The Canadian Journal of Neurological Sciences

Le Journal Canadien des Sciences Neurologiques

XXVIIIth Canadian Congress of Neurological Sciences
June 16-19, 1993
Toronto, Ontario

The Official Journal of

The Canadian Neurological Society
The Canadian Neurosurgical Society
The Canadian Society of Clinical Neurophysiologists
The Canadian Association for Child Neurology

Volume 19, No. 3 August 1992

To a parkinsonian patient, a little help means a lot.

Adding Parlodel to levodopa can improve symptom control. Because you want to help your patient get more out of life's little pleasures.

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PARLODEL®
(bromocriptine mesylate)

Because quality of life is the issue.

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VOLUME 19, NO. 3, AUGUST, 1992

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IMPORTANT NEWS ABOUT THE USE OF ELDEPRYL.

Deprenyl Research and Purdue Frederick are pleased to announce that Eldepryl (selegiline hydrochloride) is now indicated for first line therapy in newly diagnosed patients with Parkinson's disease.

As you may know, Eldepryl first line has been shown to delay disability thereby prolonging functional life in early, untreated patients. In fact, Eldepryl can delay the onset of functional disability and the need for levodopa therapy by as much as one year.[1,2]

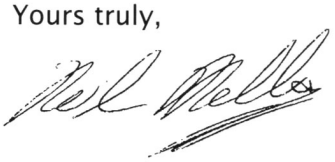
As well, there is increasing evidence that Eldepryl may have a neuroprotective effect.*

Eldepryl also appears to have a remarkable safety profile. It has been generally well tolerated with few side effects.[3,4,5]

For all these reasons, it makes sense to start Eldepryl upon diagnosis and to continue therapy even if there is no obvious symptomatic improvement.

So for your parkinsonian patients, prescribe Eldepryl first line. It's their first line of defence against the progression of disability.

Yours truly,



Neil Mellor
Product Manager

For your supply of new Patient Information Pads, please contact:
Deprenyl Research Limited, Toronto, Ontario M6R 2M7.
Telephone (416) 537-4372 Fax (416) 537-4087.

ELDEPRYL® FIRST LINE
selegiline hydrochloride

* Animal research findings suggest that selegiline may have a neuroprotective effect. It is not clear, however, how this relates to human parkinsonism and its treatment. **1** The Parkinson Study Group. Effect of Deprenyl on the Progression of Disability in Early Parkinson's Disease. New Eng Journ 321, November 1989, 1364-1371. **2** Tetrud JW, Langston JW. The Effect of Deprenyl (Selegiline) on the Natural History of Parkinson's Disease. Science, August 1989, vol. 245, 519-522. **3** Langston JW in Lees A. Deprenyl in Parkinson's Disease: Guidelines for Clinicians. North American Round Table Series, No. 1, 1988, 9-10. **4** DuVoisin RC in Lees A. Deprenyl in Parkinson's Disease: Guidelines for Clinicians. North American Round Table Series, No. 1, 1988, 10. **5** The Parkinson Study Group. Effect of Deprenyl on the Progression of Disability in Early Parkinson's Disease. New Eng Journ 321, November 1989, 1368.

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Getting more reliable data for more confident evoked potential and electrophysiologic analyses is easy. All you need is the new Nicolet Spirit.™

