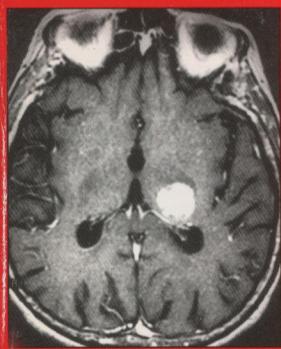




THE CANADIAN JOURNAL OF
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Primary CNS Lymphoma



Metachromatic Leukodystrophy

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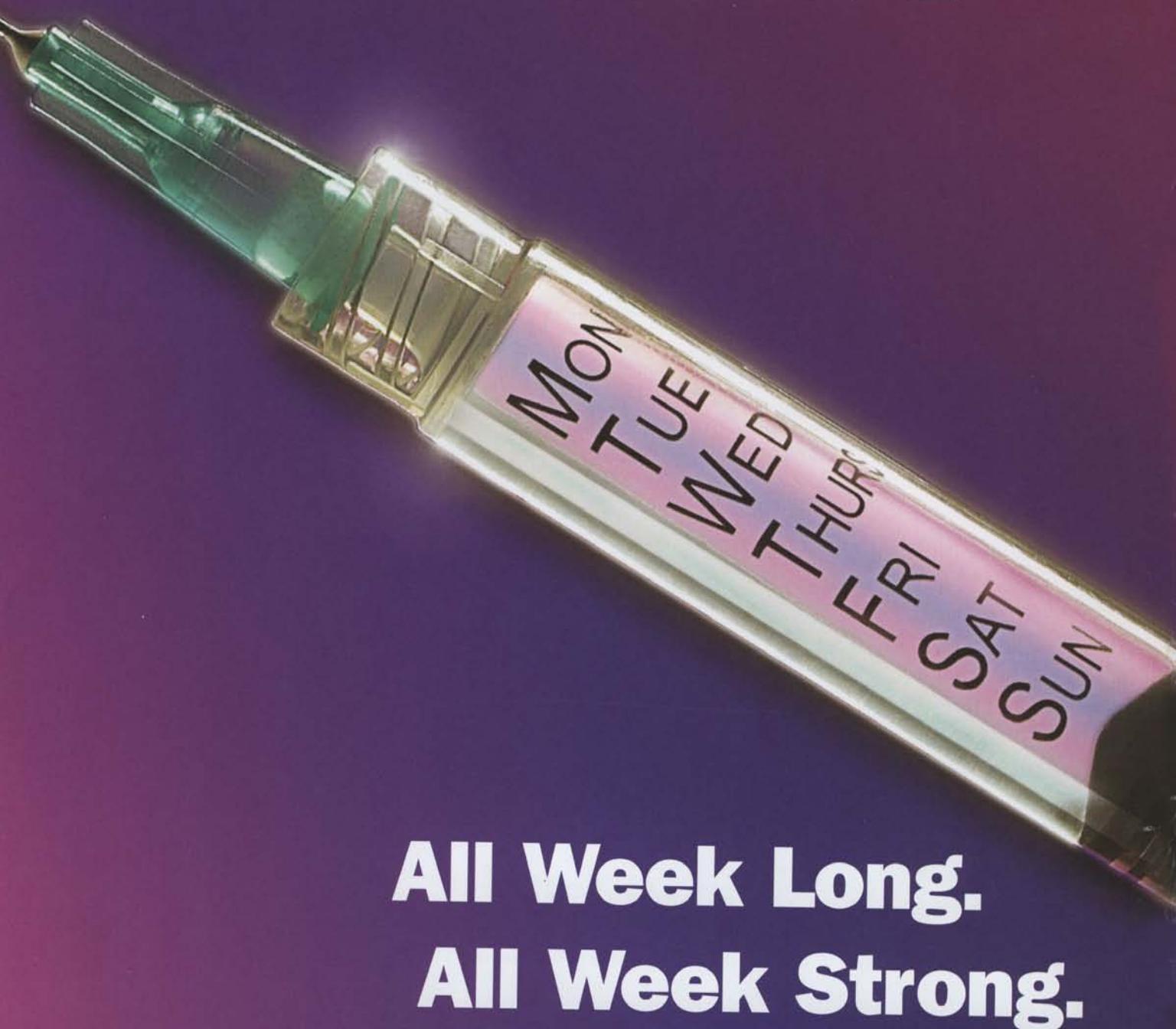
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has demonstrated a low propensity to produce dyskinesias.^{‡††} Maybe it's time to rethink Parkinson's. And start early Parkinson's patients on ReQuip alone.

