



THE FEDERATION OF MEDICAL SOCIETIES OF HONG KONG

香港醫學組織聯會

Annual Scientific Meeting 2023

Revolutionising Healthcare Through Innovations

Date: 22 October 2023, Sunday **Time:** 09:00-17:00

Format: Hybrid

- 1) Online: Zoom Webinar
- 2) Onsite: The Ballroom, 7/F, Cordis, Hong Kong
555 Shanghai Street, Mong Kok, Kowloon

Programme Book

The FIRST
Anti-Inflammatory Reliever

SYMBICORT™ ANTI-INFLAMMATORY RELIEVER DELIVERS EFFICACY WHEN IT MATTERS

REDUCES EXACERBATIONS,
ALONE OR WITH MAINTENANCE.¹⁻⁷

NOW INDICATED FOR MILD,
MODERATE AND SEVERE PATIENTS⁸

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HK-5814 27/08/2021

Symbicort
budesonide/formoterol

**EFFICACY
WHEN IT MATTERS**

References: 1. O'Byrne PM et al. N Engl J Med 2018; 378: 1865-76. 2. Bateman ED et al. N Engl J Med 2018; 378: 1877-87. 3. Beasley R et al. N Engl J Med 2019; DOI: 10.1056/NEJMoa1901963. 4. Hardy J et al. Lancet 2019; Published online Aug 23, 2019; [http://dx.doi.org/10.1016/S0140-6736\(19\)31948-8](http://dx.doi.org/10.1016/S0140-6736(19)31948-8). 5. Kuna P et al. Int J Clin Pract 2007 (May); 61(5): 725 – 36. 6. Bousquet J et al. Respir Med 2007; 101: 2437 – 46. 7. Sobieraj DM et al. JAMA 2018; doi: 10.1001/jama.2018.2769. 8. Symbicort Hong Kong Package Insert. Feb 2021.

Presentation: Budesonide/Formoterol Turbuhaler. **Indications:** In adults and adolescents (12 years and older), for the treatment of asthma, to achieve overall asthma control, including the relief of symptoms and the reduction of the risk of exacerbations. Symptomatic treatment of moderate to severe COPD in adults. **Dosage: Asthma 1) Symbicort anti-inflammatory reliever therapy (patients with mild disease) 160/4.5 mcg Turbuhaler Adult & Adolescent ≥ 12yr:** 1 inhalations as needed in response to symptoms. If symptoms persist after a few minutes, 1 additional inhalation should be taken. No more than 6 inhalations should be taken on any single occasion. A total daily dose of more than 8 inhalations is normally not needed, however a total daily dose of up to 12 inhalations can be used temporarily. **2) Symbicort maintenance and reliever therapy Adult & Adolescent ≥ 12yr:** Patients should take 1 inhalation of Symbicort Turbuhaler 160/4.5 mcg as needed in response to symptoms to control asthma. If symptoms persist after a few minutes, 1 additional inhalation should be taken. No more than 6 inhalations should be taken on any single occasion. Recommend maintenance dose is 1 inhalation b.d. and some may need 2 inhalations b.d.. A total daily dose of more than 8 inhalations is normally not needed, however a total daily dose of up to 12 inhalations can be used temporarily. **3) Symbicort maintenance therapy 160/4.5 mcg Turbuhaler Adult & Adolescent ≥ 12yr:** 1-2 inhalations b.d.. Max daily dose is 4 inhalations. **COPD 160/4.5 mcg Turbuhaler Adult:** 2 inhalations b.d.. Max daily dose is 4 inhalations. **Contraindications:** Hypersensitivity to budesonide, formoterol or lactose. **Precautions:** Should be used for the shortest duration of time required to achieve control of asthma symptoms. Should only be used long-term in patients whose asthma cannot be adequately controlled on asthma controller medications. Not be used to initiate treatment with inhaled steroids in patients being transferred from oral steroids. It is recommended that the maintenance dose be tapered when long-term treatment is discontinued. Potential systemic effects of ICS, HPA axis suppression and adrenal insufficiency, bone density, growth, visual disturbance, infections/tuberculosis, sensitivity to sympathomimetic amines, cardiovascular disorders, hypokalaemia, diabetes, pneumonia, lactose, pregnancy & lactation. Not recommended for children below 12 years of age. Incidence of candidiasis can be minimized by having patients rinse their mouth out with water after inhaling their maintenance dose. **Interactions:** CYP3A4 inhibitors, beta-receptor blocking agents, other sympathomimetic agents, Xanthine derivatives, mineralocorticosteroids and diuretics, Monoamine oxidase inhibitors, tricyclic antidepressants, quinidine, disopyramide, procainamide, phenothiazines and antihistamines. **Undesirable effects:** Palpitations, Candida infections in the oropharynx, headache, tremor, mild irritation in the throat, coughing, hoarseness. **Full local prescribing information is available upon request.** API.HK.SYM.0721

Please visit contactazmedical.astrazeneca.com, for (1) enquiring Medical Information (MI), (2) reporting Individual Case Safety Report (ICSR) and/or (3) reporting product quality complaint (PQC) to AstraZeneca Hong Kong Limited.

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BRING PROTECTION TO LIFE IN CKD

THE
ONLY
SGLT2i

Now Approved for
Chronic Kidney Disease
Treatment^{1,11}



↓39% Composite of CKD progression[†],
ESKD, and renal or CV death[‡] vs
placebo (NNT=19 patients)

(HR 0.61; 95% CI, 0.51, 0.72; p<0.001)²



↓31% All-cause mortality vs placebo

(HR 0.69; 95% CI, 0.53, 0.88; p=0.004)²



↓29% Composite of CV death
or hHF vs placebo

(HR 0.71; 95% CI, 0.55, 0.92; p=0.009)²



Slowed eGFR deterioration

(Between-group change/year in mean eGFR (chronic slope)):
1.9 mL/min/1.73 m² (FORXIGA/placebo)²



Consistent Efficacy⁵

Regardless of T2D status³, baseline eGFR^{8,2}, CKD stage¹¹ and aetiology^{11,3,4}



Simple and well tolerated

Consistent safety shown in patients with CKD, with or without T2D^{2,3}.
Similar hypoglycaemia rates⁵ and less frequent AKI-related SAEs vs placebo^{1,5}

INITIATE TREATMENT¹⁵

GFR
≥25



**For broad range^{††} of CKD patients,
TREAT EARLY WITH FORXIGA NOW**

* FORXIGA is indicated for the treatment of chronic kidney disease in adult patients with or without T2D.

[†] ≥50% sustained decline in eGFR.

[‡] There were comparable rates of the individual component of CV death vs placebo (3.0% vs 3.7%; HR 0.81; 95% CI, 0.58, 1.12).

[§] Primary composite endpoint of ≥50% sustained decline in eGFR, reaching ESKD, and renal or CV death. ESKD is defined as the need for maintenance dialysis for at least 28 days and renal transplantation or sustained eGFR <15 mL/min/1.73m² for at least 28 days.

^{||} Baseline eGFR categories: <45 mL/min/1.73m² and ≥45 mL/min/1.73m².

[¶] Observed only in T2D patients.

^{**} CKD stage groups: Stage 4 and Stage 5.

^{††} Diabetic nephropathy, glomerulonephritis, ischemic or hypertensive CKD, or CKD of other or unknown cause.

^{‡‡} In patients with severe hepatic impairment, a starting dose of 5 mg is recommended. If well tolerated, the dose may be increased to 10 mg.

^{§§} In CAPLUS-CKD, patients may continue on FORXIGA 10 mg once daily if eGFR falls below 25 mL/min/1.73m².

^{|||} Due to limited experience, it is not recommended to initiate treatment with dapagliflozin in patients with GFR <25 mL/min.

AKI, acute kidney injury; CI, confidence interval; CKD, chronic kidney disease; CV, cardiovascular; CVD, cardiovascular disease; eGFR, estimated glomerular filtration rate; ESKD, end-stage kidney disease; HF, heart failure; hHF, hospitalization for heart failure; HR, hazard ratio; SAE, serious adverse event; SGLT2i, sodium-glucose co-transporter-2 inhibitor; T2D, type 2 diabetes; UACR, urine albumin/creatinine ratio.

References: 1. FORXIGA Hong Kong Prescribing Information. 2. Heerspink HJL, et al. N Engl J Med. 2020;383:1436-1446. 3. Wheeler DC, et al. Lancet Diabetes Endocrinol. 2021;9:22-31. 4. Chertow GM, et al. J Am Soc Nephrol. 2021;32:2352-2361. 5. Heerspink HJL, et al. Kidney Int. 2021;50085-25382/10085-4.

Abbreviated Prescribing Information (API)

FORXIGA (dapagliflozin)

Composition: Dapagliflozin propanediol monohydrate film-coated tablet, 5 mg or 10 mg. **Therapeutic Indications:** For the treatment of insufficiently controlled type 2 diabetes mellitus in adults as an adjunct to diet and exercise, either as monotherapy when metformin is considered inappropriate due to intolerance, or in addition to other medicinal products for the treatment of type 2 diabetes. For the treatment of symptomatic chronic heart failure with reduced ejection fraction. For the treatment of chronic kidney disease. **Dosage and Administration:** Type 2 diabetes mellitus: Recommended dose is 10 mg to be taken orally once daily at any time of day with or without food. Tablets are to be swallowed whole. Heart Failure: Recommended dose is 10 mg to be taken orally once daily. Chronic Kidney Disease: Recommended dose is 10 mg to be taken orally once daily. In patients with severe hepatic impairment, a starting dose of 5 mg is recommended. **Contraindications:** Hypersensitivity to the active substance or to any of its excipients. **Warnings and Precautions:** Renal function, risk of volume depletion and/or hypotension should be taken into account in patients. Dosage of insulin and sulphonylurea (SU) may need to be reduced to reduce the risk of hypoglycaemia. May add to the diuretic effect of thiazide and loop diuretics and may increase the risk of dehydration and hypotension. Use with caution in patients with increased risk of diabetic ketoacidosis, or anti-hypertensive therapy with a history of hypotension, elderly (≥65 years). Treatment should be temporarily interrupted when volume depleted, when treating pyelonephritis or uropathy, in patients who are hospitalized for major surgical procedures or acute serious medical illnesses, until ketone values are normal. Should not be initiated in patients with type 1 diabetes, hereditary problems of galactose intolerance, total lactase deficiency, or glucose-galactose malabsorption. Additional glucose lowering treatment should be considered for glycaemic control improvement if GFR is persistently below 45 mL/min for the treatment of diabetes; no dose adjustment is required based on renal function for the treatment of heart failure and chronic kidney disease. Due to limited experience, it is not recommended to initiate treatment with dapagliflozin in patients with GFR < 25 mL/min. **Discontinue if:** suspected or diagnosed diabetic ketoacidosis, if Fournier's gangrene is suspected, when pregnancy is detected, while breast-feeding. Limited or no data in cardiac failure NYHA class IV, pregnancy, and paediatric population. **Adverse Reactions:** Very common: hypoglycaemia when used with SU or insulin. Common: vulvovaginitis, balanitis and related genital infections, urinary tract infection, dizziness, rash, back pain, dysuria, polyuria, dyslipidaemia, decreased daytime renal clearance (during initial treatment), and increased haematocrit. Uncommon: Fungal infection, volume depletion, thirst, constipation, dry mouth, nosebleed, vulvovaginal and genital pruritus, increased blood urea, and decreased weight. Rare: diabetic ketoacidosis (when used in type 2 diabetes). Very rare: necrotising fasciitis of the perineum (Fournier's gangrene), angioedema. Not known: acute kidney injury. **Drug Interactions:** Co-administration with rifampicin may reduce dapagliflozin systemic exposure; co-administration with metformin acid may increase dapagliflozin systemic exposure. Monitoring glycaemic control with 1-5 AG assay is not recommended in patients taking SGLT2 inhibitors. **Storage:** Store below 30 °C. Local prescribing information is available upon request. APIHK.FOR.1221

Intended for Healthcare professionals only.

Please visit contactmedinfo.astrazeneca.com, for (1) enquiring Medical Information (MI), (2) reporting Individual Case Safety Report (ICSR) and/or (3) reporting Product Quality Complaint (PQC) to AstraZeneca Hong Kong Limited.

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Programme

Time	Ballroom I & II	Ballroom III
0900-0930	Onsite & Online Reception	
0930-1000	Opening Ceremony	Live Streaming of Opening Ceremony
1000-1100	Session 1 [Plenary Session]	
	Chairpersons: Dr. Raymond See-kit LO, Dr. Alson Wai-ming CHAN	
1000-1025	中國人口老齡化現狀、挑戰與老年醫學發展機遇 王建業教授 Prof. WANG Jianye	
1025-1050	Medical Advance in Exoskeleton for Neurorehabilitation Prof. Raymond Kai-yu TONG	
1050-1100	Q&A	
1100-1120	Coffee Break	
1120-1220	Session 2 (AstraZeneca Session) Advances in Management of Asthma and Chronic Kidney Disease	
	Chairpersons: Dr. NG Chun-kong, Dr. Samuel Ka-shun FUNG	
1120-1145	Practice Changing Update in GINA 2023 Dr. Terence Chi-chun TAM	
1145-1210	Advancing the Management in Chronic Kidney Disease - From Primary to Collaborative Care Dr. Winston Wing-shing FUNG	
1210-1220	Q&A	
1220-1310	Lunch Symposium [Keynote Lecture]	
	Chairperson: Dr. Edwin Chau-leung YU	
1220-1300	Modernising Chinese Medicine Prof. BIAN Zhaoxiang	Live Streaming of Lunch Symposium
1300-1310	Q&A	
1310-1320	Break	
1320-1420	Session 3A (Otsuka Session) New Advances in Management of Leukaemia	Session 3B Advances in Bladder and Rectal Diseases Treatments
	Chairpersons: Dr. Ludwig Chun-hing TSOI, Dr. SIU Kwai-ming	Chairpersons: Dr. Peggy Sau-kwan CHU, Dr. Victor Hip-wo YEUNG
1320-1345	Unmet Needs in the Management of Acute Myeloid Leukaemia (AML) and Myelodysplastic Syndromes (MDS) Dr. Harinder Singh Harry GILL	Hemorrhoidal Crisis - How Can Be Treated and Avoided? Dr. Philip Ming-ho KAM
1345-1410	Tyrosine Kinase Inhibitors in CML and Ph+ ALL Dr. Garret Man-kit LEUNG	Overactive Bladder Treatment Strategies: Insights from the OAB Consensus Statement Dr. Peggy Sau-kwan CHU
1410-1420	Q&A	Q&A

Time	Ballroom I & II	Ballroom III
1420-1520	Session 4A Advances in Paediatric Neuro-developmental Disorders	Session 4B Chinese Medicine Session
	<i>Chairpersons:</i> <i>Dr. Peggy Sau-kwan CHU, Dr. Samuel Ka-shun FUNG</i>	<i>Chairperson:</i> <i>Dr. Edwin Chau-leung YU</i>
1420-1445	Holistic Care in Paediatric Pharmaco Resistant Epilepsy in Era of Genomics: Etiologies Based Medical, Dietary and Surgical Intervention & Neuropsychology Dr. Mario Wai-kwong CHAK, Ms. Vitti Wai-kei POON	Potential Role of Evidence-based Herbal Medicines in Cancer Management Prof. Clara Bik-san LAU
1445-1450	Q&A	Q&A
1450-1515	Breakthrough in Early Identification of Autism: Genomic and Neural Encoding Testing Dr. Fanny Wai-fan LAM	
1515-1520	Q&A	
1520-1540	Coffee Break	
1540-1640	Session 5 Advances in Allergy & Immunology Session	
	<i>Chairpersons:</i> <i>Dr. Jane Chun-kwong CHAN, Dr. Kingsley Hau-ngai CHAN</i>	
1540-1605	Recent Advances in House Dust Mite Allergy Immunotherapy (Lecture via Zoom) Prof. Eike Gunther WÜSTENBERG	
1605-1630	Innovative Management Strategies for Type 2 Inflammatory Diseases Dr. Alson Wai-ming CHAN	
1630-1640	Q&A	
1640-1650	Closing Ceremony	Live Streaming of Closing Ceremony

■ Welcome Message from the President

Prof. Bernard Man-yung CHEUNG

President, The Federation of Medical Societies of Hong Kong



On behalf of the Federation of Medical Societies of Hong Kong, I wish to offer my warmest welcome to our distinguished guests, our member societies and to all the conference participants for coming to and taking part in our Annual Scientific Meeting this year. After more than three hard-fought years, we have now come through the COVID-19 pandemic, and the hardships and tragedies it brought. This is now the time for renewal, reinvention and relaunch. Hence, the theme of this year's meeting is: Revolutionising Healthcare Through Innovations.

The stress on innovations chimes with the priorities of the Hong Kong SAR Government as well as national policies. There is wide agreement that there are new ways of doing things. COVID-19 has profoundly changed our values, habits and way of doing things that we have been taking for granted. We appreciate health and well-being as never before. We are now more prepared to spend on health and disease prevention. We have grown accustomed to working from home and taking part in online meetings. More than ever before, we rely on the internet and artificial intelligence to organise our lives, from ordering food to planning our journeys. It goes without saying that the revolution in medicine is no less profound. Telemedicine has taken off out of necessity. Initial scepticism of mRNA vaccines has been replaced by the realisation that they work.

This year's programme is teeming with innovations in medicine, including intriguing topics such as exoskeleton, genomic medicine, novel treatments for asthma, allergies, leukaemia, haemorrhoids, and overactive bladder. In the meantime, we also look at Chinese Medicine from a new angle, and thereby modernising the approach, such as using Chinese Medicine in cancer management. We are honoured to have Prof. Wang Jianye from the Chinese Medical Association giving the plenary lecture to set the scene for the meeting by discussing the challenges posed by the ageing population.

The Annual Scientific Meeting is not the only vehicle through which the Federation delivers its mission on continuous professional education. There are numerous certificate courses, seminars and webinars scattered throughout the year to cater for the interests and professional needs of our different member societies and their members. Our monthly Medical Diary, has been a valuable source of update information for medical



and health professionals for many years. Its chief editor, Dr. Raymond Lo, our former President, sees to it that the contents reflect current clinical practice and are suitable for continuous medical education for our wide readership. Tying in with the themes of the Hong Kong Medical Diary is our collaboration with Healthpedia (精靈一點), the lunchtime health programme on Radio One, Radio Television Hong Kong. On this live phone-in programme, two authors from each Medical Diary issue introduce the advances in their fields and answer questions from the public.

