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HIV and Sexually Transmitted Infection

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立即成為
「慢性疾病共同治理先導計劃」家庭醫生
Enrol as a Family Doctor under the Chronic Disease Co-Care Pilot Scheme

參與 **政府資助計劃**
包括「慢性疾病共同治理先導計劃」
Participate in Government-subsidised schemes including Chronic Disease Co-Care Pilot Scheme

透過政府資助計劃
擴大服務覆蓋面
Expand service coverage through Government-subsidised schemes

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The Cover Shot

Sketches from a Madrid Muse: A Journey Through Art's Beauty

This still life, inspired by the treasures found from my trip to Spain, highlights the vibrant hues of freshness and the figure of a fan reminiscent of the lively spirit of flamenco dancing. Painting this still life has been a most joyful process for me. Enriched by my teachers' guidance, I refined my drawing skills via adhering to the core technical principles to navigate the objects' details. Through this expressive medium, I celebrated nature's beauty, weaving in Spain's zest for life and its radiant sunshine. May all of us invite brilliant colour, in whatever forms, to enrich our lives.

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Advancing the Fight: Updates in HIV and Sexually Transmitted Infections

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Immediate Past President,
The Hong Kong Society for Infectious Diseases

Issue Editor

Dr Ada Wai-chi LIN

As we navigate the evolving landscape of infectious diseases in Hong Kong, the theme of this issue - HIV and sexually transmitted infections (STIs) - could not be more timely. Despite an encouraging decline in new HIV cases, with 365 reported in 2024 and 180 in the first half of 2025, the local epidemic remains a pressing concern, with men who have sex with men (MSM), accounting for over 60% of projected new cases by 2030. These figures underscore the need for continued vigilance and innovation in clinical practice to combat the infection. Yet, in recent years, there have been continuous groundbreaking advancements that promise to reshape prevention, treatment, and management strategies. This editorial highlights key developments, contextualised for Hong Kong's healthcare ecosystem, and introduces feature articles in this issue that delve deeper into specific facets: landscape of HIV treatment options and public health control measures, prevention of maternal-to-child-transmission (MTCT) of HIV, management of comorbidities from antiviral therapy, and human papillomavirus (HPV) testing.

The past year has seen remarkable progress in HIV therapeutics, driven by novel antiretroviral (ARV) agents and modalities. Chief among these is lenacapavir, a long-acting capsid inhibitor now FDA-approved as the first twice-yearly injectable for HIV prevention, offering six months of protection per dose. Presented at the International AIDS Society (IAS) 2025 conference, data from trials like PURPOSE[1] demonstrated near-100% efficacy in preventing HIV acquisition among cisgender women, with similar promise in diverse populations. For treatment, lenacapavir's integration into regimens for multidrug-resistant HIV has been transformative, reducing viral loads rapidly and sustaining suppression with minimal dosing. Regarding using newer antiretroviral agents, updated CDC guidelines for pre-exposure prophylaxis (PrEP) incorporate newer ARVs like cabotegravir[2], emphasising rapid initiation to avert infections. WHO's 2025 recommendation for swift ART in HIV-mpox coinfections underscores the need to mitigate opportunistic risks[3].

Preventing MTCT of HIV has seen renewed focus, with WHO's guidance on triple elimination of HIV, syphilis, and hepatitis B virus (HBV) released in 2025. This integrated, person-centred framework promotes universal screening and antiretroviral therapy (ART) initiation during pregnancy, building on antiretroviral regimens that have slashed transmission rates globally. In India, recent estimates highlight progress through enhanced modelling and access, reducing vertical transmissions significantly. ART's role in suppressing maternal viral loads and modulating immune activation is pivotal, with studies affirming its safety and efficacy. A universal antenatal HIV screening programme has been implemented in Hong Kong since 2001. Rapid HIV testing targeting women presented late in peripartum was also integrated into the local MTCT programme in 2008[4]. The article on the reduction in maternal transmission of HIV in this issue provides evidence-based strategies, including neonatal prophylaxis, tailored for the local context.

Antiviral therapy's complications - ranging from metabolic disturbances to drug interactions - demand proactive management. At CROI 2025, sessions on ageing and complications highlighted ART's long-term effects, advocating for personalised monitoring. In Hong Kong, with access to ART and good HIV care, people living with HIV should be prepared for long term medical multidisciplinary care as part of integrated HIV care. Our feature on prevention of complications from antiviral therapy offers tools for side effect mitigation, including lipid management and bone health assessments. As for STIs, HPV is one of the most commonly encountered infections and could potentially lead to serious consequences. Yet at the same time, it is preventable in terms of infection as well as progression to serious outcomes among high risk infections. The article featuring HPV testing provides an update in this important aspect.

In conclusion, these updates empower Hong Kong's medical community to advance towards UNAIDS' 95-95-95 targets of HIV infection by 2030. By embracing long-acting antiviral agents, integrated prevention and complication management, we can further reduce transmissions and improve the quality of life of people living with HIV. Local doctors and healthcare professionals are urged to engage with the Advisory Council's strategies, advocate for equitable access, and participate in ongoing education. Together, we can turn these scientific strides into tangible health gains for our patients. Last but not least, the lifestyle article of this issue depicted an art journey in Spain this summer, with the author also contributing his painting of still life as the cover. May this issue bring all of you a vibrant and colourful year of 2026 ahead.

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An Update on HIV Testing Recommendations

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Dr Siu-tim NG Dr Bonnie Chun-kwan WONG

This article has been selected by the Editorial Board of the Hong Kong Medical Diary for participants in the CME programme of the Medical Council of Hong Kong (MCHK) to complete the following self-assessment questions in order to be awarded 1 CME credit under the programme upon returning the completed answer sheet to the Federation Secretariat on or before 31 December 2025.

THE CURRENT STATE OF HIV MEDICINE

With the advancement of antiretroviral therapy (ART), Human Immunodeficiency Virus (HIV) infection has shifted from a deadly disease to **a manageable chronic medical condition**. Early testing and diagnosis allow early initiation of ART, which not only effectively prevents the progression of HIV infection into advanced HIV disease (AHD) or acquired immunodeficiency syndrome (AIDS), but also hastens one's immune recovery. Moreover, scientific evidence has proven that a sustained undetectable viral load will not result in HIV transmission via sexual contact (known as "**Undetectable equals Untransmittable",** or "**U=U**"). An earlier achievement of viral suppression can thus prevent ongoing transmission as a result of '**Treatment as Prevention' (TasP)**.

THE LATEST LOCAL HIV EPIDEMIOLOGY AND THE CHALLENGES IN HIV RESPONSE IN HONG KONG

In Hong Kong, the prevalence of HIV infection among the general public has remained at 0.1%, a level well below the global average. The annual number of newly reported HIV cases in Hong Kong has declined for nine consecutive years since 2015, and in 2024, on average, there was one newly reported case every day. Sexual contact remains the most common route of transmission accounting for over 95% of the newly reported cases.

Despite a decline in the number of newly reported HIV cases, there is an increasing proportion of late presenters among them[1]. Late presenters refer to individuals with a very low CD4 count (less than 200 cells/mm^3) or those who have already progressed to AIDS at the time of HIV diagnosis. The proportion of late presenters has risen from 28.5% in 2014 to as high as 40 to 60% in recent years. Those who presented late were more likely to be aged 50 or above, non-Chinese Asians, and male or female contracting HIV via heterosexual contact. The Centre for Health Protection (CHP) has conducted in-depth analyses and found that the proportion of late presenters among high-risk populations (such as men who have sex with men, and sex workers) was around 40 to 50%, while, not surprisingly, those who do not belong to high-risk populations had an even higher proportion of late presenters of up to 60 to 70%. It is believed that people who do not belong to high-risk populations may have overlooked their risk of acquiring HIV infection and have been less proactive in seeking HIV testing.

People who present late are not only at greater risks of developing concurrent opportunistic infections or malignancies, but they also tend to have poorer and slower immune recovery and have a higher risk of mortality. Moreover, with an unsuppressed HIV viral load, these individuals who are unaware of their HIV status are more likely to transmit the virus to their sexual partners compared to those who are diagnosed early during their course of HIV infection[2].

Globally, the Joint United Nations Programme on HIV/AIDS (UNAIDS) has set the 95-95-95 targets in the global AIDS strategies[3], aiming for 95% of people living with HIV (PLWH) to be aware of their HIV status, 95% of people who know that they are PLWH to be put on ART, and 95% of people who are on ART to be virally suppressed. Early testing and diagnosis have thus become the key to a successful HIV response. To address the phenomenon of a high proportion of late presenters, an effective HIV testing strategy is therefore essential for achieving the 95-95-95 target.

BARRIERS TO HIV TESTING

Various barriers of HIV testing, such as social stigma and misconceptions related to HIV, have been identified and contributed to HIV late presentations[4]. Studies conducted in Asia[5] also identified several factors that could have contributed to HIV late presentation, including fear of stigmatisation and discrimination to both testing and accessing treatment; lack of perceived risk and lack of knowledge by individuals; and lack of referral for testing by healthcare providers. These factors are also relevant in our locality and effort should be made to tackle these barriers.

ADDRESSING THE BARRIERS TO HIV TESTING

Different strategies are employed to enhance the

coverage of HIV testing services in Hong Kong. Promotional campaigns have been launched to increase the public awareness of HIV testing (the latest Announcement in the Public Interest (API) related to HIV testing can be viewed at https://www.rrc.gov.hk/english/z47.html). Besides, a new HIV testing recommendation has been released by the Scientific Committee and AIDS and STI (SCAS)[6], with an aim to increase the awareness among healthcare providers, from all different specialities and healthcare settings, to proactively offer HIV testing to their clients who may benefit from HIV testing.

Who should be tested

In general, HIV testing is indicated in the following contexts:

(1) As part of integral clinical care

In Hong Kong, HIV testing is being offered with an 'opt-out' approach in certain settings:

- Universal antenatal testing programme (UATP)
- Individuals diagnosed with tuberculosis
- Attendees of methadone clinics
- Attendees of sexual health clinics or people seeking testing and management of sexually transmitted infections

The 'opt out' approach not only increases the uptake rate of HIV testing but also reduces the fear of stigma and discrimination among individuals seeking HIV testing. A systemic review and meta-analysis have shown that an 'opt-out' approach has resulted in a higher test uptake rate compared to an 'opt-in' approach[7].

(2) For individuals with behavioural or epidemiological risk

HIV testing should also be offered for individuals with epidemiological or behavioural risk factors that put them at increased risk of exposure to HIV, for example:

- People who have multiple sex partners, or people whose sex partner(s) have multiple sex partners
- Sex workers and their clients
- People who inject or use drugs
- Men who have sex with men (MSM)
- People in the transgender community who have sex with men
- People originated from areas of unknown or high HIV prevalence, or whose sex partners did
- Sex partners of people living with HIV with unknown treatment status or detectable viral load

(3) For individuals with clinical indicators

HIV testing should be performed for conditions which are known as 'HIV indicator conditions', examples are as followed[8,9].

- Individuals adopting pre-exposure prophylaxis (PrEP)[10] should receive HIV testing prior to the initiation of PrEP and regularly at a three-month interval
- Individuals receiving post-exposure prophylaxis (PEP)[11] for HIV should be tested before starting PEP and at follow-up
- Individuals who attend healthcare facilities for drug-related mental health conditions should be enquired about risk behaviours and offered HIV testing
- People with a medical diagnosis that would impact the way either HIV or the disease itself is managed, for example, Hepatitis B
- People diagnosed with conditions sharing the same transmission mode as HIV, such as any sexually transmitted infections, hepatitis B, hepatitis C or mpox
- Conditions suggesting underlying dysregulated immunity, such as recurrent herpes zoster, chronic diarrhoea, unexplained blood dyscrasia or weight loss of unknown cause

Some studies have demonstrated that late presenters might have presented to the healthcare system with an HIV indicator condition at some time before being diagnosed with HIV infection[12], suggesting that the occurrence of these conditions is indeed an opportunity for earlier HIV testing and diagnosis for these individuals, leading to earlier treatment and improved health outcomes.

Apart from these HIV indicator conditions, it is clear that individuals presenting with AIDS-defining illnesses (ADI) should be offered HIV testing. Common examples of these ADIs include *Pneumocystis jirovecii* Pneumonia (PCP), Oesophageal candidiasis, *Mycobacterium tuberculosis* infection, disseminated non-tuberculosis Mycobacterial infection, CMV disease, *Talaromycosis*, Kaposi Sarcoma and lymphoma etc. A summary of common examples of HIV indicator conditions and ADIs can be found in Table 1 of the latest HIV testing guidelines[6].

(4) For the general population without the abovementioned factors

In Hong Kong, a significant proportion of individuals with newly diagnosed HIV infection do not belong to any of the classical key populations and they do not have any of the abovementioned clinical, epidemiological or behavioural indications. Since sexual contact is the major route of HIV transmission in Hong Kong, it is recommended to offer HIV testing to all people who have ever had sex. Similar recommendations have also been adopted in other regions such as the United States of America[13] and Singapore[14].