[†]Hoehn and Yahr stages I-II ^{††}A 6 month interim analysis of a 5-year, double-blinded, randomized, multicenter study of patients with early Parkinson's disease. N = 268; 179 patients received ropinirole and 89 received L-dopa. The mean daily dose was 9.7 mg and 464.0 mg respectively. There was no difference in Clinical Global Improvement scale in patients with Hoehn and Yahr stages I-II although L-dopa showed improvement in a greater proportion of patients with more severe disease. The proportion of responders was 58% in the L-dopa group and 48% in the ropinirole group: this was not of statistical significance. ^{†††}In early therapy, the respective incidences of dyskinesia in early therapy of patients receiving ropinirole was 1.2% and of patients receiving L-dopa was 11.2%. Meta-analysis, n = 1364, 17 months. Nausea (39.1%), somnolence (12.3%) and insomnia (12.3%) were the most common side effects of ReQuip therapy. Six percent of ropinirole patients and nine percent of L-dopa patients had at least one psychiatric symptom (confusion, hallucinations, or delusions).



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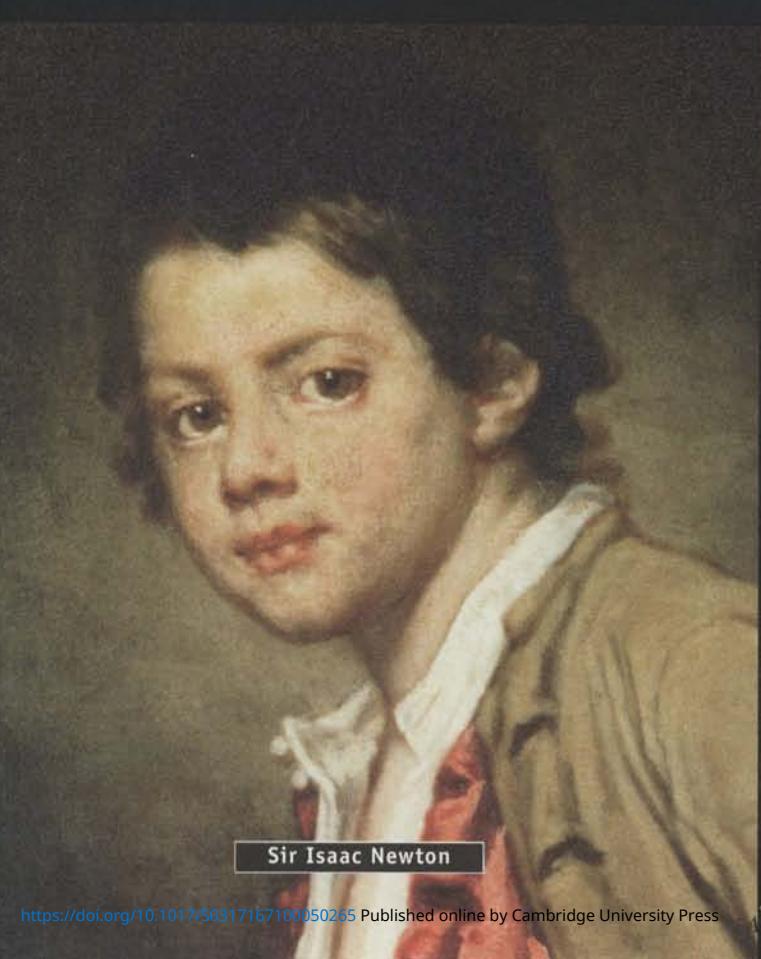


