.0%), vomiting (1.0%), and dizziness (1.0%).
††Please refer to Product Monograph for dose adjustment of LAMICTAL according to the concomitant AED withdrawn.

For Control Over a Wide Range of Seizure Types, with a Low CNS Side-Effect Profile

Effective monotherapy has been largely accepted as the regimen of choice for achieving seizure control with minimal side effects in the management of patients with epilepsy.[1] Now, extending its proven success as adjunctive therapy,[2] LAMICTAL is indicated for monotherapy in adults following withdrawal of concomitant antiepileptic drugs (AEDs).[3]

HIGHLY EFFECTIVE MONOTHERAPY

In one add-on/withdrawal to monotherapy open-label trial, LAMICTAL monotherapy following withdrawal of concomitant AEDs kept 30% (n=50) of the successfully treated patients seizure-free.*[4] In a similarly designed trial, ≥ 40% of the patients were maintained with at least 50% reduction of seizure frequency across all phases of the trial.*[5]

GENERALLY BETTER TOLERATED†

Pooled data from three monotherapy trials show that withdrawals due to CNS-related side effects were 2.5% (n=443) with LAMICTAL monotherapy compared to phenytoin (7.4%; n=95) or carbamazepine (7.7%; n=246).[6] Incidence of somnolence, asthenia, and ataxia were reported less frequently with LAMICTAL compared to carbamazepine and phenytoin. There was no difference in the rate of withdrawal due to skin rash between LAMICTAL (6.1%) and phenytoin (5.3%) or carbamazepine (8.9%).[6] A higher incidence of skin rash has been associated with more rapid initial titration of LAMICTAL or use of concomitant valproic acid.[3]

CONTROL OVER A WIDE RANGE OF SEIZURE TYPES

LAMICTAL add-on polytherapy has been successfully used across a wide range of seizure types.[2] Now, opt to switch with confidence from LAMICTAL polytherapy to LAMICTAL monotherapy,†† particularly when you are concerned with CNS-related side-effects.

Lamotrigine

Lamictal®

FROM POLYTHERAPY TO MONOTHERAPY

GlaxoWellcome

Glaxo Wellcome Inc.

PMAC

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PAAB CCPP

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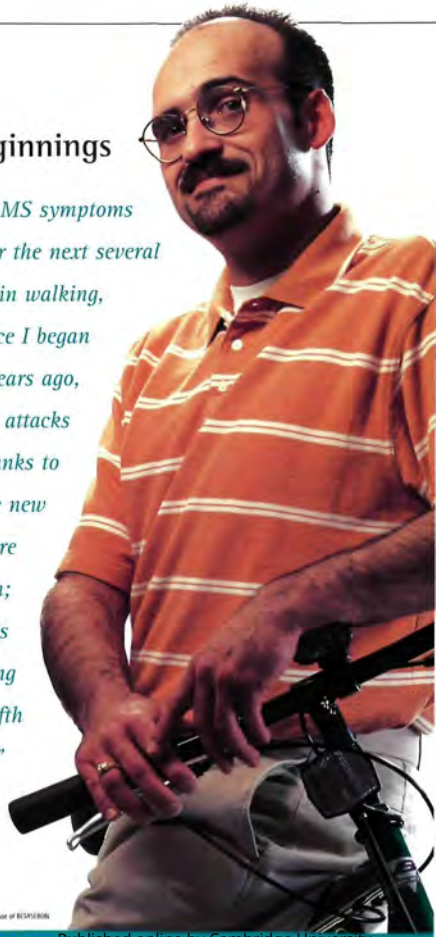
For brief prescribing information see pages A-37, A-38

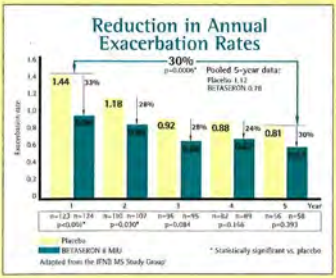
Fred on New Beginnings

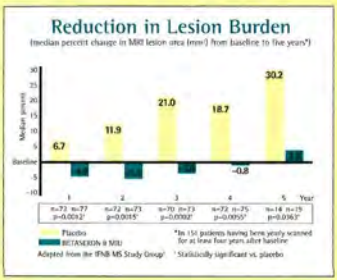
"I first experienced MS symptoms in 1985. Over the next several years, I had difficulties in walking, with speech ... But since I began BETASERON, *11 years ago, I have had no attacks whatsoever. Thanks to* BETASERON, *I now face new challenges. I can be there for my children; I'm preparing my master's degree; and I'm getting ready for my fifth MS bike-a-thon!"*



This real BETASERON patient testimonial may not be representative of all cases involving the use of BETASERON.