It is important to note that obtaining a detailed history is not a prerequisite for testing, especially in the context of client-initiated testing in the absence of indications. In this case, a person's preference not to disclose their risk factors should be respected and HIV testing should be conducted.

Fig 1: Screen capture of the HIV testing website www.hivtest.gov.hk showing the two different modalities of HIV self-testing (Excerpted from www.hivtest.gov.hk)

METHODS OF HIV TESTING

Different options of HIV testing are available to cater for the different needs of different individuals. These include conventional laboratory-based testing, point-of-care testing (POCT) and self-testing. Self-testing may offer more privacy and provide an opportunity to improve acceptance to testing among individuals who might experience unease associated with conventional testing[15], and these testing kits are available to obtain through ordering from the government's HIV testing website in Hong Kong.

Regardless of the type of testing method used, one must bear in mind that there is a window period for all types of HIV testing. Considering all antibody-based tests associated with different window periods, a negative HIV antibody test performed 90 days from an exposure can declare an individual not infected by HIV if there are no further exposures. For more details on the performance and limitations, including the window period of different testing methods, one may refer to the HIV testing webpage (www.hivtest.gov.hk).

APPROACH TO THE TESTING RESULTS

Although HIV infection is now a manageable chronic medical condition, it is still associated with stigma and a negative impression in certain individuals. Therefore, a positive HIV result could still lead to significant psychological stress. Post-test counselling is essential to facilitate an individual with a newly diagnosed HIV to adjust to the diagnosis. Healthcare providers should deliver the test results to their clients face-to-face in a setting where privacy is ensured. Healthcare providers should also address the concern and fear of their clients and update them with the latest knowledge of HIV infection and treatment. Individuals with newly diagnosed HIV infection should also be linked to clinical care as soon as possible. Important concepts such as 'Treatment as prevention', the importance of drug adherence, and 'Undetectable equals Untransmittable (U=U)' should also be explained to the clients to encourage early linkage to care and adherence to antiretroviral treatment. Currently, there are three public HIV clinics in Hong Kong, including the Kowloon Bay Integrated Treatment Centre of the Department of Health, Infectious Disease Special Medical Clinic of Princess Margaret Hospital and the AIDS Clinical Service of Queen Elizabeth Hospital.

DH2293 e-form

Apart from linkage to HIV clinical care, healthcare providers are also encouraged to anonymously report newly diagnosed HIV cases to the HIV/AIDS voluntary reporting system using the HIV/AIDS report form (DH2293). The data submitted would be kept strictly confidential and would be used for facilitating epidemiological analysis of the HIV trend in Hong Kong.

On the other hand, individuals with negative testing results should not be simply dismissed. These individuals should be assessed for any ongoing risk factors for acquiring HIV infection. Adoption of different HIV prevention strategies, such as behavioural modification, use of PrEP, counselling on harm reduction or other supportive services may be appropriate in selected individuals to minimise their risks of HIV acquisition in the future. Repeated testing should also be considered with these individuals if indicated.

CONCLUDING REMARKS

Early diagnosis and treatment of HIV infection have been shown to improve outcomes in individual clients and reduce transmission in the community. An effective HIV testing strategy is the essential first step for the achievement of UNAIDS 95-95-95 targets. Healthcare providers should be more aware of the clinical, epidemiological and behavioural risks and offer HIV testing proactively if indicated. With the effort from healthcare professionals across different specialties and settings, it is hoped that HIV testing can be normalised and people living with HIV are diagnosed early, facilitating their health and reducing transmission

within the community. All individuals with newly diagnosed HIV should be offered counselling tailored to their needs and be linked to clinical care as soon as possible, while those with negative results should be linked to the relevant preventive service as appropriate.

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MCHK CME Programme Self-assessment Questions

Please read the article entitled "An Update on HIV Testing Recommendations" by Dr Siu-tim NG and Dr Bonnie Chun-kwan WONG and complete the following self-assessment questions. Participants in the MCHK CME Programme will be awarded CME credit under the Programme for returning completed answer sheets via fax (2865 0345) or answer link: https://forms.gle/S29sJ8DL6TEpXx6S8 or by mail to the Federation Secretariat on or before 31 December 2025. Answers to questions will be provided in the next issue of The Hong Kong Medical Diary. (Address: Duke of Windsor Social Service Bldg., 4/Fl., 15 Hennessy Rd., Wan Chai. Enquiry: 2527 8898)

Questions 1 - 10: Please answer T (true) or F (false)

1. **Individuals having a CD4 count of less than 200 cells/mm^3 at the time of HIV diagnosis usually have a similar immune recovery compared to those having a higher presenting CD4 count.**
2. **The annual number of new cases of HIV infection and the proportion of late presenters among newly reported HIV cases in Hong Kong has decreased in recent years.**
3. **Offering HIV testing as part of integral clinical care, for example, in Universal Antenatal Testing Programme (UATP) or during sexual health consultation, can improve the acceptance to HIV testing.**
4. **For individuals without any behavioural or epidemiological risk factors, HIV testing should not be offered unless there are strong clinical indications.**
5. **For people who use methamphetamine and related psychostimulants during sexual activities, only those who use the drugs via the injection route are considered to have a higher risk of HIV infection.**
6. **A negative HIV antibody test performed immediately after an exposure cannot rule out HIV infection safely.**
7. **A healthcare provider should obtain a detailed history on the risk factors of HIV acquisition before offering HIV testing for an individual.**
8. **Individuals with positive HIV result should be referred to the Social Hygiene Clinic if he/she wishes to be followed up in the public sector.**
9. **Post-test counselling is not essential for individuals with newly diagnosed HIV infection because HIV is now a manageable chronic medical condition.**
10. **Individuals with negative HIV test results should be evaluated for on-going risk factors of HIV acquisition and referred to suitable preventive services.**

ANSWER SHEET FOR DECEMBER 2025

Please return the completed answer sheet to the Federation Secretariat on or before 31 December 2025 for documentation. 1 CME point will be awarded for answering the MCHK CME programme (for non-specialists) self-assessment questions.

An Update on HIV Testing Recommendations

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Answer Link

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

Name (block letters):_____ HKMA No.: _____ CDSHK No.: _____

HKID No.: __ __ - __ __ __ __ X X (X) HKDU No.: _____ HKAM No.: _____

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Answers to November 2025 Issue

Updates on Classification of JIA and Management of Non-systemic JIA

1. F 2. T 3. T 4. T 5. F 6. T 7. F 8. F 9. F 10. T

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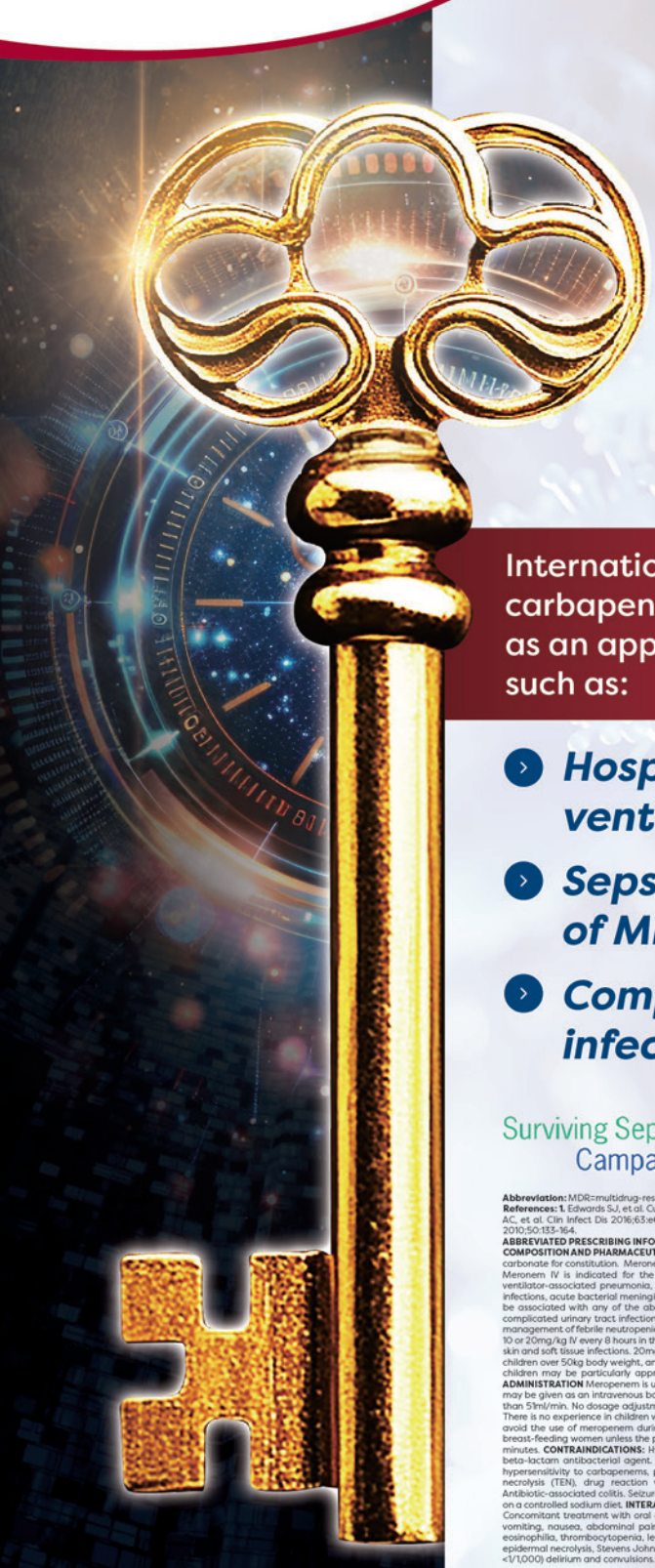

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- ***Sepsis or septic shock and high risk of MDR[6]***
- ***Complicated intra-abdominal infections[7]***

Surviving Sepsis Campaign · ERS · SIS Surgical Infection Society · IDSA Infectious Diseases Society of America

Abbreviation: MDR=multidrug-resistant

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ABBREVIATED PRESCRIBING INFORMATION

COMPOSITION AND PHARMACEUTICAL FORM: Meronem IV is presented as a sterile white powder containing meropenem; 500mg or 1g as the trihydrate blended with anhydrous sodium carbonate for constitution. Meronem IV injection contains 208mg sodium carbonate for each gram of meropenem (anhydrous potency). **THERAPEUTIC INDICATIONS AND POSOLOGY:** Meronem IV is indicated for the treatment of the following infections in adults and children aged 3 months and older, such as severe pneumonia including hospital and ventilator-associated pneumonia, complicated urinary tract infection, complicated intra-abdominal infections, intra- and post-partum infections, complicated skin and soft tissue infections, acute bacterial meningitis, neutropenic patients with fever that are suspected to be due to a bacterial infection and bacteraemia that occurs in association or suspected to be associated with any of the above-listed infections. **ADULT AND ADOLESCENTS** 500mg or 1g IV every 8 hours in the treatment of severe pneumonia (including HAP and VAP), complicated urinary tract infections, complicated intra-abdominal infections, intra- and post-partum infections, complicated skin and soft tissue infections. 1g IV every 8 hours in the management of febrile neutropenic patients. 2g IV every 8 hours in the treatment of acute bacterial meningitis. **CHILDREN** (from 3 months to 11 years of age and up to 50kg body weight) 10 or 20mg/kg IV every 8 hours in the treatment of severe pneumonia (including HAP and VAP), complicated urinary tract infections, complicated intra-abdominal infections, complicated skin and soft tissue infections. 20mg/kg IV every 8 hours in the management of febrile neutropenic patients. 40mg/kg IV every 8 hours in the treatment of acute bacterial meningitis. For children over 50kg body weight, an adult dose should be administered. A dose of up to 2g three times daily in adults and adolescents and a dose of up to 40mg/kg three times daily in children may be particularly appropriate when treating some types of infections, such as infections due to less susceptible bacterial species, or very severe infections. **DOSAGE ADMINISTRATION** Meropenem is usually given by intravenous infusion over approximately 15 to 30 minutes. Alternatively, meropenem doses of up to 1g in adults or 20mg/kg in children may be given as an intravenous bolus over approximately 5 minutes. **DOSAGE ADJUSTMENT** The dose for adults and adolescents should be adjusted when creatinine clearance is less than 51ml/min. No dosage adjustment is necessary in patients with hepatic insufficiency or elderly patients with normal renal function or creatinine clearance values above 50ml/min. There is no experience in children with altered hepatic or renal function. **PREGNANCY:** No or limited amount of data from the use of meropenem in pregnant women. It is preferable to avoid the use of meropenem during pregnancy. **LACTATION:** Small amounts of meropenem have been reported to be excreted in human milk. Meropenem should not be used in breast-feeding women unless the potential benefit for the mother justifies the potential risk to the baby. **METHOD OF ADMINISTRATION:** IV bolus over 5 minutes, IV infusion over 15-30 minutes. **CONTRAINDICATIONS:** Hypersensitivity to the active substance or any of the excipients, or any other carbapenem antibacterial agent. Severe hypersensitivity to any other beta-lactam antibacterial agent. **SPECIAL WARNINGS AND PRECAUTIONS FOR USE:** Enterobacteriaceae, Pseudomonas aeruginosa and Acinetobacter spp. resistance. History of hypersensitivity to carbapenems, penicillin or other beta-lactam antibiotics. Severe cutaneous adverse reactions (SCAR), such as Stevens-Johnson syndrome (SJS), toxic epidermal necrolysis (TEN), drug reaction with eosinophilia and systemic symptoms (DRESS), erythema multiforme (EM) and acute generalised exanthematous pustulosis (AGEP). Antibiotic-associated colitis. Seizures. Hepatic function monitoring. Direct antiglobulin test (Coombs test) seroconversion. Concomitant use with valproic acid/sodium valproate. Patients on a controlled sodium diet. **INTERACTIONS:** Probenecid can increase the elimination half-life and plasma concentration of meropenem. Meronem may reduce serum valproic acid levels. Concomitant treatment with oral anti-coagulants. **UNDESIRABLE EFFECTS: COMMON** (≥1/100 to <1/10) rash, pruritic, inflammation, pain, headache, thrombocythaemia, diarrhoea, vomiting, nausea, abdominal pain, increase in transaminases, alkaline phosphatase and lactate dehydrogenase. **UNCOMMON** (≥1/1000 to <1/100) oral and vaginal candidiasis, eosinophilia, thrombocytopenia, leucopenia, neutropenia, agranulocytosis, haemolytic anaemia, angioedema, anaphylaxis, paraesthesiae, antibiotic-associated colitis, urticaria, toxic epidermal necrolysis, Stevens Johnson syndrome, erythema multiforme, thrombophlebitis, pain at the injection site, increase in blood bilirubin, creatinine and urea. **RARE** (≥ 1/10,000 to <1/1,000) delirium and convulsions. **NOT KNOWN** DRESS syndrome. **SPECIAL PRECAUTIONS FOR STORAGE:** Do not store above 30°C. Do not freeze. Date of revision of text: 2 Dec 2024.