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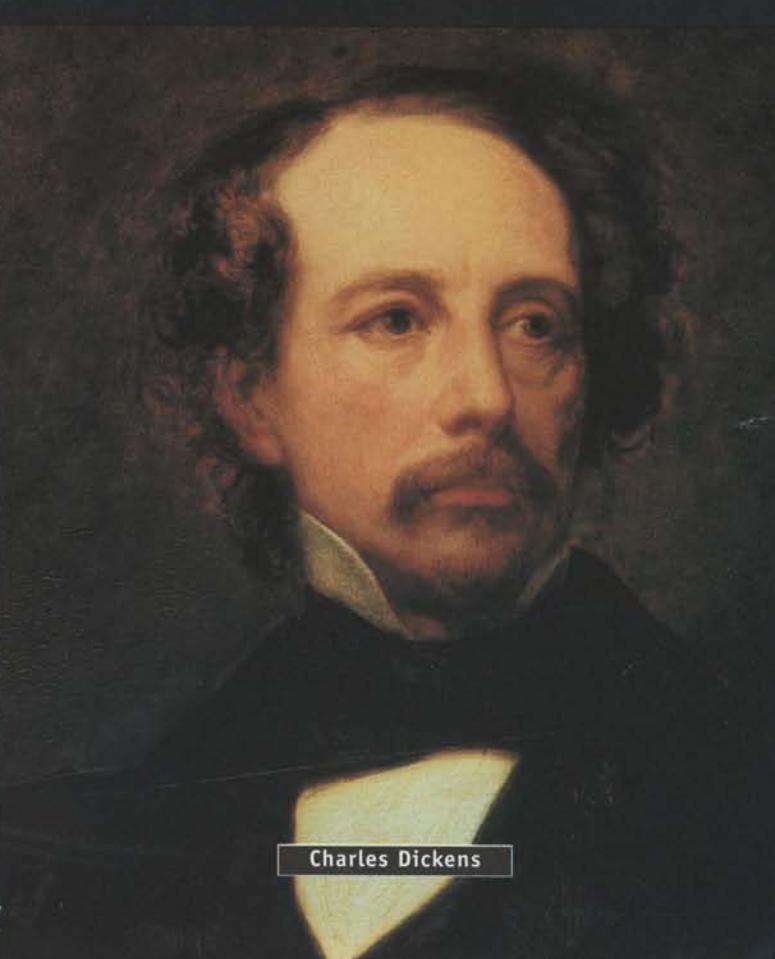


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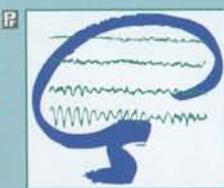
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[§] CNS adverse events: Somnolence (30.1%), dizziness (28.3%), ataxia (21.2%), speech disorders (16.8%), psychomotor slowing (16.8%), nystagmus (15.0%), paresthesia (15.0%), nervousness (15.9%), difficulty with concentration/attention (8.0%), confusion (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.

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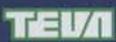
COPAXONE® has many clinical studies that confirm its consistent efficacy in relapse rate reduction.³⁻⁷

COPAXONE® has a long-term safety profile that has been demonstrated in clinical trials from 6 months (693 patients) to over 7 years (69 patients).⁸

COPAXONE® is indicated for Relapsing-Remitting Multiple Sclerosis. The safety and efficacy of COPAXONE® in chronic progressive MS have not been established.

The most commonly observed adverse events associated with the use of COPAXONE® in controlled trials which occurred at higher frequency than placebo were: injection site reactions, vasodilation, chest pain, asthenia, infection, pain, nausea, arthralgia, anxiety and hypertension.

