

## POLICY & PRACTICE

### President Signs TBI Legislation

President Bush recently signed legislation to expand funding for traumatic brain injury rehabilitation programs. The reauthorization of the Traumatic Brain Injury Act (S. 793) also provides funding to study the incidence of traumatic brain injury and disability associated with it. Each year, about 1.4 million people sustain a traumatic brain injury, resulting in long-term disability, according to Sen. Orrin Hatch (R-Utah), a bill sponsor. In addition, TBI accounted for \$60 billion in both direct medical costs and indirect costs, such as lost productivity. "The reauthorized TBI Act promises to build on its tremendously successful first 10 years by extending services and establishing new studies to register brain injured veterans of Iraq and Afghanistan," Rep. Bill Pascrell (D-N.J.), another sponsor, said.

### Inpatient Rehab Proposal Issued

Officials at the Centers for Medicare and Medicaid Services issued a proposal to change payment rates for services provided at inpatient rehabilitation facilities, including rehabilitation for stroke and spinal cord injuries. CMS estimates the proposed changes will result in a decrease in aggregate payments of \$20 million in fiscal year 2009. The CMS proposed rule also calls for changing the case mix group relative weights and the average length of stay values based on updated data. The payment changes would go into effect on Oct. 1 and would apply to more than 200 freestanding facilities and inpatient rehabilitation facilities, and more than 1,000 units in acute care hospitals. Comments will be accepted until July 20. A final rule is expected Aug. 1.

### 2008 Potamkin Prize Awarded

The American Academy of Neurology has awarded three researchers the Potamkin Prize in Alzheimer's disease research. The three researchers will split the \$100,000 prize, designated for continuing their research efforts. This year's prize went to Dr. Clifford R. Jack Jr. of the Mayo Clinic in Rochester, Minn., and to Dr. William E. Klunk and Chester A. Mathis, Ph.D., both of the University of Pittsburgh. Dr. Jack's research involves the use of MRI measurements to assess the neurodegenerative stages of Alzheimer's disease. Dr. Klunk and Dr. Mathis developed a novel tracer for positron emission tomography that can identify the amyloid protein deposits characteristically present with Alzheimer's disease to help identify Alzheimer's earlier.

### Half of Health Spending Wasted

Wasteful spending in the U.S. health system could amount to as much as \$1.2 trillion of

the \$2.2 trillion spent annually, according to a report from the PriceWaterhouseCoopers' Health Research Institute. Defensive medicine was identified as the biggest excess, followed by inefficient administration and the cost of care necessitated by preventable conditions, such as obesity, according to the report. The impact of issues such as non-adherence to medical advice and prescriptions, alcohol abuse, smoking, and obesity "are exponential," the report said.

### Demand Strong for New MDs

The job market for new physicians in New


York is characterized by strong demand, according to a recent study from the Center for Health Workforce Studies at the University of Albany School of Public Health. The need for primary care physicians was comparable with the demand for specialists, with new primary care doctors reporting an increasing number of job offers and increasing median starting income. In addition, the median starting income for new physicians grew by 13% from 2005 to 2007. Median starting income was \$142,100 for primary care physicians.

### Disciplinary Actions Decline

The number and rate of serious discipli-

nary actions against physicians has decreased for the third consecutive year, according to Public Citizen's annual ranking of state medical boards. Since 2004, the number of serious disciplinary actions against doctors has decreased 17%, resulting in 553 fewer serious actions in 2007 than in 2004. Taking into account the increasing number of U.S. physicians since 2004, the rate of serious actions has fallen 22% since then, when calculated per 1,000 physicians, according to Public Citizen. The annual rankings are based on data from the Federation of State Medical Boards.

—Mary Ellen Schneider



**memantine HCl**

**Tablets/Oral Solution Rx Only**

**Brief Summary of Prescribing Information.**

*For complete details, please see full Prescribing Information for Namenda.*

**INDICATIONS AND USAGE**  
Namenda (memantine hydrochloride) is indicated for the treatment of moderate to severe dementia of the Alzheimer's type.

**CONTRAINDICATIONS**  
Namenda (memantine hydrochloride) is contraindicated in patients with known hypersensitivity to memantine hydrochloride or to any excipients used in the formulation.

