INFORMATION FOR AUTHORS SUBMISSION PROCESS

Before submitting a manuscript, please gather the following information:

- All Authors First Names, Middle Names/Initials, Last Names
- Author affiliations/Institutions
- Departments
- Phone and Fax Numbers
- Street Addresses
- E-mail Addresses
- Title and Running Title (you may copy and paste these from your manuscript) YOUR TITLE MUST BE UNDER 80 CHARACTERS (including spaces)

Cover Letter

A cover letter is required and must state that the manuscript has not been published elsewhere, except in abstract form, and is not under simultaneous consideration by another journal.

Once a decision is made by the Editor on your manuscript, the Journal office will send you an Author Release form and a Conflict of Interest form only if your manuscript has been accepted for revision.

Abstracts

For articles that require abstracts either Structured (250 words) or Unstructured (150 words), see website for Manuscript Category specifications.

Articles with structured abstracts should be submitted under conventional headings of introduction, methods and materials, results, discussion, but other headings will be considered if more suitable.

Figures Ideal resolution/Minimum resolution

- Figures/Images in TIF, EPS, PDF, or JPG formats (must follow high resolution formats below)
- Line Bitmap 1200 dpi (ideal) 600 dpi (min)
- Color photo CMYK 300 dpi (ideal) 200 dpi (min)
- B/W halftone (black and white photo) Grayscale 300 dpi (ideal) 200 dpi (min)
- Line/halftone Grayscale 600 dpi (ideal) 200 dpi (min)

Tables

- Tables accepted in DOC format only.
- Type tables double-spaced on pages separate from the text.
- Provide a table number and title for each.
- Particular care should be taken in the preparation of tables to ensure that the data are presented clearly and concisely.
- Each column should have a short or abbreviated heading.
- Place explanatory matter in footnotes, not in the heading.
- Do not submit tables as photographs.

Acknowledgements

Acknowledgements, including recognition of financial support, should be typed on a separate page at the end of the text.

The SI system (système international d'unités) should be used in reporting all laboratory data, even if originally reported in another system.

References

- References should be numbered in the order of their citation in the text. Those cited only in tables and legends for illustrations are numbered according to the sequence established by the first identification in the text of a particular table or illustration.
- Titles of journals should be abbreviated according to the style used in Index Medicus.
- List all authors when there are six or fewer; for seven or more, list only the first three and add "et al".
- Provide the full title, year of publication, volume number and inclusive pagination for journal articles.
- Unpublished articles should be cited as [in press]. Do not reference unpublished or "submitted" papers; these can be mentioned in the body of the text.
- Avoid "personal communications" and, if necessary, include them in the body of the text, not among the references.
- Reference citations should not include unpublished presentations or other non-accessible material.
- Books or chapter references should also include the place of publication and the name of the publisher.

For Uniform Requirements for Sample References go to http://www.nlm.nih.gov/bsd/uniform_requirements.html.

Examples of correct forms of reference:

Journals


Chapter in a book


Permissions and Releases

- Any non-original material (quotations, tables, figures) must be accompanied by written permission from the author and the copyright owner to reproduce the material in the Journal.
- Photographs of recognizable persons must be accompanied by a signed release from the legal guardian or patient authorizing publication.

Conflict of Interest

Authors who have non-scientific or non-academic gain, whether it be financial or other, from publishing their article are responsible for declaring it to the Editor. Any financial interest, research grant, material support, or consulting fee associated with the contents of the manuscript must be declared to the Editor.

These guidelines apply to each author and their immediate families. Conflicts of interest are not necessarily wrong, nor do they necessarily change the scientific validity of research or opinion, but the Journal and readers should be aware of the conflict. If the Editor considers the conflict to compromise the validity of the paper, it will not be accepted for publication.

Authors, editorial staff and reviewers are asked to declare any relationship that would be considered as a conflict of interest whether or not they believe that a conflict actually exists.

Information that the Journal receives about conflict or potential conflict will be kept confidential unless the Editor or Associate Editor considers it to be important to readers. Such conflicts will be published in the author credits or as a footnote to the paper, with knowledge of the authors.
INFORMATION FOR AUTHORS SUBMISSION PROCESS (continued)

For detailed instructions regarding style and layout refer to "Uniform requirements for manuscripts submitted to biomedical journals". Copies of this document may be obtained on the website http://www.icmje.org.

