

Editorial	1
Symposium Report	3
Parallel Processing of Cutaneous Information in the Somatosensory System of the Cat — Robert W. Dykes	9
Stroke in Coronary Bypass Surgery — W.R. Wayne Martin and Stanley A. Hashimoto	21
Plasma Exchange of Malignant Multiple Sclerosis — K.G. Warren, P.A. Gordon, T.A. McPherson	27
Heterotopic Growth of Dysplastic Cerebellum in Frontal Encephalocele in an Infant of a Diabetic Mother — Harvey B. Sarnat, Daphne E. deMello, John D. Blair, and Safeda Y. Siddiqui	31
Cerebrospinal Fluid and Blood Thiamine Concentrations in Phenytoin-Treated Epileptics — M.I. Botez, Claude Joyal, Urs Maag and Jocelyne Bachevalier	37
Le Méningite de Mollaret — M. Saint-Martin, F. Duplantis, M. Laverdière, J. Lachapelle, S. Rousseau, L.E. Roy et J. Boileau	41
Familial Benign Intracranial Hypertension and Depression — C. Edward Coffey, Donald R. Ross, W. Wayne Massey, C. Warren Olanow	45
Extramedullary Hematopoiesis Simulating Parasagittal Meningioma — R.A. Kandel, K.P.H. Pritzker, A.S. Gordon and J.M. Bilbao	49
New Data on the Genetics of Parkinson's Disease — André Barbeau and Emmanuelle Pourcher	53
Dr. James K. Murray: An Appreciation . . . Ronald A. Dolan	61
Notes and Announcements	62
Book Reviews	64

SUBJECT REVIEW: The Somatosensory Evoked Potential — A. Eisen	65
The Effects of Intermittent Insulin Therapy on the Autonomic Neuropathy in The Streptozotocin Rat G. Monckton & E. Pehowich	79
Neonatal Myasthenia Gravis in the Infant of an Asymptomatic Thymectomized Mother C.W. Olanow, R.J.M. Lane, K.L. Hull & A.D. Roses	85
Transient Choreiform Dyskinesias During Alcohol Withdrawal L. Fornazzari & P.L. Carlen	89
QUEBEC COOPERATIVE STUDY OF FRIEDREICH'S ATAXIA. Phase Three: Clinical Pathophysiology Part Two: Enzymology and Experimental Trials	91
(detailed Table of Contents on Page 93)	
XVII CANADIAN CONGRESS OF NEUROLOGICAL SCIENCES: Program and Abstracts	265
Notes and Announcements	299
Book Reviews	301

HYPOTHESIS: Limbic Predilection in Alzheimer Dementia: Is Reactivated Herpesvirus Involved? Melvyn J. Ball	303
Sodium Valproate in the Treatment of the Intractable Childhood Epileptic D.L. Keene, K. Metrakos, G.V. Watters and A. Sherwin	307
Anticholinergics in Adult-Onset Focal Dystonia Anthony E. Lang, Michael P. Sheehy and C. David Marsden	313
Epidural Hematoma: Report of Seven Cases with Delayed Evolution of Symptoms B.G. Benoit, N.A. Russell, M.T. Richard, H. Hugenholtz, E.C.G. Ventureyra and S.H. Choo	321
Flash Electroretinogram Abnormalities in Patients with Clinically Definite Multiple Sclerosis Stuart G. Coupland and Trevor H. Kirkham	325
Orientation-Specific Visual Evoked Potential Deficits in Multiple Sclerosis Stuart G. Coupland and Trevor H. Kirkham	331
Mechanisms of Brain Damage in Twins — Margaret G. Norman	339
Benign Familial Neonatal Convulsions Otilia Dobrescu and Albert Larbrisseau	345
Sixth National Scientific Workshop of the Muscular Dystrophy Association of Canada — Conference Report	349
— Program and Abstracts	353
Notes and Announcements	369
Book Reviews	371

PRESIDENTIAL ADDRESS: XVII CONGRESS OF NEUROLOGICAL SCIENCES - Cushing's Disease: 50 Years Later — Jules Hardy	375
THE 1981 SILVERSIDES LECTURE — The Symptomatology of Tumours of the Anterior Visual Pathways W.I. McDonald	381
Percutaneous Localization of Conduction Abnormalities in Human Entrapment Neuropathies W.F. Brown and S.K. Yates	391
Childhood Cerebral Cysticercosis: Clinical Features and Computed Tomographic Findings in 89 Mexican Children — Arturo López-Hernández and Carmen Garaizar	401
Clinical-Radiological Correlates in Intracerebral Hematomas due to Aneurysmal Rupture B.G. Benoit, D.D. Cochrane, F. Durity, G.G. Ferguson, D. Fewer, K.M. Hunter, M.I. Khan, G. Mohr, A.R. Watts, B.K.A. Weir and W.B. Wheelock	409
Multiple Sclerosis and Diabetes Mellitus: Further Evidence of a Relationship Sharon A. Warren and K.G. Warren	415
Distribution of Dopamine in 35 Subregions of the Rat Caudate-Putamen: A High Performance Liquid Chromatography with Electrochemical Detection Analysis Thérèse Di Paolo, Michel Daigle and André Dupont	421
Auditory Brainstem Response Abnormalities in Autistic Children M.J. Taylor, B. Rosenblatt and L. Linschoten	429
Valproic Acid Producing a Reye-Like Syndrome D.L. Keene, P. Humphreys, B. Carpenter and J.P. Fletcher	435
Spino-Cerebello-Cerebral Degeneration with Amyloid Plaques (Gerstmann, Sträussler, Scheinker Syndrome) C.L. Dolman and L.L. Daly	439
Respiratory Arrest and Cervical Spinal Cord Infarction Following Lumbar Puncture in Meningitis Margaret G. Norman	443
SUBJECT REVIEW: Adrenoleukodystrophy — Brian P. O'Neill and Hugo W. Moser	449
HISTORICAL VIEWPOINT: The Neurology of Alice in Wonderland T.J. Murray	453
Announcements	459
Book Reviews	465
Index to Volume 9 - 1982	(i)