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Management of Comorbidities in People Living with HIV

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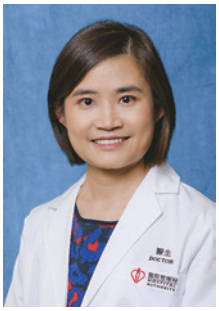

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BACKGROUND

With the expanded use of effective antiretroviral therapy (ART) in recent decades, HIV has transformed from a fatal infection to a chronic condition. As people with HIV (PWH) are surviving longer, the prevalence of chronic end organ diseases has increased[1]. Despite virologic suppression, studies have shown an increased risk of comorbidities compared to the demographically matched uninfected population at all ages[2-5]. In addition, comorbidities may appear from 10 to 20 years earlier than they do among people without HIV[6-7]. Therefore, understanding and managing comorbidities, in addition to sustained viral suppression, has become essential to restore health in PWH.

IMMUNOLOGICAL CONSEQUENCES OF HIV INFECTION AND CHRONIC INFLAMMATION

Ongoing HIV replication is believed to sustain chronic immune dysfunction, and such defects induced by HIV are not completely restored despite early-initiated and long-term ART. These chronic immune abnormalities allow certain mechanisms such as cytomegalovirus chronic replication, dysbiosis or bacterial translocation to occur, which result in low-level inflammation, promote immunosenescence and ultimately leads to the development of comorbidities.

Comorbidities in PWH

1. Cardiovascular and metabolic diseases
Atherosclerotic cardiovascular diseases have tripled in the past 20 years and are among the leading causes of hospitalisations, disability, and death among PWH[8]. It is estimated that PWH have a 1.5- to 2-fold increased risk of developing ASCVD[9]. Increase ASCVD in PWH is multifactorial. Firstly, the use of certain class of ART, namely Protease Inhibitors contribute partly to this excess risk as it was linked to the development of cardiovascular disease risk factors, such as dyslipidaemia, lipodystrophy, and glucose intolerance. Some antiretroviral drugs, such as abacavir, are also implicated as an association with higher risk of cardiovascular disease events was observed[10]. Secondly, chronic inflammation leads to accelerated development of atherosclerosis through vascular inflammation, endothelial dysfunction, hypercoagulability, and disrupted cholesterol transport and capacity[11-12]. PWH are at slightly higher risk for developing diabetes, which is associated with a longer time living with HIV, chronic low levels of inflammation, oxidative stress, and mitochondrial damage caused by HIV treatment[13]. Thirdly, traditional risk factors including smoking, also held a position as smoking rates among PWH are above the general population.

2. Kidney disease
Chronic Kidney Disease is reported commonly in PWH with a global prevalence of 6.4% in a recent systematic review[14]. While HIV-related renal disorders, such as HIV-associated nephropathy continues to be one of the reasons, the pattern of disease has changed significantly over time due to the consequences of other common comorbidities in PWH, such as diabetes and hypertension. Regarding HIV specific risk factors, the use of some antiretroviral drugs, low CD4+ T cell counts, high HIV viral load and history of AIDS-defining illness were found to link to the development of kidney disease[15-16].

3. Liver disease
Co-infection with hepatitis B and hepatitis C is common in PWH, so is metabolic dysfunction-associated steatotic liver disease. Liver disease has been estimated to account for 13%-18% of all-cause mortality in PWH and is one of the leading causes of non-AIDS-related death[17]. Apart from viral hepatitis, hepatic steatosis and oxidative stress, bacterial translocation with activation of hepatic macrophages and stellate cells, and direct toxicities from alcohol and drugs of abuse are contributing to development of liver diseases in PWH. Notably, the use of integrase inhibitor appears to result in more weight gain and treatment emergent obesity[18].

4. Lung disease
Lung disease in PWH is associated with both infectious and non-infectious conditions. While many of the AIDS-defining illnesses, including Pneumocystis jirovecii pneumonia and tuberculosis primarily affect the lungs and may cause post-infective chronic lung changes, non-infectious conditions like chronic obstructive pulmonary disease (COPD) are also more common among PWH[19]. Indeed, COPD has emerged as a major cause of morbidity in PWH. HIV was identified as an independent risk factor for COPD, probably due to changes in immune function, direct effects of HIV, increased susceptibility to infection, and inflammatory factors[20]. Other conditions like lung cancer, pulmonary arterial hypertension were found to be more prevalent in PWH as well[21].

5. Mental and cognitive health
The prevalence of mental illnesses can be as high as around 50% in PWH due to a wide variety of factors including direct effects of the virus, pre-existing psychiatric conditions, personal vulnerabilities, substance and alcohol use, or responses to the social isolation and disenfranchisement that are frequently isolated with the diagnosis of HIV[22]. Common psychiatric conditions include depressive disorders, anxiety disorders, bipolar disorder, schizophrenia, posttraumatic stress disorders and substance-related disorders. In contrast to the early stage of HIV infection, later stages are commonly associated with the neurocognitive complications of HIV infection e.g. HIV-associated neurocognitive disorders.

6. Bone disease
HIV itself has effects on bone, causing loss of bone mass. Rates of osteoporosis appear to be higher in those with HIV with an overall prevalence of 15% and a 3.68-fold increased risk of osteoporosis compared to those without HIV[23]. In addition, the risk of fracture in these individuals is increased. The use of certain antiretroviral drugs, such as tenofovir disoproxil fumarate (TDF), have been associated with decreased bone marrow density[24].

7. Ageing and frailty
Approximately 10-30 % of the over 36 million people living with HIV worldwide are now over 50 years of age, with this number is expected to triple over the next three decades[25]. Frailty is a critical ageing-related syndrome marked by diminished physiologic reserve and heightened vulnerability to stressors, predisposing to major adverse clinical outcomes, including hospitalisation, institutionalisation, disability and death in the general population of older adults. PWH are more prone to frailty, and it occurs up to two decades earlier compared to the general population[26]. Factors contributing to this include persistent immune dysregulation and inflammation, changes in body composition and the presence of other comorbidities.

8. Cancers
Cancers in PWH are typically divided into AIDS-defining cancers, such as Kaposi's sarcoma, non-Hodgkin lymphoma, and cervical cancer, which may be associated with advanced immunosuppression, and non-AIDS-defining cancers (NADCs), such as lung, liver, and anal cancers, which may be associated with inflammation and certain risk behaviours.

MANAGEMENT OF COMORBIDITIES IN HIV

With various comorbidities in PWH, clinical evaluations would be of greater complexity and input from different specialists outside the HIV field maybe required. The prescription of drugs to treat comorbidities may influence the choice of ART regimens and warrants a cautious evaluation of drug-to-drug interactions. Moreover, the issue of polypharmacy will be a great concern, which further complicates adherence rate, and worsens patient outcomes, including increased risk of geriatric syndromes such as falls, fractures, and dementia in the elderly population.

As newer ART are developed, drug toxicities are of less concern nowadays. However, drug-drug interaction remains one of the obstacles in managing comorbidities. Some of these potential drug-drug interactions can be managed by dose adjustment or monitoring, whereas others require a change to alternative therapies for HIV or the associated comorbidities. Moreover, some antiretroviral drugs are associated with the development of certain comorbidities as described above, the use of these drugs should be avoided in people with or at risk of having these comorbidities.

Table 1: Common Adverse Effects Associated with Antiretroviral Therapy (Developed by the author)

Drug	Adverse Effects
Tenofovir disoproxil fumarate(TDF)	- Associated with greater loss of bone mineral density - Elevated creatinine, proteinuria, hypophosphataemia, urinary phosphate wasting, glycosuria, hypokalaemia, and non-anion gap metabolic acidosis
Abacavir(ABC)	Associated with an increased risk of myocardial infarction
Lopinavir/ritonavir (LPV/r)	Diabetes Mellitus and Insulin Resistance
Zidovudine(ZDV), Tenofovir alafenamide(TAF), Efavirenz(EFV), Ritonavir (RTV)- or cobicistat(COBI)-Boosted Protease inhibitors, Elvitegravir/cobicistat(EVG/c)	Dyslipidaemia
Integrase strand transfer inhibitor(INSTI)	- Weight gain - Insomnia, depression, and suicidality

STRATEGIES TO PREVENT DEVELOPMENT OF COMORBIDITIES

1. Specific screening programmes with monitoring protocols
PWH should undergo specific prevention and screening procedures that may differ from the general population. Given that the risk of comorbidities is not homogeneous even within the population of PWH, in terms of epidemiology, risk assessment, management and prevention, more susceptible patients would benefit from more targeted interventions. For example, specific programmes could be prioritised in subjects with a greater prevalence of classical risk factors (e.g., smoking or intravenous drug use, high estimated cardiovascular risk) and/or greater immunological harm (low nadir CD4 cell count, low CD4/CD8 ratio)[27], or those who have current or prior exposure to more toxic ART regimens.

2. Modification of lifestyle and risk factors
The development of comorbidities in PWH is primarily influenced by modifiable risk factors, which open avenues for interventions. For example, a smoking cessation programme is helpful since smoking reduces life expectancy in PWH more than HIV itself. Another example is the lower threshold to use statin as high rates of dyslipidaemia and cardiovascular disease are observed in PWH.

3. Optimising integrated and person-centred care for

comorbidities in PWH

In Hong Kong, the HIV clinics can provide healthcare services for the prevention and screening of comorbidities in PWH, management of some comorbidities and referral to other specialists for the management of more complex conditions. Future services should take into consideration the provision of more integrated and person-centred care.

CONCLUSION

Management of HIV nowadays goes beyond virologic suppression. While comorbidities strongly influence HIV care, from preventive and screening strategies, to the choice of ART, they are reciprocally affected by HIV, which in turn interferes in their assessment and treatment. In order to optimise health in PWH, clinicians should be aware of the multiple comorbidities so as to deliver personalised, integrated and multidisciplinary care to prevent the development and to treat these conditions.