After the manuscript is submitted, you will be asked to select the order you would like the files to be displayed in a merged PDF file that the system will create for you.

Next, you will be directed to a page that will allow you to review your converted manuscript. If the conversion is not correct, you can replace or delete your manuscript files as necessary.

You may also add additional files at this time. After you have reviewed the converted files, you will need to click on "Approve Converted Files." This link will have a red arrow next to it. Throughout the system, red arrows reflect pending action items that you should address.

Getting Help
If you need additional help, you can click on the help signs spread throughout the system. A help dialog will pop up with context-sensitive help.

Manuscript Status
After you approve your manuscript, you are finished with the submission process.

You can access the status of your manuscript at any time via:

- Logging into the AllenTrack system with your password
- Clicking on the link represented by your manuscript tracking number and abbreviated title
- Clicking on the "Check Status" link at the bottom of the displayed page

This procedure will display detailed tracking information about where your manuscript is in the submission/peer-review process.

Manuscript Categories include:
- Review Article*
- Original Article*
- Historical Article*
- Editorial
- Neuroimaging Highlights*
- Critically Appraised Topics (CATs)
- Brief Communications
- Reflections
- Obituary
- Letters to the Editor
- Medical Hypothesis
- Commentary
- Experimental Neuroscience
- Autobiographies (by invitation only)

* preferred Manuscript Category

Starting

The manuscript submission process starts by pressing the "Submit Manuscript" link. Please make sure you have gathered all the required manuscript information listed above BEFORE starting the submission process.

http://cjns.allentrack.net/cgi-bin/main.plex

To view and download General Manuscript Specifications, applicable to all Manuscript Categories, in addition to the specifications of a specific Manuscript Category, please visit http://www.cjns.org and click the "Authors" tab on the right side of the Journal website.

All editorial matter in the Canadian Journal of Neurological Sciences (CJNS) represents the opinions of the authors and not necessarily those of the Canadian Neurological Sciences Federation (CNSF). The CNSF assumes no responsibility or liability for damages arising from any error or omission or from the use of any information or advice contained in the CJNS.

ADVERTISERS INDEX

| CNSF Congress | 2013 Sponsors  | IFC |
| Fraser Health | Careers       | A-3 |
| King Medical  | Medical Supplies | A-7 |
| Teva          | Copaxone      | OBC / A-8, A-9 |
| Toronto Memory Program | Fellowship | A-7 |
Attention Residents - CNSF 2013 Congress News

For 2013, residents that are members of CNSF societies, are being offered an additional $100 discount on Congress registration prior to the early bird deadline. Full Congress registration, which includes all sessions, plus pre-congress on June 11th, only $395 + tax.

Make sure that your member dues are paid prior to registering in order to receive this special rate. Only available to CNSF Junior members and only available until April 30, 2013.

2013 Congress highlights include a Tuesday evening “Resident Career Networking Social”. This is a wine and cheese event, organized by the society resident representatives.

Wednesday features two concurrent, all day, Resident Review courses. “Emergency Neurosurgery” and “Movement Disorders and Parkinson’s Disease”

Program details and course outlines are available under the “Program” tab on our website at http://congress.cnsfederation.org/.

We encourage neurosurgery and neurology residents to participate in our Annual Canadian Congress. It provides the opportunity to network with colleagues and mentors from across the country, creating positive connections for future opportunities.

Join us at the Fairmont Queen Elizabeth in Montreal, June 11-14.

