THE FEDERATION OF MEDICAL SOCIETIES OF HONG KONG
香 港 醫 學 組 織 聯 會

Annual Scientific Meeting 2019

Innovative Medical Technologies

Date : 22 September 2019 (Sunday) Time : 9:00 – 17:00
Venue : 3/F, Sheraton Hong Kong Hotel & Towers,
20 Nathan Road, Tsim Sha Tsui, Kowloon

PROGRAMME BOOK

Are your SLE patients having difficulty moving forward with standard therapy alone?

Could it be time to consider adding BENLYSTA IV?

Adding BENLYSTA IV to standard therapy:

- Superior reduction in SLE disease activity[1,2*†‡]
- Reduction in corticosteroid dose in patients on > 7.5 mg/day at baseline[1,2#]
- 39% relative risk reduction of first severe flare[1,2§¶]
- Significant improvement in fatigue as early as Week 8[2^]
- Rates of adverse events were similar between BENLYSTA IV and placebo[1-3*]

Benlysta (belimumab)

Physicians should exercise caution when considering the use of BENLYSTA in patients with chronic infections or a history of recurrent infection. Live vaccines should not be given for 30 days before, or concurrently with BENLYSTA[1].

BENLYSTA (belimumab) powder for concentrate for solution for infusion 120mg, 400mg

Integrated Safety Information

Contraindications:

· Hypersensitivity to the active substance (belimumab) or to any of the excipients of the captioned product.

Warnings and Precautions:

· Not recommended in patients with severe active central nervous system lupus, severe active lupus nephritis, HIV, history of/current hepatitis B or C, hypogammaglobulinaemia (IgG <400mg/dl) or IgA deficiency (IgA <10mg/dl) and patients with a history of major organ transplant or hematopoietic stem/cell/marrow transplant or renal transplant.
· Caution in patients receiving other B cell targeted therapy or cyclophosphamide.
· Administration of BENLYSTA may result in hypersensitivity reactions and infusion reactions which can be severe, and fatal. In the event of a severe reaction, BENLYSTA administration must be interrupted and appropriate medical therapy administered.
· Physicians should exercise caution when considering the use of BENLYSTA in patients with severe or chronic infections or a history of recurrent infection Patients who develop an infection while undergoing treatment with BENLYSTA should be monitored closely and careful consideration given to interrupting immunosuppressant therapy including belimumab until the infection is resolved.
· Patients should be monitored for any of these new or worsening symptoms or signs suggestive of progressive multifocal leukoencephalopathy (PML), and if such symptoms/signs occur, referral to a neurologist and appropriate diagnostic measures for PML should be considered. If PML is suspected, further dosing must be suspended until PML has been excluded.
· Live vaccines should not be given for 30 days before, or concurrently with BENLYSTA
· Caution should be exercised when considering belimumab therapy for patients with a history of malignancy or when considering continuing treatment in patients who develop malignancy.

The following adverse events have been reported with a frequency of –

Very common (≥1/10): Bacterial infections, e.g. bronchitis, cystitis, Diarrhoea, Nausea Common (≥1/100 to <1/10): Gastroenteritis viral, Pharyngitis, Nasopharyngitis, Leucopenia, Hypersensitivity reactions, Depression, Insomnia, Migraine, Pain in extremity, Infusion-related reactions, Pyrexia

Abbreviated Prescribing Information

BENLYSTA is a human IgG1λ monoclonal antibody specific for soluble human B Lymphocyte Stimulator protein (BLyS, also referred to as BAFF and TNFSF13B). **Indication:** As add-on therapy in adult patients with active, autoantibody-positive systemic lupus erythematosus (SLE) with a high degree of disease activity (e.g positive anti-dsDNA and low complement) despite standard therapy. **Dosage and Administration:** BENLYSTA is administered intravenously by infusion, and must be reconstituted and diluted before administration. Treatment should be initiated and supervised by a qualified physician experienced in the diagnosis and treatment of SLE. BENLYSTA infusions should be administered by a qualified healthcare professional trained to give infusion therapy. Administration of BENLYSTA may result in severe or life-threatening hypersensitivity reactions and infusion reactions several hours after the infusion has been administered. BENLYSTA should be administered in an environment where resources for managing such reactions are immediately available. Patients should remain under clinical supervision for a prolonged period of time (for several hours), following at least the first 2 infusions, taking into account the possibility of a late onset reaction. BENLYSTA should be infused over a 1hour period. BENLYSTA must not be administered as an intravenous bolus. The infusion rate may be slowed or interrupted if the patient develops an infusion reaction. The infusion must be discontinued immediately if the patient experiences a potentially life-threatening adverse reaction. **Contraindications:** Hypersensitivity to active substance (belimumab) or any excipients. **Special warnings & Precautions:** Not recommended in patients with severe active central nervous system lupus, severe active lupus nephritis, HIV, history of/current hepatitis B or C, hypogammaglobulinaemia (IgG <400mg/dl) or IgA deficiency (IgA <10mg/dl) and patients with a history of major organ transplant or hematopoietic stem/cell/marrow transplant or renal transplant. Caution in patients receiving other B cell targeted therapy or cyclophosphamide and patients with a history of malignancy or who develop malignancy whilst receiving treatment. Administration of BENLYSTA may result in hypersensitivity reactions and infusion reactions which can be severe, and fatal. In the event of a severe reaction, BENLYSTA administration must be interrupted and appropriate medical therapy administered. Risk of hypersensitivity reactions is greatest with the first two infusions; however the risk should be considered for every infusion. Patients with a history of multiple drug allergies or significant hypersensitivity may be at increased risk. Premedication including an antihistamine, with or without antipyretic, may be administered before infusion of BENLYSTA. There is insufficient knowledge to determine whether premedication could diminish the frequency or severity of infusion reactions. In clinical studies, serious infusion and hypersensitivity reactions affected approximately 0.9% of patients, and included anaphylactic reaction, bradycardia, hypotension, angioedema, and dyspnea. Infusion reactions occurred more frequently during the first two infusions and tended to decrease with subsequent infusions. Patients should be advised that hypersensitivity reactions are possible on the day of, or the day after infusion, and be informed of potential signs and symptoms and the possibility of recurrence. Patients should be instructed to seek immediate medical attention if they experience any of these symptoms. The package leaflet should be provided to the patient each time BENLYSTA is administered. Delayed-type, non-acute hypersensitivity reactions have also been observed and included symptoms such as rash, nausea, fatigue, myalgia, headache, and facial oedema. The mechanism of action of BENLYSTA could increase the risk for the development of infections, including opportunistic infections. Severe infections, including fatal cases, have been reported in SLE patients receiving immunosuppressant therapy, including belimumab. Physicians should exercise caution when considering the use of BENLYSTA in patients with severe or chronic infections or a history of recurrent infection. Patients who develop an infection while undergoing treatment with BENLYSTA should be monitored closely and careful consideration given to interrupting immunosuppressant therapy including belimumab until the infection is resolved. The risk of using BENLYSTA in patients with active or latent tuberculosis is unknown. Progressive multifocal leukoencephalopathy (PML) has been reported with BENLYSTA treatment for SLE. Physicians should be particularly alert to symptoms suggestive of PML that patients may not notice (e.g., cognitive, neurological or psychiatric symptoms or signs). Patients should be monitored for any of these new or worsening symptoms or signs, and if such symptoms/signs occur, referral to a neurologist and appropriate diagnostic measures for PML should be considered. If PML is suspected, further dosing must be suspended until PML has been excluded. Live vaccines should not be given for 30 days before, or concurrently with BENLYSTA, as clinical safety has not been established. No data are available on the secondary transmission of infection from persons receiving live vaccines to patients receiving BENLYSTA. Because of its mechanism of action, belimumab may interfere with the response to immunisations. However, in a small study evaluating the response to a 23-valent pneumococcal vaccine, overall immune responses to the different serotypes were similar in SLE patients receiving BENLYSTA compared with those receiving standard immunosuppressive treatment at the time of vaccination. Limited data suggest that BENLYSTA does not significantly affect the ability to maintain a protective immune response to immunisations received prior to administration of BENLYSTA. In a substudy, a small group of patients who had previously received either tetanus, pneumococcal or influenza vaccinations were found to maintain protective titres after treatment with BENLYSTA. Immunomodulatory medicinal products, including belimumab, may increase the risk of malignancy. Caution should be exercised when considering belimumab therapy for patients with a history of malignancy or when considering continuing treatment in patients who develop malignancy. Patients with malignant neoplasm within the last 5 years have not been studied, with the exception of those with basal or squamous cell cancers of the skin, or cancer of the uterine cervix, that has been fully excised or adequately treated. **Interactions**: No interaction studies have been performed. **Pregnancy and lactation**: Limited data on use in pregnant women. Not to be used unless the potential benefit justifies the potential risk to the foetus. Not known whether BENLYSTA is excreted in human milk or absorbed after ingestion. Maternal IgG is secreted in breast milk so recommended to either discontinue BENLYSTA or breast feeding, taking into account the benefit of breast feeding for the child and the benefit of therapy for the woman. **Undesirable effects**: See PI for full details. Very common: Bacterial infections, e.g. bronchitis, cystitis, Diarrhoea, Nausea. Common: Gastroenteritis viral, Pharyngitis, Nasopharyngitis, Leucopenia, Hypersensitivity reactions, Depression, Insomnia, Migraine, Pain in extremity, Infusion-related reactions, Pyrexia. Uncommon: Anaphylactic reaction, Angioedema, Urticaria, Rash. Rare: Delayed-type, non-acute hypersensitivity reactions. **Overdose:** Limited clinical experience with overdose of BENLYSTA. In case of inadvertent overdose, patients should be carefully observed and supportive care administered, as appropriate. 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, Tsimshatsui, Kowloon, Hong Kong. Abbreviated Prescribing Information based on PI version: GDS13/EMA(20160915).

Remarks: * Defined as positive anti-dsDNA (≥30 IU/mL) and low C3 and/or C4 complement. † Standard therapies permitted, alone or in combination: corticosteroids, immunosuppressants, antimalarials, and NSAIDs. ‡ BLISS-52 and BLISS-76 pooled data. § HR (95% CI) = 0.61 (0.44, 0.85); p = 0.004 vs placebo + standard therapy over 52 weeks. ¶ 19.0% of patients on BENLYSTA + standard therapy vs 29.6% of patients on placebo + standard therapy had a severe flare over 52 weeks (p < 0.004). # Reduction to ≤7.5 mg/day: 24.6% vs 15.0% (p = 0.035). ^ FACIT-Fatigue score improvement at Week 52: 4.07 vs 1.80 (p = 0.004).

References: 1. Benlysta IV Prescribing Information version GDS13. **2.** van Vollenhoven RF, Petri MA, Cervera R, et al. Belimumab in the treatment of systemic lupus erythematosus: high disease activity predictors of response. Ann Rheum Dis. 2012;71:1343-1349. **3.** Navarra SV, Guzmán RM, Gallacher AE, et al. Efficacy and safety of belimumab in patients with active systemic lupus erythematosus: a randomised, placebo-controlled, phase 3 trial. Lancet. 2011;377(9767):721-731.

The material is for the reference and use by healthcare professionals only. For adverse event reporting, please call GlaxoSmithKline Limited at (852) 9046 2498 (Hong Kong).
Full Prescribing Information is available upon request. Please read the full prescribing information prior to administration, available from GlaxoSmithKline Limited.

GlaxoSmithKline Limited
23/F, Tower 6, The Gateway, 9 Canton Road, Tsimshatsui, Kowloon, Hong Kong Tel: (852) 3189 8989 Fax: (852) 3189 8931 hk.gsk.com

HKRX/BEL/0005/18a (02/2021)
Date of preparation: 04/03/2019

ONCE-A-DAY

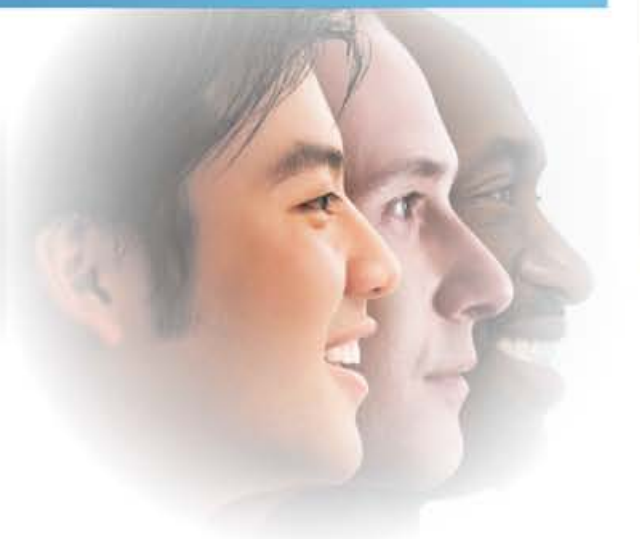
Plavix®

(clopidogrel bisulfate) 75 mg tablets

FIT FOR THE NEEDS OF ASIANS

Preferred $P2Y_{12}$ inhibitor in 2018 Chinese Expert Consensus on Antiplatelet Therapy for Special Populations with ACS in the following populations:

For details of the recommendations and other recommendations stated in the consensus, please refer to the full publication in Chinese.



Clopidogrel in DAPT for Special Populations with ACS

- History of stroke/TIA†
- Comorbidities
  - Severe renal impairment**
  - Renal impairment with concomitant use of ARB††
  - Acute gout arthritis‡‡
- ≥75 years of age‡
- Low platelet counts‖
- High GI bleeding risk§
- Thrombolytic therapy in STEMI¶

† For ACS patients with a history of ischaemic stroke or TIA, clopidogrel (75 mg/day) plus aspirin (100 mg/day) should be continued to 12 months.

‡ For patients with ACS ≥75 years of age, on top of using aspirin, clopidogrel is recommended as the first-choice $P2Y_{12}$ inhibitor.

§ For ACS patients with a high risk of GI bleeding (including the elderly and patients taking other medications such as warfarin, glucocorticoids or NSAIDs etc.), PPIs for 1-3 months are recommended on the basis of clopidogrel and aspirin.

¶ Patients with STEMI receiving thrombolytic therapy should initiate DAPT as soon as possible. Aspirin is given at a loading dose of 200-300 mg (chew and swallow) followed by 100 mg/day. For patients aged ≤75 years, clopidogrel at a loading dose of 300 mg followed by 75 mg/day should be given; No loading dose is given for patients aged >75 years. Ticagrelor is not recommended for patients with STEMI receiving thrombolytic therapy. In the case of patients undergoing PCI after thrombolytic therapy, taking into account both ischaemic and haemorrhagic risks, administration of ticagrelor can be considered 48 hours after thrombolytic therapy.

‖ If the ACS patient has a low platelet count of <100 x 10^9/L and ≥60 x 10^9/L, it is needed to carefully assess the safety of DAPT. For patients with low bleeding risk, clopidogrel plus aspirin is preferred. For patients with high bleeding risk, monotherapy (clopidogrel or aspirin) can be considered. The use of ticagrelor should be avoided. If the ACS patient has a platelet count of <60 x 10^9/L and >30 x 10^9/L, it is recommended to use monotherapy (clopidogrel or aspirin) as maintenance treatment. The use of ticagrelor should be avoided. If the ACS patients has a platelet count <30 x 10^9/L, it is recommended to stop antiplatelet therapy and to avoid PCI.

** For ACS patients with severe renal impairment (eGFR <30 mL/min), clopidogrel (75 mg/day) plus aspirin (100 mg/day) is preferred.

†† If a concomitant ARB is given to ACS patients with renal impairment, DAPT of clopidogrel plus aspirin is preferred.

‡‡ For ACS patients with comorbid acute gout arthritis flares, clopidogrel at 75-150 mg/day is preferred. Once symptoms are relieved, initiate clopidogrel at 75 mg/day plus aspirin at 75-100 mg/day. After 6-12 months, maintain with clopidogrel at 75 mg/day for long-term treatment. In case of acute gout during administration of DAPT following PCI, concomitant use of antigout agents with DAPT of clopidogrel plus aspirin can be considered taking into account of the risks for ischaemia and gout. Low-dose aspirin (75-325 mg/day) has a mild effect on increasing plasma uric acid, which raises the risk of gout. If the risk of gout has been increased by aspirin, stop using aspirin or replace with cilostazol plus clopidogrel.

ACS=acute coronary syndrome; ARB=angiotensin II receptor blocker; CHD=coronary heart disease; DAPT=dual antiplatelet therapy; eGFR=estimated glomerular filtration rate; GI=gastrointestinal; NOAC=novel oral anticoagulant; NSAID=non-steroidal anti-inflammatory drug; PCI=percutaneous coronary intervention; PPI=proton pump inhibitor; PTE=pulmonary thromboembolism; STEMI=ST-elevation myocardial infarction; TIA=temporary ischaemic attack.

Reference

Specialty Committee on Prevention and Treatment of Thrombosis of Chinese College of Cardiovascular Physicians, Interventional Cardiology Branch of Chinese Society of Cardiology of Chinese Medical Association and Editorial Board of Chinese Journal of Cardiology. Chinese expert consensus on antiplatelet therapy for special patients with acute coronary syndrome. Chin J Cardiol 2018;46:255-266.

