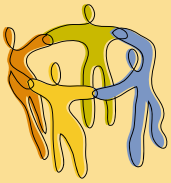
What can a child with ADHD **learn** this weekend?

He has friends.

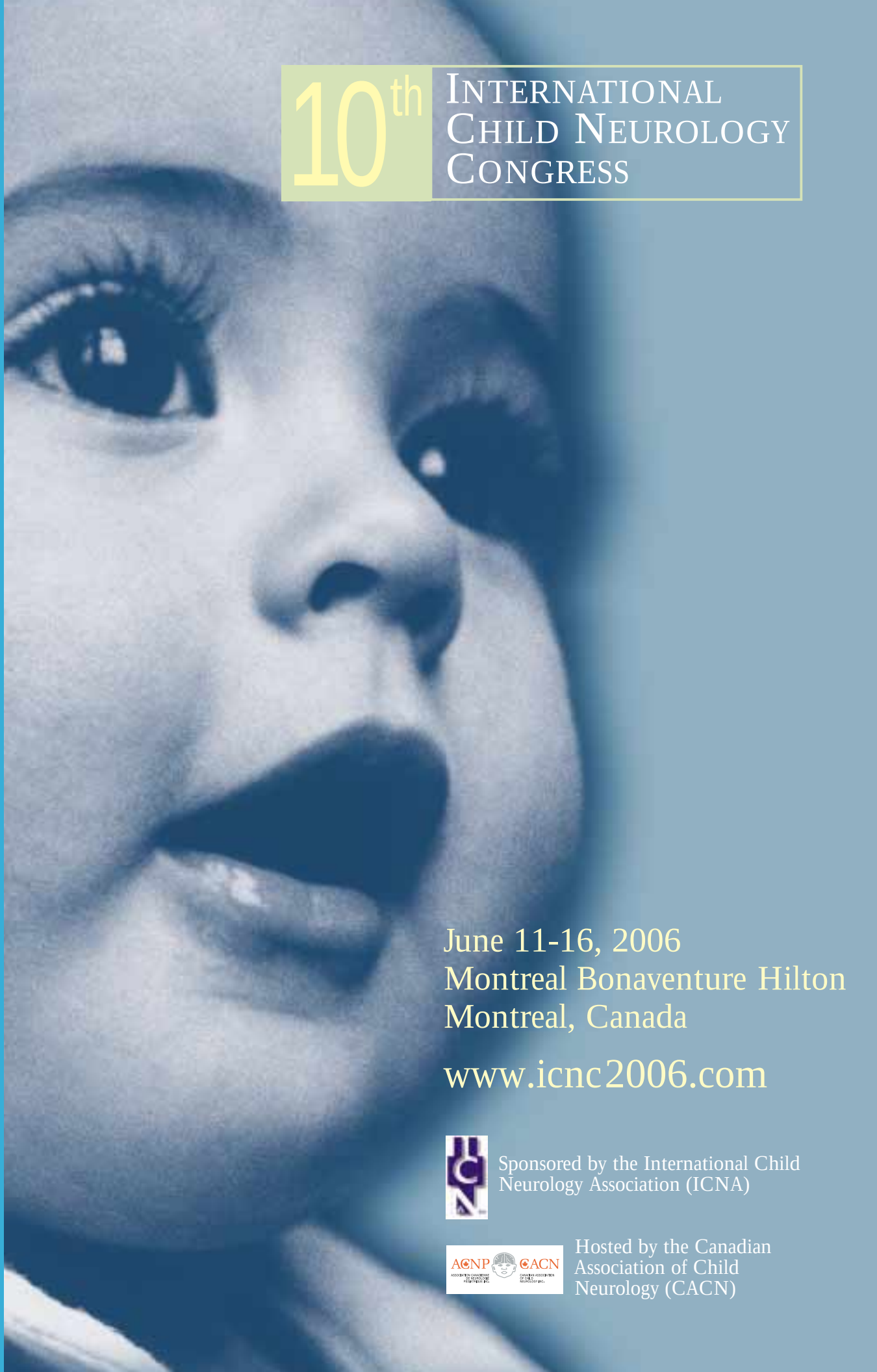
Life is a continuous classroom—one more reason Lilly is exploring new approaches to ADHD care.



Lilly

Answers That Matter.

SECOND ANNOUNCEMENT



10th International Child Neurology Congress

June 11-16, 2006
Montreal Bonaventure Hilton
Montreal, Canada

www.icnc2006.com

Sponsored by the International Child Neurology Association (ICNA)

Hosted by the Canadian Association of Child Neurology (CACN)

Have you heard of...

POMPE DISEASE?

(also called **Glycogen Storage Disease Type II or Acid Maltase Deficiency**)

A CONTINUUM OF CLINICAL PHENOTYPES

- A continuous spectrum of disease, ranging from a rapidly progressive, fatal, infantile-onset form to a steadily progressive, debilitating, late-onset form
- Inherited muscle disease caused by an absence or deficiency of the lysosomal enzyme acid alpha glucosidase (GAA)
- Characterized by muscle weakness, delayed motor development/loss of motor milestones, and progression to cardiac and respiratory failure

	Infantile-onset	Late-onset
Clinical Features	■ Cardiomegaly/ cardiomyopathy ■ Severe hypotonia/weakness ■ "Floppy baby" appearance	■ Proximal muscle weakness — Predominant involvement of lower limbs ■ Progression to respiratory insufficiency
Prognosis	■ Death typically in 1st year of life due to cardiac and respiratory failure	■ Respiratory failure leading to premature death

Gene for acid α-glucosidase located on long arm of Chromosome 17 (17q).

Skeletal muscle biopsy showing glycogen accumulation.

Infant with characteristic "floppy baby" appearance.

www.pompe.com

genzyme

Reference: Hirschhorn R, Reuser AJJ. Glycogen storage disease type II: acid α-glucosidase (acid maltase) deficiency. In: Scriver CR, Beaudet A, Sly WS, Valle D, eds. *The Metabolic and Molecular Bases of Inherited Disease*. 8th ed. New York, NY: McGraw-Hill; 2001:3389-3420.

JANSSEN-ORTHO Inc.

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- Advancing Treatment of ADHD

- *Aider les enfants à réaliser leur plein potentiel*
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19 Green Belt Drive, Toronto, Ontario M3C 1L9

MESSAGES FROM THE ICNA PRESIDENT AND THE ICNC 2006 CHAIRMAN

On behalf of the Executive Board of ICNA, it is my great pleasure to invite you to participate in the 10th International Child Neurology Congress to be held from June 11-16, 2006 in Montreal, Canada.

Clinical and basic research in child neurology has rapidly developed in the last few years and I strongly believe that in this century, we will move closer to our collective goal – as expressed in the ICNA constitution – which is to improve and upgrade the worldwide care for children affected by neurological diseases.

The Congress is designed to present an update in the diagnosis and management of diseases of the nervous system in children, and demonstrate the dramatic progress achieved in our field. This gathering of pediatric neurologists and other related medical and scientific professionals from all over the world is a unique opportunity to disseminate knowledge and share personal experiences.

The 9th ICNA Congress in Beijing was a great success in all aspects of the meeting. Montreal will be our host city in 2006 and we are fortunate to gather in such a charming and delightful location.

With your active participation, I am sure that this 10th Congress will be an even greater success.

I look forward to seeing you at the meeting.

Professor Paolo Curatolo, MD
President, International Child Neurology Association (ICNA)

On behalf of the Organizing Committee of the 10th World Congress of the International Child Neurology Association, I would like to invite all those with a professional interest in pediatric neurological disorders to attend the Congress in June 2006 here in Montreal.

Close to 1000 health professionals are expected to attend this premier international gathering in pediatric neuroscience.

The Organizing Committee has worked hard to provide a scientific programme that addresses the extensive breadth of pediatric neurology. Leading experts have assumed responsibility for the content of over 30 symposia that will provide you with cutting edge scientific information that will make a difference in the care provided to the child with a neurological disorder. Attendees will have ample opportunities to present their own work in either open platform or poster formats.

The Organizing Committee has also labored to provide a first rate social programme that will compliment the extensive exchange of scientific information and provide the attendee with a balanced Congress experience.

Proudly bilingual and multi-cultural, Montreal has an extensive tradition of hosting international events. Its French heritage and flavor make it distinct from any other North American city.

I look forward to hosting you all in Montreal in June 2006.

Michael Shevell, MD, CM, FRCP
Chairman, ICNC 2006

10th International Child Neurology Congress

IMPORTANT DATES TO REMEMBER:

Early bird registration deadline:
OCTOBER 31, 2005

Abstract submission deadline:
NOVEMBER 1, 2005

SCIENTIFIC DAILY PROGRAMME

www.icnc2006.com

ABSTRACT SUBMISSION DEADLINE: NOVEMBER 1, 2005

The ICNC 2006 Scientific Committee welcomes the submission of abstracts for presentation as oral presentations and posters. Abstracts will be selected on the basis of scientific merit.

SUBMISSION PROCEDURES

Authors must submit abstracts online at **www.icnc2006.com**. Please direct any questions to: **icnc2006@eventsintl.com**. **Please note that only electronic submissions will be accepted.**

GENERAL POLICIES

- Authors are permitted to submit a maximum of two (2) abstracts as presenting author. There is no limit on co-authors.
- The abstracts must be submitted in English.
- Notifications of acceptance will be sent to presenting authors in February 2006. Scheduling details and instructions for oral and poster presentations will be included with this correspondence.
- Authors whose abstracts are accepted MUST register for the Congress by March 1, 2006. Failure to do so will result in exclusion from the meeting's final programme.
- Only the name of the presenting author will appear in the meeting's final programme.
- Submissions not conforming to established guidelines will not be reviewed.
- All accepted abstracts will be published in the Congress abstract book.

ABSTRACT CONTENT

- Objective – briefly describes the purpose of the investigation.
- Methods – describes the materials or subjects, as well as the imaging protocols and other methods; outlines in detail any statistical analysis if appropriate.
- Results – confirms or refutes the hypothesis, supported by statistics if appropriate.
- Conclusions – describes relevance of findings, presents limitations of the statistics and other methods, and emphasizes the important outcomes of the study. Abstracts stating merely that the results will be presented or discussed are considered uninformative and will be subject to rejection.