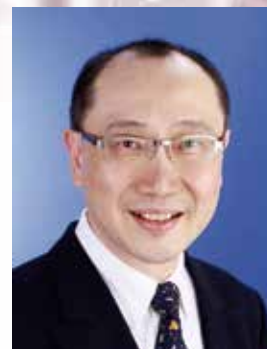
Finally, I must thank our officiating guests for showing their support of our meeting with their presence. I must congratulate our Organising Committee for putting together a stimulating programme and the Secretariat for the smooth running of the meeting. I must thank our sponsors for their generosity in supporting this meaningful educational event. Most of all, I need to thank all our participants for their active participation. I hope we all learn something from this meeting and apply it to our professional activities.



Welcome Messages from Chairpersons

Dr. Samuel Ka-shun FUNG

Co-chairman, Annual Scientific Meeting 2023



On behalf of the Organising Committee of the Federation of Medical Societies of Hong Kong, it gives me great pleasure and honour, together with my co-chair Dr. Siu Kwai-ming, to welcome you to the Annual Scientific Meeting 2023. The title theme this year is **"Revolutionising Healthcare Through Innovations"**.

For the past years especially due to COVID, we have seen great changes to our daily lives and medical practices. It is important to learn how advances in new technologies and medical science have made a positive outcome in facing and overcoming this and future challenges.

This year's program covers Challenges in Ageing Population, Modernising in Chinese Medicine, Advances in Exoskeleton, Respiratory and Chronic Kidney Disease, Leukemia, Bladder and Rectal Diseases Disorders, Genomics with Epilepsy, Autism, Allergy and Immunology.

We are delighted to have many distinguished speakers who are renowned in their fields to share with us their expertise and give a vision of the future on the innovative advances in the current and future practice of medicine. The interruptive technologies we see today will have an important impact on the health and mankind.

We thank you for your participation in the ASM and hope you will have enjoyed the program. Our appreciations also go to the working committee and staff, as well as the generous support from our sponsors.

A handwritten signature in black ink, reading "Samuel Ka-shun FUNG". The signature is stylized with a large, sweeping flourish at the end.

■ Welcome Messages from Chairpersons

Dr. SIU Kwai-ming

Co-chairman, Annual Scientific Meeting 2023



On behalf of the Organising Committee of the 2023 Annual Scientific Meeting (ASM) of the Federation of Medical Society of Hong Kong (FMSHK), it is my great pleasure as co-chairman together with Dr. Samuel Ka-shun Fung to welcome you to join our Annual Scientific Meeting on 22 October 2023.

The theme of this year is **"Revolutionising Healthcare Through Innovations"**. There will be multiple lectures and symposiums with outstanding speakers. Our Chinese national speaker Professor Jianye Wang (王健業教授), Chairman of the Chinese Society of Geriatrics, Chinese Medical Association, is going to enlighten us on the topic '中國人口老齡化現狀、挑戰與老年醫學發展機遇'. In addition, we have other speakers to cover topics on medical advances in exoskeleton, management of asthma, chronic kidney disease, leukaemia, bladder and rectal diseases, paediatric neuro-development disorders, allergy & immunology as well as Chinese medicine. I am sure it will be a wonderful opportunity to experience and exchange the most updates knowledge on the practice of healthcare through innovations.

Our ASM will be conducted in hybrid mode to facilitate your participation in our meeting this year. We believe that by joining this event in person, you will also have the opportunity to meet friends. I appreciate deeply the diligent work of the members of the Organising Committee and the enthusiastic contribution of faculties. I also thank our sponsors for their unfailing support.

Finally, I thank all of you for your active participation and hope you will find this meeting enjoyable, stimulating, and educational. Thank you.

A handwritten signature in black ink, appearing to read 'Siu Kwai-ming'.



MINIMICRO POWER FOR MAXI PEI PATIENTS SUPPORT

#1 prescribed PERT¹ in the world

RIGHT DIAGNOSIS

Many patients with chronic & acute pancreatitis², cystic fibrosis^{3,4} pancreatic cancer^{3,4} pancreatectomy^{3,4} and diabetes mellitus² may have undiagnosed PEI. If you don't recognise PEI on time, it would increase the risk of long-term complications, such as: cardiovascular diseases, sarcopenia and osteoporosis⁵

RIGHT PATIENTS

Patients with untreated PEI have increased mortality risk⁶ and suffer from impaired quality of life due to steatorrhea, weight loss, and abdominal discomfort⁷

RIGHT TREATMENT

Pancreatic enzyme replacement therapy (PERT) is the cornerstone of treatment and is associated with improved survival and quality of life (QoL) in patients with PEI⁸



PEI — pancreatic exocrine insufficiency, PERT — pancreatic enzyme replacement therapy. *PEI prevalence: up to 90% for chronic pancreatitis and up to 40% for acute pancreatitis. **PEI prevalence: up to 50% for type 1 diabetes and up to 30% for type 2 diabetes. 1. Data on file. Abbott, 2022. 2. Capurso G., Traini M., Piciucchi M. et al. Exocrine pancreatic insufficiency: prevalence, diagnosis and management. Clin Exp Gastroenterol. 2019; 12:129-139. 3. Struyvenberg M.R., Martin C.R., Freedman S.D. Practical guide to exocrine pancreatic insufficiency – Breaking the myths. In BMC medicine, 2017; 15(1):29. 4. What causes PEI? | Think PEI. <https://www.thinkpei.com/en-gb/understanding-pei/whatcauses-pei>. Accessed December 2021. 5. Chaudhary A, et al. Pancreatic Exocrine Insufficiency as a Complication of Gastrointestinal Surgery and the Impact of Pancreatic Enzyme Replacement Therapy. Dig Dis. 2020;38(1):53-68. 6. Iglesias-Garcia D. et al. Increased Risk of Mortality Associated With Pancreatic Exocrine Insufficiency in Patients With Chronic Pancreatitis. J Clin Gastroenterol. 2018;52(8):e63-e72. doi: 10.1097/MCG.0000000000000917. 7. Lindkvist B. Diagnosis and treatment of pancreatic exocrine insufficiency. World J Gastroenterol. 2013; 19(42):7258-7266. 8. Phillips ME, Hopper AD, Leeds JS, et al. Consensus for the management of pancreatic exocrine insufficiency: UK practical guidelines BMJ Open Gastroenterology 2021;8:e000643. doi: 10.1136/bmjgast-2021-000643. HKG2273872

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12 SQ-HDM oral lyophilisate
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Redefine control in HDM allergies



Proven efficacy demonstrated in the largest clinical development programme in allergy immunotherapy²



Reduces recurrences of rhinitis & asthma symptoms with reduced need for symptomatic medications²



A convenient, sublingual once a daily dosing with no up-titration, which fits your patient's busy lifestyle³



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References: 1. Search Drug Database Department of Health website Available at: <https://www.drugoffice.gov.hk/eps/drug/productSearchOneFieldAction2> accessed on 5 Jan 2023. 2. Journal of the American Medical Association publishes Phase III data from allergic asthma trial with ALK's house dust mite SLIT-tablet, Acarizax[®]: <https://www.alk.net/cn/en/node/50>; accessed on 6 August 2019. 3. Acarizax[®] Package Insert. Hong Kong Abbott Laboratories Ltd June 2020.

ACARIZAX[®] Abbreviated Prescribing Information:

Product name: ACARIZAX 12 SQ-HDM oral lyophilisate. Active ingredient: Standardised allergen extract from Dermatophagoides pteronyssinus and D. farinae. Indications: Diagnosed by clinical history and a positive test of house dust mite sensitisation (skin prick test and/or specific IgE) – adolescent and adult patients (12-65 years) with persistent moderate to severe house dust mite allergic rhinitis despite use of symptom-relieving medications; Adult patients (18-65 years) with house dust mite allergic asthma not well controlled by inhaled corticosteroids and associated with mild to severe house dust mite allergic rhinitis. Posology and method of administration: one oral lyophilisate (12 SQ-HDM) daily for 3 years with reference to International treatment guidelines. Sublingual route. The first oral lyophilisate should be taken under medical supervision, and patient should be monitored for at least half an hour. Contraindications: Hypersensitivity to Gelatine (fish source), mannitol, sodium hydroxide. Patients with FEV1 < 70% of predicted value (after adequate pharmacological treatment) at initiation of treatment; severe asthma exacerbation within the last 3 months; patients with asthma and concomitant acute respiratory tract infection; active or poorly controlled autoimmune diseases, immune defects, immunodeficiencies, immunosuppression or malignant neoplastic diseases with current disease relevance; acute severe oral inflammation or oral wounds. Special warnings and precautions for use: Asthma exacerbation; Reduction in other asthma control medication; Severe systemic allergic reactions – recommendation for medical supervision at first oral lyophilisate intake; Oral inflammation; Local allergic reactions; Eosinophilic esophagitis; Autoimmune diseases in remission; Food allergy (trace of fish protein present). Interactions: Concomitant therapy with symptomatic anti-allergic drugs may increase the tolerance level of the patient to immunotherapy. Fertility, pregnancy and lactation: Acarizax treatment should not be initiated during pregnancy. If pregnancy occurs during treatment, the treatment may be continued after medical evaluations. Effects on ability to drive and use machines: no or negligible influence. Undesirable effects: Very common: nasopharyngitis, ear pruritus, throat irritation, lip oedema, oedema mouth, oral pruritus; Common: bronchitis, pharyngitis, rhinitis, sinusitis, dysgeusia, asthma, dysphonia, dyspnoea, oropharyngeal pain, pharyngeal oedema, abdominal pain, diarrhoea, nausea, oral discomfort, oral mucosal erythema, paraesthesia oral, stomatitis, tongue oedema, vomiting. Date of revision: Jun 2020

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Congratulatory Messages

The Hon. John Ka-chiu LEE, GBM, SBS, PDSM, PMSM
The Chief Executive



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■ Congratulatory Messages

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Secretary for Health



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Legislative Council Member



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Dr. the Hon. Edward Che-hung LEONG, GBM, GBS, JP



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■ Congratulatory Messages

Prof. Gilberto Ka-kit LEUNG

President, Hong Kong Academy of Medicine



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謹賀

■ **Congratulatory Messages**

Prof. Francis KL CHAN, JP

Dean, Faculty of Medicine, The Chinese University of Hong Kong



It is my privilege and pleasure to be invited to contribute a congratulatory message for the 2023 Annual Scientific Meeting organized by the Federation of Medical Societies of Hong Kong which sheds light on “Revolutionising Healthcare Through Innovations”.

Technological advancements have brought transformative changes not only to how we live our life but also to the landscape of medical and health care. By embracing innovation, we have opened the door to revolutionary ideas, technologies, and practices that will shape the future of healthcare. Increasingly, medical practitioners are applying cutting-edge technology to improve practice and patient outcomes, pushing the boundaries of medical knowledge and setting a new standard in healthcare.

May this Annual Scientific Meeting serve as a catalyst for further exploration, collaboration, and implementation of groundbreaking innovations for the betterment of humanity.



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Eating prunes is recommended as one of
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A full osmotic effect
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Treatment is suitable for
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CIC = chronic idiopathic constipation, PEG = polyethylene glycol.
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An organic disorder should have been ruled out before initiation of treatment. FORLAX® 10g should remain a
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3-months treatment course in children. If symptoms persist despite associated dietary measures, an underlying
cause should be suspected and treated. **DOSE AND ADMINISTRATION** The dosage is 1 to 2 sachets per day. The
content of each sachet must be dissolved in a glass of water for oral consumption. The effect of FORLAX® becomes
apparent within 24 to 48 hours after its administration. In children, treatment should not exceed 3 months.
Treatment induced restoration of bowel movement will be maintained by lifestyle and dietary measures. In all cases,
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inflammatory bowel disease (ulcerative colitis, Crohn's disease), toxic mega colon, perforation or risk of perforation,
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reason, and known hypersensitivity to FORLAX® or to one of the components. Due to the presence of sorbitol
(traces), this medicine is contraindicated in persons who are intolerant to fructose. **DRUG INTERACTIONS AND
OTHER INTERACTIONS** FORLAX® may interfere with the absorption of other drugs if administered simultaneously.
Generally, it is better to take FORLAX® at least 2 hours apart from other products. **ADVERSE EFFECTS** Adverse
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common (≥1/100 to <1/100); uncommon (≥1/1,000 to <1/10,000); rare (≥1/10,000 to <1/100,000); very rare (<1/100,000);
unknown (cannot be estimated from the available data). Adult population: The undesirable effects listed below have
been reported during clinical trials (including 600 adult patients) and postmarketing use. Generally, adverse
reactions have been minor and transitory and have mainly concerned the gastrointestinal system: **Adverse
reactions: Gastrointestinal disorders (Common)** Abdominal pain and/or distension, Diarrhoea, Nausea
(Uncommon) Vomiting, Urgency to defecate, Faecal incontinence **Metabolism and Nutrition Disorders (Unknown)**
Electrolyte disorders (Hyponatremia, Hypokalaemia) and/or dehydration, especially in elderly patients **Immune
system disorders (Very rare)** Hypersensitivity reactions (Pruritus, Rash, Face oedema, Quincke oedema, Urticaria,
Anaphylactic shock) **Paediatric population:** The undesirable effects listed below have been reported during clinical
trials including 147 children aged from 6 months to 15 years and post-marketing use. As in adult population, adverse
reactions have generally been minor and transitory and have mainly concerned the gastrointestinal system: **Adverse
reactions: Gastrointestinal disorders (Common)** Abdominal pain, Diarrhoea (Uncommon) Vomiting, Bloating,
Nausea **Immune system disorders (Unknown)** Hypersensitivity reactions **STORAGE CONDITIONS AND SHELF LIFE**
To be stored below 25°C. Do not exceed the expiry date plainly indicated on the pack. Keep out of reach of children
Country of origin: France

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Convenient subcutaneous injection¹

LIBERTY ASTHMA VENTURE Study Design¹: 1902 patients were randomly assigned with oral glucocorticoid-treated asthma to receive add-on DUPIXENT (at a dose of 300 mg) or placebo every 2 weeks for 24 weeks. After a glucocorticoid dose-adjustment period before randomization, glucocorticoid doses were adjusted in a downward trend from week 4 to week 20 and then maintained at a stable dose for 4 weeks. The primary end point was the percentage reduction in the glucocorticoid dose at week 24. Key secondary end points were the proportion of patients at week 24 with a reduction of at least 50% in the glucocorticoid dose and the proportion of patients with a reduction to a glucocorticoid dose of less than 5 mg per day. Severe exacerbation rates and the forced expiratory volume in 1 second (FEV₁) before bronchodilator use were also assessed.

LIBERTY ASTHMA QUEST Study Design²: 1902 patients who were 12 years of age or older with uncontrolled asthma were randomly assigned in a 2:2:1:1 ratio to receive add-on subcutaneous DUPIXENT at a dose of 200 or 300 mg every 2 weeks or matched-volume placebo for 52 weeks. The primary end points were the annualized rate of severe asthma exacerbations and the absolute change from baseline to week 12 in the forced expiratory volume in 1 second (FEV₁) before bronchodilator use in the overall trial population. Secondary end points included the exacerbation rate and FEV₁ in patients with a blood eosinophil count of 300 or more per cubic millimetre. Asthma control and DUPIXENT safety were also assessed.

EOS, eosinophils; FeNO, fractional exhaled nitric oxide; ICS, inhaled corticosteroid; OCS, oral corticosteroid; Q2W, once every 2 weeks; SOC, standard of care.

References: 1. DUPIXENT Summary of Product Characteristics. May 2020. 2. Rabe KF, Nair P, Brusselle G, et al. Efficacy and safety of dupilumab in glucocorticoid-dependent severe asthma. *N Engl J Med*. 2018;378(26):2475-2485. 3. Castro M, Corren J, Pavord ID, et al. Dupilumab Efficacy and Safety in Moderate-to-Severe Uncontrolled Asthma. *N Engl J Med*. 2018;378(26):2486-2496.

Presentation: Dupilumab solution for injection in a pre-filled syringe with needle shield. **Indications:** Atopic Dermatitis (AD): Moderate-to-severe AD in adults and adolescents ≥12 years who are candidates for systemic therapy; severe atopic dermatitis in children 6 to 11 years old who are candidates for systemic therapy. Asthma: In adults and adolescents ≥12 years as add-on maintenance treatment for severe asthma with type 2 inflammation characterised by raised blood eosinophils and/or raised FeNO, who are inadequately controlled with high dose ICS plus another medicinal product for maintenance treatment. Chronic rhinosinusitis with nasal polyposis (CRSwNP): As an add-on therapy with intranasal corticosteroids for the treatment of adults with severe CRSwNP for whom therapy with systemic corticosteroids and/or surgery do not provide adequate disease control (for 300mg). **Dosage & Administration:** Subcutaneous injection. AD adults: Initial dose of 600 mg (two 300 mg injections), followed by 300 mg every other week. AD adolescents (12-17y/o): Body weight <60 kg: initial dose of 400 mg (two 200mg injections), followed by 200 mg every other week. Body weight ≥60 kg: same dosage as adults. Dupilumab can be used with or without topical corticosteroids. Topical calcineurin inhibitors may be used, but should be reserved for problem areas only, e.g. face, neck, intertriginous and genital areas. Consider discontinuing treatment in patients who have shown no response after 16 weeks. AD Children (6-11y/o): Body weight 15Kg- <60 kg: initial dose of 300mg on Day 1 follow by 300mg on Day 15, then 300mg every 4 weeks. Body weight ≥60 kg: same dosage as adults. * The dose may be increased to 200 mg Q2W in patients with body weight of 15 kg ~ < 60 kg based on physician's assessment. Asthma: Initial dose of 400 mg, followed by 200 mg every other week. For patients with severe asthma and on oral corticosteroids or with severe asthma and co-morbid moderate-to-severe AD or adults with co-morbid severe CRSwNP: initial dose of 600 mg, followed by 300 mg every other week. Patients receiving concomitant oral corticosteroids may reduce steroid dose gradually once clinical improvement with dupilumab has occurred. The need for continued dupilumab therapy should be considered at least annually as determined by a physician. CRSwNP: for adult patients initial dose of 300 mg followed by 300 mg given every other week. Consideration should be given to discontinuing treatment in patients who have shown no response after 24 weeks of treatment for CRSwNP. Some patients with initial partial response may subsequently improve with continued treatment beyond 24 weeks. If a dose is missed, administer it asap and thereafter, resume dosing at the regular scheduled time. **Contraindications:** Hypersensitivity to dupilumab or any of the excipients. **Precautions:** Safety and efficacy in children <6 years or <15kg not been established. Not be used to treat acute asthma symptoms, acute exacerbations, acute bronchospasm or status asthmaticus. Do not discontinue corticosteroids abruptly upon start of dupilumab. Reduction should be gradual and performed under supervision of a physician; it may be associated with systemic withdrawal symptoms and/or unmask conditions previously suppressed by systemic corticosteroid therapy. Biomarkers of type 2 inflammation may be suppressed by systemic corticosteroid use. If systemic hypersensitivity reaction occurs, discontinue dupilumab and initiate appropriate therapy. Be alert to vasculitic rash, worsening pulmonary symptoms, cardiac complications, and/or neuropathy presenting in patients with eosinophilia. Treat pre-existing helminth infections before initiating dupilumab. If patients become infected while receiving dupilumab and do not respond to anti-helminth treatment, discontinue dupilumab until infection resolves. Patients who develop conjunctivitis and keratitis that does not resolve following standard treatment should undergo ophthalmological examination. AD patients with comorbid asthma should not adjust or stop asthma treatments without consultation with physicians. Carefully monitor patients after discontinuation of dupilumab. Do not give live and live attenuated vaccines concurrently with dupilumab. Patients should be brought up to date with immunisations before starting dupilumab. **Drug Interactions:** Immune responses to Tdap vaccine and meningococcal polysaccharide vaccine were assessed. Patients receiving dupilumab may receive concurrent inactivated or non-live vaccinations. **Pregnancy and lactation:** Should be used during pregnancy only if potential benefit justifies potential risk to foetus. Unknown whether dupilumab is excreted in human milk or absorbed systemically after ingestion. Decision must be made whether to discontinue breast-feeding or dupilumab taking into account benefit of breast feeding for the child and benefit of therapy for the woman. **Undesirable effects:** Most common adverse reactions reported: injection site reactions, conjunctivitis, oral herpes and eosinophilia. Safety profile observed in adolescents consistent with that seen in adults. For other undesirable effects, please refer to the full prescribing information. **Preparation:** 2 x 300mg/2ml in pre-filled syringe with needle shield, 2 x 200mg/1.14ml in pre-filled syringe with needle shield. **Legal Classification:** Part 1, First & Third Schedules Poison **Full prescribing information is available upon request.** APH-K-DUP-22-06

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- Only AD therapy:
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 - » Approved in patients as young as 6 years old¹

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- » DUPIXENT is not an immunosuppressant¹
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*DUPIXENT is indicated to treat adults and adolescents ≥12 years with moderate-to-severe atopic dermatitis, and children aged 6 to 11 years with severe atopic dermatitis who are candidates for systemic therapy¹



AD, atopic dermatitis; QoL, quality of life.