**CALL FOR ABSTRACTS FOR THE
XVIII Canadian Congress of
Neurological Sciences
ST. JOHN'S, NEWFOUNDLAND
JUNE 21 - JUNE 25, 1983**

ABSTRACTS FOR SCIENTIFIC PAPERS

Abstracts submitted for the Scientific Program must be typed, single spaced, within the ruled area on the reverse side of this announcement. Abstracts should summarize data and conclusions and contain no more than 200 words. Seven (7) copies of the Abstract (original and 6 photocopies) are required. Papers accepted for platform delivery will be allotted 10 minutes for presentation and 5 minutes for discussion.

Abstracts should report original material. They will be published in the Canadian Journal of Neurological Sciences. They may be submitted either in English or in French.

POSTER SESSIONS

Since the number of platform presentations is limited abstracts will be considered for poster presentation unless a request is made not to do so (see reverse side). Special arrangements will be made to allow time for poster presentations when presenters will be available for discussion. Abstracts of poster presentations will be published in the same fashion as platform presentations.

ALL ABSTRACTS SHOULD BE MAILED TO:

DR. WILLIAM PRYSE-PHILLIPS
HEALTH SCIENCES CENTRE
ST. JOHN'S, NEWFOUNDLAND
A1B 3V6

The deadline for receipt of abstracts is February 15, 1983.

**XVIII CANADIAN CONGRESS OF
NEUROLOGICAL SCIENCES
Scientific Program Abstract Form**

Presenter's Name and Mailing Address:

Please check your choice

- either platform or poster presentation
 poster presentation only
 platform presentation only

(see over for poster session information)

Co-author's Names and Institutions:

Name: _____

Institution: _____

Name: _____

Institution: _____

Please indicate if you wish your paper considered for:

McNaughton Prize

McKenzie Prize

Jasper Prize

Title:

**ANNONCE DU PROGRAMME SCIENTIFIQUE
ET INVITATION À PRÉSENTER DES RÉSUMÉS
DE COMMUNICATIONS SCIENTIFIQUES POUR LE
XVIII ième Congrès Canadien des
Sciences Neurologiques
ST-JEAN, TERRE-NEUVE
DU 21 AU 25 JUIN 1983**

RESUMES DES ARTICLES SCIENTIFIQUES

Les résumés soumis comme communications scientifiques doivent être dactylographiés, à simple interligne, dans la zone quadrillée au verso. Le résumé doit contenir, en moins de 200 mots, toutes les données et les conclusions essentielles. On demande l'original et six (6) copies de chaque résumé. Les communications orales auront une durée de 10 minutes, plus 5 minutes pour la discussion.

Le résumé doit porter sur des travaux originaux. Il sera publié dans le Journal Canadien des Sciences Neurologiques. Les résumés sont acceptés au choix, en français ou en anglais.

PRESENTATIONS PAR AFFICHES

Puisque le nombre des communications orales est limité, les résumés seront orientés vers une présentation par affiches, à moins d'une demande expresse à l'effet contraire (voir au verso). Le comité verra à prévoir une période spécifique de temps pour les présentations par affiches, ce qui permettra à leurs auteurs d'être présents et disponibles pour toute discussion.

Les résumés des présentations par affiches seront publiés de la même façon que ceux des communications orales.

SOUMETTRE LES RESUMES À:

DR. WILLIAM PRYSE-PHILLIPS
HEALTH SCIENCES CENTER
ST-JEAN, TERRE-NEUVE
A1B 3V6
avant le 15 Février 1983.

**XVIII^{ème} CONGRÈS CANADIEN DES
SCIENCES NEUROLOGIQUES**
**Formule de soumission d'un résumé de
communication scientifique**

Nom et adresse postale du présentateur
ou de la présentatrice.

Cocher le genre de communication choisi:

- oral ou affiche
 affiche seulement
 oral seulement

(voir au verso pour la présentation
par affiches).

Noms et lieux de travail des co-auteurs:

Nom: _____

Lieu de travail: _____

Nom: _____

Lieu de travail: _____

Je désire soumettre cette communication à l'étude en vue de l'obtention du

prix McNaughton

prix McKenzie

prix Jasper

Titre:

Errata

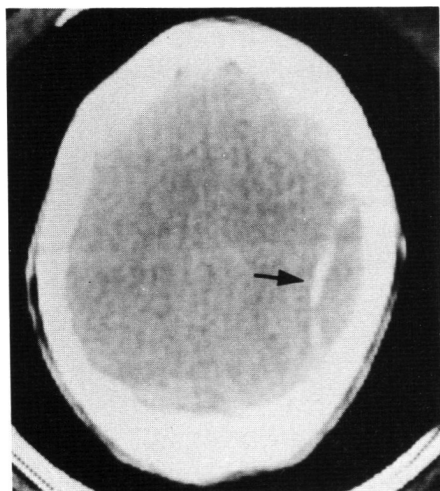


Figure 1 — Case 3 - Inner “Rim” of Increased Density Representing Membrane of Chronic Epidural Hematoma.