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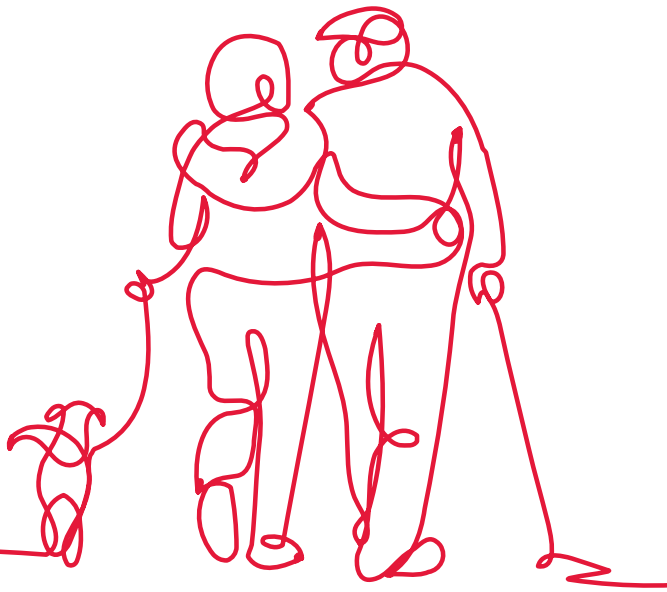

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ART, antiretroviral therapy; HIV, human immunodeficiency virus; RNA, ribonucleic acid.

References: 1. BIKTARVY® Hong Kong Prescribing Information. (HK-SEP22-EU-JUN22-AU-MAR22). **2.** de Los Rios P, et al. Prevalence, determinants, and impact of suboptimal adherence to HIV medication in 25 countries. Prev Med. 2020;139:106182. **3.** Maggiolo F, et al. B/F/TAF forgiveness to non-adherence. Sex Transm Infect. 2024;100(7):418-422.

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Not recommended in patients with estimated CrCl ≥ 15 mL/min and < 30 mL/min, or < 15 mL/min who are not receiving chronic haemodialysis. Hepatic impairment: No dose adjustment for patients with mild or moderate hepatic impairment (Child-Pugh-Turcotte [CPT] Class A or B). Not recommended in patients with severe hepatic impairment (CPT Class C). Paediatric population: The safety and efficacy in children and adolescents aged less than 18 years have not yet been established. **Contraindications:** Hypersensitivity to the active substances or to any of the excipients. Co-administration with rifampicin and St John's Wort *(Hypericum perforatum)*. **Warnings and Precautions:** Patients co-infected with HIV and hepatitis B or C virus: Patients with chronic hepatitis B or C treated with antiretroviral therapy are at an increased risk for severe and potentially fatal hepatic adverse reactions. Discontinuation of Biktarvy therapy in patients co-infected with HIV and HBV may be associated with severe acute exacerbations of hepatitis. Patients co-infected with HIV and HBV who discontinue Biktarvy should be closely monitored with both clinical and laboratory follow-up for at least several months after stopping treatment. Liver disease: Patients with pre-existing liver dysfunction, including chronic active hepatitis, have an increased frequency of liver function abnormalities during combination antiretroviral therapy (CART) and should be monitored according to standard practice. If there is evidence of worsening liver disease in such patients, interruption or discontinuation of treatment must be considered. Weight and metabolic parameters: An increase in weight and in levels of blood lipids and glucose may occur during antiretroviral therapy. Lipid disorders should be managed as clinically appropriate. Mitochondrial dysfunction following exposure *in utero*: Nucleos(t)ide analogues may impact mitochondrial function to a variable degree. The findings do not affect current national recommendations to use antiretroviral therapy in pregnant women to prevent vertical transmission of HIV. Immune Reactivation Syndrome: In HIV infected patients with severe immune deficiency at the time of institution of CART, an inflammatory reaction to asymptomatic or residual opportunistic pathogens may arise and cause serious clinical conditions, or aggravation of symptoms. Any inflammatory symptoms should be evaluated and treatment instituted when necessary. Autoimmune disorders have also been reported. Opportunistic infections: Patients should remain under close clinical observation by physicians experienced in the treatment of patients with HIV associated diseases. Osteonecrosis: Patients should be advised to seek medical advice if they experience joint aches and pain, joint stiffness or difficulty in movement. Use in Renal Impairment: Patients taking tenofovir prodrugs who have impaired renal function and those taking nephrotoxic agents, including non-steroidal anti-inflammatory drugs, are at increased risk of developing renal related adverse reactions. Prior to or when initiating Biktarvy, and during treatment with Biktarvy on a clinically appropriate schedule, assess serum creatinine, estimated creatinine clearance, urine glucose, and urine protein in all patients. In patients with chronic kidney disease, also assess serum phosphorus. Discontinue Biktarvy in patients who develop clinically significant decreases in renal function or evidence of Fanconi syndrome. Co-administration of other medicinal products: Biktarvy should be administered at least 2 hours before, or with food 2 hours after antacids containing magnesium and/or aluminium. Biktarvy should be administered at least 2 hours before iron supplements, or taken together with food. Biktarvy should not be co-administered with other antiretroviral medicinal products. **Adverse reactions:** Most frequently reported adverse reactions were headache, diarrhoea and nausea. Please refer to full prescribing information for full list of adverse reactions. **Drug interactions:** Interactions between Biktarvy and other medicinal products: St. John's wort, rifampicin, rifabutin, rifapentine, atazanavir ± cobicistat, azithromycin, clarithromycin, carbamazepine, oxcarbazepine, phenobarbital, phenytoin, magnesium/aluminium-containing antacid suspension, ferrous fumarate, sucralfate, ciclosporin and metformin.

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Prevention of HIV Infection: From PMTCT to U=U

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Since the discovery of the Human Immunodeficiency Virus (HIV) causing the acquired immunodeficiency syndrome (AIDS) in the 1980s, alongside the search for treatment effective in controlling or eradicating the disease, much interest and effort were paid to prevent the spread of the infection. With the understanding of the routes of transmission, namely sexual, perinatal and haematogenous, measures were derived to limit the dissemination of the virus accordingly. Early in the history of HIV prevention, measures like needle-exchange programme and screening of blood products for the virus were employed to halt the spread of the virus through haematogenous route.

Mother to child transmission of HIV (MTCT) is another important route of HIV transmission. The rate of transmission of HIV from a mother living with HIV to her child during pregnancy, labour, delivery or breastfeeding ranges from 15% to 45% without any intervention, with transmission risk being associated with higher maternal viral load near delivery. Breakthrough in prevention of MTCT (PMTCT) of HIV came in the year 1994, when the Paediatric AIDS Clinical Trial Group Study 076 (PACTG076) reported a dramatic reduction in the rate of transmission from 25.8% to 8.3% by giving the antiretroviral zidovudine to the mother since the second trimester, during delivery and to the newborn. This landmark study led to the worldwide incorporation of antiretroviral use into standard management protocol for HIV-infected pregnant women and their newborns. Further studies also established the role of caesarean section for mothers having high HIV viral load near delivery, as well as the avoidance of breastfeeding in PMTCT of HIV. As a result, with proper intervention including effective maternal HIV treatment, a managed delivery, antiretroviral prophylaxis in newborns and avoidance of breastfeeding, the risk of vertical transmission can be greatly reduced to less than 1%. As scientific evidence built up over time, it is now clear that vaginal delivery can be recommended in women having suppressed viral load with antiretroviral treatment in the absence of obstetric contraindication. Locally in Hong Kong, the Scientific Committee on AIDS and STI (SCAS) had first published in year 2001 the Recommended Clinical Guidelines on the Prevention of Mother-to-Child HIV Transmission, which was last updated in March 2024, outlining the essential measures to be applied in the local setting, from HIV testing, antiretroviral use throughout pregnancy and delivery, to post-natal management of neonates, in order to minimise the risk of vertical transmission of HIV.

Given the promising outcomes brought about by the preventive measures mentioned, it is important to note that the success of these preventive measures relies on early diagnosis of HIV infection in infected women. It is therefore imperative to make the diagnosis, preferably before conception, or as soon as possible in the antenatal period, so that timely intervention can be employed. Locally in Hong Kong, the Universal antenatal HIV testing programme (UATP) was started in 2001. The programme uses an opt-out approach to test all pregnant women for HIV infection. Since 2008, UATP has been supplemented with rapid HIV testing in labour wards of public hospitals to fill the gap for late-presenting pregnant women without documented HIV status in the antenatal period. Since 2018, re-testing of HIV infection in 34th to 36th gestational weeks for women with ongoing risk exposure has been recommended in response to incidences of HIV infection in neonates born to mothers who tested negative for HIV in the early antenatal period but acquired HIV infection during the course of pregnancy.

Moving on to the prevention of HIV transmission through sexual exposure, the history of which has evolved significantly since the beginning of the AIDS epidemic. Early prevention efforts focused on raising awareness, reducing stigma and promoting safer sex practices. However, major advances were not seen until early 2010s, when the ground-breaking study HPTN052, carried out by the HIV Prevention Trials Network, demonstrated that early initiation of antiretroviral treatment in the HIV-infected individuals of sero-discordant heterosexual couples, at a CD4 white cell higher than the recommended treatment threshold at that time, greatly reduced the risk of HIV transmission to the uninfected partner by 96%. Protecting the uninfected partner through treating the infected individual was subsequently termed "Treatment as Prevention" (TasP), and is a strategy analogous to that used in PMTCT. TasP broadened the indications of early antiretroviral treatment initiation and paved the way to "Treat All Approach" in the management of people living with HIV (PLWH), leading to the profound impact of dramatic improvement in HIV-related morbidity and mortality among PLWH, as well as a significant reduction in new HIV infections at both individual and population levels. Further studies including HPTN052, PARTNER and Opposites Attract Studies all together demonstrated zero risk of sexual transmission of HIV when the infected partner achieved sustained undetectable viral load (typically less than 200 copies/ml) for more than six months through

antiretroviral treatment, bringing about the scientific consensus of "Undetectable equals Untransmittable (U=U)" (測不到 = 傳不到) in the context of sexual transmission. With the support of 1,100 international organisations from 105 countries, including The Hong Kong Society for HIV Medicine, The Hong Kong AIDS Foundation and AIDS Concern Hong Kong, the U=U campaign was launched in 2016, aiming to raise awareness of U=U among the public and to dismantle the stigma and discrimination associated with HIV.

Understanding the significant impact brought about by TasP, it is also crucial to elucidate pre-exposure prophylaxis (PrEP), which is equally important in the prevention of sexual transmission of HIV. PrEP involves the use of antiretrovirals in HIV-negative individuals who are at high risk of acquiring the virus. Since the 2000s, a number of clinical trials encompassing both homosexuals and heterosexuals, men, women and transgenders at risk of HIV infection, were conducted to examine the effectiveness of antiretrovirals when being used as PrEP (such as PARTNERS PrEP, iPrEx, The Ring Study, HPTN083, PURPOSE1&2 etc). These trials illustrated a substantial reduction of more than 90% in the risk of HIV transmission when study participants were highly adherent to the PrEP regimen. Year 2012 marked the first time in the history of HIV prevention that, daily oral tenofovir disoproxil fumarate 300 mg (TDF) plus emtricitabine 200 mg (FTC) was approved by the Food and Drug Administration (FDA) for the purpose of PrEP. Up till now, there are different forms of PrEP approved for use, including daily oral PrEP, event-driven oral PrEP, antiretroviral-impregnated vaginal ring, two-monthly injectables and six-monthly ultra long-acting injectables. PrEP users should get tested for HIV before first-time-ever initiation of PrEP, and receive HIV testing and relevant clinical and laboratory monitoring of adverse effects regularly thereafter. Given the favourable effect delivered by PrEP, many countries around the world have implemented, or are in the process of upscaling PrEP programmes in line with the local settings. Locally in Hong Kong, the SCAS first published the Guidance on the use of HIV Pre-exposure Prophylaxis (PrEP) in 2018, which was last updated in 2022, outlining the principles of PrEP use in the local setting. However, as of today, there is no public PrEP programme available in Hong Kong, and PrEP users are required to seek assessment and prescription in private or overseas clinics.

Lastly, while preventive vaccines are the key to the prevention of many other infections, there is still no vaccine available currently that can prevent HIV infection. Major scientific challenges in HIV vaccine development include the ability of the virus to mutate rapidly producing many variants, and its ability to evade the immune system. Scientists are determined to overcome these difficulties by exploring various approaches, one example would be designing a vaccine that can stimulate the body to produce broadly neutralising antibodies (bNAbs) capable of simultaneously recognising many strains of the virus at once. Given all the ongoing research, the dream of an effective vaccine becomes a more realistic possibility now.

In summary, continual advancement in the management for HIV-infected people as well as in the preventive strategies for HIV-negative individuals outlined above led to a gradual reduction in the annual incidences of new HIV infections, therefore facilitating the process towards the UNAIDS 95-95-95 targets (namely 95% of PLWH know their status, 95% of those diagnosed receive antiretroviral therapy, and 95% of those on treatment achieve viral load suppression, a target set to be achieved by year 2030), and are crucial for the ultimate aim of ending the AIDS epidemic.