Presentation: Clopidogrel film-coated tablets. **Indications:** Prevention of atherothrombotic events in (a) adult patients suffering from myocardial infarction (from a few days until less than 35 days), ischaemic stroke (from 7 days until less than 6 months) & established peripheral arterial disease (b) adult patients suffering from acute coronary syndrome: (i) Non-ST segment elevation acute coronary syndrome (unstable angina or non-Q-wave myocardial infarction), including patients undergoing a stent placement following percutaneous coronary intervention, in combination with acetylsalicylic acid (ASA) (ii) ST segment elevation acute myocardial infarction, in combination with ASA in medically treated patients eligible for thrombolytic therapy. Prevention of atherothrombotic and thromboembolic events, including stroke, in adult patients with atrial fibrillation who have at least one risk factor for vascular events, are not suitable for treatment with Vitamin K antagonists (VKA) and who have a low bleeding risk. **Dosage:** Adults and elderly: 75mg once daily. For patients with UA/NQWMI, loading dose 300mg, followed by 75mg once daily (with ASA 75mg-325mg daily). Since higher doses of ASA were associated with higher bleeding risk, recommended dose of ASA ≤100 mg. For patients with ST segment elevation myocardial infarction, 75mg once daily with a 300mg loading dose in combination with ASA and with or without thrombolytics. For patients ≥75 years, initiate clopidogrel without loading dose. For patients with atrial fibrillation, 75 mg daily with ASA (75-100 mg daily). Children and adolescents: not recommended under 18 years. **Contraindications:** Hypersensitivity to clopidogrel or excipients; severe hepatic impairment; active pathological bleeding such as peptic ulcer & intracranial haemorrhage. **Precautions:** If a patient is to undergo elective surgery and antiplatelet effect is not necessary, clopidogrel should be discontinued 7 days prior to surgery. Patients who may be at risk of increased bleeding from trauma, surgery or other pathological conditions; hypersensitivity to thienopyridines; patients with renal impairment; patients with moderate hepatic disease who may have bleeding diatheses. Not recommended during the first 7 days after an acute ischaemic stroke. Patients with genetically reduced CYP2C19 function. Patients treated concomitantly with clopidogrel and CYP2C8 substrates. **Interactions:** Not recommended with oral anticoagulants, caution with glycoprotein IIb/IIIa inhibitors, aspirin, heparin, thrombolytics or NSAIDs (including Cox-2 inhibitors), selective serotonin reuptake inhibitors (SSRIs). Drugs that inhibit CYP2C19, including proton pump inhibitors. CYP2C8 substrates such as rapaglinide and paclitaxel. **Undesirable effects:** haemorrhagic disorders; haematological including bleeding such as purpura, bruising, haematoma and epistaxis; gastrointestinal system disorders such as dyspepsia, abdominal pain and diarrhea. For uncommon, rare and very rare undesirable effects, please refer to the full prescribing information. **Preparations:** 75 mg x 14's; 300 mg x 30's. **Legal Classification:** Part 1, First & Third Schedules

Please refer to full prescribing information is available upon request.

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SANOFI

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Programme

	Ballroom C	Ballroom AB	Tang Rooms
0900-0930	**Registration (Foyer)**		
0930-1000	**Opening Ceremony**		
	Officiating Guests Prof. the Hon. Sophia CHAN Siu-chee , JP *Secretary for Food & Health* Prof. LAU Chak-sing, JP *President, Hong Kong Academy of Medicine* Dr. Tony KO Pat-sing *Chief Executive, Hospital Authority* Honorable Guests 李文慎 *中聯辦協調部副部長* Dr. the Hon. Pierre CHAN *Legislative Council Member (Medical)* Dr. the Hon. Edward LEONG Che-hung GBM, GBS, JP		
1000-1045	**Session I - Practice of Health Service Management**		
	Chairpersons: Dr. Ludwig Chun-hing TSOI & Mr. Benjamin Cheung-mei LEE		
1005-1020	**Opportunities and Challenges in Greater Bay Area** Prof. Geoffrey LIEU		
1020-1035	**101 of Innovative Healthcare - The Role of Medical Entrepreneurs** Dr. LIU Shao-haei		
1035-1045	Q&A		
1045-1105	***Coffee Break***		
1105-1210	**Session II A - Respiratory Health**		**Session II C - Urology**
	Chairpersons: Dr. Jane Chun-kwong CHAN & Dr. NG Chun-kong		Chairpersons: Dr. MAK Siu-king & Dr. Victor Hip-wo YEUNG
1110-1135	**Small Lung Nodule - What Should Be Done?** Dr. CHU Chung-ming		**Erectile Dysfunction – The Quest for the Optimal PDE5-I** Dr. Andrew Wai-chun YIP
1135-1200	**Update in Airway Diseases Management: COPD and Asthma** Dr. David Chi-leung LAM		**MRI USG Fusion Biopsy of Prostate** Dr. Peter Ka-fung CHIU
1200-1210	Q&A		Q&A
1210-1310	**Luncheon Symposium** (Session sponsor: Lundbeck HK Limited)		
		Chairpersons: Dr. Raymond See-kit LO	
1215-1300		**Updates on Management of Depression** Dr. TSANG Fan-kwong	
1300-1310		Q&A	

1310-1415	**Session III A - Dermatology** (Session sponsor: Pfizer Corporation Hong Kong Limited)		**Session III C - Care for Advanced Diseases (I): Innovative Approach for Advanced Cancer Pain** (Session sponsor: Kyowa Kirin Hong Kong Co., Limited)
	Chairpersons: Dr. Mario Wai-kwong CHAK & Dr. Kingsley Hau-ngai CHAN		Chairpersons: Dr. Raymond See-kit LO & Prof. Bernard Man-yung CHEUNG
1315-1340	**Steroid Phobia in Atopic Dermatitis** Prof. Ellis KL HON		**Drug Management for Difficult and Refractory Cancer Pain** Dr. YUEN Kwok-keung
1340-1405	**The Future of Atopic Dermatitis Treatment: Children in Focus** Prof. Ellis Kam-lun HON		**Novel Treatment on Interventional Pain Relief** Dr. Timmy Chi-wing CHAN
1405-1415	Q&A		Q&A
1415-1520	**Session IV A - Cardiovascular Diseases**	**Session IV B - Child Health**	**Session IV C - Care for Advanced Diseases (II): Care for Dementia Across the Full Trajectory** (Session sponsor: Nutricia Clinical (Hong Kong) Limited)
	Chairpersons: Prof. Bernard Man-yung CHEUNG & Dr. Samuel Ka-shun FUNG	Chairpersons: Dr. Stephenie Ka-yee LIU & Ms. Tina Woan-tyng YAP	Chairpersons: Dr. Jane Chun-kwong CHAN & Dr. NG Chun-kong
1420-1445	1420-1445 **Lipid Management** Dr. Steve Wai-keung LAI 1445-1450 **Q&A**	**Precision Medicine in Epilepsy** Dr. Mario Wai-kwong CHAK	**Screening, Diagnosis and Treatment of Early Dementia** Dr. Jenny Shun-wah LEE
1445-1510	1450-1515 **Antiplatelet therapy after PCI** Dr. Michael Pak-hei CHAN	**Common Paediatric Behavioural and Psychiatric Disorders** Dr. Venus Fung-ling TAM	**Supportive and Palliative Care for Dementia: From the Beginning Not The End** Dr. Raymond See-kit LO
1510-1520	1515-1520 Q&A	Q&A	Q&A
1520-1540	***Coffee Break***		
1540-1645	**Session V A - Diabetes Mellitus & Renal Health**	**Session V B - Neurosurgery**	**Session V C - Rheumatology & Immunology**
	Chairpersons: Dr. Samuel Ka-shun FUNG & Dr. YUNG Chun-yu	Chairpersons: Dr. Mario Wai-kwong CHAK & Dr. YAM Kwong-yui	Chairpersons: Dr. NG Chun-kong & Dr. CHAN Kai-ming
1545-1610	**Complications of Phosphate in Cardiovascular Morbidities - Challenges to Chronic Kidney Patients and Doctors** Dr. Samuel Ka-shun FUNG	**Frameless Stereotactic Radiosurgery from Brain Metastasis to AVM, What Next?** Dr. YAM Kwong-yui	**Allergic Rhinitis** Dr. LO Pui-yee
1610-1635	**Diabetic Kidney Disease -A Growing Threat in Asia; Counter-measures** Dr. CHENG Yuk-lun	**Epilepsy Surgery: Progress with Technology Advancement** Dr. Wong Sui-to	**Advances in the Management of Axial Spondyloarthritis** Dr. Tommy Tsang CHEUNG
1635-1645	Q&A	Q&A	Q&A
1645-1655	***Closing Ceremony & Lucky Draw***		

Welcome Message from the President

Ladies and gentlemen, on behalf of the Federation, may I extend the warmest welcome to you for attending our Annual Scientific Meeting 2019. This year, the theme of our ASM is "Innovative Medical Technologies".

The growing trend of digitalisation has resulted in technological breakthroughs in the patient care equation and transformational changes across the global health industry. Let me give you some examples of the new medical technologies in 2019:

Now, the 3-D printing could be used to create implants, prosthesis, and even joints to be used during surgery. The digital functionalities enable them to match an individual's measurements down to the millimetre. This results in unprecedently levels of comfort and mobility.

Bio-printing of artificial organs is also an emerging medical technology. Now scientists are able to create blood vessels, synthetic ovaries, and even pancreas which grow within the patient's body to replace the original faulty one. These organs are not rejected by the body's immune system, saving millions of patients who depend on life-saving transplants every year.

People today use their phones and health wearables to track everything from their steps, physical fitness, and heartbeat, to their sleeping patterns. The advancement of these wearable technologies aims to combat chronic diseases by helping patients to monitor and improve their fitness.

By using virtual reality technology, medical students and surgeons are able to get close to real-life experience by rehearsing procedures and providing a visual understanding of how human anatomy is connected.

Telehealth allows patients to receive medical care through their digital devices, instead of waiting for face-to-face appointments with their doctors.

Clustered Regularly Interspaced Short Palindromic Repeats (CRISPR) is the most advanced gene-editing technology. Through cutting DNA, some of the previously incurable disorders such as Spinal Muscular Atrophy become treatable. Also, some of the biggest threats to our health, like cancer and HIV, could potentially be overcome in a matter of years.

Robotic surgery is being used widely in orthopaedic, urological and neurosurgical procedures and helps to aid in precision, control, and flexibility. Therefore, surgeons can perform very complex procedures that are otherwise either highly difficult or impossible.

As medical technology advances it is becoming more and more personalised to individual patients. Precision medicine, for example, allows physicians to select medicines and therapies to treat diseases, such as cancer-based on an individual's genetic make-up. This

personalised medicine is far more effective as it attacks tumour based on the patient's specific genes and proteins, causing gene mutations and making it more easily destroyed by the cancer meds.

New smart technology has the potential to tackle deeply-rooted clinical, societal and industry challenges, like ageing populations and the rising cost of healthcare. Patients would be able to receive more accurate diagnoses and efficient delivery of highly personalised healthcare services – at reduced costs.

Regular evaluation is necessary in order to find ways to improve the quality of innovative drug and equipment from time to time. That requires a joint effort of scientist and clinical professionals of multiple centres with overseas collaboration, consistent working synchronously in the same direction and goals for many years.

The Federation would like to thank wholeheartedly all our officiating and distinguished guests for their presence and support. It is very much our honour and privilege to have various local experts and presidents of our member societies to share with us the latest developments in medical technology and innovative device during this Annual Scientific Meeting.

Federation as an umbrella organisation of 142 member societies of various specialties and subspecialties is an excellent platform to unite joint effort of our medical and health professionals to advocate new medical technology and follow the global international trend of development.

Next year, Federation will celebrate his 55th anniversary, and will continue to work hand in hand with our frontlines medical and health professionals as well as our member societies, through innovative medical technology to face our existing health challenge and to improve the medical and health care of our Hong Kong populations.

Finally, I would like to express our greatest appreciation to our organising committee and the secretariat in ensuring the meeting a success. The kind sponsorship from our industry partners is also duly acknowledged. May I wish everyone participating in today's meeting a most fruitful time and we look forward to furthering the collaboration with you for a better and healthier Hong Kong.

Dr. Mario Wai-kwong CHAK

President,
The Federation of Medical Societies of Hong Kong

Welcome Messages from Chairpersons

Welcome Messages from the Annual Scientific Meeting 2019.

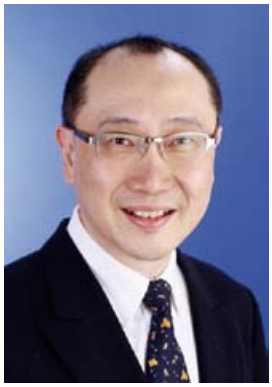
On behalf of the Organizing Committee of the FMSHK Annual Scientific Meeting (ASM) 2019, it is my great pleasure as Co-chairman together with Dr. Victor Hip-wo YEUNG to welcome you all for attending the 2019 Annual Scientific Meeting. This year the theme is on “Innovative Medical Technologies”.

Medical advances and innovations are remarkable driving forces to enhance the quality of healthcare practice and from bench to bedside translating to clinical care and quality patients’ outcome. The scientific programme this year covers important topics on Health Service Management, Respiratory Health, Urology, Psychiatry, Dermatology, Care for Advanced Diseases, Advanced Cancer Pain, Cardiovascular Diseases, Child Health, Care for Dementia, Diabetes Mellitus, Renal Health, Neurosurgery, Rheumatology & Immunology.

This year, we are privileged to have the leading experts in their fields to share with us important medical innovative therapies and clinical advances for our practice.

The ultimate goal for medical advances is the improvement of community health in our society. All the health care practitioners and partners are key stakeholders in health service and I believe we can work together for the benefits of our patients and community. I take great pride in our federation tradition to promote the fraternity and partnership among different specialties and disciplines. So I hope while you are enjoying the comprehensive scientific programme, please don’t miss this opportunity to meet old friends and get new acquaintance to colleagues from other specialties.

I look forward to meeting all of you in person during the meeting and wish you have a fruitful day in this ASM.



Dr Samuel Ka-shun FUNG

Co-chairman,
Annual Scientific Meeting 2019

Welcome Messages from Chairpersons

On behalf of the Organising Committee of 2019 Annual Scientific Meeting (ASM) of the Federation of Medical Societies of Hong Kong (FMSHK), it is my honour to welcome you to this year's meeting with the theme of "Innovative Medical Technologies".

In the era of artificial intelligence, medical investigations and treatments have improved tremendously. With these advancements, doctors are able to better assess the burden of the disease and provide appropriate management to the patients. This year we have a wide range of topics presented by distinguished speakers in healthcare management, respiratory medicine, urology, psychiatry, dermatology, anesthesiology, clinical oncology, internal medicine, cardiology, pediatrics, geriatric medicine, nephrology, neurosurgery, ENT and rheumatology. In their exciting lectures, they will bring us the latest updates and future trends in the management of the important diseases in Hong Kong. In addition, we will be able to have a deeper insight into healthcare management in the Greater Bay Area.

The annual FMSHK ASM aims at bringing expertise in various medical fields together, and promotes partnerships among different specialties. I look forward to meeting you all at the conference, and wish you a fruitful day at the ASM this year.

Sincerely,

Dr. Victor Hip-wo YEUNG

Co-chairman,
Annual Scientific Meeting 2019

Congratulatory Messages

The Hon. Mrs. Carrie LAM CHENG Yuet-ngor, GBM, GBS

The Chief Executive

革新醫術
造福民康

香港醫學組織聯會二零一九年科研大會

行政長官林鄭月娥

Congratulatory Messages

李文慎
中聯辦協調部副部長

创新医疗
弘仁濩惠

Congratulatory Messages

饒克勤
中華醫學會副會長

香港医学组织联会自成立以来，为满足香港对充足、优质医疗服务的需求，一直致力于推广有关医疗的教育及知识，集合各专业团体的力量在各方面做出了很多努力，发挥了重要作用。

本次周年科研大会将围绕创新医疗科技发展前瞻展开学术交流。周年科研大会为贵会的年度盛事，通过凝聚各医护界代表，就各项热门的创新医疗科技进行深入探讨，为政府的相关医疗政策提供建议，进而促进市民健康。中华医学会与香港医学组织联会一直保持着紧密的联系，去年周年科研大会邀请了我会计划生育学分会主任委员顾向应教授做大会报告。两会为促进两地医学交流和发展一直同心协力，我们期待在双方的共同努力和协作下，香港和内地的医学交流与合作更加活跃。

我谨代表中华医学会预祝本次周年科研大会圆满成功。

饶克勤

中华医学会副会长兼秘书长

2019 年 7 月 29 日

Congratulatory Messages

Prof. the Hon. Sophia CHAN Siu-chee, JP

Secretary for Food and Health

香港醫學組織聯會二零一九年科研大會

明醫博論

濟病扶康

食物及衞生局局長陳肇始

Congratulatory Messages

Dr. Constance CHAN Hon-yee, JP

Director of Health

香港醫學組織聯會二零一九年科研大會誌慶

羣賢術砥醫探礪新

衞生署署長陳漢儀

Congratulatory Messages

Prof. the Hon. Joseph LEE Kok-long, PhD, RN, SBS, JP

Legislative Councillor (Health Services)

It is a great pleasure for me to extend my heartiest congratulations to the Annual Scientific Meeting 2019 organized by the Federation of Medical Societies of Hong Kong.

With the theme of "Innovative Medical Technologies", the Societies marks a momentous milestone in promoting the advancement of healthcare standard and development over the years. It is no doubt that its significant contributions on the provision of healthcare service and quality to the community are to be highly commended.

On this remarkable occasion, I would like to express my gratitude on the hard work and dedication of all the members of the Societies. May I also take this opportunity to wish the event an every success.

