



The Federation of Medical Societies of Hong Kong
香港醫學組織聯會

ANNUAL SCIENTIFIC MEETING 2024

EMBRACING ADVANCES TO TRANSFORM HEALTHCARE

27 October 2024 (Sunday) | 09:00 - 17:00

Format: Hybrid

1) Online: Zoom Webinar

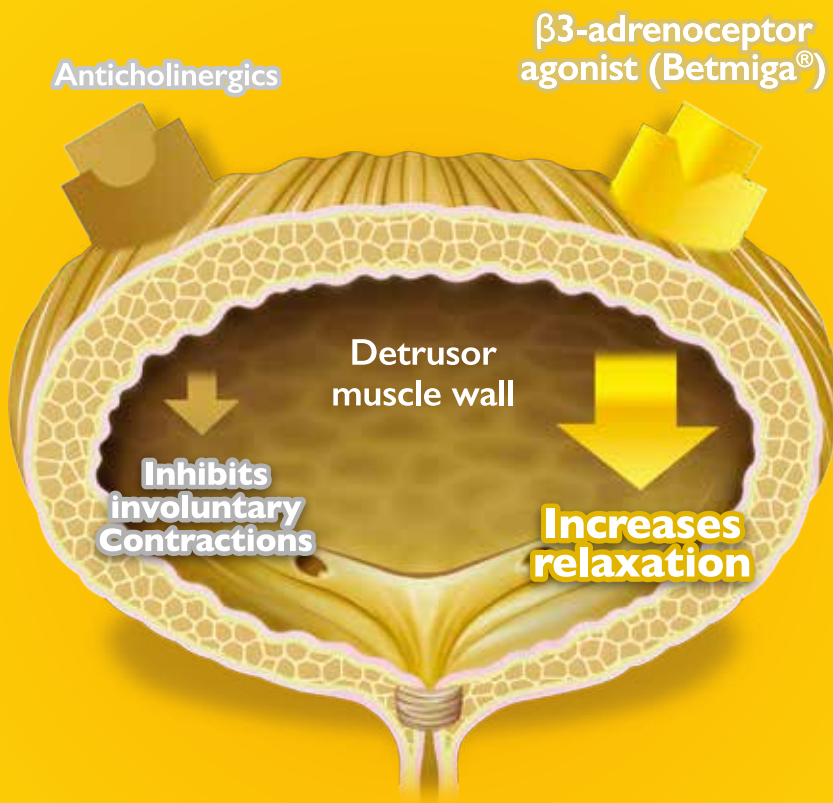
**2) Onsite: The Ballroom, 7/F, Cordis, Hong Kong
555 Shanghai Street, Mong Kok, Kowloon**

Programme Book

BETMIGA[®]

THE 1ST β_3 AGONIST THERAPY FOR OAB PATIENTS¹

An alternative, cost-effective treatment strategy^{2,3} for the management of OAB in the frail, at-risk of cognitive impairment, and elderly population as it is **not shown to increase anti-cholinergic burden**^{4,5,6}



FAVORABLE SAFETY PROFILE



No impact on cognitive function^{5,6}



Not contraindicated in patients with narrow-angle glaucoma or AUR^{10,11}

PROVEN EFFICACY



13% higher in 12-month persistence compared to solifenacin⁹



58% more reduction in nocturia episodes/24h as compared to Placebo⁸



Please scan the QR Code for the abbreviated product information of Betmiga[®]

Abbreviations: AUR, acute urinary retention; OAB, overactive bladder; EAU, European Association of Urology; ER, extended release; UII, urgency urinary incontinence. **References:** 1. Imran M, et al. Urol J. 2013;10(3):935-40. 2. Nazir J, et al. Pharmacoecon Open. 2017;1(1):25-36. 3. Parise H, et al. Pharmacoecon Open. 2020;4(1):79-90. 4. Burkhard FC, et al. European Association of Urology guidelines on urinary incontinence in adults 2020. European Association of Urology 2020. 5. Kelleher C, et al. Eur Urol. 2018;74(3):324-333. 6. Griebing TL, et al. BMC Geriatr. 2020;20(1):109. 7. Gouloze SC, et al. Br J Clin Pharmacol. 2015;80(4):762-64. 8. Chapple CR, et al. Int Urogynecol J. 2013;24:1447-1458. 9. Chapple CR, et al. Eur Urol. 2017;72(3):389-99. 10. Novack GD, et al. J Ocul Pharmacol Ther. 2013;29(7):674-80. 11. Betmiga 50mg Hong Kong Prescribing Information.

THE FIRE OF MENOPAUSAL VMS STARTS IN HER HYPOTHALAMUS

Altered activity of neurons
in the brain signals the heat^{1,2}

For too long, explanations of Vasomotor Symptoms (VMS) associated with menopause, commonly known as hot flashes and night sweats, have been limited to declining estrogen alone. Advances in science have expanded our understanding of the role of specific neuronal pathways in the hypothalamus.^{1,2}



**EXPLORING
THE SCIENCE
BEHIND VMS**



Please scan and
leave your contact
to receive more info
about VMS later



References: **1.** Rapkin AJ. vasomotor symptoms in menopause: physiological condition and central nervous system approaches to treatment. Am J Obstet Gynecol 2007; 196(2):97-108. **2.** Modi M, Dhillon WS. Neurokinin 3 receptor antagonism: a novel treatment for menopausal hot flashes. Neuroendocrinology 2019;109(3):242-8.



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PROGRAMME

Time	Ballroom I & II	Ballroom III
0900-0930	Onsite & Online Reception	
0930-1000	Opening Ceremony	<i>Live Streaming of Opening Ceremony</i>
1000-1030	Session 1 Plenary Lecture (Health Policy)	
	<i>Chairpersons:</i> <i>Prof. Bernard Man-yung CHEUNG / Dr. Alson Wai-ming CHAN</i>	
1000-1030	Healthcare Reform in Modern China: Challenges and Opportunities Prof. Ying-lian HU	
1030-1045	Tea Break	
1045-1145	Session 2 (Western and Chinese Medicine for Diabetic Nephropathy)	
	<i>Chairpersons:</i> <i>Dr. Edwin Chau-leung YU / Dr. Samuel Ka-shun FUNG</i>	
1045-1115	Therapeutic Pillars of Diabetic Kidney Disease: Advances in Management Dr. Gary Chi-wang CHAN	
1115-1145	Evidence-based Management of Diabetic Kidney Disease with Chinese Medicine Dr. Chris Kam-wa CHAN	
1145-1245	Session 3A (Atopic Dermatitis Therapeutics)	Session 3B (Allergy)
	<i>Chairpersons:</i> <i>Dr. Kingsley Hau-ngai CHAN / Ms. Ellen Wai-yin KU</i>	<i>Chairperson:</i> <i>Dr. Chun-Kong NG</i>
1145-1215	New Horizons in the Management of Atopic Dermatitis from Infancy to Adulthood: Safety and Efficacy Dr. Lai-san WONG	Myths & Truth about Allergy Diagnostics Dr. Alson Wai-ming CHAN
1215-1245	Novel Approaches for Optimizing Outcomes of Moderate-to-Severe Atopic Dermatitis: JAK Inhibition Dr. Charles Walter LYNDE	Early Intervention & Desensitisation Programme for Food Allergy Ms. Sabrina Wing-shan MOK
1245-1355	Lunch Symposium (Medical Advance for Chronic Diseases)	
	<i>Chairpersons:</i> <i>Dr. Jane Chun-kwong CHAN / Dr. Ludwig Chun-hing TSOI</i>	
1245-1315	From Good to Great – Revolutionizing the Management of Diabetic Complications with SGLT2 Inhibitors Prof. Merlin THOMAS	Live Streaming of Lunch Symposium
1315-1345	Cardiopulmonary Risk in COPD Dr. Ken Ka-pang CHAN	

Time	Ballroom I & II	Ballroom III
1355-1455	Session 4A (Dementia & Diabetes)	Session 4B (Women & Child Health)
	<i>Chairperson: Prof. Benard Man-yung CHEUNG</i>	<i>Chairpersons: Dr. Mario Wai-kwong CHAK / Ms. Tina Woan-tyng YAP</i>
1355-1425	Advances in the Screening and Management of Dementia Dr. Raymond See-kit LO	How do Advances in Genomic Testing Transform Early Diagnosis of Autism Spectrum Disorder and its Comorbidities? Dr. Fanny Wai-fan LAM
1425-1455	Diabetes and Fatty Liver Dr. Norman CHAN	Understanding Menopause: An Ignored Medical Condition Dr. Ellen Man-wa LUI
1455-1555	Session 5A (Psoriasis and Prostate Hypertrophy)	Session 5B (Geriatrics & Palliative Care)
	<i>Chairperson: Dr. Victor Hip-wo YEUNG</i>	<i>Chairpersons: Dr. Raymond See-kit LO / Dr. Janice Wing-hang TSANG / Ms. Ellen Wai-yin KU</i>
1455-1525	The Importance of Early Treatment in Psoriasis Dr. Kingsley Hau-ngai CHAN	Cancer Care for the Older Population: Getting the Right Perspective Assoc Prof. Ravindran KANASVARAN
1525-1555	Tips on BPH Diagnosis & Management Dr. Lung-wai CHAN	Delivering Palliative Care in the UK: Sharing our Experience Dr. Phoebe WRIGHT
1555-1610	Tea Break	
1610-1710	Session 6A (Neuropsychiatry)	Session 6B (Artificial Intelligence & Informative Technology)
	<i>Chairperson: Dr. Kwai-ming SIU</i>	<i>Chairperson: Dr. Edwin Chau-leung YU</i>
1610-1640	Precision Management in Paediatric Epilepsy: What have we Learnt from Past Experience and What Enlightening us from Recent Advance Dr. Mario Wai-kwong CHAK	A Multimodal Large Language Model with Advanced Generalizability and Explainability for Medical Data Understanding & Generation Dr. Li-jian XU
1640-1710	I Will Survive – Update on Management of Treatment-Resistant Depression (TRD) Dr. Christie King-yee CHONG	Artificial Intelligent Aided 3D Printing for High-risk Medical Procedure Training Models Dr. Carrison Ka-shun TONG

■ WELCOME MESSAGE FROM THE PRESIDENT

Prof Bernard Man-yung CHEUNG

President, The Federation of Medical Societies of Hong Kong



Good morning, esteemed colleagues, and welcome to this year's annual scientific meeting of the Federation of Medical Societies of Hong Kong. It's an absolute honour to stand before you today, surrounded by such brilliant minds and passionate individuals dedicated to improving the health and well-being of our communities.

We are living in an age of unprecedented innovation, where groundbreaking research, cutting-edge technologies, and new approaches to patient care are converging to revolutionize the way we diagnose, treat, and manage diseases.

The theme of our meeting, "Embracing Advances to Transform Healthcare," encapsulates the spirit of collaboration, innovation, and progress that drives our work. We are here to learn from each other, share insights, and explore the potential of these advances to bring about a truly transformative impact on the lives of patients. We will explore the intersection of medicine, technology, and patient-centered care, examining how we can harness these forces to create a more equitable, accessible, and personalized healthcare system.

The scientific programme this year embraces an unusually wide range of topics, from depression to diseases of the skin, from Western therapies to Chinese medicine. This meeting is not just a platform for broadening our horizons, it is also an opportunity to forge new friendships and cultivate new interests.

I am confident that this gathering will be a catalyst for meaningful change and a stepping stone towards future healthcare that is not only effective but also compassionate and truly patient-centred. Let us start this journey together, filled with the excitement of discovery and the spirit of collaboration. I wish you all a very enjoyable, enlightening and enriching conference!

A handwritten signature in black ink, appearing to be 'B. Cheung', written in a cursive style.

■ WELCOME MESSAGES FROM CHAIRPERSONS

Dr Alson Wai-ming CHAN

Co-chairman, Annual Scientific Meeting 2024

Hon Secretary, The Federation of Medical Societies of Hong Kong



Welcome to the Federation of Medical Societies of Hong Kong Annual Scientific Meeting 2024. As highlighted by our main theme: **Embracing Advances to Transform Healthcare**, the meeting this year continues to serve as an important platform to facilitate the exchange of innovative ideas among healthcare professionals from a variety of specialties.

Thanks to the combined efforts of our organizing committee, the scientific programme this year covers a wide spectrum of hot topics: Western & Chinese Medicine collaborations, artificial intelligence, allergy, neurology, oncology, palliative care, mental health, pulmonology, endocrinology, dermatology, urology as well as woman & child health sessions. This year, we are thankful and privileged to have the leading expert Prof. HU Yinglian (胡穎廉教授) from the Chinese Academy of Governance to be our special guest speaker to share with us the challenge in the development and implementation of healthcare policy in our country, together with distinguished international and local speakers to share with us recent medical advances.

The goal of medical advances is improving the quality of life for all of us. Being healthcare professionals, we are important stakeholders and key players in achieving this goal. I believe that when we work together seamlessly, transformation takes place. I take great pride in our federation tradition of promoting the fraternity among healthcare professionals, not just within Hong Kong but now extending to the Greater Bay Area and beyond. So I invite you to actively participate in this event, enjoy the comprehensive scientific programme and further strengthen our bonding.

A handwritten signature in black ink, appearing to be 'Alson Chan', written in a cursive style.

■ WELCOME MESSAGES FROM CHAIRPERSONS

Prof Edwin Chau-leung YU

Co-chairman, Annual Scientific Meeting 2024

Exco Member, The Federation of Medical Societies of Hong Kong



The Annual Scientific Meeting has been running successfully for years by the Federation of Medical Society of Hong Kong (FMSHK). Thankful for the cooperation and trust of the organisation committee; it gives me great excitement to be Co-chairman with Dr Alson CHAN to introduce this fest as it provides a forum for exchanging views by eminent speakers across the fields of Western and Chinese medicine.

The theme for 2024 is "Embracing Advances to Transform Healthcare". A very special welcome to our Chief guest, Prof HU Yinglian (胡穎廉教授), Chinese Academy of Governance, who, with his talk on '中國基層醫療與醫改面臨的挑戰和機遇', will address us for refreshing our medical journey. The review of medical excellence accompanied by other renowned speakers covering on updated discourses would be stimulating and enlightening. We deeply appreciate and welcome their presence.

We look forward to you in person or over the air joining and exploring the advances in the fields of vaccines in **senior care, neurological problems including Alzheimer's Disease, Parkinsonism and Stoke, Asthma, COPD, diabetes complication management, diabetic nephropathy, men's health, microbiome in early life, New Diagnostics and other exciting topics**. Gathered together, discussing among accomplished peers in the open venue, meanwhile supported by medical firms and their demonstration booths, always generate lively moments with new friends and experiences.

May we show a warm welcome to you all for active participation. Thanks also to the sponsors for their unfailing support. I am sure it will be a wonderful opportunity to experience and exchange the most updated knowledge on healthcare practice through innovations. Hope you will find this meeting enjoyable, stimulating, and educational. Thank you.

A handwritten signature in black ink, appearing to read 'Yu CLS', written in a cursive style.

Freedom to live a complete childhood



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

Complete Cosentyx Approach

Give your paediatric patients a chance to



Look
Better



Move
Better



Feel
Better

✓ Fast, strong, and sustained* **skin clearance**^{1,2}

✓ Fast and sustained* **relief from the physical and psychosocial burden of psoriasis**^{1,2}

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

✓ Favorable **long-term safety profile**^{2,3*}

Indication

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

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

Cosentyx®
secukinumab

Cosentyx®

Important note: Before prescribing, consult full prescribing information. **Presentation:** Secukinumab solution for subcutaneous injection in pre-filled pen contains 150 mg or 300 mg of secukinumab. **Indications:** **Adult plaque psoriasis** Cosentyx is indicated for the treatment of moderate to severe plaque psoriasis in adults who are candidates for systemic therapy. **Paediatric plaque psoriasis** Cosentyx is indicated for the treatment of moderate to severe plaque psoriasis in children and adolescents from the age of 6 years who are candidates for systemic therapy. **Psoriatic arthritis** Cosentyx, alone or in combination with methotrexate (MTX), is indicated for the treatment of active psoriatic arthritis in adult patients when the response to previous disease-modifying anti-rheumatic drug (DMARD) therapy has been inadequate. **Axial spondyloarthritis (axSpA)** Cosentyx is indicated for the treatment of active ankylosing spondylitis (AS, radiographic axSpA) or spondyloarthritis (axSpA, non-radiographic axSpA) in adults who have responded inadequately to non-steroidal anti-inflammatory drugs (NSAIDs). **Dosage and administration:** **Dosage Adult plaque psoriasis:** The recommended dose is 300 mg by subcutaneous injection with initial dosing at weeks 0, 1, 2, 3 and 4, followed by monthly maintenance dosing. Based on clinical response, a maintenance dose of 300 mg every 2 weeks may provide additional benefit for patients with a body weight of 90 kg or higher. Each 300 mg dose is given as one subcutaneous injection of 150 mg. Each 150 mg dose is given as one subcutaneous injection of 150 mg. Each 300 mg dose is given as one subcutaneous injection of 300 mg or as two subcutaneous injections of 150 mg. The solution for injection in pre-filled pen 150 mg/ml and 300 mg/2ml are not indicated for administration to paediatric patients with a weight <50 kg. Cosentyx may be available in other strengths and/or presentations depending on the individual treatment needs. **Paediatric plaque psoriasis (adolescents and children from the age of 6 years)** The recommended dose is based on body weight and administered by subcutaneous injection with initial dosing at weeks 0, 1, 2, 3 and 4, followed by monthly maintenance dosing. Each 300 mg dose is given as two subcutaneous injections of 150 mg or one subcutaneous injection of 300 mg. For other patients, the recommended dose is 150 mg by subcutaneous injection with initial dosing at weeks 0, 1, 2, 3 and 4, followed by monthly maintenance dosing. Based on clinical response, the dose can be increased to 300 mg. Each 300 mg dose is given as two subcutaneous injections of 150 mg or one subcutaneous injection of 300 mg. **Axial spondyloarthritis (axSpA)** The recommended dose is 150 mg by subcutaneous injection with initial dosing at weeks 0, 1, 2, 3 and 4, followed by monthly maintenance dosing. For all of the above indications, available data suggest that a clinical response is usually achieved within 16 weeks of treatment. Consideration should be given to discontinuing treatment in patients who have shown no response by 16 weeks of treatment. Some patients with an initial partial response may subsequently improve with continued treatment beyond 16 weeks. **Elderly patients (aged 65 years and over):** No dose adjustment is required. **Paediatric population (aged below 18 years):** The safety and efficacy of Cosentyx in children below the age of 6 years have not been established. The safety and efficacy of Cosentyx in children below the age of 18 years in other indications have not yet been established. All data are available. **Renal impairment / hepatic impairment:** Cosentyx has not been studied in these patient populations. No dose recommendations can be made. **Administration:** Cosentyx is to be administered by subcutaneous injection. If possible, areas of the skin that show psoriasis should be avoided as injection sites. The solution in the pen must not be shaken. **Contraindications:** **• Cosentyx is contraindicated in patients who have had hypersensitivity reactions to the active substance or to any of the excipients.** **• Clinically important active infection (eg, active tuberculosis).** **Warnings and precautions:** **• Traceability:** In order to improve the traceability of biological medicinal products, the name and the batch number of the administered product should be clearly recorded. **• Infections:** Cosentyx has the potential to increase the risk of infections. Caution in patients with chronic infection or history of recurrent infection. Patients should be instructed to seek medical advice if signs or symptoms suggestive of an infection occur. If a patient develops a serious infection, the patient should be closely monitored and Cosentyx should not be administered until the infection resolves. **Anti-tuberculosis therapy** should be considered prior to initiation of Cosentyx in patients with latent tuberculosis. Cosentyx should not be given to patients with active tuberculosis. **• Inflammatory bowel disease (including Crohn's disease and ulcerative colitis):** If a patient develops signs and symptoms of inflammatory bowel disease or experiences an exacerbation of pre-existing inflammatory bowel disease, secukinumab should be discontinued and appropriate medical management should be initiated. **• Hypersensitivity reactions:** In clinical studies, rare cases of anaphylactic reactions have been observed in patients receiving Cosentyx. Administration of Cosentyx should be discontinued immediately and appropriate therapy initiated if an anaphylactic or other serious allergic reaction occurs. **• Latex-sensitive individuals (for 150 mg pre-filled syringe/pen only):** The removable cap of the Cosentyx 150 mg pre-filled syringe/pen contains a derivative of natural rubber latex. **• Vaccinations:** Cosentyx should not be given concurrently with live vaccines. Patients receiving Cosentyx may receive concurrent inactivated or non-live vaccinations. **• Concomitant immunosuppressive therapy:** In psoriasis studies, the safety and efficacy of Cosentyx in combination with immunosuppressants, including biologics, or phototherapy have not been evaluated. Secukinumab was administered concomitantly with methotrexate (MTX), sulfasalazine and/or corticosteroids in arthritis studies (including in patients with psoriatic arthritis and ankylosing spondylitis). Caution should be exercised when considering concomitant use of other immunosuppressants and secukinumab. **Women of childbearing potential:** Effective method of contraception during treatment and for at least 20 weeks after treatment should be used. **Pregnancy:** There are no adequate data from the use of secukinumab in pregnant women. As a precautionary measure, it is preferable to avoid the use of Cosentyx in pregnancy. **Breast-feeding:** It is not known whether secukinumab is excreted in human milk. Because of the potential for adverse reactions in nursing infants from secukinumab, a decision on whether to discontinue breast-feeding during treatment and up to 20 weeks after treatment or to discontinue therapy with Cosentyx must be made taking into account the benefit of breast-feeding to the child and the benefit of Cosentyx therapy to the woman. **Adverse drug reactions:** **Very common (≥10%):** Upper respiratory tract infections. **Common (≥1% to <10%):** Oral herpes, tinea pedis, headache, diarrhea, rhinitis, nausea, fatigue. **Uncommon (≥0.1% to <1%):** Oral candidiasis, neutropenia, otitis externa, lower respiratory tract infections, conjunctivitis, inflammatory bowel disease, urticaria, dyshidrotic eczema. **Rare (≥0.01% to <0.1%):** Anaphylactic reactions, exfoliative dermatitis, hypersensitivity vasculitis. **Not known (cannot be estimated from the available data):** Mucosal and cutaneous candidiasis (including oropharyngeal candidiasis). **Interactions:** Live vaccines should not be given concurrently with Cosentyx. In a study in subjects with plaque psoriasis, no interaction was observed between secukinumab and midazolam (CYP3A4 substrate). No interaction was seen when Cosentyx was administered concomitantly with methotrexate (MTX) and/or corticosteroids in arthritis studies (including in patients with psoriatic arthritis and axial spondyloarthritis). **Packs:** For 150 mg pre-filled pen: Solution in pre-filled pen, 1's or 2's. For 300 mg pre-filled pen: Solution in pre-filled pen, 1's. Not all pack sizes are marketed. **Legal classification:** P151S3 Last revised: Mar 2023 Ref: EU Jan 2022

