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

Annual Scientific Meeting 2022

Innovations in Disease Diagnosis and Management

Date: 16 October 2022 (Sunday) **Time:** 09:30 - 17:00 **Format:** Hybrid

Venue: 3/F & 4/F, Sheraton Hong Kong Hotel & Towers,
20 Nathan Road, Tsim Sha Tsui, Kowloon

Programme Book

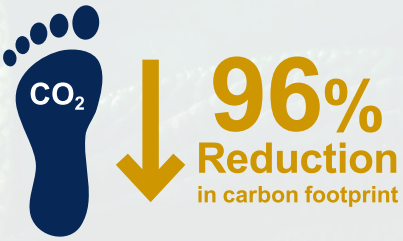
ANORO ELLIPTA
umeclidinium/vilanterol

TRELEGY ELLIPTA
fluticasone furoate/umeclidinium/vilanterol

Friendly to both the patients and the environment

GSK is committed to have a net zero impact on climate and net positive impact on nature by 2030.

Analysis has shown that one **MDI has the equivalent carbon footprint as 24 Ellipta DPIs.**[†1]



For every patient that receives a DPI rather than MDI, the **carbon footprint of treatment could be reduced by 96%**[†1]

Over 99% of patients **can generate the required inspiratory flow for optimal drug delivery** with Ellipta[2]

ANORO ELLIPTA (umeclidinium/vilanterol) Safety Information • Should not be used in patients with asthma • As with other inhalation therapies, administration of ANORO may produce paradoxical bronchospasm that may be life-threatening. Treatment with ANORO should be discontinued immediately if paradoxical bronchospasm occurs and alternative therapy instituted if necessary • Not indicated for acute episodes of bronchospasm • Sh ould be used with caution in patients with severe cardiovascular disease • Should be used with caution in patients with urinary retention or with narrow-angle glaucoma • Should be used with caution in patients with convulsive disorders or thyrotoxicosis, and in patients who are unusually responsive to β_2-adrenergic agonists.

TRELEGY ELLIPTA (fluticasone furoate/umeclidinium/vilanterol) Safety Information • Trelegy Ellipta should not be used in patients with asthma since it has not been studied in this population • Not for the treatment of acute episodes of bronchospasm, or to treat an acute COPD exacerbation (i.e. as a rescue therapy) • Use with caution in patients with unstable or life threatening cardiovascular disease • Do not stop therapy without physician supervision since symptoms may recur after discontinuation

MDI, metered-dose inhaler. †Net $kgCO_2e$ rounded per day of Ellipta and pMDI is 0.026 and 0.650 respectively.

References: 1. Janson C, *et al. Thorax* 2020;75:82-84. **2.** Anderson M, *et al. Int J Chron Obstruct Pulmon Dis* 2021;16:933-943.

HK63414 –
Anoro Ellipta inhalation powder pre-dispensed 62.5mcg/25mcg

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

GlaxoSmithKline Limited
23/F, Tower 6, The Gateway, 9 Canton Road, Tsimshatsui, Kowloon, Hong Kong

PM-HK-UCV-ADVT-220002 (08/2024)
Date of preparation: 14/09/2022

DUODART
(dutasteride/tamsulosin HCl) Capsules

gsk

*The **ONLY** fixed-dose combination in relieving BPH symptoms and reduce risk of AUR or BPH-related surgery*

DUAL ACTION:

- **Superior symptoms improvement**[1]
  (adjusted mean change in IPSS from baseline to year 4 was **-6.3** points for combination therapy versus **-3.8** points for tamsulosin)
- **Reduce prostate size up to 27%**[1#]

DUAL PROTECTION:

Reduce relative risk of

- **AUR by 68%**
- **BPH related surgery by 71%**

vs tamsulosin monotherapy[1]

BPH: Benign Prostatic Hyperplasia
AUR: Acute Urinary Retention

DUODART Safety Information: 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 α-blockers and PDE5 inhibitors can lower blood pressure and cause symptomatic hypotension. **Fertility and sexual function 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.

DUODART (Dutasteride-tamsulosin) abbreviated prescribing information[2]: Indications Treatment of moderate to severe symptoms of benign prostatic hyperplasia (BPH). Reduction in the risk of acute urinary retention (AUR) and surgery in patients with moderate to severe symptoms of BPH. Limitations of use: Dutasteride-containing products, including DUODART, are not approved for the prevention of prostate cancer. **Dosage and Administration** The recommended dose of DUODART (Dutasteride-tamsulosin) is one capsule (0.5 mg/ 0.4 mg) taken once daily. The capsules should be swallowed whole and not chewed or opened. Contact with the contents of the dutasteride capsule contained within the hard-shell capsule may result in irritation of the oropharyngeal mucosa. **Contraindications** Patients with known hypersensitivity to dutasteride, other 5 alpharedуctase inhibitors, tamsulosin (including tamsulosin - induced angio-edema), soya, peanut or any of the excipients; history of orthostatic hypotension; with severe hepatic impairment; women and children and adolescents. **Warnings and Precautions** *Cardiac Failure* In two 4-year clinical study, the incidence of cardiac failure (a composite term of reported events, primarily cardiac failure and congestive cardiac failure) was higher among subjects taking the combination of dutasteride and an alpha1 - adrenoceptor antagonist, primarily tamsulosin, than it was among subjects not taking the combination. In these two trials, the incidence of cardiac failure was low (≤1%) and variable between the studies. *Effect on prostate-specific antigen (PSA) and prostate cancer detection* Serum prostate-specific antigen (PSA) concentration is an important component in the detection of prostate cancer. DUODART causes a decrease in mean serum PSA levels by approximately 50%, after 6 months of treatment. Patients receiving DUODART should have a new PSA baseline established after 6 months of treatment with DUODART. It is recommended to monitor PSA values regularly thereafter. Any confirmed increase from lowest PSA level while on DUODART may signal the presence of prostate cancer or noncompliance to therapy with DUODART and should be carefully evaluated, even if those values are still within the normal range for men not taking a 5-alpha reductase inhibitor. In the interpretation of a PSA value for a patient taking dutasteride, previous PSA values should be sought for comparison. Treatment with DUODART does not interfere with the use of PSA as a tool to assist in the diagnosis of prostate cancer after a new baseline has been established. Total serum PSA levels return to baseline within 6 months of discontinuing treatment. The ratio of free to total PSA remains constant even under the influence of DUODART. If clinicians elect to use percent free PSA as an aid in the detection of prostate cancer in men undergoing DUODART therapy, no adjustment to its value appears necessary. Digital rectal examination, as well as other evaluations for prostate cancer or other conditions which can cause the same symptoms as BPH, must be performed on patients prior to initiating therapy with DUODART and periodically thereafter. *Prostate cancer and high grade tumours* The REDUCE study, a 4-year, multicentre, randomised, double-blind, placebo controlled study investigated the effect of dutasteride 0.5 mg daily on patients with a high risk for prostate cancer (including men 50 to 75 years of age with PSA levels of 2.5 to 10 ng/ml and a negative prostate biopsy 6 months before study enrolment) compared to placebo. Results of this study revealed a higher incidence of Gleason 8 – 10 prostate cancers in dutasteride treated men (n=29, 0.9%) compared to placebo (n=19, 0.6%). The relationship between dutasteride and Gleason 8 – 10 prostate cancers is not clear. Thus, men taking Avodart should be regularly evaluated for prostate cancer. *Renal impairment* The treatment of patients with severe renal impairment (creatinine clearance of less than 10 ml/min) should be approached with caution as these patients have not been studied. *Hypotension* Orthostatic: As with other alpha1-adrenoceptor antagonists, a reduction in blood pressure can occur during treatment with tamsulosin, as a result of which, rarely, syncope can occur. Patients beginning treatment with DUODART should be cautioned to sit or lie down at the first signs of orthostatic hypotension (dizziness, weakness) until the symptoms have resolved. Symptomatic: Caution is advised when alpha adrenergic blocking agents including tamsulosin are co-administered with PDE5 inhibitors. Alpha1-adrenoceptor antagonists and PDE5 inhibitors are both vasodilators that can lower blood pressure. Concomitant use of these two drug classes can potentially cause symptomatic hypotension. *Intraoperative Floppy iris Syndrome* (IFIS, a variant of small pupil syndrome) has been observed during cataract surgery in some patients on or previously treated with tamsulosin. IFIS may increase the risk of eye complications during and after the operation. The initiation of therapy with DUODART in patients for whom cataract surgery is scheduled is therefore not recommended. During pre-operative assessment, cataract surgeons and ophthalmic teams should consider whether patients scheduled for cataract surgery are being or have been treated with DUODART in order to ensure that appropriate measures will be in place to manage the IFIS during surgery. Discontinuing tamsulosin 1 – 2 weeks prior to cataract surgery is anecdotally considered helpful, but the benefit and duration of stopping therapy prior to cataract surgery has not yet been established. *Leaking Capsule* Dutasteride is absorbed through the skin, therefore women and children and adolescents must avoid contact with leaking capsules. If contact is made with leaking capsules, the contact area should be washed immediately with soap and water. *Inhibitors of CYP3A4 and CYP2D6* Concomitant administration of tamsulosin hydrochloride with strong inhibitors of CYP3A4, or to a lesser extent, with strong inhibitors of CYP2D6 can increase tamsulosin exposure. Tamsulosin hydrochloride is therefore not recommended in patients taking a strong CYP3A4 inhibitor and should be used with caution in patients taking a moderate CYP3A4 inhibitor, a strong or moderate CYP2D6 inhibitor, a combination of both CYP3A4 and CYP2D6 inhibitors, or in patients known to be poor metabolisers of CYP2D6. *Hepatic Impairment* DUODART has not been studied in patients with liver disease Caution should be used in the administration of DUODART to patients with mild to moderate hepatic impairment. *Excipients* This medicinal product contains the colouring agent Sunset Yellow (E110), which may cause allergic reactions. *Breast neoplasia* There have been rare reports of male breast cancer reported in men taking dutasteride in clinical trials and during the post-marketing period. However, epidemiological studies showed no increase in the risk of developing male breast cancer with the use of 5-alpha reductase inhibitors. Physicians should instruct their patients to promptly report any changes in their breast tissue such as lumps or nipple discharge. **Interactions** *Tamsulosin* Concomitant administration of tamsulosin hydrochloride with drugs which can reduce blood pressure, including anaesthetic agents, PDE5 inhibitors and other alpha1 - adrenoceptor antagonists could lead to enhanced hypotensive effects. Dutasteride-tamsulosin should not be used in combination with other alpha1 - adrenoceptor antagonists. Concomitant administration of tamsulosin hydrochloride and ketoconazole (a strong CYP3A4 inhibitor) resulted in an increase of the Cmax and AUC of tamsulosin hydrochloride by a factor of 2.2 and 2.8 respectively. Concomitant administration of tamsulosin hydrochloride and paroxetine (a strong CYP2D6 inhibitor) resulted in an increase of the Cmax and AUC of tamsulosin hydrochloride by a factor of 1.3 and 1.6 respectively. A similar increase in exposure is expected in CYP2D6 poor metabolisers as compared to extensive metabolisers when co-administered with a strong CYP3A4 inhibitor. The effects of co-administration of both CYP3A4 and CYP2D6 inhibitors with tamsulosin hydrochloride have not been evaluated clinically, however there is a potential for significant increase in tamsulosin exposure. Concomitant administration of tamsulosin hydrochloride (0.4 mg) and cimetidine (400 mg every six hours for six days) resulted in a decrease in the clearance (26%) and an increase in the AUC (44%) of tamsulosin hydrochloride. Caution should be used when dutasteride-tamsulosin is used in combination with cimetidine. A definitive drug-drug interaction study between tamsulosin hydrochloride and warfarin has not been conducted. Results from limited in vitro and in vivo studies are inconclusive. Diclofenac and warfarin, however, may increase the elimination rate of tamsulosin. Caution should be exercised with concomitant administration of warfarin and tamsulosin hydrochloride. **Fertility, pregnancy and lactation** DUODART is contraindicated for use by women. There have been no studies to investigate the effect of DUODART on pregnancy, lactation and fertility. As with all 5 alpha reductase inhibitors, when the patient's partner is or may potentially be pregnant it is recommended that the patient avoids exposure of his partner to semen by use of a condom. As with other 5 alpha reductase inhibitors, dutasteride inhibits the conversion of testosterone to dihydrotestosterone and may, if administered to a woman carrying a male foetus, inhibit the development of the external genitalia of the foetus. 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. The effects of dutasteride 0.5 mg/day on semen characteristics were evaluated in healthy volunteers aged 18 to 52 (n=27 dutasteride, n=23 placebo) throughout 52 weeks of treatment and 24 weeks of post-treatment follow-up. At 52 weeks, the mean percent reduction from baseline in total sperm count, semen volume and sperm motility were 23%, 26% and 18%, respectively, in the dutasteride group when adjusted for changes from baseline in the placebo group. Sperm concentration and sperm morphology were unaffected. After 24 weeks of follow-up, the mean percent change in total sperm count in the dutasteride group remained 23% lower than baseline. While mean values for all parameters at all time points remained within the normal ranges and did not meet the predefined criteria for a clinically significant change (30%), two subjects in the dutasteride group had decreases in sperm count of greater than 90% from baseline at 52 weeks, with partial recovery at the 24 week follow-up. The possibility of reduced male fertility cannot be excluded. It is not known whether dutasteride or tamsulosin are excreted in human milk. **Adverse Reactions** *Clinical Trial Data* (Dutasteride and tamsulosin co-administration): Impotence, altered (decreased) libido, ejaculation disorders, breast disorders (includes breast tenderness and breast enlargement), dizziness and cardiac failure. (Dutasteride monotherapy): Impotence, altered (decreased) libido, ejaculation disorders, breast disorders (includes breast tenderness and breast enlargement), alopecia (primarily body hair loss), hypertrichosis. (Tamsulosin Monotherapy): Dizziness, abnormal ejaculation, palpitations, constipation, diarrhoea, vomiting, asthenia, rhinitis, rash, pruritis, urticaria, orthostatic hypotension, syncope, headache, nausea, angioedema, priapism, Stevens-Johnson syndrome. During postmarketing surveillance, reports of Intraoperative Floppy Iris Syndrome (IFIS), a variant of small pupil syndrome, during cataract surgery have been associated with alpha1 - adrenoceptor antagonists, including tamsulosin. In addition atrial fibrillation, arrhythmia, tachycardia, dyspnoea, epistaxis, vision blurred, visual impairment, erythema multiforme, dermatitis exfoliative, ejaculation disorder, retrograde ejaculation, ejaculation failure and dry mouth have been reported in association with tamsulosin use. The frequency of events and the role of tamsulosin in their causation cannot be reliably determined. Abbreviated PI based on HK072017(GDS15v1/eMC20170628). Please refer to the full prescribing information before prescribing. Full prescribing information is available upon request.

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

References: 1. Roehrborn CG, *et al. Eur Urol* 2010;57(1):123–31 **2.** DUODART Hong Kong Full Prescribing Information. Version number: HK072017(GDS15v1/eMC20170628).

For adverse events report, please call GlaxoSmithKline Limited at (HK) 852 9046 2498. Full prescribing information is available on request from GlaxoSmithKline Ltd., 23/F, Tower 6, The Gateway, 9 Canton Road, Tsimshatsui, Kowloon, Hong Kong.
Please read the full prescribing information prior to administration. This material is for the reference and use by healthcare professionals only.

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

PM-HK-DTT-PSTR-210002 (08/2023)
Date of Preparation: 09/2021

Programme

Time	Ballroom C (3/F)	Ballroom AB (3/F) & Sung Rooms (4/F)	Tang Rooms (3/F)
0900-0930	**Onsite and Online Reception (Foyer)**		
0930-1000	**Opening Ceremony**		***Live Streaming of Opening Ceremony***
1000-1100	**Session I A (AstraZeneca Session)**		**Session I B**
	Chairpersons: *Dr. Jane Chun-Kwong CHAN, Ms. Ellen Wai-Yin KU*		*Chairpersons:* *Dr. Samuel Ka-Shun FUNG, Dr. Victor Hip-Wo YEUNG*
1000-1025	**SGLT2 Inhibitors on Cardio-Renal Disease Management** Dr. Enoch WU		**Breakthroughs in the Treatment of Heart Failure** Dr. Michael Ka-Lam WONG
1025-1050	**An Update of Inhaled Therapies for Mild Asthma in Adults** Dr. Jamie Chung-Mei LAM		**Local Clinical Updates on Ketoanalogues Therapy with CKD Patients** Dr. Achilles Hoi-Kan LEE
1050-1100	Q&A		Q&A
1100-1120		**Coffee Break**	
1120-1220	**Session II A (GlaxoSmithKline Session)**		**Session II B**
	Chairpersons: *Prof. Bernard Man-Yung CHEUNG, Dr. Peggy Sau-Kwan CHU*		*Chairpersons:* *Dr. Kai-Ming CHAN, Dr. Raymond See-Kit LO*
1120-1145	**Treatable Trait in COPD** Dr. Terence Chi-Chun TAM		**Burden of Antibody Deficiency & Feasibility of Subcutaneous Immunoglobulin Replacement in Hong Kong** Dr. Philip Hei LI
1145-1210	**Starting Treatment Early for the Right Patients with Lower Urinary Tract Symptoms: 4 Things We Need to Know** Dr. Raymond Wai-Man KAN		**New Opportunities to Treat Cognitive Impairment** Dr. Alexander Yuk-Lun LAU
1210-1220	Q&A		Q&A
1220-1315		**Luncheon Symposium**	
		Chairperson: *Dr. Desmond Gia-Hung NGUYEN*	
1220-1305		**Long COVID: Brain Fog and Other Psychiatric Sequelae** Prof. MAK Ki-Yan	
1305-1315		Q&A	

1315-1415	**Session III A (Sanofi Session)**		**Session III B**
	Chairpersons: *Dr. NG Chun-Kong, Ms. Tina Woan-Tyng YAP*		*Chairpersons:* *Dr. Mario Wai-Kwong CHAK, Dr. Kai-Ming CHAN*
1315-1340	**The Importance of Early Insulinisation in Glycemic Control** Dr. Rose Zhao-Wei TING	(1315-1340)	**Medication and Cognitive Behavioral Training of ADHD** Dr. Fanny Wai-Fan LAM
1340-1345	Q&A		
1345-1410	**Novel Therapeutics of Biologics in Management of Chronic Rhinosinusitis with Nasal Polyp** Dr. Joseph Chun-Kit CHUNG	(1340-1405)	**Management of COVID-19 Infection in Renal Failure Patients** Dr. Desmond Yat-Hin YAP
1410-1415	Q&A	(1405-1415)	Q&A
1415-1515	**Session IV A**		**Session IV B**
	Chairpersons: *Dr. NG Chun-Kong, Prof. Eric Wai-Choi TSE*		*Chairpersons:* *Dr. CHAN Chi-Kuen, Prof. Bernard Man-Yung CHEUNG*
1415-1440	**Suspecting, Diagnosing & Managing ATTR-Cardiomyopathy** Dr. Kevin Ka-Ho KAM		**Latest Updated Management of Gout** Dr. Priscilla Ching-Han WONG
1440-1505	**Management of Severe Asthma - From Triple Inhalers Therapy to Biologics** Dr. David Chi-Leung LAM		**Osteoporosis in Primary Care Clinic Settings** Dr. David Tak-Wai LUI
1505-1515	Q&A		Q&A
1515-1535	**Coffee Break**		
1535-1635	**Session V A**		
	Chairpersons: *Dr. Kingsley Hau-Ngai CHAN, Prof. Eric Wai-Choi TSE*		
1535-1600	**CAR-T Cell Therapy: New Hope for Patients with Haematological Malignancy** Dr. Thomas Sau-Yan CHAN		
1600-1625	**The Use of Top Graft (Decalcified Tooth Tissue) in Modified Khoury's Technique with Autologous Concentrated Growth Factor (CGF) Preparation in Alveolar Augmentation** Dr. Spencer Chiu-Yee CHAN		
1625-1635	Q&A		
1635-1645	**Closing Ceremony & Lucky Draw**		

Welcome Message from the President

Prof. Bernard Man-Yung CHEUNG
President, The Federation of Medical Societies of Hong Kong

To all our distinguished guests, representatives from our member societies and to all the participants attending in person or joining us online, I would like to offer you my warmest welcome for taking part in the 2022 Annual Scientific Meeting of the Federation of Medical Societies of Hong Kong. The world has seen an unprecedented pandemic that has affected hundreds of millions of people and severely tested our medical services. I hope, as you all do, that there is light at the end of the tunnel. At least, we have learnt to cherish health and well-being as we have never done before. Medical advances have played a huge part in seeing us through this pandemic, from accurate and rapid diagnostic testing, to the production of effective vaccines, the mass vaccination of whole populations, and the use of proven treatments for those infected with COVID-19. It is therefore fitting that our theme this year is "Innovations in Disease Diagnosis and Management".

The Federation, in partnership with the Department of Health, has produced guidelines on COVID-19 vaccination for people with different chronic diseases. We were able to do this thanks to the input from our member societies, such as the Hong Kong Association for the Study of Liver Diseases, the Hong Kong Cancer Therapy Society, the Hong Kong Society for Infectious Diseases, the Hong Kong Society for HIV Medicine, the Hong Kong Society of Haematology and the Hong Kong Society of Rheumatology. The Hong Kong Institute of Allergy and the Hong Kong Society of Transplantation have also provided their own guidance notes to the Department of Health. These guidelines provide useful references for clinicians to advise their patients on COVID-19 vaccination. Basically, most people in the population are eligible for vaccination with few exceptions, and people who have the greatest burden of chronic diseases benefit the most from vaccination. The Federation has been as keen as the Department of Health on promoting this important message to the population as well as to health professionals. Thus, we have organised numerous seminars and webinars on topics related to COVID-19 and vaccination against it, informing the public and health professionals alike, and allaying unfounded fears.

The Federation was among the first to recognise that elderly and disabled people residing in nursing homes had difficulties in getting vaccinated, but were also at the highest risk should there be an outbreak. Together with The Hong Kong Council of Social Service, the Federation has taken the lead in engaging health professionals, including doctors and nurses, to go out to the community and offer vaccination to those residing in nursing

homes. This excellent initiative caught the attention of the SAR government and the HSBC, so that we received strong financial support for these programmes.

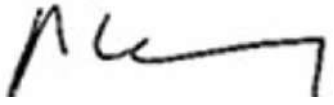
Although we are fully pre-occupied by the pandemic and all its complications, we must not lose sight of other pressing priorities. One such is action against narcotics. The Federation has a strong record in speaking out against substance abuse, such as our strong stand against electronic cigarettes and heat-not-burn tobacco. Last year and this year, we are beginning to turn our attention to drug abuse in the population, especially amongst young people.

Following the successful open forum held during our annual scientific meeting last year, we are holding another forum to start our annual scientific meeting, in partnership with Action Committee Against Narcotics (ACAN), so as to highlight the problems and challenges facing Hong Kong.

Our annual scientific meeting has always been packed full of informative lectures covering the widest spectrum of medicine, reflecting the diverse interests and expertise of our 147 member societies. This year is no exception, and so common diseases as well as less common diseases are covered. I hope you will, as I do, find the scientific programme both interesting and educational.

For those whose appetite is whetted by the sumptuous programme of lectures, please also read our monthly Medical Diary, which is now available both in print and online. To tie in with the themes of the Hong Kong Medical Diary, the Federation is collaborating with Healthpedia (精靈一點) the lunchtime health programme on Radio One, Radio Television Hong Kong. This is a live programme in which some of the authors of the Medical Diary appear live to talk about common diseases and take phone calls from the public.

Finally, I wish to thank our officiating guests for lending their strong support to our meeting with their presence. I also appreciate the brilliant work of the Organising Committee and the sterling work from our Secretariat. I should also thank our sponsors for making this event possible. Last but not least, I must thank all our participants for making this meeting an interactive and fruitful meeting. I hope you all enjoy the meeting and may I wish you good health.



Welcome Messages from Chairpersons

Dr. NG Chun-Kong

Co-chairman, Annual Scientific Meeting 2022

On behalf of the Annual Scientific Meeting Organizing Committee, it is my great pleasure to welcome all of you to attend the FMSHK 2022 ASM with the theme "**Innovation in Disease Diagnosis and Management**". Building on past successes, our 2022 ASM programme continues to strive for high scientific value, comprehensive coverage and clinical practicability. Advances in medical diseases treatments on diabetes mellitus, congestive heart failure, asthma and chronic obstructive pulmonary disease, infection, haematological malignancy and cardiomyopathy will be included in the programme. In addition, novel developments in surgery, ENT, Paediatrics, Psychiatry and Dentistry will also be introduced. The 2022 ASM offers an excellent opportunity to update ones' knowledge and acquire insights from other specialties.

We are also delighted to have invited many distinguished local speakers coming from the Public, University and Private streams. Together, they will enlighten us on the most contemporaneous advances and developments in their own specialties, from different angles and perspectives.

COVID-19 pandemic has fundamentally changed the format of scientific meetings and social gatherings. This year, our ASM will be conducted in hybrid mode to cater for different social needs. You may choose to attend the lectures online, but you are also welcomed to come to the Sheraton Hotel to attend meetings in person. After 2-years' social isolation, this is a good opportunity to meet your friends and colleagues face-to-face, and to see the rich exhibitions of different medical products and equipment prepared by our sponsors. Last but not the least, we hope you will enjoy our programmes and have a fruitful learning through attending the 2022 Annual Scientific Meeting.

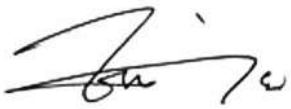
Welcome Messages from Chairpersons

Prof. Eric Wai-Choi TSE

Co-chairman, Annual Scientific Meeting 2022

It is my great pleasure to welcome you to the 2022 Annual Scientific Meeting (ASM) of the Federation of Medical Societies of Hong Kong (FMSHK). I am honoured to co-chair this meeting with Dr. Chun-kong Ng, the 1st Vice-President of the FMSHK. The ASM is a key programme and one of the most important events of the FMSHK. It provides a platform for knowledge exchange for health care professionals. This year, the Organising Committee has prepared a rich and exciting one-day programme for all of you, focusing on "Innovations in Disease Diagnosis and Management". The programme covers a wide range of topics and they include practical management of common diseases such as asthma and heart failure, and new medical advances such as novel treatment for transthyretin amyloid cardiomyopathy and chimeric antigen receptor T-cell therapy.

On behalf of the Organising Committee, I would like to thank you for your participation in the ASM and hope you would enjoy the programme. I would also like to take this opportunity to thank the sponsors for their generous support. Thank you very much.