*Comparative clinical significance unknown



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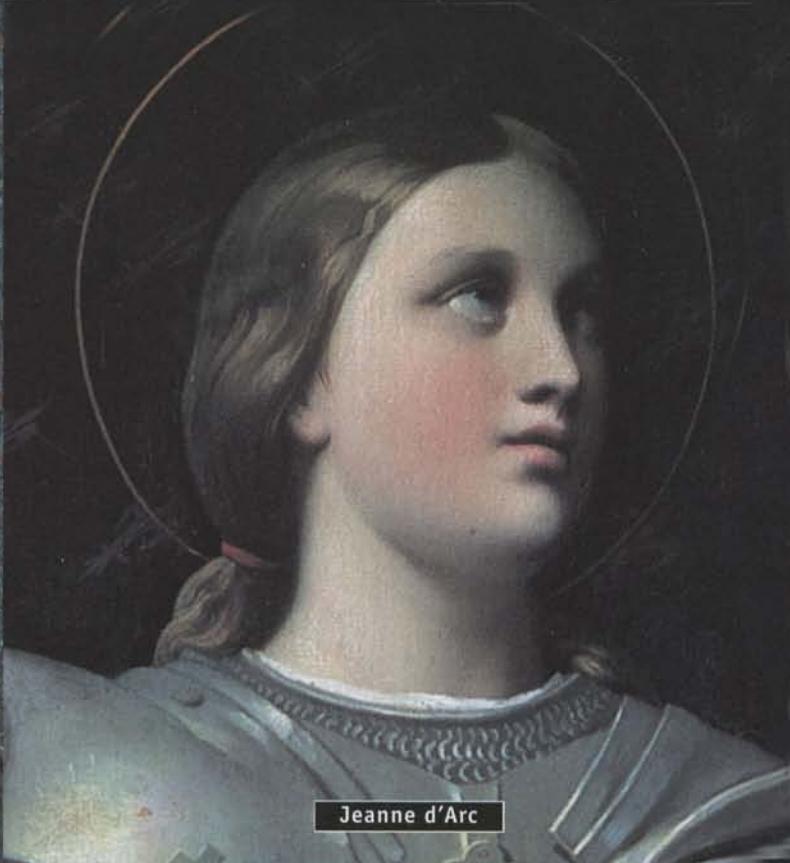
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Efficacy backed by evidence.