ABSTRACT FORMAT

- Entire abstract (including title, authors and affiliation) must not exceed 300 words.
- Abstracts must be typed no smaller than a font size of 10 points.
- Abstract title must be in CAPITAL letters. Do not indent. Title should be concise and indicate the content of the abstract.
- Author and co-author names, institutions, cities and countries are to be typed under the title. Initials should always precede the family name (i.e., J. Brown, A. Gonzalez). Underline the name of the presenting author. Each author should be listed by institution, city, state and country. Do not include degrees or professional titles (Dr., PhD, Prof., MD, etc.).
- Leave one line space between the title/author block and the body of the abstract.
- Abstract text must be single-spaced. Do not leave blank lines between paragraphs.
- The headings Objective, Methods, Results and Conclusions must be bolded and followed by a colon (:). Text must follow immediately after.
- Neither graphs, pictures nor other types of images should be included in abstracts. Should you need to add tables, please embed them in the text, even if they were created using other software applications.
- Use standard abbreviations. Place special or unusual abbreviations in parentheses after the full term the first time it appears.
- Do not include references, credits or grant support.

ABSTRACT CATEGORIES

1. Fetal & Neonatal Neurology
2. Epilepsy
3. Headaches
4. Behavioural Neurology
5. Autism
6. Neurodevelopmental Disabilities and Cerebral Palsy
7. Neuromuscular
8. Movement Disorders
9. CNS Infections
10. Neurology in the Developing World
11. Neurogenetics
12. Neuroimaging
13. Neuroepidemiology
14. Neurorehabilitation
15. Outcomes in Child Neurology
16. Neuropharmacology
17. Neurooncology
18. History and Ethics of Child Neurology
19. Cognitive Neurology
    (including Attention & Learning Disorders)

ABSTRACT SAMPLE

CLINICAL DISORDERS OF BRAIN PLASTICITY
M.V. Johnston
Kennedy Krieger Institute and Johns Hopkins
University School of Medicine, Baltimore, MD, USA

Objectives: ……
Methods: ……..
Results: ……..
Conclusions: ……

PLENARY SPEAKERS

Leon Epstein, USA	Preventing & Curing CNS Infections	**Monday, June 12th**
Karin B. Nelson, USA	New Insights into the Causes of Cerebral Palsy	**Tuesday, June 13th**
Victor Dubowitz, United Kingdom	Therapeutic Innovations in the Neuromuscular Disorders	**Wednesday, June 14th**
Robert Zimmerman, USA	Current Status & Future Challenges in Fetal & Neonatal Neuro-imaging	**Thursday, June 15th**
Shunsuke Ohtahara, Japan	Frank Ford Memorial Lecture: Age-dependent Epileptic Encephalopathy. A Contribution to Modern Epileptology	**Thursday, June 15th**
Takao Takahashi, Japan	Neocortical Histogenesis & Pediatric Higher Cortical Functioning	**Friday, June 16th**

ACKNOWLEDGEMENT

We gratefully acknowledge the generous support of McGill University and its Faculty of Medicine in providing McGill Travel Awards for this Congress.

MORE INFORMATION AND APPLICATION DETAILS CAN BE OBTAINED BY VISITING THE SCIENTIFIC PROGRAMME PAGE ON THE CONGRESS WEBSITE AT:

www.icnc2006.com

CONTINUING MEDICAL EDUCATION (CME)

The ICNC 2006 Scientific Programme Committee is applying for CME credits and will confirm which accrediting body will offer Continuing Medical Education credits for physicians and nurses. Information will be posted on the Congress website www.icnc2006.com.

PROGRAMME-AT-A-GLANCE

TIME	SUNDAY JUNE 11TH	MONDAY JUNE 12TH	TUESDAY JUNE 13TH
8:00 - 8:45		Plenary: Preventing & Curing CNS Infections	Plenary: New Insights into the Causes of Cerebral Palsy
8:45 - 9:30		Coffee & Poster Viewing	Coffee & Poster Viewing
9:30 - 11:30		Concurrent Symposia	Concurrent Symposia
		Ischemic Stroke in Infants and Children: Updates from the Field	Traumatic Brain Injury
		Infections of the Central Nervous System	Neurometabolic Disorders
		Pediatric Neurotransmitter Diseases	Developmental Neuroblast Migratory Disorders
		Congenital Myopathies and Muscular Dystrophies	Advances in Cerebral Palsy
		Medical & Surgical Treatment of Epilepsy	Advances in Childhood Peripheral Neuropathies
		Myelin	Genetic Basis of our Understanding of Epileptic Syndromes
11:30 - 14:00		(12:00-13:30) Sponsored Symposia-SHS North America	(12:00-13:30) Sponsored Symposia-UCB / Janssen-Ortho
14:00 - 15:30		Platform Presentations	Platform Presentations
15:30 - 16:15		Coffee & Poster Viewing	Coffee & Poster Viewing
16:15 - 17:00		Prichard Memorial Lecture	General Assembly
17:00 - 18:00		Special Interest Groups	Special Interest Groups
19:00	Opening Ceremony/ Reception (17:30-19:00)	Open Evening	Classical Concert

PROGRAMME-AT-A-GLANCE

TIME	WEDNESDAY JUNE 14TH	THURSDAY JUNE 15TH	FRIDAY JUNE 16TH
8:00 - 8:45	Plenary: Therapeutic Innovations in the Neuromuscular Disorders	Plenary: Current Status & Future Challenges in Fetal & Neonatal Neuro - Imaging	Plenary: Neocortical Histogenesis - Initial Steps towards Acquiring Higher Cortical Functioning
8:45 - 9:30	Coffee & Poster Viewing	Coffee & Poster Viewing	Coffee & Poster Viewing
9:30 - 11:30	Concurrent Symposia	Concurrent Symposia	Concurrent Symposia
	Neuroinformatics & Technology in Child Neurology	Updates in Pediatric Neurosurgery	Ethical Issues in Child Neurology
	Neuroimmunology	Neonatal Brain Injury	Genetic Diagnosis of Neurological Conditions
	Complementary/Alternative Medicine	Channelopathies and Generalized Seizures	Revisiting the Cerebellum: From Structure to Function
	Myaesthenia and Myaesthenic Syndromes	Cognitive Neuroscience in Childhood	Neurologic Basis of Autism
	Developmental Delay/Mental Retardation	Movement Disorders: Stereotypies	Neuroprotection
	Neuro-oncology	Global Burden of Neurologic Diseases in Children	Headaches
11:30 - 14:00		(12:00-13:30) Sponsored Symposia - Eli Lilly and Company/Genzyme Corp.	
14:00 - 15:30		CACN Symposium: Epileptic Encephalopathies in Infancy and Childhood (14:00-16:00)	
	Open Afternoon/Evening Family Forums (15:00-17:00)	Platform Presentations	
15:30 - 16:15		Coffee & Poster Viewing	
16:15 - 17:00		Frank Ford Memorial Lecture: Age-dependent Epileptic Encephalopathy. A Contribution to Modern Epileptology	
17:00 - 18:00		Special Interest Groups	
19:00		Party	

CONCURRENT SYMPOSIA TOPICS & ORGANIZERS

MONDAY, JUNE 12TH

Myelin	Hugo Moser, United States
Medical & Surgical Treatment of Epilepsy	Raili Riikonen, Finland
Congenital Myopathies and Muscular Dystrophies	Francesco Muntoni, United Kingdom
Pediatric Neurotransmitter Diseases	Masaya Segawa, Japan
Infections of the Central Nervous System	Charles R.J.C. Newton, Kenya
Ischemic Stroke in Infants and Children: Updates from the Field	Gabrielle DeVeber, Canada

TUESDAY, JUNE 13TH

Epilepsy Syndromes	Frederick Andermann, Canada
Advances in Childhood Peripheral Neuropathies	Robert Ouvrier, Australia
Advances in Cerebral Palsy	Peter Baxter, United Kingdom
Developmental Neuroblast Migratory Disorders	Paolo Curatolo, Italy
Neurometabolic Disorders	Ingrid Tein, Canada
Traumatic Brain Injury	Daune L. MacGregor, Canada

WEDNESDAY, JUNE 14TH

Neuro-oncology	Sergio Rosemberg, Brazil
Developmental Delay/ Mental Retardation	Michael Shevell, Canada
Myaesthenia and Myaesthenic Syndromes	Hugo A. Arroyo, Argentina
Complimentary/ Alternative Medicine	Virginia Wong, P.R. China
Neuroimmunology	Harvey Singer, United States
Neuroinformatics and Technology in Child Neurology	David A. Stumpf, United States

THURSDAY, JUNE 15TH

Global Burden of Neurologic Disease in Children	Karin B. Nelson, United States
Stereotypies	Emilio Fernandez Alvarez, Spain
Cognitive Neuroscience in Childhood	Lieven Lagae, Belgium
Channelopathies and Generalized Seizures	Massimo Avoli, Canada
Neonatal Brain Injury	Donna M. Ferriero, United States
Updates in Pediatric Neurosurgery	Shlomi Constantini, Israel
CACN Symposium: Epileptic Encephalopathies in Infancy and Childhood	Elaine Wirrell, Canada

FRIDAY, JUNE 16TH

Headaches	Kenneth Mack, United States
Neuroprotection	Michael V. Johnston, United States
Autism	Isabelle Rapin, United States
Revisiting Cerebellum: From Structure to Function	Catherine Limperopoulos, Canada
Genetic Diagnosis of Neurological Conditions	Alan K. Percy, United States
Ethical Issues in Child Neurology	Stephen Ashwal, United States

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DAILY PROGRAMME

MONDAY, JUNE 12TH

08:00-08:45 **PLENARY SESSION**

PREVENTING & CURING CNS INFECTIONS

Leon G. Epstein, Northwestern University, Chicago, IL, United States

09:30-11:30 **CONCURRENT SYMPOSIA**

ISCHEMIC STROKE IN INFANTS AND CHILDREN: UPDATES FROM THE FIELD

Co-Chairs
Gabrielle DeVeber, Hospital for Sick Children, Toronto, ON, Canada
Donna M. Ferriero, University California San Francisco, San Francisco, CA, United States