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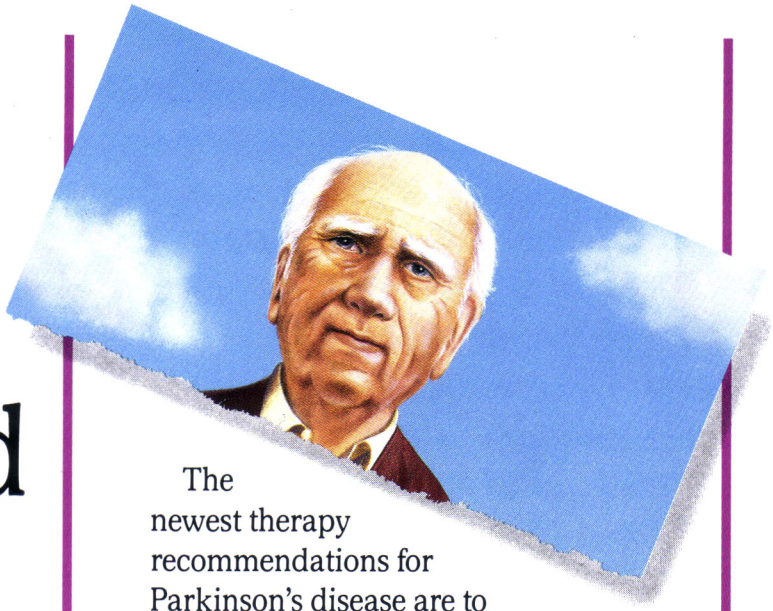
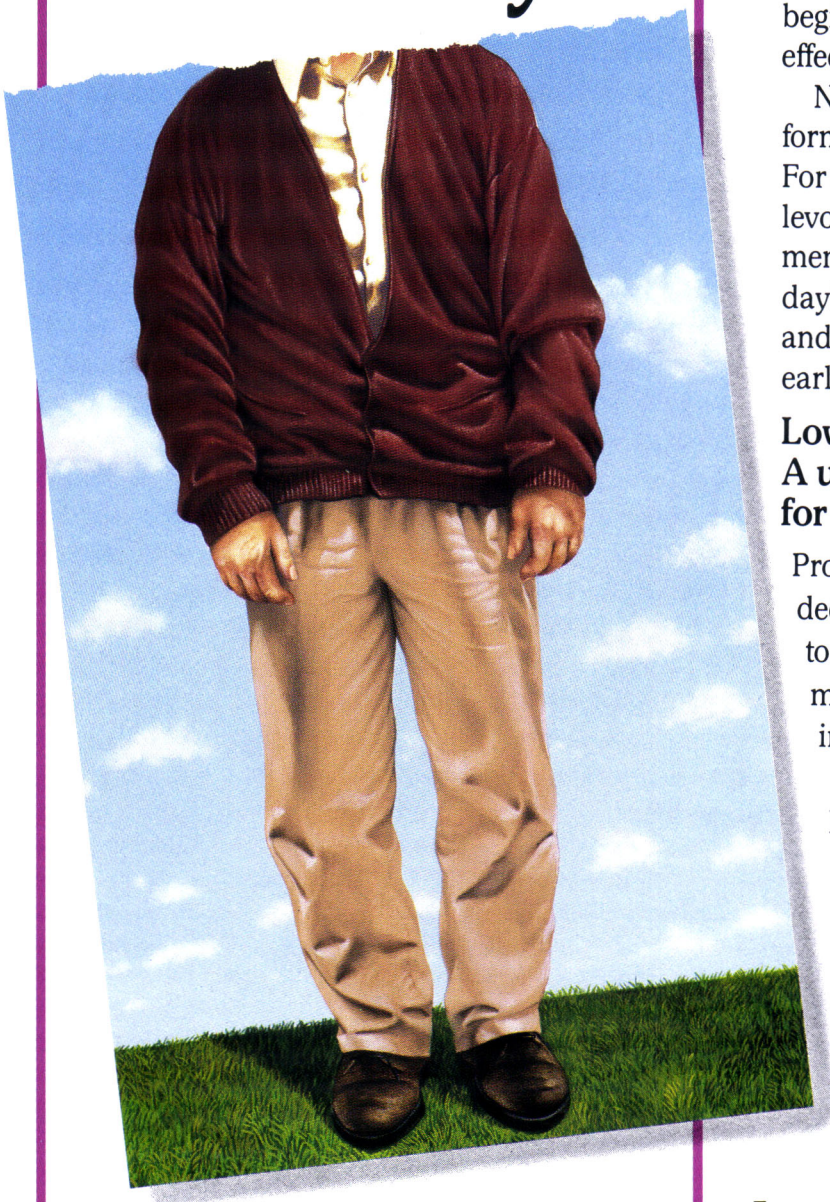
Low-dose Prolopa. Benefits for the brain and the body.





The newest therapy recommendations for Parkinson's disease are to begin levodopa therapy at the lowest effective dose.

Not all levodopa combinations are formulated to be used at low doses.* For example, the manufacturer of 100 levodopa/25 carbidopa (MSD) recommends the equivalent of 3 tablets per day[1] to reduce the incidence of nausea and vomiting so often associated with early levodopa therapy.[1]

Low-dose Prolopa (50/12.5). A unique levodopa formulation for few G.I. side effects.

Prolopa uses a different peripheral decarboxylase inhibitor.[1] It allows you to start therapy with the lowest recommended levodopa dosage and a low incidence of nausea and vomiting.[2]

Consider initiating with Prolopa. For early Parkinson's control with a lower dose.

PROLOPA® 50/12.5
(levodopa 50 mg / benserazide 12.5 mg)

Levodopa that starts lower.

*Less than 300 mg of levodopa per day

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Certains antiépileptiques peuvent réprimer plus que les crises.

Il arrive malheureusement que certains antiépileptiques tels la phénytoïne affaiblissent la fonction cognitive.[1,2,3,4]

D'autre part, Tegretol® CR (carbamazépine à libération contrôlée) a peu d'impact sur la fonction cognitive tout en procurant un excellent contrôle des crises.[1,2,3,4]

Tegretol CR réalise des taux sanguins plus uniformes que le Tegretol conventionnel, ce qui a pour effet de réduire la fréquence des effets secondaires intermittents et de produire un modèle de fonction cognitive plus stable.[1,4]

Lorsque vous amorcez un traitement ou qu'il est médicalement nécessaire de le changer, pensez au Tegretol CR. Il est présenté en comprimés à 200 mg et 400 mg facilement divisibles pour une plus grande souplesse d'administration. Sa posologie à deux prises par jour seulement favorise l'observance du patient.