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

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

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■ CONGRATULATORY MESSAGES

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



香港醫學組織聯會二零二四年周年科研大會

雋才匯智
仁術拓新

行政長官李家超



■ CONGRATULATORY MESSAGES

Dr Ronald Man-kin LAM, JP

Director of Health



弘研
學醫
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衛生署署長林文健

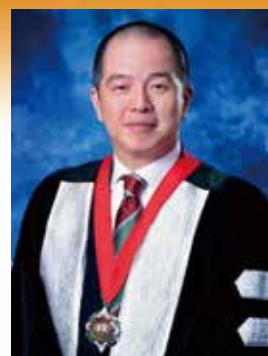


香港醫學組織聯會二零二四年周年科研大會誌慶

■ CONGRATULATORY MESSAGES

Prof Gilberto Ka-kit LEUNG

President, Hong Kong Academy of Medicine



香港醫學組織聯會二零二四年週年科研大會

精研醫學
探究新知

香港醫學專科學院主席梁嘉傑教授



■ CONGRATULATORY MESSAGES

Dr the Hon David Tzit-yuen LAM

Legislative Council Member



香港醫學組織聯會二零二四年學術年會 誌慶

薪傳醫道
精益求精

立法會議員 林哲玄醫生



敬賀

二零二四年夏

■ CONGRATULATORY MESSAGES

Mr Henry Hung-ling FAN, SBS, JP

Chairman, Hospital Authority



香港醫學組織聯會周年科研大會誌慶

匯賢濟世
醫術流芳

醫院管理局主席范鴻齡



■ CONGRATULATORY MESSAGES

Dr Tony Pat-sing KO

Chief Executive, Hospital Authority



香港醫學組織聯會周年科研大會誌慶

同業薈萃為科研

精進日新護民康

醫院管理局行政總裁高拔陞



Cosentyx® 150 mg Powder in Vial arrived



WOW Campaign

The image above is not in actual size/ appearance.

Important note: Before prescribing, consult full prescribing information. **Presentation:** Secukinumab. Powder for solution for subcutaneous injection containing 150 mg of secukinumab. **Indications:** **Adult plaque psoriasis** Cosentyx is indicated for the treatment of moderate to severe plaque psoriasis in adults who are candidates for systemic therapy. **Paediatric plaque psoriasis** Cosentyx is indicated for the treatment of moderate to severe plaque psoriasis in children and adolescents from the age of 6 years who are candidates for systemic therapy. **Hidradenitis suppurativa (HS)** Cosentyx is indicated for the treatment of active moderate to severe hidradenitis suppurativa (acne inversa) in adults with an inadequate response to conventional systemic HS therapy. **Psoriatric arthritis** Cosentyx, alone or in combination with methotrexate (MTX), is indicated for the treatment of active psoriatic arthritis in adult patients when the response to previous disease-modifying anti-rheumatic drug (DMARD) therapy has been inadequate. **Axial spondyloarthritis (axSpA)** **Ankylosing spondylitis (AS, radiographic axial spondyloarthritis)** Cosentyx is indicated for the treatment of active ankylosing spondylitis in adults who have responded inadequately to conventional therapy. **Non-radiographic axial spondyloarthritis (nraxSpA)** Cosentyx is indicated for the treatment of active non-radiographic axial spondyloarthritis with objective signs of inflammation as indicated by elevated C-reactive protein (CRP) and/or magnetic resonance imaging (MRI) evidence in adults who have responded inadequately to non-steroidal anti-inflammatory drugs (NSAIDs). **Juvenile idiopathic arthritis (JIA)** **Enthesitis-related arthritis (ERA)** Cosentyx, alone or in combination with methotrexate (MTX), is indicated for the treatment of active enthesitis-related arthritis in patients 6 years and older whose disease has responded inadequately to, or who cannot tolerate, conventional therapy. **Juvenile psoriatic arthritis (JPsA)** Cosentyx, alone or in combination with methotrexate (MTX), is indicated for the treatment of active juvenile psoriatic arthritis in patients 6 years and older whose disease has responded inadequately to, or who cannot tolerate, conventional therapy. **Dosage and administration:** **Dosage** **Adult plaque psoriasis** The recommended dose is 300 mg of secukinumab by subcutaneous injection with initial dosing at weeks 0, 1, 2, 3 and 4, followed by monthly maintenance dosing. Based on clinical response, a maintenance dose of 300 mg every 2 weeks may provide additional benefit for patients with a body weight of 90 kg or higher. Each 300 mg dose is given as two subcutaneous injections of 150 mg. **Paediatric plaque psoriasis (adolescents and children from the age of 6 years)** The recommended dose is based on body weight (Table 1) and administered by subcutaneous injection with initial dosing at weeks 0, 1, 2, 3 and 4, followed by monthly maintenance dosing. Each 75 mg dose is given as one subcutaneous injection of 75 mg. Each 150 mg dose is given as one subcutaneous injection of 150 mg. Cosentyx may be available in other strengths and/or presentations depending on the individual treatment needs. **Psoriatric arthritis** For patients with concomitant moderate to severe plaque psoriasis, please refer to adult plaque psoriasis recommendation. For patients who are anti-TNFα inadequate responders (IR), the recommended dose is 300 mg by subcutaneous injection with initial dosing at weeks 0, 1, 2, 3 and 4, followed by monthly maintenance dosing. Each 300 mg dose is given as two subcutaneous injections of 150 mg. For other patients, the recommended dose is 150 mg by subcutaneous injection with initial dosing at weeks 0, 1, 2, 3 and 4, followed by monthly maintenance dosing. Based on clinical response, the dose can be increased to 300 mg. **Axial spondyloarthritis (axSpA)** **Ankylosing spondylitis (AS, radiographic axial spondyloarthritis)** The recommended dose is 150 mg by subcutaneous injection with initial dosing at weeks 0, 1, 2, 3 and 4, followed by monthly maintenance dosing. Based on clinical response, the dose can be increased to 300 mg. Each 300 mg dose is given as two subcutaneous injections of 150 mg. **Non-radiographic axial spondyloarthritis (nraxSpA)** The recommended dose is 150 mg by subcutaneous injection with initial dosing at weeks 0, 1, 2, 3 and 4, followed by monthly maintenance dosing. **Juvenile idiopathic arthritis (JIA)** **Enthesitis-related arthritis (ERA)** and **Juvenile psoriatic arthritis (JPsA)** The recommended dose is based on body weight (Table 2) and administered by subcutaneous injection at weeks 0, 1, 2, 3, and 4, followed by monthly maintenance dosing. Each 75 mg dose is given as one subcutaneous injection of 75 mg. Each 150 mg dose is given as one subcutaneous injection of 150 mg. Cosentyx may be available in other strengths and/or presentations depending on the individual treatment needs. **Hidradenitis suppurativa (HS)** The recommended dose is 300 mg of secukinumab by subcutaneous injection with initial dosing at weeks 0, 1, 2, 3, and 4, followed by monthly maintenance dosing. Based on clinical response, the maintenance dose can be increased to 300 mg every 2 weeks. Each 300 mg dose is given as two subcutaneous injections of 150 mg. For all of the above indications, available data suggest that a clinical response is usually achieved within 16 weeks of treatment. Consideration should be given to discontinuing treatment in patients who have shown no response by 16 weeks of treatment. Some patients with an initial partial response may subsequently improve with continued treatment beyond 16 weeks. **Elderly patients (aged 65 years and over):** No dose adjustment is required. **Paediatric population (aged below 18 years):** The safety and efficacy of Cosentyx in children with plaque psoriasis and in the juvenile idiopathic arthritis (JIA) categories of ERA and JPsA below the age of 6 years have not been established. The safety and efficacy of Cosentyx in children below the age of 18 years in other indications have not yet been established. No data are available. **Renal impairment / hepatic impairment:** Cosentyx has not been studied in these patient populations. No dose recommendations can be made. **Administration:** Cosentyx is to be administered by subcutaneous injection. If possible, areas of the skin that show psoriasis should be avoided as injection sites. The powder for solution for injection must be reconstituted before use. The reconstitution, dose preparation and administration of the powder for solution for injection is to be done by a healthcare professional. For instructions on reconstitution of the medicinal product before administration, see section 6.6 and the Instructions for Use in the package leaflet. **Contraindications:** Cosentyx is contraindicated in patients who have/had severe hypersensitivity reactions reaction to the active substance or to any of the excipients. **Clinically important, active infection (e.g. active tuberculosis)** **Warnings and precautions:** **Traceability:** In order to improve the traceability of biological medicinal products, the name and the batch number of the administered product should be clearly recorded. **Infections:** Cosentyx has the potential to increase the risk of infections. Caution should be exercised when considering the use of Cosentyx in patients with chronic infection or history of recurrent infection. Patients should be instructed to seek medical advice if signs or symptoms suggestive of an infection occur. If a patient develops a serious infection, the patient should be closely monitored and Cosentyx should not be administered until the infection resolves. Anti-tuberculosis therapy should be considered prior to initiation of Cosentyx in patients with latent tuberculosis. Cosentyx should not be given to patients with active tuberculosis. **Inflammatory bowel disease (including Crohn's disease and ulcerative colitis):** Cosentyx is not recommended in patients with inflammatory bowel disease. If a patient develops signs and symptoms of inflammatory bowel disease or experiences an exacerbation of pre-existing inflammatory bowel disease, secukinumab should be discontinued and appropriate medical management should be initiated. **Hypersensitivity reactions:** In clinical studies, rare cases of anaphylactic reactions have been observed in patients receiving secukinumab. If an anaphylactic or other serious allergic reactions occur, administration of secukinumab should be discontinued immediately and appropriate therapy initiated. **Vaccinations:** Cosentyx should not be given concurrently with live vaccines. Patients receiving Cosentyx may receive concurrent inactivated or non-live vaccinations. Prior to initiating therapy with Cosentyx, it is recommended that paediatric patients receive all age-appropriate immunisations as per current immunisation guidelines. **Concomitant immunosuppressive therapy:** In psoriasis studies, the safety and efficacy of Cosentyx in combination with immunosuppressants, including biologics, or phototherapy have not been evaluated. Secukinumab was administered concomitantly with methotrexate (MTX), sulfasalazine and/or corticosteroids in arthritis studies (including in patients with psoriatic arthritis and ankylosing spondylitis). Caution should be exercised when considering concomitant use of other immunosuppressants and secukinumab. **Women of childbearing potential:** Effective method of contraception during treatment and for at least 20 weeks after treatment should be used. **Pregnancy:** There are no adequate data from the use of secukinumab in pregnant women. As a precautionary measure, it is preferable to avoid the use of Cosentyx during pregnancy. **Breast-feeding:** It is not known whether secukinumab is excreted in human milk. Because of the potential for adverse reactions in nursing infants from secukinumab, a decision on whether to discontinue breast feeding during treatment and up to 20 weeks after treatment or to discontinue therapy with Cosentyx must be made taking into account the benefit of breast feeding to the child and the benefit of Cosentyx therapy to the woman. **Fertility:** The effect of secukinumab on human fertility has not been evaluated. Animal studies do not indicate direct or indirect harmful effects with respect to fertility. **Adverse drug reactions:** **Very common (≥10%):** Upper respiratory tract infections. **Common (1 to <10%):** Oral herpes, headache, diarrhoea, rhinorrhoea, nausea, fatigue. **Uncommon (0.1 to <1%):** Oral candidiasis, lower respiratory tract infections, otitis externa, tinea pedis, neutropenia, inflammatory bowel disease, conjunctivitis, urticaria, dyshidrotic eczema. **Rare (0.01 to <0.1%):** Anaphylactic reactions, Exfoliative dermatitis, Hypersensitivity vasculitis. **Not known (cannot be estimated from the available data):** Mucosal and cutaneous candidiasis (including oesophageal candidiasis), Pyoderma gangrenosum. **Interactions:** Live vaccines should not be given concurrently with Cosentyx. In a study in adult subjects with plaque psoriasis, no interaction was observed between secukinumab and midazolam (CYP3A4 substrate). No interaction was seen when Cosentyx was administered concomitantly with methotrexate (MTX) and/or corticosteroids in arthritis studies (including in patients with psoriatic arthritis and axial spondyloarthritis). **Packs:** Powder in Vial: 1x. **Legal classification:** P1S1S3. Last revision: Jul 2024 Ref: EMA Aug 2023.

■ CONGRATULATORY MESSAGES

Prof LAU Chak-sing

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



香港醫學組織聯會二零二四週年學術會議

聚賢匯智
共建民康

香港大學李嘉誠醫學院院長劉澤星



謹賀

■ CONGRATULATORY MESSAGES

Prof Philip Wai-yan CHIU

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



香港醫學組織聯會二零二四週年學術會議

仁術仁心惠社群
共創醫療新良方

香港中文大學醫學院院長趙偉仁



謹賀

■ CONGRATULATORY MESSAGES

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



香港醫學組織聯會

醫護同心
造福人群

梁智鴻

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HELP YOUR PATIENTS DISRUPT MODERATE TO SEVERE ATOPIC DERMATITIS



RAPID ITCH RELIEF^{*1}

RINVOQ® 30 mg achieved significant itch reduction (vs placebo) as early as DAY ONE after treatment initiation¹



PROVEN SKIN IMPROVEMENT²

- EASI-90 at week 16: 62%¹ (RINVOQ® 30 mg) vs 7% (placebo)²
- EASI-75 at week 16: 76%¹ (RINVOQ® 30 mg) vs 15% (placebo)²



SUPERIORITY OF RINVOQ® 30 MG VS DUPILUMAB³

- EASI-75 at week 16: 72.4%⁴ (RINVOQ® 30 mg) vs 62.6% (DUPILUMAB 300 mg)³
- EASI-90 at week 16: 61.6%⁵ (RINVOQ® 30 mg) vs 40.3% (DUPILUMAB 300 mg)³
- Mean improvement in Worst Pruritus NRS at week 16: 67.8%⁴ (RINVOQ® 30 mg) vs 49.6% (DUPILUMAB 300 mg)³



EXPERIENCE IN MULTIPLE INDICATIONS^{4,5}

- Well-studied safety profile with long-term exposure (>15,000 patient-years)⁴
- RINVOQ® 15 mg is approved in moderate to severe AD for adolescents from 12 years of age⁵
- Similar safety profile in adolescents and adults using RINVOQ® 15 mg for AD⁵

^{*}Itch (≥ 4-point improvement in Worst Pruritus NRS from baseline assessed in patients with Worst Pruritus NRS ≥ 4 at baseline) at Day 1 for RINVOQ® 30 mg was a key ranked secondary endpoint

¹Integrated data at week 16. p<0.001 vs placebo ITT (NRI-C) (placebo-controlled population)

²Data at week 16. p=0.007 vs dupilumab multiplicity-controlled analysis

³Data at week 16. p<0.001 vs dupilumab multiplicity-controlled ITT (NRI-C)

⁴Data at week 16. p<0.001 vs dupilumab ITT (MMRM)

⁵Patient-years of combined exposure to RINVOQ® 15 mg or 30 mg. Data are for RINVOQ® 15 mg in RA, PsA, AS and AD, and RINVOQ® 30 mg in AD only.⁵

For RINVOQ® Abbreviated Prescribing Information, please scan the QR code



Full prescribing information is available upon request. All adverse event should be reported drugsafety.pv@abbvie.com For Healthcare Professionals Only

MEASURE UP 1 & 2 Study Design: Integrated summary of efficacy of two Phase 3, randomized, placebo-controlled studies of 847 (MEASURE UP 1) and 836 (MEASURE UP 2) adult and adolescent (12 years of age) patients with moderate to severe AD. Patients were randomized 1:1 to RINVOQ® 15 mg (n=281 and 276) or 30 mg (n=285 and 282) QD monotherapy, or placebo (n=281 and 278). At Week 16, patients entered a blinded extension with no placebo control and patients were aware they were on treatment but blinded to dose. Co-primary endpoints were EASI-75 & VIGA-AD O/1 at Week 16, ITT (NRI-C) EASI-90 at Week 16 was a ranked secondary endpoint multiplicity-controlled analysis ITT (NRI-C).^{1,2}

HEADS UP Study Design: a Phase 3b, randomized, active controlled, double-dummy trial of 692 adult patients with moderate to severe AD. Patients were randomized 1:1 to RINVOQ® 30 mg QD + placebo SC Q2W for dupilumab (n=331) or dupilumab 300 mg SC Q2W + placebo QD for RINVOQ® (n=342). Patients randomized to the dupilumab 300 mg SC Q2W group received the starting dose of 600 mg at the baseline visit. Primary endpoint was EASI-75 at Week 16. EASI-90 at Week 16 and percent improvement in Worst Pruritus NRS at Weeks 1, 4 and 16 were ranked secondary endpoints.³

AD, atopic dermatitis; **EASI-75**, at least a 75% improvement in Eczema Area and Severity Index (EASI) score from baseline; **EASI-90**, at least a 90% improvement; **ITT**, intention-to-treat; **MMRM**, mixed model repeated measures; **NRI-C**, non-responder imputation incorporating multiple imputation to handle missing data due to COVID-19; **NRS**, numerical rating scale; **OLE**, open label extension; **QD**, once daily; **Q2W**, once every 2 weeks; **SC**, subcutaneous; **VIGA-AD**, validated investigator global assessment scale for atopic dermatitis.

