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Neurological Sciences

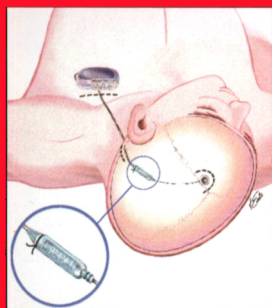
LE JOURNAL CANADIEN DES

Sciences Neurologiques

AN INTERNATIONAL JOURNAL / UN JOURNAL INTERNATIONAL



Ligamentum flavum cysts



Deep brain stimulation

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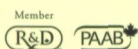
References: 1. Korczyn AD *et al.* Dosing with ropinirole in a clinical setting. *Acta Neurologica Scandinavica* 2002;106:200-204. 2. Rascol O *et al.* A five-year study of the incidence of dyskinesia in patients with early Parkinson's disease who were treated with ropinirole or levodopa. *N Eng J Med* 2000;342(20):1484-1491. 3. Product Monograph of REQUIP[®] (ropinirole hydrochloride), GlaxoSmithKline, March 2004.

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† 28-week, randomized, multicentre, double-blind, parallel-group, placebo-controlled U.S. study in patients (≥ 50 years) with moderate to severe Alzheimer's disease. Patients were randomized to treatment with EBIXA[®] 20 mg daily (n=126) or placebo (n=126).

* Function was measured on the Alzheimer's Disease Cooperative Study - Activities of Daily Living Inventory (ADCS-ADL_{...}) scale with LOCF data - Change from baseline at study endpoint for EBIXA[®] vs. placebo: 2.1 units, p=0.02.

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Ω Less caregiver time was needed per month (45.8 hrs) for patients treated with EBIXA[®] vs. placebo, p=0.01.

1. Cummings JL. Alzheimer's disease (review). *N Engl J Med* 2004;351:56-67. 2. EBIXA[®] Product Monograph. Lundbeck Canada Inc., 2004. 3. Reisberg B, Doody R, Stöffler A, Schmitt F, Ferris S, Möbius HJ for the Memantine Study Group. Memantine in Moderate-to-Severe Alzheimer's Disease. *N Engl J Med* 2003;348(14):1333-1341.

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- Effective in moderate to severe stages²
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- Excellent safety and tolerability profile²
- 45.8 hrs less caregiver time demonstrated per month vs. placebo^{3‡}

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- ▶ **37% reduction** in the probability of disability progression at 2 years (21.9% vs. 34.9%; p=0.02)⁺⁵
- ▶ **32% reduction** in annual exacerbation rate over 2 years (0.61 vs. 0.90; p=0.002)^{Δ,5}

✓ Patient Convenience

- ▶ The only once-a-week MS therapy.

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44% reduction in the risk of developing clinically definite MS in patients with a single demyelinating event over 3 years compared to placebo (confidence interval = 0.38 to 0.81; p=0.002)^{Δ,5}

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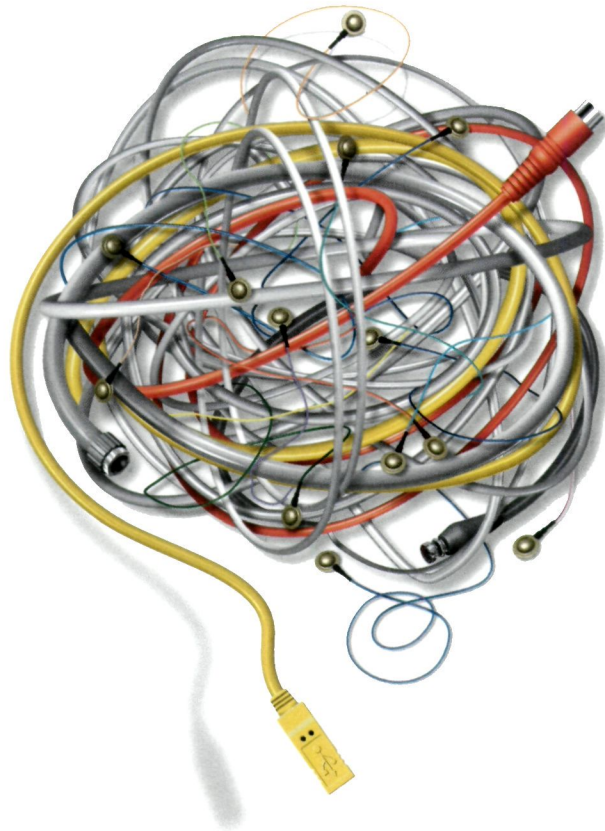
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- Rapid clinical improvement demonstrated by week 2 during a 14-week evaluation period ($p < 0.001$)¹¹



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Keppra is indicated as adjunctive therapy in the management of patients with epilepsy who are not satisfactorily controlled by conventional therapy.

The most significant CNS adverse events were somnolence (Keppra 15% vs placebo 10%) and asthenia (Keppra 14% vs placebo 10%), behavioural/psychiatric symptoms (nonpsychotic: Keppra 14% vs placebo 6%; psychotic: Keppra 1% vs placebo 0%) and coordination difficulties (Keppra 3% vs placebo 2%). These adverse events were observed in controlled clinical trials with concomitant AEDs.