Pre-filled syringes available soon

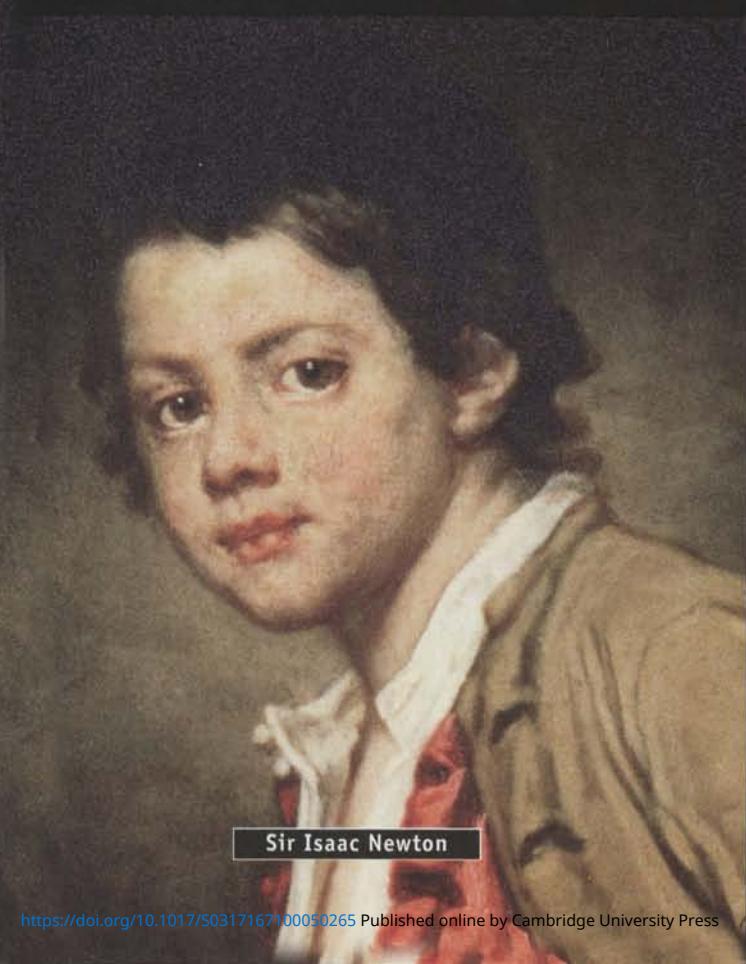


Vincent Van Gogh

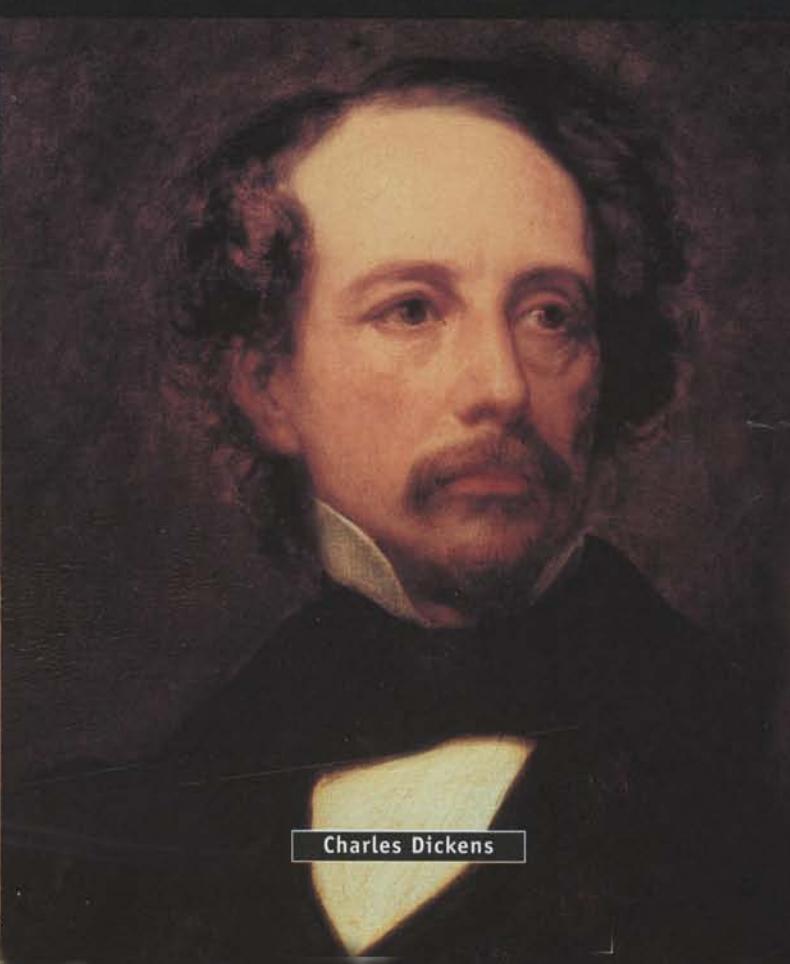


Jeanne d'Arc

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



Sir Isaac Newton



Charles Dickens

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-Gastaut¹
- Des résultats souhaitables avec absence totale de crises chez 19 % des adultes¹ et 22 % des enfants¹ 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^{1,2}

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

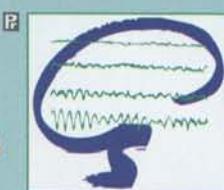
- 73 % ($n = 52$) des patients ont subi une perte de poids de 5,97 lb en moyenne (Analyse provisoire. Durée moyenne de 60 jours)⁴
- 96 % des enfants traités dans le cadre des essais cliniques pendant au moins un an et ayant subi une perte de poids ont repris du poids au cours de la période d'exécution des essais^{5,6}

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 adjvant 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 limités¹.

