Hong Kong Paediatric Haematology & Oncology Study Group

Annual Scientific Symposium 2023 & 30th Anniversary Celebration

22 April 2023 (Saturday)

Website: https://www.fmshk.com.hk/hkphosg/home.htm

Biotherapies for Life™ **CSL Behring**

IDELVION™

Coagulation Factor IX (Recombinant), Albumin Fusion Protein

For adults and children with hemophilia B

LONG-LASTING BLEED PROTECTION

The only entended half-life Factor IX therapy to deliver:

0 BLEEDS MEDIAN AsBR[1-3]

Zero median annualized spontaneous bleeding rate (AsBR) on all dosing regimens[1-3*]

UP TO 21 DAY DOSING[†4]

Dosing schedule flexibility that meets your patient's needs

21% FIX TROUGH LEVELS WITH ONCE-WEEKLY DOSING[‡5]

High and sustained FIX trough levels

* *In the pivotal trial, the median AsBR was zero both for subjects ≥12 years receiving 7-day and 14-day prophylactic treatment [1]. In the extension study, the median AsBR was zero both of subjects ≥12 years receiving 7-day and >18 years receiving 21-day prophylactic treatment[3]. Patients <12 who dosed every 7 days achieved 0 AsBR [2].*

† *The 21 days dosing is only for patients aged >18 years.*

‡ *Mean steady-state FIX trough level of 21% with 7-day dosing at a mean dose of 41.3 IU/kg in patients ≥12 years*

Before prescribing, please review the approved Hong Kong Package Insert, August 2021

IDELVION 250/500/1000/2000 IU powder and solvent for solution for injection

Indications: Treatment and prophylaxis of bleeding in patients with haemophilia B (congenital factor IX deficiency). IDELVION can be used for all age groups. **Dosage and Administration:** On demand treatment: For patients <12 years of age; Dose (IU) = body weight (kg) x desired factor IX rise (IU/dl) x 1 dl/kg. For patients ≥12 years of age; Dose (IU) = body weight (kg) x desired factor IX rise (IU/dl) x 0.77 dl/kg. See package insert for example calculations and further dosing guidance in bleeding episodes and surgery. Prophylaxis Treatment: The usual doses are 35 to 50 IU/kg once weekly. Patients who are well-controlled on a once-weekly regimen might be treated with up to 75 IU/kg every 10 or 14 days. For patients >18 years, further extension of the treatment interval may be considered. In some cases, e.g. younger patients, shorter dose intervals or higher doses may be necessary. After a bleeding episode during prophylaxis, the prophylaxis regimen should be maintained as closely as possible, with two doses being administered at least 24 hours apart but longer as deemed suitable. Paediatric population: For long term prophylaxis the recommended regimen is 35 to 50 IU/kg once weekly. For adolescents of 12 years of age and above, the dose recommendations are the same as for adults. **Method of administration:** The reconstituted preparation should be injected slowly intravenously at a comfortable rate up to a maximum of 5 ml/min. After reconstitution the chemical and physical in-use stability has been demonstrated for 8 hours at 2-25 °C. If not used immediately, in-use storage times and conditions prior to use should not be longer than 4 hours at room temperature (below 25 °C). **Contraindications:** Hypersensitivity to the active or to any of the excipients. Known allergic reaction to hamster protein. **Precautions:** *Hypersensitivity*: Allergic type hypersensitivity reactions are possible. *Inhibitors*: Formation of inhibitor to factor IX has been reported with IDELVION in the treatment of haemophilia B. Patients should be monitored for the development of neutralising antibodies (inhibitors) after repeated treatment. *Thromboembolism*: Due to a potential risk of thrombotic complications, patients with liver disease, post-operatively, newborn infants, patients at risk of thrombotic phenomena or DIC should be monitored for early signs of thrombotic and consumptive coagulopathy. *Cardiovascular events*: Patients with existing cardiovascular risk factors, FIX therapy may increase cardiovascular risk. *Catheter-related complications*: If a central venous access device (CVAD) is required, risk of CVAD-related complications including local infections, bacteraemia and catheter site thrombosis should be considered. *Immune tolerance induction*: Safety and efficacy for immune tolerance induction has not been established. *Sodium content*: Idelvion contains up to 8.6 mg sodium per vial. *Traceability*: Name and batch number of the product administered should be recorded. **Undesirable effects:** Dizziness, injection site reactions, headache, hypersensitivity, rash, eczema.

Reference

1. *Santagostino E, Martinowitz U, Lissitchkov T, et al. Blood. 2016;127(14):1761–1769.*
2. *Kenet G, Chambost H, Male C, et al. Thromb Haemost. 2016;116(4):659–668.*
3. *Mancuso M.E., Lubetsky A., Pan-Petesch B., et al. J Thromb Haemost. 2020;18(5):1065-1074.*
4. *Idelvion Hong Kong Package insert, Aug 2021*
5. *Gill JC, Roberts J, Li Y, Castaman G. Haemophilia. 2019;25:e219–e222*

CSL Behring Asia Pacific Limited
4201,4205-4209, AIA Tower, 183 Electric Road
North Point, Hong Kong

HKG-IDL-02230002
Date of preparation: Feb 2023

Message from the Chairperson

Dr Lam Kee See Grace

HKPHOSG Chairperson (2021 – 2023)

It is my great pleasure and honour to celebrate the 30th anniversary of the Hong Kong Paediatric Haematology and Oncology Study Group (HKPHOSG).

"The only time you should ever look back, is to see how far you've come."

Established in 1993, HKPHOSG had built the foundation for the close partnership among paediatricians in different hospitals to provide standardized treatment and care for children with haematology and oncology conditions in Hong Kong. Through this platform, we have actively participated in successive clinical trials in collaboration with national and international groups. The 45th Congress of the International Society of Paediatric Oncology (SIOP) was hosted in Hong Kong in 2013. We started a new phase for paediatric haematology and oncology service in Hong Kong with the opening of Hong Kong Children's Hospital in 2018, further consolidating our efforts under one roof to better patient care. The subspecialty of paediatric haematology and oncology (PHO) is now formally established within the Hong Kong College of Paediatricians, and the PHO subspecialty training program have started in 2023. The 30th anniversary of HKPHOSG is a timely celebration of all the milestones achieved. I would like to express our gratitude to our founders and seniors for their wisdom, leadership and perseverance over the years.

"Teamwork makes the dream work."

Paediatric haematology and oncology is often considered as a field in which research and care are highly integrated. We witnessed the improvement in survival and quality of life for our children with blood disorders and cancers over the past decades through evidenced-based treatments and enhancing supportive care. Against all odds, these are made possible by the strong collaboration among multidisciplinary teams and stakeholders. I extend our sincere appreciation to all the professional healthcare teams, university research teams, Children's Cancer Foundation, patient groups, and many organizations for their unfailing support. As we enter the exciting era of personalized and precision medicine, we should seek to turn new challenges into opportunities. With active engagement of our younger generation of PHO specialists and trainees, I trust that our group will continue to evolve and move forward together in our missions of "care, support, treatment, education".

Last but not least, I would like to dedicate a special thanks to all our patients and their families, who are our passion and our motivation. It has been a privilege to share the incredible journey with the little warriors.

Wish everyone good health and hope you enjoy the celebration.

HKPHOSG Office Bearers 2021-2023

Chairperson	Dr Lam Kee See Grace
Vice-chairperson	Dr Leung Wing Kwan Alex
Honorary Secretary	Dr Yan Lai Sim Carol
Honorary Treasurer	Dr Liu Pak Yin Anthony
Council Members	Dr Cheuk Ka Leung Daniel Dr Li Chak Ho Rever Dr Ku Tak Loi Dennis Dr Chiu Ka Ho Jackie

Organizing Committee Members of HKPHOSG 30th Anniversary

- Dr Lam Kee See Grace
- Dr Leung Wing Kwan Alex
- Dr Yan Lai Sim Carol
- Dr Liu Pak Yin Anthony
- Dr Ku Tak Loi Dennis
- Dr Chow Tin Wai Terry
- Dr Chan Yau Ki Wilson
- Dr Tong Pui Yung Grace
- Dr Hoo Pui Lun Calvin
- Dr Yeung Tsz Wing Valerie
- Dr Leung Wing Yan Cindy
- Dr Li Wai Tung Mario

Programme Rundown

Hong Kong Paediatric Haematology & Oncology Study Group
Annual Scientific Symposium 2023 & 30th Anniversary Celebration

Theme	:	Development of Paediatric Haematology and Oncology Subspeciality in Hong Kong – Past Present and Future
Date	:	22 April 2023 (Saturday)
Venus	:	Venus: Shanghai Room, Level 8, Cordis, Hong Kong *(555 Shanghai Street, Mongkok, Kowloon, Hong Kong)*

Program

Annual Scientific meeting	5:30 – 7:30 pm *(Reception commences at 5:15pm)*
Keynote Lectures:	
Lecture 1	Advances in Paediatric Brain Tumours and the Use of Novel Agents *~ by Dr Eric Bouffet*
Lecture 2	Development of Paediatric Haematology and Oncology Subspeciality in Hong Kong – Past Present and Future *~ by Prof. Li Chi Kong*
Dinner	7:45 – 9:00 pm

Advances in Paediatric Brain Tumours and the Use of Novel Agents

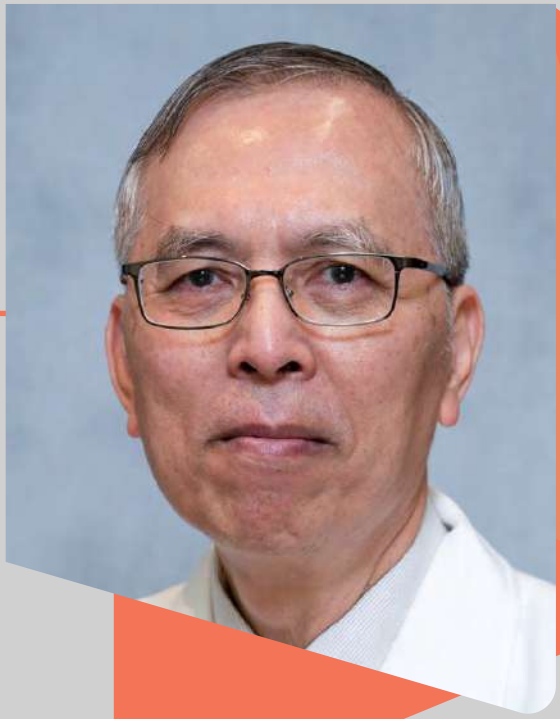
Dr Eric Bouffet

Emeritus Professor of Paediatrics,
University of Toronto, Canada

Speaker Biography

Dr Bouffet is an Emeritus Professor of Paediatrics in the University of Toronto. He initially trained and practiced in France before he moved to the United Kingdom in 1996. In 2000, he was recruited to The Hospital for Sick Children in Toronto to develop and head a multidisciplinary Paediatric Neuro-oncology Program. His research interests are in the area of novel treatments and clinical trials in children with brain tumours and implementation of neuro-oncology programs in countries with limited resources. He is author or co-author of over 600 peer-reviewed manuscripts and author/co-author on numerous book chapters in the field of neuro-oncology. He was President of the International Society of Paediatric Oncology (2016-2019) and the recipient of the SNO Life Achievement Award in 2021.