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† The overall number of patients studied in the landmark trials is 11,868 with Phase III: 4325; EPICS: 1630; SMART-1:327; CombAT: 4844; CONDUCT: 742. The number of patients studied in landmark trials with dutasteride as monotherapy or in combination with tamsulosin is 6,909 with Phase III: 2167; EPICS: 813; SMART-1:327; CombAT: 3233; CONDUCT: 369[3-8]

◊ Change in IPSS from baseline to year 4 was -6.3 points for combination therapy vs. -3.8 points for tamsulosin ($p<0.001$, Combination: n=1575, Tamsulosin: n=1582)[3]

‡ At month 48, the adjusted mean percentage change from baseline in prostate volume was -27.3 % for combination therapy, +4.6% ($p< 0.001$) for tamsulosin, and -28.0% ($p= 0.42$) for dutasteride[3]

❖ Compared with tamsulosin, combination therapy reduced the relative risk of AUR by 67.6% and BPH-related surgery by 70.6%[3]

Duodart(dutasteride/tamsulosin) 0.5/0.4mg Safety Information[9]:

- Renal impairment: Patients with creatinine clearance of less than 10 mL/min should be approached with caution as these patients have not been studied.
- Hypotension: Patients beginning treatment with Duodart should be cautioned to sit or lie down at the first signs of orthostatic hypotension until the symptoms have resolved. Concomitant use of α1- adrenoceptor antagonists and PDE5 inhibitors can potentially cause symptomatic hypotension.
- Fertility in men: Dutasteride has been reported to affect semen characteristics (reduction in sperm count, semen volume and sperm motility) in healthy men. The possibility of reduced male fertility cannot be excluded. Effects of tamsulosin hydrochloride on sperm counts or sperm function have not been evaluated.
- Contraindications: - Hypersensitivity to dutasteride, other 5-alpha reductase inhibitors, or any component of the preparation. - Women, adolescent and children. - A history of orthostatic hypotension - Severe hepatic impairment
- Common adverse events: Dizziness, Impotence, Altered libido, Ejaculation disorders, Breast disorder

Duodart Prescribing Information:

HK61184 – Duodart capsules 0.5mg/0.4mg dutasteride/ tamsulosin HCL

References: 1. Data on file Duodart first received approval in 2010; August 2024. **2.** Data on File;2022N516537_00;1-2 **3.** Roehrborn CG, et al. European urology 2010;57;123-131. **4.** Roehrborn CG, et al. BJU international 2015 ;116(3):450-459. **5.** Roehrborn CG, et al. Urology 2002;60(3);434-41. **6.** Barkin J, et al. European urology 2003;44;461-6. **7.** Debruyne F, et al. European urology 2004;46;488-495. **8.** Nickel JC, et al. BJU International 2011;108;388-394. **9.** DUODART Hong Kong Full Prescribing Information. Version number: HK072017(GDS15v1/eMC20170628)

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Navigating the Landscape of HIV Treatment Options

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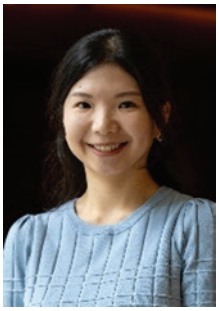

Dr Daphne LAU

INTRODUCTION

Over the past three decades, antiretroviral therapy (ART) has revolutionised the management of HIV infection, transitioning it from a once-fatal disease to a manageable chronic condition with outcomes comparable to those of other chronic illnesses. Since the advent of highly active antiretroviral therapy (HAART) in 1996, significant milestones have included the introduction of single-tablet regimens, two-drug regimens, and more recently, long-acting injectable formulations. These innovations have substantially expanded the therapeutic landscape for people living with HIV (PLWH).

Contemporary ART regimens typically involve a combination of agents from major classes, including nucleoside reverse transcriptase inhibitors (NRTIs), non-nucleoside reverse transcriptase inhibitors (NNRTIs), protease inhibitors (PIs), and integrase strand transfer inhibitors (INSTIs). The current standard of care for initial ART in most PLWH is a regimen comprising a second-generation INSTI combined with two NRTIs. Second-generation INSTIs, such as dolutegravir and bictegravir, are preferred due to their high genetic barrier to resistance, minimal drug-drug interactions, robust virologic suppression rates, and favourable tolerability profiles[1, 2]. These advancements have enabled sustained viral suppression to undetectable levels, achieving the principle of "undetectable equals untransmittable" (U=U), which has profound implications for both individual health and public health.

ADVANCEMENTS AND CHALLENGES IN ANTIRETROVIRAL THERAPY: ADHERENCE, INNOVATIONS, AND EMERGING CONCERNS

Despite the remarkable efficacy of ART in improving health outcomes and extending life expectancy, adherence remains a complex issue influenced by multifaceted barriers. These include socioeconomic factors, such as limited access to healthcare and financial constraints, as well as personal and systemic challenges, like stigma, substance misuse and mental health issues. The forgiveness of HIV ART regimens - defined as their ability to maintain virologic suppression despite occasional missed doses or suboptimal adherence - is a critical factor in treatment success. Modern ART regimens, particularly those incorporating INSTIs like dolutegravir or bictegravir, exhibit high forgiveness due to their robust pharmacokinetic profiles, extended half-lives, and high genetic barriers to resistance. For instance, multiple studies have demonstrated the durable efficacy of bictegravir/emtricitabine/tenofovir alafenamide (B/F/TAF) in sustaining viral suppression despite imperfect adherence, underscoring its robust forgiveness[3]. By prioritising regimens with greater forgiveness, clinicians can optimise treatment outcomes, reduce the risk of virologic failure, and improve long-term health for diverse patient populations, particularly those facing adherence challenges.

To further address adherence barriers and enhance treatment success, ongoing research has focused on developing novel ART agents, particularly long-acting formulations that reduce dosing frequency. Among these, lenacapavir, a first-in-class HIV-1 capsid inhibitor, represents a breakthrough; it acts by interfering with multiple phases of the viral lifecycle, including capsid-mediated nuclear uptake, viral assembly, and capsid core formation. Currently, lenacapavir, administered biannually, is approved for use in combination regimens for patients with multidrug-resistant HIV-1[4]. Additionally, in June 2025, it received approval for HIV pre-exposure prophylaxis (PrEP), establishing it as the first twice-yearly PrEP option.

Contemporary ART regimens have significantly reduced toxicities compared to earlier generations. However, new challenges have emerged, suspected association between weight gain and new ART regimen have become a significant concern among PLWH on ART, sparking considerable debates within the medical and research communities.

Studies have demonstrated association between weight gain and the newer ARTs, namely INSTIs and tenofovir alafenamide (TAF)[5,6]. In 2019, two large prospective randomised trials, both utilising INSTIs and one incorporating TAF, reported significantly greater weight gain compared to an efavirenz-containing comparator arm[7,8]. Additionally, studies involving HIV-negative individuals using pre-exposure prophylaxis (PrEP) showed greater weight gain among TAF users compared to those using tenofovir disoproxil fumarate (TDF)[9]. It remains unclear whether these differences result from TDF's potential to mitigate weight gain, TAF's direct contribution to weight gain, or a combination of both mechanisms.

Multiple theories have been proposed, however, the precise mechanisms by which INSTIs and TAF could potentially induce weight gain are yet to be understood.

One hypothesis suggests that weight gain in the INSTI group may result from the cessation of weight-suppressive effects of efavirenz. Furthermore, the direct weight gain effects from specific ARTs are challenged by the lack of weight loss observed after switching to other drugs. Another theory suggests that ART-associated weight gain may reflect a "return-to-health" process rather than a direct drug effect on appetite or adipocytes. However, data from the CASCADE cohort, which analysed weight changes in PLWH initiating ART early after HIV acquisition, indicate a direct effect of INSTIs and TAF on body weight gain, rather than a return-to-health phenomenon[10].

To conclude, the association between weight gain and ART and the long-term implications remain insufficiently understood, highlighting the need for further research to clarify its clinical significance and underlying mechanisms. The combination of INSTIs and NRTIs, particularly TAF, is preferred due to its favourable side effect profile and high efficacy in achieving viral suppression. To optimise health outcomes, prioritising the management of metabolic and cardiovascular risk factors through a healthy lifestyle - emphasising dietary modifications and regular exercises - is critical for people living with HIV.

DUAL THERAPY

With the advent of highly effective ART, achieving virological suppression has become increasingly attainable. However, the extended life expectancy resulting from optimised ART has shifted the clinical focus towards managing non-communicable diseases that pose ongoing challenges for PLWH. The introduction of two-drug regimens in recent years offers an additional treatment option, particularly for those who have developed or are at risk for developing toxicity from NRTIs, such as patients with renal impairment and cardiovascular diseases.

Two-drug regimens reduce lifetime exposure to antiretroviral medications while maintaining effective viral suppression. The virological non-inferiority of selected two-drug regimens have been demonstrated by multiple randomised controlled trials, in comparison to traditional three-drug combinations[11]. In 2019, the fixed-dose combination tablet containing the INSTI, dolutegravir (DTG), and the NRTI, lamivudine (3TC), was approved as a complete ART regimen for the initial treatment of HIV. Since late 2019, international guidelines have recommended DTG/3TC dual therapy as one of the first-line treatment options for PLWH without hepatitis B co-infection and with an HIV viral load less than 500,000 copies/ml[1,2].

Another significant advancement in HIV management is the development of long-acting injectable ART. These formulations offer a viable alternative to oral ART for selected patients facing challenges such as difficulty swallowing tablets, concerns about medication storage due to confidentiality or stigma, or a preference for non-daily dosing oral tablets. In 2021, cabotegravir and rilpivirine (CAB/RPV), administered intramuscularly, were approved as the first long-acting injectable regimen for HIV treatment, providing a novel option for PLWH. Currently, CAB/RPV, administered every two months, with an optional oral lead-in phase, is recommended as a switch option for PLWH with sustained virological suppression, provided there is no documented or suspected resistance to either drug[12]. Large-scale studies have reported rare cases of virological failure despite adherence, with factors such as HIV subtypes A1 or A6 and obesity identified as potential contributors. Notably, CAB/RPV injections must be administered by a healthcare professional, as they are not approved for self-administration or at-home use, making this regimen less suitable for patients who are unable to attend bimonthly clinic visits. Careful patient selection and counselling are critical to ensure long-acting injectables are appropriately tailored to individual needs and circumstances.

It is important to note that, especially in regions with high hepatitis B virus (HBV) seroprevalence, as in our locality, the risk of acute HBV infection in individuals on such dual-therapy regimens warrants careful consideration, as these combinations lack activity against HBV. There have been cases of acute hepatitis B infections, both locally and abroad, among PLWH receiving CAB/RPV, resulting in the subsequent need to switch back to tenofovir-based oral ART regimens[13]. Clinicians must prioritise risk stratification, patient counselling, and HBV vaccination if appropriate, when considering switching to dual-therapies that do not have activity against HBV. Monitoring anti-HBs titres is essential to ensure protective immunity, especially given the reduced vaccine response in PLWH.

PATIENT EMPOWERMENT

Patient empowerment has become an important transformative approach in healthcare over recent years, emphasising active patient involvement in their treatment journey. This paradigm shift encourages individuals to be well-informed, engaged, and collaborative partners in decisions about their health. In the context of HIV treatment, empowerment means equipping patients with the knowledge and confidence to take charge of their treatment decisions. With access to information through the internet and social media, patient groups, non-governmental organisations (NGOs) and healthcare providers, patients can stay updated on the latest advancements in HIV treatment options. The diverse array of therapies available today allows patients to work closely with their healthcare teams to tailor treatment plans that align with their unique needs, preferences, and lifestyles. For example, patients who struggle with daily pills may opt for long-acting injectables, while others, such as those that do not wish for frequent clinic visits for injections, may prefer daily tablets for simplicity. By fostering open communication and shared decision-making, patient empowerment not only enhances adherence to treatment but also promotes a sense of ownership and responsibility for maintaining and improving long-term health outcomes.

CONCLUSION

While viral suppression remains the cornerstone of HIV management, the goals of ART have expanded to prioritise holistic well-being, including the "fourth 90" - optimising quality of life. By leveraging modern HIV

treatment options, patient education, and promoting patient empowerment, healthcare providers can enhance outcomes through shared decision-making, ultimately improving both clinical results and the lived experiences of people with HIV.

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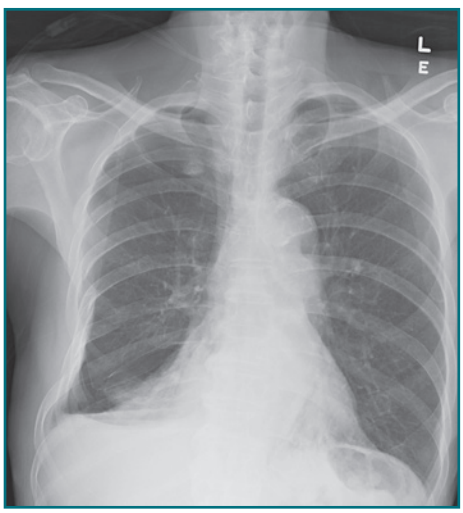
Radiology Quiz

Dr Natalie MOK

MBBS, FRCR

Dr Natalie MOK



An adult patient is presenting with shortness of breath following trauma.