KING MEDICAL

THE CANADIAN ELECTRODE PLACE

- ALPINE BIOMED Mono/Conc. Needles
- AMBU Blue Sensor • Neuroline
- CHALGREN Needles • Bar/Ring/Clip
- KENDALL Adhesive • NuTab
- MAVIDON Lemon Skin Prep
- NIKOMED USA Adhesive Electrodes
- PARKER LAB. Electrode Paste
- TECHNOMED Corkscrew • Mono/Conc.
- 3M CANADA Micropore • Transpore
- VERMED Adhesive Electrodes
- D.O. WEAVER Ten20 • NuPrep

Clavis™ • MyoGuide™ • Chalgren • Inoject™
Large stock of Hypodermic Needles

Tel 905-833-3545   Fax 905-833-3543
E-mail: soren@kingmedical.com
Web Site: www.kingmedical.com

King Medical Ltd.
145 Kingsworth Road
King City • Ontario L7B 1K1

Clinical Trials Investigator Fellowship

Available July 1, 2013

Toronto Memory Program is now accepting applications for the new Pfizer-Alzheimer Society of Ontario Dementia Trial Investigator Fellowship to commence July 1, 2013. This one year fellowship was created to address the need for Qualified Investigators in the field of clinical pharmacological research in dementia and will be of interest to those who wish to be involved in advancing treatment options in dementia. The successful applicant will acquire the practical experience in dementia research and dementia practice to assume the role of Principal Investigator at an independent trial site. The fellowship takes place at Toronto Memory Program, Canada’s largest dementia clinical pharmacological research site.

Supervisor: Dr. Sharon Cohen, Behavioural Neurologist and PI.

The fellowship curriculum includes practical experience with:
- Clinical research regulations, guidelines, standards
- Principal Investigator responsibilities
- Study design; protocol development
- Research contracts, business development
- Clinical trial operations
- Clinical and research diagnostic criteria in dementia
- Standard of care in dementia clinical practice

To apply, applicants must be licensed, or eligible to be licensed, to practice medicine in Ontario and have completed training in any of the following: family medicine, neurology, geriatrics, psychiatry, or internal medicine.

Salary: $70,000 (plus practice generated income)

Interested applicants should send:
- A letter of intent detailing your interest in this fellowship
- Current CV, signed and dated

Applications will remain confidential and can be sent to:
Dr. Sharon Cohen, Toronto Memory Program, 400 - 1 Valleybrook Dr., Toronto, ON M3B 2S7 or by email to: cohen@memorydisorders.ca
COPAXONE®
(glartiramer acetate injection)

Treat from the start. Treat for the long run.

Prescribing Summary

THERAPEUTIC CLASSIFICATION: Immunomodulator

INDICATIONS AND CLINICAL USE

COPAXONE® is indicated for: the treatment of ambulatory patients with Relapsing Remitting Multiple Sclerosis (RRMS), to decrease the frequency of clinical exacerbations, to reduce the number and volume of active brain lesions identified on Magnetic Resonance Imaging (MRI) scans; for the treatment of patients who have experienced a single demyelinating event, accompanied by abnormal MRI scans and are considered to be at risk of developing Clinically Definite MS (CDMS), after alternative diagnoses are excluded, to delay the onset of definite MS, to decrease the number and volume of active brain lesions and overall disease burden (as identified by MRI scans). The safety and efficacy of COPAXONE® in chronic progressive MS have not been established.

CONTRAINDICATIONS

COPAXONE® (glartiramer acetate) is contraindicated in patients with known hypersensitivity to glartiramer acetate or mannitol.

Safety Information

WARNINGS AND PRECAUTIONS

The only recommended route of administration of COPAXONE® (glartiramer acetate) injection is the subcutaneous route. COPAXONE® should not be administered by the intravenous route.

Cardiovascular: Symptoms of Potentially Cardiac Origin: Approximately 13% of COPAXONE® patients in the multicenter controlled trials (compared to 5% of placebo patients) experienced at least one episode of what was described as transient chest pain (see ADVERSE REACTIONS: Chest Pain). While some of these episodes occurred in the context of the Immediate Post-Injection Reaction (see ADVERSE REACTIONS: Immediate Post-Injection Reaction), many did not. The pathogenesis of this symptom is unknown. Patients in controlled clinical trials were free of significant cardiovascular problems (New York Heart Association Class I and II) and thus the risks associated with COPAXONE® treatment for Multiple Sclerosis patients with cardiovascular disease are unknown. COPAXONE® has been associated with an Immediate Post-Injection Reaction consisting of a constellation of episodes occurring immediately after injection that can include feelings of intense cold, flushing, chest pain, palpitations, anxiety, dyspnea, constriction of the throat and urticaria (individual symptoms may be present).