References: 1. Guttman-Yassky E, Teixeira HD, Simpson EL, et al. Once-daily upadacitinib versus placebo in adolescents and adults with moderate-to-severe atopic dermatitis (Measure Up 1 and Measure Up 2): results from two replicate double-blind, randomized controlled phase 3 trials. *Lancet* 2021;397(10290):2151-2168. doi:10.1016/S0140-6736(21)00588-2. 2. Simpson E, Papp K, Blauvelt A, et al. Efficacy and Safety of Upadacitinib in Patients With Atopic Dermatitis: Results Through Week 52 From Replicate, Phase 3, Randomized, Double-Blind, Placebo-Controlled Studies: Measure Up 1 and Measure Up 2. Poster at the 2021 Dermatology Education Foundation (DEF) Essential Resource Meeting (DERM2021), August 5-8, 2021, Las Vegas NV, USA. 3. Blauvelt A, Teixeira HD, Simpson EL, et al. Efficacy and Safety of Upadacitinib vs Dupilumab in Adults With Moderate-to-Severe Atopic Dermatitis: A Randomized Clinical Trial. *JAMA Dermatology*, 2021;157(9):1047-1055. doi:10.1001/JAMADERMATOL.2021.3023. 4. Burmester GR, et al. "Safety profile of upadacitinib over 15 000 patient-years across rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis and atopic dermatitis" *RMD Open* 2023;9(1):e002735. 5. RINVOQ Hong Kong prescribing information. Sept 2023.

REGAIN CONTROL FROM DRUG-RESISTANT EPILEPSY WITH XCOPRI®^{1,2}

XCOPRI® is indicated for the adjunctive treatment of focal-onset seizures with or without secondary generalisation in adult patients with epilepsy who have not been adequately controlled despite a history of treatment with at least 2 anti-epileptic medicinal products.¹

Achieved primary outcome for treatment-resistant focal epilepsy³

- Median baseline seizure frequency was 6.5 in 28 days (range 0-237)
- Median percent reduction in seizure frequency per 28 days was 56% for XCOPRI group, compared to 22% in placebo group ($p < 0.0001$)

Yielded seizure-free responders³

- 100% response (Seizure free) rate for XCOPRI group was 27.5%, compared to 9.1% in placebo group ($p = 0.0003$) during the maintenance phase

Well-tolerated as adjunctive therapy³

- With 74% TEAEs as mild/moderate and only 4 withdrawals due to AE

Conveniently schedule³

- With once-daily schedule and titration at 2-week intervals



References: 1. Xcopri (Cenobamate) prescribing information, Ignis Therapeutics (HK) Ltd., 2023. 2. Kwan P, et al. Definition of drug resistant epilepsy: Consensus proposal by the ad hoc Task Force of the ILAE Commission on therapeutic strategies, Epilepsia, 2010;51(6):1069-77. 3. Chung SS, et al. Randomized phase 2 study of adjunctive cenobamate in patients with uncontrolled focal seizures, Neurology, 2020;94(22):e2311-e2322. 6. French JA, et al. Long-term safety of adjunctive cenobamate in patients with uncontrolled focal seizures: Open-label extension of a randomized clinical study, Epilepsia, 2021;62(9):2142-2150.

XCOPRI (TABLETS 12.5MG AND 25MG (TITRATION PACK); TABLETS 50MG)

ACTIVE INGREDIENT(S): Cenobamate INDICATION(S): XCOPRI is indicated for the adjunctive treatment of focal-onset seizures with or without secondary generalisation in adult patients with epilepsy who have not been adequately controlled despite a history of treatment with at least 2 anti-epileptic medicinal products. DOSAGE & ADMINISTRATION: The recommended initial dosage of XCOPRI is 12.5 mg once daily, titrated to the recommended maintenance dosage of 200 mg once daily. The recommended titration schedule should not be exceeded. The maximum dosage is 400 mg once daily. CONTRAINDICATIONS: XCOPRI is contraindicated in any patients with known hypersensitivity to the compound or any of the components of the drug product. XCOPRI is contraindicated in patients with Familial Short QT syndrome, SPECIAL WARNINGS & PRECAUTIONS: Suicidal ideation: Suicidal ideation and behaviour have been reported in patients treated with anti-epileptic medicinal products in several indications. A meta-analysis of randomised placebo-controlled trials of anti-epileptic medicinal products has also shown a small increased risk of suicidal ideation and behaviour. The mechanism of this risk is not known, and the available data do not exclude the possibility of an increased risk for cenobamate. Therefore, patients should be monitored for signs of suicidal ideation and behaviours and appropriate treatment should be considered. Patients (and caregivers of patients) should be advised to seek medical advice should signs of suicidal ideation or behaviour emerge. Drug reaction with eosinophilia and systemic symptoms (DRESS): Drug reaction with eosinophilia and systemic symptoms (DRESS), which can be life-threatening or fatal, has been reported in association with cenobamate when started at higher doses and titrated rapidly (weekly or faster titration) (see section 4.8). When cenobamate was initiated at 12.5 mg/day and titrated every two weeks, in an open-label safety study of 1,340 epilepsy patients, no cases of DRESS were reported. At the time of prescription, patients should be advised of the signs and symptoms of DRESS and monitored closely for skin reactions. Symptoms of DRESS include typically, although not exclusively, fever, rash associated with other organ system involvement, lymphadenopathy, liver function tests abnormalities and eosinophilia. It is important to note that early manifestations of hypersensitivity, such as fever or lymphadenopathy, may be present even though rash is not evident. If signs and symptoms suggestive of these reactions appear, cenobamate should be withdrawn immediately and an alternative treatment considered (as appropriate). QT-shortening: A dose-dependent shortening of the QTcF interval has been observed with cenobamate. Reductions of the QTcF interval below 340 msec were not observed (see section 5.1). In clinical trials there was no evidence that the combination of cenobamate with other antiepileptic medicines led to further QT-shortening. Clinicians should use caution when prescribing cenobamate in combination with other medicinal products that are known to shorten the QT. Familial Short QT syndrome is a rare genetic syndrome, which is associated with an increased risk of sudden death and ventricular arrhythmias, particularly ventricular fibrillation. Cenobamate must not be used in patients with Familial Short-QT syndrome (see section 4.3) Contains lactose: Patients with rare hereditary problems such as galactose intolerance, total lactase deficiency or glucose-galactose malabsorption should not take this medicine. SIDE EFFECTS: The most commonly reported adverse reactions were somnolence, dizziness, fatigue and headache. SPECIAL POPULATIONS: Women of childbearing potential and contraception in males and females: Cenobamate is not recommended in women of childbearing potential not using contraception. Women of reproductive potential concomitantly using oral contraceptives should practice additional or alternative non-hormonal measures of birth control during treatment with cenobamate and until 4 weeks after treatment discontinuation (see section 4.5). Pregnancy: Risk related to epilepsy and antiepileptic medicinal products in general: It has been shown that in the offspring of treated women with epilepsy, the prevalence of malformations is two to three times greater than the rate of approximately 3% in the general population. In the treated population, an increase in malformations has been noted with polytherapy, however, the extent to which the treatment and/or the underlying condition is responsible has not been elucidated. Discontinuation of anti-epileptic treatments may result in exacerbation of the disease which could be harmful to the mother and the foetus. Risk related to cenobamate: There are no adequate data from the use of XCOPRI in pregnant women. Animal studies have shown that cenobamate crosses the placenta of rats. Studies in animals have shown reproductive toxicity at levels below clinical exposure (see section 5.3). XCOPRI should not be used during pregnancy unless the clinical condition of the woman requires treatment with cenobamate. Women of childbearing potential must use effective contraception during use of cenobamate and until 4 weeks after treatment discontinuation (see section 4.5). Breast-feeding: It is unknown whether cenobamate or its metabolites are excreted in human milk. Studies in rats showed excretion of cenobamate in the maternal milk (see section 5.3). A risk to the suckling child cannot be excluded. As a precautionary measure, breast-feeding should be discontinued during treatment with XCOPRI. Fertility: The effects of cenobamate on human fertility are unknown. Animal data are insufficient due to exposure below clinical levels (see section 5.3).

PLEASE REFER TO FULL PRESCRIBING INFORMATION BEFORE PRESCRIBING.
XCOPRI aPI ver.1.0



BOWEL PREPARATION

THE INTERNATIONAL STANDARD SOLUTION TO PREPARE EFFECTIVELY AND SAFELY ALL BOWEL CLEANSING PROCEDURES

- ▼ Fortrans® was first marketed in 1987¹
- ▼ Fortrans® is marketed in over 50 countries¹
- ▼ Fortrans®, Made in France²
- ▼ 4 Sachets per box²

MACROGOL 4000
(POLYETHYLENE GLYCOL 4000, PEG 4000)

References: 1. Data on file, 2. Fortrans PI.

Fortrans, powder for oral solution, in sachets – Polyethylene glycol (PEG) 4000 for a sachet of 73.690 g. **Therapeutic Indications:** Cleansing of the colon as bowel prep for patients before: endoscopic and radiological examinations, colonic surgery. Fortrans is indicated only for use in adults. **Dosage and method of administration:** Oral administration – dissolve the contents of the sachet in one litre of water. Stir until the powder is completely dissolved. The dosage is about 1 litre of solution for every 15 to 20 kg of body weight which corresponds to an average dose of 3 to 4 litres. **Method of administration:** the preparation can be taken either as a single dose or as divided doses, as long as the total amount of the prepared solution is fully ingested (average of 3 to 4 litres of solution according to the patient's body weight) : in divided doses : either 2 litres ingested the evening before the procedure and 1 to 2 litres the morning of the procedure, with the last glass being ingested 3 to 4 hours before the procedure, or alternatively, 3 litres ingested the evening before the procedure and 1 litre the morning of the procedure, with the last glass being ingested 3 to 4 hours before the procedure. As a single dose: 3 to 4 litres the evening before the procedure, possibly with a break of one hour after the first 2 litres. The recommended ingestion rate is 1 to 1.5 litres an hour (i.e. 250 ml every 10 to 15 minutes). The doctor may adjust the recommended rate according to the patient's clinical condition and to potential comorbidities. Patients with renal impairment. Insufficient data are available for this population. Pediatric population. The safety and efficacy of FORTTRANS in children aged <18 years has not been established. **Contraindications** Hypersensitivity to the active substances or to any of the excipients. Severe heart failure. Serious deteriorations in general health, such as dehydration. Advanced carcinoma or any other colonic pathology causing excessive mucosal fragility. Acute phases of intestinal tract inflammation including Crohn's disease and ulcerative colitis. Gastrointestinal perforation or risk of perforation. Toxic colitis or toxic megacolon. Patients likely to have or who already have an ileus. Patients likely to have or who already have a gastrointestinal obstruction or stenosis. Gastric emptying disorders (e.g.: gastroparesis, gastric stasis). Children and teenagers under 18 years of age. **Special warnings and precautions for use** This product should be administered to elderly patients in a frail general condition only under medical supervision. Diarrhea provoked by administration of this medication is likely to cause considerable disturbance in the absorption of simultaneously administered drugs. This medicine contains macrogol (polyethylene glycol or PEG). Allergic-type reactions have been reported with preparations based on macrogol: anaphylactic shock, rash, urticaria, angioedema. Although not expected due to the isotonic composition of this product, rare cases of water electrolyte disturbances have been reported in at-risk patients. Patients with pre-existing electrolyte abnormalities should have them corrected before the bowel cleansing solution is administered. This product should also be used with caution in patients with these conditions or in patients treated with medications that may increase the risk of water electrolyte disturbances, including hyponatremia and hypokalemia, or may increase the risk of potential complications (such as patients with altered renal function, cardiac insufficiency, or those being treated concomitantly with diuretics). In this case, patients should be appropriately monitored. The product should be administered carefully and only under attentive supervision in patients with a tendency towards regurgitation, bedridden patients, or those with disturbances in neurological and/or motor function, due to the risk of inhalation. The product should be administered to these patients after first putting them in a sitting position, and possibly even via gastric tube. In patients with cardiac or renal insufficiency, there is a risk of acute pulmonary edema due to fluid overload. This medicine contains sodium. This medicine contains 2,890 g of sodium per sachet. This fact must be taken into account in patients on a strict low-sodium diet. Ischemic colitis. Post-marketing surveillance has revealed that cases of ischemic colitis, some of them serious, have been reported in patients treated with macrogol as part of their bowel preparation. Macrogol should be used with caution in patients with known risk factors for ischemic colitis or if there is concomitant use of stimulant laxatives (such as bisacodyl or sodium picosulfate). Patients presenting with sudden abdominal pain, rectal bleeding, or other symptoms of ischemic colitis should be evaluated promptly. **Adverse effects** Diarrhoea is an expected effect resulting from the use of fortans. Nausea and vomiting have been reported at the start of administration, usually disappearing with continued administration. The table below lists adverse reactions collected from clinical trial data, and adverse events reported from post-marketing sources. The frequency of adverse reactions are as follows: Very common (≥ 1/10), Common (≥ 1/100 to < 1/10), Uncommon (≥ 1/1000 to < 1/100), Rare (≥ 1/10000 to < 1/1000), Very rare (< 1/10000), Unknown frequency (cannot be estimated from the available data). Gastrointestinal disorders: Very common, Nausea, abdominal pain, abdominal distention, Common, Vomiting, Immune system disorders: Unknown, hypersensitivity (such as anaphylactic shock, angioedema, urticaria, rash, pruritis) **Fertility, pregnancy and lactation** **Pregnancy** - There are no data, or a limited amount, relating to the use of FORTTRANS in pregnant women. Animal studies have been insufficient for the purposes of determining whether or not it is a reproductive toxic agent. FORTTRANS should only be used when necessary. **Lactation** - There are no data, or a limited amount, relating to the use of fortans in lactating women. There is no data available for determining whether or not fortans is excreted in human milk. Risk to newborns/infants cannot be excluded. Animal studies have been insufficient for the purposes of determining whether or not it is a reproductive toxic agent. Fortrans should only be used when necessary. **Fertility** - There are no data documenting the effects on fertility with the use of fortans.



Constipated?

Forlax® liberates you with softness

Forlax® 10g is indicated for symptomatic treatment of constipation in adults and children 8 years and above

forlax® 10g
Macrogol 4000



Eating prunes is recommended as one of self-care management interventions to help relieve mild-to-moderate constipation².

Macrogol 4000 undergoes neither gastrointestinal resorption nor biotransformation following oral ingestion

Forlax can be used during pregnancy¹

The effect becomes apparent within 24 to 48 hours after its administration¹

24-48 hours

References: 1. Forlax® Hong Kong prescribing information, 2. Cleveland Clinic, Health Library, Disease & Conditions, Constipation, Available at: <https://my.clevelandclinic.org/health/diseases/4059-constipation> (Accessed June 08, 2021). **PRESENTATION AND FORM** Powder for oral solution, Box of 10 or 20 sachets. **THERAPEUTIC INDICATION** FORLAX® 10g is indicated in symptomatic treatment of constipation in adults and children aged 8 years and above. An organic disorder should have been ruled out before initiation of treatment. FORLAX® 10g should remain a temporary adjuvant treatment to appropriate lifestyle and dietary management of constipation, with a maximum 3-months treatment course in children. If symptoms persist despite associated dietary measures, an underlying cause should be suspected and treated. **DOSAGE AND ADMINISTRATION** The dosage is 1 to 2 sachets per day. The content of each sachet must be dissolved in a glass of water for oral consumption. The effect of FORLAX® becomes apparent within 24 to 48 hours after its administration. In children, treatment should not exceed 3 months. Treatment induced restoration of bowel movement will be maintained by lifestyle and dietary measures. In all cases, you must strictly comply with your doctor's prescription or your pharmacist's advice. **CONTRAINDICATIONS** Severe inflammatory bowel disease (ulcerative colitis, Crohn's disease), toxic mega colon, perforation or risk of perforation, ileus or suspicion of intestinal obstruction or symptomatic stenosis, painful abdominal syndromes of undetermined reason, and known hypersensitivity to FORLAX® or to one of the components. Due to the presence of sorbitol (traces), this medicine is contraindicated in persons who are intolerant to fructose. **DRUG INTERACTIONS AND OTHER INTERACTIONS** FORLAX® may interfere with the absorption of other drugs if administered simultaneously. Generally, it is better to take FORLAX® at least 2 hours apart from other products. **ADVERSE EFFECTS** Adverse Drug Reactions are listed under headings of frequency using the following categories: 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); unknown (cannot be estimated from the available data). Adult population: The undesirable effects listed below have been reported during clinical trials (including 600 adult patients) and post-marketing use. Generally, adverse reactions have been minor and transitory and have mainly concerned the gastrointestinal system. **Adverse reactions: Gastrointestinal disorders** (Common) Abdominal pain and/or distension, Diarrhoea, Nausea (Uncommon) Vomiting, Urgency to defecate, Fecal incontinence **Metabolism and Nutrition Disorders** (Unknown) Electrolytes disorders (Hyponatremia, Hypokalaemia) and/or dehydration, especially in elderly patients **Immune system disorders** (Very rare) Hypersensitivity reactions (Pruritus, Rash, Face oedema, Quincke oedema, Urticaria, Anaphylactic shock) **Paediatric population:** The undesirable effects listed below have been reported during clinical trials including 147 children aged from 6 months to 15 years and post-marketing use. As in adult population, adverse reactions have generally been minor and transitory and have mainly concerned the gastrointestinal system. **Adverse reactions: Gastrointestinal disorders** (Common) Abdominal pain, Diarrhoea (Uncommon) Vomiting, Bloating, Nausea Immune system disorders (Unknown) Hypersensitivity reactions **STORAGE CONDITIONS AND SHELF LIFE** To be stored below 25°C. Do not exceed the expiry date plainly indicated on the pack. Keep out of reach of children **Country of origin:** France

LASTING CHANGE* IS ACHIEVABLE

DUPIXENT® is the first and only biologic that achieves long-lasting change* in patients with atopic dermatitis (AD) as young as 6 months^{1-7†}

6+
MONTHS
OF AGE

RAPID & SUSTAINED CONTROL AFTER THE FIRST DOSE

- » Sustained[‡] improvement of itch, skin clearance and QoL up to 52 weeks, with rapid control after the first dose^{1-6§}

BROAD RANGE OF USAGE

- » Approved in patients as young as 6 months of age^{4,5}

UNIQUE LONG-TERM SAFETY PROFILE[‡]

- The only AD biologic therapy
- » With 156 weeks safety profile in children aged 6 months⁸ to 5 year consistently with that seen in adults and adolescents^{4,5}
- » Consistent safety profile for those aged 6 to 12 up to 52 weeks¹

START WITH EASE, STAY WITH CONFIDENCE

- » DUXIPENT® is not an immunodepressant^{4,5}
- » 85% patient satisfaction with DUXIPENT® treatment at 1 year^{9¶}

*Sustained improvement of itch, skin clearance and QoL up to 52 weeks, with rapid control after first dose.