**adult population only

References: 1. DUPIXENT Summary of Product Characteristics. 2022. 2. Blauvelt A et al. *Lancet* 2017; 389:2287–2303. 3. Data on file (AD-1224 CSR). Sanofi and Regeneron Pharmaceuticals, Inc. 2016. 4. Blauvelt A et al. *Lancet* 2017; 389:2287–2303. [suppl.]. 5. Data on file (AD-1224 CSR DLQI rate). Sanofi and Regeneron Pharmaceuticals, Inc. 2021. 6. Data on file (AD-1652 CSR EASI). Sanofi and Regeneron Pharmaceuticals, Inc. 2019. 7. Data on file (AD-1652 CSR CDLQI rate). Sanofi and Regeneron Pharmaceuticals, Inc. 2019. 8. Paller AS et al. *J Am Acad Dermatol* 2020; 83(5):1282–1293. 9. Cork MJ et al. Poster presented at the Revolutionizing Atopic Dermatitis Conference; 2021: June 13; Virtual Conference. Poster 468. 10. Data on file (AD-1652 CSR pruritus NRS). Sanofi and Regeneron Pharmaceuticals, Inc. 2019. 11. Simpson EL et al. *JAMA Dermatol* 2020; 156(1):44–56. 12. Data on file (AD-1526 CSR EASI). Sanofi and Regeneron Pharmaceuticals, Inc. 2019. 13. Paller AS et al. *Am J Clin Dermatol* 2020; 21:119–131. 14. Data on file (AD-1539 EASI). Sanofi and Regeneron Pharmaceuticals, Inc. 2022. 15. Data on file (AD-1539 pruritus NRS). Sanofi and Regeneron Pharmaceuticals, Inc. 2022. 16. Data on file (AD-1539 CDLQI). Sanofi and Regeneron Pharmaceuticals, Inc. 2022. 17. Beck L et al. *Am J Clin Derm* 2022; May;23(3):393–408. 18. Strober B et al. *JAMA Dermatol* 2022;158(2):142–150. 19. Data on file (Patient numbers, May 2022). Sanofi and Regeneron Pharmaceuticals, Inc. 2022.

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DUPIXENT
(dupilumab)
CONTINUOUS CONTROL

Abstracts

王建業教授 Prof. WANG Jianye

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北京醫學會泌尿外科學分會前任主任委員
國家老年健康標準委員會主任委員
國務院老齡委專家組成員
國務院醫改領導小組專家組成員
《Ageing Medicine》總編輯
《中華泌尿外科雜誌》副總編輯



「中國人口老齡化現狀、挑戰與老年醫學發展機遇」

一、中國人口老齡化的現狀與挑戰

目前中國老年人口（60 歲及 60 歲以上）已達到 2.7 億，人口老齡化水準為 18.9 %，到 2036 年，老年人將達到 4.2 億，人口老齡化水準接近 30 %。

中國人口老齡化的特點為絕對數量大、發展速度快、未富先老、高齡化顯著、東西部發展不平衡，且波動幅度大。

嚴重的人口老齡化將會對社會帶來勞動力老化、勞動力短缺，經濟增長放緩、公共支出加大而儲備不足、消費結構改變等問題。就醫療衛生行業而言，人口老齡化引起的疾病負擔加重，老年醫學人口、機構相對短缺，醫保基金風險加大等問題。

二、老年醫學發展的機遇

醫療服務，健康管理，慢病管理，健康促進及健康保險等相關服務需求加大。增加醫護、康復養老行業人員就業機會，與老年健康及養老相關的產品需求加大。

三、目前中國政府的應對措施

健康老齡化促進行動，包括健康宣教、健康管理、慢病管理。規範老年多發病常見病的診治流程和服務模式，加速康復、護理及醫養人才的培養。推進全民人口老齡化國情教育，建設老年友善型就醫和老年友好型醫院。

各級政府加大促進健康老齡化的投入，包括老年醫學的基礎研究，人才培養，老年健康，醫療康復護理及養老機構的建設。

Abstracts

Prof. Raymond Kai-yu TONG

*BEng (HKU), PhD (Strathclyde University), FHKIE
Professor and Founding Chairman,
Department of Biomedical Engineering, the Chinese University of Hong Kong*

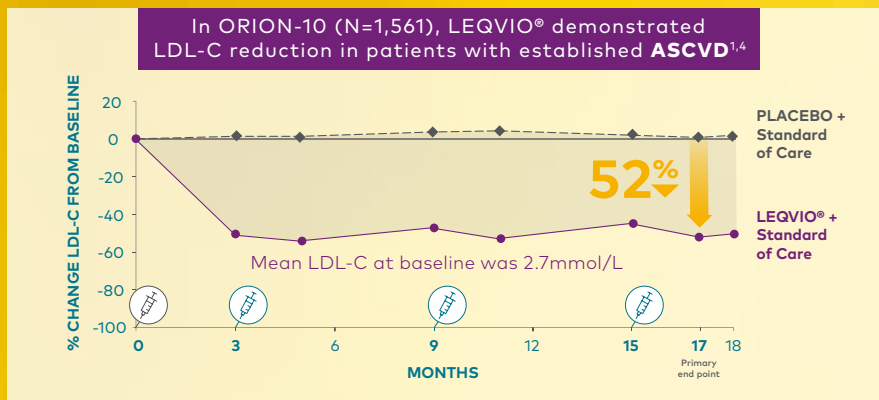


Prof. Raymond Kai-yu Tong is the Professor and Founding Chairman of the Department of Biomedical Engineering, the Chinese University of Hong Kong. His research interests include Rehabilitation Robotics (e.g. Hand of Hope, Hopebotics), Brain-Computer Control Interface (BCI), Neural Engineering, Functional Electrical Stimulation (FES) and Cognitive Assessment Software. Projects have been funded by Innovation and Technology Fund and UGC CERG/GRF as principal investigator. His research, innovation and service have received the "Global Ageing Influencers 2021" award in Singapore, Awardee of the 2013 Ten Outstanding Young Persons (Hong Kong); the Grand Prix Award (the highest honour) of the International Exhibition of Inventions of Geneva 2012; Winner Award (e-Health) (the highest honour) in the Asia Pacific ICT Award 2012; and HKIE innovation awards for young members (2008), gold awards in international invention exhibitions (2004, 2007, 2010, 2015, 2016, 2023). Webpage: <http://www.bme.cuhk.edu.hk/kytong>

Medical Advance in Exoskeleton for Neurorehabilitation

Effective motor recovery after stroke depends on intensive voluntary practice of the paretic limbs. We investigate the characteristics of brain waves and muscle activities related to the paretic upper limb movements after stroke. Brain waves and muscle activities are recorded by electroencephalography (EEG) and electromyography (EMG) respectively through electrodes attached to the scalp and skin surface. EEG has been applied in Brain-computer-interface (BCI), which is opening doors to use the power of the mind to overcome the limitations of the body. Then, we developed interactive control strategies to control different rehabilitation training systems for hand training in clinical trials, such as exoskeleton rehabilitation robot. The system incorporated the EMG and EEG as the bio-parameters to indicate the voluntary effort of a subject. We applied these engineering-based technologies in the field of Neurorehabilitation, robotic system uses soft material or electric motor to provide external assistive force during the rehabilitation training. The clinical studies showed functional improvement in the clinical outcome measures on the upper limb and lower limb after the exoskeleton robotic training for 20-session on stroke survivors.

2 DOSES A YEAR* FOR EFFECTIVE AND SUSTAINED LDL-C REDUCTION^{1†}



Patients in both study arms were on a maximally tolerated statin.^{1,4}

In ORION-10 clinical trial, LEQVIO® demonstrated LDL-C reduction in ASCVD patients:⁴

52%
EFFECTIVE
LDL-C
REDUCTION

Between-group difference of -52.3% (95% CI: -55.7%, -48.8%; P<0.001) refers to the difference between the placebo group (1.0%) and the LEQVIO® group (-51.3%) at month 17.

*LEQVIO® is dosed initially, again at 3 months, and then once every 6 months.¹

†LDL-C reduction was maintained during each 6-month dosing interval.¹



Study design: ORION-10 was a multicenter, double-blind, randomized, placebo-controlled 18-month clinical trial. Patients with established ASCVD were taking a maximally tolerated dose of statin with or without other lipid-modifying therapy and required additional LDL-C reduction. The ORION-11 trial, in addition to patients with ASCVD, included adults who were ASCVD risk equivalent [type 2 diabetes, familial hypercholesterolemia, or a 10-year risk of a cardiovascular event of ≥20% as assessed by the Framingham Risk Score for Cardiovascular Disease or equivalent].

Abbreviations: ASCVD, atherosclerotic cardiovascular disease; CI, confidence interval; LDL-C, low-density lipoprotein cholesterol

References: 1. Leqvio. Hong Kong Prescribing Information. Novartis Pharmaceuticals. 2021. 2. U.S. Food & Drug Administration. FDA approves add-on therapy to lower cholesterol among certain high-risk adults. <https://www.fda.gov/drugs/news-events-human-drugs/fda-approves-add-therapy-lower-cholesterol-among-certain-high-risk-adults>. Published Dec 2021. Accessed on 12 Apr 2022. 3. European Medicine Agency. <https://www.ema.europa.eu/en/medicines/human/EPAR/Leqvio>. Accessed on 22 Mar 2022. 4. Ray KK, Wright RS, Kallend D, et al; ORION-10 and ORION-11 Investigators. Two phase 3 trials of inclisiran in patients with elevated LDL cholesterol. N Engl J Med. 2020;382(16):1507-1519.

Leqvio® Important note: Before prescribing, consult full prescribing information. **Presentation: Solution for injection:** Each pre-filled syringe contains 1.5 mL of solution containing 284 mg inclisiran (equivalent to 300 mg inclisiran sodium). **Indications:** Leqvio is indicated in adults with primary hypercholesterolaemia (heterozygous familial and nonfamilial) or mixed dyslipidaemia, as an adjunct to diet: • in combination with a statin or statin with other lipid lowering therapies in patients unable to reach LDL-C goals with the maximum tolerated dose of a statin, or • alone or in combination with other lipid lowering therapies in patients who are statin intolerant, or for whom a statin is contraindicated. **Dosage and administration:** Recommended dose: 284 mg inclisiran administered as a single subcutaneous injection; initially, again at 3 months, followed by every 6 months. **Missed dose:** • If a planned dose is missed by less than 3 months, inclisiran should be administered and dosing continued according to the patient's original schedule. • If a planned dose is missed by more than 3 months, a new dosing schedule should be started – inclisiran should be administered initially, again at 3 months, followed by every 6 months. **Treatment Transition from PCSK9 Inhibitor Monoclonal Antibody:** Inclisiran can be administered immediately after the last dose of a monoclonal antibody PCSK9 inhibitor. **Special populations:** Renal impairment: No dose adjustments are necessary for patients with mild, moderate or severe renal impairment or patients with end stage renal disease. There is limited experience with inclisiran in patients with severe renal impairment. Inclisiran should be used with caution in these patients. Hepatic impairment: No dose adjustments are necessary for patients with mild (Child Pugh class A) or moderate (Child Pugh class B) hepatic impairment. No data are available in patients with severe hepatic impairment (Child Pugh class C). Inclisiran should be used with caution in patients with severe hepatic impairment. **Pediatric patients (below 18 years):** The safety and efficacy of inclisiran have not been established. **Geriatric patients (65 years of age or above):** No dose adjustment is necessary. **Method of administration:** Intended for administration by a healthcare professional. For subcutaneous injection into the abdomen. Alternative injection sites include the upper arm or thigh. Injections should not be given into areas of active skin disease or injury such as sunburns, skin rashes, inflammation or skin infections. Leqvio should be inspected visually for particulate matter prior to administration. Each pre-filled syringe is for single use only. **Contraindications:** Hypersensitivity to the active substance or to any of the excipients. **Warnings and precautions:** Haemodialysis: Considering that inclisiran is eliminated renally, haemodialysis should not be performed for at least 72 hours after inclisiran dosing. **Pregnancy, lactation, females and males of reproductive potential:** Pregnancy: There are no or limited amount of data from the use of inclisiran in pregnant women. Animal studies do not indicate direct or indirect harmful effects with respect to reproductive toxicity. As a precautionary measure, it is preferable to avoid the use of inclisiran during pregnancy. **Lactation:** It is unknown whether inclisiran is excreted in human milk. Available pharmacodynamic/toxicological data in animals have shown excretion of inclisiran in milk. A risk to newborns/infants cannot be excluded. A decision must be made whether to discontinue breast feeding or to discontinue/abstain from inclisiran therapy, taking into account the benefit of breast feeding for the child and the benefit of therapy for the woman. **Fertility:** No human data. No effects on animal fertility. **Adverse drug reactions:** Common (≥1 to <10%): Adverse events at the injection site (includes injection site reaction, injection site pain, injection site erythema, and injection site rash). **Interactions:** Not a substrate, inhibitor or inducer of CYP450 enzymes or common drug transporters. Not expected to have clinically significant interactions with other medications. Drug-drug interaction assessments demonstrated a lack of clinically meaningful interactions with either atorvastatin, rosuvastatin or other statins. **Packs:** Solution in pre-filled syringe: 1's **Legal classification:** P1S153 Last revision: Sep 2021 Ref: EU Dec 2020

Freedom to live a complete childhood



Make Cosentyx your 1st-line systemic treatment for paediatric patients with moderate to severe psoriasis

Complete Cosentyx Approach

Give your paediatric patients a chance to



Look
Better



Move
Better



Feel
Better

- ✓ Fast, strong, and sustained* skin clearance^{1,2}
- ✓ Fast and sustained* relief from the physical and psychosocial burden of psoriasis^{1,2}
- ✓ Favorable long-term safety profile^{2,3*}

*Long-term-through Week 52.^{2,3}

Indication

Paediatric Plaque psoriasis: Cosentyx® is indicated for the treatment of moderate to severe plaque psoriasis in children and adolescents from the age of 6 years who are candidates for systemic therapy.⁴

75 mg syringe supporting the paediatric patients with body weight <50 kg is not marketed in Hong Kong.