1) In the article entitled ‘Epidural Hematoma: Report of Seven Cases with Delayed Evolution of Symptoms’ by Brien G. Benoit et al. which appeared in Volume 9, No. 3, Figure 1 on page 322 was poorly reproduced. A better quality reproduction is included here. We sincerely apologize to the authors and the readers for this error.

2) In reference to the Abstracts for the XVII Canadian Congress of Neurological Sciences, Volume 9, No. 2, the Abstract P18 on page 285 titled ‘The Use of Auditory Evoked Responses as a Diagnostic Measure in Determining Unilateral Cortical Injury in Childhood’ by M.J. Taylor, F.V. Khadem, A. O’Gorman and G.V. Watters, the name of the fifth author, *B. Rosenblatt*, was omitted.

PAEDIATRIC NEUROLOGIST

The Children’s Hospital of Eastern Ontario, Ottawa, invites applications for the above posting. This individual will join the present complement of two in the Neurology Service.

The position is a geographic full time post at the Hospital, which is the Paediatric teaching unit of the Department of Paediatrics of the University of Ottawa. The University appointment would be commensurate with the experience of the candidate. Experience in related research as well as EEG interpretation and evoked potentials would be advantageous.

The Children’s Hospital of Eastern Ontario is a modern 301 bed facility serving a one million plus paediatric population and provides paediatric teaching to all levels of undergraduate and postgraduate students.

Interested persons should apply to Dr. Pierre Beaudry, Chairman, Department of Paediatrics, University of Ottawa and Chief, Department of Paediatrics, Children’s Hospital of Eastern Ontario.

401 Smyth Road
Ottawa, Ontario
K1H 8L1

FELLOWSHIP IN NEUROSCIENCE

One Year Appointment

Our expanding Neuroscience facility has an additional full-time position available for an individual with three years experience in neuroscience with emphasis on neurology. Knowledge of in-patient and out-patient procedures is preferred.

The Department of Neuroscience is located in a large Medical Center affiliated with Northwestern University Medical School and Chicago Medical School. The selected appointee will be working with other professionals associated with Loyola Stritch School of Medicine and the University of Illinois Medical School.

Varied responsibilities include Clinical Neurology, Evoked Potentials, Electroencephalography and 24-hour Holter E.E.G.’s.

Cover letter and curriculum vitae of interested candidates should be sent to: D.M. Vuckovich, M.D., Vice-President — Neuroscience, Columbus-Cuneo-Cabrini Medical Center, 2520 N. Lakeview, Chicago, Illinois 60614. An Equal Opportunity Employer M/F/H

COLUMBUS-CUNEO-CABRINI MEDICAL CENTER

fiorinal®

2 Fiorinal stat stops headaches fast

Analgesic/Sedative Prescribing information

Indications - Fiorinal® (Regular): In all conditions where simultaneous sedative and analgesic action is required, such as muscle contraction (tension) headache and mixed migraine headaches, menstrual and postpartum tension and pain. May be given in combination with Cafergot and Cafergot-PB when there is a tension headache in association with or following a vascular headache.

* **Fiorinal®-C:** In all types of pain situations including: non-vascular headaches, postoperative pain, postpartum pain, pain following trauma, arthralgia, bursitis, dysmenorrhea, pain associated with neoplasia, strains, sprains, dislocations and fractures, sinusitis, influenza, low back pain, pain associated with dental procedures.

Contraindications: Porphyria, hypersensitivity to any of the components. (**Fiorinal®-C only** - gastrointestinal ulceration). Overdose of, or intoxication due to, alcohol, hypnotics, analgesics and psychotropic drugs.

Precautions: Due to the presence of butalbital in Fiorinal® and butalbital and codeine in Fiorinal®-C, these drugs may be habit forming. Excessive or prolonged use should be avoided. As with most drugs, activities necessitating mental alertness such as operating hazardous equipment or driving a vehicle, should not be undertaken until the patient's response and sensitivity to the medication are established.

Fiorinal® (Regular) should be used with caution in the presence of peptic ulcer. During pregnancy and lactation **Fiorinal®** and **Fiorinal®-C** should be taken only upon medical advice. Keep out of the reach of children.

Adverse Reactions: In rare instances, drowsiness, dizziness, nausea, vomiting, constipation, skin rash and miosis are possible adverse effects.

Composition: Fiorinal® (Regular) - Sandoptal® (butalbital) 50 mg, Caffeine U.S.P. 40 mg, Acetylsalicylic Acid U.S.P. 330 mg.
Fiorinal®-C ¼ - Sandoptal® (butalbital) 50 mg, Acetylsalicylic Acid U.S.P. 330 mg, Caffeine U.S.P. 40 mg, Codeine Phosphate U.S.P. 15 mg.
Fiorinal®-C ½ - Sandoptal® (butalbital) 50 mg, Acetylsalicylic Acid U.S.P. 330 mg, Caffeine U.S.P. 40 mg, Codeine Phosphate U.S.P. 30 mg.

Supply - Fiorinal® (Regular): Available in capsules or tablets for the patient's convenience. Bottles of 100 and 500 capsules and tablets.