† DUXIPENT® is indicated for the treatment of moderate-to-severe atopic dermatitis in adults and adolescents 12 years and older who are candidates for systemic therapy. DUXIPENT® is indicated for the treatment of severe atopic dermatitis in children 6 months to 11 years old who are candidates for systemic therapy.^{4,5}

‡ Real World Data (EASI, POEM, DLQI) of up to 84 weeks.⁷

§ Peak pruritus NRS score improvement ≥4 points from baseline at week 2.

¶ The most common adverse reactions in atopic dermatitis are injection site reactions (includes erythema, oedema, pruritus, pain and swelling), conjunctivitis, conjunctivitis allergic, arthralgia, oral herpes, and eosinophilia.^{4,5}

‡ In adult patients with AD.

Abbreviations: AD, atopic dermatitis; DLQI, Dermatology Life Quality Index; EASI, Eczema Area and Severity Index; NRS, numerical rating scale; POEM, Patient Oriented Eczema Measure; QoL, quality of life.

References: 1. Cork MJ, et al. Br J Dermatol. Rev. 2021;184:857–858. 2. Wollenberg A, et al. Acta Derm Venereol. 2022;102:adv0. 3. Blauvelt A, et al. Am J Clin Dermatol. 2022 May;23(3):365-383. 4. DUXIPENT 200 mg Hong Kong Prescribing Information. 5. DUXIPENT 300 mg Hong Kong Prescribing Information. 6. Blauvelt A et al. Lancet. 2017;389(10086):2287–2303. 7. Bosma AL et al. J Am Acad Dermatol. 2020;83:1375–84. 8. Paller AS, et al. Br J Dermatol. 2023 Jun;188(Supplement_3). 9. Strober B et al. JAMA Dermatol. 2022;158(2):142-150.

DUPIXENT Abbreviated Prescribing Information

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 months 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. In children 6 to 11 years old 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 medium to high dose ICS plus another medicinal product for maintenance treatment. For 300 mg only – Chronic rhinosinusitis with nasal polyps (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. Prurigo Nodularis (PN): Moderate-to-severe PN in adults who are candidates for systemic therapy. Eosinophilic esophagitis (EoE): In adults and adolescents ≥12 years, weighing ≥40 kg, who are inadequately controlled by, are intolerant to, or who are not candidates for conventional medicinal therapy. **Dosage & Administration:** Subcutaneous injection. AD adults: Initial dose of 600 mg (two 300 mg injections), followed by 300 mg Q2W. AD adolescents (12–17y/o): Body weight <60 kg: initial dose of 400 mg (two 200 mg injections), followed by 200 mg Q2W. Body weight ≥60 kg: same dosage as adults. AD children (6–11y/o): Body weight 15kg–<60 kg: initial dose of 300 mg on Day 1 followed by 300 mg Q2W. 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. AD children (6 months–5y/o): Body weight 5kg–<15 kg: initial dose of 200 mg, then 200 mg Q4W. Body weight 15kg–<30 kg: initial dose of 300 mg, then 300 mg Q4W. 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. Asthma adults and adolescents: Initial dose of 400 mg, followed by 200 mg Q2W. 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 Q2W. Asthma children (6–11y/o): Body weight 15kg–<30 kg: 300 mg Q4W. Body weight 30kg–<60 kg: 200 mg Q2W; or 300 mg Q4W. Body weight ≥60 kg: 200 mg Q2W. For paediatric patients (6–11y/o) with asthma and co-morbid severe atopic dermatitis, as per approved indication, the recommended dose should follow AD children (6–11y/o). Patients receiving concomitant oral corticosteroids may reduce steroid dose gradually once clinical improvement with dupilumab has occurred. The need for continued dupilumab therapy should be considered at least annually as determined by a physician. CRSWNP: Initial dose of 300 mg, followed by 300 mg Q2W. Consider discontinuing treatment in patients who have shown no response after 24 weeks. EoE: Initial dose of 600 mg (two 300 mg injections), followed by 300 mg Q2W. Dupilumab can be used with or without topical corticosteroids. Consider discontinuing treatment in patients who have shown no response after 24 weeks. FeNO: 300 mg QW. Dupilumab 300 mg QW has not been studied in patients with EoE weighing <40 kg. Dosing beyond 52 weeks has not been studied. **For Missed dose instructions, please refer to the full prescribing information.** **Contraindications:** Hypersensitivity to dupilumab or any of the excipients. **Precautions:** Not to 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. Cases of enterobiasis were reported in children 6 to 11 years old in the paediatric asthma development program. Advise patients to promptly report new onset or worsening eye symptoms. Patients who develop conjunctivitis, dry eye and keratitis that does not resolve following standard treatment should undergo ophthalmological examination. Sudden changes in vision or significant eye pain that does not settle warrant urgent review. Patients with comorbid asthma should not adjust or stop asthma treatments without consultation with physicians. Carefully monitor patients after discontinuation of dupilumab. Avoid using 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 TdP 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, conjunctivitis allergic, arthralgia, oral herpes, eosinophilia and injection site bruising. Safety profile observed in adolescents and children 6 months to 11 years old 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.** APHKK-DUP-23.10

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Atopic Dermatitis (AD)

- Moderate-to-severe AD in adults and adolescents ≥12 years old[†]
- Severe AD in children 6 months to 11 years old[†]



Asthma

- In adults and adolescents ≥12 years old as add-on maintenance treatment for severe asthma with Type 2 inflammation*
- In children 6 to 11 years old as add-on maintenance treatment for severe asthma with Type 2 inflammation[^]



Chronic rhinosinusitis with nasal polyposis (CRSwNP)

- As an add-on therapy with intranasal corticosteroids for the treatment of adults with severe CRSwNP[#]



Prurigo Nodularis (PN)

- Moderate-to-severe PN in adults who are candidates for systemic therapy



Eosinophilic Esophagitis (EoE)

- In adults and adolescents ≥12 years old weighing ≥40 kg[†]

[†] Candidates for systemic therapy

* Characterised by raised blood eosinophils and/or raised FeNO, who are inadequately controlled with high dose ICS plus another medicinal product for maintenance treatment.

[^] Characterised by raised blood eosinophils and/or raised FeNO, who are inadequately controlled with medium to high dose ICS plus another medicinal product for maintenance treatment.

[#] For whom therapy with systemic corticosteroids and/or surgery do not provide adequate disease control.

[†] Those who are inadequately controlled by, are intolerant to, or who are not candidates for conventional medicinal therapy.

Abbreviations: AD=atopic dermatitis; CRSwNP= chronic rhinosinusitis with nasal polyposis; EoE= eosinophilic esophagitis; FeNO=fractional exhaled nitric oxide; ICS=inhaled corticosteroids; PN=prurigo nodularis.

References:

1. Guttman-Yassky E, et al. J Allergy Clin Immunol. 2019;143(1):155-172. 2. Gandhi NA, et al. Nat Rev Drug Discov. 2016;15(1):35-50 3. DUPIXENT® Hong Kong Prescribing Information

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 months 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. In children 6 to 11 years old 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 medium to high dose ICS plus another medicinal product for maintenance treatment. For 300 mg only – 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. Prurigo Nodularis (PN): Moderate-to-severe PN in adults who are candidates for systemic therapy. Eosinophilic esophagitis (EoE): In adults and adolescents ≥12 years, weighing ≥40 kg, who are inadequately controlled by, are intolerant to, or who are not candidates for conventional medicinal therapy. **Dosage & Administration:** Subcutaneous injection. AD adults: Initial dose of 600 mg (two 300 mg injections), followed by 300 mg Q2W. AD adolescents (12-17y/o): Body weight <60 kg- initial dose of 400 mg (two 200 mg injections), followed by 200 mg Q2W. Body weight ≥60 kg- same dosage as adults. AD children (6-11y/o): Body weight 15kg–<60 kg- initial dose of 300 mg on Day 1 follow by 300 mg on Day 15, then 300mg Q4W. 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. AD children (6 months-5y/o): Body weight 5kg–<15 kg- initial dose of 200 mg, then 200 mg Q4W. Body weight 15kg–<30 kg- initial dose of 300 mg, then 300 mg Q4W. 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. Asthma adults and adolescents: Initial dose of 400 mg, followed by 200 mg Q2W. 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 Q2W. Asthma children (6-11y/o): Body weight 15kg–<30 kg- 300 mg Q4W. 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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 allergic, arthralgia, oral herpes, eosinophilia and injection site bruising. Safety profile observed in adolescents and children 6 months to 11 years old consistent with that seen in adults. 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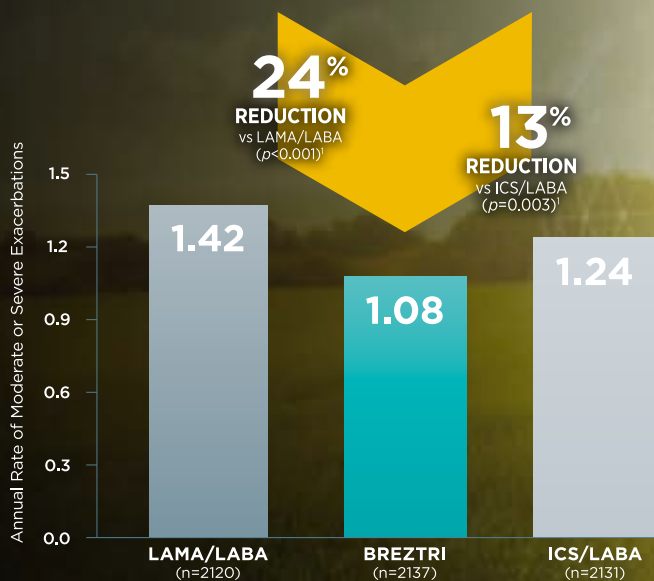
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(budesonide, glycopyrronium, and
formoterol fumarate) Inhalation Suspension

BREZTRI significantly reduces the rate of moderate or severe exacerbations vs both LAMA/LABA and ICS/LABA¹



BREZTRI is indicated as a maintenance treatment in adult patients with moderate to severe chronic obstructive pulmonary disease who are not adequately treated by a combination of an inhaled corticosteroid and a long-acting beta₂-agonist or combination of a long-acting beta₂-agonist and a long-acting muscarinic antagonist.²

The most commonly reported adverse reactions in patients receiving this medicinal product were pneumonia (4.6%), headache (2.7%), and urinary tract infection (2.7%).²

Study Design:

ETHOS is a 52-week, phase 3, randomized trial to evaluate the efficacy and safety of triple therapy at two dose levels of inhaled glucocorticoid in patients with moderate-to-very-severe COPD and at least one exacerbation in the past year. 8,588 patients were assigned in a 1:1:1 ratio to receive twice-daily inhaled doses of triple therapy (inhaled glucocorticoid [320 µg or 160 µg of budesonide], a LAMA [18 µg of glycopyrronium], and a LABA [9.6 µg of formoterol]) or one of two dual therapies (18 µg of glycopyrronium plus 9.6 µg of formoterol or 320 µg of budesonide plus 9.6 µg of formoterol). The primary end point was the annual rate (the estimated mean number per patient per year) of moderate or severe COPD exacerbations, as analyzed in the modified intention-to-treat population with the use of on-treatment data only.

Budesonide/glycopyrronium/formoterol fumarate dihydrate 160/14.4/10µg is not an approved dose.

In the clinical trial programme for BREZTRI, inhaled corticosteroid (ICS)/long-acting beta₂-agonist (LABA) refers to budesonide/formoterol fumarate, and long-acting muscarinic antagonist (LAMA)/LABA refers to glycopyrronium/formoterol fumarate.

COPD, chronic obstructive pulmonary disease; ICS, inhaled corticosteroid; LABA, long-acting beta₂-agonist; LAMA, long-acting muscarinic antagonist.

References: 1. Rabe KF, et al. N Engl J Med. 2020;383:35-48. 2. Breztri Aerosphere. Hong Kong Summary of Product Characteristics. Version Oct 2022.

ABBREVIATED PRESCRIBING INFORMATION

Presentation: Aerosphere pressurised inhalation, suspension budesonide 160µg/glycopyrronium 7.2µg/formoterol fumarate dihydrate 5µg per inhalation. **Indications:** As a maintenance treatment in adult patients with moderate to severe chronic obstructive pulmonary disease (COPD) who are not adequately treated by a combination of an inhaled corticosteroid and a long-acting beta₂-agonist or combination of a long-acting beta₂-agonist and a long-acting muscarinic antagonist. **Dosage:** Two inhalations twice daily (two inhalations in the morning and two inhalations in the evening). **Contraindications:** Hypersensitivity to the active substances, norflurane, 1,2-distearoyl-sn-glycero-3-phosphocholine, calcium chloride. **Precautions:** Not for acute use. Should be discontinued immediately if paradoxical bronchospasm occurs. It is recommended that treatment should not be stopped abruptly. Caution in patients with clinically significant uncontrolled and severe cardiovascular disease. Potential systemic effects of inhaled corticosteroid. Particular care is needed in patients transferring from oral steroids. Increase in the incidence of pneumonia in patients with COPD. Risk in visual disturbance, hypokalaemia, hyperglycaemia. Used with caution in patients with thyrotoxicosis, symptomatic prostatic hyperplasia, urinary retention or with narrow-angle glaucoma, severe renal impairment and severe hepatic impairment. Co-administration with other anticholinergic is not recommended. No or limited data on pregnancy, breast-feeding & fertility. **Interactions:** Strong CYP3A inhibitors, itraconazole, cimetidine, not recommended other anticholinergic and/or long-acting B2-adrenergic agonist. Other beta-adrenergic, xanthine derivatives, steroids and non-potassium sparing diuretics, β-adrenergic blockers, quinidine, disopyramide, procainamide, antihistamines, monoamine oxidase inhibitors, tricyclic antidepressants, phenothiazines, L-dopa, L-thyroxine, oxytocin and alcohol. **Undesirable effects:** Pneumonia, headache, urinary tract infection, oral candidiasis, hyperglycaemia, anxiety, insomnia, palpitations, dysphonia, cough, nausea, muscle spasms. **Full local prescribing information is available upon request.** APLHK.BRE.1022

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Intended for healthcare professionals.

■ ABSTRACTS

Prof HU Ying-lian

*Professor, Department of Social & Ecological Civilization of China,
National Academy of Governance*



HU Ying-lian is a professor and teaching secretary at the Department of Social & Ecological Civilization of China National Academy of Governance, where he conducts research on social governance, government regulation and healthcare policy. He got a bachelor's degree in law from Tsinghua University and studied at the University of Hong Kong as an exchange student for half a year. He has published three monographs and more than 40 articles in CSSCI and SCI journals. His research is funded by China National Office for Philosophy and Social Sciences and other prestigious institutes. In 2021, he was awarded of National Youth Talent Program. He serves as a youth fellow of the China Public Administrative Society and is a major draftsman of the Vaccine Administration Law of the People's Republic of China.

■ Healthcare Reform in Modern China: Challenges and Opportunities

1. Chinese-Style Modernization and Healthy China

- Huge population size, emphasizing both medical care and public health
- Common prosperity, basic medical and health system and services
- Coordination of material and spiritual civilization, physical and mental health
- Harmony between humans and nature, traditional Chinese medicine and ethnic medicine
- Peaceful development path, human health and wellness community

2. Challenges Facing Our Healthcare System

- Temporal Dimension: Healthcare reform process since the Reform and Opening-Up
- Structural Dimension: Medical and health service levels between urban and rural areas, regions, and groups
- Supply-Demand Dimension: Coordination of "Three Medicines" (medical care, medical insurance, and pharmaceuticals)
- Production and Management Dimension: Quantity safety, quality safety, and industrial safety

3. Blueprint Outlined by the 20th National Congress of the Communist Party and the 20th Central Committee's Third Plenary Session

- Implement the strategy of prioritising health development and improve the public health system
- Promote coordinated development and governance of medical care, medical insurance, and pharmaceuticals
- Facilitate the expansion and regional balanced distribution of high-quality medical resources
- Deepen the reform of public hospitals with a public welfare orientation
- Improve the mechanisms supporting the development of innovative drugs and medical devices

4. Potential Opportunities

- Commercial health insurance
- Specialised medical services
- Innovative drug supply

■ ABSTRACTS

Dr Gray Chi-wang CHAN

*PhD; The University of Hong Kong
MBBS; University College London
B.Sc. Pharmacology; University College London
Honorary Clinical Assistant Professor, HKU*



Dr Gary CHAN is an Associate Consultant and Honorary Clinical Assistant Professor from the Department of Medicine at Queen Mary Hospital and University of Hong Kong School of Clinical Medicine. He obtained his Bachelor of Medicine and Surgery from University College London and his PhD from the University of Hong Kong. He is the Training Programme Director for Nephrology at Queen Mary Hospital and currently serves as chair and deputy chair for the Hong Kong Society of Nephrology Scientific Committee and the Asian Pacific Society of Nephrology CME Committee.

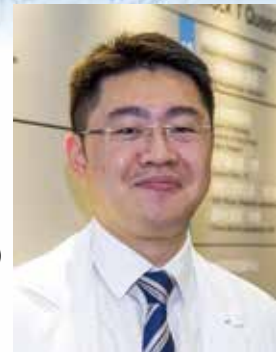
■ **Therapeutic Pillars of Diabetic Kidney Disease: Advances in Management**

The burden of diabetes mellitus is rapidly rising, and diabetic kidney disease (DKD) has become more and more prevalent. The aim of this presentation is to review the available pharmacological armamentaria for DKD with an emphasis on recent advances in the field.

■ ABSTRACTS

Dr Chris Kam-wa CHAN

MD, Guangzhou University of Chinese Medicine
PhD, Department of Medicine, HKU
Master of Chinese Medicine, HK Baptist University
MSc Public Health, London School of Hygiene & Tropical Medicine, U Lond (London-based)
Bachelor of Chinese Medicine & BSc in Biomedical Science (1st), HK Baptist University
Assistant Professor, School of Chinese Medicine, HK Baptist University



Chris is currently the Assistant Professor of the School of Chinese Medicine, HK Baptist University. He is the designer and coordinator of multiple clinical trials, cohorts and biobank which showed that **1) rehmannia-6-based add-on Chinese medicine treatment and 2) astragalus reduces kidney function decline in diabetes, 3) add-on Chinese medicine was associated with significant mortality reduction in hospitalised COVID, and 4) add-on Chinese medicine was associated with reduced mortality in hospitalised acute exacerbated chronic obstructive pulmonary disease.** Chris also showed that selective endothelin A receptor antagonist **atrasentan was associated with less pain events and reduced use of analgesics** in patients with type 2 diabetes and chronic kidney disease by using the SONAR trial. These findings were published in *Kidney Int*, *Clin J Am Soc Nephrol*, *Phytomedicine*, *Am J Chin Med*, etc. He is also a sub-investigator of a multi-national Chinese medicine industrial clinical trial.

