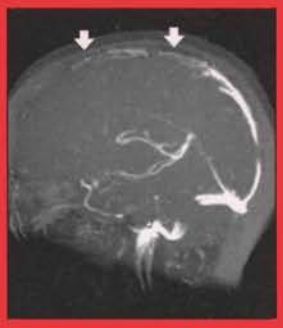
Volume 28 Number 4 November 2001

THE CANADIAN JOURNAL OF
Neurological Sciences
LE JOURNAL CANADIEN DES
Sciences Neurologiques

AN INTERNATIONAL JOURNAL / UN JOURNAL INTERNATIONAL

Amyotrophic Lateral Sclerosis



Neuroimaging Highlight

The official Journal of: The Canadian Neurological Society, The Canadian Neurosurgical Society, The Canadian Society of Clinical Neurophysiologists, The Canadian Association of Child Neurology

Nouveaux critères de la RAMQ†

Rebif®. Efficacité dépendante de la dose dans la SEP rémittente[1]*.

Pas encore

Pr Rebif®

Interféron bêta-1a

prêt à l'emploi

préremplie

Les effets secondaires les plus fréquemment observés sont les réactions au point d'injection et les symptômes pseudo-grippaux (asthénie, pyrexie, frissons, arthralgie, myalgie et céphalées). Leur fréquence et leur intensité tend à diminuer avec la poursuite du traitement. Veuillez consulter la monographie du produit pour les renseignements posologiques complets. Les données portant sur l'innocuité et l'efficacité proviennent d'observations sur 2 ans seulement.

* Rebif® est indiqué pour le traitement de la sclérose en plaques rémittente chez des patients dont la cote EDSS se situe entre 0 et 5,0, afin de réduire le nombre et la gravité des poussées cliniques, de ralentir la progression de l'invalidité physique, et de réduire les besoins de corticothérapie et le nombre de séjours à l'hôpital pour le traitement de la sclérose en plaques.

†Consultez votre représentant Serono pour plus de détails ou appelez au 1-877-777-3243.

RÉFÉRENCE :

[1] Groupe d'étude PRISMS (Prevention of Relapses and Disability by Interferon ß-1a Subcutaneously in Multiple Sclerosis), 1998. Randomised double-blind placebo-controlled study of Interferon ß-1a in relapsing/remitting multiple sclerosis. *Lancet*, 352:1498-1504

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Pour documentation voir pages A-26, A-27

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LE JOURNAL CANADIEN DES Sciences Neurologiques

The official journal of: / La Revue officielle de:

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La Société Canadienne de Neurologie

The Canadian Neurosurgical Society
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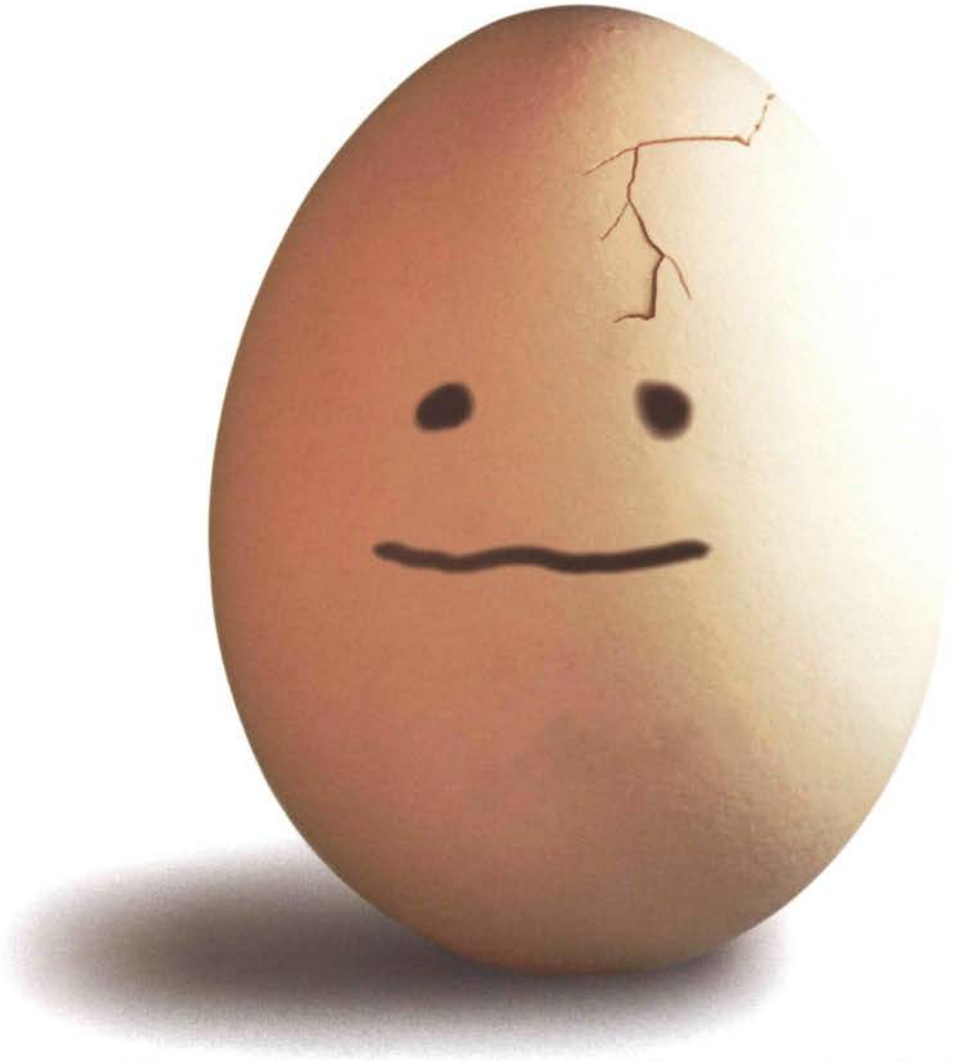
Are you using ASA for the prevention of a second stroke?



"Every patient who has experienced an atherothrombotic … stroke or TIA and has no contraindication should receive an antiplatelet agent regularly …"

- Fifth ACCP Consensus Conference on Antithrombotic Therapy[1]

Reassess your options...

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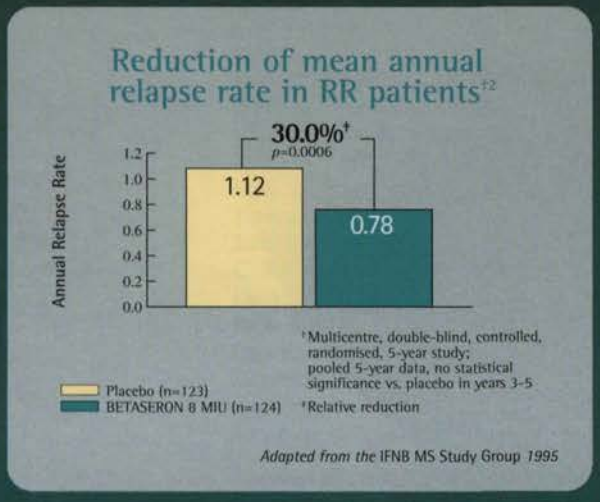
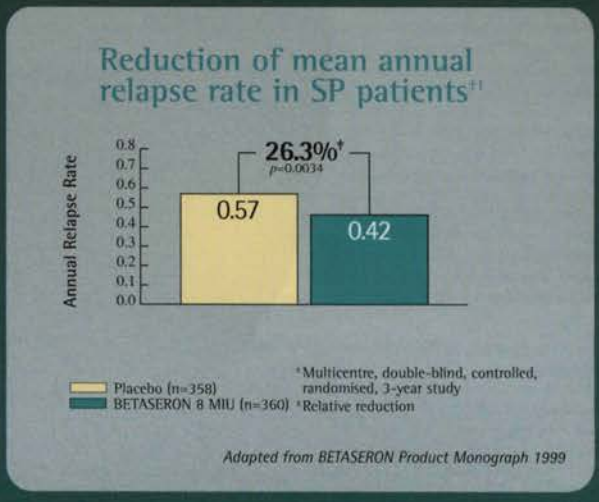
For brief prescribing information see pages A-30, A-31

BETASERON delays disability progression*[1]

BETASERON reduces relapse rate in both relapsing-remitting[2] and secondary progressive MS[1]





BETASERON has a manageable side-effect profile[1]

The most common side effects related to BETASERON in patients with SPMS are: flu-like syndrome (61%); fever (40%); chills (23%); injection-site inflammation (48%); injection-site reactions (46%); myalgia (23%); hypertonia (41%); rash (20%)[1]

Flu-like symptoms and injection-site reactions are manageable and lessen markedly with time[1]

*BETASERON has been demonstrated to delay the progression of disability in secondary progressive MS patients.[1] The safety and efficacy of BETASERON in primary progressive MS have not been evaluated. Efficacy of treatment for longer than 2 years has not been substantially demonstrated in relapsing-remitting MS. For secondary progressive MS, safety and efficacy data beyond 3 years are not available.