In the 4 placebo-controlled studies reported a post-injection reaction immediately following subcutaneous administration of COPAXONE® patients. Whether these episodes are mediated by an immunologic or non-immunologic mechanism, and whether several similar episodes seen in the given patient have identical mechanisms is unknown. In fact, whether or not this constellation of symptoms actually represents a specific syndrome is unknown. During the postmarketing period, there have been reports of patients with similar symptoms who received emergency medical care (see WARNINGS AND PRECAUTIONS: Symptoms of Potentially Cardiac Origin).

Chest Pains: Approximately 13% of glartiramer acetate patients in the 4 placebo-controlled studies (compared to 5% of placebo patients) experienced at least one episode of what was described as transient chest pain. While some of these episodes occurred in the context of the Immediate Post-Injection Reaction described above, many did not. The pathogenesis of this symptom is unknown. Patients in controlled clinical trials were free of significant cardiovascular problems (New York Heart Association Class I and II) and thus the risks associated with COPAXONE® treatment for Multiple Sclerosis patients with cardiovascular disease are unknown. COPAXONE® has been associated with an Immediate Post-Injection Reaction consisting of a constellation of episodes occurring immediately after injection that can include feelings of intense cold, flushing, chest pain, palpitations, anxiety, dyspnea, constriction of the throat and urticaria (individual symptoms may be present). COPAXONE® is indicated for: the treatment of ambulatory patients with Relapsing Remitting Multiple Sclerosis (RRMS), to decrease the frequency of clinical exacerbations, to reduce the number and volume of active brain lesions identified on Magnetic Resonance Imaging (MRI) scans; for the treatment of patients who have experienced a single demyelinating event, accompanied by abnormal MRI scans and are considered to be at risk of developing Clinically Definite MS (CDMS), after alternative diagnoses are excluded, to delay the onset of definite MS, to decrease the number and volume of active brain lesions and overall disease burden (as identified by MRI scans). The safety and efficacy of COPAXONE® in chronic progressive MS have not been established.

with its use. Whether COPAXONE® can alter normal human immune responses, such as the recognition of foreign antigens is unknown. It is therefore possible that treatment with COPAXONE® may undermine the body’s defenses against infections and tumor surveillance. Systematic assessments of these risks have not been done. Continued alteration of cellular immunity due to chronic treatment with glartiramer acetate might result in unfavorable effects.

COPAXONE®-reactive antibodies in patients with impaired renal function have not been determined. COPAXONE® has not been studied in patients with a history of severe anaphylactoid reactions, obstructive pulmonary disease, or diabetes mellitus.

COPAXONE® has not been studied in patients with a history of severe anaphylactoid reactions, obstructive pulmonary disease, or diabetes mellitus.

Safety Information

COPAXONE® is indicated for: the treatment of ambulatory patients with Relapsing Remitting Multiple Sclerosis (RRMS), to decrease the frequency of clinical exacerbations, to reduce the number and volume of active brain lesions identified on Magnetic Resonance Imaging (MRI) scans; for the treatment of patients who have experienced a single demyelinating event, accompanied by abnormal MRI scans and are considered to be at risk of developing Clinically Definite MS (CDMS), after alternative diagnoses are excluded, to delay the onset of definite MS, to decrease the number and volume of active brain lesions and overall disease burden (as identified by MRI scans). The safety and efficacy of COPAXONE® in chronic progressive MS have not been established.

with its use. Whether COPAXONE® can alter normal human immune responses, such as the recognition of foreign antigens is unknown. It is therefore possible that treatment with COPAXONE® may undermine the body’s defenses against infections and tumor surveillance. Systematic assessments of these risks have not been done. Continued alteration of cellular immunity due to chronic treatment with glartiramer acetate might result in unfavorable effects.

COPAXONE®-reactive antibodies in patients with impaired renal function have not been determined. COPAXONE® has not been studied in patients with a history of severe anaphylactoid reactions, obstructive pulmonary disease, or diabetes mellitus.