Fiorinal®-C: Bottles of 100 and 500 capsules.

Dosage:

Fiorinal® (Regular)

Adults: 2 capsules or tablets at once, followed if necessary by 1 capsule or tablet every 3 to 4 hours; up to a maximum of 6 capsules or tablets daily, or as directed by the physician.

Children: One to 3 capsules or tablets a day, according to age.

Fiorinal®-C ¼ & C ½:

Adults: One or 2 capsules at once, followed if necessary by 1 capsule every 3 to 4 hours; up to a maximum of 6 capsules daily, or as directed by the physician.

References: 1. Kibbe MH. *Dis Nerv Syst* 1955; 16:3. * 2. Weisman SJ. *Am Pract Digest Treat* 1955; 6(7): 1019-21. * 3. Glassman JM, Soyka JP. *Curr Ther Res* 1980; 28(6): 904-15. 4. Data on file. Sandoz (Canada) Ltd.

*The composition of Fiorinal used in the reference studies was: Sandoptal (butalbital) 50 mg; caffeine - 40 mg; ASA - 200 mg; and phenacetin - 130 mg.

Full prescribing information available to physicians and pharmacists upon request.

SANDOZ®



(xxii) - NOVEMBER 1982

Sandomigran® DS 1 mg pizotyline (Double Strength)

Brief Prescribing Information

Since vascular headache is a paroxysmal but basically chronic disorder, treatment must extend over an adequate period of time in order to obtain maximal benefit. While some patients have responded rather quickly, most investigators agree that a four-week trial period should be instituted to determine the true efficacy of pizotyline in specific cases. The periodic nature of the disorder will have to be considered in determining when and for how long therapy should be maintained. Since some investigators have observed a change in headache pattern after several months of therapy, a drug-free interval is advisable to reassess the necessity of continuing treatment. The dosage should be reduced gradually during the last two weeks of each treatment course to avoid a "headache rebound".

Contraindications: Anticholinergic agents, including pizotyline, are contraindicated in patients taking monoamine oxidase inhibitors, and in patients with pyloroduodenal obstruction and stenosing pyloric ulcer. Pizotyline is also contraindicated for patients who have a known sensitivity to the drug. Until further studies are completed, the drug is not recommended for children under the age of twelve.

Warnings and precautions: Since drowsiness may occur with pizotyline, sensitive patients should be cautioned against activities requiring rapid and precise response (i.e. driving an automobile or operating dangerous machinery) until their response to the drug has been determined. Since the effects of antihistamines can potentiate those of other drugs affecting the central nervous system, patients should be cautioned against drinking alcoholic beverages or taking hypnotics, sedatives, psychotherapeutic agents or other drugs with CNS depressant effects during pizotyline therapy. Administer pizotyline with caution to patients with narrow angle glaucoma or with urinary retention (e.g. prostatic hypertrophy). Since it is desirable to keep drug administration to a minimum during pregnancy, pizotyline should be given only when the benefits derived from treatment exceed the possible risks to mother and fetus.

Some patients developed tolerance to pizotyline with prolonged use of the drug. An increase in dosage may overcome this tolerance.

After prolonged use, hepatotoxic effects might occur and patients should be advised to report for adequate laboratory evaluation.

Patients with diabetes, cardiovascular disease and known or suspected impaired renal or hepatic function should be given pizotyline with caution, and appropriate laboratory tests should be done at regular intervals.

Lens opacities occurred in two cases, but did not appear to be drug-related. However, it is recommended that any impairment in vision be reported to the attending physician for further investigation.

Dosage: Days 1-4: ½ DS tablet increasing to 1 DS tablet at bedtime. Days 5-28: increasing to between 1 and 2 DS tablets per day and, if necessary, gradually up to 6 DS tablets a day in divided doses.

Side effects: Increased appetite, weight gain, and drowsiness are the most frequent side effects. An appropriate diet should be recommended by the physician for patients benefiting from the drug but gaining excessive weight. A gradual increase in the dosage of pizotyline is recommended to minimize or reduce the incidence of drowsiness. The following adverse effects have been observed less frequently in relation to the aforementioned reactions: fatigue, nausea, dizziness, headache, confusion, edema, hypotension, depression, weakness, epigastric distress, dry mouth, nervousness, impotence and muscle pain.

Composition: Each single-scored white DS tablet contains 1 mg of pizotyline as the hydrogen malate. Supplied 1 mg scored DS (Double Strength) tablets in bottles of 100.

Complete prescribing information available to physicians and pharmacists on request.

References:

1. Sicuteri F et al. An antaminic drug, BC-105, in the prophylaxis of migraine. *Int Arch Allergy* 1967; 31:78-93.
2. Peet KMS. Use of pizotyline in severe migraine: A long-term study. *Curr Med Res Opin* 1977; 5:192-99.
3. Schaar J. BC-105 - A new serotonin antagonist in the treatment of migraine. *Headache* 1970; 10:67-73.
4. Lawrence ER et al. Sandomigran for migraine prophylaxis; controlled multicenter trial in general practice. *Headache* 1977; 17:109-12.
5. Schaar J. Experience with BC-105 in the treatment of migraine. In: *Proceedings of the Int Headache Symposium*, Eisinoere, Denmark. Dalessio, D et al (eds), Basel, Switzerland. Sandoz Ltd. The American Association for the Study of Headache and The Danish Migraine Society 1971; 185-187.
6. Behan PO. Pizotyline in the treatment of severe recurrent headache. Single and divided dose therapy compared. *Brit J Clin Pract* 1982; 36:13-17.