Prof Hon Joseph Lee Kok-long, PhD, RN, SBS, JP
Member, Legislative Council

Congratulatory Messages

Dr. the Hon. Pierre CHAN

Legislative Councillor (Medical)

It is with great pleasure that I congratulate The Federation of Medical Societies of Hong Kong on its Annual Scientific Meeting 2019 "Innovative Medical Technologies".

I wish to extend my appreciation to the FMSHK for its valuable contribution to the health of local community. May it continue to craft new ideas and techniques in the way we provide care, and in the way we study illness, injury and quality of life.

Dr Pierre CHAN

Legislative Councillor (Medical), HKSAR

Congratulatory Messages

Prof. LAU Chak-sing

President, Hong Kong Academy of Medicine

On behalf of the Hong Kong Academy of Medicine, it gives me great pleasure to offer my warmest congratulations to The Federation of Medical Societies of Hong Kong for organising the Annual Scientific Meeting 2019.

The changing demographic landscape is intensifying pressures on healthcare systems in countries worldwide. People are living longer now, with higher expectation on the quality of healthcare services. Therefore, it is important not only to ensure the quality of services provided, but also provide customised care to patients in a cost-effective way. Thanks to the many medical innovations and technologies, health outcomes can be improved but with healthcare costs reduced.

With the theme "Innovative Medical Technologies", this Meeting gathers experts to deliberate on the recent advancement in various specialty medicine as well as their application in improving the diagnosis and treatment of patients. I believe the participants would gain insights into the latest innovations driving excellence in medicine.

I would like to congratulate The Federation of Medical Societies of Hong Kong for putting together this structured programme. May I wish all participants a most fruitful Meeting.

Yours sincerely,

CS

Professor LAU Chak-sing, JP
President
Hong Kong Academy of Medicine

Congratulatory Messages

Prof. Gabriel M LEUNG, GBS, JP
Dean of Medicine, The University of Hong Kong

二零一九年度香港醫學組織聯會週年學術會議

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香港大學李嘉誠醫學院院長梁卓偉

敬賀

Congratulatory Messages

Prof. Francis KL CHAN, JP

Dean, Faculty of Medicine, CUHK

It is my privilege and pleasureto be invited to contribute acongratulatory message for the 2019Annual Scientific Meeting organized by the Federation of Medical Societies of Hong Kong.

Similar to all developed societies, Hong Kong is grappling with the healthcare burden of an ageing population. Advances in information technology, big data and machine learning, have made many inroads into our lives including health and healthcare delivery. It is imperative for medical and healthcare professionals to learn lessons from success stories of applications of innovative medical technologies, innovationsthat improve outcomes for patients, ease pressure on healthcare professionals to refocus on the art of medicine, andadd value to healthcare systems and to society.

Please join me to thankmembers of the Organizing Committee fortheir visionand leadership for choosing this this year's theme "Innovative Medical Technologies". Ibelieve that participantswillfind the experiences and insights shared by the distinguishedspeakerseye-opening and stimulating.

Let all stakeholders work together to build a healthier tomorrow.

Professor Francis K L Chan
Dean, Faculty of Medicine
The Chinese University of Hong Kong

Congratulatory Messages

Prof. John LEONG Chi-yan, SBS, JP

Chairman, Hospital Authority

香港醫學組織聯會周年科研大會誌慶

醫護科創

造福萬民

醫院管理局主席梁智仁

Congratulatory Messages

Dr. Tony KO Pat-sing

Chief Executive, Hospital Authority

I am delighted to extend my warmest congratulations to the Federation of Medical Societies of Hong Kong in holding this Annual Scientific Meeting 2019.

As we all know, innovation in science and technology advancement is a major driving force in the world of medicine. It enables us health services providers to continuously meet ever growing demand and complex challenges. The use of state-of-the-art cutting edge technology has opened up a new world in the prevention, diagnosis and treatment of diseases.

Nonetheless, humanity is never overlooked in caring of patients. Innovation is a tool which drives us along in the pursuit for the ultimate benefit of the sick and needy.

Effectiveness and efficiency of disease management can often be optimised through multi-disciplinary team approach. Your commitment to continuous learning and exchange of knowledge, insights and best practices with the common aim to deliver better care for patients is greatly admired. I am sure this meeting provides an unparalleled opportunity for experts from different professional disciplines to achieve this aim, enabling us to learn from one another and leading to improvement in treatment modality and finally better outcome and quality of care.

Challenges abound, yet I am confident that with your devotion to medicine, improvement of quality of patient services will never cease. I wish the Annual Scientific Meeting 2019 every success and all participants an inspiring and fruitful experience.

Dr Tony Ko Pat-sing
Chief Executive
Hospital Authority

Congratulatory Messages

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

I write to congratulate the Federation of Medical Society of Hong Kong on her Annual Scientific Meeting.

The Annual Scientific Meeting is one of the very much sought after scientific conference of the medical and health care professions.

The theme this year is "Innovative Medical Technologies" answering to myriads of many still unsolved questions of human pathologies.

Members of the Federation which encompass health care professionals from various disciplines will no doubt put their brains together to solve many of these problems and learn from one another.

It is through cooperation and understanding the needs that our patients will be better served and medical science will progress.

My sincere congratulations to the Federation for her sustained efforts.

Congratulatory Messages

Dr. LEE Tsz-leung
Chief Executive, Hong Kong Children's Hospital

賢醫薈萃

創優革新

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Prolia® (Denosumab) Abbreviated Prescribing Information

Prolia® (denosumab) Solution for Injection in Pre-filled Syringe 60 mg/mL **INDICATIONS** Prolia is indicated for: i) treatment of postmenopausal women with osteoporosis at high risk for fracture, defined as a history of osteoporotic fracture, or multiple risk factors for fracture; or patients who have failed or are intolerant to other available osteoporosis therapy; ii) treatment to increase bone mass in men with osteoporosis at high risk for fracture, defined as a history of osteoporotic fracture, or multiple risk factors for fracture; or patients who have failed or are intolerant to other available osteoporosis therapy; iii) treatment to increase bone mass in men at high risk for fracture receiving androgen deprivation therapy for nonmetastatic prostate cancer. In these patients Prolia also reduced the incidence of vertebral fractures; iv) treatment to increase bone mass in women at high risk for fracture receiving adjuvant aromatase inhibitor therapy for breast cancer. **DOSAGE AND ADMINISTRATION** The recommended dose of Prolia is 60 mg administered as a single subcutaneous injection once every 6 months. Administer Prolia via subcutaneous injection in the upper arm, the upper thigh, or the abdomen. All patients should receive calcium 1000 mg daily and at least 400 IU vitamin D daily. **CONTRAINDICATIONS** Hypocalcemia and pregnancy, as well as hypersensitivity to any component of the product. **SPECIAL WARNINGS AND PRECAUTIONS FOR USE** *Hypersensitivity:* Clinically significant hypersensitivity including anaphylaxis has been reported with Prolia. Symptoms have included hypotension, dyspnea, throat tightness, facial and upper airway edema, pruritis, and urticaria. *Hypocalcemia and Mineral Metabolism:* Hypocalcemia may be exacerbated by the use of Prolia. Pre-existing hypocalcemia must be corrected prior to initiating therapy with Prolia. Hypocalcemia following Prolia administration is a significant risk in patients with severe renal impairment [creatinine clearance < 30 mL/min] or receiving dialysis. Adequately supplement all patients with calcium and vitamin D. *Osteonecrosis of the Jaw (ONJ):* ONJ has been reported in patients receiving Prolia. The start of treatment or of a new course of treatment should be delayed in patients with unhealed open soft tissue lesions in the mouth. A dental examination with preventive dentistry and an individual benefit-risk assessment is recommended prior to treatment with Prolia in patients with concomitant risk factors. All patients should be encouraged to maintain good oral hygiene, undergo routine dental check-ups, and immediately report any oral symptoms such as dental mobility, pain or swelling, or non-healing of sores or discharge during treatment with Prolia. While on treatment, invasive dental procedures should be performed with caution and avoided in close proximity to Prolia treatment. *Atypical Subtrochanteric and Diaphyseal Femoral Fractures:* Atypical low-energy or low trauma fractures of the shaft have been reported in patients receiving Prolia. Patients should be advised to report new or unusual thigh, hip, or groin pain. *Multiple Vertebral Fractures (MVF) Following Discontinuation of Prolia Treatment:* Following discontinuation of Prolia treatment, fracture risk increases, including the risk of multiple vertebral fractures. If Prolia treatment is discontinued, consider transitioning to an alternative antiresorptive therapy. *Serious Infections:* Serious infections leading to hospitalization were reported in clinical trial. Advise patients to seek prompt medical attention if they develop signs or symptoms of severe infection, including cellulitis. *Dermatologic Adverse Reactions:* Dermatitis, eczema, and rashes. Most of these events were not specific to the injection site. Consider discontinuing Prolia if severe symptoms develop. *Musculoskeletal Pain:* Severe and occasionally incapacitating bone, joint, and/or muscle pain. Consider discontinuing use if severe symptoms develop. *Suppression of Bone Turnover:* In clinical trials treatment with Prolia resulted in significant suppression of bone remodeling as evidenced by markers of bone turnover and bone histomorphometry. *Osteonecrosis of the external auditory canal:* Osteonecrosis of the external auditory canal has been reported with denosumab. Possible risk factors include steroid use and chemotherapy and/or local risk factors such as infection or trauma. **INTERACTIONS** In subjects with postmenopausal osteoporosis, Prolia (60 mg subcutaneous injection) did not affect the pharmacokinetics of midazolam, which is metabolized by cytochrome P450 3A4 (CYP3A4), indicating that it should not affect the pharmacokinetics of drugs metabolized by this enzyme in this population. **PREGNANCY AND LACTATION** *Pregnancy:* Category X. *Breast-feeding:* It is not known whether Prolia is excreted into human milk. **PEDIATRIC, GERIATRIC AND RENAL IMPAIRMENT** *Pediatric:* Prolia is not recommended in pediatric patients. *Geriatric:* No overall differences in safety or efficacy were observed in clinical studies between elderly patients and younger patients and other reported clinical experience has not identified differences in responses between the elderly and younger patients, but greater sensitivity of some older individuals cannot be ruled out. *Renal Impairment:* No dose adjustment is necessary in patients with renal impairment. **UNDESIRABLE EFFECTS** The most common adverse reactions reported with Prolia in patients with postmenopausal osteoporosis are back pain, pain in extremity, musculoskeletal pain, hypercholesterolemia, and cystitis. The most common adverse reactions reported with Prolia in men with osteoporosis are back pain, arthralgia, and nasopharyngitis. The most common (per patient incidence ≥ 10%) adverse reactions reported with Prolia in patients with bone loss receiving androgen deprivation therapy for prostate cancer or adjuvant aromatase inhibitor therapy for breast cancer are arthralgia and back pain. Pain in extremity and musculoskeletal pain have also been reported in clinical trials. The most common adverse reactions leading to discontinuation of Prolia in patients with postmenopausal osteoporosis are back pain and constipation. **OVERDOSE** There is no experience with overdosage with Prolia. Abbreviated Prescribing Information Version: HKPROPI01

Reference: 1. Henry G Bone, Rachel B Wagman, Maria L Brandi, et al. *The Lancet Diabetes & Endocrinology 2017;7[Vol 5]:513-523.*

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Placebo + Statin	13,780	13,148	13,524	8290	925
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Study details: Randomized, double-blind, placebo-controlled trial to evaluate the efficacy of evolocumab in patients with atherosclerotic cardiovascular disease and LDL cholesterol levels of 70 mg per deciliter (1.8 mmol per liter) or higher who were receiving statin therapy. The primary efficacy end point was the composite of cardiovascular death, myocardial infarction, stroke, hospitalization for unstable angina, or coronary revascularization. The key secondary efficacy end point was the composite of cardiovascular death, myocardial infarction, or stroke. The median duration of follow-up was 2.2 years.

Repatha® (evolocumab)

Repatha® (Evolocumab) Abbreviated Prescribing Information
Repatha® Solution for Injection in Pre-filled Syringe/ Autoinjector 140 mg/mL

INDICATIONS: Hypercholesterolaemia and mixed dyslipidaemia: Repatha is indicated in adults with primary hypercholesterolaemia (heterozygous familial and non familial) 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. Homozygous familial hypercholesterolaemia: Repatha is indicated in adults and adolescents aged 12 years and over with homozygous familial hypercholesterolaemia in combination with other lipid-lowering therapies. Established atherosclerotic cardiovascular disease: Repatha is indicated in adults with established atherosclerotic cardiovascular disease (myocardial infarction, stroke or peripheral arterial disease) to reduce cardiovascular risk by lowering LDL-C levels, as an adjunct to correction of other risk factors: in combination with the maximum tolerated dose of a statin with or without other lipid-lowering therapies 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:** Primary hypercholesterolaemia and mixed dyslipidaemia in adults: The recommended dose of Repatha is either 140 mg every two weeks or 420 mg once monthly; both doses are clinically equivalent. Homozygous familial hypercholesterolaemia in adults and adolescents aged 12 years and over: The initial recommended dose is 420 mg once monthly. After 12 weeks of treatment, dose frequency can be up titrated to 420 mg once every 2 weeks if a clinically meaningful response is not achieved. Patients on apheresis may initiate treatment with 420 mg every two weeks to correspond with their apheresis schedule. Established atherosclerotic cardiovascular disease in adults: The recommended dose of Repatha is either 140 mg every two weeks or 420 mg once monthly; both doses are clinically equivalent. No dose adjustment is necessary in patients with mild to moderate renal impairment. No dose adjustment is necessary in patients with mild hepatic impairment. No dose adjustment is necessary in elderly patients. The safety and efficacy of Repatha in children aged less than 18 years has not been established in the indication for primary hypercholesterolaemia and mixed dyslipidaemia. The safety and efficacy of Repatha in children aged less than 12 years has not been established in the indication for homozygous familial hypercholesterolaemia. Repatha is for subcutaneous injection into the abdomen, thigh or upper arm region. Injection sites should be rotated and injections should not be given into areas where the skin is tender, bruised, red, or hard. Repatha must not be administered intravenously or intramuscularly. The 420 mg dose should be delivered using three pre-filled syringes/ autoinjectors administered consecutively within 30 minutes. **CONTRAINDICATIONS:** Hypersensitivity to the active substance or to any of the excipients. **SPECIAL WARNINGS AND PRECAUTIONS FOR USE:** Renal impairment: There is limited experience with Repatha in patients with severe renal impairment (defined as eGFR < 30 mL/min/1.73 m2). Repatha should be used with caution in patients with severe renal impairment. Hepatic impairment: In patients with moderate hepatic impairment, a reduction in total evolocumab exposure was observed that may lead to a reduced effect on LDL C reduction. Therefore, close monitoring may be warranted in these patients. Patients with severe hepatic impairment (Child-Pugh C) have not been studied. Repatha should be used with caution in patients with severe hepatic impairment. Dry natural rubber: The needle cover of the glass pre-filled syringe/ autoinjector is made from dry natural rubber (a derivative of latex), which may cause allergic reactions. Sodium content: This medicinal product contains less than 1 mmol sodium (23 mg) per dose, i.e. it is essentially 'sodium-free'. **INTERACTIONS:** An approximately 20% increase in the clearance of evolocumab was observed in patients co-administered statins. This increased clearance is in part mediated by statins increasing the concentration of Proprotein Convertase Subtilisin/Kexin Type 9 (PCSK9) which did not adversely impact the pharmacodynamic effect of evolocumab on lipids. No statin dose adjustments are necessary when used in combination with Repatha. **PREGNANCY AND LACTATION:** Pregnancy: There are no or limited amount of data from the use of Repatha in pregnant women. Repatha should not be used during pregnancy unless the clinical condition of the woman requires treatment with evolocumab. Breast-feeding: It is unknown whether evolocumab is excreted in human milk. A risk to breastfed newborns/infants cannot be excluded. A decision must be made whether to discontinue breast-feeding or discontinue/abstain from Repatha therapy taking into account the benefit of breast-feeding for the child and the benefit of therapy for the woman. Fertility: No data on the effect of evolocumab on human fertility are available. **ADVERSE REACTIONS:** The most commonly reported adverse reactions during pivotal trials, at the recommended doses, were nasopharyngitis (7.4%), upper respiratory tract infection (4.6%), back pain (4.4%), arthralgia (3.9%), influenza (3.2%), and injection site reactions (2.2%). The safety profile in the homozygous familial hypercholesterolaemia population was consistent with that demonstrated in the primary hypercholesterolaemia and mixed dyslipidaemia population. Injection site reactions: The most frequent injection site reactions were injection site bruising, erythema, haemorrhage, injection site pain, and swelling. Paediatric population: There is limited experience with Repatha in paediatric patients. No difference in safety was observed between adolescent and adult patients with homozygous familial hypercholesterolaemia. The safety and effectiveness of Repatha in paediatric patients with primary hypercholesterolaemia and mixed dyslipidaemia has not been established. Elderly population: No overall differences in safety or efficacy were observed between these patients and younger patients. Immunogenicity: In clinical studies, 0.3% of patients (49 out of 17,592 patients) treated with at least one dose of Repatha tested positive for binding antibody development. The patients whose sera tested positive for binding antibodies were further evaluated for neutralising antibodies and none of the patients tested positive for neutralising antibodies. The presence of anti-evolocumab binding antibodies did not impact the pharmacokinetic profile, clinical response, or safety of Repatha. **SPECIAL PRECAUTIONS FOR STORAGE, DISPOSAL AND OTHER HANDLING:** Store in a refrigerator (2°C – 8°C). Do not freeze. Keep in the original carton in order to protect from light. If removed from the refrigerator, Repatha may be stored at room temperature (up to 25°C) in the original carton and must be used within 1 month. Before administration, the solution should be inspected. Do not inject the solution if it contains particles, or is cloudy or discoloured. To avoid discomfort at the site of injection, allow the medicine to reach room temperature (up to 25°C) before injecting. Inject the entire contents.