COPAXONE® has not been studied in patients with a history of severe anaphylactoid reactions, obstructive pulmonary disease, or diabetes mellitus.
Because clinical trials are conducted under very specific conditions, the adverse event rates obtained in the clinical trials may not reflect the rates observed in practice. Adverse drug reaction information from clinical trials is useful for identifying drug-related adverse events and for approximating rates. The adverse reaction data in this section is derived from 4 pivotal, double-blind, placebo-controlled clinical trials which were conducted during premarketing and post-marketing periods in a total of 517 patients treated with glatiramer acetate and 567 patients treated with placebo for up to 3 years. These trials were conducted in 1985.

The fourth trial was in patients presenting with relapsing-remitting disease and who were given 20 mg of glatiramer acetate and 238 patients treated with placebo. All adverse events were recorded by the clinical investigators, using terminology of their own choosing. To provide a meaningful estimate of the proportion of individuals having adverse events, similar types of events were grouped into standard categories using MedDRA dictionary terminology. The following table lists treatment-emergent adverse events that occurred at least as common in patients treated with glatiramer acetate as in the placebo-controlled trials. These signs and symptoms were normally more common in patients treated with glatiramer acetate than in patients treated with placebo.

Table 1: Controlled Trials – Incidence of Glatiramer Acetate Adverse Reactions (≥2% and More Frequent than Placebo)

<table>
<thead>
<tr>
<th>MedDRA Version 10.3</th>
<th>GA 20 mg (n=517)</th>
<th>Placebo (n=509)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Blood and Lymphatic System Disorders</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lymphophagia</td>
<td>3.2</td>
<td>2.9</td>
</tr>
<tr>
<td><strong>Cardiovascular Disorders</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polymyositis</td>
<td>7.6</td>
<td>3.3</td>
</tr>
<tr>
<td>Tachycardia</td>
<td>4.7</td>
<td>1.6</td>
</tr>
<tr>
<td><strong>Eye Disorders</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye Disorder</td>
<td>3.3</td>
<td>1.2</td>
</tr>
<tr>
<td>Diplopia</td>
<td>2.9</td>
<td>1.8</td>
</tr>
<tr>
<td><strong>Gastrointestinal Disorders</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nausea</td>
<td>14.5</td>
<td>10.4</td>
</tr>
<tr>
<td>Vomiting</td>
<td>7.4</td>
<td>4.3</td>
</tr>
<tr>
<td>Constipation</td>
<td>7.0</td>
<td>6.3</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>6.4</td>
<td>6.5</td>
</tr>
<tr>
<td>Diaphoresis</td>
<td>2.2</td>
<td>1.7</td>
</tr>
<tr>
<td>Oedema</td>
<td>2.2</td>
<td>2.0</td>
</tr>
<tr>
<td><strong>General Disorders and Administration Site Conditions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injection-Site Hypersensitivity</td>
<td>46.1</td>
<td>10.6</td>
</tr>
<tr>
<td>Injection-Site Pain</td>
<td>36.3</td>
<td>17.1</td>
</tr>
<tr>
<td>Injection-Site Mass</td>
<td>25.8</td>
<td>5.9</td>
</tr>
<tr>
<td>Injection-Site Pruritus</td>
<td>24.4</td>
<td>2.8</td>
</tr>
<tr>
<td>Arthrosis</td>
<td>23.9</td>
<td>23.2</td>
</tr>
<tr>
<td>Injection-Site Edema</td>
<td>20.9</td>
<td>4.5</td>
</tr>
<tr>
<td>Pain</td>
<td>18.9</td>
<td>16.7</td>
</tr>
<tr>
<td>Chills</td>
<td>12.5</td>
<td>4.9</td>
</tr>
<tr>
<td>Injection-Site Inflammation</td>
<td>8.3</td>
<td>7.6</td>
</tr>
<tr>
<td>Injection-Site Reaction</td>
<td>8.3</td>
<td>1.4</td>
</tr>
<tr>
<td>Pyrexia</td>
<td>6.4</td>
<td>5.7</td>
</tr>
<tr>
<td>Injection-Site Hypersensitivity</td>
<td>6.1</td>
<td>4.0</td>
</tr>
<tr>
<td>Local Reactions</td>
<td>3.7</td>
<td>1.4</td>
</tr>
<tr>
<td>Fever</td>
<td>3.3</td>
<td>0.6</td>
</tr>
<tr>
<td>Edema Pauca</td>
<td>3.3</td>
<td>2.4</td>
</tr>
<tr>
<td>Chills</td>
<td>2.9</td>
<td>0.4</td>
</tr>
<tr>
<td>Injection-Site Itchiness</td>
<td>2.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Injection-Site Fibrosis</td>
<td>2.0</td>
<td>0.6</td>
</tr>
<tr>
<td><strong>Immunologic System Disorders</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypersensitivity</td>
<td>3.3</td>
<td>1.8</td>
</tr>
<tr>
<td><strong>Infections and Infections</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infection</td>
<td>31.8</td>
<td>30.0</td>
</tr>
<tr>
<td>Influenza</td>
<td>15.4</td>
<td>14.5</td>
</tr>
<tr>
<td>Rhinitis</td>
<td>7.4</td>
<td>5.9</td>
</tr>
<tr>
<td>Bronchitis</td>
<td>6.4</td>
<td>5.7</td>
</tr>
<tr>
<td>Gastroenteritis</td>
<td>6.3</td>
<td>4.3</td>
</tr>
<tr>
<td>Vaginal Candidiasis</td>
<td>4.9</td>
<td>2.6</td>
</tr>
<tr>
<td>Otitis Media</td>
<td>3.7</td>
<td>2.9</td>
</tr>
<tr>
<td>Herpes Zoster</td>
<td>2.5</td>
<td>1.8</td>
</tr>
<tr>
<td>Tooth Abscess</td>
<td>2.3</td>
<td>2.2</td>
</tr>
<tr>
<td><strong>Metabolism and Nutrition Disorders</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight Increased</td>
<td>2.9</td>
<td>0.8</td>
</tr>
<tr>
<td>Anorexia</td>
<td>2.3</td>
<td>2.2</td>
</tr>
<tr>
<td><strong>Musculoskeletal and Connective Tissue Disorders</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Back Pain</td>
<td>13.5</td>
<td>11.2</td>
</tr>
<tr>
<td>Arthritis</td>
<td>10.4</td>
<td></td>
</tr>
<tr>
<td>Neck Pain</td>
<td>4.5</td>
<td>3.9</td>
</tr>
</tbody>
</table>