FOR COMPLETE WARNINGS AND PRECAUTIONS, PLEASE REFER TO THE PRODUCT MONOGRAPH. PRODUCT MONOGRAPH AVAILABLE TO HEALTH CARE PROFESSIONALS UPON REQUEST.

Member R&D PAAB

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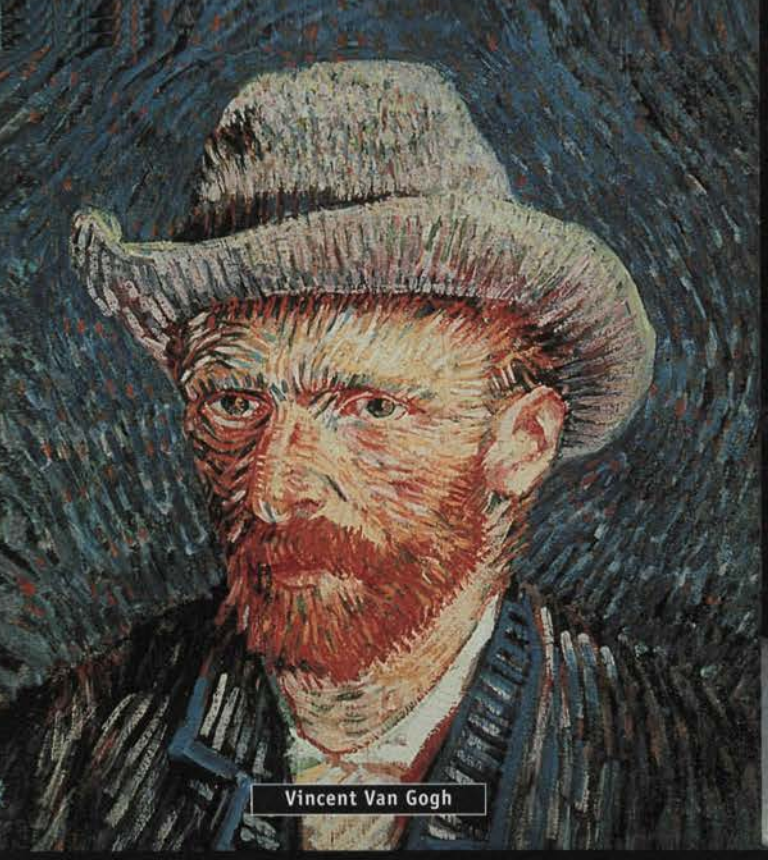
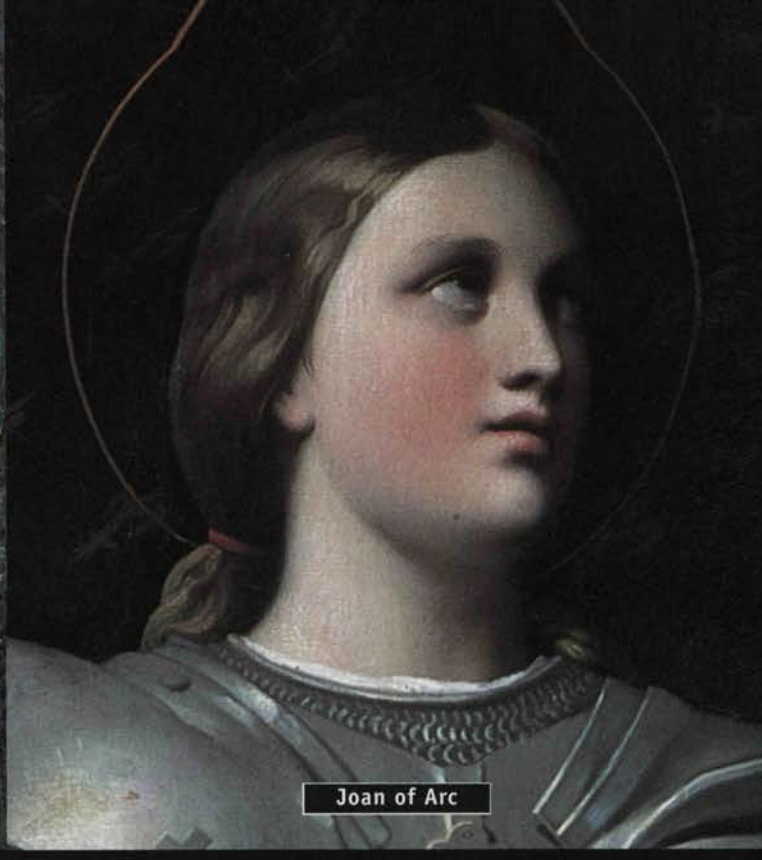
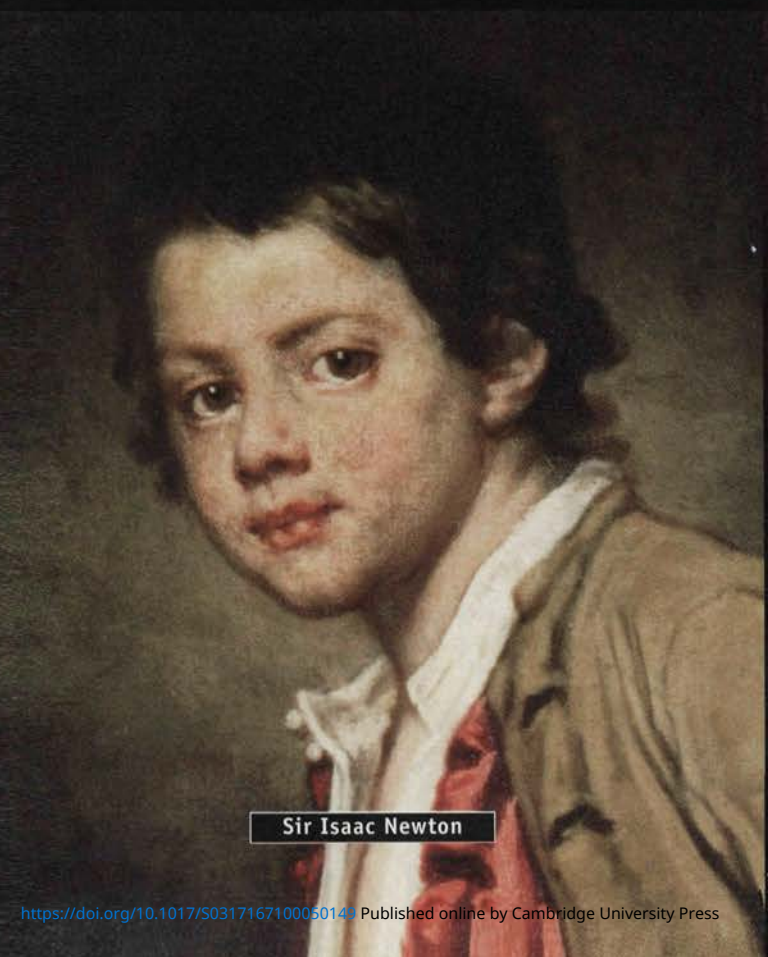
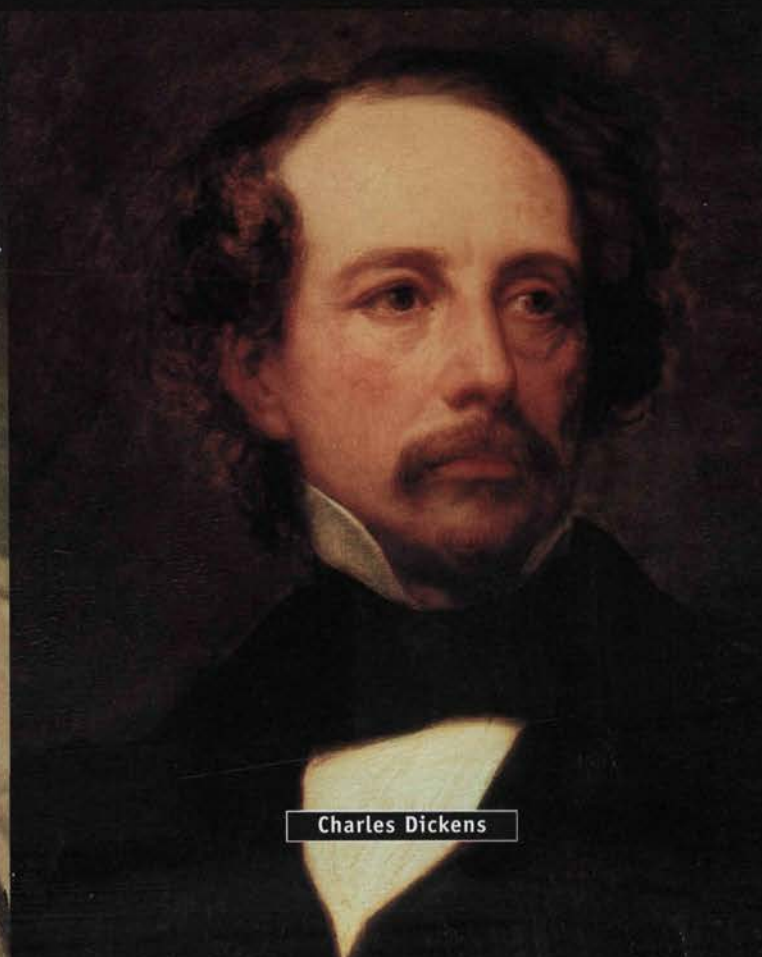
For brief prescribing information see pages A-34, A-35, A-36