Abbreviated Prescribing Information Version: HKREPPI02

Please read the full prescribing information prior to administration and full prescribing information is available upon request.
REPATHA® is a registered trademark owned or licensed by Amgen Inc., its subsidiaries, or affiliates.

Reference: 1. Sabatine MS, et al. Supplementary Appendix to: Evolocumab and clinical outcomes in patients with cardiovascular disease. *N Engl J Med.* 2017;376(18):1713-1722.

HK-02026-REP-2019-Mar

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Abstracts

Prof. Geoffrey LIEU

DBA, MHA, LFACHE
Adjunct Professor, HKUSEA

Professor Lieu is a veteran executive in hospital management and healthcare reform. He is also adviser to a number of health policy formulation, health system and hospital reform, and governance and leadership development initiatives.

Prof. Lieu has held top executive positions in community hospitals, academic medical centers and multihospital systems in the US and overseas. During his tenure as a director at the inception of the Hospital Authority, he led the reforms in advancing the management of Hong Kong's public hospitals into a new era. He is also Founder and Chairman Emeritus of The Institute for Health Policy and Systems Research, established in 1997, the first independent not-for-profit healthcare think-tank in Hong Kong at the time. He was the architect and principal author of the Bauhinia Foundation Research Centre's Development and Financing of Hong Kong's Future Health Care published in 2007.

In recent years, he has joint-ventured to invest, develop and operate hospital and healthcare projects in China. In addition, he spends much of his time implementing initiatives to embrace longevity as social and economic powerhouses, in advocating effective financing and protection of the health of the elderly, and in promoting the professionalisation of hospital executives and healthcare leaders.

Opportunities and Challenges in the Greater Bay Area

Opportunities in advancing healthcare for the Greater Bay Area abound. But there are also challenges. Whatever initiatives that are contemplated to harness the opportunities, it is important to recognise that health is a community affair and strongly impacted by its social determinants. To ensure initiatives will be successful and are sustainable, apart from having adequate capital and competent leadership in management, they must also address and are aligned to at least three strategic issues: (1) common objectives – there ought to be clear articulation of shared goals and future developmental direction of the concept of a Greater Bay Area health ecosystem; (2) value creation – the structure and mode of care delivery, quality improvement and financing and payment must be re-designed such that they create added value (as health can be an engine for economic growth) and contribute to the further development of a strong health promoting system; and (3) rewards and incentives - the remuneration or payments of clinicians and other stakeholders are based on performance or outcome and are rewarded equitably and fairly.

Abstracts

Dr. LIU Shao-haei

MBBS(HK), MRCP(UK),MHA(NSW)
President of Hong Kong College of Health Service Executives,
Advisor, Synergy Healthcare Hong Kong

Dr. S. H. Liu has served for a long time at the Hong Kong public medical system. He was the first Medical Superintendent of Tuen Mun Hospital, the first HCE of Ruttonjee hospital, and ex-Chief Manager at Hospital Authority. Dr. Liu has been active in community service and served for various committees of Medical Council of Hong Kong, Hong Kong Red Cross, Advisory Council on AIDS, Auxiliary Medical Service, & etc. He has founded the Innovative Healthcare Hong Kong which is a professional society aiming to promote startup initiative in the healthcare sector. Dr. Liu was awarded CE's Commendation for Community Service (2009) and the Medal of Honour (2019) by the HKSAR government.

101 of Innovative Healthcare - The Role of Medical Entrepreneurs

Being a specialist doctor seems impossible for one to turn into business as the stake is high. The gap in training for management and business is often quoted as the barrier to entrepreneurship for the medical profession. However, the society needs a vigorous and sustainable business model for the evolving disease epidemiology and a challenging era of ageing. Multi-segmental connectivity in biotech, big data analysis, health informatics, wellness apps, digital healthcare and precision medicine is generating a new opportunity for people who are interested in research, to explore, and to organise for better healthy living and effective healthcare provision. This session presents the essential elements of medical entrepreneur as well as the role of the new breed of physicians who can succeed in leading the changes.

Abstracts

Dr. CHU Chung-ming

MBBS(HK), MD(HK), MSc(Respirat Med)(Lond), MRCP(UK), FRCP (Lond, Edin.Glasg), FHKCP, FHKAM(Med), PDipID(HK), Dip Epidemiology And Applied Statistics (CUHK), Specialist in Respiratory Medicine
Honorary Consultant, Department of Medicine & Geriatrics, United Christian Hospital
Private Practice, Virtus Medical Group

Dr. C M Chu is currently Honorary Consultant Physician and formerly Chief of Service (2009 - 2011) of the Department of Medicine & Geriatrics, United Christian Hospital, Hong Kong. He was also formerly President (2007 - 2009) and Governor (2009 – 2013) of the American College of Chest Physicians (Hong Kong & Macau Chapter).

Dr. Chu's primary research interests are in chronic obstructive pulmonary disease (COPD), non-invasive ventilation, home ventilation and emerging respiratory infections. He led the fight against severe acute respiratory syndrome (SARS) in United Christian Hospital in 2003.

Dr. Chu is widely regarded as Hong Kong's leading authority in the research and application of non-invasive ventilation. Dr. Chu has also introduced electromagnetic navigation bronchoscopy (ENB) to Hong Kong and pioneered its use. He has trained a generation of bronchoscopists in Hong Kong, Japan, Korea, Singapore, Taiwan, Malaysia and Thailand in the use of ENB and related technologies.

Dr. Chu has published more than 70 scientific papers, book chapters and thesis on various aspects of respiratory medicine. He was awarded a Medal of Honour by the Hong Kong Government in 2004 for his work.

Small Lung Nodule - What Should Be Done?

Solitary pulmonary nodule (SPN) is a common medical problem. The key concern is it being an early asymptomatic lung cancer[1-2]. Small SPNs are increasingly detected by CT scan, often done for other purposes, or as screening for lung cancer. The burden of SPN is higher in Asia, and the probability of it being malignant is less predictable because tuberculosis is endemic in Asia, and a significant proportion of lung cancer patients in Asia are non-smoker. PET scan and risk calculator developed in Caucasian population are less helpful in the differential diagnosis of the above diagnosis in Asia[3].

Because of the size, some smaller SPN cannot be biopsied with conventional bronchoscopic biopsy. Transthoracic needle aspiration under CT guidance may not be suitable for deeply seated SPNs because of pneumothorax risk. Conventionally, SPNs which cannot be biopsied can be followed by serial CT scans or resected by surgical means. Neither method is ideal because there are false negatives (delayed diagnosis of lung cancer), or false positives (unneccessary surgery for benign pathologies). Both approaches are also resource intensive.

Electromagnetic navigation bronchoscopy (ENB) can improve transbronchial biopsy yield by 70 – 90%, obviating serial CT monitoring or unnecessary surgical resection in many cases[4,5]. It extends the current capability of bronchoscopists and localisation techniques (fluoroscopy, endoscopic ultrasound) to reach and biopsy small SPNs. ENB consists of 2 components: (i) a software to construct a virtual bronchoscopy (VB) image that allows biopsy pathway planning using available CT thorax data; (2) an electromagnetic field generator and sensors to guide the bronchoscope to reach the target(s). The American College of Chest Physicians (Grade 1C evidence) recommends that in patients with peripheral lung lesions difficult to reach with conventional bronchoscopy, electromagnetic navigation guidance is recommended if the equipment and the expertise are available[1].

In this presentation, the theoretical and technical aspects of ENB and related techniques will be discussed[6,7].

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Abstracts

Dr. David Chi-Leung LAM

MBBS(HKU), BSc(BiomedSc)(HKU), MD(HKU), PhD(HKU), FHKCP, FHKAM(Medicine), FRCP (Edin, Glasg, Lond)
Clinical Associate Professor, Department of Medicine, University of Hong Kong

David CL Lam is currently Clinical Associate Professor, in the Division of Respiratory Medicine, Department of Medicine, HKU. He is a respiratory physician with interests in translational research and clinical trials in respiratory diseases including lung cancer, COPD, smoking and airway physiology, and interventional pulmonology.

David Lam is currently in the International Lung Screening Trial consortium studying lung cancer screening in high-risk smokers. He also performs bronchoscopy including endobronchial ultrasonography and autofluorescence imaging.

In his research laboratory at HKU, new lung cancer and immortalised normal bronchial epithelial cell lines representing local Chinese population are established and characterised, and these new cell lines are used as cellular models for translational research on lung cancer, smoking and airway physiology research. Plasma EGFR mutations and circulating tumour markers are being studied in lung cancer.

David Lam is also the President of the Hong Kong Thoracic Society (HKTS) and a co-convenor in the Special Interest Group in Interventional Pulmonology and the Hong Kong Pleural Disease Network under HKTS. He is Deputy Editor of Respirology and an Associate Editor of Respirology Case Report.

Update in Airway Diseases Management: COPD and Asthma

Airway diseases are a major cause of morbidity and mortality in Hong Kong. Acute exacerbations of COPD (AECOPD) place considerable burden on the health care system. An important goal of management would be prevention of acute exacerbation, which is characterised by aggravation from baseline those respiratory symptoms of dyspnea, cough, increased sputum volume or purulence, that calls for acute management and changes in regular medication. Maintenance therapy for COPD in chronic phase with long-acting bronchodilators, including long-acting β2-agonists (LABA) or long-acting anti-muscarinic agents (LAMA), when they are used alone or in combination with inhaled glucocorticosteroid (ICS), have all been shown to be efficacious in reducing COPD exacerbations. Newer evidence supports that dual bronchodilatation is an effective strategy, in preventing both AECOPD frequency and severity. Escalation from dual- to triple-therapy should be considered if AECOPD is persistent despite dual therapy. De-escalation from triple- to dual- therapy with ICS withdrawal has been shown to be safe in stable COPD subjects with relatively low risk of exacerbations.

Other key management initiatives for COPD is smoking cessation and management of comorbidities, which have been shown to reduce the rate of decline of lung function and to improve survival of smokers who quit. Seasonal flu and pneumococcal vaccines should be used to prevent infective exacerbation of COPD. Appropriate exercise training and pulmonary rehabilitation will have a significant impact on patient quality of life as well as reducing chances of exacerbation. Bronchoscopic lung volume reduction could be considered for symptom relief in selected subjects with advanced COPD.

The new release of the Global Initiatives for Asthma (GINA) 2019 Strategy recommended major changes with the commencement of ICS-containing controller instead of short-acting β2-agonists alone for mild asthma. The purpose of such a change in recommendations is again to reduce the risk of asthma exacerbation and to achieve better symptom control. With increasing recognition of the role of peripheral eosinophilia, the introduction of new biologics targeting interleukin-5 (IL5) and IL5-receptor allowed the expansion of treatment options for more-difficult to control asthma, in addition to conventional ICS, anti-IgE antibodies as well as bronchial thermoplasty for selected cases of asthma.

There are many new therapeutic options available for management of COPD in both acute exacerbation and in the chronic phase, and for management of asthma with different clinical presentation and phenotypes. The overall goals of management for airway diseases like COPD and asthma would still be the reduction of risk and severity of exacerbations, preservation of lung function and exercise capacity and hence the quality of life for patients with airway diseases.

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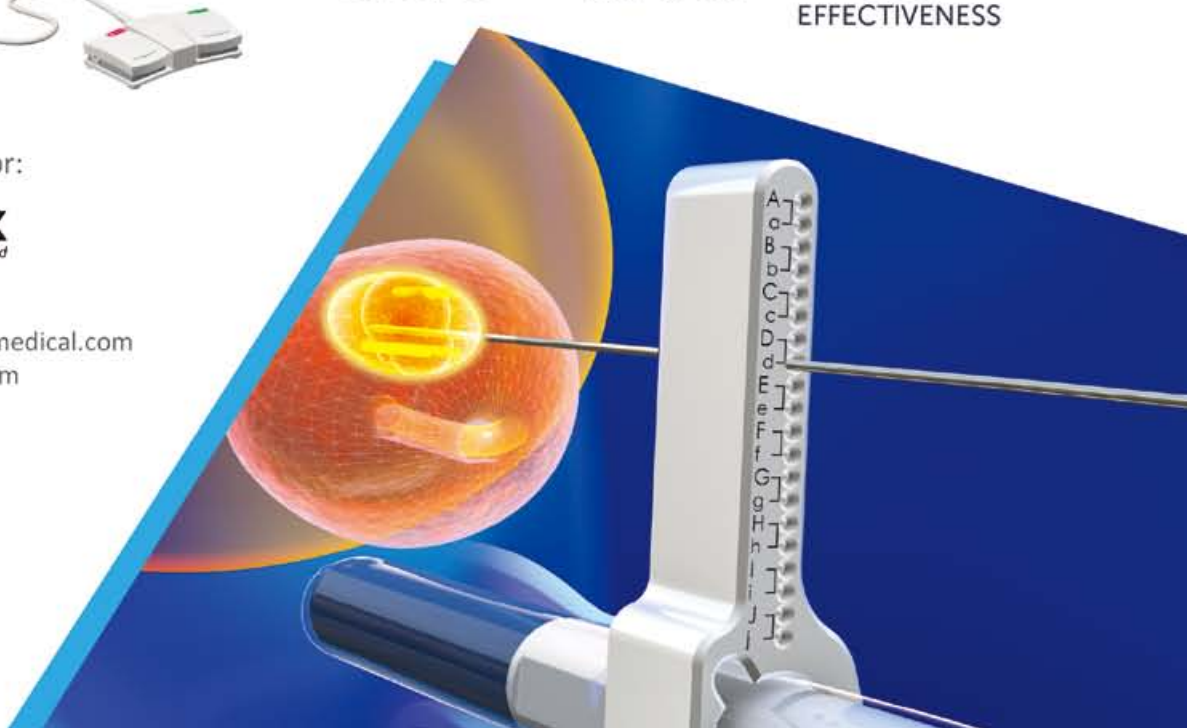

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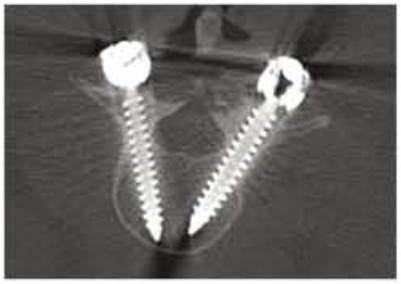

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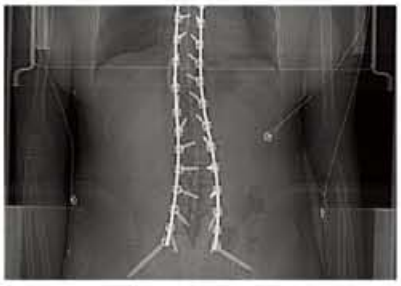
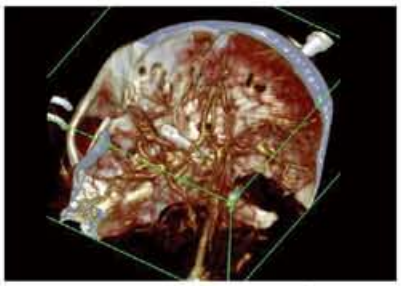
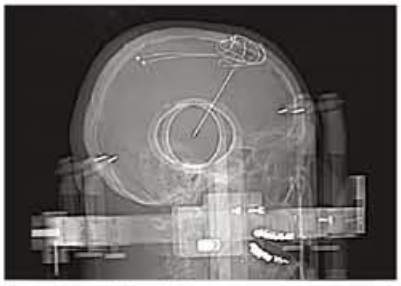


Intra-op PA Scout Scans



Intraoperative CT angiography



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Abstracts

Dr. Andrew Wai-chun YIP

MBBS (HKU) 1981, FHKAM (Surgery)
Specialist in Urology
Private Practice

Dr. YIP Wai Chun, obtained the degrees of Bachelor of Medicine and Bachelor of Surgery from the University of Hong Kong in 1981. Dr. Yip began his career as a surgeon in Queen Mary Hospital. He was awarded the fellowships of the Royal Colleges of Surgeons of Edinburgh and Glasgow in 1986 and that of Australia in 1988. He took up the surgeon's appointment in Kwong Wah Hospital in 1986 and was promoted to the post of consultant surgeon in 1991. Dr. Yip was made Chief of Service of Department of Surgery of Kwong Wah Hospital with the Hospital Authority in 1992. Dr. Yip is a specialist in Urology and has been in private practice since 2012.

Dr. Yip was an awardee of Hong Kong Ten Outstanding Young Persons in 1996. In 2006, he received the Outstanding Staff Award of Hospital Authority. Dr. Yip was Vice-President of the College of Surgeons of Hong Kong from 2004 till 2010. Presently, he is the honorary associate professor, Medicine, of University of Hong Kong and Chinese University of Hong Kong. Dr. Yip is also the honorary consultant and executive director of medical service of Tung Wah Group of Hospitals.