Now Approved ATECTURA® BREEZHALER® INDACATEROL / MOMETASONE for Asthma

1x daily

Low - dose IND/MF: 150/80 µg
Medium - dose IND/MF:150/160 µg
High - dose IND/MF: 150/320 µg

ATECTURA® BREEZHALER® powerful efficacy to Asthma Patients

**Secondary analysis, analyzed using MMRM, not controlled for multiplicity.
†From a pre-specified pooled analysis across PALLADIUM and IRIDIUM to evaluate benefit of ATECTURA® BREEZHALER® high-dose vs. SAL/FLU high-dose.[1,2,3]
IND / MF: Indacaterol / Mometasone
SAL / FLU: Salmeterol / Fluticasone

26%

Pooled analysis across IRIDIUM and PALLADIUM:**
Reduction in **severe exacerbation rate** with ATECTURA® BREEZHALER® high-dose (once-daily) vs. SAL/FLU high-dose (twice-daily) over 52 weeks†[1,2,3]

ATECTURA® BREEZHALER® Important note: Before prescribing, consult full prescribing information. **Presentation:** Inhalation powder hard capsules containing indacaterol (as acetate) 150 micrograms and mometasone furoate 80 or 160 or 320 micrograms respectively. **Indications:** Atectura Breezhaler is indicated as a maintenance treatment of asthma in adults and adolescents 12 years of age and older not adequately controlled with inhaled corticosteroids and inhaled short-acting beta2-agonists. **Dosage and administration: Adults and adolescent age 12 years and above:** The recommended dose is one capsule to be inhaled once daily. ♦Patients should be given the strength containing the appropriate mometasone furoate dosage for the severity of their disease and should be regularly reassessed by a healthcare professional. ♦The maximum recommended dose is Atectura Breezhaler 150/320 micrograms once daily. **Pediatric patients (below 12 years):** The safety and efficacy in paediatric patients below 12 years of age have not been established. No data are available. **Special populations:** ***Renal impairment:*** No dose adjustment. ***Hepatic impairment:*** No dose adjustment in patients with mild and moderate hepatic impairment. No data is available for subjects with severe hepatic impairment, should be used in these patients only if the expected benefit outweighs the potential risk. ***Geriatric patients (65 years of age and older):*** No dose adjustment. **Method of administration** ♦For inhalation only. Must not be swallowed. Patients who do not experience improvement in breathing should be asked if they are swallowing the capsule rather than inhaling it. ♦Should only use the Atectura Breezhaler inhaler with each new prescription. ♦Should be administered at the same time of the day each day; can be administered irrespective of the time of the day. ♦After inhalation, patients should rinse their mouth with water without swallowing. ♦If a dose is missed, it should be taken as soon as possible. Patients should be instructed to not take more than one dose in a day. ♦Atectura Breezhaler capsules must always be stored in the blister to protect from moisture and light, and only removed immediately before use. **Contraindications:** ♦Hypersensitiv ty to any of the active substances or excipients. **Warnings and precautions:** ♦**Deterioration of disease:** Should not be used to treat acute asthma symptoms including acute episodes of bronchospasm. A short acting bronchodilator should be used. Patients should not stop treatment without physician supervision since symptoms may recur after discontinuation. It is recommended that treatment with this medicinal product should not be stopped abruptly. ♦**Hypersensitivity:** If hypersensitivity reaction occurs, Atectura Breezhaler should be discontinued immediately and alternative therapy instituted. ♦**Paradoxical bronchospasm:** As with other inhalation therapy, administration may result in paradoxical bronchospasm that may be life-threatening. If paradoxical bronchospasm occurs, Atectura Breezhaler should be discontinued immediately and alternative therapy instituted. ♦**Cardiovascular effects:** Like other medicinal products containing beta-adrenergic agonists, may produce a clinically significant cardiovascular effect in some patients as measured by increases in pulse rate, blood pressure, and/or symptoms. If such effects occur, treatment may need to be discontinued. Should be used with caution in patients with cardiovascular disorders (coronary artery disease, acute myocardial infarction, cardiac arrhythmias, hypertension), convulsive disorders, thyrotoxicosis, or in patients who are unusually responsive to beta2-adrenergic agonists. Long-acting beta2-adrenergic agonists (LABA) or LABA-containing combination products such as Atectura Breezhaler should therefore be used with caution in patients with known or suspected prolongation of the QT interval or who are being treated with medicinal products affecting the QT interval. ♦**Hypokalemia:** Beta2-adrenergic agonists may produce significant hypokalemia in some patients, which has the potential to produce adverse cardiovascular effects. In patients with severe condition, hypokalemia may be potentiated by hypoxia and concomitant treatment which may increase the susceptibility to cardiac arrhythmias ♦**Hyperglycemia:** Inhalation of high dose of beta2-adrenergic agonist and corticosteroids may produce increase in plasma glucose. Upon initiation of treatment with Atectura Breezhaler, plasma glucose should be monitored more closely in diabetic patients. ♦**Prevention of oropharyngeal infections:** In order to reduce the risk of oropharyngeal candida infection, patients should be advised to rinse their mouth or gargle with water without swallowing it or brush their teeth after inhaling the prescribed dose. ♦**Systemic effects of corticosteroids:** Systemic effects of inhaled corticosteroids may occur, particularly at high doses prescribed for prolonged periods. Should be administered with caution in patients with pulmonary tuberculosis or in patients with chronic or untreated infections. ♦**Excipients:** This medicinal product contains lactose. Patients with rare hereditary problems of galactose intolerance, total lactase deficiency or glucose-galactose malabsorption should not take this medicinal product. **Pregnancy:** Should only be used if the expected benefit to the patient justifies the potential risk to the fetus. **Lactation:** A decision must be made whether to discontinue breast-feeding or to discontinue/abstain from therapy, taking into account the benefit of breast-feeding for the child and the benefit of therapy for the woman. **Labor and delivery:** Reproduction studies and other data in animals did not indicate a concern regarding fertility in either males or females. **Adverse reactions:** ♦**Very Common (>10%):** nasopharyngitis, asthma (exacerbation). ♦**Common (>0.1 to <10%):** upper respiratory tract infection, hypersensitivity, headache, oropharyngeal pain, dysphonia, musculoskeletal pain. ♦**Uncommon (>0.1 to <1%):** candidiasis, angioedema, hyperglycaemia, vision blurred, cataract, tachycardia, rash, pruritus, muscle spasms. **Interactions:** ♦**Beta-adrenergic blockers:** Should not be given together with beta-adrenergic blockers (including eye drops) unless there are compelling reasons for their use ♦**Medicinal products prolong QTc interval:** Should be administered with caution to patients being treated with monoamine oxidase inhibitors, tricyclic antidepressants, or drugs known to prolong the QT-interval. ♦**Hypokalemic treatment:** Concomitant treatment with methylxanthine derivatives, steroids, or non-potassium sparing diuretics may potentiate the possible hypokalemic effect of beta2-adrenergic agonists. ♦**CYP3A4 and P-glycoprotein inhibitors:** Inhibition of CYP3A4 and P-gp has no impact on the safety of therapeutic doses of Atectura Breezhaler. ♦**Other long acting beta2-adrenergic agonists:** Co-administration with other medicinal products containing long-acting beta2-adrenergic agonists is not recommended. **Packs:** 30 x 1 hard capsules, together with 1 inhaler **Legal classification:** P1S1S3 Last revision: Jun 2021 Ref: EU Mar 2021

Reference: 1. Champman K, et al. Poster A3004. ATS, Philadelphia; 15-20 May, 2020. **2.** Kerstjens M, et al. IRIDIUM trial. Lancet Respir Med 2020 Oct; 8(10): 1000-1012. **3.** Vvan ZylSmit RN, et al. PALLADIUM trial. Lancet Respir Med 2020 Oct; 8(10): 987-99.

The materials for Atectura contained in this virtual exhibition are approved for use only in Hong Kong. Prescribing information may vary depending on local approval in each country / location. Therefore, before prescribing any product, always refer to local materials such as the prescribing information and/or the Summary of Product Characteristics (SPC)

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Novartis Pharmaceuticals (HK) Limited
7/F, Citi Tower, One Bay East, 83 Hoi Bun Road, Kwun Tong,
Kowloon, Hong Kong Tel: +852 2882 5222 Fax: +852 2577 0274

ONCE DAILY
ATECTURA® breezhaler®
Indacaterol acetate / mometasone furoate inhalation powder

HK2108183978

ENERZAIR® BREEZHALER®

1x daily

ENERZAIR® BREEZHALER® provides substantial reduction of asthma attacks*

In a secondary analysis,**
ENERZAIR® BREEZHALER® IND/GLY/MF (once-daily)
reduced exacerbations vs. SAL/FLU high-dose(twice-daily)

36%
Reduction in annualized rate of
moderate or severe exacerbations[1]
Rate ratio (95% CI), 0.64
(0.52, 0.78); p<0.001

42%
Reduction in annualized rate of
severe exacerbations[1]
Rate ratio (95% CI), 0.58
(0.45, 0.73); p<0.001

ENERZAIR® BREEZHALER® :IND/GLY/MF 150/50/160µg (once-daily); SAL/FLU high-dose = SAL/FLU 50/500µg (twice-daily)

*In symptomatic asthma patients, despite treatment with medium- or high-dose LABA/ICS.[1]

**Secondary analysis, not controlled for multiplicity – analyzed using a generalized linear model assuming the negative binomial distribution.[1] 52-week randomized study in 3,092 asthma patients, inadequately controlled on medium- or high-dose ICS/LABA.[1]

ENERZAIR® BREEZHALER® Important note: Before prescribing, consult full prescribing information. **Presentation:** Inhalation powder hard capsules containing indacaterol (as acetate) 150 micrograms, glycopyrronium 50 micrograms and mometasone furoate 160 micrograms respectively. **Indications:** Enerzair Breezhaler is indicated as a maintenance treatment of asthma in adult patients not adequately controlled with a maintenance combination of a long acting beta$_2$ agonist and a high dose of an inhaled corticosteroid who experienced one or more asthma exacerbations in the previous year. **Dosage and administration: Adults:** The recommended dose is one capsule to be inhaled once daily. ♦The maximum recommended dose is Enerzair Breezhaler 150/50/160 micrograms once daily. **Pediatric patients (below 18 years):** The safety and efficacy of Enerzair Breezhaler in paediatric patients below 18 years of age have not been established. No data are available. **Special populations:** ***Renal impairment:*** No dose adjustment is required in patients with mild to moderate renal impairment. Caution should be observed in patients with severe renal impairment or end stage renal disease requiring dialysis. ***Hepatic impairment:*** No dose adjustment is required in patients with mild or moderate hepatic impairment. No data are available for the use of the medicinal product in patients with severe hepatic impairment, therefore it should be used in these patients only if the expected benefit outweighs the potential risk. ***Geriatric patients:*** No dose adjustment is required in elderly patients (65 years of age or older) **Method of administration:** ♦For inhalation only. Must not be swallowed. Patients who do not experience improvement in breathing should be asked if they are swallowing the capsule rather than inhaling it. ♦The capsules must be administered only using the inhaler provided with each new prescription. ♦Should be administered at the same time of the day each day; can be administered irrespective the time of the day. ♦After inhalation, patients should rinse their mouth with water without swallowing. ♦If a dose is missed, it should be taken as soon as possible. Patients should be instructed to not take more than one dose in a day. ♦Enerzair Breezhaler capsules must always be stored in the blister to protect from moisture and light, and only removed immediately before use. **Contraindications:** ♦Hypersensitivity to any of the active substances or excipients. **Warnings and precautions:** ♦**Deterioration of disease:** Should not be used to treat acute asthma including acute episodes of bronchospasm. A short acting bronchodilator should be used. Patients should not stop treatment without physician supervision since symptoms may recur after discontinuation. It is recommended that treatment with this medicinal product should not be stopped abruptly. ♦**Hypersensitivity:** If hypersensitivity reaction occurs, Enerzair Breezhaler should be discontinued immediately and alternative therapy instituted. ♦**Paradoxical bronchospasm:** As with other inhalation therapy, administration may result in paradoxical bronchospasm that may be life-threatening. If paradoxical bronchospasm occurs, Enerzair Breezhaler should be discontinued immediately and alternative therapy instituted. ♦**Cardiovascular effects:** Like other medicinal products containing beta$_2$adrenergic agonists, may produce a clinically significant cardiovascular effect in some patients as measured by increases in pulse rate, blood pressure, and/or symptoms, ECG changes. Should be used with caution in patients with cardiovascular disorders (coronary artery disease, acute myocardial infarction, cardiac arrhythmias, hypertension, known or suspected prolongation of the QT interval), convulsive disorders, thyrotoxicosis, or in patients who are unusually responsive to beta$_2$-adrenergic agonists. ♦**Hypokalemia:** Beta$_2$-adrenergic agonists may produce significant hypokalemia in some patients, which has the potential to produce adverse cardiovascular effects. In patients with severe condition, hypokalemia may be potentiated by hypoxia and concomitant treatment which may increase the susceptibility to cardiac arrhythmias. ♦**Hyperglycemia:** Inhalation of high doses of beta$_2$-adrenergic agonists and corticosteroids may produce increases in plasma glucose. Upon initiation of treatment with Enerzair Breezhaler, plasma glucose should be monitored more closely in diabetic patients. ♦**Anticholinergic effects:** Use with caution in patients with narrow-angle glaucoma and urinary retention. Patients should be advised about signs and symptoms of acute narrow angle glaucoma and should be instructed to stop treatment and to contact their doctor immediately should any of these signs or symptoms develop. ♦**Patients with severe renal impairment:** Caution should be observed in patients with severe renal impairment or end stage renal disease requiring dialysis ♦**Prevention of oropharyngeal infections:** In order to reduce the risk of oropharyngeal candida infection, patients should be advised to rinse their mouth or gargle with water without swallowing it or brush their teeth after inhaling the prescribed dose. ♦**Systemic effects of corticosteroids:** Systemic effects of inhaled corticosteroids may occur, particularly at high doses prescribed for prolonged periods. Should be administered with caution in patients with pulmonary tuberculosis or in patients with chronic or untreated infections. ♦**Excipients:** This medicinal product contains lactose. Patients with rare hereditary problems of galactose intolerance, total lactase deficiency or glucose-galactose malabsorption should not take this medicinal product. **Pregnancy:** Should only be used if the expected benefit to the patient justifies the potential risk to the fetus. **Lactation:** A decision must be made whether to discontinue breast-feeding or to discontinue/abstain from therapy, taking into account the benefit of breast-feeding for the child and the benefit of therapy for the woman. **Labor and delivery:** Like other medicinal products containing beta$_2$-adrenergic agonists, indacaterol may inhibit labor due to a relaxant effect on uterine smooth muscle. **Adverse drug reactions:** ♦**Very Common (≥10%):** nasopharyngitis, asthma (exacerbation) ♦**Common (≥1% to <10%):** upper respiratory tract infection, candidiasis, urinary tract infection, hypersensitivity, headache, tachycardia, oropharyngeal pain, cough, dysphonia, gastroenteritis, musculoskeletal pain, muscle spasms, pyrexia. ♦**Uncommon (≥0.1% to <1%):** hyperglycaemia, cataract, dry mouth, rash, pruritus, dysuria. **Interactions:** ♦**Beta-adrenergic blockers:** Should not be given together with beta-adrenergic blockers (including eye drops) unless there are compelling reasons for their use. ♦**Medicinal products prolong QTc interval:** Should be administered with caution to patients being treated with monoamine oxidase inhibitors, tricyclic antidepressants, or drugs known to prolong the QT-interval ♦**Hypokalemic treatment:** Concomitant treatment with methylxanthine derivatives, steroids, or non-potassium sparing diuretics may potentiate the possible hypokalemic effect of beta$_2$-adrenergic agonists. ♦**CYP3A4 and P-glycoprotein inhibitors:** Inhibition of CYP3A4 and P-gp has no impact on the safety of therapeutic doses of Enerzair Breezhaler. ♦ **Other long acting antimuscarinics and long acting beta$_2$-adrenergic agonists:** Co-administration with other medicinal products containing long-acting muscarinic antagonists or long-acting beta2adrenergic agonists is not recommended. ♦**Cimetidine or other inhibitors of the organic cation transport:** No clinically relevant drug interaction is expected. **Packs:** 30 x 1 hard capsules, together with 1 inhaler **Legal classification:** P1S1S3 Last revision: Sep 2021 Ref: EU May 2021

Reference: 1. Kersjens H, *et al. Lancet Respir Med* 2020;8(10):1000-1012.

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Indacaterol acetate / glycopyrronium bromide / mometasone furoate inhalation powder

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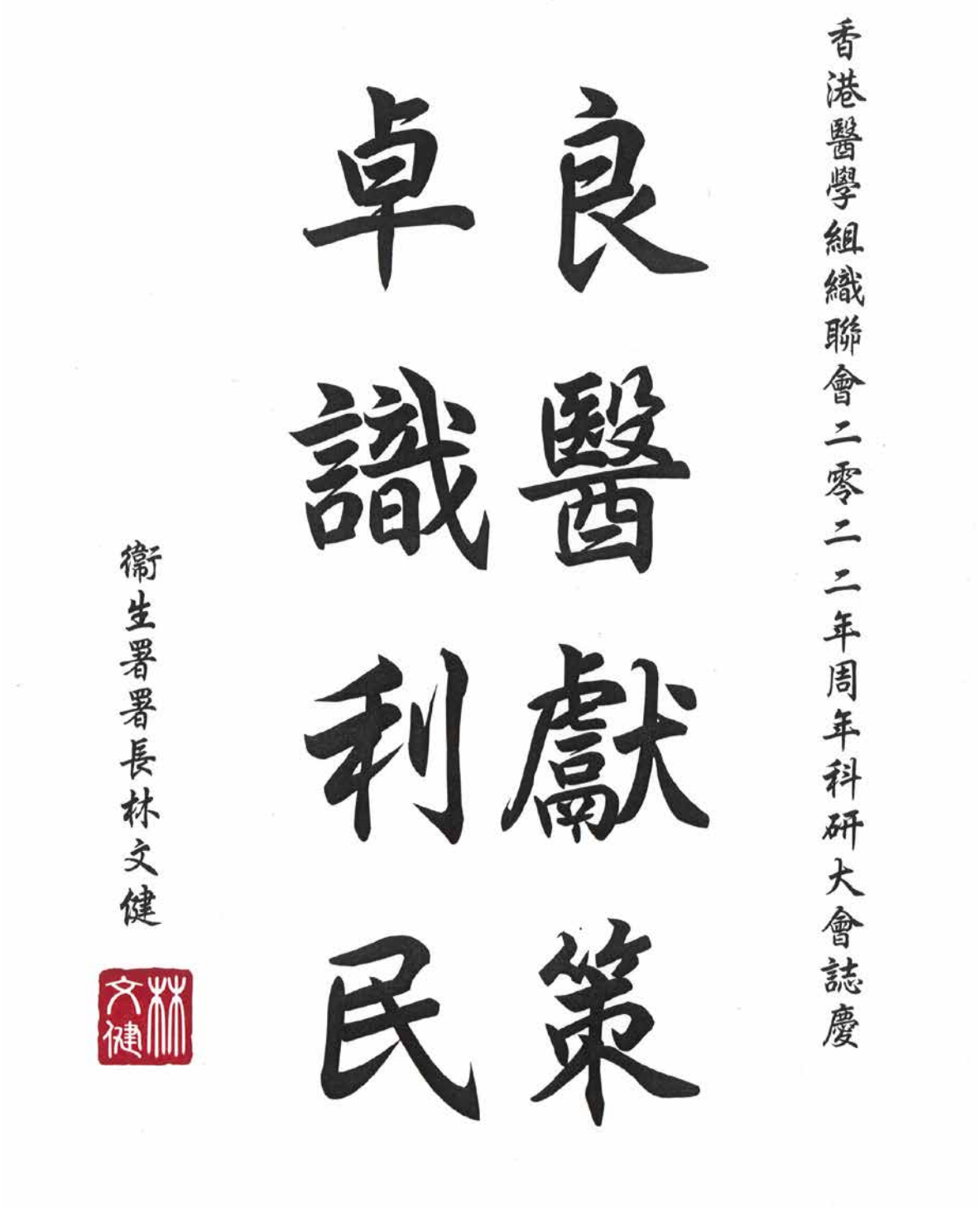

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Congratulatory Messages

Prof. LAU Chak-Sing

Dean, Li Ka Shing Faculty of Medicine,
The University of Hong Kong

It gives me great pleasure in congratulating the Federation of Medical Societies of Hong Kong for organising the Annual Scientific Meeting 2022, with the theme 'Innovations in Disease Diagnosis and Management'.

Advancement in medicine is a never-ending pursuit, expedited by scientific and technological innovations. Indeed, such innovations have helped inform and equip medical practitioners to tackle new challenges brought about by new diseases, pandemics and epidemics, as well as the rapidly ageing global population.

Innovations can evolve fast, yet our patient-centred approach always remains constant. Medical advancements enable better prevention, diagnosis and clinical care, and their successful implementation rests with medical practitioners' genuine empathy and understanding of patient needs; involving patients in the decision-making process; as well as having access to new knowledge. Only then can innovations in medicine serve to enhance the well-being of our local and wider community.

This Meeting is a valuable assembly of experts across specialties to shed light and exchange ideas on the latest healthcare innovations. I wish the Federation and the organising committee every success in the coming Scientific Meeting, and trust that the concerted efforts of all the medical practitioners and stakeholders will contribute to a better and healthier world.

Prof CS Lau
Dean of Medicine

Congratulatory Messages

Prof. Francis KL CHAN, JP

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

The Annual Scientific Meeting 2022 of The Federation of Medical Societies of Hong Kong focuses on "Innovations in Disease Diagnosis and Management".

Medical innovations such as new medicines, novel technologies, and alternative delivery models will be crucial to improving the health of the world's population. These innovations not only aim to cure diseases but also predict and prevent various health hazards, therefore improving our quality of life.

The Government has invested substantial resources in innovation and technology. This is a golden opportunity for us to join hands to make positive changes to healthcare.

Innovation, however, will require the shared vision and concerted efforts by different parties, including pharmaceutical companies, medical technology companies, and academia. This Annual Scientific Meeting provides a good platform to gather interested parties together and share the latest development on "Innovations in Disease Diagnosis and Management".

May I take this opportunity to wish the conference every success.

Congratulatory Messages

Mr. Henry Hung-Ling FAN, SBS, JP
Chairman, Hospital Authority

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

The rapid advances of medical sciences and increasing knowledge of the public has resulted in both our patients and our health care professionals seeking more accurate and succinct diagnosis and evidence based treatment. Gone are the days for example when radical mastectomy are done for any cancer of the breast with disfiguring and socially unacceptable results. Today malignant breast lumps are usually subjected to local excision, sentinel lymph node biopsy, histopathology determination of the cell type followed by exact adjuvant therapy. Many other examples abound.

The theme of this year's scientific meeting "Innovation in Disease Diagnosis and Management" is therefore appropriate. It is the quest for all health professions who aspire for better health for patients we care.

Congratulations to the Federation of Medical Societies, I wish the Annual Scientific Meeting every success.

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75% of patients with Major Depressive Disorder (MDD) reported experiencing ANHEDONIA[1-3]

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Brintellix® demonstrated a SUPERIOR EFFECT compared to agomelatine on ANHEDONIA and FUNCTIONING[5]

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Reference: 1. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). 2013; 2. Cao B et al. Front Psychiatry. 2019 Jan 31; 10:17; 3. Conradi HJ, et al. Psychol Med 2011; 41: 1165-117; 4.Fagiolini A et al. J Affect Disord. 2021;283:472-479; 5. McIntyre RS, et al. Neuropsychiatr Dis Treat. 2021;17:575–585; 6.Christensen MC, et al. CNS Spectr. 2021;1-26.

BRINTELLIX® (VORTIOXETINE) - ABBREVIATED PRESCRIBING INFORMATION
Brintellix®: Active Substance: Vortioxetine Hydrobromide. **Presentation:** Film-coated tablets 5mg, 10mg and 20mg. **Indication:** Treatment of major depressive episodes in adults. **Dosage:** Adults: starting and recommended dose is 10mg, once-daily, taken with or without food. Elderly ≥65 years: Starting dose 5mg. Children and adolescents (<18 years): should not be used. Discontinuation: Patients can abruptly stop taking the medicinal product without the need for a gradual reduction in dose. **Contraindications:** Hypersensitivity to vortioxetine or to any of the excipients. Combination with MAO-inhibitors. Should not be used during pregnancy or lactation unless clearly needed and after careful consideration of the risk/benefit. **Special warnings and precautions:** Depression is associated with an increased risk of suicidal thoughts, self-harm and suicide. It is a general clinical experience that the risk of suicide may increase in the early stages of recovery. Close supervision of high-risk patients should accompany drug therapy. Patients (and caregivers) should be alerted about the need to monitor for any clinical worsening, suicidal behavior or thoughts and unusual changes in behaviour and to seek medical advice immediately if these symptoms present. Should be introduced cautiously in patients who have a history of seizure or in patients with unstable epilepsy. Patients should be monitored for the emergence of signs and symptoms of Serotonin Syndrome or Neuroleptic Malignant Syndrome. Should be used with caution in patients with a history of mania/hypomania and should be discontinued in any patient entering a manic phase. Patients treated with antidepressants, including vortioxetine, may also experience feelings of aggression, anger, agitation and irritability. Patient's condition and disease status should be closely monitored. There have been reports of cutaneous bleeding abnormalities with the use of SSRIs/SNRIs. Hyponatraemia has been reported rarely with the use of SSRIs/SNRIs. Mydriasis has been reported in association with use of antidepressants, including vortioxetine. This mydriatic effect has the potential to narrow the eye angle resulting in increased intraocular pressure and angle-closure glaucoma. Caution should be exercised for patients with renal or hepatic impairment. **Interactions:** Caution is advised when taken in combination with MAO-inhibitors, serotonergic medicinal products, products lowering the seizure threshold, lithium, tryptophan, St. John's Wort, oral anticoagulants or antiplatelet agents, and products predominantly metabolised by the enzymes CYP2D6, CYP3A4, CYP2C9, and Cytochrome P450. There have been reports of false positive results in urine enzyme immunoassays for methadone in patients who have taken vortioxetine. **Undesirable effects:** Very common: Nausea. Common: abnormal dreams, dizziness, diarrhoea, constipation, vomiting, pruritus, including pruritus generalised. Uncommon: flushing, night sweats. Rare: Mydriasis (which may lead to acute narrow angle glaucoma). Not known: Anaphylactic reaction, Hyponatraemia, Insomnia, Serotonin Syndrome, Haemorrhage (including contusion, ecchymosis, epistaxis, gastrointestinal or vaginal bleeding), Angioedema, Urticaria, Agitation, Aggression, Rash. **Overdose:** Symptomatic treatment. The most frequently reported symptoms were nausea and vomiting for overdoses of up to 80 mg and seizure and serotonin syndrome for overdoses above 80 mg. **Legal category:** POM. **Marketing Authorisation Holder:** Lundbeck HK Limited, Suite 4303, Central Plaza, 18 Harbour Road, Wanchai, Hong Kong. **Revision Date:** Jan 2021 based on HK SmPC dated Sep 2020. **Full prescribing information is available upon request.**

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ATTR-CM, a life-threatening and progressive disease that is widely and frequently underdiagnosed[1,2]

25% of adults aged 80 years or older were found to have significant myocardial TTR amyloid deposition at autopsy[2]

What is ATTR-CM?[2]

- A type of cardiac amyloidosis
- Can occur as either wild type or hereditary type
- Progressive and life-threatening
- When the protein transthyretin misfolds, fibril deposits build up in the heart causing ATTR-CM

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The following *Red Flags* warrant your immediate attention[2-4]:

Cardiac:

- HFpEF[2]
- **HF therapy intolerance**[*3]
  [*]The standard therapies for HF, including ACEI, ARB, and BB[3]
- LVH on Echo[2]
- **Imaging and ECG discrepancy**[**2]
  [**]Imaging finding of LVH and normal/low QRS voltage on ECG[2]

Non-cardiac:

- **Orthopaedic syndromes** (e.g carpal tunnel syndrome, lumbar spinal stenosis and bicep tendon rupture)[2]
- Polyneuropathy[2]
- Family history of TTR amyloidosis[4]

Abbreviations: ACEI: Angiotensin-converting enzyme inhibitors; **ARB:** Angiotensin-receptor blockers; **ATTR-CM:** Transthyretin amyloid cardiomyopathy; **BB:** Beta blockers; **ECG:** Electrocardiogram; **Echo:** Echocardiography; **HF:** Heart failure; **HFpEF:** Heart failure with preserved ejection fraction; **LVH:** Left ventricular hypertrophy; **TTR:** Transthyretin

References: 1. Rapezzi C et al. *Nat Rev Cardiol.* 2010;7(7):398-408. **2.** Witteles RM et al. *JACC Heart Fail.* 2019;7(8):709-16. **3.** Castano A et al. *Heart Fail Rev.* 2015;20(2):163-78. **4.** Kittleson MM. *Circulation.* 2020;142(1):e7-e22.

VYNDAMAX ABBREVIATED PRESCRIBING INFORMATION

1. TRADE NAME: Vyndamax™ capsules (Tafamidis 61 mg) **2. PRESENTATION:** 61mg soft capsules **3. INDICATIONS**: Vyndamax is indicated for the treatment of wild-type or hereditary transthyretin amyloidosis in adult patients with cardiomyopathy (ATTR-CM). **4. DOSAGE**: The recommended dose is one capsule of Vyndamax 61 mg (tafamidis) orally once daily. **5. CONTRAINDICATIONS**: Hypersensitivity to the active substances or to any of the excipients of the drug (Please refer to the full prescribing information for details). **6. WARNINGS & PRECAUTIONS:** Women of childbearing potential should use appropriate contraception when taking tafamidis and continue to use appropriate contraception for 1-month after stopping treatment with tafamidis. Tafamidis should be added to the standard of care for the treatment of patients with transthyretin amyloidosis. Physicians should monitor patients and continue to assess the need for other therapy, including the need for organ transplantation, as part of this standard of care. Tafamidis should be discontinued in patients who undergo organ transplantation. **7. INTERACTIONS:** Substrates of efflux transporter BCRP (breast cancer resistant protein; e.g., methotrexate, rosuvastatin, imatinib); substrates of uptake transporters OAT1 and OAT3 (organic anion transporters; e.g., non-steroidal anti-inflammatory drugs, bumetanide, furosemide, lamivudine, methotrexate, oseltamivir, tenofovir, ganciclovir, adefovir, cidofovir, zidovudine, zalcitabine). **8. PREGNANCY AND LACTATION:** Tafamidis is not recommended during pregnancy and in women of childbearing potential not using contraception. Tafamidis should not be used during breast-feeding. **9. SIDE EFFECTS:** Flatulence and liver function test increased. A causal relationship has not been established. Reference: Prescribing Information HK PI (Version Jul 2020) Date of preparation: Nov 2020 Identifier number: VYNX1120 **FULL PRESCRIBING INFORMATION IS AVAILABLE UPON REQUEST.**

Pfizer Rare Disease

Pfizer Corporation Hong Kong Limited
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PP-VDM-HKG-0063 MAY 2021

Paxlovid™

(nirmatrelvir 150 mg tablets | ritonavir 100 mg tablets)

The first oral protease inhibitor designed to treat COVID-19[1,2]

PAXLOVID™ can reduce the risk of COVID-19 related hospitalisation or death by[2,3]*:

88%

* Reduced risk of COVID-19 related hospitalisation or death from any cause vs. placebo through day 28 in symptomatic adult patients - at high risk for progression to severe COVID-19 - treated within 5 days of symptom onset in a phase 2/3 clinical trial.

References: 1. Lamb YN. Nirmatrelvir plus Ritonavir: first approval. *Drugs*. 2022;19:1-7. 2. Owen DR, Allerton CMN, Anderson AS, *et al*. An oral SARS-CoV-2 Mpro inhibitor clinical candidate for the treatment of COVID-19. *Science*. 2021;374(6575): 1586-1593. 3. Hammond J, Leister-Tebbe H, Gardner A, *et al*. Oral nirmatrelvir for high-risk, nonhospitalized adults with Covid-19. *N Engl J Med*. Published online February 16, 2022. doi:10.1056/NEJMoa2118542.