**PRECAUTIONS**  
**Information for Patients and Caregivers:** Caregivers should be instructed in the recommended administration (twice per day for doses above 5 mg) and dose escalation (minimum interval of one week between dose increases).  
**Neurological Conditions**  
Seizures: Namenda has not been systematically evaluated in patients with a seizure disorder. In clinical trials of Namenda, seizures occurred in 0.2% of patients treated with Namenda and 0.5% of patients treated with placebo.  
**Genitourinary Conditions**  
Conditions that raise urine pH may decrease the urinary elimination of memantine resulting in increased plasma levels of memantine.

**Special Populations**  
**Hepatic Impairment**  
Namenda undergoes partial hepatic metabolism, with about 48% of administered dose excreted in urine as unchanged drug or as the sum of parent drug and the N-glucuronide conjugate (74%). No dosage adjustment is needed in patients with mild or moderate hepatic impairment. Namenda should be administered with caution to patients with severe hepatic impairment.  
**Renal Impairment**  
No dosage adjustment is needed in patients with mild or moderate renal impairment. A dosage reduction is recommended in patients with severe renal impairment (see CLINICAL PHARMACOLOGY and DOSAGE AND ADMINISTRATION in Full Prescribing Information).

**Drug-Drug Interactions**  
**N-methyl-D-aspartate (NMDA) antagonists:** The combined use of Namenda with other NMDA antagonists (amantadine, ketamine, and dextromethorphan) has not been systematically evaluated and such use should be approached with caution.  
**Effects of Namenda on substrates of microsomal enzymes:** *In vitro* studies conducted with marker substrates of CYP450 enzymes (CYP1A2, -2A6, -2C9, -2D6, -2E1, -3A4) showed minimal inhibition of these enzymes by memantine. In addition, *in vitro* studies indicate that at concentrations exceeding those associated with efficacy, memantine does not induce the cytochrome P450 isoenzymes CYP1A2, CYP2C9, CYP2E1, and CYP3A4/5. No pharmacokinetic interactions with drugs metabolized by these enzymes are expected.  
**Effects of inhibitors and/or substrates of microsomal enzymes on Namenda:** Memantine is predominantly renally eliminated, and drugs that are substrates and/or inhibitors of the CYP450 system are not expected to alter the metabolism of memantine.  
**Acetylcholinesterase (AChE) inhibitors:** Coadministration of Namenda with the AChE inhibitor donepezil HCl did not affect the pharmacokinetics of either compound. In a 24-week controlled clinical study in patients with moderate to severe Alzheimer's disease, the adverse event profile observed with a combination of memantine and donepezil was similar to that of donepezil alone.  
**Drugs eliminated via renal mechanisms:** Because memantine is eliminated in part by tubular secretion, coadministration of drugs that use the same renal cationic system, including hydrochlorothiazide (HCTZ), triamterene (TA), metformin, cimetidine, ranitidine, quinidine, and nifedipine, could potentially result in altered plasma levels of both agents. However, coadministration of Namenda and HCTZ/TA did not affect the bioavailability of either memantine or TA, and the bioavailability of HCTZ decreased by 20%. In addition, coadministration of memantine with the antihyperglycemic drug Glucovance® (glyburide and metformin HCl) did not affect the pharmacokinetics of memantine, metformin and glyburide. Furthermore, memantine did not modify the serum glucose lowering effect of Glucovance®.  
**Drugs that make the urine alkaline:** The clearance of memantine was reduced by about 80% under alkaline urine conditions at pH 8. Therefore, alterations of urine pH towards the alkaline condition may lead to an accumulation of the drug with a possible increase in adverse effects. Urine pH is altered by diet, drugs (e.g. carbonic anhydrase inhibitors, sodium bicarbonate) and clinical state of the patient (e.g. renal tubular acidosis or severe infections of the urinary tract). Hence, memantine should be used with caution under these conditions.