THE FIRST TREATMENT ALTERING MS NATURAL HISTORY





- **Proven long-term efficacy as first-line treatment in relapsing-remitting MS**
  - Over five years, exacerbation rate reduced by 30% (p=0.0006)[1]
  - At two years, moderate and severe exacerbations reduced by 49% (p=0.002);[2] significant annual reduction maintained over five years[1]
  - Median time to first exacerbation twice as long as in placebo patients (p=0.015)[2]
- **The only treatment studied for five years, both clinically and with MRI[1]**
  - MRI measured *lesion burden* significantly reduced over five years[1]
  - MRI measured *lesion activity* decreased (a median of 80% fewer active scans compared to placebo; p=0.0062; measured for two years)[3]
- **Trend toward slower disability progression demonstrated over a five year period[1]**
- **Low incidence of serious side effects:[1] injection-site reactions and flu-like symptoms are manageable and lessen markedly with time[4]**

More than 60,000 patients treated to date worldwide[5]

BETASERON®
INTERFERON BETA-1b
Proven first-line treatment for MS

MULTIPLE SCLEROSIS PATHWAYS™ FOR CANADA
1 800 977-2770 CODE 4000

Provincial reimbursement available in British Columbia, Saskatchewan, Manitoba, Ontario and Quebec

WITH LONG-TERM BENEFICIAL EFFECTS FOR MS PATIENTS

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• Submit five high quality copies of the manuscript and original illustrations. Papers will be accepted in English or French. Manuscripts must be double spaced throughout including references, tables and legends for illustrations. Margins of at least 25mm should be left on all sides.

• After a paper has been reviewed, the author will be requested to submit four copies of the revised manuscript, including illustrations and a computer diskette (3 1/2" or 5 1/4" size) containing the article. Identify clearly first author's name, file name, word processing program and version, and system (i.e. PC or Mac). Clearly indicate the order and importance of headings.

• For detailed instructions regarding style and layout refer to *"Uniform requirements for manuscripts submitted to biomedical journals"*. Copies of this document may be obtained by writing to the Journal office, but the main points are summarized here. Articles should be submitted under conventional headings of *introduction, methods and materials, results, discussion*, but other headings will be considered if more suitable. Clinical trials must be reported in Consort format (JAMA 1996; 276: 637-639). Pages of text should be numbered consecutively.

• ***A title page*** should identify the title of the article which should be no more than 80 characters including spaces; name of institution(s) from which the work originated; and the name, address, telephone, and fax number of the corresponding author.

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• ***Acknowledgements*** including recognition of financial support should be typed on a separate page at the end of the text.

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Journals

Yang JF, Fung M, Edamura R, et al. H-Reflex modulation during walking in spastic paretic subjects. Can J Neurol Sci 1991; 18: 443-452.

Chapter in a book

McGeer PL, McGeer EG. Amino acid neurotransmitters. *In*: Siegel GJ, Albers RW, Agranoff BW, Katzman R, eds. Basic Neurochemistry. Boston: Little, Brown & Co., 1981: 233-254.