Find Additional Information
about PAXLOVID™, including the Hong Kong Product Insert,
at https://www.covid19oralrx.com/en
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Pfizer

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GALDERMA EST. 1981

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ONCE-A-DAY

INVANZ®

(ertapenem, MSD) IV/IM

1 vial 1 gram ONCE Daily[1,*]

Indicated for:[1]

Treatment

- ✓ Complicated Urinary tract infections
- ✓ Community-acquired Pneumonia
- ✓ Complicated intra-abdominal infections
- ✓ Complicated skin and skin structure infections
- ✓ Acute pelvic infections

Prophylaxis

- ✓ Prophylaxis of Surgical site infection following elective colorectal surgery in adults

Covering a wide range of bacteria included:[1]

Gram-positive

- ✓ *Staphylococcus aureus*
- ✓ *Streptococcus agalactiae*
- ✓ *Streptococcus pneumoniae*
- ✓ *Streptococcus pyogenes*

(Note: Methicillin-resistant staphylococci are resistant to INVANZ®. Many strains of *Enterococcus faecalis* and most strains of *Enterococcus faecium* are resistant.)

Gram-negative

- ✓ ***Escherichia coli*** (+/- ESBL^)
- ✓ ***Klebsiella pneumoniae*** (+/- ESBL^)
- ✓ *Haemophilus influenzae* (including β-lactamase-producing strains)
- ✓ *Moraxella catarrhalis*
- ✓ *Proteus mirabilis*

Anaerobes

- ✓ *Bacteroides fragilis*
- ✓ *Clostridium* spp (excluding *C difficile*)
- ✓ *Eubacterium* spp
- ✓ *Peptostreptococcus* spp
- ✓ *Prevotella* spp
- ✓ *Porphyromonas asaccharolytica*

^ESBL = Extended Spectrum β-lactamases

*For adult (aged 13 and older) with creatinine clearance >30 mL/min/1.73m²

Reference: 1. Hong Kong INVANZ Product Circular.

INVANZ® Selected Safety information

Indications:

- INVANZ® (Ertapenem for Injection) is indicated in adult patients and pediatric patients (3 months of age and older) for the treatment of the following moderate to severe infections caused by susceptible bacteria:
  - Complicated Intra-Abdominal Infections
  - Complicated Skin and Skin Structure Infections, including diabetic foot infections without osteomyelitis
  - Community Acquired Pneumonia
  - Complicated Urinary Tract Infections including pyelonephritis
  - Acute Pelvic Infections including postpartum endomyometritis, septic abortion and post-surgical gynecologic infections
- INVANZ® is indicated in adults for the prophylaxis of surgical site infection following elective colorectal surgery.

Contraindications:

- INVANZ® is contraindicated in patients with known hypersensitivity to any component of this product or to other drugs in the same class or in patients who have demonstrated anaphylactic reactions to beta-lactams.
- Due to the use of lidocaine HCl as a diluent, INVANZ® administered intramuscularly is contraindicated in patients with a known hypersensitivity to local anesthetics of the amide type and in patients with severe shock or heart block (Lidocaine HCl is the diluent for intramuscular administration of INVANZ®).

Precautions:

- Serious and occasionally fatal hypersensitivity (anaphylactic) reactions have been reported in patients receiving therapy with beta-lactams. These reactions are more likely to occur in individuals with a history of sensitivity to multiple allergens. There have been reports of individuals with a history of penicillin hypersensitivity who have experienced severe hypersensitivity reactions when treated with another beta-lactam. Before initiating therapy with INVANZ®, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, other beta-lactams and other allergens. If an allergic reaction to INVANZ® occurs, discontinue the drug immediately. **Serious anaphylactic reactions require immediate emergency treatment as clinically indicated.**
- Seizures and other CNS adverse experiences have been reported. Seizures, irrespective of drug relationship, occurred in 0.5% of patients during therapy plus 14 day follow-up period. Most commonly in patients with CNS disorders (e.g., brain lesions or history of seizures) and/or compromised renal function. Close adherence to dosage regimen is urged in patients with factors predispose to convulsive activity. Anticonvulsant therapy should be continued. If focal tremors, myoclonus, or seizures occur, patients should be evaluated neurologically and the dosage of INVANZ® re-examined to determine whether it should be decreased or discontinued.
- The concomitant use of ertapenem and valproic acid/divalproex sodium is generally not recommended. Anti-bacterials other than carbapenems should be considered to treat infections in patients whose seizures are well controlled on valproic acid or divalproex sodium.
- As with other antibiotics, prolonged use of INVANZ® may result in overgrowth of non-susceptible organisms. Repeated evaluation of the patient's condition is essential. If superinfection occurs during therapy, appropriate measures should be taken.
- Clostridioides difficile-associated diarrhea has been reported with nearly all antibacterial agents, including ertapenem, and may range in severity from mild to life-threatening. Therefore, it is important to consider this diagnosis in patients who present with diarrhea subsequent to the administration of antibacterial agents.
- Caution should be taken when administering INVANZ® intramuscularly, to avoid inadvertent injection into a blood vessel.

Adverse Events:

- Most adverse experiences reported in clinical studies were described as mild to moderate in severity. The most common drug –related adverse experiences (≥1/100, <1/10) reported during parenteral therapy in patients treated with ertapenem were diarrhea, infused vein complication, nausea and headache. Other common side effects include: phlebitis/thrombophlebitis, vomiting, infusion site erythema, infusion site pain, infusion site swelling, rash, etc.
- For detailed adverse events, please consult the prescribing information.

Before prescribing, please consult the full prescribing information.

MSD

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HK-CAR-00066 Apr/2022

MSD

TAKE ON THE CHALLENGES OF COVID-19[1]

TEST. TREAT. TAKE CHARGE.

molnupiravir

Reference: 1. molnupiravir US EUA Product Insert.

MOLNUPIRAVIR Selected Safety Information

Authorized Use

1. Molnupiravir is authorized for use under an Emergency Use Authorization (EUA) for the treatment of mild-to-moderate coronavirus disease 2019 (COVID-19) in adults:
   - with positive results of direct SARS-CoV-2 viral testing, and
   - who are at high risk for progression to severe COVID-19, including hospitalization or death, and
   - for whom alternative COVID-19 treatment options approved or authorized by FDA are not accessible or clinically appropriate
2. Molnupiravir is not approved for any use, including the treatment of COVID-19, but is authorized for emergency use by the FDA under an Emergency Use Authorization (EUA).
3. The emergency use of molnupiravir is only authorized for the duration of the declaration that circumstances exist justifying the authorization of the emergency use of drugs and biological products during the COVID-19 pandemic under Section 564(b)(1) of the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. § 360bbb-3(b)(1) unless the declaration is terminated or authorization revoked sooner.

Limitations of Authorized Use

4. Molnupiravir is not authorized:
   - for use in patients who are less than 18 years of age
   - for initiation of treatment in patients hospitalized due to COVID-19. Benefit of treatment with molnupiravir has not been observed in subjects when treatment was initiated after hospitalization due to COVID-19
   - for use for longer than 5 consecutive days
   - or pre-exposure or post-exposure prophylaxis for prevention of COVID-19
5. Molnupiravir may only be prescribed for an individual patient by physicians, advanced practice registered nurses, and physician assistants that are licensed or authorized under state law to prescribe drugs in the therapeutic class to which molnupiravir belongs (i.e., anti-infectives).

Contraindications

6. No contraindications have been identified based on the limited available data on the emergency use of molnupiravir authorized under this EUA.

Warnings and Precautions

7. There are limited clinical data available for molnupiravir. Serious and unexpected adverse events may occur that have not been previously reported with molnupiravir use.
8. Molnupiravir is not recommended for use during pregnancy. Based on findings from animal reproduction studies, molnupiravir may cause fetal harm when administered to pregnant individuals. There are no available human data on the use of molnupiravir in pregnant individuals to evaluate the risk of major birth defects, miscarriage or adverse maternal or fetal outcomes.
9. Molnupiravir is authorized to be prescribed to a pregnant individual only after the healthcare provider has determined that the benefits would outweigh the risks for that individual patient. If the decision is made to use molnupiravir during pregnancy, the prescribing healthcare provider must document that the known and potential benefits and the potential risks of using molnupiravir during pregnancy were communicated to the pregnant individual.
10. Advise individuals of childbearing potential of the potential risk to a fetus and to use an effective method of contraception correctly and consistently during treatment with molnupiravir and for 4 days after the final dose.
11. Prior to initiating treatment with molnupiravir, assess whether an individual of childbearing potential is pregnant or not, if clinically indicated.
12. Hypersensitivity reactions, including anaphylaxis, have been reported with molnupiravir. If signs and symptoms of a clinically significant hypersensitivity reaction or anaphylaxis occur, immediately discontinue molnupiravir and initiate appropriate medications and/or supportive care.
13. Molnupiravir is not authorized for use in patients less than 18 years of age because it may affect bone and cartilage growth. The safety and efficacy of molnupiravir have not been established in pediatric patients.

Adverse Reactions

14. The most common adverse reactions occurring in ≥1% of subjects in the molnupiravir treatment group in the Phase 3 double-blind MOVe-OUT study were diarrhea (2% versus placebo at 2%),nausea (1% versus placebo at 1%), and dizziness (1% versus placebo at 1%) all of which were Grade 1 (mild) or Grade 2 (moderate). Serious adverse events occurred in 7% of subjects receiving molnupiravir and 10% receiving placebo; most serious adverse events were COVID-19 related. Adverse events leading to death occurred in 2 (<1%) of the subjects receiving molnupiravir and 12 (2%) of subjects receiving placebo.

Drug Interactions

15. No drug interactions have been identified based on the limited available data on the emergency use of molnupiravir. No clinical drug-drug interaction trials of molnupiravir with concomitant medications, including other treatments for mild to moderate COVID-19, have been conducted.

Breastfeeding

16. There are no data on the presence of molnupiravir or its metabolites in human milk. It is unknown whether molnupiravir has an effect on the breastfed infant or effects on milk production. Based on the potential for adverse reactions in the infant from molnupiravir, breastfeeding is not recommended during treatment with molnupiravir and for 4 days after the final dose. A lactating individual may consider interrupting breastfeeding and may consider pumping and discarding breast milk during treatment and for 4 days after the last dose of molnupiravir.

Males of Reproductive Potential

17. Nonclinical studies to fully assess the potential for molnupiravir to affect offspring of treated males have not been completed. Advise sexually active individuals with partners of childbearing potential to use a reliable method of contraception correctly and consistently during treatment and for at least 3 months after the last dose of molnupiravir. The risk beyond three months after the last dose of molnupiravir is unknown.

Before prescribing, please consult the full prescribing information.

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HK-ANV-00009 May/2022

Abstracts

Dr. Enoch WU

MB BCh(Hons), MRCP(UK), LMCHK, DPD, FHKCP, FHKAM(Medicine)
Specialist in Endocrinology, Diabetes & Metabolism
Clinical Assistant Professor(Honorary), Department of Medicine & Therapeutics, Faculty of Medicine, Chinese University of Hong Kong

Dr. Enoch Wu graduated in the UK in 2003 and completed his Specialist training in Endocrinology, Diabetes and Metabolism at the Prince of Wales Hospital, and subsequently pursued overseas training in Obesity Management at the University of Sydney. He has been engaged in Medical Education and Research as an Honorary Clinical Assistant Professor at the Chinese University of Hong Kong.

His areas of expertise include Diabetes and Obesity, and he has extensive experience in the establishment of the Multidisciplinary Management Team for Obese Patients with Metabolic Syndrome, which won the Hospital Authority Outstanding Team Award in 2016. He has been in private practice since 2017, and his solo clinic is situated in Central.

SGLT2 Inhibitors on Cardiac-Renal Disease Management

Increasing evidence suggests that sodium-glucose cotransporter 2 inhibitors (SGLT2is) have beneficial effects across all stages of the cardiorenal metabolic continuum, reducing morbidity and mortality in a wide range of individuals, from those with diabetes and multiple risk factors to those with established heart failure and chronic kidney disease, regardless of the presence of diabetes. SGLT2 is have changed the therapeutic landscape of Cardiac and Renal Progression management and its role in primary care is expanded to a wider population for preventing kidney function deterioration.

Abstracts

Dr. Jamie Chung-Mei LAM

BSc(Med), MBBS(UNSW), MD(HKU), MRCP(UK),
FRCP(London, Edinburgh, Glasgow), FCCP, FHKCP, FHKAM(Medicine)
Specialist in Respiratory Medicine
Honorary Consultant in Respiratory Medicine
Honorary Clinical Assistant Professor(HKU)
Clinical Associate Professor(Honorary), Department of Medicine and Therapeutics(CUHK)

Dr. Lam is a Specialist in Respiratory and Sleep Medicine. She underwent fellowship training in respiratory and sleep medicine at Queen Mary Hospital, The University of Hong Kong. She obtained a Hong Kong Lung Foundation Fellowship Grant to pursue further training at the Woolcock Medical Research Institute and Royal Prince Alfred Hospital in Sydney, and was awarded her Doctor of Medicine degree with Sir Patrick Manson Gold Medal in 2009.

Dr. Lam is the Past President of the Hong Kong Society of Sleep Medicine and a council member of American Chest Delegation (Hong Kong & Macau Chapter). She has worked as a respiratory and sleep physician in Queen Mary Hospital for a number of years, and is currently working as the Honorary Consultant in Respiratory Medicine Centre, Hong Kong Sanatorium & Hospital. She has also been appointed as Honorary Clinical Assistant Professor at the University of Hong Kong and Honorary Associate Professor at the Chinese University of Hong Kong, actively involved in clinical services, undergraduate and postgraduate teaching as well as research projects in the field of respiratory and sleep medicine.

An Update of Inhaled Therapies for Mild Asthma in Adults

Asthma is always the most common airway disease worldwide. It has long been shown in the literature that good asthma control markedly reduces overall mortality. However, most patients appear to take notice of the problem when they have acute exacerbations of moderate to severe severity. In mild asthma, some patients may put up with their intermittent symptoms, and they are not taking any prompt actions to prevent further deterioration. According to the latest international guidelines, there has been a change of therapeutic approach for the management of mild asthma.

Inhaled therapies are the main stream of treatment across the range of asthma severity nowadays. Different combinations of these inhaled therapies dictate the quick relieving and maintenance regimens. Patients who use inhaled short-acting and long-acting beta-2 agonists, anti-cholinergic and inhaled corticosteroid are having better clinical outcomes in terms of reducing severe exacerbation risk, with a lower mean inhaled corticosteroid dose and reduced systemic corticosteroid burden, these are well proven in clinical studies.

In mild asthma, using short acting beta-2 agonists as needed is not recommended as the reliever alone regimen in our current practice. There has been accumulated evidence that asthma was under suboptimal control with this simple reliever in recent clinical trials.

Abstracts

Dr. Michael Ka-Lam WONG

MBBS, MRCP, FHKAM, FRCP
Consultant, Cardiac Medical Unit, Grantham Hospital

A visionary committed physician and team-leader who devotes himself to enhance cardiology service in Hong Kong. Always identified the major service gap in cardiology service and committed himself for quality improvement in the service. The leadership and commitment have been well recognised with various accolades, including the Hong Kong West Cluster Young Achiever Award, Grantham Hospital Young Achiever Award, team leader of Grantham Hospital Outstanding Team Award. Also active in research with publications in high impact journals such as Circulation and The Journal of Heart and Lung Transplantation. With his enthusiasm, expertise, and leadership, he has built various teams and inspired junior doctors to raise the standard of care for cardiology patients.

Breakthroughs in the Treatment of Heart Failure

Heart failure is a progressive, debilitating and potentially fatal condition that occurs when the heart cannot supply adequate circulation to meet the body's demands for oxygenated blood or to do so requires increased blood volume leading to fluid accumulation (congestion) in the lungs and peripheral tissues. There is currently a high unmet need in the treatment of heart failure, as the disease is associated with high morbidity and mortality rate.

Sodium-glucose co-transporter 2 (SGLT2) inhibitors, originally designed as oral anti-hyperglycemic agents by promoting renal excretion of glucose, were recently shown in large clinical trials to benefit patients with heart failure regardless of their diabetes status. For example, the efficacy and safety of the SGLT2 inhibitor empagliflozin were demonstrated in heart failure patients with reduced ejection fraction (in the EMPEROR-Reduced study) and heart failure patients with preserved ejection fraction (in the EMPEROR-Preserved study). The EMPULSE study also provided evidence for in-hospital initiation of empagliflozin in patients with acute heart failure following stabilisation. In this lecture, the evidence of SGLT2 inhibitors in heart failure will be discussed.

Abstracts

Dr. Achilles Hoi-Kan LEE

MBChB(CUHK), MRCP(UK), FHKCP, FHKAM(Medicine),
PDip Epidemiology and Biostatistics(CUHK)
Team head of Renal medicine team and Consultant Physician,
Department of Medicine & Geriatrics, Tuen Mun Hospital

Dr. Lee Hoi-Kan is currently the team head of Renal medicine team and Consultant Physician at the Department of Medicine & Geriatrics in Tuen Mun Hospital since Oct 2020. Dr. Lee underwent his training in Nephrology and Internal Medicine; he gained the fellowship at Hong Kong College of Physicians and Hong Kong Academy of Medicine in 2003.

Dr. Lee is also interested in Epidemiology and Biostatistics; he completed the Postgraduate Diploma in both subjects at Chinese University of Hong Kong in 2010. Being an experienced specialist in nephrology, he has been invited to the CME Bulletin Editorial Board Member in Hong Kong Medical Association since 2018.

Local Clinical Updates on Ketoanalogues Therapy with CKD Patients

Chronic Kidney Disease (CKD) is a major health issue in Hong Kong, but the practice of dietary protein restriction in CKD patients has been disregarded. It is indisputable that a low protein diet can reduce proteinuria, BP and relieve metabolic imbalance of CKD patients. The effect of protein restriction in deferring the decline in GFR of CKD patients may not be impressive, but the uraemic symptoms are definitely ameliorated; enhance delaying initiation of dialysis to preserve residual renal function. It is indicated in the palliative therapy for those CKD patients who refused dialysis. Ketoanalogues taking nitrogen in the body by transamination, can decrease uraemic toxins and permit a greater reduction of dietary protein. Therefore, Ketoanalogues supplement in dietary protein restriction can guarantee preserved nutritional status provided with an adequate calorie intake. In the clinical practice, protein intake target range should be individualised through regular follow-up by doctors and dietitians to avoid protein energy wasting in CKD patients.

Hizentra®
Immune Globulin Subcutaneous (Human) 20% Liquid

INFUSING INNOVATION
into Ig Therapy

Proven protection around the world.
Personalised treatment around each PID patient.

- **#1 Ig** used worldwide for PID[1]
- **11.3 million+** exposures worldwide[1]
- Only SCIG with **12+ years** of proven efficacy and tolerability[1,2]
- Approved in **60+ countries**[1,2]
- **215,000+** patient-years of experience[1]
- **1st 20% SCIG** in the market[3]

Established Efficacy

- Effective, consistent IgG levels delivered with Hizentra[4]
- None of the patients had a serious bacterial infection during the efficacy period of the study[4]
- Steady-state rapidly achieved and high IgG levels maintained with Hizentra[4]

Tolerability and Safety

Good tolerability[4]

- Patients' perceptions of local tolerability was good or very good in over 96% of infusions[4]
- There were no serious adverse events related to study medication[4]
- The most common adverse event was local reaction at infusion site[4]

Before prescribing, please review the approved Hong Kong Package Insert.

HIZENTRA®. Solution for subcutaneous injection. **Qualitative and quantitative composition:** Human normal IgG, 200mg/ml (purity ≥98% IgG). IgA≤50 µg/ml. Other ingredients: L-proline, Polysorbate 80. Hizentra is essentially sodium-free, contains no preservatives. **Therapeutic indications:** Replacement therapy in primary immunodeficiency syndromes with impaired antibody production; hypogammaglobulinaemia & recurrent bacterial infections in chronic lymphocytic leukaemia patients, in whom prophylactic antibiotics have failed or are contraindicated; hypogammaglobulinaemia & recurrent infections in multiple myeloma patients; hypogammaglobulinaemia in pre- & post-allogeneic haematopoietic stem cell transplantation patients. Immunomodulatory therapy in patients with chronic inflammatory demyelinating polyneuropathy (CIDP) as maintenance after stabilization with IVIg. **Contraindications:** Hypersensitivity to the active substance/excipients. Hyperprolinaemia I or II. **Undesirable effects:** Adverse reactions such as chills, headache, fever, vomiting, allergic reactions, nausea, arthralgia, low blood pressure and moderate low back pain may occur occasionally. Rarely human normal immunoglobulins may cause a sudden fall in blood pressure and in isolated cases, anaphylactic shock, even when the patient has shown no hypersensitivity to previous administration. Local reactions at infusion sites: swelling, soreness, redness, induration, local heat, itching, bruising and rash. **Manufacturer:** CSL Behring AG Bern. **Date of revision of the text:** July 2021.

Biotherapies for Life™ **CSL Behring**

CSL Behring Asia Pacific Limited
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North Point, Hong Kong
HKG-HIZ-07220001
Date of preparation: Jul 2022

References:
1. Data on File. Available from CSL Behring as DOF HIZ-005.
2. Data on File. Available from CSL Behring as DOF HIZ-004.
3. CSL Behring [press release]. CSL Behring receives FDA approval of Hizentra™, first 20 percent subcutaneous immunoglobulin therapy. CSL Behring website. https://www.cslbehring.com/newsroom/2010/20100304-hizentra-approval. Published Mar 4, 2010. Accessed January 24, 2022.
4. Jolles S, et al. Efficacy and safety of Hizentra® in patients with primary immunodeficiency after a dose-equivalent switch from intravenous or subcutaneous replacement therapy. Clin Immunol. 2011;141:90-102.

For patients with IVIg therapy needs

Privigen™: 10% liquid IVIg

Simple

- Ready-to-use 10% liquid human immunoglobulin for intravenous use (IVIg)
  - No warming or reconstitution necessary, saving preparation time and minimizing product waste
- 36-month room temperature (up to 25°C) storage
  - Saves refrigeration space

Sophisticated

- L-Proline-stabilized IVIg therapy
  - Contains no sugar (eg, sucrose or maltose)
  - Compared with other stabilizers, L-proline demonstrated better stabilizing activity and reduced dimer formation[1]
  - L-Proline also reduces immunoglobulin G (IgG) aggregation, minimizes fragmentation and prevents solution discoloration[1]
- Appropriate for a broad range of patient types
  - IgA ≤25 mcg/mL[2]
  - IgG purity ≥98%

Safe

- In a clinical trial for primary immunodeficiency syndromes, the proportion of Privigen™ infusions with temporally associated adverse events was 0.21, below the limit of 0.4 set by the USA Food and Drug Administration (FDA); 97% of adverse events were non-serious; 95% of 1,038 infusions were administered without premedication[3]
  - The most common adverse reactions (observed in >5% of subjects) were headache, fatigue, nausea, chills, back pain, pain, vomiting, pyrexia, sinusitis, cough, diarrhea and stomach discomfort

Before prescribing, please review the approved Hong Kong Package Insert.

Hong Kong Privigen Abbreviated Product Information
Privigen™ Human normal immunoglobulin, solution for infusion (10%). **Indication:** Replacement therapy in primary immunodeficiency syndromes (PID), myeloma or chronic lymphocytic leukaemia with severe secondary hypogammaglobulinaemia and recurrent infections, and children with congenital AIDS and recurrent infections. Immunomodulation in immune thrombocytopenic purpura (ITP) in children or adults at high risk of bleeding or prior to surgical interventions to correct the platelet count, Guillain-Barré syndrome, Kawasaki disease. Allogeneic bone marrow transplantation. **Dosage:** Dosage regimen is dependent on the indication. In replacement therapy the dosage may be individualized depending on pharmacokinetic and clinical response. **Method of use:** Privigen should be infused intravenously. Initial infusion at rate of 0.3 mL/kg bw/hr for 30 minutes. If well tolerated, the infusion rate can be gradually increased to 4.8 mL/kg bw/hr. Maximum rate is 7.2 mL/kg bw/hr. **Adverse effects:** Adverse reactions may include cold shivers, headache, fever, vomiting, allergic reactions, nausea, joint pain, low blood pressure and mild backache. Rare adverse reactions include hypersensitivity reactions, anaphylactic shock, temporary skin reaction and haemolytic reactions. **Contraindications:** Hypersensitivity to the active substance or excipient and homologous immunoglobulins. Hyperprolinaemia. **Precautions:** Certain severe adverse reactions may be related to rate of infusion. In case of adverse reaction, either the rate of administration must be reduced or the infusion stopped. Caution for hypersensitivity, haemolytic anaemia, aseptic meningitis syndrome, thromboembolism and acute renal failure.

CSL Behring is committed to protecting the privacy of all individuals it deals with. Additional information on how CSL Behring safeguards your privacy can be found at http://www.cslbehring.com/privacy.

privigen™
Immune Globulin Intravenous (Human), 10% Liquid
IVIg therapy made simple

References:
1. Bolli R, Woodtli K, Bärtschi M, Höfferer L, Lerch P. L-Proline reduces IgG dimer content and enhances the stability of intravenous immunoglobulin (IVIG) solutions. *Biologicals* 2010;38(1):150-157.
2. CSL Behring, Hong Kong Privigen™ Package Insert, June 2014.
3. Stein MR, Nelson RP, Church JA, et al; for the IgPro 10 in PID study group. Safety and efficacy of Privigen, a novel 10% liquid immunoglobulin preparation for intravenous use, in patients with primary immunodeficiencies. *Journal of Clinical Immunology* 2009; 29:137-144.

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HKG-PVG-0002
Date of preparation: January 2021

Abstracts

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Honorary Clinical Assistant Professor, HKU
Associate Consultant, Queen Mary Hospital

Dr. Terence Chi-Chun Tam is a specialist in Respiratory Medicine and currently holds the positions of associate consultant in the Department of Medicine at Queen Mary Hospital (QMH) and honorary clinical assistant professor for The University of Hong Kong. Dr. Tam received his medical degree in 2001. His research interests include (1) advancement in navigational bronchoscopy, (2) photo-acoustic and optical tomography imaging, (3) AI-based software development, (4) advanced pleural imaging & intervention and (5) lung cancer therapeutics, among others. He currently holds 2 patents on novel diagnostic tools designed to improve the safety and yield of bronchoscopic biopsy.

Treatable Trait in COPD

Chronic obstructive pulmonary disease (COPD) is one of the leading causes of death worldwide, and accounts for over 3 million death a year. Only 30% of COPD cases are properly diagnosed and under medical care. The disease, which impacts elderly the most, is poorly understood, and often mistakenly perceived as normal functional deterioration from ageing.

The objective of GOLD (Global Initiative for Chronic Obstructive Lung Disease) is to raise awareness of COPD and improve prevention and treatment of COPD. The GOLD guidelines have evolved over the past 2 decades from the FEV1-centric approach, to a more patient-centric approach in favour of symptoms and exacerbation history. There is significant individual heterogeneity within COPD, reflecting different biological and physiological mechanisms underlying different clinical presentations: endotypes and phenotypes respectively. New treatment algorithms were introduced towards a precision medicine approach - Treatable Traits in COPD.

Treatable traits should fulfil three characteristics: be clinically relevant and associated with specific outcomes (symptoms, health status, risk of future events), be easily identifiable and measurable, and be treatable. These markers can be biological, functional, imaging or clinical.

Identification of treatable trait can indicate the most suitable treatment for individual patients. The availability of newer fixed dose combination, e.g LAMA/LABA dual bronchodilator therapies, ICS/LAMA/LABA triple therapies, and emerging inhalers with simpler dose regimen and lower critical error rate provide opportunities for physicians and patients to choose the most suitable treatment which can fit the treatable traits and patients' lifestyle.

Abstracts

Dr. Raymond Wai-Man KAN

MBBS(HK), MRCSEd, FCSHK, FHKAM(Surgery), FRCSEd(Urol)
Specialist in Urology

Dr. Kan obtained the fellowship in Urology from the College of Surgeons of Hong Kong and the Royal College of Surgeons of Edinburgh, and was awarded the CH Leong Medal & Scholarship in 2016. He was elected distinguished young fellow of the Hong Kong Academy of Medicine in 2017.

He pursued his post-fellowship training under the auspices of Mrs. Esther Wu Memorial Fund Scholarship. During his stay in Egypt, he was trained in post-cancer surgery reconstructive urology, and he then completed his training in continence care at University College London Hospitals.

Dr. Kan is an active member in the field of minimally invasive procedure for the treatment of prostatic enlargement. He has been the local Course Director of the yearly urodynamic courses held in Hong Kong. In recognition of his contribution to the urology community, Dr. Kan was awarded the UAA-Youth Section Fellowship Award in 2019.

He is currently the Honorary Treasurer of the Hong Kong Urological Association, engaging in public education with the aim to increase the awareness of urological diseases.