Questions

1. What are the abnormalities of the radiograph?
2. What is the diagnosis?
3. What is the management of this condition?

(See P.33 for answers)

SHINGRIX
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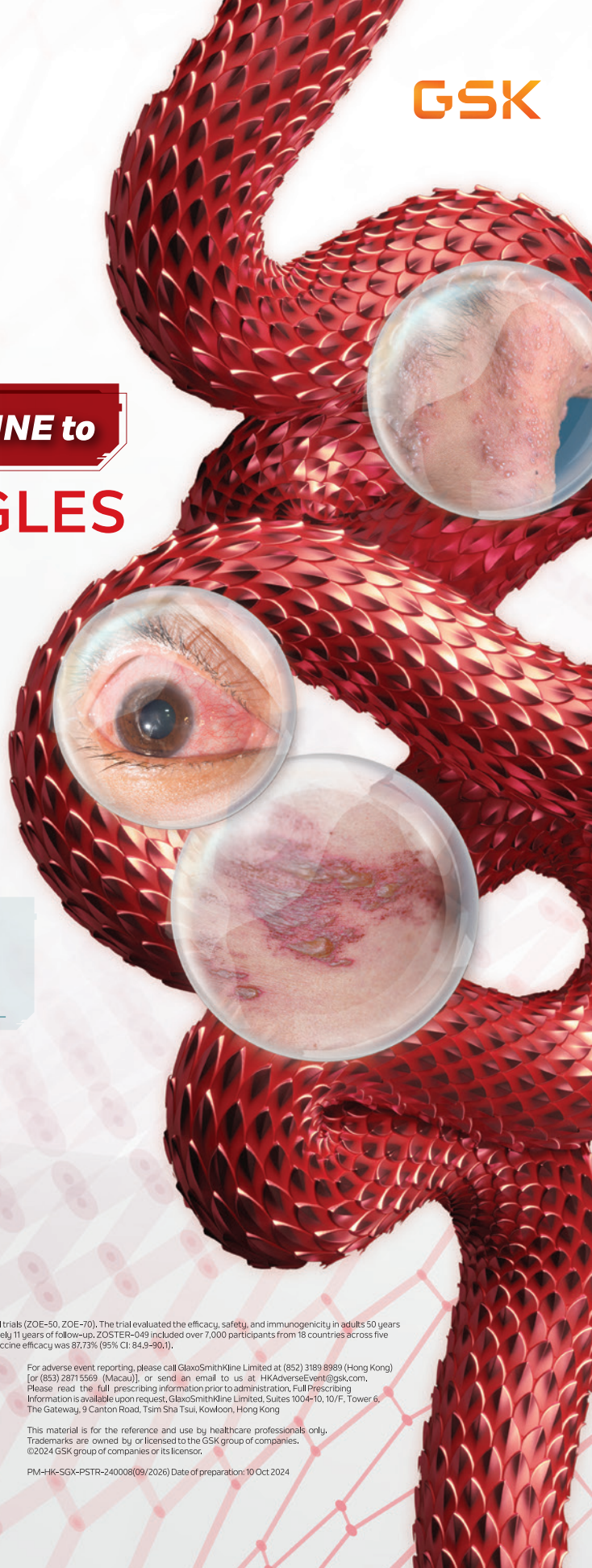

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Efficacy lasts for

11 YEARS[2]

HZ = Herpes zoster
HZV = Herpes zoster vaccine

^ Efficacy adults aged 50 years or above
* Study design: ZOSTER-049 is a phase III open-label, long-term follow-up trial from two pivotal phase III randomised clinical trials (ZOE-50, ZOE-70). The trial evaluated the efficacy, safety, and immunogenicity in adults 50 years and over at time of vaccination, for six additional years after completion of the ZOE-50 and ZOE-70 trials, up to approximately 11 years of follow-up. ZOSTER-049 included over 7,000 participants from 18 countries across five continents, with vaccine recipients compared to historical controls. From 1 month after the second dose of Shingrix, the vaccine efficacy was 87.73% (95% CI: 84.9–90.1).

For Shingrix Full Prescribing Information, please scan the below QR code

References: 1. GlaxoSmithKline. Shingrix Hong Kong Prescribing Information, GDS06.
2. Abstract;Strezova A;ECCMID;2024;1-5.

Indication statement[1]:
Shingrix is indicated for prevention of herpes zoster (HZ) and post-herpetic neuralgia (PHN), in: adults 50 years of age or older; adults 18 years of age or older at increased risk of HZ. The use of Shingrix should be in accordance with official recommendations.

Safety information
Shingrix has clinically acceptable safety and tolerability profile. Contraindications: Hypersensitivity reactions to the active substances or other components of the vaccine. Adverse reactions:
Local reactions at the injection site (pain, redness, swelling, itching) and systemic symptoms such as headache, gastrointestinal symptoms, muscle and joint pain, fatigue, shivering, fever, malaise. You are advised to read the full safety information in the Shingrix Full Prescribing Information before prescribing.

For adverse event reporting, please call GlaxoSmithKline Limited at (852) 3189 8989 (Hong Kong) [or (853) 2871 5569 (Macau)], or send an email to us at HKAdverseEvent@gsk.com. Please read the full prescribing information prior to administration. Full Prescribing Information is available upon request. GlaxoSmithKline Limited, Suites 1004-10, 10/F, Tower 6, The Gateway, 9 Canton Road, Tsim Sha Tsui, Kowloon, Hong Kong

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HPV Testing: An Era of Sampling with Autonomy

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Dr Fred Yau-lung KUNG

From a gynaecologist's point of view, I believe it will be logical to say that human papillomaviruses (HPVs) are the most common pathogens that we will encounter in our daily practice.

There are more than 200 types of HPVs. Most HPV infections, including those with carcinogenic HPV genotypes, typically resolve within 12 months. However, carcinogenic HPV infections that persist beyond 12 months increase the likelihood of precancerous or cancerous lesions. There is also evidence that HPV can enter a latent state with reactivation under certain circumstances.

In 2022, there were 522 new cases of cervical cancer in Hong Kong, rendering cervical cancer the ninth most common cancer in females with a crude incidence rate 13.1 per 100,00 population. In 2009, cervical cancer ranked seventh with 453 new cases and a crude incidence rate 12.3 per 100,000 population. Theoretically, with the introduction of territory-wide HPV vaccination programme and cervical screening programme, we should expect a significant drop in cases. Certainly, the impact of HPV vaccination may need a longer period before a significant effect can be observed. Willingness of our targeted female population to participate is another important factor. According to the cervical screening programme annual statistics report 2024 by the Department of Health released in May 2025, the cumulative number of women aged 25-64 who have registered with the Cervical Screening Information System (CSIS) was about 536,000, accounting for 21.2% of the local female population of this age group. Cervical screening is a very important strategy in fighting cervical cancer as it is highly efficacious in detecting the disease at the precancerous stage and allows timely and effective treatment before further progression into malignancy.

Traditionally, cervical screening requires a sample of cells collected from the cervix during a pelvic examination performed by health care professional. Factors like inconvenience, embarrassment etc may preclude targeted female population to seek for cervical screening, resulting in a low uptake rate for participation. More convenient screening tools which can provide higher privacy and autonomy may help increasing the participation in cervical screening in our locality.

The Hong Kong College of Obstetricians and Gynaecologists (HKCOG) has updated the guidelines for cervical cancer prevention and screening, with the fourth revised version released in January 2024. Since April 2023, the Department of Health has implemented primary HPV testing. Targeted women aged 25-29 will still be screened by cytology-based method, owing to the high prevalence of transient HPV infections that often clear on their own. With the availability of primary HPV testing, women with a negative result can undergo routine screening every five years. The screening interval is significantly lengthened compared to that of cytology-based method which is only three years. The guidelines provide a very thorough and comprehensive instruction for different scenarios of abnormal screening results. Owing to the diversity of screening methods in our locality currently, management pathways for results using different screening methods are all tackled. The suggested management logistics are further demonstrated by corresponding algorithms, which are easy for healthcare professionals to follow, not only gynaecologists but also general practitioners. In principle, the decision to refer for colposcopy depends on the immediate risk of concurrent CIN3+, this risk will also stratify the urgency of the colposcopic examination. For a female screened positive for high risk HPV, it does not mean that she automatically needs to go for further colposcopic examination. Ideally, the sample should receive further reflex cytology plus or minus HPV 16/18 genotyping. High risk HPV with reflex cytology showing atypical squamous cells of undetermined significance (ASCUS) or above require further colposcopy. If genotyping is performed confirming HPV 16 or HPV 18 positive, even if the cytology is negative, further colposcopy is indicated. The risk of developing CIN3 or cancer is found to be highly genotype dependent. HPV 16 and HPV 18 account for two-thirds of all invasive cervical cancer. The short term (within 12 weeks) risk of CIN3+ in these women is about 10%. The 10-year cumulative incidence rate of CIN3+ was 17% among HPV 16-positive women, 14% among HPV 18-positive women, but only 3% for those with other high-risk HPV infections. If only cytology is used, this group of female population may have a risk of not receiving appropriate colposcopic examination and potentially missing the chance for a timely treatment for CIN2/3.

The utilisation of self-sampling methods as screening tools is gaining popularity in recent years. Several publications showed the high sensitivity of self-sampling methods. Urine sampling and vaginal sampling have demonstrated a sensitivity of 90.5% and 98.9% respectively. Urine sampling achieved a specificity of 82.8%, while vaginal self-sampling

showed specificity ranging from 73.9% to 100% in the diagnosis of high-risk HPV. Recent studies also showed a high concordance for HPV diagnosis between clinical sampling and vaginal self-sampling. In addition, self-sampling methods have shown high acceptance rates ranging from 90.5% to 97.3%.

A timely referral based on the HPV testing result for further colposcopic examination including visual inspection and histology of biopsy can allow early detection of precancerous cervical lesions and corresponding treatment, and hope to reduce the incidence of cervical cancer by tertiary prevention. However, increasing the number of colposcopies will increase the medical burden, patient anxiety, physical discomfort and even complications of colposcopic examination which may be unnecessary. Therefore, an effective screening method with accurate triage pathways will be ideal to strike the balance.

Worldwide many countries have already implemented or are piloting HPV self-sampling for cervical screening, such as Australia, Denmark, Finland, the Netherlands and so on. Last year, the Capital Region of Denmark celebrated the 10th anniversary of introducing HPV self-sampling into the cervical screening programme. In the United States, On 14th May 2024, the Food and Drug Administration (FDA) expanded the approvals of two self-sampling tests for high risk HPV, namely Onclarity HPV and Cobas HPV, in health care settings. This year, FDA further approved the Teal Wand, a self-collection device for HPV testing solely performing at home, meaning that the ladies are not even required a visit to the clinic.

HPV urine test is currently available in the private sector in our locality, and is gaining more and more awareness recently. A recent systematic review and meta-analysis demonstrates that urine-based tests exhibit high sensitivity and specificity, which may be a potential valuable alternative to cervical or vaginal based sampling. Urine testing may be particularly promising in settings where routine cervicovaginal examinations are not feasible or less likely to be performed due to cultural barriers, for example. A commercial kit for urine HPV testing is currently available in Hong Kong with increasing awareness in our locality. Although currently urine HPV testing is not a recognised modality for cervical cancer screening by HKCOG, it may raise the awareness of the target population or even timely pick up ladies requiring further assessment and management, who will not be identified if they are unwilling to receive cervicovaginal examinations, not until they present with symptoms which may miss the golden stage for curative treatment.

Other investigation strategies are also under exploration including using menstrual blood, circulating blood or oral samples (for HPV-attributable oropharyngeal cancer). However, further research is required. Worldwide gatekeepers are waiting for large-scale studies before further validation and genuine application in clinical use can be concretely implemented.

Cervical cancer screening has been continuously evolving in recent decades, from conventional slides to liquid-based cytology, from cytology based to primary HPV testing. Self sampling, regardless of the methods, is likely the next generation screening tool, granting more convenience, more privacy and more autonomy to the women. The most important issue is these benefits do not sacrifice the accuracy of the screening tests. We are looking forward to further concreting and supporting evidence for their use, and further comments, statements and guidance from our college.

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Sketches from a Madrid Muse: A Journey Through Art's Beauty

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My passion for drawing has always been about capturing beauty - the delicate curve of a form, the interplay of light and shadow, or the raw emotion in a painted gaze. As a pathologist, drawing sharpens my eyes for details, much like studying blood cells reveals life's intricate stories. My summer trip to Madrid, Toledo, and Segovia immersed me in the masterpieces of Francisco Goya, El Greco, and others at the Prado, Real Academia de Bellas Artes de San Fernando, and El Greco Museum. The artists' passionate, multidimensional works redefined my sense of beauty's depth, stirring awe, curiosity, and joy. These reflections, drawn from my travel journal, capture the feelings sparked by these artworks, enriched by glimpses into the artists' lives.