¹Une étude couverte d'une durée de 20 semaines ($n = 450$ adultes). Posologie optimale : 300 à 350 mg/jour (moyenne : 288 mg/jour).

²Étude ouverte portant sur des enfants ($n = 72$) traités pendant au moins 3 mois. Posologie moyenne : 10 mg/kg/jour.

³Manifestations 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 trouble 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.

⁴*Les effets à long terme d'une perte de poids chez les enfants ne sont pas connus.

⁵††Médicament à usage limité : Ontario, Nouvelle-Écosse, Nouveau-Brunswick, I.-P.-É. Remboursement intégral : Québec, Saskatchewan, Colombie-Britannique, Alberta, Manitoba.

Veuillez vous reporter aux Renseignements thérapeutiques sur TOPAMAX pour les détails thérapeutiques complets.

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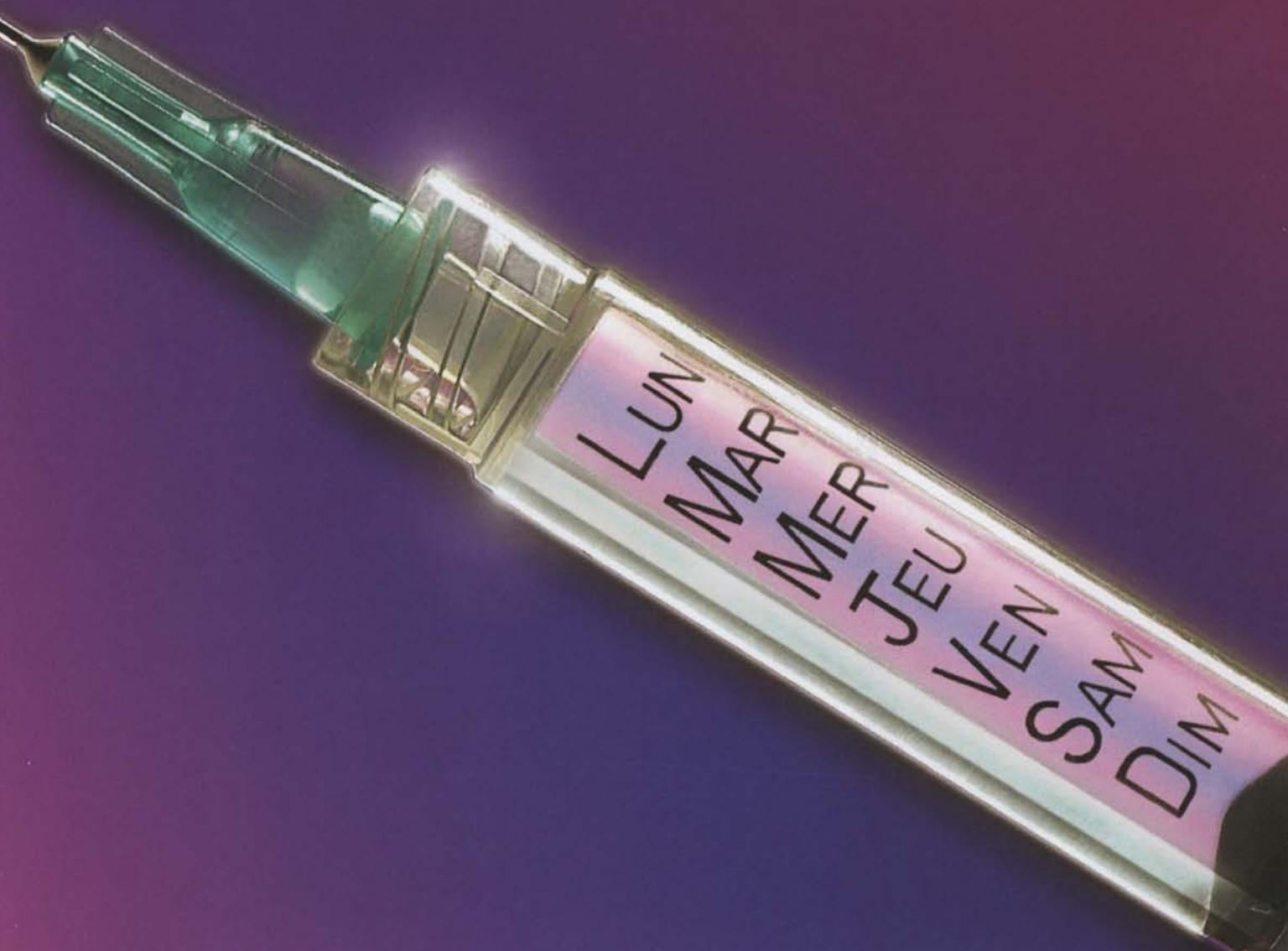
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AVONEX®