09:30-10:00 **Insights from the Canadian Pediatric Ischemic Stroke Registry: A 10 Year Perspective**
Gabrielle DeVeber, Hospital for Sick Children, Toronto, ON, Canada

10:00-10:30 **Neonatal Stroke: Epidemiology and Outcomes**
Donna M. Ferriero, University California San Francisco, San Francisco, CA, United States

10:30-11:00 **Epidemiology and Risk Factors for Childhood Stroke in Chinese Children**
Virginia Wong, University of Hong Kong, Hong Kong, P.R. China

11:00-11:30 **Childhood Stroke: Recurrence and Preventative Treatments**
Fenella Kirkham, Institute of Child Health University College London, London, United Kingdom

INFECTIONS OF THE CENTRAL NERVOUS SYSTEM

Co-Chairs:
Charles R.J.C. Newton, Wellcome Trust Research Laboratories, Kilifi, Kenya
Pratibha Dutta Singhi, Postgrad. Institution of Medical Education & Research, Chandigarh, India

09:30-10:00 **HIV Infection of the Central Nervous System**
Leon G. Epstein, Northwestern University, Chicago, IL, United States

10:00-10:30 **Viral Encephalitides**
Diane Griffin, Johns Hopkins Bloomberg School of Public Health, Baltimore, MD, United States

10:30-11:00 **Tuberculous Meningitis: A 25 Year Journey of Discovery**
Johannes Feuth Schoeman, Faculty of Health Sciences, Tygerberg, South Africa

11:00-11:30 **Neurocysticercosis**
Pratibha Dutta Singhi, Postgrad. Institution of Medical Education & Research, Chandigarh, India

PEDIATRIC NEUROTRANSMITTER DISEASES

Co-Chairs
Masaya Segawa, Segawa Neurological Clinic for Children, Tokyo, Japan
Darryl C. De Vivo, Columbia University, New York, NY, United States

09:30-10:00 **Autosomal Dominant GTP Cyclohydrolase I Deficiency**
Yoshiko Nomura, Segawa Neurological Clinic for Children, Tokyo, Japan

10:00-10:30 **Recessive Sepiapterin Reductase Deficiency**
Brian Neville, Wolfson Centre, London, United Kingdom

10:30-11:00 **Tyrosine Hydroxylase Deficiency**
Georg F. Hoffmann, University of Heidelberg, Heidelberg, Germany

11:00-11:30 **Pathophysiology of Dopamine Deficiency Disease of Children: Its Characteristics in Reference to those of Adulthood**
Jonathan W. Mink, University of Rochester Medical Center, Rochester, NY, United States

CONGENITAL MYOPATHIES AND MUSCULAR DYSTROPHIES

Co-Chairs:
Francesco Muntoni, Imperial College, Hammersmith Hospital Campus, London, United Kingdom
Kathryn North, University of Sydney, Sydney, NSW, Australia

09:30-10:00 **The Floppy Infant: A Clinical Approach**
Victor Dubowitz, Imperial College London, Hammersmith Hospital, London, United Kingdom

10:00-10:30 **Congenital Muscular Dystrophies: An Overview**
Haluk Topaloglu, Hacettepe Children's Hospital, Ankara, Turkey

DAILY PROGRAMME

MONDAY, JUNE 12TH

10:30-11:00 **What is New in Congenital Myopathies?**
Kathryn North, University of Sydney, Sydney, NSW, Australia

11:00-11:30 **Congenital Muscular Dystrophies with Structural Brain Involvement: The Role of Brain MRI**
Jiri Vajsar, The Hospital for Sick Children, Toronto, ON, Canada

MEDICAL & SURGICAL TREATMENT OF EPILEPSY

Co-Chairs: **Raili Riikonen**, University of Kuopio, Kuopio, Finland
Frederick Andermann, McGill University, Montreal, QC, Canada

09:30-10:00 **Antiepileptic Drugs and Apoptosis in Developing Brain**
Chrysanthy Ikonomidou, Children's Hospital, Dresden, Germany

10:00-10:30 **Infantile Spasms: Therapy and Outcome**
Raili Riikonen, University of Kuopio, Kuopio, Finland

10:30-11:00 **Epileptic Surgery for Neonatal or Infantile Onset Seizures: Use of PET Study**
Harry T. Chugani, Children's Hospital of Michigan, Detroit, MI, United States

11:00-11:30 **Results of Surgery with Specific Syndromes of Infants**
Frederick Andermann, McGill University, Montreal, QC, Canada

MYELIN

Co-Chairs: **Hugo Moser,** Kennedy Krieger Institute, Baltimore, MD, United States
Sakkubai Naidu, Kennedy Kreiger Institute, Baltimore, MD, United States

09:30-10:00 **Differential Diagnosis of Leukodystrophies**
Sakkubai Naidu, Kennedy Kreiger Institute, Baltimore, MD, United States

10:00-10:30 **Biology of Formation and Maintenance of Myelin**
Klaus-Armin Nave, Max-Planck-Institute of Experimental Medicine, Goettingen, Germany

10:30-11:00 **Pathogenesis and Molecular Biology of Leukodystrophies**
Marjo S. Van der Knaap, Free University Medical Center, Amsterdam, The Netherlands

11:00-11:30 **Therapy of Leukodystrophies**
Hugo Moser, Kennedy Krieger Institute, Baltimore, MD, United States

14:00-15:30 **PLATFORM SESSIONS**

16:15-17:00 **PLENARY SESSION**
PRICHARD MEMORIAL LECTURE

Speaker to be announced

DAILY PROGRAMME

TUESDAY, JUNE 13TH

08:00-08:45 PLENARY SESSION

NEW INSIGHTS INTO THE CAUSES OF CEREBRAL PALSY

Chair: **Makiko Osawa,** Tokyo Women's Medical College, Tokyo, Japan

Speaker: **Karin B. Nelson**, National Institutes of Health, Bethesda, MD, United States

09:30-11:30 CONCURRENT SYMPOSIA

TRAUMATIC BRAIN INJURY

Chair: **Daune L. MacGregor,** The Hospital for Sick Children, Toronto, ON, Canada

09:30-10:10 **Mild Closed Head Injury**
Daune L. MacGregor, The Hospital for Sick Children, Toronto, ON, Canada

10:10-10:40 **Acute Neurosurgical Management of Head Injury**
Abhaya Kulkarni, Hospital for Sick Children, Toronto, ON, Canada

10:40-11:15 **The Neuroradiology of Acute Head Injury and Longterm Outcome**
Maja Steinlin, University Children's Hospital, Bern, Switzerland

11:15-11:30 **Outcome in Pediatric Brain Injury**
Peter Rumney, University of Toronto, Toronto, ON, Canada

NEUROMETABOLIC DISORDERS

Co-Chairs: **Ingrid Tein,** The Hospital for Sick Children, Toronto, Canada
Linda De Meirleir, Vrij Universiteit Brussel, Brussels, Belgium

09:30-10:00 **Diagnostic Approach to Mitochondrial Disorders**
Linda De Meirleir, Vrij Universiteit Brussel, Brussels, Belgium

10:00-10:30 **Glucose 1 Transporter Defect**
Darryl C. De Vivo, Columbia University, New York, NY, United States

10:30-11:00 **Mechanisms of Toxicity in Mitochondrial Disorders**
Brian H. Robinson, Hospital for Sick Children, Toronto, ON, Canada

11:00-11:30 **Therapeutic Approach to Mitochondrial Encephalomyopathies**
Salvatore DiMauro, Columbia University, New York, NY, United States

DEVELOPMENTAL NEUROBLAST MIGRATORY DISORDERS

Co-Chairs: **Paolo Curatolo,** Tor Vergata University of Rome, Rome, Italy
Harvey B. Sarnat, Alberta Children's Hospital, Calgary, AB, Canada

09:30-10:00 **New Classification Scheme**
Harvey B. Sarnat, Alberta Children's Hospital, Calgary, AB, Canada

10:00-10:30 **Molecular Biology of Neuronal Migration Disorders**
Christopher Walsh, Boston Children's Hospital, Boston, MA, United States

10:30-11:00 **Tuberous Sclerosis Complex**
Paolo Curatolo, Tor Vergata University of Rome, Rome, Italy

11:00-11:30 **Hemimegalencephaly**
Laura Flores-Sarnat, Alberta Children's Hospital, Calgary, AB, Canada

ADVANCES IN CEREBRAL PALSY

Co-Chairs: **Peter Baxter,** Sheffield Children's Hospital, Sheffield, United Kingdom
Veena Kalra, All-India Institute of Medical Sciences, New Delhi, India

09:30-10:00 **The Global Burden of Cerebral Palsy: Issues and Solutions**
Veena Kalra, All-India Institute of Medical Sciences, New Delhi, India

10:00-10:30 **Advances in Neuro-imaging: Structure and Function**
Ingeborg Krageloh-Mann, University Children's Hospital, Tuebingen, Germany

10:30-11:00 **Assessment Tools for Cerebral Palsy**
Annette Majnemer, McGill University, Montreal, QC, Canada

11:00-11:30 **New Advances in Treatment**
Milivoj Velickovic, University Paediatric Hospital, Ljubljana, Slovenia

DAILY PROGRAMME

TUESDAY, JUNE 13TH

ADVANCES IN CHILDHOOD PERIPHERAL NEUROPATHIES

Co-Chairs: **Robert Ouvrier,** The Children's Hospital at Westmead, Westmead, NSW, Australia
Tom Crawford, Johns Hopkins Hospital, Baltimore, MD, United States

09:30-10:00 **Advances in Acquired Inflammatory Neuropathies**
Tom Crawford, Johns Hopkins Hospital, Baltimore, MD, United States

10:00-10:30 **X-linked and Autosomal Recessive Neuropathies of Childhood**
Robert Ouvrier, The Children's Hospital at Westmead, Westmead, NSW, Australia

10:30-10:45 **Acute Motor Axonal Neuropathy**
Fangcheng Cai, Children's Hospital, Chongqing, P.R. China