Chris received clinical Chinese medicine training from the HKBU (BCM&BSc, MCM), Tung Wah Group of Hospitals (clinical training) and Guangzhou University of Chinese Medicine (MD); clinical epidemiology, personalized medicine, internal medicine and basic science training from the London School of Hygiene & Tropical Medicine (MSc Public Health), University Medical Center Groningen (overseas training), Queen Mary Hospital and HKU (PhD). He received 23 awards (8 research related), including 2 international awards. Chris has served for Tung Wah Group of Hospitals, Hospital Authority, World Health Organization and KPMG Advisory on clinical medicine, health administration, medical research and healthcare policy previously.

■ Evidence-based Management of Diabetic Kidney Disease with Chinese Medicine

Diabetes contributed to more than 10,000 inpatient cases, accounting for over 1 % of all registered deaths in Hong Kong. The prevalence of diabetes mellitus is over 8 %, of which one-third were previously unknown.

Adults with prediabetes have a lifetime risk of 88 % developing diabetes. Some well-used functional food has an antihyperglycemic effect. A late-breaking clinical trial showed that the early use of Chinese medicine can reduce the risk of developing into diabetes.

In retrospective cohorts based on the Taiwan insurance data, the use of Chinese medicine was associated with reduced hazard of mortality and kidney failure in patients with chronic kidney disease. Recent clinical trials showed that Rehmannia-based Chinese medicine treatment and astragalus stabilised kidney function on top of conventional regimens. Further post-hoc analysis showed that the insulin resistance and TNF receptor two levels were lower with rehmannia-based Chinese medicine. These studies suggested that Chinese medicine is effective in managing diabetes on top of the current treatment.

■ ABSTRACTS

Dr Charles Walter LYNDE

Staff Dermatologist, Toronto Western Hospital



Degrees

M.D. University of Toronto – Toronto, Ontario 1975 – 1978

Graduated cum laude

B.Sc. (Honours) University of Toronto – Toronto, Ontario 1971 – 1975

Graduated cum laude

Current Employment & Positions

Associate Investigator Probit Medical Research, Dermatology - Waterloo, 2015 - Present

Ontario, Consultant Canadian Psoriasis Network Committee - Toronto, 2013 - Present

Ontario, Associate Professor Department of Medicine, University of Toronto 2012 - Present

- Toronto, Ontario, Consultant Department of Medicine, Markham Stouffville Hospital 1990 - Present

- Markham, Ontario, President, Lead Lynde Institute for Dermatology – Markham, Ontario 1988 - Present

Dermatologist, Investigator Lynderm Research Inc. – Markham, Ontario 1985 – Present

Clinic Director Dermatology Clinic, University of Toronto – Toronto, 1985 - Present

Ontario, Consultant Department of Medicine, Scarborough Grace Hospital 1985 – Present

- Scarborough, Ontario

Associate Professor University of Toronto - Toronto, Ontario 1983 - Present

Consultant Metropolitan Homes for the Aged – Toronto, Ontario 1983 - Present

Clinical Staff Department of Medicine (Dermatology), Toronto Western 1983 Present

Hospital - Toronto, Ontario

■ Novel Approaches for Optimising Outcomes of Moderate-to-Severe Atopic Dermatitis: JAK Inhibition

Atopic dermatitis (AD) is a common, chronic, inflammatory disease that manifests primarily in the skin. However, the disease-related physical and biopsychosocial burdens of this condition could have a substantial effect on patients' quality of life, particularly in those with moderate-to-severe disease severity.

A better understanding of disease aetiology has supported the development of new approaches to disease characterization and targeted therapies. As a result, after the biological therapy, oral janus kinase inhibitors (JAKi) are recently developed to control the signs and symptoms of AD through immunomodulation. With the emergence of novel therapies, patients with difficult-to-treat atopic dermatitis also benefit from updates on the latest clinical trial data and practical recommendations on how to translate those results into daily clinical decision-making.

In the lecture, the latest published evidence of JAK inhibition will be reviewed e overall outcome and convey the clinical experience in managing patients with moderate-to-severe disease.

■ ABSTRACTS

Dr WONG Lai-san

MD, Kaohsiung Medical University, Taiwan
Dermatologist, Department of Dermatology, Chang Gung Memorial Hospital,
Kaohsiung Medical Centre



Dr WONG is a distinguished dermatologist with an MD from Kaohsiung Medical University, Taiwan, obtained in 2008. She began her medical career as a Practitioner in General Medicine in Taiwan and Macao, later specialising in dermatology, earning her certification in 2013 and Ministry of Education as certified Assistant Professor in 2019. Dr Wong completed her residency in Internal Medicine at Chi Mei Medical Center, followed by a residency in Dermatology at Chang Gung Memorial Hospital-Kaohsiung Medical Center. Since July 2013, she has served as an Attending Physician in the Department of Dermatology at the same institution. In July 2023, she was appointed Chair of the Aesthetic Medical Center, where she continues to advance dermatological care and aesthetics while also contributing to medical education as a certified Assistant Professor.

Dr WONG is an accomplished dermatologist with a strong research background, including a fellowship at the Dermatological Department of Kyoto University in Japan from 2014 to 2015. She has received numerous honors and awards throughout her career, such as the Best Intern Award from Linkou Chang Gung Memorial Hospital in 2008 and the Poster Prize at the Taiwanese Dermatological Association Spring Meeting in 2012. Her contributions to the field have been recognised with travel awards from the European Society of Dermatological Research and scholarships from the Psoriasis International Network. In 2019, she earned the Diploma of Dermatological Scientist from the Japan Society of Investigative Dermatology, and in 2022, she received the La Roche-Posay Research Grants "Publication Prize." Most recently, she was awarded the Best Net Letter Award by the Indian Journal of Dermatology, Venereology, and Leprology in 2024, as well as the Gold Medical Award at the research poster competition held by the College of Medicine at National Sun Yat-Sen University. Dr WONG's scientific interests focus on itchy dermatosis and skin barrier function, reflecting her commitment to advancing dermatological research and patient care.

■ New Horizons in the Management of AD from Infancy to Adulthood: Safety and Efficacy

Atopic dermatitis (AD) is a chronic inflammatory skin condition characterised by dry, itchy, and scaly erythematous patches on the skin. The disease burden of AD is significant and affecting their quality of life, sleep, and mental health.

Dupilumab is a monoclonal antibody that targets interleukin-4 (IL-4) and interleukin-13 (IL-13), two key cytokines involved in the pathogenesis of atopic dermatitis. In March 2017, FDA first approved dupilumab for moderate-to-severe atopic dermatitis in adults. March 2023, European Union (EU) approved dupilumab for the treatment of severe atopic dermatitis in children 6 months to 5 years who are candidates for systemic therapy, making it the first and only targeted medicine indicated to treat these young children in Europe and the U.S.

The presentation aims to offer insights into the evolving landscape of AD management, stressing the significance of safety, efficacy, and patient-centred care across different age groups, from infancy to adulthood. The session will discuss the disease burden as well as best practices for disease management at different stages to show how dupilumab helps patients and their caregivers resume their normal lives.

■ ABSTRACTS

Dr Alson Wai-ming CHAN

*FHKAM(Paed), FHKCPaed, FRCPCH, DCH(Ireland), Dip Ger Med RCPS(Glasg),
PDipCmmunityGeriatrics(HK), MBChB
First Fellow, Subspecialty of Paediatric Immunology,
Allergy & Infectious Diseases,
Specialist in Paediatric Immunology, Allergy and Infectious Diseases
Hon Secretary, The Federation of Medical Societies of Hong Kong*



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

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

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

■ Myths & Truth about Allergy Diagnostics

Medical technology in allergy diagnostics has been rapidly advancing in the past few years. Nowadays, the allergy tests available for clinical usage are much more precise down to the molecular level. Clinical applications of the latest allergy diagnostic tests will be discussed, including the introduction of component-resolved diagnostics.

■ ABSTRACTS

Ms Sabrina Wing-shan MOK

*APD(Australia), Dietitian in Accredited Register(HKSAR)
BSc(Nutrition)(Hons), MA(Psychology)
Dietitian, Hong Kong Sanatorium & Hospital
Vice-chairman, Hong Kong Dietitians Association
Member of Expert Panel on Reference Frameworks, Health Bureau, HKSAR Government
Member of Promotion of Breastfeeding Committee, Health Bureau, HKSAR Government*



Sabrina MOK is a clinical dietitian working in the Lee Tak Hong Allergy Centre of the Hong Kong Sanatorium & Hospital and is dedicated to food allergy management and nutrition and dietetics promotion. As the vice-chairman of Hong Kong Dietitians Association, she also actively promotes the professional development of dietetic practices in Hong Kong. She is a member of the Hong Kong Allergy Alliance, and is part of the "Committee on Promotion of Breastfeeding" and "Expert Panel on Reference Frameworks" of the Health Bureau, HKSAR government.

■ **Early Intervention & Desensitisation Programme for Food Allergy**

Can you imagine how multiple food avoidance and the potential threat from accidental exposure could affect the lives of those with food allergy? In this presentation, Sabrina will talk about the latest evidence on food allergy treatments, including a comprehensive approach to managing food allergy, from egg and milk ladders to different food immunotherapies. She will share her experience with allergists on how early intervention with paediatric cases might help build tolerance to the allergens, prevent accidental exposure, and promote normalized diets and quality of life.

■ ABSTRACTS

Prof Merlin THOMAS

*MBChB with Distinction (University of Otago, Dunedin, New Zealand)
Fellow of the Australasian College of Physicians (FRACP)
Specialist Licensure (Nephrology & Endocrinology)
PhD (University of Melbourne, Australia)
Fellow of the Australian Academy of Health and Medical Science
Professor and Program Leader, Department of Diabetes,
School of Translational Medicine, Monash University
Chief Scientific Officer, RAGE Biotech Pty Ltd*



Professor Merlin THOMAS is a clinician scientist and program leader in the Department of Diabetes at Monash University. He is also founder and Chief Scientific Officer of RAGE Biotech Ltd that is commercialising his discoveries. Dr Thomas is renowned as a researcher, educator and medical storyteller with over 300 peer-reviewed publications, as well as author of best selling books, "The Longevity List" and "Fast Living Slow Ageing". He is also recognised as a Fellow of the Australian Academy of Health Medical Science. His research program is focused on understanding the mechanisms of diabetic complications and developing new opportunities for their prevention and treatment.

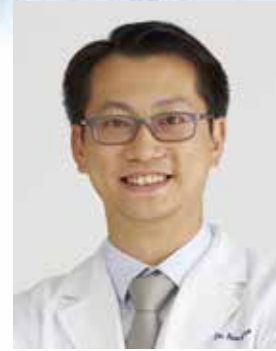
■ From Good to Great – Revolutionising the Management of Diabetic Complications with SGLT2 Inhibitors

The holistic management of patients with type 2 diabetes requires more than optimal glycemic control. Over the last 25 years, it has become apparent that intensive glucose control alone does not significantly reduce morbidity and premature mortality in patients with type 2 diabetes. Alternatively, there is now unequivocal evidence that SGLT2 inhibitors have benefits in people with type 2 diabetes beyond improving their glucose control. Together, these findings have reshaped the modern approach to managing patients with type 2 diabetes. Glucose control remains a pillar of care, along with weight loss and lipid and blood pressure control. Still, the central pillar is now organ protection, delivered by the early use of agents demonstrated to reduce the risk of hard clinical outcomes in randomised clinical trials. As the key future risks of a patient with type 2 diabetes include cardiovascular disease, heart failure and kidney disease, the prevention and management of these risks is now centre stage. In particular, there is now precise data showing that treatment of people with type 2 diabetes with SGLT2 inhibitors can reduce the incidence of kidney disease, slow the rate of decline in kidney function and reduce the risk of kidney failure requiring costly dialysis or transplantation. Global KDIGO guidelines now recommend all people with type 2 diabetes and CKD should be treated with an SGLT2 inhibitor as the new standard of care, alongside a high potency statin (to lower their CV risk), blockade of the renin-angiotensin system (for blood pressure and heart failure risk), and optimal glucose control. However, the broader utility of foundational therapy with an SGLT2 inhibitor in T2D before kidney function becomes impaired should also be considered, with real-world data suggesting beneficial effects in patients without elevated albuminuria or a reduced eGFR. If patients with type 2 diabetes could be healthy and out of the hospital, not need dialysis or transplantation, the potential cost saving would be far more significant than proactive early intervention with an SGLT2i. This lecture aims to equip healthcare professionals with the knowledge and tools necessary to revolutionise their management of diabetic complications and enhance patient outcomes.

■ ABSTRACTS

Dr Ken Ka-pang CHAN

*Specialist in Respiratory Medicine
Department of Medicine & Therapeutics,
Faculty of Medicine, CUHK*



Dr Ken KP CHAN is a respiratory specialist interested in pleural medicine, respiratory infection and airway diseases. Dr CHAN received general respiratory training at Prince of Wales Hospital and further sub-specialised training in pleural medicine at Sir Charles Gairdner Hospital, Australia. Dr CHAN has received grants for developing new diagnostic strategies in pleural effusions, studying the local burden of respiratory infections and optimizing the care of airway diseases. Through this research, he endeavours to optimise patient outcomes by improving the standard of clinical care and promoting the public understanding of these diseases.

■ Cardiopulmonary Risk in COPD

COPD remains a significant global healthcare burden. Patients with COPD have a higher risk of mortality due to COPD exacerbation and cardiovascular events.

COPD and cardiovascular events are closely related. Abundant evidence has revealed that patients with COPD have a higher risk of having cardiovascular conditions than those without COPD. In addition, patients with COPD also have a higher incidence of cardiovascular events shortly following exacerbation episodes. Systemic inflammation, hyperinflation and hypoxaemia in COPD are potential mediators of these adverse outcomes in the complex crosstalk within the cardiopulmonary system.

COPD can be a modifiable risk factor for cardiovascular disease. Therefore, the management of COPD should be appropriately optimised to reduce the risk of exacerbations, thereby helping to lower the risk of cardiopulmonary events and premature mortality. Pharmacological treatment is pivotal in reducing the risk of COPD exacerbation, which can also mitigate the increased cardiovascular risk. Long-acting bronchodilator therapy, and using inhaled corticosteroids appropriately in eligible patients, can reduce the risk of exacerbation, hospitalisation events, and all-cause and cardiovascular risk.

The lecture will explain the relationship between COPD and cardiovascular risk and how optimising COPD treatment could improve respiratory and cardiovascular outcomes in patients with COPD.

■ ABSTRACTS

Dr Raymond See-kit LO

MBBS(Lond), MD(CUHK), MHA(UNSW), Dip Geri Med(RCPS),
Dip Palliative Med(U Wales), MRCP(UK), FRCP(Lond, Edin, Glas), FHKCP, FHKAM
Specialist in Geriatrics Medicine
Honorary Clinical Professor, Department of Medicine and Therapeutics,
The Chinese University of Hong Kong
Honorary President, Federation of the Medical Societies of Hong Kong
President, British Medical Association(Hong Kong)



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

Dr LO is the Honorary President, Past President of the Federation of Medical Societies of Hong Kong, and 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 the British Medical Association (Hong Kong), expediting various activities, including the popular annual BMA(HK) Advance in Therapeutics Course.

Dr Raymond LO's clinical and research interests range from prevention and rehabilitation to palliation in various conditions of adults and older people, e.g. dementia screening and management, stroke prevention and rehabilitation, orthogeriatric condition and pain management, and palliative care for all ages.

■ Advances in the Screening and Management of Dementia

Dementia is a global health crisis with an ageing population worldwide. Previously, the treatment of dementia was only symptomatic, and diagnosis is often by clinical assessment only. Breakthrough advances have been seen very recently with the emergence of blood and fluid biomarkers made available for more accurate testing and monoclonal antibodies treatment showing clinical effects in slowing down cognitive and functional decline for patients at mild cognitive impairment and early dementia stage. This necessitates a shift in paradigm for early diagnosis, incorporating biological staging into clinical staging for earlier detection of patients who can benefit from treatment. Brain imaging using magnetic resonance with volumetric analysis and Positron Emission Tomography detecting amyloid and Tau proteins have also aided in the diagnosis. Novel screening methods by retinal vasculature photography have been developed and also applied. Dementia care, of course, needs to be person-centred throughout the disease trajectory from diagnosis to palliative stage. Key perspectives will be further highlighted in the talk.

■ ABSTRACTS

Dr Norman CHAN

*Specialist in Endocrinology, Honorary Associate Professor,
Department of Medicine, CUHK*



Dr Norman CHAN is an Endocrinologist in the private sector, a Director of the Norton Medical Laboratory and an honorary associate Professor in the Department of Medicine at the Chinese University of Hong Kong.

Born in Wuhan, China, Dr Chan moved to Hong Kong at a young age and then studied in the UK. He graduated from Liverpool University in 1991 and completed his post-graduate training in London. He obtained his MD in 2002 (in London) and was awarded a Fellowship from Royal College of Physicians (Glasgow) in 2006. His MD thesis was in "Endothelial Dysfunction in Type 1 Diabetes".

Dr CHAN began his private practice in HK in 2002, when he helped establish the Qualigenics Diabetes Centre, the first private diabetes centre in Hong Kong. He opened his clinic in Central in 2012. In addition, he has run an Endocrine clinic in Pudong, Shanghai, since 2009.

Dr CHAN has published several book chapters and numerous scientific papers in well-recognised international medical journals such as the Lancet.

■ Diabetesity & Fatty Liver

Obesity is a growing problem globally. Among people in Hong Kong aged between 15 and 84, 32.6 per cent of them are obese, 22 per cent of them are overweight, and 37.8 per cent were classified as centrally obese, according to the Population Health Survey 2020-22 conducted by the Department of Health. Being overweight is strongly associated with non-alcoholic fatty liver disease (NAFLD), which has recently been renamed Metabolic-dysfunction-associated fatty liver disease (MAFLD) based on its association with cardiovascular risk factors. Obesity also causes insulin resistance and type 2 diabetes. In this talk, pathophysiology linking obesity, MAFLD, and type 2 diabetes will be discussed, and clinical cases will be shared.

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||Acute treatment: taken as needed up to once daily. Preventive treatment: taken every other day. The maximum dose per day is 75 mg rimegepant.¹

References:

1. NURTEC (rimegepant) Prescribing Information. Pfizer Corporation Hong Kong Limited; Version November 2022. 2. Croop R, Goadsby PJ, Stock DA, et al. Efficacy, safety, and tolerability of rimegepant orally disintegrating tablet for the acute treatment of migraine: a randomised, phase 3, double-blind, placebo-controlled trial. *Lancet*. 2019;394(10200):737-745. 3. Croop R, Lipton RB, Kudrow D, et al. Oral rimegepant for preventive treatment of migraine: a phase 2/3, randomised, double-blind, placebo-controlled trial. *Lancet*. 2021;397(10268):51-60.

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*Data from 2018 to 2019.³

†Refers to the five extra serotypes covered by PCV20, but not PCV15 (i.e., 8, 10A, 11A, 12F and 15B)

Serotypes 8, 10A, 11A, 12F and 15B are known to cause⁴⁻⁶:



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Outbreaks^{5,6†}

†Outbreaks are caused primarily by serotypes 8 and 12F.^{5,6}



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CFR, case fatality rate; IPD, invasive pneumococcal disease; PCV, pneumococcal conjugate vaccine; PPSV, pneumococcal polysaccharide vaccine.