une fois par semaine



**Toute la semaine durant.
Tout aussi puissant.**

Jetez un coup d'œil sur les données.

Progression de l'incapacité liée à la SEP : Réduction de 37 % de la probabilité de progression de l'incapacité sur une période de 2 ans (21,9 % vs 34,9 %; $p=0,02$)^{†,2}

Fréquence annuelle des poussées : Réduction de 32 % de la fréquence annuelle des poussées sur une période de 2 ans (0,61 vs 0,90; $p=0,002$)^{*1,2}

Taux de patients exempts de poussées : 38 % des patients n'ont eu aucune poussée sur une période de 2 ans ($p=0,03$)^{*1,2}

Diminution de l'atrophie cérébrale : Réduction de 55 % de la progression de l'atrophie cérébrale pendant la deuxième année de traitement (-0,233 vs -0,521; $p=0,03$)^{#3}

Lésions visibles à l'examen IRM : Réduction de 89 % des lésions rehaussées par le gadolinium chez les patients qui présentaient des lésions rehaussées au départ (0,11 vs 0,50; $p=0,041$)^{†,4}

AVONEX® est indiqué pour le traitement des formes rémittentes de SEP¹.

AVONEX® est généralement bien toléré. Les effets indésirables associés le plus souvent au traitement sont les symptômes pseudo-grippaux (myalgies, fièvre, frissons et asthénie). Veuillez consulter la monographie pour obtenir des données importantes sur la sélection des patients et la surveillance du traitement¹. AVONEX® doit être utilisé avec prudence chez les patients qui souffrent de dépression et de troubles convulsifs. AVONEX® ne doit pas être administré à une femme enceinte. Les personnes souffrant d'une maladie cardiaque doivent être surveillées de près. Il est recommandé d'analyser le chimisme sanguin et la formule sanguine à intervalles réguliers pendant le traitement par AVONEX^{®1}.



UNE FOIS PAR SEMAINE
AVONEX®
(Interféron bêta-1a)
Injection par voie IM

† Méthodologie de Kaplan-Meier. AVONEX® n=158, placebo n=143.
‡ AVONEX® n=85, placebo n=87.
@ n=85.

Mesurée d'après la fraction parenchymateuse du cerveau pendant la deuxième année de traitement. AVONEX® n=68, placebo=72.

† AVONEX® n=44, placebo n=44. On ignore le lien exact entre les résultats de l'examen IRM et l'état clinique.

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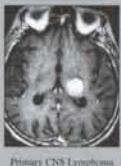
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There's cause for celebration—because Aricept® has been shown to result in improvement or stabilization in 80% of Alzheimer's disease patients over 6 months of treatment.¹² And long-term data shows that Aricept®-treated patients continued to show treatment benefits up to 3 years on cognition and global functioning compared to data expected from untreated patients.²³ What's more, Aricept® has demonstrated long-term safety and tolerability profiles.²⁴ All of which means there's even more reason to make Aricept® your standard of care.³

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.

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Interferon beta-1a



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* 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 β-1a Subcutaneously in Multiple Sclerosis) Study Group (1998). Randomised double-blind placebo-controlled study of interferon β-1a in relapsing/remitting multiple sclerosis. Lancet 352:1498-1504



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