Erectile Dysfunction – The Quest for the Optimal PDE5-I

Erectile Dysfunction has a worldwide prevalence of 20% and arises due to vascular, hormonal, neurological and psychogenic causes. The mainstay of treatment is by phosphodiesterase type 5 inhibitor (PDE5-I). However, the rates of discontinuation are high which can be due to patient's expectations of therapy with respect to response rates, rapidity of response, side effects and duration of action.

The new PDE5-I, Avanafil is both potent and highly selective. Avanafil is specific for the PDE5 enzyme. It has a rapid onset of action and a long duration of action. Most importantly, the incidence of side effect is the least among the 4 marketed PDE5-Is.

Abstracts

Dr. Peter Ka-fung CHIU

MBChB, FRCSEd, FCSHK, FRCSEd(Urol), FHKAM(Surgery)
Clinical Assistant Professor (Honorary)
Associate Consultant, Division of Urology
Department of Surgery, Prince of Wales Hospital
The Chinese University of Hong Kong

Dr. Peter Chiu graduated from the Faculty of Medicine of the Chinese University of Hong Kong and obtained the fellowship in Urology from the College of Surgeons of Edinburgh. He received post-graduate training on Prostate Cancer research and Andrology in the Erasmus Medical Centre in Rotterdam, The Netherlands. He is currently working as an Associate Consultant and Honorary Clinical Assistant Professor in the Prince of Wales Hospital, The Chinese University of Hong Kong. His clinical practice and research focus on prostate cancer, from diagnosis with novel markers like Prostate Health Index (PHI) and MRI-guided targeted prostate biopsy, to the treatment of advanced prostate cancers. He also has special interest in novel treatment of BPH including Greenlaser prostatectomy and Prostate artery embolisation.

MRI USG Fusion Biopsy of Prostate

From the Hong Kong multicentre database for fusion targeted biopsy covering 70% of Urology units, highly variable cancer detection rates in PI-RADS 3 (5-30%) and PI-RADS 4 (15-50%) lesions were observed in different units. Better cancer detection rates were observed in units with pre-biopsy lesion marking by radiologists, and presence of regular multidisciplinary meeting with pathology correlation. Dedicated training programme and close collaboration between Urologists and Radiologists in the field of PCa diagnosis would be needed to support the expanding role of MRI guided diagnosis and therapy.

Systematic prostate biopsy and MRI Ultrasound Fusion biopsy has been more commonly done via transrectal route. With increasing post-biopsy sepsis and antimicrobial resistance, it is more appropriate to do prostate biopsies with transperineal(TP) approach. It has been shown that TP systematic AND fusion biopsy can be easily done with appropriate local anaesthesia(LA) in an out-patient setting.

There are multiple MRI USG fusion biopsy platforms with pros and cons of each system. However, an organ-based real-time tracking mechanism for both lesion-targeting and prostate mapping is considered more accurate and reproducible under LA setting. Precise targeting and mapping would be required if focal treatment is being contemplated in the future.

Abstracts

Dr. TSANG Fan-kwong

MBBS(HK), MRCPsych(UK), FHKAM(Psychiatry), FHKCPsych(HK)
Psychiatrist in private practice

Dr. Tsang worked in public mental health services for 25 years and set up his own private clinic in October 2010.

Dr. Tsang's professional and research interests include psychotherapy and sex therapy, treatment of pathological gamblers, suicide and attempted suicide, newer generation of antipsychotic medications, media and psychiatry, the mental health and art, etc.

Dr. Tsang worked in the field of forensic psychiatry, as visiting psychiatrist to Lai Chi Kok Reception Centre and Siu Lam Psychiatric Centre from 1989 to 1991. During his services, he gained ample experience in conducting forensic psychiatric assessment, preparing court reports and to attend court hearings.

He established a medical psychotherapy service in Castle Peak Hospital and actively practising psychodynamic psychotherapy, treatment for psychosexual disorders and gender re-assignment assessment. He was a trainer in psychotherapy for 8 years.

He established consultation-liaison psychiatric services to Tuen Mun Hospital and Poi Oi Hospital and actively involved in seeing patients in a general hospital setting from 1992 to 2001.

Since 1996, he had been actively involved in clinical trials in newer generation antipsychotics and antidepressant medications. He was the principal investigator for more than 10 international multicentre clinical trials.

He began to take part in the Employee Compensation Assessment and was appointed as a member of Employee's Compensation Assessment Boards since 2005. He also involved in the Employees' Compensation Assessment for post-SARS patients.

He was Chairman of Institute of Mental Health, Castle Peak Hospital 2007-2010. Under his chairmanship, he managed to organise various public mental health education activities, enable the "Art-in-CPH" project to win the best team in the Hospital Authority.

He introduced a Transcranial Magnetic Stimulation Therapy System to Hong Kong in October 2014. The system was approved by the FDA in 2008 for treatment of depression with an unsatisfactory response to antidepressant medications.

Updates on Management of Depression

The lecture covers the various types of mood disorder & the diagnostic methods at the beginning. It will then describe the role of anti-psychotics in the treatment of MDD. Coupled with recent findings on antidepressant therapy, the lecture will discuss on the contemporary treatment option to further improve the cognitive functions as well as QOL for the patients.

Abstracts

Prof. Ellis Kam-lun HON

MBBS, MD(CUHK), FAAP, FCCM, FHKAM(Paed), FHKCPaed
Consultant, Department of Paediatrics and Adolescent Medicine,
The Hong Kong Children's Hospital
Honorary Professor, Department of Paediatrics, & the Hong Kong Institute of Integrative Medicine, The Chinese University of Hong Kong

Dr. Hon is the consultant intensivist at the Hong Kong Children's Hospital. He is a clinical professor (Honorary) at the Department of Paediatrics and the Hong Kong Institute of Integrative Medicine, The Chinese University of Hong Kong. He received undergraduate medical education at the University of Western Australia. He is a Fellow of the American Academy of Pediatricians (FAAP) and Fellow of Critical Care Medicine (FCCM). He received his Doctor of Medicine (MD) at the Chinese University of Hong Kong. He has published more than 300 peer-reviewed scientific papers, books and book chapters; and his research interests include many paediatric issues. He has performed extensive research on atopic diseases, topical emollients, antibiotic, corticosteroid, systemic immunotherapy, food avoidance and dietary supplementation, traditional Chinese medicine and bench research on eczema biomarkers, as well as many paediatric health issues (including SARS, respiratory infections, pneumococcus, asthma, poisoning and injuries). Dr. Hon is particularly keen to educate parents to dismiss a lot of myths and fallacies that hinder good child health.

1. Steroid Phobia in Atopic Dermatitis

Atopic eczema (AE) are common childhood diseases. AE is the prototype of these allergic diseases and is notoriously difficult to manage in the city of Hong Kong. More than 50% of patients with AE will go on to develop asthma or allergic rhinitis. Despite advances claimed in many aspects of AE management, there is still no definite life-long "cure 斷尾 " for the disease.

Treatment of AE is primarily topical and efficacious for the majority of patients. However, AE is often complicated and difficult to manage in society where fallacies (the mind devils 心魔) abound. Effective therapy is impeded by mind devils concerning: (1) skincare versus allergy treatment; (2) ambiguity about optimal bathing and moisturising, (3) hesitation about the use of adequate topical corticosteroid and immunomodulant therapies, (4) food avoidance and dietary supplementation, and (5) complementary and alternative therapies.

There is no substitute for a good rapport with the patients and their families for optimal effective management to be achieved. The first step in patient care is to accurately assess the patient and the family to evaluate possible concerns, anxiety and phobias that could impede therapeutic efficacy.

It is mandatory to perform a detail evaluation of important history and physical features critical for the diagnosis and to review trigger factors and past therapies. Education about the disease should be individualised. Conflicting recommendations of topical steroid use has a detrimental effect on patient outcomes. The many facets of steroid phobias are explored. It is believed that the only chance of success in overcoming the many mind devils is an Integrative Medicine approach with combined Western and Chinese medicine disciplines to this nuisance disease.

2. The Future of Atopic Dermatitis Treatment: Children in Focus

Many novel medications and herbal medicinals have claimed efficacy on Atopic Dermatitis (AD) but paediatric trials may be limited. This review covers evidence on efficacy of topical and oral forms of novel and investigational drugs. Topical agents include emollients, phosphodiesterase E4 (PDE4) inhibitors, and topical herbs. There is scanty evidence that ceramide or natural moisturising factors may provide relief to AD. PDE4 inhibitors have shown promise as an effective topical treatment for mild to moderate AD with minimal adverse events. In addition, dupilumab has shown promise as an effective subcutaneous agent for the treatment of moderate to severe AD in adult patients with little adverse effects. The drug, however, has not been studied in children with AD. Also, the long-term effects of dupilumab are not known. New systemic treatment includes a number of herbal concoctions. Randomised, double-blind placebo-controlled trials (RCTs) have demonstrated topical PDE4 inhibitors are effective and safe in the treatment of both children and adults with AD but further evaluations are needed. RCTs have also shown that subcutaneous dupilumab is an effective and safe agent for the treatment of AD in adults. Long-term effects of these topical and systemic investigational drugs are currently unavailable. Regarding herbal medications, scientific methods are often flawed and objective evidence is lacking.

Abstracts

Dr. YUEN Kwok-keung

MBChB (CUHK), FRCR, FHKCR, FHKAM (Radiology),
MSc in Palliative Medicine
Consultant, Department of Clinical Oncology,
Queen Mary Hospital

Dr. Yuen is the Consultant in Clinical Oncology of Queen Mary Hospital and the Honorary Associate Professor of the Department of Clinical Oncology of the University of Hong Kong.

He graduated from the Chinese University of Hong Kong in 1992 and started clinical oncology specialist training in Tuen Mun Hospital in 1994. He was admitted Fellow of the Royal College of Radiologists in 1997, Fellow of the Hong Kong College of Radiologists and Fellow of the Hong Kong Academy of Medicine in 2000. He was accredited First Fellow of the Palliative Medicine Subspecialty of the Hong Kong College of Radiologists in 2002, and he joined the Department of Clinical Oncology of Queen Mary Hospital in 2014.

He is the ex-chairman of the Hong Kong Society of Palliative Medicine and Chairman of the Palliative Medicine Subspecialty Board of the Hong Kong College of Radiologists. He is also an accredited General Mediator of the Hong Kong International Arbitration Center and the Hong Kong Mediation Accreditation Association Limited. He participated in more than 20 clinical studies and taught in professional, undergraduate and post-graduate palliative care programmes.

Drug Management for Difficult and Refractory Cancer Pain

Pain in cancer patients could be due to cancer, due to treatment or due to concurrent medical problems. Majority of cancer pain could be effectively managed by non-opioid, opioid and adjuvant analgesics as set out in the WHO analgesic ladder. For those who do not respond to ordinary analgesics, it is important to conduct a thorough assessment of the patient's disease, compliance to treatment, pain mechanisms and psychosocial factors. The management of difficult and refractory cancer pain involves a multidisciplinary holistic approach addressing various factors contributing to the pain. Effective and safe prescription of analgesics take account of cancer status, pain diagnosis, patient characteristics and clinical setting. It is a good practice to arrange regular review so that appropriate referral could be made for those who have suboptimal pain control or unacceptable side effects.

Abstracts

Dr. Timmy Chi-wing CHAN

MBBS, FANZCA, FHKCA (Anaesthesiology), FHKAM (Anaesthesiology), FFPMANZCA, FIPP, Dip of Pain Mgt (HKCA)
Pain Physician and Anaesthetic Consultant, Department of Anaesthesiology, Queen Mary Hospital

Dr. Chan is a Pain Medicine Physician and Anaesthetic Consultant at the Department of Anaesthesiology in Queen Mary Hospital, Hong Kong. He is the Clinical Service Director of Pain Management Team in his hospital.

Dr. Chan is a Fellow of the Hong Kong College of Anaesthesthesiologists (HKCA), Australian and New Zealand College of Anaesthetists (ANZCA). He is also a Fellow of the Faculty of Pain Medicine, Australian and New Zealand College of Anaesthetists (FFPM ANZCA) and the Interventional Pain Practice (FIPP), The World Institute of Pain. He is the winner of the Hassenbusch Prize of FIPP.

Dr. Chan has served in multiple advisory and organisational roles, recently chairing the Cancer Pain Management Advisory Board in 2012, and co-chairing the Work Group on Opioid Use for Non-cancer Chronic Pain in Hong Kong.

He has wide-ranging interests, including cancer pain management, interventional pain management for cancer and non-cancer pain, and acute post-operative pain management after major joints replacement.

Novel Treatment on Interventional Pain Relief

It is very common that cancer causes severe pain especially in the very end stage. This causes lots of suffering and pain, not only to patents but also the family members. The multimodal analgesic regime is usually adopted to handle cancer pain. Yet, pain is still a problem even with the aggressive multimodal analgesic regime. Therefore, interventional pain management is one of the essential components in cancer pain management. In this lecture, novel treatment on interventional pain treatment will be discussed.

Abstracts

Dr. Steve Wai-keung LAI

Dr. Lai underwent medical training in the Faculty of Medicine, University of Hong Kong and received MB.,BS degree in 1993. Subsequently, he was trained in the Dept. of Medicine, Tuen Mun Hospital. Dr. Lai's main interest is management of cardiac arrhythmia. He was awarded Hong Kong Heart Foundation Fellow Scholarship in 2001, and spent one year as electrophysiology fellow in the University of Michigan.

Dr. Lai is also interested in research methodology. He studied Epidemiology and Biostatistics in the Chinese University of Hong Kong. He received Postgraduate Diploma in Biostatistics and Epidemiology in 2010, and Master of Science in Biostatistics and Epidemiology in 2011. Dr. Lai was elected as Fellow of the American College of Cardiology in 2011, and Fellow of Royal College Physicians of Edinburg in 2012.

Dr. Lai moved out for private practice in 2012. He is currently working as Consultant Cardiologist, Union Hospital. He also worked as part-time consultant in Tuen Mun Hospital.

Achieving Optimal Management in Lipid

Cardiovascular remains a major burden of premature adult death globally. Despite the proven efficacy of cholesterol lowering with statin therapy in multiple trials, the residual risk of cerebrovascular disease remains very high. The use of various other drug classes including cholesterol absorption inhibitors and recently PCSK9 inhibitors, whether as add on or replacement therapy due to intolerable statin side effects, have proven to be of additional benefits.

Dr. Steve Wai-keung LAI has replaced Dr. Steven Siu-lung LI to be speaker under Session IV A.
This is to replace Page 38.

Abstracts

Dr. Michael Pak-hei CHAN

MD (HK), MBBS (HK), MRCP (UK), FRCP (Lond), FRCP (Edin), FRCP (Glasg), FHKCP, FHKAM (Medicine), FACC
Specialist in Cardiology
Clinical Assistant Professor, Gleneagles Hong Kong Hospital,
The University of Hong Kong

Dr. Chan is the Clinical Assistant Professor in Cardiology of the University of Hong Kong and he is currently working in the Gleneagles Hong Kong Hospital. He obtained his doctoral degree in medicine from the University of Hong Kong with his thesis titled "Stroke Prevention in Atrial Fibrillation – From Atrial Fibrillation Screening to anticoagulation". He is the fellow of the Hong Kong College of Cardiology, the Hong Kong College of Physicians, the Hong Kong Academy of Medicine, Royal College of Physicians of London, Royal College of Physicians of Edinburgh, Royal College of Physicians and Surgeons of Glasgow, and the American College of Cardiology. Prior to the commencement of private practice, he has worked for more than 14 years in the Cardiology Division of Queen Mary Hospital and as a Consultant in Cardiology in The University of Hong Kong-Shenzhen Hospital. His expertise includes percutaneous coronary intervention of complex coronary artery disease and minimally invasive trans-catheter valve therapies, including trans-catheter aortic valve implantation and left atrial appendage occlusion. Dr. Chan has published over 60 peer-reviewed articles in major cardiology journals, including JACC and Circulation. He is also the pioneer in Hong Kong for conducting community-based screening for atrial fibrillation and setting up the emergency 24-hour primary angioplasty service in the public sector.

Antiplatelet therapy after PCI

Dual antiplatelet therapy (DAPT) is an essential component of drug treatment in patients with coronary artery disease who received percutaneous coronary intervention (PCI). Recommendations for DAPT duration post-PCI PCI should consider patient-specific risk factors, clinical presentation leading to PCI, stent type, and procedural factors. Studies demonstrated that prolonged DAPT resulted in a reduction of stent thrombosis (ST) and myocardial infarction (MI) at the cost of increased bleeding. On the other hand, studies of shorter-duration DAPT demonstrated similar mortality, MI, ST, and less bleeding events when compared with longer DAPT duration. Current evidence for strategies of prolonged and abbreviated DAPT following PCI will be reviewed in this lecture.

Abstracts

Dr. Mario Wai-kwong CHAK

MBBS(HKU), MRCP(UK), DCH(Ire), Dip Ger Med (RCPS Glass),
PDipID (HKU), FHKAM(Paediatrics), FHKCPaed
Associate Consultant, Department of Paedaitrics and Adolescent Medicine, Tuen Mun Hospital
The Honorary Clinical Associate Professor of The University of Hong Kong and
The Chinese University of Hong Kong
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 Associate Professor of The University of Hong Kong and 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 Subspecialty of Paediatric Neurology and Developmental behavioural Paediatrician in 2013. Dr Chak is currently the trainer in Paediatrics and Paediatric Neurology. Dr. Chak has special interest in Paediatric Epilepsy. He has received overseas training in EEG, Epilepsy and Pre-surgical 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 Bonne, Foundation 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.

