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JOURNAL COVER

We are investigating different options for the cover of the Journal and thought it might be appropriate to include pictures of major Canadian Cities and/or Universities as taken by our readers.

If you are interested in submitting pictures, please send them to maggie-mccallion@cnsfederation.org in high resolution format, (i.e. tif or jpeg). Please also indicate your willingness to provide these pictures free of charge. Picture ‘acknowledgement’ will be provided.
Join us in Halifax, Nova Scotia for the

44th Annual Congress of the

Canadian Neurological Sciences Federation
Cymbalta® (duloxetine hydrochloride) is indicated for the management of neuropathic pain associated with diabetic peripheral neuropathy (DPN).\(^2\) Cymbalta® is not indicated for use in children under 18 years of age.\(^2\) Rigorous clinical monitoring for suicidal ideation or other indicators of potential for suicidal behaviour is advised in patients of all ages. This includes monitoring for agitation-type emotional and behavioural changes. Please see Prescribing Information for complete warnings.\(^2\) Patients currently taking Cymbalta® should NOT be discontinued abruptly due to risk of discontinuation symptoms. A gradual reduction in the dose is recommended.\(^2\)

Cymbalta® is contraindicated in patients with end-stage renal disease (requiring dialysis) or with severe renal impairment (estimated creatinine clearance <30 mL/min).\(^2\) Cymbalta® is contraindicated in patients with any liver disease resulting in hepatic impairment.\(^2\) Cymbalta® is contraindicated in patients concomitantly taking any of the following medications: monoamine oxidase inhibitors; linezolid or within at least 14 days of discontinuing treatment with an MAOI; potent CYP1A2 inhibitors (e.g. fluvoxamine and some quinolone antibiotics such as ciprofloxacin or enoxacin); and thioridazine.\(^2\)

Because it is possible that duloxetine and alcohol may interact to cause liver injury or that duloxetine may aggravate pre-existing liver disease, Cymbalta should not ordinarily be prescribed to patients with substantial alcohol use. Physicians should be aware of the signs and symptoms of liver damage and should investigate such symptoms promptly.\(^2\)

In clinical trials, Cymbalta® was associated with an increased risk of mydriasis; therefore, it is contraindicated in patients with uncontrolled narrow-angle glaucoma.\(^2\) The most commonly observed adverse events in Cymbalta®-treated patients in placebo-controlled DPN trials (incidence of 5% or greater and at least twice the incidence in placebo patients) were: nausea (24%), constipation (9%), dry mouth (8%), vomiting (5%), fatigue (12%), decreased appetite (10%), somnolence (17%), and hyperhidrosis (9%).\(^2\)

\(^1\) 12-week, multicenter, double-blind study involving 457 patients experiencing pain due to polyneuropathy caused by Type 1 or Type 2 diabetes mellitus. Patients were randomly assigned to treatment with Cymbalta® 20 mg/d (20 mg PO), 60 mg/d (60 mg QD), 120 mg/d (60 mg BID), or placebo. The primary efficacy measure was the weekly mean score of the 24-h Average Pain Score, which was rated on an 11-point (0-10) linear scale (00=least pain, 10=worst possible pain) and computed from diary scores between two site visits. Patients were permitted up to 4 g of acetaminophen per day as needed for pain. In addition to Cymbalta®, a 60 mg twice-daily dosing administration

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**Demonstrated Effective Pain Relief in Diabetic Peripheral Neuropathic Pain (DPNP)**

**Patients with neuropathic pain associated with DPN receiving Cymbalta® demonstrated improvement in the following:**

- **Stabbing pain**
  - Cymbalta® 60 mg vs. placebo (56.0% vs. 39.9%; p<0.05)
  - Cymbalta® 120 mg vs. placebo (64.8% vs. 39.9%; p<0.001)

- **Hot-burning pain**
  - Cymbalta® 60 mg vs. placebo (58.9% vs. 45.2%; p=NS)
  - Cymbalta® 120 mg vs. placebo (62.9% vs. 45.2%; p<0.05)

- **Shooting pain**
  - Cymbalta® 60 mg vs. placebo (53.8% vs. 39.4%; p=NS)
  - Cymbalta® 120 mg vs. placebo (61.9% vs. 39.4%; p<0.001)
AZILECT® (rasagiline mesylate) is indicated for the treatment of the signs and symptoms of idiopathic Parkinson’s disease as initial monotherapy and as adjunct therapy to levodopa.