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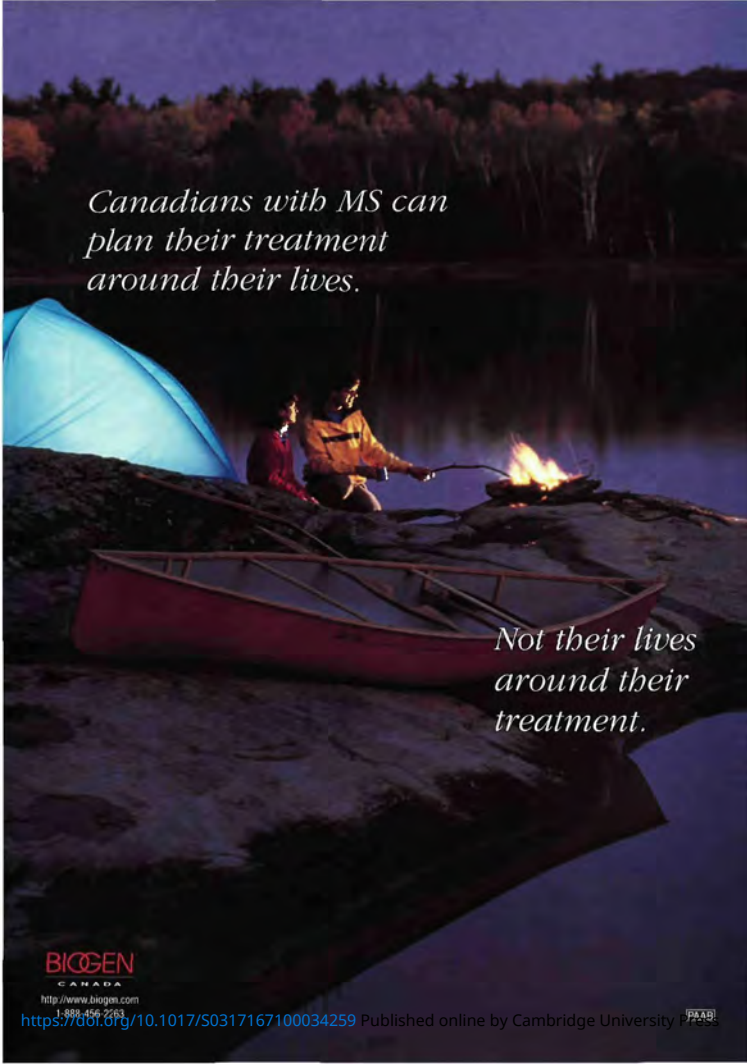


New Once-A-Week AVONEX™ (Interferon beta-1a)

Helping people with relapsing forms of MS get on with their lives.

The therapy prescribed in 18 countries is now available in Canada

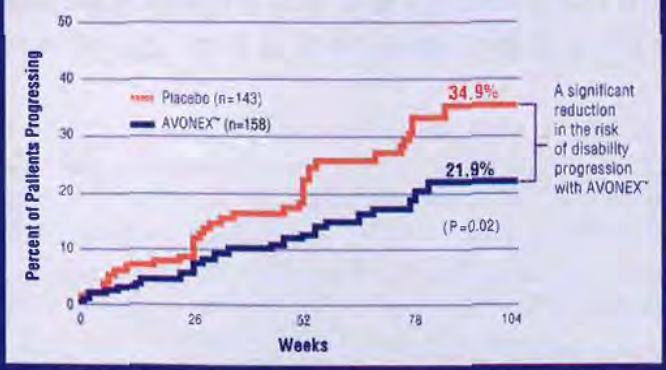
Treatment with once-a-week AVONEX™ results in minimal disruption of patients' lives and mild side effects that decrease over time for most patients.[1,2]

Our easy to plan, once-a-week IM injections may promote patient compliance.

AVONEX™ is proven to slow the progression of disability in relapsing forms of MS[1]

Prophylactic use of AVONEX™ can help patients maintain function longer. In a clinical trial, patients treated with AVONEX™ showed a significant reduction in risk of disability progression and a 32% reduction in annual exacerbation rate over two years.[1†]

Onset of sustained disability progression by time on study (Kaplan-Meier Methodology)[1]



AVONEX™ also demonstrated a significant MRI effect, showing an 89% reduction in gadolinium-enhanced lesions in patients with enhancement at baseline.[1◊]

The Avonex Support Line™: 1-888-456-2263

Biogen Canada is committed to providing healthcare professionals and their patients with the information and support they require. Our toll-free Avonex Support Line™ provides patients with information on injection training, delivery options and reimbursement counseling. Healthcare professionals are also available to answer your questions about AVONEX™.