 **Cosentyx**®
secukinumab

Cosentyx®

Important note: Before prescribing, consult full prescribing information. **Presentation:** Secukinumab Solution for subcutaneous injection in pre-filled pen contain 150 mg or 300 mg of secukinumab. **Indications:** **Adult plaque psoriasis** Cosentyx is indicated for the treatment of moderate to severe plaque psoriasis in adults who are candidates for systemic therapy. **Paediatric plaque psoriasis** Cosentyx is indicated for the treatment of moderate to severe plaque psoriasis in children and adolescents from the age of 6 years who are candidates for systemic therapy. **Psoriatic arthritis** Cosentyx, alone or in combination with methotrexate (MTX), is indicated for the treatment of active psoriatic arthritis in adult patients when the response to previous disease-modifying anti-rheumatic drug (DMARD) therapy has been inadequate. **Axial spondyloarthritis (axSpA)** Axial spondyloarthritis (AS, radiographic axial spondyloarthritis) Cosentyx is indicated for the treatment of active ankylosing spondylitis in adults who have responded inadequately to conventional therapy. **Non-radiographic axial spondyloarthritis (nr-axSpA)** Cosentyx is indicated for the treatment of active non-radiographic axial spondyloarthritis with objective signs of inflammation as indicated by elevated C-reactive protein (CRP) and/or magnetic resonance imaging (MRI) evidence in adults who have responded inadequately to non-steroidal anti-inflammatory drugs (NSAIDs). **Dosage and administration:** **Dosage Adult plaque psoriasis:** The recommended dose is 300 mg by subcutaneous injection with initial dosing at weeks 0, 1, 2, 3 and 4, followed by monthly maintenance dosing. Based on clinical response, a maintenance dose of 300 mg every 2 weeks may provide additional benefit for patients with a body weight of 90 kg or higher. Each 300 mg dose is given as two subcutaneous injections of 150 mg or one subcutaneous injection of 300 mg. **Paediatric plaque psoriasis (adolescents and children from the age of 6 years):** The recommended dose is based on body weight and administered by subcutaneous injection with initial dosing at weeks 0, 1, 2, 3 and 4, followed by monthly maintenance dosing. Each 75 mg dose is given as one subcutaneous injection of 75 mg. Each 150 mg dose is given as one subcutaneous injection of 150 mg. Each 300 mg dose is given as one subcutaneous injection of 300 mg or as two subcutaneous injections of 150 mg. The solution for injection in pre-filled pen 150 mg/ml and 300mg/2ml are not indicated for administration to paediatric patients with a weight <50 kg. Cosentyx may be available in other strengths and/or presentations depending on the individual treatment needs. **Psoriatic arthritis:** For patients with concomitant moderate to severe plaque psoriasis, please refer to adult plaque psoriasis recommendation. For patients who are anti-TNFα inadequate responders (IR), the recommended dose is 300 mg by subcutaneous injection with initial dosing at weeks 0, 1, 2, 3 and 4, followed by monthly maintenance dosing. Each 300 mg dose is given as two subcutaneous injections of 150 mg or one subcutaneous injection of 300 mg. **Non-radiographic axial spondyloarthritis (nr-axSpA):** The recommended dose is 150 mg by subcutaneous injection with initial dosing at weeks 0, 1, 2, 3 and 4, followed by monthly maintenance dosing. Based on clinical response, the dose can be increased to 300 mg. **Axial spondyloarthritis (axSpA):** Axial spondyloarthritis (AS, radiographic axial spondyloarthritis) The recommended dose is 150 mg by subcutaneous injection with initial dosing at weeks 0, 1, 2, 3 and 4, followed by monthly maintenance dosing. For all of the above indications, available data suggest that a clinical response is usually achieved within 16 weeks of treatment. Consideration should be given to discontinuing treatment in patients who have shown no response by 16 weeks of treatment. Some patients with an initial partial response may subsequently improve with continued treatment beyond 16 weeks. **Elderly patients (aged 65 years and over):** No dose adjustment is required. **Paediatric population (aged below 18 years):** The safety and efficacy of Cosentyx in children with plaque psoriasis below the age of 6 years have not been established. The safety and efficacy of Cosentyx in children below the age of 18 years in other indications have not yet been established. No data are available. **Renal impairment/hepatic impairment:** Cosentyx has not been studied in these patient populations. No dose recommendations can be made. **Administration:** Cosentyx is to be administered by subcutaneous injection. If possible, areas of the skin that show psoriasis should be avoided as injection sites. The solution in the pen must not be shaken. **Contraindications:** **•** Cosentyx is contraindicated in patients who have had hypersensitivity reactions to the active substance or to any of the excipients. **•** Clinically important, active infection (e.g. active tuberculosis). **Warnings and precautions:** **•** **Traceability:** In order to improve the traceability of biological medicinal products, the name and the batch number of the administered product should be clearly recorded. **•** **Infections:** Cosentyx has the potential to increase the risk of infections. Caution in patients with chronic infection or history of recurrent infection. Patients should be instructed to seek medical advice if signs or symptoms suggestive of an infection occur. If a patient develops a serious infection, the patient should be closely monitored and Cosentyx should not be administered until the infection resolves. Anti-tuberculosis therapy should be considered prior to initiation of Cosentyx in patients with latent tuberculosis. Cosentyx should not be given to patients with active tuberculosis. **•** **Inflammatory bowel disease (including Crohn's disease and ulcerative colitis):** If a patient develops signs and symptoms of inflammatory bowel disease or experiences an exacerbation of pre-existing inflammatory bowel disease, secukinumab should be discontinued and appropriate medical management should be initiated. **•** **Hypersensitivity reactions:** In clinical studies, rare cases of anaphylactic reactions have been observed in patients receiving Cosentyx. Administration of Cosentyx should be discontinued immediately and appropriate therapy initiated if an anaphylactic or other serious allergic reaction occurs. **•** **Latex-sensitive individuals (for 150 mg pre-filled syringe/pen only):** The removable cap of the Cosentyx 150 mg pre-filled syringe/pen contains a derivative of natural rubber latex. **•** **Vaccinations:** Cosentyx should not be given concurrently with live vaccines. Patients receiving Cosentyx may receive concurrent inactivated or non-live vaccinations. **•** **Concomitant immunosuppressive therapy:** In psoriasis studies, the safety and efficacy of Cosentyx in combination with immunosuppressants, including biologics, or phototherapy have not been evaluated. Secukinumab was administered concomitantly with methotrexate (MTX), sulfasalazine and/or corticosteroids in arthritis studies including in patients with psoriatic arthritis and ankylosing spondylitis and secukinumab. **Women of childbearing potential:** Effective method of contraception during treatment and for at least 20 weeks after treatment should be used. **Pregnancy:** There are no adequate data from the use of secukinumab in pregnant women. As a precautionary measure, it is preferable to avoid the use of Cosentyx in pregnancy. **Breast-feeding:** It is not known whether secukinumab is excreted in human milk. Because of the potential for adverse reactions in nursing infants from secukinumab, a decision on whether to discontinue breast-feeding during treatment and up to 20 weeks after treatment or to discontinue therapy with Cosentyx must be made taking into account the benefit of breast-feeding to the child and the benefit of Cosentyx therapy to the woman. **Adverse drug reactions:** **Very common (≥10%):** Upper respiratory tract infections, **Common (≥1% to <10%):** Oral herpes, throat pain, headache, diarrhea, rhinitis, nausea, fatigue. **Uncommon (≥0.1% to <1%):** Oral candidiasis, neutropenia, edema, lower respiratory tract infections, conjunctivitis, inflammatory bowel disease, urticaria, dyshidrotic eczema. **Rare (≥0.01% to <0.1%):** Anaphylactic reactions, exfoliative dermatitis, hypersensitivity vasculitis. **Not known (cannot be estimated from the available data):** Mucosal and cutaneous candidiasis (including oropharyngeal candidiasis). **Interactions:** Live vaccines should not be given concurrently with Cosentyx. In a study in subjects with plaque psoriasis, no interaction was observed between secukinumab and midazolam (CYP3A4 substrate). No interaction was seen when Cosentyx was administered concomitantly with methotrexate (MTX) and/or corticosteroids in arthritis studies (including in patients with psoriatic arthritis and axial spondyloarthritis). **Packs: For 150 mg pre-filled pen:** Solution in pre-filled pen: 1's or 2's. **For 300 mg pre-filled pen:** Solution in pre-filled pen: 1's. Not all pack sizes are marketed. **Legal classification:** FTSLS3 Last revision Mar 2023 Ref: EU Jun 2022

References
1. Magnolo N, et al. J Am Acad Dermatol 2022;86:122-30. 2. Bodemer C, et al. J Eur Acad Dermatol Venerol 2021;35:938-947. 3. Magnolo N, et al. Pediatr Drugs 2022;24:377-387. 4. Cosentyx (secukinumab) solution for injection in pre-filled pen Hong Kong prescribing information, 07 Dec 2022.

The materials for Cosentyx contained in virtual exhibition are approved for use only in Hong Kong. Prescribing information may vary depending on local approval in each country/location. Before prescribing any product, always refer to local materials such as the prescribing information and/or the Summary of Product Characteristics (SPC). For Hong Kong Healthcare Professionals' reference and sole use only.

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Kwun Tong, Hong Kong
Tel: 2882 5222 Fax: 2573 8804

 **NOVARTIS**

Abstracts

Dr. Terence Chi-chun TAM

MBBS (HK), MRCP (UK), FRCP (Lond, Edin, Glasg), FHKCP, FHKAM (Medicine)
Honorary Clinical Assistant Professor, The University of Hong Kong



Dr. Terence Chi-chun Tam is a specialist in respiratory medicine. He received his MBBS degree from The University of Hong Kong (HKU) in 2001 and pursued his post-fellowship training in interventional pulmonology in Germany, and Japan. Prior to joining private practice, Dr. Tam had worked for over 20 years in Queen Mary Hospital, where he developed the interventional pulmonology service through the introduction and improvement of multiple technologies and techniques, such as navigational bronchoscopy, perioperative tumour localisation and ultrasound-guided pleural sampling. He is also highly experienced in the treatment of lung cancer and non-cancerous lung conditions including pneumonia, interstitial lung diseases and obstructive sleep apnea.

Dr. Tam is currently an Honorary Clinical Assistant Professor in the Department of Medicine at the University of Hong Kong (HKU), where he has been actively involved in academic research and teaching. He has co-authored more than 40 publications in peer-reviewed journals on topics such as asthma, COPD, bronchiectasis, and lung cancer. Dr. Tam is a sought-after speaker and has given talks on diverse topics, both locally and internationally, to the public, medical professionals, and fellow respirologists.

Practice Changing Update in GINA 2023

The Global Initiative for Asthma (GINA) has released its highly anticipated 2023 guidelines, introducing two pivotal changes that aim to revolutionise asthma treatment. The update recommends replacing bronchodilators with anti-inflammatory relievers (i.e., inhaled corticosteroid with fast-acting beta-agonist) as primary treatment. This change is supported by emerging evidence highlighting the superior efficacy of anti-inflammatory agents in enhancing symptom control, mitigating the risk of severe attacks, and improving overall asthma control. Another significant update in GINA 2023 is the endorsement of several biologics for severe asthma management.

Addition update also include the emphasis of environmental considerations when choosing inhalers. The update recognises the impact of inhaler propellants on the environment and encourages healthcare professionals to consider environmentally friendly inhaler options to minimise their carbon footprint.

Healthcare professionals should stay informed about these guideline updates and adapt their clinical practices accordingly. The GINA 2023 update represents a significant advancement in asthma management, ushering in an era of personalised, evidence-based approaches that can deliver improved outcomes and enhanced quality of life for asthma patients.

Reference:

1. Global Initiative for Asthma. 2022 GINA report, global strategy for asthma management and prevention. Accessed August 26, 2022. <https://ginasthma.org/gina-reports>

Abstracts

Dr. Winston Wing-shing FUNG

MB BChir (Cantab), FHKCP, FHKAM (Medicine), FRCP (London)
Associate Consultant, Prince of Wales Hospital
Honorary Clinical Assistant Professor, The Chinese University of Hong Kong



Dr. Winston Fung is currently an associate consultant at Prince of Wales Hospital and an honorary clinical assistant professor for Chinese University of Hong Kong (CUHK). He graduated from University of Cambridge and went on to complete his Nephrology training in Hong Kong, where he achieved academic excellence with several awards, including the silver medal for the best dissertation from Hong Kong College of Physicians. He also obtained his FRCP (Lond) from the Royal College of Physicians two years ago. He has published more than 80 peer-reviewed publications and has won many research grants, including the Hong Kong Society of Nephrology 35th Anniversary Research Grant. He is the principal investigator for establishing the Hong Kong Polycystic Kidney Disease Registry.

He also has received numerous Exemplary Teacher Awards over the years from CUHK, including the Teacher of the Year Award in 2021. He is currently serving on the Education Committee in the Hong Kong Society of Nephrology and is an active member of the Emerging Leader Program in the International Society of Nephrology. He is also a member of the Education working group and the North East Asia Regional Board for the International Society of Nephrology.

Advancing the Management in Chronic Kidney Disease - From Primary to Collaborative Care

The global burden of chronic kidney disease (CKD) is rising, and it is estimated that about 850 million people are currently affected by different types of kidney disorders¹. Furthermore, CKD represents an enormous healthcare burden, and it is projected to become the fifth most common cause of years of life lost globally by 2040².

It is imperative to recognise the disease early as these disease groups can be prevented and progression to end-stage kidney disease can be delayed with appropriate access to basic diagnostics and early treatment. However, this is often easier said than done as the disease remains under-diagnosed with 90 % of patients with CKD stage 3 being unaware of their disease³. With the advances of newer effective treatments, the emphasis on early diagnosis and treatment is even more critical.

The government have recently introduced the Chronic Disease Co-Care programme, with a view to preventing worsening of chronic disease and occurrence of complication through early identification and early treatment by the primary care, while establishing a streamlined collaborative care pathway with the secondary care when specialist input is needed. Indeed, there has been successful implementation of primary care-specialist collaborative models across the world⁴.

This lecture would highlight the importance of early identification and effective management of chronic kidney disease, while giving a brief overview of the collaborative care model.

Reference:

1. Jager KJ, et al. A single number for advocacy and communication-worldwide more than 850 million individuals have kidney diseases. *Kidney Int.* 2019 Nov;96(5):1048-1050
2. Foreman KJ, et al. Forecasting life expectancy, years of life lost, and all-cause and cause-specific mortality for 250 causes of death: reference and alternative scenarios for 2016-40 for 195 countries and territories. *Lancet.* 2018 Nov 10;392(10159):2052-2090
3. Ravera M, et al. CKD awareness and blood pressure control in the primary care hypertensive population. *Am J Kidney Dis.* 2011 Jan;57(1):71-7
4. Haley WE, et al. Improving care coordination between nephrology and primary care: a quality improvement initiative using the renal physicians association toolkit. *Am J Kidney Dis.* 2015 Jan;65(1):67-79

NEW INDICATION

Once-daily asthma
maintenance treatment
in patients aged 18 years
and older who are not
adequately controlled
with ICS/LABA³

一開一吸¹



實話易吸



95%患者
都話易用易吸²

了解更多



• SAAWADBB •



HK65911
Treligy Ellipta inhalation
powder pre-dispensed
100mcg/62.5mcg/25mcg

TRELEGY ELLIPTA (fluticasone furoate/umeclidinium/vilanterol) Safety Information³ • TRELEGY ELLIPTA should not be used more often than recommended, at higher doses than recommended, or in conjunction with other medicines containing LABA or LAMA. • When beginning treatment with TRELEGY ELLIPTA, patients who have been taking rapid onset, short duration, inhaled beta₂-agonists on a regular basis should be instructed to discontinue the regular use of these drugs and use them only for symptomatic relief if they develop acute respiratory symptoms while taking TRELEGY ELLIPTA. • TRELEGY ELLIPTA should not be used to treat acute symptoms of COPD or asthma. Patients should be prescribed a rapid onset, short duration inhaled bronchodilator (e.g., salbutamol) to relieve acute symptoms such as shortness of breath and advised to have this available for use at all times. • Patients should be made aware that for optimum benefit, TRELEGY ELLIPTA must be used regularly, even when asymptomatic. • Adverse Events: nasopharyngitis, pneumonia, headache, back pain

References: 1. AC Grant, et al. J Aerosol Med Pulm Drug Deliv. 2015 Dec 1; 28(6): 474-485. 2. Siler TM, et al. PLoS ONE. 2022 17(8): e0273170. 3. TRELEGY Ellipta 100/62.5/25mcg Hong Kong Prescribing Information, Version number HK052023 (GDS11/Canada20230104).

Please read the full prescribing information prior to administration. Full prescribing information is available upon request. For adverse event reporting, please call GlaxoSmithKline Limited at (852) 3189 8989 (Hong Kong), or send an email to us at HKAdverseEvent@gsk.com. Trade marks are owned by or licensed to the GSK group of companies. ©2023 GSK group of companies or its licensor.

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PM-HK-FVU-JRNA-230001 (08/2025) Date of preparation: 01/09/2023



SHINGRIX
(ZOSTER VACCINE
RECOMBINANT, ADJUVANTED)

A NEW GENERATION OF HERPES ZOSTER VACCINE

**PREVENT
SHINGLES**
DON'T GIVE IT A CHANCE²

**ELIGIBLE
GROUPS²**

18+
YEARS OLD
AT INCREASED
HZ RISK

50+
YEARS OLD

**THE ONLY HZV
WITH OVER
90%**
VACCINE
EFFICACY^{2-3*}

HZ = Herpes zoster
HZV=Herpes zoster vaccine
^Efficacy in adults aged 50 years or above

The US CDC Recommends SHINGRIX As The Preferred Vaccine For The Prevention Of Shingles¹

CDC = Centers for Disease Control and Prevention

Indication: SHINGRIX is indicated for prevention of herpes zoster (HZ) and post-herpetic neuralgia (PHN), in adults 50 years of age or older; and adults 18 years of age or older at increased risk of HZ. The use of Shingrix should be in accordance with official recommendations.

Safety information: SHINGRIX is for intramuscular injection only, preferably in the deltoid muscle. The vaccine is given as a 2-dose series. The second dose can be administered as soon as 2 months after the first dose (and if necessary, anytime between 2-6 months). In adults aged 50 years or above, the most frequently reported adverse reactions include pain at the injection site, myalgia, fatigue and headache. Most of these reactions were not long-lasting. In adults 18 years or above who are immunodeficient or immunosuppressed due to disease or therapy (referred to as immunocompromised (IC)), the safety profile was consistent with that observed in adults 50 years and above. There are limited data in adults aged 18-49 years at increased risk of HZ who are not IC.

Abbreviated Prescribing Information

Name of the Medicinal Product: Shingrix vaccine powder and suspension for suspension for injection, Herpes zoster vaccine (recombinant, adjuvanted) Qualitative and Quantitative Composition: After reconstitution, 1 dose (0.5 ml) contains 50 micrograms of gE antigen adjuvanted with AS01B, Varicella Zoster Virus (VZV) glycoprotein E (gE) produced by recombinant DNA technology in Chinese Hamster Ovarian (CHO) cells, The GlaxoSmithKline proprietary AS01B Adjuvant System is composed of the plant extract Quilajia saponaria Molina, fraction 21 (QS-21) (50 micrograms) and 3-O-desacyl-4'-monophosphoryl lipid A (MPL) from Salmonella minnesota (50 micrograms) Indications: Shingrix is indicated for prevention of herpes zoster (HZ) and post-herpetic neuralgia (PHN), in adults 50 years of age or older and adults 18 years of age or older at increased risk of HZ. Posology and Administration: The primary vaccination schedule consists of two doses of 0.5 ml each: an initial dose followed by a second dose 2 months later. For subjects who are or might become immunodeficient or immunosuppressed due to disease or therapy, and whom would benefit from a shorter vaccination schedule, the second dose can be given 1 to 2 months after the initial dose. Method of administration: Intramuscular injection. Contraindications: Hypersensitivity to the active substances or to any component of the vaccine, Special Warnings and Precautions for Use: As with all injectable vaccines, appropriate medical treatment and supervision should always be readily available in case of an anaphylactic event following the administration of the vaccine. As with other vaccines, vaccination with Shingrix should be postponed in subjects suffering from an acute severe febrile illness. However, the presence of a minor infection, such as a cold, should not result in the deferral of vaccination. As with any vaccine, a protective immune response may not be elicited in all vaccinees. Do not administer the vaccine intravascularly or intradermally. Subcutaneous administration is not recommended. Maladministration via the subcutaneous route may lead to an increase in transient local reactions. Shingrix should be given with caution to individuals with thrombocytopenia or any coagulation disorder since bleeding may occur following intramuscular administration to these subjects. Syncope (fainting) can occur following, or even before, any vaccination as a psychogenic response to the needle injection. This can be accompanied by several neurological signs such as transient visual disturbance, paraesthesia and tonic-clonic limb movements during recovery. It is important that procedures are in place to avoid injury from faints. Interactions: Shingrix can be given concomitantly with unadjuvanted inactivated seasonal influenza vaccine, 23-valent pneumococcal polysaccharide vaccine (PPV23) or reduced antigen diphtheria-tetanus-acellular pertussis vaccine (dTpa). The vaccines should be administered at different injection sites. Fertility, pregnancy and Lactation: Pregnancy: There are no data from the use of Shingrix in pregnant women. The effect on breast-fed infants of administration of Shingrix to their mothers has not been studied. Undesirable effects: lymphadenopathy, hypersensitivity reactions including rash, urticaria, angioedema, headache, gastrointestinal symptoms (including nausea, vomiting, diarrhoea and/or abdominal pain), myalgia, arthralgia, injection site reactions (such as pain, redness, swelling), fatigue, chills, fever, injection site pruritus, malaise. Incompatibility: This medicinal product must not be mixed with other medicinal products. Use and handling: The powder and suspension should be inspected visually for any foreign particulate matter and/or variation of appearance. If either is observed, do not reconstitute the vaccine. Shingrix must be reconstituted prior to administration. 1. Withdraw the entire contents of the vial containing the suspension into the syringe. 2. Add the entire contents of the syringe into the vial containing the powder. 3. Shake gently until the powder is completely dissolved. The reconstituted vaccine is an opalescent, colourless to pale brownish liquid. The reconstituted vaccine should be inspected visually for any foreign particulate matter and/or variation of appearance. If either is observed, do not administer the vaccine. After reconstitution, the vaccine should be used promptly; if this is not possible, the vaccine should be stored in a refrigerator (2°C – 8°C). If not used within 6 hours it should be discarded. Before administration: 1. Withdraw the entire contents of the vial containing the reconstituted vaccine into the syringe. 2. Change the needle so that you are using a new needle to administer the vaccine. Please read the full prescribing information prior to administration. Full prescribing information is available on request from GlaxoSmithKline Ltd, 23/F, Tower 6, The Gateway, 9 Canton Road, Tsim Sha Tsui, HK.