YESTERDAY, PEOPLE WITH EPILEPSY HAD TO BE EXTRAORDINARY TO SUCCEED.





EFFICACY ACROSS A BROAD RANGE OF SEIZURES.

- TOPAMAX demonstrates efficacy in Partial Onset, Primary Generalized Tonic-Clonic, and Lennox-Gastaut Seizures[1]
- Desirable seizure-free results were shown in both Adults (19%)† and Children (22%)‡ with Partial Onset Seizures[2,3]

NO EVIDENCE OF LIFE-THREATENING SIDE EFFECTS.

- Like most antiepileptics, the most common side effects are CNS related, usually mild to moderate and transient§[1]

ADULT PATIENTS MAY EXPERIENCE WEIGHT LOSS.

- 73% of patients (n=52) showed a mean weight decrease of 5.97 lb (Interim analysis. Average duration 60 days)[4]
- 96% of children in clinical trials (≥ one year) who lost weight showed resumption of weight gain in test period**[1]

TODAY, THERE'S TOPAMAX.

B.I.D. DOSING WITH THE PATIENT IN MIND.

- TOPAMAX is initiated and titrated to clinical response regardless of existing anticonvulsant therapy
- Tablets available on formulary††

NOW AVAILABLE IN SPRINKLE CAPSULES

TOPAMAX* topiramate

NOW INDICATED FOR CHILDREN

HELPING PATIENTS MAKE MORE OF THEIR LIVES.

**TOPAMAX* topiramate Tablets and Sprinkle Capsules: indicated as adjunctive therapy for the management of patients (adults and children two years and older) with epilepsy who are not satisfactorily controlled with conventional therapy. There is limited information on the use of topiramate in monotherapy at this time.*

† Open label, 20 week trial (n=450 Adults). Optimal dosing was 300-350 mg/day(Average 288 mg/day).
‡ Open label trial for children (n=72) treated for ≥ 3 months. Average dose of 10 mg/kg/day.
§ CNS adverse events: Somnolence (30.1%), dizziness (28.3%), ataxia (21.2%), speech disorders (16.8%), psychomotor slowing (16.8%), nystagmus (15.0%), paresthesia (15.0%), nervousness (15.9%), difficulty with concentration/attention (8.0%), confusion (9.7%), depression (8.0%), anorexia (5.3%), language problems (6.2%) and mood problems (3.5%). In an audit of 1446 adults and 303 children, there appeared to be a similar pattern of adverse events.
** The long-term effects of weight loss in pediatric patients are not known.
†† Limited use benefit: Ontario, Nova Scotia, New Brunswick, PEI. Full benefit: Quebec, Saskatchewan, British Columbia, Alberta, Manitoba.
Please refer to the TOPAMAX Prescribing Information for complete prescribing details.

REFERENCES: 1. TOPAMAX* topiramate Tablets and Sprinkle Capsules Product Monograph, May 11, 1999. 2. Kamin M, Kraut L, Olson W. Dose optimization of topiramate as add-on therapy in adults with treatment-resistant partial-onset seizures *Neurology* 1999;52 (Suppl 2):A525-526. 3. Glauser TA, Elterman R, Wyllie E et al. Open label topiramate in paediatric partial epilepsy *Epilepsia* 1997:38 (Suppl 3):94. 4. Rosenfeld WE et al.Topiramate and concomitant weight loss. *Epilepsia* 1997:38 (Suppl 8):98.

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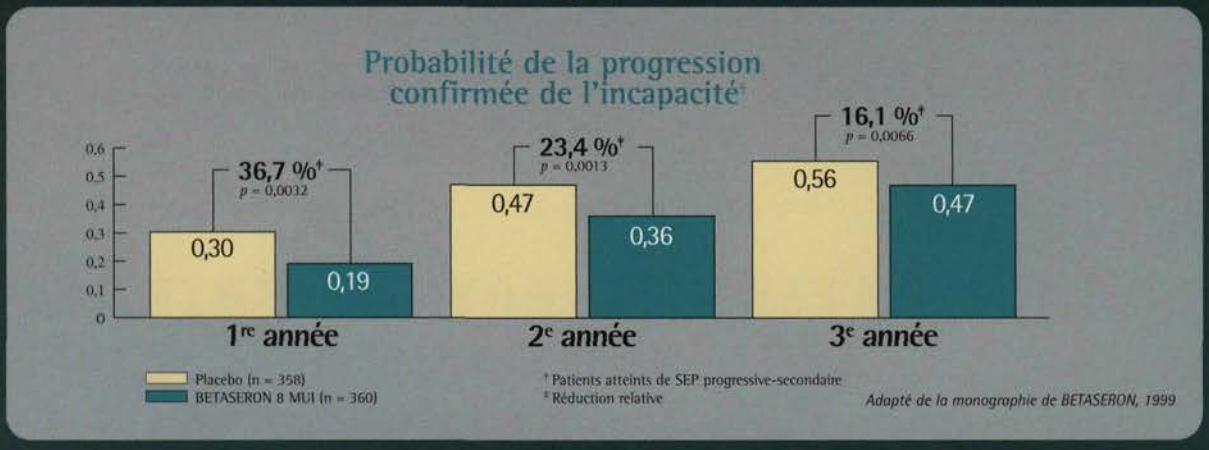
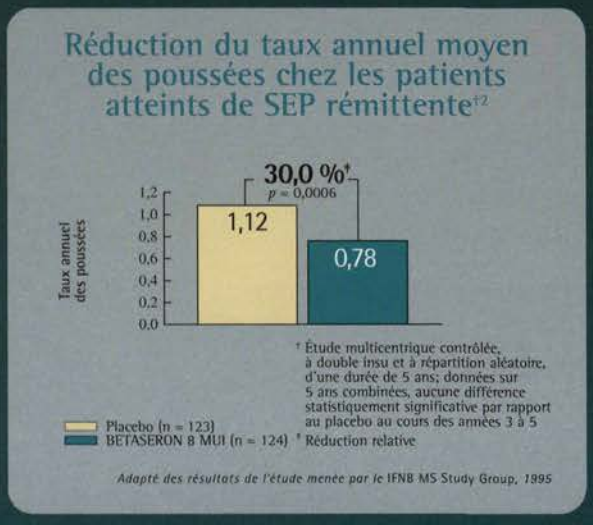
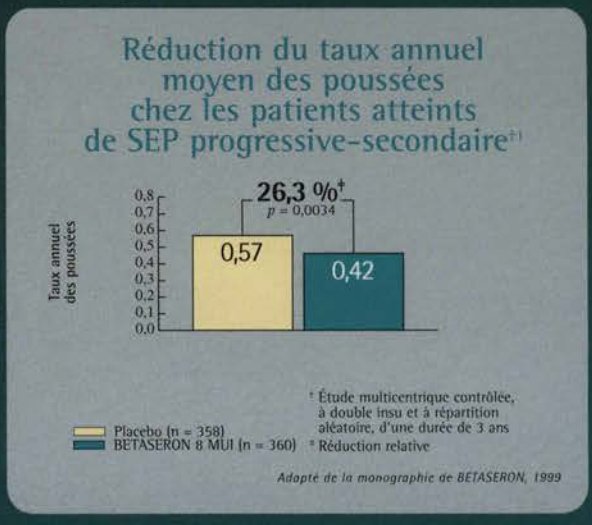
For brief prescribing information see pages A-32, A-33