Precision Medicine in Epilepsy

Precision Medicine is achievable by the recent advance of three items. Firstly, the availability of massive data; there is an unprecedented availability of data across and within individuals. Secondly, artificial intelligence through machine learning which is widely used in business and industry, recently increasingly be used in health. Thirdly, compute power increasing compute capacity, including parallel processing through cloud computing.

The recent ILAE classification of epilepsy highlights the importance to find the underlying aetiologies of epilepsy and manage accordingly.
There is a recent great discovery of gene mutation in epilepsy, especially those with medical refractory epilepsy in neonatal and infancy i.e. Early Infantile Epileptic Encephalopathy (EIEE) by using EIEE penal and Next Generation Sequencing.
The early diagnosis of the genetic mutation has transformed the clinical management of epilepsy from the previous empirical trial of anticonvulsant one by one to present specific anticonvulsant to the target of specific genetic channels defect. The loss or gain of function of receptors or channels is also an important factor to determine the choice of anticonvulsants used.

That refractory epilepsy with underlying structural causes or lesion could be potential candidates for epilepsy surgery after multidisciplinary and multimodality evaluation. For those who are not candidates for epilepsy surgery, for example, the underlying genetic or neuro-metabolic disease, we could consider Ketogenic Diet or Vagal Nerve Stimulator.

Moreover, the technological advancement in genetic diagnosis and epilepsy surgery could have revolutionary change of clinical management of epilepsy disorder from previous reactive management to clinical seizure to future more proactive management before the patient' epilepsy becomes fully symptomatic and medical refractory, and hence alter the whole clinical course of the disease and potentially improve cognitive and developmental outcome.

Precision medicine in epilepsy could lead to more early intervention and more effective specific treatment and hence to improve patient seizure and better developmental outcome.

Abstracts

Dr. Venus Fung-ling TAM

MBChB (CUHK), FHKAM (Psychiatry), FHKCPsych, Dip Med (CUHK)
Private psychiatrist (Director of Cordial Medical Centre)

Dr. Tam Fung Ling is currently a private psychiatrist, who graduated from The Chinese University of Hong Kong and subsequently received psychiatric specialist training. Dr Tam is particularly interested in the mental health of children and adolescents. She has been Associate Consultant of Child and Adolescent Psychiatric Team, Castle Peak Hospital and Honorary Clinical Assistant Professor of Department of Psychiatry, University of Hong Kong. She has extensive clinical experience in treating children and adolescents with attention-deficit/ hyperactivity disorder (ADHD), autism spectrum disorder (ASD) and other emotional or mental problems.

Common Paediatric Behavioural and Psychiatric Disorders

This talk provides a brief introduction to the causes, symptoms, and treatment updates of attention-deficit/hyperactivity disorder (ADHD) and autism spectrum disorder (ASD).

Abstracts

Dr. Jenny Shun-wah LEE

Dr. Jenny Lee graduated from The Chinese University of Hong Kong and is a Consultant Geriatrician and the head of Geriatrics in the Department of Medicine in Tai Po Hospital and Alice Ho Miu Ling Nethersole Hospital. She is currently also the Chief of Service of those departments. She is the President of the Hong Kong Geriatrics Society and the Chinese Dementia Research Association.

Dr Lee obtained her MD degree in CUHK and collaborates closely with the Institute of Ageing in the University. She is active in research and has numerous publications in old age epidemiology, health services research, dementia, end of life care and nutrition.

Screening, Diagnosis and Treatment of Early Dementia

Dementia is a common condition in old age and is a major cause of dependency. There is a good case to detect and diagnosis early. There is no evidence from randomised trials that earlier drug treatment impacts on long term cognitive outcome. However, there is evidence that cognitive stimulation can improve cognitive function in older people with early dementia. Secondly, this will allow more time for family caregivers to learn about dementia care and plan ahead. Thirdly, this will allow the people with dementia to have their say in care planning. Therefore we have developed an E cognitive test which can be administered by caregiver in five minutes. With a donation from Hong Kong Jockey Club, the ones who fail the test will be assessed by trained primary care doctors in the community, and those with dementia will be supported by a case manager for one year. In this way, dementia can be diagnosed early and be managed at the primary care level.

Reference

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Dr. Jenny Shun-wah LEE has replaced Prof. Timothy CY KWOK to be speaker under Session IV C. This is to replace Page 42.

Abstracts

Dr. Raymond See-kit LO

MBBS (Lond), MD (CUHK), MHA (UNSW), Dip Geri Med (RCPS), Dip Palliative Med (U Wales), MRCP (UK), FHKAM (Medicine), FRCP (Lond, Edin, Glas)
Clinical Professor (Honorary), Dept of Medicine and Therapeutics, Chinese University of Hong Kong

Dr. Raymond Lo graduated from United Medical and Dental Schools of Guy's and St Thomas' Hospital in London, and received a fellowship from Royal College of Physicians and Hong Kong Academy of Medicine. He is Honorary Clinical Professor of Department of Medicine and Therapeutics, Chinese University of Hong Kong, and also held visiting professorship overseas. Dr. Lo is the Immediate Past President of the Federation of Medical Societies of Hong Kong, and is the Convenor of Care for Advanced Diseases Consortium, dedicated to promoting care for patients with serious illnesses. He is a dual specialist in Palliative Medicine and Geriatrics, and currently serving in HA as Consultant in charge and Cluster-Coordinator in Hospice and Palliative Care at New Territories East. Last but not least, Dr. Lo is the President of British Medical Association (Hong Kong Branch), facilitating with the popular annual BMA(HK) Therapeutics Course.

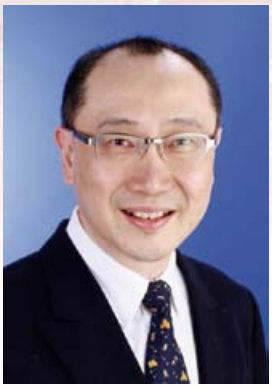
Supportive and Palliative Care for Dementia: From the Beginning Not The End

Our rapidly ageing society is bearing the full brunt of the impact and burden of dementia and its complications. While there is no cure for dementia as yet, we should soldier on with relentless efforts towards the betterment of care for our unfortunate dementia patients and caregivers.

In facing the escalating demand on dementia care, innovative approach and paradigm shift is called for. Integrated medical and social care should be further enhanced, and technology in assisted care is much needed. Palliative care has an increasingly significant role, not just at the end of the life, but at the earlier phase of the disease trajectory, once there is a need. Suitable models of care need to be explored. Clinical approach with case scenarios will be discussed, to illustrate the use of drugs, nutritional supplementations, rehabilitation, technology and various interventions, in relieving the suffering and distress from dementia.

Hong Kong is proud to enjoy the achievement of the long life expectancy for our fellow citizens. Let's concert our efforts to maximise not just the quantity of life, but also the quality of life of our older population.

Abstracts



Dr. Samuel Ka-shun FUNG

MBBS (HKU) FRCPI, FRCPE, FHKCP, FHKAM (Int Med)
Chief of Nephrology & Consultant Physician, Jockey Club Nephrology & Urology Centre
Princess Margaret Hospital

Dr. Samuel Fung is the Chief of Nephrology, Hong Kong Jockey Club Nephrology & Urology Centre, Princess of Margaret Hospital, Hong Kong.
Serving in the Hospital Authority Central Renal Committee as Vice Chairman and the Central Transplant Committee, he has contributed in the pair exchange living renal transplant program in Hong Kong. He is the chairman of the Kowloon West Cluster Transplant Coordinating Committee and 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 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 anemia, BK nephropathy and Nocturnal Home Haemodialysis. Currently, he is the Site Principal Investigator for the studies SONAR on Diabetic Nephropathy; ASCEND study on renal anemia, 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.

Complications of phosphate control in cardiovascular morbidities - Challenges to chronic kidney patients and doctors

There is a well-established association between Chronic Kidney Disease (CKD) and Coronary Vascular Disease (CVD). Patients in the later stages of these conditions are more likely to suffer various other ailments, as the kidneys and heart fail. Hyperphosphataemia is an important consideration for reducing morbidity & mortality in CKD and CVD as it has wide-ranging detrimental effects in both. Thus, the maintenance of therapeutic phosphate levels in the body represents a key target area to slow disease progression.

However, as phosphate is essential to many fundamental processes in vitro, there must be a balance between its addition to and removal from the body, as well as being mindful of the patient's existing regulatory ability. Alongside managing intake of phosphate-rich foods and additives, Sevelamer presents an important treatment option that avoids the risks of metal/calcium accumulation whilst also providing additional benefits.

Three key pivotal studies explore the efficacy of Sevelamer in comparison with calcium-based phosphate binders, confirming its clear viability within the range of phosphate-binding drugs. Primary health care and specialists together play a great role in the patients' treatment journey.

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Abstracts

Dr. CHENG Yuk-lun

MB, ChB(CUHK), MRCP(UK), FHKCP, FHKAM(Med),
FACP, FRCP(Edin), FRCP(London)
Specialist in Nephrology
Chief of Nephrology, Department of Medicine & ICU,
Alice Ho Miu Ling Nethersole Hospital

Dr. Cheng is the Chief of Nephrology of the Department of Medicine and ICU at the Alice Ho Miu Ling Nethersole Hospital. He is the Chairman of the Hong Kong Society of Nephrology, the Chairman of the Home Haemodialysis Working Group, Hospital Authority, and the Clinical Associate Professor of Medicine at the Chinese University of Hong Kong. Dr. Cheng is also a member of the Specialty Board in the Advanced Internal Medicine of the Hong Kong College of Physicians. Internationally, Dr. Cheng is the Vice President of the Local Organizing Committee, Asian Pacific Congress of Nephrology 2020, Board Member of the International Society of Nephrology, North & East Asia Regional Board, and Executive Committee member of the International Association of Chinese Nephrologists.

Dr. Cheng's research interest is in haemodialysis and he has more than 250 local & international presentations, publications and book chapters.

Diabetic Kidney Disease - A Growing Threat in Asia; Counter-Measures

Diabetic kidney disease (DKD) is the leading cause of renal failure in Hong Kong, contributing to more than half of the newly diagnosed end-stage renal disease requiring renal replacement therapy in 2018. DKD is associated with higher morbidity and mortality, and represents a heavy burden on the healthcare system. There is no dispute that DKD is also a growing threat in Asia. Reports from the United States Renal Data System in 2018 showed, out of the top 10 countries with highest incidence rate of treated end-stage renal disease due to diabetic nephropathy, 7 came from Asia. In the present talk, the factors contributing to the increasing trend in DKD are discussed, and measures to prevent progression of DKD are reviewed.

Abstracts

Dr. YAM Kwong-yui

MBBS(HK), FRCS(EDIN)
Chief of Service, Department of Neurosurgery, Tuen Mun Hospital

Dr. Yam Kwong Yui is a consultant and Chief of Service of Department of Neurosurgery Tuen Mun Hospital. He graduated from University of Hong Kong In 1986 and finished his Neurosurgical training in Queen Elizabeth Hospital. His subspecialty development includes neuro-oncology, stereotactic radiosurgery and management of spasticity in cerebral palsy patients. He was trained in the Charlottesville Gamma knife center, University of Virginia, USA and Charity Hospital, Berlin, Germany. TMH commenced the use of Linac base multi-micro-leaves single isocenter radiosurgery in 1998. The team also pioneered the use of frameless stereotactic radiosurgery In Hospital Authority Hospital. He served as President of Neurosurgical Society In year 2012-2016. Currently, he is an active participant of the radiosurgery Chapter of the Society.

Frameless Stereotactic Radiosurgery from Rain Metastasis to AVM, What Next?

This year we commemorate the 10th anniversary of the introduction of Image Guided Radiation Therapy (IGRT) and frameless stereotactic Radio-surgery (fSRS) to HA hospitals. Patients are treated in a completely non-invasive manner, and the use of skull fixation devices like pins and stereotactic frame turns obsolete. The accurate patient localisation and tracking system allows the precise delivery of a conformal radiation dose to the target. We have verified the efficacy and safety of the frameless approach. The technique can be applied to all pathologies like brain metastasis, meningioma, acoustic neuroma and arteriovenous malformation. Frameless approach also provides flexibility and advantages in treatment plan design. Lesions close to organ at risk like the brain stem, optic nerve, chasm and optic tract; big lesions previously not amenable to SRS can now be treated by hypo-fractionation or other techniques. The current single isocenter algorithm only allows treatment of one target at a time. However, with the introduction of new planning software, we are capable of treating many lesions simultaneously. This implies the patients with multiple metastases (>10) can be treated by frameless radio-surgery and avoids the risk of cognitive decline associated with conventional whole brain radiotherapy (WBRT).

Abstracts

Dr. WONG Sui-to

MBBS, MMedSc, FRCSEd(Surgical Neurology), FHKAM
Consultant, Department of Neurosurgery, Tuen Mun Hospital

Dr. Wong Sui-to is currently a Consultant Neurosurgeon at Tuen Mun Hospital. He completed his general neurosurgery training in Hong Kong in 2007, and was awarded the J. Douglas Miller Medal. To pursue subspecialty training in paediatric neurosurgery, he first trained under the guidance of Dr. Dawson Fong, and later completed fellowship training in paediatric neurosurgery at Kaiser Permanente Regional Center for Pediatric Neurosurgery in California in 2013. His main interests include developmental abnormalities of the nervous system, epilepsy surgery, neuro-oncology and intra-operative neurophysiological monitoring.

Epilepsy Surgery: Progress with Technological Advancement

Drug resistant epilepsy (DRE) affects one-third of epilepsy patients. Appropriately selected surgical treatment modalities can bring about good outcomes in a high percentage of patients with DRE. Technological advancement in various fields such as medical imaging, electrode manufacturing, intra-operative navigation, surgical robotics, and implantable devices has enabled us to pinpoint epileptogenic foci and abolish them precisely and safely. More importantly, established epilepsy surgery programmes equipped with multidisciplinary expertise have properly integrated new technologies into clinical practice, and achieved the current standard of seizure control in DRE.

Abstracts

Dr. LO Pui-yee

MBChB (HK), MRCSEd, FHKCORL, FRCSEd (ORL), DCH (Sydney)
ENT Specialist in ENT Department of Yan Chai Hospital

2001-2001 MBChB (HK)
2012 fellowship of the Hong Kong College of Otorhinolaryngologists

Trained in QEH ENT
Associate Consultant in QED ENT (2014 -2018)
Pediatric ENT training in Great Ormond Street Hospital in London, UK
Private practice in ENT
Specialist in YCH ENT (7/2019)

Allergic Rhinitis

Allergic rhinitis (AR) is an inflammatory disorder that causes rhinitis symptoms such as rhinorrhea, nasal obstruction, sneezing and itchiness when expose to environmental allergens. It affects 10-40% of the population. It was classified into seasonal, persistent or occupational AR based on the time and type of exposure and symptoms.

AR is also frequently associated with asthma, which is found in 15% to 38% of patients with AR. It affects patient's quality of life and leads to the progression of asthma. Allergic rhinitis and its impact on Asthma (ARIA) guidelines have been developed to provide updated recommendations for the treatment of AR.

The treatment strategy for allergic rhinitis includes avoidance, normal saline douching, symptomatic pharmacotherapy and immunotherapy. Symptomatic pharmacotherapy includes oral or intranasal antihistamines, intranasal corticosteroids and leukotriene receptor antagonist. Immunotherapy is the only disease-modifying agent for inducing desensitisation. The treatment regime should be tailored to the individual patient based on the severity of symptoms, co-morbidities, type of relevant allergens and persistence of symptoms despite sufficient pharmacological treatment. Sublingual immunotherapy (SLIT) is the majority of immunotherapy prescription nowadays and is known to be safer than subcutaneous immunotherapy. The efficacy of SLIT in grass-pollen induced allergic rhinoconjunctivitis is well documented in adults and children. Some new controlled trials on house dust mite allergy provide evidence of the efficacy of SLIT in adults. SLIT has fewer systemic side effects and majority of adverse effects were related to local reaction such as itching and swelling of oral mucosa. Besides, good quality of efficacious allergen extract and patient compliance is also important.

Abstracts

Dr. Tommy Tsang CHEUNG

MBBS(HK), MRCP(UK), FRCP(Edin, Glasg), FHKCP, FHKAM,
Dip Clin Tox (HKPIC&HKCEM)
Specialist in Rheumatology

Dr Tommy Cheung obtained his fellowship in Rheumatology in 2011, before continuing his training in Clinical Pharmacology and Therapeutics. He was appointed clinical assistant professor in the Department of Medicine, The University of Hong Kong in 2012. His main research interests focus on the pathogenesis of rheumatoid arthritis, efficacy and safety of biologic therapies in inflammatory arthritis and cost effectiveness evaluation.

In 2014, Dr Cheung was appointed deputy medical director of the Phase 1 Clinical Trials Centre. He initiated many phase 1 trials on healthy volunteers and many of these have been published in reputable journals. Dr Cheung joined the Hong Kong Sanatorium & Hospital in 2019 as a Specialist in Rheumatology.

Advances in the Management of Axial Spondyloarthritis

Axial spondyloarthritis (axSpA) is a chronic inflammatory condition characterized by inflammatory back pain and spinal stiffness. It has a broad phenotype which includes ankylosing spondylitis and non-radiographic axial spondyloarthritis. Syndesmophytes and ankylosis of the axial skeleton may develop, causing permanent structural damage and deformity.