References: 1. Centers for Disease Control and Prevention, MMWR, 2018 Jan 67(3):103-8, 2. GSK, SHINGRIX Hong Kong Prescribing Information GDS04, 3. MSD Live-attenuated Zoster Vaccine Product Circular.

For adverse event reporting, please call GlaxoSmithKline Limited at (852) 3189 8969 (Hong Kong) [or (853) 2871 5569 (Macau)], or send an email to us at HKAdverseEvent@gsk.com, Please read the full prescribing information prior to administration, Full Prescribing Information is available upon request at GSK, 23/F, Tower 6, The Gateway, 9 Canton Road, Tsim Sha Tsui, HK.

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PM-HK-SGX-ADVT-220002 (06/2024) Date of preparation: 01/07/2022

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GSK

Abstracts

Prof. BIAN Zhaoxiang

Honorary Professor, Guangzhou University of Traditional Chinese Medicine
Honorary Professor, Shanghai University of Traditional Chinese Medicine
Honorary Professor, Tianjin University of Traditional Chinese Medicine
Visiting Research Fellow, China Academy of Chinese Medical Science
Associate Vice-President (Chinese Medicine Development),
Hong Kong Baptist University
Director and Chair Professor of Clinical Division, School of Chinese Medicine,
Hong Kong Baptist University



Professor Bian Zhaoxiang is a leading expert in Chinese medicine clinical studies, a respected research scientist in the field of gut dysbiosis, and a relentless advocate for incorporating Chinese medicine into a holistic healthcare system. Currently, Professor Bian holds these positions in the School of Chinese Medicine at HKBU: Associate Vice-President (Chinese Medicine Development); Director and Chair Professor of the Clinical Division; Director, Centre for Chinese Herbal Medicine Drug Development; Director, Chinese EQUATOR Centre; and Director, Hong Kong Chinese Medicine Clinical Study Centre. He also serves as an associate editor and editorial board member for many international peer review journals, including Trials, BMC-Complementary and Alternative Medicine, and Chinese Medicine.

Modernising Chinese Medicine

Traditional Chinese Medicine (TCM) has been used for more than two thousand years in China, and it is always associated with holistic concepts and experience-based practices. How this traditional medicine and classic wisdom can contribute more to the healthcare system in HK is a big topic. Changing from an experience-based to an evidence-based approach, collaborating with multiple disciplines, and applying the new cutting-edge knowledge could help this process. Several cases include (1) CM telemedicine system for the COVID-19 outbreak, (2) Long COVID Chinese Medicine treatment, and (3) Stroke prevention and rehabilitation programmes are the examples in this area. Traditional wisdom contributes more to the healthcare system via modernisation.

Abstracts

Dr. GILL Harinder Singh Harry

MBBS (HK), PDipID (HK), MD (HK), MRCP (UK), FRCP (Edin, Glasg, Lond),
FRCPath, FHKCP, FHKAM (Medicine)
Clinical Associate Professor, Department of Medicine, School of Clinical Medicine,
LKS Faculty of Medicine, the University of Hong Kong.



Dr. Gill graduated from the University of Hong Kong in 2006 and joined the Department of Medicine, Queen Mary Hospital in 2007. He completed his training in Haematology and Advanced Internal Medicine and joined the University of Hong Kong in July 2014. Following that, he underwent training in Haematopathology and was conferred Fellow of The Royal College of Pathologists in 2019. He completed his doctorate degree in 2019 focusing on the genomics of myeloproliferative neoplasms (MPN).

One of his key research areas since 2010 is the application of oral arsenic trioxide (ATO) in the treatment of acute promyelocytic leukaemia (APL). He steered the research and development the first GMP grade oral formulation of ATO worldwide.

Dr. Gill also leads research on Myelodysplastic syndrome (MDS) and MPN with specific focus on molecular alterations and novel therapeutics in these disorders. Dr Gill leads key regional studies on myeloid malignancies in Asia.

Unmet Needs in the Management of Acute Myeloid Leukaemia (AML) and Myelodysplastic Syndromes (MDS)

Acute myeloid leukaemia (AML) and myelodysplastic syndrome (MDS) are genetically heterogeneous haematological malignancies. In the current era of personalised medicine, significant advances have been made in the diagnosis, classification and prognostication of these conditions. In this lecture, the current risk stratification and treatment approaches driven by genomics will be discussed. Unmet clinical needs and treatment advances in AML and MDS will be discussed.



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Greater overall
symptom relief



Persistence of
symptom relief through
sleeping hours



Potential for
less morning pain
due to extended effect

Panadol Extend

OA = osteoarthritis.

References

1. The Royal Australian College of General Practitioners. Guideline for the non-surgical management of hip and knee osteoarthritis. South Melbourne, Australia; 2009. 2. National Institute for Health and Care Excellence. Osteoarthritis: care and management. Clinical guideline, CG177, February 2014. 3. Panadol Extend product information.

Panadol Extend Acetaminophen 665mg **Abridged Prescribing Information:**

Active Ingredient: Acetaminophen 665mg **Indications:** Provides extended effective relief of osteoarthritis pain, lower back pain, shoulder pain, muscular pain, toothache. **Dosage & Administration:** Adult: Take 2 tablets, every 6 to 8 hours. Do not take more frequently than every 6 hours. Do not take more than 4000mg Acetaminophen (i.e. 6 tablets of Panadol Extend) in 24 hours. Should not use with other Acetaminophen containing products. Do not exceed the stated dose. **Contra-indication:** Contraindicated in patients with a previous history of hypersensitivity to Acetaminophen or to any of the constituents. **Warnings and Precautions:** Panadol Extend should not be crushed or chewed. If symptoms persist or you have been diagnosed with liver or kidney impairment, seek medical advice before take this medication. If you are taking anticoagulants (blood thinner e.g. Warfarin and other coumarins) and you need to take Acetaminophen on a daily basis over a long period. This may enhance the anticoagulant effect and thus increasing the risk of bleeding. However, taking occasional doses of Panadol Extend with anticoagulants have no significant effect. Before taking this medicine, make sure you consult your doctor if you are taking Warfarin or similar medicines used to thin blood. **Undesirable effects:** Thrombocytopenia, anaphylaxis, cutaneous hypersensitivity reactions including skin rashes, angioedema, and Stevens Johnson Syndrome, bronchospasm in patients sensitive to aspirin and other NSAIDs, hepatic dysfunction. **Overdose:** Massive overdose of Acetaminophen may adversely affect the liver of some people. Prompt medical attention is essential in all cases of suspected overdose even if there is no sign or symptom. Administration of N-acetylcysteine or methionine may be required. Because the dosage form is a sustained-release formulation of Acetaminophen, absorption will be prolonged in overdose. One recommendation for management of suspected overdose of sustained release tablet is to obtain an additional plasma Acetaminophen level 4-6 hours after initial measurement. If either level is above or close to the treatment line on the Acetaminophen overdose nomogram, administration of antidote would be indicated. **Please read the full prescribing information prior to administration. Full prescribing information is available on request. Abbreviated Prescribing Information version 1.0 prepared in July 2011. Acetaminophen is another name of Paracetamol.**

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NSAIDs^{†,‡,5}**

Voltaren Emulgel



* NNT refers to the number of patients that need to be treated with a therapy before one gets a response they would not have achieved with the comparator⁶. The lower the NNT, the more efficacious the drug is⁶.

[†] For treatment of strains, sprains or sports or overuse-type injuries.

[‡] Vs. topical ibuprofen, ketoprofen, benzydamine, piroxicam and indomethacin, concluded by a Cochrane meta-analysis.

NNT = number-needed-to-treat. NSAIDs = non-steroidal anti-inflammatory drugs. OA = osteoarthritis.

References

1. Voltaren Summary of Product Characteristics. 2. Davies NM, et al. Clin Pharmacokinet 1997;33:184-213. 3. Tugwell PS, et al. J Rheumatol 2004;31:2002-12. 4. Predel HG, et al. Efficacy and safety of diclofenac diethylamine 1.16% gel in acute neck pain: a randomized, double-blind, placebo-controlled study. BMC Musculoskeletal Disord 2013;14:250. 5. Derry S, et al. Cochrane Database Syst Rev 2015;11:CD007402. 6. Katz N, et al. J Pain 2015;16:116-123.

Product Name: Voltaren Emulgel 1%

Active Ingredient: 100g of Voltaren Emulgel contains 1.16g diclofenac diethylamine (equivalent to 1g of diclofenac sodium) **Indications:** For the local treatment of pain, inflammation and swelling caused by sports-related injuries or accidents. Also for local treatment of various rheumatic joint or muscle pain (e.g. stiffness in the shoulders and arthritis) if recommended by a doctor or pharmacist. **Dosage & Administration:** Adults and children over 12 years of age: Depending on the size of the painful area to be treated, gently rub in 2 to 4g of Voltaren Emulgel (an amount the size of a cherry or walnut) 3 to 4 times a day. **Children under 12 years of age:** Consult a doctor or pharmacist before use. **Contraindications:** Do not use if patients are allergic to diclofenac or to other substances which relieve pain and inflammation (in particular acetylsalicylic acid and ibuprofen), or to propylene glycol and isopropyl alcohol or to any of the other ingredients. **Precautions:** For external use only. Do not apply to an open wound or to skin that has a rash. Do not apply for long periods of time over large areas of skin unless prescribed by a doctor. Avoid contact with the eyes and mucous membranes. Consult a doctor or pharmacist if any discomfort persists. Stop using in case of any allergic reactions. Do not use in pregnant women, especially during the last 3 months of pregnancy. **Side effects:** Skin rash, itching, reddening and smarting of the skin.

Please read the full prescribing information prior to administration. Full prescribing information is available on request. Abbreviated Prescribing Information version prepared in August 2019.

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Abstracts

Dr. Garret Man-kit LEUNG

MBBS

Associate Consultant, Queen Mary Hospital



Dr. Garret Leung graduated from the University of Hong Kong in 2011 and joined the Department of Medicine of Queen Mary Hospital as Resident in 2012. He obtained his fellowship in Haematology and Haematological Oncology in 2018. He is currently the Associate Consultant in the Department of Medicine, Queen Mary Hospital. His primary interests are on myeloid malignancies, in particular myeloproliferative neoplasms (MPNs) and hematopoietic stem cell transplant.

Tyrosine Kinase Inhibitors in CML and Ph+ ALL

Tyrosine kinase inhibitors (TKIs) have revolutionised the treatment of chronic myeloid leukemia (CML) and Philadelphia chromosome-positive (Ph+) acute lymphoblastic leukemia (ALL).

In CML, the BCR:ABL1 fusion gene codes for a constitutively active tyrosine kinase protein. TKIs work by inhibiting this protein, leading to a sustained control of the disease. TKIs have made CML a manageable chronic illness with fewer toxicities from treatment. On the other hand, Ph+ B-ALL is a much more aggressive disease with poorer survival. The addition of TKIs to the treatment regimens, however, have improved the disease outcome and can lead to a deep treatment response.

In this review, we will give you an overview of the use of TKIs in the management of CML and Ph+ B-ALL.

Abstracts

Dr. Philip Min-ho KAM

MBBS (HK), MRCSEd, FRCS Ed, FCSHK, FHKAM (Surgery)
Specialist in General Surgery



Dr. Philip Ming-ho Kam is a specialist in General Surgery affiliated with the Edinburgh Orthopaedic Spine and Surgery Centre. He has undergone extensive training as a general surgeon and has completed post-fellowship training in Colorectal Surgery, with focus on minimal invasive surgery and advanced endoscopic therapy.

Dr. Kam received Bachelor of Medicine and Bachelor of Surgery (M.B.B.S.) from the University of Hong Kong and has also undergone professional training in various hospitals. During his training he has worked at Queen Elizabeth Hospital, Yan Chai Hospital, and Prince of Wales Hospital in Hong Kong. During his practice, he performed over 1,400 major emergency and elective operations, including laparoscopic surgeries for various gastrointestinal pathologies, hernia surgery, trauma surgery, as well as benign colorectal surgeries such as hemorrhoidectomy and complex anal surgeries. He has also performed significant number of both diagnostic and therapeutic endoscopies, including O.G.D., colonoscopy and endoscopic submucosal dissection (ESD).

Dr. Philip Kam's comprehensive training and expertise position him as a skilled and dedicated General Surgeon, equipped to provide exceptional surgical care to his patients.

Hemorrhoidal Crisis - How Can Be Treated and Avoided?

Hemorrhoidal disease, commonly known as hemorrhoids, is a prevalent condition that affects individuals of all ages and genders worldwide. Hemorrhoids occur when the vessels anorectal region becomes engorged or inflamed, leading to discomfort, pain, and bleeding. In this lecture, we will discuss the necessary assessment for patients present with hemorrhoids, red flag signs and symptoms that require workup, and treatment options available for this condition.

Assessment of symptoms is often clinical, with the aim to rule out the acute complication of hemorrhoids. It is also necessary to exclude other underlying etiologies that present similarly. Once the diagnosis of hemorrhoids is established, different modalities of treatment can be offered. First line treatment is often lifestyle modifications including fiber intake, hydration and engaging in regular exercise.

Medical treatment will be necessary for mild to moderate cases of hemorrhoids, including topical agents, and oral phlebotropic agents (such as Micronised purified flavonoid fraction) to reduce pain and inflammation associated with hemorrhoids. These treatments can help alleviate itching, discomfort, and swelling and promote healing of the affected area.

For more severe cases of hemorrhoids, surgical interventions may be necessary. These include office procedures such as Rubber band ligation or injection of sclerosant. Hemorrhoidectomy is a common procedure used to treat internal hemorrhoids. Other surgical options include Hemorrhoidectomy or Doppler-guided hemorrhoidal artery ligation.

In conclusion, hemorrhoid is a common condition that can cause significant discomfort and pain. However, effective treatments are available to manage the symptoms of hemorrhoids and prevent their recurrence. Lifestyle modifications, medical management, and surgical interventions are all treatment options that can be used to manage hemorrhoidal disease. Preventive measures can also be taken to avoid developing hemorrhoids. By understanding the available treatment options and taking preventive measures, individuals can effectively manage hemorrhoidal disease and improve their quality of life.

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*Prasterone is an inactive precursor that is converted into active androgens and estrogens. The mechanism of action is not fully established.



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avenue for OAB without compromising cognitive function.^{2,3}

Day Time Frequency ≥ 8 times

Nocturia ≥ 1 time

Urgency



Abbreviations: LUTS, lower urinary tract symptoms; OAB, overactive bladder

References: 1. Wagg A, et al. Efficacy, safety, and tolerability of mirabegron in patients aged ≥ 65 yr with overactive bladder wet: a phase IV, double-blind, randomised, placebo-controlled study (PILLAR). *Eur Urol*. 2020;77(2):211-20. 2. Griebing TL, et al. Effect of mirabegron on cognitive function in elderly patients with overactive bladder: MoCA results from a phase 4 randomized, placebo-controlled study (PILLAR). *BMC Geriatr*. 2020;20(1):10-3. Chapple CR, et al. Persistence and adherence with mirabegron versus antimuscarinic agents in patients with overactive bladder: a retrospective observational study in UK clinical practice. *Eur Urol*. 2017;72(3):389-99.