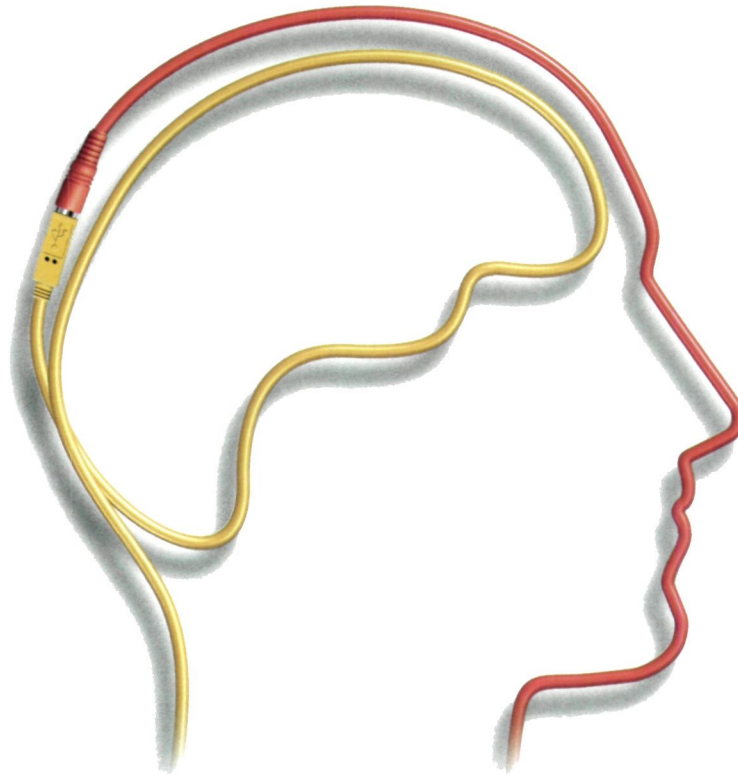
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- Low discontinuation or dosage reduction (Keppra 14.3% vs placebo 11.7%) due to adverse events[†]

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- Starting dose of 1000 mg/day (500 mg bid) shown to be effective and may be adjusted to a maximum of 3000 mg/day if required
- No blood level monitoring required
- No drug/drug interactions[§] with other AEDs, warfarin, digoxin or between Keppra 500 mg bid and a combination oral contraceptive (0.03 mg ethinyl estradiol and 0.15 mg levonorgestrel)[†]

[†] Note: Pharmacokinetic interaction studies with contraceptives have not been conducted covering the full recommended dosage range of Keppra. Physicians should advise their female patients to be alert to any irregular vaginal bleeding or spotting and report any occurrences.

^{*} Restrictions may exist by province. Please refer to your formulary for details.

[†] Data from a 38-week multicentre, randomised, add-on, double-blind, placebo-controlled, parallel-group trial. Study consisted of a 4-week titration period followed by a 14-week evaluation period. Patients received either levetiracetam 1000 mg/day (n = 98), 3000 mg/day (n = 101) or placebo (n = 95). Patient weekly seizure frequency was reduced over placebo, at week 2 of the evaluation period, by 24.9% (1.120/1.406) for Keppra 1000 mg/day and 38.6% (0.918/1.406) for Keppra 3000 mg/day. The percentage of patients achieving $\geq 50\%$ seizure reduction from baseline after the 18-week titration and evaluation period was 7.4% for placebo, 37.1% for Keppra 1000 mg/day and 39.6% for Keppra 3000 mg/day.

[‡] Based on observations in clinical studies.

[§] C_{max} of levetiracetam's metabolite (ucb L057) was approximately doubled in presence of probenecid. Renal clearance of ucb L057 decreased by 60% in presence of probenecid.

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by 26%¹

($p < 0.001$; 6.1% vs. 8.1%)



ALTACE 10 mg ramipril

GUARDING AGAINST CV DEATH

ALTACE is indicated in the treatment of essential hypertension, normally when beta-blockers and diuretics are inappropriate. It may be used alone or in association with thiazide diuretics. ALTACE is indicated following acute myocardial infarction in clinically stable patients with signs of left ventricular dysfunction to improve survival and reduce hospitalizations for heart failure.

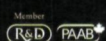
Results from the HOPE study showed that ALTACE improved survival in patients by reducing the risk of CV death by 26% ($p < 0.001$; 6.1% vs. 8.1%). ALTACE may be used to reduce the risk of MI, stroke, or CV death in patients over age 55 who are at high risk of CV events because of a history of CAD, stroke, peripheral artery disease, or diabetes accompanied by at least 1 other CV risk factor such as hypertension, elevated total cholesterol levels, low HDL levels, cigarette smoking, or documented microalbuminuria.

Like other ACE inhibitors, ALTACE is not recommended for pregnant or lactating women and should be used with caution in patients with renal insufficiency. The most frequent adverse events occurring in clinical trials with ALTACE monotherapy in hypertensive patients who were treated for at least 1 year ($n=651$) were: headache (15.1%); dizziness (3.7%); asthenia (3.7%); chest pain (2.0%). Discontinuation of therapy due to clinical adverse events was required in 5 patients (0.8%).

The reasons for stopping treatment were cough (ramipril 7.3% vs. placebo 1.8%); hypotension/dizziness (1.9% vs. 1.5%) and edema (0.4% vs. 0.2%).

ALTACE is the most prescribed ACEI among cardiologists.*

*IMS Health Canada: Canadian CompuScript Audit, Moving Annual Total ending June 2004, Total Prescriptions.



Product Monograph available to physicians and pharmacists upon request.

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- Réduction de 35 % après neuf mois (0,50 {n = 113} c. 0,77 {n = 115} placebo, moyenne, $p = 0,0077$)¹.
- Réduction de 75 % après deux ans (0,60 {n = 25} c. 2,40 {n = 25} placebo, moyenne, $p = 0,005$)¹.

*Deux études indépendantes

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