Development of Paediatric Haematology and Oncology Subspecialty in Hong Kong - Past, Present and Future



Prof. Li Chi Kong

Research Professor,
Department of Paediatrics,
Faculty of Medicine,
The Chinese University of Hong Kong,
Hong Kong

Speaker Biography

Prof. Li graduated from the University of Hong Kong in 1981. He completed general paediatric training at Hong Kong and then specialised in paediatric haematology and oncology. He received further training at John Radcliff Hospital, Oxford, and Great Ormond Street Hospital, London in 1986, and Fred Hutchison Cancer Research Centre, Seattle in 1992. Prof. Li joined the Prince of Wales Hospital in 1989 as Senior Medical Officer. He is now professor in the department of Paediatrics at the Chinese University of Hong Kong, as well as the Honorary Consultant at the Prince of Wales Hospital and Hong Kong Children's Hospital. His main interest is in childhood leukaemia, palliative care and bioethics. He is the study chair of acute lymphoblastic leukaemia trials in Hong Kong and local coordinators of several international multi-centre studies. He introduced new treatment methods for children in Hong Kong, including double unit umbilical cord blood transplantation. Prof. Li actively involves in the development of paediatric oncology in mainland China. He is currently the honorary professor in three medical universities in China. He had been the vice-chairman of China Children Cancer Group, and the vice-chairman of steering committee for three consecutive multi-centre leukaemia studies in China. Internationally he is the Immediate Past-President of Asia Continent of International Society of Pediatric Oncology. He has published over 300 peer-reviewed papers and written chapters in four books. He also served as editors in medical journals including Pediatric Blood & Cancer, Chinese Journal of Pediatrics, China Journal of Pediatric Hematology & Oncology.

Introduction of the HKPHOSG

BACKGROUND

Established in 1993, the Hong Kong Paediatric Haematology & Oncology Study Group (HKPHOSG) is a professional society comprised of medical and healthcare personnel who have special interest in the management of children with blood diseases and cancer.

OBJECTIVE

1

To advance the interest in the knowledge of haematology and oncology in children

2

To endeavour to improve the standard of care of children suffering from blood diseases and cancer

3

To promote child health in relation to haematology and oncology

MISSIONS

Care | Support | Treatment | Education

WHAT WE DO

- Organization of regular scientific meetings and workshops
- Supporting members to attend local and international conferences
- Standardization of treatment protocols
- Initiation and participation in local, national and international collaborative trials for treatment of childhood blood and malignant diseases

Milestones in the History of HKPHOSG

In the 1980s, pioneering paediatric oncologists from Princess Margaret Hospital (PMH) and Queen Elizabeth Hospital (QEH), including Dr Leung Nai Kong, Dr Li Chi Keung, Prof. Li Chi Kong, Dr Yuen Hui Leung, Dr Lee Shan Ho, Dr Lam Tai Kwan, Dr Cheng Man Yung, Prof. Lau Yu Lung, and Dr Ha Shau Yin, had regular meetings every two months to discuss patient cases. At that time, there were no unified treatment protocols for childhood cancers.

In 1984, Prof. Yuen Man-pan Patrick joined the Department of Paediatrics, CUHK, and established the paediatric haematology and oncology ward. In 1989, Prof. Li Chi Kong joined the Paediatrics in Prince of Wales Hospital (PWH), and Tuen Mun Hospital (TMH) was established in the early 1990s.

1989: The PWH ward

1989:The QMH ward

In 1994, Dr Ha Sau Yin joined the Paediatrics in Queen Mary Hospital (QMH). The haematologists and oncologists in the five paediatric units, namely PMH, PWH, QEH, QMH, and TMH, gradually came together and had the idea of establishing a study group to unify treatment protocols and support members to attend overseas conferences.

HKPHOSG was established in 1993, with Prof. Yuen as the founding chairperson and Prof. Li Chi Kong as the founding Honorary Secretary. The first scientific committee was set up in 1995, with members taking up roles in studying different oncological diseases, collecting and reviewing Hong Kong data. For example, Prof. Li Chi Kong focused on the acute lymphoblastic leukaemia (ALL) group, while Dr Ha Sau Yin focused on the acute myeloid leukaemia (AML) group. Two of the early unifying treatment protocols in Hong Kong for paediatric cancers were those for ALL and osteosarcoma in 1993. The Study Group reached out to the International BFM (I-BFM) group, with experts being invited to deliver lectures in Hong Kong, while members were also invited to attend overseas meetings.

1992: Prof. Yuen, Prof. Li at PWH

1995: Lady Pao Children's Cancer Centre

1997: QEH team

2001: Ms Anson Chan Fang On-sang visit to QMH

Milestones in the History of HKPHOSG

Initially, HKPHOSG was invited to participate in some small studies only, such as the Interfant protocol and Down's AML studies. Gradually, members fought their way into participating and contributing in large inter-continental studies, such as the I-BFM intercontinental study for ALL, lymphomas, Wilms tumour, etc. The Study Group played a key role in academic exchange with Chinese paediatric oncologists, and a joint ALL study with Singapore showed the role of regional collaboration of the Study Group. The 45th Congress of The International Society of Paediatric Oncology (SIOP) was hosted in Hong Kong in 2013, with over 1,100 participants from all over the world attending.

Jan 2004: Visit of Prof. Roger J Packer

Aug 2011: Annual Scientific Workshop

Apr 2004: Visit of Prof. Nai Kong Cheung

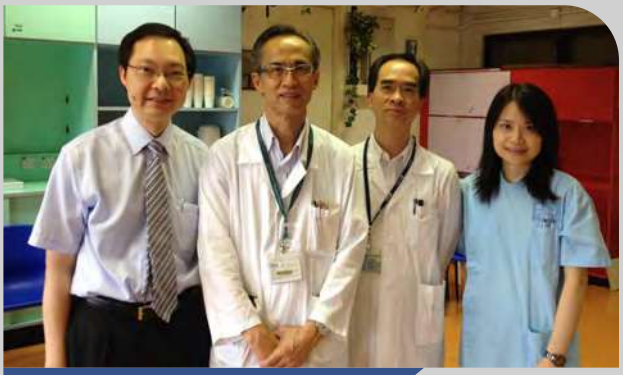
Sept 2013: SIOP Hong Kong 2013

2005: TMH team

2019: TMH team

Milestones in the History of HKPHOSG

The establishment of the Hong Kong Children's Hospital (HKCH) is a significant step forward for paediatric haematology and oncology services in Hong Kong. This achievement is due in part to the tireless efforts of Prof. Chan Chi Fung Godfrey, who has been advocating for a children's hospital in Hong Kong since the 2000s. Territory-wide paediatric oncology service has commenced since July 2019, marking a major milestone in the service landscape of Hong Kong. The oncology teams and their patients from PWH, PMH, TMH, QMH, and QEH have gradually transitioned to the new hospital, with Prof. Chan taking up the role of the first Chief-of-Service.



PMH team

Sept 2014: HKCH Ground breaking ceremony

Accreditation of subspecialty of Paediatric Haematology & Oncology (PHO) was completed in 2022. Conferment of the first fellows was held in December 2022. The training programme was commenced from January 2023.

July 2022: HKCH PHO team

Feb 2022: PHO Accreditation visit

Dec 2022: First PHO conferment ceremony

HKPHOSG Office Bearers 2013-2021

2013-2015	
Chairperson	Dr Li Chak Ho Rever
Vice-chairperson	Dr Cheng Wai Tsoi Frankie
Honorary Secretary	Dr Cheuk Ka Leung Daniel
Honorary Treasurer	Dr Chang Kai On
Council Members	Prof. Chan Chi Fung Godfrey Dr Lee Vincent Dr Ling Siu Cheung Alvin Dr Yau Ping Wa Jeffrey

2015-2017	
Chairperson	Dr Cheng Wai Tsoi Frankie
Vice-chairperson	Dr Cheuk Ka Leung Daniel
Honorary Secretary	Dr Chang Kai On
Honorary Treasurer	Dr Ku Tak Loi Dennis
Council Members	Prof. Chan Chi Fung Godfrey Dr Lee Vincent Dr Ling Siu Cheung Alvin Dr Li Chak Ho Rever

2017-2019	
Chairperson	Dr Cheuk Ka Leung Daniel
Vice-chairperson	Dr Ku Tak Loi Dennis
Honorary Secretary	Dr Leung Wing Kwan Alex / Dr Lam Kee See Grace
Honorary Treasurer	Dr Fu Chun Ho Eric
Council Members	Dr Ling Siu Cheung Alvin Dr Li Chak Ho Rever Dr Chiang Kwok Shing Alan Dr Cheng Wai Tsoi Frankie

2019-2021	
Chairperson	Dr Ku Tak Loi Dennis
Vice-chairperson	Dr Lam Kee See Grace
Honorary Secretary	Dr Chan Yau Ki Wilson
Honorary Treasurer	Dr Chiu Ka Ho Jackie
Council Members	Dr Cheng Wai Tsoi Frankie Dr Cheuk Ka Leung Daniel Dr Chiang Kwok Shing Alan Dr Li Chak Ho Rever

HKPHOSG's Latest Events

2019-2020

ANNUAL SCIENTIFIC WORKSHOP

Childhood cancer statistics, leukaemia (AML and ALL) and lymphoma (day 1); osteogenic sarcoma and CNS tumour (day 2)
(7-8 Sept 2019)

CO-ORGANIZER / SUPPORTING ORGANIZATION FOR LOCAL MEETINGS

Survivor symposium by PKW Foundation
(21 Sept 2019)

OTHERS

RTHK 精靈一點
Dr Dennis Ku and Dr Grace Lam (Sept 2019)

BIMONTHLY SCIENTIFIC MEETINGS

TOPICS:

- Management of tumour lysis syndrome
  Dr Wilson Chan (11 Mar 2019)
- Supportive care in paediatric oncology - An overview on chemotherapy-induced nausea and vomiting, pain management and chemotherapy extravasation at Hong Kong
  Ms Sharon Lam and Mr Alex Cho (6 May 2019)
- Use of eltrombopag in chronic immune thrombocytopenia and severe aplastic anaemia
  Dr Wilson Chan (8 July 2019)
- Management of severe aplastic anaemia
  Dr Queenie See (13 Jan 2020)

2020-2021

ANNUAL SCIENTIFIC MEETING

Advances in multi-disciplinary management of haemangiomas and vascular malformation
Prof. GCF Chan, Dr David Luk, Dr Michael Leung (8 Jun 2020)

BIMONTHLY SCIENTIFIC MEETINGS

TOPICS:

A rare bleeding disorder with normal clotting profile
by Dr Toria Lee (TMH) (14 Sept 2020)

TALKS BY LOCAL AND OVERSEAS SPEAKERS

- The use of tyrosine kinase inhibitors (TKIs) in paediatric Ph+ acute lymphoblastic leukaemia (Ph+ ALL)
  Prof. CK Li (19 Oct 2020)
- Palliative Care for Children with Brain Tumors
  Dr Justin Baker (20 Oct 2020)

2020-2021(Cont)

ANNUAL SCIENTIFIC WORKSHOP

Childhood cancer statistics, leukaemia (AML and ALL) and lymphoma (day 1); osteogenic sarcoma and CNS tumour (day 2)
(14-15 Nov 2020)

OTHERS

RTHK 精靈一點"Drugs and treatment of paediatric cancers"
Dr Dennis Ku and Dr Grace Lam (2 Feb 2021)

CO-ORGANIZER / SUPPORTING ORGANIZATION FOR LOCAL MEETINGS

- The 9th Cross Straits Children Oncology Meeting & the 3rd Asian Neuroblastoma Meeting - Conjoint virtual meeting with Dept of Surgery, HKU
  (21 Sept 2019)
- Paediatric SAA (CME Symposium)
  Prof. Godfrey Chan and Prof. YL Kwong (14 Dec 2020)

2021-2022

ANNUAL SCIENTIFIC MEETING

Paediatric Hereditary Cancer Syndromes
Dr Leung Wing Kwan Alex, Dr Luk Ho Ming, Dr Chung Hon Yin Brian (29 May 2021)

CO-ORGANIZER / SUPPORTING ORGANIZATION FOR LOCAL MEETINGS

- Online health talk on "COVID-19 vaccination for paediatric patients with cancers, haematological and renal diseases",
  organized by Little Life Warrior Society, HKPHOSG as supporting organization, Dr Grace Lam (Host)(22 June 2021)
- Online seminar on "Haemophilia Service in HKCH",
  co-organized by HK Haemophilia Society (31 July 2021)
- "Workshop of Ultrasonography on Patients with Haemophilia",
  co-organized by the HK Haemophilia Society (16 Oct 2021)