Data on adverse events occurring in the controlled clinical trials were analyzed to evaluate gender-related differences. No clinically significant differences were identified. In one clinical trial 95% of patients were Caucasian. This percentage reflects the higher representation of Caucasians in the MS population, even though it does not reflect the exact world-wide racial distribution among MS patients. In addition, the vast majority of patients treated with CONDEA* were between the age of 18 to 45 years. Consequently, inadequate data are available to perform an analysis of the incidence of adverse events related to distinct racial or ethnic subgroups. Laboratory analyses were performed on all patients participating in the clinical program for CONDEA*. Clinically significant changes in laboratory values for hematology, chemistry and urinalysis were noted in both CONDEA* and placebo groups in clinical trials. No patient receiving CONDEA* withdrew because of laboratory findings which were only slightly related to treatment.
2013 Canadian Neurological Sciences Federation Annual Congress
June 12-14, 2013 • Fairmont Queen Elizabeth Hotel, Montreal, Quebec

Pre-Congress June 11, 2013 *SIG - Special Interest Groups

Tuesday, June 11, 2013

9:00 am - 5:00 pm Epilepsy (UCB)
Martin del Campo

6:00 pm - 8:00 pm Neurocritical Care-Brain Death Workshop SIG
Jeanne Teitelbaum, Draga Jichici

6:00 pm - 8:00 pm Movement Disorders SIG
David Grimes, Oksana Suchowersky

6:00 pm - 8:00 pm Epilepsy Video SIG
Seyed Mirtassari

6:00 pm - 8:00 pm Headache: Migraine & Friends SIG
Elizabeth Leroux

6:00 pm - 8:00 pm Neuromuscular SIG
Mike Nicolle, Kristine Chapman

Wednesday, June 12, 2013

9:00 am - 5:00 pm Neurosurgery Residents: Emergency Neurosurgery
Max Findlay, Roberto Diaz