Upon my arrival in Madrid, I settled into a boutique hotel in the lively downtown. Despite travel fatigue, I visited the Royal Collection Museum, open until 8 PM, as a prelude to the Prado. Luisa Ignacia Roldán's Saint Michael the Archangel Defeating the Devil (1692), a vibrant polychromed wood sculpture, stopped me in my tracks. Going through its dynamic forms, I felt a thrill at Roldán's ability to breathe life into wood, her figures pulsing with triumphant energy. As Spain's first documented female sculptor, trained in her father's Seville workshop, she infused this piece with a spirit that lifted my own, its vivid colours sparking wonder, like discovering a bold new voice in art.

The next day, after a refreshing 5 km run in Retiro Park - its lush beauty perfectly captured by its Chinese name, 麗池公園 - I joined a guided tour at the Prado, meeting at the Velázquez statue. Though underwhelming with touristy comments, it oriented me to the museum's layout, where photography is banned, pushing me to sketch and scribble notes. After the tour, I skipped lunch to visit the Real Academia, which closed at 3 PM, a strategic move given my tight itinerary. Returning to the Prado on another day after day trips to Toledo and Segovia, I arrived at 1:30 PM, expecting six hours but finding the vast collection overwhelming. The audioguide lacked a map, making navigation tricky, but the ground floor's eclectic mix - from 15th-century Memling to 19th-century Fortuny - captivated me. I spent four hours sketching, leaving only two for the first floor's old masters.

At the Prado, Hieronymus Bosch's Garden of Earthly Delights (1490-1510) felt otherworldly, its fantastical imagery making me laugh at its audacity, as if Bosch, a 15th-century visionary, were an "outer-space creature" painting humanity's wild desires. Diego Velázquez's Las Meninas (1656) enveloped me in its welcoming space; standing an arm's length away, I spent ten minutes lost in its layers, feeling like an invited guest in the artist's world, his genius as Philip IV's court painter shining through. His The Spinners (Fable of Arachne) (1655) thrilled me with its delicate thread and theatrical backlighting, the background tapestry signalling Velázquez's ambition to rival Renaissance masters. Sketching Raphael's Holy Family (1510), I was moved by Mary's gentle downward gaze, a serene expression that warmed my heart, reflecting Raphael's youthful mastery before his death at 37.

Marià Fortuny's The Painter's Children in the Japanese Room (1874) struck me with its unfinished charm, the sketched shadows and delicate lines of the girl's legs revealing beauty in imperfection. Fortuny, who died at 36 that year from malaria contracted in Naples, infused this work with a Neapolitan vibrancy, his strength in drawing surpassing typical Orientalist painters. His Naked Boy on the Beach at Portici (1874), with its vivid brushstrokes, felt alive despite his tragic end, making me mourn the loss of such talent.

Goya's works, encountered across Madrid's museums, were a revelation. I once overlooked him, misled by Rococo's frilly reputation and my initial shock at Saturn Devouring His Son (1819-23), which I foolishly thought was by another artist. Madrid changed that. At the Real Academia, a special exhibition of Goya's Disasters of War etchings (1810-20) gripped me with their raw anger. The pointed hats on figures facing execution sent chills down my spine, their universal critique of human cruelty hitting hard. Goya, deaf since age 47 and shaken by Spain's Napoleonic turmoil, poured his soul into these plates, and I felt his pain and defiance. His Portrait of Manuel Godoy (1801, age 55) and La Tirana (1799, age 53) stunned me with their swift brushstrokes, each stroke so economical yet alive, reflecting his training under José Luzán. I marvelled at his "cute" anatomical style - large eyes, chubby limbs - especially in La Tirana, which felt playful yet intense, like meeting a vibrant character.

At the Prado, Goya's The 3rd of May 1808 (1814, age 68) made my heart race with its bold strokes; I could almost hear the gunfire, a testament to his ability to "paint sound" despite his deafness. The 2nd of May 1808 (1814, age 68) was even more thrilling, the boy in apple-green pinching a sword with a splash of blood so vivid I wanted to cheer for his defiance. That Goya painted these massive works in the same year left me in awe of his relentless passion at 68. The Dog (1819-

23, age 73-77), a Black Painting, broke my heart with its earthy tones and pleading eyes, its cool vibe born of Goya's isolation in his House of the Deaf, where he painted on plaster walls during Spain's repressive post-Napoleonic era. The Naked Maja (1795-1800, age 49-54) and The Clothed Maja (1800-08, age 54-62) seduced me with their soft contours, the naked version's welcoming expression daring me to linger, a bold act under the Inquisition's gaze. The Parasol (1777, age 31), a tapestry cartoon, felt breezy and joyful, its wind-blown tree and ponytail capturing a carefree moment from his early court painter days. Portrait of Asensio Julià (1798, age 52) impressed me with its precise yet expressive lines, guiding my sketches to capture both form and feeling. The Thyssen-Bornemisza Museum's Tío Paquete (1819-20, age 74-75), a portrait of a blind beggar, touched me deeply, its tender realism revealing beauty in vulnerability, a testament to Goya's empathy in his later years, marked by illness and exile to Bordeaux.

My Toledo day trip deepened this journey. The El Greco Museum, set in a serene garden, housed ~30 Mannerist works. I felt their spiritual fervour in El Greco's elongated saints, their stretched forms alive with emotion, a style shaped by his Venetian training under Titian and Tintoretto before settling in Toledo in 1577. His View and Plan of Toledo (1610-14) was a joy to read, its vibrant colours and distorted architecture making me smile at its bold vision, as if the city were a living canvas.

From Bosch's surreal visions to Fortuny's vibrant, unfinished works, this journey unveiled the vast emotional range of art across centuries. Goya's evolution, from light-hearted genre scenes to haunting etchings, taught me to embrace beauty in joy and despair, his passion undimmed by deafness, war, and exile. Velázquez's masterful compositions, with their inviting spaces and delicate details, showed me the power of precision and warmth in art. El Greco's fervent distortions and Fortuny's vibrant, unfinished works deepened my sense of art's expressive power. The Royal Collection's anecdote about Queen Maria Luisa's tooth loss from 24 pregnancies - likely due to calcium depletion from repeated childbearing - fascinated me, tying art to the cultural context of royal life in Spain.

This trip broadened my appreciation of art, spanning old masters to the vibrant 18th- and 19th-century Italian paintings, whose emotional depth rivals French Impressionism. It transformed my view of Goya, his unique style - blending Rococo elegance with raw intensity - proving utterly stunning. The appreciation of beauty is essential in life; in painting, you see human nature, diverse emotions, and the splendour of the natural world. The fleeting beauty of art, infused with an artist's perspective, personal touch, and style, mirrors medicine - a good doctor, like a good artist, sees beauty in human nature, bringing a unique lens to their work. As I wandered through Toledo's gardens, immersed in vibrant light and quiet serenity, I carried these moments of beauty in my heart, a gentle reminder of life's intricate and fleeting wonders.

Artwork	Artist (Born–Died)	Year Created
Saint Michael the Archangel Defeating the Devil	Luisa Ignacia Roldán (1652–1706)	1692
Garden of Earthly Delights	Hieronymus Bosch (1450–1516)	1490–1510
Las Meninas	Diego Velázquez (1599–1660)	1656
The Spinners (Fable of Arachne)	Diego Velázquez (1599–1660)	1655
Holy Family	Raphael (1483–1520)	1510
The Painter's Children in the Japanese Room	Marià Fortuny (1838–1874)	1874
Naked Boy on the Beach at Portici	Marià Fortuny (1838–1874)	1874
Disasters of War	Francisco Goya (1746–1828)	1810–1820
Portrait of Manuel Godoy	Francisco Goya (1746–1828)	1801
La Tirana	Francisco Goya (1746–1828)	1799
The 3rd of May 1808	Francisco Goya (1746–1828)	1814
The 2nd of May 1808	Francisco Goya (1746–1828)	1814
The Dog	Francisco Goya (1746–1828)	1819–1823
The Naked Maja	Francisco Goya (1746–1828)	1795–1800
The Clothed Maja	Francisco Goya (1746–1828)	1800–1808
The Parasol	Francisco Goya (1746–1828)	1777
Tío Paquete	Francisco Goya (1746–1828)	1819–1820
Portrait of Asensio Julià	Francisco Goya (1746–1828)	1798
View and Plan of Toledo	El Greco (1541–1614)	1610–1614

Fig. 1: Statue of Velázquez: Located in front of the main gate of the Prado Museum, it is dedicated to Diego de Velázquez (Personal collection)

Fig. 2: El Greco Museum and its garden at Toledo (Personal collection)

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^ Among participants with high baseline HIV-1 RNA (>100 000 copies/mL), 56/69 (81.2%) in the DOR/3TC/TDF group and 59/73 (80.8%) in the EFV/FTC/TDF group achieved HIV-1 RNA of <50 copies/mL at week 48.
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Abbreviations: DOR=Doravirine; EFV=Efavirenz; FTC=Emtricitabine; HIV=Human Immunodeficiency Virus; RNA=Ribonucleic Acid; TDF=Tenofovir Disoproxil Fumarate; 3TC=Lamivudine

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Indications: Delstrigo (doravirine 100 mg/lamivudine 300 mg/tenofovir disoproxil fumarate 300mg) is indicated for the treatment of adults infected with HIV-1 without past or present evidence of resistance to the NNRTI class, lamivudine, or tenofovir. Delstrigo is also indicated for the treatment of adolescents aged 12 years and older weighing at least 35kg who are infected with HIV-1 without past or present evidence of resistance to the NNRTI class, lamivudine, or tenofovir and who have experienced toxicities which preclude the use of other regimens that do not contain tenofovir disoproxil.

Contraindications: • Hypersensitivity to the active substances or to any of the excipients. Co-administration with medicinal products that are strong cytochrome P450 (CYP)3A enzyme inducers is contraindicated as significant decreases in doravirine plasma concentrations are expected to occur. For the list of contraindicated medicines, please consult the full prescribing information.

Precautions: • NNRTI substitutions and use of doravirine o Doravirine has not been evaluated in patients with previous virologic failure to any other antiretroviral therapy. There is not sufficient clinical evidence to support the use of doravirine in patients infected with HIV-1 with evidence of resistance to the NNRTI class. • Severe acute exacerbation of hepatitis B in patients co-infected with HIV-1 and HBV o All patients with HIV-1 should be tested for the presence of hepatitis B virus (HBV) before initiating antiretroviral therapy. Patients who are co-infected with HIV-1 and HBV should be closely monitored with both clinical and laboratory follow-up for at least several months after stopping treatment with Delstrigo. • New onset or worsening renal impairment o Delstrigo should be avoided with concurrent or recent use of nephrotoxic medicinal products (e.g., high-dose or multiple NSAIDs). Persistent or worsening bone pain, pain in extremities, fractures, and/or muscular pain or weakness may be manifestations of proximal renal tubulopathy and should prompt an evaluation of renal function in at risk patients. • Bone loss and mineralisation defects o The effects of tenofovir disoproxil associated changes in BMD and biochemical markers on long-term bone health and future fracture risk are unknown. Assessment of BMD should be considered for HIV-1 infected adult patients who have a history of pathologic bone fracture or other risk factors for osteoporosis or bone loss. • Co-administration with other antiviral products o Doravirine/lamivudine/tenofovir disoproxil must not be co-administered with other medicinal products containing lamivudine, or with medicinal products containing tenofovir disoproxil, or tenofovir alafenamide, or with adefovir dipivoxil • Use with CYP3A inducers o Caution should be given to prescribing doravirine with medicinal products that may reduce the exposure of doravirine • Immune reactivation syndrome o Immune reactivation syndrome has been reported in patients treated with combination antiretroviral therapy. • Lactose o Delstrigo contains lactose monohydrate. Patients with rare hereditary problems of galactose intolerance, total lactase deficiency or glucose-galactose malabsorption should not take this medicine.

Adverse events: • The most frequently reported adverse reactions considered possibly or probably related to doravirine were nausea (4%) and headache (3%). Other common adverse events (≥1% to <10%) associated with doravirine/lamivudine/tenofovir disoproxil include abnormal dreams, insomnia, dizziness, somnolence, cough, nasal symptoms, diarrhoea, abdominal pain, vomiting, flatulence, alopecia, rash, muscle disorders, fatigue, fever and alanine aminotransferase increased. For detailed side effects, please consult the full prescribing information.