BIMONTHLY SCIENTIFIC MEETINGS

TOPICS:

- Uncommon cause of neonatal thrombocytopenia
  by Dr Chiu Ka Ho Jackie (8 March 2021)
- Total Body Irradiation in Children - PWH Experience
  by Dr Yeung Wui Ming Eva (27 September 2021)
- Childhood Malignancy in Disguise - Challenging presentations in COVID 19 era
  by Dr Tong Pui Yung Grace, Dr Hoo Pui Lun Calvin, Dr Li Wai Tung Mario (10 January 2022)

OTHERS

- Review and endorsement of MIMS Education self-study video module "A Primer on Optimizing Patient Outcomes Using Patient Blood Management"
- "HKPHOSG Interim recommendations on COVID-19 vaccine" (20-6-2021), document issued to study group members and sent to HK College of Paediatricians

2022-2023

ANNUAL SCIENTIFIC SYMPOSIUM

Advances in Paediatric Oncology - Keynote lecturesby Prof. Hubert Caron, Prof NK Cheung, Prof. Wing Leung & HKPHOSG presentations + free paper presentations
(30 Apr 2022)

CO-ORGANIZER / SUPPORTING ORGANIZATION FOR LOCAL MEETINGS

- Online health talk on "Safety and efficacy of COVID-19 vaccination for young children"organized by Little Life Warrior Society, HKPHOSG as supporting organization
  Dr Grace Lam(Host), Dr Anthony Liu (Speaker) (21 Sep 2022)
- Hong Kong Haemophilia Society Keynote Lecture 2022: "A brief history of haemophilia care in Hong Kong"

BIMONTHLY SCIENTIFIC MEETINGS

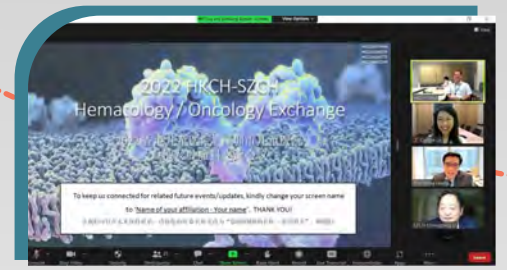
TOPICS:

- Lessons from Two Children with Abnormal Haemoglobin Level
  Dr Evelyn Lu, Dr Wilson Chan, Dr SY Ha, Dr Jason So (11 July 2022)
- The Prospect of Proton Therapy Development in Paediatric Oncology
  Dr Kam Koon Ming Michael (14 Nov 2022)

OTHERS

- Review and endorsement of MIMS Education self-study video module "Congenital bleeding disorders: How to spot the tell-tale signs"
- RTHK 精靈一點 - 香港兒科醫學院系列 - 兒童血液及腫瘤疾病
  Dr Grace Lam and Dr Anthony Liu (30 Jan 2023)

Miscellaneous event photos



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FOR THE UNSTOPPABLE

ALPROLIX®
[Coagulation Factor IX (Recombinant), Fc Fusion Protein]

API-HK-ELO-21.05
Presentation: Eloctate (efmoroctocog alfa) powder and solvent for solution for injection. Indications: For use in adults and children with haemophilia A for control and prevention of bleeding episodes, or routine prophylaxis to prevent or reduce the frequency of bleeding episodes, or perioperative management. Dosage & Administration: Control and prevention of bleeding episodes: Minor and Moderate Bleed – 20-30 IU/kg, repeat Q24-48H until bleeding resolved (Q12-24H if less than 12 years old), Major Bleed – 40-50 IU/kg, repeat Q12-24H until bleeding resolved (Q8-24H if less than 12 years old). Routine Prophylaxis: 50 IU/kg every 3-5 days, may be adjusted based on patient response in the range of 25-65 IU/kg. More frequent or higher doses up to 80IU/kg may be required in children less than 12 years old. 65 IU/kg for weekly prophylaxis. Perioperative Management: Minor Surgery – 25-40 IU/kg, repeat Q24H (Q12-24H if less than 12 years old) as needed, Major Surgery – initial preoperative dose of 40-60 IU/kg, then repeat dose at 40-50 IU/kg after 8-24 hours (8-24 hours if less than 12 years old), then Q24H. For Intravenous Use Only After Reconstitution. For full dosage information, please refer to the full prescribing information. Contraindications: Severe hypersensitivity reactions, including anaphylaxis, to product or its components. Precautions: Determine plasma level of factor VIII if bleeding is not controlled; presence of an inhibitor should be suspected, and appropriate testing performed. Advise patients to discontinue use of Eloctate if hypersensitivity symptoms occur and seek immediate emergency care. Perform an assay to determine if factor VIII inhibitors are present if bleeding is not controlled with Eloctate. In comparison with adolescents and adults, children less than 12 years of age may have a higher clearance and a shorter half-life. These differences should be taken into account when dosing. More frequent or higher dosing may be needed in patients less than 12 years of age. Drug Interactions: No known drug interactions reported. Pregnancy and lactation: Use Eloctate only if potential benefit justifies potential risk during pregnancy. It is unknown if Eloctate is excreted into human milk. Exercise caution if Eloctate is administered to nursing mothers. Use Eloctate only if clinically indicated. Undesirable effects: There is no common adverse reaction reported. For other undesirable effects, please refer to the full prescribing information. Preparation: 1 x 250IU or 500IU or 1000IU or 2000IU Eloctate vial, with 1 pre-filled syringe with solvent and 1 vial adapter. Legal Classification: Part 1, First & Third Schedules Poison Full prescribing information is available upon request.

API-HK-ALP-21.05
Presentation: Alprolix (eftrenonacog alfa) powder and solvent for solution for injection. Indications: For use in adults and children with haemophilia B for control and prevention of bleeding episodes, or routine prophylaxis to prevent or reduce the frequency of bleeding episodes, or perioperative management. Dosage & Administration: Control and prevention of bleeding episodes: Minor and Moderate Bleed – 30-60 IU/kg, repeat Q48H if further evidence of bleeding, Major Bleed – 100IU/kg, follow guidelines for repeat dosing. Higher doses or more frequent dosing may be needed in patients less than 12 years of age. Routine Prophylaxis: 50 IU/kg once weekly or 100IU/kg once every 10 days; Perioperative Management: Minor Surgery – 50-80 IU/kg, repeat as needed after 24-48 hours, Major Surgery – 100 IU/kg, consider repeat dose at 80 IU/kg after 6-10 hours and then every 24 hours for first 3 days. Frequency may be extended after day 3 to every 48 hours. For Intravenous Use Only After Reconstitution. Higher doses or more frequent dosing may be needed in patients less than 12 years of age. For full dosage information, please refer to the full prescribing information. Contraindications: Severe hypersensitivity reactions, including anaphylaxis, to product or its components. Precautions: Determine plasma level of factor IX if bleeding is not controlled; present of an inhibitor should be suspected, and appropriate testing performed. Advise patients to discontinue use of Alprolix if hypersensitivity symptoms occur and seek immediate emergency care. Closely observe patients for signs and symptoms of acute hypersensitivity reactions. Perform an assay to determine if factor IX inhibitors are present if bleeding is not controlled. Drug Interactions: No known drug interactions reported. Pregnancy and lactation: Use Alprolix only if potential benefit justifies potential risk during pregnancy. It is unknown if Alprolix is excreted into human milk. Exercise caution if Alprolix is administered to nursing mother. Only use Alprolix if clinically indicated. Undesirable effects: Common reactions reported include headache, paresthesia oral and obstructive uropathy. For other undesirable effects, please refer to the full prescribing information. Preparation: 1 x 500IU or 1000IU or 2000IU or 3000IU Alprolix vial, with 1 pre-filled syringe with solvent and 1 vial adapter. Legal Classification: Part 1, First & Third Schedules Poison Full prescribing information is available upon request.

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HKPHOSG 30th Anniversary: Challenges in Paediatric Haematology & Oncology in the 21st Century - Interview with Professor Yuen Man-pan Patrick

During a lunch gathering on March 18th, 2023, Professor Yuen Man-pan Patrick shared his thoughts on the progress made in paediatric haematology and oncology over the last two decades. "20 years ago, I could not imagine Hong Kong would have a children's hospital!" he exclaimed after finishing his dim sum.

Prof. Yuen graduated from the University of Saskatchewan in Canada in 1964 and was trained in general paediatrics before developing an interest in paediatric haematology and oncology. He returned to Hong Kong in 1974 and later joined the newly formed Department of Paediatrics at the University of Hong Kong. In 1984, he joined the Prince of Wales Hospital (PWH).

"At that time, patients were all mixed in the same ward – neonates and adolescents; infectious and non-infectious; stable and ill," Prof. Yuen explained. "Haematology and oncology in paediatrics were largely neglected. Paediatricians were discouraged by the poor outcomes in children suffering from cancer and blood diseases." It was the parents who urged for improvement in the field, which led to the idea of establishing a centre dedicated to the treatment of cancer at PWH.

Professor Yuen Man-Pan Patrick

Founding Chairperson of HKPHOSG
Emeritus Professor, Honorary Clinical Professor,
Department of Paediatrics,
The Chinese University of Hong Kong

Prof. Yuen established the "Hong Kong Paediatric Bone Marrow Transplant Fund" in 1988 to support local clinical medicine and research in paediatric haematology and oncology. The first bone marrow transplant was performed in February 1991 for a child with chronic myeloid leukemia, and the Lady Pao Children's Cancer Centre was established in March 1995. After retiring in 2003, Prof. Yuen has been actively involved in teaching and charities, including Children's Cancer Foundation, Little Life Warrior Society, Ronald McDonald House Charities, and Camp Quality Hong Kong.

HKPHOSG 30th Anniversary: Challenges in Paediatric Haematology & Oncology in the 21st Century - Interview with Professor Yuen Man-pan Patrick

CHALLENGE 1: *EDUCATION*

Prof. Yuen observed that basic science teaching should be started in the university, where the foundation is built. "Paediatric haematology and oncology cannot be practiced to the highest level without basic science support." He expressed concern over the decreasing number of people entering the academic field after graduation from medical school. "I worry that there would be no successors. For those who entered, many quit because basic science support was insufficient, but they were expected to produce a lot of research papers. Basic science teaching in the medical school is lacking. Graduates should be encouraged to do research from university. You can't expect the horse to run fast when you don't let it graze (又要馬兒好, 又要馬兒不吃草)."

Prof. Yuen emphasized professionalism and passion as the essential qualities of paediatricians. "Professionalism is about delivering the best and effective care to your patients. Knowledge, like the ocean, is boundless. Diligence is the only best way for learning (學無止境, 唯勤是岸). This is passion." He also highlighted the importance of person-to-person mentorship in the education of graduate and post-graduate students, which broadens their horizons and experiences. Prof. Yuen himself has been an excellent mentor to many outstanding paediatricians. When asked about his mentor, he replied, "Prof. Baxter." Prof. Yuen met Prof. Donald Baxter in the medical school at the University of Saskatchewan, where he worked in Prof. Baxter's lab as a laboratory assistant. Together, they published their discovery in a paper titled "The morphology of Marinesco bodies (paranucleolar corpuscles) in the melanin-pigmented nuclei of the brain-stem" in the Journal of Neurology, Neurosurgery, and Psychiatry in 1963. "He has since become my professor, mentor, and friend," Prof. Yuen added.

Prof. Yuen also shared his thoughts on administration. "Talents are the most precious asset in an institution. An institution works if there are talents but no money, but not vice versa. Talents are the number 1, 2, and 3 important!"

CHALLENGE 2: *PAEDIATRIC CANCER SURVIVORS*

"There are around 135 childhood cancer survivors each year," Prof. Yuen stated. "Curing their disease is only the first step in their lives. Their roads ahead are long. The number of survivors is increasing, and they have multiple medical, psychological, and social issues. Many of them have problems in education, employment, marriage, fertility, etc. I know a lot of survivors and their struggles."