MOVING?

PLEASE NOTIFY US OF YOUR
CHANGE OF ADDRESS IN
ADVANCE.

PASTE OLD
ADDRESS LABEL
HERE

NEW ADDRESS:

NAME:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

(LAST) (FIRST) (MIDDLE INITIAL)

STREET ADDRESS:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

CITY:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

PROVINCE/STATE:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

COUNTRY:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

POSTAL/ZIP CODE:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

MAIL TO:

Editor
University of Calgary
Faculty of Medicine
Dept. of Clinical Neuro Sciences
Calgary, Alberta
T2N 4N1

SANDOZ®



SANDOZ (Canada) LTD.
Dorval, Quebec H9R 4P5

The Canadian Journal of Neurological Sciences

Brief Prescribing Information

Lioresal® baclofen

Action

The precise mechanisms of action of Lioresal (baclofen) are not fully known. It inhibits both monosynaptic and polysynaptic reflexes at the spinal level, probably by hyperpolarization of afferent terminals, although actions at supra-spinal sites may also occur and contribute to its clinical effect. Although Lioresal is an analog of the putative inhibitory neurotransmitter gamma-aminobutyric acid (GABA), there is no conclusive evidence that actions on GABA systems are involved in the production of its clinical effects. Peak plasma concentrations of Lioresal are achieved within 2 hours and the plasma half-life is 2-4 hours.

Indications and Clinical Uses

Lioresal (baclofen) is useful for the alleviation of signs and symptoms of spasticity resulting from multiple sclerosis.

Lioresal may also be of some value in patients with spinal cord injuries and other spinal cord diseases.

Contraindications

Hypersensitivity to Lioresal (baclofen).

Warnings

Abrupt Drug Withdrawal: Following abrupt withdrawal of Lioresal (baclofen), visual and auditory hallucinations, confusion, anxiety with tachycardia and sweating, insomnia, and worsening of spasticity have occurred.

Therefore, except for serious adverse reactions, the dose should be reduced slowly when the drug is discontinued.

Impaired Renal Function: Because Lioresal is primarily excreted unchanged through the kidneys, it should be given with caution, and it may be necessary to reduce the dosage.

Stroke: Lioresal has not significantly benefited patients with stroke. These patients have also shown poor tolerability to the drug.

Pregnancy: Safe use of Lioresal during pregnancy or lactation has not been established. High doses are associated with an increased incidence of abdominal hernias in the fetuses of rats and of ossification defects in those of rats and rabbits.

Therefore, the drug should be administered to pregnant patients, or women of child-bearing potential only when, in the judgment of the physician, the potential benefits outweigh the possible hazards.

Precautions
Safe use of Lioresal (baclofen) in children under age 12 has not been established and it is, therefore, not recommended for use in children. Because of the possibility of sedation, patients should be cautioned regarding the operation of automobiles or dangerous machinery, and activities made hazardous by decreased alertness. Patients should also be cautioned that the central nervous system effects of Lioresal may be additive to those of alcohol and other CNS depressants. Lioresal should be used with caution where spasticity is utilized to sustain upright posture and balance in locomotion, or whenever spasticity is utilized to obtain increased function. Extreme caution should be exercised in patients with epilepsy or a history of convulsive disorders. In such patients, the clinical state and electroencephalogram should be monitored at regular intervals during therapy, as deterioration in seizure control and EEG has been reported occasionally in patients taking Lioresal. Caution should be used in treating patients with peptic ulceration, severe psychiatric disorders, elderly patients with cerebrovascular disorders, and in patients receiving antihypertensive therapy. It is not known whether Lioresal is excreted in human milk. As a general rule, nursing should not be undertaken while a patient is on a drug since many drugs are excreted in human milk.

Adverse Reactions
The most common adverse reactions associated with Lioresal (baclofen) are transient drowsiness, dizziness, weakness and fatigue. Others reported: **Neuropsychiatric:** Headache (<10%), insomnia (<10%), and, rarely, euphoria, excitement, depression, confusion, hallucinations, paresthesia, muscle pain, tinnitus, slurred speech, coordination disorder, tremor, rigidity, dystonia, ataxia, blurred vision, nystagmus, strabismus, miosis, mydriasis, diplopia, dysarthria, epileptic seizures. **Cardiovascular:** Hypotension (<10%), rare instances of dyspnea, palpitation, chest pain, syncope. **Gastrointestinal:** Nausea, (approx. 10%), constipation (<10%), and, rarely, dry mouth, anorexia, taste disorder, abdominal pain, vomiting, diarrhea, and positive test for occult blood in stool.

Genitourinary: Urinary frequency (<10%), and, rarely, enuresis, urinary retention, dysuria, impotence, inability to ejaculate, nocturia, hematuria. **Other:** Instances of rash, pruritus, ankle edema, excessive perspiration, weight gain, nasal congestion. Some of the CNS and genitourinary symptoms reported may be related to the underlying disease rather than to drug therapy.

The following laboratory tests have been found to be abnormal in a few patients receiving Lioresal: SGOT, alkaline phosphatase and blood sugar (all elevated).