Drug interactions: Delstrigo is a complete regimen for the treatment of HIV-1 infection; therefore, Delstrigo should not be administered with other antiretroviral medicinal products. *Effects of other medicinal products on doravirine, lamivudine, and tenofovir disoproxil* • Doravirine o Doravirine is primarily metabolised by CYP3A, and medicinal products that induce or inhibit CYP3A are expected to affect the clearance of doravirine • Lamivudine o Because lamivudine is primarily eliminated by the kidneys through a combination of glomerular filtration and active tubular secretion, co-administration of doravirine/lamivudine/tenofovir disoproxil with medicinal products that reduce renal function or compete for active tubular secretion may increase serum concentrations of lamivudine. • Tenofovir disoproxil o Because tenofovir is primarily eliminated by the kidneys through a combination of glomerular filtration and active tubular secretion, co-administration of doravirine/lamivudine/tenofovir disoproxil with medicinal products that reduce renal function or compete for active tubular secretion via OAT1, OAT3 or MRP4 may increase serum concentrations of tenofovir. *Effects of doravirine, lamivudine, and tenofovir disoproxil on other medicinal products* • Doravirine o Doravirine at a dose of 100 mg once daily is not likely to have a clinically relevant effect on the plasma concentrations of medicinal products that are dependent on transport proteins for absorption and/or elimination or that are metabolised by CYP enzymes. • Lamivudine o Lamivudine does not inhibit or induce CYP enzymes. • Tenofovir o Based on the results of in vitro experiments and the known elimination pathway of tenofovir, the potential for CYP-mediated interactions involving tenofovir with other medicinal products is low.

Before prescribing, please consult the full prescribing information.

References: 1. Delstrigo HKPC. 2. Orkin C, Squires KE, Molina JM, *et al.; and DRIVE-AHEAD Study Group.* Doravirine/lamivudine/tenofovir disoproxil fumarate is non-inferior to efavirenz/emtricitabine/tenofovir disoproxil fumarate in treatment-naive adults with human immunodeficiency virus-1 infection: week 48 results of the DRIVE-AHEAD trial. Clin Infect Dis. 2019;68(4):535-544.

MSD

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HK-DOR-00137 Nov/2025

Federation Sports Day 2025

The Federation President's Cup Soccer 5 and Table Tennis Tournament for 2025 was held at Ying Wah College on 21st September 2025. There were six soccer teams and five table tennis teams that participated in the tournament this year, including Hong Kong Academy of Medicine, The Hong Kong Medical Association, Hong Kong Dental Association, Hong Kong Doctors Union, AstraZeneca Hong Kong Ltd, Roche Hong Kong Limited and Jacobson Pharma Corporation Ltd.

This year, we were honoured to have again the participation of the Sun Hei All Stars Football team (晨曦明星足球隊) on the final day. Our Federation United Team, comprising members from various tournament teams, played a friendly exhibition match with the Sun Hei All-Star Football team.

We congratulate the winning teams and express our sincere gratitude for the support from all the participating teams and guests. We look forward to seeing you again at the Federation President Cup Soccer Five & Table Tennis Tournament in 2026!

The final results were as follows:

Table Tennis Tournament	
Champion :	Hong Kong Dental Association
1st Runner Up :	The Hong Kong Medical Association - Team 1
2nd Runner Up :	The Hong Kong Medical Association - Team 2

Soccer Five Tournament	
Champion :	The Hong Kong Medical Association
1st Runner Up :	Hong Kong Academy of Medicine
2nd Runner Up :	The Federation of Medical Societies of Hong Kong


香港牙醫學會
Hong Kong Dental Association
HONG KONG
DOCTORS UNION
香港西醫工會
香港醫學會
The Hong Kong Medical Association
FEDERATION
SPORTS DAY 2025
SUNDAY, 21 SEPTEMBER 2025

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	★ HKMA CME Portal (Online) Topic: Shingles Vaccines as Part of Comprehensive Cancer Care: Multidisciplinary Implementation **1**	★ In-person Topic: Data to Vaccination: Use of One Jab PCV20 in High Risk Adult **2**	★ In-person Topic: Neuroprotective Agents in Ischemic Stroke: Past Failures and Future Opportunities **3**	★ Certificate Course on Healthcare Mediation 2025 – Beyond Complaints: Proactive Patient Relations (Video Lectures) **4**	★ In-person Topic: Individualise Your T2D Treatment – Case-Based Insights for Optimised Care **5**	**6**
7	**8**	**9**	★ The Hong Kong Neurosurgical Society Monthly Academic Meeting – To be confirmed ★ In-person Topic: Update of Cardiac and Hypertension Management **10**	★ Certificate Course on Healthcare Mediation 2025 – Beyond Complaints: Proactive Patient Relations (Video Lectures) **11**	★ HKMA CME Portal (Online) Topic: Beyond the Skin: Gut Microbiome Modulation in Eczema Management—Insights from the Gut-Skin Axis **12**	**13**
14	★ HKMA CME Portal (Online) Topic: Application for Clinic License & Exemption for Small Practice Clinic **15**	★ In-person / HKMA CME Portal (Online) HKMA-GHK CME Programme 2025 Topic: To-Be-Confirmed **16**	**17**	★ FMSHK Executive Committee Meeting **18**	**19**	**20**
21	**22**	**23**	**24**	**25**	**26**	**27**
28	**29**	**30**	**31**			

Date / Time	Function	Enquiry / Remarks
1 MON 2:00 PM	**HKMA CME Portal (Online)** **Topic: Shingles Vaccines as Part of Comprehensive Cancer Care: Multidisciplinary Implementation** Organiser: The Hong Kong Medical Association Speaker: Dr Yu-chung LI	HKMA CME Dept. Tel: 2527 8452 1 CME Point
2 TUE 2:00 PM	**In-person** **Topic: Data to Vaccination: Use of One Jab PCV20 in High Risk Adult** Organiser: The Hong Kong Medical Association Speaker: Dr Wang-chun KWOK Venue: Unit A, 10/F, Greater China Club, D2 Place ONE, 9 Cheung Yee Street, Lai Chi Kok, Kowloon	HKMA CME Dept. Tel: 2527 8452 1 CME Point
3 WED 2:00 PM	**In-person** **Topic: Neuroprotective Agents in Ischemic Stroke: Past Failures and Future Opportunities** Organiser: The Hong Kong Medical Association Speaker: Dr Sonny Fong-kwong HON Venue: Ballroom I, 2/F, Courtyard by Marriott Hong Kong Sha Tin, 1 On Ping Street, Shatin, Hong Kong	HKMA CME Dept. Tel: 2527 8452 1 CME Point
4 TUE 7:00 PM	**Certificate Course on Healthcare Mediation 2025 – Beyond Complaints: Proactive Patient Relations (Video Lectures)** Organisers: The Federation of Medical Societies of Hong Kong & Hong Kong Society for Healthcare Mediation Speaker: Dr Carl LEUNG	Ms ToTo CHAN Tel: 2821 3512
5 FRI 2:00 PM	**In-person** **Topic: Individualise Your T2D Treatment – Case-Based Insights for Optimised Care** Organiser: The Hong Kong Medical Association Speaker: Dr John Tai-hung WONG Venue: HEYA, Shop 1130-1143, L1/F, YOHO MALL I , 9 Yuen Lung Street, Yuen Long	HKMA CME Dept. Tel: 2527 8452 1 CME Point
10 WED 7:30 AM	**The Hong Kong Neurosurgical Society Monthly Academic Meeting – To be confirmed** Organiser: Hong Kong Neurosurgical Society Speaker(s): Dr Mei-ting WONG Chairman: Dr Samuel Siu-kei LAM Venue: Seminar Room, G/F, Block A, Queen Elizabeth Hospital; or via Zoom meeting	CME Accreditation College: 1.5 points College of Surgeons of Hong Kong Enquiry : Dr Jason CHOW Tel: 2595 6456 Fax. No.: 2965 4061
2:00 PM	**In-person** **Topic: Update of Cardiac and Hypertension Management** Organiser: The Hong Kong Medical Association Speaker: Dr Pak-hei CHAN Venue: The HKMA Central Clubhouse, 2/F, Chinese Club Building, 21-22 Connaught Road Central, Central	HKMA CME Dept. Tel: 2527 8452 1 CME Point
11 THU 7:00 PM	**Certificate Course on Healthcare Mediation 2025 – Beyond Complaints: Proactive Patient Relations (Video Lectures)** Organisers: The Federation of Medical Societies of Hong Kong & Hong Kong Society for Healthcare Mediation Speaker: Dr Paul LAI	Ms ToTo CHAN Tel: 2821 3512
12 FRI 2:00 PM	**HKMA CME Portal (Online)** **Topic: Beyond the Skin: Gut Microbiome Modulation in Eczema Management – Insights from the Gut-Skin Axis** Organiser: The Hong Kong Medical Association Speaker: Dr Pok-yu CHOW	HKMA CME Dept. Tel: 2527 8452 1 CME Point
15 MON 2:00 PM	**HKMA CME Portal (Online)** **Topic: Application for Clinic License & Exemption for Small Practice Clinic** Organiser: The Hong Kong Medical Association Speaker: Dr Darwin Wai-lai MAK	HKMA CME Dept. Tel: 2527 8452 1 CME Point
16 TUE 2:00 PM	**In-person / HKMA CME Portal (Online)** **HKMA-GHK CME Programme 2025** **Topic: To-Be-Confirmed** Organisers: The Hong Kong Medical Association and Gleneagles Hong Kong Hospital Speaker: To-Be-Confirmed Venue: The HKMA Wanchai Premises, 5/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong	HKMA CME Dept. Tel: 2527 8452 1 CME Point
18 THU 8:00 PM	**FMSHK Executive Committee Meeting** Organiser: The Federation of Medical Societies of Hong Kong Venue: Council Chamber, 4/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong	Ms Nancy CHAN Tel: 2527 8898

Answers to Radiology Quiz

Answers:

1. Volume loss over R hemithorax. A pleural line and air-fluid level are seen over R hemithorax. In addition, there are multiple contiguous right ribs (5-8th) fractures.

2. Right sided flail chest, hydropneumothorax, right lower lobe collapse compatible with recent trauma.

3. Clinicians should be immediately informed. These patients frequently require stabilisation, adequate pain control and respiratory support. Refractory cases may require surgical intervention.

Dr Natalie MOK
MBBS, FRCR

Certificate Course for Doctors, Registered / Enrolled Nurses (General) and Allied Health Professionals

● Course No. C431 ● CME/CNE Course

Certificate Course on

Mental Health 2026 -

Empowering Professionals to Support Mental Well-being (Video Lectures)

Jointly organised by

The Federation of Medical Societies of Hong Kong

The Hong Kong College of Psychiatrists

Objectives:

Mental health is an essential part of holistic care, this course equips Doctors, Registered / Enrolled Nurses (General) and Allied Health Professionals with a comprehensive introduction to the aetiology, progression, and management of common psychiatric disorders encountered in Hong Kong. Each module is delivered by a specialist psychiatrist with both clinical and academic expertise.

By completion, participants will gain deeper insight into the nature, clinical course, and current evidence-based treatment approaches for a range of prevalent psychiatric conditions. The program is particularly suited for professionals working in mental health services, general hospital settings, and community-based social care environments.

Date	Topics	Speakers
8 Jan 2026	Psychosis and Updates of Treatment	Dr. Tam Fung Ling Specialist in Psychiatry
15 Jan 2026	Psychotherapeutic Interventions in Psychiatry - Psychotherapies Overview, Evidence Base and Application to Psychiatric Disorders	Dr. Hung Chi Hong, Rommel Specialist in Psychiatry
22 Jan 2026	Beyond the Individual - A Relational Perspective on Psychotherapy	Dr. Tang Wing Ki Specialist in Psychiatry
29 Jan 2026	From Lows to Highs - Diagnosing and Treating Depression and Bipolar Disorder	Dr. Lam Yun Ting, Christina Specialist in Psychiatry
5 Feb 2026	When Eating becomes a Nightmare - Stress Eating and Eating Disorder	Dr. Lok Chi Wing Specialist in Psychiatry
12 Feb 2026	The Overarching Impact of Digital Addiction on Children's Brain and Development - Evidence-based Support for Children with Special Education Need (SEN)	Dr. Liu Kwong Sun Specialist in Psychiatry

Date : 8, 15, 22, 29 January and 5, 12 February 2026 (THUR)
Duration of Session : 1.5 hours (6 sessions)
Time : 7:00 pm – 8:30 pm *(or within 4 days from each Lecture Date)*
Course Feature : Video lectures (with Q&A platform for participants to post the questions)
Language Media : Cantonese (Supplemented with English)
Quiz for Doctors : DOCTORS are required to complete a quiz after the completion of each lecture
Course Fee : HK$1,200
Certificate : Awarded to participants with a minimum attendance of 70% (4 out of 6 sessions)
Deadline : **2 January 2026**
Enquiry : The Secretariat of The Federation of Medical Societies of Hong Kong
Tel: 2821 3512 Fax: 2865 0345 Email : toto.chan@fmshk.org

CME / CNE Accreditation in application
Online Application from website: http://www.fmshk.org