AZILECT® is contraindicated with meperidine, tramadol, methadone, propoxyphene, dextromethorphan, St. John’s wort, cyclobenzaprine, sympathomimetic amines, antidepressants and other MAO inhibitors. Patients taking AZILECT® should not undergo elective surgery requiring general anesthesia. AZILECT® is contraindicated in patients with pheochromocytoma. AZILECT® may cause hallucinations and as an adjunct to levodopa there is the possibility of increased dyskinesia and postural hypotension. AZILECT® should not be used at daily doses exceeding the maximum recommended (1 mg/day) because of the risks associated with nonselective inhibition of MAO. Patients taking ciprofloxacin and other CYP1A2 inhibitors should use 0.5 mg daily of AZILECT®.

No significant differences in safety profile were observed based on age or gender. Overall, in phase III clinical trials, the long-term safety profile was similar to that observed with shorter duration exposure.

The most commonly observed adverse events that occurred in >5% of patients and were at least 1.5 times the incidence in the placebo group were flu syndrome (5%, 1%), arthralgia (7%, 4%), depression (5%, 2%), dyspepsia (7%, 4%) and falls (5%, 3%) in patients receiving AZILECT® 1 mg as monotherapy; and dyskinesia (18%, 10%), accidental injury (12%, 5%), weight loss (9%, 3%), postural hypotension (9%, 3%), vomiting (7%, 1%), anorexia (5%, 1%), arthralgia (6%, 4%), abdominal pain (5%, 1%), nausea (12%, 6%), constipation (9%, 5%), dry mouth (6%, 3%), rash (6%, 3%), ecchymoses (6%, 3%), somnolence (6%, 4%) and paresthesia (5%, 3%) for AZILECT® 1 mg as adjunct therapy.

1 Comparative clinical significance unknown.

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MAXALT® (rizatriptan benzoate) is indicated for the acute treatment of migraine attacks with or without aura in adults. MAXALT® is not intended for the prophylactic therapy of migraine or for use in the management of hemiplegic, ophthalmoplegic or basilar migraine. Safety and effectiveness of MAXALT® have not been established for cluster headache, which is present in an older, predominantly male population.

MAXALT® is contraindicated in patients with history, symptoms, or signs of ischemic cardiac, cerebrovascular or peripheral vascular syndromes, valvular heart disease or cardiac arrhythmias (especially tachycardias). In addition, patients with other significant underlying cardiovascular diseases should not receive MAXALT®.

MAXALT® is also contraindicated in patients with uncontrolled or severe hypertension.

MAXALT® is contraindicated in co-administration with monoamine oxidase (MAO) inhibitors within 2 weeks after discontinuation of treatment, and within 24 hours of administration of 5-HT, agonists or ergot-type medications. For a complete list of contraindications, please consult the Product Monograph.

The recommended single adult dose is 5 mg. The maximum recommended single dose is 10 mg.

The most common adverse events during treatment with MAXALT® (rizatriptan benzoate) tablets 10 mg were dizziness (8.9%), somnolence (8.4%), asthenia/fatigue (6.9%), nausea (5.7%) and pain/pressure sensation (chest, 3.1%; neck/throat/jaw, 2.5%; upper limb, 1.8%).