**Carcinogenesis, Mutagenesis and Impairment of Fertility**  
There was no evidence of carcinogenicity in a 113-week oral study in mice at doses up to 40 mg/kg/day (10 times the maximum recommended human dose [MRHD] on a mg/m<sup>2</sup> basis). There was also no evidence of carcinogenicity in rats orally dosed at up to 40 mg/kg/day for 71 weeks followed by 20 mg/kg/day (20 and 10 times the MRHD on a mg/m<sup>2</sup> basis, respectively) through 128 weeks.  
Memantine produced no evidence of genotoxic potential when evaluated in the *in vitro* S. typhimurium or E. coli reverse mutation assay, an *in vitro* chromosomal aberration test in human lymphocytes, an *in vivo* cytogenetics assay for chromosome damage in rats, and the *in vivo* mouse micronucleus assay. The results were equivocal in an *in vitro* gene mutation assay using Chinese hamster V79 cells.  
No impairment of fertility or reproductive performance was seen in rats administered up to 18 mg/kg/day (9 times the MRHD on a mg/m<sup>2</sup> basis) orally from 14 days prior to mating through gestation and lactation in females, or for 60 days prior to mating in males.

**Pregnancy**  
Pregnancy Category B: Memantine given orally to pregnant rats and pregnant rabbits during the period of organogenesis was not teratogenic up to the highest doses tested (18 mg/kg/day in rats and 30 mg/kg/day in rabbits, which are 9 and 30 times, respectively, the maximum recommended human dose [MRHD] on a mg/m<sup>2</sup> basis).

Slight maternal toxicity, decreased pup weights and an increased incidence of non-ossified cervical vertebrae were seen at an oral dose of 18 mg/kg/day in a study in which rats were given oral memantine beginning pre-mating and continuing through the postpartum period. Slight maternal toxicity and decreased pup weights were also seen at this dose in a study in which rats were treated from day 15 of gestation through the post-partum period. The no-effect dose for these effects was 6 mg/kg, which is 3 times the MRHD on a mg/m<sup>2</sup> basis.  
There are no adequate and well-controlled studies of memantine in pregnant women. Memantine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers**  
It is not known whether memantine is excreted in human breast milk. Because many drugs are excreted in human milk, caution should be exercised when memantine is administered to a nursing mother.

**Pediatric Use**  
There are no adequate and well-controlled trials documenting the safety and efficacy of memantine in any illness occurring in children.

**ADVERSE REACTIONS**  
The experience described in this section derives from studies in patients with Alzheimer's disease and vascular dementia.  
**Adverse Events Leading to Discontinuation:** In placebo-controlled trials in which dementia patients received doses of Namenda up to 20 mg/day, the likelihood of discontinuation because of an adverse event was the same in the Namenda group as in the placebo group. No individual adverse event was associated with the discontinuation of treatment in 1% or more of Namenda-treated patients and at a rate greater than placebo.  
**Adverse Events Reported in Controlled Trials:** The reported adverse events in Namenda (memantine hydrochloride) trials reflect experience gained under closely monitored conditions in a highly selected patient population. In actual practice or in other clinical trials, these frequency estimates may not apply, as the conditions of use, reporting behavior and the types of patients treated may differ. Table 1 lists treatment-emergent signs and symptoms that were reported in at least 2% of patients in placebo-controlled dementia trials and for which the rate of occurrence was greater for patients treated with Namenda than for those treated with placebo. No adverse event occurred at a frequency of at least 5% and twice the placebo rate.

Table 1: Adverse Events Reported in Controlled Clinical Trials in at Least 2% of Patients Receiving Namenda and at a Higher Frequency than Placebo-Treated Patients.

Body System Adverse Event	Placebo (N = 922) %	Namenda (N = 940) %
<b>Body as a Whole</b>		
Fatigue	1	2
Pain	1	3
<b>Cardiovascular System</b>		
Hypertension	2	4
<b>Central and Peripheral Nervous System</b>		
Dizziness	5	7
Headache	3	6
<b>Gastrointestinal System</b>		
Constipation	3	5
Vomiting	2	3
<b>Musculoskeletal System</b>		
Back pain	2	3
<b>Psychiatric Disorders</b>		
Confusion	5	6
Somnolence	2	3
Hallucination	2	3
<b>Respiratory System</b>		
Coughing	3	4
Dyspnea	1	2

Other adverse events occurring with an incidence of at least 2% in Namenda-treated patients but at a greater or equal rate on placebo were agitation, fall, inflicted injury, urinary incontinence, diarrhea, bronchitis, insomnia, urinary tract infection, influenza-like symptoms, abnormal gait, depression, upper respiratory tract infection, anxiety, peripheral edema, nausea, anorexia, and arthralgia.  
The overall profile of adverse events and the incidence rates for individual adverse events in the subpopulation of patients with moderate to severe Alzheimer's disease were not different from the profile and incidence rates described above for the overall dementia population.