BETASERON retarde la progression de l'incapacité*[1]



BETASERON réduit le taux de poussées dans la SEP rémittente[2] et dans la SEP progressive-secondaire[1]





Effets indésirables pouvant être pris en charge[1]

Chez les patients atteints de SEP progressive-secondaire, les effets indésirables les plus fréquents de BETASERON sont : syndrome pseudo-grippal (61 %), fièvre (40 %), frissons (23 %), inflammation au point d'injection (48 %), réactions au point d'injection (46 %), myalgie (23 %), hypertonie (41 %) et éruption cutanée (20 %)[1].

Les symptômes pseudo-grippaux et les réactions au point d'injection peuvent être pris en charge et diminuent de façon marquée avec le temps[1].

*Il a été démontré que BETASERON retarde la progression de l'incapacité chez les patients atteints de SEP progressive-secondaire[1].
L'efficacité et l'innocuité de BETASERON dans la SEP progressive-primaire n'ont pas été évaluées.
On ne dispose pas de données probantes sur l'efficacité du traitement dans la SEP rémittente au-delà de deux ans, ni de données sur l'efficacité et l'innocuité du traitement dans la SEP progressive-secondaire au-delà de trois ans.

VEUILLEZ CONSULTER LA MONOGRAPHIE DE PRODUIT POUR OBTENIR LA LISTE COMPLÈTE DES MISES EN GARDE ET DES PRÉCAUTIONS.
MONOGRAPHIE DE PRODUIT OFFERTE SUR DEMANDE AUX PROFESSIONNELS DE LA SANTÉ.

Membre R&D CCPP

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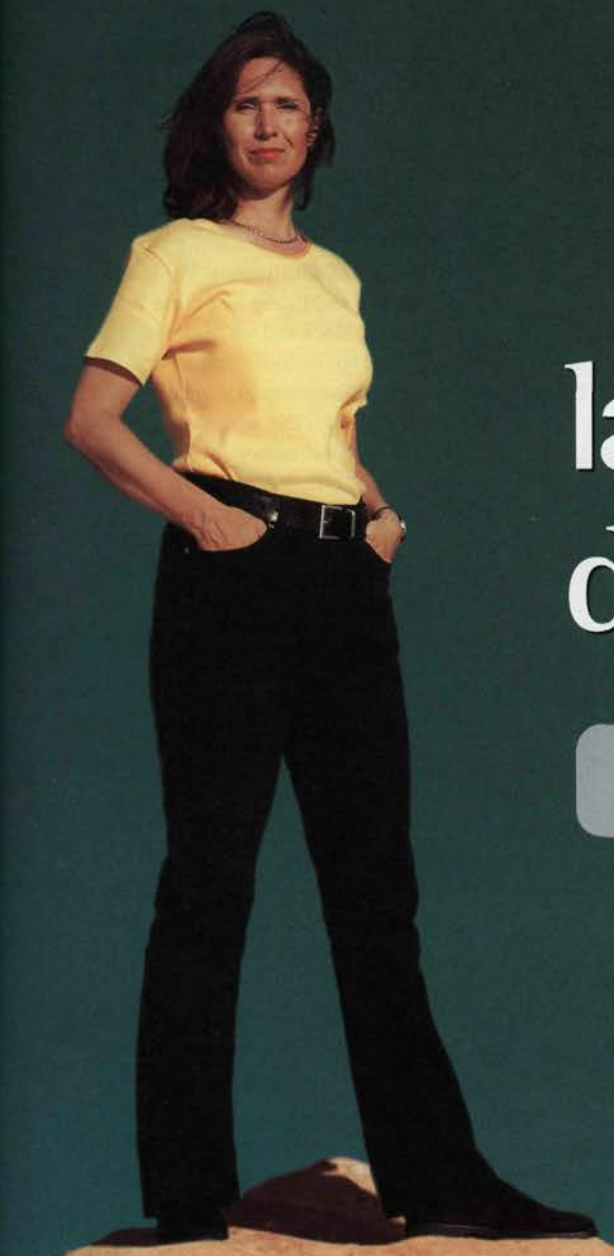

Retarde la progression de l'incapacité*

Indiqué dans la SEP rémittente et la SEP progressive-secondaire

Dans la SEP rémittente et la SEP progressive-secondaire

Pr BETASERON®

INTERFÉRON BÊTA-1b

Dès le tout début

SCLÉROSE EN PLAQUES
ACCÈS
POUR LE CANADA

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Pour documentation voir pages A-34, A-35, A-36

INFORMATION FOR AUTHORS

The Canadian Journal of Neurological Sciences publishes original articles in neurology, neurosurgery and basic neurosciences. Manuscripts are considered for publication with the understanding that they, or the essence of their content, have not been published elsewhere except in abstract form and are not under simultaneous consideration by another journal. Articles undergo peer review. Manuscripts should be submitted to: Douglas Zochodne, M.D., Editor. Canadian Journal of Neurological Sciences, P.O. Box 5456, Station A, Calgary, AB, Canada T2H 1X8

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• ***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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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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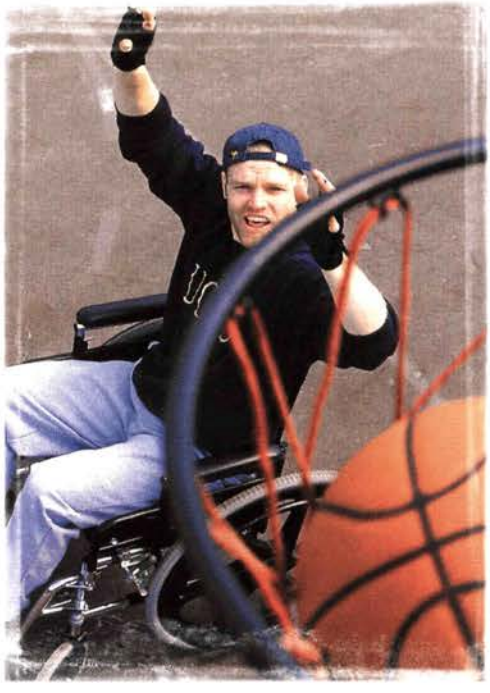
Introducing Pr Zanaflex®
A new option in the treatment of spasticity

Start from a position of strength



Zanaflex is effective first-line therapy for patients with spasticity associated with disorders and conditions such as *Multiple Sclerosis, stroke, cerebral palsy, spinal cord injury and traumatic brain injury.*[1,2,3] The **dual mechanism of action**, targeting both the locus ceruleus and polysynaptic pathways, reduces hyperactivity of spinal motor neurons.[2,4]

Reduces muscle tone. Preserves muscle strength.[1]

DRAXIS

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PAAB

In multiple-dose, placebo-controlled studies, the most frequently reported adverse events included dry mouth (49%), sedation/somnolence (48%), asthenia (weakness, fatigue and/or tiredness) (41%) and dizziness (16%).[4] The most common adverse events leading to discontinuation of therapy were asthenia (3%), somnolence (3%) and dry mouth (3%).[5]
Sedation may be additive when Zanaflex is taken in conjunction with drugs or substances that act as CNS depressants. Caution is advised when treatment is used in patients who have a history of orthostatic hypotension or are receiving concurrent antihypertensive therapy. Monitoring of aminotransferase levels is recommended during the first six months of treatment, and periodically thereafter, based on clinical status.

