The ment with IPX066 compared with IR CD-LD, regardless of disease severity subgroup.

improvements in “off” time without worsening troublesome dyskinesia after treat-

subgroups (P < 0.001) and lower severity subgroups (P = 0.02) without reaching significance (P = 0.02) in melatonin group but this result was concluded based on a small number of

The mean difference (MD) or standardized mean difference (SMD) was calculated to allow dosing every 6 hours. This post hoc analysis investigated whether baseline

In TEMSO/TOWER, a total of 108/1169 patients with varying MS were randomized (1:1:1) to once-daily teriflunomide 14 mg, teriflunomide 7 mg, or placebo. Treatment duration was 108 weeks (TEMSO) or variable, based on time of enrollment (TOWER, 48–152 weeks, ending 48 weeks after last patient randomized). Primary and key secondary endpoints were analyzed relative to placebo. The Expanded Disability Status Scale confirmed for 12 weeks.

The efficacy of intravenous corticosteroids.

Panitch definition; (D) relapses leading to hospitalization; and (E) relapses requir-

ing treatment with intravenous corticosteroids. RESULTS: Teriflunomide 14 mg significantly reduced both ARR and disability progression versus placebo. Teriflunomide 7 mg significantly reduced ARR but not disability progres-

sion. Teriflunomide 14 mg significantly reduced annualized rates of severe relapse outcomes compared with placebo in TEMSO/TOWER by: (A) 36.2% (P = 0.004); (B) 56.2% (P < 0.0001); (C) 38.5% (P = 0.026); (D) 52.5% (P = 0.0015); and (E) 38.7% (P = 0.0003)/35.7% (P = 0.0032). Teriflunomide 14 mg also reduced annualized rates of severe relapse and disability progression, although not significantly in all definitions. Both teriflunomide doses showed simi-

lar safety profiles across the 2 studies. CONCLUSIONS: Teriflunomide 14 mg has shown consistent and significant positive effects on ARR and disability progression in all definitions. Both teriflunomide doses reduced or resolved relapses. CONCLUSION: Our analysis

in patients with varied neurological disorders.

well-defined and diverse FBA patient population, showing statistically significant improvement in a range of validated clinical and HRQOL outcomes relevant for the treatment of FBA. CONCLUSIONS: The evidence base for off-label agents used for treatment of FBA is limited, relying on small often uncontrolled studies showing ill-defined treatment effects and little or no safety tracking. DM/Q is the only treatment for FBA that has demonstrated efficacy in well-conducted clinical trials in patients with varied neurological disorders.

improvement in global impression of change and greater improvements in dyskinesia scores in those without worse post-dopamine dyskinesia after treatment with IPX066 compared with IR CD-LD, regardless of disease severity subgroup.

We did not find any evidence of statistical heterogeneity and publication bias. We performed a systematic review of randomized controlled tri-

The mean difference (MD) or standardized mean difference (SMD) was calculated to allow dosing every 6 hours. This post hoc analysis investigated whether baseline

dopa (CD-LD), is designed to produce a rapid increase in plasma levodopa concen-

OBJECTIVES: We performed a systematic review of randomized controlled tri-

The efficacy of melatonin versus placebo or other hypnotic agents on the improvement of sleep quality and quantity in patients with primary insomnia. METHODS: We searched the published literatures in eight electronic databases, including Ovid-Medline, EMBASE, the Cochrane Library, and five Korean databases through October 2014. We included articles comparing efficacy for sleep between melatonin and placebo or other hypnotic agents for at least 4 weeks for at least 2 weeks. The quality of studies was evaluated by using the Cochrane’s risk of bias.

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