10:45-11:00 **Merosin Deficiency and Hypermyelinating Neuropathy**
Francesco Guzzetta, Universita Cattolica del Sacro Cuore Policlin, Gemelli, Roma, Italy

11:00-11:30 **Treatment of Peripheral Neuropathies**
Monique M. Ryan, University of Sydney, Children's Hospital at Westmead, Westmead, NSW. Australia

GENETIC BASIS OF OUR UNDERSTANDING OF EPILEPTIC SYNDROMES

Chair: **Frederick Andermann,** McGill University, Montreal, QC, Canada

09:30-09:55 **Genetic Advances and Dissection of the Generalized Epilepsies**
Ingrid Scheffer, University of Melbourne, Melbourne, Australia

09:55-10:10 **Calcium Channels and Childhood Absence Epilepsy**
Xi Ru Wu, Beijing Medical University, Beijing, P.R. China

10:10-10:35 **The Benign Focal Epilepsies of Childhood. How Many Syndromes and their Clinical Significance?**
Orvar Eeg-Olofsson, University Children's Hospital, Uppsala, Sweden

10:35-11:00 **Genetically Determined Focal Epilepsy Syndromes**
Frederick Andermann, McGill University, Montreal, QC, Canada

11:00-11:25 **Genetically Determined Epileptic Syndromes in Patients with Disorders of Neuronal Migration and Cortical Organization**
Eva Andermann, McGill University, Montreal, QC, Canada

11:25-11:30 General Discussion

14:00-15:30 **PLATFORM SESSIONS**

16:15-17:00 **GENERAL ASSEMBLY**

DAILY PROGRAMME

WEDNESDAY, JUNE 14TH

08:00-08:45 PLENARY SESSION

THERAPEUTIC INNOVATIONS IN THE NEUROMUSCULAR DISORDERS

Victor Dubowitz, Imperial College London, Hammersmith Hospital, London, United Kingdom

09:30-11:30 CONCURRENT SYMPOSIA

NEUROINFORMATICS & TECHNOLOGY IN CHILD NEUROLOGY

09:30-10:00 **Data Sharing in the Information Age**
TBA

10:00-10:30 **Electronic Communication with Colleagues**
Steven Leber, University of Michigan Health Sciences, Ann Arbor, MI, United States

10:30-11:00 **Creating a Neuro-Patient Resource Centre**
Eileen Beany Peterson, Montreal Neurological Hospital, Montreal, QC, Canada

11:00-11:30 **The Child Neurology Knowledge Environment**
David A. Stumpf, ICNA, Evanston, IL, United States

NEUROIMMUNOLOGY

Co-Chairs: **Harvey Singer,** Johns Hopkins University School of Medicine, Baltimore, MD, United States
Robert Rust, University of Virginia, Charlottesville, VA, United States

09:30-10:00 **Immunology and the Nervous System**
Jack Antel, McGill University, Montreal, QC, Canada

10:00-10:30 **Acute Disseminated Encephalomyelopathy and Multiple Sclerosis**
Robert Rust, University of Virginia, Charlottesville, VA, United States

10:30-11:00 **Practical Immunology in Neuromuscular Disease**
Alan Pestronk, Washington University School of Medicine, Saint-Louis, MO, United States

11:00-11:30 **Autoimmune Movement Disorders**
Harvey Singer, Johns Hopkins University School of Medicine, Baltimore, MD, United States

COMPLEMENTARY/ALTERNATIVE MEDICINE

Co-Chairs: **Virginia Wong**, University of Hong Kong, Hong Kong, P.R. China
Ein-Yiao Shen, Taipei Medical University, Taipei, Taiwan

09:30-10:00 **Autism Spectrum Disorders and Overlapping Syndromes**
Malcom Hooper, United Kingdom

10:00-10:30 **Antiseizure/Cognition Effect of Traditional Chinese Medicine and its Molecular Mechanism**
Li Wang, Peking University First Hospital, Beijing, P.R. China

10:30-11:00 **Integration of Traditional Chinese Medicine (Acupuncture) & Western Approach in Child Neurology**
Virginia Wong, University of Hong Kong, Hong Kong, P.R. China

11:00-11:30 **TCM Mechanism in Child Neurology**
Ein-Yiao Shen, Acupuncture Mechanism in Child Neurology, Taipei, Medical University, Taipei, Taiwan

MYAESTHENIA AND MYAESTHENIC SYNDROMES

Chair: **Hugo A. Arroyo,** Hospital de Pediatria Prof. Dr. Juan P Garrahan, Buenos Aires, Argentina

09:30-10:00 **Congenital Myaesthenic Syndromes**
Samuel I. Pascual Pascual, Hospital Universitario "La Paz", Madrid, Spain

10:00-10:30 **Childhood Myasthenia Gravis**
Yoshiko Nomura, Segawa Neurological Clinic for Children, Tokyo, Japan

10:30-11:00 **Generalized Juvenile Myasthenia Gravis**
Banu Anlar, Hacettepe University, Ankara, Turkey

11:00-11:30 **New and Old Strategies in the Treatment of Myasthenia Gravis**
Daniel B. Drachman, Johns Hopkins School of Medicine, Baltimore, MD, United States

DAILY PROGRAMME

WEDNESDAY, JUNE 14TH

DEVELOPMENTAL DELAY/MENTAL RETARDATION

Co-Chairs: **Michael Shevell,** McGill University, Montreal, QC, Canada
Elliott Sherr, UCSF, San Francisco, CA, United States

09:30-10:00 **Nutritional Deficiencies in Developmental Delay**
Veena Kalra, All-India Institute of Medical Sciences, New Delhi, India

10:00-10:30 **Outcomes of Antenatal Anomalies**
Shaul Harel, Tel Aviv University, Ramat-Gan, Israel

10:30-11:00 **Outcomes of Developmental Delay**
Michael Shevell, McGill University, Montreal, QC, Canada

11:00-11:30 **Genetics and the Etiologic Diagnosis of Developmental Delay**
Elliott Sherr, UCSF, San Francisco, CA, United States

NEURO-ONCOLOGY

Co-Chairs: **Patricia K. Duffner,** Buffalo Children's Hospital, Buffalo, NY, United States
Roger J. Packer, Children's National Medical Center, Washington, DC, United States

09:30-10:00 **Molecular Genetics of the Tumors of the Nervous System in Children**
Peter Collins, University of Cambridge, Cambridge, United Kingdom

10:00-10:30 **Epidemiology of the Tumors of the Nervous System in Childhood**
Sergio Rosemberg, Santa Casa of Sao Paulo School of Medicine, Sao Paulo, Brazil

10:30-11:00 **What is New on Medulloblastomas and Supratentorial PNETs**
Patricia K. Duffner, Buffalo Children's Hospital, Buffalo, NY, United States

11:00-11:30 **State-of-Art on Treatment of Tumors of the Nervous System in Childhood**
Roger J. Packer, Children's National Medical Center, Washington, DC, United States

DAILY PROGRAMME

THURSDAY, JUNE 15TH

08:00-08:45 PLENARY SESSION

CURRENT STATUS & FUTURE CHALLENGES IN FETAL & NEONATAL NEURO-IMAGING

Chair: **Generoso G. Gascon,** King Faisal Specialist Hospital/Research Center, Jeddah, Saudi Arabia

Speaker: **Robert Zimmerman,** The Children's Hospital of Philadelphia, Philadelphia, PA, United States

09:30-11:30 CONCURRENT SYMPOSIA

UPDATES IN PEDIATRIC NEUROSURGERY

Co-Chairs: **David A. Stumpf,** ICNA, Evanston, IL, United States
Shaul Harel, Tel Aviv University, Ramat-Gan, Israel

09:30-10:00 **Technical and Conceptual Advances in Pediatric Neurosurgery**
Shlomi Constantini, Dana Children's Hospital, Tel-Aviv, Israel

10:00-10:30 **Update in Pediatric Hydrocephalus**
James Drake, Hospital for Sick Kids, Toronto, ON, Canada

10:30-11:00 **Surgical Treatment and Decision Making in Neural Tube Defects**
David G. McLone, Children's Memorial Hospital, Chicago, IL, United States

11:00-11:30 **Surgery for Pediatric Brain Tumors: Success and Limitations**
Jeffrey Wisoff, New York University, New York, NY, United States

NEONATAL BRAIN INJURY

Co-Chairs: **Donna M. Ferriero,** University of California San Francisco, San Francisco, CA, United States
Steven Miller, University of British-Columbia, Vancouver, BC, Canada

09:30-10:00 **Genetic Polymorphisms Associated with Preterm Brain Injury**
Donna M. Ferriero, University of California San Francisco, San Francisco, CA, United States

10:00-10:30 **White Matter Injury in Newborns with Cardiac Disease**
Steven Miller, University of British-Columbia, Vancouver, BC, Canada

10:30-11:00 **Short-Term and Long-Term Effects of Early Seizures on Developing Brain Function**
Yu-Wu Jiang, Peking University First Hospital, Beijing, P.R. China

11:00-11:30 **Early Diagnosis of Neonatal Stroke**
Linda DeVries, Wilhelmina Children's Hospital, Utrecht, The Netherlands

CHANNELOPATHIES AND GENERALIZED SEIZURES

Co-Chairs: **Massimo Avoli,** McGill University, Montreal, QC, Canada
Jeffrey L. Noebels, Baylor College of Medicine, Houston, TX, United States

09:30-10:00 **Genes and Channels**
Jeffrey L. Noebels, Baylor College of Medicine, Houston, TX, United States

10:00-10:30 **Sodium Channel Mutations**
David Ragsdale, McGill University, Montreal, QC, Canada

10:30-11:00 **GABA Type B and Absence Seizures**
Massimo Avoli, McGill University, Montreal, QC, Canada

11:00-11:30 **Channels as Targets for AEDs**
Vincenzo Crunelli, Cardiff University, Cardiff, United Kingdom

COGNITIVE NEUROSCIENCE IN CHILDHOOD

Co-Chairs: **Lieven Lagae**, University Hospital Gasthuisberg, Leuven, Belgium
Daune L. MacGregor, The Hospital for Sick Children, Toronto, ON, Canada