Tegretol CR - Parce qu'un antiépileptique ne doit pas affaiblir la capacité d'acquisition.

TEGRETOL® CR.

Aide les épileptiques à réaliser leur plein potentiel.

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L5N 2W5

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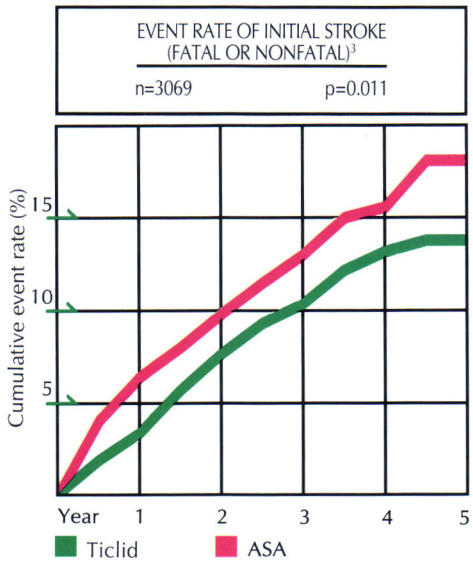
The first agent proven more effective than ASA in preventing initial stroke.

Ticlid (ticlopidine HCl) is a unique antiplatelet therapy that inhibits ADP-induced platelet-fibrinogen binding. Unlike ASA, Ticlid does not inhibit prostacyclin, thromboxane or prostaglandins.[1]

In the Ticlopidine Aspirin Stroke Study (TASS) involving 3,069 TIA and minor stroke patients, Ticlid was shown to reduce the risk of initial stroke by a considerable margin compared with ASA.[2]



TICLID REDUCED THE RISK 47.6% RELATIVE TO ASA IN THE FIRST YEAR (p=0.0004)[3]

"The benefit of ticlopidine was apparent early in the first year and persisted for the entire five years of follow-up."

Ticlopidine Aspirin Stroke Study (TASS)
New England Journal of Medicine 1989

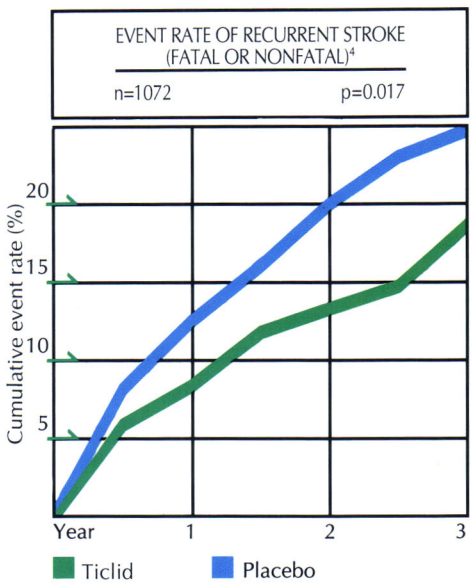
Proven effective in preventing recurrent stroke.

In the placebo-controlled Canadian American Ticlopidine Study (CATS), 1,072 patients who had experienced a recent thromboembolic stroke were treated and observed for up to 3 years.

Over the course of the study, Ticlid was shown to reduce the risk of non-cardiogenic stroke by 34%.[4]

"...the efficacy of ticlopidine was consistent and significant for both men and women."

Canadian American Ticlopidine Study (CATS)
The Lancet 1989



TICLID REDUCED THE RISK 34% RELATIVE TO PLACEBO OVER 3 YEARS[4]

Proven safety profile

The most common side effects were generally mild, transient and occurred early in therapy.[1] Often they were resolved by a temporary dose reduction.[2]

In clinical trials, there was a reported 2.4% incidence of neutropenia (0.8% severe). Upon immediate discontinuation of therapy, the neutrophil count returned to normal within 1 - 3 weeks.[1]

To manage the risk of neutropenia, regular WBC monitoring is required every 2 weeks for the first 3 months of therapy.[1]

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ark studies
r efficacy of Ticlid in
risk of stroke.

TICLID IS INDICATED FOR PATIENTS WHO HAVE EXPERIENCED ANY OF THE FOLLOWING EVENTS:[1]

- Transient Ischemic Attack (TIA)
- Transient Monocular Blindness (TMB)
- Reversible Ischemic Neurological Deficit (RIND)
- Minor stroke (minimal deficit, >80% recovery)
- Complete thromboembolic stroke

Blood monitoring is required every 2 weeks for the first 3 months of Ticlid therapy.

Dosage: 250 mg BID with meals

For information on this unique stroke prevention therapy, call the Ticlid Information Hotline 1-800-263-8918.

SYNTEX®

"...the benefits of ticlopidine clearly outweigh the associated risks."

Canadian American Ticlopidine Study (CATS)
The Lancet 1989

Ticlid®

The risk of stroke has never been lower.

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