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■ ABSTRACTS

Dr Ellen Man-wa LUI

*Specialist in Obstetrics and Gynaecology, Honorary Clinical Assistant Professor,
The University of Hong Kong*



Dr Ellen Man-wa LUI is a specialist in obstetrics and gynaecology and an honorary clinical assistant professor at the University of Hong Kong. After finishing her fellowship training in Hong Kong, she completed subspecialty training in reproductive medicine under the Royal College of Obstetricians and Gynaecologists in 2019. She has published over ten articles in peer-reviewed journals during her training and was awarded the SS Ratnam Young Gynaecologists Award of the Asia & Oceanic Federation of Obstetrics and Gynaecology in 2017. Her special interests are in endometriosis and reproductive endocrinology.

■ **Understanding Menopause: An Ignored Medical Condition**

Menopause is one of the inevitable stages of women. Nearly all women suffer from different severity of menopausal symptoms on certain occasions. Symptoms can range from vasomotor symptoms to urogenital symptoms, sleep and mood disturbance, to even sex problems. The mean duration of menopausal symptoms women suffered was 3-5 years. Despite the significant impact, it is a common medical condition that was ignored.

Hormonal replacement therapy is one of the most effective treatments for climacteric symptoms, but the utilisation of it was suboptimal due to different myths and misunderstandings of it. With newer regimens and bio-identical estrogen available, the safety profile of HRT has been improved significantly. Apart from HRT, there are other non-hormonal alternatives available nowadays, which can be one of the alternatives for women contraindicated for HRT or did not want to have hormonal treatment.

Common myths and misunderstandings of menopause, including different treatment modalities, will be discussed.

■ ABSTRACTS

Dr Fanny Wai-fan LAM

MBChB(CUHK), DCH(Irel), MRCP(UK), FHKCPaed, FHKAM(Paed)
Specialist in Developmental-Behavioural Paediatrics
Tutor, the Association for Research in Infant and Child Development, UK
Honorary Clinical Assistant Professor in Paediatrics and Adolescent Medicine,
University of Hong Kong



Dr Fanny Wai-fan LAM is a Developmental-Behavioural Paediatrics with specialist specialising in developmental-behavioural paediatrics, with postgraduate training in Australia and Canada and three decades of clinical and research experience in Hong Kong.

Currently, Dr LAM is the Consultant Developmental Paediatrician at Hong Kong Developmental Paediatrics Centre, Matilda International Hospital, Union Hospital and Gleneagles Hong Kong Hospital. Dr Lam is also actively involved in public and professional education and expert witness services in Paediatrics litigations and medical council inquiries. Currently, she is committed to enabling children to develop their best potential, through the evidence-based and scalable Comprehensive Autism Screening (CAS), a Hong Kong Cyberport-funded Programme.

■ How do Advances in Genomic Testing transform Early Diagnosis of Autism Spectrum Disorder and its Comorbidities?

Autism Spectrum Disorder (ASD) is characterised by impairment in reciprocal social interaction and communication, as well as sensory processing behaviour. ASD is highly heritable, as genes contribute to 40 - 80 % of its risk, and has been related to many genetic disorders and comorbidities (e.g. Developmental Delay, Epilepsy).

Currently, we heavily rely on the clinical diagnosis made by paediatricians through tedious observational assessment, leading to extremely long waiting times and inconsistency of diagnosis.

Since differentiation of polygenic and multifactorial ASD from medically actionable syndromes, as well as earliest identification and intervention is crucial to children presenting with ASD features, we seek to develop a Comprehensive Autism Screening Program which uses scalable and evidence-based tools including next generation Sequencing, Neural Encoding screening (EEG), and faecal microbiome to ascertain ASD risk as early as infancy.

This presentation will present a retro-prospective cohort study paediatrics patients who presented with ASD features or had been diagnosed ASD by Specialist in developmental-behavioural paediatrics composed of about 100 pediatric patients who presented with ASD features or had been diagnosed with ASD by specialists in developmental-behavioural paediatrics using standardised assessment tools. We will present findings, including the yield of medically actionable genetic syndromes and other comorbidities, as well as discuss the implementability of the early screening program at the current stage and in the future.

■ ABSTRACTS

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 of the Hong Kong Medical Association (2008 - present) and Federation of Medical Societies of Hong Kong (2008 - present).

He works as an honourary consultant dermatologist in the Hospital Authority.

■ The Importance of Early Treatment in Psoriasis

Early psoriasis treatment is essential in managing symptoms and preventing disease progression. Early intervention can reduce the incidence of flare-ups and patient outlook. Moreover, early treatment helps to minimise the risk of developing comorbidities such as psoriatic arthritis and cardiovascular diseases. Effective early treatment also enhances overall quality of life, reducing emotional distress. In summary, prioritising early treatment benefits individuals and lessens the long-term healthcare costs related to advanced psoriasis management.

■ ABSTRACTS

Dr CHAN Lung-Wai

MBChB, FRCS(Edin), FCSHK, FHKAM(Surgery)
Specialist in Urology



Dr CHAN is currently the Director of Urology Care and Director of Unity Care in Hong Kong. He was entitled Honorary Clinical Assistant Professor in Urology of the Chinese University of Hong Kong (CUHK) since 1992. He joined Tsuen Wan Adventist Hospital (TWAH) as an associate Urologist in 2008. He started his administrative career after the appointment of Chief of Medical Staff of TWAH since 2011. He established their Lithotripsy Centre in November 2012, and was developing their Urology Centre to stay at cutting edge level abreast with international standards. In 2016, Dr CHAN was appointed a member of the Board of Governors of the Hong Kong Adventist Hospital Foundation (Tsuen Wan). He was also appointed Co-Chairman of the Medical Fund of the Hong Kong Adventist Hospital Foundation (Tsuen Wan).

Dr CHAN graduated from CUHK in 1986. He was trained in Urology under Professor Peter Chan in CUHK since 1992. He obtained the title of Research Fellow in Urological Oncology from Stanford University Medical School in USA in 1997, under the guidance of Professor Thomas Stamey. After returning to Hong Kong he was active in developing laparoscopic urological surgery in CUHK. He founded the Men's Health Clinic in CUHK in 2003, established the Men's Health Centre in Union Hospital in 2005, and became Director of Urology Centre in Union Hospital in 2005. He started his own private practice in 2007.

Dr CHAN has published widely in various medical journals, delivered lectures in international meetings in China, Taiwan and Malaysia; providing medical education talks to doctors in Hong Kong, and offered specialist support to various health organisations and magazines. His research interest is in Minimally Invasive Urological Surgery, Prostatic Diseases and Men's Health.

■ Optimizing Primary Care Management of LUTS in Aging Men: Practical Approaches and Evidence-Based Strategies

Lower urinary tract symptoms (LUTS) are frequently encountered in primary care settings, with their prevalence rising as patients age. Research indicates that 50 % of men aged 50 and above, and up to 80 % of men aged 70 and older, suffer from LUTS. Despite this, a significant number of individuals do not seek medical advice, leading to underdiagnosis in primary care. This presentation aims to equip primary care physicians in Hong Kong with practical advice for assessing and managing LUTS associated with Benign Prostatic Hyperplasia (BPH). Early detection and intervention can slow disease progression and reduce the necessity for surgical intervention. Evaluations can be conducted in the clinic using the International Prostate Symptom Score (IPSS), along with various tests and imaging techniques. The lecture will explore treatment modalities, including lifestyle changes and pharmacological approaches. International guidelines from the European Association of Urology (EAU) and the American Urology Association (AUA) endorse combination therapy (alpha blockers and 5-alpha reductase inhibitors) as a treatment option. Clinical research has shown that combination therapy provides better symptom relief and lowers the risk of disease progression compared to monotherapy. Inadequate treatment can affect prostate volume, lead to bladder remodeling, and increase the incidence of acute urinary retention (AUR). The lecture will conclude with a discussion on strategies for patient follow-up.

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[^] The CombAT study was a 4-year, multicenter, randomised, double-blind, parallel-group study in 4844 men ≥ 50 years of age with BPH. Eligible subjects were randomised to receive one of following treatments orally once daily for 4 years: dutasteride 0.5mg and tamsulosin 0.4mg, dutasteride 0.5mg and tamsulosin-matched placebo, or dutasteride-matched placebo and tamsulosin 0.4mg.
¹ Relative Risk of AUR and BPH-related surgery was reduced by 67.6% [p<0.001] and 70.6% [p<0.001] respectively with combination therapy vs. tamsulosin (combination: n=1610; tamsulosin: n=1611).
² Mean adjusted change in IPSS from baseline to year 4 was -5.0 points for combination therapy versus -3.8 points for tamsulosin [p<0.001]. Change from baseline to year 4 in total prostate volume was -22.3% for combination therapy vs. +4.6% for tamsulosin [p<0.001] [Combination: n=1575; Tamsulosin: n=1582].
³ The 2-year Phase III clinical studies were randomised, double-blind, placebo-controlled of the efficacy and safety of dutasteride 0.5mg once daily in the treatment of men with symptomatic BPH. 4325 patients were randomised to dutasteride 0.5mg/day or placebo. Pooled data from 3 Phase III studies.

AUR: Acute Urinary Retention; BPH: Benign Prostatic Hyperplasia. References: 1. Roehrborn CG, et al. Eur Urol 2010;57(1):123-31. 2. Roehrborn CG, et al. Urology 2002;60:434-441.

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Duodart Prescribing Information:



HK61184-Duodart capsules 0.5mg/0.4mg



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TRELEGY ELLIPTA (fluticasone furoate/umeclidinium/vilanterol) Safety Information^{1,2}

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

TRELEGY Ellipta is indicated for the long-term, once-daily, maintenance treatment of asthma in patients aged 18 years and older who are not adequately controlled with a maintenance combination of a medium or high dose of an ICS and a LABA.^{1,2}

References:

1. TRELEGY Ellipta 100/62.5/25mcg Hong Kong Prescribing Information. Version number HK052023 (GDS11/Canada20230104).
2. TRELEGY Ellipta 100/62.5/25mcg & 200/62.5/25mcg Hong Kong Prescribing Information. Version number HK082023 (GDS11/Canada20230104).

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HK65911 – Trelegy Ellipta
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HK67942 – Trelegy Ellipta
Inhalation powder pre-dispensed
100/62.5/25mcg & 200/62.5/25mcg

■ ABSTRACTS

Dr Phoebe WRIGHT

*BSc, MBChB, MRCP, PGCert
Consultant in Palliative Medicine, Palliative Care Virtual Ward Clinical Lead,
Guy's and St Thomas' NHS Foundation Trust*



Professional Profile

Enthusiastic, motivated and highly collaborative palliative care consultant with a demonstrated ability to deliver quality care for patients and their loved ones across settings. Experience in leading change and innovation, and collaborating with teams across a system having completed the Darzi Fellowship in Clinical Leadership and currently working in a clinical lead role developing a new service. Experience in providing palliative care in different settings and cultures having worked in India and Uganda.

*Education and Qualifications Certificate of Completion of Training in Palliative Medicine General Medical Council (2023) PGCert Leadership in Health (Darzi), Distinction London South Bank University (2021) Specialty Certificate Examination in Palliative Medicine Royal College of Physicians, London (2020) MRCP (UK) Full Diploma Royal College of Physicians, London (2017) MBChB University of Edinburgh (2013) BMedSci Reproductive Biology, 1st class Hons University of Edinburgh (2010) A Levels: 3 As; GCSEs: 10 A*s The School of St. Helen & St. Katharine (1998-2007)*

Career Summary

Jan 2024-Present Consultant in Palliative Medicine and Palliative Care Virtual Ward Clinical Lead, Guy's and St Thomas' NHS Foundation Trust

Oct 2021-Jan 2023 Registrar in Palliative Medicine at Royal Marsden Hospital (ST5); Chelsea and Westminster Hospital (ST6); King's College Hospital (Grace Period)

Sept 2020-Sept 2021 Darzi Fellowship, London South Bank University and Central London Community Healthcare Trust

Oct 2018-Sept 2020 Registrar in Palliative Medicine at Royal Trinity Hospice (ST4) and Meadow House Hospice (ST3)

Aug 2016-Aug 2018 Core Medical Training at The Whittington Hospital, London (2016-2018) Aug 2015-Aug 2016 Year out of training, Pallium India Hospice, Kerala, India (Nov 2015) and Mulago Hospital, Kampala, Uganda (April-July 2016)

Aug 2013-2015 Foundation Year training at Chelsea and Westminster Hospital, London (2013- 2015)

■ Delivering Palliative Care in the UK: Sharing Our Experience

Hospice and Palliative Care are increasingly important for the healthcare needs of our global population. Many countries are rapidly ageing, and cancer or other serious life-limiting conditions are increasingly prevalent in the younger age groups, too. The UK is one of the very first countries where the concept of modern hospice care originated. It has continually developed into its current strength. Much has evolved in the palliative care systems and services deliveries in the UK, to be shared with colleagues in Hong Kong for reference in further development.

■ ABSTRACTS

Assoc Prof Ravindran KANASVARAN

MRCP(UK), BSc(Hons), MD, FAMS(Med Onco)
Chairman and Senior Consultant, National Cancer Centre Singapore



Dr Ravindran KANESVARAN is a chairman/senior consultant in the division of medical oncology at the National Cancer Centre Singapore. He is also an Associate Professor at Duke-NUS Medical School and a clinical senior lecturer at the Yong Loo Lin School of Medicine, National University of Singapore. He is actively involved in graduate medical education and is a core faculty member of the Medical Oncology Senior Residency Program and the Singhealth Internal Medicine Residency Program. He completed his medical oncology speciality training at the National Cancer Centre Singapore. After completing ofng that training, he followed up with a fellowship in genitourinary oncology (GU) and geriatric oncologyat Duke Cancer Institute in North Carolina, USA, on a Healthcare Manpower Development Program (HMDP) scholarship awarded by the Ministry of Health Singapore. His research interests include GU oncology and geriatric oncology. He has published in several well-known peer-reviewed journals, including Journal of Clinical Oncology and Lancet Oncology.

He has also been awarded a number of awards, including the American Society of Clinical Oncology (ASCO GU) Merit Award 2009, the American Association for Cancer Research (AACR) Scholar-in-training Award 2010 and the European Society of Medical Oncology (ESMO) fellowship award 2012. He is currently the President of the Singapore Society of Oncology (SSO) and the Singapore Geriatric Oncology Society. He was appointed European Society of Medical Oncology (ESMO) Faculty 2015-2016. He is on the Scientific and Education Committee and the National Representative for Singapore in the International Society of Geriatric Oncology (SIOG). He was awarded the National Representative of the Year SIOG 2014 award.

■ **Cancer Care for the Older Population: Getting the Right Perspective**

Cancer is very much a disease of the older age groups. With the life expectancy rising in Hong Kong and other parts of the world, many older patients are bearing the brunt of the cancer burden. Geriatric Oncology is now developing into a very relevant clinical interest and service, crossing over and sharing expertise between the two specialities. Recent advances in this emerging field will be shared in the talk.

■ ABSTRACTS

Dr Mario Wai-kwong CHAK

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

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



Dr CHAK is the Associate Consultant at the Department of Paediatrics and Adolescent Medicine in Tuen Mun Hospital. He is also the Honorary Clinical Assistant Professor of The University of Hong Kong and the Clinical Associate Professor (Honorary) of The Chinese University of Hong Kong. Dr CHAK attained the Fellowship of the Hong Kong Academy of Medicine (Paediatrics) and Hong Kong College of Paediatricians in 2002. Dr CHAK was accredited to be the first fellow of the Subspecialty of Paediatric Neurology and Developmental Behavioural Paediatrician in 2013. Dr CHAK is currently a 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 at British Columbia Children's Hospital in Vancouver, Royal Children's Hospital in Melbourne and Department of Epileptology, The University Clinic in Bonn, Fondation Ophtalmologique Adolphe de Rothschild in Paris, respectively. Dr CHAK has passed the ASEPA (Asian Epilepsy Academy)- ASNA (Asean Neurological Association) EEG Examination Board in 2009 and is now certified as qualified Electroencephalographer. Dr CHAK is also the team leader of the Tuen Mun Hospital Paediatrics and Adolescent Epilepsy Surgery Team, which attained the outstanding team award in NTWC in 2016.

Dr CHAK is currently appointed to be the Chairman of the Neurophysiology Subcommittee of the Electro-Medical Diagnostic Unit of New Territories West Cluster.

■ Precision Medicine in Paediatric Epilepsy: What We Learnt from our Past Experience and What Enlightening us from the Recent Advance

Through this talk, we will take this opportunity to discuss how underlying aetiologies and genetic test results affect clinical intervention of drug-resistant epilepsy patients. As we all know, more than one-third of patients with epilepsy are drug-resistant. There is an increased application of resective surgery as a curative treatment for those whose has underlying focal epileptogenic lesions. For those non-surgical candidates, there is an increase in the use of the ketogenic diet and vagus nerve stimulator implantation as adjuvant therapy to improve seizure for those drug-resistant patient who has an underlying genetic causes, acquired brain insult. There are also some drug-resistant epilepsy patients with an underlying immunological or genetic causes whose epilepsy could be benefited from immunotherapy.

With the recent rapid technical advancement of genetic tests, for example, genetic panel, next generation sequencing, whole exome sequencing and whole genome sequencing, we found more and more infants, children and adolescent patients with epilepsy have underlying genetic causes such as chromosomal abnormalities, monogenic mutation, copy number variant, multi genetic interaction etc. The genetic finding opens a window for precision medicine.

■ ABSTRACTS

Dr Christie King-yee CHONG

*Specialist in Psychiatry, Honorary Clinical Assistant Professor,
The University of Hong Kong*



Dr CHONG is a Specialist in Psychiatry and an Honorary Clinical Assistant Professor at the University of Hong Kong. She obtained a Bachelor of Medicine and Bachelor of Surgery from the Chinese University of Hong Kong and a Bachelor of Theology in the Pontifical University of Urbaniana (B.T., P.U.U.Rome).

Dr CHONG is active in international psychiatric and psychological education: she serves as a peer reviewer for the British Medical Journal (BMJ) case reports is on the committee of the World Psychiatric Association (WPA) scientific section on Religion, Spirituality and Psychiatry, and is the Chinese translator of the WPA Position Statement on Spirituality and Religion in Psychiatry. She has a scientific research study regarding the management of mental disorders from family perspective and psychiatric comorbidity in common physical disorders in Hong Kong. She is also a council member of the Hong Kong Community Psychological Medicine Association (HKCPMA) and Hong Kong Andrology and Mens Health Society (HKAMHS) providing high-quality continuous medical education (CME) in psychological medicine for family doctors and specialists who have a special interest in mental health and mens health.

In addition to medical professional education, Dr CHONG is active in professional education and supervises counsellors, social workers, and teachers. She is the honorary consultant for counselling services and SEN (special educational need) student support in local tertiary institutes. She provides professional training in Addiction Psychiatry, in particular pathological gambling and substance addiction, and Child and Adolescent psychiatry for social workers in non-government organisations (NGO). She is the trainer of the Hong Kong Academy of Social Work and Hong Kong Social Workers' Association for supporting SEN students and providing training to teachers in mental health and teenage suicide prevention.

To reduce the stigma towards psychiatric disorders, she has been invited by various mass media for mental health public education. She is also the speaker for the Professional and Continuing Education School mental health programme in Hong Kong.