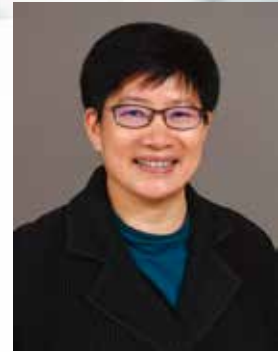
Abbreviated prescribing information of Betmiga® prolonged-release tablets

Version: 003 **Composition:** Mirabegron **Indication:** Symptomatic treatment of urgency, increased micturition frequency and/or urgency incontinence as may occur in adult patients with overactive bladder (OAB) syndrome. **Dosage:** Adult including elderly 50 mg once daily with or without food. **Administration:** Swallow whole with liquids. Do not chew/divide/crush. **Contraindications:** Mirabegron is contraindicated in patients with - Hypersensitivity to the active substance or to any of the excipients. - Severe uncontrolled hypertension defined as systolic blood pressure ≥ 180 mm Hg and/or diastolic blood pressure ≥ 110 mm Hg. **Special warnings and precautions for use:** **Renal impairment** Betmiga has not been studied in patients with end stage renal disease (GFR < 15 mL/min/1.73 m² or patients requiring haemodialysis) and, therefore, it is not recommended for use in this patient population. Data are limited in patients with severe renal impairment (GFR 15 to 29 mL/min/1.73 m²) based on a pharmacokinetic study a dose reduction to 25 mg is recommended in this population. Betmiga is not recommended for use in patients with severe renal impairment (GFR 15 to 29 mL/min/1.73 m²) concomitantly receiving strong CYP3A4 inhibitors. **Hepatic impairment** Betmiga has not been studied in patients with severe hepatic impairment (Child-Pugh Class C) and, therefore, it is not recommended for use in this patient population. Betmiga is not recommended for use in patients with moderate hepatic impairment (Child-Pugh B) concomitantly receiving strong CYP3A4 inhibitors. **Hypertension** Mirabegron can increase blood pressure. Blood pressure should be measured at baseline and periodically during treatment with Betmiga, especially in hypertensive patients. Data are limited in patients with stage 2 hypertension (systolic blood pressure ≥ 160 mm Hg or diastolic blood pressure ≥ 100 mm Hg). **Patients with congenital or acquired QT prolongation** Betmiga, at therapeutic doses, has not demonstrated clinically relevant QT prolongation in clinical studies. However, since patients with a known history of QT prolongation or patients who are taking medicinal products known to prolong the QT interval were not included in these studies, the effects of mirabegron in these patients is unknown. Caution should be exercised when administering mirabegron in these patients. **Patients with bladder outlet obstruction and patients taking antimuscarinics** medications for OAB Urinary retention in patients with bladder outlet obstruction (BOO) and in patients taking antimuscarinic medications for the treatment of OAB has been reported in postmarketing experience in patients taking mirabegron. A controlled clinical safety study in patients with BOO did not demonstrate increased urinary retention in patients treated with Betmiga; however, Betmiga should be administered with caution to patients with clinically significant BOO. Betmiga should also be administered with caution to patients taking antimuscarinic medications for the treatment of OAB. **Undesirable effects:** Summary of the safety profile. The safety of Betmiga was evaluated in 8,433 patients with OAB, of which 5,648 received at least one dose of mirabegron in the phase 2/3 clinical program, and 622 patients received Betmiga for at least 1 year (365 days). In the three 12-week phase 3 double-blind, placebo-controlled studies, 88% of the patients completed treatment with Betmiga, and 4% of the patients discontinued due to adverse events. Most adverse reactions were mild to moderate in severity. The most common adverse reactions reported for patients treated with Betmiga 50 mg during the three 12-week phase 3 double-blind, placebo-controlled studies are tachycardia and urinary tract infections. The frequency of tachycardia was 12% in patients receiving Betmiga 50 mg. Tachycardia led to discontinuation in 0.1% patients receiving Betmiga 50 mg. The frequency of urinary tract infections was 2.9% in patients receiving Betmiga 50 mg. Urinary tract infections led to discontinuation in none of the patients receiving Betmiga 50 mg. Serious adverse reactions included atrial fibrillation (0.2%). Adverse reactions observed during the 1-year (long term) active-controlled (muscarinic antagonist) study were similar in type and severity to those observed in the three 12-week phase 3 double-blind, placebo-controlled studies. **List of adverse reactions:** The table below reflects the adverse reactions observed with mirabegron in the three 12-week phase 3 double-blind, placebo-controlled studies. The frequency of adverse reactions is defined as follows: very common (≥ 1/10); common (≥ 1/100 to < 1/10); uncommon (≥ 1/1,000 to < 1/100); rare (≥ 1/10,000 to < 1/1,000); very rare (< 1/10,000). Within each frequency grouping, adverse reactions are presented in order of decreasing seriousness. **Infections and infestations:** Common: Urinary tract infection. **Uncommon:** Vaginal infection, Cystitis. **Psychiatric disorders:** Not known (cannot be estimated from the available data); Insomnia. **Eye disorders:** Rare: Eyelid oedema. **Cardiac disorders:** Common: Tachycardia. **Uncommon:** Palpitation, Atrial fibrillation. **Vascular disorders:** Very rare: Hypertensive crisis. **Gastrointestinal disorders:** Common: Nausea, Constipation, Diarrhoea. **Uncommon:** Dyspepsia, Gastritis. **Rare:** Lip oedema. **Skin and subcutaneous tissue disorders:** **Uncommon:** Urticaria, Rash, Rash macular, Rash papular, Pruritus. **Rare:** Leukocytoclastic vasculitis, Purpura, Angioedema. **Musculoskeletal and connective tissue disorders:** **Uncommon:** Joint swelling. **Reproductive system and breast disorders:** **Uncommon:** Vulvovaginal pruritus. **Investigations:** **Uncommon:** Blood pressure increased, GGT increased, AST increased, ALT increased. **Renal and urinary disorders:** **Rare:** Urinary retention. **Nervous system disorders:** Common: Headache, Dizziness. *observed during post-marketing experience. Full prescribing information is available upon request.

Abstracts

Dr. Peggy Sau-kwan CHU

MBBS(HK), FRCS(Edin), FCS(HK), FHKAM(Surg), Dip Urol(London)
Consultant Urologist, Department of Surgery, Tuen Mun Hospital, Hong Kong
President, Hong Kong Urological Association (2010-2012)



Dr. Peggy Chu is the consultant urologist in Tuen Mun Hospital and the past president of the Hong Kong Urological Association, 2010 - 2012.

Dr. Chu received her medical degree from the University of Hong Kong. She then received her urology training from Queen Elizabeth Hospital. Her overseas training took place at the Institute of Urology, University College London. After coming back from London, she continued to work at Queen Elizabeth Hospital until 2006; since then, she continued her career in Tuen Mun Hospital.

Dr. Peggy Chu specialises in reconstructive, neuro and female urology. She led the team, including urologists from Princess Margaret Hospital and toxicologists from United Christian Hospital, which reported the first 10 cases in Hong Kong with contracted bladder and upper urinary tract damage associated with ketamine abuse. This discovery has raised the Hong Kong Government's and the community's awareness of the social problems associated with Ketamine abuse. She also provided an affidavit to the Hong Kong High Court, thus leading to more stringent guidelines on sentencing of ketamine abuse since June 2008. Dr. Chu received the Outstanding Staff Award from Hong Kong Hospital Authority in 2009.

Dr. Chu is the trustee of British Journal of Urology International since June 2019. Dr. Chu delivered the UAA lecture at the AUA 2019 in Chicago.

Overactive Bladder Treatment Strategies: Insights from the OAB Consensus Statement

The incidence of overactive bladder increases with increasing age. Hong Kong citizen is well known to have longevity. Thus, there will be an increasing number of elderly patients requiring treatment for their overactive bladder symptoms. If patients suffering from overactive bladder symptoms are left untreated, they may suffer from complications like falls and fractures, depression, etc. Elderly patients are prone to have polypharmacy due to multiple comorbidities. Antimuscarinic drugs and B3 agonists are the two classes of drugs for managing patients suffering from overactive bladder. Whenever prescribing drugs for these patients, physicians need to take into account the cognitive function, frailty score and anticholinergic burden of the drugs that the patients are taking. The Hong Kong Geriatric Society and The Hong Kong Urological Association have joined hand in hand in establishing consensus statements, hoping to assist physicians involved in providing the best treatment for these patient groups.

Abstracts

Dr. Mario Wai-kwong CHAK

MBBS(HKU), MRCP(UK), DCH(Ire), Dip Ger Med(RCPS Glass), PDipID(HKU),
FHKAM(Paediatrics), FHKCPaed
Paediatrician

The Honorary Clinical Assistant Professor, The University of Hong Kong
Clinical Associate Professor (Honorary), The Chinese University of Hong Kong
Immediate Past President, The Federation of Medical Societies of Hong Kong



Dr. Chak is the Associate Consultant at the Department of Paediatrics and Adolescent Medicine in Tuen Mun Hospital. He is also the Honorary Clinical Assistant Professor of The University of Hong Kong and the Clinical Associate Professor (Honorary) of The Chinese University of Hong Kong. Dr. Chak attained the Fellowship of Hong Kong Academy of Medicine (Paediatrics) and Hong Kong College of Paediatricians in 2002. Dr. Chak has been accredited to be the first fellow of the Subspecialty of Paediatric Neurology and Developmental Behavioural Paediatrician in 2013. Dr. Chak is currently the trainer in Paediatrics and Paediatric Neurology. Dr. Chak has a special interest in Paediatric Epilepsy. He has received overseas training in EEG, Epilepsy and Presurgical Evaluation for Epilepsy Surgery in British Columbia Children's Hospital in Vancouver, Royal Children's Hospital in Melbourne and Department of Epileptology, The University Clinic in Bonn, Fondation Ophtalmologique Adolphe de Rothschild in Paris, respectively. Dr. Chak is also the team leader of Tuen Mun Hospital Paediatrics and Adolescent Epilepsy Surgery Team which has just attained the outstanding team award in NTWC in 2016. Dr. Chak is currently appointed to be the Chairman of Neurophysiology Subcommittee of Electro-Medical Diagnostic Unit of New Territories West Cluster.

Ms. Vitti Wai-kei POON

MSocSc in Clinical Psychology (CUHK)
Clinical Psychologist



Ms. Poon obtained her professional training in clinical psychology at the Chinese University of Hong Kong. She had clinical experience in working with the medical population in the Queen Elizabeth Hospital before assuming her current position in the Department of Health Child Assessment Service. She is the co-head of the acquired cognitive impairment team of the service. She has experience conducting neuropsychological assessments for children with conditions such as epilepsy, brain tumor and traumatic brain injury etc., as well as working in a multidisciplinary setting in supporting the children's coping and reintegration into school and community upon brain injury.

Abstracts

Holistic Care in Paediatric Pharmacoresistant Epilepsy in Era of Genomics: Etiologies Based Medical, Dietary and Surgical Intervention & Neuropsychology

With the recent rapid technical advancement of genetic tests for example, genetic panel, next generation sequencing, whole exome sequencing and whole genome sequencing, we found more and more infants, children and adolescent patients with epilepsy have underlying genetic cause such as chromosomal abnormalities, monogenic mutation, copy number variant, multi genetic interaction etc. On the other hand, some patient with underlying focal cortical dysplasia was also found to have somatic genetic mutation in their surgical pathological specimen. As we all know, more than one-third of patient with epilepsy are drug resistant. There is an increase application of surgical as curative treatment. For those non-surgical candidates, there is an increase in use of ketogenic diet and vagus nerve stimulator implantation as adjuvantive therapy to improve seizure. Through this talk, we will take this opportunity to discuss how underlying aetiologies and genetic test results affect clinical intervention of drug resistant epilepsy patients.

Abstracts

Dr. Fanny Wai-fan LAM

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Dr. Fanny Wai-fan Lam is a Specialist in Developmental-Behavioural Paediatrics with three decades of clinical experience in Hong Kong, Canada, and Australia.

Currently, Dr. Lam serves as the Developmental-Behavioural Paediatrician at Hong Kong Developmental Paediatrics Centre, Matilda International Hospital, Union Hospital and Gleneagles Hong Kong Hospital. Dr. Lam is also actively involved in public and professional education, as well as expert witness services in paediatrics litigations and medical council inquiries. She is committed to enabling children to develop their best potentials through parenting coaching and early identification and intervention of children developmental needs.

Breakthrough in Early Identification of Autism: Genomic and Neural Encoding Testing

Autism Spectrum disorder (ASD) greatly influences one's development and going undetected could potentially lead to worsened conditions and less effective treatments. ASD is also highly heritable and its gene factors contribute 40 - 80 % of its risk, ASD has also been linked to many other prominent genetic disorders as comorbidities (e.g. Epilepsy). Therefore, early identification of ASD is critical as it could allow for the detection of any potential comorbidities and earlier interventions.

In order to allow for early detection, providing a Comprehensive Autism Screening (CAS) programme for children as early as age 1 that combines Neural Encoding technology, genomic testing technologies to determine ASD risk should be provided.

Neural encoding Electroencephalogram (EEG) identifies biomarkers, specifically language deficit biomarkers, that are associated with early signs of ASD. Following that, whole genome sequencing analyzes over 20,000 genes and 3 billion base pairs in the human genome. This detects genetic mutations associated with ASD, and its comorbidities (e.g. speech delay, intellectual disability, developmental regression, movement disorder, and seizures).

By combining both Genomic and Neural Encoding tests in the early identification of ASD, it allows for cross identification which increases the power of the test results. Additionally, CAS can also provide a whole picture of the ASD situation. Whether ASD was genetically inherited, or a comorbidity of some other condition in this specific autistic child. This improves the accuracy and specificity of the ASD diagnosis, which allows targeted treatments and programmes towards the root cause, ultimately providing better support for the autistic child and their family.

In this presentation, we will go through current literature and practices on genomic and neural encoding tests in early identification of Autism. We will also be presenting data and local experiences from our Comprehensive Autism Screening programme.

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Abstracts

Prof. Clara Bik-san LAU

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Prof. Clara Lau is the Associate Director of the Institute of Chinese Medicine and the State Key Laboratory of Research on Bioactivities and Clinical Applications of Medicinal Plants at The Chinese University of Hong Kong. With BPharm and PhD in Pharmacy (Pharmacognosy) from King's College London, University of London, UK, she has over 29 years' expertise in Pharmacology of herbal/natural medicines research. Her main research areas include anti-cancer herbs/natural products, and the beneficial herb-drug combinations. She has published over 280 refereed journal articles (h-index=45) and 11 book chapters, and edited 1 book. She is the co-inventor of 9 granted or published US non-provisional or PRC patents. She serves as member of ChP-USP Advisory Group on Monographs for TCM Ingredients and Products; President of Good Practice in Traditional Chinese Medicine Research Association (GP-TCM RA); Acting Secretary-General and Council member of The Consortium for Globalization of Chinese Medicine (CGCM); Council member of Modernized Chinese Medicine International Association (MCMIA). She is the Associate Editors of Journal of Ethnopharmacology and Journal of Traditional and Complementary Medicine (eJTCM), Consulting Editor of Pharmacological Research, and Editorial Board member of various journals. She also serves as Editor of the book series "Natural Products Chemistry of Global Plants".

Potential Role of Evidence-based Herbal Medicines in Cancer Management

Cancer management for patients involves multiple treatment modalities, including surgery, chemotherapy, immunotherapy, radiation therapy, hormonal therapy, etc., as well as multidisciplinary teams in oncology among different specialised professionals involved in cancer care. In Chinese community worldwide, Chinese herbal medicines are, in fact, widely consumed by cancer patients. In the past two decades, Prof. Clara Lau has a continuous research interest in the potential anti-cancer activities of both western herbals and traditional Chinese herbal medicines (CHM), and is dedicated to provide scientific evidence to illustrate the potential adjuvant values of CHM in conventional cancer management. In this talk, she will share her research experiences in exploring the multi-component, multi-target, and synergistic nature of herbal medicines using various experimental systems. She will also demonstrate the beneficial efficacies of the combined use of herbal medicines and conventional drugs, specifically on both efficacy augmentation and toxicity reduction in preclinical models. The recent clinical findings on the novel use of an herb for esophageal cancer patients will also be presented. It is anticipated that scientific findings from the evidenced-based efficacy studies will support the use of herbal medicines in cancer management, and also increase the awareness and acceptance by cancer patients and cancer care providers.

Abstracts

Prof. Eike Gunther WÜSTENBERG

Medical Doctor, Specialist for Otorhinolaryngology, Allergology
Professor of Medicine
Vice President of Medical Affairs



Professor Wüstenberg is an Otorhinolaryngologist and Allergologist. He studied medicine at the University of Mainz, Germany, and holds a doctoral degree in medicine. He is a Professor of human medicine at the medical faculty at Dresden University with clinical preference for middle ear and nasal surgery as well as allergology.

Besides his clinical career, Professor Wüstenberg is Vice President of the Medical Department at ALK Germany and Global Advisor to Research and Development at ALK in Denmark. His current major research fields are allergic diseases of the upper and lower airways. He has been involved in many large clinical trials, especially in designing state of the art trails leading to marketing authorisation of several new allergy immunotherapy products in Europe. Professor Wüstenberg holds several patents for optical rhinometry to document nasal provocation tests as well as allergy immunotherapy. He is author of many peer reviewed international publications, mostly dealing with allergy immunotherapy.

Recent Advances in House Dust Mite Allergy Immunotherapy

The talk will give a practical overview of the treatment of allergic diseases with allergen specific immunotherapy (AIT). Allergic diseases like allergic rhinitis or asthma are diagnosed by a clinical history and a proof of IgE sensitisation towards the allergen that causes the allergic symptoms.

AIT induces immunological tolerance against the allergens causing the allergic inflammation. It therefore not only reduces allergic symptoms but also has longterm effects and is able to prevent the progression from allergic rhinitis towards asthma. Recently also allergen unspecific effects of AIT like reduction of infections or reduction of the use of antibiotics were demonstrated.

Sublingual SQ-standardised house dust mite tablets (SLIT) were developed in a large and multinational clinical development programme and consequently gained marketing authorisation in many countries worldwide, including European countries, the US or Japan. It is also authorised in Hong Kong.

The first intake of SLIT is performed in the physicians' office, if it is well tolerated the treatment can be continued at home. In order to secure compliance a correct first intake, including a good information about the patient about the treatment is crucial (managing expectations). Practical tips and tricks are shared and discussed.

Abstracts

Dr. Alson Wai-ming CHAN

*FHKAM(Paed), FHKCPaed, FRCPCH, DCH (Ireland), Dip Ger Med RCPS (Glasg), PDipCmmunityGeriatrics(HK), MBChB
First Fellow, Subspecialty of Paediatric Immunology, Allergy & Infectious Diseases, HKCPaed
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Dr. Alson Chan is the Honorary Consultant at Lee Tak Hong Allergy Centre of Hong Kong Sanatorium & Hospital. He is the founding fellow specialised in Paediatric Immunology, Allergy & Infectious Diseases. He received medical education awards for his overseas subspecialty training at Great Ormond Street Hospital in London and Boston Children's Hospital of Harvard Medical School.

His main research interests are allergy prevention, biologicals and allergen specific immunotherapy. He is the corresponding & first author of the Guidelines for Allergy Prevention, the co-author of the Guidelines for Prevention of Peanut Allergy, and the co-author of China Consensus Document on Allergy Diagnostics.

He is currently the Vice President of Allergy Prevention & Control Committee of Guangdong Preventive Medicine Association, Deputy Head of Paediatric Allergy Subcommittee of Chinese Research Hospital Association, Honorary Secretary of the Federation of Medical Societies of Hong Kong, Council Member of Hong Kong Society for Paediatric Immunology Allergy & Infectious Diseases and Council Member of Hong Kong Institute of Allergy.

Innovative Management Strategies for Type 2 Inflammatory Diseases

Type 2 inflammation is characterised by an increase and overexpression of type 2 cytokines, mediators and relevant white blood cells in the inflammatory pathway. It was found to be the common mechanism in various diseases such as atopic dermatitis, asthma, chronic rhinosinusitis and eosinophilic esophagitis. The common pathophysiology of type 2 inflammation offers an innovative treatment strategy which is more targeted than the conventional immunomodulators. The international and local experience in using this new management strategy will be elaborated and discussed in this session.