In recent years, the treatment armamentarium for axSpA has expanded significantly. In addition to non-steroidal anti-inflammatory drugs, tumor necrosis factor inhibitors and interleukin 17 inhibitors have been widely used in our clinical practice for patients with an inadequate response to the first-line treatment.

Besides, inhibition of structural progression is now possible with biologic therapies and it remains a hot topic in axial spondyloarthritis. Current research strategies aim to test whether disease remission is more achievable with early and stratified use of biologic therapies in patients with axSpA.

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Adverse event should be reported. For further information please contact Hongkong Medical Supplies Ltd., 2806 3112, sales2@hkmedsup.com.hk

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Abbreviations:
CKD = Chronic Kidney Disease, HD = Haemodialysis, IV = Intravenous, ESA = Erythropoiesis Stimulating Agent, TSAT = Transferrin Saturation, Hb = Haemoglobin

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VAD2019

Chairpersons

Dr. Ludwig Chun-hing TSOI

MBChB, MRCP, MPH, FRCSEd, FHKCEM, FHKAM (Emergency Medicine)
Consultant, A&E Department, QMH
Deputy Service Director (Quality & Safety),
Hong Kong West Cluster, Hospital Authority
Honorary Clinical Associate Professor, Faculty of Medicine, Chinese University of Hong Kong

President, Hong Kong Society for Emergency Medicine & Surgery
President, Hong Kong Society for Healthcare Mediation
Member, Regulation Framework and Public Education & Publicity Subcommittees, Steering Committee on Mediation, DoJ

Mr. Benjamin Cheung-mei LEE

Honorary Treasurer of the Federation of the Medical Societies of Hong Kong
Honorary Secretary and Treasurer of the Institute for Health Policy & Systems Research.

Mr. Benjamin Lee joined the Hong Kong Government Service 33 years ago and has dedicated his career in healthcare management ever since. Mr. Lee obtained his first qualification in health administration from the University of New South Wales, Australia, under its Master Degree Program. He has gained vast experience in healthcare management through his various positions in regional acute hospitals and the Hospital Authority Head Office. Given his vast experience and his dedications to the professional advancement of healthcare executives through his contributions in various positions of the Hong Kong Society of Health Service Executives, he was awarded Fellow and Founding Fellow both by the Australian College of Health Service Executives and the Hong Kong College of Health Service Executives in 2003 and 2005 respectively. Mr. Lee is a member of the Institute of Health Services Management of the UK, and a Board Member of the Efficient Consumer Response Hong Kong. Mr Lee is also the Honorary Treasurer of the Federation of the Medical Societies of Hong Kong, and the Honorary Secretary and Treasurer of the Institute for Health Policy & Systems Research. Mr. Lee is currently holding the position of Chief Manager (Business Support Services) of the Hospital Authority, Hong Kong. His main skill set and interests include strategy and policy setting in procurement and materials management, business support services, operational methods and technologies.

Chairpersons

Dr. Jane Chun-kwong CHAN

MD (U of Chicago), FHKCP, FHKAM (Medicine), FRCPE, Diplomate, American Board of Internal Medicine (Pulmonary Disease & Critical Care 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 training in Respiratory and Critical Care Medicine at Stanford University. She joined the Department of Medicine at University of Hong Kong as Clinical Lecturer in 1986. She became doubly accredited by the H. K. College of Physicians in Respiratory Medicine and Critical Care Medicine in 1992. In 1996 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. She has been in private practice since 2005, and is currently Editor-in-Chief of the e-Newsletter of the Hong Kong Institute of Allergy.

Dr. NG Chun-kong

MBBS (HK), MRCP (UK), FHKCP, FHKAM (Medicine), MPH (HK), FRCP (Edin, Lond)
Consultant Respiratory Physician, Department of Medicine, Queen Elizabeth Hospital
Honorary Clinical Associate Professor, The University of Hong Kong
Honorary Clinical Associate Professor, The Chinese University of Hong Kong

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 ventilation, home ventilation and auto-fluorescent bronchoscopy. He is the Course Director of the Hospital Authority Respiratory Failure Management Course since 2017 and Faculty of the Hong Kong Academy Jockey Club Innovative Learning Center for Medicine for the Advanced Simulation Training in Mechanical Ventilation since 2017. 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 member of the KCC/KEC Research and Ethics Committee.

He now serves as the Second Vice President in the Federation of Medical Societies of Hong Kong, Immediate Past President of the CHEST Delegation Hong Kong and Macau, Board Member of the Hong Kong Lung Foundation and EXCO member of the Hong Kong Society of Sleep Medicine.

Chairpersons

Dr. MAK Siu-king

MBBS (HK), MRCSEd, FCSHK, FRCSEd(Urol), FHKAM(Surgery)
Associate Consultant, NTEC Urology Team

Vice President, Hong Kong Society of Practicing Urologists
Council member, Hong Kong Medical Association
Assessor, Inquiry Panel of Medical Council of Hong Kong
President, Hong Kong Public Doctors' Association. (2017-2019)
Special interest in minimal invasive surgery, male infertility, 3D navigation procedure and multi-disciplinary cancer treatment.

Mr. Victor Hip-wo YEUNG

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

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 both HKU and the Chinese University of Hong Kong (HKU). In 2017, he started his own private practice in Wanchai.

Apart from clinical work, Dr. Yeung is an active researcher with many articles published in various international journals. He has also presented in 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 has 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 (JHUHKAA). Also, he is the honorary secretary of Hong Kong Medical Association (HKMA), council member of Medical Council of Hong Kong (MCHK), Federation of Medical Societies of Hong Kong (FMSHK), Hong Kong Society of Endourology (HKSE) and Nocturia Academy.

Chairpersons

Dr. Raymond See-kit LO

MBBS (Lond), MD (CUHK), MHA (UNSW), Dip Geri Med (RCPS), Dip Palliative Med (U Wales), MRCP (UK), FHKAM (Medicine), FRCP (Lond, Edin, Glas)
Immediate Past President,
Federation of the Medical Societies of Hong Kong
President, British Medical Association (Hong Kong)

Dr. Raymond Lo graduated from United Medical and Dental Schools of Guy's and St Thomas' Hospital in London, and received a fellowship from Royal College of Physicians and Hong Kong Academy of Medicine. He is Honorary Clinical Professor of Department of Medicine and Therapeutics, Chinese University of Hong Kong, and also held visiting professorship overseas. Dr. Lo is the Immediate Past President of the Federation of Medical Societies of Hong Kong, and is the Convenor of Care for Advanced Diseases Consortium, dedicated to promoting care for patients with serious illnesses. He is a dual specialist in Palliative Medicine and Geriatrics, and currently serving in HA as Consultant in charge and Cluster-Coordinator in Hospice and Palliative Care at New Territories East. Last but not least, Dr. Lo is the President of British Medical Association (Hong Kong Branch), facilitating with the popular annual BMA(HK) Therapeutics Course.

Dr. Mario Wai-kwong CHAK

MBBS(HKU), MRCP(UK), DCH(Ire), Dip Ger Med (RCPS Glass), PDipID (HKU), FHKAM(Paediatrics), FHKCPaed
Associate Consultant, Department of Paedaitrics and Adolescent Medicine, Tuen Mun Hospital
The Honorary Clinical Associate Professor of The University of Hong Kong and The Chinese University of Hong Kong
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 Associate Professor of The University of Hong Kong and 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 Subspecialty of Paediatric Neurology and Developmental behavioural Paediatrician in 2013. Dr. Chak is currently the trainer in Paediatrics and Paediatric Neurology. Dr. Chak has special interest in Paediatric Epilepsy. He has received overseas training in EEG, Epilepsy and Pre-surgical 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 Bonne, Foundation 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.

Chairpersons

Dr.Kingsley Hau-ngai CHAN

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

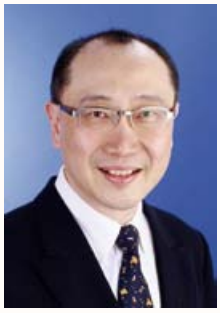
Dr. Kingsley Chan is a dermatologist in private practice in Hong Kong. He received his medical training at the University of Hong Kong. He completed his basic physician training at the Queen Mary Hospital and his specialist training at the Department of Health. He has overseas training in St John's Institute of Dermatology.
Dr. Chan's practise encompasses both medical and cosmetic dermatology. He is also an active member in the Hong Kong medical professional and serves as a Council Member at the Hong Kong Medical Association (2008 – present) and Federation of Medical Societies (2008 – present). He is also an editor of Hong Kong Medical Diary (2008 – present) and the HKMA CME Bulletin (2009 – present). He works as honorary consultant dermatologist in Hospital authority and honorary assistant professor, department of medicine, CUHK and adviser of the consumer council.

Prof. Bernard Man-yong CHEUNG

MB BChir, PhD, FRCP, FRCPE, FHKCP, FHKAM(Medicine), FBPhS, FBHS
Sun Chieh Yeh Heart Foundation Professor in Cardiovascular Therapeutics at the University of Hong Kong
Honorary Consultant Physician, Queen Mary Hospital

Bernard Cheung is the First Vice-President of the Federation of Medical Societies of Hong Kong. He graduated from the University of Cambridge. In 2007-2009, he held the chair in Clinical Pharmacology and Therapeutics in Birmingham. He is now the Sun Chieh Yeh Heart Foundation Professor in Cardiovascular Therapeutics at the University of Hong Kong, and heads the Division of Clinical Pharmacology and Therapeutics. He is an Honorary Consultant Physician of Queen Mary Hospital and the Medical Director of the Phase 1 Clinical Trials Centre. He is an Honorary Professor at the Hong Kong University Shenzhen Hospital and a Visiting Professor of Shenzhen University. He is the Editor-in-Chief of Postgraduate Medical Journal. He has more than 300 publications, 7900 citations and an h-index of 45.

Dr. Sammel Ka-shun FUNG



MBBS (HKU) FRCPI, FRCPE, FHKCP, FHKAM (Int Med)
Chief of Nephrology & Consultant Physician, Jockey Club Nephrology & Urology Centre
Princess Margaret Hospital

Dr. Samuel Fung is the Chief of Nephrology, Hong Kong Jockey Club Nephrology & Urology Centre, Princess of Margaret Hospital, Hong Kong.
Serving in the Hospital Authority Central Renal Committee as Vice Chairman and the Central Transplant Committee, he has contributed in the pair exchange living renal transplant program in Hong Kong. He is the chairman of the Kowloon West Cluster Transplant Coordinating Committee and 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 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 anemia, BK nephropathy and Nocturnal Home Haemodialysis. Currently, he is the Site Principal Investigator for the studies SONAR on Diabetic Nephropathy; ASCEND study on renal anemia, 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.

Chairpersons

Dr. Stephenie Ka-yee LIU

First Fellow, Subspecialty of Developmental and Behavioral Paediatrics (Dec 2013)
Fellowship of Hong Kong College of Paediatrician (June 2004)
Fellowship of Hong Kong Academy of Medicine (Paediatrics) (June 2004)
Bachelor of Medicine and Bachelor of Surgery, The University of Hong Kong (July 1993)
Senior Medical Officer, Child Assessment Service, Department of Health.

Current Post/ work: Senior Medical Officer, CAS, DH since 2007. Head of the Disruptive behavioural team/ Acquired cognitive impairment team/ Knowledge Management team/ Public and Professional Education team.
Honorary appointment/ Post: Accredited College Trainer of the Hong Kong College of Paediatrician in both Basic and Higher training
Honorary Secretary of the Hong Kong Society of Child Neurology and Developmental Paediatricis (HKCNDP)
Member of Subspecialty Board of Developmental-Behavioral Paediatrics of HK College of Paediatrics

Ms. Tina Woan-tyng YAP

BSC Pharmacy (USA), Licenced Pharmacist (HK)
Executive Committee Member, The Federation of Medical Societies of Hong Kong

Ms. Tina Yap is the Executive Committee Member and House Committee Chairperson of The Federation of Medical Societies of Hong Kong.
Ms. Yap graduated from the School of Pharmacy at the University of Kansas, USA. While in the US, she had vast experience in hospital pharmacy. She was also a certified nursing home pharmacy consultant.
Currently, Ms. Yap works for a pharmaceutical company now as the company pharmacist. She oversees pharmaceutical product registration, marketing, management in distribution practice & code of practice.
Ms. Yap is also the founding & current chairman of The Pharmaceutical Distributors Association of Hong Kong.

Dr YUNG Chun-yu

MBBS MRCP (UK) FRCP (Edin & Lond) FHKCP FHKAM (Med)
Chief of Service, Department of Medicine & Geriatrics, Pok Oi Hospital & Tin Shui Wai Hospital
Chief of Nephrology, Department of Medicine & Geriatrics, Pok Oi Hospital & Tin Shui Wai Hospital

Dr. Yung possesses over 29 years' experience in practising general medicine. He is currently Chief of Service of the Department of Medicine & Geriatrics, Pok Oi Hospital & Tin Shi Wai Hospital. He is a nephrologist by specialty and had been Chief of Nephrology in these hospitals since 2015.
Dr. Yung is currently the Cluster Program Director of Advanced Internal Medicine Board of the Hong Kong College of Physicians and was responsible for higher physician training in NTW cluster. He also actively participates in promoting the Self-learning tool program, an online program for trainees as an integral part of their training in AIM when he was appointed as Member of the SLT Committee under HKCP in 2015.
Dr. Yung's contribution to the community and professional bodies was instrumental in 2012 when he was elected as Council Member of the Hong Kong Society of Nephrology. He then served as Hon Treasurer of HKSN since 2018.
He is now the Vice chairman of the Cluster Drugs & Therapeutics Committee of NTWC. His major service at corporate level includes Chairman of the Medication Orders & Decision Support Working Group of Hospital Authority (HA) since 2017, as well as Co-chairman of the eHR, IS Domain Group on Drug record, a combined working group from HA & Food & Hygiene Bureau.

Chairpersons

Dr. Warren Wa-hou TAI

MD,,PhD
Consultant Neurosurgeon
President, Macau Neuromedical Society
Chief, Department of Neurosurgery, CHCSJ MACAU
Director, Macau Children Assessment & Early Intervention Center

Dr Tai is currently actively engaged in clinical work and research in neurosurgery in Macau. His main interests are cerebrovascular diseases, epilepsy and congenital disorders, and he has published more than 30 papers in various journals. He is also involved in healthcare administration and medical education, and is a board member of Macau Medical Academy, focusing on physician's training.

Dr. YAM Kwong-yui

MBBS(HK), FRCS(EDIN)
Chief of Service, Department of Neurosurgery, Tuen Mun Hospital

Dr Yam Kwong Yui is consultant and Chief of Service of Department of Neurosurgery Tuen Mun Hospital. He graduated from University of Hong Kong In 1986 and finished his Neurosurgical training in Queen Elizabeth Hospital. His subspecialty development include neuro-oncology, stereotactic radiosurgery and management of spasticity in cerebral palsy patients. He was trained in the Charlottesville Gamma knife center, University of Virginia, USA and Charity Hospital, Berlin, Germany. TMH commenced the use of Linac base multi-micro-leaves single isocenter radiosurgery in 1998. The team also pioneered the use of frameless stereotactic radiosurgery In Hospital Authority Hospital. He served as President of Neurosurgical Society In year 2012-2016. Currently he is an active participant of the radiosurgery Chapter of the Society.

Dr. CHAN Kai-ming

MBBS(HK), MRCP(UK), DTM&H(UK), PDipID(HK), FHKAM(Medicine), FHKCP, M Sc(Epidemiology and Biostatistics)(CUHK)
Private Practice, Specialist in Infectious Disease

Dr. Chan Kai Ming is a Private Specialist in Infectious Disease since 2016. He previously worked in Tuen Mun Hospital, New Territories of West Cluster, Hospital Authority of Hong Kong since his graduation in 1993, Faculty of Medicine, The University of Hong Kong. Dr. Chan obtained his fellowships in Advance Internal Medicine & Infectious Disease in 2005. From 2006 to 2016, Dr. Chan was posted as Associate Consultant in Infectious Disease Management, New Territories West Cluster. Microbiology & Infectious Disease Team was set up, and Dr. Chan has extensive exposure in the field of both Microbiology and Infectious Disease. His team provided consultation services to all clinical departments on management of infection and infection control. During his stay in Hospital Authority, he was the QA/QC Chairman, Clinical Pathology, Tuen Mun Hospital, Trainer in Infectious Disease, Examination Board Member in Infectious Disease. Currently, Dr. Chan is a member of the Working Group on Influenza Vaccination (WGIV), Centre for Health Protection, Department of Health, Council Member of Hong Kong Society of Infectious Diseases, Executive Committee Member of The Federation of Medical Societies of Hong Kong. His special interest is the use of antibiotics and antibiotics stewardship programme. His team has seen over thirty thousand cases of complicated problems related to the use of antibiotics and infection.

ONEXTON®

(Clindamycin Phosphate and Benzoyl Peroxide) Gel, 1.2%/3.75%

The equalibrium between

Efficacy and Tolerability

↓60%
in inflammatory acne at 12 weeks. (n=253)[1]

↓52%
in comedonal acne at 12 weeks. (n=253)[1]

Proven Safety

No patients discontinuation due to TEAE* in clinical trials.[2]

Formulated for Acne

Preservative-free, surfactant-free and alcohol-free[1]

*TEAE: Treatment-Emergent Adverse Event

References: 1. ONEXTON Gel HK prescribing information. 2. Pariser DM, Rich P, Cook-Bolden FE, Korotzer A. An aqueous gel fixed combination of clindamycin phosphate 1.2% and benzoyl peroxide 3.75% for the once-daily treatment of moderate to severe acne vulgaris. J Drugs Dermatol. 2014;13(9):1083-1089.