Starting Treatment Early for the Right Patients with Lower Urinary Tract Symptoms: 4 Things We Need to Know

Benign prostatic obstruction is prevalent, and the most common cause of lower urinary tract symptoms in men. Lower urinary tract symptoms associated with benign prostatic obstruction, especially urinary urgency & nocturia, significantly impact patients' quality of life. While it is important to differentiate extra-prostatic causes of lower urinary tract symptoms, there are four assessment tools which are helpful in quantifying symptom severity and predicting disease progression:

1. Questionnaire-based symptom score
2. Prostate size
3. Serum PSA level
4. Maximal flow rate

Management of patients with lower urinary tract symptoms include watchful waiting with lifestyle advice, medical treatments including monotherapy and combination therapy, as well as various surgical options. Recent evidence suggested that an individualised treatment strategy is preferred to the traditional step-wise treatment ladder. In men at risk of disease progression, early use of combination medical therapy (alpha blocker plus 5-alpha reductase inhibitor) resulted in reduced risk of clinical progression, better long-term symptom improvement, as well as reduction in medical expenditure. The key to successful treatment outcome depends on accurate and early identification of patients at risk of disease progression.

Reference:

1. Roehrborn CG et al. Eur Urol. 2010 Jan;57(1):123-31
2. Roehrborn CG et al. BJU Int. 2015 Sep;116(3):450-9
3. D'Agate S et al. World J Urol. 2020 Feb;38(2):463-472

Abstracts

Dr. Philip Hei LI

MB BS, M Res(Med), PDipID, MRCP, FHKCP, FHKAM(Medicine)
Clinical Assistant Professor, HKU

Dr. Philip Li is a Specialist in Immunology & Allergy and Clinical Assistant Professor of the University of Hong Kong. He currently serves as Chief of the Division of Rheumatology & Clinical Immunology of the Department of Medicine.

Dr. Li also leads the Immunology & Allergy services of the Hong Kong West Cluster of the Hospital Authority. He established the first adult Immunology Clinics and in-patient consultation services of the Hospital Authority. Dr. Li also set up Hong Kong's first specialist training centre in Immunology & Allergy and leads the territory-wide Hong Kong Drug Allergy Delabelling Initiative (HK-DADI).

Dr. Li has special interests in anaphylaxis, drug hypersensitivity and immunodeficiency. He has led and authored many of Hong Kong's Immunology & Allergy guidelines, including consensus statements on anaphylaxis and COVID19 vaccine allergy safety. He has published over 80 peer-reviewed articles in the fields of allergy, immunology and autoimmunity; and serves on the Editorial Boards of Frontiers in Immunology, Frontiers in Allergy, and Journal of Clinical Rheumatology and Immunology. Currently, he is the Principal Investigator of multi-disciplinary "HOPE" (HKU Optimising Protection and Effectiveness) of COVID19 vaccines study.

Burden of Antibody Deficiency & Feasibility of Subcutaneous Immunoglobulin Replacement in Hong Kong

Immunodeficiency remains an important but severely under-recognised entity, with antibody deficiency being the most common subtype. Antibody deficiencies can be classified as either primary or secondary - with secondary being much more common than their primary counterparts among adult patients. Moreover, the prevalence of antibody deficiency continues to increase due to the rising use of novel immunosuppressants and B-cell-depleting therapies (e.g. anti-CD20 monoclonal antibodies such as rituximab). Traditionally, immunoglobulin has been administered intravenously (IVIg) or, uncommonly, intramuscularly. Subcutaneous immunoglobulin (SCIg) is a newer route of immunoglobulin replacement which was only introduced to Hong Kong recently. In contrast to the IVIg which requires recurrent venous access and is administered during monthly hospital/day centre admissions, SCIg can be self-administrated by patients (or their carers) in the comfort of their own homes.

During this session, the burden of antibody deficiencies and feasibility of SCIg in Hong Kong will be discussed. There has been significantly increasing immunoglobulin demand over the past decade. The burden of adult antibody deficiency in Hong Kong is substantial but under-recognised, characterised by the dominance of secondary antibody deficiency with haematological diseases as the most common cause. Adult antibody deficiency patients on SCIg replacement had significantly better clinical outcomes and quality of life compared to those on IVIg. Despite higher drug costs, SCIg was overall more cost-effective than IVIg among adult patients with antibody deficiency. We should advocate for wider adoption and subsidisation of SCIg in Hong Kong.

Abstracts

Dr. Alexander Yuk-Lun LAU

SB(Chicago), MB ChB(CUHK), MRCP(UK), FHKCP, FHKAM(Medicine)
Consultant Neurologist, CUHK Medical Centre
Clinical Associate Professor(Honorary),
Department of Medicine and Therapeutics, Faculty of Medicine, CUHK

Alex is the Consultant Neurologist at the CUHK Medical Centre. He is also a Clinical Associate Professor (Honorary) at the Department of Medicine and Therapeutics of the Faculty of Medicine, CUHK, and the Medical Director of the Hong Kong Institute of Integrative Medicine of CUHK. After receiving undergraduate education in biochemistry at the University of Chicago in 1998, Alex returned to Hong Kong and obtained his medical degree from CUHK in 2003, followed by physician training in internal medicine and neurology at the Prince of Wales Hospital. He was awarded the gold medal of Best Thesis Award by the Hong Kong College of Physicians in 2010. In 2011, he went to the University of California San Francisco for post-doctoral fellowship as a recipient of the Croucher Foundation Fellowship and CUHK Henry Leung Fellowship. His research focuses on stroke, multiple sclerosis, and integrative medicine.

New Opportunities to Treat Cognitive Impairment

Mild cognitive impairment (MCI) among an ageing global population is a growing burden in the world. In most instances, MCI is a medical condition, or an early sign of dementia. Early and accurate diagnosis of MCI provides an opportunity to improve the outcomes, where suitable use of neuropsychological tests combined with a careful clinical history are required in clinical practice.

A multidomain intervention would be a viable option for MCI management; recent data suggest that dietary and nutritional interventions should be considered alongside individualised lifestyle modifications. For a specialised drink containing a mixture of precursors and cofactors (long-chain omega-3 fatty acids, uridine, choline, B vitamins, vitamin C, vitamin E, and selenium), which was developed to support the formation and function of neuronal membranes and synapses, the latest evidence from randomised controlled trials suggests that it should be considered as an option for some patients with early Alzheimer's disease (AD), including those with MCI due to AD (prodromal AD). This talk will discuss the latest evidence, and make recommendations about the diagnosis and management of MCI, and the identification of candidates for multi-nutritional intervention.

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† ≥50% sustained decline in eGFR.
‡ There were comparable rates of the individual component of CV death vs placebo (3.0% vs 3.7%; HR 0.81; 95% CI, 0.58, 1.12).
§ Primary composite endpoint of ≥50% sustained decline in eGFR, reaching ESKD, and renal or CV death. ESKD is defined as the need for maintenance dialysis for at least 28 days and renal transplantation or sustained eGFR <15 mL/min/1.73m² for at least 28 days.
¶ Baseline eGFR categories: <45 mL/min/1.73m² and ≥45 mL/min/1.73m².
¶ Observed only in T2D patients.
** CKD stage groups: Stage 4 and Stage 2/3.
†† Diabetic nephropathy, glomerulonephritides, ischaemic or hypertensive CKD, or CKD of other or unknown cause.
‡‡ In patients with severe hepatic impairment, a starting dose of 5 mg is recommended. If well tolerated, the dose may be increased to 10 mg.
§§ In DAPA-CKD, patients may continue on FORXIGA 10 mg once daily if eGFR falls below 25 mL/min/1.73m².
** Due to limited experience, it is not recommended to initiate treatment with dapagliflozin in patients with GFR <25 mL/min.

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

References: 1. FORXIGA Hong Kong Prescribing Information. 2. Heerspink HJL, et al. N Engl J Med. 2020;383:1436-1446. 3. Wheeler DC, et al. Lancet Diabetes Endocrinol. 2021;9:22-31. 4. Chertow GM, et al. J Am Soc Nephrol. 2021;32:2352-2361. 5. Heerspink HJL, et al. Kidney Int. 2021:S0085-2538(21)00865-6.

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

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

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

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Abstracts

Prof. MAK Ki-Yan

MBBS(HK), DPM(UK), MHA(NSW), MD(HKU)
Honorary Professor, HKU
Psychiatrist

Dr. Mak has been awarded the Justice of the Peace (JP) and Bronze Bauhinia Star (BBS), Hong Kong Special Administrative Region, People's Republic of China. He is a fellow of FHKAM (Psychiatry) (Fellow of the Hong Kong Academy of Medicine, Hong Kong) and FHKCPsych (Fellow of the Hong Kong College of Psychiatrists).

Dr. Mak was the Chairman of the organising committee for BETA (Bipolar Educational Training for Asia) (2007-2011), the ex-Chairman of the Society for the Advancement of Bipolar Affective Disorders and ex-Chairman of Asian Network of Bipolar Disorders (2007-2010). He was the former Chairman of Queen Elizabeth Foundation, Hong Kong (2003-2011), and the ex-Chairman of Hong Kong Association of Psychiatric Rehabilitation. He was also the ex-Member of the Social Worker Training & Manpower Development Committee, Social Welfare Department (2005-2011), ex-Member of the Long-term Board for Prisoners, Security Bureau and former Member of the Rehabilitation Advisory Committee, Health & Welfare Bureau, Hong Kong.

Dr. Mak is currently the Chief Executive of Asian of Neuropharmacology and a Ex co-chairman of Guangdong-Hongkong-Macau Bipolar Forum since 2010. He is also the Vice-President & former Chairman of the Mental Health Association of Hong Kong.

Dr. Mak was the ex-Chief Examiner of the Hong Kong College of Psychiatrists, former Editor-in-chief, Journal of the Hong Kong College of Psychiatrist and former editorial board member of the Chinese Journal of New Therapeutics, People's Republic of China. He is an Editorial Board Member of International Journal of Bipolar Disorders.

Besides, Dr. Mak is a Honorary Advisors to various organisations serving mental patients and is the Chief Author of over hundreds of local & international papers & book chapters (English & Chinese) in mental health & psychiatry.

Long COVID: Brain Fog and Other Psychiatric Sequelae

Long COVID, or post-COVID syndrome, is the aftermaths of a COVID-19 infection. This syndrome involves multiple body systems, especially the respiratory, but also has long-lasting effects on the nervous system, leading to neurological and psychological symptoms. Coupled with the multiple psycho-social stress-inducing factors, long-covid patients can present with a variety of psychiatric conditions, notably brain fog, chronic fatigue, anxiety and depression, somatisation, and even trauma-related disorders.

This lecture will begin with some statistical figures on the prevalence of post-covid psychiatric conditions and discuss in some details a few common disorders. Possible etiological factors and pathological findings are presented, followed by proposed therapies including psychopharmacotherapy. Prevention by vaccination is the best solution!

Abstracts

Dr. Rose Zhao-Wei TING

MBBS, MRCP(UK), FHKCP, FHKAM(Medicine)
Specialist in Endocrinology, Diabetes and Metabolism

Dr. Rose Zhao-Wei Ting graduated from the Faculty of Medicine, University of Hong Kong, with the Bachelor of Medicine and Bachelor of Surgery.

From 2005 to 2006, Dr. Ting completed her internship at Queen Mary Hospital, Prince of Wales Hospital and Princess Margaret Hospital. She joined the Department of Medicine and Therapeutics, Prince of Wales Hospital in 2006. And she started her specialist training in Diabetes and Endocrinology in 2008. He obtained the Fellowship of the Hong Kong College of Physicians and the Fellowship of the Hong Kong Academy of Medicine in 2012.

In 2015, Dr. Ting was promoted to Associate Consultant at Prince of Wales Hospital, and moved to private practice at the end of the same year. Her current services in her clinic include diabetes, thyroid disease and transgender hormone therapy.

The Importance of Early Insulinisation in Glycemic Control

Timely insulinisation is critical as chronic hyperglycemia and elevated free fatty acids exert harmful effects on beta-cell function and regeneration, as well as on the metabolic memory. It is suggested that 50% of β -cell function has been lost by the onset of diabetes. Thus, by early insulin treatment and optimal glycemic control, we aim to prevent diabetes-related complications, and to achieve potential recovery of residual beta-cell function. Apart from that, timely insulinisation is shown to reduce the impact of 'dysglycemic legacy'. Indeed, patients with HbA1c≥7% not receiving intervention within 1 year had a significant increased risk of MI, stroke, HF etc.

It is well-understood that one of the major barriers to timely insulinisation is hypoglycemia. Fear of hypoglycemia can lead to not only delayed initiation of insulin treatment but also potential ineffective titration in the future management. Choosing an ideal insulin therapy for our patients requires a fine balance between achieving the glycemic target and minimising the risk of hypoglycemia.

In this lecture, Dr. Rose Ting will share the importance of early optimal glycemic control and how it can be potentially achieved by initiating insulin earlier on in our patients' DM treatment. BRIGHT study - a RCT supporting the use of Insulin glargine 300 U/mL (IGlar U300), a second-generation basal insulin that was shown to have the advantages of effective glycemic control and a low risk of hypoglycemia, in DM management, and in high risks sub-groups such as elderly patients and patients with renal impairment will also be discussed in the lecture.

Abstracts

Dr. Joseph Chun-Kit CHUNG

MBBS(HK), MRCSEd, FRCSEd(ORL), FHKCORL, FHKAM(ORL)
Consultant, Department of Ear, Nose & Throat, Queen Mary Hospital
Honorary Clinical Associate Professor, School of Clinical Medicine,
Li Ka Shing Faculty of Medicine, The University of Hong Kong
President Elect, The Hing Kong Society of Otorhinolaryngology, Head & Neck Surgery

Dr. Joseph Chung is currently the Consultant surgeon of the Department of Ear, Nose and Throat, Queen Mary Hospital and the Honorary Clinical Associate Professor, at the University of Hong Kong. He obtained his specialist qualification in otolaryngology in 2011 and sub-specialised in the field of both head and neck surgery and sleep apnea surgery. He underwent overseas trainings in major head and neck and sleep surgery centres, namely University of California San Francisco; MD Anderson Cancer Center, Houston; Singapore General Hospital, Singapore and microvascular training in China Medical University Hospital, Taichung.

His clinical interests include head and neck cancer resection with free flap reconstruction, minimally invasive surgery, and multi-level sleep surgery for obstructive sleep apnea. He has published over 20 papers in peer review journals and delivered over 40 presentations at local and international conferences related to head and neck/sleep surgery.

He is currently the President Elect of the Hong Kong Society of Otorhinolarynology - Head and Neck Surgery, Vice President of the Hong Kong Society of Sleep Medicine and Honorary Treasurer of the Hong Kong Head & Neck Society. He is also a board member of both the Head and Neck Surgery Board and Facial Plastic Surgery board of the Hong Kong College of the Otorhinolaryngologists.

Novel Therapeutics of Biologics in Management of Chronic Rhinosinusitis with Nasal Polyp

Chronic rhinosinusitis with nasal polyp (CRSwNP) estimated to affect 1-2.6% of the global population. It is characterised by nasal congestion, rhinorrhoea, loss of smell and facial pain with endoscopic evidence of nasal polyps. Standard treatment with local and systemic corticosteroids and endoscopic sinus surgery may be associated with recurrence of symptoms with nasal polyps and an increased risk of short- and long-term adverse effect.

As predominant CRSwNP is a chronic disease driven by type 2 inflammation, novel biologic therapies have been developed to target the upstream mediators. They are monoclonal antibodies which block the specific cytokines and hence the underlying type 2 inflammatory response. Current randomised controlled trials on the efficacy and safety of different biologics for CRSwNP will be discussed in the presentation.

Reference:

1. *Chen S, et al. Systematic literature review of the epidemiology and clinical burden of chronic rhinosinusitis with nasal polyposis. Curr Med Res Opin. 2020 Nov;36(11):1897-1911.*
2. *Gevaert P, et al. Efficacy and safety of omalizumab in nasal polyposis: 2 randomized phase 3 trials. J Allergy Clin Immunol. 2020 Sep;146(3):595-605*
3. *Bachert C, et al. Efficacy and safety of dupilumab in patients with severe chronic rhinosinusitis with nasal polyps (LIBERTY NP SINUS-24 and LIBERTY NP SINUS-52): results from two multicentre, randomised, double-blind, placebo-controlled, parallel-group phase 3 trials. Lancet. 2019 Nov 2;394(10209):1638-1650.*
4. *Han JK, et al. Mepolizumab for chronic rhinosinusitis with nasal polyps (SYNAPSE): a randomised, double-blind, placebo-controlled, phase 3 trial. Lancet Respir Med. 2021 Oct;9(10):1141-1153.*

Abstracts

Dr. Fanny Wai-Fan LAM

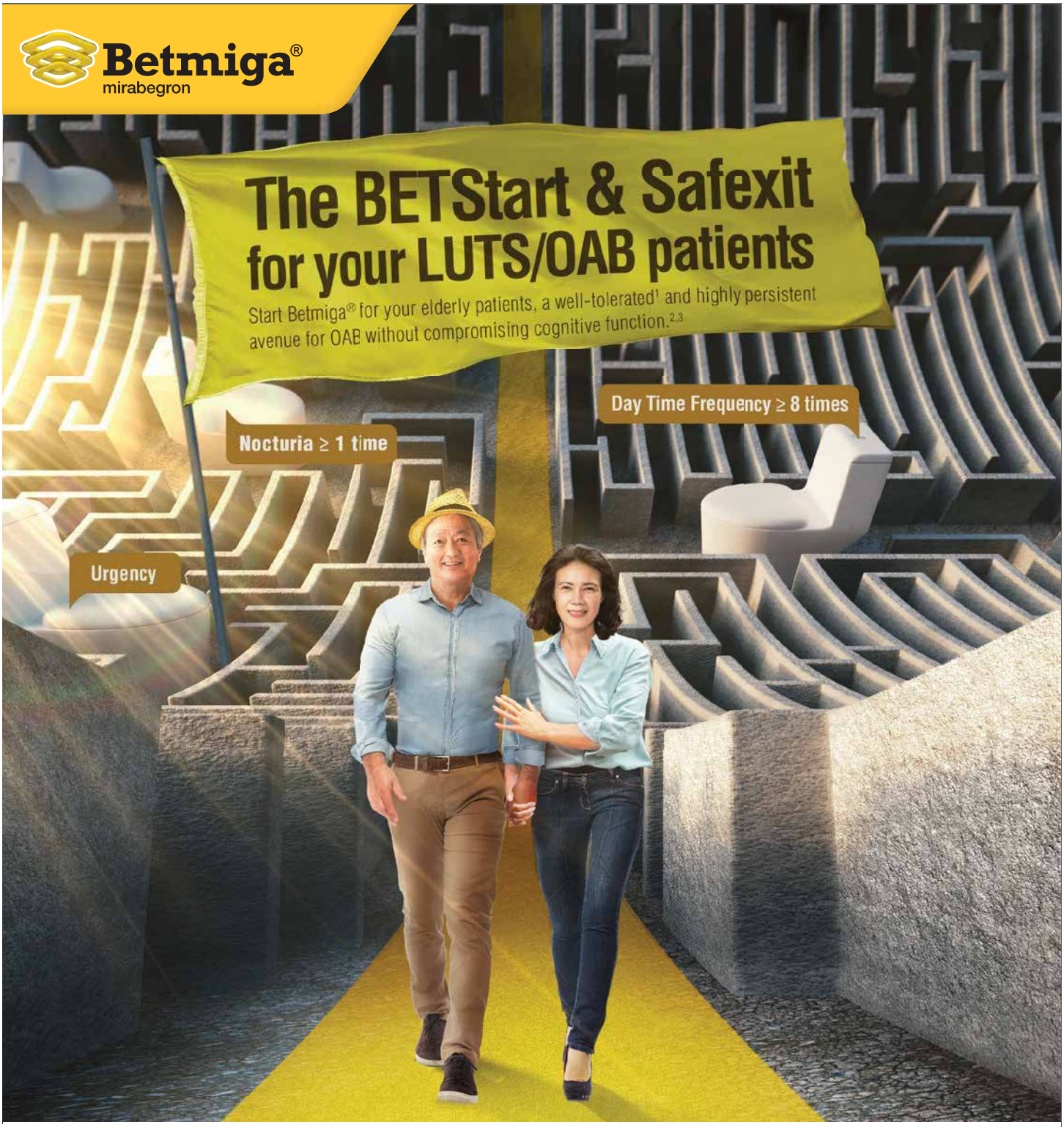
MBChB(CUHK), DCH(Irel), MRCP(UK), FHKAM(Paediatrics), FHKCPaed
Specialist in Developmental-Behavioural Paediatrics

Dr. Fanny Wai-Fan Lam, Specialist in Developmental-Behavioural Paediatrics, received her hospital-based paediatrics training in Hong Kong before pursuing further academic training positions in Australia and Canada. Throughout her career, Dr. Lam has authored and co-authored medical/ scientific peer-reviewed research papers in the fields of genetics, Developmental Paediatrics and education. In recognition of her endeavors in research and teaching, she was awarded Tutor by the Association for Research in infant and Child Development, United Kingdom, and Honorary Assistant Clinical Professor by the Department of Paediatrics and Adolescent Medicine, the University of Hong Kong.

Currently, Dr. Lam serves as the Developmental Paediatrician at the Hong Kong Developmental Paediatrics and Child Neurology Centre, Matilda International Hospital and Gleneagles Hospital Hong Kong, as well as the member of the Board of Directors of Heep Hong Society and of Bring Me a Book. She is also actively involved in promoting evidence-based parenting to the public and best practice of Developmental Paediatrics to medical professionals. She has extensive experience writing expert reports and acting as expert witness in medico-legal cases.

Medication and Cognitive Behavioural Training of ADHD

Attention Deficit Hyperactivity Disorder(ADHD) is a heterogeneous and complex chronic condition. Its symptoms may start to develop in preschool years, continue to evolve all the way till adulthood or even stay throughout the lifetime, with or without comorbidity. In this symposium, Dr. Fanny Lam will discuss the causes, diagnosis and treatment of ADHD.



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

References: 1. Wagg A, *et al*. Efficacy, safety, and tolerability of mirabegron in patients aged≥ 65 yr with overactive bladder wet: a phase IV, double-blind, randomised, placebo-controlled study (PILLAR). *Eur Urol*. 2020;77(2):211-20. **2.** Griebling TL, *et al*. Effect of mirabegron on cognitive function in elderly patients with overactive bladder: MoCA results from a phase 4 randomized, placebo-controlled study (PILLAR). *BMC Geriatr*. 2020;20(1):1-0. **3.** Chapple CR, *et al*. Persistence and adherence with mirabegron versus antimuscarinic agents in patients with overactive bladder: a retrospective observational study in UK clinical practice. *Eur Urol*. 2017;72(3):389-99.

Abbreviated prescribing information of Betmiga® prolonged-release tablets

Version: 003 Composition: Mirabegron **Indication:** Symptomatic treatment of urgency, increased micturition frequency and/or urgency incontinence as may occur in adult patients with overactive bladder (OAB) syndrome. **Dosage:** Adult including elderly 50 mg once daily with or without food. **Administration:** Swallow whole with liquids. Do not chew/divide/crush. **Contraindications:** Mirabegron is contraindicated in patients with - Hypersensitivity to the active substance or to any of the excipients. - Severe uncontrolled hypertension defined as systolic blood pressure ≥ 180 mm Hg and/or diastolic blood pressure ≥ 110 mm Hg. **Special warnings and precautions for use:** Renal impairment Betmiga has not been studied in patients with end stage renal disease (GFR < 15 mL/min/1.73 m^2 or patients requiring haemodialysis) and, therefore, it is not recommended for use in this patient population. Data are limited in patients with severe renal impairment (GFR 15 to 29 mL/min/1,73 m^2); based on a pharmacokinetic study a dose reduction to 25 mg is recommended in this population. Betmiga is not recommended for use in patients with severe renal impairment (GFR 15 to 29 mL/min/1,73 m^2) concomitantly receiving strong CYP3A inhibitors. Hepatic impairment Betmiga has not been studied in patients with severe hepatic impairment (Child-Pugh Class C) and, therefore, it is not recommended for use in this patient population. Betmiga is not recommended for use in patients with moderate hepatic impairment (Child-Pugh B) concomitantly receiving strong CYP3A inhibitors. Hypertension Mirabegron can increase blood pressure. Blood pressure should be measured at baseline and periodically during treatment with Betmiga, especially in hypertensive patients. Data are limited in patients with stage 2 hypertension (systolic blood pressure ≥ 160 mm Hg or diastolic blood pressure ≥ 100 mm Hg). Patients with congenital or acquired QT prolongation Betmiga, at therapeutic doses, has not demonstrated clinically relevant QT prolongation in clinical studies. However, since patients with a known history of QT prolongation or patients who are taking medicinal products known to prolong the QT interval were not included in these studies, the effects of mirabegron in these patients is unknown. Caution should be exercised when administering mirabegron in these patients. Patients with bladder outlet obstruction and patients taking antimuscarinics medications for OAB Urinary retention in patients with bladder outlet obstruction (BOO) and in patients taking antimuscarinic medications for the treatment of OAB has been reported in postmarketing experience in patients taking mirabegron. A controlled clinical safety study in patients with BOO did not demonstrate increased urinary retention in patients treated with Betmiga; however, Betmiga should be administered with caution to patients with clinically significant BOO. Betmiga should also be administered with caution to patients taking antimuscarinic medications for the treatment of OAB. **Undesirable effects:** Summary of the safety profile The safety of Betmiga was evaluated in 8,433 patients with OAB, of which 5,648 received at least one dose of mirabegron in the phase 2/3 clinical program, and 622 patients received Betmiga for at least 1 year (365 days). In the three 12-week phase 3 double blind, placebo controlled studies, 88% of the patients completed treatment with Betmiga, and 4% of the patients discontinued due to adverse events. Most adverse reactions were mild to moderate in severity. The most common adverse reactions reported for patients treated with Betmiga 50 mg during the three 12-week phase 3 double blind, placebo controlled studies are tachycardia and urinary tract infections. The frequency of tachycardia was 1.2% in patients receiving Betmiga 50 mg. Tachycardia led to discontinuation in 0.1% patients receiving Betmiga 50 mg. The frequency of urinary tract infections was 2.9% in patients receiving Betmiga 50 mg. Urinary tract infections led to discontinuation in none of the patients receiving Betmiga 50 mg. Serious adverse reactions included atrial fibrillation (0.2%). Adverse reactions observed during the 1-year (long term) active controlled (muscarinic antagonist) study were similar in type and severity to those observed in the three 12-week phase 3 double blind, placebo controlled studies. List of adverse reactions The table below reflects the adverse reactions observed with mirabegron in the three 12-week phase 3 double blind, placebo controlled studies. The frequency of adverse reactions is defined as follows: very common (≥1/10); common (≥1/100 to <1/10); uncommon (≥1/1,000 to <1/100); rare (≥1/10,000 to <1/1,000); very rare (<1/10,000). Within each frequency grouping, adverse reactions are presented in order of decreasing seriousness. **Infections and infestations: Common:** Urinary tract infection. **Uncommon:** Vaginal infection, Cystitis **Psychiatric disorders: Not known (cannot be estimated from the available data):** Insomnia* **Eye disorders: Rare:** Eyelid oedema **Cardiac disorders: Common:** Tachycardia. **Uncommon:** Palpitation, Atrial fibrillation **Vascular disorders: Very rare:** Hypertensive crisis* **Gastrointestinal disorders: Common:** Nausea*, Constipation*, Diarrhoea*. **Uncommon:** Dyspepsia, Gastritis. **Rare:** Lip oedema **Skin and subcutaneous tissue disorders: Uncommon:** Urticaria, Rash, Rash macular, Rash popular, Pruritus. **Rare:** Leukocytoclastic vasculitis, Purpura, Angioedema* **Musculoskeletal and connective tissue disorders: Uncommon:** Joint swelling **Reproductive system and breast disorders: Uncommon:** Vulvovaginal pruritus **Investigations: Uncommon:** Blood pressure increased, GGT increased, AST increased, ALT increased **Renal and urinary disorders: Rare:** Urinary retention* **Nervous system disorders: Common:** Headache*, Dizziness* *observed during post-marketing experience **Full prescribing information is available upon request.**

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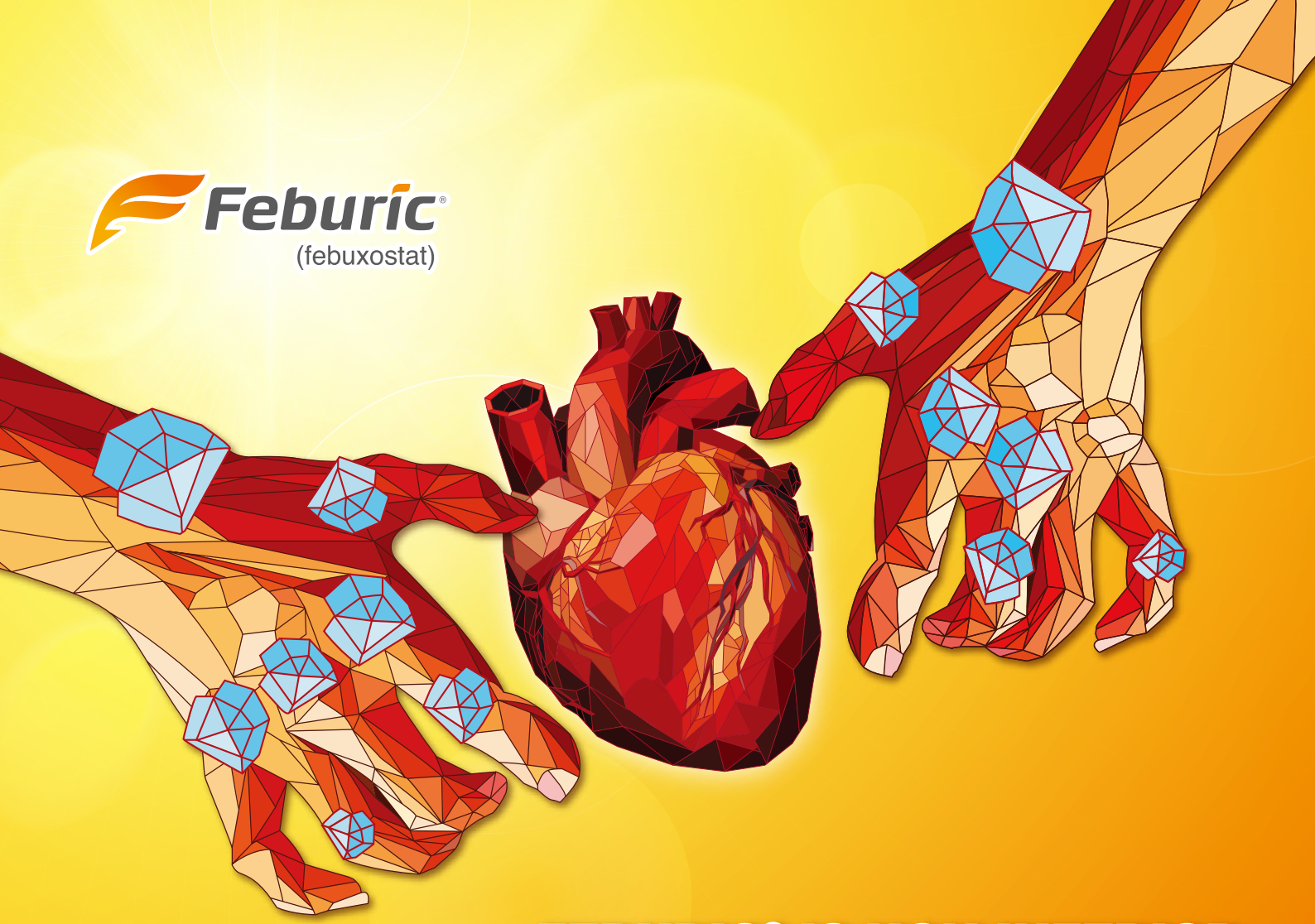

FEBURIC® IS NON-INFERIOR TO ALLOPURINOL FOR CV ADVERSE EVENTS IN GOUT PATIENTS ≥60 YEARS WITH 1 CV RISK FACTOR[1]

Study Design:[1] The FAST trial was a prospective, randomised, open-label, non-inferiority trial investigating febuxostat versus allopurinol in patients with gout in the UK, Denmark and Sweden. A total of 6128 patients aged ≥60, already receiving allopurinol, and with at least one cardiovascular risk factor were randomly assigned 1:1 to continue allopurinol (n=3065) or start febuxostat at 80mg/day (n=3063), increasing to 120mg/day if necessary to achieve target serum urate concentration. The primary outcome was a composite of hospitalisation for non-fatal myocardial infarction or biomarker-positive acute coronary syndrome, non-fatal stroke, or cardiovascular death. Median follow-up time in the study was 1467 days, and median on-treatment follow-up period was 1324 days. In the primary on-treatment analysis, febuxostat was found non-inferior to allopurinol with regards to the primary endpoint (HR=0.85; 95% CI: 0.70-1.03; p<0.0001). Cardiovascular death occurred in 2.0% and 2.7% of febuxostat and allopurinol patients, respectively, and also showed non-inferiority (HR=0.91; 95% CI: 0.66-1.27; p=0.018).