09:30-10:00 **Neuropsychological Dysfunctions in ADHD**
Christopher Gillberg, Goteborg University, Goteborg, Sweden

10:00-10:30 **Functional Imaging Studies in Dyslexia**
S. E. Shaywitz, Yale University of Medicine, New Haven, CT, United States
Bennett Shaywitz, Yale University of Medicine, New Haven, CT, United States

10:30-11:00 **Arithmetic and the Brain**
Brian Butterworth, Institute of Cognitive Neuroscience, University College London, London, United Kingdom

11:00-11:30 **Non-verbal Learning Disabilities**
Byron P. Rourke, University of Windsor, Windsor, ON, Canada

DAILY PROGRAMME

THURSDAY, JUNE 15TH

MOVEMENT DISORDERS: STEREOTYPIES

Co-Chairs: **Emilio Fernandez Alvarez**, Hospital Sant Joan de Deu, Barcelona, Spain
Jonathan W. Mink, University of Rochester Medical Center, Rochester, NY, United States

09-30-10:00 **Stereotypies: General Basis, Definition, and Classification**
Emilio Fernandez Alvarez, Hospital Sant Joan de Deu, Barcelona, Spain

10:00-10:30 **Primary (Physiologic) Stereotypies**
Harvey Singer, Johns Hopkins University School of Medicine, Baltimore, United States

10:30-11:00 **Epileptic Stereotypies**
Thierry Deonna, Centre Hospitalier Universitaire Vaudois, Lausanne, Switzerland

11:00-11:30 **Secondary and Syndromic Stereotypies**
Roberto F. Tuchman, Miami Children's Hospital, Weston, FL, United States

GLOBAL BURDEN OF NEUROLOGIC DISEASES IN CHILDREN

Co-Chairs: **Maureen Durkin,** University of Wisconsin-Madison, Madison, WI, United States
Charles R.J.C. Newton, Wellcome Trust Research Laboratories, Kilifi, Kenya

09:30-10:00 **Assessing Needs, Setting Priorities**
Maureen Durkin, University of Wisconsin-Madison, Madison, WI, United States

10:00-10:30 **The Toll of Cerebral Malaria in Children**
Charles R.J.C. Newton, Wellcome Trust Research Laboratories, Kilifi, Kenya

10:30-11:00 **Thyroid and Brain Development in Developed and Developing Countries**
Karin B. Nelson, National Institutes of Health, Bethesda, Bethesda, MD, United States

11:00-11:30 **Neurocysticercosis**
Wendy Mitchell, Children's Hospital Los Angeles, Los Angeles, CA, United States

14:00-15:30 PLATFORM SESSIONS

14:00-16:00 CACN SYMPOSIUM: EPILEPTIC ENCEPHALOPATHIES IN INFANCY AND CHILDHOOD

Chair: **Elaine Wirrell,** Alberta Children's Hospital, Calgary, AB, Canada

14:00-14:25 **Epileptic Encephalopathies: Defining the Syndromes**
O. Carter Snead, Hospital for Sick Children, Toronto, ON, Canada

14:25-14:50 **Epidemiology of Epileptic Encephalopathies**
Joseph Michael Dooley, Dalhousie University and IWK Health Centre, Halifax, NS, Canada

14:50-15:15 **Treating Epileptic Encephalopathies: Beyond the Traditional AEDs**
Lionel Carmant, Montreal University, Montreal, QC, Canada

15:15-15:40 **Co-morbidities of the Epileptic Encephalopathies**
Lorie Hamiwka, Alberta Children's Hospital, Calgary, AB, Canada

15:40-16:00 Discussion
All Speakers

16:15-17:00 PLENARY SESSION
FRANK FORD MEMORIAL LECTURE

Age-dependent Epileptic Encephalopathy. A Contribution to Modern Epileptology
Shunsuke Ohtahara, Okayama University Medical School, Okayama, Japan

DAILY PROGRAMME

FRIDAY, JUNE 16TH

08:00-08:45 PLENARY SESSION

NEOCORTICAL HISTOGENESIS - INITIAL STEPS TOWARDS ACQUIRING HIGHER CORTICAL FUNCTIONING

Chair: **Paolo Curatolo,** Tor Vergata University of Rome, Rome, Italy

Speaker: **Takao Takahashi**, Keio University School of Medicine, Tokyo, Japan

09:30-11:30 CONCURRENT SYMPOSIA

ETHICAL ISSUES IN CHILD NEUROLOGY

Chair: **Stephen Ashwal**, Loma Linda University School of Medicine, Loma Linda, CA, United States

09:30-09:55 **Are Organ Donors After Cardiac Death Really Dead?**
James Bernat, Dartmouth Medical School, Hanover, NH, United States

09:55-10:20 **What is Death? How Language Influences Medical Concepts**
Alan D. Shewmon, Olive View-UCLA Medical Center, Sylmar, CA, United States

10:20-10:45 **The Personhood of Individuals with Disabilities**
David L. Coulter, Harvard Medical School, Boston, MA, United States

10:45-11:05 **The Vegetative and Minimally Conscious States in Children**
Stephen Ashwal, Loma Linda University School of Medicine, Loma Linda, CA, United States

11:05-11:30 **Physicians Should Be Advocates, but Who Should We Advocate for? The Patient? The Parent? Or Society?**
John M. Freeman, Johns Hopkins Hospital, Baltimore, MD, United States

GENETIC DIAGNOSIS OF NEUROLOGICAL CONDITIONS

Co-Chairs: **Alan K. Percy,** Civitan Intl Research Center, University of Alabama School of Medicine, Birmingham, AL, United States
Marjo S. Van der Knaap, Free University Medical Center, Amsterdam, The Netherlands

09:30-10:00 **Rett Syndrome**
Alan K. Percy, Civitan Intl Research Center, University of Alabama School of Medicine, Birmingham, AL, United States

10:00-10:30 **Organic Acidurias**
Märten Kyllerman, Sahlgrenska University, Göteborg, Sweden

10:30-11:00 **Neurofibromatosis**
Bruce Korf, The University of Alabama, Birmingham, AL, United States

11:00-11:30 **Leukodystrophies**
Marjo S. Van der Knaap, Free University Medical Center, Amsterdam, The Netherlands

REVISITING THE CEREBELLUM: FROM STRUCTURE TO FUNCTION

Co-Chairs: **Catherine Limperopoulos,** McGill University, Montreal, QC, Canada
Eugen Boltshauser, Children's University-Hospital, Zurich, Switzerland

09:30-10:00 **The Cerebellum and Eye-movements**
Michael Salman, Children's Hospital, Winnipeg, MB, Canada

10:00-10:30 **Cerebellar Cognitive Affective Syndrome**
Jeremy D. Schmahmann, Harvard Medical School, Boston, MA, United States

10:30-11:00 **The Vulnerable Immature Cerebellum: Consequences for Survivors Following Early Life Injury**
Catherine Limperopoulos, McGill University, Montreal, QC, Canada

11:00-11:30 **Developmental Disorders of the Cerebellum**
Eugen Boltshauser, Children's University-Hospital, Zurich, Switzerland

NEUROLOGIC BASIS OF AUTISM

Co-Chairs: **Isabelle Rapin,** Albert Einstein College of Medicine, Bronx, NY, United States
Roberto F. Tuchman, Miami Children's Hospital, Weston, FL, United States

09:30-10:00 **Autism as a Disorder of the Immature Brain**
Isabelle Rapin, Albert Einstein College of Medicine, Bronx, NY, United States

DAILY PROGRAMME

FRIDAY, JUNE 16TH

10:00-10:30 **The "Autism Epidemic" and Known Causes of Autism**
Eric Fombonne, McGill University, Montreal, QC, Canada

10:30-11:00 **Autistic Regression and Epilepsy in Autism**
Roberto F. Tuchman, Miami Children's Hospital, Weston, FL, United States

11:00-11:30 **Effective Interventions: Educational and Pharmacologic**
Marc Mitnz, Bancroft NeuroHealth, Cherry Hill, NJ, United States

NEUROPROTECTION

Co-Chairs: **Michael V. Johnston**, Kennedy Krieger Institute, Baltimore, MD, United States
Chao-Ching Huang, National Cheng Kung University Hospital, Tainan, Taiwan

09:30-10:00 **Cascade of Brain Injury**
Michael V. Johnston, Kennedy Krieger Institute, Baltimore, MD, United States

10:00-10:30 **Hypothermia for Asphyxia**
Donna M. Ferriero, University California San Francisco, San Francisco, CA, United States

10:30-11:00 **Growth Factors and Brain Injury**
Pierre Gressens, Hopital Robert-Debre, Paris, France

11:00-11:30 **Transcriptions and Neuroprotection**
Chao-Ching Huang, National Cheng Kung University Hospital, Tainan, Taiwan

HEADACHES

Co-Chairs: **Kenneth Mack,** Mayo Clinic, Rochester, MN, United States
A. David Rothner, Cleveland Clinic, Cleveland, OH, United States

09:30-10:00 **Migraines**
A. David Rothner, Cleveland Clinic, Cleveland, OH, United States

10:00-10:30 **Chronic Daily Headaches**
Kenneth Mack, Mayo Clinic, Rochester, MN, United States

10:30-11:00 **Psychological Co-morbidities of Migraine**
Matti Lauri Sillanpää, TURKU University, Turku, Finland

11:00-11:30 **Migraine Equivalents**
Ian A. Wilkinson, John Hunter Children's Hospital, Newcastle, NSW, Australia

INVITED FACULTY

Andermann	Frederick	Canada
Andermann	Eva	Canada
Anlar	Banu	Turkey
Antel	Jack	Canada
Ashwal	Stephen	United States
Avoli	Massimo	Canada
Bernat	James	United States
Boltshauser	Eugen	Switzerland
Butterworth	Brian	United Kingdom
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Sherr	Elliott	United States
Shevell	Michael	Canada
Shewmon	D. Alan	United States
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Singer	Harvey	United States
Singhi	Pratibha Dutta	India
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Wilkinson	Ian A.	Australia
Wirrell	Elaine	Canada
Wisoff	Jeffrey	United States
Wong	Virginia	P.R. China
Wu	Xi Ru	P.R. China
Zimmerman	Robert	United States

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REGISTER ONLINE BY VISITING: **WWW.ICNC2006.COM**

FOR ANY INQUIRIES, PLEASE CONTACT THE
ICNC 2006 CONGRESS SECRETARIAT AT:
ICNC2006@EVENTSINTL.COM

REGISTRATION FEES – *All fees are in US dollars*

	If payment is received before October 31, 2005	If payment is received before March 1, 2006	If payment is received on or after March 1, 2006
ICNA Member	$ 550	$ 600	$ 650
Non-ICNA Member	$ 600	$ 650	$ 700
Students / Residents	$ 325	$ 350	$ 400
Single Day Rate	$ 200	$ 200	$ 200
Accompanying Persons	$ 150	$ 150	$ 150

Registration fees for full Congress delegates (students and residents as well) include:
Participation in all scientific sessions (including posters), access to the Congress exhibition, opening reception, coffee breaks, one ticket to each scheduled social event, lunches and all Congress materials.