"Paediatric oncologists have the moral obligation to look after these survivors. Frequently, their problems were taken care of by the adult teams, and they are busy. We, the paediatric oncologists, are the most qualified persons because we know them best. We know their diseases and their family well."

We thank Prof. Yuen for sharing his wisdom in education and patient care.

HKPHOSG 30th Anniversary: Words from the Past Chairpersons

Dr Yuen Hui Leung
HKPHOSG Chairperson: 1997 - 1999

I feel like it was just yesterday when the Hong Kong Paediatric Haematology & Oncology Study Group established 30 years ago. It has been a wonderful journey all together. I appreciate all the hard work and achievement that we have made thus far to improve understanding and treatment of childhood blood and cancer illnesses.

Let us keep up the great work and hope for the best in the coming years.

Have a happy 30th Anniversary.

Prof. Ha Shau Yin
HKPHOSG Chairperson: 1999 - 2001

十年樹木，百年樹人。在過去的三十年，香港兒童血液及腫瘤科學會(HKPHOSG)切實地提供了一個有用的平台，以供同仁在專業方面分享經驗，交流新知，進行合作研究，從而持續提升治療病人的水平。

祝願學會百尺竿頭，更進一步！

Dr Shing Ming Kong Matthew
HKPHOSG Chairperson: 2001 - 2003

It has been thirty years of an amazing journey for the members of the Hong Kong Paediatric Haematology and Oncology Study Group since it began. Lots of effort has been spent in organising monthly meetings to discuss the interesting and difficult cases; as we shared the knowledge and clinical experiences, and collaborated in multi-centred clinical trials in Hong Kong, China and overseas. This is because we desire to help the children with cancers. We are proud that the cure rate of childhood cancers in Hong Kong is raised to more than 80 per cent. Besides this, it has been a real joy to develop friendship and mutual support among our members.

Dr Lee Chi Wai Anselm
HKPHOSG Chairperson: 2003-2005

As an individual, every one of us is powerless. There were numerous obstacles, red tapes, restrictions that frustrated us every day while our patients were struggling with their lives. The Study Group provides a common and supporting platform where everyone can share and support each other.

Prof. Chan Godfrey Chi-Fung
HKPHOSG Chairperson: 2005 - 2007

It is a nice to witness the growth and achievements of the Study Group over the years. All of our members have contributed and that ‘s how we can go so far.

“Great things are done by a series of small things brought together.” - ***Vincent Van Gogh***

My best wishes to the future development of the Society!

Dr Chiang Kwok Shing Alan

HKPHOSG Chairperson: 2007-2009

I congratulate Hong Kong Paediatric Haematology and Oncology Study Group on this auspicious day of her 30th Anniversary.

The society has a pivotal role in the development of paediatric haematology and oncology in Hong Kong from setting up the discipline in the early 1990s through fostering collaboration and establishing treatment guidelines and clinical databases to merging the teams of five treatment centres to one team of dedicated colleagues at Hong Kong Children's Hospital over the past three decades. The future of paediatric haematology and oncology in Hong Kong looks bright. Structural training program in the subspecialty has commenced with the first intake of trainees in January 2023. New generation of colleagues are working towards our goals to become the centre of excellence in paediatric haematology and oncology in the region and serve our patients in Hong Kong and the region with humility and compassion.

Dr Vincent Lee

HKPHOSG Chairperson: 2009 - 2011

Congratulations to the 30th Anniversary of the Study Group. The Study Group has come a long way and accomplished a great success through these three decades of years, starting from gathering colleagues in the field from various Paediatric Units, establishing the childhood cancer registry, unifying treatment protocols to participating in clinical and scientific researches. This is gratifying to see the Study Group now stands at the forefront in promoting and advancing knowledge and science in Paediatric Haematology and Oncology, not only locally, but also regionally and internationally. In the new era that lies ahead, with the establishment of the sub-specialty of Paediatric Haematology and Oncology, I have no doubt that the stature and the success of the Study Group will continue to grow with strength and wisdom.

Dr Yau Ping Wa Jeffrey

HKPHOSG Chairperson: 2011-2013

Happy HKPHOSG 30th anniversary!

I want to congratulate the SG for the great achievements in this 30 years of fight for the health of this group of poor, sick cancer kids and long term blood disease patients. When I reflect on all the work of the SG, the objectives still hold as to advance the interest in the medical knowledge, to endeavor to improve the standard care and to promote the child health in relation to "haemonc" problems. I've been there in the council board with many other hard-working colleagues for more than 10 years since 2003 and it's happened to be the SARS outbreak year too! I did remember all the paperwork and collaborations between different hospitals and various sub-specialists, difficult but important and helped the SG to grow. With the commencement of the HKCH in 2019, the SG is adopting a different role, though will be as essential as always. Congratulations to the SG, be proud of what we have done and continue to be as successful and glorious as our God ordained.

Dr Li Chak Ho Rever

HKPHOSG Chairperson: 2013-2015

2023 is a special year! Hong Kong celebrates the victory of fighting COVID-19. It also marks the 30th anniversary of the Hong Kong Paediatric Haematology & Oncology Study Group. I was honored and humbled to serve as the chairlady of the Study Group in 2013-15. We organized the SIOP 2013 conference in Hong Kong when the Study Group celebrated its 20th birthday. The SIOP Hong Kong conference attracted more than 3000 delegates to come and share the most updated scientific knowledge and management on paediatric oncological diseases.

In 2019, the opening of the Hong Kong Children Hospital marked the new page in the development of paediatric haematology and oncology in Hong Kong. All the five children cancer centers migrated into one unit in HKCH. I truly believe the wisdom of all the paediatric oncologists in HKCH will lead the new development in the research and clinical management.

Last but not the least, my sincere and heartfelt "thank you" goes to the organizing committee members who have tirelessly dedicated themselves to organize this annual scientific meeting and the anniversary dinner. I am looking forward to meeting all of you and sharing the joy!

Dr Cheng Wai Tsoi Frankie

HKPHOSG Chairperson: 2015 - 2017

I would like to express my most sincere and heartfelt congratulation to the Hong Kong Paediatric Haematology & Oncology Study Group for the 30th Anniversary. With the tremendous amount of effort made by our pioneers, the 30th Anniversary year of Study Group also landmarks the official establishment of Paediatric Haematology & Oncology (PHO) as one of the specialties in Hong Kong. I, as the Programme Director of the subspecialty training, am greatly inspired by the passions spread out from our next generations. Today's milestone relies on the concrete foundation paved by our pioneers; the future of us depends on what we do today. Congratulations again, Study Group.

Dr Cheuk Ka Leung Daniel

HKPHOSG Chairperson: 2017-2019

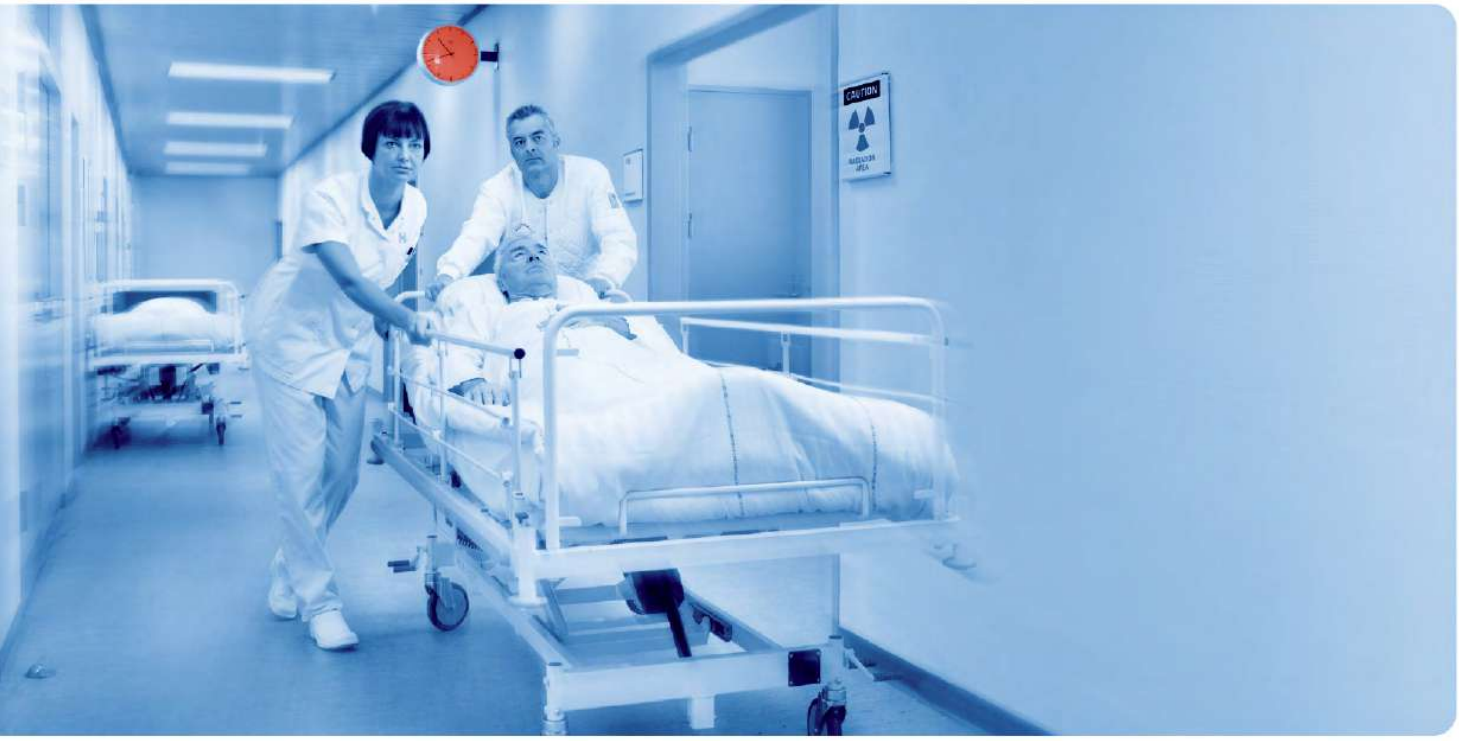
I still remember I was excited when I first joined the SG 20 years ago, experiencing the cohesive collaborative attitudes of members. Each monthly meeting was a fantastic learning and sharing platform. Being a council member continuously for the past 12 years, I witnessed the growth of SG and new members, alongside continuous improvement in managing our patients, who are certainly the greatest motives for us to strive. There are many 30 years in the future for us to pass on the baton. Let's keep the momentum to serve our members and our dear patients with our hearts and minds.

Dr Ku Tak Loi Dennis

HKPHOSG Chairperson: 2019 - 2021

I once laughed about the name of this Study Group as it sounds like the nerdy library group we had in medical schools. Soon I realized that it is exactly a group of humble and passionate paediatricians who strive their best to find novel, evidence-based therapies for sick children in the last three decades. It is my pleasure to meet many inspiring mentors here, and I look forward to mentoring young fellows soon. I am proud to be part of this warm family. Let's celebrate our 30th Anniversary with stories and joy!

Spot. Confirm. Stop.