For more information, call 1-800-563-7546.

Pr Zanaflex® (tizanidine hydrochloride)

Relief. Strength. Flexibility.

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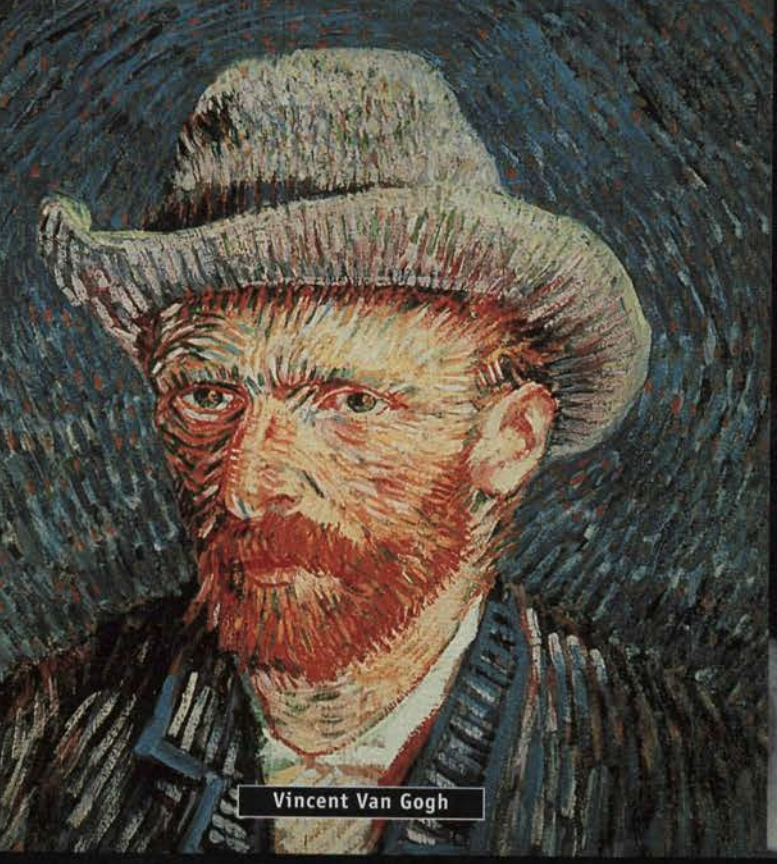
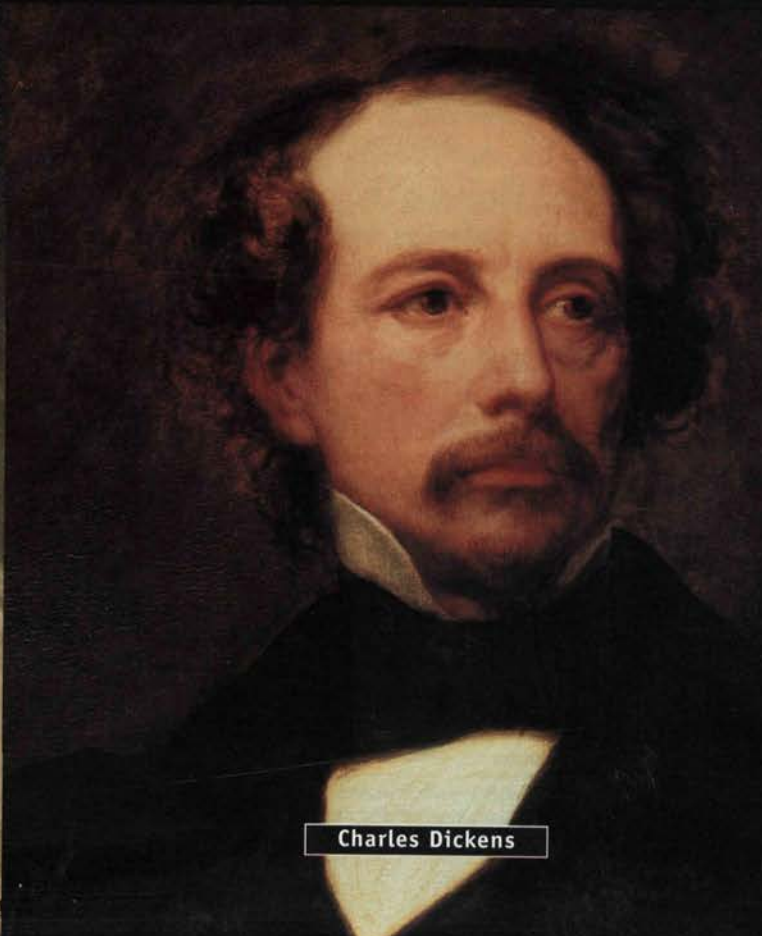


AUPARAVANT, LES PERSONNES ÉPILEPTIQUES DEVAIENT SE MONTRER EXCEPTIONNELLES POUR RÉUSSIR.



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EFFICACE CONTRE UN GRAND NOMBRE DE TYPES DE CRISES.

- TOPAMAX est efficace contre les crises partielles initiales, les crises tonico-cloniques primaires généralisées et les crises associées au syndrome de Lennox-Gastaut[1]
- Des résultats souhaitables avec absence totale de crises chez 19 % des adultes† et 22 % des enfants‡ atteints de crises partielles initiales[2,3]

AUCUN SIGNE D'EFFETS SECONDAIRES CAPABLES DE MENACER LE PRONOSTIC VITAL.

- Comme pour la plupart des antiépileptiques, les effets secondaires le plus fréquemment signalés relèvent du SNC et sont généralement légers à modérés et de nature passagère§[1]

IL EST POSSIBLE QUE LES PATIENTS ADULTES SUBISSENT UNE PERTE DE POIDS.

- 73 % (n = 52) des patients ont subi une perte de poids de 5,97 lb en moyenne (Analyse provisoire. Durée moyenne de 60 jours)[4]
- 96 % des enfants traités dans le cadre des essais cliniques pendant au moins un an et ayant subi une perte de poids ont repris du poids au cours de la période d'exécution des essais**[1]

AUJOURD'HUI, IL Y A TOPAMAX.

UNE POSOLOGIE BIQUOTIDIENNE POUR TENIR COMPTE DU PATIENT.