■ I Will Survive – Update on Management of Treatment-Resistant Depression (TRD)

Student suicide has been a major concern for medical professionals, social workers and educators in recent years. DSM-5 diagnostic criteria of Major Depressive Disorder include “recurrent thought of death, recurrent suicidal ideation without a specific pain, or a suicide attempt or a specific plan for committing suicide.” Therefore, the presence of suicidal ideas in adolescents is an important clue for doctors when assessing their mental conditions. It is more common in children and adolescents to have atypical presentation of mood disorder. A depressed mood can be presented as an irritable mood, and somatic symptoms are more common. Treatment of early onset depression is challenging because of the difficulty in identifying atypical symptoms and significant variation in treatment responses, which may be related to different co-morbidities. Depression in adolescents may persist in adulthood and develop treatment-resistant depression (TRD). In this lecture, clinical management with risk assessment of treatment-resistant depression (TRD) will be discussed, which includes characteristics of early onset depression, analysis of co-morbidities (ADHD, ASD, Irritable bowel syndrome, eating disorder), and clinical management of treatment-resistant depression using Esketamine nasal spray.

■ ABSTRACTS

Dr XU Lijian

*Scientist, Centre for Perceptual and Interactive Intelligence,
The Chinese University of Hong Kong*



XU Lijian is a scientist in the Centre for Perceptual and Interactive Intelligence at the Chinese University of Hong Kong. He received PhD in Mechanics from Chiba University in 2017, an M.S. from Shanghai Jiao Tong University in 2013, and a B.E. from Zhejiang University in 2010. Dr XU's research is on the interface of medical image analysis, computer mechanics and machine learning. His current work is related to cardiovascular biomechanics, with research activities being focused on the development of computational modelling methods for addressing biomechanical problems related to cardiovascular pathophysiology or those arising from clinical practice and biomechanics-inspired innovation of medical devices for non-invasively assessing cardiovascular mechanical/functional indices. He is an author of over twenty peer-reviewed journal papers and an inventor of three authorised patents.

■ A Multimodal Large Language Model with Advanced Generalisability and Explainability for Medical Data Understanding and Generation

Medicine is inherently multimodal and multitasking, with diverse data modalities spanning text and imaging. However, most models in the medical field are unimodal single tasks and lack good generalisability and explainability. In this talk, I will introduce some traditional computational modelling and image analysis approaches for addressing biomechanical problems related to cardiovascular pathophysiology. After that, I will focus on our current research on novel deep learning approaches towards a generalist model for medical data that can flexibly encode and interpret various forms of medical data.

■ ABSTRACTS

Dr Carrison Ka-shun TONG

Medical Physicist, Pamela Youde Nethersole Eastern Hospital



Carrison Ka-shun TONG finished his PhD in Medical Imaging at the Royal Postgraduate Medical School, Imperial College, UK. Dr TONG is a fellow member of British Computer Society, professional member of Institution of Mechanical Engineers, Chartered Engineer and Scientist. Dr TONG was been working as a Medical Physicist for Pamela Youde Nethersole Eastern Hospital (PYNEH) since 1996. He has published more than forty papers in the area of medical imaging and modelling.

Dr TONG has built various medical imaging networks for different specialties including Nuclear Medicine Departments, Radiology Departments, Neurosurgery Departments, Ear Noise Throat Department, Dental & Maxillofacial Surgery Department, and Oncology Department for surgical and treatment purposes. From 1999 to 2003, Dr TONG was appointed medical physicist in-charge for the building of the Tseung Kwan O Hospital as the first filmless hospital project in Hong Kong and PR China which project has awarded the ISO27000 certificate. From 2006 to 2023, Dr TONG has been awarded 9 Hong Kong Information & Communication Technology (HKICT) Awards including grand, gold, silver, and bronze awards, 3 Asia Pacific Information & Communication Technology Awards, 2 HKIE Grand Awards, 2 finalist certificates in the Science and Engineering Visualization Challenge 2006 organized by National Science Foundation and Science.

■ Artificial Intelligent Aided 3D Printing for High-risk Medical Procedure Training Models

Thoracentesis, Vascular Cannulation, Robotic Partial Nephrectomy, Cranioplasty, Stenting for Brain and Aorta Aneurysms are essential skills for life saving in hospitals. Junior doctors need hands on experience on these trainings. Otherwise, it will be too risk both for doctors and patients. Traditional trainings were performed through reading, lecturing, virtual operation using computer simulation, and operation on dead animals. However, reading and lecturing can provide theory only. Computer simulation is expensive and can provide a visual environment only. The dead animals have no blood flow and pressure. A multi-disciplinary team in Pamela Youde Nethersole Eastern Hospital has developed 3D Printed Haptically corrected and Ultrasound Visible Human Models providing high fidelity teaching and training for trainers and trainees. The traditional medical training has been changed from “See One, Do One, Teach One” into “See Many, Do Many, Teach Many”.

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Abbreviations: BDNF, brain-derived neurotrophic factor; MDD, major depressive disorder.

References: 1. Wu H, et al. Biol Psychiatry. 2021 Jun 1;89(11):1030-1032. 2. Hayley S, et al. Front Cell Neurosci. 2013 Nov 20;7:218. 3. Castrén E, et al. Biol Psychiatry. 2021 Jul 15;90(2):128-136. 4. Bathina S, et al. Arch Med Sci. 2015 Dec 10;11(6):1164-78. 5. Salahudeen MS, et al. Ther Adv Drug Saf. 2020 Jul 23;11:2042098620937899. 6. Jamieson C, et al. Health Qual Life Outcomes. 2023 May 8;21(1):40. 7. Canuso CM, et al. J Clin Psychopharmacol. 2021 Sep-Oct 01;41(5):516-524. 8. Daly EJ, et al. JAMA Psychiatry. 2019;76(9):893-903. 9. Zaki N, et al. Neuropsychopharmacology. 2023 Jul;48(8):1225-1233. 10. SPRAVATO® Hong Kong Prescribing Information P03.

■ CHAIRPERSONS

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*



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.

Dr Alson Wai-ming CHAN

*FHKAM(Paed), FHKCPaed, FRCPCH, DCH(Ireland), Dip Ger Med RCPS(Glasg),
PDipCmmunityGeriatrics(HK), MBChB
First Fellow, Subspecialty of Paediatric Immunology,
Allergy & Infectious Diseases,
Specialist in Paediatric Immunology, Allergy and Infectious Diseases
Hon Secretary, The Federation of Medical Societies of Hong Kong*



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

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

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

■ CHAIRPERSONS

Dr Edwin Chau-leung YU

*FRCP(Glas), FHKAM, FHKCPaed, Croucher Fellow, MBA, RCMP
Currently Director, InteMed Hong Kong
Adjunct Professor, The Chinese University of Hong Kong
Exco Member, The Federation of Medical Societies of Hong Kong*



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

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

Dr Samuel Ka-Shun FUNG

*MBBS(HKU), FRCPI, FRCPE, FRCPL, FHKCP, FHKAM(Int Med)
Consultant Physician, Department of Medicine & Geriatrics,
Princess of Margaret Hospital
Exco Member, The Federation of Medical Societies of Hong Kong*



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

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

Dr FUNG served as Hong Kong college of Physician Specialty Programme Director, Nephrology Training Board, Kowloon Region; Hon Associate Professor of the CUHK, Council member and past chairman of Society HONG Kong Society of Nephrology and to serve the community in the board of the Hong Kong Kidney Foundation.

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

■ CHAIRPERSONS

Dr Kingsley Hau-ngai CHAN

*FRCP(Edinburgh), FRCP(Glasgow), FHKAM(Medicine), FHKCP,
Diploma in Dermatology(Glasgow), MRCP(UK), MBBS(HK)
Specialist in Dermatology & Venereology
Exco Member, The Federation of Medical Societies of Hong Kong*



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 of the Hong Kong Medical Association (2008 - present) and Federation of Medical Societies of Hong Kong (2008 - present).

He works as an honorary consultant dermatologist in the Hospital Authority.

Ms Ellen Wai-yin KU

*RN, BHSc(Nursing), MPh
Senior Lecturer, S.K. Yee School of Health Sciences, Saint Francis University
President, College of Nursing, Hong Kong
Executive Member of Chinese Nurses Association
Executive Committee Member of Federations of Medical Societies
Board member of eHealth Consortium
Exco Member, The Federation of Medical Societies of Hong Kong*



She serves as the president of College of Nursing Hong Kong, which is the regional member association of International Council of Nurses (ICN). She is a graduate of Global Nursing Leadership Institute, International Council for Nurses (ICN), 2012. Since 2015, she worked on service-learning projects with students of various disciplines to promote healthy living at developing countries, namely Kyrgyzstan, Vietnam, Rwanda and Myanmar. She serves as professional consultant to various Non-governmental organisations for service development and training.

■ 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, noninvasive 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.

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■ CHAIRPERSONS

Dr Jane Chun-kwong CHAN

*MD(U Chicago), FHKCP, FHKAM(Medicine),
Diplomate American Board of Internal Medicine,
Specialist in Respiratory Medicine
Exco Member, The Federation of Medical Societies of Hong Kong*



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

Dr Ludwig Chun-hing TSOI

*MBChB, MPH, MRCP, FRCP, FRCSEd, FHKCEM, FHKAM(Emergency Medicine), LLM
Consultant, A&E Department, Queen Mary Hospital
2nd Vice-President, The Federation of Medical Societies of Hong Kong*



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

■ CHAIRPERSONS

Dr Mario Wai-kwong CHAK

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

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



Dr CHAK is the Associate Consultant at the Department of Paediatrics and Adolescent Medicine in Tuen Mun Hospital. He is also the Honorary Clinical Assistant Professor of The University of Hong Kong and the Clinical Associate Professor (Honorary) of The Chinese University of Hong Kong. Dr CHAK attained the Fellowship of the Hong Kong Academy of Medicine (Paediatrics) and Hong Kong College of Paediatricians in 2002. Dr CHAK was accredited to be the first fellow of the Subspecialty of Paediatric Neurology and Developmental Behavioural Paediatrician in 2013. Dr CHAK is currently a 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 at British Columbia Children's Hospital in Vancouver, Royal Children's Hospital in Melbourne and Department of Epileptology, The University Clinic in Bonn, Fondation Ophtalmologique Adolphe de Rothschild in Paris, respectively. Dr CHAK has passed the ASEPA (Asian Epilepsy Academy)- ASNA (Asean Neurological Association) EEG Examination Board in 2009 and is now certified as qualified Electroencephalographer. Dr CHAK is also the team leader of the Tuen Mun Hospital Paediatrics and Adolescent Epilepsy Surgery Team, which attained the outstanding team award in NTWC in 2016.

Dr CHAK is currently appointed to be the Chairman of the Neurophysiology Subcommittee of the Electro-Medical Diagnostic Unit of New Territories West Cluster.

Ms Tina Woan-tyng YAP

*Registered Pharmacist
Fellow, Hong Kong College of Pharmacy Practice (2022)*



Tina YAP graduated from the University of Kansas, USA with the degree of Bachelor of Science in Pharmacy. She currently works in a pharmaceutical company as the Company Pharmacist supervising product registration, quality assurance and marketing of pharmaceutical products.

Honorary Posts

Honorary Treasurer - The Federation of Medical Societies of Hong Kong
Chairman - The Pharmaceutical Distributors Association of Hong Kong
Executive Committee Member - The Pharmaceutical Society of Hong Kong
Committee Member (Manufacturers Licensing) - Pharmacy & Poisons Board, HKSAR

Past Honorary Post

Non-official member (2009 - 2010)
Review Committee on Regulation of Pharmaceutical Products in Hong Kong, HKSAR

■ CHAIRPERSONS

Dr Victor Hip-wo YEUNG

*MBBS(HK), FRCSEd(Urology), FCSHK, FHKAM(Surgery)
Honorary Clinical Assistant Professor, Department of Surgery(CUHK)
Specialist in Urology
Exco Member, The Federation of Medical Societies of Hong Kong*



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 the Johns Hopkins University Hong Kong Alumni Association (JHUKHAA). Also, he is the Vice-President of the Hong Kong Medical Association (HKMA) and the University of Hong Kong Medical Alumni Association (HKUMAA). In addition, he is the Honorary Treasurer of the Hong Kong Society of Practising Urologists (HKSPU), the Chairman of the Ethics Committee and council member of the Medical Council of Hong Kong (MCHK), the Federation of Medical Societies of Hong Kong (FMSHK) and the Hong Kong Society of Endourology (HKSE).

Dr SIU Kwai-ming

*MBChB(CUHK), FHKCOS, FHKAM(Ortho), FRCS Ed(Ortho)
Consultant, Department of Orthopaedics and Traumatology,
Princess Margaret Hospital and North Lantau Hospital
Exco Member, The Federation of Medical Societies of Hong Kong*



Dr SIU graduated from the Chinese University of Hong Kong in 1989. He has been a Fellow of the Royal College of Surgeons of Edinburgh (Ortho.), Fellow of the Hong Kong College of Orthopaedic Surgeons and Fellow of the Hong Kong Academy of Medicine (Orthopaedic Surgery) since 1998.

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

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

He has been the invited speaker for various international and regional conferences e.g. Scientific Meeting of the International Federation of Foot and Ankle Societies (IFFAS), Asian Pacific Orthopaedic Association Congress, International Annual Congress of Chinese Orthopaedic Association, Scientific Meeting of the Asian Federation of Foot & Ankle Societies and Parekh Global Foot & Ankle Town Hall Meeting.

■ CHAIRPERSONS

Dr Raymond See-kit LO

*MBBS(Lond), MD(CUHK), MHA(UNSW), Dip Geri Med(RCPS),
Dip Palliative Med(U Wales), MRCP(UK), FRCP(Lond, Edin, Glas), FHKCP, FHKAM
Specialist in Geriatrics Medicine
Honorary Clinical Professor, Department of Medicine and Therapeutics,
The Chinese University of Hong Kong
Honorary President, Federation of the Medical Societies of Hong Kong
President, British Medical Association(Hong Kong)*



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

Dr LO is the Honorary President, Past President of the Federation of Medical Societies of Hong Kong, and 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 the British Medical Association (Hong Kong), expediting various activities, including the popular annual BMA(HK) Advance in Therapeutics Course.

Dr Raymond LO's clinical and research interests range from prevention and rehabilitation to palliation in various conditions of adults and older people, eg dementia screening and management, stroke prevention and rehabilitation, orthogeriatric condition and pain management, and palliative care for all ages.

■ CHAIRPERSONS

Dr Janice TSANG

*MBBS, MRCP(UK), FRCP(Lond), FRCP(Edin), FHKCP, FHKAM(Medicine)
Specialist in Medical Oncology, Hon. Clinical Assistant Professor,
Li Ka Shing Faculty of Medicine, The University of Hong Kong
Founding Convenor, Hong Kong Breast Oncology Group (HKBOG)
Founding Convenor, Hong Kong Society of Geriatric Oncology (HKSGO)*



Dr Janice TSANG is a Specialist in Medical Oncology and the immediate past Assistant Dean (Alumni Affairs) at the Li Ka Shing Faculty of Medicine, The University of Hong Kong. Janice is currently the Hon. Clinical Assistant Professor at the Li Ka Shing Faculty of Medicine, The University of Hong Kong. Her research interests lie mainly in Breast Oncology, Geriatric Oncology, Translational Research and Psycho-Oncology. Being the first female academic medical oncologist at The University of Hong Kong, Dr. Tsang was awarded the 2014 Hong Kong Ten Outstanding Young Persons Award, and the 2012 Hong Kong City Lady Award (Professional & Academic Category) as the only medical professional receiving this award for the year. She was also the winner of the Psychosocial Oncology Young Investigator Award at the 16th Hong Kong International Cancer Congress & 6th Annual Meeting of Centre for Cancer Research in 2009 and was bestowed the Faculty Teaching Medal in 2012, and the Outstanding Teaching Award (Team Award) for Medical Humanities in 2013 in recognition of her being one of the pioneers in incorporating Medical Humanities in the formal medical curriculum. She has conducted over 80 clinical trials including local, regional and international multi-centred clinical trials, and has been serving as Chairperson for Data Monitoring Committee, Steering Committee Members for major multi-centred clinical trials, and various International and Regional Advisory Boards. She is a key opinion leader in breast oncology both locally and regionally. Janice is the Founding Convenor of the Hong Kong Breast Oncology Group (HKBOG) which is a member of the “Breast International Group” (BIG), being the third Asian member after Japan and Taiwan. She was appointed as Chair of the CTRG Audit Committee for the National Cancer Institute in 2017, and a member of the International Society of Geriatric Oncology (SIOG), serving as co-track chair for translational research, and Publication Committee Member in SIOG, and the Founding Convenor of the Hong Kong Society of Geriatric Oncology (HKSGO) which is part of the SIOG. Janice also served as the Co-Chair of the Organizing Committee of the 8th Global Chinese Breast Cancer Organizations Alliance Conference 2021 with Hong Kong as the hosting city.

Currently, Janice serves on the Scientific Committee for the European Society of Medical Oncology (ESMO) 2025 as the Track Chair for the Metastatic Breast Cancer Scientific Committee, and she has served on the Scientific Committee for the “Metastatic Breast Cancer Track” for the ESMO Annual Congress 2023 in Madrid, and the ESMO Breast Meetings in 2023 & 2024 in Berlin. She also serves on the ESMO National Representatives Committee as the representative for Hong Kong SAR, China, and the Deputy Chair for the ESMO Women for Oncology (W4O) Committee. Women in Medicine and Holistic Medicine are also areas of research interests for Janice as she serves as the Deputy Chairman for the ESMO W4O Committee, and the Founding Convenor of the Hong Kong Women for Oncology (HKW4O). Since the challenge of COVID-19, she serves as member of the World Health Organization (WHO) Faith-Based Organizations Communities of Practice Research & Learning Committee, the Co-Convenor for the Anglican

■ CHAIRPERSONS

Health & Community Network (AHCN), and the Anglican Representative Member on Commission of Health & Healing at the World Council of Churches in Geneva.

Janice is currently a Member of the Specialty Board of Medical Oncology and used to be the Programme Director for Medical Oncology in the Hong Kong Island at the Hong Kong College of Physicians, a member of the Co-ordinating Committee (CoC) for Medical Oncology at the Hospital Authority, and the Deputy Chairperson for the Institutional Review Board for the Hong Kong West Cluster/ HKU (2012-2016). She was the Director of Cancer Centre at the Queen Mary Hospital (2015-2016). She has various appointments in different professional bodies such as the Honorary Advisor for various cancer self-help groups including the Hong Kong Christian Cancer Care Association, the Haven of Hope Holistic Care Centre etc. She serves as Executive Committee Member and Medical Advisor for the Hong Kong Cancer Fund, and the Education Committee Member for the Hong Kong Anti-Cancer Society etc. Furthermore, Janice is involved in various public services including serving on the Social Welfare Advisory Committee and the Rehabilitation Advisory Committee at the HKSAR Government. She is the Founding Vice President of the Hong Kong Women Doctors Association (HKWDA), now the Hon. Councilor of the HKWDA, the Immediate Past Warden of the Starr Hall at The University of Hong Kong, and the Vice President of the Hong Kong Women Professionals & Entrepreneurs Association.