Symptoms and Treatment of Overdosage
Signs and Symptoms: Vomiting, muscular hypotonia, hypotension, drowsiness, accommodation disorders, coma, respiratory depression, and seizures. The signs and symptoms may be further aggravated by co-administration of a variety of other agents including alcohol, diazepam, and tricyclic antidepressants. **Treatment:** The treatment is symptomatic. In the alert patient, empty the stomach promptly by induced emesis followed by lavage. In the obtunded patient, secure the airway with a cuffed endotracheal tube before beginning lavage (do not induce emesis). Maintain adequate respiratory exchange; do not use respiratory stimulants. Muscular hypotonia may involve the respiratory muscles and require assisted respiration. A high urinary output should be maintained since Lioresal (baclofen) is excreted mainly by the kidneys. Dialysis is indicated in severe poisoning associated with renal failure.

Dosage and Administration
The determination of optimal dosage of Lioresal (baclofen) requires individual titration. Start therapy at a low dosage and increase gradually until optimum effect is achieved (usually between 40-80 mg daily). The following dosage titration schedule is suggested:

5 mg t.i.d. for 3 days
10 mg t.i.d. for 3 days
15 mg t.i.d. for 3 days
20 mg t.i.d. for 3 days

Thereafter additional increases may be necessary but the total daily dose should not exceed a maximum of 80 mg daily (20 mg q.i.d.). The lowest dose compatible with an optimal response is recommended. If benefits are not evident after a reasonable trial period, patients should be slowly withdrawn from the drug (see Warnings).

Availability: Lioresal (baclofen) 10 mg tablets.
Description: White to off-white flat-faced, oval tablets with Geigy monogram on one side and the identification code 23 below the monogram. Fully bisected on the reverse side. Available in bottles of 100 tablets.

References:
1. R.F. Jones, J.W. Lance, Medical Journal of Australia, 1976, May:654-657.
2. R.G. Feldman: Symposia Reporter, Vol. 3, No. 2 June 1979.
3. Lioresal Product Monograph.

Product monograph supplied on request.

Geigy Dorval, Qué. H9S 1B1

PAAB
CCPP

G-0018

Geigy Dorval, Qué. H9S 1B1

G-0018

G-0018

G-0018

G-0018

G-0018

G-0018

this publication is available in microform



Please send me additional information.
University Microfilms International
300 North Zeeb Road 18 Bedford Row
Dept. P.R. Dept. P.R.
Ann Arbor, MI 48106 London, WC1R 4EJ
U.S.A. England

Name _____
Institution _____
Street _____
City _____
State _____ Zip _____

Brief Prescribing Information Tegretol® No substitution. 200 mg carbamazepine

Indications and clinical use

a) Trigeminal Neuralgia:

Tegretol is indicated for the symptomatic relief of pain of trigeminal neuralgia only during periods of exacerbation of true or primary trigeminal neuralgia (tic douloureux). It should not be used preventively during periods of remission. In some patients, Tegretol has relieved glossopharyngeal neuralgia. For patients who fail to respond to Tegretol, or who are sensitive to the drug, recourse to other accepted measures must be considered. Tegretol is not a simple analgesic and should not be used to relieve trivial facial pains or headaches.

b) Tegretol has been found useful:

1. in the management of psychomotor (temporal lobe) epilepsy and,
2. as an adjunct, in some patients with secondary or partial epilepsy with complex symptomatology or secondarily generalized seizures, when administered in combination with other antiepileptic medication.
3. as an alternative medication in patients with generalized tonic-clonic seizures who are experiencing marked side effects or fail to respond to other anticonvulsant drugs.

Tegretol is essentially ineffective in controlling petit mal, minor motor, myoclonic and predominantly unilateral seizures, and does not prevent the generalization of epileptic discharge.

Contraindications

Tegretol should not be administered to patients with a history of hepatic disease or serious blood disorder.

Tegretol should not be administered immediately before, in conjunction with, or immediately after a monoamine oxidase inhibitor. When it seems desirable to administer Tegretol to a patient who has been receiving an MAO inhibitor, there should be as long a drug-free interval as the clinical condition allows, but in no case should this be less than 14 days. Then the dosage of Tegretol should be low initially, and increased very gradually.

Tegretol should not be administered to patients presenting atrioventricular heart block.

Safe use in pregnancy has not been established. Therefore, Tegretol should not be administered during the first three months of pregnancy.

Tegretol should not be given to women of child-bearing potential unless, in the opinion of the physician, the expected benefits to the patient outweigh the possible risk to the foetus (See Reproductive Studies). Because of demonstrated toxicity in nursing animals, Tegretol should not be administered to nursing mothers.

Because of the similarity of chemical structure, Tegretol should not be administered to patients with known hypersensitivity to any of the tricyclic compounds, such as amitriptyline, trimipramine, imipramine, or their analogues or metabolites.

Warnings

Although reported infrequently, serious adverse effects have been observed during the use of Tegretol. Agranulocytosis and aplastic anemia have occurred in a few instances with a fatal outcome. Leucopenia, thrombocytopenia and hepatocellular and cholestatic jaundice have also been reported. It is, therefore, important that Tegretol should be used carefully and close clinical and frequent laboratory supervision should be maintained throughout treatment in order to detect as early as possible signs and symptoms of a possible blood dyscrasia.

Long-term toxicity studies in rats indicated a potential carcinogenic risk. Therefore, the possible risk of drug use must be weighed against the potential benefits before prescribing carbamazepine to individual patients.