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Spot: Acquired Haemophilia

- Rare, but severe bleeding disorder caused by autoantibodies against coagulation factors, most commonly FVIII[8]
- Approximately 1 in 1.5 million persons affected annually[9]
- Occurs in patients with no previous history of bleeding[10,11]
- 21% overall mortality rate[12]
- Fatal bleeds may occur at any time until the inhibitor has been eliminated[10,11]

Confirm: Diagnosis

- Acute onset of severe and life-threatening bleeding or wide-spread subcutaneous bleeds[11]
- Isolated prolonged activated partial thromboplastin time (aPTT) with normal prothrombin time (PT)[10,11]

Stop: NovoSeven® offers

- 95% effective or partially effective as first-line therapy[1]
- Well tolerated with low incidence of adverse events[2-4,13] and no risk of human to human pathogen transfer [5-7]
- Rapid and flexible dosing for convenient administration and optimal, predictable response[13]
- Precise mode of action – controls bleeding at site of vascular injury[14]

NovoSeven®: Prescribing Information (Please consult the full prescribing information before prescribing) NovoSeven® 1 mg (50 KIU) powder and solvent (vial or pre-filled syringe) for solution for injection. **Composition:** eptacog alfa (activated), eptacog alfa (activated) is recombinant coagulation factor VIIa (rFVIIa) produced in baby hamster kidney cells (BHK Cells) by recombinant DNA technology. 1 mg/vial (corresponds to 50 KIU/vial), 1mg/ml eptacog alfa (activated) after reconstitution. **List of excipients:** *Powder:* Sodium chloride, Calcium chloride dihydrate, Glycylglycine, Polysorbate 80, Mannitol, Sucrose, Methionine, Hydrochloric acid, Sodium hydroxide, *Solvent:* Histidine, Hydrochloric acid, Sodium hydroxide, Water for injections. Indications: treatment of bleeding episodes and prevention of bleeding in those undergoing surgery or invasive procedures in the following patient groups: • patients with congenital haemophilia with inhibitors to coagulationfactors VII or IX >5 BU; • patients with congenital haemophilia who are expected to have a high anamnestic response to factor VIII or factor IX administration; • patients with acquired haemophilia; • patients with congenital FVII deficiency; • patients with Glanzmann's thrombasthenia with antibodies to GP IIb-IIa and/or HLA, and with past or present refractoriness to platelet transfusions. **Posology:** Haemophilia A or B with inhibitors or expected to have a high anamnestic response: **Mild to moderate bleeding episodes (including home therapy):** Early intervention has been shown to be efficacious in the treatment of mild to moderate joint, muscle and mucocutaneous bleeds. Two dosing regimens can be recommended: 1) Two to three injections of 90 µg per kg body weight administered at three-hour intervals, If further treatment is required, one additional dose of 90 µg per kg body weight can be administered, 2) One single injection of 270 µg per kg body weight, The duration of the home therapy should not exceed 24 hours, There is no clinical experience with administration of a single dose of 270 µg per kg body weight in elderly patients, **Serious bleeding episodes:** An initial dose of 90 µg per kg body weight is recommended and could be administered on the way to the hospital where the patient is usually treated, The following dose varies according to the type and severity of the haemorrhage, Dosing frequency should initially be every second hour until clinical improvement is observed, If continued therapy is indicated, the dose interval can then be increased to 3 hours for 1 – 2 days, Thereafter, the dose interval can be increased successively to every 4, 6, 8 or 12 hours for as long as treatment is judged as being indicated, A major bleeding episode may be treated for 2 - 3 weeks but can be extended beyond this if clinically warranted, **Invasive procedures/surgery:** An initial dose of 90 µg per kg body weight should be given immediately before the intervention, The dose should be repeated after 2 hours and then at 2 – 3 hour intervals for the first 24 – 48 hours depending on the intervention performed and the clinical status of the patient, In major surgery, the dose should be continued at 2 – 4 hour intervals for 6–7 days, The dose interval may then be increased to 6–8 hours for another 2 weeks of treatment, Patients undergoing major surgery may be treated for up to 2–3 weeks until healing has occurred, *Acquired Haemophilia:* NovoSeven should be given as early as possible after the start of a bleeding episode, The recommended initial dose, administered by intravenous bolus injection, is 90 µg per kg body weight, Following the initial dose of NovoSeven further injections may be given if required, The duration of treatment and the interval between injections will vary with the severity of the haemorrhage, the invasive procedures or the surgery being performed, The initial dose interval should be 2 – 3 hours, Once haemostass has been achieved, the dose interval can be increased successively to every 4, 6, 8 or 12 hours for as long as treatment is judged to be indicated, *Factor VII deficiency:* The recommended dose range is 15 – 30 µg per kg body weight every 4–6 hours until haemostasis is achieved. Dose and frequency of injections should be adapted to each individual. Limited clinical experience in long term prophylaxis in paediatric population has been gathered in the paediatric population below 12 years of age, with a severe clinical phenotype. Dose and frequency of injections for prophylaxis should be based on clinical response and adapted to each individual. *Glanzmann's thrombasthenia:* The recommended dose is 90 µg (range 80–120 µg) per kg body weight at intervals of two hours (1.5–2.5 hours). At least three doses should be administered to secure effective haemostasis. The recommended route of administration is bolus injection as lack of efficacy may appear in connection with continuous infusion. For those patients who are not refractory, platelets are the first line treatment for Glanzmann's thrombasthenia. **Contraindications:** Hypersensitivity to the active substance, or to any of the excipients, or to mouse, hamster or bovine protein. **Interaction with other medicinal products and other forms of interaction:** The risk of a potential interaction between NovoSeven and coagulation factor concentrates is unknown. Simultaneous use of prothrombin complex concentrates, activated or not, should be avoided. Anti-fibrinolytics have been reported to reduce blood loss in association with surgery in haemophilia patients, especially in orthopaedic surgery and surgery in regions rich in fibrinolytic activity, such as the oral cavity. Experience with concomitant administration of anti-fibrinolytics and rFVIIa treatment is however limited. Based on a non-clinical study it is not recommended to combine rFVIIa and rFXII. There are no clinical data available on interaction between rFVIIa and rFXII. **Fertility, pregnancy and lactation** *Pregnancy:* As a precautionary measure, it is preferable to avoid the use of NovoSeven® during pregnancy. Data on a limited number of exposed pregnancies within approved indications indicate no adverse effects of rFVIIa on pregnancy or on the health of the foetus/newborn child. To date, no other relevant epidemiological data are available. Animal studies do not indicate direct or indirect harmful effects with respect to pregnancy, embryonal/foetal development, parturition or postnatal development. *Breastfeeding:* It is unknown whether rFVIIa is excreted in human breast milk. The excretion of rFVIIa in milk has not been studied in animals. A decision on whether to continue/discontinue breastfeeding or to continue/discontinue therapy with NovoSeven® should be made taking into account the benefit of breastfeeding to the child and the benefit of NovoSeven® therapy to the woman. *Fertility:* Data from non-clinical studies as well as post-marketing data show no indication that rFVIIa has a harmful effect on male or female fertility.**Undesirable effects:** Rare (> 1/10,000, < 1/1,000): Disseminated intravascular coagulation and related laboratory findings including elevated levels of D-dimer and decreased level of AT, coagulopathy, hypersensitivity, headache, arterial thromboembolic events (myocardial infarction, cerebral infarction, cerebral ischaemia, cerebral artery occlusion, cerebrovascular accident, renal artery thrombosis, peripheral ischaemia, peripheral arterial thrombosis and intestinal ischaemia), angina pectoris, nausea, injection site reaction including injection site pain, increased fibrin degradation products, increase in alanine aminotransferase, alkaline phosphatase, lactate dehydrogenase and prothrombin. Uncommon (> 1/1,000, < 1/100): Venous thromboembolic events (deep vein thrombosis, thrombosis at i.v. site, pulmonary embolism, thromboembolic events of the liver including portal vein thrombosis, renal vein thrombosis, thrombophlebitis, superficial thrombophlebitis and intestinal ischaemia), rash (including allergic dermatitis and rash erythematous), pruritus and urticaria, therapeutic response decreased, pyrexia. Inhibitory antibody formation: In post-marketing experience, there have been no reports of inhibitory antibodies against NovoSeven® or FVII in patients with congenital haemophilia A or B . Development of inhibitory antibodies to NovoSeven has been reported in a post-marketing observational registry of patients with congenital FVII deficiency. Not known: Intracardiac thrombus, anaphylactic reaction, flushing, angioedema. **Overdose:** Four cases of overdose have been reported in patients with haemophilia in 16 years. The only complication reported in connection with an overdose was a slight transient increase in blood pressure in a 16 year-old patient receiving 24 mg rFVIIa instead of 5.5 mg. No cases of overdose have been reported in patients with acquired haemophilia or Glanzmann's thrombasthenia. In patients with factor VII deficiency, where the recommended dose is 15–30 µg/kg rFVIIa, one episode of overdose has been associated with a thrombotic event (occipital stroke) in an elderly (> 80 year) male patient treated with 10–20 times the recommended dose. In addition, the development of antibodies against NovoSeven and FVII has been associated with overdose in one patient with factor VII deficiency. The dose schedule should not be intentionally increased above the recommended doses due to the absence of information on the additional risk that may be incurred. **Administration:** NovoSeven® (eptacog alfa activated) is administered intravenously over 2–5 minutes. **Caution:** Some needleless connectors with an internal spike used with central venous access devices (CVADs) may be incompatible with the pre-filled glass syringe and prevent administration. Therefore, use of an alternative sterile 10ml luer-lock plastic syringe may be required for withdrawal and injection of the reconstituted solution. Follow the instructions for use for the CVAD and needleless connector. **Storage:** 3 years shelf life when product is stored below 25°C. Store powder and solvent below 25°C and protect from light. Do not freeze solvent vial/pre-filled syringe. After reconstitution, chemical and physical stability has been demonstrated for 6 hours at 25°C and 24 hours at 5°C. It is recommended the product be used immediately after reconstitution.If not used immediately, storage time and storage conditions prior to use are the responsibility of the user, and should not be longer than 24 hours at 2°C – 8°C, unless reconstitution has taken place in controlled and validated aseptic conditions. The reconstituted solution should be stored in the vial. Date of review: 2022 Feb.

References: 1. Sumner MJ, *et al.* Haemophilia 2007;13:451-61. **2.** Hay CR, *et al.* Thromb Haemost 1997;78:1463-7. **3.** Abshire T, Kenet G. Haemophilia 2008;14:898-902. **4.** Baudo F, *et al.* Haematologica 2004;89:759-61. **5.** Hedner U, Erhardtsen E.Transfusion 2002;42:114-24. **6.** Croom KF, McCormack PL. BioDrugs 2008;22:121-36. **7.** Ma AD, Carrizosa D. Hematology Am Soc Hematol Educ Program 2006:432-7. **8.** Delgado J, *et al.* Br J Haematol 2003;121:21-35. **9.** Collins PW, *et al.* Blood 2007;109:1870-7. **10.** Huth-Kuhne A, *et al.* Haematologica 2009;94:566-75. **11.** Collins P, *et al.* BMC Res Notes 2010;3:161. **12.** Bitting RL, *et al.* Blood Coagul Fibrinolysis 2009;20:517-23.**13.** NovoSeven® Summary of Product Characteristics. **14.** Hoffman M, Monroe DM, 3rd. Dis Mon 2003;49:14-21.

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戰士專訪 - 崔家浩

「關關難過關關過，就算你有什麼難關，只要你肯克服它，只要你肯挑戰它，你一定可以做得到，你一定可以跨越那難關。」
——崔家浩

家浩，今年17歲，自小喜愛畫畫和書法。五年前，他被確診左腦枕葉惡性膠質肉瘤 (left occipital gliosarcoma, BRAF V600E positive)。「那晚剛放完暑假，準備翌日返中一上課。家浩突然頭暈，頭痛，不停地嘔，抽筋，然後暈倒。腦掃描發現他腦出血，情況很危險，當晚要進行緊急手術。」爸爸回憶說。11歲的家浩，在小六暑假的尾聲接受了人生第一次開腦手術。誰知腦腫瘤一次又一次流血，他在3個月內需要多兩次手術，再接受局部放射治療 (focal radiotherapy) 和六個療程的化療 (temozolomide)。「當時身體很容易疲累，真的非常非常的疲累，此外還有間歇性的頭脹痛。」家浩說。除了身體的不適，治療也帶來心靈的傷害。「做完手術，頭髮都脫光，回到家，好唔開心，很想哭。」

家浩捱過了一年的治療，可惜好景不常。爸爸：「醫生告訴我們，他的腦腫瘤比惡性，隨時都復發。」停藥後三個月，腫瘤在脊柱復發，需要第二輪的局部放射治療和藥物治療，家浩遇上大難關。「我會幫自己按摩頭皮，還有做自己鐘意做的事，例如寫字，畫畫。」畫畫和寫字，為家浩減輕治療的不適；而疾病的痛苦，又為家浩的藝術字體和語錄增添了一份歷練。

靠著意志，家浩渡過了第二次右腦的復發，以及第四和第五次的開腦手術。「手術有兩條疤痕，左邊就是頭幾次手術的，右邊的疤痕就是醫生幫我放喉管的地方。」他輕輕撥開頭髮向我們展示長長的刀痕，彷彿一位上沙場無數的老將軍。復發期間，家浩沒有停止畫畫和出posts。過去一年，家浩靠著三種口服標靶藥物(Dabrafenib, Trametinib, Alpelisib)控制著病情，讓他有機會重返校園。「我在紅十字會讀中四，有老師上門補習。」他拿出幾幅畫：「這幅畫是畫環遊世界，畫了許多國家的建築物出來。我現在上堂就是畫時裝設計的。」以前有幫學校設計教科書封面的家浩，近年在南豐紗廠擺檔，裡面有他設計的鎖匙扣、貼紙和聖誕卡。他亦為兒童癌病基金會紓緩科設計貼紙，為331戴帽日做設計。充滿才華的家浩，對未來有甚麼期盼呢？「對於未來，最緊要健健康康，先有體力做我想做的事！」

想了解更多家浩的故事和作品？
快啲Follow家浩的IG: _khmarco_!