**Vital Sign Changes:** Namenda and placebo groups were compared with respect to (1) mean change from baseline in vital signs (pulse, systolic blood pressure, diastolic blood pressure, and weight) and (2) the incidence of patients meeting criteria for potentially clinically significant changes from baseline in these variables. There were no clinically important changes in vital signs in patients treated with Namenda. A comparison of supine and standing vital sign measures for Namenda and placebo in elderly normal subjects indicated that Namenda treatment is not associated with orthostatic changes.

**Laboratory Changes:** Namenda and placebo groups were compared with respect to (1) mean change from baseline in various serum chemistry, hematology, and urinalysis variables and (2) the incidence of patients meeting criteria for potentially clinically significant changes from baseline in these variables. These analyses revealed no clinically important changes in laboratory test parameters associated with Namenda treatment.

**ECG Changes:** Namenda and placebo groups were compared with respect to (1) mean change from baseline in various ECG parameters and (2) the incidence of patients meeting criteria for potentially clinically significant changes from baseline in these variables. These analyses revealed no clinically important changes in ECG parameters associated with Namenda treatment.

**Other Adverse Events Observed During Clinical Trials**  
Namenda has been administered to approximately 1350 patients with dementia, of whom more than 1200 received the maximum recommended dose of 20 mg/day. Patients received Namenda treatment for periods of up to 884 days, with 862 patients receiving at least 24 weeks of treatment and 387 patients receiving 48 weeks or more of treatment. Treatment emergent signs and symptoms that occurred during 8 controlled clinical trials and 4 open-label trials were recorded as adverse events by the clinical investigators using terminology of their own choosing. To provide an overall estimate of the proportion of individuals having similar types of events, the events were grouped into a smaller number of standardized

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categories using WHO terminology, and event frequencies were calculated across all studies.

All adverse events occurring in at least two patients are included, except for those already listed in Table 1, WHO terms too general to be informative, minor symptoms or events unlikely to be drug-caused, e.g., because they are common in the study population. Events are classified by body system and listed using the following definitions: frequent adverse events - those occurring in at least 1/100 patients; infrequent adverse events - those occurring in 1/100 to 1/1000 patients. These adverse events are not necessarily related to Namenda treatment and in most cases were observed at a similar frequency in placebo-treated patients in the controlled studies.

**Body as a Whole:** *Frequent:* syncope. *Infrequent:* hypothermia, allergic reaction.

**Cardiovascular System:** *Frequent:* cardiac failure. *Infrequent:* angina pectoris, bradycardia, myocardial infarction, thrombophlebitis, atrial fibrillation, hypotension, cardiac arrest, postural hypotension, pulmonary embolism, pulmonary edema.

**Central and Peripheral Nervous System:** *Frequent:* transient ischemic attack, cerebrovascular accident, vertigo, ataxia, hypokinesia. *Infrequent:* paresthesia, convulsions, extrapyramidal disorder, hypertension, tremor, aphasia, hyposesthesia, abnormal coordination, hemiplegia, hyperkinesia, involuntary muscle contractions, stupor, cerebral hemorrhage, neuralgia, ptosis, neuropathy.

**Gastrointestinal System:** *Infrequent:* gastroenteritis, diverticulitis, gastrointestinal hemorrhage, melena, esophageal ulceration.

**Hemic and Lymphatic Disorders:** *Frequent:* anemia. *Infrequent:* leukopenia.

**Metabolic and Nutritional Disorders:** *Frequent:* increased alkaline phosphatase, decreased weight. *Infrequent:* dehydration, hyponatremia, aggravated diabetes mellitus.