Precautions

Monitoring of Haematological and Other Adverse

Reactions: Complete blood studies, including platelet counts, and evaluation of hepatic and renal function and urinalysis should be carried out before treatment is instituted. Careful clinical and laboratory supervision should be maintained throughout treatment, including frequent performance of complete blood counts, in order to detect any early signs or symptoms or blood dyscrasia. Should any signs or symptoms or abnormal laboratory findings suggestive of blood dyscrasia or liver disorder occur, Tegretol should be immediately discontinued until the case is carefully reassessed.

Urinary Retention and Increased Intraocular Pressure: Because of its anticholinergic action, Tegretol should be given cautiously, if at all, to patients with increased intraocular pressure or urinary retention. Such patients should be followed closely while taking the drug.

Occurrence of Behavioural Disorders: Because it is closely related to the other tricyclic drugs, there is some possibility that Tegretol might activate a latent psychosis, or, in elderly patients, produce agitation or confusion, especially when combined with other drugs. Caution should also be exercised in alcoholics.

Use in Patients with Cardiovascular Disorders: Tegretol should be used cautiously in patients with a history of coronary artery disease, organic heart disease, or congestive failure. If a defective conductive system is suspected, an E.K.G. should be performed before administering Tegretol, in order to exclude patients with atrioventricular block.

Use in Patients taking Oral Contraceptives: In women under treatment with Tegretol, the reliability of oral contraceptives may be adversely affected; such patients should accordingly be advised to use some alternative, non-hormonal method of contraception.

Driving and Operating Hazardous Machinery: Because dizziness and drowsiness are possible side effects of Tegretol, patients should be warned about the possible hazards of operating machinery or driving automobiles.

Adverse Reactions

The reactions which have been most frequently reported with Tegretol are drowsiness, unsteadiness on the feet, vertigo, dizziness, gastrointestinal disturbances, and nausea.

These reactions usually occur only during the initial phase of therapy. They have rarely necessitated discontinuing Tegretol therapy, and can be minimized by initiating treatment at a low dosage.

The more serious adverse reactions observed are the haematologic, hepatic, cardiovascular and dermatologic reactions, which require discontinuation of therapy.

The following adverse reactions have been reported:

Haematological reactions: Transitory leucopenia, eosinophilia, leucocytosis, thrombocytopenic purpura, agranulocytosis, macrocytic anemia and aplastic anemia. In a few instances, deaths have occurred.

Hepatic disturbances: During the long-term administration of Tegretol abnormalities in liver function tests and cholestatic or hepatocellular jaundice have been observed.

Dermatological reactions: The following reactions occurred during treatment with Tegretol: skin sensitivity reactions and rashes, erythematous rashes, pruritic eruptions, urticaria, photosensitivity, pigmentary changes, neurodermatitis and in rare cases Stevens-Johnson syndrome, exfoliative dermatitis, alopecia, diaphoresis, erythema multiforme, erythema nodosum, and aggravation of disseminated lupus erythematosus.

Neurological reactions: The reactions reported as occurring during treatment with Tegretol include vertigo, somnolence, disturbances of coordination, confusion, headache, fatigue, blurred vision, transient diplopia and oculomotor disturbances, speech disturbances, abnormal involuntary movements and increase in motor seizures. In addition, peripheral neuritis and paresis, depression with agitation, talkativeness,

nystagmus, and tinnitus have been reported but only very rarely. There have been some reports of paralysis and other symptoms of cerebral arterial insufficiency but no conclusive relationship to the administration of Tegretol could be established.

Cardiovascular systems: Recurrence of thrombophlebitis in patients with a prior history of thrombophlebitis, congestive heart failure, aggravation of hypertension, Stokes-Adams in patients with AV block, hypotension, syncope and collapse, edema, aggravation of coronary artery disease. Some of these complications (including myocardial infarction and arrhythmia) have been associated with other tricyclic compounds.

Genitourinary reactions: Urinary frequency, acute urinary retention, oliguria with elevated blood pressure, and impotence. Elevation of BUN, albuminuria and glycosuria also have been observed.

Digestive tract: Disturbances associated with Tegretol therapy have included nausea, vomiting, gastric or abdominal discomfort, diarrhoea, anorexia and dryness of the mouth and throat, glossitis and stomatitis.

Eyes: There is no conclusive evidence that Tegretol produces pathological changes in the cornea, lens or retina. However, it should be recognized that many phenothiazines and related drugs have been shown to cause eye changes. By analogy, periodic eye examinations, including slitlamp funduscopy and tonometry, are recommended.

Other reactions reported during treatment with Tegretol include fever and chills, lymphadenopathy, aching joints and muscles, leg cramps and conjunctivitis.

Dosage and Administration

Use in Epilepsy (see Indications): A low initial daily dosage with a gradual increase in dosage is advised. Dosage should be adjusted to the needs of the individual patient.

Adults and Children over 12 years of age: Initially, 100 to 200 mg once or twice a day depending on the severity of the case and previous therapeutic history. The initial dosage is progressively increased, until the best response is obtained, up to 600 mg daily. The usual optimal dosage is 600 mg daily, but occasionally dosage up to 800 to 1000 mg have been used for short periods. As soon as disappearance of seizures has been obtained and maintained, dosage should be reduced very gradually until a minimum effective dose is reached.