Once-a-week AVONEX™ is generally well tolerated[1]

The unique once-weekly dosing regimen with AVONEX™, means fewer opportunities for injection-related side effects to disrupt patient's lifestyle.*

- The most common side effects associated with AVONEX™ treatment are flu-like side effects and usually resolve within 24 hours after injection.[1,2]
- Incidence of side effects decrease over time with continued treatment for most people.[2]
- Compared to subcutaneous injections, intramuscular injections result in far fewer site reactions.[3]
- No cases of injection site necrosis have been reported for patients on AVONEX™ therapy.[4]
- Please see product monograph for important patient selection and monitoring information.

℞ ONCE-A-WEEK AVONEX™ (Interferon beta-1a) IM Injection

*Versus a more frequent dosing regimen

† P= 0.002. Placebo annual exacerbation rate 0.90, N:87. Avonex annual exacerbation rate 0.61, N:85.

◊ P=0.041. Placebo median ratio 0.50, N=44. Avonex median ratio 0.11, N=44. The exact relationship between MRI findings and clinical status is unknown.

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

ONCE IT TOOK EXCEPTIONAL EFFORT OR EXTRAORDINAR
LUCKILY, YOUR PATIENTS CAN NO

Adapted from reference 1. Double-blind trial of placebo vs. TOPAMAX b.i.d. as adjunctive therapy in 145 patients with refractory partial onset epilepsy receiving one or two other AEDs. *p=0.01.

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]

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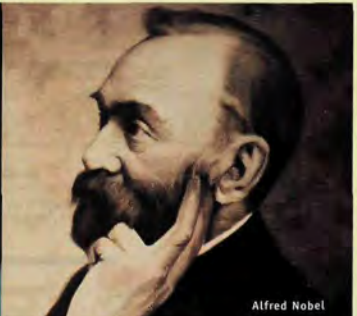
NOVA SCOTIA & QUEBEC FORMULARIES.



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)[2]
- No evidence of serious rash or aplastic anemia[2]
- Dosage adjustments to primary therapy are generally not required; patients on phenytoin showing clinical signs or symptoms of toxicity should have phenytoin levels monitored[1,2]
- **Convenient BID dosing**

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

	TOPAMAX 200-400 mg (n=313)	PLACEBO (n=216)
Somnolence	30.1	9.7
Dizziness	28.3	15.3
Ataxia	21.2	6.9
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

TAs 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.[3] In one study(n=1200), 83%(15 of 18) of patients elected to continue therapy.[4] Ensure adequate hydration and avoid concomitant use with other carbonic anhydrase inhibitors.[1] ®Trademark ©Janssen-Ortho Inc. 1997

TOPAMAX®
topiramate
Helping patients make more of their lives

For brief prescribing information see pages A-50, A-51, A52

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 5ug. of ouabain. Animals receiving 1.9 x 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 x 10-2 M for running seizures and 4.63 x 10-2 M for clonic-tonic seizures; that of B-alanine was 14.01 x 10-2 M for running seizures and 5.5 x 10-2 M for clonic-tonic seizuares. 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