Abbreviations: CI, confidence interval; CV, cardiovascular; HR, hazard ratio; UK, United Kingdom

Reference: 1. Mackenzie IS et al. The Lancet. 2020;396 (10264):1745-1757.

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Abstracts

Dr. Desmond Yat-Hin YAP

MBBS(HK), MD(HK), PhD(HK), MRCP(UK), FHKCP, FHKAM, FRCP(Edin, Glasg, Lond)
Clinical Associate Professor, HKU
Honorary Consultant

Dr. Desmond Yat-Hin Yap joined the University Department of Medicine after his graduation from MBBS at the University of Hong Kong. He later pursued his Doctor of Medicine (MD) and Doctor of Philosophy (PhD) degrees at the University of Hong Kong, both along with the study of the immunopathogenesis and treatment of lupus nephritis.

Dr. Yap was the co-First author of the Asian Guidelines for the management of lupus nephritis, co-published in the official journals of regional nephrology and rheumatology societies [Nephrology (Carlton) 2014; 19: 11-20 & Int J Rheum Dis 2013; 16: 25-36], and his research findings have also contributed to the latest KDIGO Clinical Practice Guideline for Glomerulonephritis 2021. He received the Hong Kong Society of Nephrology Young Investigator Award in 2009 and worked as a research fellow at the Fiebiger-Nikolaus Centre, Friedrich-Alexander University, Germany. Dr. Yap was awarded the LKS Faculty Teaching Medal in 2019, and the prestigious Sir David Todd Lectureship by the Hong Kong College of Physicians in 2021 for his contributions to lupus nephritis research.

Dr. Yap's other research interest pertains to infective complications in renal failure patients, focusing on viral hepatitis in kidney transplant recipients and recently COVID-19 infection in renal patients. Dr. Yap is currently the EXCO member of the APSN and also serves as a Council Member of various important professional societies including the Hong Kong Society of Nephrology, Hong Kong Society of Transplantation and the Hong Kong Society for Histocompatibility and Immunogenetics. Dr. Yap has published over 120 peer-reviewed articles in various internationally renowned journals, and is currently Subject Editor for Nephrology, the official journal of the Asian Pacific Society of Nephrology.

Management of COVID-19 Infection in Renal Failure Patients

The COVID-19 pandemic caused by SARS-CoV-2 remains a global health concern. Patients with chronic kidney disease (CKD) and renal failure are highly susceptible to COVID-19 infection, and are associated with substantial patient morbidity and mortality. In this context, CKD and renal failure patients show impaired immunogenicity of COVID-19 immunisation, although vaccination is generally safe in renal patients. Other issues that are pertinent to renal failure patients are the infection control measures and isolation policies in dialysis and renal transplant units. There is uncertainty regarding the efficacy of oral viral agents (e.g. molnupiravir, paxlovid) in dialysis and renal transplant recipients. The optimal dosage adjustment, side effects profile and drug-drug interactions are important concerns when using these oral anti-viral agents in renal patients. There is also limited data regarding the application of anti-inflammatory agents (e.g. anti-IL-6 antibody, baracitinib) and prophylactic anti-viral monoclonal antibodies in patients with CKD and renal failure.

Abstracts

Dr. Kevin Ka-Ho KAM

MB ChB(CUHK); FHKAM(Medicine)
Associate Consultant, Prince of Wales Hospital
Honorary Clinical Associate Professor, CUHK

Dr. Kevin Kam is the Associate Consultant of Prince of Wales Hospital and Honorary Clinical Associate Professor of the Chinese University of Hong Kong. He received his medical degree from the Chinese University of Hong Kong and completed his General Cardiology training in the Department of Medicine & Therapeutics, Prince of Wales Hospital. From the year 2016 to 2017, he completed one-year clinical fellowship in Advanced Echocardiography at Mayo Clinic, Rochester (United States). His clinical interest included cardiomyopathy, heart failure and pulmonary hypertension. He has awarded the Hospital Young Achiever in year 2018 as recognition of improving Cardiology services. He was appointed as director of Electro-diagnostic unit in 2019.

Suspecting, Diagnosing and Managing ATTR-Cardiomyopathy

Transthyretin cardiac amyloidosis (ATTR-CA) is a progressive, potentially life-threatening infiltrative cardiomyopathy secondary to deposition of transthyretin-derived amyloid fibrils in the myocardium. ATTR-CA, which has been underdiagnosed for many decades, has now been increasingly recognised as a cause of heart failure with preserved ejection fraction among the ageing population. With the advancement of cardiac imaging such as strain imaging of Echocardiography, Cardiac MRI and Pyrophosphate Scintigraphy of heart, more cases of ATTR-CA are being uncovered.

Recently, the efficacy of several disease-modifying agents on ATTR-CA has been demonstrated to improve survival and major cardiovascular events. ATTR-CA has been changing from incurable to treatable condition. Therefore, it is crucial for clinicians to be aware of this clinical entity for early referral, prompt diagnosis and appropriate treatment. This session is to introduce the pathogenesis, genotype, and phenotype of Transthyretin cardiac amyloidosis (ATTR-CA), as well as its clinical manifestations. The red flags and clinical features of ATTR-CA would be explored using state-of-art imaging and diagnostic tools. Last but not the least, the session will cover the latest ESC guideline, overview of current treatment and the real-world evidence.

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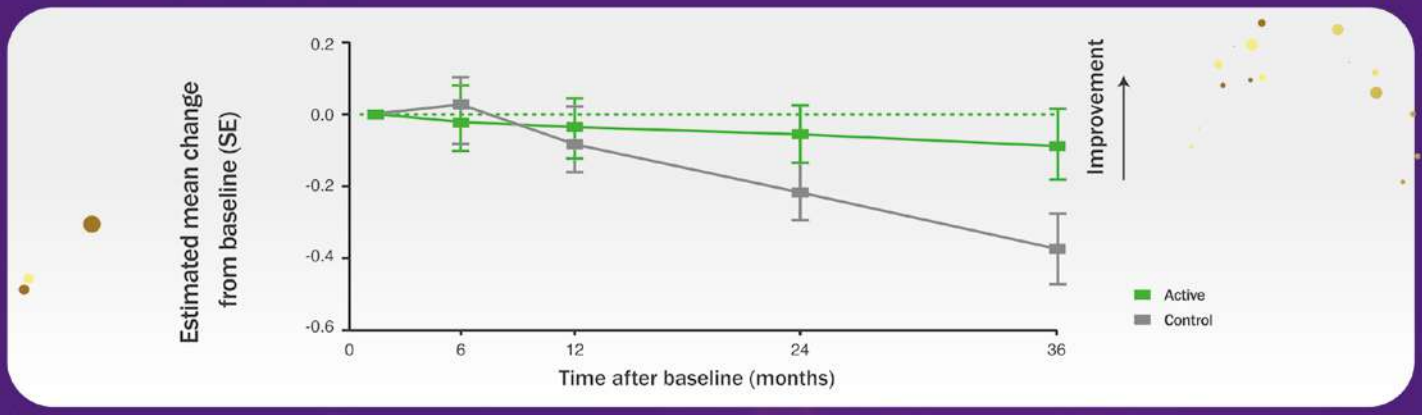
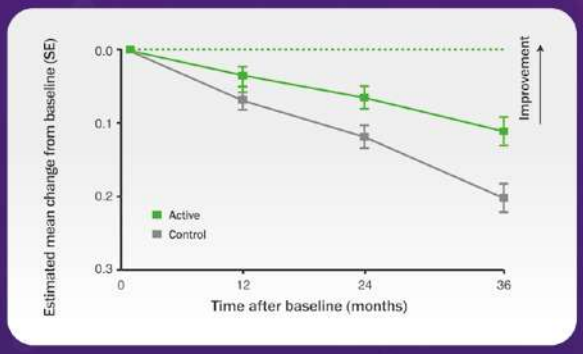
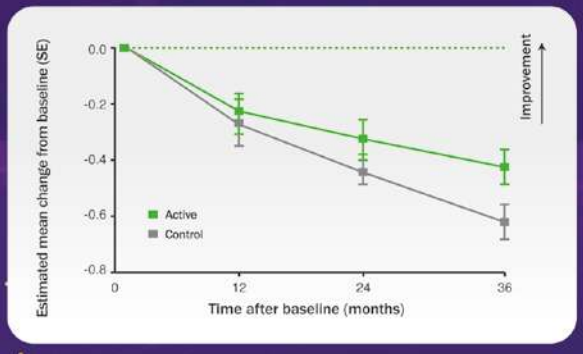


45% Less disease worsening



33% Diminished hippocampal atrophy



Reference: Soininen H, et al. LipiDiDiet clinical study group. 36-month LipiDiDiet multinutrient clinical trial in prodromal Alzheimer's disease. Alzheimers Dement. 2021 Jan;17(1):29-40

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Reference: Soininen H, et al. 36-month LipiDiDiet multinutrient clinical trial in prodromal Alzheimer's disease. Alzheimer's & Dementia, the Journal of Alzheimer's Association. 2020; DOI:10.1002/alz.12172

Abstracts

Dr. David Chi-Leung LAM

MBBS, BSc, MD, PhD, FRCP(Edin, Glasg, Lond), FHKCP, FHKAM(Medicine)
Clinical Associate Professor, Department of Medicine, HKU
Chief of Division of Respiratory Medicine of the Department of Medicine, HKU

Dr. Lam is a Clinical Associate Professor in the Department of Medicine, HKU.

He is currently the Chief of the Division of Respiratory Medicine of the Department of Medicine, HKU.

Dr. Lam is a respiratory physician with interests in translational research and clinical trials in respiratory diseases, including lung cancer, COPD and airway inflammation. He also performs bronchoscopy including endobronchial ultrasonography and autofluorescence imaging for the early detection of lung cancer. He also establishes a lung nodule programme to complement lung screening study.

He is on the International Lung Screening Trial Consortium, steering international multi-centre collaboration on lung screening and biomarker research. In his research laboratory, new lung cancer cell lines and organoids serve as cellular models for biomarker research in lung cancer and airway inflammation.

Dr. Lam is currently the President of the Asian Pacific Society of Respirology (APSR). He is also Deputy Editor of Respirology and Associate Editor of Respirology Case Report. He is also the Immediate Past President of the Hong Kong Thoracic Society.

Dr. Lam has received multiple international research awards, including the Tohoku Medical Society Medal (2019) and the APSR Woolcock Research Award (2021).

Management of Severe Asthma - From Triple Inhalers Therapy to Biologics

Asthma is a global health problem, being targeted as one of the Big Five respiratory problems by the World Health Organization, implying a significant health care burden from the prevalence of asthma and also the socioeconomic burden of inadequately controlled asthma. Asthma prevalence is growing by approximately 50% each decade. In Asia, a significant number proportion of asthma patients were found to have suboptimal control of asthma. This is attributed to multiple different reasons, including suboptimal compliance, inadequate treatment or even access to appropriate treatment.

The impact on exacerbations and resource utilisation and the critical need to improve adherence and persistence in patients with asthma have been vastly discussed in recent decades. This lecture aims to discuss how we can maximise the potential of LABA/LAMA/ICS inhaler therapies and options for Asthma biologics for severe asthma in correlation to the current GINA Report. Good symptom control and reduced exacerbations are key to achieving asthma control.

Abstracts

Dr. Priscilla Ching-Han WONG

MB ChB(CUHK), MRCP(UK), FHKCP, FHKAM(Medicine), FRCP(Edin)
Specialist in Rheumatology
Clinical Associate Professor(Honorary),
Department of Medicine and Therapeutics, CUHK

Dr. Priscilla Wong completed her fellowship in 2011 and is currently the Honorary Clinical Associate Professor at CUHK. She has been a council member of the HK Society of Rheumatology since 2017 and a task force member for HKSR Musculoskeletal Ultrasound Special Interest Group as well as HKSR MRI Special Interest Group. She is also the Convenor of the Asia Pacific League of Associations for Rheumatology Young Rheumatologists (AYR) Board since 2021. Dr. Wong is now practising as a Private Rheumatologist in Virtus Medical Group starting February this year.

Latest Updated Management of Gout

Gout is a metabolic disorder characterised by the production and deposition of monosodium urate crystals in various tissues. The consequence of this deposition in the body causes gouty arthritis, which often presented by the recurrent acute attack and chronic tophi development. Gout or hyperuricaemia alone represents a significant independent risk factor of all-cause and cardiovascular morbidity and mortality. Many patients with hyperuricemia and gout have risk factors typical for metabolic syndrome or suffer from other comorbidities and hence maintaining urate level below 6mg/dL is crucial for successful treatment. In this presentation, we summarise the recent knowledge about hyperuricemia and gout, with a focus on its physiology and correlation with cardiovascular disease and other comorbidities. We will discuss the possible positive effects of urate lowering agents to reduce urate levels in patients with cardiovascular disease. The cardiovascular safety of febuxostat compared to allopurinol for the treatment of gout remains controversial. However, the outcome of a recently published FAST study has demonstrated that febuxostat is non-inferior to allopurinol therapy with respect to the primary cardiovascular endpoint, and its long-term use is not associated with an increased risk of death or serious adverse events compared with allopurinol. Besides, gout patients are at increased risk of Covid-19 and its adverse outcomes, particularly if they have cardiometabolic comorbidities, hyperuricaemia, or frequent gouty attacks. Maintaining adequate disease control through continued use of gout medications such as febuxostat and colchicine, is important to prevent gout flares and severe Covid-19 during the pandemic.

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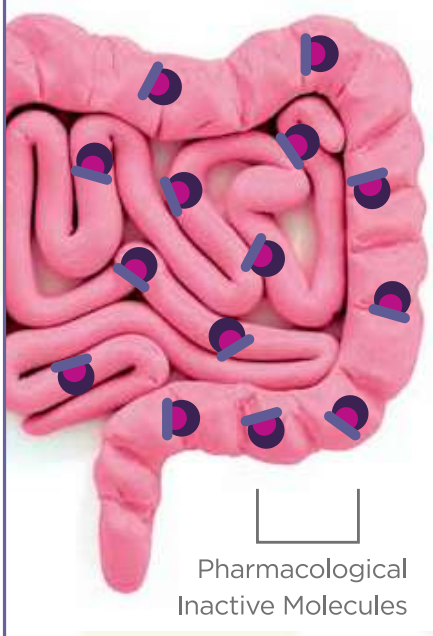
VYVANSE delivers its stimulant effect through a unique, prodrug approach:[7]

In Gut

Vyvanse is rapidly absorbed from the GI tract into the bloodstream[*,8]

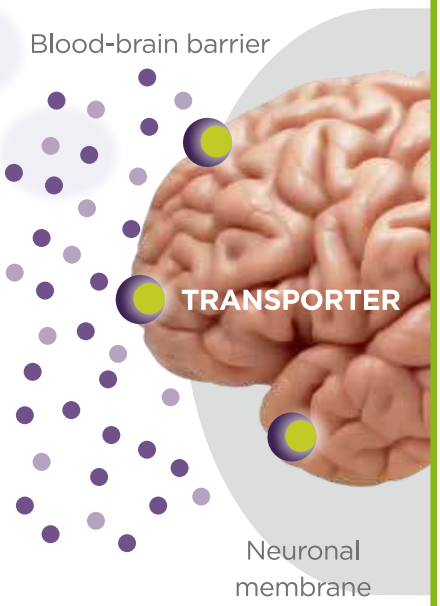


In BLOOD

Vyvanse is hydrolysed in red blood cells to the active molecule, d-amphetamine[†,8,9]

In Brain

d-Amphetamine is taken up by dopamine and noradrenaline transporters[†,10]



[*] Based on animal studies which may not predict clinical effects.
[†] Based on ***in vitro*** data which may not predict clinical effects.

ADHD = attention-deficit/hyperactivity disorder.
DAT = dopamine transporter.

NAT = noradrenaline transporter.
d-amphetamine = dextroamphetamine.
GI = gastrointestinal.

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Prodrug formulation for

ADHD TREATMENT

in Children, Adolescents & Adults[1]

Indication: VYVANSE® is indicated for the treatment of Attention Deficit / Hyperactivity Disorder (ADHD)[1]

- **Prodrug formulation** in ADHD treatment [1]
- **Once daily, Capsule or Capsule free administration** [1]
- Long acting efficacy **for up to 13 Hours in children 6-12 year old** [3*] **& up to 14 hours in adults** [4#]

* Study design: Study 311 was a randomised, double-blind, multicentre, placebo-controlled, crossover, analogue-classroom study14 of children (6 - 12 years) with a primary diagnosis of ADHD. Following screening (-3 weeks) and washout (up to 1 week), eligible subjects received open-label VYVANSE, titrated from 30 mg QD, to reach an optimal dose in 4 weeks. Afterwards, 117 patients were randomised (1:1) to receive VYVANSE at the optimised QD dose × 1 week followed by placebo QD × 1 week or vice versa, in a double-blind manner. The primary end point was the SKAMP-D subscale score at 1.5 hours post-dose on the last day of each week (dosed at 7 a.m.)

\# Study design: Study 316 was a randomised, double-blind, placebo-controlled, 2-way crossover study21 of adults (18 - 55 years) with a primary diagnosis of ADHD, conducted in a simulated adult workplace environment (AWE). Following a 4-week, open-label dose-optimisation phase, 127 patients were then randomized to receive their optimised dose of VYVANSE × 7 days followed by placebo × 7 days or vice versa. The primary efficacy end point was the total PERMP scale scores averaged over all post-dose time points during the visits at week 5 and 6

Abbreviated Prescribing Information - VYVANSE® (lisdexamfetamine dimesylate) Capsules 20 mg, 30 mg, 50 mg (Hong Kong PI Nov 2019)
Indication: VYVANSE is indicated for the treatment of Attention Deficit Hyperactivity Disorder (ADHD) **Dosage:** The recommended starting dose is 30 mg once daily in the morning in patients ages 6 and above. Dosage may be adjusted in increments of 10 mg or 20 mg at approximately weekly intervals up to maximum dose of 70 mg/day. **Administration:** Take VYVANSE by mouth in the morning with or without food; avoid afternoon doses because of the potential for insomnia. Swallow VYVANSE capsules whole, or open capsules, empty and mix the entire contents with yogurt, water, or orange juice. Do not take anything less than one capsule per day. A single dose should not be divided. **Contraindications:** Known hypersensitivity to amphetamine products or other ingredients of Vyvanse. Patients taking monoamine oxidase inhibitors (MAOIs), or within 14 days of stopping MAOIs. **Warnings & Precautions:** Potential for abuse and dependence, serious cardiovascular reactions, blood pressure and heart rate increases, psychiatric adverse reactions, suppression of growth, peripheral vasculopathy including Raynaud's phenomenon, serotonin syndrome. **Adverse Reactions (incidence ≥5% and at a rate at least twice placebo):** reported in children, adolescents, and/or adults were anorexia, anxiety, decreased appetite, decreased weight, diarrhea, dizziness, dry mouth, irritability, insomnia, nausea, upper abdominal pain, and vomiting.
Full prescribing information is available upon request.

References: 1. Vyvanse (lisdexamfetamine dimesylate) capsules Hong Kong Prescribing information Nov 2019 version **2.** IQVIA worldwide sales data MAT 12/2021 **3.** Wigal SB et al. Child Adolesc Psychiatry Ment Health 2009;3:17. **4.** Wigal T et al. 316 study group. Behav Brain Funct 2010;6 :34 **5.** Pennick M. Neuropsychiatr Dis Treat. 2010;6:317-327 **6.** Roncero C. Alvarez FJ, Expert Rev Neurother 2014 ;14 :849-865 **7.** VYVANSE® (lisdexamfetamine dimesylate) capsules Hong Kong prescribing information. Hong Kong: ; Nov 2019. **8.** Pennick M. Absorption of lisdexamfetamine dimesylate and its enzymatic conversion to d-amphetamine. Neuropsychiatr Dis Treat. 2010;6:317-327. doi: 10.2147/ndt.s9749 [doi]. **9.** Sharman J, Pennick M. Lisdexamfetamine prodrug activation by peptidase-mediated hydrolysis in the cytosol of red blood cells. Neuropsychiatr Dis Treat. 2014;10:2275-2280. doi: 10.2147/NDT.S70382 [doi]. **10.** Heal DJ, Cheetham SC, Smith SL. The neuropharmacology of ADHD drugs in vivo: Insights on efficacy and safety. Neuropharmacology. 2009;57(7-8):608-618. doi: 10.1016/j.neuropharm. 2009.08.020 [doi].

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C-APROM/HK/Vyv/0047 (06/2022)

Abstracts

Dr. David Tak-Wai LUI

MBBS(Hons) (HK), MRCP(UK), FHKCP, FHKAM(Medicine)
Clinical Assistant Professor, HKU

Dr. David Lui obtained his MBBS degree with Honours from the University of Hong Kong in 2012 and completed his specialty training in Endocrinology, Diabetes and Metabolism in 2019 at the Queen Mary Hospital. He is now a Clinical Assistant Professor at the Department of Medicine, the University of Hong Kong.

Dr Lui's research interests include diabetic bone disease, pharmacoepidemiology in type 2 diabetes and the interrelationship between COVID-19 and endocrinology. Supported by the Health and Medical Research Fund (HMRF), he is currently leading a randomised controlled trial of the effect of statin on bone health among postmenopausal women with type 2 diabetes. He has published over 50 peer-reviewed articles in international journals, including Diabetes Care, EClinicalMedicine, and BMC Medicine. Two of his publications have been listed among the Highly Cited Articles (2019–2021) in the Journal of Clinical Endocrinology & Metabolism, and the Top Cited Articles (2020–2021) in Clinical Endocrinology, respectively. In recognition of his research work, he has been awarded both locally and internationally, including the Distinguished Research Paper Award for Young Investigators from the Hong Kong College of Physicians (2021 and 2022) and the Rising Star Award in the International Congress of Diabetes and Metabolism (2021).

Osteoporosis in Primary Care Clinic Settings

Osteoporosis is a skeletal disorder characterised by compromised bone strength predisposing a person to an increased risk of fracture. It is a significant global health problem affecting 1 in 3 postmenopausal women. Hip fractures are one of the most devastating consequences of osteoporosis, associated with significant morbidities and mortality. There are treatments with proven efficacy in reducing fracture risks. Hence, it is important to identify patients with osteoporosis and offer treatments accordingly. Primary care physicians play a crucial role in this regard.

Dual-energy x-ray absorptiometry for the measurement of bone mineral density is key to the diagnosis of osteoporosis. Furthermore, comprehensive clinical assessment, physical examination and laboratory investigations are essential in planning the appropriate treatment strategy.

In managing patients with osteoporosis, clinicians should not overlook the non-pharmacological components. As for pharmacological agents, they are broadly divided into anabolic and antiresorptive agents. The choice of the initial agents depends on the fracture risk assessment and any contraindication. Clinicians should be well equipped to discuss with patients the risks and benefits of various agents, and to inform them about the necessary precautions while on various agents. Since osteoporosis is a chronic health problem, considerations while on long-term anti-osteoporosis treatment will be discussed to wrap up the session.

Abstracts

Dr. Thomas Sau-Yan CHAN

MBBS(Hons, HK), MRCP(UK), FHKCP, FHKAM(Medicine), FRCP(Edin, London)
Consultant, Division of Hematology, Queen Mary Hospital

Dr. Thomas Sau-Yan Chan is a Consultant in the Division of Hematology at Queen Mary Hospital. He graduated in 2006 with an MBBS (Honours) from the University of Hong Kong, and embarked on his career to become an internal physician. He obtained his Fellowship in Haematology and Haematological Oncology in 2013. His current clinical and research interests include chronic lymphocytic leukemia, immunotherapies for lymphoid malignancies and infection in immunocompromised hosts.

CAR-T Cell Therapy: New Hope for Patients with Haematological Malignancy

In the last two decades, immuno-oncology has been advancing at an unprecedented pace. In the context of haematological malignancies, chimeric antigen receptor T cell (CAR-T cell) therapy is the most important breakthrough in cancer immunotherapy to date. CAR-T cell therapy is a form of cellular immunotherapy. Patient's own T-lymphocytes are extracted through leukapheresis and genetically modified ex vivo to express chimeric antigen receptors (CARs). These T-lymphocytes which express CARs recognise tumour specific antigens (TSA) on the cancer cell surface and mediate cell killing by cellular cytotoxicity. CAR-T cell therapy demonstrates remarkable efficacy in patients with relapsed/refractory B-cell malignancies. Across all CAR-T products, around 40-50% of patients may be cured in relapsed/refractory settings, which was unachievable by conventional chemotherapy. The side-effect profile of CAR-T cell therapy is also unique, which is mainly caused by the activation of the immune system and the release of cytokines. In the talk, I will begin with the background of CAR-T cell therapy, followed by the clinical efficacy and toxicity profile, and finish with the current landscape of CAR-T cell therapy both locally and internationally.

Abstracts

Dr. Spencer Chiu-Yee CHAN

DMD(U.E. Phil.)
Vice-President, Hong Kong Dental Association

- *DMD (U.E. Phil.)*
- *Advance Diploma in Implant Dentistry, RCS England.*
- *MSc Clin Dent (Implant Dentistry), University of Leeds, UK.*
- *Founding Committee member of the Hong Kong International Association of Oral Facial Rehabilitation (HKIAOFR)*
- *Vice President of the Hong Kong Dental Association 2021-2023*
- *Chairman of Mainland China Affairs Committee, HKDA 2021*
- *Chairman of Publication Committee, HKDA 2021*
- *Council Member of the Hong Kong Chinese Dentists Association*
- *Committee Member of Board of Hong Kong Licensing Examination*
- *Examiner of MFDS Royal College of Physicians and Surgeons of Glasgow*
- *Joint Chair of Implant Management Board, FGDP RCS England*

The Use of Top Graft (Decalcified Tooth Tissue) in Modified Khoury's Technique with Autologous Concentrated Growth Factor (CGF) Preparation in Alveolar Augmentation

In recent decades, the use of dental implants has been proven to be a successful solution for restoring edentulous spaces to full arches rehabilitation. By means of osseointegration, dental implants serve well as supports to dental prostheses in different designs, either fixed or removable. The foundation of dental implants is known to be sufficient supporting bone tissue. However, a bone recession occurs gradually over time due to tooth loss, periodontal infections, and other factors like ageing. Grafting the deficiency might be necessary before or during the implantation.