KHMARCO

Cancer Warrior – Elim

Alpha and Omega, the Beginning and the End

“ Life has a beginning,
Life has an end,
No one can determine the length of life,
but You can contribute to the depth of it. ”

10 years ago, my daughter Elim was diagnosed with neuroblastoma. With all the shock, fear, and perplex, together with the sleepless nights in a tiny foldable bed, Life went on.

CT scans → Diagnosis → Surgeries → Chemos → MIBGs → Bone marrow transplant → Second line chemo → Third line chemo → Target therapy

Just 22 months she lived; not long. Three-quarters of her life was spent in the hospital. Most of her time, the people she met were you. You created and framed her world!

Dear Friends,

Do you know you played a part in creating depth in my daughter's life? Please cherish the time that you are with the children, your support, your warmth, and your kindness mean the world to them.

These two paintings were completed for KEYS gallery in Jan 2023. The title of the painting is Alpha & Omega, which is the beginning and the end. On the second day Elim was born, she held her little hands, seems that she was praying. My good friend took a photo of this precious moment. On her last day on earth, I prepared 300 balloons, we released the balloons as a symbolic meaning of “letting her go!” She lived a good life with her sweet smile, and what she has done will be told in memory of her.

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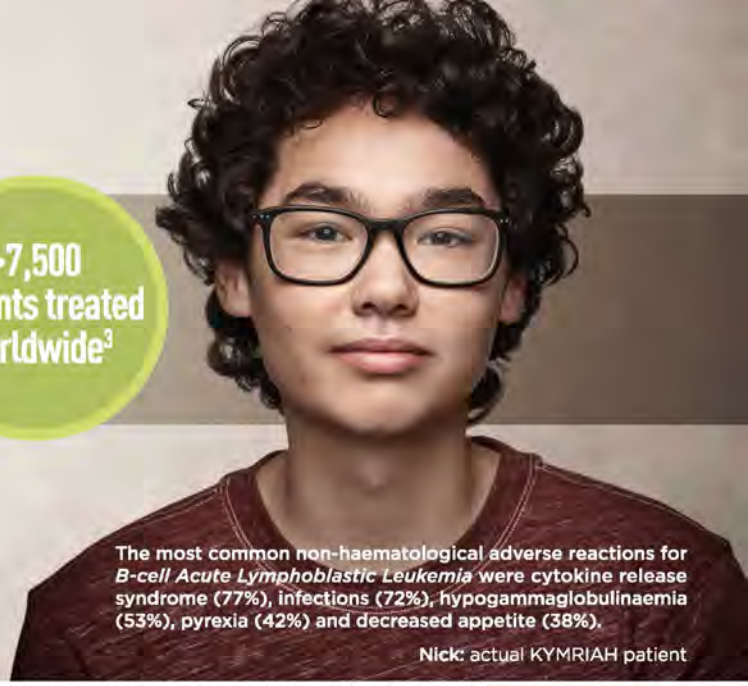

>7,500 patients treated worldwide[3]

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44%
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43
Months
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n=65, (95% CI, (12-NE))

Median OS was **NOT REACHED**
for all infused patients
n=79, (95% CI, (46-NE))

The most common non-haematological adverse reactions for *B-cell Acute Lymphoblastic Leukemia* were cytokine release syndrome (77%), infections (72%), hypogammaglobulinaemia (53%), pyrexia (42%) and decreased appetite (38%).

Nick: actual KYMRIAH patient

* Relapsed/refractory pediatric and young adult (25 years old) acute lymphoblastic leukemia (ALL) # More than 1 dose might be needed for some patients **Abbreviation:** r/r, relapsed/ refractory; ALL, Acute Lymphoblastic Leukemia; CR, complete remission; CRi, CR with incomplete blood count recovery; RFS, relapse-free survival; CI, Confidence Interval; OS, Overall Survival.
References: 1. Kymriah® Hong Kong Package Insert. Sep 2022. 2. Rives, S. et.al, Oral presentation at: 2022 EHA, June 9-12, Vienna, Austria. Abstract #S112. 3. Data on File 247763. Novartis Pharmaceuticals Corp.; August 2022.