Indication: ONEXTON Gel is a combination of clindamycin phosphate (a lincosamide antibacterial) and benzoyl peroxide indicated for the topical treatment of acne vulgaris in patients 12 years of age and older.

Important Safety Information

Contraindictaion Hypersensitivity: ONEXTON Gel is contraindicated in those individuals who have shown hypersensitivity to clindamycin, benzoyl peroxide, any components of the formulation, or lincomycin. Anaphylaxis, as well as allergic reactions leading to hospitalization, has been reported in postmarketing use with ONEXTON Gel. **Colitis/Enteritis** ONEXTON Gel is contraindicated in patients with a history of regional enteritis, ulcerative colitis, or antibiotic-associated colities. **Warning and precautions: Colitis** Systemic absorption of clindamycin has been demonstrated following topical use of clindamycin. Diarrhea, bloody diarrhea, and colitis (including pseudomembranous colitis) have been reported with the use of topical and systemic clindamycin. If significant diarrhea occurs, ONEXTON Gel should be discontinued. Severe colitis has occurred following oral and parenteral administration of clindamycin with an onset of up to several weeks following cessation of therapy. Antiperistaltic agents such as opiates and diphenoxylate with atropine may prolong and/or worsen severe colitis. Severe colitis may result in death. Studies indicate toxin(s) produced by Clostridia is one primary cause of antibiotic-associated colitis. The colitis is usually characterized by severe persistent diarrhea and severe abdominal cramps and may be associated with the passage of blood and mucus. Stool cultures for Clostridium difficile and stool assay for C. difficile toxin may be helpful diagnostically. **Ultraviolet Light annd Environmental Exposure** Minimize sun exposure (including use of tanning beds or sun lamps) following drug application.

To reported SUSPECTED ADVERSE REATIONS, contact Bausch & Lomb Hong Kong at 2213 3333.

HK-PH-2019-03-009

BAUSCH + LOMB

Bausch & Lomb (H.K.) Ltd.
Room 1502-07, 15/F, One Kowloon,
1 Wang Yuen Street, Kowloon Bay, Hong Kong
Tel: 2213 3333

Memo

THE FEDERATION OF MEDICAL SOCIETIES OF HONG KONG
香 港 醫 學 組 織 聯 會

Annual Scientific Meeting 2019
Innovative Medical Technologies

Lucky Draw

To win the iPad mini

Name:_____(Block letter)

1	2	3	4	5	6
7	8	9	10	11	12

Terms and Conditions

1. To enter the Lucky Draw you must collect a chop after you visit to a booth.
2. You have to fill the ten boxes above with all the ten chops.
3. Put the completed form into lucky draw box before 15:40, 22 September 2019.
4. Only one entry per person. Entries on behalf of another person will not be accepted and joint submissions are not allowed.
5. One winner will be chosen from a random draw, the winner will receive an iPad mini.
6. If the winner does not show up at ballroom C at 4:45pm and respond to the announcement, then the prize will be forfeited.

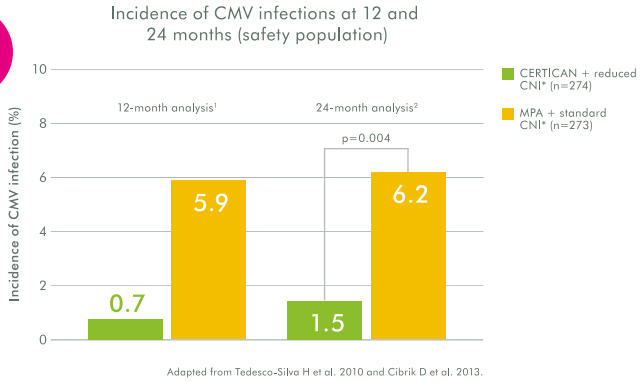
Memo

TRUST CERTICAN®

Efficacy meets Protection

SIGNIFICANT REDUCTION IN THE INCIDENCE OF VIRAL INFECTION

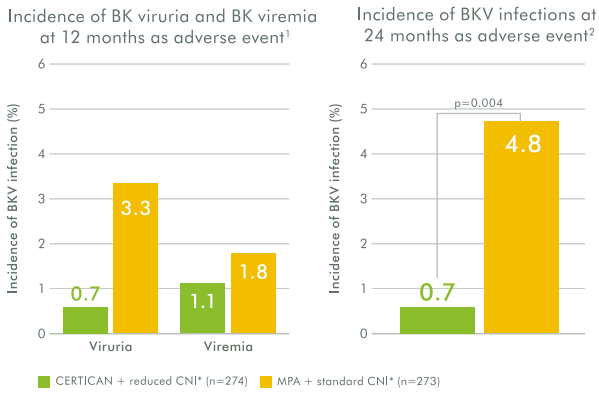
CMV



Adapted from Tedesco-Silva H et al. 2010 and Cibrik D et al. 2013.

SIGNIFICANT REDUCTION IN THE INCIDENCE OF VIRAL INFECTION

BKV



References: 1. Tedesco-Silva H Jr et al. Am J Transplant 2010; 10(6): 1401-1413. **2.** Cibrik D et al. Transplantation 2013; 95(7): 933-942.

CERTICAN Tablets

Important note: Before prescribing, consult full prescribing information. Presentation: Everolimus. Tablet containing 0.25, 0.5, 0.75, or 1.0 mg of everolimus.

Indications: Kidney and heart transplantation

Certican is indicated for the prophylaxis of organ rejection in adult patients at low to moderate immunological risk receiving an allogeneic renal or cardiac transplant. In kidney and heart transplantation, Certican should be used in combination with ciclosporin for microemulsion and corticosteroids. Liver transplantation Certican is indicated for the prophylaxis of organ rejection in patients receiving a hepatic transplant. In liver transplantation, Certican should be used in combination with tacrolimus and corticosteroids. Dosage: Recommended general daily dose is 0.75 mg b.i.d. for kidney and heart transplant population. For the hepatic transplant population, recommended general daily dose is 1.0 mg b.i.d with the initial dose starting approximately 4 weeks after transplantation. Whole blood trough levels of everolimus should be closely monitored in patients with impaired hepatic function. Dose should be reduced to approximately two-thirds in patients with mild hepatic impairment, to approximately one half in patients with moderate hepatic impairment and approximately one third of the normal dose for patients with severe hepatic impairment. Very limited experience in children. Contraindications: Hypersensitivity to everolimus, sirolimus or to any of the excipients. Warnings/Precautions: An increased risk of acute rejection and an improved renal function were observed in patients who discontinued the administration of ciclosporin from month 4.5 after renal transplantation compared with those who continued the administration of ciclosporin. Caution is advised with the use of thymoglobulin (rabbit anti-thymocyte globulin) induction and the Certican/ciclosporin/steroid regimen. Increased risk of developing lymphomas and other malignancies, particularly of the skin. Oversuppression of the immune system with increased susceptibility to infections, especially infections with opportunistic pathogens (bacterial, fungal, viral, protozoal) which can include BK virusassociated nephropathy which can lead to kidney graft loss and the potentially fatal JC virusassociated progressive multiple leukoencephalopathy (PML). Patients should be monitored for hyperlipidemia. Angioedema has been observed with Certican, in the majority of cases reported, patients were receiving ACE inhibitors as co-medication. Proteinuria is increased in transplant recipients and may increase in severity when Certican is substituted for a calcineurin inhibitor in a maintenance therapy renal transplant patient with pre-existing mild proteinuria. Reduced doses of ciclosporin are required for use in combination with Certican in order to avoid renal dysfunction. In liver transplant study Certican with reduced exposure tacrolimus has not been found to worsen renal function in comparison to standard exposure tacrolimus. Regular monitoring of blood drug levels (everolimus and ciclosporin), proteinuria and renal function is recommended. Co-administration of everolimus with known strong CYP3A4 inhibitors and inducers is not recommended unless the benefit outweighs the risk. Increased risk of kidney arterial and venous thrombosis, resulting in graft loss, mostly within the first 30 days post-transplantation. Certican, like other mTOR inhibitors, can impair healing increasing the occurrence of post-transplant complications. Lymphocele is the most frequently reported such event in renal transplant recipients and tends to be more frequent in patients with higher body mass index. The frequency of pericardial and pleural effusion is increased in cardiac transplant recipients and the frequency of incisional hernias in liver transplant recipients. The concomitant administration of Certican with a calcineurin inhibitor (CNI) may increase the risk of CNI-induced hemolytic uremic syndrome/thrombotic thrombocytopenic purpura/thrombotic microangiopathy. Cases of interstitial lung disease (ILD), some fatal, have been reported with Certican. Mostly, the condition resolves after discontinuation of Certican and/or addition of glucocorticoids. However, fatal cases have also occurred. Certican may increase the risk of new-onset diabetes mellitus. Blood glucose concentrations should be monitored closely in patients treated with Certican. There are literature reports of reversible azoospermia and oligospermia in patients treated with mTOR inhibitors. Potential risk for male infertility with prolonged Certican therapy. Women of child-bearing potential: Highly effective contraception methods must be used while receiving Certican, and for up to 8 weeks after ending treatment. Pregnancy: Should not be used during pregnancy unless clearly necessary. Breast-feeding: Should not be used by breast-feeding women. Excipients: Patients with rare hereditary problems of galactose intolerance, severe lactase deficiency or glucose-galactose malabsorption should not take this medicine. Interactions: Caution should be exercized when co-administering everolimus with CYP3A4- and CYP2D6-substrates having a narrow therapeutic index. Caution with concomitant use of rifampicin, rifabutin or ketoconazole, itraconazole, voriconazole, clarithromycin, telithromycin or ritonavir, as it may be necessary to modify the dose of Certican. Caution with inducers of CYP3A4 (e.g St. John's Wort, anticonvulsants, (e.g carbamazepine), phenobarbital, phenytoin, anti-HIV drugs (e.g efavirenz, nevirapine), erythromycin, verapamil, inhibitors of PgP, and moderate inhibitors of CYP3A4 (e.g. antifungal substances: fluconazole, calcium channel blockers: nicardipin, diltiazem, protease inhibitors: nelfinavir, indinavir, amprenavir, octreotide and midazolam. Avoid grapefruit juice, grapefruit. Avoid use of live vaccines. Adverse reactions: Very common (>10%) Infections (viral, bacterial, fungal), lower respiratory tract infection, upper respiratory tract infection, urinary tract infections, anemia/erythropenia, leucopenia, thrombocytopenia, hyperlipidemia (cholesterol and triglycerides), new onset diabetes mellitus, hypokalemia, insomnia, anxiety, headache, venous thromboembolic events, hypertension, cough, dyspnea, diarrhea, nausea, vomiting, abdominal pain, pericardial and pleural effusion, peripheral edema, healing impairment, pain and pyrexia. Common (1 to 10%) Malignant and unspecified tumors, skin neoplasms, wound infection, sepsis, pancytopenia, thrombotic thrombocytopenic purpura/hemolytic uremic syndrome, tachycardia, epistaxis, lymphocele, renal graft thrombosis, stomatitis/mouth ulceration, oropharyngeal pain, myalgia angioedema, acne arthralgia, pancreatitis, proteinuria, erectile dysfunction, renal tubular necrosis, incisional hernia and hepatic enzyme abnormal. Uncommon (0.1 to 1%) Lymphomas, male hypogonadism, interstitial lung disease, hepatitis (non-infectious) and jaundice. Unknown Pulmonary alveolar proteinosis, erythroderma and leukocytoclastic vasculitis.

HK1907711095

NOVARTIS
Novartis Pharmaceuticals (HK) Ltd
7/F, Citi Tower, One Bay East, 83 Hoi Bun Road, Kwun Tong, Kowloon, Hong Kong
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CERTICAN® everolimus

SMALL PILL BIG IMPACT

XELJANZ in 1-2-3

- 1st and ONLY monotherapy superior to MTX in inhibiting radiographic progression[1,2]
- 2nd line positioning in ACR 2015[3] and EULAR 2016[4]
- 3 hours half-life[1]

XELJANZ® ABBREVIATED PACKAGE INSERT

1. **TRADE NAME:** XELJANZ®
2. **PRESENTATION:** 5 mg tofacitinib tablet: White, round, immediate-release film-coated tablets, debossed with "Pfizer" on one side, and "JKI 5" on the other side.
3. **INDICATIONS:** XELJANZ (tofacitinib) is indicated for the treatment of adult patients with moderately to severely active rheumatoid arthritis who have had an inadequate response or intolerance to methotrexate. It may be used as monotherapy or in combination with methotrexate or other non-biologic disease-modifying antirheumatic drugs (DMARDs). XELJANZ in combination with biologic DMARDs or with potent immunosuppressants, such as azathioprine and cyclosporine is not recommended.
4. **DOSAGE:** Recommended dose of XELJANZ is 5 mg twice daily. Moderate or severe renal insufficiency or moderate hepatic impairment: Recommended dose is XELJANZ 5 mg once daily. **(Please refer to the full Prescribing Information for details)**
5. **CONTRAINDICATIONS:** None.
6. **WARNINGS & PRECAUTIONS:** Serious and sometimes fatal infections due to bacterial, mycobacterial, invasive fungal, viral, or other opportunistic pathogens have been reported in rheumatoid arthritis patients receiving XELJANZ. Avoid use of XELJANZ if a serious infection develops until the infection is controlled. Prior to starting XELJANZ, perform a test for latent tuberculosis; if it is positive, start treatment for tuberculosis prior to starting XELJANZ. Monitor all patients for active tuberculosis during treatment, even if the initial latent tuberculosis test is negative. Caution is also recommended in patients with a history of chronic lung disease, or in those who develop interstitial lung disease, as they may be more prone to infection. Lymphoma and other malignancies have been observed in patients treated with XELJANZ. Epstein Barr Virus-associated post-transplant lymphoproliferative disorder has been observed at an increased rate in renal transplant patients treated with XELJANZ and concomitant immunosuppressive medications. Avoid use of XELJANZ during an active, serious infection, including localized infections. Viral reactivation, including cases of herpes virus reactivation (e.g., herpes zoster), were observed in clinical studies with XELJANZ. The impact of XELJANZ on chronic viral hepatitis reactivation is unknown. Patients who screened positive for hepatitis B or C were excluded from clinical trials. Screening for viral hepatitis should be performed in accordance with clinical guidelines before starting therapy with XELJANZ. The risk of herpes zoster is increased in patients treated with XELJANZ and appears to be higher in patients treated with XELJANZ in Japan and Korea. Non-melanoma skin cancers (NMSCs) have been reported in patients treated with XELJANZ. Periodic skin examination is recommended for patients who are at increased risk for skin cancer. Other malignancies were observed in clinical studies and post-marketing setting including, but not limited to, lung cancer, breast cancer, melanoma, prostate cancer and pancreatic cancer. Gastrointestinal Perforations – Use with caution in patients that may be at increased risk. Laboratory Monitoring –Recommended as lymphocyte abnormalities, neutropenia, anemia, liver enzyme elevations and lipid elevations are possible. Immunizations – Live vaccines: Avoid use with XELJANZ. **(Please refer to the full Prescribing Information for details)**
7. **INTERACTIONS:** Potent inhibitors of Cytochrome P450 3A4 (CYP3A4) (e.g., ketoconazole): Reduce dose to 5 mg once daily. One or more concomitant medications that result in both moderate inhibition of CYP3A4 and potent inhibition of CYP2C19 (e.g., fluconazole): Recommended dose is XELJANZ 5 mg once daily. Potent CYP3A4 inducers (e.g., rifampin): May result in loss of or reduced clinical response. **(Please refer to the full Prescribing Information for details)**
8. **PREGNANCY AND LACTATION:** There are no adequate and well-controlled studies in pregnant women. The estimated background risks for major birth defects and miscarriage for the indicated population are unknown. It is not known whether tofacitinib is excreted in human milk. Decision should be made whether to discontinue breastfeeding or to discontinue the drug.
9. **SIDE EFFECTS:** The most common serious adverse reactions were serious infections. The most commonly reported infections with XELJANZ were upper respiratory tract infections, nasopharyngitis, urinary tract infections, diverticulitis and appendicitis

(Please refer to the full Prescribing Information for details)

Reference: Hong Kong PI (version date/LPD date) Sep 2017. Date of preparation: Aug 2018 Identifier number: XELJ0818

FULL PRESCRIBING INFORMATION IS AVAILABLE UPON REQUEST.

References:

1. Xeljanz (tofacitinib). Prescribing Information. Pfizer Corporation Hong Kong Limited. Version Sep 2017.
2. Fleischmann R, Kremer J, Cush J, et al; for the ORAL Solo Investigators. Placebo-controlled trial of tofacitinib monotherapy in rheumatoid arthritis. *N Engl J Med.* 2012; 367(6):495-507
3. Singh JA, Saag KG, Bridges SL Jr, et al. 2015 American College of Rheumatology guideline for the treatment of rheumatoid arthritis. November 6 2015. *Arthritis Care Res.* DOI:10.1002/acr.22783
4. Smolen JS, Landewé R, Bijlsma J, et al. EULAR recommendations for the management of rheumatoid arthritis with synthetic and biological disease-modifying antirheumatic drugs: 2016 update. March 17, 2017. *Ann Rheum Dis* 2017;0:1-18. DOI:10.1136/ annrheumdis-2016-210715

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