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**UP TO 2 TABLETS
AT BREAKFAST**



T2DM = Type 2 diabetes mellitus

References: 1. Zaccardi F, et al. Diabetes Obes Metab. 2020;1–10. DOI: 10.1111/dom.14169. 2. Jia Y, et al. Obes Rev. 2018. doi: 10.1111/obr.12753. 3. Mohamed H et al. Diabetes Res and Clin Pract. 2020 <https://doi.org/10.1016/j.diabres.2020.108154>. 4. Perkovic V, et al. Kidney Int. 2013;83(3):517–523. 5. Patel A, et al. N Engl J Med. 2008;358(24):2560–2572.

COMPOSITION* Diamicon MR 60 mg, modified release tablet containing 60 mg of gliclazide, contains lactose as an excipient. **INDICATION*** Non insulin-dependent diabetes (type 2) in adults when dietary measures, physical exercise and weight loss alone are not sufficient to control blood glucose. **DOSAGE AND ADMINISTRATION*** One half to 2 tablets per day i.e. from 30 to 120 mg taken orally as a single intake at breakfast time, including in elderly patients and those with mild to moderate renal insufficiency with careful patient monitoring. One tablet of Diamicon MR 60 mg is equivalent to 2 tablets of Diamicon MR 30 mg. The breakability of Diamicon MR 60 mg enables flexibility of dosing to be achieved. In patients at risk of hypoglycaemia, daily starting dose of 30 mg is recommended. Combination with other antidiabetics: Diamicon MR 60 mg can be given in combination with biguanides, alpha glucosidase inhibitors or insulin (under close medical supervision). **CONTRAINDICATIONS*** Hypersensitivity to gliclazide or to any of the excipients, other sulfonylurea or sulphonamides; type 1 diabetes; diabetic pre-coma and coma, diabetic ketoacidosis; severe renal or hepatic insufficiency (in these cases the use of insulin is recommended); treatment with miconazole (see interactions section); lactation (see fertility, pregnancy and lactation section). **WARNINGS*** Hypoglycaemia may occur with all sulfonylurea drugs, in cases of accidental overdose, when calorie or glucose intake is deficient, following prolonged or strenuous exercise and in patients with severe hepatic or renal impairment. Hospitalization and glucose administration for several days may be necessary. Patient should be informed of the importance of following dietary advice, of taking regular exercise and of regular monitoring of blood glucose levels. To be prescribed only in patients with regular food intake. Use with caution in patients with G6PD-deficiency. Excipients: contains lactose. **INTERACTION(S)*** Risk of hypoglycaemia – contraindicated: miconazole; not recommended: phenylbutazone; alcohol; use with caution: other antidiabetic agents, beta-blockers, fluconazole, ACE inhibitors (captopril, enalapril), H2-receptor antagonists, MAOIs, sulfonamides, clarithromycin, NSAIDs. Risk of hyperglycaemia – not recommended: danazol; use with caution: chlorpromazine at high doses; glucocorticoids; ritodrine; salbutamol; terbutaline; Saint John's Wort (hypericum perforatum) preparations. Risk of dysglycaemia – use with caution: fluoroquinolones. Potentialization of anticoagulant therapy (e.g. warfarin), adjustment of the anticoagulant may be necessary. **PREGNANCY*** Change to insulin before a pregnancy is attempted, or as soon as pregnancy is discovered. **BREASTFEEDING*** contraindicated. **DRIVE & USE MACHINES*** Possible symptoms of hypoglycaemia to be taken into account especially at the beginning of the treatment. **UNDESIRABLE EFFECTS*** hypoglycaemia, abdominal pain, nausea, vomiting, dyspepsia, diarrhoea, constipation. Rare changes in haematology generally reversible (anaemia, leucopenia, thrombocytopenia, granulocytopenia). Raised hepatic enzymes levels (AST, ALT, alkaline phosphatase), hepatitis (isolated reports). If cholestatic jaundice: discontinuation of treatment. Transient visual disturbances at start of treatment. More rarely: rash, pruritus, urticaria, angioedema, erythema, maculopapular rashes, bullous reactions such as Stevens-Johnson syndrome and toxic epidermal necrolysis and autoimmune bullous disorders, and exceptionally, drug rash with eosinophilia and systemic symptoms (DRESS). As for other sulfonylureas: observed cases of erythrocytopenia, agranulocytosis, haemolytic anaemia, pancytopenia, allergic vasculitis, hyponatraemia, elevated liver enzymes, impairment of liver function (cholestasis, jaundice) and hepatitis which led to life-threatening liver failure in isolated cases. **OVERDOSE*** Possible severe hypoglycaemia requiring urgent IV glucose, immediate hospitalization and monitoring. **PROPERTIES*** Diamicon MR 60 mg is a sulfonylurea reducing blood glucose levels by stimulating insulin secretion from beta cells in the islets of Langerhans, thereby restoring the first peak of insulin secretion and increasing the second phase of insulin secretion in response to a meal or intake of glucose. Independent haemovascular properties. **PRESENTATION*** Box of 30 tablets of Diamicon MR 60 mg in blister. **SERVIER HONG KONG LIMITED** Room 103, 31/F, Tower 5, The Gateway, 15 Canton Road, Harbour City, Tsim Sha Tsui, Kowloon, Hong Kong www.servier.hk. *For complete information, please refer to the complete summary of product characteristics.

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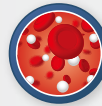
Regardless of patients' profile



HbA_{1c} level



BMI



Background
glucose-lowering
therapy



UP TO 2 TABLETS AT BREAKFAST

BMI, body mass index; HbA_{1c}, glycated hemoglobin; MR, modified release; T2DM, type 2 diabetes mellitus.

References: 1. Khunti K et al. Diabetes Care. 2017;40(15):1588-1596. 2. Leiter LA, Shestakova MV, Sattman I. Effectiveness of gliclazide MR 60 mg in the management of type 2 diabetes: analyses from the EASYDia trial. Diabetol Metab Syndr. 2018;10:30.

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Dr. Raymond Lo graduated from United Medical and Dental Schools of Guy's and St Thomas' Hospital in London, and received fellowships from Royal College of Physicians and Hong Kong Academy of Medicine. He is Honorary Clinical Professor of the Department of Medicine and Therapeutics, Chinese University of Hong Kong, and also held visiting professorship overseas.

Dr. Lo was Past President of the Federation of Medical Societies of Hong Kong, and currently serving the Federation as Honorary President. He is a dual specialist in geriatrics and palliative medicine. Amongst his other capacities, Dr. Lo is also the President of British Medical Association (Hong Kong), expediting various activities including the popular annual BMA(HK) Advance in Therapeutics Course.

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Dr. Alson Chan is the Honorary Consultant at Lee Tak Hong Allergy Centre of Hong Kong Sanatorium & Hospital. He is the founding fellow specialised in Paediatric Immunology, Allergy & Infectious Diseases. He received medical education awards for his overseas subspecialty training at Great Ormond Street Hospital in London and Boston Children's Hospital of Harvard Medical School.

His main research interests are allergy prevention, biologicals and allergen specific immunotherapy. He is the corresponding & first author of the Guidelines for Allergy Prevention, the co-author of the Guidelines for Prevention of Peanut Allergy, and the co-author of China Consensus Document on Allergy Diagnostics.

He is currently the Vice President of Allergy Prevention & Control Committee of Guangdong Preventive Medicine Association, Deputy Head of Paediatric Allergy Subcommittee of Chinese Research Hospital Association, Honorary Secretary of the Federation of Medical Societies of Hong Kong, Council Member of Hong Kong Society for Paediatric Immunology Allergy & Infectious Diseases and Council Member of Hong Kong Institute of Allergy.

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Dr. NG Chun-kong

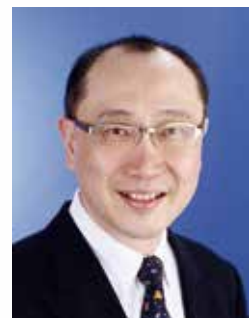
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Dr. CK Ng is currently the Consultant Physician in the Department of Medicine, Queen Elizabeth Hospital. He is a Respiratory Physician, and his sub-specialisations are in sleep medicine, non-invasive and home ventilation and auto-fluorescent bronchoscopy. He is the Hong Kong College of Physicians speciality programme director in respiratory medicine of the Kowloon Central/ Kowloon East cluster. He is the Vice-Chairman of the Steering and Development Committee on Sleep Service in Kowloon Central Cluster (KCC) and Cluster Representative of the HAHO Working Group on Sleep Laboratory Service. He also serves as panel chairman of the KCC/KEC Research and Ethics Committee, and deputy panel chairman of the HAHO Central Institutional Review Board. He now serves as the First Vice President in the Federation of Medical Societies of Hong Kong, and a board member of the Hong Kong Lung Foundation.

Dr. Samuel Ka-shun FUNG

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Dr. Samuel Fung was the Chief of Nephrology, Hong Kong Jockey Club Nephrology & Urology Centre, Princess of Margaret Hospital, Hong Kong.

Serving in Hospital Authority Central Renal Committee as Vice Chairman and the Central Transplant Committee, he has contributed to the pair exchange living renal transplant programme in Hong Kong. He is the chairman of Kowloon West Cluster Community Engagement & Volunteer Service Coordinating Committee.

Dr. Fung serves as Hong Kong College of Physician Specialty Programme Director, Nephrology Training Board, Kowloon Region; Hon Associate Professor of the Chinese University of Hong Kong; council member and past chairman of the Society Hong Kong Society of Nephrology and serves the community in the Board of the Hong Kong Kidney Foundation.

He has publications in peer-reviewed journals in research on renal anaemia, BK nephropathy and Nocturnal Home Haemodialysis. Currently, he is the Site Principal Investigator for the studies SONAR on Diabetic Nephropathy; ASCEND study on renal anaemia, VALOR study on Chronic Kidney Disease, TESTING & PROTECT Studies on IgA Nephropathy. Recently, he led his unit in introducing the new Claria APD to treat patients in Asia and was instrumental in the first paired living renal transplantations in Hong Kong.

Chairpersons

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Currently Director, InteMed Hong Kong
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Dr. Yu graduated in 1975 from The University of Hong Kong with Mun Gold Medal in Psychiatry. He completed a degree in Chinese Medicine and learnt under master Fan Siu Chun while pursuing postgraduate study under the renowned Professor Hutchison at Queen Mary Hospital, also furthering Specialist training in UK in Paediatric Nephrology. Recruited as an expert in Nephrology in the Legal Aid Department. He worked as Honorary Clinical Associate Professor, and Honorary Consultant in Queen Mary Hospital till retirement. Obtained Croucher Fellow in 1987 and nominated FRCP (Glasgow) in 1989. Strict believer in life-long learning, after full medical qualifications, he further obtained MBA (Strathclyde) in 1997. Registered as Chinese medicine practitioner in 2000. Conferred as Honorary Professor, School of Chinese Medicine, Hong Kong Baptist University in 2004.

Dr. Yu founded the Paediatric Nephrology Society in 1989. After the formation of CWEMED in 1998, Dr. Yu was also the Founder director, and now Honorary President for the Hong Kong Association for Integration of Chinese-Western Medicine (HKAIM) since 2001. Since 2015, he advanced the Integrative Joint Organizational Platform, IJOP, funded by ITC, for promoting Chinese-Western Medicine collaboration. His ITC funded project, the HKIE Grand Prize winning 3D-Acu-Man in 2021, was recorded in the Hong Kong Yearbook. Currently spending half of his time seeing patients, and mentoring doctors, Chinese medicine practitioners and medical students in InteMed HK, he was elected as a Mentor among top experts in the Innovation & Technology Scholarship Award Scheme, Innovation & Technology Commission, Hong Kong SAR.

Dr. Ludwig Chun-hing TSOI

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Consultant, A&E Department, Queen Mary Hospital
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Dr. Ludwig TSOI graduated from the Faculty of Medicine CUHK in 1992. He is the Consultant of A&E Department, Queen Mary Hospital. He also holds a master degree in law, with a strong interest in alternate dispute resolution. He was the Founding President of the Hong Kong Society for Healthcare Mediation and past President of the Hong Kong Society for Emergency Medicine & Surgery. He is also an Honorary Clinical Associate Professor of both CUHK and HKU.

Chairpersons

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*MBChB (CUHK), FHKCOS, FHKAM (Ortho) FRCS Ed (Ortho)
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Dr. Siu graduated from the Chinese University of Hong Kong in 1989. He is the Fellow of the Royal College of Surgeons of Edinburgh (Ortho.), Fellow of the Hong Kong College of Orthopaedic Surgeons and Fellow of the Hong Kong Academy of Medicine (Orthopaedic Surgery) since 1998.

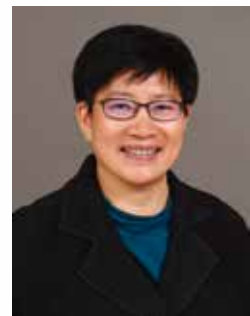
Dr. Siu is the Past President of The Hong Kong Orthopaedic Association; National Delegate of The Asian Pacific Orthopaedic Association; and, Committee Member of The Asian Pacific Orthopaedic Association(Foot & Ankle Section).

Furthermore, Dr. Siu is the Executive Committee Member of The Federation of Medical Societies of Hong Kong and the Immediate Past President of the Hong Kong Foot & Ankle Society. Last but not least, the Vice Secretary General of the Asia-Pacific Society for Foot and Ankle Surgery.

He has been the invited speaker for various conferences e.g. Asian Pacific Orthopaedic Association Congress (2019 - 22, 2024), International Annual Congress of Chinese Orthopaedic Association (2006, 2007, 2010, 2012 - 14, 2018 - 19, 2023), Scientific Meeting of the Asian Federation of Foot & Ankle Societies (2011 - 12, 2015, 2018 - 19, 2023) and Parekh Global Foot & Ankle Town Hall Meeting (2021 - 23).

Dr. Peggy Sau-kwan CHU

*MBBS(HK), FRCS(Edin), FCS(HK), FHKAM(Surg), Dip Urol(London)
Consultant Urologist, Department of Surgery, Tuen Mun Hospital, Hong Kong SAR
President, Hong Kong Urological Association (2010-2012)*



Dr. Peggy Chu is the consultant urologist in Tuen Mun Hospital and the past president of the Hong Kong Urological Association, 2010 - 2012.

Dr. Chu received her medical degree from the University of Hong Kong. She then received her urology training from Queen Elizabeth Hospital. Her overseas training took place at the Institute of Urology, University College London. After coming back from London, she continued to work at Queen Elizabeth Hospital until 2006; since then, she continued her career in Tuen Mun Hospital.

Dr. Peggy Chu specialises in reconstructive, neuro and female urology. She led the team, including urologists from Princess Margaret Hospital and toxicologists from United Christian Hospital, which reported the first 10 cases in Hong Kong with contracted bladder and upper urinary tract damage associated with ketamine abuse. This discovery has raised the Hong Kong Government's and the community's awareness of the social problems associated with Ketamine abuse. She also provided an affidavit to the Hong Kong High Court, thus leading to more stringent guidelines on sentencing of ketamine abuse since June 2008. Dr. Chu received the Outstanding Staff Award from Hong Kong Hospital Authority in 2009.

Dr. Chu is the trustee of British Journal of Urology International since June 2019. Dr. Chu delivered the UAA lecture at the AUA 2019 in Chicago.

Chairpersons

Dr. Victor Hip-wo YEUNG

*MBBS(HK), FRCSEd(Urology), FCSHK, FHKAM(Surgery)
Honorary Clinical Assistant Professor, Department of Surgery(CUHK)
Specialist in Urology*



Dr. Yeung obtained his bachelor degree in Biophysics at Johns Hopkins University (USA), and then pursued his medical degree at the University of Hong Kong (HKU). After graduation, he continued his career as a urological trainee, and eventually received his fellowship in 2013. He was then promoted to associate consultant, and appointed as honorary clinical assistant professor of the Chinese University of Hong Kong (CUHK). In 2017, he started his own private practice in Causeway Bay.

Apart from clinical work, Dr. Yeung is an active researcher with many articles published in various international journals. He has also presented at many conferences, and received the best poster presentation award at the 14th Urological Association of Asia Congress in 2016. In addition, he has designed a wall-attached urinal that can measure men's urinary flow rate, and it is now patented in both Hong Kong and China. This new design minimises the patient's embarrassment while urinating at the traditional funnel while performing the flow rate exam. In 2019, it received the Gold Award in the FITMI Asian International Innovation Technology Exhibition.

Dr. Yeung plays an active role in many medical societies and alumni associations. He is currently the president emeritus of Johns Hopkins University Hong Kong Alumni Association (JHUKHAA). Also, he is the Vice-President of the Hong Kong Medical Association (HKMA), chairperson of the Ethics Committee and council member of the Medical Council of Hong Kong (MCHK), Federation of Medical Societies of Hong Kong (FMSHK), Hong Kong Society of Practising Urologists (HKSPU), Hong Kong University Medical Alumni Association (HKUMAA) and the Hong Kong Society of Endourology (HKSE).

Chairpersons

Dr. Jane Chun-kwong CHAN

*MD (U Chicago), FHKCP, FHKAM (Medicine),
Diplomate American Board of Internal Medicine,
Specialist in Respiratory Medicine*



Dr. Jane Chan graduated from the University of Chicago in 1982, followed by training in Internal Medicine at Washington University, and in Respiratory and Critical Care Medicine at Stanford University. She joined the Department of Medicine at the University of Hong Kong as Clinical Lecturer in 1986. She became doubly accredited in Respiratory Medicine and Critical Care Medicine by the H. K. College of Physicians in 1992. In 1995, she became Consultant in Intensive Care and Director of the Adult Intensive Care Unit at Queen Mary Hospital. In 2003, after having fought the SARS battle, she took up the position of Consultant in Medical Development at the Hospital Authority Head Office, focusing on post-SARS work. During this period, she organised and cleaned up the clinical data of all Hong Kong SARS patients, and worked as co-editor partnering with Dr. Vivian Wong on the compilation of a 300-page scientific monograph on SARS authored by over 70 local SARS frontline workers. She has been in private practice since 2005. She is currently Honorary Clinical Associate Professor at HKU and President of the Hong Kong Chinese Medical Association, the latter aspiring to be a platform for promoting fellowship, continuing medical education and professional links with the Mainland for the Hong Kong medical community.

Dr. Kingsley Hau-ngai CHAN

*FRCP(Edinburgh), FRCP(Glasgow), FHKAM(Medicine), FHKCP,
Diploma in Dermatology(Glasgow), MRCP(UK) , MBBS(HK)
Specialist in Dermatology & Venereology*



Dr. Kingsley Chan is a dermatologist in private practice in Hong Kong. He received his medical training at the University of Hong Kong. He completed his basic physician training at the Queen Mary Hospital and his specialist training at the Department of Health. Dr. Chan's practice encompasses both medical and cosmetic dermatology. He is also an active member of the Hong Kong medical professional and serves as a Council Member at the Hong Kong Medical Association (2008 - present) and Federation of Medical Societies of Hong Kong (2008 - present). He works as an honorary consultant dermatologist in Hospital Authority.