The Khoury technique involves the use of thin cortical plates harvested from the ramus, and in a 'sandwich' manner, interposing these bone plates with cancellous bone harvested from the same site can result in a three-dimensional augmentation. We modified the above technique by utilising the patient's own extracted tooth as the cortical plates after decalcification and sterilisation, known as a "top graft" to reduce patients' morbidity. The effectiveness was further enhanced by using "sticky bone" as the osteoinductive fillers in between the layers of the top graft, which refers to a mixture of alloplast and autologous fibrin glue, and the second generation of Platelets Rich Plasma (PRP), also known as Concentrated growth Factors Fibrin (CGF).

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1. European public assessment report (EPAR). Updated 18th September 2013. Available from www.ema.europa.eu/en/medicines/ human/EPAR/cholib. Accessed 2 Dec 2020. 2. Cholib Hong Kong Package Insert, Aug 2022

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CV Indication Approved

JARDIANCE demonstrated 38% RRR in CV death[1,2]

- Established HbA1c efficacy[2]
- Demonstrated safety profile[1,2]
- Convenient, once-daily oral dosing[2]

ADA & EASD recognize JARDIANCE as the SGLT2 inhibitor with stronger evidence of CV benefits[3#]

Jardiance® (empagliflozin)

CV: cardiovascular; RRR: relative risk reduction; ADA: American Diabetes Association; EASD: European Association for the Study of Diabetes; CVD: cardiovascular disease; OAD: oral antidiabetic drug; T2DM: type 2 diabetes mellitus

Reference: 1. Zinman B, et al. N Engl J Med. 2015;373(22):2117-2118. **2.** Jardiance Hong Kong Prescribing Information. **3.** Davies MJ, D'Alessio DA, Fradkin J,et al. Management of hyperglycaemia in type 2 diabetes, 2018. A consensus report by the American Diabetes Association (ADA) and the European Association for the Study of Diabetes (EASD). Diabetologia. 2018.

† JARDIANCE demonstrated RRR in CV death in adult patients with insufficiently controlled type 2 diabetes (baseline HbA1c 7-10%) and established CV disease (coronary artery disease, peripheral artery disease, or a history of myocardial infarction or stroke).[1]
‡ Standard of care included CV medications and glucose-lowering agents given at the discretion of physicians.[1]
§ Empagliflozin versus placebo on top of standard of care.[1]
# Management of hyperglycemia in type 2 diabetes, 2018. A consensus report by the ADA and EASD stated that among patients with established CVD, there is likely cardiovascular benefit, with the evidence of benefit modestly stronger for empagliflozin than canagliflozin[3]

JARDIANCE® Abbreviated Prescribing Information (aPI-JARD-02)

Presentation: Empagliflozin. Film-coated tablets 10 mg; 25 mg. **Indications: 10 mg and 25 mg:** Indicated in the treatment of type 2 diabetes mellitus to improve glycaemic control in adults as: monotherapy when diet and exercise alone do not provide adequate glycaemic control in patients for whom use of metformin is considered inappropriate due to intolerance; and as add-on combination therapy with other glucose-lowering medicinal products including insulin, when these, together with diet and exercise, do not provide adequate glycaemic control. Indicated in patients with type 2 diabetes mellitus and established cardiovascular disease to reduce the risk of cardiovascular death. **10 mg:** Jardiance is indicated in adults for the treatment of symptomatic chronic heart failure. **Dosage and administration: Type 2 diabetes mellitus:** 10 mg once daily. In patients tolerating 10 mg once daily and requiring additional glycaemic control, the dose can be increased to 25 mg once daily. Can be taken with or without food. No dose adjustment is required for patients with eGFR ≥ 30 mL/min/1.73m² or with hepatic impairment, or for elderly patients. **Heart Failure:** 10 mg once daily. Can be taken with or without food. In HF patients with or without T2DM, 10 mg may be initiated or continued down to an eGFR of 20 ml/min/1.73m² or CrCl of 20 ml/min. **Contraindication:** Hypersensitivity to empagliflozin or any of the excipients. For the treatment of Type 2 diabetes, JARDIANCE should not be used in patients with severe renal impairment (eGFR <30 mL/min/1.73m²), end-stage renal disease and patients on dialysis, as glycaemic efficacy depends on renal function. **Special warnings and precautions:** Should not be used in patients with type 1 diabetes or for treatment of ketoacidosis. Discontinue immediately when ketoacidosis is suspected or diagnosed. Treatment should be interrupted in patients who are hospitalised for major surgical procedures or acute serious medical illnesses, and may be restarted once the patient's condition has stabilised. For type 2 diabetes mellitus, should not be used in patients with severe renal impairment (eGFR <30 mL/min/1.73m²), end-stage renal disease and patients on dialysis. For HF, not recommended for use when eGFR < 20 mL/min/1.73m². Discontinue in cases of recurrent UTI. Due to a risk of modest decrease in blood pressure, caution should be exercised in patients with known cardiovascular disease, patients on diuretics, patients with history of hypotension or patients aged 75 years and older. Monitoring of volume status and electrolytes is recommended. Regularly examine the feet and counsel patients on routine preventative footcare. Caution is advised in patients at increased risk of genital infections. Avoid use during pregnancy and breast-feeding. Safety and effectiveness in children under 18 years of age have not been established. Initiation is not recommended in patients aged 85 years and older. Urine will test positive for glucose while patients are taking JARDIANCE. **Interactions:** Risk of dehydration and hypotension may increase when used in combination with thiazide and loop diuretics. Lower dose of insulin or an insulin secretagogue may be required to reduce the risk of hypoglycemia when used in combination with JARDIANCE. **Adverse reactions:** Hypoglycaemia (depends on type of background therapy of patients); Urinary tract infection, vaginal moniliasis, vulvovaginitis, balanitis and other genital infection; Increased urination, dysuria; Pruritus; Volume depletion; Thirst; Glomerular filtration rate decreased, blood creatinine increased, haematocrit increased, serum lipids increased. Post-marketing experience: Ketoacidosis, complicated urinary tract infections, necrotising fasciitis of the perineum (Fournier's gangrene), allergic skin reaction, angioedema. **Storage condition:** Please refer to outer packaging for special precautions for storage. **Note:** Before prescribing, please consult full prescribing information.

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Jardiance is indicated in T2DM patients and established cardiovascular disease to reduce the risk of cardiovascular death[2]

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LVEF ≤ 40%^[2]

21% RRR
LVEF > 40%‖[1]

Established safety and tolerability profile[1-3]

Simple dosing: oral, 10 mg once daily, no titration‡[3]

Recognizing EMPEROR-Reduced and EMPEROR-Preserved trial **JARDIANCE** is recommended across the LVEF spectrum**[4]

Jardiance® (empagliflozin)

* Approved = Jardiance 10mg is indicated in adults for the treatment of symptomatic chronic heart failure in Hong Kong

‡ Adult patients with chronic heart failure (NYHA class **II**, **III**, or **IV**) and reduced ejection fraction (LVEF ≤ 40%). Adult patients with chronic heart failure (NYHA class **II**, **III**, or **IV**) and preserved ejection fraction (LVEF > 40%).[1,2]

§ In the EMPEROR-Preserved trial, a randomised, double-blind, parallel-group, placebo-controlled study of 5988 patients with HFpEF, the efficacy and safety of JARDIANCE 10 mg (n=2997) were evaluated vs placebo (n=2991). The primary endpoint in the EMPEROR-Preserved trial was a composite of CV death or HHF, analysed as time to the first event. Patients treated with JARDIANCE experienced a 21% RRR in this endpoint (HR=0.79; 95% CI: 0.69, 0.90; p<0.001). In the EMPEROR-Reduced trial, a randomised, double-blind, parallel-group, placebo-controlled study of 3730 patients with HFrEF, the efficacy and safety of JARDIANCE 10 mg (n=1863) were evaluated vs placebo (n=1867). The primary endpoint in the EMPEROR-Reduced trial was a composite of CV death or HHF, analysed as time to the first event. Patients treated with JARDIANCE experienced a 25% RRR in this endpoint (HR=0.75; 95% CI: 0.65, 0.86; p<0.001).[1,2]

^ In the EMPEROR-Reduced trial, a randomised, double-blind, parallel-group, placebo-controlled study of 3730 patients with HFrEF, the efficacy and safety of JARDIANCE 10 mg (n=1863) were evaluated vs placebo (n=1867). The primary composite endpoint in the EMPEROR-Reduced trial was a composite of CV death or HHF, analysed as time to the first event. Patients treated with JARDIANCE experienced a 25% RRR in this endpoint (HR=0.75; 95% CI: 0.65, 0.86; p<0.001).[2]

‖ In the EMPEROR-Preserved trial, a randomised, double-blind, parallel-group, placebo-controlled study of 5988 patients with HFpEF, the efficacy and safety of JARDIANCE 10 mg (n=2997) were evaluated vs placebo (n=2991). The primary composite endpoint in the EMPEROR-Preserved trial was a composite of CV death or HHF, analysed as time to the first event. Patients treated with JARDIANCE experienced a 21% RRR in this endpoint (HR=0.79; 95% CI: 0.69, 0.90; p<0.001).[1]

‡ When Jardiance is used in combination with a sulphonylurea or with insulin, a lower dose of the sulphonylurea or insulin may be considered to reduce risk of hypoglycaemia.[3]

** The SGLT2i class, such as Jardiance, has gained a 1A recommendation for HFrEF and a 2a-B-R recommendation for HFmrEF and HFpEF.[4]

CI=confidence interval; CV=cardiovascular; HFpEF=heart failure with preserved ejection fraction; HFrEF=heart failure with reduced ejection fraction; HFmrEF=heart failure with mid range ejection fraction; HHF=hospitalisation for heart failure; HR=hazard ratio; LVEF=left ventricular ejection fraction; NYHA=New York Heart Association; RRR=relative risk reduction; SGLT2i=sodium-glucose cotransporter 2 inhibitor

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Chairpersons

Dr. Mario Wai-Kwong CHAK

MBBS(HKU), MRCP(UK), DCH(Ire), Dip Ger Med(RCPS Glass), PDipID(HKU), FHKAM(Paediatrics), FHKCPaed
Associate Consultant, Department of Paedaitrics and Adolescent Medicine, Tuen Mun Hospital
The Honorary Clinical Assistant Professor, The University of Hong Kong
Clinical Associate Professor(Honorary), The Chinese University of Hong Kong
Immediate Past President, The Federation of Medical Societies of Hong Kong

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

Dr. CHAN Chi-Kuen

MBBS(HK), FHKAM(Medicine), FRCP(Edin)
Part-time Consultant Physician, PYNEH

Retired Consultant Physician, QMH, 2012.
Ex-Deputy HCE, QMH, 2007-2012
Ex-Deputy HCE (Clinical Service), HKU-Shenzhen Hospital, 2012-2017
Ex-1st Vice-President, FMSHK, 1993-1995

Chairpersons

Dr. Jane Chun-Kwong CHAN

MD(U of Chicago), FHKCP, FHKAM(Medicine), Diplomate,
American Board of Internal Medicine(Pulmonary Disease & Critical Care Medicine)
Specialist in Respiratory Medicine
Editor-in-Chief, Hong Kong Medical Diary

Dr. Jane Chan graduated from the University of Chicago in 1982, followed by training in Internal Medicine at Washington University, and training in Respiratory and Critical Care Medicine at Stanford University. She joined the Department of Medicine at the University of Hong Kong as Clinical Lecturer in 1986. She became doubly accreditated by the H. K. College of Physicians in Respiratory Medicine and Critical Care Medicine in 1992. In 1995 she became Consultant in Intensive Care and Director of the Adult Intensive Care Unit at Queen Mary Hospital.

In 2003, after having fought the SARS battle, she took up the position of Consultant in Medical Development at the Hospital Authority Head Office, focusing on post-SARS work. During this period, she organised and cleaned up the clinical data of all Hong Kong SARS patients, and worked as co-editor partnering with Dr. Vivian Wong on compilation of a 300-page scientific monograph on SARS authored by over 70 local SARS frontline workers.

For the past decade and a half as a private practitioner, she has continued to contribute to medical education and the promotion of community health. She is currently Honorary Clinical Associate Professor of HKU, Global Governor of Chest Delegation Hong Kong & Macau Ltd, and the Editor-in-Chief for the monthly Newsletter of the Federation of Medical Societies of Hong Kong. She is the President of the Hong Kong Chinese Medical Association, an organisation which aspires to provide a platform for the Hong Kong medical community in promoting fellowship, continuing medical education and professional links with the Mainland.

Dr. CHAN Kai-Ming

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

Dr. Chan Kai-Ming is a Specialist in Infectious Disease. He previously worked in Tuen Mun Hospital, New Territories of West Cluster, Hospital Authority of Hong Kong since his graduation in 1993, Faculty of Medicine, The University of Hong Kong. Dr. Chan obtained his fellowships in Advance Internal Medicine & Infectious Disease in 2005. From 2006 to 2016, Dr. Chan was posted as Associate Consultant in Infectious Disease Management, New Territories West Cluster. Microbiology & Infectious Disease Team was set up, and Dr. Chan has extensive exposure in the field of both Microbiology and Infectious Disease. His team provided consultation services to all clinical departments on the management of infection and infection control.

During his stay at Hospital Authority, he was the QA/QC Chairman, Clinical Pathology, Tuen Mun Hospital, Trainer in Infectious Disease, Examination Board Member in Infectious Disease. Currently, Dr. Chan is a member of the Working Group on Influenza Vaccination (WGIV), Centre for Health Protection, Department of Health, Council Member of Hong Kong Society of Infectious Diseases, Executive Committee Member of The Federation of Medical Societies of Hong Kong. His special interest is the use of antibiotics and antibiotics stewardship programme. His team has seen over thirty thousand cases of complicated problems related to the use of antibiotics and infection. Currently, Dr. Chan is serving the Social Hygiene Services in the Department of Health.

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References
1. Garneata L, Stancu A, Dragomir D et al. Ketoanalogues-supplemented Vegetarian Very Low Protein Diet and CKD Progression. J Am Soc Nephrol 2016;27(7):2164-2176. **2.** Brunori G, Viola BF, Parrinello G et al. Effi cacy and safety of a very-low-protein diet when postponing dialysis in the elderly: a prospective randomized multicenter controlled study. Am J Kidney Dis 2007;49:569-580. **3.** Shah AP, Kalantar-Zadeh K, Kopple JD. Am J Kidney Dis. 2015;65:659-673 **4.** Mircescu G, Garneata L, Stancu SH, Capusa C. Effects of a Supplemented Hypoproteic Diet in Chronic Kidney Disease. J Ren Nutr. 2007;17(3):179-188. **5.** Cupisti A, D'Alessandro C, Gesualdo L, et al. Non-Traditional Aspects of Renal Diets: Focus on Fiber, Alkali and Vitamin K1 Intake. Nutrients. 2017 Apr 29;9(5). pii: E444. doi: 10.3390/nu9050444.

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Chairpersons

Dr. Kingsley Hau-Ngai CHAN

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

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

Prof. Bernard Man-Yung CHEUNG

PhD (Cantab), FRCP, FRCPE, FHKCP, FHKAM(Medicine), FBPhS, FBHS
Sun Chieh Yeh Heart Foundation Professor in Cardiovascular Therapeutics,
School of Clinical Medicine, The University of Hong Kong
President, The Federation of Medical Societies of Hong Kong

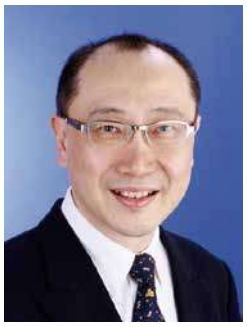
Prof. Bernard Cheung graduated from the University of Cambridge. He was a research fellow at Cambridge before taking up lectureships in Sheffield and Hong Kong. In 2007-2009, he was the Professor of Clinical Pharmacology and Therapeutics at the University of Birmingham. He is currently the Sun Chieh Yeh Heart Foundation Professor in Cardiovascular Therapeutics and heads the Division of Clinical Pharmacology and Therapeutics in the School of Clinical Medicine of the University of Hong Kong. He is an Honorary Consultant Physician of Queen Mary Hospital and the Medical Director of the Phase 1 Clinical Trials Centre. He is the Editor-in-Chief of Postgraduate Medical Journal. Prof. Cheung's main research interest is in cardiovascular diseases and risk factors, including hypertension and the metabolic syndrome. He is currently the President of the Federation of Medical Societies of Hong Kong.

Chairpersons

Dr. Peggy Sau-Kwan CHU

MBBS(HK), FRCS(Edin), FCS(HK), FHKAM(Surg), Dip Urol(London)
Consultant, Division of Urology, Department of Surgery,
Tuen Mun Hospital, New Territories West Cluster

Dr. Chu received her medical degree from the University of Hong Kong. She then received her urology training from Queen Elizabeth Hospital. Her overseas training took place at the Institute of Urology, University College London. After coming back from London, she continued to work in Queen Elizabeth Hospital until 2006; since then, she continued her career at Tuen Mun Hospital. Dr. Peggy Chu led the team, including urologists from Princess Margaret Hospital and toxicologists from United Christian Hospital, which reported the first 10 cases in Hong Kong with contracted bladder and upper urinary tract damage associated with ketamine abuse. This discovery has raised the Hong Kong Government's and the community's awareness of the social problems associated with Ketamine abuse. She also provided an affidavit to the Hong Kong High Court, thus leading to more stringent guidelines on the sentencing of ketamine abuse since June 2008. Dr. Chu received the Outstanding Staff Award from Hong Kong Hospital Authority in 2009. Dr. Chu is the trustee of the British Journal of Urology International since June 2019. Dr. Chu is also currently serving as the international adviser of the guideline committee of the European Association of Urology. Dr. Chu had delivered the UAA lecture in the AUA 2019 in Chicago.



Dr. Samuel Ka-Shun FUNG

MBBS(HKU), FRCPI, FRCPE, FHKCP, FHKAM(Int Med)
Chief of Nephrology & Consultant Physician, Department of Medicine & Geriatrics

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

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

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

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

Change the heart. Change heart failure [1,4,7,9]

Reverse cardiac remodelling, improve cardiac structure and function, and target HF via a unique dual MOA that inhibits neprilysin and RAAS

Provide the HF treatment superior to ACEi in all stages of the HFrEF patient journey [4-6,8]

Your first choice in the hospital or outpatient setting, whether patients are newly diagnosed or have worsening symptoms

Make a lasting difference patients can feel [2-5,11]

Help your patients stay out of the hospital, live longer, and feel better, so they have more time for what matters

*In place of an ACEi or ARB **ACEi**=angiotensin-converting enzyme inhibitor; **ARB**=angiotensin II receptor blocker; **HF**=heart failure; **MOA**=mechanism of action; **ESC**=European Society of Cardiology; **AHA**=American Heart Association; **ACC**=American College of Cardiology; **HFSA**=Heart Failure Society of America

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Entresto®
sacubitril/valsartan

The Essential HF Intervention

ENTRESTO tablets Important note: Before prescribing, consult full prescribing information. **Presentation: ENTRESTO 50 mg film-coated tablets** Each film-coated tablet contains 24.3 mg sacubitril and 25.7 mg valsartan (as sacubitril valsartan sodium salt complex). **ENTRESTO 100 mg film-coated tablets** Each film-coated tablet contains 48.6 mg sacubitril and 51.4 mg valsartan (as sacubitril valsartan sodium salt complex). **ENTRESTO 200 mg film-coated tablets** Each film-coated tablet contains 97.2 mg sacubitril and 102.8 mg valsartan (as sacubitril valsartan sodium salt complex). **Indications:** Treatment of symptomatic chronic heart failure (NYHA class II-IV) in adult patients with reduced ejection fraction to reduce the risk of cardiovascular death and hospitalization due to heart failure. **Dosage and administration: Adults:** •The recommended starting dose of ENTRESTO is 100 mg twice daily. The dose should be doubled at 2-4 weeks to the target dose of one tablet of 200 mg twice daily, as tolerated by the patient. •A starting dose of 50 mg twice daily is recommended for patients not currently taking an angiotensin-converting enzyme (ACE) inhibitor or an angiotensin II receptor blocker (ARB), and should be considered for patients previously taking low doses of these agents. •**Geriatric patients:** The dose should be in line with the renal function.•**Pediatric patients:** ENTRESTO has not been studied. Use of ENTRESTO is not recommended. •**Renal impairment:** No dose adjustment is required in patients with mild renal impairment (Estimated Glomerular Filtration Rate [eGFR] 60-90 ml/min/1.73 m²); A starting dose of 50 mg twice daily is recommended in patients with moderate renal impairment(eGFR 30-60 ml/min/1.73 m²); A starting dose of 50 mg twice daily and caution is recommended in patients with severe renal impairment (eGFR <30 ml/min/1.73 m²). Not recommended for patients with end-stage renal disease. •**Hepatic impairment:** No dose adjustment is required in patients with mild hepatic impairment (Child-Pugh A classification). A starting dose of 50 mg twice daily is recommended in patients with moderate hepatic impairment (Child-Pugh B classification) or with AST/ALT values more than twice the upper limit of the normal range. In patients with severe hepatic impairment use of ENTRESTO is not recommended. •**Method of administration** For oral use. May be administered with or without food. **Contraindications:** •Hypersensitivity to the active substance, sacubitril, valsartan, or to any of the excipients. •Concomitant use with ACE inhibitors. ENTRESTO must not be administered until 36 hours after discontinuing ACE inhibitor therapy. •Known history of angioedema related to previous ACE inhibitor or ARB therapy. •Concomitant use with aliskiren in patients with diabetes mellitus or in patients with renal impairment (eGFR <60 ml/min/1.73 m²). • Second and third trimester of pregnancy. •Hereditary or idiopathic angioedema •Severe hepatic impairment, biliary cirrhosis and cholestasis **Warnings and precautions:** •**Dual blockade of the Renin-Angiotensin-Aldosterone System (RAAS):** ENTRESTO must not be administered with an ACE inhibitor due to the risk of angioedema. ENTRESTO must not be initiated until 36 hours after taking the last dose of ACE inhibitor therapy. If treatment with ENTRESTO is stopped, ACE inhibitor therapy must not be initiated until 36 hours after the last dose of ENTRESTO. • The combination of ENTRESTO with direct renin inhibitors such as aliskiren is not recommended. The combination of ENTRESTO with aliskiren-containing products is contraindicated in patients with diabetes mellitus or in patients with renal impairment (eGFR <60 ml/min/1.73 m²). • ENTRESTO contains valsartan, and therefore should not be co-administered with another ARB containing product.•**Hypotension:** If hypotension occurs, temporary down-titration or discontinuation of ENTRESTO is recommended. Dose adjustment of diuretics, concomitant antihypertensive drugs, and treatment of other causes of hypotension (e.g. hypovolemia) should be considered. Sodium and/or volume depletion should be corrected before starting treatment with ENTRESTO. •**Impaired renal function:** •Evaluation of patients with heart failure should always include assessment of renal function. Down titration of ENTRESTO should be considered in patients who develop a clinically significant decrease in renal function. Caution should be exercised when administering ENTRESTO in patients with severe renal impairment (eGFR <30 ml/min/1.73 m²). •**Hyperkalemia:** Treatment should not be initiated if the serum potassium level is >5.4 mmol/l. Medications known to raise potassium levels (e.g. potassium-sparing diuretics, potassium supplements) should be used with caution. If clinically significant hyperkalemia occurs, measures such as adjustment of concomitant medicinal products, temporary down-titration or discontinuation should be considered. Monitoring of serum potassium is recommended especially in patients with risk factors such as renal impairment, diabetes mellitus, hypoaldosteronism, receiving a high potassium diet or mineralocorticoid antagonists. If serum potassium level is >5.4 mmol/l discontinuation should be considered. •**Angioedema:** If angioedema occurs, ENTRESTO should be immediately discontinued and appropriate therapy and monitoring should be provided until complete and sustained resolution of signs and symptoms has occurred. ENTRESTO must not be re-administered. Patients with a prior history of angioedema were not studied. As they may be at higher risk for angioedema, caution is recommended if ENTRESTO is used in these patients. ENTRESTO must not be used in patients with a known history of angioedema related to previous ACE inhibitor or ARB therapy. Black patients may have increased susceptibility to develop angioedema. •**Patients with renal artery stenosis:** Caution is required in patients with renal artery stenosis and monitoring of the renal function is recommended. •**Patients with NYHA functional classification IV:** Caution should be exercised. •**B-type natriuretic peptide (BNP):** BNP is not a suitable biomarker of heart failure in patients treated with ENTRESTO. •**Hepatic impairment:** Caution is recommended when using ENTRESTO in patients with moderate hepatic impairment (Child-Pugh B classification) or with AST/ALT values more than twice the upper limit of the normal range. ENTRESTO is contraindicated in patients with severe hepatic impairment, biliary cirrhosis or cholestasis (Child-Pugh C classification). **Pregnancy:** The use of ENTRESTO is not recommended during the first trimester of pregnancy and is contraindicated during the second and third trimesters of pregnancy. **Breast-feeding:** It is not known whether ENTRESTO is excreted in human milk. Because of the potential risk for adverse drug reactions in breastfed newborns/infants, ENTRESTO is not recommended during breastfeeding. **Adverse drug reactions:** ***Very common (≥1/10):*** Hyperkalemia, hypotension, renal impairment. ***Common (≥1/100 to <1/10):*** Anaemia, hypokalemia, Hypoglycaemia, Dizziness, Cough, Headache, Syncope, Vertigo, Orthostatic hypotension, Diarrhoea, Nausea, Gastritis, Renal failure (renal failure, acute renal failure), Fatigue, Asthenia ***Uncommon (≥1/1,000 to <1/100):*** Hypersensitivity, Dizziness postural, Pruritis, Rash, Angioedema. **Interactions:** •***Concomitant use contraindicated:*** aliskiren in patients with diabetes mellitus or in patients with renal impairment (eGFR <60 ml/min/1.73 m²); Use with ACE inhibitors: ENTRESTO must not be started until 36 hours after taking the last dose of ACE inhibitor therapy. ACE inhibitor therapy must not be started until 36 hours after the last dose of ENTRESTO. •***Concomitant use not recommended:*** ARB containing products •***Caution when used concomitantly*** with OAT1B1 and OATP1B3 substrates(e.g. statins), PDE5 inhibitors (e.g. sildenafil), lithium, potassium-sparing diuretics (triamterene, amiloride) , mineral corticoid antagonists (e.g. spironolactone, eplerenone), potassium supplements, salt substitutes containing potassium, other agents that may lead to increased serum potassium level (e.g. heparin), non-steroidal anti-inflammatory agents (NSAIDs) including selective cyclooxygenase-2 inhibitors (COX-2 Inhibitors), inhibitors of OATP1B1, OATP1B3, OAT3 (e.g. rifampin, cyclosporine),OAT1 (e.g. tenofovir, cidofovir) or MPR2 (e.g. ritonavir), furosemide, nitrates (e.g. nitroglycerine), metformin. **Packs:** 50mg: 28's; 100mg: 28's and 56's; 200mg: 56's. Not all pack sizes may be marketed. **Legal classification:** P1S1S3. **Ref:** EMA Nov 2015. **FULL PRESCRIBING INFORMATION IS AVAILABLE UPON REQUEST.**

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KYMRIAH® CAR-T

The transformation of cancer treatment is here

The first and only CAR-T therapy for your DLBCL patients:[1,2]

Response attained in difficult-to-treat patients

52%

ORR with KYMRIAH®[3]

Consistently high rates of durable response

60%

response probability for responders at 24 and 36 months[4]

Ongoing success with strong overall survival*

11.7 months

median OS[5]

(95% CI: 6.6%-NE)

KYMRIAH® has a manageable safety profile The most common ARs** were cytokine release syndrome (58%), infection (54%), pyrexia (35%), diarrhea (32%), nausea (29%), hypotension (26%) and fatigue (26%).[2,3]

*Overall survival is defined as the time from the date of KYMRIAH® infusion to the date of death due to any cause

**Please refer to Hong Kong Package Insert for detailed ARs[3]

Abbreviations: AR, adverse reaction; CAR, chimeric antigen receptor; CI, confidence interval, DLBCL, diffuse large B-cell lymphoma; NE, non-estimable; ORR, overall response rate; OS, overall survival