KYMRIAH® abbreviated prescribing information **Important note:** Before prescribing, consult full prescribing information. **Presentation:** Cell suspension for infusion in one or more bags for intravenous use (tisagenlecleucel). **Indications:** Kymriah is indicated for the treatment of: • Paediatric and young adult patients up to and including 25 years of age with B-cell acute lymphoblastic leukaemia (ALL) that is refractory, in relapse post-transplant or in second or later relapse. • Adult patients with relapsed or refractory diffuse large B-cell lymphoma (DLBCL) after two or more lines of systemic therapy. • Adult patients with relapsed or refractory follicular lymphoma (FL) after two or more lines of systemic therapy. **Dosage and administration:** Kymriah is intended for autologous use only. Manufacture and release of Kymriah® usually takes about 3 to 4 weeks. **B-cell ALL patients:** • **For patients 50 kg and below:** 0.2 to 5.0 x 10⁶ CAR-positive viable T-cells/kg body weight. • **For patients above 50 kg:** 0.1 to 2.5 x 10⁸ CAR-positive viable T-cells (non-weight based). **DLBCL and FL patients:** • 0.6 to 6.0 x 10⁸ CAR-positive viable T-cells (non-weight based). Kymriah must be administered in a qualified treatment centre. Therapy should be initiated under the direction of and supervised by a healthcare professional experienced in the treatment of haematological malignancies and trained for administration and management of patients treated with Kymriah. Tocilizumab for use in the event of cytokine release syndrome (CRS) and emergency equipment must be available per patient prior to infusion. The treatment centre must have access to additional doses of tocilizumab within 8 hours. In the exceptional case where tocilizumab is not available due to shortage, suitable alternative measures to treat CRS instead of tocilizumab must be available prior to infusion. **Pretreatment conditioning lymphodepleting chemotherapy:** The availability of Kymriah must be confirmed prior to starting the lymphodepleting regimen. Lymphodepleting chemotherapy may be omitted if a patient is experiencing significant cytopenia, e.g., white blood cell (WBC) count <1,000 cells/microL within one week prior to infusion. **Precautions before manipulation or administering Kymriah:** Kymriah contains genetically modified human blood cells. Healthcare professionals handling Kymriah should take appropriate precautions (e.g. wearing gloves and glasses) to avoid potential transmission of infectious diseases. **Preparation for infusion:** The timing of thaw of Kymriah and infusion should be coordinated. Once Kymriah has been thawed and is at room temperature (20°C to 25°C), it should be infused within 30 minutes to maintain maximum product viability, including any interruption during the infusion. **Administration:** Kymriah should be administered as an intravenous infusion through tubedine intravenous tubing without a leukocyte-depleting filter, at approximately 10 to 20 mL per minute by gravity flow. All contents of the infusion bag(s) should be infused. **Clinical assessment prior to infusion:** Kymriah treatment should be delayed in some patient groups at risk (see Warnings and precautions). • There is no experience with manufacturing Kymriah for **patients with a positive test for HIV, with active HBV or active HCV infection.** Leukapheresis material from these patients will not be accepted for Kymriah manufacturing. Screening for HIV, HBV and HCV must be performed in accordance with clinical guidelines before collection of cells for manufacturing. • **Active central nervous system (CNS) leukemia or lymphoma:** There is limited experience of use of Kymriah in patients with active CNS leukemia and active CNS lymphoma. Therefore, the risk/benefit of Kymriah has not been established in these populations. **Monitoring prior to infusion:** Due to the risks associated with Kymriah, the infusion should be delayed if a patient has any of the following conditions: • Unresolved serious adverse reactions (especially pulmonary reactions, cardiac reactions or hypotension) from preceding chemotherapy. • **Active** uncontrolled infection. • Active graft versus host disease (GvHD). • Significant clinical worsening of leukemia burden or rapid progression of lymphoma following lymphodepleting chemotherapy. **Monitoring after infusion:** • Patients should be monitored daily for the first 10 days following infusion for signs and symptoms of potential CRS, neurological events and other toxicities. Physicians should consider hospitalisation for the first 10 days post infusion or at the first signs/symptoms of CRS and/or neurological events. • After the first 10 days following the infusion, the patient should be monitored at the physician's discretion. • Patients should be instructed to remain within proximity (within 2 hours of travel) of a qualified clinical facility for at least 4 weeks following infusion. **Elderly (65 years or above):** Safety and efficacy have not been established in elderly B-cell ALL patients. No dose adjustment is required in patients 65 years or above in DLBCL and FL patients. **Pediatric patients:** No formal studies have been performed in pediatric patients with B-cell ALL below 3 years of age. The safety and efficacy of Kymriah in children and adolescents below 18 years of age have not yet been established in DLBCL and FL. No data are available. **Contraindications:** Hypersensitivity to tisagenlecleucel or to any excipient. Contraindication of the lymphodepleting chemotherapy must be considered. **Warnings and precautions:** • **Patient information:** Patients should be educated to inform their treating physician immediately when signs of CRS or neurological events are observed. Patients should stay within 2 hours distance from Kymriah infusion location for 4 weeks. • **Risk of CRS:** Occurred in almost all cases within 1 to 14 days post infusion with a median time to onset of 3 to 4 days and a median time to resolution of 4 (FL), 7 (DLBCL) or 8 (B-cell ALL) days. See full prescribing information for CRS management. • **Risk of neurological toxicities:** Majority of severe or life-threatening events, in particular encephalopathy, confusional state or delirium, occurred within 8 weeks post infusion and were transient. The median time to onset of first neurological events was 8 days and the median time to resolution was 7 days for B-cell ALL, 6 and 13 days for DLBCL, and 9 and 2 days for FL respectively. Patients should be monitored for neurological events. • **Risk of infections:** Patients with active, uncontrolled infection should not start Kymriah treatment until the infection is resolved. As appropriate, administer prophylactic antibiotics and employ surveillance testing prior to and during treatment with Kymriah. Serious infections were observed in patients, some of which were life threatening or fatal. After Kymriah administration observe patient and ensure prompt management in case of signs of infection. • **Risk of febrile neutropenia:** Frequently observed after Kymriah infusion, may be concurrent with CRS. Appropriate management necessary. • **Risk of prolonged cytopenias:** Appropriate management necessary. Prolonged cytopenia associated with increased risk of infections. Myeloid growth factors, particularly granulocyte macrophage-colony stimulating factor (GM-CSF), have the potential to worsen CRS symptoms and are not recommended during the first 3 weeks after Kymriah infusion or until CRS has resolved. • **Risk of secondary malignancies:** Patients treated with Kymriah may develop secondary malignancies or recurrence of their cancer and should be monitored life-long for secondary malignancies. • **Risk of hypogammaglobulinaemia:** In patients with low immunoglobulin levels, pre-emptive measures such as infection precautions, antibiotic prophylaxis and immunoglobulin replacement should be taken according to age and standard guidelines. • **Risk of tumor lysis syndrome (TLS):** Patients with elevated uric acid or high tumor burden should receive allopurinol, or an alternative prophylaxis, prior to Kymriah infusion. Signs and symptoms of TLS should be monitored and events managed according to standard guidelines. • **Concomitant disease:** Patients with a history of active CNS disorder or inadequate renal, hepatic, pulmonary or cardiac function were excluded from the studies. These patient are likely to be more vulnerable to the consequences of the adverse reactions described below and require special attention. • **Prior stem cell transplantation:** Kymriah infusion is not recommended within 4 months of undergoing an allogenic stem cell transplant (SCT) because of potential risk of worsening GvHD. Leukapheresis for Kymriah manufacturing should be performed at least 12 weeks after allogenic SCT. • **Serological testing:** Screening for HBV, HCV and HIV must be performed in accordance with clinical guidelines before collection of cells for manufacturing. HBV reactivation, can occur in patients treated with medicinal products directed against B cells and could result in fulminant hepatitis, hepatic failure and death. • Prior treatment with anti CD19 therapy: There is limited experience with Kymriah in patients exposed to prior CD19 directed therapy. Kymriah is not recommended if the patient has relapsed with CD19-negative leukaemia after prior anti-CD19 therapy. • **Risk of interference with serological testing:** Due to limited and short spans of identical genetic information between the lentiviral vector used to create Kymriah and HIV, some commercial HIV nucleic acid tests (NAT) may give a false positive result. • **Sodium and potassium content:** Kymriah contains 24.3 to 121.5 mg sodium per dose, equivalent to 1 to 6% of the WHO recommended maximum daily intake of 2 g sodium for an adult. Potassium-free. • **Risk due to content of dextran 40 and DMSO:** contains 11 mg dextran 40 and 82.5 mg DMSO per mL known to possibly cause anaphylactic reactions following parenteral administration. Patients should be observed closely during the infusion period. • **Risks due to live vaccines:** The safety of immunisation with live vaccines during or following Kymriah treatment has not been studied. Vaccination with live vaccines is not recommended for at least 6 weeks prior to the start of lymphodepleting chemotherapy, during Kymriah treatment, and until immune recovery following treatment with Kymriah. • **Risk of driving and engaging in hazardous activities:** within 8 weeks after infusion, these activities should be avoided due to risks for altered or decreased consciousness or coordination. **Pregnancy, lactation, females and males of reproductive potential. Pregnancy:** There are no data with Kymriah use in pregnant women. It is not known whether Kymriah has the potential to be transferred to the fetus via the placenta and could cause fetal toxicity, including B-cell lymphocytopenia. Kymriah is not recommended during pregnancy and in women of child-bearing potential not using contraception. Pregnant women should be advised on the potential risks to the foetus. Pregnancy after Kymriah therapy should be discussed with the treating physician. Pregnant women who have received Kymriah may have hypogammaglobulinaemia. Assessment of immunoglobulin levels is indicated in newborns of mothers treated with Kymriah. **Lactation:** It is unknown whether Kymriah cells are excreted in human milk. A risk to the breast-fed infant cannot be excluded. Women who are breast-feeding should be advised of the potential risk to the breast-fed latent. Following administration of Kymriah, breast-feeding should be discussed with the treating physician. **Females and males of reproductive potential.:** Pregnancy status for females of child-bearing age should be verified prior to starting treatment with Kymriah. Consider the need for effective contraception in patients who receive lymphodepleting chemotherapy. There are insufficient exposure data to provide a recommendation concerning duration of contraception following treatment with Kymriah. **Fertility:** There are no data on the effect of Kymriah on fertility. **Adverse drug reactions: Very common (≥10%):** Infections - pathogen unspecified, viral infections, bacterial infections, pneumia, haemorrhage, febrile neutropenia, neutropenia, thrombocytopenia, cytokine release syndrome, hypogammaglobulinaemia, decreased appetite, hypocalcaemia, hypophosphataemia, hypomagnesaemia, headache, encephalopathy, tachycardia, hypotension, cough, dyspnoea, hypoxia, diarrhoea, nausea, vomiting, constipation, abdominal pain, hepatic enzyme increased, rash, arthralgia, musculoskeletal pain, acute kidney injury, pyrexia, fatigue, oedema, pain, lymphocyte count decreased, white blood cell count decreased, hemoglobin decreased, neutrophil count decreased, platelet count decreased. **Common (≥1 to <10%):** Fungal infections, haemophagocytic lymphohistiocytosis, leukopenia, pancytopenia, coagulopathy, lymphopenia, infusion-related reaction, graft-versus-host disease, hypoalbuminemia, hyperglycaemia, hypercalcaemia, hyperuricaemia, hyperuricaemia, hypercalcaemia, tumour lysis syndrome, hyperkalaemia, hyperphosphataemia, hypernatraemia, hypermagnesaemia, hyperfibrinolysis, hypocalcaemia, anxiety, delirium, sleep disorder, dizziness, peripheral neuropathy, tremor, motor dysfunction, seizure, speech disorders, neuralgia, immune effector cell-associated neurotoxicity syndrome, visual impairment, cardiac failure, cardiac arrest, atrial fibrillation, thrombosis, capillary leak syndrome, hypertension, oropharyngeal pain, pulmonary oedema, nasal congestion, pleural effusion, tachypnoea, acute respiratory distress syndrome, stomatitis, abdominal distension, dry mouth, ascites, hyperbilirubinaemia, pruritus, erythema, hyperhidrosis, night sweats, myalgia, influenza-like illness, asthenia, multiple organ dysfunction syndrome, chills, blood bilirubin increased, weight decreased, blood fibrinogen decreased, international normalised ratio increased, Sirs D dimer increased, activated partial thromboplastin time prolonged, platelet dysfunction. **Uncommon (≥0.1 to <1%):** B-cell aplasia, ischaemic cerebral infarction, ataxia, ventricular extrasystoles, flushing, lung infiltration. **Adverse reaction from spontaneous report (not known):** anaphylactic reaction/infusion related reaction, exanthicity. **Interactions:** The co-administration of agents known to inhibit T-cell function has not been formally studied. Administration of low-dose steroids as per the CRS treatment algorithm does not impact the expansion and persistence of CAR-T cells. The co-administration of agents known to stimulate T-cell function has not been investigated and the effects are unknown. **Packs:** Ethylene vinyl acetate (EVA) infusion bag with polyvinyl chloride (PVC) tubing and a luer spike interconnector closed by a luer-lock cap containing either 10-30 mL (50 mL bags) or 36-50 mL (250 mL bags) **Legal classification:** P(S)153 **Reference:** EMA Apr 2022 Revision date: Feb 2023

NOVARTIS **Novartis Pharmaceuticals (HK) Ltd** 7/F, Citi Tower, One Bay East, 83 Hoi Bun Road, Kwun Tong, Kowloon, Hong Kong Tel: (852) 2582 5222 Fax: (852) 2577 0274

 04/25 HK2304142931 (Approved 04/23)

JAKAVI® ruxolitinib

Improve your Myelofibrosis patients' chance of survival by starting JAKAVI® earlier

In a pooled analysis of COMFORT-I and COMFORT-II, early initiation of JAKAVI® resulted in greater reductions in risk of death in INT-2 risk and high risk MF patients[1]

* Ruxolitinib prolonged survival compared with control (median OS, 5.3 vs 2.4 years; HR [ruxolitinib vs censored at crossover], 0.53 [95% CI, 0.36–0.78]; p=0.0013)

- The incidence of Grade 3 or 4 anaemia of ruxolitinib arm were 45%[2] and 42%[3] in COMFORT-I & COMFORT-II at year 1, respectively
- Grade 3 or 4 thrombocytopenia of ruxolitinib arm were 13%[2] and 8%[3] in COMFORT-I & COMFORT-II at year 1, respectively

Median overall survival per timing of JAKAVI® initiation[1]

2.4 YEARS 95% CI (2.0-NE)
Control group (BAT and placebo censored at crossover to JAKAVI®)

VS

3.8 YEARS 95% CI (3.2-4.6)
Delayed JAKAVI® initiation (control group including BAT and placebo crossed over to JAKAVI®)

VS

5.3 YEARS 95% CI (4.7-NE)
JAKAVI® arm with immediate JAKAVI® initiation

*Overall survival benefit is expressed as a reduction in risk of death. **Abbreviation:** BAT=Best Available Therapy; CI=confidence interval; COMFORT=Controlled Myelofibrosis Study with Oral JAK Inhibitor Treatment; HR=hazard ratio; MF=Myelofibrosis; NE=Not Evaluable; RPSFT=risk-preserving structural failure time.
References: 1. Verstovsek S, Gotlib J, Mesa RA, et al. J Hematol Oncol. 2017;10(156):1-6. 2. Verstovsek S, et al. N Engl J Med. 2012 Mar;366(9):799-807. 3. Harrison C, et al. N Engl J Med. 2012 Mar;366(9):787-798.