■ Note

- **Note**

The Crack of Light in Darkness

All Known Single Point Mutations



ICLUSIG® is indicated in adult patients with:¹

CP-, AP- or BP-CML

- Resistant to dasatinib or nilotinib
- Intolerant to dasatinib or nilotinib and subsequent treatment with imatinib is not clinically appropriate
- With T315I mutation

Ph+ ALL

- Resistant to dasatinib
- Intolerant to dasatinib and subsequent treatment with imatinib is not clinically appropriate
- With T315I mutation



Potent activities
against multiple
BCR-ABL1 mutants,
including T315I and
compound
mutants.^{2,3,*}



of responders with
CP-CML are
estimated to
maintain MCyR at 5
years after dose
reduction.

5-year PACE trial^{3†}

ICLUSIG® delivered deep and durable responses
in CP-CML

60% achieved MCyR **40%** achieved MMR
41% of patients with resistant Ph+ ALL
achieved MaHR by 6 months.

ALL: acute lymphoblastic leukaemia; AP-CML: accelerated phase; chronic myeloid leukaemia; BP-CML: blast phase chronic myeloid leukaemia; CML: chronic myeloid leukaemia; CP-CML: chronic phase chronic myeloid leukaemia; MaHR: major hematologic response; MCyR: major cytogenetic response; MMR: major molecular response; PACE trial: the pivotal phase 2 Ponatinib Ph+ ALL and CML evaluation trial; Ph+: Philadelphia chromosome-positive; TKI: tyrosine kinase inhibitor.

* ICLUSIG® (ponatinib) is active against G250E, F317L, V299L, E255K, E255V, F359C, F359V, F359L, Y253H and T315I. No BCR-ABL1 compound mutation was identified that consistently conferred resistance to ponatinib in patients with heavily pretreated CP-CML from the PACE trial.

† The pivotal phase 2 PACE trial evaluated the efficacy and safety of ICLUSIG® (ponatinib) in patients with CP-CML or Ph+ ALL resistant to or intolerant of at least two prior BCR-ABL1 TKIs or with T315I mutation. Patients were randomly assigned to 3 cohorts receiving ICLUSIG® (ponatinib) 45, 30, or 15 mg once daily. 59% of enrolled patients had at least one dose reduction as of 3 September 2013 (from 45 mg to 30 mg per day, 45 mg to 15 mg per day, 30 mg to 15 mg per day, and other reduction), including 71% of CP-CML patients. The median follow-up was 56.8 months in patients with CP-CML.

References: 1. ICLUSIG® (ponatinib) Hong Kong Prescribing Information revised Jan 2019. 2. NCCN Clinical Practice Guidelines in Oncology: Chronic Myeloid Leukemia. National Comprehensive Cancer Network. Available at https://www.nccn.org/professionals/physician_gls/pdf/cml.pdf. Version 1.2023; Accessed 21/11/2022. 3. Cortes JE, Kim DW, Pinilla-Ibarz J, et al. Ponatinib Efficacy and Safety in Philadelphia Chromosome-Positive Leukemia: Final 5-year Results of the Phase 2 PACE Trial. Blood. 2018;132(4):393-404. doi:10.1182/blood-2016-09-739086

Abbreviated Prescribing Information

ICLUSIG® (ponatinib) 15 mg/45 mg tablets. **Indications:** in adult patients with (1) chronic phase, accelerated phase, or blast phase chronic myeloid leukaemia (CML) who are resistant to dasatinib or nilotinib who are intolerant to dasatinib or nilotinib and for whom subsequent treatment with imatinib is not clinically appropriate; or who have the T315I mutation; and (2) Philadelphia chromosome positive acute lymphoblastic leukaemia (Ph+ ALL) who are resistant to dasatinib and for whom subsequent treatment with imatinib is not clinically appropriate; or who have the T315I mutation. **Contraindications:** Hypersensitivity to the active substance or any of the excipients. **Warnings and precautions:** Risk of myelosuppression: a complete blood count should be performed every 2 weeks for the first 3 months and then monthly or as clinically indicated. Monitoring for evidence of arterial occlusion and thromboembolism; interrupt treatment in such events. If decreased vision or blurred vision occurs, perform an ophthalmic examination (including fundoscopy). Reports of treatment-emergent hypertension; urgent clinical intervention required for hypertension associated with confusion, headache, chest pain or shortness of breath. Discontinue treatment in patients developing serious heart failure. Caution recommended in patients with a history of pancreatitis or alcohol abuse. Patients with severe hypertriglyceridemia should be appropriately managed to avoid pancreatitis. Liver function tests should be performed prior to treatment initiation and monitored periodically, as clinically indicated. Interrupt treatment and evaluate patients for serious or severe haemorrhage. Monitor for active HBV infection in HBV carriers throughout therapy and for several months after treatment. Interrupt treatment in the event of posterior reversible encephalopathy syndrome. Caution recommended in patients with hepatic/renal impairment. Not advised in pregnancy; only used when clearly necessary. Stop breastfeeding during treatment & use effective contraception during treatment. **Drug interactions:** Caution in concomitant use with CYP3A inhibitors/inducers, transporter substrates (e.g. P-gp and BCRP) & anti-clotting agents in patients who may be at risk of bleeding events. **Adverse reactions:** pneumonia, pancreatitis, abdominal pain, atrial fibrillation, pyrexia, myocardial infarction, peripheral arterial occlusive disease, anaemia, angina pectoris, platelet count decreased, febrile neutropenia, hypertension, coronary artery disease cardiac failure congestive, cerebrovascular accident, sepsis, cellulitis, acute kidney injury, UTI and lipase increased. **Please see full Prescribing information for details.** (Ref: HKPI Revised Jan 2019; Last Update: Oct 2022)



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ICLUSIG®
(ponatinib) tablets
45 mg, 15 mg

Delay the Renal Deterioration with JINARC® in ADPKD^{1,2}



Effectively slow kidney growth
and renal function decline¹



Slower decline in eGFR at 1 year in patients
with later-stage ADPKD vs placebo
(1.27ml/min/1.73m² net difference; 95% CI,
0.86 to 1.68; P<0.001)²



Effectively reduced incidence of
kidney pain, kidney stone,
urinary tract infection, and
haematuria³

ERA WGIKD / ERKNeT Position Statement 2021

JINARC® is recommended in:

Adult ADPKD patients ≤55 years of age
with an eGFR ≥25ml/min/1.73m².⁴

Start as soon as rapid disease progression
determined in patients ≥ 18 years of age.⁴

⁴Who have demonstrated or who are likely to have rapidly progressive disease based on a hierarchical decision algorithm in 2021 consensus statement by ERA, WGIKD, ERKNet and PKD International.

ADPKD: autosomal dominant polycystic kidney disease; CI: confidence interval; eGFR: estimated glomerular filtration rate; ERA: European Renal Association; ERKNet: European Rare Kidney disease reference NETwork; PKD: polycystic kidney disease; WGIKD: Working Group on Inherited Kidney Disorders.

References:
1. Torres VE, Chapman AB, Devuyst O, Gansevoort RT, Grantham JJ, Higashihara E, Perrone RD, Krasa HB, Ouyang J, Czerwiec FS; TEMPO 3:4 Trial Investigators. Tolvaptan in patients with autosomal dominant polycystic kidney disease. N Engl J Med. 2012 Dec 20;367(25):2407-2418. 2. Torres VE, Chapman AB, Devuyst O, Gansevoort RT, Perrone RD, Koch G, Ouyang J, McQuade RD, Blais JD, Czerwiec FS, Sergeeva O; REPRISE Trial Investigators. Tolvaptan in Later-Stage Autosomal Dominant Polycystic Kidney Disease. N Engl J Med. 2017 Nov 16;377(20):1930-1942. 3. Castelleijn NF, Blais JD, Chapman AB, Czerwiec FS, Devuyst O, Higashihara E, Leliveld AM, Ouyang J, Perrone RD, Torres VE, Gansevoort RT; TEMPO (Tolvaptan Efficacy and Safety in Management of Autosomal Dominant Polycystic Kidney Disease and Its Outcomes) 3:4 Trial Investigators. Tolvaptan and Kidney Pain in Patients With Autosomal Dominant Polycystic Kidney Disease: Secondary Analysis From a Randomized Controlled Trial. Am J Kidney Dis. 2017 Feb;69(2):210-219. 4. Müller RU, Messchendorp AL, Birn H, Capasso G, Cornec-Le Gall E, Devuyst O, van Eerde A, Guirchoun P, Harris T, Hoon EJ, Knoers NVAM, Korst U, Mekahli D, Le Meur Y, Nijenhuis T, Ong ACM, Sayer JA, Schaefer F, Servais A, Tesar V, Torra R, Walsh SB, Gansevoort RT. An update on the use of tolvaptan for autosomal dominant polycystic kidney disease: consensus statement on behalf of the ERA Working Group on Inherited Kidney Disorders, the European Rare Kidney Disease Reference Network and Polycystic Kidney Disease International. Nephrol Dial Transplant. 2022 Apr 25;37(5):825-839.

Abbreviated Prescribing Information

JINARC (tolvaptan) 15mg, 30mg, 15mg + 45mg, 30mg + 60mg, 30mg + 90mg tablets.

INDICATION: indicated to slow the progression of cyst development and renal insufficiency of autosomal dominant polycystic kidney disease (ADPKD) in adults with CKD stage 1 to 4 at initiation of treatment with evidence of rapidly progressing disease.

DOSE: twice daily in split dose regimens: initially 60mg/day as 45 mg + 15 mg (45 mg taken upon waking & prior the morning meal and 15 mg taken 8 hours later). Titrate upward to 90mg/day (60 mg + 30 mg) and then to a target dose of 120mg/day (90 mg + 30 mg), if tolerated, with at least weekly intervals between titrations. Based on tolerability, down-titrate and maintain on the highest tolerable dose. Take morning dose at least 30 min before breakfast. Take 2nd dose with or without food. Swallow whole with a glass of water, do not chew or crush. Avoid grapefruit juice. **CONTRAINDICATION:** Hypersensitivity to this product, or to benzazepine or its derivatives; Elevated liver enzymes and/or signs or symptoms of liver injury before initiation of treatment; Anuria; Volume depletion; Hyponatraemia; Patients who cannot perceive or respond to thirst; Pregnancy and breastfeeding. **WARNINGS AND PRECAUTIONS:** Idiosyncratic hepatic toxicity. Perform blood testing for hepatic transaminases & bilirubin prior to initiation of treatment, continuing monthly for 18 month & at regular 3-monthly intervals thereafter. Monitor for symptoms that may indicate liver injury. Drink water or other aqueous fluids to avoid excessive thirst or dehydration. Monitor volume, fluid & electrolyte status. Urinary output must be secured. Correct hyponatraemia or hypernatraemia before initiation of treatment. Rare hereditary problems of galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption. Exclude pseudohyponatraemia in DM patients prior & during treatment. May cause hyperglycaemia. Evaluate ureic acid concentration prior to initiation of therapy & as indicated during treatment based on symptoms. Reversible reduction in GFR. Discontinue treatment if renal insufficiency progresses to CKD stage 5. Severe hepatic impairment. Minor influence on the ability to drive or use machines. Not recommended in the paediatric age group. **ADVERSE REACTIONS:** Very common - polydipsia; headache; dizziness; diarrhoea; dry mouth; nocturia; pollakiuria; polyuria; fatigue; thirst. Common - dehydration, hypernatraemia, decreased appetite, hyperuricaemia, hyperglycaemia, insomnia; palpitations; dyspnoea; abdominal pain, abdominal distension, constipation, dyspepsia, GERD, abnormal hepatic function; rash, pruritus; muscle spasms; asthenia; increased ALT & AST, decreased weight. **DRUG INTERACTIONS:** Increased exposure with moderate or strong CYP3A4 inhibitors. Decreased exposure & efficacy with potent CYP3A4 inducers. Higher risk for developing hypernatraemia with medicinal products that increase serum Na concentration. Potential to lead to severe dehydration with loop & thiazide diuretics. Increased steady state concentration of digoxin. Use with caution when co-administered with OATP1B1 & OATP1B3 substrates (e.g. statins). OAT3 substrates (e.g. methotrexate, ciprofloxacin), BCRP substrates (e.g. sulfasalazine) or OCT1 substrates (e.g. metformin). Possible attenuation of effect of vasopressin analogues e.g. desmopressin. **Please see full Prescribing information for details.** (Ref: HKPI Revised May 2020; Last Update: Oct 2022)



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NOW
AVAILABLE

FOR THE TREATMENT OF MODERATE TO SEVERE ATOPIC DERMATITIS

in adults and adolescents 12 years and older who are candidates for systemic therapy¹

- Rapid skin clearance with EASI 75 as early as **WEEK 2**²
- Rapid itch relief as soon as **DAY 1** after treatment initiation for RINVOQ 30mg (≥4-Point reduction in NRS)²

References: 1. RINVOQ® Hong Kong Prescribing Information Feb 2022. 2. Guttman-Yassky E, Teixeira H, Simpson E, et al. Once-daily upadacitinib versus placebo in adolescents and adults with moderate-to-severe atopic dermatitis (Measure Up 1 and Measure Up 2): results from two replicate double-blind, randomised controlled phase 3 trials. *Lancet*. 2021; 397(10290): 2151-2168.

EASI: Eczema Activity and Severity Index. EASI 75/90: at least a 75% or 90% improvement in EASI score from baseline. NRS: numerical rating scale

RINVOQ abbreviated product information

Presentation: Prolonged-release tablet: Upadacitinib 15/30 mg Indication: Rheumatoid arthritis: treatment of moderate to severe active rheumatoid arthritis in adult patients who have responded inadequately to, or who are intolerant to one or more disease-modifying anti-rheumatic drugs (DMARDs) as monotherapy or in combination with methotrexate. Psoriatic arthritis: treatment of active psoriatic arthritis in adult patients who have responded inadequately to, or who are intolerant to one or more DMARDs as monotherapy or in combination with methotrexate. Ankylosing spondylitis: treatment of active ankylosing spondylitis in adult patients who have responded inadequately to conventional therapy. Atopic dermatitis: treatment of moderate to severe atopic dermatitis in adults and adolescents 12 years and older who are candidates for systemic therapy. Dosage and administration: Rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis: 15 mg once daily. Atopic dermatitis: Adult: 15 mg or 30 mg once daily based on individual patient presentation. Adult ≥ 65 years of age: 15 mg once daily. Adolescent 12-17 yr, ≥30kg: 15mg once daily. Contraindications: Known hypersensitivity to upadacitinib or any of its excipients; active tuberculosis or active serious infections; severe hepatic impairment; pregnancy. Warning and Precautions: Immunosuppressive medical products: Upadacitinib has not been evaluated with other potent immunosuppressants, combination use is not recommended. Serious infections: Upadacitinib should not be initiated in patients with an active, serious infection, including localised infections. Closely monitor for the development of signs and symptoms of infection during and after treatment. Interrupt upadacitinib if serious or opportunistic infection develops. Use with caution in the elderly ≥ 65 years of age. Tuberculosis (TB): Screen for TB before initiation. Upadacitinib should not be given to patients with active TB. Monitor for signs and symptoms of TB. Anti-TB therapy should be considered prior to initiation of upadacitinib in patients with previously untreated latent TB or in patients with risk factors for TB infection. Viral reactivation: If herpes zoster develops, upadacitinib interruption should be considered until the episode resolves. Screen for viral hepatitis and monitor for reactivation before starting and during therapy. Vaccination: Use of live, attenuated vaccines during or immediately prior to upadacitinib is not recommended. Prior to initiating upadacitinib, it is recommended that patients be brought up to date with all immunisations, including prophylactic zoster vaccinations, in agreement with current immunisation guidelines. Malignancy: The risks and benefits of upadacitinib treatment should be considered prior to initiating therapy in patients with a known malignancy other than a successfully treated non-melanoma skin cancer (NMSC) or when considering continuing upadacitinib in patients who develop a malignancy. Periodic skin examination is recommended for patients who are at increased risk for skin cancer. Haematological abnormalities: Upadacitinib should not be initiated, or should be temporarily interrupted, in patients with an ANC < 1 x 10⁹ cells/L, ALC < 0.5 x 10⁹ cells/L, or haemoglobin < 8 g/dL. Diverticulitis: Upadacitinib should be used with caution in patients with diverticular disease and especially in patients chronically treated with concomitant medications associated with an increased risk of diverticulitis. Cardiovascular risk: Manage risk factors of cardiovascular disorders as part of usual standard of care. Lipids: Dose-dependent increases in lipid parameters, including total cholesterol, low-density lipoprotein (LDL) cholesterol, and high-density lipoprotein (HDL) cholesterol. Hepatic transaminase elevations: Evaluate at baseline and thereafter according to routine patient management. If increase in ALT or AST are observed and drug-induced liver injury is suspected, upadacitinib therapy should be interrupted until this diagnosis is excluded. Venous thromboembolism: Use with caution in patients at high risk for DVT/PE. If clinical features of DVT/PE occur, upadacitinib treatment should be discontinued and patients should be evaluated promptly, followed by appropriate treatment. Women with childbearing potential: Use effective contraception during treatment and for 4 weeks following the final dose. Pregnancy: Upadacitinib is contraindicated during pregnancy. Breast feeding: It is unknown whether upadacitinib/metabolites are excreted in human milk. Upadacitinib should not be used during breast-feeding. Interactions: Metabolism mainly by CYP3A4. Coadministration with Strong CYP3A4 inhibitors: Upadacitinib 15mg once daily should be used with caution in patients receiving chronic treatment with strong CYP3A4 inhibitors. Upadacitinib 30 mg once daily dose is not recommended for patients receiving chronic treatment with strong CYP3A4 inhibitors. Consider alternatives to strong CYP3A4 inhibitor when used in the long-term. Coadministration with Strong CYP3A4 inducers: Monitor for changes in disease activity. Undesirable effects: Rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis - upper respiratory tract infections, blood creatine phosphokinase (CPK) increased, alanine transaminase increased, bronchitis, nausea, cough, aspartate transaminase increased, and hypercholesterolaemia; Atopic dermatitis - upper respiratory tract infections, acne, herpes simplex, headache, CPK increased, cough, folliculitis, abdominal pain, nausea, neutropenia, pyrexia, and influenza. Please read the full prescribing information before prescribing. Full prescribing information is available upon request. HK_API Rinvq PI FEB 2022

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