Registration fees for single day registrants include:
Participation in all scientific sessions (including posters), access to the Congress exhibition, coffee breaks, lunches and all Congress materials.

Registration fees for accompanying persons include:
Opening reception, one ticket to each scheduled social event, and Congress materials.

Confirmation of Registration
Letters of confirmation will be sent to those registering before March 1, 2006.

Cancellation and Refund Policy
Delegates who are unable to attend the ICNC 2006 Congress after having paid their registration fees must provide a written request for their refund (less 25% administrative charges) on or before March 1, 2006. Requests received after this date will not be considered. All approved refunds will be issued after the Congress.

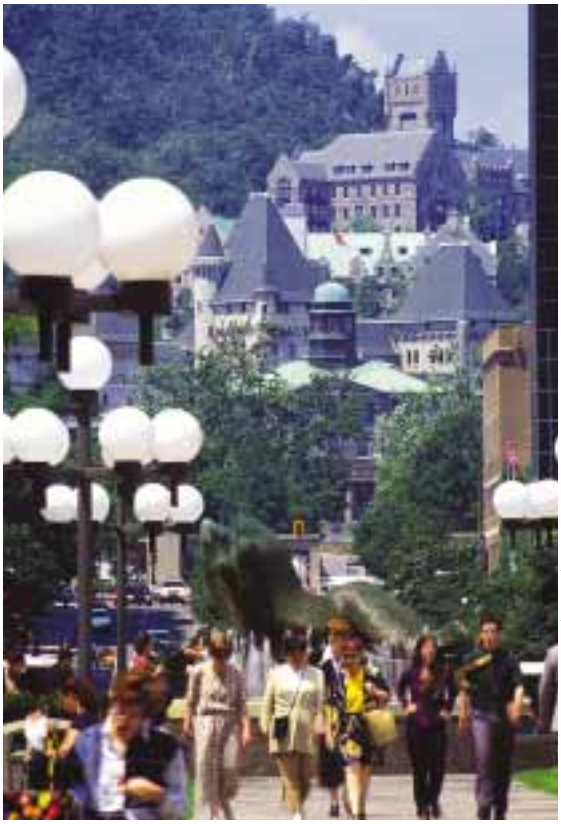
ACCOMMODATION INFORMATION

The ICNC 2006 Housing Bureau is pleased to offer accommodations to ICNC 2006 delegates at the Montreal Bonaventure Hilton (Congress venue) and Le Centre Sheraton Hotel (within walking distance of the Hilton).

Reservations should be made directly with the hotel of your choice. By indicating that you will be attending the 10th International Child Neurology Congress, you will be offered a preferential room rate.

For more information on accommodations, please visit the Congress website:
www.icnc2006.com

WELCOME TO MONTREAL



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Montreal's distinctive character owes much to its multicultural heritage, which has contributed to creating one of the most dynamic and interesting cities in all of North America. The city has a unique mix of historical, natural and cultural offerings to satisfy even the most diverse groups and individual travelers. The city offers the perfect mix of old and modern, as well as an exciting mix of European warmth and North American modernity. Everywhere, lovingly preserved Victorian mansions, stately buildings from past centuries, and Beaux-Arts style monuments blend with the long cool lines of modern skyscrapers, making Montreal one of the most creative and eclectic urban landscapes on the planet.

The swinging Latin Quarter, overflowing with terraces, complements the trendy Plateau Mont-Royal. A leisurely stroll through Old-Montreal with its tight network of streets transports you back to the once-fortified area of the city where you can enjoy fine dining, local artisan works, and the Old Port.

Montreal also boasts a summer festival season that showcases world-class jazz artists, star comedians and international fireworks competitors. To discover Montreal is to experience a culturally-diverse and exciting urban lifestyle in a historically beautiful city.
Bienvenue! Welcome!

Languages
Although Canada is a bilingual country (French and English are widely spoken by the population of Quebec especially), the official language of the Congress is English.

Climate & Clothing
June in Montreal is a pleasant time of year, with daytime temperatures ranging from 20 degrees Celsius (68 F) to 26 degrees Celsius (77 F). The evenings can be cool so it is recommended that you bring a light sweater or jacket.

Currency
The Canadian dollar is the national currency. Automatic teller machines and exchange offices are readily available; most hotels, restaurants and shops accept major credit cards.

Shopping neighbourhoods of Montreal
Chinatown - Notre Dame Street (Antiques) - Old Montreal - Rue Sherbrooke - Rue Ste-Catherine with its underground & Public Markets (Atwater & Jean-Talon)

Dining
Montrealers do much of their socializing around the table, so it is little wonder the city is famous for its gourmet cuisine and sidewalk cafés. Diners enjoy an enormous variety of regional and international fare, with well over 5,000 restaurants serving delicacies from every corner of the globe.

Getting to Montreal
It is advisable that you contact the Canadian Embassy in your country to inquire if you need a VISA to enter Canada.

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Keppra® is indicated as adjunctive therapy in the treatment of partial onset seizures in adults and children 4 years of age and older with epilepsy.

In adults, Keppra® use is associated with the occurrence of central nervous system adverse events including somnolence and fatigue, coordination difficulties, and behavioral abnormalities, as well as hematological abnormalities. In pediatric patients 4 to 16 years of age, Keppra® is associated with somnolence, fatigue, and behavioral abnormalities, as well as hematological abnormalities.

In adults, the most common adverse events associated with Keppra® in combination with other AEDs were somnolence, asthenia, infection, and dizziness. Of these, most appeared to occur predominantly during the first 4 weeks of treatment. In pediatric patients 4 to 16 years of age, the most common adverse events associated with Keppra® in combination with other AEDs were somnolence, accidental injury, hostility, nervousness, and asthenia.

For more information please see the brief summary on the adjacent page.

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INDICATIONS AND USAGE: Keppra® (levetiracetam) is indicated as adjunctive therapy in the treatment of partial onset seizures in adults and children 4 years of age and older with epilepsy.

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WARNINGS: Neuropsychiatric Adverse Events: Adults In adults, Keppra® use is associated with the occurrence of central nervous system adverse events that can be classified into the following categories: 1) somnolence and fatigue, 2) coordination difficulties, and 3) behavioral abnormalities. In controlled trials of adult patients with epilepsy, 14.8% of Keppra®-treated patients reported somnolence, compared to 8.4% of placebo patients. There was no clear dose response up to 3000 mg/day. In a study where there was no titration, about 45% of patients receiving 4000 mg/day reported somnolence. The somnolence was considered serious in 0.3% of the treated patients, compared to 0% in the placebo group. About 3% of Keppra®-treated patients discontinued treatment due to somnolence, compared to 0.7% of placebo patients. In 1.4% of treated patients and in 0.9% of placebo patients the dose was reduced, while 0.3% of the treated patients were hospitalized due to somnolence. In controlled trials of adult patients with epilepsy, 14.7% of treated patients reported asthenia, compared to 9.1% of placebo patients. Treatment was discontinued in 0.8% of treated patients as compared to 0.5% of placebo patients. In 0.5% of treated patients and in 0.2% of placebo patients the dose was reduced. A total of 3.4% of Keppra®-treated patients experienced coordination difficulties, (reported as either ataxia, abnormal gait, or incoordination) compared to 1.6% of placebo patients. A total of 0.4% of patients in controlled trials discontinued Keppra® treatment due to ataxia, compared to 0% of placebo patients. In 0.7% of treated patients and in 0.2% of placebo patients the dose was reduced due to coordination difficulties, while one of the treated patients was hospitalized due to worsening of pre-existing ataxia. Somnolence, asthenia and coordination difficulties occurred most frequently within the first 4 weeks of treatment. In controlled trials of patients with epilepsy, 5 (0.7%) of Keppra®-treated patients experienced psychotic symptoms compared to 1 (0.2%) placebo patient. Two (0.3%) Keppra®-treated patients were hospitalized and their treatment was discontinued. Both events, reported as psychosis, developed within the first week of treatment and resolved within 1 to 2 weeks following treatment discontinuation. Two other events, reported as hallucinations, occurred after 1-5 months and resolved within 2-7 days while the patients remained on treatment. In one patient experiencing psychotic depression occurring within a month, symptoms resolved within 45 days while the patient continued treatment. A total of 13.3% of Keppra® patients experienced other behavioral symptoms (reported as aggression, agitation, anger, anxiety, apathy, depersonalization, depression, emotional lability, hostility, irritability etc.) compared to 6.2% of placebo patients. Approximately half of these patients reported these events within the first 4 weeks. A total of 1.7% of treated patients discontinued treatment due to these events, compared to 0.2% of placebo patients. The treatment dose was reduced in 0.8% of treated patients and in 0.5% of placebo patients. A total of 0.8% of treated patients had a serious behavioral event (compared to 0.2% of placebo patients) and were hospitalized. In addition, 4 (0.5%) of treated patients attempted suicide compared to 0% of placebo patients. One of these patients successfully committed suicide. In the other 3 patients, the events did not lead to discontinuation or dose reduction. The events occurred after patients had been treated for between 4 weeks and 6 months. Pediatric Patients In pediatric patients, Keppra® is associated with somnolence, fatigue, and behavioral abnormalities. In the double-blind, controlled trial in children with epilepsy, 22.8% of Keppra®-treated patients experienced somnolence, compared to 11.3% of placebo patients. The design of the study prevented accurately assessing dose-response effects. No patient discontinued treatment for somnolence. In about 3.0% of Keppra®-treated patients and in 3.1% of placebo patients the dose was reduced as a result of somnolence. Asthenia was reported in 8.9% of Keppra®-treated patients, compared to 3.1% of placebo patients. No patient discontinued treatment for asthenia, but asthenia led to a dose reduction in 3.0% of Keppra®-treated patients compared to 0% of placebo patients. A total of 37.6% of the Keppra®-treated patients experienced behavioral symptoms (reported as agitation, anxiety, apathy, depersonalization, depression, emotional lability, hostility, hyperkinesia, nervousness, neurosis, and personality disorder), compared to 18.6% of placebo patients. Hostility was reported in 11.9% of Keppra®-treated patients, compared to 6.2% of placebo patients. Nervousness was reported in 9.9% of Keppra®-treated patients, compared to 2.1% of placebo patients. Depression was reported in 3.0% of Keppra®-treated patients, compared to 1.0% of placebo patients. One Keppra®-treated patient experienced suicidal ideation. A total of 3.0% of Keppra®-treated patients discontinued treatment due to psychotic and nonpsychotic adverse events, compared to 4.1% of placebo patients. Overall, 10.9% of Keppra®-treated patients experienced behavioral symptoms associated with discontinuation or dose reduction, compared to 6.2% of placebo patients. **Withdrawal Seizures:** Antiepileptic drugs, including Keppra®, should be withdrawn gradually to minimize the potential of increased seizure frequency.