The most common adverse events during treatment with MAXALT RPD® (rizatriptan benzoate) wafers 10 mg were dizziness (8.6%), nausea (7.0%), dry mouth (6.0%), somnolence (5.3%), asthenia/fatigue (3.6%), and pain/pressure sensation (chest, 1.7%; neck/throat/jaw, 2.0%; upper limb, 2.0%).

MAXALT RPD® wafers contain phenylalanine (a component of aspartame).

*The wafer will dissolve rapidly and be swallowed with saliva. No liquid is needed to take the wafer. RPD = Rapidly dissolving

References:

BEFORE PRESCRIBING MAXALT®, PLEASE CONSULT THE ENCLOSED PRESCRIBING INFORMATION.

PRODUCT MONOGRAPH AVAILABLE FOR DOWNLOAD AT www.merckfrosst.com

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LYRICA® (pregabalin) is an analgesic indicated for the management of neuropathic pain (NeP) associated with DPN and PHN. LYRICA is contraindicated in patients who are hypersensitive to pregabalin or to any ingredient in the formulation or component of the container.

The most commonly observed adverse events in NeP patients were usually mild to moderate in intensity. Discontinuation rates due to adverse events for LYRICA and placebo, respectively, were 9% and 4% in DPN, 14% and 7% in PHN and 21% and 13% in central NeP.

Dosage reduction is required in patients with renal impairment (creatinine clearance <60 mL/min) as LYRICA is primarily eliminated by renal excretion.

**Powerful Pain Relief**

**Pregabalin: First and only first-line analgesic with a conditional indication in central neuropathic pain**

**Powerful. Fast onset. Sustained relief.**
- Pain relief shown in postherpetic neuralgia (PHN) and central NeP as early as week 1 and demonstrated over 3 months*1-3.
- Improvement shown in pain-related sleep interference in PHN and central NeP as early as week 1 and demonstrated over 3 months*1-4.

**Significant improvement in overall status.**
- Significant improvement demonstrated in patient-reported overall status (Patient Global Impression of Change [PGIC]) in patients with peripheral NeP (diabetic peripheral neuropathy [DPN] or PHN) and central NeP*1-3,5,9.

**References:**
3. Efficacy and tolerability of twice-daily pregabalin for treating pain and related sleep interference in postherpetic neuralgia: a 13-week, parallel-group, double-blind, placebo-controlled study in 368 patients with PHN. *A significant difference in pain reduction was shown over placebo for all doses: 150 mg/day, 300 mg/day, and 600 mg/day (ps0.01, week 1 and 3-13). Sleep interference was improved over all time points (weeks 1 to 13 and endpoint) for all three doses evaluated (ps0.01 vs. placebo). PGIC was reported as (at least minimally) improved by 56.5% and 21.5% of patients in the LYRICA and placebo treatment groups, respectively (ps0.001 for overall LYRICA comparison vs. placebo across “improved,” “unchanged” and “worse” subgroups).
4. A 12-week, multicenter, double-blind, placebo-controlled trial in 380 patients with PHN. A significant difference in pain reduction was shown over placebo for all doses: 150 mg/day, 300 mg/day, and 600 mg/day (ps0.01, week 1 and 3-13). Sleep interference was improved over all time points (weeks 1 to 13 and endpoint) for all three doses evaluated (ps0.01 vs. placebo). PGIC was reported as (at least minimally) improved by 56.5% and 21.5% of patients in the LYRICA and placebo treatment groups, respectively (ps0.001 for overall LYRICA comparison vs. placebo across “improved,” “unchanged” and “worse” subgroups).
5. A 12-week, multicenter, double-blind, placebo-controlled trial of flexible and fixed doses (150-600 mg/day) of LYRICA in patients with peripheral NeP (diabetic peripheral neuropathy) and central NeP*. 6. A 12-week, multicenter, double-blind, placebo-controlled trial of flexible and fixed doses (150-600 mg/day) of LYRICA in patients with peripheral NeP (diabetic peripheral neuropathy) and central NeP*.

**See prescribing summary A-29, A-30.**