Use in trigeminal neuralgia: The initial daily dosage should be small; 200 mg, taken in two doses of 100 mg each is recommended. The total daily dosage can be increased by 200 mg per day until relief of pain is obtained. This is usually achieved at a dosage between 200 and 800 mg daily, but occasionally up to 1200 mg per day may be necessary. As soon as relief of pain has been obtained and maintained, progressive reduction in dosage should be attempted until a minimum effective dosage is reached. Because trigeminal neuralgia is characterized by periods of remission, attempts should be made to reduce or discontinue the use of Tegretol at intervals of not more than 3 months, depending upon the individual clinical course.

Prophylactic use of the drug in trigeminal neuralgia is not recommended.

Tegretol should be taken in two or three divided doses daily, with meals whenever possible.

Dosage Forms

Tegretol is available as a 200 mg white, round, flat bevelled edge single-scored tablet, engraved with Geigy signet.

Availability

Bottles of 50 and 500 tablets. Protect from heat and humidity.

Full information available on request.

Geigy

Mississauga, Ontario
LSN 2W5

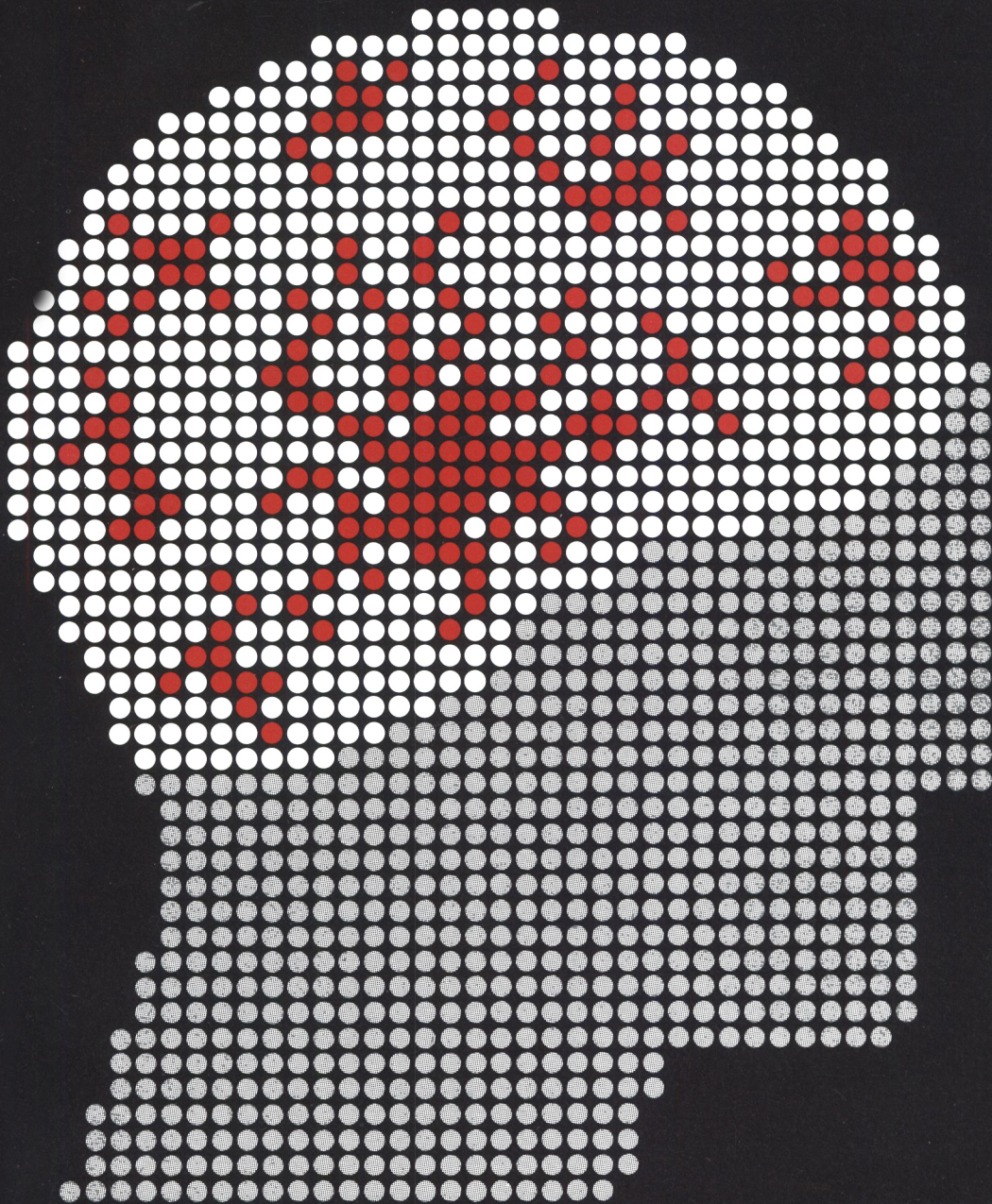
PAAB
CCPP

G-2005

Tegretol[®]

carbamazepine

To help control
refractory generalized
tonic-clonic seizures
without excessive sedation





Spasticity: It can spoil everything

Lioresal[®] (baclofen) helps relieve spasticity resulting from spinal cord injury, multiple sclerosis or other spinal cord diseases.

Lioresal

- facilitates physiotherapy/ rehabilitation²
- improves the outlook for long term management¹
- reduces the risk of troublesome over-sedation¹
- is capable of inhibiting both monosynaptic and polysynaptic reflexes at the spinal cord level³

Lioresal[®]

(baclofen)

**where it acts
could be
why it acts
so well**

Geigy

Dorval, Qué.
H9S 1B1

PAAB
CCPP
G-0018