JAKAVI® abbreviated prescribing information **Important note:** Before prescribing, consult full prescribing information. **Presentation:** Tablets containing 5 mg, 10 mg, 15 mg, and 20 mg ruxolitinib. **Indications:** •Treatment of disease-related splenomegaly or symptoms in adult patients with primary myelofibrosis (also known as chronic idiopathic myelofibrosis), post polycythaemia vera myelofibrosis or post essential thrombocythaemia myelofibrosis. •Treatment of adult patients with polycythaemia vera (PV) who are resistant to or intolerant of hydroxyurea. •Treatment of patients aged 12 years and older with acute or chronic graft-versus-host disease who have inadequate response to corticosteroids or other systemic therapies. **Dosage and administration:** •Complete blood cell counts must be performed before initiating Jakavi®. Complete blood counts should be monitored every 2 to 4 weeks until optimal dose is reached. •Administration twice daily at the same time every day, with or without food. •Recommended starting dose for adults in MF: 20 mg (platelet count >200,000/mm³) and 10 mg (platelet count between 100,000 and 200,000/mm³) and 10 mg (platelet count between: 75,000 and 100,000/mm³), 5mg (platelet count between: 50,000 and 75,000/mm³), orally twice daily. •Recommended starting dose for adults in PV and for pediatrics aged 12 years and older and adults in GvHD: 10 mg twice daily. •Dose adjustments and temporary interruptions are recommended in MF-patients with thrombocytopenia and in GvHD-patients with thrombocytopenia, neutropenia, and hyperbilirubinemia (see full prescribing information). •Treatment should be interrupted if platelet counts <50,000/mm³ or ANC <500/mm³ (MF and PV patients) or Hb <8g/dl. (in PV patients). •In PV, dose reduction to be considered if Hb <12 g/dl. and recommended if Hb <10 g/dl.. •Dose adjustment may be required due to thrombocytopenia or when used with strong CYP3A4 inhibitors or dual moderate inhibitors of CYP2C9 and CYP3A4 enzymes (e.g. fluconazole; avoid concomitant use of fluconazole >200 mg daily). •The starting dose should not be increased within the first 4 weeks of treatment and thereafter no more frequently than at 2-week intervals. •Maximum dose is 25 mg twice daily. •Treatment to be continued as long as the benefits outweigh the risks for the patient. Tapering in GvHD-patients may be considered in responders who have discontinued corticosteroids. 50% dose reduction every 2 months recommended. If signs or symptoms reoccur during or after the taper, consider treatment re-escalation. •Recommend to reduce the starting dose by approximately 50% in MF, PV and GvHD patients with severe renal impairment (Clcr <30 mL/min), and with hepatic impairment. Patients diagnosed with renal or hepatic impairment should be monitored and the dose should be reduced as appropriate. •No additional dosage adjustment required for elderly patients. •The safety and efficacy of Jakavi in children and adolescents aged up to 18 years with MF and PV have not been established. The Jakavi dose in paediatric patients with GvHD aged 12 years and older is the same as in adults. The safety and efficacy of Jakavi have not been established in patients less than 12 years of age. **Contraindications:** Hypersensitivity to ruxolitinib or to any of the excipients. Pregnancy and lactation. **Warnings/Precautions:** •Decrease in blood cell count: hematologic adverse drug reactions, including thrombocytopenia, anaemia and neutropenia, have been reported with Jakavi treatment. Complete blood counts must be performed. Dose reduction or interruption may be required in patients developing thrombocytopenia, anaemia and neutropenia. •Infections: Serious bacterial, mycobacterial, fungal, viral and other opportunistic infections have occurred in patients treated with Jakavi. Patients should be assessed for the risk of developing serious infections. Physicians should carefully observe patients receiving Jakavi for signs and symptoms of infections and initiate appropriate treatment promptly. Jakavi therapy should not be started until active serious infections have resolved. Tuberculosis cases have been reported. Before starting treatment patients should be evaluated for active and inactive ("latent") tuberculosis, as per local recommendations. Hepatitis B viral load (HBV-DNA titre) increases have been reported in patients with chronic HBV infection. Patients with chronic HBV infection should be treated and monitored according to clinical guidelines. •Herpes zoster: Physician to educate patients about early signs and symptoms of herpes zoster, advising that treatment should be sought as early possible. •Progressive multifocal leukoencephalopathy (PML) has been reported. Physicians should be alert for symptoms suggestive of PML (e.g., cognitive, neurological or psychiatric symptoms or signs). If PML suspected suspend treatment until PML is excluded. •**Non-Melanoma Skin Cancer (NMSC):** NMSC, including basal cell, squamous-cell, and Merkel cell carcinoma, have been reported in Jakavi treated patients. Periodic skin examination recommended. •**Lipid Abnormalities/Elevations:** Increases in lipid parameters, including total cholesterol, low- density lipoprotein (LDL) cholesterol, and triglycerides have been associated with Jakavi. Monitoring and treatment of dyslipidemia is recommended. •Hepatic and severe renal Impairment: Due to increased Jakavi exposure, dose reduction is required. **Pregnancy, lactation, females and males of reproductive potential** Pregnancy: Use in pregnancy is contraindicated. **Breast-feeding:** Women taking Jakavi must not breast-feed. Contraceptives: Sexually active females should use effective contraception during treatment. In case pregnancy should occur during treatment, a risk/benefit evaluation must be carried out with careful counselling regarding potential risks to the foetus **Adverse drug reactions: Myelofibrosis** Very common (>10%): Urinary tract infections, herpes zoster, pneumonia, anaemia, thrombocytopenia, neutropenia, gastrointestinal bleedings, other bleedings, hypercholesterolaemia, hypertriglyceridaemia, dizziness, headache, elevated lipase, constipation, ALT increased, AST increased, hypertension, bruising, weight gain. Common (1 to 10%): Sepsis, pancytopenia, intracranial bleeding, flatulence. Uncommon (0.1 to 1%): Tuberculosis. Polycythemia vera Very common (>10%): Urinary tract infections, herpes zoster, anaemia, thrombocytopenia, bruising, other bleedings, hypercholesterolaemia, hypertriglyceridaemia, weight gain, dizziness, headache, elevated lipase, constipation, ALT increased, AST increased, hypertension. Common (1 to 10%): Pneumonia, neutropenia, pancytopenia, gastrointestinal bleeding, flatulence. Not known (frequency cannot be estimated): Tuberculosis. **Acute Graft versus host disease Very common (>10%):** CMV infections, sepsis, UTI, thrombocytopenia, anaemia, neutropenia, pancytopenia, hypercholesterolaemia, hypertension, nausea, increased ALT and AST. Common (1 to 10%): headache. Chronic Graft versus host disease Very common (>10%): Thrombocytopenia, anaemia, neutropenia, hypercholesterolemia, headache, hypertension, increased lipase, increased amylase, increased ALT and AST, increased blood CPK, increased blood creatinine. Common (1 to 10%): CMV infections, UTI, URI virus infections, constipation **Interactions:** •Dose of Jakavi should be reduced by approx. 50%, to be administered twice daily, when co-administered with strong CYP3A4 inhibitors or dual inhibitors of CYP3A4 and CYP2C9 enzymes. Avoid fluconazole daily doses >200 mg. **Packs and prices:** 55's pack **Legal classification:** P(S)153 **References:** EMA Mar 2022 (included Canada Jun 2021 PI on YTD, 2018-PSB/GLC-01050-6, 2020-PSB/GLC-11106-x and 2020- PSB/GLC-11155-x)

NOVARTIS **Novartis Pharmaceuticals (HK) Ltd** 7/F, Citi Tower, One Bay East, 83 Hoi Bun Road, Kwun Tong, Kowloon, H.K. Tel: 2882 5222 Fax: 2577 0274

04/25 HK2304143183 (Approved 04/23)

戰士專訪 - 心心

相片中精靈可愛的心心，是勇敢的AML小戰士。一歲的時候突然不舒服，經過一連串的檢查後發現患上myeloid sarcoma, 一種罕見的AML. 密集的治療隨後展開，但心心總是笑面迎人，努力地邊玩邊"落藥"。

心心與媽媽其中一個奇妙的連繫就是咖啡。心心媽是網上咖啡店店主，也是手沖咖啡愛好者。心心年紀小小已經十分"識貨", 總在媽媽沖咖啡時好奇地嗅，細細欣賞。

心心在兩歲的時候"畢業"。然而媽媽對心心的愛是永不止息的。媽媽為心心及兒童癌病基金推出"一心同行"咖啡包義賣計劃，讓大家一面品嚐咖啡，一面記住心心以及其他小戰士。

如果大家都想品嘗如此有愛的咖啡，請到以下連結了解更多：

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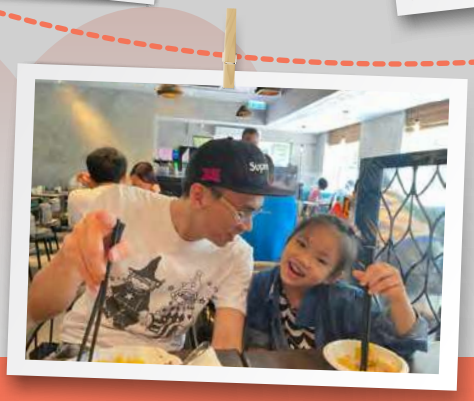
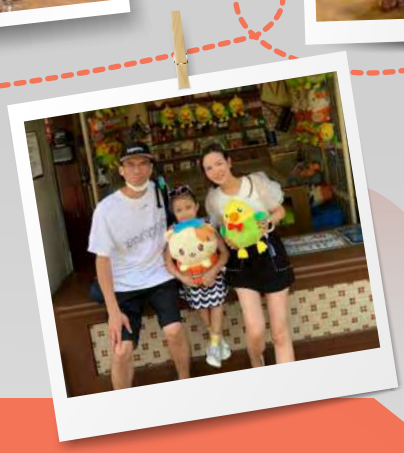
MATAFALIFESTYLE

戰士專訪 - 思澄

從思澄的公主裙相簿和cosplay蝴蝶忍的美照，可以看到思澄是一個愛美好動的女孩。即使於確診DIPG(瀰漫性內生性腦幹膠質瘤)後，思澄仍然堅強面對。每次回醫院覆診，她都會戴上七彩的髮夾，努力地做物理治療。雖然思澄漸漸不能走路、說話，她仍然會用眼神跟父母和醫生姑娘溝通，連打新冠疫苗都不怕!





思澄最後化作小天使，而媽媽在懷念她的同時，努力創作，將對她的思念化為一幅幅可愛的卡通，將愛永遠保存。

Sponsorship Acknowledgement

PLATINIUM

CSL Behring

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GOLD

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FOUNDATIONONE® LIQUID CDx

AVAILABLE NOW

FIND THEIR PERSONALISED PATH WITH LIQUID BIOPSY

See a way forward for all patients with solid tumours – using FoundationOne®Liquid CDx, our **FDA-approved liquid biopsy** comprehensive genomic profiling service, as a **minimally-invasive** option, **alternative or complementary** to FoundationOne®CDx at **optimal times beneficial to their treatment journey.**[1-3]

Our highly accurate and extensively validated, next-generation liquid biopsy genomic profiling service provides prognostic, diagnostic and predictive insights that inform research or treatment decisions for individual patients across all solid tumours.[2,3]

>300 genes MSI + bTMB

Comprehensive panel
Reports all four main classes of genomic alterations* in >300† cancer-relevant genes and reports MSI‡, bTMB and Tumour Fraction[3]

High accuracy
High sensitivity and specificity§ for key genomic alterations, MSI‡ and bTMB across all solid tumours[3]

Extensively validated
Based on an analytically and clinically validated FDA-approved comprehensive platform, and bioinformatics workflow¥[1-6]

Comprehensive report
Clear, in-depth report provides insights on the genomic profile of your patient to support personalised clinical decisions[2,3]

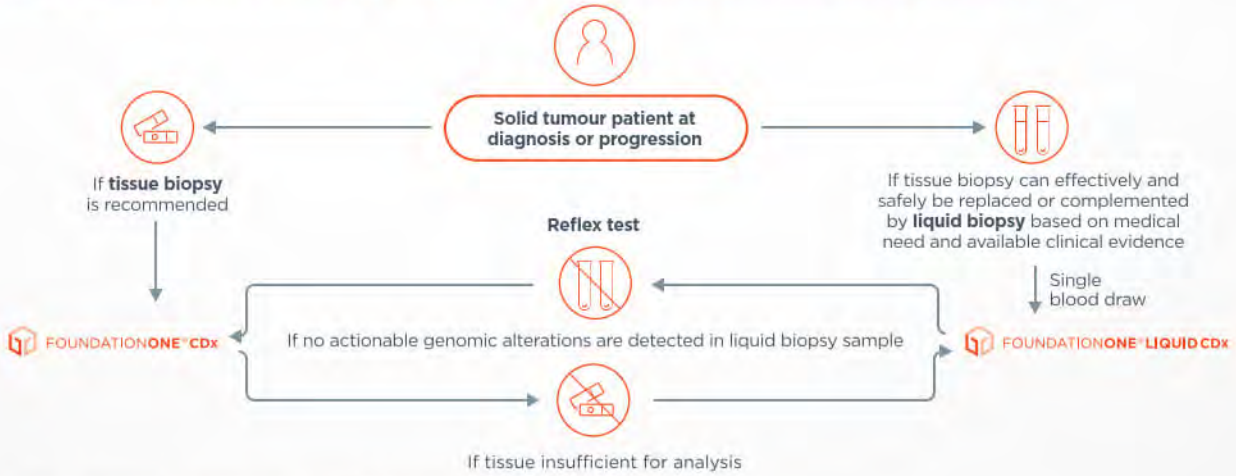
Quick and convenient single blood draw and short turnaround time enable faster treatment decisions[2,7-10]

Two tubes of whole blood (8.5 mL each)
Quick and convenient single blood draw helps avoid invasive biopsies and enables faster treatment decisions[2,7-11]

<2 WEEKS

Quick turnaround time
Less than 2 weeks turnaround time from receipt of sample at our laboratory to report[2]

Suitable for all solid tumours based on your patient's profile and the available clinical evidence[2,3,9,10]



*Base substitutions, insertions or deletions, copy number alterations and gene rearrangements.
†309 genes with complete coding exonic coverage, 15 genes with select intronic or non-coding regions only.
‡FoundationOne Liquid CDx reports MSI-H status.
§75 genes are baited with enhanced sensitivity for all variant types (selected based on increased actionability with current or future targeted therapies; for more information of these 75 genes, please refer to our full gene list); other genomic regions are baited with high sensitivity.
¥Clinical validation based on evidence gathered using an earlier version of Foundation Medicine's current liquid biopsy service, FoundationOne Liquid CDx. For concordance results between these two tests, please see our full intended use at www.foundationmedicine.com/F1LCDx.

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愛常在


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HAPPY
30th
Anniversary