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Kymriah®

Important note: Before prescribing, consult full prescribing information. **Presentation:** Cell suspension for infusion in 1-3 bags for intravenous use (tisagenlecleucel). **Indications:** •Paediatric and young adult patients up to 25 years of age with B-cell acute lymphoblastic leukaemia (ALL) that is refractory, in relapse post-transplant or in second or later relapse. •Adult patients with relapsed or refractory diffuse large B-cell lymphoma (DLBCL) after two or more lines of systemic therapy. **Dosage:** • Kymriah is intended for autologous use only. **•Paediatric and young adult B ++ cell ALL patients:** For patients 50 kg and below, 0.2 to 5 x 10⁸ CAR-positive viable T cells (non-weight based). **•Adult DLBCL patients:** 0.6 to 6 x 10⁸ CAR-positive viable T cells (non-weight based). **Administration:** Refer to full package insert. **Special Population: •Paediatric population:** For B-cell ALL, no formal studies have been performed in paediatric patients below 3 years of age. For DLBCL, the safety and efficacy of Kymriah in children and adolescents below 18 years of age have not yet been established. No data are available. **•Elderly:** For B-cell ALL, the safety and efficacy of Kymriah in this population have not been established. For DLBCL, no dose adjustment is required in patients over 65 years of age. **Contraindications:** Hypersensitivity to tisagenlecleucel or to any of the excipients. Contraindications of the lymphodepleting chemotherapy must be considered. **Warnings/Precautions: •Reasons to delay treatment:** Delay infusion if a patient has unresolved serious adverse reactions (especially pulmonary reactions, cardiac reactions or hypotension) from preceding chemotherapy/active uncontrolled infection/active graft-versus- host disease (GVHD)/significant clinical worsening of leukaemia burden or lymphoma following lymphodepleting chemotherapy. **•Blood, organ, tissue and cell donation:** Patients treated with Kymriah should not donate blood, organs, tissues and cells for transplantation. **•Active CNS leukaemia or lymphoma:** Limited experience of use of Kymriah in patients with active CNS leukaemia and active CNS lymphoma. Risk and benefit of Kymriah has not been established in these populations. **•Cytokine release syndrome:** Occurring in almost all cases between 1 to 10 days (median onset 3 days) after Kymriah infusion. The median time to resolution of cytokine release syndrome is 7 days. **•Neurological adverse reactions:** Patients should be monitored for neurological events. In case of neurological events, patients should be diagnostically worked up and managed depending on the underlying pathophysiology and in accordance with local standard of care. **•Infections:** Patients should be monitored for signs and symptoms of infection and treated appropriately. As appropriate, prophylactic antibiotics should be administered and surveillance testing should be employed prior to and during treatment with Kymriah. **•Febrile neutropenia:** Infection should be evaluated and managed appropriately with broad-spectrum antibiotics, fluids and other supportive care, as medically indicated. **•Prolonged cytopenias:** Prolonged neutropenia has been associated with increased risk of infection. Myeloid growth factors, particularly GM-CSF, have the potential to worsen cytokine release syndrome symptoms and are not recommended during the first 3 weeks after Kymriah infusion or until cytokine release syndrome has resolved. **•Secondary malignancies:** Patients treated with Kymriah may develop secondary malignancies or recurrence of their cancer. They should be monitored life-long for secondary malignancies. **Hypogammaglobulinaemia:** Immunoglobulin levels should be monitored after treatment with Kymriah. In patients with low immunoglobulin levels pre-emptive measures such as infection precautions, antibiotic prophylaxis and immunoglobulin replacement should be taken. **Tumour lysis syndrome (TLS):** Patients with elevated uric acid or high tumour burden should receive allopurinol, or an alternative prophylaxis, prior to Kymriah infusion. Signs and symptoms of TLS should be monitored. **•Concomitant disease:** Patients with a history of active CNS disorder or inadequate renal, hepatic, pulmonary or cardiac function were excluded from the studies. These patients require special attention. **•Prior bone marrow transplant:** Not recommended that patients receive Kymriah within 4 months of undergoing an allogeneic stem cell transplant (SCT) because of the potential risk of Kymriah worsening GVHD. Leukapheresis for Kymriah manufacturing should be performed at least 12 weeks after allogeneic SCT. **•Patients seropositive for HBV, HCV and HIV:** No experience with manufacturing Kymriah for patients testing positive for HBV, HCV and HIV. Leukapheresis material from these patients will not be accepted for Kymriah manufacturing. Screening for HBV, HCV and HIV must be performed. **•Prior treatment with anti-CD19 therapy:** Limited experience with Kymriah in patients exposed to prior CD19-directed therapy. Kymriah is not recommended if the patient has relapsed with CD19-negative leukaemia after prior anti-CD19 therapy. **•Interference with serological testing:** Some commercial HIV nucleic acid tests may give a false positive result. **•Content of dextran 40 and dimethyl sulfoxide (DMSO):** These excipients are known to possibly cause anaphylactic reaction following parenteral administration. Patients not previously exposed to dextran and DMSO should be observed closely during the first minutes of the infusion period. **•Women of childbearing potential:** Pregnancy status for females of child-bearing age should be verified prior to starting treatment with Kymriah. Kymriah is not recommended in women of childbearing potential not using contraception. **•Pregnancy:** No data from the use of Kymriah in pregnant women. No animal studies have been conducted with Kymriah to assess whether it can cause foetal harm when administered to a pregnant woman. It is not known whether Kymriah has the potential to be transferred to the foetus via the placenta and could cause foetal toxicity, including B-cell lymphocytopenia. Kymriah is not recommended during pregnancy. Pregnant women who have received Kymriah may have hypogammaglobulinaemia. Assessment of immunoglobulin levels is indicated in newborns of mothers treated with Kymriah. **•Breast-feeding:** It is unknown whether Kymriah cells are excreted in human milk. A risk to the breast-fed infant cannot be excluded. Women who are breast-feeding should be advised of the potential risk to the breast- fed infant. **•Fertility:** No data on the effect of Kymriah on fertility. Effects of Kymriah on male and female fertility have not been evaluated in animal studies. **Interactions:** •No pharmacokinetic or pharmacodynamic drug interaction studies with tisagenlecleucel have been performed. The co-administration of agents known to inhibit T-cell function has not been formally studied. Administration of low-dose steroids as per the cytokine release syndrome treatment algorithm does not impact the expansion and persistence of CAR-T cells. The co-administration of agents known to stimulate T-cell function has not been investigated and the effects are unknown. **•Live vaccines:** The safety of immunisation with live viral vaccines during or following Kymriah treatment has not been studied. Vaccination with live virus vaccines is not recommended for at least 6 weeks prior to the start of lymphodepleting chemotherapy, during Kymriah treatment, and until immune recovery following treatment with Kymriah. **Adverse reactions: •Very common (≥10%):** Infections-pathogen unspecified, viral infections, bacterial infections, fungal infections, febrile neutropenia, leukopenia, lymphopenia, anaemia, thrombocytopenia, cytokine release syndrome, hypogammaglobulinaemia, decreased appetite, hypokalaemia, hypophosphataemia, hypocalcaemia, hypomagnesaemia, hyponatraemia, hyperuricaemia, hyperglycaemia, delirium, anxiety, sleep disorder, headache, encephalopathy, dizziness, tachycardia, hypotension, hypertension, cough, hypoxia, dyspnoea, pulmonary oedema, pleural effusion, tachypnoea, diarrhoea, nausea, vomiting, constipation, abdominal pain, rash, back pain, myalgia, arthralgia, acute kidney injury, pyrexia, fatigue, oedema, pain, chills, haemoglobin decreased, lymphocyte count decreased, white blood cell count decreased, neutrophil count decreased, platelet count decreased, aspartate aminotransferase increased, alanine aminotransferase increased, blood bilirubin increased, international normalised ratio increased, weight decreased **•Common (1 to 10%):** Disseminated intravascular coagulation, coagulopathy, hypocytosis haemophagic, pancytopenia, graft-versus-host disease, fluid overload, hypermagnesaemia, hyponatraemia, hyperphosphataemia, tumour lysis syndrome, tremor, peripheral neuropathy, speech disorders, seizure, cerebral haemorrhage, neuralgia, ischaemic cerebral infarction, cardiac failure, arrhythmia, cardiac arrest, capillary leak syndrome, flushing, epistaxis, lung infiltration, dry mouth, mouth haemorrhage, stomatitis, abdominal distension, ascites, abdominal compartment syndrome, hyperbilirubinaemia, pruritus, erythema, night sweats, petechiae, hypothyroidism, asthenia, influenza-like illness, multiple organ dysfunction syndrome, activated partial thromboplastin time prolonged, blood fibrinogen decreased, serum ferritin increased, blood alkaline phosphatase increased, fibrin D dimer increased, prothrombin time prolonged **Packs and prices:** Ethylene vinyl acetate (EVA) infusion bag with polyvinyl chloride (PVC) tubing and a luer spike interconnector closed by a luer-lock cap containing either (1)-30 mL (50 mL Bags) or 30-50 mL (100 mL bags) cell dispersion

Legal classification: PP5153

Reference: EMA Sep 2019

KYMRIAH® (tisagenlecleucel)

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Chairpersons

Ms. Ellen Wai-Yin KU

RN, BHSc(Nursing), MPh
Senior Lecturer, School of Health Sciences, Caritas Institute of Higher Education
Executive Member, Federations of Medical Societies of Hong Kong

Ms. Ku is the Senior Lecturer, School of Health Sciences, Caritas Institute of Higher Education, president of the College of Nursing Hong Kong, which is the regional member association of the International Council of Nurses (ICN).

She is a council member of the Chinese Nurses Association. She was trained as Registered Nurses in the Government School of Nursing at Queen Mary Hospital and receiving her post registration education and training in Palliative Care and Management. Her practice interests are caring for death and dying of both adults and children, plus, supporting their families. She serves as a professional volunteer for various Non-governmental organisations for service development and training.

Dr. Raymond See-Kit LO

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

Dr. Raymond Lo graduated from United Medical and Dental Schools of Guy's and St Thomas' Hospital in London, and received fellowships from Royal College of Physicians and Hong Kong Academy of Medicine. He is Honorary Clinical Professor of the Department of Medicine and Therapeutics, Chinese University of Hong Kong, and also held visiting professorship overseas. Dr. Lo was Past President of the Federation of Medical Societies of Hong Kong, and is the Convenor of Care for Advanced Diseases Consortium, dedicated to promoting care for patients with serious illnesses. He is a dual specialist in geriatrics and palliative medicine. Amongst his other capacities, Dr. Lo is also the President of British Medical Association (Hong Kong), expediting various activities including the popular annual BMA(HK) Advance in Therapeutics Course.

Chairpersons

Dr. NG Chun-Kong

MBBS(HK), MRCP(UK), FHKCP, FHKAM(Medicine), MPH(HK), FRCP(Edin, Lond)
Consultant Respiratory Physician, Department of Medicine, Queen Elizabeth Hospital Honorary Clinical Associate Professor, The University of Hong Kong
Honorary Clinical Associate Professor, The Chinese University of Hong Kong
1st Vice-President, The Federation of Medical Societies of Hong Kong

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

Dr. Desmond Gia-Hung NGUYEN

MBBS(HK), MHA(NSW) FRCPsych(UK), FHKCPsych, FHKAM(Psychiatry)
Hospital Chief Executive, Kwai Chung Hospital

Dr. Desmond Nguyen is the Hospital Chief Executive and Consultant Psychiatrist of a public psychiatric hospital providing a wide spectrum of cross discipline psychiatric service in Hong Kong, including substance abuse.

In addition to his role as Consultant of Psychiatry, a position he was held since 2008, Dr. Nguyen is an experienced senior clinician with rich experience in Consultation Liaison Psychiatry and Early Intervention Service for Psychosis. He is actively involved in psychiatric service planning and improvement, such as introducing psychiatric services in accident and emergency department, implementing measures for the prevention of inpatient suicide as well as organising psychological support services for staff.

A LOT CAN HAPPEN IN EXTRA TIME

FIRMAGON®
degarelix

- THANKS TO ITS DISTINCT MOA[1,2], COMPARED WITH LHRH AGONISTS, FIRMAGON®:
  - *Provides significantly faster[3†] and lasting[4‡] suppression of testosterone and PSA levels*
  - *Delivers significantly improved overall survival during the 1st year of treatment[4‡, 5††]*
  - *Significantly improves QoL and reduces prostate size compared with LHRH agonist + antiandrogen treatment[6‡‡]*
- PATIENTS ARE ASSOCIATED WITH 48% LESS RISKS OF CARDIOVASCULAR EVENTS WHEN RECEIVING FIRMAGON® COMPARED TO LHRH AGONISTS[5††]
- EAU RECOMMENDS LHRH ANTAGONISTS FOR PROSTATE CANCER PATIENTS WITH AN IMPENDING SPINAL CORD COMPRESSION OR BLADDER OUTLET OBSTRUCTION[7]

EAU: European Association of Urology; LHRH: luteinising hormone-releasing hormone; MOA: mechanism of action; PSA: prostate-specific antigen; QoL: quality of life

† A phase III, randomized, open-label trial that evaluated the efficacy of FIRMAGON vs leuprolide in achieving testosterone suppression in patients with prostate cancer (N=610). The primary endpoint was suppression of testosterone to ≤0.5 ng/mL at all monthly measurements from day 28 to day 364 (treatment response).

‡ Pooled analysis of 5 phase III/IIIb trials (N=1925) comparing prostate cancer disease control outcomes in patients received FIRMAGON vs LHRH agonists. Efficacy and safety outcomes were assessed.

†† Meta-analysis of 8 randomized controlled trials (N=2632) on clinical safety and oncologic outcomes in metastatic prostate cancer, in patients receiving FIRMAGON vs LHRH agonist±anti-androgen.

‡‡ A randomized, open-label trial comparing 3-month neoadjuvant FIRMAGON vs goserelin + bicalutamide in men with intermediate- to high-risk prostate cancer (N=244). Primary endpoint was total prostate volume reduction. Secondary objectives included the effect on lower urinary tract symptom relief and changes of quality of life related to urinary symptoms.

FOR PATIENTS WITH ADVANCED HORMONE-DEPENDENT PROSTATE CANCER[1,2]

START STRONG.
STAY IN CONTROL.

REFERENCES: 1) Hong Kong Product Package Insert of FIRMAGON 80mg (Date of revision: May 2015); 2). Hong Kong Product Package Insert of FIRMAGON 120mg (Date of revision: May 2015); 3) Klotz L, *et al. BJU Int.* 2008;102:1531–8; 4) Klotz L, *et al. Eur Urol.* 2014;66:1101–8; 5) Abufaraj M, *et al. Eur Urol.* 2021 Jan;79(1):44-53; 6) Mason M *et al. Clin Oncol.* 2013 Mar;25(3):190-6; 7) EAU Guidelines. Edn. presented at the EAU Annual Congress Amsterdam 2020.

Abbreviated Prescribing Information of FIRMAGON

Active Ingredient: Degarelix. **Indications:** Treatment of advanced hormone-dependent prostate cancer in adult males. **Dosage and Administration:** Initially: 240 mg administered as 2 SC inj of 120 mg each. Maintenance: 80 mg administered as 1 SC inj mthly. The first maintenance dose should be given one mth after the starting dose. Administered as SC inj in abdominal region. **Contraindications:** Hypersensitivity. **Special Warnings and Precautions:** The vials should not be shaken. Administration of other conc is not recommended. Long-term androgen deprivation therapy may prolong QT interval. Use w/ caution in patients with Hx of QTc interval >450 msec. Hx or risk factors of torsades de pointes or CVD. Hx of severe untreated asthma, anaphylactic reactions, severe urticaria or angioedema. May decrease bone density. May reduce glucose tolerance. diabetic patients may require more frequent monitoring of blood glucose. Use w/ caution in patients w/ severe renal & hepatic impairment. ADR of fatigue & dizziness might influence ability to drive or operate machinery. May inhibit male fertility as long as the testosterone is suppressed. No relevant indication for use in women, children and adolescents. Must not be mixed with other medicinal products. **Side Effects:** Hot flush, inj site reactions, anaemia, increased wt, insomnia, dizziness, headache, diarrhoea, nausea, increased liver transaminases, hyperhidrosis (incl. night sweats), rash, musculoskeletal pain & discomfort, gynaecomastia, testicular atrophy, erectile dysfunction, chills, pyrexia, fatigue, flu-like illness. **Interactions:** Medicinal products known to prolong the QTc interval or able to induce torsades de pointes such as Class IA (e.g. quinidine, disopyramide) or Class III (amiodarone, sotalol, dofetilide, ibutilide) antiarrhythmics, methadone, cisapride, moxifloxacin, antipsychotics.

Reference:

Hong Kong Product Package Insert of FIRMAGON 80mg (Date of revision: MAY 2015)
Hong Kong Product Package Insert of FIRMAGON 120mg (Date of revision: MAY 2015)

Product registration conditions differ internationally, please refer to country-specific product information for more details.

For additional information, please consult the product package insert before prescribing.

FERRING PHARMACEUTICALS

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BECKMAN COULTER

Chairpersons

Prof. Eric Wai-Choi TSE

BSc(BiomedSc)(HK), MBBS(HK), PhD(Cantab), FRCP, FRCP(Edin), FRCP(Glasg), FRCPath, FHKCP, FHKAM(Medicine)
Clinical Professor, Division of Hematology, Medical Oncology and Hematopoietic Stem Cell Transplantation, Department of Medicine, The University of Hong Kong

Prof. Eric Wai-Choi Tse obtained his primary and medical degrees from The University of Hong Kong, and PhD from the University of Cambridge. He is currently the Clinical Professor and Honorary Consultant Physician in the Division of Haematology, Medical Oncology and Hematopoietic Stem Cell Transplantation, of the Department of Medicine, at The University of Hong Kong.

Prof. Tse is a clinician scientist with an academic interest in the study of cancer cell signalling and experimental cancer therapy. His basic and translational research focuses on the development of novel therapeutic approaches in cancer treatment through identifying potential targets and understanding the fundamental biology of cancer cells. Prof. Tse has pioneered the development of intracellular antibodies in the treatment of cancer. He is currently examining the role of peptidyl-prolyl-isomerase PIN1 and investigating the therapeutic potential of arsenic trioxide in cancers. He is also a clinical haematologist focusing on the management of haematological malignancies and venous thromboembolism.

Prof. Tse is a recipient of the Max Perutz Research Prize from the MRC Laboratory of Molecular Biology Cambridge, the Outstanding Young Researcher Award from The University of Hong Kong, and the Sir David Todd Lectureship from the Hong Kong College of Physicians.

Ms. Tina Woan-Tyng YAP

BSC Pharmacy(USA), Registered Pharmacist(HK)
Fellow, Hong Kong College of Pharmacy Practice(FCPP)
Honorary Treasurer, The Federation of Medical Societies of Hong Kong

Ms. Tina Yap is the Honorary Treasurer of The Federation of Medical Societies of Hong Kong.

Ms. Yap graduated from the School of Pharmacy at the University of Kansas, USA. While in the US, she had vast experience in hospital pharmacy. She was also a certified nursing home pharmacy consultant.

Currently, Ms. Yap works as the company pharmacist of a pharmaceutical company where she oversees pharmaceutical product registration, marketing, management in distribution practice & code of practice. Ms. Yap is also the founding & current chairman of The Pharmaceutical Distributors Association of Hong Kong.

Chairpersons

Dr. Victor Hip-Wo YEUNG

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

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

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

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

骨質疏鬆關注組
Osteoporosis Care Group

六十歲 卜卜脆

即掃了解更多有關
骨質疏鬆資訊

年齡減體重
大過20
骨質疏鬆程度即高危![1]

AMGEN

根據臨床研究，亞洲婦女如果其年齡減體重(公斤)相差大於20*，經DEXA檢測後，有61%婦女患上骨質疏鬆。
*算式經過簡化，原本算式(OSTA)為「0.2 x (體重 – 年齡)」，結果低於–4為高風險。[1]
參考資料：1. Koh LK, et al. Osteopors Int 2001;12:699–705
內容僅供參考用途，不能取替求醫需要，亦不能作為自我診斷或選擇治療的依據。唯有您的醫生方能為您作出準確的診斷及提供適當的治療。
安進香港有限公司　香港銅魚涌華蘭路18號港島東中心4樓407–412室　電話：+852 2843 1178　傳真：+852 2808 2820

HK–08169–PRO–2022–Apr　Date of Approval: Sep 2022

EVENITY®
(romosozumab) injection

prolia®
(denosumab)

Every patient has a different starting point

MEET HER THERE

and help make her bones stronger

For your patients with **very low T-score** (e.g. less than -3.0) or with other serious risk factors, start with the sequence of **EVENITY®** followed by **PROLIA®** to help build and protect her bone.[1]

For your partients **with history of fragility fracture or low T-score** (e.g. less than -2.5) with other risk factors, start with **PROLIA®** to help strengthen her bone.[2,3]

* The risk of hip fracture was lowered by 38% (41 of 2046 patients [2.0%] vs. 66 of 2047 patients [3.2%]; P = 0.02) in the romosozumab-to-alendronate group than in the alendronate-to-alendronate group in ARCH Study.[1]

† Indicators of very high fracture risk in patients with low bone density would include advanced age, frailty, glucocorticoids, very low T-scores, or increased fall risk. Patients who have been diagnosed with osteoporosis but are not at very high fracture risk are defined as high risk.[3]

ARCH=Active-Controlled Fracture Study in Postmenopausal Women with Osteoporosis at High Risk; BMD=Bone mineral density.

References: 1. Evenity (romosozumab) Hong Kong prescribing information. March 2020. **2.** Prolia (denosumab) Hong Kong prescribing information. Aug 2020. **3.** Camacho PM, et al. Endocr Pract. 2020;26(Suppl 1).

Prolia® (Denosumab) Abbreviated Prescribing Information
Prolia® (denosumab) Solution for Injection in Pre-filled Syringe 60 mg/mL

INDICATIONS Prolia is indicated for: i) treatment of postmenopausal women with osteoporosis at high risk for fracture, defined as a history of osteoporotic fracture, or multiple risk factors for fracture; or patients who have failed or are intolerant to other available osteoporosis therapy; ii) treatment to increase bone mass in men with osteoporosis at high risk for fracture, defined as a history of osteoporotic fracture, or multiple risk factors for fracture; or patients who have failed or are intolerant to other available osteoporosis therapy; iii) treatment of glucocorticoid-induced osteoporosis in men and women at high risk of fracture who are either initiating or continuing systemic glucocorticoids in a daily dosage equivalent to 7.5 mg or greater of prednisone and expected to remain on glucocorticoids for at least 6 months. High risk of fracture is defined as a history of osteoporotic fracture, multiple risk factors for fracture, or patients who have failed or are intolerant to other available osteoporosis therapy; iv) treatment to increase bone mass in men at high risk for fracture receiving androgen deprivation therapy for nonmetastatic prostate cancer. In these patients Prolia also reduced the incidence of vertebral fractures; v) treatment to increase bone mass in women at high risk for fracture receiving adjuvant aromatase inhibitor therapy for breast cancer. **DOSAGE AND ADMINISTRATION** The recommended dose of Prolia is 60 mg administered as a single subcutaneous injection once every 6 months. Administer Prolia via subcutaneous injection in the upper arm, the upper thigh, or the abdomen. All patients should receive calcium 1000 mg daily and at least 400 IU vitamin D daily. **CONTRAINDICATIONS** Hypocalcemia and pregnancy, as well as hypersensitivity to any component of the product. **SPECIAL WARNINGS AND PRECAUTIONS FOR USE** Hypersensitivity: Clinically significant hypersensitivity including anaphylaxis has been reported with Prolia. Symptoms have included hypotension, dyspnea, throat tightness, facial and upper airway edema, pruritis, and urticaria. Hypocalcemia and Mineral Metabolism: Hypocalcemia may be exacerbated by the use of Prolia. Pre-existing hypocalcemia must be corrected prior to initiating therapy with Prolia. Hypocalcemia following Prolia administration is a significant risk in patients with severe renal impairment (creatinine clearance < 30 mL/min) or receiving dialysis. Concomitant use of calcimimetic drugs may worsen hypocalcemia risk and serum calcium should be closely monitored. Adequately supplement all patients with calcium and vitamin D. Osteonecrosis of the Jaw (ONJ): ONJ has been reported in patients receiving Prolia. The start of treatment or of a new course of treatment should be delayed in patients with unhealed open soft tissue lesions in the mouth. A dental examination with preventive dentistry and an individual benefit-risk assessment is recommended prior to treatment with Prolia in patients with concomitant risk factors. All patients should be encouraged to maintain good oral hygiene, undergo routine dental check-ups, and immediately report any oral symptoms such as dental mobility, pain or swelling, or non-healing of sores or discharge during treatment with Prolia. While on treatment, invasive dental procedures should be performed with caution and avoided in close proximity to Prolia treatment. Atypical Subtrochanteric and Diaphyseal Femoral Fractures: Atypical low-energy or low trauma fractures of the shaft have been reported in patients receiving Prolia. Patients should be advised to report new or unusual thigh, hip, or groin pain. Multiple Vertebral Fractures (MVF) Following Discontinuation of Prolia Treatment: Following discontinuation of Prolia treatment, fracture risk increases, including the risk of multiple vertebral fractures. If Prolia treatment is discontinued, patients should be transitioned to an alternative antiresorptive therapy. Serious Infections: Serious infections leading to hospitalization were reported in clinical trial. Advise patients to seek prompt medical attention if they develop signs or symptoms of severe infection, including cellulitis. Dermatologic Adverse Reactions: Dermatitis, eczema, and rashes. Most of these events were not specific to the injection site. Consider discontinuing Prolia if severe symptoms develop. Musculoskeletal Pain: Severe and occasionally incapacitating bone, joint, and/or muscle pain. Consider discontinuing use if severe symptoms develop. Suppression of Bone Turnover: In clinical trials treatment with Prolia resulted in significant suppression of bone remodeling as evidenced by markers of bone turnover and bone histomorphometry. Osteonecrosis of the external auditory canal: Osteonecrosis of the external auditory canal has been reported with denosumab. Possible risk factors include steroid use and chemotherapy and/or local risk factors such as infection or trauma. **PREGNANCY AND LACTATION** Pregnancy: Contraindicated. Breast-feeding: No information regarding the presence of denosumab in human milk, the effects on the breastfed infant, or the effects on milk production **PEDIATRIC, GERIATRIC AND RENAL IMPAIRMENT** Pediatric: Prolia is not recommended in pediatric patients younger than age 4 years. Geriatric: No overall differences in safety or efficacy were observed in clinical studies between elderly patients and younger patients, and other reported clinical experience has not identified differences in responses between the elderly and younger patients, but greater sensitivity of some older individuals cannot be ruled out. Renal Impairment: No dose adjustment is necessary in patients with renal impairment. **UNDESIRABLE EFFECTS** The most common adverse reactions reported with Prolia in patients with postmenopausal osteoporosis are back pain, pain in extremity, musculoskeletal pain, hypercholesterolemia, and cystitis. The most common adverse reactions reported with Prolia in men with osteoporosis are back pain, arthralgia, and nasopharyngitis. The most common adverse reactions reported with Prolia in patients with glucocorticoid-induced osteoporosis are back pain, hypertension, bronchitis, and headache. The most common (per patient incidence ≥ 10%) adverse reactions reported with Prolia in patients with bone loss receiving androgen deprivation therapy for prostate cancer or adjuvant aromatase inhibitor therapy for breast cancer are arthralgia and back pain. Pain in extremity and musculoskeletal pain have also been reported in clinical trials. The most common adverse reactions leading to discontinuation of Prolia in patients with postmenopausal osteoporosis are back pain and constipation. **OVERDOSE** There is no experience with overdosage with Prolia.