- Le traitement par TOPAMAX peut être commencé et ajusté selon la réponse clinique quel que soit le traitement anticonvulsivant en cours
- Les comprimés sont inscrits au formulaire††

MAINTENANT OFFERT EN CAPSULES À SAUPOUDRER

TOPAMAX* topiramate

MAINTENANT INDIQUÉ CHEZ L'ENFANT

POUR AIDER LES PATIENTS À MIEUX PROFITER DE LA VIE

Comprimés et capsules à saupoudrer TOPAMAX (topiramate) : indiqués comme traitement adjuvant chez les patients (adultes et enfants âgés de deux ans ou plus) atteints d'épilepsie dont l'état n'est pas maîtrisé de façon satisfaisante avec le traitement traditionnel. Les renseignements sur l'emploi du topiramate en monothérapie sont encore limités[1].*

†Une étude ouverte d'une durée de 20 semaines (n = 450 adultes). Posologie optimale : 300 à 350 mg/jour (moyenne : 288 mg/jour).
‡Étude ouverte portant sur des enfants (n = 72) traités pendant au moins 3 mois. Posologie moyenne : 10 mg/kg/jour.
§Manifestations indésirables liées au SNC : Somnolence (30,1 %), étourdissements (28,3 %), ataxie (21,2 %), troubles de la parole (16,8 %), ralentissement psychomoteur (16,8 %), nystagmus (15 %), paresthésie (15 %), nervosité (15,9 %), difficulté à se concentrer/troubles de l'attention (8 %), confusion (9,7 %), dépression (8 %), anorexie (5,3 %), problèmes de langage (6,2 %) et troubles de l'humeur (3,5 %). Une évaluation de 1 446 adultes et 303 enfants a indiqué que ces deux groupes semblent présenter des profils de manifestations indésirables similaires.
**Les effets à long terme d'une perte de poids chez les enfants ne sont pas connus.
††Médicament à usage limité : Ontario, Nouvelle-Écosse, Nouveau-Brunswick, Î.-P.-É. Remboursement intégral : Québec, Saskatchewan, Colombie-Britannique, Alberta, Manitoba.
Veuillez vous reporter aux Renseignements thérapeutiques sur TOPAMAX pour les détails thérapeutiques complets.

RÉFÉRENCES : **1.** Monographie des comprimés et capsules à saupoudrer TOPAMAX* (topiramate), 11 mai 1999. **2.** Kamin M, Kraut L, Olson W. Dose optimization of topiramate as add-on therapy in adults with treatment-resistant partial-onset seizures *Neurology* 1999;52 (Suppl 2):A525-526. **3.** Glauser TA, Elterman R, Wyllie E *et al.* Open label topiramate in paediatric partial epilepsy *Epilepsia* 1997:38 (Suppl. 3):94. **4.** Rosenfeld WE *et al.* Topiramate and concomitant weight loss. *Epilepsia* 1997:38 (Suppl 8):98.

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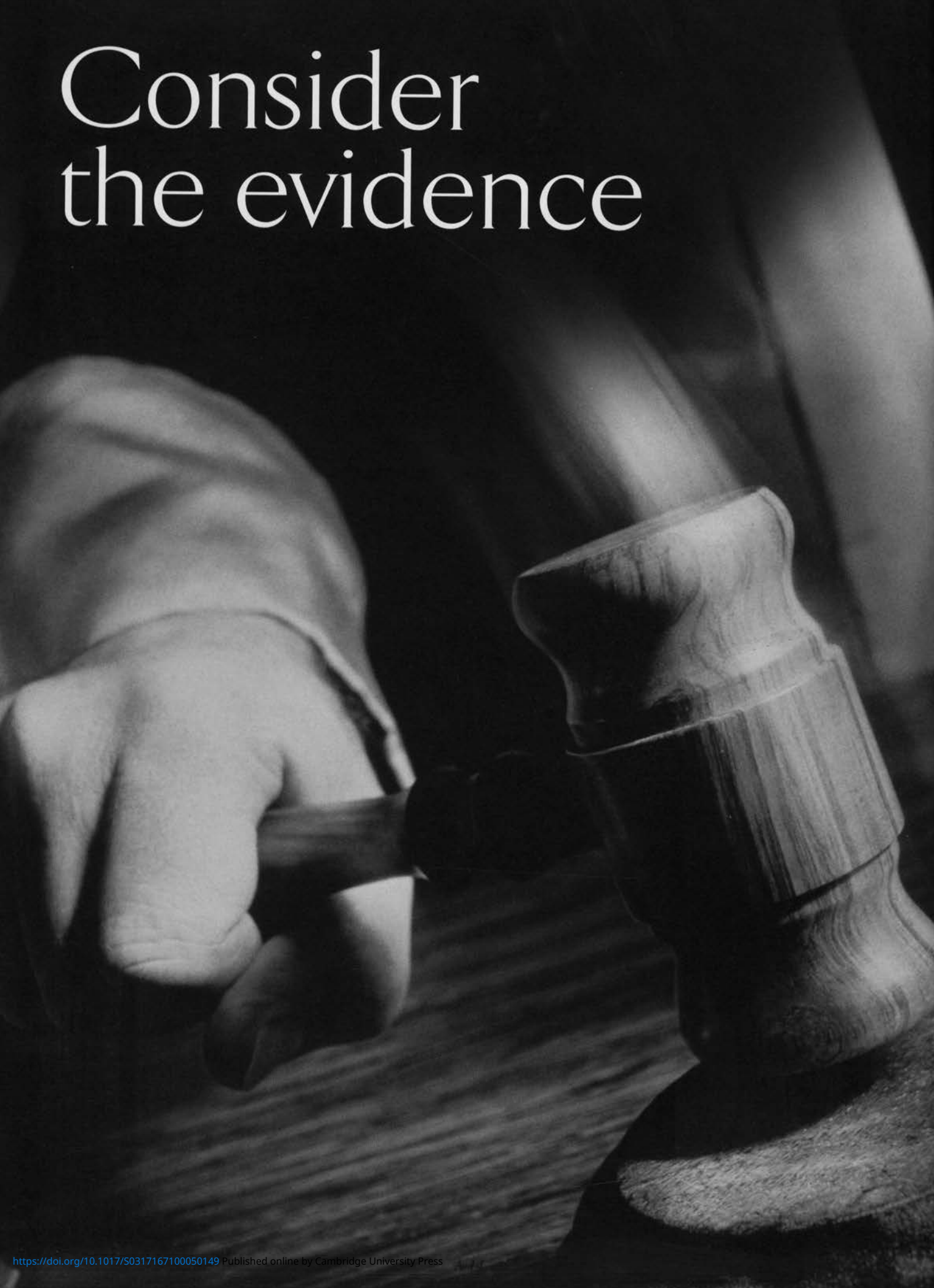
https://doi.org/10.1017/S0317167100050149 Published online by Cambridge University Press

Pour documentation voir pages A-32, A-33

Consider the evidence



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AVONEX® is proven effective in Relapsing Remitting MS

- 37% reduction in the probability of disability progression over two years (21.9% vs. 34.9%; p=0.02)¶[1,2]
- 32% reduction in the annual exacerbation rate over two years (0.61 vs. 0.90; p=0.002)*[1,2]
- 38% of patients remained relapse free at two years (p=0.03)@[1,2]
- 55% reduction in brain atrophy progression during the second year of therapy (-0.233 vs. -0.521; p=0.03)#[3]
- 89% reduction in gadolinium-enhanced lesions in patients with enhancement at baseline (0.11 vs. 0.50; p=0.041)†[4]
- AVONEX® is indicated for the treatment of relapsing forms of MS.[1]

AVONEX® is generally well tolerated. The most common side effects associated with treatment are flu-like symptoms (muscle ache [myalgia], fever, chills, and asthenia). Please see product monograph for important patient selection and monitoring information.[1] AVONEX® should be used with caution in patients with depression and in patients with seizure disorders. AVONEX® should not be used by pregnant women. Patients with cardiac disease should be closely monitored. Routine periodic blood chemistry and hematology tests are recommended during treatment with AVONEX®.[1]

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

¶ Kaplan-Meier methodology. AVONEX® n=158, placebo n=143.
* AVONEX® n=85, placebo n=87.
@ n=85.
# As measured by brain parenchymal fraction in the second year of treatment. AVONEX® n=68, placebo n=72.
† AVONEX® n=44, placebo n=44. The exact relationship between MRI findings and clinical status is unknown.