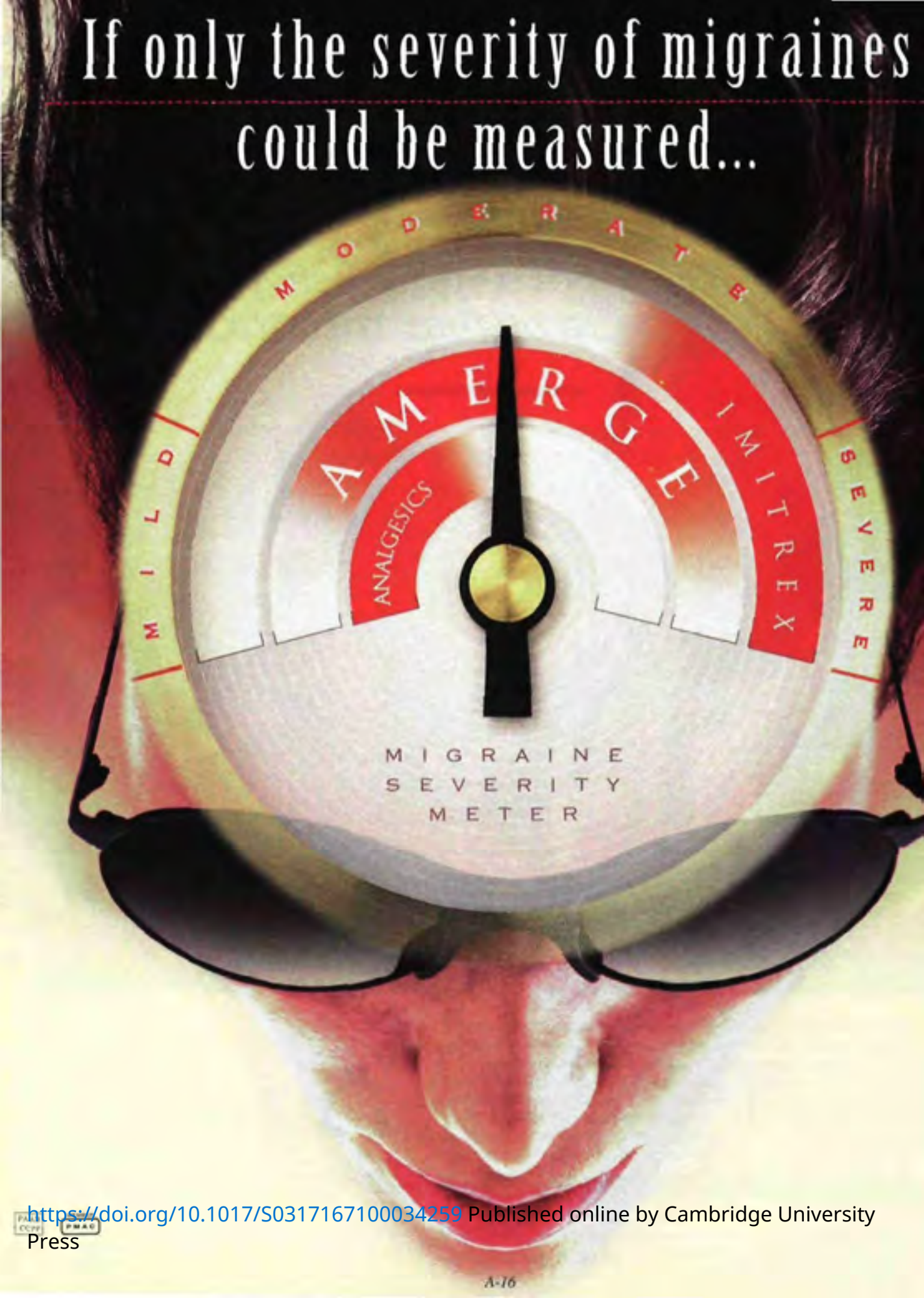
Electrical Stimulation of the Human Visual Cortex
Preliminary Report

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

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



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New Amerge® naratriptan hydrochloride from Glaxo Wellcome

*A highly selective 5-HT$_1$ 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 placebo[1-3]
  (31% AMERGE 2.5 mg vs. 32% placebo)[2]
- Chest and neck sensations characteristic of the 5-HT$_1$ agonist class reported in 1.2 - 2.1% of patients[1†‡]
- Tolerability maintained regardless of number of attacks treated[4]

5-HT$_1$ 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.

†**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 Amerge® naratriptan hydrochloride

Highly tolerable, long-lasting migraine relief
Also available in 1 mg tablets

GlaxoWellcome

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

For brief prescribing information see pages A-39, A-40

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

**Un passage réussi à la lamotrigine en monothérapie a été obtenu chez 50 patients sur 60 [illegible]

[illegible] Veuillez consulter la monographie pour de plus amples renseignements concernant [illegible]

***Les effets indésirables le plus fréquemment associés à des arrêts de la monothérapie à LAMICTAL ont été l'éruption cutanée (6,1 %), l'asthénie (3,5 %), la céphalée (1,1 %), la rhinite (0,7 %) et les convulsions (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'épilepsie[1]. Maintenant, renforçant son succès éprouvé comme traitement d'appoint[2], LAMICTAL est indiqué comme monothérapie chez l'adulte après le retrait d'antiépileptiques administrés en concomitance[3].

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 antiépileptiques administrés en concomitance, la monothérapie à LAMICTAL a permis à 30 % (n = 50) des patients traités avec succès de rester exempts de crises[4]. *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'essai[5,6].

GÉNÉRALEMENT MIEUX TOLÉRÉ[7]

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)[6]. 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 %)[6]. 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 valproïque[8].