PRECAUTIONS: Hematologic Abnormalities: Adults Minor, but statistically significant, decreases compared to placebo in total mean RBC count (0.03 x 10^9/mm^3), mean hemoglobin (0.09 g/dL), and mean hematocrit (0.38%), were seen in Keppra®-treated patients in controlled trials. A total of 3.2% of treated and 1.8% of placebo patients had at least one possibly significant (≤2.8 x 10^9/L) decreased WBC, and 2.4% of treated and 1.4% of placebo patients had at least one possibly significant (≤1.0 x 10^9/L) decreased neutrophil count. Of the treated patients with a low neutrophil count, all but one rose towards or to baseline with continued treatment. No patient was discontinued secondary to low neutrophil counts. Pediatric Patients Minor, but statistically significant, decreases in WBC and neutrophil counts were seen in Keppra®-treated patients as compared to placebo. The mean decreases from baseline in the Keppra®-treated group were -0.4 x 10^9/L and -0.3 x 10^9/L, respectively, whereas there were small increases in the placebo group. Mean relative lymphocyte counts increased by 1.7% in Keppra®-treated patients, compared to a decrease of 4% in placebo patients (statistically significant). In the well-controlled trial, more Keppra®-treated patients had a possibly clinically significant abnormally low WBC value (3.0% Keppra®-treated versus 0% placebo), however, there was no apparent difference between treatment groups with respect to neutrophil count (5.0% Keppra®-treated versus 4.2% placebo). No patient was discontinued secondary to low WBC or neutrophil counts. **Hepatic Abnormalities:** There were no meaningful changes in mean liver function tests (LFT) in controlled trials in adult and pediatric patients; lesser LFT abnormalities were similar in drug and placebo-treated patients in controlled trials (1.4%). No adult or pediatric patients were discontinued from controlled trials for LFT abnormalities except for 1 (0.07%) adult epilepsy patient receiving open treatment. **Information For Patients:** Patients should be instructed to take Keppra® only as prescribed. Patients should be advised to notify their physician if they become pregnant or intend to become pregnant during therapy. Patients should be advised that Keppra® may cause dizziness and somnolence. Accordingly, patients should be advised not to drive or operate machinery or engage in other hazardous activities until they have gained sufficient experience on Keppra® to gauge whether it adversely affects their performance of these activities. Physicians should advise patients and caregivers to read the patient information leaflet which appears as the last section of the labeling. **Laboratory Tests:** Although most laboratory tests are not systematically altered with Keppra® treatment, there have been relatively infrequent abnormalities seen in hematologic parameters and liver function tests. **Drug Interactions:** In vitro data on metabolic interactions indicate that Keppra® is unlikely to produce, or be subject to, pharmacokinetic interactions. Levetiracetam and its major metabolite, at concentrations well above C_{max} levels achieved within the therapeutic dose range, are neither inhibitors of nor high affinity substrates for human liver cytochrome P450 isoforms, epoxide hydrolase or UDP-glucuronidation enzymes. In addition, levetiracetam does not affect the in vitro glucuronidation of valproic acid. Levetiracetam circulates largely unbound (<10% bound) to plasma proteins; clinically significant interactions with other drugs through competition for protein binding sites are therefore unlikely. Potential pharmacokinetic interactions were assessed in clinical pharmacokinetic studies (phenytoin, valproate, oral contraceptive, digoxin, warfarin, probenecid) and through pharmacokinetic screening in the placebo-controlled clinical studies in epilepsy patients. Drug-Drug Interactions Between Keppra® And Other Antiepileptic Drugs (AEDs): *Phenytoin*: Keppra® (3000 mg daily) had no effect on the pharmacokinetic disposition of phenytoin in patients with refractory epilepsy. Pharmacokinetics of levetiracetam were also not affected by phenytoin. *Valproate*: Keppra® (1500 mg twice daily) did not alter the pharmacokinetics of valproate in healthy volunteers. Valproate 500 mg twice daily did not modify the rate or extent of levetiracetam absorption or its plasma clearance or urinary excretion. There also was no effect on exposure to and the excretion of the primary metabolite, ucb L057. Potential drug interactions between Keppra® and other AEDs (carbamazepine, gabapentin, lamotrigine, phenobarbital, phenytoin, primidone and valproate) were also assessed by evaluating the serum concentrations of levetiracetam and these AEDs during placebo-controlled clinical studies. These data indicate that levetiracetam does not influence the plasma concentration of other AEDs and that these AEDs do not influence the pharmacokinetics of levetiracetam. Effect of AEDs in Pediatric Patients: There was about a 22% increase of apparent total body clearance of levetiracetam when it was co-administered with enzyme-inducing AEDs. Dose adjustment is not recommended. Levetiracetam had no effect on plasma concentrations of carbamazepine, valproate, topiramate, or lamotrigine. Other Drug Interactions: *Oral Contraceptives*: Keppra® (500 mg twice daily) did not influence the pharmacokinetics of an oral contraceptive containing 0.03 mg ethinyl estradiol and 0.15 mg levonorgestrel, or of the luteinizing hormone and progesterone levels, indicating that impairment of contraceptive efficacy is unlikely. Coadministration of this oral contraceptive did not influence the pharmacokinetics of levetiracetam. *Digoxin*: Keppra® (1000 mg twice daily) did not influence the pharmacokinetics and pharmacodynamics (ECG) of digoxin given as a 0.25 mg dose every day. Coadministration of digoxin did not influence the pharmacokinetics of levetiracetam. *Warfarin*: Keppra® (1000 mg twice daily) did not influence the pharmacokinetics of R and S warfarin. Prothrombin time was not affected by levetiracetam. Coadministration of warfarin did not affect the pharmacokinetics of levetiracetam. *Probenecid*: Probenecid, a renal tubular secretion blocking agent, administered at a dose of 500 mg four times a day, did not change the pharmacokinetics of levetiracetam 1000 mg twice daily. C^{ss}_{max} of the metabolite, ucb L057, was approximately doubled in the presence of probenecid while the fraction of drug excreted unchanged in the urine remained the same. Renal clearance of ucb L057 in the presence of probenecid decreased 60%, probably related to competitive inhibition of tubular secretion of ucb L057. The effect of Keppra® on probenecid was not studied. **Pregnancy: Pregnancy Category C:** In animal studies, levetiracetam produced evidence of developmental toxicity at doses similar to or greater than human therapeutic doses. Administration to female rats throughout pregnancy and lactation was associated with increased incidences of minor fetal skeletal abnormalities and retarded offspring growth pre- and/or postnatally at doses ≥350 mg/kg/day (approximately equivalent to the maximum recommended human dose of 3000 mg [MRHD] on a mg/m^2 basis) and with increased pup mortality and offspring behavioral alterations at a dose of 1800 mg/kg/day (6 times the MRHD on a mg/m^2 basis). The developmental no effect dose was 70 mg/kg/day (0.2 times the MRHD on a mg/m^2 basis). There was no overt maternal toxicity at the doses used in this study. Treatment of pregnant rabbits during the period of organogenesis resulted in increased embryofetal mortality and increased incidences of minor fetal skeletal abnormalities at doses ≥600 mg/kg/day (approximately 4 times MRHD on a mg/m^2 basis) and in decreased fetal weights and increased incidences of fetal malformations at a dose of 1800 mg/kg/day (12 times the MRHD on a mg/m^2 basis). The developmental no effect dose was 200 mg/kg/day (1.3 times the MRHD on a mg/m^2 basis). Maternal toxicity was also observed at 1800 mg/kg/day. When pregnant rats were treated during the period of organogenesis, fetal weights were decreased and the incidence of fetal skeletal variations was increased at a dose of 3600 mg/kg/day (12 times the MRHD). 1200 mg/kg/day (4 times the MRHD) was a developmental no effect dose. There was no evidence of maternal toxicity in this study. Treatment of rats during the last third of gestation and throughout lactation produced no adverse developmental or maternal effects at doses of up to 1800 mg/kg/day (6 times the MRHD on a mg/m^2 basis). There are no adequate and well-controlled studies in pregnant women. Keppra® should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. **Keppra® Pregnancy Registry:** UCB Pharma, Inc. has established the Keppra® Pregnancy Registry to advance scientific knowledge about safety and outcomes associated with pregnant women being treated with Keppra®. To ensure broad program access and reach, either a healthcare provider or the patient can initiate enrollment in the Keppra® Pregnancy Registry by calling (888) 537-7734 (toll free). Patients may also enroll in the North American Antiepileptic Drug Pregnancy Registry by calling (888) 233-2334 (toll free). **Labor And Delivery:** The effect of Keppra® on labor and delivery in humans is unknown. **Nursing Mothers:** Levetiracetam is excreted in breast milk. Because of the potential for serious adverse reactions in nursing infants from Keppra®, a decision should be made whether to discontinue nursing or discontinue the drug, taking into account the importance of the drug to the mother. **Pediatric Use:** Safety and effectiveness in patients below 4 years of age have not been established. Studies of levetiracetam in juvenile rats (dosing from day 4 through day 52 of age) and dogs (dosing from week 3 through week 7 of age) at doses of up to 1800 mg/kg/day (approximately 7 and 24 times, respectively, the maximum recommended pediatric dose of 60 mg/kg/day on a mg/m^2 basis) did not indicate a potential for age-specific toxicity. **Geriatric Use:** Of the total number of subjects in clinical studies of levetiracetam, 347 were 65 and over. No overall differences in safety were observed between these subjects and younger subjects. There were insufficient numbers of elderly subjects in controlled trials of epilepsy to adequately assess the effectiveness of Keppra® in these patients. A study in 16 elderly subjects (age 61-88 years) with oral administration of single dose and multiple twice-daily doses for 10 days showed no pharmacokinetic differences related to age alone. Levetiracetam is known to be substantially excreted by the kidney, and the risk of adverse reactions to this drug may be greater in patients with impaired renal function. Because elderly patients are more likely to have decreased renal function, care should be taken in dose selection, and it may be useful to monitor renal function. **Use In Patients With Impaired Renal Function:** Clearance of levetiracetam is decreased in patients with renal impairment and is correlated with creatinine clearance. Caution should be taken in dosing patients with moderate and severe renal impairment and in patients undergoing hemodialysis. The dosage should be reduced in patients with impaired renal function receiving Keppra® and supplemental doses should be given to patients after dialysis (see CLINICAL PHARMACOLOGY and DOSAGE AND ADMINISTRATION, Adult Patients with Impaired Renal Function in package insert).

