tory to treatment, thus introducing a selection bias. To address this concern, we reanalyzed our data to determine the outcomes of the 62 excluded patients. If the excluded patients were treatment failures, one would expect a higher mortality rate than in the analyzed group. However, the in-hospital mortality for the excluded patients was 60% (37/62), which was slightly lower than the population included in the study (68%), arguing against therapeutic failure in the patients with incomplete documentation.

Brain herniation is a medical emergency analogous to cardiopulmonary arrest and delaying treatment in order to obtain central venous access is unacceptable. Thus, 23.4% may only be used as a first-line hyperosmolar agent in patients with a pre-existing central venous catheter. In others, a peripherally compatible hyperosmolar agent such as mannitol should be given initially, until central access has been established. In our Neurosciences Critical Care Unit this has rarely been an issue, since a high proportion of patients who experience herniation already have central venous access.

*Robert D. Stevens, Matthew A. Koenig,
Baltimore, MD*

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CORRECTION

Lamotrigine extended-release as adjunctive therapy for partial seizures

In the article “Lamotrigine extended-release as adjunctive therapy for partial seizures” by D.K. Naritoku et al. (*Neurology*® 2007;69:1610–1618), as a result of changes to the database from audits conducted across all participating study sites, some of the data reported in the manuscript have changed slightly. These audits were conducted by the study sponsor, GlaxoSmithKline, in preparation for response to the FDA approvable letter for the Lamictal XR New Drug Application. The outcome of the audits did *not* change the overall conclusions of the study, but did lead to small changes in some of the data in the manuscript. The new data have replaced the previous numbers published in the abstract, now in brackets:

ABSTRACT

Objective: To evaluate the efficacy and tolerability of once-daily adjunctive lamotrigine extended-release (XR) for partial seizures in epilepsy.

Methods: Patients more than 12 years old diagnosed with epilepsy with partial seizures and taking one to two baseline antiepileptic drugs were randomized to adjunctive once-daily lamotrigine XR or placebo in a double-blind, parallel-group trial. The study comprised a baseline phase, a 7-week double-blind escalation phase, and a 12-week double-blind maintenance phase during which doses of study medication and concomitant antiepileptic drugs were maintained.

Results: Of the 243 randomized patients, 239 (118 lamotrigine XR, 121 placebo) entered the escalation phase and received study medication. Lamotrigine XR was more effective than placebo with respect to median percent reduction from baseline in weekly partial seizure frequency (primary endpoint—entire 19-week treatment phase: 46.6% [was 46.1%] vs 24.5% [was 24.2%], $p = 0.0001$ [was 0.0004] via Wilcoxon test; escalation phase: 29.8% [was 28.0%] vs 15.6% [was 16.3%], $p = 0.027$ [was 0.028]; maintenance phase: 58.4% [was 58.0%] vs 26.8% [was 26.7%], $p < 0.0001$). The percentage of patients with $\geq 50\%$ reduction in partial seizure frequency (44.0% [was 42.2%] vs 20.8% [was 24.2%], $p = 0.0002$ [was 0.0037]) and time to $\geq 50\%$ reduction in partial seizure frequency ($p = 0.0001$) (was 0.0007) also favored lamotrigine XR over placebo. A similar pattern of results was observed for secondarily generalized seizures. The most common adverse events were headache (lamotrigine XR 16% [was 17%], placebo 18% [was 15%]) and dizziness (lamotrigine XR 19% [was 18%], placebo 5%). Differences between lamotrigine XR and placebo on health outcomes measures were not significant.

Conclusions: Once-daily adjunctive lamotrigine extended-release compared with placebo effectively reduced partial seizure frequency and was well tolerated in this double-blind study. Results support the clinical utility of this new once-daily formulation.

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Lamotrigine extended-release as adjunctive therapy for partial seizures

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