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 polythérapie[2]. Vous pouvez passer avec confiance de LAMICTAL comme traitement d'appoint en polythérapie à LAMICTAL en monothérapie[3], 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.
Bureau d'affaires du Québec

Pour documentation avec pages A 37, A 38

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 occuring 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 Bundey, Susan Sanders

SUMMARY: We have reported six individuals (five certain heterozygotes for cleido-cranial-dysostosia 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. Sic. 1974; 4: 242

Polarteritis 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

PARKINSON'S DISEASE

A world in which the therapeutic options are limited[1]

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.[1-3] With its unique mode of action, i.e. stimulating both D_1 and D_2 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.*[1,3,4]

Successful treatment with Permax can last for up to 3-5 years[4,5] and renewed improvement has been demonstrated when Permax was given to patients (n=10) in whom the beneficial effect of bromocriptine had waned,[6] 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.[6]

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

PMAB

* 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

For brief prescribing information see page A-54

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DU NOUVEAU EN ÉPILEPSIE. MAINTENANT REMBOURSÉ PAR LES FORMULAIR


Vincent Van Gogh


Alexandre le Gra


Lord Byron


Charles Dicken

NAGUÈRE ENCORE, LA RÉUSSITE EXIGEAIT D'UN ÉPILEPTIQ
HEUREUSEMENT POUR VOS PATIENTS, IL EXIS

Extrait de référence N° 1. Étude en double aveugle avec placebo contre TOPAMAX (J.J.G. comme traitement d'appoint, portant sur 381 patients atteints d'épilepsie partielle réfractaire et recevant une ou deux autres médications antiépileptiques. * p = 0,01 %

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]

JANSSEN-ORTHO Inc. 19 Green Belt Drive, North York, Ontario M3C 1L9 *Monographie de Janssen-Ortho Inc., 1997

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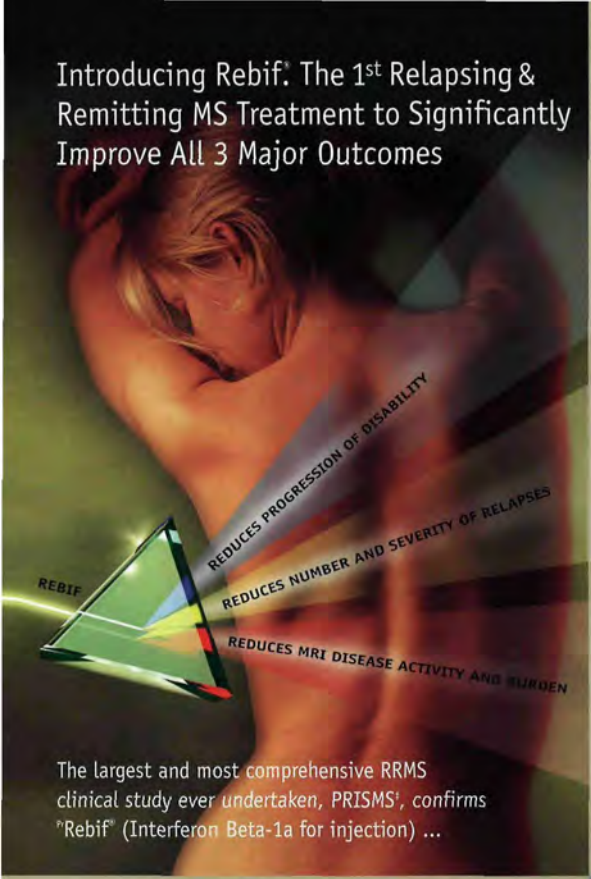
For brief prescribing information see pages A-50, A-51, A-52

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



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.[1]

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.[1]

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.[1]

Flexible dosing for optimal response

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

The largest and most comprehensive RRMS clinical study ever undertaken, PRISMS[1], confirms ®Rebif® (Interferon Beta-1a for 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.

[1]Evidence of efficacy is derived from 2-year trials only.

Serono For more information contact our website at http://www.rms-interferon.com

Rebif® Interferon beta-1a

RE/SIF®

MULTIPLE EFFICACY. MULTIPLE SUPPORT.

For brief prescribing information see pages A-31, A-32