Abbreviated Prescribing Information Version: HKPROPI02
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EVENITY® (Romosozumab) Abbreviated Prescribing Information
EVENITY® Solution for Injection in Prefilled Syringe 105 mg/1.17 ml

INDICATIONS EVENITY is indicated in treatment of severe osteoporosis in postmenopausal women at high risk of fracture. **DOSAGE AND ADMINISTRATION** The recommended dose is 210 mg romosozumab (administered as two subcutaneous injections of 105 mg each) once monthly for 12 months. Patients should be adequately supplemented with calcium and vitamin D before and during treatment. Following completion of romosozumab therapy, transition to antiresorptive therapy is recommended in order to extend the benefit achieved with romosozumab beyond 12 months. Missed doses: If the romosozumab dose is missed, administer as soon as it can be feasible. Thereafter, the next romosozumab dose should not be given earlier than one month after the last dose. Elderly: No dose adjustment is necessary in elderly patients. Renal impairment: No dose adjustment is required in patients with renal impairment. Serum calcium should be monitored in patients with severe renal impairment or receiving dialysis. Hepatic impairment: No clinical trials have been conducted to evaluate the effect of hepatic impairment. Paediatric population: The safety and efficacy of romosozumab in paediatric patients (age <18 years) have not yet been established. No data are available. Method of administration: Subcutaneous use. To administer the 210 mg dose, 2 subcutaneous injections of romosozumab should be given into the abdomen, thigh, or upper arm. The second injection should be given immediately after the first one but at a different injection site. Administration should be performed by an individual who has been trained in injection techniques. **CONTRAINDICATIONS** Hypersensitivity to the active substance(s) or to any of the excipients. Hypocalcaemia. History of myocardial infarction or stroke. **SPECIAL WARNINGS AND PRECAUTIONS FOR USE** Myocardial infarction and stroke: In randomised controlled studies, an increase in serious cardiovascular events (myocardial infarction and stroke) has been observed in romosozumab treated patients compared to controls. When determining whether to use romosozumab for an individual patient, consideration should be given to her fracture risk over the next year and her cardiovascular risk based on risk factors (e.g. established cardiovascular disease, hypertension, hyperlipidaemia, diabetes mellitus, smoking, severe renal impairment, age). Romosozumab should only be used if the prescriber and patient agree that the benefit outweighs the risk. If a patient experiences a myocardial infarction or stroke during therapy, treatment with romosozumab should be discontinued. Hypocalcaemia: Transient hypocalcaemia has been observed in patients receiving romosozumab. Hypocalcaemia should be corrected prior to initiating therapy with romosozumab and patients should be monitored for signs and symptoms of hypocalcaemia. If any patient presents with suspected symptoms of hypocalcaemia during treatment, calcium levels should be measured. Patients with severe renal impairment (estimated glomerular filtration rate [eGFR] 15 to 29 ml/min/1.73 m2) or receiving dialysis are at greater risk of developing hypocalcaemia and the safety data for these patients is limited. Calcium levels should be monitored in these patients. Hypersensitivity: Clinically significant hypersensitivity reactions, including angioedema, erythema multiforme, and urticaria occurred in the romosozumab group in clinical trials. If an anaphylactic or other clinically significant allergic reaction occurs, appropriate therapy should be initiated and use of romosozumab should be discontinued. Osteonecrosis of the jaw: Osteonecrosis of the jaw (ONJ), has been reported rarely in patients receiving romosozumab. All patients should be encouraged to maintain good oral hygiene, receive routine dental check-ups, and immediately report any oral symptoms such as dental mobility, pain or swelling or non-healing of sores or discharge during treatment with romosozumab. Patients who are suspected of having or who develop ONJ while on romosozumab should receive care by a dentist or an oral surgeon with expertise in ONJ. Discontinuation of romosozumab therapy should be considered until the condition resolves and contributing risk factors are mitigated where possible. Atypical femoral fractures: Atypical low-energy or low trauma fracture of the femoral shaft, which can occur spontaneously, has been reported rarely in patients receiving romosozumab. Any patient who presents with new or unusual thigh, hip, or groin pain should be suspected of having an atypical fracture and should be evaluated to rule out an incomplete femur fracture. Patient presenting with an atypical femur fracture should also be assessed for symptoms and signs of fracture in the contralateral limb. Interruption of romosozumab therapy should be considered, based on an individual benefit-risk assessment. Sodium content: This medicinal product contains less than 1 mmol sodium (23 mg) per dose, that is to say essentially sodium-free. **INTERACTIONS** No drug interaction studies have been performed with romosozumab. No pharmacokinetic drug interactions are expected with romosozumab. **PREGNANCY AND LACTATION** Pregnancy: Romosozumab is not indicated for use in women of child-bearing potential or in pregnant women. There are no data from the use of romosozumab in pregnant women. A risk for malformations of developing digits in the human foetus is low following romosozumab exposure due to the timing of digit formation in the first trimester in humans, a period when placental transfer of immunoglobulins is limited. Breast-feeding: Romosozumab is not indicated for use in breast-feeding women. No data are available on excretion of romosozumab in human milk. Human IgGs are known to be excreted in breast milk during the first few days after birth, which is decreasing to low concentrations soon afterwards; consequently, a risk to the breast-fed infant cannot be excluded during this short period. Fertility: No data are available on the effect of romosozumab on human fertility. Animal studies in female and male rats did not show any effects on fertility endpoints. **ADVERSE REACTIONS** The most common adverse reactions were nasopharyngitis (13.6%) and arthralgia (12.4%). Hypersensitivity-related reactions occurred in 6.7% of patients treated with romosozumab. Hypocalcaemia was reported uncommonly (0.4% of patients treated with romosozumab). In randomised controlled studies, an increase in serious cardiovascular events (myocardial infarction and stroke) has been observed in romosozumab treated patients compared to controls. Adverse reactions are presented in order of decreasing seriousness by System Organ Class: *Infections and infestations:* Nasopharyngitis, Sinusitis; *Immune system disorders:* Hypersensitivity, Rash, Dermatitis, Urticaria, Angioedema, Erythema multiforme; *Metabolism and nutrition disorders:* Hypocalcaemia; *Nervous system disorders:* Headache, Stroke; *Eye disorders:* Cataract; *Cardiac disorders:* Myocardial infarction; *Musculoskeletal and connective tissue disorders:* Arthralgia, Neck pain, Muscle spasms; *General disorders and administration site conditions:* Injection site reactions **OVERDOSE** There is no experience with overdose in clinical trials.

Abbreviated Prescribing Information Version No.: HKEVEPI01
Please read the full prescribing information prior to administration and full prescribing information is available upon request.
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Date of Approval: 21 Sep 2022
HK-08946-EVE-2022-Sep

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P-CORP-22N13 09/22

Lucky Draw

THE FEDERATION OF MEDICAL SOCIETIES OF HONG KONG
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Annual Scientific Meeting 2022
Innovations in Disease Diagnosis and Management

To win the iPad
Two Winners

Lucky Draw **Name:**_____ **(Block letter)**

1	2	3	4	5
6	7	8	9	10
11	12	13	14	15

Terms and Conditions

1. To enter the Lucky Draw you must collect a chop after you visit to a booth.
2. You have to fill the fifteen boxes above with all the fifteen chops.
3. Put the completed form into lucky draw box before 15:40, 16 October 2022.
4. Only one entry per person. Entries on behalf of another person will not be accepted and joint submissions are not allowed.
5. One winner will be chosen from a random draw, the winner will receive an iPad.
6. If the winner does not show up at ballroom C at 4:35pm and respond to the announcement, then the prize will be forfeited.

Memo

Xarelto® rivaroxaban

BAYER

RIVA-DM : New Real-world Findings Confirm the Efficacy and Safety of Xarelto® in Patients with NVAF and Diabetes[1-3]

REDUCED RISKS WITH XARELTO® vs WARFARIN

Composite Outcome[1]

↓9%

SSE/CV death

Diabetes-related Complications

↓19%

Need for dialysis or renal transplant[2]

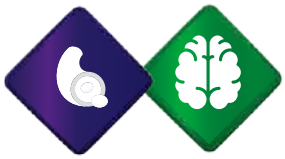
↓15%

MALE[2]

↓15%

Any type of diabetic retinopathy[3]

Bleeding Events[1]



↓20%

Major bleeding

↓28%

ICH

RIVA-DM study was a cohort analysis within the US Optum® De-Identified EHR dataset between 2010 to 2019. It included patients with NVAF and diabetes: 32,078 patients on Xarelto® and 83,971 patients on warfarin. Patients had follow-up data for an average of 2.9 years. The primary efficacy and safety outcomes were incidence rates of developing the composite of SSE/vascular death or major/CRNM bleeding resulting in hospitalization.

CRNM=clinically relevant non-major; CV=cardiovascular; ICH=intracranial hemorrhage; MALE=major adverse limb events; NVAF=non-valvular atrial fibrillation; SSE=stroke/systemic embolism.

References: 1. Coleman CI, et al. Thromboembolism, bleeding and vascular death in nonvalvular atrial fibrillation patients with type 2 diabetes receiving rivaroxaban or warfarin. Cardiovasc Diabetol 2021;20:52. **2.** Costa OS, et al. Kidney, limb and ophthalmic complications and death in patients with nonvalvular atrial fibrillation and type 2 diabetes prescribed rivaroxaban or warfarin: an electronic health record analysis. EHRA Congress. 23–25 April 2021. **3.** Costa OS, et al. Ophthalmic complications in patients with nonvalvular atrial fibrillation and type 2 diabetes prescribed rivaroxaban or warfarin. EHRA Congress. 23–25 April 2021.

Xarelto 10 mg / 15 mg / 20 mg film-coated tablets
Abbreviated Prescribing Information (Please refer to the full prescribing information before prescribing)
Composition: Active ingredient: 10 mg / 15 mg / 20 mg rivaroxaban. Excipients: Microcrystalline cellulose, croscarmellose sodium, lactose monohydrate, hypromellose, sodium laurilsulfate, magnesium stearate, macrogol 3350, titanium dioxide (E171), iron oxide red (E172). **Indication and Posology:** Prevention of stroke and systemic embolism in adult patients with non-valvular atrial fibrillation (NVAF) with one or more risk factors, such as congestive heart failure, hypertension, age ≥ 75 years, diabetes mellitus, prior stroke or transient ischaemic attack: Recommended dose is 20 mg once daily (recommended maximum dose). Treatment of deep vein thrombosis (DVT) and pulmonary embolism (PE) and prevention of recurrent DVT and PE in adults: The recommended dose for the initial treatment of acute DVT or PE is 15 mg twice daily for the first three weeks followed by 20 mg once daily for the continued treatment and prevention of recurrent DVT and PE. When extended prevention of recurrent DVT and PE is indicated (following completion of at least 6 months therapy for DVT or PE), the recommended dose is 10 mg once daily. A dose of 20 mg once daily should be considered in patients with high risk. Prevention of venous thromboembolism (VTE) in adult patients undergoing elective hip or knee replacement surgery: The recommended dose is 10 mg once daily. The initial dose should be taken 6 to 10 hours after surgery, provided that haemostasis has been established. For patients undergoing major hip surgery, a treatment duration of 5 weeks is recommended. For patients undergoing major knee surgery, a treatment duration of 2 weeks is recommended. **Patients with NVAF who undergo percutaneous coronary intervention (PCI) with stent placement:** There is limited experience of a reduced dose of 15 mg Xarelto once daily (or 10 mg Xarelto once daily for patients with moderate renal impairment [creatinine clearance 30 – 49 ml/min]) in addition to a P2Y12 inhibitor for a maximum of 12 months in patients with non-valvular atrial fibrillation who require oral anticoagulation and undergo PCI with stent placement. **Renal impairment:** No dose adjustment is necessary in patients with mild renal impairment (creatinine clearance 50 - 80 ml/min). In patients with moderate (creatinine clearance 30 - 49 ml/min) or severe (creatinine clearance 15 - 29 ml/min) renal impairment the following dosage recommendations apply: For the prevention of stroke and systemic embolism in patients with non-valvular atrial fibrillation, the recommended dose is 15 mg once daily. For the treatment of DVT, treatment of PE and prevention of recurrent DVT and PE: 15 mg twice daily for the first 3 weeks. Thereafter, the recommended dose is 20 mg once daily. When the recommended dose is 10 mg once daily, no dose adjustment from the recommended dose is necessary. Limited clinical data for patients with severe renal impairment (creatinine clearance 15 - 29 ml/min) indicate that rivaroxaban plasma concentrations are significantly increased; therefore, Xarelto is to be used with caution in these patients. Use is not recommended in patients with creatinine clearance < 15 ml/min. **Contraindications:** Hypersensitivity to the active substance or any of the excipients; active clinically significant bleeding; lesion or condition if considered a significant risk for major bleeding; concomitant treatment with any other anticoagulants except under specific circumstances of switching anticoagulant therapy or when unfractionated heparin is given at doses necessary to maintain an open central venous or arterial catheter; hepatic disease associated with coagulopathy and clinically relevant bleeding risk including cirrhotic patients with Child Pugh B and C; pregnancy and breast feeding. **Warnings and Precautions:** Clinical surveillance in line with anticoagulation practice is recommended throughout the treatment period. Not recommended: in patients receiving concomitant systemic treatment with strong concurrent CYP3A4- and P-gp-inhibitors, i.e. azole antimycotics or HIV protease inhibitors; in patients with increased bleeding risk; in patients with severe renal impairment (creatinine clearance < 15 ml/min); in the treatment of acute pulmonary embolism; due to lack of data: in patients below 18 years of age, in patients with prosthetic heart valves, in patients concomitantly treated with dronedarone, in NVAF-PCI patients with a history of stroke/transient ischemic attack. Use with caution: please refer to the full prescribing information. Xarelto contains lactose. **Undesirable effects:** Common: anaemia, dizziness, headache, eye haemorrhage, hypotension, haematoma, epistaxis, haemoptysis, gingival bleeding, gastrointestinal tract haemorrhage, gastrointestinal and abdominal pains, dyspepsia, nausea, constipation, diarrhoea, vomiting, pruritus, rash, ecchymosis, cutaneous and subcutaneous haemorrhage, pain in extremity, urogenital tract haemorrhage, fever, renal impairment, peripheral oedema, decreased general strength and energy, increase in transaminases, post-procedural haemorrhage, contusion, wound secretion. Other undesirable effects (uncommon, rare, frequency not known): please refer to the full prescribing information.

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The **FIRST AND ONLY** asthma biologic to inhibit IL-4 and IL-13 signaling

AN ADD-ON MAINTENANCE TREATMENT FOR PATIENTS (12+ YEARS) WITH **INADEQUATELY CONTROLLED SEVERE ASTHMA** WITH TYPE 2 INFLAMMATION[1]

A CLEAR PATH TO ASTHMA CONTROL

NOW AVAILABLE

UP TO 72% REDUCTION

SIGNIFICANT EXACERBATION REDUCTION

in annualized severe exacerbations at Week 24 with DUPIXENT 200 mg Q2W + SOC vs placebo + SOC (*P*=0.0003)[1]

86% OF PATIENTS

REDUCED OR NO INCREASE IN THEIR OCS DOSE

by Week 24 with DUPIXENT 300 mg Q2W + SOC vs 68% with placebo + SOC (P<0.001)[2]

200 mL IMPROVEMENT

RAPID AND SUSTAINED IMPROVEMENT IN LUNG FUNCTION

at Week 52 with DUPIXENT 200 mg Q2W + SOC vs placebo + SOC (*P*<0.001)[3]

UP TO 75% OF PATIENTS

HIGH RESPONDER RATE

in Asthma Control Questionnaire measures of **sleep, activity limitations, and breathing**[1]

SELF-INJECTABLE

Convenient subcutaneous injection[1]

LIBERTY ASTHMA VENTURE Study Design[2]: 210 patients were randomly assigned with oral glucocorticoid-treated asthma to receive add-on DUPIXENT (at a dose of 300 mg) or placebo every 2 weeks for 24 weeks. After a glucocorticoid dose-adjustment period before randomization, glucocorticoid doses were adjusted in a downward trend from week 4 to week 20 and then maintained at a stable dose for 4 weeks. The primary end point was the percentage reduction in the glucocorticoid dose at week 24. Key secondary end points were the proportion of patients at week 24 with a reduction of at least 50% in the glucocorticoid dose and the proportion of patients with a reduction to a glucocorticoid dose of less than 5 mg per day. Severe exacerbation rates and the forced expiratory volume in 1 second (FEV_1) before bronchodilator use were also assessed.

LIBERTY ASTHMA QUEST Study Design[3]: 1902 patients who were 12 years of age or older with uncontrolled asthma were randomly assigned in a 2:2:1:1 ratio to receive add-on subcutaneous DUPIXENT at a dose of 200 or 300 mg every 2 weeks or matched-volume placebos for 52 weeks. The primary end points were the annualized rate of severe asthma exacerbations and the absolute change from baseline to week 12 in the forced expiratory volume in 1 second (FEV_1) before bronchodilator use in the overall trial population. Secondary end points included the exacerbation rate and FEV_1 in patients with a blood eosinophil count of 300 or more per cubic millimetre. Asthma control and DUPIXENT safety were also assessed.

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

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

Presentation: Dupilumab solution for injection in a pre-filled syringe with needle shield. **Indications:** Atopic Dermatitis (AD): Moderate-to-severe AD in adults and adolescents ≥12 years who are candidates for systemic therapy; severe atopic dermatitis in children 6 to 11 years old who are candidates for systemic therapy. Asthma: In adults and adolescents ≥12 years as add-on maintenance treatment for severe asthma with type 2 inflammation characterised by raised blood eosinophils and/or raised FeNO, who are inadequately controlled with high dose ICS plus another medicinal product for maintenance treatment. Chronic rhinosinusitis with nasal polyposis (CRSwNP): As an add-on therapy with intranasal corticosteroids for the treatment of adults with severe CRSwNP for whom therapy with systemic corticosteroids and/or surgery do not provide adequate disease control(for 300mg) **Dosage & Administration:** Subcutaneous injection. AD adults: Initial dose of 600 mg (two 300 mg injections), followed by 300 mg every other week. AD adolescents(12-17y/o): Body weight <60 kg- initial dose of 400 mg (two 200mg injections), followed by 200 mg every other week. Body weight ≥60 kg- same dosage as adults. Dupilumab can be used with or without topical corticosteroids. Topical calcineurin inhibitors may be used, but should be reserved for problem areas only, e.g. face, neck, intertriginous and genital areas. Consider discontinuing treatment in patients who have shown no response after 16 weeks. AD Children(6-11y/o): Body weight 15Kg~<60 kg- initial dose of 300mg on Day 1 follow by 300mg on Day 15, then 300mg every 4 weeks. Body weight ≥60 kg- same dosage as adults. * The dose may be increased to 200 mg Q2W in patients with body weight of 15 kg ~ < 60 kg based on physician's assessment. Asthma: Initial dose of 400 mg, followed by 200 mg every other week. For patients with severe asthma and on oral corticosteroids or with severe asthma and co-morbid moderate-to-severe AD or adults with co-morbid severe CRSwNP- initial dose of 600 mg, followed by 300 mg every other week. Patients receiving concomitant oral corticosteroids may reduce steroid dose gradually once clinical improvement with dupilumab has occurred. The need for continued dupilumab therapy should be considered at least annually as determined by a physician. If a dose is missed, administer it asap and thereafter, resume dosing at the regular scheduled time. **Contraindications:** Hypersensitivity to dupilumab or any of the excipients. **Precautions:** Safety and efficacy in children <6 years or <15kg not been established. Not be used to treat acute asthma symptoms, acute exacerbations, acute bronchospasm or status asthmaticus. Do not discontinue corticosteroids abruptly upon start of dupilumab. Reduction should be gradual and performed under supervision of a physician; it may be associated with systemic withdrawal symptoms and/or unmask conditions previously suppressed by systemic corticosteroid therapy. Biomarkers of type 2 inflammation may be suppressed by systemic corticosteroid use. If systemic hypersensitivity reaction occurs, discontinue dupilumab and initiate appropriate therapy. Be alert to vasculitic rash, worsening pulmonary symptoms, cardiac complications, and/or neuropathy presenting in patients with eosinophilia. Treat pre-existing helminth infections before initiating dupilumab. If patients become infected while receiving dupilumab and do not respond to anti-helminth treatment, discontinue dupilumab until infection resolves. Patients who develop conjunctivitis and keratitis that does not resolve following standard treatment should undergo ophthalmological examination. AD patients with comorbid asthma should not adjust or stop asthma treatments without consultation with physicians. Carefully monitor patients after discontinuation of dupilumab. Do not give live and live attenuated vaccines concurrently with dupilumab. Patients should be brought up to date with immunisations before starting dupilumab. **Drug Interactions:** Immune responses to TdaP vaccine and meningococcal polysaccharide vaccine were assessed. Patients receiving dupilumab may receive concurrent inactivated or non-live vaccinations. **Pregnancy and lactation:** Should be used during pregnancy only if potential benefit justifies potential risk to foetus. Unknown whether dupilumab is excreted in human milk or absorbed systemically after ingestion. Decision must be made whether to discontinue breast-feeding or dupilumab taking into account benefit of breast feeding for the child and benefit of therapy for the woman. **Undesirable effects:** Most common adverse reactions reported- injection site reactions, conjunctivitis, oral herpes and eosinophilia. Safety profile observed in adolescents consistent with that seen in adults. For other undesirable effects, please refer to the full prescribing information. **Preparation:** 2 x 300mg/2ml in pre-filled syringe with needle shield, 2 x 200mg/1.14ml in pre-filled syringe with needle shield. **Legal Classification:** Part 1, First & Third Schedules Poison **Full prescribing information is available upon request.**
APIHK-DUP-22.06

MAT-HK-2200819-1.0-09/2022 4IC_1408

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DUPIXENT® (dupilumab) Injection
200mg · 300mg

FOR ADULTS, ADOLESCENTS AND CHILDREN FROM THE AGE OF 6 YEARS WITH TYPE 1 OR TYPE 2 DIABETES MELLITUS REQUIRING BASAL INSULIN[1]

Toujeo®

From the start, there to help[1]

- Help your patients find **balance between HbA_{1c} reduction and hypoglycemic risk**[1-7]
- With a more stable 24-hour **glycemic** profile[1,8*]
- In a convenient† **insulin experience**[1,9,10]

Help your patients get **the start** they deserve[1]

* In steady-state PK/PD analyses in T1DM, Toujeo® showed a more stable and prolonged glucose lowering **effect compared to insulin glargine 100 units/mL.**[1,8]

† Toujeo® is available in easy-to-use pens,[1,9,10] to be administered once daily at any time of the day, preferably at the same time every day.[1] When needed, patients can administer Toujeo® up to 3 hours before or after their usual time of administration. Flexible dosing time was evaluated in two randomized, open-label clinical studies in patients with T2DM.[1]

References: 1. Toujeo® Hong Kong prescribing information. 2020 ver 1. 2. YkH-Järvinen H, et al. Diabetes Care. 2014:37:3235-3243. 3. Bolli GB, et al. Diabetes Obes Metab. 2015:17:386-394. 4. Terauchi Y, et al. Diabetes Obes Metab. 2016:18:366-374. 5. Home PD, et al. Diabetes Care. 2015:38:2217-2225. 6. Matsuhisa M, et al. Diabetes Obes Metab. 2016:18:375-383. 7. Bergenstal RM, et al. Diabetes Care. 2017:40:554-560. 8. Becker RHA, et al. Diabetes Care. 2015;38(4):637-43 9. Singh R, et al. Eur Endocrinol. 2018;14:47-51 10. Pohlmeier H, et al. J Diabetes Sci Technol. 2017;11;263-269

Abbreviated prescribing information: Presentation Insulin glargine 300 IU/ml solution for injection. **Indications** Treatment of diabetes mellitus in adults, adolescents and children from the age of 6 years. **Dosage** Once daily (preferably at the same time every day up to 3 hours before or after the usual time of administration), with adjusted individual dosage. Please refer to the full prescribing information for guidelines on switching between other insulin preparations. **Administration** Subcutaneous injection. Toujeo is NOT INTENDED FOR INTRAVENOUS USE since it could result in severe hypoglycaemia. Toujeo must not be drawn from the cartridge of the SoloStar pre-filled pen into a syringe or severe overdose can result. **Contraindications** Hypersensitivity to insulin glargine or to any of the excipients. **Precautions** Toujeo has not been studied in children below 6 years of age. Elderly: Progressive deterioration of renal function may lead to a steady decrease in insulin requirements. Renal impairment: Insulin requirements may be diminished due to reduced insulin metabolism. Hepatic impairment: Insulin requirement may be diminished due to reduced capacity for gluconeogenesis and reduced insulin metabolism. Perform continuous rotation of injection site to reduce risk of lipodystrophy and cutaneous amyloidosis. Blood glucose monitoring is recommended after change in injection site. Hypoglycaemia. Intercurrent illness. Combination of Toujeo with pioglitazone. Medication errors prevention. **Interactions** Effects enhanced by oral antidiabetics, ACEI, disopyramide, fibrates, fluoxetine, MAOIs, pentoxifylline, propoxyphene, salicylates, sulfonamide antibiotics. Effects reduced by corticosteroids, danazol, diazoxide, diuretics, glucagons, isoniazid, oestrogens and progestogens, phenothiazine derivatives, somatropin, sympathomimetics, or thyroid hormones, atypical antipsychotics and protease inhibitors. Beta-blockers, clonidine, lithium or alcohol may either potentiate or weaken the effects of insulin. Pentamidine may cause hypoglycaemia, followed by hyperglycaemia. The signs of adrenergic counter-regulation may be reduced or absent under the influence of sympatholytic medicinal products such as beta-blockers, clonidine, guanethidine and reserpine. **Fertility, pregnancy and lactation** Animal studies do not indicate direct harmful effects with respect to fertility and reproductive toxicity. The use of Toujeo may be considered during pregnancy if clinically needed. It is unknown whether insulin glargine is excreted in human milk. **Overdose** Insulin overdose may lead to severe and sometimes long-term and life-threatening hypoglycaemia. Mild episodes of hypoglycaemia can usually be treated with oral carbohydrates. More severe episodes with coma, seizure or neurologic impairment may be treated with glucagon (intramuscular or subcutaneous) or concentrated glucose solution (intravenous). **Undesirable effects** Hypoglycaemia, lipohypertrophy, injection site reactions. For common, uncommon, rare and very rare undesirable effects, please refer to the full prescribing information. **Storage** Before first use: Store in a refrigerator (2°C - 8°C). Do not freeze. Protect from light. After first use: Store below 30°C. Use within 42 days. Do not freeze. **Preparation** Toujeo 5 x 1.5 ml (450 IU) pre-filled pens.
Legal classification Part 1 Poison **Full prescribing information is available upon request.**
API-HK-TOU-20.09

MAT-HK-2200793- 1.0- 08/2022

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Toujeo® insulin glargine 300U/mL

Lexapro®

the power to tackle

depression / anxiety

at its core

Lexapro® is approved for use in[1]:

- Major Depressive Disorder (MDD)
- Generalized Anxiety Disorder (GAD)
- Social Anxiety Disorder (SAD)
- Panic Disorder (PD)
- Obsessive-Compulsive Disorder (OCD)

Reference: 1. Lexapro® Summary of Product Characteristics. May 2017.

Lexapro Abbreviated Prescribing Information
Presentation: Escitalopram Film-coated tablets 5 mg, 10 mg, 15 mg, 20 mg. **Indication:** Treatment of major depressive episodes, Treatment of panic disorder with or withoutagoraphobia, Treatment of social anxiety disorder (social phobia), Treatment of generalised anxiety disorder, Treatment of obsessive-compulsive disorder (OCD). **Dosage** Adults: Usual dosage is 10 mg once daily. Depending on individual patient response, the dose may be increased to a maximum of 20 mg daily. An initial starting dose of 5 mg once daily is recommended in the treatment of elderly (>65 years), in panic disorder and in patients with reduced hepatic function. Children and adolescents (< 18 years): Lexapro should not be used. Discontinuation: Discontinue gradually over a period of at least one to two weeks to reduce the possibility of discontinuation symptoms. **Contraindications:** Concomitant treatment with non-selective, irreversible monoamine oxidase inhibitors (MAO-inhibitors). Patients with known QT interval prolongation or congenital long QT syndrome. Concomitant treatment with pimozide. Should not be used during pregnancy unless clearly needed and after careful consideration of the risk/benefit ratio. Breast-feeding is not recommended. **Precautions:** Depression is associated with an increased risk of suicidal thoughts, self-harm and suicide. It is a general clinical experience that the risk of suicide may increase in the early stages of recovery. Close supervision of patients and in particular those at high risk should accompany drug therapy especially in early treatment and following dose changes. Patients (and caregivers) should be alerted about the need to monitor for any clinical worsening, suicidal behaviour or thoughts and unusual changes in behaviour and to seek medical advice immediately if these symptoms present. SSRIs should be avoided in patients with unstable epilepsy, and patients with controlled epilepsy should be closely monitored. SSRIs should be used with caution in patients with a history of mania/hypomania. SSRIs should be discontinued in any patient entering a manic phase. Treatment with SSRIs may alter glycaemic control. Insulin and/or oral hypoglycaemic dosage may need to be adjusted. The use of SSRIs/SNRIs has been associated with the development of akathisia. Hyponatraemia has been reported rarely with the use of SSRIs. There have been reports of cutaneous bleeding abnormalities. Escitalopram has been found to cause a dose-dependent prolongation of the QT interval. **Interactions:** Caution is advised when taken in combination with MAO-inhibitors or medicinal products known to prolong the QT interval, serotonergic medicinal products, products lowering the seizure threshold, lithium, tryptophan, St. John's Wort, oral anticoagulants or antiplatelet agents (NSAIDs), and products predominantly metabolised by the enzymes CYP2C19, CYP3A4 and CYP2D6. **Undesirable effects:** Adverse reactions are most frequent during the first or second week of treatment and usually decrease in intensity and frequency with continued treatment. Very common: Nausea. Common: Decreased/increased appetite, weight increased, anxiety, restlessness, abnormal dreams, libido decreased, anorgasmia, insomnia, somnolence, dizziness, paraesthesia, tremor, sinusitis, yawning, diarrhoea, constipation, vomiting, dry mouth, sweating increased, arthralgia, myalgia, ejaculation disorder, impotence, fatigue and pyrexia. Uncommon: weight decreased, bruxism, agitation, nervousness, panic attack, confusional state, taste disturbance, sleep disorder, syncope, mydriasis, visual disturbance, tinnitus, tachycardia, epistaxis, gastrointestinal haemorrhages (including rectal haemorrhage), urticaria, alopecia, rash, pruritus, metrorrhagia, menorrhagia, oedema. Rare: anaphylactic reaction, aggression, depersonalisation, hallucination, serotonin syndrome, bradycardia. Not known: thrombocytopenia, inappropriate ADH secretion, hyponatraemia, anorexia, mania, suicidal ideation, suicidal behaviour, dyskinesia, movement disorder, convulsion, psychomotor restlessness/akathisia, electrocardiogram QT prolonged, orthostatic hypotension, hepatitis, liver function test abnormal, ecchymosis, angioedemas, urinary retention, galactorrhoea, priapism. Class effects: Epidemiological studies, mainly conducted in patients 50 years of age and older, show an increased risk of bone fractures in patients receiving SSRIs and TCAs. **Overdose:** Cases of overdose with escitalopram doses between 400 mg and 800 mg have been reported without any severe symptoms. **Legal category:** POM. **Date of preparation or last review** May 2017.

Further information is available upon request

HK-LU-2202.05-AD01

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