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BIOGEN CANADA

PAAB

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For brief prescribing information see pages A-42, A-43, A-44

In Canada, IVIG is approved for 5 indications.[1,2,3*] Why are Doctors using it for approximately 100?[4]

* Idiopathic thrombocytopenic purpura,[A,B] primary humoral immune deficiency[A,B,C] and secondary immune deficiency,[C] allogeneic bone marrow transplant,[A] pediatric AIDS[A] and B-cell chronic lymphocytic leukemia.[B] A Gamimune™ B Gammagard™ C Iveegam Immuno™

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Bayer Canada is looking for answers.

This is what we found.

In making the decision to use IVIG (Intravenous Immune Globulin) in specific indications, Canadian physicians rely on tools such as the published literature and/or available guidelines. The development of guidelines for the appropriate use of IVIG was sponsored by Bayer, who provided an unrestricted educational grant, including extensive literature review and specialist consultation.[4,5]

A recent survey found that over 80% of IVIG use in Canadian hospitals is in keeping with these consensus guidelines for appropriate use.[6] But 80% is not 100%.

We're still looking.

We spend $8M in Research & Development, which includes IVIG use as a priority, and we are committed to sponsoring Canadian clinical trials to investigate possible new indications.

And because physicians are the key, we also sponsor two Immunology Fellowships (one in co-operation with CIHR) worth $250,000, and we develop and offer CME promoting appropriate use through Canadian hospitals. For more information about the Appropriate Use of IVIG, contact Bayer at gamimune.canada@bayer.com

Appropriate Use.

Bayer

maker of Gamimune®N, 10%
Immune Globulin Intravenous (Human), 10%

Member R&D PAAB

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25 Years Ago in the Canadian Journal of Neurological Sciences

Quebec Cooperative Study of Friedreich's Ataxia
Phase One: A Prospective Survey of 50 Cases

Organized and Edited by André Barbeau

Electroencephalographic Findings in Friedreich's Ataxia

G. Remillard, F. Andermann, L. Blitzer and E. Andermann

SUMMARY: Electroencephalographic tracings of 50 patients who presented the classical features of Friedreich's ataxia were reviewed. Mild nonspecific abnormalities were found in 33% and consisted of:

a) Abnormal slow or irregular background rhythms in 15 patients (30%).
b) Intermittent paroxysmal rhythms, considered to be projected from diencephalic or upper midbrain structures, in four patients (8%).
c) Unilaterally absent driving responses in two affected siblings (4%).

There was no response to intermittent photic stimulation in 60% of the patients. This finding is not considered a definite abnormality, and its significance remains unclear.

Four patients (8%) had epileptic seizures, but of these, only two had interictal epileptic abnormalities.

There was no correlation between the duration and severity of the disease and the presence of electroencephalographic abnormalities.

Friedreich's ataxia is mainly a spinal disorder. Involvement of supraspinal and, in particular, brain stem or diencephalic structures may be more extensive in those patients who show electrographic abnormalities. This would require confirmation with comparative data based on pathological observations.

Impaired function of brain stem inhibitory mechanism may be responsible for the slightly raised incidence of seizures in patients with Friedreich's ataxia and other cerebellar degenerations

Can. J. Neurol. Sci. 1976;4:309

Nerve Conduction Studies and Electromyography in Friedreich's Ataxia

J.M. Peyronnard, L. LaPointe, J.P. Bouchard, A. Lamontagne, B. Lemieux and A. Barbeau

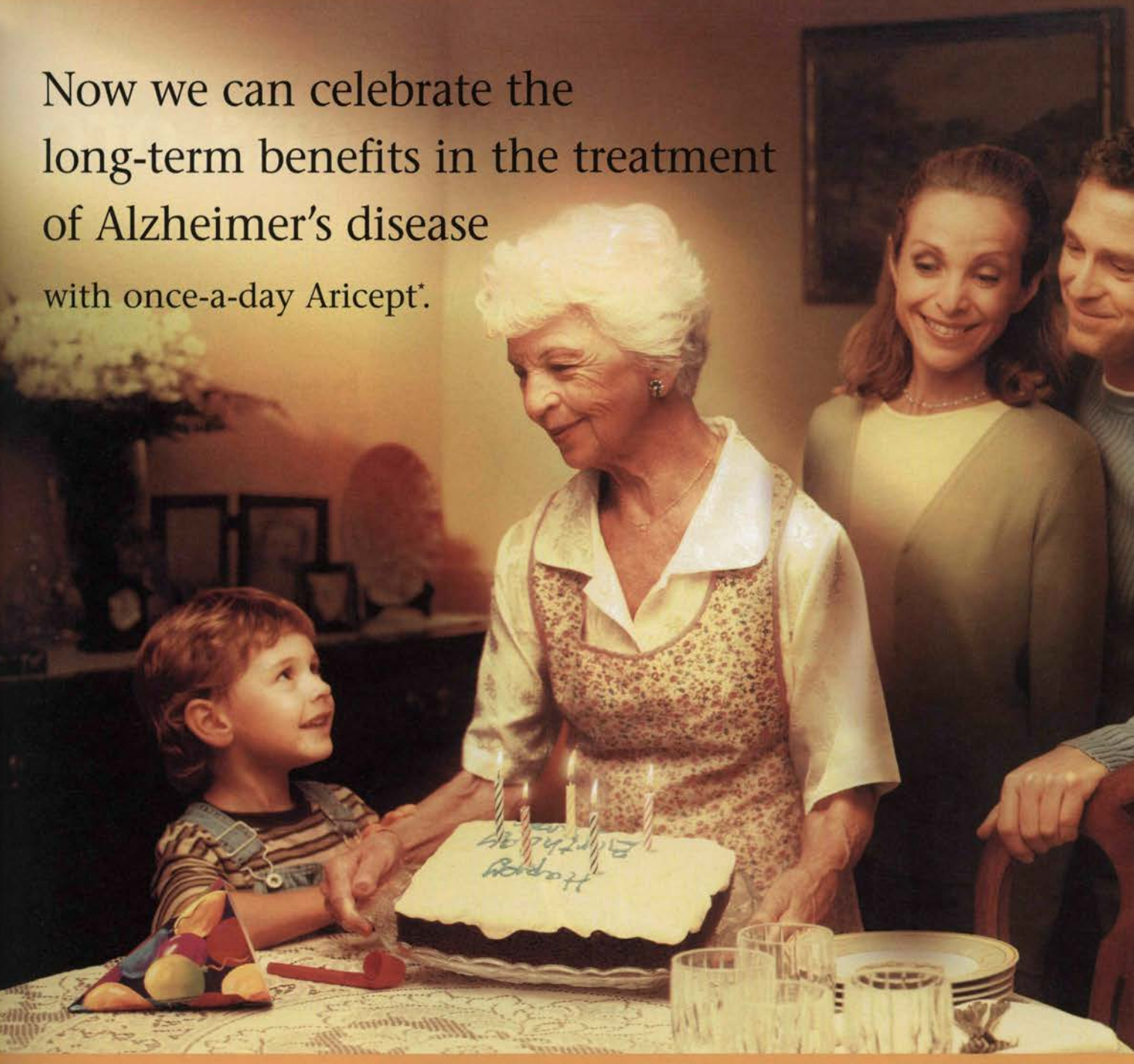
SUMMARY: Twenty-six of 50 patients were investigated with nerve conduction studies and electromyography using a standard protocol and were compared to the findings in 50 normal control subjects. Almost all cases of typical Friedreich's ataxia had absent sensory action potentials (SAP) in the digital (92%) or sural (96%) nerves. The others had markedly decreased SAPs. In these same patients, motor conduction velocities were either normal or only slightly decreased. In the second, atypical group of nine patients, the motor conduction velocities were considerably decreased.

Because of the absence of sensory action potentials in Friedreich's ataxia, and that the absence was noted in our very mild cases, it is proposed that this measure be used to facilitate early diagnosis.

Can. J. Neurol. Sci. 1976;4:313

Now we can celebrate the long-term benefits in the treatment of Alzheimer's disease

with once-a-day Aricept*.