Furthermore, Janice is an alumnus of the Hong Kong Sheng Kung Hui Ming Hua Theology College and has completed her Clinical Pastoral Education Training in 2018 and 2019, further studied the DMin programme at The Graduate Institute of the College of Pastoral Supervision & Psychotherapy (CPSP) with the Dean, Professor Raymond Lawrence with particular research interests in psycho-oncology, breast cancer patients and geriatric oncology patients and families. She is also trained in qualitative analyses with Emeritus Professor Cecilia Chan and Professor Siu-Man Ng at the Department of Social Work & Social Administration, Faculty of Social Sciences, The University of Hong Kong.

■ MEMO

Japanese expert consensus:
1st line recommendation for
both sleep initiation and
maintenance insomnia¹

Say Goodnight to Insomnia with DAYVIGO

Help patients fall asleep fast and stay asleep longer with minimal residual morning effects^{2,3}

DAYVIGO is a DORA indicated for both sleep onset and maintenance by regulating the sleep-wake cycle.⁴

Clinical Efficacy



Improved sleep efficiency, onset and maintenance^{2*}



Long-term benefits continued over 12 months²



Successful next-dose transition from a GABA agonist[†] to DAYVIGO⁵

Safety Profile



Chronic treatment was not associated with physical dependence or withdrawal effects^{2,4}

Minimal residual effects on:³



Postural stability



Memory



Driving capabilities



Well tolerated in switch patients⁵

*Within the first week of treatment. [†]Immediate- and extended-release.

DORA, dual orexin receptor antagonist; GABA, gamma aminobutyric acid.

ABBREVIATED PRESCRIBED INFORMATION INDICATION. • DAYVIGO (lemborexant) is an orexin receptor antagonist indicated for the treatment of adult patients with insomnia, characterized by difficulties with sleep onset and/or sleep maintenance. **CONTRAINDICATIONS.** • DAYVIGO is contraindicated in patients with narcolepsy. **WARNINGS AND PRECAUTIONS.** • Central Nervous System (CNS) Depressant Effects and Daytime Impairment: • DAYVIGO can impair daytime wakefulness. CNS depressant effects may persist in some patients up to several days after discontinuing DAYVIGO. Prescribers should advise patients about the potential for next-day somnolence. • Driving ability was impaired in some subjects taking DAYVIGO 10 mg. Risk of daytime impairment is increased if DAYVIGO is taken with less than a full night of sleep remaining or if a higher than recommended dose. If taken in these circumstances, patients should be cautioned against driving and other activities requiring complete mental alertness. • Co-administration with other classes of CNS depressants (e.g., benzodiazepines, opioids, tricyclic antidepressants, alcohol) increases the risk of CNS depression, which can cause daytime impairment. Dosage adjustments of DAYVIGO and concomitant CNS depressants may be necessary when administered together. Use of DAYVIGO with other drugs to treat insomnia is not recommended. Patients should be advised not to consume alcohol in combination with DAYVIGO. • Because DAYVIGO can cause drowsiness, patients, particularly the elderly, are at a higher risk of falls. Sleep Paralysis, Hypnagogic/Hypnopompic Hallucinations, and Cataplexy-Like Symptoms: • Sleep paralysis, an inability to move or speak for up to several minutes during sleep-wake transitions, hypnagogic/hypnopompic hallucinations, including vivid and disturbing perceptions can occur with DAYVIGO. Prescribers should explain the nature of these events to patients when prescribing DAYVIGO. • Symptoms similar to mild cataplexy can occur with DAYVIGO and can include periods of leg weakness lasting from seconds to a few minutes, can occur either at night or during the day, and may not be associated with an identified triggering event (e.g., laughter or surprise). Complex Sleep Behaviours: • Complex sleep behaviours, including sleep-walking, sleep driving, and engaging in other activities while not fully awake (e.g., preparing and eating food, making phone calls, having sex), have been reported to occur with the use of hypnotics such as DAYVIGO. Events can occur in hypnotic-naïve and hypnotic-experienced persons. Patients usually do not remember these events. Complex sleep behaviours may occur following the rest or any subsequent use of DAYVIGO, with or without the concomitant use of alcohol and other CNS depressants. Discontinue DAYVIGO immediately if a patient experiences a complex sleep behaviour. Patients with Compromised Respiratory Function: • The effect of DAYVIGO on respiratory function should be considered for patients with compromised respiratory function. DAYVIGO has not been studied in patients with moderate to severe obstructive sleep apnoea (OSA) or chronic obstructive pulmonary disease (COPD). Worsening of Depression/Suicidal Ideation: • Incidence of suicidal ideation or suicidal behaviour, as assessed by questionnaire, was higher in patients receiving DAYVIGO than placebo (0.3% for DAYVIGO 10 mg, 0.4% for DAYVIGO 5 mg, and 0.2% for placebo). In primarily depressed patients treated with hypnotics, worsening of depression and suicidal thoughts and actions (including completed suicides) have been reported. Suicidal tendencies may be present in such patients and protective measures may be required. Intentional overdose is more common in this group of patients; therefore, the lowest number of tablets that is feasible should be prescribed at any one time. The emergence of any new behavioural sign or symptom of concern requires careful and immediate evaluation. Need to Evaluate for Co-morbid Diagnoses: • Treatment of insomnia should be initiated only after careful evaluation of the patient. The failure of insomnia to remit after 7 to 10 days of treatment may indicate the presence of a primary psychiatric and/or medical illness that should be evaluated. Worsening of insomnia or the emergence of new cognitive or behavioural abnormalities may be the result of an unrecognized underlying psychiatric or medical disorder and can emerge during the course of treatment with sleep-promoting drugs such as DAYVIGO. **ADVERSE REACTIONS.** • The most common adverse reaction (reported in 5% of patients treated with DAYVIGO and at least twice the rate of placebo) in one study and (0% for DAYVIGO 10 mg, 7% for DAYVIGO 5 mg, 1% for placebo) in another study was somnolence. **DRUG INTERACTIONS.** • Drugs Having Clinically Important Interactions with DAYVIGO: • The maximum recommended dose of DAYVIGO is 5 mg no more than once per night when co-administered with weak CYP3A inhibitors. Avoid concomitant use of DAYVIGO with moderate or strong CYP3A inducers. **USE IN SPECIFIC POPULATIONS.** • Pregnancy: • There are no available data on DAYVIGO use in pregnant women to evaluate for a drug-associated risk of major birth defects, miscarriage, or adverse maternal or foetal outcomes. Lactation: • There are no data on the presence of DAYVIGO in human milk, the effects on the breastfed infant, or the effects on milk production. Infants exposed to DAYVIGO through breastmilk should be monitored for excess sedation. Geriatric Use: • Exercise caution when using doses higher than 5 mg in patients - 65 years old. Renal Impairment: • Patients with severe renal impairment may experience an increased risk of somnolence. Hepatic Impairment: • The maximum recommended dose of DAYVIGO is 5 mg no more than once per night in patients with moderate hepatic impairment. DAYVIGO is not recommended in patients with severe hepatic impairment. Patients with mild hepatic impairment may experience an increased risk of somnolence. **DRUG ABUSE AND DEPENDENCE.** • Abuse: • Individuals with a history of abuse or addiction to alcohol or other drugs may be at increased risk for abuse and addiction to DAYVIGO, follow such patients carefully. Dependence: • Chronic administration of DAYVIGO did not produce withdrawal signs or symptoms upon drug discontinuation. This suggests that DAYVIGO does not produce physical dependence. Please see the full Prescribing Information.

References: 1. Takeasu Y, et al. *Front Psychiatry* 2023;14:1168100. 2. Yardley J, et al. *Sleep Med* 2021;80:333-342. 3. Moline M, et al. *Postgrad Med* 2021;133:71-81. 4. DAYVIGO® (lemborexant) [Prescribing Information]. Hong Kong: Eisai Hong Kong Co., Ltd; 2021. 5. Rosenberg R, et al. *Am J Geriatr Psychiatry* 2021;29:45.



Eisai (Hong Kong) Company Limited
Unit D, 18/F, Lee & Man Commercial Centre,
169 Electric Road, North Point, Hong Kong
Tel: (852) 2516 6128 | Fax: (852) 2561 5042

DAYVIGO
(lemborexant) 5mg tablets

HK-DG-MM-23G-01

IS NOW AVAILABLE IN HONG KONG



The **FIRST** disease-modifying therapy received
FULL approval from FDA for early Alzheimer's Disease¹⁻³

LEQEMBI® allows those affected by early AD*
to preserve precious time and live an independent life.⁴



Dual-acting LEQEMBI® clears not only plaques,
but also protofibrils, the most neurotoxic form of Aβ.^{4,5}



*MCI due to AD and mild AD

Abbreviations: Aβ, amyloid-beta; AD, Alzheimer's Disease; FDA, Food and Drug Administration; MCI, mild cognitive impairment

References: 1. U.S. Food & Drug Administration. Available online: <https://www.fda.gov/news-events/press-announcements/fda-converts-novel-alzheimers-disease-treatment-traditional-approval>. Last accessed: 28 June 2024. 2. LEQEMBI® Hong Kong Prescribing Information (Version April 2024). 3. Hoang LS, et al. *Alzheimers Res Ther*. 2024;16(1):105. 4. van Dyck CH, et al. *New Engl J Med*. 2023;388(1):9-21. 5. Hampel H, et al. *Mol Psychiatry*. 2021;26(10):5481-503.

LEQEMBI® Abbreviated Prescribing Information

LEQEMBI® (Lecanemab) concentrate for solution for infusion 200 mg/2 mL, 500 mg/5 mL

Indication: LEQEMBI is indicated for the treatment of Alzheimer's disease. Treatment with LEQEMBI should be initiated in patients with mild cognitive impairment or mild dementia stage of disease, the population in which treatment was initiated in clinical trials. **Dosage and administration:** The recommended dosage of LEQEMBI is 10 mg/kg that must be diluted then administered as an intravenous infusion over approximately one hour, once every two weeks. If an infusion is missed, administer the next dose as soon as possible. **Contraindications:** LEQEMBI is contraindicated in patients with serious hypersensitivity to lecanemab or to any of the excipients of LEQEMBI. **Warnings and precautions:** Amyloid Related Imaging Abnormalities (ARIA): ARIA, characterized as ARIA with edema (ARIA-E) and ARIA with hemosiderin deposition (ARIA-H), can be caused. ARIA usually occurs early in treatment and is usually asymptomatic, although serious and life-threatening events, including seizure and status epilepticus, rarely can occur. When present, reported symptoms associated with ARIA may include headache, confusion, visual changes, dizziness, nausea, and gait difficulty. Focal neurologic deficits may also occur. Symptoms associated with ARIA usually resolve over time. The risk of ARIA, including symptomatic and serious ARIA, is increased in apolipoprotein E ε4 (ApoE ε4) homozygotes. Intracerebral hemorrhages greater than 1 cm in diameter have also occurred in patients treated with LEQEMBI. **Hypersensitivity reactions:** Hypersensitivity reactions, including angioedema, bronchospasm, and anaphylaxis, have occurred in patients who were treated with LEQEMBI. Promptly discontinue the infusion upon the first observation of any signs or symptoms consistent with a hypersensitivity reaction, and initiate appropriate therapy. LEQEMBI is contraindicated in patients with a history of serious hypersensitivity to lecanemab or to any of the excipients of LEQEMBI. **Infusion-related reactions:** Infusion-related reactions were mostly mild (69%) or moderate (28%) in severity. Symptoms of infusion-related reactions include fever and flu-like symptoms (chills, generalized aches, feeling shaky, and joint pain), nausea, vomiting, hypotension, hypertension, and oxygen desaturation. In the event of an infusion-related reaction, the infusion rate may be reduced, or the infusion may be discontinued, and appropriate therapy initiated as clinically indicated. Prophylactic treatment with antihistamines, acetaminophen, nonsteroidal anti-inflammatory drugs, or corticosteroids prior to future infusions may be considered. **Adverse reactions:** The most common adverse reaction (led to discontinuation in 2% of patients treated with LEQEMBI) was infusion-related reactions in one study, and ARIA-H microhemorrhages in another study. Common adverse reactions (reported in at least 5% of patients treated with LEQEMBI 10 mg/kg every two weeks and at least 2% higher than placebo) include headache, cough, diarrhea, ARIA-E, superficial siderosis of central nervous system, rash, and nausea/vomiting. Refer to the full Prescribing Information for other adverse reactions. **Use in specific populations:** **Pregnancy:** There are no adequate data on the safety of LEQEMBI use in pregnant women. **Lactation:** There are no data on the presence of LEQEMBI in human milk, the effects on the breastfed infant, or the effects of the drug on milk production. **Pediatric use:** Safety and effectiveness of LEQEMBI in pediatric patients have not been established. **Geriatric use:** No overall differences in safety or effectiveness of LEQEMBI have been observed between patients 65 years of age and older and younger adult patients. **Storage:** Unopened vial: Store in a refrigerator at 2°C to 8°C. Store in the original carton to protect from light. Do not freeze or shake. **Diluted solution:** [See Dosage and Administration (2.4)]. Please refer to the full Hong Kong Prescribing Information for details.

HK-LEQ-1-1003 (Aug 2024)

Eisai (Hong Kong) Company Limited

Unit A, 29/F, Lee & Man Commercial Center, 169 Electric Road,
North Point, Hong Kong
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Maintaining fluid balance in hyponatremia with **SAMSCA®**¹

Thinking One Step Ahead



SAMSCA® is indicated for the treatment of clinically significant hypervolemic and euvoletic hyponatremia [serum sodium <125mEq/L or less marked hyponatremia that is symptomatic and has resisted correction with fluid restriction], including patients with heart failure and SIADH.²

Effective in correcting hyponatremia in CHF and SIADH patients over 24 hours³



Significantly increased the average daily AUC of change from baseline in **serum sodium concentration** vs. placebo^{1*}

- Day 4: 4.0 mEq/L vs. 0.4 mEq/L ($p < 0.0001$)
- Day 30: 6.2 mEq/L vs. 1.8 mEq/L ($p < 0.0001$)



Significant effect on **fluid balance** in HF patients with hyponatremia at Day 1¹

SAMSCA® -1860ml vs. placebo -787ml (p -value=0.0027)



Help **preserving renal function** in HF patients with baseline hyponatremia⁴



*Data based on the pooled analysis in the placebo-controlled phase 3 hyponatremia trials which enrolled the subjects with euvolemic or hypervolemic hyponatremia

AUC: area under the curve; CHF: congestive heart failure; HF: heart failure; SIADH: Syndrome of Inappropriate Antidiuretic Hormone

References

1. Integrated Summary of Efficacy of Tolvaptan for the Indication of Hyponatremia (2017). Otsuka Pharmaceutical Development & Commercialization, Inc. 2. SAMSCA Hong Kong Prescribing Information. Revised Mar 2019. 3. Muris JP, Bohn AM, Newkirk BD, et al. *Am J Kidney Dis*. 2016 Jun;111(5):772-782. 4. Kurland MM, Sheorajpuri M, Burnell JC, et al. *JAMA*. 2017;297(12):1318-1331.

Abbreviated Prescribing Information

SAMSCA (tolvaptan) 15 mg & 30 mg oral tablets. INDICATION: Treatment of clinically significant hypervolemic and euvoletic hyponatremia (serum sodium <125 mEq/L or less marked hyponatremia that is symptomatic and has resisted correction with fluid restriction), including patients with heart failure and Syndrome of Inappropriate Antidiuretic Hormone (SIADH). DOSAGE: Patients should be in a hospital for initiation and titration of therapy to evaluate the therapeutic response. For rapid correction of hyponatremia (e.g., >12 mEq/L/24 hours) oral use is not recommended. Recommended starting dose: 15 mg once daily. Dose may be increased at intervals of 24 hr to 30 mg once daily, and to a maximum of 60 mg once daily. Limit use to 30 days to minimize the risk of liver injury. Avoid fluid restriction during the first 24 hours of therapy. CONTRAINDICATIONS: Anionemia; Concomitant Hepatic or Renal Disease; Agent used to raise serum sodium activity; Ability of the patient to absorb or adequately respond to thirst. HYPERNATREMIA: Hyponatremia. Concomitant use of strong CYP3A4 inhibitors (e.g., azole antifungals, macrolides, tetracyclines, tacrolimus, sirolimus, cyclosporine, grapefruit juice) is not recommended. Avoid co-administration with CYP3A4 inducers. Sildenafil: Avoid use in patients with underlying liver disease. Not recommended for patients with CVD <10 mg daily. WARNINGS AND PRECAUTIONS: Avoid co-administration with moderate CYP3A4 inhibitors. The rapid correction of serum sodium can cause serious neurologic sequelae. Liver injury & discontinuous treatment have been associated with symptoms indicative of liver injury. Cholestasis and Hypoalbuminemia. Caution when co-administered with hypotensive agents not recommended. Avoid co-administration with CYP3A4 inducers. Sildenafil may be increased when co-administered with high inhibitors. Monitor signs of hyponatremia and caution when co-administered with drugs that increase serum potassium. ADVERSE REACTIONS: Thirst, dry mouth, anorexia, constipation, polyuria or polydipsia, hyperglycemia, pyrexia & anorexia. DRUG INTERACTIONS: CYP3A4 inhibitors, grapefruit juice, P-gp inhibitors, strong and oral CYP3A4 inducers, concomitant use increases digoxin AUC. For details, please refer to the full prescribing information which is available upon request. (Last full revision: Mar 2019; Last Update: Oct 2022)

Otsuka

Otsuka Pharmaceutical (H.K.) Ltd.

21/F, East Exchange Tower, 38 Leighton Road, Causeway Bay, Hong Kong.
Tel: 2881 6299 Fax: 2577 5206

BRING PROTECTION TO LIFE IN CKD



Now Recommended as
First-Line Treatment in
KDIGO 2024 CKD Guideline^{*,11,1}



↓39%

Composite of CKD progression, ESKD, or renal or CV death vs placebo (NNT=19 patients)[§]

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



↓31%

All-cause mortality vs placebo

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



↓29%

Composite of CV death or hHF vs placebo

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



Slowed eGFR deterioration

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



Consistent efficacy[§]

Regardless of T2D status³, baseline eGFR^{11,2}, CKD stage^{**} and aetiology^{††,3,4}



Simple and well tolerated

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

INITIATE TREATMENT^{§§}

GFR

≥25



For broad range* of CKD patients,
TREAT EARLY WITH FORXIGA NOW**

* FORXIGA is indicated for the treatment of chronic kidney disease in adult patients with or without T2D.⁶

[§] Primary composite endpoint of ≥50% sustained decline in eGFR, reaching ESKD, or renal or CV death. ESKD is defined as maintenance dialysis for ≥28 days, kidney transplantation, or an estimated GFR of <15 mL per minute per 1.73 m² confirmed by a second measurement after ≥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, glomerulonephritis, 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.

^{§§§} Consistent efficacy regardless of T2D status and eGFR baseline.

AKI, acute kidney injury; CI, confidence interval; CKD, chronic kidney disease; CV, cardiovascular; eGFR, estimated glomerular filtration rate; ESKD, end-stage kidney disease; GFR, glomerular filtration rate; HF, heart failure; hHF, hospitalization for heart failure; HR, hazard ratio; KDIGO, Kidney Disease Improving Global Outcomes; NNT, number needed to treat; SAE, serious adverse event; SGLT2i, sodium-glucose co-transporter-2 inhibitor; T2D, type 2 diabetes; UACR, urine albumin-creatinine ratio.

References: 1. KDIGO. Kidney Int. 2024 Apr;105(4S):S117-S314. 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. 6. FORXIGA 10 mg film-coated tablets. Hong Kong Prescribing Information. December 2023.



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