9:00 am - 5:00 pm Neurology Residents: Movement Disorders and Parkinson’s Disease
Pierre J. Blanchet, Nailyn Rasool, Serena Orr

9:00 am - 12:00 pm Stroke
Alex Poppe, Sylvain Lanthier

9:00 am - 12:00 pm Hot Topics in Child Neurology
Asif Doja

9:00 am - 12:00 pm Minimally Invasive Neurosurgery
Kesh Reddy

12:15 pm - 1:45 pm Co-Developed Symposium TBD
Sian Spacey

12:15 pm - 1:45 pm Scotiabank Lunch n’ Learn TBD
Mike Nicolle, Kristine Chapman

2:00 pm - 5:00 pm Headache
Jeanne Teitelbaum, Draga Jichici

2:00 pm - 5:00 pm Neuromuscular

2:00 pm - 5:00 pm Neurocritical Care

5:00 pm - 7:30 pm Exhibitors’ Reception

Thursday, June 13, 2013

8:30 am - 11:00 am Grand Plenary
Michelle Demos, Craig Campbell

11:15 am - 12:15 pm Child Neurology Day: CACN Abstract
Michelle Demos, Craig Campbell

11:15 am - 12:15 pm CNS Abstract
Jorge Burneo

11:15 am - 12:15 pm CNS/ CSCN Abstract
Seyed Mirtassari

12:15 pm - 1:45 pm Co-Developed TBA
Eric Massicotte

12:15 pm - 1:45 pm Lunch n’ Learn
Peter Dirks

2:00 pm - 5:00 pm Canadian Neurosurgical Innovations & Discoveries
Brian Toyota

2:00 pm - 5:00 pm Child Neurology Day
Michelle Demos, Craig Campbell

2:00 pm - 5:00 pm Epilepsy
Jorge Burneo

2:00 pm - 5:00 pm EEG
Seyed Mirtassari

2:00 pm - 5:00 pm MASS: Minimal Access Spine Surgery
Eric Massicotte

2:00 pm - 5:00 pm Promises of Stem Cells in the Neurosciences
Peter Dirks

5:00 pm - 6:30 pm Digital Poster Author Standby

Friday, June 14, 2013

8:00 am - 11:00 am Platform Sessions

11:15 am - 1:00 pm Grand Rounds

1:00 pm - 2:15 pm Digital Poster Author Standby

2:15 pm - 5:15 pm Difficult Cases in Neurosurgery

2:15 pm - 5:15 pm Multiple Sclerosis

2:15 pm - 5:15 pm Neurovascular & Interventional Neuroradiology

2:15 pm - 5:15 pm Genetics of Neurological & Neuro Degenerative Syndromes

2:15 pm - 5:15 pm Neuro-Opthalmology

Joseph Megyesi

Paul Giacomini, Catherine Larochelle

Gary Redekop

Matt Farrer

Jason Barton
COPAXONE®

PATIENT EXPERIENCE DATA

15 YEARS
USE IN CLINICAL PRACTICE IN CANADA

OVER 1 MILLION
PATIENT-YEARS OF EXPERIENCE WORLDWIDE

COPAXONE® is indicated for the treatment of ambulatory patients with Relapsing Remitting Multiple Sclerosis (RRMS) to decrease the frequency of clinical exacerbations, to reduce the number and volume of active brain lesions identified on Magnetic Resonance Imaging (MRI).

COPAXONE® is indicated for the treatment of patients who have experienced a single demyelinating event, accompanied by abnormal MRI scans, and are considered to be at risk of developing Clinically Definite MS (CDMS), after alternative diagnoses are excluded: to delay the onset of definite MS; to decrease the number and volume of active brain lesions and overall disease burden (as identified by MRI scans).

The safety and efficacy of COPAXONE® in chronic progressive MS have not been established. In placebo-controlled clinical trials, the most commonly observed adverse events associated with the use of COPAXONE® occurring at an incidence of at least 10% and at least 1.5 times higher than in placebo treated patients were: injection site reactions, vasodilatation, rash, dyspnea and chest pain.