There's cause for celebration—because Aricept* has been shown to result in improvement or stabilization in 80% of Alzheimer's disease patients over 6 months of treatment.[1‡] And long-term data shows that Aricept*-treated patients continued to show treatment benefits up to 3 years on cognition and global functioning compared to data expected from untreated patients.[2§] What's more, Aricept* has demonstrated long-term safety and tolerability profiles.[2†] All of which means there's even more reason to make Aricept* your standard of care.[3]

Now on several provincial formularies.[¶]

Aricept* does not change the underlying course of the disease. Aricept* is indicated for the symptomatic treatment of patients with mild-to-moderate dementia of the Alzheimer's type.

† With appropriate dose escalation 5 mg/day dose, 10 mg/day dose and placebo were shown to have comparable adverse events. Most common adverse clinical events with Aricept*: diarrhea, nausea, insomnia, fatigue, vomiting, muscle cramps and anorexia. These events are usually mild and transient, resolving with continued Aricept* treatment without need for dose modification.

‡ In a 24-week, double-blind, placebo-controlled study, 473 mild-to-moderate AD patients were randomized to receive Aricept* 5 mg/day, 10 mg/day or placebo. The mean difference for Aricept*-treated patients (10 mg/day) vs. placebo was –2.87 ± 0.63 ($p<0.0001$) units in ADAS-cog, 0.47 ± 0.11 ($p<0.0001$) units in CIBIC-plus, and 0.59 ± 0.17 ($p=0.0007$) units in CDR-SB.

§ In a 162-week, multicentre, open-label extension study, 579 patients who had previously completed a randomized, double-blind, placebo-controlled study with Aricept* were treated with Aricept* 5 mg which could be increased to 10 mg between weeks 6 and 24, as per clinician's judgement. At study endpoint, ADAS-cog declined 15.57 points (95% CI,12,19.2) vs. the estimated decline of 6-12 points per year in untreated patients.

¶ In Saskatchewan, Quebec, Alberta, Manitoba and Ontario. Please see individual formularies for special-, exceptional-, and limited-use drug status. For more information on coverage criteria, please call 1-800-510-6141.

Once-a-day

Aricept*

donepezil HCl 5 & 10 mg tablets

Hope for a brighter tomorrow

Product Monograph available upon request.

* TM Eisai Co. Ltd., Tokyo, Japan
Pfizer Canada Inc., licensee

PAAB R&D

Pfizer CNS
Life is our life's work

For brief prescribing information see page A-23

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June 18-22, 2002
Vancouver, Canada

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VANCOUVER

CCNS/CCSN

Tuesday June 18, 2002

Pre-Congress Courses

- Neurobiology Review Course
- ALS Strategies for Quality of Life and Quality of Care
- Movement Disorder Video Session
- Epilepsy Video Session

Wednesday June 19, 2002

Course Day

- Spinal Surgery Course
- Evidence Based Neurology
- CSCN EMG Course
- Update on Radiosurgery
- Introduction of Design and Analysis of Clinical Research
- CSCN EEG Course
- Imaging in Neurocritical Care

Welcome Reception

Thursday June 20, 2002

- Meet the Expert Breakfast: Neurosurgery
- **Plenary Session I: Neurogenetics**
- Platform Sessions
- Grand rounds
- Creutzfeldt-Jacob Disease Course

Wine and cheese Poster viewing

Friday June 21, 2002

- **Plenary Session II: Neuroimaging**
- Platform Sessions
- What's New in Epilepsy?
- Update on Peripheral Nerve Surgery
- Ultrasound in Neurology

Neuroscience Challenge and Social Night

Saturday June 22, 2002

- **Plenary Session III: Neuroinflammation, Good and Bad**
- Child Neurology Day
- Stroke Course: Neurovascular / Endovascular surgery
- MS Course

37th meeting of the

Canadian Congress of Neurological Sciences

Special joint meeting with the Australian Association of Neurologists

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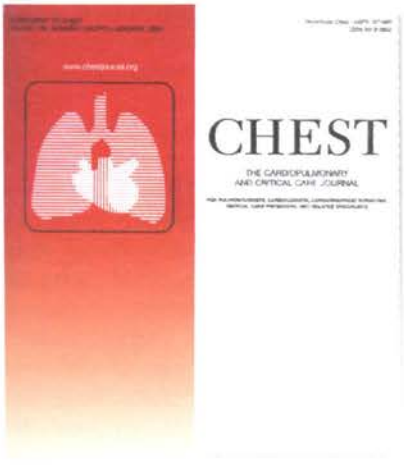
Introducing...

New Aggrenox®

Prevented twice as many strokes vs. ASA[2,3,4*]

New American College of Chest Physician Stroke Guidelines state[1]:



"Aggrenox is more effective than ASA alone for the prevention of [secondary] stroke" (grade 1A evidence)

Consider switching your ASA patients to Aggrenox:

- 22.1% additional stroke protection over ASA (p=0.008)[3†§]
- 36.8% additional stroke protection over placebo (p<0.001)[3]
- Proven safety and tolerability profile[3††] (Most common adverse events vs. ASA alone and vs. placebo: headache 39.2%, 33.8%, 32.9%; nausea 16.0%, 12.7%, 14.1%.)
- One capsule B.I.D.[3]

The overall discontinuation rate for Aggrenox was 27.8%, 23.2% for ASA and 23.7% for placebo.[3]
Aggrenox is indicated for the prevention of stroke in patients who have had a previous stroke or transient ischemic attack (TIA).[3]
Aggrenox is contraindicated in patients with hypersensitivity to dipyridamole, ASA, or any of the other product components. Due to the ASA content, Aggrenox is also contraindicated in patients with known allergy to nonsteroidal anti-inflammatory drug products and in patients with the syndrome of asthma, rhinitis and nasal polyps.[3]
Due to the ASA component, Aggrenox should be avoided in patients with severe hepatic insufficiency or severe renal failure, used with caution in patients with inherited/acquired bleeding disorders or who consume three or more alcoholic drinks every day, and avoided in patients with a history of active peptic ulcer disease.
Aggrenox should not be used in pediatric patients or during the third trimester of pregnancy.[3]
Aggrenox has a vasodilatory effect and should be used with caution in patients with severe coronary artery disease (e.g., unstable angina or recently sustained myocardial infarction).[3]

* For every 1,000 patients treated for two years, Aggrenox prevented 58 strokes vs. only 29 for ASA, compared to placebo.[2,3]

† Percentage of patients experiencing a stroke within two years: Aggrenox 9.5%, ASA 12.5%, placebo 15.2%.[3]

§ Randomised, double-blind, placebo-controlled trial, 6602 patients with history of TIA or ischemic stroke, mean age 66.7 years, 58% male, 42% female.[3]

†† When headache occurred, it was particularly evident in the first month of therapy. 8.9% of patients discontinued due to headache, 66% of these discontinued within the first month.[3]

Full Product Monograph is available upon request.
®Aggrenox is a registered trademark of Boehringer Ingelheim (Canada) Ltd.

Boehringer Ingelheim

Member R&D PAAB

Aggrenox®
ASA/Extended Release Dipyridamole
Helping to maximize stroke protection

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For brief prescribing information see pages A-30, A-31

Rebif®. Dose-dependent Efficacy in Relapsing MS[1]*.

Pr Rebif®

Interferon beta-1a

The most common reported adverse events are injection-site reactions and flu-like symptoms – e.g., asthenia, pyrexia, chills, arthralgia, myalgia, and headache. These tend to decrease in frequency and severity with continued treatment. Please see product monograph for full prescribing information. Evidence of safety and efficacy derived from 2-year data only.

* Rebif® is indicated for the treatment of relapsing-remitting multiple sclerosis in patients with an EDSS between 0 and 5.0, to reduce the number and severity of clinical exacerbations, slow the progression of physical disability, reduce the requirement for steroids, and reduce the number of hospitalizations for treatment of multiple sclerosis.

REFERENCES:

[1] PRISMS (Prevention of Relapses and Disability by Interferon ß-1a Subcutaneously in Multiple Sclerosis) Study Group (1998). Randomised double-blind placebo-controlled study of interferon ß-1a in relapsing/remitting multiple sclerosis. Lancet 352:1498-1504

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