ADVERSE REACTIONS: In well-controlled clinical st udies in adults, the most frequently reported adverse events associated with the use of Keppra® in combination with other AEDs, not seen at an equivalent frequency among placebo-treated patients, were somnolence, asthenia, infection and dizziness. In the well-controlled pediatric clinical study, the adverse events most frequently reported with the use of Keppra® in combination with other AEDs, not seen at an equivalent frequency among placebo-treated patients, were somnolence, accidental injury, hostility, nervousness, and asthenia. Table 1 lists treatment-emergent adverse events that occurred in at least 1% of adult epilepsy patients treated with Keppra® participating in placebo-controlled studies and were numerically more common than in patients treated with placebo. Table 2 lists treatment-emergent adverse events that occurred in at least 2% of pediatric epilepsy patients (ages 4-16 years) treated with Keppra® participating in the placebo-controlled study and were numerically more common than in pediatric patients treated with placebo. In these studies, either Keppra® or placebo was added to concurrent AED therapy. Adverse events were usually mild to moderate in intensity. The prescriber should be aware that these figures, obtained when Keppra® was added to concurrent AED therapy, cannot be used to predict the frequency of adverse experiences in the course of usual medical practice where patient characteristics and other factors may differ from those prevailing during clinical studies. Similarly, the cited frequencies cannot be directly compared with figures obtained from other clinical investigations involving different treatments, uses, or investigators. An inspection of these frequencies, however, does provide the prescriber with one basis to estimate the relative contribution of drug and non-drug factors to the adverse event incidences in the population studied. **Table 1: Incidence (%) Of Treatment-Emergent Adverse Events In Placebo-Controlled, Add-On Studies, In Adults By Body System (Adverse Events Occurred In At Least 1% Of Keppra®-Treated Patients And Occurred More Frequently Than Placebo-Treated Patients).** Keppra® (N=769) vs Placebo (N=439): **Body System/Adverse Event: Body as a Whole:** Asthenia (15% vs 9%); Headache (14% vs 13%); Infection (13% vs 8%); Pain (7% vs 6%). **Digestive System:** Anorexia (3% vs 2%). **Nervous System:** Amnesia (2% vs 1%); Anxiety (2% vs 1%); Ataxia (3% vs 1%); Depression (4% vs 2%); Dizziness (9% vs 4%); Emotional Lability (2% vs 0%); Hostility (2% vs 1%); Nervousness (4% vs 2%); Paresthesia (2% vs 1%); Somnolence (15% vs 8%); Vertigo (3% vs 1%). **Respiratory System:** Cough Increased (2% vs 1%); Pharyngitis (6% vs 4%); Rhinitis (4% vs 3%); Sinusitis (2% vs 1%). **Special Senses:** Diplopia (2% vs 1%). Other events reported by 1% or more of adult patients treated with Keppra® but as or more frequent in the placebo group were the following: abdominal pain, accidental injury, amblyopia, arthralgia, back pain, bronchitis, chest pain, confusion, constipation, convulsion, diarrhea, drug level increased, dyspepsia, ecchymosis, fever, flu syndrome, fungal infection, gastroenteritis, gingivitis, grand mal convulsion, insomnia, nausea, otitis media, rash, thinking abnormal, tremor, urinary tract infection, vomiting and weight gain. **Table 2: Incidence (%) Of Treatment-Emergent Adverse Events In A Placebo-Controlled, Add-On Study In Pediatric Patients Ages 4-16 Years By Body System (Adverse Events Occurred In At Least 2% Of Keppra®-Treated Patients And Occurred More Frequently Than Placebo-Treated Patients).** Keppra® (N=101) vs Placebo (N=97): **Body System/Adverse Event: Body as a Whole:** Accidental Injury (17% vs 10%); Asthenia (9% vs 3%); Pain (6% vs 3%); Flu Syndrome (3% vs 2%); Face Edema (2% vs 1%); Neck Pain (2% vs 1%); Viral Infection (2% vs 1%). **Digestive System:** Vomiting (15% vs 13%); Anorexia (13% vs 8%); Diarrhea (8% vs 7%); Gastroenteritis (4% vs 2%); Constipation (3% vs 1%). **Hemic and Lymphatic System:** Ecchymosis (4% vs 1%). **Metabolic and Nutritional:** Dehydration (2% vs 1%). **Nervous System:** Somnolence (23% vs 11%); Hostility (12% vs 6%); Nervousness (10% vs 2%); Personality Disorder (8% vs 7%); Dizziness (7% vs 2%); Emotional Lability (6% vs 4%); Agitation (6% vs 1%); Depression (3% vs 1%); Vertigo (3% vs 1%); Reflexes Increased (2% vs 1%); Confusion (2% vs 0%). **Respiratory System:** Rhinitis (13% vs 8%); Cough Increased (11% vs 7%); Pharyngitis (10% vs 8%); Asthma (2% vs 1%). **Skin and Appendages:** Pruritis (2% vs 0%); Skin Discoloration (2% vs 0%); Vesiculobullous Rash (2% vs 0%). **Special Senses:** Conjunctivitis (3% vs 2%); Amblyopia (2% vs 0%); Ear Pain (2% vs 0%). **Urogenital System:** Albuminuria (4% vs 0%); Urine Abnormality (2% vs 1%). Other events occurring in 2% or more of pediatric patients treated with Keppra® but as or more frequent in the placebo group were the following: abdominal pain, allergic reaction, ataxia, convulsion, epistaxis, fever, headache, hyperkinesias, infection, insomnia, nausea, otitis media, rash, sinusitis, status epilepticus (not otherwise specified), thinking abnormal, tremor, and urinary incontinence. **Time Course Of Onset Of Adverse Events:** Of the most frequently reported adverse events in adults, asthenia, somnolence and dizziness appeared to occur predominantly during the first 4 weeks of treatment with Keppra®. **Discontinuation Or Dose Reduction In Well-Controlled Clinical Studies:** In well-controlled clinical studies, 15.0% of patients receiving Keppra® and 11.6% receiving placebo either discontinued or had a dose reduction as a result of an adverse event. Table 3 lists the most common (>1%) adverse events that resulted in discontinuation or dose reduction. **Table 3: Adverse Events That Most Commonly Resulted In Discontinuation Or Dose Reduction In Placebo-Controlled Studies In Adult Patients With Epilepsy.** Keppra® (N=769) vs Placebo (N=439): [Number (%)]: Asthenia [10 (1.3%) vs 3 (0.7%)]; Convulsion [23 (3.0%) vs 15 (3.4%)]; Dizziness [11 (1.4%) vs 0]; Somnolence [34 (4.4%) vs 7 (1.6%)]; Rash [0 vs 5 (1.1%)]. In the well-controlled pediatric clinical study, 16.8% of patients receiving Keppra® and 20.6% receiving placebo either discontinued or had a dose reduction as a result of an adverse event. The adverse events most commonly associated (≥3% in patients receiving Keppra®) with discontinuation or dose reduction in the well-controlled study are presented in Table 4. **Table 4: Adverse Events Most Commonly Associated With Discontinuation Or Dose Reduction In The Placebo-Controlled Study In Pediatric Patients Ages 4-16 Years With Epilepsy.** Keppra® (N=101) vs Placebo (N=97): [Number (%)]: Somnolence [3 (3.0%) vs 3 (3.1%)]; Hostility [7 (6.9%) vs 2 (2.1%)]; Asthenia (3 (3.0%) vs 0 (0.0%)]. **Comparison Of Gender, Age And Race:** The overall adverse experience profile of Keppra® was similar between females and males. There are insufficient data to support a statement regarding the distribution of adverse experience reports by age and race. **Postmarketing Experience:** In addition to the adverse experiences listed above, the following have been reported in patients receiving marketed Keppra® worldwide. The listing is alphabetized: leukopenia, neutropenia, pancreatitis, pancytopenia (with bone marrow suppression identified in some of these cases) and thrombocytopenia. Alopecia has been reported with Keppra® use; recovery was observed in the majority of cases where Keppra® was discontinued. There have been reports of suicidal behavior (including completed suicide) with marketed Keppra®. These adverse experiences have not been listed above, and data are insufficient to support an estimate of their incidence or to establish causation.

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