**Psychiatric Disorders:** *Frequent:* aggressive reaction. *Infrequent:* delusion, personality disorder, emotional lability, nervousness, sleep disorder, libido increased, psychosis, amnesia, apathy, paranoid reaction, thinking abnormal, crying abnormal, appetite increased, paroniria, delirium, depersonalization, neurosis, suicide attempt.

**Respiratory System:** *Frequent:* pneumonia. *Infrequent:* apnea, asthma, hemoptysis.

**Skin and Appendages:** *Frequent:* rash. *Infrequent:* skin ulceration, pruritus, cellulitis, eczema, dermatitis, erythematous rash, alopecia, urticaria.

**Special Senses:** *Frequent:* cataract, conjunctivitis. *Infrequent:* macula lutea degeneration, decreased visual acuity, decreased hearing, tinnitus, biphthalmia, blurred vision, corneal opacity, glaucoma, conjunctival hemorrhage, eye pain, retinal hemorrhage, xerophthalmia, diplopia, abnormal lacrimation, myopia, retinal detachment.

**Urinary System:** *Frequent:* frequent micturition. *Infrequent:* dysuria, hematuria, urinary retention.

**Events Reported Subsequent to the Marketing of Namenda, both US and Ex-US**

Although no causal relationship to memantine treatment has been found, the following adverse events have been reported to be temporally associated with memantine treatment and are not described elsewhere in labeling: aspiration pneumonia, asthma, atrioventricular block, bone fracture, carpal tunnel syndrome, cerebral infarction, chest pain, cholelithiasis, claudication, colitis, deep venous thrombosis, depressed level of consciousness (including loss of consciousness and rare reports of coma), dyskinesia, dysphagia, encephalopathy, gastritis, gastroesophageal reflux, grand mal convulsions, intracranial hemorrhage, hepatitis (including increased ALT and AST and hepatic failure), hyperglycemia, hyperlipidemia, hypoglycemia, ileus, increased INR, impotence, lethargy, malaise, myoclonus, neuroleptic malignant syndrome, acute pancreatitis, Parkinsonism, acute renal failure (including increased creatinine and renal insufficiency), prolonged QT interval, restlessness, sepsis, Stevens-Johnson syndrome, suicidal ideation, sudden death, supraventricular tachycardia, tachycardia, tardive dyskinesia, thrombocytopenia, and hallucinations (both visual and auditory).

**ANIMAL TOXICOLOGY**  
Memantine induced neuronal lesions (vacuolation and necrosis) in the multipolar and pyramidal cells in cortical layers III and IV of the posterior cingulate and retrosplenial neocortices in rats, similar to those which are known to occur in rodents administered other NMDA receptor antagonists. Lesions were seen after a single dose of memantine. In a study in which rats were given daily oral doses of memantine for 14 days, the no-effect dose for neuronal necrosis was 6 times the maximum recommended human dose on a mg/m<sup>2</sup> basis. The potential for induction of central neuronal vacuolation and necrosis by NMDA receptor antagonists in humans is unknown.

**DRUG ABUSE AND DEPENDENCE**  
**Controlled Substance Class:** Memantine HCl is not a controlled substance.

**Physical and Psychological Dependence:** Memantine HCl is a low to moderate affinity noncompetitive NMDA antagonist that did not produce any evidence of drug-seeking behavior or withdrawal symptoms upon discontinuation in 2,504 patients who participated in clinical trials at therapeutic doses. Post marketing data, outside the U.S., retrospectively collected, has provided no evidence of drug abuse or dependence.

**OVERDOSAGE**  
Signs and symptoms associated with memantine overdose in clinical trials and from worldwide marketing experience include agitation, confusion, ECG changes, loss of consciousness, psychosis, restlessness, slowed movement, somnolence, stupor, unsteady gait, visual hallucinations, vertigo, vomiting, and weakness. The largest known ingestion of memantine worldwide was 2.0 grams in a patient who took memantine in conjunction with unspecified antidiabetic medications. The patient experienced coma, diplopia, and agitation, but subsequently recovered.

Because strategies for the management of overdose are continually evolving, it is advisable to contact a poison control center to determine the latest recommendations for the management of an overdose of any drug. As in any cases of overdose, general supportive measures should be utilized, and treatment should be symptomatic. Elimination of memantine can be enhanced by acidification of urine.

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